University Hospitals of Leicester NHS
NHS Trust

# Cover report to the Trust Board meeting to be held on 3 June 2021

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| | **Trust Board paper J2** |
| **Report Title:** | **Quality and Outcomes Committee – Committee Chair's Report** |
| **Author:** | Hina Majeed – Corporate and Committee Services Officer |

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| **Reporting Committee:** | **Quality and Outcomes Committee (QOC)** |
| **Chaired by:** | Ms Vicky Bailey – Non-Executive Director |
| **Lead Executive Director(s):** | Andrew Furlong – Medical Director<br>Carolyn Fox – Chief Nurse |
| **Date of meeting:** | 27 May 2021 |

**Summary of key public matters considered by the Committee:**

This report provides a summary of the key issues considered at the Quality and Outcomes Committee meeting on 27 April 2021:- *(involving Ms V Bailey, QOC Non-Executive Director Chair, Professor P Baker, Non-Executive Director, Mr B Patel, Non-Executive Director, Mr I Orrell, Associate Non-Executive Director, Mr A Furlong, Medical Director, Ms C Fox, Chief Nurse, Ms B O'Brien, Director of Quality Governance, Ms C West, CCG Representative, Ms J Smith, Patient Partner, Mr P Aldwinckle, Patient Partner and Mr A Haynes, Adviser to the Trust Board. Ms L Cowan, Head of Operations, MSS, Mr Z Sentence, General Manager, Ophthalmology, Mr T Palser, Consultant Surgeon, Ms S Leak, Director of Operational Improvement, Dr H Brooks, Chair of the Cancer Board, Mr K Mayes, Head of Patient and Community Engagement attended to present their respective items.)*

- **Minutes and Summary of QOC meeting held on 29 April 2021** – papers A1 & A2 (public and private QOC Minutes from 29 April 2021) were accepted as an accurate record and papers A3 & A4 (public and private QOC summaries from 29 April 2021) were received and noted, having been submitted to the Trust Board on 6 May 2021.

- **Matters Arising Log** – paper B noted.

- **Ophthalmology Long Term Follow-Up (LTFU) Update**
  The Head of Operations, MSS and General Manager, Ophthalmology attended the meeting to present paper C, which provided an update on the current position with ophthalmology long term follow-up. Members noted that systems and processes had been put into place to mitigate further risk. A process had been put in place to clinically assess patients to ensure that patients who were waiting were not coming to harm. The LTFU waiting list was being tracked and monitored and patients were being risk stratified through locally agreed criteria due to the absence of nationally defined risk stratification for outpatients. A Task and Finish Group had been established to focus on short-term mitigating actions, the action plan from this Group had been appended to the report. The longer term work regarding restoration and recovery/system planning would come under the LLR Ophthalmology Steering Group. Work was underway with System colleagues to access cost effective in-sourcing and out-sourcing capacity. Members noted that significant activity had been transferred from UHL to a community setting in order to create additional capacity for follow-up patients who needed to be seen in a secondary care setting. The Leicester, Leicestershire & Rutland Community Eye Service (LLRCES) scheme had been established to support the care of emergency patients in the community and reduce attendance at the Emergency Department. This service had been funded via Covid-19 funding and was currently funded until September 2021. A longer term funding source was needed and the Clinical Commissioning Groups were exploring options. Further to a detailed discussion, it was noted that progress had been made and there was System ownership in respect of this matter. However, there remained partial assurance in terms of the achievement of a reduction in the backlog particularly due to workforce challenges. In conclusion, it was agreed that a further update be provided to QOC in September 2021 and an update on the following also be included - long term funding for the LLRCES scheme, any issues in relation to health inequalities and management of new follow-up patients.

- **Integrated Quality Assurance System (IQAS)**
  Mr T Palser, Consultant Surgeon attended the meeting to present paper D, an update on the Integrated Quality

Assurance System (IQAS). This system brought together multiple data sources to provide business intelligence and drive improvement. There was potential for the system to be further developed in order that there was one central source of data, however, this was subject to availability of resources and integration of the Trust's different IT systems. The system would be piloted across Vascular Services, General Surgery and Urology in June 2021 and across surgical specialities in October 2021, with full roll-out expected by the end of March 2022. The plan was to include finance and equity metrics during the course of the year and specialty-specific metrics in future. The system was based on the Qliksense platform. Mr Palser gave a demonstration of the system showcasing the dashboard and breakdown of metrics by CMG, data relating to clinical audit and the GMC survey had also been included. Members commended the system noting that it was a comprehensive clinical performance system. It was agreed that an update on next steps/resources required would be provided to QOC, further to discussion at EQB once the roll-out to the pilot specialities had been completed. The CCG Representative also highlighted the opportunities this system was likely to provide and suggested that a presentation be given to the System Quality and Performance meeting, when UHL colleagues thought it was appropriate.

- **Cancer Performance Recovery**
  The Director of Operational Improvement and the Chair of the Cancer Board attended the meeting to present paper E. Members were advised that 6 of the cancer-related performance targets had been achieved in March 2021. The biggest challenge remained the 31-day surgery waits due to decreased theatre capacity and the growing 104-day backlog. There had been a significant increase in 2-week wait referrals which would have subsequent challenge to the 31-day and 62-day performance depending on conversion numbers. A decrease in staff uptake of waiting list initiatives in ENT and Skin Services would have an impact on the 2-week wait performance, however, it was noted that some actions were being put in place to resolve this matter. The Director of Operational Improvement was optimistic that there would be a sustained recovery of 31-day backlogs with the increased theatre capacity. Feedback from the CQC visit in respect of a review of management of cancer pathways during Covid-19 was expected to be provided in June 2021. The Chair of the Cancer Board reiterated that capacity was being managed based on clinical need. In response to a suggestion from Ms J Smith, Patient partner, the Director of Operational Improvement undertook to contact colleagues in Barts Health NHS Trust to source ideas on improving UHL's cancer performance position. The Medical Director advised that this report had been discussed in-depth at the Executive Finance and Performance Board in May 2021 and the performance on the trajectory would be monitored through the CMG Performance Review Meetings. In response to a comment from Mr A Haynes, Adviser to the Trust Board in respect of health inequalities and impacts, the Director of Operational Improvement advised that work was underway with Public Health England in relation to colorectal cancer survival rates at UHL. Although QOC was assured on the harm review process, it noted the current performance position was challenging. In a brief discussion on demand/capacity, the Medical Director advised that the H2 planning guidance for 2021-22 had indicated that plans should be based on capacity and not demand. The contents of this report were received and noted.

- **Patient Engagement Update**
  The Head of Patient and Community Engagement attended the meeting to present paper F, an update on patient engagement activity undertaken over the last six months. Since the onset of the Covid-19 pandemic, all face to face engagement had been suspended and virtual engagement activity had been put in place instead. Although Covid-19 had challenged the implementation of the 2019 Patient and Public Involvement (PPI) Strategy, it had also presented new opportunities to approach PPI. In discussion on the Trust Board's support for a 'co-production' approach to PPI, Mr B Patel, Non-Executive Director suggested a 'fresh eyes' approach be taken given that patients, carers and families who used the Trust's services would be more informed and could make a difference if they worked in partnership with Clinicians and Managers. In response to a query from Ms J Smith, Patient Partner in respect of re-commencing face to face engagement, the Committee Chair suggested that this be discussed outwith the meeting. The contents of the report were received and noted and a further update was requested to be provided in November 2021.

- **Quality Transformation Update**
  The Director of Quality Transformation and Efficiency Improvement presented paper G, an update on the role and functions of the Transformation Team. The aim of the Transformation Team was to deliver true transformation internally and across the system by providing better value for money and improved outcomes for patients. The Transformation Team strategy report, structure and proposed improvement road map were received and noted. In discussion on a dosing schedule/model, it was agreed that the Mr A Haynes, Adviser to the Trust Board and the Director of Quality Transformation and Efficiency Improvement should have a discussion outwith the meeting.

- **Quality Impact Assessment (QIA) Process for CIP**
  The Director of Quality Transformation and Efficiency Improvement presented paper H, which set out some of the lessons learned from the 2020-21 QIA process, the proposed changes for 2021-22 and next steps. A revised CIP Project Initiation Document (PID) would be introduced. The CMG CIP trackers would be reviewed to identify those

schemes which did not need a QIA. It was hoped that the new process would be streamlined and that QIAs would be easier to complete and review. Quarterly updates on the 2021-22 CIP scheme QIA process would be presented to EQB and QOC. The QOC Chair suggested that (a) in due course, a review of the revised approach to quality impact assess CIP schemes be undertaken to ensure that the required outputs from this process were being achieved, and (b) in future, consideration be given to whether the new process had had an impact and if it had brought about a transformative change.

- **UHL Mortality and Learning from Deaths Report**
  The Medical Director presented the latest quarterly report (paper I refers) – Quarter 4: January to March 2021 - relating to learning from deaths, the contents of which were received and noted and ***recommended onto the Trust Board for its approval*** **(appendix 5 attached to this summary)**. A summary of UHL's mortality rates, both risk adjusted and crude was presented and discussed. Members were reminded that the Trust had commissioned Dr Foster Intelligence (DFI) Consultant to undertake a deep-dive analysis of UHL's HSMR data which had highlighted 6 diagnosis groups that warranted further review. It was noted that reviews had been completed for 3 (Septicaemia, Acute Bronchitis and Senility and organic mental disorders) of these diagnosis groups. The Medical Director advised that UHL's Summary Hospital Mortality Indicator (SHMI) for 2020, was still within expected range but was now above 100 at 103. The latest Hospital Standard Mortality Ratio (HSMR) between February 2020 and January 2021 was 115 and continued to be above expected. All Covid-19 activity and deaths had been excluded from the SHMI (around 2.8% of admissions) but some Covid-19 activity had been included in the HSMR where Covid-19 had been a secondary code. UHL's crude mortality for 2020-21 was 1.9% which reflected both the reduced activity and increased number of deaths resulting from the Covid-19 pandemic. The DFI Consultant had also highlighted the need for a review of the Trust's palliative care coding. The review indicated that due to remote working, coders had not been able to review patients' medical records and therefore were not always aware of palliative medicine input. Retrospective re-coding had now been completed and re-submitted, the impact of these changes would be seen at the end of May 2021. In relation to the step-wise change in the 'Pneumonia' diagnosis group, the Respiratory team would be reviewing the relative risk to ascertain if there had been any changes in the pneumonia pathway. The number of Covid-19 admissions and deaths had been reviewed and UHL's crude mortality for the Covid-19 diagnosis group 'Viral Infection' was below the average of all Acute Trusts. One of the main developments in Quarter 4 of 2020-21 included the Paediatric Medical Examiner (ME) secondment, it was noted that discussion was underway with the Children's Hospital and Paediatric Emergency Department about next steps. Following the successful pilot of providing a ME service to LOROS and the limited pilot within Primary Care, the Trust had been notified of plans to extend the ME process to cover all deaths in all health care sectors and for Acute Trusts to act as 'host ME offices'. A proposed approach to phased implementation of the ME service within LLR was discussed. The Quarterly Perinatal Mortality Report was set out in **appendix 7 (attached to this summary)** and members were advised that the perinatal mortality rate for the first 3 months of 2021 was approximately in line with previous years. In conclusion, it was noted that the 3 deep-dive reviews undertaken so far into sepsis, acute bronchitis and delirium had not identified major issues with clinical pathways but had identified some learning points in a number of cases.

- **2021-22 Quality and Performance (Q&P) Report Month 1**
  The Medical Director and Chief Nurse presented the Month 1 Quality and Performance report (paper J refers), which provided a high-level summary of the Trust's performance against the key quality and performance metrics and complemented the full Quality and Performance report. The Chief Nurse and Medical Director highlighted the following in particular:- (a) 8 C Difficile cases in-month, although this was below trajectory, it would be reviewed at the Infection Prevention Committee; (b) reduction in nosocomial infections in respect of Covid-19; (c) SMS text messaging service had now commenced in ED, which had led to an improvement in the Friends and Family Test indicator; (d) one never event reported in April 2021; (e) deterioration in performance in respect of Fractured Neck of Femur and Stroke TIA indicators – it was noted that the respective Services had been requested to provide further reports to the Executive Finance and Performance Board in July 2021, and (f) improvement had started to be seen in the turnaround times of clinic letters due to actions taken by CMGs locally. The Committee received and noted the contents of this report.

- **Patient Safety Highlight Report**
  The Director of Quality Governance presented paper K which detailed the monthly update on patient safety, including complaints data. Specific points of note highlighted in this month's report included: (1) update from the Parliamentary and Health Service Ombudsman (PHSO) on changes to their service in relation to complaints process and the impact that this might have on UHL referrals; (2) new learning resource from NHS Resolution (NHSR) about retained foreign objects post-procedure. In response to a query from Ms J Smith, Patient Partner, the Medical Director provided a brief update on the Safer Surgery workstream in place within the Trust; (3) actions required by the Patient Safety Specialists to commence work to align UHL to the NHS Patient Safety Strategy, and (4) the risk and actions being taken in relation to the Patient Safety Team staffing. The contents of this report were received and noted.

- **Covid-19 Position**
  The Medical Director and Chief Nurse reported orally and briefed the Committee on key issues in relation to the COVID-19 pandemic, highlighting the following matters in particular: (a) the number of Covid-19 patients being treated currently within the Trust remained low; (b) surge testing and vaccination update, and (c) visiting arrangements and meeting arrangements within the organisation would be kept under review.

- **Items for noting**
  The following reports were received and noted for information:-
  **(1) Organ Donation at UHL - Update** (paper L);
  **(2) Deteriorating Patient, Resuscitation and End of Life and Palliative Care Quarterly Report** (paper M);
  **(3) Infection Prevention – Board Assurance Framework (BAF)** (paper N) – members were advised that the BAF had been reviewed and updated in line with the recommendations of NHSE/I;
  **(4) Safeguarding Annual Report 2020** (paper O);
  **(5) Care of Patients with a Learning Disability at UHL – Annual Report 2020** (paper P);
  **(6) NIPAG Annual Report** (paper Q);
  **(7) Data Quality and Clinical Coding Report** (paper R), and
  **(6) EQB Minutes – 13 April 2021** (paper S).

**Public matters requiring Trust Board consideration and/or approval:**

***Recommendations for approval***

- **Learning from Deaths Quarterly Report (appendix 5 appended).**

***Items highlighted to the Trust Board for information***:

- **Quality Impact Assessment Process for CIP** – to note that this process was fundamental to ensure appropriate governance on CIP schemes;
- **Infection Prevention – Board Assurance Framework (BAF)**;
- **Safeguarding Annual Report 2020**, and
- **Care of Patients with a Learning Disability at UHL – Annual Report 2020.**

**Matters deferred or referred to other Committees:** none.

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| **Date of next QOC meeting:** | 24 June 2021 |

**Ms V Bailey – Non-Executive Director and QOC Chair**

# UHL'S LEARNING FROM DEATHS

MAY 21

# UHL's "Learning from Deaths" Framework

- **Medical Examiners (MEs)** – (Currently 12 MEs working the 0.5- 2 PA a week). ME process includes all ED and Inpatient adult cases – MEs support the Death Certification process and undertake Mortality Screening – to include speaking to the bereaved relatives/carers and 'proportionate scrutiny' of the deceased's clinical records (paper and electronic) .
- Where Screening identifies potential areas for learning by the clinical team(s), the case will be sent to the relevant Specialty for further review.
- **Specialty Mortality & Morbidity Programme (M&M)** – involves full Mortality Reviews (SJRs) where meet National criteria (death of a child/neonate; death of a patient with a Learning Disability or Serious Mental Illness; death following an elective procedure) or are referred by the ME or members of the Clinical Team.
- M&M meetings confirm Death Classification, Lessons to be Learnt and should oversee the taking forward of agreed Actions to improve the care for all patients
- **Clinical Teams** – responsible for reviewing the care of patients where Mortality screening has identified potential learning about the end of life care or other patient experience issues
- **Bereavement Support Nurses (BSSNs**)– 'follow up contact' for bereaved families of adult patients, liaises with both the MEs and Clinical Teams where families have unanswered questions or their feedback to the Medical Examiner has led to a request for further review of care.
- The BSSNs also sign post the bereaved to appropriate support agencies where unmet bereavement needs identified.
- **Patient Safety Team (PST)** – if a death considered to be due to problems in care, will review against the Serious Incident reporting framework and take forward as an investigation where applicable.
- **Mortality Review Committee (MRC)** – oversee the above and support cross specialty/trust-wide learning and action

# MEDICAL EXAMINER PROCESS

- The ME process involves:

– Preparing relevant clinical information to support effective discussion with the certifying doctors i.e. Datix, Ambulance Records, NerveCentre, ICE letters, CITO records and latterly ICE COVID results (Medical Examiner Officer)
– Identifying the appropriate doctor to discuss cause of death (Bereavement Services)
– Discussion with the Certifying Doctor and agreeing cause of death or referral to the Coroner (occasionally completing MCCDs/Crem Forms on behalf of Clinical Team)
– Reviewing Coronial Referrals (occasionally completing referrals on behalf of the ED team)
– Explaining the proposed cause of death to the Next of Kin and giving them the opportunity to ask questions about this or care provided
– Proportionate Scrutiny (screening) of the electronic and paper clinical records
– Triangulating the above to make a judgement as to whether any need for further review by the Specialty M&M or Clinical Team or for feedback for reflection and learning

– In Quarter 4 the MEOs prepared and the MEs discussed 1,249 deaths with the Clinical Team
– The MEs then spoke to 1046 bereaved relatives and 1262 patients' records were screened

# OVERVIEW OF UHL'S ME PROCESS IN 20/21

| CAUSE OF DEATH OR CORONER REFERRAL DISCUSSED WITH THE MEDICAL EXAMINER? | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes | % Yes | Adult - No | Neonate - No | Child - No | Comm Death - No | Stillbirth | ALL DEATHS |
| Q1 | 990 | 98.2% | 2 | 10 | 6 | 8 | 7 | 1023 |
| Q2 | 707 | 99.6% | | 2 | 1 | 3 | 11 | 724 |
| Q3 | 1019 | 99.4% | | 4 | 2 | 4 | | 1029 |
| Q4 | 1249 | 98.6% | 2 | 15 | 1 | 14 | | 1281 |
| | **3965** | **98.9%** | **4** | **31** | **10** | **29** | **18** | **4057** |

| PROPORTIONATE SCRUTINY OF CLINICAL RECORDS? - ADULT DEATHS | | | |
|---|---|---|---|
| | Yes | No - Comm Death | % Yes |
| Q1 | 994 | 1 | 99.9% |
| Q2 | 691 | 3 | 99.5% |
| Q3 | 988 | 5 | 99.5% |
| Q4 | 1242 | 8 | 99.3% |
| **ALL** | **3915** | **17** | **99.3%** |

| BEREAVED SPOKEN TO BY THE MEDICAL EXAMINER | | | | | | |
|---|---|---|---|---|---|---|
| QUARTER | Yes | No | Taken for Invx by the Coroner | Child/ Neonatal Death | ALL | % YES (where not Coroner Case or Child Death) |
| Q1 | 838 | 103 | 65 | 17 | 1023 | 89% |
| Q2 | 524 | 94 | 83 | 23 | 724 | 85% |
| Q3 | 863 | 67 | 76 | 23 | 1029 | 93% |
| Q4 | 1046 | 116 | 95 | 24 | 1281 | 90% |
| **ALL** | **3271** | **380** | **319** | **87** | **4057** | **90%** |

- Due to ME capacity, not all Community Deaths were discussed with the ME (these were discussed directly between the Coroner's Officer and Certifying Doctor
- Similarly we saw a drop in % of bereaved relatives having a discussion with the ME. As before this was predominantly relating to deaths at the LGH/GH. We have now changed our process completely and relatives are phoned without waiting for the case notes to come over
- Reassuringly we have been able to screen almost all deaths albeit there were delays with the process which will have had a knock on effect of sending out requests for further reviews.

# MEDICAL EXAMINER SCREENING OUTCOME

- There were 3942 adult deaths that were included in the UHL Learning from Deaths programme in 20/21
- This included deaths at LOROS where ME discussion/review identified potential learning for UHL
- 2,745 deaths were not referred for further review as no potential learning identified as part of the ME Screening
- All Child or Neonatal Deaths have been included in either the Child Death Review or Perinatal Mortality Review process as per national requirements
- The table below shows the outcome where further learning identified as part of the ME screening process or the death met other national or local criteria
- During 20/21, if possible the Medical Examiners have tried to address concerns raised by the bereaved or have involved the Bereavement Nurses in order to reduce the burden of further reviews being undertaken by the Clinical team
- Theming of learning identified through the ME process will be reported to the June MRC

| Why Review/Feedback | SJR | Clin Review | Feedback | Investi-gation | PST F/Up | Theme | BSS F/Up | ALL |
|---|---|---|---|---|---|---|---|---|
| 1. ME | 121 | 187 | 121 | | 8 | 268 | | 705 |
| 2. Relatives | 17 | 83 | 182 | | 18 | 26 | 42 | 368 |
| 3. Child /Neonate | 107 | | | 7 | | | | 114 |
| 4. Elective Proc | 36 | | | | | | | 36 |
| 5. Learning Disabiltiy | 38 | | | | | | | 38 |
| 6. SMI | 41 | 3 | | | 1 | | | 45 |
| 7. QI Project | | 1 | | | | | | 1 |
| 8. Specialty | 54 | 8 | | | | | | 62 |
| 9. Bereavement Nurses | 1 | 1 | | | | | | 2 |
| 10. Pt Safety Team | 3 | | | 1 | 2 | | | 6 |
| **ALL** | **418** | **283** | **303** | **8** | **29** | **294** | **42** | **1377** |

# BEREAVEMENT SUPPORT NURSES

| | Verbal Contact Made | Not able to Contact by Phone (Letter sent) | F/up contact declined or No NoK | In Progress | Grand Total | % Verbal Contact made, where requested |
|---|---|---|---|---|---|---|
| Q1 | 492 | 146 | 357 | | 995 | 77% |
| Q2 | 307 | 121 | 267 | | 695 | 72% |
| Q3 | 556 | 190 | 253 | | 999 | 75% |
| Q4 | 648 | 230 | 284 | 91 | 1253 | 67%* |
| | **2003** | **687** | **1161** | **91** | **3942** | **72%** |

- Follow up contact is still being made with bereaved families of patients who died in March (9%)
- The Bereavement Nurses have worked extremely hard to speak to relatives where 'follow up contact has been requested'. This will include the increased number where the Medical Examiners have asked for early contact to be made because relatives are particularly distressed.
- It should also be noted that in addition to making contact with 100 more families in Q4, the Bereavement Nurses have played a key part in keeping the ME/LfD process on track during the significantly increased activity in Quarters 3 and 4.
- A full update on the Bereavement Nurses work during 20/21 will be submitted to the July MRC

# PROGRESS WITH REVIEWS – ADULT DEATHS

| | Clin Reviews /SJRs /Invx | Completed | % Completed | Review in Progress | | SJRs Requested | SJRs Completed | % Completed |
|---|---|---|---|---|---|---|---|---|
| Q1 | 158 | 107 | 68% | 51 | | 81 | 67 | 83% |
| Q2 | 165 | 112 | 68% | 53 | | 80 | 63 | 79% |
| Q3 | 175 | 87 | 50% | 88 | | 79 | 44 | 56% |
| Q4 | 168 | 57 | 34% | 111 | | 71 | 12 | 17% |
| | **666** | **363** | **55%** | **303** | | **311** | **186** | **60%** |

2 deaths thought to be related to problems in care following review by the Specialty M&M. Both have been discussed at MRC and further information requested for one – due to be discussed at the June MRC

2 additional cases discussed at the May MRC as the Specialty M&M considered deaths were related to problems in care. MRC asked for further details for both and also about proposed actions but provisionally supported the Specialties' decision (see next slide.

## COMPLETED SJRs BY CMG – ADULT DEATHS

| | Completed | Review in Progress | Adult SJRs | % Completed |
|---|---|---|---|---|
| CHUGGS | 68 | 24 | 92 | **74%** |
| ESM | 56 | 46 | 102 | **55%** |
| ITAPS | 4 | 5 | 9 | **44%** |
| MSS | 8 | 6 | 14 | **57%** |
| RRCV | 48 | 41 | 89 | **54%** |
| W&C | 2 | 3 | 5 | **40%** |
| | **186** | **125** | **311** | **60%** |

The LfD team are currently checking that all completed SJRs have been received and inputted into the LfD Database in order to send out an end of year progress report to all the M&M Leads

Learning and actions identified through Specialty reviews will be included in the next Quarterly report

# Deaths related Problems in Care

**M&M Ref 2664**

- There were delays in making the diagnosis, subsequent referral to Cardiothoracics and transfer to theatre for definitive, life-saving surgery. If these delays had not occurred then death may have been prevented

**ACTIONS**:

- ED lightning learning/ guideline for detection of thoracic dissection

**M&M Ref 3967**

- Elderly patient with prolonged period of unnecessary mobility due to delayed Orthopaedic Review which on balance of probability contributed to the development of HAP

**ACTIONS**

- Acute Medicine Learning Bulletin “Failure of teams to review patients requires escalation to consultant” and consultant to consultant referrals
- For discussion at the T&O M&M

# PERINATAL MORTALITY REVIEWS
## (Maternity Incentive Scheme for Trusts

**Safety action 1**: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

| REQUIRED STANDARD | ELIGIBLE | STANDARD MET? |
|---|---|---|
| i. (a) All perinatal deaths eligible to be notified to MBRRACEUK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days | 21 | Yes |
| i. (b) and the surveillance information where required must be completed within four months of the death. | 21 | Yes |
| At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021. | 20 | All in progress |
| For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought | 96 (end Mar 21) | Yes |
| Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion. | See Appendix 4 | |

# UHL perinatal mortality

Quarterly update, April 2021

## 1. UHL perinatal mortality figures

The reports provided by MBRRACE-UK analyse data almost 2 years in retrospect. We endeavour to analyse the perinatal mortality data prospectively to identify any concerning themes/trends.

| | Total SB | Corrected Stillbirths | SB rate | Total NND | Corrected Neonatal deaths | NND rate |
|---|---|---|---|---|---|---|
| **2009** | 86 | | | 48 | | |
| **2010** | 77 | | | 49 | | |
| **2011** | 63 | | | 43 | | |
| **2012** | 70 | 65 | | 51 | | |
| **2013** | 47 | 45 | 4.55 | 50 | 27 | 2.65 |
| **2014** | 56 | 51 | 4.59 | 46 | 23 | 2.37 |
| **2015** | 52 | 43 | 4.23 | 50 | 29 | 2.98 |
| **2016** | 55 | 47 | 4.25 | 52 | 25 | 2.39 |
| **2017** | 43 | 37 | 4.05 | 39 | 21 | 2.18 |
| **2018** | 33 | 26 | 3.48 | 56 | 28 | 2.69 |
| **2019** | 34 | 29 | | 46 | 24 | |
| **2020** | 48 | 40* | | 45 | 24** | |
| **2021 Jan to March** | 9 | 9 | | 11 | 7 | |

The stillbirth and neonatal deaths rates provided are the stabilised and adjusted rates provided by MBRRACE-UK, which allow for population size, deprivation, ethnicity and multiple births. They cannot be calculated locally.

* Predicted number of stillbirths after corrections for TOP

** Predicted number of neonatal deaths after corrections for <24 weeks and termination of pregnancy. This number is likely to be a slight underestimate, as there may be babies who were born in Leicester and died elsewhere to add to this figure.

Colour shading represents comparison to our peer trusts as provided by MBRRACE-UK. They have changed the definitions of the traffic-light colour codes in comparison with previous years, in an attempt to be aspirational and encourage trusts to further improve their mortality rates. So yellow is now 5-15% better than the peer group average (previously 0-10% better), and orange is within 5% better or worse (previously 0-10% worse). Our peer group of trusts (>6000 births with neonatal surgical facility) have a higher stillbirth and neonatal death rate than the national average due to the complexity of cases.

**Summary of 2019 data**

The 2019 data has now been verified with MBRRACE-UK, although the report analysing the data is not expected to be published until the end of 2021. However the crude figures do not give any cause for concern.

**Summary of 2020 data**

The number of stillbirths in 2020 was significantly above that of the previous 2 years. An excess of approximately 10 stillbirths was noted in the first quarter of 2020, with a return to normal rates for the remainder of the year.

A detailed analysis of the January stillbirths was presented to the Mortality Review Committee in March 2020. Two cases were undergoing RCA and escalation as Serious Incidents (one was already escalated prior to the review and one as a consequence of the review).

The review of February/March stillbirths was presented to MRC in August 2020.

Changes to practice due to the COVID pandemic were noted to have affected a small number of mortalities, however the other factors involved in these cases means that the changes to practice cannot be definitively linked to the deaths.

**2021 January to March**

The perinatal mortality rate for the first quarter of 2021 is approximately in line with previous years. The stillbirth rate appears to have returned to our baseline after the excess of stillbirths noted in the first quarter of 2020.

## 2. Perinatal Mortality Reviews

The summary report of the Perinatal Mortality Review Group for the quarter September to December 2020 is in appendix 1.

**Perinatal mortality review tool and the Maternity Incentive Scheme**

We achieved the standards required for Year 2 of the Maternity Incentive Scheme. Year 3 builds on these standards and increases the requirements for the reporting of perinatal deaths, and investigation using the Perinatal Mortality Review Tool. The requirements for Year 3 were modified in March 2021 to recognise the burden on Trusts due to the COVID pandemic. The requirement to use PMRT for deaths of babies born outside UHL has now been removed, although we may anticipate that this will be required for future years of the Maternity Incentive Scheme. The PMRT reviews undertaken within UHL have already met the standards set by the Maternity Incentive Scheme.

**NHS Resolution Maternity Incentive Scheme – Safety Action 1**
**Performance as at end April 21**

| STANDARD | TARGET % | ACHIEVED % | STANDARD MET? |
|---|---|---|---|
| a) i) Eligible Perinatal Deaths (from 11/01/21 onwards) notified to MBRRACE within 7 working Days | 100% | 100% | On Track |
| Surveillance information completed within 4 months | 100% | 100% | On Track |
| a) ii) Review started before 15th July 2021 using Perinatal Mortality Review Tool of eligible deaths between 20/12/19 to 15/03/21 | 95% | 98% | Exceeded |
| b) Draft Report completed by 15th July 2021 for deaths between 20/12/19 to 15/03/21 | 50% | 70% | Exceeded |
| c) Parents of deaths of babies born and died in UHL (from 20/12/19) told review taking place and their perspective of care sought | 95% | 94.4% | On Track* |

***The expectation is that we will be 95% at time of reporting on 15th July.**

### 3. Implementation of the Saving Babies Lives Care Bundle version 2

Implementation of this care bundle was finalised in March 2020. This care bundle has 5 elements:

1. Smoking cessation
2. Fetal growth surveillance
3. Fetal movement monitoring
4. Intrapartum fetal monitoring
5. Preterm birth prevention

Implementation was originally due by the end of March 2021, but has been adversely affected by COVID-19 (elements 1 and 2). Full implementation of this care bundle is required to meet the Year 3 standards for the Maternity Incentive Scheme. The main issue was with the implementation of the fetal growth surveillance element due to the significantly increased burden on the ultrasound pathway. However additional sonographer training was undertaken in late 2020 and a Task and Finish group drew up an action plan to assist with implementation. This part of the care bundle is now in place and fully implemented.

## 5. Summary

- COVID-19 has had a minimal effect so far on our perinatal mortality rate. A small number of cases may have been impacted by changes to practice due to COVID, however other factors mean that these changes cannot be definitively linked to the deaths.
- Changes to practice due to COVID-19 have now been lifted with the implementation of the Saving Babies Lives care bundle V2.
- The increased requirements for the use of the PMRT will require cross specialty working to embed its use for deaths outside maternity and neonatal services.

**Appendix 1**

**University Hospitals of Leicester Perinatal Mortality Quarterly Report**

**January to March 2021**

**Deaths occurring in January to March 2021**

| Month | Stillbirths | | | Neonatal deaths (up to 28 days) | | |
|---|---|---|---|---|---|---|
| | **Total** | **TOP** | **Corrected** | **Total** | **<24w/TOP** | **Corrected** |
| January | 3 | 0 | 3 | 4 | 2 | 2 |
| February | 4 | 0 | 4 | 3 | 1 | 2 |
| March | 2 | 0 | 2 | 4 | 1 | 3 |
| TOTAL | **9** | **0** | **9** | **11** | **4** | **7** |

One of the neonatal deaths was of a baby born outside Leicester. This was a preterm baby who had a difficult birth and significant cranial trauma, who died just a few hours after arriving in Leicester.

Of the 10 neonatal deaths of inborn babies, all had booked at UHL and intended to give birth in Leicester. Four of these babies were previable (gestations 19-22 weeks). Of the remaining 6 babies, 2 died from major congenital anomaly, 2 from complications of extreme prematurity, and 2 from hypoxic brain injury. One of these deaths is being investigated as a Serious Incident.

Of the nine stillbirths, none were due to termination of pregnancy. Gestation at stillbirth ranged from 24-41 weeks gestation. Four of the babies were at term, and 2 of these stillbirths are being investigated by the Healthcare Safety Investigation Branch (HSIB). All of these babies were normally grown. The five preterm stillbirths included three babies with major congenital anomaly (trisomy 18, cloacal exstrophy and a complex cardiac anomaly with hydrops), one baby with early onset growth restriction at 24 weeks gestation and a growth restricted baby in a woman with gestational diabetes.

**Perinatal mortality review meetings held in January to March 2021**

Review meetings were held on 15th January, 4th February, 11th March and 19th March

Cases discussed were from January to November 2020 (the January 2020 case was discussed very late due to a misplaced set of notes).

| | |
|---|---|
| 15th January | 1 SB, 2 ENND, 2 LNND and 1 late fetal loss |
| 4th February | 2 SB |
| 11th March | 3 SB, 1 ENND and 2 late fetal losses |
| 19th March | 1 ENND, 1 LNND and 2 late fetal losses |

None of the deaths were considered to be likely to have been due to issues with care.

Issues with care identified:

- Failure to refer for growth scan when fundal height measurement had significantly changed centiles
- Failure to offer postnatal karyotype of baby
- Change to scan schedule due to COVID contributed to failure to identify a growth restricted baby (although failure to attend some appointments may also have contributed)

Actions to be taken were added to the rolling action plan

Appendix 2 includes details of all actions agreed from cases discussed between January 20 to April 21.

# PERINATAL MORTALITY REVIEW GROUP ACTION LOG FOR CASES DISCUSSED BETWEEN JAN 20 – APRIL 21

| PMRT Ref | Action | Lead | By When | RAG |
|---|---|---|---|---|
| **C1.02/20** | Lack of an established pathway for management of babies at the limits of viability.<br>Implement the new BAPM guidance regarding management of preterm babies, including the guidance about management of babies at 22 weeks gestation. | RM/HoS NN | 29/02/20 | **5** |
| **C1.03/20** | (i) This mother was assessed as high risk and in need of aspirin but aspirin was not prescribed<br>**Individual feedback** | FC | 31/07/20 | **5** |
| **C1.03/20** | (ii) Induction or elective delivery was indicated but the timing of the induction/elective delivery was not appropriate for 'other' reasons To suggest to education team to include trauma scenario in future skills drills days | PM | 31/07/20 | **5** |
| **C1.03/20** | (iii) This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately<br>To suggest to education team to include trauma scenario in future skills drills days | PM | 31/07/20 | **5** |
| **C1.03/20** | (iv) This mother had a Caesarean section but this was not carried out with appropriate urgency<br>To suggest to education team to include trauma scenario in future skills drills days | PM | 31/07/20 | **5** |
| **C2.03/20** | (i) Estimated fetal weights from scans had not been plotted on a chart<br>To send out learning bulletin with learning points from mortality Cases | PM | 30/06/20 | **5** |
| **C3.03/20** | Estimated fetal weights from scans had not been plotted on a chart. Learning bulletin to be made with key messages from mortality reviews. | PMRG Chair | 31/05/20 | **5** |
| **C5.03/20** | (i) Referrals for scans and/or further investigations were not undertaken when required.<br>Scan to be booked even if the patient self-discharges | PM | 30/06/20 | **5** |
| **C5.03/20** | (ii) This mother presented on more than one occasion with reduced fetal movements after 28 weeks, a scan was indicated but not carried out.<br>Scan to be booked even if the patient self-discharges | PM | 30/06/20 | **5** |
| **C5.03/20** | (iii) This mother presented with reduced fetal movements, scans and /or other investigations were indicated but were not carried out<br>Scan to be booked even if the patient self-discharges | PM | 30/06/20 | **5** |
| **C6.03/20** | (i) The parents were not told that a review of their care and that of their baby is being carried out and (ii) The parents' perspectives and any concerns about their care and the care of their baby have not been sought<br>**A letter has been designed and will be given to bereaved parents on NNU explaining the PMRT review process** | RM | 30/05/20 | **5** |
| **C1.04/20** | (i) This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate<br>**To ensure is covered in redesign of bereavement paperwork** | HJ | 31/08/20 | **5** |
| **C1.04/20** | (ii) This mother was not assessed for the need for aspirin<br>**Feedback to the CMW involved in the p/t care** | FC | 30/06/20 | **5** |

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| RAG Status Key: | 5 | Complete | 4 | On Track | 3 | Some Delay – expected to be completed as planned | 2 | Significant Delay – unlikely to be completed as planned | 1 | Not yet commenced |
|---|---|---|---|---|---|---|---|---|---|---|

| PMRT Ref | Action | Lead | By When | RAG |
|---|---|---|---|---|
| **C2.04/20** | (vii) Large for dates on antenatal scan but HbA1c not carried out<br>**To highlight at sonographer team meetings to investigate if it is possible to link Viewpoint and GROW** | PMcP | 30/06/20 | **5** |
| **C2.04/20** | (i) During this mothers labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out<br>Feedback to individual and general comms via facebook page paperwork alterations to facilitate compliance | JR & HJ | 31/08/20 | **5** |
| **C2.04/20** | (ii) This mother's progress in labour was monitored on a partogram but the partogram was only partially completed<br>Feedback to individual and general comms via facebook page paperwork alterations to facilitate compliance | JR & HJ | 31/08/20 | **5** |
| **C2.04/20** | (iii) The confirmed/suspected delay in this mother's labour was not managed appropriately<br>Feedback to individual | JR | Completed | **5** |
| **C2.04/20** | (iv) This mother required oxytocin during her labour, but this was not managed appropriately<br>Feedback to individual | JR | Completed | **5** |
| **C2.04/20** | (v) This mother's second stage of labour was not of an appropriate duration<br>Feedback to individual | JR | Completed | **5** |
| **C2.04/20** | (vi) This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately<br>Feedback to individual | JR | Completed | **5** |
| **C2.04/20** | (viii) This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate and her risk status was not assessed during the course of her labour<br>Feedback to individual and general comms via facebook page paperwork alterations to facilitate compliance | JR | Completed | **5** |
| **C3.04/20** | This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate<br>Update bereavement documentation to include prompt to carry out risk assessment | HJ | 31/08/20 | **5** |
| **C3.04/20** | During this mothers labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out<br>Update bereavement documentation to include prompt to carry out risk assessment Include information on newsletter | HJ | 31/07/20 | **5** |
| **C4.04/20** | (i) This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate Update bereavement documentation to include prompt to carry out risk assessment. Put on band 7 and matrons checklist for spot checks | HJ | 31/08/20 | **5** |
| **C4.04/20** | (ii) During this mothers labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out<br>Update bereavement documentation to include prompt to carry out risk assessment. Put on band 7 and matrons checklist for spot checks | HJ | 31/08/20 | **5** |
| **C4.04/20** | (iii) This mother's progress in labour was not monitored on a partogram<br>Update bereavement documentation to include prompt to carry out risk assessment. Put on band 7 and matrons checklist for spot checks | HJ | 31/08/20 | **5** |
| **C1.05/20** | (i) This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care | HJ | 31/08/20 | **5** |

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|---|---|---|---|---|---|---|---|---|---|---|

| PMRT Ref | Action | Lead | By When | RAG |
|---|---|---|---|---|
| | in labour was appropriate<br>**Introduction of new bereavement paperwork** | | | |
| **C1.05/20** | (ii) This mother's risk status during labour was not assessed during the course of her labour<br>**Introduction of new bereavement paperwork** | HJ | 31/08/20 | **5** |
| **C7.05/20** | (i) Neonatal staff were predicted to be required when the baby was born but the staff called were not of an appropriately senior grade<br>**To be discussed at neonatal consultant level** | NNU Cons | 31/07/20 | **5** |
| **C8.05/20** | (i) This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals<br>**To write learning bulletin and send to all staff** | PM | 31/07/20 | **5** |
| **C8.05/20** | (ii) The placenta was not sent for histological examination<br>To include in learning bulletin, and relaunch placental histology form | PM | 31/07/20 | **5** |
| **C1.06/20** | (i) This mother had a risk factor(s) for having a growth restricted baby but the plan to carry out serials scans was not followed<br>New fetal surveillance guideline – though currently suspended due to COVID-19 | PM via IWS | Completed | **5** |
| **C1.06/20** | (ii) This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals because of capacity issues<br>New fetal surveillance guideline – though currently suspended due to COVID-19 | PM via IWS | Completed | **5** |
| **C1.06/20** | (iii) This mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements<br>New notes booklet will have this information highlighted in | FC | Completed | **5** |
| **C2.06/20** | P/t to be referred to Fetal Diagnostic Group Meeting for r/v of images and management | PM | 31/07/20 | **5** |
| **C3.06/20** | P/t did not receive MMR vaccine on discharge<br>**Send letter to p/t to inform her to get the vaccine at the GP** | PM | 31/07/20 | **5** |
| **C9.6/20** | (i) This mother had poor/no English and an interpreter was not used on every occasion when she was seen for her antenatal Care<br>Needs to be highlighted in the Learning Bulletin | PM | 30/09/20 | **5** |
| **C9.6/20** | (ii) This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals<br>Restructuring of combined diabetic clinic to improve scan timings and to improve clinical leadership | HoS via PM | 30/09/20 | **5** |
| **C9.6/20** | (iii) This mother had a previous baby which was growth restricted/small for gestational age and her antenatal care was not appropriate given this history<br>Restructuring of combined diabetic clinic to improve scan timings and to improve clinical leadership | HoS via PM | 30/09/20 | **5** |
| **C9.6/20** | (iii) This mother lives with family members who smoke but they were not offered referral to smoking cessation services<br>Community matron to communicate to teams | FC | 30/09/20 | **5** |

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|---|---|---|---|---|---|---|---|---|---|---|

| PMRT Ref | Action | Lead | By When | RAG |
|---|---|---|---|---|
| **C6.07/20** | MW will be asked to reflect and be given feedback on leaving p/t with a call bell in the room once her epidural was sited | KW | 30/09/20 | **5** |
| **C7.07/20** | Liaise with Con HM that she has had this passed to her for debrief and to plan for subsequent pregnancies | PM | 30/09/20 | **5** |
| **C7.07/20** | This mother presented with reduced fetal movements; the written material about reduced fetal movements available to give her during her antenatal care was not written in a language that she could read<br>To discuss availability of literature in other languages. | PM | 31/10/20 | **5** |
| **C1.08/20**<br>**C1.10/20**<br>**C11.11/20**<br>**C2.12/20**<br>**C4.01/21**<br>**C4.09/20**<br>**C5.01/21**<br>**C5.10/20**<br>**CEO4.2/21** | The opportunity to take their baby home was not offered to the parents as there is no local policy for this.<br>Plan to review local policy to see if this should be aligned to the recent national guidance. | Bereavement MDT | 31/08/21 | **4** |
| **C10.06/20** | This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care<br>To be highlighted in Learning bulletin | PM | 30/09/20 | **5** |
| **C11.06/20** | This mother had poor/no English and an interpreter was not used on every occasion when she was seen for her antenatal Care This will be incorporated into a learning bulletin | PM | 30/09/20 | **5** |
| **C12.06/20** | P/t with complex diabetes was discharged by Specialist MW without a medical r/v.<br>Look at the discharge process used by Specialist Midwives | KW | 31/08/20 | **5** |
| **C18.6/20** | (i) Symphysis fundal height measurements were not performed at correct times/intervals<br>Individual feedback | FC | Completed | **5** |
| **C18.6/20** | (ii) Fundal height measurements were not correctly plotted<br>Individual feedback | FC | Completed | **5** |
| **C18.6/20** | (iii) Referrals for scans and/or further investigations were not undertaken when required<br>Individual feedback | FC | Completed | **5** |
| **C2.08/20** | (i) At first presentation with reduced fetal movements this mother was not appropriately risk assessed<br>Correct the fetal movement guideline to remove the ambiguity. Individual feedback to the midwife Inclusion in the Learning Bulletin | PM | 31/10/20 | **5** |
| **C2.08/20** | (ii) This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance<br>Correct the fetal movement guideline to remove the ambiguity. Individual feedback to the midwife Inclusion in the Learning Bulletin | PM | 31/10/20 | **5** |

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|---|---|---|---|---|---|---|---|---|---|---|

| PMRT Ref | Action | Lead | By When | RAG |
|---|---|---|---|---|
| **C2.08/20** | (iii) It is not possible to tell whether all calls to MAU and the community midwives were documented<br>**Implement new maternity information system** | IWS | Completed | **5** |
| **C2.08/20** | (iv) Community office now record all phone contact from women on E3 ( since 17th August) so that we can audit actions taken, who was given the details and when to enable us to identify that messages are passed on. | FC | Completed | **5** |
| **C4.08/20** | This mother's progress in labour was not monitored on a Partogram<br>Intrapartum matron to discuss with midwife present at the birth | KW | 31/10/20 | **5** |
| **C5.08/20** | (i) This mother had preterm labour or had preterm pre-labour rupture of membranes during her pregnancy which was not managed according to national or local guidelines<br>**Review preterm labour guideline and ensure awareness of guidance at limits of viability. Arrange teaching session on preterm labour around the limits of viability-** Guideline completed. Teaching session to be arranged post COVID | PM HA | 30/06/21 | **4** |
| **C9.08/20** | (i) This mother booked late. **Write a late booking guideline** | PM FC | 31/12/20 | **5** |
| **C9.08/20** | (iii) Fundal height measurements had not been plotted on a chart<br>Feedback to community team and individual | FC | 31/10/20 | **5** |
| **C9.08/20** | (iv) Referrals for scans and/or further investigations were not undertaken when required<br>Feedback to community team and individual | FC | 31/10/20 | **5** |
| **C9.08/20** | (ii) Symphysis fundal height measurements were not performed at correct times/intervals<br>Feedback to community team and individual Inclusion in learning bulletin | PM FC | 31/10/20 | **5** |
| **C3.9/20** | (i) It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes<br>Bereavement Specialist Midwife to send out communication to all Midwives regarding the need to document that they have discussed the availability of the Chaplain service and the possibility of taking the baby home with parents | HJ | 31/12/20 | **5** |
| **EOC5.9/20** | (i) This mother had obstetric cholestasis during her pregnancy and there was a delay in the diagnosis<br>Ensure that all staff are aware of the availability of bile acid testing and how to access results | PM vis HoS | 31/10/20 | **5** |
| **EOC5.9/20** | (ii) The care of this women and/or her baby was possibly affected by changes to the organisation of care and services to deal with the COVID-19 pandemic although these changes were the result of an organisational risk assessment<br>Consultants need reminding that they are responsible for antenatal ward reviews at weekends/bank holidays | PM vis HoS | 31/10/20 | **5** |
| **C4.10/20** | This mother missed some of her antenatal appointments but was not followed-up according to the local DNA policy. 2nd appointment due to Covid restrictions, unclear from notes if telephone consultation was offered at 15/40.<br>Remind community midwives re documentation about attendances and DNAs | FC | 30/06/21 | **4** |
| **C7.11/20** | This mother's progress in labour was not monitored on a Partogram. To ensure that use of the partogram is included in the notes booklet for IUFD/stillbirth | HJ | 29/02/20 | **5** |
| **C8.11/20** | The care of this women and/or her baby was adversely affected by changes to the organisation of care and services to deal with the COVID-19 pandemic although these changes were the result of an organisational risk assessment<br>**Head of midwifery to write to the Registrar on behalf of the Trust** | HoM | 28/02/21 | **5** |

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|---|---|---|---|---|---|---|---|---|---|---|

| PMRT Ref | Action | Lead | By When | RAG |
|---|---|---|---|---|
| **C11.11/20** | (ii) The parents were not offered a hospital post-mortem<br>**Bereavement paperwork to be reviewed and to be brought in line with national bereavement pathway.** | RM/KY | 31/05/21 | **4** |
| **C11.11/20** | (iii) It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious / spiritual / cultural wishes<br>**Update bereavement guideline and checklist for neonatal services** | RM/KY | 31/05/21 | **4** |
| **C2.12/20** | (i) This mother met the national guideline criteria for screening for gestational diabetes but was not offered screening<br>Feedback to all Midwifery Staff via Maternity Unit newsletter to remind them to review the need for routine antenatal screening in women who are inpatients | ET & FF | 30/04/21 | **4** |
| **C2.12/20** | (iii) It is not possible to tell from the notes if the parents were provided with written support information around emotional issues before they left hospital<br>Bereavement Checklist to be updated to include tick box prompt for support information and to include offering option to take baby home once this process has been finalised | AK | 31/05/21 | **4** |
| **C4.12/20** | (i) Referrals for scans and/or further investigations were not undertaken when required<br>**Community matron to discuss with individuals, and to remind all midwives to ensure GAP training up to date.** | FC | 31/03/21 | **5** |
| **C4.12/20** | (ii) The baby was small for gestational age at birth, scans were indicated but had not been performed<br>**Community matron to discuss with individuals, and to remind all midwives to ensure GAP training up to date.** | FC | 31/03/21 | **5** |
| **C4.12/20** | (i) Referrals for scans and/or further investigations were not undertaken when required<br>Community matron to discuss with individuals, and to remind all midwives to ensure GAP training up to date. | FC | 31/03/21 | **5** |
| **C4.12/20** | (ii) The baby was small for gestational age at birth, scans were indicated but had not been performed<br>Community matron to discuss with individuals, and to remind all midwives to ensure GAP training up to date. | FC | 31/03/21 | **5** |
| **C4.01/21** | (i) The glycaemic management and hypoglycaemia prevention of the baby during first 24 hours of arrival on the neonatal unit was not appropriate Guideline for central line insertion amended and now includes a section on complications which has information about having an oversight of the time taken for central line insertion and maintenance of normoglycemia during this time. This was discussed in guideline meeting. This learning point was disseminated to wider team members. | KY and AK | 30/04/21 | **4** |
| **CEO1.2/21** | (i) This mother only had partial investigations for underlying metabolic and/or haematological abnormalities<br>Advise patients consultant of need for antiphospholipid testing | PM | 28/02/21 | **5** |
| **CEO2.2/21** | To remind MW's of the importance of placing SB babies in Cold Cots | HJ | Completed | **5** |
| **CEO3.02/21** | Although indicated this mother was not offered chromosome analysis for her baby<br>Dissemination of information to all staff groups regarding cytogenetic sampling requirements. | ET | 30/04/21 | **5** |
| **CEO4.2/21** | (i) This mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements Community Matron to remind all Community teams of the importance of documenting that they have advised women of the importance of monitoring their fetal movements and to show them the relevant page in the maternity notes booklet and sign and date this. | FC | 30/06/21 | **4** |
| **CEO4.2/21** | This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate Intrapartum Matrons to send reminder in staff newsletter and arrange spot checks of notes. | ET | 30/06/21 | **4** |

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|---|---|---|---|---|---|---|---|---|---|---|

| PMRT Ref | Action | Lead | By When | RAG |
|---|---|---|---|---|
| **C20.03/21** | Review local USS guidelines from the time and current Also review current national guidance | HJ | 30/04/21 | **5** |
| **C21.03/21** | This mother had a placental abruption during her pregnancy which was not managed according to national or local guidelines Feedback to the staff manage suspected abruption as an emergency - escalate to HoS | HA | Completed | **5** |

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| *RAG Status Key:* | *5* | *Complete* | *4* | *On Track* | *3* | *Some Delay – expected to be completed as planned* | *2* | *Significant Delay – unlikely to be completed as planned* | *1* | *Not yet commenced* |
|---|---|---|---|---|---|---|---|---|---|---|