RCOG National Maternity Performance Audit 2017

Clinical Report Summaries for Save the DGH Campaign Group

ANALYSIS OF ONS STUDY COMMENTS

Summary for Save the DGH Campaign Group

by Kathy Ballard & Rose Gibbins pages 7-9

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Clinical Report Summary 1 for Save the DGH Campaign Group

ABOUT THE REPORT

1. The report is extensive on methodology of collection. Presumably because it is the first such report and the parameters required for such an Annual National Survey need to be laid down clearly. It is certainly a national audit which the country has been waiting for over several generations and we must be glad that it has now become an annual governmental audit involving the Royal College of Obstetricians & Gynaecologists [RCOG], The Royal College of Paediatrics and Child Health [RCPCH] and The Royal College of Midwives [RCM]. There are in fact two segments to the full report: (i) The RCOG NMPA Organisational Report and (ii) The RCOG NMPA Clinical Report.
2. This requirement does make the survey repetitive and protracted but it presumably follows an internationally accepted format for such a document. But such methodology can lead to missing information which the unwary might consider has been answered in the early summary only to find that more detailed analysis occurs later in the document.
3. The funnel graphs, from page 28, are interesting as a presentation but unfortunately do not carry any information on which mark represents which maternity unit, although the differing shape of the markers does show the type of unit, either a black circle for an Obstetric unit[OU] , black triangle for OU & Attached Midwifery Unit [AMU] or a black square for a Free standing Midwifery unit [FMU]. A numerical listing within the marks that relate to the individual units shown in the tables from page 76 in appendix 2 would have been more helpful in understanding the local situation and its relationship to the nationally accepted norm.
4. Whilst both Eastbourne and The Conquest Hospital Maternity units are listed in the NMPA Organisational Survey 2017. In the clinical report for East Sussex Healthcare Trust [ESHT] only The Conquest hospital, as an OU, is listed. Suggesting any Eastbourne FMU figures have been excluded purposefully from the 2015/2016 figures which run from 1 April 2015 to 31 March 2016. The first full year that could be collated when the National Maternity & Perinatal Audit [NMPA] was commissioned in July 2016.
5. The data collected is based on the time honoured parameters involved in attempting to analyse the methodology by which Maternity units in England, Scotland and Wales function. Northern Ireland is not included in the initial report. 6 maternity units did not enter any data and 4 units were excluded because the data was insufficient to allow them to be representative. Interestingly those were all well known units considered to be centres of clinical excellence which suggests that the collection of maternity data in ESHT is not a problem.
6. The clinical key parameters scrutinised in the audit and its summary findings are:
    a) **Weight:** Only 47.3% of mothers have a normal body mass index [BMI] of 18.5 – 25.0. 2.3% have a booking BMI greater than 30.
    b) **Age:** 52.5% of women giving birth age 30+ and 27% aged 40+.
    c) **Delivery Site Access:** Only 13% of women deliver in a midwife lead unit and as 18.5%, nationally, transfer out of such units to an OU, only 15% of women wish to attempt delivery in a MLU, be it an AMU or FMU.
    d) **Smoking cessation in pregnancy:** Wide variations in the number of women giving up smoking during their pregnancy and the success of ‘smoking cessation schemes’ is not related to either the size of the maternity unit or the trust.
    e) **3rd & 4th Degree perineal tears:** 3.5% of singleton vaginal births sustain a 3rd or 4th degree tear. Such lesions have a lifetime effect on pelvic floor comfort and both urinary and rectal continence. Unit variations are from 0.6% to 6.5% suggesting that

perineal support and protection during delivery is not consistent across all maternity units.

f) **Haemorrhage:** 2.7% of women with w term singleton delivery in England & Wales haemorrhage 1500 mls, or more. Unit variation 1.1% to 5.6% suggesting a possible variability in the way the 3rd stage [Afterbirth delivery] is conducted. Risk to mother of imminent maternal death or future medical morbidity.

g) **Apgar score:** Birthing assessment of baby's basis parameters, scored 0 to 10. 1.2% of babies have an AGAR of less than ? Which has an association with both short and long term morbidity. Unit variations 0.3% to 3.5% suggesting possible delivery methodology variations could be involved.

h) **Foetal weight:** 55.5% of Small for Gestational Age [SGA, less than 10th centile] babies born **after** expected date of delivery. Not identified antenatally either clinically or by Ultrasound scan. Identification should reduce both stillbirths and severe neonatal complications.

i) **Elective delivery:** With 37 to 38 wk inductions it was found that 28.7% of cases had no clinical indication for this action in the clinical documents. More common in Wales and Scotland than England. Early term delivery increases risks to the foetus both intra partum and as a neonate.

j) **Skin to skin contact:** Wide variation of skin to skin contact within an hour, when it is known to increase the chances of breast feeding and the first feed being breast milk. Both situations being to the babies long term advantage. Such delays could be due to clinical reasons involving either the mother or the baby but that is unlikely to account for all such delays.

ADVICE WAS GIVEN TO:

- **Clinicians:** On methodology of care investigations in future.
- **Services:** Recording of data and ensuring action of findings actively introduced.
- **Commissioners**: Informing GP's and other relevant bodies of known demographic risks.
  - Collecting data on individual places of birth.
  - Holding providers of services to account.
  - Ensuring sufficient staff and financial resources for proper data collection and staff time to input data.
- **Systems suppliers:** To improve access to systems throughout pregnancy and post-partum. Not just booking & Delivery.
- **National Organisations, Professional bodies and Policy makers to**:
  - Establish tools for investigation to reduce unwarranted variations.
  - Review present procedures and ensure fit for purpose.
  - Ensure data concerns of units dealt with speedily and underperforming units helped to improve local situation using both Information professionals and clinicians.

CONCLUSIONS:

First set of NMPA measures confirm, even with variability in quality, it can be used to make meaningful observations. Should enable national and local improvements. Should be a starting point for reflection and measurements of clinical care.

Birth rates are rising across the British Isles:

Country	*Reported to NMPA 2016*	*Registered*
England	611,959 up 9,000 on 2015	667,351 (92%)
Scotland	54,119 up 1000 on 2015	54,485 (99%)
Wales	30,660 up 300 on 2015	33,437 (92%)
Overall	696,738 up 3000 on 2015	775,273 (92%)

*E & W Stats on registerable births not finalised at publication, so an estimate only.

405 Maternity units:

England	157 Obstetric units[OU's]
Scotland	16 OU.s
Wales	12 OU's.

England	106 Alongside Midwifery Units [AMU's]
Scotland	6 AMU's
Wales	12 AMU's.

England	63 Freestanding Midwifery Units [FMU's]
Scotland	19 FMU's
Wales	14 FMU's

APPENDIX 2: SITE LEVEL RESULTS…

These are a series of individual unit assessments of aspects of care and include:

VBAC	% vaginal births after a caesarean section
Spontaneous vaginal delivery	% of term, singleton, cephalic births that are spontaneous vaginal
Instrumental	% of singleton, cephalic births that are instrumental
Caesarean	% of term, singleton, cephalic births that are caesarean sections
Episiotomy	% term, singleton, cephalic births that have an episiotomy
Induction	% of term, singleton, cephalic births commencing with an induction
Early elective	% of elective deliveries between 37 & 38 weeks without a documented clinical indication
SGA 40 weeks	% of SGA babies[under 10th centile] born at or after 40 weeks
Haemorrhage	% of term singleton cephalic births with an obstetric haemorrhage more than or equal to 1500mls.
Low Apgar	% of liveborn, singleton, term babies with and Apgar of less than 7 at 5 minutes.
3rd/4th degree tears	% term, singleton, cephalic, vaginal births with a 3rd or 4th degree perineal tear.

These are shown in colour charted tables to confirm:

a) No data available.	[Pink]
b) Within expected range for a site of this size.	[Grey]
c) Lower than expected for a site of this size.	[Blue]
d) Higher than expected for a site of this size.	[Purple]

On page 78, ESHT is represented by the Conquest Hospital as an OU. It had 6 Purple listings, No blues, 4 greys and 1 pink. The **purples** included a SGA rate of 65.5%; Induction rate of 34.6%; Episiotomy rate of 32.5%; Caesarean rate of 26%; Instrumental rate of 16.7%; Vaginal birth after Caesarean [VBAC] section rate of 51.9%. The **greys** included spontaneous vaginal delivery, low apgar, haemorrhage and perineal tears. There was no data on early elective deliveries.

COMMENTS

Whatever the possible explanation for some of the purple results, the result that is most concerning is the rate of SGA babies. At one time all assessment was clinical by hand but now with the availability of very competent scanning equipment, and well trained staff in the use of that equipment, such a finding is not only unacceptable …it most likely has a lot to do with all the other purple results.

Unfortunately it also suggests that either staff are not being careful enough when palpating a baby, or doing it through clothing rather than directly on the skin. Or they simply are not experienced to know what they are feeling and thus assessing it incorrectly.

RCOG NMPA 1.4.15-31.3.16

Second Summary for Campaign Group

This audit was undertaken by the Royal College of Obstetrics and Gynaecology, Royal College of Midwives, Royal College of Paediatrics and Child Health and the London School of Tropical Medicine and Hygiene. It examined the electronic records of 700,000 births in England, Scotland and Wales. This represents 92% of all births and is the largest such audit in the world. They concluded that some variation was to be expected but unwarranted deviation from the average required investigation. They stated that stretched and understaffed services adversely affected the quality of care to mothers and babies but felt that such, larger than expected, variations should stimulate thought amongst users, providers and commissioners to identify areas where there was need for improvement.

Importantly they observed that the majority of statistics related to singleton, term babies. They took pains to adjust for risk factors such as age, ethnicity, level of socio-economic depravation and clinical risk factors.

The audit begins with a national overview of results and **urges clinicians to familiarise themselves with their own services and compare them with the national average *in order to focus on quality improvements needed.* Commissioners are urged to disseminate the results to GPs and *local authorities* (page 16).**

Statistics in the report given as a proportion of events occurring within the group to which the outcome or intervention is applicable, i.e. 3rd and 4th degree tears are restricted to those women who gave birth vaginally.

Using funnel graphs it allows the comparison of performance between units taking the size of each unit into account. Even with all the precautions taken there will be some variation between units, based on a lack of evidence-based clinical standards, and differing clinical preferences. The authors hope that uncertainty will diminish with subsequent audits.

Initially the audit reveals details at a national level, for example that only 22% were offered the NICE recommended choice of 4 delivery methods, that is: obstetric led delivery, alongside midwifery unit, freestanding midwifery unit, home birth. In England only 1.5%of mothers gave birth in freestanding midwifery units with slightly higher figures in Scotland and Wales.

Where the audit drilled down to unit level it made it clear that it did so by comparison against the national average not an unknown “ideal” rate.

Appendix 2 presents data at a site level. The data for each site was presented graphically (with 99.8 confidence limits) and each criterion was expressed as falling above the expected rate, lower than the expected rate or within the expected range. Clearly there are some criteria such as rate of spontaneous vaginal delivery and vaginal delivery where a higher than expected rate is desirable but of the 11 criteria examined only 2 could be described thus.

Of the 182 units represented only ESHT and 3 others had percentages that were significantly higher than would be expected. Of these 4, 2 were judged to be above expected rates in the 2 areas; vaginal deliver in eligible women who had had a previous caesarian section and spontaneous vaginal delivery that would be classed as desirable outcomes. ESHT scored above expected in only one desirable outcome.

Clearly this is a complex audit which needs to be interpreted with caution. It could well be that the above scores achieved by ESHT in the fields of Instrumental deliveries, Caesarean, Episiotomy, Induction and 40 week gestation small-for-dates actually demonstrated increased vigilance and timely intervention. If that were the case it would be reasonable to assume that measures such as 3rd or 4th degree tears and low APGARs would be lower than expected. Which was not the case.

In Summary

1) Comprehensive, recent, authoritative audit
2) Every effort to take into account factors outside the control of the unit
3) ESHT scored poorly
4) Commissioners etc. advised to study the results and take action

COMMENTS

None of the surveys, audits and medical papers show ESHT or stand alone midwifery units in a particularly favourable light. Each piece of evidence can be explained away by "special circumstances" or "being an outlier" but taken as a whole they add up to an alarming picture.

It is now at the stage that if ESHT or the CCG, or preferably both won't review their initial decision other bodies must. ESHT can no longer hide behind the fact that most mothers are happy with the result of the pregnancy. Of course they are - they have a healthy baby. That is not the same as having concerns over course their pregnancy took. The survey undertaken by the borough council is more revealing in the individual comments.

This is not a time for commissioners and providers to be complacent. If I owned a hotel and Tripadvisor gave me 3 stars I wouldn't shrug and say that was average so everything was fine. I would study the comments looking for themes and think long and hard about what I could do to make people happier.

ANALYSIS OF ONS STUDY COMMENTS

Summary for Save the DGH Campaign Group

453 comments were looked at from Eastbourne, Hailsham, Seaford CCG Catchment

POSITIVE/NEGATIVE RESPONSES TO CARE AT EDGH & CONQUEST

Of 453 respondees:

101 responded positively to care at EMU 101/453 (22.3%)
77 responded positively to care at Conquest 77/453(17%)
26 responded positively-did not state place of care 26/453(5.7%)

0 responded negatively to care at EMU
102 responded negatively to care at Conquest 102/453(22.5%)
5 responded negatively but did not state place of care 5/453(1%)

TRANSFERS BETWEEN EDGH AND CONQUEST

Of 56 respondees who commented on transfers:

42 said transfer was a problem 42/56 (75%)

14 who commented but did not complain 14/56 (25%)
0 responded positively regarding the transfer

In order of most concern:

28 stated anxiety/stress/fear was a problem in transfer	28/56 (50%)
14 long journey	14/56 (25%)
10 journey time over 40 mins	10/56 (18%)
9 uncomfortable journey while pregnant or in labour	9/56 (16%)
9 worried they would not get there in time to deliver in hospital	9/56 (16%)
7 arrangements for other children an issue	7/56 (12.5%)
7 problems because they do not drive	7/56 (12.5%)
7 worried about the baby when making a transfer by car	7/56 (12.5%)
6 partner cannot stay at Conquest 6 travel time too long	6/56 (11%)
6 cost of travel too high	6/56 (11%)
5 lonely and isolated	5/56 (10%)
5 traffic was horrific	5/56 (10%)
3 bad commute on the road	3/56 (5%)
3 difficult for visitors	3/56 (5%)
2 transfer experience traumatic and horrendous	2/56 (3%)
2 reduced continuity of care	2/56 (3%)
1 records were not transferred with them	1/56 (2%)
1 inconvenient	1/56 (2%)

REASONS FOR NEGATIVE RESPONSES TO CARE

46 staff too busy, of these 46, 45 related to Conquest 1 related to EDGH

Problems at Conquest were stated as:

45 Staff too busy at Conquest	45/45 (100%)
26 short staffing levels	26/45 (57%)
22 lack of support and empathy	22/45 (48%)
14 left for long periods during labour and postnatally	14/45 (31%)
13 lack of advice and communication	13/45 (28%)
10 lack of continuity of carer	10/45 (22%)
10 medical checks were omitted	10/45 (22%)
8 staff were rude	8/45 (17%)
5 unhappy with facilities for fathers to stay	5/45 (11%)
5 facilities were dirty	5/45 (11%)

POSTNATAL CARE WHERE SPECIFICALLY NOTED IN GENERAL CARE

Of 133 women who commented on postnatal care:

33 specifically stated their postnatal care was positive at EMU	33/133 (25%)
15 specifically stated postnatal care was positive at Conquest	15/133 (11%)
7 who responded positively did not say where they were treated	7/133 (5%)
71 responded negatively about postnatal care in Conquest	71/133 (53%)
7 responded negatively but did not state place of birth	7/133 (5%)
0 responded negatively about postnatal care at EMU	

BREASTFEEDING

Of 453 responses, 22 commented on breastfeeding advice. Of those 22:

6 had a positive experience at EMU	6/22 (27%)
1 did not comment where advice was given	1/22 (4.5%)
0 commented positively about advice at Conquest	
16 had negative experience at Conquest	16/22 (72%)
4 had negative experience did not state where	4/22 (18%)
0 had negative experience at EMU	

OPINIONS OF OBSTETRIC SERVICES

Of those who specifically expressed an opinion, 131/453 (29%) expressed a preference for full obstetric services to return to EDGH

Of those who specifically expressed an opinion, 32/453 (7%) did not use EDGH as they feared no doctors would be available

1 mother who had her baby at the Conquest said she was put off having another baby altogether

SUMMARY OF KEY POINTS TO NOTE

- Of the people who commented, 101 were positive about EMU, no one was negative.
- Of the people who commented on Conquest, 102 responded negatively and 77 responded positively.
- It is worth noting that Hastings deals with more mothers than EMU so there will be higher figures on every comment for Conquest, however it is worrying that more people complained about Conquest than were positive about EMU, and more people were negative about Conquest than were positive about it.
- On transfers, particularly of note is that 75% of those commenting were negative about the transfer experience.
- 50% said that the stress and anxiety caused by transfer was a factor.
- 18% stated that their journey time was over 40 minutes.
- Implications of Long distance: worry they would not get there in time; travel process was bad; cost a factor.
- Problems of note at the Conquest were: of 45 complaints, 100% said staff appeared to them to be too busy.
- 57% blamed this on short staffing levels.
- What is of most concern is that 22% reported that medical checks were omitted.
- Breastfeeding of note, 72% were negative about breastfeeding advice at the Conquest. No one made positive comments about the breastfeeding advice at the Conquest.
- At EMU no one was negative about breastfeeding advice. 27% had a positive experience at EMU regarding breastfeeding advice.
- 131 people expressed a preference for full obstetric services to return to EDGH.
- 1 mother was put off having another baby by her experience.

Report by Kathy Ballard and Rosie Gibbins 20/11/17