University Hospitals of Leicester NHS
NHS Trust

Paper H

Meeting title:	Trust Board – public					
Date of the meeting:	14 December 2023					
Title:	**Mortality and Learning from Deaths Quarterly Report**					
Report presented by:	Andrew Furlong, Medical Director					
Report written by:	Rebecca Broughton, Head of Learning from Deaths Penny McParland, Head of Service for Obstetrics and Chair of the Perinatal Mortality Group					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Mortality Review Committee – 07.11.23 Patient Safety Committee – 21.11.23 Quality Committee – 30.11.23					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The UHL Learning from Deaths (LfD) framework provides assurance in respect of both the national risk adjusted mortality metrics 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 – ME staffing 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 LfD 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 Ratio (56 diagnosis groups in hospital deaths); DFI – Dr Foster Intelligence, MRC – Mortality Review Committee; QC – Trust Board Quality Committee

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 and HM Coroner's Inquests

Recommendation

The Board 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.
- 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 Year 5 Maternity Incentive Scheme/Clinical Negligence Scheme for Trusts (MIS/CNST)

Summary

UHL's crude mortality continues to be below the usual seasonal average and our risk adjusted mortality indicators are within the expected range - UHL's SHMI is 103 and our HSMR is 98.9.

We continue to undertake further analysis, benchmarking and cross referencing with our Learning from Deaths data any patient or diagnosis groups with an above expected relative risk to identify any areas for improvement in clinical care.
We have continued to see referrals from LPT and LOROS to the Medical Examiner officer and we are working with ICB colleagues to look at how to further improve GP engagement ahead of the planned national roll out in April 2024.

Good progress has been made with improving our 'turn around times' for identifying relevant doctors to discuss causes of death with the Medical Examiner and with proportionate scrutiny.
Following Specialty M&M review and subsequent discussion at the Mortality Review Committee, 2 deaths were considered to be more likely than not due to problems in care in the last quarter.
The quarterly Perinatal Mortality report was reviewed at the November Mortality Review & Quality Committees with detailed summaries of the cases reviewed during Quarter 2 by the Perinatal Mortality Review Group.

Main report detail

1. UHL's crude mortality for 23/24 to date is 1% - there have been fewer deaths for the 5 months May to September than for the same period in the last 5 years.

2. Both of our risk adjusted indicators (HSMR and SHMI) are 'within expected' - our SHMI is 103 and our HSMR 98.4 (See Appendix 1).

3. Three Diagnosis Groups have been reviewed this quarter after flagging (either because of a CuSUM alert or the Relative Risk is more than expected) – Actions taken in relation to these were discussed at the MRC and QC.

4. The SHMI value for ‘Septicaemia (except in Labour) is now ‘within expected’. Further analysis was presented by our DFI Consultant at the November MRC and is being shared with the UHL Sepsis Leads to inform their work programme.

5. At the November MRC and QC, members received the quarterly report from the Perinatal Mortality Review Group (PMRG) and noted that the number of stillbirths in 2023 was similar to the pre COVID pandemic year and that there were fewer neonatal deaths in quarter 2 (23/24 financial year) than there had been for the previous two quarters.

6. Members also received summaries of the reviews undertaken of the 2022 neonatal deaths and an update on actions being taken by the Service (as reported to the September meeting of QC).

7. Members were also advised that we are on track with the CNST Maternity Incentive Scheme Standard 1 requirements and received detailed summaries of the 29 perinatal deaths reviewed by PMRG during Quarter 2. None of the deaths reviewed in Q2 were considered to be more likely than not due to problems in care.

8. In respect of our Learning from Deaths programme, the number of primary care referrals to the Medical Examiner office continues to be lower than we would like. We are working closely with ICB colleagues to look at what measures can be taken to improve engagement. We continue to receive referrals from both the Community Hospitals and Hospices.

9. Our turnaround times for both UHL and non UHL Medical Examiner discussions and agreeing cause of death or referral to the Coroner have improved. We have also maintained performance for meeting requests for urgent certification and release both in and out of hours with support from the Mortuary and Duty Managers.

10. The Bereavement Nurses have spoken to just over 500 bereaved relatives/friends for deaths in Quarter 1 and offered bereavement support.

11. Feedback about care was provided by just under 400 bereaved relatives/friends and whilst most (331) felt care was good or very good, there were 20 who felt care was poor/very poor. The most recurring themes were related to attitude and communication. Feedback has been shared directly with the clinical/ward team and the End of Life Steering Group.

12. There has been further progress made with completion of SJRs requested in 22/23 although some are still behind schedule due to delays with the LfD team sending requests.

13. Emerging themes identified by Specialty reviews of 22/23 were discussed at the recent M&M Leads Forum. Final theming data to be presented to the December MRC.

14. Since the last Quarterly Report, MRC members have received details of 2 adult deaths which were considered to be more likely than not due to problems in care. Actions in response to learning were discussed at the MRC and QC and are being tracked either by the Adverse Events Committee or MRC.

APPENDIX 1

UHL'S MORTALITY SLIDE DECK

UHL'S CRUDE IN-PATIENT MORTALITY

Discharges During	ALL DISCHARGES (incl Day Case)	ALL IN-PATIENT DEATHS	INPATIENT CRUDE MORTALITY RATE
FY 2023/24 YTD (Oct 23)	152,547	1,538	1.0%
FY 2022/3	243,413	3,067	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%

2023/2024	April	May	June	July	August	September	October
Activity	19641	21778	21944	21636	22528	22192	22828
Deaths	263	209	202	206	225	203	230
Crude Rate	1.3%	1.0%	0.9%	1.0%	1.0%	0.9%	1.0%

Our YTD Crude Mortality is still 1.0%
(as at end of Oct 23)

The average monthly number of deaths during 2023/24 has been 219 to date (was 231 for the same time period in 22/23).

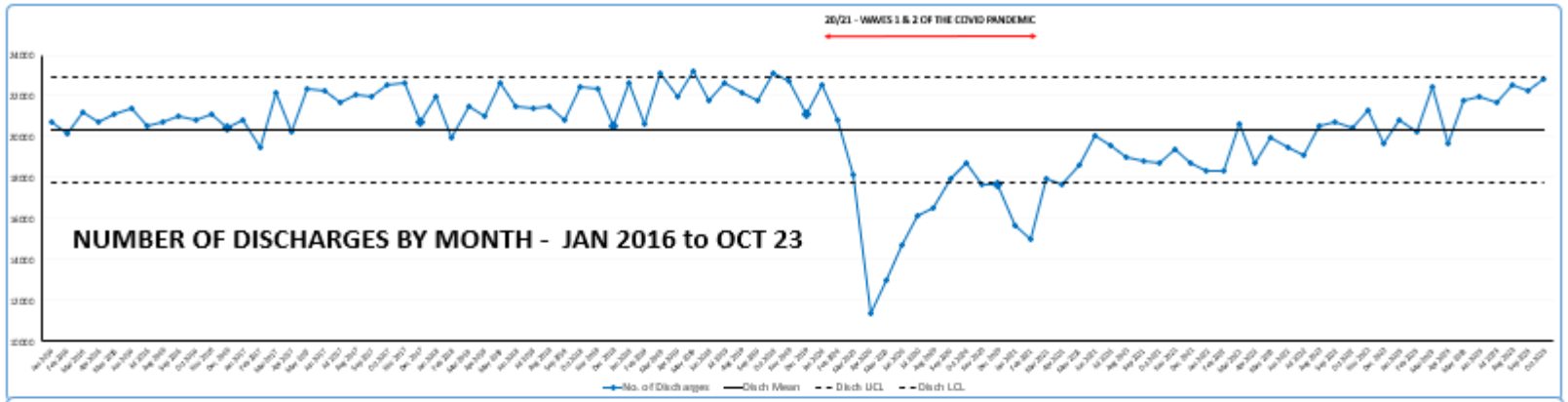
Elective Activity

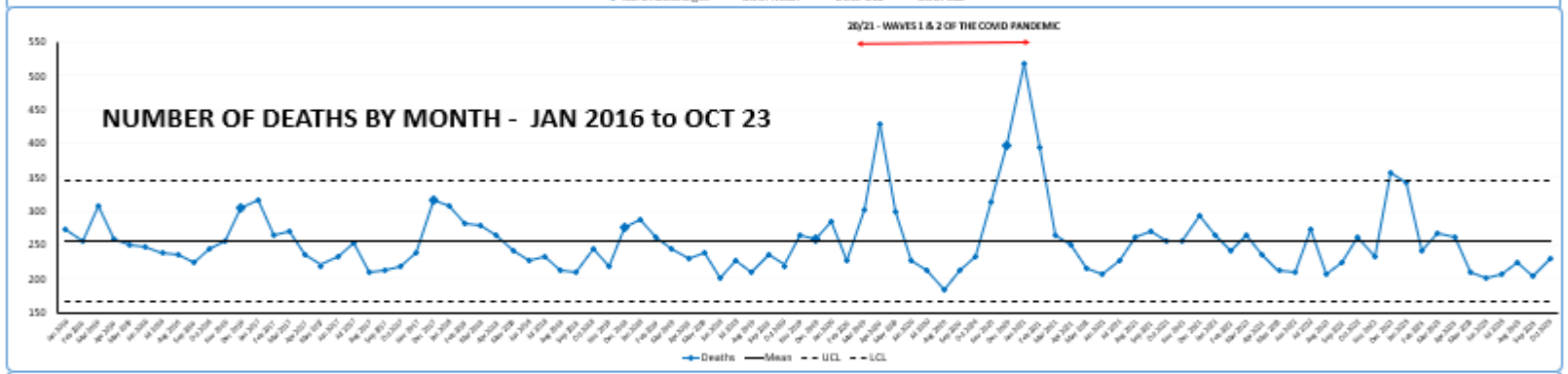
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Total
Activity	8238	9023	8662	8650	9571	9481	9399	9900	8556	9369	9599	10364	8622	10313	10434	9959	10622	10354	10755	181871
Deaths	6	3	5	6	8	10	6	7	7	1	5	8	8	6	3	8	4	6	6	113
%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%

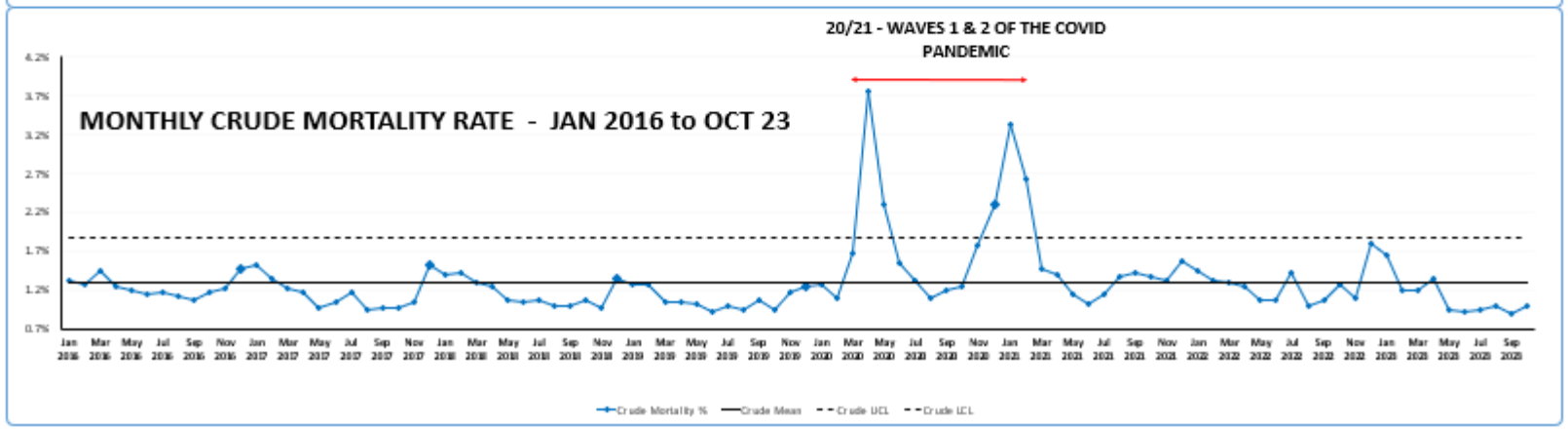
Non Elective Activity

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Total
Activity	10513	10889	10820	10469	10964	11221	11040	11382	11162	11467	10631	12085	11019	11465	11510	11677	11906	11838	12073	214131
Deaths	231	210	204	266	199	213	256	226	350	343	237	260	255	203	199	198	221	197	224	4492
%	2.2%	1.9%	1.9%	2.5%	1.8%	1.9%	2.3%	2.0%	3.1%	3.0%	2.2%	2.2%	2.3%	1.8%	1.7%	1.7%	1.9%	1.7%	1.9%	2.1%

UHL's Crude Monthly In-Patient Activity & Mortality





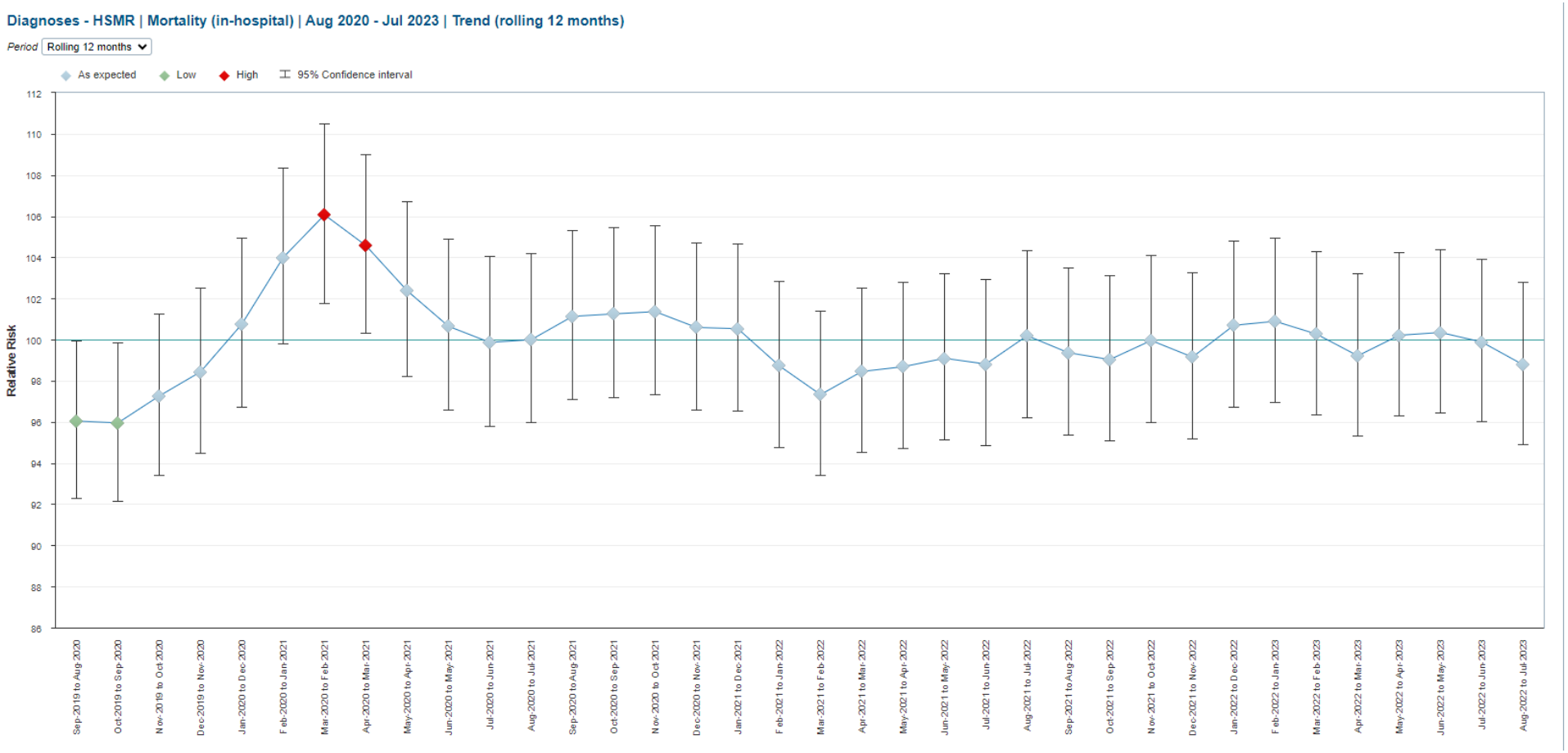


We saw the lowest number of deaths in September since before 2016. Activity was also up on previous years therefore our overall crude mortality rate for this month was the lowest we've ever seen.

The number of deaths in October increased to 230 but is still lower than for the same month in the past 3 years

Our risk adjusted mortality data does not yet capture these more recent months and obviously other Trusts may have seen a similar drop in numbers of deaths.

UHL's Rolling 12 month HSMR (Sep 19/Aug 20 to Aug 22/Jul 23)



UHL's HSMR has been within expected since the COVID peak but has inconsistently been below 100.

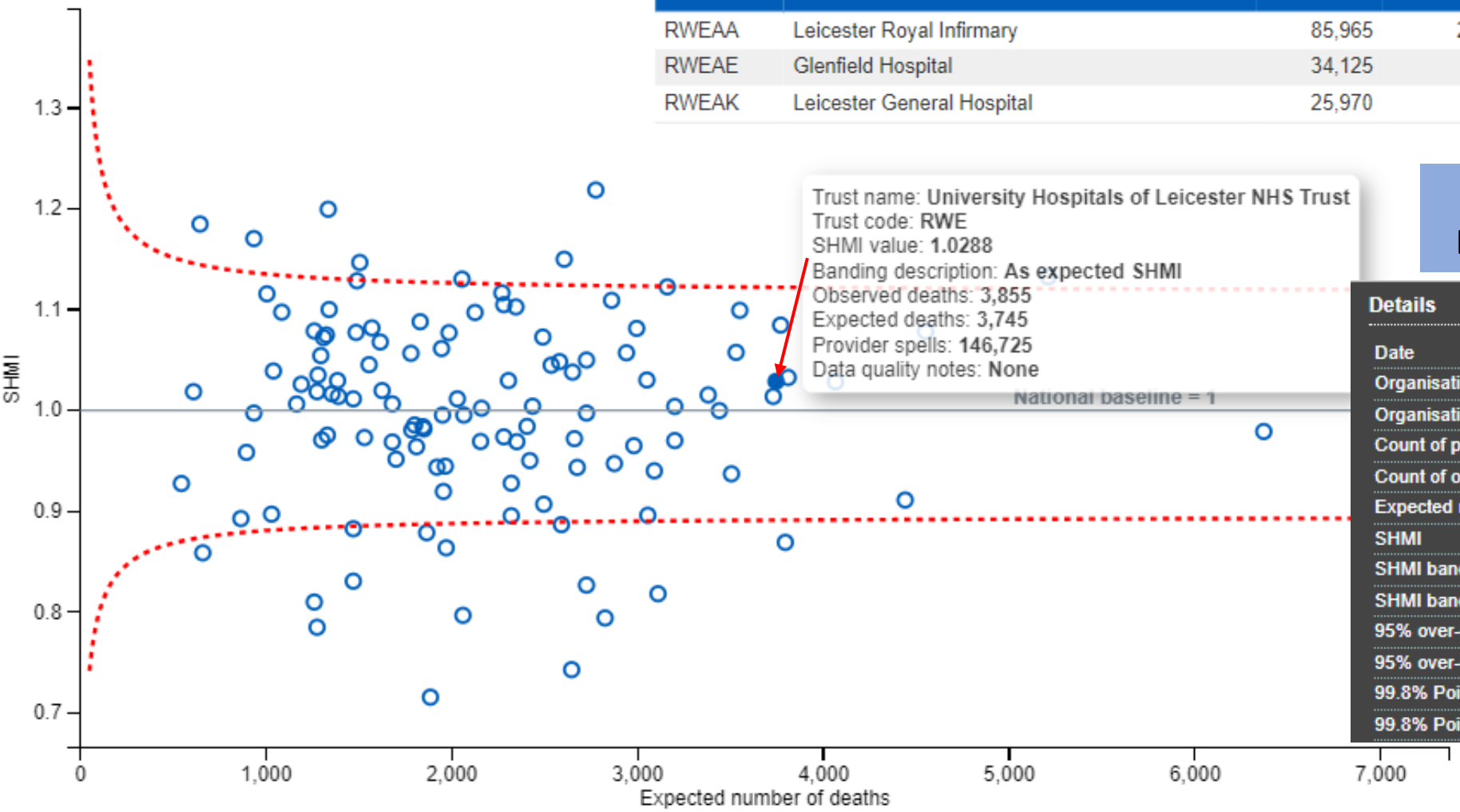
UHL's LATEST PUBLISHED SHMI

Summary Hospital-level Mortality Indicator (SHMI), England, June 2022 - May 2023

Funnel plot Return to contents

- UHL's latest published SHMI is 103

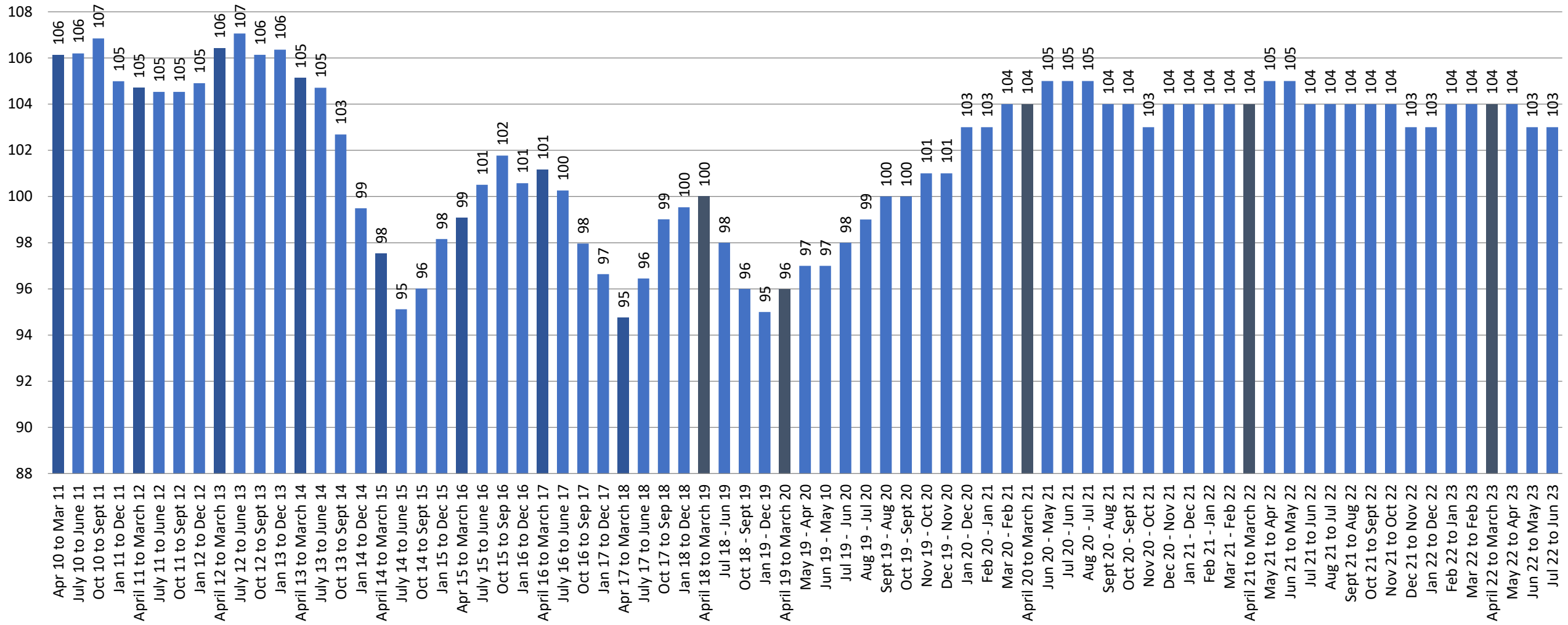
Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
RWEAA	Leicester Royal Infirmary	85,965	2,835	2,425	1.1702	As expected SHMI
RWEAE	Glenfield Hospital	34,125	925	1,185	0.7814	Lower than expected SHMI
RWEAK	Leicester General Hospital	25,970	90	135	0.6672	Lower than expected SHMI



UHL'S SHMI JUL 22 – JUN 23
DUE TO BE PUBLISHED 09/11/23

Details	
Date	July 2022 – June 2023
Organisation code	RWE
Organisation name	UNIVERSITY HOSPITA
Count of provider spells	147872
Count of observed events	3859
Expected number of events calculated by the risk model	3763.89
SHMI	1.03
SHMI banding	2
SHMI banding description	As expected
95% over-dispersion lower control limit	0.8913
95% over-dispersion upper control limit	1.122
99.8% Poisson lower control limit	0.9504
99.8% Poisson upper control limit	1.0514

UHL's SHMI from 2010/11 to Jul 22/Jun 23 (Published Quarterly 10/11 to 18/19; Monthly thereafter)



UHL's SHMI continues to be above 100 and within expected.