

MEETING	Board of Directors	
PAPER/REPORT TITLE:	Adult Mortality Report 17/18 Q3	
DATE OF MEETING:	Friday, 02 February 2018	
ACTION REQUIRED	For Assurance	
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director	
AUTHOR(S):	Devender Roberts – Associate Medical Director Amanda Cringle – Quality Improvement Lead	
STRATEGIC OBJECTIVES:		
	<p>Which Objective(s)?</p> <ol style="list-style-type: none"> To develop a well led, capable, motivated and entrepreneurial <i>workforce</i> <input type="checkbox"/> To be ambitious and <i>efficient</i> and make the best use of available resource <input type="checkbox"/> To deliver <i>safe</i> services <input checked="" type="checkbox"/> To participate in high quality research and to deliver the most <i>effective</i> Outcomes <input checked="" type="checkbox"/> To deliver the best possible <i>experience</i> for patients and staff <input type="checkbox"/> 	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):		
	<p>Which condition(s)?</p> <ol style="list-style-type: none"> Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust <input type="checkbox"/> The Trust is not financially sustainable beyond the current financial year <input type="checkbox"/> Failure to deliver the annual financial plan <input type="checkbox"/> Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision <input type="checkbox"/> Ineffective understanding and learning following significant events <input checked="" type="checkbox"/> Inability to achieve and maintain regulatory compliance, performance and assurance <input checked="" type="checkbox"/> Inability to deliver the best clinical outcomes for patients <input checked="" type="checkbox"/> Poorly delivered positive experience for those engaging with our services <input type="checkbox"/> 	
CQC DOMAIN		
	<p>Which Domain?</p> <p>SAFE- People are protected from abuse and harm <input type="checkbox"/></p> <p>EFFECTIVE - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. <input type="checkbox"/></p> <p>CARING - the service(s) involves and treats people with compassion, kindness, dignity and respect. <input type="checkbox"/></p> <p>RESPONSIVE – the services meet people's needs. <input type="checkbox"/></p> <p>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. <input checked="" type="checkbox"/></p> <p>ALL DOMAINS <input type="checkbox"/></p>	

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	1. Trust Constitution <input type="checkbox"/> 2. Operational Plan <input checked="" type="checkbox"/> 3. NHS Compliance <input type="checkbox"/>	4. NHS Constitution <input type="checkbox"/> 5. Equality and Diversity <input type="checkbox"/> 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: <i>(eg: The Board/Committee is asked to:-.....)</i>	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	<i>Choose an item.</i> Or type here if not on list: Effectiveness Senate
	Date of meeting	Friday, 16 February 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 3 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 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 3		
	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- 3

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	-	-	-
Total	14	-	9	-	1	-
		-		2		2
Overall total deaths	14		11		3	

Conclusion/Recommendation

There have been no gynaecological, obstetric or LeDer (Learning disability) deaths within quarter 3 reporting period. Work against the Adult Mortality Strategy is progressing steadily.

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 3 – (Oct, Nov & Dec)

- Adult Mortality Q3 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 3 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

No actions have been identified from this report but due to the small number of deaths, the Governance team will perform a 'deep dive' into 2016/17 & 2017/18 deaths to gain more information on unexpected deaths.

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.

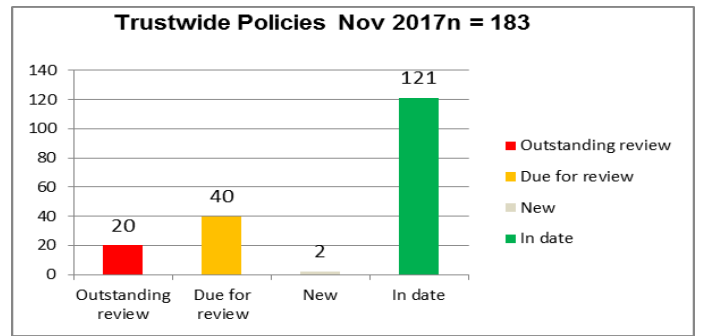
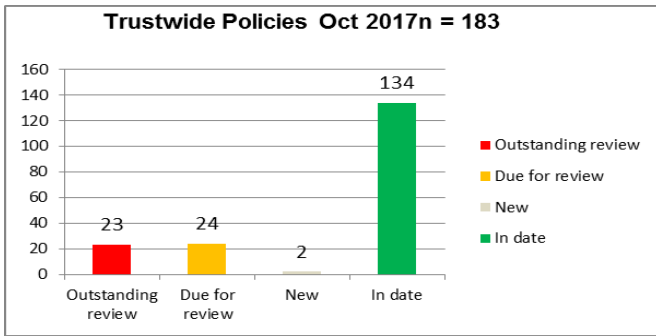
This overview outlines the most recent Trust figures and headline findings in regards to mortality. It provides details to the Board of their own accountabilities while setting out the responsibilities of the Quality Committee and Effectiveness Senate to monitor progress regularly and escalate as required; 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.

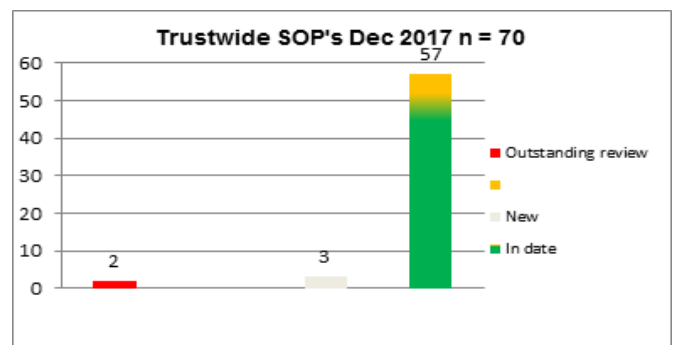
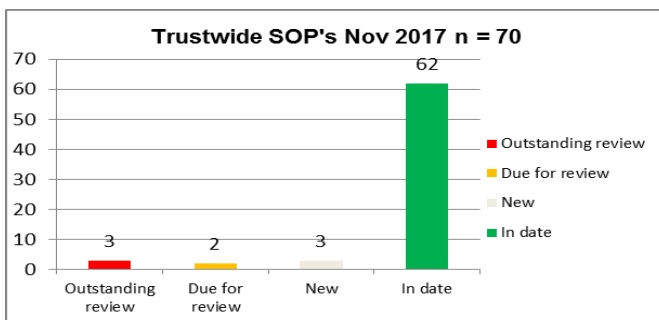
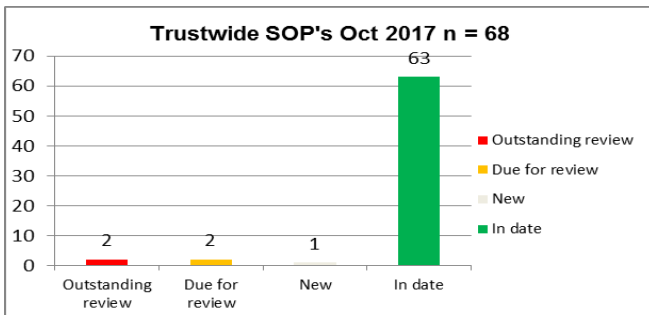
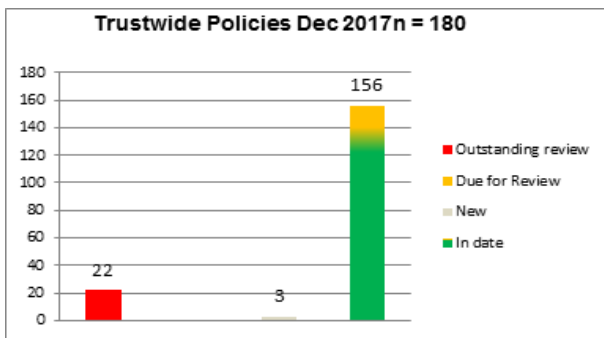
2. Prevention

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 (Q3)

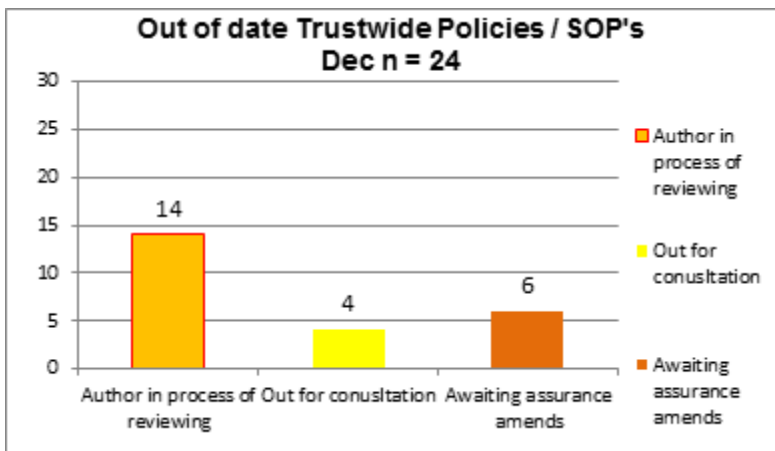
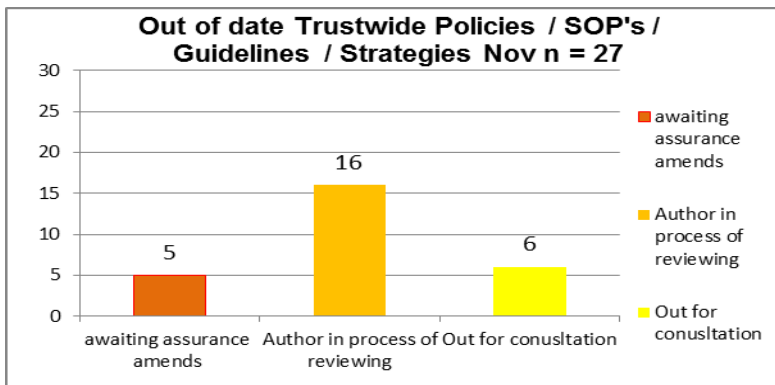
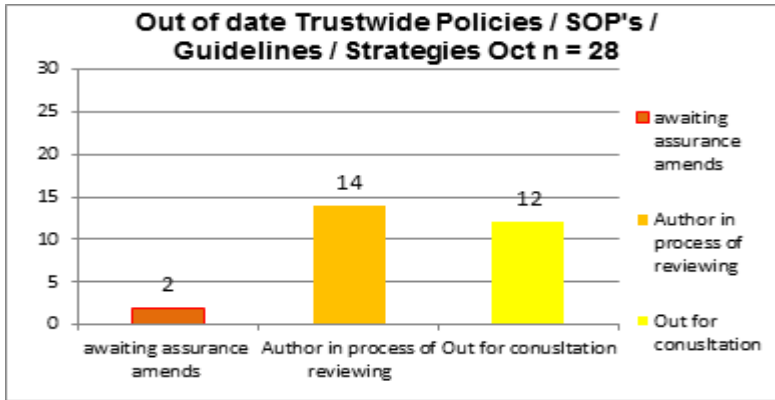


Documents in the amber bar chart are those within 3 months of requiring review



Those documents outstanding for review are going through the ratification processes via each appropriate scrutiny committees at both divisional level and then corporate ratification.

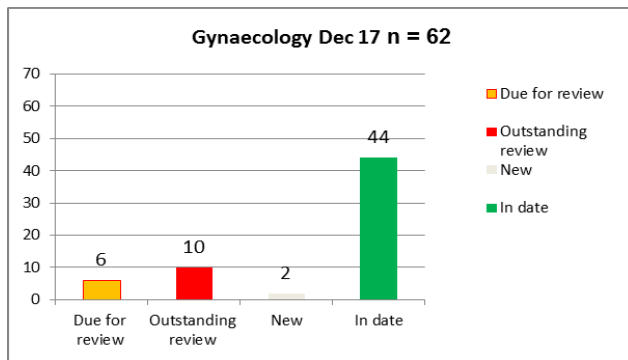
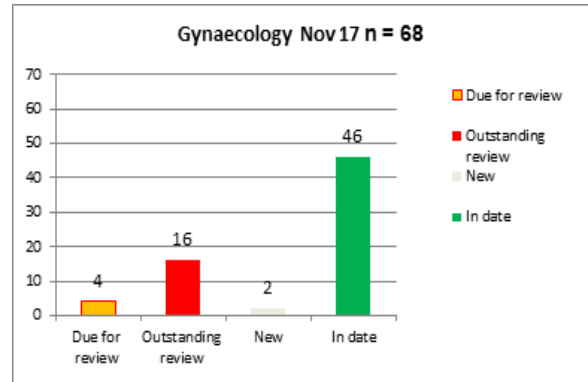
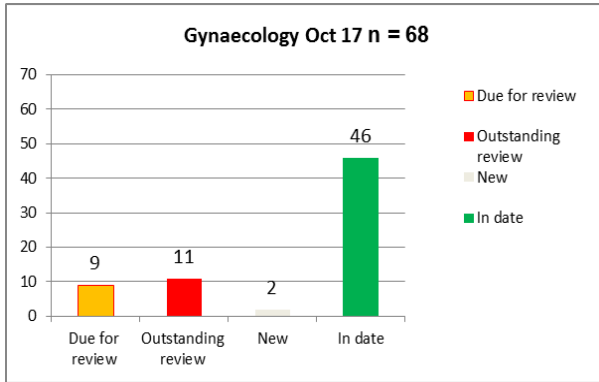
b) In the below three charts for October, November and December 2017, there are currently 26 Trust wide Policies, SOP's, Guidelines and Strategies out of date. Out of the 26 documents 22 are policies; of which 4 are awaiting assurance amendments before final upload and 3 are awaiting ratification. The residual 15 documents are in process of being reviewed. The remaining 4 out of date documents consist of 2 Guidelines and 2 SOP's.



The data processing for reporting has now changed from December, the bars on the charts are now in the process order as a policy or SOP works the way through the document monitoring system.

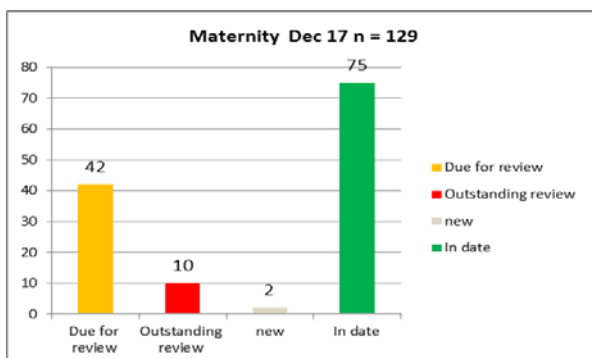
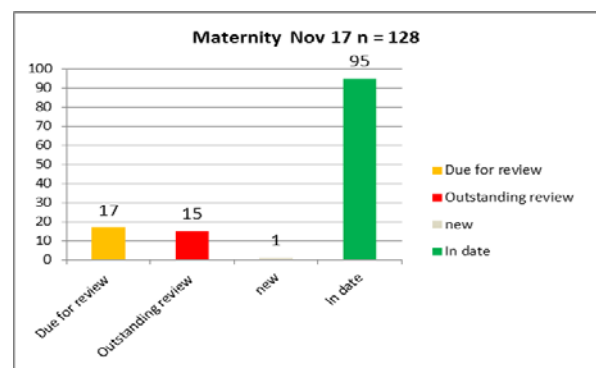
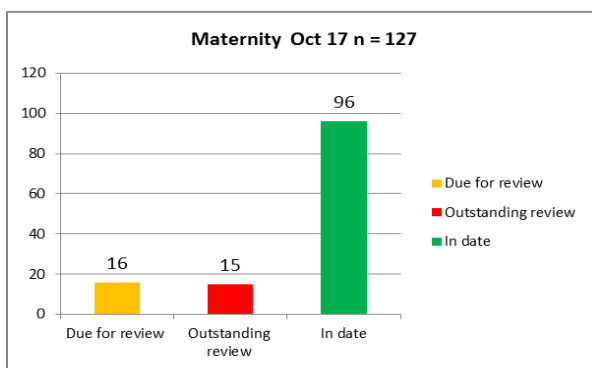
Gynaecology Policies and Guidelines

- c) Policies / guidelines are currently being monitored via Gynaecology Clinical meeting; there are 10 documents outstanding review, of which 12 are awaiting ratification from the October meeting.



Maternity Policies and Guidelines

Policies / guidelines are currently being monitored via Maternity Clinical meeting; there are 10 documents outstanding review, of which 3 are awaiting ratification. The remaining 7 are currently being reviewed and updated by the author.



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 2; See below progress table for clinical audits.

Adult Mortality – Clinical Audit progress October 2017

Topic	Clinical Audit Title/s	Progress
Haemorrhage	Use of O Negative blood	Data collection in progress. Provision of report including action plan deadline extended from Dec-17 to Feb-18. (Amber on audit database)
	Bedside transfusion (including consent)	Data collection in progress. Provision of report including action plan deadline extended from Dec-17 to Jan-18. (Amber on audit database)

	SHOT NCA of TACO prevention	Received report and evidence of action implementation. (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. Report including action plan expected Aug-18. (Red 1 on audit database)
Sepsis	Audit of the management of pregnant women with asymptomatic bacteraemia at booking visit <i>(Previously titled: "Maternal and Congenital sepsis")</i>	Audit has been registered and data collection ongoing. Report including action plan expected Mar-18. (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. (No audit required)
	Audit of the management of patients with sepsis/compliance to the 1 hour Sepsis Bundle – Gynaecology	Data being captured via NUMIS. 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. (Red 1 on audit database)
	Postoperative surgical site infections following caesarean sections	Received report including action plan. 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 Audit completed
Venous thromboembolism	Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk	Received report including action plan. Re-audit in progress.
Neurological Disease	An audit of outcomes in women who attend the Joint Obstetrics/Neurology clinic	This will be on 2018-2019 audit plan

4. Mortality Dashboard

Due to the small number of in-hospital deaths, it has been agreed with the Head of Governance, 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	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0
Discharges	1665	1873	1751	1790	1792	1712	1726	1791	1666	15766
Rate per 1000 Discharges	0	0	0	0	0	0	0	0	0	0

502 - GYNAE	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0
Discharges	925	934	1054	1018	1035	1050	1014	1026	821	8877
Rate per 1000 Discharges	0	0	0	0	0	0	0	0	0	0

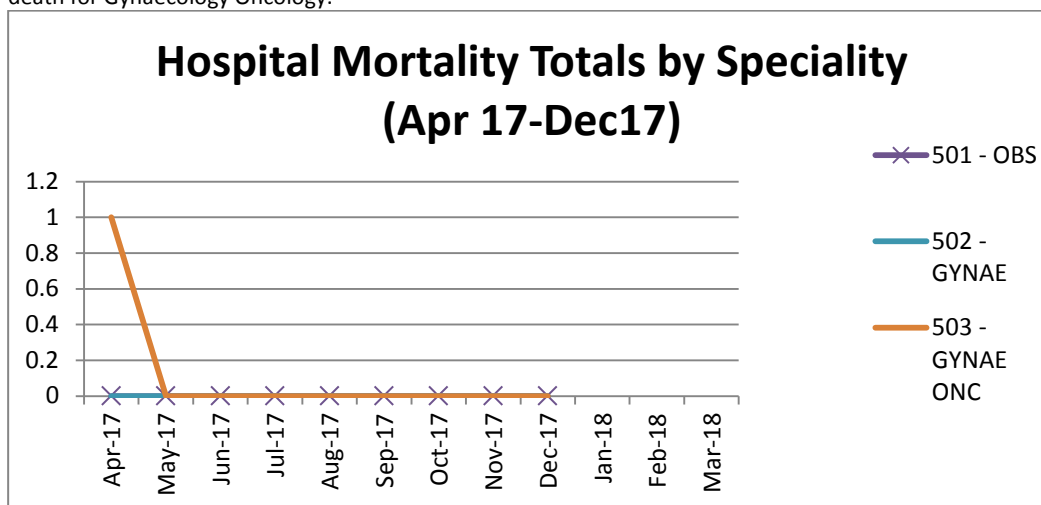
503 - GYNAE ONC	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	TOTAL
Total Mortality	1	0	0	0	0	0	0	0	0	1
Discharges	93	90	81	92	71	69	101	86	74	757
Rate per 1000 Discharges	10.8	0	0	0	0	0	0	0	0	1.3

The single death in April for Gynaecology Oncology represents an overall rate of 1.3 per 1000 Oncology discharges for Q1-3 of 2017/18.

Adult Gynaecological Deaths

Figure 1 below: Cumulative Adult Gynaecology Deaths: Apr 2016-Dec 2017

There have been no deaths recorded in hospital for Obstetrics or Gynaecology, there has only been 1 expected death for Gynaecology Oncology.



Out of hospital deaths 2017-18 Quarters 1- 3

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.

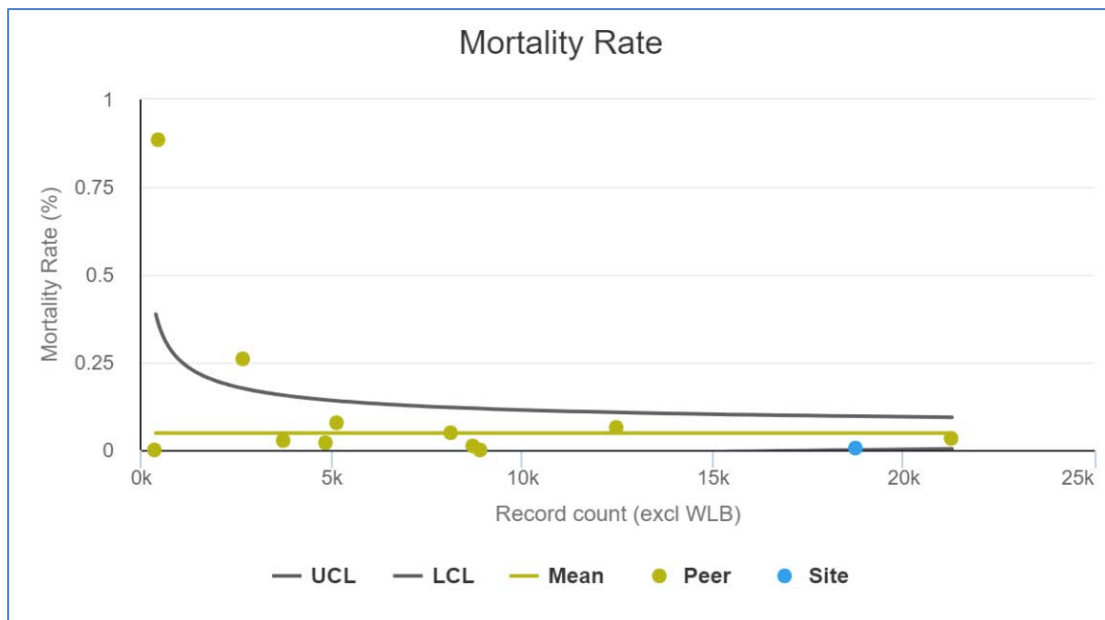
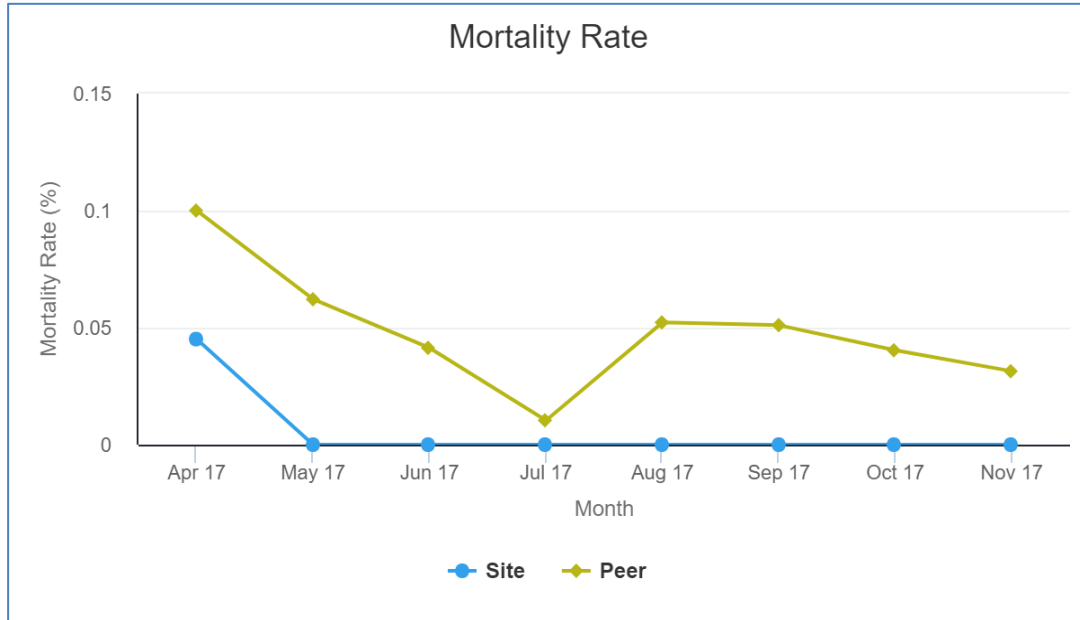
The AMD and Governance team have put in a place a process for triangulating out of hospital deaths with the MBRRACE-UK midwives and the surrounding Trusts to get better ascertainment.

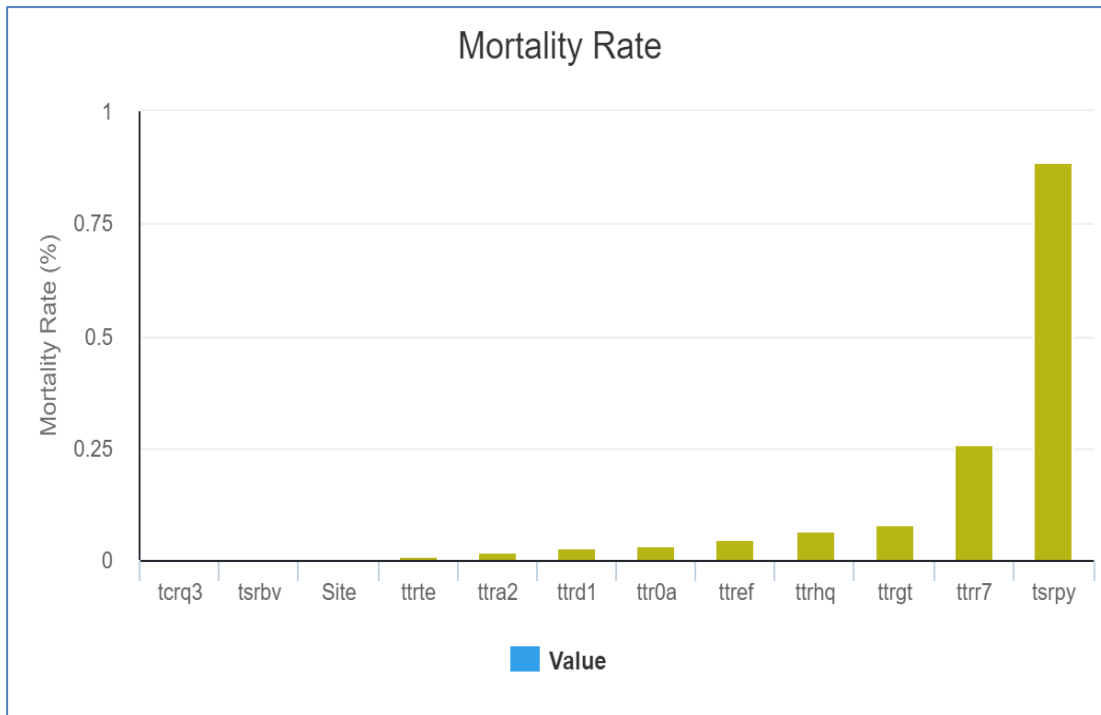
Table below depicts the number of adult deaths in-hospital, including expected and unexpected deaths.

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	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			
Total	14	-	9		1	
				2		2
Overall total deaths	14		11		3	

5. Benchmarking

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





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Date range: April 2017 to November 2017

Filters: Treatment Function = 501 – Obstetrics, 502 – Gynaecology, 503 - Gynaecological Oncology; excluding Hewitt Centre and Bedford Clinic

Peer group:

RQ3 - Birmingham Children's Hospital NHS Foundation Trust (*now Women's and Children's*)

RBV - The Christie NHS Foundation Trust

RPY - The Royal Marsden NHS Foundation Trust

ROA - 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 3		
	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 are going to perform a deep dive on the two unexpected deaths in 2016/17 in order to provide assurance to the Board.

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: November 2017 – January 2018

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

CQC – no updates found for the period covered

NCPOD – 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 – Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15

MBRRACE-UK

This [report](#) into maternal mortality and morbidity shows an overall fall in maternal deaths from 11 per 100,000 in 2006-08 to 10 per 100,000 in 2010-12. The RCOG & RCM joint statement on this report can be accessed [here](#)

9. Conclusion

There have been no gynaecological, obstetric or LeDer (Learning disability) deaths within quarter 3 reporting period. Work against the Adult Mortality Strategy is progressing steadily.

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