The Shrewsbury and Telford Hospital NHS Trust

NHSR Scorecard Q1 (April-June 2024)

Date: August 2024

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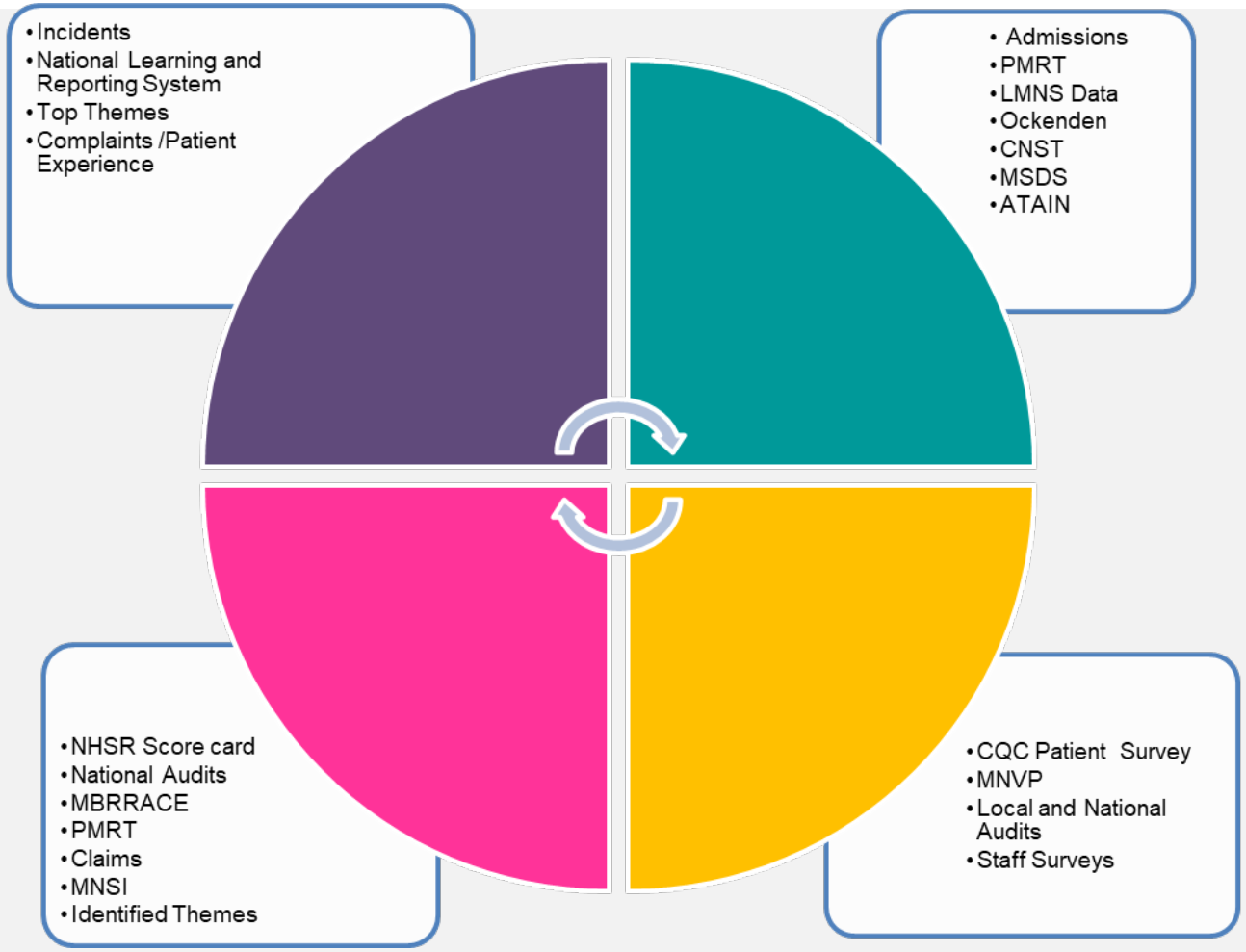
Head of Midwifery

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 Q1

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Theme	Example
Neonatal	ATAIN (Term Admissions) /Unexpected admission to NNU
Care/Monitoring	Delay /Failure to undertake investigations /failure to follow clinical guidelines
Operational Pressures (OPEL)	Internal capacity pressures
Communication with Patients and Carers	Communication failure with patient, parent or carer/ Wrong information on admit letter/appointment
Medication – Prescribing Error	Dose or strength wrong or unclear/ Frequency of medication wrong /Prescription issues

Incidents Top 5 Themes Q1 Maternity

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

Incidents & Actions Q1 Maternity and Neonates

Maternity

No PSII'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 PSII's Commissioned

No After-Action Review Commissioned

Compliments Complaints FFT MNVP Staff Survey

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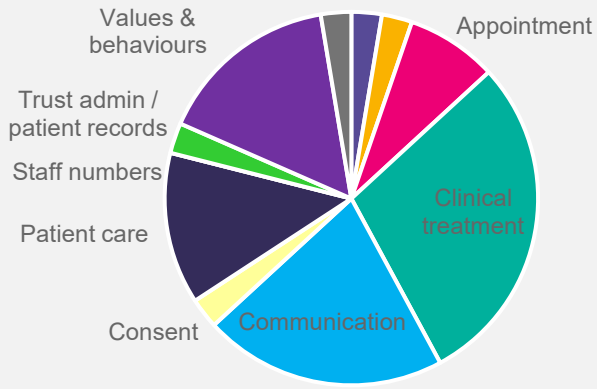
Complaints Obstetrics & Maternity	TOTALS
Access to treatment / drugs	1
Appointment	3
Clinical treatment	11
Communication	8
Consent	1
End of life care	1
Facilities	1
Patient care	5
Prescribing	1
Privacy & dignity	1
Staff numbers	1
Trust admin	1
Values & behaviours	6
Waiting time	1
Neonates	**TOTALS**
Communication	1
Patient Care	1
Values & Behaviours	1
PALS – Maternity	**TOTALS**
Obstetrics & Maternity	
Access to treatment / drugs	1
Appointment	2
Admission / discharge	1
Clinical treatment	1
Communication	9
Consent	1
Trust admin	1
Patient Care	4
Values & Behaviours	1
PALS - Neonatal	
Neonatal	0

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

Q1 Maternity Complaints Subjects



ATAIN

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ATAIN

Data

April 2024

318 Term births at PRH – 6.3% of all term births at >37 weeks (n = 20) Avoidable admissions: (n=1)

May 2024

312 Term births at PRH– 2.9% of all term births at >37 weeks (n =9) Avoidable admissions: (n=2)

June 2024

296 Term births at PRH – 5.1% of all term births at >37 weeks (n = 15)

Avoidable admissions: (n=1)

Themes

Intensive Oxygen support

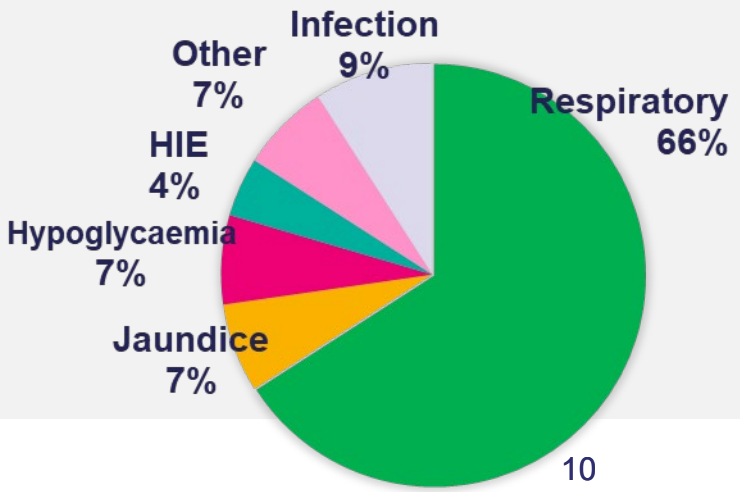
NG Feeding

Hypoglycaemia Policy

Jaundice (Capacity and Treatment)

NEWT Observations

Primary Reason for Admission to NNU Q1



PMRT MBRRACE

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April-June 2024 (Q 1)	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	2	Yes – 2 SaTH PMRT
Late Neonatal Death (Live birth >20 weeks or 400g) 7-28 days post birth	1	Yes
Post-Neonatal Deaths (7 days to 1 year post birth)	1	Babies born after 22 weeks who receive neonatal care and die >28 days after birth.
Termination of Pregnancy (any gestation)	8	Over 22 weeks or Livebirth from 20 weeks
Stillbirths (over 24 weeks)	1	Yes

PMRT Themes

Fluid balance recording, management, and escalation.

Skin care bundle on the NNU

Appointments in antenatal clinic

Timely review of pathology results

Documentation

Learning

Quality Improvement Project

Ratified in NN governance, being rolled out.

Review of antenatal clinic processes in progress.

PMRT monthly newsletter for maternity and neonatal units.

Collaborative working with MCoC and EDI Midwives

MNSI Publications

1 report was published in quarter 1 and a safety recommendation was received pertaining to MI-036488 in May 2024:

"*The Trust ensures that mothers with moderate or severe continuous abdominal pain are observed and monitored as part of an ongoing holistic assessment".*

1 report has been received for factual accuracy and a response has been sent by the trust. The final report is expected in July/August 2024, and the trust are expecting to receive safety recommendations.

4 MNSI referrals were made in quarter 1 and 3 have been accepted for review:

- Therapeutic cooling - CTG concerns in 2nd stage of labour. Normal MRI. (Accepted)
- Antepartum haemorrhage and neonatal death. (Accepted)
- Hypoglycaemic and hypoxic brain injury with seizure activity and abnormal MRI. (Accepted)
- Reduced fetal movements, abnormal CTG, and therapeutic hypothermia. Normal MRI and excellent management. (Rejected)

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 (Good)

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

CQC Maternity Survey 2023 (GAP Analysis and Action Plan co-produced) Learning re: Postnatal Services, Triage, CS pathways.

Litigation NHSR Scorecard

Since the data was pulled for this Scorecard (1 July 2024) the following claims have been received:

April x2

May x0

June x2

3 Early Notification Scheme cases have been reported in Q1

All 3 cases have been referred to MNSI and are under review.

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

Quality Improvement ATAIN (Chorioamnionitis and Nasogastric tube Feeding)

Quality Improvements Postnatal Ward (Handover, Drug ward rounds, Discharge Processes)

Quality Improvements Community Review (Review of Community Services)

Quality Improvements Outpatients (CRT and Diabetes Services)

Quality Improvements Triage

Improvements

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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