Mortality Report - Learning from Deaths
Quarter 1 2019/2020

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 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

Summary Hospital-Level Mortality Indicator (SHMI)

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 February 2018 to January 2019 is 98.89. A review of data submissions which inform the SHMI will form a local indicator for the Quality Account for the current year.

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 86.0, rolling year as at March 2019, which is in the expected range against national benchmarks. This position has improved significantly over the last year.

The latest report from Dr Foster with a data set from March 2018 to February 2019 highlights the Trust's position with both HSMR and SHMI being statistically significantly low. In terms of the weekday/weekend split the Trust is similar to the national position for week day and as expected on weekends. The South West region has a statistically higher mortality rate during weekends with the Trust being slightly better than the rest of the area.

We continue to have a high recorded palliative care rate across the local peer group. This reflects the Trust's 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.

As patients with a palliative care code are removed from the cohort analysed within the HSMR data set we have audited a sample of patients to ensure those who have been reviewed by the palliative care team are categorised appropriately. This review, along with the low SHMI (data which does not exclude this cohort of patients) has reassured us that our current position is a true reflection and that there is no underlying problem masked by our higher than average palliative care coding.

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. Cusum is short for cumulative sum and an alert occurs when the number of deaths, readmissions or activity within the Trust in a cohort of patients with the same coded condition, (taking account of their comorbidities) is higher than anticipated.

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 a percentage of records where the patient has died within the hospital. We no longer use the Copelands Risk Adjusted Barometer (CRAB) to define the risk of mortality within certain groups of patients and highlight patients with triggers for review. In future these patients requiring a full review will be identified through an initial assessment process at the time of completing the formal death certification. The Medical Examiner role will assist with this process at the time when advice on the cause of death and consideration of referral to the Coroner's Office may be required. This will ensure that all patients where there is a suspicion of a problem with care or management will be prioritised for a detailed mortality review to identify any concerns and to ensure learning for improvement.

Our intention is that the initial assessment findings along with the current palliative care reviews will be incorporated into the current database for ease of reporting and avoidance of duplication. More importantly this will ensure that we identify and act on any issues within this cohort of patients.

Cases will continue to be reviewed via speciality Morbidity and Mortality meetings with presentation of findings at local Clinical Governance Meetings which will in turn inform improvements in care delivery. These monthly meetings have a set agenda with the outcomes reported back through the Clinical Governance Team. 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 as well as continuing to review patients where a second level review is indicated.

The Mortality Review Group has identified one death in Quarter 1 where concerns are thought to have contributed to the outcome for the patients. This case will be reviewed as part of the Serious Incident Review process which will determine the action to be taken.

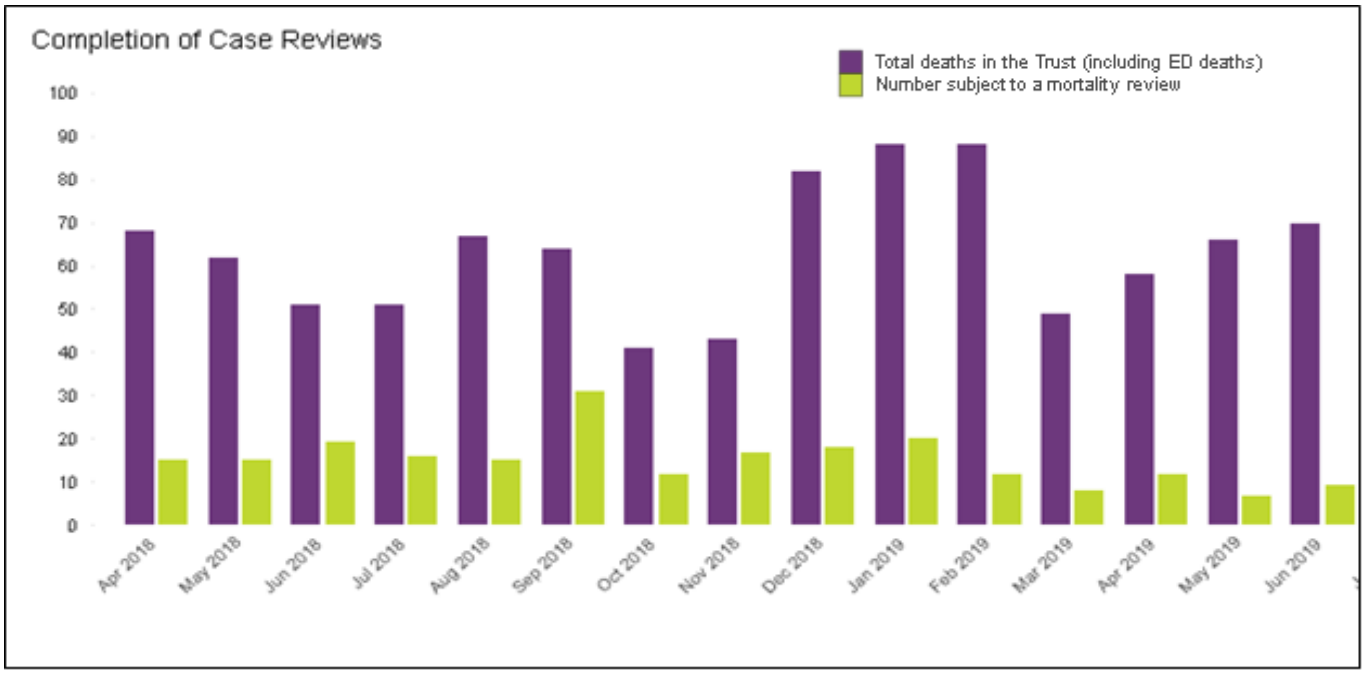
This table provides the number of deaths in month against the number reviewed and where concerns have been identified. Please note there is a delay in accurate reporting of in-quarter reviews due to the time frames of external surveillance data from Dr Foster and the mortality review process.. This table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

2017/18					2018/19																2019/20			
	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	April	May	June	Q1 Total
Total deaths in the Trust (including ED deaths)	89	94	95	**278**	68	62	51	**181**	51	67	64	**182**	41	43	82	**166**	88	88	49	**225**	58	66	70	**194**
Number subject to a mortality review	11	12	20	**43**	17	15	19	**51**	16	15	31	**62**	12	17	18	**47**	20	12	8	**40**	12	7	9	**28**
Number investigated under the serious incident framework	0	0	0	**0**	1	0	0	**1**	2	2	0	**4**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**
Number of learning disability deaths	1	0	1	**2**	0	1	0	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**
Number of bereavement concerns	2	0	3	**5**	3	3	2	**8**	2	0	0	**2**	1	2	0	**3**	3	3	2	**8**	1	1	1	**3**
Number thought more likely than not to be due to problems with care	1	1	0	**2**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**

Of the 32 deaths subject to a case review so far in Q1:

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

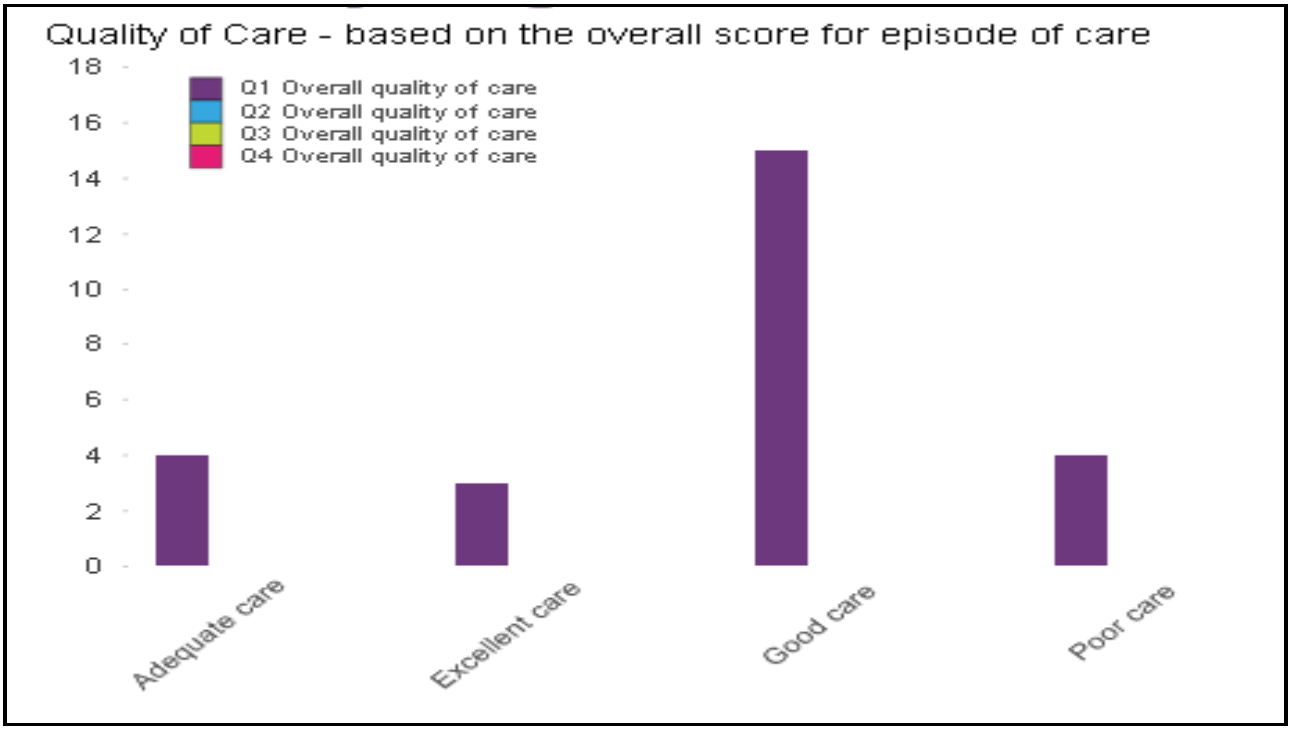
This data is summarised in the following charts:



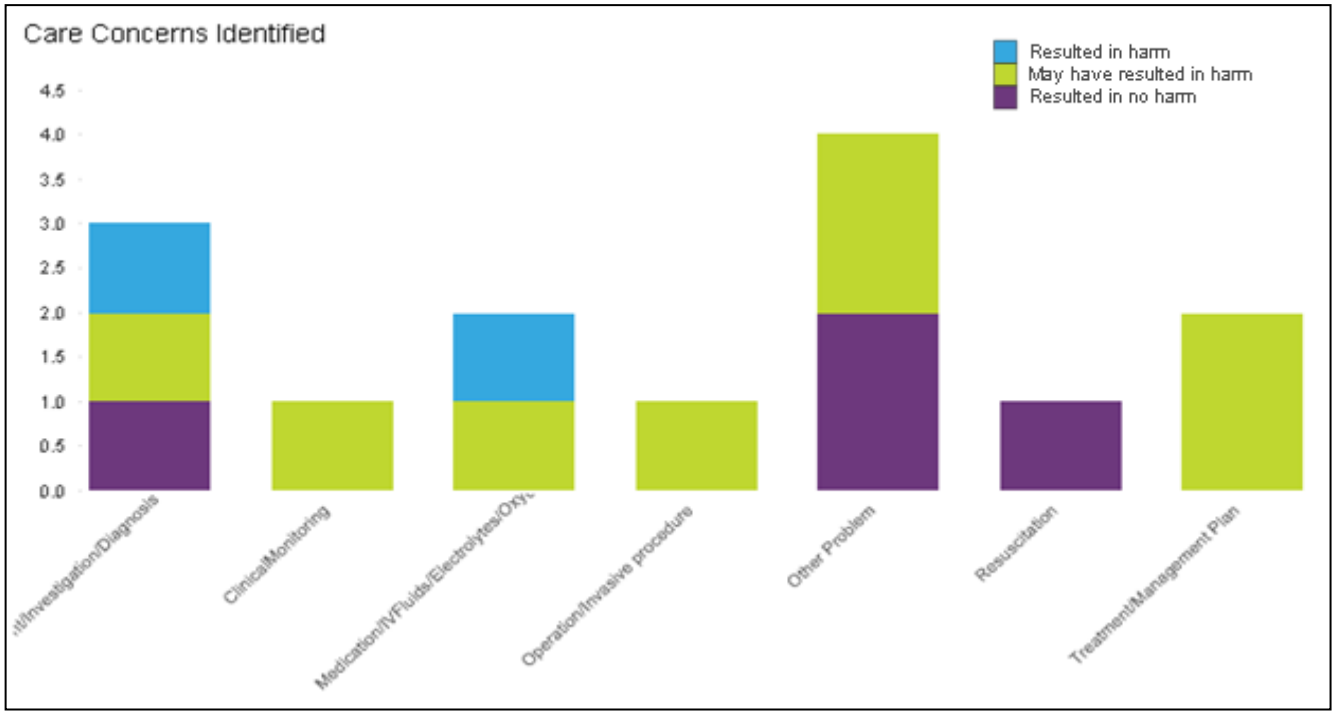
It should be noted that these figures relate to case reviews performed using the Structured Judgement Tool and does not yet include all mortality reviews undertaken within the Trust.

Overall Findings from case reviews completed using the Structured Judgement Tool

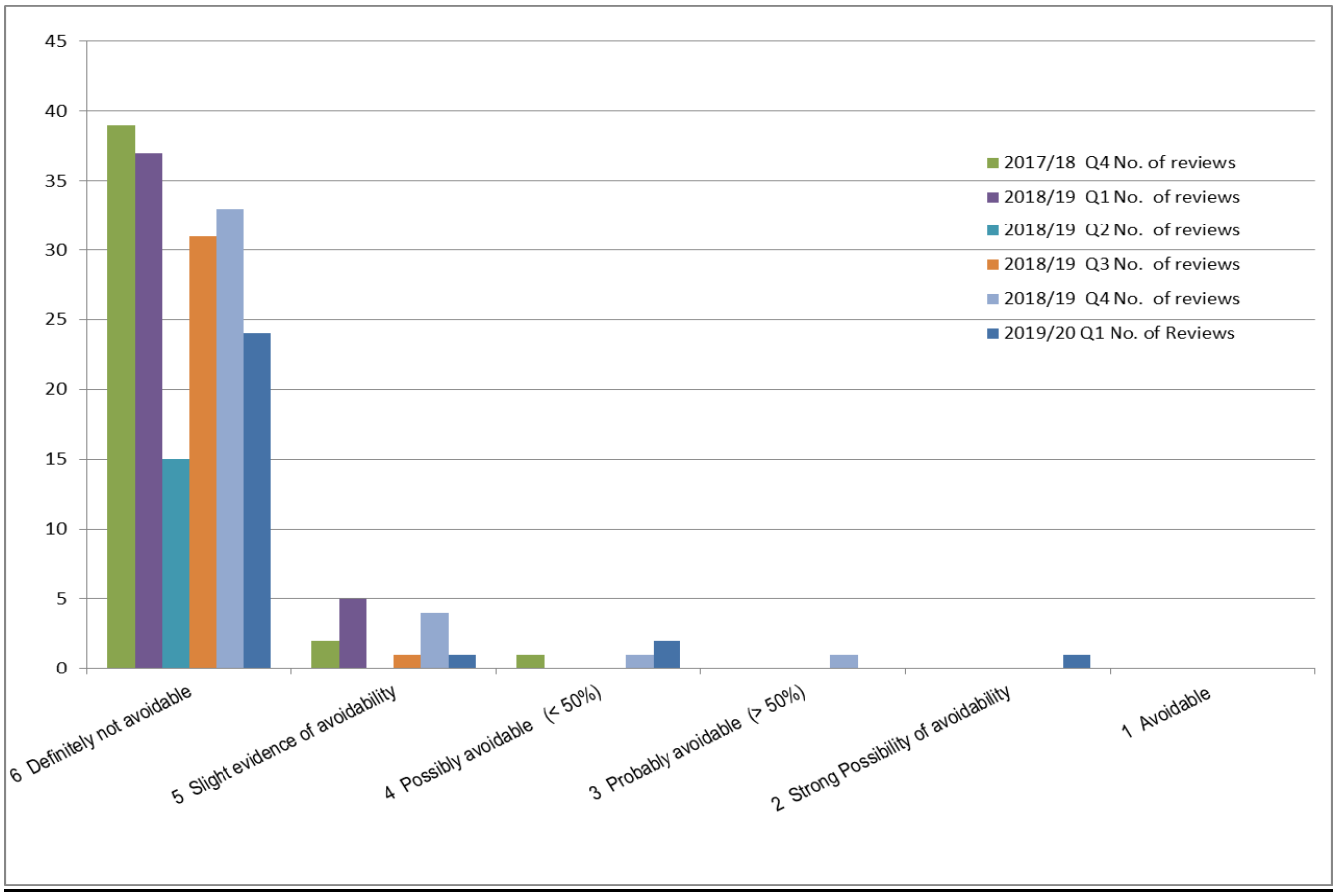
Quarter 1 2019/20- Quality of Care



Q1 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 mortality reviews and investigations undertaken within the quarter:

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.
- One case was considered as having evidence of avoidability using the RCP definitions, scoring a 2 – Strong Possibility of avoidability.

Issues positive and negative from reviews undertaken:

- The majority of cases reviewed using the SJR tool evidence appropriate and timely senior review.
- Several examples of a good standard or record keeping from all types of staff.
- Appropriate referrals to the Palliative Care Team and where the rapid deterioration had made a referral difficult appropriate end of life measures had been commenced.
- The Countywide DNAR process is not yet providing a seamless transition across care settings.

Lessons Learned from Mortality Reviews and investigations:

- The need to ensure all differential diagnoses are considered at all stages of management. Treat new and ongoing symptoms.
- Fit for discharge/transfer criteria must be met, especially when patients are frail or at end stage and are transferring for end of life care. Documentation and assessment must be timely
- Good communication with nursing homes can prevent misunderstandings about the development of tissue damage in the last days of life.
- Staff should ensure that relatives are aware of what to expect when the patient dies, especially if this is the first time they have been in this position.
- Radiology requests for whole spine MRI need to be clear in the reason for including the thoracic spine, particularly when other investigations have been performed.

Actions Taken:

- Rollout of discharge packs to ensure that patients have appropriate information when leaving the hospital.
- Review of discharge procedures and documentation on general medical ward where failed discharge occurred.

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 56 notifications. Of these 38 initial reviews have now been undertaken and 33 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

- Flexible appointment times with slots at quieter times of day have proved beneficial for patients with a learning disability.
- Quiet waiting areas can prevent anxiety, especially if the waiting time is lengthy.

- People with a learning disability are more at risk from sepsis as they are at higher risk from infection and get sicker faster. This is potentially due to communication issues and symptoms being seen as part of their pre-existing illness. The LeDeR programme has produced posters on sepsis and recognising deterioration in this group of patients.
- The importance of using patient passports and easy read documentation has again been highlighted.
- Clinicians should be fully aware of the need to actively engage with families and carers, especially when the patient with a learning disability cannot express details of their condition and best interest decisions need to be made on their behalf.

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 the 12th December 2019, both presenting to The Maternity Unit's Labour Ward with intrauterine deaths (IUDs). The first case was an intrauterine death at 23 weeks of pregnancy and was reviewed at the PMRT multidisciplinary review panel on 15th April 2019. The fetus was very small, regular scans identified that growth was significantly restricted with oligohydramnios. The pregnancy was supported by both YDH and The Fetal Medicine Unit at Bristol, following appropriate referral. The second more recent case will be reviewed by the panel on 11th July 2019.

Overall reviews to date have identified two main emerging themes that require action to aid improvement:-

- Identification that smoking cessation support of those who live with pregnant woman is not documented. Therefore we are unable to evidence that this is taking place. Matron for Community has been instrumental in supporting learning to address this with the community team and aid improvement. Additionally we are now offering CO monitoring for household members who smoke, when they attending the First Trimester Screening appointment. Support for cessation is offered with the CO reading and action recorded electronically onto a spread sheet.
- Quality conversations must be had with women about monitoring fetal movements and changes in fetal movement patterns; clinicians should ensure that the women have good understanding and that they know when to seek support. Community Matron is addressing this with the Community Midwifery leads to support learning for teams. The telephone triage process has also been addressed. As well as enquiring about quantity of fetal movements, it is equally important to ascertain duration of reduced fetal movements and enquire about patterns of fetal movement. The triage book has been updated to aid deeper enquiry.

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.