The Shrewsbury and Telford Hospital NHS Trust

Paper 14

Recommendation ☑ **DECISION** ☑ **NOTE**	**The Trust Board is asked to:** • **Discuss** the current performance in relation to key quality indicators as at the end of July 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	30 August 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 July 2018. **Key points to note:** A period of increased incidence of ESBL was identified linked to ward 25 in May. Post infection reviews have been carried out and found that cross infection cannot be ruled out despite the patients not being on the ward at the same time. We have reported a further MRSA Bacteraemia in July bringing the total for 2018-2019 to three following a long period of no such incidents. However, two of these three relate to contamination at the point of collection rather than a bacteraemia. Both incidents occurred in the ED at PRH. We did not report any C Diff infections in July – the first time in over 12 months that this has been the case. The local panel that meets to consider the C Diff infections and the findings of the investigations following them found that four of the six reported in Qtr one were attributable to the Trust and that three of these related to the lack of evidence of antibiotic stewardship. We have not reported any avoidable grade three or four pressure ulcers in 2018-2019 to date – the last avoidable grade three was in March 2018. We had no falls reported as serious incidents in July. However, we did see an unusual number of falls resulting in moderate harm or above in June which has taken us above the national benchmark for the first time since December 2016. The outcomes of the reviews will demonstrate any trends and themes and learning. There was one serious incident reported in July that was classified as a Never Event due to being related to the wrong administration route of a medication although it did not completely meet the Never Event criteria. This brings our total Never Events in 2018-2019 to three. Two patients waited more than 104 days to start cancer treatment in July – the review of their cases showed that this would not have resulted in harm to them – the delays were due to the complexity of their cases and the requirement for a number of investigations to be carried out. We reported one episode of mixed sex accommodation breach in July in an area outside our critical care areas. This affected two patients. There were eight safeguarding concerns raised affecting the Trust – two raised by external agencies/family members. One has been closed by the local authority safeguarding team but is subject to an internal investigation.

	Sixty complaints were received in July – an increase from June. Main themes remain staff attitude, communication and clinical treatment. Friends and Family Test feedback continues to indicate high levels of satisfaction with Trust services. 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 July 2018 for VBAC is 28.6 %. This rate will be observed going forward. Percentage of Babies born at less than 2500gms - This is a National Maternity Indicator. The expected GIRFT rate for this descriptor is 2.3%. The Local SaTH data for July 2018 was 8.2%. Moving forward we will be monitoring this closely.
Sponsoring Director	Deirdre Fowler, Director of Nursing and Quality
Author(s)	Dee Radford, Quality Manager Sam Hooper, Medical Performance Manager Anthea Gregory-Page – Deputy Head of Midwifery
Recommended / escalated by	Quality and Safety Committee 22 August 2018
Previously considered by	**Quality and Safety Committee 22 August 2018**
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	RR561 RR951 RR1185
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

Quality Governance Report

August 2018

Introduction

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

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

The report will be submitted to our commissioners 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 to the Committee 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	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
CDI due to lapse in care (CCG panel)	13	1	1	1	1	3	1	1	0	1	1	2		4	0	25
Total CDI reported	32	3	1	1	3	6	6	2	2	2	2	2	0	6	None	None
MRSA Bacteraemia Infections	0	0	0	0	0	0	0	0	0	1	1	1	1	3	0	0
MSSA Bacteraemia Infections	26	6	2	3	2	4	2	3	1	1	1	3	2	7	None	None
E. Coli Bacteraemia Infections	29	3	3	1	4	2	6	5	2	4	2	6	6	18	None	None
MRSA Screening (elective) (%)		95.6	95.6	95.5	96.4	96.0	94.0	95.0	95.4	96.5	96.5	95.7	95.6	96.0	95%	95%
MRSA Screening (non elective) (%)		96.1	97.0	97.2	95.3	95.5	94.8	94.0	95.62	96.7	95.9	96.6	96.2	96.4	95%	95%
Grade 2 Avoidable	46	4	3	4	6	4	6	4	3	0	2	1	0	3	0	0
Grade 2 Unavoidable	157	18	13	12	12	12	14	17	9	14	6	9	4	33	None	None
Grade 3 Avoidable	9	2	1	2	2	1	0	0	1	0	0	0	0	0	0	0
Grade 3 Unavoidable	22	3	0	1	0	2	6	1	2	2	1	0	4	7	None	None
Grade 4 Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grade 4 Unavoidable	1	0	0	0	0	0	0	0	0	0	1	0	0	1	None	None
Falls reported as serious incidents	3	1	0	0	0	0	0	1	0	0	0	1	0	1	None	None
Number of Serious Incidents	77	3	4	9	7	3	8	15	13	2	4	9	1	17	None	None

Measure	Year end 17/18	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
Never Events	2	0	0	0	1	1	0	1	0	1	1	1	1	3	0	0
Catheter Associated UTI (number of patients on prevalence audit)		3	6	5	6	6	3	1	6	3	2	10	1	16	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE Assessment		95.2	95.4	96.4	95.9	95.5	95.1	95.68	95.2%	95.1%	95.9%	95.9%		95.6%	95%	95%
ITU discharge delays>12hrs	380	39	31	37	33	39	17	28	35	41	27	35	35	138	None	None
No of MSA breaches other areas	1	0	0	0	1	0	0	0	0	0	0	0	1	1	None	None
Complaints (No)	600	50	45	45	61	31	49	60	56	54	55	55	60	224	None	None
Friends and Family Response Rate (%)	23.8%	20.1%	18.3%	15%	14.3%	12.3%	11.1%	13.6%	16.1%	19.9%	17.7%	20.4%	20.8%	19.7%	None	None
Friends and Family Test Score (%)	96.6%	97.1	97.2	96.1	96.8	97.4	96.6	96.2%	96.4%	97.3%	96.6%	96.6%	95.6%	96.5%	95%	95%

Section Two: Key Messages by exception

Infection Prevention and Control

Period of Increased Incidence

Certain strains of bacteria are resistant to treatments with commonly used antibiotics such as penicillin and cephalosporins. These bacteria produce enzymes known as Extended Spectrum Beta-Lactamases or ESBLs for short. A period of increased incidence of ESBL Klebsiella Gent R (two cases in total) was identified linked to Ward 25 in May 2018.

Following a formal meeting and investigation it was identified that although the specimens could not be typed, that cross infection could not be ruled out although the patients were not in the ward at the same time, or using the same high risk equipment.

The action plans and lessons learnt derived from this investigation will be shared through by the care group at IPCC.

MRSA Bacteraemia

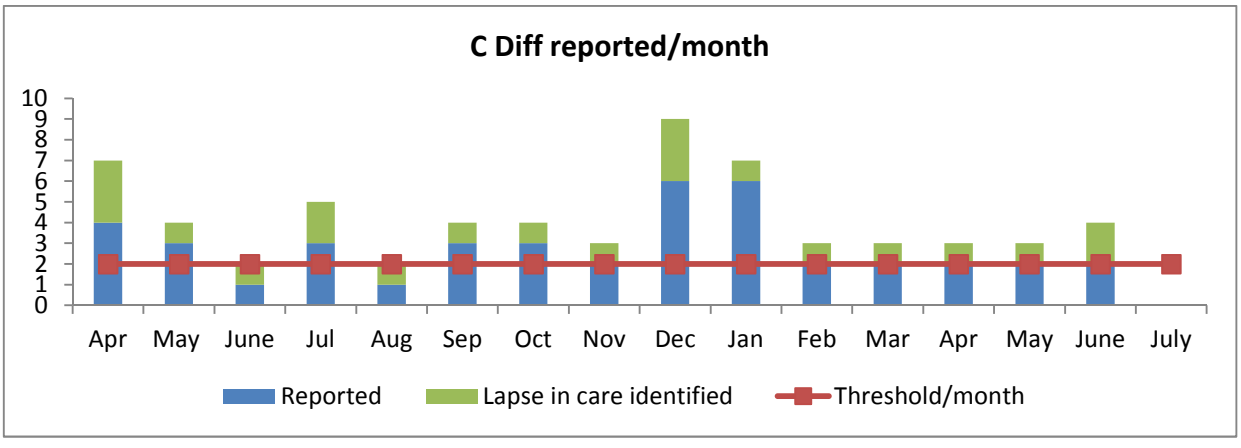
We have had three cases of MRSA bacteraemia apportioned to the trust by local Post Infection Review since April 2018. The first was a post 48 case where the source was a longstanding pressure sore but it was felt that on balance the patient had probably acquired the strain in SaTH. This patient was very complex and came from a nursing home (where the MRSA may also have been acquired) but over the last few months had had multiple admissions to SaTH. Generally however the care given was extremely good and this was probably unavoidable.

The other two cases were pre 48 hour cases but in both cases it was likely that the blood cultures had been contaminated during collection. Although these are not true MRSA bacteraemias, i.e. the patient does not have a bloodstream infection, they are assigned to the place where the blood culture was collected. In both cases this was the Emergency Department at PRH. Overall From Jan to July blood culture contamination rate was 3.3% (our target is less than 3%). For ED at PRH the rate was 5.7%. As a result, the blood culture collection technique in the ED of PRH is being reviewed and training implemented.

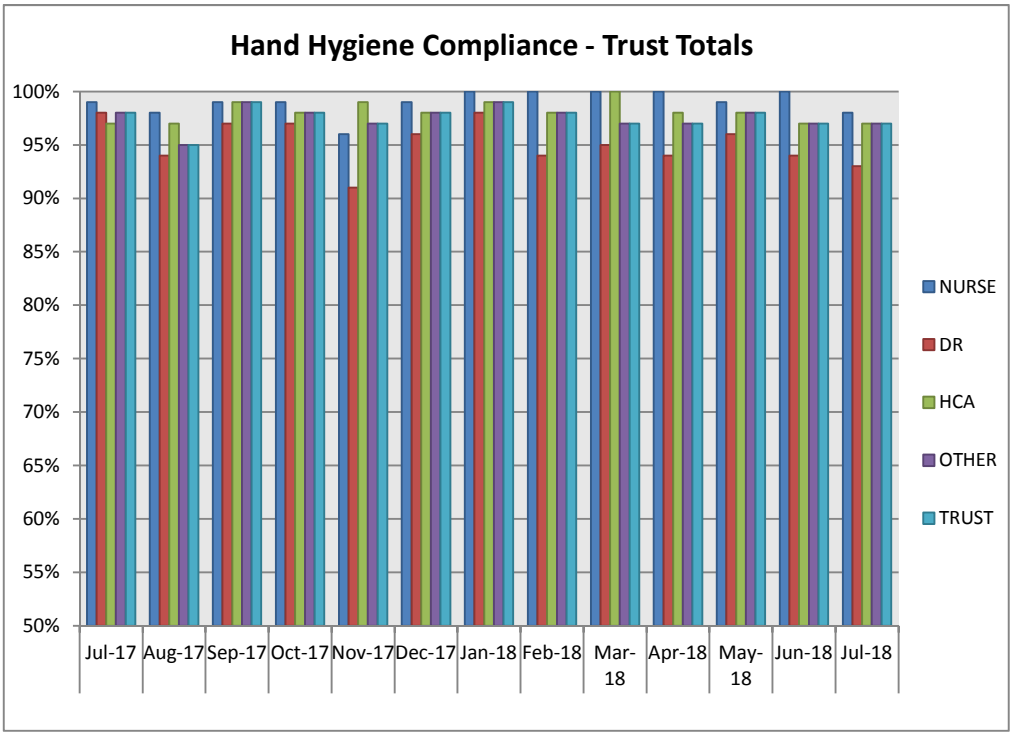
Clostridium Difficile (C Diff) Incidence

We reported no incidences of C Diff in July 2018. Our total reported for the year to date is six of which four were considered by the CCG panel that met at the end of Qtr one to be attributable to the Trust. The rationale for the decision in three cases was that there was a lack of evidence relating to antimicrobial stewardship and the fourth was because there was a lack of evidence relating to the potential for cross infection.

The run chart below illustrates the position relating to C Diff incidence since April 2017 to date:



Hand Hygiene Compliance



NURSE	DR	HCA	OTHER	TRUST
98%	93%	97%	95%	97%

Learning from in service pressure ulcer incidence

In July 2018 there were four category three pressure ulcers that developed which did not meet the criteria for reporting as Serious Incidents and are in the process of being managed as High Risk Case Reviews.

There were no category four pressure ulcers, either avoidable or unavoidable.

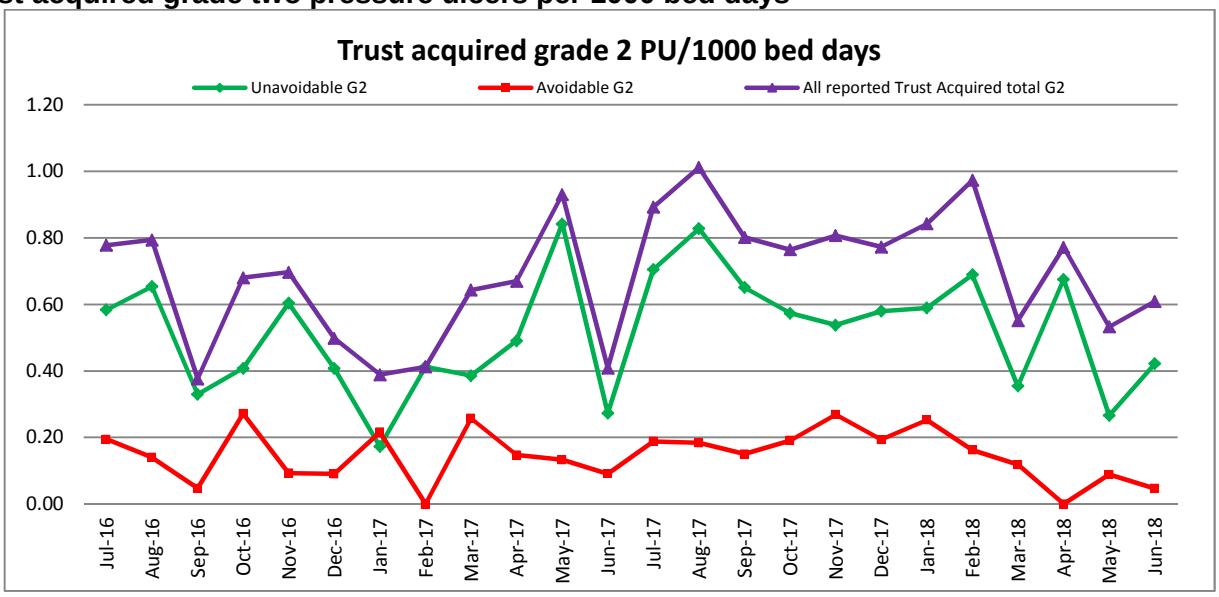
High Risk Case Review (HRCR) Pressure Ulcers July 2018

Category 3 foot	Ward 10	Patient admitted from a care home - deterioration from a category 2/DTI (deep tissue injury) to a category 3 during admission. Good evidence of implementation of care in accordance with guidance. Patient very frail, with poor oral intake. Determined to be unavoidable – no omissions in care identified
Category 3 Ear/shoulder	Ward 22TO	Deterioration from a DTI noted on admission. Patient in an aspen collar for an unstable #C2, attempts made to source alternate option (none suitable). Patient frail. Priority was keeping neck stable. Determined to be unavoidable – no omissions in care identified
Category 3 Natal cleft	Ward 22 Resp	Deterioration from category 2 pressure ulcers noted on admission. Good evidence of implementation of care in accordance with guidance. Developed combination moisture lesion and category 3. Patient had multiple comorbidities. Determined to be unavoidable – no omissions in care
Category 3 Buttock	Ward 24E	Patient suffering from lupus has multiple wounds over their body from the lupus including hands, arms, face and legs and sacrum/buttock. Good evidence of implementation of care in accordance with guidance. Determined to be unavoidable – no omissions in care

No category 2 pressure ulcers have so far been determined to be avoidable for July 2018.

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

Trust acquired grade two pressure ulcers per 1000 bed days

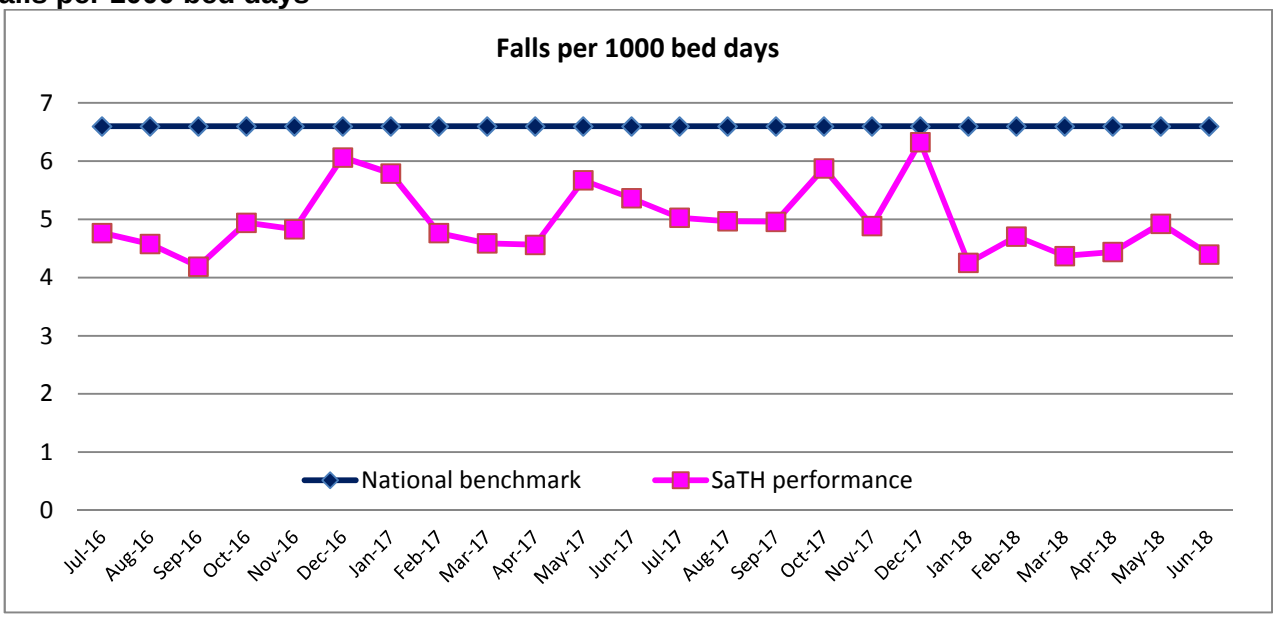


Learning from falls

In July 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 June 2018. While there was an increase in the number of falls in December 2017 which was replicated in December 2016, since January 2018 there has been a consistent level of reporting well below the national benchmark.

Falls per 1000 bed days

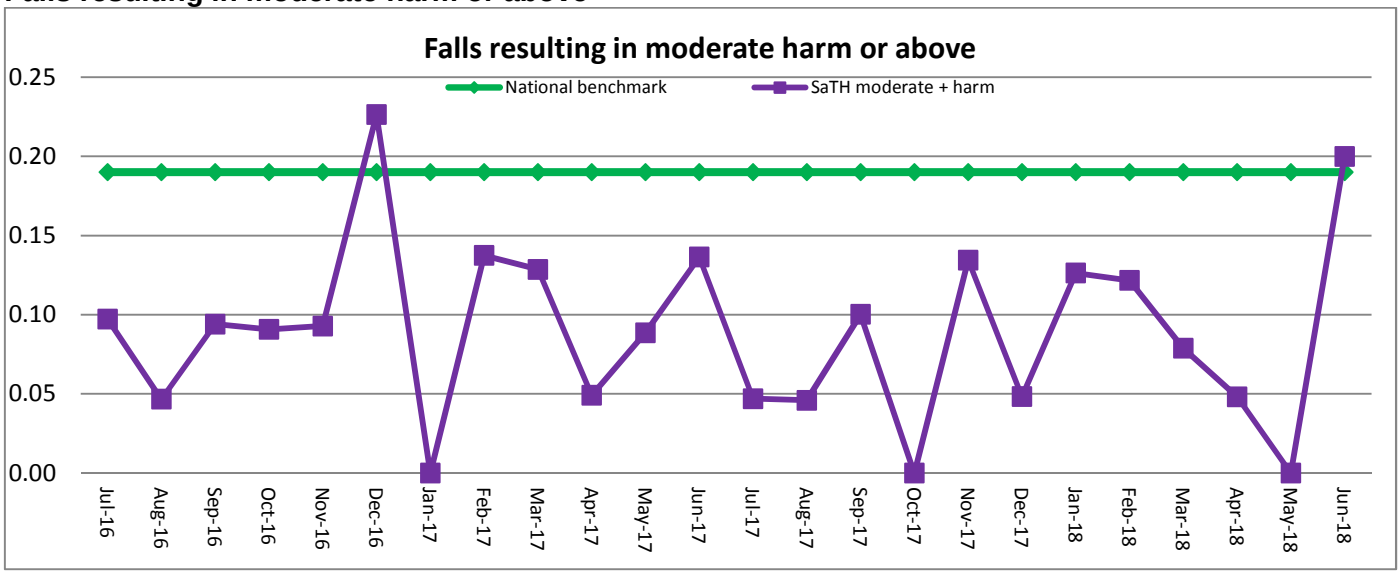


Falls resulting in moderate harm or above
The chart below shows that we also remain below the benchmark for falls resulting in moderate harm or above to May 2018.

From December 2016 to May 2018 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. There was an unusual number of falls resulting in moderate harm and above during June 2018 which took the Trust above the national benchmark for the first time since December 2016. As there have been none during July, this is likely to be an unusual fluctuation, but the outcomes of the investigations (all managed as HRCR) will be reviewed for trends/themes and learning.

Over the past 12 months the average number of moderate harms or above measured per 1000 bed days is sustained at 0.08/1000 bed days which is half the national benchmark.

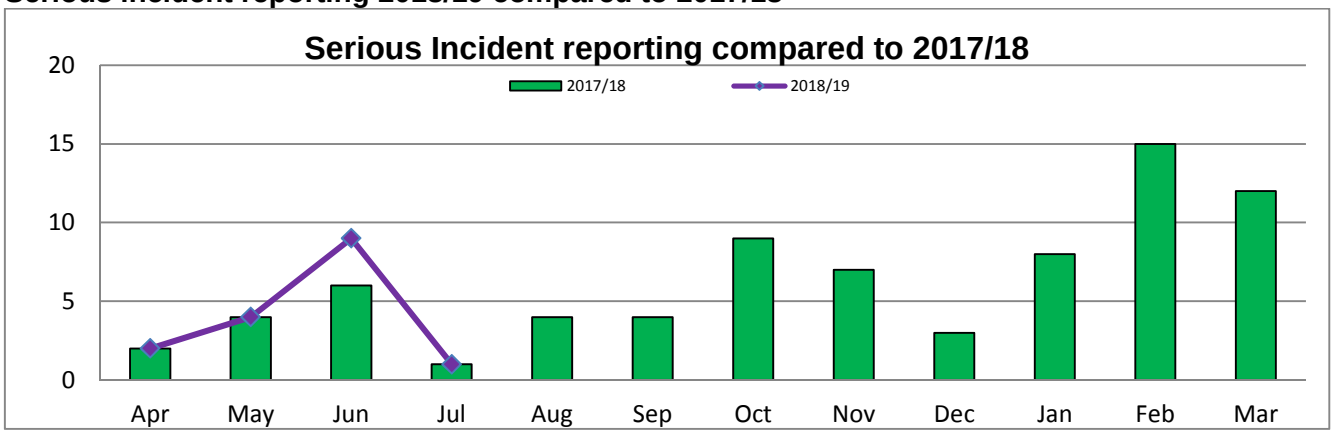
Falls resulting in moderate harm or above



Learning from moderate and serious incidents

In July 2018 we reported one serious incident as shown below and are currently following a similar pattern to reporting as the previous financial year.

Serious incident reporting 2018/19 compared to 2017/18



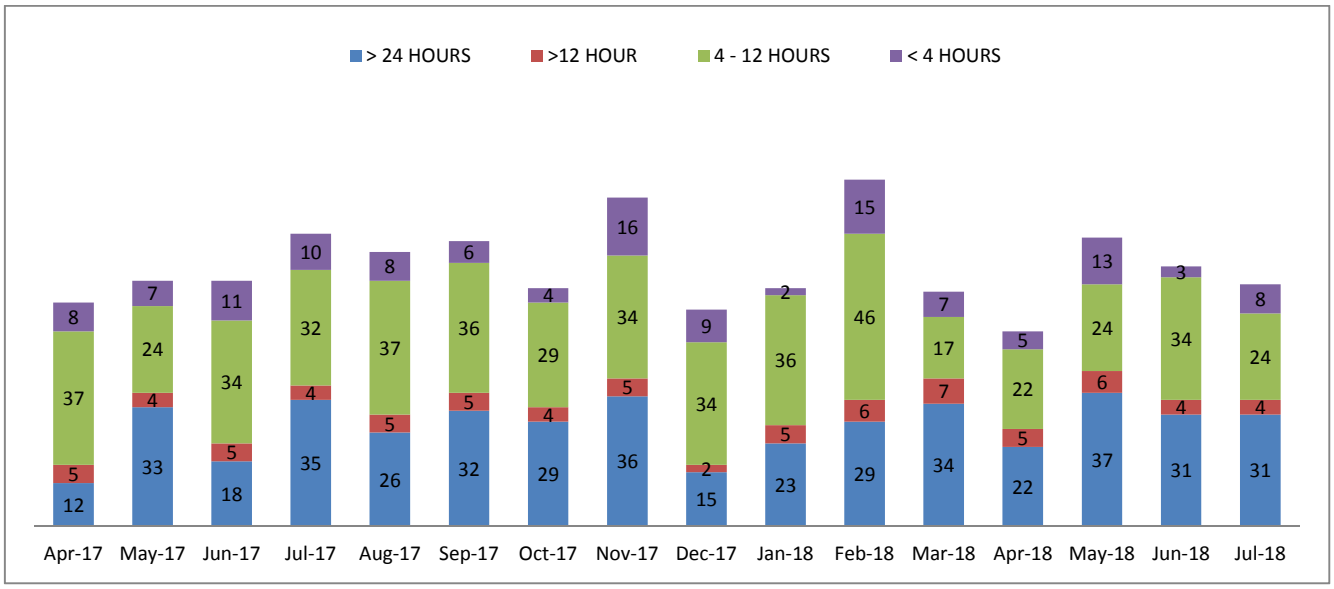
The incident reported in July was reported as a Never Event as it related to the administration of a medicine by the wrong route although did not meet the specific criteria of the Never Events list (NHSE, 2018). The incident took place in the ED at RSH. The incident is being investigated through the serious incident process at present.

Waiting for cancer treatment for more than 104 days

There were two patients who waited more than 104 days for cancer treatment that were reviewed in July. Both investigations found that delays were clinically justified due to the complexities of their conditions.

The cases related to cancers in lung and upper gastrointestinal and the investigation took the form of a clinical review which was then reviewed by the Deputy Chief Officer and the Clinical Lead for cancer services who has the final approval. Learning is shared through the multidisciplinary team meetings.

Delayed Discharges from ITU and potential Mixed Sex Accommodation Breaches.



In July the number of patients that were waiting more than 12 hours to be transferred from our high dependency areas to a ward remained the same as in June (35). The total number of patients transferred from the units was slightly less (67 in July compared to 72 in June). This was due to the pressures on the sites particularly at the Royal Shrewsbury Hospital where 21 patients waited more than 12 hours, 18 of whom were delayed more than 24 hours. At the Princess Royal Hospital, 14 patients waited between 12 and 24 hours, 13 over 24 hours. Thirteen patients were transferred in less than 12 hours at the Royal Shrewsbury Hospital and 19 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.

There was one incident resulting in a breach of Mixed Sex Accommodation definitions outside of the critical care areas which resulted in two patients being affected.

Safeguarding Adults at Risk and Children and Young People

In July there were eight safeguarding concerns raised with the local authorities that affected the Trust. Six were raised by Trust staff and related to concerns about potential neglect/omission of care provided by residential care homes or family members, one case of self neglect and one of domestic abuse.

Two concerns were raised about Trust services – both wards at PRH and both relating to potential neglect or omission of care. One has been closed by the safeguarding team at the local authority but an internal investigation is ongoing to clarify the circumstances.

None are subject to a Section 42 level inquiry.

In July one referral was made to social care by the Trust relating to safeguarding concerns about a child.

Patient and Carer Experience

Complaints and PALS

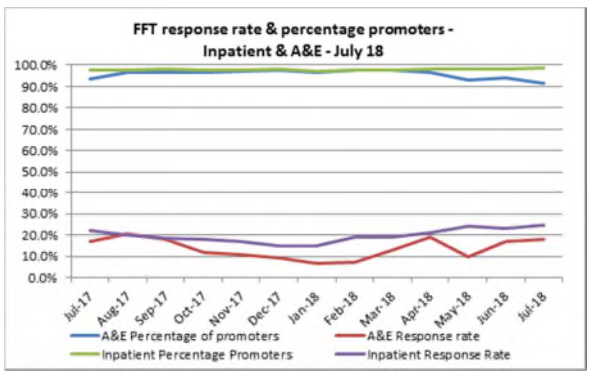
A total of 60 complaints were received in July 2018. Staff attitude, communication and clinical treatment continue to be the main subjects of complaints, but there has also been an increase in complaints about appointments with a recent increase in complaints relating to Ophthalmology appointments. There were 135 PALS contacts in July 2018; these again reflect concerns about appointments.

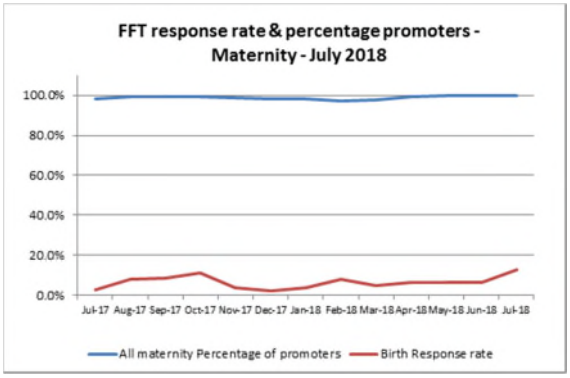
Friends and Family

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 95.6% which was 1% lower than in June. Individually, Inpatients saw an increase in the percentage of patients who would recommend compared to June and Maternity remained at 100%. A&E and Outpatients saw a decrease in the percentage of patients recommending compared to June.

The overall response rate was 20.8% which is a steady improvement for the past two months. Maternity, Birth and Inpatients all individually saw improved response rates compared to June and A&E was just 0.2% lower than June.

	Percentage Promoters	Response Rate
Maternity overall	100%	13.0% (Birth only)
A&E	91.6%	18.0%
Inpatient	98.9%	24.6%
Outpatients	94.4%	NA





Section Three: Mortality Review

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[1]. The following is an update of progress in this area, based on the most up to date information available.

1. Mortality Rate

This indicator provides a basic view of mortality: the number of deaths divided by the total spells.

SaTH Mortality Rate (April 2017 – April 2018)
SaTH 1.05% v Peer 1.35%

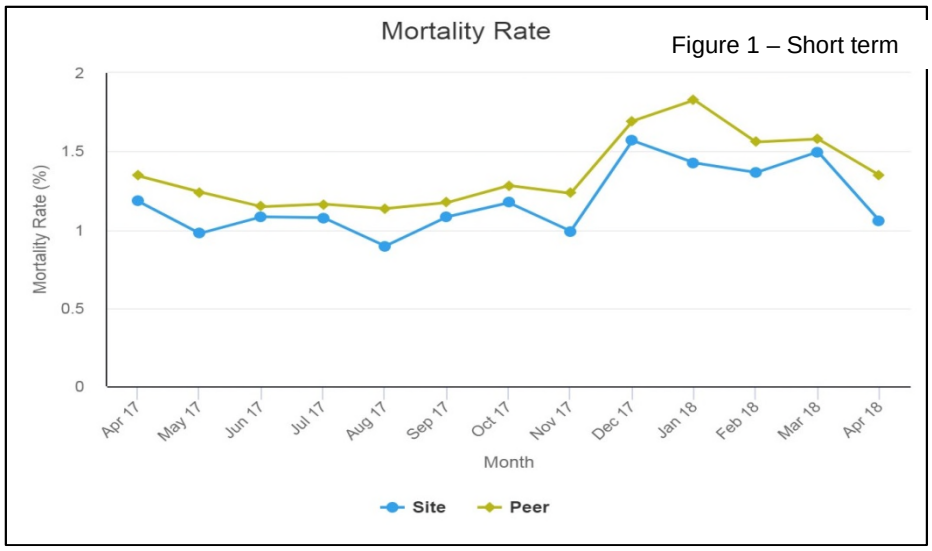


Figure 1 – Short term

SaTH Mortality Rate (January 2013 – April 2018)

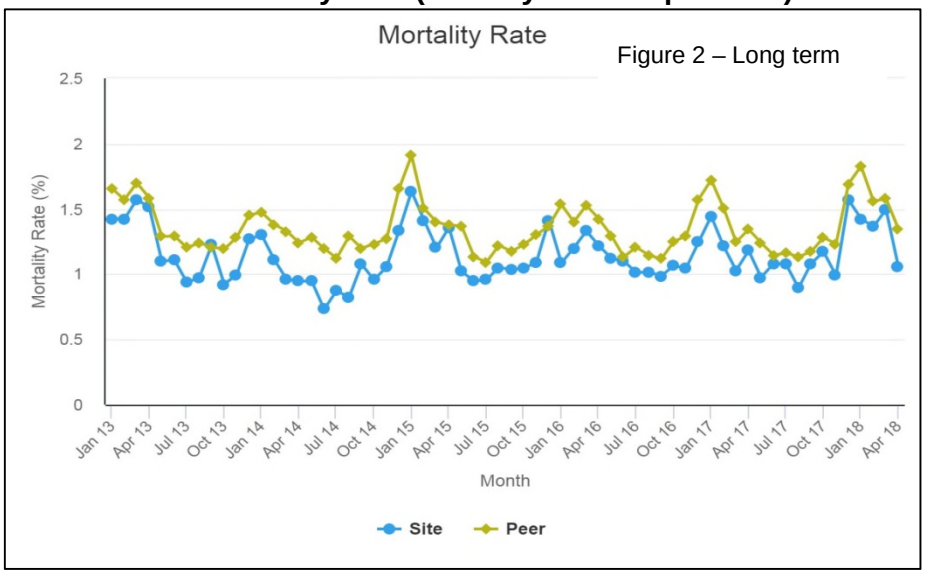


Figure 2 – Long term

2. RAMI – Risk Adjusted Mortality Index *

RAMI (April 2017 – April 2018)
SaTH 79.25 v Peer 88.26

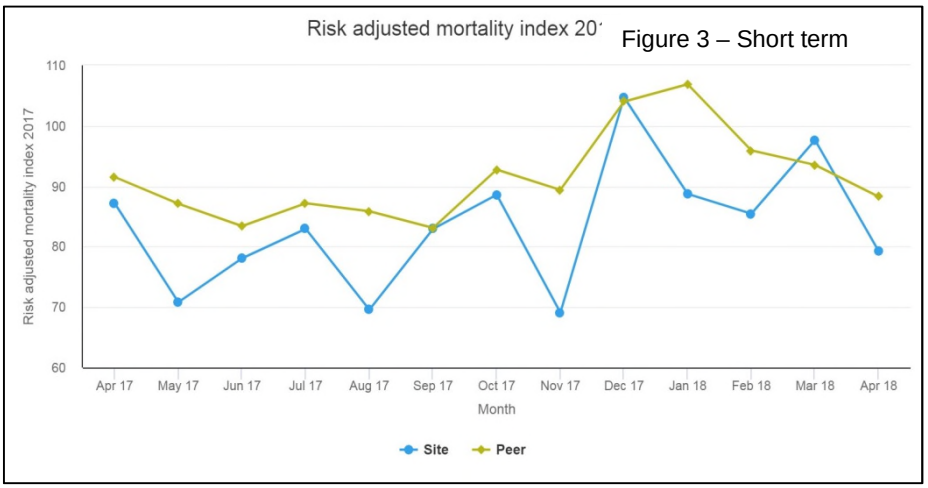


Figure 3 – Short term

RAMI – SaTH v Trust Peer (January 2013 – April 2018)

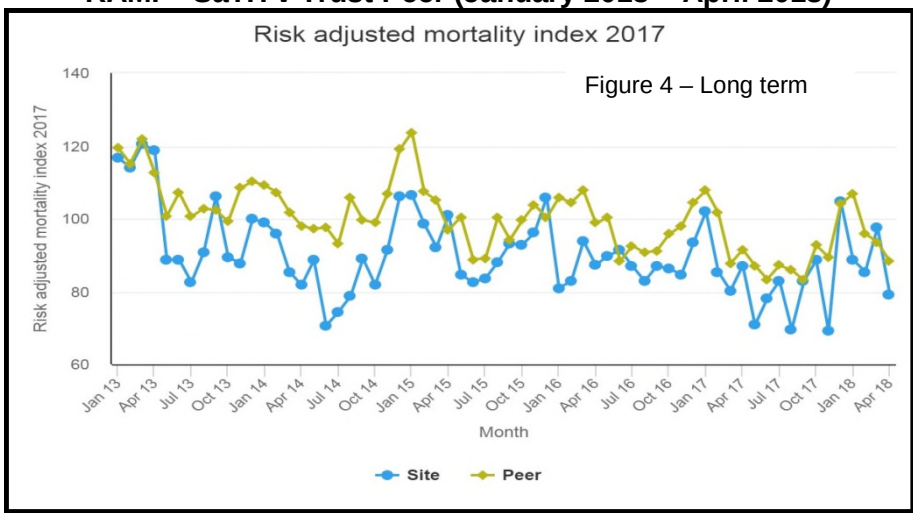


Figure 4 – Long term

* This mortality ratio is described as the number of observed deaths divided by the number of predicted deaths. RAMI were 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.

3. HSMR – Hospital Standardised Mortality Ratio **

HSMR (April 2017 – April 2018)
SaTH 85.59 v Peer 106.07

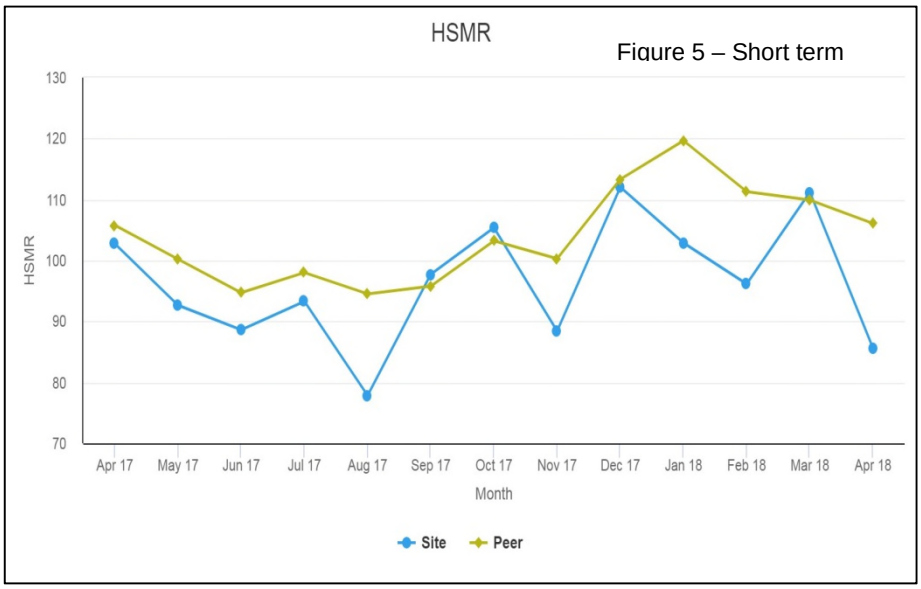


Figure 5 – Short term

HSMR - SaTH v Trust Peer (January 2013 – April 2018)

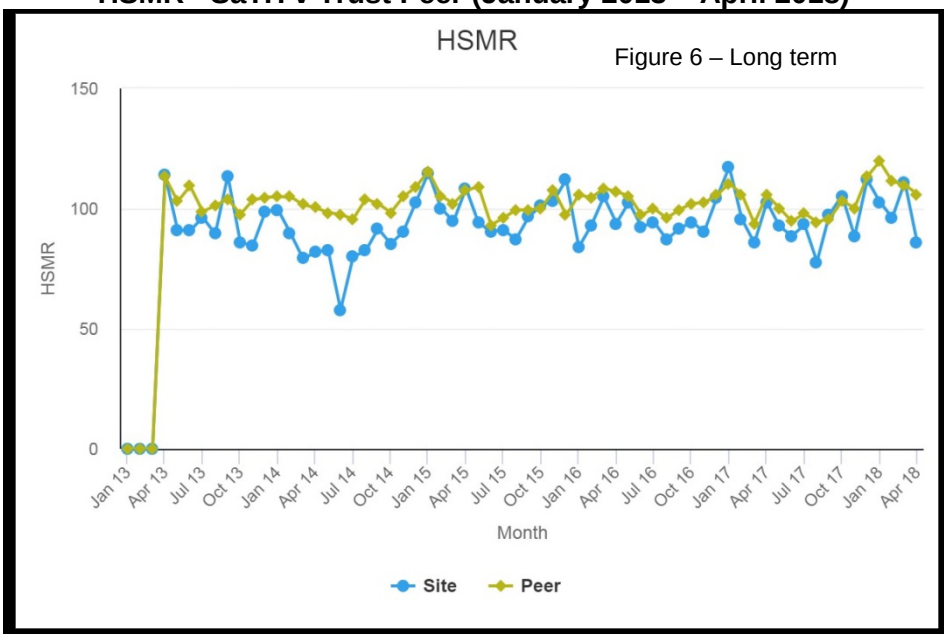


Figure 6 – Long term

** 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.

4. SHMI – Summary Hospital-level Mortality Indicator (In-hospital) ***

In-Hospital SHMI (April 2017 – April 2018)
SaTH 56.63 v Peer 66.95

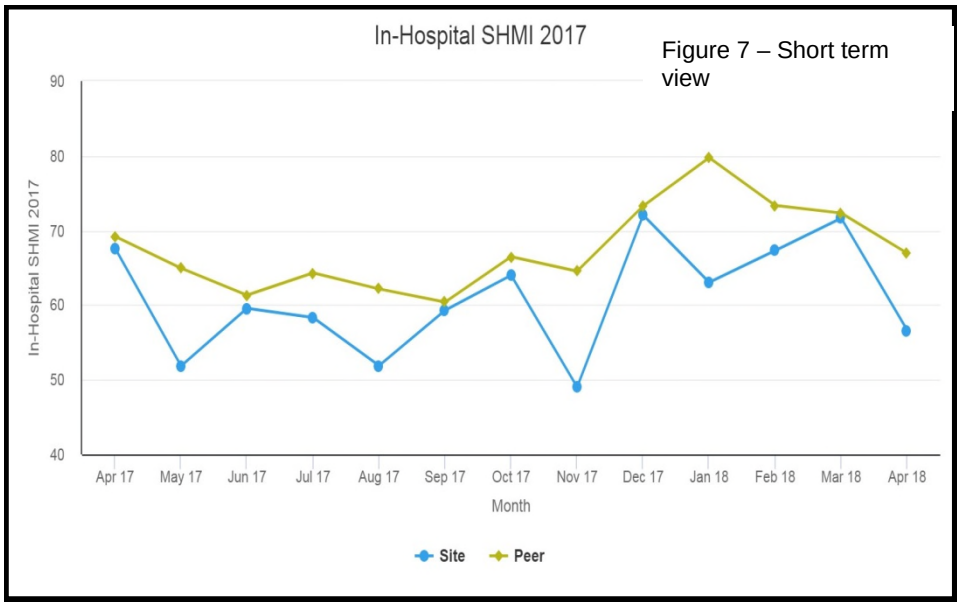


Figure 7 – Short term view

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

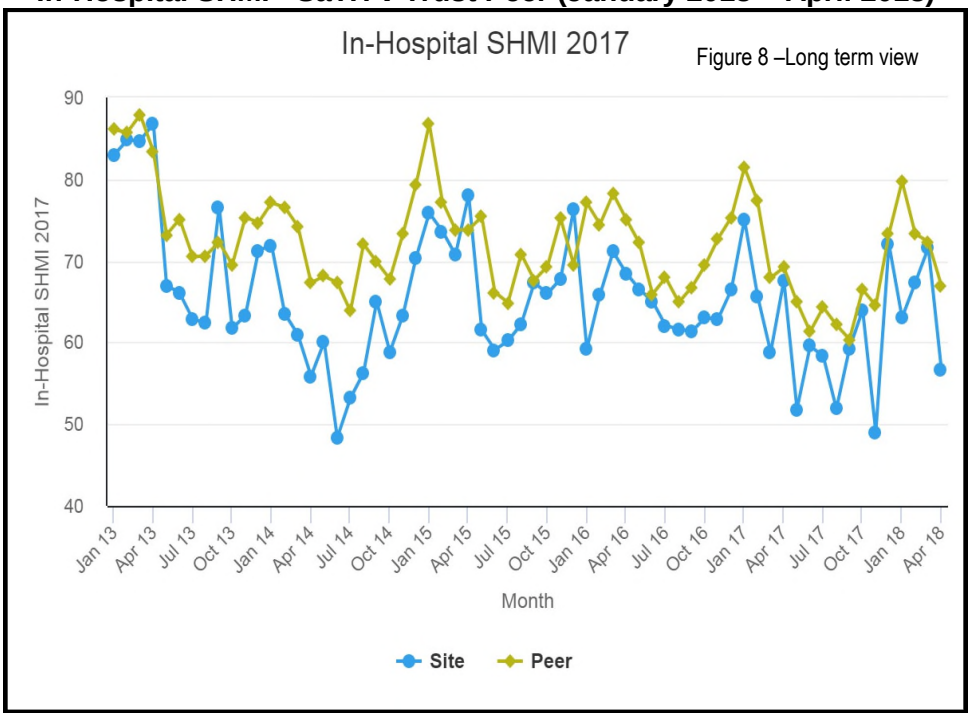


Figure 8 –Long term view

*** 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

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 6 months to assess any changes
- Identify administrative personnel to address the administrative errors.
- SaTH Medical Director to speak with Shropshire Community 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, 4 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 2 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

Appendix 1 – Peer Group

The Peer group used for this report comprises of the following Trusts:

- Gloucestershire Hospitals NHS Trust
- Sandwell and West Birmingham NHS Trust
- York Teaching Hospitals NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- The Royal Wolverhampton Hospital NHS Trust
- The Dudley Group NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust
- East and North Hertfordshire NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- Western Sussex Hospitals NHS Foundation Trust

Section four: Maternity Report

The purpose of this report is to provide the Board with an analysis of data within the maternity clinical dashboard for July 2018. The report highlights any elements 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. July 2018 has seen a live delivery figure of 354 (90.8%). This is above the national target of 86.6%.

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 the five Midwife-Led units was 28 births in July 2018 (7.2 %). The National MLU birth figure is 11.8%. Bridgnorth, Ludlow and Oswestry MLU were all closed during July 2018 and Shrewsbury MLU has reduced capacity (whilst building works continue). However the births in these units for July 2018 were:-

- Ludlow MLU = 1 birth (but closed)
- Wrekin had 24 births
- Shrewsbury 3 births

The Home births for July 2018 were seven births (1.8%); this is above the national rate set by the NMPA data of 1.4%. There was one Born before Arrival (BBA) in July (0.3%)

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 July 2018 for VBAC is 28.6 %. This rate will be observed going forward.

Smoking at Time of Delivery. The expected national figure is 11.7%. The Maternity SaTH rate for July 2018 is 15.6 %. 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 2500gms. This is a National Maternity Indicator. The expected GIRFT rate for this descriptor is 2.3%. The Local SaTH data for July 2018 was 8.2%. 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 from the unit. The NMPA rate is 68.1% SaTH rates have been measured at 42.3% for July 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 43% in July 2018. This is the highest rate recorded. 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 7.1 % reported in July 2018 is below this rate.

Stillbirth – The MBBRACE expected rate was 0.38% (2015). The local rate for July 2018 was 0% (no cases). First quarter figure for 2018 is 0.3%

Access to screening services - % 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 QA standard set by NHS England. The July 2018 figure was 64.9%.This is the third 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 - % 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 July 2018 was 87.3% 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 July 2018 there were 362 bookings.

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 June 2018. HIE is graded into three categories – mild, moderate and severe.

There were no reported HIE's during July 2018 demonstrating 0%.

Maternity Clinical Dashboard - 2018/19 - All SaTH Activity

No	Indicator	Descriptor	APR	MAY	JUN	Q1	JUL	YTD	National Figure	National Data Source
1	CQUIM - Clinical Quality Improvement Metrics	Smoking rate at booking	17.6%	20.6%	16.6%	**18.5%**	18.8%	**18.5%**	**19.9%**	**NMPA**
		Normal birth rate	69.9%	68.7%	68.4%	**68.9%**	65.1%	**68.0%**	**66.0%**	**NMPA**
		Caesarean section delivery rate in Robson group 1 women	8.5%	3.6%	12.4%	**8.2%**	4.7%	**7.3%**		
		Caesarean section delivery rate in Robson group 2 women	28.2%	26.2%	21.3%	**25.0%**	30.2%	**26.4%**		
		Caesarean section delivery rate in Robson group 5 women	25.4%	28.6%	29.2%	**27.9%**	34.9%	**29.7%**		
		3rd and 4th degree tear rate among women delivering vaginally	2.2%	3.4%	3.6%	**3.1%**	1.7%	**2.7%**	**3.5%**	**NMPA**
		Rate of postpartum haemorrhage of 1500ml or greater	1.4%	1.7%	1.3%	**1.5%**	2.9%	**1.8%**	**2.7%**	**NMPA**
		Rate of successful vaginal birth after a single previous caesarean section	27.3%	32.4%	40.0%	**34.1%**	28.6%	**32.3%**	**57.7%**	**NMPA**
		Smoking rate at delivery	14.0%	17.2%	16.1%	**15.9%**	15.6%	**15.8%**	**11.7%**	**NMPA**
		Proportion of babies born at term with an Apgar score <7 at 5 minutes	0.3%	0.8%	0.8%	**0.7%**	0.3%	**0.6%**	**3.5%**	**NMPA**
		Proportion of babies born at term admitted to the neonatal intensive care unit	16.2%	17.0%	16.6%	**16.6%**	18.9%	**17.2%**		
		Proportion of babies readmitted to hospital at <30 days of age								
		Breastfeeding initiation rate	76.5%	76.6%	78.6%	**77.3%**	76.3%	**77.0%**		
2	National Maternity Indicators (NMI); Domain 1: Mortality and morbidity	Stillbirth rate	0.3%	0.7%	0.0%	**0.3%**	0.0%	**0.3%**	**0.38% (2015)**	**MBRRACE**
		Neonatal Mortality Rate							**0.17% (2015)**	**MBRRACE**
		Brain injuries - HIE	0.0%	0.0%	0.0%	**0.0%**	0.3%	**0.1%**		**NMPA**
		Proportion with singleton term infants with a 5-minute Apgar score of less than 7	0.3%	0.8%	0.8%	**0.7%**	0.3%	**0.6%**	**1.2%**	**NMPA**
		Proportion of vaginal births with a 3rd/4th degree perineal tear	2.2%	3.4%	3.6%	**3.1%**	1.7%	**2.7%**	**3.5%**	**NMPA**
		Proportion of birth episodes with severe PPH of greater than or equal to 1500ml	1.4%	1.7%	1.3%	**1.5%**	2.9%	**1.8%**	**2.7%**	**NMPA**
3	National Maternity Indicators (NMI); Domain 2: Clinical care and health promotion	Normal birth rate	69.9%	68.7%	68.4%	**68.9%**	65.1%	**68.0%**	**66.0%**	**NMPA**
		Caesarean section delivery rate in Robson group 1 women	8.5%	3.6%	12.4%	**8.2%**	4.7%	**7.3%**		**NMPA**
		Caesarean section delivery rate in Robson group 2 women	28.2%	26.2%	21.3%	**25.0%**	30.2%	**26.4%**		**NMPA**
		Caesarean section delivery rate in Robson group 3 women	2.8%	0.0%	2.2%	**1.6%**	1.2%	**1.5%**		**NMPA**
		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	6.8%	7.9%	4.8%	**6.5%**	8.2%	**6.9%**	**2.3%**	**GIRFT**
		Proportion of live born babies who are breastfed for the first feed	69.3%	70.8%	70.2%	**70.1%**	66.9%	**69.3%**	**73.6%**	**NMPA**
		Proportion of births between 23+0 and 27+6 which occur outside of a hospital with a neonatal intensive care unit	0.0%	0.0%	0.0%	**0.0%**	0.0%	**0.0%**		**NMPA**

4	**Other metrics not included in CQIM or NMI**	Episiotomy rate overall	10.0%	14.8%	8.7%	**11.3%**	14.0%	**12.0%**	**22.0%**	**NMPA**
		Overall assisted birth rate - Primip	16.0%	17.9%	18.1%	**17.3%**	19.6%	**17.9%**	**25.3%**	**NMPA**
		Overall assisted birth rate - Multip	1.8%	1.2%	2.0%	**1.7%**	4.3%	**2.3%**	**5.6%**	**NMPA**
		Skin to skin contact within 1 hour of birth	99.4%	99.3%	100.0%	**99.6%**	100.0%	**99.7%**	**79.8%**	**NMPA**
		Babies breastfeeding at discharge	48.2%	47.6%	44.7%	**46.8%**	42.3%	**45.7%**	**68.1%**	**NMPA**
		Shoulder Dystocia rate	0.0%	0.7%	0.5%	**0.4%**	1.5%	**0.7%**	**0.7%**	**RCOG**
		Induction of labour rate	38.4%	37.0%	37.0%	**37.4%**	43.0%	**38.8%**	**28.5%**	**NMPA**
		Rate of 1:1 care in established labour	98.0%	95.2%	96.1%	**96.4%**	97.7%	**96.7%**		
		Percentage of deliveries from mothers with placenta-praevia and abruption (spontaneous, unassisted vaginal delivery)	0.0%	0.2%	0.0%	**0.1%**	0.0%	**0.1%**	**0.7%**	**GIRFT**
5	**Births activity by Unit**	**Overall Trust total births**	355	418	396	**1169**	390	**1559**	**375-425**	**Local**
		Telford Consultant Unit	300	372	347	**1019**	354	**1373**	**4-10**	**Local**
		Bridgnorth MLU	1	3	0	**4**	0	**4**	**4-10**	**Local**
		Ludlow MLU	3	0	0	**3**	1	**4**	**4-10**	**Local**
		Oswestry MLU	3	0	1	**4**	0	**4**	**4-10**	**Local**
		Shrewsbury MLU	7	3	4	**14**	3	**17**	**10-20**	**Local**
		Wrekin MLU	35	28	31	**94**	24	**118**	**20-30**	**Local**
		BBA/Other	1	1	1	**3**	1	**4**	**0-2**	**Local**
		Home	5	11	12	**28**	7	**35**	**0-5**	**Local**
		% of births in Consultant Unit	84.5%	89.0%	87.6%	**87.2%**	90.8%	**88.1%**	**86.6%**	**NMPA**
		% of birth in a MLU or at home	15.2%	10.8%	12.1%	**12.6%**	9.0%	**11.7%**	**14.3%**	**NMPA**
		% of births in any MLU	13.8%	8.1%	9.1%	**10.2%**	7.2%	**9.4%**	**11.8%**	**NMPA**
		% Home Births	1.4%	2.6%	3.0%	**2.4%**	1.8%	**2.2%**	**1.4%**	**NMPA**
		% BBA/Other	0.3%	0.2%	0.3%	**0.3%**	0.3%	**0.3%**	**0.3%**	**NMPA**
6	**Operative Deliveries**	Overall Assisted Births rate %	7.7%	8.0%	7.9%	**7.9%**	10.3%	**8.5%**	**10%-13%**	**GIRFT**
		Forceps rate %	6.3%	6.1%	4.8%	**5.7%**	6.9%	**6.0%**	**0%-8%**	**Local**
		Ventouse rate %	1.4%	1.9%	3.1%	**2.2%**	2.9%	**2.4%**	**0%-11%**	**Local**
		Dual Instruments rate %	0.0%	0.0%	0.0%	**0.0%**	0.5%	**0.1%**	**0%-2%**	**Local**
		Caesarean Section rate %	20.3%	20.4%	22.7%	**21.2%**	22.7%	**21.6%**	**25%**	**NMPA**
		Primip Caesarean Section rate %	22.9%	21.4%	27.8%	**23.9%**	26.4%	**24.5%**	**25.8%**	**NMPA**
		Multip Caesarean Section rate %	17.4%	19.8%	19.8%	**19.0%**	20.3%	**19.4%**	**24.4%**	**NMPA**
		% of Deliveries - Category 1 C/Section	1.7%	2.4%	2.8%	**2.3%**	2.4%	**2.4%**	**0%-4%**	**Local**
		% of Deliveries - Category 2 C/Section	8.3%	5.6%	7.4%	**7.0%**	7.1%	**7.1%**	**0%-8%**	**Local**
		% of Deliveries - Category 3 C/Section	1.7%	2.7%	0.3%	**1.6%**	1.6%	**1.6%**	**0%-4%**	**Local**
		% of Deliveries - Category 4 C/Section	8.9%	10.0%	12.2%	**10.4%**	12.1%	**10.8%**	**0%-10%**	**Local**
7	**Access to Maternity Services**	Number of Bookings	476	494	368	**1338**	362	**1700**	**400-450**	**Local**
		% of bookings with a gestation of less than 10 weeks	54.6%	64.6%	62.0%	**60.3%**	64.9%	**61.3%**	**50%-100%**	**Local**
		% of bookings with a gestation of less than 12 weeks 6 days	85.5%	85.4%	85.3%	**85.4%**	87.3%	**85.8%**	**90%-100%**	**CMS**

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 July 2018
- Consider the actions being taken where performance requires improvement
- Question the report to ensure appropriate assurance is in place