Learning from Deaths

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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 Quarters 1 and 2 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 it be completed?

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 'year to date' crude mortality remains at 1.1% Our monthly mortality rate increased to1.5% in December in line with previous years' seasonal variation and has reduced slightly to 1.4% for January 18.

UHL's latest published SHMI is 100 (covering the time period July 16 to June 17) and our HSMR is 99 (for same time period).

Analysis of our SHMI and HSMR, using the HED clinical benchmarking tool, shows that both our HSMR and unpublished SHMI are 96 for the 12 months Oct 16 to Sept 17.

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 continues with a particular focus on sepsis and acute kidney injury.

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

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 and 2 the MEs screened 1381 (97%) of all adult deaths (includes community deaths where deceased brought to UHL's mortuary). At time of reporting, 89% of Quarter 3'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 has been undertaken during January and February.

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 383 deaths have been referred or met the national requirement for SJR in Quarters 1 to 3. This includes deaths meeting the national SJR criteria (32 deaths of patients with Learning Disability or Severe Mental Illness; 92 deaths of Children/Neonates and 47 deaths following an 'elective' procedure).

271 deaths were referred for SJR in Quarters 1 and 2 and 218 (80%) SJRs have been completed and death classifications confirmed. Our internally set target is that 75% of SJRs should be completed within 4 months of death and 100% within 6 months.

Therefore all of Quarter 1's deaths should have had SJRs completed at the end of December but current performance is 89%. However, not all SJR details have been collated due to capacity constraints within the Corporate M&M Admin team and capacity within the Specialty M&M teams. 75% of July and August's deaths should have had completed SJRs and current performance is 68%.

There were 5 patients where problems in care were thought more likely than not to have contributed to the death (Death Classification = 1) and these have been or are being investigated as Patient Safety Incidents. Two have been confirmed as being Serious Incidents, one involved a patient who self-discharged from the Emergency Department and the other was an Intrauterine Fetal Death following a complicated pregnancy and delayed induction of labour.

"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 Medical Examiners 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'.

End of Life and DNACPR is a also key theme from the Specialty reviews, with communication issues being another, especially between Specialties or with relatives.

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.

In addition to the specific actions being taken in response to the learning identified through individual reviews, there continues to be the trust-wide focus on embedding the Sepsis Clinical Rules and NerveCentre as a handover tool.

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.

A business case has been submitted for additional administrative and analytical support and for increased capacity in the Bereavement Support Service.

3. LLR Clinical Quality Audit

Due to the complexity of arranging data sharing agreements and access to the primary care records, significantly fewer patients case notes were audited than planned. The audit findings are due to be reported in March 2018.

Mazars identified 11 patients for individual review by the Trust. The case notes for these patients have been retrieved and are being reviewed for discussion at the Mortality Review Committee.

Input Sought

Members of the Trust 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 Clinical Quality Audit will not include all patients as originally planned and that the report is due in March 2018.

Appendix 1

UHL Mortality Report Slide-deck

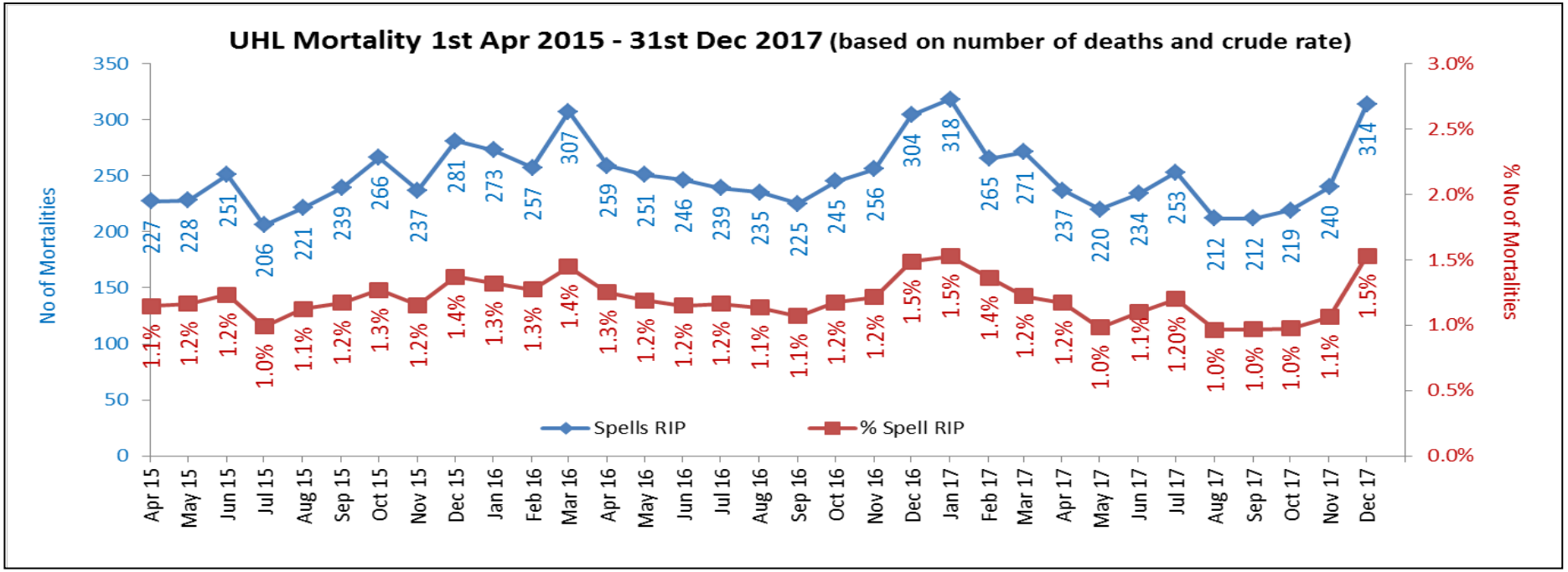
2017/18 - Quarters 1 - 3

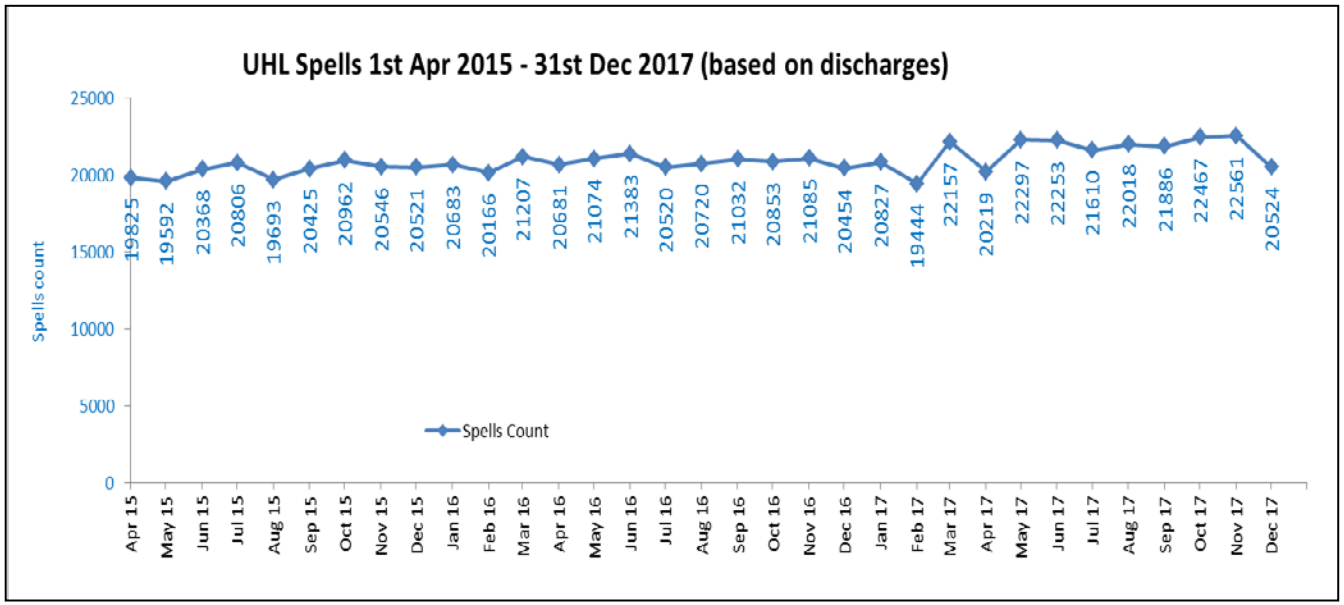
Head of Outcome & Effectiveness and Deputy Medical Director
Sponsor: Medical Director

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 April and December 2017 and what is the Trust's crude mortality rate?





What is the data telling us?

The number of deaths in Dec 17 have risen compared to previous few months but appears to be in line with the usual seasonal variation. In addition the number of admissions during December was reduced as some Elective activity was 'taken down' Therefore our crude mortality for December was1.5%. January's mortality rate has come down slightly to 1.4%

UHL's 17/18 'year to date' crude mortality rate is 1.1%

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

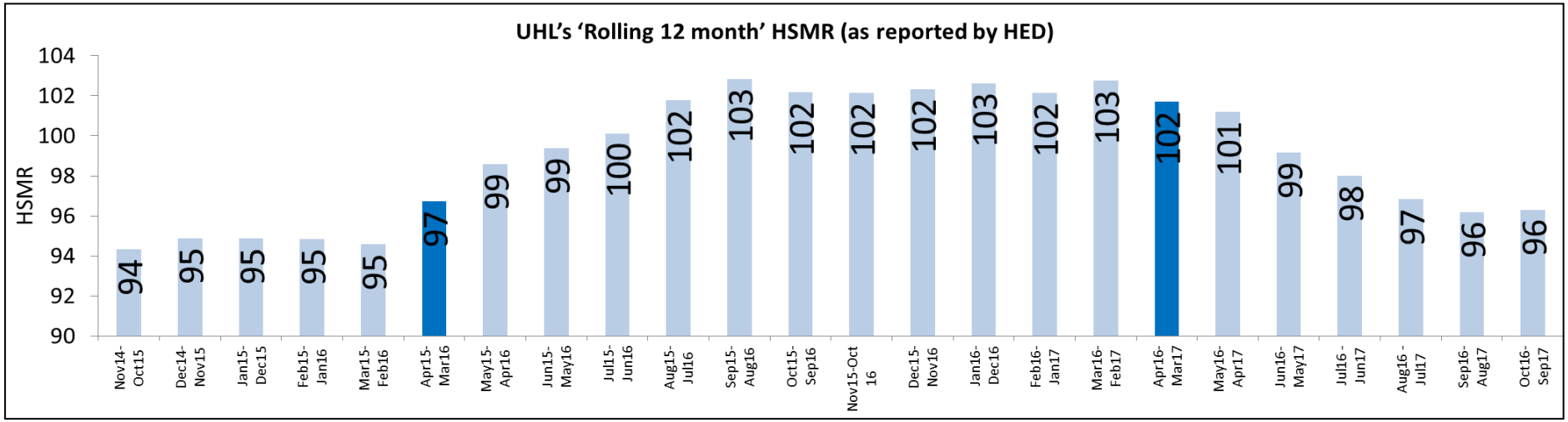
HSMR:
Hospital Standardised Mortality Ratio

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

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

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

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



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 (Oct16 to Sep17) is 96 and our monthly HSMR has been below 100 for the past 7 months in both the DFI and HED tools.

It is anticipated that the monthly HSMR will remain below 90 for October but is then likely to increase for November and December due to the increase in number of deaths for those months.

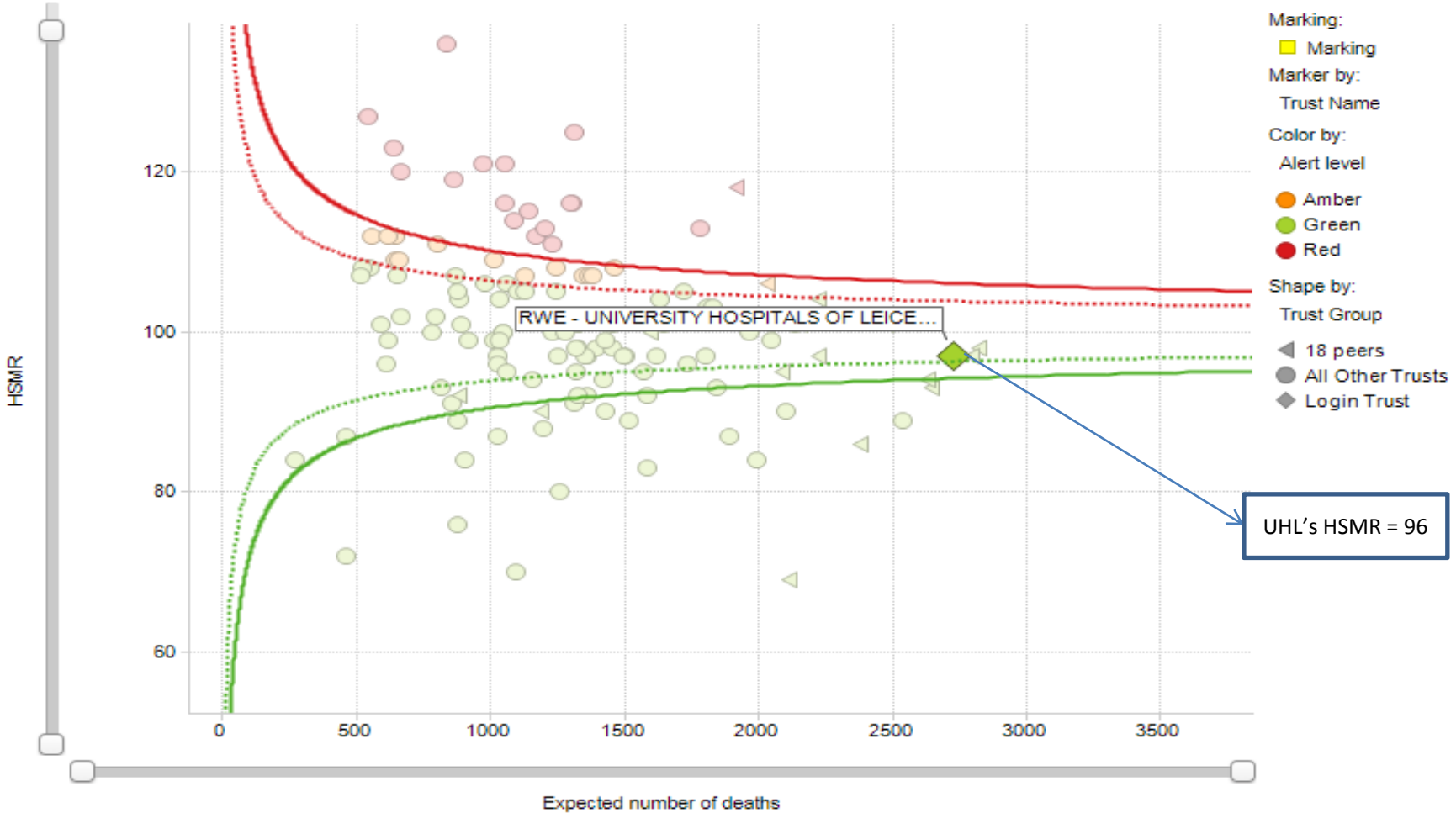
The 17/18 HSMR is 92 (as reported by HED) for the first 6 months of this financial year.

Financial Year	HSMR (HED)	HSMR (DFI)
2014/15	95	94
2015/16	97	96
2016/17	102	101
2017/18 (Apr-Sep 17)	92	86

How does UHL's HSMR* compare with other trusts? (Oct 16 – Sep 17)
*Data taken from HED

Figure 1b: Funnel Plot (Rebasing period up to September-17)

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



What is the data telling us?

UHL's latest HSMR and is in line with our 'peer trusts' (similar sized trusts) and is almost 'below expected' for the 12 months Oct 16 to Sept 17

Update where UHL has received a DFI CUSUM[1] alert

Alert	Alert Details	Latest HSMR (Oct 16-Sept 17)	Actions being taken
Acute Myocardial Infarction (AM)	139 (Aug 15 to Jul 16)	95	Embedding Clinical Decision Tool To be linked to ICE and further 'awareness raising' On-going audit – due to report in March Review of Cardiology Service capacity and configuration
Coronary Artery Bypass Graft – Complex and with Valves (CABG Other)	212 (Apr 16 to Mar 17)	208*	Pre-publication of NICOR data shows UHL has a a higher risk case mix and our outcomes are in line with national average. Cardiac Surgery Flow Co-ordinator in place Referral Criteria and Pathway reviewed and revised
Coronary atherosclerosis and other heart disease (CAD)	199 (Jan to Dec 16)	139	Actions link to above Review of Out of Hospital Cardiac Arrest pathway and coding rules

***UHL's HSMR for CABG Other is still 'above expected'**

[1]CuSum stands for Cumulative Sum and is an alert where the outcome is at least twice as high as the national benchmark.

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

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

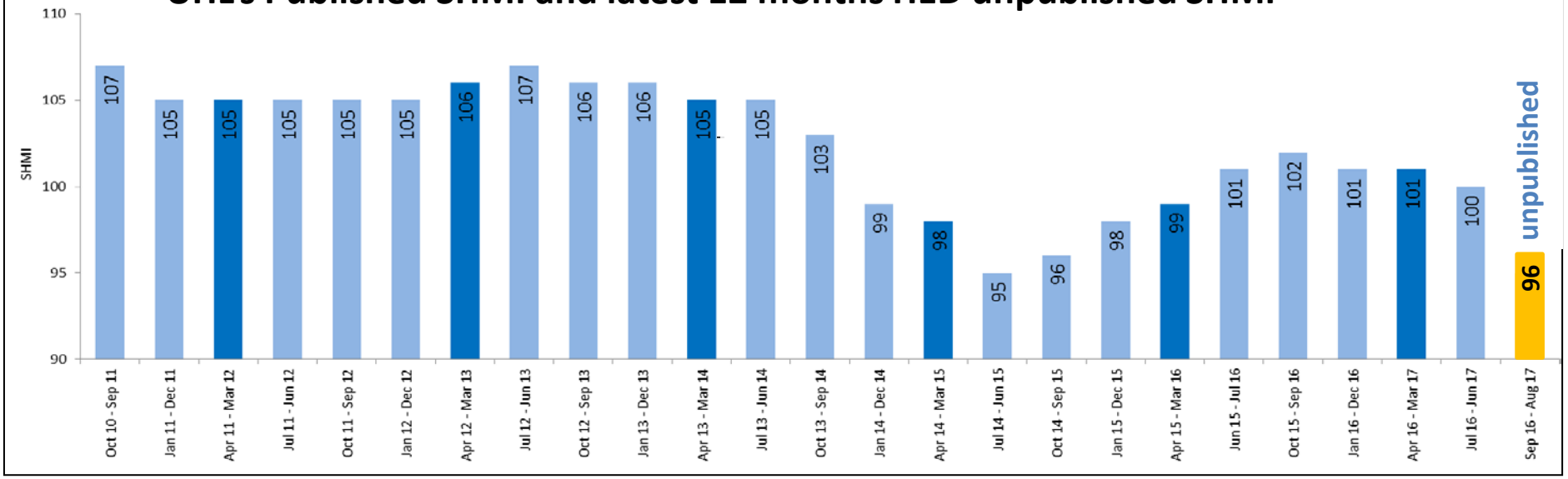
UHL subscribes to the University Hospitals of Birmingham's "Hospital Evaluation Dataset" Clinical Benchmarking tool (HED) which uses HSCIC methodology to replicate SHMI. This then allows us to review our SHMI pre publication.

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

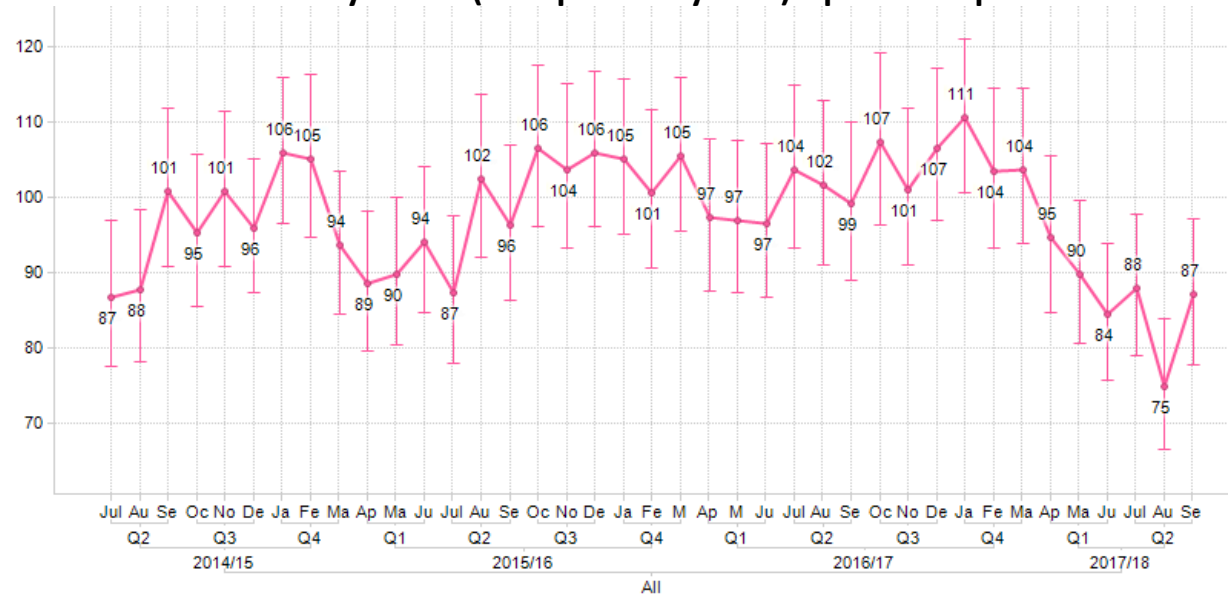
Due to the SHMI involving 'out of hospital deaths' the reporting timeframe is a month behind that for the HSMR.

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

UHL's Published SHMI and latest 12 months HED unpublished SHMI



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



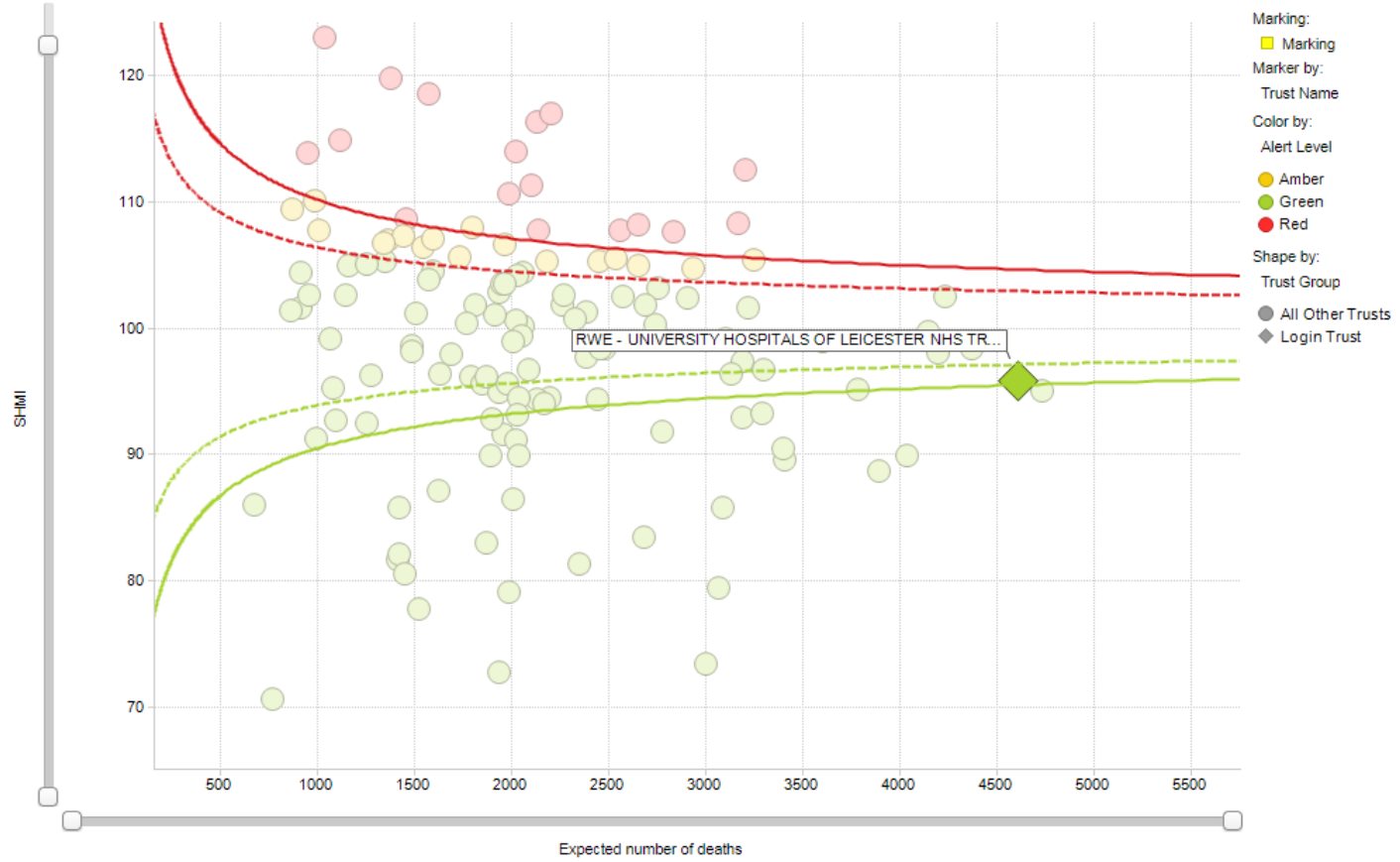
What is the data telling us?

- UHL subscribes to HED which uses HSCIC methodology to replicate the SHMI
- UHL's latest published SHMI (Jul 16-Jun 17) is **100**
- The monthly SHMI has been below 100 for the last 6 consecutive months so dependant upon national rebasing, we may see a further reduction in our published SHMI (Oct 16 to Sept 17 – due March 18).

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

Figure 1.2: Poisson Distribution (PD) Funnel Plot

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



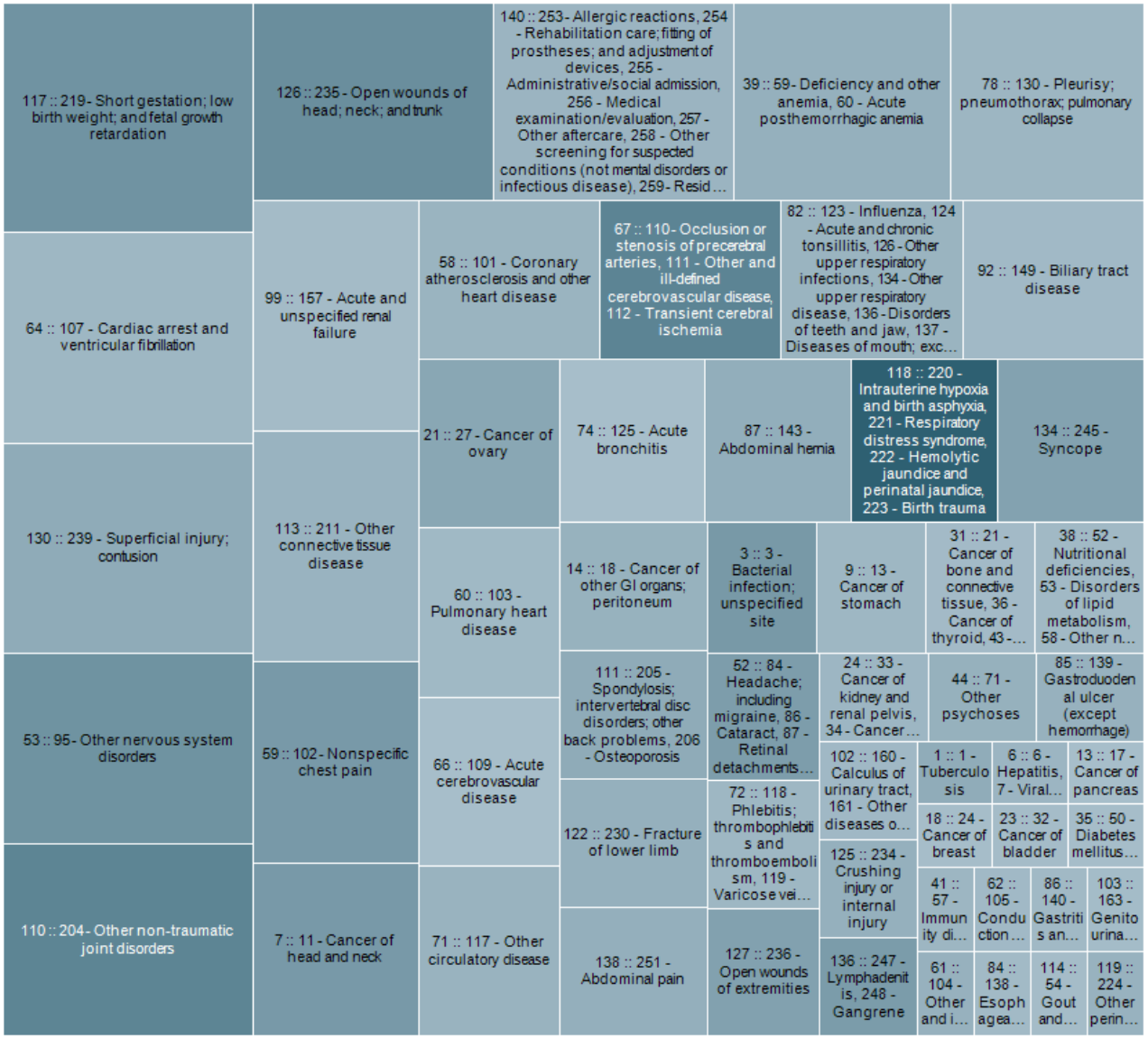
What is the data telling us?

UHL's unpublished SHMI for the period Oct 16 to Sept 17 is 96 and is almost 'better than expected'

Whilst our published SHMI for this time period will not be available until March 18 and may not remain at 96 - following further rebasing nationally - there has been a continual improvement in our unpublished 'rolling 12 month SHMI' for the past 7 months.

Which are the diagnosis groups most contributing to our SHMI?

Diagnosis Groups with a SHMI above 100 (Oct 16 to Sept 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

'Intrauterine hypoxia & birth asphyxia', 'Other non traumatic joint disorders' and 'Occlusion or stenosis of precerbral arteries' are the top 3 diagnostic groups with a SHMI score of 323, 239 and 237 respectively.

'Cardiac Arrest' , Short gestation; low birth weight' and 'Superficial Injury' are the top 3 diagnostic groups with excess deaths. The number of excess deaths to the expected is 12, 11 and 11 respectively.

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. Cardiology Head of Service reviewing the 'activity recording' of such patients and Head of Information reviewing the national clinical coding rules.
Superficial Injury	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' 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. Clinical Coding Auditor reviewing case notes to clarify

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 to December17

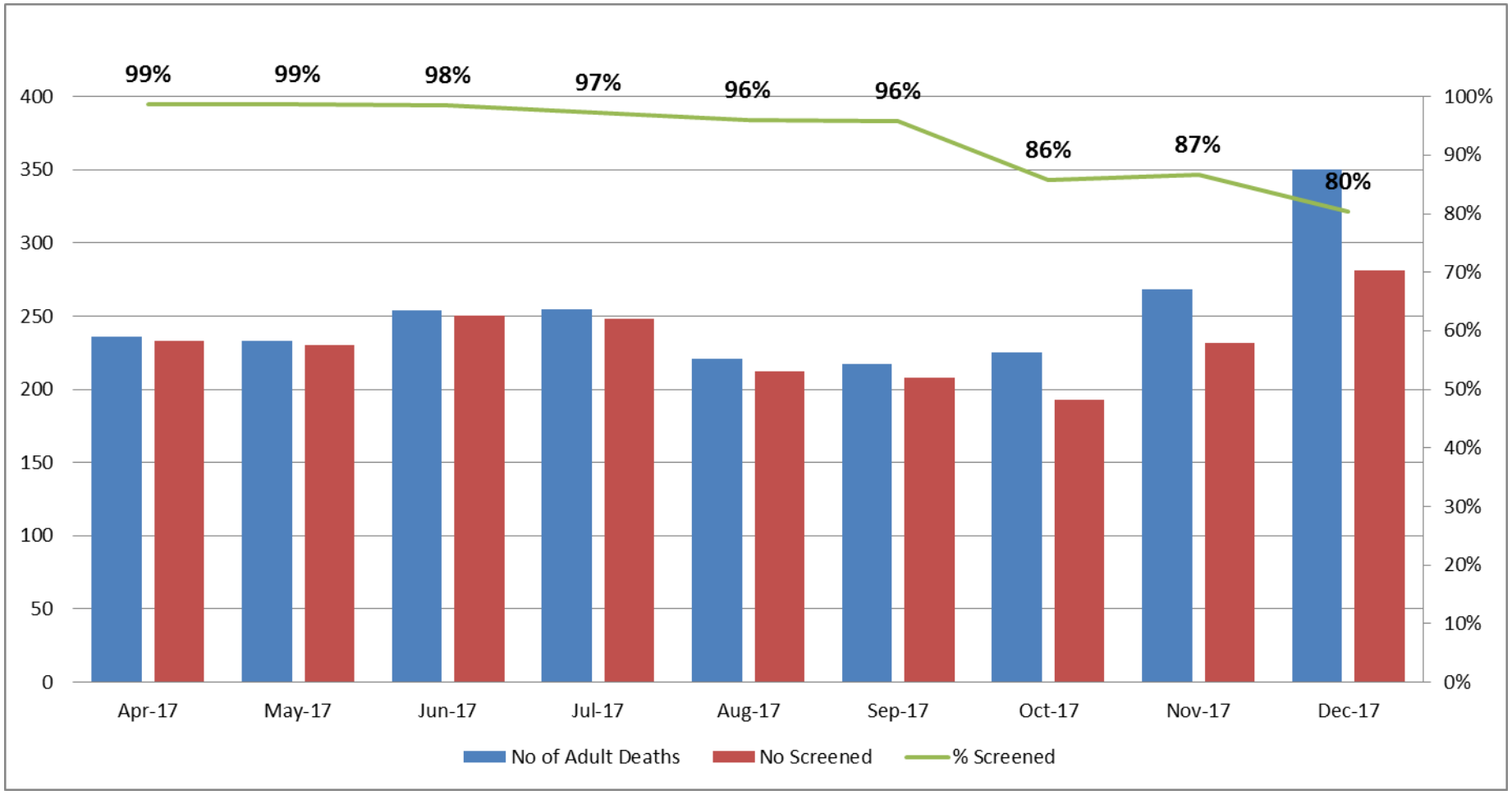
PLACE OF DEATH	ADULT / CHILD / NEONATE	NUMBER OF DEATHS
ED		**164**
	Adult	154
	Child	10
Inpatient		**2161**
	Adult	2078
	Child	21
	Neonate	62
All	Adults/Paeds	**2325**
COMMUNITY DEATHS *		**63**

What is the data telling us?

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

❖ Some Community Deaths are dealt with by the Medical Examiners, where deceased brought to UHL's Mortuary

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



What is the data telling us?

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

Of the Q3 cases not yet screened, most for October and November were referred to the Coroner which delays the screening process. Two new MEs started in December which increased capacity but at the same time there was an increase in the number of deaths

Mortality Screening - Key Themes – Quarters 1-3

The table below summarises feedback/comments from the Medical Examiners after their 'screening' of the case notes and speaking to the bereaved relatives. The themes were not mutually exclusive.

Theme	No.	Sub themes
End of Life (EoL) / Do Not Resuscitate Orders) DNACPR	110	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	56	Mainly relates to relatives' concerns, includes communication relating to prognosis, deterioration, death or being able to contact ward/consultant
Discharge / Admission	41	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	41	Includes in-patient observations, ward round reviews, out-patient follow up; transfer between sites; delays with senior review
Acting on Results	20	Investigations – both following up and acting on results
Nursing Care	30	Responding to Buzzers, Feeding, General Care and Staff Attitude
Sepsis	32	Earlier recognition, timely delivery of Sepsis Care Bundle; risk of Fluid Overload
Escalation	11	Escalation of EWS or escalating for senior review or higher level of care
Medication	15	Delays, Toxicity, Omissions of Critical Medicines
Others		Pain Management (7); CT - Delays/AKI (5) Chest Drain/Pneumothorax (5) Pathways (8) Diabetes Management (4)

Mortality Screening Themes - Learning & Actions Being Taken

Where Mortality Screening by the ME (to include speaking to the Bereaved) identifies potential learning or problems in care, cases will be referred for further review of the individual patient's care and immediate feedback given to individual clinicians, where applicable.

Whilst individual reviews will help identify areas for improvement for clinical teams at a local level, the Mortality Review Committee has also reviewed the themes to consider if appropriate actions are in place at a trust level.

Theme from ME Screening	Actions being taken
End of Life / DNACPR	End of Life Care Health Improvement Team undertaken 'Fresh Eyes Visit' to help support the Trust with improving End of Life Care. Resuscitation Committee working in collaboration with the End of Life & Palliative Care Board to develop implementation plans for ReSPECT Further discussions to take place at the LLR End of Life Care Board
Communication	Plans to relaunch 'Dying Matters' as communication related to patients' deterioration and end of life care is a key aspect.
Discharge / Admission	Implementation of ReSPECT should support better discharge planning for patients approaching end of life care and should also provide appropriate plans for supporting patients whilst in the community
Clinical Monitoring	Links to the 7 Day Services work streams and earlier Consultant Reviews, Daily Consultant Ward Rounds
Acting on Results	One of UHL's Quality Commitment work streams
Sepsis / EWS escalation	Sepsis rules being tested. Continual monitoring of compliance with sepsis care bundle and eObs / escalation process.

What happens where MEs think further review required?

- **MEs refer cases for:**
  - Structured Judgement Review through Specialty M&M (see slide 23)
  - Clinical Review by Consultant responsible for patient care or Matron/Ward Sister
  - Feedback to other organisations

- **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

- **Feedback to other organisation has been sent to:**
  - Ambulance Trust (EMAS); Mental and Community Hospitals (LPT); Primary Care; Nursing Homes 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.

Medical Examiner Screening (including speaking to Bereaved) – Requests for Further Review in Q1-3

Review Request / Feedback sent to	Number
UHL Review Requested for:	**464***
Structured Judgement Review (SJR)	203 **
Clinical Review by UHL medical/nursing team	261
Non UHL Feedback:	**115***
EMAS	17
Primary Care (via Pt Safety at CCG)	56
LPT (Community Health / Mental Health)	18
Care Home (via Pt Safety at CCG)	15
Other (KGH, Private Hospital, ULH, Carers at Home)	5

*For 36 patients reviews/feedback were for both UHL and non-UHL
** A further 84 SJRs were requested for adult deaths because they met the National Criteria

Feedback received in the early part of 17/18 not always forwarded to relevant organisations as 'communication channels' have been developed and put in place over the year

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

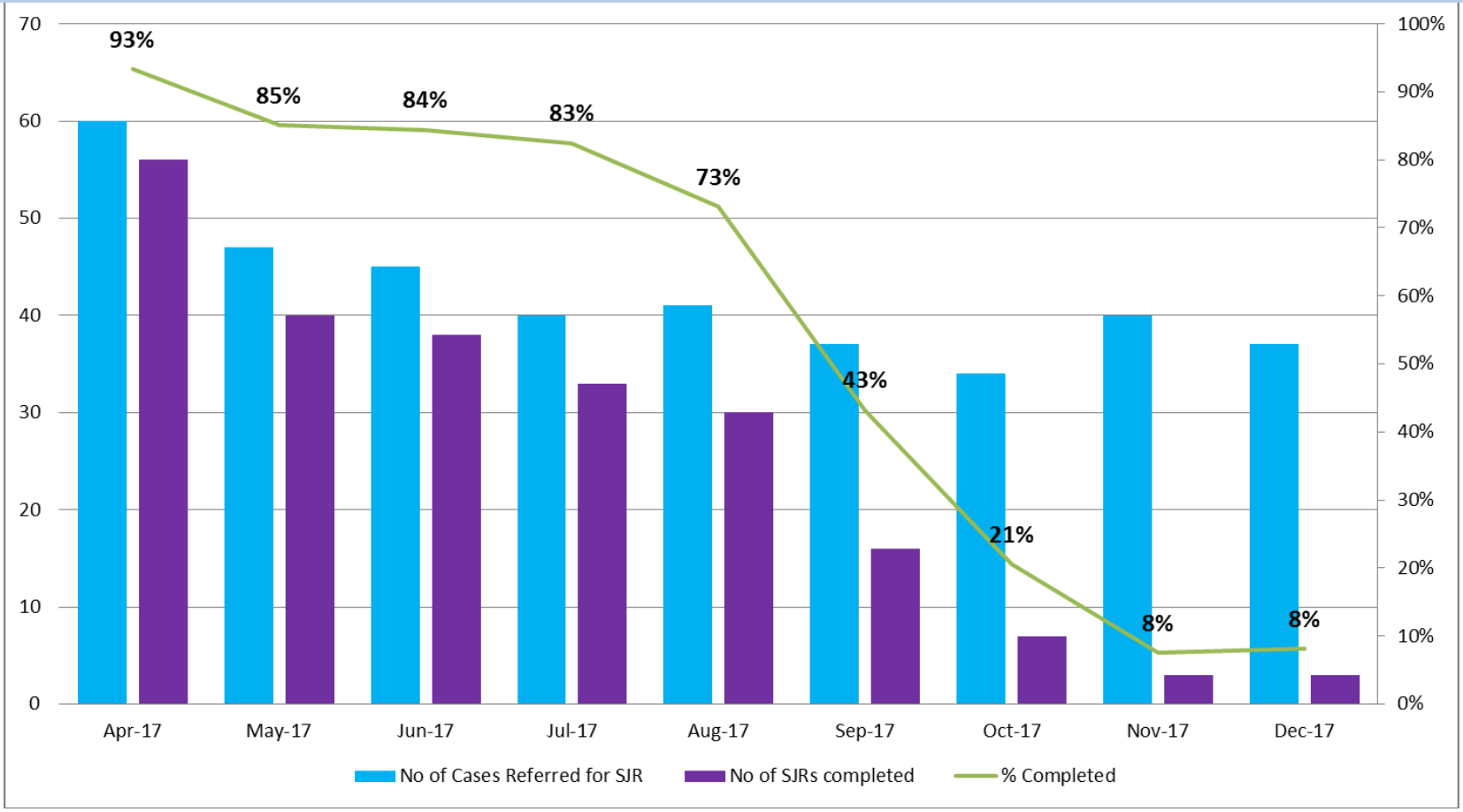
Reasons for SJR Referral

Month of Death	Medical Examiner Screening	Relative's Feedback	Child or Neonatal Death	Death Post Elective Procedure	Death of Patient with LD*	Death of Patient with SMI**	Death where Alert/QI***	All deaths referred for SJR
Apr-17	32	3	13	6	2	2	2	60
May-17	23	2	15	2		4	1	47
Jun-17	26	2	8	4	2	3		45
Jul-17	17	2	11	7	2	2		41
Aug-17	16	2	12	7	2	1	1	41
Sep-17	19	3	7	6	1	1		37
Oct-17	14	1	12	2	3	2		34
Nov-17	24		7	7	1	1		40
Dec-17	19	2	7	6	2	1	1	38
Q1-3	**189**	**17**	**92**	**47**	**15**	**17**	**5**	**383**

*Learning Disability; **Severe Mental Illness, *** Quality Improvement Programme

There were 32 deaths which met the National Criteria for SJR and had also been referred for Structured Judgement Review by the Medical Examiner.

Deaths in Q1 – Q3 Referred for SJR and Number / % Completed



What is the data telling us?

136 of the 152 (89%) cases referred for SJR in Quarter 1 and 82 of the 120 (68%) of the Quarter 2 cases have been completed.

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

Therefore all of Quarter 1's deaths should have had SJRs completed at the end of December and 75% of July and August's deaths should have had completed SJRs. Not all SJR details have been collated due to capacity constraints within the Corporate M&M Admin team and capacity within the Specialty M&M teams.

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

DC	ME Mortality Screening	Feedback from Bereaved	Child/ Neonatal Deaths	Deaths of Patients with LD	Deaths of Patients with SMI	Deaths post Elec Procedure	Deaths where QI / CUSUM	Specialty M&M	All SJRs completed in Q2
1	2		3						5
2	7	1	1		1		1		11
3	50	4	9	5	6	4	1		79
4	44	6	48	5	1	5	2	1	112
5	8	1	6	6	2				23
tbc	78	5	25	31	5	8	1		153
All	189	17	92	47	15	17	5	1	383

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.

Details where Death Classification = 1

M&M Ref	DETAILS OF DEATH	JUDGEMENT STATEMENT	LEARNING	ACTIONS	SI INVESTIATION DETAILS
049	Self Discharged from ED following Asthma attack. Subsequent Cardiac Arrest	Should not have been considered for discharge according to ED pathway. Opportunities missed in ED to keep patient under review	Need for access to clinical information where patients attending the 'Difficult Asthna Clinic" (DAC) Need to improve teenage transition and continuity of care.	DAC to look at putting clinic letters on ICE Review of Teenage Transition process for patients with asthma Education and awareness raising of Asthma guidelines	SI investigation completed. See M&M Actions
551	Patient presented to ED with swollen leg – due to have hernia surgery in private sector days later. Cardiac arrest when adm to private hosp.	Diagnosis of DVT not considered on initial presentation	tbc following receipt of feedback from Locum GP	Seek feedback from Locum GP re clinical decision making	Being reviewed against the SI Framework
1389	Pt died following ischaemic stroke and had previously been admitted with Atrial Fibrillation but anticoagulation not considered	Anticoagulation likely to have prevented stroke which led to death.	Patients with new AF must be considered for anticoagulation urgently All stroke patients must be referred to the stroke team	Disseminate learning to all clinicians in ESM	Currently being investigated as Serious Incident.

Details where Death Classification = 1

M&M Ref	DETAILS OF DEATH	JUDGEMENT STATEMENT	LEARNING	ACTIONS	SI INVESTIATION DETAILS
2663	Intrauterine Fetal Death in patient with history of multiple early miscarriages 39+wks -MAU - no Fetal Movements overnight CTG normal.	Breach of reduced FM guideline, risk factor of age <20 years not recognised when presented with reduced FM	Learning for the individual midwife Need for highlighting that teenage pregnancies are risk factors in themselves if present with reduced Fetal Movements	Feedback to Individual Midwife Highlight in Guidelines Flow and communicate to all Midwives	Moderate Incident RCA undertaken
2668	Intrauterine Fetal Death in Complicated pregnancy, rare blood group Prev PPH Presented with ruptured membranes. Miscommunication with blood bank so blood not x-matched in time so IOL not appropriate to start	There were 4 different Intrapartum care plans in the p/t notes regarding different aspects of care, which facilitated the missed opportunity with the blood bank x-matching.	Mother had 4 different Care Plans filed in different places in notes. Communication failure between the Obstetricians and Blood Bank Staff unaware of significance of the Lu8 antigen ret supply of cross matched blood. There is little guidance for staff regarding the management of women with ruptured fetal membranes.	Design and roll out a single ICP proforma on which all specialist clinics use for Plans. When a red cell antibody ICP is completed a copy will be sent to Blood Bank along with the most recent EMPATH results. Guidance on the monitoring of maternal and fetal wellbeing where fetal membranes have ruptured prior to the onset of labour	SI outcome = Failure in both written and verbal communication that caused a delay in the supply of blood and so in the planned induction of labour.

Deaths being investigated under the Serious Incident framework

- Deaths for review by the Patient Safety Team have been identified by:
  - ME mortality screening
  - SJR
  - Patient Safety Incident reporting
- 24 deaths in Q1-3 have reviewed by the Patient Safety Team against the NHSI Serious Incident Framework
- 5 investigated as a Serious Incident

Learning from the Deaths of Patients in Our Care– Quarters 1 to 3

- **Further theming of Medical Examiner Screening, Clinical Reviews, SJRs being undertaken during Quarter 4**

- **Wide range of learning identified to date, through both ME Screening and Specialty Reviews but most fall into the following categories:**
  - Recognition of patients at the end of life, including communication with patients/relatives about prognosis
  - Escalation of the deteriorating patient / sepsis treatment
  - Acting on results, communicating where bloods or investigations not carried out
  - Senior review / Setting of 'Ceilings of Care'
  - Handover and Transfer between specialties and sites

- **Other learning includes:**
  - Recognition of digoxin toxicity
  - Recognition of thyroid crisis
  - Need for increase in steroids
  - Cardiology pathway
  - Management of delirium
  - Recognition of post chemo/operative paralytic ileus

Actions being taken in response to "Learning from the Deaths of Patients in our Care"

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

- **Trust wide actions include:**
  - Work with LLR colleagues to develop plans to implement ReSPECT, supported by the LLR End of Life Care Board
  - Review and triangulate ME and SJR data relating to End of Life care with other data sources in order to understand root causes
  - Report to the UHL and LLR End of Life Care Boards and the LLR Learning Lessons to Improve Care Taskforce in order to clarify UHL vs Health Economy actions
  - Embedding use of Sepsis Clinical Rules
  - Improved communication/handover using NerveCentre
  - Complete theming of Q1-3 data and present to the March Mortality Review Committee to confirm whether existing work-streams place or need to be established

- Specific actions in respect of cases with a Death Classification of 1 have been described above in Slides 28 and 29

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

- 58% of Q2 and 60% of Q1 bereaved relatives requested follow up contact by the Bereavement Support Nurse
- 58% of those requesting following up were spoken to by phone (letter sent to all where the Bereavement Support Nurse was unable to make telephone contact)
- Further information was requested by 79 families as part of the follow up contact
- Meetings with the clinical team were facilitated for 35 families
- Signposting to bereavement services eg CRUSE, LOROS, Sharma Women's Centre, Child Bereavement UK was given to 122 bereaved relatives/carers

Learning from Deaths in our Care - Next Steps

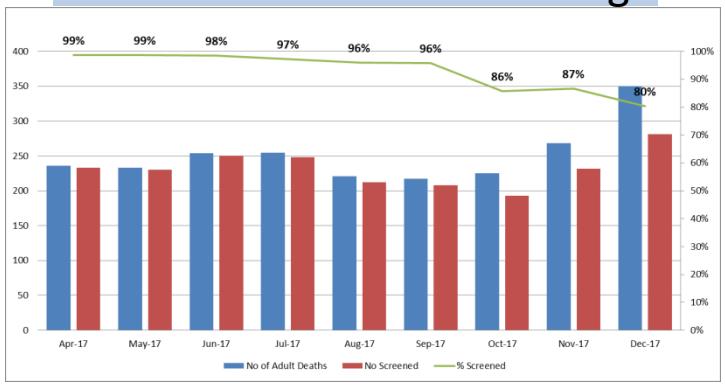
- Continue monitoring UHL's risk adjusted mortality rates (HSMR and SHMI) and undertake more detailed reviews where applicable
- Improve timeliness of ME Mortality Screening in respect of Coroner Referrals and LGH/Glenfield cases
- Identify resources to support LFD process both corporately and at a Specialty level
- 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

Learning from the Deaths of Patients in our Care Dashboard

Deaths in Q1-3

PLACE OF DEATH	ADULT / CHILD / NEONATE	NUMBER OF DEATHS
ED		164
	Adult	154
	Child	10
Inpatient		2161
	Adult	2078
	Child	21
	Neonate	62
All		2325
COMMUNITY DEATHS *		63

Medical Examiner Screening



Reasons for referral for Structured Judgement Review (SR)

Month of Death	Medical Examiner Screening	Relative's Feedback	Child or Neonatal Death	Death Post Elective Procedure	Death of Patient with LD*	Death of Patient with SMI**	Death where Alert/QI***	All deaths referred for SJR
Apr-17	32	3	13	6	2	2	2	60
May-17	23	2	15	2		4	1	47
Jun-17	26	2	8	4	2	3		45
Jul-17	17	2	11	7	2	2		41
Aug-17	16	2	12	7	2	1	1	41
Sep-17	19	3	7	6	1	1		37
Oct-17	14	1	12	2	3	2		34
Nov-17	24		7	7	1	1		40
Dec-17	19	2	7	6	2	1	1	38
Q1-3	189	17	92	47	15	17	5	383

Q1-3 SJR Completion

UHL DEATH CLASSIFICATIONS	
DC	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
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tbc	78	5	25	31	5	8	1		153
All	189	17	92	47	15	17	5	1	383

Learning identified in Q1-3 where problems in care

- Need for access to 'Difficult Asthma Clinic' information
- Improve teenage transition and continuity of care.
- Patients with new AF must be considered for anticoagulation urgently
- All stroke patients must be referred to the stroke team
- Teenage pregnancies are risk factors in themselves if present with reduced Fetal Movements
- Need for co-ordination of multiple Care Plans
- Importance of good communication between Obstetricians and Blood Bank
- Limited guidance regarding the management of women with ruptured fetal membranes.
- Importance of communicating key patient risk factors between clinical teams
- Increase use of handover information on NerveCentre
- Inform Neonatology if maternal pyrexia in labour
- Improved communication / use of SBAR
- Postnatal care should be patient centred
- Include baby's general condition as part of NEWS assessment
- Importance of documenting rationale for deviating from guidelines