Appendix:	5

REPORT TO:	Board of Directors
REPORT BY:	Janet Ebdon, Learning from Deaths Manager
PRESENTED BY:	Meridith Kane, Chief Medical Officer
EXEC SPONSOR:	Meridith Kane, Chief Medical Officer
REPORT TITLE:	Learning from Deaths/Mortality Report
DATE:	3 November 2021

Purpose of Paper (Please select any which are relevant to this paper)		
☒ For Assurance	☐ For Approval / Decision	☐ For Information

Reason for Presentation to Committee/Board	The Trust has implemented the required recommendations in implementing the National Guidance on Learning from Deaths. The Mortality Report includes summary tables for the Trust, which should be presented to the Board on a quarterly basis. This is a requirement of the National Quality Board Guidance on Learning from Deaths March 2017 and the NHS Improvement Implementing the Learning from Deaths framework, key requirements for Trust Boards July 2017.
Any Key Issues to Note	The Quarter 2 report reflects the ongoing progress with the Medical Examiner identifying cases requiring further investigation through Mortality Reviews or Clinical Investigations. In addition the difficulties that are experienced when demand exceeds capacity.

Links to Strategic Priorities / Board Assurance Framework (Please select any which are impacted on / relevant to this paper)	
☒ **Care for our Population**	☒ **Develop our People**
☐ **Innovate and Collaborate**	☐ **Develop a Sustainable System**

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☒ Patient Safety / Quality

Reference to CQC domains (Please select any which are relevant to this paper)				
☒ Safe	☒ Effective	☒ Caring	☐ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

Mortality Report
Learning from Deaths

Quarter 2 2021/2022

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 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) required 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 Trust responded to new and emerging information and guidance as the pandemic evolved and adhered to all National Infection Prevention and Control Guidance. 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 Quarterly Learning from Deaths report confirms 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 2020 to April 2021 is 95.09 a slight increase slightly compared to the previous 12 month period.

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 2020 to June 2021 is 94.8 remains within the expected range. A weekday split shows our weekday and weekend figures within the expected range.

There have been changes to the way that Dr Foster receives the national HES (Hospital Episode Statistics) data and this now comes directly from NHS Digital. This new data feed offers several advantages, with a richer data set and improved filters to ensure age related anomalies are excluded. Enhanced methodology will include 24 diagnosis code positions available in the HES data and this will improve the accuracy of comorbidity and palliative code indicators and the predictive ability of Dr Foster's risk model.

These changes do not allow Dr Foster to provide the previous level of specialty analysis with the necessary patient re-identification service from within the Healthcare Intelligence Portal (HIP) toolkit. The Trust intends to set up a local data feed to enable the full external analysis to continue.

Dr Foster HealthCare Intelligence Mortality Data

The Dr Foster analysis 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 May 2020 to April 2021 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. The new Dr Foster data set will increase numbers of cases analysed which may have an impact on risk adjusted and crude rates within future reports.

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. Currently if all Covid-19 activity is removed from the HSMR the figure reduces to 92.8 which is within the expected range but close to being statistically lower than expected.

There were 2 new CUSUM alerts reported by Dr Foster in Quarter 2. 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 CUSUM alerts relate to Diabetes Mellitus with complications with a statistically significantly higher than expected relative risk, with 8 reported deaths vs an expected figure of 3.3. The second alert for 'other joint' also has a statistically higher relative risk with 4 deaths vs 0.7. This alert relates to procedures that do not fit into a more meaningful clinical group. This and the low numbers involved make this an alert where monitoring will be sufficient.

All CUSUM 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.

In respect of the Alerts for Congestive Heart Failure and Senility and Organic Mental Disorders from Quarter one, originating in May; these diagnosis groups were very low numbers and it was agreed that these two categories should be monitored and investigated if the numbers increase. The absence of re-identification data through the quarter has meant that it has not been possible to interrogate patient level details, but these two alerts will continue to be monitored once the dataset and reports are fully functional.

Learning from Deaths

The Process

In addition to the above overview 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's Learning from Deaths Manager holds responsibility for ensuring robust systems are used to identify and share learning from 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 Mortality Review Group continues to allocate formal review to clinicians with the expectation that they will perform the formal review and discuss with colleagues, ensuring a robust process.

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.

Update from the Medical Examiners

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. Recruitment is ongoing to ensure effective cover is provided in future, both for inpatient and community deaths.

- 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.

- Extending the Medical Examiners Remit to include deaths in the community provides a new challenge, both in the increased level of activity that will be evident and the coordination required across the acute and community setting. We are also collaborating with Somerset Foundation Trust to provide a seamless cross-country process.

Quarter 2 Review Outcomes

Quarter 2 saw 121 inpatient deaths scrutinised by the Medical Examiner. These would be classified as a Mortality Review at level 1 as described above. Of these cases 33 were referred to the Coroner for agreement about the cause of death, 12 were referred for a full review using the Structured Judgement Tool. 10 of these to be completed through the Mortality Review Group and 2 by the clinical teams.

Of those cases referred to the Coroner for agreement about the cause of death, the majority resulted 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 2, and none from deaths in the previous quarter. One out of hospital death from alcohol related liver disease with recent attendance; one patient developed sepsis following surgical procedure; a patient readmitted with unexplained liver decompensation diagnosed with Weil's disease; two patients with cerebral haemorrhage – one fall at home and one a recent discharge following a fall in another hospital. Formal statements have been obtained with no omission or care problems identified that would be considered to have contributed to the patients' deaths. No inquests were held in the quarter requiring Trust attendance but one complex case continues to be subject to Pre-inquest reviews with the Dorset Coroner and a second case from a death in 2017 is also due to be relisted.

Learning Disability Deaths

One patient with a Learning Disability died in the quarter. The death has 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.

Reviews undertaken and the findings are detailed in the Trust's Quarterly Maternity Quality Report.

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.

	2020/21				Green line indicates the point where the Medical Examiners process was introduced and the mortality review process changed.												2021/22							
	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)	61	51	55	**167**	37	53	51	**141**	52	81	96	**229**	104	76	57	**237**	61	68	59	**188**	68	71	62	**201**
Number subject to a Level 1 Mortality Review	N/A	N/A	N/A		33	47	51	**131**	49	62	58	**169**	85	49	37	**171**	49	47	33	**129**	49	47	25	**121**
Number subject to a Level 2/3 Mortality Review	6	7	3	**16**	5	6	4	**15**	7	14	17	**38**	10	16	8	**34**	8	3	4	**15**	3	3	2	**8**
Number investigated as a Serious Incident	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**
Learning Disability deaths	4	1	0	**5**	0	1	0	**1**	0	0	1	**1**	0	1	1	**2**	1	0	0	**1**	0	1	0	**1**
Bereavement concerns	0	0	2	**3**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	1	1	**2**	0	0	1	**1**
Coroner's Inquest investigations	2	2	0	**4**	0	3	3	**6**	3	1	2	**6**	0	1	1	**2**	0	1	1	**2**	2	2	1	**5**
Number thought more likely than not to be due to problems with care	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	0	0	**1**	**0**	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.

In Q2 121 cases were reviewed by the Medical Examiner as a first level Mortality Review and15 deaths had a full case review so far in the quarter

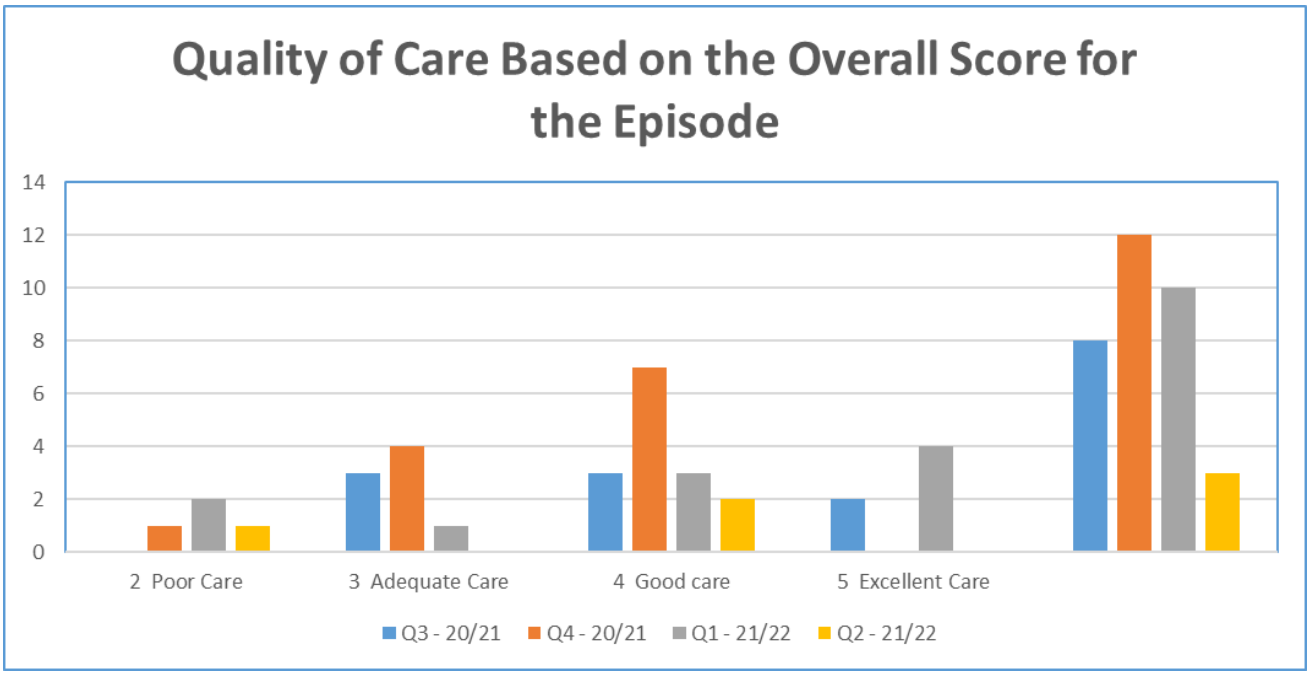
- 8 were subject to a level 2 Mortality Review using the SJR tool
- 1 case was referred for a LeDeR review following initial local review.
- 1 case was reviewed where bereavement concerns were raised and 5 will be reviewed as part of the coronial process.

For those reviews undertaken using the Structured Judgement Tool in Quarter 2 (and the updated cases from the previous quarter), there was one case scoring 3 from a death in June. This case is currently under investigation. All other cases reviewed using the SJR approach within Quarter 2 scored 5 or 6.

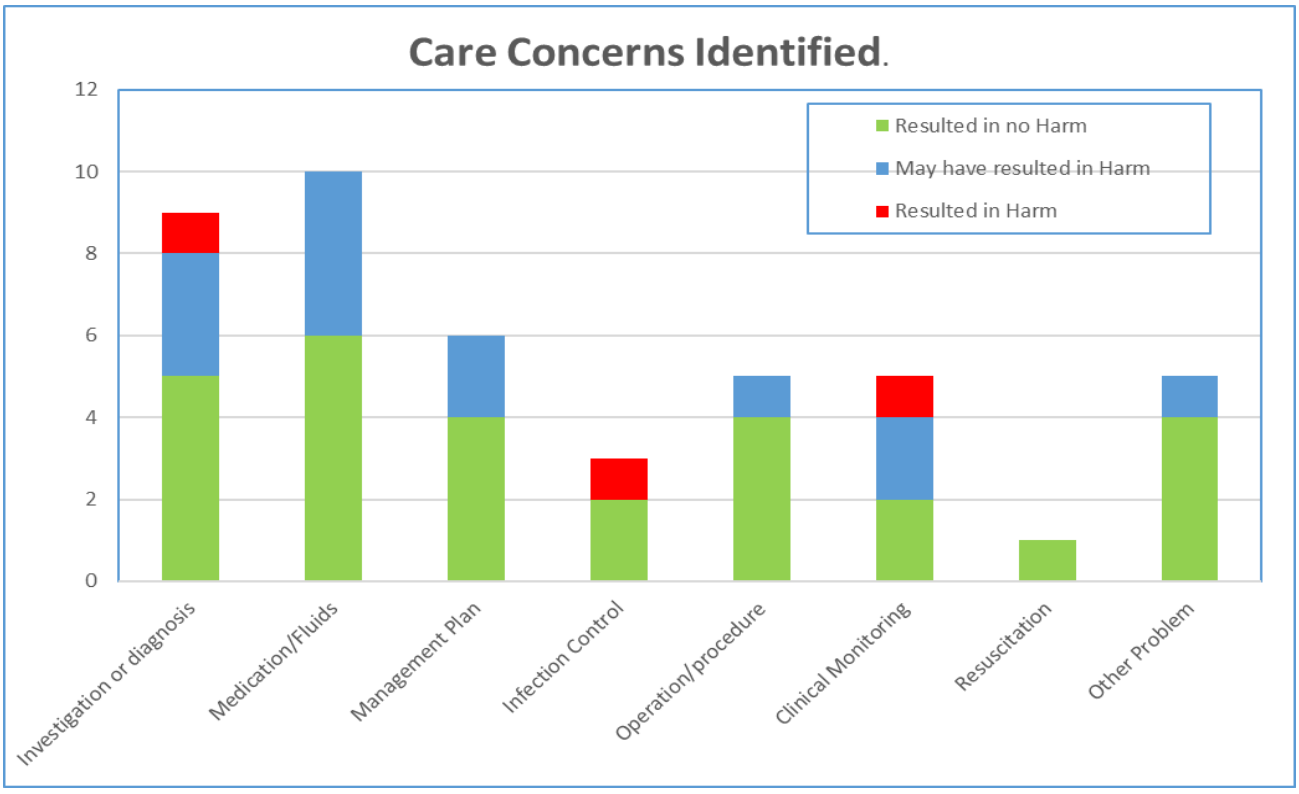
This data is summarised in the following charts:

Overall Findings from case reviews completed using the Structured Judgement Tool

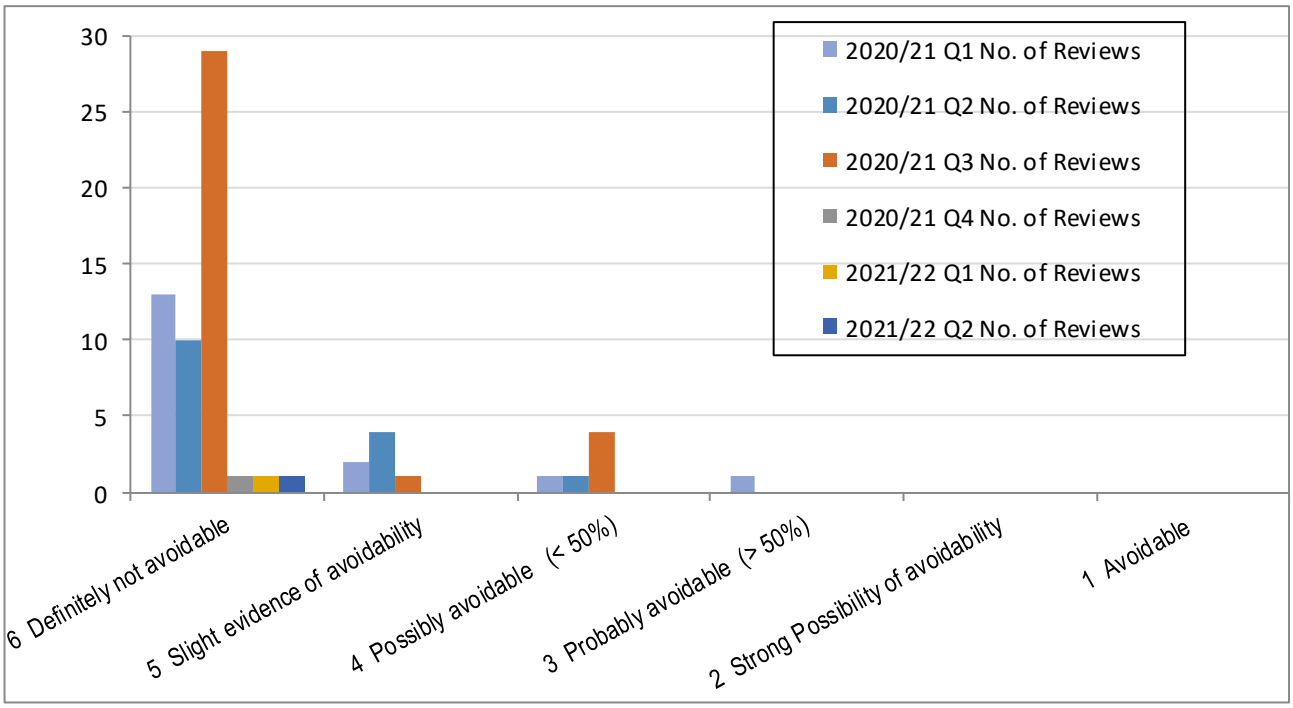
Quarter 2 2021/22- Quality of Care



Care Concerns Identified rolling year to date



Level of avoidability of death in each case reviewed - Rolling data 2022-2021



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.
- 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. Where a patient has COVID-19 identified as a cause of death documented on their death certificate a formal review is undertaken. These have included hospital-acquired infections and those patients admitted with a positive status. Outcomes of reviews for individual hospital-acquired cases will be reported in the future Learning from Deaths report where any omission of care problem is identified. For reports completed in the quarter no omissions have been identified.

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.
- Structured Judgement Review scores continue to show low avoidability in the majority of cases.

Issues positive and negative:

- Delays in escalation of the deteriorating patient has become more significant in the reviews.
- Although it is difficult to triangulate this data staffing issues have been cited as leading to a lack of senior decision making.
- Evidence of good practice is being identified and recorded.
- Medical Examiners do not have capacity to review all inpatient deaths leading to a lower number of identified cases for full Mortality Review.
- The number of patients readmitted who die within 48 hours appears to have increased.

Lessons Learned:

- Patients with chronic haematological diseases must be discussed with the specialist team when decisions about surgical management are being made.
- Clear Treatment Escalation plans are essential to minimise inappropriate patient transfers back to the acute hospital setting.

Actions Taken:

- Joint review of Haematology patient to ensure collaborative learning.
- Review of pathways for patients with conditions where long-term remission is anticipated.
- Ongoing work relating to DNAR and Treatment Escalation plans.

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