DATE OF MEETING	**26 July 2016**
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	**Lawrence Roberts, Medical Director**
CONTACT OFFICER	**As above**
SUBJECT	**Mortality Performance & Assurance Committee – June 2016**
BACKGROUND DOCUMENT (IF ANY)	**N/A**
REPORT PREVIOUSLY CONSIDERED BY & DATE(S)	**N/A**
EXECUTIVE COMMENT (INCLUDING KEY ISSUES OF NOTE OR, WHERE RELEVANT, CONCERN AND / OR NED CHALLENGE THAT THE BOARD NEED TO BE MADE AWARE OF)	**Minutes of the MPAC meeting held in June 2016**
HAVE THE STAFF SIDE BEEN CONSULTED ON THE PROPOSALS?	**N/A**
HAVE THE RELEVANT SERVICE USERS/CARERS BEEN CONSULTED ON THE PROPOSALS?	**N/A**
ARE THERE ANY FINANCIAL CONSEQUENCES ARISING FROM THE RECOMMENDATIONS?	**N/A**
IF YES, HAVE THESE BEEN AGREED WITH THE RELEVANT BUDGET HOLDER AND DIRECTOR OF FINANCE, AND HAVE ANY FUNDING ISSUES BEEN RESOLVED?	**N/A**
ARE THERE ANY LEGAL IMPLICATIONS ARISING FROM THIS PAPER THAT THE BOARD NEED TO BE MADE AWARE OF?	**N/A**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO THE NHS CONSTITUTION IN ANY DECISIONS OR ACTIONS PROPOSED?	**N/A**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO SUSTAINABILITY IMPLICATIONS (QUALITY & FINANCIAL) & CLIMATE CHANGE?	**N/A**
THE PROPOSAL OR ARRANGEMENTS OUTLINED IN THIS PAPER SUPPORT THE ACHIEVEMENT OF THE TRUST OBJECTIVE(S) AND COMPLIANCE WITH THE REGULATORY STANDARDS LISTED	**N/A**
ACTION REQUIRED BY THE BOARD	**For information**

Minutes

Mortality Performance and Assurance Committee (MPAC)
Minutes of the meeting held on Tuesday 21 June 2016 - 2.00pm to 5.00pm
in the Main Boardroom DPoW vtc'd to the Boardroom, SGH

Present:

Mrs Anne Shaw	Non-Executive Director **(Chair)**
Dr Jim Whittingham	Trust Chairman
Dr Kate Wood	Deputy Medical Director & Mortality Lead
Mr Jeremy Daws	Head of Quality Assurance
Mrs Karen Fanthorpe	Interim Chief Operating Officer
Mr Mike Bateson	Chair of Health Watch, N E Lincs
Mrs Lisa Revell	Chief Nurse for Care Plus Group & Strategic Lead for Palliative & EOL Care in N E Lincs
Mrs Jan Haxby	Director of Quality & Nursing, N E Lincs CCG
Mr Stuart Baugh	Associate Medical Director
Mr Ali Wickham	Manager for unplanned care
Mrs Tara Filby	Chief Nurse
Mrs Sarah Mainprize	Head of Communications & Marketing
Mr Phil Croft	Information Analysis and Benchmarking Manager
Miss Laura Owen	PA to Medical Director **(Minute taker)**

In attendance:

Miss Elizabeth Wisher	Observer - Mathematics Student, working with Mr Daws
Mrs Ashy Shanker	Associate Chief Operating Officer, Women & Children's Services
Mrs Julie Dixon	Head of Midwifery
Dr Yasso	Work-stream Lead, Respiratory

1.0 Apologies for Absence were received from:

Mrs Linda Jackson, Prof Sewell, Dr Papageorgiou, Dr Jerry Thomas, Mr Vijh, Mr David Broomhead, Dr Jaggs-Fowler, Mr Marcus Hassall, Mrs Wendy Booth, Mr Manohar, Mr Chaudhary, Mr Pete Bowker, Mr Ashaolu, Mr Roberts.

Mrs Shaw welcomed Miss Wisher and Mr Bateson to the meeting.

2.0 Minutes of the MPAC meeting held on 17 May 2016

The minutes were agreed as a true and accurate reflection of the previous meeting.

3.0 Matters arising:

3.1 Proposed extension to membership (minute 3.2 refers)

In her capacity as Chair, Mrs Shaw advised that Mr Bateson was in attendance as the representative for Health Watch, N E Lincs and that Mr Bateson will now be part of this committee. The invitation to join the committee has also been extended to Public Health and we are currently awaiting a response from them.

In her capacity as Mortality Lead, Dr Wood advised that the suggestion has been made to extend the membership to junior doctors within the organisation. Dr Wood has drafted a document focusing on what we would the committee would expect from a Junior doctor who attends this committee and potential benefits to the junior doctor in terms of their professional development. Dr Wood hopes the draft document will be ready for distribution within a week. Trainee GP representation was also suggested, Dr Wood has discussed this and considered the possibility of whether a trainee GP within the hospital working on rotation could attend but decided that would be too complex to incorporate currently.

Mrs Shaw invited any further comments or questions and none were received.

Action: Dr Wood to distribute the draft document.

Committee action:
The Committee received the update and noted the progress made so far on the extension to the membership.

3.2 Routine Annual Review (minute 3.4 refers)

In her capacity as Chair, Mrs Shaw advised that Miss Owen will email out the annual review questionnaire template tomorrow, with a deadline for returns by 11th July. The Terms of Reference for MPAC and QPEC will also be distributed.

Mrs Shaw commented that it would be helpful to reflect on the performance of the Committee and the Terms of Reference therefore Mrs Shaw proposed to allocate the first hour of the July meeting to the annual review.

Mrs Shaw invited any further comments or questions and none were received.

Action: Miss Owen to distribute the Annual Review documents as above.

Committee action:
The Committee received the update

3.3 Update on Pre-admission Pathway (action log no. 29 refers)

Mrs Clipson was due to attend today's meeting in her capacity as Director of Strategy and Planning to provide an update however unfortunately she had been called to an urgent meeting this afternoon.

Action: Miss Owen to invite Mrs Clipson to attend the July meeting to provide an update.

Mrs Shaw invited any further comments or questions and none were received.

Committee action:
The Committee noted Mrs Clipson's apologies and deferred the item to the next meeting.

4.0 Receive the QPEC challenge

In her capacity as Executive Lead for QPEC Mrs Filby reported that there was no specific challenge from QPEC this month however reported that QPEC continues to note the progress made with mortality.

Mrs Shaw invited any further comments or questions and none were received.

5.0 Patient story/Structured Judgement Review

In her capacity as Head of Midwifery, Mrs Dixon presented a patient story relating to a still birth. Mrs Shaw thanked Mrs Dixon and reminded members that the committee's usual practice was to reflect on the story before discussing the story under agenda item 11.

WORKSTREAM REPORTS AND ACTION PLANS

6.0 In-depth Workstream reports (as scheduled)

6.1 Respiratory

In his capacity as Respiratory Work-stream Lead, Dr Yasso summarised the key points of the Work-stream report;

The Respiratory Work-stream is now well established and is made up of multi-disciplinary

members; the Work-stream is consultant led.

The Trust Respiratory mortality rate from April 2015 to March 2016 was 558 out of 9846 respiratory discharges. 70% of respiratory mortality cases were under non-respiratory consultants

The total number of respiratory discharges for SGH amounts to approx. 5080 and for DPoW 4689.

Trends identified from case note reviews - Accuracy of death certificates, unavoidable deaths, avoidable hospital admissions, timely initiation of end of life, Delayed diagnosis, lung cancer.

Lung cancer is a common theme with approx. 340 patients seen per year and a proportion of those patients present through A&E. These are noted as unavoidable deaths as there is Little that can be done at this late stage other than to make them as comfortable as possible.

Respiratory Mortality audit - Using the trust crude mortality data in May 2015, a Sample of 53 cases of respiratory mortality were reviewed including the detail of death certificates. The findings of the audit highlighted that the average age of death was 82.2, 15% of deaths were patients between 90 and 99 years old. 17% of the deaths allocated to respiratory were not actually respiratory. The audit also revealed that the quality of death certificates needs to be improved. Pneumonia and COPD remain the 2 main conditions. 27% of the patients had significant comorbidities.

Action Plan - There is a need to implement Respiratory In-Reach across the Trust, both Acute sites are of equal priority. To redesign the trust-wide clerking sheet used for acute medical admissions. Trainees need to contact their consultants before completing a death certificate. The Clinical coding team should discuss the primary diagnosis with consultants as required to ensure and improve accurate coding.

Respiratory In Reach - at DPoW it was discussed recently at the respiratory Clinical Governance meeting. There are teething problems for the implementation at DPoW. This was escalated to Mr Ashaolu the then AMD to be discussed at the forthcoming Consultant physician meeting. The same should be implemented in SGH to ensure that patients with respiratory conditions are seen within 24 hours. The latter is not possible with the current level of consultant structure at SGH, however a business case for a fourth consultant is under consideration.

Dr Yasso would like to relate to colleagues in primary care for them to see the action plans and give their input to say whether or not they agree that these are unavoidable admissions.

COPD national prospective audit due in 2017 - The COPD project is on-going and hopefully should be able to report how the project is going within the next Work-stream update.

Recommendations

- To implement respiratory In-reach soon
- HDU action plan, this has been approved
- Emergency 02 therapy for adults - the new drug charts are ready to use
- Thoracic ultrasound led by the Respiratory team at DPoW and led by the Radiology team at SGH.
- Training issue at SGH; the trainees are not being trained to perform the ultrasound or the procedure and would like for it to be available on Ward 22.

Measure effectiveness of the actions being taken - To share with colleagues at the Respiratory Clinical Governance meetings. To use NICE guidance as benchmark. To monitor mortality rates for Respiratory.

Cross cutting themes (system issues) that affect this area and other Work-streams

- 7 day working
- Clinical coding
- EoL
- Avoidable admissions.

- HDU capacity at SGH
- Retention and recruitment
- 2 acute sites

The group will continue to hold bi-monthly meetings to help to improve quality and safety across all 3 sites and will fully engaged with other specialties. Dr Yasso's main wish is to feedback avoidable admissions with our primary care colleagues.

Mrs Shaw invited any comments or questions.

In her capacity as Mortality Lead, Dr Wood asked where the findings from the case note reviews had been found to be coded incorrectly whether these already been shared with Mrs Blow the Coding Manager and if so does she agree they were coded correctly. In response Dr Yasso confirmed he has already shared the findings with Mrs Blow who agreed that the coding was correct. Dr Yasso confirmed it is more of a documentation issue rather than a coding issue.

In his capacity as Trust Chairman, Dr Whittingham commented that as a committee we need to have a mechanism in place to understand progress and monitoring progress accepting the complexities of the specialties, however as it stands these look like ambitions not actions.

The next delivery plan will include all of these elements and will be presented as an action plan, with any crucial elements included. In her capacity as Director of Quality and Nursing for N E Lincs CCG, Mrs Haxby queried how the group had tried to engage with primary care; whether they had attempted it already or whether Dr Yasso was asking for help with that.

In his capacity as Associate Medical Director for Medicine, Mr Baugh noted that there should be a direct feedback, the survival figures are around 10% if we wanted to start shifting the mortality rates in this area then we need to be asking why the patients are not presenting sooner.

In her capacity as Interim Chief Operating Officer, Mrs Fanthorpe advised that there is a North Lincs monthly event for GPs at which there are occasional invites for secondary care. It is a proposal that in October there could be protected learning time for GPs with a focus on respiratory. In his capacity as Trust Chairman, Dr Whittingham asked whether there was any obstacle to those GPs with a particular interest in respiratory to attend the Respiratory Business and Governance meetings. Mr Baugh knows of a GP with respiratory interest at N Lincs but not at N E Lincs. In her capacity as Director of Quality & Nursing for N E Lincs CCG, Mrs Haxby recommended Dr OFlynn for N E Lincs as this is a good way forward focusing on collaborative working.

Mrs Shaw invited any further comments or questions and none were received.

Committee action:
The Committee received the Work-stream update for Respiratory.

6.2 Still Birth

In her capacity as Associate Chief Operating Officer for Women and Children's group, Mrs Shanker summarised the key points of the Work-stream report;

The aim of the report was to explain how as a service still births are managed, to address in more detail what the challenges are, where the obstetrics services are and to update the committee on what the service offers in comparison to our peers.

The still birth rates for NLaG increased in 2013 compared to the Yorkshire and Humber and National rates which remained steady. The majority of still births are picked up prior to delivery, it is very rare that a still birth would only be picked up at the delivery stage.

Mrs Shanker referred to item 4.0 of the report which gives an indication of the complexities of the service in understanding the pregnancy.

Causes of still birth - Have been categorised into the following risk factors; 6% are caused due to complications in labour, 5% caused by complications prior to labour, 4% due to mother's health, 4% due to the umbilical cord, 3% due to infection, 4% not reported, 46% from unknown causes and 22% due to placental problems.

Post-mortem uptake - the uptake is low, 9 out of 10 families were offered a post-mortem for their babies but only 4 out of 10 families consented to a post-mortem.

Saving Babies' lives (2016) – National direction – this was designed to tackle stillbirths and early neonatal deaths. The evidence-base is still developing however it brings together four elements of care that are recognised as evidence-based and/or best practice;

- Reducing smoking in pregnancy
- Risk assessment and surveillance for foetal growth restriction
- Raising awareness of reduced foetal movement, mMonitoring fetal gestation
- Effective foetal monitoring during labour

The National maternity review – list of aspirations for maternity services

- Personalised care centred on the woman her baby and her family based around their needs and their decisions where they have genuine choice informed by unbiased information.
- Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.
- Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
- Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
- Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed .A payment system that fairly and adequately compensates providers for delivering high quality care to all woman, whilst supporting commissioners to commission for personalisation, safety and choice
- Maternity services should be fully funded across the area.

Recommendations - Key recommendations from the Still Birth Action Group and Yorkshire and the Humber Clinical Networks were;

- For the Trust to introduce reduced foetal movements and small for gestational age policies against the RCOG green-top guideline.
- The Trust should provide all pregnant women with healthy lifestyle advice including smoking cessation and reducing obesity.
- The Trust should have a systematic approach to identify vulnerable woman at booking and follow up.
- Trust should ensure guidelines include definition and management and foetal risk assessment in the latent phase of labour.
- The Trust should have some kind of bereavement services to support parents as we have a high birth rate in this area.

In her capacity as Head of Midwifery and Work-stream lead, Mrs Dixon advised that they have put together an action and improvement plan dating back to 2013 which looked at what the issues were, the problems have been picked up nationally since and are still a problem today. There are 3 pages of activities included within the plan which have been actioned in order to reduce NLaG's still birth rates. In the last 6 months we have had 6 still births and are hoping to see a further reduction for the rest of the year. The rates have been brought down in part through the use of the customised growth charts, NLaG were an early implementer in 2013. The charts form part of the national care bundle.

Future, next steps - Looking at term babies who go to NICU, all consultants are due to attend a master class this year, ensuring our doctors are trained to the highest standard.

All of our still births are registered on the national still birth register.

SCORE – strategic report on still births, all the information is inputted, it then compares us nationally to see what the trends for other trusts are as all are reporting the same.

A speaker will be attending one of the clinical review meetings to discuss the use of MRIs as the uptake of post-mortems is low an MRI is an alternative which could be preferred.

There is now a bereavement room set up at SGH, as it is appreciated that it is not ideal for bereaved parents to be surrounded by crying babies. A support group has been set up for bereaved mothers and a still birth day has been arranged for all staff and chaplaincy to attend to help with dealing with a still birth situation.

In her capacity as Mortality Lead, Dr Wood asked whether the scan capacity issue has been addressed, particularly if the higher risk ladies are going to be given more regular scans this needs to be considered. Dr Wood also asked how care following still births could be integrated with the hospice. In her capacity as Chief Nurse for Care Plus Group & Strategic Lead for Palliative and EOL Care in N E Lincs , Mrs Revell advised that Revd. Charles Thody is part of the new integrated model which is taking bereavement from any source, as part of that model the intention is to support anyone going back into the community.

In his capacity as Trust Chairman, Dr Whittingham commented that he did not get a sense of the gap in terms of where we are now and where we want to be. In response Mrs Shanker advised that internally the pressures are ensuring the establishment is appropriate and the frame of mind is to provide priority care. Pre-conceptional care support is progressing already. From an external perspective the gaps are for Midwives, it has been suggested that we need to provide more information for the business case. An additional full time sonographer is needed to cover the additional workload.

Dr Whittingham felt that the update had been very helpful particularly in working towards collaborative working with the commissioners. There is the opportunity to put together a full updated action plan. The still birth report/action plan is now on the reporting schedule. Mrs Haxby noted that within that it would be useful to identify where partner support is needed and from a commissioner perspective it would be useful to see where they could help with that.

In her capacity as Chair, Mrs Shaw noted that when she had started working for the Trust the Midwives had received an award and queried what that was. Mrs Dixon confirmed the award was from the Royal College of Midwives for the customised growth charts. Mrs Shaw asked picking up the establishment what our retention looks like. In response Mrs Dixon noted that this would not usually be an issue, but it is more retirement that is a worry at present as we lose the skills mix and experience - we need to think about succession planning.

In her capacity as Interim Chief Operating Officer Mrs Fanthorpe noted that at one point N E Lincs were the worst in the country for pregnant mothers smoking. Mrs Haxby noted we are currently the second highest in the country, all midwives have gone through training provided via public health, but it would be interesting to see what the effect of the training has been.

Mrs Fanthorpe suggested for the next scheduled reports from still birth and respiratory to be linked in and Mrs Haxby to invite the smoking cessation team to link in.

Dr Whittingham noted with regards to numbers, looking at the graph on 3.1, just a small change in the number of still births either way will have an effect. The national numbers could tell us an indication of the performance and a trend line on the NLaG figures. In his capacity as Head of Quality Assurance, Mr Daws informed that there are not many data points, could look at putting some statistical limits in to give some confidence for the limits on what our own data is telling us. Dr Whittingham explained his reasoning , to be able to understand the data more clearly given the overlap and similarity do we track the changing performance across the system for example for smoking cessation. Mrs Haxby thinks some of what he is asking for sits with Public Health indicators. Once we have a representative from Public health attending this committee it would be

interesting to see some of these issues tracked.

In his capacity as Associate Medical Director for Medicine, Mr Baugh advised that the Cancer Network is in the process of producing a report which includes parents who are smoking, the report is due out on Monday.

Mrs Shaw invited any further comments or questions and none were received.

Action: Dr Yasso will provide a copy of that report to this committee.

Committee action:
The Committee received the Work-stream update for Still births.

6.3 Clinicians View

In her capacity as Mortality Lead, Dr Wood explained that the idea of this agenda item was to encourage the clinicians present to have input however all clinicians present have already had valuable input into today's meeting.

Action: Miss Owen to add to the July agenda.

Mrs Shaw invited any further comments or questions and none were received.

7.0 Mortality Lead's exception report on workstream action plans

In her capacity as Mortality Lead, Dr Wood advised that work is continuing with each of the Work-streams. She highlighted the following issues;

Respiratory – Dr Wood reported that the new respiratory meeting structure seems to be working well.

Sepsis – A Work-stream meeting was held yesterday, the pilot with EMAS continues. New NICE guidance is due out at the end of June which may lead to changes.

Stroke – Dr Ali wants to encourage GP engagement and is addressing this.

Cardiology – The Work-stream met last month, having a new Clinical Leader in post has allowed for re- focus on the action plan and meetings are being re-structured so that clinicians will have protected time to be able to attend.

EoL - Dr Wood reported that the group are due to meet next Monday, at the previous meeting the engagement was brilliant and the Terms of Reference and Strategy were agreed. This committee will receive Work-stream reports as per the schedule. Dr Wood is reviewing the KPIs to make the mechanism more user friendly.

Case note reviews – Dr Wood advised the analysis of case note reviews to identify themes is currently manual and highly labour intensive. Dr Wood reported previously that she and Mr Daws had met with a representative from Hull University to look at putting in place a more robust analytical process probably using computer software. We now have that software package and the licence has been obtained. The next step is to get the data populated into the system.

Mrs Shaw invited further comments or questions and none were received.

Committee action:
The Committee noted the Mortality Lead's exception report.

8.0 Community-wide Strategic Review

In her capacity as Director of Quality and Nursing for N E Lincs CCG, Mrs Haxby reported that N

E Lincs have done some case note reviews trying to understand why our out of hospital SHMI seems to be so high at this end of the patch. Through the 7 sets of case notes reviewed it was evident that there were people coming into hospital who did not need to, once they came in multiple investigations were done and once it was identified that they were for end of life care were discharged to the preferred place. This relates to the piece of work that Mrs Clipson was due to present today re: pre admission pathways. It is possible that the work from N E Lincs can be used to translate to N Lincs. Mrs Haxby thinks it is a very valuable piece of work helping us to be able to move forward in understanding and addressing the out of hospital SHMI. The next step will be to meet again to review more cases of those patients who have died within 30 days and a data analysis to determine where we need to go for there. In his capacity as Head of Quality Assurance, Mr Daws advised that session 2 will be looking at a 24 hour sample.

In his capacity as Trust Chairman, Dr Whittingham commented that one of the committee's intuitions was that if a patient is admitted they are automatically incorporated into our SHMI but this is about what happens to the patient prior to admission. In his capacity as Chair of Healthwatch Mike Bateson questioned whether although the people had come into the hospital, were the services available to them in the community to meet their needs, more evidence is needed to show whether or not this is the case.

Mrs Shaw invited further comments or questions and none were received.

Committee action:
The Committee noted the update.

8.1 Mortality Strategy – update on meetings progress (N E Lincs)

In his capacity as Head of Quality Assurance, Mr Daws reported that he had met with Mrs Haxby and Mrs Revell and they are working jointly to produce an outline to show what they are trying to achieve jointly, the intention is to have one document which sets out the visions and aims and to include within that a number of different delivery plans; Joint plans, visions, what's CCG doing and NLaG and how it all joins together.

A date is in the diaries to talk to the Council of Members about this approach and to get GPs engaged. It is felt that opportunities should be offered for greater involvement and CCG will try to get this message across to Public Health too. In her capacity as Interim Chief Operating Officer, Mrs Fanthorpe advised that a System Resilience Group meeting is held at each end, which includes CCGs etc and perhaps Mrs Haxby could share information there, it could be a good opportunity to take some of the key messages there, EMAS and mental health are also included in that group.

Timeframe for joint N E Lincs Mortality Strategy; it is hoped to have a draft for the next meeting.

In her capacity as Mortality Lead, Dr Wood requested for it to be formally agreed that the mortality strategy for N E Lincs would be reported through this committee for the organisation. Members agreed with this approach, this is the appropriate group.

Mrs Shaw invited further comments or questions and none were received.

Committee action:
The Committee noted the update and agreed the action.

9.0 Communications plan

In her capacity as Head of Communications & Marketing, Mrs Mainprize reported that the next SHMI publication is due to be released 23rd June 2016. The news release has been signed off and will be published at 9.30am on Thursday, NLaG's release will be issued shortly after to the media and stakeholders will be informed.

Mrs Shaw invited further comments or questions and none were received.

Committee action:
The Committee received the update.

BOARD ASSURANCE

10. Response to QPEC Challenge

There was no QPEC challenge this month.

11. Reflection on patient story/structured judgement review

At Mrs Shaw's request, Mrs Dixon summarised the patient story. The patient story was in relation to a lady who had a still birth. All still births are reviewed and this case highlighted that had things been done differently the outcome could have been different.

This was a planned pregnancy, the lady had a high BMI of 40, was a non-smoker, all booking bloods were normal. Due to high BMI glucose tolerance was measured at 20 weeks, which showed no problems. At 20 weeks the women see their baby for the first time and this is a very significant time for the parents. The lady subsequently had 3 admissions for diminished foetal movements, the first at 30 weeks. It was felt that she was measuring large for the dates but a scan was not given at that time. The second admission was at 35 weeks, the CTG showed everything was satisfactory, a scan was given which showed normal growth, blood flow was as it should be and estimated baby weight was approx.3kgs. The lady got to term plus 7 and was invited to attend hospital with a view to being induced but the scan showed there was no foetal heartbeat and it was an intra-uterine death. The lady was obviously upset and went home to discuss with family members. What the lady did not realise was that she would still have to go through labour, the lady went into labour, in a side room on ward 26, where you can hear babies crying, it took 3 days to go into labour. There was severe shoulder dystocia; the growth was below the 8th centile. The post-mortem showed it was a still birth, a heart defect was found but it would not have caused a still birth. A 'cold cot' is in situ where the baby is kept so that the parents can create memories. The RCA picked up that had the lady received serial growth scans this may have been picked up sooner, this was also discussed at the Perinatal Mortality meeting. The lady did get pregnant again and had to have a termination due to foetal abnormality.

In her capacity as Chair Mrs Shaw commented how she felt this was a very powerful story and reflection of the real life issues which ladies have to go through. Dr Whittingham was really struck by the emotional support and resources required. It provides evidence that further reassurance is needed to ensure sensitive reassurance and support for these scenarios as it is not ideal to be hearing babies crying etc when a family is going through such a difficult time.

Mrs Shaw asked whether Mrs Dixon is content that we are providing the support to Midwives and Clinical colleagues. Mrs Dixon is happy to be able to share the problems they encounter within their specialty.

In her capacity as Interim Chief Operating officer, Mrs Fanthorpe noted that we had a case recently of a lady with an exceptionally high BMI who needed 8 staff to help her to give birth, this lady must have already been in a place of need prior to becoming pregnant, these are the types of lifestyle choices that should be considered before making the decision to embark on parenthood.

In his capacity as Chair of Healthwatch, Mr Bateson asked whether the Trust had given any consideration to sound proofing the room to prevent them being able to hear the babies crying. Mrs Fanthorpe suggested Mrs Dixon could approach the Health Tree foundation for funding.

Mrs Shaw invited comments or questions and none were received.

Mrs Shaw gave the committee's thanks to Mrs Dixon and Mrs Shanker for presenting the patient story.

Committee action:
The Committee received the patient story.

12. Review of Monthly Mortality Report

In his capacity as Head of Quality Assurance, Mr Daws referred members to the monthly mortality report distributed. Mr Daws drew members' attention to the crude mortality figures for March 2015 to February 2016 - 1.45% which have decreased slightly when compared against the previous year which was 1.48%.

The last SHMI released in March 2016 was in the 'as expected' range. The latest HED SHMI for the period October 2014 to November 2015 was 106, which was an improvement on the 2014 figures which was 110. The latest figures are in the 'as expected' range, which is a good indicator for the future official SHMI releases.

The crude mortality dashboard shows across the board that all 3 indicators have reduced but some of that is not translating through to the SHMI data.

The non-elective crude mortality (non-MAT), shows worsening performance for January and February 2016, however there are no extreme peaks seen as in previous years (particularly January 2015). This is a positive indication and the performance in coming months will tell us more in terms of trends.

Mr Daws outlined from the report that the crude mortality rate at the weekend is higher than that of a weekday. The group questioned if this was due to a difference in the data, or if this was related to practice differences between weekdays and weekends, for instance differences in staffing levels. Mr Daws agreed to take this back to the information team to review the data in greater detail and provide clarification prior to the report being received by the Board.

Post meeting note: Mr Daws and the information team have reviewed the data in greater detail and have identified that the way the mortality by day of the week information has been presented is confusing and could lead to an incorrect conclusion. The crude mortality percentage is calculated by dividing the total number of in hospital deaths by the total number of discharges per day (which includes, but is not limited to, those who died in hospital), expressed as a percentage. There is a significant difference between the numbers of discharges at weekends (significantly lower) compared to weekdays (higher), whereas the number of deaths remains fairly consistent across the week. As a result of the significantly lower number of discharges at a weekend, using this as the denominator to calculate a percentage from results in an artificially inflated crude mortality percentage which could be misleading, implying the Trust has a higher death rate, when it does not. This page in the mortality report has been amended to remove any future source of confusion.

The coding indicators shown on page 24 have a big impact on the SHMI. The depth of coding at GDH has been flagged as well as multiple consultant episodes which impact on the quality of the coding and the diagnosis that the patient is given. This will be discussed in more detail at the Mortality Reduction Committee meeting.

In his capacity as Chair of Healthwatch, Mr Bateson asked about the growth in R codes and asked whether there was a reason for this. Mr Daws advised that a lot of work has already been completed with regards to coding and training juniors. The R Codes are crucially important as are the consultant transfers.

In his capacity as Trust Chairman, Dr Whittingham noted that the SHMI is a relative measure and it is worth noting the deterioration in our relative position on crude mortality compared to our HED with regards to performance. The shape of the curve on page 22 in terms of out of hospital SHMI is remarkable (each month is a data point). In her capacity as Chief Nurse for Care Plus Group and Strategic Lead for Palliative and EoL Care in N E Lincs, Mrs Revell reported that in December the Haven Team moved into the hospital and wondered if there was any correlation which will show more people died outside of hospital which is right and appropriate but needs marking as so. The direct correlation would then need to be seen in a positive light rather than negative.

Action: Mr Daws to update the report to noting Mrs Revell's comments prior to the report going to the Trust Board.

Mrs Shaw invited comments or questions and none were received.

Committee action:
The Committee received the Monthly Mortality Report

13. Priorities/Actions by exception for Mortality Lead

In her capacity as Mortality Lead, the Committee agreed to Dr Wood's proposals on the issues which she should prioritise;

- To continue to engage with the Work-streams
- To put together the draft Proposed extension to membership for Junior doctors
- To draft the Joint NEL Strategy approach document for Mortality
- Continue reviewing case notes regarding out of hospital SHMI

14. MPAC Terms of Reference

Already discussed.

15. Board highlight report

At Mrs Shaw's request, members agreed the key issues to be included in the Committees highlights report to the Board as follows;

- Patient story
- SHMI release on Thursday
- Review of the mortality report
- Mike as a new attendance to the committee
- From Mrs Haxby – enhanced collaborative working

16. Action Log

Mrs Shaw will update the action log in readiness for the next meeting.

17. Items for Information

See items for information

18. Any Other Business

None raised

19. Date and time of next meeting

Date: Tuesday 19th July
Time: 2pm – 5pm
Venue: Finance Meeting Room, DPoW vtc Facilities Meeting Room, SGH.