

Paper 12i

Recommendation <input checked="" type="checkbox"/> DECISION <input checked="" type="checkbox"/> NOTE	The Trust Board is asked to <ul style="list-style-type: none"> • Receive the performance report in relation to key quality indicators as at the end of February 2018 • Question the report to ensure appropriate assurance is in place
Reporting to:	Trust Board
Date	29 March 2018
Paper Title	Quality Performance Report
Brief Description	<p>The purpose of this report is to provide the Board with assurance relating to our compliance with quality performance indicators during February 2018.</p> <p>Key points to note:</p> <ul style="list-style-type: none"> • The Quality and Safety Committee received the paper on 21 March 2018 <p>The Trust is compliant with a number of quality measures however:</p> <ul style="list-style-type: none"> • We are not compliant with Mixed Sex Accommodation (MSA) requirements due to the number of patients that wait for more than 12 hours to be transferred from our critical care units. • Whilst we have made an improvement in training compliance for Prevent, we will not, on current trajectory, achieve 85% compliance by the end of March 2018 (end of Feb position 37%) with WRAP training requirements • We continue to have 4 hour breaches in our EDs with 12 SI 12 hour breaches outlined within this paper • 1 Never Event in February • C Difficile cases 2 in month with 14 proven lapses of care ytd against a contractual threshold of 25 • Maternity performance exceptions are outlined
Sponsoring Director	Deirdre Fowler, Director of Nursing and Quality
Author(s)	Dee Radford, Associate Director of Patient Safety Sarah Jamieson, Head of Midwifery
Recommended / escalated by	Quality and Safety Committee
Previously considered by	Quality and Safety Committee
Link to strategic objectives	<p>Patient and Family – through partnership working we will deliver operational performance objectives</p> <p>Safest and Kindest – delivering the safest and highest quality care causing zero harm</p>

Link to Board Assurance Framework	RR561 RR951 RR1185
Equality Impact Assessment	<input checked="" type="radio"/> Stage 1 only (no negative impacts identified) <input type="radio"/> Stage 2 recommended (negative impacts identified) <ul style="list-style-type: none"><input type="radio"/> negative impacts have been mitigated<input type="radio"/> negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	<input type="radio"/> This document is for full publication <input type="radio"/> This document includes FOIA exempt information <input type="radio"/> This whole document is exempt under the FOIA

Strategic Objectives 2017/18

PATIENT AND FAMILY - Deliver a transformed system of care (VMI) and partnership working that consistently delivers operational performance objectives

SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm

SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach

HEALTHIEST HALF MILLION ON THE PLANET – Build resilience and social capital so our communities live healthier and happier lives and become the healthiest 0.5 million on the planet through distributed models of health

INNOVATIVE AND INSPIRATIONAL LEADERSHIP - Through innovative and inspirational leadership achieve financial surplus and a sustainable clinical services strategy focussing on population needs

VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce

BAF Risks

If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards (RR 561)

If we do not work with our partners to reduce the number of patients on the Delayed Transfer of Care (DTC) lists, and streamline our internal processes we will not improve our 'simple' discharges (RR 951)

If there is a lack of system support for winter planning then this would have major impacts on the Trust's ability to deliver safe, effective and efficient care to patients (RR 1134)

If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage (RR 1204)

If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected (RR 1185)

If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision (RR 1186)

If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients (RR 668)

If we are unable to resolve the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties & address the modernisation of our ageing estate & equipment (RR 670)

If we do not deliver our CIPs and budgetary control totals then we will be unable to invest in services to meet the needs of our patients (RR1187)

If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve (RR 423)

Risk to sustainability of clinical services due to shortages of key clinical staff (RR 859)



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Quality Performance Report

March 2018

Introduction

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of February 2018 (Month eleven of 2017/2018). The report will provide assurance to the Trust that we are compliant with key performance measures and that where we have not met our targets that there are recovery plans in place.

The report was submitted to the Quality and Safety Committee on 21 March 2018.

The report is also submitted to our commissioners (Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group) to provide assurance to them that we are fulfilling our contractual requirements as required in the Quality Schedule of our 2017-2018 contract.

This report relates to the Care Quality Commission (CQC) domains of quality – that we provide safe, caring, responsive and effective services that are well led, as well as the goals laid out within our organisational strategy and our vision to provide the safest, kindest care in the NHS.

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Section one: Our Key Quality Measures

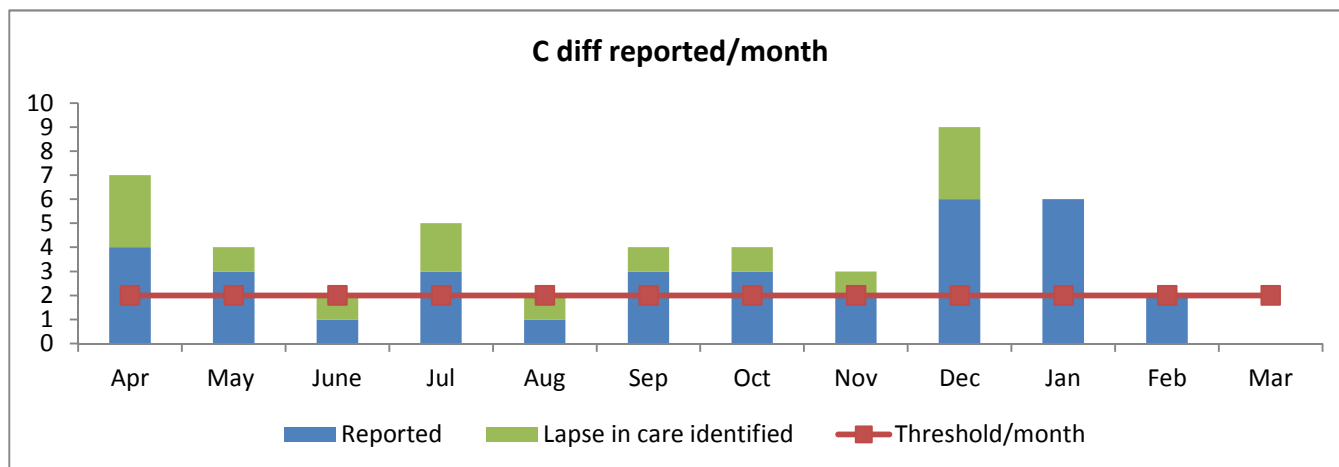
Measure	Year end 16/17	Mar 17	April 17	May 17	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Year to date 2017/18	Monthly Target 2017/18	Annual Target 2017/18
CDI due to lapse in care (CCG panel)			3	1	1	2	1	1	1	1	3			14	0	25
Total CDI reported	21	3	3	4	3	1	3	1	1	3	6	6	2	33	None	None
MRSA Bacteraemia Infections	1		0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia Infections	9	1	0	1	1	1	6	2	3	2	4	2	3	25	None	None
E. Coli Bacteraemia Infections	31	1	1	1	1	1	3	3	1	4	2	6	5	28	None	None
MRSA Screening (elective) (%)	95.2	95.5	95.5	95.4	95.9	95.9	95.6	95.6	95.5	96.4	96.0	94.0	95.0	95.5	95%	95%
MRSA Screening (non elective) (%)	94.4	95.2	95.2	96.3	95.0	96.1	96.1	97.0	97.2	95.3	95.5	94.8	94.0	95.8	95%	95%
Grade 2 Avoidable	35	6	3	2	2	4	3	3	4	4	2	2	3	32	0	0
Grade 2 Unavoidable	112	9	10	19	6	12	16	13	7	10	9	7	8	117	None	None
Grade 3 Avoidable	9	0	0	0	1	0	1	2	1	3	0	0	0	8	0	0
Grade 3 Unavoidable	9	1	0	1	2	4	3	0	2	1	1	3	3	20	None	None
Grade 4 Avoidable	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grade 4 Unavoidable	2	0	0	0	1	0	0	0	0	0	0	0	0	1	None	None
Falls reported as serious incidents	5	0	0	0	1	0	1	0	0	0	0	0	0	2	None	None
Number of Serious Incidents	61	1	2	4	6	1	4	4	10	7	3	8	15	63	None	None

Measure	Year end 16/17	Mar 17	April 17	May 17	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Year to date 2017/18	Monthly Target 2017/18	Annual Target 2017/18
Never Events	5	0	0	0	0	0	0	0	1	0	0	0	1	2	0	0
Harm Free Care (%)	94.17%	93.9	94.31	94.81	93.48	91.15	92.09	89.91	90.86	90.45	89.06	90.16	92.52	91.94	None	95%
No New Harms (%)	97.94%	97.16	98.47	98.18	97.49	95.24	96.59	96.83	96.34	94.84	94.0	96.82	96.13	96.52	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE Assessment		95.96	95.6	95.5	95.4	95.2	95.4	96.4	95.9	95.5	95.1	95.68		95.6	95%	95%
MSA including ITU discharge delays>12hrs	361	30	26	17	37	39	31	37	33	39	17	28	35	369	None	None
Complaints (No)	424	49	44	56	42	61	50	45	45	61	31	49	60	593	None	None
Friends and Family Response Rate (%)	23.8%	23.8	32.2	22.5	23.3	19.5	20.1	18.3	15%	14.3%	12.3%	11.1%	13.6%	13.6%	None	None
Friends and Family Test Score (%)	96.6%	96.6	97.1	96.7	97.0	96.2	97.1	97.2	96.1	96.8	97.4	96.6	96.2%	96.2%	75%	75%

Section Two: Key Messages by exception

Infection Prevention and Control

Clostridium Difficile Infections (CDI)



The Commissioning panel has met for cases up to the end of Qtr 3. To date they have identified 14 cases of CDI that they felt were due to lapses in care on the part of the Trust. In addition there are a further two cases that were not submitted to panel as the lapses in care, when reviewed internally, were clear. This brings the number of attributable CDI to 16 against an annual threshold of 25.

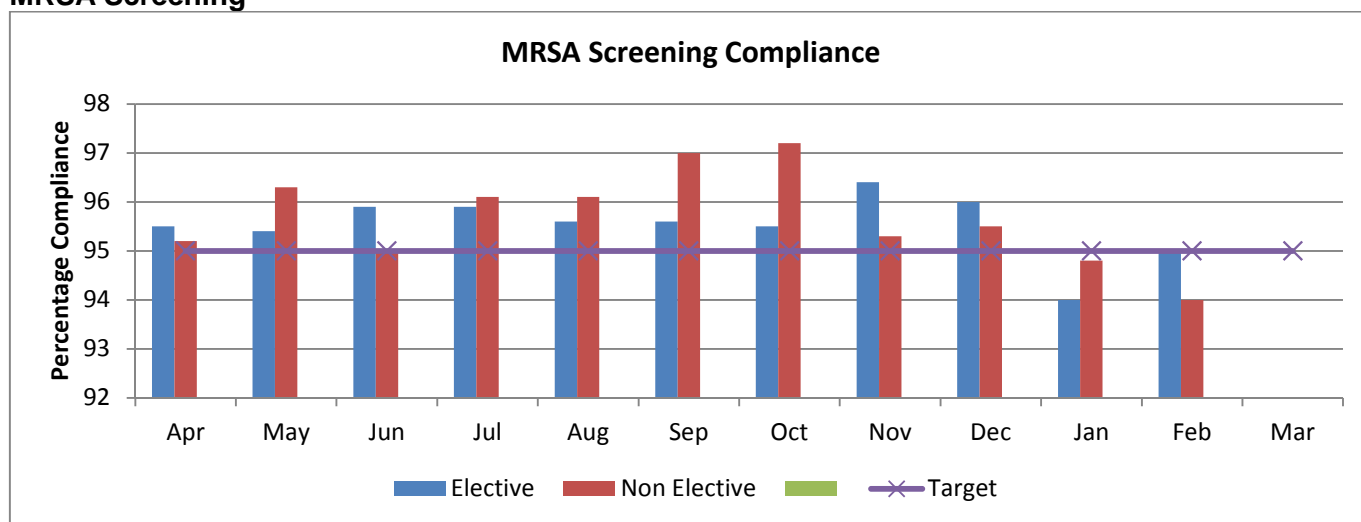
Issues considered to be lapses in care

- Lack of evidence of antimicrobial stewardship/poor active input from pharmacist during admission and treatment not in line with Trust antibiotic policy.
- Lack of assurance that cross infection had not taken place due to poor levels of hygiene in the environment and on equipment from quality walks.
- Delay in isolating patients at times, wards isolating after result rather than on symptoms
- Inadequate action plan to address the issues (in some cases the action plan was not complete)

Interventions put in place by the Trust to prevent further cases of CDI

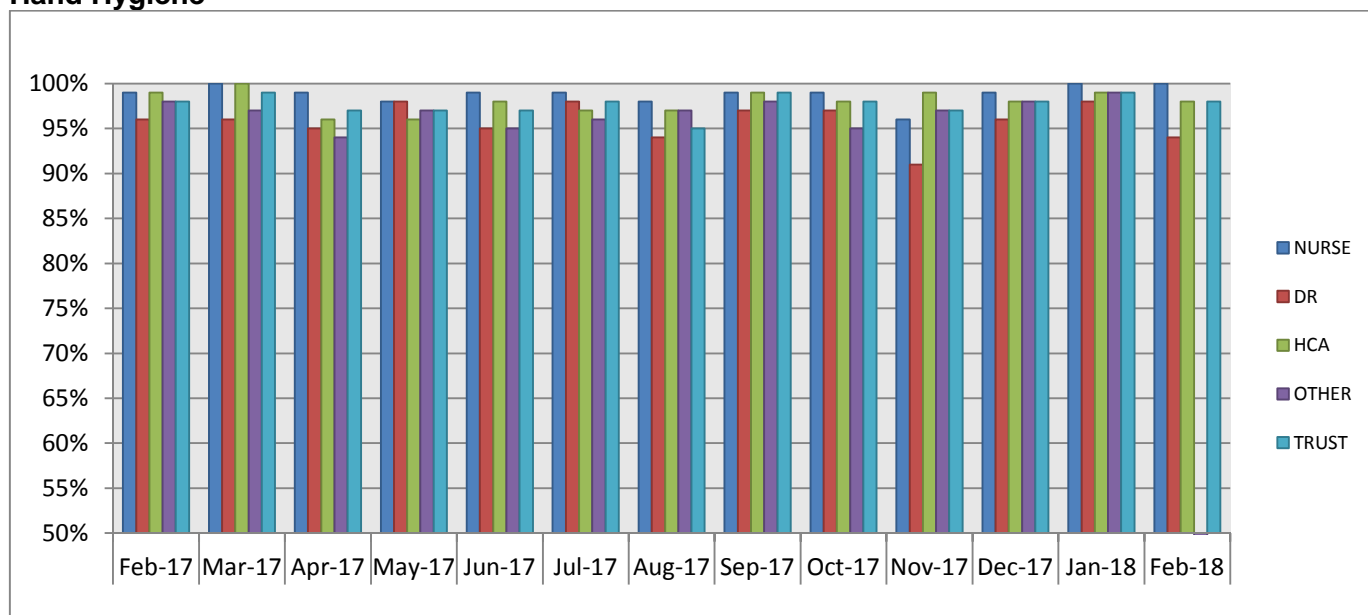
- Antibiotic stewardship (audits of prescribing but also all antibiotic prescriptions are checked by pharmacy staff to ensure they are in line with guidelines).
- Care Groups to lead on investigation and provide assurance to CCG that actions from lapses of care are being addressed
- Reinforcing need for rapid testing and isolation via statutory training and link nurses, reminding staff of need to escalate if no side room is available
- Monitoring environmental cleanliness through daily domestic supervisor monitoring (all wards are routinely Tristel cleaned once a month), weekly and monthly ward manager audits, multidisciplinary walkabouts (matrons, estates, domestic services, IPC), quality ward walks by IPC staff
- Continuing to complete investigations for all SaTH apportioned cases and feeding back common problems through Band 7 meetings, 'episodes of care', and clinical governance meetings
- IPC mandatory training, hand hygiene audits as per Trust high impact intervention programme, hand hygiene assessments (now also being put into place for doctors)

MRSA Screening



The overall compliance rate for MRSA screening for the year to date is above 95% for both elective and non elective patients. However, in January compliance dropped to below 95% for both with elective achieving 95% in February. The total number of patients affected in February were 151 non elective patients (out of a total of 2,450) and 41 out of a total of 828 for elective.

Hand Hygiene



The chart shows the hand hygiene results for the Trust by staff group which were:

- Nursing Staff 100%
- Medical Staff 94%
- Health care Assistants 98%
- Other staff Groups 97%

Overall compliance in the Trust was 98%.

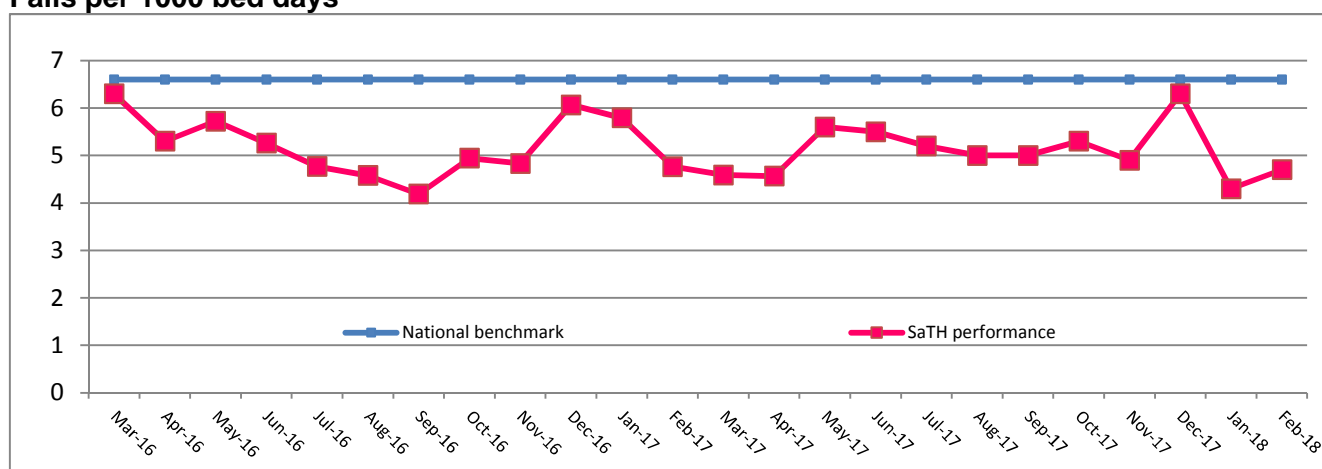
Learning from falls

In February 2018, we did not report any falls resulting in fractures as serious incident, but there were two falls resulting in fractures which were determined suitable to manage as High Risk Case Review (HRCR):

Fall injury	Rationale for not reporting as an SI
Fall – chipped teeth	Relevant risk reduction strategies in place, i.e. correct footwear, call bell in hand, yellow wrist band etc. Patient used bedside table to steady himself, this moved and unbalanced him precipitating the fall (Not RIDDOR reportable)
Fractured wrist & C1/2	Patient was independently mobile, was in the waiting area of the renal unit, bent to pick up an item and tripped over her husband's leg. Deemed severe harm and has been referred to UHNM, but determined to be an unpredictable and unpreventable incident

The chart below shows that we remain below the national benchmark for falls per 1000 bed days to February 2018.

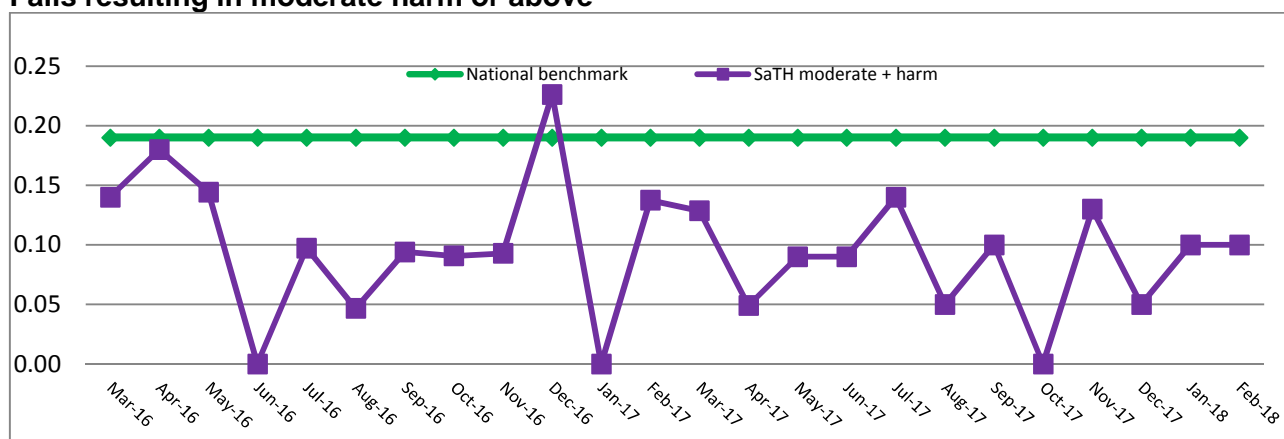
Falls per 1000 bed days



The chart below shows that we also remain below the benchmark for falls resulting in moderate harm or above to February 2018.

Since December 2016 the Trust has sustained a lower than the national benchmark number of falls resulting in moderate harm or above for our patients. The inference is that while there has been an increase in reporting of falls during December, this has not resulted in more significant harms, the falls prevention strategies for our highest risk patients therefore appears to continue to be effective.

Falls resulting in moderate harm or above



Learning from pressure ulcers

In February there were three grade 3 pressure ulcers that developed which did not meet the criteria for reporting as Serious Incidents and are in the process of being managed as High Risk Case Reviews

High Risk Case Review (HRCR) Pressure Ulcers February 2018

Grade 3 PU	WD 4TO	Combination moisture lesion/grade 3; despite best efforts and a number of factors, TVN/Ward Manager and Matron concur that this was unavoidable.
Grade 3 PU	WD 25C	Grade 3 developed; Patient was at the end of their life and engagement with patient and family agreed that patient comfort and wishes highest priority.
Grade 3 PU	WD 24E	All appropriate care in place. Patient has multiple co-morbidities. Good evidence of monitoring, management and escalation. Overall agreement that this appears to be unavoidable.

Three grade 3 pressure ulcers have so far been determined to be avoidable for February 2018; the contributory factors/learning is below:

Case 1

Delay in obtaining pressure relieving cushion for high risk patient. Although some compliance issues were recorded as patient declined to have skin checks.

Case 2

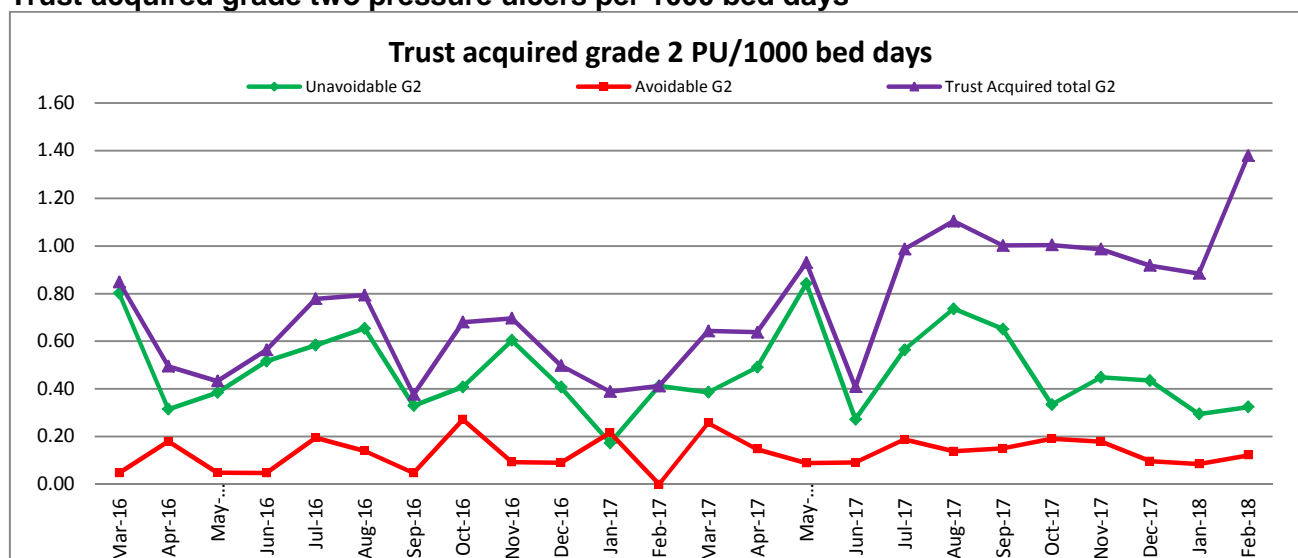
Lack of compliance is well documented, patient was confused, staff did not engage with family as additional step to gain support with repositioning plan. Wound improved, as did patient engagement, as delirium resolved.

Case 3

Generally good engagement with the patient, clear records of explanation of plans regarding skin integrity. However, possible delay in obtaining pressure relieving cushion, but may be a factor associated with poor documentation.

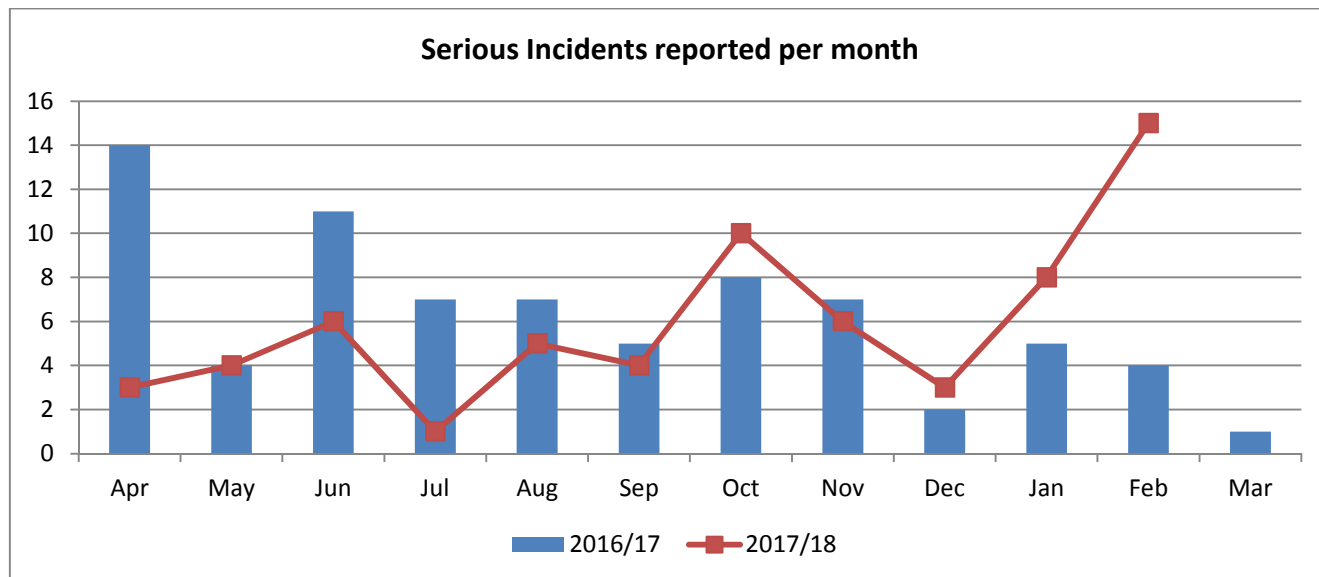
The numbers of pressure ulcers that we are reporting are shown in the table below. This indicates that overall the total number of grade two pressure ulcers reported has increased since June 2017. There are still a number that require investigations to be carried out by the ward manager to identify whether these were avoidable.

Trust acquired grade two pressure ulcers per 1000 bed days



Learning from serious incidents

In February we reported 15 serious incidents. This increase (from eight the previous month) reflects the continued requirement to report 12 hour breaches as serious incidents and brings the total reported to 63 in the year to date compared to 61 in the whole of 2016-2017.



Details of the serious incidents reported

In February we reported 12 serious incidents relating to thirty 12 hour trolley breaches all of which occurred in January 2018. Some incidents relate to multiple breaches which occurred on the same day and therefore can be reported on one StEIS report. However, if breaches occur on the same day but on different sites, then more than one report has to be submitted as StEIS is site specific.

Although investigation is still in progress the initial review of these incidents shows the following:

- The potential to review and agree a pathway for transfer to another local Trust
- One admission appeared to be purely social due to the patient's living arrangements
- Staff shortages and adverse weather noted as reasons for some of the delays

A more detailed report and action plan will be brought to the Committee when all investigations are complete – we plan to have an overarching action plan to pull together the issues and the learning across all the incidents.

In addition we reported three further serious incidents:

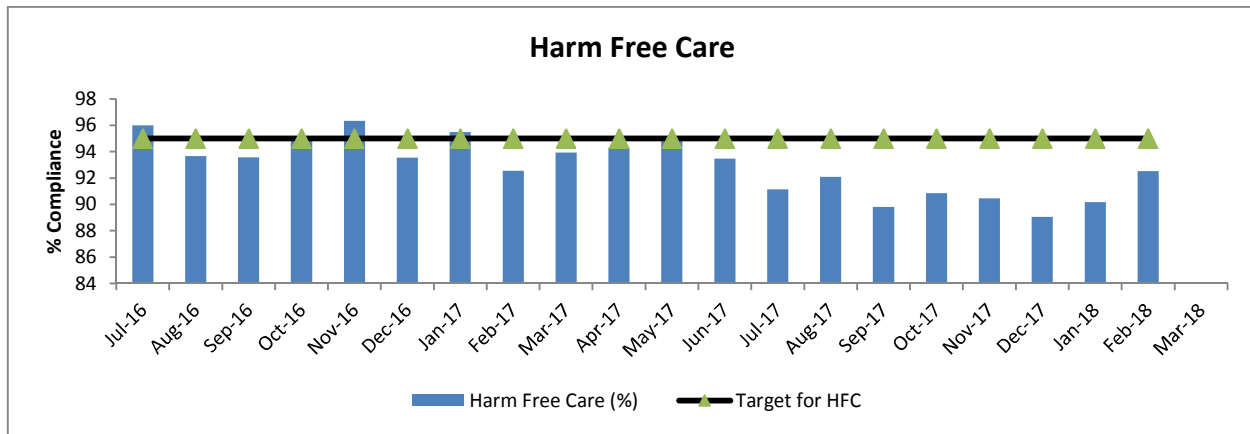
- One related to the care of a patient that had arterial disease that required urgent surgery. It was reported as an SI due to a delay in treatment, the investigation will try to ascertain if the delay impacted on the outcome and if earlier intervention may have prevented the need for a life-saving amputation.
- One related to the care of a patient that had undergone a procedure at a different Trust and then presented at ED at PRH. From the information available there appears to be a delay in implementing treatment for this gentleman following his arrival at PRH Emergency department resulting in a cardiac arrest and subsequent death. We are reviewing our input into this patient's care as are the other Trust.

- One Never Event was reported in February – the administration of Oromorph (a medication that should be taken orally) through the IV route. This brings the total number of Never Events in the Trust in year to two. This has been reported appropriately and in line with our Trust Standing Operating Procedure and the investigation into this case has begun.

NHS Safety Thermometer

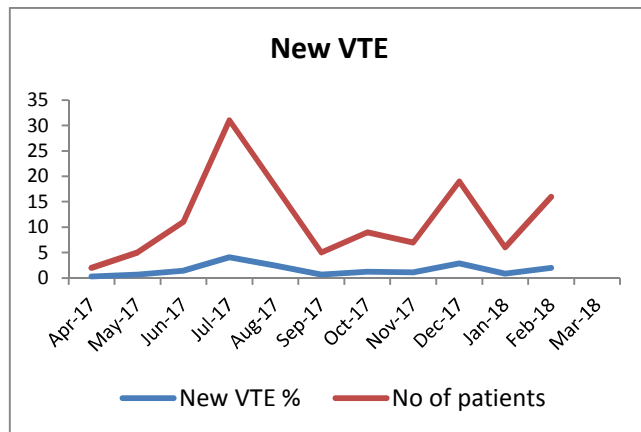
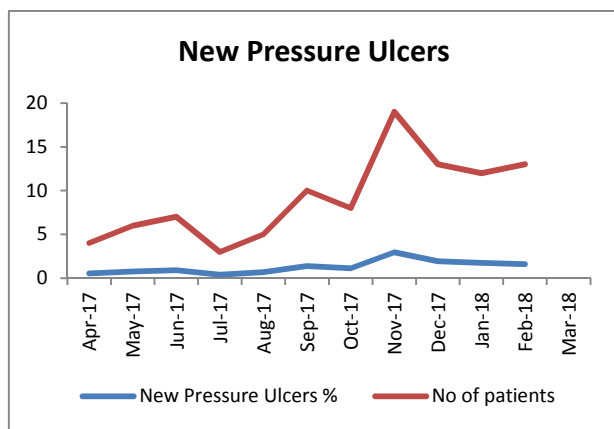
In February 2018 the total cohort for the NHS Safety Thermometer measurement was 802 patients. Of these, 742 were found to be harm free from the four harms in the data collection – falls, pressure ulcers, VTE and catheter associated urinary tract infections. This is equivalent to 92.52% of the cohort.

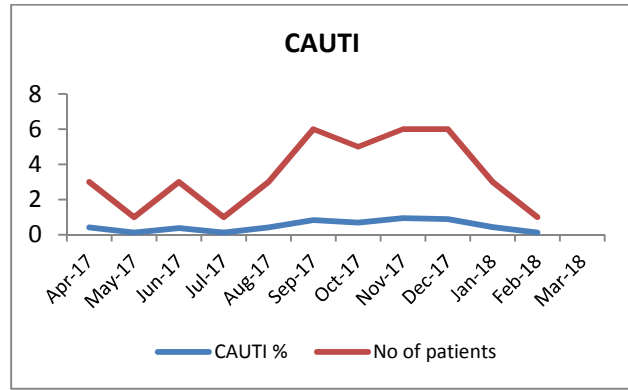
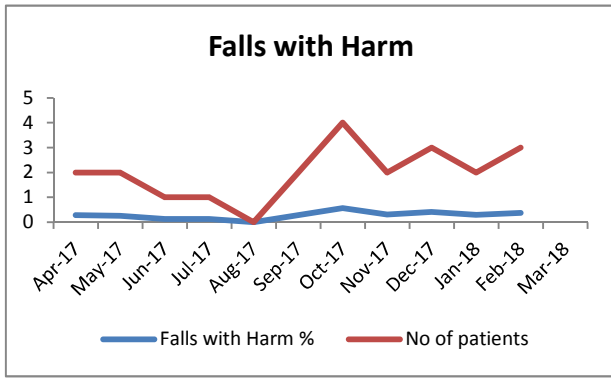
The tool measures “old” and harm – that which occurred before the patient was admitted (for example, a pressure ulcer or a fall in the previous 72 hours) and “new” harm – that which occurred in our care.



New Harms

A total of 31 patients were recorded as having at least one of the four harms (3.87% of the cohort) in February 2018. The trends over the financial year are shown in the graphs below:





The Quality and Safety Committee requested further detail to provide assurance about the harms that we are recording. A recent paper has been received relating to falls prevention and a detailed report into pressure ulcer incidence is expected in May 2018. The Committee noted the reduction in CAUTI over the period and agreed that further investigation into the VTE figures would also be required.

Mixed Sex Accommodation (MSA) Breaches

We have not reported any mixed sex accommodation breaches in the Trust in February in any areas outside our intensive care areas. The total number of MSA breaches outside these areas during 2017-2018 affected four patients in one incident.

In February we saw a slight increase in the number of patients that were waiting more than 12 hours to be transferred from our high dependency areas to a ward. This was due to the pressures on the sites particularly at the Royal Shrewsbury Hospital where 21 patients waited more than 12 hours, 18 of whom were delayed more than 24 hours. At the Princess Royal Hospital three patients waited between 12 and 24 hours and eleven over 24 hours.

Whilst waiting for transfer patients are cared for in an area that may have members of the opposite sex also receiving care. Every effort is made to ensure that patients' privacy and dignity is maintained during this time and that when a bed is available on the appropriate ward they are moved as soon as possible. The number of patients waiting for transfer is discussed at the three times a day bed meeting so that a suitable bed is identified for them in a timely way.

Safeguarding Vulnerable Adults and Children

In February there were seven safeguarding concerns raised which involved the Trust – five were raised by the Trust against others and two were made by residential and nursing homes against the Trust. Investigations are progressing. Further detail will be provided in the quarterly report in April.

In February the Trust raised one safeguarding concern relating to a child that had been admitted with an injury.

The Committee received a verbal update in relation to the recent publicity surrounding Child Sexual Exploitation (CSE) in Telford and Wrekin. The Safeguarding Children's Board for Telford and Wrekin met on 21 March 2017 and have requested that providers share a number of key facts with their staff in order to provide clarity for them and members of the public. The Trust will ensure that these facts are shared with staff through a One Minute Brief.

Additionally an extraordinary meeting of the Safeguarding Group will be convened as soon as possible to consider whether we are doing all we can to ensure that we are meeting the needs of children and young people who may be at risk of CSE not only in Telford and Wrekin but also in Shropshire. The outcome of the meeting will be presented to the Quality and Safety Committee to provide assurance that our processes are robust.

We continue to prioritise the Prevent training (part of the counter terrorism strategy) in the Trust. We will not meet the requirement of 85% of appropriate staff having received the one hour Workshop to Raise Awareness of Prevent (WRAP) by the end of March 2018 but we continue to improve and have now recorded that 37% of those staff that need to attend the enhanced training have done so.

Patient, Family and Carer Experience

Complaints and PALS

Sixty complaints were received in February 2018. Twelve of these related to closures of rural Midwife Led Units (MLUs). The remaining complaints were primarily about staff attitude, communication and clinical treatment.

A total of 121 PALS contacts were received. The majority of contacts related to cancelled appointments and poor communication although there are no trends noted within this.

Patient Experience

The overall percentage of patients who would recommend the ward they were treated on to friends and family, if they needed similar care and treatment, was 96.2%. This was a slight decrease compared to last month.

Individually, Maternity and Inpatients saw an increase in the proportion of patients who would recommend compared to last month. A&E and Outpatients however saw a decrease compared to January.

The overall response rate was 13.6% which was an increase compared to January's response rate of 11.1%. Individually, Inpatients, A&E and Maternity Birth saw an increase in the response rates. We are also exploring a variety of different platforms with to collect the FFT survey data in an attempt to increase our response rate. We have modified the ward IPads that are currently used by ward staff to collect RATE data to include the FFT question. We are encouraging wards to use their volunteers to ask patients to complete the FFT survey on the IPads. The Trust has recently recruited Emergency Department volunteers, part of their role will to be distributing the FFT cards to patients.

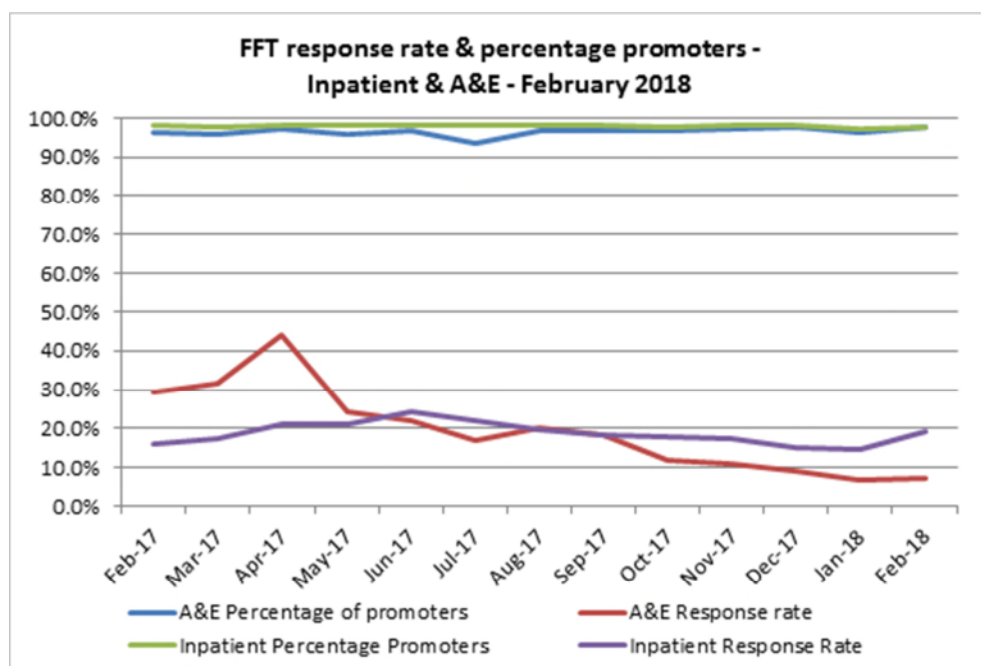
The Trust is also exploring the use of a text based FFT survey with Netcall, a SMS provider we currently use for text appointment reminders.

The Committee were made aware that NHS England has announced a review of the Friends and Family Test. The FFT gathers huge volumes of feedback, and publishes them on a monthly basis. NHS England's Director for Patient Experience acknowledges that the FFT "has not been without its problems and criticisms". But he feels that overall "it has raised the bar, helping patients influence decisions large and small and lifting the morale of staff".

Among other things, the review will consider:

- Changing the wording of the FFT question.
- Removing the burden in meeting some of the specifics in the guidance (such as the 48-hour rule for acute trusts and the fixed "touchpoints" across maternity care).
- Supporting the best possible use of the data and increasing the value of it.

	Percentage Promoters	Response Rate
Maternity overall	97.3%	7.8% (Birth only)
A&E	94.2%	7.4%
Inpatient	97.7%	19.3%
Outpatients	95.5%	NA



Section three: Maternity Dashboard

The maternity dashboard is attached at Appendix One to this report.

The report will provide the Board with an analysis of data within the maternity dashboard for February 2018. The report highlights the RAG rating elements by exception and indicates a description for the indicators that are red or amber below:

Telford Consultant Unit Births. The expected locally set range for this descriptor is between 300-350 births per month. February 2018 has seen a live delivery figure of 289. The rolling year total births for the Consultant Unit are 3709 births. The increasing number of births and activity within the consultant unit (85.8%) will be observed going forward to the end of financial year to identify any further increases and trends.

Midwife led unit Births – The expected locally set range for this descriptor is 2-50 births per month depending on the MLU. The overall numbers of births in our five Midwife led units were 42 births in February 2018 demonstrating a green rating of 14.2%. Ludlow had 5 births (green rating) , Bridgnorth had 4 deliveries (green rating), Oswestry had 1 birth (red rating), Wrekin had 27 births (green rating) and Shrewsbury MLU demonstrates a red rating; with 1 birth, however the reason for this red rating was due to the unit only having one delivery /postnatal room during February. The delivery figures for MLU activity (including home birth) for the year to date is 555 births (14.2%) demonstrating a green rating. The reduction in MLU births will be observed going forward to the end of financial year to identify any further decreases and trends.

Normal and assisted deliveries – Forceps Rate. The expected locally set range for this descriptor is 0-8% with an upper limit of 8% per month. There is no set lower limit; therefore the rate of 6.5% is reported as green in February 2018.

Vaginal breech rate. The expected locally set range for this descriptor is 0-1% with an upper limit of 1.5% per month. The lower limit is 2; therefore the rate of 0% is green.

Operative deliveries - % of C/Section. The expected locally set range for this descriptor is 0-20% with an upper limit of 25% per month. Therefore the rate of 20.5% is reported as amber during February 2018. The National rate is between 25-30%. Moving forward we will be realigning our locally set figures where possible with the national figures.

Operative deliveries Category 4 (Elective C/S) The expected locally set range of between 0-8%. February 2018 is reported green at 7.8%. The rolling year to date rate is 9.5%.

Maternal outcomes – Induction rate. The expected locally set range for this descriptor is 20-30% with an upper limit of 35% per month. Therefore the rate of 37.3% reported as red during February 2018. The education of women around reduced fetal movements has played a part in this increase. This rate will be observed going forward to identify any further increases and trends.

Maternal Outcomes - % of deliveries with PPH >1000 mls. The expected rate for this descriptor is 0-3% with a lower limit of 0.5% and an upper limit of 4%. Therefore the rate of 5.1% is reported as Red for February 2018. This rate will be observed going forward to identify any further increases and trends.

Maternal outcomes % of deliveries with PPH>2000mls. The expected rate for this descriptor is 0-0.5%. February 2018 demonstrates a green rating of 0.9%. This rate will be observed going forward to identify any further increases and trends.

Maternal Outcomes - 3/4 degree tear of (Primip). The locally expected range for this descriptor is 0-5%. Therefore the rate of 5.3 % reported as Amber in February 2018. The YTD figure is 5.2% (amber rating) but in line with national statistics (NMPA).

Maternal Outcomes -3/4 degree tear Assisted (Multip) The locally expected range for this descriptor is 0-3% with an upper limit of 5% per month. Therefore the rate of 0% is reported as green for February 2018. These are small numbers and will continue to be monitored in line with national statistics (NMPA)

Stillbirth – The expected range for this descriptor is 0% to 1%. Therefore the rate of 0% is reported as green on the dashboard for February 2017. The YTD figure of 0.5% is in line with the local and National statistics (MBBRACE)

Access to maternity services - % of bookings with a gestation of less than 10 weeks. This KPI' submission data is collected to inform PHE England and the Regional Screening Board on the Trisomy 13 and 18 rates. The screening Midwife Specialist submits this data monthly. The expected locally set range for this descriptor is 50-100% with a lower limit of 40% per month. The rate of 47.5% is reported as amber on the dashboard during December 2017. Work continues to improve this target.

Access to maternity services - % of bookings with a gestation of less than 12 weeks and 6 days. The expected National set range for this descriptor is 90-100% with a lower limit of 85% per month. The rate of 84.9% reported as Red during February 2018. Regular booking meetings are taking place to look at ways of improving these figures.

Access to screening services % of bookings with a gestation of less than 10 +0 weeks. The National and regional target for this screening is 50% as the acceptable standard with an aim of 75%. This target is a QA standard set by NHS England. The January 2018 figure demonstrates an amber rating of 46.8%. This has been raised by the national screening programme board and has been added to the Women and Children's risk register scoring 16.

Care Standards (Shropshire, T&W patients only) - % patients delivered who received 1:1 care during established labour. The expected nationally set range for this descriptor is 100% with a lower limit of 95% per month. The rate of 97.4 % reported as Amber during February 2018. This is only based on a single question in the Medway data.

Hypoxic Ischemic Encephalopathy – (HIE). This data is collected on the neonatal IT system "Badger net" and will be a feature on the maternity Dashboard from April 2018. HIE is graded into three categories.

HIE Grade 1 Mild

- Muscle tone may be slightly increased and deep tendon reflexes may be brisk during the first few days
- Transient behavioural abnormalities, such as poor feeding, irritability, or excessive crying or sleepiness (typically in an alternating pattern), may be observed
- Typically resolves in 24h

HIE Grade 2 Moderate

- The infant is lethargic, with significant hypotonia and diminished deep tendon reflexes
- The grasping, Moro, and sucking reflexes may be sluggish or absent
- The infant may experience occasional periods of apnoea
- Seizures typically occur early within the first 24 hours after birth
- Full recovery within 1-2 weeks is possible and is associated with a better long-term outcome

HIE Grade 3 Severe

- Seizures are usually generalized, and their frequency may increase during the 24-48 hours after onset, correlating with the phase of reperfusion injury.
- Stupor or coma is typical; the infant may not respond to any physical stimulus except the most noxious.
- Breathing may be irregular, and the infant often requires ventilatory support
- Generalized hypotonia and depressed deep tendon reflexes are common
- Neonatal reflexes (eg, sucking, swallowing, grasping, Moro) are absent
- Disturbances of ocular motion, such as a skewed deviation of the eyes, nystagmus, bobbing, and loss of "doll's eye" (ie, conjugate) movements may be revealed by cranial nerve examination
- Pupils may be dilated, fixed, or poorly reactive to light
- Irregularities of heart rate and blood pressure are common during the period of reperfusion injury, as is death from cardiorespiratory failure

During the last quarter the HIE's graded as September = one at level 1, October = one at level 1, November = one at level 1. There were no HIE's reported in December 2017, January 2018 or February 2018.

HIE 2016-2017

- HIE- Grade 1 - (2016-17 x 6 reported cases)
- HIE- Grade 2 - (2016-17 x 0 reported cases)
- HIE- Grade 3 - (2016-17 x 6 reported cases)

SATOD figures (Smoking at time of delivery)

Smoking at time of delivery figures for February 2018 demonstrated an overall green rating of 16.4% and a year to date figure of 15.1% a reduction of 1.1% on the previous year's (2016/17) SATOD figures.

The breakdown of February 2018 SATOD figures for each individual CCG's were:-

- Telford and Wrekin = 16%
- Shropshire = 16.7%
- Powys = 22.2% (not Sath referrals)

Section four: Recommendations for Trust Board

The Trust Board is asked to:

- **Receive** the performance report in relation to key quality indicators as at the end of February 2018
- **Question** the report to ensure appropriate assurance is in place

Maternity Quality and Safety Dashboard - Rolling 12 months - All SaTH Activity

No	Indicator	Descriptor	Lower Limit	Expected Range	Upper Limit	Rolling 12 Months												YTD	
						Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18		
1	Births by Unit	Telford Consultant Unit	270	300-350	370	340	316	383	321	323	360	345	359	325	341	347	289	4049	
		Bridgnorth MLU	2	4-10	15	8	7	7	2	Closed	Closed	Closed	Closed	Closed	Closed	4	4	32	
		Ludlow MLU	2	4-10	15	2	3	3	0	Closed	Closed	Closed	Closed	Closed	Closed	1	5	14	
		Oswestry MLU	2	4-10	15	10	4	4	2	Closed	Closed	Closed	Closed	Closed	Closed	3	1	24	
		Shrewsbury MLU	5	10-20	25	14	8	15	16	15	9	10	19	15	4	1	5	131	
		Wrekin MLU	15	20-40	50	27	31	25	22	31	43	26	25	29	37	28	27	351	
		BBA/Other		0-2	3	3	0	0	2	0	1	0	0	0	0	0	0	0	6
		Home		0-10	13	6	2	8	4	4	5	9	11	6	3	6	6	70	
Overall Trust total births		350	370-450	500	410	371	445	369	373	418	390	414	375	385	390	337	4677		
2	Birth rate by Location Type	% of births in Consultant Unit	70%	80%-90%	90%	82.9%	85.2%	86.1%	87.0%	86.6%	86.1%	88.5%	86.7%	86.7%	88.6%	89.0%	85.8%	86.6%	
		% of birth in a MLU or at home	5%	10%-20%	25%	16.3%	14.8%	13.9%	12.5%	13.4%	13.6%	11.5%	13.3%	13.3%	11.4%	11.0%	14.2%	13.3%	
		% of births in any MLU	5%	10%-20%	25%	14.9%	14.3%	12.1%	11.4%	12.3%	12.4%	9.2%	10.6%	11.7%	10.6%	9.5%	12.5%	11.8%	
		% Home Births		0%-3%	4%	1.5%	0.5%	1.8%	1.1%	1.1%	1.2%	2.3%	2.7%	1.6%	0.8%	1.5%	1.8%	1.5%	
			0%-1%	1.5%	0.7%	0.0%	0.0%	0.5%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	
3	Normal and Assisted Deliveries	Overall Normal Births rate %	55%	60%-80%	85%	70.7%	68.2%	69.9%	71.8%	71.0%	68.9%	71.0%	71.7%	68.3%	64.4%	65.1%	68.5%	69.2%	
		Overall Assisted Births rate %		0%-15%	25%	8.5%	10.2%	9.2%	8.7%	7.0%	9.6%	9.2%	8.2%	7.2%	12.5%	9.5%	9.5%	9.1%	
		Primip Assisted Births %		0%-28%	30%	19.4%	21.9%	18.2%	14.9%	14.0%	16.5%	21.5%	16.2%	15.0%	24.6%	20.5%	20.9%	18.6%	
		Multip Assisted Births %		0%-10%	15%	2.7%	2.3%	4.5%	5.4%	1.9%	4.5%	1.7%	3.4%	2.6%	2.4%	3.3%	2.5%	3.1%	
		Forceps rate %		0%-8%	8%	3.7%	4.6%	3.8%	4.6%	3.8%	6.7%	5.4%	4.3%	4.3%	9.1%	6.7%	6.5%	5.3%	
		Ventouse rate %		0%-11%	13%	4.9%	4.9%	4.9%	3.3%	3.2%	2.4%	3.6%	2.9%	2.7%	2.6%	2.6%	2.4%	3.4%	
		Dual Instruments rate %		0%-2%	3%	0.0%	0.8%	0.4%	0.8%	0.0%	0.5%	0.3%	1.0%	0.3%	0.8%	0.3%	0.6%	0.5%	
		Vaginal Breech rate		0%-1%	1.5%	1.0%	0.5%	1.1%	1.4%	0.5%	1.0%	0.8%	0.0%	2.4%	0.8%	1.0%	0.0%	0.9%	
			0%-6%	9%	3.9%	3.5%	2.3%	2.8%	2.4%	1.5%	4.4%	2.5%	3.8%	2.4%	2.3%	2.1%	2.8%		
4	Operative Deliveries	Caesarean Section rate %		0%-20%	25%	19.7%	19.6%	19.3%	17.5%	20.4%	20.9%	18.5%	19.3%	22.3%	21.7%	22.9%	20.5%	20.2%	
		% of C/S following failed Ventouse		0%-3%	4%	1.3%	0.0%	2.4%	1.6%	1.3%	0.0%	0.0%	0.0%	4.9%	1.2%	1.1%	0.0%	1.2%	
		% of C/S following failed Forceps		0%-5%	6%	0.0%	2.8%	2.4%	0.0%	2.7%	2.3%	4.2%	2.6%	0.0%	2.4%	0.0%	1.5%	1.7%	
		% of Deliveries - Emg C/S following instrumental		0%-4%	5%	0.2%	0.3%	0.5%	0.0%	0.5%	0.2%	0.5%	0.5%	0.8%	0.5%	0.3%	0.0%	0.4%	
		% of Deliveries - Category 1 C/Section		0%-4%	6%	1.2%	1.9%	0.7%	1.7%	1.9%	2.4%	1.5%	2.0%	2.7%	2.1%	1.6%	1.8%	1.8%	
		% of Deliveries - Category 2 C/Section		0%-8%	10%	5.2%	6.8%	6.0%	4.5%	7.6%	7.3%	5.9%	6.9%	6.8%	6.1%	7.0%	7.5%	6.5%	
		% of Deliveries - Category 3 C/Section		0%-4%	6%	1.7%	1.6%	1.9%	3.1%	1.9%	1.5%	2.3%	1.7%	1.6%	3.2%	3.9%	3.3%	2.3%	
			0%-8%	10%	11.5%	9.3%	10.7%	8.4%	9.0%	9.7%	9.0%	8.6%	11.1%	10.3%	10.4%	7.8%	9.7%		
5	Maternal Outcomes	Induction rate	15%	20%-30%	35%	32.7%	35.4%	33.2%	36.8%	34.2%	35.8%	35.0%	39.8%	36.4%	34.1%	36.6%	37.3%	35.6%	
		% of deliveries with PPH >1000 mls		0%-3%	4%	2.9%	3.3%	2.6%	2.5%	1.4%	1.9%	3.1%	3.0%	4.6%	5.0%	4.2%	5.1%	3.3%	
		% of deliveries with PPH >2000 mls		0%-1%	1.5%	0.5%	0.5%	0.0%	1.4%	0.0%	0.5%	0.5%	1.5%	0.5%	1.1%	1.3%	0.9%	0.7%	
		Manual Removals rate		0%-2%	4%	1.7%	1.6%	0.9%	0.3%	0.5%	1.0%	1.5%	0.5%	2.2%	2.1%	0.5%	1.5%	1.2%	
		3rd/4th Degree tears rate (overall)		0%-5%	6%	3.4%	3.0%	3.0%	1.9%	3.0%	1.7%	0.8%	2.7%	1.1%	1.9%	2.6%	2.4%	2.3%	
		3/4 degree tear of NVD (Primip)		0%-5%	7%	8.6%	6.9%	7.5%	3.2%	8.6%	3.8%	2.3%	5.4%	2.1%	5.0%	7.2%	5.3%	5.5%	
		3/4 degree tear of NVD (Multip)		0%-4%	8%	2.0%	1.8%	0.0%	0.6%	0.6%	0.5%	0.0%	0.5%	1.2%	0.0%	1.7%	1.3%	0.8%	
			0%-8%	10%	3.3%	6.1%	15.6%	13.6%	4.3%	3.4%	3.1%	10.3%	0.0%	4.7%	3.3%	6.9%	6.2%		
			0%-3%	5%	14.3%	0.0%	0.0%	0.0%	0.0%	9.1%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	3.4%		
			0%-18%	20%	12.0%	12.3%	12.3%	8.6%	11.1%	11.7%	10.8%	11.1%	9.2%	15.1%	9.4%	10.2%	11.2%		
			0%-1%	1.5%	1.0%	0.3%	0.5%	0.3%	0.3%	0.2%	0.8%	0.5%	0.8%	1.1%	0.3%	0.0%	0.5%		
6	Fetal Outcomes	Actual number of Stillbirths		0%-3%	4%	4	1	2	1	1	3	2	3	4	1	0	23		
		Shoulder Dystocia rate		0%-2%	3%	0.7%	0.3%	0.2%	0.8%	1.3%	1.2%	0.5%	1.4%	0.0%	1.3%	0.5%	0.6%	0.8%	
		% Term babies - Birthweight <2.5Kg		10%	1.3%	3.1%	4.1%	3.3%	2.3%	2.6%	2.8%	3.1%	1.4%	3.9%	3.8%	3.8%	2.8%		
		% Birthweight >4Kg		0%-20%	25%	13.0%	13.6%	10.7%	12.3%	13.6%	13.1%	10.8%	11.4%	13.3%	10.6%	11.2%	9.9%	12.0%	
		% Apgars <7 at 5 mins		0%-2%	3%	1.7%	0.5%	0.2%	1.1%	2.1%	1.0%	1.3%	1.7%	0.8%	1.8%	1.3%	0.3%	1.2%	
7	National Smoking and Breastfeeding Targets	Breastfeeding within 48 hours of delivery	65%	67%-100%		75.3%	72.5%	78.2%	75.3%	78.3%	74.3%	74.3%	72.3%	72.4%	73.9%	76.2%	75.8%	74.9%	
		'Current Smoker' at booking		0%-20%	22%	17.8%	15.6%	15.4%	0.0%	17.6%	17.2%	18.5%	16.6%	16.9%	16.1%	15.7%	15.2%	15.3%	
		'Current Smoker' at delivery		0%-20%	22%	12.5%	15.8%	17.2%	13.9%	13.9%	15.3%	17.0%	13.1%	14.4%	13.7%	14.2%	16.4%	14.8%	
8	Access to Maternity Services	Number of Bookings	375	400-450	500	488	418	455	398	433	407	433	476	479	354	426	440	5207	
		% of bookings with a gestation of less than 10 weeks	40%	50%-100%		41.6%	40.4%	46.6%	37.4%	40.2%	44.0%	36.5%	39.5%	46.8%	47.5%	38.7%	46.8%	42.2%	
		% of bookings with a gestation of less than 12 weeks 6 days	85%	90%-100%		87.7%	87.8%	88.6%	90.5%	88.0%	88.0%	85.5%	86.6%	87.3%	89.0%	85.0%	84.5%	87.3%	
9	Care Standards (Shropshire and T&W patients only)	% of patients booked who had a CO reading taken at Booking	70%	75%-100%		100.0%	100.0%	100.0%	100.0%	93.2%	93.0%	90.3%	94.7%	97.6%	96.2%	92.9%	95.1%	96.1%	
		% Patients booked and assigned a named midwife	85%	90%-100%		99.8%	99.5%	100.0%	100.0%	100.0%	99.2%	99.8%	100.0%	99.8%	99.4%	99.8%	99.8%	99.8%	
		% of patients with access to same midwife throughout pregnancy	70%	75%-100%		83.1%	82.0%	83.2%	81.0%	82.6%	83.2%	88.9%	85.6%	88.6%	91.3%	92.5%	92.5%	86.2%	
		% patients delivered who received 1:1 care during established labour (Shropshire and Telford & Wrekin patients only)	95%	100%		96.7%	98.5%	98.0%	97.9%	94.6%	95.9%	95.2%	97.5%	96.7%	98.0%	98.8%	97.4%	97.2%	