University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 6 December 2018

	Trust Board paper I

Report Title:	**Quality and Outcomes Committee – Committee Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
Author:	Helen Stokes – Corporate and Committee Services Manager

Reporting Committee:	**Quality and Outcomes Committee**
Chaired by:	Col (Ret'd) Ian Crowe – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse
Date of meeting:	29 November 2018

Summary of key public matters considered by the Committee and any related decisions made:

This report provides a summary of the key public issues considered at the Quality and Outcomes Committee on 29 November 2018:

- **Modernisation of the UHL Stroke TIA clinic** – the Deputy Clinical Director ESM presented a report highlighting actions to improve Stroke TIA clinic performance, noting that a recent dip in performance was linked primarily to increased demand. At present, the majority of patients seen were not diagnosed with a TIA/stroke, and the performance improvement actions included strengthening referral guidelines and implementing more appropriate referral pathways. Changes would also be made to PRISM, the GP referral tool. The actions would also be in line with the new national definition of 'high risk', currently out for consultation. Non-Executive Directors queried the factors behind the rise in demand, noting the ease and speed of accessing the TIA clinic. The new referral guidelines would be audited in January/February 2019, and Non-Executive Directors suggested that those audits would be useful in highlighting any need for further information to primary care on the referral criteria. QOC was assured by the report, and agreed that it would only require a further update on this issue if the expected performance improvement had not taken place as anticipated by March 2019.

- **Rheumatology DEXA scanner reporting** – the Deputy Clinical Director ESM advised QOC of a reporting issue with the rheumatology DEXA scanner, which although reporting the correct headline diagnosis had been registering mean T-scores since a software upgrade by the manufacturer. QOC received assurance that the reporting had now been corrected and that no issues remained ongoing. Any clinical risk was felt to be negligible to very low. GPs were aware, and the MHRA had been informed by UHL. QOC was assured by this report, and considered that all appropriate action looked to have been taken. QOC was also advised that, going forward, the DEXA scanner would sit – as was appropriate – in the Clinical Support and Imaging CMG rather than with ESM.

- **UHL Imaging response to CQC radiology reporting review** – the Head of Operations Clinical Support and Imaging, outlined the position of UHL's Imaging service in respect of the national CQC report issued in Summer 2018. He provided assurance to QOC that the Trust had effective oversight of radiology reporting, that risks to patients were fully assessed and managed, and that staffing and other resources were used effectively to ensure examinations were reported in an appropriate timeframe. QOC was advised of a very significant reduction in the number of unreported examinations, and welcomed the transparent monthly reporting of performance KPIs via the CSI CMG dashboard to the Performance Review Meetings. It was also planned to report quarterly to the Executive Quality Board, and the KPIs were already shared with Commissioners. The QOC Non-Executive Director Chair received assurance that the CQC was also appropriately sighted to the KPIs. QOC also welcomed UHL's success in recruiting radiologists (a profession in shortfall nationally). In further discussion, QOC noted the very significant growth in ED CT demand, and received assurance that this was being appropriately explored by Imaging. Noting the potential demand impact of the national focus on cancer, Ms V Bailey Non-Executive Director commented on the wider need to look at whether increased diagnostics resulted in better patient outcomes.

- **Radiation Safety – Glenfield Hospital** – further to the update provided in October 2018, QOC reviewed the report submitted to the Environment Agency in early November 2018, a response to which was awaited. As previously confirmed, no patient harm had occurred, and any associated staff risk was assessed as minimal. Separately, the Director of Safety and Risk also noted positive outcomes from November 2018 visits to the catheter labs by the Environment Agency and the CQC. QOC also discussed an internal risk-based assurance review carried out by UHL's Radiation Safety team, looking at safety and compliance in using radiation – following discussion, it was agreed to receive a further update (on that work and on the issue of seeking a

potential external peer review) at EQB and QOC in March 2019. The QOC Non-Executive Director Chair reiterated the need for appropriate SOPs to be followed in all cases, and for appropriate induction of staff particularly in any related areas of high turnover. The Director of Safety and Risk agreed to discuss potential options for an 'early flag' system to highlight instances of non-compliance. In response to a query, the Director of Clinical Quality confirmed that any external visits/inspections were captured in her regular report to QOC.

- **Nursing and Midwifery quality and safe staffing report (September 2018)** – the report provided triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those wards triggering a level 3, 2 or 1 concern in the judgement of the Chief Nurse and Corporate Nursing team. A specific medical ward at the LRI continued to face pressures, although a staffing plan was in place and improvements had started to take effect. Recent nursing and HCA recruitment events had been very successful, and the Chief Nurse also advised QOC of UHL's (welcomed) involvement in NHS Improvement's Formal Retention Programme, recognising the key importance of retaining staff once recruited. QOC also welcomed the Chief Nurse's focus on reviewing the 'team around the patient', and noted that ward leadership would also be discussed further at a Trust Board thinking day – as part of that discussion, Ms V Bailey Non-Executive Director also suggested looking at the scope for ward-based apprentices.

  In response to a query from Mr B Patel Non-Executive Director, the Chief Nurse outlined the actions taken by UHL to welcome and orientate overseas nurses (given their potential influence in attracting other overseas staff), and she noted her view that UHL performed very strongly in that regard. QOC discussed the crucial importance of good communication in reaching out to all staff groups to attract them to UHL, and the Medical Director outlined the specific measures planned re: junior doctors.

- **Monthly highlight report from the Director of Safety and Risk** – QOC considered a suite of reports covering:- (i) the triangulation of themes from the review of incidents and learning from deaths process; (ii) the updated never event action plan; (iii) the patient safety report for October 2018, and (iv) the complaints performance report for October 2018. The Director of Safety and Risk also briefed QOC verbally on a number of VTE incidents, noting the position of the inquests into those deaths. In addition to a task and finish group review of VTE practice, a number of immediate actions were also planned including an assessment of CMGs' positions against new NICE guidance. A further report would be provided to the January 2019 QOC, including the Trust's response to a Regulation 28 report.

  QOC received assurance that the position re: Never Event Director-led safety walkabouts had improved since the production of the monthly highlight report. Following a regional NHS Improvement event in November 2018, QOC was also advised that UHL was not an outlier in terms of Never Events. In further discussion, the Director of Safety and Risk advised QOC that UHL had achieved HEE funding for 2 Safety Fellows (1 day per week for a year) from January 2019 – interviews would be held shortly and an encouraging number of applications had been received. QOC was also advised that UHL's patient safety twitter account would launch in January 2019.

- **Waiting list management** – at the request of the QOC Non-Executive Director Chair, QOC received an update from the Director of Performance and Information on progress in improving waiting list management within UHL. The report also briefed QOC on a recent processing error involving outpatient appointment letters, and the Director of Performance and Information confirmed that all affected patients had now received their appointment and that no harm had been identified. QOC noted ongoing work to address human error factors including staff refresher training, development of a simplified access policy and moves to paperless referrals to reduce the scope for human error. QOC also recognised the crucial role played by UHL's administrative staff in managing waiting lists, often at relatively low pay bands. In further discussion, QOC noted the wider issue of the appropriateness of follow-up appointments in general.

- **Outpatients transformation update** – the Head of Outpatient Transformation attended to update QOC on the outpatient transformation programme, noting the significant progress made in the 6 months since the previous update. Progress had particularly been made in improving outpatient appointment letters, with automation of the new-style letters scheduled for early 2019. A 2-way text reminder service for outpatients would also being in mid-December 2018, and the report set out the further IT improvements planned. The Head of Outpatient Transformation also noted the need to take appropriate account of the Royal College of Physicians' report on outpatient practices, and she outlined work on new models of care in outpatients. The QOC Non-Executive Director Chair welcomed the progress being made on the outpatient transformation programme, taking particular assurance from the extension of the work beyond the initial specialties. QOC agreed to receive a further update in 6 months' time.

- **CQC update –** the report updated QOC on work to refresh the Trust's Statement of Purpose, gave details of the next CQC Provider Engagement Meeting, and provided an update on the Internal Audit review of governance to assess ongoing compliance with CQC requirements. The latest CQC Insight report was also appended, and QOC commented on the impact of the arrow trends. In response, the Medical Director commented on the age of the

data being used and clarified that the 'change' position related simply to performance compared to the previous month. He advised that the national comparison column was more useful and he provided assurance that (with the exception of one issue being explored by the Head of Midwifery) any of the indicators where UHL was adverse to the national position were already known to the Trust.

- **QOC Annual Workplan 2018-19** – noted. Any updated/specified reporting frequencies arising from this meeting would be reflected in the next iteration.

- **the quarterly report on learning from deaths** – the report set out UHL's crude and adjusted mortality rates for the second quarter of 2018-19 – the crude mortality rate for that period was 1.1% with no undue variations. UHL's HSMR and SHMI were both 95. The report also updated QOC on UHL's processes for learning from deaths, and advised that 95.9% all adult deaths had been reviewed by UHL's Medical Examiners in 2018-19 to date (although there had been some capacity-related slippage on the % of Structured Judgement Reviews completed within 4 months of death). As previously reported, the main themes emerging from Medical Examiner (ME) review related to end of life care and communication around DNACPR decisions. Where the ME review identified potential for learning, or the bereaved raised concerns about clinical management, cases were referred on for further internal review using the national mortality review template – in quarter 1 of 2018-19 1 death had been considered to be 'more likely than not' due to problems in care (death classification 1). In a further 7 instances, problems in care had been considered 'unlikely to have contributed to the death' (death classification 2). The Medical Director noted the very significant resource implications of national plans to roll out the ME model to children and to primary care. The Medical Director further advised that the national Medical Examiner was visiting UHL on 20 December 2018, and noted that the Trust was hosting a conference in February 2019 on how to run the ME process (the 'Leicester model'). The learning from deaths report also briefed QOC on the work of the Trust's Bereavement Support Service, and contained information on perinatal mortality (noting work in progress to correct UHL's stillbirths figure).

  The quarterly learning from deaths report is appended to this meeting summary, for review by the Trust Board.

- **Minutes for information** – Executive Quality Board minutes 2.10.18; Executive Quality Board actions 6.11.18; Executive Performance Board minutes 23.10.18.

Matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

1. quarterly learning from deaths report (as per the report appended to this summary);

Items highlighted to the Trust Board for information:

1. VTE incidents and the related Regulation 28 report

Matters referred to other Committees:

None

Date of next meeting:	20 December 2018

MORTALITY REPORT

Authors: Head of Outcomes & Effectiveness; M&M Information and Project Manager; Deputy Medical Director,
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 framework for implementing "Learning from Deaths" which includes our Medical Examiner Process, Bereavement Support Service; and Specialty Mortality Reviews using the nationally developed Structured Judgement Review tool.

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

Questions

1. What are the data telling us around UHL's mortality rates and what actions are being taken to improve these?
2. Are we making good progress with our Learning from Deaths framework and what learning has taken place
3. What are the implications for UHL following publication of the LLR LLtIC Clinical Quality Audit report?

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 overall crude mortality for 2017/18 was 1.2%. Our mortality rate 18/19 to date (end October is 1.1%.

UHL's latest published SHMI is 95 (covering the financial year 2017/18) and our HSMR was also 95 for same time period. Both these numbers are within the expected range.

There have been several 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, with a particular focus on sepsis has been one of the 2017/18

priorities. In 17/18 we saw a reduction in the SHMI for patients admitted with a sepsis diagnosis and the pneumonia SHMI continues to be below 100.

MRC monitor both our HSMR and SHMI at both a trust and patient group level. UHL's HSMR and SHMI continue to be above 100 for diagnosis groups relating to neonates. Discussions with Dr Foster has confirmed that the risk adjustment methodology used for the HSMR and SHMI do not fully reflect the complexity of case mix, particularly for Trusts providing Level 3 neonatal care. In addition UHL is a tertiary referral centre for congenital heart disease and cardiac surgery.

2. UHL's 'Learning from Deaths' Process (Appendix 2)

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

2.1 **Medical Examiner Screening**

MEs have screened 1382 (95.9%) of all adult deaths in Quarters 1 and 2 and we have therefore achieved our internally set target of screening 95% of deaths.

Where MEs identify potential for learning, through screening of the case notes and speaking to the certifying doctor, or the bereaved raise a concern about clinical management, the case is referred to the Specialty M&M for full Structured Judgement Review (SJR) using the national mortality review template.

302 deaths have been referred for either a clinical review or SJR in Quarters 1 and 2 with 123 deaths being referred for SJR. Our internally set target is that 75% of SJRs should be completed within 4 months of death and 100% within 6 months. Our current performance is 61% of SJRs requested in Quarter 1have been completed. This figure will increase as not all SJR details have been collated yet due to on-going capacity constraints within the Corporate M&M Admin team.

2.2 **Specialty M&M Reviews**

Following completion of a Structured Judgement Review, where problems in care are identified, the death will then be discussed at the Specialty M&M meeting and death classification agreed. There was 1 death in Quarter 1 which was considered by the Specialty M&M to be more likely than not due to problems in care (Death Classification = 1) which related to planned surgery (cholecystectomy) being cancelled on two occasions due to the winter 'bed pressures'. The patient subsequently went on to develop pancreatitis. The review findings were discussed at the Mortality Review Committee, where it was agreed that the case should be investigated as a patient safety incident, whilst noting that the cancellation had been related to the winter 'bed pressures' and 'cancer operations' having clinical priority. A meeting was due to be held with the family to feedback the findings of the review/investigation but this has now been cancelled at the family's request.

7 cases have been given a death classification of 2 (problems in care but unlikely to have contributed to the death) All cases given were discussed at the MRC in November where it was noted that the problems in care related to the recognition and management of patients presenting with abdominal pain. Work has already commenced on the development of an 'acute abdomen pathway' and following discussion at MRC, a 'task and finish group' has been established to take this work forward and support implementation.

The main learning theme identified through the ME screening process continues to be around the timing of discussion and decision making of do not attempt cardiopulmonary resuscitation (DNACPR) and recognition of patients approaching end of life in both primary and secondary care.

Another emerging theme coming through from both the Medical Examiner and Specialty M&M process is "cross site transfer of patients with more than one clinical problem" and first steps will be to look at the ED to CDU transfer process, this work is being led by the Deputy Medical Director.

2.3 **Bereavement Support Service**

Bereavement Support follow up was requested by 576 bereaved families in Quarter 1 and verbal contact was made with 397 (74%). Where the BSS were unable to speak to the family by phone, a letter was sent with relevant contact details. Meetings with the clinical team were requested by 16 bereaved relatives (mainly due to concerns about the quality of care provided). Often the relatives had questions for more than one specialty and there have been challenges arranging meetings with representatives from all relevant specialties. Following feedback and discussion amongst the Corporate team, we are looking at how to reduce the burden on clinical teams whilst still being able to effectively answer questions and respond to concerns raised by the bereaved.

3. The LLR Clinical Quality Audit was presented to the Trust Board in September and is now available on our website https://www.leicestershospitals.nhs.uk/aboutus/performance/learning-lessons-to-improve-care/

The audit identified areas for improvement in respect of the care of the frail older person and particularly those patients at the end of life and it has been agreed that this needs to be used as a driver for improving the scale and pace of actions across the LLR health care system.

There has been limited media interest in the Mazars' Report findings. Initially the Leicester Mercury noted that a higher proportion of deaths in the community were on a Monday. This has been looked at by Public Health and is not felt to be a significant finding. The Mercury also recently did a feature "Hospital staff failed to notice patient had died" (on 15th November) which related a bullet point in the report. The Trust has not been asked to comment further since this article was published. No other detail was given in Mazars' Report and so it has not been possible to look into this further.

The Report findings and recommendations were reviewed and discussed at the October Mortality Review Committee meeting and Members looked in detail at recommendations that were specifically relevant to UHL.

It was noted that almost all had already been identified as areas for improvement with work streams being overseen by Trust-wide committees. It was therefore agreed that these committees should be asked to confirm that the existing or planned work streams would address the report recommendations and to monitor progress accordingly. The following Committees have therefore been contacted:

Ref	Recommendation	UHL Committee
4	Promote improved Advance Care Planning across the system in primary care and on discharge from secondary or community provision (ReSPECT) -	Resuscitation Committee.
4	Implementation of GREAT	EoL & Palliative Care Board
7a (i)	Identify actions to support the management of Catheter Associated UTIs in the frail elderly patient.-	Infection Prevention Committee
7a (ii)	Fluid balance management and recording on wards	Nerve Centre Board. Deteriorating Adult Patient Board
7b	Diabetic management and glucose monitoring/recording throughout the pathway -	Insulin Safety Group
7c (i)	Warfarin management - including as part of falls risk assessments monitoring	Antimicrobial Working Party
7d (ii)	Warfarin management -additional risks presents on prescribing antibiotics	ePrescribing Board
7d (i)	Weight management and monitoring	Nutrition Committee
7d (ii)	Weight management and monitoring particularly in relation to correct medication dose	ePrescribing Board
7e	Clearer recording of decision making at end of life in regards to completing observations and taking blood glucose reading	EoL &PC Board
8	Stabilisation protocols for transfers to other units (including Glenfield Hospital) should be agreed.	Mortality Review Committee
17	Examine ways to prevent ward moves for patients at end of life.	EoL & PC Board / Urgent Care Board

Responses from the Committee Chairs will be reviewed at the December MRC.

Input Sought

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

- Be advised that significant work has been undertaken to ensure 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 progress being made with screening of adult deaths by the Medical Examiners and completion of Structured Judgment Reviews by Specialty M&Ms

- Be advised that capacity issues are affecting progress with the Learning from Deaths programme both corporately and at specialty level that additional resources have been approved and the Recruitment process is in progress.

- Note the continuing challenge to ensure that the learning identified as part of our Learning from Deaths process, and other sources of learning such as patient safety incidents and investigations leads to sustainable improvement within the organisation.

- Support the proposed approach to taking forward actions identified in response to the LLR Clinical Audit recommendations and to be advised that the Mortality Review Committee will liaise with the relevant committees for updates for feeding back to the LLR Clinical Task force on a quarterly basis.

Appendix 1

UHL Mortality Rates Slide-deck

Nov 2018

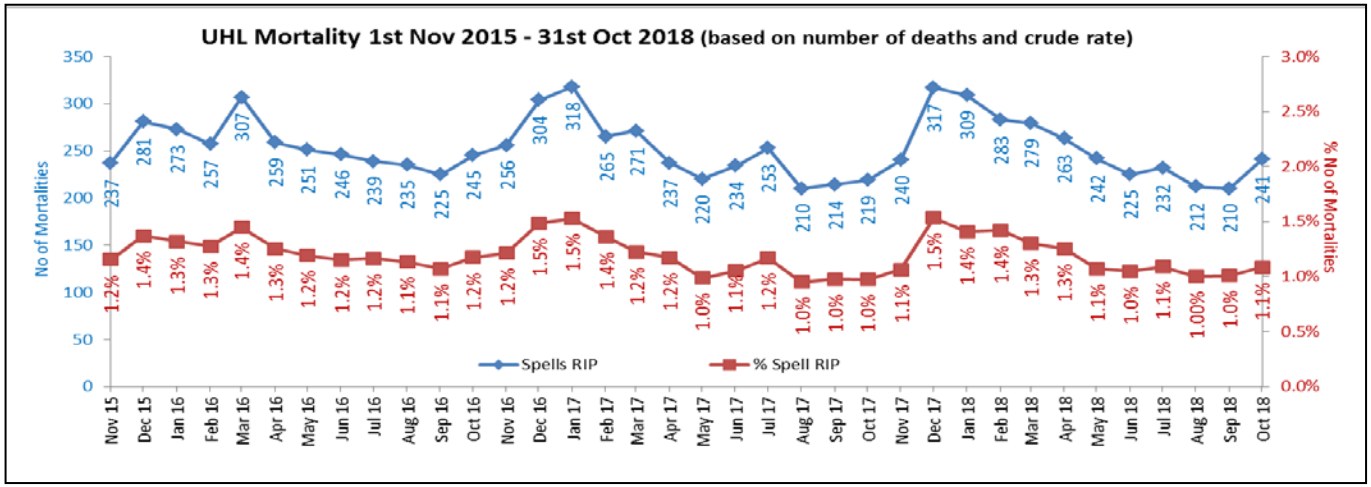
Sponsor: Medical Director

M&M Information & Project Manager
Head of Outcomes & Effectiveness
Deputy Medical Director

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

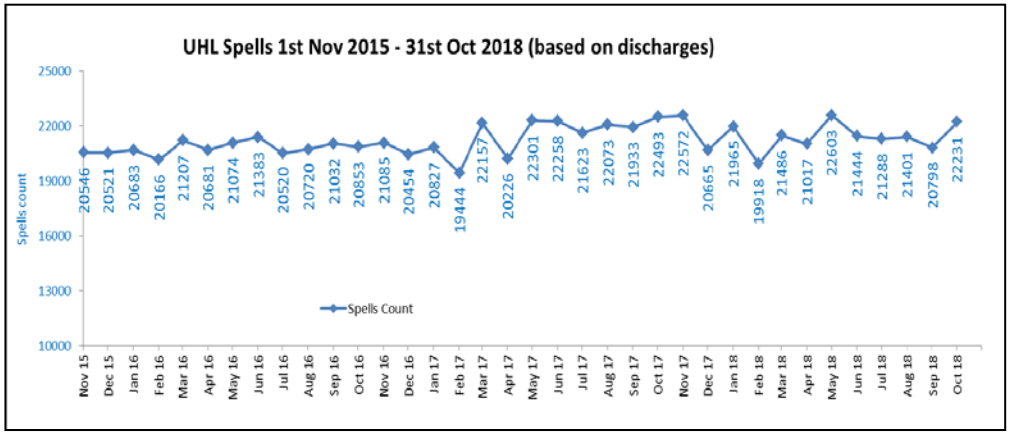
Crude mortality:
i.e. number deaths and proportion of discharges where death is the outcome

How many people died in the Trust between Nov 2015 and Oct 2018 and what is the Trust's crude mortality rate? (excluding ED data)



What is the data telling us?

- UHL's crude mortality rate is just showing signs of winter change.
- Oct 18 deaths is high when compared to Oct 17 although the activity level is less in comparison to the same time frame last year.



Discharged During…	Emergency Discharges Deaths % Rate	Elective IPs Discharges Deaths % Rate	Daycase Discharges Deaths % Rate	Total Discharges Deaths % Rate
FY 2018/19 (Apr to Oct)	78,669 1588 2.0%	12,229 38 0.3%	60,034 1 0.0%	150,932 1627 1.1%

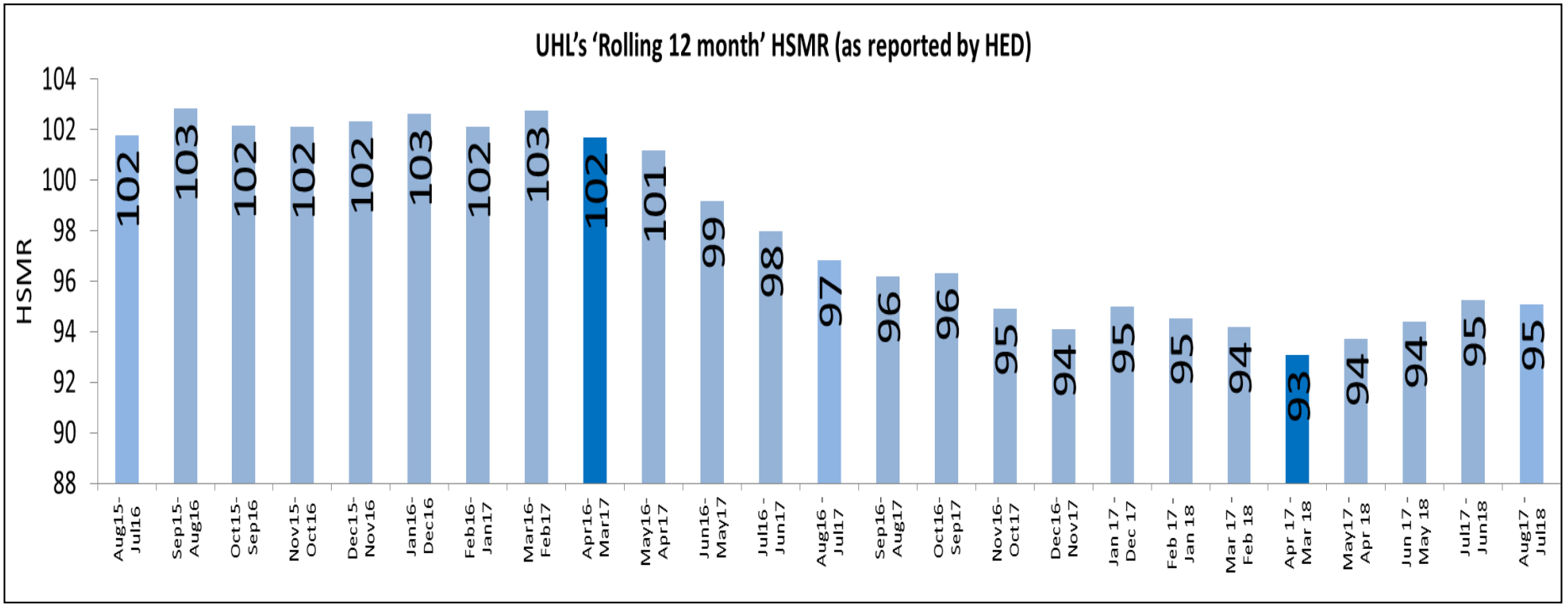
HSMR:
Hospital Standardised Mortality Ratio

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)?



What is the data telling us?

The latest 'rolling 12 month' HSMR in the HED tool covers the period August 17 to July 18 and UHL's HSMR is 95. **Dr Fosters HSMR** for the same period is **94.**

UHL's HSMR was above 93 for the financial year 2017/18 (as reported by HED) and 92 (as reported by DFI). DFI have changed their rebasing approach and so it is expected that future data will correlate more closely with that provided by HED.

Financial Year	HSMR (HED)	HSMR (DFI)
2014/15	95	95
2015/16	97	95
2016/17	102	102
2017/18	93	92

How does UHL's HSMR* compare with our Peer trusts? (Aug 17 – Jul 18)

*Data taken from HED

What is the data telling us?

- UHL's latest HSMR is **94** and is in line with expected.

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)

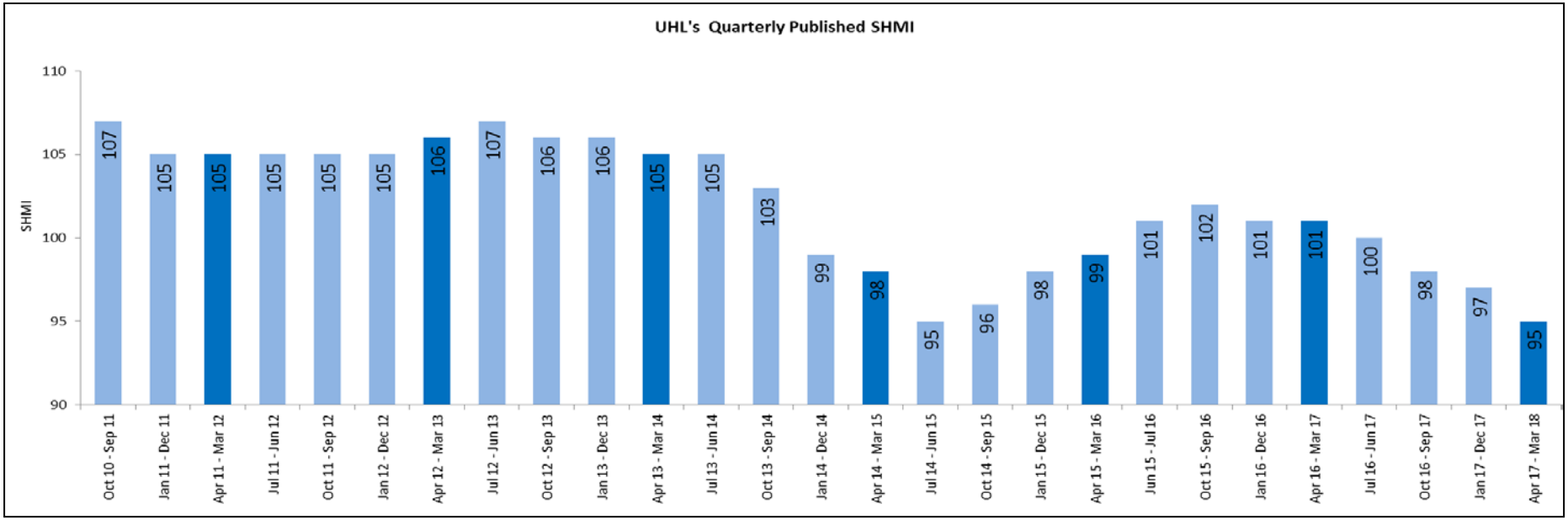
The SHMI is published on a Quarterly basis by NHS Digital (previously the HSCIC).

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.

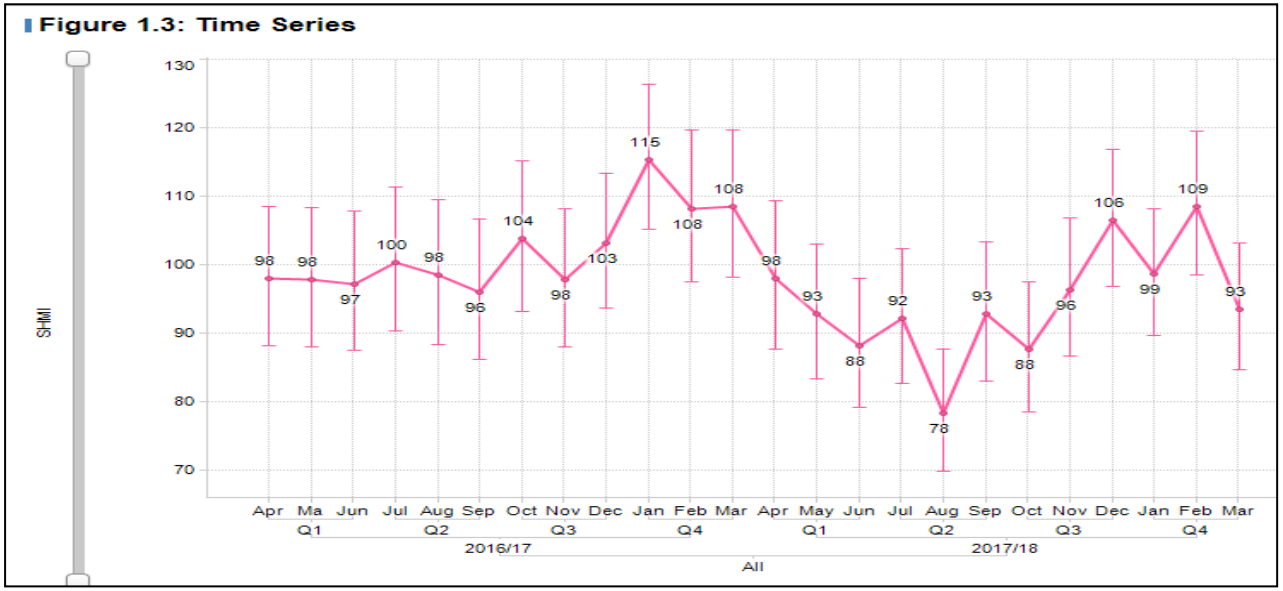
NOTE:
Although HED rebase their SHMI database following uploading of new data, the unpublished SHMI value is usually 1 or 2 below the final NHS Digital published SHMI

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) Apr 16 – Mar 18



What is the data telling us?

- UHL subscribes to HED which uses HSCIC methodology to replicate the SHMI (unpublished SHMI)
- UHL's published SHMI for FY 2017/18 is 95 – the lowest since 2010/11.
- The monthly SHMI corresponds to the seasonal variation and as expected, has been high during winter months.

How does UHL's SHMI – as reported by HED - compare against all Trusts (Apr 17 to Mar 18)

What is the data telling us?

- UHL's latest published SHMI is **95**

Appendix 2

Learning From the Deaths of Patients in our Care 18/19 Q1-2

November 2018
Medical Examiner Screening
Specialty Structured Judgement Reviews
Bereavement Support Follow Up

UHL's "Learning from Deaths" Framework

- **Medical Examiners (MEs)** – (Currently 12 MEs working 1 PA a week). ME process includes all ED and Inpatient adult cases – MEs support the Death Certification process and undertake Mortality Screening – to include speaking to the bereaved relatives/carers and screening the deceased's clinical records. Where Screening identifies potential areas for learning by the clinical team(s), the case will be sent to the relevant Specialty for further review.

- **Specialty Mortality & Morbidity Programme (M&M)** – involves full Mortality Reviews (SJRs) where meet National criteria (see previous slide) or are referred by the ME or members of the Clinical Team. M&M meetings confirm Death Classification, Lessons to be Learnt and taking forward agreed Actions

- **Clinical Teams** – involves reviewing care of patients where families have raised concerns about the end of life care or other patient experience issues

- **Bereavement Support Nurse (BSN**)– 'follow up contact' for bereaved families of adult patients, liaises with both the MEs and Clinical Teams where families have unanswered questions. Also sign posts bereaved relatives to appropriate support agencies where unmet bereavement needs identified.

- **Patient Safety Team (PST)** – where death considered to be due to problems in care, will review against the Serious Incident reporting framework and take forward as an investigation where applicable.

- **Mortality Review Committee (MRC)** – oversee the above and support cross specialty/trust-wide learning and action

Deaths covered by UHL's "Learning from the Death" process

April to Sept 18 (as at 31st October)

Type of Death Quarter	Adult	Child	Neonate	ALL
Community**	**77**	**1**		**78**
Q1	35	1*		36
Q2	42			42
ED	**116**	**5**		**121**
Q1	56	1		57
Q2	60	4		64
Inpatient	**1325**	**15**	**49**	**1389**
Q1	690	7	36	731
Q2	635	8	13	636
ALL	**1518**	**21**	**49**	**1588**

What is the data telling us?

* Child died at Rainbows

** Not all Community deaths will go through the full screening process. Therefore 'Screening Performance data' will only include Inpatient and ED Deaths.

Paediatric / Neonatal Deaths – Quarters 1 to 2

What is the data telling us?

There have been 69 'Child' or 'Neonate' ED/In-patient deaths in Q1/2

49 were babies either born/stillborn in UHL and died on the Labour ward/Neonatal Unit (Neonates)

12 babies (0-1 yr) were either born in UHL and transferred to Cardiac surgery or were transfers into UHL from other hospitals or admitted to the Paediatric Intensive Care Unit from Home

There were 5 babies (0-1 yr) who died in the Emergency Department

There were 3 children admitted to the LRI via ED and died in Intensive Care

1 baby's death has been reviewed as part of the UHL LFD programme although they died at Rainbows

Medical Examiner Process

At the present time the Medical Examiner process – death certification and screening - only applies to adult deaths.

The proposed national roll out of the Medical Examiner process includes paediatric and neonatal deaths.

In the interim all paediatric and neonatal deaths are subject to a Structured Judgement Review by the relevant Specialty M&M. They are also reviewed by the LLR Child Death Overview Panel (CDOP).

Outcomes of reviews undertaken during Q1-2 are being collated.

None of the deaths reviewed to date were considered to be due to problems in care.

Adult Deaths - Number and % Screened by a Medical Examiner in Q1-2 (April to September 18)

	Adult Deaths	Screened	Not Yet	No*	% Screened
ED	**116**	**113**	**3**		**97%**
Q1	56	56	0		100%
Q2	60	57	3		95%
Inpatient	**1325**	**1269**	**33**	**23**	**96%**
Q1	690	672	2	16	97%
Q2	636	597	31	7	94%
Q1-2 Total	**1441**	**1382**	**36**	**23**	**95.9%**

What is the data telling us?

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

There were 1,518 adult deaths that were processed by the Bereavement Services Office during Q1-Q2

Of these, 77 were 'community death' where the deceased's body was brought to the UHL Mortuary for Death Certification purposes
87% of community cases were also screened by the Medical Examiner

During Q1-2, there were 1,441 deaths in either ED (116) or In-Patient (1,325). This is similar to the first 6 months of 17/19 (1462 deaths)

Of these 1,449 (95.9%) have been screened by the Medical Examiner to date.

Medical Examiner Screening – Quarters 1 to 2

What is the data telling us?

97.6% of Q1 deaths and 94.1% of Q2 ED/In-Patient deaths have been screened to date.

At time of reporting (31/10/18) there are 2 Q1 and 34 Q2 Adult deaths that have not yet been screened nor referred for SJR - 26 of these have been referred to the Coroner for either Post Mortem or Inquest.

Almost all were August/Sept deaths and retrospective screening will be undertaken in Quarter 3.

To date there are 23 Adult deaths in Q1-2 (either in ED or Inpatients) that will not be going through the ME screening process. 21 of these had been referred to the Coroner and the 3 cases not referred were Glenfield deaths.

All 23 have been referred for SJR without being Screened by the ME, either because of meeting the national requirement or because the Specialty themselves referred.

What happens where Medical Examiners (ME) think further review required?

- **MEs refer cases for:**
  - Structured Judgement Review through Specialty M&M**)**
  - Clinical Review by Consultant responsible for patient care or Matron/Ward Sister
  - Follow up by Bereavement Support Nurse
  - Feeding back to Non UHL organisations
- **Structured Judgement Reviews are requested where the Medical Examiner thinks there is potential for learning in respect of:**
  - Clinical management
  - Delays or omissions in care
  - Meets the national criteria for SJR (death post elective surgery, patient had a Learning Disability, Severe Mental Illness)
- **Clinical Reviews are requested where concerns are raised by the bereaved about:**
  - Pain management; end of life care, DNACPR
  - Nursing care, such as help with feeding; responding to buzzers
  - Communication with patient/relatives about patient's prognosis, deterioration
  - Previous discharge arrangements
- **Bereavement Support Nurse follow up will be requested where**
  - The relatives appear to be particularly distressed - to signpost to 'bereavement counselling services'
  - Say they have questions or concerns about the care provided but do not feel ready to talk about them
- **Feeding back to Non UHL Organisations**
  - Process established with the EMAS, LPT and CCG Quality & Safety Leads for feeding back where relatives raise concerns about care provided outside UHL, or MEs think there may be learning for other organisations,

Number of Adult Deaths and Further Review Q1-2

Medical Examiner Screening Outcome	Q1	Q2	All
No further review	543	480	1023
Structured Judgement Review	65	58	123
Clinical Review	95	84	179
Feedback	46	54	100
Theme already identified and actions in progress	1	2	3
Follow up by Bereavement Support	8	6	14
Referred to Patient Safety Team / SI Investigation	3	3	6
All (includes Community Deaths where screened)	**761**	**687**	**1448**

What is the data telling us?

71% of Q1 and Q2 deaths screened by the Medical Examiner were not considered to need further review.

8% of deaths have been referred for Structured Judgement Review by the Specialty M&M – this includes deaths meeting the national criteria

12% of deaths were referred for Clinical Review by the clinical team looking after the patient

7% of deaths have been referred for Feedback only – mostly relates to staff attitude, communication issues

18/19 Q1 Adult Deaths Referred for Structured Judgement Review or Clinical Review – Progress Update

Q1	Completed	In progress	%	ALL
Clin Review	46	49	48%	95
SJR	**50**	**32**	**61%**	**82**

What is the data telling us?

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.

61% of SJRs for Q1 Adult deaths have been completed to date – which is below the 75% threshold. Progress updates have been sought on all outstanding SJRs.

Specialties with most SJRs requested in Q1-2 were:
Geriatrics - 11
Gen Surg & HPB (LGH) -15
Gen Surg (LRI) - 12
Cardiac Surgery – 13
Acute Medicine – 14

Death Classifications for Q1 Adult Deaths where SJR Completed

DEATH CLASSIFICATION	REASON FOR REQUESTING SJRS FOR ADULT DEATHS IN Q1						
	ME	Rels	El Proc	LD	SMI	Specialty	Total
1		1					1
2	6			1			7
3	7	2	1	1			11
4	3		7	1			11
5	4		4	2	1	1	12
All	**20**	**3**	**12**	**5**	**1**	**1**	**42**

What is the data telling us?

- 1 case have been given Death Classification of 1 by the Specialty M&M
  - Due to cancellation of elective cholecystectomy surgery and patient then developing pancreatitis
- 7 cases were given a Death Classification of 2 by the Specialty M&M.
  - 3 related to patients presenting with abdominal pain

All will be discussed at the Mortality Review Committee on 6th November

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

- Contact offered either by the Ward staff or Bereavement Services. Where death referred to the Coroner, the BSN contacts the family directly
- **There were 781 adult deaths in Quarter 1 and 75% (576) of** bereaved relatives requested follow up contact by the Bereavement Support Nurse
- BSN managed to speak to **74%** (397) of bereaved relatives (of patients who died in Quarter 1) who requested telephone follow up (a letter or email is sent to the remaining where the Bereavement Support Nurse was unable to speak to the family on the phone)
- Further information was requested by **105** families contacted
- Meetings with the clinical team/s were requested by **16** families
- Signposting to bereavement services included CRUSE, LOROS, Sharma Women's Centre, Child Bereavement UK

Feedback from Bereaved Relatives where the Patient died in Quarter 1

At the end of the 'follow up' telephone contact, relatives are asked for feedback on the overall standard of 'end of life care' their loved one received

Response	Number
Very Good / Excellent	159
Good	91
Satisfactory/Adequate	23
Poor	15
Very Poor	10

What is the data telling us?

- Communication issues or perceptions about the patient being in pain or distressed, particularly in the final phase of dying, were the main issues where relatives considered care to be poor or very poor - some have been taken forward as a complaint and for others a meeting has been arranged with the clinical team.
- Further detail of the responses, where considerd to be poor or very poor, will be reviewed at MRC on 6th November

Feedback about the Bereavement Support Service

- Relatives are also asked whether they considered the Bereavement Support follow up call as helpful

- 43% said they felt they hadn't needed support.
- 51% said that the call had been helpful
- 1 relative said the call had not been helpful – they were very unhappy with the care provided to their loved one and did not want to talk to anyone working at UHL