

# NHS Ayrshire & Arran



<b>Meeting:</b>	<b>Ayrshire and Arran NHS Board</b>
<b>Meeting date:</b>	<b>Monday 28 March 2022</b>
<b>Title:</b>	<b>Scottish Patient Safety Programme – Maternity &amp; Children Quality Improvement Collaborative: Maternity Workstream</b>
<b>Responsible Director:</b>	<b>Jennifer Wilson, Interim Deputy Nurse Director</b>
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## 1. Purpose

This is presented to the Board for:

- Awareness

This paper relates to:

- Annual operational plan

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective

## 2. Report summary

### 2.1 Situation

This paper provides an overview of progress in relation to core Scottish Patient Safety Programme (SPSP) measures within the Maternity programme.

Board members are asked to be aware of and discuss the quality improvement and safety activity in Maternity Services underway as part of the Maternity and Children Quality Improvement Collaborative (MCQIC) programme

### 2.2 Background

MCQIC was launched in March 2013 and is a programme of quality improvement (QI). The MCQIC collaborative covers three workstreams of Maternity, Neonatal and Paediatrics. This paper presents the Maternity improvement work.

The overall aim of the programme is to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies, children and families across all care settings in Scotland.

A partnership agreement between MCQIC and NHS Ayrshire & Arran in relation to the way forward with new measurements was signed off and sent to all relevant parties on 21 December 2018. These are due to be updated and we are currently in discussion with the national team to produce a draft Partnership Agreement for 2022 – 2025.

The Maternity Work stream continues to report nationally on agreed measures within the Maternity Care Measurement matrix. Under the terms of the joint Partnership Agreement with the MCQIC Team, NHS Ayrshire & Arran have agreed to measure the following within maternity services:

Core: Reduce stillbirth rates and to reduce the rate of severe PPH

Our priorities are to:

- Achieve a reduction in rates of perinatal morbidity and mortality.
- Collaborate with Neonatal colleagues in relation to the Management of Preterm Babies

Due to Covid19, the MCQIC Programme was suspended nationally to allow staff to be deployed where necessary. This has also had an impact on the improvement work and data collection within Women and Children's Services. The local improvement meetings (MQIG) were also suspended at this time.

Although the MCQIC Team remobilised in September 2020, there have been challenges within Women and Children's Services due to staff absence and deployment to other areas of work due to whole system pressures. Improvement activity is therefore monitored on a regular basis and further suspensions have been necessary. Senior Management are working with staff involved in QI to develop a plan for moving forward.

Maternity Service currently has no QI Champion since this post holder left to take up another post. We are currently recruiting to this position as a developmental opportunity and planned to recruit two champions to ensure resilience and a less person dependant role. The interviews took place on 17 February and two successful applicants have been appointed. The date for commencing post will be agreed in due course.

## **2.3 Assessment**

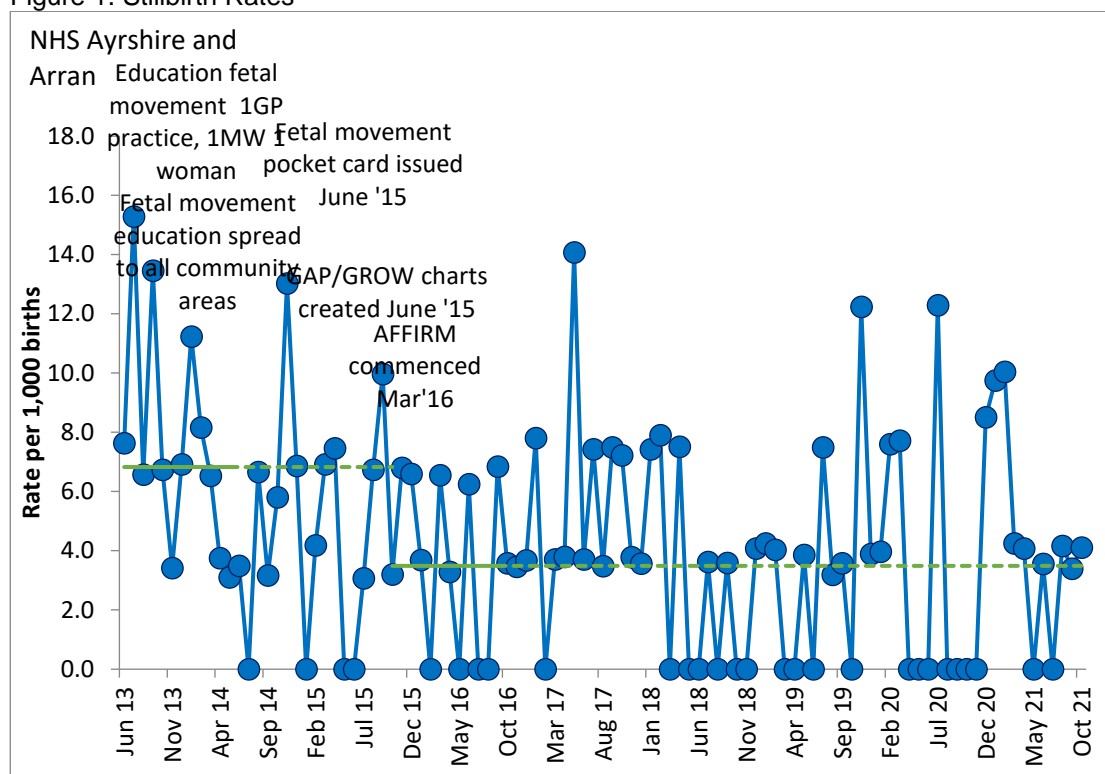
The overall aims of the Maternity Care strand continue to be ensuring the best possible care is given to our mums and babies within Ayrshire Maternity Unit. We are looking at ways of capturing information on service user satisfaction from Care Opinion, Social media sites (Facebook), and also via complaints to ensure any issues are addressed and improvements made where necessary. We are also currently working toward utilising service user satisfaction within Badgernet

### **Stillbirth**

NHS Ayrshire and Arran continue to demonstrate sustained improvement. To date, in 2021 we have recorded ten stillbirths within our Unit. Each case has been reviewed utilising the Perinatal Mortality Review Tool (PMRT) and subject to the Being Open process.

**figure 1** below demonstrates the rate of still births per 1,000 births from June 2013 through to October 2021

Figure 1. Stillbirth Rates



The MCQIC workstream includes measures to identify the small for gestational age fetus and recommends the use of a customised chart being used to plot growth measurements.

In 2015, Ayrshire maternity services implemented the Growth Assessment Protocol (GAP) developed by the Perinatal Institute in Birmingham. This is a more objective technique of monitoring fetal growth through clinical palpation and ultrasound.

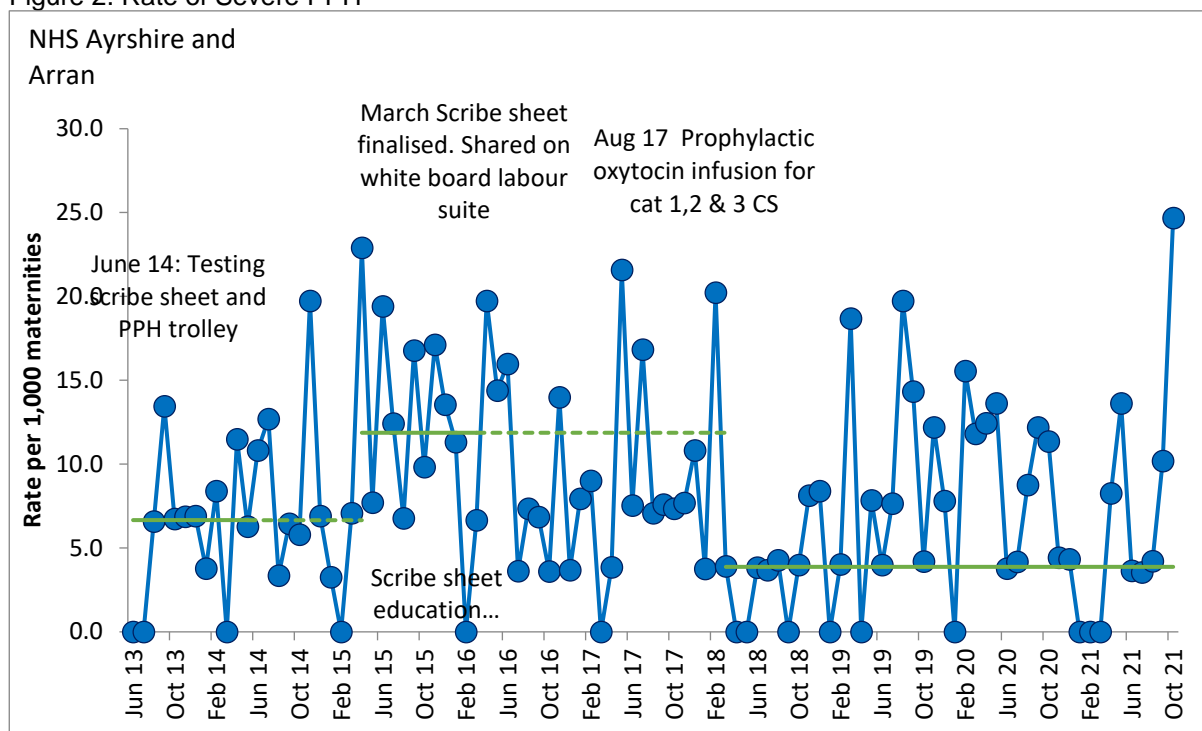
Use of customised growth charts has been shown to better identify stillborn babies as small for gestational age (SGA), reducing the number of losses with no explainable cause.

### Rate of Severe Post-Partum Haemorrhage (PPH)

Although still statistically demonstrating sustained improvement the data has been variable since May 2019. All severe PPHs are reviewed and appropriate management of these cases has been delivered in all cases.

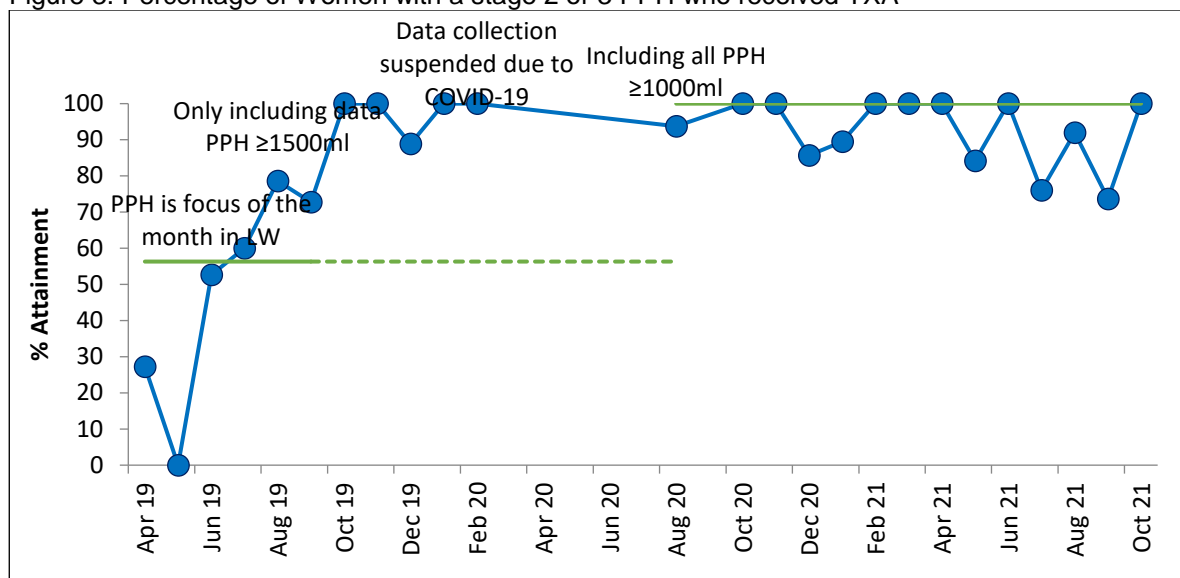
**Figure 2** below demonstrates the rate of severe PPH per 1,000 maternities from June 2013 through to October 2021.

Figure 2. Rate of Severe PPH



Stage 2 PPH is defined as  $\geq 1000-1499\text{ml}$  blood loss. A Stage 3 PPH is defined as  $>1500-2499\text{ml}$  blood loss. Tranexamic Acid (TXA), a medicine that controls blood loss is therefore recommended. The administration of TXA was tested and implemented in Apr 2019. Agreement was made with MCQIC to adapt data collection to PPH  $\geq 1500\text{ml}$  due to skewed data. In October 2020, we modified the data collection to include all PPHs  $>1000\text{ml}$ s

Figure 3. Percentage of Women with a stage 2 or 3 PPH who received TXA

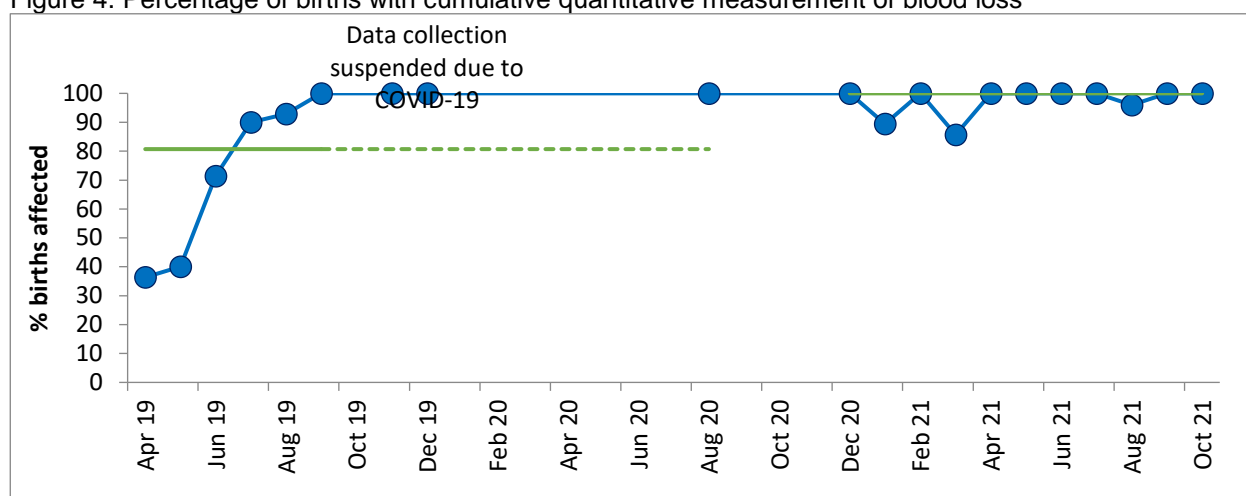


Delay in recognition of large blood losses is a common finding in cases of maternal morbidity and mortality from haemorrhage. A policy of waiting to quantify blood loss only after the excessive loss does not address this problem.

All women, regardless of mode of delivery, should have a measured blood loss. A quantitative approach (i.e. volume in ml) to communicate blood loss is more reliable

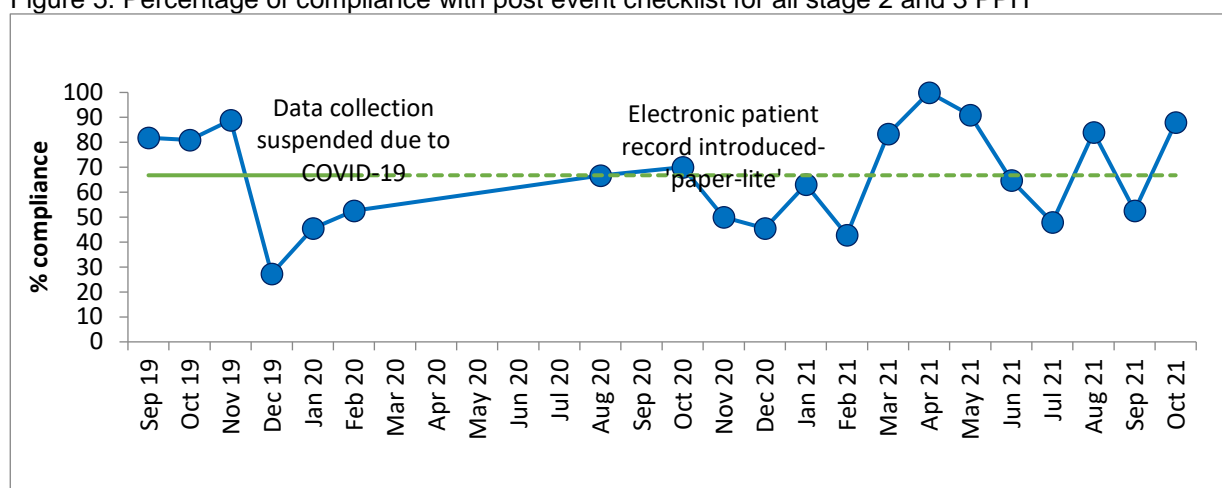
than the use of descriptors such as 'small amount', 'trickle', 'moderate blood loss'. In addition, every time blood loss is measured this should be added to previous measurement to give a cumulative total. It is encouraging to see the median has recently been recalculated from 80 to 100%

Figure 4. Percentage of births with cumulative quantitative measurement of blood loss



A Post Event Checklist should be completed after the event by a member of the obstetric or anaesthetic team. This checklist reduces reliance on memory, and thus reduces errors of omission while contributing to team communication and increasing situational awareness amongst clinicians. Compliance with completing the checklist is variable as shown in **Figure 5** below and is subject to further discussion at the QI meeting and with the labour ward management team

Figure 5. Percentage of compliance with post event checklist for all stage 2 and 3 PPH



### Future improvement activity

#### Scottish Improvement Leader Programme (ScIL)

One of our midwives has recently completed the ScIL programme. The aim of the project was to Improve women's perception of lower back pain while undergoing Induction of Labour (IOL) with prostaglandin by offering sterile water injections (SWI) as an alternate therapy. This has proven to be successful and guidance has been written and is currently awaiting ratification at the Maternity Clinical Effectiveness meeting. This will then be taken through Clinical Governance for implementation.

## **Caesarean Sections (CS)**

It has previously been highlighted that CS rates are high and Scotland was an outlier in comparison to the rest of the UK. We continue to look at the data for CS in NHS Ayrshire & Arran with a view to driving improvement in this area. We plan to look at the CS rates vs PPH rates. The national team have recently carried out a scoping of CS in Scotland and it is envisaged that this will be included in the national programme moving forward..

### **2.3.1 Quality/patient care**

The overall aim of the programme is to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies, children and families across all care settings in Scotland.

- NHS Ayrshire & Arran continue to demonstrate sustained improvement with stillbirth rates
- Although still statistically demonstrating sustained improvement with PPH data is variable. All PPHs are reviewed and findings would indicate appropriate management of all cases has been delivered.
- There is a high compliance rate with the administration of Tranexamic Acid (TXA) for post-partum haemorrhages.

### **2.3.2 Workforce**

There is currently no MCQIC Champion in Maternity services at this time. Interviews took place on 17 February and two successful candidates were appointed. A start date will be agreed in due course. Meanwhile the QI Advisor is obtaining data where possible to ensure there is no gaps in the programme. There have been suspensions periodically this year to prioritise clinical work due to whole system clinical pressures as a result of Covid-19.

### **2.3.3 Financial**

There may be financial implications identified as new National Standards of care are identified. This will be discussed as the programme progresses.

### **2.3.4 Risk assessment/management**

Delivery of the programme is aimed at reducing harm within Women & Children's services. Non delivery of the programme could impact on the provision of a safe service and reputation of the organisation if timely effective implementation does not happen.

### **2.3.5 Equality and diversity, including health inequalities**

By working toward compliance with each of the measures as agreed with the MCQIC Partnership we aim to protect and improve the health and wellbeing of the population and reduce inequalities, including through advocacy, prevention and anticipatory care.

No impact assessment has been completed as the operational definitions as outlined by the MCQIC programme set out the inclusion of the population to be included in any measurement and this is a national programme of work.

### **2.3.6 Other impacts**

The delivery of the elements contained within the MCQIC programme and the SPSP programme will support the Boards commitment to safe, effective and person centred care.

We aim to provide compassionate partnerships between patients, their families and those delivering health and care services which respect individual needs and values; and result in the people using our services having a positive experience of care to get the outcome they expect.

We will protect and improve the health and wellbeing of the population and reduce inequalities, including through advocacy, prevention and anticipatory care.

### **2.3.7 Communication, involvement, engagement and consultation**

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- A partnership agreement between MCQIC and NHS Ayrshire & Arran in relation to the way forward with new measurements was signed off and sent to all relevant parties on 21 December 2018. We have recently engaged the appropriate staff in producing a draft partnership agreement for 2022-25. This has been sent to the national team as a draft and will be subject to change when formally agreeing.
- The work contained within this measure plan are discussed at the bi-monthly meetings held by the Maternity Quality Improvement Group (MQIG). These meetings have been suspended again due to Covid, however a scheduled programme for 2022 will be distributed in due course.
- Any issues arising are taken forward at the Maternity Clinical Governance Group.

### **2.3.8 Route to the meeting**

As above the work detailed in this paper is discussed at the MQIG meeting and the Maternity CG meeting.

A version of this paper was presented to the Healthcare Governance Committee on 28 February 2022.

## **2.4 Recommendation**

For awareness. The Board is asked to receive this report on the quality improvement and safety activity in Maternity Services as part of the Maternity and Children Quality Improvement Collaborative (MCQIC) programme