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

Mortality Review extract from Quality Report November 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 October 2018

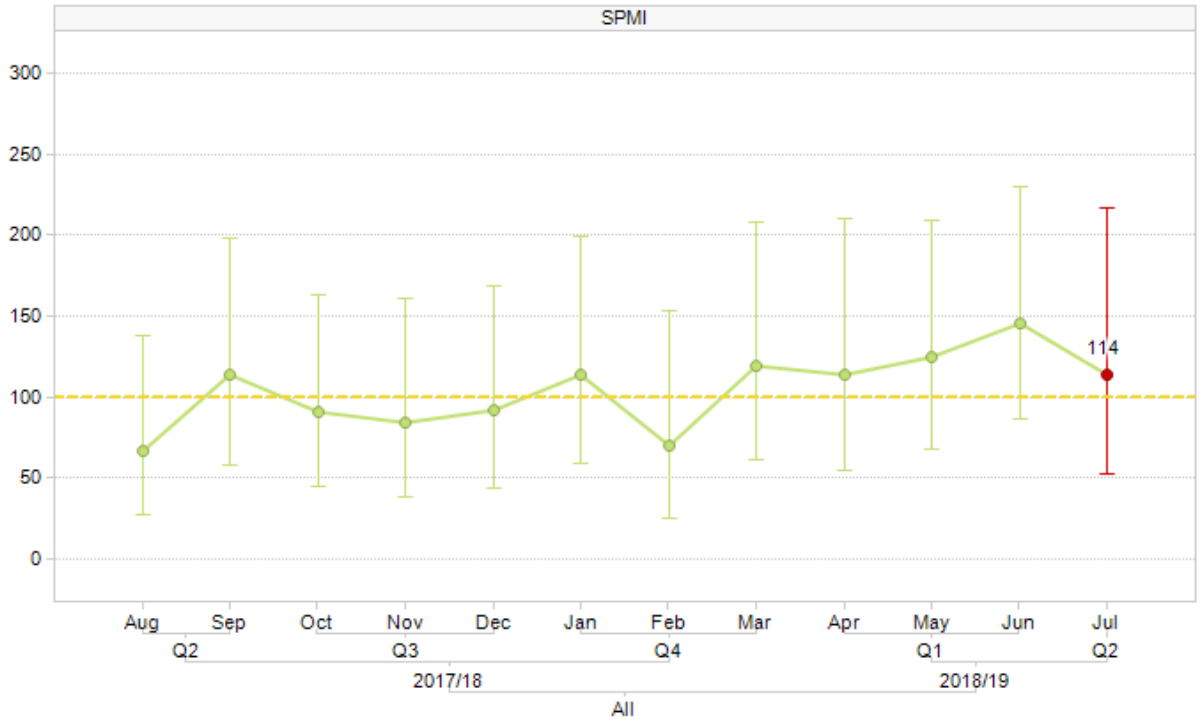
BWH: 8 deaths: *5 still births & 3 neonatal deaths*

BCH: 10 deaths: *all 10 were inpatients*

FTB: 0 reported deaths *of service users.*

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

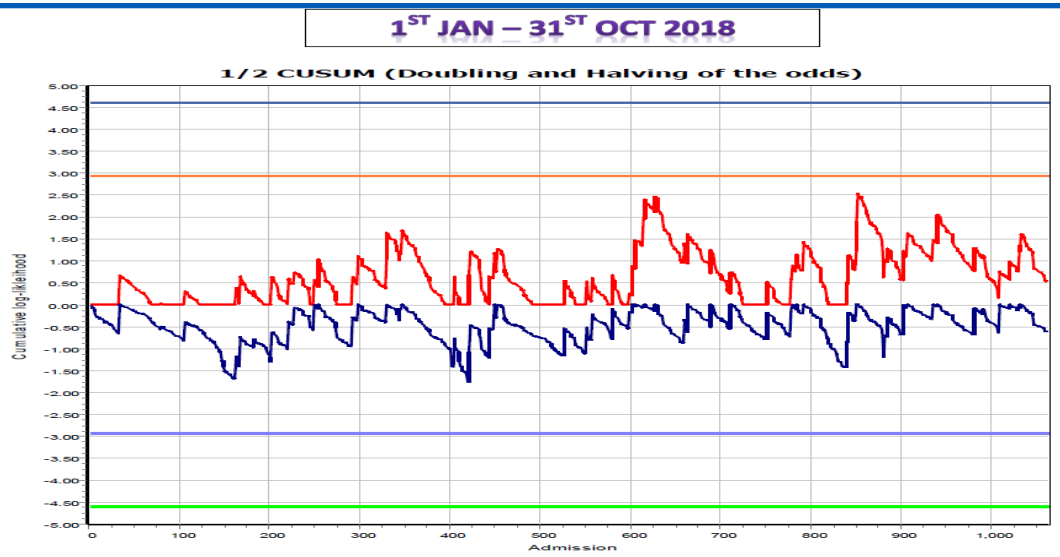
The Mortality Review Committee met in October and graded 2 BCH case as outcome 3 (yellow category; The care provided was less than adequate; and different management would not reasonably be expected to have altered the outcome.) One case was due to be subject to a DLR, due to deterioration in PEWS leading up to the arrest. For the second case, the committee noted an avoidable hypoglycaemic event with lapses in care prior to the terminal event.



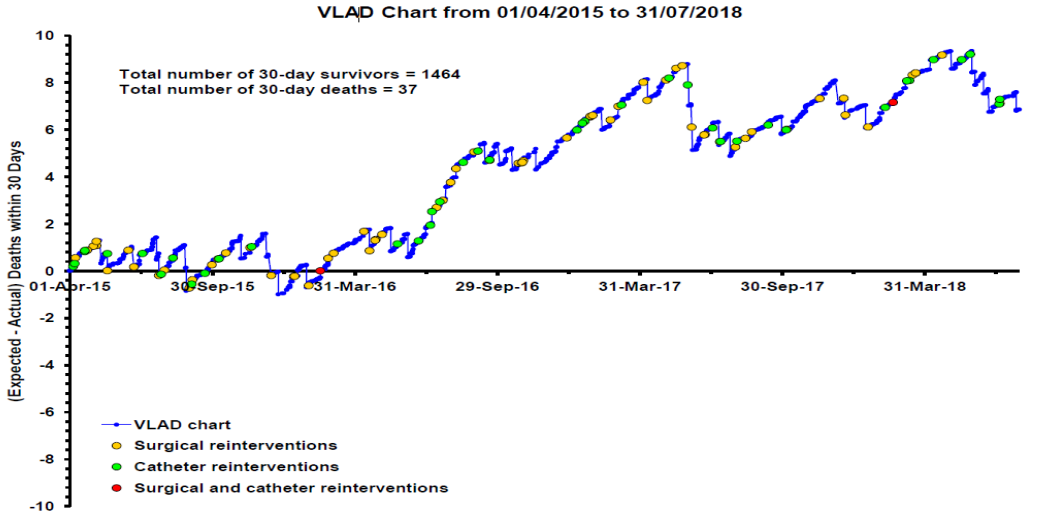
- This Standardised Paediatric Mortality Index shows the last available figure (annotated) calculated from data available in July.
- This was the last date that Mortality outcome data has been available from NHS Digital.
- Equivalent data is not available for maternity cases

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.