University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 5 March 2020

Trust Board paper G

Report Title:	**Quality and Outcomes Committee – Committee Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
Author:	Gill Belton – Corporate and Committee Services Officer

Reporting Committee:	**Quality and Outcomes Committee (QOC)**
Chaired by:	Col (Ret'd) Ian Crowe – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse Darryn Kerr – Director of Estates and Facilities
Date of meeting:	27 February 2020

Summary of key public matters considered by the Committee and any related decisions made:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 27 February 2020:-

- **Learning from Deaths Quarterly Report**
  The Medical Director presented the latest quarterly report in respect of Learning from Deaths, the contents of which were received and noted and ***recommended onto the Trust Board for its approval*** (copy attached to this summary). A summary of UHL's mortality rates, both risk adjusted and crude, were set out in the slide deck at Appendix 1 to the report. Quarter 1-3's 'Learning from Deaths' activity was summarised in Appendix 2 to the report. The Medical Director advised of work currently being undertaken as arising out of the Perinatal Mortality Review Group, further details relating to which were referenced within the main report. In discussion on this item, note was made of the need for further work to be undertaken in relation to the coding element of the report, in order to aid comprehension. In response to the Trust Chairman's request for the Committee to receive a report on maternity safety, it was noted that a quarterly report on Maternity Safety was due to be submitted to the Executive Quality Board and Quality Outcomes Committee in March 2020 and that applicable reports from the Healthcare Safety Investigation Branch (HSIB) would also be submitted to EQB and QOC as they were received. In concluding discussion on this item, the QOC Non-Executive Director Chair expressed his thanks to all staff involved in the progression of the work described within this report and particular recognition was made of the well-established Medical Examiner process within UHL, which was well ahead of the position within Trusts nationally.

- **UHL ED Safety Checklist Audit Report**
  Further to the referral of this matter to the Quality Outcomes Committee from the Audit Committee meeting of 24 January 2020, the Clinical Director and Head of Nursing for Emergency and Specialist Medicine attended to present a report detailing actions implemented following the results of the Internal Audit of the UHL ED Safety Checklist, which had resulted in a 'medium' risk rating. The audit undertaken had reviewed a small sample of 25 sets of case notes which indicated that staff were not always fully compliant with the completion of the checklist on an hourly basis and that, on a number of occasions, it was only partially completed or not at all in some cases. The report documented details of the 25 sets of case notes audited, in terms of which elements of documentation had or had not been completed, and detailed a number of actions implemented to provide additional assurance of safety across the Emergency Department including, but not limited to, progressing the planned change to an electronic checklist (planned for May 2020) in line with ED's plans to move to paperless documentation. This would be streamlined to avoid duplication and repetition and would provide real-time on-going assurance in respect of checklist completion. In discussion on this item, Ms Bailey, Non-Executive Director queried whether the planned new electronic checklist would overcome the findings of the audit in relation to the variability of recording. In response, it was noted that clinically relevant findings would be recorded and it was expected that this system would overcome the shortcomings of the paper-based method which relied on staff duplicating the entry of data (across both patient notes and in separate checklists). The QOC CCG Representative sought assurance that the electronic system would record nutrition and hydration, and it was confirmed that this would be the case. In conclusion, QOC confirmed that it had taken assurance from the report presented today, noting their intention to receive a further report for assurance purposes in Summer 2020 (July or August QOC meeting) following the introduction of the electronic checklist in May 2020.

- **Schwartz Rounds Update**
  Ms Boyle, Consultant Surgeon, attended to provide an update to the Committee on progress to-date in the introduction of Schwartz Rounds to UHL. Schwartz Rounds provided a structured forum where all staff, clinician and non-clinical, came together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Rounds was to understand the challenges and rewards intrinsic to providing care. The underlying premise was that the compassion shown by staff could make all the difference to a patient's experience of care but that, in order to provide compassionate care staff must, in turn, feel supported. Schwartz Rounds were integral to UHL's Quality Strategy and clearly reflected the Trust's values and the implementation of Schwartz Rounds had been supported by charitable funding. Four Rounds had been held to-date and staff feedback following their attendance at these events was detailed within the report, and was positive, with those attending as panellists finding the experience to be empowering. Professor Baker, Non-Executive Director and Dean of the Medical School, University of Leicester, briefed members of plans underway at the Medical School to increase and promote empathy and he considered this initiative at UHL to help in continuing to build upon this as staff moved through their careers in healthcare. In discussion, it was noted that this initiative formed part of the work on-going around culture and speaking up and the Director of Safety and Risk verbally reported on the planned re-launch of the Peer Support Unit. Also discussed were practical considerations such as the dates for and timing of the Rounds so as to maximise the number of staff members who could attend and the QOC CCG Representative noted the value in briefing the Clinical Leaders Group of this work. The Committee considered this a really important initiative and requested that Mr Patel, CFC Non-Executive Director Chair, expressed their thanks to the Charitable Funds Committee for funding its introduction in UHL. The Committee also expressed their thanks to Ms Boyle personally for the work she had undertaken in establishing Schwartz Rounds at UHL and noted the need to continue to progress the Rounds such that they became embedded in the culture of UHL.

- **Ward Assessment and Accreditation**
  Ms Bradley, Lead Nurse for Assessment and Accreditation, attended to present a report, the purpose of which was to update the Committee on the introduction of Ward Assessment and Accreditation across UHL in adult in-patient wards and to provide an overview of the outcomes of the assessments undertaken to-date. The Chief Nurse noted that this was considered an exemplar process by NHSI, the focus of which was on improvement and represented the start of the nursing excellence journey. There was an opportunity for wards to apply for 'Blue' status when they had achieved three consecutive 'green' ratings against the assessed standards. In discussion, the QOC Non-Executive Director Chair queried whether the use of technology had been considered as a standard for assessment, in response to which it was confirmed that this was already included in the standards assessed. Mr Caple Patient Partner, queried whether the standards covered how staff cared for patients with dementia, in response to which it was confirmed that this element ran through all the standards rather than being standalone. Ms Bailey, Non-Executive Director highlighted the importance of this being a systematic 'business as usual' approach and noted the need to consider how it linked to training for middle managers in Becoming the Best (BtB), in response to which the Chief Nurse confirmed the intention to continue to take this process forward into induction programmes etc. In response to a query raised by Mr Patel, CFC Non-Executive Director Chair, as to how to ignite and maintain enthusiasm amongst staff, the Chief Nurse noted that her experience of the process to-date was that it was self-perpetuating with staff wishing to continue to improve on past achievements. Particular discussion took place regarding e-beds, which would become increasingly prominent, and the Chief Nurse noted the socialisation process in place whereby elements not yet being assessed were referenced on the assessment form ahead of their formal introduction. The Chief Nurse explained that individual wards received their results (both quantitative and qualitative) and ward teams immediately began to address any issues identified. In response to a query raised by Mr Caple, Patient Partner, as to whether there was any correlation between any standards currently assessed as 'red' and low staffing levels, it was confirmed that no direct correlation of such had been observed to-date. In conclusion, the Committee received and noted the contents of this report and expressed their thanks to Ms Bradley for all her hard work in this valuable area. The QOC Non-Executive Director Chair made note that the challenge for the future would be in developing a systematic approach to assuring clinical services.

- **UHL's response to the recommendations arising from the Paterson Inquiry**
  The Medical Director presented a report to the Committee which addressed the Trust's response to recommendations arising from the Paterson Inquiry by means of the provision of a gap analysis of the current UHL position against the recommendations applicable to NHS Trusts. It was expected that there would also be a co-ordinated NHSE/I response to the recommendations of the Inquiry. The contents of this report were received and noted.

- **Report from the Director of Safety and Risk**
  The Director of Safety and Risk presented her monthly report to the Committee, the particular focus of which this month related to (1) the findings and recommendations from the recently published Healthwatch report 'Shifting the Mindset – a closer look at Hospital Complaints' and (2) the responsibilities for the Director On Call within the 3636 staff concerns process. The Committee received and noted the contents of this report. In discussion, Mr Patel, CFC Non-Executive Director Chair, noted the value in the Trust Chief Executive using relevant information

within this report for his forthcoming meeting with the local Healthwatch group. In response to a query raised by the Trust Chairman as to how the Trust monitored the learning from complaints, the Director of Safety and Risk advised that this was through a number of means: (1) individual CMGs and directorates were sent data relating to complaints raised about their services to which they were asked to respond and identify learning (2) learning themes were identified through the Bi-Annual Patient Experience report and (3) themes were also identified through the annual Complaints report. Mr Caple, Patient Partner, suggested that the Director of Safety and Risk consider including information on the Trust's website regarding the variety of ways in which Patient Partners contributed to the work of the Trust in this respect. The contents of this report were received and noted.

- **Update from the Patient Partners re their involvement in the Trust's Quality Strategy 'Becoming the Best'**
  Mr Caple, Patient Partner, reported verbally to confirm the outcome of recent communication between himself and the Trust's Head of Patient and Community Engagement. The deadline for the completion of the Quality Priorities was 31 March 2020 and workshops were being undertaken on the approach to patient and public involvement (PPI) to assist UHL staff in progressing this agenda, in recognition of the fact the progress to-date had been slower than desired. It was the expectation of the Trust Chief Executive that the 31 March 2020 deadline would be met. Mr Caple was requested to continue reporting verbally on this item to QOC at its monthly meetings.

- **Clinical Audit Quarter 3 (2019-20) Report**
  The Deputy Director of Quality Assurance presented the quarterly Clinical Audit report, noting that clinical audit was both an important Quality Improvement and Assurance process and work had been undertaken to align the clinical audit programme with the Becoming the Best QI Strategy and create a Quality Management and Learning system. The QOC Non-Executive Director Chair queried why this reporting (currently on a July to July cycle) was out of synch with the Caring at its Best Awards in September and suggested that it be aligned with Caring at its Best, a proposal which was supported by Ms Bailey, Non-Executive Director. Ms Bailey also suggested that the auditors should be Improvement Agents, if they were not already such. The Committee received and noted the contents of his report.

- **Nursing and Midwifery Safe Staffing and Workforce Report**
  The Chief Nurse presented the latest Safe Staffing and Workforce report, noting that registered Nursing vacancies for December 2019 represented an 11.33% vacancy rate against a 10% vacancy rate nationally, which was a significant improvement compared to quarter 1 and 2. Health Care Support Worker (HCSW) vacancies for December 2019 represented a 7.22% vacancy rate against a 10% vacancy rate nationally. Specialty Medicine continued to report a high number of nurse vacancies, but Datix incidents (re lower than required numbers of registered nurses and poor skill mix) for December had decreased compared to the previous month. The Chief Nurse noted that the Trust continued to move staff in order to maintain patient safety, albeit noting the practical difficulties this could sometime cause for staff, particularly if the move was across site, as highlighted by the Trust Chairman. The QOC Non-Executive Director Chair noted the clarity of the recent Trust Board Thinking Day presentation on this issue and the contents of this report were received and noted.

- **Any Other Business** – Col (Ret'd) Crowe noted that this was his last meeting as QOC Non-Executive Director Chair. He would be commencing as the Non-Executive Director Chair of the People, Process and Performance Committee from March 2020 onwards and Ms V Bailey would be commencing as the Non-Executive Director Chair of QOC also from March 2020.

<u>Items for noting:</u>

- **Medicines Optimisation Committee Report**
- **Blood Sciences Accreditation Update**
- **Surgical Site Surveillance in Elective Orthopaedics**
- **Infection Prevention Update – Quarter 3**
- **2019-20 Clinical Coding and Data Quality Quarterly Update**
- **Claims and Inquest Report – Quarter 3**
- **EQB action notes 14.1.20**

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

- Learning from Deaths Quarterly Report (copy attached to this summary).

Public items highlighted to the Trust Board from this meeting:-

- None

Matters referred to / from other Committees:

- To reassure the Audit Committee of QOC's oversight and continued planned follow-up of the UHL ED Safety

Checklist Audit Report (as referred to QOC by the Audit Committee at its meeting on 24 January 2020).	
Date of next meeting:	26 March 2020

Col (Ret'd) I Crowe – Non-Executive Director and QOC Chair

UHL Mortality and Learning from Deaths Report

Author: [Head of Outcomes & Effectiveness & Deputy Medical Director] Sponsor: [Medical Director]

QOC paper C

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	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
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)	04/02/20	Discussion
Executive Board	11/02/20	Discussion and assurance
Trust Board Committee		
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 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 A summary of UHL's mortality rates, both risk adjusted and crude, are set out in the slide deck (Appendix 1). UHL's crude mortality continues to be stable at 1.1% and our risk adjusted mortality remains within expected. Our latest SHMI is 96 for the 12 months October 2018 to September 2019 (due to be published end of February) and our HSMR for September 2018 to August 2019 is 95.

No individual diagnosis groups are above expected in the SHMI and there are only two groups with a 'CUSUM' alert in the HSMR both of which have been previously reviewed and found to be due to coding nuances.

3.2 Quarter 1- 3's "Learning from Deaths" activity is summarised in Appendix 2. We have recently made further improvements to our Medical Examiner process, in collaboration with the Senior Coroner, and current performance is that 98% of adult deaths in Q1-3 have been screened. Further work continues to fully implement the ME process for 'out of hours urgent release of deceased' and also child deaths.

We have worked hard over the summer months to improve our processes in order to reduce delays in requesting further reviews and the Bereavement Support Nurses have been working with the team to ensure requested reviews appropriately respond to questions raised by the bereaved. However, the increased deaths in the past 3 months have led to a back log in collation of further review findings.

647 (28%) of adult cases screened have been referred for further review – 232 were for a Structured Judgement Review (SJR). A further 88 paediatric/neonatal deaths were also referred for SJR.

Of the 206 SJRs requested in Q1 & Q2, 151 have had a Death Classification (DC) agreed by the Specialty M&M. In addition to the 2 cases reported as having a Death Classification of 1 in the previous report, we have a further 3 cases where the DC of 1 is being confirmed following review by the Mortality Review Committee, two have already been investigated by the Patient Safety Team. Further information has been requested for the other case. If all 5 cases are confirmed as a DC of 1 this equates to 0.2% of all our deaths being more likely than not due to problems in care

Appendix 4 summarises numbers of reviews requested and completed and learning/actions agreed by Specialty (ordered within CMGs).

Cross cutting themes from both clinical reviews and SJRs continue to be around communication with patients and relatives, recognition of patients approaching end of life and reviewing / interpretation of observations and investigations. Following discussion with M&M Leads and SJR Reviewers we have changed our SJR template to focus on learning and actions and to enable more timely collation of learning themes at both a specialty and trust level.

We continue to seek feedback from the bereaved either via the Medical Examiners or Bereavement Support Nurses and to see how we can increase feedback from relatives at the Glenfield and LGH

sites. We facilitated a multi disciplinary and multi-agency forum to look at Bereavement Support for child deaths and we are liaising with the Children's Hospital, Paediatric Emergency Dept and Bereavement Support Agencies to take this forward in conjunction with plans to revise the Child Death Review process

3.3 Slides 13-15 in Appendix 2 demonstrate that we achieved the standards required for Year 2 of the Maternity Incentive Scheme. Part of the requirement is reporting of deaths to Trust Board level every quarter.

Appendix 3 is the Quarterly report by the Perinatal Mortality Review Group (PMRG) which was reviewed at the last Mortality Review Committee meeting where members noted that our neonatal death rate for 2018 is higher than previous years, and it is likely that we will show as 'red' i.e. worse than our peer group average in the next MBRRACE-UK report. A review of all cases is being undertaken jointly by the Chair of PMRG and the Neonatal Head of Service. Members were also advised we have already had 10 stillbirths in January this year and 5 were of term/near term normally formed babies. An urgent review meeting is being held on 12th February to review these cases. An early emerging theme relates to the management of women with diabetes and changes have already been made to the ante natal care for this group of patients.

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:

	(X)	
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 Mortality Report Slide-deck

February 2020

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

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

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

*Excludes Deaths in the Emergency Department

How many in-patients have died in our Trust?

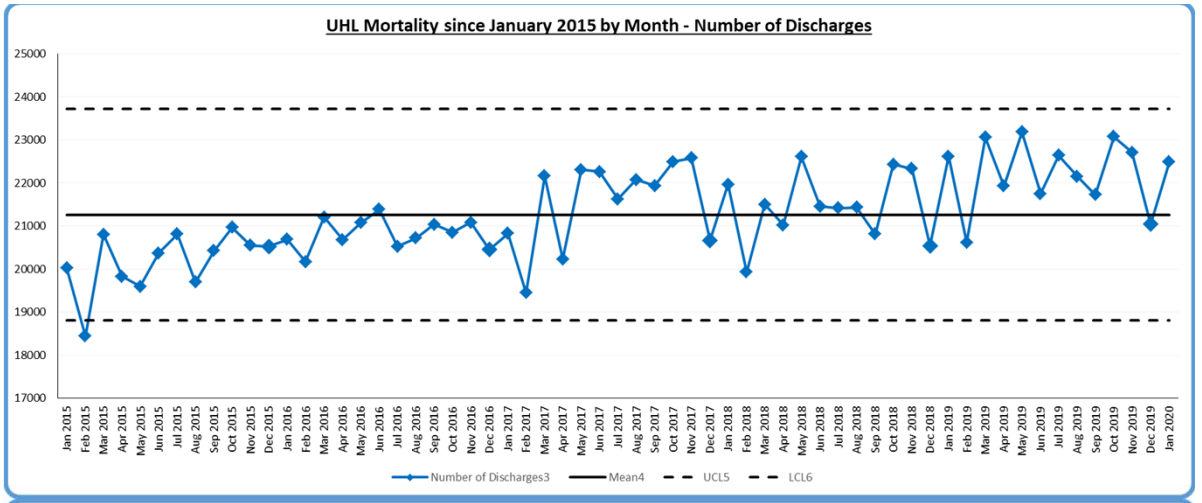
UHL's Monthly Activity, Deaths and Crude Mortality Rate Jan 2015 to Jan 2020 (using SPC)

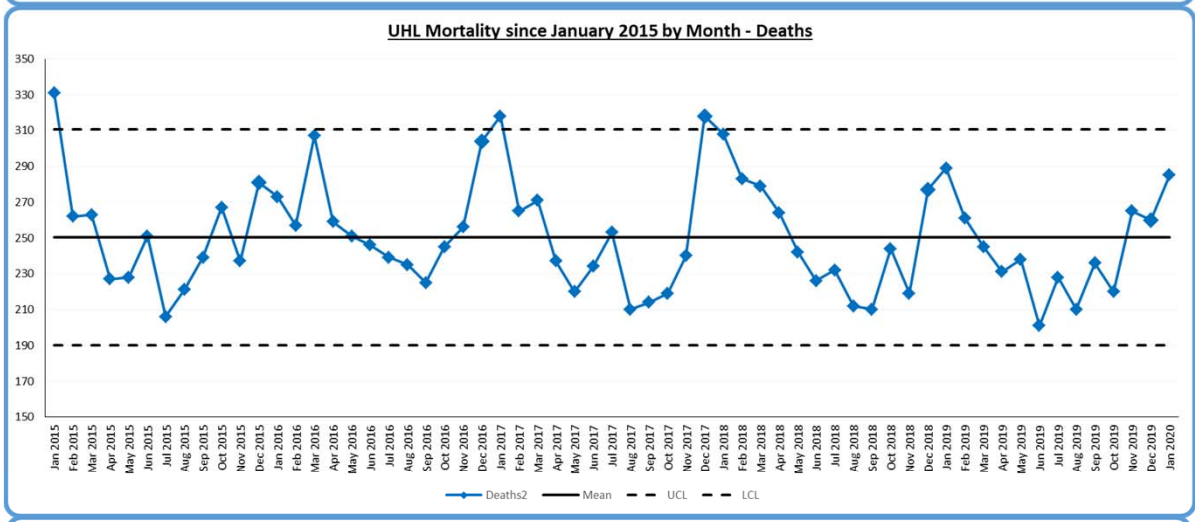
Admissions for December were slightly lower due to a reduction in elective activity (both day case and inpatient).

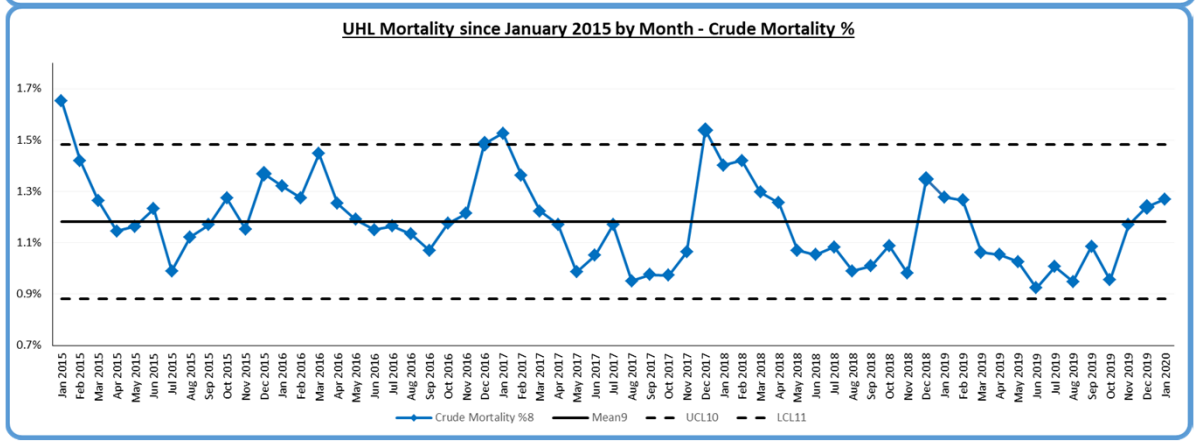
The number of deaths and our crude mortality rate are showing the usual seasonal peak but currently both the number of deaths and crude rate are below that of last year for December and January .

Our overall mortality for 19/20 year to date is also slightly lower than for 18/19.

Discharged During…	All Discharges (incl Day	All In-Patient Deaths	In-Patient Crude Mortality Rate
FY 2019/20 YTD (Jan 20)	**222685**	**2374**	**1.07%**
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%





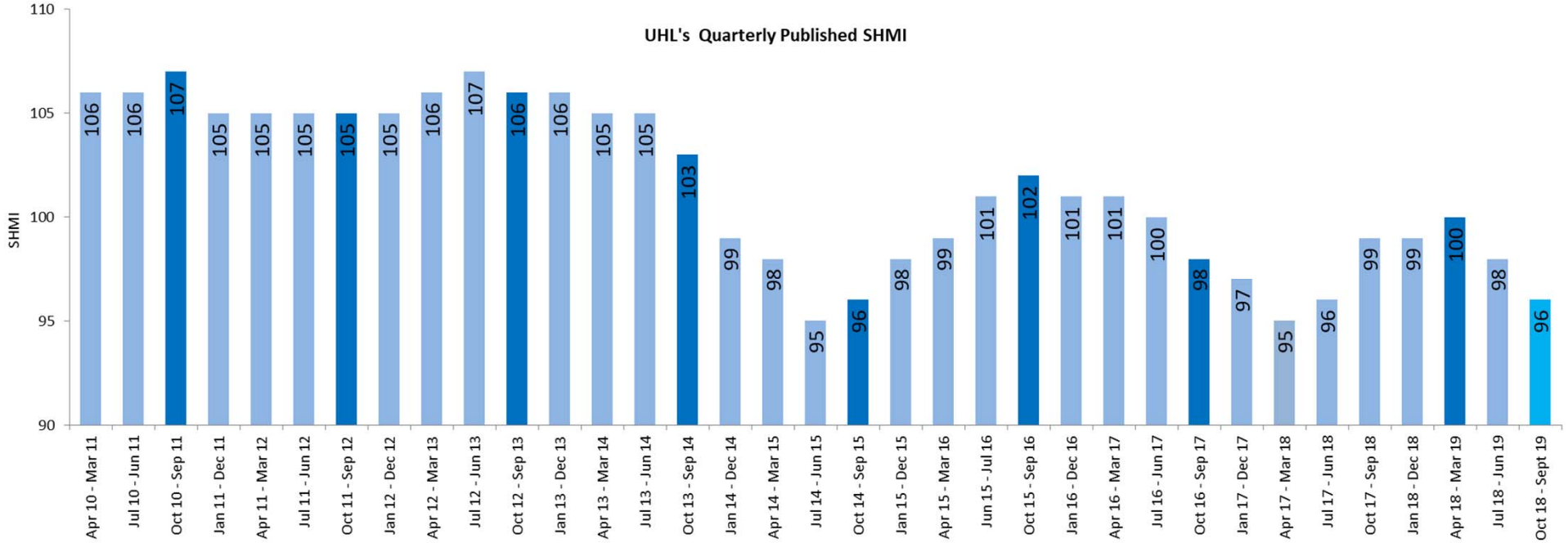


SHMI:
Summary Hospital Mortality Index
ie risk adjusted mortality where patients die either in UHL or within 30 days of discharge
(incl those transferred to a community trust)

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. The expected number of deaths is estimated using the characteristics of the patients treated including age, sex, method and month of admission, current and underlying medical condition(s) and birthweight (perinatal diagnosis groups only). It covers patients admitted to non-specialist acute trusts who died either while in hospital or within 30 days of being discharged.

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



UHL's latest 'Quarterly SHMI' (covering the 12 month period Oct 18 to Sept 19) has reduced further to 96 (due for publication end of February 20)

The chart above suggests there may always be variation in our SHMI performance but with a down ward trend over time.

LATEST SHMI and HSMR

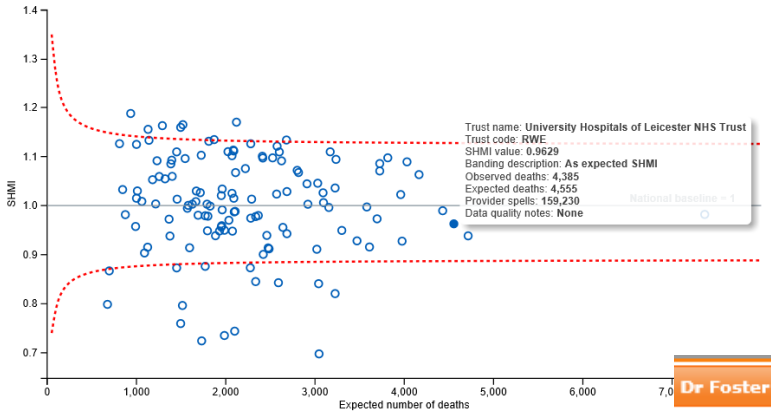
Summary Hospital-level Mortality Indicator (SHMI), England, October 2018 - September 2019

Funnel plot Return to contents

NHS Digital

For any given number of expected deaths, a range of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the trust in question is considered to have a higher or lower SHMI than expected. The extremes of this range are called control limits and they are shown in the funnel plot by the two dotted lines. The circles represent individual trusts.

- Trusts whose SHMI falls above the upper control limit are categorised as 'higher than expected'.
- Trusts whose SHMI falls between the upper and lower control limit are categorised as 'as expected'.
- Trusts whose SHMI falls below the lower control limit are categorised as 'lower than expected'.



SHMI as reported by NHS Digital

"Deaths following time in hospital",

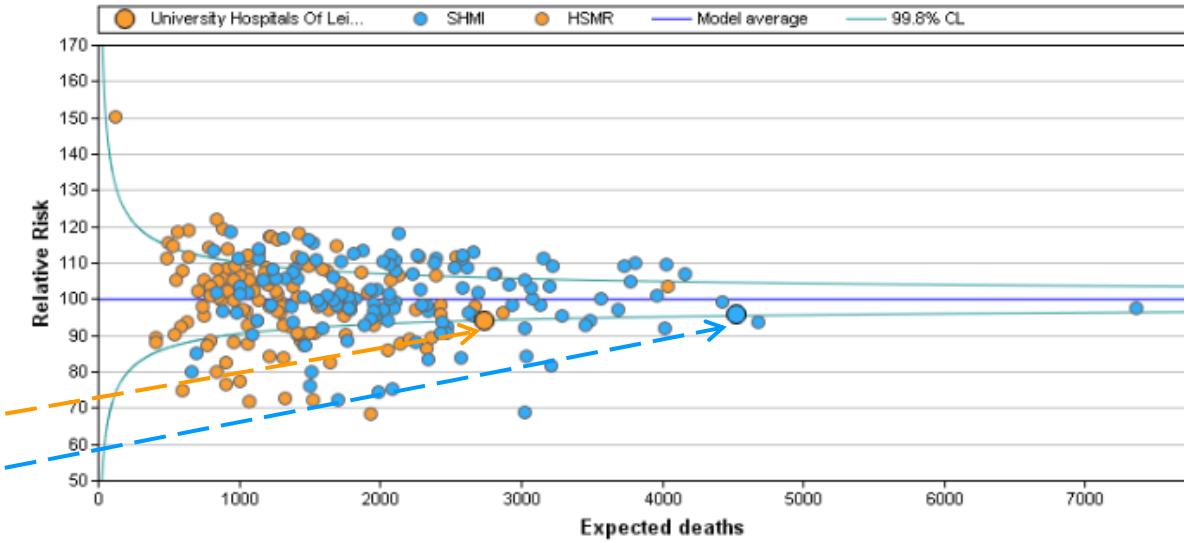
UHL continues to be one of the Trusts with most 'expected deaths' in both the SHMI and HSMR

UHL's SHMI & HSMR as reported Dr Foster Intelligence

UHL's SHMI = 96
UHL's HSMR = 95

Dr Foster Intelligence: Mortality Comparator

SHMI and HSMR by provider (all non-specialist acute providers) for all admissions in Sep 2018 to Aug 2019



NHS Digital have created an Interactive Visual Display tool which provides some limited drill down / comparison analysis of our SHMI once data publically available

Summary Hospital-level Mortality Indicator (SHMI), England, September 2018 - August 2019

Trust-level summary Return to contents

NHS Digital

To support the interpretation of the SHMI, various contextual indicators are published alongside it. A breakdown of the data by site of treatment is also available. The SHMI, site level breakdown and contextual indicator data for a particular trust are summarised on this page (scroll down the table to see all of the indicators / sites). Further information on the contextual indicators is presented on the following pages. Please see the SHMI interpretation guidance for more information ε level breakdown.

Select or search for a trust to display a summary of their data

- University Hospitals of Derby and Burton NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- University Hospitals of North Midlands NHS Trust

Trust-level data

As expected SHMI

Provider spells	Observed deaths	Expected deaths	SHMI value
158,495	4,350	4,530	0.9595

SHMI contextual indicators

Indicator	Value	England average
Palliative care		
Percentage of provider spells with palliative care treatment specialty coding		0.1
Percentage of provider spells with palliative care diagnosis coding	1.6	1.8
Percentage of provider spells with palliative care coding	1.6	1.8
Percentage of deaths with palliative care treatment specialty coding	0.0	2.0
Percentage of deaths with palliative care diagnosis coding	31.0	36.0
Percentage of deaths with palliative care coding	31.0	36.0
Admission method		
Crude percentage mortality rate for elective admissions	1.0	1.0
Crude percentage mortality rate for non-elective admissions	3.1	3.4
In and out of hospital deaths		
Percentage of deaths which occurred in hospital	65.0	70.0
Percentage of deaths which occurred outside hospital within 30 days of discharge	35.0	30.0

Site level breakdown (experimental statistics)

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
RWEAA	Leicester Royal Infirmary	89,980	3,155	2,985	1.0580	As expected SHMI
RWEAE	Glenfield Hospital	31,470	875	1,145	0.7656	Lower than expected SHMI
RWEAK	Leicester General Hospital	36,100	315	405	0.7808	Lower than expected SHMI
NT226	Nuffield Health, Leicester Hospital	25	0			
NT322	Spire Leicester Hospital	35	0			

Data quality notes

None

Some values are not shown because they have been suppressed for the purposes of disclosure control. All other sub-national counts are rounded to the nearest 5, with SHMI values calculated from the unrounded values. Percentages are calculated from the rounded values.

The above data includes number of admissions and deaths across each site. MRC noted that whilst the LRI continues to have a higher SHMI than the other two sites which is above 100, this is 'within expected'. Further sub-analysis will be undertaken to see if there are any diagnosis groups most contributing to the LRI's higher SHMI.

Note Nuffield Health and Spire are considered to be part of UHL's activity for a small number of patients.

Summary Hospital-level Mortality Indicator (SHMI), England, September 2018 - August 2019

Trust-level summary

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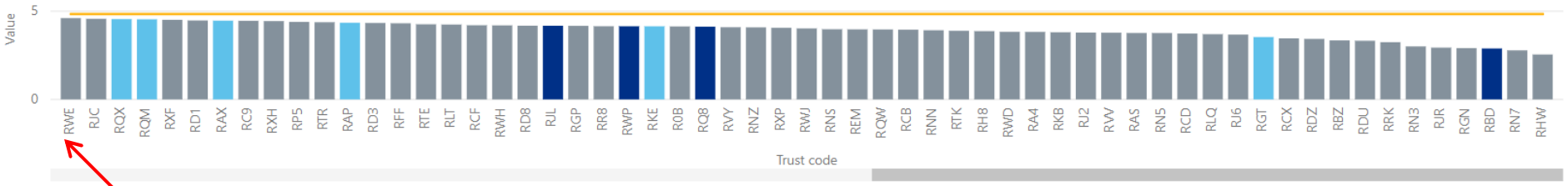
The SHMI data also contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected number of deaths. 'Depth of coding' is defined as the number of secondary diagnosis codes for each record in the data. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities, but may also be due to differences in coding practices between trusts.

Select a trust to highlight on the charts

Trust code	Trust name
RCF	Airedale NHS Foundation Trust
RTK	Ashford and St Peters Hospitals NHS Foundation Trust
RF4	Barking, Havering and Redbridge University Hospitals NHS Trust
RFF	Barnsley Hospital NHS Foundation Trust
R1H	Barts Health NHS Trust

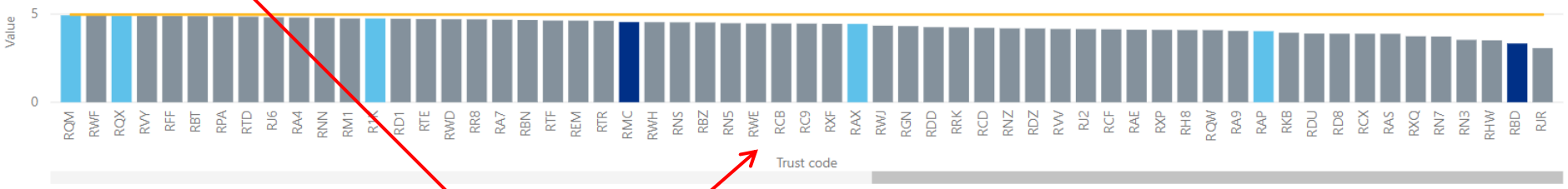
Mean depth of coding for elective admissions

As expected SHMI | Higher than expected SHMI | Lower than expected SHMI | England average



Mean depth of coding for non-elective admissions

As expected SHMI | Higher than expected SHMI | Lower than expected SHMI | England average



UHL's depth of coding – for both elective and emergency admissions - is in the bottom half of all trusts and for emergency admissions is in the bottom quartile. Further work is being undertaken to better understand if this lower depth of coding is having a direct impact on the Charlson comorbidity scores recorded for our patients (the Charlson Comorbidity Score is used for the risk adjustment model).

We are also undertaking a project with PwC to see if we can prospectively check our coding in order to ensure that all relevant comorbidities have been appropriately captured.

SHMI DIAGNOSIS GROUPS

Where Observed Deaths are 5+ above Expected for Last 4 Reporting Periods

SHMI DIAGNOSIS GROUP	Discharges Oct 18-Sep 19	Obs Deaths Oct 18 - Sep 19	Exp Deaths Oct 18-Sept 19	Obs vs Exp Oct 18-Sept 19	Obs vs Exp Sept 18-Aug 19	Obs vs Exp Aug 18-Jul 19	Obs vs Exp Jul 18-Jun 19
Cardiac arrest and ventricular fibrillation	132	78	67	**11**	10	10	10
Open wounds of head; neck; and trunk	571	19	9	**10**	10	5	5
Urinary tract infections	2558	110	101	**9**	5	10	10
Coronary atherosclerosis and other heart disease	1612	26	18	**8**	5	5	5
Disease of veins and lymphatics	701	19	12	**7**	10	15	15
Pleurisy; pneumothorax; pulmonary collapse	732	46	39	**7**	10	15	15
Other nervous system disorders	944	19	12	**7**	10	5	5
Thyroid disorders, Other endocrine disorders	**520**	**18**	**11**	**7**	**5**	**10**	**10**
Other connective tissue disease	1702	30	25	**5**	5	10	10
Cancer of breast	**573**	**23**	**18**	**5**	**10**	**5**	**5**
Fracture of lower limb	**777**	**14**	**9**	**5**	**5**	**5**	**5**
Diabetes mellitus with complications	**608**	**26**	**21**	**5**	**10**	**10**	**10**

In the latest SHMI dataset there are no diagnosis groups with an 'above expected SHMI' and there are now only 16 diagnosis groups with 5 or more deaths above expected with just 2 of these being in double figures. (In the Oct 16 to Sept 17 SHMI there were 28 diagnosis groups with 5 or more deaths above expected and 14 of these were in double figures with Acute Myocardial Infarction having 50 deaths more than expected.)

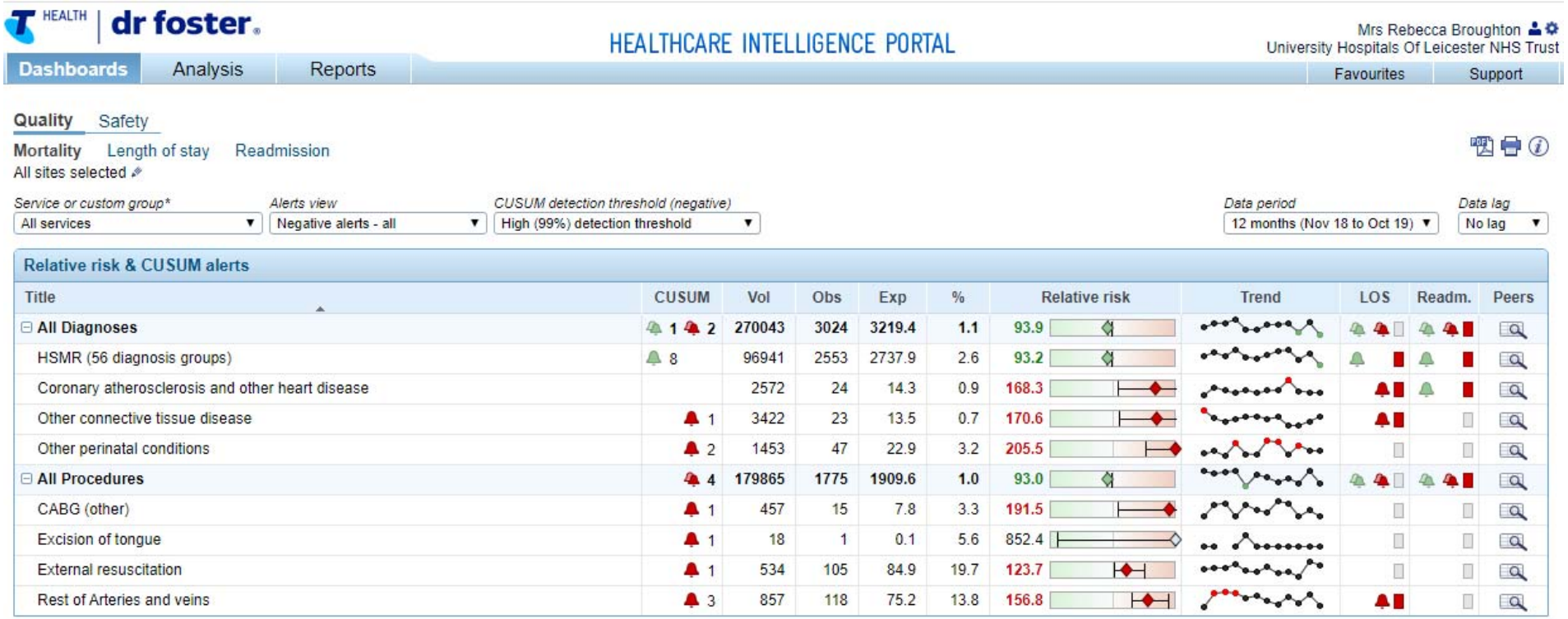
The above table includes those diagnosis groups where there have been 5 or more deaths above expected for the past 4 SHMI reporting periods. Most have been previously looked into and reviews in progress for the others (**Blue Bold**) for reporting to the next MRC. Preliminary findings are that all were 'expected deaths'.

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

DR FOSTER INTELLIGENCE QUALITY DASHBOARD



HEALTH | dr foster

HEALTHCARE INTELLIGENCE PORTAL

Mrs Rebecca Broughton
University Hospitals Of Leicester NHS Trust

Dashboards | Analysis | Reports | Favourites | Support

Quality | Safety

Mortality | Length of stay | Readmission

All sites selected

Service or custom group*: All services
Alerts view: Negative alerts - all
CUSUM detection threshold (negative): High (99%) detection threshold
Data period: 12 months (Nov 18 to Oct 19)
Data lag: No lag

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 2	270043	3024	3219.4	1.1	93.9				
HSMR (56 diagnosis groups)	8	96941	2553	2737.9	2.6	93.2				
Coronary atherosclerosis and other heart disease		2572	24	14.3	0.9	168.3				
Other connective tissue disease	1	3422	23	13.5	0.7	170.6				
Other perinatal conditions	2	1453	47	22.9	3.2	205.5				
All Procedures	4	179865	1775	1909.6	1.0	93.0				
CABG (other)	1	457	15	7.8	3.3	191.5				
Excision of tongue	1	18	1	0.1	5.6	852.4				
External resuscitation	1	534	105	84.9	19.7	123.7				
Rest of Arteries and veins	3	857	118	75.2	13.8	156.8				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Rest of Arteries and veins	156.8	857	118	75.2	42.8
Other perinatal conditions	205.5	1453	47	22.9	24.1
External resuscitation	123.7	534	105	84.9	20.1
Cardiac arrest and ventricular fibrillation	116.8	130	72	61.7	10.3
Coronary atherosclerosis and other heart disease	168.3	2572	24	14.3	9.7

Highest crude rates

Title	Rel. risk	Vol	Obs	%
Cardiac arrest and ventricular fibrillation	116.8	130	72	55.4
Shock	80.1	2	1	50.0
External resuscitation	123.7	534	105	19.7
Aspiration pneumonitis, food/vomitus	84.5	349	65	18.6
Respiratory failure, insufficiency, arrest (adult)	91.0	140	24	17.1

There are no new diagnosis or procedure groups with a CUSUM alert this month and there are only 2 diagnosis groups alerting.

Appendix 2

Learning From the Deaths of Patients in our Care 19/20 Q1-Q3

FEBRUARY 2020

UHL's "Learning from Deaths" Framework

- **Medical Examiners (MEs)** – (Currently 14 MEs working 1 PA a week). ME process includes all ED and Inpatient adult cases – MEs support the Death Certification process and undertake 'proportionate' Mortality Screening – to include speaking to the bereaved relatives/carers and screening the deceased's clinical records. Where Screening identifies potential areas for learning by the clinical team(s), the case will be sent to the relevant Specialty for further review.

- **Specialty Mortality & Morbidity Programme (M&M)** – involves full Mortality Reviews (SJRs) where meet National criteria (see previous slide) or are referred by the ME or members of the Clinical Team. M&M meetings confirm Death Classification, Lessons to be Learnt and taking forward agreed Actions

- **Clinical Reviews** – involves reviewing care of patients where families have raised concerns about the end of life care or other patient experience issues

- **Bereavement Support Nurse (BSN**)– 'follow up contact' for bereaved families of adult patients, liaises with both the MEs and Clinical Teams where families have unanswered questions. Also sign posts bereaved relatives to appropriate support agencies where unmet bereavement needs identified.

- **Patient Safety Team (PST)** – where 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.

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

‘Deaths covered by UHL’s “Learning from the Death” process 19/20 – Quarters 1 to 3 by Hospital Site

Hospital Site	Q1	Q2	Q3	Q4	19/20 YTD
LRI	541	545	618		1704
GH	173	152	199		524
LGH	54	51	62		167
All Sites	**768**	**748**	**879**		**2395**

What is the data telling us?

- **The above table includes adult, child and neonatal deaths and both ED and Inpatient deaths as well as those in the Community where deceased brought back to UHL for death certification purposes.**
- The number of deaths in Quarters 1 and 2 is always lower than for Quarters 3 and 4

Place of Death	Q1 – Q3
InPatient	2091
Em Dept	200
Community	104

Type of Admission	Q1 – Q3
Emergency	2350
Elective	45

Deaths covered by UHL's "Learning from the Death" process
19/20 Quarters 1 to 3 – Adult, Child, Neonate

	Q1	Q2	Q3	Q4	19/20 to date
ADULT	739	720	850		2309
CHILD	7	12	10		29
NEONATES/ PERINATAL	22	16	19		57
	768	**748**	**879**		**2395**

What is the data telling us?

For the purposes of our Learning from Deaths framework Neonates are babies who are born in UHL or in another hospital and transferred to our Neonatal Unit (can also be referred to as Perinatal Mortality but this is 'age specific') and who subsequently die either in the Maternity Unit or Neonatal Unit.

Children includes all children between 0 and 16 years (where not considered to be 'Neonates)

Number and % of Adult Deaths Screened by a Medical Examiner

	Q1	Q2	Q3	Q4	19/20 YTD
Adult Deaths	739	720	850		2309
Adult Deaths Screened	739	716	799*		2254
% Adult Deaths Screened	**100%**	**99%**	**95%**		**98%**

Both the scope of the ME process and percentage of cases screened has increased year on year.

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

***Retrospective screening of incomplete LGH/GH December deaths being undertaken in January and February**

What is the data telling us?

Following review and changes to our administrative processes with close support from the Bereavement Services team and flexible working from our Medical Examiners we have been able to consistently exceed our target of 95% and to routinely screen community deaths (where the death certification process is facilitated by UHL).

Meeting this target has been particularly challenging during Quarter 3 where we have seen over 100 more deaths

In 19/20 our focus has been to improve the timeliness of screening, particularly for deaths at the LGH and Glenfield site and those referred to the Coroner.

During Quarter 3 we have implemented further changes to our Medical Examiner process:

- Routine discussion with Certifying Doctors 'out of hours' where 'urgent release requested' – in addition to speaking to the doctor, the Medical Examiners are also speaking to the bereaved over the phone to confirm they are in agreement with the cause of death and do not have concerns which may necessitate referral to the Coroner
- Discussion with Certifying doctors for paediatric death – not all deaths are currently being discussed but there has been increasing Medical Examiner input

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, DNACPR
  - 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,

Adult Deaths Referred for Further Review

Further Review	Q1	Q2	Q3	Q4	All	%
Yes	206	201	240		647	28%
No	533	515	559		1607	72%
Screening not done/in progress		4	51		55	
All Adult Deaths	**739**	**720**	**850**		**2309**	

Type of Further Review Requested (Adult Deaths)

Further Review details	Q1	Q2	Q3	Q4	All	% of all Adult Deaths
Structured Judgement Review*	73	76	83		232	10%
Clinical Review	73	63	86		222	10%
Feedback	31	45	52		128	6%
Theme Review	3		4		7	0.5%
Follow up by Bereavement Support	21	16	12		49	2%
PS Team / SI Investigation	5	1	3		9	0.25%
ALL REFERRED FOR REVIEW	**206**	**201**	**240**		**647**	

Reasons for Requesting Further Review

Reason for Further Review	Q1	Q2	Q3	Q4	All	%
Medical Examiner Screening	89	74	117		280	43%
Concerns raised by the Bereaved	85	90	89		264	41%
Death after Elective Procedure	13	25	9		47	7%
Patient with a Learning Disability	3	2	4		9	1%
Patient with a Serious Mental Illness	13	7	12		32	5%
Patient Safety Team						
Specialty M&M requested review	3	3	9		15	2%
ALL REFERRED FOR FURTHER REVIEW	**206**	**201**	**240**		**647**	

What is the data telling us?

647 (28%) of Adult deaths were referred for further review

Some deaths may be referred directly for SJR without ME screening if meets National Criteria

All child and neonatal deaths will automatically be taken for SJR = 88 in 19/20 to date.

Current position on Q1 and Q2 Adult, Child and Neonatal Deaths Where Structured Judgement Review or SI Investigation required

	Q1	Q2	Q3	Q4	19/20 YTD
SJR completed	80	71			151
Review still in progress	22	33			55
All SJRs in Q1 & Q2	102	104			206
% Reviews Completed	**78%**	**68%**			**73%**

- Where a death is subject to a Serious Incident Investigation, an SJR may not be undertaken as the SI investigation findings will be used to inform the Learning from Deaths programme.
- There have been 5 deaths to date in Q1-3 where an SI investigation has been carried out / started.
- UHL's standard is that 75% of SJRs should be completed within 4 months of the death and 100% within 6 months.
- Unfortunately we have not achieved either of these standards.
- It is possible that the SJRs have been completed and Death Classifications agreed but due to vacancies in the Corporate M&M team and increased activity for the Medical Examiners office we are behind schedule with following up and collating review findings from the Specialty M&Ms.

Death Classifications agreed
Where Structured Judgement Review or SI Investigation completed

Death Classification	Q1	Q2	Q3	Q4	19/20 YTD
1	4	1			**5 (3 tbc)**
2	6	4			**10**
3	17	18			**35**
4	41	35			**76**
5	13	12			**25**

DC	Death Classification Rational
1	**Problems in care thought more likely than not to have contributed to death**
2	**Problems in care but unlikely to have contributed to death**
3	**Problems in care but not thought to have contributed to death**
4	**No problems in care**
5	**Good or Excellent Care.**

2 cases in Quarter 1 were given a DC of 1 (both previously reported to EQB and QOC)
There are 3 cases where the DC of 1 is being confirmed following review by the Mortality Review Committee, two have already been investigated by the Patient Safety Team. Further information has been requested for the other case.

M&M Ref 364– high risk patient who bled post procedure with poor anticoagulation control
M&M Ref 888– patient where bypass tubing became disconnected and subsequently suffered a stroke due to air embolism
M&M 1506 - Failure to induce labour earlier in a diabetic mother following a scan that showed a sudden increase in liquor volume

If all 5 cases are confirmed as a DC of 1 this equates to 0.2% of our deaths being more likely than not due to problems in care

Changes made to the Death Classification

- Following feedback from M&M Leads and SJR reviewers and discussion at national forums, we have reviewed and revised the Death Classification slide within the SJR template.
- The new template has been designed to focus on whether the review "identified learning to improve care in the future" and if actions should be taken as a result
- Deaths will not now be classified from 1 to 5. Instead the Reviewer and M&M will be asked to confirm "whether or not the death was considered to be a problem in care"
- These cases will then be escalated both as a potential Serious Incident (if not already done) and to the Mortality Review Committee and also will be reported in our Quarterly Mortality Report to the Trust Board
- Other changes made to the template include
  - Having just two Ratings for the Phases of Care - "below standard" or "met/above standard"
  - Learning Themes slide (see next slide)

5. LEARNING OUTCOMES	Yes / No	IF YES – DOES THIS PRIMARILY RELATE TO			
Has this review identified areas of learning to improve care in the future?		Clinical Management		End of Life Care	

	Area of Learning	Y / N	If yes - Details of Learning
1.	***Assessment, Diagnosis & Plan.*** *i.e. initial assessment, missed/incorrect diagnosis or the management plan*		
2.	***Communication – Patients & Relatives:*** *i.e. investigation results, management or discharge plans; diagnosis, prognosis; ReSPECT / DNACPR, imminence of death; Reasonable Adjustments e.g. Language, Hearing*		
3.	***Dignity & Compassion:*** *i.e. assistance with ADL's; lack of compassion; attitude; making reasonable adjustments e.g. dementia care*		
4.	***Discharge:*** *i.e. discharge planning process; follow up arrangements, equipment; "Package of Care"*		
5.	***Documentation: Paper/Electronic:*** *i.e. correspondence with patients or other professions; documentation in clinical records; completion of forms e.g. DNACPR, consent, nursing assessments*		
6.	***Investigations and Acting on Results:*** *i.e. requesting/obtaining investigations; review of or acting upon results received?*		
7.	***Multi-Disciplinary Team Working:*** *i.e. inter-speciality referrals or reviews; liaison and continuity of care/ownership; or Inter-team issues within the same specialty*		
8.	***Medications:*** *i.e. prescribing; supply ; administration; review*		
9	**Monitoring , Recognition & Escalations/Ceiling** *i.e. monitoring of the patient's condition; recognition of the unwell/dying patient; escalating care or identifying ceiling of care?*		
10.	***Transfer & Handover:*** *i.e. delays to correct speciality; Inappropriate outlying or transfer (level of acuity / fitness for transfer/dying patient; errors /omissions in handover*		

NHS Resolution Maternity incentive scheme – year two

Requirements for Safety action 1:

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

a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.

b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.

c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.

d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.

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

- We achieved the standards required for Year 2 of the Maternity Incentive Scheme.
- Year 3 replicates those standards, resetting the clock to 20th December 2019 and reporting in September 2020.

NHS Resolution Maternity Incentive Scheme – Safety Action 1

Perinatal Mortality Review Tool (PMRT) Dashboard – Performance as at end Nov 2019

Month	Eligible Stillbirth	Eligible Neonatal Death	Eligible Late Fetal Death	Total Eligible Cases	a) % PMRT started by 4 months	b) No. draft reports within 4 months	b) Cumulative % draft report within 4 months	c)Parents Inf'd & consulted pre review
Dec 18	2	0	0	2	100%	1	50%	2 / 100%
Jan 19	1	1	0	2	100%	1	50%	2 / 100%
Feb 19	3	4	0	7	100%	5	63.6%	7 / 100%
Mar 19	3	1	0	4	100%	2	60%	4/ 100%
Apr 19	1	3	3	7	100%	2	50%	6* / 86%
May 19	4	3	1	8	100%	4	46.7%	8 / 100%
Jun 19	5	2	0	7	100%	5	51.4%	7 / 100%
Jul 19	1	2	0	3	100%	2	52.5%	3 / 100%
Aug 19	3	2	0	5	100%	1	48.9%	5 / 100%
Sept 19	4	2	0	6	100%	5	52.9%	6 / 100%
Oct 19	1	4	0	5	100%	5		5 / 100%
Nov 19	1	5	0	6	100%	6		6 / 100%
Dec 19	2	2	0	4	100%	4		4/100%
Dec-Sept	27	20	4	51	100%	28	54.9%	98%

Safety Action 1d) Learning and Actions of PMRT Cases completed in last Quarter

M&M Ref	Mth of Death	Learning	Action	Due Date	Action Status
62919	May 19	Use of partogram to monitor labour and documentation of surfactant	Individual feedback and reminder to all staff	Jan 20	Completed
63944	Jul 19	Use of Interpreters where little/no English. Fetal heart rate monitoring as per guidelines Diagnosis and management of placental abruption Timing of Induction of Labour Escalation where intrapartum complications	Being investigated as a Serious Incident	Feb 20	
64703	Aug 19	To ensure that use of the partogram is included in the notes booklet for IUFD/stillbirth	Include use of a partogram in a SB/IUFD in the new pathway	Feb 20	Completed
64942	Sept 19	Risk assessment at first presentation with reduced fetal movements Need for cytogenetic testing	'Tea Trolley Teaching' and individual feedback Implementation of new fetal movement gjuideline	Mar 20	In progress

A summary of UHL's latest MBRRACE report and Perinatal Mortality work programme is given in Appendix 3

Seeking Feedback from the Bereaved

- The Medical Examiners aim to speak to all bereaved relatives to explain the cause of death and ask if they have any questions about care provided. They do not speak to the families where the death has been taken by the Coroner
- We do not currently have Medical Examiners on site at either the LGH and Glenfield, therefore a much smaller proportion of these families are spoken to as following feedback from relatives, it has been agreed that the MEs will only try and phone the family if the LGH/GH case notes come over to the LRI for screening within 2 weeks of the death.
- We have been working with the Medical Records offices at the LGH and Glenfield site to try and get the case notes over as soon as possible after death certification and coding completed as screening will then be within the 2 week timeframe. However, this has proved difficult over the winter period.

Hospital Site	Not Referred or Taken by Coroner	No. ME spoke to Rels	% ME spoke to Rels
LRI	916	879	96%
GH	273	37	13%
LGH	80	25	31%
All	**1256**	**941**	**74%**

- The national expectation is that all relatives will be spoken to ahead of the MCCD being issued. From June 19 we have been trying to monitor when the ME (at the LRI site) spoke to the bereaved.
- 61% of LRI bereaved relatives were spoken to before the MCCD was issued (Quarter 2 deaths)
- 25% of bereaved relatives had a 'face to face' conversation with the Medical Examiner – usually when they come to collect the MCCD.

Seeking Feedback from the Bereaved cont....

- Although the Medical Examiners do not speak to the relatives where the death has been referred and accepted by the Coroner, the Bereavement Support Nurses will make contact with the family to see if they need any support or have questions we are able to answer, with the Coroner's agreement.
- The Bereavement Support Nurses will also prioritise trying to make contact with those families that have not been spoken to by the Medical Examiner – unless the relatives have explicitly declined Bereavement Support follow up.
- As can be seen from the table below, there is a much higher proportion of relatives at the LGH and Glenfield site declining BSS follow up. Following discussion with the Bereavement Services Office there was a slight increase in the number of relatives accepting follow up in October and November and further work is being done to improve this further.

	Spoken to either ME or BSS Nurse	Not Spoken to by either ME or BSS Nurse	Not spoken to either ME or BSS Nurse BUT (either Taken by Coroner and/or Declined BSS f/up)	Not spoken to ME but BSS F/up still in progress
LRI	91%	1%	7%	1%
GH	37%	9%	52%	2%
LGH	53%	1%	45%	1%
% All Sites	76.5%	3%	19.5%	1%
Number All Sites	1157	40	284	19

Feedback on Standard of Care Received

Both the Medical Examiners and the Bereavement Support Nurses ask the relatives/carers about their experience of care or for feedback on the care provided

Q1 & Q2	Compliment	Gen Happy / No Concern	Concern		Total Asked
Feedback to MEs	**211**	**548**	**192**		**922***
%	**20%**	**60%**	**20%**		

*29 relatives who spoke to the ME had both concerns and compliments

During Quarter 2, the Medical Examiners started to record where relatives gave negative or positive feedback about the End of Life care provided and also about communication relating to end of life care, imminence of death, etc.

Quarter 2	Positive	Negative	No Feedback
End of Life Care	222	31	220
Communication	**210**	**16**	**247**

Bereavement Support Service

- The Bereavement Support Service (Adult) offers bereaved families/carers the opportunity to talk about what matters to them regarding their bereavement and offers information and support and signposting to bereavement counselling and other support organisations as required
- **Follow up contact by the Bereavement Support Service is offered to the bereaved relative/carer for all UHL adult deaths**.
- Contact is offered either by the Ward staff or Bereavement Services. Where death referred to the Coroner, the BSN contacts the family directly
- Contact is made by the Bereavement Support Nurse (BSN) 6-8 weeks after the death

- 518 families requested BSS follow up contact (72%).
- 489 families requested a phone call, 25 requested a letter, 4 requested email and 1 follow up was requested by one of our Medical Examiners.
- The BSS Nurses had contact with 394 families (55% of total number).

Outcome of BSN Follow Up

The BSN follow up contact has two main aims

Firstly to identify if the relative/carer has any unmet bereavement needs in order to give them advice about available support agencies.

- A total of 83 bereaved family members / carers (21%) were signposted for ongoing bereavement support or counselling

The other aim of the BSN phone call is to identify if the relatives have any unanswered questions about the care provided.

- Of the 394 contacts made, further follow up contact was required for 39 families (10%).

- 22 where a Learning from Deaths (LFD) Review was already in progress and family required input and/or feedback

- 17 where new actions were taken forward by BSS Nurses

Standard of Care Received – Q1 and Q2

- As can be seen from the table below, most relatives/carers fed back that care provided was good or very good.

Feedback to Bereavement Support Nurse	Q1	Q2	All
1.Very Poor	13	6	19
2.Poor	17	8	25
3.Satisfactory/Adequate	23	37	60
4.Good	102	127	229
5.Very Good/Excellent	190	171	361
6.Unable to say	70	48	118
	415	397	812
% Poor or Very Poor	7%	4%	5%
% Good/Very Good/Excellent	70%	75%	73%

Progress made with our LfD Programme in Q1 - 3

- In Quarter 3, we have maintained timely send out of requests for further reviews. We have revised the SJR template to better prompt consideration of learning and actions to improve care
- We have introduced a quality assurance process for Coroner Referrals and continue to liaise with the Senior Coroner
- The Out of Hours Urgent Release ME process has now started to become embedded in collaboration with the Duty Managers and Mortuary team
- We have had further visits from other Trusts looking to implement an ME process and we were invited to present 'Leicester's Experience of Implementing Medical Examiners at a recent North West Medical Examiners Workshop (hosted by Dr Foster Intelligence)
- We have started to apply the Theming Framework which will enable us to look across the last 3 years of 'LfD data' and going forwards to better evaluate the impact of quality improvements undertaken
- We facilitated a multi disciplinary forum to look at Bereavement Support for child deaths and we are liaising with the Children's Hospital, Paediatric Emergency Dept and Bereavement Support Agencies to take this forward in conjunction with plans to revise the Child Death Review process
- We held another Medical Examiner update session, attended by the Leicester Senior Coroner, to review our ME process look at how to ensure consistency and discuss further developments.
- We have submitted our Medical Examiner activity data to the National ME office and await details of reimbursement
- The Bereavement Support Nurses continue to work closely with the Medical Examiners and Corporate M&M Admin team to try and ensure the requests for further reviews are clearer and incorporate questions from bereaved relatives as applicable so that clinical reviews / SJR reviewers are more sighted to concerns raised when doing their reviews.

Challenges

- As a result of the increased activity in Quarter 3 we are behind with following up and collating completed reviews for Q1 and Q2 deaths.
- The increased activity has also meant that MEs do not have as long for screening as they will have done in the summer months. We have looked at ways of trying to highlight potential issues (the ME Assistant routinely checks if a Patient Safety Incident has been reported or when the patient was last in hospital) In Quarter 3 we also started to highlight where patients had been in ED for over 4 hours.
- We continue to have most doctors arriving to speak to the Medical Examiner in the afternoons and often towards the end of the working day which means that it is not possible for the ME to complete the screening and cremation form process and so the case carries over to the next ME which has a knock on effect of needing to re-discuss with the certifying doctor (where cremation involved)
- We have made some progress with implementing the ME process for paediatric deaths and discussion with the Regional ME has confirmed that the long term plan is for all deaths to be included and therefore we will continue to progress this during Quarter 4 with the aim of fully embedding from 1st April 2020. Plans for including neonatal deaths will be revisited once reimbursement details are fully understood.
- We still have not made progress with plans to have MEs on site at the LGH and Glenfield due to capacity and lack of clarity around funding.
- National guidance is also due to be released on the 'Out of Hours Urgent Release' process but we have been informally advised to continue with our current approach

Areas for focus in Quarter 4

- Following review of the Corporate M&M / ME Administrative team roles and revision of job descriptions we will be recruiting to current vacancies. Existing staff are working additional hours on the bank to cover the gap in the interim.
- We continue to look at how to bring forward attendance by certifying doctors to earlier in the day in order to reduce duplication of effort We aim to have all inpatient paediatric deaths being discussed with the Medical Examiner by the end of Quarter 4
- We are working with the Coroner's office on plans to implement a new e-referral system
- We will complete assigning the agreed themes to the 19/20 reviews and also retrospectively to the reviews completed in 18/19 in order to see if there has been any changes
- The ME screening proforma has been amended to support evaluation of the ReSPECT implementation
- We are attending the Midlands Medical Examiner forum and have been asked to share our experience with other Trusts who have recently started implementing the ME process
- Following confirmation of reimbursement plans by the National ME funding, we will be looking to recruit additional Medical Examiners
- The Corporate M&M team will follow up outstanding reviews and seek updates on actions
- One of the Clinical Fellows is working with the Head of Outcomes & Effectiveness to look at how to best disseminate review findings to junior medical staff
- We will also be working with the Patient Safety Team to triangulate learning themes for 19/20 and consider how to improve dissemination of learning themes

APPENDIX 4 - REVIEWS REQUESTED IN QUARTER 1 AND 2 BY SPECIALTY

	Reviewing Specialty	Reviews Requested (Incl SJR, Clin Rev, PST, BSS f/up)	SJRs Requested	All Reviews Completed	SJRs Completed	Learning (all Reviews)	Actions Agreed
ESM	Acute Medicine	32	8	12	7	3	3
	Dermatology	1	1	1	1	1	1
	EDU	1	1	1	1		
	Em Dept	18	7	9	6	1	1
	Geriatrics	84	28	41	20	23	20
	IDU	2	1	2	1		
	Metabolic Medicine	14	4	4	2	1	1
	Neurology	6	1	1		1	1
	Paeds ED	1	1	1	1		
	Rehabilitation	1		0			
	Stroke	18	4	5	4		
CHUGGS	Gastro	14	7	6	3		
	Gen Surgery LRI	15	10	9	9	2	2
	Haem & BMT	11	6	6	4	4	4
	HPB & Gen Surg LGH	15	9	6	5	2	2
	LRI Gen Surgery	1		0			
	Oncology	19	2	12	2	3	3
	Pall Medicine	3		1			
	Urology	4	4	1	1		
CSI	Physiotherapy	1		0			
	Radiology	1		0			
ITAPS	GH ECMO & CC	4	3	3	2	1	1
	LRI Crit Care	7	1	3	1	1	1
MSS	T&O	12	9	7	5	2	2
RRCV	Cardiac Surgery	15	15	9	8	4	4
	Cardiology	23	11	18	11	7	6
	Nephrology	9	5	5	4	2	2
	Respiratory	17	2	8	2	3	3
	Thoracic Surgery	4	3	4	3		
	Transplant	2	2	1	1		
	Vascular Surgery	7	5	5	3	2	2
W&C	Neonatology	14	14	14	10	3	3
	Obstetrics	25	24	25	21	9	9
	Paed Cardiac/ITU & All	7	7	6	6	5	5
	Paed ITU & Medical	10	10	7	7	6	5
CORP	DART	1		0			
	Discharge Team	1		0			
	IPC	1		0			