Agenda Item	20/21/198

MEETING	**Quality Committee**
PAPER/REPORT TITLE:	**Lessons learnt from mortality, Q3 2020/21**
DATE OF MEETING:	Monday, 22 February 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Lynn Greenhalgh, Medical Director
AUTHOR(S):	Andrew Drakeley, Acting Deputy Medical Director, Allan Hawksey, Risk and Patient Safety Manager, Louise Robertson, Consultant Obstetrician, Ai-Wei Tan, Consultant Obstetrician and Rebecca Kettle, Consultant Neonatologist
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust……* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	☒ ☒ ☒	**4.** NHS Constitution **5.** Equality and Diversity ***6.*** Other: **Click here to enter text.**	☒ ☒
FREEDOM OF INFORMATION (FOIA):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Committee members are asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board			
PREVIOUSLY CONSIDERED BY:	**Committee name**		***Choose an item.*** Or type here if not on list: Quality Committee	
	Date of meeting		Monday, 22 February 2021	

Executive Summary

This is the 2020/21 Quarter 3 (Q3) learning from deaths report for the Trust. There are processes in place for review in all three types of death at the Trust. Every death in the Trust, including expected adult deaths, is reviewed.

Key areas the report addresses:

- All adult deaths, stillbirths & neonatal deaths have a mortality review conducted.
- One in-hospital related adult death occurred in Q3 of 2020/21.
- The Q3 stillbirth rate of 4.0/1000 (3.5/1000 excluding fetal abnormalites) was slightly lower than Q2 (4.1 and 3.9/1000 respectively).
- One neonatal case was identified where care could have been adversely affected by COVID 19 related restrictions and/or amended guidance or due to mothers delaying accessing maternity healthcare. This has been escalated to a serious incident and is being investigated. Full report to follow.
- The overall standard of care in stillbirth and neonatal deaths was good.
- The Trust demonstrates a high level of learning from mortality reviews. Themes are identified and action plans in place to address issues that arise.

Report

Learning from deaths 2020/21

Strategic context

Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). In February 2017 the CQC set out new requirements for the investigation of deaths to run alongside the local existing processes. The National Quality Board has subsequently provided further guidance and recommendations for learning from deaths entitled 'National Guidance for Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. A quarterly Adult and Perinatal Mortality report is presented to the Quality Committee as a core requirement of the National Guidance for Learning from Deaths.

This report is the 20/21 Q3 Board assurance report regarding compliance with review process and learning from deaths. It is set within the context of the Coronavirus Covid-19 pandemic.

Local context

The number of adult deaths in the Trust is low. Deaths are usually expected, end of life care related. Due to the low level of mortality numbers encountered and the complexity of the patients cared for by the Trust, adult mortality data is presented as pure data, not standardised mortality such as SHMI. The use of pure data and not standardised mortality rates has been previously agreed with the CCG as the Trust's approach to monitoring adult mortality rates. Stillbirths and neonatal mortality rates are reported in absolute numbers and /1000 births. Stillbirths are reported as overall rate and rate excluding terminations. Neonatal deaths are reported as overall rate and rate for in-booked babies.

Data is presented for adults, maternity/perinatal and neonatal deaths:

1. Adult:

The Trust's policy for analysis after an adult death relies upon the following activities:
• Gathering detailed intelligence on all individual instances of adult mortality in the Trust
• Identifying local issues arising from each of those events individually
• Exploring themes that may be emerging from groups of events

The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust.

The data contained in this report is pure data and is not standardised mortality data such as SHMI, due to the low level of mortality numbers encountered and the complexity of the patients cared for by the Trust.

The use of pure data and not standardised mortality rates has been previously agreed with the CCG as the Trusts approach to monitoring mortality rates.

Key findings:

- There were 2 deaths within Gynaecology Oncology for Q3. Both were subject to Mortality Reviews. 1 was declared as a Serious Incident. In the other case, there were no issues identified with the end-of-life care provided.
- The Safety and Effectiveness Senates have clear overview of and show evidence of responsiveness to potential areas of risk to adult mortality.

Table 1: Obstetric Mortality
This includes all obstetric activity in-hospital.

Obstetrics	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0				0
Discharges	1490	1632	1689	1835	1921	1806	1850	1690	1684				15597

Table 2: Gynaecology Mortality (non-oncology)

Gynaecology (non oncology)	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0				0
Discharges	258	203	293	470	546	554	614	637	478				4053

Table 3: Gynaecology Oncology

Gynaecology Oncology	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	TOTAL
Total Mortality	0	0	0	0	1	1	1	0	1				4
Discharges	70	60	66	76	72	65	67	64	62				408

<u>Out of hospital deaths 2020-21 Quarter 3</u>

Out of hospital deaths in Maternity are considered as Community deaths and not allocated to the Trust. The Trust does however, review care provided in all these cases to determine any thematic points for learning.

There were no reported out of hospital maternal deaths related to women who died within 12 months of delivering a baby at LWH in Q3.

There was a lady who sadly passed away at 10 weeks pregnant (reported in Q1), prior to having her 12 week scan. It was a suspected suicide; however, remains subject to ongoing investigation by HM Coroner. The Trust had not provided any care for this lady immediately prior to her death. The Trust review was completed in November 2020 and has been submitted to HM Coroner. The recommendations were as follows:

- Gynaecology Emergency Department to develop a Standard Operating Procedure for follow-up of non-attendance of appointments to include a review of PENS. Relevant information to be shared with named midwife and obstetrician in the case of ongoing pregnancy.

- Review findings to be shared with Liverpool University Hospitals (who had had direct contact on a number of occasions with the patient relating to their mental health).

There were no out of hospital Gynaecological deaths in Q3.

Table 4 Mortality reviews and Key Themes

Mortality reviews in Q3		
	Maternity (Direct)	**Gynaecology**
No of Adult Deaths	0	2
No of Mortality Reviews completed	0	2
No of deaths requiring RCA's	0	1
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A
Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

Unexpected adult gynaecology deaths trigger a 72- hour report and are recorded on Ulysses (Trust risk management and incident recording system).

There was 1 unexpected gynaecology death recorded in this quarter (December). Pre-operatively, the patient was noted to have potential endometrial cancer and associated infection. Post-operatively the patient declined very quickly and sadly passed away. The Trust are currently undertaking a Serious Incident investigation to identify if there are any opportunities for learning. The post-mortem results have indicated natural causes with no concerns raised by HM Coroner that the Trust have caused or contributed to the patient's death. Report submitted to the CCG in December 2020.

All **direct maternal deaths** trigger serious incident investigation. No direct maternal deaths were recorded in this quarter.

2. Maternity / perinatal

Table 5. perinatal deaths

PERINATAL DEATHS

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	TOTAL
ADULT Obstetrics	0	0	0	0	0	0	0	0	0				0
STILLBIRTHS Total stillbirths	1	5	4	2	3	1	4	1	2				23
Stillbirths (excl.terminations)	1	5	4	2	2	1	2	1	2				20
Births	596	579	638	658	677	681	669	605	605				5708
Overall Rate per 1000 births	1.68	8.63	6.27	3.03	4.43	1.47	5.98	1.65	3.31				4.0
Rate (excluding TOP) per 1000	1.68	8.63	6.27	3.03	2.95	1.5	1.47	1.65	3.31				3.5

All Perinatal deaths in the Trust are subject to review using the Perinatal Mortality Review Tool. The tool grades care as shown in the table below. This report encompasses all babies >23+6 weeks

Table 6: MBRRACE - UK Care Grading

Care Grade	Description
Grade A	No improvements in care identified
Grade B	Improvements in care identified that would not have changed the outcome
Grade C	Improvements in care identified that **may** have changed the outcome
Grade D	Improvements in care provided that **would** have changed the outcome

Any cases graded D are automatically reported as a Serious Incident and added to StEIS. A root cause analysis, (RCA), investigation is completed, and the family are informed of the findings.

All our parents are invited to submit questions for the review panel to answer through the Honeysuckle team.

Stillbirth reviews and Key Themes

Table 7. Grading of antenatal care for babies in Q3 2020-21

Grade	Care in antenatal period
A	2
B	1
C	0
D	0
UNK	2

One baby has been escalated to an SI as the death occurred in the unit. This mother had recently been positive for COVID 19. This mother's care was possibly adversely affected by COVID 19. This will be addressed through the SI investigation process.

Table 8. Details of the deaths for this period and consequent actions taken

Gestation	Cause of death	Issues	Actions	Parental involvement
30 weeks (Outstanding from Q2 report)	Placental abruption	No issues identified	None	No questions submitted
37 weeks	Massive perivillious fibrin deposition in the placenta. Covid positive mum and evidence of covid in placenta	Death of baby occurred between MAU and delivery suite. COVID policies not adhered to	Escalated to SI	Questions submitted
40 weeks	Fetal Vascular thrombosis and chornagiosis	No Issues identified	NA	Questions submitted
25 weeks	Maternal vascular under perfusion in placenta	No issues identified	NA	Questions submitted
31 weeks	Feta anomaly (cardiac) and fetal vascular	No formal referral process for FMU when a mother moves in	Booking trust were involved in the review. We	No questions submitted

	malperfusion	pregnancy. There was no fetal information leaflet in the notes in a language the woman's own language	have shared our link to FM leaflets (Tommy's website) Formal process of referral when women who are high risk FMU move in pregnancy	
24 weeks	To be reviewed 3/3/21 awaiting investigations	To be reviewed	To be reviewed	Questions submitted

Actions taken to address the findings for Q3

- Share link to Tommy's website with Northwick Park for non-English speaking women
- FMU to develop a referral system when a woman relocates in pregnancy
- Await SI report and embed actions into stillbirth action plan

Progress on previous actions

- K2 system, online live notes system in place as of Jan 2021
- A service evaluation to ensure the service is meeting the needs of non-English speaking women with particular reference to interpreter services and communication. A meeting between the stillbirth team and NEST leads is being organised to outline the issues and identify solutions.
- Update to guidance on reduced fetal movements whilst an inpatient has been chased

Revised Feb 2021 CNST requirement targets

The Trust was in receipt of the revised maternity invective scheme guidance which has included updated timescales and deadlines for the reporting and reviewing of stillbirths and neonatal deaths.

The stillbirth PMRT team are aware of the changes to the guidance and can provide assurance that standards required will be met.

This quarterly report (and pervious quarterly reports) will continue to be discussed with the maternity safety champion.

3. Neonates

This section updates the Committee regarding the Trust systems and processes to review and learn from deaths of neonates under their care. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place within the department which is reported to the neonatal NWODN (North West operational delivery network) and reviewed at CDOP (child death overview panel).

Key findings:

- Q3 mortality rate for all LWH neonatal deaths is 3.7 /1000 births
- Q3 mortality for LWH booked babies is 2.1 /1000 births
- 20/21 year to date mortality rate for all LWH neonatal deaths is 6.1/1000 births
- 20/21 year to date mortality for LWH booked babies is 3.0/1000 births

1. Mortality Dashboard

It has been agreed with the Head of Governance and Deputy Medical Director, that the following table showing the total mortality and the rate of death per 1000 births will be used as the mortality dashboard metric. Tables 9 and 10 refer to LWH NICU in-hospital mortality before discharge. The end of year annual neonatal mortality report will detail all neonatal deaths (<28 days), both on NICU and labour ward, all deaths before discharge, deaths at home or in another organisation after delivery and / or care in LWH neonatal unit.

Table 9: NICU Mortality

NICU	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Total
Discharges	110	99	78	102	108	91	94	98	90	870
Total Mortality	3	0	4	9	3	9	0	3	4	35
Births	584	572	631	658	677	681	669	605	605	5708
Mortality Rate per 1000 births	5.1	0	6.3	13.6	4.4	13.2	0	4.9	6.6	6.1

There have been a higher than usual number of deaths in July and September 2020. On initial review there are no clear themes and all will be reviewed through the PMRT process, however at this point it is not possible to comment further as not all deaths have been reviewed to date. Tables 12 and 13 detail the breakdown of the deaths by gestation and cause. As a regional tertiary surgical and cardiac NICU we accept in-utero and post-natal

transfers of high-risk babies requiring intensive care after birth and have an increased risk of mortality. Table 10 details the mortality for babies booked at LWH only, excluding in-utero and post-natal transfers.

Table 10: NICU Mortality (booked LWH)

NICU (LWH BOOKED)	**Apr 20**	**May 20**	**Jun 20**	**Jul 20**	**Aug 20**	**Sep 20**	**Oct 20**	**Nov 20**	**Dec 20**	**Total**
Discharges	110	99	78	102	108	91	94	98	90	588
Total Mortality	1	0	3	6	1	3	0	2	2	17
Births	584	572	631	658	677	681	669	605	605	5712
Mortality Rate per 1000 births	1.7	0	4.8	9.1	1.5	4.4	0	3.3	1.5	3.0

Some variation is to be expected month on month, however July is noted to be higher than usual. There was an initial overview of the cases for any clear themes, pending full review through the PMRT process for issues and identifiable themes.

Some babies who are born and or cared for in NICU are subsequently transferred to Alder Hey (AH) for ongoing management. If a baby dies after transfer to AH the case is reviewed through the AH mortality review process by the hospital mortality review group with neonatal input from the LWHNSFT. If a baby is transferred to a hospice for end of life care the case is reviewed through the LWH PMRT process.

Table 11: Mortality ***after*** discharge from NICU

	Apr 20	**May 20**	**Jun 20**	**Jul 20**	**Aug 20**	**Sep 20**	**Oct 20**	**Nov 20**	**Dec 20**			
Alder Hey Children's Hospital								3 (2 book				

								ed)				
Hospice												
Repatriation to booking hospital												
Home												

The 3 babies who died after transfer to AH in Q3 will be reviewed through the LWH PMRT process which will then feed into the AH HMRG (hospital mortality group) for a complete review of the mother and babies' care.

In Q3, 3 babies died after transfer to another care setting: 1 baby was transferred to AH for surgical management of NEC, the other 2 babies were transferred for ENT assessment of airway after difficulty intubation both had multiple other congenital anomalies.

Table 12: All mortality by gestation Q3 20/21

	LWH booked mortality	**Non-LWH booked mortality**	**All mortality**
Extremely preterm (<28 weeks)	3	4	**7**
Very preterm (28-32 weeks)			
Moderate preterm (32-37 weeks)	1	1	**2**
Term (>37 weeks)	1		**1**

The highest mortality group remains the extremely premature babies. Of the 3 deaths in the moderate and term babies, all 3 had congenital anomalies: 1 congenital diaphragmatic hernia and 2 had multiple congenital abnormalities without a unifying diagnosis and died after transfer to AH for specialist intervention.

Table 13 details the breakdown by primary cause of death as stated on the death certificate, overall for Q3 the majority of deaths were due to prematurity, accounting for 5 out of the 10 deaths this quarter. There were also a significant proportion of deaths attributable to congenital anomalies, which is similar to the proportion seen in the last quarter, although the overall number was higher.

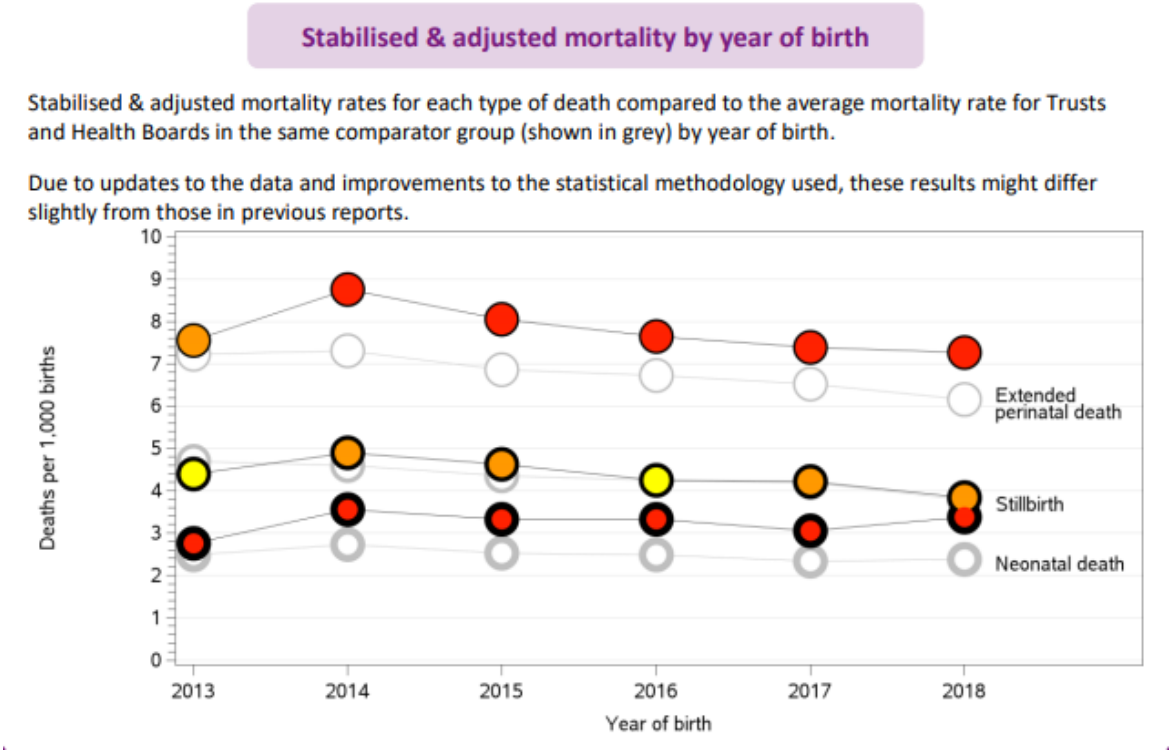
Table 13: All mortality by cause Q3 20/21

	LWH Booked	**In-utero transfers (non-LWH booked)**	**Ex-utero transfers (non-LWH booked)**	**Unbooked**	**Total**
Prematurity	3	1	1		**5**
Infection		1			**1**
Hypoxic ischaemic encephalopathy					
Congenital abnormality	2	1			**3**
Respiratory		1			**1**
Cardiovascular					
Abdominal / Renal					
Neurological					
Other					

Benchmarking data

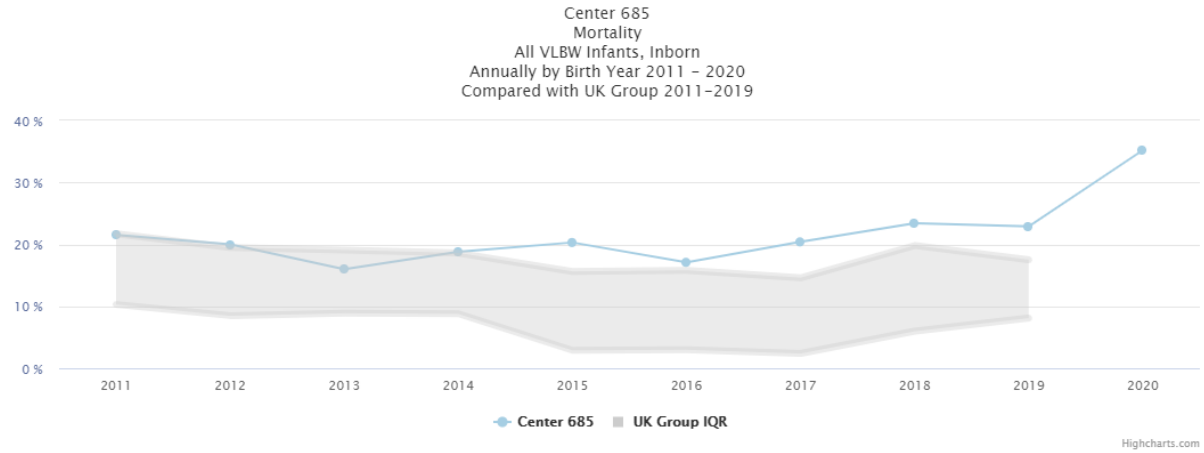
We benchmark our mortality through MBRRACE nationally and the international VON network. MBRRACE has reported most recently on 2018 data, figure 1 demonstrates mortality rates over time, the grey lines demonstrate UK average for the LWH comparator group i.e. other NICUs with neonatal surgery.

Figure 1.



We also benchmark through an international group VON, we can compare within the UK members of this network for various aspects of care, figure 2 is the mortality rates specifically for in born, VLBW (<1500g) babies over time. The 2020 increase is notable, there is yet to be a trend analysis the whole comparator group for 2020, this is usually available in June of the following year. We have remained at the upper end of or above the interquartile range for mortality but have mostly followed the trend.

Figure 2



2. Mortality reviews

All neonatal deaths on NICU are reviewed using the standardised national perinatal mortality review tool (PMRT). There is a monthly multi-disciplinary review meeting with representation from neonatal, obstetrics, bereavement support and palliative care teams. Reviews are planned for 6-8 weeks after the baby has died. Where there has been an in-utero transfer or a baby has been transferred post-natally for higher level care, the hospital of booking and or/ birth along with other care providers involved are invited to the meeting to complete a joint review encompassing all aspects of care. Each case is then assigned a grade (A-D, see below) for each of the following areas: antenatal care, neonatal care and care after the baby has died.

Table 14. perinatal mortality review tool

A	no issues with care identified up to the point that the baby was confirmed as having died
B	care issues which the panel considered would have made no difference to the outcome for the baby
C	care issues which the panel considered may have made a difference to the outcome for the baby
D	care issues which the panel considered were likely to have made a difference to the outcome for the baby

Cases where a grading of C or D has been assigned will be then reviewed further as a table-top review, or if deemed appropriate a formal review or serious incident. Local mortality review outcomes and learning are shared within the department and at the Clinical Effectiveness Group for Cheshire and Mersey NWODN. The PMRT outcomes are reported to the regional child death overview panel (CDOP).

The PMRT process encourages parental engagement, all parents are informed of the review process at the time the baby dies, followed up with a letter detailing the process and how they can engage is provided. Any comments / questions / concerns which the parents send in are addressed as part of the review and parents are offered an appointment to discuss the response thereafter and a letter detailing the PMRT outcome is provided following the appointment.

Table 15: 20/21 Neonatal Mortality Summary

	Q1	Q2	Q3	Q4	Total
NICU deaths	7	21	7		
LWH booked NICU deaths	**5**	**10**	**4**		
Mortality rate /1000 births	3.9	10.4	3.7		
LWH booked mortality rate / 1000 births	**2.2**	**4.7**	**2.1**		
PMRT Reviews completed	7	21	3		
No. of deaths were care issues were identified (grade B/ C/D)					
Antenatal	*6*	*7*	*1* under review		
Neonatal	*6*	*14*	*3*		
Care of mother after death of baby	*2*	3	*1*		
No. of deaths were care issues may have or were likely to have affected the outcome (grade C/D)					
Antenatal					
Neonatal	*1*	*1(D)*	*1 under review*		
Care of mother after death of baby	*1*	*1(C)*			
Non-NICU deaths of babies cared for on NICU	4	3	*3*		

Learning from Deaths from Q2 – all reviews completed

In Q2 only 10 out of 21 cases had been reviewed at the time of the Q2 report. All 21 have now had a full PMRT review. 13 of the 21 had been graded B, 1 grade C or D, below is a complete list of the Q2 issues identified.

Neonatal care

Of the 5 cases with neonatal care issues identified: 4 were graded B (care issues identified which would not have made a difference to the outcome), whilst through the detailed review process care issues have been identified and afford opportunities for learning and improvement, they have not impacted on the outcome for the babies.

Care issues identified which did not impact on the death of the baby included:

- Not achieving targets of initial management on admission
- Prolonged handling after admission in extreme preterm baby
- Multiple line insertions in a challenging baby, a necessary intervention however these were not fully documented and the parents found this experience particularly difficult – communication, documentation and support of the parents could have been improved.
- Multiple intubations for a baby on several occasions – care could have been improved with a better oversight and acknowledgement of the history and consideration of more experienced first intubator on the later occasions.
- Several hours of high peak pressures on the ventilator before consideration of optimising respiratory support with high frequency oscillation ventilation.
- Sub-optimal documentation – this was identified in several reviews but in different areas of documentation.
- Fluid management
- Delayed blood gases
- Admission temperature low – although reasonable interventions used
- Diagnostic testing – investigating early for congenital infections in the context of symmetrical IUGR
- Medication error
- Delayed administration of surfactant afterbirth – local DGH
- Delayed antibiotic administration at birth due to IV access issues – referring hospital
- Use of language line / interpreter for difficult and pertinent conversations
- Accidental extubation

Actions proposed to address the issues above include:

- Working group to review of initial management of preterm babies on admission (in development)

- Include initial management and admissions procedures in Junior doctor induction 6 monthly with LOTW reminder (induction session completed September 2020, LOTW pending)
- Feedback to wider NICU team at clinical governance day regarding patient experience and importance of documentation (November 2020)
- LOTW for ventilation key points – for both medical and nursing staff (pending)
- LOTW for documentation (w/c9/11/20)
- Fluid guideline reviewed and updated (Jan 2021 including accompanying LOTW)
- Nursing education in fluid balance documentation
- Medication error – has been through medicine management processes, utilising shift leader in managing nursing staff and task delegation during resuscitations

Antenatal Care

There were no antenatal care issues identified in the majority of cases reviewed. There was a case of an un-booked pregnancy and there were no concerns identified for why pregnancy was not booked? Antenatal care issues identified that were not considered to have changed the outcome include:

- Lack of use of partogram in preterm labour
- Inadequate communication with community MW teams regarding diagnosis of fetal abnormality from FMU
- Lack of record of telephone triage and advise given to patients
- Failure to FU when patient did not attend for ODU appointment
- Delay in reviews and keeping patients informed of abnormal MSU results such as recurrent contamination and asymptomatic bacteriuria and need for the appropriate follow-up with repeated samples
- Not following FMU plan of having neonatal team present at delivery

To address some of these issues, the following has been carried out:

- Sharing of LOTW to Obstetric staff on intrapartum management of preterm labour that includes utility of partogram, consideration of MgSO4, IV antibiotics and steroids, depending on the gestation of the pregnancy
- Reminder sent by MAU manager to MAU team on importance of FU on patients who DNA ODU appointments
- Agreed process of sharing FMU reports with the community teams on the new K2 Athena electronic patient records which include attaching all reports onto K2
- Feedback to staff on importance of following FMU plans for labour

Both lack of documentation of telephone triage and management of abnormal MSU are known recurrent antenatal care issues and have been escalated and put onto the risk register, and regularly assessed.

Of all the cases reviewed, there was 1 case where antenatal care was graded D, where care issues identified were considered by the panel to likely to have made a difference to the outcome of the baby. This case was also reviewed through the HSIB process and investigated in LWH as a serious incident. Safety recommendations have

been advised, with a plan put in place to ensure continued training for all staff on Situational Awareness in an MDT manner.

Care after the death of the baby

For 2 of these families, we identified care issues after the death of the baby which included lack of Honeysuckle support for the family in the first days after the death due to no cross cover for annual leave and delayed communication with a booking hospital regarding the death of the baby.

Action:

- Bereavement checklist to be reviewed and pathways of communication confirmed

Learning from Deaths Q3 – 3/10 reviews completed

Of the 3 reviews completed to date all 3 identified care issues which would not have affected the outcome for the baby (B). The issues identified include:

- Sub-optimal admission documentation
- Multiple unplanned extubations in 1 baby
- Inappropriate grade of staff performing procedures
- Subcapsular haematoma – awaiting review through incident process
- Hypothermia after being out for skin to skin

Actions planned to address the above issues:

- Ongoing admission documentation QIP
- Unplanned extubation audit to identify themes and rates of incidence
- Extreme preterm pathway working group in progress of reviewing and creating a targeted package of care for this group of infants – to include guidance around skin to skin and grades of staff to be involved in practical procedures

Antenatal Care

Of these 3 reviews, only 2 of these cases received antenatal care here and there were no care issues identified in both cases until the delivery of baby.

Care after the death of the baby

For 1 of these families, we identified that we could have made improvements to their care which included the use of bereavement / baby loss lanyards to identify the issue without parents having to explain to staff. These are available in maternity but have not been introduced in neonatal unit.

Action:

- Bereavement team to link with neonatal bereavement nursing staff on NICU and supply lanyards to be used when needed.

Learning and action plans from quarterly reports to be reported through monthly neonatal MDT.

Overall summary: Learning from Deaths

There have been 2 Gynaecology Oncology deaths, 1 expected and 1 unexpected, reported in Q3 and subject to a Mortality Review. There were no issues identified with the end of life care in relation to the expected death. The unexpected death case remains subject to ongoing investigation. There were no non-oncology patient deaths.

There have been no maternal deaths.

There were 5 stillbirths in Q3, fewer than Q1/2, with one possibly Covid-19 related.

NICU experienced 7 deaths, which was lower than Q2 and the same as Q1.

As part of the Trusts assurance processes, the Safety and Effectiveness Senates work to gain assurance as to actions taken in relation to Serious Incident reviews, Lessons Learnt, External Alerts and National guidance on Quality and Safety. The Effectiveness Senate also has oversight and scrutinises clinical and effectiveness audits and service evaluations.

The Committee members are asked to review the contents of the paper and take assurance that there are adequate processes and progress against the requirements laid out by the National Quality Board and to take assurance that there are effective processes in place to assure the Board, regarding governance arrangements to drive quality and learning from deaths in receipt of care at the Trust.