NHSR Scorecard Q2 (July-September 2024)

Date: October 2024

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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

- Incidents
- National Learning and Reporting System
- Top Themes
- Complaints /Patient Experience

- Admissions
- PMRT
- LMNS Data
- Ockenden
- CNST
- MSDS
- ATAIN

- NHSR Score card
- National Audits
- MBRRACE
- PMRT
- Claims
- MNSI
- Identified Themes

- CQC Patient Survey
- MNVP
- Local and National Audits
- Staff Surveys

Data Collection

- 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 Q2

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 failure within team	Incorrect information on BadgerNet/ Lack of detail information in handover between departments
Medication – Administration	Frequency of medication incorrectly given /Prescription issues

Incidents Top 5 Themes Q2 Maternity

Theme	Example
Unexpected admission to NNU	Transfer of babies for intensive care (e.g. Respiratory support)
Discharge of patient problems	Self discharge against medical advice
Intrapartum	Post Partum Haemorrhage > 1500mls 3rd and 4th Degree Tears
Communication failure within team correctly/Handover	Communication problem between staff, teams, depts (e.g. BadgerNet information not reviewed
Care / Monitoring / Review Delays	Possible delay or failure to implement care (e.g. delay to IOL due to increased activity/lack of staff)

Incidents & Actions Q2 Maternity and Neonates

Maternity

2 PSII's were Commissioned (both were MNSI cases accepted for review)

Reported to STEIS as per current policy

1. Hypoglycaemia and seizure activity with significant brain injury on MRI, Accepted by MNSI. Interviews being arranged.
2. HIE/Cooling - Suspected HIE Therapeutic hypothermia treatment, Neonatal cardiac arrest at home - normal MRI but at parental request accepted by MNSI. Interviews being completed.

MNSI HIE/Cooling – Final report received 25/09/2024. The Trust received 6 safety recommendations

No After-Action Review Commissioned

Neonates

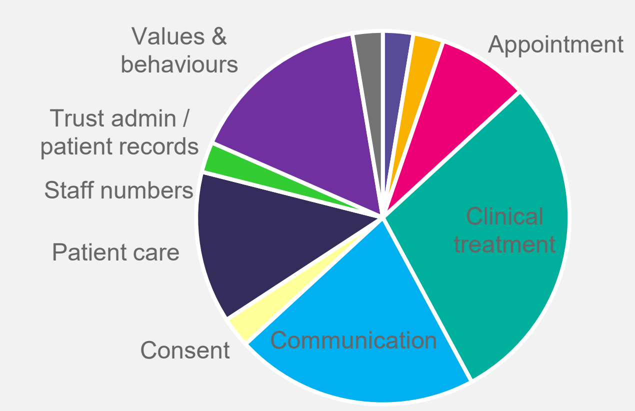
No PSII's Commissioned

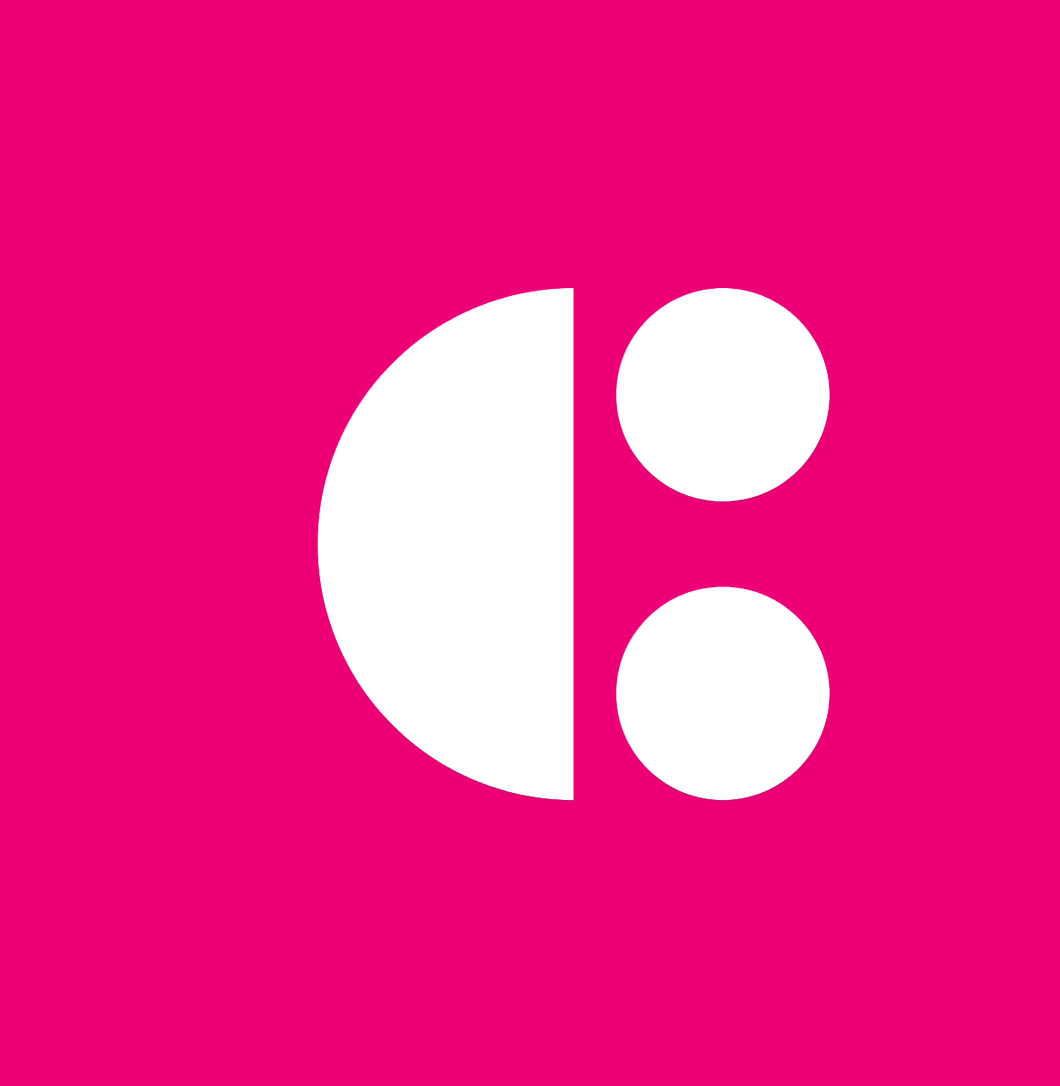
No After-Action Review Commissioned

Compliments Complaints FFT MNVP Staff Survey

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





ATAIN

ATAIN

Data

July 2024

309 Term births at PRH – 6.2% of all term births at >37 weeks (n = 19) Avoidable admissions: (n=0)

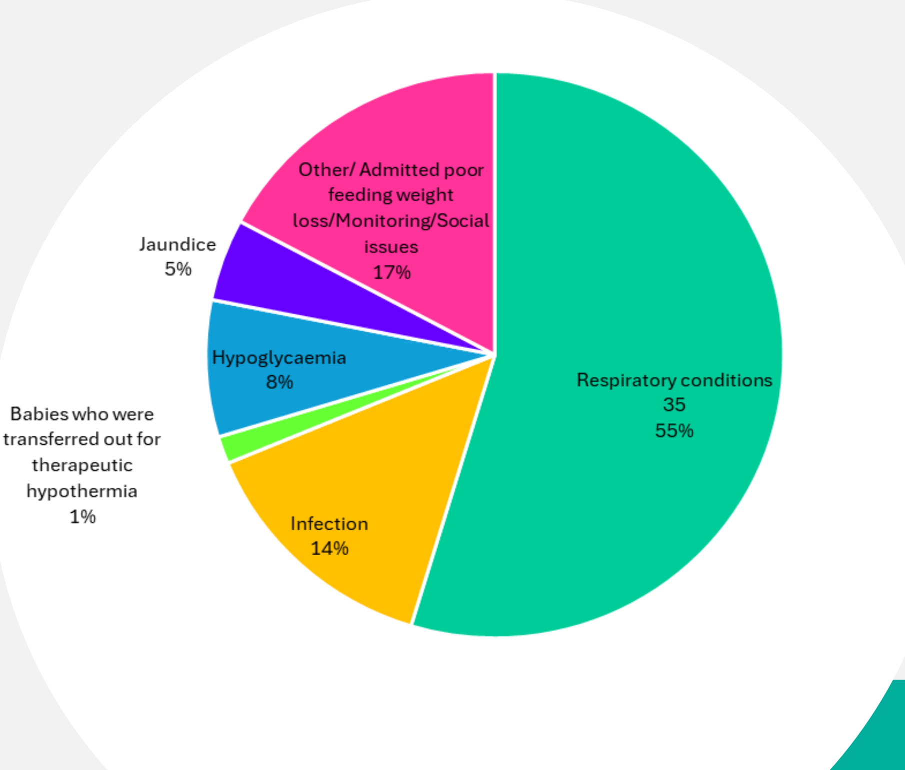
August 2024

292 Term births at PRH - 7.2% of all term births at >37 weeks (n =21) Avoidable admissions: (n=0)

September 2024

333 Term births at PRH – 7.2% of all term births at >37 weeks (n = 24)

Avoidable admissions: (n=tbc)



Primary Reason for Admission to NNU Q2

Respiratory conditions	35
Infection	9
Babies who were transferred out for therapeutic hypothermia	1
Hypoglycaemia	5
Jaundice	3
Other/ Admitted poor feeding weight loss/Monitoring/Social issues	11

Themes

Intensive Oxygen support

NG Feeding

Hypoglycaemia Policy

Jaundice (Capacity and Treatment)

NEWT Observations

PMRT MBRRACE

July-September 2024 (Q 2)	Number	MBRRACE Reportable
Late Fetal Loss (22-23+6 weeks)	1	Yes
Early Fetal Loss (16-19+6 weeks)	5	No
Early Neonatal death (Live birth >20 weeks or 400g) < 7 completed days post birth	0	Yes – 2 SaTH PMRT
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)	1	Babies born after 22 weeks who receive neonatal care and die >28 days after birth.
Termination of Pregnancy (any gestation)	6	Over 22 weeks or Livebirth from 20 weeks
Stillbirths (over 24 weeks)	3	Yes

PMRT Themes

Fluid balance recording, management, and escalation.

Skin care bundle on the NNU

Booking of pregnancy for women accessing care late

Communication between obstetric and neonatal teams

Massive haemorrhage in the neonate

Learning

Quality Improvement Project

Ratified in NN governance, being rolled out.

Early bird clinic in place to improve booking capacity

PMRT monthly newsletter for maternity and neonatal units.

MNSI Publications

1 report was published in quarter 2 and 6 safety recommendation was received pertaining to **M1-032592 HIE/Cooling received 25/09/2024.**

MNSI Safety Recommendations

6 New safety recommendations were received in September linked to MI-032592.

It is recommended that:

1. The Trust to ensure that a robust system is in place for women with gestational diabetes to trigger a face-to-face specialist review when there are concerns with engagement and reduced compliance with blood glucose testing, in order to provide ongoing support to mothers, with timely commencement of medication when required.
2. The Trust to provide mothers with accurate personalised information and to ensure their understanding of this, to enable them to make an informed choice regarding mode of birth.
3. The Trust to ensure they have consistent guidance to support clinicians in planning care when there are signs of chronic hypoxia on a cardiotocograph prior to the onset of labour.
4. The Trust to ensure that staff use and understand the checklist for determining if chronic hypoxia or pre-existing fetal injury is present to ensure that there is a consistent assessment of and management of CTG findings.
5. The Trust to review the process of the fresh eyes CTG reviews in labour to ensure they are independent and effective, to optimise the opportunity for recognising fetal heart rate abnormalities.
6. The Trust to ensure that clinicians are supported to follow guidance and commence variable rate insulin infusion when required while caring for women with diabetes in labour.

The most recent safety recommendation prior to this was received in May 2024 pertaining to MI-036488:

The Trust ensures that mothers with moderate or severe continuous abdominal pain are observed and monitored as part of an ongoing holistic assessment.” An action planning meeting will be arranged to address this recommendation. The Division is also reviewing additional learning identified from the final report and generating additional actions.

Local & National Audits CQUIM MSDS & Maternity Dashboard

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

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

This year's Scorecard was received in September 2024, it contains data for 10 years of claims by incident date- 1/4/2014-31/3/24.

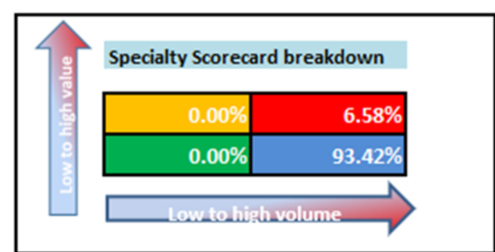
The 2023 Scorecard had no claim with an incident date from April 2021 onwards, we now have 3 claims from 2021/22 but none for 22/23 or 23/24.

The claims received post the Independent Maternity Review have incident dates as far back as 1994, so most of these claims will not be included on the scorecard.

In the 2023 scorecard. the most common theme in both the high and low volumes section of the scorecard for obstetrics was "fail/delay in treatment". This remains the most common theme in the low value, high volume claims, however in the high value, high volume section "failing to respond to abnormal fetal heart rate" is now the most common theme (and is second in the low volume section).

Obstetrics

Specialty drop down list:	Obstetrics



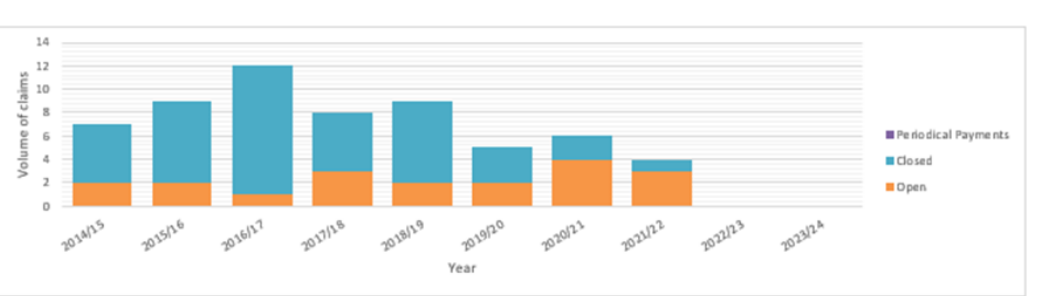
Notification Window (Years)		
Specialty	2.89	The average notification window for Obstetrics claims is 0.68 year(s) longer than the average notification window for all claims received by the trust.
Trust	2.21	

Specialty - Volume of Claims	Specialty - Value of claims (£)	Specialty - Ave. Claim Value (£)
76	69,349,749	912,497

% of Trust Clinical Claims - Volume	% of Trust Clinical Claims - Value	% Trust - Ave. Clinical Claim Value
15%	35%	242%

Volume of claims by Incident Year (Incidents Excluded)

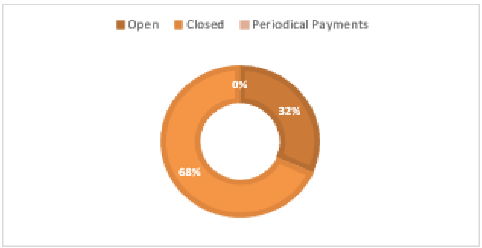
Year	Open	Closed	Periodical Payments
2014/15	2	5	0
2015/16	2	7	0
2016/17	1	11	0
2017/18	3	5	0
2018/19	2	7	0
2019/20	2	3	0
2020/21	4	2	0
2021/22	3	1	0
2022/23	0	0	0
2023/24	0	0	0
Total	19	41	0



Obstetrics Themes

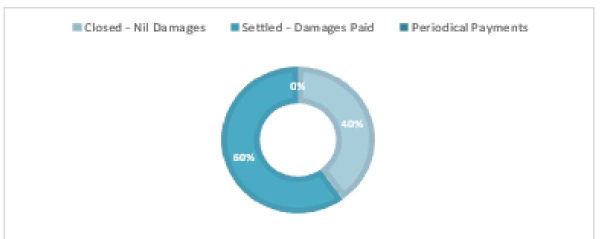
Current Status (Incidents Excluded)

	Volume
Open	19
Closed	41
Periodical Payments	0
Total	60



Claim Outcomes (Incidents Excluded)

	Volume	Value	Ave Total Value	%
Closed - Nil Damages	16	116,692	7,293	40%
Settled - Damages Paid	24	3,059,522	127,480	60%
Periodical Payments	0	-	-	0%
Total	40	3,176,214	79,405	



Top 5 injuries by volume for Obstetrics

					% of Specialty	
	Injury	Volume	Value	Ave Claim Value	Volume	Value
1	Stillborn	16	1,640,344	102,522	21%	2%
2	Fatality	10	1,394,301	139,430	13%	2%
3	Unnecessary Pain	8	462,863	57,858	11%	1%
4	Psychiatric/Psychological Dmge	7	504,197	72,028	9%	1%
5	Brain Damage	6	44,457,888	7,409,648	8%	64%
Total Top 5 injuries by Volume for Obstetrics		47	48,459,593	1,031,055	62%	70%

Top 5 injuries by value for Obstetrics

					% of Specialty	
	Injury	Volume	Value	Ave Claim Value	Volume	Value
1	Brain Damage	6	44,457,888	7,409,648	8%	64%
2	Cerebral Palsy	4	15,058,273	3,764,568	5%	22%
3	Erb's Palsy	2	1,711,710	855,855	3%	2%
4	Stillborn	16	1,640,344	102,522	21%	2%
5	Fatality	10	1,394,301	139,430	13%	2%
Total Top 5 injuries by Volume for Obstetrics		38	64,262,516	1,691,119	50%	93%

Top 5 causes by volume for Obstetrics

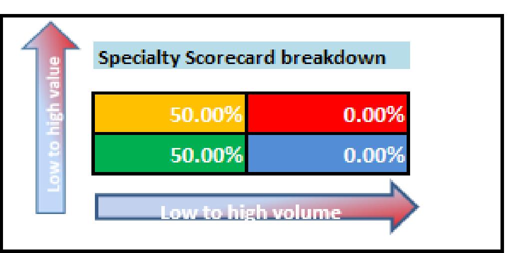
					% of Specialty	
	Causes	Volume	Value	Ave Claim Value	Volume	Value
1	Fail / Delay Treatment	28	5,467,229	195,258	37%	8%
2	Fail To Warn-Informed Consent	6	15,034,472	2,505,745	8%	22%
3	Fail To Make Resp To Abnrm FHR	5	30,071,849	6,014,370	7%	43%
4	Fail To Monitor 2nd Stg Labour	4	287,950	71,987	5%	0%
5	Fail To Act On Abnorm Test Res	4	14,993,411	3,748,353	5%	22%
Total Top 5 causes by Volume for Obstetrics		47	65,854,911	1,401,168	62%	95%

Top 5 causes by value for Obstetrics

					% of Specialty	
	Causes	Volume	Value	Ave Claim Value	Volume	Value
1	Fail To Make Resp To Abnrm FHR	5	30,071,849	6,014,370	7%	43%
2	Fail To Warn-Informed Consent	6	15,034,472	2,505,745	8%	22%
3	Fail To Act On Abnorm Test Res	4	14,993,411	3,748,353	5%	22%
4	Fail / Delay Treatment	28	5,467,229	195,258	37%	8%
5	Fail To Diag Pre-Eclampsia	1	670,000	670,000	1%	1%
Total Top 5 causes by Volume for Obstetrics		44	66,236,961	1,505,385	58%	96%

Neonates

Specialty drop down list:	Neonatology



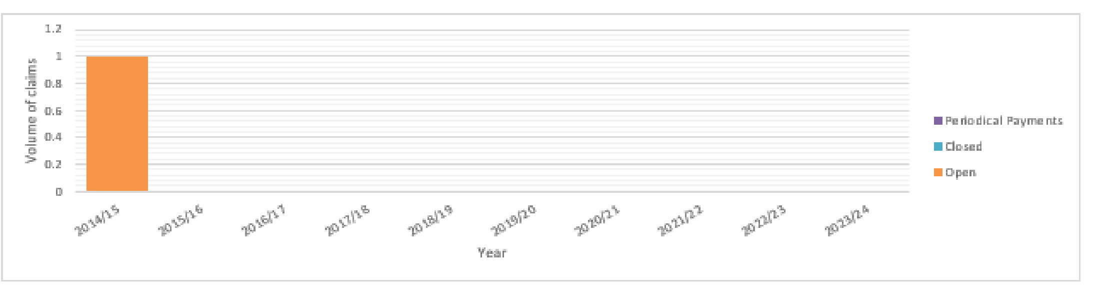
Notification Window (Years)		
Specialty	5.46	The average notification window for Neonatology claims is 3.25 year(s) longer than
Trust	2.21	the average notification window for all claims received by the trust.

Specialty - Volume of Claims	Specialty - Value of claims (£)	Specialty - Ave. Claim Value (£)
2	14,610,000	7,305,000

% of Trust Clinical Claims - Volume	% of Trust Clinical Claims - Value	% Trust - Ave. Clinical Claim Value
0%	7%	1938%

Volume of claims by Incident Year (Incidents Excluded)

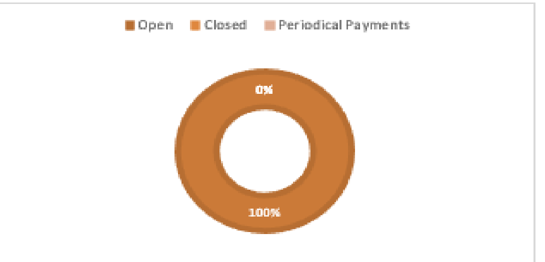
Year	Open	Closed	Periodical Payments
2014/15	1	0	0
2015/16	0	0	0
2016/17	0	0	0
2017/18	0	0	0
2018/19	0	0	0
2019/20	0	0	0
2020/21	0	0	0
2021/22	0	0	0
2022/23	0	0	0
2023/24	0	0	0
Total	1	0	0



Neonatology Themes

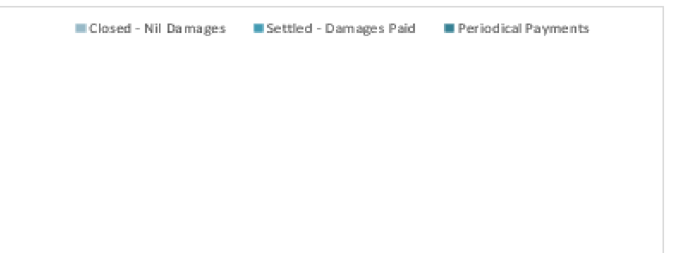
Current Status

	Volume
Open	1
Closed	0
Periodical Payments	0
Total	**1**



Claim Outcomes

	Volume	Value	Ave Total Value	%
Closed - Nil Damages	0	-	-	#DIV/0!
Settled - Damages Paid	0	-	-	#DIV/0!
Periodical Payments	0	-	-	#DIV/0!
Total	0	-	#DIV/0!	



Top 5 injuries by volume for Neonatology

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Meningitis	1	14,130,000	14,130,000	100%	100%
2						
3						
4						
5						
Total Top 5 injuries by Volume for Neonatology		1	14,130,000	14,130,000	100%	100%

Top 5 injuries by value for Neonatology

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Meningitis	1	14,130,000	14,130,000	100%	100%
2						
3						
4						
5						
Total Top 5 injuries by Volume for Neonatology		1	14,130,000	14,130,000	100%	100%

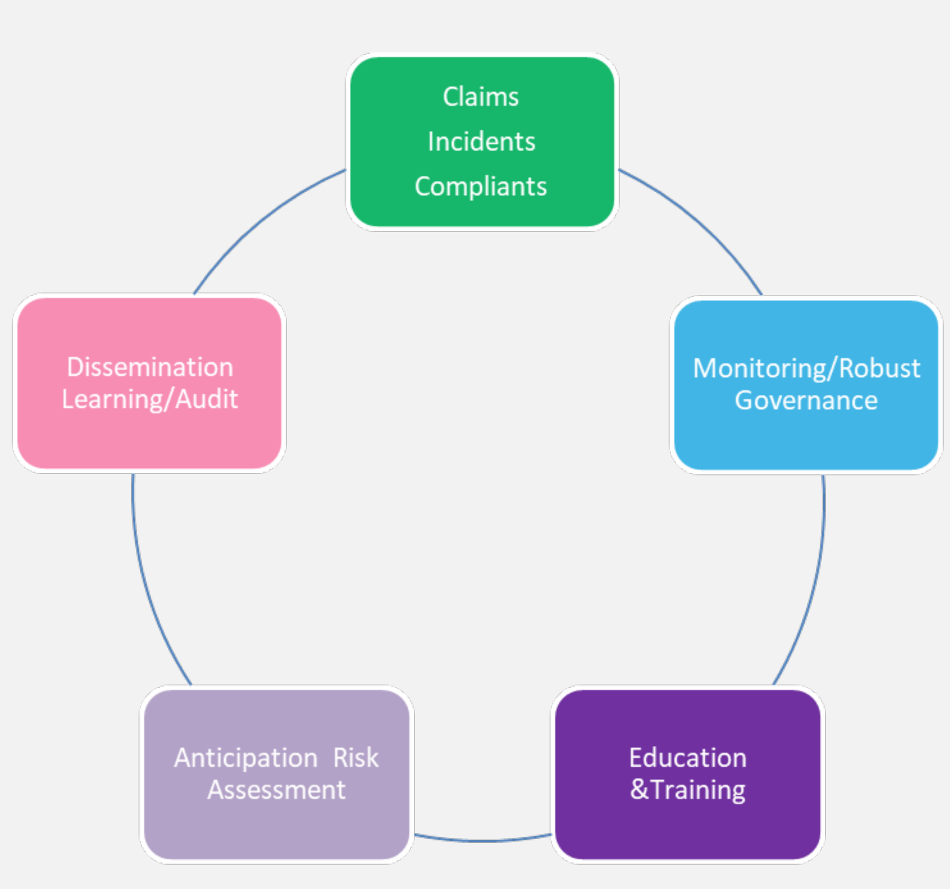
Top 5 causes by volume for Neonatology

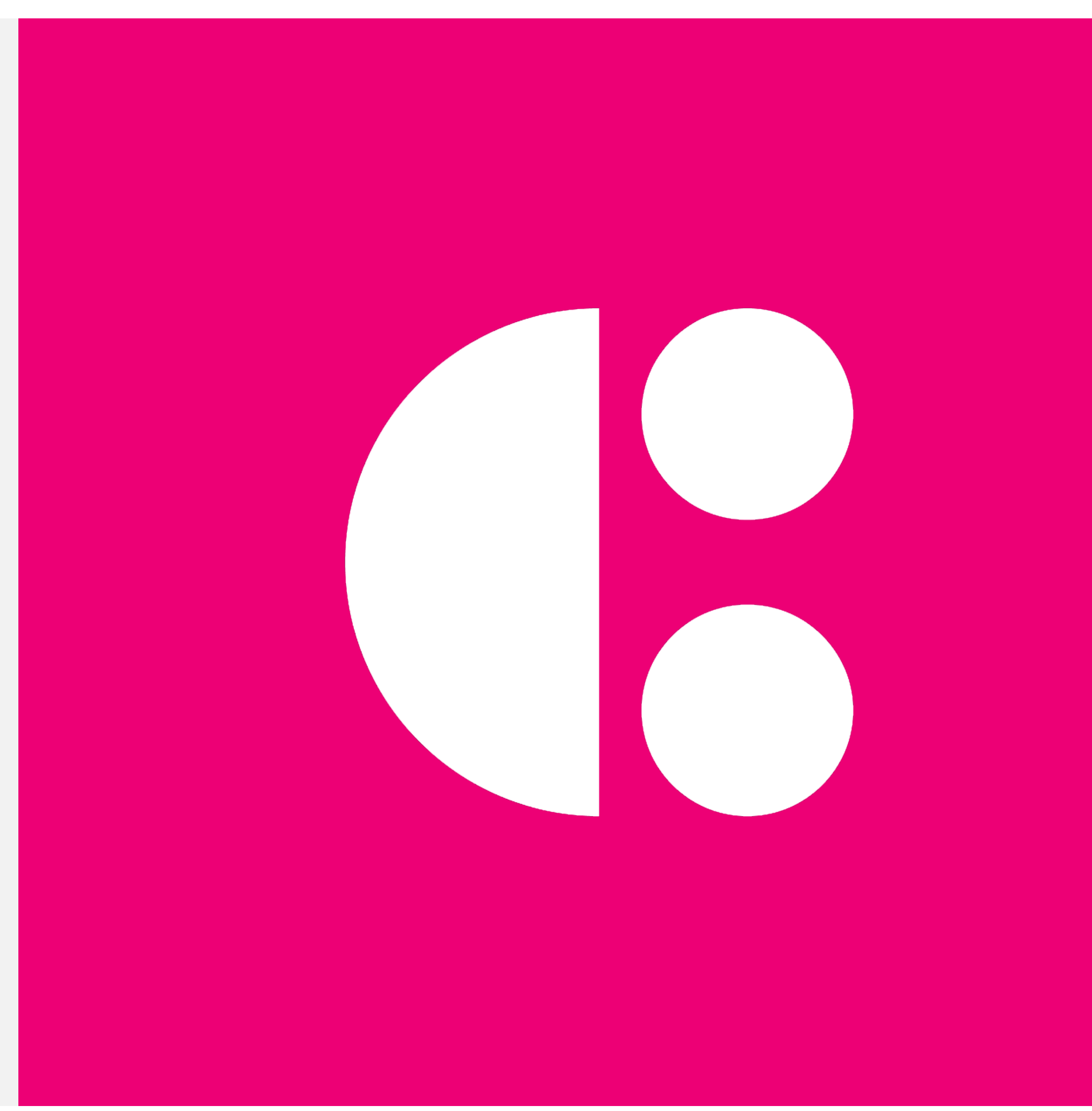
	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Failure To Interpret X-Ray	1	14,130,000	14,130,000	100%	100%
2						
3						
4						
5						
Total Top 5 injuries by Volume for Neonatology		1	14,130,000	14,130,000	100%	100%

Top 5 causes by value for Neonatology

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Failure To Interpret X-Ray	1	14,130,000	14,130,000	100%	100%
2						
3						
4						
5						
Total Top 5 injuries by Volume for Neonatology		1	14,130,000	14,130,000	100%	100%

Monitoring Safety





Triangulation

Failure/delay in treatment

Fetal Monitoring and Interpretation

Escalation (Maternal Observations and in the immediate Newborn period)

Treatment of Hypertension

Placental Storage and appropriate pathological examination in line with National guidance.

Term Admissions

Test Results (Follow up)

Perineal Tears

Diabetes Service (Including Pre-conception)

Communication/Values & Behaviours

Waiting Times

Consent

Improvements

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

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

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

Reflections

PMA support

Perinatal Pelvic Health Service

OPEL Framework/Manager of the Day/Workforce Plan

Thank you