NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Learning from Deaths Group update	**Date**: 6th April 2023
Prepared By:	Main report: John Tansley, Clinical Director for Patient Safety & Chair Learning from Deaths Group HSMR update: Nigel Marshall, Advisor to the Medical Director SHMI update: John Tansley LeDeR update: Lisa Richmond, Specialist Learning Disability Nurse	
Approved By:	David Selwyn, Medical Director	
Presented By:	David Selwyn and John Tansley	

Purpose

The purpose of this paper is to present a Summary of Mortality intelligence reviewed by the Learning from Deaths group and the ongoing resultant work to both respond to and improve that intelligence.		
	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	X

Identify which principal risk this report relates to:

PR1 Significant deterioration in standards of safety and care	X
PR2 Demand that overwhelms capacity	X
PR3 Critical shortage of workforce capacity and capability	X
PR4 Failure to achieve the Trust's financial strategy	
PR5 Inability to initiate and implement evidence-based Improvement and innovation	X
PR6 Working more closely with local health and care partners does not fully deliver the required benefits	
PR7 Major disruptive incident	
PR8 Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Some components of report previously presented to Quality Committee

Acronyms

NHS - National Health Service
SFH - Sherwood Forest Hospitals NHS Foundation Trust
KMH - King's Mill Hospital
HSMR - Hospital Standardised Mortality Ratio
SHMI - Summary Hospital-level Mortality Indicator
CUSUM - cumulative sum
CQC - Care Quality Commission
ICB - Integrated Care Board
PSIRF - Patient safety Investigation Response Framework
LeDer - Learning from Lives and Deaths; people with a Learning Disability and autistic people
LD - Learning Disability
Datix - Risk Management Information System
ICE - Integrated Clinical Environment; electronic system holding and managing patient diagnostic test results
DN - Divisional Nurse
CNS - Clinical Nurse Specialist

SPC - Specialist Palliative Care
ReSPECT - Recommended Summary Plan for Escalation & Treatment
DNAR - Do not attempt resuscitation
MCA - Mental Capacity Act
EOL - End of life
FCE - Finished Consultant Episode
COPD - Chronic Obstructive Pulmonary Disease
UTI - Urinary Tract Infection
RAMI - Risk Adjusted Mortality Index
SJR - Structured Judgement Review
MRT - Mortality Review Tool
MCCD - Medical Certificate of Cause of Death
NUH - Nottingham University Hospitals
EPMA - Electronic Prescribing and Administration
T&F - Task and Finish
DMD - Deputy Medical Director

Executive Summary

This report provides an update on SFH mortality intelligence and the work of the Learning from Deaths group since the last report to the Board of Directors in October 2022.

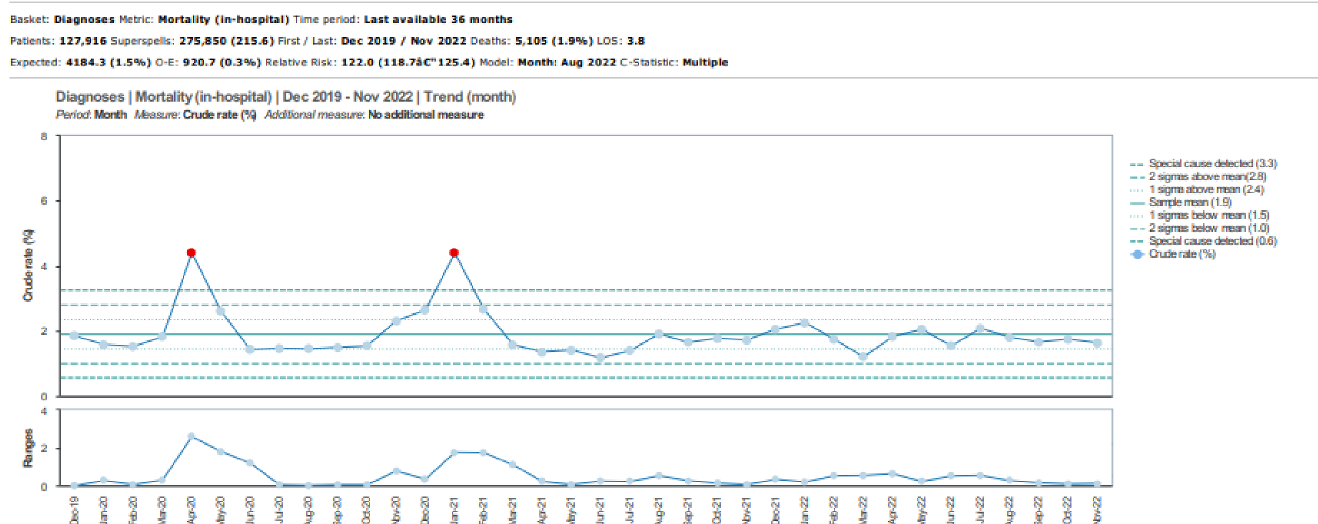
The Trust Board is asked to note;

- Our analysis and interpretation of current Mortality Surveillance data which remains focussed on the Trusts unfavourable HSMR position (**122.1** for the period Nov 2021 to Oct 2022) Contrasting with the SHMI with remains **as expected (1.0327** for the same period) although trending upwards. We believe similar contributing factors are driving both these observations (coding processes and the structure of palliative care services)
- Updates on progress with clinical reviews into established outlying diagnoses groups and new areas of focus identified by triangulating mortality metrics
- Outputs of local mortality surveillance and learning from deaths processes; lessons learned, good practice identified. Along with progress on and proposals for, the future development of our capacity for learning
- Examples of integration of Learning from Deaths with other learning processes (Coronial Inquests, CQC and ICB quality reviews, internal quality summits and speciality and divisional escalations, LeDer deep dives, Patient safety Investigation Response Framework (PSIRF) methodology
- Actions identified in the report and proposals for actions in the next 6 months.
  The Learning from Deaths Group will
  - Continue to work with our external HSMR provider and our internal analysts to refine our mortality data intelligence and reflect on future direction of this relationship
  - Signpost Clinical Mortality leads areas which require further investigation and use findings to direct improvements
  - Update on those areas where work is ongoing
  - Continue to support the Divisions in establishing a workable mortality review tool on the Datix digital platform supported by processes and training
  - Continue to ensure that mechanisms for Learning from Deaths work constructively and collaboratively with other internal and external governance processes.

1 Mortality Surveillance Data

1.1 Crude Mortality

The figure below show that the Trust's crude mortality rate is relatively stable at around the pre-pandemic rate. The peaks in mortality associated with the two main Covid waves are easily identifiable and above the upper 2 sigma control limit.



1.2 Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)

This metric remains an area of focus for the Learning from Deaths Group as the HSMR remains significantly higher than expected on the 12-month rolling average (**122.1** for the period Nov 2021 to Oct 2022) although appears to be on a downward trajectory in the month-by-month data. In the attached paper (appendix 1) Dr Nigel Marshall gives a detailed account of our current understanding of the factors contributing to this which continues to point to capture of comorbidities through the clinical documentation and coding processes and the structure of our palliative care services. The role of palliative care in calculation of the HSMR is a topic of ongoing discussion. A meeting held recently by Telstra (Dr Foster) our supplier of mortality intelligence at which the Trust was represented confirms a lack of agreement of the interpretation of palliative care (Palliative- not directed at cure, End of life- likely in the last year of life, and Last days of life when a patient is identified as actually dying). The coding Z51.5 is only applicable when that care involves direct input from a colleague who is a recognised specialist and effectively removes the death from the HSMR figures. Notably palliative care is not a consideration in **SHMI** which **remains as expected**.

Appendix 2 contains a more detailed analysis of the Trust's SHMI which forms part of the draft Trust's Quality account submission. There is a gradual upward trend in the SHMI within the as expected band. An overall fall in expected mortality from pre-pandemic levels may be contributing. A healthier patient cohort is not consistent with our clinical experience of an ageing, multi-morbid population or the National picture which shows relatively stable mortality either side of the pandemic waves.
Again, a likely explanation of this is the clear decline in the depth of coding This is consistent with concerns we have around clinical documentation which are also suggested by HSMR and feedback from our medical examiners.

Activity within the coding department has been externally validated and we are confident that we are capturing what is written in the notes within the coding rules. The analysis described in Appendix 1 (missed coding- where a chronic condition which is unlikely to have resolved is not documented in subsequent admissions) provides further evidence. A clinically led task & finish working group headed by the Deputy Medical Director is reviewing our documentation and processes, including our interface with Primary care to see if there is scope for improvement which could address our concerns and potentially improve the Trust's position. This drift is highly likely to be a consequence of a clerking document revision and change, introduced pre-pandemic.

Medical documentation has also been identified as a theme in our Consultation around our **Patient Safety Incident Response Plan** (PSIRP) and as such this work will fit well with our wider Safety Improvement activities.

1.3 Clinical review of outlying diagnosis groups and progress on actions

Liver disease- this is an established outlying group and clinical teams have previously been engaged. The records review is nearing completion and the group is awaiting report on this. Proposals for reinforcing the pathways have also been made by the Gastroenterology Specialty. It is recognising that we have limited specialised hepatology clinical input at SFH and further development will require resourcing.

Fractured Neck of Femur- we are awaiting a formal report on the clinical review from our Orthopaedic colleagues, but early indications are that many of the cases were managed non-operatively. Feedback from our Medical Examiner Team is that documented evidence of multidisciplinary decision-making is improved in those notes that have been scrutinised following previous scrutiny via Patient Safety Committee. A cross divisional approach to strengthening the orthogeriatric input into this pathway is under development but again will require resourcing. The speciality teams are also considering the logistical challenges of cohorting and ring fencing #NOF ward beds.

Sepsis - mortality data had shown an increase over December 21 – February 22. Other sources of intelligence had not flagged up concerns over care or abnormal variations to cause concern. 29/31 cases reviewed – 2 sets of notes unavailable. The key findings are:

- Age range 59 yrs. – 96 yrs. All patients had multiple significant comorbidities or terminal metastatic carcinoma.
- Sepsis treatment was started in a timely manner & no lapse in sepsis care was identified.
- There was good evidence documented of discussions with microbiology team
- There was good evidence documented of discussions with the patients where appropriate or families of end-of-life planning
- 10/29 cases had sepsis nomenclature in either 1a or 1b of the death certificate (including 1 as urosepsis despite an abdominal source being treated)
- Cases were wrongly coded for sepsis as a primary diagnosis – these were discussed with the coding team
- In 4 cases there is no clinical evidence the patient had sepsis & it highlights the tendency for medical documentation of sepsis to refer to infections e.g. urosepsis for UTI, chest sepsis for pneumonia. 1 case had no clinical evidence of any underlying infection at all. Sepsis is not a diagnosis, purely a prompt to find a source
- None of the deaths were avoidable in the opinion of the reviewer who believes the mortality rate is reflective of the clinical picture over winter, mid Omicron wave. Excellent / good patient care was evident throughout at what was a very busy, challenging time of year.

Palliative Care

- Referral process has been migrated to ICE, ensuring ubiquitous access is nearly complete
- Interrogating ICE, an average of around 40-50 patients / month (often for multiple visits) have been identified as potentially matching criteria

- Utilising this dataset, has allowed us to check the coding accuracy. Only one case has been missed by the coders where the entry was in the Last days of Life documentation. Coding colleagues have been reminded to review this section of the notes
- A new lead nurse for the End-of-Life Care team has been appointed. The appointee has considerable experience previously having been a DN, a palliative care CNS at KMH and in the community. The medical lead role for End-of-Life Care team is out to advert
- A presentation at the medical managers meeting on Specialist Palliative Care is arranged for 25th April

Review of ReSPECT (Recommended **S**ummary **P**lan for **E**scalation & **T**reatment) **in patients presenting to ED**

- Care was good but the discussions were effectively DNAR
- Diagnosis groups where patients may have benefitted from earlier discussion;
- Oncology
- Respiratory (esp. COPD)
- Cardiology (esp. heart failure)
- Further work is planned around; identification of patients at the “Front door” and
- Development of an advice booklet and a ReSPECT training package

Triangulation of patient impact methodology

- As described in the last update we have sought a methodology to triangulate information from our mortality metrics to identify areas for focussed clinical reviews. Three new areas of focus have been identified
- **Pleurisy, pneumothorax, pulmonary collapse**- ongoing
- **“infections”** (non-HSMR group)- provisional review undertaken through Dr Foster. Initial indications are that out-of-hospital deaths recorded for this group have triggered the alert and may benefit from a case-note review; this has been escalated through Learning from Deaths.
- **“Other infections”** Thought to be due to deaths occurring later in the clinical pathway and in higher risk groups (i.e. from sepsis, pneumonia and UTI). This has been raised in Learning from Deaths and actioned for highlighting to the documentation working group as it is felt there may be a relationship with nomenclature and recording of uncertain diagnoses within the Primary Diagnosis field

1.4 External Mortality Intelligence Provider

The Trust’s contract with Telstra (Dr Foster) is due for renewal in September 2023. There is regional interest in moving away from proprietary metrics (HSMR, RAMI etc) in favour of SHMI. We are involved in these discussions and will consider our options as part of this process but a more forward looking, timely and pro-active mortality intelligence tool remains highly desirable.

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

2.1 Mortality Review Tool

Completion rates for the standalone Trust Mortality Review Tool are shown in Figure 2.1

Fig 2.1 SFH Mortality review tool

Month	Total Deaths (Inpatient and A&E)	Mortality Reviews completed	% Reviewed
Apr-22	157	125	79.62%
May-22	168	114	67.86%
Jun-22	118	87	73.73%
Jul-22	166	121	72.89%
Aug-22	136	90	66.18%

Sep-22	136	88	64.71%
Oct-22	155	96	61.94%
Nov-22	159	103	64.78%
Dec-22	228	98	42.98%
Jan-23	236	96	40.68%
Feb-23	158	59	37.34%
Qtr 1	443	326	73.59%
Qtr 2	438	299	68.26%
Qtr 3	542	297	54.80%
Qtr 4	394	155	39.34%
Year 22/23	1817	1077	59.27%

The digital infrastructure to migrate to the new Datix platform is now in place as part of a suite of mortality tools. The Bereavement Centre is ready to go live with their module which will partially populate the MRT which should reduce workload. The Learning from Deaths Group awaits feedback from the established task and finish group regarding whether the tool should be retained as is or in a modified form. Ideally, we would ask for this to be completed at the time of completion of MCCD to avoid the ongoing lag shown above.

2.2 Data from Medical Examiner Service Office

2.2.1 – Acute Adult Deaths. 100% of 546 adult deaths (including 4 ambulance deaths) were scrutinised in Q3 within the following timeframes –

Day of death or 1st Day after death-	288
2nd Day after death -	122
3rd Day after death -	88
4th Day after death -	25
5th Day after death -	14
Over 5 days -	5
MCCD's issued within 3 calendar days of death (Excluding referrals to Coroner)	89.87%

2.2.2 Acute Child Deaths
We had 5 child deaths reported in Q3

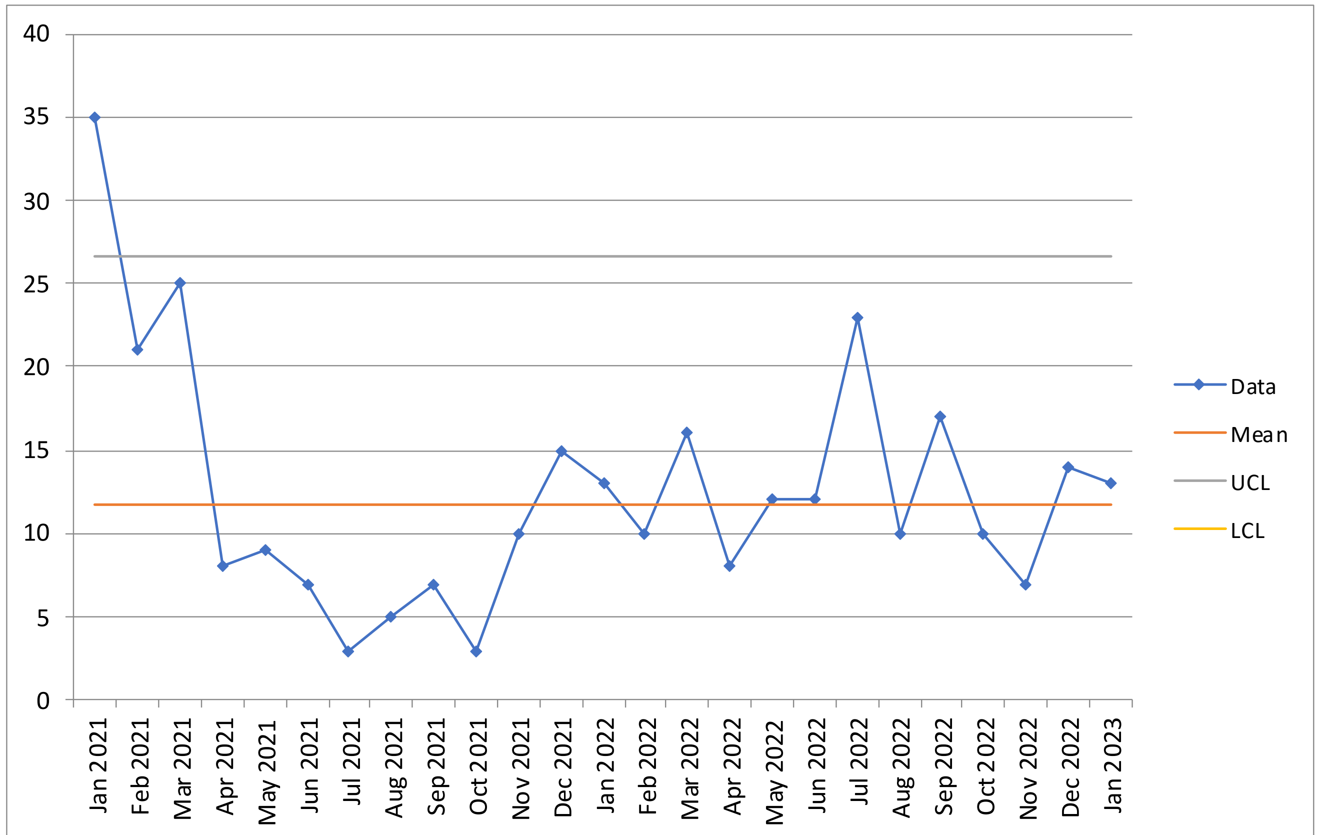
2.2.3 Community Deaths
65 community deaths were scrutinised during Q3

The Medical Examiner service continues to perform effectively against demanding deadlines. Reduction in performance against 3 days target related to Christmas and New Year falling at the weekend. We have received excellent feedback for the service from families to date. Also, we would like to recognise the supportive role played by members of the team not only to bereaved families but also to distressed staff in a time of unprecedented pressure on our services.

Input was invited from the Lead Medical Examiner (along with Complaints/ Patient Experience) into the Trust's PSIRP consultation process. This resulted in a valuable contribution to more joined-up learning.

2.3 Structured Judgement reviews

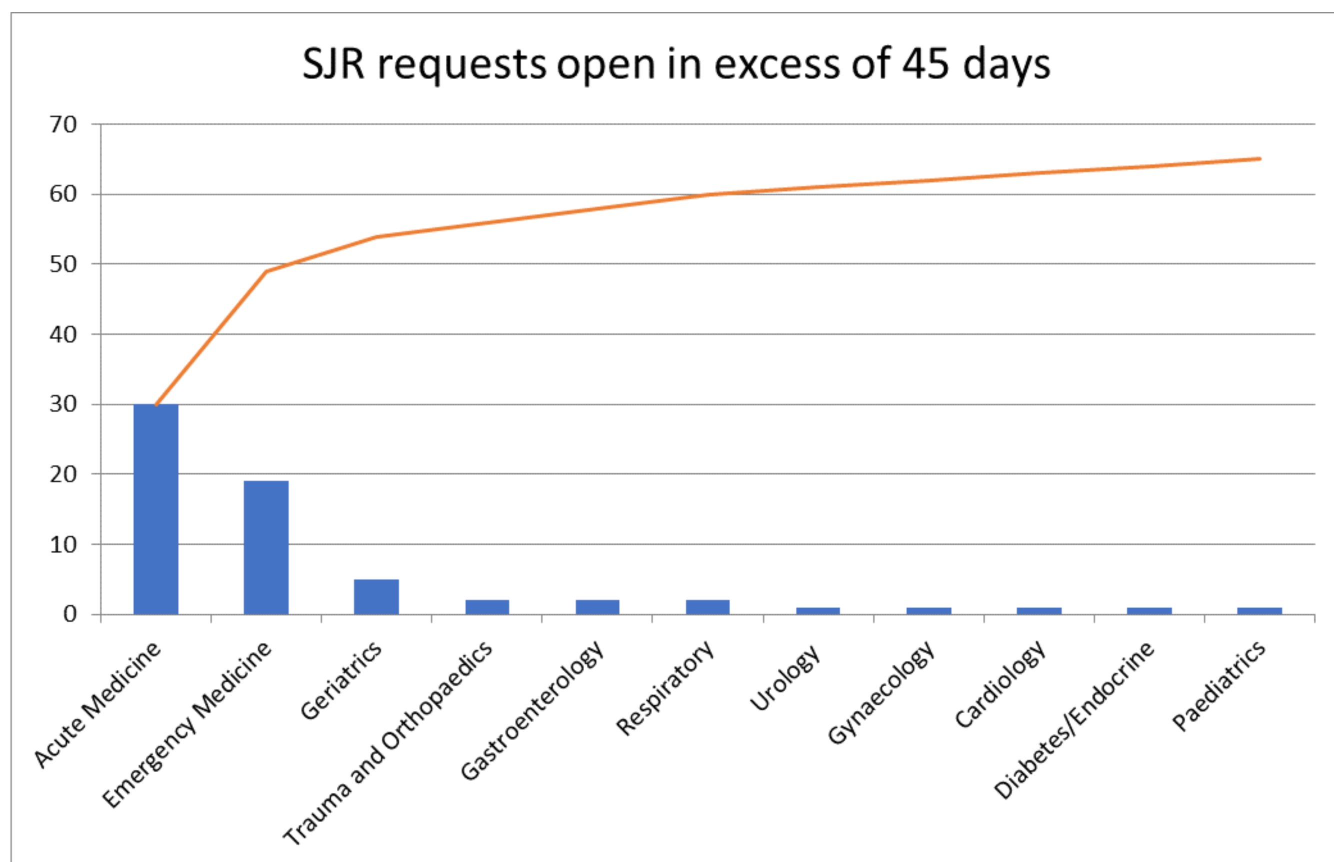
Figure 2.3 Structured Judgement review requests at Q3 2022/23



The number of SJRs identified are shown in Figure 2.3 The mean being close to 10% of total deaths.

Figure 2.4 shows our progress in reviewing the SJRs requested. Of note, Acute and Emergency Medicine have the largest number of reviews outstanding. This may reflect the fact that these services are subject to much of the operational pressure at the front door which the Trust continues to experience. Overall, the number of outstanding reviews is reducing and engagement with the process appears to be improving.

Figure 2.4 Structured Judgement review requests at open in excess of 45 days at Q3 2022/23



2.3.4 Learning themes from SJRs

Following review, overall care was found to be generally good. No death was deemed to be avoidable although free text entries did reveal a range of understanding of the concept of avoidability. Further training on completion of SJRs is planned.

Specific learning around management of falls (e.g. the importance of lying and standing Blood Pressure) was noted and communicated formally via specialty teaching, Medical Grand Round teaching and less formally via staff messaging "Serious issues" groups.

The importance of multidisciplinary best interest's meetings, involving relatives was highlighted. With review hindsight, there were examples where care could have been improved and where last-days-of life care could have been expedited, but there were also examples of good recognition of dying patients with significant family involvement.

The importance of making decisions regarding escalation and ReSPECT form has been communicated and discussed via morning MDT Handover and relayed to the admissions and ward teams.

Similar themes around capacity and decision-making were identified from feedback on LeDeR reviews. The Chair and Learning Disability Specialist Nurse met with the Regional LeDeR team which is undergoing some organisational significant changes. We will work closely together to support them through this change. The full LeDeR report is attached in Appendix 3

3. Feedback and Learning from Coroner

We have had an unprecedented number of new coronial matters raised this year (105 so far, the previous maximum was 70) and we will provide a fuller Board update regarding learning in the next report.

The new bereavement centre Datix module will allow us to monitor these referrals in real time through a dashboard that is being developed with the Medical Examiner's Office. This will provide the Group with an additional source of real time mortality information.

A useful meeting the local Coroners took place at the Trust senior medical leadership meeting, Medical Managers. We were able to discuss issues relating to coronial frustration, deliver a teaching session on PSIRF and additionally discuss and agree a joint approach to the implementation of PSIRF. Preparing and signing off incident reports for inquests under the current SI framework remains challenging. The increased number of options available to us under PSIRF has the potential to reduce this workload.

4. Learning from Deaths meetings.

4.1 Attendance at meetings

Despite significant clinical pressure over the winter, we have seen improved clinical representation at Learning from Deaths meetings over the last 6 months. Job planning for governance activities remains a challenge, but we interpret this engagement as a good reflection of the quality, value and benefit of meeting discussions.

4.2 Dashboard

Our mortality dashboard continues to evolve for use both in our meetings and for outward communications of our activities and learning. This contains data from macro (HSMR and SHMI) to micro (individual family feedback) scales.

The latest quarterly position is included in Appendix 4. The Learning from Deaths group hopes that the Board finds this useful and would welcome feedback.

5. Plans for Q1&2 2023/24

The Learning from Deaths Group will

- Continue to work with our external provider and our internal analysts to refine our mortality data intelligence. A review of our external mortality provider relationship will aim to maximise the financial and operational efficiency, for the Trust
- Signpost Clinical Mortality leads to areas which require further investigation and use findings to direct quality of care improvements
- Update on those areas where work is continuing
- Continue to support the 5 Divisions in establishing a workable mortality review tool on the Datix digital platform supported by processes and training
- Continue to ensure that mechanisms for Learning from Deaths work constructively and collaboratively with other internal and external governance processes.
- Develop our system intelligence and presence via the Learning from Deaths Regional Forum