University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 5 December 2019

	Trust Board paper H
Report Title:	**Quality and Outcomes Committee – Committee Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
Author:	Helen Stokes – Corporate and Committee Services Manager

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:	28 November 2019

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 28 November 2019:

- **Mortality report and Learning from Deaths update (August-November 2019)** – the Medical Director advised that UHL's position remained steady, with a continued low crude mortality rate of 1%, and SHMI and HSMR rates within expected ranges (98 and 95 respectively). The Medical Director advised that – following analysis – the HSMR alert on the 'CABG other' procedure group was considered to be due to clinical coding issues. UHL was monitoring the result of the recoding exercise now underway, and QOC received assurance that tracking against NICOR (National Institute for Cardiovascular Outcomes Research) data had highlighted no concerns for this procedure group. Appendix 2 of the report outlined progress against UHL's Learning from Deaths framework, noting improvements to the timeliness for Medical Examiner (ME) reviews with 99% of adult deaths in quarters 1 and 2 of 2019/20 screened. Circa 28% of adult deaths screened had then been further reviewed through the Structured Judgement Review (SJR) process. Paediatric/neonatal deaths were also automatically referred for that SJR process. QOC was advised that in 2019/20 to date, 2 deaths were considered 'more likely than not to be due to problems in care' (death classification 1), and the Medical Director confirmed that both of those deaths had been through the Serious Incident process. The report set out the themes from those cases – which related to delays in diagnosis and treatment and on which actions had been agreed accordingly – and also from the 3 deaths classed as 'problems in care but unlikely to have contributed to death' (death classification 2). In further discussion, the Medical Director noted that national progress was awaited on the ME funding model, and he also commented on the good performance by Bereavement Support Service Nurses with regards to contacting the family of the deceased. The paper also highlighted that UHL's 2017 stillbirth, neonatal death, and perinatal mortality rates were below the average for its peer group, as shown in the latest data available (national MBRRACE report published in October 2019 and the quarterly UHL Perinatal Mortality Review Group report). The Medical Director provided assurance that UHL was on track against the CNST maternity incentive scheme requirements re: perinatal mortality reporting.

  QOC took assurance from the update in the paper, and voiced its thanks to the Medical Examiners for their work. The QOC Non-Executive Director Chair queried the actions being taken to address workforce capacity issues in the Mortality and Morbidity corporate team – in response, the Medical Director advised that he was meeting with the Deputy Medical Director and the Head of Outcomes and Effectiveness to identify appropriate mitigations. In response to a further query from the QOC Non-Executive Director Chair on the issue of the missed STEMI diagnosis referenced within the report, the Medical Director advised that further work was needed on a region-wide solution for the transfer of ECG images.

  The Learning from Deaths quarterly update is recommended for Trust Board approval, as appended to this summary.

- **Patient Partner involvement in UHL's Quality Strategy "Becoming the Best" –** the QOC Patient Partners reported verbally on their involvement in "Becoming the Best", noting discussions with both UHL's Head of Quality Improvement and the Head of Patient and Community Engagement. Not all Patient Partners were yet directly involved with a UHL Quality Priority, although the Medical Director advised that this was now being progressed

through the Executive Planning Team. Mr B Patel Non-Executive Director sought assurance that there was an appropriate focus on co-production, and it was agreed that QOC would consider this when reviewing the patient and public involvement update scheduled for its December 2019 meeting (*en route* to the January 2020 Trust Board). The Trust Chairman emphasised the need for that update to focus on outputs rather than processes/structures, and he also commented on the need for both Executive and Clinical Directors to champion active patient and public input to the Quality Improvement projects. Mr M Caple, Patient Partner, also commented on the need to look more widely than solely Patient Partners.

- **Patient safety report** – the Director of Safety and Risk advised QOC that the 2019/20 quarter 1 harms review had identified no significant concerns. Harm rates would continue to be monitored each quarter for report to the Executive Quality Board and QOC. The report also advised QOC that the process of monitoring overdue actions from Serious Incidents had been strengthened, which was welcomed by the QOC Non-Executive Director Chair. In response to a Patient Partner comment on the same issues featuring in the top 5 complaints themes, the Director of Safety and Risk outlined the ways in which CMGs were informed of those issues through the monthly Performance Review Meetings. The themes particularly reflected the high-volume nature of the specialties involved, and concerns were escalated to appropriate Executive Boards and Board Committees (patient experience aspects also discussed at UHL's PIPEAC group). Some "mystery shopper" work was also planned for some of the areas in 2020/21, and the Director of Safety and Risk agreed to contact Patient Partners about that. The QOC Non-Executive Director Chair requested that this work also be fed into the Outpatient Transformation Programme.

- **Mental health service work priorities –** in response to a query from the QOC Non-Executive Director Chair, the Chief Nurse outlined the process for mental health Serious Incidents. She agreed to contact the Director of Safety and Risk and the Head of Safeguarding outside the meeting, to discuss how best to provide assurance that appropriate lessons were being learned from such incidents (noting that they might not be UHL incidents). Ms V Bailey Non-Executive Director suggested that it would be useful to have more clarity as to what was covered in the service workplan, given the broad nature of the term 'mental health'.

- **Nursing safe staffing and workforce report –** the report for August 2019 triangulated a number of key staffing metrics and considerations, including CMG planned versus actual staffing, nurse staffing fill rates (which had improved slightly in August 2019), vacancies for Registered Nurses and for Healthcare Support Workers (latter at 7.99% - lower than the national average), Care Hours Per Patient Day (CHPPD) rates, Red Flags, and Datix reports relating to safe staffing. The Chief Nurse advised that CHPPD rates (higher than the national median) were skewed by adult ICU, and she confirmed that future reports would also separate out Registered Nurses and Healthcare Support Workers. In considering the report, QOC briefly discussed the potential factors behind the level of 1:1 HCA shift requests (new metric), and also emphasised the importance of retaining staff following their training, noting the high quality training provided at the in-house Glenfield facility.

- **CQC update** – in a verbal update, the Chief Nurse advised that the draft CQC report was expected in December 2019, with a likely limited window of availability then for factual accuracy checking and comments. The Trust Chairman expressed this thanks to all UHL staff involved in the CQC inspection.

Items for noting:

- **Health and safety report for June – September 2019;**
- **Infection prevention report for June – September 2019;**
- **Safeguarding report for June - September 2019;**
- **Inquests and claims report for June – September 2019, and**
- **Executive Quality Board Minutes 8.10.19 and actions 12.11.19.**

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

- Learning from Deaths quarterly report

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

- None

Matters referred to other Committees:

- None.

Date of next meeting:	19 December 2019

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

EXECUTIVE QUALITY BOARD – 12TH NOVEMBER 2019
QUALITY AND OUTCOMES COMMITTEE – 28 NOVEMBER 2019
TRUST BOARD – 5TH DECEMBER 2019

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
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee	28/11/19	For Discussion, Decision and 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 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). Members of QOC are requested to note that the format of the slide deck has changed due to our subscription to the HED clinical benchmarking tool ending.

UHL's crude mortality continues to be stable at 1.0% and our risk adjusted mortality remains within expected. Our latest SHMI is 98 for the 12 months July 2018 to June 2019 (published on 14th of November) and our HSMR for June 2018 to May 2019 is 95.

MRC noted there were two diagnosis groups with a higher SHMI which had not been previously reviewed and it was agreed to undertake further analysis and do some cross matching with our Learning from Deaths data. It was also noted that the HSMR for the procedure group 'CABG Other' has alerted again but members were advised that there have been staffing issues within the Coding team and several notes are currently being recoded. It was therefore agreed that no further analysis needed at this time but to continue monitoring until the recoding work completed.

3.2 Quarter 1 and 2'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 99% of adult deaths in Q1&2 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.

407 (28%) of adult cases screened were referred for further review – 146 were for a Structured Judgement Review (SJR). A further 57 paediatric/neonatal deaths were also referred for SJR.

Of the 203 SJRs requested, 74 have had a Death Classification (DC) agreed by the Specialty M&M. Three cases were given a DC of 2 and two cases a DC of 1 - both cases have been investigated as a serious incident. Problems in care for both patients related to delays in diagnosis and treatment and actions have been agreed by the Specialty M&M and SI team.

Cross cutting themes were reviewed and discussed at the November M&M Leads Forum where it was agreed that changes need making to the review template to ensure focus on learning.

We continue to seek feedback from the bereaved either via the Medical Examiners or Bereavement Support Nurses and to date 76% of bereaved relatives of adult patients who died in Quarters 1 and 2 have been asked if they have any questions and the care provided. We are looking at how we can increase feedback from relatives at the Glenfield and LGH sites. We have also been liaising with the Children's Hospital to provide Bereavement Support to the parents of deceased children, where needed.

3.3 Details of all Death Classifications and also Perinatal Mortality data are given in Slides 14 to 16. The latest MBRRACE report was published in October which includes babies born/died in the calendar year 2017. The report findings and quarterly report by the Perinatal Mortality Review Group (Appendix 3) were reviewed by the Perinatal Mortality Oversight Group and subsequently the MRC where members noted that the stillbirth, neonatal death and perinatal mortality rates for UHL for 2017 are below the average for our peer group

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 (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]

QOC PAPER C
APPENDIX 1

UHL Mortality Report Slide-deck

November 2019

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

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

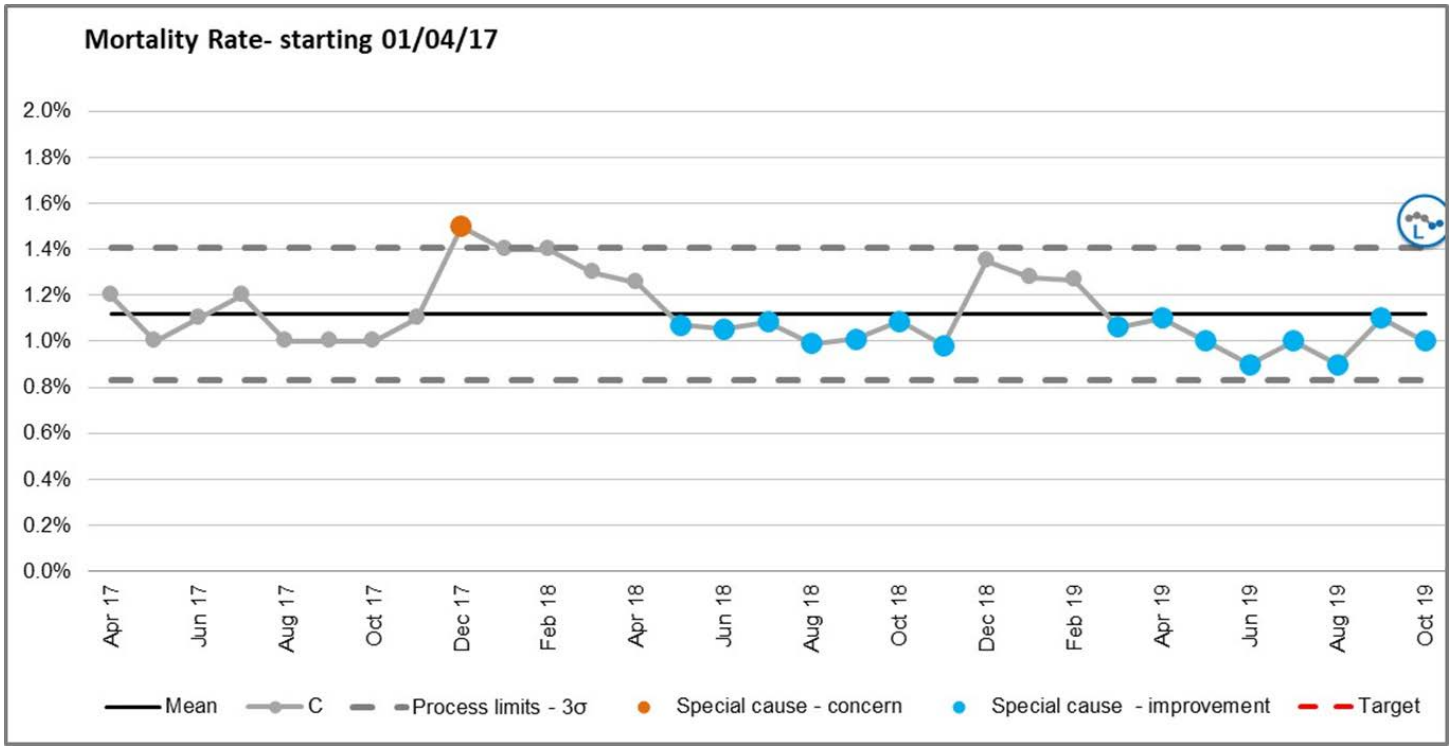
Crude mortality:
i.e. number deaths and proportion of discharges where death is the outcome

How many people died in the Trust between 2014/15 and 2019/20 (to date)

Discharged During…	Emergency Discharges Deaths % Rate	Elective IPs Discharges Deaths % Rate	Total Discharges Deaths % Rate
FY 2019/20 **YTD (Oct)**	**81,302** **1523** **1.9%**	**74,976** **40** **0.1%**	**156,278** **1563** **1.0%**
FY 2018/19	135,543 2849 2.1%	124,758 72 0.1%	260,301 2921 1.1%
FY 2017/18	136,684 2948 2.2%	122,855 68 0.1%	259,539 3016 1.2%
FY 2016/17	129,047 3043 2.4%	121,186 71 0.1%	250,233 3114 1.2%
FY 2015/16	128,524 2913 2.3%	116,252 80 0.1%	244,776 2993 1.2%
FY 2014/15	122,456 2932 2.4%	113,433 65 0.1%	234,889 2997 1.3%

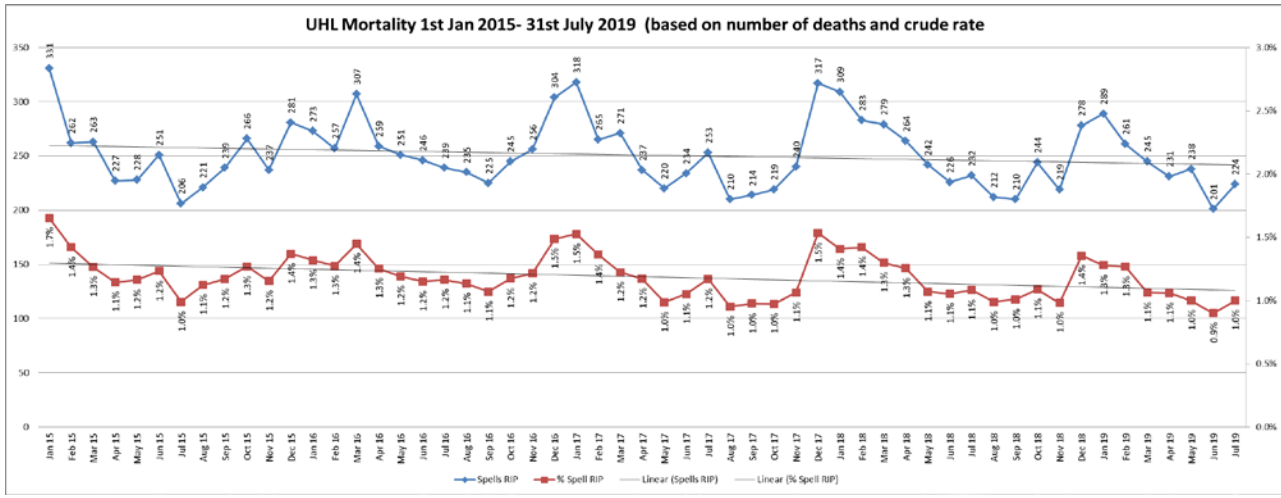
- UHL's overall crude mortality rate for 19/20 (to date) has further improved on previous years' performance and whilst there has been a further increase in activity this financial year, there have been fewer deaths in our hospitals.

UHL's Crude Mortality Rate



As previously reported UHL's crude mortality has been reducing over the past two years and whilst we continue to see the winter increases, the 2018 peak was lower than in 2017.

The above SPC chart shows that our crude mortality has been 'below the mean' for the past 8 months.



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)

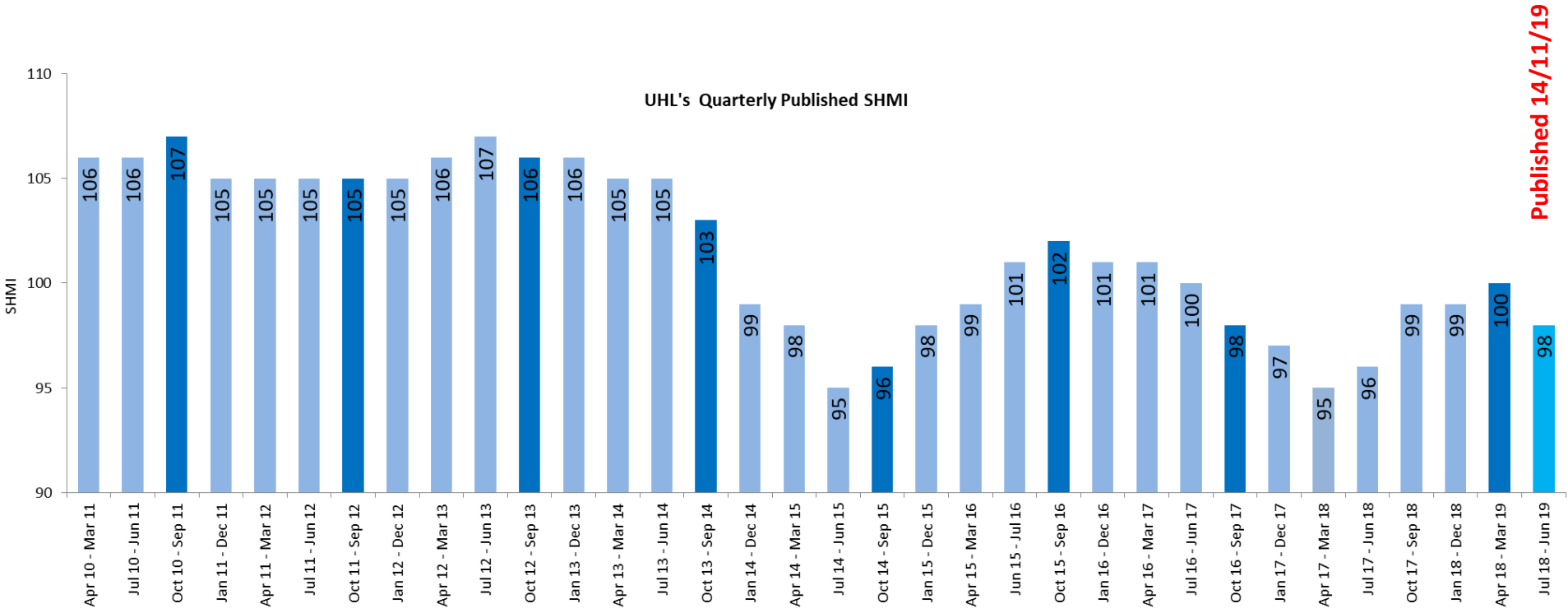
From May 19 the SHMI has been published on a monthly basis by NHS Digital and other contextual data is also being published to include 'hospital site' SHMI.

NHS Digital have recently made some changes to the SHMI methodology:

- two new diagnosis groups (Livebirths; Non Hodgkin's lymphoma)
- Adjusting for birthweight for patients under one year of age
- Adjusting for seasonality
- Using the latest version of Deprivation (in contextual indicators)

The impact of these changes have been very small (less than 1% for all trusts)

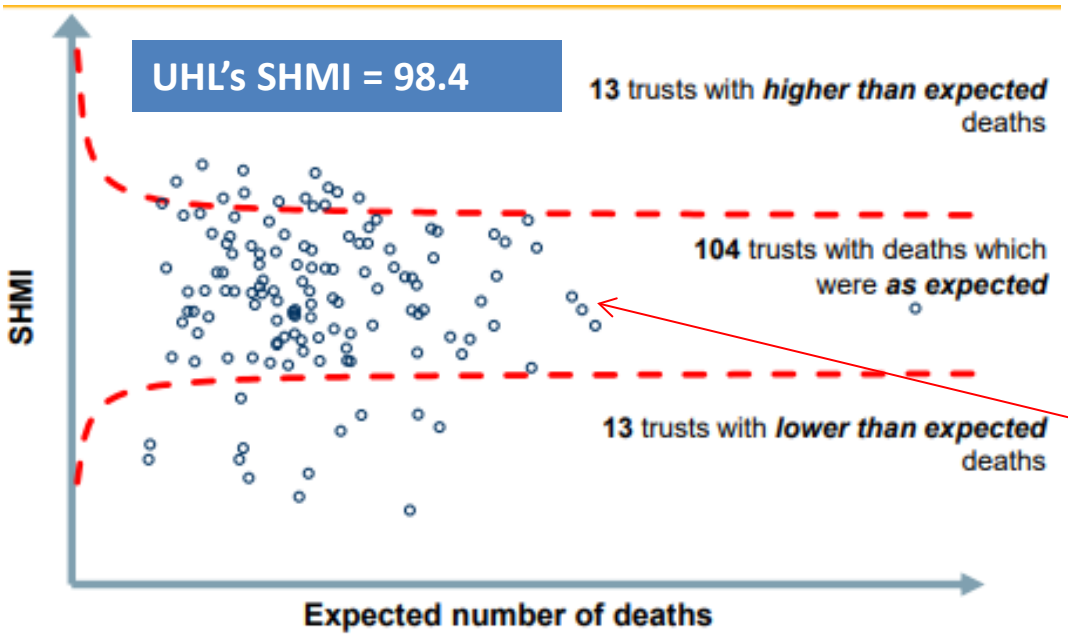
UHL's Quarterly SHMI – as published by NHS Digital



UHL's latest 'Quarterly published SHMI' is below 100 again at 98.

The chart above suggests there will always be variation in our SHMI performance but reassuringly the latest peak did not go above 100.

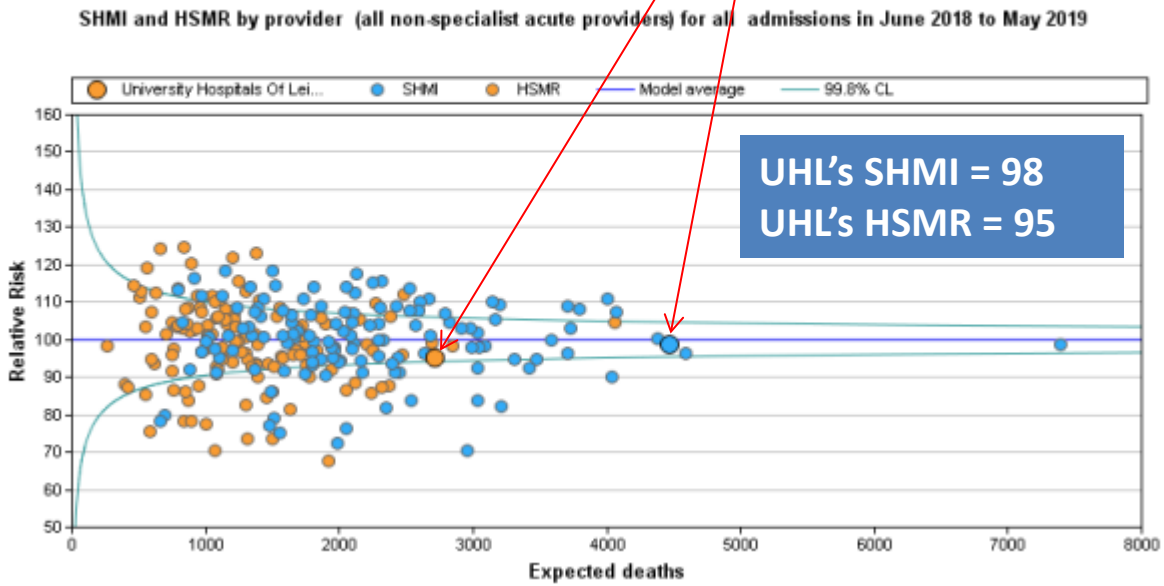
LATEST SHMI DATA – JUN 18 TO MAY 19



SHMI as reported by NHS Digital
"Deaths following time in hospital",

UHL

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



SHMI & HSMR as reported by DFI

DIAGNOSIS GROUPS WHERE SHMI OR HSMR LOWER CONTROL LIMIT IS >100 (Jun 18 to May 19)

Diagnosis Group	SHMI Spells	SHMI	Obs	Exp	95% CI	SMR (RR)	Obs	Exp	95% CI
(119) Other perinatal conditions	1385	263.85	16	6.06	150.72-428.51	185.45	40	21.57	132.47-252.54
(72) Phlebitis, thrombophlebitis, thromboembolism, Varicose veins, Haemorrhoids, Other diseases of veins and lymphatics	683	230.71	26	11.27	150.67-338.06	229.75	13	5.66	122.21-392.90
(7) Cancer of head and neck	146	206.46	13	6.3	109.83-353.08	237.52	8	3.37	102.27-468.04
(103) Genitourinary symptoms and ill-defined conditions	972	178.63	17	9.52	104.00-286.01	114.29	3	2.62	22.97-333.94
(117) Short gestation, low birth weight, and fetal growth retardation	501	175.32	16	9.13	100.14-284.72	115.26	12	10.41	59.49-201.34
(113) Other connective tissue disease	1523	125.85	28	22.25	83.61-181.90	203.55	23	11.3	128.99-305.44

The above diagnoses groups have a SHMI or HSMR which is 'above expected' and were discussed at the November MRC. Members noted that all but two of the diagnosis groups (Cancer of Head and Neck and Genitourinary Symptoms) had previously been reviewed and no clinical issues identified.
It was agreed to undertake a more in depth analysis of the SHMI data for these two diagnoses groups and to and cross reference this with our Learning from Deaths data for further review by the Committee.

SHMI DIAGNOSIS GROUPS WHERE OBSERVED vs EXPECTED = /> 6

Diagnosis Group	SHMI Spells	SHMI	Obs	Exp	Obs vs Exp
(72) Phlebitis, thrombophlebitis thromboembolism, Varicose veins of lower extremities, Haemorrhoids	683	230.71	26	11.27	14.73
(78) Pleurisy, pneumothorax, pulmonary collapse	722	133.97	47	35.08	11.92
(64) Cardiac arrest and ventricular fibrillation	114	120.43	69	57.29	11.71
(128) Complication of device, implant or graft	2155	123.78	52	42.01	9.99
(119) Other perinatal conditions	1385	263.85	16	6.06	9.94
(101) Urinary tract infections	2480	110.1	108	98.09	9.91
(89) Intestinal obstruction without hernia	719	114.63	63	54.96	8.04
(103) Genitourinary symptoms and ill-defined conditions	972	178.63	17	9.52	7.48
(35) Diabetes mellitus with complications	583	136.19	27	19.82	7.18
(117) Short gestation, low birth weight, and fetal growth retardation	501	175.32	16	9.13	6.87
(7) Cancer of head and neck	146	206.46	13	6.3	6.7
(122) Fracture of lower limb	771	170.86	16	9.36	6.64
(92) Biliary tract disease	1922	118.99	41	34.46	6.54
(107) Skin and subcutaneous tissue infections	2310	116.93	42	35.92	6.08

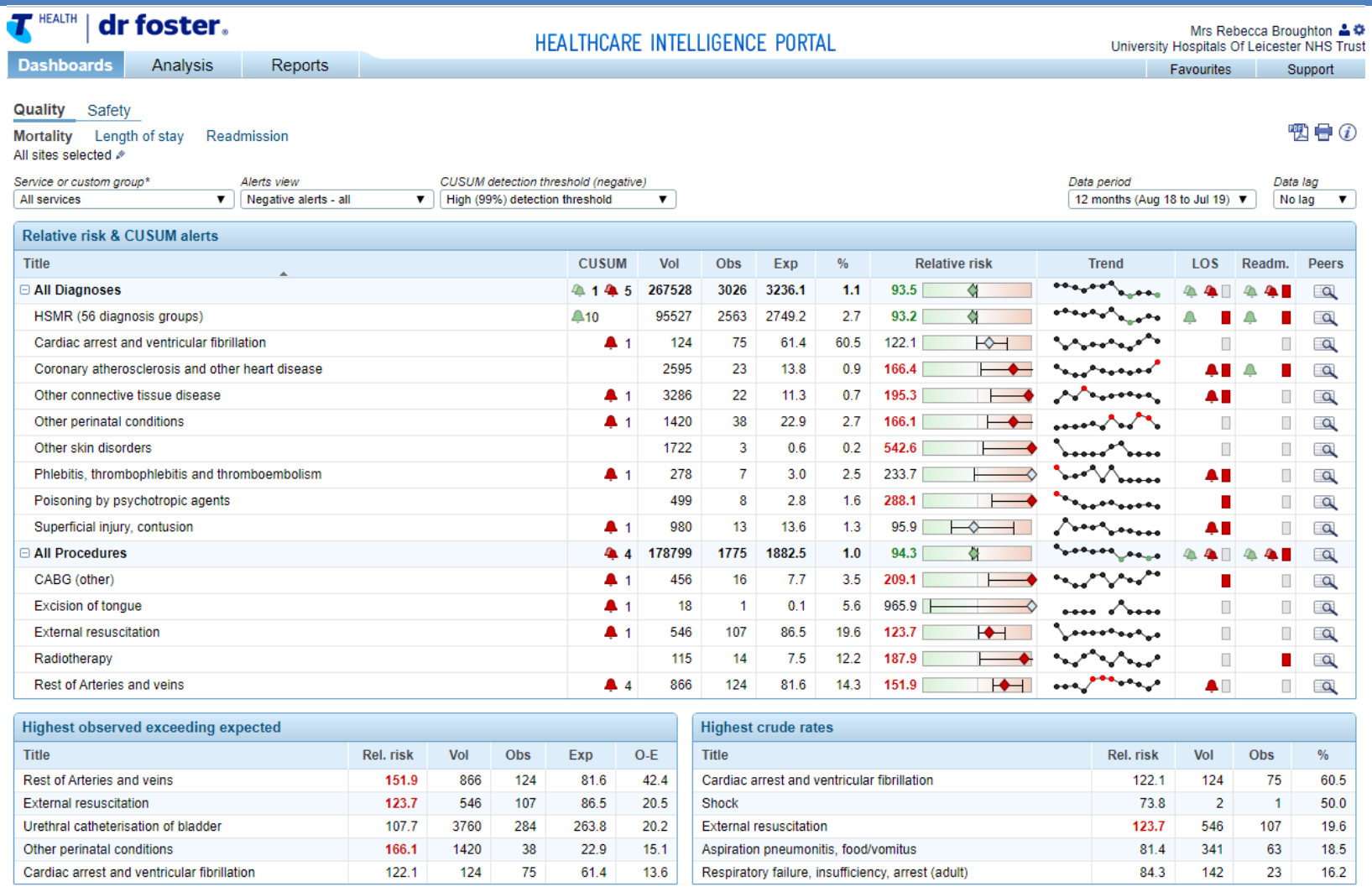
MRC Members also reviewed those diagnosis groups where there were 6 or more deaths above expected. Again all have either been previously reviewed or are in the process of being looked at.

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 (Aug 18 to Jul 19)
Data lag : No lag

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 5	267528	3026	3236.1	1.1	93.5				
HSMR (56 diagnosis groups)	10	95527	2563	2749.2	2.7	93.2				
Cardiac arrest and ventricular fibrillation	1	124	75	61.4	60.5	122.1				
Coronary atherosclerosis and other heart disease		2595	23	13.8	0.9	166.4				
Other connective tissue disease	1	3286	22	11.3	0.7	195.3				
Other perinatal conditions	1	1420	38	22.9	2.7	166.1				
Other skin disorders		1722	3	0.6	0.2	542.6				
Phlebitis, thrombophlebitis and thromboembolism	1	278	7	3.0	2.5	233.7				
Poisoning by psychotropic agents		499	8	2.8	1.6	288.1				
Superficial injury, contusion	1	980	13	13.6	1.3	95.9				
All Procedures	4	178799	1775	1882.5	1.0	94.3				
CABG (other)	1	456	16	7.7	3.5	209.1				
Excision of tongue	1	18	1	0.1	5.6	965.9				
External resuscitation	1	546	107	86.5	19.6	123.7				
Radiotherapy		115	14	7.5	12.2	187.9				
Rest of Arteries and veins	4	866	124	81.6	14.3	151.9				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Rest of Arteries and veins	151.9	866	124	81.6	42.4
External resuscitation	123.7	546	107	86.5	20.5
Urethral catheterisation of bladder	107.7	3760	284	263.8	20.2
Other perinatal conditions	166.1	1420	38	22.9	15.1
Cardiac arrest and ventricular fibrillation	122.1	124	75	61.4	13.6

Highest crude rates

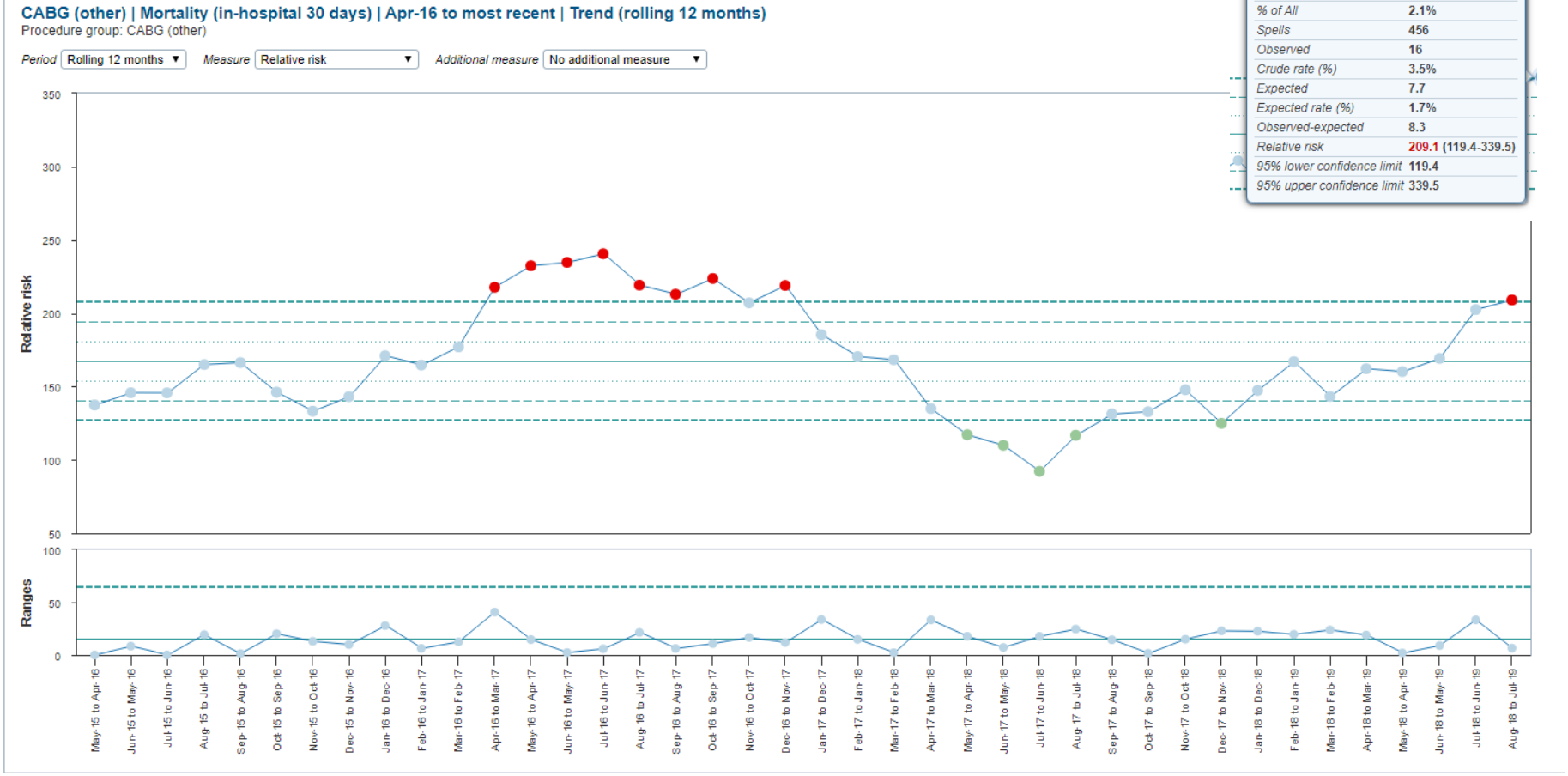
Title	Rel. risk	Vol	Obs	%
Cardiac arrest and ventricular fibrillation	122.1	124	75	60.5
Shock	73.8	2	1	50.0
External resuscitation	123.7	546	107	19.6
Aspiration pneumonitis, food/vomitus	81.4	341	63	18.5
Respiratory failure, insufficiency, arrest (adult)	84.3	142	23	16.2

MRC Members noted that there were no new diagnosis groups with a CUSUM alert but there is a new procedure group – “CABG Other” and that this may be linked to the increased relative risk for the diagnosis group “Coronary atherosclerosis”.

“CABG OTHER” Rolling 12 mth HSMR (Apr 16 – Jul 19)

Basket: Procedures *Metric*: Mortality (in-hospital 30 days) Time period: Apr-16 to most recent
Procedure group: CABG (other)
Patients: 1,730 Superspells: 1,730 (100.0) *First / Last*: Apr 2016 / Jul 2019 *Deaths*: 54 (3.1%) *LOS*: 13.1
Expected: 30.2 (1.7%) *O-E*: 23.8 (1.4%) *Relative Risk*: 178.6 (134.1–233.0) Model: Month: Mar 2019

Compare **Trend** Drilldown Records
XMR CUSUM Relative risk (CL) Relative risk (CI) Crude rate (p-chart) Simple



CABG Other previously alerted in 2017 when the Trust received a letter from the CQC.
Our Dr Foster Consultant advised that Imperial College won’t be escalating the new alert.

"CABG OTHER" Rolling 12 mth CRUDE RATE (Apr 16 – Jul 19) compared with 'Top 6 Similar Case Mix Trusts'

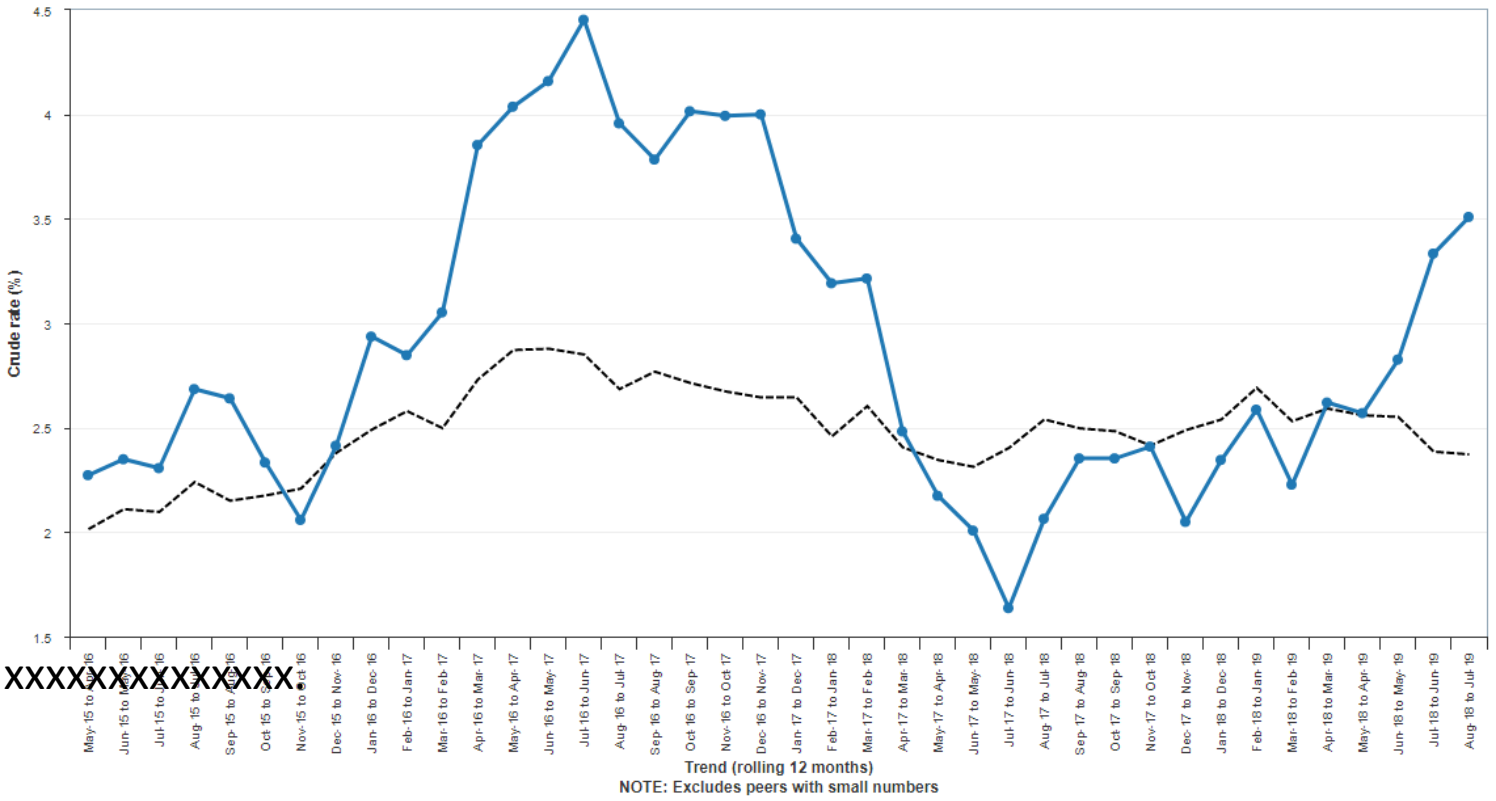
Reports

Basket: Procedures *Metric*: Mortality (in-hospital 30 days) Time period: Apr-16 to most recent
Procedure group: CABG (other)
Patients: 1,730 Superspells: 1,730 (100.0) *First / Last*: Apr 2016 / Jul 2019 *Deaths*: 54 (3.1%) *LOS*: 13.1
Expected: 30.2 (1.7%) *O-E*: 23.8 (1.4%) *Relative Risk*: 178.6 (134.1–233.0) Model: Month: Mar 2019

Compare Trend Drilldown Records
Funnel Column **Time-series** Nested Cross-tab Case-mix explorer Unit peer finder

CABG (other) | Mortality (in-hospital 30 days) | Apr-16 to most recent | Trend (rolling 12 months)
Procedure group: CABG (other)

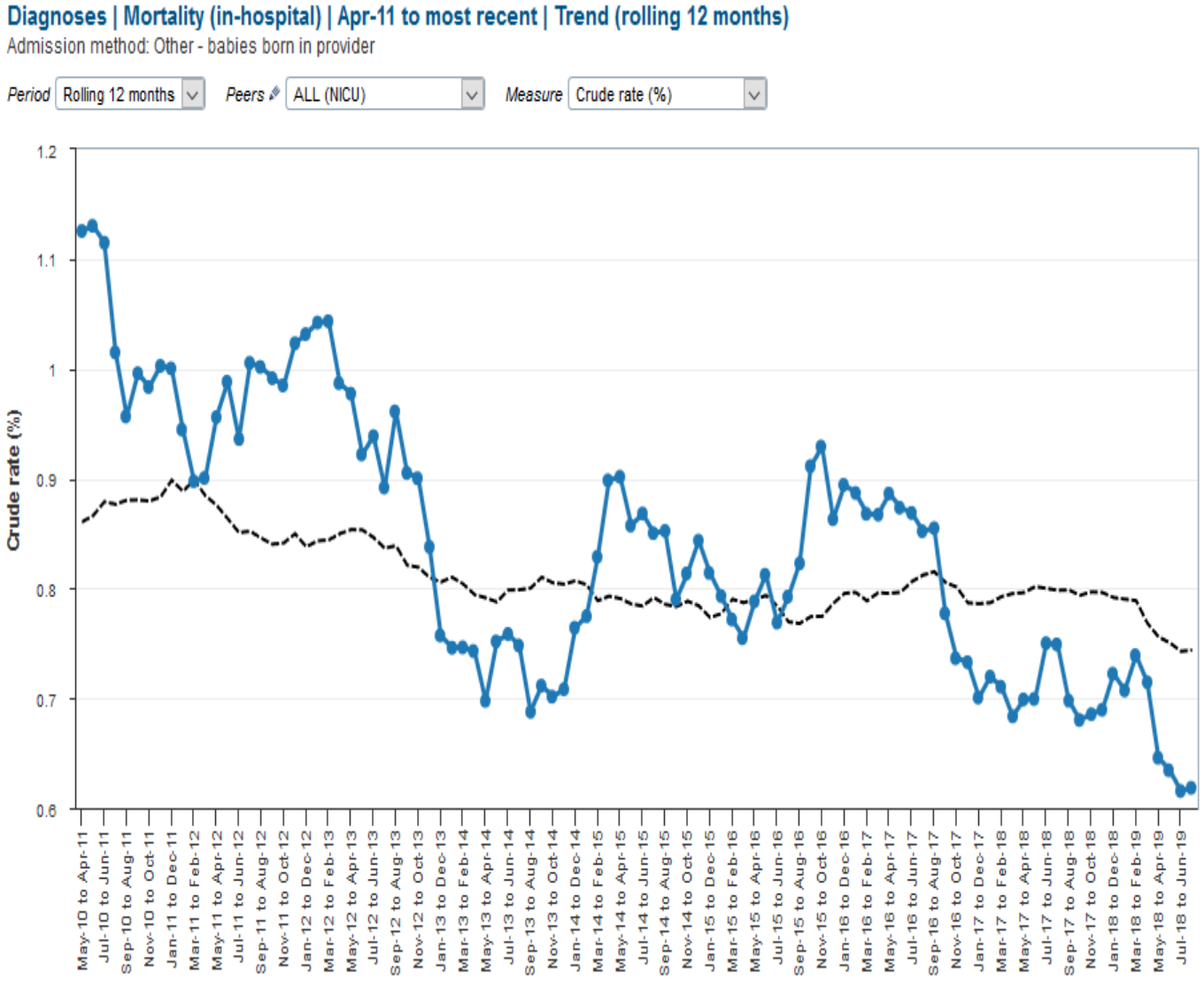
Period Rolling 12 months *Peers* CASE-MIX (top 6 similar) *Measure* Crude rate (%)



Members were advised that the Cardiac Surgery Coder has been off work since April and 're-coding' work is currently underway. It was also noted that the latest Society of Cardiothoracic Surgery shows UHL's survival rate to be 'within limits'.

It was therefore agreed that there was no need to do any further analysis but to ensure the Service was sighted to the alert; to cross reference with the Learning from Death Reviews and to review after the re-coded data has been submitted to SUS.

UHL's Relative Risk for 'Babies born in the Provider' vs Other Level 3 NICU Centres



At the November MRC meeting, members received an update from our Dr Foster Consultant on the Trust's perinatal mortality as reported by MBRRACE

The Committee also reviewed the HSMR and SHMI for maternity related diagnosis groups.

Whilst' UHL's SHM and HSMR is still above expected for 'Other Perinatal' and 'Short Gestation', we are seeing a downward trend in our crude mortality rate.

UHL's Relative Risk for 'babies born in our hospitals' is currently below other Trusts providing Level 3 NICU care.

Work Programme Quarters 3 and 4

- Review SHMI Diagnosis Groups – Cancer of Head and Neck and Genitourinary Symptoms
- Meet with Cardiac Surgery to confirm coding work and M&M review findings for CABG procedures
- Complete review of the Cardiac Arrest and Myocardial Infarction SHMI diagnosis groups
- Liaise with the Head of Business Intelligence (Planned Care / LLR PCL / Alliance) in respect of re-subscribing to the HED clinical benchmarking tool

Appendix 2

Learning From the Deaths of Patients in our Care 19/20 Q1-Q2

November 2019

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 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 Teams** – 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 and 2 – Place of Death

PLACE OF DEATH	Q1	Q2	Q3	Q4	19/20 YTD
IN PATIENT	668	677			1345
ED	62	46			108
COMMUNITY*	37	26			63
	767	**749**			**1516**

What is the data telling us?

The above table includes adult, child and neonatal deaths

- Community Deaths are usually those where death certification is facilitated by UHL’s Bereavement Services, requested by the Coroner’s Office. Not all will involve the Medical Examiner Screening and therefore will not be included in “performance data”

- The number of deaths in Quarters 1 and 2 is nearly always lower than for Quarters 3 and 4

Deaths covered by UHL's "Learning from the Death" process 19/20 Quarters 1 and 2 – Adult, Child, Neonate

	Q1	Q2	Q3	Q4	19/20 to date
ADULT	738	721			1459
CHILD	7	12			19
NEONATES/ PERINATAL	22	16			38
	767	**749**			**1516**

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

	Number of Deaths	Number Screened	% Screened
Q1	738	738	100%
Q2	721	703	98%
Q3			
Q4			
Total	**1459**	**1441**	**99%**

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'

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).

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 2 we have implemented two changes to the Coroner Referral process –

- all referrals are now reviewed by the Medical Examiner before being sent to the Coroner.
- following new national rules that all referrals must be written, the Medical Examiners have been supporting the Emergency Department with referring deaths following an Out of Hospital Arrest and no Return of Spontaneous Circulation – this negates the need for ED doctors to attend the Bereavement Services Office for 'automatic referrals'

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	203	204			407	28%
No	535	503			1038	71%
Screening not yet completed		14			14	1%
	738	**721**			**1459**	

Reasons for Requesting Further Review

Reason for Further Review	Q1	Q2	Q3	Q4	All	%
Medical Examiner Screening	86	76			162	40%
Concerns raised by the Bereaved	85	91			176	43%
Death after Elective Procedure	13	25			38	9%
Patient with a Learning Disability	3	2			5	1%
Patient with a Serious Mental Illness	13	8			21	5%
Patient Safety Team						
Specialty M&M requested review	3	3			5	1%
ALL REFERRED FOR FURTHER REVIEW	**203**	**204**			**407**	

Number of Adult Deaths and Type of Review

Further Review details	Q1	Q2	Q3	Q4	All	%
Structured Judgement Review*	72	74			146	36%
Clinical Review	62	61			123	30%
Feedback	43	53			96	24%
Theme Review					15	0.5%
Follow up by Bereavement Support	21	15			36	9%
Patient Safety Team / SI Investigation	5	1			6	1%
ALL REFERRED FOR FURTHER REVIEW	**203**	**204**			**407**	**28%**

What is the data telling us?

407 (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 = 57 in 19/20 to date.

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

	Q1	Q2	Q3	Q4	19/20 YTD
Death Classification Agreed	59	15			74
Review still in progress	42	87			128
All SJRs	101	102			203
% Reviews Completed	**58%**	**15%**			**37%**

- 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 4 deaths to date in Q1-2 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 are not on track to achieve this for Quarter 1. 60% of April's deaths and 63% of May's deaths are known to have been completed but neither meet the 4 month threshold.
- It is possible that the SJRs have been completed and Death Classifications agreed but due to vacancies in the Corporate M&M team, we are behind schedule with following up and collating review findings from the Specialty M&Ms.

SJR completion / DC agreed by CMG

	CHUGGS	ESM	ITAPS	MSS	RRCV	W&C
ALL SJRs	**33**	**49**	**3**	**7**	**37**	**57**
SJRs with DC	**10**	**22**	**1**	**2**	**12**	**22**
% with DC	**30%**	**45%**	**33%**	**29%**	**32%**	**40%**

	DC?		DC
1. CHUGGS 2. ESM	No	1. MSS 2. ESM	No
1. CHUGGS 2. ITAPS	Yes	1. MSS 2. RRCV	No
1. CHUGGS 2. ITAPS	No	1. RRCV 2. CHUGGS	Yes
1. CSI 2. ESM	No	1. RRCV 2. ESM	Yes
1. ESM 2. W&C	No	1. RRCV 2. ITAPS	Yes
1. ITAPS 2. RRCV	No	1. W&C 2. ESM	No

The number of SJRs requested is similar for 4 out of the 7 CMGs and performance is also similar. Interestingly those CMGs with the higher number of SJRs have completed the most.

14 SJRs were requested to done jointly between two Specialties (CMGs) and these are usually very difficult to organise but where have place have lead to a more effective review

Death Classifications agreed
Where Structured Judgement Review or SI Investigation completed

Death Classification	Q1	Q2	Q3	Q4	19/20 YTD	
1	2				2	
2	3				3	
3	13	3			16	
4	32	9			41	
5	9	3			12	

Two cases have been given a DC of 1

M&M Ref 193 – patient who developed an acute abdomen post elective knee surgery. Failure to recognise deteriorating patient and escalate for senior review

M&M Ref 217 – patient who presented with chest pain but diagnosis of STEMI missed both by Ambulance Crew and Emergency Dept.

Both deaths have been investigated as Serious Incidents and actions agreed by the Specialty M&M.

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.

Death Classifications for All Deaths where SJR or SI Completed

DEATH CLASSIFICATION	REASON FOR REQUESTING SJRS FOR ADULT DEATHS IN 2019/20 (to date)							
	ME	Rels	Child / Neonate	El Proc	LD	SMI	Specialty	Total
1		1		1				2
2	1		2					3
3	8	1	3	2		2		16
4	10	2	13	9	2	5		41
5	5		4			3		12
All	24	4	22	12	2	10		74

What is the data telling us?

Of the 74 cases where Death Classification agreed, 20 (27%) were found to have had problems in care. This equates to 1.3% (to date) of all deaths in Quarters 1 and 2

2 deaths were given a Death Classification of 1 and therefore 0.13% of deaths (to date) in 19/20 were considered to be more than likely due to problems in care

Examples of Learning Identified in Quarters 1 & 2

- Presentation and Diagnosis of Lymphoma
- Senior Review/Assessment on Admission
- InterSpecialty Referral – Consultant to Consultant discussion
- Escalation to Seniors
- Acute Abdomen Pathway
- ECG interpretation, communication and electronic transfer
- Communication with Patient/Relatives re Management Plan and Prognosis
- Earlier identification of Advanced Care Planning / EoL Care Planning and DNACPR discussions

For most areas of learning, the agreed action has been to feedback and share the learning with individuals and clinical teams for review and reflection

An update on all agreed actions related to 18/19 deaths will be given in the next quarterly report.

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

- As can be seen from the next two slides, we are on track for meeting a) c) and d).
- The parents of one child were not informed about the review of their baby's death but 'year to date' performance is above the 95% threshold
- Additional meetings were held in September and October in order to get back on track with review completion within 5 months
- Details of learning and actions are given in Slide 14. An update on all actions will be given in the next quarterly report

NHS Resolution Maternity Incentive Scheme – Safety Action 1

Perinatal Mortality Review Tool (PMRT) Dashboard – **Performance as at end Sept 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 Informed & 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**	**50%**	**8 / 100%**
Jun 19	**5**	**2**	**0**	**7**	**100%**	**5**	**54.1%**	**7 / 100%**
Jul 19	1	2	0	3	100%			3 / 100%
Aug 19	3	2	0	5	100%			
Sept 19	4	2	0	6				
YTD	**27**	**20**	**4**	**51**	**100%**	**20**	**54.1**	**97%**

* one family not informed in April. YTD percentage informed remains above 95%.

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
61620	Mar 19	The ongoing haematological management of the baby on the neonatal unit was not appropriate	Matron to review the transfusion problem and identify training needs	End Oct 19	In Progress
62664	May 19	This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care There is no evidence in the notes that this mother was asked about domestic abuse at Booking	Matron to include in Team News Letter	End Oct 19	In Progress
63570	Jun 19	This mother met the national guideline criteria for screening for gestational diabetes but was not offered Screening The test used to screen for gestational diabetes does not follow national Guidance	Performance management plan to be completed by community midwife	Dec 19	In Progress
61836	Apr 19	NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	To highlight "need For community midwives have access to C02 monitoring "	End Oct 19	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.
- The Medical Examiners do not speak to the families where the death has been referred to and is 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.
- In Quarters 1 and 2, the MEs spoke to 73% of all relatives (where the death was not referred to the Coroner) but as can be seen from the table below these were predominantly relatives of deceased patients on the LRI site and only a very small percentage of Glenfield relatives were spoken to.

Hospital Site	Not Referred or Taken by Coroner	No. ME spoke to Rels	% ME spoke to Rels
LRI	908	854	94%
GH	270	25	9%
LGH	78	37	47%
All	**1256**	**916**	**73%**

- 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.
- Between June and September 65% of LRI bereaved relatives were spoken to before the MCCD was issued.

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, theres is a much higher proportion of relatives at the LGH and Glenfield site declining BSS follow up. Recent discussions have been held with the Bereavement Services Office to try and understand the reasons for this and if there is any staff training or information material needed.

	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	All Adult Deaths
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	1116	40	284	19	1459

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

18/19	Very Poor / Poor	Satisfactory / Adequate	Good/ Very Good	Unable to say	Total Asked
Feedback to BSNs	40	52	533	119	744`
	5%	7%	71%	16%	

18/19	Concern	Gen Happy / No Concern	Compliment		Total Asked
Feedback to MEs	191	543	199		993
	20%	60%	20%		

*18 relatives had both concerns and compliments

The % in the above table are similar to those reported at the end of 18/19 and although further work needs to be undertaken to properly understand the data, it seems that immediately after death, relatives are more likely to have a more negative perception of the experience and care provided to their loved one / themselves

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

- **1023 (78%) families of deceased patients in Quarters 1 and 2 requested** follow up by the Bereavement Support Nurse (BSN)
- BSN have to date managed to speak to **744 (73%)** of bereaved relatives who requested telephone follow up
- Where telephone follow up requested but the BSNs are unable to speak to the family on the phone, a voice mail message, letter or email is sent (as agreed at time of requesting follow up) with the BSN contact details for future reference

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.

Of the 1023 relatives/carers where follow up contact by the BSNs was made 162 were ‘signposted’ to support agencies with most frequent being:

- Bereavement/Advice Centre
- The Carers Centre- Leics
- Coping with Cancer
- Crisis Helpline
- CRUSE
- LOROS
- (The) Shama Centre
- 4Silverline
- Way up (50+)

Outcome of BSN Follow Up

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

- Of the 774 relatives spoken to, 660 did not have any further questions or require further information
- 23 families had either made a complaint or were planning to do so
- 53 families had questions / feedback to/from the clinical team facilitated by the BSNs
- 31 families had meetings with the clinical team facilitated by the BSNs

Achievements

- During Quarters 1 and 2 the Corporate M&M team have caught up on the back log and have almost eliminated delays in sending feedback to Clinical Teams and/or requesting further reviews following ME screening
- The Bereavement Support Nurses are working more 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.
- We have also further improved the Medical Examiner process in respect of supporting the Emergency Department and liaising with the Coroner's office
- We have had further visits from other Trusts looking to implement an ME process
- We were invited to present 'Leicester's Experience of Implementing Medical Examiners within our Learning from Deaths Framework' at the recent RCP Mortality Conference
- We have agreed a Theming Framework which should 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 carried out a scoping exercise for providing Bereavement Support to the Children's Hospital and there were plans to appoint a Child Death Administrator but this has not yet happened. We are therefore liaising with the Children's Hospital to see if the current 'Adult' Bereavement Support Nurses could extend their scope to include Children.
- The ME Assistant has recently attended the National Medical Examiner Officer face to face training.
- The M&M Leads Forum was held on the 11th November and further improvements to the Structured Judgement Review template agreed to ensure there is a focus on learning outcomes.

Challenges

- One of the main challenges for the ME Process is the availability of the certifying doctors to discuss the cause of death (or need for referral to the Coroner) with the Medical Examiner. Most doctors will come to the ME Office mid to later afternoon which then causes backlogs for the MEs and means cases have to be carried over to the next day – leading to duplication of effort. The backlogs are further compounded due to the peaks and troughs in activity and particularly after weekends and bank holidays.
- We have not yet been able to formally start implementation of the ME process for paediatric deaths but have had further discussions with the Children's Hospital and the MEs have been involved in some 'expected deaths' certification process
- We 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. Whilst some of this work is already being undertaken by the MEs (ie discussion by phone with Certifying Doctor and Screening of Case Notes, the difficulty with scheduling the process means that we cannot expand the service without additional capacity
- The Urgent Release out of hours ME process has not properly 'got off the ground' due to lack of clarity around the process – the Urgent Releases Policy has just been revised and so the plan is to carry out an 'awareness raising campaign' to include the ME invovlement. We are meeting the Muslim and Jewish Faith Leaders to discuss our plans later this month.
- The anticipated increase in activity over the winter months and resignation of one of our admin team is a cause for concern and likely to lead to further delays in collating completed SJRs.
- Actions to ensure escalation of cases where problems have been identified was discussed at the M&M Leads Forum on Monday, 11th November.

Areas for focus in Quarters 3 and 4

- Members of the Corporate M&M team have agreed to work extra hours (on the Bank) to try and cover the gap until vacancies have been filled.
- We are looking at how to bring forward attendance by certifying doctors to earlier in the day in order to reduce duplication of effort
- We are also working with the Coding Office and Medical Records at the Glenfield to get case notes over for screening as soon as possible so that it is still appropriate to phone the relatives to ask if they have any questions.
- We will be looking to embed the 'out of hours' ME process for 'urgent releases' in collaboration with Faith Leaders, the Mortuary and Duty Managers
- We will continue to take forward the ME process for paediatric deaths
- In collaboration with the Bereavement Office we will embed the improvements made in respect of Coroner referrals
- The Corporate M&M team will follow up outstanding reviews and seek updates on actions
- We will complete collation of learning identified through reviews (both SJRs and clinical review, patient safety reviews) to confirm if cross cutting themes and to share with Specialty M&M Leads
- Changes to the SJR template and M&M process to be circulated to all M&M Leads and submitted to MRC for approval

UHL perinatal mortality

Update for Mortality Review Committee 5th November 2019

Report by Dr Penny McParland, Cons Obstetrician and Chair of the Perinatal Mortality Review Group (PMRG)

UHL perinatal mortality figures

The reports provided by MBRRACE-UK analyse data almost 2 years in retrospect. We endeavour to analyse the perinatal mortality data prospectively to identify any concerning themes/trends.

	Total SB	Corrected Stillbirths	SB rate	Total NND	Corrected Neonatal deaths	NND rate
2009	86			48		
2010	77			49		
2011	63			43		
2012	70	65		51		
2013	47	45	4.55	50	27	2.65
2014	56	51	4.59	46	23	2.37
2015	52	43	4.23	50	29	2.98
2016	55	47	4.25	52	25	2.39
2017	43	37	4.05	39	21	2.18
2018	33	25*		55	27**	

The stillbirth and neonatal deaths rates provided are the stabilised and adjusted rates provided by MBRRACE-UK, which allow for population size, deprivation, ethnicity and multiple births. They cannot be calculated locally.

* Predicted number of stillbirths after corrections for TOP

** Predicted number of neonatal deaths after corrections for <24 weeks and termination of pregnancy. This number is likely to be a slight underestimate, as there may be babies who were born in Leicester and died elsewhere to add to this figure.

Colour shading represents comparison to our peer trusts as provided by MBRRACE-UK. They have changed the definitions of the traffic-light colour codes in comparison with previous years, in an attempt to be aspirational and encourage trusts to further improve their mortality rates. So yellow is now 5-15% better than the peer group average (previously 0-10% better), and orange is within 5% better or worse (previously 0-10% worse). Our peer group of trusts (>6000 births with neonatal surgical facility) have a higher stillbirth and neonatal death rate than the national average due to the complexity of cases.

2017

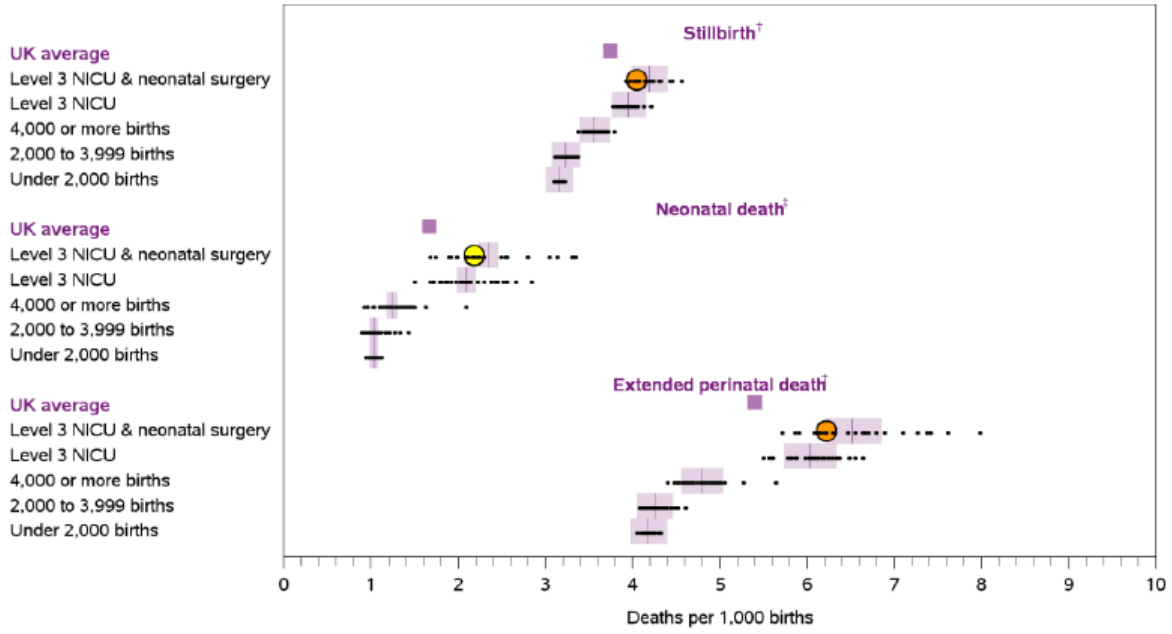
The 2017 report from MBRRACE-UK has now been released and shows that we have a lower stillbirth, neonatal death, and extended perinatal mortality rate than our peer group average. The significant fall, especially in our stillbirth rate, has been somewhat masked by the statistical stabilisation which essentially makes the assumption that large changes in rates are partly due to statistically chance.

	Mortality rate per 1,000 births [§] (95% confidence interval)		
	Stillbirth [†]	Neonatal [‡]	Extended perinatal [†]
Crude	3.58	2.04	5.61
Stabilised & adjusted [◊]	4.05 (3.32 to 4.81)	2.18 (1.53 to 3.11)	6.22 (5.47 to 7.62)

[§] excluding terminations of pregnancy and births <24[+0]; [†] per 1,000 total births; [‡] per 1,000 live births.

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a circle:

- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group



The trends observed at UHL mirror the national trends: steadily falling stillbirth rate, particularly amongst stillbirths at term; with little change in the neonatal death rate.

2018

Provisional local figures suggest that the fall in the stillbirth rate observed in 2017 appears to have been sustained. The 2018 MBRRACE-UK dataset closed last week, and we will be provided with the crude figures by them this month to verify the numbers.

In the first half of 2018 we noted an apparent increase in neonatal deaths. This was not sustained over the year, or into 2019, and on review appears to reflect normal statistical variation. The deaths were not confined to a specific cause/location that would give us cause for concern. The total number for 2018, however, remains at the upper end of our previous range of neonatal death rates.

2019

In the first 10 months of 2019 we have had 29 stillbirths (26 corrected) and 25 neonatal deaths (19 corrected).

Saving Babies Lives 2

The update to the Saving Babies Lives Care Bundle was launched in March 2019, and now comprises 5 components: Smoking cessation; intrapartum monitoring; fetal growth assessment; management of reduced fetal movements; and prevention of preterm birth. The last component is a new addition and is aimed at reducing the preterm birth rate from 8% to 6%. The other sections have been modified based on the assessments made of the implementation of the first SBL care bundle, launched in 2016. The new care bundle refines the interventions advised in SBLCB1, with a reduction in the number of women recommended to have regular growth scans and also in those recommended to have induction of labour. It is hoped that these changes will ease the burden on the ultrasound services and the delivery suite. The new care bundle also focuses on the prevention of preterm birth, via specialist prematurity antenatal clinics and via improvement in care of twin pregnancies. We have applied for funding to commission an external review of our services for women with twin pregnancies, which would be carried out by the Twins Trust.

We need to implement the new care bundle by the end of March 2020, and provide evidence of it's implementation. There are teams working on all elements of the care bundle, and our progress is regularly reported to NHS England. Implementation of SBLCB2 is required for the Maternity Incentive Scheme. The implementation, however, is dependent on the reporting of data via the Maternity Services Data Set 2, which requires the new version of our Maternity Information System E3 to be installed and functioning. This has now been delayed several times this year and has a current estimated implementation date of March 2020.

Each Baby Counts and HSIB

Each Baby Counts is a 5 year project that is due to end in December 2019.

Year	Cases reported	% inadequate reviews
2015	14	79%
2016	16	25%
2017	14	0%
2018	16	Not yet assessed by EBC
2019 to date	7	

This group of babies reflects our number of term intrapartum related stillbirths/neonatal deaths, along with the 'near misses' (significant neonatal brain injury). The number of cases reported to EBC has fallen in 2020. It is too soon to tell if this is a true reduction or a statistical 'blip'.

We started working with the HSIB on 18th March 2019, and 6 out of the 7 cases this year have been reported to them (one case was prior to 18th March). The reviews for Each Baby Counts will now be undertaken by the HSIB, with anticipated completion times of 6 months from the incident. We have not yet received any completed reviews from HSIB.

Perinatal mortality review tool and the Maternity Incentive Scheme

The perinatal mortality reviews are now being undertaken using the Perinatal Mortality Review Tool for all eligible cases. We are striving to achieve the standards set by the Maternity Incentive Scheme (see Appendix 2) Parents are now routinely informed of the review and given the opportunity to ask

questions of the review either via the Bereavement Midwife, or via a dedicated email box. Feedback from the questions asked is individualised.

Summary

- The stillbirth, neonatal death and extended perinatal mortality rates for 2017 were all below the average for our peer group.
- We are maintaining the standard of mortality reviews using the Perinatal Mortality Review Tool set by the Maternity Incentive Scheme.
- We are on target to implement Saving Babies Lives Care Bundle 2 by the target data of March 2020, as long as there are no further delays to the new Maternity Information System E3.