Board of Directors

Subject:	Learning from Deaths Group (formerly Mortality Surveillance Group)– Q2 update	**Date: 04/11/21**	
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Approved By:	David Selwyn, Medical Director		
Presented By:	David Selwyn		

Purpose		
The purpose of this paper is to update Trust Board 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**
		X		

Risks/Issues	
Financial	Consistent Divisional job planning of mortality review activities is required which is likely to demonstrate a funding gap
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 and impact on staff satisfaction
Services	Changes to practice and care will be identified through the Mortality Review Process
Reputational	Potential to impact on HSMR and SHMI with external regulator interest

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 Q1 and Q2 2021/22 (April to September). We give details of our progress against actions identified in the 2020/21 Q4 report presented to Board in May.

- The effects of the second wave, and of the whole of the Covid pandemic to date, are reflected in our mortality data
- Analysis of nosocomial Covid cases is ongoing demonstrating the value of a consistent multidisciplinary approach. Whilst no specific trends have become apparent early indications are that some contributary factors have been addressed as the pandemic

unfolded and local practices evolved

- The HSMR for the 12 months to May 2021 is at 105.5 and statistically 'as expected'
- The SHMI for the 12 months to April 2021 is **98.09** (as expected)
- Work on those area either currently or recently identified as outliers continues
    - Palliative Care
    - Alcohol related Liver disease
    - Fractured Neck of Femur
    - COPD
- Focus on Alcoholic Liver Disease has highlighted a system-wide issue which will require an ICS response.
- Review of the mortality management policy and associated review tool is complete. An action plan has been formed following consultation and work has begun on these actions.
- Medical Examiner service is now fully recruited to and we are achieving 100% scrutiny of cases. Roll-out of scrutiny of community deaths has commenced.

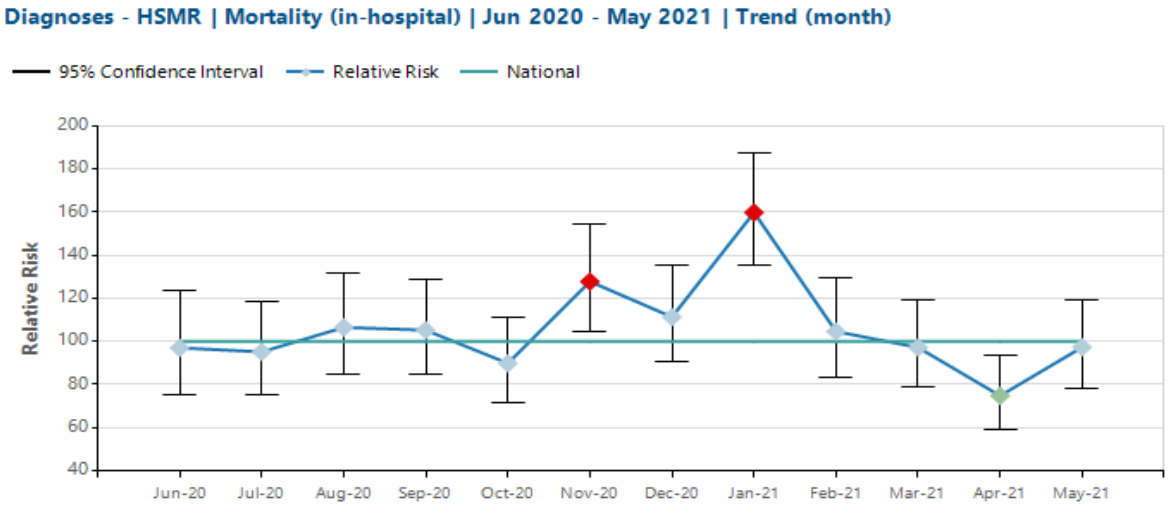
Trust Board is asked to;

- Note the improvement in HSMR, data submission and data intelligence
- Note the update and the significant work involved and still in progress to refine and evolve the learning from deaths process.
- Recognise that whilst HSMR has improved, our review work has identified a number of areas where we can continue to improve the quality of our patient care

2. COVID 19

The effects of the second wave of Covid 19 during the winter of 2020/21can clearly be seen in figure 1.1 below. There is now a full year of Covid 19 activity included in the Dr Foster Model model and risk scores are becoming increasingly adjusted for the changes we have seen over the pandemic. Covid19 diagnoses fall into the 'Viral Infection' CCS diagnosis group. Viral infection, historically a low-risk group, does not appear within the 56 diagnosis groups accounted for in the HSMR. However, COVID related activity will still be included in the HSMR if found in a secondary diagnosis position, for a patient admitted with a primary diagnosis which is within the HSMR basket.

Figure 1.1 – HSMR Trend (month)



The Trust Continues to identify a small number of Hospital acquired/ identified Covid 19 infections which are analysing using our locally agreed process (Infection control root cause analysis and medically-led structured judgement review using the Royal College of Physicians methodology). Once these processes are complete the output has reviewed by multi-disciplinary team which has served as a testing ground for the SJCR panel model described in the Q4 report. This process is quite time-consuming and is limited by clinician availability but we feel that it is worthwhile as it has identified learning that would have been missed by a purely medical review- specifically the effects of discharge pressures on patient care, identified by nursing colleagues. Whilst no specific trends have become apparent early indications are that some contributary factors have been addressed as the pandemic unfolded and local practices evolved (e.g. discontinuation of certain sessional PPE and adoption of short sleeves seems to have reduced patient to patient spread). Further learning will be undertaken as these trends evolve.

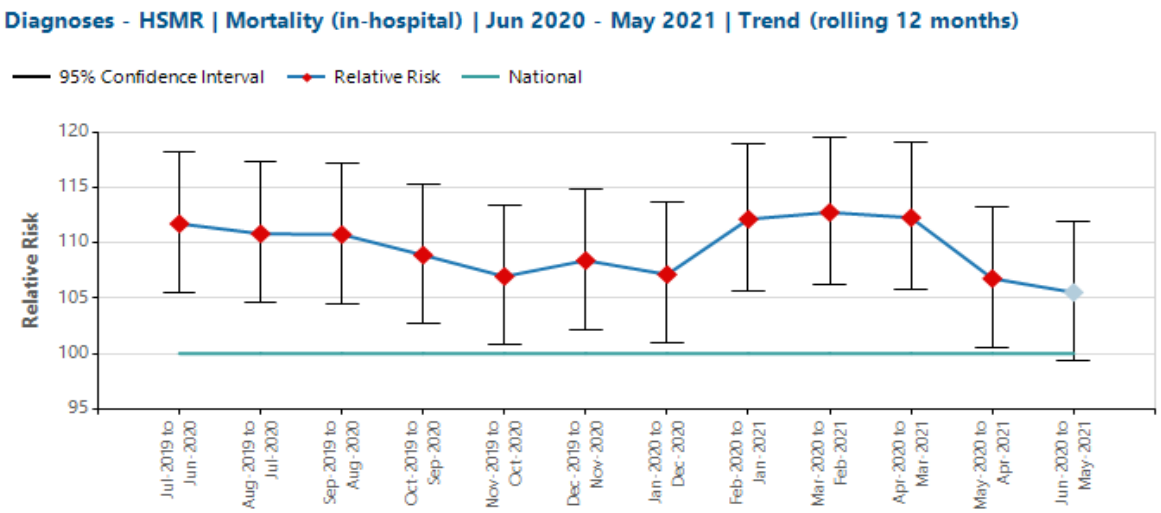
3. Progress on actions in Q3

- Review of Learning from deaths process and mortality review tool complete. Consultation on recommendations complete and mortality management policy updated.
- SJCR Faculty model continues to develop
- Ongoing work between clinical, coding and Dr Foster colleagues in four areas of focus
    - Palliative Care
    - Alcohol related Liver disease
    - Fractured Neck of Femur

- COPD

4. Dr Foster Mortality Data

Figure 3.1 – HSMR Trend (rolling 12 months)



The HSMR for the 12 months to May 2021 is at 105.5 and statistically 'as expected'.

It is worthy of note that the HSMR for the 12 months to May 21 removing Covid is 96.9 and also statistically 'as expected'.

Figure 3.2 HSMR 12 month peer trend comparison

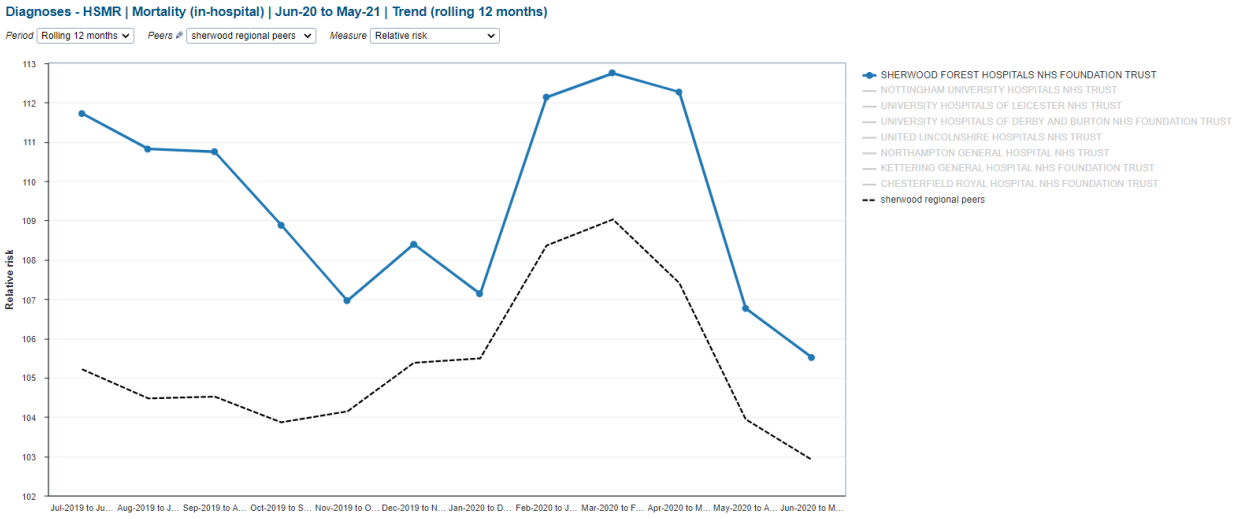
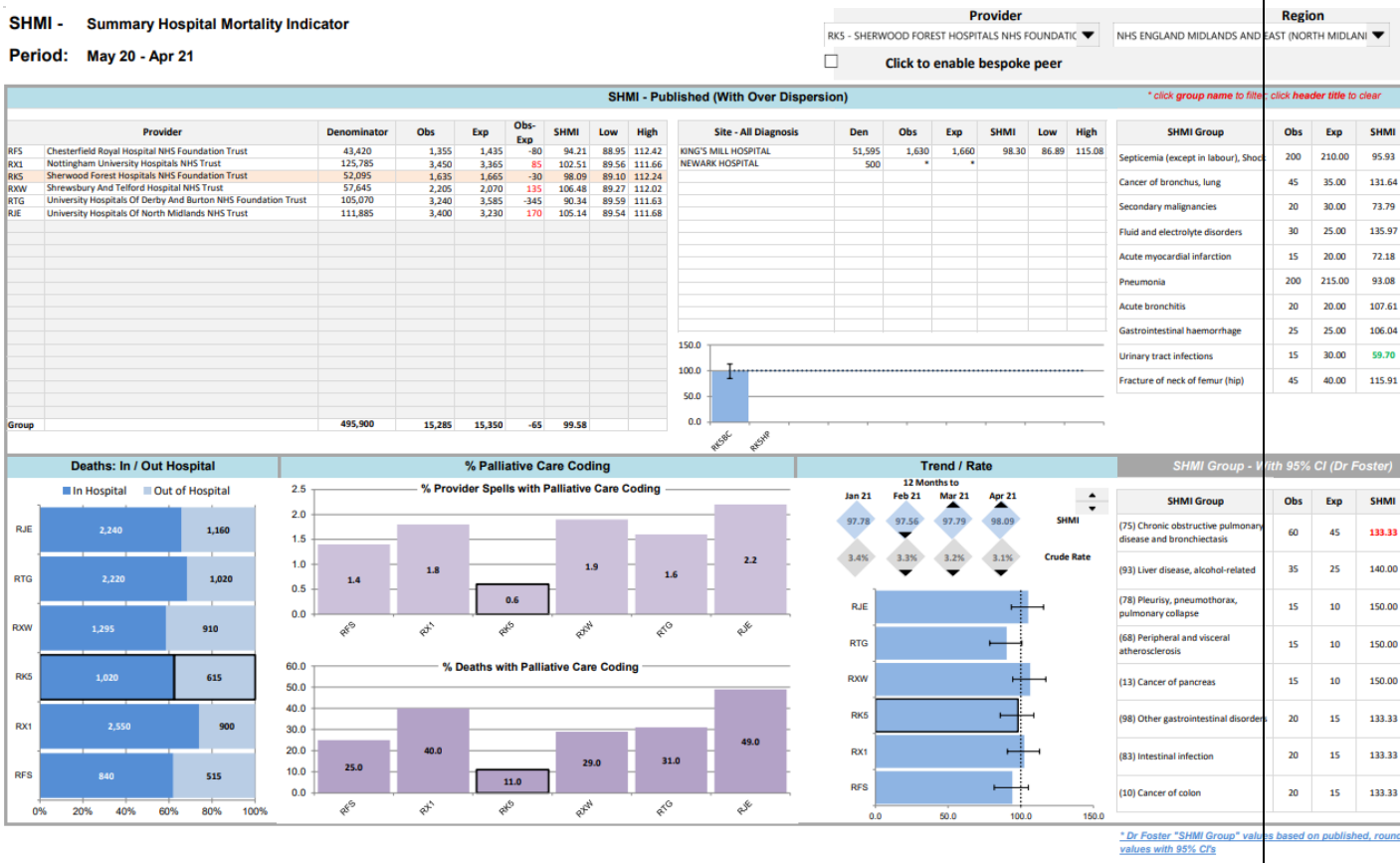


Figure 3.2 shows that our HSMR has generally followed per group trends but the gap seems to have narrowed over the last year.

The causes of this are multifactorial. For the most recent report (October 21, reporting on data up to May 21) Dr Foster have updated their analysis methodology to the effects of a whole year

of Covid-19 and also improved access to data which had previously not been available due to opt-outs. A full description of this is included in Appendix 1. This appears to have made a small difference to our historical HSMR and may have contributed to the current figure. We will liaise with our Dr Foster consultant to understand this further. This effect of data processing highlights the dangers of reliant on single source data and emphasises the importance of using multiple sources of mortality intelligence and we feel supports the work around our clinical mortality review tool described in **section 4**.

Figure 3.4 SHMI



The SHMI for the 12 months to April 21 is **98.09** (as expected)

There are no published outlying diagnosis groups.

A summary of the project work with clinical teams can be found in an addendum to this report in Appendix 2. Difficulties with availability for clinical engagement seem to be a common theme. This is partly due to additional work from both the Covid pandemic and addressing the backlog of work but also due to an apparent lack of dedicated time for these activities. A review of medical job planning may help address this and this risk has been discussed at the Trust Risk Committee.

However the focus on Alcoholic Liver disease has highlighted a system-wide issue with management of these patients. Whilst we recognise that there are areas of our management that we must improve we have identified that a local non-NHS, non-CCG funded detox facility that appears to be resulting in a significant number of patients presenting to us with already advanced disease, often acutely unwell. We are preparing an overview report of those cases

that have presented to the Trust and have liaised with colleagues in PHE and the CCG to establish if there are other system-wide effects. There is the possibility of further similar facilities opening in our catchment area and we must consider how this might impact on our other patients.

Data quality and analytic factors

Postcode issues

The previous postcode submission issue appears to have been resolved with the Trust now having 4.2% of activity with no postcode compared to 5.3% across the regional peer group.

Information and Analysis provision

The Trust's Contract with Dr Foster has been renewed for three years. Early indications of cost savings were found not to be the case on further analysis. An improved and improving working relationship with a new Dr Foster analyst has provided increased assurance to the group and mitigated a number of the concerns raised around data quality, interpretation and intelligence supplied back to the Trust. Further details of the consultation process can be found in Appendix 3.

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

Figure 4.1 Learning from Deaths Dashboard at Q2 2021/22

Inpatient & Emergency Department Deaths	Total	On MRT	% Reviewed	Avoidability Assessments *
Apr-21	100	76	76.0	
May-21	118	87	73.7	
Jun-21	103	80	77.7	
Jul-21	125	73	58.4	
Aug-21	153	71	46.4	
Sep-21	134	26	19.4	
Qtr 1	**321**	**243**	**75.7**	
Qtr 2	**412**	**170**	**41.3**	
Qtr 3				
Qtr 4				
Year 21/22	**733**	**413**	**56.3**	
Year 20/21	1772	1535	86.6	92
Year 19/20	1514	1366	90.2	41
Year 18/19	1446	1267	87.62	11
Year 17/18	1550	1300	83.9%	21

*See below**

Figure 4.1 shows the number of deaths entered onto the mortality review tool. The Trust Target for this is 90% and we continue to struggle to achieve that. There is also a delay of several months in carrying out these reviews. This is partly explained by the workload of the clinical teams in which deaths occur- busier specialties have more deaths and higher clinical workload

resulting in less time to carry out these reviews. Our qualitative and quantitative review of the mortality review process has been completed and reported up through Patient Safety Committee and Quality Committee. The full report is included in Appendix 4.

The key findings were

- The number of deaths on the MRT (as reported in figure 4.1) have not had a full structured judgement clinical review (SJCR) using the Royal College of Physicians (RCP) methodology although some interpreted the initial screen as such. There was lack of clarity about when a SJCR was indicated
- approximately 15% of deaths had in fact had an SJCR
- approximately 50% of those reviews carried out did not follow the methodology
- there was a lack of clarity when further investigation (i.e. avoidability assessments) should be carried out (RCP suggests when care is deemed to be poor)
- there was lack of clarity about what avoidability meant and its value is unclear
- the number of Trust avoidable deaths was significantly lower than expected 0.13% cf 3.4-6% in available literature. (**on this basis it does not seem appropriate to continue to report on the number of avoidability assessments and this data has not been included in figure 4.1. However, findings of 9 SI investigations where patients died are reported below)

Most of these problems seem to be due to

1. lack of clarity agreement on the process (these issues were identified in the 360 Assurance audit report)
2. lack of ongoing training to support the tool

It was also noted that the SJCR is carried out through a relatively narrow medical “lens” and learning may be missed, as discussed in our review of Covid deaths.

The report makes the following recommendations which were consulted through Clinical Chairs Group and the Patient Safety Committee and accepted.

1. Mortality Management Policy to be updated accepting the action from 360 Assurance and to reflect current practice
2. Agree what defines a “problem in care” and how this is to be recorded in the MRT
3. Clinical Teams to complete MRT at time of ME Scrutiny
4. Mortality management policy to be amended to clarify the level of review required when “SJR” is requested
5. Training for reviewers should be re-established by the Trust
6. Structured Judgement Reviews should be undertaken for at least 10% of deaths (some specialties may wish to review more) which will represent a qualitative uplift based on approx. 50% of current reviews falling below standard
7. Dedicated Structured Judgement Reviewers should be identified (and formally job planned) from a range of backgrounds
8. A multidisciplinary review panel should be established and trained to provide stage 2 SJRs and quality assurance where care is deemed adequate or better. This panel should feed into other Trust governance processes and report to the Learning from Deaths Group
9. Deaths where overall care is judged to be to very poor (score 1) or poor (score 2), or when harms have been identified, or if concerns have been raised about a case should be subject to the Trust’s agreed SUI process
10. SJR methodology could be adopted for preparation of all scoping reports (may be a further training need)
11. Datix Mortality tool build “time out” day using Sprint/ Agile principles

The Mortality management policy has been updated and we are trying to identify a suitable date and venue for the time out day.

Learning from incidents involving the avoidable death of a patient:

- One incident related to a gentleman who died in ED 4 hours after attending – he had not yet had a medical review. The investigation highlighted a lack of knowledge with regard to the presentation of a potential AAA at the point of triage and also issues with the senior streaming processes and management of blood gases.
- The second incident was in relation to an intrauterine fetal death at 39+6 in a lady with diabetes. This was felt to be potentially avoidable had an HbA1c result been acted upon and escalated in the usual time frames.
- The third incident related to a neonatal death and was investigated by HSIB. The post mortem revealed meconium aspiration as the cause of death. Learning was put in place to address issues concerning holistic assessment, handover and CTG monitoring.
- The fourth incident relates to a patient who needed NIV and this was reflected in her treatment plan. However she did not receive NIV and sadly she died. The investigation for this is ongoing.
- There have been 5 incidents reported to StEIS relating to Nosocomial Covid deaths occurring since the NHSE guidance to investigate these as Serious Incidents was received in March 21. The 5 incidents relate to 6 deaths: 4 individuals and 2 as part of a cluster which is being investigated as 1 incident in line with NHSE guidance. Learning from these cases is described earlier in the report.

6. Medical Examiner (ME) Role

Our Medical Examiner Service continues to develop and we now have fully recruited to cover weekdays. The effect of this is shown below in Fig 5.1 which shows we have now achieved 100% scrutiny of Trust deaths.

Figure 5.1 Medical Dashboard at Q2 2021/22

Inpatient & Emergency Department Deaths	Total Deaths	Reviews completed	SJRs Requested
Qtr 1	321	319	28
Qtr 2	412	412	11

As all deaths are independently scrutinised in the light of a discussion with the responsible team we are assured that both mandatory SJCRs (patients with learning difficulties, patients detained under the mental health act, deaths where concerns have been raised by the family or clinical team etc) are being identified as our Medical examiners have agreed to perform this task using our Datix system.

The roll-out of scrutiny of community deaths has also begun

7. Plans for Q3,Q4 & 2022/23

- Complete review of hospital identified Covid deaths.
- Complete build of mortality review tool build on DCIQ. Including monitoring of timescales of reviews.
- Recruit specialty/ divisional mortality reviewers through job planning process and deliver training.
- Continue work of SJCR Faculty to ensure consistency of quality mortality review processes and support learning from deaths.

• Continue clinical project work in those areas which have been identified as mortality outliers
Trust Board is asked to; • Note the improvement in HSMR, data submission and data intelligence • Note the update and the significant work involved and still in progress to refine and evolve the learning from deaths process. Recognise that whilst HSMR has improved, our review work has identified a number of areas where we can continue to improve the quality of our patient care