

NAME OF NHS HEALTH BOARD / TRUST

National Clinical Audit & Outcome Review Programme

All health boards / trusts participating in national clinical audits and outcome reviews must electronically send a completed front page and Part A version of this form to the mailbox address below within 4 weeks of the publication of reports and, a completed Part B within 3 months to : Mailbox address : wqclinicalaudit@wales.gsi.gov.uk

Audit / Registry Title - National Maternity and Perinatal Audit

Date of published report - 2019 (data included April 2016 – march 2017)

HB Clinical Lead / Champion - Mr Marsham Moselhi

Is the HB currently participating in this audit? YES)

if the answer is “Yes” are all relevant services included in the audit? YES

If your organisation or any relevant services are not participating please indicate why

If you are participating please complete the following table.

% of patients fitting inclusion criteria reported in current audit cycle or registry.	
% of patients fitting inclusion criteria with full dataset in this audit cycle or registry.	

Has the audit formally identified your organisation or any parts of your organisation as an “Outlier”? YES

If the answer is YES please describe what actions are being taken to address concerns	<u>Singleton Hospital</u> Outlier for elective caesarean section The elective Caesarean section rate is 14.6% at Singleton hospital compared to the mean of 11.7%. Further work is required to look at indications to determine appropriateness, and to identify any themes, and trends. In addition further work is required to ensure maternity information system can correctly calculate robson
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groups for all caesarean sections.

Outlier for low rates of instrumental births

It is acknowledged that the instrumental birth rate is 11.1% at Singleton hospital slightly lower than the mean of 13%. The overall caesarean section rate is showing as an outlier but it is the elective caesarean section rate that is high not the emergency caesarean section rate. Further work required as highlighted above.

Outlier for Third and fourth degree tears

It is acknowledged that the 3rd and fourth degree tear rate is 5.4% compared to national mean of 3.5%. Further work is required in ensuring midwives compete maternity information correctly so accurate rates are highlighted on our dashboard. In addition an action plan to be developed through Labour ward forum to review clinical practice, identify and minimise the variation in practice and outcomes and identify areas for potential quality improvement.

PART A. What are the key national and local findings / recommendations from the last published report which your organisations needs to address (see guidance note below)

National	<ul style="list-style-type: none"> Quality and completeness of data improved between 15/16 and 16/17 however many units are still excluded from one or more measures owing to poor data quality completeness.
	<ul style="list-style-type: none"> Only a minority of units submitted data of sufficient completeness and quality to be included in the measure of birth without intervention (spontaneous onset, progress and birth, without epidural, spinal, or general anaesthetic and without episiotomy). Of the data used, there was substantial variation in this rate (between 23% and 48%).
	<ul style="list-style-type: none"> Quality of data collected about smoking in pregnancy and at the time of birth is poor. This is concerning given the importance of smoking cessation as part of initiatives to reduce stillbirth.
	<ul style="list-style-type: none"> More than half (50.4%) of women with a recorded BMI at booking were overweight or obese which is up from 47.3% in previous year.
	<ul style="list-style-type: none"> There is a small increase in induction rates 27.9% to 29.2% and a small decrease in the proportion of small-for-gestational-age babies born at or after 40 weeks (55.3% to 52.3%) in England only compared with 15/16 data. This coincides with the introduction of the Saving Babies' Lives care bundle and requires further monitoring.
	<ul style="list-style-type: none"> There remains variation, beyond that which would be expected, in the proportion of women experiencing complications in the form of a third or fourth degree tear, or a postpartum haemorrhage of 1500mls or more.
	<ul style="list-style-type: none"> 5.8% of babies born between 37+0 and 42+6 weeks gestation (term) and 41.9% of those born between 34 and 36 weeks (late preterm) are admitted to a neonatal unit. There is substantial variation in these rates, even after adjustment for maternal case mix factors, perhaps reflecting different organisational provision for babies requiring additional care after

	birth.
	<ul style="list-style-type: none"> • 5.8 in 1000 babies born between 37+0 and 42+6 weeks gestation (term), receive mechanical ventilation in the first 3 days of life. There are a number of trusts and health boards with levels of ventilation that are higher than expected, even after adjustment for maternal case mix factors.
	<ul style="list-style-type: none"> • 1.7 in 1000 babies born between 35+0 and 42+6 weeks gestation develop an encephalopathy, a component of neonatal brain injury, in the first 3 days of life. Following adjustment for case mix, there are a number of trusts and boards with higher levels of encephalopathy than expected.
Local	<ul style="list-style-type: none"> • Undertake audit to Monitor and improve accuracy of data on information system
	<ul style="list-style-type: none"> • Undertake improvements with welsh maternity information system to ensure :- <ul style="list-style-type: none"> ❖ appropriate data is inputted to provide accuracy around proportion of births that occurred without intervention, ❖ data available for proportion of women with live births (34 weeks and above) where skin to skin contact occurred within one hour of birth ❖ data provided on proportion of live births who were given breast milk (34 weeks and over) at first feed and at discharge.
	<ul style="list-style-type: none"> • There is a health board strategy in place to improve quality of data input by community midwives in relation to smoking around the time of birth.
	<ul style="list-style-type: none"> • Maternity service to work with other appropriate services to ensure there is appropriate provision to support weight management prior to, during and after pregnancy
	<ul style="list-style-type: none"> • Further work is required in ensuring midwives compete maternity information correctly so accurate rates are highlighted on our dashboard when shared with staff. In addition an action plan to be developed through Labour ward forum to review clinical practice, identify and minimise the variation in practice and outcomes and identify areas for potential quality improvement.
	<ul style="list-style-type: none"> • Although singleton is not identified as an outlier an audit is being undertaken on women that have had post-partum haemorrhages of 1500mls or greater to ensure any themes or trends can be identified and shared to improve outcomes.
	<ul style="list-style-type: none"> • NMPA does not currently include welsh data for babies that have required neonatal admission. <p>Following a safety notice from WG last year there are systems in place where all term babies to NNU have a multidisciplinary review to identify whether care was appropriate or not. The plan is for a quarterly governance report to be presented to staff at multidisciplinary audit where any lessons/ themes can be shared to improve outcomes for babies.</p> <p>Singleton Hospital is currently undergoing extensive works to develop a designated transitional care baby unit area on the post natal ward to improve quality of care for mother and baby by minimising separation where appropriate.</p>

Part A Guidance Note

The recommendations which your organisation needs to address must be listed. On a separate sheet however, you may choose to highlight areas which the audit recognises you are doing particularly well (this information may be useful to other health boards / trusts looking for information to guide their service improvement).

National findings are common problems identified across the audit where healthcare nationally is generally falling below the standard identified by the audit. If your organisation is meeting these standards or performing significantly better than the audit average it should not be necessary to list them (see comment above).

Local findings are where specific weaknesses have been identified within you organisation. This may be an organisation wide issue or relate to individual hospitals or services, but significant variation in the delivery of services across the organisation should be highlighted.

For information a link to NICE guidance on how audit data is mapped to recommendations and quality measures is provided below:

<https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance>

The completed assurance pro-forma should be signed by the health board clinical lead for the audit / review and the Medical Director or their representative.

Health board / trust clinical lead for the audit / review :

Medical Director's Office :

Date