Learning from Deaths

Author: Head of Outcomes & Effectiveness, Deputy Medical Director Sponsor: Medical Director **Trust Board paper K**

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.

The locally commissioned LLR Clinical Quality Audit (looking at the care provided to patients who died either in LPT or UHL or within 30 days of discharge from UHL) is in progress.

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 2017/18 and are we on track to meet the national mortality reporting requirements?
3. At what stage is the LLR Clinical Quality Audit and when should the findings be available?

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 crude mortality for 2017/18 was 1.2%. Our monthly mortality rate increased to 1.5% in December in line with previous years' seasonal variation and was 1.3% in March.

UHL's latest published SHMI is 98 (covering the time period Oct 16 to Sept 17) and our HSMR was 96 (for same time period).

Analysis of our SHMI and HSMR, using the HED clinical benchmarking tool, shows that our HSMR is 94 and our unpublished SHMI is 96 for January to December 2017

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 have seen a reduction in the SHMI for patients admitted with a sepsis diagnosis and the pneumonia SHMI continues to be below 100 (88)

Another HSMR/SHMI related work-stream has been improving the pathway for cardiac patients – both those presenting medically and for surgical intervention. Our HSMR has previously been above expected for 2 diagnosis and 1 procedure group related to cardiac disease and mortality reviews have been undertaken for all 3 groups which did not find any deaths due to problems in care. However, the reviews did identify areas for improvement with the cardiac surgery pathway, both the referral process and also time to theatre once patients accepted for surgery both of which have been taken forward by the service.

The HSMR for both diagnostic groups is now within expected but still remains as an alert for the procedure group (CABG Other). Pre-publication of the national cardiac audit data via NICOR includes the Dr Foster alert time period (16/17) and this shows that UHL has a higher risk case mix and our outcomes are in line with national average

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 1-4 the MEs screened over 3,000 (95%) of all adult deaths (includes some community deaths where deceased brought to UHL's mortuary). At time of reporting, 87% of Quarter 4's deaths have been screened. Although 2 new MEs started in post in December, this coincided with the seasonal increased number of deaths. Retrospective screening is continuing until the end of May 18.

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. To date 487 deaths have been referred for SJR. Breakdown of this group of patients is shown in slide deck.

270 deaths were referred for SJR in Quarters 1 and 2 and 114 in Quarter 3. Our internally set target is that 75% of SJRs should be completed within 4 months of death and 100% within 6 months.

Therefore all of Quarter 1 and 2's deaths should have had SJRs completed and death classifications confirmed at the end of March and 75% of Quarter 3's deaths should be classified before the end of April 2018.

Our current performance is 89% of Quarter 1 and 2's SJRs have been completed and 54% of Quarter 3s. However, not all SJR details have been collated due to capacity constraints within

the Corporate M&M Admin team and the increased activity pressures have affected clinical teams' capacity to review cases and have also led to cancellation of some M&M meetings.

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. To date there have been 3 deaths considered to be more likely than not due to problems in care (Death Classification = 1) and all have been investigated as Patient Safety Incidents and confirmed as being Serious Incidents. Details of these cases have been previously reported in the Q3 report. 2 cases, previously reported with a Death Classification of 1, have been given a revised death classification of 2 (problems in care but unlikely to have contributed to the death) following review with the Patient Safety Team and discussion at MRC.

No new death classifications of 1 (Problems in care more likely than not to have contributed to death) have been identified since the last report. One death has been identified as 'more than likely due to problems in care following investigation as a Serious Incident. This had been given a Death Classification of 2 by the Specialty M&M.

"Learning from the Deaths of Patients in our Care" is identified through the Medical Examiner process, Bereavement Support Service, Specialty M&M reviews and meetings plus Patient Safety Investigations.

The main theme identified by the 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'.

Most concerns raised by the bereaved, to either the Medical Examiners or Bereavement Support Nurse (BSN), 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 facilitate a meeting with the clinical team.

Additional Medical Examiner sessions and temporary admin support by Medical Students has been arranged to address the backlog of Quarter 4 cases to be screened but it is unlikely we will meet the internally set threshold of 95% for the Quarter. Collation and theming and analysis of the SJR data is also in progress but timescales will depend upon capacity of both the Corporate and Clinical teams.

The continuing challenge is 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. A number of the themes link in with existing work streams or boards and a potential way forward in terms of organisation of this work is suggested in the slide deck.

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

3. LLR Clinical Quality Audit

A draft report of the Mazars mortality clinical audit findings has been shared with the core members of the LLR Learning Lessons to Improve Care Clinical Taskforce and will be discussing the findings at the next meeting on 22nd May.

In the meantime, as previously reported, Mazars identified 11 patients for individual review by the Trust. The case notes for these patients have been retrieved and were discussed at the last MRC Meeting. All 11 cases have been reviewed by the Deputy Medical Director (DMD) and Head of Outcomes and Effectiveness (HOE) to consider if there were 'missed opportunities' in respect of our internal Learning from Deaths Process and whether appropriate actions had been taken where problems in care identified.

There were 2 deaths which occurred post discharge and so had not been through our UHL Learning from Deaths process but one case had been through the 'Hospital Acquired Thrombosis 'Root Cause Analysis' process where it had been confirmed that all appropriate thrombo-prophylactic measures had been in place. No learning for UHL was identified in the second case.

6 of the 9 in-patient deaths had been referred for further UHL review by the Medical Examiner as they had identified potential problems in care. Of the 3 cases not referred, the DMD and HOE considered one should have been as it was felt that there was learning related to end of life care. The Senior Medical Examiner has given feedback accordingly. In respect of the other 2 cases, it was considered appropriate that the ME had not referred for further review as there was no obvious learning. On further detailed review of these 2 cases there was potential learning related to end of life care in 1 case and learning related to pre-hospital care in the other.

Internal reviews by the relevant speciality had already been conducted in the remaining 6 cases and had identified problems in care, 3 of which were around end of life care, 2 related to handover between departments and one to delayed recognition of sepsis and escalation. Communication with primary care (both to and from) was a second problem for 2 cases.

Although problems in care were identified for the 6 cases, these were considered to be unlikely (2) or very unlikely (4) to have contributed to the death. Earlier DNACPR discussions and recognition of end of life care needs; improving sepsis management and effective handover are all part of existing work streams.

Input Sought

Members of the Board are requested to receive this report and appendix 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 and additional resources are required.

- 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.

- Note that the LLR wide review findings will be included in the next quarterly report.

- Consider how to ensure the learning identified leads to improvement in patient care.

Appendix 1

UHL Mortality Report Slide-deck

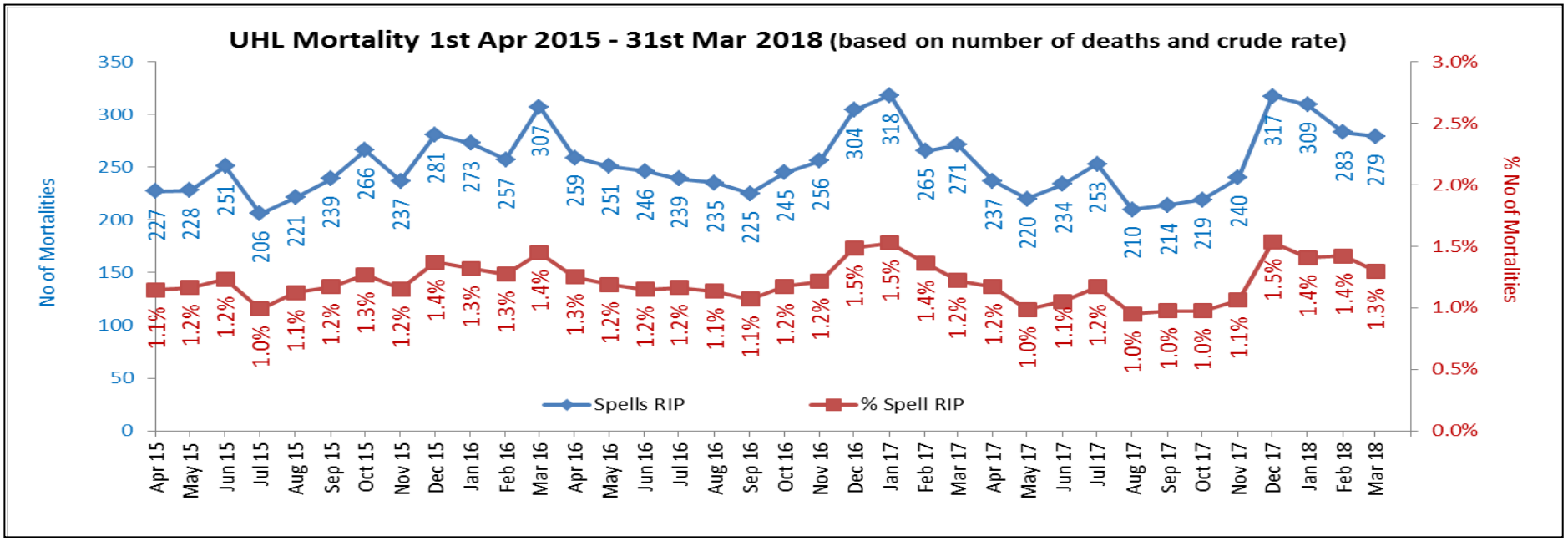
2017/18 - Quarters 1 - 4

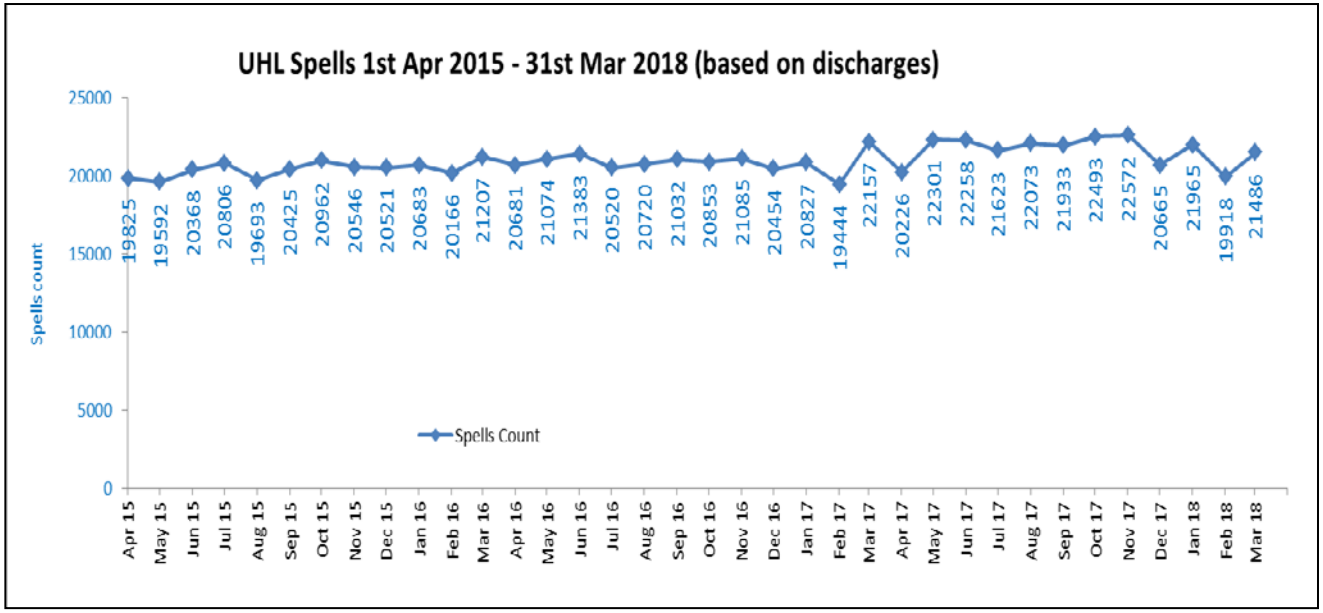
Head of Outcome & Effectiveness, Quality Project Manager and Deputy Medical Director
Sponsor: Medical Director
Apr 2018

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 April 2015 and March 2018 and what is the Trust's crude mortality rate for 17/18? (excluding ED data)



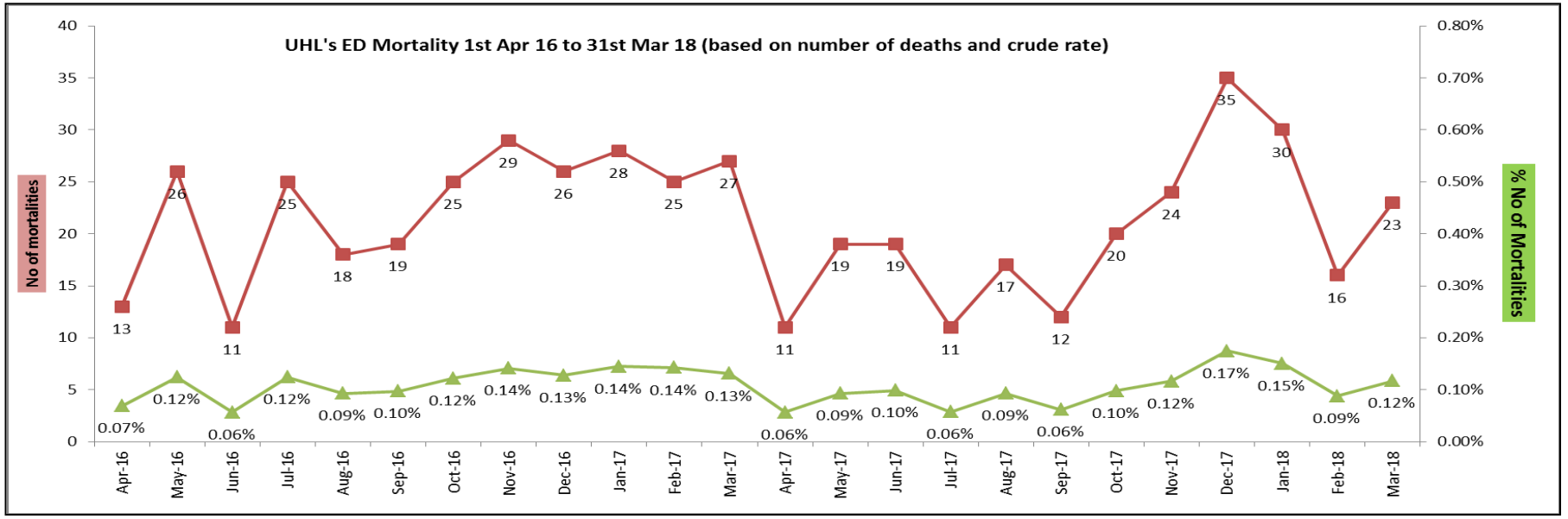


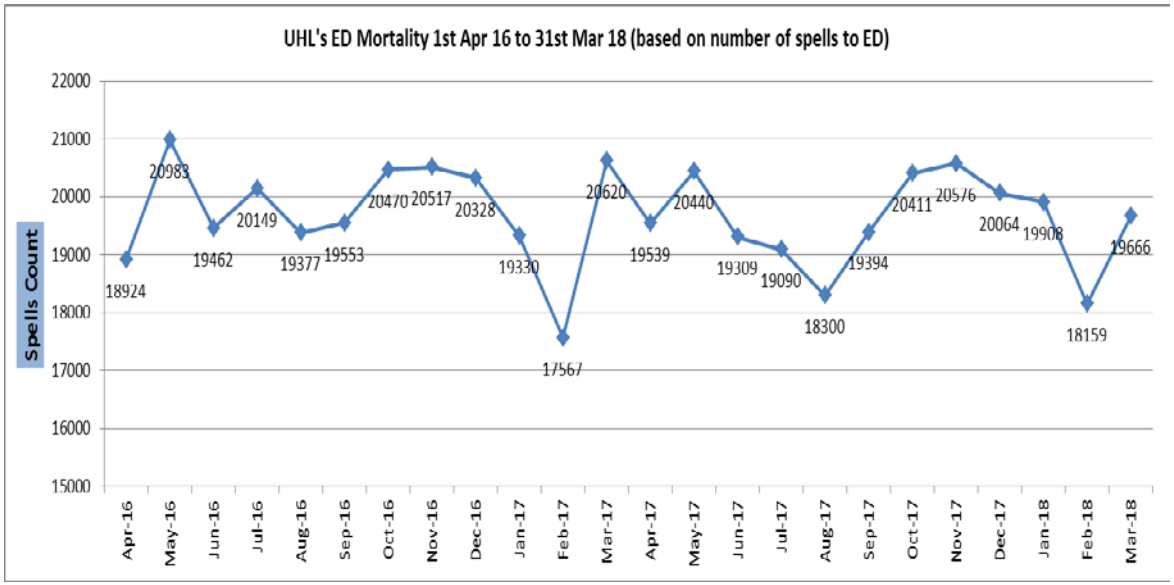
What is the data telling us?

- The number of deaths and the crude mortality rate increased in Dec 17 in line with the usual seasonal variation.
- The number of admissions during December was reduced as some Elective activity was 'taken down'.
- Numbers and mortality rates have reduced in Q4, again in line with normal variation.
- UHL's mortality rate for 17/18 was 1.2%

Please note: These figures exclude ED data and for the latest month discharges may change due to late data recording on the system

Deaths in the Emergency Department (ED) between April 2016 and March 2018





	17/18	16/17
ED Attendances	234,856	237,280
Deaths	237	272
Mortality Rate	0.10%	0.11%

What is the data telling us?

- Deaths in the ED do not include those admitted to the EDU

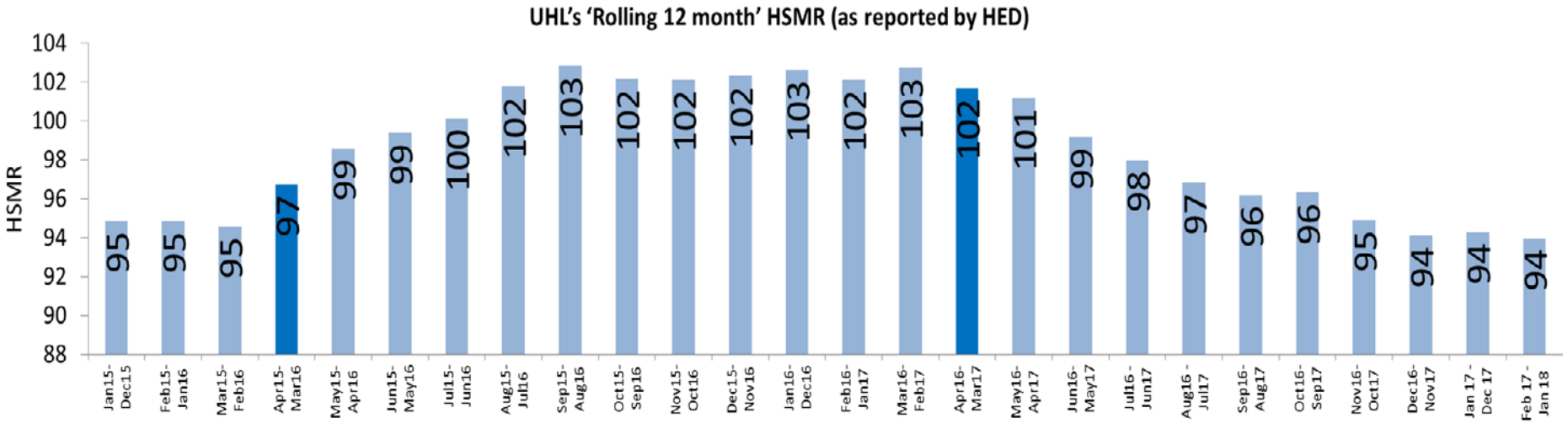
HSMR:
Hospital Standardised Mortality Ratio

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 DFI HSMR is usually slightly below that of HED. UHL's HSMR was above 100 for the financial year 2016/17 (as reported by HED and DFI) but was still within the expected range compared to all trusts.

The latest 'rolling 12 month' HSMR (Feb 17 to Jan 18) is 94 and our monthly HSMR has been below 100 consistently in 2017/18 in DFI tool and in July and December has exceeded 100 in HED tool .

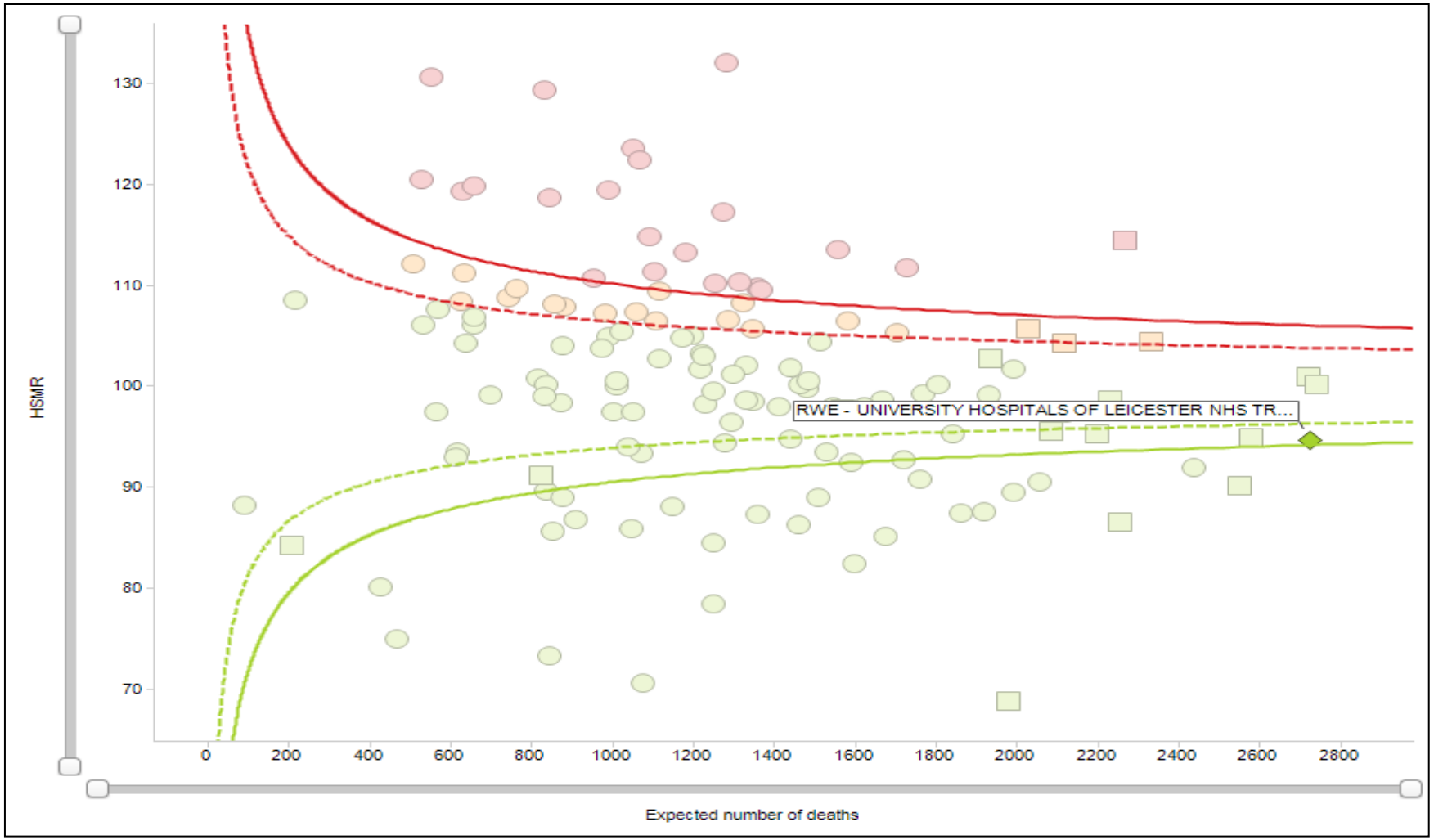
It is anticipated that the monthly HSMR may go over 100 in Q4 due to the increased number of deaths in the winter months.

The 17/18 YTD HSMR is 93 (as reported by HED).

Financial Year	HSMR (HED)	HSMR (DFI)
2014/15	95	95
2015/16	97	95
2016/17	102	102
2017/18 (Apr-Dec 17)	93	88

How does UHL's HSMR* compare with other trusts? (Feb 17 – Jan 18)

*Data taken from HED



What is the data telling us?

UHL's latest HSMR is 94 and is in line with our 'peer trusts' (similar sized trusts) and is almost 'below expected' for the 12 months Feb 17 to Jan 18

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)

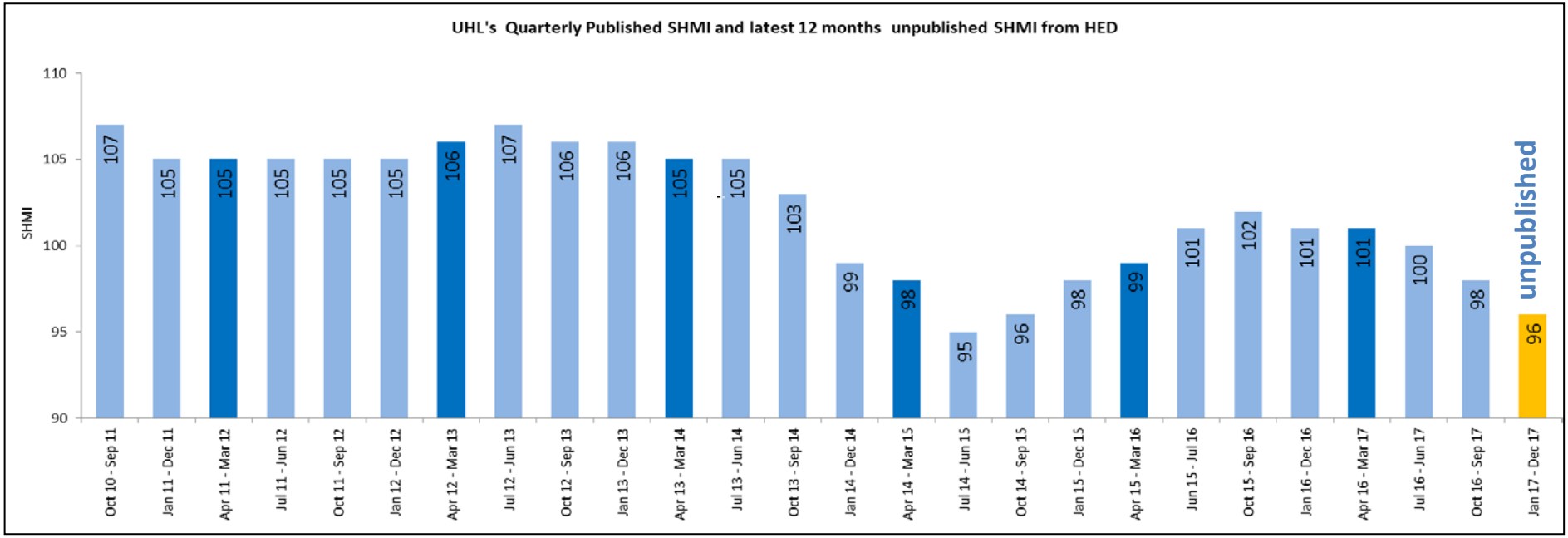
The SHMI is published on a Quarterly basis by NHS Digital (previously the HSCIC).

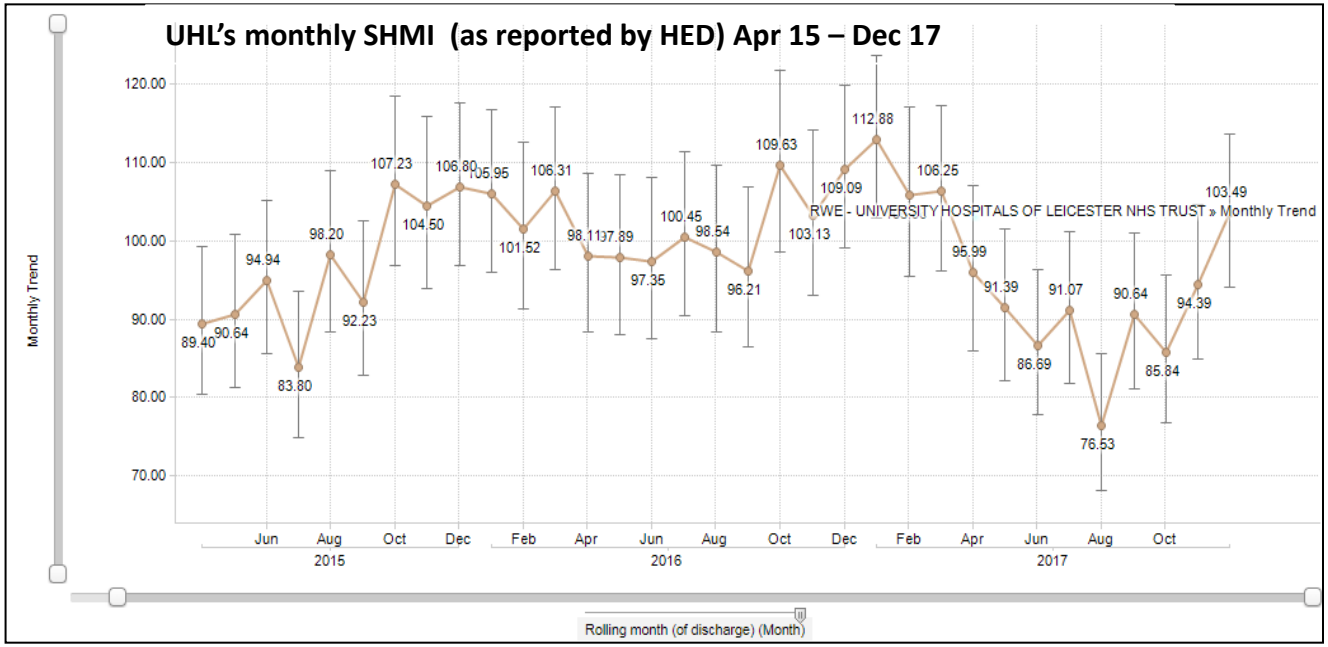
UHL subscribes to the University Hospitals of Birmingham's "Hospital Evaluation Dataset" Clinical Benchmarking tool (HED) which uses HSCIC methodology to replicate SHMI. This then allows us to review our SHMI pre publication.

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)?

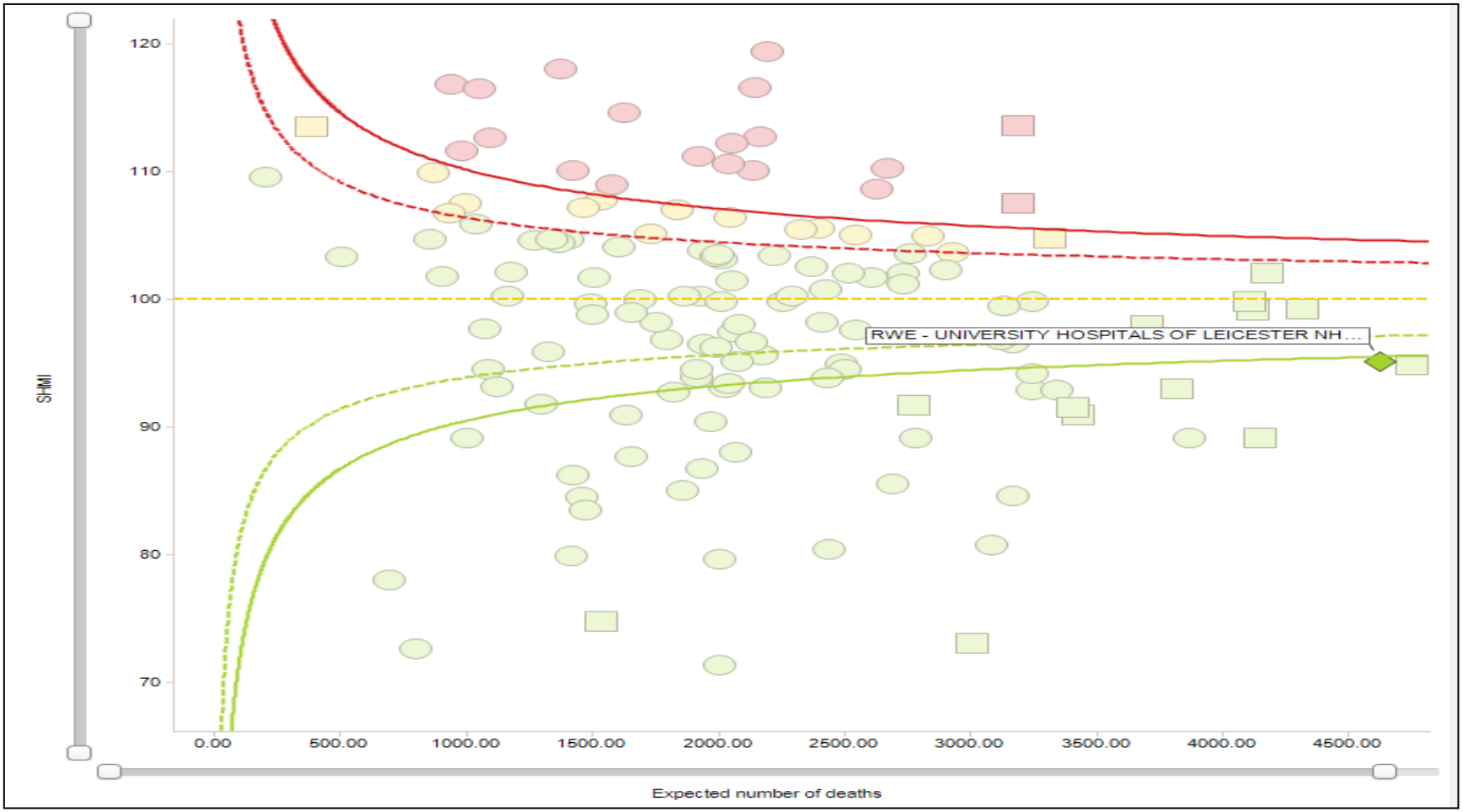




What is the data telling us?

- UHL subscribes to HED which uses HSCIC methodology to replicate the SHMI
- UHL's latest published SHMI (Oct 16 - Sep 17) is **98**
- UHL's monthly SHMI has been below 100 from Apr to Nov 2017.
- Dependant upon national rebasing, we may see a change in our next published SHMI (Jan 18 to Dec 17 – which is due Jun 18).

UHL's latest unpublished SHMI – as reported by HED - compared against Peer Trusts (Jan 17 to Dec 17)

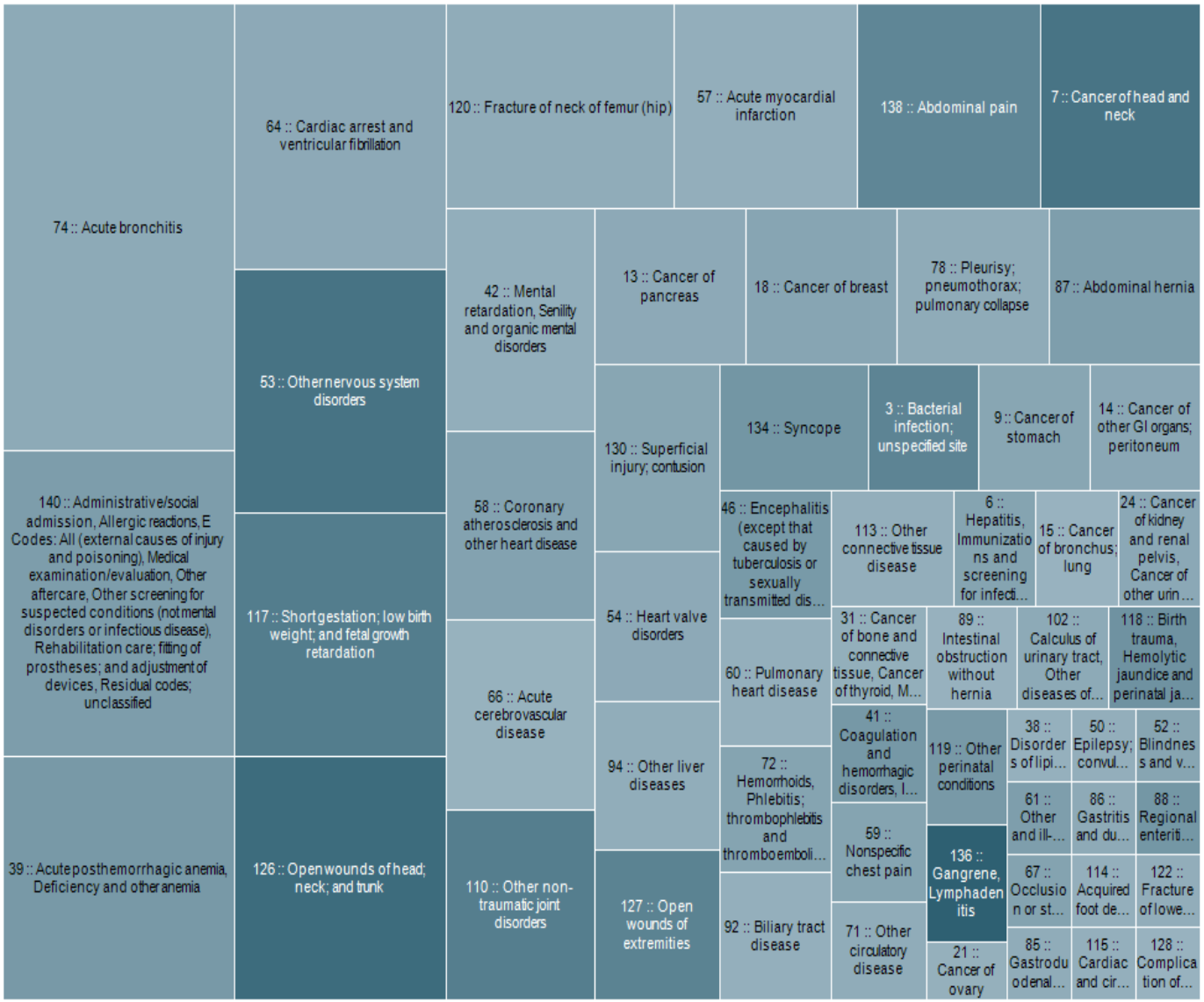


What is the data telling us?

UHL's unpublished SHMI for the period Jan 17 to Dec 17 is 96 and is almost 'better than expected'

Which are the diagnosis groups most contributing to our SHMI?

Diagnosis Groups with a SHMI above 100 (Jan 17 to Dec 17)



What is the data telling us?

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

Top 3 Diagnostic Groups with excess deaths:

1. 74 :: Acute bronchitis *(Observed=146, Expected=124, Excess deaths = 22*)
2. 140 :: Administrative/social admission, Allergic reactions, E Codes; *(Observed=50, Expected=35, Excess deaths = 15)*
3. 64 :: Cardiac arrest and ventricular fibrillation - *(Observed=78, Expected=66, Excess deaths = 12)*

Top 3 Diagnostic Groups with Highest SHMIs:

1. 136 :: Gangrene, Lymphadenitis - *SHMI = 253*
2. 126 :: Open wounds of head; neck; and trunk -*SHMI = 231*
3. 53 :: Other nervous system disorders – *SHMI = 217*

MRC continue to monitor the SHMI at a diagnosis level and commission further analysis as applicable.

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, some have identified areas for improvement (see below).

Diagnosis Group	Review Findings / Improvement Work Stream
Other Perinatal Conditions, Small for Gestation, Intrauterine Hypoxia	All stillbirths and neonatal deaths are reviewed by the Perinatal Mortality Review Group who are currently trialling the new nationally developed perinatal mortality structured judgement review proforma. Various actions have been undertaken to reduce both stillbirths and neonatal deaths to include; better detection of smaller babies and identifying those that have reduced movements and we have seen a reduction in the number of stillbirths in 2017 The latest published perinatal mortality data by MBRRACE (the Maternal, Newborn and Infant Clinical Outcome Review Programme) covers the calendar year 2016. UHL had a higher neonatal mortality rate than other trusts for this time period. Further analysis of the data showed significantly more of our neonatal deaths are due to congenital anomaly compared to the UK average. A review of the case notes showed that there had been discussions with the parents about chances of survival but that ultimately the baby had been born and died, whereas previously may have been stillborn.
Cardiac Arrest	Reflects increased number of patients – having an out of hospital cardiac arrest (OoHCA) - being admitted directly to the Coronary Care Unit at Glenfield. OoHCA patients in other trusts will usually be taken to the Emergency Department and therefore fewer deaths would be included in the HSMR/SHMI (as only includes inpatient activity. No issues with care identified through case note review. Coding practice has also been reviewed against the national rules.
Superficial Injury. Open Wounds, Joint Disorders	Previous case note reviews have not identified any problems in care and key findings have been that the patient had an underlying significant illness but due to their 'superficial injury, wound or joint disorder' being investigated/treated on admission, this is coded as the primary diagnosis.
Residual Codes	Preliminary review suggests that this may be related to multiple 'Consultant Episodes' for patients so that their admission diagnosis is not documented until they are in the 3rd episode so earlier 'symptom codes' are being captured in the SHMI and HSMR methodology. Meeting being held between Acute Medicine clinical and managerial leads and Head of Information.

Learning From the Deaths of Patients in our Care

What does "Learning from Deaths" involve?

- The National Guidance on Learning from Deaths includes a requirement for Acute Trusts to publish on a quarterly basis via Trust Board papers and in the annual Quality Accounts:
  - 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 children; 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 or a Quality Improvement initiative
- **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** 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.
- **Death due to a problem in care** is one 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

UHL's "Learning from Deaths" Framework

- **Medical Examiners (MEs)** – (Currently 14 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

- **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

- **Bereavement Support Nurse (BSN**)– 'follow up contact' for bereaved families of adult patients, liaises with both the MEs and Clinical Teams

- **Patient Safety Team (PST)** – Investigation where death considered to be due to problems in care

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

- Implementation of the LFD's framework part of the Trust's **Quality Commitment**

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

April 17 to March 18

PLACE OF DEATH	ADULT / CHILD / NEONATE	NUMBER OF DEATHS
ED		**236**
	Adult	222
	Child	14
Inpatient		**3027**
	Adult	2919
	Child	25
	Neonate*	83
Community Deaths **		**97**
Total	**"UHL Learning from Deaths"**	**3360**

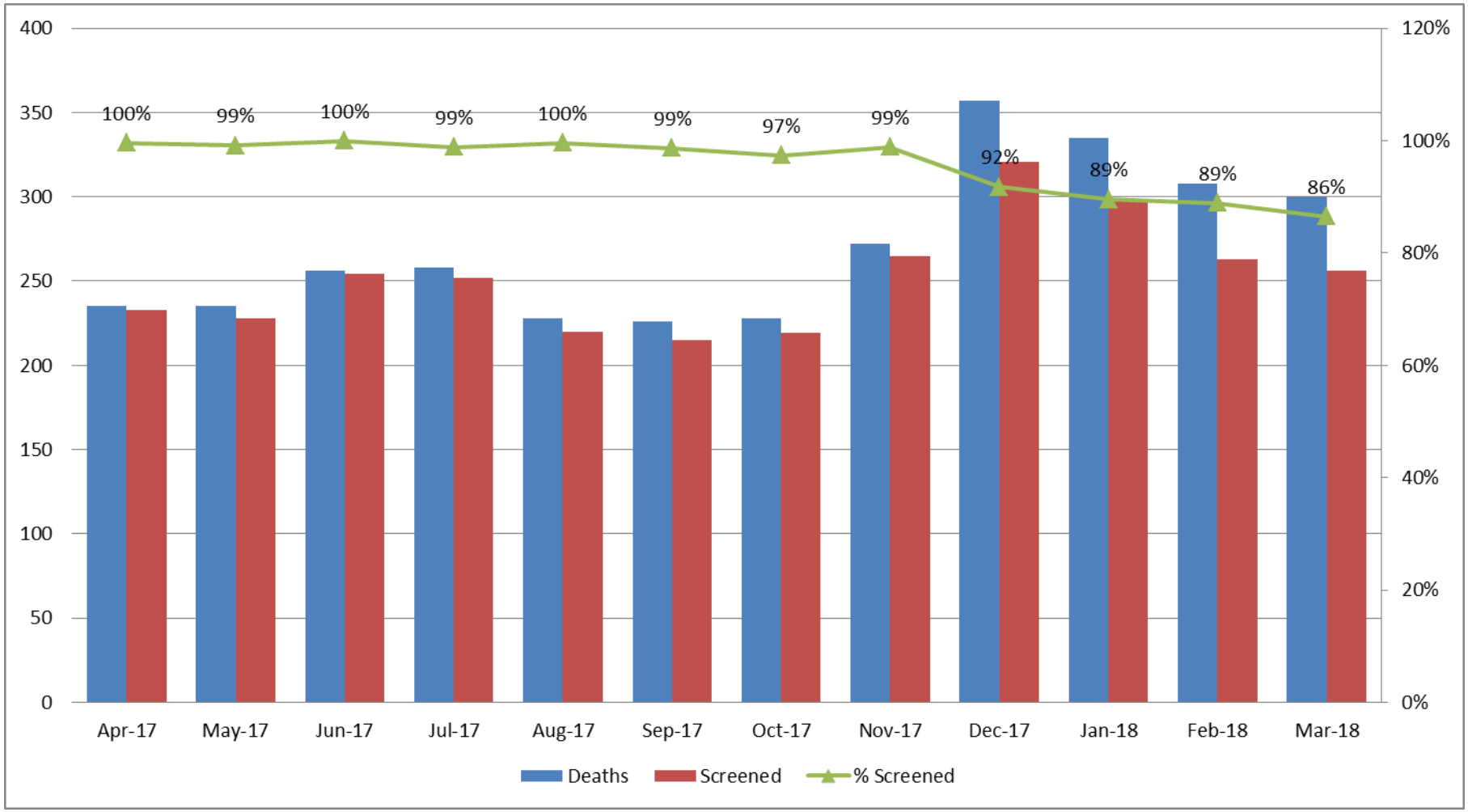
What is the data telling us?

- UHL is one of England 'top 5' trusts for activity and also for the number of deaths.
- The table above shows the number of patients included in UHL's "Learning from Deaths" Process

* Neonates are babies who are born in UHL or in another hospital and transferred to our Neonatal Unit. Children includes all children between 0 and 16 years (where not considered 'Neonates)

** Community Deaths are part of our Medical Examiner process, where deceased brought to UHL's Mortuary

Number / % of Adult Deaths Screened by the MEs (April 17 to Mar 18)



What is the data telling us?

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

MEs have screened 3024 (95%) of all adult deaths during 2017/18 to date (includes some community deaths where deceased brought to UHL's mortuary). At time of reporting, 87% of Quarter 4's deaths have been screened. Although 2 new MEs started in post in December, this coincided with the seasonal increased number of deaths. Retrospective screening is continuing until the end of May 18.

What happens where MEs think further review required?

- **MEs refer cases for:**
  - Structured Judgement Review through Specialty M&M (13% to date)
  - Clinical Review by Consultant responsible for patient care or Matron/Ward Sister (13% to date)

- **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 about patient's prognosis, deterioration
  - Previous discharge arrangements

- During 17/18 a process has been established with the EMAS, LPT and CCG Quality & Safety Leads for feeding back where relatives raise concerns about care provided outside UHL, or the MEs think there may be learning for other organisations,
- **Feedback has been sent for 152 cases (to date) to:**
  - Ambulance Trust (EMAS); Mental and Community Hospitals (LPT); Primary Care; Other Non LLR Trusts and the Private Sector
  - Relates to: Ambulance Delays; Care Home not contacting GP soon enough; Lack of End of Life Care in Nursing Home; Difficulty in contacting the GP; Earlier Referral by GP; Care in Mental Health and Community Hospitals.

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

Reasons for a Structured Judgement Review being requested as part of the Speciality M&M process

Reason for SJR	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	ALL
ME Screening	32	23	27	16	18	17	14	25	21	17	16	21	247
Feedback from Bereaved	3	2	3	2	2	2	1		1	3		1	20
Neonatal / Child Deaths	13	15	8	12	12	7	12	7	7	10	8	11	122
Deaths post Elective Procedure	6	2	3	7	6	6	2	7	6		2	2	49
Death of patient with LD	2		2	3	2	2	3	1	2	1	4	3	25
Death of patient with SMI	2	2	3	2	1	1	1	2	1		1	1	17
Death where QI / CUSUM	2								1				3
Speciality M&M		1			1						1	1	4
ALL	**60**	**45**	**46**	**42**	**42**	**35**	**33**	**42**	**39**	**31**	**32**	**40**	**487**

What is the data telling us?

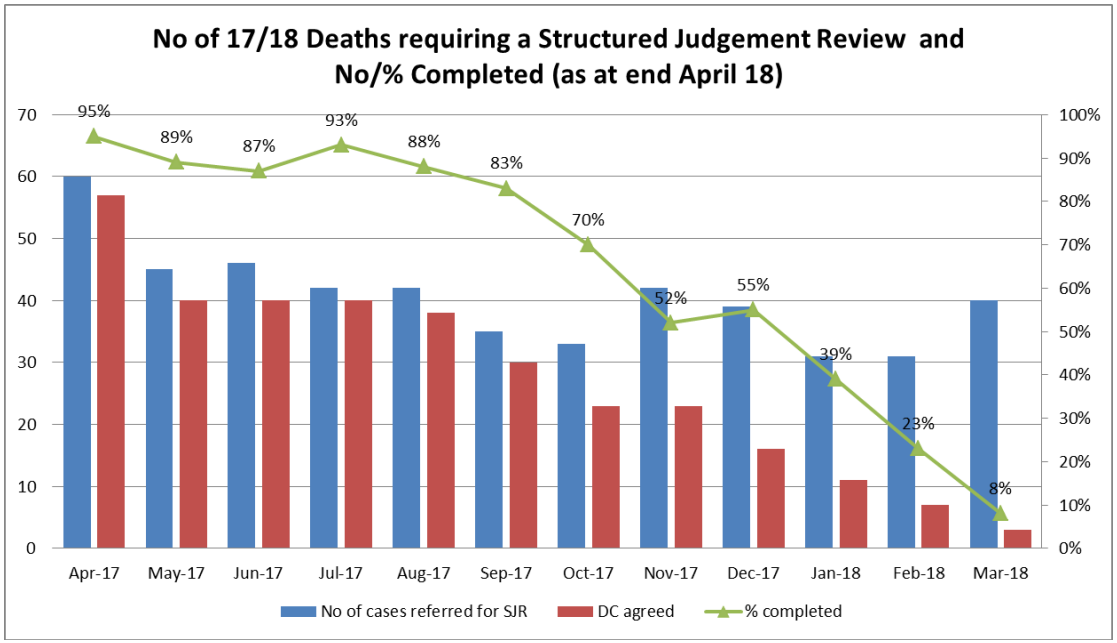
267 deaths have been referred for SJR because of ME screening (either by the ME or because of feedback received from the bereaved relatives) and a further 219 because they met the national requirement for SJR.

This includes deaths 42 deaths of patients with Learning Disability or Severe Mental Illness; 122 deaths of Children/Neonates and 49 deaths following an ‘elective’ procedure)

Death where QI/CUSUM relates to where UHL has received an HSMR alert for a procedure or diagnostic group

Specialty M&M SJRs are where ME screening has not identified any issues but the Clinical Team have referred for SJR as potential learning.

Deaths in Q1 – Q4 Referred for SJR and Number / % Completed



Month of Death	No of cases referred for SJR	DC agreed	% completed	% completed in Quarters
Apr-17	60	57	95%	90%
May-17	45	40	89%	
Jun-17	46	40	87%	
Jul-17	42	40	93%	89%
Aug-17	42	38	88%	
Sep-17	35	30	83%	
Oct-17	33	23	70%	54%
Nov-17	42	23	52%	
Dec-17	39	16	55%	
Jan-18	31	11	39%	22%
Feb-18	32	7	23%	
Mar-18	40	3	8%	
Grand Total	**487**	**328**	**67%**	

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.

89% of Quarter 1 and 2's SJRs have been completed and 54% of Quarter 3s which is below our internally set thresholds.

However, not all SJR details have been collated due to capacity constraints within the Corporate M&M Admin team and the increased activity pressures have affected clinical teams' capacity to review cases and have also led to cancellation of some M&M meetings

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*	Problems in care thought more likely than not to have contributed to death	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.** MRC review and confirm Death Classification and details of learning/actions Patient Safety Team review against the NHSI Serious Incident Framework and **undertake SI Investigation if meets criteria.**
2*	Problems in care but unlikely to have contributed to death	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 to have 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

Death Classifications where SJR Completed

Death Category	ME Mortality Screening	Feedback from Bereaved	Child/Neonatal Deaths	Deaths post Elective Procedure	Deaths of patients with LD	Deaths of patients with SMI	Deaths where QI / CUSUM	Speciality M&M	All SJRS completed in Q1-Q4
1			2					1	3
2	10	1	4	1	1				13
3	74	5	10	6	6	6	1		107
4	61	8	50	9	1	6	1	1	131
5	14	1	15	13	4				44
tbc	10			4				2	21
All	**169**	**15**	**81**	**33**	**12**	**12**	**2**	**4**	**328**

What is the data telling us?

- No new cases have been confirmed as a Death Classification of 1 since previously reported
- All 3 cases given a Death Classification of 3 have been investigated and confirmed as being a Serious Incident with Major/Permanent Harm.
- A 4th Death was investigated as a Serious Incident and Consequence was considered to be Major/Permanent Harm but the Specialty M&M agreed a Death Classification of 2 (Problems in care but unlikely to have contributed to death).
- Actions are being tracked by MRC for all deaths where problems in care identified. –

Category	Rationale
1	Problems in care thought more likely than not to have contributed to death
2	Problems in care but unlikely to have contributed to death
3	Problems in care but very unlikely to have contributed to death
4	No problems in care
5	Good or Excellent Care.

Key Themes from the Learning from Deaths Programme in 17/18 (to date)

The table below summarises the areas of learning identified from the ME screening process , completed clinical reviews , Specialty M&M reviews and Bereavement Support follow up.

Theme	% of cases	Sub themes
End of Life (EoL) / Do Not Resuscitate Orders) DNACPR	29%	Delayed recognition of End of Life; DNACPR not in place early enough; Invalid DNACPR; EoL care in place but continued active treatment; Fluids not given when patients on EoL care
Communication – mainly with Relatives	15%	Mainly relates to relatives' concerns, includes communication relating to prognosis, deterioration, death or being able to contact ward/consultant
Discharge / Admission	11%	Previous discharge – perceived appropriateness, expectations re prognosis, effective planning of post discharge care or follow up; medication Admission – perceived appropriateness; emergency pathway (ED/GPAU)
Clinical Monitoring	11%	Includes in-patient observations, ward round reviews, out-patient follow up; transfer between sites; senior review/setting of 'ceilings of care', handover and transfer between specialties and sites
Acting on Results	5%	Investigations – both following up and acting on results
Nursing Care	8%	Responding to Buzzers, Feeding, General Care and Staff Attitude
Sepsis	8%	Earlier recognition, timely delivery of sepsis care bundle; risk of fluid overload
Escalation	3%	Escalation of EWS or escalating for senior review or higher level of care
Medication	4%	Delays, Toxicity, Omissions of Critical Medicines
Others	8%	Pain Management (7); CT - Delays/AKI (5) Chest Drain/Pneumothorax (5) Pathways (8) Diabetes Management (4)

Proposed Structure for Addressing Issues

The table below shows how themes and learning could be taken forward to achieve a 'joined up approach' to improving patient care. This approach was supported at the May EQB meeting.

Theme	Group overseeing actions
Recognition of End of Life (EoL) / Do Not Resuscitate Orders) DNACPR	Resuscitation Committee End of Life Care Board
Communication – mainly with Relatives	Individual M&M meetings and M&M Leads Forum
Discharge / Re-admission	UHL, LPT and Social Services Integrated Care Team Leaders
Clinical Monitoring	Deteriorating Adult Patient Board
Acting on Results	Acting on results work stream
Nursing Care	Heads of Nursing/Matrons
Sepsis	Sepsis Working Group/Deteriorating Adult Patient Board
Escalation	Deteriorating Adult Patient Board
Medication	Medicines Optimisation Committee
Others	Heads of Service, Corporate Teams as applicable

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

- A total of **3233** cases taken up so far by Bereavement Support Nurse for FY 2017/18.
- **56% (1814)** of bereaved relatives requested follow up contact by the Bereavement Support Nurse
- An attempt to contact by phone was made for **93%** of those requesting following up.
- BSN managed to speak to **57%** of those relatives (letter/email sent to the remaining where the Bereavement Support Nurse was unable to speak to the family on the phone)
- Further information / follow up was requested by **136** families as part of the follow up contact
- Meetings with the clinical team/s were facilitated for **74** families
- Signposting to bereavement services eg CRUSE, LOROS, Sharma Women's Centre, Child Bereavement UK was given to **224** bereaved relatives/carers

Learning from Deaths in our Care - Next Steps

- Continue monitoring UHL's risk adjusted mortality rates (HSMR and SHMI) and undertake more detailed reviews where applicable
- Scope potential for benchmarking with other Trusts and Health Economies with similar patient demographics and organisational structures
- Improve timeliness of ME Mortality Screening in respect of Coroner Referrals and LGH/Glenfield cases
- Improve process for collating, theming and analysis of Mortality Screening and Specialty Review data
- Ensuring dissemination of learning and appropriate actions being taken
- Develop and disseminate Learning from Deaths Bulletin
- Include details of Learning from Deaths in our 17/18 Quality Account
- Work in collaboration with other Trusts to identify ways of improving our Learning from Deaths process
- Identify resources to support the above both corporately and at a Specialty level

Learning from the Deaths of Patients in our Care Dashboard

Deaths in 17/18

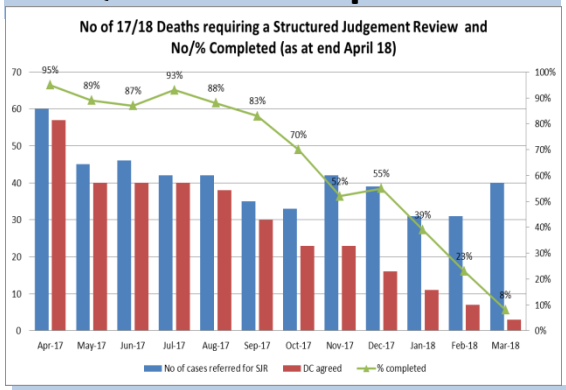
PLACE OF DEATH	ADULT / CHILD / NEONATE	NUMBER OF DEATHS
ED		236
	Adult	222
	Child	14
Inpatient		3027
	Adult	2919
	Child	25
	Neonate*	83
Community Deaths **		97
Total	"UHL Learning from Deaths"	3360

Medical Examiner Screening

Reasons for referral for Structured Judgement Review (SJR)

Reason for SJR	Q1	Q2	Q3	Q4	17/18
1. ME	82	51	60	54	247
2. Relatives	8	6	2	3	20
3. Child	36	31	26	29	122
4. Elective Procedure	11	19	15	4	49
5. LD	4	7	6	8	25
6. SMI	7	4	4	2	17
7. CUSUM Alert	2	0	1	0	3
8. Other	1	1	0	2	4
All	151	119	114	103	487

Q1-4 SJR Completion



UHL DEATH CLASSIFICATIONS	
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Learning identified in 17/18

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Actions being taken forward in 18/19

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