

Public Trust Board Paper I

Meeting title:	Public Trust Board
Date of the meeting:	8 October 2026
Title:	UHL MORTALITY AND LEARNING FROM DEATHS QUARTERLY REPORT
Report presented by:	Gang Xu, 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 – 6 th August 2026 Patient Safety Committee - 18 th August 2026 Quality Committee – August 2026					

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); CUSUM - Cumulative Sum Control Charts; NICOR (the national cardiac surgery audit data); PSII Patient Safety Incident Investigation
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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

The Board is asked to be assured by actions taken including:

- Monitor our crude and risk adjusted mortality rates using SHMI and HSMR.
- Ongoing work to meet the Statutory requirements in respect of the expanded Medical Examiner process implemented across all of Leicester, Leicestershire and Rutland (LLR).
- Progress with our Learning from Deaths (LfD) programme which includes both Specialty reviews of adult deaths (either SJRs or clinical reviews) and also the work of our Perinatal Mortality Review Group (PMRG)
- Ongoing support of the Bereaved and using feedback received either by the ME office (MEO) or Bereavement Nurses (LfD)

Mortality:

UHL's crude mortality rate has been on a downward trend for the past 4 years and whilst our mortality rate will be positively impacted by an increase in activity, as can be seen below, the number of inpatient deaths remains low.

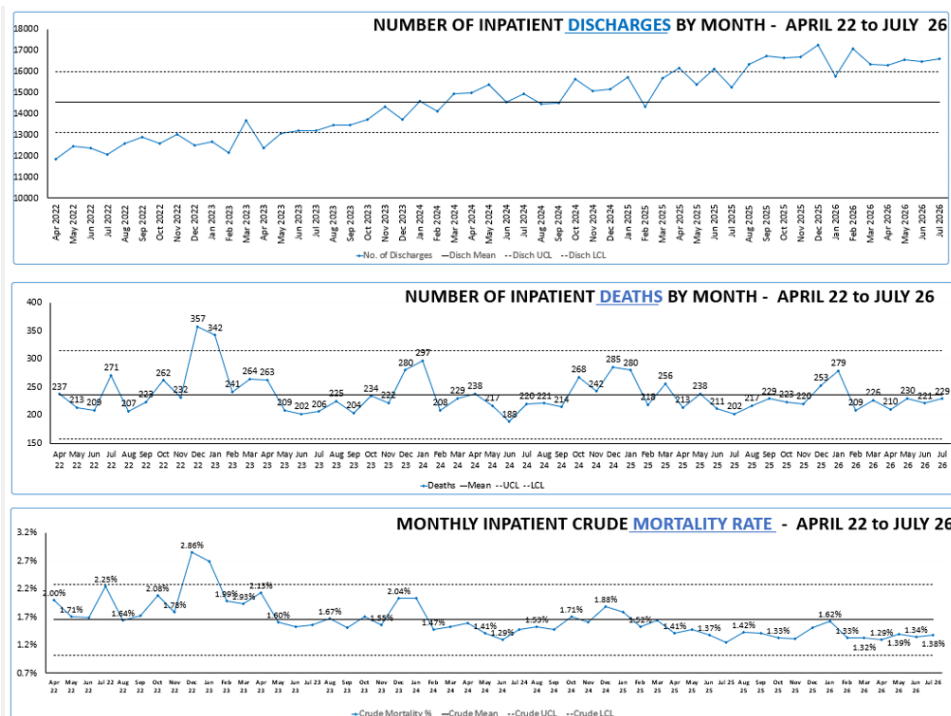


Figure 1 – UHL's Monthly Crude Mortality

Our crude mortality also compares favourably against the England average both for elective and emergency activity.

SHMI contextual indicators			
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		2.4	3.4

Figure 2 – UHL's Crude Mortality for Mar 25 to Feb 26 compared with the national average

UHL's risk adjusted mortality indicators remain reassuring with both our SHMI (94) and HSMR (97.95) being below the national benchmark of 100.

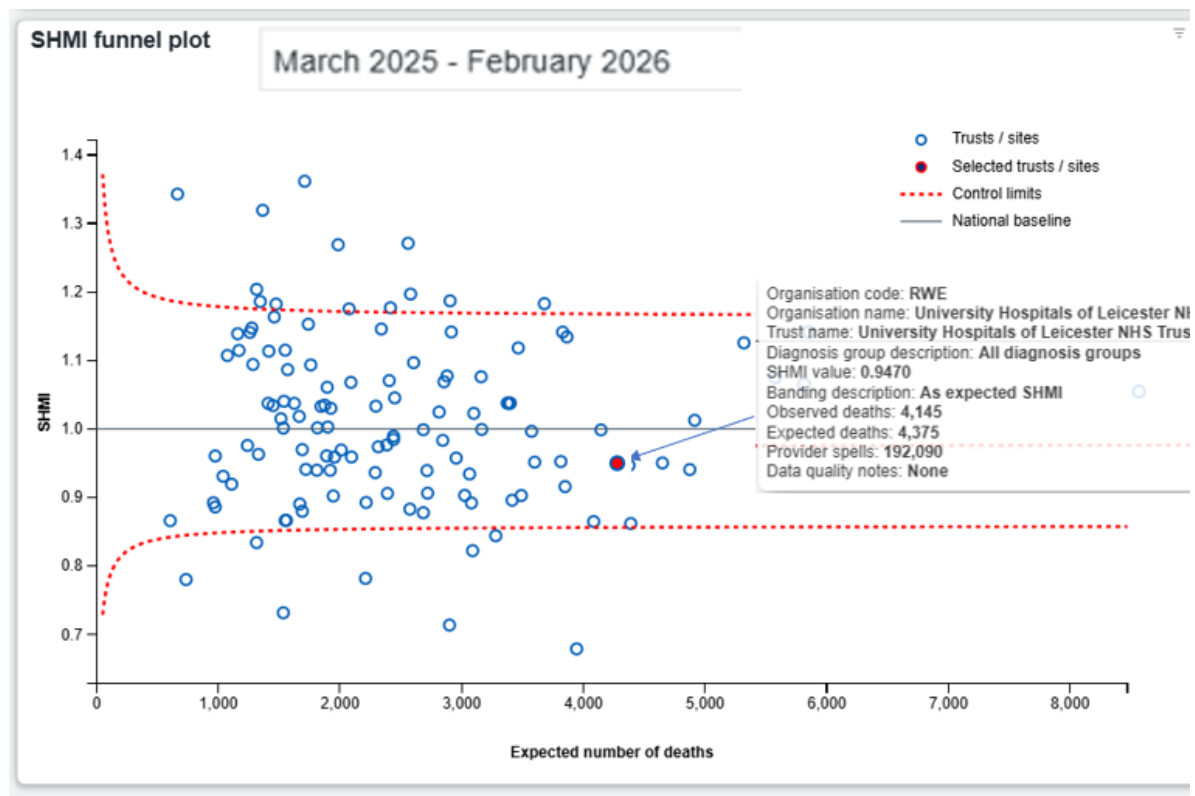


Figure 3 – UHL's Risk Adjusted SHMI value compared with other Trusts

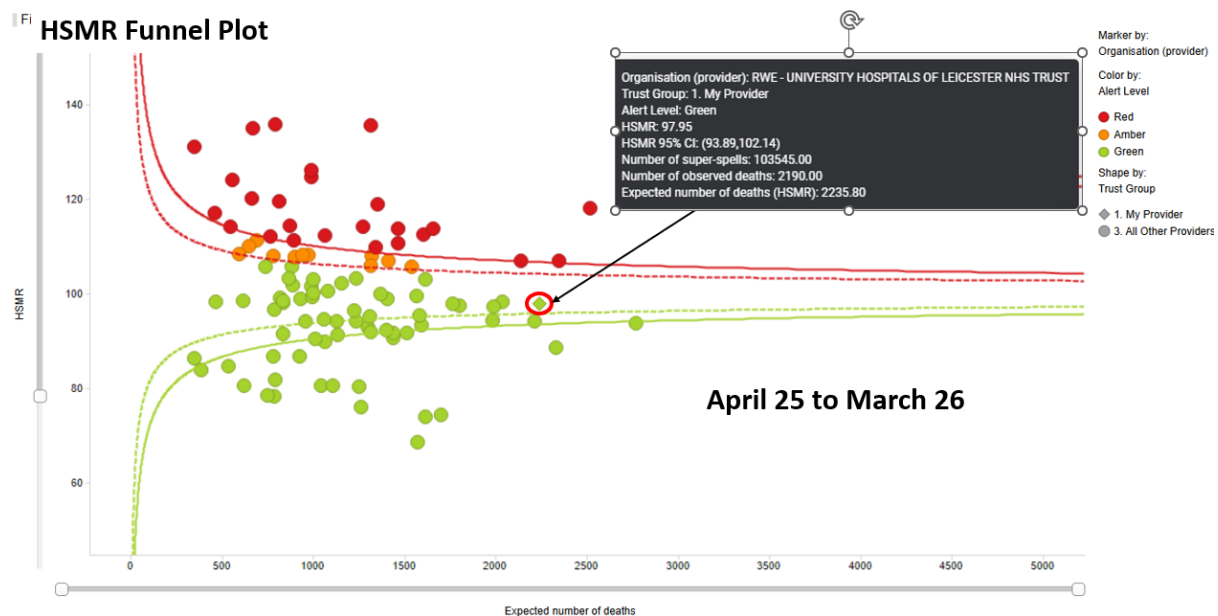


Figure 4 – UHL's Risk Adjusted HSMR value compared with other Trusts

The only diagnosis-group outlier is Acute Bronchitis, driven almost entirely by J22X (Unspecified Lower Respiratory Tract Infection) coding (slides 4 & 5). Given UHL's exceptionally high volume of

activity in this coding category (only 2 other Trusts have similar numbers of admissions), further review will focus on coding practice and case-mix before interpreting this as excess mortality.

Overall, the data suggests that our mortality outcomes remain in line with or better than expected for a trust of UHL's size and complexity – which appears to be supported by review of our 'causes of death' data for hospital deaths.

PERINATAL MORTALITY

At the August MRC, Chair of the Perinatal Mortality Review Group (PMRG) presented the Quarterly Perinatal Mortality Report.

It was noted the predicted Corrected number of neonatal deaths was much lower than in previous years but it is not yet known how this will compare with other Trusts.

Members also received details of cases reviewed where problems in care may have contributed to outcome. There was one death where it was thought that failure to identify a deteriorating baby likely contributed but this related to care in a different Trust prior to transfer to UHL

Following publication of the 2024 MBRRACE report, work continues to review deaths of babies born at 32-36 week to identify any patterns/themes.

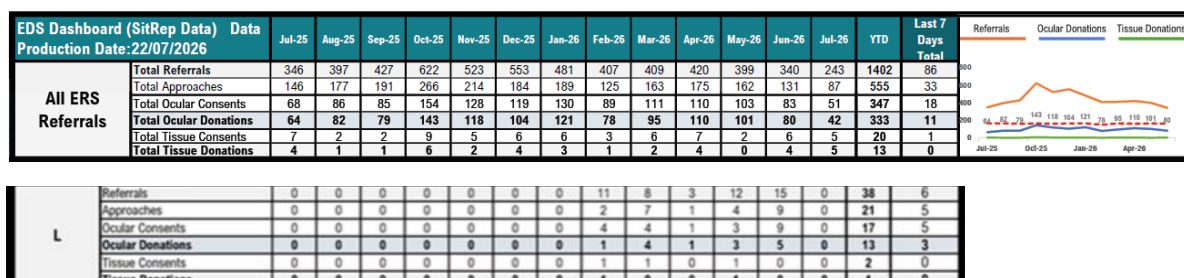
Bereavement Services

In Quarter 1 the Bereavement Services team have had several challenges due to the multiple bank holidays and also the Resident Doctors' strike after Easter but as previously the UHL Consultants have gone above and beyond to support the death certification process, often coming to discuss with the ME before/after their clinical shift or during 'lunch breaks'. This meant that the delays to families was kept to a minimum.

The Bereavement Officers are now routinely checking the Verification of Death list provided in NerveCentre and using the Case Notes function to identify doctors involved in the patient's care prior to death and both are having a positive impact on the effectiveness of the service.

During Quarter 1 the Bereavement Services (BSO) also started implementing the Eye Donation Scheme (EDS) for UHL –we are in the top 6 Trusts for numbers of hospital death. The NHS Blood and Transplant team has been asking UHL to sign up to the EDS programme for some time but without success. After discussion between the Bereavement and Medical Examiner Services, it was agreed to take on this work – to be lead by the UHL BSO with support from the ME Office (MEO) in respect of confirming clinical details and provisional causes of death.

In April we started at Glenfield and after a slow start (Glenfield Mortuary was undergoing refurbishment, identifying the most compassionate way to approach families) we had 13 deceased patients donate their eyes by July.



We have now started approaching families of deceased patients who have died at the LRI.

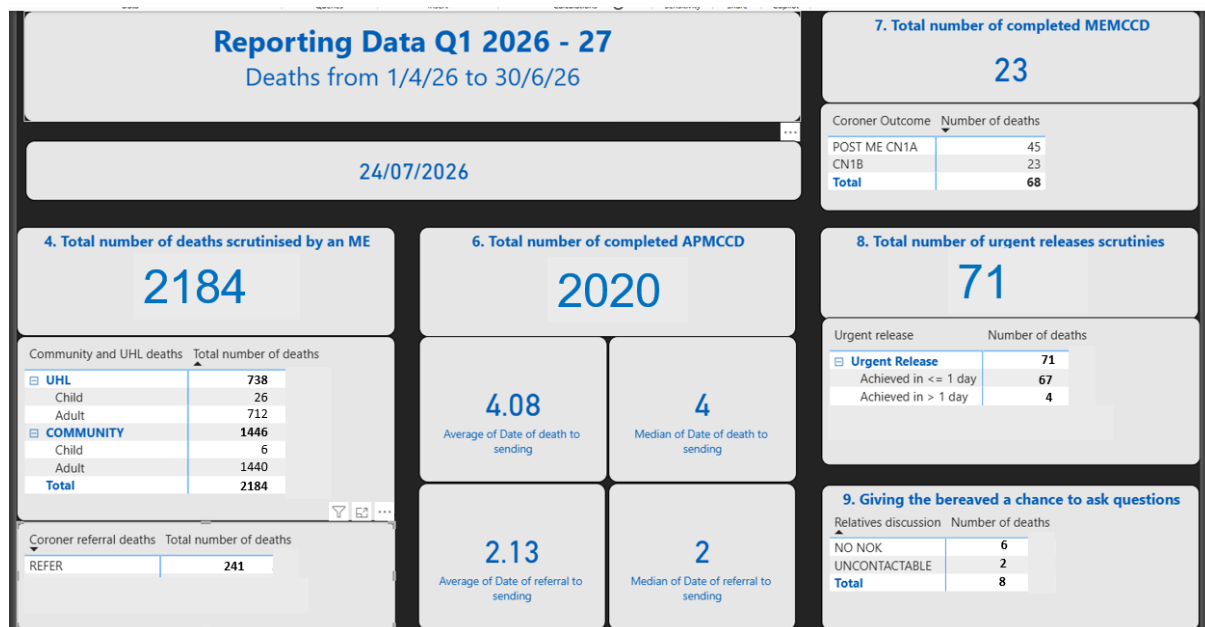
We hope to have recruited to the additional staff before the anticipated increase in activity during the winter months but there has been some delay due to capacity issues/unexpected bereavement within the LfD team and the changes made to the Recruitment process.

Lack of capacity has also impacted the work being undertaken to review the process for the management of Lost Property which still sits with the Bereavement Services office.

The Manager of the Bereavement Office and LfD Business Manager are having ongoing discussions with Estates in respect of the lack of an appropriately located Bereavement Family Room at the Glenfield Hospital (currently the team are using an old storeroom in Clinic D).

LLR Medical Examiner Service:

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



We continue to achieve better than average performance in terms of turn around times for the MCCD being sent to the Registrars (both from death and receipt of referral)

Time from Death to sending MCCD to the Registrars was 4 days for Quarters 3 and 4 (winter months) with the average across all ME Offices being 4.7. Time from receipt of referral to sending the MCCD was 2.6 days for the LLR ME Office against an average of 2.8.

The National Medical Examiner has recently disseminated ME Standards and preliminary review suggests we are meeting the majority of these. A full 'gap analysis' is in progress to consider if any actions needed.

A review of ME comments following their proportionate scrutiny of UHL records found that most screened deaths demonstrated appropriate clinical care and good end-of-life management.

The main recurring opportunities for improvement were:

- Communication with families
- Recognition of deterioration
- Documentation quality
- Timeliness of investigations and referrals

- Safeguarding of vulnerable patients
- Learning from procedural complications and falls

Feedback from the Bereaved to the ME Office was largely positive with families reporting good to excellent care and thanking staff for compassion, dignity and communication.

Recurrent themes for improvement were Communication, discharge planning, coordination between teams, timely updates to families, and availability of private end-of-life spaces.

Similar themes have been seen following ME screening of UHL deaths in Quarter 1 with key learning points being

- Continue strengthening communication with patients and families, particularly around prognosis and end-of-life decisions.
- Maintain thorough documentation of clinical reasoning, escalation decisions, and family discussions.
- Ensure robust pain and symptom management in challenging end-of-life cases.

Isolated cases raised safeguarding concerns, discharge-related queries, or opportunities for improvement in escalation and symptom management.

Learning from Deaths in UHL:

MRC members were advised that there are still 35 out of 173 SJRs outstanding for Adult deaths in 25/26 of but almost all have been through the Coroner's Inquest process with most being recognised complications of necessary procedures.

Where further reviews have been completed, most deaths were judged not to be caused by poor clinical care, but opportunities for improvement were identified around communication, documentation, escalation, specialist access, pathway design, imaging review, and learning disability support.

Cross cutting learning themes will be taken to the M&M Leads Forum being held on 17th September.

The Corporate team will also be seeking updates on identified actions in response to learning.

26 SJRs have been requested for Adult deaths in 26/27 to date.

The Corporate LfD team continues to work closely with the Patient Safety team, specifically in respect of cases where Medical Examiner scrutiny or feedback from relatives suggests there may have been problems in care which may have affected outcome.

Priorities for Quarter 3 include

- Reviewing and updating the MRC Terms of Reference and Work Programme
- Reviewing and updating the Learning from Deaths Policy, to make appropriate reference to the Trust's PSIRF and to review UHL's Death Classification for Adult Deaths
- Holding an M&M Leads Forum to consult on the above and to share learning, highlight available support for M&M Leads
- Confirming appropriate actions in place and on track relating to deaths reviewed in 25/26

Bereavement Support Service

The Bereavement Nurses continue to support the bereaved (predominantly where the death was in UHL) both in terms of their bereavement but also where they raise further questions or review outcomes awaiting

MRC Members received a summary of the feedback provided to the bereavement nurses in 25/26 when they made their follow up contact at 6-8 weeks post death and how this compared with the feedback given to the ME office (within a day or two after death).

As might be expected the two services capture different perspectives from the same families:

- ME Office feedback more often uncovers clinical, diagnostic and process-related concerns, including questions about cause of death, treatment decisions, delays, discharge, and whether care contributed to the outcome.
- BSN feedback primarily reflects the human experience of care, focusing on compassion, communication, support and end-of-life care.

This suggests the services are complementary: the ME office captures learning opportunities and concerns relating to the clinical journey and cause of death and whilst the Bereavement Nurses will also identify potential learning opportunities they also capture the lived experience of the bereaved and specifically aspects relating to end of life care

Conclusion

Mortality indicators remain reassuring (HSMR 97.95, SHMI 94).

The LfD reviews show relatively few deaths attributable to problems in care, with most learning centred around communication, documentation, escalation and pathway design.

Taken together, the data support a narrative that UHL is caring for a population with very high levels of complexity while maintaining mortality outcomes that are broadly in line with, or better than, national expectations.

And bereaved families of patients who die in UHL are well supported both in terms of understanding the cause of death and being given the opportunity to ask questions or raise concerns about care but also receiving support with the emotional impact of the death.