Board of Directors (April 2022)

Subject:	Learning from Deaths Group update	**Date:** 7th April 2022	
Prepared By:	Main report: Dr John Tansley, Clinical Director for Patient Safety Chair Learning from Deaths Group HSMR update: Dr Nigel Marshall, Medical Examiner and Project Advisor to the Medical Director LeDeR update: Lisa Richmond, Specialist Learning Disability Nurse		
Approved By:	David Selwyn		
Presented By:	David Selwyn, Medical Director		

Purpose		
The purpose of this paper is to present a Summary of Mortality intelligence reviewed by the Learning from Deaths group and to update on the work on-going to both respond to and improve that intelligence.	**Approval**	**x**
	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	Formal job planning of mortality review activities
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

An earlier version of the main report was presented to Patient Safety Committee on11/3/2022
The HSMR update was presented to Quality Committee on 15/3/2022

Executive Summary

This report provides an update on mortality intelligence and the work of the learning from deaths group since the last update in November 2021. We give details of our current mortality measures, progress against actions identified in that update and other recent activity from the group.
The Board is asked to note

- The HSMR for the 12 months to October 2021 is **117.0** and statistically 'above expected'

- It is worthy of note that the HSMR this period removing covid is **108.8**
- The SHMI is **97.25** (as expected)
- A detailed update on our work around these mortality measures is provided in an addendum to this report from Dr Nigel Marshall, Project advisor to the Medical Director describing
    - New methodology, applied by Dr Foster, which is now being used for monthly reporting. The presence of a high number of residual codes and issues with data submission have led to the need to lag data reporting by one-month. This is actively being investigated between the Trust and Dr Foster.
    - Latest HSMR has seen a recent rise but there are a few factors impacting this, including the recent re-modelling
    - Continuing work with Dr Foster to ensure best use of data in supporting review of the overall picture, trends, and outlier areas (both historical and current)

- **Progress on actions in Q3/4**
    - Work on new mortality review tool continues. This has been challenging in the face of clinical pressure. Key actions and enablers have been identified to allow a proposed roll-out in August 2022
    - Mortality Management policy has been updated to reflect recommendations of external auditors and represent relevant KPIs within the mortality tool/ process

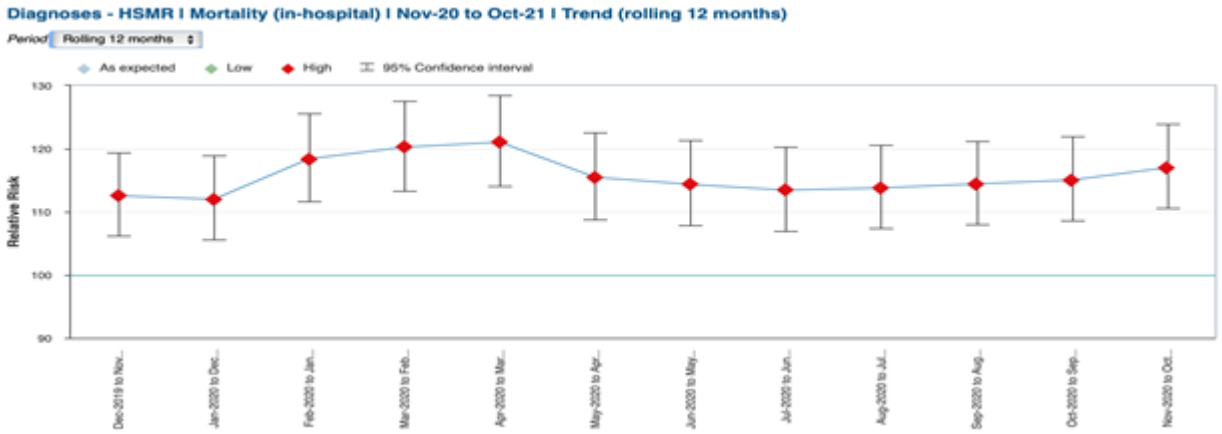
- **New developments**
    - Initial discussion regarding better use of coded data to provide more timely intelligence
    - New mortality dashboards

- **Plans for Q4 & 2022/23**
  The learning from deaths Group will

    - Continue to work with Dr Foster and internal analysts to ensure flow of robust and timely data
    - Complete build of mortality review tool build on DCIQ. Including monitoring of timescales of reviews.
    - Redevelop Mortality dashboard to align with improved mortality review infrastructure
    - 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

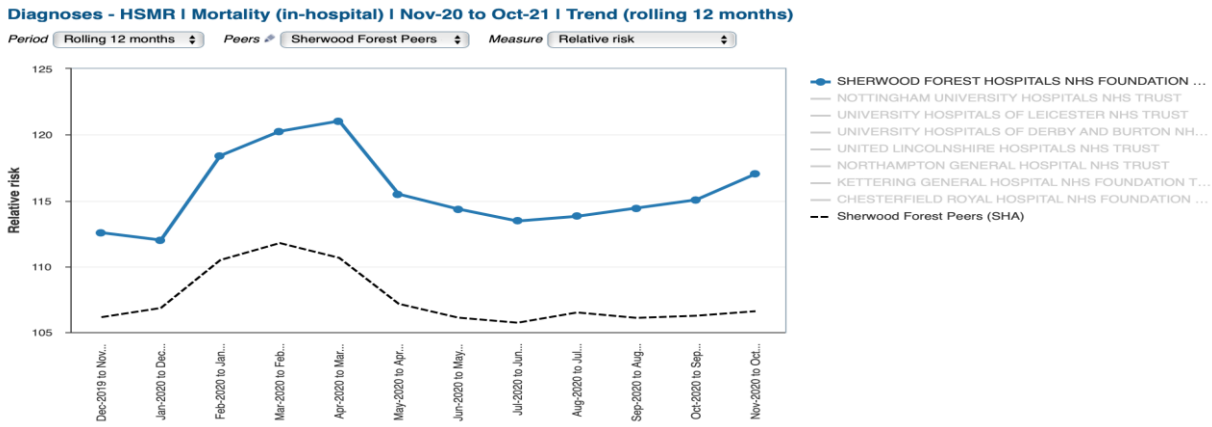
1. Dr Foster Mortality Data

Figure 1.1 – HSMR Trend (rolling 12 months)



The HSMR for the 12 months to October 2021 is at **117.9** and statistically 'above expected'. This would be **108.8** if Covid were removed. Covid appears to have a greater impact on HSMR in Trusts where they have seen a "3rd spike". SFHT has seen rates of 2.1% v 1.6% nationally- this will have impact on overall HSMR and our performance when compared against peers. As seen in the upturn in Figure 1.2

Figure 1.2 HSMR 12 month peer trend comparison



Reporting (February 2022) highlights 7 alerting diagnosis groups, including:

- Inflammation of the eye,
- Coagulation / Haemorrhagic disorders,
- Viral infections,
- Epilepsy,
- Respiratory failure,
- Deficiency and anaemia,
- COPD (see below)

Some of these numbers are small and with removal of Covid-19 activity epilepsy and viral infections no longer produce alerts.

A detailed report covering the details of the ongoing work with clinical teams in current and

historical outlier groups is included as an addendum to this report Dr Nigel Marshall (appendix 1). This was presented to Quality Committee in March.

The SHMI for the 12 months to July 21 is **97.45** (as expected)

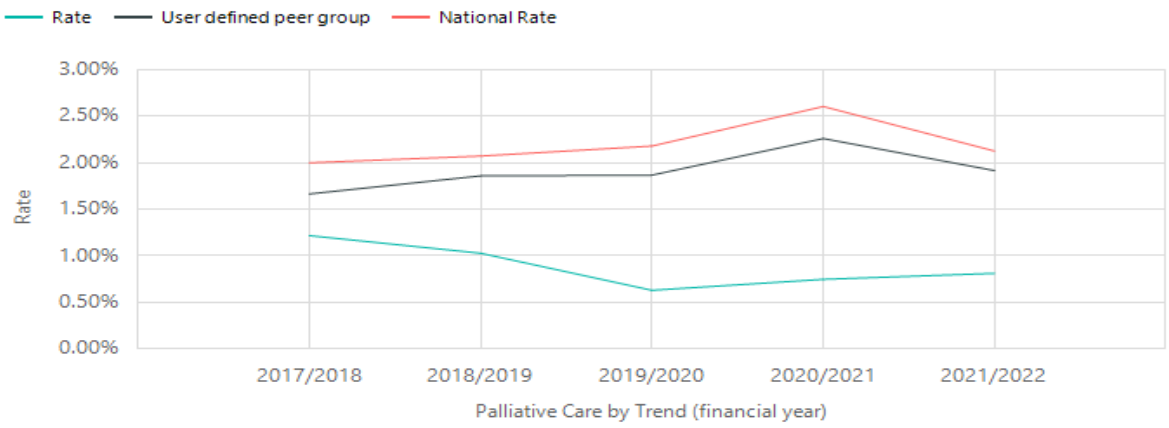
Trends in coding

Palliative Care: The Trust continues to see a low rate with both the HSMR and across all activity. This will continue to impact on the Dr Foster model (HSMR) but will not impact the SHMI.

Signs & Symptoms: The Trust now has a comparable rate of signs & symptoms with peers both regionally and nationally

Comorbidity rates (Non-elective HSMR): As can be seen within Figure 1.3 the Trust has a lower proportion of activity a 0 Charlson score and higher proportion with a score of above 20.

Figure 1.3 – Coding Rate Vs National



Coding / Casemix	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)	12.3%	31.0%	38.4%
% Non-elective spells with palliative care (HSMR)	1.7%	4.0%	4.9%
% Spells in Symptoms & Signs chapter	7.4%	7.6%	7.8%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	37.4%	40.1%	41.1%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	18.1%	17.0%	15.6%
% Non-elective spells in Risk Band (0-10%) (HSMR)	83.6%	85.0%	84.3%

A deep dive into a series of COPD deaths appears to have identified a step-change in coding behaviour in 2020. This appears to be associated with a change in the admission documentation at round the same time. This is possibly an example of how a change to an artefact (document) can have an unintended impact on behaviours (record keeping and subsequent coding) resulting a in a gap between work as done and work as disclosed (see The Varieties of Human Work – Humanistic Systems) and we believe is worth further investigation. This documentation is currently being reviewed and we have recommended that colleagues from clinical coding are added to the stakeholder group which is being consulted on these changes.

The Trust has experienced some issues with high residual codes in the data provided by NHSD to Dr Foster. This is caused when incomplete data is received by NHSD from the Trust. This results in unreliable results in our comparative mortality measures and have made it necessary to "lag" our data by one month to allow more complete data (this practice is not unprecedented in other Trusts). Following discussion with our local data analysts we believe this to be as a result of lack of clarity around the deadline for data submission and anticipate that a revised internal reporting schedule will rectify this. These data issues have interrupted the usual reporting by Dr Foster but we have used the contracted analyst time to work on understanding our project areas.

As part of these discussions and also due to the requirement to submit separate data to Dr Foster to allow re-identification of individual patients as a result of their methodology changes we have looked at our data flows within the Trust. We are conscious that Dr Foster data typically runs 4 to 5 months in arrears (more so if we maintain the "lag") but our own coded data is more up-to-date and could provide more immediate signals of changes within the Trust. We have begun initial discussions with our internal data analysts exploring what might be possible. We hope to update in our next report.

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

Figure 2.1 Mortality Review Tool at Q2 2021/22

Inpatient & Emergency Department Deaths	Total	On MRT	% Reviewed
Oct-21	155	121	78.1
Nov-21	147	82	55.8
Dec-21	167	80	47.9
Qtr 1	**321**	**255**	**79.4**
Qtr 2	**412**	**320**	**77.7**
Qtr 3	**469**	**283**	**60.3**
Qtr 4			
Year 21/22	**1202**	**858**	**71.2**
Year 20/21	1772	1535	86.6
Year 19/20	1514	1366	90.2
Year 18/19	1446	1267	87.62
Year 17/18	1550	1300	83.9%

Figure 2.1 shows the number of deaths entered onto the mortality review tool. The Trust Target for this is 90% which we struggle to achieve. There is also a delay of several months in carrying out these reviews. We anticipate that introduction of our new Mortality Review Tool on the DCIQ platform which is planned for August 2022 (see below) will significantly improve this in both Quantitative and Qualitative terms as it streamlines the process and also will more clearly identify roles and responsibilities, together with appropriate job planning to achieve this important activity.

Q3 Data from ME Office – Acute Adult Deaths

Oct 21 - 154
Nov 21 - 147
Dec 21 - 167 Total = 468 Adult

100% of all deaths were scrutinised & within the following timeframes –
Day of death or 1st Day after death - 298
2nd Day after death - 75
3rd Day after death - 55
4th Day after death - 23 – Xmas & New Year Bank holidays reflect this figure
5th Day after death - 16 - Xmas & New Year Bank holidays reflect this figure
Over 5 days - 1 – This is the only breach in Q3 and relates to a death at Newark which they failed to notify us of.

Q3 Data from ME Office – Acute Child Deaths

We had only one reportable in Q3 and this case was scrutinised on day of death.

Q3 – Data from ME Office – Community Deaths.

40 x community deaths were scrutinised during Q3

Figure 2.2 Structured Judgement review requests at Q3 2021/22

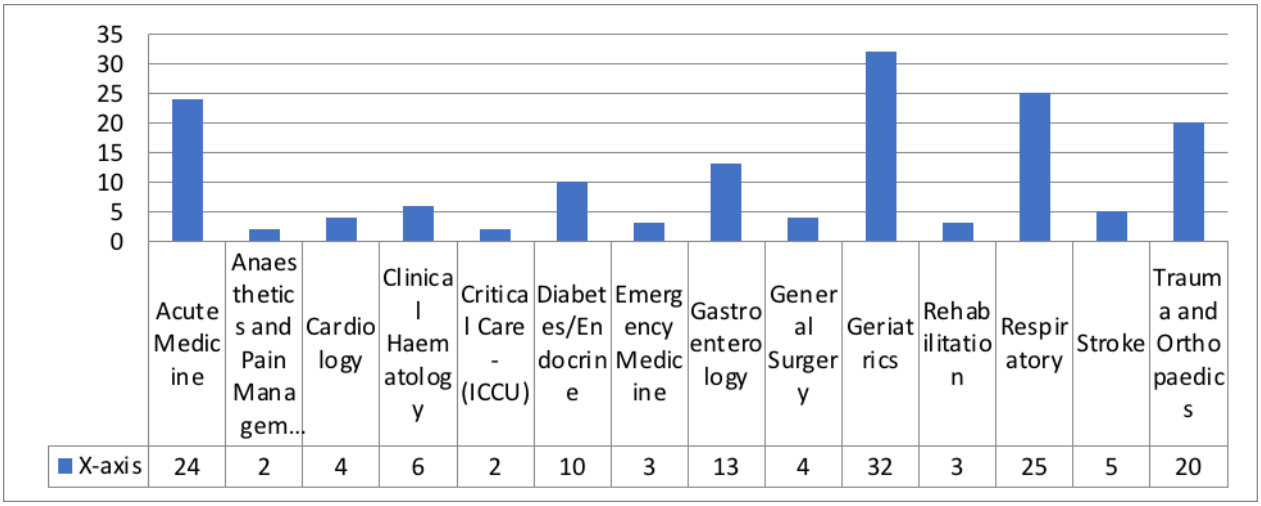
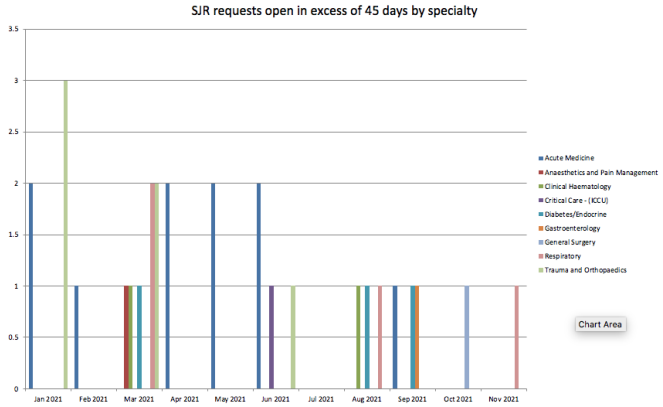


Figure 2.2 shows the number of SJRs requested on Datix following Medical Examiner review for the Year Jan 2021-22 Higher request numbers might be expected in Acute Medicine, Geriatrics and Respiratory (especially given Covid). Higher requests in gastroenterology possibly reflect our recognised challenges in Alcohol related liver disease. There are ongoing concerns being raised regarding multidisciplinary decision-making around fitness for surgery in T&O. Improved MDT working as described elsewhere in this report aims to address this.

Now that these requests are made through Datix we are able to monitor their progress Figure 2.3 below is an example showing how many SJRs remain open after 45 days (the same standard as

other Datix events)

Figure 2.3 Structured Judgement review requests at open in excess of 45 days at Q3 2021/22



A Mortality review/ SJR stakeholder event to agree the governance and IT infrastructure (on the DCIQ platform) took place on 27/1/22 facilitated on-line by Service Improvement Colleague. Medical representation was disappointing despite agreement to release colleagues as there were extraordinary clinical pressures in January.

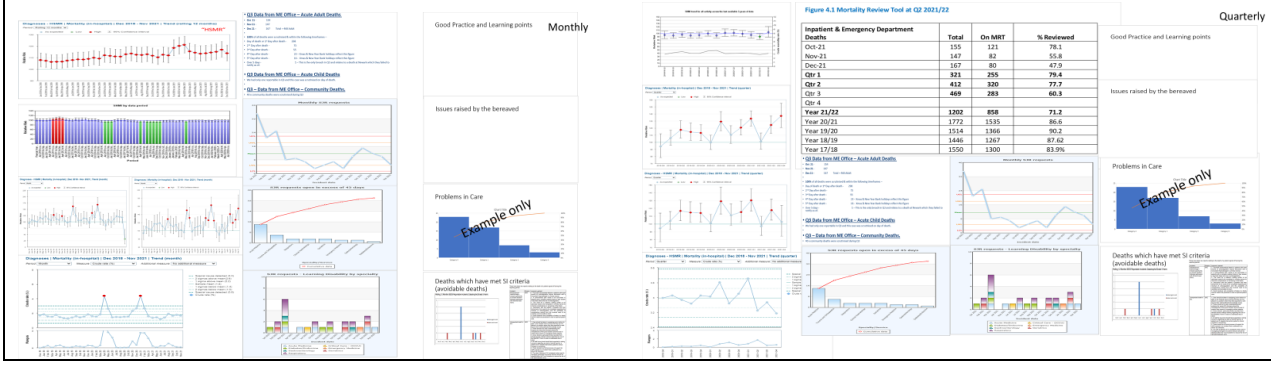
Outputs were

- Detailed process map and proposed timeline for introduction of the new process
- Requirement for Individual Specialties/ Divisions to review outputs and provide SOP for mortality review to achieve stage 1 and 2 reviews which must include
  - Estimate of PAs required (specialty breakdown for year 21-22 included in Appendix 1 of LFD report to guide this)
  - Identification of those individuals who will carry out SJRs to be trained/ refreshed in SJR methodology)
  - Confirmation that this is being considered in Team and individual job planning

A roll-out date of August 2022 to coincide with the changeover of Doctors in training is proposed.

The Medical Director has agreed that a further discussion around job planning will take place in the Clinical Chairs' forum. It will be difficult to realise improvements in quality of our mortality reviews without appropriate allocation of human resource to training and the review process. This is an ongoing challenge in the face of mounting clinical pressures.

The Mortality Management Policy has been further updated and approved by the Group to reflect key performance indicators requested by external auditors 360Assurance. The new platform will allow us to monitor these KPIs and assist in performance managing these processes. Draft monthly and quarterly dashboards have been proposed to reflect mortality intelligence at Mega/Macro (National/ Trust), Meso (ME scrutiny and specialty) and Micro (individual feedback and learning) levels



Interactive versions can be found in Appendix 2

Plans for Q4 & 2022/23
The Learning from Deaths Group will

- Continue to work with Dr Foster and internal analysts to ensure flow of robust and timely data
- Complete build of mortality review tool build on DCIQ. Including monitoring of timescales of reviews.
- Redevelop Mortality dashboard to align with improved mortality review infrastructure
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LeDer update – please find see Appendix 3 for report.