Meeting title:	TRUST BOARD **public paper I**
Date of the meeting:	1st December 2022
Title:	UHL MORTALITY AND LEARNING FROM DEATHS QUARTERLY REPORT
Report presented by:	ANDREW FURLONG, MEDICAL DIRECTOR
Report written by:	REBECCA BROUGTON, HEAD OF LEARNING FROM DEATHS

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	MORTALITY REVIEW COMMITTEE – 1ST November 2022 EXECUTIVE QUALITY BOARD – 8th November 2022 (Deferred to 15/11/22) TRUST BOARD QUALITY COMMITTEE – 24 November 2022					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

The UHL Learning from Deaths framework provides assurance in respect of both the national risk adjusted mortality measure (SHMI) and also delivery of Death Certification, Medical Examiner Scrutiny and Case Record Review as per national statutory requirements.

There are currently 2 Risks open on the Risk Register relating to the Learning from Deaths Process:

3961 – Medical Examiner staffing in order to meet the requirements for expanding the ME service into primary care (Risk Score 9)

3918 – Maternity Staffing Establishment being below the Birth rate to ensure continuity of care (Risk Score 16)

This report provides details of actions being taken in respect of Learning from Deaths actions relating to the above risks

Impact assessment

Use this section to highlight any specific impact as a result of this report. You should think about:

- Monitoring Quality of Care for patients who die in UHL
- Improving Outcomes of future patients

Acronyms used:
LfD – Learning from Deaths; ME – Medical Examiners; MCCD – Medical Certification of Cause of Death; SJR – Structured Judgement Review (Case Record Review)' SHMI – Summary Hospital Mortality Index (all inpatient deaths and deaths within 30 days of discharge to the community setting); HSMR – Hospital Standardised Mortality Ration (56 diagnosis groups in hospital deaths)

Purpose of the Report

To receive an update on UHL's Mortality Rates and Learning from Deaths programme which includes

- Bereavement Services Office – Facilitation of Death Certification Paperwork
- Medical Examiner Process – both within UHL and across the Leicester, Leicestershire, and Rutland (LLR) Healthcare System – Cause of Death Discussions, Proportionate Case Record Scrutiny and Speaking to the Bereaved
- Bereavement Support Service – Supporting the bereaved with questions for the clinical team and identifying and signposting where unmet bereavement needs
- Specialty Mortality Reviews – case record reviews sing the national Structured Judgement Review tool
- Child Death Reviews and Perinatal Mortality Reviews using the national Review Tools and external reporting to the relevant Child Death Overview Panels and MBRRACE
- Clinical Team reviews and reflections
- Triangulation of learning related to mortality as identified through:
    - Complaints and Incidents
    - HM Coroner's Inquests

Recommendation

The committee is asked to be assured that:

- appropriate actions are being taken to monitor our crude and risk adjusted mortality rates and to review in more detail any patient or diagnostic group which is 'above expected' or appears to have increased over time
- we continue to robustly review and work with other agencies to identify learning in relation to our prenatal deaths.
- our learning from deaths programme is supporting identification of learning to improve the outcomes of future patients and plans are in place to meet:
    - anticipated statutory requirements in respect of the Medical Examiner process being implemented across all of Leicester, Leicestershire and Rutland (LLR)
    - external reporting of neonatal deaths and stillbirths to the Mothers and Babies – Reducing Risk through Audit and Confidential Enquiries (MBRRACE)
    - Safety Action 1 of the Maternity Incentive Scheme/Clinical Negligence Scheme for Trusts (MIS/CNST)

Summary

Our crude mortality for 22/23 to date is similar to pre COVID pandemic rates (1.2%). UHL's latest Summary Hospital Mortality Indicator (SHMI) is 104 and our latest Hospital Standardised Mortality Ratio (HSMR) is 101.7. Both mortality indicators are within the expected range.

We are meeting our internal and national standards in respect of the learning from deaths process and are making progress with rolling out the Medical Examiner process across LLR although there is still a lot to do. We continue to recruit more Medical Examiners and Medical Examiner Officers to support this expansion.

We have now received completed reviews for 93% of deaths in 21/22 and therefore now are able to collate learning themes identified through Specialty clinical reviews for reporting to both Specialty/CMGs and to relevant Trust Committees.

Our Bereavement Support Service has expanded to include child deaths and also cover all adult deaths in both UHL and LPT. We have taken remedial actions to address the back log in follow up calls during Quarter 2 and we have now recruited additional bereavement nurses to support this increased activity (partially funded by LPT). We continue to meet requests for Urgent Death Certification for religious purposes, both in and out of hours.

The 2020 MBRRACE report has been published and UHL's perinatal mortality rate was above our Peers. A detailed review of our 2020 Stillbirth deaths has already been undertaken and previously reported to Quality Committee and it appears that the higher number of neonatal deaths may be related to an increased number of babies with congenital cardiac abnormalities.

We were on track to achieve Standard 1 of the Maternity Incentive Scheme but there was a delay with reporting one death earlier this month due to mistakenly thinking the death did not meet the reporting criteria. There has been a review of the reporting process to identify remedial actions and Maternity Services have recently appointed additional administrative support to make our reporting processes more robust going forward.

Main report detail

1. UHL's latest risk adjusted mortality (SHMI and HSMR) are both 'within expected'. Our SHMI for the 12 months July 21 to June 22 is 104 (due to be published on 10th November) and our latest HSMR covering the 12 months August 21 to July 22 is 101.7.
2. We saw a higher number of deaths in July which has led to an above expected HSMR for the month. Preliminary review of our Medical Examiner screening data has not identified any themes or concerns re care.
3. Whilst there were an increased number of patients admitted with dehydration, likely to be related to the heatwave, screening by the Medical Examiner found only one case where further review was indicated to confirm appropriate management. We did see an increase in the number and proportion of cases with COVID on the death certificate in July
4. Further analysis of our risk adjusted data and review of our Learning from Deaths data for cases in July is being undertaken for reporting to the December meeting of MRC.
5. During Quarter 2, MRC have continued to receive details of reviews undertaken of diagnosis groups where the relative risk was above expected. No deaths in these 'alert groups' were considered to be more likely than not due to problems in care and no cross-cutting themes were identified.
6. At the November meeting of MRC, members received the Quarterly report from the Perinatal Mortality Review Group (PMRG) and noted that UHL had a higher than expected perinatal mortality rate identified in the recently published MBRRACE report for 2020.
7. This higher rate of stillbirths was identified and thoroughly reviewed during 2020 and has previously been reported to the Quality Committee. Issues with maternal diabetes and ultrasound scan scheduling were actioned promptly at the time.
8. The number of neonatal deaths is much smaller than stillbirths, with just 24 babies who died at 24 weeks gestation or greater in the first 28 days of life in 2020. Hence one or two babies can affect our rate significantly.
9. Neonatal deaths are ascribed to the unit of birth, so deaths of babies born to mothers transferred to Leicester for 'high risk' clinical care are included in our data.
10. Our 2021 dataset has now been verified with MBRRACE, and whilst the number of neonatal deaths is the same as in 2020, the numbers of stillbirths are higher. We will not know how this compares to our peer group until October 2023, though some degree of increase in the national stillbirth rate is anticipated from informal discussion.

11. Thorough review of our stillbirths in 2021 was reported to the Quality Committee in August. The review identified higher numbers of deaths from placental causes, congenital anomaly and infection (COVID related), but did not find any consistent care issues and no deaths which were more likely than not due to problems in care.
12. We have benchmarked our review process against one of our peer trusts (Leeds Teaching Hospitals) and no significant differences of grading of care were identified. Further benchmarking meetings are being arranged and we are sharing learning of governance arrangements.
13. The outcome of the Leeds visit was discussed at the Perinatal Mortality Oversight Group (PMOG) and it was agreed that one of the actions to take forward was review the follow up arrangements of mothers whose baby had died between January to April 2022 to inform how to best seek their views in the mortality review process
14. Cluster reviews of perinatal deaths have so far focussed on our stillbirth rate with the latest being a review of 'term stillbirths between June and August this year. However, a thematic review of our 2020 neonatal deaths is in progress to confirm there are no cross-cutting themes and to consider the impact of babies with congenital anomalies.
15. We continue our rigorous mortality review process for all perinatal deaths through both the Perinatal Mortality Review Group and the use of HSIB and/or Serious Incident Investigations where applicable. It was noted that HSIB have recently reviewed a cluster of cases and have advised us that this review had not highlighted any areas of concern.
16. At the recent PMOG meeting, it was also agreed to arrange a further action review meeting of the leads of the Diversity and Variable Needs work-streams. The PMRG Chair has been invited to attend the system-wide Task & Finish Group being chaired by Dr Ruw Abeyratne, Director of Health Equality and Inclusion, looking at the differential experiences of BAME mothers.
17. We were on track to achieve all elements of Standard 1 of the Maternity Incentive Scheme but there was a delay with reporting one death earlier this month due to mistakenly thinking the death did not meet the reporting criteria (Standard 1a). There has been a review of the reporting process to identify remedial actions and Maternity Services have recently appointed additional administrative support to make our reporting processes more robust going forward. The Quality Committee reviewed a summary of the outcomes of reviews undertaken in Quarter 2 in line with the requirements of Standard 1e.
18. In respect of our Learning from Deaths programme, the priority for 22/23 to date has been to expand the Medical Examiner process across LLR in line with national requirements. We are now routinely discussing deaths in the LPT Community Hospitals and have had discussions with the Mental Health Medical Director to look at providing the ME service for non-coronial inpatient deaths. We are working closely with the ICS Medical Director team and have appointed more Medical Examiner/Officers with a further recruitment round in progress.
19. We continue to meet our internally set standards around the Medical Examiner Office activity and have received confirmation of full funding for Quarter 1.
20. The Bereavement Nurses struggled to meet their follow up standards during July 22 and so letters were sent to all families not contacted by phone apologising for this and inviting them to call the service if they had any unanswered questions/feedback about care provided or wanted to talk about their loss.
21. We now have a 3rd Bereavement Nurse in post and the team are back on track with making their follow up calls. A 4th Nurse started in November in order to create increased capacity to provide Bereavement Support for LPT deaths.
22. 25% of deaths in Quarters 1 and 2 have been referred for further review by the Specialty or feedback sent to the Clinical team.
23. The Corporate LfD team have been working closely with the Specialty M&M Leads to capture the outcomes of all SJRs undertaken in 21/22 and have now received 397 completed SJRs (93%).

24. Two deaths have been reported to MRC during Quarter 2 were considered to be more likely than not due to problems in care and are currently being investigated as Serious Incidents
25. At the September MRC members received the report on reviews undertaken into deaths of patients with a Learning Disability (LD) and noted that communication is a continued learning theme but that the main area of learning was around Mental Capacity Assessment (MCA) and best interest decision making. It was felt that there had been an improvement in documentation around staff acting in the patient's best interest but not about how the patient's capacity to make a decision was assessed or what was done to try and make reasonable adjustments to enable them to be involved in decision making.
26. The MCA tool and an LD Assessment are now on NerveCentre which should improve awareness across all disciplines.
27. The next steps will be to collate learning identified by the Specialty M&M for 21/22 deaths, to include both Learning Disability and Serious Mental Illness SJRs and to confirm whether actions have been completed or are on track.
28. Learning themes will then be discussed at the M&M Leads Forum in December for wider dissemination and sharing with relevant Trust Committees such as the Deteriorating Patient Board.