

MORTALITY REPORT

Trust Board paper G

Authors: Head of Outcomes & Effectiveness, Quality Project Manager and Deputy MD, Sponsor: Medical Director

Executive Summary

Background and Context

UHL's crude and risk-adjusted mortality rates, and the work-streams being undertaken to review and improve review these, are overseen by the Trust's Mortality Review Committee (MRC), chaired by the Medical Director.

MRC also oversee UHL's Mortality and Morbidity process which has recently been revised in line with national requirements^{i, ii, iii} which focus on 'Learning from Deaths' in hospitals in order to improve the care of all patients.

One of the Learning from Deaths requirements is for Trusts to submit nationally and publish mortality data on a quarterly basis, from December 2017, including the number of deaths reviewed and/or investigated, and the number of those found to be more than likely due to problems in care.

In addition to the work being undertaken in response to national guidance, the locally commissioned 'health economy-wide audit' looking at the care provided to patients who died either in LPT or UHL or within 30 days of discharge from UHL - has started.

Questions

1. What are the data telling us around UHL's mortality rates and what actions are being taken to improve these?
2. What has been the Learning from Deaths in Quarters 1 and 2 and are we on track to meet the national mortality reporting requirements?
3. What progress has been made with the LLR Clinical Quality Audit?

1. UHL's Mortality Rates and Actions

A summary of UHL's mortality rates, both risk adjusted and crude, are set out in the slide deck (Appendix 1).

UHL's published Summary Hospital-level Mortality Indicator (SHMI) is 101 (for the time period April 16 to March 17) and our Hospital Standardised Mortality Ratio (HSMR) is 102 and are both within the expected range.

Analysis of our SHMI and HSMR, using the HED clinical benchmarking tool, shows that our HSMR is 97 for the 12 months August 16 to July 17 and our unpublished SHMI is expected to reduce further for the 12 months July 16 to June 17.

There have been a number of actions undertaken to reduce mortality as part of our Quality Commitment over the past 3 years. The work on recognition and appropriate management of the deteriorating patient continues with a particular focus on sepsis and acute kidney injury.

A current area of focus is cardiac patients – both those presenting medically and for surgical intervention. Our HSMR has been above expected for 2 diagnosis and 1 procedure group related to cardiac disease and detailed reviews have not shown any significant concerns with the service.

2. UHL's 'Learning from Deaths' Process and Publication of Data

UHL's 'Learning from the Deaths of Patients in our Care' Framework is underpinned by the:

- Medical Examiner Process, in collaboration with Bereavement Services
- Specialty Mortality & Morbidity Meetings and Structured Judgement Review Process
- Bereavement Support Service
- Serious Incident Reporting and Investigation Process

In Quarters 1 & 2, MEs screened 1378 (97% of all adult deaths, to include community and ED). Part of this screening process involves contacting the next of kin.

Where MEs identify potential for learning or the bereaved raise a concern about clinical care, the case is referred to the Specialty M&M for full Structured Judgement Review (SJR) using the national mortality review template. To date, 249 deaths have been referred or met the national requirement for SJR in Quarters 1 and 2. This includes 9 deaths of patients with Learning Disability and 49 deaths of children/neonates.

112 SJRs have been completed and death classifications confirmed. Our internally set target is that 75% of SJRs should be completed within 4 months of death and 100% within 6 months. Therefore all April's deaths should have had SJRs completed at the end of October and 75% of May and June's deaths should have had completed SJRs. However, not all SJR details have been collated due to resource constraints within the Corporate M&M Admin team and capacity within the Specialty M&M teams.

There was one patient where problems in care were thought more likely than contributed to the death and this has been investigated as a Patient Safety Incident and confirmed as being a Serious Incident with 'Major Harm' as the outcome. The investigation into this case identified multiple contributory factors with specific learning for both ED and the Difficult Asthma Clinic. Completion of actions and learning points will be tracked through the Adverse Events Committee with escalation to the CMG Assurance Performance Review meetings as required by exception.

In addition to our Medical Examiners speaking to the bereaved relatives/carers to ask if they have any concerns about the care provided to the deceased, follow up by the Bereavement Support Nurse (BSN) is offered to all families/carers of patients who have died in our care.

Most concerns raised by the bereaved relate to the last few days of life or the death and often because of communication difficulties. Where concerns can't be resolved over the phone, or the bereaved would like a better understanding about clinical management plans or decisions made about end of life care, the BSN will arrange a meeting with the clinical team.

Further details about the number of deaths, how many have been through the SJR process and Death Classification agreed plus emerging themes are given in the slide deck (Appendix 1).

The final slide in Appendix 1 provides an overarching summary of UHL's Learning from Deaths framework (meeting the requirements to publish a Learning from Deaths Dashboard).

3. LLR Clinical Quality Audit

Following on from the Learning Lessons to Improve Care (LLTIC) review published in 2014, a follow up LLR system-wide review has been commissioned. The audit has commenced, is being undertaken by Mazars and is expected to report to the LLTIC task force in February 2018.

Input Sought

Members of the Trust Board are requested to receive this report and appendix and to:

- Be advised that UHL's mortality rates are closely monitored and that any patient groups with a higher HSMR or SHMI are being reviewed and learning and action taken where applicable.
- Note the good progress made with screening of adult deaths by the Medical Examiners and completion of Structured Judgment Reviews by Specialty M&Ms.
- Be advised that resource issues are affecting tracking of progress with the Learning from Deaths programme and also analysis of data.
- Be assured that where deaths have been considered to be 'more than likely due to problems in care' these have been investigated by the Patient Safety Team as a Serious Incident.
- Note that the LLR Clinical Quality Audit is underway.

ⁱ **Learning, candour and accountability** - A review of the way NHS trusts review and investigate the deaths of patients in England, Care Quality Commission, December 2016 - <https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf>

ⁱⁱ **National Guidance on Learning from Deaths** - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, National Quality Board, March 2017 - <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>

ⁱⁱⁱ **Implementing the Learning from Deaths framework**: key requirements for trust boards, NHS Improvement, July 2017 - https://improvement.nhs.uk/uploads/documents/170921_Implementing_LfD_-_information_for_boards_JH_amend_3.pdf

**UHL Trust Board Mortality Report Slide-deck
2017/18 - Quarter 1 & 2**

Report from UHL Medical Director

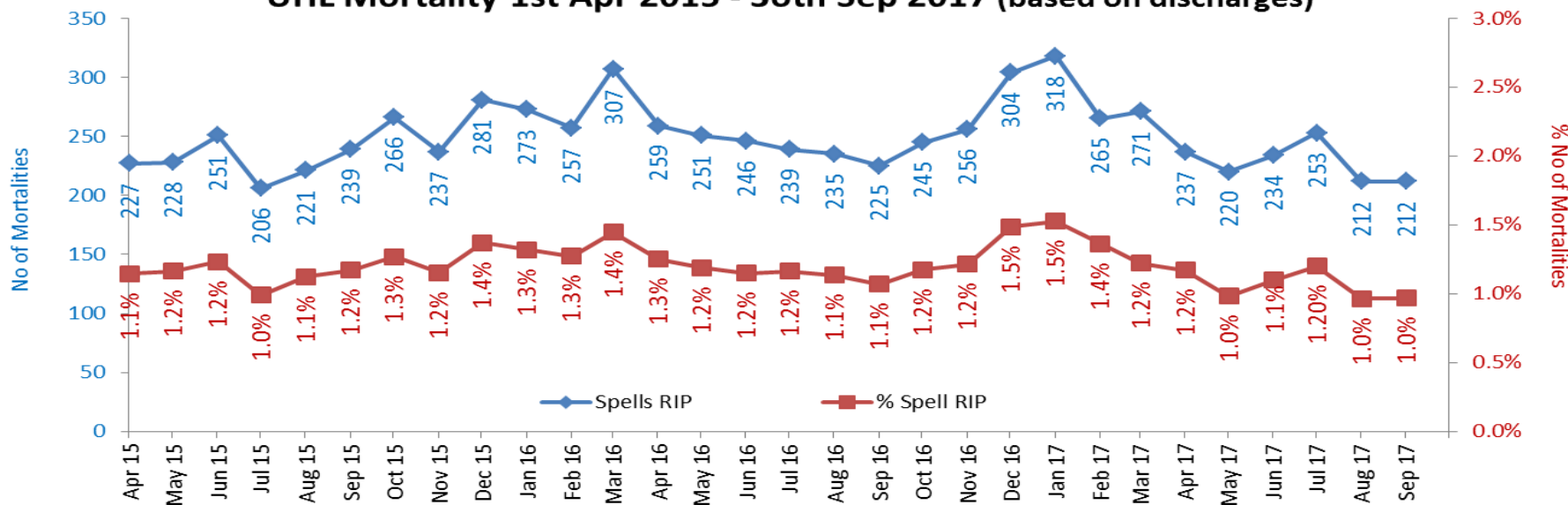
What are UHL's current overall crude and risk adjusted mortality rates?

Crude mortality:

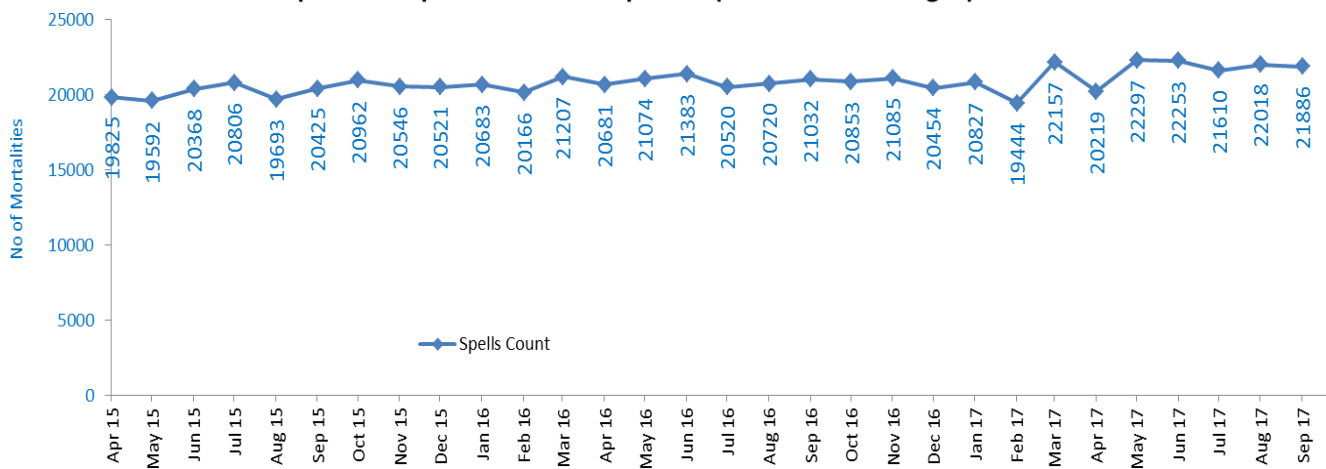
**i.e. number deaths and proportion of discharges
where death is the outcome**

How many people died in the Trust during the first 6 months of this financial year and what is the Trust's crude mortality rate?

UHL Mortality 1st Apr 2015 - 30th Sep 2017 (based on discharges)



UHL Spells 1st Apr 2015 - 30th Sep 2017 (based on discharges)



What is the data telling us?

There were 1,368 in-patient deaths during Q1-Q2 with August and September having the lowest number of deaths since August 15.

The monthly mortality rate has been between 1.0-1.2% during the first 6 months of this financial year.

However, it should be noted that these are typically the months with fewer deaths.

Please note: Figures for the latest months discharges may change due to late data recording on the system

HSMR: Hospital Standardised Mortality Ratio

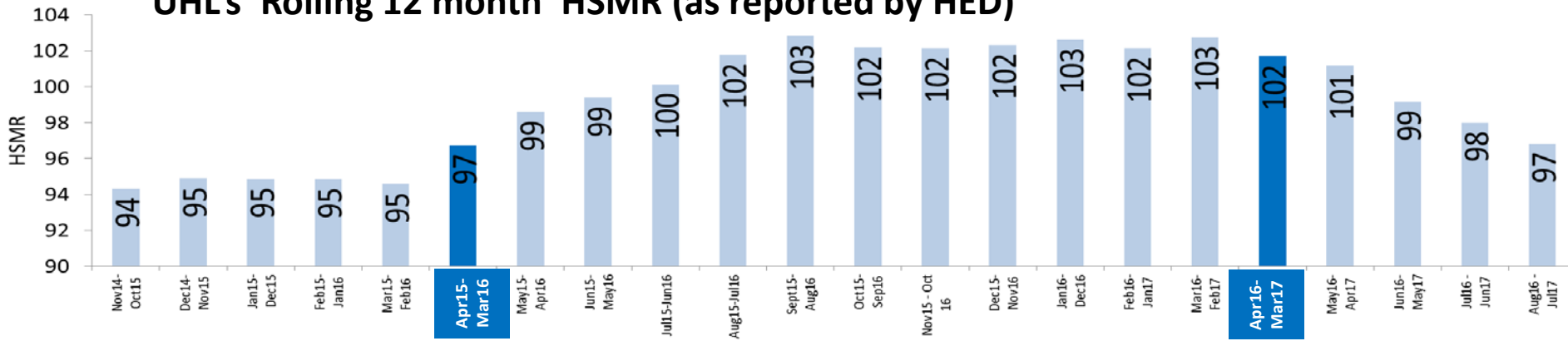
HSMR is risk adjusted mortality where patients die in hospital (either in UHL or if transferred directly to another NHS hospital trust) over a 12 month period within 56 diagnostic groups (which contribute to 80% of in-hospital deaths).

The HSMR methodology was developed by the Dr Foster Unit at Imperial College (DFI) and is used as by the CQC as part of their assessment process, however the 'rolling 12 month' data presented in the next chart is taken from the Hospital Evaluation Dataset (HED) as their HSMR has been more recently rebased against all other trusts.

NOTE: Following upload of new national data, both HED and DFI 'rebase' their HSMR dataset and therefore Trusts may see a change in their previously reported HSMR.

What is the Trust's current Hospital Standardised Mortality Ratio (HSMR)?

UHL's 'Rolling 12 month' HSMR (as reported by HED)

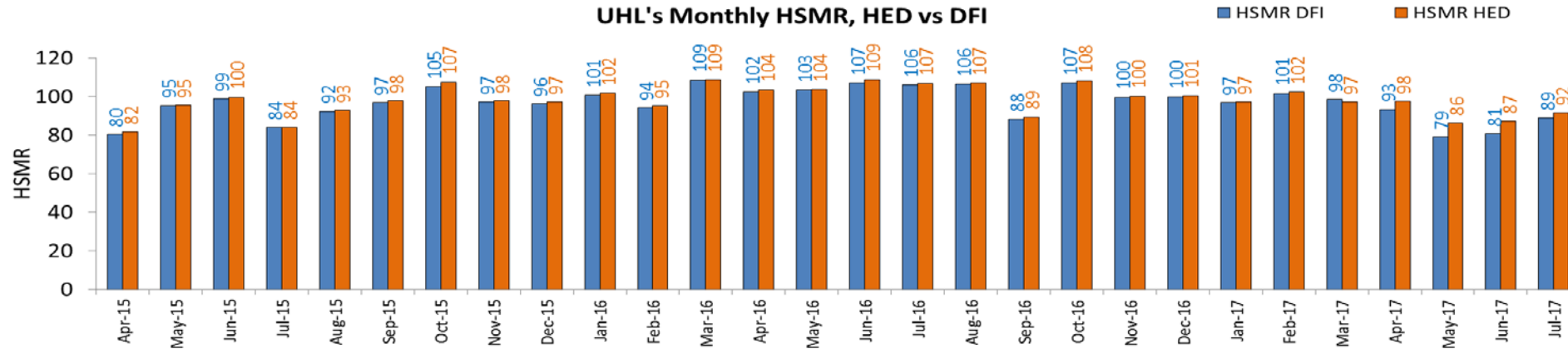


What is the data telling us?

UHL's HSMR was above 100 for the financial year 2016/17 (as reported by HED) but was still within the expected range compared to all trusts.

The latest 'rolling 12 month' HSMR (Aug 16 to Jul 17) is 97 and our monthly HSMR has been below 100 for the past 5 months in both the HED and DFI tools.

UHL's Monthly HSMR, HED vs DFI

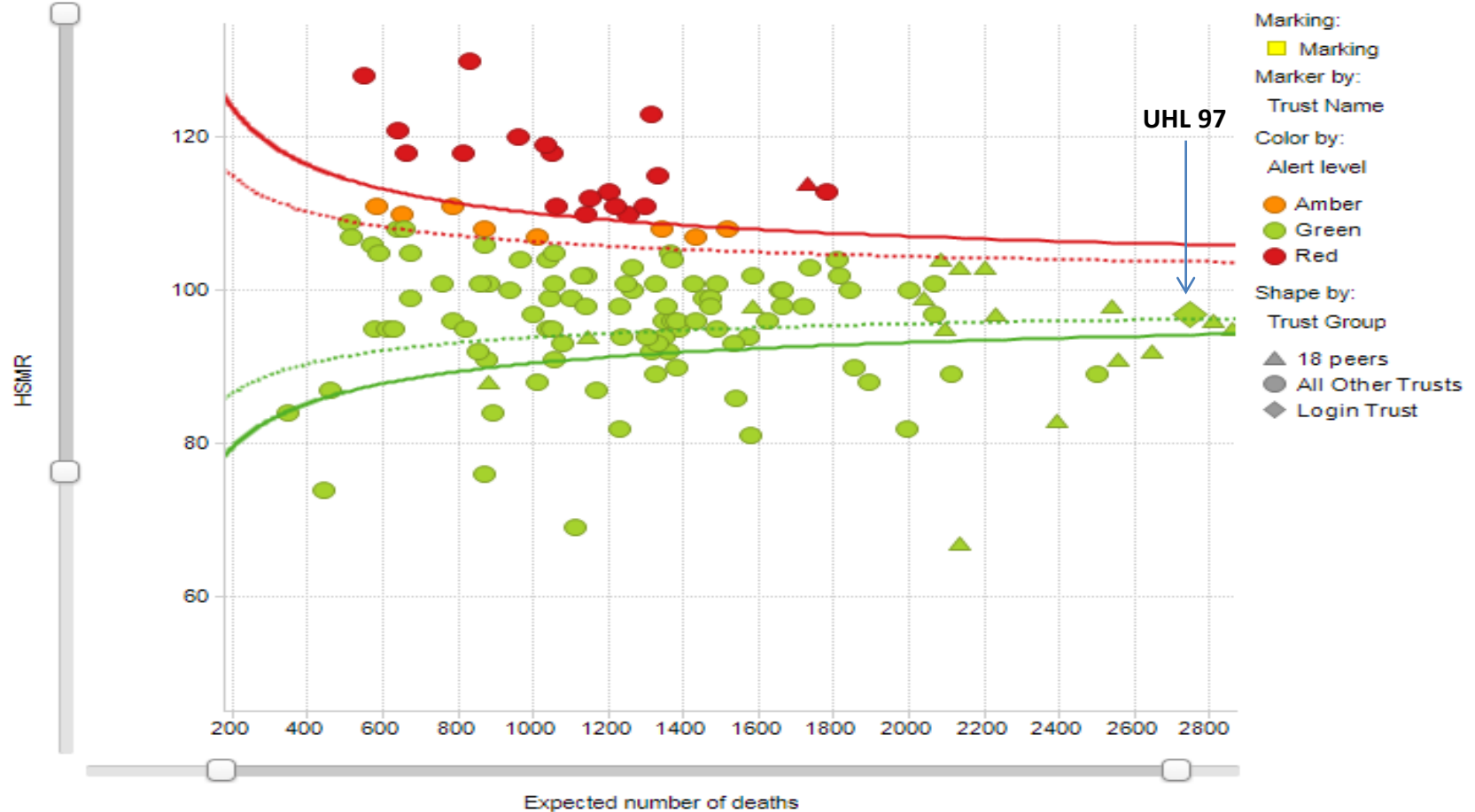


How does UHL's latest HSMR* compare with other trusts? (Aug 16 – Jul 17)

*Data taken from HED

Figure 1.2: Funnel Plot (Rebasing period up to Jul-17)

Please note that the funnel plot is only valid when the overall HSMR score is around 100.



What is the data telling us?

UHL's HSMR is within the funnel plot (i.e. within expected) and whilst it was above 100 for the financial year Apr 16 to Mar 17 our latest '12 month HSMR' is now at 97.

SHMI:
Summary Hospital Mortality Index
ie risk adjusted mortality where patients die either in
UHL or within 30 days of discharge
(incl those transferred to a community trust)

The SHMI is published on a Quarterly basis by NHS Digital (previously the HSCIC).

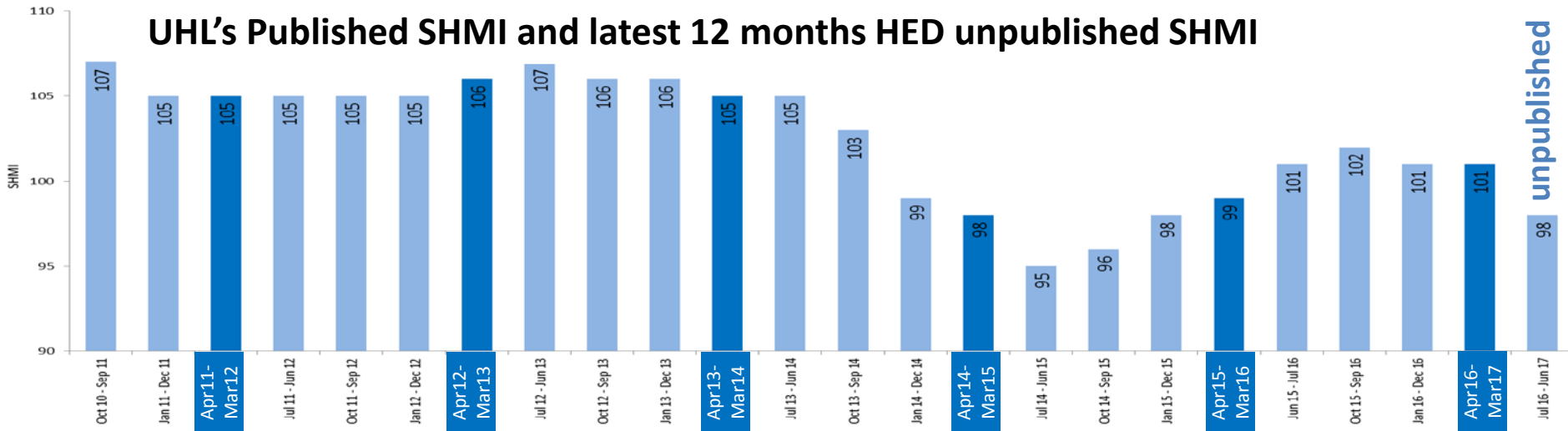
UHL subscribes to the University Hospitals of Birmingham's "Hospital Evaluation Dataset" Clinical Benchmarking tool (HED) which uses HSCIC methodology to replicate SHMI. This then allows us to review our SHMI pre publication.

NOTE:

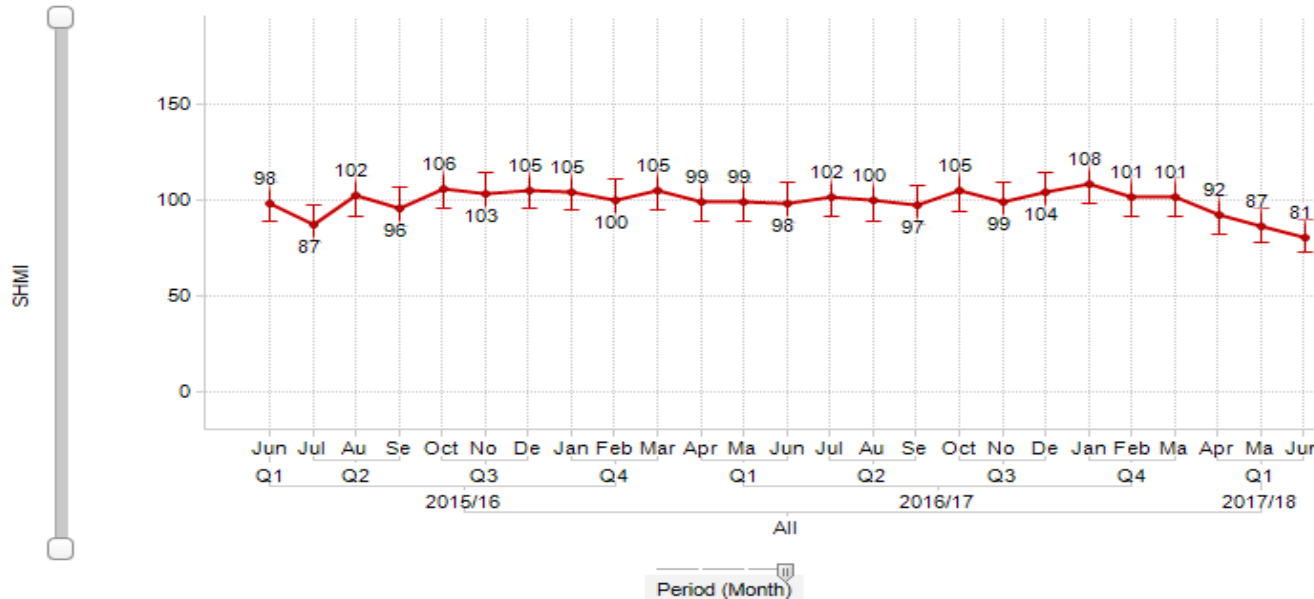
Although HED rebase their SHMI database following uploading of new data, the unpublished SHMI value is usually 1 or 2 below the final NHS Digital published SHMI

Due to the SHMI involving 'out of hospital deaths' the reporting timeframe is a month behind that for the HSMR.

What is the Trust's current Summary Hospital Mortality Index (SHMI)?



UHL's monthly SHMI (as reported by HED) Jun 15 – Jun 17



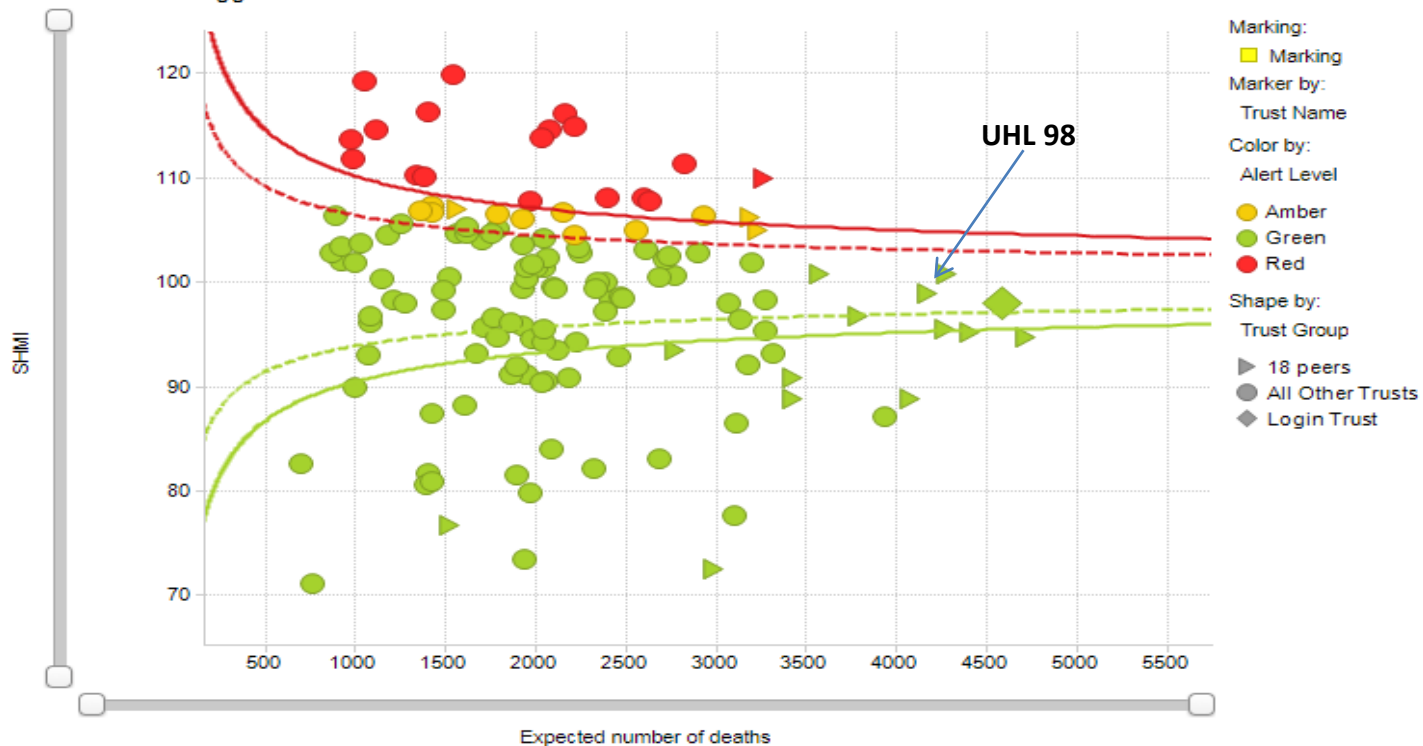
What is the data telling us?

- UHL's published SHMI was above 100 for the first 3 financial years of reporting and was then below 100 for the next 2.
- Our latest published SHMI is 101 for the financial year 16/17.
- UHL's unpublished SHMI - as reported by HED - has come down to 98 for Jul16-Jun 17 which is the next reporting period for the Published SHMI – due end of December 17.
- It is therefore anticipated that, following national rebasing, our next published SHMI will be 99-100.

How does UHL's SHMI – as reported by HED - compared against all Trusts (Jul 16 to Jun 17)

Figure 1.2: Poisson Distribution (PD) Funnel Plot

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.



What is the data telling us?

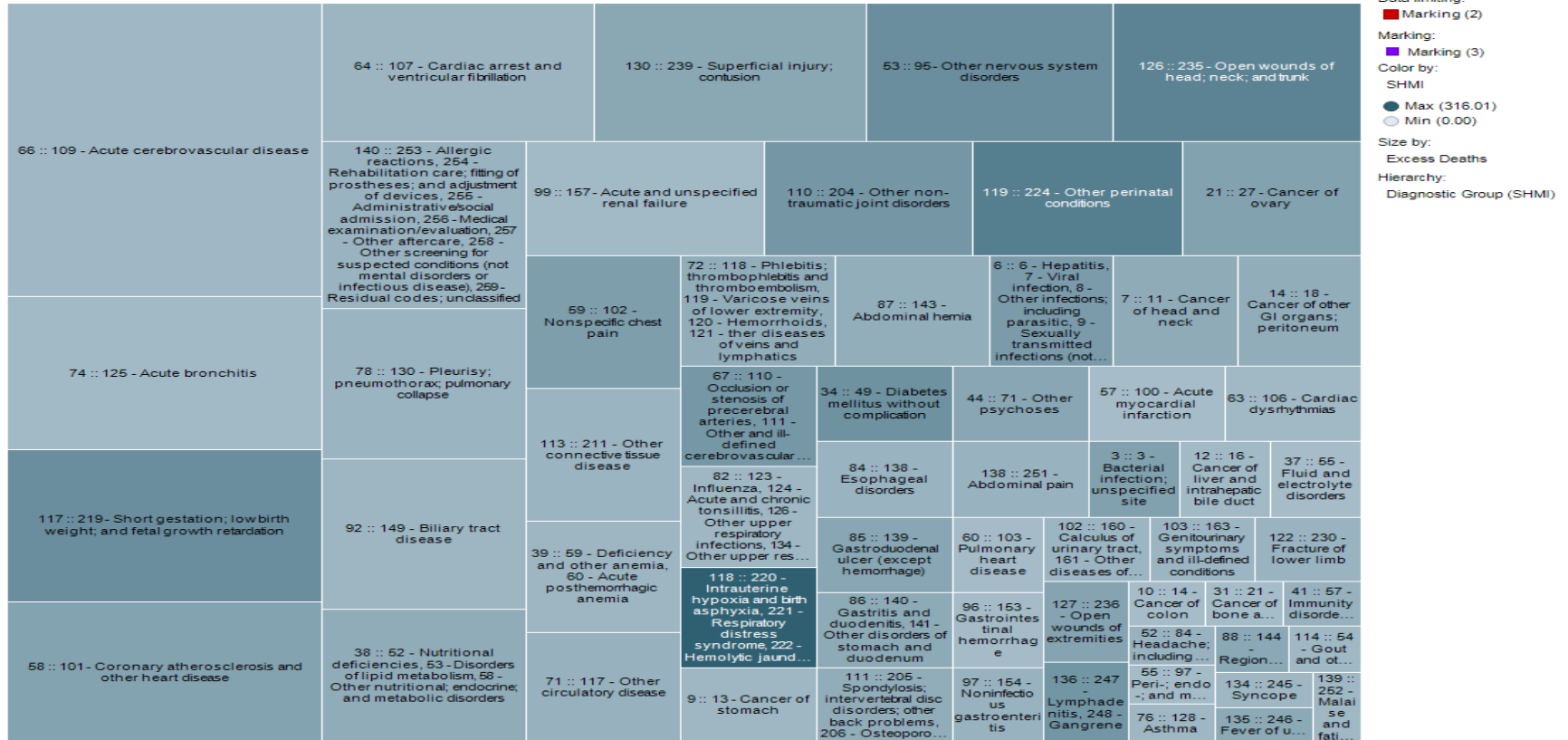
UHL is one of the England 'top 5' trusts for activity and also for the number of deaths.

Our SHMI is 's unpublished SHMI for the period Jul 16 to Jun 17 is 98 which is slightly below the expected of 100 and is in line with other trusts with similar numbers of deaths.

Which are the diagnosis groups most contributing to our SHMI?

Diagnosis Groups with a SHMI above 100 (Jul 16 to Jun 17)

Figure 2.1: Number of Excess Deaths



What is the data telling us?

The above chart presents those diagnosis groups with a SHMI above 100. The size of the box indicates the number of deaths and the colour indicates the SHMI i.e. The larger the box, the greater the number of deaths; and the darker the colour, the higher the SHMI

‘Open wounds of head; neck; and trunk’, ‘Other Perinatal Conditions’, and ‘Intrauterine hypoxia and birth asphyxia’ are the top 3 diagnosis groups with the highest SHMIs. For these groups, the numbers of deaths are small (18, 11 and 6 respectively) but only 8, 5 and 2 deaths were expected, hence the high SHMI. Of all the diagnosis groups with a SHMI above 100, Acute cerebrovascular disease has the most deaths (225 against an expected 198).

Actions being taken to improve UHL's SHMI and HSMR

Case note reviews have been undertaken for those diagnosis groups with a higher SHMI or HSMR and whilst none have found deaths more than likely due to problems in care, we have identified areas for improvement (see below).

Whilst we have identified learning to improve patient pathways, a common theme from the reviews has also been the need to improve the accuracy of the primary reason for hospital admission as this affects the adjusted mortality risk prediction.

Diagnosis Group	Review Findings / Improvement Work Stream
Acute Myocardial Infarction / Coronary Atherosclerosis and Other Heart Disease	<p>Ongoing case note review of patients admitted to LRI with AMI as primary diagnosis to confirm appropriateness of admission and cardiology involvement.</p> <p>'Acute Coronary Syndrome' Clinical Decision Tool developed and launched in Aug 17 – aim to support more accurate diagnosis and earlier referral.</p> <p>Cardiology Consultant presence in ED</p> <p>Review of pathway for patients referred urgently from other centres for cardiac surgery.</p>
Stroke	<p>Correlation of data with the national Stroke Audit (SSNAP) Mortality reporting – this shows UHL's mortality rate is in line with the national average.</p> <p>Liaison with Clinical Coders to improve depth of coding of type of stroke</p> <p>Continued focus on improving 'time to thrombolysis' and 'time to stroke unit'.</p>
Other Perinatal Conditions, Small for Gestation, Intrauterine Hypoxia	<p>Comparison of UHL's perinatal mortality data as reported to MBRRACE (the Maternal, Newborn and Infant Clinical Outcome Review Programme). For 2015 significantly more of the stillbirths and neonatal deaths at UHL were due to congenital anomaly compared to the UK average.</p> <p>The GROW protocol has been implemented in maternity to support earlier recognition of foetal growth retardation.</p>
Cardiac Arrest	<p>Reflects increased number of patients having an out of hospital cardiac arrest being admitted directly to the Coronary Care Unit at Glenfield. OoHCA patients in other trusts will usually be taken to the Emergency Dept and therefore fewer deaths included in the HSMR/SHMI.</p>
Open Wounds of Head, Neck & Trunk	<p>Review identified that although the patients had a wound on admission, they had an underlying significant condition (cancer, dementia) which had necessitated hospital stay and had been the primary cause of death.</p>

Learning From the Deaths of Patients in our Care

What's involved?

- In December last year, the Care Quality Commission published its review [Learning, candour and accountability: A review of the way NHS Trusts review and investigate deaths of patients in England.](#)
- In response to the review recommendations, the [National Guidance on Learning from Deaths](#) has been published which includes a requirement for Acute Trusts to publish on a quarterly basis:
 - total numbers of in-hospital deaths from 1st April 2017
 - numbers of deaths fully reviewed as part of the relevant Specialty M&M process ([using the Structured Judgement Review tool \(SJR\) which is part of the National Mortality Case Record Review programme](#))
 - number of deaths assessed as having been more likely than not to have been caused by problems in care
 - evidence of learning and action that is happening as a consequence of this information
- There are certain categories of deaths where a full review is automatically expected (ie patients with Learning Disabilities, Severe Mental Illness, following an elective procedure).
- Full reviews should also be undertaken where
 - family, carers or staff have raised a concern about the quality of care provision;
 - there is the potential for learning and improvement
 - There is a CUSUM alert for a diagnosis group

Learning from Deaths Terminology

Review vs Investigation

- **Case record review** can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work. Review also identifies good practice that can be spread.
- **Investigation** starts either after case record review or straight after an incident, where problems in care that need significant analysis are likely to exist. Investigation is more in-depth than case record review as it gathers information from many additional sources. The investigation process provides a structure for considering how and why problems in care occurred so that actions can be developed that target the causes and prevent similar incidents from happening again.
- Data generated from case record review and investigation, for example estimates of the number of deaths thought more likely than not to be due to problems in care, are subjective and so not useful for making external judgements about the safety of trusts.

Death due to a problem in care:

- A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision.
- Note, this is not a legal term and is not the same thing as 'cause of death'.
- *The term 'avoidable mortality' should not be used as this has a specific meaning in public health that is distinct from 'death due to problems in care'.*

UHL's "Learning from Deaths" Framework

- Medical Examiners (MEs) – screen all adult cases, speak to relatives
- Specialty Mortality & Morbidity Programme (M&M) – Mortality Reviews (SJR), Learning Lessons and taking forward Actions
- Bereavement Support Nurse (BSN)– ‘follow up’ contact for bereaved families of adult patients
- Patient Safety Team (PST) – Investigation where death considered to be due to problems in care
- All part of the Trust's Quality Commitment

UHL's LFD Framework – Medical Examiners

In order to meet the NHS England requirement of 'high level assessment of all deaths' UHL implemented the Medical Examiner Process (from July 16) which is now in place across all 3 sites

- Currently we have 11 Senior Consultants providing 10.5 Medical Examiner sessions a week

Medical Examiners:

- Are involved in the death certification and screening of adult in-patient and ED deaths
- Provide advice to certifying doctor cause of death for the death certificate and which Deaths should be referred to the Coroner (where not nationally mandated)
- Complete Part 2 of the Cremation Form (LRI only)
- Speak to the bereaved to confirm they understand the cause of death and also if they have any concerns about care provided
- Undertake 'mortality screening' of the clinical record (paper and electronic) to see if any potential problems in care
- Cross reference with the Trust's Patient Safety Incident reporting data as part of the mortality screening process
- Refer cases to the relevant Specialty M&M for further review or formal structured judgement review as applicable.

How are deaths in UHL selected for Structured Judgment Review?

National requirements for Structured Judgement Review (Case Record Review)

- Infant and Child Deaths and Maternal Deaths
- Deaths where the patient had a Learning Disability or Severe Mental Illness
- Deaths following an elective procedure
- Deaths where primary diagnosis on admission is part of a SHMI/HSMR alert

UHL Medical Examiner Criteria for SJR referral - identified either via 'case note screening' or bereaved relatives feedback or from speaking to the Certifying Doctor

All cases identified as having potential problems in care relating to

- Assessment, Investigation, Diagnosis
- Medication, IV fluids / Electrolytes / Oxygen
- Treatment and Management Plan
- Infection control
- Operation/Invasive Procedure
- Clinical Monitoring
- Resuscitation following cardiac or respiratory arrest

Other Criteria for SJR referral

- Members of the clinical team consider potential learning
- Bereaved Relatives' feedback to Bereavement Support Nurse
- Death occurred in diagnosis/patient group that is part of a quality improvement work-stream

How is the Case Record Review process carried out?

Using the Royal College of Physician's Structured Judgement Review method:

- Involves a detailed review of patient's case notes by a Consultant / Senior Trainee in the relevant Specialty, but not involved in the care of the patient, to assess the quality of care for each phase of admission as shown below:
 - On admission (first 36 hours)
 - Procedural and Post Operative
 - Ongoing
 - End of Life/Discharge
- Each phase given a score of 1 to 5 with a score also being given to the overall care:



- An explicit statement then needs to be given to support the score given for each phase of care / overall, for example:
 - *Very good care – rapid triage and identification of diabetic ketoacidosis with appropriate treatment. (On admission care = 5)*
 - *Good documentation of clinical findings, investigation results, management plan and discussion with other teams (Ongoing care = 4)*
 - *Overall, a fundamental failure to recognise the severity of this patient's respiratory failure (Overall care = 2).*
- The Reviewer is also asked to confirm whether there were problems in care, what type of problems and in which phase of care these occurred.
- Where problems identified, these are then assessed as to whether caused harm or not

What are UHL's Death Classification Criteria and Next Steps?

Following review of phases of care and confirmation as to whether any problems in care led to harm, deaths are classified in line with the criteria below and action taken accordingly:

Category	Rationale	Next Steps
1*	Death is more likely than not to have resulted from a problem in care	Upon initial classification of DC = 1 (i.e. by Reviewer, M&M Lead or at MDT M&M): Confirm Category as applicable. Check if reported as Patient Safety Incident (PSI). If not already on Datix as Moderate, Major or Death graded incident, M&M Lead to ensure reported as PSI with Major Harm on Datix . Reporter to advise PSI identified thru SJR Review/M&M. MDT M&M to Escalate to MRC for further review via Mortality Mailbox and Confirm learning and actions.
2*	Problems in care which may have contributed to death but not very likely	Upon initial classification of DC = 2 (i.e. by Reviewer, M&M Lead or at MDT M&M): Confirm Category as applicable. Check if reported as PSI If not consider if requires reporting as PSI. SJR findings to be reported to MRC via Mortality Mailbox. Update SJR proforma. Confirm learning and actions.
3*	Problems in care but very unlikely that these contributed to death	Discuss at M&M meeting. Confirm learning and actions and Patient Safety Implications. Update SJR proforma with M&M discussion and send to Mortality Mailbox
4**	No problems in care	Confirm if any learning and disseminate accordingly. Update SJR proforma if discussed at M&M meeting and send to Mortality Mailbox
5**	Good or Excellent Care.	Confirm if any learning /sharing of best practice and disseminate accordingly. Update SJR proforma if discussed at M&M meeting and send to Mortality Mailbox

* **MUST** be discussed at Specialty M&M ** Death Classification can be 'signed off' by M&M Lead

UHL's Learning from Death process

April to September 17

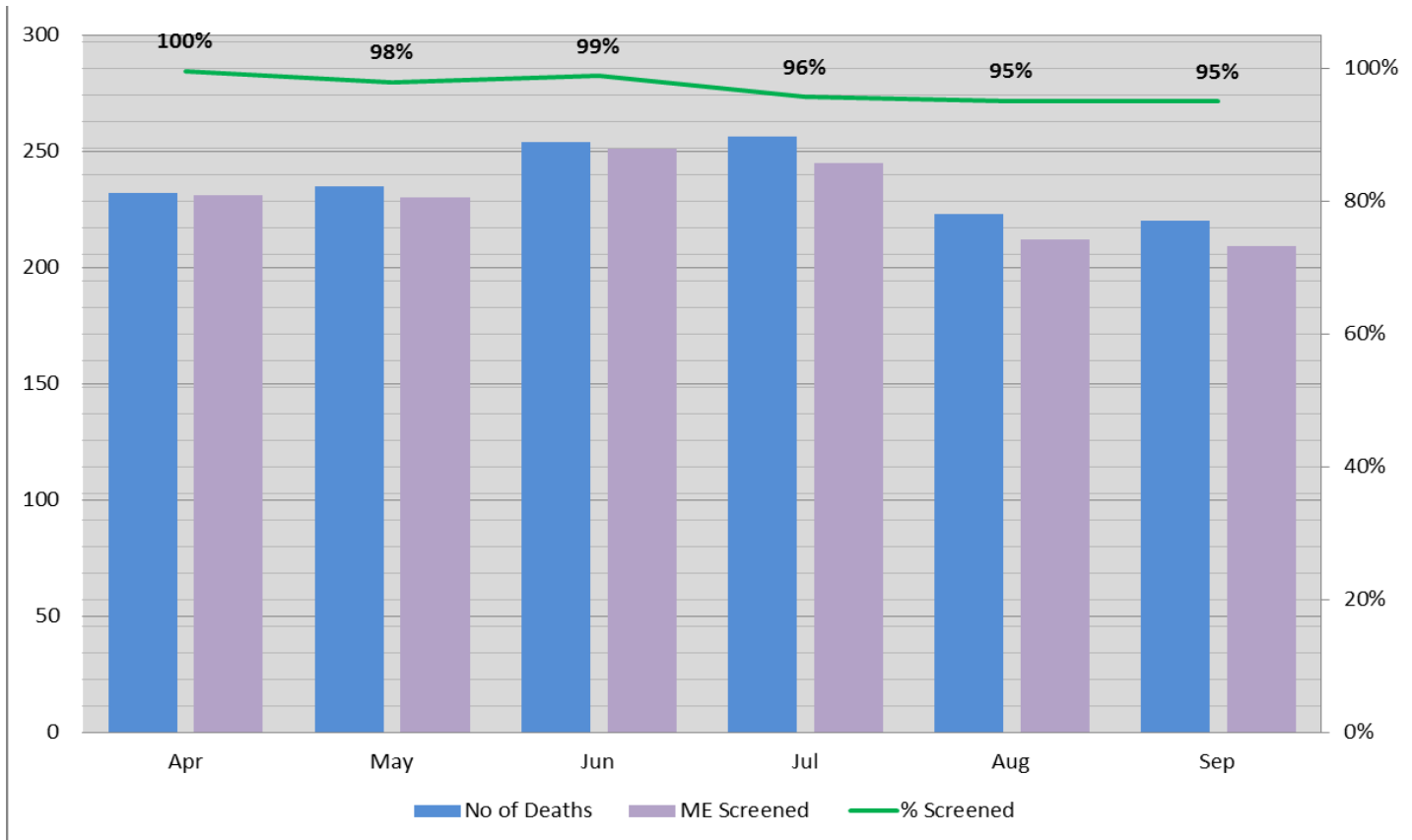
PLACE OF DEATH	ADULT / CHILD / NEONATE	NUMBER OF DEATHS
ED		88
	Adult	85
	Child	3
Inpatient		1358
	Adult	1308
	Child	13
	Neonate	37
TOTAL		1446

What is the data telling us?

UHL is one of the England 'top 5' trusts for activity and also for the number of deaths. The table above shows the number of patients who died either in the Emergency Department or as an in-patient. Neonates are babies who are born in UHL or in another hospital and transferred to our Neonatal Unit.

UHL's Medical Examiner Process

Number / % of Adult Deaths Screened by the MEs – April to Sept 17



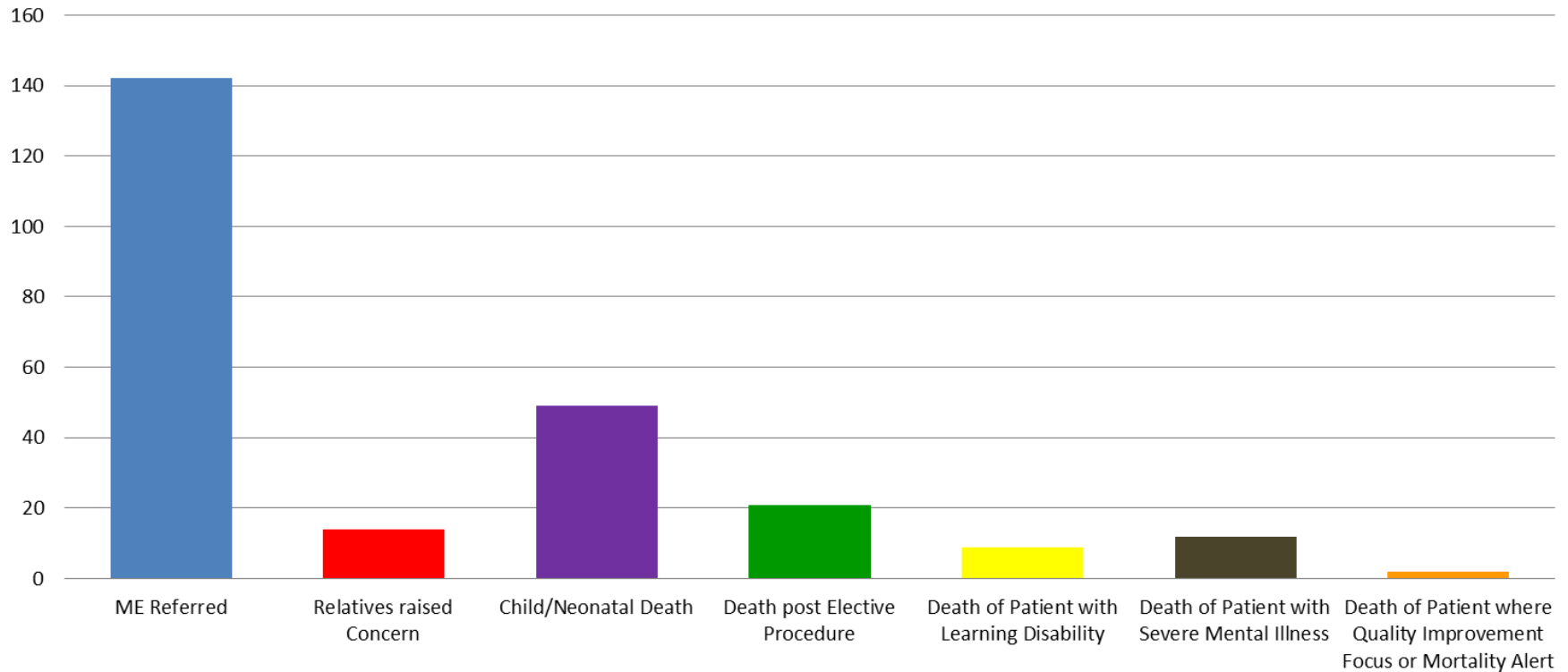
What is the data telling us?

UHL target is 95% of all Adult Deaths to be 'screened'

Of the Jul to Sept cases not yet screened, most were referred to the Coroner and cause of death details required to inform ME Screening

Structured Judgement Review Criteria

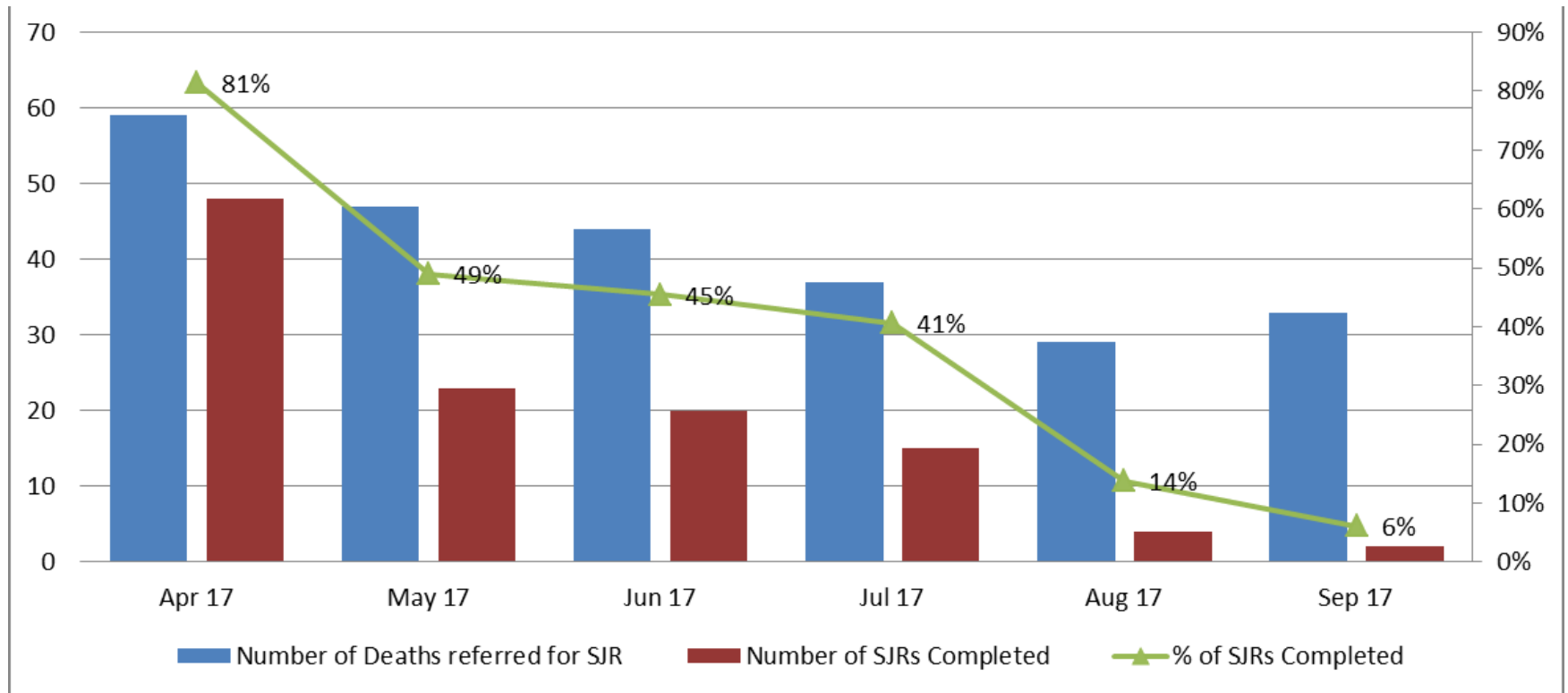
Reasons Deaths Referred for Structured Judgment Review via Specialty
M&M Process during Apr - Sept 17 n = 249



What is the data telling us?

ME referral for SJR makes up over half the cases with paediatric/neonatal deaths being the next largest group.

Deaths in Q1 – Q2 Referred for SJR and Number / % Completed



What is the data telling us?

112 of the 249 cases referred for SJR between April to September 17 have been completed (45%)

Following discussion with the Specialty M&M Leads, an internally set target for completion of SJRs was agreed as:
75% within 4 months of death and 100% within 6 months.

Therefore all April's deaths should have had SJRs completed at the end of October and 75% of May and June's deaths should have had completed SJRs. However, not all SJR details have been collated due to capacity constraints within the Corporate M&M Admin team and capacity within the Specialty M&M teams.

Death Classifications where SJR Completed

	UHL Death Classification Criteria	No of Deaths
1	Death is more likely than not to have resulted from a problem in care	1
2	Problems in care which may have contributed to death but not very likely	9
3	Problems in care but very unlikely that these contributed to death	29
4	No problems in care	59
5	Good or Excellent Care.	14
	ALL	112

What is the data telling us?

The number of deaths where there was a problem in care that contributed to the patient's death is small. In a significant number of cases, no problems were found or good or excellent care was identified.

The death in Category 1 has been investigated as a Serious Incident and identified multiple contributory factors with specific learning for both ED and the Difficult Asthma Clinic at Glenfield.

Learning from Deaths – Quarters 1 & 2

- Wide range of learning identified but most fall into the following categories:
 - Escalation of the deteriorating patient / sepsis treatment / acting on results
 - Communication where bloods or investigations not carried out
 - Senior review / Setting of ‘Ceilings of Care’
 - Recognition of patients at the end of life

Actions being taken

- For most cases, the actions were around raising awareness and disseminating the clinical teams lessons learnt – specifically:
 - risk of paralytic ileus for patients receiving chemotherapy
 - risk of sudden deterioration of patients with endocarditis
 - risks for patients on long term steroids
 - importance of referral to Anticoagulation clinic

How is UHL engaging with bereaved families and carers

Bereavement Support Service

Follow up contact by the Bereavement Support Service is offered to the bereaved relative/carer for all UHL deaths.

Contact is made by the Bereavement Support Nurse (BSN) 6-8 weeks after the death

- 60% of bereaved requested follow up in Quarter 1 and 60% of those were spoken to by phone (letter sent to all where the Bereavement Support Nurse was unable to make telephone contact)
- Further information was requested by 38 families as part of the follow up contact
- Meetings with the clinical team were facilitated for 15 families
- Signposting to bereavement services eg CRUSE, LOROS, Sharma Women's Centre, Child Bereavement UK was given to 60 bereaved relatives/carers

Deaths being investigated under the Serious Incident framework

- Deaths for investigation have been identified by:
 - ME mortality screening
 - SJR
 - Patient Safety Incident reporting
- 4 deaths have been investigated in Q1 and Q2
 - 1 investigation has been completed and confirmed as a serious incident (relates to case given a Death Classification of 1 in slide 25)
 - Remaining 3 – investigation ongoing

UHL's "Learning from Deaths" Framework

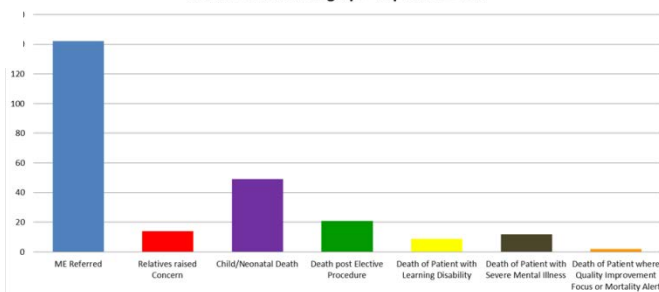
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UHL's LEARNING FROM DEATH PROCESS INVOLVES:

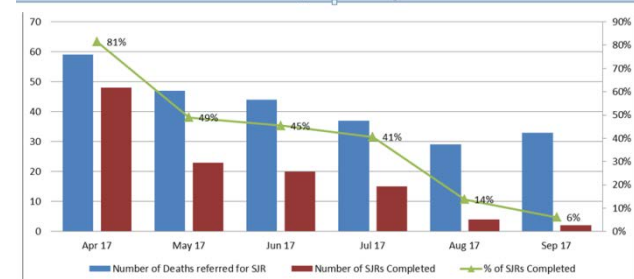
April to September 17

PLACE OF DEATH	ADULT / CHILD / NEONATE	NUMBER OF DEATHS
ED		88
	Adult	85
	Child	3
Inpatient		1358
	Adult	1308
	Child	13
	Neonate	37
TOTAL		1446

Reasons Deaths Referred for Structured Judgment Review via Specialty M&M Process during Apr - Sept 17 n = 249

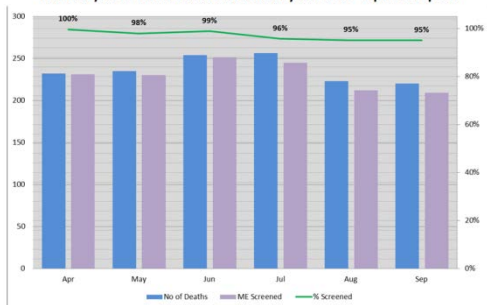


Deaths in Q1 – Q2 Referred for SJR and Number / % Completed



UHL's Medical Examiner Process

Number / % of Adult Deaths Screened by the MEs – April to Sept 17



	UHL Death Classification Criteria	No of Deaths
1	Death is more likely than not to have resulted from a problem in care	1
2	Problems in care which may have contributed to death but not very likely	9
3	Problems in care but very unlikely that these contributed to death	29
4	No problems in care	59
5	Good or Excellent Care.	14
	ALL	112

Learning from Deaths – Quarters 1 & 2

- Wide range of learning identified but most fall into the following categories:
 - Escalation of the deteriorating patient / sepsis treatment / acting on results
 - Communication where bloods or investigations not carried out
 - Senior review / Setting of ‘Ceilings of Care’
 - Recognition of patients at the end of life

Actions being taken

- For most cases, the actions were around raising awareness and disseminating the clinical teams lessons learnt – specifically:
 - risk of paralytic ileus for patients receiving chemotherapy
 - risk of sudden deterioration of patients with endocarditis
 - risks for patients on long term steroids
 - importance of referral to Anticoagulation clinic

Bereavement Support Service

Follow up contact by the Bereavement Support Service is offered to the bereaved relative/carer for all UHL deaths. Contact is made by the Bereavement Support Nurse (BSN) 6-8 weeks after the death

- 60% of bereaved requested follow up in Quarter 1 and 60% of those were spoken to by phone (letter sent to all where the Bereavement Support Nurse was unable to make telephone contact)
- Further information was requested by 38 families as part of the follow up contact
- Meetings with the clinical team were facilitated for 15 families
- Signposting to bereavement services eg CRUSE, LOROS, Sharma Women’s Centre, Child Bereavement UK was given to 60 bereaved relatives/carers