Report: Quality of maternity services for East Sussex residents

To: East Sussex Health Overview and Scrutiny Committee

From: Allison Cannon, Chief Nurse, Sussex CCGs

Date: 19 March 2018

1. Executive Summary

1.1 The purpose of this briefing is to provide information to the East Sussex Health and Overview Scrutiny Committee (HOSC) about the quality and safety of the maternity services commissioned on behalf of East Sussex residents.

1.2 The predominant focus of this report is East Sussex Healthcare NHS Trust (ESHT) due to the number of residents within the county who give birth there, and the interest in these services expressed by HOSC members.

1.3 Where the available data allows this paper will draw upon comparable information from Brighton and Sussex University Hospitals NHS Trust (BSUH) and Maidstone and Tunbridge Wells NHS Trust (MTW) where a proportion of East Sussex residents choose to receive their maternity care.

1.4 This report provides key data relating to the quality and safety of services based upon a range of supporting themes:

- Summary of ESHT maternity service sustained improvement since the temporary reconfiguration in May 2013, that was subsequently made substantive following public consultation;
- Key Quality and Safety indicators; and,
- Women's experience of maternity services.

1.5 Analysis of the information in this report indicates that the quality and safety of ESHT's maternity services have improved following the "Better Beginnings" service reconfiguration of 2013/14. An ESHT maternity action plan remains in place which is monitored on a regular basis by both the Trust and the CCGs to continue to review and improve services in line with best practice.

1.6 The configuration of provider maternity services which East Sussex residents are most likely to access is as follows:

- ESHT hosts a single sited consultant led maternity service at the Conquest Hospital at Hastings with a Midwifery Led Unit (MLU) hosted at the Eastbourne District General Hospital (EDGH);
- Brighton and Sussex University Hospitals NHS Trust (BSUH) provides a Consultant led service at both the Royal Sussex County Hospital (RSCH) in Brighton and the Princess Royal Hospital (PRH) in Hayward's Heath. BSUH does not have a Midwifery Led Unit (MLU); ,
- BSUH is a tertiary centre for neo-natal and paediatric care within East and West Sussex; and,

- MTW hosts a Consultant led service at both Tunbridge Wells Hospital in Pembury and two MLUs at the Maidstone Birthing Centre (MBC) and the Crowborough Birthing Centre (CBC). [1]

1.7 A glossary of terms used in this report can be found under Annex one.

2. Sustained improvements in ESHT maternity service since the reconfiguration to a single obstetric-led service and MLU

2.1 Based upon the 2017/18 year to date information available for review, the following areas have been identified as improvements:

- Sustained reduction of overall number of serious incidents reported
- Sustained reduction in the number of serious incidents where workforce is a contributing factor;
- Overall reduction in reported trust level Babies Born before Arrival (BBA) events over consecutive years;
- Improved Consultant presence (72 hour standard) on obstetric wards maintained;
- A position for a visiting Oncologist has been met;
- Improved levels of workforce regarding substantive middle grade clinical and midwifery staff, with no over reliance upon locum midwives;
- Midwifery mandatory training compliance at 90%+;
- Midwife to birth ratio 1:28 (compared with our locally agreed indicator of 1:30, and a ratio of 1:29 or lower that Birthrate plus recommends);
- Favourable patient feedback in relation to the CQC (Care Quality Commission) maternity survey (2017);
- Improved performance within the following areas:
    - Reduction in % of reported 3rd and 4th degree tears;
    - Reduction in reported occurrences of shoulder dystocia;
    - Increased in % of Initiation of Breast feeding;
    - Continued standard of no reported cases of eclampsia;
    - Reduction in occurrences of post-partum hysterectomies;
    - Reduction in % of numbers of women who were declared to be smokers at the time of booking; and,
    - Reduction in % of the numbers women who were declared to be smokers at the time of delivery.

2.2 Areas of ongoing review for the trust include:

- Ensuring that midwifery levels are maintained;
- Ensuring that the improvements in the spontaneous vaginal delivery rate is improved via the “Normalising Birth” programme;
- Continuing with the overall improvement regarding planned Lower Segment C-Section (LSCS) and Emergency LSCS;
- Improving Cardiotachographic (CTG) interpretation; and,
- Avoidable unexpected admissions of term babies to the Special Care Baby Unit (SCBU) at the Conquest Hospital.

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[1] **Please note:** The CBC was transferred to MTW from ESHT in 2016.

3. Key maternity Quality and Safety indicators

3.1 This section provides performance across a range of quality and safety indicators and is included for all three providers where this information is available. It should be noted that not all data periods are the same as data and have been used to provide a helpful overview of the indicator.

3.2 Number of Births by site (April 2015 – January 2018)

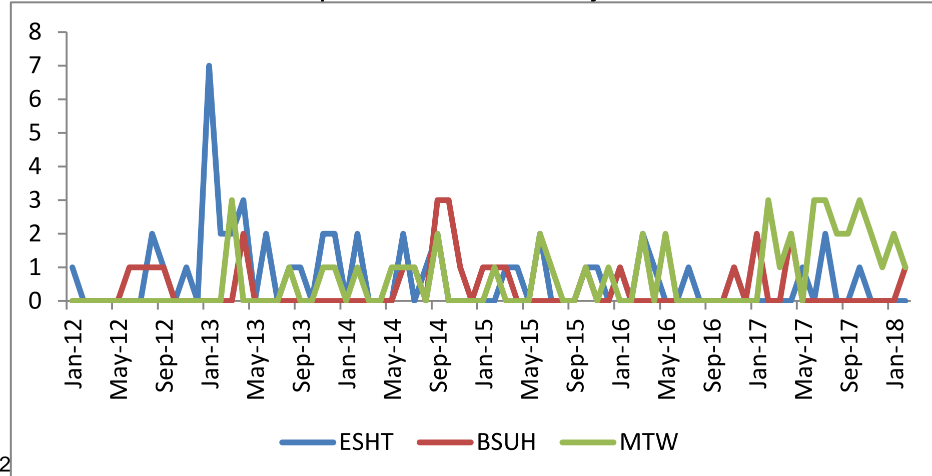
The birth rates by financial year for ESHT, BSUH and MTW are indicated below (the dates have been chosen to take into account two clear years of data and give an overview of numbers across the sites):

Trust	2015/16	2016/17	2017/18 (YTD)
Conquest Hospital	2894	2874	2619
Eastbourne Midwifery Unit	287	302	285
Royal Sussex County Hospital	3300	3235	2649
Princess Royal Hospital	2482	2350	1855
Tunbridge Wells Hospital	5742	5977	5036
Crowborough Birthing Centre	175	160	132
Maidstone Birthing Centre	429	492	404

3.2 Serious Incidents

3.2.1 The graph below indicates the number of serious incidents (SIs) reported by ESHT, BSUH and MTW from January 2012 to latest data available at the time

of writing. The numbers of SIs reported from January 2012 to latest data equate to:[2]



The key trends that have been identified by trust include:

3.2.2 ESHT

The HOSC has previously been updated around SI themes up until May 2013 which included:

- a lack of consultant presence across two obstetric led maternity sites prior to reconfiguration,
- poor middle grade doctor clinical decision making
- overreliance upon locum midwifery and middle grade clinical staff which on occasion saw shifts not filled due to same day cancellation;
- long term obstetric consultant vacancies; and,
- poor interpretation of Cardiotachographic (CTG) results.

The themes relating to ESHT maternity related serious incidents since the reorganisation of ESHT services now relate mainly to CTG issues and failure to follow trust policies and protocols. The following improvements should be noted:

- Following reconfiguration there has been no key trends identified relating to medical and midwifery staffing levels;
- The few serious incidents that are reported relate predominately to the interpretation of CTGs and a programme of training and education is underway.
- The Trust has not reported any “Never Events” in relation to maternity services during the period under review;
- No Serious Incidents have been declared as a result of a transfer from the EDGH MLU to the Conquest Hospital; and,
- There have been no maternal deaths reported by the Trust since the reconfiguration of 07 May 2013.

[2] This data is based upon national Strategic Executive Information System (STIES) data downloaded on 06 March 2018 and does not reflect any previously reported serious incident that has subsequently been downgraded. The MTW data has been taken from their internal midwifery dashboard as well as STIES to ensure that those events that take place at Maidstone District General Hospital (MDGH) are captured. The MTW data prior to April 2017 refers to Tunbridge Wells Hospital

3.2.3 BSUH

Key themes relate to:

- poor interpretation of Cardiotachographic (CTG) results; and,
- the management of high risk pregnancies/labours, and maternal health are the most common features of these incidents;
- The trust has reported one maternity related “Never Event” since January 2012 regarding a retained swab during November 2017.

3.2.4 MTW

The trust has informed commissioners that no specific themes or trends have been identified in relation to the serious incidents reported during the timeframe under review.

The trust is reporting an increase in serious incidents and this is being reviewed by NHS West Kent CCG who is the lead commissioner for the organisation.

3.3 NHS England (South Region) Maternity Serious Incidents (2016/17)

NHS England has undertaken an analysis of all reported maternity related Serious Incidents during 2016/17. This review has concluded that ESHT, BSUH and MTW are not outliers for maternity related serious incidents when compared with peer organisations.

The supporting details can be found under Annex two however the performance of the three trusts under review can be seen in the table below against the highest and lowest performing acute organisations in our region during the 2016/17 year.

3.3.1 SI per 1,000 births 2016/17 (NHS England South East sub region)

Trust	Number of births	Number of reported SIs	SI per 1,000 births
Ashford and St Peters NHS Foundation Trust (Worst)	4, 044	18	4.45
Western Sussex Hospitals NHS Foundation Trust (Best)	5,243	3	0.57
MTW	5,742	6	1.04
ESHT	3176	3	0.85
BSUH	5,856	4	0.68

3.4 Still births[3]

3.4.1 The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) Perinatal Mortality Surveillance Report published in June 2017 indicated that stillbirth rates within the Sussex and East Surrey footprint area are at or below UK average figures.[4]

MBRRACE – UK (Jan – Dec 2015)	Births	Stillbirth rate per 1,000 births
Total UK	782,720	3.87
England	667,398	3.93
Sussex & East Surrey STP	19,358	3.86
BSUH	5,678	4.28
MTW	5, 700	3.96
ESHT	3,180	3.45

Commissioners and trusts use MBRRACE-UK for benchmarking purpose rather than Office of National Statistics (ONS) data to ensure a standardised approach is adopted as this is the recommended data source as recommended by the NHS England Improvement and Assessment Framework.[5]

The key points to note by trust can be found below:

3.4.2 ESHT

The trust has undertaken a review of stillbirth rates between 2015 and 2017:

- The overall ESHT figure for 2016 was 3.52 per 1,000 births, and within this, for women from Eastbourne the figure was 4.08;

[3] A Stillbirth has been defined as a delivery that occurred at 24 weeks and above.

[4] https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2015%20FINAL%20FULL%20REPORT.pdf

[5] https://www.england.nhs.uk/wp-content/uploads/2017/11/ccg-improvement-and-assessment-framework-2017-18.pdf and https://www.england.nhs.uk/wp-content/uploads/2017/11/ccg-technical-annex-2017-18-v1-1.pdf

- An overall reduction in the Eastbourne women stillbirth rates from 4.08 per 1,000 in 2016 to 2.96 per 1,000 in 2017 has been identified;

- The overall ESHT figure is now below the national average of 3.19 per 1,000 births and there is evidence to suggest that the 2016 Eastbourne figure is part of a longer term trend;

- Every stillbirth is reviewed and discussed in depth at daily risk meetings and again at a Weekly Patient Safety Summit (WPSS) if classified as an amber rated incident;[6]

- ESHT have confirmed that all serious incidents will be forwarded to the new Health and Safety Executive Health Investigation Branch (HSIB) in line with national guidance.[7] This independent body will review all still births to ensure lessons are learnt and improvement requirements embedded in practice; and,

- A list of current and planned improvement actions in relation to stillbirths can be found under Annex three.

3.4.3 BSUH

Key points to note include:

- Most recent national data from 2014 shows crude, stabilised and adjusted stillbirth, neonatal, and extended perinatal mortality rates were below the national average; and,

- The CCG undertook a deep dive following a number of intrapartum stillbirths between November 2016 and April 2017, with no further cases in 2017. There were no common themes and actions have been taken to mitigate risk following individual cases.

3.4.4 MTW

Key points to note include:

- The trust has reported that all stillbirths since April 2015 have occurred at the obstetric led maternity unit at TWH and none have been reported at either the CBC or MBC;

- The organisation has undertaken a review of the events and concluded that the majority of them do not have an identifiable root cause. Of those that do have an identified cause, foetal growth restriction, foetal anomalies, complications of multiple pregnancy are most common; and,

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[6] An AMBER incident within ESHT is an enhanced level for those patient safety incidents which do not meet the Serious Incident criteria however require review to protect patients from similar occurrences.

[7] From April 2018 every stillbirth, early neonatal death and severe brain injury cases each year will be referred to the HSIB

- The trust has noted that the Stillbirth rate is reducing overall with a rate per 1,000 births of 3.86, 3.79 and 3.08 from April 2015 to January 2018.

3.5 Babies Born Before Arrival (BBA)[8]

3.5.1 There is no nationally agreed definition for a baby born before arrival. For the purpose of this report the BBA definition refers to those babies born before the arrival of a midwife; as a result, even if a paramedic is in attendance it will still be a BBA. It should be noted this can give rise to slightly different figures being reported. [9]

Following a BBA the mother and baby are reviewed by a Community Midwife. If clinically indicated both mother and baby will be transferred to the most appropriate maternity unit otherwise they remain at home.

The key headlines in relation to ESHT BBAs are:

- No adverse outcomes for mothers or babies have been reported in relation to BBAs (some babies will have been transferred into maternity units for observation checks or "warming up" in line with standard practice);
- The two key themes in relation to BBAs occurring include births taking place quicker than expected and expectant mothers not seeking advice from a midwife as early as might be recommended;
- Following review the Trust has not identified proximity to a birthing unit as a significant factor in reported BBAs taking place;
- No serious incident has been declared as a result of a BBA event following the reconfiguration of ESHT maternity services; and,

Neither BSUH nor MTW has declared a Serious Incident as a result of a BBA event occurring during the time frame reviewed:[10]

The graph below indicates the breakdown of BBAs occurring at both the EMU and Conquest sites from January 2012 to January 2018 by number, with CBC included for the period where the service there was delivered by ESHT:

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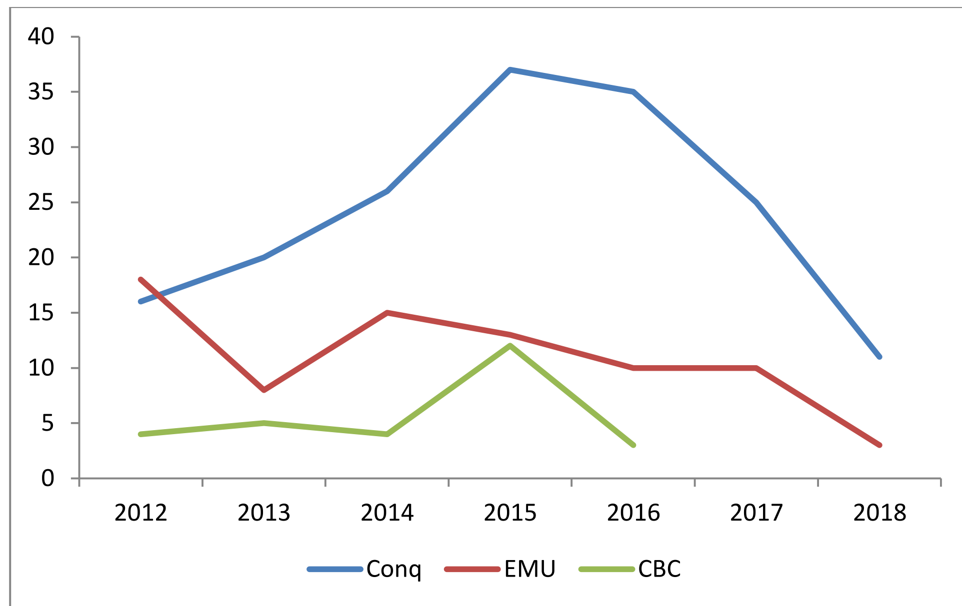
[8] The agreed definition between ESHT and Commissioners of a BBA event is a birthing episode where a midwife was unable to attend. To address this the Trust has taken action to ensure that BBAs are reported in a consistent manner with sub categories of birth (for example, Born in transit in a car and Born in transit in an Ambulance), together with a conclusion as to whether the BBA was either "avoidable" or "unavoidable". This was fully implemented from 01 April 2015.

[9] The BBA figures are based upon the site where mothers were booked to give birth.

[10] Please note: MTW have reported their figures as per financial year rather than calendar months.

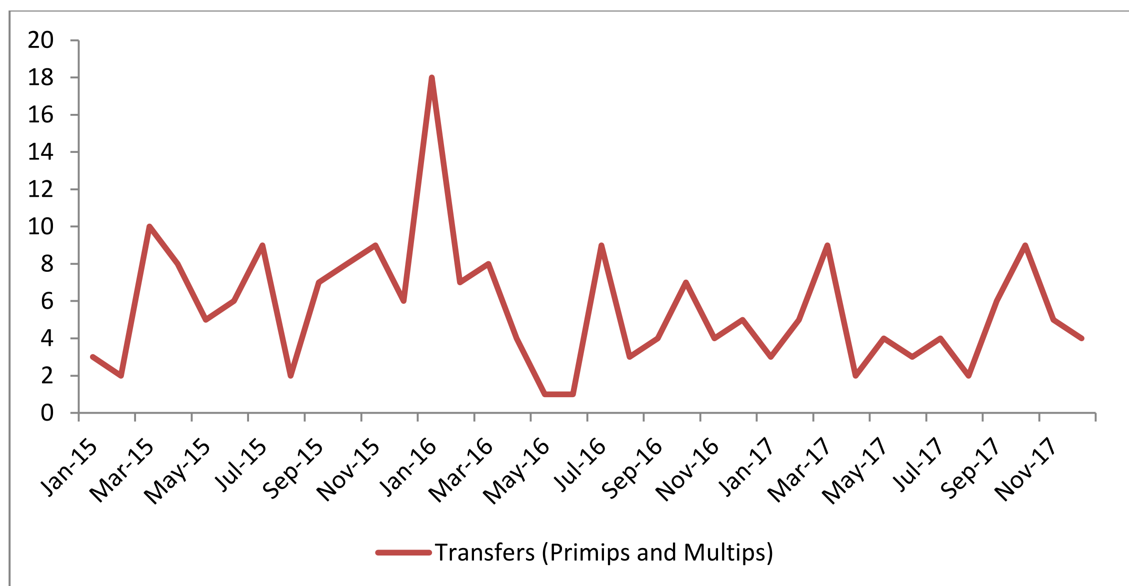


The trends in relation to ESHT remain the same as previously reported to the HOSC with the majority of BBA events taking place within the Hastings area given the data provided by ESHT.

3.6 Transfers from Midwifery Led Units (MLU)'s

3.6.1 ESHT

The graph below indicates the number of transfers from the EMU to Conquest Hospital between January 2015 to December 2017:



Primip = first time pregnancy
Multips = second or subsequent pregnancy

The top three reasons for Primip transfers during this period include:

- Delay in first stage;
- Meconium; and,
- Analgesia.

The top three reasons for Multip transfers during this period include:

- Fetal heart changes;
- Meconium; and,
- Delay in second stage.

The trust has identified improvement work regarding the provision of analgesia and action has been taken to introduce hypnobirthing from May 2018 together with the implementation of a project focusing upon sterile water injections for back pain in labour.

The trust has recorded a combined transfer rate of 20.31%, 24.25% and 25.58% for 2015, 2016 and 2017 respectively.

3.6.2 MTW

The trust has provided transfer information for the 2015/16, 2016/17 and 2017/18 (to date) years and the transfer rates for both first time mothers and subsequent births combined were 20%, 21% and 24% respectively.

The top three causes of transfer from the MLU to an obstetric unit include:

- Delays in birth stages (particularly the first);
- Analgesia; and,
- Maternal problems.

The trust has not reported a serious incident as a result of the transfers noted above.

3.6.3 BSUH

The trust maternity services comprise two obstetric consultant led units only therefore transfers from an MLU are not applicable.

3.7 Overall Lower Segment Caesarean Sections (LSCS) Rate and Emergency LSCS Rate

3.7.1 For ESHT, both these rates remain below the national standard of 11% for elected C-Sections and slightly above the 13% standard for Emergency C-Sections as of the time of writing.

They are rising at a rate of 0.33% as opposed to 0.97% pre the May 2013 - reconfiguration therefore improvement has been taking place.

The overall 2017/18 YTD (January 2018) rate for the trust for elective C-Sections stands at 10.71% and emergency C-Sections 13.89%. The combined standard stands at 24.61% against a standard of 23%.

BSUH and MTW C- Section performance (April 2017 – January 2018) can be found below:

Trust	Total C-Section Rate (%)	Elective C-Section (%)	Emergency C-Section (%)
ESHT	24.61	10.71	13.89
BSUH	28.1	15.4	12.7
MTW	27	13	14

4. Section Four: Women's experience of maternity services

4.1 Care Quality Commission (CQC) Maternity Survey (2017) review findings

During the summer of 2017 the CQC opened a national survey for all women who gave birth during February 2017. The results of this survey were published during January 2018.

Following analysis of the CQC findings the three trusts under review all fall in the "about the same as other trust" category.[11]

ESHT is taking action to ensure that women feel that they are receiving the best possible care post birth as this is an area where improvement is required.

4.2 Friends and Family Test (FFT)

4.2.1 ESHT

The trust consistently scores above the required minimum standard in relation to FFT *(this is a simple question where people are asked if they would recommend this department or ward to their friends and family)* thresholds on a monthly basis. Comments received from the FFT and other patient feedback functions are reviewed as part of quality improvement process within the trust on a regular basis.

4.2.2 BSUH

The Trust is not an outlier in terms of national patient experience measures and very much performs in line with most other Trusts. However, response rates to FFT needs further attention given the periodic dips in response rates.

[11] The other two categories being "worse than other trusts" and "better than other trusts".

More localised information tells us that continuity of midwife, consistency of information, the triage area of care and postnatal are the most challenged. But again this is in line with national trends. There is a wealth of very positive comments received about the compassion, dedication and willingness of the midwifery workforce.

4.2.3 MTW

The trust consistently scores above the required minimum standard in relation to FFT thresholds on a monthly basis. There has been a significant increase in responses in relation to the FFT rates.

4.3 East Sussex Healthwatch and maternity engagement

4.3.1 East Sussex Healthwatch has undertaken a significant amount of engagement with residents of East Sussex during 2016 to understand the experience and feedback of those who have experienced trust maternity services.

East Sussex Healthwatch engaged with the local population for the purposes of this review in the following manner:

- published a “call for evidence” during January/February 2016;
- involved women in the planning and shaping of the review;
- engaged with women and their families using enter and view activity; and
- established a working group to evaluate the feedback received and to develop an action/learning plan.

The recommendations made by HealthWatch have been incorporated into the ESHT maternity wide improvement action plan. These included actions such as a protocol for travel between units; access to units at night; labour induction review; information available to women and their families.

4.4. ESHT Maternity Review (2016/17)

4.4.1 The trust undertook a service wide midwifery review during the 2016/17 year. The findings of this review were shared previously with both Commissioners and the HOSC during September 2016.

The trust has undertaken a significant amount of improvement work in relation to maternity services during the 2016/17 year focusing upon areas such as team working, improvement and development of services, respect and compassion and engagement and involvement.

The recommendations made following this review have been incorporated into the ESHT maternity wide improvement action plan.

5. Conclusion

Following analysis of the information provided, there has been sustained improvement in the quality and safety of maternity services within ESHT following the service reconfiguration of 2013/14.

None of our local services is an outlier regarding the number of serious incidents reported per 1,000 births, BBA events or patient feedback as per the publication of the CQC maternity survey.

Ongoing improvement work continues for all providers to ensure women experience safe and high quality maternity services wherever they choose to receive their care.

Date: 20 March 2018

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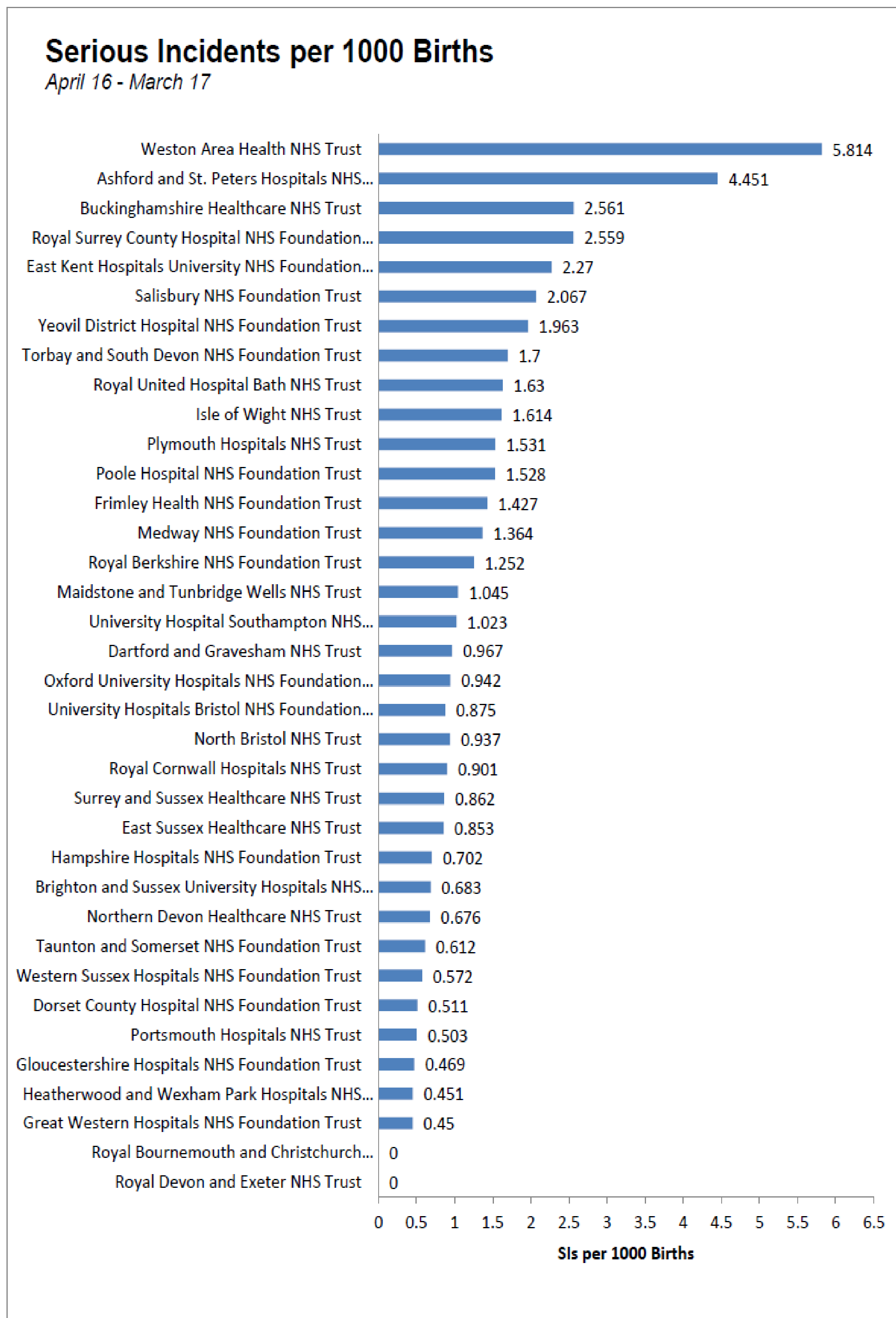
Annex One: Glossary of abbreviations

Abbreviation	Meaning
BBA	Babies Born before Arrival
BSUH	Brighton and Sussex University Hospitals NHS Trust
BH	NHS Brighton and Hove CCG
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CTG	Cardiotachographic
CQRG	Clinical Quality Review Group
EDGH	Eastbourne District General Hospital
EHS	NHS Eastbourne, Hailsham and Seaford
EMLU	Eastbourne Midwifery Led Unit
ESHT	East Sussex Healthcare NHS Trust
HR	NHS Hastings and Rother
HIE	Hypoxic Ischemic Encephalopathy
HOSC	Health and Overview Scrutiny Committee
HWLH	NHS High Weald Lewes Havens
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MLU	Midwifery Led Unit
MTW	Maidstone and Tunbridge Wells NHS Trust
NHSE	NHS England
ONS	Office of National Statistics
PRH	Princess Royal Hospital
QRM	Quality Review Meeting
RSCH	Royal Sussex County Hospital
SANDS	Stillbirth and Neo-natal Death
STP	Sustainable Transformation Plan
SI	Serious Incident
UK	United Kingdom
WTE	Whole Time Equivalent
WPSS	Weekly Patient Safety Summit

Annex Two: Serious Incidents per 1,000 births (April 2016 – March 2017)



Annex Three: ESHT Improvement actions to reduce occurrences of Stillbirths

The trust has identified the following assurance actions to ensure the occurrence of a Still Birth occurring is minimised:

- Each case of stillborn is reviewed and discussed in depth at the daily risk meetings and again at the Weekly Patient Safety Summit (WPSS) if classified as an amber rated incident. All amber incidents are thoroughly scrutinised and investigated;

- All cases of still birth are discussed with the bereavement and obstetric lead to highlight any practice issues or trends in health or clinical practice. All outcomes of investigations are recorded within the DATIX system;

- As an additional level of scrutiny the Assistant Director of Nursing and Midwifery has commissioned a further audit whereby an additional review of these cases will be reviewed to be further assured with the current processes in place and outcome measures;

- Since this data was collected in 2015 the trust has recruited to a bereavement midwifery post of 0.4WTE;[12] and,

- The bereavement midwife meets with the Still Birth and Neo-natal Death (SANDS) team six weekly to review the service and feedback any concerns raised and aim to develop a service of excellence.[13]

[12] This post oversees bereavement and provides support, guidance and training to staff to empower them to support women and their families following the bereavement of their child

[13] This team has further been shortlisted for the Royal College of Midwifery (RCM) awards as a recognition for their commitment to shared learning and service provision.