		Agenda Item	**19/20/135**
MEETING	**Quality Committee**		
PAPER/REPORT TITLE:	**Adult and Perinatal Mortality Report Quarter 2 2019/20**		
DATE OF MEETING:	Monday, 25 November 2019		
ACTION REQUIRED	**Assurance**		
EXECUTIVE DIRECTOR:	Devender Roberts, Deputy Medical Director		
AUTHOR(S):	Christopher Lube, Head of Governance and Quality, Louise Robertson, Consultant Obstetrician and Rebecca Settle, Consultant Neonatologist		
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 clinical 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) ……* ☒		
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 Committee members are asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

The following information is the Adult and Perinatal Mortality report covering the Quarter 2 period of 2019/20. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust.

The data contained in this report is pure data and is not standardised mortality data such as SHMI, due to the low level of mortality numbers encountered and the complexity of the patients cared for by the Trust.

The use of pure data and not standardised mortality rates has been previously agreed with the CCG as the Trusts approach to monitoring mortality rates.

The following report is broken down into three sections: Section One relates to Adult Mortality and Section Two relates to Perinatal Mortality and Section Three relates to Neonatal Mortality.

Recommendations
It is recommended that the Quality Committee:

a. Take assurance that there is adequate processes and 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 neonates in receipt of care at the Trust
c. Discuss the Saving Babies' Lives care bundle action plan as part of the CNST maternity safety incentive scheme requirements

Conclusion
The Committee members are asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board.

Adult and Perinatal Mortality Quarterly Report 2019/20

Quarter 2

SECTION ONE - ADULT MORTALITY

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:

- No specific themes were identified from the 1 expected death in Q2. Morality review identified that the care, which had been provided, was Good.
- The 2 out of hostile death did not relate to care provided by LWH

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.

Obstetrics	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	TOTAL
Total Mortality	0	0	0	0	0	0	0
Discharges	1819	1747	1857	2095	2071	1944	11533

Table 2: Gynaecology Mortality (non-oncology)

Gynaecology	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	TOTAL
Total Mortality	0	0	0	0	0	1	1
Discharges	875	857	828	933	917	867	4496

Table 3: Gynaecology Oncology

Gynaecology Oncology	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	TOTAL
Total Mortality	2	1	1	0	0	0	4
Discharges	66	60	67	62	73	69	397

Out of hospital deaths 2019-20 Quarter 2

There were 2 reported out of hospital deaths for quarter 2 relation of women who had delivered babies at LWH within 12 months of delivery.

- One death was in relation to the mother committing suicide 6 months after the birth of her baby. The mother was under the care of the Mersey care and LWH have provided information in relation to their Serious Incident Investigation. There were no issues in relation to her care at LWH.
- The second death occurred at a Tertiary cardiothoracic centre in Leeds of a mother following delivery at LWH. The patient had a significant cardiac history and following delivery required transfer to the national centre for further care. There were no issues in relation to her care at LWH.

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 Q2		
	Maternity (Direct)	**Gynaecology**
No of Adult Deaths	0	1
No of Mortality Reviews completed	0	1
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

Learning from Deaths

No specific themes were identified from the 1 expected death in Q2.

- Morality review identified that the care, which had been provided, was Good.

Risk Assurances in relation to Mortality

As part of the Trusts assurances processes the Safety and Effectiveness Senates work to gain assurance as to actions taken in relation to Serious Incident reviews, Lessons Learnt, external Alerts and National guidance on Quality and Safety. The effectiveness senate also have oversight and scrutinise clinical and effectiveness audits and service evaluations.
During Quarter 2 the main issues which were discussed which contribute to safety were:

Safety Senate

- **Transfusion –** Issue that blood analyser for group and save are not supported after March 2020. Discussions with LCL who will come back with a resolution for this problem and will be discussed at the Pathology Steering Group, on risk register. Work to be done to involve clinicians to determine what is required on site out of hours for bloods. Training levels are low throughout the trust, with 20-30% competency training. There are 20 cascade trainers within the trust and 2 transfusion practitioners for 2 days per week. It is difficult for clinical staff to be freed up for training. The monthly reports for training are sent to the Heads of Nursing who can monitor the training levels.

- **Group and Save Sample Incidents -** Sample 360 is being introduced in the Trust as part of the digital development work. This is system which uses bar code scanning facility to confirm the details and labels are printed on the blood bottle. This system can be used for a transfusion bedside system, administering the blood by scanning the ID band of the patient and the blood.

- **Serious Incident and Action Plan Monitoring Report -** H0GH&Q has reviewed S.I. themes which was requested by the Quality Committee. Between 2016/17/18, the main themes were delay in diagnosis, reviewing of x-ray scans and clinical presentation

- **Feeding tubes –** the Royal are currently placing the feeding tubes for LWH patients which requires a transfer, some patient do not return due to lack of staff able to manage feeding tubes. Issue has been discussed at Nutrition Group, plan to bring this back in house when process can be put in place.

- **LocSSIPs Progress Update -**The group is still meeting, DR commissioned IT to build a database but IT found there was already one in place which was being used by theatres only. This is moving forward and progressing

- **Gynaecology Services Report -**Key risk within Gynaecology relates to the reduced consultant number for Gynaecology down to 2 form the establishment of 6 by January 2020. Plans are in place to support the service.

Effectiveness Senate

- **Completion of clinical Audits -** Good progress has been made in relation to clinical audit outstanding actions.

- **Deprivation of liberty Safeguards -** DoLS audit compliance is so good that it is being sent to Communications as a 'Good News' story.

- **Medicines Management -** The MMC Audit Programme is being streamlined going forward. It was noted that there were three or four different antimicrobrial audits being carried out and

the Senate was advised that these are being pulled together to be more in line with the work that is carried out at the Royal Liverpool Hospital.

- **Obstetrics Foetal Monitoring -** Compliance with Liverpool Women's NHS Guideline in the use of an Electronic Foetal monitoring interpretation tool (fresh eyes)' was discussed and the findings showed particularly poor documentation and need for further education and training.

Learning identified for dissemination within the Trust

- Staff need to ensure that they maintain high standards of clinical record keeping.
- Staff undertaking the consent process need to ensure that they meet all required standard of information to the patient and recording information shared and consent on relevant forms.
- There is an increase in needle stick injuries across all areas of the Trust and staff need to ensure they are using safety devices and following the policy.

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:

- Haemorrhage
- Sepsis
- Venous thromboembolism
- Cardiac
- Neurological
- Psychiatric

The outcome form these audits will be discussed in Quarter 4 of this mortality report.

Horizon Scanning

Horizon Scanning Summary for guidance, reports and publications
Subject(s): Adult mortality (Maternity/ Gynaecology)
Period: July 2019 – Septmber 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
- **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**.**

Overall Recommendations

It is recommended that the Quality Committee:

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

e. 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 neonates in receipt of care at the Trust
f. Discuss the Saving Babies' Lives care bundle action plan as part of the CNST maternity safety incentive scheme requirements

Overall Conclusion

The Committee members are asked to review the contents of the paper and Take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board

Appendix 1 - Obstetric Mortality review Process

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

From February 2019 HSIB (Health Safety Investigation Branch) have commenced independent investigations into babies that meet their eligibility criteria. This includes intrapartum stillbirth and early neonatal death after 37 weeks and babies that undergo active cooling or suffer severe brain injury. Formal investigation reports are awaited. LWHNHSFT continues to ensure these babies also undergo a local review in order to identify learning from the care provided and establish if local formal review is indicated.

These reviews require close co-ordination between Midwives, Obstetricians, Neonatologists, Neonatal Nurses and Ultra-Sonographers. The Pathology Team at Alder Hey Children's Hospital are also invited to participate in the reviews and when required an 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)
- Divisional Governance Manager

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
- 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 is 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