Agenda Item	2017/246

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Quarterly Mortality Report: Quarter 1 of 2017-18**
DATE OF MEETING:	Friday, 08 September 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	G. Hope, Head of Governance
STRATEGIC OBJECTIVES:	**Which objective(s)?** **1.** To develop a well led, capable, motivated and entrepreneurial **workforce** ☐ **2.** To be ambitious and **efficient** and make the best use of available resource ☐ **3.** To deliver **safe** services ☒ **4.** To participate in high quality research and to deliver the most **effective** Outcomes ☒ **5.** To deliver the best possible **experience** for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**Which condition(s)?** **1.** Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust ☐ **2.** The Trust is not financially sustainable beyond the current financial year ☐ **3.** Failure to deliver the annual financial plan ☐ **4.** Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ☐ **5.** Ineffective understanding and learning following significant events ☒ **6.** Inability to achieve and maintain regulatory compliance, performance and assurance ☒ **7.** Inability to deliver the best clinical outcomes for patients ☒ **8.** Poorly delivered positive experience for those engaging with our services ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	☐ ☒ ☐	**4.** NHS Constitution **5.** Equality and Diversity **6.** Other please state: **Click here to enter text.**	☐ ☐
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: **(eg: The Board/Committee is asked to:-….)**	**The Board is asked to:** 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 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. Or type here if not on list: Click here to enter text.	
	Date of meeting		Click here to enter a date.	

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 1 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 being overseen by Effectiveness Senate and GACA.

Report

1. Introduction and summary

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 Governance and Clinical Assurance 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.

2. Issues for consideration

The Board of Directors at its meeting on 15 May 2017 received the Adult Mortality Strategy and Perinatal Mortality Strategy for approval. The Board felt that the strategies needed additional emphasis on the trust's ambitions and aspirations on reducing avoidable deaths. The Board was also advised that a number of amendments had been requested by clinicians particularly with regards to the Perinatal Mortality Strategy. It was therefore agreed by the Board at its meeting on 15 May 2017 that both strategies would be approved subject to further review by GACA at its meeting on 15 May 2017. This work took place at GACA and was reported back to the Board through the Chair's report.

In parallel with this internal work, when the National Quality Board launched its Learning From Deaths policy in March 2017 in response to the CQC's report 'Learning, candour and accountability', it was made clear that trusts should be developing their systems and processes relating to how to review and learn from the deaths of patients under their care. Supported by NHS Improvement, they laid down several key requirements including

- From April 2017, trusts must collect new quarterly information on deaths including: the total number of patient deaths; the number of deaths subject to case record review; the number investigated as SIs; an estimate of the number thought more likely than not to have been caused by problems in care; the main themes and trends emerging from review and investigation; and what the trust is doing to address those themes and trends in order to improve care
- By September 2017, trusts should publish an updated policy on how they respond to and learn from the deaths of patients in their care
- From Q3 2017 onwards they must publish information on deaths, reviews and investigations quarterly via an agenda item and paper to their public board meetings.
- From June 2018, trusts must publish an annual summary of this data in their quarterly accounts.

3. Key Themes

Gap analysis versus the requirements of the National Quality Board

Requirement	Progress
From April 2017, trusts must collect new quarterly information on deaths including: • the total number of patient deaths; • the number of deaths subject to case record review; • the number investigated as SIs; • an estimate of the number thought more likely than not to have been caused by problems in care; • the main themes and trends emerging from review and investigation; and • what the trust is doing to address those themes and trends in order to improve care	**Complete** – This information is collected and reported to divisional mortality and morbidity meetings and is overseen by the Effectiveness Senate as a standing agenda item
By September 2017, trusts should publish an updated policy on how they respond to and learn from the deaths of patients in their care	**Partially Complete** – The recently approved Adult Mortality Strategy and Perinatal Mortality Strategy set out the trust's approach to responding to and learning from the deaths of patients in our care. The key elements of these documents will form the Trust Mortality Policy that will be approved by Effectiveness Senate on 15 September.

From Q3 2017 onwards they must publish information on deaths, reviews and investigations quarterly via an agenda item and paper to their public board meetings.	**Complete** – This information is included as part of the Serious Incident Update Report which is scheduled quarterly on the Board's Business Cycle
From June 2018, trusts must publish an annual summary of this data in their quarterly accounts.	**Partially Complete** – Data is available and will be published in quarterly accounts from 2018-19 onwards as per the requirement.

Mortality themes in Quarter 1

Adult Gynaecological Deaths

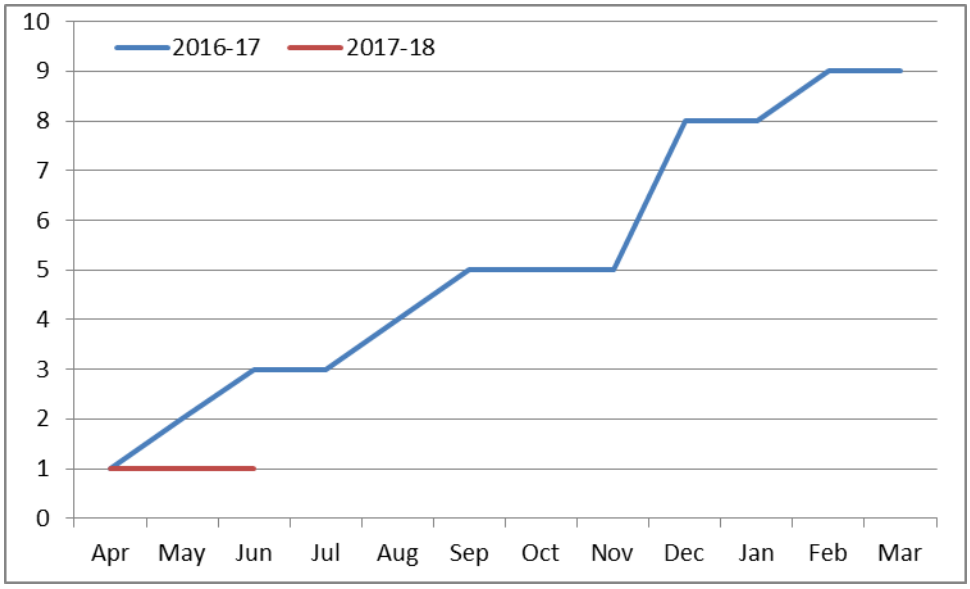

Figure 1: Cumulative Adult Gynaecology Deaths: Apr 2016-Jun 2017

- There was one adult gynaecology death in Quarter 1 of 2017-18. This compares to 3 in Quarter 1 of 2016-17.
- There were 12 adult gynaecology deaths in 2016-17, a reduction on the 14 in 2015-16
- The Quarter 1 death was assessed as an expected death.
- 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.
- The most recent serious incident investigation arising from a gynaecology death related to a death in August 2016. This patient was not an oncology patient. The investigation identified underlying co-morbidities not linked to the patient's treatment at Liverpool Women's.
- Benchmarking over the most recent period available (April 2016-June 2017) indicates Liverpool Women's is in the middle quartile of similar trusts, marginally below the mean mortality rate. If the current trajectory continues this position will further improve.

Stillbirths

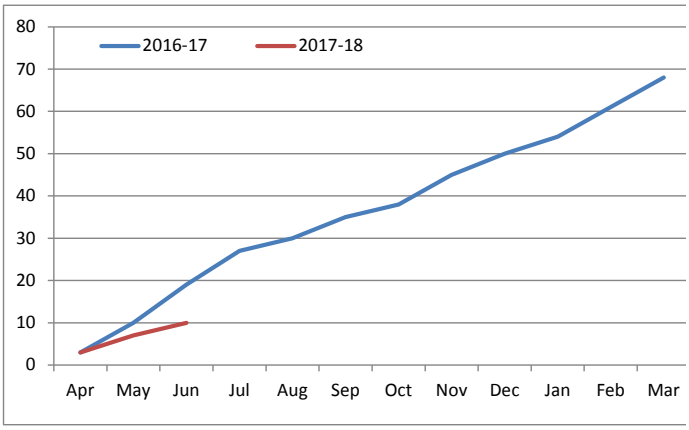

Figure 2: Cumulative Stillbirths: Apr 2016 - Jun 2017

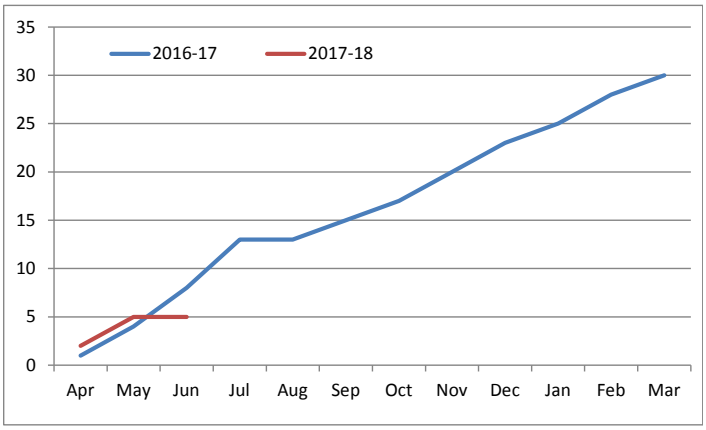

Figure 3: Cumulative Stillbirths (excluding terminations): Apr 2016 - Jun 2017

- Stillbirth can be defined as fetal death between the gestation of potential viability and the time of birth.
- There were 10 stillbirths at the trust in Quarter 1 of 2017-18. This compares to 19 in Quarter 1 of 2016-17. Included in these figures are late terminations. As a result it is more useful to consider the number of stillbirths excluding terminations when considering prevention and improvement.
- There were 5 non-termination stillbirths in Quarter 1 of 2017-18. This compares to 8 in Quarter 1 of 2016-17.
- There were 30 non-termination stillbirths in 2016-17, a significant reduction on the 43 recorded in 2015-16.
- All non-termination stillbirths are discussed at the trust Stillbirth Review meeting which includes external pathology and histology presentations. As part of this process all are given a CESDI grading indicating any potential for improvement in care.
- Any stillbirths meeting the criteria for Each Baby Counts are reported nationally and fully reviewed with external input
- All Intrapartum stillbirths trigger a serious incident investigation. The most recent serious incident investigations followed intrapartum stillbirths in Quarter 3 of 2016-17. This led to the commissioning of a review of the Maternity Assessment Unit led by Professor Alfirevic and a number of subsequent changes in practice. These included alterations to staffing mix and the introduction of traffic light triaging. Audits and monitoring of outcomes indicates these are proving a success thus far but will continue to be monitored closely.
- Benchmarking over the most recent period available (April 2016-June 2017) indicates Liverpool Women's is in the middle quartile of similar trusts, marginally above the mean mortality rate. The trust has previously been identified as an outlier and was firmly in the upper quartile until 2016-17.
- External benchmarking includes all stillbirths and there is no risk-adjusted methodology in place nationally for assessing stillbirth rates. This methodology is likely to overstate the risk at this trust due to its failure to take account of either terminations or case mix.

Neonatal Deaths

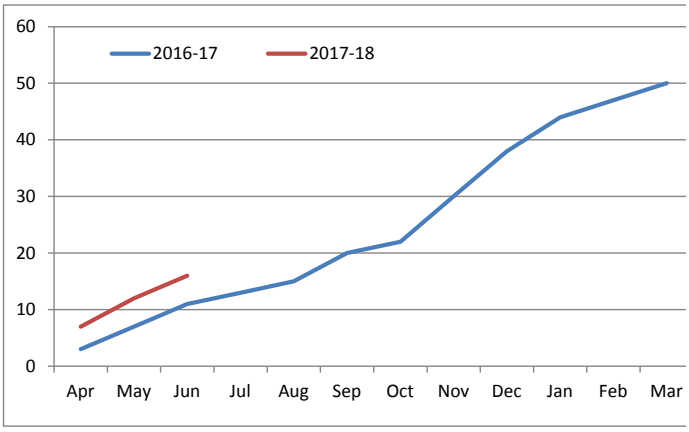

Figure 4: Cumulative Neonatal Deaths: Apr 2016 - Jun 2017

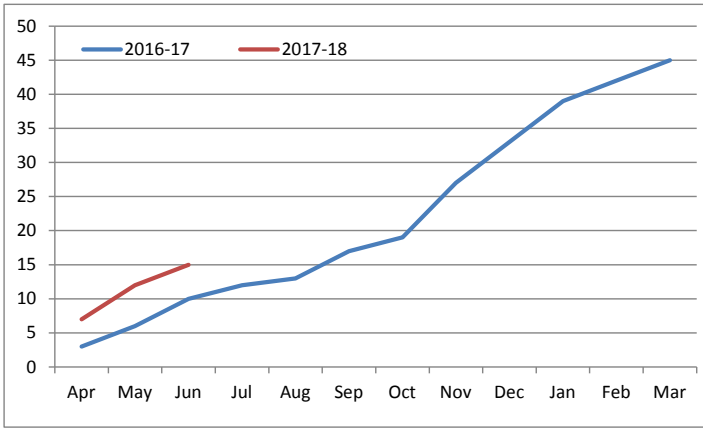

Figure 5: Cumulative Neonatal Deaths (excluding pre-viable neonatal deaths and terminations): Apr 2016 - Jun 2017

- Neonatal death is the death of a baby in the first 28 days of its life.
- There were 16 neonatal deaths at the trust in Quarter 1 of 2017-18. This compares to 11 in Quarter 1 of 2016-17. Included in these figures are pre-viable neonatal deaths and some terminations. As a result it is more useful to consider the number of neonatal deaths excluding pre-viable neonatal deaths and terminations when considering prevention and improvement.
- There were 15 neonatal deaths excluding pre-viable neonatal deaths and terminations in Quarter 1 of 2017-18. This compares to 10 in Quarter 1 of 2016-17.
- There were 45 neonatal deaths excluding pre-viable neonatal deaths and terminations in 2016-17, in line with the 44 recorded in 2015-16.
- Preterm birth is the single most important determinant of neonatal death, with over two thirds of all neonatal deaths occurring in babies born before 32 weeks gestation. The care of preterm babies at birth and in the early hours is an important determinant of survival. National recommendations are that a neonatal service providing the volume of intensive care that this trust does should have a consultant presence for 24 hours a day. The Trust's present commitment, contained in the Operational Plan, is to increase the consultant body by one new consultant per year over the next five years
- All neonatal deaths within the Trust are subject to multidisciplinary team review using a standard methodology. This allows the team to identify any deaths meeting the threshold for triggering a Sudden Unexplained Death in Infancy (SUDI) investigation, deaths requiring discussion with the Coroner and deaths necessitating a Serious Incident investigation. The intelligence produced by this approach has been used to inform service development priorities and drive service improvement.
- Any neonatal deaths meeting the criteria for Each Baby Counts are reported nationally and fully reviewed with external input
- Benchmarking over the most recent period available (January-December 2016) indicates that when only births booked at this trust are considered the Neonatal Mortality Rate at Liverpool Women's is below the national rate at 2.1 deaths per 1,000 live births. Many women are referred into this trust during their pregnancies because of concerns about fetal development or severe cardiac abnormality. Even when those babies transferred here for specialist treatment are considered the trust mortality rate is 0.4% above the national rate, within the Trust target of remaining within 1% of the national rate.
- The Vermont Oxford Neonatal network collects data that allow us to benchmark our very low birthweight and extreme preterm mortality against other neonatal units across UK and across the world, with risk adjustment for case mix. This provides reassurance that our mortality rates are currently within the expected range.

4. Conclusion

In conclusion the Board can take assurance that work to develop systems and processes to review and learn from the deaths of patients under their care is on track and has been implemented to a significant extent. There are plans in place to ensure full compliance within the necessary timeframes as set out by the National Quality Board.

Quarter 1 of 2017-18 saw reductions in adult gynaecology deaths and non-termination stillbirths. While there was an increase in neonatal deaths there is assurance available from all specialties that mortality rates remains within the expected range. There are detailed arrangements for the escalation and investigation of unexpected deaths across the trust and the strategies agreed at Board and GACA earlier in 2017 are beginning to become embedded.

5. 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 there are effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this trust