Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors

Subject:	Learning from Deaths – Quarter One Report	**Date:** 6/08/2020	
Prepared By:	Dr John Tansley, Clinical Director for Patient Safety		
Approved By:	Dr David Selwyn, Executive Medical Director		
Presented By:	Dr David Selwyn, Executive Medical Director		
Purpose			
The purpose of this paper is to provide the Board of Directors with the Quarter One (20/21) update on compliance against the Learning from Deaths Guidance and the wider Mortality agenda.		**Approval**	
		Assurance	**x**
		Update	**x**
		Consider	

Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
x	**x**	**x**	**x**	**x**
Indicate which strategic objective(s) the report support				

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
Indicate the overall level of assurance provided by the report -	External Reports/Audits	Triangulated internal reports	Reports which refer to only one data source, no triangulation	Negative reports

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	No financial implications are anticipated at this time
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 reputational damage

Committees/groups where this item has been presented before

N/A

1. Executive Summary

The Board of Directors is asked to note:

1. The content of the report
2. The Group noted that this was Elaine Jeffers' last MSG meeting, and thanked Elaine for all her hard work and support over the past 4 years, and in helping to focus the Trust on patient needs

1. Routine business

MSG remained stood-down throughout the COVID-19 surge. No meetings occurred during March and April. The May meeting was postponed until June. Similarly a number of the processes which report into the MSG were paused, interrupting the information normally reported to the group.
The Covid-19 pandemic created a pause in 'business as usual' whilst all efforts focussed on the pandemic, providing some time for a review of processes to be considered and reflection on how this could look going forwards. The focus of the postponed May and the scheduled June meetings was to undertake a group review of the Mortality Surveillance Group and consider the future direction, areas of focus and structure of the Group.
The Group agreed that identifying learning is a challenge, but felt that themes and trends can be identified from cases (both from deaths and from near misses too). Going forwards, the Group noted that Dr Dave Selwyn (Medical Director) would like to see this Group becoming a **Learning from Deaths Group**, with discussions moving away for a focus on numbers and guidance and to focus on where and how changes have been made in practice, how the Trust/ areas are working differently and the difference these changes have made.
There will also be opportunities for Divisions/Specialties to define what they require and to define the information they wish to report to MSG going forwards, for example themes and trends.
A review of the terms of reference will be conducted for approval by the Quality and Safety Cabinet.

3. Structured Judgement Reviews (SJRs)

Additional support was put in place from the Bereavement Centre, from Dr Remy Bahl (Medical Examiner) and from colleagues who were unable to undertake their usual job roles due to the Covid-19 Pandemic, and instead provided valuable additional support to the Bereavement Centre and undertaking SJRs.

The Group discussed whether SJRs needed to be undertaken on all Covid-19 mortality cases. The Group noted that as the surge in Covid-19 patients had been lower than expected, a review had been undertaken for a significant number of Covid-19 patients who had died. The review had not identified any concerns, therefore it is felt that full SJRs are no longer required on Covid-19 patients.

Discussions are taking place with interested Consultant colleagues to develop a Medical Examiners Service Team going forwards. There are potentially significant advantages to having a more “independent” panel to conduct these reviews. Further updates to be provided in the Q2 report.

4. Mortality Intelligence

4.1. Mortality Review tool

The Mortality dashboard (Appendix 1) Shows that the overall performance for the quarter against the 90% review of all deaths standard is 84.55%.

Data for completion of avoidability assessments are not available for Q1. These data are not an output the mortality review tool but are captured manually. This data collection did not occur due to the interruptions to routine business caused by COVID. There have been discussions around whether the existing Mortality review Tool remains fit for purpose. An alternative exists as part of the new audit platform (AMaT). The group will update in the Q2 report.

4.2. Dr Foster Monthly Report

4.2.1. COVID 19

Covid-19 activity in the 'Signs and Symptoms' diagnosis group will be manually moved to the 'Virus Infection Group' to help identify the data more easily

Dr Foster colleagues have agreed not to change the diagnosis methodology/model for HSMR and SHMI at this point in time, this will be reviewed in due course to ascertain whether any changes will be required

Additions will be made to the HIP tool to help identify all Covid-19 activity (whether primary or secondary diagnosis). Ventilation (invasive and non-invasive) will also be included

SHMI – NHS Digital will be removing all Covid-19 data (primary, secondary and mentions of Covid-19 on community death certificates). Data will be published by Hospital admissions (primary and secondary diagnosis)

Analysis of Early COVID-19 data was made available

4.2.2. Impact of COVID-19 on activity

The data below shows the percentage change in activity (superspells) between expected volumes of superspells for March 20 (based on the average from historic data in the same month, to account for seasonal variability, for the last 5 years) and actual volumes of admissions split by admission type

(For clarity a superspell is the whole of a treatment episode (e.g. if you are admitted through SFH ED with a head injury and transferred to NUH then sent back to SFH for rehab that is one superspell made up of 3 spells SFH, NUH the SFH again). If the patient dies then both Trusts have the mortality counted against them)

Trust

	Average of Mar 15-19	Difference Mar 20 vs Average	% Difference Mar 20 vs Average	Difference Mar 20 vs Mar 19	% Difference Mar 20 vs Mar 19
Elective	3,654	-927	-25.4%	-743	-21.4%
Non-Elective	4,159	-166	-4.0%	-398	-9.1%

National (Acute, non-specialist)

	Average of Mar 15-19	Difference Mar 20 vs Average	% Difference Mar 20 vs Average	Difference Mar 20 vs Mar 19	% Difference Mar 20 vs Mar 19
Elective	638,200	-147,888	-23.2%	-151,932	-23.7%
Non-Elective	631,643	-74,034	-11.7%	-100,295	-15.2%

4.2.3. COVID-19 Activity vs. Regional Peers

For the 12 months to March 20, the trust reported 39 superspells with a primary diagnosis of COVID-19 (U07.1 or U07.2). Of these superspells, 17 died resulting in a crude rate of 43.6%.
Across the Regional peer 464 superspells were reported with 107 deaths resulting in a crude rate of 23.1%

Basket: **Diagnoses** Metric: **Mortality (in-hospital)** Time period: **Last available 12 months**

Diagnosis group: **Residual codes, unclassified**

ICD10 (4-char): **U07.1 Emergency use of U07.1, U07.2 Emergency use of U07.2**

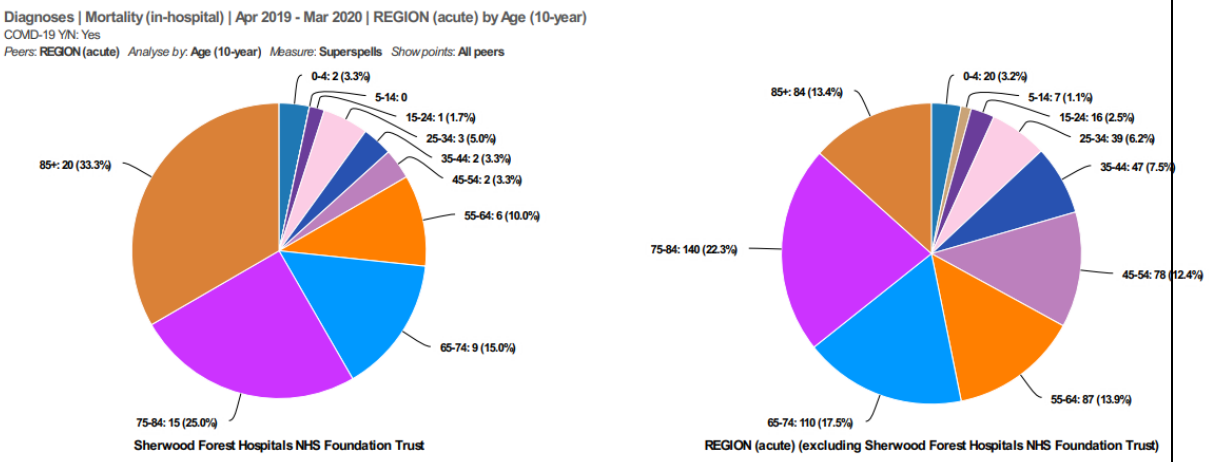
Patients: **38** Superspells: **39 (102.6)** First / Last: **Mar 2020 / Mar 2020** Deaths: **17 (43.6%)** LOS: **4.1**

Expected: **1.3 (3.3%)** O-E: **15.7 (40.3%)** Relative Risk: **1312.0 (763.9â€"2100.8)** Model: **Month: Dec 2019** C-Statistic: **0.89 (High)** Model cases: **1408969** Model deaths: **32994** Adjustment: **Variables**

REGION (acute)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
All	464	100.0%	465	107	23.1%	14.7	3.2%	92.3	725.9	594.9	877.2
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	120	25.9%	120	19	15.8%	3.7	3.1%	15.3	517.3	311.3	807.9
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	118	25.4%	119	28	23.7%	3.5	3.0%	24.5	803.7	534.0	1161.7
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	61	13.1%	61	10	16.4%	2.7	4.5%	7.3	367.9	176.1	676.7
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	46	9.9%	46	8	17.4%	1.1	2.4%	6.9	723.0	311.3	1424.7
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	39	8.4%	39	17	43.6%	1.3	3.3%	15.7	1312.0	763.9	2100.8
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	37	8.0%	37	11	29.7%	1.2	3.3%	9.8	908.0	452.7	1624.9
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	26	5.6%	26	7	26.9%	0.5	1.9%	6.5	1416.3	567.4	2918.2
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	17	3.7%	17	7	41.2%	0.8	4.5%	6.2	923.7	370.1	1903.2

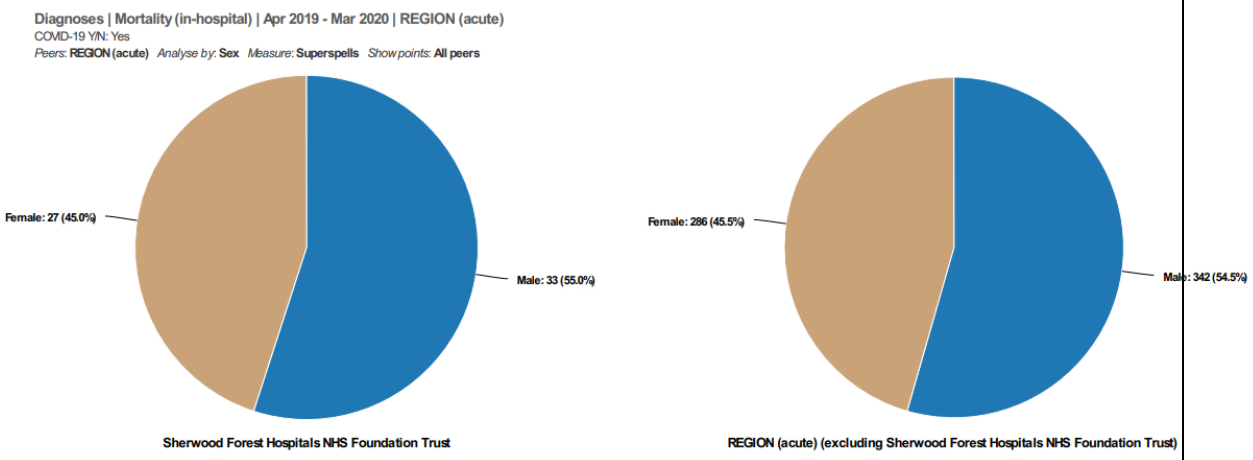
4.2.4. Case mix: Age

The Trust has an older cohort of Covid patients than average. The Trust has 58.3% Covid patients aged >75yrs (vs. 35.7% Regional average)



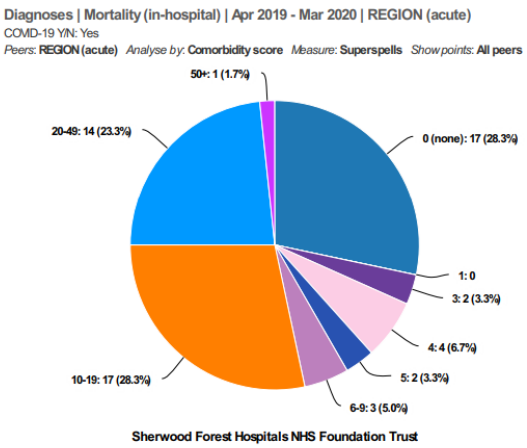
4.2.5. Case mix: Sex

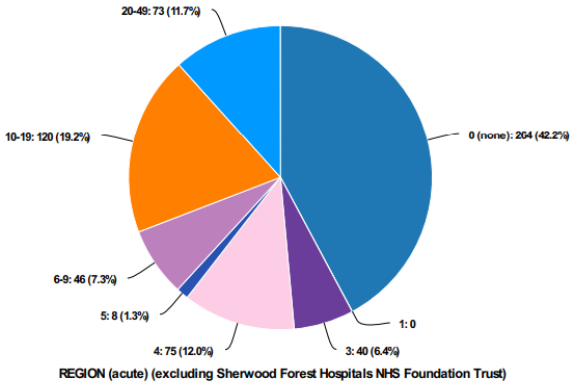
The Trust has a comparable percentage of male Covid patients than average. The Trust has 55% male Covid patients (vs. 54.5% Regional average)



4.2.6. Case mix: Charlson co-morbidity score

The Trust appears to have a more co-morbid cohort of Covid patients than the national average. Only 28.3% have a '0' co-morbidity score (42.2% Regional average) and 53.3% having a Charlson score >10 (30.9% Regional average)





Conclusion

The national and local picture around impact of Covid-19 mortality is evolving and we are working with Dr Foster to further describe this. Our initial data interpretation would suggest that there are understandable reasons for a higher than national average, Covid-19 mortality.

The Mortality surveillance group/ learning from deaths group will continue to feed into and report to the Quality and Patient safety Cabinet.