Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/164*	Date: 12/10/2023		
Report Title	Mortality and Learning from Deaths Report Quarter 1, 2023/24			
Prepared by	**Chris Dewhurst, Deputy Medical Director.** Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and			
Presented by	**Lynn Greenhalgh, Medical Director**			
Key Issues / Messages	The Board is 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			
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.*			
	It is requested that the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. *Given the paper identifies several deaths related to non- co-location of maternity and adult/paediatric acute services, the Board is asked to note the following for additional assurance:* *1.The last 18 months learning from deaths papers have been reviewed to identify deaths which may have been contributed to by non-colocation.* *2. A retrospective review of gynaecology SIs identified 2 deaths. In neither was non-colocation identified as learning however in one case the woman was transferred to another hospital for ongoing care as this care was unable to be provided on the LWH site.* *It is recommended:* *1. There is a wide-ranging review of the IUT pathways and discussion with the NWODN and LMNS regarding the discrepancies seen across the system and why LWH receives 3.5X the IUTs than other similar local providers.* *2. Consideration from the Trust Board regarding where the learning from deaths information relating to learning from non-colocation is shared.* *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.* *• the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity and neonatal system*			
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 “Mortality and Learning from Deaths” paper presents the mortality data for Q1 2023/24 with the learning from the reviews of deaths from Q4 2022/23 The ‘learning’ can take some time after the death occurs due to the formal processes and MDT reviews that occur. Learning from SI reviews, Coroner’s inquests, HSIB investigations and elsewhere may take longer to be reported. This results in the learning being presented at least one quarter behind the data.

In quarter 1 there were the following deaths:

Adult deaths	**1 (expected death)**
Direct Maternal Deaths	**0**
Stillbirths	**3 (excluding ToP)**
Neonatal deaths (inborn)	**12 (6.8/1000 live births)**

The updated learning from 3 **maternal deaths** in 2021/22 is included in this paper. Not being co-located with surgical and

There were two **unexpected gynaecology deaths** in women who underwent surgery at LWH and were then transferred to RLUH due to post operative complications in Q2 2022/23. The lack of co-location with an acute hospital trust was identified as a root cause in the SI review.

The **stillbirth** rate for this quarter was 1.7/1000. This is the lowest rate for the previous 3 years. Incomplete stillbirth investigations being completed were identified as a care issues.

The **neonatal mortality** rate for inborn babies was 6.8/1000 livebirths. The mortality for in-born preterm infants (24 to 31+6 weeks) was 7.1% mortality. This is above the NWODN benchmark of 6.3%, however discussions with the appropriateness of this benchmark with the ODN have commenced.

The review of neonatal deaths from Q4 22/23 identified 5 examples of care issues identified which may have made a difference to the outcome (Grade C), two of these cases have been referred for a SUI investigation. Delay in performing radiology investigations was highlighted as a recurring safety issue and has resulted in executive approval for a 24/7 radiology on-site presence.

This paper includes an overview of **in-utero transfers (IUTs) and the impact on mortality**. Over a 2-year period, IUTs accounted for nearly half (26/55, 47%) of all deaths at LWH. IUTs were 6x more likely to die than non-IUTs (1.5% vs 8.8%). The excess mortality is mainly seen in the more mature infants related to the presence of congenital anomalies.

On reviewing all of the learning from deaths for this recent quarter, the **lack of co-location** of LWH services with both adult and paediatric acute services has been highlighted as contributory factor to the following:

1. a maternal death in Q4 2022/23 related to a woman presenting at 18 weeks gestational age with bowel ischaemia.
2. two unexpected gynaecology deaths in women with post-operative complications in Q2 2022/23
3. A stillbirth occurring in a 14-year-old girl presenting to another trust in the city
4. A neonatal death related to transfer between Alder Hey and Liverpool Women’s Hospital

Recommendation: It is requested that the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths.

Given the paper identifies several deaths related to non- co-location of maternity and adult/paediatric acute services, the Board are asked to note the following for additional assurance:

1. The last 18 months learning from deaths papers have been reviewed to identify deaths which may have been contributed to by non-colocation.
2. A retrospective review of gynaecology SIs identified 2 deaths. In neither was non-colocation identified as learning however in one case the woman was transferred to another hospital for ongoing care as this care was unable to be provided on the LWH site.

It is recommended:

1. There is a wide-ranging review of the IUT pathways and discussion with the NWODN and LMNS regarding the discrepancies seen across the system and why LWH receives 3.5X the IUTs than other similar local providers.
2. Consideration from the Trust Board regarding where the learning from deaths information relating to learning from non-colocation is shared.

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.
- the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system

MAIN REPORT

This is the quarter 1 2022/23 mortality report for adults, stillbirths and neonates. 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 “National Guidance on Learning from Deaths” 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 Q1 2022-23. The learning relates to deaths in Q4 22/23 2022-23. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred.

Additional data/information relating to mortality is presented in the embedded word documents.

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 number of deaths in our care 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/ICB as the Trusts approach to monitoring mortality rates.

The requirement is to report adult deaths that occur at LWH. However given the isolated nature of our services, women who deteriorate whilst an in-patient at LWH will be transferred to other hospitals for ongoing care any may die at external trusts. The learning from deaths report now also includes information related to these deaths. These deaths may not be reported the quarter after the death occurs due to data collection and sharing and this is highlighted.

1.1 Obstetric Mortality Data Q1 2023/24

There were no maternal deaths in Q1 2023/24.

1.2 Learning from Obstetric Mortality Data

Due to the significant time delay for investigations to conclude following a maternal death, the deaths will continue to be reported through this paper until the learning is concluded.

Case 1 Q4 2022/23

This related to the death of a woman at 18 weeks gestational age who deteriorated whilst an in-patient at LWH. She was transferred to LUFHT where she sadly died. This death is being investigated via a HSIB investigation, a Serious Untoward Incident investigation (led by the Gynaecology division due to her presenting the GED) and also by the Coroner. The cause of death has been recorded as

1A- acute intestinal ischaemia
1B- Thrombophilia and pregnancy.

The SI report (2023/5813) identified the following as a root cause of the incident:

- The lack of onsite surgical team and managing the patient in isolation and not ‘shared care’ with other acute specialties.
- Lack of co-location of LWH with acute trust.

The Lessons Learned and Recommendations are as follows:

Lessons Learned

- Acute surgical abdomen needs to be suspected and investigated appropriately.
- Patients who are unwell or cause for concern should be prioritised on the morning ward round
- Arranging Inter-hospital transfer and reviews by external consultants should be expected to be challenging during times of high clinical pressure on both Hospital Trusts and may require senior medical input.
- Pain assessment was not undertaken and documented on the NEWS observation chart.

The learning from the HSIB investigation and Coroner’s Inquest will be included in future reports.

Case 2 Q3 2022/23

This was a death of a woman who was originally booked in a hospital outside of the Cheshire and Merseyside network. She delivered at LWH due to a fetal/neonatal condition which resulted in a neonatal death. She was discharged to her local hospital subsequently home, where she died unexpectedly. This is not recorded as an LWH maternal death due to the antenatal and postnatal care being provided by another organisation.

The DRAFT HSIB report has been provided and although the patient did not receive input from LWH following discharge there were some key learning points relevant to the reporting trust that we have taken and outlined in the appendix paper on maternal mortality. We have used this case at the MPMET training days to reiterate the need for the appropriate investigations to be done in a timely fashion.

This death will continue to be investigated via the coroner with the Trust contributing to that investigations.

Case 3 Q4 2021/22
In Q4 22/23 2021/22, 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 the Ockenden review, a multiagency review has been completed. The Coroner's inquest has not yet taken place but is planned for Q2/3 22/23. The internal SI has been completed with learning included in previous 'Learning from Deaths' report. The outcome from the Coroner's investigation will be included in this report when available.

1.3 Gynaecology Mortality data Q1 2022/23

There was 1 expected deaths within Gynaecology Oncology in Q1 2023/24.
There were 0 unexpected deaths within Gynaecology services in Q1 2023/24.

2023/24	Expected	Unexpected	Deaths of LWH patients transferred as in-patients
Q1	1	0	0
Q2			
Q3			
Q4			
ANNUAL	**1**	**0**	**0**

1.4 Learning from Gynaecology Mortality Q4 22/23 2022/23

There were two unexpected deaths of women who underwent surgery at LWH and then subsequently deteriorated post-operatively (both in Q2 2022/23). These were both subject to SIs that provided learning in Q1 23/24. (NB Details of one of these deaths was included in the previous Learning from Deaths report).

Both were transferred to the Royal Liverpool Hospital where they died later. Joint SI investigations were completed for both. The root cause for both incidents was the lack of an onsite surgical team, CT scanner (at the time) and radiology department on the LWH site t resulting in the post operative management of potential bowel obstruction/ complication being managed in isolation and not as "shared care" with other surgical specialties.

Given the identification of lack of co-location with adult acute services being a contributor to the above 2 deaths, a retrospective review of SIs since 2018 from the gynaecology and clinical support services divisions was undertaken. This review identified two post operative deaths since 2018. In 2020, one woman died at LWH following a deterioration in the post operative period. She had several co-morbidities. The cause of death was a pulmonary embolus. She was managed by LWH teams with no

input from adult acute services (2020 – 25044). A second woman deteriorated post-operatively with sepsis. She was transferred to St Helens and Knowsley hospital for support and further surgery (SI 2019-11592). Neither of these two cases identified lack of co-location with adult services as a root cause of the death. However the woman in the second case was transferred for ongoing care as the care required could not be provided on the LWH site due to lack of on-site adult acute services.

2 Stillbirths

2.1 Stillbirth data

There were 4 stillbirths, excluding terminations of pregnancy (TOP) in Q1 2022/2023. This has resulted in an adjusted stillbirth rate of 2.3/1000 live births for Q4 22/23. This is the lowest stillbirth rate for past 3 years although caution must be taken in interpreting small numbers.

STILLBIRTHS	July-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-22	May - 22	June-22	TOTAL 2023/24
Total Stillbirths	7	3	3	2	2	6	2	4	1	5	4	10	19
Stillbirths (excluding TOP)	**3**	**3**	**1**	**1**	**2**	**5**	**1**	**3**	**0**	**0**	**2**	**1**	**3**
Births	645	659	656	649	596	619	630	519	613	613	599	554	1766
Overall Rate /1000	10.9	4.6	3.0	4.7	6.7	9.7	3.2	7.7	1.6	8.2	6.7	18.1	10.8
Rate (excluding TOP)/1000	**4.7**	**4.6**	**1.5**	**1.6**	**3.4**	**8.1**	**1.6**	**5.8**	**0**	**0**	**3.3**	**1.8**	**1.7**
Pregnancy loss 22-24 weeks (excluding TOP)	0	0	1	1	1	1	1	0	0	1		2 (twins)	3

Table 1 Stillbirth rates for 2022-23. The stillbirth rate is 1.7/1000 births

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23	Rate 2022/23
Q1	4.0	5.5	4.0	3.7	1.7
Q2	4.1	2.5	5.3	3.6	
Q3	1.5	2.7	5.1	4.3	
Q4	1.7	3.2	5.0	2.3	
ANNUAL	2.9	3.4	4.9	3.5	

Table 2: Quarter and Annual Stillbirth rate/1000 births since 2019/20 (excluding terminations)

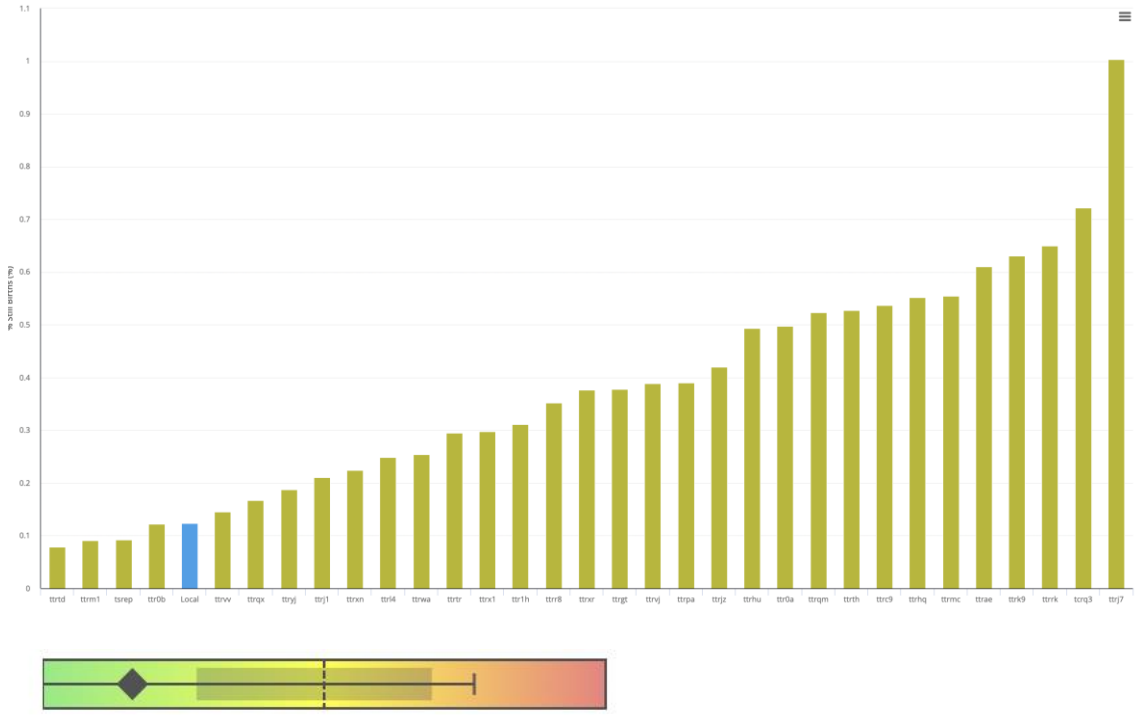


Figure 1 and 2. Stillbirth data with LWH benchmarked against other large maternity services (>7000 deliveries) Q1 2023-24. The blue bar and triangle are LWH data demonstrating the observed rate is within the lowest quartile for stillbirths.

The stillbirth rate for Q1 23/24 is the lowest since 2019/20. When benchmarked against similar large organisations, we are below the interquartile range and at the lower end for stillbirth mortality. Whilst this is encouraging, the numbers are small and future quarters data will need to be reviewed.

Two stillbirths related to antepartum haemorrhage, one of these was an unbooked pregnancy in a woman of Asian Bangladeshi origin who did not speak English as her first language. Translation services were used appropriately.

Of note, there was a case of stillbirth of a 14-year-old girl who received antenatal care in LWH, but had presented septic and managed in another trust. She sadly experienced a stillbirth at 28 weeks in Alder Hey Hospital. This case is planned to be a region wide review coordinated by ICB due to the issue of non-colocation nature of the maternity services in Liverpool.

2.1 Learning from Stillbirth and PMRT reviews Q4 22/23 2022-23 N=11

All eligible cases (Stillbirths > 22 weeks but excluding ToPs) underwent a full multidisciplinary team PMRT review with external clinician presence. Care from across the antenatal and intrapartum period was subject to clinical and managerial scrutiny. 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 reviews of Q4 22/23 stillbirths (n=5) identified that 2 (40%) cases had no antenatal care issues identified and 3 (60%) had care issues identified which would not have changed the outcome of the pregnancy. The postnatal care in all cases (5/5, 100%) was graded B, including arranging stillbirth investigations, including genetic tests, which remains a recurrent issue. The team has met to discuss an action to address this, building this into the training of honeysuckle support champions.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	2	40	0	0
B	3	60	5	100
C	0	0	0	0
D	0	0	0	0

Table 3 PMRT review panel grading of care provided in cases of Stillbirth (N=5)

The attached appendices provide information on progress with on-going actions from related to prior still

3. Neonatal Mortality

3.1 Neonatal mortality Data Q1 2022/23

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 (reported in MBRRACE), those occurring prior to discharge from the NICU and those who die following transfer to another hospital. The population examined may be defined by weight and/or gestational age. The data may include or exclude babies with congenital anomalies. Due to the complexities of measuring neonatal mortality, a board development session is taking place in September 23 to educate and update around neonatal mortality.

The table below presents the total number of deaths at LWH, the mortality for babies born at LWH, the number of deaths eligible to report to MBRRACE and the number of deaths of inborn babies born at between 24 to 31+6 weeks gestational age. This last group is reported national by the national neonatal audit project and monitored locally by the ODN. The benchmark of 6.3% is locally derived bu thte ODN. The threshold was the overall mortality in the UK between 2015 – 2018 for the population of 24 – 31+6 week babies. As LWH receives IUTs of (higher risk) preterm mortality it is unlikely that our mortality would be below the average for the whole population. This issue is being discussed with the ODN to identify a more suitable benchmark.

	Apr-23	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*March-24*	*Total*
Births	**613**	**599**	**554**										**1766**
Total mortality on NICU	3	1	6										**10**
INBORN Neonatal Mortality (all live births)	2	1	9*										**12**
INBORN Neonatal Mortality Rate/1000LB	3.2	1.7	10.8										**6.8**
MBRRACE eligible deaths *Excl. cong anom*	*0* *0*	*1* *1*	*3* *2*										*4*
Benchmark: MBRRACE data 2021 ***3.36/1000LBs*** ***(excl. cong anom) 1.44/1000LBs***	 *0* *0*	 *1.7* *1.7*	 *5.4* *3.6*										 ***2.3*** ***1.7***
NWNODN benchmark 24-31 w	*0*	*1*	*2*										*3*
Benchmark % (NNAP >6.3% of admissions)	*0*	*5.3*	*14.2*										*7.1*
NWNODN benchmark 24-27 w	*0*	*1*	*1*										*2*
Benchmark (NNAP >15%	*0*	*20*	*50*										*18.2*

**2 deaths in AHCH, 1 from surgical congenital anomaly, 1 from NEC; 1 death in YGC after re-patriation*

Table 4: NICU Mortality by month for the past 12 months. Red indicates breaching the NWODN threshold. This threshold however is being challenged as not appropriate for level 3 NICUs.

Quarter	NMR *in born*
Q1 (23_24)	6.8
Q2 (23_24)	
Q3 (23_24)	
Q4 (23_24)	

Table 5: Neonatal Mortality Rate per quarter.

In this quarter there was a total of 10 deaths on the NICU. There were 12 babies who were born at LWH who died before discharge – 2 deaths occurred in Alder Hey Hospital and 1 at Ysbyty Glan Clwyd.

There were 3 deaths in the preterm population (24 to 31+6 weeks). This resulted in a 7.1% mortality figure. The benchmark figure of 6.3% is derived from the overall mortality in this population nationally, however as LWH receives the majority of extreme preterm babies from Cheshire and Merseyside, the mortality in our inborn population would be expected to be higher than the national average. The use of this benchmark is being discussed with the ODN.

3.3. Learning from neonatal mortality reviews for Q4 22/23

There were 13 deaths subject to a PMRT review. There were no cases identified with care issues which were likely to have made a difference to the outcome.

There was 1 case (8%) where issues were identified in the antenatal care that may have affected the outcome. This was related to the escalation the timeliness of removal of a cervical suture. This case is being investigated through a maternity SI.

There were 4 cases (31%) where issues were identified in the neonatal care that may have affected the outcome. These issues were:

- In one case there was a delay in performing a chest x-ray due to lack of 24/7 radiographer provision. This has been escalated as a safety issue with executive approval for the on-site radiography cover to commence in Q2/3 2023/24.
- Non-colocation with surgical services and transfer between alder hey and Liverpool women's Hospital

- A femoral vessel bleed following an attempt at femoral line insertion. A serious incident review of this case has been concluded with an action plan developed.
- A delay in the management of hypotension and metabolic acidosis.

3.4 Update regarding mortality action plans.

The updated action plans from the Birmingham Women's Hospital review of mortality and the NWODN review of mortality are included in thois paper. The actions from the Birmingham Women's Hospital review were superseded by those from the ODN.

The Birmingham Women's action plan is complete. The NWODN action plan is complete or in progress and on track for completion. Of note, there has been recent approval to proceed with the 24/7 radiology cover for the LWH site. There remains the issue of non-colocation with neonatal surgical services. The planned opening for the neonatal intensive care unit at Alder Hey children's Hospital is January 2025.

The NWODN action plan is currently monitored through the neonatal integrated governance meeting and the LNP board.

4. Impact of In-utero transfers (IUTs) (see Appendix for report)

For this paper, in-utero transfers includes all women who originally booked their pregnancy elsewhere, but then delivered at LWH. This will include women who transfer their pregnancy following an antenatal diagnosis of congenital anomaly who will have a high mortality associated with them, as well as extreme preterm infants who require level 3 neonatal intensive care.

The previous external review of mortality by the NWODN highlighted that LWH received over 3.5x the number of IUTs than St Mary's Hospital, Manchester (134 vs 38 between 2019 - 2021). The reasons for this discrepancy are unclear and this has been raised with the NWODN to investigate further.

The data related to the two populations of babies IUT vs non-IUT is below.

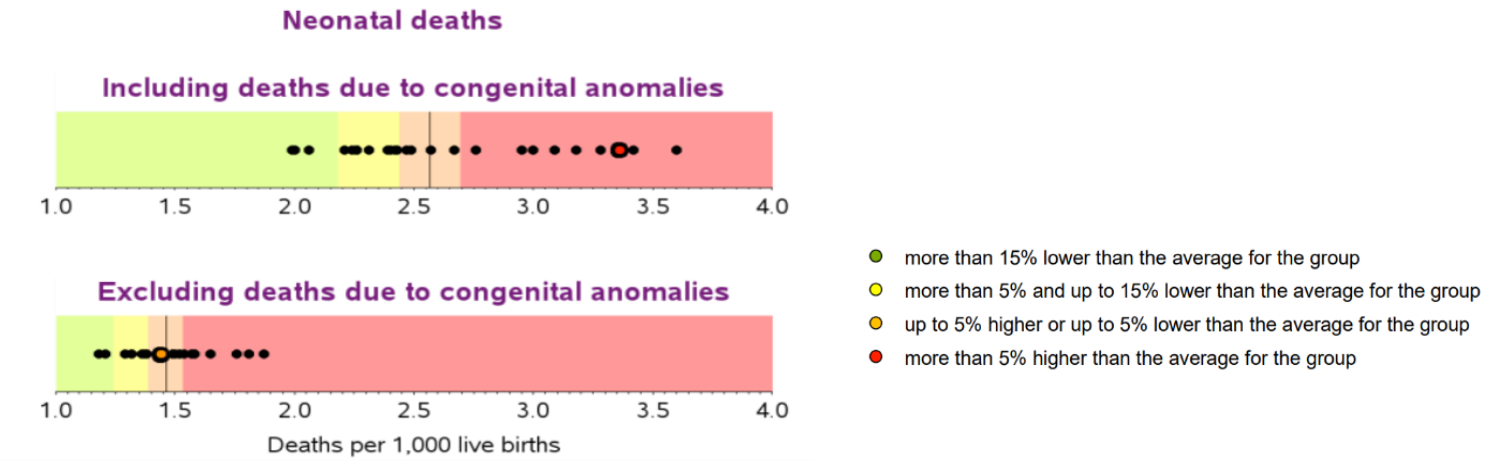
	Non-IUT admissions N=1965	IUT admissions N=295	Non-IUT mortality N=29	IUT mortality N= 26	Non-IUT mortality %	IUT Mortality %
Gestation	Range 22-42 w Median 37w	Range 22-41w Median 35 w	Range 22-41w Median 27w	22-40w Median 26w		
Female	877	124	7	8		
Male	1088	171	22	18		
<1500 g	144	98	26	15	18.1	15.3
<1000g	49	70	22	14	44.9	20
<750 g	24	29	15	11	62.5	37.9
<500g	2	2	2	2	100	100
22-23w	16	4	9	4	56.3	100
24-27w	40	61	15	10	37.5	16.4
28-31w	127	29	2	1	1.6	3.4
32-36w	694	69	2	5	0.3	7.2
>37w	1089	132	1	6	0.1	4.5
ALL					**1.5%**	**8.8%**

These data highlight the following:

- Over a 2-year period (2021 – 2023), IUTs accounted for nearly half (26/55, 47%) of all deaths at LWH.
- IUTs were 6x more likely to die than non-IUTs (1.5% vs 8.8%).
- The excess mortality is seen in the more mature infants (> 28 weeks) related to the presence of congenital anomalies.
- 37% (14/38) of the deaths in preterm infants (22 to 27 weeks) occurred in the IUT population.
- The mortality for the IUT population in this extremely preterm group was 22% (14/65) and in the non-IUT population was 43%.

In summary, the excess mortality for IUTs is mainly seen in the more mature infants related to the presence of congenital anomalies. This is to be expected as LWH is a tertiary/quaternary referral centre. Discussions with the NWODN and LMS are ongoing regarding the referral pathways into the fetal medicine unit as there are discrepancies between the planned pathways and the actual pathways followed from some referral centres outside of the Cheshire and Mersey network.

These data help to explain the MBRRACE data that shows LWH as an outlier for deaths overall, but not once congenital anomalies are removed. In other words, the overall mortality is high because we accept a large number of IUTs into our service who have congenital anomalies.



The IUTs do not explain the mortality seen in the extremely preterm population that benchmarks higher than the UK average.

On reviewing the grading of antenatal care related to IUTs there were care issues identified which may have made a difference to the outcome for the baby in 2/27 (7%) non-IUT and 3/21 (14%) IUTs. We have therefore not identified a difference in AN care gradings however these numbers are too small to make any meaningful interpretation.

5. Retrospective Review of Learning from Deaths reports since Q3 21/22

Given this learning from deaths paper has identified non co-location with acute services in 5 deaths/stillbirths, a retrospective review of the learning from Death papers since Q3 21/22 (when the current report author commenced writing the reports) was conducted. This identified there was 1 further death of a neonate in Q3 22/23 where non-colocation with paediatric services was deemed to be contributory to the death. (see table below).

	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
Adult Deaths	0	2	2	2	0	1	1
Adult deaths where non-colocation idenitifed in the learning	0	0	0	2	0	1	
Stillbirths (excl TOP)	10	9	10	7	8	4	3
Stillbirths non-colocation	0	0	0	0	0	0	
Neonatal Deaths (total)	11	13	13	17	16	17	
Neonatal Deaths where non-colocation idenitifed in the learning	0	0	0	0	1	1	

6. Recommendations

It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths.

Given the paper identifies several deaths related to non- co-location of maternity and adult/paediatric acute services, the Board is asked to note the following for assurance:

1. The last 18 months learning from deaths papers have been reviewed to identify deaths which may have been contributed to by non-colocation.
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It is recommended:

1. There is a wide-ranging review of the IUT pathways and discussion with the NWODN and LMNS regarding the discrepancies seen across the system and why LWH receives 3.5X the IUTs than other similar local providers.
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In addition, as per The Learning from Deaths framework requirements the Board is requested to note:

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- 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.
- the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system

3. Appendices