University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper K

Meeting title:	TRUST BOARD
Date of the meeting:	9 October 2025
Title:	UHL MORTALITY AND LEARNING FROM DEATHS QUARTERLY REPORT
Report presented by:	Andrew Furlong, Medical Director
Report written by:	Gang Xu, Deputy Medical Director Rebeca Broughton, Head of Learning from Death

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Mortality Review Committee – 05.08.25 Patient Safety Committee – 19.08.25 Trust Board Quality Committee – 28.08.25					

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 Ratio (56 diagnosis groups in hospital deaths); CUSUM - Cumulative Sum Control Charts; NICOR (the national cardiac surgery audit data); PSII Patient Safety Incident Investigation
M&M – Morbidity & Mortlaity

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

Summary

Trust Board is asked to be assured by actions taken to:

- Monitor our crude and risk adjusted mortality rates using SHMI and HSMR.
- Meet the Statutory requirements in respect of the expanded Medical Examiner process implemented across all of Leicester, Leicestershire and Rutland (LLR).
- Progress learning from the annual child death report and the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries group – (MBRRACE)

Mortality Metrics:

For the Financial Year (24/25), UHL's crude mortality rate is in line with the England average for elective admissions and below the England average for emergency admissions.

Indicator	Value	England average
Admission method		
Crude percentage mortality rate for elective admissions	1.0	1.0
Crude percentage mortality rate for non-elective admissions	2.6	3.4

Our SHMI for the same time period (April 2024 to March 2025) data sits at 0.99, within expected range using NHS England's 95% control limits adjusted for over-dispersion (Figure 1).

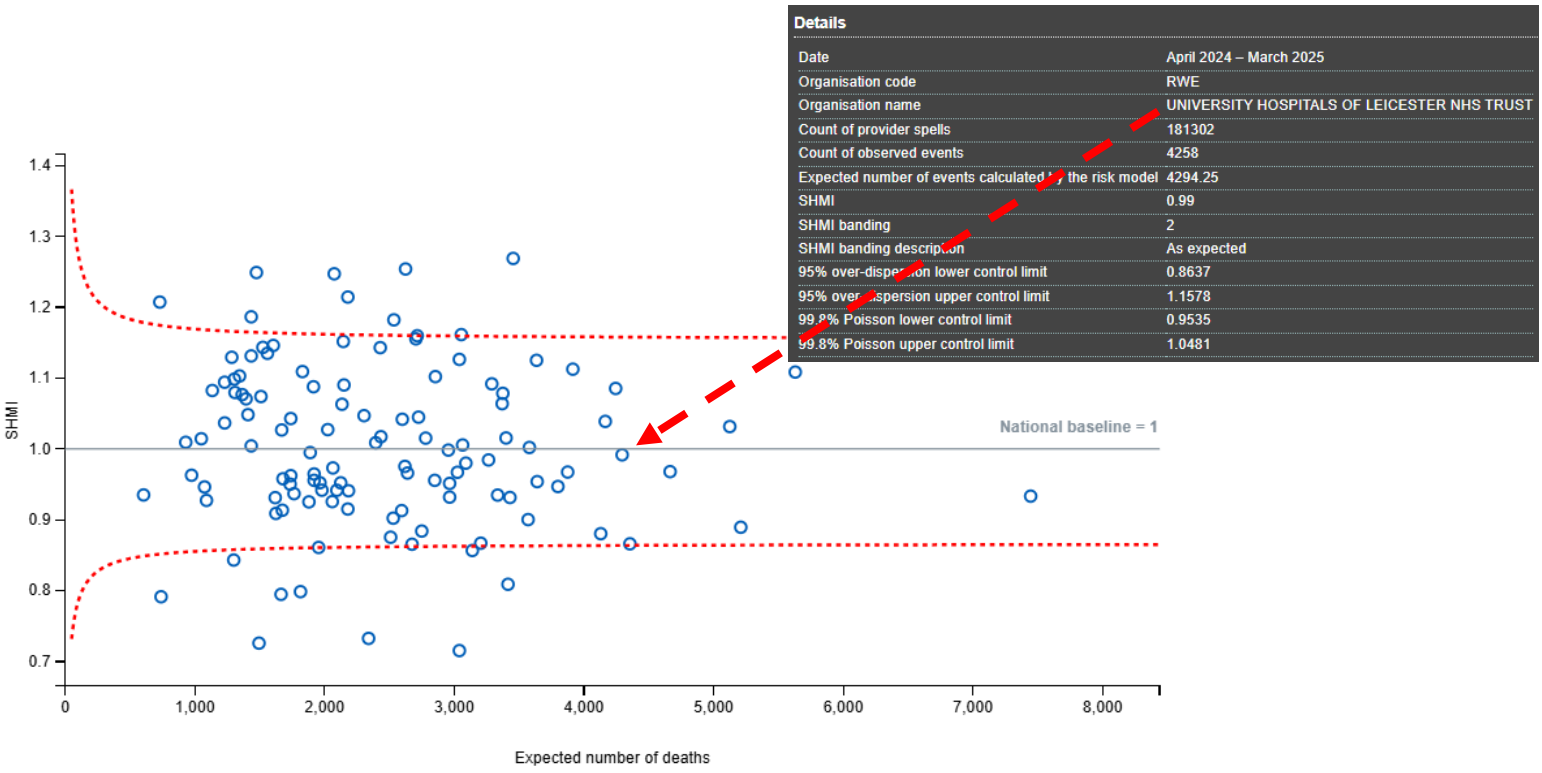

Figure 1: UHL SHMI vs Other NHS Trusts funnel plot.

Previously we reported concerns regarding UHL's depth of coding for co-morbidity data. The national SHMI is still using data prior to most of the changes made to our coding process (a new co-morbidity validation SPO was approved for use at the start of May 2025).

UHL's 12 month rolling HSMR value is 101.64 - within expected range

LLR Medical Examiner Service:

The LLR Medical Examiner Service 'turn around times' have improved following the initial 'post implementation phase' and increased winter activity.

The number of new cases being referred to the ME office is unpredictable (ranging from 20 to 75 each day) but Mondays and Tuesdays are usually the days when most deaths are referred through.

The 'time from referral' to sending of MCCD to the Registrars does not change much for UHL deaths as we are aware of UHL deaths on the day/next working day. However, there is a significant difference for Non UHL deaths as the turnaround time for non UHL deaths is very much affected by time taken by the GP, LPT or LOROS to refer to the ME office as we have not yet been able to establish a process for being informed directly of deaths in the community.

Ongoing actions being taken to try and maintain a sustained improvement are:

- Current staff working extra hours to cover vacancies (until new staff start in August and September)
- Successful recruitment to vacancies both (Medical Examiners and Clinical Medical Examiner Officers)
- Discussion with the ICB and LMC to see how to improve the referral process and information provided (to reduce 'email traffic')
- Meetings held with both the Leicester and Leicestershire/Rutland Coroners to seek further clarity on referral criteria
- Transitioning our 'ME Tracking' system to Teams (more conducive to multiple users)
- Further streamlining of processes within the ME Office to reduce 'hand offs'
- Triaging of EMAS Notification of Death emails and proactively contacting the GP surgery to request a referral – where information suggests a natural cause of death
- Liaising with UHL Clinical Teams to support death certification by UHL clinicians where deceased was 'fast tracked' to a new care home and not yet seen by any of the GPs as only just registered with the Practice
- Further discussions with the UHL Clinical Information Officers about scoping of a Case Management System (as the proposed national solution is still not a viable option)

Learning from Deaths in UHL:

Structure Judgement Reviews:

The Corporate LfD Team Leader/Analyst has developed an LfD dashboard as part of her MultiVerse Apprenticeship.

24/25 Learning from Deaths

Of the 3051 Adult UHL deaths in 24/25, Structured Judgement Reviews were requested for 212 deaths. Most were due to the death meeting the Specialty's M&M criteria – e.g. death within 30 days of chemotherapy or the national criteria such as death post elective surgery.

80% of the SJRs requested for adult deaths in 24/25 deaths have been completed with the case then being discussed at the Specialty M&M meeting. The remainder are on track for completion by our next quarterly report.

Learning was identified in a third of completed reviews. Theming is in progress but Assessment, Diagnosis and Management (including both recognition of diagnosis; delays in treatment/surgery) and Communication (both between clinical teams and between clinicians and patient/family) appear to be the most frequently seen themes. The finalised theming of identified learning will be presented to the Quality Committee at our next quarterly review.

4 deaths were considered to be more likely than not to be due to problems in care – all have been previously reported to the Patient Safety Committee and Trust Board Quality Committee.

25/26 Learning from Deaths

Of the 950 deaths in UHL between April and July, 55 SJRs have been requested for Adult Deaths (all neonatal deaths are automatically subject to review by the Perinatal Mortality Review Group (PMRG) and all child deaths are reviews as part of the Child Death Review process)

Following the introduction of the national Patient Safety Incident Response Framework, the Learning from Deaths team has been working closely with the Medical Examiner Office and any cases referred to the Coroner because of concerns about care are being flagged for consideration of an early 'Tabletop' review so any immediate actions are identified whilst awaiting the outcome of an SJR or full Patient Safety Incident investigation as applicable.

Perinatal Mortality:

The Mortality Review and Trust Board Quality Committees also received the UHL Perinatal Mortality Quarterly Report, which showed during the last 12-month period, there were 41 stillbirths and 58 neonatal deaths, with a significant proportion involving congenital anomalies.

The Perinatal Mortality Review Tool (PMRT) was used to review cases for babies born between October 2024 to March 2025. No deaths were given a D Grading of Care (care issues likely to have made a difference to the outcome). There were two deaths where care issues may or may not have made a difference to outcome. Both deaths and learning identified have been reported through to the Trust Board Quality Committee. All actions identified are tracked on the Perinatal Mortality Review Group Action Log and progress reviewed at each meeting.

The 2023 MBRRACE report showed a reduction in stillbirth rates, aligning UHL with peer averages, but our neonatal mortality remains elevated.

The Mortality Review and Trust Board Quality Committees were advised of the preliminary findings of a review undertaken by the Chair of PMRG which looked at 2023 deaths of the 20 'term' babies

(37+weeks gestation) who died post-delivery – this was undertaken because analysis of the 2023 MBRRACE report suggested that there was a higher-than-expected number of deaths number of deaths at this gestation. 11 of the deaths had been referred at the time for an independent Maternity & Newborn Safety Investigation (MNSI).

Three of the 20 deaths in the term group had issues in care which may have affected the babies' outcome - two with antenatal care and one with neonatal care. However, there were no common themes and the care for all 3 of these babies had been subject to a Maternity & Newborn Safety Investigation. Safety recommendations were made for 2 cases. These recommendations have been actioned and are tracked through the Perinatal Assurance Committee.

Trust Board has previously been advised of the ongoing work to peer review our perinatal mortality learning and actions being taken to understand the wider determinants affecting our perinatal mortality - this work is monitored through the Perinatal Assurance and Trust Board Quality Committees.