University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 5 September 2019

Trust Board paper K

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 Darryn Kerr – Director of Estates and Facilities
Date of meeting:	29 August 2019

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

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 29 August 2019:

- **Mortality report and Learning from Deaths update (2018/19 and April - July 2019/20)** – the Medical Director advised that UHL's position remained steady, with a continued low crude mortality rate of 1%, and SHMI and HSMR rates within expected ranges (100 and 95 respectively). Appendix 2 of the report outlined progress against UHL's Learning from Deaths framework, noting improvements to the timeliness for Medical Examiner (ME) reviews. It was also reported that national intent is to expand the Medical Examiner process to cover all child deaths. QOC was also briefed on UHL's intent to review all perinatal mortality deaths, in accordance with CNST maternity incentive scheme requirements. Circa 10% of adult deaths had then been reviewed through the Structured Judgement Review process, and QOC was advised that in 2018/19 5 deaths (0.15% of deaths) were considered 'more likely than not to be due to problems in care' (death classification 1). The report set out the themes from those cases and also those assessed as.19 'problems in care but unlikely to have contributed to death' (death classification 2). QOC welcomed assurance from the Medical Director that the Learning from Death themes and data were appropriately triangulated and fed into UHL's quality priorities and wider quality improvement work. A Consultant from Dr Foster also attended for this item, and shared his professional view that UHL's mortality performance was genuinely good, that it had a very robust process in place to understand and verify its mortality data, and that he often advised other Trusts to contact UHL for advice on its processes. QOC welcomed this assurance, and considered that Learning from Deaths was an area of strong performance for the Trust.
  The Learning from Deaths quarterly update is recommended for Trust Board approval, as appended to this summary.

- **CQC Inspection** – the Chief Nurse provided a verbal update on the forthcoming CQC core services and Well-Led inspections, and noted the timescale for the Use of Resources assessment. QOC noted the information available to staff. Wider discussion also took place on the appearance of some public areas of the Trust's sites; the Director of Estates and Facilities was sighted to these issues, but QOC recognised the very significant capital constraints on the Trust.

- **Quality outcomes for cancer across LLR** – the Cancer Centre Clinical Lead presented an analysis of the cancer data relating to quality for the three CCGs within LLR, with reference to overall performance in the East Midlands Cancer Alliance and England as a whole. A discussion on the wider EM Cancer Strategy had also taken place in the joint session between QOC and People, Process and Performance Committee members earlier that day. With regard to the quality outcomes report, QOC particularly discussed the position of patients covered by Leicester City CCG in having a significantly lower percentage uptake of screening compared to the England average, and a higher than England average for cancers diagnosed through an emergency presentation (percent). In response to Non-Executive Director queries, QOC received assurance that local public health representatives were appropriately involved in addressing these issues. QOC queried the role of both UHL and the wider LLR system in addressing differential access issues, recognising that that EM Cancer Strategy had recently been introduced. It was agreed to receive a further update on cancer strategy progress (including the scope for prevention opportunities and making every contact count, as now raised by Non-Executive Directors) in

12 months' time, recognising that detailed quality outcomes data might not be available in that timeframe.

- **Information for patients – 6 month update** – QOC received an update from the Library Services Manager and the Patient Information Librarian. Progress had been made, although at a slightly slower rate than initially hoped, and QOC recognised the scale of the work required. Work continued to engage CMGs more fully (including plans to have identified Patient Information leads in each CMG), and Non-Executive Directors commented on the benefits to both patients and CMG staff of improving access to services by having more readily accessible patient information available, as well as its crucial relationship with the consent process. QOC Patient Partners queried the scope for co-production of patient information. It was agreed to receive a further update in 6 months' time.

- **CQC maternity review report and UHL action plan –** the Chief Nurse provided assurance that (as with all action plans) actions would not be closed by UHL unless supported by appropriate evidence. She also confirmed that the Trust's robust factual accuracy checking comments on the report had largely been accepted by the CQC.

- **Nursing safe staffing and workforce report** – QOC took assurance from this new style report, which triangulated key data and covered vacancies, planned versus actual fill rates, care hours per patient, staff moves in month to support safe staffing across the Trust, and any red flags and Datix reports relating to safe staffing. June 2019 vacancies had reduced for both registered nurses and healthcare support workers (which was welcomed), and the care hours per patient data demonstrated that safe standards were being maintained (albeit involving a number of staff moves, which was noted by QOC). Specialty Medicine remained a challenging area in terms of staffing, however, and was a key focus for UHL. The Deputy Chief Nurse also noted progress on both overseas nursing recruitment, and on reviewing the most appropriate use of Nursing Associates. Preparation was also in hand for a key NMC approval event on 17-18 September 2019 for UHL's Nursing Associate programme.

- **CRO (Carbapenemase Resistant Organism) update** – the Chief Nurse provided assurance that she was working with the Director of Estates and Facilities to develop SOPs for cleaning and ward re-use. Further national guidance on CRO was still awaited from Public Health England – once received that would feed into work to develop an overarching UHL approach to CRO.

- **Patient Experience 2019/20 quarter 1 report and the Infection Prevention 2019/20 quarter 1 report** – the Chief Nurse confirmed that these were both for noting.

- **Monthly safety update** – the Director of Safety and Risk particularly briefed QOC on the new National Patient Safety Strategy published in July 2019; based on 3 underlying approaches (insight, involvement, and improvement), the Strategy demonstrated a continuing move away from a culture of blame and towards a culture of learning and improvement, which was welcomed by QOC. The monthly safety report also highlighted the need for the Trust to reduce the number of overdue patient safety incidents, and advised that good practice on this from the Emergency and Specialist Medicine CMG was being shared more widely.

- **Food safety task and finish group update –** reporting verbally, the Director of Estates and Facilities advised that a further report would be provided to QOC following the 2nd meeting of the food safety task and finish group in early October 2019. He noted that a series of EHO audits were due in September 2019.

Items for noting

- **Getting it Right First Time (GIRFT) report: Leadership;**
- **Leicester Radiation Safety Service Annual Report 2018/19** - QOC received assurance that the staffing position reflected in the report had improved, and
- **Report on Claims and Inquests (2019/20 quarter 1).**

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

- Learning from Deaths quarterly update.

Public items highlighted to the Trust Board from this meeting:-

- None

Matters referred to other Committees:

- None.

Date of next meeting:	26 September 2019

MORTALITY REPORT Paper C

Authors: Head of Outcomes & Effectiveness; Deputy Medical Director, Lead Medical Examiner
Sponsor: Medical Director

1. BACKGROUND AND CONTEXT

1.1 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.

1.2 MRC also oversee UHL's "Learning from Deaths" framework which includes learning identified through the:

- Medical Examiner Process
- Bereavement Support Service
- Specialty Mortality Reviews using the national Structured Judgement Review tool
- LLR Child Death Overview Panel reviews
- Perinatal Mortality Review Group reviews using the national Perinatal Mortality Review Tool
- Clinical Team reviews and reflections
- Patient Safety Incident Reviews, Investigations and Complaints
- Inquest findings and Prevention of Future Death letters
- LLR 'Learning Lessons to Improve Care' Clinical Quality Audit

1.3 One of the national Learning from Deaths requirements is for Trusts to 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. Another requirement is to publish the outcomes of reviews undertaken of perinatal deaths in line with the criteria for the Clinical Negligence Scheme for Trusts' (CNST) Maternity Incentive Scheme.

1.4 In 18/19 as part of the Trust's Internal Audit programme, a review was undertaken of UHL's Learning from Deaths framework looking specifically at the Medical Examiner screening and referral for SJR as part of the Specialty Mortality & Morbidity (M&Ms) process.

1.5 There has also been several national guidance documents published in the past 12 months with implications for UHL's Learning from Deaths framework, specifically the Medical Examiner process.

2. QUESTIONS

2.1 What are the data telling us around UHL's mortality rates and what actions are being taken to improve these?

2.2 Are we making good progress with our Learning from Deaths framework and what learning has taken place

2.3 Are we meeting the national reporting requirements?

2.4 What were the findings of the Internal Auditors and what actions have been taken in response?

2.5 How have we responded to recommendations from nationally published guidance?

3. UHL's MORTALITY RATES AND ACTIONS (Appendix 1)

3.1 A summary of UHL's mortality rates, both risk adjusted and crude, are set out in the slide deck (Appendix 1). Changes have been made to some of the risk adjusted mortality slides as we are testing out how to better use the extended data now freely available from NHS Digital.

3.2 UHL's crude mortality remains stable at 1.0% for 18/19 and our risk adjusted mortality remains within expected (latest SHMI 100 for the financial year 18/19 and HSMR 95)

3.4 The Mortality Review Committee (MRC) has undertaken in-depth analysis and reviews of several diagnosis groups with either an HSMR or SHMI above 100. None of these reviews have identified particular issues in care. One of the key challenges continues to be capturing the complexity of case mix in our clinical coding. One of the main contributing factors appears to relate to the short length of stay on our Assessment Units.

3.5 Review of UHL's mortality data by our Dr Foster Intelligence Consultant has not identified any patient or diagnosis groups of concern.

4. UHL's 'LEARNING FROM DEATHS' Framework (LfD) (Appendix 2)

4.1 Good progress is being made with all aspects of UHL's LfD framework.

4.2 Our Medical Examiner (ME) process has been in place for 3 years and is now a national requirement. Over 7,000 adult deaths have been through our ME process since July 2016. (Slide 5) We have recently expanded the process to include deaths where 'urgent release out of hours' is needed.

4.3 In April MEs began attending the ED morning handover where overnight deaths had occurred and from June 'out of hours' ME telephone advice has been available for certifying doctors where 'out of hours urgent release of the deceased' is requested.

4.4 Next steps are to expand the ME process to include child deaths. Future plans include having MEs present on the LGH and GH site but this requires confirmation of national funding arrangements. We are also looking to further improve our administrative processes in order to make best use of the MEs' time.

4.5 Our Bereavement Support Services (BSS) started in January 2016 and at the end July 2019 over 4,700 relatives have received telephone follow up (at 6-8 weeks post bereavement) to see if they had any unmet bereavement needs or unanswered questions.

4.6 In 18/19 follow up contact was requested by 2,250 bereaved relatives and the Bereavement Supports Nurses (BSNs) provided verbal follow up contact with 1,740 relatives. Positive feedback was given by most of the bereaved (80%). Questions and concerns mainly related to communication and meetings with the clinical teams for further discussion were requested and facilitated for over 60 families. (Slides 8 to 11)

4.7 Structured Judgement Reviews (SJRs) as part of the Specialty M&M were requested for 327 (10%) of adult deaths in 18/19 and 66 (9%) in Quarter 1 of 19/20. This includes those meeting the national criteria for SJR (i.e. death post elective surgery, death of patient with a learning disability or serious mental illness). (Slides 12 & 13)

4.8 In addition to cases being referred for SJR via the Specialty M&M, some will be referred directly to the clinical team involved in the care for the patient. 400 adult deaths in 18/19 (60 in Q1 in 19/20) were referred to relevant members of the multi-disciplinary team for review and reflection following the MEs speaking to the bereaved relatives/carers or screening of the case notes.

4.14 388 of the 446 cases referred for SJR (or SI investigation) in 2018/19, have been completed and Death Classification agreed. (Slide 15)

4.15 A summary of the emerging learning themes can be seen on Slide 16. Actions to improve the care of all patients have been agreed for 177 cases with the most frequently occurring action being related to feeding back for reflection or raising awareness.

4.16 Two specific work streams related to cross site transfers and patients presenting with abdominal pain and the Inter Site Hospital Transfer and Acute Abdomen Pathway 'task and finish' groups have have made further progress since the last report;

"Inter Site Hospital Transfers" -. The task and finish group consists of representatives from ED, CDU, ESM and ICU. High level principles of how patients are selected for transfer, how their initial treatment is commenced, how they are monitored, how the receiving site inputs into the decision making and how the patient is transferred have been agreed.

There is agreement to pilot this, with face to face senior review in ED of all patients being transferred to CDU from the Emergency Room in ED. The plan is to produce a checklist to ensure the process is adhered to which will eventually be electronic and the possibility of creating an electronic referral from ED to CDU is being explored.

Outcome metrics are being developed which will monitor the effectiveness of the changes and help understand the frequency at which problems arise. The timeline for completion of this work is the end of October 2019.

"Acute Abdomen Pathway" – The Adult Acute Abdominal Pain Triage and Immediate Action Tool has been successfully piloted and will continue to be used. An audit will now be undertaken to evaluate full implemenation.

4.8 There were 27 deaths of patients with a Learning Disability in 2018/19 and a report on the review findings of all cases was reported to the June meeting of MRC. Learning themes were subsequently reported to the Learning Disability Steering Group to consider if these were already being taken forward as part of the LD work programme or additional actions required (Slide 18).

4.9 In 18/19 37 child deaths (7 in Q1 in 19/20) were referred for review by the Specialty M&M as well as the LLR Child Death Overview Panel (CDOP). Focused work has been undertaken in 2018/19 to closer align the work of the Specialty M&Ms with that of CDOP. (Slide 19)

4.10 There were 82 perinatal deaths reviewed by the Perinatal Mortality Review Group (PMRG) in 18/19 (Slide 20). All deaths have been reported to the Mothers and Babies: Reducing Risk through Audits Confidential Enquiries across the UK (MBRRACE). The Chair of the PMRG attended the July MRC and it was noted that the 2017 MBRRACE data would not be available until October 19.

4.12 The Corporate LfD team is working closely with the Patient Safety and Inquest teams to try and ensure there is joint working, sharing of information and taking forward identified learning.

4.13 MRC continue to liaise with relevant trust committees and clinical leads taking forward quality improvement work streams which align to the LLR Learning Lessons to Improve Care (LLtIC) Clinical Quality Audit recommendations.

5.0 Publication of UHL's Learning from Deaths data

5.1 There have been 5 deaths in 18/19 (confirmed to date) where problems in care were considered more than likely to have contributed to the death. All have been reviewed by the Patient Safety Team. (Slide 16).

5.2 Data for the NHS Resolution Maternity incentive scheme was reviewed at the Perinatal Mortality Oversight Group meeting on 13th August. (Slides 21 to 23). We are on track to achieve the end of year threshold for all 4 indicators.

6.0 Internal Audit's Review of UHL's Learning from Deaths framework

6.1 No areas of 'high risk' were identified by the Internal auditors. There were two areas of medium risk (manual processes for data collation and delays with child and neonatal death reviews) and one low risk (lack of MEs on site at the LGH/GH and only adult deaths covered by the ME process).

6.2 Actions were agreed in response to the Auditors findings and recommendations all but two have been completed – both of which relate to the area of low risk.

6.3 A revised timescale has been agreed for the action relating to piloting of a paediatric ME process which will be completed by end of September. The final action relates to standardising the Medical Examiners process at the LGH and Glenfield. At the August MRC meeting, members noted that until there is clarity around national funding available for the Medical Examiner process, it will not be possible to have MEs at the other two sites. However, changes have been made to reduce delays with the screening of cases and speaking to the bereaved and to standardise other aspects of the ME process, therefore this action is now considered to have been closed.

7.0 National and Regional implications for UHL's Learning from Deaths framework

7.1 Recommendations from the following national guidance documents have been reviewed by the MRC in the past 12 months and changes made to our processes as applicable.

- **Learning from deaths**: Guidance for NHS trusts on working with bereaved families and carers (NHSE - July 2018)
- **Child Death Review** - Statutory and Operational Guidance (England) (HM Government – October 2018)
- **Learning from deaths** - A review of the first year of NHS trusts implementing the national guidance (CQC - March 2019)
- **The national Medical Examiner system** (NHSI - April 2019)
- **Learning Disability Mortality Review (LeDeR) Programme**: Action from Learning (NHSE/NHSI - May 2019)
- **The NHS Patient Safety Strategy** (NHSI - July 2019)

7.2 Following a visit by the Director of Patient Safety from NHSI in December and more recently the newly appointed Regional Medical Director, we have reviewed our Medical Examiner process to consider the national recommendations regarding the role of Medical Examiner Officers

7.3 In the past 12 months we have hosted visits from 6 Trusts looking to set up a Medical Examiner process and in February we hosted a half day conference on 'Leicester's experience of implementing Medical Examiners'.

8.0 Next Steps

8.1 In respect of UHL's mortality rates, the next steps will be to continue monitoring our crude and risk adjusted mortality at a trust level on a monthly basis with quarterly review of diagnosis or patient groups with an HSMR or SHMI consistently 'above expected'.

8.2 From a 'Learning from Deaths' perspective, next steps will be to expand our ME process to cover all deaths, taking into account the national approach to using Medical Examiner Officers.

8.3 We will continue to work with the Specialty M&Ms to improve the timeliness of undertaking further reviews requested

8.4 We will complete collating the 18/19 review findings from both Specialty and Clinical Team reviews plus feedback received from bereaved relatives via the MEs and BSNs and correlate this with learning identified through patient safety incidents, complaints and inquests.

8.5 The learning themes identified will then be reviewed by MRC to consider if appropriate quality improvement work streams are already in place.

8.6 The MRC will continue to receive regular reports on reviews of child and perinatal deaths, and deaths of patients with a learning disability. A report on the reviews of patients with Serious Mental Illness is due to be presented to the October meeting of MRC.

8.7 The Regional ME has asked that we continue to host visits from other Trusts who have not yet established an ME process.

8.8 We have been invited to give a presentation of UHL's Learning from Deaths framework at the Royal College of Physicians Annual Mortality Conference in October.

9.0 Input Sought

9.1 Members of the Committee are requested to receive and note the contents of this report and appendix and to support the next steps.

PAPER C
APPENDIX 1

UHL Mortality Report Slide-deck

Head of Outcome & Effectiveness, and Deputy Medical Director
Sponsor: 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

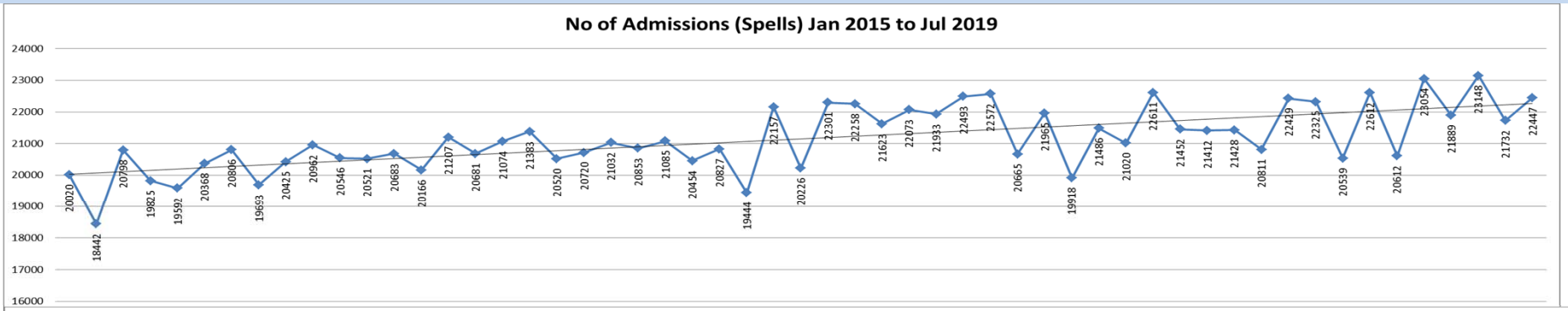
How many people died in the Trust between 2014/15 and 2019/20 (to date)

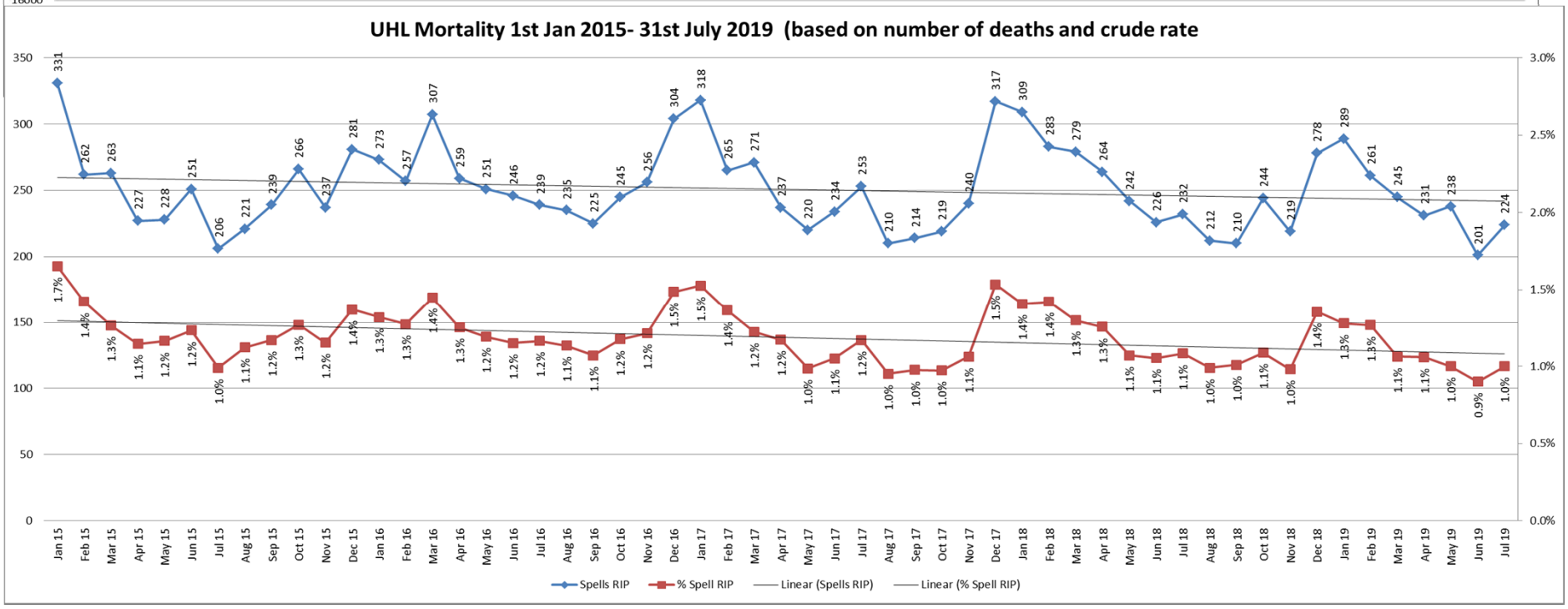
Discharged During…	Emergency Discharges Deaths % Rate	Elective IPs Discharges Deaths % Rate	Daycase Discharges Deaths % Rate	Total Discharges Deaths % Rate
FY 2019/20 YTD (Jul)	**46,828 870 1.9%**	**6,840 24 0.4%**	**36,094 0 0.0%**	**89,216 894 1.0%**
FY 2018/19	135,509 2847 2.1%	20,867 74 0.4%	103,899 1 0.0%	260,275 2922 1.1%
FY 2017/18	136,684 2948 2.2%	20,290 67 0.3%	102,565 1 0%	259,539 3016 1.2%
FY 2016/17	129,047 3043 2.4%	21,340 71 0.3%	99,846 0 0%	250,233 3114 1.2%
FY 2015/16	128,524 2913 2.3%	21,622 77 0.4%	94,630 3 0%	244,776 2993 1.2%
FY 2014/15	122,456 2932 2.4%	22,252 65 0.3%	91,181 0 0%	234,889 2997 1.3%

What is the data telling us?

- UHL's overall crude mortality rate for 19/20 (to date) has further improved on previous years' performance and whilst there has been an increase in activity in the first 4 months of this financial year, there have been fewer deaths in our hospitals.

what is the Trust's crude Inpatient mortality rate?





What is the data telling us?

UHL's crude monthly mortality rate continues to show the same seasonal variation with annual peaks of numbers of deaths in December/January but the 2018/19 peak was not as high as in previous years and in June this year we saw the lowest number of deaths and lowest crude rate for the past 4 years.

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)

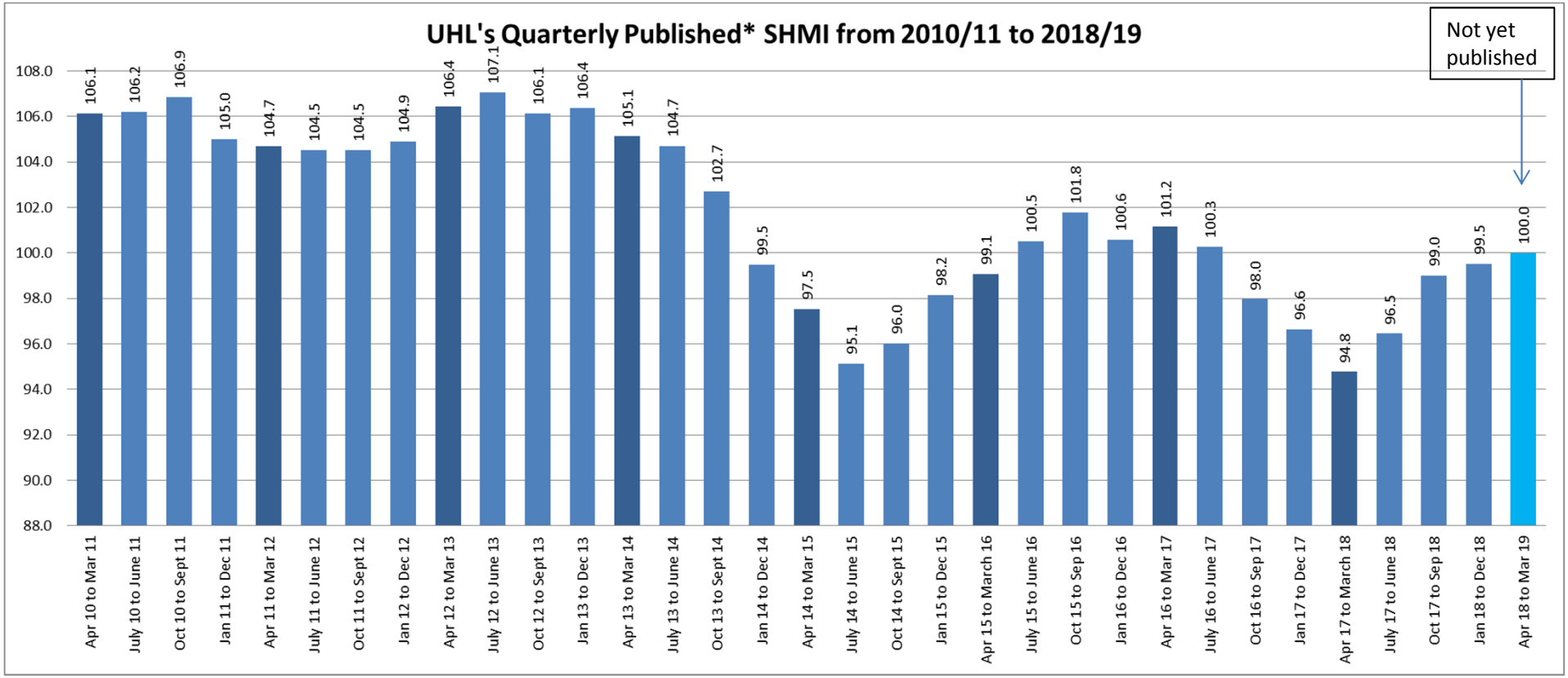
From May 19 the SHMI has been published on a monthly basis by NHS Digital and other contextual data is also being published to include 'hospital site' SHMI.

NHS Digital have recently made some changes to the SHMI methodology:

- two new diagnosis groups (Livebirths; Non Hodgkin's lymphoma)
- Adjusting for birthweight for patients under one year of age
- Adjusting for seasonality
- Using the latest version of Deprivation (in contextual indicators)

The impact of these changes have been very small (less than 1% for all trusts)

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



What is the data telling us?

UHL's quarterly SHMI has been 100 or below for the past two years with some natural variation between each quarter

Although UHL's crude mortality has come down, the number of expected deaths in the SHMI methodology has also come down (see Slide 8)

This is because there have been fewer deaths across all Trusts in 18/19 (288,000) than in 17/18 (299,000) and so nationally there has been fewer 'expected deaths'

Deaths following time in hospital, England, March 2018 – February 2019

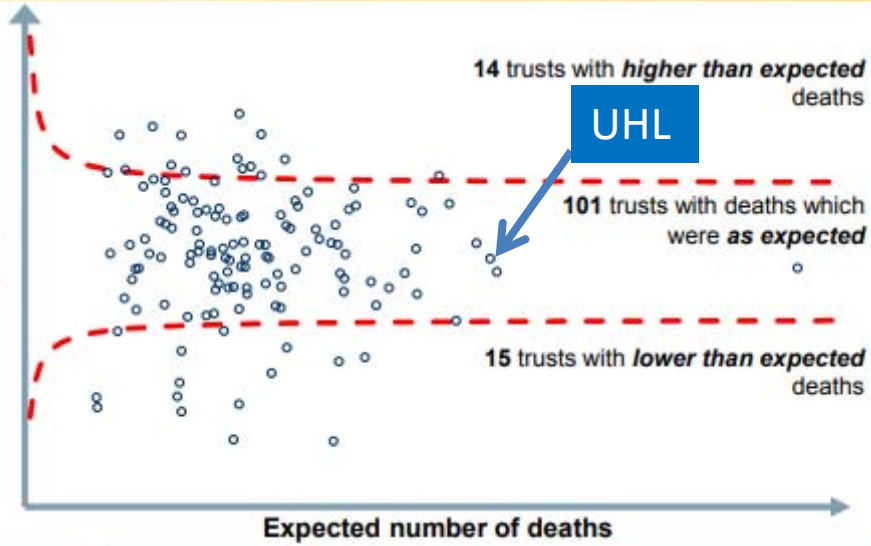
Monthly statistics: Published 18th July 2019

NHS Digital

This publication compares the actual number of deaths following time in hospital with the expected number of deaths, using the Summary Hospital-level Mortality Indicator (SHMI).

The expected number of deaths is estimated using the characteristics of the patients treated; age, sex, method and month of admission, current and underlying medical condition(s) and birthweight (for babies). It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

Between March 2018 and February 2019, there were around 9.2 million discharges, from which approximately 288,000 deaths were recorded either while in hospital or within 30 days of discharge for the 130 hospital trusts covered. This includes deaths from other causes as well as deaths related to the reason for the hospital admission.



The 14 trusts with a ***higher than expected*** number of deaths were:

- Blackpool Teaching Hospitals NHS FT
- Bolton NHS FT
- Dorset County Hospital NHS FT
- East Suffolk and North Essex NHS FT
- East Sussex Healthcare NHS Trust**
- George Eliot Hospital NHS Trust
- Northern Lincolnshire and Goole NHS FT
- Tameside and Glossop Integrated Care NHS FT
- The Dudley Group NHS FT
- The Princess Alexandra Hospital NHS Trust
- The Royal Wolverhampton NHS Trust
- University Hospitals Plymouth NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- Wrightington, Wigan and Leigh NHS FT

The 15 trusts with a ***lower than expected*** number of deaths were:

- Cambridge University Hospitals NHS FT
- Chelsea and Westminster Hospital NHS FT
- Great Western Hospitals NHS FT
- Guy's and St Thomas' NHS FT
- Homerton University Hospital NHS FT
- Imperial College Healthcare NHS Trust
- Kingston Hospital NHS FT
- London North West University Healthcare NHS Trust
- North Middlesex University Hospital NHS Trust
- Royal Free London NHS FT
- Royal Surrey County Hospital NHS FT
- St George's University Hospitals NHS FT
- University College London Hospitals NHS FT
- Weston Area Health NHS Trust
- Whittington Health NHS Trust

'FT' means 'Foundation Trust'. Trusts in the same category in the same period in the previous year cannot be highlighted because SHMI values for the same period in the previous year are not available. This is due to the SHMI now being published monthly rather than quarterly.
** Results for this trust have been affected by diagnosis coding problems and should be treated with caution.

The SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust.

It is used along with other information to inform the decision making of trusts, regulators and commissioning organisations.

The SHMI is not a measure of quality of care. A *higher/lower than expected* number of deaths should not immediately be interpreted as indicating poor/good performance and instead should be viewed as a '**smoke alarm**' which requires further investigation.

The SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts by their SHMI.

See the full release at https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi

Responsible Statistician: Madeleine Watson

Tel: 0300 303 5678

Email: enquiries@nhsdigital.nhs.uk

UHL's latest SHMI (published 22nd Aug 19)

NHS Digital Clinical Indicator Previewer

Welcome | NHS Choices | SHMI

Overview | Indicator preview | Diagnosis group breakdown

Summary Hospital-level Mortality Indicator (SHMI) preview

Organisation selection

RWE: UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Indicator period selection

Select period to view:

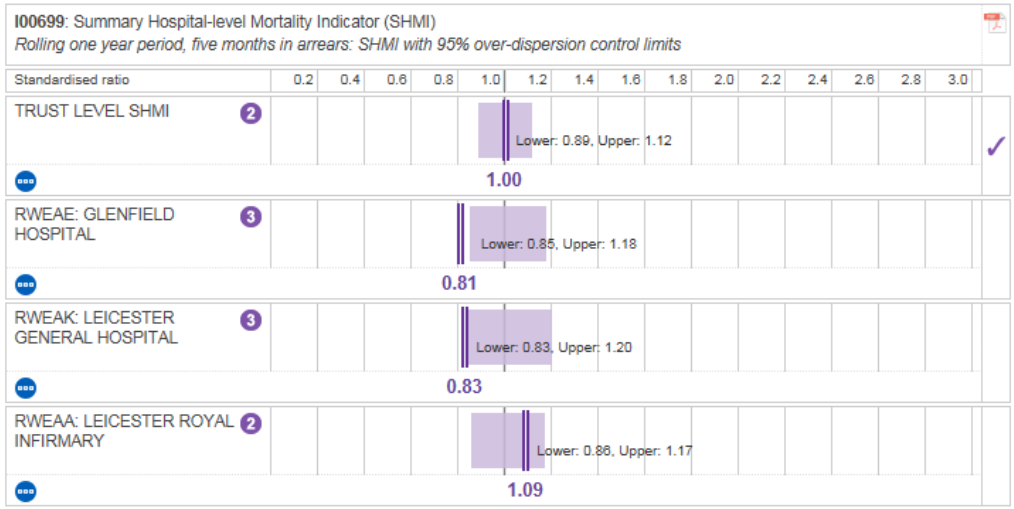
INDICATOR PERIOD: Latest: April 2018 - March 2019

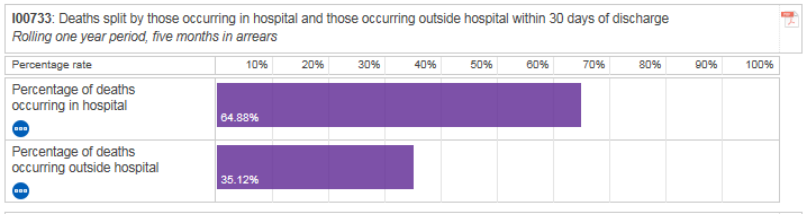
From the period January 2018 – December 2018, a breakdown of the data by site of treatment is available alongside the trust level data. A contextual indicator on the percentage of provider spells where the site of treatment changed between the first and last episodes in the spell is also available to support the interpretation of this breakdown.

Preview requirements

The SHMI value can be queried – click on the 'query' tab at the right of the chart and complete the pop-up form. Submission of the form will send an email to the Clinical Indicators team at the NHS IC, copy you in for reference and set the status of the indicator to 'queried'. It is not possible to recall a query once it has been submitted.

Summary Hospital-level Mortality Indicator (SHMI) • April 2018 - March 2019





What is the data telling us?

Although NHS Digital have moved to monthly publication of data they are continuing to release a quarterly SHMI and Trusts are able to 'preview' their SHMI ahead of publication

UHL's latest published SHMI is 100 and remains in Band 2 'as expected'

NHS Digital are now publishing Trust's SHMI by hospital site. UHL's sites include St Mary's Birthing Unit and the Community Hospitals used by the Alliance. These sites do not have a SHMI as there have been no deaths associated with inpatient activity.

For the 3 main sites, the SHMI for the LRI is 'as expected' and for the LGH and Glenfield it is 'below expected'. NHS Digital have emphasised that 'site SHMIs' are provided for information only and differences between sites is expected due to the configuration of services.

UHL has always had a higher proportion of 'post discharge deaths' compared with other Trusts and the proportion has increased since 17/18

SHMI Diagnosis Groups with the most deaths
(as reported by NHS Digital SHMI Previewer)

Diagnosis Group	Spells	All Deaths (Observed)	Expected Deaths	InHosp Deaths	Post Disch Deaths	SHMI	% InHosp Deaths
Pneumonia (excluding TB/STD)	4390	612	638	445	167	0.96	73%
Septicaemia (except in labour), Shock	3092	549	564	407	142	0.97	74%
Acute cerebrovascular disease	1292	196	212	152	44	<100*	78%
Congestive heart failure; nonhypertensive	1573	193	200	137	56	<100*	71%
COPD & bronchiectasis	2709	127	147	83	44	<100*	65%
Acute bronchitis	**3608**	**125**	**117**	**66**	**59**	**1.07**	**53%**
Urinary tract infections	**2493**	**103**	**98**	**52**	**51**	**1.05**	**50%**
Secondary malignancies	705	96	104	33	63	0.92	34%
Aspiration pneumonitis; food/vomitus	310	93	104	58	35	<100*	62%
Acute myocardial infarction	**1217**	**85**	**83**	**75**	**10**	**1.03**	**88%**
Cancer of bronchus; lung	508	81	85	38	43	0.96	47%
Acute and unspecified renal failure	567	74	76	43	31	<100*	58%
Cardiac arrest and ventricular fibrillation	**115**	**70**	**57**	**69**	**1**	**>100***	**99%**
Organic mental disorders	640	66	71	27	39	<100*	41%
Intestinal obstruction without hernia	**706**	**63**	**54**	**38**	**25**	**>100***	**60%**
Fracture of neck of femur (hip)	853	62	63	48	14	0.98	77%
Fluid and electrolyte disorders	809	60	54	34	26	1.10	57%
Complication of device; implant; or graft	**2070**	**52**	**39**	**21**	**31**	**>100***	**40%**
Skin and subcutaneous tissue infections	**2322**	**45**	**36**	**29**	**16**	**>100***	**64%**
Other gastrointestinal disorders	1681	45	47	23	22	<100*	51%
Gastrointestinal hemorrhage	862	44	49	31	13	0.90	70%
Pleurisy; pneumothorax; pulmonary collapse	**706**	**44**	**34**	**23**	**21**	**>100***	**52%**
Biliary tract disease	**1938**	**44**	**33**	**21**	**23**	**>100***	**48%**
TOTAL DEATHS WITHIN ALL SHMI DIAGNOSIS GROUPS	**157,043**	**4442**	**4446**	**2882**	**1560**		**65%**

What is the data telling us?

* <100* / >100* Exact SHMI value not known as not provided in Previewer dataset but whether > or < 100 taken from Expected vs Observed deaths

- Of the 23 diagnosis groups (with more than 40 deaths in 18/19) 14 had fewer deaths than expected in the SHMI methodology
- MRC routinely review those diagnosis groups with more observed deaths than expected and cross reference with the Learning from Deaths data. No new areas of concern have been identified (see next slide)

Actions being taken for Diagnosis Groups with the most deaths and a SHMI >100

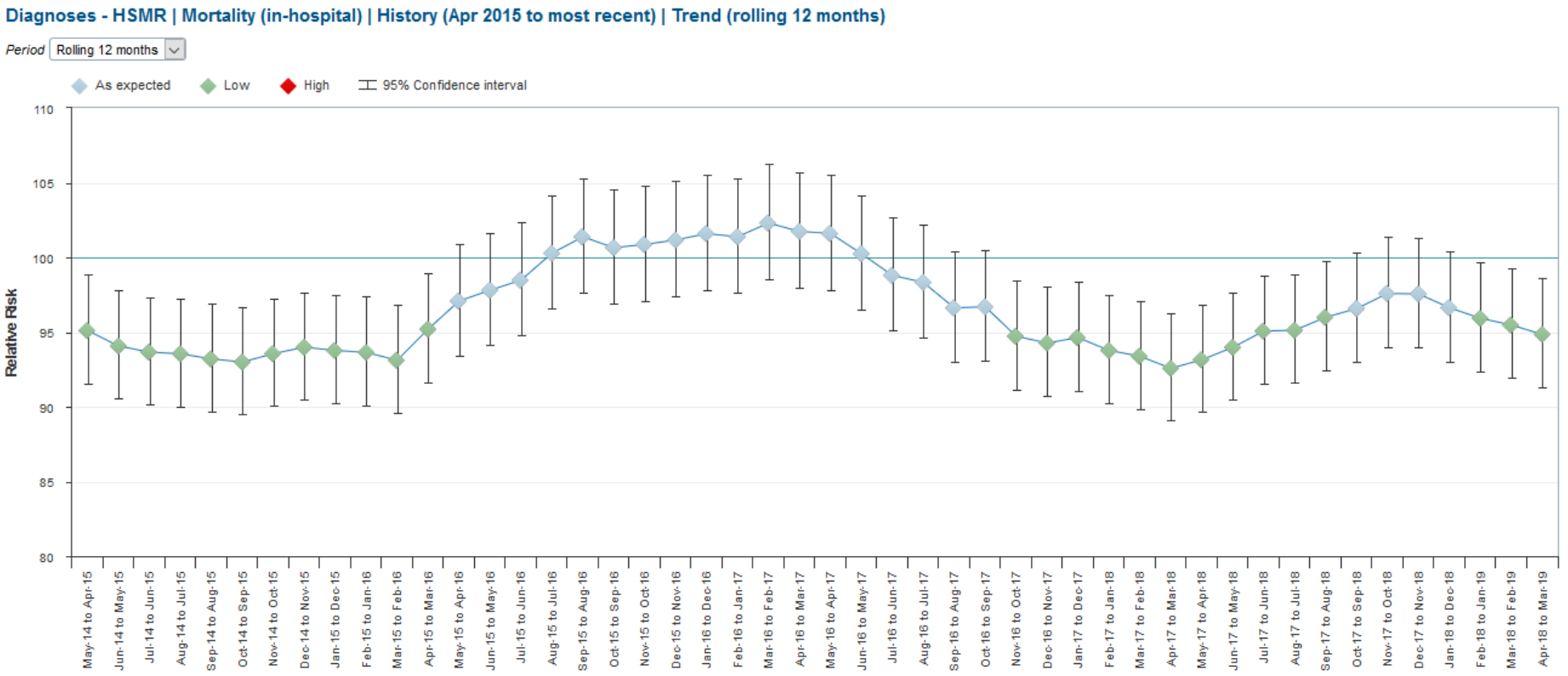
Diagnosis Group	Comment	Actions/Next Steps
Acute bronchitis	Previously reviewed and main finding was that most patients had been not had the appropriate diagnosis code assigned – a third had pneumonia.	Review Learning from Deaths data to compare presenting symptoms / cause of death and consider if case note review required
Urinary tract infections	Relates to 'assessment and initial treatment plan being for 'presumed UTI' in the first episode of care.	Documented clinical confirmation of diagnosis prior to treatment is one of the national CQUINs which is likely to have an impact on coding of all patients. To review in December 2019.
Acute myocardial infarction	Ongoing quality improvement work stream. SHMI is almost 100. Latest case note review did not identify any issues in care Links to higher SHMI for Cardiac Arrest	Continue to monitor and review following Cardiology service improvement plans.
Cardiac arrest and ventricular fibrillation	Known to be related to our CCU accepting Out of Hospital Cardiac Arrests.	Prospective audit planned.
Intestinal obstruction without hernia	New diagnosis group.	Review Learning from Deaths data to compare presenting symptoms / cause of death and consider if case note review required
Complication of device; implant; or graft	New diagnosis group	Review Learning from Deaths data to compare presenting symptoms / cause of death and consider if case note review required
Skin and subcutaneous tissue infections	New Diagnosis Group	Review Learning from Deaths data to compare presenting symptoms / cause of death and consider if case note review required
Pleurisy; pneumothorax; pulmonary collapse	Case note review and pathway review undertaken. Key finding was that most patients have an underlying malignancy (known or newly diagnosed following admission) but present with pleural effusion or other pleural complication secondary to their malignancy.	Clinical team will improve documentation of malignancy to support coders.
Biliary tract disease	Previously reviewed and found to be related to patients being admitted for palliative ERCP	None

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

HSMR Rolling 12 Month Trend



- UHL's latest HSMR is 98
- Over the past 4 years our HSMR has remained at either below or within the expected range. The most recent data shows a sustained period below the expected rate

Dr Foster HSMR Alerts (Apr 18 to Mar 19)

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp		Trend
All Diagnoses	1 8	**264699**	**3102**	**3235.9**	**95.9**	
HSMR (56 diagnosis groups)	14	93124	2605	2746.8	94.8	
Cardiac arrest and ventricular fibrillation	1	114	68	57.3	118.6	
Intrauterine hypoxia and birth asphyxia	1	719	10	5.7	175.8	
Other connective tissue disease	1	3229	23	12.4	186.1	
Other perinatal conditions	1	1334	41	22.5	182.5	
Other skin disorders		1713	3	0.5	568.4	
Phlebitis, thrombophlebitis and thromboembolism	1	259	7	2.7	263.1	
Senility and organic mental disorders	1	634	33	36.3	90.8	
Short gestation, low birth weight, and fetal growth retardation	1	483	13	10.8	120.4	
Syncope	1	879	6	2.9	205.3	
All Procedures	4	**176702**	**1801**	**1890.9**	**95.2**	
Excision of tongue	1	15	1	0.1	849.6	
External resuscitation	1	549	99	81.9	120.9	
Radiotherapy		113	14	7.0	201.1	
Rest of Arteries and veins	3	866	133	85.2	156.1	
Therapeutic endoscopic procedures on biliary tract	1	876	27	23.3	115.9	

- The Dr Foster alerts are generated at individual diagnosis and procedure group level. They demonstrate higher than expected mortality (either over a short or longer term – CUSUM or RR
- At the August meeting, MRC noted that there were no new diagnosis or procedures groups alerting
- The Perinatal Mortality Oversight Group, chaired by the W&C CMG CD, continue to work with Dr Fosters and have made changes to their activity coding processes

HSMR Diagnosis groups with higher volumes of Deaths

		Crude Rate	Expected Rate
Acute cerebrovascular disease	Highest Q	14.0%	13.6%
	Lowest Q	15.5%	15.2%
	UHL	14.1%	13.1%
Acute myocardial infarction	Highest Q	5.8%	6.0%
	Lowest Q	7.0%	7.4%
	UHL	6.3%	7.1%
Cardiac arrest and ventricular fib	Highest Q	36.2%	45.4%
	Lowest Q	52.5%	50.3%
	UHL	59.6%	50.3%
Chronic obstructive pulmonary disease and bronchiectasis	Highest Q	3.4%	4.0%
	Lowest Q	4.4%	4.2%
	UHL	3.2%	4.5%

		Crude Rate	Expected Rate
Congestive heart failure nonhype	Highest Q	9.7%	10.1%
	Lowest Q	11.2%	10.7%
	UHL	9.0%	10.5%
Pneumonia	Highest Q	11.8%	12.4%
	Lowest Q	13.7%	13.5%
	UHL	10.7%	11.8%
Septicemia (except in labour)	Highest Q	14.8%	14.5%
	Lowest Q	18.3%	16.5%
	UHL	13.3%	14.7%
Urinary tract infections	Highest Q	1.7%	2.0%
	Lowest Q	2.3%	2.4%
	UHL	2.3%	2.0%

Dr Foster have looked at the impact of our crude (observed) mortality on our HSMR for those diagnosis groups with the highest volume of deaths (and so contribute most to the HSMR)

They have compared our mortality with 20 other trusts – ranked by % of actual crude mortality and by % of expected crude mortality (ordered from lowest % to highest %)

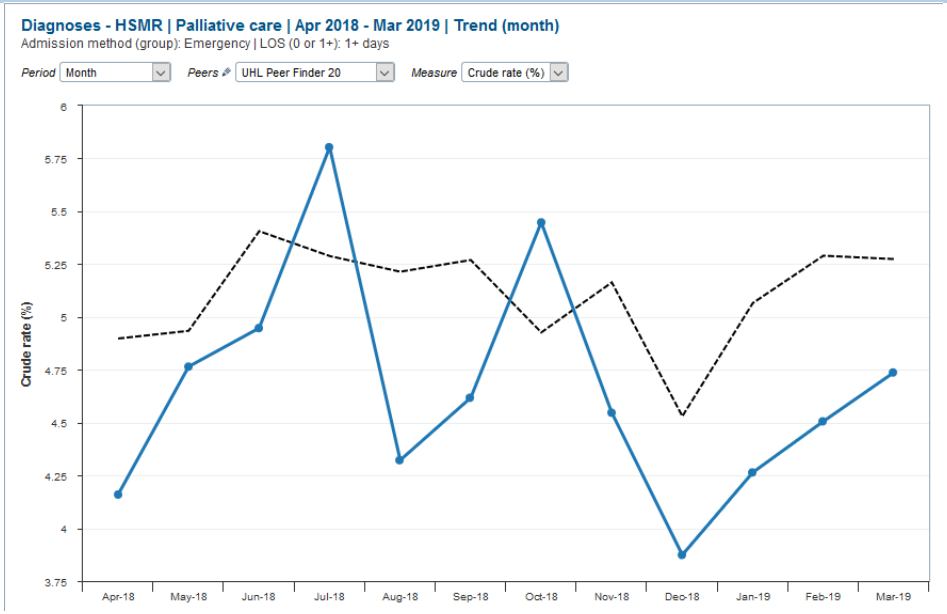
- All the above diagnosis groups were discussed at the August MRC and it was noted that pneumonia and septicaemia continue to below 100
- Members noted that Cardiac Arrest and UTI have crude rates in the top 75% of a peer group of similar hospitals. Members discussed that we have a higher number of deaths with Cardiac Arrest due to accepting Out of Hospital Arrests directly to our CCU which counts as an admission (OoHCA patients will normally get taken to ED and if die in the Department will not be included in the SHMI data).
- It was also noted that one of this year's CQUINs is to improve the management and documentation of Urinary Tract Infection diagnosis and treatment plans and therefore it is likely our data will change.

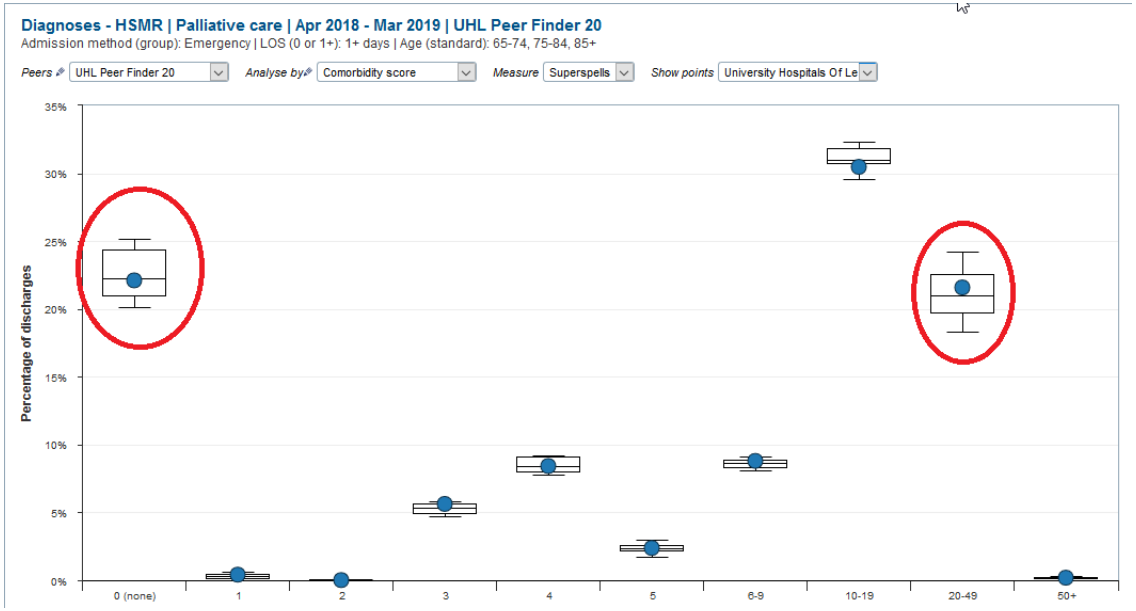
CoMorbidity and Palliative Care Coding

Although Palliative Care coding is not included in the SHMI methodology, it is important as it is included in the methodology for HSMR.

In the most recent data, UHL have coded lower rates of palliative care (solid blue line) than the average across a peer group of similar trusts (dotted black line)

Note: HSMR includes 'specialist palliative care code (Z515) but not end of life care code (Z518)





Charlson CoMorbidity Index Score

The comorbidity score is used as a proxy measure for the likely completeness of comorbidity coding. This chart compares the proportion of spells with low/high comorbidity scores. The data presented here is for emergency admissions, 65 yrs+ with a stay of at least 1 day in order to ensure robust comparison.

As can be seen, UHL's comorbidity score for this group of patients is average compared to a peer group of similar hospitals

Appendix 2

Learning From the Deaths of Patients in our Care 18/19 and 19/20 Q1

August 2019

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. 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 17/18 to Q1 19/20 – Place of Death

PLACE OF DEATH	APR 17 to MAR 18	APR 18 to MAR 19	APR to JUN 19 Q1
IN PATIENT	3026	2923	670
ED	235	254	62
COMMUNITY	100	165	36
	3361	**3342**	**768**

What is the data telling us?

The above table includes adult, child and neonatal deaths

There were 100 fewer inpatient deaths in 18/19 but there were 20 more ED and 65 more community deaths so the overall number was very similar

* Community Deaths are usually those where death certification is facilitated by UHL's Bereavement Services, requested by the Coroner's Office. Not all will involve the Medical Examiner Screening and therefore will not be included in "performance data"

Deaths covered by UHL's "Learning from the Death" process 17/18 to Q1 19/20 – Adult, Child, Neonate

	APR 17 to MAR 18	APR 18 to MAR 19	APR to JUN 19 Q1
ADULT	3026	3223	739
CHILD	35	37	7
NEONATES/PERINATAL	100	82	22
	3361	**3342**	**768**

What is the data telling us?

- UHL is one of England 'top 5' trusts for activity and also for the number of deaths
- UHL has both children, maternity and specialised neonatal services

For the purposes of our Learning from Deaths framework Neonates are babies who are born in UHL or in another hospital and transferred to our Neonatal Unit (can also be referred to as Perinatal Mortality but this is 'age specific') Children includes all children between 0 and 16 years (where not considered to be 'Neonates)

Death Certification discussed with the Medical Examiner July 2016 to July 2019 - Adult Deaths only

	Year 1	% Discussed	Year 2	% Discussed	Year 3	% Discussed
LRI	2180	**75%**	2281	**87%**	2228	**92%**
Glenfield	585	**14%**	677	**80%**	710	**90%**
LGH	219	**14%**	221	**82%**	211	**94%**
Total	**2984**	**59%**	**3179**	**85%**	**3149**	**91%**

What is the data telling us?

UHL's Medical Examiner process started in July 2016 and MEs have supported over 7,000 certifying doctors to date

The data in the above table includes Adult Inpatient and ED deaths only as death certification of Community deaths is arranged by the Coroner's office.

In the first 12 months of implementation of the ME process, certifying doctors were encouraged but not required to discuss with the MEs.

- Until recently deaths within an hour of ED /CCU arrival (usually 'out of hospital cardiac arrests') were automatically referred to the Coroner's office by Bereavement Services without discussion with the Medical Examiner. The Coroner's office has now asked that all deaths are initially discussed with the MEs even if referral is an absolute requirement (i.e. no return of spontaneous circulation following cardiac arrest).
- Medical Examiners are now available to speak to certifying doctors over the phone where 'out of hours urgent release' is requested.
- Future plans are to provide advice to certifying doctors for child and neonatal deaths, in line with national requirements

Number and % of Adult Deaths Screened by a Medical Examiner

	16/17 In-Patient Deaths at the LRI Only		17/18 All Sites – ED and In-Patient Deaths		18/19 All Sites - ED/InPt/Comm		Q1 - 19/20 All Sites ED/InPt/Comm	
	Deaths	**Screened**	**Deaths**	**Screened**	**Deaths**	**Screened**	**Deaths**	**Screened**
Q1	N/A	N/A	726	99%	781	99%	735	99%
Q2			711	98%	737	99%		
Q3			858	97%	810	99%		
Q4			941	91%	895	99%		
Total	**1511**	**86%**	**3236**	**96%**	**3223**	**99%**	**735**	**99%**

What is the data telling us?

Both the scope of the ME process and percentage of cases screened has increased year on year.

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

Following review and changes to our administrative processes with close support from the Bereavement Services team and flexible working from our Medical Examiners we have been able to consistently exceed our target of 95% and to routinely screen community deaths (where the death certification process is facilitated by UHL).

In 19/20 our focus will be to improve the timeliness of screening, particularly for deaths at the LGH and Glenfield site and those referred to the Coroner.

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,

Bereavement Support Service

- The Bereavement Support Service (Adult) offers bereaved families/carers the opportunity to talk about what matters to them regarding their bereavement and offers information and support and signposting to bereavement counselling and other support organisations as required
- **Follow up contact by the Bereavement Support Service is offered to the bereaved relative/carer for all UHL adult deaths**.
- Contact is offered either by the Ward staff or Bereavement Services. Where death referred to the Coroner, the BSN contacts the family directly
- Contact is made by the Bereavement Support Nurse (BSN) 6-8 weeks after the death

- **2,250 (70%) families of deceased patients in 18/19 requested** follow up by the Bereavement Support Nurse (BSN)
- BSN have to date managed to speak to **1,740** of bereaved relatives who requested telephone follow up
- Where telephone follow up requested but the BSNs are unable to speak to the family on the phone, a voice mail message, letter or email is sent (as agreed at time of requesting follow up) with the BSN contact details for future reference

Outcome of BSN Follow Up

The BSN follow up contact has two main aims

Firstly to identify if the relative/carer has any unmet bereavement needs in order to give them advice about available support agencies.

Of the 1740 relatives/carers given follow up contact

- 402 were 'signposted' to support agencies with most frequent being:
  - Age UK (29)
  - The Carers Centre – Leics (40)
  - Child Bereavement UK (37)
  - CRUSE (37)
  - The Sharma Centre (40)
  - Silverline (25)
  - Way Up (50+) (25)
  - GP (31)
  - Amica (14)
  - Bereavement Trust (11)
  - Coping with Cancer (13)
  - Hopesupport – online for 11-25 yrs (15)
  - WAYoung (11)

Outcome of BSN Follow Up

The other aim of the BSN phone call is to identify if the relatives have any unanswered questions about the care provided.

123 contacts led to feedback being given to the team about the relatives' experience

For 68 relatives/carers, the BSN were asked to organise a meeting with the clinical team

62 relatives / carers had either already made a complaint or the BSNs assisted with complaint process

Where further questions/ meeting requested and "case closed"

	Yes	Partially	No
Were Questions Answered	125	6	3
Satisfied with Outcome	107	11	4

When asked if the BSN follow up contact had been helpful, where response provided:

807 said they didn't feel they needed

899 said Yes

3 said No

Since October 2018, the BSNs have been asking relatives if the Medical Examiner phone call was helpful

Yes – helpful – 539

Unable to say / Didn't need – 378

No – unhelpful - 4

Feedback on Standard of Care Received

Both the Medical Examiners and the Bereavement Support Nurses ask the relatives/carers about their experience of care or for feedback on the care provided

18/19	Very Poor / Poor	Satisfactory / Adequate	Good/ Very Good	Unable to say	Total Asked
Feedback to BSNs	119	154	1116	297	1686
	9%	11%	80%	N/A	

18/19	Concern	Gen Happy / No Concern	Compliment		Total Asked
Feedback to MEs	503*	835	518*		1758
	29%	47%	29%		

*98 relatives had both concerns and compliments

The above data is currently being reviewed to better understand what it is telling us as this is the first year we have collated both BSN and ME feedback.

Number of Adult Deaths and Further Review in 2018/19

Further Review details	All	
No further review	2,266	69%
Structured Judgement Review*	327	10%
Clinical Review	400	12%
Feedback	192	6%
Theme Review	15	0.5%
Follow up by Bereavement Support	43	1%
Patient Safety Team / SI Investigation**	20	0.5%
ALL (includes Community Deaths where screened)	**3,223**	

What is the data telling us?

***Some deaths may be referred directly for SJR without ME screening if meets National Criteria**
*** 7 Deaths were subject to a Serious Incident investigation**

6% of deaths have been referred for Feedback only – mostly relates to staff attitude, communication issues

Of the 327 adult cases referred for Structured Judgement Review 118 met the national criteria for review (death post elective surgery 62; patient with learning disability 30; serious mental illness 26)

Reviews Requested in Q1 19/20

	Adult	Child	Neonatal	All
None	542			542
SJR	66	7	22	95
Clin Review	60			60
BSS F/Up	15			15
Feedback	47			47
PST F/Up	2			2
Theme Review	4			4
Awaiting screen	4			4
Grand Total	**739**	**7**	**22**	**768**

Progress Update on ALL 18/19 Deaths Where Structured Judgement Review, SI Investigation

	Completed	In progress	% completed	ALL
SJR/SIs*				
Q1	120	9	93%	129
Q2	96	11	90%	107
Q3	91	15	86%	106
Q4	81	28	74%	109
All (to date)	**388**	**58**	**86%**	**453**

- Where a death is subject to a Serious Incident Investigation, an SJR may not be undertaken as the SI investigation findings will be used to inform the Learning from Deaths programme.

- There were 7 deaths in 18/19 where an SI Investigation was undertaken

Death Classifications for All Deaths where SJR or SI Completed

DEATH CLASSIFICATION	REASON FOR REQUESTING SJRS FOR ADULT DEATHS IN 2018/19 (to date)							
	ME	Rels	Child / Neonate	El Proc	LD	SMI	Specialty	Total
1	2	2	1					5
2	21	4	6	2	1	3	1	38
3	58	14	26	6	8	5	3	119
4	35	11	40	24	10	8	5	133
5	18	5	35	11	10	9	5	93
All	134	36	108	43	29	25	14	388

What is the data telling us?

There have been no further cases since the last report given a Death Classification of 1

0.15% of deaths in 18/19 were considered to be more than likely due to problems in care

DC	Death Classification Rational
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 not thought to have contributed to death
4	No problems in care
5	Good or Excellent Care.

Adult Deaths in 18/19

For the adult deaths given a Death Classification of 1:

Cardiology and Cardiac Surgery – problems in care related to delays with referral from a another hospital and also once arriving at UHL . The death has been investigated by the Patient Safety Team.

- Need for a TAVI Co-ordinator identified as the key action.

Nephrology and Renal Transplant – CMV negative patient received CMV positive kidney without appropriate prophylaxis – this death has been investigated and reported externally as a Serious Incident and was a Coroner's Inquest

- Actions related to review and changes being made to the Transplant work up and pre op pathway

Trauma and Orthopaedics – problem in care related to patient not receiving thromboprophylaxis when immobile due to injury who then had a cardiac arrest due to pulmonary embolism. Investigated and reported as a Serious Incident and reported to the Coroner.

- Lower Limb Immobility Pathway and Thromboprophylaxis implemented in ED and Fracture Clinic

Emergency Department / Vascular Surgery

Delay in recognising a patient presenting with features suggestive of AAA.

32 Adult cases have given a Death Classification of 2 by the Specialty M&M.

- Key Learning points were:

• **Delay in transfer to CCU**	• **Review of Hb in dialysis patients receiving EPO**
• **Staff need to be very careful with relevant blood results. Serum Calcium blood tests on admission**	• **Recognising and treating Type 2 Respiratory failure and familiarity with NIV at the LRI**
• **Xray reviews – should be reviewed on admission and when reaching base wards**	• **Interpretation of abnormal findings on CXR and positioning of NG tube**
• **Sub-optimal management of PD meds**	• **Access to gastroenterology advice out of hours**
• **Knowledge and communication / treatment of Atrial Fibrillation**	• **Patient on surgical ward at LGH - should have had Medical review**
• **Regular blood tests in relation to fluid management/obstructing type problems**	• **Fluid management of hypernatraemia Recognition of delirium**

Early themes from Feedback and Reviews of Deaths in 18/19

- Over 1,000 cases have been sent either for an SJR, clinical review, patient safety review/investigation, or as feedback for reflection

- Learning has been identified from 300 reviews to date with actions agreed for over 260 cases

- The main area of learning from adult deaths identified through both the ME process and specialty reviews appears to still relate to end of life care, ceiling of care, palliative care and DNACPR
- The other key learning theme is around communication – this was identified through feedback to the BSNs as well as MEs and relates to communication between clinical teams and also between staff and patients/relatives

- Other areas of learning are similar to 17/19:
  - Escalation, Senior Review (both in ED and on the Ward)
  - Handover, Transfer of Care
  - Fluid management, Sepsis, Acting on Results, Diabetes management
  - Pathways of care: Acute abdomen, cardiology, TAVI

- The majority of actions relate to raising awareness of learning or feeding back to individuals

- Theming of Learning and Review of Actions has been commenced.

- In addition to feeding back to clinical teams and awareness raising, improvement actions identified include:

  - Addisons Crisis Guidelines development and ePMA prompt about steroid safety
  - Review of Postpartum Haemorrhage Guideline
  - Development of Acute Abdomen Pathway
  - Review of Cross Site Transfers Pathway
  - Training about using hoists in bariatric patients

Learning from Deaths of Patients with a Learning Disability

- 31 reviews were undertaken of patients with a Learning Disability/Difficulty during 18/19

	1	2	3	4	5
Overall Care Score	0	3	7	16	6
Death Classification	0	0	11	11	10

- There were no deaths where problems in care were considered to have contributed to death – usually due to the patients' severity of illness or co-morbidities. Where problems in care were identified, these were similar to those seen in previous UHL mortality reviews of patients with a learning disability and, for most part, in reviews of all patients.

- Feeding
- Clarity around end of life care
- Recognition of sepsis
- Communication with carers/relatives
- Staff Knowledge of the Mental Capacity Act
- Documentation of MCA Assessments and Best Interest Decisions
- Issues with DNACPR's, ie not being being done inappropriately, no consultation with relatives etc
- Use of Patient Portfolios/Grab Sheets to support care whilst in hospital

- A report with details of all cases reviewed has been presented to the Learning Disability Steering Group to confirm if actions to improve care have already been incorporated into their work programme

Score	Death Classification Rational	Quality of Care Score Criteria
1	**Problems in care thought more likely than not to have contributed to death**	**Very Poor**
2	**Problems in care but unlikely to have contributed to death**	**Poor**
3	**Problems in care but not thought to have contributed to death**	**Adequate**
4	**No problems in care**	**Good**
5	**Good or Excellent Care.**	**Excellent**

Child Deaths – 18/19

"Child Deaths" include babies under one year, where the baby died outside Maternity / Neonatal Unit.

There were 37 Child Deaths included in the UHL Learning from Deaths Process in 18/19

All child deaths are also reviewed by the LLR Child Death Overview Panel (CDOP).

5 Child Deaths were reviewed as part of the Specialty M&M process but the child died following discharge or transfer from UHL .

All 32 in-hospital deaths have been or are being reviewed as part of the relevant Specialty M&M process.

Work has already started to better co-ordinate UHL's M&M process with that of the LLR Child Death Overview Panel (CDOP) and we are looking to pilot the ME process for child deaths in the Autumn

There were two cases given a death classification of 2 (problems in care but unlikely to have contributed to death)

The reason for the death classification was because:

- problems with ECMO cannulation
- known procedural complication

Agreed actions are:
Early cath+/- intervention if early postop ECMO required
Conduct resuscitation simulation within the Cath Lab
Change in VA cannulation practice

Neonatal Deaths – in 18/19

"Neonatal Deaths" include babies who either die on the Maternity Unit or in the Neonatal Unit.

There were 82 deaths during 18/19

All deaths are reviewed and discussed at the Perinatal Mortality Review Group which reports to the Perinatal Mortality Oversight Group. Deaths of babies born from 23 weeks of gestation are also reviewed by CDOP

UHL reports on its perinatal mortality nationally to Mothers and Babies: Reducing Risk through Audits Confidential Enquiries across the UK (MBRRACE). From December 18 we have been using the Perinatal Mortality Review Tool (PMRT) in line with the NHS Resolution Maternity Incentive Scheme Safety Action 1

76 Reviews have been completed for Q1-4 deaths

There were 4 deaths where there were problems in care but unlikely these contributed to death.

Identified learning related to:

- Growth monitoring (2)
- Fetal movement monitoring (1)
- Diabetes (1)

1 death was considered to be due to problems in care and has been investigated as a Serious Incident in collaboration with the Ambulance Service.

Actions have been agreed for all 5 cases which are on track or have been completed..

NHS Resolution Maternity incentive scheme – year two

- NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.
- The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.
- The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Requirements for Safety action 1:

Are you using the National Perinatal Mortality Review Tool to review perinatal deaths* to the required standard?

a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.

b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.

c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.

d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.

* Includes babies born from 23 weeks gestation onwards and excludes deaths arising from Termination of Pregnancy

NHS Resolution Maternity Incentive Scheme

Perinatal Mortality Review Tool (PMRT) Dashboard – Performance as at end July 2019

				SAFETY ACTION 1		
Month	**Eligible Stillbirth**	**Eligible Neonatal Death**	**Eligible Late Fetal Death**	**a) % PMRT started by 4 months**	**b) % draft report within 4 months**	**c)Parents Informed & consulted before the review**
Dec 18	**2**	**0**	**0**	**100%**	**50%**	**50%**
Jan 19	**1**	**1**	**0**	**100%**	**50%**	**100%**
Feb 19	**3**	**4**	**0**	**100%**	**71%**	**100%**
Mar 19	**3**	**1**	**0**	**100%**	**50%**	**100%**
Apr 19	1	3	3	100%		86%
May 19	4	3	1	100%		100%
Jun 19	5	2	0	100%		100%
Dec 18 to Mar 19	**9**	**6**	**0**	**100%**	**60%**	**95%**

Safety Action 1d) Learning and Actions of PMRT Cases completed in last Quarter

M&M Ref	Mth of Death	Mth of Review	Learning	Action	Action Status
2669	Jan 19	May 19	Patient should have been referred to FM Team within ½ weeks of the anomaly scan as early identification of IUGR would have given the option of an early delivery. CMW did not realise p/t had suffered from an IUFD	Meet with antenatal services manager to arrange feedback to sonographers Review the new stillbirth care pathway to ensure that agencies are informed at time of IUFD not at time of delivery	In Progress
2920	Feb 19	May 19	There is a lack of appreciation and understanding of the impact of diabetes (especially poorly controlled) on pregnancy and how this should alter the care There is a lack of awareness regarding the local guidance around care of women with Diabetes The working practices, patient pathways and physicality of the Maternity Assessment Unit (MAU)at LRI can lead to a lack of oversight and a failure to escalate patients to senior clinicians	Task & Finish Group to review MAU to include -working practices, patient pathways, physicality of the unit, escalation of workload concerns and junior doctor support provision Local training, information dissemination and aids to improve knowledge regarding Diabetes and its' relevance in pregnancy	In Progress
2921	Feb 19	May 19	This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals because of capacity issues Estimated fetal weights from scans were not correctly plotted	Meet with antenatal services manager regarding GROW training for sonographers	In Progress
3195	Mar 19	May 19	This mother's progress in labour was not monitored on a partogram	The intrapartum matron will undertake 'tea trolley teaching' on the importance of the partogram when caring for a woman with an IUFD.	In Progress
3311	Mar 19	Jun 19	Management of trauma in pregnant women	Head of service to liaise with A&E team to discuss. For O&G SpR to review care.	

Next steps

- Improve the timeliness of Medical Examiner screening
- Embed the ‘out of hours’ ME process for ‘urgent releases’
- Pilot the ME process for paediatric deaths
- Embed the improvements made in respect of Coroner referrals
- Follow up outstanding reviews and seek updates on actions
- Complete collation of learning identified through reviews (both SJRs and clinical review, patient safety reviews) to confirm if cross cutting themes and to share with Specialty M&M Leads
- Continue to liaise with the Regional Medical Examiner
- Share our experience with other Trusts at the National Annual Mortality Conference in October