Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/106

MEETING	**Quality Committee**
PAPER/REPORT TITLE:	**Lessons Learnt from Mortality: Quarter 1 2020/21**
DATE OF MEETING:	Monday, 21 September 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts, Deputy Medical Director Allan Hawksey, Risk and Patient Safety Manager Louise Robertson, Consultant Obstetrician 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.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *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):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
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 process in place for learning from deaths.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

This is the 2020/21 Quarter 1 (Q1) learning from deaths report for the Trust.
There are processes in place for review in all three types of death at the Trust. Unlike other Trusts, **every** death in the Trust, including expected adult deaths, are reviewed.

Key areas the report addresses:

- All adult deaths, stillbirths & neonatal deaths have a mortality review conducted.
- No in-hospital or LeDeR related adult deaths occurred in Q1 of 2020/21.
- The Trust has a good reporting system in place for out-of hospital deaths.
- The stillbirth rate for Q1 is 5.5/1000 which represents a spike since the previous quarter and Q1 2019/20.
- Some of the increase in the stillbirth rate in Q1 of 2020/21 (5.5/1000) as compared to Q1 in 2019/20 (4.0/1000) is due to ~200 fewer births in Q1 of 20/21 compared to 19/20. Further review does not suggest that Covid-19 related changes contributed to these deaths other than the one case where ultrasound scan for growth was declined. There was a noticeable spike in non-fetal abnormality related stillbirths in May 2019 as well as in May 2020. Reviews have not shown any significance in the spikes occurring in the same month. No persistent care issue themes were identified.
- The overall standard of care in stillbirth and neonatal deaths was good with no cases grade 'D'.
- 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 2019/2020

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 Q1 Board assurance report regarding compliance with review process and learning from deaths. **It covers the first three months of the changes to clinical services as a consequence of 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.

Table 1. Overall mortality rate in the Trust 2019/20

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	TOTAL
ADULT	0	0	0										0
Obstetrics													
Gynaecology (Oncology)	0	0	0										0
Gynaecology (non-Oncology)	0	0	0										0
STILLBIRTHS													
Total stillbirths	1	5	4										10
Stillbirths (excl.terminations)	1	5	4										10
Births	597	582	639										1818
Overall Rate per 1000 births	1.67	8.59	4.27										5.5
Rate (excluding TOP) per 1000	1.67	8.59	4.27										5.5

NEONATAL MORTALITY Total Mortality	3	0	4									7
Deliveries	597	582	639									1818
Mortality Rate per 1000 Deliveries	5.1	0	6.3									3.9
Mortality for LWH in-booked babies	1	0	3									4
Mortality rate per 1000 LWH in-booked babies	1.7	0	4.7									2.1

1. ADULT DEATHS:

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

Adult deaths - Mortality reviews Q1		
	Maternity (Direct)	**Gynaecology**
No of Adult Deaths	0	0
No of Mortality Reviews completed	0	0
No of deaths requiring RCA's	0	0
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

Out of hospital adult deaths 2019-20

GYNAECOLOGY

There was 1 out of hospital Gynaecological death in Q1. This related to a Gynae-Oncology patient who had advanced endometrial cancer and was resident in care provision. Merseycare are currently undertaking a serious incident investigation and the Trust have provided a timeline of information to assist in the investigation. There are no current concerns relating to deficiencies in care provided by the Trust.

MATERNITY

One maternal death at 10 weeks, prior to the lady having her 12-week scan has been reported. It was a suspected suicide. The Trust awaits the findings of HM Coroner prior to commencing full review.

2. PERINATAL DEATHS

All Perinatal death in the Trust are subject to review using the Perinatal Mortality Review Tool. The tool grades care as shown in the table below.

Table 2: 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.

Stillbirth reviews and Key Themes

Table 3. Grading of antenatal care for babies in Q1 2020-21

Grade	Care in antenatal period
A	**2**
B	**6**
C	**3**
D	**0**
UNK	**0**

Table 4. Reasons for review panel grading of antenatal management when different care may or could have changed the outcome

Situation	Grading of care	Level of investigation	Learning
Referral for moderate risk condition not made to Consultant led clinic on transfer of care from a neighbouring Trust. Scan declined by main dept. during COVID-19	C	PMRT	Scan declined during Covid-19 as woman had had a recent scan in neighbouring Trust. Guidance for the management of thrombocytosis and whether it requires a referral to Consultant-led clinic is required.
Stillbirth at 32 weeks. PPROM admitted to ward. Delay in CTG in the morning	C	SI	The RFM guideline needs to specify a timeframe for CTG when reduced fetal movements are reported as an inpatient. Interpreters/Language Line should be used on ward rounds for agreeing plans of care with non-English speaking women A benchmark against methods of translator services used at other Trusts is required.
Stillbirth in a woman with dual maternal medicine condition and complex fetal abnormality.	C	PMRT	All high risk AN mothers should have a MDT discussion with neonates, maternal medicine consultant and Obs ward round consultant to plan threshold for delivery

Actions taken to address the findings

- Covid policies for growth scans have been reviewed and were compliant with national guidance.
- SOP for management of thrombocytosis has been completed
- Criteria for midwife referral to Consultant led clinic will be reviewed
- A service evaluation is required to ensure the service is meeting the needs of non-English speaking women with particular reference to interpreter services and communication.

- The RFM guideline is being updated to a timeframe for CTG when reduced fetal movements are reported as an inpatient.
- NEST team leader to link with other specialist midwifery teams to evaluate language barrier solutions and present these findings at Maternity Risk meeting
- This will tie in with the overall action plan for improving the perinatal journey of non-English speaking and other vulnerable women.

Progress on previous actions

- PGD for aspirin prescription and simplifying the aspirin prescription in pregnancy has been signed off
- Regional Pre-term labour guideline for counselling and management of extreme prematurity labour is being reviewed and updated at NW Coast Clinical Network level. An Obstetrician and Neonatologist from the Trust are part of the sub-group for this guideline.

Neonatal reviews and key themes

3 babies died in PICU at Alder Hey having been cared for in LWH, all 3 cases had ante-natally known congenital cardiac anomalies. One was originally LWH booked and 2 were non-LWH booked. All 3 cases were transferred for ongoing cardiac management; one with concurrent surgical concerns.

For babies who die in PICU, the case is reviewed through the Alder Hey mortality review process with neonatal input from LWNHSFT partnership team.

1 baby also died after repatriation to the local NICU with multiple complications of prematurity.

Table 5: Mortality (in-hospital) summary for Q1 20/21

Number of reviews	
	NICU* Total number (non-LWH booked)
No. of Neonatal Deaths	7(3)
No. of Mortality Reviews completed	5
No. of neonatal deaths requiring RCAs	1

Of the 2 deaths yet to have a full PMRT review completed, 1 case had an initial discussion however the panel were unable to grade due to lack of information from other care providers, and an

outstanding PM. This will be re-discussed at the next PMRT meeting, along with the other outstanding case.

Table 6. Grading of antenatal care for babies in Q1 2020-21

Grade	Antenatal management	Neonatal management
A	**0**	**0**
B	**4**	**3**
C	**1**	**2**
D	**0**	**0**

In Q1 5 out of 7 cases have had a full PMRT review to date. Of the 5 cases, 4 had neonatal care issues identified and 5 had antenatal care issues identified; there was 1 case with care issues after the death of the baby identified.

Of the 4 cases with neonatal care issues identified 2 were graded C (may have made a difference to the outcome for the baby). One of these cases has been subject to an SI investigation; the second case has a further review pending following the PMRT outcome.

Issues identified include:

- Arterial(femoral) line related injuries
- Insufficient surfactant dose administered

The other cases were graded B (issues would not have made a difference to the outcome) and included equipment not being set up at delivery, documentation and communication concerns from the parents' perspectives.

AN care issues were identified in all 5 cases; 4 cases were graded B for reasons including the placenta not being sent for histological examination, loss of AN follow up and delayed review of symptoms. One case was graded C due to missed opportunity for care in pre-term labour clinic despite having risk factors.

Actions taken to address the findings

These will be reported in Q2 following the SI review findings and further review following the PMRT outcome.

3. Conclusion:

The Board is asked to note that:

- All adult deaths, stillbirths & neonatal deaths have a mortality review conducted.
- No in-hospital or LeDeR related adult deaths in Q1 of 2020/21.
- The Trust has a good reporting system in place for out-of hospital deaths.
- Some of the increase in the stillbirth rate in Q1 of 2020/21 (5.5/1000) as compared to Q1 in 2019/20 (4.0/1000) is due to ~200 fewer births in Q1 of 20/21 compared to 19/20. Further review does not suggest that Covid-19 related changes contributed to these deaths other than the one case where ultrasound scan for growth was declined. There was a noticeable spike in non-fetal abnormality related stillbirths in May 2019 as well as in May 2020. Reviews have not shown any significance in the spikes being in the same month. No persistent care issue themes were identified.
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