University Hospitals of Leicester NHS
NHS Trust

Meeting title:	TRUST BOARD **Public Trust Board paper G**
Date of the meeting:	9 MARCH 2023
Title:	UHL MORTALITY AND LEARNING FROM DEATHS QUARTERLY REPORT
Report presented by:	MEDICAL DIRECTOR
Report written by:	REBECCA BROUGTON, HEAD OF LEARNING FROM DEATHS

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	MORTALITY REVIEW COMMITTEE – 7 FEBRUARY 2023 EXECUTIVE QUALITY BOARD – 14 FEBRUARY 2023					

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

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

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

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

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

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

Impact assessment

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

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

Purpose of the Report

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

- Bereavement Services Office – Death Certification

- Medical Examiner Process – both within UHL and across the Leicester, Leicestershire and Rutland (LLR) Healthcare System
- Bereavement Support Service
- Specialty Mortality Reviews using the national Structured Judgement Review tool
- LLR Child Death Overview Panel reviews and Perinatal Mortality Review Group reviews using the national Perinatal Mortality Review Tool
- Clinical Team reviews and reflections
- Learning identified through:
    - Complaints and Incidents
    - HM Coroner's Inquests

Recommendation

The committee is asked to be assured that

- appropriate actions are being taken to monitor our crude and risk adjusted mortality rates and to review in more detail any patient or diagnostic group which is 'above expected' or appears to have increased over time. Deteriorating Patient Board dashboard suggest clinical acuity has returned to 'baseline' noting Acute Kidney Injury rate which track mortality peaked in late November 2023 and is now at baseline.
- our learning from deaths programme is supporting identification of learning to improve the outcomes of future patients and plans are in place to meet;
    - anticipated statutory requirements in respect of the Medical Examiner process being implemented across all of Leicester, Leicestershire and Rutland (LLR)
    - external reporting of neonatal deaths and stillbirths to the Mothers and Babies – Reducing Risk through Audit and Confidential Enquiries (MBRRACE)
    - Safety Action 1 of the Maternity Incentive Scheme/Clinical Negligence Scheme for Trusts (MIS/CNST)

Summary

We have seen the usual winter increase in our crude mortality – which has been reflected nationally - and our 22/23 'year to date' mortality is now back to 1.3% (which is the same as in 21/22). UHL's latest Summary Hospital Mortality Indicator (SHMI) remains at 104 and our latest Hospital Standardised Mortality Ratio (HSMR) is 100. Both risk adjusted mortality indicators are within the expected range.

MRC members noted that the 3 deaths in August 22 following an Ivor Lewis procedure had flagged as a Dr Foster CuSUM alert. Reviews have been undertaken of all 3 deaths and discussed at a joint Specialty M&M and no issues in care identified.

We have made further progress with rolling out the Medical Examiner process across LLR and we have more Medical Examiners and Medical Examiner Officers to support this expansion. However, the ME office is only receiving referrals for approximately 10% of primary care deaths despite close liaison with the ICB's Medical Director team.

We have been meeting our internal and national standards in respect of the learning from deaths process but there have been delays with sending out requests for further reviews by the clinical teams or Specialty M&Ms due to capacity constraints within the Learning from Deaths team. This is likely to have an impact on timeliness of review completion by Specialty Teams and M&Ms

We have now received completed Structured Judgement Reviews (SJRs) for 95% of cases referred for review in 21/22 and identified learning themes and improvement actions were discussed at the M&M Leads forum in December.

Our Bereavement Support Service is back on track with providing follow up contact of all bereaved relatives/carers (unless declined) after appointment of the new Bereavement Nurses.

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

We previously advised that UHL's perinatal mortality rate was above our Peers in the 2020 MBRRACE report. All Stillbirths and Neonatal Deaths are reviewed as part of our Perinatal Mortality Review Group using the national review tool.

A thematic review of our 2020 Stillbirths has been previously reported to the Trust Board Quality Committee. Since the last report a similar review has been carried out of our 2020 neonatal deaths. We have a very high-risk case mix even within our peer group but we have not found any significant issues with neonatal care and none of the deaths in 2020 were considered to have been avoidable. We will be undertaking a similar peer group review of these cases in the way that we did with our 2020 Stillbirth cases.

We have seen a further increase in the number of Stillbirths and Neonatal deaths in 2021 although currently we do not know how we will compare to other trusts. We understand that the 2021 UHL MBRRACE report with our local data will be available at the end of March 2023, which is much earlier than in previous years. We have met with the Perinatal Programme Lead at MBRRACE-UK for advice and input regarding further analysis and/or review of data and cases.

We have made improvement to our reporting process in order to meet the MIS/CNST Safety Standard 1 and currently are on track.

Main report detail

1. UHL's latest risk adjusted mortality (SHMI and HSMR) are both in line with the national average. Our Summary Hospital-level Mortality Indicator (SHMI) for the 12 months October 21 to September 22 is 104 (due to be published 09/02/23) and our latest Hospital Standardised Mortality Ratio (HSMR) covering the 12 months November 21 to October 22 is 100 (See Slides 3-5 of Appendix 1).
2. At the December Mortality Review Committee (MRC) it was noted that there was one a diagnosis group alerting in the Dr Foster 'HIP dashboard' – "Hepatitis". Provisional review of the data has not found any issues or theme and noted that there seemed to be a wide variation of causes of the hepatitis within the full diagnosis group (alcohol, infection, auto immune disease)
3. In August 2022 there were 3 deaths following an Ivor Lewis procedure and details of the reviews undertaken by the General Surgery M&M were subsequently discussed at a joint M&M meeting with Intensive Care. MRC members received details of these reviews and considered noted that there were no concerns about the management of the individual patients or the clinical pathway and therefore agreed no further action needed but that it was likely this 'cluster' would flag as a Procedural CuSUM alert in the Dr Foster clinical benchmarking tool.
4. We saw a higher number of deaths in December – which has also been seen at a national level. A high proportion of deaths were related to pneumonia, influenza and COVID 19.
5. How this increase will compare with our Peer Trusts will not be known until for another 3 to 4 months due to the timescales involved for publication of both the SHMI and HSMR.
6. A similar proportion of cases were referred for further review after Medical Examiner scrutiny of deaths and we will be working with the clinical teams to support early completion of those reviews.

7. At the February meeting of MRC, members received the Quarterly report from the Perinatal Mortality Review Group (PMRG) which included details of the thematic review undertaken of our 2020 Neonatal deaths to better understand why our mortality rate was higher than the peer group average. (Slide 6)
8. Members were advised that UHL has a level 3 neonatal unit. We also accept babies requiring neonatal surgery, and we have a cardiac surgery and ECMO facility. We accept both in utero and ex utero transfers of babies. We also have many extremely preterm babies, and a significant proportion of our neonatal deaths will be of pre-viable babies.
9. None of the deaths in 2020 were considered to have been an avoidable death by the PMRT review team. Learning themes included:
    a. Issues regarding pathway being used for assessment of fetal growth (scans done when not required, scan pathway changed due to COVID)
    b. Documentation issues regarding neonatal bereavement care
    c. Visiting restrictions surrounding COVID affecting parental contact in the immediate time on NNU
    d. Delay in stabilising and transferring a baby born in the standalone birth centre
10. We continue our rigorous mortality review process for all perinatal deaths through both the Perinatal Mortality Review Group and the use of Healthcare Safety Investigation Branch (HSIB) and/or Serious Incident Investigations where applicable.
11. Our Neonatal mortality rate continues to be higher than we expect looking at preliminary data for 2021 and 2022, although we do not know how we compare to other trusts. As previously reported our Stillbirth rate was higher 2021 but has come down for 2022.
12. We understand that the 2021 UHL MBRRACE report with our local data will be available at the end of February 2023 (in contrast to October in previous years).
13. To support further analysis of our neonatal mortality and to see if we can identify if there are any specific areas of care/groups of babies where there are issues, we have met with Professor Liz Draper, Perinatal Programme Lead at MBRRACE-UK, for her advice and input. We have also arranged a further peer group review meeting with Leeds Teaching Hospitals to look at our neonatal deaths.
14. We are on track to meet MIS/CNST Safety Standard. Additional administrative support has been identified to work with the Chair of the Perinatal Mortality Review Group to help track progress and ensure reporting requirements are met in the future.
15. In respect of our Learning from Deaths programme, we are now routinely discussing deaths in the LPT Community Hospitals, and we are working closely with the ICS Medical Director team to further increase the number of primary care deaths referred to the ME Office (Slide 8)
16. It is recognised that we only seeing approximately 10% of primary care deaths being referred to the ME Office and we only have 6 weeks before the planned Statutory requirements are meant to be in place. At the recent Regional Medical Examiner Office forum there was a suggestion that the Legislation may not be finalised until the end of April.
17. Our newly recruited Medical Examiners and ME Officers are in post and most have completed their induction period. We will be recruiting more MEs and ME Officers later this month so that we have all staff in place to support full implementation.
18. We are in the process of setting up an ME Office at the Glenfield site from the middle of March to improve the timeliness of full ME scrutiny for Glenfield deaths.
19. As can be seen from the Learning from Deaths (LfD) section of the appended slide deck, we continue to meet our internally set standards around the Medical Examiner Office activity and have received confirmation of full funding for Quarter 3. (Slides 8 to 10)
20. We continue to try and improve our ‘turn around times’ for both causes of death discussions and proportionate scrutiny.

21. It should be noted that we have had excellent support from the Clinical teams in respect of attending the Bereavement Services Office to discuss the cause of death with the Medical Examiner, particularly taking into account the clinical pressures and also the Christmas/New Year bank holidays affecting availability of doctors.
22. The Duty Managers and the Mortuary Team have also worked very closely with the Medical Examiner service to try and facilitate urgent release of the deceased when requested out of hours.
23. Discussions have been held with the Assistant Chief Nurse /Chief Nursing Information Officer about the development of a 'Verification of Death' assessment on NerveCentre as this would help improve the timeliness of death certification
24. It was also noted at MRC that use of the 'Last Days of Life' profile on NerveCentre (where death anticipated) could be used by the clinical teams and this would enable the Bereavement Services office to pre-empt requests for urgent death certification/release of the deceased
25. The Bereavement Nurses have been able to improve their performance, both in terms of percentage cases where verbal contact is made and in respect of timeliness of that contact. (Slide 11)
26. We have been fortunate to secure funding from the Organ Donation Charitable Funds to create a new Bereavement Room for families at the LRI.
27. From 1st January we have been able to provide bereavement support follow up to families of deaths in the Community Hospitals (funded by LPT). Most of these patients were previously in UHL.
28. The Learning from Deaths team have accrued a back log with sending out requests for further reviews due to resources being diverted to the Medical Examiner service. The focus for this month will be to ensure all reviews have been sent out and to assess the risk for any delayed requests.
29. Where significant concerns raised by the Medical Examiners, there has been early escalation to the clinical team and discussion with the Patient Safety team where applicable. (Slide 12)
30. The LfD team have been working closely with the Specialty M&M Leads to capture the outcomes of all SJRs undertaken in 21/22 and have now received 408 completed SJRs (95% of all those requested). (Slides 13 & 14)
31. 10 SJRs are still outstanding. A further 11 SJRs were 'closed down' without completion following review by the Head of LfD and Deputy Medical Director as alternative reviews had taken place either as part of the Inquest or Complaint process etc.
32. Learning themes identified by the Specialty reviews were presented at the December M&M Leads Forum. (Slides 15 to 18)
33. The main theme within the 'clinical management' category was 'Assessment, Diagnosis and Management Planning and specifically the importance of Ward Rounds. Noted that discussions being held within the Medical Director's team to confirm whether appropriate improvement actions already in place.
34. In respect of 'end of life care' and 'patient experience' the main theme continues to be poor communication with both patients and their next of kin and is obviously a major issue where the patient subsequently dies and the bereaved have not been kept appropriately informed of prognosis or ceiling of treatment plans.
35. In Quarter 3 MRC received details of 3 deaths which were considered to be more likely than not due to problems in care - all have been reviewed by the Patient Safety Team and 2 investigated as a Serious Incident and actions are being taken forward (see Slide 19).
36. The final slide (20) in Appendix 1 summarises the number of deaths previously/due to be reported in our annual Quality Accounts as being deaths more likely than not due to problems in care.

APPENDIX 1

UHL'S MORTALITY & LEARNING FROM DEATHS QUARTERLY REPORT SLIDE DECK

FEBRUARY 2023

UHL'S CRUDE & RISK ADJUSTED MORTALITY

UHL'S CRUDE IN-PATIENT MORTALITY

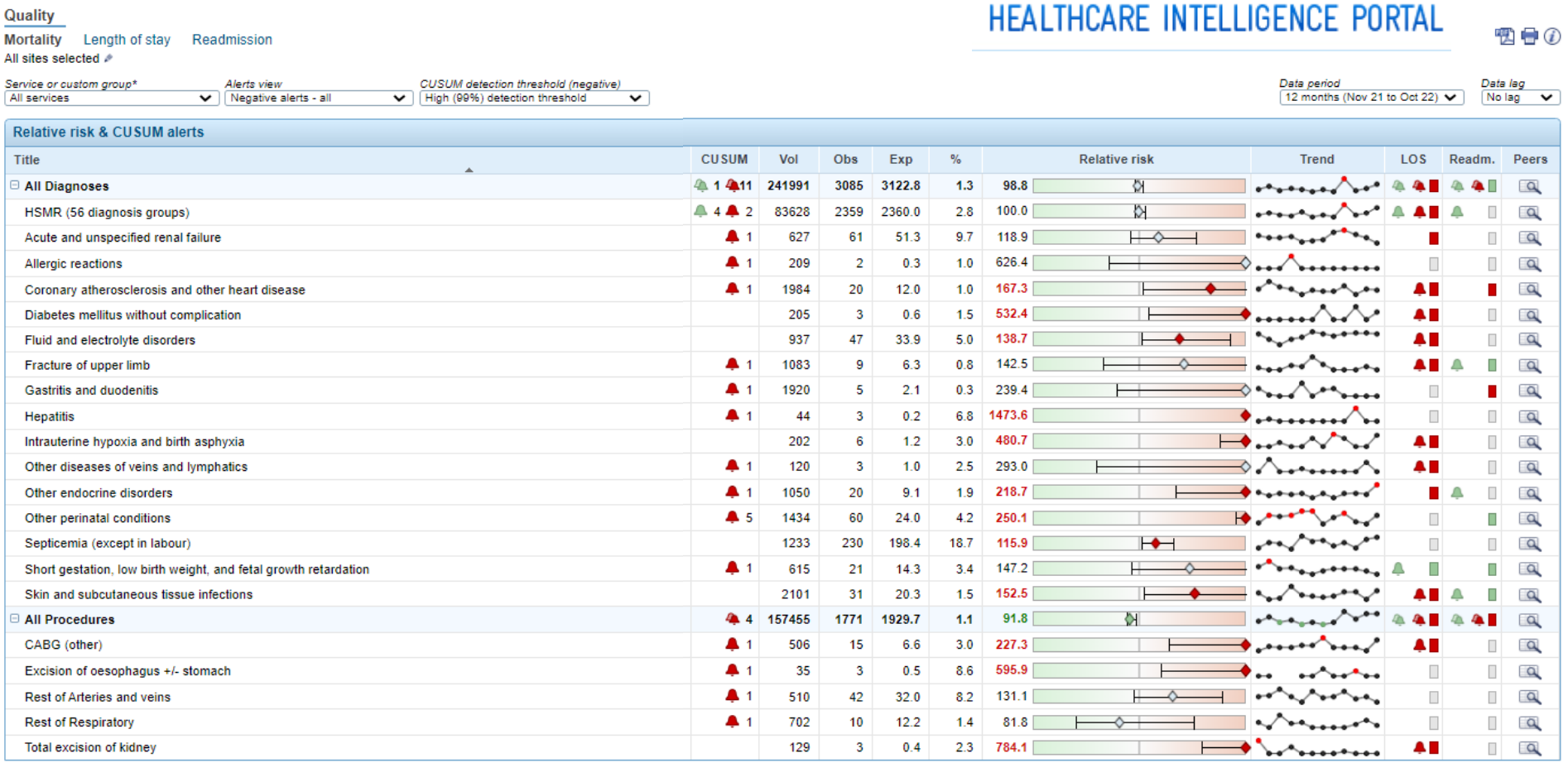
Discharges During	ALL DISCHARGES (incl Day Case)	ALL IN-PATIENT DEATHS	INPATIENT CRUDE MORTALITY RATE
FY 2022/23 to date (end Jan 23)	**200,454**	**2553**	**1.3%**
FY 2021/22	227,753	3,010	1.3%
FY 2020/21	192,065	3688	1.9%
FY 2019/20	261,647	2906	1.10%
FY 2018/19	260,301	2921	1.12%
FY 2017/18	259,539	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%

As anticipated we saw an increase in our crude mortality rate for both December (1.8%) and January (1.7%) and this was predominantly due to an increase in the number of In-patient deaths compared to previous months.

Our year to date crude mortality is now 1.3% and if activity and number of deaths for February and March are similar to this time last year, this will be our end of year position.

20/21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	22/23 to date
192,065	17698	18648	20017	19543	18955	18771	18736	19417	18709	18309	18326	20624	227,753	18744	19911	19480	19101	20533	20701	20418	21262	19700	20604			200454
3,688	249	216	207	227	261	270	256	256	294	265	243	266	3,010	237	213	209	272	207	223	262	233	357	340			2553
1.9%	1.40%	1.20%	1.00%	1.20%	1.40%	1.40%	1.40%	1.30%	1.60%	1.40%	1.30%	1.30%	1.3%	1.30%	1.10%	1.10%	1.40%	1.00%	1.10%	1.30%	1.10%	1.80%	1.70%			1.3%

UHL's HSMR – AS REPORTED BY DR FOSTER INTELLIGENCE



Quality

Mortality Length of stay Readmission

All sites selected

HEALTHCARE INTELLIGENCE PORTAL

Service or custom group*: All services | Alerts view: Negative alerts - all | CUSUM detection threshold (negative): High (99%) detection threshold | Data period: 12 months (Nov 21 to Oct 22) | Data lag: No lag

Relative risk & CUSUM alerts

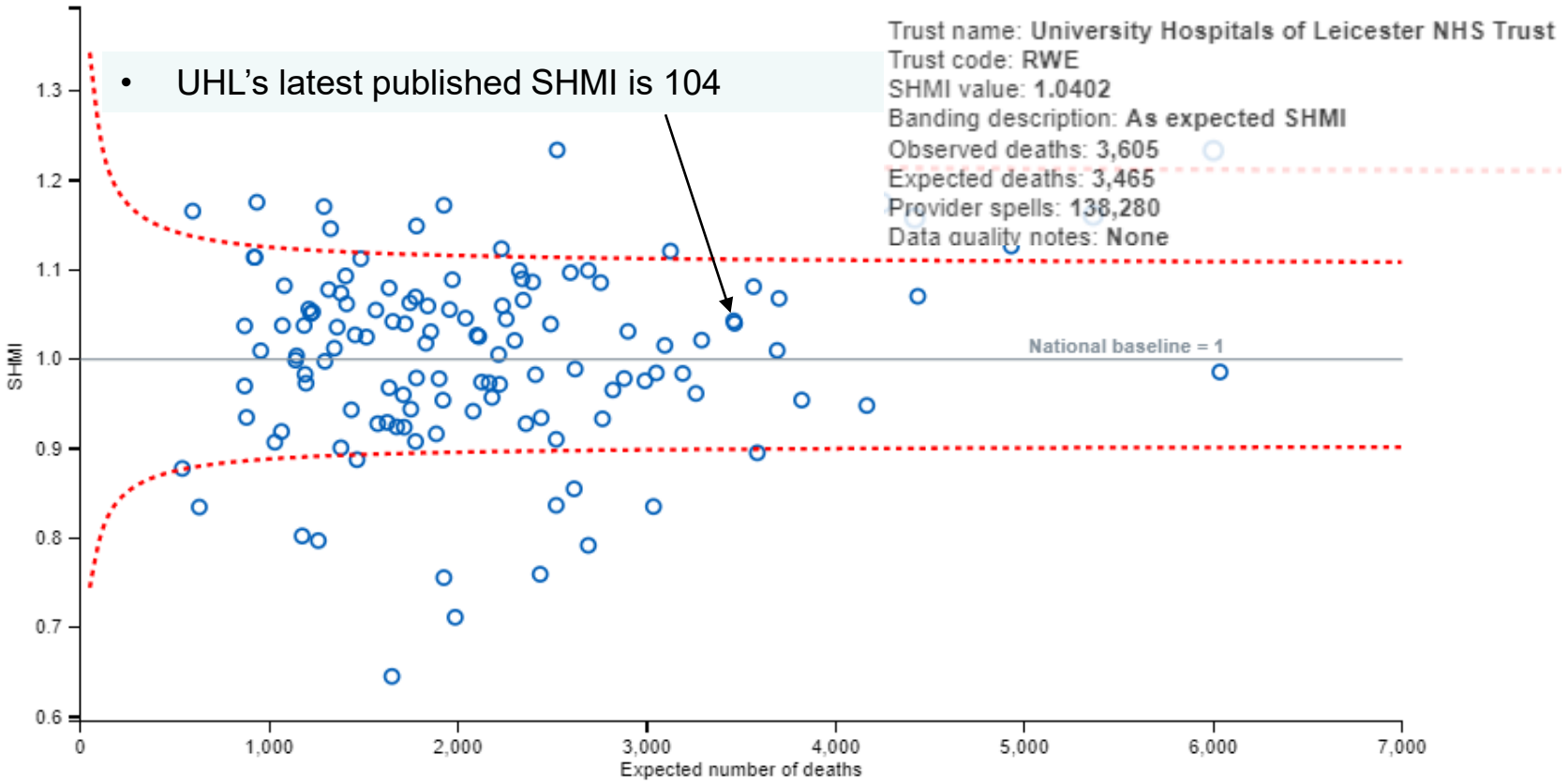
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 11	241991	3085	3122.8	1.3	98.8				
HSMR (56 diagnosis groups)	4 2	83628	2359	2360.0	2.8	100.0				
Acute and unspecified renal failure	1	627	61	51.3	9.7	118.9				
Allergic reactions	1	209	2	0.3	1.0	626.4				
Coronary atherosclerosis and other heart disease	1	1984	20	12.0	1.0	167.3				
Diabetes mellitus without complication		205	3	0.6	1.5	532.4				
Fluid and electrolyte disorders		937	47	33.9	5.0	138.7				
Fracture of upper limb	1	1083	9	6.3	0.8	142.5				
Gastritis and duodenitis	1	1920	5	2.1	0.3	239.4				
Hepatitis	1	44	3	0.2	6.8	1473.6				
Intrauterine hypoxia and birth asphyxia		202	6	1.2	3.0	480.7				
Other diseases of veins and lymphatics	1	120	3	1.0	2.5	293.0				
Other endocrine disorders	1	1050	20	9.1	1.9	218.7				
Other perinatal conditions	5	1434	60	24.0	4.2	250.1				
Septicemia (except in labour)		1233	230	198.4	18.7	115.9				
Short gestation, low birth weight, and fetal growth retardation	1	615	21	14.3	3.4	147.2				
Skin and subcutaneous tissue infections		2101	31	20.3	1.5	152.5				
All Procedures	4	157455	1771	1929.7	1.1	91.8				
CABG (other)	1	506	15	6.6	3.0	227.3				
Excision of oesophagus +/- stomach	1	35	3	0.5	8.6	595.9				
Rest of Arteries and veins	1	510	42	32.0	8.2	131.1				
Rest of Respiratory	1	702	10	12.2	1.4	81.8				
Total excision of kidney		129	3	0.4	2.3	784.1				

- Following the refresh of data in the Dr Fosters clinical benchmarking tool, UHL's HSMR for the 12 months November 21 to October 22 is 100 (as expected)
- As anticipated the Procedure Group 'Excision of oesphagus +/- stomach' is newly alerting
- No issues identified on preliminary review of the 'Hepatitis' Diagnosis group but noted by MRC members that this group includes a wide range of reason for Hepatitis.

UHL's SHMI

Summary Hospital-level Mortality Indicator (SHMI), England, October 2021 - September 2022

Funnel plot Return to contents



- The latest SHMI covers the 12 months Oct 21 to Sept 22
- UHL's SHMI remains at 104 - as expected.
- "Fluid & Electrolyte Disorders" and "Acute Bronchitis" continue to be the diagnosis groups with an above expected SHMI – both have been previously reviewed at MRC and no significant issues with care identified

UHL's PERINATAL MORTALITY

	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	3.74	45	24	2.51
2021	56	50		49	28	
2022	47	40**		61	31***	

** 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 be added.

Colour shading represents comparison to our peer trusts as provided by MBRRACE-UK.

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.

We have not found any significant issues with care when PMRT reviews were undertaken for babies who died in 2020. We have already undertaken a peer review of stillbirths with Leeds. It is proposed that we undertake a similar peer review of neonatal deaths to benchmark our PMRT review standards.

UHL'S
LEARNING FROM DEATHS PROGRAMME
QUARTER 3

LEARNING FROM DEATHS PERFORMANCE – 22/23 QUARTERS 1 – 4 (Jan 23)

LfD Cases	Q1	Q2	Q3	Jan 23		YTD
Community	**61**	**68**	**69**	**52**		250
ED/InPt	**748**	**781**	**960**	**392**		2881
ALL DEATHS	**809**	**849**	**1029**	**444**		**3131**

ED/INPT LfD DEATHS	Q1	Q2	Q3	Jan 23		YTD
ADULT	719	747	918	377		2761
CHILD	7	9	11	5		32
NEONATE*	22	25	31	10		88
ALL DEATHS	**748**	**781**	**960**	**392**		**2881**

*Includes 33 Stillbirths

LfD = all deaths included in UHL's LfD Programme
(ie includes both community deaths which are referred to the LLR ME Services and also non UHL deaths where UHL requested to review UHL's care

Cause of Death Discussed with Medical Examiner?

COMM DEATHS	Q1	Q2	Q3	Jan 23		YTD
LPT COMM HOSP	38	43	24	8		113
PRIMARY CARE	**13**	**21**	**41**	**43**		**118**
HOSPICE		1	1			2
OTHER TRUST		1				1
ALL DISCUSSIONS	**52**	**65**	**66**	**41**		**224**

ED/INPT DEATHS	Q1	Q2	Q3	Jan 23		YTD
Disc with ME	**737**	**759**	**937**	**383**		**2816**
Not Disc	4	7	13	8*		32
ALL	**741**	**766**	**950**	**391**		**2848**
% Discussed	**99%**	**98%**	**99%**	**99%***		**99%**

- Whilst the number of Community Deaths being referred to the ME is still low, we have started to see a steady increase in the number of primary care deaths being referred to the ME service since the beginning of January.

*7 cases still going through the ME process at time of reporting
Stillbirths are not included in the above table as these are out with the scope of the Medical Examiner process (33 to date in 22/23)
Other ED/InPatient Deaths not discussed with the ME were:
- 22 referred directly to the Coroner by the Police
- 1 clinical team referred to the Coroner
- 2 neonatal deaths where team issued MCCD without discussion

LEARNING FROM DEATHS PERFORMANCE – 22/23 QUARTERS 1 – 4 (Jan 23)

Cause of Death Discussion < 4 Days

COMM DEATHS	Q1	Q2	Q3	Jan 23		YTD
Disc < 4 Days	34	49	41	33		157
ALL DISCUSSED	**52**	**65**	**66**	**51**		**234**
% < 4 Days	65%	75%	62%	65%		**67%**

ED/INPT DEATHS	Q1	Q2	Q3	Jan 23		YTD
Disc < 4 Days	633	695	841	350		2519
ALL DISCUSSED	**741**	**759**	**937**	**383**		**2816**
% < 4 Days	86%	92%	90%	91%		**89%**

- Our internal standard is for ME Discussion with the Certifying Doctor to be within 3 days of death and it is reassuring that we have continued to meet 90% performance despite the increased winter activity and Bank Holidays.
- We are looking to raise this target to within 2 days (as some MCCDs will not be sent to the Registrar until the next day due to timing of discussion)
- In respect of Community deaths, the time to discussion is more related to when the ME office receives the referral – 92% of deaths were discussed within 3 days of referral being received by the ME office.

Urgent Death Certification Requested

- In Q1, there were 31 'Urgent Release' requests. All but 1 achieved – where referral to the Coroner indicated
- In Q2 there were 44 requests (13 Out of Hours) – All but 3 achieved – difficulty contacting the NoK (2) and Police referral to Coroner (1)
- In Q3 there were 43 requests (12 Out of Hours) – All but 6 not achieved ie within 24 hrs – 3 over the Christmas weekend and difficulties locating doctors who had treated the patient and working over the Bank Holiday and able to discuss with the out of Hours Medical Examiner

LEARNING FROM DEATHS PERFORMANCE SUMMARY – 22/23 Quarters 1 - 3

Proportionate Scrutiny by the ME?

ED/INPT DEATHS	Q1	Q2	Q3	Jan 23		22/23
ME SCREENED	748	781	959			
% Screened	**99.7%**	**99.7%**	**99%**			**2488**
ME Screened < 6 days						**2430**
% Screened < 6 days	75%	70%	65%			**70%**

COMMUNITY DEATHS	Q1	Q2	Q3	Jan 23		22/23
ME SCREENED	52	65	65	51		233
% Screened	**100%**	**100%**	**100%**	**100%**		**100%**
ME Screened < 6 days	44	56	54	48		202
% Screened < 6 days	85%	86%	83%	94%		87%

94% of LRI Cases are screened within 6 days but only 26% of GH and 9% of LGH deaths are. This is due to delays with case notes being transferred to the LRI, especially where death referred to the Coroner. This should be improved from March when we open up the Glenfield ME Office
Whilst all Primary Care cases have been subject to full proportionate scrutiny, we are currently reliant on information provided by EMIS Practices due to lack of access to the GP records on SystmOne. Discussion being held with IT colleagues to address

Medical Examiner spoke to the Bereaved?

UHL ED/INPT DEATHS	Q1	Q2	Q3	Jan 23		22/23
ME SPOKE TO BEREAVED	642	645	780	280		2347
Not Applicable (ie Coroner Taken)	67	90	125	31		313
% Spoke to ME (where applic)	96%	96%	96%	98%		96%

COMMUNITY DEATHS	Q1	Q2	Q3	Jan 23		22/23
ME SPOKE TO BEREAVED	46	55	57	35		193
Not Applicable (ie Coroner Taken)	4	8	9	4		4
% Spoke to ME (where applic)	**96%**	**96%**	**100%**	**97%**		**97%**

We continue to maintain our performance with % of bereaved spoken to by the ME (does not include deaths taken for further investigation by the Coroner) but we still have work to do to improve timeliness.

LEARNING FROM DEATHS PERFORMANCE SUMMARY – Quarters 1 – 4 (Jan 23)

Bereavement Nurses follow up of the Bereaved

UHL ED/INPT DEATHS	Q1	Q2	Q3	Jan 23		22/23
BSS f/up requested	707	737	901	273		2618
Verbal Contact Made to date	**503**	**453**	**573**	**54**		**1583**
6-8 week F/up in progress	**0**	**0**	**155**			
% Spoken to BSNs	**71%**	**61%**	**77% to date**			

UHL ED/INPT DEATHS	Q1	Q2	Q3	Jan 23		22/23
% F/up contact (verbal or letter) < 8 weeks	**78%**	**71%**	**99%**			**83%**

- As previously reported there were significant challenges with meeting the Bereavement Nurses' standard of making verbal contact with all Bereaved families in Quarter 2
- We also struggled with meeting the 8 week standard specifically in July due to both increased activity (following changes made to the process) and also annual/bereavement leave.
- Following appointment of 2 additional Bereavement Nurses we have been able to make contact (either by Phone or Letter) with almost all Bereaved families within 8 weeks and it is anticipated that for Quarter 3 deaths we will be back to around 75% of the Bereaved having verbal contact.
- From January 2023, the Bereavement Support Service has been expanded to include follow up of Bereaved Families where patients have died in the Community Hospitals.
- We are also now routinely providing Bereavement Support for the Parents of child deaths in UHL – in collaboration with the Child Death Overview Panel Nurses where unexpected deaths.

22/23 LEARNING FROM DEATHS PROPORTIONATE SCRUTINY OUTCOME –

Reason for Further UHL Review/Feedback (UHL INPATIENT / ED)

REASON FURTHER REVIEW REQUESTED OR FEEDBACK SENT	Q1	Q2	Q3	ALL Reviews/ Feedback	%
1. ME - SJR, Clin Rev requested or feedback given because ME thought issue	54	74	96	224	38%
2. Rels - SSJR, Clin Rev requested or feedback given because Rels raised concern re care	55	55	49	159	27%
3. Child - Child/Neonatal death	20	17	23	60	10%
4. El Proc - Death post Elec Procedure	6	15	19	40	7%
5. LD - Death of Pt with LD - SJR mandated requirement	6	7	14	27	5%
6. SMI - Pt with Severe Mental Illness	13	10	17	40	6.7%
7. QI - SJR req for Death in area where Quality Improvement workstream or	3	1		4	0.7%
8. Specialty have requested SJR or CR even though ME said no further review	13	10	17	40	6.7%
9. BSS have requested SJR or CR after their contact with family		1		1	0.2%
10. PST have requested SJR or CR			1	1	0.2%
ALL	**739**	**764**	**927**	**2430**	**100%**

TYPE OF FURTHER REVIEW – UHL DEATHS ONLY

OUTCOME AFTER ME SCREENING (UHL DEATHS)	Q1	Q2	Q3	ALL	%
NO FURTHER REVIEW / FEEDBACK	526	526	623	1675	69%
SJR BY SPECIALTY M&M	65	70	101	236	10%
CLINICAL REVIEW BY TEAM	43	49	60	152	6%
FEEDBACK	45	49	57	152	6%
BEREAVEMENT SUPPORT F/UP	36	37	59	132	5%
COMPLAINT	6	12	5	23	1%
HAC19 SI	7	11	11	29	1%
MEETING FACILITATED BY BSNs	1		2	3	0%
PATIENT SAFETY MEETING	5	1	2	8	0%
SERIOUS INCIDENT	1	2	2	5	0%
THEME	4	7	4	15	1%
ALL (ADULTS & CHILDREN)	**739**	**764**	**927**	**2430**	**100%**

Progress with Completion of 22/23 SJRs

	Q1	Q2	Q3	Jan-23	22/23
COMPLETED	45%	15%	1%	0%	16%
SEMI COMPLETED	4%	4%	2%	0%	3%
IN PROGRESS	51%	80%	97%	100%	81%
ALL SJRS	**67**	**71**	**102**	**19**	**259**

UHL's Learning from Deaths Programme – 21/22

3437 Deaths included in UHL's 21/22 LfD Programme:

- 3022 Inpatients (3689 in 20/21)
- 291 ED Patients (244 in 20/21)
- 1 Outpatient (Arrested in Clinic)
- 123 Deaths in the Community
- (LPT, Hospice, Primary Care, Other Acute Trust)

CMG	DEATHS IN 21/22	FEEDBACK / REVIEW*	%
CHUGGS	424	170	**40%**
CSI	0	4	
ESM	1865	442	**24%**
ITAPS	119	19	**16%**
MSS	66	17	**26%**
RRCV	758	221	**29%**
W&C	158	164	**104%**
ALL ED/INPT DEATHS	**3390**	**1037**	**31%**

CMG / SPECIALTY	ADULT	CHILD	NEONATE	ALL DEATHS	FEEDBACK / FURTHER REVIEW	%
CHUGGS	**423**	**1**		**424**	**170**	**40%**
GASTRO	74			74	22	30%
GENSURG	69			69	20	29%
HAEM	43			43	25	58%
HPB	99			99	47	47%
ONC	105	1		106	31	29%
PALLMED					7	
UROL	33			33	18	55%
CSI					**4**	
IMAGING					2	
PATH					1	
PHARM					1	
ESM	**1845**	**19**	**1**	**1865**	**442**	**24%**
ACUTMED	436	1		437	77	18%
EDU	7			7	1	14%
EMDEPT	272	2		274	79	29%
GENMED	344			344	94	27%
GERIS	540			540	109	20%
IDU	14			14	4	29%
METMED	66			66	27	41%
NEURO	8			8	4	50%
PAEDSED	1	16	1	18	15	83%
RHEUM					1	
STROKE	157			157	31	20%
ITAPS	**118**	**1**		**119**	**19**	**16%**
GHCC	18	1		19	7	37%
LGHCC					1	
LRICC	100			100	11	11%
MSS	**66**			**66**	**17**	**26%**
ENT	5			5	1	**20%**
MAXFAX	1			1	2	**200%**
T&O	60			60	14	**23%**
RRCV	**758**			**758**	**221**	**29%**
CARD	267			267	67	25%
CSURG	32			32	21	66%
NEPH	61			61	20	33%
RESP	357			357	86	24%
THOR	11			11	10	91%
TRANS	1			1	1	100%
VASC	29			29	16	55%
W&C	**5**	**46**	**107**	**158**	**164**	**104%**
CHD		9		9	13	144%
GENPAED	2	35		37	34	92%
GYNAE	3			3	3	100%
OBS		2	69	71	74	104%
SCBU			38	38	40	105%
ALL DEATHS	**3215**	**67**	**108**	**3390**	**1037**	**31%**

*INCLUDES REVIEWS REQUESTED WHERE PATIENT DIED IN A DIFFERENT CMG AND WHERE PATIENT DIED POST DISCHARGE

	REVIEW REQUESTED	REVIEW COMPLETED	% COMPLETED
CHUGGS	**125**	100	80%
GASTRO	18	14	78%
GENSURG	16	15	94%
HAEM	21	20	95%
HPB	30	22	73%
ONC	21	18	86%
PALLMED	5	2	40%
UROL	14	9	64%
CSI	**3**	2	67%
IMAGING	1	1	100%
PATH	1		0%
PHARM	1	1	100%
ESM	**272**	202	74%
ACUTMED	45	30	67%
EDU	1	1	100%
EMDEPT	58	42	72%
GENMED	55	41	75%
GERIS	65	46	71%
IDU	4	4	100%
METMED	11	8	73%
NEURO	3	3	100%
PAEDSED	15	15	100%
RHEUM	1	1	100%
STROKE	14	11	79%
ITAPS	**9**	7	78%
GHCC	6	5	83%
LGHCC	0		
LRICC	3	2	67%
MSS	**13**	11	85%
BREAST	1	1	100%
ENT	1		0%
T&O	11	10	91%
RRCV	**167**	144	86%
CARD	48	42	88%
CSURG	21	14	67%
NEPH	14	12	86%
RESP	62	57	92%
THOR	10	10	100%
TRANS	0		
VASC	12	9	75%
W&C	**164**	160	98%
CHD	13	13	100%
GENPAED	34	33	97%
OBS	74	71	96%
SCBU	40	40	100%
GYNAE	3	3	100%
ALL REVIEWS	**753**	**626**	**83%**

In 21/22 - 753 Further reviews were requested either as part of the Learning from Deaths or Patient Safety Process

626 Completed Reviews have been received (83%)

430 Reviews were SJRs and 408 have been completed (95%)

	SJR REQUESTED	COMPLETED	IN PROGRESS	UN-COMPLETED
CHUGGS	**63**	**95%**	**2%**	**3%**
GASTRO	5	100%	0%	0%
GENSURG	10	100%	0%	0%
HAEM	13	100%	0%	0%
HPB	15	80%	7%	13%
ONC	12	100%	0%	0%
PALLMED	1	100%	0%	0%
UROL	7	100%	0%	0%
ESM	**121**	**91%**	**2%**	**7%**
ACUTMED	27	81%	0%	19%
EDU	1	100%	0%	0%
EMDEPT	24	83%	8%	8%
GENMED	15	93%	0%	7%
GERIS	24	96%	0%	4%
IDU	3	100%	0%	0%
METMED	6	100%	0%	0%
NEURO	2	100%	0%	0%
PAEDSED	15	100%	0%	0%
RHEUM	1	100%	0%	0%
STROKE	3	100%	0%	0%
ITAPS	**5**	**100%**	**0%**	**0%**
GHCC	3	100%	0%	0%
LRICC	2	100%	0%	0%
MSS	**6**	**100%**	**0%**	**0%**
T&O	6	100%	0%	0%
RRCV	**76**	**92%**	**8%**	**0%**
CARD	22	100%	0%	0%
CSURG	19	68%	32%	0%
NEPH	4	100%	0%	0%
RESP	19	100%	0%	0%
THOR	8	100%	0%	0%
VASC	4	100%	0%	0%
W&C	**159**	**99%**	**1%**	**0%**
CHD	13	100%	0%	0%
GENPAED	34	97%	3%	0%
OBS	71	99%	1%	0%
SCBU	40	100%	0%	0%
GYNAE	1	100%	0%	0%
ALL SJRS	**430**	**95%**	**2.6%**	**2.6%**

21/22 SJR STATUS	Q1	Q2	Q3	Q4	ALL
COMPLETED	102	112	111	83	408
IN PROGRESS	1	2	3	4	10
CLOSED DOWN WITHOUT COMPLETION		3	4	4	11
ALL SJRS	**103**	**117**	**118**	**91**	**429**
% COMPLETED	**99%**	**96%**	**94%**	**91%**	**95%**

LEARNING CATEGORIES & THEMES*

CATEGORIES
- **CLINICAL MANAGEMENT**
- **END OF LIFE CARE / PATIENT EXPERIENCE**

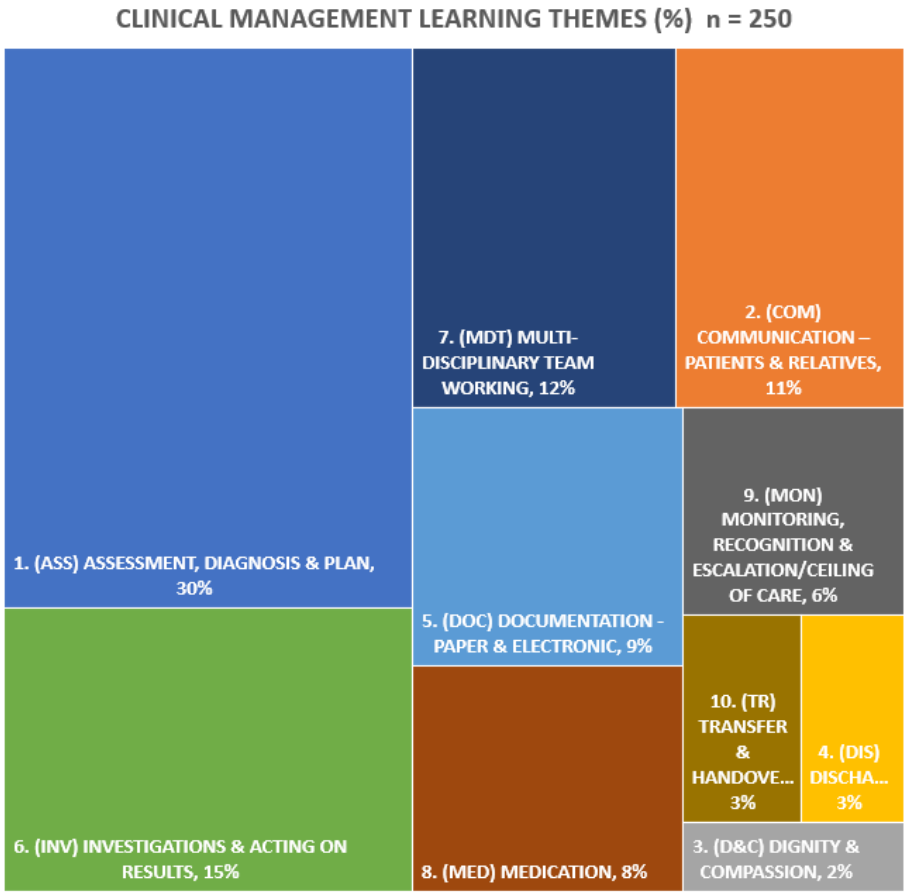
LEARNING THEMES
1. (Ass) Assessment, Diagnosis & Plan
2. (Com) Communication – Patients & Relatives
3. (D&C) Dignity & Compassion
4. (Dis) Discharge
5. (Doc) Documentation - Paper & Electronic
6. (Inv) Investigations & Acting on Results
7. (Mdt) Multi-Disciplinary Team Working
8. (Med) Medication
9. (Mon) Monitoring, Recognition & Escalation/Ceiling of Care
10. (Tr) Transfer & Handover

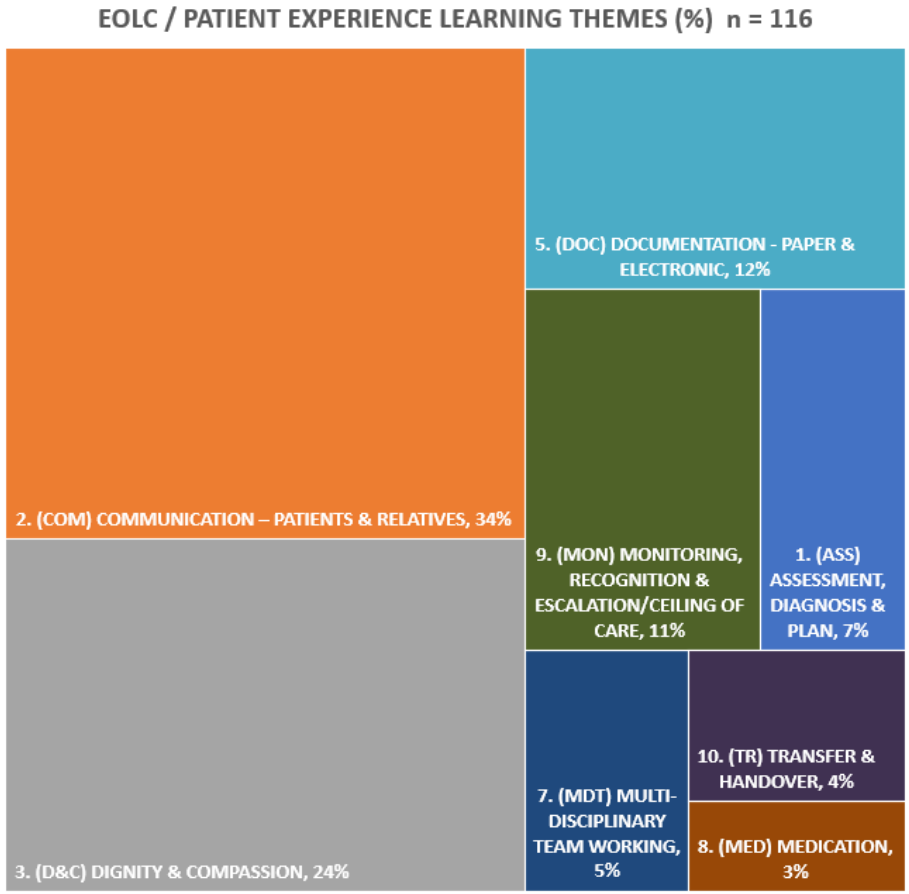
LEARNING SUBTHEMES
1. Assessment
2. Diagnosis
3.Management plan
4. Comms - Results/Management Discharge/Plan
5. Comms - Imminence of Death / DNACPR / Prognosis
6. Comms - Reasonable adjustments
7. ADL Assistance / Reasonable adjustments
8. Compassion / Attitude
9. Environment
10. F/up management plan
11. Equipment / POC
12. Discharge planning
13. Correspondence - with patients, other clinical teams
14. Clinician documentation with the clinical record
15. Completion of clinical forms i.e. DNACPR, Consent, Nursing
16. Investigations
17. Results
18. Inter-speciality liaison / continuity of care . ownership
19. Inter-speciality referrals / review
20. Inter-team issues (within same speciality)
21. Prescribing
22. Supply
23. Administration
24. Review
25. Monitoring
26. Recognition
27. Escalation / Ceiling of Care
28. Delays to correct speciality / setting
29. Inappropriate outlying / Transfer arrangements incl where pt not
30. Omissions / Errors in Handover Communication

*Agreed with M&M Leads in 2020

LEARNING FROM DEATH THEMES IDENTIFIED BY TEAM / SPECIALTY IN 2021/22

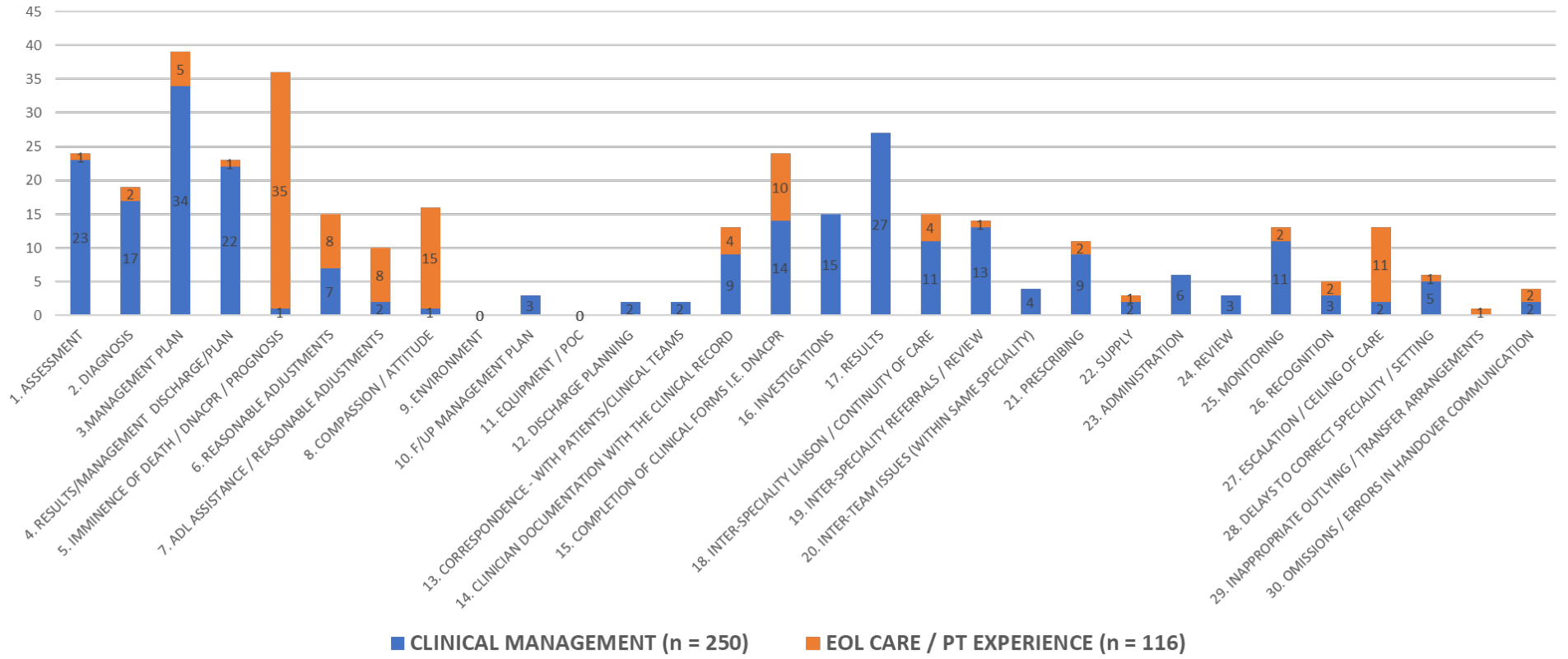
(Clinical Reviews, Complaints, Incidents or SJRs n = 366)





IDENTIFIED LEARNING SUB THEMES – FOLLOWING SPECIALTY/CLINICAL TEAM REVIEW

1. Ass	2. Comm	3. D&C	4. Disch	5. Docum	6. Invest	7. MDT	8. Meds	9. Mon	10. Transf



Cross Cutting Themes identified in 21/23 discussed at MRC and M&M Leads Forum

- **Anticoagulation – initial prescribing, 'unintended consequences', review, bridging**
- **Clinic / Ward Round Reviews – 'holistic review' vs immediate clinical issue; review of images vs reports;**
- **Post Falls Management – Initial Post Fall Review and Subsequent Senior Review; Bed Holding Consultant oversight and Neuro Obs**
- **Requests for Imaging – initial clinical detail – urgency and escalation if 'delays'**
- **Cross Site Transfer – need for specialty care vs stability of patient for transfer**
- **InterSpecialty Referral and Review – Virtual Reviews – use of N/C for communication**
- **Discharge – 'sense check' – importance of discharge communication 'patient not seen by me'**
- **ReSPECT – rationale, who discussed with – review prior to discharge - interpretation in the community of 'ward based ceiling of treatment'**

Cases discussed at MRC where

"Death more likely than not due to problems in care"

M&M Ref 1390 – Critical Care

Elective admission for liver resection surgery for neuroendocrine cancer treatment. Open liver resection and right hemicolectomy uncomplicated on the 21st July 2022. Patient died due to an air embolism following a CVC line not being capped off properly.

- Vascular Access Policy and use of Line ports reviewed.
- Inquest held 07/02/23 and Coroner assured that appropriate actions being taken by UHL to reduce risk of recurrence

M&M Ref 2298 - Oncology

Patient with ongoing background of metastatic endometrial cancer and having check scans - delays in identifying and treating a thrombo-embolus, initially due to non reporting and then 6 months later due to the report not triggering a Concerus Alert (CT reporting was being outsourced at this time) and the clinical team not acting on the result.

- Clinical team reviewing their process for cross referencing with CT images with Radiology reports and Imaging requested to take the case to their Discrepancy meeting.
- Meeting being held with family

M&M Ref 1287

Patient who had right hemicolectomy and spent week post operatively on the ward - thought to have an ileus and treated as such but subsequently confirmed had an anastomotic leak. Issues around over reliance of imaging and lack of triangulation of all clinical information.

- Learning Bulletin being disseminated to highlight importance of above

DEATHS CONSIDERED TO BE MORE LIKELY THAN NOT DUE TO PROBLEMS IN CARE

Quality Account Year	Quarter	Number of Deaths (either as an Inpatient or in the Em Dept)	SJR/Serious Incident Investigation Completed	Death considered to be more likely than not due to problems in care
18/19	Q1	790	126	0
	Q2	719	103	3
	Q3	790	101	3
	Q4	877	103	2
		3176	**433**	**8**
19/20	Q1	731	98	4
	Q2	722	99	2
	Q3	832	108	4
	Q4	902	116	4
		3187	**421**	**14**
20/21	Q1	1,010	102	0
	Q2	651	106	2
	Q3	1,014	94	1
	Q4	1,258	92	1
		3,933	**394**	**4**
21/22	Q1	721	101	0
	Q2	829	112	2
	Q3	895	106	2
	Q4	869	83	3
		3314	**402**	**7**
22/23	Q1	748	75	1*
	Q2	781	89	3*
	Q3	960	124	0*
	Q4	335	22	0*
		2824	**310**	**4* (data incomplete)**

All Trusts are required to publish in their annual Quality Accounts the number of deaths they consider to have been more likely than not due to problems in care following review/ investigation