Mortality Report
Learning from Deaths

Quarter 2 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 included 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 included specific guidance for NHS Trusts in working with families, published in July 2018 and the introduction of Medical Examiners who commenced their role in the Trust on 1st July 2020. The intention 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 was published by the CQC in March 2019. 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.

The Quarterly Learning from Deaths report will confirm the Trust's position in relation to these challenges as well as documenting our progress with the evolving systems used to identify and learn from a patient's death.

The Trust Position

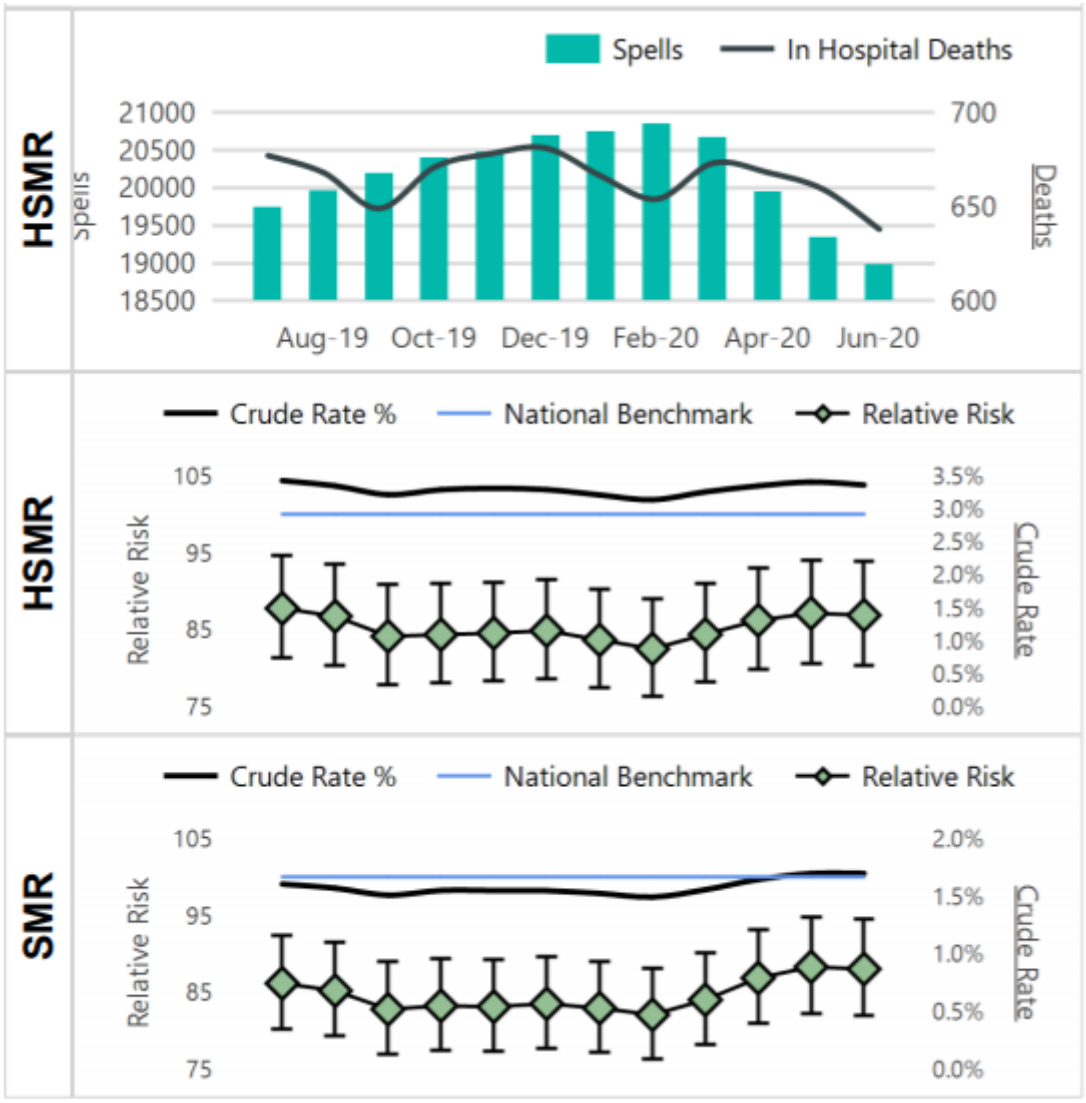
Mortality Rates. In hospital deaths per month

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 May 2019 to April 2020 is 86.97, which is statistically significantly lower than expected using NHS Digitals 95% control limit. Covid-19 activity is excluded from the SHMI. The Trust percentage of spells with Covid-19 coding is 0.9% compared to the national average of 0.8%.

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 latest reporting period July 2019 to June 2020 is 86.8 remains statistically significantly lower than expected and the second 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.



Dr Foster HealthCare Intelligence Mortality Data

Dr Foster provides external assurance, providing a monthly analytical review of outcomes data in respect of Mortality within the Trust.

The latest Dr Foster report with a data set from July 2019 to June 2020 highlights the Trust's position with both HSMR and SMR remaining statistically significantly low. Monitoring of our data reassures 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 Quarter 4 of the previous year and no subsequent new alerts. 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 mortality alerts are reviewed firstly by identifying the patients in the cohort and checking the accuracy of the code allocated to their case. If this does not show any issues an assessment of care and management from the patient records is completed. This allows us to ascertain why the alert has occurred and to identify any actions that should be taken to address any issues with the management of this group of patients. This process may result in the coding for the patient spell being amended if their main documented condition or cause of death has changed since their admission. Reviews are carried out through the Mortality Review Group or by the clinical teams involved, with the outcome fed back through the Clinical Outcomes Committee.

The CUSUM alert in Quarter 4 was for cases coded as 'other liver disease' with 10 cases observed compared to an expected 4.7. The Clinical Outcomes Committee is responsible for investigating all CUSUM alerts with any actions taken referred back through the committee. The 10 cases have been identified with 9 of the case notes being reviewed.

- 7 of these patients had previously been subject to a formal Mortality Review providing assurance that there had been no evidence of avoidability. One of these case reviews scored an avoidability score of 2 as a result of delays due to information received from the referral centre.

- One patient had been referred to the coroner for post-mortem with the diagnosis confirmed.

- One set of notes was not retrieved from archive and therefore not reviewed.

- Two Patients were recoded as a result of the review and no other discrepancies were found within this group of patients.

Learning from Deaths

The Process

In addition to the above reporting mechanisms it is important to provide a formal system to review the care and management of any patient who dies within the Trust. The Trust has appointed a Learning from Deaths Lead who holds responsibility for ensuring robust systems are used to identify and share learning form any death within the hospital.

The Structured Judgement Review Tool (SJR) from the Royal College of Physicians 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 and the Learning from Deaths Lead 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 the formal Medical Examiner interventions at the time of completing the death certification.

- Mortality review 1 - An initial assessment completed by the Medical Examiner enables 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 is identified. Any such case is referred to the Specialty Team or the Mortality Review group who are responsible for undertaking a detailed mortality review to identify any concerns and to ensure learning for improvement. This system ensures that all patient deaths are subject to an initial review of their management and care, with a small number going forward for a full formal review.

- Mortality Review 2 - Cases identified for this type of review will undergo a full review via speciality Morbidity and Mortality meetings with presentation of any significant findings at local Clinical Governance Sessions. Outcomes from these meetings, in particular any learning and actions taken will be recorded through the Learning from Deaths Lead within the Structured Judgement Review tool. The SJR tool summarises each review with an avoidability score. This is used to determine whether the information identified during the review, shows any evidence that the patient's death could have been avoided if different actions had been taken or the circumstances had been different. Any investigation undertaken outside of this process, for instance Serious Untoward Incident Investigations where death has occurred will now 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 regardless of the investigative process.

- Mortality Review 3 - The third stage of the process involves the referral of any patient whose Mortality review has identified a degree of avoidability greater than 50% to the Mortality Review Group for verification and action. The Medical Examiner may also refer cases direct to this level of review. These cases may also include those where an incident investigation has been undertaken or where a case has been referred for a formal coroner's inquest.

The current investigation processes 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 liaise closely to avoid duplication and ensure that all deaths in hospital are reviewed at an appropriate level with outcomes, both positive and negative, recorded and shared.

The Trust's Learning from Deaths Lead has responsibility for collating any learning from all inpatient deaths whichever review method is used. Outcomes are reported through the Incident Investigation and Learning Group, Local Governance Meetings, the Mortality Review Group and the Clinical Outcomes Committee and summarised within this quarterly report.

The Mortality Review Group has experienced difficulties in meeting to enable case reviews to take place due to the Covid restrictions as a formal review of records cannot be done in a virtual setting. The group will be reformed with new ways of working introduced to ensure that the quality and quantity of formal reviews is not adversely affected.

Report from the Medical Examiner

The introduction of the Medical Examiner Role from 1st July 2020 has helped to formalise the above systems. Changes that have been instituted or planned are summarised below

- All patients who die in the hospital will have a notes review by the Medical Examiner. (Due to the number of Medical Examiner sessions this is currently not yet every patient)

- All deaths that are scrutinised also include a discussion with the doctor who completes the Medical Certificate of Cause of Death (MCCD). This may prompt individual learning for the individual doctor and reduce the possibility of the documented cause of death being rejected by the Registrar's Office.

- All deaths also result in a conversation between the ME and the patient's Next of Kin to explore any care concerns that they may have. This allows us to address any issues at an early stage.

Quarter 2 Review Outcomes

Quarter 2 saw 131 patient deaths scrutinised by the Medical Examiner. These would be classified as a Mortality Review at level 1 as described above. Of these cases 11 were referred for a full review using the Structured Judgement Tool, 6 to be completed through the Mortality Review Group and 5 by the clinical teams.

30 cases were referred to the Coroner, the vast majority resulting in a form 100A being issued. This means the Coroner was informed of the death but the doctor has been given permission by the coroner to issue the Medical Certificate and the registrar is advised that they are aware of the death but no further investigation is necessary.

Coronial Activity

There are cases where the coroner has requested investigative statements from staff in relation to the death of an inpatient or where the patient had a recent admission or procedure that could be relevant to their death. 6 new instructions were received in quarter 2. One patient had undergone a surgical procedure and died within 3 months. One sustained a significant head injury before admission. Two patients presented with self-harm and did not survive. 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. The remaining two deaths followed from incidents within the hospital, both of these cases are being investigated through the incident reporting system as well as subject to a Coroner review. No inquests were held in the quarter requiring Trust attendance.

Learning Disability Deaths

There was one patient with a Learning Disability who died in the quarter. The death has been reported in line with national requirements and will be reviewed as patient of the Trust's formal process and referred for a full LeDeR review. There were no immediate actions required and the death was not identified as being 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.

In the quarter the unit has cared for 2 women whose pregnancies have sadly ended in uterine death. These cases have been referred for investigation in line with the requirement for Perinatal Mortality review.

There were also 3 reported neonatal deaths in the quarter but these were as the result of planned termination of pregnancies; 1 for fetal heart anomalies and the other 2 were conjoined twins, which were unable to be separated and incompatible with life. These cases have to be reported as neonatal deaths but investigation is not required.

This table provides the number of deaths in month against the number reviewed using any of the investigative processes available. 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							
	April	May	June	Q1 Total	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
Total deaths in the Trust (including ED deaths)	58	66	70	**194**	55	61	44	**160**	64	51	46	**162**	88	67	71	**226**	61	51	55	**167**	37	53	50	**140**
Number subject to a Level 1 Mortality Review	N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		33	47	51	**131**
Number subject to a Level 2/3 Mortality Review	14	17	25	**56**	13	14	16	**43**	18	18	16	**52**	28	15	17	**60**	5	7	3	**15**	4	2	3	**9**
Number investigated as a Serious Incident	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	1	1	0	**2**	0	0	0	**0**	0	0	1	**1**
Learning Disability deaths	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	4	1	0	**5**	0	1	0	**1**
Bereavement concerns	1	1	1	**3**	1	1	3	**4**	2	1	2	**5**	4	1	0	**5**	0	0	2	**3**	0	1	0	**1**
Coroner's Inquest investigations	5	3	1	**9**	0	4	0	**4**	2	1	1	**4**	2	2	3	**7**	2	2	0	**4**	0	3	3	**6**
Number thought more likely than not to be due to problems with care	0	1	1	**2**	0	0	1	**1**	0	1	1	**2**	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**

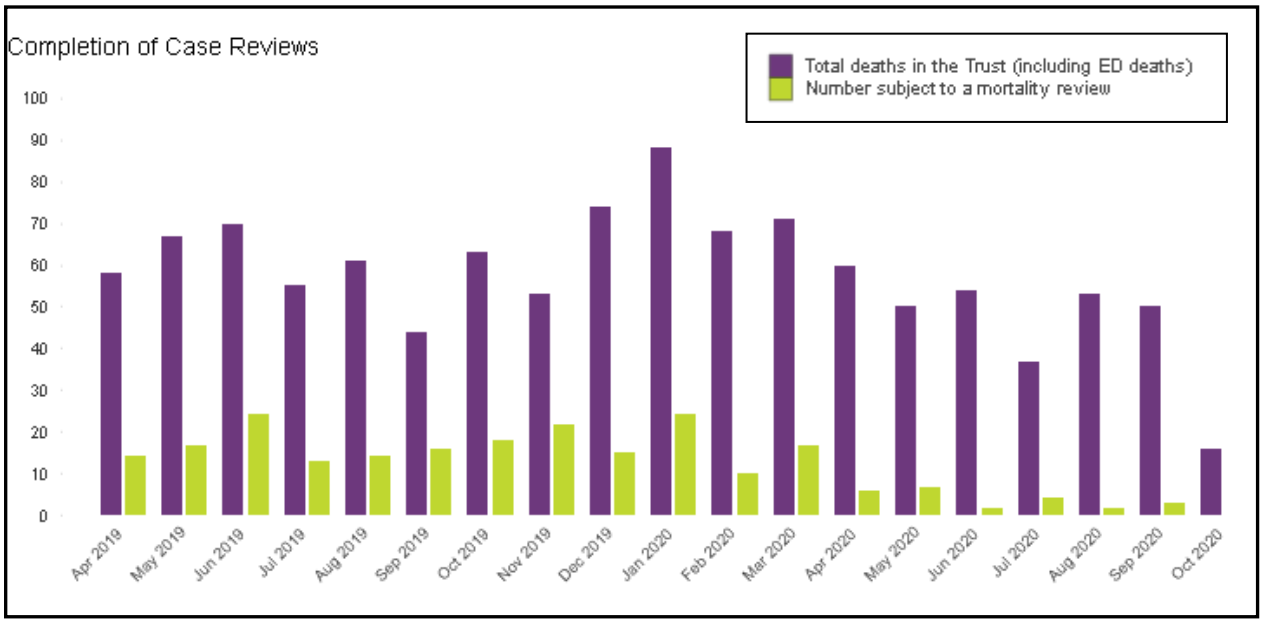
It should be noted that scrutiny of all patient deaths by the Medical Examiner and the resultant change in process means that comparative data is not yet available for all types of investigative review. Where available retrospective data has been added to the above chart.

Of the 18 deaths subject to a full case review so far in Q2-

- 9 were subject to a level 3 Mortality Review using the SJR tool (131 Level 1 Mortality Reviews were also completed by the Medical Examiner)
- 1 case was referred for a LeDeR review following initial local review.
- 1 was reviewed where bereavement concerns were raised and 6 will be reviewed as part of the coronial process.

For those reviews undertaken using the Structured Judgement Tool in Quarter 2 (and the updated cases from the previous quarter), there were 2 cases with a score below 5. One case in June scoring a 3 is also subject to a formal complaint and in line with the Duty of Candour requirements the outcome of the Mortality review will be shared with the patient's Next of Kin. Initial review has identified a lack of appropriate fluid management, delays in referral and poor communication with the family. No other care concerns are thought to have contributed to the outcome other patients reviewed.

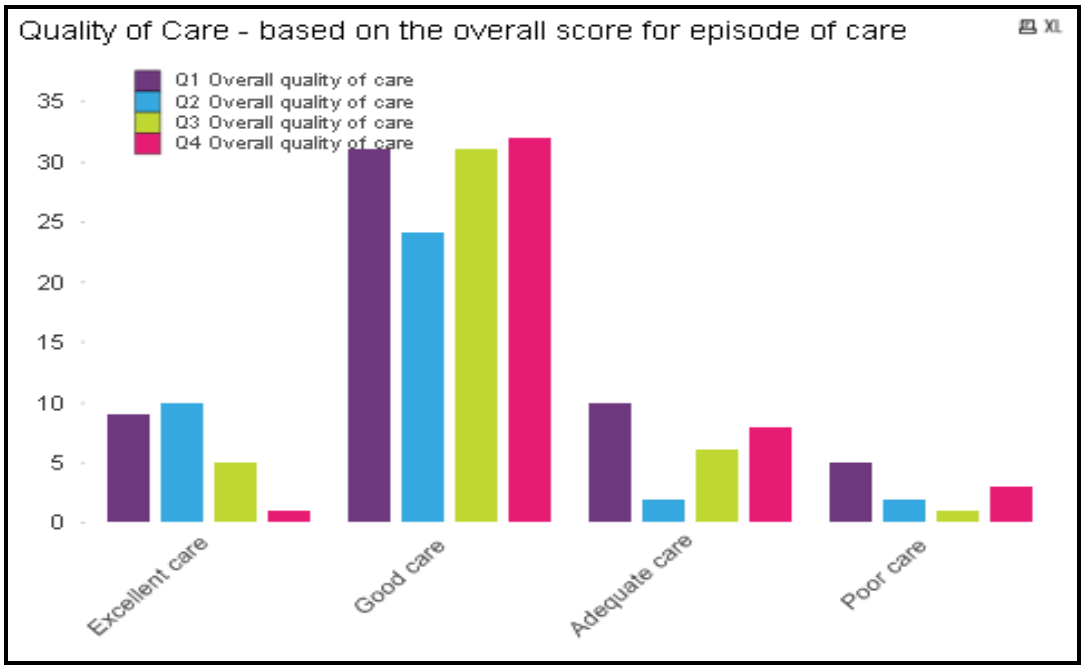
This data is summarised in the following charts:



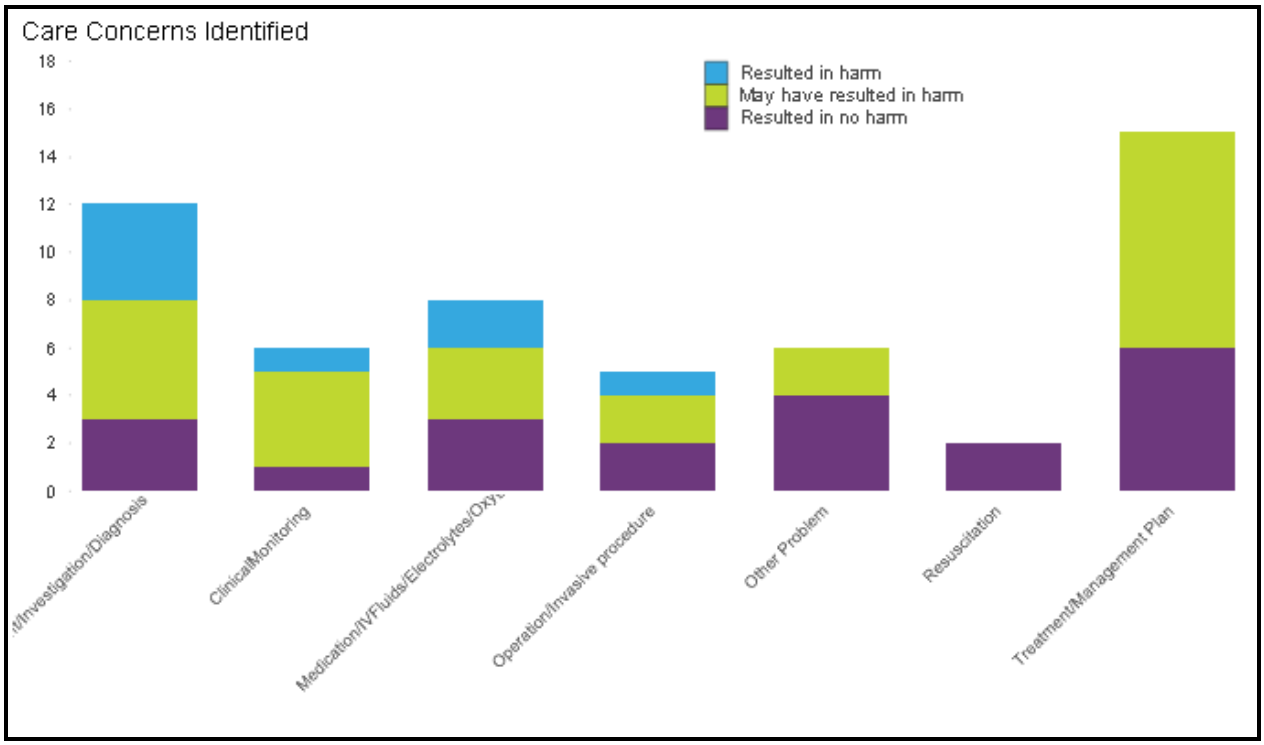
It should be noted that these figures relate to Level 3 case reviews performed using the Structured Judgement Tool only with the previous quarter update in place.

Overall Findings from case reviews completed using the Structured Judgement Tool

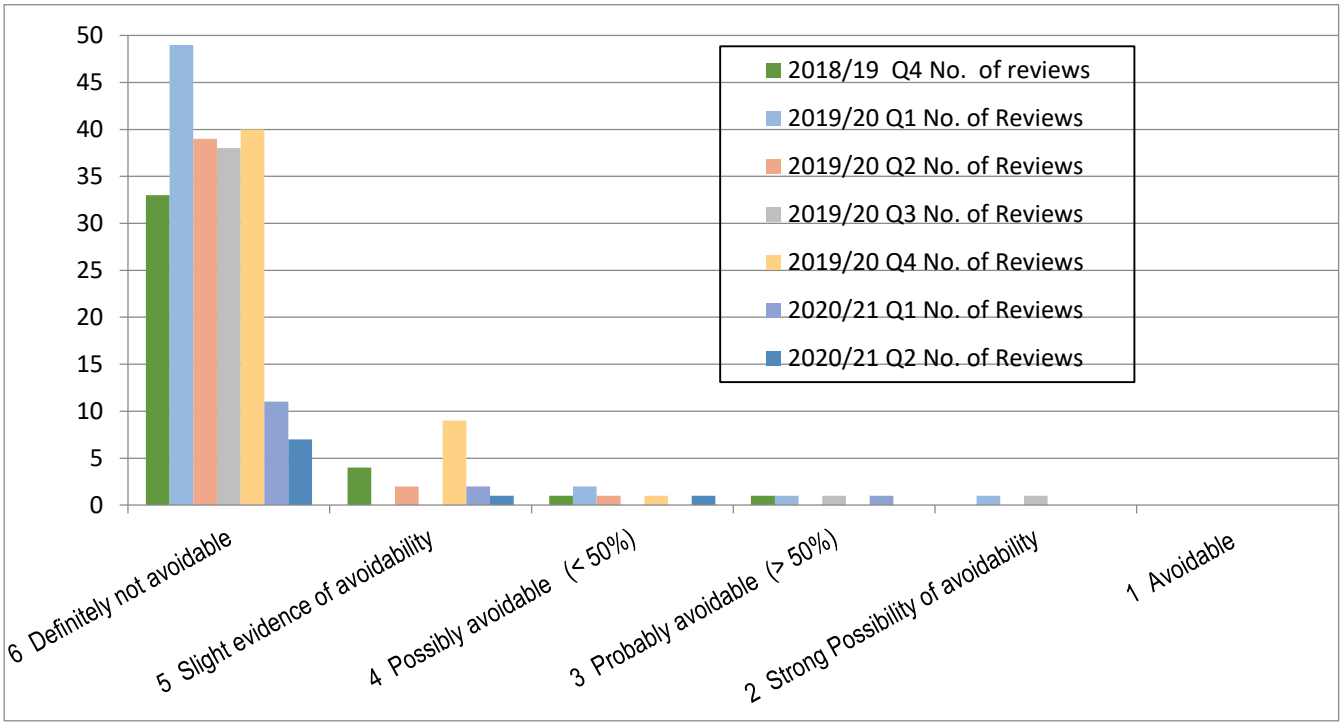
Quarter 2 2020/21- Quality of Care



Care Concerns Identified rolling year



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

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 those detailed above;

- 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 Trust wide learning and address any issues that have been identified.

Themes from mortality reviews and investigations including Coroners referrals 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 assessed as good or excellent
- No significant issues were identified.
- The Medical Examiner role has increased communication with HM Coroner and enabled an initial assessment of the majority of deaths.

Issues positive and negative:

- There was one death from the previous quarter scoring a 3 on the SJR with a degree of avoidability identified. (This case is subject to a formal complaint investigation) – Findings from the Mortality Review will be shared with the family.
- Poor fluid management identified as a potential cause for patient deterioration.
- Poor management of skin damage and late involvement of Tissue Viability Team.
- Failures in completing all risk assessments on admission and to reassess when the situation changes. In particular falls risk assessments.
- Timely and appropriate DNAR discussions and decisions were made.
- Community escalation plans were transferred to acute care and followed for the individual patients involved.
- The Trust process for accepting, storing and acting on Advance Directives provided by individual patients was found to be lacking.

Lessons Learned:

- Potential delays in patient management can be caused by admission to an inappropriate ward area and subsequent transfer.
- Earlier consultation with Palliative Care Team could reduce unnecessary investigations and invasive procedures.
- Early referral to the Tissue Viability Team could reduce the potential for infection and subsequent deterioration.
- Ongoing work to detect Acute Kidney Injury and educate about the importance of adequate fluid replacement needs to continue.
- Ward moves can detract from the completion of formal documented assessments, leading to less knowledge about the individuals' limitations and risks at a time when they may be unsettled from the transfer.
- The process by which a patient can provide an Advance Directive and the way their expectations are managed needs to be reviewed.

Actions Taken:

- Continued monitoring of patients for and management of AKI.
- Active interventions through the Trust falls group including continued use of Tag Nursing and observational activities for 'wandering patients'.
- Discussion relating to the provision of Advance Directives at the Clinical Ethics Committee.
- Further work planned to look at the processes in place to manage a patient expectations in respect of an Advance Directive and ensure a formal process is in place to store and flag the document.

Themes and Trends from PMRT reviews

Recent learning from previous case reviews has centred on:

- Documentation improvement drive
- The use of a partogramme to record maternal observations for all women in labour including those with IUD
- Baby organ donation

This information concludes the Quarterly Mortality and Learning from Deaths report for Quarter 2.