# Mortality Report
# Learning from Deaths

# Quarter 4 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 highlighted several challenges for Trusts in the future. These include:

- Monitoring and evolving 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 Trust also faces the additional challenge of setting up and maintaining additional processes to investigate and learn from cases where COVID-19 has been identified as the cause of death or a contributory factor. The Mortality processes and Medical Examiner Role link closely with the Post Infection Review (PIR) carried out for all patients with a hospital acquired COVID-19 infection confirmed by a positive test.

The South West Regional Healthcare Setting Outbreak Framework from NHS England and NHS Improvement – South West, highlights the need for formal reviews to capture learning from these cases. The guidance states that where there is any evidence that the COVID-19 infection may have been hospital-acquired and a death has resulted, there is scope for learning. If the infection was acquired due to issues in healthcare provision, such as non-compliance with IPC processes this is potentially a Serious Incident. The choice of format to capture learning remained a decision for each Trust. We have evolved a formal Post-Infection Review process, enabling inclusion of the initial review by the Medical Examiner and where required a full Mortality Review using the Structured Judgement Tool.

The Trust responded to new and emerging information and guidance as the pandemic evolved and adhered to all National Infection Prevention and Control Guidance. We adapted our practice in line with updated guidance, increasing the frequency of patient testing. Patients are now tested on day one, three and six of admission, and then weekly, or if there is a change in condition. This has changed the standard for identification of patients with a possible or definite hospital-acquired infection who require a Mortality Review.

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

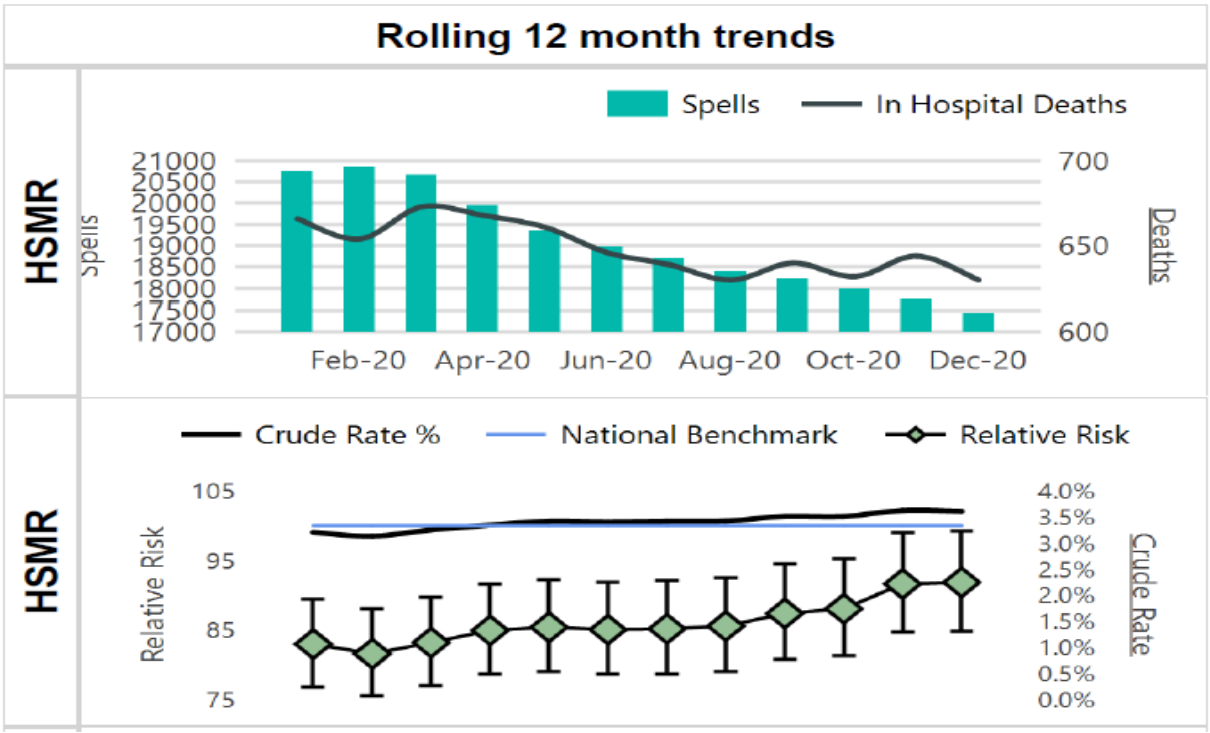
**Mortality Rates. In hospital deaths per month**

**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 November 2019 to October 2020 is 86.96, which is statistically significantly lower than expected. The Trust percentage of spells with COVID-19 coding is 0.5% compared to the national average of 1.8%. This is an indication of the number of patients in hospital with a coded diagnosis of COVID-19 as a percentage of total activity. The relevance of this is the exclusion of this group of patients from the SHMI.

**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 January to December 2020 is 91.8 remains statistically significantly lower than expected and lowest in the regional acute peer group. A weekday split shows our weekday HSMR 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 January 2020 to December 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 Mortality alert originating in October and two in November, both reported by Dr Foster this month. 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 alerts in the quarter were one for occlusion or stenosis of pre-cerebral arteries and one for a statistically higher relative risk for non-hypertensive heart failure. There was also a recurrence of an alert for other perinatal conditions, last highlighted in the Dr Foster report from November 2020.

The first case from October (Occlusion of pre-cerebral arteries) was a patient who unfortunately died following a collapse at home leading to an admission of less than 24 hours. This case has been more effectively coded and had already been subject to an incident investigation.

The congestive heart failure, non-hypertensive alert showed 60 observed deaths in a 12-month period compared with an expected 44.6. The rolling trend showed a gradual increase resulting in a higher than expected relative risk. The COVID pandemic has resulted in a change in patient activity which has reduced the denominator data and the variation in the number of observed deaths in some diagnoses groups. This trend will be monitored as will the higher than expected relative risk for other perinatal conditions will also be monitored.

## 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 Manager 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 Manager oversee reviews of the management and care of all patients who have died within the hospital. A three-stage process is used 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 Mortality or Clinical 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 Manager 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.

  There are some groups of patient who will automatically be subject to a Mortality Review 2, regardless of any findings identified by the Medical Examiner. These are where the number of deaths in the specialty is small, where the patient had a Learning Disability and where there is evidence of a hospital acquired COVID-19 infection which has been cited as the cause or contributed to the death.

- 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 for this level of review. These cases may also include those where an incident investigation has been undertaken which does not cover the patient's death 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, 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 Manager 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 Manager has responsibility for collating 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 as well as being summarised within this quarterly report.

The Mortality Review Group has experienced difficulties in meeting to facilitate case reviews due to the Covid restrictions, as a formal review of records cannot be completed in a virtual setting. The group has reformed with new ways of working introduced to ensure that the quality and quantity of formal reviews is not adversely affected. Virtual meetings to provide feedback from the month's reviews and to collate learning have been introduced.

## Update from the Medical Examiner

The introduction of the Medical Examiner Role in 2020 has helped to formalise the above systems.

- Plans for all patients who die in the hospital to have a notes review by the Medical Examiner has not yet been possible due to the number of available Medical Examiner sessions.

- The majority of deaths are scrutinised and assessed to identify any issues for referral. A discussion also occurs with the doctor responsible for completing the Medical Certificate of Cause

of Death (MCCD). This may prompt learning for the individual doctor and can serve to reduce the possibility of the documented cause of death being rejected by the Registrar's Office.

- There will be a conversation between the Medical Examiner Officer or Medical Examiner and the patient's Next of Kin to explore any care concerns that they may have. This allows the team to identify any potential issues and to address these at an early stage.

**Quarter 4 Review Outcomes**

Quarter 4 saw 171 inpatient deaths scrutinised by the Medical Examiner. These would be classified as a Mortality Review at level 1 as described above. Of these cases 19 were referred for a full review using the Structured Judgement Tool, 9 to be completed through the Mortality Review Group and 10 by the clinical teams.

Of those cases referred to the Coroner for agreement about the cause of death, 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 the Coroner has been made 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. 2 new instructions were received relating to deaths in quarter 4 and one from a death in the previous quarter. One patient had an out of hospital arrest 6 days following discharge with a possible MI or Pulmonary Embolism. One was a fall at home sustaining a subdural haematoma and the third a fall sustaining fractured ribs and pneumothorax whereby the patient refused admission following initial assessment by the paramedics. Formal statements have been obtained with no omission or care problems identified that would be considered to have contributed to the death. No inquests were held in the quarter requiring Trust attendance but one complex case has been subject to an initial Pre-inquest review meeting with the Dorset Coroner.

**Learning Disability Deaths**

Two patients with a Learning Disability died in the quarter. These deaths have been reported in line with national requirements and will be reviewed as part of the Trust's formal process and referred externally for a full LeDeR review. Following the changes to the current process these cases will be subject to a full Mortality Review (MR2) using the Structured Judgement Tool. No immediate actions have been identified and the deaths are not believed to be 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. Review is undertaken by a multidisciplinary panel of clinicians which has to include a panel member who is external to the unit.

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.

Two intrauterine deaths and one neonatal death occurred in quarter 4. These will be subject to PMRT panel reviews with the findings shared in future Learning from Death reports.

There has been a requirement to review one case in quarter 4; the case was an intrauterine death at 28 weeks gestation with history of prolonged rupture of membranes. PMRT findings have identified learning from this case – detailed below.

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 | | | | Green line indicates the point where the Medical Examiners process was introduced and mortality review process changed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 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)** | 64 | 51 | 46 | **162** | 88 | 67 | 71 | **226** | 61 | 51 | 55 | **167** | 37 | 53 | 51 | **141** | 52 | 81 | 96 | **229** | 104 | 76 | 57 | **237** |
| **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 | | 33 | 47 | 51 | **131** | 49 | 62 | 58 | **169** | 85 | 49 | 37 | **171** |
| **Number subject to a Level 2/3 Mortality Review** | 18 | 18 | 16 | **52** | 28 | 15 | 17 | **60** | 6 | 7 | 3 | **16** | 5 | 6 | 4 | **15** | 7 | 14 | 17 | **38** | 5 | 13 | 1 | **19** |
| **Number investigated as a Serious Incident** | 0 | 0 | 0 | **0** | 1 | 1 | 0 | **2** | 0 | 0 | 0 | **0** | 0 | 0 | 1 | **1** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** |
| **Learning Disability deaths** | 0 | 0 | 0 | **0** | 0 | 2 | 0 | **2** | 4 | 1 | 0 | **5** | 0 | 1 | 0 | **1** | 0 | 0 | 1 | **1** | 0 | 1 | 1 | **2** |
| **Bereavement concerns** | 2 | 1 | 2 | **5** | 4 | 1 | 0 | **5** | 0 | 0 | 2 | **3** | 0 | 1 | 0 | **1** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** |
| **Coroner's Inquest investigations** | 2 | 1 | 1 | **4** | 2 | 2 | 3 | **7** | 2 | 2 | 0 | **4** | 0 | 3 | 3 | **6** | 3 | 1 | 2 | **6** | 0 | 1 | 1 | **2** |
| **Number thought more likely than not to be due to problems with care** | 0 | 1 | 1 | **2** | 0 | 0 | 0 | **0** | 0 | 0 | 1 | **1** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 1 | **1** |

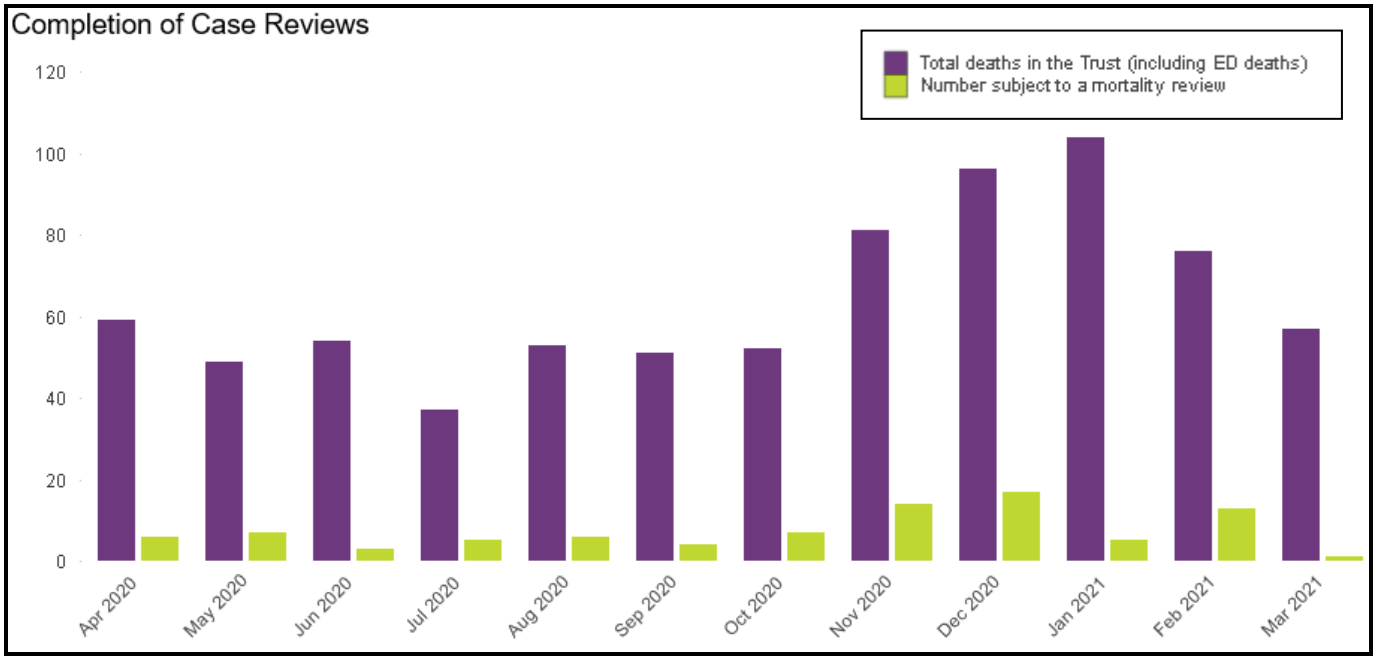
It should be noted that scrutiny of all patient deaths by the Medical Examiner and the resultant change in process means that comparative data is not yet available for all types of investigative review. Where available retrospective data has been added to the above chart.

In Q4 171 cases were reviewed by the Medical Examiner as a first level Mortality Review and 23 deaths were subject to a full case review

- 19 were subject to a level 2 Mortality Review using the SJR tool
- 2 cases were referred for a LeDeR review following initial local review.
- No cases were reviewed where bereavement concerns were raised and 2 will be reviewed as part of the coronial process.

For those reviews undertaken using the Structured Judgement Tool in Quarter 4 (and the updated cases from the previous quarter), there was one case scoring 3 and one scoring 4 with all other cases scoring 5 or 6. The two potentially avoidable deaths have been referred back to the clinical team to provide further information and ensure actions to mitigate a recurrence have been taken.

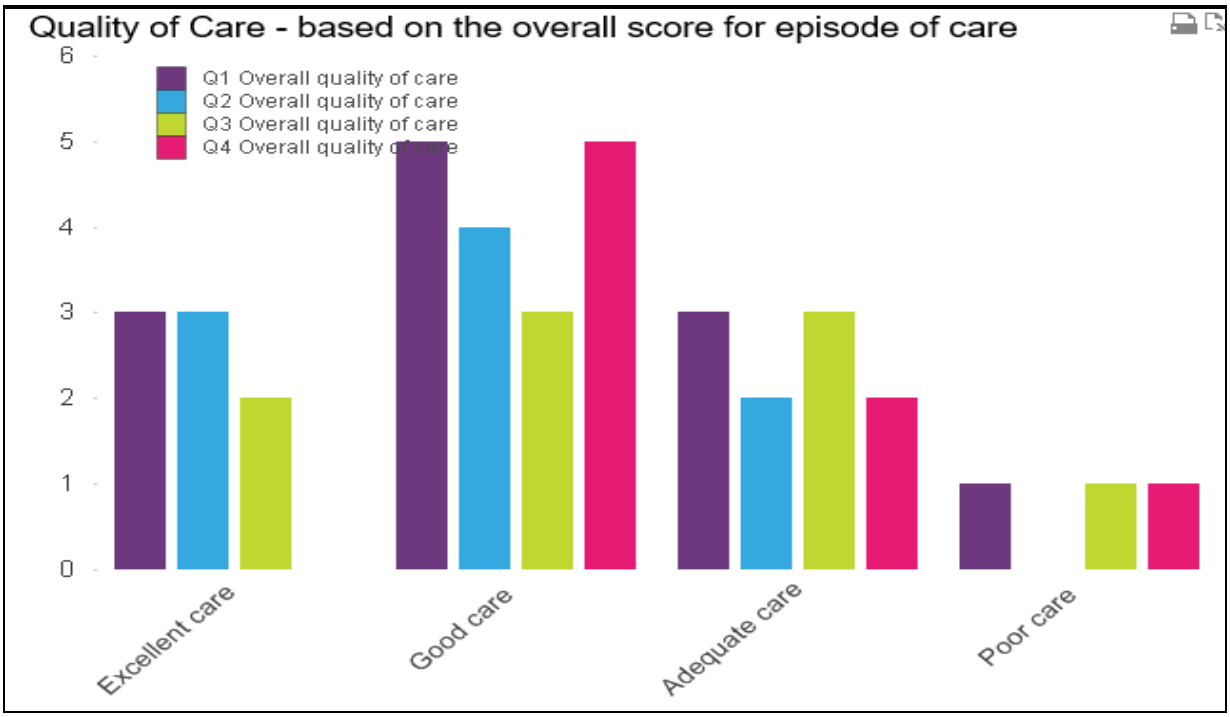
This data is summarised in the following charts:



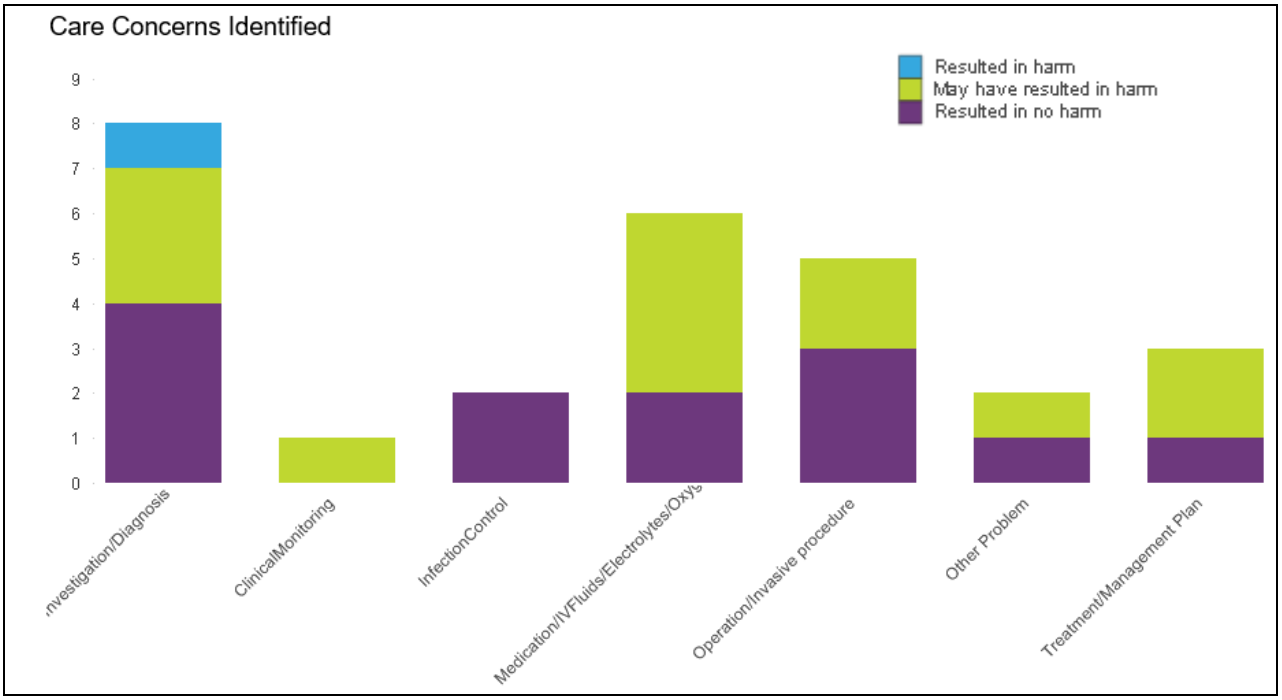

It should be noted that these figures relate to Level 2 case reviews performed using the Structured Judgement Tool only with the previous quarter update in place.

## Overall Findings from case reviews completed using the Structured Judgement Tool

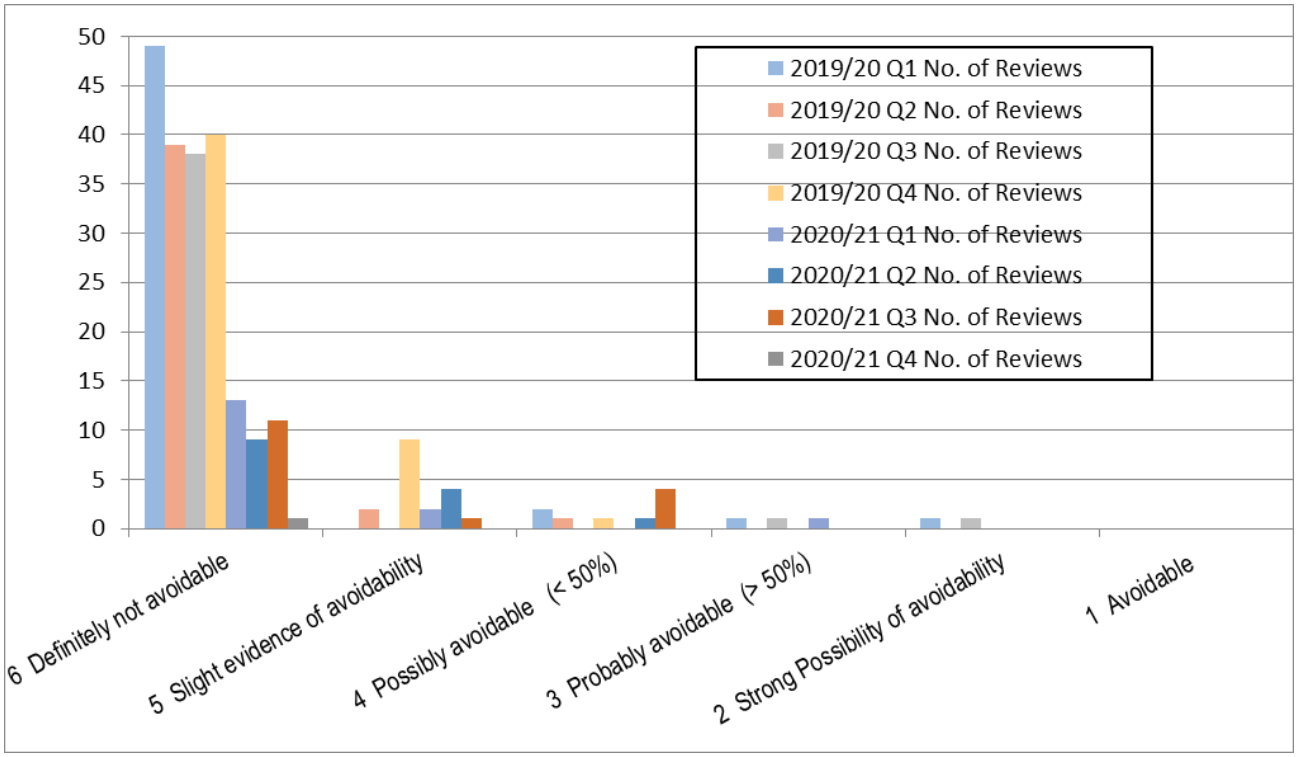
### Quarter 4 2020/21- Quality of Care



## Care Concerns Identified rolling year to date




## Level of avoidability of death in each case reviewed - Rolling data 2019-2021




<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 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.
- Review of COVID-19 related deaths

The Trust has developed processes to identify any care and service delivery problems within the group of patients where a COVID-19 infection has contributed to or caused their death. This is important as the number of deaths increases both nationally and within the Trust. Current data shows that in the first wave (March to June 2020) 29 patients had COVID-19 listed as a cause or contributory factor on their death certificate. With an additional 106 patients in this position since November 2020. These numbers include hospital-acquired infections and those patients admitted with a positive status. Outcomes of reviews for hospital-acquired cases will be reported in the future Learning from Deaths report.

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:

- There were no significant issues with the quality of documentation in the quarter.
- One case identified care issues and delays that may have contributed to a patient's death (Score 3).
- The Medical Examiner role continues to allow targeted clinical reviews to take place.
- Outcomes of Clinical Notes reviews requested by the ME have been discussed at Specialty Governance Meetings

**Issues positive and negative:**

- Timely and appropriate DNAR discussions and decisions were made.
- Cases where a hospital acquired COVID-19 infection has been identified and linking to a patient's death require formal review including a first level mortality review. To date our Infection Prevention and Control reviews have not identified any care and service delivery problems or any specific events where there is evidence that this would have contributed to the outcome or transmission of Covid 19
- Delays in diagnostic tests and commencement of antibiotics due to difficulties with cannulation. Not escalated in order to resolve issue.

- Surgical procedure necessitating withhold of anticoagulation with unclear plan for recommencement potentially contributed to patient death from pulmonary embolism.

- Potential delays due to COVID-19 restrictions leading to lack of management plan and ongoing treatment.

**Lessons Learned:**

- There is a need to provide effective formal review of patients who have died as a result of a COVID-19 infection, particularly if this is hospital-acquired. Formal SJR using retrospective review of patient records does not identify any infection control issues. Post-Infection Reviews incorporating Mortality elements have been required.

- Continued review of anticoagulation guidance is required to ensure that patients are aware of the need to recommence medication appropriately and report any complications in a timely manner.

**Actions Taken:**

- As a consequence of the challenges and changing guidance relating to the COVID-19 pandemic there has been increased cleaning regimes, continued access to personal protective equipment (PPE) for all staff as required, continual review of patient pathways and substantial environmental improvements.

- Development of a Post-Infection Review and Duty of Candour templates to capture and share relevant data.

- Review of patient information in relation to withholding medication to facilitate day case procedures.

- Measures are already in place to facilitate continued non-covid activity and encourage patients to report symptoms and attend the hospital.

**Themes and Trends from PMRT reviews**

Recent learning from previous case reviews has centred on:

- Smoking in the family home is a common theme running through PMRT outcomes with local and national drive to aid improvement. There is currently no fail safe system for partner referrals. The referral process will be amended to make sure this is followed up in the future and included in a compliance audit.

- Unit learning action plans from PMRT continue to focus on documentation. Especially documentation of routine assessments and expectations such as discussions around risk assessment for need of aspirin and enquiry about domestic abuse.

This information concludes the Quarterly Mortality and Learning from Deaths report for Quarter 4.