	Trust Board Paper G
Meeting title:	Public Trust Board
Date of the meeting:	9 June 2022
Title:	UHL Mortality and Learning from Deaths Report
Report presented by:	Mr J Jameson, Deputy Medical Director
Report written by:	Head of Learning from Deaths; Deputy Medical Examiner, Lead Medical Examiner

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The report provides details of the assurance that robust processes and oversight is in place to review deaths, involves families and identify learning where appropriate.

Impact assessment
Not applicable

Acronyms used:
HSMR – Hospital Standardised Mortality Ratio
SHMI - Summary Hospital-Level Mortality Indicator

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 (LfD framework) which includes learning identified through the:

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

1.3. There are an increasing number of external reporting requirements relating to UHL's LfD process

- Daily reporting of COVID related deaths to NHSEI
- Publication of our Learning from Deaths data in our Public Trust Board papers on a Quarterly basis
- Publication of our Mortality review outcomes and SHMI data in our annual Quality Accounts
- Reporting of Medical Examiner activity and outcomes to the National Medical Examiner office on a Quarterly basis – to include ME activity relating to both UHL and LLR deaths

- Publication of perinatal mortality data and review outcomes on a quarterly basis in order to meet 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 LfD framework and what learning has taken place?

2.3 Are we meeting the national reporting requirements?

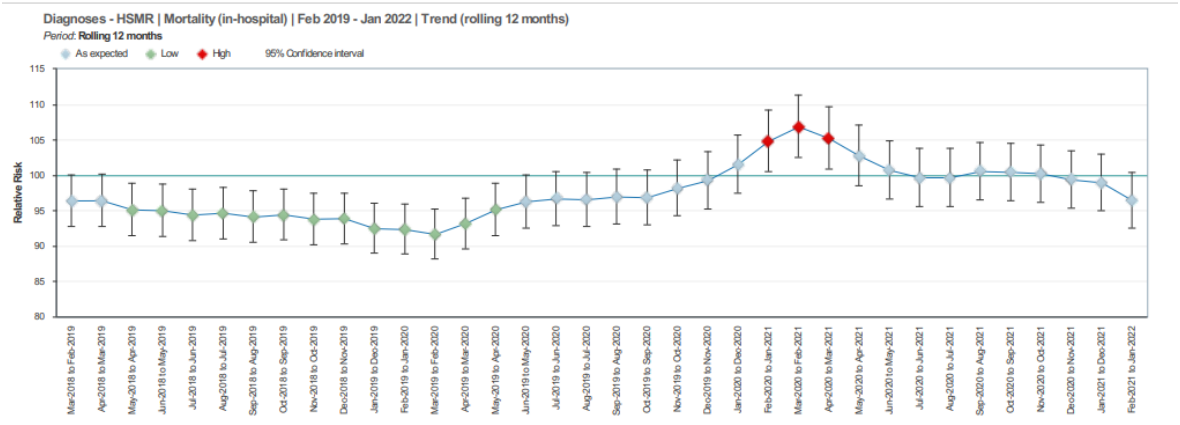
3. Conclusion

3.1 UHL's MORTALITY RATES

3.1(i) UHL's latest crude and risk adjusted mortality were reviewed in detail at the 3rd May Mortality Review Committee (MRC) meeting and it was noted that whilst our crude inpatient mortality rate of 1.3% for the financial year 2021/22 was still above pre pandemic years, this was mainly because there has been a reduction in activity and the number of deaths for 21/22 was similar to pre pandemic years.

Discharges During	ALL DISCHARGES (incl Day Case)	ALL IN-PATIENT DEATHS	INPATIENT CRUDE MORTALITY RATE
2021/22	**227,878**	**3,010**	**1.3%**
FY 2020/21	192,065	3688	1.9%
FY 2019/20	261,647	2906	1.10%
FY 2018/19	260,301	2921	1.12%

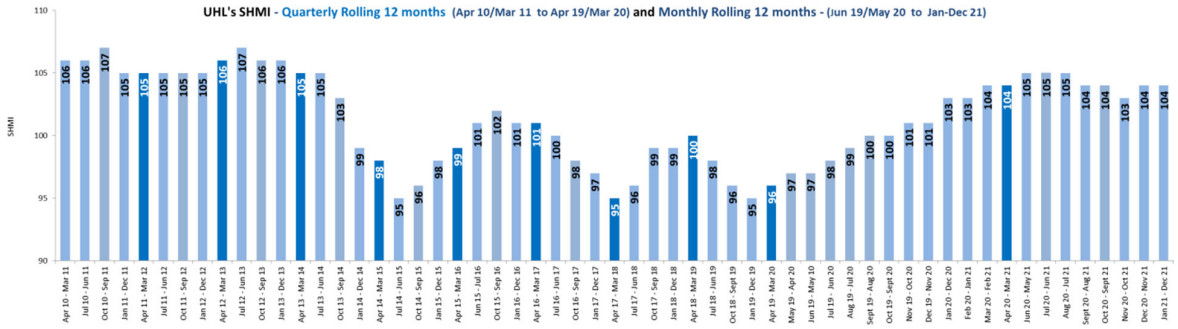
3.1(ii) Members also noted that our 'rolling 12 month' risk adjusted mortality (HSMR) has been below 100 for the past 3 reporting periods and the latest HSMR for Feb 21 to Jan 22 was 96 (within expected).



Following 'rebasing' of the HSMR benchmarking, UHL's HSMR is now only 'above expected' for 3 'rolling 12 month' periods and as can be seen from the monthly HSMR below, the increased HSMR directly correlates with the 1st and 2nd peaks of the COVID pandemic

The Dr Foster clinical benchmarking tool provides a Healthcare Improvement dashboard which summarises those diagnosis groups with a higher or 'above expected' relative risk. At the April MRC it was noted that 'Acute Cerebrovascular Disease' was a newly alerting group for the 12 months January to December 2021. The main reason for the alert is the increased number of observed deaths against the expected in June 21. Preliminary review of our Learning from Deaths data has not identified any deaths due to problems in care but details have been sent to Stroke M&M for a full review.

3.1(iii) UHL's latest SHMI was 104 (Jan to Dec 2) published 12/05/22 and is 'within expected'.



3.1 (iv) Members noted that the SHMI for the diagnosis group "Acute Myocardial Infarction" is now above expected. Preliminary review has not identified any obvious issues with care but details of cases within the 'alert' have been sent to the Cardiology Head of Service and M&M Lead for their review

3.2 UHL'S "LEARNING FROM DEATHS" PROGRAMME – 2021/22.

3.2(i) **Bereavement Services Office**

a) One of the main roles of the Bereavement Services Office (BSO) is to identify and contact the most appropriate doctor to discuss the death with the Medical Examiner. Part of the Quarterly reporting to the National Medical Examiner is number of MCCDs not completed within 3 days of the death (where not reported to the Coroner).

b) In Sept 21 the BSO changed their processes and as seen in the table below, there has been an improvement seen across all CMGs, most noticeably in ESM. However preliminary data for April suggests there has been a drop in performance which may be related to the Easter Bank Holiday but probably more due to the rescinding of the Coronavirus Emergency Legislation (which allowed doctors to complete MCCDs on behalf of a treating doctor).

CMG	UHL DEATHS	Q1	Q2	Q3	Q4
CHUGGS	395	78%	73%	83%	91%
ESM	1837	78%	75%	88%	95%
ITAPS*	259	93%	90%	92%	96%
MSS	65	83%	77%	84%	86%
RRCV	659	82%	79%	87%	89%
W&C**	156	86%	96%	94%	100%
UHL	**3371**	**81%**	**78%**	**88%**	**94%**

*ME Discussion may involve other Specialties
**Stillbirths not discussed with ME and some child deaths referred directly to the Coroner by the Police

c) Prior to the COVID pandemic, Cremations required two UHL doctors to complete paperwork and view the deceased in the Mortuary. Viewing of the deceased in the Mortuary was put on hold during the pandemic and only one doctor had to complete paperwork (Crem Form 4). This change has been maintained post rescinding of the emergency legislation which has had a positive impact both on clinicians and mortuary staff's time. The National ME office has confirmed they will continue to fund the loss of Crem Form 5 income. Clear documentation by the doctor verifying death on the ward will be essential to prevent any delays with completion of the death certification and cremation form paperwork. Timely verification of death is also very important particularly where death is late evening as verification after midnight will change the date of death.

d) In 21/22 we were able to support the Urgent Death Certification and Release of Deceased for 136 families. However this is becoming increasingly challenging to achieve particularly with the rescinding of the Emergency Legislation and also numbers of patients 'fast tracked' home for End of Life Care

Discussions are being held with both the Duty Management and Discharge team to consider how to highlight patients anticipated to die in the next 24 hours to try and pre-empt availability of a doctor to discuss the cause of death and complete a death certificate.

3.2(ii) **Medical Examiner Office**

a) Whilst there has been very slow progress made with ME scrutiny of Primary Care deaths, we have seen a steady increase in the number of deaths referred from the Community Hospitals and had our first case referred for discussion from LPT's Mental Health Care of the Elderly Ward.

CASES INCLUDED IN UHL'S 2021/22 LEARNING FROM DEATHS PROGRAMME					
	Q1	**Q2**	**Q3**	**Q4**	**21/22**
INPATIENT	675	759	813	777	3024
ED	46	70	82	92	290
COMMUNITY/OTHER TRUST	13	14	23	41	91
PRIMARY CARE			8	20	28
ALL	**734**	**844**	**927**	**931**	**3436**

b) The focus for Quarter 1 in 22/23 is to recruit additional Community MEs and to encourage GPs to engage with the ME process. We have been recently advised that our ME Officer model is not in line with the National requirements and we are therefore looking to recruit Clinical ME Officers in Quarter 1.

c) Our MEs have continued to meet the national requirements for proportionate scrutiny of all UHL adult deaths (to include discussion with the certifying doctor, screening of case notes and speaking to the bereaved) and are now routinely involved in deaths of children and neonates (where there is not an automatic referral to the Coroner or a stillbirth). 99% of all ED/Inpatient deaths discussed in 21/22.

d) Unless the death is taken for investigation by the Coroner, the MEs phone the bereaved before the MCCD is sent to the Registrar to ask if they understand the cause of death or have any questions about care. 96% of bereaved relatives (of non-coronial adult deaths) in 21/22 were spoken to by the ME

e) Feedback from the bereaved is generally positive – Over 500 (16%) compliments have been sent to the clinical teams. However, 420 (12%) of bereaved raised concerns about care or communication which have been fed back to the team - most concerns were around restricted visiting, poor communication and difficulties in getting to speak to a member of the clinical team.

f) Following ME scrutiny (to include speaking to the certifying doctor; bereaved relatives and screening of the clinical records) further reviews were requested either because of national requirements (i.e. death following elective surgery, death of patient with a Learning Disability or Serious Mental Illness, or a child/neonatal death) or because of questions or concerns by the Medical Examiner.

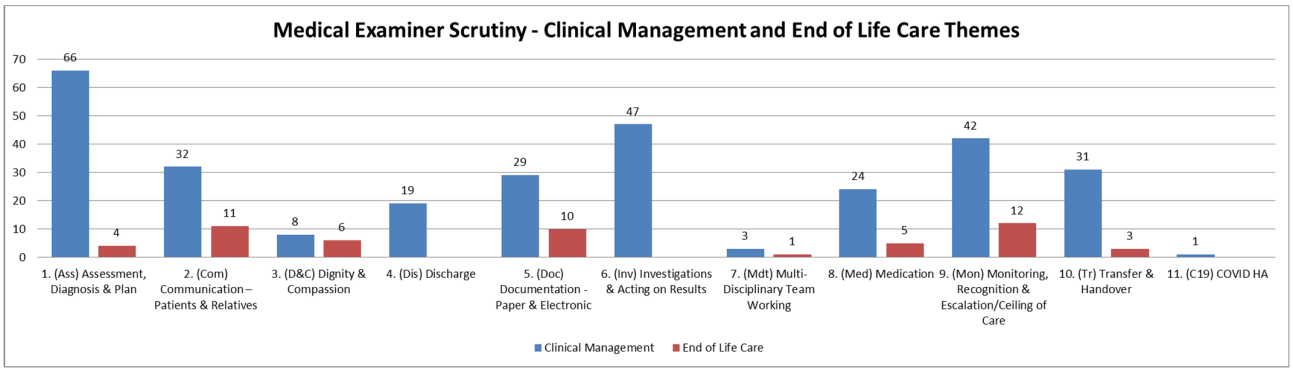
Type of Review*	**Number**	**%**
NONE	2292	66.6%
SJR (CDR; PMRT)**	432	12.6%
CLINICAL REVIEW	234	6.8%
PATIENT SAFETY TEAM F/U (COMPLAINT; PSI, SI, HAC19 SI)	110	3%
FEEDBACK TO CLINICAL TEAM	244	7.1%
THEME	28	0.8%
BEREAVEMENT NURSE F/Up	96	2.8%
	3436	**100%**

*Includes Stillbirths and Community Deaths where further review by UHL requested
** All child and neonatal deaths are subject to SJR

g) Most clinical reviews or SJRs requested by the ME related to Clinical Management, where the ME thought there was potential learning around Assessment, Diagnosis or Management Plan; Investigations/Acting on Results or Monitoring, Recognition and Escalation of Care. Feedback to the clinical teams around 'End of Life' themes mainly related to ReSPECT documentation, Communication or Recognition and End of Life care planning.

h) The table below summarises the potential learning themes and type of theme identified by the MEs.

i) Clinical Management themes are where the learning is considered to relate to active management of the patient and End of Life themes are around 'recognition of end of life'; documentation of ReSPECT discussion and communication with relatives about prognosis and imminence of death etc.



3.2(iii) **Bereavement Nurses**

a) The Bereavement Nurses work closely with the Medical Examiners and also the Clinical Teams where families raise questions or request further reviews.

b) Since Quarter 2 the Bereavement Nurses have attempted to make verbal contact with all bereaved relatives within 6-8 weeks of adult patients' deaths (unless explicitly declined). Where unable to contact verbally, a letter is sent to the relative with contact details of the Bereavement Nurses.

BSS SPOKE TO BEREAVED	Q1	Q2	Q3	Q4*	ALL
YES	463	575	605	561	2204
% SPOKEN TO	77%	75%	71%	73%*	73%*
CONTACT PLANNED	**604**	**771**	**849**	**815**	**3039**

*37 Bereaved relatives yet to be contacted

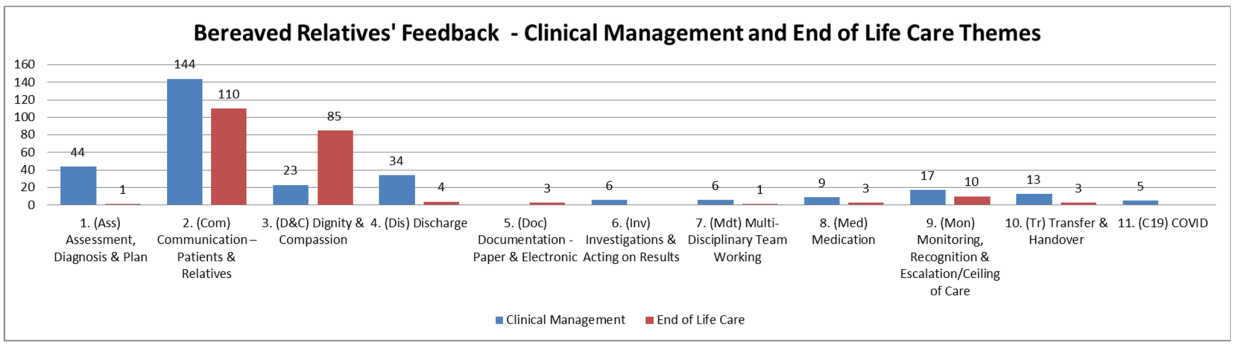
c) The purpose of the Bereavement Follow up call is to

- identify if any unmet bereavement needs
- provide relatives with an opportunity to raise any questions or concerns
- feedback where further information requested from the clinical team

d) Where appropriate, the Bereavement Nurses will ask the Relatives for feedback on their perception about the overall standard of care received. Quarter 4 saw fewer relatives giving positive feedback – mainly related to communication difficulties and visiting restrictions.

	Q1	Q2	Q3	Q4	All
Poor/Very Poor	6%	8%	8%	6%	7%
Satisfactory Adequate	5%	17%	21%	33%	19%
Good/Excellent	90%	75%	72%	61%	74%
Feedback Received	**376**	**431**	**514**	**391**	**1712**

e) In 21/22 to date 97% of bereaved relatives (of adult ED/inpatient deaths) have been spoken to by either the ME or Bereavement Nurse. The same Category and Themes are used to capture potential areas of learning as identified through the Medical Examiners scrutiny.



f) The main theme where feedback was "poor/very poor" related to communication issues (about management plans and prognosis/imminence of death). Lack of compassion and reasonable adjustments in respect of restricted visiting was the second theme.

g) A breakdown of potential learning themes by CMG/Specialty (from both the ME Scrutiny and Bereaved Relatives Feedback) will be presented to the M&M Leads forum in June but preliminary analysis shows that communication is the main area of concern across all areas.

h) Following recent discussions with the Bereavement Nurses and the Medical Examiners, we have made another change to our process and from May 22, the Bereavement Nurses will make earlier calls to those families who have raised concerns about experiential care or communication/visiting restrictions in order to provide more informed feedback to the clinical team.

3.2(iv) **Further Reviews and Specialty M&M**

a) There has been an increase in the number of completed SJRs particularly in Quarter 1 but we are still struggling to meet our internally set standard – 75% <4 mths 95% <6 mths. Clinical pressures have been the main reason for SJRs not being undertaken or discussed at the Specialty M&M.

b) The table below summarises our performance in respect of adult deaths*.

LEAD CMG	Q1	Q2	Q3	Q4	21/22
	Number of Reviews Requested (% Completed) as at end of April 2022				
CHUGGS	19 (100%)	16 (75%)	13 (46%)	15	63
ESM	24 (71%)	32 (35%)	33 (21%)	23	112
ITAPS**			3	1	4
MSS	2 (50%)	2 (50%)	1	1	6
RRCV	21 (86%)	19 (69%)	21 (38%)	13	74
ADULT DEATHS	66 (83%)	69 (54%)	71 (31%)	53	259

* All Child/Neonatal Deaths subject to SJR, includes some Comm Deaths
**ITAPs will be involved in SJRs where other CMGs leading

c) Little progress has been made with completion of SJRs over the winter months due to several Specialties needing to cancel their M&M meetings because of clinical pressures and staffing sickness. There have also been delays with sending out review requests during Quarter 4 due to capacity constraints within the Corporate LfD team. The Corporate LfD team are working closely with the M&M Leads to ensure they have the appropriate support.

d) There have been 3 cases reviewed by MRC since the last report where problems in care were felt to have 'more likely than not' contributed to death:

ESM/Stroke/Acute Medicine - Missed opportunity in previous admission for repeating investigations to confirm if U&Es back to baseline or needed further treatment prior to discharge. Subsequent readmission when further deterioration and inpatient fall 2 days post admission which led to #NOF and need for surgery under GA. Falls validation found lapses in care. Hypoglycaemia, hyperglycaemia, fluid overload were not immediately addressed post op. Patient had a stroke day 1 post op – **Action** - Individual and Clinical Team feedback and Falls Prevention teaching sessions.

RRCV/Respiratory - Patient admitted with pneumonia. Background of previous DVT on warfarin. Put on treatment dose dalteparin as INR subtherapeutic on admission. Patient subsequently received both treatment dose dalteparin and warfarin and deteriorated 48 hrs later - found to have low haemoglobin possibly due to GI bleed. Post Mortem confirmed significant GI bleed – **Action** – eMeds programme asked to amend 'alert' level for anticoagulation to 'force' justification for dual prescribing.

RRCV/Nephrology - Patient who died of cavitating pneumonia and there appeared to be a 'missed diagnosis' of tuberculosis 6 months previously. Serious Incident investigation in progress due to learning both about acting on results and also issues within the laboratory. Action – Feedback re responsibility of reviewing results. Agreed that Renal MDT to review results for all new Dialysis patients

3.3 EXTERNAL REPORTING

3.3i Perinatal Mortality

UHL's neonatal deaths and stillbirths (perinatal mortality) are reviewed by the Perinatal Mortality Review Group (PMRG) and the work of this Group is overseen by the Perinatal Mortality Overview Group (PMOG)

a) <u>UHL Perinatal Mortality Data</u>

The reports provided by MBRRACE-UK analyse data almost 2 years in retrospect. The PMRG 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	26	3.48	56	28	2.69
2019	34	29	3.46	46	24	2.45
2020	48	40		45	23	
2021	55	49*		36	27**	
2022 Q1	15	14*		16	10**	

* Predicted number of stillbirths after corrections for TOP

** Predicted number of neonatal deaths after corrections for <24 weeks and termination of pregnancy.

*** 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.

b) UHL's Stillbirth Rate

Provisional data provided by ONS for the first quarter of 2021 suggested a small increase in the national stillbirth rate of up to 10%. Personal communication with MBRRACE-UK suggests a possible higher rate for the UK for the calendar year 2021 of 5-10% higher than the previous year. However, the increase in the number of UHL's stillbirths appears to be above that seen elsewhere.

In view of this, a careful analysis of the 49 stillbirths that occurred at UHL in 2021 has been carried out. The demographic data, clinical features of the women and babies, cause of stillbirth, and outcomes of the review of each stillbirth using the Perinatal Mortality Review Tool have all been examined.

Preliminary findings were presented to the May MRC and members were advised that the increase in stillbirths appears to relate to placental causes, infection (primarily COVID) and congenital anomaly. It was noted that whilst none of the stillbirths were considered to be 'more likely than not' due to problems in care but issues with care for 6 cases 'may have affected the outcome for the baby' relating to: scanning; communication – specifically in the Maternity Assessment Unit; following guidelines; and non UHL organisations.

Members noted further work being undertaken to fully understand contributory causes to our higher number of stillbirths in 2021, particularly around the placental causes, and supported plans to ask another University Teaching Hospital Maternity Unit to QA our internal review processes in relation to these 49 cases.

c) Maternity Incentive Scheme Year 4 – Standard 1

The Maternity Incentive Scheme (MIS) Year 4 was suspended in December 2021 due to the COVID pandemic. We have now received confirmation that Year 4 standards have been relaunched to cover all eligible deaths from 6th May 22. Although we had challenges with meeting the MIS standards during 2021 we have implemented a new review scheduling process and tracker and therefore we should be able to meet the Year 4 standards for eligible cases in 2022.

3.3ii National Medical Examiner Office

a) We have met the requirements for reporting our Quarter 4 Medical Examiner activity to the National ME Office and are awaiting confirmation of income by the national team.

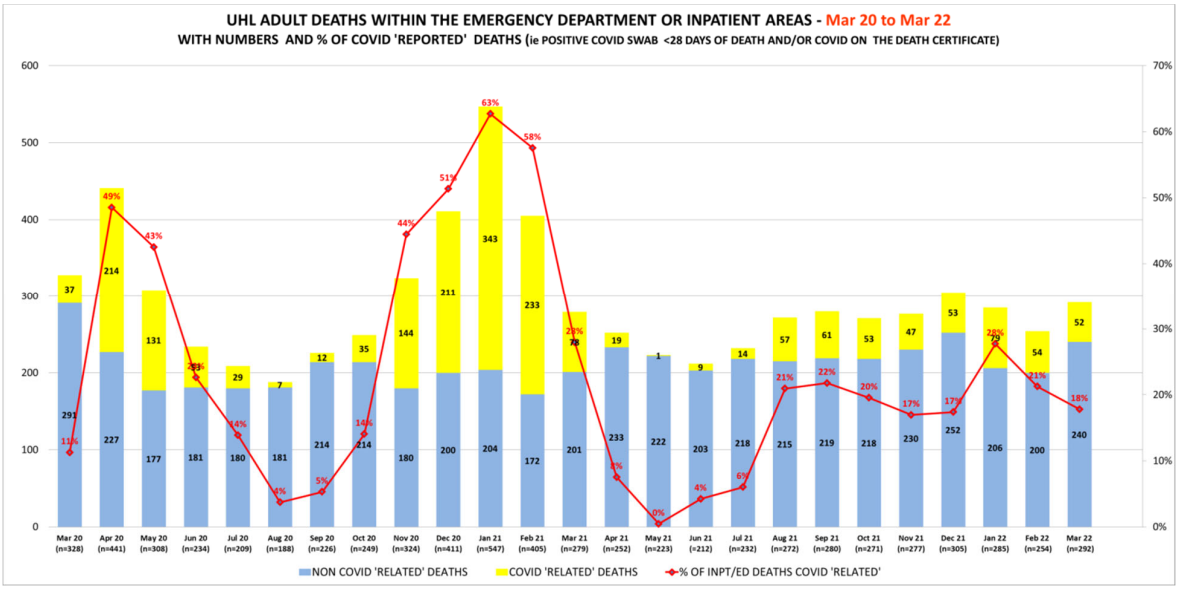
3.3iii Quality Accounts

a) We have provided Mortality and Learning from Deaths data for inclusion in the Trust's 21/22 Quality Accounts. Currently we have reported 6 deaths for 21/22 which were more likely than not due to problems in care.

3.3iv COVID 19 Deaths

a) We have seen a slight increase in the number of COVID 'related' deaths in Quarter 4 but this is much lower than last year. Member of MRC also noted that whilst we continue to see patients with a positive swab within 28 days of death, there has been an increased proportion where COVID is not thought to have been a contributory cause of death.

b) As may be expected, in line with the national increase of COVID cases in January to March this, we saw an increase in the number of deaths of patients with Hospital Acquired COVID



c) The Retrospective Cohort SI reporting of HA COVID deaths (June 20 to March 21) is nearing completion and the next stage will be to carry out a second Retrospective Cohort SI report for the deaths meeting the NHSIE SI criteria between April 21 and March 22 (44 cases).

4.0 Next Steps

4.1 Mortality Rates

i) Continue monitoring our risk adjusted mortality and correlating this with both our crude mortality as well as other available monitoring data

ii) To undertake further analysis of our mortality data for the LRI and cross reference with our Learning from Deaths data as applicable.

4.2 Learning from Deaths

i) Continue to monitor our processes for arranging certifying doctors to attend the ME office and review our Urgent Release process

ii) We will also continue to recruit more GP Practices into the ME service and embed the process within the Community Hospitals

iii) Recruitment to support this expansion will be essential and will include additional Medical Examiners, Clinical and Administrative Medical Examiner Officers, Learning from Deaths Officers and a Bereavement Support Nurse.

iv) Continue to work with the Specialty M&M Leads and Clinical Leads in order to complete requested SJRs and Clinical Reviews and collate the learning themes and confirm appropriate actions in place.

v) More detailed analysis of themes identified through feedback from the Bereaved and Medical Examiner scrutiny to be sent to Specialty M&M Leads for discussion at the next Forum in June

vi) At the Executive Quality Board, CMG Clinical Directors were requested to highlight to clinical teams the importance of

- Timely verification of death and clear documentation
- Identifying doctors to attend BSO as soon as possible to discuss cause of death
- Considering after death requirements as part of end of life care planning

4.3 External Reporting

i) Continue to oversee and support the associated work streams as applicable.

5.0 Input Sought

5.1 To receive and note the content of this report

5.2 To be advised that learning themes identified through Specialty Reviews of deaths in 21/22 (Clinical Reviews and SJRs) and details of agreed actions will be included in the next Quarterly report to the Committee