NHS
The Shrewsbury and Telford Hospital
NHS Trust

Recommendation ☑ **DECISION** ☑ **NOTE**	**The Trust Board is asked to:** • **Discuss** the current performance in relation to key quality indicators as at the end of March 2018 • **Consider** the actions being taken where performance requires improvement • **Question** the report to ensure appropriate assurance is in place
Reporting to:	**Trust Board**
Date	03 May 2018
Paper Title	Quality Governance Report
Brief Description	The purpose of this report is to provide the Board with assurance relating to our compliance with quality performance measures during March 2018 and for Qtr 4 as a whole. Key points to note: • 0 G3 pressure ulcers for 4 months • 70% of complaints were closed within agreed timescale compared to 40% in February 2017. • More falls reported in Q4 compared to last year although overall falls incidence and falls with harm remain lower than national benchmark • Although the Trust FFT satisfaction scores remain high the response rate remains challenged with an overall response rate of 16.1%. The most challenged response rates are from maternity at 5.1% and ED at 12.8%. • We remain non-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. In March 2018, 41 patients across both sites waited for more than 12 hours to be transferred. • A total of 4309 patient safety incidents were reported in Q4 2017/18 from 2991 in same period during 2016/17, an increase of 1318 overall. The numbers of incidents graded as near miss/no harm in Qtr 2017/18 were 2970 (69% of total incidents in the quarter). In Qtr 4 2016/17 the percentage of near miss/low harm was 62% of the total reported. • Whilst we have made an improvement in training compliance for Prevent 41.7% we have not achieved 85% compliance by the end of March 2018. The 85% compliance was an NHSE three year trajectory which SaTH has been pursuing only since Qtr1 2017. • The Trust declared 35 SIs and 1 NE in Q4 of which 28 were ED 12 hr trolley breaches • In March the Trust reported a higher than expected number of intrauterine deaths at 1.8% (seven IUD) against an expected range of 0-1%. The overall figure for the year is 0.5%. • No obvious themes or trends identified in analysis of 104+ cancer waits but learning shared and monitored via Cancer Board and CQRM.
Sponsoring Director	Deirdre Fowler, Director of Nursing and Quality

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Author(s)	Dee Radford, Associate Director of Patient Safety
Recommended / escalated by	None
Previously considered by	**Quality & Safety Committee** **Clinical Quality Review Meeting**
Link to strategic objectives	**Patient and Family** – through partnership working we will deliver operational performance objectives **Safest and Kindest –** delivering the safest and highest quality care causing zero harm
Link to Board Assurance Framework	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 (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges (RR 951) If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected (RR 1185)
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	○ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

The Shrewsbury and Telford Hospital NHS Trust

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Quarterly Quality Governance Report

Quarter Four 2017-2018

January – March 2018

Introduction

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of March 2018 (Month twelve for 2017/2018) and also for the fourth quarter of the year as a whole.

The report will provide assurance to the Clinical Quality Review Meeting that we are compliant with key performance measures and where we are not, recovery plans are in place to improve our current position.

The report has been submitted to the Quality and Safety Committee as a standalone document and will then be presented to Trust Board with the Integrated Performance Paper for consideration and triangulation with performance and workforce indicators.

The report is being 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 contracts.

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Section one: Our Key Quality Measures – how are we doing?

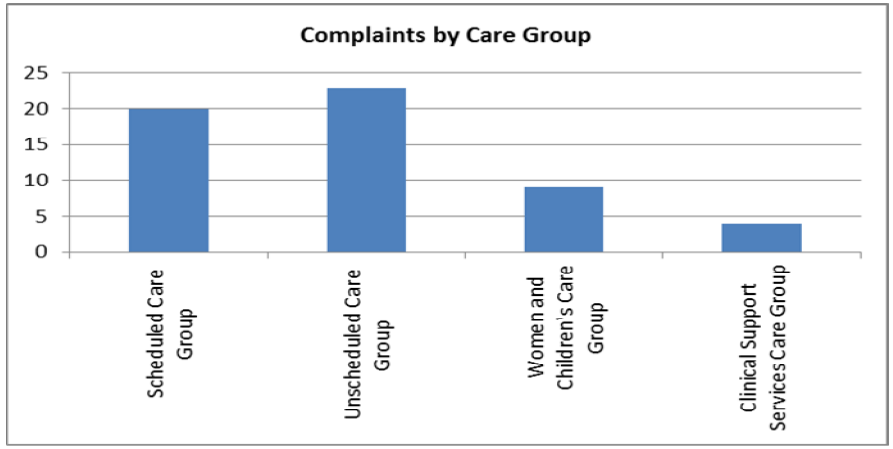
Measure	Year end 16/17	April 17	May 17	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Year to date 2017/18	Monthly Target 2017/18	Annual Target 2017/18
CDI due to lapse in care (CCG panel)		3	1	1	2	1	1	1	1	3				14	0	25
Total CDI reported	21	3	4	3	1	3	1	1	3	6	6	2	2	35	None	None
MRSA Bacteraemia Infections	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia Infections	9	0	1	1	1	6	2	3	2	4	2	3	1	26	None	None
E. Coli Bacteraemia Infections	31	1	1	1	1	3	3	1	4	2	6	5	2	30	None	None
MRSA Screening (elective) (%)	95.2	95.5	95.4	95.9	95.9	95.6	95.6	95.5	96.4	96.0	94.0	95.0	94.07	95.4%	95%	95%
MRSA Screening (non elective) (%)	94.4	95.2	96.3	95.0	96.1	96.1	97.0	97.2	95.3	95.5	94.8	94.0	95.62	95.67%	95%	95%
Grade 2 Avoidable	35	3	2	2	4	3	3	4	4	2	2	4	1	34	0	0
Grade 2 Unavoidable	112	10	19	6	15	17	13	8	11	11	9	9	2	130	None	None
Grade 3 Avoidable	9	0	0	1	0	1	2	1	3	0	0	0	0	8	0	0
Grade 3 Unavoidable	9	0	1	2	4	3	0	2	1	1	3	3	2	22	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	1	0	0	0	0	0	0	0	0	0	0	None	None
Falls reported as serious incidents	5	0	0	1	0	1	0	0	0	0	0	1	0	3	None	None
Number of Serious Incidents	61	2	4	6	1	4	4	10	7	3	8	15	13	77	None	None
Never Events	5	0	0	0	0	0	0	1	0	0	0	1	0	2	0	0

Measure	Year end 16/17	April 17	May 17	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Year to date 2017/18	Monthly Target 2017/18	Annual Target 2017/18
Harm Free Care (%)	94.17%	94.31	94.81	93.48	91.15	92.09	89.91	90.86	90.45	89.06	90.16	92.52	89.68	91.72%	None	95%
No New Harms (%)	97.94%	98.47	98.18	97.49	95.24	96.59	96.83	96.34	94.84	94.0	96.82	96.13	96.31	96.48%	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE Assessment		95.6	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	26	17	37	39	31	37	33	39	17	28	35	41	380	None	None
Complaints (No)	424	44	56	42	61	50	45	45	61	31	49	60	56	600	None	None
Friends and Family Response Rate (%)	23.8%	32.2	22.5	23.3	19.5	20.1	18.3	15%	14.3%	12.3%	11.1%	13.6%	16.1%	16.1%	None	None
Friends and Family Test Score (%)	96.6%	97.1	96.7	97.0	96.2	97.1	97.2	96.1	96.8	97.4	96.6	96.2%	96.4%	96.4%	75%	75%

Section Two – Patient Experience

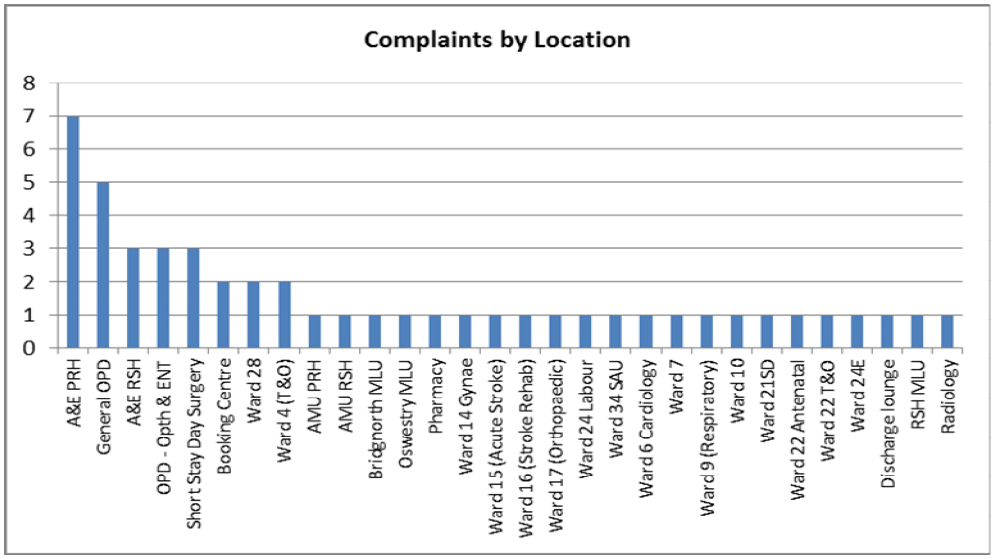
Complaints and Patient Advice and Liaison Service (PALS) Update –

The Committee receive a separate Quarterly report in relation to Complaints and PALS. Therefore the summary below shows complaints received and closed in March 2018.



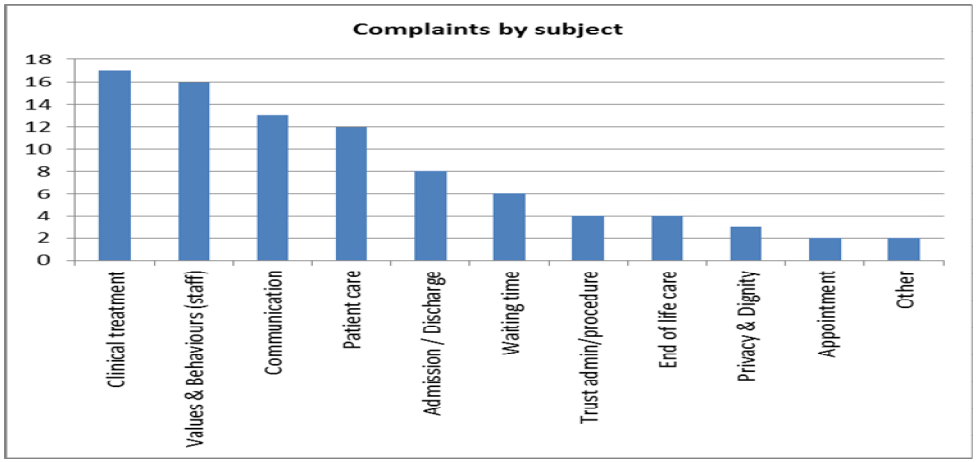
New Complaints

Fifty six formal complaints were received in March 2018 in line with expected figures.



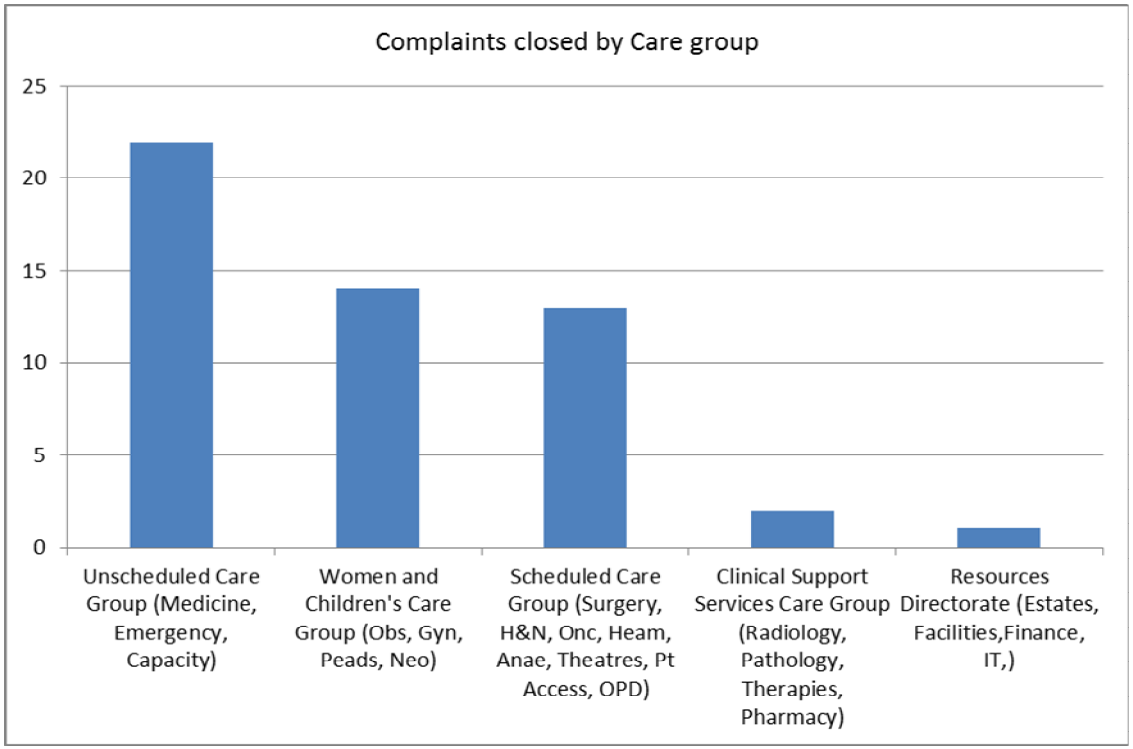
Top Locations of Complaints

Outpatients and A&E at both sites received the most complaints; this correlates with higher levels of activity.



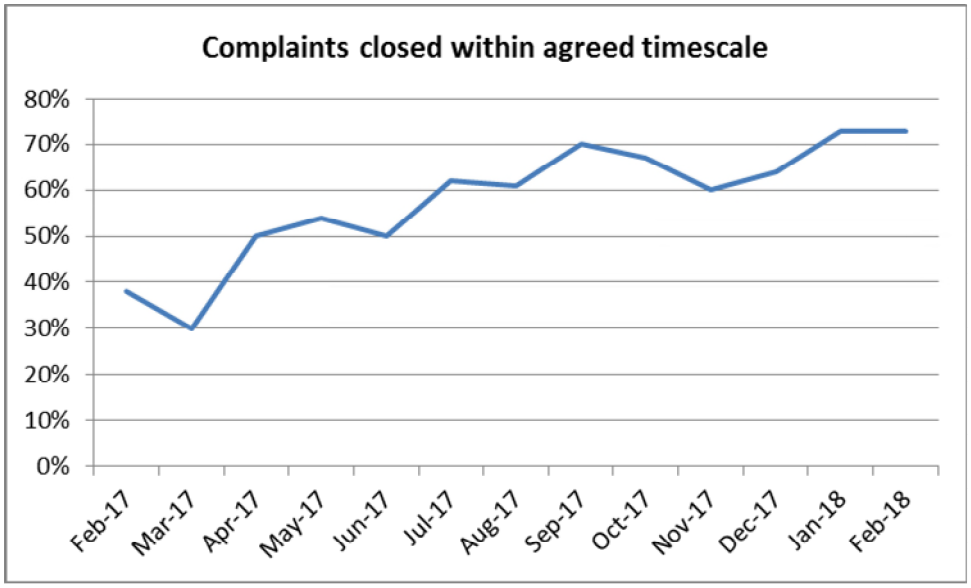
Complaints by Subject

The majority of complaints continue to be about staff attitude, communication and clinical treatment; however within these areas, there are no specific trends noted.



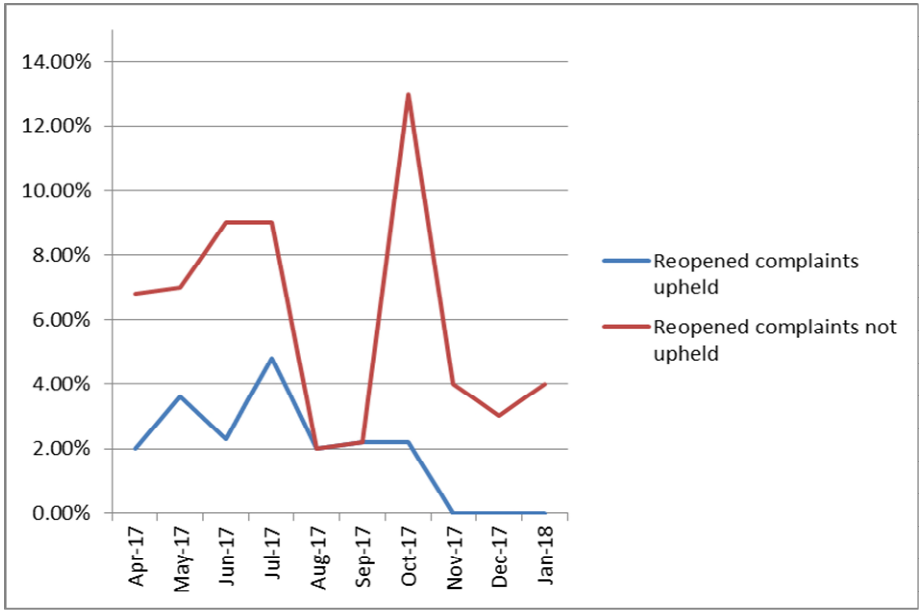
Closed Complaints

52 complaints were closed in March 2018.



Complaints closed within agreed timescale

The number of complaints closed within timescale continues to increase slightly; however, there continue to be a number of late responses received from the Care Groups. These delays can be due to a variety of reasons, including clinical pressures, staff being off sick, and notes being unavailable.



Reopened complaints

There were four complaints reopened in March, relating to complaints from July 2017, October 2017 and March 2018. One has been upheld because on review it is acknowledged that the response could have been clearer. The others have not been upheld as they are asking further questions.

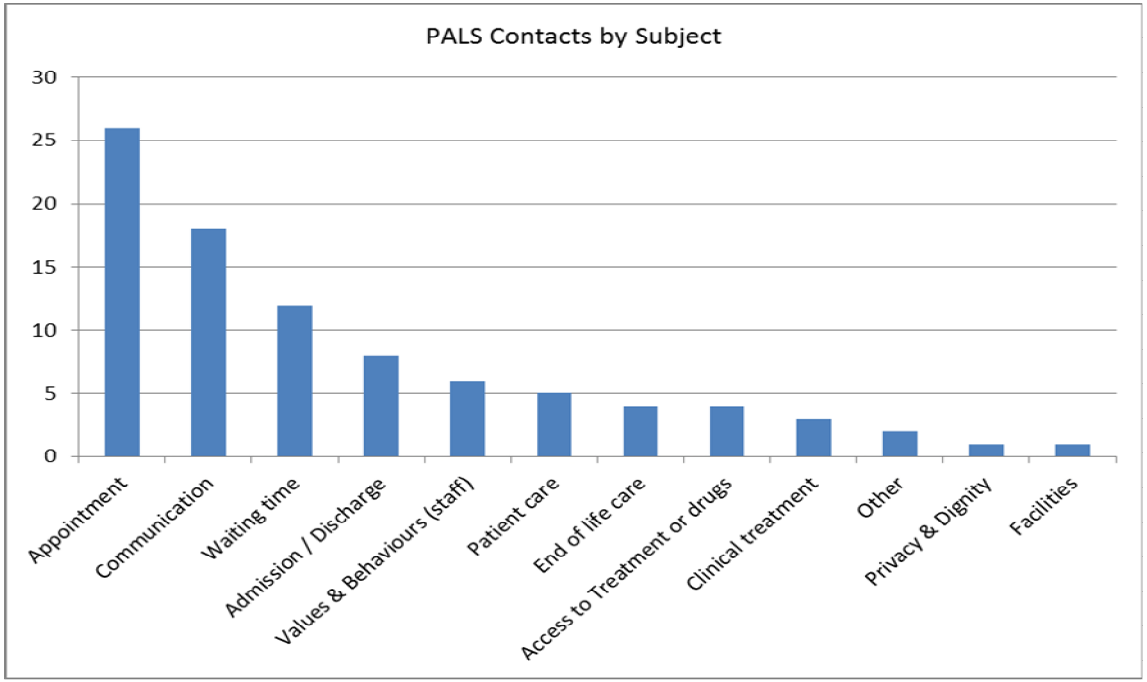
Parliamentary & Health Service Ombudsman (PHSO)

The Trust has been advised of two new referrals to the PHSO in quarter four. One related to concerns regarding delays in an MRI scan and medication being stopped and the other relates to concerns about the care of a patient with dementia.

Two complaints were closed by the PHSO in quarter four. One was not upheld, and one was partially upheld due to poor communication in relation to a woman undergoing gynaecological surgery.

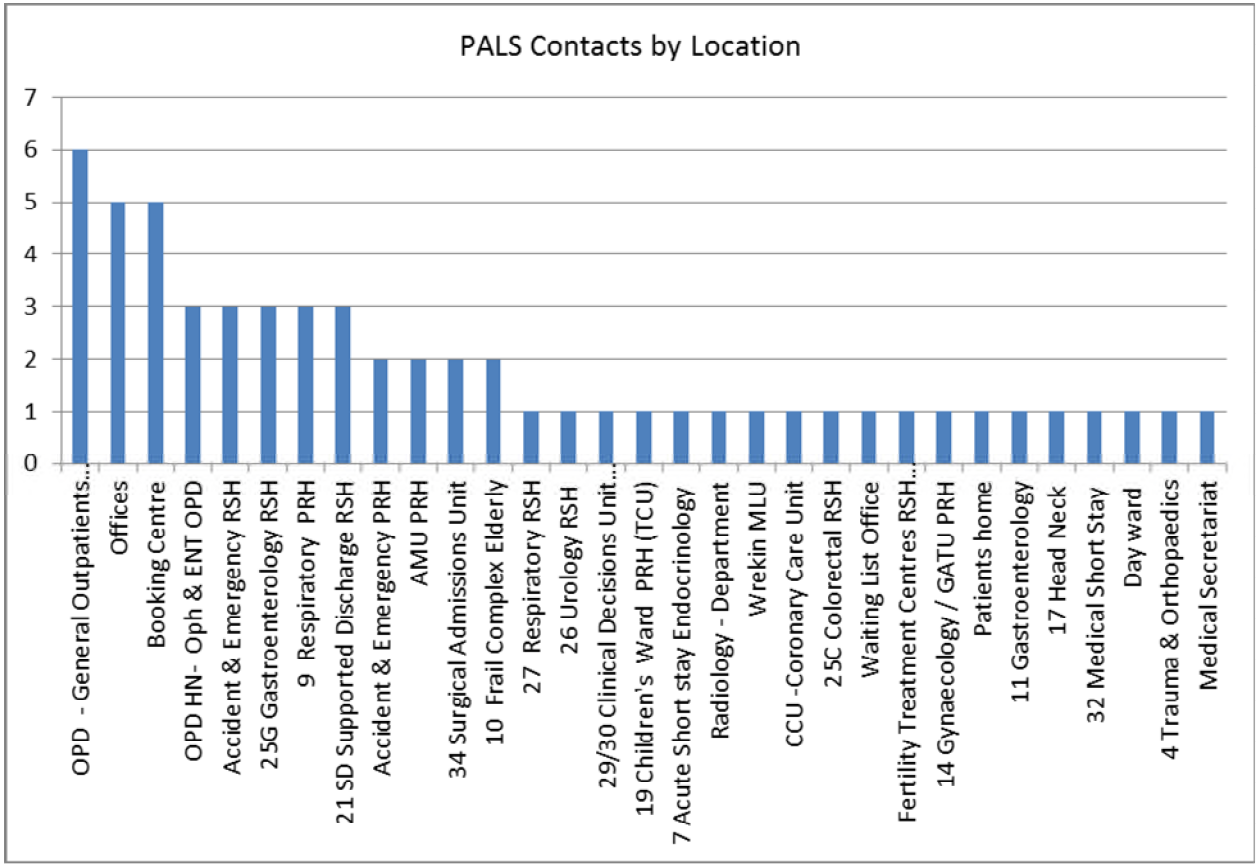
Patient Advice and Liaison Service (PALS)

The Trust received 93 PALS contacts in March 2018.



PALS Contacts by Subject

The majority of contacts related to cancelled appointments and poor communication although there are no trends noted within this.

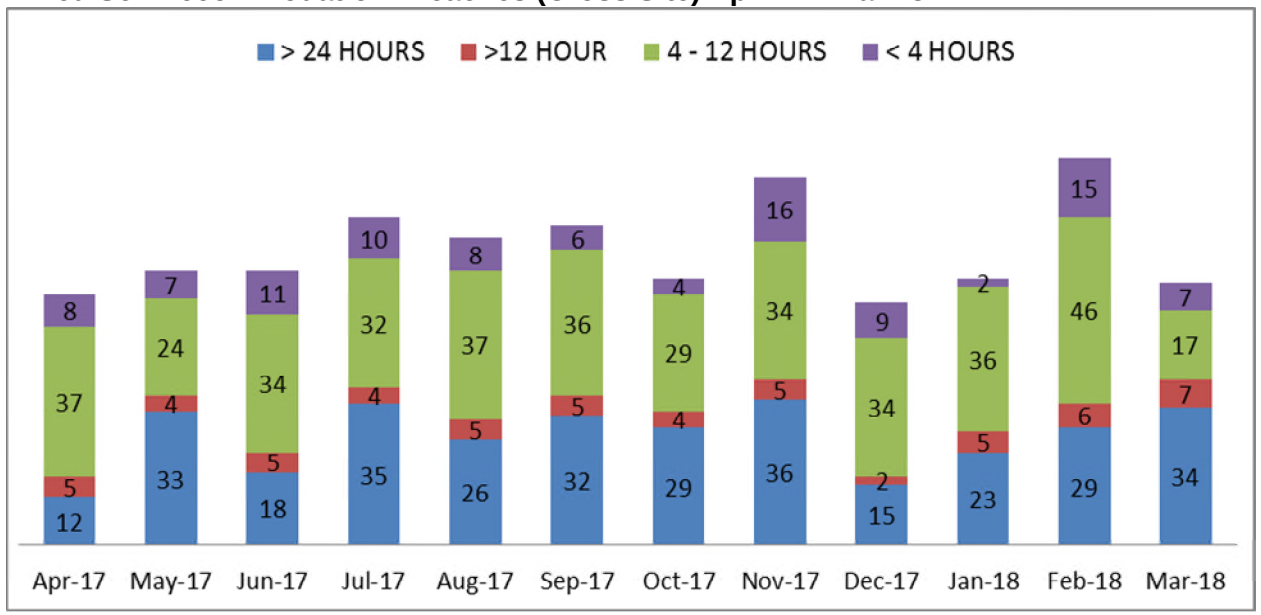


Top Locations for PALS Contacts

In line with the main subjects, most PALS contacts related to the bookings office or outpatients.

Mixed Sex Accommodation Breaches (MSA)

Mixed Sex Accommodation Breaches (Cross Site) Apr 17 – Mar 18



We continue to record patients waiting for more than four hours to be transferred from the high dependency areas (HDU) once they are well enough to do so.

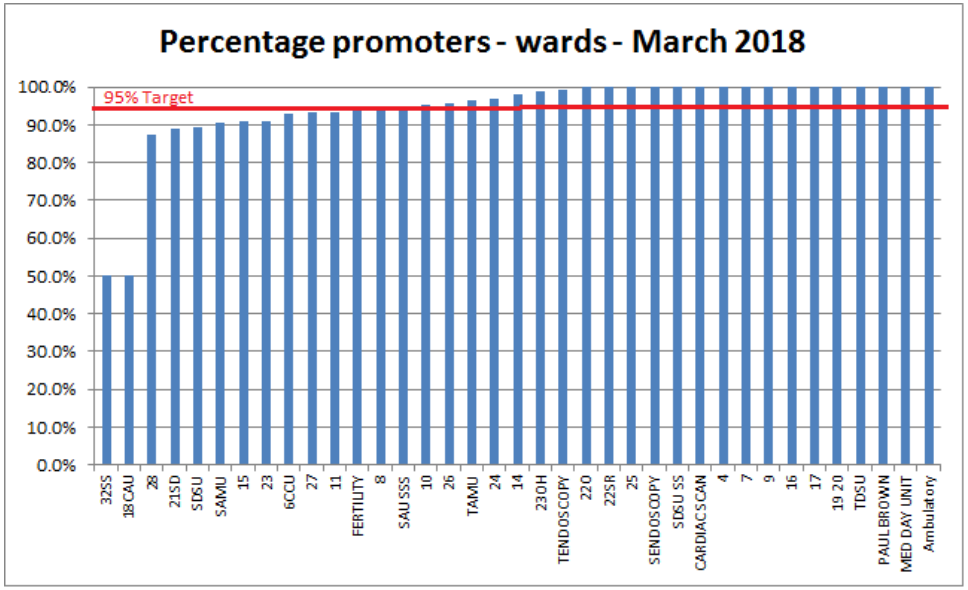
In March, across both sites, 34 patients waited for more than 24 hours to be transferred from HDU, 22 of them at RSH. A total of 24 patients waited between four and 24 hours and seven less than four hours. In total during the month 58 patients across both sites experienced a delay greater than four hours.

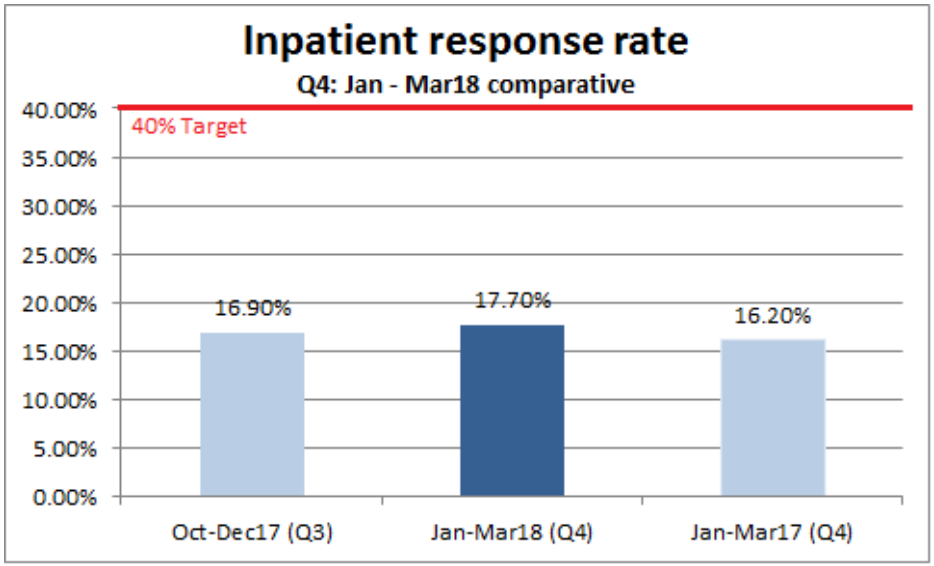
The number of MSA breaches outside the HDU areas remains at four for the year – all in one incident.

Friends and Family Test Feedback (FFT)

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 96.4%. This was a slight increase compared to last month. Individually, Maternity, Inpatients and Outpatients saw an increase in the proportion of patients who would recommend compared to last month. A&E however saw a decrease compared to February.

The overall response rate was 16.1% which was an increase compared to February response rate of 13.6%. Individually, A&E saw an increase of 5.4% since last month's 7.4% response rate. Inpatients and Maternity Birth saw a decrease in the response rates compared to last month.





Inpatient Summary

- The most recent National Inpatient promoter figures available are for Jan18 at 95.7%. SaTH exceeded this with a rate of 97.4% for inpatients in Jan18. SaTH has remained consistently high reaching 97.8% in Mar18.
- The majority of inpatient areas are achieving the Trust target of 95% for patients who would recommend the ward (percentage of promoters).
- The National response rate for inpatients in Jan18 was 23.3% which is higher than SaTH's response rate of 19%.
- This quarter (Jan-Mar18) has seen an improved response rate compared to the previous quarter (Oct-Dec17) as well as compared to this time last year (Jan-Mar17).

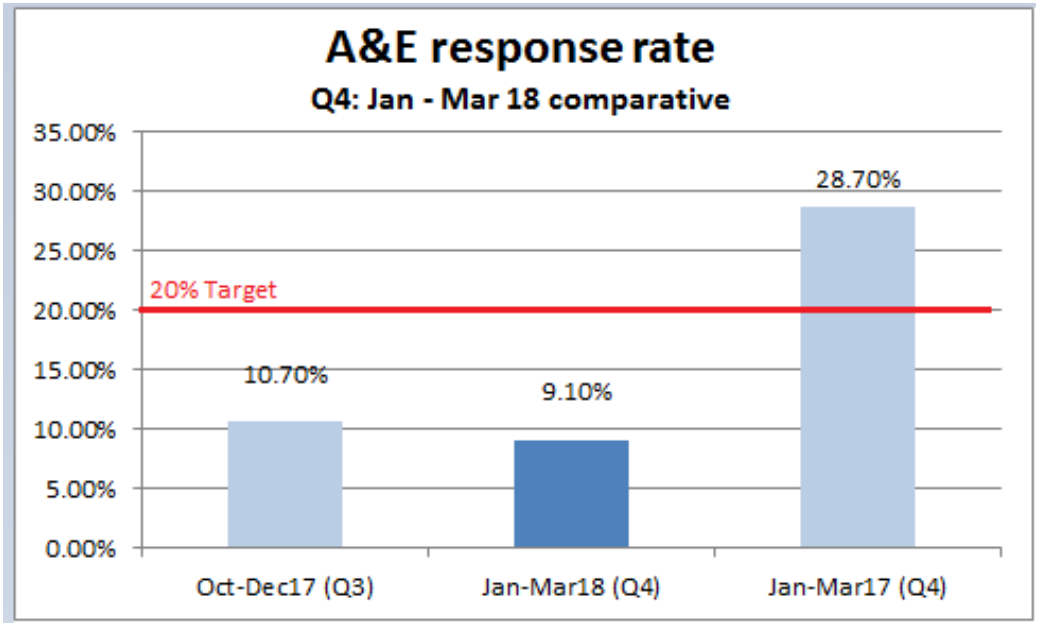
Maternity

- The most recent National percentage of promoter figures for Maternity was Jan18 which was 96.4%. SaTH results were higher than the National Jan18 figures, at 98.3%.
- The response rate for Maternity only includes 'birth'. SaTH was 3.9% in Jan18 which is considerably lower than the National response rate of 22.5% in Jan18. There was a slight improvement in the most recent Mar18 SaTH results at 5.1% for birth.

AE	TARGET	Jan-18	Feb-18	Mar-18
SaTH Response Rate	>=20%	7.0%	7.4%	12.8%
SaTH % Recommenders	>=95%	96.4%	94.2%	93.8%
National Response Rate	No Target	12.2%		
National % Recommend	No Target	86%		

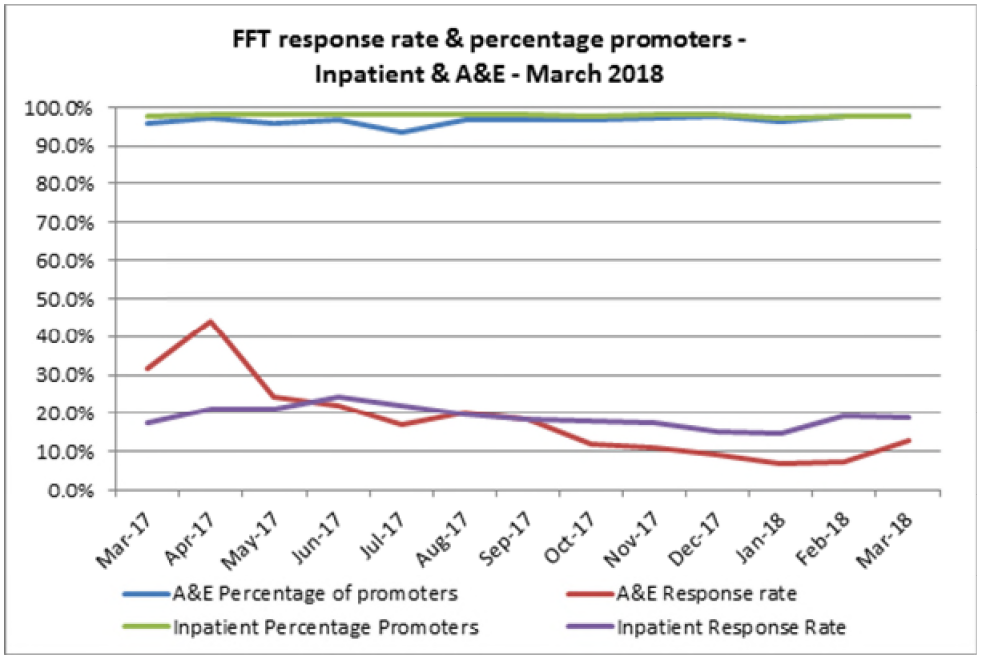
A&E Summary

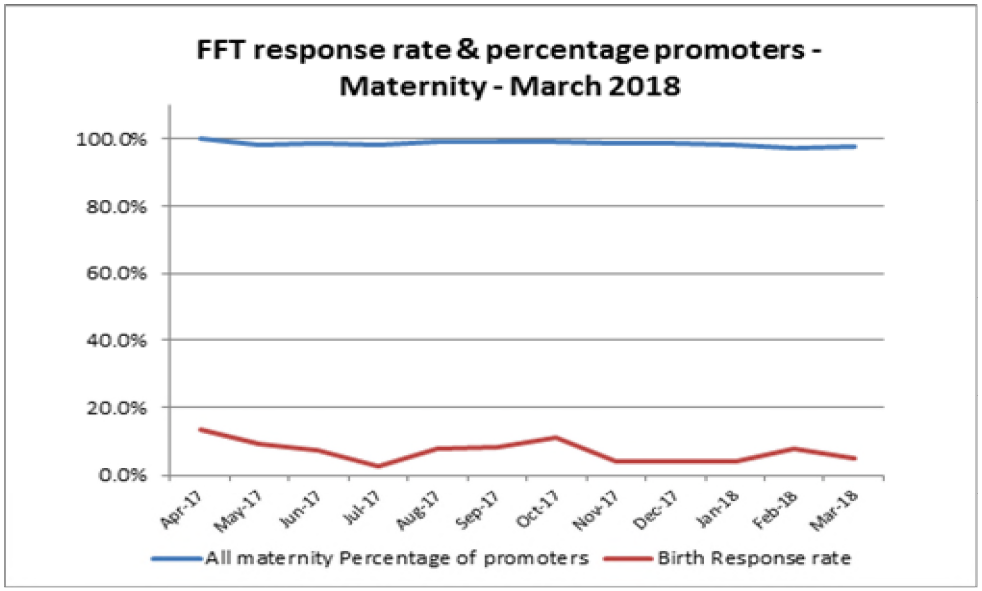
- The most recent National percentage of promoters figure for A&E is Jan18 at 86.4%, which SaTH exceeded with 96.4%.
- SaTH's response rate at 7% in Jan18 was lower than the National response rate at 12.2%. SaTH has however improved this reaching 12.8% in Mar18.
- Overall, this quarter (Jan-Mar18) has a considerable lower response rate than this time last year (Jan-Mar17) at 28.7%. It is also slightly lower than the previous quarter (Oct-Dec17) at 10.7%.



Outpatients

- SaTH has seen consistently high percentage of promoter figures for Outpatients in Q4. Jan18 was 96.9%, Feb 95.5% and Mar18 96.5%
- These figures compare favourably to the most recent National results which are Jan18 at 94%.

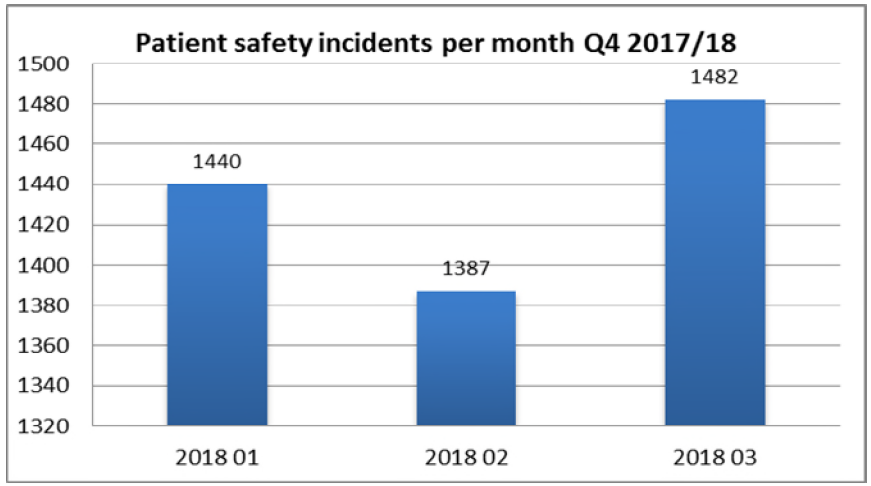


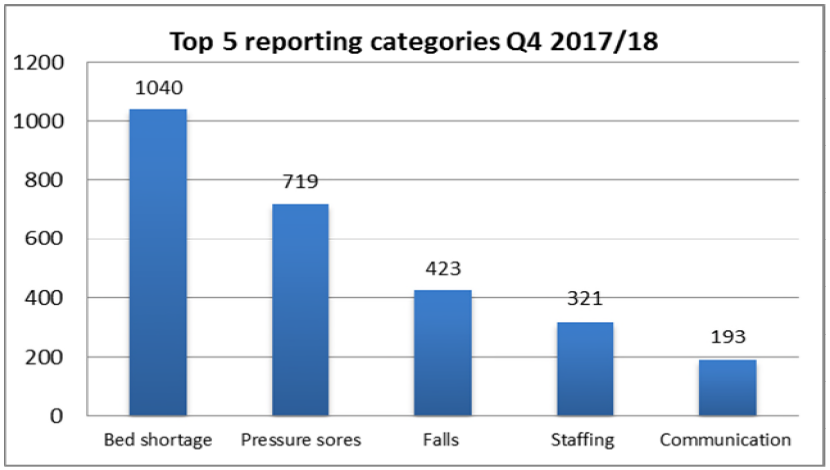


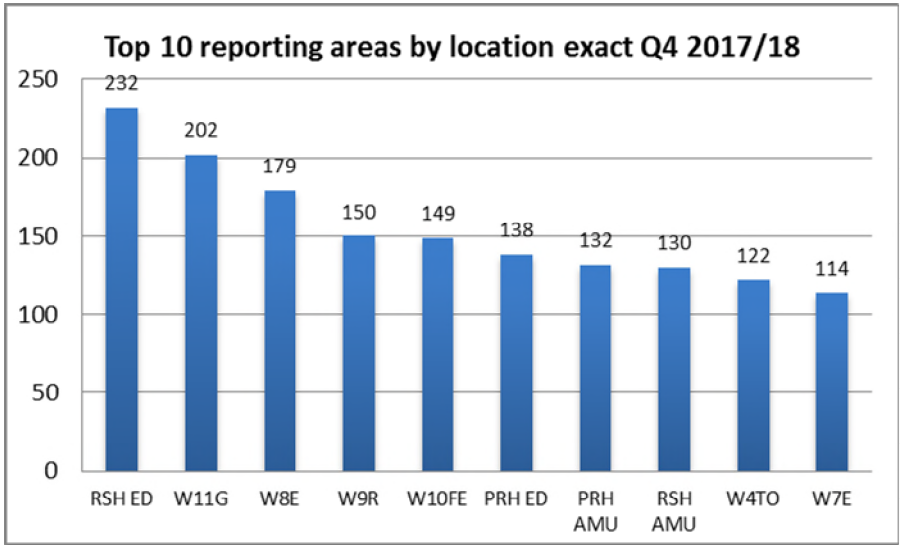
	Percentage Promoters	Response Rate
Maternity overall	97.8%	5.1% (Birth only)
A&E	93.8%	12.8%
Inpatient	97.8%	19.0%
Outpatients	96.5%	NA

Section Three – Patient Safety

All Patient Safety Incidents







Patient Safety Incidents

A total of 4309 patient safety incidents were reported in Qtr 4 2017-2018 across the Trust. This compares to 2991 in the same quarter of 2016-2017. It is an increase from the 3894 reported in Qtr 3 of 2017-2018.

Top Five Reporting Categories/Top Ten Areas

It should be noted that of the 719 pressure ulcers reported, 474 were present on admission, 118 were skin conditions other than pressure ulcers, meaning that 127 potential pressure ulcers were reported as having occurred in our care. Following review and validation by the ward managers and, if required, the Tissue Viability Team, this number will reduce.

Patient safety incident management during Q4 2017/18	In holding area, awaiting review	Being reviewed	Awaiting final approval	Final approval	Total
Unscheduled Care Group	357	83	402	1543	2385
Scheduled Care Group	302	125	364	521	1312
Women and Children's Care Group	86	78	28	262	454
Clinical Support Services Care Group	46	30	35	13	124
Resources Directorate	7	4	1	9	21
Ambulance/ Patient first	4	0	2	0	6
Corporate Governance Directorate	4	0	1	0	5
Workforce Directorate	0	1	0	0	1
Quality & Safety Directorate	0	0	0	1	1
Totals:	**806**	**321**	**833**	**2349**	**4309**

The table above shows the detail relating to the status of the incidents that have been reported in the Quarter. The Trust Incident Reporting Policy requires managers to whom the incidents have been reported (the handler of the incident) to review and close the incident within specified timescales depending on the severity of the harm that may have occurred. Final approval is a process by which the relevant member of the Patient Safety Team reviews the actions and ensures that the Datix record is correct.

The Executive Rapid Review Meeting has met weekly since early September. The aim of the meeting is to provide assurance that immediate actions are taken in relation to serious and moderate incidents (clinical and health and safety) and complaints about patient care and that themes are identified and addressed. Also the group is to ensure that lessons to be learned are identified and allocated for action.

Care Group Heads of Nursing (or a representative) are required to attend as are the Patient Safety Advisors. The Heads of Nursing are to ensure that learning identified each week is shared through the quality processes within the care groups. Learning points that have been identified so far include ensuring that the requirements of the Duty of Candour have been fulfilled and the importance of reviewing, acting upon and closing Datix incidents within the timescales in the Incident Reporting Policy.

The group identifies trends and concerns at each meeting. These include:

- Complaints relating to delay in appointments following cancellation of routine clinics as a result of winter pressures
- Complaints relating to discharge are a recurring theme
- We continue to see incidents that appear to relate to the high levels of escalation within the Trust in addition to the lower levels of staffing and the impact of this on patient care including issues with communication and cleanliness on the wards.

Serious Incidents Reported in Quarter Four 2017-2018

Category/Type of Incident	Care Group	Date of incident		Category/Type of Incident	Care Group	Date of incident
January:				**March:**		
Other	SCG	Dec 2017		Fall resulting in fracture	Estates	Feb 2018
12 hr trolley breach	USCG	Dec 2017		12 hr trolley breach	USCG	Feb 2018
12 hr trolley breach	USCG	Dec 2017		12 hr trolley breach	USCG	Feb 2018
12 hr trolley breach	USCG	Dec 2017		12 hr trolley breach	USCG	Feb 2018
12 hr trolley breach	USCG	Dec 2017		12 hr trolley breach	USCG	Feb 2018
12 hr trolley breach	USCG	Dec 2017		12 hr trolley breach	USCG	Feb 2018
Information Governance	SCG	Jan 2018		12 hr trolley breach	USCG	Feb 2018
Maternity/Obstetric	W&C CG	Jan 2018		12 hr trolley breach	USCG	Feb 2018
February:				12 hr trolley breach	USCG	Feb 2018
Delayed Treatment	USCG	Jan 2018		12 hr trolley breach	USCG	Feb 2018
Surgical/invasive procedure	SCG/USCG	Jan 2018		12 hr trolley breach	USCG	Feb 2018
12 hr trolley breach	USCG	Jan 2018		12 hr trolley breach	USCG	Mar 2018
12 hr trolley breach	USCG	Jan 2018		Sub-optimal Care	USCG	Mar 2018
Never Event	USCG	Feb 2018				
12 hr trolley breach	USCG	Jan 2018				
12 hr trolley breach	USCG	Jan 2018				
12 hr trolley breach	USCG	Jan 2018				
12 hr trolley breach	USCG	Jan 2018				
12 hr trolley breach	USCG	Jan 2018				
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12 hr trolley breach	USCG	Jan 2018				
12 hr trolley breach	USCG	Jan 2018				
12 hr trolley breach	USCG	Jan 2018				
12 hr trolley breach	USCG	Jan 2018				
					Total	**36**

Incidents reported in March were:

Incident Date	Reported Date	Care Group	Description of Incident (StEIS category with additional explanation
04 Mar 2018	29 Mar 2018	USCG	Reported as a serious incident following mortality review of patient's care.
01 Mar 2018	09 Mar 2018	Estates	Patient fell and sustained a fracture in one of the outpatient areas of the hospital.
Multiple	Multiple	USCG	12 hour breaches in both ED

Serious Incident (SI) Reporting Status
The table below shows that there are 38 incidents open to investigation. Of these, eight have agreed extensions with commissioners due to factors affecting capacity to complete the investigation. There is one SI which has breached the external deadline due to a variety of internal and external factors, an extension has not been requested for this case. Progress on this is being managed to ensure resolution as soon as possible.

Overall, 21 serious incident investigations were completed and submitted for closure/removal on the StEIS system with the commissioners during Qtr 4. Currently 27 remain open, of which we have requested that nine be downgraded, six of these are 12 hour trolley breaches.

Incident Status at 6 April 2018

	New Incidents for Q4	36
	Incidents being investigated	38
	Out of internal deadline (excludes external deadline & RCAs with extensions)	0
	Out of external deadline with CCG/CSU (excludes RCAs with extensions)	1
	CCG/CSU have been asked to close/remove incident	4

Action plan completion status
There are 12 incident action plans out of date for 2016/17, with five closed since the last report. There are 18 action plans out of date for 2017/18 with eight closed since the last report. Overall the total number of action plans going out of deadline has increased.

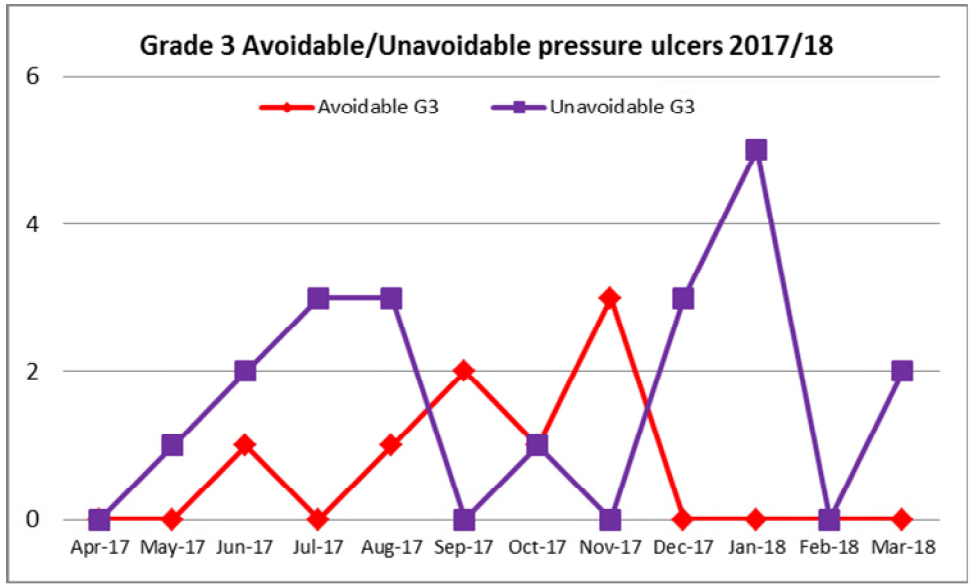
Serious Incidents submitted to the Clinical Commissioning Groups in Quarter four 2017-2018 with learning identified

StEIS No	Type of Incident	Clinical Area	Learning identified
2017/26402	Delayed diagnosis	RSH ED	The importance of accurate communication and updating of information provided to patients and families. Post mortem findings suggested that the outcome was not a direct result of the delay.
2017/29191	IG Breach	Ward 22TO	Secure disposal of handover sheets
2017/25537	G3 Pressure ulcer	Ward 15	It is felt that this is likely to have been inherited damage, but a lack of consistency of record keeping and late escalation to the TVN service are prevalent.
2017/25320	Sub-optimal care	Anaesthetic service / Ward 32SS	Consultants must speak face to face to ensure there is understanding of the urgency and nature of referrals

StEIS No	Type of Incident	Clinical Area	Learning identified
			Alternative methods for administration of anti-epileptic medication should be considered in patients who are unable to take their regular medication by oral route, or for whom there are difficulties with IV access
2017/29047	G3 Pressure ulcer	Ward 27R	More vigilance with pressure area care where skin compromised on admission, completing assessments and implementing risk reduction strategies in a timelier manner.
2018/1606	IG Breach	PRH ITU	Having personal/sensitive information in paper format is a high risk – patient identifiers should be minimised to move to digital media encrypted by the Trust to record the Outreach record keeping
2017/25798	Incorrect lens	Ophthalmology	Continue with the theatre safety days
2017/14815	Maternity Incident affecting baby	Maternity	Utilisation of standard procedures to resolve unusual presentations of babies with shoulder dystocia. Communication of actions during internal manoeuvres for shoulder dystocia.
2017/24547	Possible delay in transfer/treatment	ITU/UHNM	To standardise the management of head injury guidance so that there is one policy for the Trust. To clarify and agree with the Tertiary Centre the process for if they have accepted a patient but have no bed whether the patient should be sent directly to the Tertiary Referral Centres ED department especially if they have a need for time critical surgery.
2017/31791	Delayed treatment	PRH AMU/Ward 11	Individual learning for the practitioners concerned regarding documentation. Ward and trainee doctor teaching regarding the Decompensated cirrhosis care Bundle, particularly in the presence of sepsis.
2017/25455	Retained guidewire	Radiology/theatres	A clip is now attached to the outside part of the wire to prevent the wire from moving. If in Theatre the wire is not seen outside the chest and is not visible within the tissues, a chest x-ray will be taken.
2017/25441	Delayed diagnosis	PRH ED	Lessons learned may not materially have contributed to the incident but relate to key safer practice issues: The need to ensure regular training and education in sepsis for all healthcare professionals.
2017/22944	G3 PU	Ward 22SR	Improved communication and early escalation Early use of Medical photography Early consideration of additional supportive equipment Clear management plans (supported by advice from TV link nurses or TVNs)
2018/177	Other	ED/WMAS/Shropdoc	Clearer documentation. Improved processes to support the recording of observations in ED (Consider use of Vitalpac)
2017/2207	Delayed diagnosis	Paediatrics	Use of Vitamin D supplements in high risk groups. Support from PHE being gained for wider campaign.
2018/729 **2018/730** **2018/732**	12 hour trolley wait	RSH/PRH EDs	Long term recommendations will form part of on-going capacity planning to prevent re-occurrence.

StEIS No	Type of Incident	Clinical Area	Learning identified
2018/733 **2018/735**			
2017/28111	G3 PU	Ward 26	Assessment of skin integrity and recognition of deep tissue injury.

Avoidable Hospital Acquired Pressure Ulcers



We reported no avoidable Grade three pressure ulcers for Quarter 4. We have not identified or reported any avoidable Grade four pressure ulcers in 2017-2018.

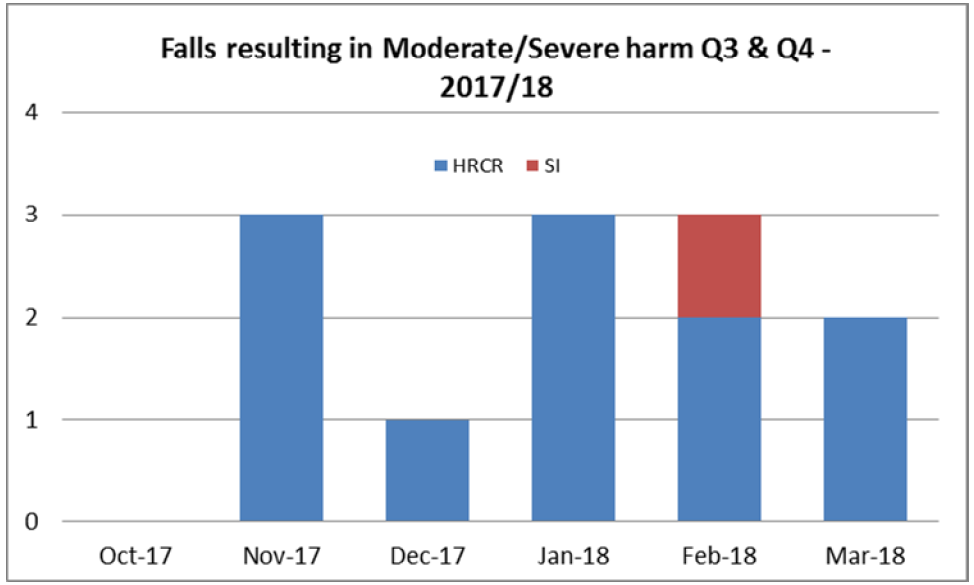
To date we have identified six avoidable Grade two pressure ulcers during Quarter 4 2017/18. Investigations have been completed and appropriate actions identified and shared with the ward staff. The learning related to the regular reassessment of potential skin damage, implementation of some risk reduction strategies and the monitoring of any areas of concern.

We have now had 34 avoidable grade two pressure ulcers in the financial year to date.

During March there were two Grade three pressure ulcers classified as unavoidable

Pressure Ulcer Site	Rationale for not reporting as an SI
Knee	Appropriate care and monitoring identified but difficult to ensure optimum positioning
Sacrum	Appropriate care and monitoring in place. Rapid deterioration from grade 1 to grade 3 despite all appropriate intervention. Rapid escalation to TVN service for advice.

Patient Falls

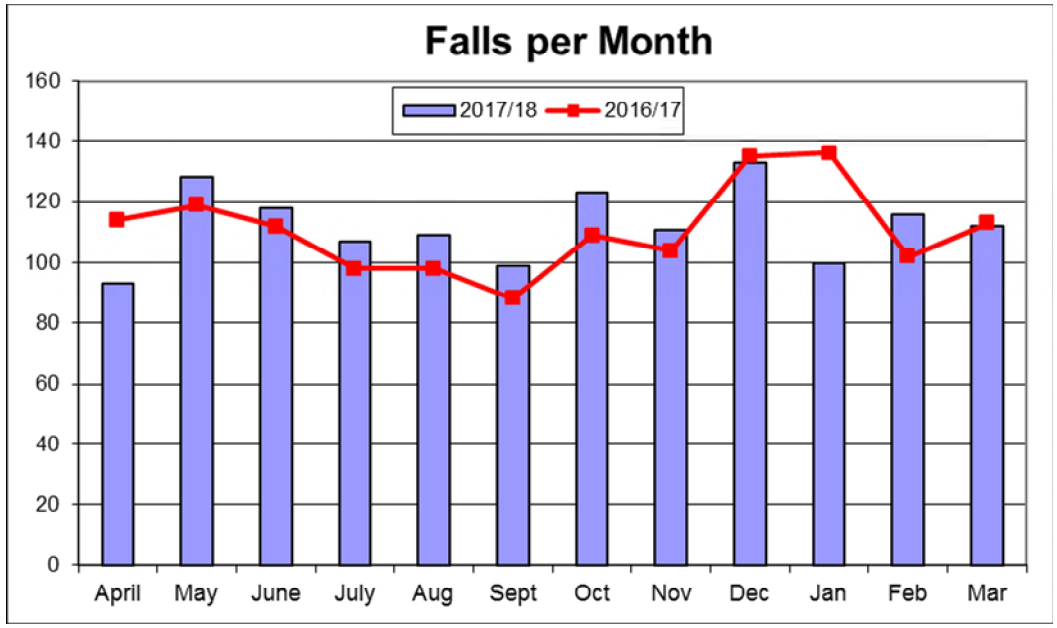


Patient falls resulting in severe harm

In Quarter 4, eight patient falls resulting in moderate to severe harm were reported. One of these met the criteria for reporting as a Serious Incident the remainder are being managed as high risk case reviews.

During March there were two falls resulting in fractures which did not meet the criteria for reporting as serious incidents:

Fall fracture site	Rationale for not reporting as an SI
Fractured Neck of Femur	All relevant risk assessments in place. Patient assessed as independently mobile by therapy and nursing staff. Patient had full capacity Not RIDDOR reportable, classed as unpreventable
Subdural Haematoma	All relevant risk assessments in place. Patient had full capacity, able to stand and mobilise independently Patient accidentally spilt urine from bottle on the floor and subsequently slipped Not RIDDOR reportable, classed as unpreventable

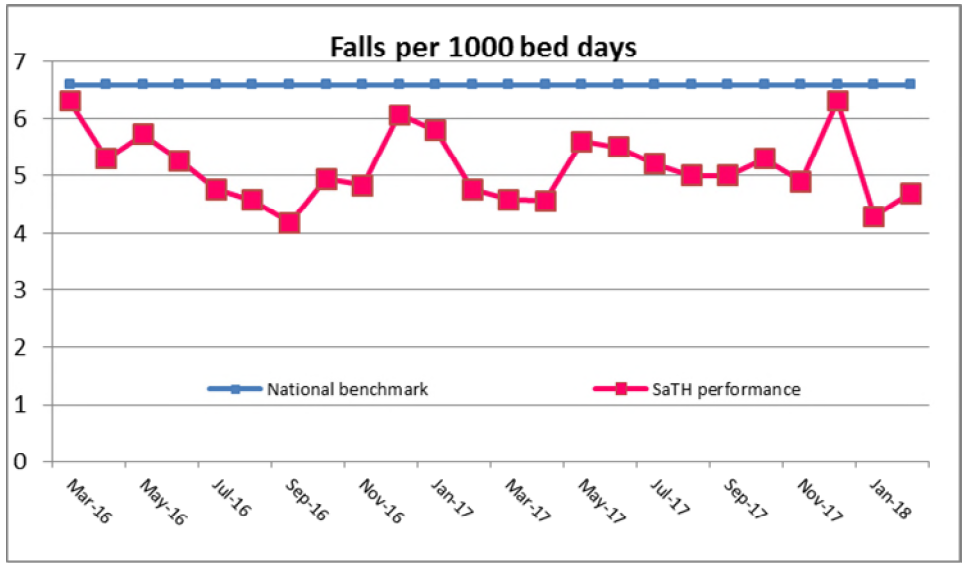


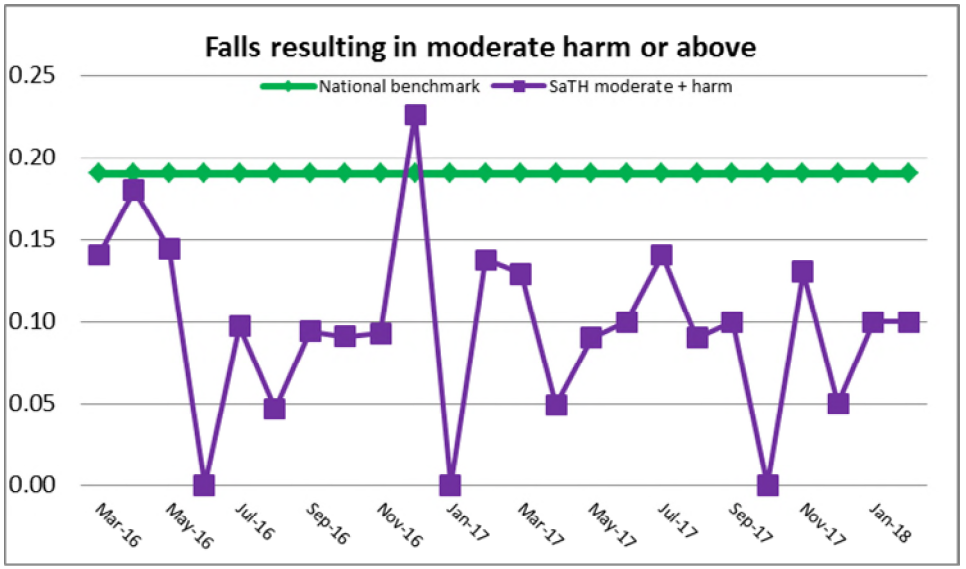
Patient Falls

The chart indicates the number of patient falls reported per month compared to 2016-2017. As may be seen with the exception of April we have reported more falls per month than the same period last year.

We have recently contributed to the National Audit for Inpatient Falls data collection for 2017 – the report is expected later this year and the results will be brought back to the Committee.

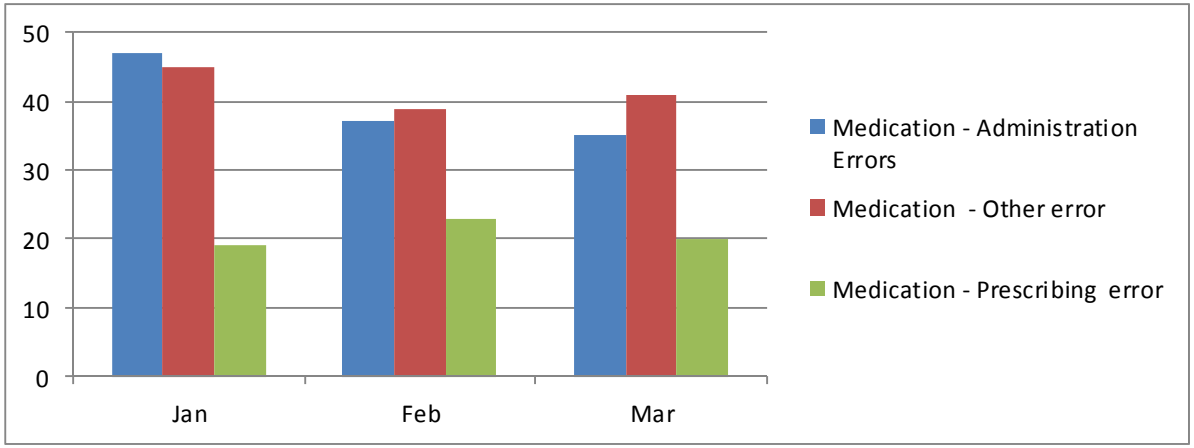
The charts below show the falls per 1000 bed days compared to the national benchmark.





Medication Incidents Jan – Mar 18

Types of medication error/Severity of Harm



	Jan	Feb	Mar
Near miss/no harm	90	67	78
Low	21	32	17
Moderate	0	0	0
Severe	0	0	0
Fatal	0	0	0
Totals:	111	99	96

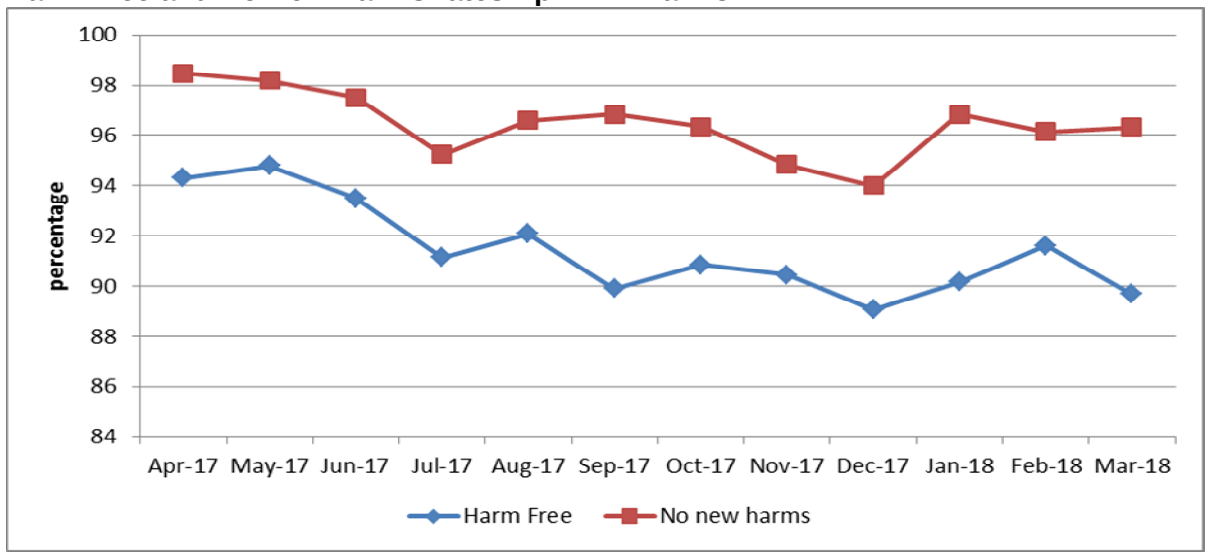
Actions to improve safety

The Safe Medicines Group meets alternate months. Some recent actions in response to incidents and identified risks include:

- Green bags' have been issued for the safer transfer of medicines when a patient is transferred between wards.
- Storage of medicines is to be improved with the trial at RSH of lockable storage bins on the wards for deliveries of medicines. In addition, a review of storage areas, and daily monitoring of the ambient temperature in medicine storage rooms is being enforced to ensure maximum storage temperatures are not exceeded and medication wasted.
- New guidelines have been issued for continuing anti-epileptic medication when a patient is unable to take their normal tablet regimes.
- A guide for the administration of Furosemide infusions is being developed following an incident in February when an infusion was delivered too quickly.

NHS Safety Thermometer

Harm Free and No New Harms rates Apr 17 – Mar 18



The NHS Safety Thermometer is a point prevalence audit carried out on a specific day across services providing NHS services.

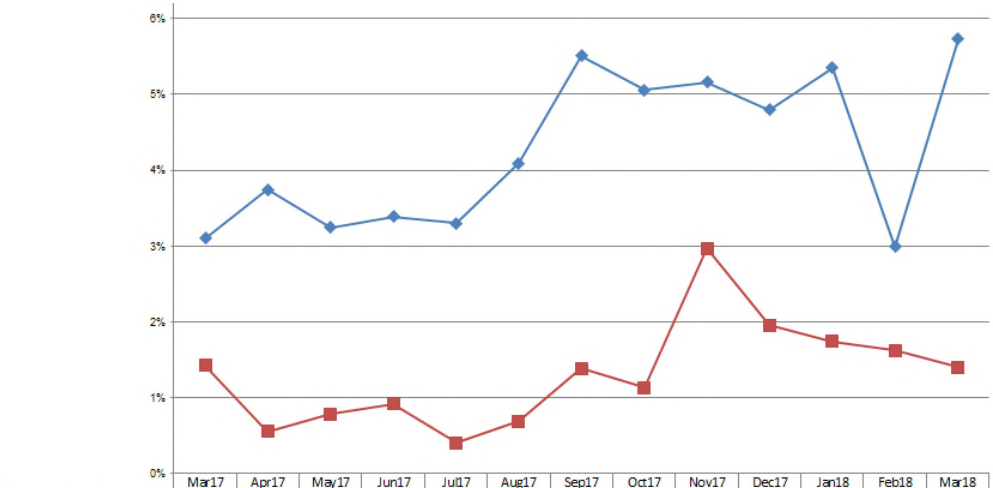
The data collection measures whether a patient has one or more of four specific "harms" including pressure ulcers, falls, VTE and catheter associated urinary tract infections (CAUTI)

Harms as described as new – those that occurred whilst in our care or old – those that were present when the patient was admitted to our care.

The data that was collected during March 2018 included 785 patients that were in our inpatient areas on the day of the data collection.

Overall, we recorded that 89.68% of the patient cohort (704/785) on the day were free from any of the four harms measured in the data collection. We also found that 96.31% (756/785) were free from any harm that occurred whilst in our care. Therefore, 29 patients that were present on the data collection day had been recorded as having either a pressure ulcer, fall, CAUTI or a VTE during their admission.

Pressure Ulcers



	Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18
Pressure Ulcers - Old	3.1	3.74	3.24	3.39	3.3	4.09	5.51	5.06	5.16	4.8	5.35	2.99	5.73
Pressure Ulcers - New	1.42	0.55	0.78	0.91	0.4	0.68	1.38	1.13	2.97	1.95	1.74	1.62	1.4
Patients	774	721	771	767	757	733	726	711	639	667	691	802	785

The trend over the year has shown that the harm with the highest prevalence are pressure ulcers both “old” and “new”. The chart illustrates that there is a decline in the number of new pressure ulcers since November 2017.

Falls

Overall, the number of falls recorded has reduced over the year (1.68% to 1.27%) or 13 to ten patients in a similar sized cohort.

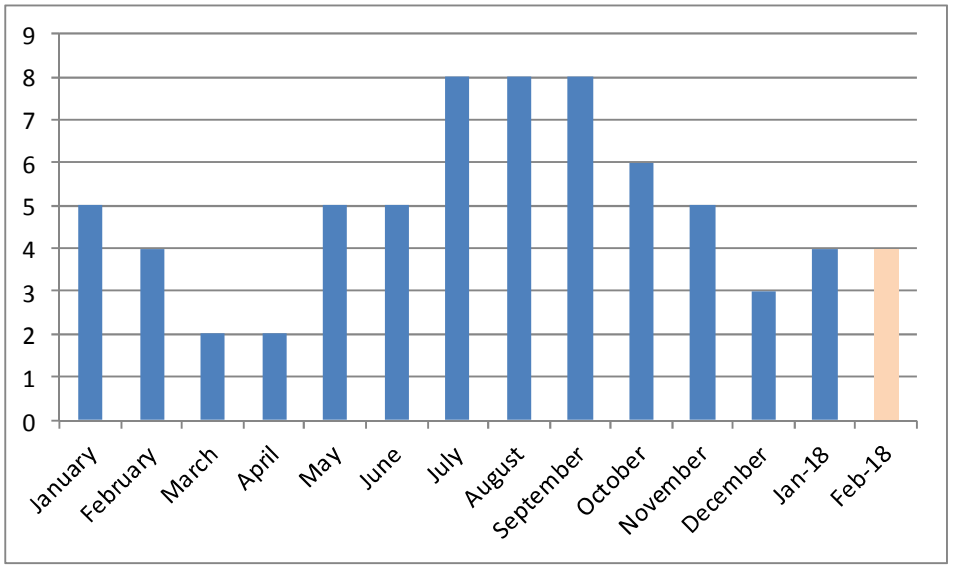
CAUTI

The percentage prevalence of CAUTI over the year (both new and old) has increased from 1.03% in April 2017 to 2.68% in March 2018. The in service prevalence has increased from 0.65% to 0.76% of the cohort (from five patients in April 2017 to six patients in March 2018 in very similar sized cohorts).

VTE

All VTE is showing a reducing trend from 4.65% to 2.8% in the same period.

Patients waiting more than 104 days for Cancer Treatment



Learning from the four patients who waited for more than 104 days for cancer treatment showed that there were different reasons for each of them having to wait for that time. No obvious themes or trends identified

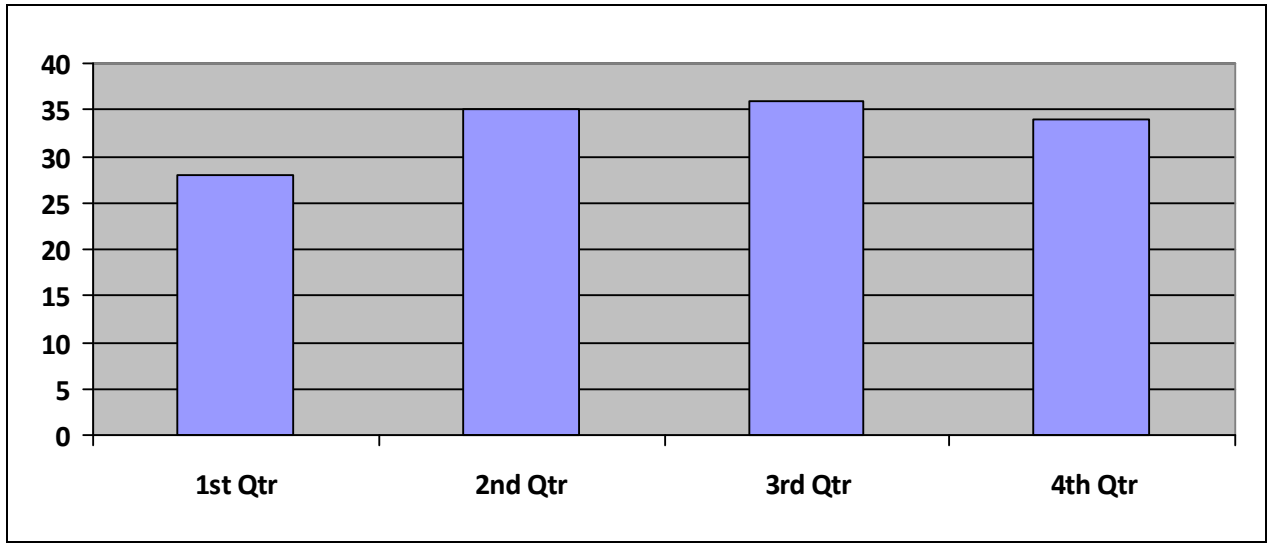
The learning reports were completed and actions identified and sharing agreed and the completed reports have been submitted to our commissioners

Safeguarding

Safeguarding Vulnerable Adults

In Qtr 4 2017-2018 there were 34 safeguarding concerns raised that involved the Trust. Of these, 23 were raised by the Trust against other agencies and eleven raised against the Trust during the period.

Safeguarding concerns involving the Trust



Concerns against the Trust included:

- One section 42 Enquiry (allegation of neglect whilst in hospital)
- Pressure ulcers and bruising
- Staff conduct /Standards of care
- Hospital Discharges

Concerns initiated by the Trust (23) the majority of these referrals related to concerns about paid carers.

Deprivation of Liberty Safeguards (DoLS)
There were 22 DoLS applications made by the Trust in Quarter 4 compared to 13 in quarter 3 and 22 in quarter 2.

January:
A total of 10 urgent referrals were made. Three of these referrals were approved. One referral was withdrawn as patient sectioned under the Mental Health Act. The remaining six referrals were not approved as patients discharged and had not been assessed by the Supervisory Body (local authority)

February:
A total of 5 urgent referrals were made. One of the referrals was approved. The remaining four referrals were not approved as patients discharged and had not been assessed by the Supervisory Body.

March:
A total of 7 urgent referrals were made. One of the referrals was approved. One referral was withdrawn as patient sectioned under the Mental Health Act. The remaining five referrals were not approved as patients discharged and had not been assessed by the Supervisory Body.

Safeguarding Children

During Quarter four 2017-2018 there were four Safeguarding Children alerts involving the Trust bringing the total for the year to 24. All were raised by Trust staff and none were made against the Trust services.

The Trust continues to contribute to Serious Case Reviews when our services have been involved in the care of children.

Prevent

Prevent is part of the Government counter-terrorism strategy CONTEST and aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism.

Prevent focuses on all forms of terrorism and operates in a 'pre-criminal' space'. The Prevent strategy is focused on providing support and re-direction to individuals at risk of, or in the process of being groomed /radicalised into terrorist activity before any crime is committed. Radicalisation is comparable to other forms of exploitation; it is a safeguarding issue that staff working in the health sector must be aware of.

The Prevent Duty 2015 requires all specified authorities including NHS Trusts and Foundation Trusts to ensure that there are mechanisms in place for understanding the risk of radicalisation. Furthermore, they must ensure that health staff understand the risk of radicalisation and how to seek appropriate advice and support. Healthcare staff will meet, and treat people who may be vulnerable to being drawn into terrorism. The health sector needs to ensure that healthcare workers are able to identify early signs of an individual being drawn into radicalisation.

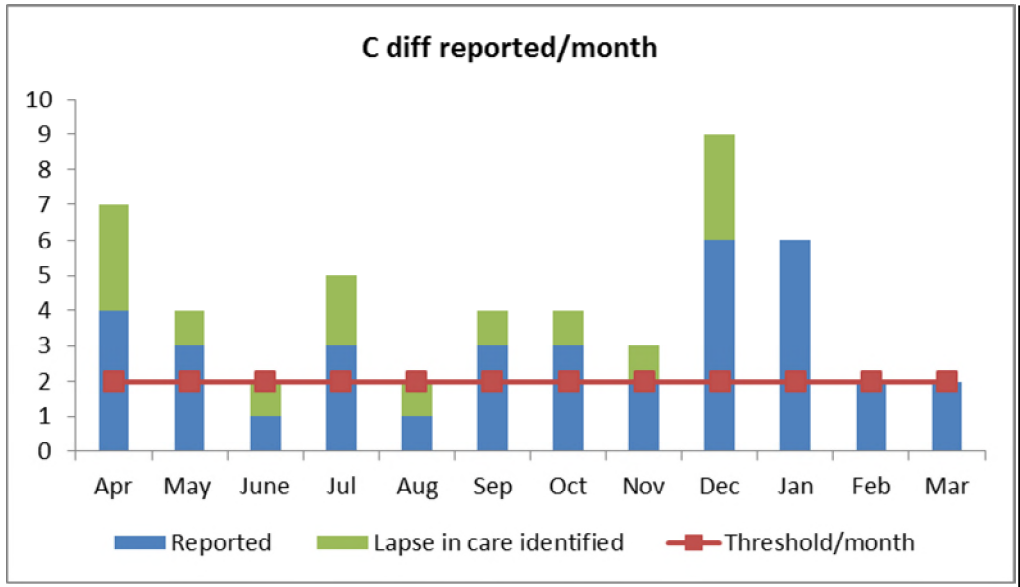
Staff must be able to recognise key signs of radicalisation and be confident in referring individuals to their organisational safeguarding lead or the police thus enabling them to receive the support and intervention they require.

There are two levels of training:

- Basic Awareness Training – we provide this to all staff on Corporate Induction and then through Safeguarding Updates.
- Workshop to Raise Awareness of Prevent (WRAP) – required by specific staff and provided through face to face training by facilitators who have been provided with a Home Office reference number (currently four in the Trust). NHS England have stated that all Trusts must have achieved a compliance rate of 85% of applicable staff trained through WRAP by March 2018.

During Qtr four 2017-2018 the Trust continued to train members of staff through WRAP sessions and our total of trained staff is now 41.7% against the target of 85%. Whilst this is an improvement against our baseline, we have not achieved the required compliance rate of 85% by the end of March. We have identified further opportunities when we can train staff to achieve as high a compliance rate as possible and are working with commissioners to provide assurance to them that we are doing all we can to train staff.

Infection Prevention and Control

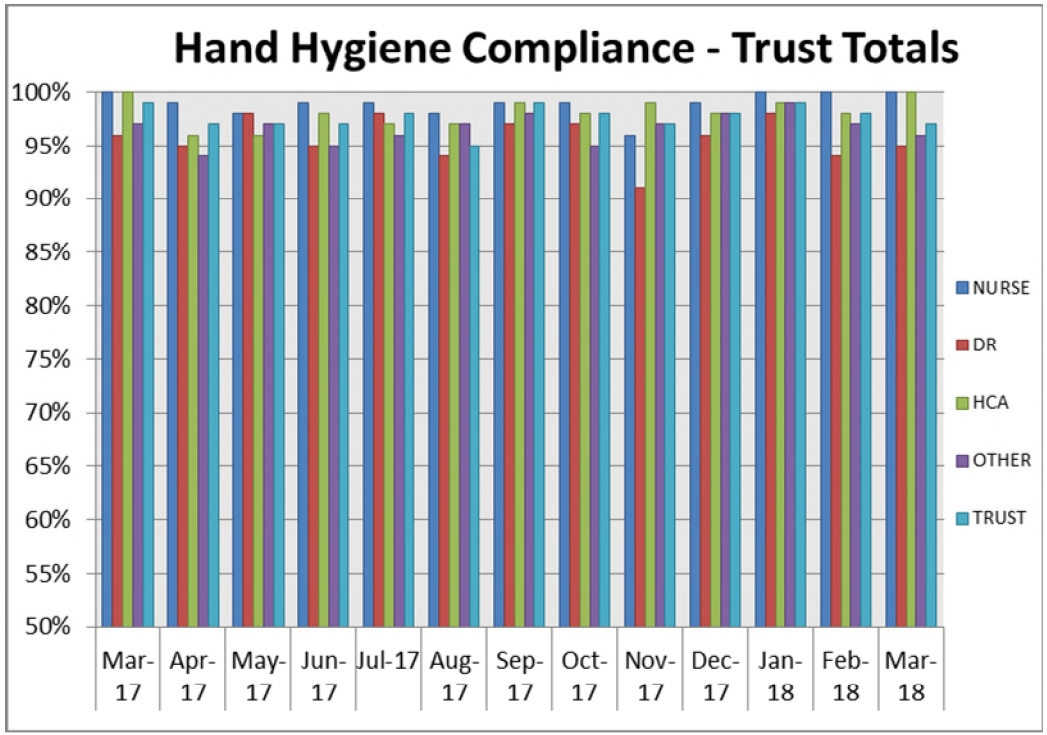


Clostridium Difficile (C Diff)

We are above our internal target for C Diff for the year so far – we have reported thirty five cases and up to the end of Qtr 3, 16 had been considered attributable to our care against a tolerance limit of no more than 25.

Post Incident Reviews (PIR) are carried out on all cases and submitted to the CCG for review and consideration of whether the infection is attributable to the care provided by the Trust. As at the end of September, four cases had been considered not attributable to the Trust and nine were considered to have elements that contributed to the infection.

The hand hygiene observational audit results have been analysed against staff groups and show the following level of compliance:



NURSE	DR	HCA	OTHER	TRUST
100%	**94%**	**98%**	**97%**	**98%**

Section four: Maternity Services

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

No	Indicator	Descriptor	Lower Limit	Expected Range	Upper Limit	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
1	Births by Unit	Telford Consultant Unit	270	300-350	370	316	383	321	323	360	345	359	325	341	347	289	351	4060
		Bridgnorth MLU	2	4-10	15	7	7	2	Closed	Closed	Closed	Closed	Closed	Closed	4	4	2	26
		Ludlow MLU	2	4-10	15	3	3	0	Closed	Closed	Closed	Closed	Closed	Closed	1	5	0	12
		Oswestry MLU	2	4-10	15	4	4	2	Closed	Closed	Closed	Closed	Closed	Closed	3	1	1	15
		Shrewsbury MLU	5	10-20	25	8	15	16	15	9	10	19	15	4	1	5	3	120
		Wrekin MLU	15	20-40	50	31	25	22	31	43	26	25	29	37	28	27	27	351
		BBA/Other		0-2	3	0	0	2	0	1	0	0	0	0	0	0	0	3
		Home		0-10	13	2	8	4	4	5	9	11	6	3	6	6	4	68
		Overall Trust total births	350	370-450	500	371	445	369	373	418	390	414	375	385	390	337	388	4655
2	Birth rate by Location Type	% of births in Consultant Unit	70%	80%-90%	90%	85.2%	86.1%	87.0%	86.6%	86.1%	88.5%	86.7%	86.7%	88.6%	89.0%	85.8%	90.5%	87.2%
		% of birth in a MLU or at home	5%	10%-20%	25%	14.8%	13.9%	12.5%	13.4%	13.6%	11.5%	13.3%	13.3%	11.4%	11.0%	14.2%	9.5%	12.7%
		% of births in any MLU	5%	10%-20%	25%	14.3%	12.1%	11.4%	12.3%	12.4%	9.2%	10.6%	11.7%	10.6%	9.5%	12.5%	8.5%	11.3%
		% Home Births		0%-3%	4%	0.5%	1.8%	1.1%	1.1%	1.2%	2.3%	2.7%	1.6%	0.8%	1.5%	1.8%	1.0%	1.5%
		% BBA/Other		0%-1%	1.5%	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%	68.2%	69.9%	71.8%	71.0%	68.9%	71.0%	71.7%	68.3%	64.4%	65.1%	68.5%	69.1%	69.0%
		Overall Assisted Births rate %		0%-15%	25%	10.2%	9.2%	8.7%	7.0%	9.6%	9.2%	8.2%	7.2%	12.5%	9.5%	9.5%	8.0%	9.1%
		Primip Assisted Births %		0%-28%	30%	21.9%	18.2%	14.9%	14.0%	16.5%	21.5%	16.2%	15.0%	24.6%	20.5%	20.9%	17.3%	18.4%
		Multip Assisted Births %		0%-10%	15%	2.3%	4.5%	5.4%	1.9%	4.5%	1.7%	3.4%	2.6%	2.4%	3.3%	2.5%	3.6%	3.2%
		Forceps rate %		0%-8%	8%	4.6%	3.8%	4.6%	3.8%	6.7%	5.4%	4.3%	4.3%	9.1%	6.7%	6.5%	5.4%	5.4%
		Ventouse rate %		0%-11%	13%	4.9%	4.9%	3.3%	3.2%	2.4%	3.6%	2.9%	2.7%	2.6%	2.6%	2.4%	2.6%	3.2%
		Dual Instruments rate %		0%-2%	3%	0.8%	0.4%	0.8%	0.0%	0.5%	0.3%	1.0%	0.3%	0.8%	0.3%	0.6%	0.0%	0.5%
		Vaginal Breech rate		0%-1%	1.5%	0.5%	1.1%	1.4%	0.5%	1.0%	0.8%	0.0%	2.4%	0.8%	1.0%	0.0%	2.1%	1.0%
		VBAC rate		0%-6%	9%	3.5%	2.3%	2.8%	2.4%	1.5%	4.4%	2.5%	3.8%	2.4%	2.3%	2.1%	1.3%	2.6%
4	Operative Deliveries	Caesarean Section rate %		0%-20%	25%	19.6%	19.3%	17.5%	20.4%	20.9%	18.5%	19.3%	22.3%	21.7%	22.9%	20.5%	20.4%	20.3%
		% of C/S following failed Ventouse		0%-3%	4%	0.0%	2.4%	1.6%	1.3%	0.0%	0.0%	0.0%	4.9%	1.2%	1.1%	0.0%	0.0%	1.1%
		% of C/S following failed Forceps		0%-5%	6%	2.8%	2.4%	0.0%	2.7%	2.3%	4.2%	2.6%	0.0%	2.4%	0.0%	1.5%	1.3%	1.8%
		% of Deliveries - Emg C/S following instrumental		0%-4%	5%	0.3%	0.5%	0.0%	0.5%	0.2%	0.5%	0.5%	0.8%	0.5%	0.3%	0.0%	0.5%	0.4%
		% of Deliveries - Category 1 C/Section		0%-4%	6%	1.9%	0.7%	1.7%	1.9%	2.4%	1.5%	2.0%	2.7%	2.1%	1.6%	1.8%	2.4%	1.9%
		% of Deliveries - Category 2 C/Section		0%-8%	10%	6.8%	6.0%	4.5%	7.6%	7.3%	5.9%	6.9%	6.8%	6.1%	7.0%	7.5%	6.0%	6.5%
		% of Deliveries - Category 3 C/Section		0%-4%	6%	1.6%	1.9%	3.1%	1.9%	1.5%	2.3%	1.7%	1.6%	3.2%	3.9%	3.3%	1.6%	2.3%
		% of Deliveries - Category 4 C/Section		0%-8%	10%	9.3%	10.7%	8.4%	9.0%	9.7%	9.0%	8.6%	11.1%	10.3%	10.4%	7.8%	10.5%	9.6%
5	Maternal Outcomes	Induction rate	15%	20%-30%	35%	35.4%	33.2%	36.8%	34.2%	35.8%	35.0%	39.8%	36.4%	34.1%	36.6%	37.3%	37.2%	36.0%
		% of deliveries with PPH >1000 mls		0%-3%	4%	3.3%	2.6%	2.5%	1.4%	1.9%	3.1%	3.0%	4.6%	5.0%	4.2%	5.1%	3.1%	3.3%
		% of deliveries with PPH >2000 mls		0%-1%	1.5%	0.5%	0.0%	1.4%	0.0%	0.5%	0.5%	1.5%	0.5%	1.1%	1.3%	0.9%	0.5%	0.7%
		Manual Removals rate		0%-2%	4%	1.6%	0.9%	0.3%	0.5%	1.0%	1.5%	0.5%	2.2%	2.1%	0.5%	1.5%	0.8%	1.1%
		3rd/4th Degree tears rate (overall)		0%-5%	6%	3.0%	3.0%	1.9%	3.0%	1.7%	0.8%	2.7%	1.1%	1.9%	2.6%	2.4%	2.4%	2.2%
		3/4 degree tear of NVD (Primip)		0%-5%	7%	6.9%	7.5%	3.2%	8.6%	3.8%	2.3%	5.4%	2.1%	5.0%	7.2%	5.3%	2.8%	5.0%
		3/4 degree tear of NVD (Multip)		0%-4%	8%	1.8%	0.0%	0.6%	0.6%	0.5%	0.0%	0.5%	1.2%	0.0%	1.7%	1.3%	2.4%	0.9%
		3/4 degree tear of Assisted (Primip)		0%-8%	10%	6.1%	15.6%	13.6%	4.3%	3.4%	3.1%	10.3%	0.0%	4.7%	3.3%	6.9%	6.9%	6.5%
		3/4 degree tear of Assisted (Multip)		0%-3%	5%	0.0%	0.0%	0.0%	0.0%	9.1%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	2.3%
		Episiotomies rate		0%-18%	20%	12.3%	12.3%	8.6%	11.1%	11.7%	10.8%	11.1%	9.2%	15.1%	9.4%	10.2%	11.5%	11.1%
6	Fetal Outcomes	Stillbirths rate		0%-1%	1.5%	0.3%	0.5%	0.3%	0.3%	0.2%	0.8%	0.5%	0.8%	1.1%	0.3%	0.0%	1.8%	0.6%
		Actual number of Stillbirths		0%-3%	4%	1	2	1	1	1	3	2	3	4	1	0	7	26
		Shoulder Dystocia rate		0%-2%	3%	0.3%	0.2%	0.8%	1.3%	1.2%	0.5%	1.4%	0.0%	1.3%	0.5%	0.6%	1.0%	0.8%
		% Term babies - Birthweight <2.5Kg		0%-5%	10%	3.1%	4.1%	3.3%	2.3%	2.6%	2.8%	3.1%	1.4%	3.9%	3.8%	3.8%	2.3%	2.9%
		% Birthweight >4Kg		0%-20%	25%	13.6%	10.7%	12.3%	13.6%	13.1%	10.8%	11.4%	13.3%	10.6%	11.2%	9.9%	9.2%	11.6%
		% Apgars <7 at 5 mins		0%-2%	3%	0.5%	0.2%	1.1%	2.1%	1.0%	1.3%	1.7%	0.8%	1.8%	1.3%	0.3%	0.8%	1.1%
7	National Smoking and Breastfeeding Targets	Breastfeeding within 48 hours of delivery	65%	67%-100%		72.5%	78.2%	75.3%	78.3%	74.3%	74.3%	72.3%	72.4%	73.9%	76.2%	75.8%	74.7%	74.9%
		'Current Smoker' at booking		0%-20%	22%	15.6%	15.4%	0.0%	17.6%	17.2%	18.5%	16.6%	16.9%	16.1%	15.7%	15.2%	16.1%	15.2%
		'Current Smoker' at delivery		0%-20%	22%	15.8%	17.2%	13.9%	13.9%	15.3%	17.0%	13.1%	14.4%	13.7%	14.2%	16.4%	15.4%	15.0%
8	Access to Maternity Services	Number of Bookings	375	400-450	500	418	455	398	433	407	433	476	479	354	426	440	411	5130
		% of bookings with a gestation of less than 10 weeks	40%	50%-100%		40.4%	46.6%	37.4%	40.2%	44.0%	36.5%	39.5%	46.8%	47.5%	38.7%	46.8%	37.5%	41.8%
		% of bookings with a gestation of less than 12 weeks 6 days	85%	90%-100%		87.8%	88.6%	90.5%	88.0%	88.0%	85.5%	86.6%	87.3%	89.0%	85.0%	84.5%	83.2%	86.9%
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%	93.2%	93.0%	90.3%	94.7%	97.6%	96.2%	92.9%	95.1%	97.4%	95.9%
		% Patients booked and assigned a named midwife	85%	90%-100%		99.5%	100.0%	100.0%	100.0%	99.2%	99.8%	100.0%	99.8%	99.4%	99.8%	99.8%	99.5%	99.7%
		% of patients with access to same midwife throughout pregnancy	70%	75%-100%		82.0%	83.2%	81.0%	82.6%	83.2%	88.9%	85.6%	88.6%	91.3%	92.5%	92.5%	88.8%	86.6%
		% patients delivered who received 1:1 care during established labour (Shropshire and Telford & Wrekin patients only)	95%	100%		98.5%	98.0%	97.9%	94.6%	95.9%	95.2%	97.5%	96.7%	98.0%	98.8%	97.4%	97.5%	97.1%

The purpose of this report is to provide the committee with an analysis of data within the maternity dashboard for March 2018. The report highlights the RAG rating elements by exception and indicates a description for the indicators that are red or amber below:

1. **Telford Consultant Unit Births**. The expected locally set range for this descriptor is between 300-350 births per month. March 2018 has seen a live delivery figure of 388. The end of year total births for the Consultant Unit was 4060 births. The increasing number of births and activity within the consultant unit (90.5%) will be observed going forward to the end of financial year to identify any further increases and trends.
2. **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 33 births in March 2018 demonstrating a red rating of 8.5%. The delivery figures for MLU births for the end of year 524 births (11.3%) demonstrating an amber rating. The reduction in MLU births is partly due to one or more MLU's being closed since June 2017 and the higher risk woman needing to deliver in a Consultant Unit. The Home births were 68 for the year 2017/18 (1.5%) demonstrating a green rating.
3. **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 5.4 % is reported as green in March 2018.
4. **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 2.1% is demonstrated a red rating. The end of year figure 2017/18 was 1.0%
5. **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 20.4 % is reported as amber during March 2018. The End of year figure was 20.3%. The National rate is between 25-30%.
6. **Operative deliveries Category 4 (Elective C/S**) The expected locally set range of between 0-8%. March 2018 is reported red at 10.5%. The end of year figure 2017/18 was 9.6%.
7. **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 37.2% reported as red during March 2018. The end of year figure of 36% 2017/18 is demonstrated as amber.
8. **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 3.1% is reported as amber in March 2018. The end of year date was 3.3% with an amber rating.
9. **Maternal outcomes -% of deliveries with PPH>2000mls**. The expected rate for this descriptor is 0-0.5%. March 2018 demonstrates a green rating of 0.5%. The end of year data was 0.7% demonstrating a green rating.
10. **Maternal Outcomes - 3/4 degree tear of (Primip**). The locally expected range for this descriptor is 0-5%. Therefore the rate of 2.8 % reported as green in March 2018. The end of year 2017/18 is 5.0% demonstrating an amber rating.

11. **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 2.4% is reported as green for March 2018. The end of year dates 2017/18 were 0.9% and are represented by a green rating
12. **Stillbirth –** The expected range for this descriptor is 0% to 1%. Therefore the rate of 1.8% is reported as red in March 2018. The end of year figure 2017/18 is 0.5% and represents a green rating.
13. **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 37.5% is reported as red for March 2018. The end of year figure is 41.8 % demonstrated by the amber rating.
14. **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 83.2% reported as Red during March 2018. The end of year figure of 86.9% is demonstrated as amber.
15. **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 97.5 % reported as Amber during March 2018. The end of year figures 2017/18 were 97.1%.
16. **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, February 2018 or March 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 March 2018 demonstrated an overall green rating of 16.1% and an end of year figure of 15.2.

Section five: Recommendations for the Trust Board

The Trust Board is asked to:

- **Discuss** the current performance in relation to key quality indicators as at the end of March 2018
- **Consider** the actions being taken where performance requires improvement
- **Question** the report to ensure appropriate assurance is in place