Mortality Report
Learning from Deaths

Quarter 4 2018/2019

Introduction

In December 2016 the CQC report Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England, identified that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. In March 2017 the National Quality Board published national guidance on learning from deaths to initiate a standardised approach to learning which includes a number of recommendations to be included into Trust's governance frameworks.

These recommendations include having a Director responsible for the learning from deaths agenda, a Non-Executive Director to take oversight of progress and implementing a systematic approach to identifying the deaths requiring review, with a robust and effective methodology for case record reviews.

Ongoing developments include specific guidance for NHS Trusts in working with families, published in July 2018 and the planned introduction of medical examiners now scheduled for implementation from April 2020. The aim of this new system is to make sure that all deaths not investigated through the coronial process are subject to a degree of independent scrutiny, with increased transparency for the bereaved and an opportunity for them to raise concerns.

A review of the first year of NHS Trusts implementing the Learning from Deaths National Guidance has recently been published by the CQC. This document highlights the progress that has been made with implementation of the Learning from Deaths Programme as observed during the CQC well-led inspections. The report acknowledges the early progress and the need for cultural change in the NHS, especially in respect of engagement with families. The Trust Learning from Deaths Policy will be amended to reflect these developments and the outcomes reported within this quarterly report

The report highlights several challenges for Trusts in the future. These include:

- Providing consistency in the way Trusts implement the role of the medical examiner, providing continuous safety improvement, and responding to complaints and concerns.

- Developing systems to allow learning from deaths that have occurred outside of a hospital, with effective information sharing across NHS providers.

- Improving support for staff as agreed across national bodies, including NHS Improvement and the Healthcare Safety Investigation Branch to enable them to carry out robust reviews and investigations of deaths and serious incidents.

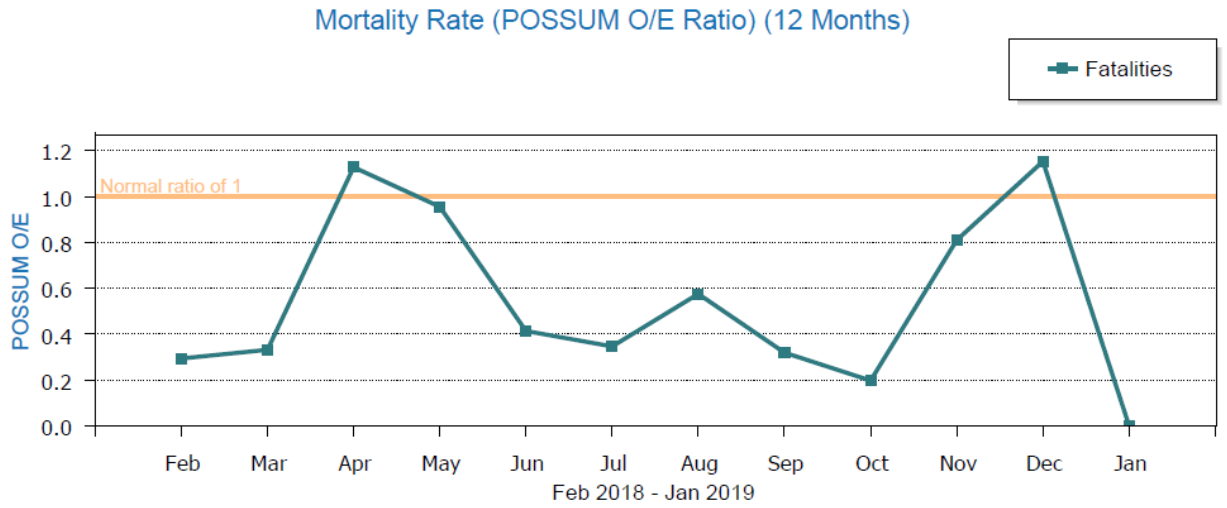
Mortality Rates

In hospital deaths per month

The number of deaths in hospital is captured through the Summary Hospital-Level Mortality Indicator (SHMI). This reports mortality at Trust level using a standard and transparent methodology which is published quarterly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Our latest SHMI covering 12 months October 2017 to September 2018 is 100.94. A review of data submissions which inform the SHMI will form a local indicator for the Quality Account for the current year.

The Trust has continued to use the Copelands Risk Adjusted Barometer (CRAB) to provide outcomes data. CRAB data defines the risk of mortality within certain groups of patients. The following table shows risk adjusted mortality over the last year in patients who have undergone surgery. The normal mortality O/E (observed number of adverse outcomes/predicted number of adverse outcomes) ratio for surgical patients is 1.00. The Trust has remained below this acceptable norm throughout the year. Drilling down into this data allows the Trust to identify any adverse outcomes and look at these in relation to volume of procedures performed.

Risk Adjusted Mortality



Please note at the time of writing January data has not been uploaded to this report.

The Clinical Outcomes Committee monitors outlier reports produced by CRAB and the Mortality Review group monitors speciality mortality reviews and has undertaken a review of deaths with more than 4 triggers which have occurred to identify opportunities for improvements in care.

It should be noted that the CRAB baseline data includes deaths within 30 days of discharge and is provided approximately six weeks after the patients' death. This means a percentage of these patients will have been reviewed as part of the routine mortality review process.

Hospital Standardised Mortality Ratio (HSMR)

The Trust continues to use Dr Foster to support analytical review of outcomes data. This includes reporting of the Hospital Standardised Mortality Ratio (HSMR), which reviews a set number of indicators to inform understanding of quality and improvements in clinical care. The Trust HSMR is reported at 86.6, rolling year as at December 2018, which is in the expected range against national benchmarks. This position has improved significantly over the last year.

The latest report from Dr Foster highlights the Trust's position as the second highest recorded palliative care rate across the local peer group. This reflects the visible and engaged Palliative Care Team who are seeing approximately 100 patients per month. A higher number of patients coded as receiving palliative care contribute to our significantly improved HSMR, as does effective coding of all patient diagnoses. It should be noted that a palliative care code removes the patient from the cohort analysed within the HSMR data set, therefore care is needed to ensure that the palliative care code is used correctly. To ensure accuracy we will be reviewing a sample of patient records to ensure that patients who have been reviewed by the palliative care team are categorised appropriately.

The Dr Foster data also shows that we continue to maintain a high level of reporting of significant comorbidities. Effective recording of comorbidities positively affects our HSMR as this figure is calculated by comparing the number of expected deaths with the actual number of deaths. Patients with more comorbidities are by definition in a higher risk group for anticipated death.

There were no new Cusum alerts in this quarter. There was one new relative risk alert but this was a single patient coded as being admitted with malaise and fatigue. The notes for this case have been reviewed and the coding updated. A review was undertaken for two patients with a high relative risk from Q3, cancer of the female genital organs. No clinical issues were identified and the coding confirmed as accurate.

Learning from Deaths

The Structured Judgement Review Tool from the Royal College of Physicians has been adopted throughout the Trust to ensure that formal mortality reviews are undertaken and that this data is available to inform improvements in care and reporting to the Board. The newly published toolkit has valuable information which will enhance the existing process for future mortality reviews.

The Mortality Review Group continues to meet monthly to review those deaths flagged with four or more triggers to identify any concerns and to ensure learning for improvement. Cases are also reviewed via speciality Morbidity and Mortality meetings. These cases are presented at the local Clinical Governance Meetings to share findings and inform improvements in care delivery. These monthly meetings have a set agenda with the outcomes reported back through the Clinical Governance Team.

The Mortality Review Group has not identified any deaths in the patient cohort with greater than 4 triggers, where concerns were thought to have contributed to the outcome for those patients. It should be noted this data includes deaths within 30 days of discharge. Speciality based reviews have been formalised and have increased in number. It is anticipated that the Mortality Review Group's role will continue to evolve into one of monitoring and defining the final judgement from the mortality review data submitted at specialty level.

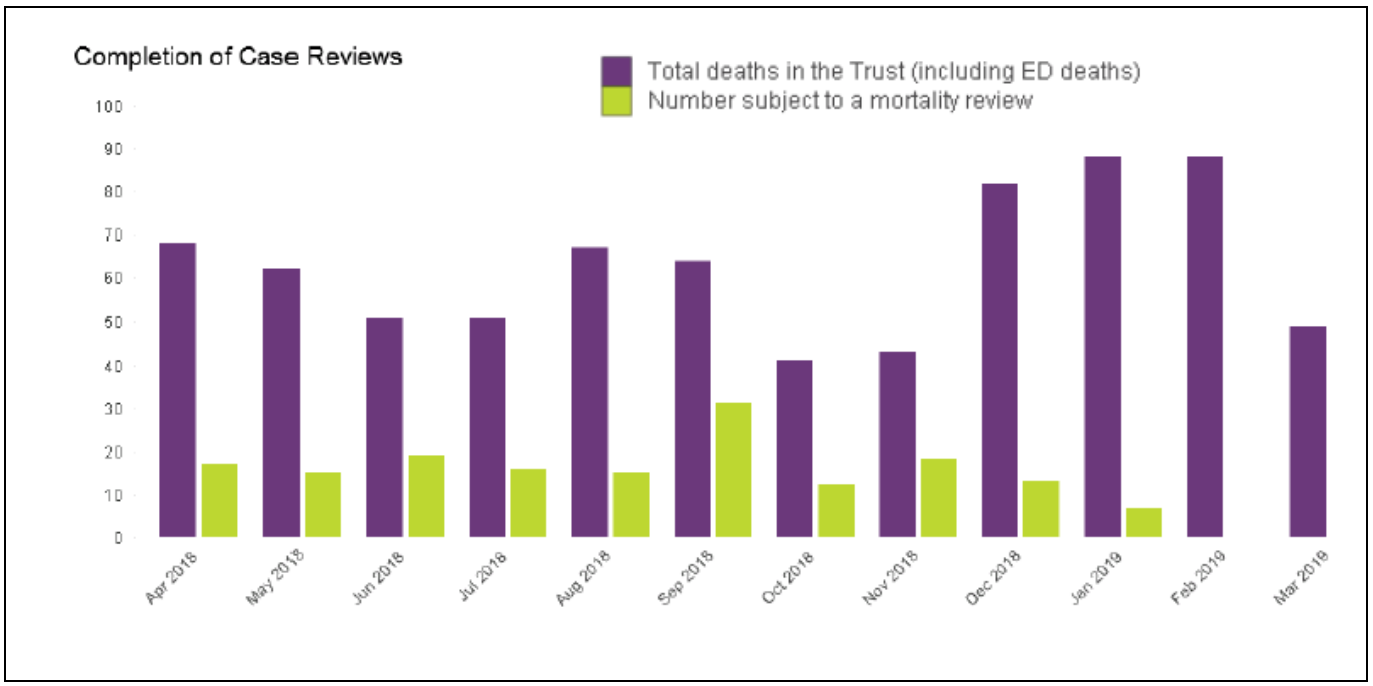
This table provides the number of deaths in month against the number reviewed and where concerns have been identified. Please note there is a delay in accurate reporting of in-quarter reviews due to the time frames of external surveillance data (CRAB and Dr Foster). This table will be updated quarterly.

2017/18									2018/19														
	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	April	May	June	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Marc	Q4 Total
Total deaths in the Trust (including ED deaths)	62	61	80	**203**	89	94	95	**278**	68	62	51	**181**	51	67	64	**182**	41	43	82	**166**	88	88	49	**225**
Number subject to a mortality review	19	24	18	**61**	11	12	20	**43**	17	15	19	**51**	16	15	31	**62**	12	18	13	**43**	7	0	0	**7**
Number investigated under the serious incident framework	1	0	0	**1**	0	0	0	**0**	1	0	0	**1**	2	2	0	**4**	0	0	1	**1**	0	0	0	**0**
Number of learning disability deaths	0	0	0	**0**	1	0	1	**2**	0	1	0	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**
Number of bereavement concerns	0	4	2	**6**	2	0	3	**5**	3	3	2	**8**	2	0	0	**2**	1	2	0	**3**	3	3	2	**8**
Number thought more likely than not to be due to problems with care	4	2	1	**7**	1	1	0	**2**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**

Of the 15 deaths subject to a case review so far in Q4:

- 7 were subject to a SJR
- No cases has been referred for a LeDeR review
- 8 were reviewed where bereavement concerns were raised

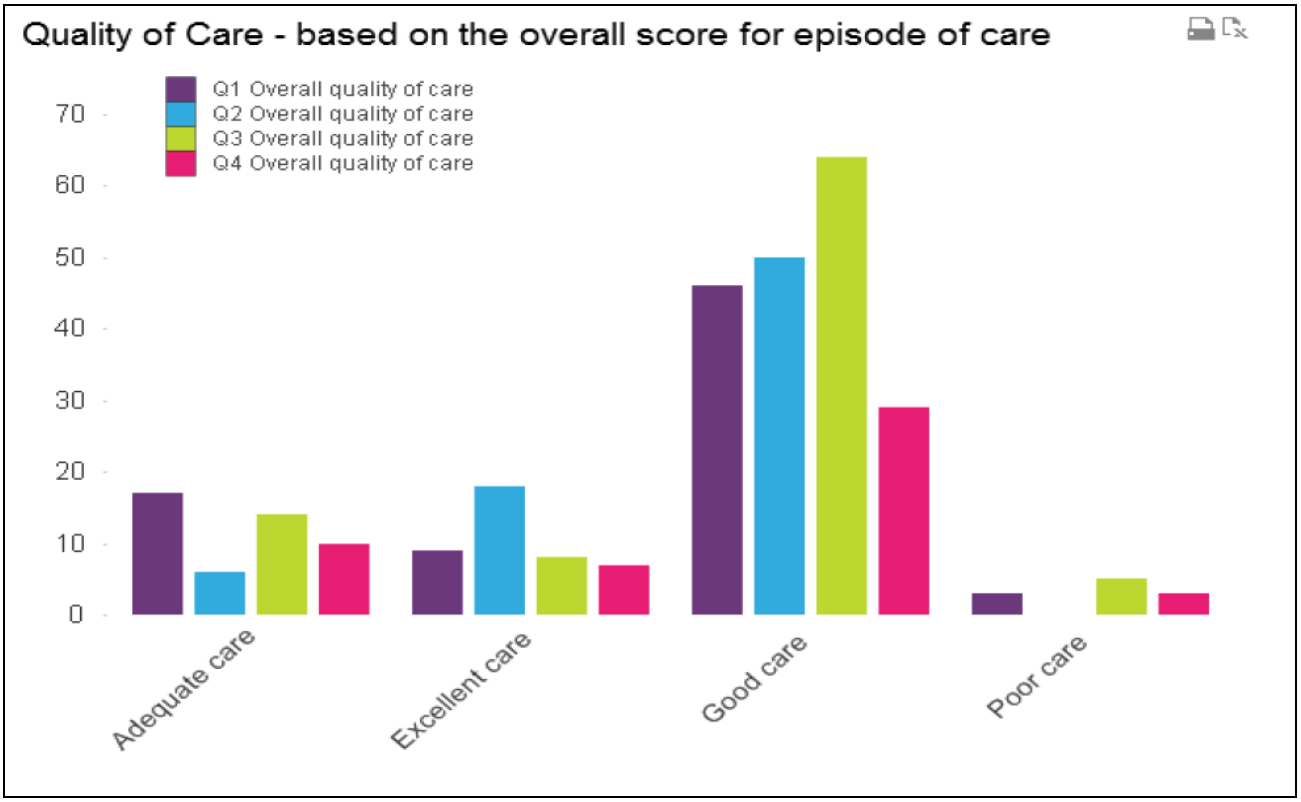
This data is summarised in the following charts:



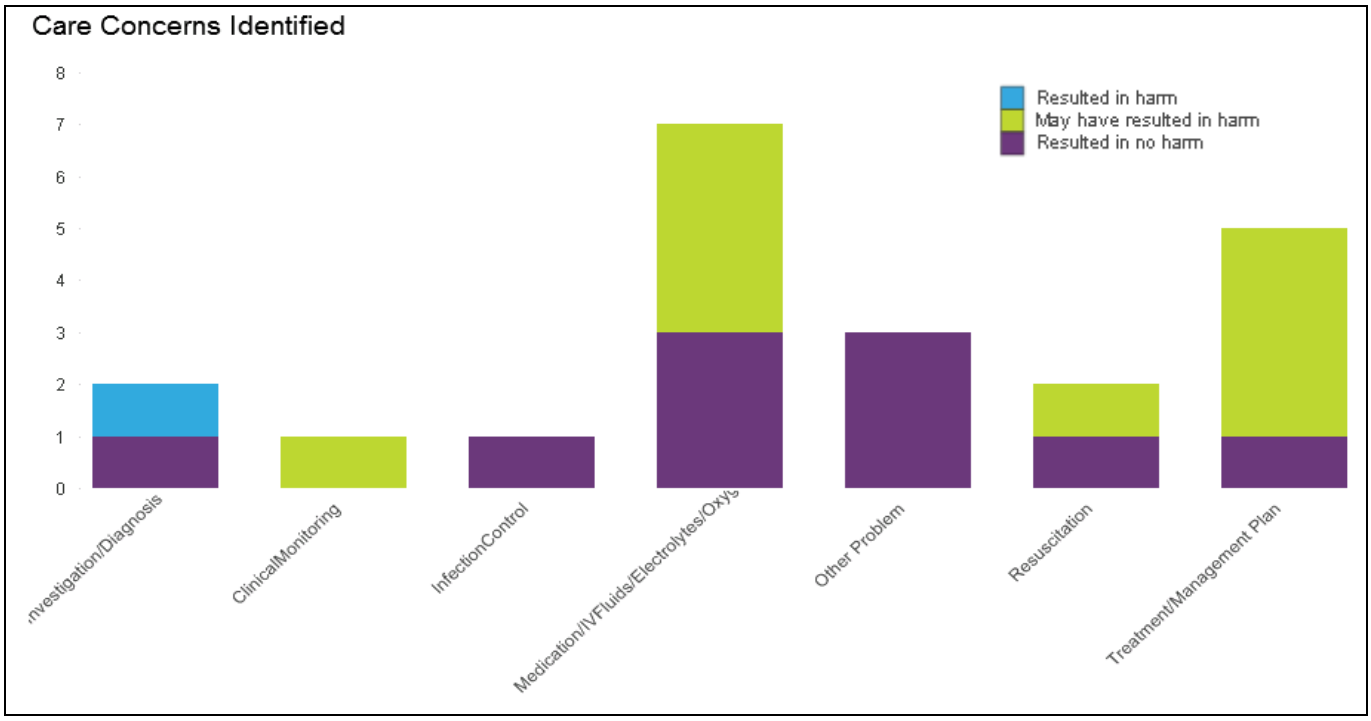
It should be noted that these figures relate to case reviews performed using the Structured Judgement Tool and does not yet include all mortality reviews undertaken within the Trust.

Overall Findings from case reviews completed using the Structured Judgement Tool

Quarter 4 2018/19- Quality of Care

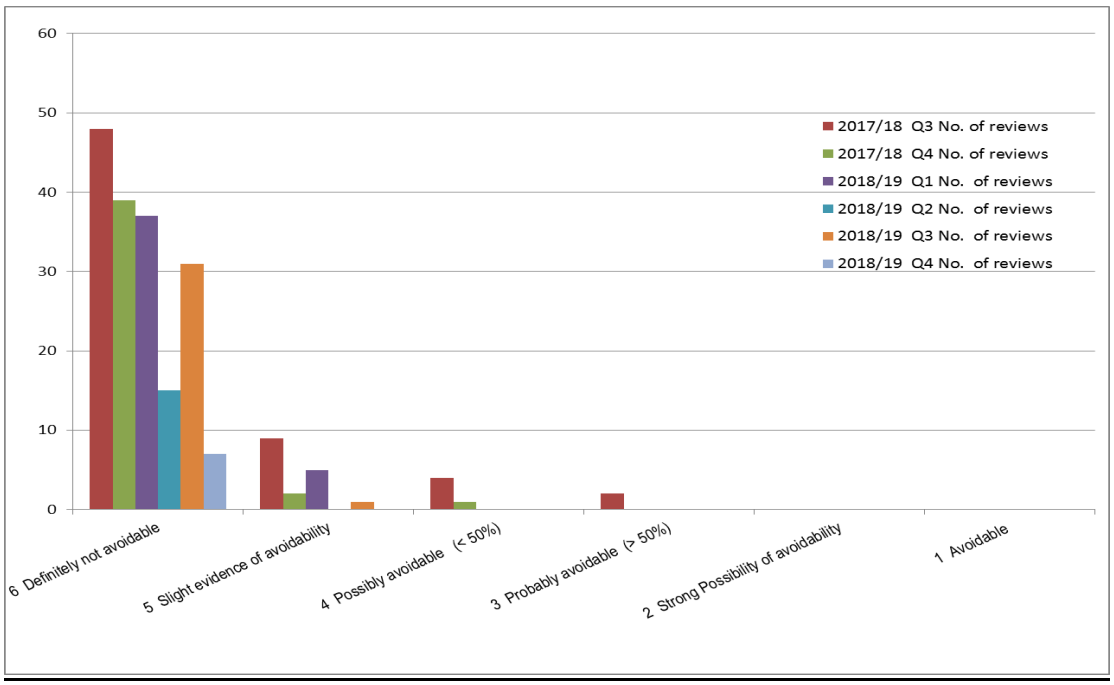


Rolling Year 2018/19 - Care Concerns Identified



Level of avoidability of death in each case reviewed - Rolling Year to date

Structured Judgement Tool Avoidability Score



1 – Definitely avoidable
2 - Strong possibility of avoidability
3 – Probably avoidable greater than 50%
4 - Possibly avoidable less than 50%
5 - Slight evidence of avoidability
6 - Definitely not avoidable

Themes from reviews and investigations undertaken:

Of the deaths reviewed using the Structured Judgement Tool so far in the quarter:

- No cases were identified where care concerns were considered to have directly contributed to a death.
- No cases were considered as having evidence of avoidability using the RCP definitions.

Issues positive and negative:

- A continued improvement was noted in identifying and referral for advice in respect of end of life care - this is reflected in the coded data as reported by Dr Foster.
- Any patient who dies within 30 days of chemotherapy treatment is currently subject to a specialist review – plans to incorporate these into the Trust wide system will increase our ability to review deaths within 30 days as recommenced in the CQC's recent progress report.
- There has been a decrease in the overall number of case reviews undertaken both in the specialist areas and in general. This may be attributed to the increased activity and number of deaths in the quarter.

Lessons Learned from Mortality Reviews:

- Discussions regarding end of life care need to be clearly documented and reiterated, especially in respect of the DNAR decisions where patients lack capacity and prior views are not known.
- Family wishes should be taken into account when discussing end of life decisions at the bedside for a patient with dementia
- Importance of clinicians reviewing scans and asking questions when a patient's clinical condition no longer fits with the formal reported outcome.
- Junior doctors require experience to identify abnormalities including air under the diaphragm on routine chest x-rays.
- The importance of ensuring plans for escalation are in place when activity is exceptionally high and interruptions continuous. (Specifically radiology out of hours reporting)
- Escalation plans documented in medical records not accompanied by a completed Treatment Escalation Plan or DNAR form can cause delay in clinical decisions and appropriate resuscitation.
- When oxygen saturations fall below target range failure to administer oxygen was found to cause a delay in recognition and management of ongoing deterioration.
- No agreed pathway for patients who require admission following ERCP leading to failure to identify cause of deteriorating patient.

Actions Taken:

- Audit of DNAR decisions in patients with a Learning Disability
- Feedback provided to ward staff and medical team reminding of the importance of the right discussion with the right people in the right place.
- Chest X-ray interpretation and escalation on teaching curriculum for all medical staff
- Coroner recommendations to be sent direct to external radiology reporting service
- Further training and audit of records of administration of oxygen
- Delivery of Trust wide governance session on TEP/DNAR
- Development of Standard Operating Procedure for post-procedure ERCP care

Learning Disability Deaths

There were no patients with a Learning Disability who died in the quarter. Where such a death occurs these are reported in line with national requirements and reviewed in the first instance for any immediate actions. The Trust is fully compliant with the LeDer Programme and will report such cases to the Commissioners for appropriate review and investigation. No deaths have been identified as a consequence of concerns about hospital care.

The County's LeDeR Programme has to date received 48 notifications. Of these 35 initial reviews have been undertaken and 25 cases closed. The Trust participates in the review process, providing information where care has been received at any stage of the deceased's life. If death occurs in hospital a full review is undertaken to commence the external LeDeR process.

Learning and actions from these reviews is shared across all care providers and includes the following which relate to acute Trusts

- Changes in Safer Swallowing and Accident and Incident policies and procedures have been prompted. This includes the importance of updating Risk Assessments and action plans for people who are known to swallow inedible objects.
- Hospitals need to ensure that all Best Interests reports are forwarded to GP Surgeries for medical records and to inform Advance Care Planning
- Hospital Passports are not always referred to or followed by hospital staff. Our LD Liaison Practitioner is promoting the effective use of patient passports across the Trust
- Health providers need to ensure clear recording on how best interest decisions are reached and ensure that forms such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) or a Treatment Escalation Plan are correctly completed and shared
- Support is required for vulnerable patients with procedures such as blood tests, if they are needle phobic, or with other simple investigations to prevent delayed or misunderstood diagnoses. Patients known to have LD or dementia can be supported through this process by pre-procedure visits and knowledge from our LD practitioner and Dementia Team

Neonatal and Maternal Deaths

There were no maternal deaths reported in the quarter.

From 12 December 2018 The Clinical Negligence Scheme for Trusts (CNST) requires that cases and actions reviewed using the Perinatal Mortality Review Tool (PMRT) are reported to the Trust Board quarterly. The PMRT facilitates a comprehensive, robust and standardised review of all perinatal deaths from 22+0 gestations (excluding terminations) to 28 days after birth; as well as babies who die after 28 days following neonatal care.

The web-based tool presents a series of questions about care from pre-conception to bereavement and follow-up care. The factual information is entered in advance of a multidisciplinary panel of internal and external peers (allowing for a 'Fresh eyes' perspective) review of cases. The tool is used to identify required learning with action plans generated, implemented and monitored.

There have been two cases that require review using PMRT, since 12 December 2018, both presenting to the Maternity Unit's Labour Ward with intrauterine deaths (IUDs). The first was discussed at the PMRT multidisciplinary review panel on 15 April 2019. The second case will be reviewed by the panel in June 2019. An overview of the cases and any generated learning and action plan will be submitted through this Mortality Report on a quarterly basis.

Working with Families

The End of Life Steering Group, launched a Family Liaison Service in November 2018 in response to recommendations from the Learning from Deaths report. This supplements the existing Bereavement Service, capturing concerns at the time of reporting a death, providing information and ongoing support to those dealing with a death in the family. This good practice may be augmented by the proposed implementation of the Medical Examiner role providing a further means of support for families and a degree of external assurance and learning for the Trust.