Mortality Report
Learning from Deaths

Quarter 4 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 plan to 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

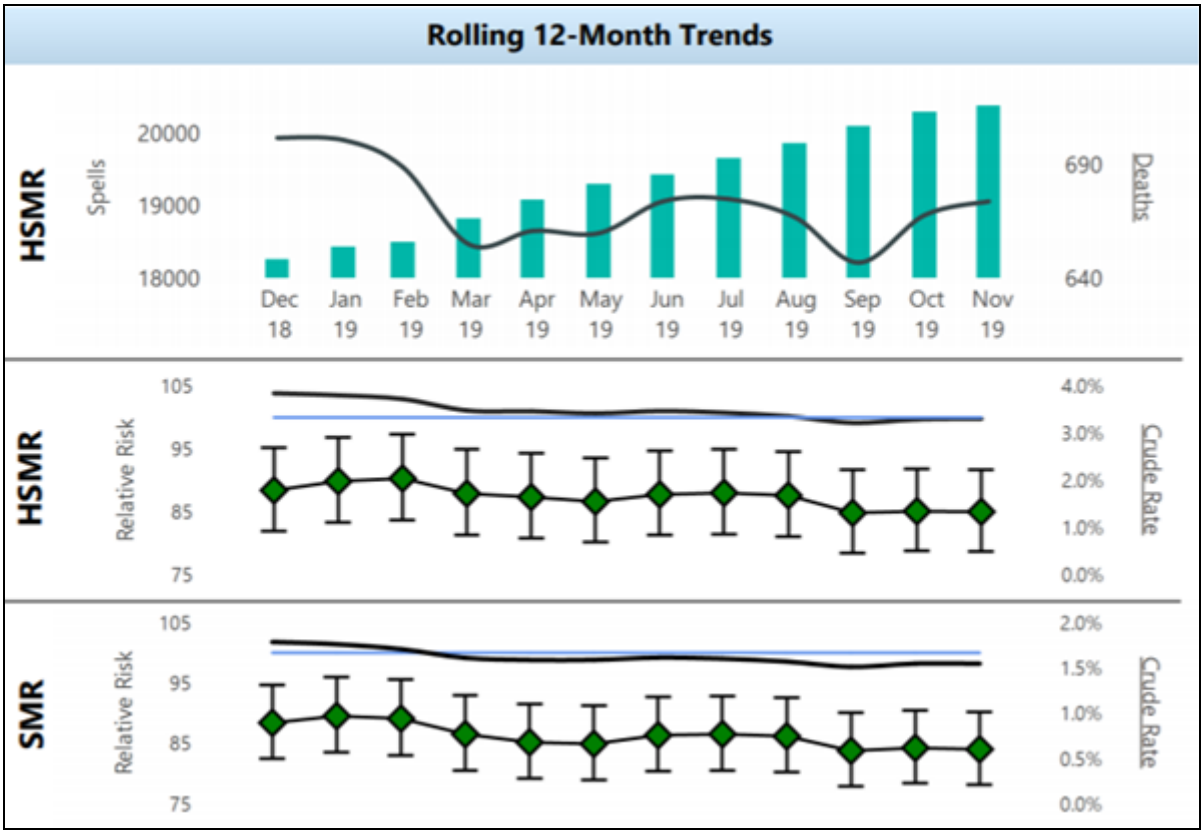
Summary Hospital-Level Mortality Indicator (SHMI)

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 October 2018 to September 2019 is 91.53, 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 85.0, rolling year as at November 2019, which is statistically lower than anticipated.



The latest report from Dr Foster with a data set from December 2018 to November 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. 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 CUSUM alerts in the previous quarter and one in Quarter 4. 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. All alerts are 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 previous alerts for, Nutritional deficiencies (3 observed deaths) and Haemolytic jaundice/Perinatal Jaundice (1 observed death) have been reviewed and no care issues have been identified. As the Doctor Foster data picks up on the initial coding detail, any developments or changes to the main condition treated during a longer length of stay are not used. Two of the three patients with nutritional deficiency have been recoded and the case of Haemolytic jaundice had already been reviewed.

There was one new CUSUM alert in quarter 4. This was for cases coded as 'other liver disease' with 10 cases involved. The Clinical Outcomes committee are responsible for investigating all CUSUM alerts with any actions taken referred back through the committee. These 10 cases will be reviewed.

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 had been developed with those patients requiring a formal review identified through an initial assessment at the time of completing the death certification. This first review (Mortality Review 1), will be completed in future by the Medical Examiner who 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. 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.

Cases identified for a full review (Mortality Review 2), have been assessed via speciality Morbidity and Mortality meetings with presentation of findings at local Clinical Governance Sessions. Outcomes from these meetings, in particular any learning and actions taken will be recorded on the Structured Judgement Review tool. 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 ensures all patient in hospital deaths can be categorised depending on the level of avoidability in each individual case.

Due to the Covid19 pandemic implementation of the Medical Examiner Role is on hold. The current review process will continue where an incident has been reported, the coroner is involved, for patients with a learning disability or where other potential issues have been identified.

Quarter 4 Reviews

The number of reviews recorded in the quarter in line with the numbers achieved previously and as would be anticipated concentrated in the first 2 months. It should be noted that due to the process of retrospective reviews, data would continue to require amendment in the following quarter to reflect the true numbers of reviews undertaken. Therefore, the number of cases reviewed in quarter 3 has been significantly improved and this is reflected in this report.

For those reviews undertaken in quarter 4 there were no cases yet reviewed with a score below 5 The Q3 case assessed as scoring a 3 meaning the death was probably avoidable (more than 50%) underwent additional review by the clinical team to identify and share learning and was presented at the local governance meeting.

The Mortality Review Group has not identified any 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.

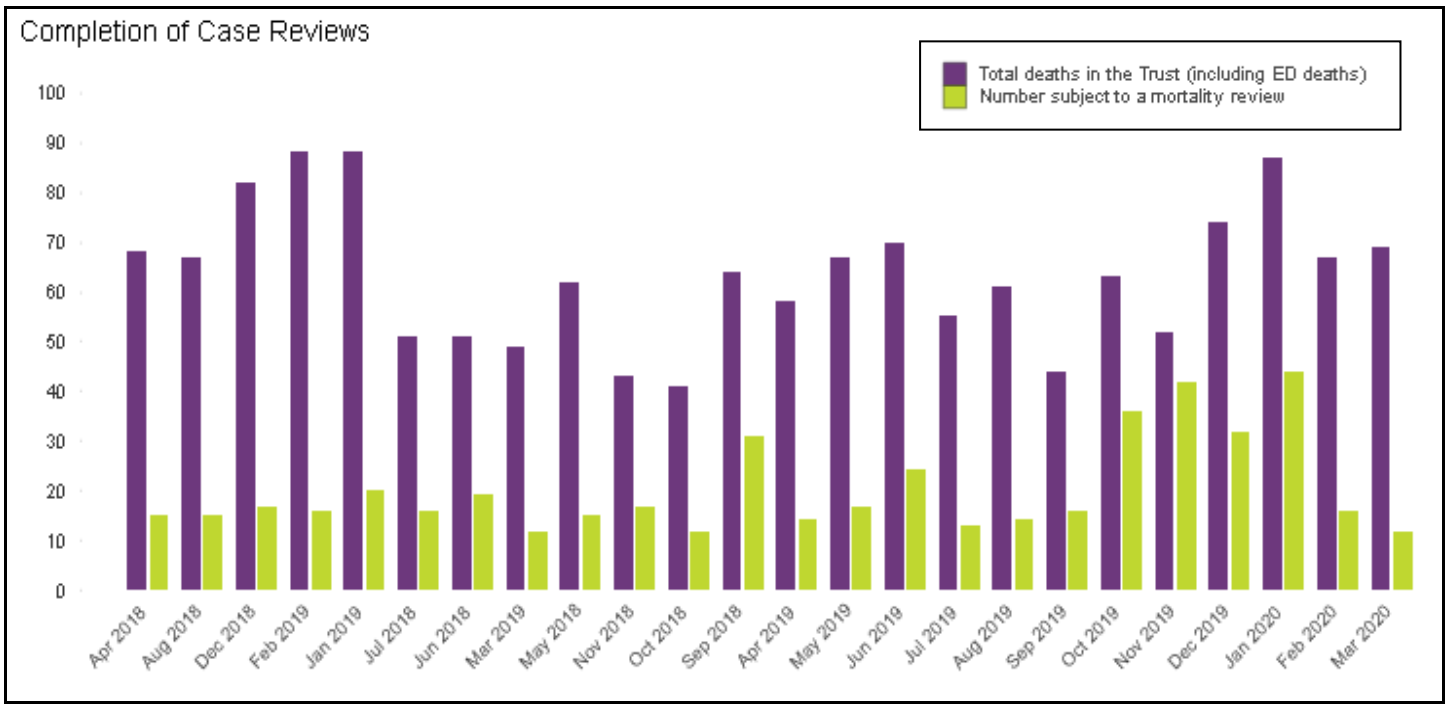
This table provides the number of deaths in month against the number reviewed and where concerns have been identified. Please note there is a delay in accurate reporting of in-quarter reviews due to the time frames of external surveillance data from Dr Foster and the mortality review process . This table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

2018/19									2019/20														
	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	Mar	Q4 Total
Total deaths in the Trust (including ED deaths)	41	43	82	**166**	88	88	49	**225**	58	66	70	**194**	55	61	44	**160**	64	51	46	**162**	87	67	69	**223**
Number subject to a mortality review	12	17	18	**47**	20	12	8	**40**	14	17	25	**56**	13	14	16	**43**	18	18	16	**52**	21	8	6	**35**
Number investigated under the serious incident framework	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	1	1	0	**2**
Number of learning disability deaths	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**
Number of bereavement concerns	1	2	0	**3**	3	3	2	**8**	1	1	1	**3**	1	1	3	**4**	2	1	2	**5**	4	1	0	**5**
Number thought more likely than not to be due to problems with care	0	0	0	**0**	0	0	0	**0**	0	1	1	**2**	0	0	1	**1**	0	1	1	**2**	0	0	0	**0**

Of the 37 deaths subject to a case review so far in Q4

- 35 were subject to a SJR
- 1 case has been referred for a LeDeR review
- 5 were reviewed where bereavement concerns were raised

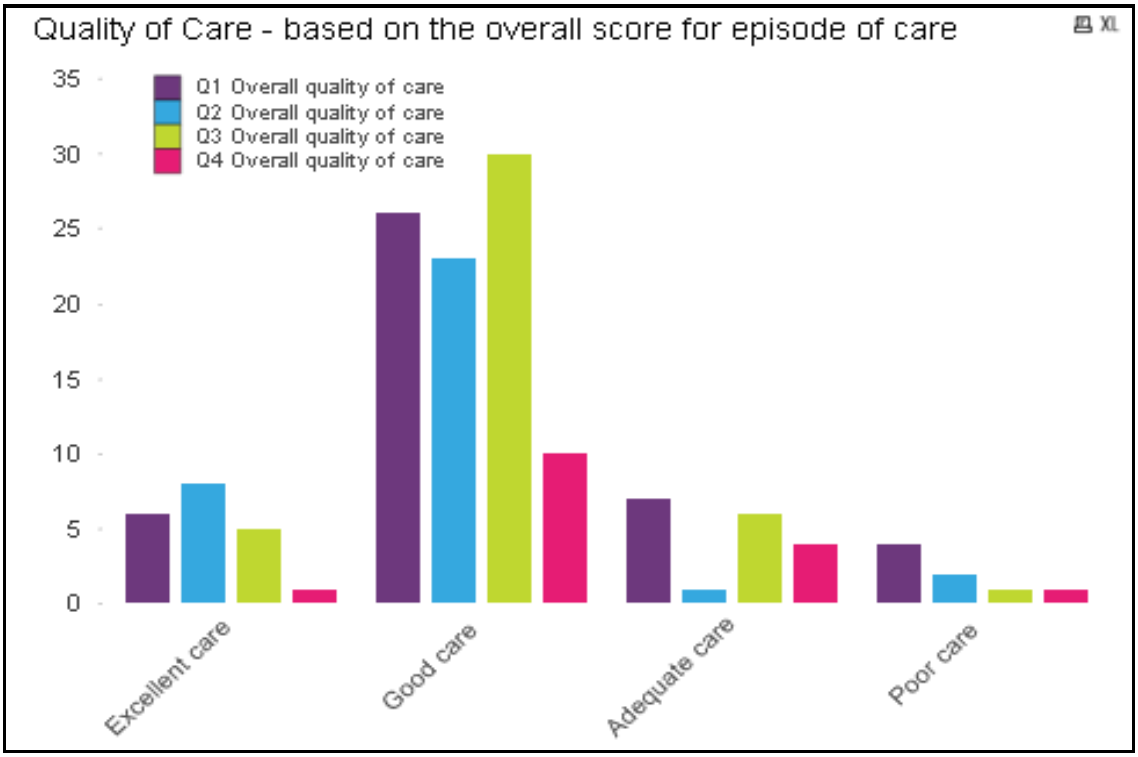
This data is summarised in the following charts:



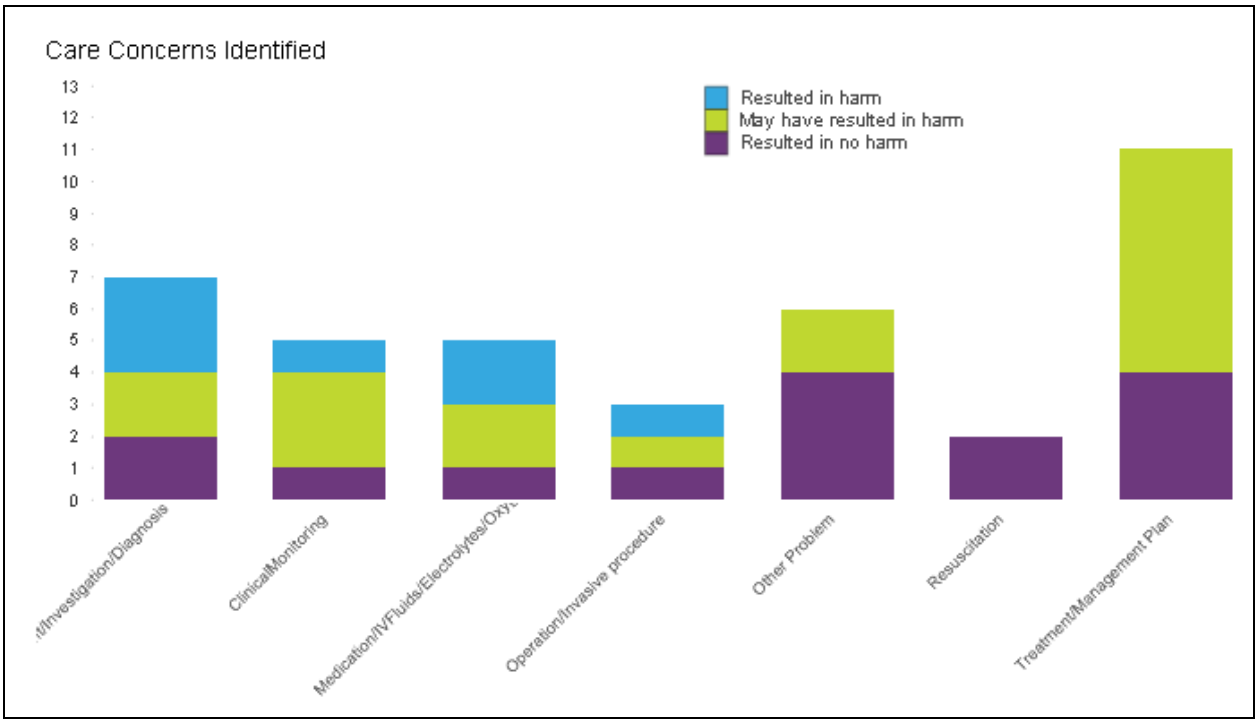
It should be noted that these figures relate to case reviews performed using the Structured Judgement Tool only with the previous quarter update in place.

Overall Findings from case reviews completed using the Structured Judgement Tool

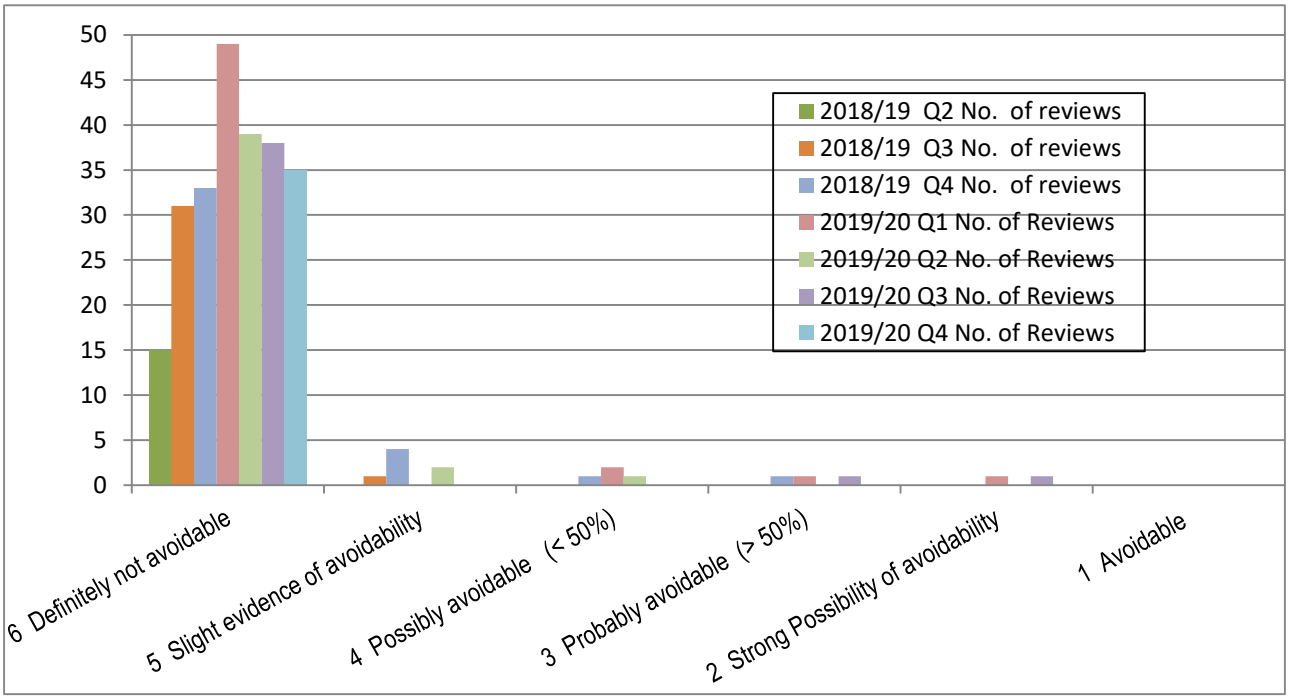
Quarter 4 2019/20- Quality of Care



Q1 – Q4 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:

- The quality of documentation in the quarter was either adequate or good.

Issues positive and negative from reviews undertaken:

- There were no avoidable deaths and no problems identified which contributed to a patient death.
- In two cases, there was a delay in identifying the terminal phase and unrecoverable status of the patient.

Lessons Learned from Mortality Reviews and investigations:

- Decisions relating to the escalation of treatment and Do Not Attempt Resuscitation rest with the clinicians. Treatment that would be futile should not be offered.
- Disputes between family members and clinical staff require the staff to seek advice to ensure consensus.

Actions Taken:

- Continued use of the countywide STEP process.
- Presentations at Trust Wide Governance relating to the clinicians' responsibility in decision making in relation to escalation plans and DNAR decisions.

Coronial Activity

7 new instructions were received in quarter 4. Three cases resulted from injuries sustained in falls prior to admission and one from injuries sustained in a road traffic accident. Two developed sepsis from existing long-term conditions and one case was referred to the coroner by a family following a dispute about the escalation of care. 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.

Learning Disability Deaths

There was one patient 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 two cases using the PMRT in Quarter 4. 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

Themes emerging from previous reviews are currently centred on-

- Documentation with key drivers in place to aid improvement. This will be influenced by record keeping audits.

- Arrangements for debrief. The Unit needs a more structured approach with regards to debrief, following sad outcome events and will gain guidance from the wider Trust to support this development.

The unit is awaiting a finalised HSIB report following review of an intrauterine death within the previous quarter. Safety recommendations were initially made and have been acted upon with staff learning/update and changes made to guidance. An action learning plan has been devised following review of the draft report, which amongst other actions, includes supernumerary status of the labour ward coordinator not always achieved and the emerging themes from recent PMRT reviews.

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.