University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 4 June 2020

	Trust Board paper E1
Report Title:	**Quality and Outcomes Committee assurance conference call – Committee Chair's Report** *This was not a formally-constituted virtual Board Committee meeting, and was confined to any time-critical items/governance must-dos only. Its purpose was to provide information on, and assurance of, progress.*
Author:	Hina Majeed – Corporate and Committee Services Officer

Reporting Committee:	**Quality and Outcomes Committee (QOC)**
Chaired by:	Ms Vicky Bailey – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse
Date of meeting:	28 May 2020

Summary of key public matters considered by the Committee:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee assurance conference call on 28 May 2020:- *(involving Ms V Bailey, QOC Non-Executive Director Chair, Professor P Baker QOC Non-Executive Director Deputy Chair, Mr J Jameson, Deputy Medical Director (on behalf of Medical Director), Ms C Fox, Chief Nurse, Miss M Durbridge, Director of Safety and Risk and Ms C Trevithick, CCG Representative. Apologies for absence were received from Mr A Furlong, Medical Director. The Clinical Director, Women's and Children's attended to provide an update on one item):*

- **Summary of QOC Conference Call held on 30 April 2020** – this was noted, having been submitted to the Trust Board on 7 May 2020.

- **Matter Arising Log** – noted. The matters arising log would be populated with any updates provided at this meeting.

- **Covid-19 Position**
  The Chief Nurse provided a verbal update in respect of the latest position with regard to Covid-19 in terms of patients being treated and staff sickness absence levels. She advised that data in respect of nosocomial Covid-19+ve cases for inpatients had been gathered and accuracy checks were currently being undertaken.

- **Director of Safety and Risk Report**
  Paper D, as presented by the Director of Safety and Risk provided the detailed key safety events (Serious Incidents, Never Events, RIDDORs, deaths etc.) for the month of April 2020. The following was highlighted in particular:-
  i. a significant reduction in the number of reported patient safety and prevented patient safety incidents and an increase in the rate of moderate or above harm incidents reported (however, in May 2020, there had been an increase in the number of reported incidents);
  ii. a decrease in the number of formal complaints and concerns received. There had been a national "pause" of the NHS complaints process, however, UHL would be restarting the complaints process from 1 June 2020;
  iii. 1 never event relating to a misplaced Nasogastric tube used for administration of medication and nutrition;
  iv. the Trust was compliant with HSE guidance on RIDDOR reporting on Covid-19;
  v. an increase in the number of safeguarding referrals;
  vi. NHS improvement had so far published two covid-19 patient safety updates;
  vii. a standard operating procedure (SOP) had been put in place for the assessment of potential harm to cancer patients who have had their treatment plans changed as a consequence of Covid-19, and
  viii. UHL had collaborated with Loughborough University to complete a National Institute of Healthcare Research bid in relation to staff in full PPE working in 'hot' Covid-19 zones. The study would focus on the fit, functionality and thermal conditions for staff working in critical care areas.

  The CCG Representative advised that regular discussions were taking place with the Trust and she was

assured that focus in safety and harm was being maintained. The CCG Representative queried the steps that the Trust would be taking to respond to the F2SU concerns relating to demands for additional space from staff in order to comply with social distancing requirements. In response, it was noted that actions were being taken forward to implement the 'Working Safely Guidance' particularly in communal and staff room areas. The ward assessment and accreditation process when reconvened would also apply to these areas. The Deputy Medical Director advised that alternative ways of working (e.g. having a shared rota, with some staff working in the Trust whilst others worked from home) were being utilised as a means of preventing additional pressure on space.

- **Learning from Deaths Quarterly Report**
  The Deputy Medical Director presented the latest quarterly report – Quarter 4: January to March 2020 - relating to learning from deaths, the contents of which were received and noted and ***recommended onto the Trust Board for its approval*** (appendix 1 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 1-4's 'Learning from Deaths' activity was summarised in Appendix 2 to the report. In presenting this report, the Deputy Medical Director noted that there were no particular areas for concern based on the data. An analysis had been undertaken which showed that the number of non-COVID related deaths were similar to the corresponding time period from the previous year. There was a brief discussion on the move into new arrangements for Medical Examiners, an area on which the Deputy Medical Director would report further in the next quarterly report.

- **HSIB Reports on Maternity Cases**
  The Director of Safety and Risk provided a brief background and introduced discussion on paper F. The Clinical Director, Women's and Children's was in attendance for this item. Members noted the outcome of three specific investigations into maternity cases at UHL undertaken by the Healthcare Safety Investigation Branch (HSIB) and the resulting action plans (where relevant). Such cases were reported to HSIB by the Trust dependent upon specific criteria and these cases were then investigated by HSIB. The contents of this report were received and noted and members were assured by the process in place.

- **Nursing and Midwifery Safe Staffing and Workforce Report**
  The report for March 2020 (paper G refers, as presented by the Chief Nurse) noted that Registered Nurses (RNs) vacancies were 397wte; a reduction compared to the previous quarters but a 10.33% vacancy rate against a 10% vacancy rate nationally. The vacancy rate for Healthcare Support Workers (HCSWs) was at 7.13%, which was lower than the national average of 10%. Overall fill rates for RNs and HCSWs had improved for March 2020, despite the number of vacancies being reported, demonstrating that staff were being moved and deployed appropriately across CMGs/the Trust to cover shortfall areas. Those present noted that NHSI/E had developed a set of Covid-19 principles for the management of demand outstripping the capacity of nursing workforce on critical care units and adult inpatient wards.

- **UHL Safeguarding Annual Report 2019-20**
  Paper H, as presented by the Chief Nurse, described safeguarding activity during the previous year together with the achievements and priorities for the year ahead. In presenting this report, the Chief Nurse made particular note of the increase in safeguarding referrals. The Trust's internal auditors had undertaken a review of safeguarding practices in the Trust's Volunteer Services. As a result of this work, changes had been made to the systems used to recruit volunteers and the training provided to this group of staff, to align with the Trust wide approach to safeguarding and recruitment practice. In response to a query from the QOC Non-Executive Director Chair on the reason for the significant increase in Deprivation of Liberty Safeguards (DoLS), the Chief Nurse advised that she was in discussion with the CCG representative to undertake an external review of DoLS in order to ensure that the interpretation of the existing DoLS framework was robust. Members were advised that the new Liberty Protection Safeguards were expected to be implemented from October 2020, whereby the lead responsibility for deprivation of liberty would be transferred from the local authorities to NHS Trusts. The significant work undertaken by the Safeguarding Team was acknowledged and the QOC Non-Executive Director Chair placed on record her thanks to Mr M Clayton, Head of Safeguarding for the work undertaken.

- **UHL Learning Disability Annual Report 2019-20**
  Paper I, as presented by the Chief Nurse, detailed the annual report for the care of patients with a learning disability and sought to provide assurance of the Trust's commitment to facilitate equality of access and improve the experience for patients with a learning disability. In presenting this report, the Chief Nurse advised that in 2019, there had been a significant improvement in the number of patients referred to the Acute Liaison Nurse Team, particularly, due to the improvements made in the flagging system. The QOC Non-Executive Director Deputy Chair commended the work that had been undertaken to improve the experience of patients with learning disabilities using the hospital. In response to a query, members were advised that paper I was the final version of the report and it had been marked as 'draft' in error.

- **Items for noting:**– the following reports were received for information:-
    - **Health and Safety Quarter 4 Report (2019-20) –** the Director of Safety and Risk drew members' attention to the quarter 4 (2019-20) report which highlighted the significant increase in bariatric admissions. She advised that an updated strategy would be put in place for patients requiring use of specialist bariatric equipment. The Director of Safety and Risk also particularly highlighted that at the request of the former QOC Non-Executive Director Chair, a brief description of the types of physical assault recorded against UHL staff in 2019-20 had been included in the report.
    - **Infection Prevention Quarter 4 Report (2019-20)** – the Chief Nurse advised that the infection prevention annual report would be presented to QOC in due course. She advised that 5 MRSA bacteraemia had been identified for the year 2019-20 and an aggregated MRSA report would be provided to the next Infection Prevention and Assurance Group meeting (not EQB as noted in the report).
    - **EQB actions 12.5.20**

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval

- **Learning from Deaths Quarterly Report (appended)**

Items highlighted to the Trust Board for information:

- **HSIB Reports on Maternity Cases**;
- **UHL Safeguarding Annual Report 2019-20**, and
- **UHL Learning Disability Annual Report 2019-20.**

Matters deferred or referred to other Committees:
None

Date of next QOC assurance conference call:	25 June 2020

Ms V Bailey – Non-Executive Director and QOC Chair

UHL Mortality and Learning from Deaths Report

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

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
Mortality Review Committee (MRC)	05/05/20	Analysis and Discussion
Executive Board	12/05/20	Assurance
Trust Board Committee – QOC	28/05/20	Assurance
Trust Board		

Executive Summary

1. Context

1.1 UHL's crude and risk-adjusted mortality rates, and the work-streams being undertaken to review and improve review these, are overseen by the Trust's Mortality Review Committee (MRC), chaired by the Medical Director

1.2 MRC also oversee UHL's "Learning from Deaths" framework which includes learning identified through the:

- Medical Examiner Process
- Bereavement Support Service
- Specialty Mortality Reviews using the national Structured Judgement Review tool
- LLR Child Death Overview Panel reviews and Perinatal Mortality Review Group reviews using the national Perinatal Mortality Review Tool
- Clinical Team reviews and reflections
- Patient Safety Incident Reviews, Investigations and Complaints
- Inquest findings and Prevention of Future Death letters

1.3. One of the national Learning from Deaths requirements is for Trusts to publish their Learning from Deaths data on a quarterly basis and this is also one of the requirements of the 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 for 2019/20 was the same as for 2018/19 at 1.1% and our risk adjusted mortality remains within expected. Our latest SHMI is 95 for the 12 months January to December 2019 (published 14th May) and our HSMR for February 2019 to January 2020 is 94.

No individual diagnosis groups are above expected in the SHMI and there are only two groups with a 'CUSUM' alert in the HSMR – 'Other Perinatal' which has been reviewed before and found to be due to differences in Trusts approach to clinical coding and 'Viral Infections' which was discussed at the last MRC and no issues with care identified.

3.2 Quarter 1- 4's "Learning from Deaths" activity is summarised in Appendix 2. Although we saw an increase in the number of deaths in March with the start of the Coronavirus (COVID) admissions, we have been able to meet our 95% threshold for screening in Quarter 4 and 98% of all adult deaths in 2019/20 been screened. This was despite 9 out of the 12 MEs having to prioritise clinical duties over their ME sessions. We have been very fortunate that 3 of our retired/non directly clinical MEs were prepared to work extra sessions and thanks are extended to them. With the anticipated increase in activity, the ME office was open for two consecutive weekends including the Easter Bank Holiday which was run as a rapid cycle test. The anticipated benefits weren't realised and urgent out of hours releases are being dealt with using a telephone service facilitated by Consultant Connect is available to support either Urgent Out of Hours Releases or where certifying doctors won't be available the following week.

With the publication of the Emergency Coronavirus Legislation, the Medical Examiners have also been supporting the clinical teams with completion of MCCDs (27 to date) where the 'would be certifying doctor' was unavailable either due to clinical commitments or because they were self-isolating.

The Medical Examiners have also been advising bereaved relatives about the need for reporting details of COVID deaths to NHSIE and explaining why the cause of death was considered to be COVID related despite a negative swab. This has proved very distressing for some relatives due to the implications both for their own self isolation but also funeral arrangements.

During the financial year 19-20, 1003 (32%) of adult cases screened by Medical Examiners have been referred for further review – 316 were for a Structured Judgement Review (SJR). A further 123 SJRs have been or are also being undertaken for child (36) and neonatal (87) deaths.

In an attempt to understand excess deaths in UHL and whether there has been any detrimental effect on patients dying of non-COVID related causes, an analysis has been carried out identifying deaths where the patient tested positive for COVID-19 or COVID-19 was mentioned on the death certificate (Slide 5) This shows that non-COVID related deaths are similar to the corresponding time period from the previous year.

Whilst we have managed to maintain the Medical Examiner service despite an increase in workload and expansion of role, we have been less successful in respect of the 'further reviews' aspect of the Learning from Deaths programme.

The Bereavement Nurses have been providing a lot of support to ensure requested reviews include all relevant information and also are sent out as timely as possible. However, due to COVID related sickness and self-isolation, the Corporate LfD team are very behind with following up and collating reviews undertaken by clinical teams/ Specialty M&Ms. The team have also not been able to support M&M Leads with ensuring case notes are available for reviews Also very few Specialty M&M meetings have been held and therefore Structured Judgement Reviews have not been 'signed off'.

Of the 437 SJRs requested in 2019/20 (to date), a death classification has been agreed for 243 to and as can be seen from Appendix 2, we have not met our internally agreed standards for either Quarters 1 or 2 and are unlikely to do so for Quarter 3. Our processes are being reviewed to see if improvements can be made for 2020/21.

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.

Communication and End of Life Care have been specifically asked about by both the Medical Examiners and Bereavement Support Nurses when speaking to bereaved relatives during the COVID phase as we were aware that relatives have been quite distressed due to the difficulty with visiting. The Bereavement Support Nurses have also been helping the ITU clinical teams with speaking to relatives of patients on the Unit and also with the End of Life/ Palliative Care Team.

Most feedback from relatives has been that they are very grateful for the care given and also the clinical team's communication with them by phone. There have been a few instances where relatives were not able to visit at end of life – this appears to be more on 'non COVID wards' possibly due to strict application of the no visiting policy. This has been fed to the COVID Tactical Group.

From a Medical Examiner perspective, we have not yet seen any COVID related deaths where there were obvious delays in treatment or issues with escalation of treatment and documentation in the main has been good. There has also been good use of the ReSPECT documentation although there is still room for improvement in terms of recording the rationale for 'ceiling of treatment decisions'.

We have recently submitted data to the National Medical Examiner office to include activity for 19/20 and anticipated activity for 2020/21. We have been advised that our proposed Service is Medical Examiner top heavy for the number of deaths and that we do not have enough Medical Examiner Officers (MEOs). The national model is for MEOs to discuss causes of death with certifying doctors and then to explain the cause of death to bereaved relatives, with 'escalation' to the Medical Examiner if needed. The UHL approach has been for both discussions to be held with the Medical Examiners, initially because the MEs were also screening the case notes to confirm if further review was needed and also completing Part 2 of the Cremation Forms, where applicable. Whilst some discussions with certifying doctors and relatives could potentially be held with a suitably trained clinical (non-medical) MEO, local experience suggests that this would not be as effective and sustainable. One of the priorities during May and June will be to review our service model in order to balance national requirements without 'dumbing down' our process.

3.3 There were 9 deaths in 2019/20 which were more likely than not due to problems in care which equates to 0.27% of all deaths covered by our LfD programme and these data will be published as part of our Quality Account. All these cases have been reviewed by the Patient Safety Team and SI investigations carried out as appropriate.

Slides 29 to 31 give details of our performance against the NHS Resolution Maternity Scheme. Although there have been some delays with completing reviews within the 4 month timescale, we have still achieved all the standards.

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: September 2020

6. Executive Summaries should not exceed **5 sides** [My paper does comply]]

Appendix 1

UHL Mortality Report Slide-deck

May 2020

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

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

How many Patients have died in our Trust?

UHL's Crude In-Patient and Emergency Dept Mortality 2014/15 to 2019/20

Discharged During…	All Discharges (incl Day	All In-Patient Deaths	In-Patient Crude Mortality Rate
FY 2019/20	**261627**	**2906**	**1.11%**
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%

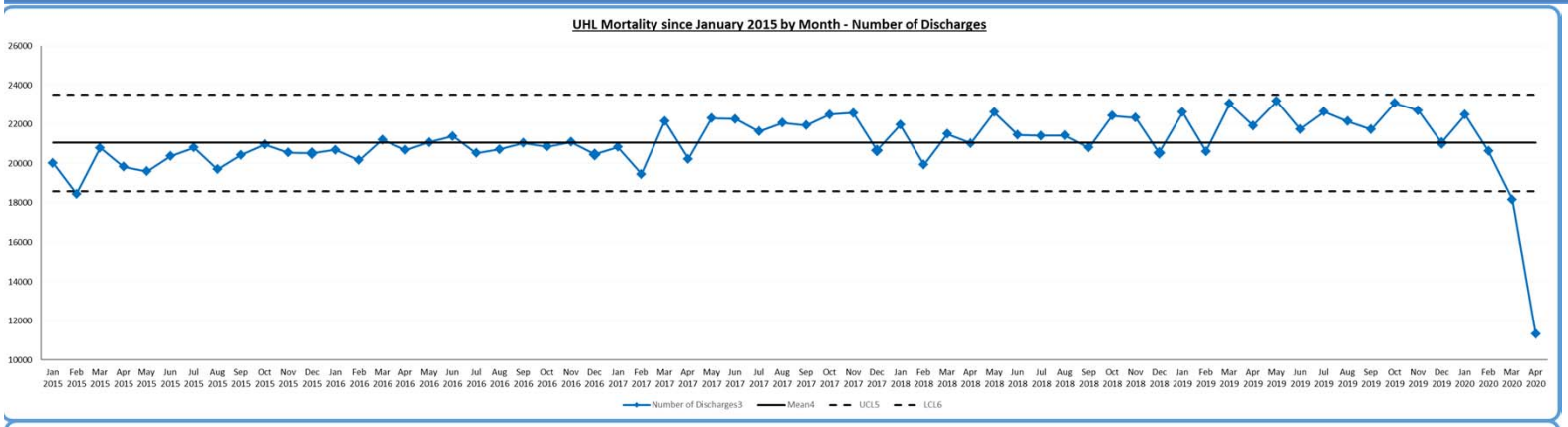
UHL's crude inpatient mortality remained at just above 1.1% for the financial year 2019/20 and the number of deaths was 15 fewer than in 2018/19.

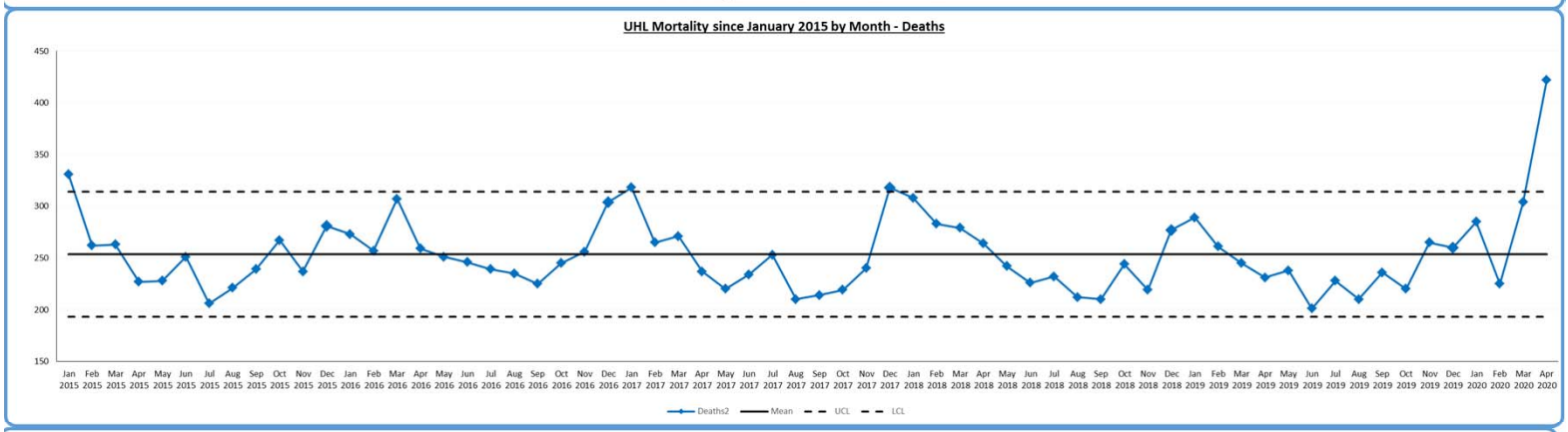
The number of attendances and deaths in the Emergency Dept for 19/20 was higher than in 18/19 (does not include EDU deaths)

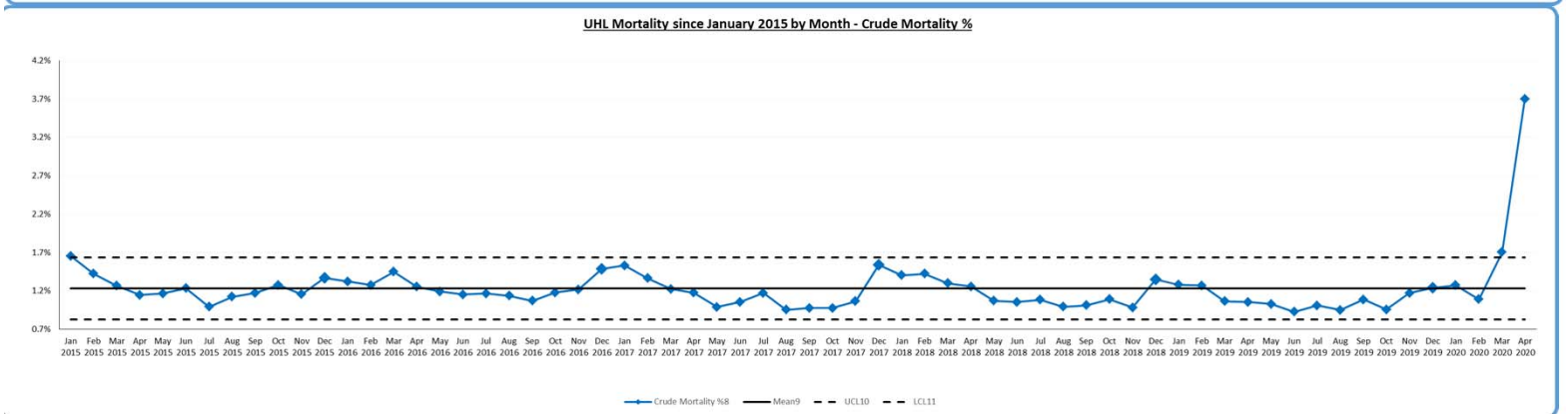
	ED Attendances	ED Deaths	ED Crude Mortality
FY 2019/20	235,600	271	0.12%
FY 2018/19	230,449	247	0.11%
FY 2017/18	209,857	237	0.11%
FY 2016/17	145,706	272	0.19%

How many in-patients have died in our Trust?

UHL's In-Patient Monthly Mortality using SPC

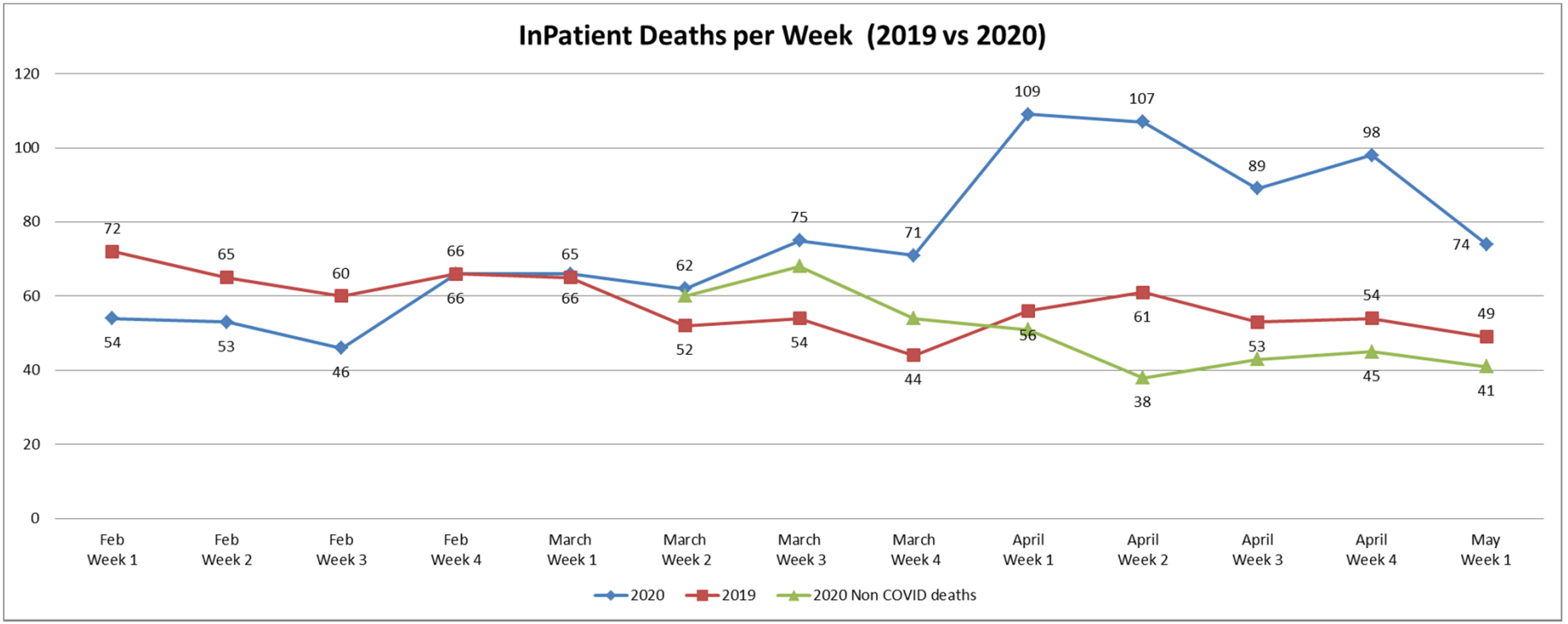






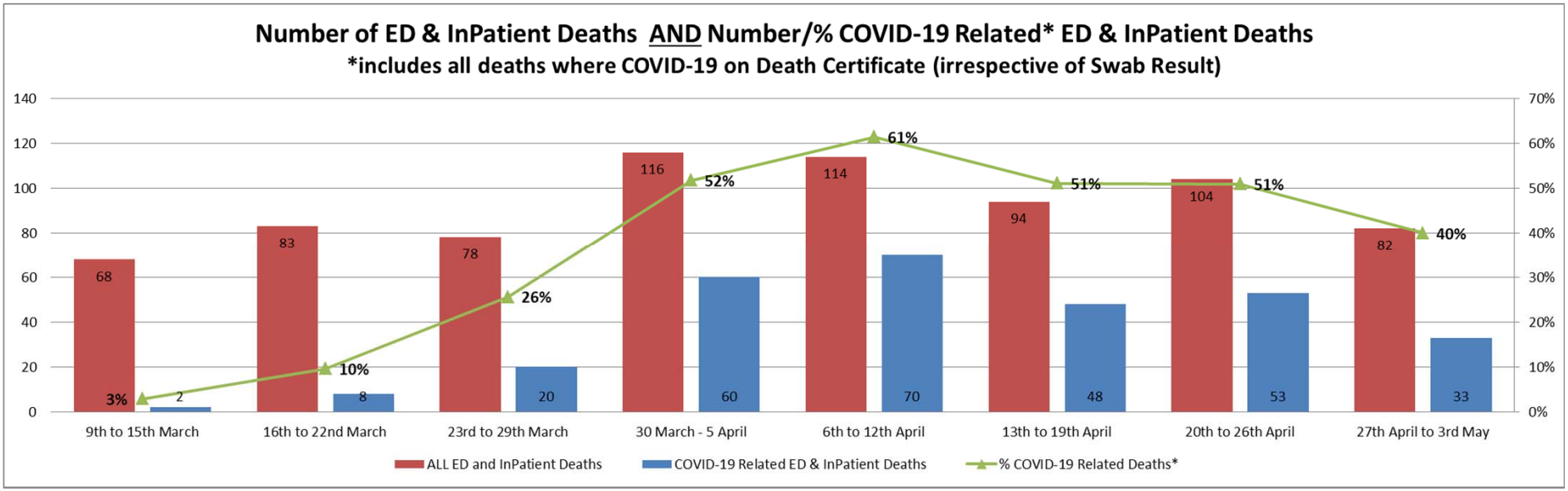
As can be seen from the SPC charts for UHL's inpatient activity, observed deaths and mortality rate, March saw a 'step change' in activity, number of deaths and mortality rate which was when we first started to see COVID related deaths.

IMPACT OF COVID ON UHL'S MORTALITY



- The weekly number of deaths started to increase during the last two weeks of March and then almost doubled – compared to the same time last year
- The green line in the above chart shows the number of 'non COVID related deaths' over the past 8 weeks and is compared to the same period in 2019.

IMPACT OF COVID ON UHL'S MORTALITY



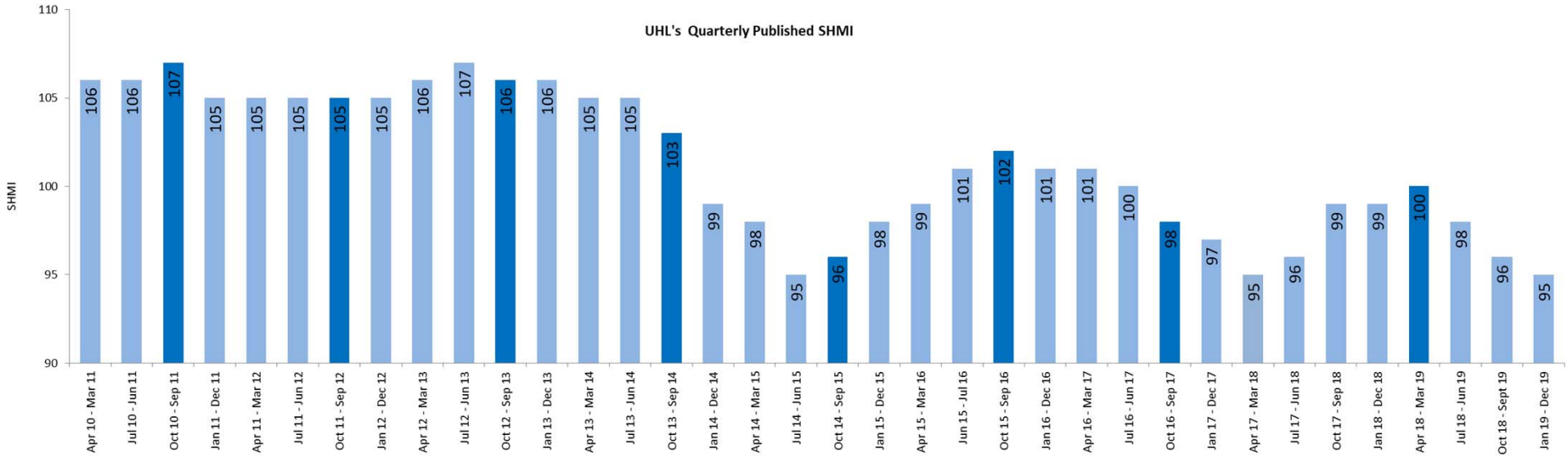
- Until 28th April, the only 'COVID death's reported to NHSIE were those where patients had a positive COVID swab.
- The chart above includes all COVID related deaths (from 12th March) i.e. those where COVID was recorded on the death certificate irrespective of swab result
  - There were 38 'COVID related deaths' in March 20 (all but 2 had tested positive)
  - There were 257 'COVID related deaths' between 1st April and 3rd May (220 tested positive)
- During the 4 weeks of April over half the deaths in UHL were COVID related

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 January to December 2019) has reduced further to 95 (published 14th May 2020)

No diagnosis groups within our SHMI are 'above expected' and there are no new diagnosis groups with a SHMI above 100.

Although UHL's overall SHMI continues to be below 100 it should be noted that the latest SHMI period does not include the COVID period. The SHMI covering April to June will not be published until November 20. However, it is not known how the increased number of deaths across most hospitals will be reflected in the SHMI methodology.

Dr Foster Intelligence has put forward a proposal to undertake a benchmarking exercise between trusts using directly submitted data.

LATEST PUBLISHED SHMI and HSMR

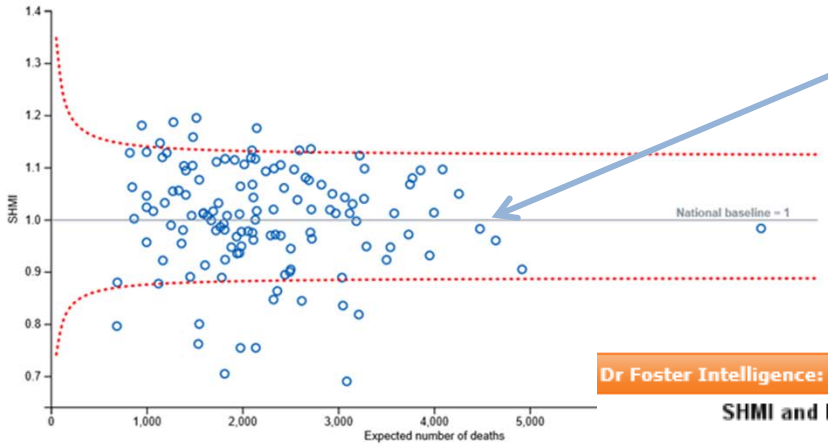
Summary Hospital-level Mortality Indicator (SHMI), England, December 2018 - November 2019

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'.



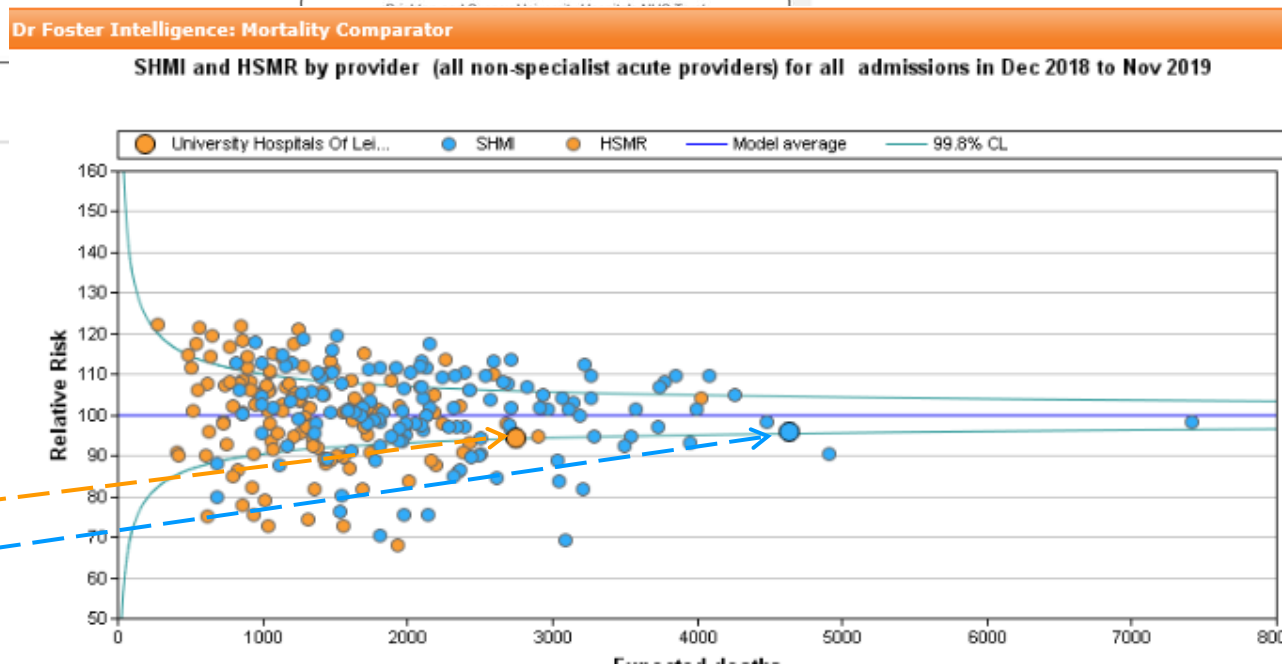
SHMI as reported by NHS Digital

"Deaths following time in hospital",

UHL continues to be one of the Trusts with most 'expected deaths' in both the SHMI and HSMR and both measures continue to be below 100

UHL's SHMI & HSMR as reported Dr Foster Intelligence

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

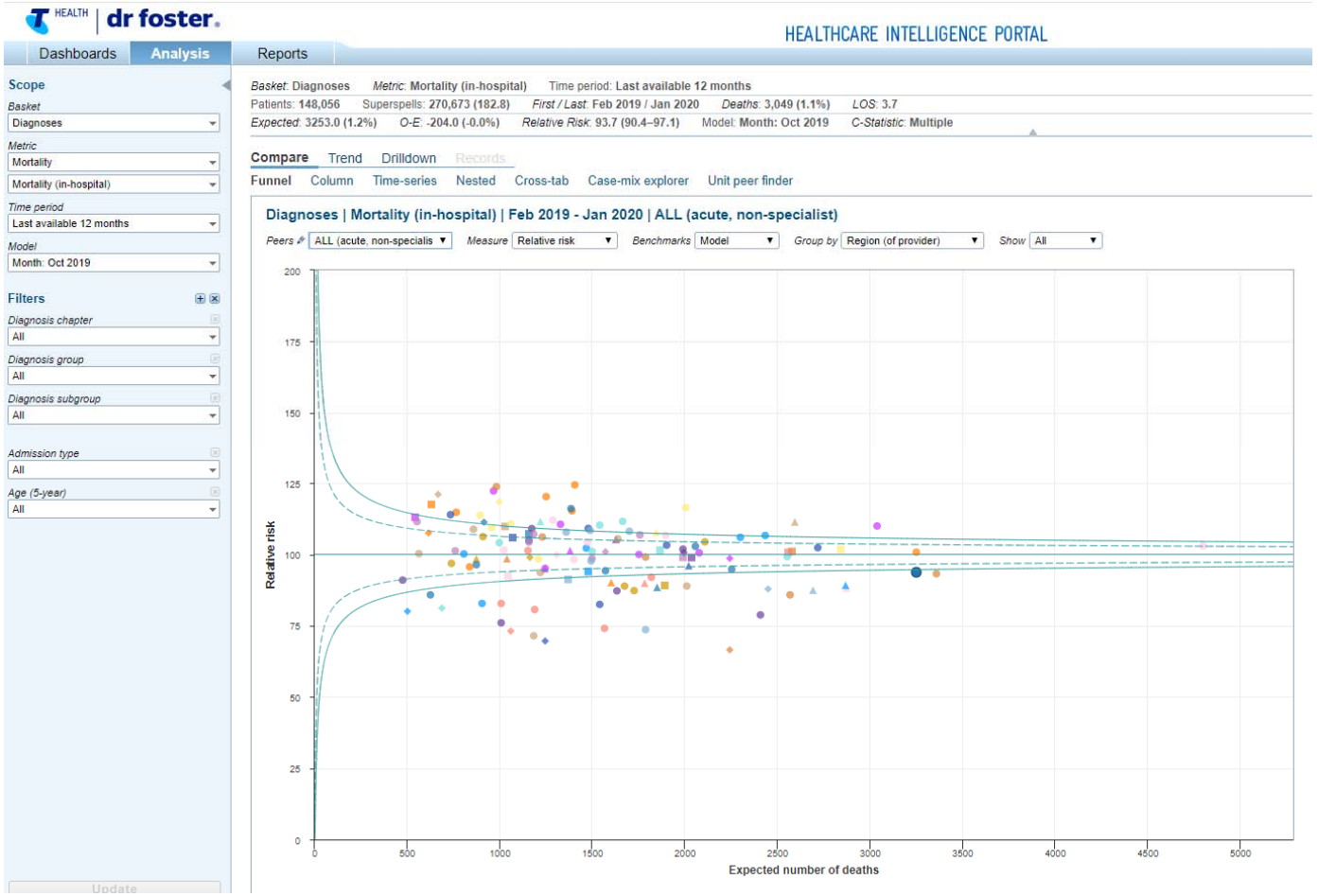


HSMR:
Hospital Standardised Mortality Ratio

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).

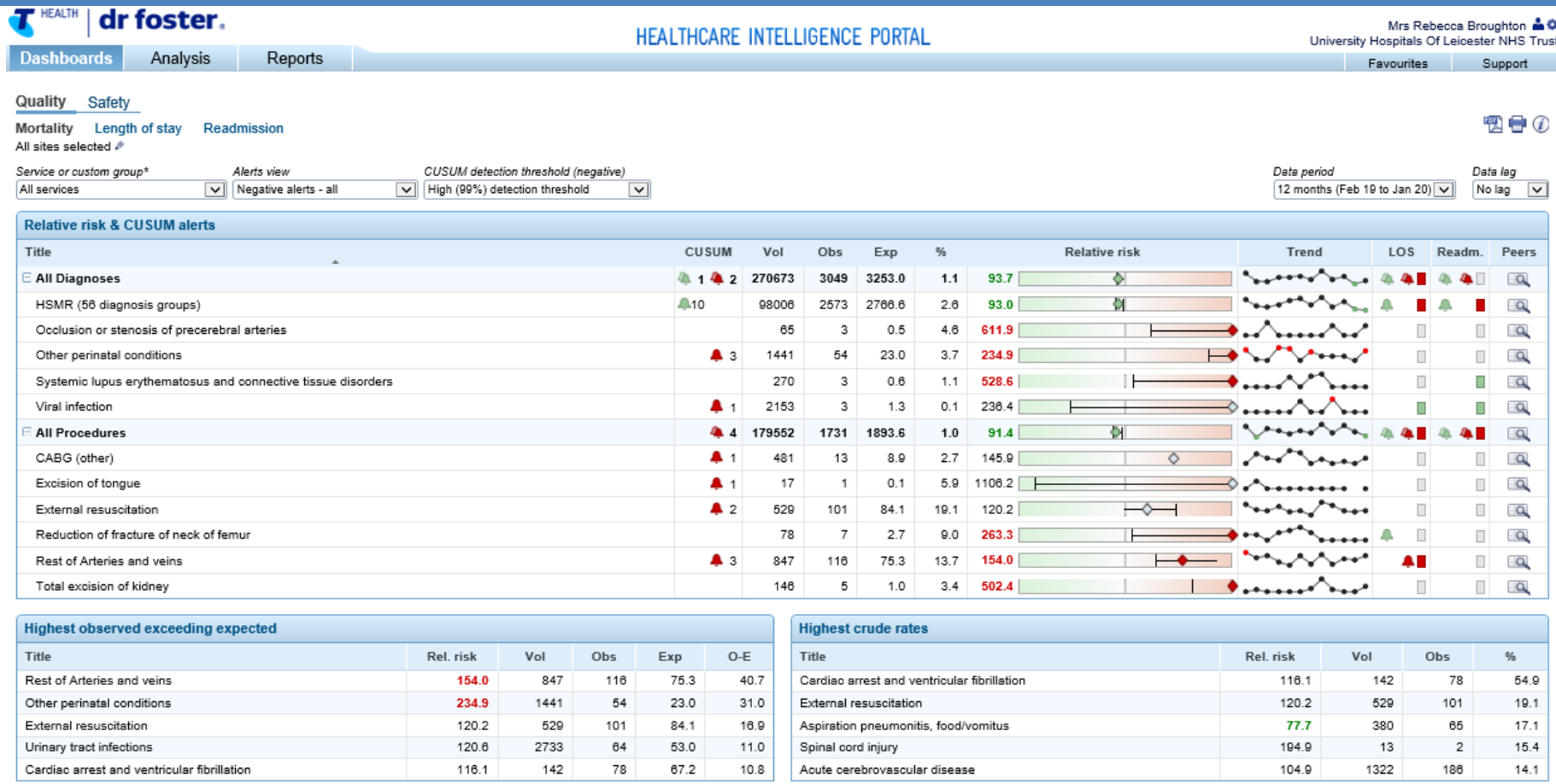
The HSMR methodology was developed by the Dr Foster Unit at Imperial College (DFI) and is used as by the CQC as part of their assessment process

UHL's All Deaths Relative Risk as Reported by DFI



- UHL's latest Relative Risk (includes all activity/deaths) in the Dr Foster Healthcare Intelligence Portal covers the period Feb 19 to Jan 20
- Our Relative Risk was 94 (271,742 spells, 3049 deaths, crude mortality rate 1.1%)

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 (Feb 19 to Jan 20) | Data lag: No lag

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 2	270673	3049	3253.0	1.1	93.7				
HSMR (56 diagnosis groups)	10	98008	2573	2766.6	2.6	93.0				
Occlusion or stenosis of precerebral arteries		65	3	0.5	4.6	611.9				
Other perinatal conditions	3	1441	54	23.0	3.7	234.9				
Systemic lupus erythematosus and connective tissue disorders		270	3	0.6	1.1	528.6				
Viral infection	1	2153	3	1.3	0.1	236.4				
All Procedures	4	179552	1731	1893.6	1.0	91.4				
CABG (other)	1	481	13	8.9	2.7	145.9				
Excision of tongue	1	17	1	0.1	5.9	1106.2				
External resuscitation	2	529	101	84.1	19.1	120.2				
Reduction of fracture of neck of femur		78	7	2.7	9.0	263.3				
Rest of Arteries and veins	3	847	116	75.3	13.7	154.0				
Total excision of kidney		148	5	1.0	3.4	502.4				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Rest of Arteries and veins	154.0	847	116	75.3	40.7
Other perinatal conditions	234.9	1441	54	23.0	31.0
External resuscitation	120.2	529	101	84.1	16.9
Urinary tract infections	120.6	2733	64	53.0	11.0
Cardiac arrest and ventricular fibrillation	116.1	142	78	67.2	10.8

Highest crude rates

Title	Rel. risk	Vol	Obs	%
Cardiac arrest and ventricular fibrillation	116.1	142	78	54.9
External resuscitation	120.2	529	101	19.1
Aspiration pneumonitis, food/vomitus	77.7	380	65	17.1
Spinal cord injury	194.9	13	2	15.4
Acute cerebrovascular disease	104.9	1322	186	14.1

- There is one new diagnosis group ‘Viral infection’ with an HSMR CUSUM alert because we have had 5 deaths against an expected 1.4. Three of the 5 deaths have been cross referenced with our Learning from Deaths database (2 cases died after transfer from UHL and have not been reviewed). Learning had been identified by the Specialty M&M for one death - around CT scanning in patients with an enlarged spleen but there were not considered to be any problems in care.
- The findings of the 3 cases were discussed at the April MRC and no further review or actions was felt to be needed.
- At the May MRC it was agreed to cross reference with the Learning from Deaths database those deaths contributing to the Higher Relative Risk for the Diagnosis Groups ‘Occlusion or stenosis of pre-cerebral arteries’ and ‘Systemic lupus ervthematous and connective tissue disorders’.

UHL's CRUDE AND RISK ADJUSTED MORTALITY

- UHL's crude In-Patient mortality has remained stable during 2019/20
- The increase in ED deaths during 19/20 is being looked into by members of MRC to understand if there is a need to undertake a more detailed review
- There was a statistically significant increase in the number of In-Patient deaths in April but this is believed to be directly related to the number of COVID related deaths
- Our SHMI has improved from 100 for the 12 mths Jan to Dec 2018 to 95 for the 12 mths Jan to Dec 2019
- Our HSMR remains 'below expected'
- There are no new diagnosis groups with a higher than expected SHMI or HSMR
- We do not know what the impact of COVID will have on either or SHMI or HSMR
- MRC continue to monitor our crude and risk adjusted mortality

Appendix 2

Learning From the Deaths of Patients in our Care 19/20 Q1-Q4

MAY 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 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 to 4 by Hospital Site

Hospital Site	Q1	Q2	Q3	Q4	19/20 YTD
LRI	541	545	619	687	2392
GH	173	152	199	183	707
LGH	54	51	62	66	233
All Sites	**768**	**748**	**880**	**936**	**3332**

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 – Q4
In-Patient	2907
Em Dept	280
Community	145

Type of Admission	Q1 – Q4
Emergency	3251
Elective*	80
Outpatients**	1

* Elective includes both patients admitted via the Waiting List for an Elective Procedure and those with a Planned admission – i.e. given a date 'to come in' – usually for chemotherapy.

** One patient attended for an Outpatients Appointment and then collapsed and died after leaving the Clinic – not related to the reason for attendance

Deaths covered by UHL's "Learning from the Death" process 19/20 Quarters 1 to 4 – Adult, Child, Neonate

	Q1	Q2	Q3	Q4	19/20 to date
ADULT	739	720	850	900	3209
CHILD	7	12	10	7	36
NEONATES/ PERINATAL	22	16	20	29	87
	768	**748**	**880**	**936**	**3332**

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	900	3209
Adult Deaths Screened	739	718	835	857	3148
% Adult Deaths Screened	**100%**	**99%**	**99%**	**95%**	**98%**

- In April 2020 there were 445 adult deaths and 331 (75%) have been screened to date
- Due to the increased 'COVID related activity' we have not been able to further progress plans for including all child deaths within the ME process nor have we been able to start having ME presence at the LGH and Glenfield sites
- Following submission of data to the National Medical Examiner office we have been advised that our proposed ME Service is 'ME top heavy' and that we do not have enough 'ME Officers'.

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 to see if Learning

Further Review	Q1	Q2	Q3	Q4	All	%
Yes	206	208	256	333	1003	32%
No	533	512	592	523	2160	68%
Screening in progress/not done			2	44	46	
All Adult Deaths	**739**	**720**	**850**	**900**	**3209**	

In April of the 345 adult cases screened, 87 (24%) have been referred for further review which is slightly lower than previously

Type of Further Review Requested (Adult Deaths)

Further Review details – where screened	Q1	Q2	Q3	Q4	All	% of Adult Deaths
Structured Judgement Review	71	73	84	88	316	10%
Clinical Review	71	60	92	96	319	10%
Feedback	33	57	51	77	218	7%
Theme Review	3	0	7	25	35	1%
Follow up by Bereavement Support	22	16	15	37	90	3%
PS Team / SI Investigation	6	2	7	9	24	1%
ALL REFERRED FOR REVIEW	**206**	**208**	**256**	**332**	**1002**	**32%**

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

	Q1	Q2	Q3	Q4	19/20 YTD
SJR completed	91	81	58	17	243
Review still in progress	9	20	54	107	194
All SJRs Requested (to date)	100	101	112	124	437
% Reviews Completed	**91%**	**80%**	**48%**	**14%**	**56%**

- 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.

Death due to Problems in care
Where Structured Judgement Review or SI Investigation completed

Since December 2019 we have stopped using the Death Classifications 1 to 5

SJR reviewers/ M&Ms are now asked to confirm whether the death was more likely than not to be due to problems in care and if 'Yes' this equates to Death Classification of 1

Of the 243 completed SJRs there are currently 9 cases where the Specialty M&M considered the death was more likely than not due to a problem in care. All 9 have been investigated by the Patient Safety Team, all have been discussed and learning and actions reviewed by the UHL Mortality Review Ctte.

The table below shows the number of cases with a DC of 1 compared to all deaths for 2019/20 as will be reported in our Quality Account. (There were 8 cases (0.24% of all deaths) in 2018/19)

Time Period	Deaths reviewed or investigated (as at end of May 2020) and judged to be "more likely than not to have been due to problems in the care " (% of all deaths in that period)
Q1	4 (0.52%)
Q2	2 (0.27%)
Q3	3 (0.34%)
Q4	Data not yet available
19/20	9 (0.27%) Data not yet complete

There are another 2 cases where the SJR Reviewer has given a provisional DC of 1 but these are awaiting discussion and confirmation by the Specialty M&M

The Corporate Learning from Deaths team are currently collating all the Review findings in order to theme learning identified and confirm actions being taken to improve care of all patients.

Seeking Feedback from the Bereaved

	Q1	Q2	Q3	Q4	19/20
Coroner Case	83	111	134	147	475
Not Spoken To	204	145	190	215	754
Spoken to	452	464	526	539	1981
% Non Coroner Cases Spoken To	**65%**	**76%**	**73%**	**71%**	**72%**

Currently not all bereaved relatives are spoken to by the Medical Examiners and this is particularly so for deaths at the Glenfield and LGH. Almost all bereaved relatives at the LRI are spoken to by the Medical Examiner (where death not referred to the Coroner).

The percentage of LGH/GH bereaved spoken to in April 20 has increased to 50% due to MEs having the notes sooner and also phoning without the notes to advise of NHSIE requirements for reporting COVID deaths

With the national implementation of the ME process, we have been trying to speak to the bereaved before the MCCD is issued - ideally when they come to collect the MCCD (at the LRI only).
However, due to difficulties in scheduling appointments, we have found phoning the relatives before they collect the MCCD works best.

Feedback from the Bereaved

In addition to the Medical Examiners speaking to the bereaved relatives, they are also offered follow up by the Bereavement Support Nurses – this includes relatives where the death has been referred to the Coroner

The table below shows the overall number/% of all bereaved relatives **(for adult deaths)** spoken to either by the ME or BSS Nurses. Although there is still work to be done to reduce the number of relatives declining BSS follow up at the LGH/GH, there seems to have been a positive response in Q4 to the actions taken to date.

	Q1	Q2	Q3	Q4	19/20
Yes	562	558	633	675	2428
No	16	27	21	79	143
No but Coroner Case and declined BSS f/up	23	26	5	43	97
No but declined BSS F/up	126	85	154	53	418
No, but Coroner Case	12	24	37	51	124
% of All Relatives spoken to either by ME/BSS	**76%**	**78%**	**74%**	**75%**	**76%**
LGH/GH Bereaved Relatives Declined BSS F/Up	**121 (53%)**	**85 (39%)**	**137 (56%)**	**65 (27%)**	**408**

Feedback about Care provided (either to the ME or BSS Nurses)

- Medical Examiners ask relatives if they have any comments about care provided and then select 'No Concern' 'Concern' or 'Compliment' as an option for feedback given. They have also been asked to indicate if positive comments are specifically made about 'end of life care'.
- Bereavement Support Nurses explicitly ask the Bereaved to score 'end of life care' provide (1= Very Poor – 5 = Very Good / Excellent)
- The table below collates the 3 types of feedback received – as might be expected there was an increased negative feedback in Q4 (Jan to Mar) which was when we saw increased activity due to the winter pressures
- Early review of April's data shows 11% of relatives have given negative feedback to the Medical Examiners about overall care.
- Reassuringly, despite the challenges with relatives not being able to visit during April, there has not been a rise in the number of relatives giving negative feedback about communication – specifically relating to 'prognosis' and 'imminence of death'.

	Q1	Q2	Q3	Q4	19/20
Positive Feedback	324	369	379	401	1473
% Positive Feedback (where spoken to)	58%	66%	60%	59%	61%
Negative Feedback	92	93	105	126	416
% Negative Feedback (where spoken to)	16%	17%	17%	19%	17%
No Concerns	146	97	150	148	541
Not Spoken to	177	161	216	226	780

Next Steps

- Review our Medical Examiner Service model in order to meet the national requirements and provide an equitable service across all 3 sites whilst maintaining the quality of service
- Support Specialty M&Ms and Clinical Teams with completion of reviews in order to complete collating and theming of learning and ensure identified actions are taken forward to improve care for all patients
- Determine how we can continue to improve how we obtain feedback from the bereaved

NHS Resolution Maternity incentive scheme

Safety action 1

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 **April 2020**

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	c Cumulative % of Parents Informed & consulted pre review
Dec-18	2	0	0	2	100%	1	50.0%	2	100%
Jan-19	1	1	0	2	100%	1	50.0%	2	100%
Feb-19	3	4	0	7	100%	5	63.6%	7	100%
Mar-19	3	1	0	4	100%	2	60.0%	4	100%
Apr-19	1	3	3	7	100%	2	50.0%	6*	95%
May-19	4	3	1	8	100%	4	50.0%	8	97%
Jun-19	5	2	0	7	100%	5	54.1%	7	97%
Jul-19	1	2	0	3	100%	2	55.0%	3	98%
Aug-19	3	2	0	5	100%	1	51.1%	4*	96%
Sep-19	4	2	0	6	100%	5	54.9%	6	96%
Oct-19	1	4	0	5	100%	4	57.1%	5	96%
Nov-19	1	5	0	6	100%	2	54.8%	6	97%
Dec-19	2	2	0	4	100%	0	51.5%	4	97%
Dec-Dec	31	31	4	66	100%	34	51.5%	64	98%

*** one family not informed in April and one family in August. Total 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
65479	Sept 19	The review of care identified an issue with recognition of 2nd trimester glycosuria, although this did not contribute to the outcome.	Feedback to Clinician	Feb 20	Completed
65485	Oct 19	Earlier neonatal input for palliative care and pain relief would have been appropriate	Implement the new BAPM guidance regarding management of preterm babies, including the guidance about management of babies at 22 weeks gestation.	Mar 20	Completed
66337	Nov 19	The review group did not identify any issues with care that would have affected the outcome. It was noted that the estimated fetal weights from the fetal medicine scans were not plotted on the growth chart.	To include in learning bulletin regarding plotting on charts	May 20	In Progress