Liverpool Women's NHS Foundation Trust

Quality Committee

COVER SHEET

Agenda Item (Ref)	*21/22/36*		Date: 23/05/2022	
Report Title	**Learning from Deaths Quarter 4, 21/22**			
Prepared by	Lidia Kwasnicka, gynaecology risk lead; Ai-Wei Tan, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and Chris Dewhurst, Deputy Medical Director.			
Presented by	Lynn Greenhalgh, Medical Director			
Key Issues / Messages				
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	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			
Supporting Executive:	Lynn Greenhalgh Medical Director			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐		Policy ☐		Service Change ☐		Not Applicable ☒	
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒		To participate in high quality research and to deliver the most ***effective*** Outcomes	☒			
To be ambitious and ***efficient*** and make the best use of available resource	☒		To deliver the best possible ***experience*** for patients and staff	☒			
To deliver ***safe*** services	☒						

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*	Comment: N/A
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: No

EXECUTIVE SUMMARY

This "Learning from Deaths" paper presents the mortality data for quarter 4 2021/22 with the learning from the reviews of deaths from quarter 3 2021/22. The 'learning' can take some time after the death occurs due to the formal processes and MDT reviews that take place. This results in the learning being presented a quarter behind the data. The review of stillbirths and neonatal deaths are subject to a multidisciplinary review panel meeting with external professionals utilising the Perinatal Mortality Review Tool (PMRT). All cases invited parents to be involved in the review by submitting comments and questions for discussion.

In quarter 4 there were the following deaths:

Adult deaths	**0**
Direct Maternal Deaths	**0**
Stillbirths	**9 (rate 5.0/1000 total births)**
Neonatal deaths	**8 inborn (rate 4.4/1000 inborn births) + 0 deaths from postnatal transfers**

The Annual data for 21/22 are below

Adult Deaths	**4**
Direct Maternal Deaths	**0**
Stillbirths (excluding TOP)	**4.9/1000 total births**
Stillbirths (incl. TOP)	**7.1/1000 total births**
Neonatal Deaths	**3.6/1000 deliveries (inborn)**

In this quarter neonatal deaths and stillbirths are reported using a regional standardised template. These standardised templates are included in this report.

The stillbirth rate has increased at LWH since 2019/20. It is unknown if this is a pattern replicated in the UK with ONS data awaited. There has been no increase in issues with the clinical care provided at LWH from the reviews of stillbirths.

A thematic review of stillbirths will be conducted in Q2 2022/23 when the learning from stillbirths in Q4 from 2021/22 will be available.

Lessons learnt from quarter 3 and actions taken are presented in this paper. Common themes from recent learning from deaths reviews include:

1. Importance of accurate growth plotting on fetal growth charts
2. Quality improvement programme to reduced unplanned neonatal extubation
3. Timely radiology provision out of hours for the neonatal unit.

Recommendation: It is it is requested that the members of the quality committee review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. In addition, as per The Learning from Deaths framework requirements the board are requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- Specific recommendations

- the monitoring and review of the stillbirth rate continues by the Family Health board, with a thematic review to be conducted with Q4 data and learning . Issues identified at the reviews and recommendations made will now be tracked through the Maternity Clinical Meeting
- the monitoring and review of the neonatal mortality rate continues with an external review of mortality for extremely preterm infants to be available in Q1 2022-23.

MAIN REPORT

This is the quarter 4 2021/22 mortality report for adults, perinatal and neonates. This report updates the Quality Committee regarding the Trust systems and processes to review and learn from deaths of patients under their care. 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. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee.

The data presented in this report relates to quarter 4 2021-22. The learning relates to deaths in Q3. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred.

Additional data relating to mortality is presented in the embedded word document.

1 Adult Mortality

The data relating to adult mortality 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.

1.1 Obstetric Mortality Data Q4

There were no direct maternal deaths (deaths within 42 days of delivery) in quarter 4.

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. In Q3, there was one death of a woman who died approximately 8 weeks after delivery. This case is subject to a Coronial investigation and as per the requirements of Ockenden a multiagency review has been initiated.

1.2 Gynaecology Mortality data Q4

There were no deaths within Gynaecology Oncology nor out of hospital deaths in Q3.

1.2.1 Learning from Gynaecology Mortality Q3

A Serious Incident investigation was conducted for a woman who died in Q2 2021/22. She had undergone debulking surgery for ovarian cancer and died 8 days later following a sudden deterioration due to an acute gastric dilatation and intra-abdominal haemorrhage. This is a rare complication of surgery but can also be related to other aetiologies. Learning from the review included;

- Ward round changed to 08:30 am rather than previously prescribed 10:30 to allow time for actioning and addressing clinical tasks, particularly in the unwell patients.
- Better communication with family should be addressed by senior team members at all levels, constant checking of understanding to resolve any unmet expectations.
- CT scans should be done in postoperative patients who had abdominal surgery, particularly those with delayed or unexpected recovery delays.

2 Stillbirths

2.1 Stillbirth data

There were 9 stillbirths, excluding terminations of pregnancy (TOP), in the third Quartile of 2021/2022. This has resulted in an adjusted stillbirth rate of 5.1/1000.

STILLBIRTHS	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL 2021/22
Total Stillbirths	3	6	4	7	4	2	4	6	3	7	4	6	56
Stillbirths (excluding TOP)	**3**	**3**	**2**	**7**	**3**	**1**	**3** (2 preg)	**5**	**2**	**4**	**0**	**5**	**38**
Births	639	672	696	692	695	684	655	665	622	659	561	595	7835
Overall Rate /1000 births	4.7	8.9	5.7	10.1	5.8	2.9	6.1	9.0	4.8	10.6	7.1	10.1	7.1
Rate (excluding TOP)/1000	**4.7**	**4.5**	**2.9**	**10.1**	**4.3**	**1.5**	**4.6**	**7.5**	**3.2**	**6.0**	**0**	**8.4**	**4.85**

Table 1 Stillbirth rates for 2021-22

The annual stillbirth rate for 2021-22 is higher than in previous years. (see fig 2 below). The NHS Long Term plan has set a target of reducing stillbirths by 50% by 2025. That would require England to reduce its stillbirth rate to 2.6 stillbirths per 1,000 births. The most recent ONS data from 2020 records the still birth rate for England and Wales to be 3.8/1000 births. There has been a slow decline in the national stillbirth rate in the years prior to this. The ONS data for 2021 is awaited.

Quarter	Rate 2019/2020	Rate 2020/2021	Rate 2021/2022
Q1	4.0	5.5	4.0
Q2	4.1	2.5	5.3
Q3	1.5	2.7	5.1
Q4	1.7	3.2	5.0
ANNUAL	2.9	3.4	4.9

Table 2: LWH Stillbirth rates by quarter in and year since 2019. NB The difference between 2020/21 and 2021/22 is not statistically significant, though it is statistically significantly increased when 2021/22 is compared with 2019/20

It is not clear if the increasing still birth rate in the LWH data is replicated throughout the UK. There have been worldwide reports of an increased stillbirth rate during the covid pandemic. UK data from a single centre in London demonstrated a fourfold increase in the still birth rate during the first lockdown of 2020. The ONS data for 2020 however showed a still birth rate of 3.8/1000 births, a decrease from 3.9/1000 in the previous year. The ONS data relating to stillbirth rates for 2021 are not yet available. We are not therefore unable to determine if the rise in stillbirth rate at LWH since 2020 is also seen on a national scale and await the ONS national data to benchmark against.

National data is available from the NHS trusts that submit data to the CHKS group for benchmarking. CHKS data for Jan – Dec 2021 are below. These data demonstrate compare trusts with >7000 births demonstrating that LWH stillbirth rates are within the expected range when compared with peers (range is from 3.1 to 5.6 stillbirths/1000 births.

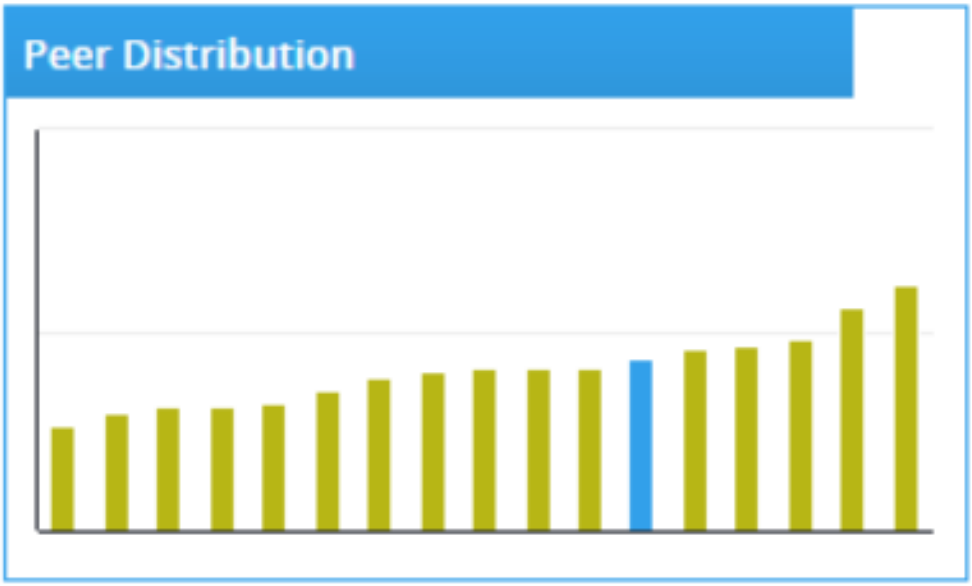

Chart 1 Stillbirths for Jan – Dec 21, LWH in blue. Comapritos = maternity serices with > 7000 deliveires who submit data to CHKS

2.1 Learning from Stillbirth reviews Q3

All eligible cases undergo a full PMRT review, with care from across the antenatal and intrapartum period being subject to clinical and managerial scrutiny. The care that the mother receives is subject to a grade which aligns with the MBRRACE-UK grading system Postnatal care is reviewed, typically with a focus on the bereavement care the family receive. Any complications of labour and within the postnatal period are subject to the same grading system

All 10 cases in Q3, have been reviewed and subject to grading of care provided as below. In the antenatal period, the proportion of cases with no care issues identified has remained similar to those percentages reported in previous quarters.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	7	66.7	7	66.7
B	1	11.1	3	33.3
C	1	11.1	0	0
D	1	11.1	0	0

Table 3. Grading of care from review of stillbirths.

All stillbirths in Q3 (n=10) have been subject to a full multidisciplinary review panel meeting utilising the PMRT tool with external clinician presence.

All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review.

The MDT reviews of Q3 cases (N=10) has evaluated the majority (66.7%) of stillbirth cases as having had appropriate antenatal care and were graded as 'A' in accordance with the MBRRACE grading system.

Learning from antenatal care:

- The need for appropriate charting on GROW chart, and the awareness to act on abnormal findings. This led to missed opportunities to refer for fetal growth surveillance which may have identified growth restriction. Individual feedback has taken place, and there is ongoing training for utility of the GAP/GROW programme and the audit on the rate of missed FGR.
- The importance of effective communication between various hospitals on confirming the chorionicity of twin pregnancies prior to any counselling or intervention. In view of this, the referral pathway into the FMU Multiple Pregnancy Clinic is being reviewed.

Learning from post natal care:

- the importance to perform SB investigations in trying to identify a cause, and a LOTW has been shared to remind all clinicians regarding this
- The importance of clarifying uncertainties with senior medical staff prior to completing SB certificate.

Actions that are completed from areas of learning from Q2 include:

- A new SOP in place for the process of cross-covering FMU clinics and rescheduling of appointments if required in unexpected illness
- Individual feedback and LOTW shared on the importance of complete risk assessment when patients attend MAU

There is ongoing progress for the following:

- Implementation of the CoC model to improve process in arranging for follow up for community midwifery reviews
- Integration of K2 with electronic GROW package to have an electronic system for fetal growth surveillance
- Review provision of bereavement care and support out of hours

In order to maintain a close monitoring of any identified themes, trends, rising data and issues resulting from stillbirth reviews, the stillbirth data and a summary of cases discussed at the PMRT MDT reviews will be an agenda item at the monthly Maternity Clinical Meeting.

A full review of the LWH stillbirth data and lessons learnt will be undertaken once the learning from Q4 21/22 is completed. A report will then be submitted to QC in Autumn 2022/23.

3. Neonatal Mortality

3.1 Neonatal mortality Data

Neonatal deaths can be reported in several ways. The population can include in-born babies only, LWH booked pregnancies or all babies cared for in LWH (including babies transferred to LWH from other care providers). Deaths may be those within 28 days, those occurring prior to discharge from the NICU and those who die following transfer to another hospital. The data may include or exclude babies with congenital anomalies. Table 4 provides the total number of deaths, and deaths of those born at LWH.

	Apr-21	*May-21*	*Jun-21*	*Jul-21*	*Aug-21*	*Sep-21*	*Oct-21*	*Nov-21*	*Dec-21*	*Jan-22*	*Feb-22*	*Mar-22*	*Total*
Discharges	100	97	106	93	119	113	129	129	114	126	96	108	1330
Total Neonatal Mortality	3	1	2	5	3	3	8	5	3	2	3	3	41
INBORN Neonatal Mortality	**2**	**0**	**0**	**3**	**2**	**2**	**4**	**4**	**3**	**2**	**3**	**3**	**28**
Deliveries	622	654	673	692	695	684	655	665	622	659	561	595	7777
INBORN Neonatal Mortality Rate/1000 deliveries	**3.2**	**0**	**0**	**4.3**	**2.9**	**2.9**	**6.1**	**6.0**	**4.8**	**3.0**	**5.3**	**5.0**	**3.6**

Table 4: NICU Mortality.

Quarter	NMR all babies	NMR *in born*
Q1	3.1	1.0
Q2	5.3	3.3
Q3	8.2	5.7
Q4	4.4	4.4
4 Q rolling average	5.3	3.6

Table 5 Neonatal mortality/quarter.

An ongoing external review by the North West Neonatal ODN of LWH mortality for extremely preterm infants is continuing. This was initiated following benchmarking data relating to a higher mortality in infants of 24 weeks gestation age when compared with other level 3 neonatal units in the North West and a spike in mortality rates in 2020. This report is now due to be available in Q2 2022.

3.3. Learning from neonatal mortality reviews for Q3

There were 15 deaths subject to a PMRT review, 1 baby died in alder Hey Children's Hospital. The LWH care of the mother anc child have been reviewed, but the care after death has not yet been reviewed jointly with AHCH.

All neonatal deaths on NICU were reviewed using the standardised national perinatal mortality review tool (PMRT) within 2 months of the death occurring (MIS requirement). All Q3 reviews have been completed (15/11). The grading of care for the PMRT is as follows;

- Grade A No issues with care identified from birth up to the point the baby died.
- Grade B Care issues identified which would have made no difference to the outcome for the baby.
- Grade C Care issues identified which may have made a difference to the outcome for the baby.
- Grade D Care issues identified which were likely to have made a difference to the outcome for the baby.

PMRT grading	Care provided to the mother up to the point that the baby was delivered	Care provided to the baby up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A	9	5	14
PMRT grade B	6 (*2 PN transfer*)	9	1
PMRT grade C	1	2	
PMRT grade D			
Total cases	16	16	15*

Table 6. PMRT review panel grading of care provided in cases of Neonatal Death Q3

Of 16 reviews 13 were found to have care issues which would not have affected the outcome. 3 cases identified care issues which may have made a difference to the outcome. One case related to not being co-located with adult ITU services, and another to not being co-located with paediatric services.

LWH Learning identified included the following (see attachment for further detail)

1. Need for radiology attendance out of hours in a timely manner. Plan for revised provision out of hours to ensure attendance within 30 minutes of request.
2. Two unplanned extubations have resulted in development of a QI initiative to reduce this risk

5. Revised Year 4 Maternity Incentive Scheme requirements

The MIS was paused in Q3. However the adherence to the safety actions continued. The MIS year 4 recommenced rom May 2022 and in future reports adherence to safety action 1 will be presented.

This quarterly report (and pervious quarterly reports) will continue to be discussed with the maternity, neonatal and Board level safety champions. Dissemination of learning will continue through associated clinical meetings and feedback to staff.

4. Recommendations

It is it is requested that the members of the quality committee review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. In addition, as per The Learning from Deaths framework requirements the board are requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- Specific recommendations
    - the monitoring and review of the stillbirth rate continues by the Family Health board, with a thematic review to be conducted with Q4 data. Issues identified at the reviews and recommendations made will now be tracked through the Maternity Clinical Meeting
    - the monitoring and review of the neonatal mortality rate continues with an external review of mortality for extremely preterm infants to be available in Q2 2022-23

Appendix 1

Regional Standardised Reports