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)	03/11/20	Discussion
Executive Board	10/11/20	Assurance
Trust Board Committee – QOC	26/11/20	Assurance
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:

- 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 this is also one of the requirements of the NHS Resolution 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 A summary of UHL's mortality rates, both risk adjusted and crude, are set out in the slide deck (Appendix 1). Our crude mortality has reduced from 2.5% in Quarter 1 to 1.2% in Quarter 2 and the 'Year to Date' mortality rate is now 1.7%. Slide 4 in Appendix 1, shows that the monthly number of deaths for the past 4 months has been similar to 2019/20; however activity has not returned to normal levels since the COVID pandemic which is why our crude mortality is still slightly above that of previous years

UHL's SHMI was 95 for two 'monthly' reporting periods (Feb 19 to Jan 20 and Mar 19 to Feb 20) but since then has increased each time. The latest Published SHMI covers the 12 months July 19 to June 20 and UHL's value is 98. This 12 month period takes into account the 3 months of greatest COVID related deaths and also reduction in activity.

We have seen a similar increasing pattern in our HSMR (as reported by Dr Foster Intelligence (DFI)) and the latest HSMR (covering the 12 months August 19 to July 20) is 102 which whilst above the England average is within expected limits.

At the October MRC, members noted that there have been changes made to both the SHMI and HSMR methodology in that all admissions coded with COVID-19 as a primary or secondary diagnosis have been removed from the dataset and in the SHMI deaths with COVID-19 on the death certificate have also been removed. The full impact of these exclusions will only be fully understood over time and will obviously be affected by the number of admissions/deaths attributed to COVID-19 across acute Trusts.

At the November MRC members reviewed analysis undertaken by our new Dr Foster Intelligence Consultant, looking at both our HSMR and SHMI and noted that changes made to our data with the COVID pandemic appeared to have affected both diagnosis group numbers and also our case mix. Members discussed that these have led to a reduction in the 'expected number of deaths' which has then led to an increase in our HSMR and SHMI.

Further work looking at the diagnosis groups within the SHMI is currently being undertaken to see if there is any immediate actions needed to be taken. In the meantime we will continue to monitor the impact of COVID on our crude and risk adjusted mortality.

3.2 The 20/21 (Q1 & Q2) "Learning from Deaths" activity is summarised in Appendix 2.

After the significant increase in number of deaths in Q1, we saw a slightly lower than average numbers in Quarter 2. Although almost all deaths have been through our Medical Examiner screening process, we need to improve our timeliness of screening – only half the cases were screened within 3 days of death with 81% of all cases being screened within 10 days. Screening delays are mainly associated with deaths at Glenfield and LGH due to case notes being needed for coding purposes before being transferred over to the LRI Medical Examiner Office.

In July 34% of LGH and Glenfield notes were available for ME screening within 5 days of the death, however in August only 17% were and in September this had dropped to 11%. This caused a backlog of cases needing screening and meant that notes were not readily available in time for the MEs to contact bereaved relatives within 2 weeks of death (our internally set 'cut off' time).

After lots of discussion and collaborative working with both the Coding teams and Medical Records, we have seen a much better turnaround time during October and 95% of relatives have been spoken to. However, although October saw an improvement in the number/% of bereaved relatives being spoken to by the ME, few at the LGH or GH were spoken to within 5 days of death

Therefore, further work is needed to improve timeliness in order to meet the national requirement that relatives are spoken to before MCCD is issued. The latest Lockdown gives us an opportunity to try and implement this approach as Coders will again revert to coding from electronic records and so the case notes for LGH and Glenfield deaths will be sent directly to the LRI Medical Examiner office after the MCCD (hospital death certificate) has been completed.

Following discussion with colleagues at LOROS and in order to 'test out' the feasibility of UHL providing an ME Service for Primary / Community Care, we extended the ME service to LOROS at the beginning of July

The agreed process was that - upon email notification of a death - the ME would speak to the LOROS doctor, review the LOROS clinical records using SystmOne and would also speak to the bereaved relatives. There were far more deaths in August than anticipated (based on LOROS normal numbers) and this was exacerbated by the fact that 10 of the deaths were in the last week of August and coincided with the bank holiday.

Getting access to and using SystmOne took time but has meant that the Medical Examiners are now much more familiar with the system which has been beneficial when discussing UHL deaths where little known about their past medical history. Using SystmOne will also be essential for the proposed Primary Care pilot.

There were 8 families who raised concerns about care provided by UHL which are being taken forward by the Bereavement Nurses. At an evaluation meeting held with LOROS at the end of September, feedback was that LOROS doctors were very pleased with the process but would be less keen if they had to both complete the notification form and also the MCCD/Cremation paperwork

Due to the increased number of deaths within UHL and the Primary Care pilot it has been agreed to suspend the ME service for LOROS at the end of November.

Following discussion with our Regional Medical Examiner and NHSIE Midlands Medical Director's team, it has been agreed that we will work with 2 local GP Practices in December and January to pilot providing an ME service for primary care deaths

Initially all cases will be discussed with the UHL Lead ME, Professor Peter Furness, in order to provide consistency of approach and facilitate changes to the process as needed. The plan will then be to invite other MEs to join the second phase of the pilot –to run between January and March and to recruit more Practices. The aim is to then be in a position to recruit additional MEs and ME officers (subject to funding being agreed with the National Medical Examiner Office) in order to roll out to the rest of primary care during 2021/22.

The UHL Bereavement Nurses are working with the Lead Medical Examiner to confirm available resources (either via the GP Practice or Charitable Organisations) and to draft up an information booklet that can be given to the bereaved. Routine follow up contact will not be offered but where

bereaved relatives raise issues with the Medical Examiners about care provided by UHL, the Bereavement Support Nurses will take this forward with the relevant clinical team as with any concerns raised through the LOROS ME process.

Slides 10 to 14 provide a summary of the Bereavement Support Nurses' work in 19/20 and Quarters 1 and 2 this year.

The Bereavement Nurses are to be congratulated on managing to speak to so many bereaved relatives despite the significantly higher number of deaths in Quarter 1 and the fact they were supporting the ITU clinical teams with speaking to relatives during the Coronavirus peak.

The number of relatives requesting bereavement support follow up in Quarter 1 was significantly higher than in previous quarters which reflects both the increased number of deaths due to Coronavirus but also the fact that relatives were unable to visit as normal. Although only 60% of those requesting were then spoken to (contact was attempted x 2), all those not contactable were sent a letter with details for the Bereavement Support Nurses if needed

Slides 15 to 20 give details of the number and types of reviews requested in Quarters 1 and 2 and also an update on completion of requested SJRs for 19/20. As can be seen from slide 18, we still have 47 SJRs or Investigations not completed. The corporate M&M team is working closely with the Specialty leads and during November the plan is to review reasons for requesting outstanding SJRs in order to assess if non completion poses a risk or not.

Following close down of the 19/20 SJRs and Clinical Review, learning outcomes will be themed and updates on actions sought for reporting as part of the next Quarterly report and cross cutting themes fed back to the Specialty M&Ms

3.3 13 deaths have been reported as being more likely than not due to a problem in care for 19/20. This may not be the final figure as not all SJRs have been completed. There are 2 cases for 20/21 which have been previously reviewed and discussed at MRC and final Death Classification to be confirmed after further consideration by the Specialty M&M. This data will be included in our next Quality Accounts.

The next Quarterly report will include details of performance against the recently updated NHS Resolution Maternity incentive scheme – year three.

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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]
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]
Embedded research, training and education	[Not applicable]
Embed innovation in recovery and renewal	[Yes /No /Not applicable]
Sustainable finances	[Yes /No /Not applicable]

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 (X)**	**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: February 2020
6. Executive Summaries should not exceed **5 sides** [My paper does comply]]

Appendix 1

UHL's Crude and Risk Adjusted Mortality

November 2020

What are UHL's current overall crude and risk adjusted mortality rates?*

Crude mortality:
i.e. number deaths and proportion of discharges where death is the outcome

***Excludes Deaths in the Emergency Department**

How many In-patients have died in our Trust?

UHL's Crude In-Patient Mortality
2014/15 to 2020/21 (to end Oct 20)

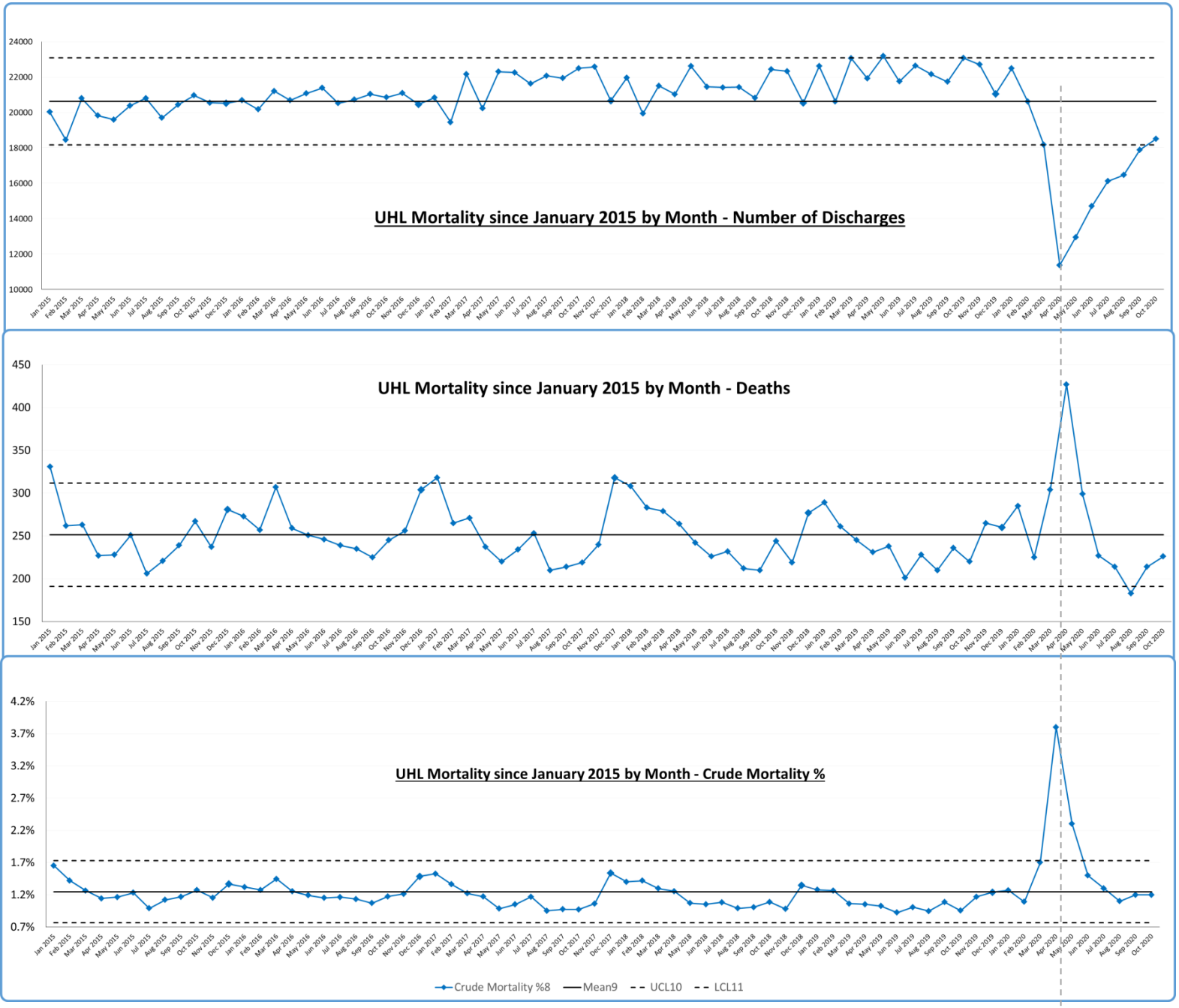
Discharged During…	All Discharges (incl Day Case)	All In-Patient Deaths	In-Patient Crude Mortality Rate
2020/21 YTD (Apr - Oct 20)	**108,140**	**1796**	**1.7%**
FY 2019/20	261,647	2906	1.10%
FY 2018/19	260,301	2921	1.12%
FY 2017/18	259,539	3016	1.20%
FY 2016/17	250,233	3114	1.20%
FY 2015/16	244,776	2993	1.20%
FY 2014/15	234,889	2997	1.30%

Our Crude Mortality Rate for Quarter 2 was 1.2% (was 2.5% at end of Q1) and this brought our 'year to date' mortality rate down to 1.7% which has continued at end of October.

This reduction is due to both fewer deaths in Quarter 2 (611) than in Quarter 1 (953) and overall activity getting back to normal numbers (50,461 in Quarter 2 – was 39,018 in Quarter 1)

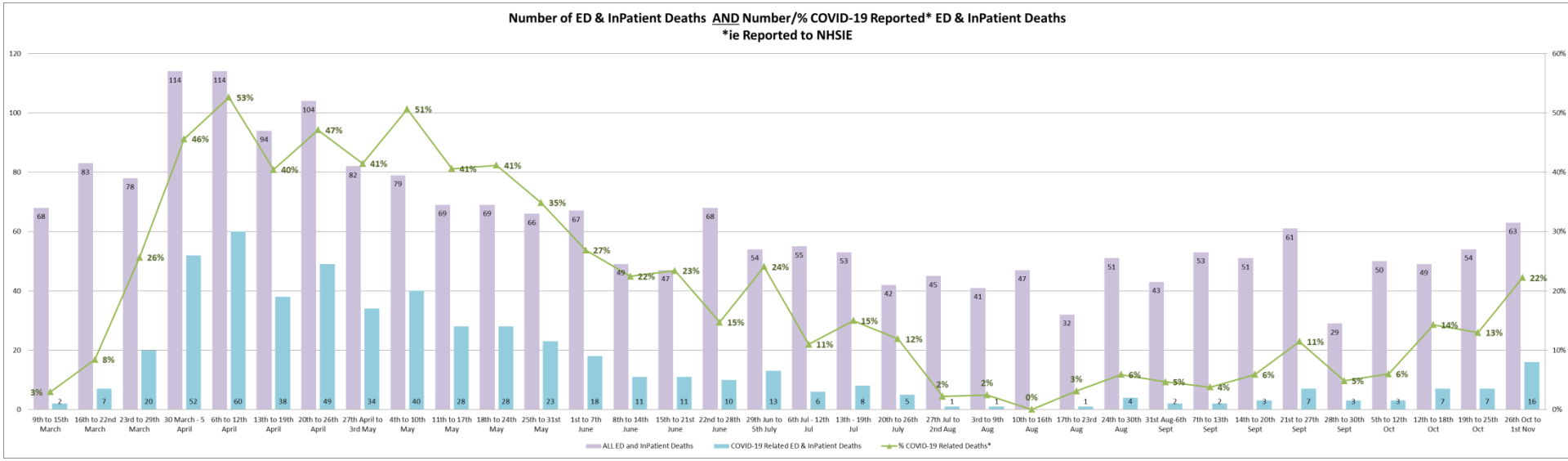
In October there were 18,655 inpatient spells with 231 deaths giving a mortality rate of 1.2% for the month

UHL's Crude In-Patient Mortality using SPC



Both our crude mortality and activity is back within 'normal variation'

COVID RELATED MORTALITY – as reported to NHSIE March to October 2020



Provisional data for November shows that there were 21 COVID deaths in week 1 and 32 in Week 2.

NHSIE Reporting Criteria are:

- Positive Swab within 28 days of death irrespective as to whether there have been negative swabs in the meantime or the patient was believe to have died from a completely unrelated cause and/or
- COVID 19 is included in the Death Certificate as a direct or contributory cause of death

NHSIE Publication numbers only include where positive swab within 28 days of death

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

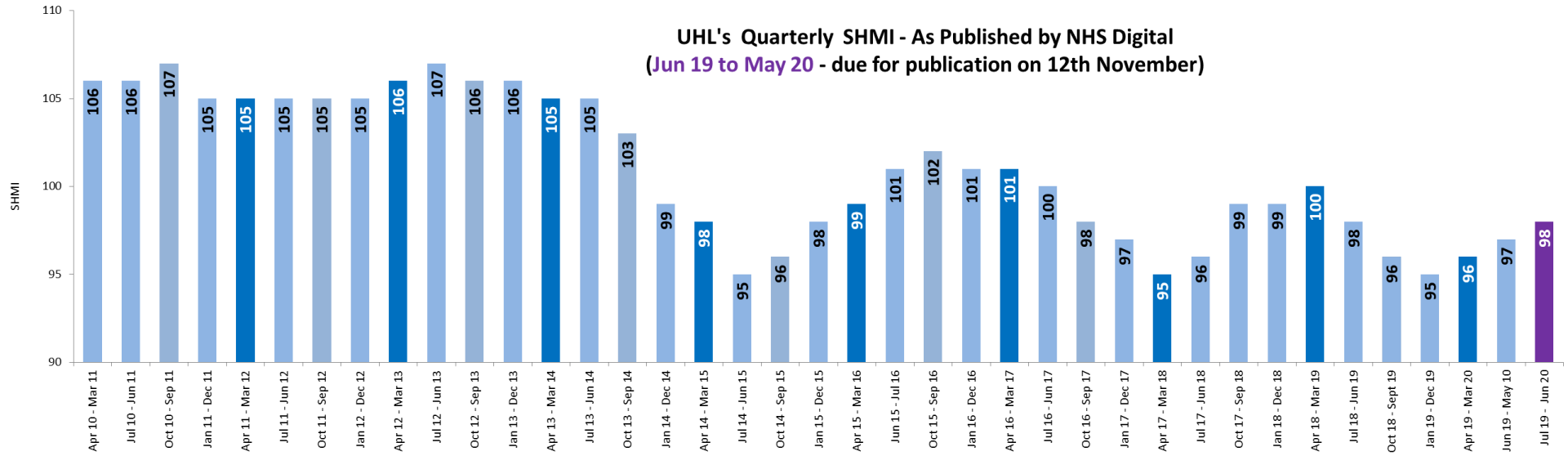
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge. **COVID-19 deaths are excluded from the SHMI**. The expected number of deaths is calculated from statistical models derived to estimate the risk of mortality based on the characteristics of the patients (including the condition the patient is in hospital for, other underlying conditions the patient suffers from, age, gender, method of admission to hospital, month of admission and birthweight).

The data used to produce the SHMI are generated from data the trusts submit to the Secondary Uses Service (SUS). The data are processed by NHS Digital to create Hospital Episode Statistics (HES) data, which are then linked with death registrations data from the Office for National Statistics (ONS) to allow deaths which occur outside of hospital to be captured. A combination of finalised and provisional HES data is used in the calculation of the SHMI to ensure that the indicator is as timely as possible.

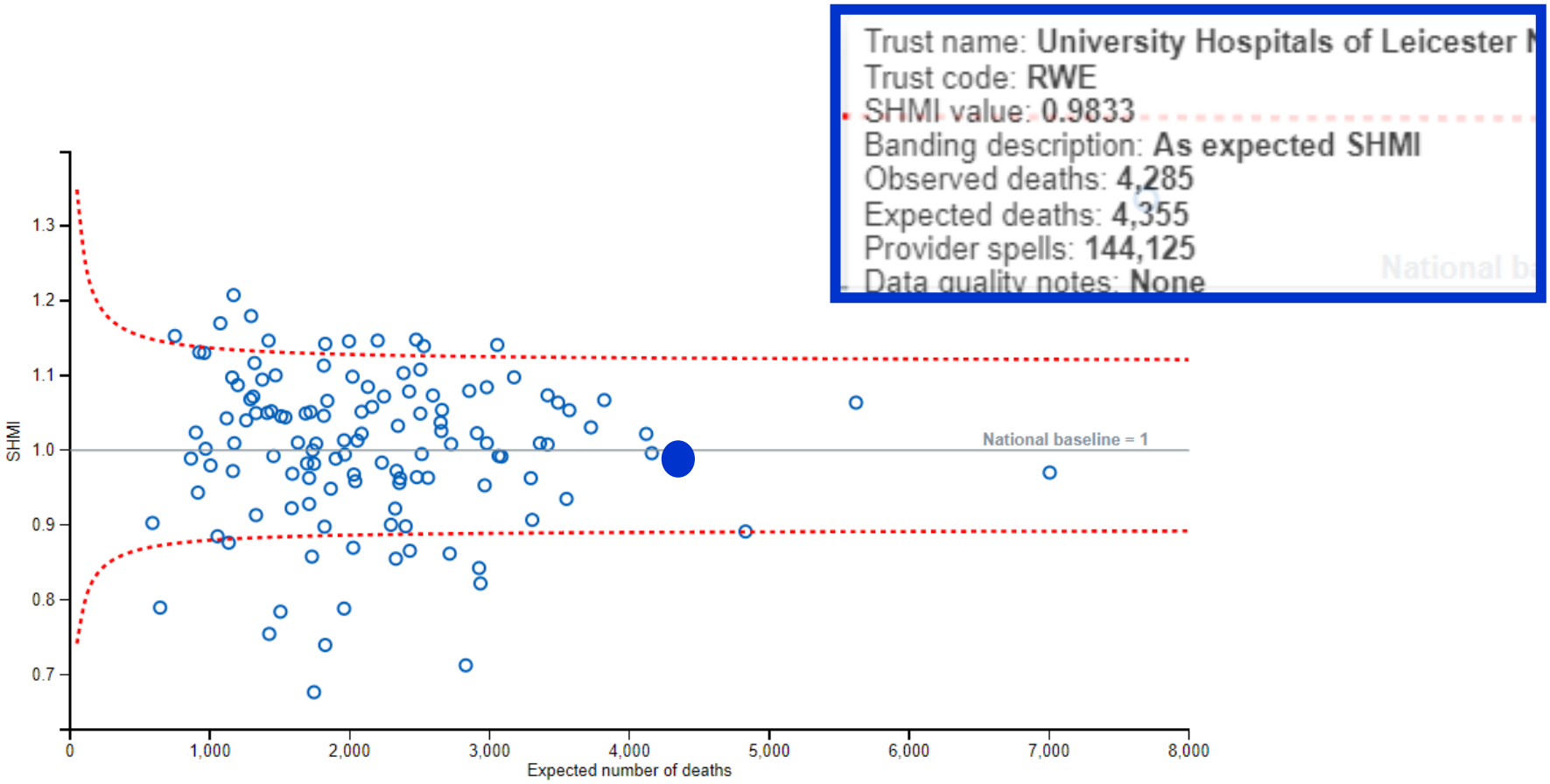
The SHMI is not a measure of quality of care. A higher than expected SHMI should not immediately be interpreted as indicating poor performance and should instead be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance. The SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts according to their SHMI.

UHL's Quarterly SHMI – as published by NHS Digital



- The latest 'Quarterly Published' SHMI covers the 12 months June 19 to May 20 and UHL's SHMI was 97.
- The most recent 'Monthly Published SHMI' covers the 12 months Jul 19 to Jun 20 which included the 3 months of greatest COVID related deaths and reduced activity. UHL's SHMI value is 98

Quarterly Published SHMI Values for all Trusts – Jul 19 / Jun 20



HSMR:
Hospital Standardised Mortality Ratio

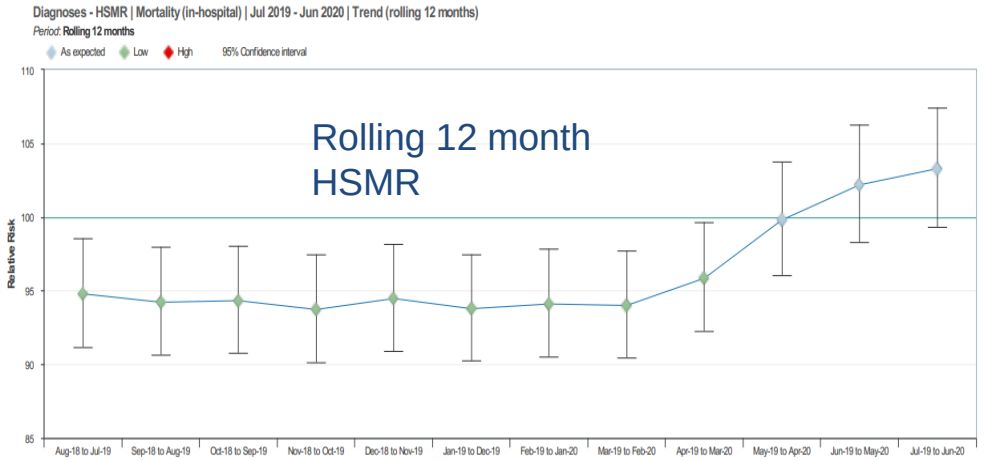
HSMR is risk adjusted mortality where patients die in hospital (either in UHL or if transferred directly to another NHS hospital trust) **over a 12 month period within 56 diagnostic groups**
(which contribute to 80% of in-hospital deaths).

The HSMR methodology was developed by the Dr Foster Unit at Imperial College (DFI) and is used as by the CQC as part of their assessment process

HSMR Trends (July 20)

Although “as expected” the HSMR (102.2) continues to track upwards driven by a significant fall in activity in April & May.

Observed Mortality has remained static in May, June & July



Rolling 12 month HSMR

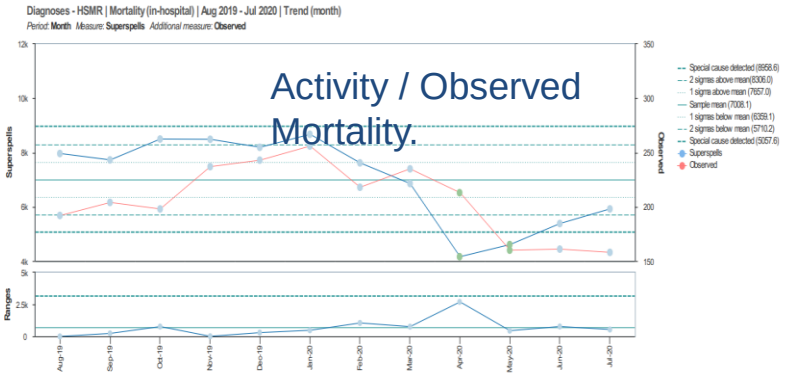
Basket: **HSMR** Metric: **Mortality (in-hospital)** Time period: **Last available 24 months**

Patients: **92,193** Superspells: **179,563 (194.8)** First / Last: **Aug 2018 / Jul 2020** Deaths: **5,049 (2.8%)** LOS: **5.6**

Expected: **5143.8 (2.9%)** O-E: **-94.8 (-0.0%)** Relative Risk: **98.2 (95.5â€"100.9)** Model: **Month: Apr 2020** C-Statistic: **Multiple**

Monthly HSMR

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
All	179,563	100.0%	180,170	5,049	2.8%	5143.8	2.9%	-94.8	98.2	95.5	100.9
Aug-18	7,567	4.2%	7,575	194	2.6%	198.8	2.6%	-4.8	97.6	84.3	112.3
Sep-18	7,251	4.0%	7,272	187	2.6%	187.4	2.6%	-0.4	99.8	86.0	115.2
Oct-18	8,023	4.5%	8,053	220	2.7%	228.3	2.8%	-8.3	96.4	84.0	110.0
Nov-18	8,031	4.5%	8,068	206	2.6%	219.5	2.7%	-13.5	93.9	81.5	107.6
Dec-18	7,684	4.3%	7,720	242	3.1%	247.3	3.2%	-5.3	97.9	85.9	111.0
Jan-19	8,549	4.8%	8,568	262	3.1%	281.3	3.3%	-19.3	93.1	82.2	105.1
Feb-19	7,492	4.2%	7,526	231	3.1%	228.7	3.1%	2.3	101.0	88.4	114.9
Mar-19	8,241	4.6%	8,278	222	2.7%	245.9	3.0%	-23.9	90.3	78.8	103.0
Apr-19	8,126	4.5%	8,151	199	2.4%	230.4	2.8%	-31.4	86.4	74.8	99.2
May-19	8,422	4.7%	8,450	208	2.5%	232.6	2.8%	-24.6	89.4	77.7	102.4
Jun-19	7,766	4.3%	7,791	190	2.4%	201.6	2.6%	-11.6	94.3	81.3	108.7
Jul-19	8,326	4.6%	8,355	215	2.6%	222.1	2.7%	-7.1	96.8	84.3	110.6
Aug-19	7,957	4.4%	7,974	190	2.4%	214.6	2.7%	-24.6	88.6	76.4	102.1
Sep-19	7,726	4.3%	7,753	204	2.6%	206.0	2.7%	-2.0	99.0	85.9	113.6
Oct-19	8,498	4.7%	8,532	198	2.3%	229.4	2.7%	-31.4	86.3	74.7	99.2
Nov-19	8,489	4.7%	8,509	237	2.8%	238.6	2.8%	-1.6	99.3	87.1	112.8
Dec-19	8,193	4.6%	8,221	243	3.0%	273.0	3.3%	-30.0	89.0	78.2	100.9
Jan-20	8,673	4.8%	8,696	256	3.0%	272.6	3.1%	-16.6	93.9	82.8	106.2
Feb-20	7,620	4.2%	7,653	218	2.9%	222.6	2.9%	-4.6	97.9	85.3	111.8
Mar-20	6,857	3.8%	6,894	235	3.4%	210.9	3.1%	24.1	111.4	97.6	126.6
Apr-20	4,160	2.3%	4,174	213	5.1%	133.5	3.2%	79.5	159.5	138.8	182.4
May-20	4,607	2.6%	4,619	160	3.5%	125.4	2.7%	34.6	127.5	108.5	148.9
Jun-20	5,383	3.0%	5,404	161	3.0%	146.3	2.7%	14.7	110.0	93.7	128.4
Jul-20	5,922	3.3%	5,934	158	2.7%	146.9	2.5%	11.1	107.6	91.5	125.7



Activity / Observed Mortality.

COVID activity and deaths are not included in the HSMR

APPENDIX 2

Learning From the Deaths of Patients in our Care

20/21 - Quarter 1 and Quarter 2

Nov 2020

‘Deaths covered by UHL’s “Learning from the Death” process 2020/20210 Quarter 1 and Quarter 2

DEATHS BY HOSPITAL SITE		
	Q1	Q2
LRI	731	473
GH	197	148
LGH	95	40
All Sites	**1023**	**661**

ADULT vs CHILD vs NEONATE		
	Q1	Q2
ADULT	995	633
CHILD	9	8
NEONATES/ PERINATAL	19	20
All	**1023**	**661**

There were nearly 400 fewer adult deaths across the 3 sites in Quarter 2 with the LRI seeing the greatest reduction.

At time of reporting there have been 226 deaths in October.

Cause of Death Discussed with the Medical Examiner? Q1 & Q2

	Q1	Q2
ADULT	995	633
ME discussed CoD	986	631
CHILD	9	8
ME discussed CoD	2	7
NEONATES	19	19
ME discussed CoD	2	6
ME Disc CoD - ALL	990	644
% of All Discussed	97%	97%

All but two deaths in October have been discussed with the Medical Examiner to date

ME Screening of Case Notes (Adult Deaths) – Q1 & Q2

Screened	Q1	Q2
ADULT	**995**	633
Screened	**994**	**627**
In Progress		**3**
Not Screened		**3**
% Screened (to date)	**99.9%**	**99%**

Due to difficulties with retrieving the case notes for 3 patients, screening of electronic records is in progress.

There were 3 community deaths in Quarter 2 where screening of case notes was not undertaken

Speaking to the Bereaved – Q1 and Q2 (Adult Deaths only)

	20/21 Q1		Q2
ADULT DEATHS	995		633
ME spoke to the Bereaved	827		463
Bereaved not spoken to	94		102
% ME spoke to Bereaved	90%		82%
N/A (Taken by Coroner)	72		68

Medical Examiners have not routinely been speaking to the bereaved where death was referred to the Coroner but we are now trying to ensure that the bereaved are spoken to if the Coroner does not take for investigation.

The deterioration in September's performance is mainly related to delays with case notes of LGH and Glenfield deaths being available for Medical Examiner screening – following feedback from bereaved relatives in early days of implementation, the MEs do not contact if screening is more than 2 weeks after death.

Timescales for Screening and Speaking to the Bereaved – Oct 20

Days to Screening / Relatives being spoken to (where death not referred to the Coroner)					
		LRI	GH	LGH	Oct 20
0 – 5 days after death		104 94%	1 5%	2 22%	108 77%
6 – 10 days after death		5	7	3	14
10+ days after death		2	8	3	13
Not spoken to		0	4	1	5
ADULT DEATHS NOT REFERRED TO THE CORONER		111	20	9	140

Reassuringly, preliminary review of October's data shows that there has been a significant improvement with 95% of bereaved relatives (mainly adult deaths) being spoken to by the Medical Examiner.

However, few relatives were spoken to within 5 days of the death if at the LGH or Glenfield which means the MCCD has already sent to the Registrars of Births, Marriages and Deaths.

PILOT OF IMPLEMENTING A MEDICAL EXAMINER SERVICE FOR COMMUNITY DEATHS – L.O.R.O.S

LOROS DEATHS				
Jul	Aug	Sept	Oct	**Total to date**
3	**34**	**25**	**14**	**76**

2 deaths were subsequently referred to the Coroner and out of the other 74 deaths, all but 6 were cremations.

Feedback from Bereaved	No.	Which Organisation – where compliment or concern (some related to more than 1 organisation)
Compliment	28	LOROS (28) UHL (2)
Both	8	Compliment - LOROS (8) Concern - UHL Concern (6) GP (1) LOROS (1)
Gen Happy	4	
No Concern	21	
Concern	8	UHL (4) LOROS (4) GP (2) Comm (2)
Not spoken to	6	(either because Coroner Referral or Unable to Contact)

LOROS PILOT EVALUATION AND NEXT STEPS

- More deaths than anticipated
- 'Peaks and troughs' difficult to manage and usually coincided with UHL's own 'peaks and troughs'
- Steep learning curve with using SystmOne
- Limited 'added value' from cause of death being discussed with the Medical Examiner
- Few concerns raised by bereaved in respect of LOROS Care (2)
- 8 concerns about UHL care raised by bereaved
- No concerns / learning identified by Medical Examiner screening of LOROS clinical records or UHL electronic records
- Well received by LOROS doctors but only if MEs continue to complete MCCDs and Crem Forms
- Agreed to continue whilst have capacity and if need to 'suspend' full service, will continue to provide advice if needed

PROPOSED PRIMARY CARE PILOT

- Regional Support from both NHSIE and Regional ME Office
- Phase 1 - November / December – 2 Practices
- PF , UHL Lead Medical Examiner, will lead on discussions
- Phase 2 - January to March, to involve other Medical Examiners
- Regional ME has advised to submit case of need for resources anticipated for Pilot phase
- Similar Process as used for LOROS although some GPs may wish to complete MCCD and Crem Forms
- Where referral to the Coroner indicated, GPs will be responsible for taking forward
- Bereavement Support implications also being taken into consideration as part of pilot preparation
- Also need to confirm process for feeding back any concerns

Bereavement Nurse Follow up – Adult deaths

	19/20		20/21 Quarter 1		20/21 Quarter 2
Adult Deaths	**3209**		**995**		**695**
Requested BSS telephone follow up	**2246**		**598**		**355**
%	**75%**		**58%**		**51%**
Verbal contact made where requested	**1682**		**455**		**254 (to date)***
In progress					**47**
%	**75%**		**76%**		**70% (to date)***
All verbal contacts*	**1736**		**491**		**274**

*Some families may have initially declined BSS follow up but subsequently either contacted the Service or the Bereavement Nurses were asked to contact the family by the Medical Examiner

Families of patients who died in September still being followed up

Bereavement Support - Signposting

Signposting to Bereavement Counselling Organisations?					
	19/20		20/21 Q1		20/21 Q2
Yes	**380**		**151**		**56**
All	**1736**		**340**		**56**
% Yes	**22%**		**31%**		**21% (to date)**

The CRUSE, Sharma Centre, Silverline , Way Up (50+)and Age UK were the most frequently signposted Bereavement Support agencies in 19/20, Other agencies include:

Al-Anon; Alliance of Hope; Amica; Bereav /Advice Centre; Bereav/Trust; Brake; British Inst for Learning Disabilities; The Carers Centre- Leics; Care for the Family (under s website); Child Bereavement UK; Childline; (the)Compassionate Friends; Contact the Elderly; Coping with Cancer; The Counselling Directory; Crisis Helpline; CRUSE; Forget me not- social support Group- Melton M; Harborough Christian Counselling Service; Haven Counselling Centre; Hope support- online for -yrs; Hopeagainorguk- for young/via CRUSE; Jolly Dollies; Laura Centre; Leicester Aids Support Service; Leics Women's Counselling Centre; Leicester Counselling Centre; Lets Talk; LOROS; Lung cancer/Mesothelioma Support Group GH; Macmillan- online support Community; Maggies Centres (cancer- Nottm); Merry Widows- under ; New Beginnings- Support group Melton M; New Chapter- Support Group Thurmaston; Rip Rap (on line -y- cancer); Rutland House (Leics Counselling- Private); The Samaritans; Scope; Step by step support group (finished June); SOBS (suicide); Victim Support Group (crime); Turnusorg (financial/welfare advice); uasitesorguk; Voluntary action Leics; Way up (+); WAYoung; Winstons Wish- Child; The Tomorrow project (suicide); Community Champions Project- Mkt Harborough; (The) Bodie Hodges Foundation- child (/donation- retreat); (The) Good Grief Project - child (films/workshops); Citizens Advice Bureau; N/A; Counselling provided by their employer; Alzheimers society; Birstall BAGS; The Mix;

Bereavement Nurse Follow up – 1st Contact Outcome

Outcome after the 1st Contact Call	19/20	Quarter 1	Quarter 2
Verbal Contact made	**1736**	**491**	**274 (to date)**
No queries / closed down after 1st call	**1454**	**392**	**208**
BSS resolved any queries, shared outcomes of reviews (requested after ME phone call) (+/- feedback to UHL team)	**56**	**19**	**8**
Further f/up as review still in progress or additional questions	**72**	**9**	**13**
New action (bereaved requested review, have queries or meeting with clinical team)	**109**	**30**	**15**
Complaint already in progress or intends to submit complaint	**31**	**11**	**6**
Further Bereavement support only	**14**	**30**	**24**
Total further f/up needed	**195**	**69**	**52 (to date)***

Only one call is required for most families

*Bereavement Support follow up contact calls are made 6-8 weeks after death and therefore not families will have been contacted for deaths in Quarter 2 and so the above numbers will change

Bereavement Nurse Follow up – Final Outcome

	19/20		Quarter 1		Quarter 2
BSS Nurses resolved queries / provided bereavement support	**20**		**5**		**2)**
BSS Nurses facilitated questions/feedback from family to UHL team with/without further contact with bereaved	**42**		**8**		**0**
BSS Nurses facilitated questions/feedback from family to Non UHL team with/without further contact with bereaved	**2**		**0**		**1**
Meeting with Clinical Team facilitated	**52**		**4**		**5**
Learning from Deaths review outcomes shared with bereaved	**42**		**7**		**3**
Complaint either due to non resolution through BSS or support to compose complaint requested at 1st contact	**19**		**4**		
Family declined further engagement with BSS or unable to contact / no consent received from NoK	**10**				
Ongoing	**10**		**36**		**39**

Very few meetings were facilitated in Q1 due to the COVID pandemic restrictions

FEEDBACK FROM BEREAVED

	19/20		Quarter 1		Quarter 2
MEDICAL EXAMINER PHONE CALL HELPFUL?	**Yes - 937 Unable to say – 108 Didn't need - 7 No - 4**		**Yes – 491 Unable to say – 38 Didn't need 0 3 No - 3**		**Yes – 127 Didn't need - 14 No - 1**
BEREAVEMENT SUPPORT CONTACT SUPPORTIVE?	**Yes – 1047 Didn't need – 634 No - 2**		**Yes – 267 Didn't need – 206 No - 3**		**Yes – 148 Didn't need - 117**
WHERE MEETING HELD – SATISFIED WITH OUTCOME?	**Yes – 40 Partially – 5 No 1**		**Yes – 4**		**Yes – 4**

Follow up contact still in progress for August and September deaths

Where ME or BSS calls felt to be unhelpful, families normally had a number of other concerns

Feedback or Further Reviews requested by Medical Examiner either following discussion with bereaved or screening of clinical records or death meets local/national criteria for SJR
Adult Deaths – Q1 and Q2

Further Review?	Apr	May	Jun	Q1	Jul	Aug	Sept	Q2
ME/ Relatives	56	76	66	**198**	**63**	58	55	176
% of all deaths	15%	25%	29%	**22%**	**30%**	**30%**	**24%**	**28%**
National / Local Criteria	22	15	7	**44**	**13**	**15**	**13**	**41**
% of all deaths	5%	5%	3%	**4%**	**6%**	**8%**	**6%**	**6%**
No Further Review	366	222	165	**753**	**133**	**120**	**159**	**412**
All Adult Deaths	**444**	**313**	**238**	**995**	**210**	**194**	**229**	**633***
% All Reviews Requested	**298%**	**30%**	**32%**	**26%**	**36%**	**38%**	**30%**	**34%**

*Need for further review to be confirmed for 4 cases

Types of Reviews Requested / Feedback – Adult Deaths*

Further Review?	Q1	% of all Deaths		Jul	Q2	% of all Deaths
SJR	80	8%		25	77	12%
Clinical Review	55	6%		25	74	12%
Investigation	1	0.1%				
PST F/Up	5	1%			3	0.5%
Feedback	66	7%		21	49	8%
BSS F/Up	18	4%		4	8	4%
Theme	14	1%		1	7	1%
All	239	26%		76	218	37%

*All Child/Neonatal Deaths will be subject to full review or investigation either as part of UHL's mortality review process or the LLR Child Death Overview Panel (CDOP)

Reason for Structured Judgement Review or Investigation (All Deaths)

Further Review?	Q1		Q2
1. ME	38		31
2. Rels	3		5
3. Child	28		28
4. El Proc	4		8
5. LD	9		5
6. SMI	14		11
8. Specialty	12		13
9. BSS			1
10. PST			1
All	109		103

Investigations will include child deaths subject to review by CDOP as well as any deaths subject to a Patient safety incident investigation

PROGRESS WITH SJR / INVESTIGATION COMPLETION

	19/20	Q1	Q2
Adult SJR/Invx	**327**	**81**	**75**
In Progress	29	29	48
Completed	**298 (91%)**	**55**	**27**
Child SJR/Invx	**35**	**9**	**8**
In Progress	5	2	7
Completed	**30 (86%)**	**3**	1
Neonate SJR/Invx	**88**	**19**	**20**
In Progress	5	8	19
Completed	**83 (94%)**	**11**	1
All SJRS / Investigations	**449**	**109**	**103**
% Completed	**89%**	**65%**	**28%**

Death Classification – SJR and Investigations- ALL DEATHS

Death thought to be more likely than not due to a problem in care?	19/20	Q1 20/21	Q2 20/21
No	374	66	28
Yes	13	1 tbc	1 tbc
Review in Progress	63	42	74
All SJRs/Investigations	450	109	103

All deaths in 2019/20 considered more likely than not to be due to a problem in care have been previously discussed at MRC and also reviewed or investigated by the Patient Safety Team.

There have been 2 deaths to date in 2020/21 thought to possibly be due to a problem in care. Both have been discussed at either at the MRC subgroup or full committee and are due for further review by the Emergency Dept M&M.

Learning where death considered to be more likely than not due to a problem in care

Prompt investigation and surgical referral for severe abdominal pain Risks of non steroidal anti inflammatory drugs in post operative situation, and either stop prescription or give PPI drugs
All cardiology staff to be reminded of appearances of STEMI in RBBB Lack of adoption of available solution to share ECG images in less than straightforward cases Review of prioritisation of ED transfers to CDU
There was a delay once the IOL process had commenced. The mother was not transferred to the delivery room for 23 hours. This led to a delay in the provision of care with no continuous fetal monitoring and resulted in an ARM with an unengaged head taking place at 01:50 hours.
There was a missed opportunity to identify a baby with fetal growth restriction. If fetal growth restriction had been identified, an induction of labour could have been arranged. UHL (2017)
There was inadvertent disconnection of the cardio-pulmonary bypass circuit with resultant bleeding and air entrainment. This manifested as protracted seizures and stroke postoperatively from which the patient did not recover.
Lack of clear guidance regarding timing of delivery and 'red flags' for poor outcomes This mother had gestational diabetes during her pregnancy which was not managed according to national or local guidelines Ultrasound scans and clinic appointments were not booked for the same day
- Imperative to inform patient of consequence of not attending if discharging patient from follow up if DNA.
Chemotherapy prescribing issues
Failure to recognise significance and investigate new oxygen requirement in patient being treated for unrelated condition Failure to interpret ABG result and request senior assistance Failure of normal systems for escalation and review (including DART)
Investigations such as Xrays should be handed over for review between junior doctors (at least Registrar level) . Prompt administration of IV antibiotics for the condition. It is important that critical medication is prescribed and administered in a timely way.
Death due to heart failure attributed to chemotherapy. That could have been anticipated and therefore prevented
Ensuring medication prescribed and administered where patients seen by 'in reach team' in the Emergency Dept
Rivaroxaban put on hold on EPMA and not restarted post operatively