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| **Agenda Item** | **2018/127** |

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| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | **Adult Mortality Report 17/18 Q4** |
| **DATE OF MEETING:** | Friday, 04 May 2018 |
| **ACTION REQUIRED** | **For Assurance** |
| **EXECUTIVE DIRECTOR:** | Andrew Loughney, Medical Director |
| **AUTHOR(S):** | Devender Roberts – Associate Medical Director<br>Amanda Cringle – Quality Improvement Lead |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐<br>2. To be ambitious and *efficient* and make the best use of available resource ☐<br>3. To deliver *safe* services ☒<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☒<br>5. To deliver the best possible *experience* for patients and staff ☐ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐<br>***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐<br>***3.*** *Failure to deliver the annual financial plan* ☐<br>***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐<br>***5.*** *Ineffective understanding and learning following significant events* ☒<br>***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒<br>***7.*** *Inability to deliver the best clinical outcomes for patients* ☒<br>***8.*** *Poorly delivered positive experience for those engaging with our services* ☐ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☐<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐<br>***RESPONSIVE –*** *the services meet people's needs.* ☐<br>***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒<br>***ALL DOMAINS*** ☐ |

| | | |
|---|---|---|
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution ☐<br>**2.** Operational Plan ☒<br>**3.** NHS Compliance ☐ | **4.** NHS Constitution ☐<br>**5.** Equality and Diversity ☐<br>***6.*** Other: **Quality Strategy & Quality Schedule** |
| | | |
| **FREEDOM OF INFORMATION (FOIA):** | 1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting | |
| | | |
| **RECOMMENDATION:**<br>***(eg: The Board/Committee is asked to:-….)*** | The Board is asked to:<br>a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board<br>b. Confirm that the Board are confident there are effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this trust | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee name** | *Choose an item.*<br>Or type here if not on list:<br>Effectiveness Senate |
| | **Date of meeting** | Friday, 04 May 2018 |
| | | |

## Executive Summary

The Board have previously been informed that both the National Quality Board and the Care Quality Commission have made clear that trusts should be developing systems and processes to review and learn from the deaths of patients under their care. It is expected that the Board of Directors oversee this work and receive quarterly reports on progress.

This report details how the trust is meeting the requirements laid down externally and provides details of mortality within the Trust during Quarter 4 of 2017-18. It concludes that there is currently evidence available that adequate progress is being made and that mortality rates are within expected ranges. The report outlines the work taking place operationally and is being overseen by Quality Committee.

## Report

### Introduction

Liverpool Women's NHS Foundation Trust recognises that although most of the adult death it encounters is the expected end point of a known disease process, the principles described above are equally valid to its own services. In the Trust's Risk Management Strategy, commitment is given to minimise risk through the systematic embedding of relevant, efficient and effective risk management processes.

### Issues for Consideration

- Each in-hospital death has a mortality review. All adult gynaecology deaths are discussed at the gynaecology Morbidity & Mortality meeting. As part of this process an adult mortality sheet is completed indicating any potential for improvement in care. Unexpected adult gynaecology deaths trigger a serious incident investigation.
- All direct maternal deaths trigger serious incident investigation.

- A new mortality review tool has been developed for risk and incident reporting system Ulysses. This avoids losing any paper documents (current system) and allows for searching, monitoring and auditing of an electronic system.

| Adult Mortality Quarter 4 | | |
|---|---|---|
| | **Maternity** | **Gyneacology** |
| No of Adult Deaths | 0 | 0 |
| No of Mortality Reviews completed | 0 | 0 |
| No of deaths requiring RCA's | 0 | 0 |
| No of deaths due to deficiencies in care | 0 | 0 |
| Mortality Themes | N/A | N/A |
| Progress v Smart Plans | N/A | N/A |
| Mortality Outcomes | N/A | N/A |
| Measures for ongoing scrutiny | N/A | N/A |

**Actions Taken**

## Out of hospital deaths 2017-18 Quarters 1- 4

There were two maternal deaths reported externally via MBRRACE-UK national reporting system. Both were due to indirect causes: brain haemorrhage and leukaemia.

Work is now ongoing with other Trusts in developing an alert process of expected or unexpected deaths of patients who had previously been under the care of LWH. Aintree Hospital has already agreed an alert system.

The AMD and Governance team have put in a place a process for triangulating out of hospital deaths with the MBRRACE-UK midwives and the surrounding Trusts to get better ascertainment.

Table below depicts the number of adult deaths in-hospital, including expected and unexpected deaths.

| **Reporting Quarter** | **2015-2016** | | **2016-2017** | | **2017-2018** | |
|---|---|---|---|---|---|---|
| | **In-hospital** | **Out-hospital** | **In-hospital** | **Out-hospital** | **In-hospital** | **Out-hospital** |
| **Q1** | 1 | - | 3 | | 1 | 2 |
| **Q2** | 4 | - | 2 | | 0 | |
| **Q3** | 4 | - | 3 | 2 | 0 | |
| **Q4** | 5 | - | 1 | | 1 | 0 |
| **Total** | **14** | **-** | **9** | | **2** | |
| | | | | 2 | | 2 |
| **Overall total deaths** | **14** | | **11** | | **4** | |

**Deep Dive Reviews**

The deep dive into these two SI's has shown that there was opportunity for further learning to be drawn from the review.

Next steps

- To review all shared learning and any gaps / omissions to be addressed as service evaluation of the department. And a process to ensure shared learning takes place and is then evaluated as how effective it has been.
- There was no clear evidence if shared learning had all been completed from the original report.
- There should be an internal process to double check that Lessons Learnt from the original SI report has been completed. Current systems (Ulysses) do not record if this has occurred and difficult to ascertain if all shared learning was disseminated as not included as part of the original action plan.

**Conclusion/Recommendation**

There has been one expected gynaecological oncology death; no deaths in obstetric or LeDer (Learning disability) deaths within quarter 4 reporting period.

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board.
b. Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust.

# Adult Mortality Quarterly Report

# 17/18 Quarter 4 – (Jan, Feb & Mar)

- Adult Mortality Q4 report prepared by A. Cringle
- Clinical Author: D. Roberts

## Executive Summary

This report updates the Board regarding the Trust systems and processes to review and learn from deaths of patients under their care. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by Effectiveness Senate and GACA.

Key findings:

- There were no in-hospital deaths during Quarter 4 of 2017-18.
- Adequate progress is being made in systems to reduce mortality
- The Trust rates are within the expected low levels for a specialty hospital.
- The Trust is getting better ascertainment of out of hospital deaths by triangulating with other acute Trusts and MBRRACE-UK midwives

## 1. Introduction

Around 500 000 people die in the UK every year and of these, nearly half die in an NHS hospital. While many of these deaths represent the expected end point of a known disease process, the CQC have recently highlighted the need for NHS Trusts to review the care they provide so that they can learn from their experiences, fulfil their duty of candour and make themselves accountable for any deficiencies or failures that they might have.

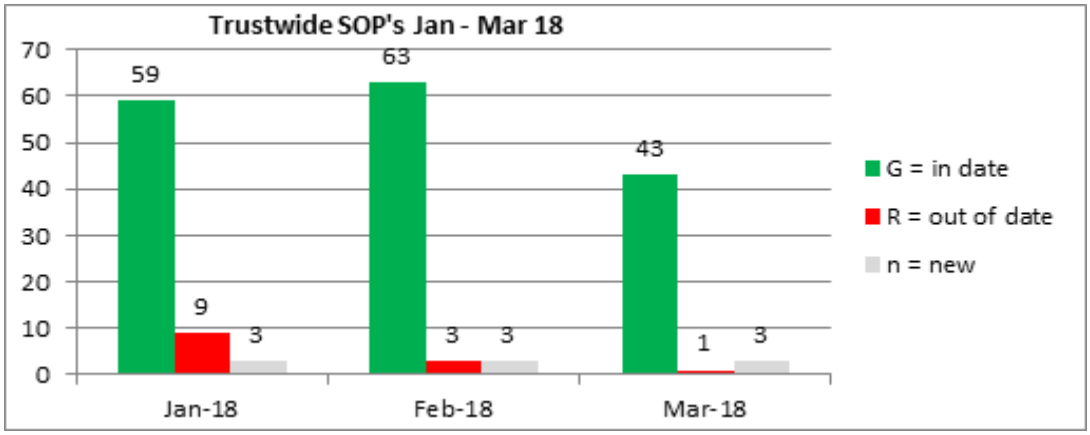
This overview outlines the most recent Trust figures and headline findings in regards to mortality. It provides details to the Board of their own accountabilities while setting out the responsibilities of the Quality Committee and Effectiveness Senate to monitor progress regularly and escalate as required; this includes escalation of exceptions from any audit work related to the risk of adult mortality, stillbirth and neonatal death.

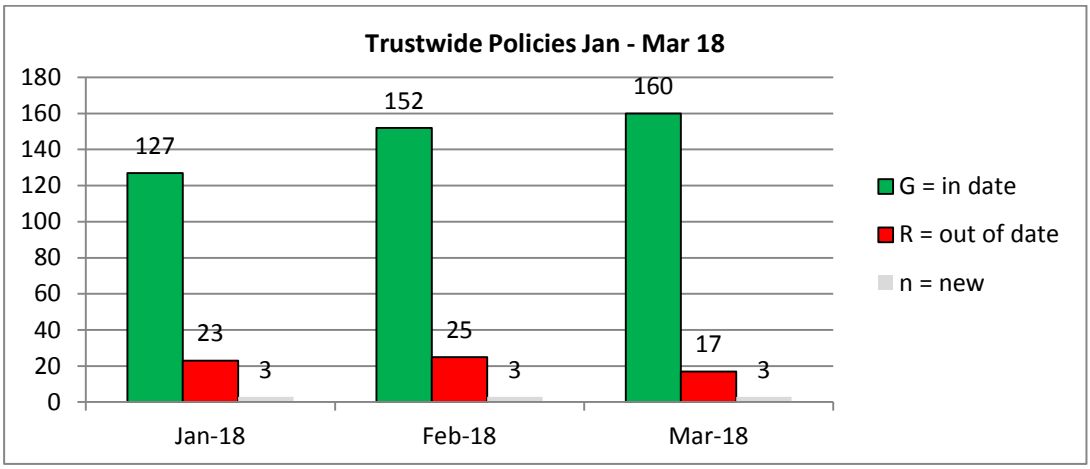
Liverpool Women's NHS Foundation Trust recognises that although most of the adult death it encounters is the expected end point of a known disease process, the principles described above are equally valid to its own services. In the Trust's Risk Management Strategy, commitment is given to minimise risk through the systematic embedding of relevant, efficient and effective risk management processes.

## 2. Prevention

The below charts are extracted from a 'real time' database, therefore on any given day the numbers could fluctuate slightly either positively or negatively. Outstanding review means that the document is over the due date for document expiry; due for review means 3 months before document expiry date. In date refers to all documents are all current and up to date.

a) Trust wide policies and SOPs (Q4)


Trustwide SOP's Jan - Mar 18
70
60
50
40
30
20
10
0
59
9
3
63
3
3
43
1
3
Jan-18
Feb-18
Mar-18
G = in date
R = out of date
n = new


Trustwide Policies Jan - Mar 18
180
160
140
120
100
80
60
40
20
0
127
23
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152
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160
17
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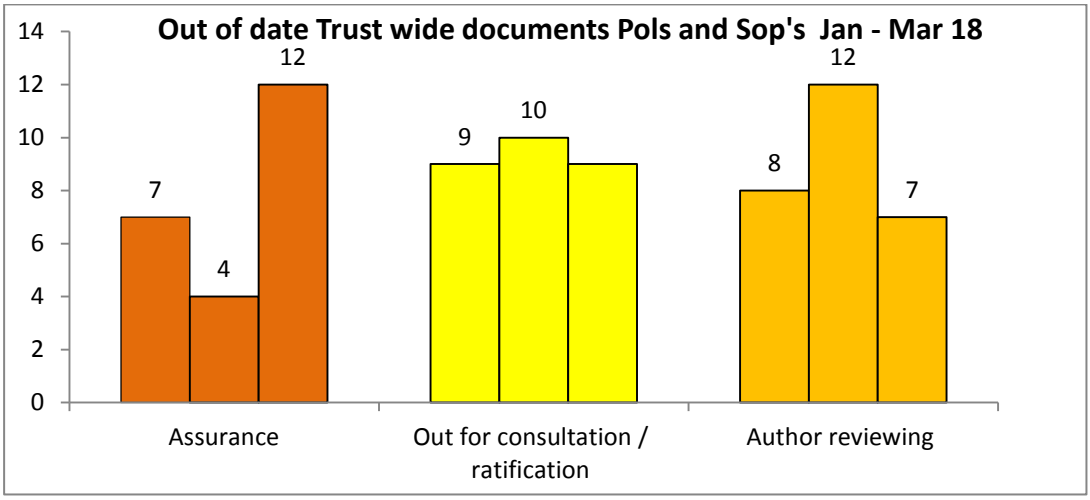
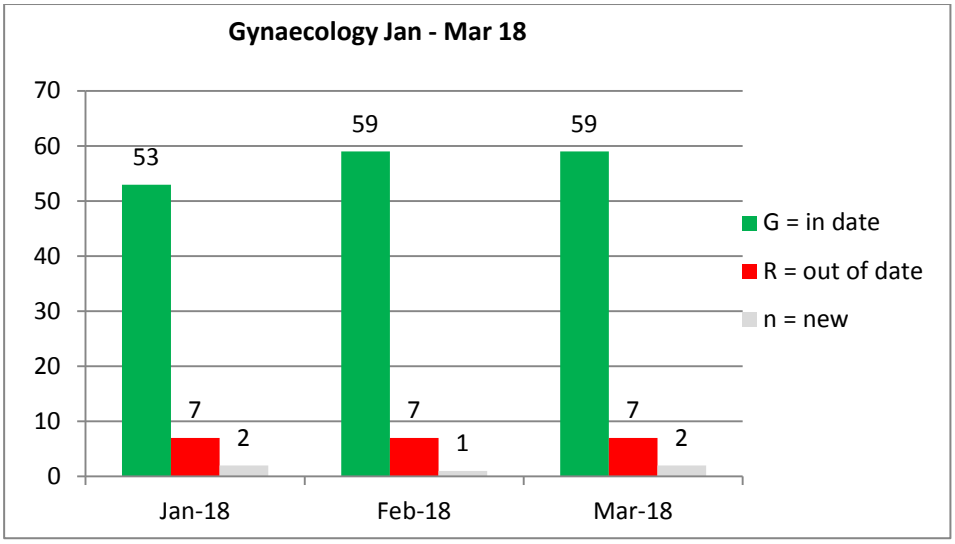
Jan-18
Feb-18
Mar-18
G = in date
R = out of date
n = new


Out of date Trust wide documents Pols and Sop's Jan - Mar 18
14
12
10
8
6
4
2
0
7
4
12
9
10
8
12
7
Assurance
Out for consultation / ratification
Author reviewing

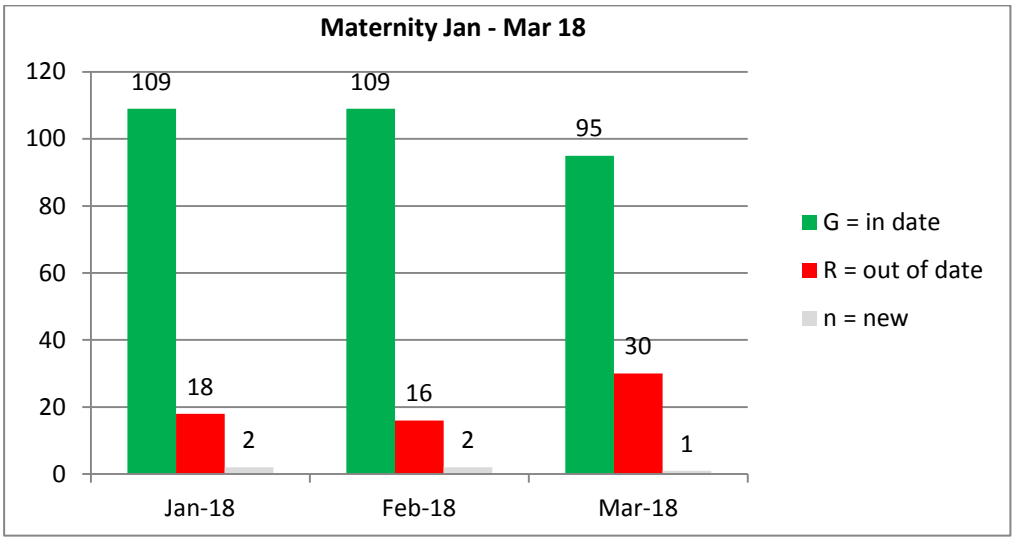
## Gynaecology Policies and Guidelines

**b)** Policies / guidelines are currently being monitored via Gynaecology Clinical meeting.




## Maternity Policies and Guidelines

Policies / guidelines are currently being monitored via Maternity Clinical meeting.




The Effectiveness Committee has agreed that by the end of Quarter 4 there should be no outstanding Guidelines or SOPS. The Effectiveness leads have been tasked with improving performance on all guidelines and SOPs within their Divisions.

## 3. Audit

From April 2017 the Trust has committed to the principle that it must include work of relevance to the highest risk areas for adult mortality in the Clinical Audit Forward plans - including:

- Haemorrhage
- Psychiatric disease
- Sepsis
- Neurological disease
- Venous thromboembolism
- Cardiac Disease

The Annual Audit Programme for 2017 – 18 had been informed by intelligence from a number of different audits in Quarter 4; See below progress table for clinical audits.

### Adult Mortality – Clinical Audit progress March 2018

| Topic | Clinical Audit Title/s | Progress |
|---|---|---|
| **Haemorrhage** | Use of O Negative blood | Received report including action plan.<br><br>Results have been presented at Gynae' Divisional Meeting and the Hospital Transfusion Committee.<br><br>Actions are due for completion Sep-18<br><br>(Green 1 on audit database) |
| | Bedside transfusion (including consent) | Received report including action plan.<br><br>Results are planned to be presented at the Hospital Transfusion Team meeting and the Hospital Transfusion Committee in May18. |

| | | |
|---|---|---|
| | | Actions are due for completion May-18<br><br>(Green 1 on audit database) |
| | SHOT NCA of TACO prevention<br>Require evidence presented | Received report and evidence of action implementation.<br><br>Awaiting evidence that results have been presented.<br><br>(Green 1 on audit database) |
| **Psychiatric disease** | Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital | Audit in the process of being registered.<br><br>As audit not registered 2017-18 it has been carried over to the 2018-19 audit plan.<br><br>(Red 1 on audit database) |
| **Sepsis** | Audit of the management of pregnant women with asymptomatic bacteuria at booking visit<br>*(Previously titled: "Maternal and Congenital sepsis")* | Data collection and analysis is complete.<br><br>Awaiting final Report including action plan.<br><br>As audit not complete 2017-18 it has been carried over to the 2018-19 audit plan.<br><br>(Amber on audit database) |
| | SEPSIS bundle – Maternity | Data being captured via NUMIS. The HDU delivery group and Sepsis lead will collate themes for presentation in Quarter 4 report.<br><br>(No audit required) |
| | Audit of the management of patients with sepsis/compliance to the 1 hour Sepsis Bundle – Gynaecology | Data being captured via NUMIS and is also a CQUIN. AMD has met with Sepsis lead. Sepsis |

| | | |
|---|---|---|
| | | guideline will be updated in line with current recommendations. The HDU delivery group and Sepsis lead will collate themes for presentation in Quarter 4 report.<br><br>(No audit required) |
| | Postoperative surgical site infections following caesarean sections | Received report including action plan.<br><br>Overall, we were compliant with guidelines, with all patients receiving prophylactic antibiotics. Therefore, a re-audit is not required. The Maternity Division is exploring vaginal douching prior to CS as an infection risk reduction strategy.<br><br>Audit completed. |
| **Venous thromboembolism** | Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk | Initial audit – completed.<br><br>Received report including action plan for Re-audit.<br><br>One action due for completion in relation to PENS, has passed its original completion date of Feb-18 but is being chased up appropriately.<br><br>(Green 1 on audit dashboard) |
| **Neurological Disease** | An audit of outcomes in women who attend the Joint Obstetrics/Neurology clinic | This is no longer required as a clinical audit as it is being monitored through monthly reporting by the performance team. |

## 4. Mortality Dashboard

Due to the small number of in-hospital deaths, it has been agreed with the Head of Governance and Associate Medical Director, that the following table showing the total mortality and the rate of death per 1000 discharges will be used as the mortality dashboard.

| 501 - OBS | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Mortality | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Discharges | 1665 | 1873 | 1751 | 1790 | 1792 | 1712 | 1726 | 1791 | 1668 | 1753 | 1577 | 1759 | 20857 |
| Rate per 1000 Discharges | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

| 502 - GYNAE | Apr-15 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Mortality | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Discharges | 1004 | 925 | 934 | 1054 | 1018 | 1035 | 1050 | 1014 | 1026 | 823 | 1000 | 969 | 1004 | 11852 |
| Rate per 1000 Discharges | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

| 503 - GYNAE ONC | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Mortality | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 |
| Discharges | 93 | 90 | 81 | 92 | 71 | 69 | 101 | 86 | 74 | 67 | 70 | 65 | 959 |
| Rate per 1000 Discharges | 10.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 15.4 | 2.1 |

The two deaths in April 2017 and March 2018 for Gynaecology Oncology represents an overall rate of 2.1 per 1000 Oncology discharges for Q1-4 of 2017/18.

**Adult Gynaecological Deaths**

Figure 1 below: Cumulative Adult Gynaecology Deaths: Apr 2017-Mar 2018
There have been no deaths recorded in hospital for Obstetrics or Gynaecology; there have been 2 expected deaths for Gynaecology Oncology in this financial year.

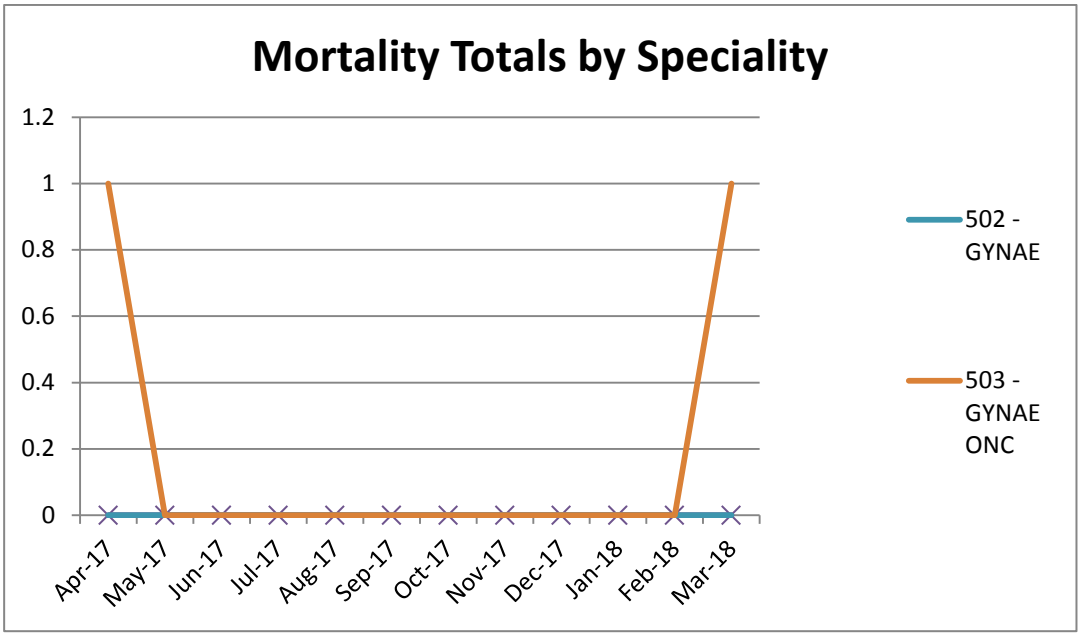
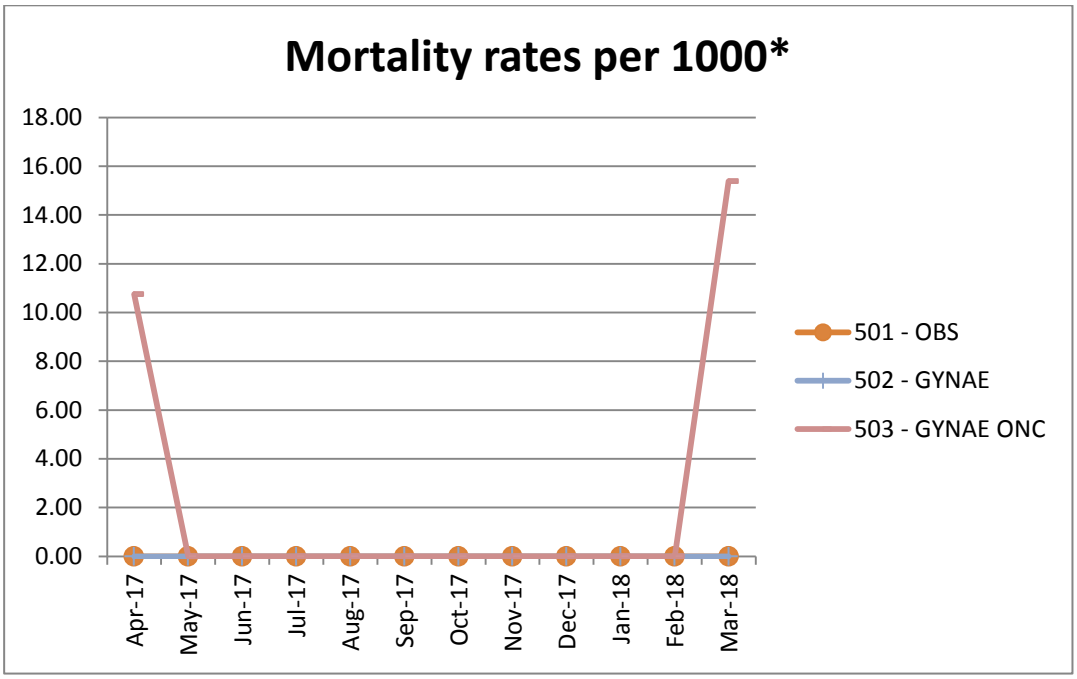



Figure 2 below: Is the rate adult mortality rate per 1000* of the population, overall for the year for Gynaecology Oncology it is 26 per 1000* of the population




## Out of hospital deaths 2017-18 Quarters 1- 4

There were two maternal deaths reported externally via MBRRACE-UK national reporting system. Both were due to indirect causes: brain haemorrhage and leukaemia.

Work is now ongoing with other Trusts in developing an alert process of expected or unexpected deaths of patients who had previously been under the care of LWH. Aintree Hospital has already agreed an alert system.

The AMD and Governance team have put in a place a process for triangulating out of hospital deaths with the MBRRACE-UK midwives and the surrounding Trusts to get better ascertainment.

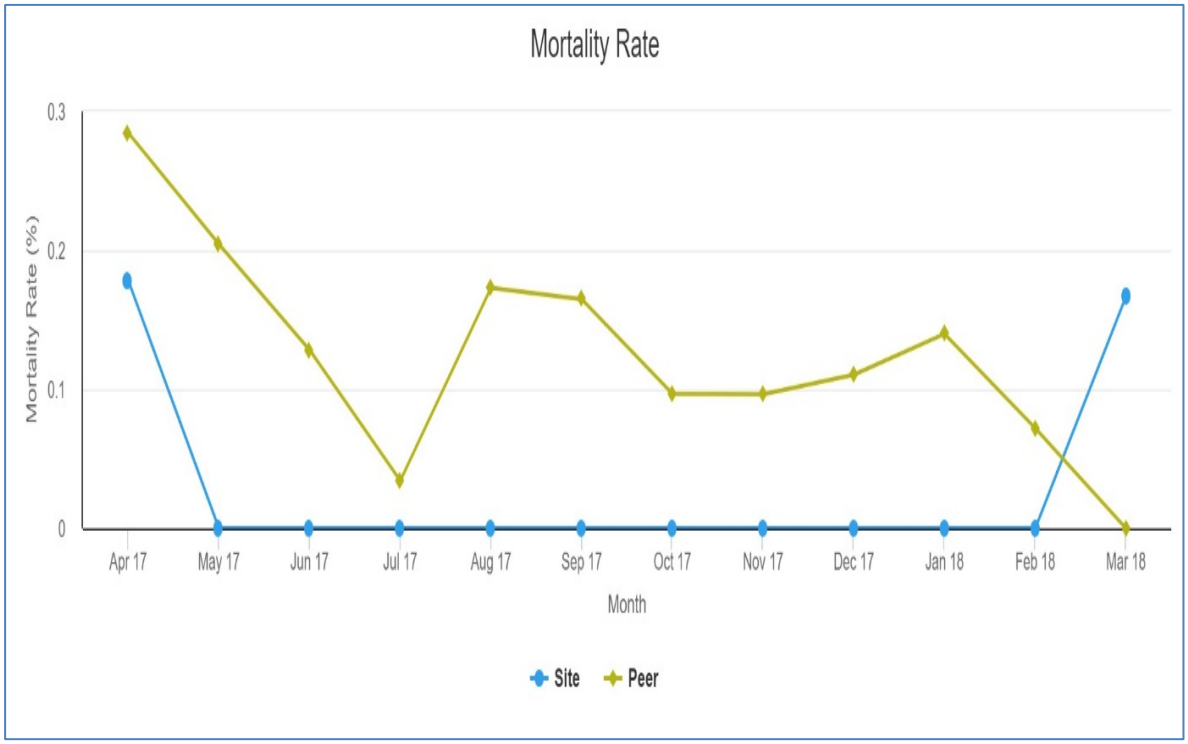
Table below depicts the number of adult deaths in-hospital, including expected and unexpected deaths.

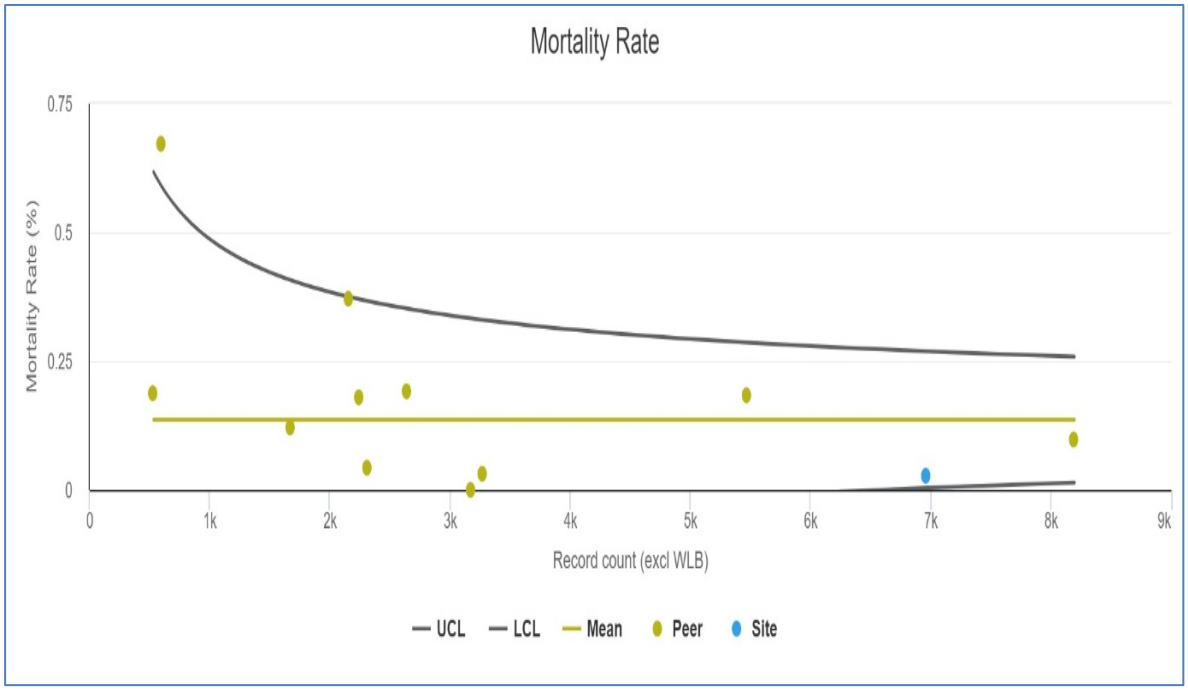
| Reporting Quarter | 2015-2016 | | 2016-2017 | | 2017-2018 | |
|---|---|---|---|---|---|---|
| | In-hospital | Out-hospital | In-hospital | Out-hospital | In-hospital | Out-hospital |
| **Q1** | 1 | - | 3 | | 1 | 2 |
| **Q2** | 4 | - | 2 | | 0 | |
| **Q3** | 4 | - | 3 | 2 | 0 | |
| **Q4** | 5 | - | 1 | | 1 | 0 |
| **Total** | **14** | **-** | **9** | | **2** | |
| | | | | 2 | | 2 |
| **Overall total deaths** | **14** | | **11** | | **4** | |

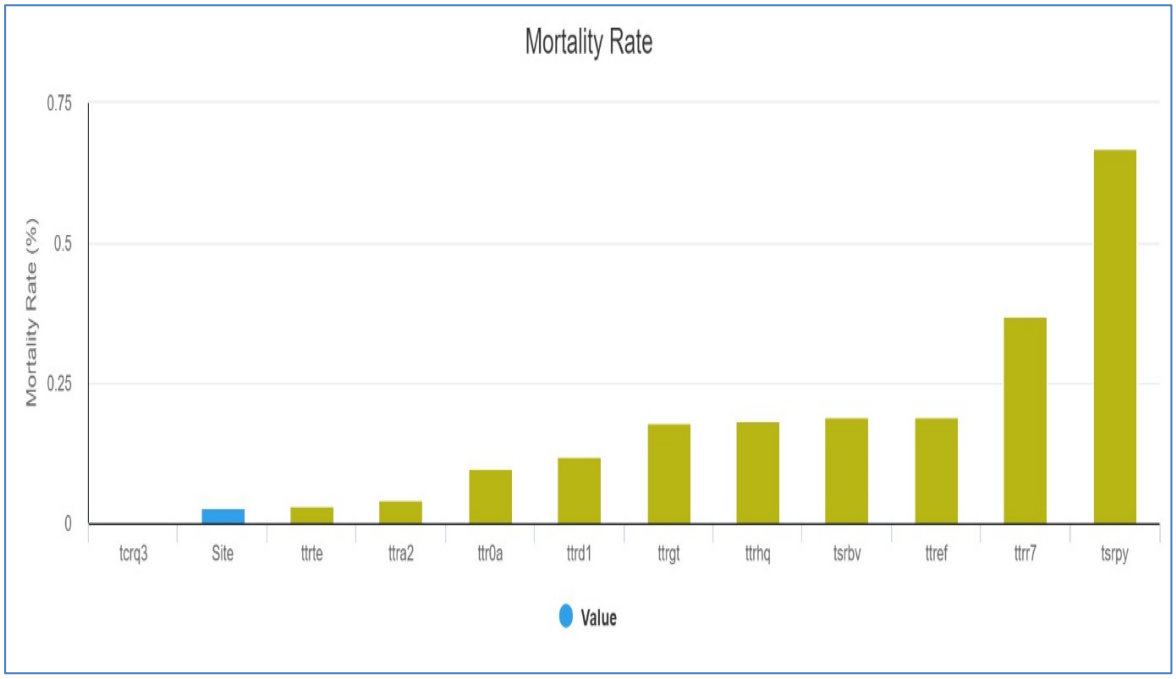
## 5. Benchmarking

CHKS excludes Bedford and Hewitt patients for better comparison with other Trusts. The chart shows that for the time period April 2017 – Mar 2018 LWH mortality rate is below average compared to other peer Trusts.

There were 2 deaths at the trust in the period.

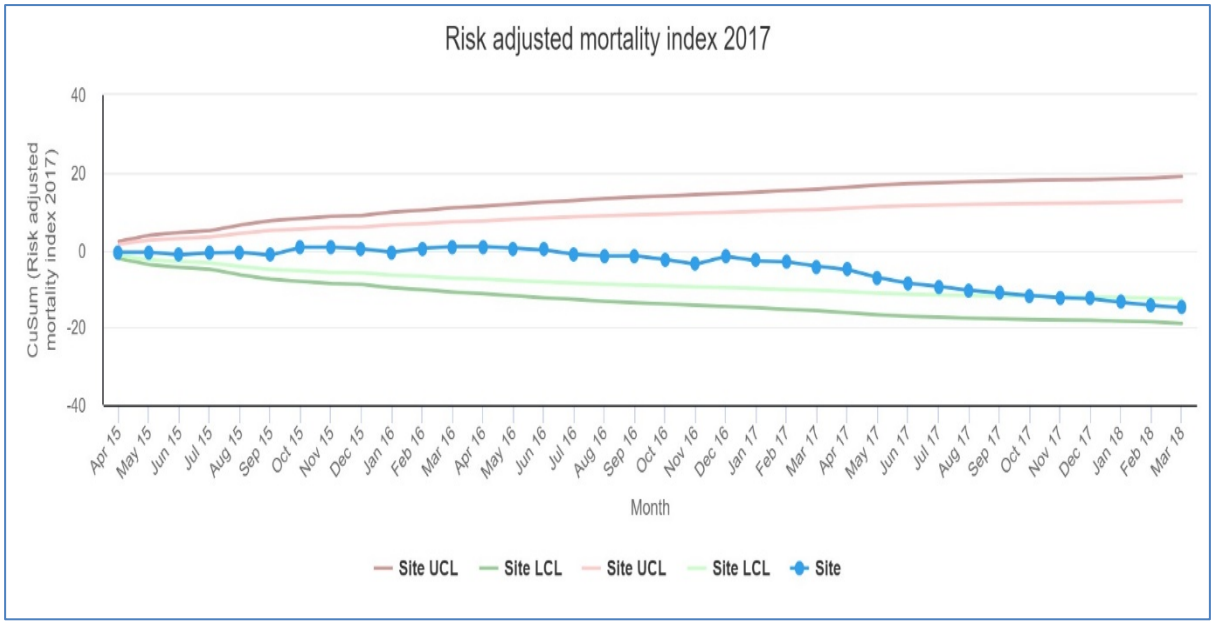







The following chart is a CuSum chart for our risk-adjusted mortality index (RAMI) over a three year period with the same filters applied as above. It plots the cumulative difference between the actual number of deaths and number of deaths 'expected' by the model.




What this is showing is that up to December 2016 the number of gynaecology patient deaths at the trust was fairly consistently as would be expected. Since January 2017 the downward trend shows that fewer patients are dying than would be expected. Obviously the numbers of deaths are small but using the long time period and this cumulative chart provides a good view of our Trust trend and should provide assurance to the Board.

Date range: April 2017 – March 2018

Filters: Treatment Function = 502 – Gynaecology, 503 - Gynaecological Oncology; excluding Hewitt Centre and Bedford Clinic (using HRGs)

Peer group (NOTE that there is no peer data for the month of March 2018):

RQ3 - Birmingham Women's and Children's NHS Foundation Trust

RBV - The Christie NHS Foundation Trust

RPY - The Royal Marsden NHS Foundation Trust

R0A - Manchester University NHS Foundation Trust

RA2 - Royal Surrey County Hospital NHS Foundation Trust

RD1 - Royal United Hospital Bath NHS Trust

REF - Royal Cornwall Hospitals NHS Trust

RGT - Cambridge University Hospitals NHS Foundation Trust

RHQ - Sheffield Teaching Hospitals NHS Foundation Trust

RR7 - Gateshead Health NHS Foundation Trust

RTE - Gloucestershire Hospitals NHS Foundation Trust

For the charts above, peers are based on Gynaecology units of a similar size and type to Liverpool Women's Trust. The adult mortality figures for LWH are historically low as the majority of deaths that occur are 'expected' deaths within gynaecology and oncology units.

## 6. Mortality reviews and Key Themes

Each in-hospital death has a mortality review. All adult gynaecology deaths are discussed at the gynaecology Morbidity & Mortality meeting. As part of this process an adult mortality sheet is completed indicating any potential for improvement in care. Unexpected adult gynaecology deaths trigger a serious incident investigation.

All direct maternal deaths trigger serious incident investigation.

A new mortality review tool has been developed for risk and incident reporting system Ulysses. This avoids losing any paper documents (current system) and allows for searching, monitoring and auditing of an electronic system.

| Adult Mortality Quarter 4 | | |
|---|---|---|
| | **Maternity** | **Gyneacology** |
| No of Adult Deaths | 0 | 0 |
| No of Mortality Reviews completed | 0 | 0 |
| No of deaths requiring RCA's | 0 | 0 |
| No of deaths due to deficiencies in care | 0 | 0 |
| Mortality Themes | N/A | N/A |
| Progress v Smart Plans | N/A | N/A |
| Mortality Outcomes | N/A | N/A |
| Measures for ongoing scrutiny | N/A | N/A |

## 7. Progress / Learning from Deaths

Currently there have been no deaths to comment on in which to provide specific learning from death outcomes. However, we introduced a deep dive review on the two unexpected deaths in 2016/17 in order to provide assurance to the Board.

The deep dive into these two SI's has shown that there was opportunity for further learning to be drawn from the review.

Overarching conclusion from both deep dive reviews

- Ascertain from IMT about ensuring an access to external ICE until EPR comes on line.
- Develop a process to ensure action plans included lessons learnt and shared learning action points are shared appropriately across the Trust and evidenced and recorded as having been completed.
- Utilise Ulysses system to record all elements of SI investigation including actions and shared learning actions. This will also provide an auditing of SI investigations from a thematic perspective.
- In the event of GP service refusing to provide patient information as part of SI investigation, liaise with CCG. Ensure LWH staff are fully appraised of what information is reasonable to request during and SI investigation, escalation and advice and guidance should be sought from Data protection team.
- Develop a process internally to assess when SI action plans are completed they are subject to review and evaluation of effectiveness of both impact to services, patient outcomes and shared learning.
- Check referral forms from GP and or other Trusts do provide all relevant information for the patient, such as – has the patient recently been referred and what diagnostics are outstanding?

Next steps

- To review all shared learning and any gaps / omissions to be addressed as service evaluation of the department. And a process to ensure shared learning takes place and is then evaluated as how effective it has been.
- There was no clear evidence if shared learning had all been completed from the original report.
- There should be an internal process to double check that Lessons Learnt from the original SI report has been completed. Current systems (Ulysses) do not record if this has occurred and difficult to ascertain if all shared learning was disseminated as not included as part of the original action plan.

## 8. Horizon Scanning

### NICE Guidance:

Nice guidance updates and new guides are presented and assigned owners to review at the monthly Effectiveness Senate, this is then monitored, reviewed and audited through the senate.

A review for the past quarter of NICE guidance and updates has yielding no results in any outstanding or updates to guides in relation to Adult Mortality.

### Other Professional Organisations:

Library services provide monthly horizon scanning of any new clinical reports, documents, guidance, and research across a wide range of clinical subject matter for review at the monthly Effectiveness Senate, this is then monitored, reviewed and audited through the senate.

**Horizon Scanning Summary for guidance, reports and publications**

**Subject(s):** Adult mortality (Maternity/ Gyneacology)

**Period:** January 2018 – March 2018

**Sources**: CQC; NCPOD; NHS Digital, NHS Resolution, Public Health England, RCOG,

**CQC** – no updates found for the period covered

**NCEPOD** – no updates found for the period covered

**NHS Digital –** no updates found for the period covered

**NHS Resolution** – no updates found for the period covered

**Public Health England** – no updates found for the period covered

**RCOG –** no updates for the period covered

## 9. Conclusion

There has been one expected gynaecological oncology death; no deaths in obstetric or LeDer (Learning disability) deaths within quarter 4 reporting period.

## 10. Recommendations

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board
b. Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust