Mortality Report
Learning from Deaths

Quarter 3 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 has been amended to reflect these developments and the outcomes reported within future quarterly reports.

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

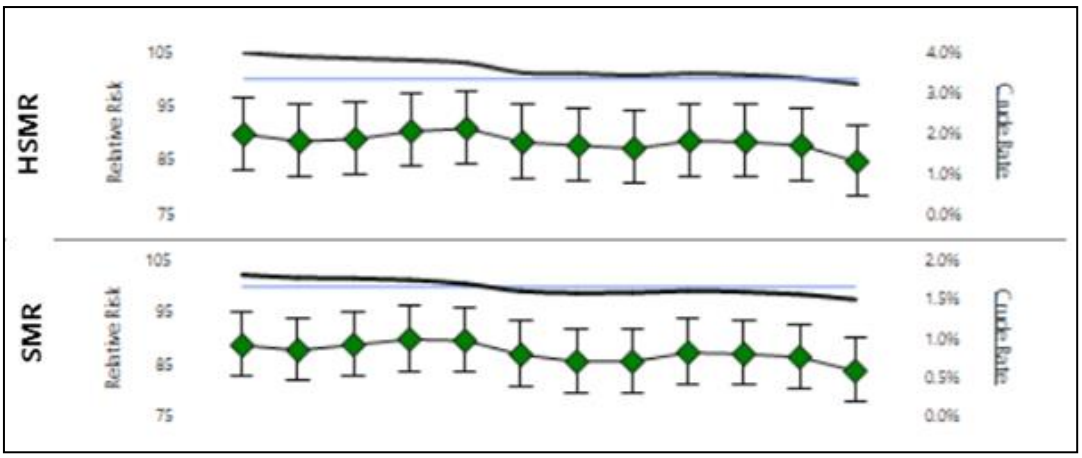
In hospital deaths per month

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 August 2018 to July 2019 is 95.12 which is within the expected range. No SHMI Group is statistically higher than expected and Septicaemia is statistically significantly lower than anticipated.

Hospital Standardised Mortality Ratio (HSMR)

The Trust uses 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 84.7, rolling year as at September 2019, which is statistically lower than anticipated and showing a linear decline.



The latest report from Dr Foster with a data set from October 2018 to September 2019 highlights the Trust's position with both HSMR and SHMI remaining statistically significantly low. The Trust HSMR is the lowest in the regional acute peer group. This can in part be attributed to our continued higher than average recorded palliative care rate as patients with a palliative care code are removed from the cohort analysed within the HSMR data set. A recent audit has reassured us that the reported figures are a true reflection of the current position.

The Dr Foster data also shows that we have maintained a high level of reporting of significant comorbidities. This positively affects our HSMR as this 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 three 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.

The alerts were for Nutritional deficiencies (3 observed deaths) and Haemolytic jaundice/Perinatal Jaundice (1 observed death). Each of these cases will be reviewed to identify why the alert has occurred and to identify any actions that should be taken to address any issues with the management of this cohort of patients. The Clinical Outcomes committee are responsible for investigating all CUSUM alerts with any actions taken referred back through the committee.

Learning from Deaths

It is important to provide a formal system to review the care and management of any patient who dies within the Trust. The Structured Judgement Review Tool from the Royal College of Physicians (RCP) has been adapted to facilitate its use throughout the hospital. Formal mortality reviews are undertaken with data analysis used to inform improvements in care and provide reports to the Board.

The Mortality Review Group continues to meet monthly to oversee reviews of the management and care of all patients who have died within the hospital. A three stage process has been developed with those patients requiring a formal review identified through an initial assessment at the time of completing the death certification. A first review by will be completed at a time when advice on the cause of death and consideration of referral to the Coroner's Office is required. This will ensure that any patient where a suspicion of a problem with care or management has been identified will undergo a detailed mortality review to identify any concerns and to ensure learning for improvement.

A record of the initial assessment and the routine palliative care reviews will be incorporated into the current database and the Structured Judgement Mortality Tool and Bereavement database have been combined for ease of reporting and avoidance of duplication. This ensures that we can identify and act on any issues whether or not the patient's death was anticipated with an End of Life Pathway in place or an unexpected event requiring further consideration. The first review (Mortality Review 1), to be completed in future by the Medical Examiner, will identify any case where a potential problem exists. For example, where the cause of death does not follow from the admission diagnosis or where a potential omission in care or poor management has been identified.

Cases identified for a full review (Mortality Review 2), may be assessed via speciality Morbidity and Mortality meetings with presentation of findings at local Clinical Governance Sessions. In specialties where the number of deaths in the month is small the RCP guidance states that all cases should be subject to this level of review. In medicine where the number of deaths is greatest a percentage of cases, filtered during the first review process, will be undertaken.

Monthly Governance Meetings have a set agenda including Mortality with the conclusions reported back through the Clinical Governance Team. Outcomes from these meetings, in particular any learning and actions taken will be recorded on the Structured Judgement Review tool. In addition any investigation undertaken outside of this process, for instance Serious Untoward Incident Investigations where death has occurred will include an avoidability score as part of the investigation summary. This will ensure all patient in hospital deaths can be categorised depending on the level of avoidability in each individual case.

In respect of any patient with a learning disability who dies within the Trust a Mortality Review 2 will be undertaken by nominated staff trained in the LeDeR process. This will ensure a comprehensive review including the patient's previous admissions and any reasonable adjustments that have been made during their interactions with the hospital. An assessment of whether the patient's disability was in any way contributory to their death and a formal avoidability score using the RCP tool will provide additional information for a subsequent multiagency LeDeR investigation.

Quarter 3 Reviews

The number of reviews recorded in the quarter is greater than achieved previously and as would be anticipated concentrated in the first 2 months. Changes to the recording process have enhanced the number of review outcomes being recorded centrally. It should be noted that due to the process of retrospective reviews, data will continue to require amendment in the following quarter to reflect the true numbers of reviews undertaken. Therefore the number of cases reviewed in quarter 2 has been significantly improved and this is reflected in this report.

For those reviews undertaken in Quarter 3 there was one case assessed as scoring a 3 meaning the death was probably avoidable (more than 50%). This case will be subject to additional review by the clinical team to identify and share learning. The outcome of this will be shared in the Quarter 4 report. One case was identified as score 2 – strong possibility of avoidability. The review showed that earlier referral for advice about the possibility of a specialist procedure could have led to a different management plan for the patient, but it is not certain that this would have made a difference to the outcome. The case is now under review by the specialist centre. The Mortality Review Group has not identified any other deaths in the Quarter where care concerns are thought to have contributed to the outcome for the patients. Again it should be noted that there is a data lag in the reports and this figure may change in the subsequent quarterly report.

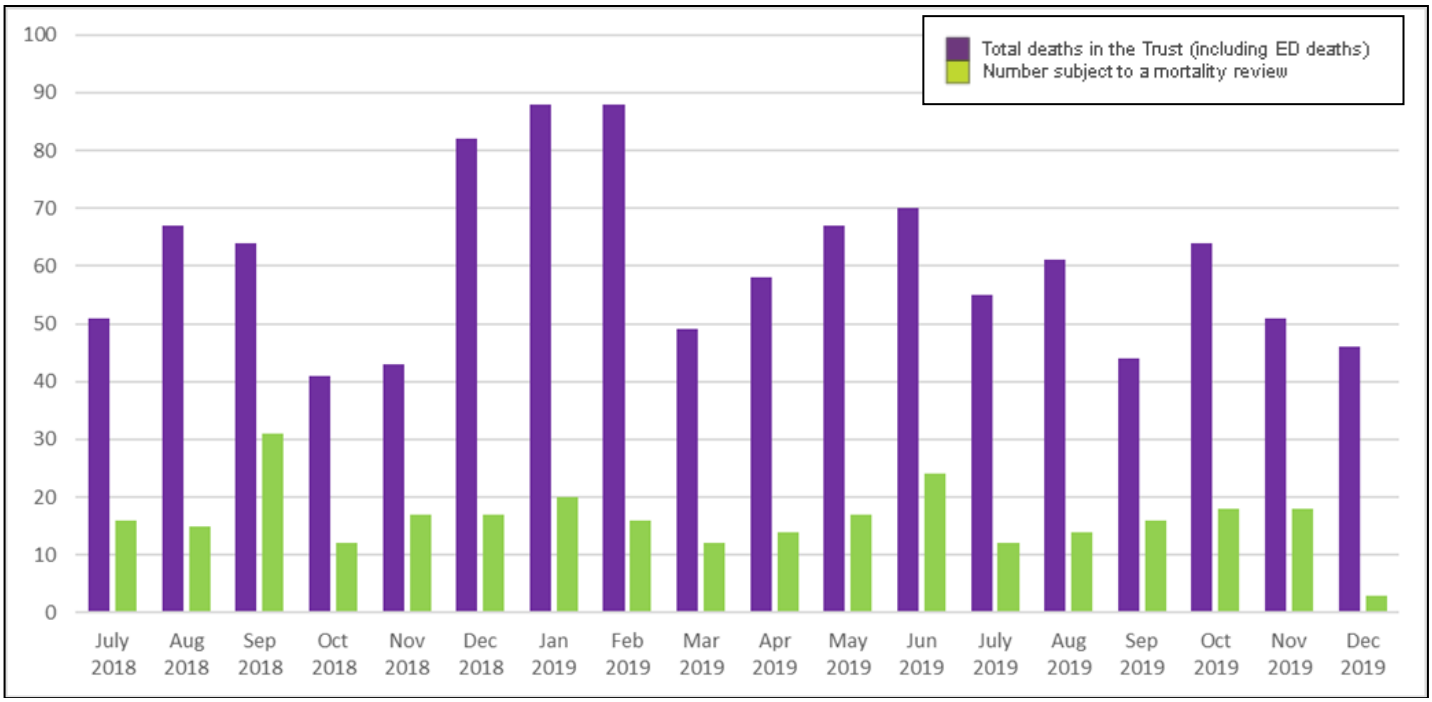
This table provides the number of deaths in month against the number reviewed and where concerns have been identified. Please note there is a delay in accurate reporting of in-quarter reviews due to the time frames of external surveillance data from Dr Foster and the mortality review process . This table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

2018/19													2019/20											
	Jul	Aug	Sep	Q2 Total	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
Total deaths in the Trust (including ED deaths)	51	67	64	**182**	41	43	82	**166**	88	88	49	**225**	58	66	70	**194**	55	61	44	**160**	64	51	46	**162**
Number subject to a mortality review	16	15	31	**62**	12	17	18	**47**	20	12	8	**40**	14	17	23	**54**	13	18	16	**47**	18	18	4	**40**
Number investigated under the serious incident framework	2	2	0	**4**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**
Number of learning disability deaths	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**
Number of bereavement concerns	2	0	0	**2**	1	2	0	**3**	3	3	2	**8**	1	1	1	**3**	1	1	3	**4**	2	1	2	**5**
Number thought more likely than not to be due to problems with care	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	1	**2**	0	0	1	**1**	0	1	1	**2**

Of the 45 deaths subject to a case review so far in Q3

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

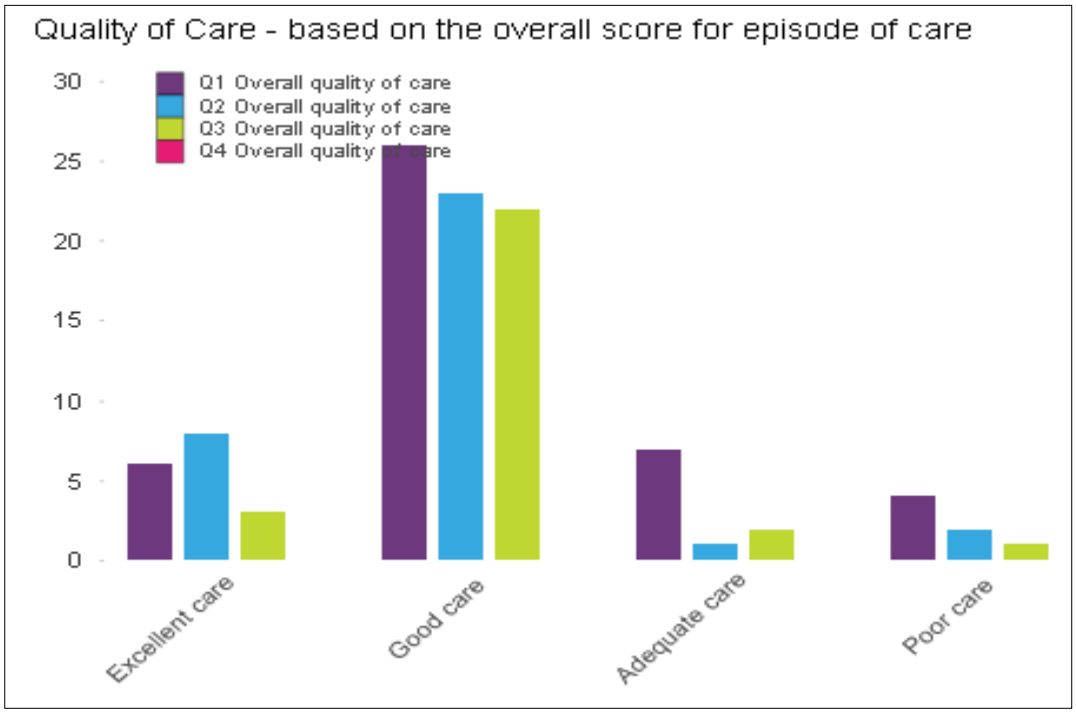
This data is summarised in the following charts:



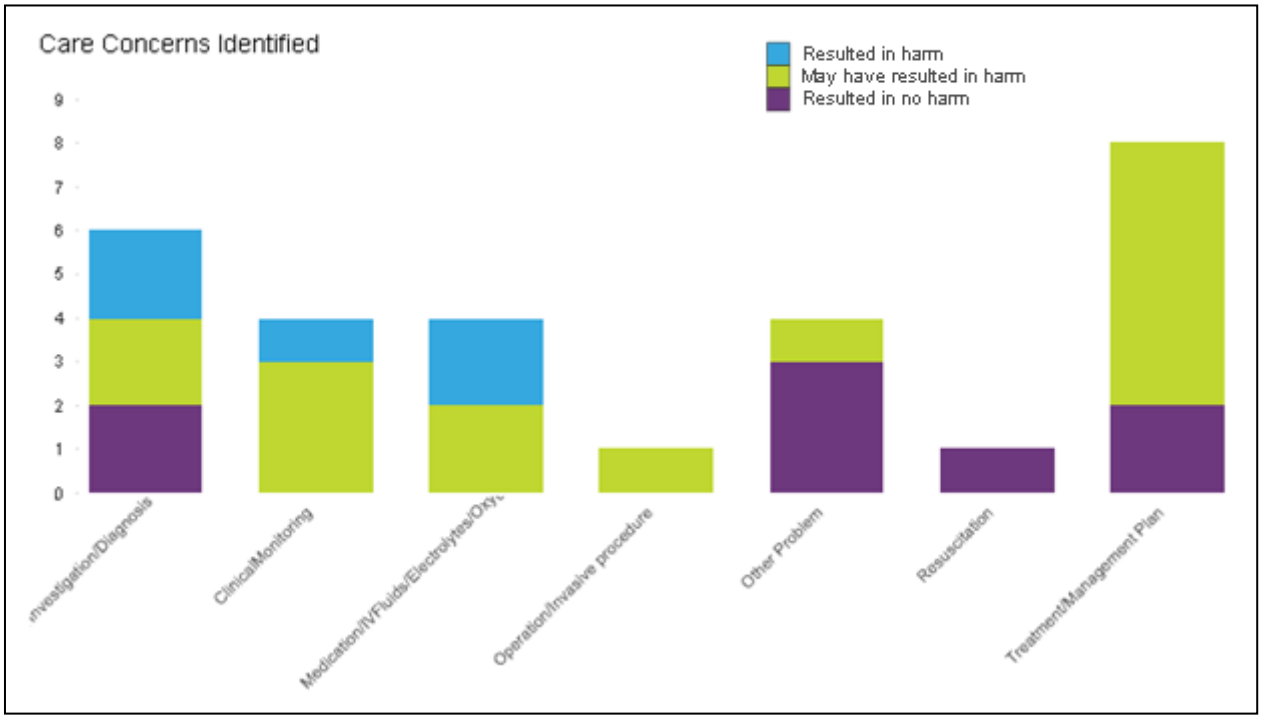
It should be noted that these figures relate to case reviews performed using the Structured Judgement Tool only with the previous quarter update in place.

Overall Findings from case reviews completed using the Structured Judgement Tool

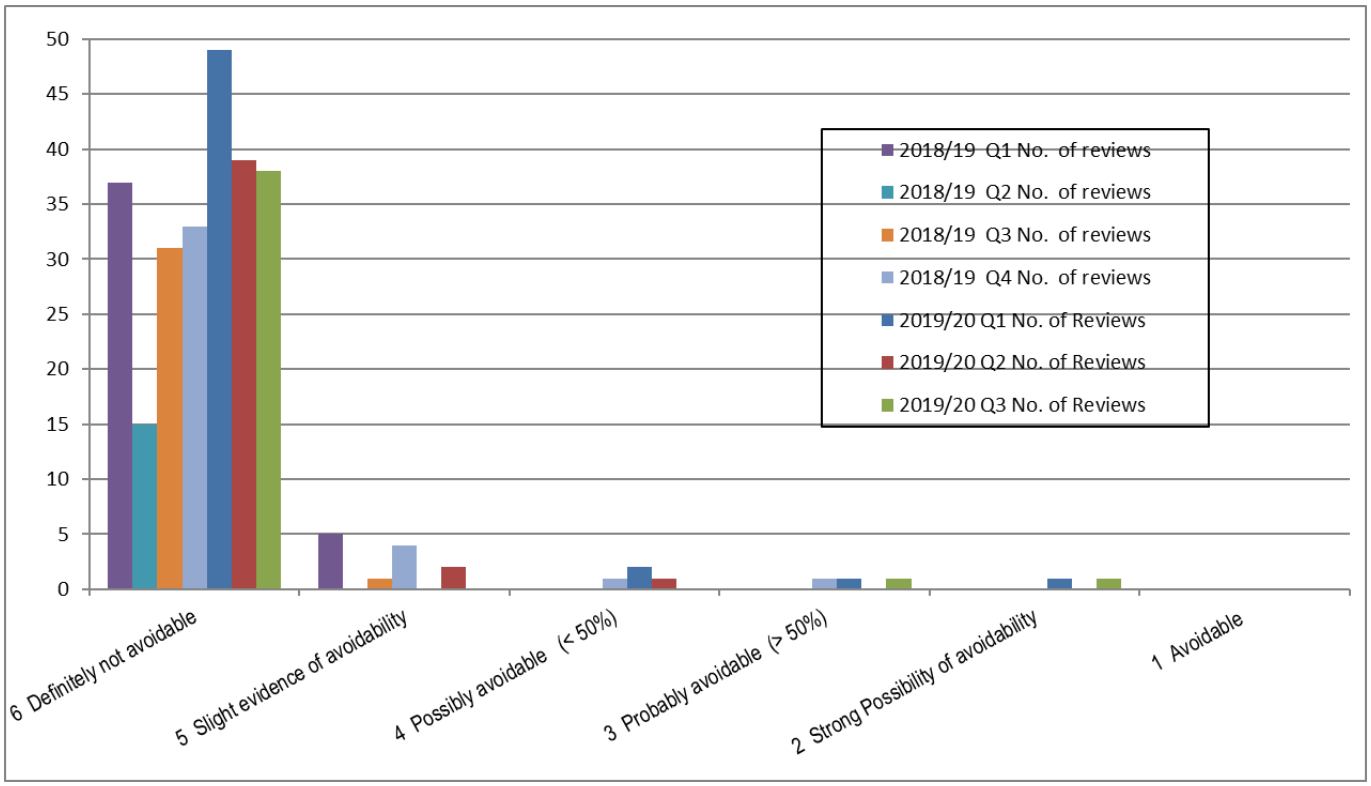
Quarter 3 2019/20- Quality of Care



Q1 - Q3 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:

- One case was identified where an earlier referral to a tertiary centre may have resulted in a different management plan - This case is under review with the specialist care team at BRI.

- One case review showed poor fluid management and a lack of senior review. A worsening Acute Kidney Injury was probably a contributory factor in the patient's deterioration and subsequent death.

Issues positive and negative from reviews undertaken:

- The majority of cases reviewed using the SJR tool evidence appropriate and timely senior review.

- Not all cases had a clear weekend plan with appropriate escalation identified.

- One elderly patient was admitted inappropriately and her condition may have been better managed at home.

- Cross county TEP and DNAR were not always followed when decisions relating to admission are required.

- Sepsis screening appears to have been timely and appropriate.

- The majority of patients received appropriate and timely palliative care regardless of a formal referral.

Lessons Learned from Mortality Reviews and investigations:

- Good communication and liaison with community regarding DNAR and treatment escalation plans improves the patient experience.

- Lack of timely decision making and weekend planning can result in an inappropriate level of treatment by on call teams.

Actions Taken:

- Continued monitoring of the countywide STEP process.

Coronial Activity

5 new instructions were received in quarter 3. Two cases resulted from self-harm and two from injuries sustained prior to the patients' admission. In all cases formal statements have been obtained with no omission or care problems identified that would be considered to have contributed to the patient's death. No inquests were held in the quarter and no learning has yet been identified.

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.

Neonatal and Maternal Deaths

CNST requires that cases and actions reviewed using the **Perinatal Mortality Review Tool (PMRT)** are reported to 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.

The Maternity Unit has reviewed three cases using the PMRT in Quarter 3. The tool was populated during multi-disciplinary panel review which included external clinical representation. The families are notified of these reviews and have an opportunity to raise any issues. Questions raised by the families are addressed at the time of the review.

Themes and Trends from PMRT reviews

Review of cases in the quarter has shown some areas where learning has been evident; There were no trends. Learning includes;

The importance of asking about domestic abuse at the time of booking which will be audited for compliance by record reviews.

The importance of screening for gestational diabetes. This has been highlighted with Glucose Tolerance Tests incorporated into care planning and audits of records to determine compliance.

The procedures around reduced fetal movements require a standardised approach. This includes the way we provide information to parents and the way we gain information from mothers who report reduced or changes in fetal movement and the management of these reports. The unit has recruited a Fetal Surveillance Midwife and reviewed and updated the units 'Reduced Fetal Movements' Guidance.

The case load planner has been redesigned to include a prompt to ask about smoking history in the household and offer support for smoke cessation.

Working with Families

The End of Life Steering Group continues to promote the Family Liaison Service 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 will be augmented by the 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.