University Hospitals of Leicester NHS
NHS Trust

Meeting title:	Trust Board					Public Trust Board paper G
Date of the meeting:	8 June 2022					
Title:	UHL Mortality & Learning from Deaths Quarterly Report					
Report presented by:	Dr Dan Barnes, Deputy Medical Director					
Report written by:	Rebecca Broughton, Head of Learning from Deaths Dr Penny McParland, Consultant Obstetrician & Chair of PMRG					

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Mortality Review Committee – 02/05/23 Trust Leadership Team – 09/05/23 Quality Committee – 25.05.23					

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

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

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

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

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

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

Impact assessment

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

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

Purpose of the Report

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

- Bereavement Services Office – Death Certification
- Medical Examiner Process – both within UHL and across the Leicester, Leicestershire and Rutland (LLR) Healthcare System
- 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
- Learning identified through:
    - Complaints and Incidents
    - HM Coroner's Inquests

Recommendation

The committee is asked to be assured that

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

Summary

UHL's latest Summary Hospital Mortality Indicator (SHMI) is103 and our latest Hospital Standardised Mortality Ratio (HSMR) is 100.9. Both risk adjusted mortality indicators are within the expected range.

No diagnosis group within the SHMI is 'above expected'. There have been 6 new diagnosis groups with a CuSUM alert in the HSMR benchmarking tool and the deaths within those alerts have been cross referenced with our Learning from Deaths data – none of the deaths were related to problems in care.

Although there has been a postponement to the national plans for rolling out the Medical Examiner process to cover all deaths in primary care, we have received an increased number of referrals from GP Practices over the last quarter and LOROS will recommence using the ME service from May.

We have been meeting the agreed internal and national standards in respect of the ME Service despite the 2 recent periods of Industrial Action and have managed to open up a second ME office at the Glenfield Hospital.

We continue to meet requests for Urgent Death Certification for religious purposes, both in and out of hours, including over the Easter weekend/bank holiday period.

Early review of potential learning themes following ME screening show that the themes are similar to those identified in 21/22.

Our Bereavement Support Service has seen an increase in the number of referrals for early follow up calls and our Bereavement Room has now been refurbished at the LRI.

At the May meeting of MRC members received the Quarterly report from the Perinatal Mortality Review Group which reviews all Stillbirths and Neonatal Deaths using the national review tool. The learning from these cases using the Perinatal Mortality Review Tool was reviewed by the May Quality Committee.

The 2021 MBBRACE report was published on 12 May 2023 – our still birth and neonatal mortality rates remain more than 5% higher than our peer group. The Medical Director and Chief Nurse updated the Quality Committee verbally on further actions that have been agreed following publication of the report. The report will be further discussed at the June Maternity Assurance Committee and a written report detailing work to date and further actions will be presented to the June Quality Committee.

We have made improvements to our reporting process to meet the MIS/CNST Safety Standard 1.

2 adult and 1 perinatal death were felt to be more likely than not due to problems in care in the last quarter. All have been investigated as a Serious Incident with learning identified and actions being taken forward.

Main report detail

1. UHL's latest risk adjusted mortality (SHMI and HSMR) are both within expected control limits. Our SHMI for the 12 months January to December 2023 is 103 and our latest HSMR covering the 12 months February 22 to January 23 is 100.9
2. In response to Diagnosis Group CuSUM Alerts in the Dr Foster Healthcare Intelligence dashboard, MRC have received details of reviews undertaken for 6 groups. Whilst learning has been identified, no deaths in these groups were felt to be attributable to problems in care.
3. At the May meeting, MRC members received the Quarterly report from the Perinatal Mortality Review Group. Publication of the 2021 national benchmarked data by MBRRACE-UK took place after the May MRC and Maternity Assurance Committee had met - the report was published on 12 May 2023 and showed that our still birth and neonatal mortality rates remain more than 5% higher than our peer group. The Medical Director and Chief Nurse updated the Quality Committee verbally on further actions that have been agreed following publication of the report. The report will be further discussed at the June Maternity Assurance Committee and a written report detailing work to date and further actions will be presented to the June Quality Committee.
4. The Chair of PMRG advised that the review of the 2022 Neonatal deaths has almost been completed and gave an update on the Quality Improvement actions being undertaken:
    a. Piloting of the CardMedic app, which allows interpreting of common issues via an app on Trust devices as well as realtime interpreting.
    b. Development of an app for use by families who speak the commonest Asian languages, with verbal information on common complications of pregnancy. These videos of local experts have been filmed and dubbed into a number of different languages.
    c. Change to Maternity Assessment Unit function. There are now protected staff on the MAU with a single telephone triage service to take calls for both LRI and LGH. This should reduce the stress on the MAU and provide consistency of advice, which have been issues in previous mortality reviews
5. Quality Committee received a summary of perinatal deaths reviewed during Q4 (Jan to Mar 23) and details of learning identified.

6. MRC received details of a stillbirth where the PMRG had felt 'issues with care were likely to have affected outcome' (Category D). This death has been subject to a Serious Incident Investigation and the main learning was that there is a lack of clarity in the guidance relating to 'late bookers' who have received care elsewhere. Review of the Maternity Booking Process and associated guidance has been actioned.

7. Although there has been a national postponement of the roll out of the ME process to include all primary care deaths, we have continued to see a higher number of referrals during April. We have also started to take referrals from LOROS
8. We opened an ME Office at the Glenfield site on 20th March which has significantly improved the timeliness of full ME scrutiny for Glenfield deaths.
9. Despite both the Easter Bank Holiday and the 2 periods of Industrial Action in March/April, we have continued to meet our 'timeliness of ME discussions' standard. This was as a result of close working between the Bereavement Services / Medical Examiner offices and the Medical Teams. We were also well supported by the Coroner's Office where there were anticipated delays with MCCD completion, particularly after the Easter Bank Holiday.
10. The Duty Managers and the Mortuary Team have also worked very closely with the Medical Examiner service to try and facilitate urgent release of the deceased when requested out of hours.

11. Preliminary analysis of potential learning themes identified by the Medical Examiners after their proportionate screening shows that the main themes are similar to those identified in 21/22
    a. Assessment, Diagnosis and Management Plan was the main theme within the Clinical Management Category
    b. Communication with Patient /Relatives and Ceiling of Treatment/ReSPECT discussions were the 2 main themes within the 'End of Life/Experience of Care' Category
12. Following further analysis of sub-themes, details will be sent to relevant Trust Committees (e.g. Deteriorating Patient Board; End of Life Committee) and the Specialty Mortality Leads.

13. The Bereavement Nurses have improved their performance both in terms of percentage cases where verbal contact is made, and in respect of timeliness of that contact.
14. There has been a further increase in the number of cases where the Medical Examiner has asked the Bereavement Nurses to make an earlier call to the family either due to distress or to talk through their questions/concerns about care in more detail
15. We have secured funding from the Organ Donation Charitable Funds to create a new Bereavement Room for families at the LRI and have created a meeting area in the Bereavement Nurses' office at the LGH.
16. From 1st January we have been able to provide bereavement support follow up to families of deaths in the Community Hospitals (funded by LPT). Most of these patients were previously in UHL.

17. At the May MRC meeting the UHL Mental Health Lead attended to present the findings from mortality reviews undertaken of patients with a Serious Mental Illness. Most learning themes were similar to those identified in mortality reviews of all patients but the Medication learning theme identified a lack of recognition of Clozapine as a Time Critical Medicine and recognition of Lithium

Toxicity as issues – actions to address are being taken forward by the UHL Mental Health Lead. One of the deaths is being reviewed in more detail by the Rib Fracture Pathway Task and Finish Group – the patient's Serious Mental Illness was not thought to be relevant to their presentation or management.

18. A similar proportion of reviews have been requested following ME screening (either because of potential learning identified by the ME or on speaking to the Bereaved or because the death met a national criteria.
19. There has been further progress made with completion of Structured Judgement Reviews requested in 22/23 although the Learning from Deaths Corporate team are still behind with sending out some review requests. The aim is to have the majority of reviews completed in time for preliminary theming for the next Quarterly Report.

20. In addition to the Neonatal death described above, at the May MRC members received details of 2 adult deaths which were potentially more likely than not due to problems in care. Both have been investigated as a Serious Incident and actions are being taken forward.
21. Another death was also reviewed at MRC where the Specialty did not believe death was due to problems in care; but there was felt to be significant learning relating to Thromboprophylaxis. It was noted that over the last 6 months, there have been a number of deaths where learning in relation to anticoagulation treatment (either omission or complications of) was a common theme – albeit the issues identified were all slightly different.
22. The June Quality and Safety half day will focus on learning from patient safety events due to thromboprophylaxis and anticoagulation, and changes have already made to NerveCentre / eMeds to try and support better assessment / review. However, it has been agreed to collate all cases and all Patient Safety Incidents for further discussion with the Trust Thrombosis Committee to consider if there are any other quality improvement interventions needed.