NHS
Birmingham Women's and Children's
NHS Foundation Trust

Mortality Review extract from Quality Report August 2018

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Safe – Key Measures
Mortality Review Process at BWC

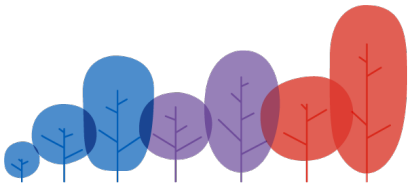
Birmingham Women's and Children's NHS Foundation Trust

Identify cases for review, using criteria listed below → Undertake mortality review using relevant structured tool → Involve parents, family or carers in the process → Link with the Serious Incident process, if applicable → Report outcome of review to Mortality Review Group → Monitor internal and external trends → Identify and share learning across the Trust

BWC is committed to learning from deaths, and reducing our mortality rates as much as possible. Due to the unique and specialist nature of our organisation, benchmarking BWC mortality rates nationally, and with other similar providers, is difficult. The main value is in monitoring the overall trends, as individual rates cannot be adjusted accurately enough to be meaningful. Therefore, BWC has an extensive inclusion criteria for cases that will be subject to a detailed mortality review, to ensure we are learning lessons and identifying areas for improvement.

BWC will review all deaths meeting the following criteria:

- 100% child deaths
- All perinatal deaths >22 weeks, >500g, excluding termination of pregnancy (unless it is a live birth)
- 100% maternal deaths
- All unexpected adult deaths and expected adult deaths in where concerns are raised
- 100% deaths of patients with a learning disability
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.



Safe – Key Measures
Monthly Mortality at BWC

Birmingham Women's and Children's NHS Foundation Trust

Number of deaths in July 2018

BWH: 4 deaths: *1 still birth, and 3 neonatal deaths*

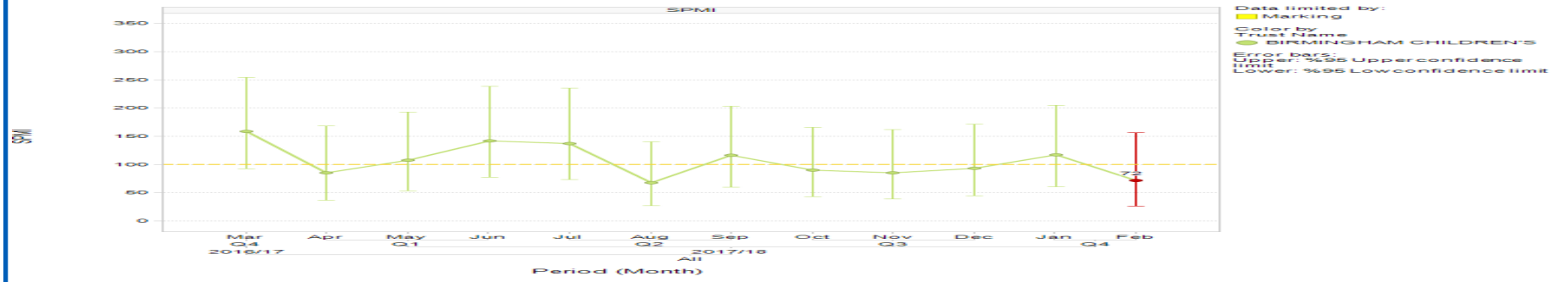
BCH: 8 deaths: *all inpatient deaths.*

FTB: 0 reported deaths *of service users.*

All of the BWH and BCH cases will undergo the standard mortality review.

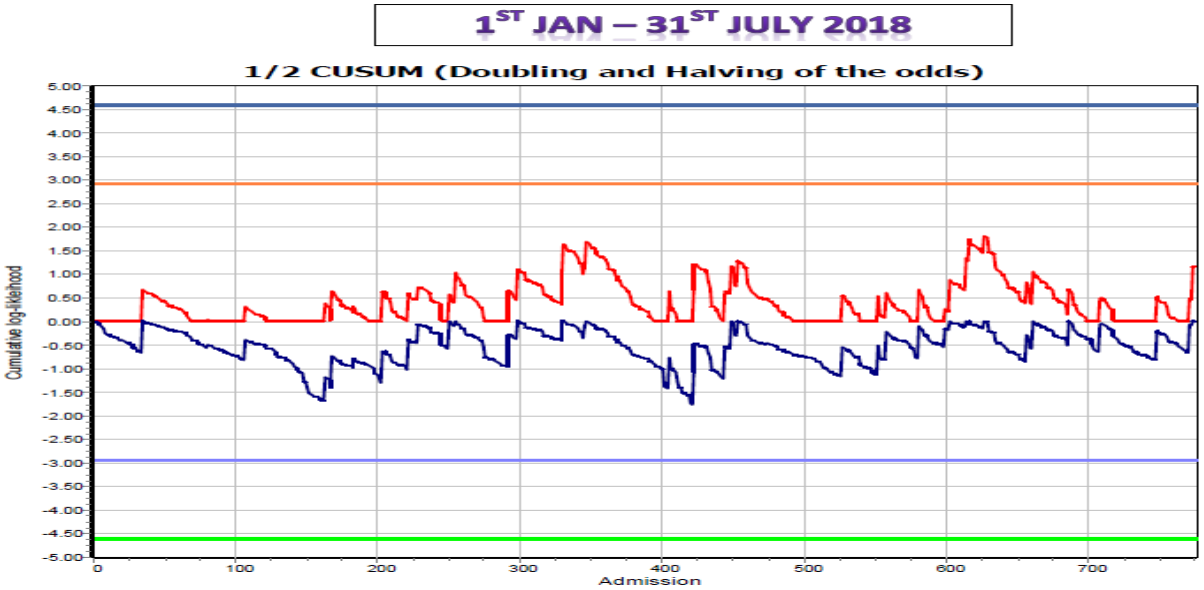
The Mortality Review Committee met in July and graded 1 BCH case as outcome 3 (yellow category; The care provided was less than adequate; and different management would not reasonably be expected to have altered the outcome.) This case was not subject to RCA. The committee noted 3 failures in care which were not considered causal in the death. The failures were: that the patient who had been stable on PICU started to display an increased heart rate and decreased blood pressure before discharge from PICU, and then required readmission within 4 hours – this was a premature discharge; the patient was suffering with hypoglyceamia and was not given IV fluids as should have happened; and that the local hospital was not notified of the patient's death. The committee will review current data on PICU readmission rates to determine if further action is required.

The chart below details the Standardised Paediatric Mortality Index with the last available figure annotated. Equivalent data is not available for maternity cases. Due to ongoing issues with NHS Digital's external data supplier mortality outcome data has not been updated since June. NHS Digital are not able to provide a resolution date for this issue. The June data is below.

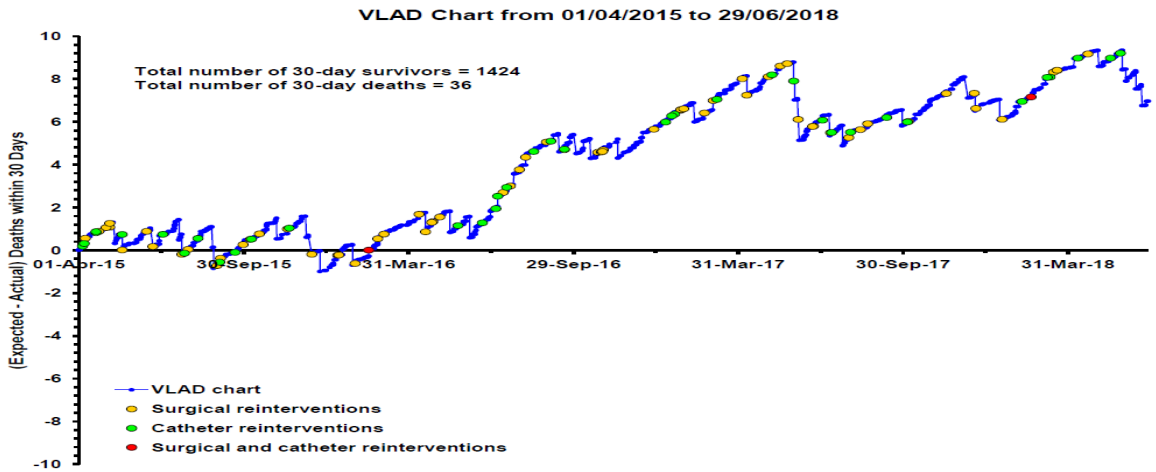


Mortality and external benchmarking information

Birmingham Women's and Children's NHS Foundation Trust



This chart represents the clinical outcome for patients cared for on the PICU. The chart does not highlight any cause for concern.



This chart represents the clinical outcome for patients who have undergone cardiac surgery. The chart shows that overall the outcomes are better than expected and this chart does not highlight any cause for concern.