University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper H

Meeting title:	Trust Board
Date of the meeting:	12 September 2024
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

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Mortality Review Committee – 06/08/24 Trust Safety Committee – 20/08/24 TB QUALITY COMMITTEE – 29/08/24					

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.

This report provides details of actions being taken in respect of LfD actions relating to the Risk 3961

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

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 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.
- Review of Learning themes from 19/20-23/24 triangulates with ongoing active patient safety work programmes at UHL.
- Our learning from deaths programme is supporting identification of learning to improve the outcomes of future patients and plans are in place to meet:
    - Statutory requirements in respect of the Medical Examiner process being implemented across all of Leicester, Leicestershire and Rutland (LLR) from 9th September 2024
    - HM Senior Coroner's request to refer all deaths which may be due to problems in care
    - Reporting of child deaths to the Child Death Overview Panel (CDOP) and 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 for 24/25 to date is 0.88% and continues to be at its lowest since we started reporting. Our risk adjusted mortality indicators (HSMR & SHMI) remain 'within expected'.

Changes to risk adjustment and UHL's current coding practice may cause changes to our adjusted mortality indicators.

We have recently undertaken a review of all deaths in the past 5 years considered to be more likely than not due to problems in care to see if there are any cross-cutting themes and to cross reference with existing quality improvement workstreams.

We are routinely receiving referrals from LPT and LOROS to the Medical Examiner officer and appear to be seeing a steady increase in number of Primary Care. Practices to ensure we have the correct details and also share information about the ME process ahead of the 'launch date' of 9th September.

We have maintained our improved 'turn around times' for identifying relevant doctors to discuss causes of death with the Medical Examiner and with proportionate scrutiny.

We have submitted our Quarter 1 data to the National ME Office.

The quarterly Perinatal Mortality report was reviewed at the August MRC which included outcomes of reviews undertaken by the Perinatal Mortality Review Group of deaths between September 23 and March 24.

In the last quarter, 2 deaths were considered to be more likely than not due to problems in care.

Main report detail

1. UHL's crude mortality rate for the first 4 months of 24/25 still remains low at 0.88%.

2. Both risk adjusted indicators (HSMR and SHMI) are in line with the national average (within expected). UHL's latest SHMI is 99 (for the 12 months March 23 to February 24) and our HSMR is 100 (for the 12 months April 2023 to March 2024)

3. At the August MRC, members reviewed the Dr Foster Intelligence quarterly report on UHL's risk adjusted mortality and discussed in detail the reasons for UHL's "expected mortality rate" seeming to be lower than other Trusts and how our comorbidity index score has dropped in the past 3 years from 114 to 89. There is existing work at UHL to improve coding; however challenges and risk remain.

4. Improving our documentation and coding of comorbidities will be particularly important as TelstraHealth (DFI) are planning to change their methodology for calculating 'expected mortality rates' and will now be using the Elixhauser-Bottle co-morbidity index. UHL's relative risk is predicted to increase with the change of the risk adjustment.

5. Members also considered how Frailty is captured in the Dr Foster benchmarking tool using clinical coding data for over 75-year-old patients and how this compared with UHL's recording of Frailty (which is based on the Rockwood Frailty Score). The MD team is active pursuing the establishment of a clinical frailty lead.

6. MRC members received the latest Quarterly report from the Perinatal Mortality Oversight Group (PMOSG). There have not been any immediate concerns re care raised although there are emerging learning themes around 'late booking' and maternal substance misuse.

7. The Chair of the Perinatal Mortality Review Group (PMRG) presented details of learning and actions identified through perinatal reviews completed for deaths between October 23 and March 24 as reported to MBRRACE to the August MRC and TB Quality Committee. No deaths were felt to be due to problems in care.

8. Members were advised that all 2023 deaths have now been reviewed and none to date had been given a Category D (i.e. issues in care likely to have affected outcome). The next steps are for the PMRG Chair and Neonatal M&M Lead to look across the individual review findings for 2023 to identify any cross-cutting themes and confirm if appropriate improvement actions being taken.

9. In respect of our wider Learning from Deaths programme, there has been a continued increase in numbers of referrals from Primary Care as the 9th September deadline for statutory review of all deaths approaches.

10. We have completed our recruitment for both Medical Examiners and ME Officers and we are in the process of making phone calls to each LLR GP Practice to ensure we have correct contact details and to encourage GPs to try out the process before the 9th September.

11. We have increased the proportion of patients receiving verbal follow up from the Bereavement Support Nurses following a slight change to our process. We are looking at how to sustain this approach going forwards.

12. The Learning from Deaths team have been liaising with Specialty M&M Leads in respect of 23/24 SJRs and 85% of reviews have now been completed. Learning themes continue to be around Assessment, Diagnosis and Management Plans; Multi-Disciplinary Team working and Monitoring, Recognition and Escalation/Ceiling of Treatment. These themes interlink with some of the clinical areas of risk identified through other sources (e.g. safety incidents) with 'capacity issues' and 'cross site working' being interlinked to all 3 themes.

13. We have carried out a review of the 55 deaths (between 2019 and 2024) that were considered to be more likely than not due to problems in care. A summary of the learning themes and the actions being taken to improve care was presented to the August TB Quality Committee.

14. Delays to or missed diagnosis, medications management and escalation were the most common area of learning. These themes are consistent with areas of learning seen across all deaths reviewed and are in line with other sources of data (e.g. clinical incidents, clinical risks, complaints about care), and form core priorities within our PSRIF strategy as well our eHospital program which aims to use digital technology to reduce risk associated with miscommunication.

15. We continue to work closely with the Patient Safety Team and members of the LfD team have attended PSIRF meetings to better align the two processes and avoid duplication of effort. The plan will be to do more of this as we release resource back into the LfD Team, once the new Clinical MEOs are fully inducted and the 9th September implementation phase completed.

16. Since the last Quarterly Report, MRC members reviewed 2 adult deaths which were considered be more likely than not due to problems in care following SJR/SI Investigation. Further information has been requested about one of the cases following review by MRC members. Details of the other case and actions being taken were reviewed at the August MRC and TB Quality Committee.