Agenda Item	19/20/34 (V2)

MEETING	**Quality Committee**
PAPER/REPORT TITLE:	**Adult and Perinatal Mortality Report Q4 / End of Year 2018/19**
DATE OF MEETING:	Monday, 20 May 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Devender Roberts, Acting Medical Director
AUTHOR(S):	Devender Roberts Amanda Cringle Louise Robertson Sian McNamara
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.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☐ ***10.*** *Potential for 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	☐	**4.** NHS Constitution	☐
	2. Operational Plan	☒	**5.** Equality and Diversity	☐
	3. NHS Compliance	☒	***6.*** Other: **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:-….)***	**Adult Mortality Q4 2018-2019** The Committee: a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board; and b. Confirm that the Committee is confident that there are effective processes in place to assure the Committee and the Board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust **Perinatal Mortality Q4, 2018 - 2019** The Committee: c. Take assurance that it is confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from stillbirths.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Not Applicable	
	Date of meeting			

Executive Summary

- All adult deaths and stillbirths have a mortality review conducted.
- The single out of hospital non-oncology Gynaecological death was declared as a Serious Incident. No specific actions impacting on care or affecting the outcome were identified but some areas of improving practice were identified and have been actioned.
- No LeDeR related adult deaths in the period 18/19.

- The stillbirth rate for 2018/19 is 3.91/1000 (lower than the peer average of 4.4/1000)
- The overall standard of care in stillbirth was good. The proportion of babies where different care may have prevented the outcome has reduced from 21 to 14%.
- The Perinatal Mortality Review Tool (PMRT) has been used to support all stillbirths reviews during 2018/19
- Learning and themes from the stillbirth reviews were identified and have been or are being actioned.

Recommendations from the Report

Adult Mortality Q4 2018-2019

The Committee:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board; and

b. Confirm that the Committee is confident that there are effective processes in place to assure the Committee and the Board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust

Report

Adult Mortality Quarterly Report

18/19 Quarter 4 / End of Year

- Adult Mortality Q4, 2018 - 2019 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 Quality Committee.

Key findings:

- All deaths have had a mortality review conducted.

1. 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.

Table 1: Obstetric Mortality

This includes all obstetric activity across all the clinics and wards.

501 - OBS	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	1712	1900	2005	2006	1886	1905	1970	1845	1864	1852	1775	1903	22627
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

Table 2: Gynaecology Mortality (non-oncology)

502 - GYNAE	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	883	955	905	908	897	895	950	1006	750	916	879	959	10892
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

Table 3: Gynaecology Oncology

503 - GYNAE ONC	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total Mortality	1	1	0	2	1	0	0	0	0	0	0	1	6
Discharges	63	69	73	78	54	71	69	75	55	58	63	62	791
Rate per 1000 Discharges	15.9	14.5	0.0	25.6	18.5	0.0	0.0	0.0	0.0	0.0	0.0	16.1	7.6

2. Out of hospital deaths 2017-18 Quarters 4

There were no reported out of hospital deaths for quarter 4.

3. Mortality reviews and Key Themes

Since 2017 each in-hospital gynaecology death has a mortality review using the adult mortality review tool on Ulysses which assesses standards of care and identifies any potential for improvements in care.

To date all expected deaths have shown good quality of care including end of life.

Unexpected adult gynaecology deaths trigger a serious incident investigation and are recorded on Ulysses (Trust risk management and incident recording system). No unexpected deaths were recorded in this quarter.

All **direct maternal deaths** trigger serious incident investigation. No maternal deaths were recorded in this quarter.

Mortality reviews in Q4		
	Maternity	**Gynaecology**
No of Adult Deaths	0	1
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

4. Progress / Learning from Deaths

No specific themes were identified from the single expected death in Q4.

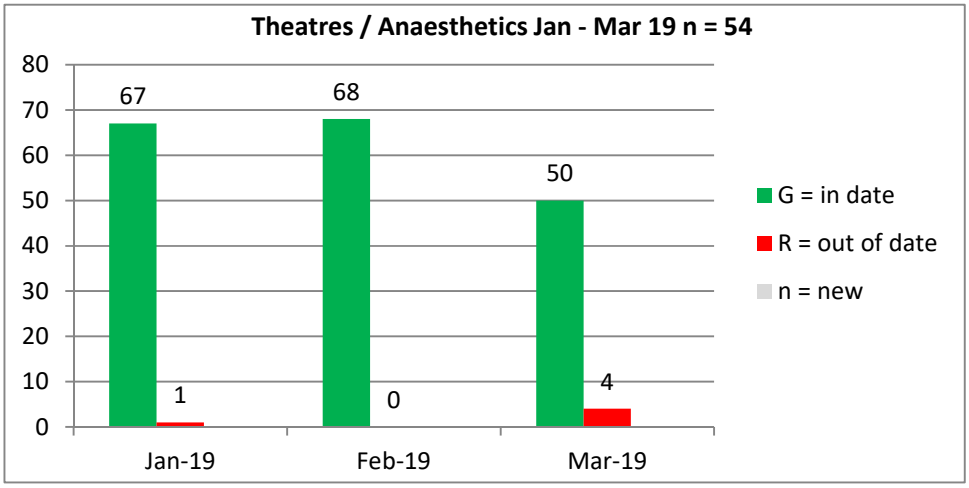
5. Prevention – What does Liverpool Women's do to Mortality

The Trust guidelines and SOPs (Standard Operating Procedures) have undergone scrutiny, merging and updating as they have migrated onto a new on-line easy access intranet for clinical staff to access 24/7.

This section reports on the status of mortality related guidelines and SOPs (this includes critical care and anaesthetics).

Anaesthetics / Theatres

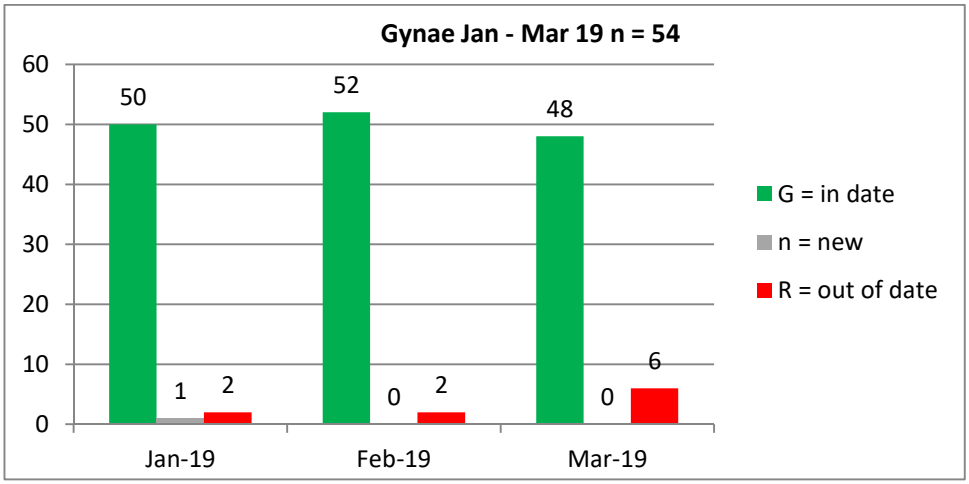
The chart below shows the number of Anaesthetics mortality related policies or guidelines for each month of quarter 4 (Jan-Mar). **(NB: for all data charts, status as reported at end of Q3, please note these figures will fluctuate as completion is a constant process)**



The four policies shown as red in March 2019 have been amalgamated and updated into one document for obstetrics and gynaecology and are now green.

Gynaecology

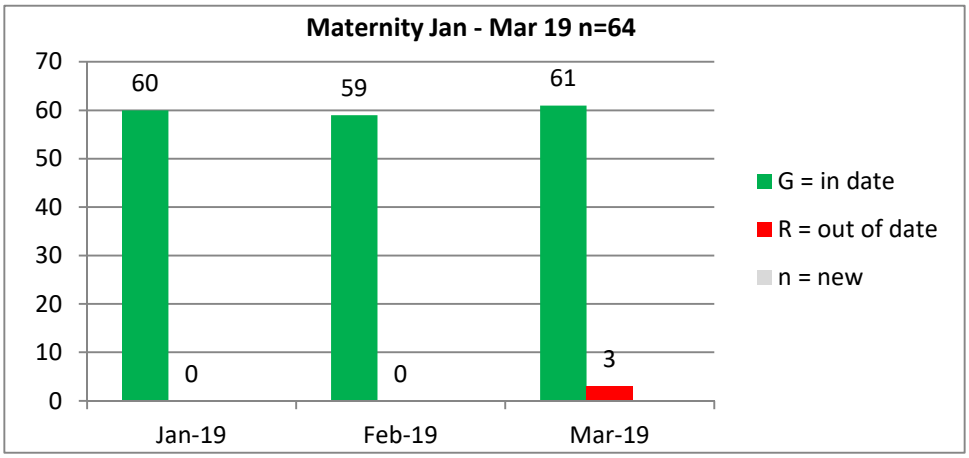
The chart below shows the number of Gynaecology mortality related policies or guidelines for each month of quarter 4 (Jan-Mar). **(NB: for all data charts, status as reported at end of Q3, please note these figures will fluctuate as completion is a constant process)**



Three policies shown as red are in progress and the other three are under consultation and should be ratified soon. One is a cancer network policy which has to go through the cancer group. Initial review does not show any risk to mortality from these policies not having the most up to date versions uploaded i.e. only minor amendments required.

Maternity

The chart below shows the number of Maternity mortality related policies or guidelines for each month of quarter 4 (Jan-Dec). **(NB: for all data charts, status as reported at end of Q3, please note these figures will fluctuate as completion is a constant process)**



One policy shown red in March – the Electronic Filing of results policy – was reviewed in the March pathology steering group meeting. This policy overlaps with Gynaecology. Comments and amendments circulated to maternity & gynaecology divisions for final checks pending final version ratification at the May Pathology steering group.

The Intrapartum management of multiple pregnancy has been extended for a further 3 months whilst the team developing a major revision of the guideline with associated booklets which will combine all previous guidelines on multiple pregnancy. Initial review does not show any risk to mortality from these policies not having the most up to date versions uploaded as the current guideline covers the mortality specific criteria.

Multi agency safe sleeping guideline is external guidance. Merseyside Child Death panel has confirmed the guideline is unchanged therefore this policy is green. An extension for 3 months has been granted for final sign off.

6. Audit

From April 2017 the Trust 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
- Sepsis
- Venous thromboembolism
- Cardiac
- Neurological
- Psychiatric

The below table is The Annual Audit Programme for 2018 – 2019.

Adult Mortality – Clinical Audit Q4

Topic	Clinical Audit Title/s	Progress
Haemorrhage	Use of O Negative blood	Audit and actions completed from 2017-18. Re-audit report and action plan received. Results presented at GREAT Day. Awaiting evidence of final action implementation due Nov-19.
	Bedside transfusion (including consent)	Audit and actions completed from 2017-18.Re-audit registered due Jul-19
	National Comparative audit of blood transfusion programme – Audit of Massive Haemorrhage Autumn 2018	National Audit registered. Report and action plan due Jun-19.

Psychiatric disease	Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital	Audit registered. Awaiting report and action plan.
	Trust wide Mental Health	Audit carried over to 2019-20 as not registered 2018-19 as planned.
Venous thromboembolism	Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk re-audit	Re-audit report and action plan received. Two actions awaited: 1) Local Guideline to be updated in accordance with NICE guideline 2) No unified input method to facilitate compliance exists. The Trust currently awaits the implementation of EPR but medical and nursing staff are looking at means to align Meditech and PENS for patient documentation re VTE scoring Action completion not due till Aug 2019
Neurological Disease	An audit of outcomes in women who attend the Joint Obstetrics/Neurology clinic (Management of pregnant women with epilepsy)	Audit registered. Report and action plan due Jun-19.
Cardiac Disease	Clinical standards for cardiac disease in pregnancy audit	Registered May 2019 – data collection in design

7. Horizon Scanning

Horizon Scanning Summary for guidance, reports and publications

Subject(s): Adult mortality (Maternity/ Gynaecology)

Period: Jan 2019 – March 2019.

Sources: CQC, NCEPOD, NHS Digital, NHS Resolution, Public Health England, RCOG.

CQC – No specific updates on adult mortality (maternity / gynaecology) for the period covered but there was an update from the CQC on Learning from deaths in March 2019.

NCEPOD – No updates on these subjects for the period covered.

NHS Digital - No updates on these subjects for the period covered**.**

NHS Resolution – No updates on these subjects for the period covered.

Public Health England – No updates on these subjects for the period covered.

RCOG – No updates on these subjects for the period covered**.**

8. End of Year Review

In 2018-19:

1) There were 6 expected gynaecology oncology deaths. All deaths had a mortality review conducted. The feedback from the reviews provides assurance that care was good and appropriate for the patient and they were supported with their end of life pathway.
   We committed in our Quality Strategy to offering palliative end of life care to Gynaecology cancer patients in the Liverpool Women's, and providing help and support for patients and their families whether their preferred place of death is the Liverpool Women's Hospital or home.

2) There were no direct maternal deaths

3) There was one unexpected death following Gynaecology treatment.
   This was reported to the CCG and the coroner. A Serious Incident (SI) review was undertaken within the hospital, and we participated fully in the Coroner's Inquest investigations and the CCG review.
   Though no specific action around this patient's treatment was felt to be the cause of her death, lessons identified around her care which could improve future practice were fed back to the clinical staff. These lessons were described in the Q2 report but in presented below:
   - Escalation and communication issues - complete
   - Regularity of observations post operatively required review and audit to improve practice – complete (includes rolling audit of observations).
   - Review of the SOP for peri-operative Fragmin to ensure consistency of practice – ongoing.

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