Agenda Item	2018/260

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Adult Mortality Quarterly Report 2018/19 Quarter 1**
DATE OF MEETING:	Friday, 05 October 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts – Associate Medical Director of Governance Amanda Cringle – Quality Improvement Lead
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 ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☐	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***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:-….)***	***Board is asked to take assurance that there is adequate progress being made against the requirements laid out by the National Quality Board.***		
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee	
	Date of meeting	July 2018	

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:

- There were 2 in-hospital expected gynaecology oncology deaths during Quarter1 of 2018-19.
- Adequate progress is being made in systems to reduce mortality through good governance.
- 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.

Report

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

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	0	0	0	0	0	0	0	0	0	0	3612
Rate per 1000 Discharges	0.0	0.0											0.0

Table 2: Gynaecology Mortality

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	0	0	0	0	0	0	0	0	0	0	1838
Rate per 1000 Discharges	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	0	0	0	0	0	0	0	0	0	2
Discharges	63	69	0	0	0	0	0	0	0	0	0	0	132
Rate per 1000 Discharges	15.9	14.5											15.2

Out of hospital deaths 2017-18 Quarters 1

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 that commenced February 2018.

There were no reported out of hospital deaths for quarter 1.

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

Reporting Quarter	2016-2017		2017-2018		2018-2019	
	In-hospital	Out-hospital	In-hospital	Out-hospital	In-hospital	Out-hospital
Q1	3	-	1	2	2	-
Q2	2	-	0	-	0	-
Q3	3	-	0	-	0	-
Q4	1	-	1	-	0	-
Total	**9**	**-**	**2**		**2**	
		0		2		0
Overall total deaths	**9**		**4**		**2**	

2. 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 1		
	Maternity	**Gyneacology**
No of Adult Deaths	0	2
No of Mortality Reviews completed	0	2
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

3. 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

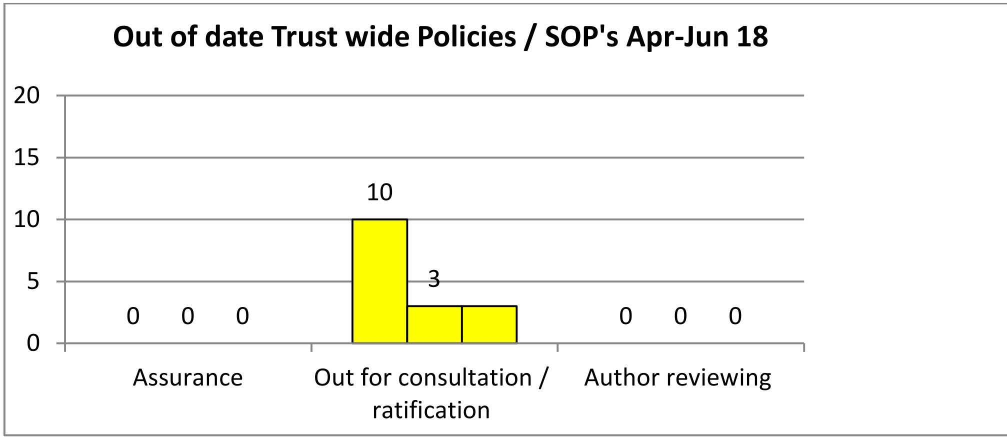
- To review all shared learning and any gaps / omissions to be addressed as service evaluation of the department. And a process to ensure shared learning takes place and is then evaluated as how effective it has been.
- There was no clear evidence if shared learning had all been completed from the original 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.

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

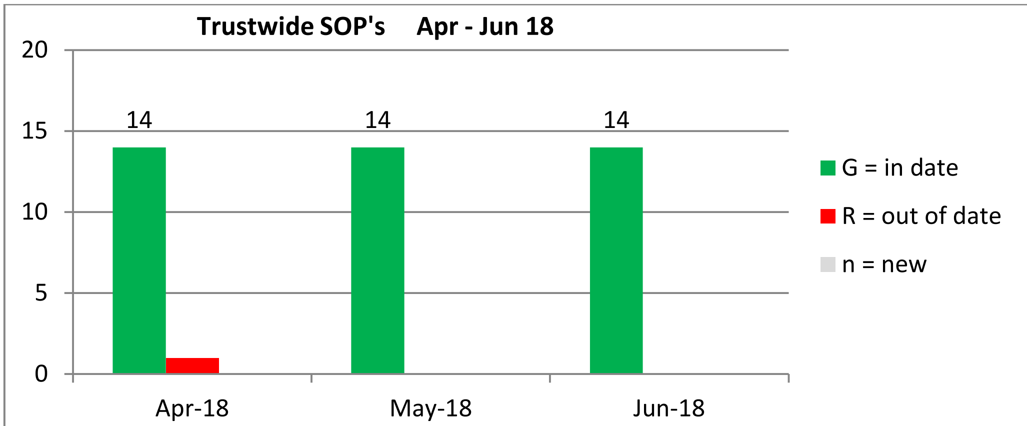
The Trust guidelines and SOPS have undergone scrutiny, merging and updating as they have migrated onto a new on-line easy access intranet for clinical staff to access 24/7. The phase commenced with Maternity department during 2017/18, this has been successful; it is now planned to commence work to roll out for gynaecology and neonatal departments for all their guidelines and SOPs to be fully accessible on line.

Trustwide

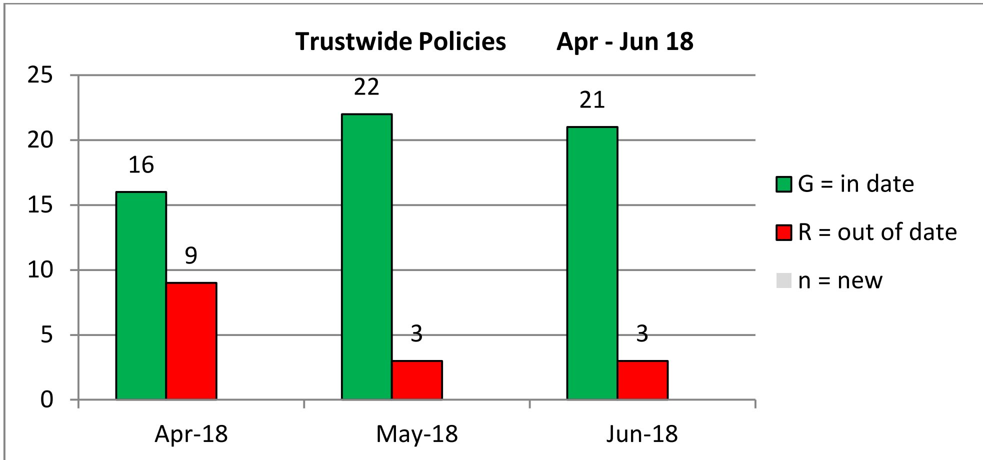
a) Trust wide policies, guidelines and SOPS



b) The chart below shoes the number of Trustwide SOPs for each month of quarter 1, there are currently no out of date SOPs

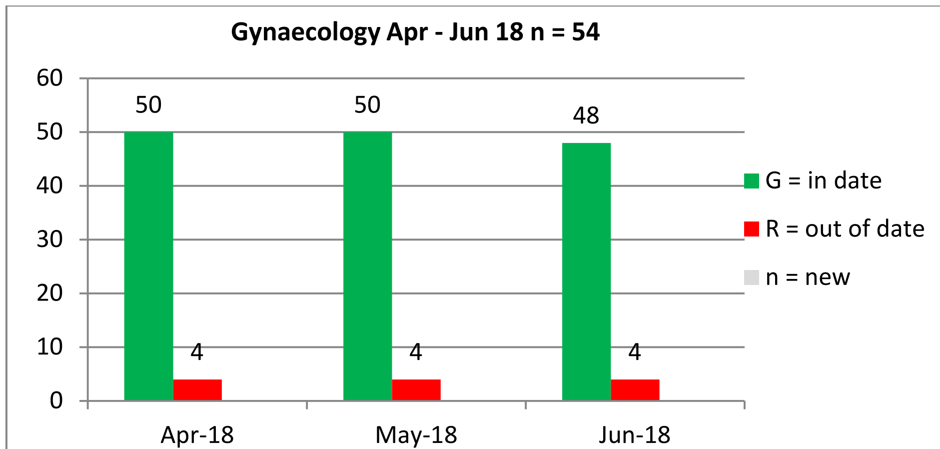


c) The chart below shoes the number of Trustwide Policies for each month of quarter 1, there are currently 3 out of date policies awaiting completion and ratification



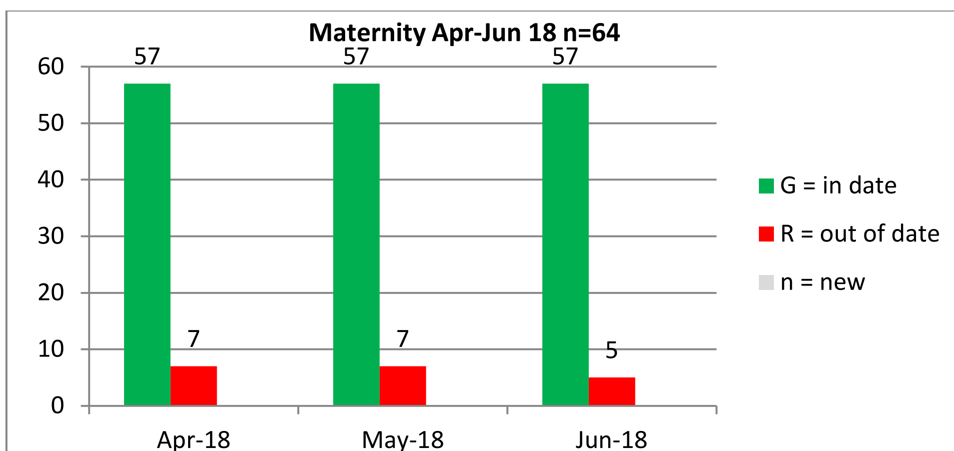
Gynaecology

The chart below shows the number of Gynaecology Policies for each month of quarter 1, there are currently 4 out of date policies awaiting completion and ratification



Maternity

The chart below shows the number of Gynaecology Policies for each month of quarter 1, there are currently 5 out of date policies awaiting completion and ratification



5. 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
- Sepsis
- Venous thromboembolism

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

Adult Mortality – Clinical Audit Q1

Topic	Clinical Audit Title/s	Progress
Haemorrhage	Use of O Negative blood	Received report including action plan. Results have been presented at Gynae' Divisional Meeting and the Hospital Transfusion Committee. Actions are due for completion Sep-18. (Audit Green 1 on audit dashboard). Re-audit scheduled to start late 2018.
	Bedside transfusion (including consent)	Received report including action plan. Results have been presented at the Hospital Transfusion Team meeting in May18. Evidence of actions complete received. As a result of this audit there has been increased emphasis on the need to: • ensure mandatory training is up to date • document the finish time of transfusion • ensure within junior doctors training sessions that they are aware that consent must be sought from the patient where possible. (Audit Complete).

		Re-audit scheduled to start late 2018 – this will also capture data in relation to TACO and NICE QS138 & NG24.
	SHOT NCA of TACO prevention Require evidence presented	Received report including action plan. Results have been presented at the Hospital Transfusion Team meeting Jan-18 and the Grand Round Mar-18. Awaiting evidence that all actions complete. (Audit Green 1 on dashboard). Re-audit data will be captured as part of the annual Bedside transfusion audit.
	National Comparative audit of blood transfusion programme – Audit of Massive Haemorrhage Autumn 2018	National Audit due to commence Sep-18.
Psychiatric disease	Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital	Audit registered. Data collection in progress. (Audit Amber on dashboard).
	Trust wide Mental Health	Audit to be completed in Qtr3 for submission Qtr4.
Sepsis	Audit of the management of pregnant women with asymptomatic bacteriuria at booking visit *(Previously titled: "Maternal and Congenital sepsis")*	Received report including action plan. The audit results showed non-compliance with the Standard Hospital Contract 2017; therefore a care pathway to take away reliance of GP's to repeat a booking of MSSU is to be devised. Once this is implemented a re-audit will be

		registered. (Audit Green 1 on dashboard).
	SEPSIS bundle – Maternity	Data being captured via NUMIS. (No clinical 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. (No clinical audit required).
Venous thromboembolism	Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk re-audit	Received report including action plan for re-audit. One action due for completion in relation to PENS has passed its original completion date of Feb-18. The delay was due to the PENS Lead at RLUH leaving and being replaced. Contact with the new Lead is in progress and this action is planned for implementation very soon. (Green 1 on audit dashboard). Further Re-audit scheduled to start late 2018.
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.
Cardiac Disease		

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8. Horizon Scanning

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

Period: Q1 March 2018 – May 2018.

Sources: CQC, NCEPOD, 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. 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 Committee regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust.