University Hospitals of Leicester NHS
NHS Trust

Meeting title:	TRUST BOARD **Public Trust Board paper G**
Date of the meeting:	14.09.23
Title:	UHL MORTALITY AND LEARNING FROM DEATHS QUARTERLY REPORT
Report presented by:	ANDREW FURLONG, MEDICAL DIRECTOR
Report written by:	REBECCA BROUGTON, HEAD OF LEARNING FROM DEATHS DR PENNY McPARLAND, CONS OBSTETRICIAN & CHAIR OF PMRG

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Mortality Review Committee – 01.08.23 Trust Patient Safety Committee – 15.08.23 Trust Board Quality Committee – 31.08.23					

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 measure (SHMI) and also delivery of Death Certification, Medical Examiner (ME) 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 Ration (56 diagnosis groups in hospital deaths); MRC – Mortality Review 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

Trust Board is asked to note 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)
    - HM Senior Coroner's request to refer all deaths which may be due to problems in care
    - 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

UHL's crude mortality has fallen and our risk adjusted mortality indicators are within the expected range.

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 received confirmation that the national planned roll out for the Medical Examiner process across primary care has been postponed to April 24. In the interim, we continue to engage with local GP Practices, LOROS and LPT.

Due to close liaison between the Bereavement Services and Medical Examiner Offices with support from clinical teams, we continue to meet the national requirements related to death registration and the ME process despite the bank holidays in Quarter 1 and industrial action by medical staff.

Our Bereavement Nurses have seen increased numbers of referrals and further increases are anticipated as the ME process includes more primary care deaths where patients die soon after discharge from UHL.

During Quarter 1, reports were received from the Perinatal Mortality Review Group with details of analysis and improvement actions undertaken following the most recent MBRRACE publication which showed UHL's neonatal mortality rate to be >5% higher than our peer group. External reviews (HSIB, Peer Trust) have not identified any recurrent themes, but we continue to carry out individual and cluster reviews internally and are looking at developing an ongoing process for external input into our review process. A further update report will be taken to the October Quality Committee.

Following discussions with HM Senior Coroner, a process has been agreed for earlier referral to the Coroner's Office if the Medical Examiner thinks there may be problems in care which possibly affected outcome (the current process would be to refer to the Coroner if there has been a patient safety incident escalated at the time of death). We have also agreed a process for retrospective referral of 16 deaths over the last 5 years where death was considered more likely than not due to problems in care that previously had not been reported to the Coroner.

Main report detail

1. UHL's crude mortality for Quarter 1 in 23/24 is 1%. Our latest risk adjusted mortality indicators (SHMI and HSMR) cover the financial year 2022/23 and are both within expected - SHMI is 104 and HSMR 98.4.

2. In response to CuSUM Alerts in the Dr Foster (DFI) Healthcare Intelligence dashboard, MRC have undertaken reviews for 2 groups:
   - Other diseases of veins and lymphatics – alerted because of 2 deaths (no deaths 'expected' in this diagnosis group). Both patients had metastatic cancer – no issues with care identified for either.
   - Removal of Metalware - all deaths related to emergency admission/surgery and were of different areas different areas of metal work and timescales since surgery. Agreed to ask the Trauma and Orthopaedic M&M to review further.

3. There is one diagnosis group with a higher SHMI value than expected in our latest SHMI data - 'Septicaemia (except in Labour). More detailed analysis was presented by our DFI Consultant at the August MRC and the Deteriorating Patient Board will correlate with internal monitoring data. Following national changes, a relaunch of the Sepsis care pathway is planned and ongoing improvement work on sepsis pathways is proposed as a priority for the Year 1 Patient Safety Incident Response Framework (PSIRF) work programme.

4. The August MRC received the Quarterly report from the Perinatal Mortality Review Group and noted the findings of the detailed reviews undertaken and actions in progress in respect of our 2021 neonatal mortality which was >5% higher than our peer group in the latest Perinatal Mortality MBRRACE-UK report.

5. We continue our rigorous mortality review process for all perinatal deaths through both the Perinatal Mortality Review Group and the use of HSIB and/or Serious Incident Investigations where applicable. Details of cases reviewed in Quarter 1 with identified learning and agreed actions were reviewed at the August Quality Committee.

6. We have also reviewed the DFI data to see if we can use this to benchmark our perinatal mortality whilst awaiting the MBRRACE publications. However, we have not yet found an effective way of using the data due to the limitations of the DFI risk adjustment methodology for deliveries and the different approaches taken by Trusts to recording obstetric activity. We are currently revisiting the DFI data to see if it is possible to accurately compare crude mortality by Ethnicity and Deprivation.

7. In respect of our Learning from Deaths programme, the number of primary care referrals to the Medical Examiner office has fallen following confirmation that the planned mandatory implementation has been deferred until April 2024. We continue to receive referrals from both the Community Hospitals and Hospices

8. We saw a slight drop in 'turn around times' for cause of death discussions and MCCD completion in May due to the 3 Bank Holidays but we were able to improve performance in June despite the Industrial Action.

9. Following a recent meeting with HM Senior Coroner, a process has been agreed for earlier referral to the Coroner's Office if the Medical Examiner thinks there may be problems in care which possibly affected outcome (the current process would be to refer to the Coroner if there has been a patient safety incident escalated at the time of death).

10. It was also agreed that there should be a retrospective referral to HM Coroner for 16 cases where death was considered to be more likely than not due to problems in care (following Specialty M&M and MRC discussion) but there had not been a referral made to the Coroner as part of the Medical Examiner process. The 16 cases span a 5-year period (the earliest being in 2018).

11. The Bereavement Nurses have seen an increase in the number of referrals from Medical Examiners speaking to bereaved relatives of patients who have died in the community but were recently in UHL.

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. Learning themes from Medical examiner screening, bereaved relatives' feedback and specialty reviews were collated for consideration as part of UHL's Year 1 PSIRF work programme. Themes include: Septicaemia, Anticoagulation and Ward Round Reviews.

14. Since the last Quarterly Report, MRC members have received details of 3 adult deaths that were considered to be more likely than not due to problems in care. Details of the learning and actions being taken were reviewed at the August Quality Committee.