

Report Title	Amenable mortality – Route to 95		
Sponsoring Executive	David Caruthers		
Report Author	David Carruthers		
Meeting	Trust Board (public)	Date	7 th March 2019

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

Several strands of work are being undertaken to improve patient outcomes and thus Trust mortality data. The influence of factors on the different mortality indices has been reviewed previously and the potential effect of each of these areas on mortality is illustrated.

- Here current mortality data is shown illustrating site and weekend differences.
- Progress in 5 of the big 6 of the Quality Plan, where there has been a major focus on:
 - identification and management of the deteriorating patient with NEWS>5
 - review of deaths from Myocardial infarction and stroke,
 - peer review of our fracture neck of femur patient deaths and management pathways
 - development of work in recording VTE assessment and reviewing patients with hospital acquired VTE.
- Progress in work of medical examiners and Learning from Deaths Committee is leading to an improved position for 1st tier mortality reviews, structure for second tier reviews and reporting learning from learning from deaths committee.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	<input checked="" type="checkbox"/>	Public Health Plan	<input type="checkbox"/>	People Plan & Education Plan	<input type="checkbox"/>
Quality Plan	<input checked="" type="checkbox"/>	Research and Development	<input type="checkbox"/>	Estates Plan	<input type="checkbox"/>
Financial Plan	<input type="checkbox"/>	Digital Plan	<input type="checkbox"/>	Other <i>[specify in the paper]</i>	<input type="checkbox"/>

3. Previous consideration *[where has this paper been previously discussed?]*

Previous submissions to Trust Board September and December 2018, and the Quality and Safety Committee in February 2019

4. Recommendation(s)

The Trust Board is asked to:

- a. Note current mortality data
- b. Agree the focus of work in 2019 from the Quality Plan
- c. Discuss plans for tier 2 (SJR) mortality reviews and learning to come from those

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	<input type="checkbox"/>					
Board Assurance Framework	<input checked="" type="checkbox"/>	BAF3				
Equality Impact Assessment	Is this required?	Y	<input type="checkbox"/>	N	<input checked="" type="checkbox"/>	If 'Y' date completed
Quality Impact Assessment	Is this required?	Y	<input type="checkbox"/>	N	<input checked="" type="checkbox"/>	If 'Y' date completed

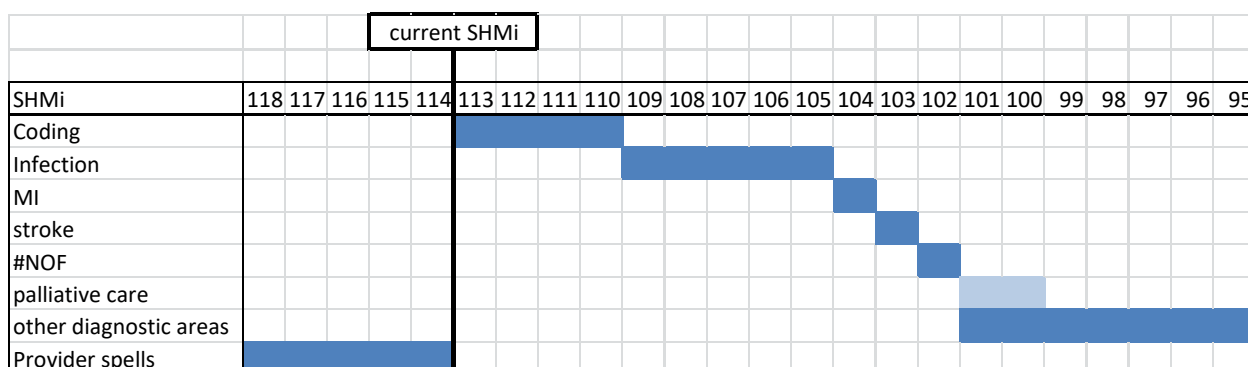
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Quality and Safety Committee: 22nd February 2019

Mortality - Route to 95

1. Introduction

1.1 The Trust is undertaking work to understand and improve mortality data looking at both the processes involved in generating mortality data as well as a focus on clinical care in those clinical areas where a higher than expected mortality rate is seen. This forms part of the Quality Plan and progress in these areas is reported here. The aim is to improve outcomes in the Trust and the potential contributions of the different strands of work is shown here on the SHMi score (palliative care recording will affect RAMi). This is based on data from initiation of the Quality Plan. However, other diagnostic areas are identified from regular review of mortality indices either because actual mortality is greater than expected or clinical areas where further improvement in an already excellent service can be made. Infection covers sepsis but also other major infection causes (respiratory, urinary). A change in provider spells can alter mortality data in either direction as illustrated by serial mortality data (appendix 1)



2. Current mortality indices (Apr 2017 – Dec 2018)

2.1 These are shown in appendix 2. The graphical illustration shows how data changes over time, with a 3-5 month delay in data availability. There are seasonal variations, different mortality indices compared and weekend/day admission mortality shown. The latter for example illustrates how a high weekend mortality in August 2017 has affected the cumulative score for the following 12 months and allows focused enquiry into this data point (appendix 3). The importance of palliative care recording is highlighted here.

2.2 To analyse changes in mortality by diagnostic group allows monitoring of the effect of service change as well as identifies potential alerts where there may be problems in care that need further investigation. Expected v actual mortality for main causes of death are shown (appendix 4) with the improved data for MI, stroke and pneumonia shown, but increased number of sepsis cases.

3. Quality plan

- 3.1 **Sepsis:** work on recording that patients with NEWS>5 have been screened for sepsis progresses with now 1:1.75 patients having their screening recorded as being undertaken. All patients not screened now have to have a review of the reason for that screening not taking place and initial data shows a combination of factors, such as bank or current staff unaware of process to record that the sepsis screening has taken place, too busy although correct assessments took place. (appendix 5)

The second stage is the QI work is looking at the assessments after the screening alert and initial work suggests that accuracy of documentation around time of sepsis assessment, administration of oxygen and monitoring of urine output are important data points to improve recording of. The audit form is now being trialled in real time on the wards with the aim that it becomes embedded in ward activity to record how they have dealt with triggering patients. This will then be part of regular ward activities to review these data weekly with education and training where needed and will link into the nursing assessment and learning from missed triggers and the themes that come from that.

- 3.2 **VTE:** data shows VTE assessments in 2 of last 3 months have been over 95%. This is an improved position on recording of VTE assessments with a number of strategies employed (availability of systems to record, email reminders to weekend teams, data to the AMU teams where the highest number of missed assessments are noted). Maternity and surgery position is improved. Prior small audit of missed or delayed assessments showed that not all were missed, were already on anticoagulation or turned out not to need prophylaxis. However there is still a percentage who have missed assessments.

To understand the potential impact of these missed assessments we are looking at all hospital acquired VTE (HAVTE). This will be via IR1 reporting and cross checking with coding data.

For nov - jan 2019 there were 100 VTE in the trust of which 27 were HAVTE (during this admission or within 90 days of discharge) which is on par with national average. Preliminary analysis of this data to help support QI work shows that underlying medical problems (cancer and other comorbidities among elderly patients) are the commonest associations with HAVTE.

As far as prophylaxis treatment is concerned, missed doses or where treatment has had to be stopped for other reasons may be contributing factors. We are going to cross reference the data of patients with delayed or missed VTE assessment with those who do develop HAVTE to make sure that all factors are considered. The RCA will allow identification of trends and modifiable factors that can develop into QI projects such as education/information given to patients. A data collection tool is being developed to allow for pattern recognition to occur. Patients managed via ambulatory units and not admitted who have a DVT will also be analysed

- 3.3 **Stroke:** data of deaths in 2017-2018 has been reviewed by the stroke team. The expected v actual mortality rate was not too different but analysis shows (in summary):
- 102 deaths in SHMI, 90 in RAMI, 14 not stroke related deaths on review.

- No increased mortality for those patients admitted on a Saturday or Sunday (highest admission death rate seen on for Friday admissions).
- 54% in hours, 46% out of hours admissions, 89% present to ED within 4 hours of symptoms, 89% direct admission to stroke unit (or ICU), 73% of those placed within 4 hours, 70% seen by stroke consultant within 14 hours, 85% have moderate to severe stroke and no problems with the coding of SAH deaths.
- No preventable deaths identified except one potential where mechanical thrombectomy not available out of hours.

This is retrospective review so outcome of this work is that stroke service will set up their own monthly mortality review of all stroke deaths and have better identification of stroke patients admitted at City

3.4 **Myocardial infarction:** Cardiology have reviewed their mortality data 2017-18

- there was no significant increase in actual v expected mortality (41 deaths).
- 13 delayed attendance until 12 hours after symptom onset, 16 died within 24 hours of admission, 7 had out of hospital cardiac arrest, 7 in hospital cardiac arrest with return of circulation.
- 13 v 26 for weekend v weekday death, 20 died in ITU, 17 on ward, 1 in ED. 24 had STEMI, 13 non STEMI.
- Not many deaths between discharge and 30 days which is reassuring, suggesting that stopping dual anti-platelets after the TTO supply runs out is not a problem, as has been suggested previously.

QI work will come out of the observation that some aspects of care could be improved identified in 15 patients (to be defined after Cardiology QIHD)

3.5 **Fracture neck of femur:** in depth data analysis of cases was undertaken with subsequent visit from WM safety group due to data showing an outlier status nationally.

- There was no weekend mortality effect associated with the 31 deaths identified (10 v 21 weekday)
- 11 cases did not have surgery, 10 patients were placed on SCP, 25 had existing DNACPR in place.
- Several QI points came from the review with target date of March 2019, spanning multi-specialties.

Subsequent visit from WM quality review service to look at pathway (January 2019) showed no areas of immediate concern over pathways or care given but report not available yet. Summary points were:

Good Practices.

- High morale within the trauma team - clinicians, SCPs, theatre and ward staff.
- Comprehensive reporting and analysis of the cases.
- Concept of QIHD is excellent. Opportunity to learn.
- Concept of Black Country Networking to share & learn is very good practice.
- ED - good practices in initial NOF management and willingness to work with T&O.
- Role & contribution of (lone) Ortho-Geriatrician.
- Protected NOF Beds and Uniform NOF pathway.
- 'Whatsapp Group' to plan and execute throughout the day, including weekends.
- Nursing Leadership in planning, training and monitoring.
- Desire to replicate/ look into 'Level 1' care.

Areas to re-visit.

- Operating surgeon - Cons vs NTMG. Benchmark the practice.
 - Access to patient records on CDA is not easy and is not in one place.
 - Understanding of Vital pack among the staff is slightly variable.
 - Weekend access to MRI for Pathological fractures.
 - Our NOF Mortality proforma is mainly T&O based. It may benefit from including the ED and Anaesthesia sides too.
 - Decision on 'Not to Operate' needs a clear SOP/ Process to avoid variations of practice.
 - Decision to 'cement' or not also needs to be standardised.
 - 'Cement Curfew' / 'Time out' during cementing.
 - 'Level 1' facility for NOF patients - where & how?
 - Consistent communication from ED to Reg on call before NOF admission & transfer to the ward.
 - Role or possibility of Frailty Nurse.
 - Weekend full Physiotherapy provision.
 - 'Golden First Patient' to start the list.
4. **Other diagnostic areas to examine:** these may be identified from local or national alerts through to the learning from Deaths committee that lead to case review and subsequent QI work (e.g. recent alert on diagnostic category of pleurisy, pneumothorax and pulmonary collapse), acute renal failure (part of sepsis plan but also relevant to other clinical areas) and high mortality in 'other connective tissue disease' group, which relates to patients presenting with soft tissue injury after falls that have other more serious underlying pathology as the cause or consequence of the fall and are currently under review.
5. **Admission spells:** this relates to those patients who may previously have been admitted to the Amu areas and then discharged but are now seen in ambulatory areas and therefore not counted towards admission figures, so that total number of admissions (and therefore expected death numbers fall) while the number of sick patients admitted (spells) does not change, rising mortality figures. Increase in admissions has the opposite effect (appendix 1)
6. **Medical examiners:** There is an improved review of patient deaths at tier one by the medical examiners who liaise with junior staff over recording on death certificate, talk with family and with coroner where needed. They identify those cases where more in depth review is needed by specialty/team involved in patient care. Cases reviewed now approaching 80% at tier 1 but not all cases reviewed by ME currently (still not enough hours to do this currently), other clinicians being asked to review outstanding deaths under old system.
- Reporting system to allow continuation in process after Unity is introduced is being developed and put in place so will allow these tier 1 assessments to be undertaken with links to family and coroner, and identification of patients in need for tier 2 review, which will be an SJR (Appendix 6 for report)

7. **Learning from Deaths committee:** The learning that comes from this committee will focus around the thematic analysis of cases within the structured judgement review process for which the attached flow chart illustrates cases for review and how that will be used to undertake review of cases from multiple sources. This links into wider work on learning and sharing information via EQC. (appendix 7)

8. Recommendations

8.1 The Committee is asked to:

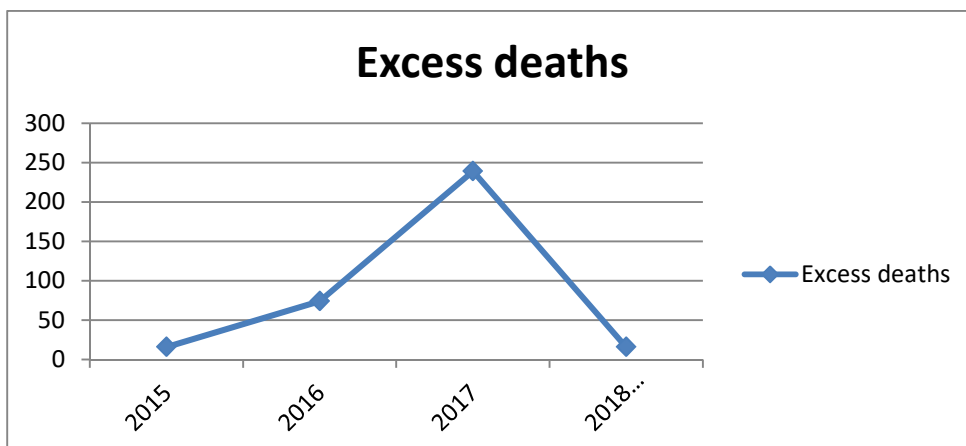
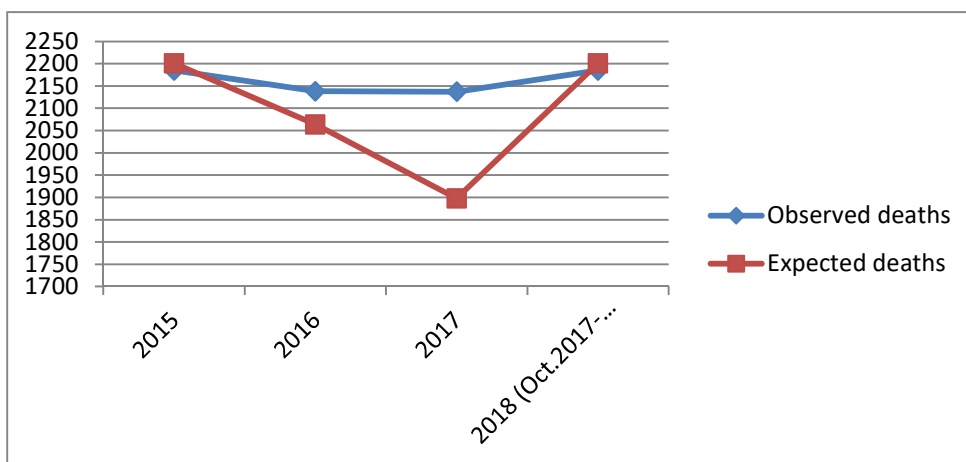
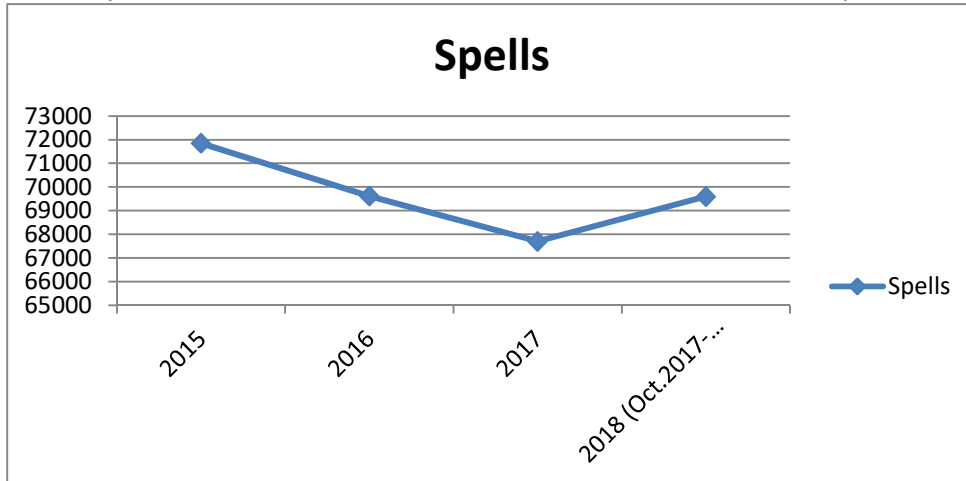
- a. Note the progress in the different domains of the amenable mortality project
- b. Recognise changing mortality data that needs change in focus of QI work
- c. On going process to respond to changing mortality data and refocus work

Dr David Carruthers
Medical Director

27/02/2019

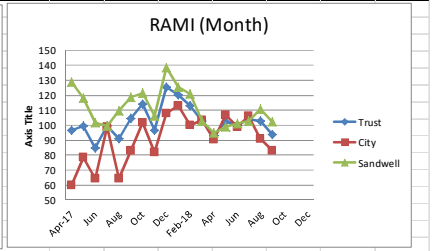
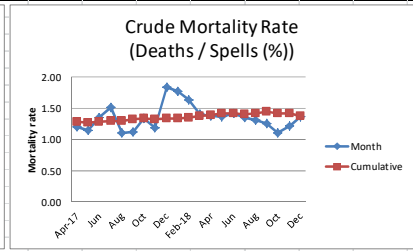
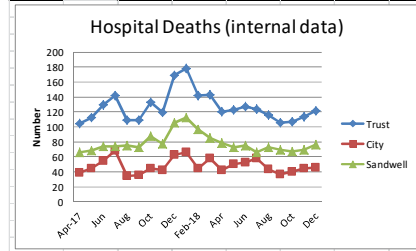
Appendix 1

Mortality Data from 2015 – 2018 (note 2017-2108 data is October to September 2018)



Appendix 2 – current Trust mortality data:

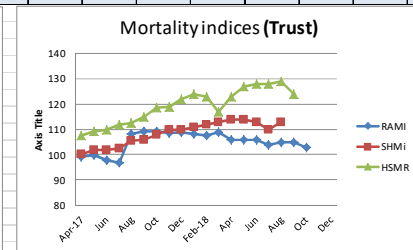
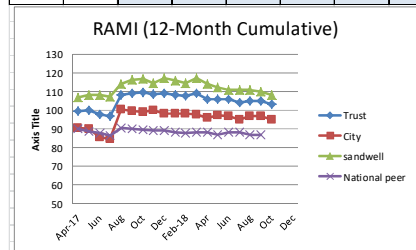
		Apr-17	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb-18	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Hospital Deaths (internal data)	Trust	105	113	129	142	109	109	133	119	169	178	142	143	120	123	127	124	116	106	107	114	122
	City	39	45	55	68	34	36	45	42	63	66	45	58	42	50	52	58	43	37	40	45	46
	Sandwell	66	68	74	74	75	73	88	77	106	112	97	85	78	73	75	66	73	69	67	69	76



		Apr-17	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb-18	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Crude Mortality Rate (Deaths / Spells)	Month	1.20	1.15	1.35	1.51	1.11	1.12	1.34	1.18	1.83	1.77	1.63	1.40	1.37	1.36	1.42	1.35	1.31	1.25	1.11	1.21	1.36
	12-month cumulative	1.28	1.27	1.28	1.30	1.30	1.32	1.33	1.32	1.34	1.34	1.35	1.38	1.39	1.41	1.42	1.40	1.42	1.44	1.42	1.42	1.42

		Apr-17	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb-18	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
RAMI (Month)	Trust	97	99	85	99	91	104	114	96	125	120	113	103	94	102	100	104	103	94			
	City	80	78	65	99	64	83	102	82	108	113	100	103	90	107	99	106	91	83			
	Sandwell	129	118	102	99	110	119	121	106	138	125	121	103	95	99	101	103	111	102			

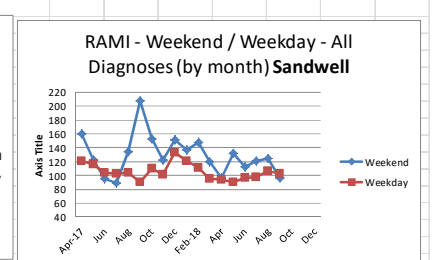
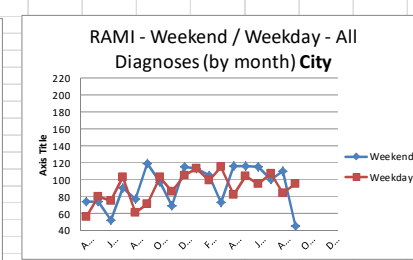
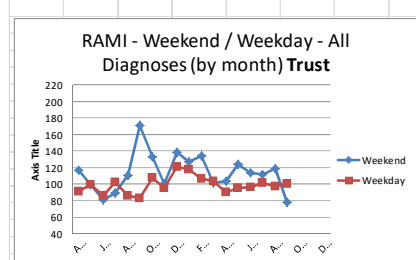
		Apr-17	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb-18	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
RAMI (12-Month Cumulative)	Trust	99	100	98	97	108	109	109	108	109	108	108	109	106	106	106	104	105	105	103		
	City	90	90	86	85	100	99	99	100	98	98	98	98	96	97	97	95	97	97	95		
	Sandwell	107	108	108	107	114	116	117	115	117	116	114	117	114	112	111	111	111	110	108		
	National HES Peer	90	89	88	87	90	90	90	89	89	88	88	88	88	87	88	88	87	87			



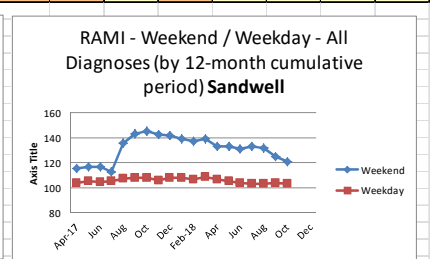
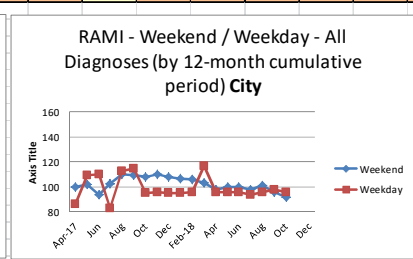
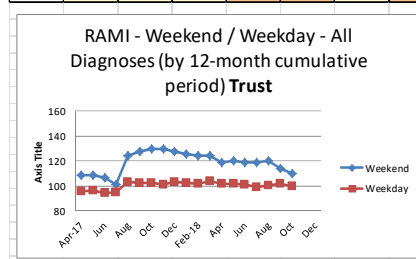
		Apr-17	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb-18	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
RAMI	Trust	99	100	98	97	108	109	109	108	109	108	108	109	106	106	106	104	105	105	103		
	SHMI	100.0	101.9	101.8	102.6	105.5	106.0	108.0	110.0	110.0	111.0	112.0	113.0	114.0	114.0	113.0	110.0	113.0	124.0			
	HSMR	107.5	109.2	109.8	112.0	112.5	115.0	118.5	118.8	122.0	124.0	123.0	117.0	123.0	127.0	128.0	128.0	129.0	124.0			

		Apr-17	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb-18	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Weekend	Trust	117	99	81	89	111	171	133	100	138	128	135	102	103	124	114	112	119	78			
Weekday	Trust	91	100	86	102	86	83	108	95	121	118	106	103	90	95	96	102	97	100			

		Apr-17	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb-18	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Weekend	City	74	74	52	90	77	119	97	69	116	114	105	73	116	115	100	110	110	45			
Weekday	City	56	80	75	103	61	71	103	86	105	113	99	115	82	104	95	107	84	95			
Weekend	Sandwell	161	123	95	89	135	208	153	122	152	137	148	119	97	132	113	121	125	97			
Weekday	Sandwell	121	116	104	102	104	90	110	102	133	121	111	96	94	90	97	98	106	103			



		Apr-17	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb-18	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Weekend	Trust	109	109	106	101	124	128	130	130	128	126	124	124	119	120	119	119	120	114	110		
Weekday	Trust	96	97	95	95	103	103	103	102	103	103	102	104	102	102	101	99	101	102	100		
Weekend	City	100	102	94	103	110	109	108	110	108	107	106	103	98	100	100	98	101	96	92		
Weekday	City	87	109	110	83	112	115	95	96	95	95	96	117	96	96	96	94	96	98	96		
Weekend	Sandwell	115	117	117	113	136	143	145	142	142	139	137	139	133	133	131	133	132	125	121		
Weekday	Sandwell	104	105	105	105	107	108	108	106	108	108	107	109	107	105	104	103	104	104	103		



Appendix 3 - Weekend mortality for September 2017

High number of low risk diagnostic groups within the 42 weekend deaths, there were 28 different diagnoses. Slightly younger group and higher percentage were male. Lower percentage of palliative care recorded than expected. 30 deaths at Sandwell, 12 at City.

Fig 1 – SWBHT (1st column) v peer mortality during September 2017 by day of week

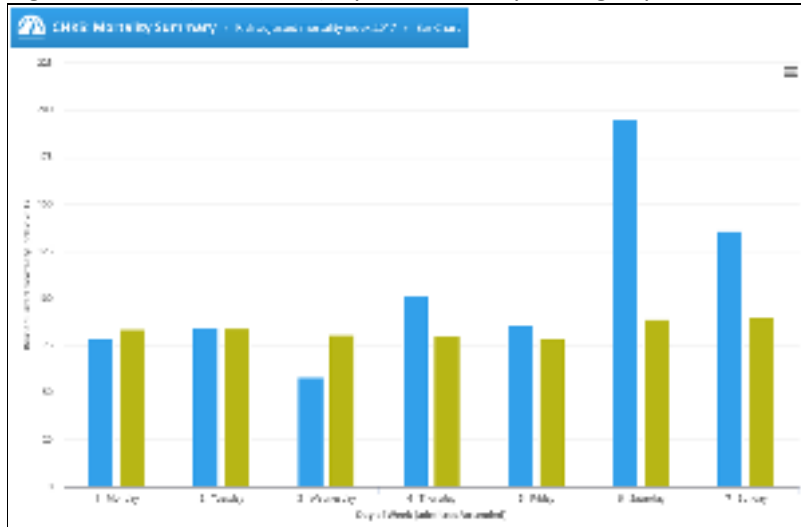


Fig 2 - SWBHT (upper line) v peer for weekend mortality during 2017 by month

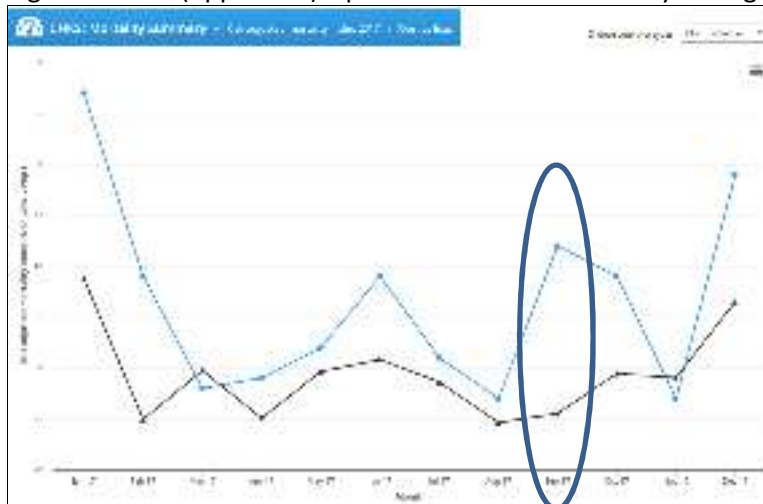
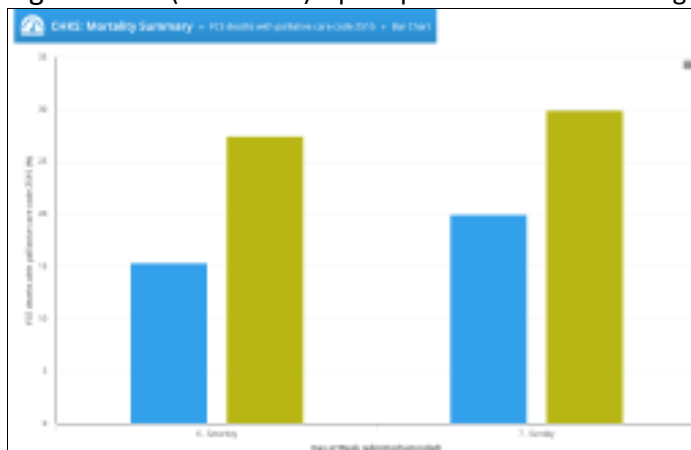
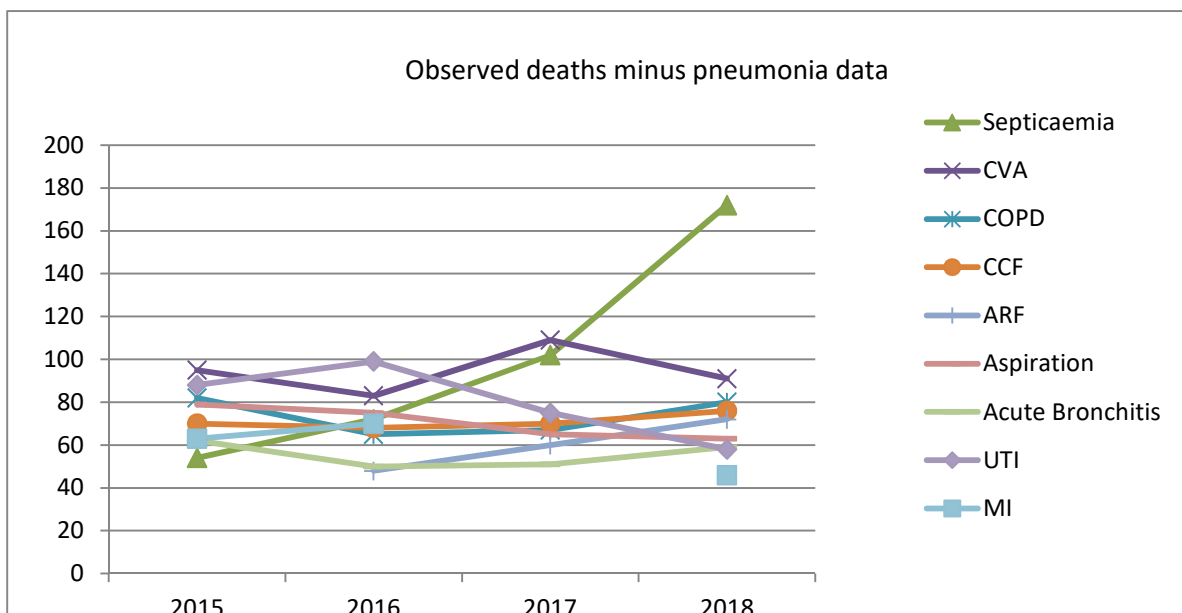
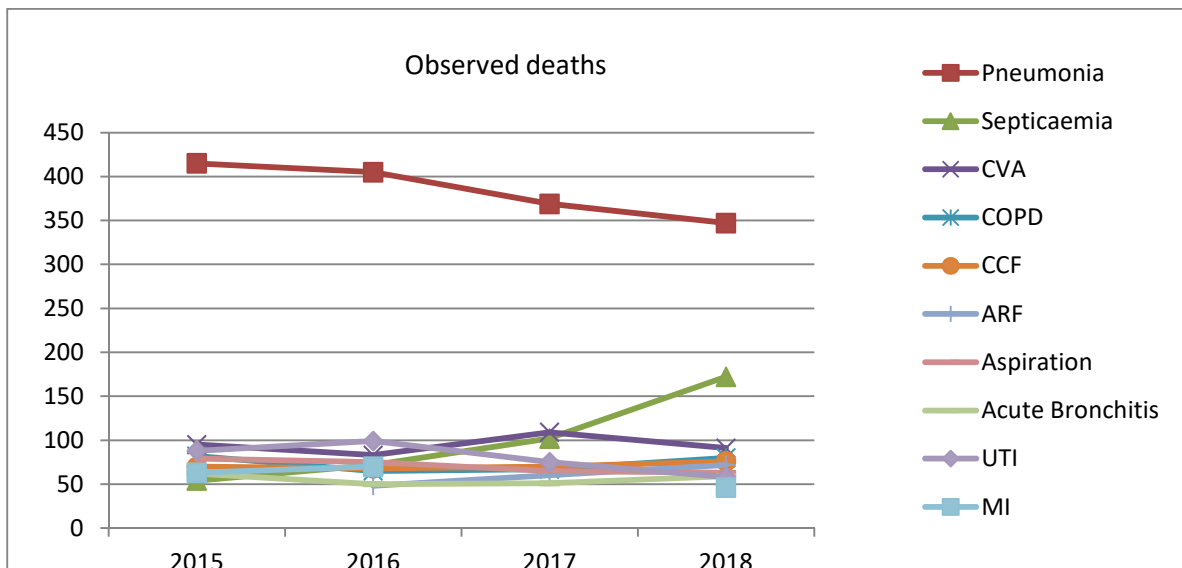
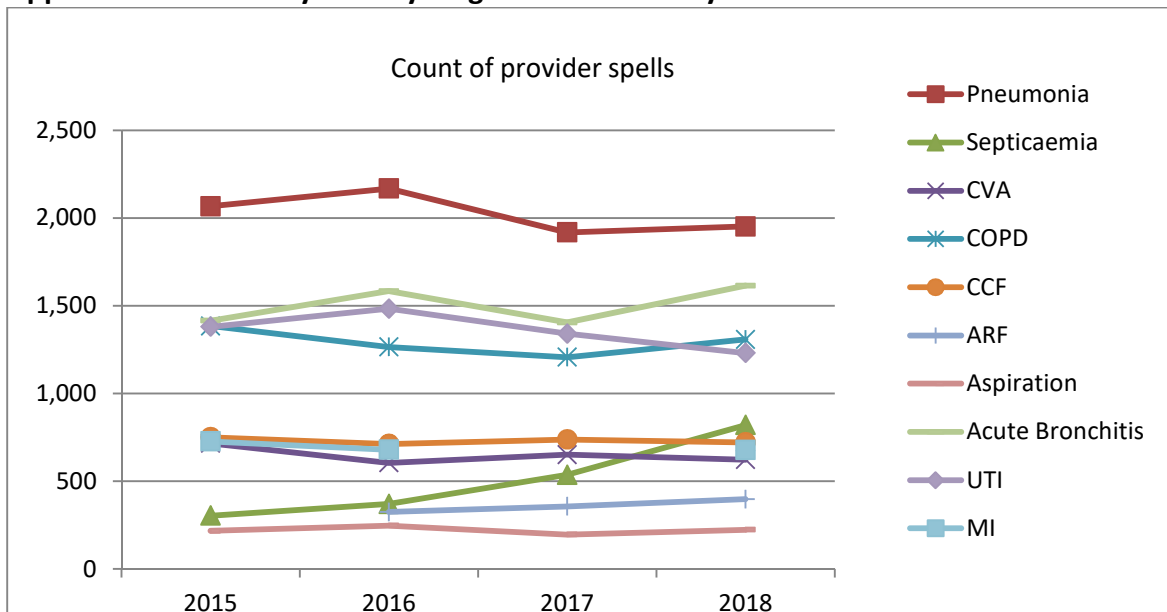
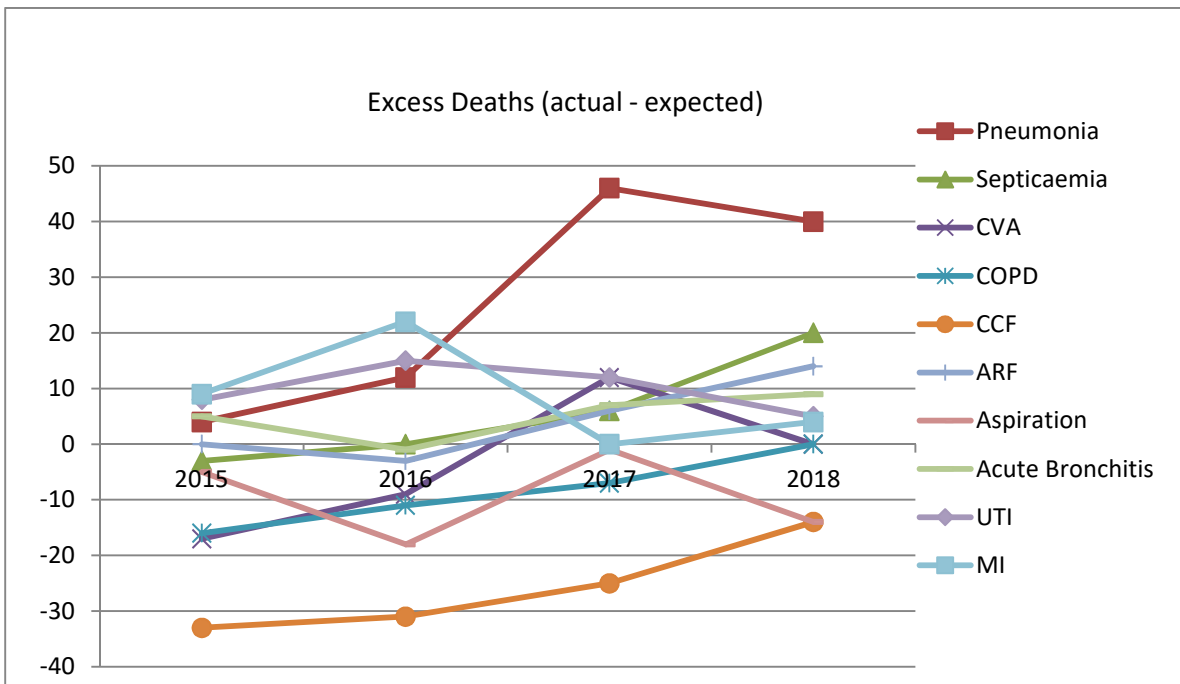
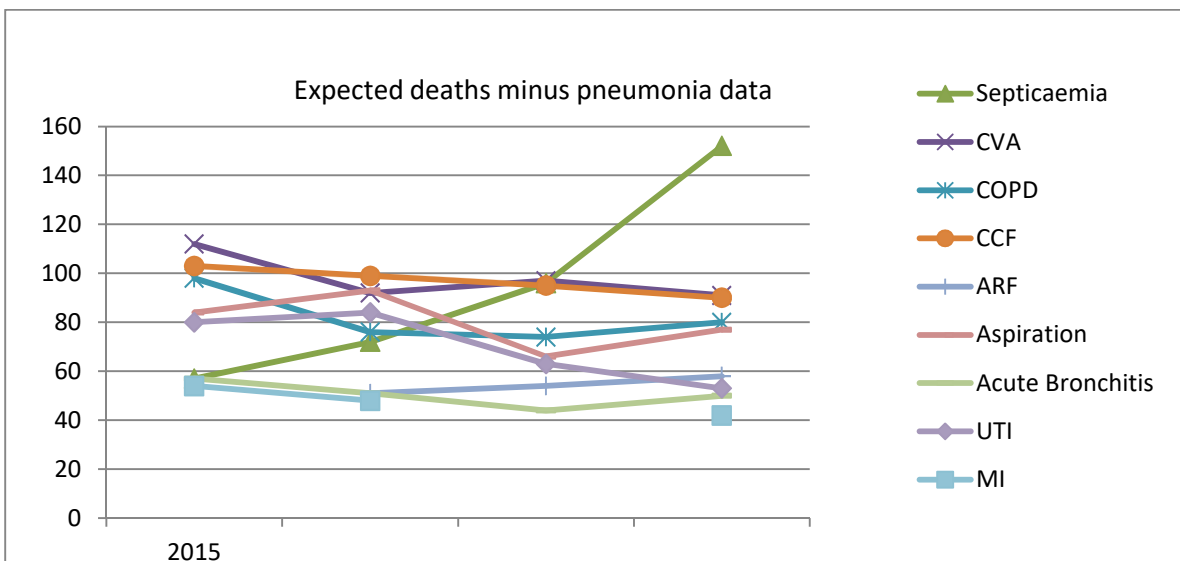
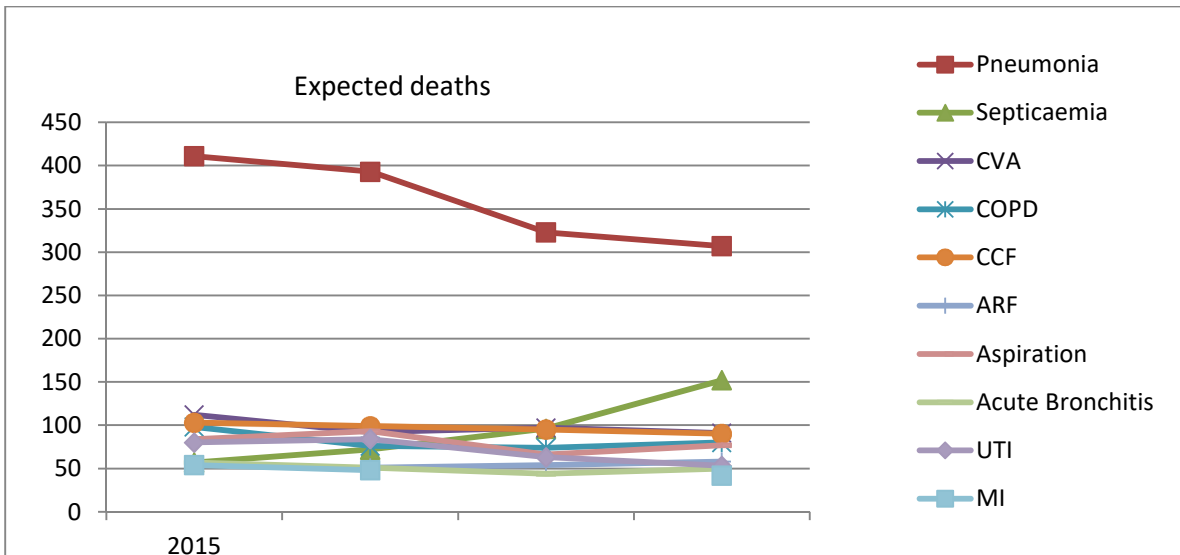


Fig 3 SWBHT (1st column) v peer palliative care recording during Saturday and Sunday September 2017



Appendix 4 – Mortality data by diagnosis over last 3 years





Appendix 5 Sepsis improvement work

Martin Chadderton, Information manager

Sepsis Screening and Treatment

The purpose of this Quality Improvement work is to reduce Patient mortality due to Sepsis. Improving sepsis screening compliance for those patients who triggered an Early warning score of 5 or above has been the main focus to date but this section will also cover an initial pilot on the Treatment tool which has been developed concurrently with the above work.

Sepsis Screening

In August 2018 our evidenced (electronically recorded) sepsis screening rate was 1 in 11 patients (so for every 11 patients that triggered an early warning score of 5 or above, 1 patient received screening for sepsis).

The purpose of this work was to improve compliance to ensure that every patient who required screening (sometimes twice daily) received it in a timely fashion.

Method(s) used

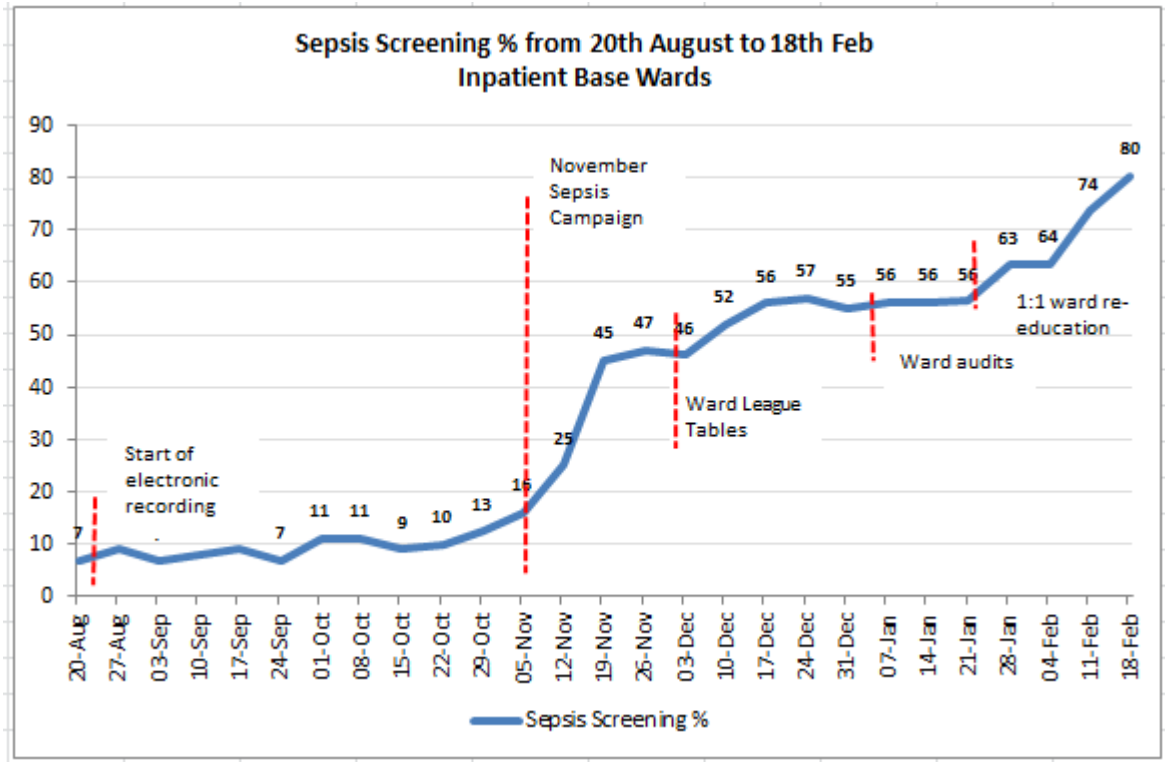
- Electronic recording of sepsis screening within Trust bed management system, ebms adopting a set of flags (patient screened, sepsis confirmed, ..).
- Daily reporting at Patient level of missed screenings
- Weekly reporting of compliance performance at ward-level.
- Coaching and education of staff (sometimes 1:1) at ward –level.
- Grip, Control and Guidance from Project Team including Medical and Nursing Director, Lead Respiratory Nurse.
- Chief Executive Support.
- Communication Team support with a concentrated Sepsis campaign in November 2018.
- Use of PMO tools within Exec PMO room and ward(s).

Results

The Sepsis Screening compliance has steadily improved from a 1 in 11 screening rate in August (9%) through November where we saw an improvement to 1 in 2 (50%). This was sustained through the winter with a slight improvement in January and has climbed to a 1:1.25 or 80.2% compliance in mid-February.

The aim now would be to sustain this improvement and reach a sustained 100% compliance across all wards.

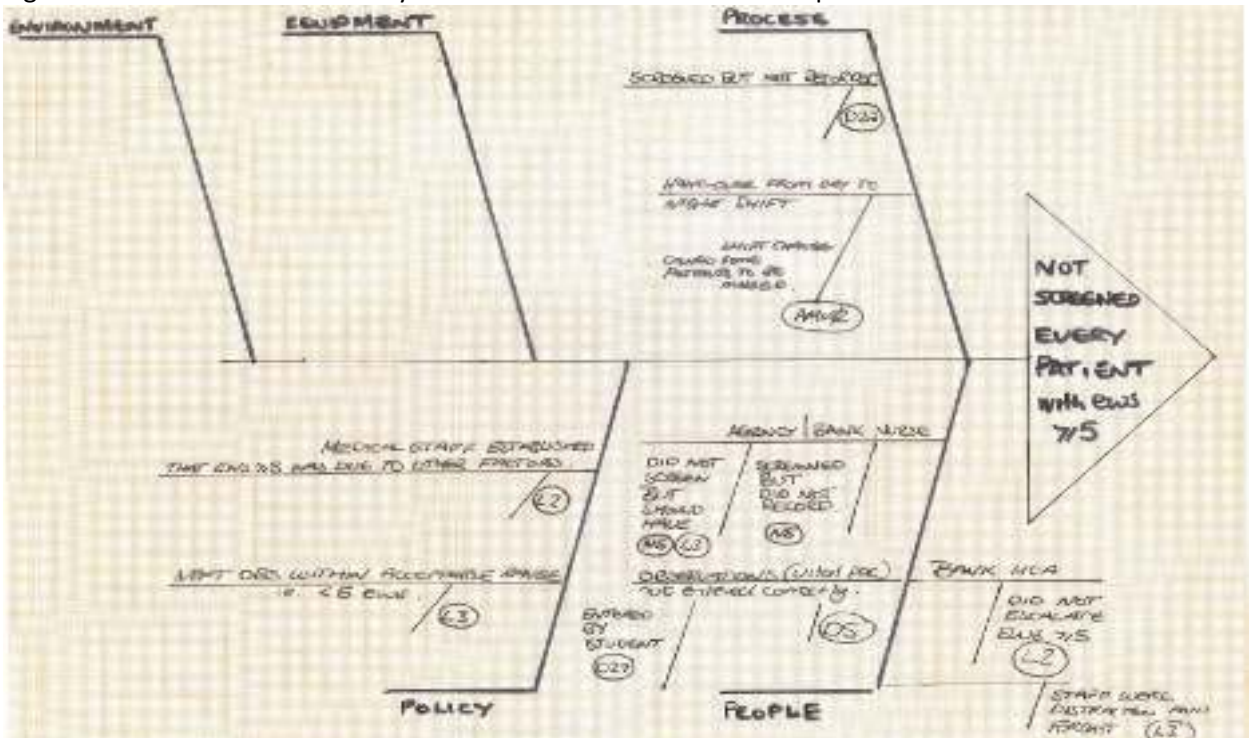
Fig a. shows the Sepsis Screening Compliance progress from 20th Aug 2018 to 18th Feb 2019.



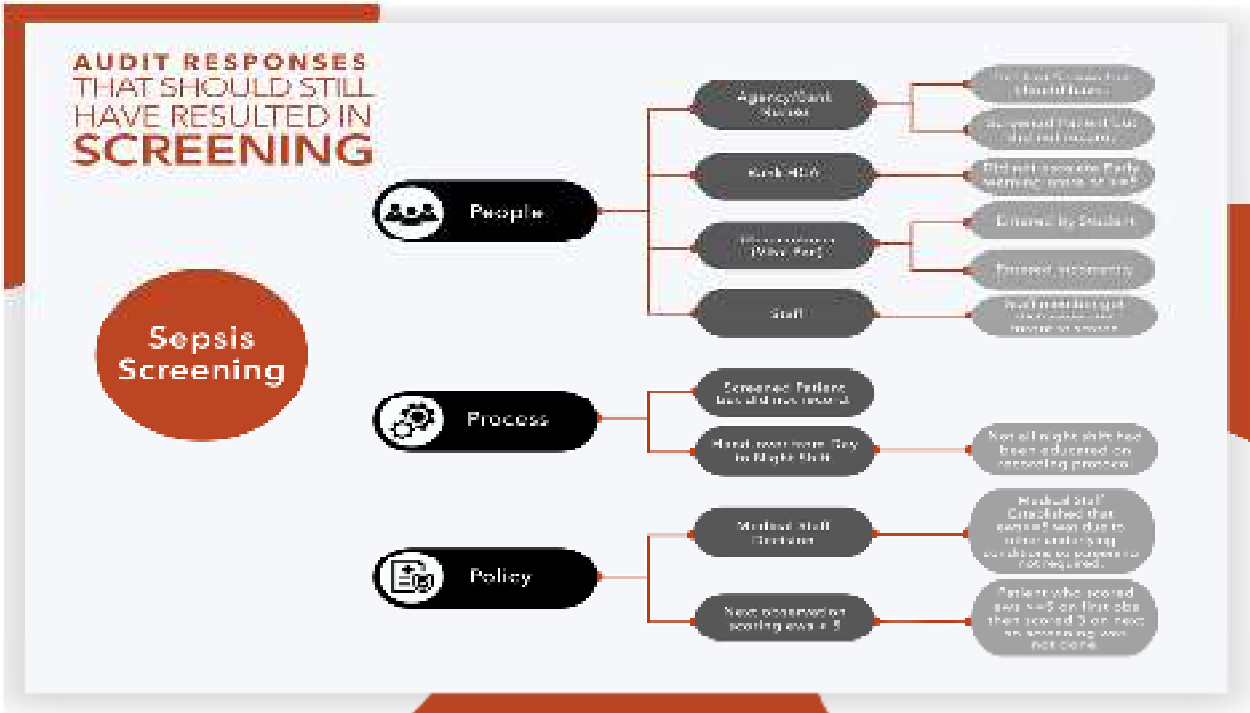
9. Ward Audits

Wards were tasked with recording reasons for not screening ew_s ≥ 5 patients in January. This audit was set up in each ward based on the daily patient compliance reports produced a set of common themes which are illustrated in fig b

Fig b. Root-Cause of 'Reasons why a Patient was not screened for Sepsis'



This themes then anonymised and distributed to the wards and used as part of a focused re-training exercise fig c.



Results

There were still some small pockets of non-compliance where a screening had taken place but not recorded and other factors such as staff slipping through the education process or incorrectly following protocol. A focused re-education process was undertaken using the results of this audit for some areas and some staff; this was often done by the ward staff themselves.

Sepsis Treatment

Fig d. is the Prototype proforma being piloted within wards as a tool for implementation of the Sepsis 6 Bundle.

Method

There are a number of wards that consistently have high daily numbers of confirmed sepsis patients; these wards will be the locations where the pilot is undertaken. On 21st Feb 2019, the pilot started in AMU 1 and 2 at City with the initial aim to determine whether the proforma is suitable to be implemented as a Treatment tool across all wards. This audit will take place for 3 weeks and will end on 7th March when the findings will be presented back to the Medical Director and Sepsis Project team.

A decision will then be made as to its suitability, and implementation plan and how we link this with real time electronic recording and reporting.

Fig d. Sepsis Treatment Tool

Sepsis AUDIT

To be completed for all patients with NEWS>5 or identified as looking sick


Patient sticker	Patient recognised as looking sick or NEWS >5: DATE: TIME: DAY: Mon/Tue/Wed/Thu/Fri/Sat/Sun
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Was the patient escalated? **YES/NO** Time escalated:

Was the patient reviewed within one hour? **YES/NO** Time reviewed:

Was the patient diagnosed as septic? **YES/NO**

If no, what was the management plan?

 If patient recognised as septic, please complete the data below (Please give all times as HH:MM)

Possible location of infection (respiratory, urinary, unknown etc.):	
Implementation of sepsis 6	
Bloods cultures	
Time taken:	
Oxygen	
O2 sat when triggered sepsis pathway:%	Oxygen applied: YES/NO
Mechanism of oxygen delivery (nasal specs, non-rebreathe mask etc.):	Time oxygen applied:
Fluids	
500ml IV fluid STAT given if hypotensive/lactate lactate>2: YES/NO/NA	Time given:
Maintenance IV fluids prescribed: YES/NO/NA	IV fluids reviewed: YES/NO
Antibiotics	
Time prescribed:	Time administered:
Title of prescriber (SHO, SpR, CNS etc.):	Title of person administering antibiotic:
Antibiotic prescribed:	
Lactate	
Was a lactate taken? YES/NO	Time repeat lactate taken (if Initial lactate>2):
Time lactate ran on blood gas analyser:	
Urine output	
Was urine output measured from time patient first passed urine? YES/NO	Was a catheter inserted?: YES/NO
Outcome	
Was sepsis 6 initiated within the hour? YES/NO	
Was a sepsis screening tool used: YES/NO	

Appendix 6

Medical examiners and progress in mortality reviews and plans for non-allocated patient reviews – Carol Cobb

Medical Examiners are likely to be the hottest topic in the near future in relation to learning From Deaths. Even though appointed in January, the name of the National Medical Examiner has not been publicised or a forward plan detailed. I have heard that regional medical examiners are likely to be the next appointment with some structure, guidance and expectations associated with publicity.

SWBH

Medical Examiner Service implemented April 2018

Workforce

- **Medical examiners**
 - We now have 11 medical Examiners, 3 recent appointments started in 2019. Together they provide 9 PAs (4 MEs do 0.5 Pas).
 - We need 2 sites covered with a minimum of 1PA per site per day (10PAs) PLUS allowance for annual leave and cover, increase work load on Monday and after bank holidays, higher number of deaths in the winter and consistently more deaths at Sandwell.
 - In March 2019 we will go out to recruit more medical examiners: from SWBH consultant and SAS body and from our primary care colleagues.
 - Funding continues to be precarious while the unpredictable number of cremation form fees are used to finance MEs hours. Funding is a key priority and expectation of the next guidance from NHSe in relation to this service. There is also a plan to replace cremation fees process in the next few years.

- **The Role of Medical Examiners Officer**
 - This is a role sitting between bereavement officers and medical examiners. This role will be focused on in next wave of national guidance on implementation of medical examiner service.
 - There will need to be a medical examiner available daily to each site (while there are 2) to work with ME officers. We will need to create and appoint to this post. This requires clear job description and specification as well as funding.
 - Administration of medical examiners outputs will involve allocation of 2nd tier reviews, follow up of 2nd tier review QI, acting on family and relative feedback concerns and compliments, incident reporting and investigation, monitoring performance, management of MEs, ME officers and bereavement service personnel, analysis of service; all require some resource. Some functions can and are being automated ; other functions will require resource.

- **Mortality review System (MRS) Improvement:** Since mid September Medical examiners have reviewed cases using MRS.

Total 2018/19

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Death	<u>115</u>	<u>116</u>	<u>122</u>	353	<u>118</u>	<u>117</u>	<u>105</u>	340	<u>106</u>	<u>109</u>	<u>118</u>	333	<u>147</u>	<u>68</u>	<u>0</u>	215	1241
Reviewed	<u>35</u>	<u>42</u>	<u>56</u>	133	<u>49</u>	<u>48</u>	<u>70</u>	167	<u>87</u>	<u>86</u>	<u>85</u>	258	<u>105</u>	<u>41</u>	<u>0</u>	146	704
% Reviewed	<u>30</u>	<u>36</u>	<u>45</u>	37	<u>41</u>	<u>41</u>	<u>66</u>	49	<u>82</u>	<u>78</u>	<u>72</u>	77	<u>71</u>	<u>60</u>		67	56
% Cumulative Reviewed	<u>30</u>	<u>33</u>	<u>37</u>	37	<u>38</u>	<u>39</u>	<u>43</u>	43	<u>48</u>	<u>52</u>	<u>54</u>	54	<u>56</u>	<u>56</u>	<u>56</u>	56	56

Present areas requiring development

MRS

- Checklist and proforma update and IT development:
- data analysis from Medical examiner log up to Jan 2019: needed and pending task
- Non allocated reviews management:
 - auto allocation still in place.
 - manual check and re allocation needed at present.
 - More medical examiners introduced and further recruitment up dated consultant and specialty lead lists to maintain,
 - checklist IT development : as above
- Non completed reviews
 - manual check and re allocation needed at present
 - possible IT development being investigated: as above.

MRS out puts

- Family & relatives: data to analyse. Feedback survey discussed
- Coroners: Good productive and collaborative meeting with Black Country Coroner with biannual meeting agreed. Registrar and coroner very appreciative of medical examiner service.
- MCCD: We have not yet found a way to show medical examiner influence on quality of MCCD. Feedback survey from junior medical staff to be considered.

Regional Medical Examiner services.

UHB have almost enough MEs to review and process all deaths. This did not include BHH at the same stage. I have no other details of performance, outputs or processes to 2nd tier review. All other Trusts locally are at different stages in the implementation of MEs

I do not think there are any Medical Examiners Officers appointed locally

LfD agenda –updates.

- No news or updates regarding Learning From Deaths nationally. This issue has not been in the health press much since change in Jeremy Hunts position as it was one of his priority projects.
- There is an important arm of the March 17 guidance regarding Public engagement :. This has not lead to any specific directive as yet . Of course medical examiners are part of this.
- SJR: There was an article in BMJ about Medical examiners (BMJ 2018;363:k5166 –) and this reports on a recently started research project through NIHR comparing medical examiner assessment and SJR at pilot sites. There are no data to support the use of medical examiner to identify cases for SJR.
- Alternative approaches to reviewing other groups of deaths is recommended. We already separately look at LD, Low risk diagnostic groups, any diagnostic group, specialty, National audit or time frame that we are alerted to by whatever means. We regularly get reports from ED, MFFD beds, palliative care, critical care, paed and maternity, incidents, complaints and others, independent of medical examiner or 2nd stage review process.

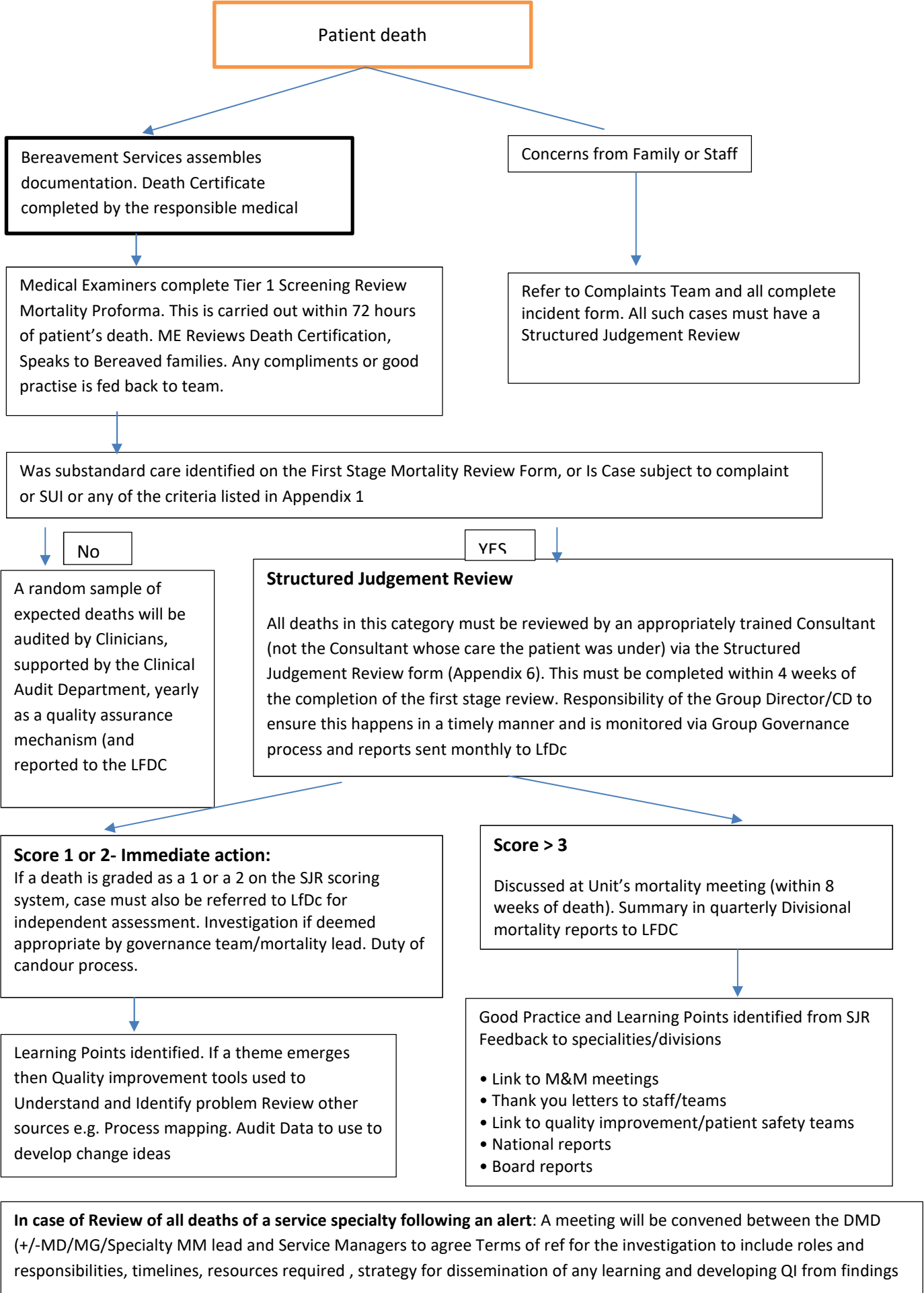
Learning From Deaths Communications. need for developement

- Death Matters Newsletter
Not published for 6 months due to staffing pressures.
- As of Feb 2019 key QI actions and LfD news in
Establish fixed monthly article in Heartbeat

Establish once weekly staff comms item

Create screen saver

Appendix 7 – flow chart for SJR process after patient death



Indications for SJR

- Any deaths identified at initial screening by Medical Examiners as requiring 2nd tier review either because poor care has been identified or more than 3 triggers
- Serious Incident Requiring Investigation (SIRI) involving a patient death (Attempts will be made not to duplicate investigations. Instead findings of SJR will feed into the SUI process)
- All deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider: Mortality alerts from alerts for Summary Hospital-level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR), Dr Foster Unit at Imperial, Care Quality Commission (CQC) or other external regulator
- Inquest and issue of a “Regulation 28 Report on Action to Prevent Future Deaths”
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- All deaths in areas where people are not expected to die, e.g. Following elective procedures
- Deaths where learning will inform SWBH’s existing or planned improvement work such as due to sepsis, acute kidney injury (AKI), unrecognised deterioration and hospital acquired venous thromboembolism. To maximise learning, such deaths may be reviewed thematically
- People known to have or who might have a Learning Disability
- People who have Severe Mental Illness [national guidance on specific issues not yet available]
- People who are less than 18 years who die in adult care units [for example in Intensive Care]
- Maternal Deaths
- All deaths in specialties that have <10 deaths per month