University Hospitals of Leicester NHS
NHS Trust

Public Trust Board Paper G

Meeting title:	Trust Board
Date of the meeting:	13 June 2024
Title:	UHL Mortality and Learning from Deaths Quarterly Report
Report presented by:	Dan Barnes, Deputy Medical Director
Report written by:	Rebecca Broughton, 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 – 07/05/24 Patient safety Committee – 21/05/24 Quality Committee – 30/05/24					

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); MRC - Mortality review Committee; PSIRF – Patient Safety Incident Response Framework

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 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 that 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:
    - 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 23/24 was 1.0% - the lowest it has been since we started reporting. Our risk adjusted mortality indicators are within the expected range - UHL's latest SHMI is 101 (for the 12 months January to December 2023) and our HSMR is 98.5 (for the 12 months February 2023 to January 2024)

We continue to undertake further analysis, benchmarking and cross referencing with our Learning from Deaths data for any patient or diagnosis groups with an above expected relative risk to identify any areas for improvement in clinical care.

The quarterly Perinatal Mortality report was reviewed at the May Mortality Review and Quality Committees with details of cases reviewed during Quarters 2 and 3 by the Perinatal Mortality Review Group. MRC also reviewed the latest MBRRACE report on UHL's Perinatal mortality for 2022 and noted the work being undertaken in relation to neonatal deaths.

We are routinely receiving referrals from LPT and LOROS to the Medical Examiner officer and saw a significant increase of primary care referrals in early April when it was thought the new mandatory process would start, but this has now reduced following announcement of a delay in the date for statutory reporting. We are working with ICB colleagues to look at how to further improve GP engagement ahead of the deferred Statutory requirement - now confirmed as 9th September 2024.

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, although there was a drop in performance in January due to the combination of increased activity, post-Christmas bank holidays and junior doctor industrial action.

We have submitted our Quarter 4 data to the National ME Office and await confirmation of income.

We continue to follow up the outcome of Structured Judgement reviews undertaken by Specialty M&Ms, with particular focus on those SJRs requested where the Medical Examiner felt there may potentially be problems in care.

In the last quarter, 3 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 financial year 23/24 was 1.0% - this was the lowest FYE crude mortality rate since first reported to the Committee (December 2013). Whilst some of this will be related to increased activity (higher in 23/24 than in 19/20 pre COVID) the actual number of deaths is also the lowest seen.

2. This is a similar picture when looking at our crude mortality by CMG, type of admission and site.

3. Both risk adjusted indicators (HSMR and SHMI) are in line with the national average – neither includes the full 2023/24 data yet.

4. Our SHMI is now 101 for the 12 months January to December 2023 and our HSMR is 98.5 for the 12 months February 2023 to January 2024. Both indicators vary slightly in terms of which activity is included but both also show UHL's crude mortality to be lower than the national average, however our 'expected mortality rate' is also lower than both the national and regional average.

5. Our TelstraHealth (Dr Foster) Consultant has advised that this is because our case mix appears to be less complex than other trusts (i.e. we have a greater proportion of patients with fewer comorbidities). Members noted that there is currently a review of our clinical coding practices, but it may take several months to see what impact this has on our 'depth of coding' within the risk adjusted mortality data.

6. MRC members also reviewed details of the 50 diagnosis and procedure groups which have previously been discussed at the Committee because they either had an 'above expected' relative risk or have 'alerted' in the Dr Foster clinical benchmarking tool in the past 3 years. It was noted that all but 5 groups are now back 'within expected' (3 diagnosis groups and 2 procedure groups).

7. In respect of the 2 procedure groups MRC has recently received reports from the relevant Specialties:
    a. 'Removal of Metalware' the Trauma & Orthopaedics M&M Lead attended the February MRC where members were advised that for 2 of the 3 deaths (leading to the alert) care had been of a good standard but both patients were very frail. Learning had been identified for the third patient about availability of appropriate 'metalware removal' equipment in theatres and there was a long discussion about the use of the WHO theatre checklist and how to ensure a consistent culture.
    b. 'CABG Other' the Cardiac Surgery Audit Lead attended MRC and advised members that cardiac surgery is routinely monitored as part of the National NICOR audit which has a more clinically sensitive risk adjustment. UHL's mortality as reported NICOR is within expected albeit this may not show in the Dr Foster data set as NICOR provide a rolling 3-year figure.
    c. None of the cases reviewed in either procedure group were considered to be deaths that were more likely than not due to problems in care.

8. In respect of the 3 diagnosis groups
    a. 'Spondylosis, Intervertebral Disc Disorders and other Bank Problems' – currently being reviewed. Preliminary review suggests these are mainly patients with secondary metastases or chronic spinal problems/arthritis with some on immunotherapy.
    b. 'Senility and Organic Mental Disorders' – previously reviewed and appeared to be related to patients being admitted with delirium where the cause of this was not confirmed until they had transferred out of the assessment unit, and so a more significant condition was not the

primary diagnosis on admission. No issues in care identified in the previous alerting cohort when reviewed by the Geriatric M&M Lead but agreed to undertake a further review of the patients contributing to this most recent alert.

c. 'Other Perinatal Mortality' - it has been previously agreed that it would be more appropriate to monitor through the MBRRACE data which is reported on a Quarterly basis to MRC.

9. At the May MRC members received the latest Quarterly report from the Perinatal Mortality Oversight Group (PMOSG) and noted that our stillbirth rate is now back at our previous rate, but our neonatal rate is still higher than our peer group. Members also received an updated report on UHL's 2022 Perinatal Mortality as published by MBRRACE and UHL's interpretation of the results and a summary of actions being taken to address. A further meeting with Leeds Neonatal Unit took place on 15 May 2024 and there has also now been a wider group established with similar Trusts with Level 3 Units providing specialised care. A planned review of our Fetal Medicine pathways by colleagues from University College London Hospitals in July was noted.

10. MRC & QC received details of learning and actions identified through perinatal reviews completed for deaths between July and December 2023 as reported to MBRRACE. No deaths were considered to be more likely than not due to problems in care.

11. In respect of our Learning from Deaths programme, the number of primary care referrals to the Medical Examiner office at the end of 23/24 was more than in 22/23 but still only 20% of practices are referring cases to the ME office. There was a sudden increase in numbers at the beginning of April linked to the planned implementation date but once it was known this was delayed, there was a drop off in referrals.

12. We have now had confirmation that the Statutory process will begin on 9th September 2024. Initially the death certificate (MCCD) will continue to be paper, but this will now have to be signed by both the certifying doctor and Medical Examiner which will be a significant change to current practice. In addition the MCCD will replace the Cremation Form paperwork and so ensuring relevant additional information is included may cause some delays until the process is fully embedded.

13. We have been successful in recruiting additional Medical Examiners and as all are GPs, it is hoped they will be able to encourage increased engagement with their colleagues. We have also recruited Clinical Medical Examiner Officers who will be able to undertake some aspects of the ME process with appropriate clinical oversight by the MEs.

14. The plan is for both of the above to also work with practices between now and end of August to encourage them to 'test out' the process to have a better understanding of referral patterns and also give Practices an opportunity to familiarise themselves with what's involved.

15. Our turnaround times for both UHL and non UHL Medical Examiner cause of death discussions (and agreeing issuing of MCCD or referral to the Coroner) has improved from 22/23 but was affected by the Bank Holidays and Industrial Action. We have maintained performance for meeting requests for urgent certification and release of the deceased, both in and out of hours with support from the Mortuary and Duty Managers. We have also seen an increasing number of requests to support families of patients who have died soon after discharge from UHL.

16. Whilst positive feedback about end-of-life care was given to the Bereavement Nurses by 86% of bereaved spoken to, 5% felt end of life care was poor. 14% of bereaved raised concerns about some aspect of care when speaking to the Medical Examiner. Concerns for both groups predominantly related to poor communication and concerns about lack of dignity and compassion. These themes are fed back to clinical teams and also to the relevant UHL working groups.

17. The Learning from Deaths team have been liaising with Specialty M&M Leads in respect of 23/24 SJRs, but we are currently behind schedule with receiving and collating completed reviews. In addition to delays with sending out SJR requests there have also been some delays in cases being discussed due to several M&M Meetings being cancelled during the Industrial Action Periods. The Corporate LfD team are working closely with Specialty M&M Leads to ensure any SJRs requested due to potential problems in care are prioritised for completion.

18. Since the last Quarterly Report, MRC members have received details of 3 adult deaths which were considered to be more likely than not due to problems in care. Details of cases and actions being taken were discussed at MRC & QC – actions are tracked to ensure learning is embedded.

19. Following discussion at the M&M Leads meeting, work is underway to look at how to better align the Learning from Deaths process with UHL's PSIRF to make most effective use of clinical teams' time and to align learning and actions.