Mortality Report
Learning from Deaths

Quarter 1 2020/2021

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:

- Implementing and monitoring 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

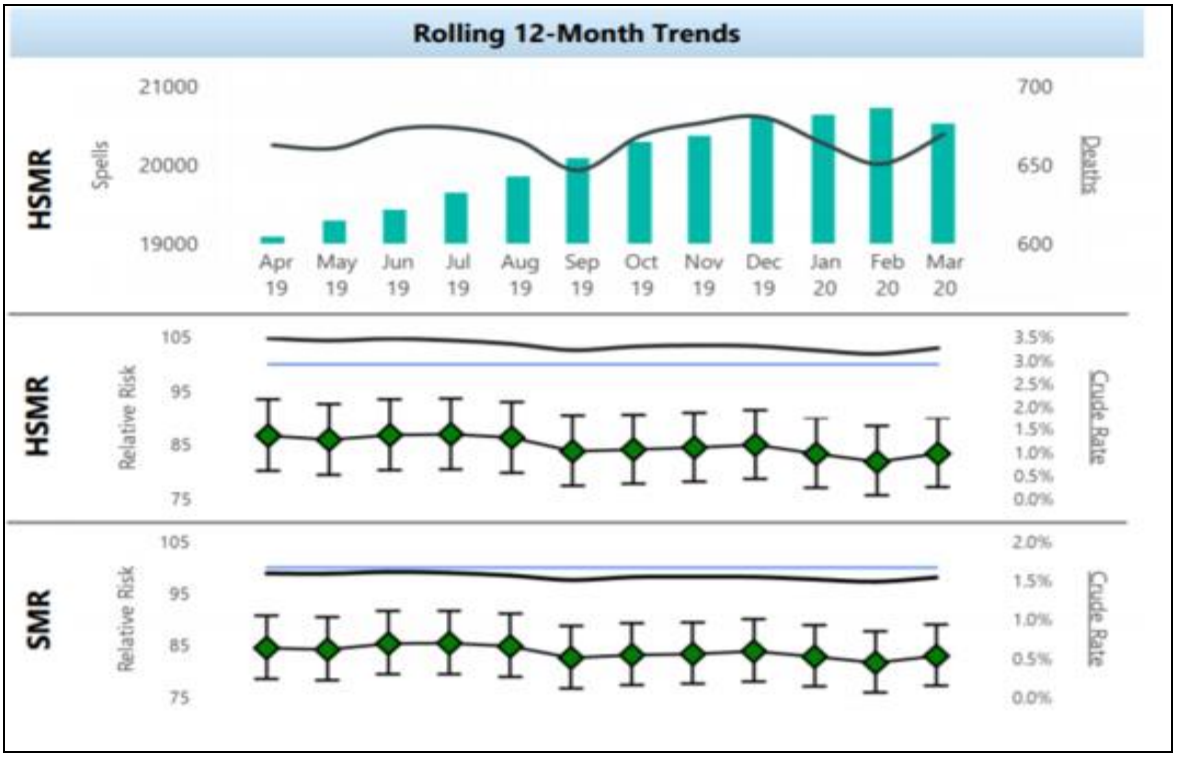
Summary Hospital-Level Mortality Indicator (SHMI)

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 2019 to January 2020 is 89.97, within

the expected range using NHS Digitals 95% control limit. No SHMI group is statistically significantly higher than expected.

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 for the reporting period April 2019 to March 2020 is 83.4 statistically significantly lower than expected and the lowest in the regional acute peer group. A weekday split shows our weekday HSMR remaining statistically significantly lower than expected, with weekend figures within the expected range.



The latest report from Dr Foster with a data set from April 2019 to March 2020 highlights the Trust's position with both HSMR and SMR remaining statistically significantly low. Continued monitoring of our data 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 was one CUSUM alert in the previous quarter and none in Quarter 1. 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 CUSUM alert in Quarter 4 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 have been identified but are yet to 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. This group will be reformed as the Medical Examiner role will have an impact on the availability of these clinicians for membership of the group. 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 by the Medical Examiner to enable early identification of 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 there is a suspicion of a problem with care or management will undergo a detailed mortality review by the specialist teams to identify any concerns and to ensure learning for improvement.

Cases identified for a full review (Mortality Review 2), will undergo a full review via speciality Morbidity and Mortality meetings with presentation of any significant findings at the local Clinical Governance Sessions. Outcomes from these meetings, in particular any learning and actions taken will be recorded through the Learning from Death's Lead 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.

The introduction of the Medical Examiner Role from 1st July 2020 formalises the above systems. The current investigation processes 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 through the complaints or bereavement process. The Medical Examiners, Medical Examiner's Officer and Learning from Deaths Lead will liaise closely to avoid duplication and ensure that all deaths in hospital are effectively reviewed and outcomes recorded and shared.

Quarter 1 Reviews

The number of reviews recorded in the quarter has been reduced by the stand down of committees and working groups due to the Covid19 measures. It should be noted that due to the process of retrospective reviews, data from Quarter 1 will be updated as the reviews form these months are undertaken. Therefore it is anticipated that the Quarter 2 report will reflect the true numbers of reviews undertaken. Reviews undertaken by speciality teams have continued but again taking account of the retrospective nature of these reviews the numbers are low.

For those reviews undertaken in Quarter 1 (and the updated cases from the previous quarter), there were no cases with a score below 5. None were identified 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 position may change in subsequent reports.

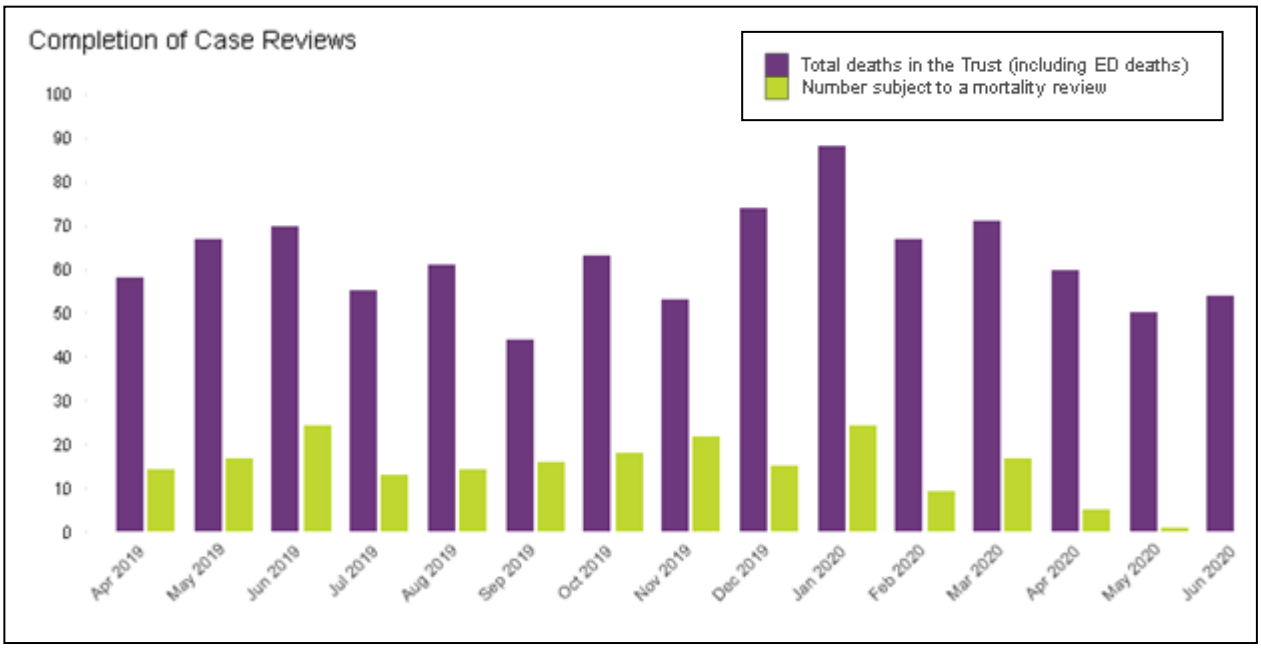
This table provides the number of deaths in month against the number reviewed and where concerns have been identified. Please note there is a delay in accurate reporting of in-quarter reviews due to the time frames of external surveillance data from Dr Foster and the mortality review process . This table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

					2019/20																2020/21			
	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	April	May	June	Q! Total
Total deaths in the Trust (including ED deaths)	88	88	49	**225**	58	66	70	**194**	55	61	44	**160**	64	51	46	**162**	88	67	71	**226**	61	51	55	**167**
Number subject to a mortality review	20	12	8	**40**	14	17	25	**56**	13	14	16	**43**	18	18	16	**52**	28	15	17	**60**	5	3	0	**8**
Number investigated under the serious incident framework	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	1	1	0	**2**	0	0	0	**0**
Number of learning disability deaths	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	4	1	0	**5**
Number of bereavement concerns	3	3	2	**8**	1	1	1	**3**	1	1	3	**4**	2	1	2	**5**	4	1	0	**5**	0	0	2	**3**
Number thought more likely than not to be due to problems with care	0	0	0	**0**	0	1	1	**2**	0	0	1	**1**	0	1	1	**2**	0	0	0	**0**	0	0	0	**0**

Of the 16 deaths subject to a case review so far in Q1- See text above for information relating to low numbers and plans to redress.

- 8 were subject to a SJR
- 5 cases have been referred for a LeDeR review following initial local review
- 3 were reviewed where bereavement concerns were raised

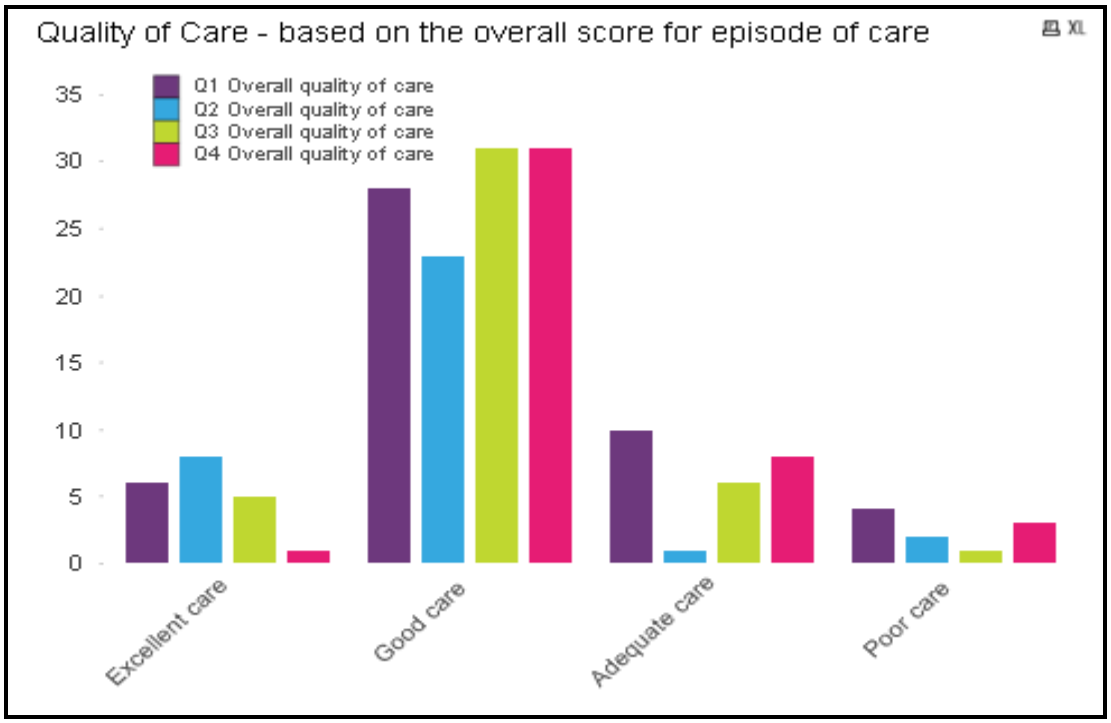
This data is summarised in the following charts:



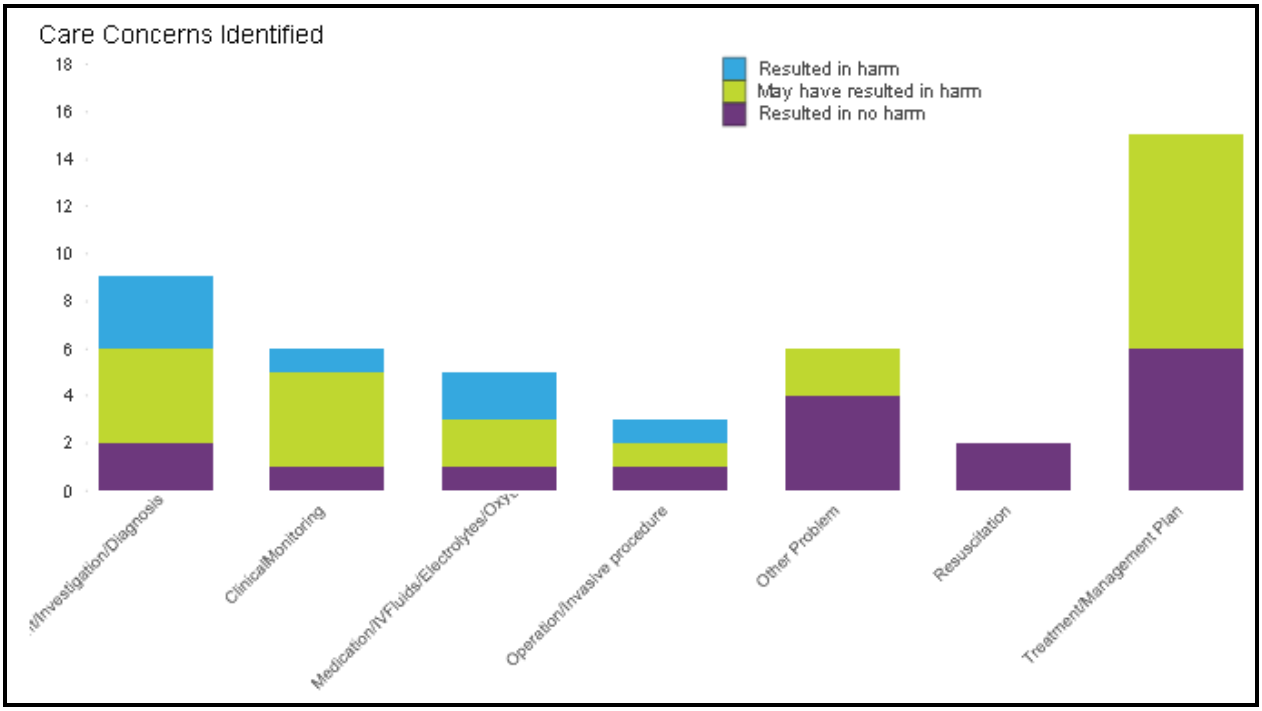
It should be noted that these figures relate to case reviews performed using the Structured Judgement Tool only with the previous quarter update in place.

Overall Findings from case reviews completed using the Structured Judgement Tool

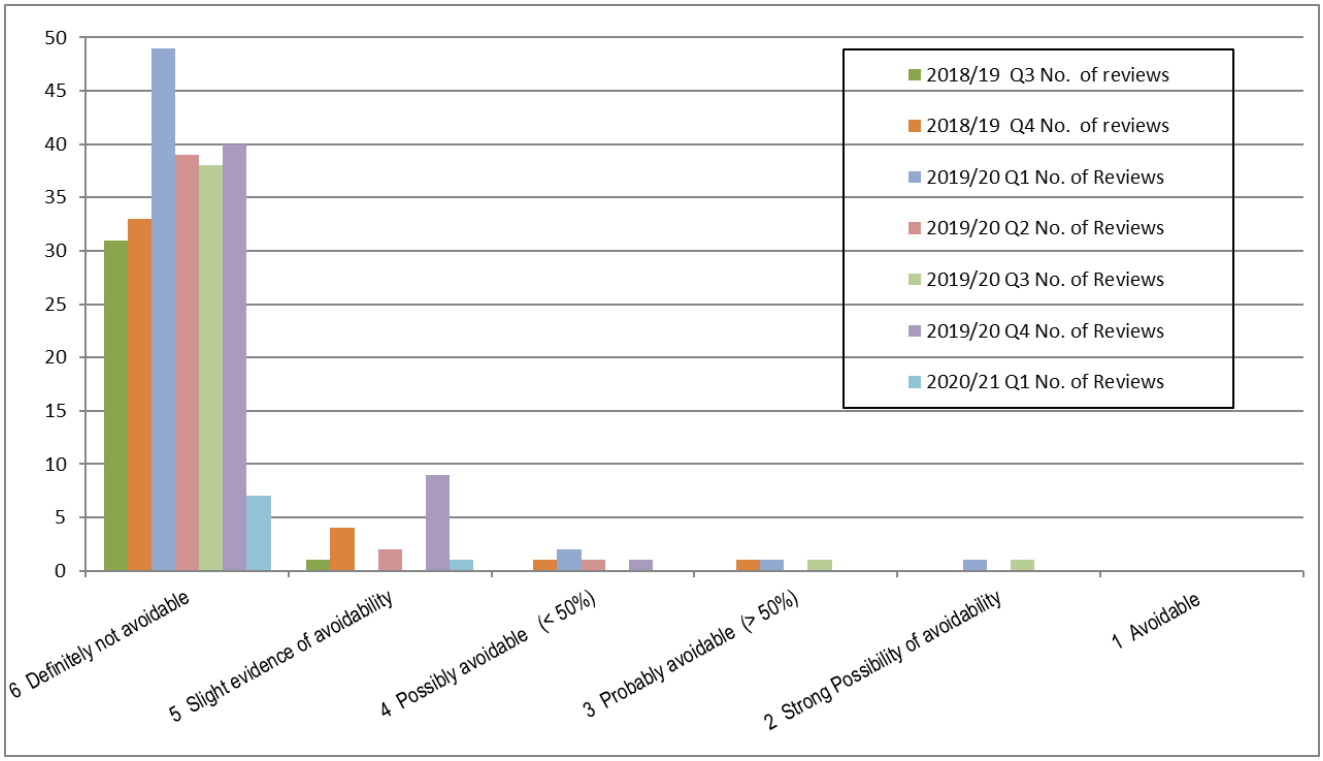
Quarter 1 2020/21- Quality of Care



Care Concerns Identified rolling year



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



<u>Structured Judgement Tool Avoidability Score</u>

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

All in hospital deaths can provide information about the individual patient's care and management. Alongside the formal mortality review process learning can take many forms and be identified through many sources including;

- Serious Incident Reviews
- Complaints and bereavement concerns
- Medical Examiner reviews
- Coronial activity
- Learning Disability Reviews (LeDeR)
- Perinatal Mortality Reviews.
- Child Death Review processes.

It is important to identify themes and trends from all of the available information to enable Trustwide learning and address any issues that have been identified.

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
- No significant issues were identified
- None of the Surgical or Orthopaedic deaths in the quarter were recorded using the tool.

Issues positive and negative from reviews undertaken:

- There were no avoidable deaths and no problems identified which contributed to any patient's death.
- Several patients with significant comorbidities were admitted where care may have been possible at home.
- Timely and appropriate DNAR discussions and decisions were made.

Lessons Learned from Mortality Reviews and investigations:

- Community DNAR and TEP does not always inform decision to admit or in hospital plan.
- Individual learning has been commented on by junior doctors when reviewing the quality and content of medical records.

Actions Taken:

- Consideration of changes to the Countywide DNAR and escalation documentation.

The Medical Examiner and Medical Examiner Officer

The Trust appointment and introduction of the Medical Examiner and the Medical Examiner Officer was delated due to Covid19 pressures. The Medical Examiners commenced practice on 1st July 2020. Their work will enable greater learning to be gained from effective reviews of in hospital deaths. It is anticipated that their findings will be reported externally via the National Learning from deaths and coronial process and internally through this quarterly report.

Coronial Activity

5 new instructions were received in quarter 1. Three patients had undergone surgical procedures, with two of these being out of hospital deaths. One had undergone investigations with a decision that nonsurgical management was the best option and one is being investigated following an overdose. 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. It should be noted that in light of Covid19 the coroner's rules have been modified with a resultant increase in the number of 'read only' inquests in cases where clinical statements are unequivocal and the cause of death determined without need for formal questioning.

Learning Disability Deaths

There were 5 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 unit has cared for 1 woman whose pregnancy have sadly ended in uterine death and there has also been 2 neonatal deaths. These cases have been referred for investigation in line with the requirement for Perinatal Mortality review.

The unit has 5 finalised HSIB reports and an action plan from findings and safety recommendations currently being produced to aid improvement.

Themes and Trends from PMRT reviews

Key emerging themes that are being addressed from all the above reviews are:-

- The essential nature of the supernumerary status of the labour ward coordinator.
- Labour issues raised – the significance of interpretation of fetal monitoring and management of induction of labour/Labour
- The drive to improve documentation
- The risks of homebirth and management of these.
- Ensuring woman make fully informed decisions at all stages of pregnancy and labour
- Importance of providing consultant cover in the antenatal clinic

This information concludes the Quarterly Mortality and Learning from Deaths report for Quarter 1.