The Shrewsbury and Telford Hospital NHS Trust

Paper 11

Recommendation ☑ **DECISION** ☐ **NOTE**	**Trust Board** is asked to **Discuss** the current performance in relation to key quality indicators as at the end of May 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	05 July 2018
Paper Title	Quality Governance Report – Month 2
Brief Description	The purpose of this report is to provide the Trust Board with assurance relating to our compliance with quality performance measures during May 2018 Key points to note: **MRSA Bacteraemia reported in April:** We reported our first MRSA bacteraemia since August 2016 in April. The investigation found that there were no specific lapses in care that could definitively have contributed to this bacteraemia. The patient lived in a care home and had multiple admissions to hospital and it was felt more likely that the recent strain was acquired in hospital so this incident will be apportioned to the Trust. **Serious Incidents reported.** We reported four serious incidents in May relating to delayed diagnosis, an information governance breach, wrong site surgery (Never Event) and a delay in treatment. **Pressure Ulcers:** In May 2018 there were no grade three pressure ulcers reported as developing in service but there was one grade four pressure ulcer reported. This incident did not meet the criteria for reporting as a Serious Incident and is in the process of being managed as a high risk case review (HRCR). **104 Day Cancer Waits:** In May there were six reviews carried out into the care of patients that had waited more than 104 days for cancer treatment to start. Four were considered to have caused no harm and two could have potentially caused harm **MSA:** 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. **Safeguarding** Workshops to Raise Awareness of Prevent (WRAP) continue to be delivered by the Safeguarding Team and to date we have trained 59% of applicable staff. **Maternity:** • **HIE:** Zero neonatal HIEs in April or May 2018 • **Induction of Labour Rate** The NMPA expected rate is 28.5%. The SaTH Maternity rate is reported as 37% in May 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.
Sponsoring Director	Deirdre Fowler, Director of Nursing, Midwifery and Quality
Author(s)	Dee Radford, Associate Director of Patient Safety Sam Hooper, Medical Performance Manager Anthea Gregory Page, Deputy Head of Midwifery
Recommended / escalated by	Quality and Safety Committee
Previously considered by	**Quality and Safety Committee**
Link to strategic objectives	**PATIENT AND FAMILY** Listening to and working with our patients and families to improve healthcare **SAFEST AND KINDEST** Our patients and staff will tell us they feel safe and received kind care
Link to Board Assurance Framework	RR561, RR1204, RR1186
Outline of public/patient involvement	The paper reflects patient feedback in the form of FFT and Complaints and PALS data.
Equality Impact Assessment	○ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** *** EIA must be attached for Board Approval** ○ 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

Paper 11

Quality Governance Report

June 2018

Introduction

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of May 2018. The report will provide assurance to the Trust Board where 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 has been submitted to the Quality and Safety Committee as a standalone document and is now presented to Trust Board for consideration and triangulation with performance and workforce indicators.

The report has been submitted to our commissioners (Shropshire Clinical Commissioning Group, Telford and Wrekin Clinical Commissioning Group and Powys Teaching Health Board) to provide assurance to them that we are fulfilling our contractual requirements as required in the Quality Schedule of our 2018-2019 contract.

Every quarter we provide a detailed report relating to a number of metrics as reported here but with the additional detailed triangulation with patient experience metrics such as complaints and PALS and further detail relating to incident reporting down to Care Group level.

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.

Contents

Section one: Our Key Quality Measures

Measure	Year end 17/18	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
CDI due to lapse in care (CCG panel)	12	1	2	1	1	1	1	3	1	1	0				0	25
Total CDI reported	32	3	1	3	1	1	3	6	6	2	2	2	2	4	None	None
MRSA Bacteraemia Infections	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0
MSSA Bacteraemia Infections	26	1	1	6	2	3	2	4	2	3	1	1	1	2	None	None
E. Coli Bacteraemia Infections	29	1	1	3	3	1	4	2	6	5	2	4	2	6	None	None
MRSA Screening (elective) (%)		95.9	95.9	95.6	95.6	95.5	96.4	96.0	94.0	95.0	95.4	96.5	96.5	96.5	95%	95%
MRSA Screening (non elective) (%)		95.0	96.1	96.1	97.0	97.2	95.3	95.5	94.8	94.0	95.62	96.7	95.9	96.3	95%	95%
Grade 2 Avoidable	48	2	3	4	4	3	4	6	4	7	5	0	2	2	2	0
Grade 2 Unavoidable	152	6	15	18	13	12	12	12	14	16	5	12	0	12	None	None
Grade 3 Avoidable	9	1	0	2	1	2	2	1	0	0	0	0	0	0	0	0
Grade 3 Unavoidable	22	2	3	3	0	1	0	2	6	1	3	2	0	2	None	None
Grade 4 Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grade 4 Unavoidable	0	1	0	0	0	0	0	0	0	0	0	0	1	1	None	None
Falls reported as serious incidents	3	1	0	1	0	0	0	0	0	1	0	0	0	0	None	None
Number of Serious Incidents	77	6	1	4	4	10	7	3	8	15	13	2	4	6	None	None
Never Events	2	0	0	0	0	1	0	0	0	1	1	0	1	1	0	0

Measure	Year end 17/18	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
Catheter Associated UTI (prevalence)		0.39	0.13	0.41	0.83	0.7	0.94	0.9	0.43	0.12	0.76	0.43	0.31	0.37	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE Assessment		95.4	95.2	95.4	96.4	95.9	95.5	95.1	95.68	95.2%	95.1%	95.9%		95.9%	95%	95%
ITU discharge delays>12hrs	380	37	39	31	37	33	39	17	28	35	41	27	43	70	None	None
Complaints (No)	600	42	61	50	45	45	61	31	49	60	56	54	55	109	None	None
Friends and Family Response Rate (%)	23.8%	23.3	19.5	20.1	18.3	15%	14.3%	12.3%	11.1%	13.6%	16.1%	19.9%	17.7%	18.8%	None	None
Friends and Family Test Score (%)	96.6%	97.0	96.2	97.1	97.2	96.1	96.8	97.4	96.6	96.2%	96.4%	97.3%	96.6%	96.95%	75%	75%

Section Two: Key Messages by exception

Infection Prevention and Control

MRSA Bacteraemia

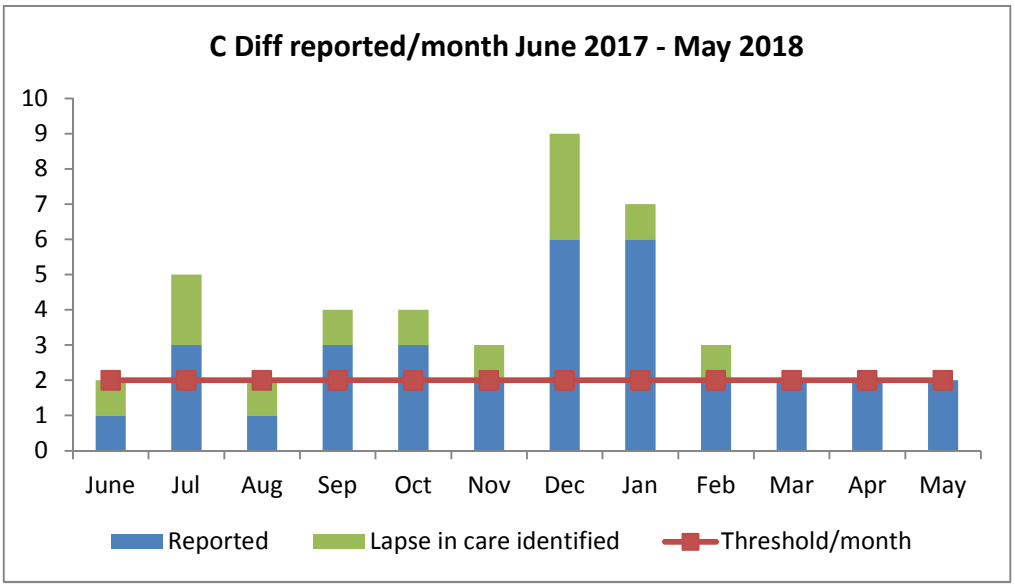
The Trust reported an MRSA Bacteraemia incident in April 2018. MRSA, or Methicillin Resistant Staphylococcal Aureus, is a highly resistant strain of the common bacteria, Staph Aureus. Bloodstream infections (bacteraemia) cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.

A post infection review is carried out for each case. We analyse the cause of infection looking at the whole patient journey and do not apportion cases on the basis of the time after admission but instead look at where the infection was acquired. The investigation into this incident has now been completed. The investigation found that there were no specific lapses in care that could definitively have contributed to this bacteraemia. The patient lived in a care home and had multiple admissions to hospital and it was felt more likely that the recent strain was acquired in hospital so this incident will be apportioned to the Trust.

We continue with our ongoing work in reducing MRSA bacteraemia and less severe infections from MRSA including improving compliance with screening of emergency admission patients, continued emphasis on isolation and clearance of colonised patients, and continued improvement in compliance with hand hygiene and prevention of line associated infections. We also monitor less severe infections and colonisations with MRSA and investigate any clusters which occur.

Clostridium Difficile

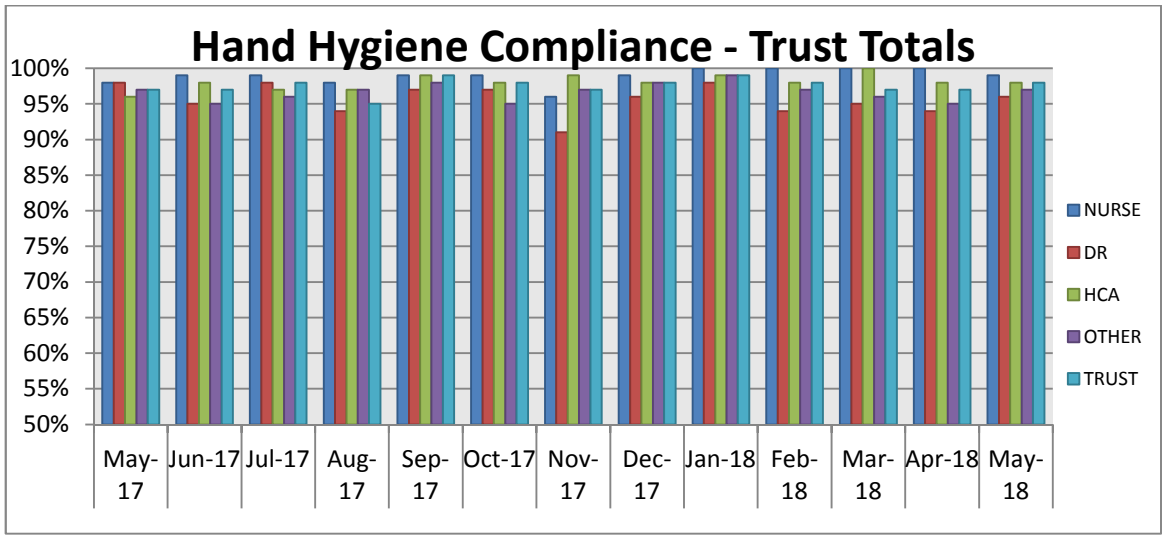
In May 2018 we reported two cases of C Diff in the Trust. These will be investigated and the findings considered by the Clinical Commissioning Group panel as to whether they are attributable to a lapse in care in the Trust.



Catheter Associated Urinary Tract Infections (CAUTI)

The monthly prevalence audit of CAUTI showed that 0.31% of the cohort of inpatients measured on the day (653) were recorded as having a new (in service) CAUTI. This relates to two patients compared to three in April 2018.

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



NURSE	DR	HCA	OTHER	TRUST
99%	96%	98%	97%	98%

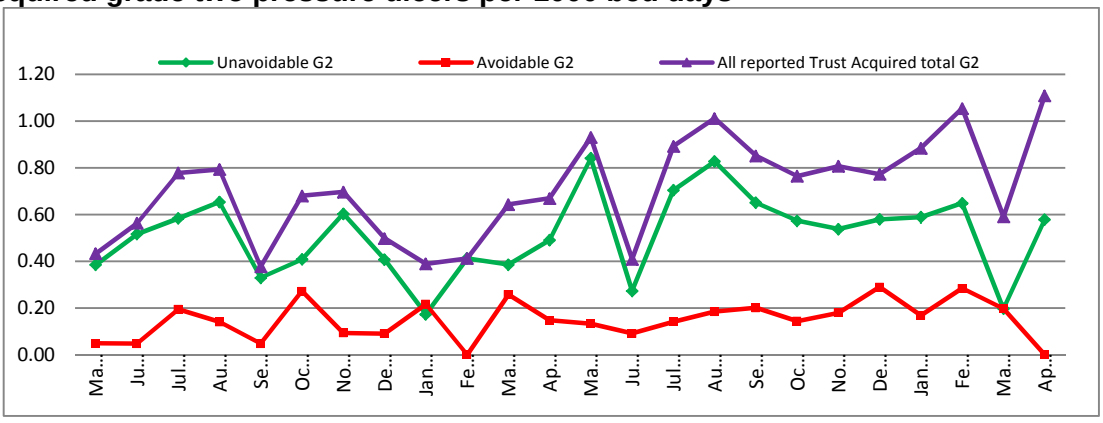
Learning from in service pressure ulcer incidence

Grade Two Pressure Ulcers
Two grade two pressure ulcers have so far been determined to be avoidable for May 2018 - the contributory factors/learning is below:

- Case One: Device related as skin damage related to a tracheostomy tube and gaps in documentation to evidence regular review of the skin.
- Case Two: Device related as the skin damage was caused by nasal cannula for oxygen administration. The ward had inadvertently stocked nasal cannula without ear cushioning sponges. The damage was noted during appropriate checking, but could have been avoided if the correct device had been used.

The numbers of grade two pressure ulcers that we are reporting are shown in the table below. This indicates that overall the total number 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

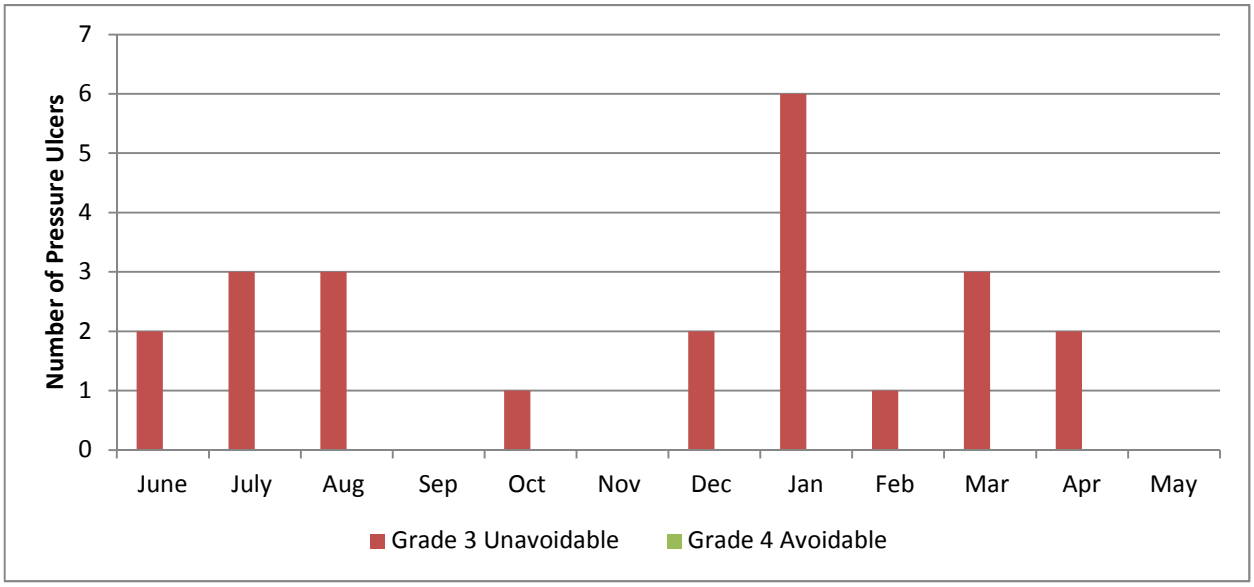


Grade Three and Four Pressure Ulcers
In May 2018 there were no grade three pressure ulcers reported as developing in service but there was one grade four pressure ulcer reported. This incident did not meet the criteria for reporting as a Serious Incident and is in the process of being managed as a high risk case review (HRCR).

This patient had a very poor nutritional status and had vascular compromise. The patient has full capacity and had chosen to not follow advice in relation to protecting their skin. There was evidence to show that staff had provided correct advice. As a result, the skin damage to the elbow, which is a vulnerable area to pressure damage, occurred, but was considered by the Tissue Viability Nurse, the Patient Safety Team and the ward manager to be unavoidable.

The chart below shows the number of avoidable grade three and four pressure ulcers developed in service from June 2017 to May 2018. There were no avoidable grade four pressure ulcers during this time period.

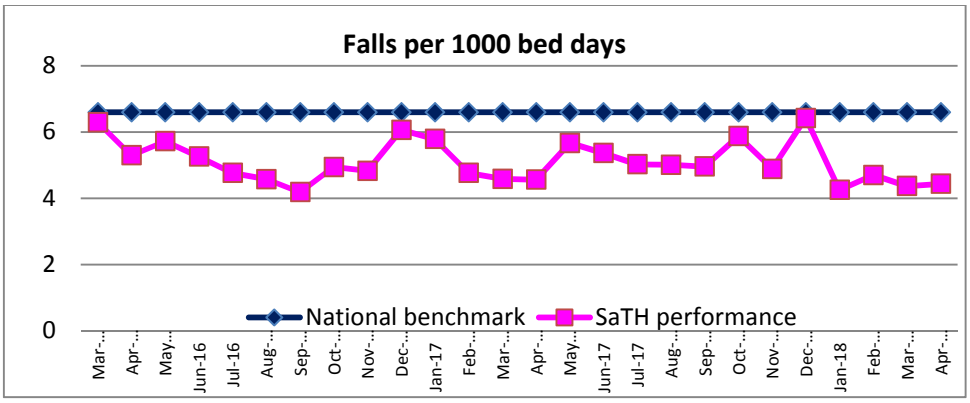
Avoidable Grade three and four pressure ulcers June 2017 – May 2018



Learning from falls

In May 2018 we did not report any falls resulting in fractures as Serious Incidents and no falls which resulted in a fracture which were determined suitable to manage as a HRCR. The chart below shows that we remain below the national benchmark for falls per 1000 bed days to April 2018. When comparing 2016/17 with 2017/18, falls per 1000 bed days decreased slightly from an average of 5.1/1000 bed days to 5.06/1000 bed days, which is a 0.04/1000 bed day reduction.

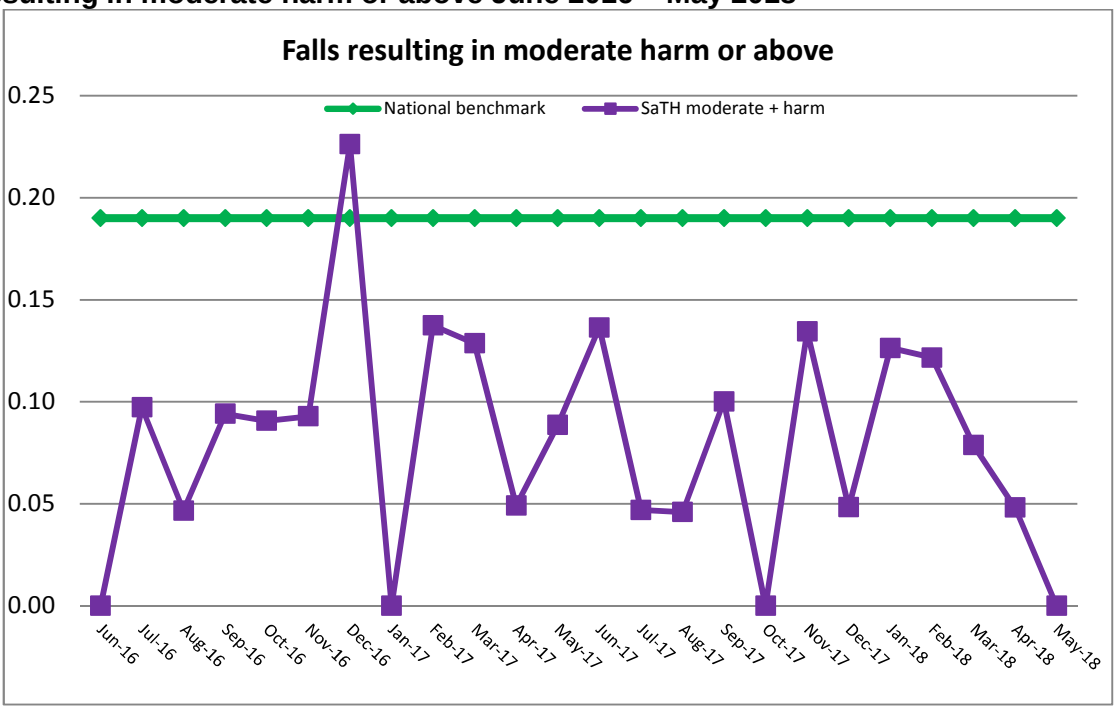
Falls per 1000 bed days Mar 2016 – Apr 2018



Falls resulting in moderate harm or above

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

Falls resulting in moderate harm or above June 2016 – May 2018



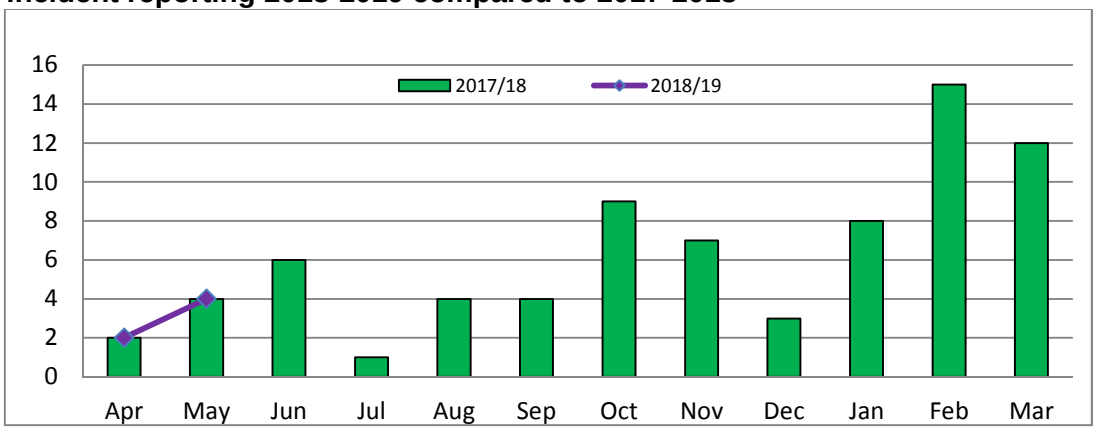
Since December 2016 the Trust has sustained a lower than the national benchmark number of falls resulting in moderate harm or above for our patients. The inference is that while there has been an increase in reporting of falls during December 2017, this has not resulted in more significant harms, the falls prevention strategies for our highest risk patients therefore appears to continue to be effective.

When comparing 2016/17 with 2017/18, falls resulting in moderate harm or above per 1000 bed days decreased slightly from an average of 0.10/1000 bed days to 0.08/1000 bed days, which is a 0.02/1000 bed day reduction.

Learning from moderate and serious incidents

In May 2018 we reported four serious incidents as shown in the chart below and are currently matching the reporting levels for the previous year.

Serious incident reporting 2018-2019 compared to 2017-2018



The categories of incident are shown below:

Categories of incidents reported in May 2018

Category	Number
Delayed diagnosis	1
Information Governance Breach	1
Never Event (wrong site surgery)	1
Treatment delay	1
Total	**4**

Detail relating to these incidents is:

- **Delayed Diagnosis**. This incident refers to a patient who was an inpatient in the Princess Royal Hospital and who sadly died whilst in hospital. The patient's death was referred to the Coroner and following review it was agreed that it should be investigated as a serious incident as there is potential that a delayed diagnosis may have contributed to their death. This has been reported by the Trust as a safeguarding concern as the patient was an adult at risk.

- **Information Governance Breach.** This related to a letter sent by fax which did not go to the intended recipient and therefore constituted a breach. The incident has been reported to the Information Commissioner and the Caldicott Guardian is the executive lead for the investigation. The patient concerned is aware of this incident.

- **Never Event.** The Committee will be aware of the Never Event that was reported in May relating to "wrong site surgery" as defined by the Never Event guidance published in January 2018. The Trust has taken immediate actions that include:

    - Lead Investigator appointed who will be supported by an external expert
    - Thematic analysis of the previous Never Events in the operating theatres over the last two years

- The Academic Health Science Network (AHSN) Patient Safety Collaborative will assist the Trust which has suggested ways in which they might support the Trust in terms of training and carrying out a cultural assessment within the clinical area.

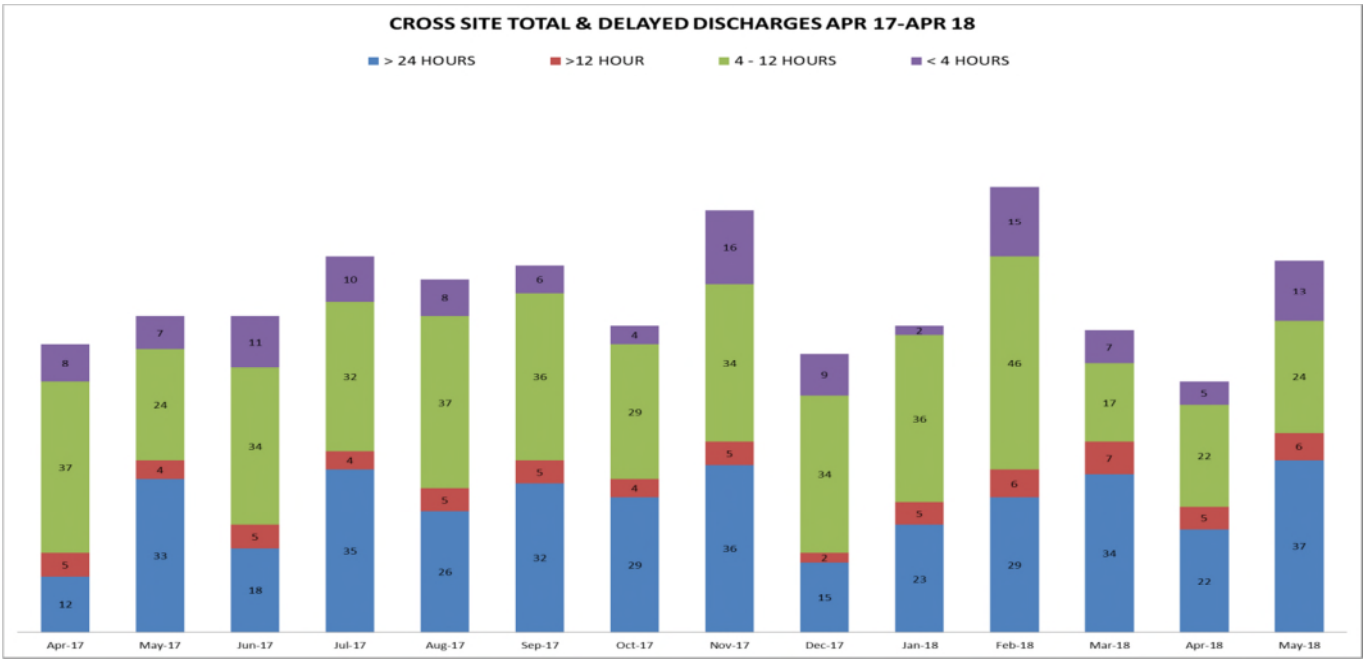
- **Treatment Delay.** This incident was reported following a transfer of a child to a specialist hospital. The child was reviewed within the ED by a paediatrician and then transferred via specialist retrieval team. The issue that caused the delay relates to the guidelines for this time critical situation which were not known to the paediatrician that saw the child on their arrival into the department.

The incidents have all been allocated a Lead Investigator and Executive Lead. All incidents will be investigated using the Trust processes for serious incident investigations and the reports submitted to the commissioners when complete.

Waiting for cancer treatment for more than 104 days

In May there were six reviews carried out into the care of patients that had waited more than 104 days for cancer treatment to start. Four were considered to have caused no harm and two could have potentially caused harm. The cases related to cancers in gynaecology (one potential harm), lung (one potential harm) and urology, took the form of a clinical review and were then reviewed Deputy Chief Officer and the Clinical Lead for cancer services who has the final approval. The cases that could potentially have caused harm are further reviewed in detail within the relevant Care Groups and oncology governance meetings as well as the cancer service to identify the issues that caused the breach and what actions have been taken to ensure that the patients receive the treatment that they need as soon as possible. Learning is then shared through the multidisciplinary team meetings

Delayed discharges from ITU (potential Mixed Sex Accommodation Breaches)



We have not reported any mixed sex accommodation breaches in the Trust in May in any areas outside our intensive care areas.

In May we saw an 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 34 patients waited more than 12 hours, 29 of whom were delayed more than 24 hours. At the Princess Royal Hospital one patient waited between 12 and 24 hours and eight over 24 hours. Twenty seven patients were transferred in less than 12 hours at the Royal Shrewsbury Hospital and ten at the Princess Royal Hospital.

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.

In order to better understand whether the delay in transfer means that a mixed sex accommodation breach has occurred, we are amending how we collect this information on datix. This will be reported at the end of July 2018.

Safeguarding Adults at Risk and Children and Young People

In May there were seven safeguarding concerns relating to adults at risk involving the Trust. All were raised by Trust services, one relating to a serious incident. The others related mainly to concerns about members of patients families and one related to a care home. Three were considered to be domestic abuse, two were neglect or omission of care, one was self neglect and one was potential financial abuse. This was a slight reduction from the ten concerns reported in April. Themes and trends for quarter one will be reported in detail in the quarterly report in July 2018.

In relation to Safeguarding Children and Young People, there was one referral made to social care by the Trust. In addition a report into a Serious Case Review was published by Telford and Wrekin Safeguarding Children's Board to which the Trust had contributed. There were two actions that the Trust had identified as part of the learning from the review, both of which are on track for completion within timescales.

Workshops to Raise Awareness of Prevent (WRAP) continue to be delivered by the Safeguarding Team and to date we have trained 59% of applicable staff. We continue to provide these sessions and have a recovery plan in place to achieve 85% by March 2019.

Patient and Carer Experience

Complaints and PALS

There were 55 formal complaints received May 2018 in line with expected figures. Twenty five related to RSH, and 31 to PRH and one to Princess House. The main themes continue to be staff attitude and clinical treatment.

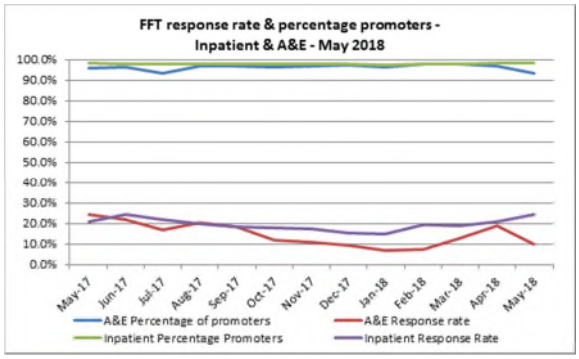
There were 163 PALS contacts received which is higher than previous months. Main issues raised relate to appointments and communication. A piece of work is being done looking at PALS contacts relating specifically to appointment problems.

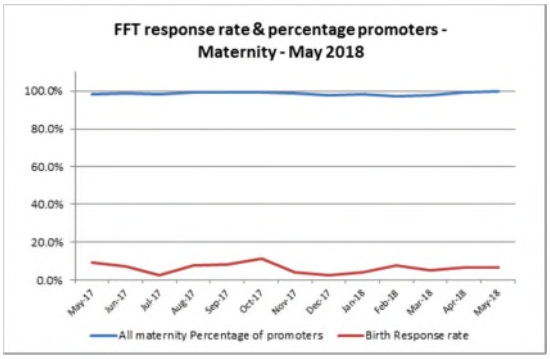
Friends and Family Test

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 96.6%. This was a slight decrease compared to last month's rate of 97.3%.

Individually, Inpatients and Maternity saw an increase in the percentage of patients who would recommend compared to April. The overall response rate was 17.7% which was a decline since April's 19.9%. Again, all four areas saw individual increases since last month

	Percentage Promoters	Response Rate
Maternity overall	100%	6.7% (Birth only)
A&E	93.3%	8.9%
Inpatient	98.4%	24.0%
Outpatients	95.4%	NA





Section three: Mortality

SaTH aspires to be an organisation delivering high quality care which is clinically effective and safe and this partly is achieved by continually monitoring and learning from mortality. These can provide SaTH with valuable insights into areas for improvement. To support that the governance around mortality is well developed, in order to provide continued learning and improvements to the clinical pathways and to reduce unnecessary harm to patients.

We have seen an improvement in our performance regarding mortality over the last four years, and this has been maintained over the last year. This is demonstrated consistently over the four mortality parameters that we use and we now are consistently lower than our peer comparators. The following is an update of progress in this area, based on the most up to date information available.

Mortality Rate: The mortality rate provides a basic view of mortality – the number of deaths divided by the total spells.

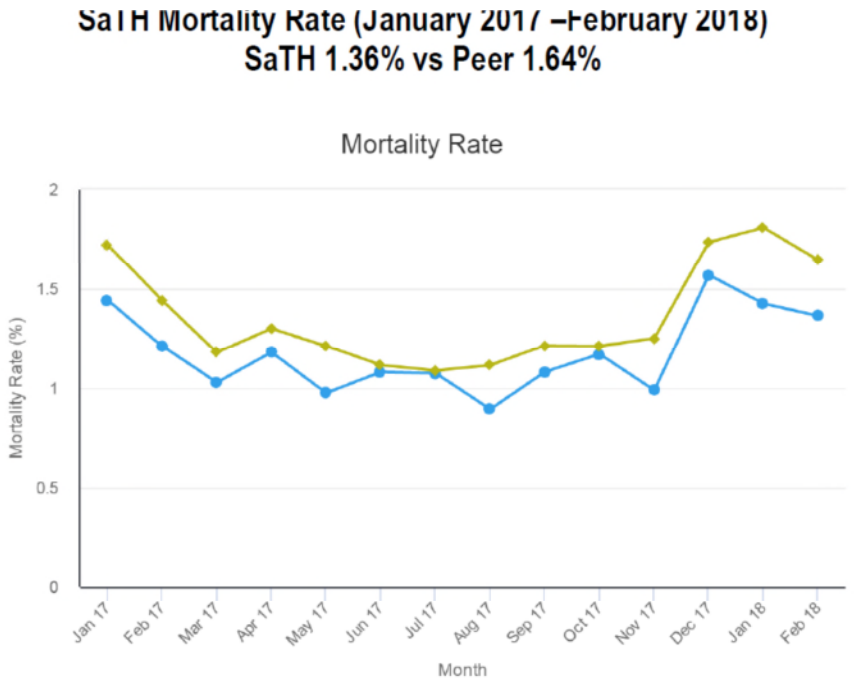


Figure 1 – Short term view

SaTH Mortality Rate (January 2013 – January 2018)

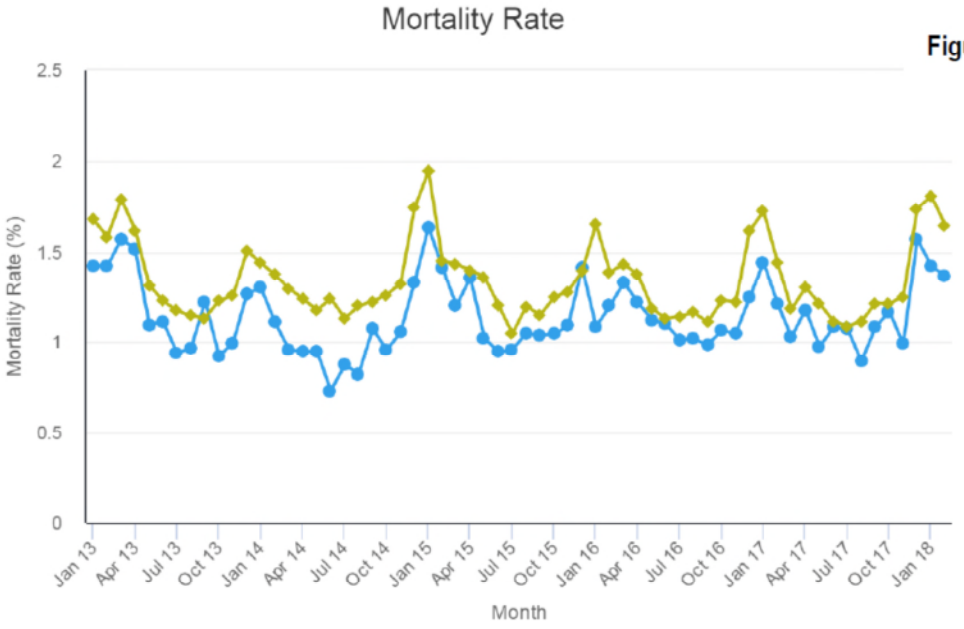


Figure 2 – Long term view

Risk Adjusted Mortality Index (RAMI)

This mortality ratio is described as the number of observed deaths divided by the number of predicted deaths. RAMI was developed by CHKS (Caspe Healthcare Knowledge System). It includes palliative care but excludes certain specialties, such as Mental Handicap, Mental Illness, Child & Adolescent Psychiatry, Forensic Psychiatry, Psychotherapy, Old Age Psychiatry.

RAMI – SaTH v Trust Peer January 2017 –February 2018
SaTH 85.45 v Trust Peer 104.98

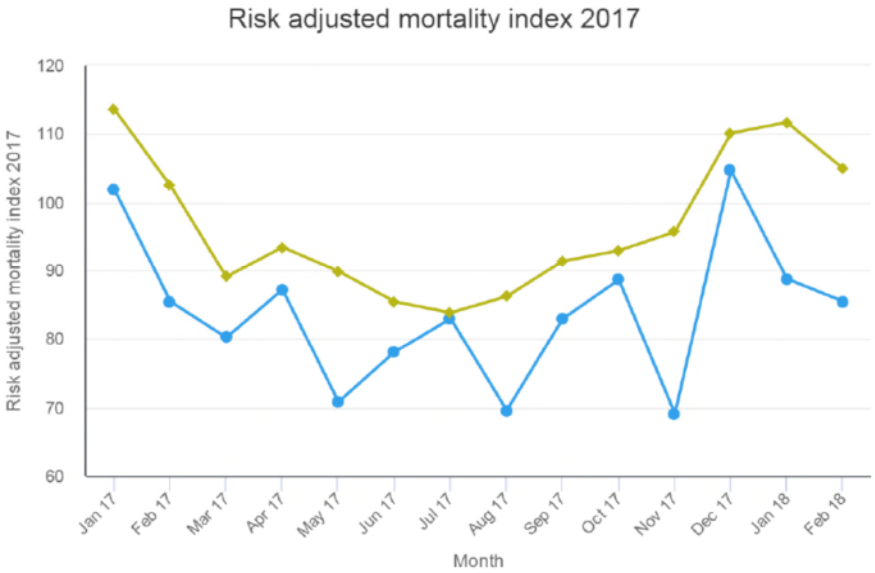


Figure 3 – Short term view

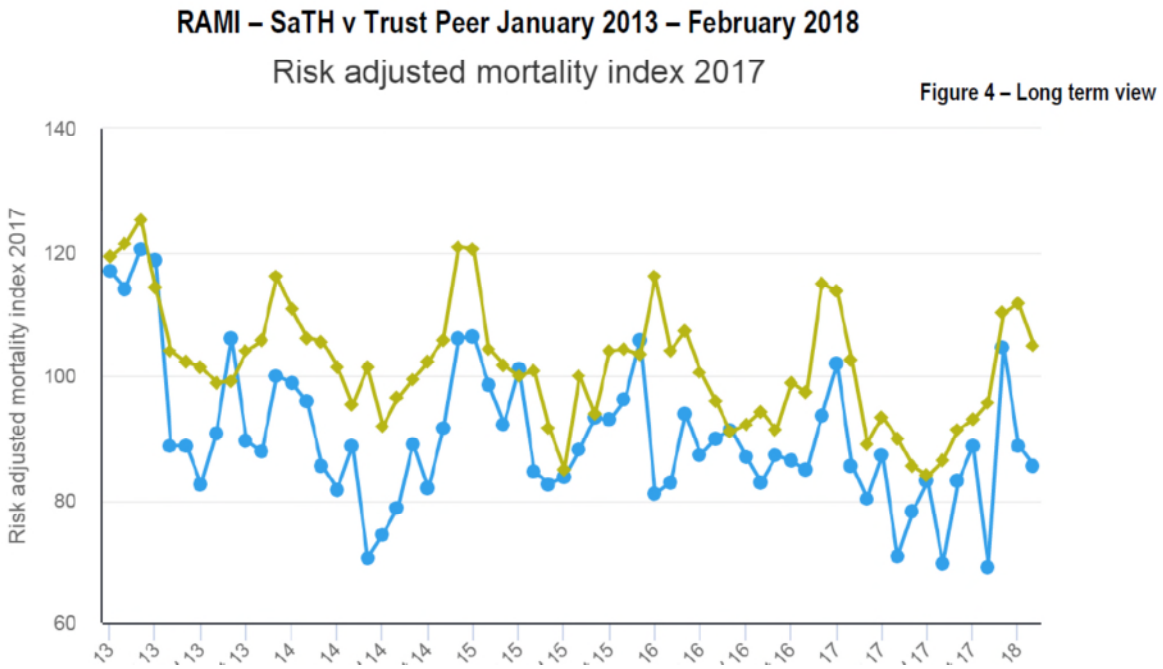


Figure 4 – Long term view

Hospital Standardised Mortality Ratio (HSMR)

The HSMR is the ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups. These groups contribute to over 80% of in-hospital deaths in England.

NB A value greater than 100 means that the patient group being studied has a higher mortality level than NHS average performance.

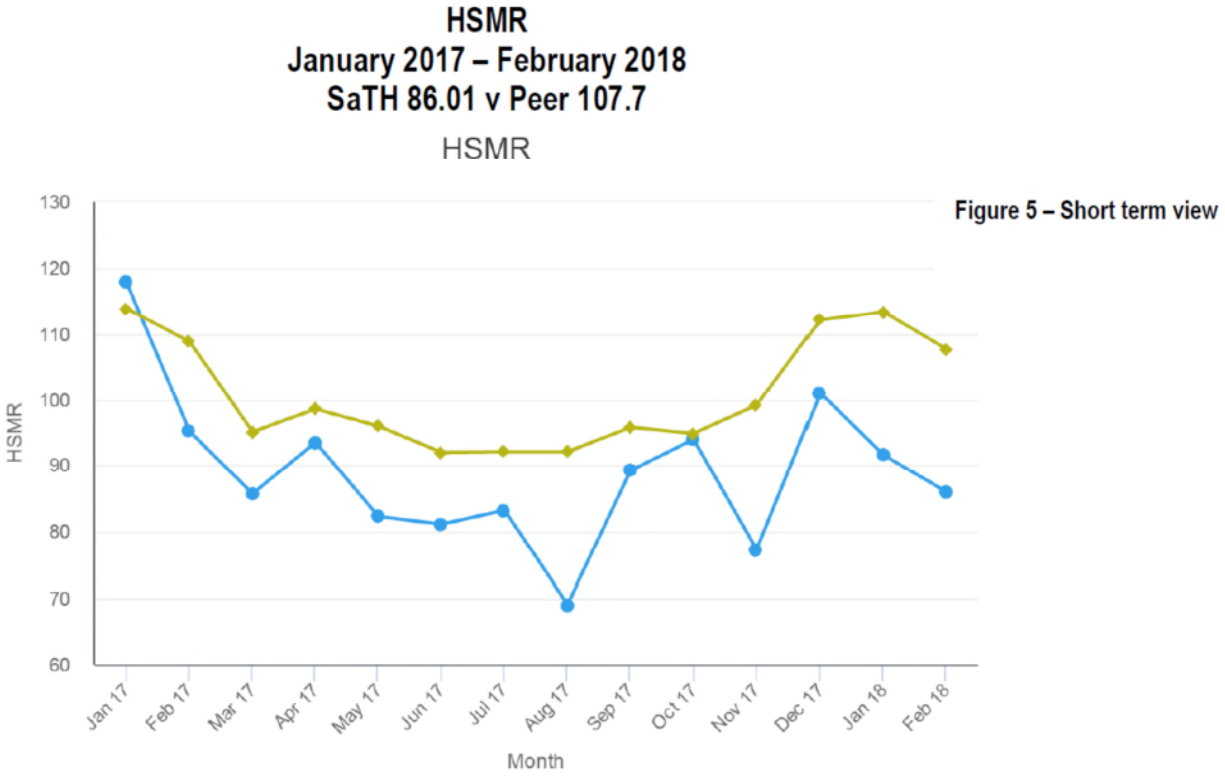


Figure 5 – Short term view

HSMR
January 2013 – January 2018

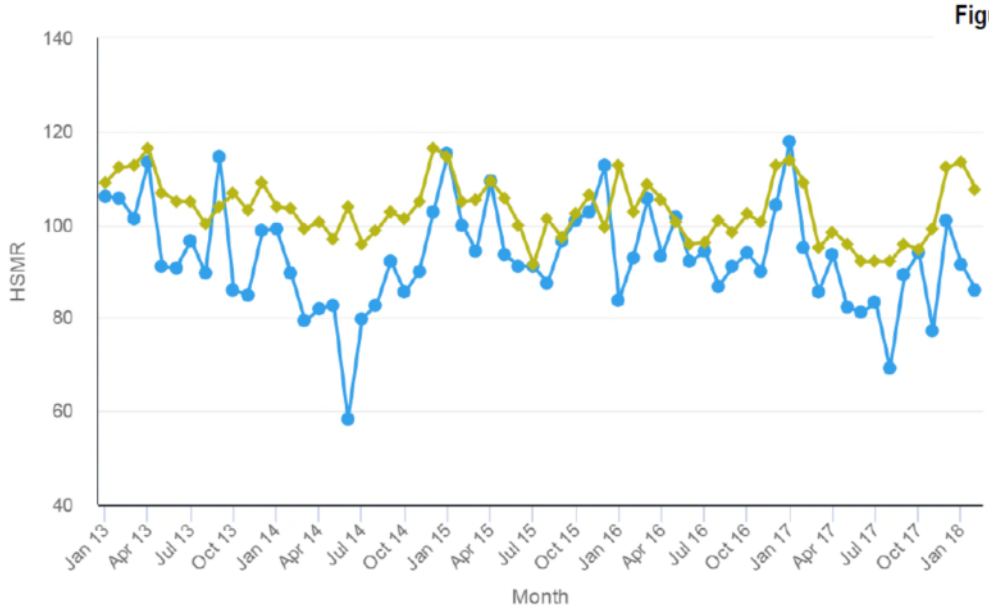


Figure 6 – Long term view

Summary Hospital Level Mortality Indicator (In Hospital) (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die, on the basis of average England figures, given the characteristics of the patients treated there. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital and is counted once against the discharging hospital. This does not exclude palliative care but does exclude day cases. It is based on 259 clinical classification system diagnostic groups. SHMI-type indicators cannot be used to quantify hospital care quality directly due to the limitations of datasets in SUS and HES.

In-Hospital SHMI – January 2017 – February 2018
SaTH 67.29 v Peer 83.76

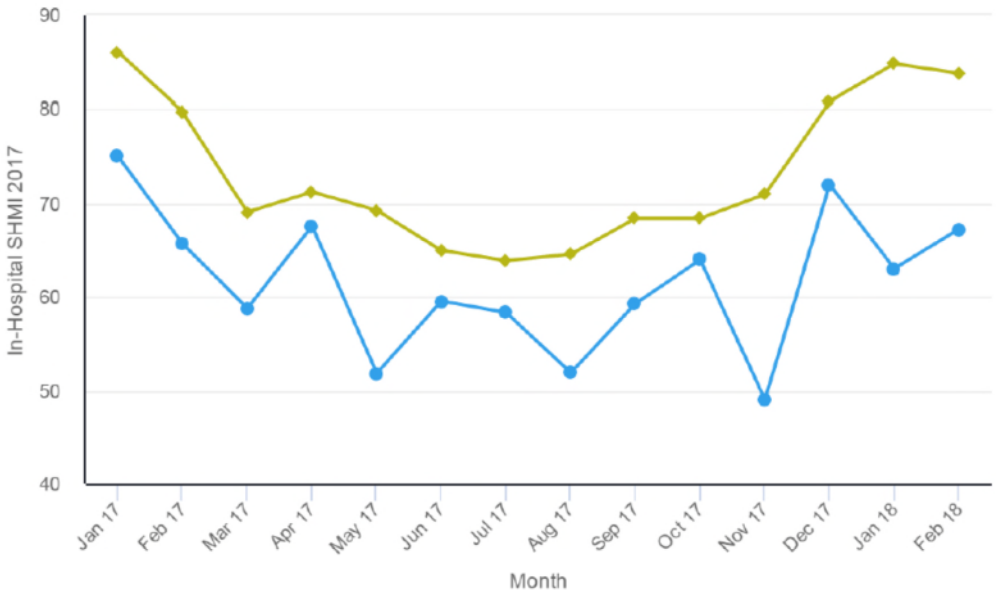


Figure 7 – Short term view

In-Hospital SHMI SaTH v Trust Peer January 2013 – January 2018

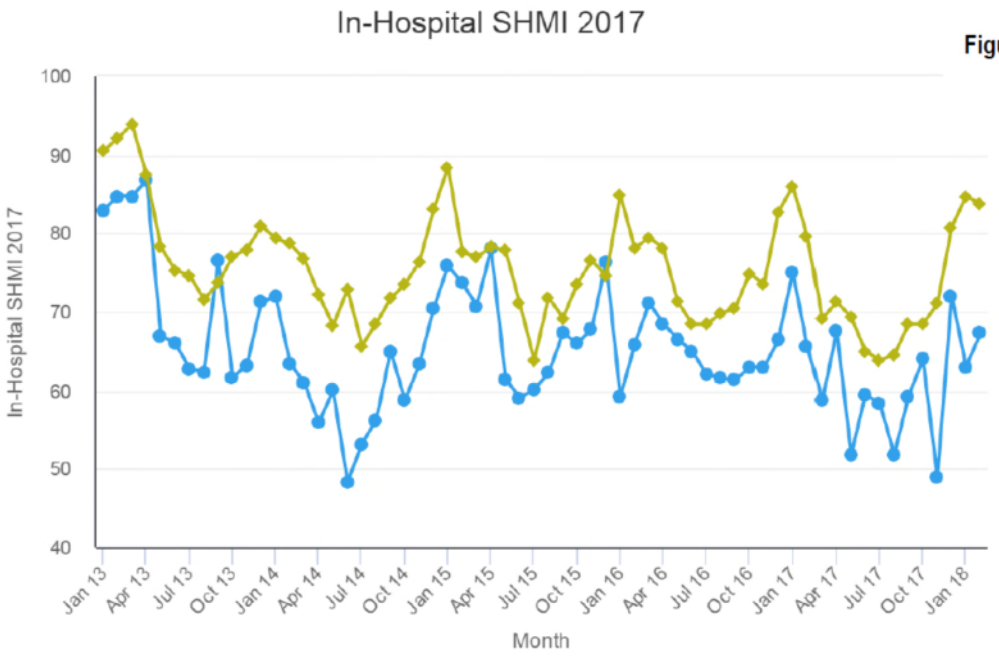


Figure 8 –Long term view

Action Schedule Summaries

Quarter 1 (2017/2018) – Fractured Neck of Femur – RSH

An in-depth review of mortality was undertaken. The formal report noted two patients whose deaths have had avoidable factors identified. In the first patient, following an inquest, a narrative verdict found that the patient died from the effects of natural disease shortly after undergoing surgery. The second patient died following an in-patient fall but did not proceed to inquest and cause of death was noted as myocardial ischaemia, coronary artery atheroma, osteoporotic fracture left hip (treated). All patients had characteristics of frailty and significant co-morbidities. All but four patients had acute illness leading up to fracture neck of femur and need for surgery. Recommendations following the review were:

- to introduce a single page guideline for the management of hypotension based on NICE guidelines for junior doctors called to see patients with a fractured neck of femur - completed.
- Extend recovery resource for monitoring post-operatively – completed.
- Additional physiotherapy support during the winter period (November - April) – completed.

Quarter 2 (2017/2018) – Fluids and Electrolytes

An in-depth review was undertaken that demonstrated that 15% of the sample were incorrectly included due to administrative errors on source of admission. This was due to incorrect coding as this not the first consultant episode, or it was readmission from Community Hospitals when end of life care would have been more appropriate. Concern was raised about an increase in December 2015, March and April 2016 which may reflect patients being readmitted with fluid and electrolyte disorders at times of high activity. Most patients were admitted with dehydration secondary to sepsis, UTI or pneumonia. Readmission rate within 28 days overall was below peer average. The figures in November 2016 showed variation between observed and expected mortality as stable and within expected control limits. Recommendations following the review were:

- Continue to monitor this group for a further six months to assess any changes
- Identify administrative personnel to address the administrative errors.

- SaTH Medical Director to speak with Shropshire Community Health NHS Trust Medical Director to share conclusions and consider how to reduce number of unnecessary transfers – completed.

Further joint review of Fluid and Electrolytes completed with the Community Trust July 2017

This demonstrated a group of frail and complex patients with underlying co-morbidities which had been recognised in the previous review. It was noted that there were a number of differences in the clinical management between Acute Trust and Community Trust which include:

- Intravenous fluid administration protocols
- Use of subcutaneous fluid administration
- Administration of the Sepsis bundle
- The need for greater co-ordination of decision making by and for patients regarding
- end of life care

This will be part of an ongoing review of continued co-operation between the Trusts.

Quarter 3 (2017/2018) - Work on Learning from Deaths Report

The standards set out within the National Quality Board Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, investigating and Learning from Deaths in Care were met within the specified timescales. In November 2017, the Medical Director presented the first Trust Mortality casenote review Dashboard at Trust Board. Findings from the mortality casenote review process and LeDeR review will continue to be published quarterly.

Quarter 4 (2017/2018) - Pneumonia – pleurisy, pneumothorax and pulmonary collapse

This classification group contains small numbers. 19 observed deaths over the year, compared to a sum of 12 expected deaths. Small cumulative variations therefore made a large difference, and in September 2017, four consecutive months of 0-2 more observed than expected deaths caused the plot line to cross the 2 SD limit, potentially triggering an alert. The two patients in July died at the Community hospitals and are included as superspells. Like the Fluid and Electrolyte group, these patients were elderly, with multiple co-morbidities, and whilst the majority were treated for a pleural effusion in the first consultant episode (FCE), the underlying cause of the effusion was the cause of their death.
Investigation complete and findings presented at Mortality Group. No further action to be taken.

Action Schedule

Mortality review meetings identify areas which need further investigation which are noted on the table below.

2015/2016	Theme
Quarter 2	Understand and implement actions to reduce avoidable deaths in nephrological conditions and Acute Kidney Injury
Quarter 3	National Indicator - PE 90 day post discharge mortality per 1,000 spells. 28 cases
Quarter 4	Deaths with bowel pathology - 'Acute abdomens' at PRH
2016/2017	**Theme**
Quarter 1	Infectious Conditions – understand and implement actions to reduce avoidable deaths from infectious conditions and Sepsis
Quarter 2	Acute Myeloid Leukaemia
Quarter 3	Acute Myocardial Infarction
Quarter 4	Other Perinatal Conditions
2017/2018	**Theme**
Quarter 1	Fractured Neck of Femur - RSH
Quarter 2	Fluid and Electrolyte Disorders
Quarter 3	Working on Learning from Deaths Report
Quarter 4	Pneumonia – pleurisy, pneumothorax and pulmonary collapse
2018/2019	**Theme**
Quarter 1	PE 90 day post-discharge

Trust Casenote Review Mortality Dashboard
As part of the National Quality Framework ' Learning from Deaths', Trusts are required to publish data on the number of Mortality reviews conducted into patient deaths within the Trust.

There were no CESDI 3 – 'probably avoidable deaths' in Quarter 4 2017/18. The dashboard is at Appendix one to this report.

Section four: Maternity Dashboard and Exception Report

The maternity dashboard for month two is below. This section of the report highlights any elements of the dashboard by exception and indicates a description for the indicators that are not aligned with local or national targets below:

Telford Consultant Unit Births The expected locally set range for this descriptor is between 300-350 births per month. May 2018 has seen a live delivery figure of 372 (89.4%). This is above the national target of 86.6%.

Midwife Led Unit (MLU) 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 the five Midwife-Led units were 34 births in May 2018 (10.8%). The National MLU birth figure is 11.8%. Bridgnorth, Ludlow and Oswestry MLU were all part closed during May 2018. However the birth in these units for May 2018 were:

- Ludlow had 0 births- closed
- Bridgnorth had 3 births –closed (25th May 2018)
- Oswestry had 0 births - closed
- Wrekin had 28 births
- Shrewsbury 3 births

The Home births for May 2018 were 11 births (2.6%), this is above the national rate set by the NMPA data of 1.4%.

Rate of Vaginal Birth after Caesarean Section (VBAC) The rate of successful vaginal birth after a single previous caesarean section is a Clinical Quality Improvement metric. The expected NMPA rate for this descriptor is 57.7%. The Maternity rate in May 2018 for VBAC is 32.4 %. This rate will be observed going forward.

Smoking at Time of Delivery The expected national figure is 11.7%. The Maternity SaTH rate is 15.3 %. A Public Health Midwife has been in post for twelve months (financed by Telford and Wrekin Council and CCG), who continues to concentrate on the Telford and Wrekin pregnant smoking population to change habits and drive down this figure.

Percentage of Babies born at less than 2500gm This is a National Maternity Indicator. The expected GIRFT rate for this descriptor is 2.3%. The Local SaTH data for April was 7.9%. Moving forward we will be monitoring this closely.

Babies Breast Feeding at Discharge from Midwife to Health Visitor This is an additional maternity metric not measured prior to 2018 by SaTH. Although initiation rates are excellent there appears to be a drop off around discharge (10-14 days). The NMPA rate is 68.1% SaTH rates have been measured at 47.6% for May 2018. This has been brought to the attention of the Infant feeding coordinator and a plan to bring this back in line will be made.

Induction of Labour Rate This is a maternity metric. The NMPA expected rate is 28.5%. The SaTH Maternity rate is reported as 37% in May 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 – Category 2 Caesarean sections This is a locally set metric. The locally expected range for this descriptor is 0-8%. Therefore the rate of 5.6 % reported in May 2018 is below this rate.

Stillbirth – The MBBRACE expected rate was 0.38% (2015). The local rate for May 2018 was 0.7% this equated to two cases.

Access to screening services The percentage of bookings with a gestation of less than 10 +0 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 national and regional target for this screening is 50% as the acceptable standard with an aim of 75%. This target is a standard set by NHS England. The May 2018 figure was 64.6%.This is only the second month it has remained on target. The previous poor rate during 2017/18 was raised by the national screening programme board and has been added to the Women and Children's risk register (current score 16).

Access to maternity services Percentage of bookings with a gestation of less than 12 weeks and 6 days. The expected national set range for this descriptor is 90-100%. The rate for May 2018 was 85.4% 2018. Regular booking meetings are taking place to look at ways of improving these figures.

Antenatal Bookings The local expected rates for antenatal bookings are 400-450 per month. During May 2018 there were 492 bookings. This is 42 greater than expected for the month. During the first two financial months there appears to be an increase in the antenatal booking rate.

Hypoxic Ischemic Encephalopathy – (HIE). This data is collected on the neonatal IT system "Badger net" and is now a feature on the Clinical maternity Dashboard from May 2018. HIE is graded into three categories – mild, moderate and severe. There were no reported HIE in May 2018.

Maternity Clinical Dashboard - 2018/19 - All SaTH Activity

No	Indicator	Descriptor	National Data Source	National Figure	APR	MAY	Q1	YTD
1	CQUIM - Clinical Quality Improvement Metrics	Smoking rate at booking	NMPA	19.9%	17.6%	20.6%	19.2%	19.2%
		Normal birth rate			69.9%	68.7%	69.2%	69.2%
		Caesarean section delivery rate in Robson group 1 women			8.5%	3.6%	5.8%	5.8%
		Caesarean section delivery rate in Robson group 2 women			28.2%	26.2%	27.1%	27.1%
		Caesarean section delivery rate in Robson group 5 women			25.4%	28.6%	27.1%	27.1%
		3rd and 4th degree tear rate among women delivering vaginally	NMPA	3.5%	2.2%	3.4%	2.8%	2.8%
		Rate of postpartum haemorrhage of 1500ml or greater	NMPA	2.7%	1.4%	1.7%	1.6%	1.6%
		Rate of successful vaginal birth after a single previous caesarean section	NMPA	57.7%	27.3%	32.4%	30.4%	30.4%
		Smoking rate at delivery	NMPA	11.7%	12.9%	15.3%	14.2%	14.2%
		Proportion of babies born at term with an Apgar score <7 at 5 minutes	NMPA	3.5%	0.3%	0.8%	0.6%	0.6%
		Proportion of babies born at term admitted to the neonatal intensive care unit			16.2%		16.2%	16.2%
		Proportion of babies readmitted to hospital at <30 days of age						
		Breastfeeding initiation rate			76.2%	76.4%	76.3%	76.3%
		Breastfeeding rate at 6-8 weeks	No Data Available					
2	National Maternity Indicators (NMI); Domain 1: Mortality and morbidity	Stillbirth rate	MBRRACE	0.38% (2015)	0.3%	0.7%	0.5%	0.5%
		Neonatal Mortality Rate	MBRRACE	0.17% (2015)				
		Brain injuries - HIE	NMPA		0.0%	0.0%	0.0%	0.0%
		Proportion with singleton term infants with a 5-minute Apgar score of less than 7	NMPA	1.2%	0.3%	0.8%	0.6%	0.6%
		Proportion of vaginal births with a 3rd/4th degree perineal tear	NMPA	3.5%	2.2%	3.4%	2.8%	2.8%
		Proportion of birth episodes with severe PPH of greater than or equal to 1500ml	NMPA	2.7%	1.4%	1.7%	1.6%	1.6%
3	National Maternity Indicators (NMI); Domain 2: Clinical care and health promotion	Normal birth rate	NMPA	66.0%	69.9%	68.7%	69.2%	69.2%
		Caesarean section delivery rate in Robson group 1 women	NMPA		8.5%	3.6%	5.8%	5.8%
		Caesarean section delivery rate in Robson group 2 women	NMPA		28.2%	26.2%	27.1%	27.1%
		Caesarean section delivery rate in Robson group 3 women	NMPA		2.8%	0.0%	1.3%	1.3%
		Proportion of infants who are small-for-gestational-age (birthweight below 10th centile) (singletons)	No Data Available - NMPA Figure is 55.4%					
		Percentage of babies < 2500g	GIRFT	2.3%	6.8%	7.9%	7.4%	7.4%
		Proportion of live born babies who are breastfed for the first feed	NMPA	73.6%	69.3%	70.8%	70.1%	70.1%
		Proportion of births between 23+0 and 27+6 which occur outside of a hospital with a neonatal intensive care unit	NMPA		0.0%	0.0%	0.0%	0.0%
4	Other metrics not included in CQIM or NMI	Episiotomy rate overall	NMPA	22.0%	10.0%	14.8%	12.6%	12.6%
		Overall assisted birth rate - Primip	NMPA	25.3%	16.0%	17.9%	17.0%	17.0%
		Overall assisted birth rate - Multip	NMPA	5.6%	1.8%	1.2%	1.5%	1.5%
		Skin to skin contact within 1 hour of birth	NMPA	79.8%	99.4%	99.3%	99.4%	99.4%
		Babies breastfeeding at discharge	NMPA	68.1%	48.2%	47.6%	47.9%	47.9%
		Shoulder Dystocia rate	RCOG	0.7%	0.0%	0.7%	0.4%	0.4%
		Induction of labour rate	NMPA	28.5%	38.4%	37.0%	37.6%	37.6%
		Percentage of deliveries from mothers with placenta praevia and abruption (spontaneous, unassisted vaginal delivery)	GIRFT	0.7%	0.0%	0.2%	0.1%	0.1%
5	Births activity by Unit	Overall Trust total births	Local	375-425	355	418	773	773
		Telford Consultant Unit	Local	4-10	300	372	672	672
		Bridgnorth MLU	Local	4-10	1	3	4	4
		Ludlow MLU	Local	4-10	3	0	3	3
		Oswestry MLU	Local	4-10	3	0	3	3
		Shrewsbury MLU	Local	10-20	7	3	10	10
		Wrekin MLU	Local	20-30	35	28	63	63
		BBA/Other	Local	0-2	1	1	2	2
		Home	Local	0-5	5	11	16	16
		% of births in Consultant Unit	NMPA	86.6%	84.5%	89.0%	86.9%	86.9%
		% of birth in a MLU or at home	NMPA	14.3%	15.2%	10.8%	12.8%	12.8%
		% of births in any MLU	NMPA	11.8%	13.8%	8.1%	10.7%	10.7%
		% Home Births	NMPA	1.4%	1.4%	2.6%	2.1%	2.1%
		% BBA/Other	NMPA	0.3%	0.3%	0.2%	0.3%	0.3%
6	Operative Deliveries	Overall Assisted Births rate %	GIRFT	10%-13%	7.7%	8.0%	7.9%	7.9%
		Forceps rate %	Local	0%-8%	6.3%	6.1%	6.2%	6.2%
		Ventouse rate %	Local	0%-11%	1.4%	1.9%	1.7%	1.7%
		Dual Instruments rate %	Local	0%-2%	0.0%	0.0%	0.0%	0.0%
		Caesarean Section rate %	NMPA	25%	20.3%	20.4%	20.4%	20.4%
		Primip Caesarean Section rate %	NMPA	25.8%	22.9%	21.4%	22.1%	22.1%
		Multip Caesarean Section rate %	NMPA	24.4%	17.4%	19.8%	18.7%	18.7%
		% of Deliveries - Category 1 C/Section	Local	0%-4%	1.7%	2.4%	2.1%	2.1%
		% of Deliveries - Category 2 C/Section	Local	0%-8%	8.3%	5.6%	6.8%	6.8%
		% of Deliveries - Category 3 C/Section	Local	0%-4%	1.7%	2.7%	2.2%	2.2%
		% of Deliveries - Category 4 C/Section	Local	0%-10%	8.9%	10.0%	9.5%	9.5%
7	Access to Maternity Services	Number of Bookings	Local	400-450	476	494	970	970
		% of bookings with a gestation of less than 10 weeks	Local	50%-100%	54.6%	64.6%	59.7%	59.7%
		% of bookings with a gestation of less than 12 weeks 6 days	CMS	90%-100%	85.5%	85.4%	85.5%	85.5%

Section five: Recommendations for the Trust Board

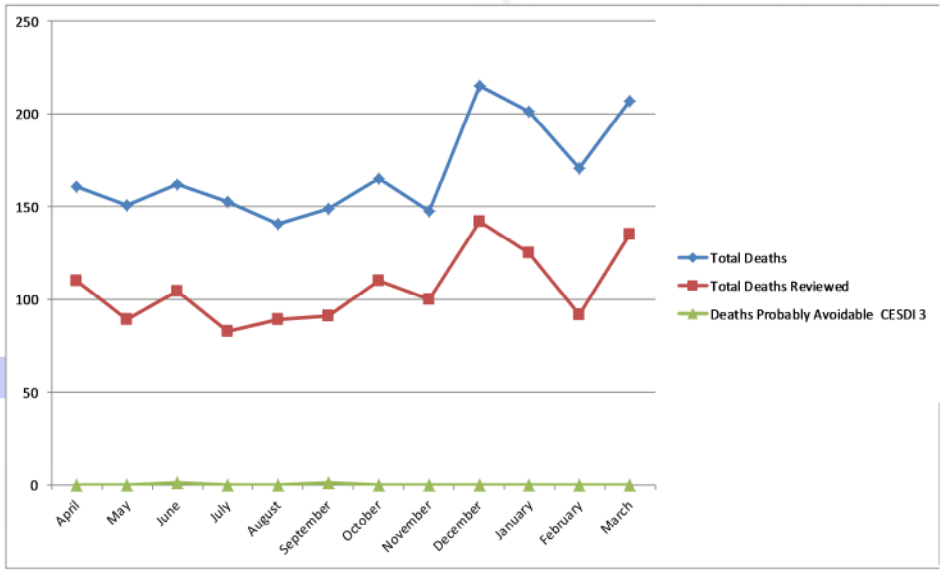
The Trust Board is asked to:

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

Summary of total number of deaths and total number of cases reviewed under the Trust Casenote Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total number of deaths considered to have been potentially avoidable (CESDI 3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
207	171	135	92	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
579	528	352	352	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2024		1270		2	



Total Deaths Reviewed by Methodology Score

CESDI 0 No sub optimal care		CESDI 1 Some sub optimal care which did not affect the patient's outcome		CESDI 2 Some sub optimal care which might have affected the patient's outcome	
This Month	121	This Month	11	This Month	3
This Quarter (QTD)	308	This Quarter (QTD)	38	This Quarter (QTD)	6
This Year (YTD)	1142	This Year (YTD)	109	This Year (YTD)	19

Summary of total number of deaths of patients with a Learning Disability and, the total number reviewed under the LeDeR and Trust methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed by Trust or Reported Through the LeDeR Methodology		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
3	0	3	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	0	4	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
14		14		0