The Shrewsbury and Telford Hospital NHS Trust

NHSR Scorecard Q4 (Jan-March 2024)

Date: May 2024

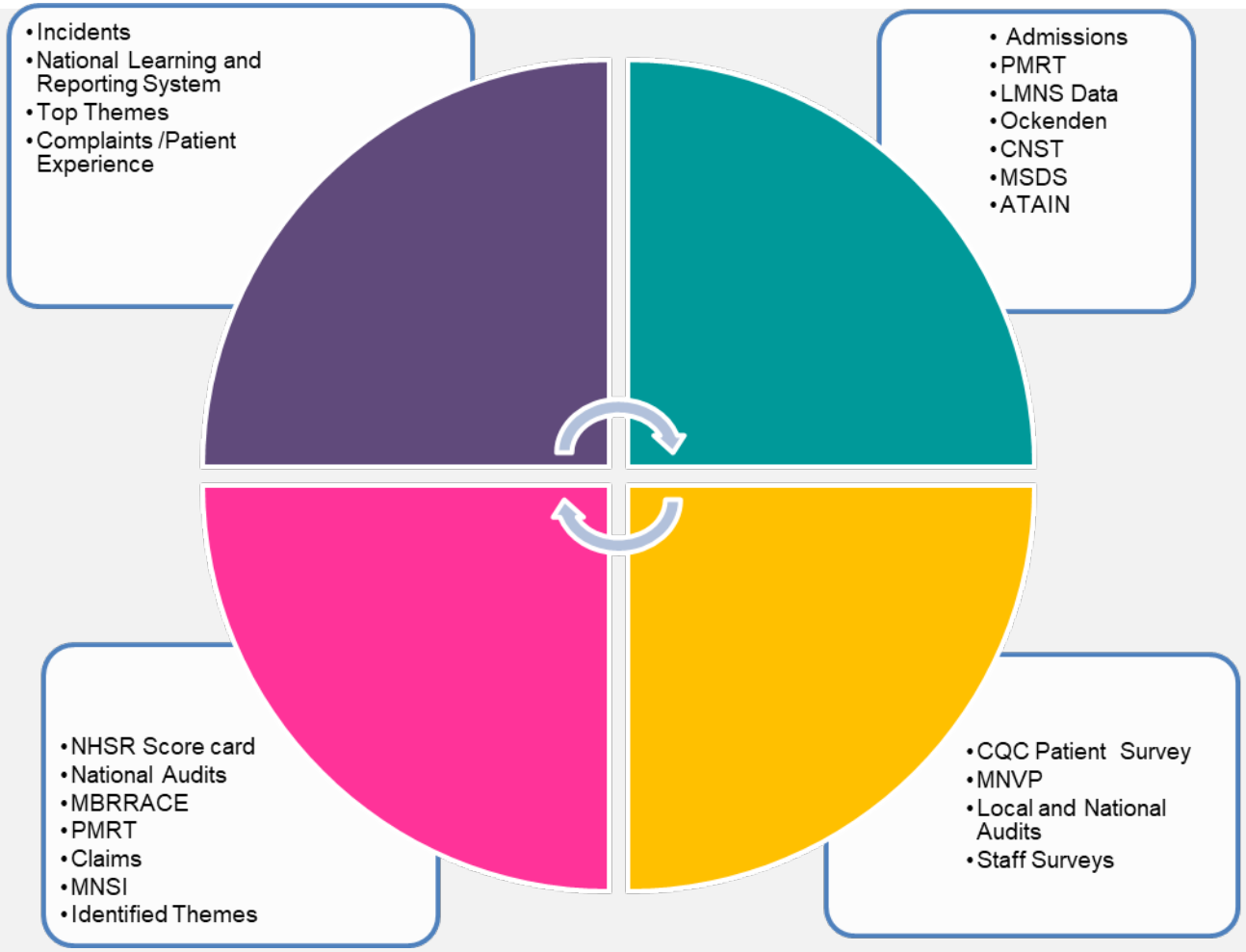
Kimberly Williams – Head of Midwifery

Maternity Incentive Scheme Year 6 – Safety Action 9

The Shrewsbury and Telford Hospital NHS Trust

Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period).

Evidence Source



Data Collection

The Shrewsbury and Telford Hospital NHS Trust

- Review of Litigation Claims/NHSR Scorecard
- Themes from Complaints/Compliments/Friends and Family
- Themes from PSII's/PMRT/External reviews (Ockenden, CQC)
- Top Themes from Incidents Reported
- National Reviews of themes/MNSI Safety Recommendations and Publications/MBRRACE/National Reports/CDOP

THEMES

Incidents by Category Neonatal Q4

The Shrewsbury and Telford Hospital NHS Trust

Theme	Example
Neonatal	ATAIN
Staffing Problems	Staffing levels/Acuity
Medical device (Medical equipment & disposables)	Lack/unavailability of device
Communication problem between staff, teams', depts	Staff availability & documentation
Care/Monitoring	Delay /Failure to undertake investigations

Incidents Top 5 Themes Q4 Maternity

The Shrewsbury and Telford Hospital NHS Trust

Theme	Example
Discharge of patient problems	Self discharge against medical advice
Labour and Birth	Staffing levels/Acuity
Care/Monitoring	Post Partum Haemorrhage > 1500mls
Red Flags	Delay in ARM/Induction of Labour
Communication between teams	Delayed results/Bleeps/reviews

Incidents & Actions Q4 Maternity and Neonates

Maternity

No PSSI's Commissioned

1 After Action Review Commissioned in January 2024.

Elective Caesarean section followed by 2 returns to theatre for Massive Obstetric Haemorrhage of 5.5litres. Resulted in subtotal hysterectomy. Draft report underway no learning available to share currently.

Neonates

No PSSI's Commissioned

No After Action Review Commissioned

Duty of Candour Documentation

Compliments Complaints FFT MNVP Staff Survey

The Shrewsbury and Telford Hospital NHS Trust

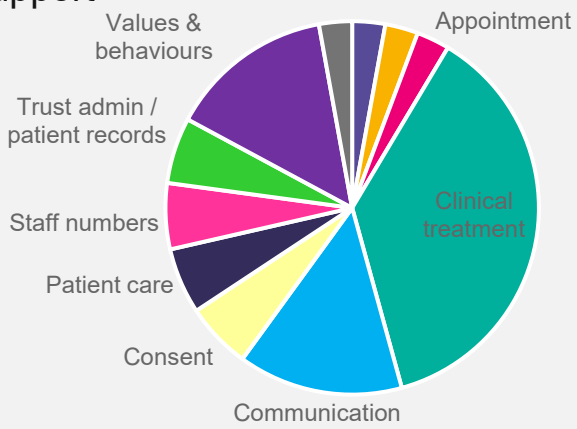
Obstetrics / Maternity	Totals
Access to treatment	1
Admission discharge	1
Appointment	1
Clinical treatment	13
Communication	5
Consent	2
Patient care	2
Staff numbers	2
Trust admin / patient records	2
Values & behaviours	5
Waiting time	1

Neonates	Totals
Clinical treatment	1
Patient care	1
Values & Behaviours	1

Learning

Staff recognition
Guideline and SOP review
Culture & Value Based Workshops
Culture Review
Staff Survey Action Plan
Individual Learning and Development Programmes
Staff Rotations
QI projects - Triage
Refresher Training
MNVP Engagement
UX Workshop
Reflections
PMA support

Q4 Maternity Complaints Subjects



ATAIN

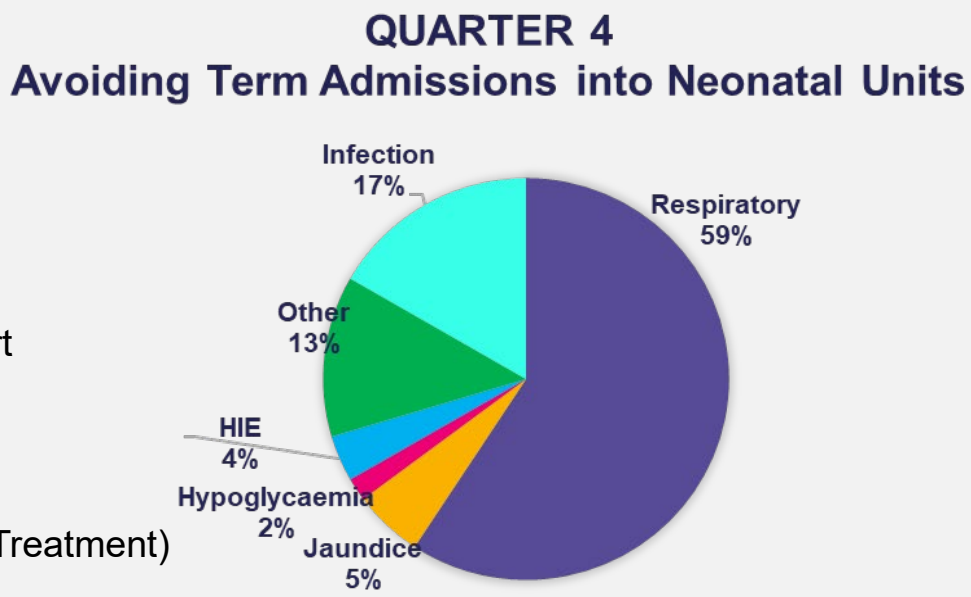
ATAIN

Data

January 2024 8.2% of all births at >37 weeks (n=25)

February 2024 5.8% of all births at >37 weeks (n=17)

March 2024 4.6% of all births at >37 weeks (n=12)



Themes

Intensive Oxygen support

NG Feeding

Hypoglycaemia Policy

Jaundice (Capacity and Treatment)

NEWT Observations

PMRT MBRRACE

The Shrewsbury and Telford Hospital NHS Trust

January-March 2024 (Q 4)	number	MBRRACE Reportable
Late Fetal Loss (22-23+6 weeks)	1	Yes
Early Fetal Loss (16-19+6 weeks)	2	No
Early Neonatal death (Live birth >20 weeks or 400g) < 7 completed days post birth	0	Yes
Late Neonatal Death (Live birth >20 weeks or 400g) 7-28 days post birth	0	Yes
Post-Neonatal Deaths (7 days to 1 year post birth)	0	Babies born after 22 weeks who receive neonatal care and die >28 days after birth.
Termination of Pregnancy (any gestation)	4	Over 22 weeks or Livebirth from 20 weeks
Stillbirths (over 24 weeks)	3	Yes

PMRT Themes

Preconceptual counselling for women with Diabetes

Routine Enquiry

PPROM Observations

GTT Referral

Documentation

Learning

Bereavement Champions

Update Patient Information

Review Guidance and SOPs

Bereavement Birth Preferences Card

Collaborative working with MCoC and EDI Midwives

MNSI Publications

Safety Recommendations (April 2022)

2 new publications for factual accuracy, safety recommendations expected

Therapeutic Cooling CTG (Accepted)

APH Cooling (Accepted)

Local & National Audits CQUIM MSDS & Maternity Dashboard

The Shrewsbury and Telford Hospital NHS Trust

Triangulation of Incidents and data analysis of Maternity Dashboard:

Postpartum Haemorrhage >500-<1500mls Audit Quarterly

Postpartum Haemorrhage > 1500mls Audit

VTE Audit Monthly

Decision to Delivery Category 2 CS

Triage Audit (Triage times and Self Discharges)

Local Guideline/SOP Audit and National Benchmarking

CQC Visit & Maternity Survey

The Shrewsbury and Telford Hospital NHS Trust

CQC Visit October 2023- published May 24

CQC Maternity Survey 2022 (Co-produced with MNVP) Action plan fully implemented

CQC Maternity Survey 2023 (Awaiting GAP Analysis and Action Plan)

Litigation NHSR Scorecard

Since the data was pulled for this Scorecard (30 June 2023) 1 new claim (this is a case from 2011 so will not appear on the scorecard).

0 Early Notification Scheme cases have been reported in Q4, 3 remain open.

Themes for the 3 open:

1.No theme recorded (MNSI report awaited – NHSR are awaiting this to decide whether to investigate further)

2.Failure to Act on abnormal FHR (MNSI report received with no recommendations – NHSR have instructed experts to investigate this, advice from Counsel expected 2024)

3.Fail to act on abnormal test results (MNSI report awaited - NHSR are awaiting this to decide whether to investigate further)

Themes Claims 2013-2024

1. Fail/delay in diagnosis = 29
2. Inappropriate treatment = 5
3. Failure to respond to an abnormal FHR = 4

   Failure to monitor 2 stage labour = 4
4. Fail/delay in antenatal screening = 3

   Consent issues = 3

   Unexpected death = 3

   Perineal tears = 3
5. Inappropriate discharge =2

   Failure to act on abnormal test results = 2

Monitoring Safety

Triangulation

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Fetal Monitoring and Interpretation

Term Admissions

Test Results (Follow up)

Perineal Tears

Diabetes Service (Including Pre-conception)

Escalation Policy/Process

Communication/Values & Behaviours

Waiting Times

Consent

Improvements

Fetal Monitoring Training (Full day, Case Reviews, Workbook and Lead Midwife & Obstetrician)

ATAIN MDT Meetings (Learning Disseminated)

Professional Development Programmes

Fresh Eyes (Full Holistic Review)

Band 7 Co-ordinator Training

Human Factors Training

Helicopter View Training

Culture Training

Action Planning (Thematic Reviews QI projects)

Staff Engagement Events

Public Engagement (Open Days)

Guideline and SOP review

Improvements

The Shrewsbury and Telford Hospital NHS Trust

Culture Workshops

Culture Review

Staff Survey Action Plan

Individual Learning and Development Programmes

Staff Rotations

QI projects (Triage, Diabetes Service & Induction of Labour)

Refresher Training

MNVP Engagement

UX Workshop

Reflections

PMA support

Perinatal Pelvic Health Service

OPEL Framework/Manager of the Day/Workforce Plan

Thank you