Board of Directors' Meeting
5 August 2021

The Shrewsbury and Telford Hospital NHS Trust

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The Trust's HSMR is in line with peer Trusts and within the expected range for 4/20 to 3/21.
In-patient deaths details are as below:

<table>
<tr><th>Date</th><th>Deaths</th><th>ME scrutiny</th><th>Speciality mortality review</th><th>Covid-19 related deaths</th><th>Serious incident investigations</th></tr>
<tr><td>Q4 20/21</td><td>651</td><td>648</td><td>306</td><td>245</td><td></td></tr>
<tr><td>Year 20/21</td><td>2103</td><td>1812</td><td>858</td><td>538</td><td>8</td></tr>
</table>
NB: Medical Examiner scrutiny available on both sites since 8/20.

The new Learning from Deaths (LfD) Mortality Review Process has been approved. New structured methodology developed by NHSE/I has been approved for undertaking mortality reviews. Multi-disciplinary training is underway.
Implementation of the new LfD process is dependent on specific IT development and resources within the Divisions.
A group is being established to respond to the NICHE Independent Review of Deaths and Serious Incidents.

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1.0 Introduction

1.1 The National Learning from Deaths Guidance (2017) provides the framework to support the Trust Learning from Deaths process. All inpatient deaths are scrutinised either by a Medical Examiner or investigated by the Coroner in defined circumstances. Some deaths are subject to further review at speciality level where the review of care delivered to our patients in the days leading up to their death aims to maximise learning opportunities and improve care for our living patients. Patient Safety concerns that are identified during case record review are referred to the Patient Safety team for investigation.

1.2 Mortality performance is monitored using external CHKS data and through analysis of internal Trust data, which is detailed within the report. Feedback from bereaved families is used to further support this work.

2.0 Mortality Performance - CHKS

2.1 The Trust Learning from Deaths Group meet on a monthly basis. As a standing agenda item CHKS provide information relating to a number of mortality metrics, indicating the performance of the Trust against a defined set of national mortality parameters. These are reported, by exception to the Board of Directors via the Integrated Performance Review report.

2.2 HSMR - Hospital Standardised Mortality Ratio. The Trust's HSMR index in March 2021 was below 100 at 86.6 as at chart 1, demonstrating performance in the better than expected range. This index value is likely to increase when the HSMR model is rebased shortly. The HSMR was higher than peer Trusts in November 2020 and January 2021, which correlates with the second wave of Covid-19 deaths. The longer-term trend for HSMR is in line with the peer and the expected range for the 12-month period. The latest available Q4 data from CHKS shows the HSMR as higher than the peer at Princess Royal Hospital (PRH) compared to Royal Shrewsbury Hospital (RSH). When reviewing mortality by day of admission, a higher index was noted on a Monday and Saturday at PRH. Further work by CHKS is underway to provide more detail. This work will be presented to the Learning from Deaths Group in August 2021.

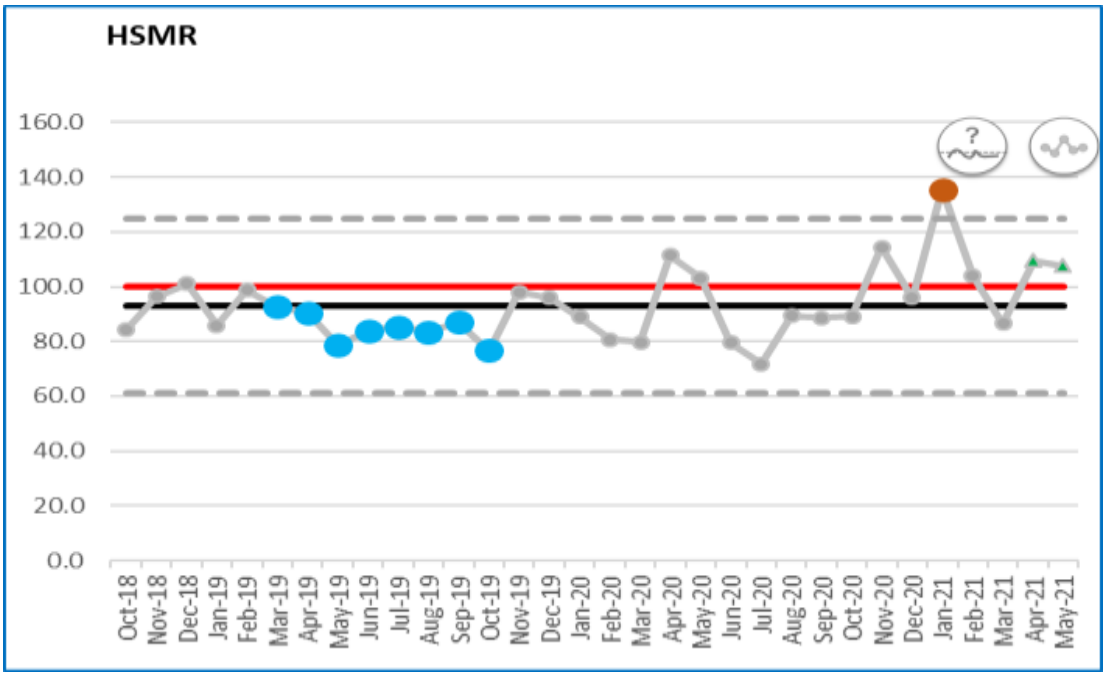


Chart 1

2.3 HSMR is adjusted to account for patients with a primary diagnosis of Covid-19 in the first or second episode of care. These patients will be excluded from HSMR. For patients where the covid-19 coding appears elsewhere in the spell or subsidiary diagnosis, this may well be included.

2.4 HSMR by condition – The conditions with a higher than expected number of deaths identified within the Q4 CHKS report are Urinary Tract Infection, Pneumonia, Aspiration Pneumonitis and Respiratory Failure, all of which were higher than the peer average and increased from the previous CHKS report. These groups are assigned based on the primary diagnosis of the first episode of care. Within this group, the condition with the highest number of these deaths which has also generated a cumulative sum (CUSUM) alert is: Urinary Tract Infection. CUSUM alerts identify specific conditions that have crossed confidence limits within the period and therefore may well be potential mortality outliers. A review of coding accuracy and the recording of primary diagnosis for urinary tract infection patients has identified modifications required for accuracy and learning for both clinicians and coders. Findings have been shared at the Learning from Deaths Group and specifically disseminated within the coding department. The sepsis team are working with clinicians to specifically address documentation of sepsis to further support this work.

2.5 RAMI – Risk Adjusted Mortality Indicator. Chart 2 indicates the Trust RAMI performance to May 2021. The RAMI indicator excludes Covid-19 patients. The Trust's RAMI position is slightly below the peer average and the index for PRH was comparable to the peer.

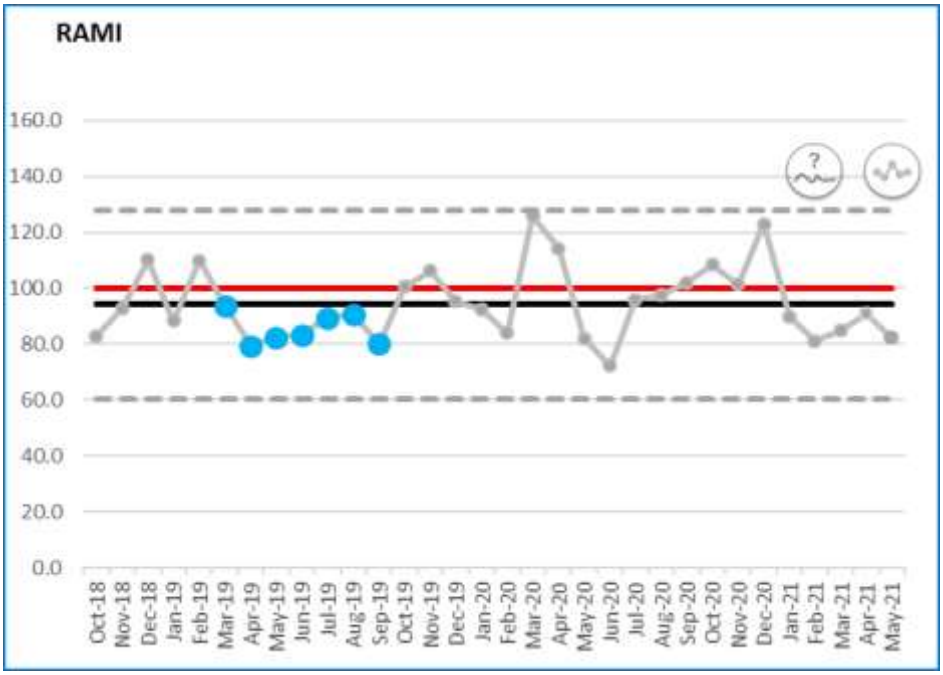


Chart 2

2.6 RAMI by condition – In RSH the conditions associated with a higher than expected number of deaths are identified in the latest CHKS report are: Urinary Tract Infections, Pneumonia, Acute and Unspecified Renal Failure. In PRH these conditions were identified as Pneumonia, Urinary tract infections and Aspiration Pneumonitis. Urinary tract infections have been reviewed as detailed above within paragraph 2.4. The Learning from Deaths team, consisting of the Trust Medical Mortality Lead and the Trust Mortality Lead have undertaken an initial analysis of the

remaining conditions in conjunction with the Coding Manager and these conditions will be monitored over the coming months by both the Trust and CHKS.

2.7 CHKS have provided specific data to review HSMR and RAMI mortality data according to weekend versus weekday and by day of the week admission. These are comparable to the peer.

2.8 SHMI – Summary Hospital-level Mortality Indicator. SHMI data includes both deaths in hospital and those which occur within 30 days of discharge. The Trust's SHMI position for the latest available period up to end December 2020 is higher than the peer average, with an increasing trend at RSH. The condition group with the highest number of deaths above those that would be expected, and that has triggered an alert at RSH is Organic Mental Disorders. Although the numbers are small and the coding includes 'Delirium', which is often a symptom of an underlying condition, further review is underway to identify any specific concerns. The other condition groups with a higher than expected number of deaths are consistent with both HSMR and RAMI indicators.

2.9 Emergency department (ED) mortality data – a new dataset is now available and reported within the latest CHKS report. There is no adjustment for risk therefore the data essentially represents crude mortality. The Learning from Deaths team are currently working with CHKS, Informatics and the ED team to gain greater understanding of potential data quality issues which may affect the findings.

3.0 Mortality Performance – Internal Trust data

3.1 Q4 performance – 651 inpatient deaths were reported during Q4. A total of 648 deaths have been scrutinised by a Medical Examiner. Direct Coroner referral took place for the remaining 3 cases. There were 5 deaths of people with confirmed learning disabilities and these cases have all received a speciality mortality review. No management was identified that if different would have affected the outcome.

3.2 A speciality mortality review has been undertaken in 306 of the total deaths within Q4 of 2020/2021. Two cases were scored CESDI 2 indicating an element of sub-optimal care that, if different, might have made a difference to the outcome. As a result, both of these cases have received additional detailed reviews using structured judgement review methodology, and involving multi-speciality clinicians. One is complete and has not confirmed any sub-optimal care requiring referral through the Trust Incident Management Process. The other review is still in process. During Q4, two inpatients deaths were investigated directly through the Trust Incident Management process and were reported as serious incidents.

3.3 Annual summary – During the 12-month period April 2020 to March 2021, 2103 inpatient deaths were reported. Of these, 1812 deaths underwent independent scrutiny by a Medical Examiner. The Board is asked to note that this service has only been available on both sites within the Trust since August 2020. Assurance can therefore now be provided that since August 2020, 100% of all inpatient deaths receive independent scrutiny either by a Medical Examiner or following direct referral to the Coroner. During the 12 month period, 858 of all inpatient deaths have undergone a further speciality mortality review. During this period 8 cases where the patient has died have been managed through the Trust Incident Management process and reported as serious incidents.

3.4 **Learning Disabilities** - During the year 2020/2021, there were 13 confirmed inpatient deaths of people with diagnosed learning disabilities. These cases have undergone an internal speciality mortality review and have additionally been reviewed through the external LeDER process. No preventable factors were identified within these reviews.

4.0 Learning from Deaths

4.1 Trust Learning from Deaths Group – the monthly meeting is now well established with good attendance from core members. A key priority for quarters 1 and 2 of 2021/2022 is to establish regular Divisional / Speciality case presentations where themes and learning that arise from the Learning from Deaths Review process are shared.

4.2 Learning from Deaths new Review process – in line with the 2017 Learning from Deaths Guidance the Trust is moving from the use of the CESDI Mortality Review Form as the primary mortality review mechanism to a Structured Judgement Review Plus (SJRPlus) model using the online platform ORIS. This has been developed by NHS England and Improvement (NHSE/I). This methodology will underpin the new Learning from Deaths Review Process, which was approved in April 2021 by the Learning from Deaths Group. The Trust policy is now under full review to reflect these changes. It was reported to Trust Board in May 2021 that the Learning from Deaths policy would be ratified by the end of June 2021 but this has been delayed whilst some of the operational details have been under review. It is now expected to be ratified in August 2021. The Learning from Deaths team are working with the Trust Kaizen Promotion Office (KPO) team and detailed process mapping is underway involving relevant stakeholders. Full implementation of the approved process is reliant on specific IT development to support speciality screening. This development is currently awaiting approval, however preliminary discussions with the Chief Clinical Information Officer have taken place to explore an interim solution of an intranet based 'Screening Output Form'. The Learning from Deaths team have identified variations between Divisions with available personnel to support the implementation of the Learning from Deaths Review Process. These will need to form part of a wider Governance framework. Appropriate resolution to these issues are crucial to the implementation of the new Learning from Deaths Review Process.

4.3 Four formal online training sessions to introduce clinicians to the SJRPlus methodology have now been facilitated by NHSE/I experts. Several one to one sessions have also been provided by the Learning from Deaths team. There are now 33 clinicians from the multi-disciplinary team trained and completed mortality reviews using the new methodology are now available for review on the online platform. The Learning from Deaths team are now working with NHSE/I to develop a Dashboard to ensure data can be analysed and inform appropriate learning within the organisation and the wider system.

4.4 The Trust Learning from Deaths team are assisting with the development of a system-wide Learning from Deaths Group. Membership of the West Midlands Learning from Deaths Forum has been established. This involvement will provide valuable insight and assist with quality improvement work both within the organisation and the wider system.

4.5 NICHE external mortality reviews – both Phase One and Two reports have been formally received into the Trust. Phase 2 report publishes system-wide recommendations. A Task and Finish Group is needed to address recommendations specific to the Trust. It is anticipated that the recommendations from these reports will further strengthen the Learning from Deaths agenda both within the organisation and across the wider system.

5.0 Covid-19 Mortality

5.1 The Trust is currently establishing a steering group chaired by the Medical Director to plan the review of hospital acquired Covid-19 cases. Incidents will be investigated and reported in line with available national guidance and is being led by the Patient Safety team within the Trust.

5.2 The Bereavement / Medical Examiner (ME) service reported 245 Covid-19 related inpatient deaths in Q4. The annual total Covid-19 related inpatient deaths for 2020/2021 was 538.

6.0 Medical Examiner and Bereavement Centre update

6.1 The Medical Examiner (ME) and Bereavement Service are managed in line with Trust, Regional and National policy and links in with the Trusts monthly Learning from Deaths Committee and monthly and quarterly Regional Medical Examiner forums.

6.2 The Q4 2020/2021 Medical Examiner (ME) and Bereavement Service report is available at the Appendix.

6.3 The Trust continues to work under the emergency Covid-19 legislation, with Medical Examiners completing the medical certificate of cause of death (MCCD) and part 1 cremation paperwork, following discussion with a qualified attending physician (QAP) involved in the patient's care. In some circumstances the Medical Examiner has the authority to super certify a death if they are unable to contact a QAP, as long as a cause of death can be established and is natural. In cases where there is concern around establishing a cause of death or that it is not natural, a referral to the Coroner will be made.

Richard Steyn

Co-Medical Director

August 2021

Appendix 1 - Medical Examiner and Bereavement Service 2020/2021 Q4 report

Cover page	
Meeting	Trust Board
Agenda Item No.	
Paper Title	Medical Examiner & Bereavement Service Report – Quarter Four 2020-21
Date of meeting	8/7/2021
Date paper was written	1/7/2021
Responsible Director	Medical Director
Author	Lindsay Barker, PALS, Bereavement & Medical Examiner Service Manager
Executive Summary	
This report sets out details of the Medical Examiner & Bereavement Service activity during quarter four, 2020/21.	
Previously considered by	N/A

The Board is asked to:			
☐ Approve	☐ Receive	☑ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	RR 1186 If we do not develop real engagement with our community we will fail to support an improvement in health outcomes and deliver our service vision

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	N/A

Main Paper
Situation
The Medical Examiner and Bereavement Service are managed in line with Trust, Regional and National policy and links in with the Trusts monthly Learning from Deaths Committee and monthly and quarterly Regional Medical Examiner forums. During quarter four 651 patients died in our care. The Medical Examiner Service reviewed 648 deaths in quarter four. The 3 deaths that weren't reviewed by the Medical Examiner will have been direct coroner referrals from either the Paramedics or Police.
Background
A full breakdown of the number of deaths managed by the Medical Examiner Service is included in the report below. Work continues to ensure that learning from deaths and supporting the bereaved is a focus of the Medical Examiner review and links with mortality processes are being developed.
Assessment
The Bereavement/ME service reported 245 Covid-19 related deaths during quarter four. The ME Service continues to work under the emergency Covid-19 legislation, with Medical Examiners completing the MCCD and part 1 cremation paperwork, following discussion with a qualified attending physician (QAP) involved in the patient's care. In some circumstances the Medical Examiner has the authority to super certify a death if they are unable to contact a QAP, as long as a cause of death can be established and is natural, in cases where there is concern around establishing a cause of death or that it is not natural, a referral to the Coroner will be made.
Recommendation
The Board is asked to note the report, and the ongoing work in using feedback from Medical Examiner review and discussions with bereaved relatives to improve services.

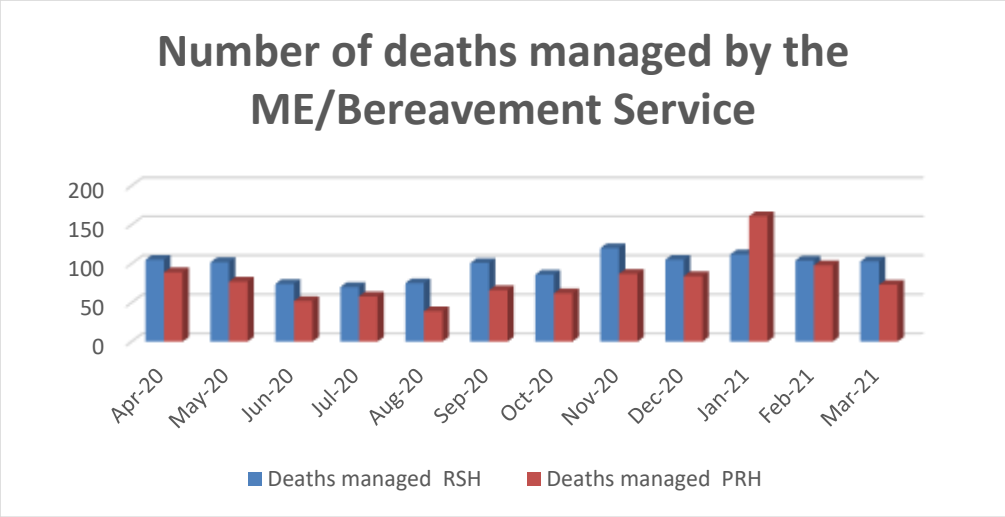
MEDICAL EXAMINER & BEREAVEMENT SERVICE REPORT
QUARTER 4 – JANUARY-MARCH 2021

1. Introduction

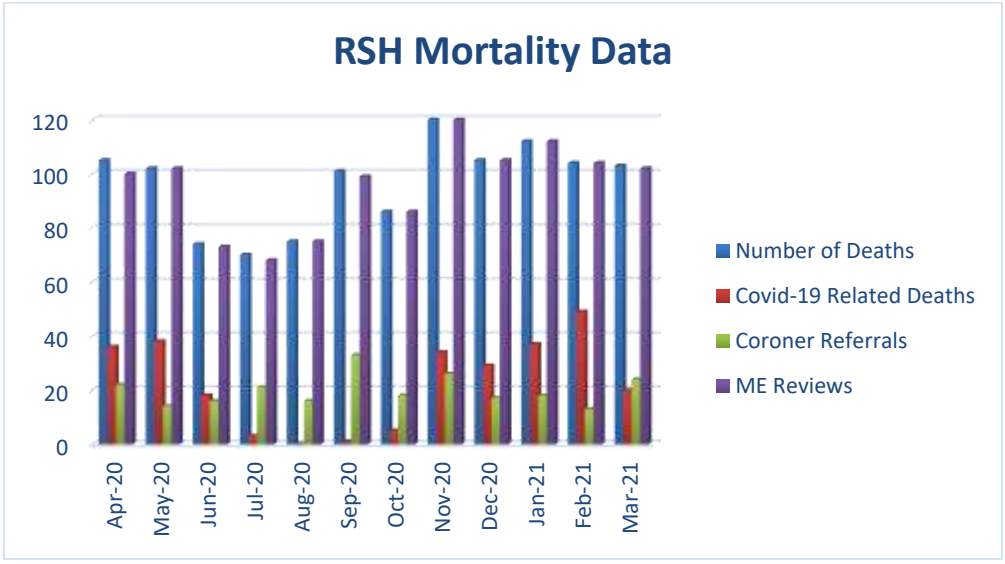
The purpose of this report is to provide the Trust Board with an overview of the hospital deaths managed by the Medical Examiner Service during quarter four (January – March 2021).

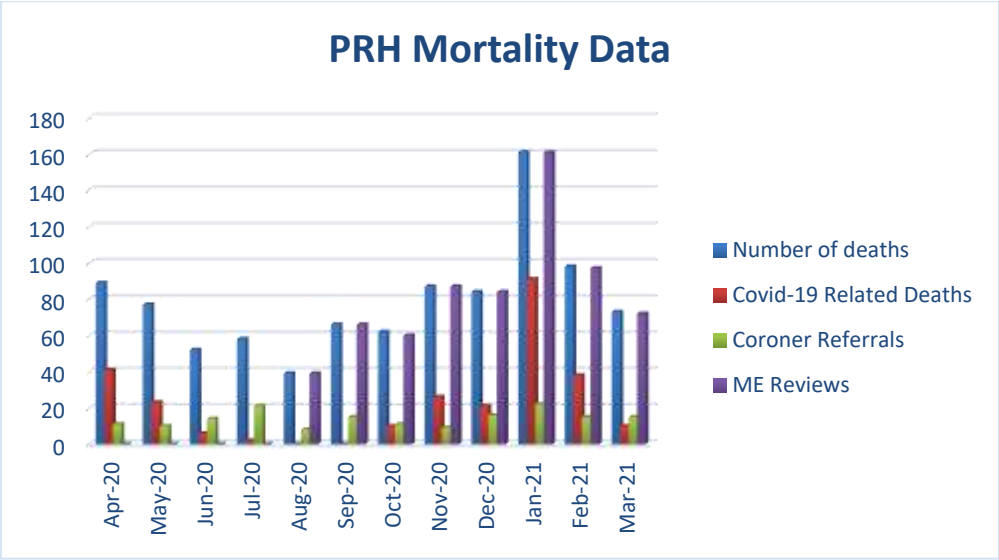
2. Hospital Deaths

During quarter four, there were 651 deaths across both of our hospitals, which is an increase of 107 deaths from quarter three of 2020 and an increase of 89 deaths for quarter four of 2019/2020.



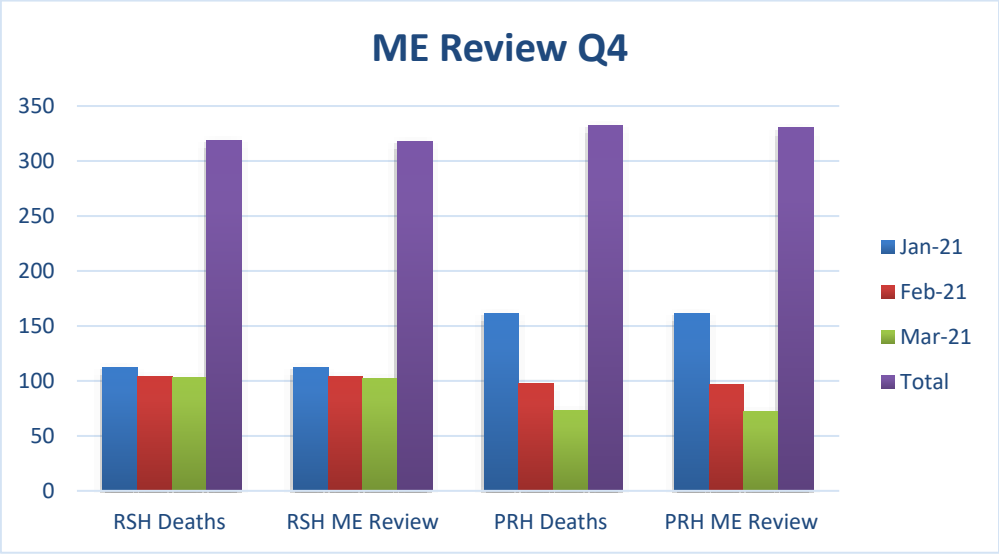
On reviewing the impact of the Covid-19 pandemic over the four quarters of this year, we can see the mortality data for each hospital below and will note the increase in covid-19 related deaths on each site in quarter four. The Bereavement service reported 106 covid-19 related deaths for RSH and 139 for PRH. These are deaths in a patient who died within 28 days of a positive PCR test for SARS-Cov-2.





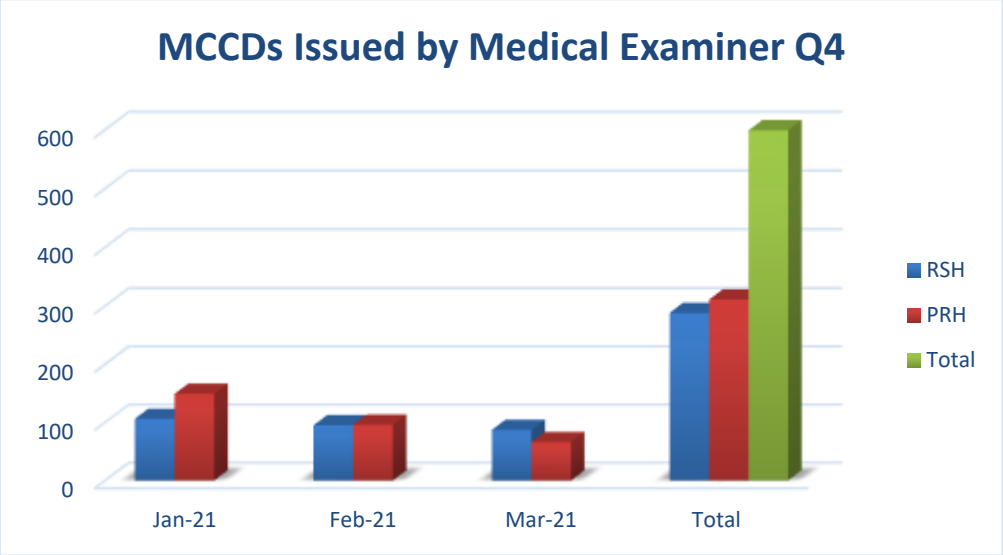
245 patients died in our care with Covid-19 during quarter four which is a significant increase from what was reported in quarter three with the Bereavement service reporting 125 cases during that period. The Bereavement Service continued with reporting all covid deaths to NHS England with support from Incident Command for weekend reporting.

Of the 651 deaths that occurred in quarter four, our Medical Examiner (ME) service reviewed 648 deaths. The other 3 deaths were referrals to the Coroner that were made directly from either the Paramedics or Police. The ME service in PRH commenced in August 2020 and continues to be very successful and well received, particularly by bereaved families who welcome the opportunity to discuss their relative's care with an independent doctor and have the circumstances and cause of death explained to them.

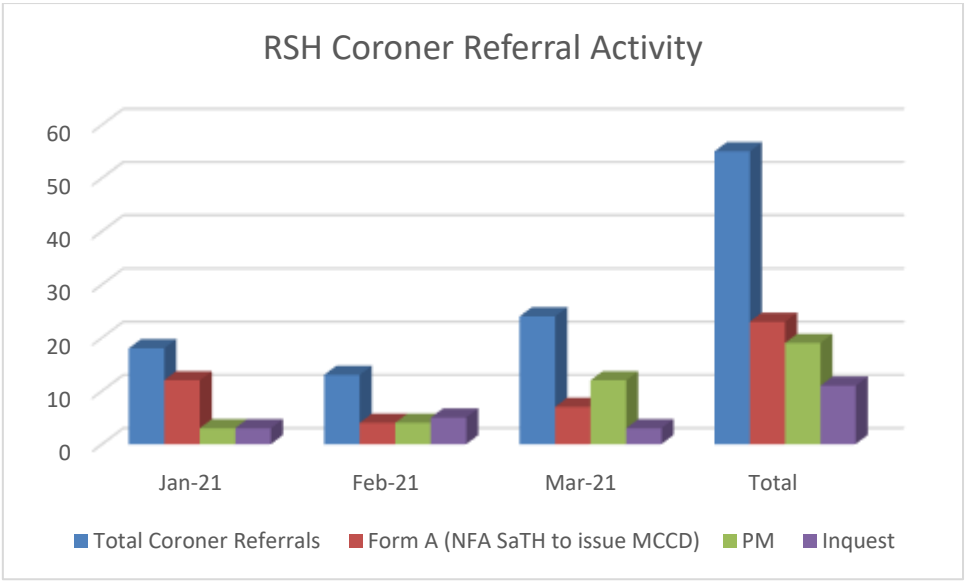


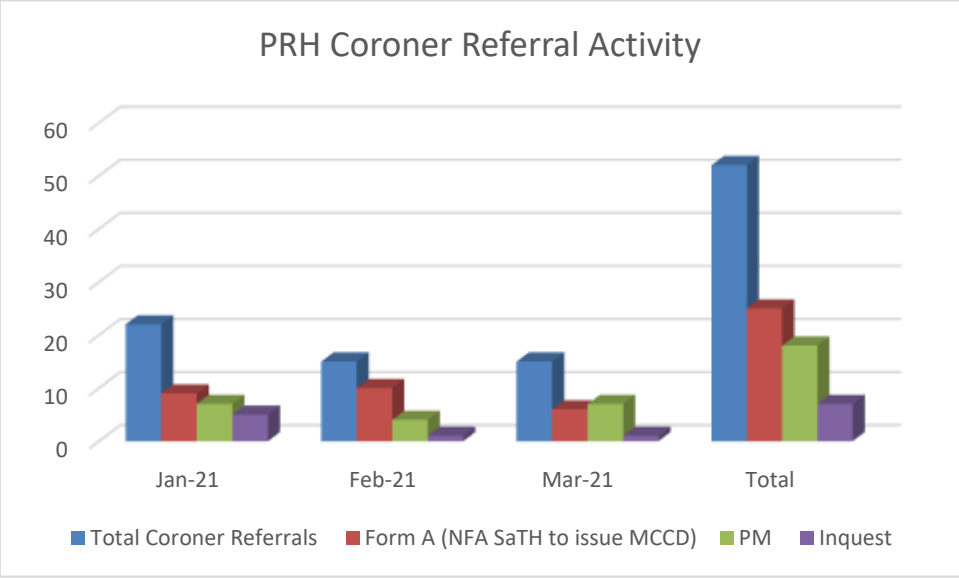
The Medical Examiner service continue to work under the emergency Covid legislation which allows any medical healthcare professional to complete the MCCD providing they have spoken with a qualified attending physician (QAP). We have been working in this way since April 2020 to relieve the operational pressures of the clinical teams and so they can maintain their presence on the ward and with clinical duties.

In some circumstances, and at the discretion of the ME, they can super certify a death if they have been unable to locate and speak with a QAP. This is to prevent any delay to the bereaved relatives in registering the death but can only be used if the ME is able to determine a cause of death, on the balance of probability. In quarter four 599 certificates were written and issued by the Medical Examiner.

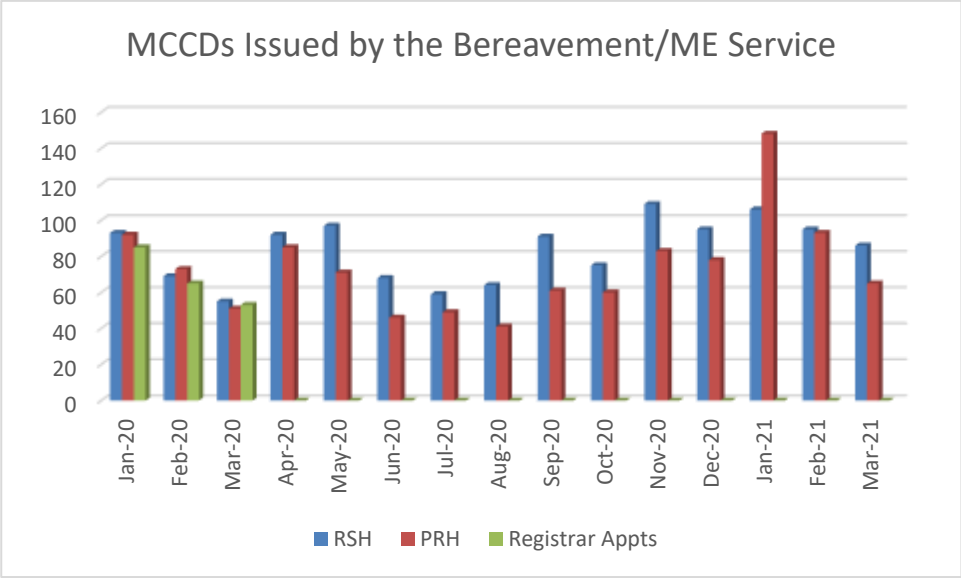


In quarter four we referred 107 deaths to the coroner which is a small increase of 11 referrals from quarter three. The outcome of referring to the Coroner can vary between no further action being taken (Form A), to an inquest and requesting a post-mortem. A breakdown of the outcomes from these referrals for each hospital is below.

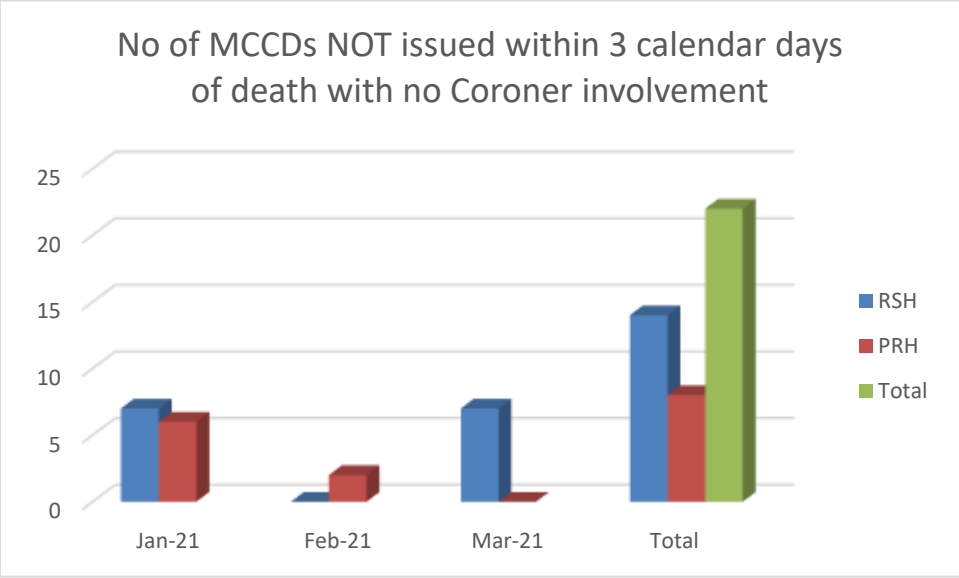




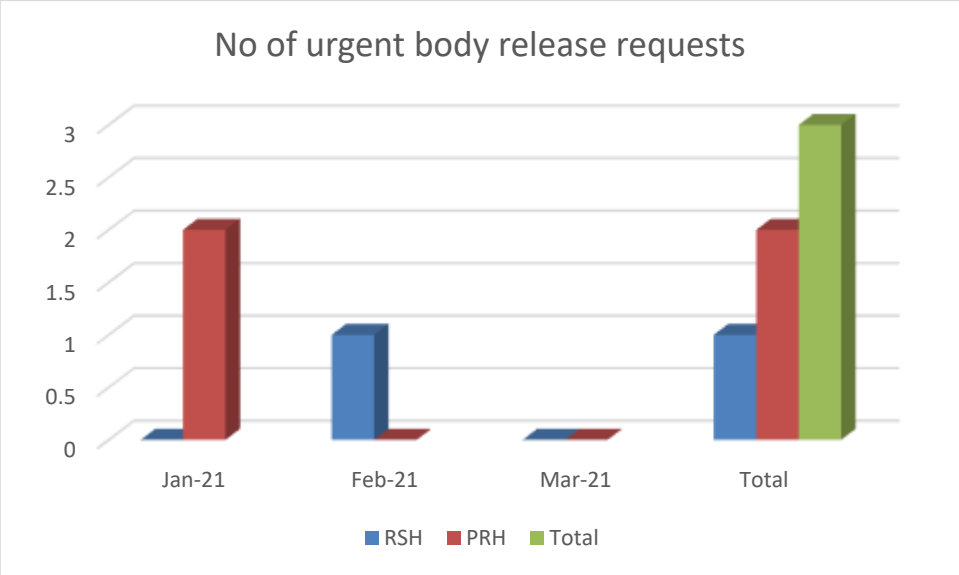
The Bereavement Service remains unable to invite bereaved relatives in to collect the Medical Certificate of Cause of Death (MCCD). The Registrar of Births Marriages and Deaths also remains off site with the main facility for registration of death being telephone registration. In partnership with Shropshire and Telford & Wrekin Registrar Services, the Bereavement Service processed 599 MCCDs by sending these electronically to the Registrar Services so that telephone registration could be facilitated for the bereaved.



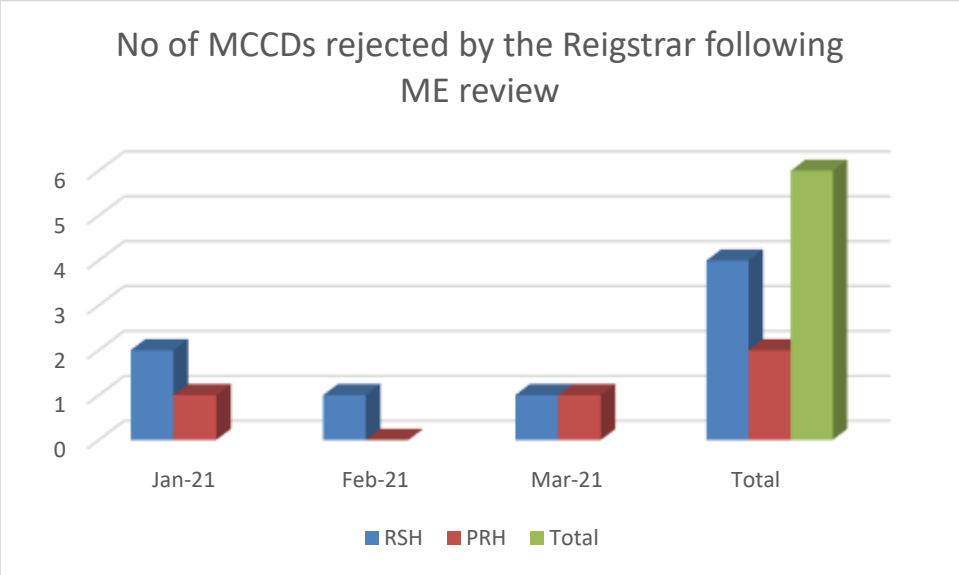
With the use of the Covid emergency legislation, it has enabled MCCDs to be written and released much sooner than in previous times, prior to the pandemic. Whilst our performance with ensuring the 5 day registration target has always been good, we are always assessing this and are mindful to ensure our work does not impact on this target. The National Medical Examiner requires our service to submit data on the number of MCCDs not issued within 3 calendar days. You will see our performance in the graph below. Out of the 599 MCCDs issued, 22 of them were over 3 calendar days.



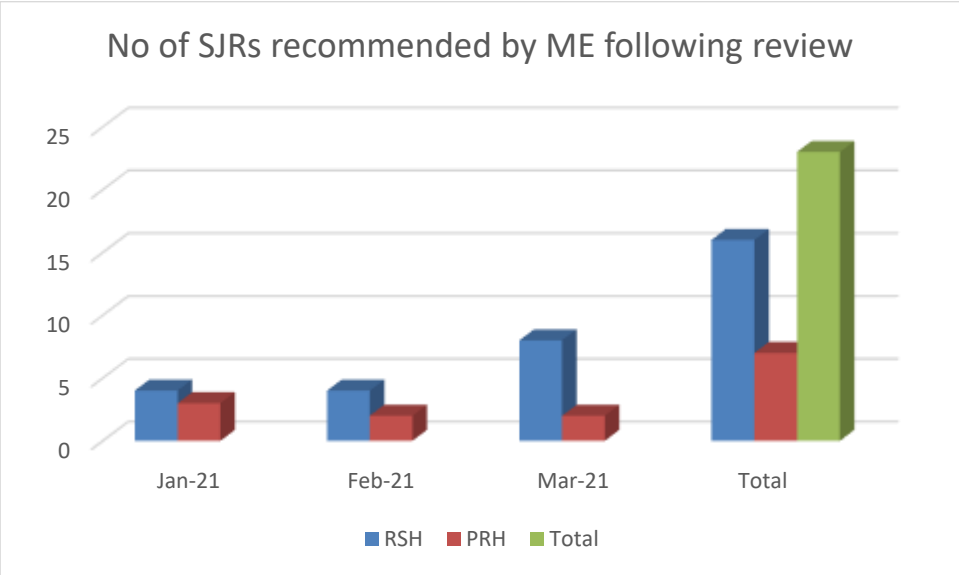
The National Medical Examiner also wishes to know the number of cases we manage in respect of urgent body release. You will see below the numbers we managed in quarter four for both hospital sites. I am pleased to report that in every case of an urgent body release request, we always ensure we work closely with the bereaved to keep them informed of our work and meet their religious and cultural requirements in respect of the burial of their relative.

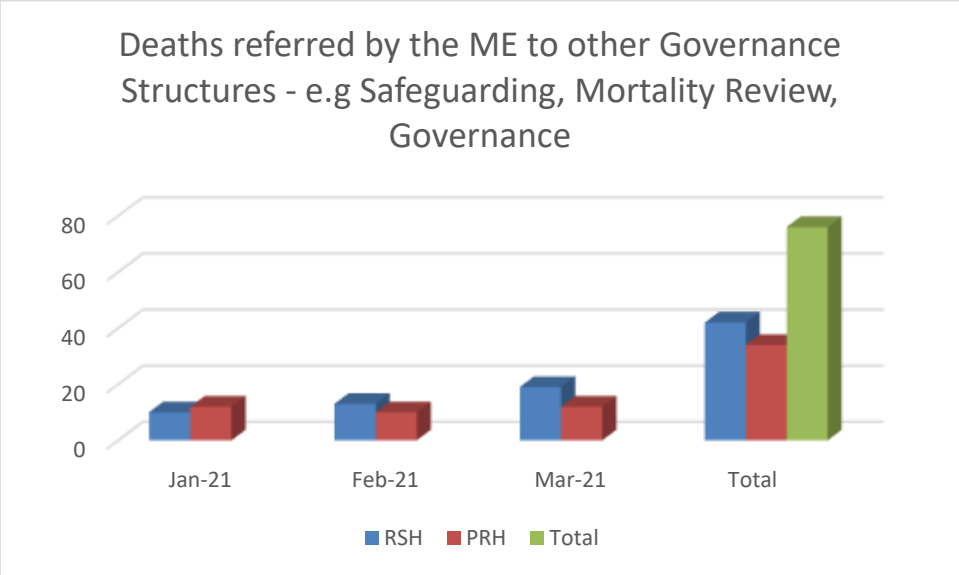


Although all adult deaths are reviewed by the Medical Examiner, and a sign off of this review is provided to the Registrar when the MCCD is sent over to confirm this has taken place, there can still be occasions where they see it necessary to reject an MCCD we have provided. In these cases the Registrar will either contact the Bereavement Service to discuss the cause of death, or they will refer the death directly to the Coroner. Out of 599 MCCDs issued, 6 were rejected in quarter four.



Part of the role of the medical examiner is to ensure any concerns or potential learning that has been identified as part of the review and discussion with the bereaved, is detected and then escalated. Work between the ME service and the Mortality Lead continues in how to ensure a robust process for escalating learning and potential SJRs takes place. In quarter four the ME service requested 23 SJRs and identified potential learning in 76 cases which was then referred on to the speciality for action and awareness. This data is also shared in the quarterly submission to the National Medical Examiner.





3. Medical Examiner and Bereavement Services Review

The ME and Bereavement Service has maintained the processes of supporting bereaved relatives, whilst not in person, by maintaining contact with them over the phone and ensuring they know what action we are taking in respect of their relatives death. Families continue to receive our swan bereavement folders via the post to help provide ongoing support and we are still open to receive enquiries from bereaved relatives and provide ongoing support to them. Medical Examiners are continuing with their reviews of all deaths and an important part of this is the support they offer to the bereaved.

During quarter four, the ME service was once again supported by the Pathology Department when our acute physicians were released from the ME rota to enable them to support clinical areas with a rising number of admissions. The Consultant Pathologists supported our service by working with us to review the deaths of all adult patients and establishing a cause of death. They were facilitating telephone calls to the bereaved relatives to discuss the care given and explain the cause of death. They were writing the MCCD and completing cremation forms where required. Without their help the service will not have been able to continue its important and necessary function.

Looking ahead to the new financial year will include expansion of the medical examiner system to the non-acute sector. The intention is that the SaTH ME service will be the lead and hub for the non-acute sectors deaths and review of these cases will be done from our service. This will require additional Medical Examiners and Medical Examiner Officers. More detailed information on the planned roll out of this service will be included in the annual report and Q1 report of 2021/2022.

Appendix One

Examples of Feedback from Bereaved Relatives

RSH

*HDU – "My brother, ***, was admitted to the Royal Shrewsbury Hospital on 25th November and within a couple of days it was confirmed that *** had Covid. All our calls were via phone calls; one day were lucky to have a FaceTime. His wife, ***, had passed away on 2nd November, at that time *** was taking care of *** at home with the help of carers. Could you please pass this cheque to the right department please (this was forwarded via internal post)"*

*Ward 28 – "All of the staff from doctors to utility were incredible. They respected *** wishes and never did we feel anything other than welcome. I really can't put into words how grateful we are. Amazing people".*

*Ward 23 – "The staff were all fantastic when treating ***, also when dealing with any questions or concerns we had".*

*Ward 32 – "My husband was in Ward **for 15 days. When he came home, he not only was sent home with Covid which he caught in the hospital, but he smelled. He was very dirty and had lost a lot of weight. Why was he not transferred to the Covid ward from Ward **. They just wanted him out of Ward ** because no-one else had it!! That's what the Sister of Ward ** told me. I cared for my husband for 5 days and then he was rushed into hospital again due to pneumonia from the Covid; he died 4 days later. I got Covid from him. He should never have been sent home! But should have been given a chance in the specialised ward earlier. No-one from the bereavement care services has been in touch with me".*

*Ward 32 – "Despite current Covid pressures on all staff, they all provided excellent care and support – far more than could have been reasonably expected. *** was profoundly mentally and physically handicapped but was treated at all times with dignity and excellent care. Through *** many stays on various wards; she was always treated with excellent care".*

Ward 27 – "It was very difficult to speak to a doctor or nurse. They told me on a number of occasions that a doctor would call me – they never did. My mum never ate for a whole week and only had sips of water. I spoke to different nurses to share how I encouraged mum to eat. The following day I had to explain this again, no notes for anyone to follow this up. The information was never shared between them. When she refused food that was that. Dementia takes different moods and my mum could be encouraged to eat, unfortunately this was ignored. There were no dementia nurses on any of the wards to help, encourage or support my mum. The dementia team visited but no practical care was given. When I spoke to the nurses the responses were robotic – 'yes, she's fine, very chatty'. Well obviously not, no food for a week, limited fluids, not taking her medication. I suggested all the time to come in and help her. Not possible due to Covid. She caught Covid in hospital with no visitors. My mum was left to her own devices which she was unable to do. She had help and support at home for 5 years, went into hospital for a week and died".

Ward 22 – "No privacy in death for mum or family members or other patients on the ward. Very difficult for everyone involved. A patient told us our mother had a fall in the final hour of her life. A doctor told us as we were leaving. Staff were kind and allowed us time with mum both when she was alive and after. We understand that an investigation is taking place into our mum's fall. Please can we have the outcome of this investigation?"

Ward 27 – "As a family, we cannot thank Ward 27 enough for all the care that my husband, my dad, had during the 5 weeks that he had on that ward. Even though we couldn't come in to see him until his final few days, we knew that he was being well cared for and in these difficult times, the staff let us know of any changes in his condition. Please can you tell the staff we are very grateful for all their professional help and caring ways in my husband's/dad's last few weeks".

Examples of Feedback from Bereaved Relatives

PRH

Ward 17 – "We provided a phone/IPad for our mum as a point of contact. We asked nurses to take the phone out of mum's bag so that we could speak with her on several occasions – this was not done.

*Ward 8 – "I wish I'd had a conversation earlier with ***, a staff nurse, who called me Monday evening before dad died. She asked lots of personal questions including where would dad like to end his life. As dad came from a nursing home it was agreed she would ask if he could return there which was granted by all concerned. However, it was too late, he died in the early hours of the day they were going to return him. If this discussion was 24 hours earlier, and he was successfully returned to the home, some of his family may have had the opportunity to see him through his bedroom window before passing".*

Ward 17 – "I understand that the coronavirus pandemic has made the situation in hospitals and for staff very different and extremely difficult, so I appreciate that staff under such pressures don't have as much time as normal. Even so, I felt there was a mixture of excellent and awful care. I saw great kindness shown to my mum, and staff were kind to me. However, my mom told me one member of staff treated her 'cruelly' on her first day in hospital by refusing to help her get to the toilet and then refusing to make her bed for 4 hours after she wet the bed. She also rang me in great distress on her last day as a nurse told her she was definitely going to die if she wouldn't tolerate the C-Pap. I felt this was rather cruel to a very poorly old lady who would have been frightened already".

*Ward 6 – "My family and I were very grateful for the time and care given to mum and ourselves on 20.11.20. Thank you Sister *** and all on Ward 6. Sincere thanks to the paramedics who attended to mum on 19.11.20. The two professionals were fantastic!"*

AMU – "The care given to my dad was outstanding. Everyone on AMU ward treated the whole family with total professionalism and nothing was too much trouble. They all supported us throughout the day; we never felt pressured to leave even after his passing. They treated my dad with dignity and grace and even set the room up, adjusting the lighting and making sure he was comfortable, pain free and warm throughout. Overall his treatment was exceptional and I thank everyone involved for this; it made the process a lot easier to come to terms with".

Ward 10 – "This was the death of my father which was sudden in the end. Due to Covid we were understandably unable to visit so don't know a great deal about his care. We were contacted to go to the hospital as he had taken a turn for the worse but unfortunately he died before we got there. A doctor and nurse spoke to us about his death briefly and we were allowed to spend as much time as we wanted with him. We were told that we could speak to the nurse who was with him and she would answer any questions after we had seen him. Unfortunately she was too busy to speak to us so we were passed to another member of staff who ushered us out into the main corridor, gave us the bereavement pack and my dad's belongings in a carrier bag. She hadn't cared for him so couldn't answer our questions. That was it, my mum and myself were left alone in the corridor".

Ward 11 – "Considering the amount of pressure the hospital were under during these Covid-19 problems, they answered all my calls with utmost respect and I was given full information at all times – the staff were more than excellent – well done Princess Royal".

Ward 9 – "I understand that the ward should have made a daily call to the next of kin, to update on condition of patient. This never happened! I spent hours daily trying to call Ward 9 with minimal success, this is unacceptable".

Ward 15 & 16 – "We were happy with the care received from staff. Please pass on our thanks to the ward staff who were very kind and helpful".