Agenda Item	2018/290

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Adult and Perinatal Mortality Report Q2 2018/19**
DATE OF MEETING:	Friday, 07 December 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts Amanda Cringle Louise Robertson
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:-….)***	***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***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee		
	Date of meeting	Monday, 22 October 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 2 of 2018-19. 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

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:

- Refinement of alert processes in the reporting of an expected death
- The stillbirth rate for 2018/19 to date is 3.37 (3.13/1000 births if we exclude fetal abnormality)
- PMRT has been used for all stillbirths in Q1 &Q2

Progress / Learning from Adult Deaths

1) A draft LeDeR SOP has been finalised and currently going through the internal ratification processes.
2) The two adult deaths in quarter 1, were expected gynaecology oncology patients and had chosen LWH as their preferred place of death.
3) There was an out of hospital death in August 2018, a multi-disciplinary review panel was convened. A timeline of events was produced and reviewed, the review team discussed the below in detail.
    - Decision for surgery
    - Surgery
    - Post-operative Care
    - Transfer to the Royal

    Following discussion on the care provided in relation to the above it was agreed that all decision making was appropriate. There were a number of lessons to be learnt which were agreed at the review however the panel felt this would not have changed the outcome. It was agreed that the incident does not meet the criteria for a SI. However when further information from the review at RLBUHT and post mortem are available, this decision will be revisited.

    The below learning outcomes were identified.

    - Escalation and communication issues
    - Observations, an audit of observations charges for regularity of observations post operatively.
    - Consistency of administering Fragmin, review SOP for peri-operative Fragmin.

    All information is to be developed into a report format, pending further information from the Royal with regards to their investigation and conclusion of post mortem results.

4) The mortality review reports for the three expected gynaecology oncology deaths in quarter 2 are complete, the third report is still under review and waiting to be finalised.

5) Benchmarking discussions have commenced with Birmingham Women's Hospital on all obstetrics, gynaecology and gynaecology oncology deaths. This will also include shared learning processes in these fields. We anticipate including their benchmarking data in the next quarter 3 mortality report.

Progress / Learning from Perinatal Deaths

1. In the babies from 2018-19 there has been one formal review to date. This was into the care received in the Maternity Assessment Unit (MAU) of a mother with a twin pregnancy. This has prompted a review of the escalation policy in the MAU for medical review.
2. There have been no SI's (Serious Incident Reviews) associated with stillbirth in the first 2 quarters.
3. There will be an analysis of the themes identified from the babies in the Q4 report as the numbers are too small at present to identify meaningful themes.

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

Adult Mortality Quarterly Report

18/19 Quarter 2 – (July, Aug & Sept)

- Adult Mortality Q2, 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:

- Refinement of alert processes in the reporting of an expected death
- Learning from a recent unexpected death

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	0	0	0	0	0	0	11413
Rate per 1000 Discharges	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	0	0	0	0	0	0	5444
Rate per 1000 Discharges	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	0	5
Discharges	63	69	73	78	54	71	0	0	0	0	0	0	408
Rate per 1000 Discharges	15.9	14.5	0.0	25.6	18.5	0.0							12.3

2. Out of hospital deaths 2017-18 Quarters 2

There was one reported out of hospital deaths for quarter 2, see section 4, bullet point 3 below for details of the review and lessons learnt. (Out of hospital refers to patients who have died either expected or unexpected within 12 months post partem for maternity cases and within 30 days after treatment at LWH for all other adult conditions.)

3. Mortality reviews and Key Themes

Since 2017 each in-hospital gynaecology death has a mortality review using the adult mortality proforma is completed indicating any potential for improvement in care, unexpected adult gynaecology deaths trigger a serious incident investigation and are recorded on Ulysses (Trust risk management and incident recording system).

All direct maternal deaths trigger serious incident investigation.

A mortality review tool has been developed for the risk and incident reporting system Ulysses.

Number of reviews		
	Maternity	**Gynaecology**
No of Adult Deaths	0	3
No of Mortality Reviews completed	0	3
No of deaths requiring RCA's	0	1
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

1) A draft LeDeR SOP has been finalised and currently going through the internal ratification processes.

2) The two adult deaths in quarter 2 were expected gynaecology oncology patients and had chosen LWH as their preferred place of death.

3) There was an out of hospital death in August 2018; a multi-disciplinary review panel was convened. A timeline of events was produced and reviewed, the review team discussed the below in detail.

- Decision for surgery
- Surgery
- Post-operative Care
- Transfer to the Royal

Following discussion on the care provided in relation to the above it was agreed that all decision making was appropriate. There were a number of lessons to be learnt which were agreed at the review however the panel felt this would not have changed the outcome. It was agreed that the incident does not meet the criteria for a SI. However when further information from the review at RLBUHT and post mortem are available, this decision will be revisited.

The below learning outcomes were identified.

- Escalation and communication issues
- Observations, an audit of observations charges for regularity of observations post operatively.
- Consistency of administering Fragmin, review SOP for peri-operative Fragmin.

All information is to be developed into a report format, pending further information from the Royal with regards to their investigation and conclusion of post mortem results.

4) The mortality review reports for the three expected oncology deaths in quarter all are complete.

5) Benchmarking discussions have commenced with Birmingham Women's Hospital on all obstetrics, gynaecology and gynaecology oncology deaths. This will also include shared learning processes in these fields. We anticipate including their benchmarking data in the next quarter 3 mortality report.

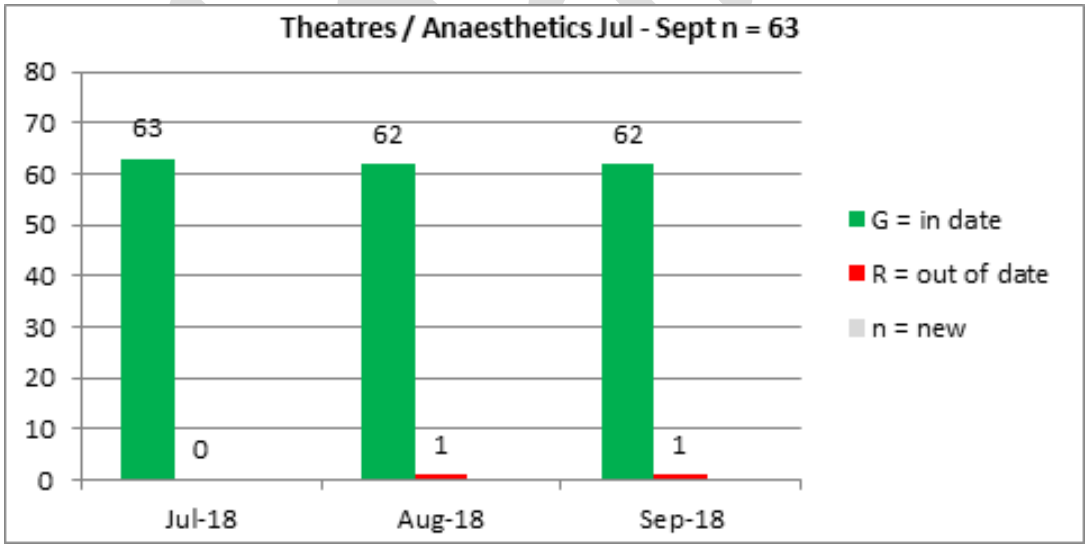
5. Prevention – What does Liverpool Women's do to Mortality

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. 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.

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

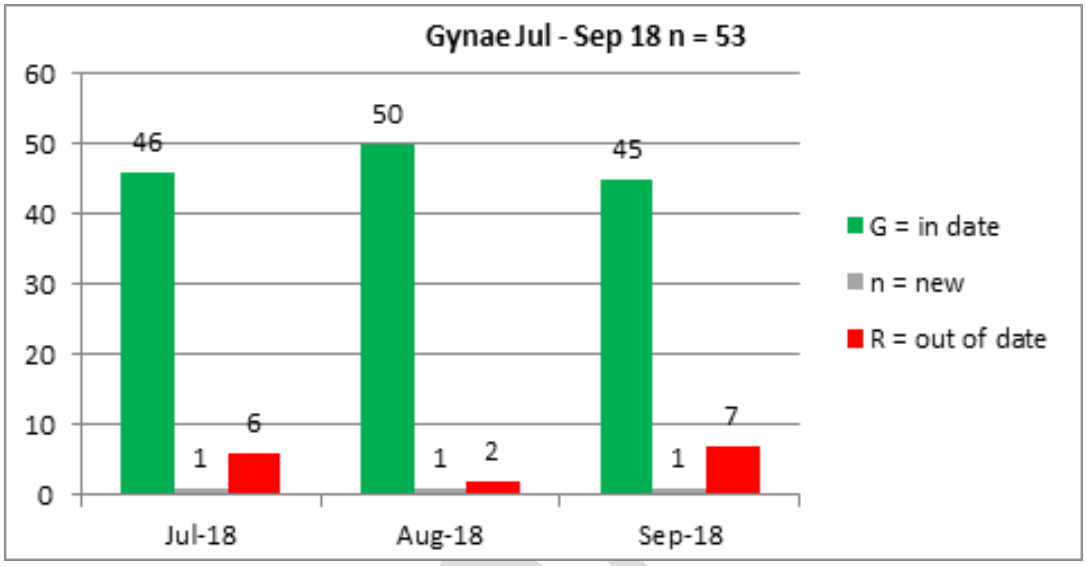
Anaesthetics / Theatres

The chart below shows the number of Anaesthetics mortality related policies or guidelines for each month of quarter 2



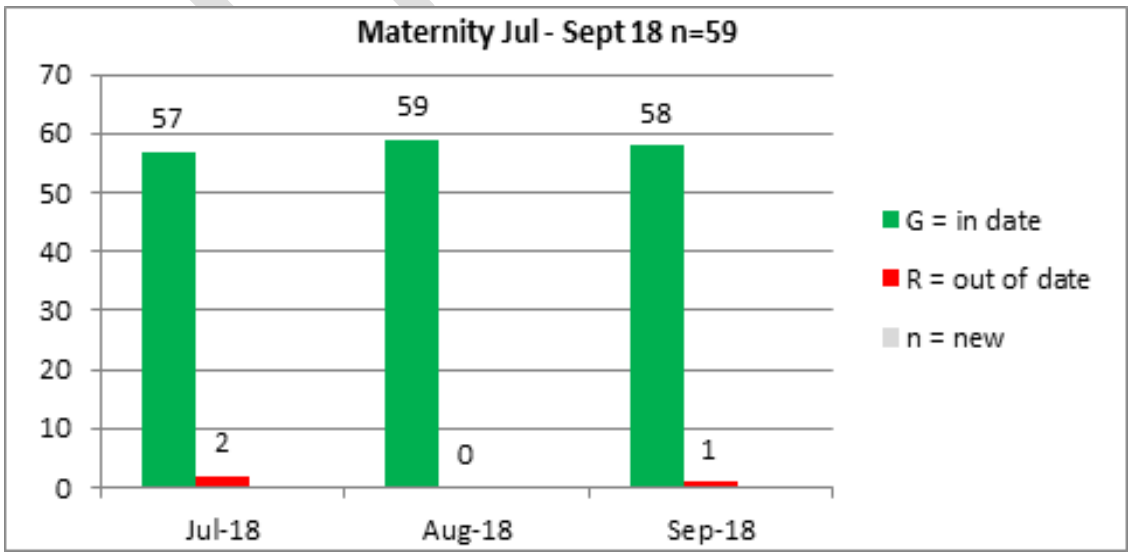
Gynaecology

The chart below shows the number of Gynaecology mortality related policies or guidelines for each month of quarter 2. Quarter 2 (Jul – Sept); 5 of these documents are cancer guidelines that had been reviewed, updated and awaiting ratification at the time of completing this report.



Maternity

The chart below shows the number of Maternity mortality related policies or guidelines for each month of quarter 2,



6. 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
- Cardiac
- Neurological
- Psychiatric

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	Audit and actions completed from 2017-18. Re-audit registered. Awaiting Final Report and action plan.
	Bedside transfusion (including consent)	Audit and actions completed from 2017-18. 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	Audit and actions completed from 2017-18. 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. Received audit pack and data collection due to commence Qtr 3.
Psychiatric disease	Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital	Audit registered. Data collection in progress. Awaiting report and action plan.
	Trust wide Mental Health	Audit planned to start Qtr 3 for submission Qtr 4.
Sepsis	Audit of the management of pregnant women with asymptomatic bacteriuria at booking visit *(Previously titled: "Maternal and Congenital sepsis")*	Audit and actions completed from 2017-18. Re-audit scheduled for 2019-20.
	SEPSIS bundle – Maternity	Data being captured via NUMIS.
	Audit of the management of patients with sepsis/compliance to the 1 hour Sepsis Bundle – Gynaecology	Ongoing monitoring by HDU/Sepsis via NUMIS.
Venous thromboembolism	Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk re-audit	Audit and actions completed from 2017-18. Re-audit scheduled to start late 2018.
Neurological Disease	An audit of outcomes in women who attend the Joint Obstetrics/Neurology clinic	Audit proposal in progress – to be submitted to Audit Dept. Nov 2018
Cardiac Disease	No audit planned for this audit cycle. Proposed for 2019/20.	

7. Horizon Scanning

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

Period: July 2018 – September 2018.

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

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

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

NHS Digital – The following reports are available:

- Compendium – mortality from cervical cancer available here
- Compendium – mortality from breast cancer available here
- Compendium – maternal mortality available here

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. 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

Perinatal Mortality Quarterly Report

18/19 Quarter 1 & 2

- Perinatal Mortality Q1 & Q2, 2018 - 2019 report prepared by L. Robertson
- Clinical Author: L. Robertson

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:

- The stillbirth rate for 2018/19 to date is 3.37 (3.13/1000 births if we exclude fetal abnormality)
- PMRT has been used for all stillbirths in Q1 &Q2

9. Mortality Dashboard

In 2017-2018 the stillbirth rate excluding termination of pregnancy was 3.6/1,000. If we were to exclude all fetal abnormality the rate is reduced to 3.31/1,000.

To date in 2018-19 the rate is 3.37 adjusted for terminations, 3.13 adjusted for fetal abnormalities.

Table 1: Stillbirths >24 weeks

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 stillbirths	7	6	0	3	4	2	-	-	-	-	-	-	22
Stillbirths (excluding terminations	4	3	0	2	3	2	-	-	-	-	-	-	14
Births	628	692	710	748	685	694	-	-	-	-	-	-	4157
Rate per 1000 births	11.1	8.7	0	4.0	5.8	2.9	-	-	-	-	-	-	5.29
Rate (excluding TOP) per 1000	6.4	4.4	0	2.7	4.4	2.9							3.37

There have been 2 early neonatal deaths in term babies. Both of which were associated with fetal abnormalities that were identified antenatally and were none compatible with life.

10. Mortality reviews and Key Themes

The Maternity Services recognise the need to review any cases that have resulted in poor or unexpected outcomes for either mother or baby related to the antenatal period and through the postnatal / neonatal period. This includes stillbirths from 22 weeks gestation and term babies who have undergone active therapeutic cooling and who meet the criteria for Each Baby Counts.

These reviews require close co-ordination between Midwives, Obstetricians, Neonatologists, Neonatal Nurses and Ultra-Sonographers. The Pathology Team at Alder Hey Children's Hospital will also be invited to participate in the reviews and when required external Midwife, Obstetrician and Neonatologist will also be asked to attend.

This is achieved through monthly multi-disciplinary review meetings to discuss perinatal mortality, morbidity and pathology.

Aims

- To review recent cases focusing on those, which resulted in perinatal mortality or morbidity
- To provide a forum for multi-disciplinary discussion and learning
- To provide a forum to discuss the recommendations of MBRRACE, other National Confidential Enquiries and relevant national or local documents.
- To develop an increased knowledge and understanding of high risk obstetric and neonatal complications.
- To provide a forum to recognise the need for changes to practice and to forward learning points to the relevant maternity and neonatal governance groups for action.
- To serve as the forum to inform completion of both Stillbirth (MBRRACE) and RCOG 'Each baby counts' and Child Death (CPOD) review paperwork.

Membership

Meetings are multi-disciplinary and open to all interested health care professionals. The meetings will uphold an environment of mutual respect for personal and professional opinions expressed with the aim of inter professional learning. They are held monthly and representatives from the following disciplines are expected at every meeting.

- Obstetricians
- Paediatricians
- Midwives
- Neonatal Nurses
- Ultra-sonographers (as appropriate to the individual cases)
- Anaesthetists (as appropriate to the individual cases)
- Governance Facilitator

A record of attendance will be kept and members will be required to sign the attendance sheet at each meeting.

Meeting format Meetings will consist of:-

Case Reviews

- Stillbirths (This includes intrapartum stillbirth from 22 weeks gestation)
- Early neonatal death (days 0–6)
- Severe brain injury, (grade III (HIE), Actively therapeutically cooled and babies who had all three of the following signs: decreased central tone, comatose; seizures of any kind)

An anonymised record of cases presented and multi-professional discussions will be kept along with any relevant presentations. Recommendations for changes in practice or guidelines may be presented to the Maternity Risk Meeting for ratification.

The PMRT will be completed and cases will be graded in line with MBRRACE grading system. Both the antenatal and postnatal care a mother receives is graded. The postnatal care is focused on the bereavement care the family receives.

Any cases graded D will automatically be reported as a Serious Incident and added to Steis. A root cause analysis, (RCA), investigation will be completed

Table 2: MBRRACE - UK Care Grading

Care Grade	Description
Grade A	No improvements in care identified
Grade B	Improvements in care identified that would not have changed the outcome
Grade C	Improvements in care identified that **may** have changed the outcome
Grade D	Improvements in care provided that **would** have changed the outcome

Table 4: Grading of care for babies in 2018-2019 (Q1 &Q2)*

Grade	No. of babies (AN)	No. of Babies (PN)
A	**6**	**12**
B	**3**	**0**
C	**2**	**0**
D	**0**	**0**
UNK	**1**	**0**
Total	**12**	**12**

*2 babies are due to be reviewed in November's Panel

Cause of stillbirth	Number of babies
Cord prolapse	1
Fetal abnormality	1
Multiple pregnancy	1
Placental abruption	4
SGA alone	3 (all undetected)

SGA associated with hypertension	1
Unknown	1

Progress / Learning from Deaths

In the babies from 2018-19 there has been one formal review to date. This was into the care received in the Maternity Assessment Unit (MAU) of a mother with a twin pregnancy. This has prompted a review of the escalation policy in the MAU for medical review.

There has been no Serious Incidents (SI's) associated with stillbirth in the first 2 quarters.

There will be an analysis of the themes identified from the babies in the Q4 report as the numbers are too small at present to identify meaningful themes.

11. Prevention – What does Liverpool Women's do to reduce mortality

An action tracker has been created that will monitor the progress with actions that arise from the perinatal meetings. This will be discussed at the start of every meeting. The intention is that this will be presented at the risk meeting bi-annually. Any delay or deviations would be escalated to safety senate. (please see attached)

An action plan for our approach to NHS England's Saving Babies' Lives care bundle is being formulated.

12. Horizon Scanning

- **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 England –** Saving Babies' Lives Care Bundle 2
- **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 –** Each Baby Counts Annual Report Due November 2018

13. Recommendations

It is recommended that the Board:

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

d. 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

e. Discuss the Saving Babies' Lives care bundle action plan as part of the CNST maternity safety incentive scheme requirements