University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 2 September 2021

	Trust Board paper L1
Report Title:	**Quality Committee – Committee Chair's Report**
Author:	Gill Belton – Corporate and Committee Services Officer

Reporting Committee:	**Quality Committee (QC)**
Chaired by:	Ms Vicky Bailey – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse
Date of meeting:	26 August 2021

Summary of key public matters considered by the Committee:

This report provides a summary of the key issues considered at the Quality Committee meeting on 26 August 2021:- *(involving Ms V Bailey, Quality Committee Non-Executive Director Chair, Ms K Gillatt, Associate Non-Executive Director, Dr A Haynes, Adviser to the Trust Board, Mr I Orrell, Associate Non-Executive Director, Mr M Williams, Non-Executive Director, Mr A Furlong, Medical Director, Ms C Fox, Chief Nurse, Miss M Durbridge, Director of Quality, Transformation and Efficiency Improvement, Ms D Mitchell, Acting Chief Operating Officer, Ms B O'Brien, Director of Quality Governance, Ms N Green, Deputy Chief Nurse, Ms S Bailey, CCG Representative, Mr P Aldwinckle, Patient Partner and Ms J Smith, Patient Partner. Dr H Brooks, Cancer Centre Lead Clinician, Ms S Khalid, Clinical Director, RRCV, Ms L Cowan, Head of Operations (MSS) and Ms E Broughton, Head of Midwifery, attended to present their respective items).*

- **Minutes and Summary of Quality Committee meeting held on 29 July 2021** – papers A1 and A2 (QC Minutes from 29 July 2021) were accepted as an accurate record and papers A3 and A4 (QC summaries from 29 July 2021) were received and noted.

- **Matters Arising Log** – paper B noted.

- **Cardiology Update**
  The Clinical Director (RRCV) attended the meeting to provide an update on the cardiology medical workforce and issues facing the cardiology service as a whole (emergency and elective). The Committee specifically received a progress update on initiatives to address concerns raised by HEEM in relation to Cardiology Trainees and was pleased to hear that following a recent HEEM visit, the issue had been de-escalated. Action was still required to: (1) substantively appoint to the Consultant and registrar medical posts for ward 15 (2) address rota issues in relation to CDU Trust Grades (3) review the acute cardiology model across site and (4) optimise catheter laboratory efficiency. In discussion on this item, members made note of the impact of increasing pressure in relation to Covid-19. The Acting Chief Operating Officer noted that her team would continue to work to support the RRCV Clinical Management Group in balancing emergency demand with elective recovery. In response to assurance sought by Dr Haynes, Adviser to the Trust Board, the Clinical Director of RRCV advised that there was nothing currently flagging in the safety data to indicate an elevated risk, but anecdotal feedback from staff suggested further focus was required and collaborative working would continue. She also made reference to system work being undertaken around revised pathways, particularly with regard to atrial fibrillation and heart failure. In response to a query raised by Mr M Williams, Non-Executive Director, as to which of the issues described were also applicable nationally or were unique to Leicester, the Clinical Director (RRCV) confirmed that an increased presentation of patients was a national issue, as was a shortage of Consultants in this field. The presentation of cardiology patients was a situation unique to Leicester. In most other Trusts, such patients presented through the Emergency Department, rather than through a dedicated Clinical Decisions Unit as was the case at UHL. In concluding discussion on this item, the Quality Committee Chair thanked Ms Khalid for her report, acknowledging the positive progress made as demonstrated at the last HEEM visit, and commended the local and system,-wide work being undertaken; the timeline relating to which would be helpful to receive in a future update. The Quality Committee Chair also acknowledged the need for an on-going focus on morale. The contents of this report were received and noted and it

was agreed that a further update would be presented in four months' time (i.e. December 2021).

- **Ophthalmology Long Term Follow Up Update**
  The Head of Operations (MSS) attended to present a report which provided assurances that patient safety concerns relating to the impact of the Covid-19 pandemic on the number of Ophthalmology patients overdue for follow-up was being addressed, monitored and reviewed and to evidence the systems and processes that had been implemented to mitigate further risk. Due to the impact of the Covid-19 pandemic, the number of ophthalmology patients overdue for follow up had increased to 31,000 patients in February 2021. This was an increase of 7,483 patients on the November 2020 position and an increase of 10,985 patients on the August 2020 position. Following an intensive period of concentrated, system wide working, this number had reduced to 23,903 by April 2021. At the end of July 2021 the backlog had reduced further to 20,185 (including paediatrics). In order to ensure that those patients waiting were not coming to any harm as a consequence, a process of manual administrative validation was completed, which was then followed by a clinical validation process. In the absence of a nationally defined risk stratification for out-patients, the Ophthalmology Clinical Team had agreed the criteria locally. Subspecialty stratification and discharge hubs had been set up to support virtual clinical review of the patients. The Leicester, Leicestershire and Rutland Community Eye Service (LLRCES) had been created under the umbrella of UHL contracting to support the care of emergency patients in the community and reduce EED attendance, the long term funding of which required identification and work was on-going in relation to this. LLRCES was the foundation of a support system that could significantly reduce the number of patients on the Glaucoma long term follow up waiting list. The Ophthalmology Service had applied for, and been granted, elective recovery funding for the community glaucoma funding scheme which would enable the transfer of a number of patients from the UHL Ophthalmology and Alliance follow up backlog into the community optometrist setting. The Cornea team had convened telephone clinics out of hours to review patients suitable for telephone follow up. Some of the general ophthalmology clinics in the Alliance had been converted into cornea clinics for high risk patients and the team had undertaken additional clinics at the weekend to ensure appointments for patients who needed to be seen within 2 weeks. The transfer of ophthalmology services into a community setting continued in order to deliver care closer to home and to create additional capacity within secondary care for high risk follow up patients on a sustained basis. The Chief Operating Officer thanked the Head of Operations (MSS) and her team for the significant amount of work undertaken in this respect, acknowledging that whilst the backlogs were large, the amount of innovative and transformative work undertaken to address these was significant. The Committee acknowledged that this issue was being owned and addressed by the system, in light of which it was agreed that a further update report should only be presented again to the Committee in three to four months' time if there were fundamental issues for consideration. If work continued to reduce the backlog successfully then a further report was not required. The contents of this report were received and noted.

- **Maternity HSIB and Maternity Safety Quarterly Report**
  The Head of Midwifery attended to inform the Committee of the progression of the Maternity Safety agenda, including Healthcare Investigation Branch (HSIB) reports, Serious Incidents and 72 hour reports for Q1 2021/22. It also highlighted the common themes from Datix reporting and progress on these. The Ockenden Report published in December 2020 specified as an 'essential and immediate' action, that the Trust Board and the Local Maternity and Neonatal System (LMNS) were sighted to any serious incidents occurring in the maternity service and made aware of the safety recommendations and learning from these incidents. Safety incidents in future would be included in the maternity safety report presented quarterly to the Executive Quality Board and Quality Committee, with any concerns or information escalated to the Trust Board. This process required embedding by December 2021, with the first review of evidence to assure the national team that UHL were compliant with the Ockenden recommendations taking place in July 2021. The main body of the report described the process for reviewing action plans and dissemination of learning with the reports and learning bulletins attached as appendices. The maternity risk strategy had been reviewed and a flow chart prepared to describe the reporting structure and governance processes to ensure compliance with the requirements described in the Ockenden Report. The contents of this report were received and noted and particular discussion took place regarding the learning from themes arising from specific HSIB reports and how this was being applied at UHL. Note was made of the value of the inclusion of patient feedback in the reports, in terms of a patient's overall experience encompassing more than just their medical care, which had led to the decision to submit HSIB reports within an overarching maternity safety report so that staff could really understand the receipt of care from a patient perspective. Whilst acknowledging the lessons that could be learned from reviewing the detail of an individual's care, the Committee also noted the benefit from review of general themes arising, and work was planned in this respect. The contents of this report were received and noted.

- **Cancer Performance Recovery**
  Dr Brooks, Cancer Centre Lead Clinician, presented an update on cancer performance recovery for the period ending June 2021. Cancer delivery and performance continued to be a key priority for the Trust. Due to the impact of the Covid-19 pandemic, there had been changes to cancer pathways, a decrease in activity and an increase in the tracking of patients. The changes made followed the National and Tumour specific Society recommendations

and ensured that patients were safe and received the time critical cancer treatments they required. In June 2021, the Trust achieved four standards against the national targets. The most significant challenges remained 2 week wait (2ww) capacity, 31 day and 62 day waits for surgery and treatment due to an increase in demand and a decrease in capacity. Overall performance was deteriorating, however more patients were being booked and changes had been put in place by clinical leads to ensure safe pathways. In presenting this report, Dr Brooks noted the finding that currently patients were presenting late and at a later stage resulting in surgical treatment no longer being a viable treatment plan for some. Staffing issues were also being experienced due to vacancies and staff absence relating to Covid-19, which was resulting in a reduced theatre capacity. Significant work was being undertaken with system partners and internally to improve the position. The Acting Chief Operating Officer acknowledged that as the Trust improved its position with regard to backlogs, an increasing number of patients were coming through the system, requiring scarce resource to be directed to the areas where it would have the most positive impact, and this position, with its inherent risks, was reflected nationally as well as locally. The pathway had observed a very significant increase in referrals and the Trust was working with primary care colleagues on how to best address this in order to ensure that the right patients received access to the appropriate clinical care and she expressed her thanks to the teams working under Dr Brooks' leadership for their continued hard work and focus in this area. Specific discussion took place regarding work on-going in relation to addressing required IT and audio-visual improvements. Note was also made of anecdotal information from patients regarding access to face to face GP appointments and assurances received from Primary Care that all relevant patients would have access to face to face appointments where appropriate. Note was also made of a particular annual non-recurrent funding stream which was to be discussed further at the Financial Recovery Board (FRB) meeting. The contents of this report were received and noted. The Committee acknowledged the positive transformation processes implemented, albeit were concerned regarding the overall backlog, particularly in view of the increasing number of referrals. The Committee were content that the Trust continued to give scrutiny to what could be resolved internally at an early stage in the process. Following discussion, and in view of the fact that the Trust Board would now be reviewing the Quality and Performance report at each of its meetings, it was agreed that a monthly report on cancer performance was no longer required for submission to the Quality Committee and that a quarterly report which focused specifically on harm (resulting from the circumstances giving rise to any decrease in cancer performance metrics) would now be appropriate.

- **CIP QIAs 21/22 – Quarter 1 Review**
  The Director of Quality, Transformation and Efficiency Improvement presented the first quarterly review of the Quality Impact Assessment (QIA process for the 2021/22 Cost Improvement Programme (CIP)). As at the date of report submission: (1) 317 CIP schemes had been registered on the Transformation 2021/22 CIP tracker as requiring QIAs (2) 101 QIAs for 21/22 had been submitted to the Transformation PMO (3) 16 schemes did not require a QIA as one was completed and approved when the scheme commenced on 20/21 or a QIA was not applicable (4) 43 schemes related to procurement; which equated to 108 QIAs across seven Clinical Management Groups, the Alliance and Corporate Teams. The outstanding PIDs for Procurement Schemes would be completed by the week commencing 30 August 2021 (5) 4 QIAs had been rejected and (6) 87 CMG and corporate area QIAs were outstanding. The Quality Committee were requested to: (a) note the progress with the completion and approval of QIAs for CIP schemes in 2021/22 (b) note that a further quarterly update would be presented in November 2021 and (c) note that the Director of Quality, Transformation and Efficiency Improvement would escalate concerns over any non-returns to the Chief Nurse and Medical Director. In presenting this report, the Director of Quality, Transformation and Efficiency Improvement, emphasised that it was an aim of the PMO to drive through cultural change, with the Quality Impact Assessments (QIAs) just one element of the process. She noted that schemes were added or suspended on a frequent basis and, as such, the number of schemes fluctuated accordingly. The table detailed under section 2.7 of the report detailed the QIAs submitted to the Transformation PMO by impact level. The Chief Nurse noted that there was to be external scrutiny of the QIA process as part of financial special measures to which the Trust was subject, and this would facilitate benefits in having the opportunity for an external view of the process. In response to a query, the Director of Quality, Transformation and Efficiency Improvement confirmed that all schemes had or were delivering with no or minimal risk and those for review by the Medical Director and Chief Nurse were sent to them in priority order. None of the 'red' schemes had commenced and would not do so until approval was received as nothing would be progressed 'at risk'. The Committee received and noted the contents of this report, with the Committee Chair acknowledging that this report constituted a helpful first report detailing the context. She requested that future such reports to the Quality Committee focused on QIAs relating to quality and safety to facilitate an understanding of any pertinent risks relating to any decisions being taken, noting it was important not to duplicate the information discussed at the Finance and Investment Committee (FIC).

- **Patient Safety, including Patient Safety Highlight Report, Patient Safety Briefing Report and Complaints Briefing Report**
  The Director of Quality Governance presented the following reports:-

  - **Patient Safety Highlight Report –** this report detailed (1) the key points from the Framework for Involving Patients in Patient Safety (2) documented the patient safety reporting requirements for the Professional

Standards of Care for Patients Waiting in Ambulances and how the Trust proposed to meet these (3) detailed the current position with regard to the Patient Safety Team staffing risk, including mitigating action and (4) detailed a proposal for future reporting to the Executive Quality Board (EQB) and Quality Committee (QC), including a monthly comprehensive Patient Safety Report, aligning the Complaints Reporting timescale with that of the Patient Experience Report and production of a Quarterly Patient Safety Update including regional and national updates and directives. The Quality Committee was requested to: (a) note the key points from the Framework for involving patients in patient safety and the proposal that the Director of Quality Governance and the Head of Patient Safety, as the Patient Safety Specialists, convened a regular meeting with the Executive Director for Patient Safety to discuss the requirements of the strategy and plan the UHL approach (b) note the incident reporting requirements of the Professional Standards document. Dedicated support was requested to support the review of the POA cases. It was requested that the Executive Director for Patient Safety approach the system for support with this significant piece of work as this represented a system issue (c) note the actions being taken to resolve the current situation, with an appeal to CMG members to respond to their complaints by the required deadline given to reduce a further administrative burden for the PILS team in chasing responses and (d) agree the proposed reporting changes which would commence for the September 2021 meetings;

- **Patient Safety Report July 2021 –** thirteen Serious Incidents (SIs) had been escalated in July 2021, including one Never Event. This maintained high number of SIs was largely due to a change in the way that inpatient falls incidents were being managed and the fact that every maternity referral to HSIB was now reported as an SI. There had been an increasing trend in the number of moderate and above harm incidents reported and validated harm incidents were also increasing (relating, this month, to reporting of some of the retrospective HCAI Covid-19 cases). There were fifteen incidents with evidence gaps in Duty of Candour which was consistent with the previous month, albeit it some were different incidents. No Safety Alerts had elapsed actions or had actions overdue their completion date during this reporting period. Specific discussion took place regarding the identification of three grade 4 pressure ulcers; two of which were Covid-19 device related and one which was not. Significant learning had been identified from review of these incidents and the Chief Nurse noted that she would be submitting the summary from the thematic review through the Quality and Safety process and would report on elsewhere within the Committee structure as appropriate. The contents of this report were received and noted;
- **Complaints Briefing Report** – this briefing paper provided a summary of complaints activity for July 2021 and the most recent performance data. The number of formal complaints this month had decreased compared to the previous month. The Emergency Department was the specialty with the most complaints and concerns and General Surgery had the largest rise in the number of complaints and concerns received in July 2021. There had been a higher number of re-opened complaints and the number of GP concerns had decreased. Four new PHSO cases had been received and no PHSO cases were closed in July. There had been a poor performance for complaints responses due to a small residual backlog of complaints, increasing activity and Corporate Patient Safety team staffing pressures, as documented on the Trust Risk Register ID 3755 at score of 16. Complaint themes and trends were now included within the bi-annual Patient Experience report to ensure the triangulation of all patient feedback. This then allowed for focused speciality or organisational actions to be developed and implemented improving quality and safety. In discussion, it was noted that the Trust did not take the view as to whether a complaint was upheld or otherwise as there were always valuable learning points, albeit it was noted that the Trust had a process for managing vexatious complaints. Note was also made of the inability to hold complaints resolution meetings during the pandemic which were frequently a very beneficial way of addressing and resolving complaints. The Quality Committee Chair noted the benefit in including within the report both the numbers, as well as percentages, of complaints. The contents of this report were received and noted.

- **Deteriorating Patient, Resuscitation and End of Life and Palliative Care Quarterly Report**

The Medical Director presented a report which provided an update on the work of the Deteriorating Patient Board, Resuscitation Committee and the End of Life and Palliative Care Committee that had taken place since the last update in May 2021. The dashboard was being moved to a 'live' environment so Clinical Management Groups could monitor their individual performance. The dashboard was being developed using an iterative process, with the aim being to facilitate understanding and ownership of the data by the individual CMGs and specialties with the view to having the data challenged and improved by those teams. The intention was for each CMG team to present their data at a selected DPB meeting. Sepsis data trends were broadly in line with the national picture with significant variation throughout the pandemic. UHL breached the upper control limit for mortality in coded sepsis patients in December 2020, January 2021 and February 2021, which was in line with the national picture and UHL returned to within control limits for March 2021. Insulin safety training compliance remained an issue for medical staff; targeted face to face training would now be undertaken to improve compliance. The role out of NerveCentre eMeds had meant that insulin prescribing would change which would reduce the number of insulin prescribing errors. The ICNARC Quarterly Quality report had demonstrated the spike in high risk admissions from wards but this was now back within control limits. Overall mortality increased, as expected, due to Covid-19 last year, this was particularly the case at Glenfield Hospital. Subsequent data analysis had demonstrated that outcomes were in line with the national picture. Tracheostomy ward rounds had recommenced following their suspension at the

beginning of the pandemic. The service remained under pressure due to the fact that tracheostomy care was an aerosol generating procedure. Cardiac arrest rates and outcomes were currently within expected ranges. An amended risk assessment and SOP had been agreed at the Resuscitation Committee and Children's Board regarding the paediatric cardiac arrest provision on the Glenfield Hospital site. A new Palliative Care Consultant and End of Life Lead had commenced in post in April 2021. Work was underway to review the clinical vision, driver diagram and terms of reference for the Committee to ensure the right representation and reflect the learning from the Covid-19 pandemic. SPELTIP continued to provide a Clinical Nurse Specialist Service to the emergency floor areas. Medium term funding has been secured and a business case was being produced to secure longer term investment. The contents of this report were received and noted.

- **Mortality and Learning from Deaths Quarterly Report**
  The Medical Director presented the Mortality and Learning from Deaths Report, the contents of which were received and noted. **The cover sheet and appendix 2 to the Mortality and Learning from Deaths Quarterly report are attached to this summary for the attention of the Trust Board**. In discussion on this report, the Quality Committee Chair noted the benefit in including specific, rather than generalised, actions within an action plan, as these were more readily measurable. The contents of this report were received and noted and it was agreed to highlight specific elements of this report (as attached) to the Trust Board for information.

- **Infection Prevention Annual Report**
  The Chief Nurse presented the Infection Prevention Annual Report, which reviewed the 2020/21 Infection Prevention successes and challenges for the Trust, and constituted a separate item on the public Trust Board agenda (paper I refers on the 2 September 2021 Trust Board agenda). The presentation of this report was a statutory requirement of the Trust and concluded that the Infection Prevention audit programme was compliant with The Health and Social Care Act: Code of Practice on the prevention and control of infections and related guidance. The audits included evidence based interventions to reduce the risk of infection to provide education and feedback to clinical staff. Section 3 of the Infection Prevention Annual Report outlined the measures taken by the Trust to ensure national and local policies and guidance were met and adhered to. In response to a query raised by Mr M Williams, Non-Executive Director, the Chief Nurse confirmed that the year-end position for UHL was 78 (out of an allotted trajectory of 108) Clostridioides Difficile Infections (CDI) cases. The contents of this report were received and noted.

- **Quality and Performance Report – Month 4 2021/22**
  As this report constituted an item for consideration on the agenda of the Trust Board meeting of 2 September 2021, its contents were received and noted by the Quality Committee.

- **Covid-19 Position – August 2021**
  The Medical Director and Chief Nurse reported verbally with regard to the Covid-19 position as at August 2021. The number of cases were, again, increasing; with the system 'running hot' at Escalation Level 3. There was significant pressure across the region in terms of ITU capacity which was likely to lead to the taking down of elective activity to accommodate this. The Trust continued to review its surge plans and specific note was made of the continuing and on-going need to vaccinate people who had not yet taken up their vaccine. The Chief Nurse noted that the increasing community transmission of Covid-19 was likely to flow through to increased hospital admissions and she confirmed that a small number of outbreaks within the Trust had now been resolved.

- **Items for noting**
  The following reports were received and noted for information:-
  (1) Falls Annual Report;
  (2) Pressure Ulcers Annual Report (the Chief Nurse highlighted that there had been a fundamental change to the way in which pressure ulcers were being monitored and measured, with the position being tracked through four quarters. There was an extensive improvement plan, with the use of QI methodology, and collaborative work was being undertaken alongside the Director of Quality, Transformation and Efficiency Improvement's team);
  (3) Transfusion Committee Update
  (4) Radiation Safety Annual Report
  (5) EQB action notes – July 2021

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval

- Infection Prevention Annual Report (features as a separate Trust Board agenda item for 2 September 2021)

Items highlighted to the Trust Board for information:

- Cardiology Update;
- Ophthalmology Long Term Follow Up Update;

• Maternity HSIB and Maternity Safety Quarterly Report; • Cancer Performance Recovery**,** in particular the intention for the Quality Committee to receive quarterly harms reports in the future rather than monthly performance reports, and • Mortality and Learning from Deaths Quarterly report (relevant sections as appended to this summary).	
Matters deferred or referred to other Committees: none.	
Date of next QC meeting:	Thursday 30 September 2021

Ms V Bailey – Non-Executive Director and Quality Committee Chair

UHL Mortality and Learning from Deaths Report

Author: [Head of O&E – Learning From Deaths & Deputy Medical Director] Sponsor: [Medical Director]

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
Mortality Review Committee (MRC)	03/08/21	Decision and Discussion
Executive Board - EQB	10/08/21	Discussion and Assurance
Trust Board Committee – QC		
Trust Board		

Executive Summary

1. 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:

- Bereavement Services Office
- Medical Examiner Process
- Bereavement Support Service
- Specialty Mortality Reviews using the national Structured Judgement Review tool
- LLR Child Death Overview Panel reviews and 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

1.3. One of the national Learning from Deaths requirements is for Trusts to publish their Learning from Deaths data on a quarterly basis and to provide quarterly data to the National Medical Examiner office. Publication of perinatal mortality data is also one of the requirements of the Clinical Negligence Scheme for Trusts' (CNST) Maternity Incentive Scheme.

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?

3. Conclusion

3.1

i) 20/21 saw both the number of admissions and the number of deaths go beyond the 'SPC limits' during the first and second peaks of the COVID pandemic with the obvious impact on our crude mortality rate. All are now back 'within control' and our crude mortality rate for 21/22 to date is similar to pre COVID years.

ii) We are also monitoring our Emergency Department mortality rates but currently are not able to compare this with other organisations either at crude or risk adjusted level. Slide 4 shows our ED mortality data using Statistical Process Control charts and again we can see that both activity and numbers of deaths were out with normal limits for the 2 COVID peaks but has also returned to normal variation.

iii) UHL subscribes to the Dr Foster Intelligence (DFI) Clinical Benchmarking tool (see Slides 5 to 7) which enables us to monitor and further analyse our HSMR risk adjusted mortality against all other Trusts. The HSMR includes 56 diagnostic groups which contribute to 80% of in-hospital deaths in England. These data are used by the CQC as part of their 'Performance Monitoring'.

iv) Although our crude mortality has now return to normal levels, our HSMR is still 'above expected' at 112 for the latest available 12 months (April 20 to March 21). The HSMR does not include COVID activity or deaths where this is the primary diagnosis on admission but will include if it is the secondary diagnosis (i.e. Congestive Cardiac Failure; COVID 19) or if the patient becomes positive for COVID after the 1st FCE (Finished Consultant Episode).

v) We are also able to use the DFI tool to compare risk adjusted mortality for all diagnoses groups (SMR) which includes COVID activity and deaths. UHL's risk adjusted mortality for the SMR for the same time frame is 118 and is also 'above expected'.

vi) Our crude mortality for both the HSMR and SMR is below the national average but is above the 'expected mortality' according to the DFI risk adjustment model.

vii) Following the Dr Foster 'Deep Dive' analysis undertaken in February 2021, we have now reviewed all the diagnosis groups flagged as having a higher relative risk for the 6 months April to November 20 (Septicaemia; Urinary Tract Infection; Acute Bronchitis; Fractured Neck of Femur; Acute Renal Failure and 'Senility and Organic Mental Disorders')

viii) The outcome of those reviews have been presented and discussed at MRC and all but one (Acute Renal Failure) have been previously included in the Quarterly Mortality Report. No issues relating to poor clinical care were found.

ix) Acute Renal Failure was discussed at the July MRC meeting where it was noted that the 'increase' in mortality for this diagnosis group was associated with the first peak of the COVID pandemic and that this would seem to fit with the national picture and which was in line with the clinical understanding

of the disease at that stage. Correlation of the Acute Renal Failure HSMR with other national speciality specific monitoring data has not identified any issues with care. Our DFI Consultant advised that if patients with a secondary diagnosis code of COVID had been excluded from the HSMR dataset, we would not have alerted in any month.

x) NHS Digital publishes the SHMI on a monthly and quarterly basis. In order to try and negate the impact of the COVID pandemic, NHS Digital have removed all COVID activity and deaths from the SHMI dataset – including where COVID is a secondary diagnosis or the patient subsequently dies within 30 days of discharge from hospital and COVID is on their death certificate.

xii) UHL's latest SHMI covers the financial year 2020/21 and, published on 12th August, was 104 and continues to be within the expected range.

xiii) As previously reported, none of the reviews undertaken have identified any significant issues either with care of individual patients or with clinical pathways. There does appear to have been a causal link between the Coders working remotely and using primarily electronic records for Coding and the change in our Expected Mortality rate.

xiv) However, taking into account the findings of all the various reviews undertaken it does appear that the risk adjustment methodology has been unable to sufficiently adjust for the COVID pandemic impact – either with or without removal of COVID cases.

xv) At the August MRC, our Dr Foster Consultant advised that a similar increased relative risk for the HSMR and SMR was being seen by other Midland Trusts where there had been a higher number of COVID related deaths and agreed to undertake a more detailed analysis for the next meeting.

3.2 The 20/21 Learning from Deaths (LfD) activity is summarised in Appendix 2.

i) There were 4,059 deaths in 20/21 which went through the UHL Learning from Deaths process, this was 650 more than in 19/20 as was expected in light of the COVID pandemic. UHL's LfD programme includes some deaths where patients have died after discharge but UHL are asked to support the death certification process. Also in 20/21, UHL's Medical Examiners supported LOROS with their death certification and proportionate scrutiny during June to September and we carried out a small pilot with Primary Care deaths.

ii) Medical Examiner Screening involves the MEs speaking to the Certifying Doctor to determine whether a cause of death can be agreed or Coroner Referral required; speaking to the Bereaved to confirm if they agree with and understand the cause of death and whether they have any questions about care and finally undertaking proportionate scrutiny of the clinical records. (see Slide 7)

iii) In 20/21 the MEs undertook all 3 aspects of ME screening for 3220 cases and referred 305 for feedback to the clinical team and 769 for further review including those meeting national requirements.

iv) The Medical Examiners spoke to 3,220 Bereaved Relatives during 20/21 (see Slide 8). Quarter 2 saw the highest proportion of negative feedback and the lowest proportion of positive feedback, both in respect of all deaths and specifically where the patient had COVID. It was noticeable at the time that Bereaved Relatives were becoming more frustrated about the Restricted Visiting and difficulties with communication after the initial period of support and understanding during the first wave of the Pandemic. Reassuringly, we saw the most positive feedback about both Communication and Care at End of Life care being received in Quarter 4.

v) If the Bereaved raise a concern or have questions about care to the Medical Examiner, they are asked if they would like to know the outcome of any review undertaken or to receive feedback from the team via the Bereavement Nurses

vi) UHL has two full time Bereavement Nurses (service started in 2015 in response to the LLR 'Learning Lessons Mortality Review') (see Slides 9 and 10).

vii) As well as making routine follow up calls to Bereaved Relatives (where requested) the Bereavement Nurses have also worked closely with the Medical Examiners, being able to urgently 'pick up cases' where either the bereaved have been very distressed or there are lots of questions and concerns which need early review or involvement of the clinical team

viii) Where possible (and appropriate) the Bereavement Nurses also try to answer questions or resolve concerns which the Medical Examiners were not able to do – either because of insufficient information available at the time or it was not the right time to try and explain clinical decision making etc.

ix) If the Bereavement Nurses are unable to make contact (after 2 attempts) a letter is sent to the Bereaved, advising that the Nurses have tried to speak to them and providing contact details if wanted.

x) Following feedback and experience, we are now adapting the letter sent to the next of kin from bereavement support to provide information about any queries raised with the Medical Examiner, where the Bereaved requested to know the outcome or to confirm that concerns expressed have been shared with the clinical team and responses received if applicable

xi) Where the Bereaved are thought to need ongoing support for their grief, the Bereavement Nurses provide advice and details about relevant Bereavement Support Agencies, dependent upon the bereaved's particular circumstances.

xii) 522 (25%) Bereaved Relatives/Carers were signposted to a support agency during 20/21 which was 3% higher than the previous year.

xiii) The proportion of cases referred for further review by the ME are similar for COVID related deaths (16%) with a slight increase in proportion referred in response to feedback from the Bereaved (12%).

xiv) Where cases are referred for further review by the Medical Examiner, just over half (51%) related to Clinical Management and just under half (49%) to End of Life Care.

xv) Of the 589 completed reviews, learning was identified for 320 cases with the majority of actions being around feeding back to individuals or clinical teams.

xvi) Assessment, Diagnosis and Plan; Communication (with Patient/Relatives); and Monitoring, Recognition and Escalation (mainly relating to End of Life Care) are identified as Top Themes for all 3 areas of the LfD programme (Medical Examiners, Bereavement Nurses and Specialty M&Ms)

xvii) 11 deaths in 20/21 were considered to be more likely than not due to problems in care (see Slide 17). Ongoing review of progress with actions will continue.

xviii) **In 21/22 Quarter 1 we had 732 deaths (see Slide 18)**

xix) Of the 732 deaths, feedback was sent or further Review requested for 202 Adult deaths (35 Child/Neonatal deaths have been automatically taken through the Child Death/Perinatal Mortality Review process).

xx) 133 Reviews (65 SJRs) have been requested (either by the Clinical Team, Specialty M&M or through the Patient Safety framework) and 32 have been completed to date. This includes 9 SJRs – no deaths were considered to be more likely than not due to problems in care.

3.3 National Reporting Requirements:

i) The perinatal mortality rate for the first 3 months of 2021 is approximately in line with previous years. The stillbirth rate appears to have returned to our baseline after the excess of stillbirths noted in the first quarter of 2020 (previously reported to EQB). Performance against Standard 1 of the Maternity Incentive Scheme is presented in this report and all parts of the standard have been met.

ii) Details of learning identified during meetings held in the last quarter and progress with actions agreed for cases reviewed at PMRG meetings between January 2020 and April 2021 were reviewed in detail at the Quality Committee

iii) CNST's requirements for Year 4 have just been published and include tighter timescales for most parts of Standard 1. Plans meet the new timescales will be discussed at the next Perinatal Mortality Review Group meeting.

iii) In July we submitted our Quarter 1 return to the National Medical Examiner Office. We are currently awaiting confirmation as to whether all costs will be funded.

4.0 Next Steps

4.1 Mortality Rates

i) Continue monitoring our risk adjusted mortality and correlating this with both our crude mortality as well as other available monitoring data

ii) Where any new diagnosis groups appear to be deteriorating, to cross reference individual patient outcomes with our Learning from Deaths data

4.2 Learning from Deaths

i) Integrate the Bereavement Services Office with the rest of the LfD team and complete a capacity and demand review of the resources needed to support all of the mortality and learning from deaths activity in adults and children.

ii) Expand the ME service to include all deaths within LLR in line with national guidance – currently on a non-statutory basis.

iii) Review the processes around communication between the ME Office and the M&M teams.

5.0 Input Sought

To receive and note the content of this report.

For Reference** (edit as appropriate)**:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Safely and timely discharge	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Not applicable]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Not applicable]
e-Hospital	[Yes]
More embedded research	[Not applicable]
Better corporate services	[Yes]
Quality strategy development	[Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required N/A
- How did the outcome of the EIA influence your Patient and Public Involvement ? N/A
- If an EIA was not carried out, what was the rationale for this decision? N/A

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	Yes	Principal Risk 2
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: November 2021

6. Executive Summaries should not exceed **5 sides** [My paper does comply]]

UHL'S LEARNING FROM DEATHS

AUGUST 21

UHL's Learning from Deaths Framework

• **Bereavement Services Offices** – Co-ordinate the Death Certification process across all 3 sites

• **Medical Examiners (MEs)** – ME Scrutiny involves discussion with a member of the Clinical Team caring for the patient before death to confirm if a death certicate can be issued or referral to the Coroner indicated. The ME then undertakes Screening of the case – to include speaking to the bereaved relatives/carers and 'proportionate scrutiny' of the deceased's clinical records (paper and electronic) .
• Where Screening identifies potential areas for learning by the clinical team(s), the case will be sent to the relevant team/discipline or Specialty M&M for further review or feedback and reflection.

• **Bereavement Support Nurses (BSSNs**)– 'follow up contact' for the bereaved relatives/carers; liaise with both the MEs and Clinical Teams where families have unanswered questions or their feedback to the Medical Examiner has led to a request for further review of care. Also sign post the bereaved to appropriate support agencies where unmet bereavement needs identified.

• **Specialty Mortality & Morbidity Programme (M&M)** – involves full Mortality Reviews (SJRs) where meet National criteria (death of a child/neonate; death of a patient with a Learning Disability or Serious Mental Illness; death following an elective procedure) or are referred by the ME or members of the Clinical Team.

• **M&M meetings** confirm Death Classification, Lessons to be Learnt and should oversee the taking forward of agreed Actions to improve the care for all patients

• **Clinical Teams** – responsible for reviewing the care of patients where Mortality screening has identified potential learning about the end of life care or other patient experience issues

• **Patient Safety Team (PST)** – if a 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.

• **Inquest Team** – support the Inquest process where a death taken for investigation by the Coroner

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

UHL'S LEARNING FROM DEATHS PROGRAMME 20/21

Where Patient Died	Adult	Child	Neonate	All Deaths
In-patient	3592	22	75	3689
Emergency Department	227	17		244
Community Hospital or Primary Care	67	4		71
LOROS (Pilot – Jul to Sept 20)	55			55
All LfD Deaths	**3941**	**43**	**75**	**4059**

Most deaths were those where patients died in our hospital (either as an In-patient or in the Emergency Department)

71 cases died in the Community (ie either in one of the Community Hospitals or in Primary Care) but the death certification process was supported by UHL or the death was reviewed as part of a Specialty M&M process

55 LOROS deaths were subject to Medical Examiner scrutiny for death certification purposes and screening of the clinical records undertaken for feeding back to LOROS as applicable

UHL'S LEARNING FROM DEATHS PROGRAMME 20/21 - COVID

20/21 was obviously an unprecedented year in respect of the increased number of deaths and the fact that this increase related to a single cause (Coronavirus)

UHL InPt/ED Death	Positive COVID Swab < 28 days of Death	Either a Negative Swab or Positive COVID Swab BUT > 28 days before Death	ALL
COVID ON MCCD	1352	83	1435
COVID NOT ON MCCD	88	20	108
ALL	1440	103	1543

1,435 deaths were considered to be related to COVID 19 infection (ie COVID 19 was on either Part 1 or Part 2 of the death certificate).

COVID numbers included in this report may differ from that recorded elsewhere because of the national reporting criteria.

There were 103 patients who had a positive swab whilst in UHL (either within 28 days or more than 28 days before death) where COVID was not thought to have contributed to death

All Coronavirus related deaths have been through the Medical Examiner process as per other deaths and referred for further review where potential for learning identified from speaking to the Bereaved or Screening of the case records. The only difference has been that all Bereaved Relatives were contacted by either the Medical Examiner or Bereavement Nurse to advise re the NHSIE reporting requirements and the ME Office team prepared relevant information for reporting purposes.

We have also added 'COVID' as a theme to our Learning Themes and considered if there any themes which are specific to COVID related deaths

Bereavement Services Office (BSO)

- The BSO Team have always worked closely with the Medical Examiner on all 3 sites and from September will be part of the Learning from Deaths Team
- As with the rest of the LfD team and the Trust overall, the BSO saw an increase in activity during 20/21 with 21% more deaths compared to 19/20

Key Roles of the BSO are:

- Ensuring a timely death certification process (involves identifying a relevant doctor to speak to the Medical Examiner (62% same/next day; 84% discussed within 4 days of death)
- Supporting the Coroner Referral process where applicable following discussion with the Medical Examiner and keeping the family informed accordingly (18% of all deaths referred; 10% taken for further Investigation)
- Liaising with the families and Funeral Directors in respect of type of funeral arrangements and co-ordinating completion and checking of Death Certificate and Cremation Forms as applicable (82% Cremations)
- Supporting the Urgent Release of the Deceased where requested in liaison with the Mortuary and Medical Examiner office (94% achieved within 24 hours)
- Arranging funerals of baby losses over 16 weeks (if requested by the mother) (86 in 20/21)
- Locating a next of kin if none known and organising a Hospital Funeral if needed (45 were arranged in 20/21)

Challenges and Priorities for 21/22

- The main challenge for the BSO is identifying doctors available for discussion about the cause of death with the Medical Examiner and having to explain to the families why there are delays with the death certification process
- Linked to this is the fact that most doctors are not available to discuss the death until the afternoon which means that the Certificate is not ready for sending to the Registrar before they close.
- One of the priorities for 21/22 is to look at what can be done to facilitate an earlier discussion with the certifying doctor
- The other priority is to review the Out of Hours Urgent Release of the Deceased Process in collaboration with the Mortuary Services and Duty Manager to see how to reduce the impact on the Duty Managers whilst meeting requests for Urgent Release

MEDICAL EXAMINER PROCESS

- **The ME process involves:**

– Preparing relevant clinical information to support effective discussion with the certifying doctors i.e. Datix, Ambulance Records, NerveCentre, ICE letters, CITO records and latterly ICE COVID results (Medical Examiner Officer)

– Identifying the appropriate doctor to discuss cause of death (Bereavement Services)

– Discussion with the Certifying Doctor and agreeing cause of death or referral to the Coroner (occasionally completing MCCDs/Crem Forms on behalf of Clinical Team)

– Reviewing Coronial Referrals (occasionally completing referrals on behalf of the ED team)

– Explaining the proposed cause of death to the Next of Kin and giving them the opportunity to ask questions about this or care provided

– Proportionate Scrutiny (screening) of the electronic and paper clinical records

– Triangulating the above to make a judgement as to whether any need for further review by the Specialty M&M or Clinical Team or for feedback for reflection and learning

SUMMARY OF UHL'S MEDICAL EXAMINER PROCESS 20/21 (EXCLUDES LOROS DEATHS)

UHL Learning from Deaths Cases	Adult	Child	Neonate	All
Cause of Death / Coroner Referral Discussed with Medical Examiner	3859	28	21	3908
% Discussed	99%	68%	53%	98.6%*
All UHL LfD Deaths	**3888**	**41**	**75***	**4004**

*35 of the Neonatal deaths were Stillbirths which - as per national guidance - are not included in the Medical Examiner process

UHL Deaths (excl Stillbirths)	Adult	Child	Neonate	All
Proportionate Scrutiny Undertaken	3872	30	21	3921
% Scrutinised	99.6%	73%	53%	99%
All UHL LfD Deaths	**3888**	**41**	**40**	**3969**

*Total does not include Stillbirths

Medical Examiners discussed the Cause of Death/Coroner Referral and Spoke to the Bereaved and Scrutinised the Clinical Records for 82% of Child and Adult Deaths

Death Referred to the Coroner	Adult	Child	Neonate	All
Not investigated - Issue MCCD	334	2	2	338
Taken for PM or Inquest	358	22	5	385
All Referrals	**692**	**24**	**7**	**723**

*Includes Coroner Referrals without discussion with the Medical Examiner primarily child deaths in the Em Dept)

UHL Deaths - Excl Stillbirths	Adult	Child	All
ME Spoke to the Bereaved	3220	3	3223
% Spoken to	91%	16%	91%
Deaths (where not investigated by the Coroner)	**3530**	**19**	**3549**

- In 20/21 the MEs were not speaking to the parents of Neonatal deaths
- Where death taken for investigation by the Coroner, the ME does not usually* speak to the Bereaved

(*unless reason for referral is due to concerns raised by the Bereaved after discussion with the ME)

UHL Learning from Deaths Cases	Adult	Child	ALL
All Aspects of Screening	3217	3	3220
% All Aspects	83%	7%	82%
All UHL LfD Deaths (excl Neonate	**3888**	**41**	**3929**

FEEDBACK FROM THE BEREAVED

	Compliment	Generally Happy	No Concern	Compliment & Concern	Concern	All
Feedback durin 20/21	20%	11%	53%	1%	15%	100%
Number who gave Feedback	634	354	1698	36	495	3217

When speaking to the Bereaved, the MEs ask them if they have any comments or questions about care overall and will also capture if positive or negative comments are made about end of life care or communication.

There was little difference in Feedback received from the Bereaved throughout the year or between COVID and non COVID patients; except for End of Life communication – mainly related to 'imminence of death' in time for 'EoL visiting' and mainly in respect of patients with COVID during Q2

Where concerns about care raised, the ME will ask the Bereaved if they would like to receive feedback about the outcome of any review.

Of the 531 Bereaved Relatives / Carer where a concern was raised (with or without a compliment) 241 (45%) said Yes to receiving feedback which is facilitated through the Bereavement Nurses

EoL COMMUNICATION	Pos	Didnt	Neg	All
Q1	34%	59%	7%	100%
Q2	32%	62%	6%	100%
Q3	39%	55%	7%	100%
Q4	41%	53%	6%	100%
All	**37%**	**56%**	**6%**	**100%**
NO. OF RELS WHERE FEEDBACK RECEIVED	**1156**	**1659**	**386**	**3201**

END OF LIFE CARE	Pos	Didnt	Neg	ALL
Q1	34%	59%	7%	100%
Q2	32%	62%	6%	100%
Q3	39%	55%	7%	100%
Q4	41%	53%	6%	100%
ALL	**37%**	**56%**	**6%**	**100%**
NO. OF RELS WHERE FEEDBACK RECEIVED	**1790**	**209**	**1207**	**3206**

UHL' Bereavement Support Nurses

- The Bereavement Nurses make 'follow up contact' calls to the primary Bereaved Relative/Carer (NoK) – usually 6 to 8 weeks after death (earlier contact made if requested by the Medical Examiner or Bereavement Services Office or Clinical Team)
- There are main purposes of the Follow Up call
  - to give the family an opportunity to raise any unanswered questions re care or cause of death (either because not thought of at time of speaking to the ME, too distressed at time of discussion with the ME or have come to mind since that conversation)
  - to see whether there are any ongoing bereavement needs – whilst not trained counsellors, the Bereavement Nurses have been trained to pick up on unmet needs or complicated grief – and to 'signpost' to the appropriate Bereavement / Counselling Agencies as applicable
  - To feedback the outcome of any reviews that were requested as a result of concerns raised by the Bereaved at time of speaking to the Medical Examiner
- In 20/21 in addition to providing the above service, the Bereavement Nurses also supported the Critical Care Units with the daily phone calls to Relatives during the COVID Pandemic
- The Bereavement Nurses have also been supporting the Head of OE – Learning from Deaths with collating the outcome of Medical Examiner Screening and requesting reviews from the Clinical Teams/Specialty M&Ms and following up review progress where outcome awaited by the Bereaved
- The Senior Bereavement Nurse has also been working closely with the Children's Hospital to review and support establishing a Bereavement Support process for the parents of children who die in our care

20/21 Bereavement Nurses Activity

- 2451 (63%) Bereaved Relatives/Carers accepted the offer of a 'follow up' phone call at 6-8 weeks from one of the Bereavement Nurses (adult deaths only) A small number (1%) requested a 'follow up' letter without a call

- During 20/21 the Bereavement Nurses provided bereavement follow up for just over 2,000 Bereaved Relatives/Carers. This is around 700 more families than in 19/20 (includes 193 Bereaved Relatives who had initially declined or asked for Written Follow up or initially thought no NoK)

- Approximately a Quarter of Relatives were 'signposted' to a Bereavement Support Agency as they appeared to be struggling with their bereavement. Main agencies signposted to were:
  CRUSE; The Sharma Centre; Way Up (for 50 yrs+); National Bereavement Partnership; Silverline; Winston's Wish (Child Bereavement); Child Bereavement UK; Hope Support (Online for 11-25 y olds) Rainbows (specifically offered during COVID)

- Most (78%) Bereaved Relatives/Carers did not need any further intervention from the Bereavement Nurses - includes those where outcomes of reviews (where requested) fed back during 1st Contact Call and any questions answered by the Bereavement Nurses

- A small number (25) had already submitted a complaint or were assisted by the Bereavement Nurses to write a complaint letter

- Further contact was arranged for 190 (10%) families to feedback the outcome of reviews as part of the LfD process or to facilitate further discussion/meeting with the clinical team

- Additional bereavement follow up from the Bereavement Nurses was provided for 251 families (12%)

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, ReSPECT, DNACPR documentation
  - 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,

OUTCOME OF MEDICAL EXAMINER SCREENING

Further Review	Adult	Child	Neonate	Grand Total
No	3235			3235
Yes	653	41	75	769
All	**3888**	**41**	**75**	**4004**

No Further Reviews or Feedback was sent for 2,487 (62%) of deaths following ME Screening . In 305 (8%) cases Feedback was sent to the clinical team and Bereavement Support follow up requested for 149 (3.5%) cases. Learning Themes identified in 294 (7.5%) cases.

Type of Review or Investigation	Adult	Child	Neonate	ALL
Structured Judgement Review	308	31	66	405 (10%)
Review by Clinical Team	283			283 (7%)
BSS Facilitated Review	27			27 (1%)
Investigation by LLR CDOP or HSIB		10	9	19 (0.5%)
SI Investigation	5			5 (0.1%)
Patient Safety Incident Review	11			11 (0.3%)
Complaint	19			19 (0.5%)
All	**653**	**41**	**75**	**769**

The above table includes reviews / investigations automatically requested without ME input

TYPES OF FURTHER REVIEWS AND REASONS REQUESTED

Reason for Review	SJR by M&M	Clinical Review by Team	BS Nurse Facilitated Review	Complaint	HSIB / CDOP Investigation	SI Investigation	Pt Safety Incident	All
Medical Examiner Scrutiny	109	179		4		2	7	**301**
Feedback from Bereaved	21	80	27	14			1	**143**
Child or Neonatal Death	96				19			**115**
Death post Elective Procedure	38							**38**
Learning Disability Death	38	1						**39**
Serious Mental Illness Death	39	4		1				**44**
Quality Improvement		1						**1**
Specialty Criteria	60	17					3	**80**
Bereavement Nurses Requested	1	1						**2**
Patient Safety Team Requested	3					3		**6**
ALL REVIEWS	**405**	**283**	**27**	**19**	**19**	**5**	**11**	**769**

In order to avoid duplication of effort, where it is known a complaint /patient safety investigation already in progress / anticipated, the ME will not usually refer for a separate review through the Learning from Deaths process until it is confirmed this is needed

PROGRESS WITH 2020/21 REVIEWS

Review Progress	Adult	Child	Neonate	Grand Total
Completed	495	27	67	589
All Reviews	653	41	75	769
% Completed	**76%**	**66%**	**89%**	**77%**

The above table includes both Clinical Reviews and SJRs and all types of Investigations

The table below shows number and % of Structured Judgement Reviews completed

SJR Progress	Adult	Child	Neonate	ALL
SJRs Completed	266	27	58	351
SJRs Requested	**308**	**31**	**66**	**405**
% Completed	**86%**	**87%**	**88%**	**87%**

UHL's M&M Policy Standards are that
75% of SJRs should be completed within 4 months of death and 95% within 6 months

Performance against UHL Standards	Q1	Q2	Q3	Q4
SJR Completed	**97 (93%)**	**99 (92%)**	**82 (86%)**	**73 (74%)**

We have not quite met our 6 Month Standard of 95% for either Quarters 1 or 2 and Quarter 3 is 10% below the threshold. However, Specialties are to be congratulated at achieving this level of performance considering the clinical pressures faced during 20/21. It is also good to see that we have almost met the 4 Month Standard of 75% for Quarter 4 reviews.

TYPES OF LEARNING THEMES
(as agreed with M&M Leads in 20/21)

OVERACHING THEMES	SUBTHEMES
1. Assessment, Diagnosis & Plan	1. Assessment 2. Diagnosis 3.Management plan
2. Communication – Patients & Relatives	4. Results/Management Discharge/Plan 5. Imminence of Death / DNACPR / Prognosis 6. Reasonable adjustments
3. Dignity & Compassion	7. ADL Assistance / Reasonable adjustments 8. Compassion / Attitude 9. Environment
4. Discharge	10. F/up management plan 11. Package of Care / Equipment 12. Discharge planning
5. Documentation - Paper & Electronic	13. Correspondence - with patients, other clinical teams 14. Clinician documentation with the clinical record 15. Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments
6. Investigations & Acting on Results	16. Investigations 17. Results
7. Multi-Disciplinary Team Working	18. Inter-specialty liaison / continuity of care . ownership 19. Inter-specialty referrals / review 20. Inter-team issues (within same specialty)
8. Medication	21. Prescribing 22. Supply 23. Administration 24. Review
9. Monitoring, Recognition & Escalation/Ceiling of Care	25. Monitoring 26. Recognition 27. Escalation / Ceiling of Care
10. Transfer & Handover	28. Delays to correct specialty / setting 29. Inappropriate outlying / Transfer arrangements incl where pt not clinically fit for transfer or inappropriate transfer arrangements - to take into account level of acuity 30. Omissions / Errors in Handover Communication
11. COVID (new theme for 21/22)	31. COVID Acquisition 32. COVID Vaccine Failure/Reaction

MAIN THEMES / ACTIONS IDENTIFIED THROUGH THE UHL LEARNING FROM DEATHS PROGRAMME IN 20/21

- Of the 589 completed reviews, learning was identified for 320 cases
- The top 3 themes for learning are Assessment, Diagnosis and Plan; Communication (with Patient/Relatives); and Monitoring, Recognition and Escalation (mainly relating to End of Life Care).
- Identified Themes were reviewed at the August Mortality Review Committee and it was noted that proportions of themes were similar between COVID and non COVID patients. However, it was also noted that Bereaved Relatives of patients who had COVID were more likely to raise concerns
- MRC Members also discussed that there had also been a number of cases where 'Multi-Disciplinary Working' and 'Inter-Disciplinary and Inter-Specialty Liaison' were considered to be underpinning causes where deaths considered to be more likely than not due to problems in care.
- Actions were agreed in response to the review outcome and identified learning for 220 cases
- Actions arsing from the themes include share learning, feedback & reflection, clinical discussion at M&M, review guidelines, develop guidelines, review processes, education and audit.

Deaths more likely than not to be due to problems in care in 20/21

There were 11 deaths during 20/21 which were considered to be 'more likely than not' due to problems in care. All have been previously reported to EQB as individual cases.

At the August MRC, Members reviewed a summary of the Learning outcomes and agreed actions:

- Complication of tracheostomy insertion – learning relates to availability of equipment/staff - ***theatre trachy SOP/guideline being agreed***
- Recognition and management of hyponatraemia – ***new guidelines being available***
- InPatient fall and disjointed and delayed review and lack of recognition of anticoagulation medication – ***Personal reflection. Future N/C development to create 'collated task list' for a patient***
- Missed opportunity for earlier diagnosis of ovarian cancer in patient who had previously had abnormal cervical smear –*Patient Safety Incident/Compliant review in progress*
- Missed diagnosis of NSTEMI and patient discharged to COVID Virtual Ward – *SI investigation in progress*
- Prolonged immobility whilst awaiting spinal clearance due to referrals not being acted upon and not escalated when no review took place – ***eReferral via NerveCentre in progress***
- Hep B prophylaxis not maintained where patient at risk and requiring chemotherapy –related to language difficuites and patient engagement – ***Pathway being reviewed by IDU***
- non compliance with diabetes medication but inpatient diabetes management may not have fully taken the impact of this into account – ***Hypoglycaemia Guidelines being reviewed***
- self discharge – deemed to have capacity – no mental health issues but medical condition may have affected judgement - *SI Investigation in progress*
- missed diagnosis of aortic dissection – ***Task and Finish Group established to agree guidelines /pathway***

The Corporate Learning from Deaths team will liaise with the Specialty/Clinical Teams and Patient Safety Team (where investigated as a Serious Incident) to confirm all agreed actions implemented.

21/22 Quarter 1 Learning from Deaths

Place of Death	ADULT	CHILD	NEONATE	ALL
INPATIENT	646	5	25	676
ED	41	4		45
COMMUNITY	10	1		11
ALL	**697**	**10**	**25**	**732**

CORONER REFERRAL?	ADULT	CHILD	NEONATE	ALL
NO	561	3	7	571
YES	136	6	2	144
TBC		1	16	17
ALL	**697**	**10**	**25**	**732**

DEATH DISCUSSED WITH MEDICAL EXAMINER	ADULT	CHILD	NEONATE	ALL
YES	695	6	7	708
NO	2	4	6	12
STILLBIRTH			12	12
ALL	**697**	**10**	**25**	**732**

DID THE ME SPEAK TO THE BEREAVED - WHERE NOT TAKEN FOR INVESTIGATION BY THE CORONER

	Apr-21	May-21	Jun-21	ALL
YES	230	190	171	591
% ME spoke to Bereaved	89%	85%	80%	85%
Quarter 1 Deaths	**259**	**224**	**214**	**697**

We have been working hard in Quarter 1 to both increase the number of Bereaved Relatives spoken to by the Medical Examiner and also the timeliness (previously this could be 2 or more weeks after death). Now the Bereaved are contacted by the ME on the same day as speaking to the Certifying Doctor wherever possible)

Feedback has been sent or further reviews requested for 202 Adult deaths (with 35 child/neonatal deaths automatically being taken through the Child/Perinatal Mortality Review process)

9 SJRs have been completed to date and none considered to be more likely than not due to problems in care.

NATIONAL REPORTING REQUIREMENTS

NHS Resolution Maternity incentive scheme – year three

Requirements for Safety action 1:

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

a) i) All perinatal deaths eligible to be notified to MBRRACEUK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.

ii) A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021

c) For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019 (includes home births where care was provided by your Trust staff and the baby died), the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought.

d) Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.

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

PERINATAL MORTALITY REVIEWS

(Maternity Incentive Scheme for Trusts – Year 3 **(Year 4 requirements in red/ bold)**

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

REQUIRED STANDARD	MET?
a) i. (a) All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days **(from 01/09/21 within 2 working days)**	Yes
i. (b) and the surveillance information where required must be completed within four months of the death. **(from 01/09/21 within 1 month)**	Yes
ii) A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021. **(deaths from 8 August 2021 will have been started within two months of each death)**	Yes
b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021. **(Births from 08/08/21 draft report within 4 mths and published within 6 mths)**	Yes
c) For at least 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. **(as above for deaths from 08/08/21)**	Yes
d) Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion. **(as above from 08/08/21)**	Yes (App 4)