Board of Directors

Subject:	Learning from Deaths Group (formerly Mortality Surveillance Group)– Q4 update	**Date: 06/05/21**	
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Approved By:	David Selwyn, Medical Director		
Presented By:	David Selwyn		

Purpose		
The purpose of this paper is to present the Board of Directors with a Summary of the implementation of the Learning from Deaths Guidance, providing an overview on compliance against the 90% standard to review all deaths, the lessons learned and plans for 2021/22	**Approval**	
	Assurance	x
	Update	x
	Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x			x	x

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**

Risks/Issues	
Financial	Further information regarding IT platform for Mortality Review Tool
Patient Impact	Improvements to services and care will be realised through the timely and comprehensive review of each death to maximise learning opportunities
Staff Impact	Changes to practice and care will be identified through the Mortality Review Process
Services	Changes to practice and care will be identified through the Mortality Review Process
Reputational	Potential to impact on HSMR and SHMI

Committees/groups where this item has been presented before

None

Executive Summary

This quarterly report provides an update on the work of the learning from deaths group during Q4 2020 (January to March 2021). We give details of our progress against actions identified in the Q3 report presented to Board in January.

- Our HSMR remains raised at 110.5 (data available to November 2020). The effects of the COVID pandemic are clear within this data and we outline our proposals for meeting the requirements of investigation of Hospital acquired COVID and learning from other COVID related mortality data. We continue to review our HSMR and SHMI data and work closely with Dr Foster to understand what drives the changes in our data

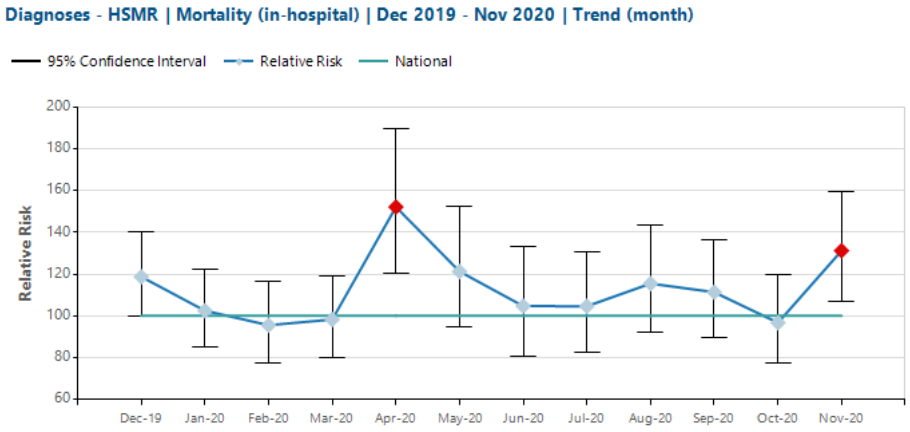
Preliminary discussions with an alternative mortality intelligence provider CHKS have raised some interesting areas for further exploration

- An update on project work with clinical specialties that are historical or current mortality outliers is included as an addendum to this report
- Interim findings of our review of Trust Mortality Review Process and proposals for further actions. The COVID pandemic has significantly affected our ability to achieve our target of 90% reviews using the mortality tool. We have noted that the quality assurance of our Learning from Death processes requires strengthening and our proposals to address this are described
- Expansion of our Medical Examiner Service has allowed independent scrutiny of 97% of hospital deaths which partially mitigates this underachievement of the MRT target and a powerful example of learning from the process is provided.

1. COVID 19

As discussed in the Q3 report we are now starting to see the impact of the second wave of COVID on our mortality figures. Dr Foster is currently reporting on December 2020 but we have validated data to November (Fig 1) which shows the expected upturn. The peak from the first wave is also easily identifiable.

Figure 1 – HSMR Trend



The small number of “hospital identified” COVID 19 cases (positive tests more than 8 days following a negative test on admission) which were flagged early by our Medical Examiners did represent a national trend and we have had instruction from the National Patient Safety Team at NHS England/Improvement that all such deaths occurring from March 2021 should be investigated. Our agreed approach to this has two components. A nosocomial infection investigation carried out at ward level and a Structured Judgement Clinical Review carried out by the responsible Medial team. Any concerns raised by either of these processed will result in escalation through the Serious Incident framework. We feel strongly that this process should be extended to all nosocomial infection, not just COVID 19. Limitations of the current Mortality Review Tool discussed in the Q3 report represent an obstacle to capturing and triangulating learning. In the light of this, ICT has agreed to upgrade our incident reporting platform to DCIQ allowing our information can be viewed on a single connected platform. Following installation (ideally May 2021) the mortality review module will be a priority to allow this analysis and learning to begin. We have also identified a cohort of around 70 patients who are likely to have contracted COVID in hospital prior to February 2021. Following, and informed by, the priority prospective investigation we are planning a retrospective thematic review. We continue to log harms (including deaths) from a number of sources which may have been contributed to either

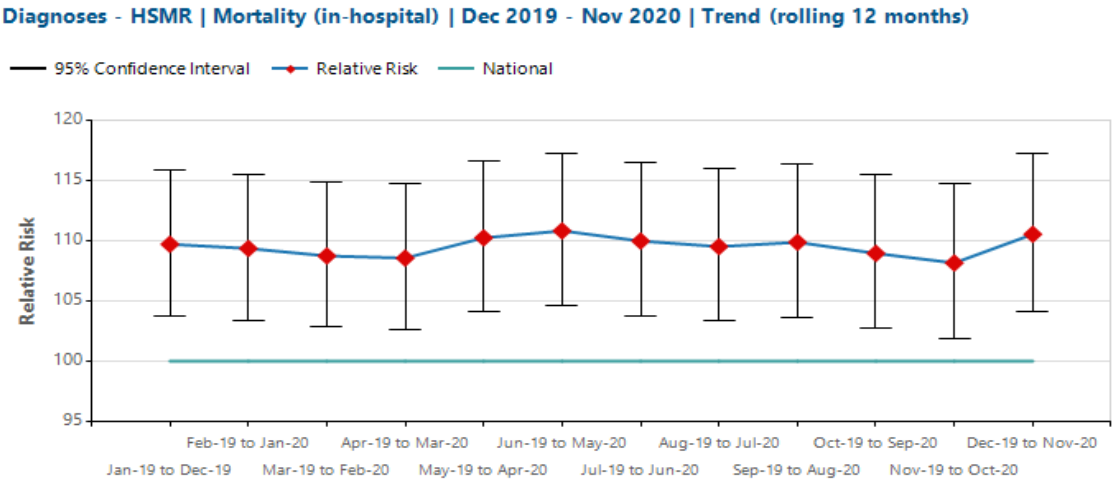
directly or indirectly by COVID and a dedicated member of staff in the Governance Support Unit has begun to analyse this information to detect learning.

2. Progress on actions in Q3

- On-going work with clinical, coding and Dr Foster colleagues has revealed no definite simple explanation for our raised HSMR although we have identified a number of areas where we feel our processes could be improved particularly in the case of Liver Disease (alcohol related) which remains an outlier.
- We have identified potential ways to improve our use of available data
- Review of our Learning from Deaths processes as described by the Mortality Management Policy and associated Mortality Review Tool to provide assurance that potential learning from deaths is identified in a timely and effective way has identified some areas of concern (see section 4) and we request an extension to the March 2021 deadline for implementation while we establish a realistic timescale for completion of this work
- Close working with our Medical Examiners has resulted in identification of a significant learning and improvement opportunity in caring for our patients with Learning Disabilities

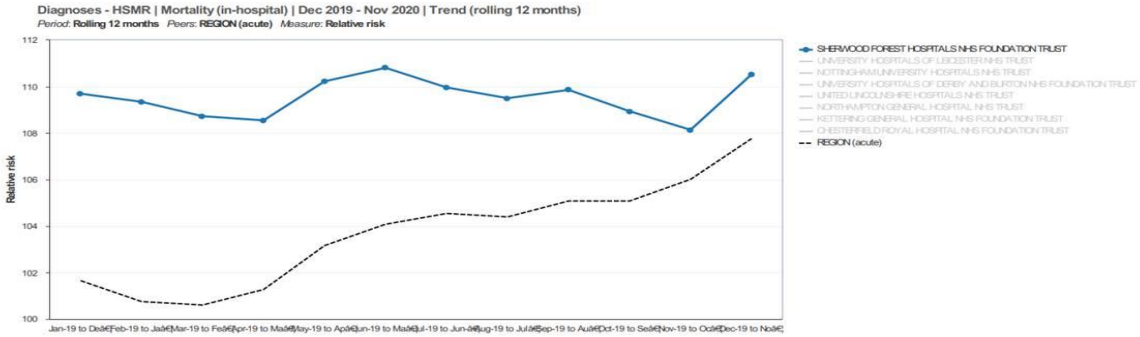
3. Dr Foster Mortality Data

Figure 3.1 – HSMR Trend (rolling 12 months)



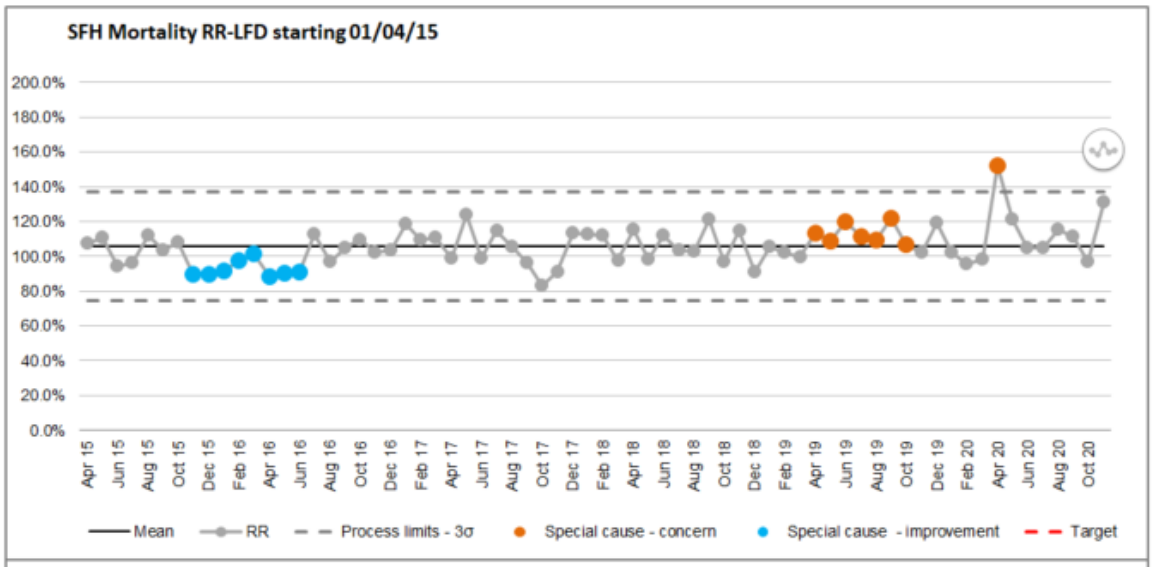
The Trust has a HSMR 110.5 in the year to November 2020 which is higher than the national/ regional average.

Figure 3.2 – HSMR Trend (rolling 12 months compared with regional peers)



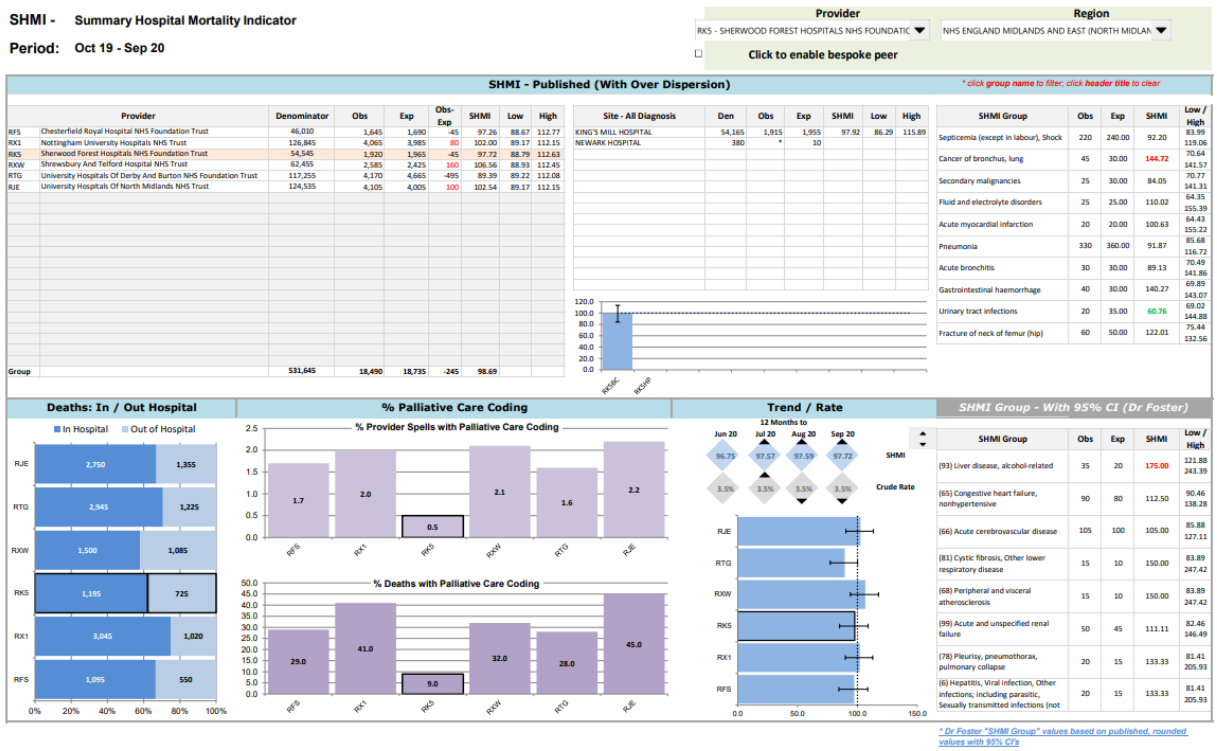
We feel it is noteworthy that whilst our HSMR is raised it does not appear to be increasing, unlike those of our peer group.

Figure 3.3 – 5 year HSMR Trend



Looking back on the last 5 years of HSMR data shows that our position is relatively stable. Review and analysis of the data thus far has failed to show a specific reason as to why the Trust saw an initial upward trend (orange data points in 2019) leading to this and its continued elevated position. The impact of COVID 19 in April 2019 can also be seen on this figure

Figure 3.4 SHMI



The SHMI is 97.72 which is as expected with two significant outliers cancer of bronchus (which is significant because of the “out of hospital” element with the in hospital element remaining stable and has seen a decrease over the last three data points to November 20) and Liver disease (alcohol related) which is a known concern.

A summary of the project work with clinical teams can be found in an addendum to this report.

Data quality and analytic factors

Postcode issues-

- Postcodes have been missing from a proportion of our submitted data leading to an impact on deprivation coding. This issue was a result of a technical change to our PAS system changing our CDS submission. Refreshed data was submitted and whilst it is understood correction of this may have reduced our HSMR slightly but does not explain all of the variance.

Residual Codes

- Up to 50% of activity has not been assigned to one of the HSMR group sub-sets on two separate reporting months over the past year. This has led to Dr Foster being unable to provide a definitive monthly report with assurance of data, resulting in the inability to perform meaningful analysis and therefore the latest confirmed report is for February 2021 (November 2020 data). We have been assured by Dr Foster this should be rectified for April 2021 reporting although confirmation of accuracy is awaited before using this in our internal analysis and discussion. Initial investigation suggests that the data are complete within the Trust and the problem lies externally. A solution to this would be to put a 1 month delay on our reporting schedule- something that Dr Foster does with other clients.

Information and Analysis provision

- Our contract with Dr Foster is coming up for renewal (August 2021). Use of the dashboard toolkit within the organisation, has been limited although and much of the functionality is dependent on a "request and response" agreement with Dr Foster which is part of our contract. The ideal situation would be to have greater data control in carrying out initial scoping /self- analysis prior to any request. A new Dr Foster Consultant has just taken over our Trust's data (2nd in 2 years) which gives us the opportunity to review this working arrangement. A priority for this work will be provision of specialty-specific mortality data available to the clinical teams in addition to the high level aggregate data provided by HSMR.
- CHKS is an alternative mortality data analysis provider and contact has been made with other Trusts who have made a switch from Dr Foster.
    - General feedback is extremely positive, citing:
        - Enhanced usability, greater functionality, and bespoke analytics.
        - Potential for full API control therefore allowing business / information intelligence teams to self-analyse more effectively.
        - Lower comparative cost

Figure 3.5 CHKS HSMR trend

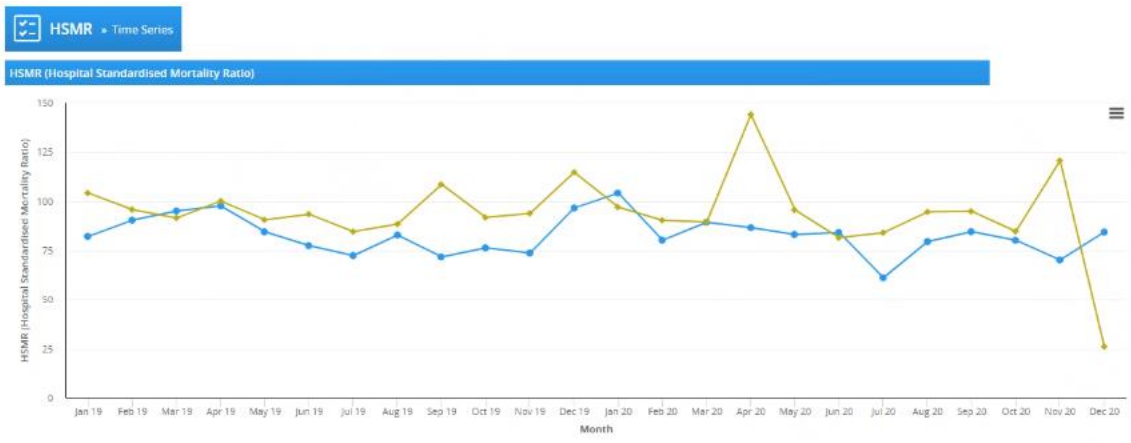


Fig 3.5 Shows HSMR data for SFH (green) plotted using the CHKS toolkit against that of another CHKS client (blue). The COVID peaks are again easily identifiable but of note our HSMR is otherwise consistently below 100. This raises the possibility that the way our data are handled is contributing to our HSMR outlier status. We feel that this is worthy additional investigation and input from internal SFH data analysts/ intelligence would be of value here.

4. Review of Deaths and Structured Judgement Review (SJR)

Figure 4.1 Learning from Deaths Dashboard at Q4 2020/21

Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Jan-21	308	200	64.9	14
Feb-21	185	116	62.7	8
Mar-21	127	51	40.2	Not recorded
Qtr 1	369	312	84.6	25
Qtr 2	307	217	70.7	9
Qtr 3	484	377	77.9	36
Qtr 4	620	367	59.2	22
Year 20/21	**1158**	**1272**	**71.5%**	**92**
Year 19/20	**1514**	**1314**	**86.79%**	**41**
Year 18/19	***1446***	***1267***	***87.62%***	***11***
Year 17/18	***1550***	***1300***	***83.87%***	***21***

Performance of reviews recorded on the mortality review tool against the 90% target remains below target. Increasing number of deaths and clinical workload during the second COVID wave are continuing contributors resulting in a delay. Screening of cases for SJR Triggers (learning disabilities, mental health, SUI, Hospital Acquired COVID etc.) has been formalised as part of the ME scrutiny process. 97% of cases (604) were scrutinised by MEs in Q4 and in order to improve traceability we are logging any SJR requests via our Datix platform and requiring the output of the MRT to be added to the Datix platform.

We are assured that any cases which require compulsory SJRs will have been identified to the parent teams and that these cases will be monitored against the same 6 week timescale as other Datix incidents satisfying the need for an audit structure to capture SJR activity and provide the information sought by the 360 assurance report. Once the dedicated Mortality Review module is built in DCIQ this will improve user experience as this workaround is somewhat cumbersome.

The new SJR panel described in the Q3 comprising Medical, Nursing, Allied Health Professional, ME and representatives of the LFD group convened in March. We reviewed the existing Trust processes and discussed where this panel would fit in. We agree a requirement for training in SJR methodology which was provided by Dr Bahl the lead Medical examiner.

During this training it has become apparent that our Trust mortality review tool does not explicitly follow the Royal College of Physicians methodology which raises questions regarding training received by those using the current tool. Whilst the data suggest that the number of SJRs and avoidability assessments is increasing we have limited confidence about the quality and consistency of this process, so propose this is worthy of further scrutiny to gain that assurance. This should also ensure that the process dovetails with other Trust governance structures and for nococomial COVID investigations, utilising our existing SI methodology, appears more appropriate. The new DCIQ platform will be a significant enabler to this work but requires an extended timeline to ensure robust and reliable delivery.

5. Medical Examiner (ME) Role

The Medical Examiner service continues to develop and whilst maintaining its independence we feel that the scrutiny process is making an increasingly valuable contribution to our Learning from Deaths process. Our lead medical examiner as described above is playing an active role in our SJR training. A small number of patients with learning disabilities were flagged for SJR by the medical examiners as they did not appear to have had input from the safeguarding team.

Whilst we are confident that these cases are being identified and notified for the appropriate LeDeR review when they have died we have identified a potential gap in our processes for identifying these patients to the Learning Disability Specialist Nurse on admission. We have been able to rapidly pull together a group of stakeholders, undertake a process mapping exercise and describe a Standard Operating Procedure which is currently going through the Trust Governance Structure for approval.

6. Plans for Q4 & 2021/22

- Complete review and refresh of mortality management policy and mortality review tool/ process including build on DCIQ.
- Implement SJCR Faculty and monitor appropriate training to ensure consistency of quality of SJR to support governance of our mortality processes and learning from deaths.
- Continue clinical project work in those areas which have been identified as mortality outliers
- Continue to improve our use of available mortality data/ intelligence working with external providers and support from SFH data analysts.