Board of Directors

Subject:	Learning from Deaths Group (formerly Mortality Surveillance Group)– Annual Summary Report (including Q2 update)	**Date: 05/11/2020**	
Prepared By:	Dr John Tansley, Clinical Director for Patient Safety Chair Learning from Deaths Group		
Approved By:	David Selwyn, Medical Director		
Presented By:	David Selwyn		
Purpose			
The purpose of this paper is to present the Board of Directors with the Annual 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 2020/21		**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	Potential additional cost of AMaT 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	Limited

Committees/groups where this item has been presented before

None

Executive Summary

This annual summary report seeks to bring together the work undertaken in the year 2019/20 and outline proposals for ongoing development of the Learning from Deaths (formerly Mortality Surveillance) Group. This report provided significant assurance regarding our mortality management arrangements.

We thank the Board for allowing presentation of this report to be delayed following the first surge of COVID-19. The report contains our most-recent information reflecting the position at Q2 2020. The report describes the impact of the COVID 19 surge on the working of the group (including some potentially positive effects) and summarises some early analysis of COVID-19 patients. The report updates on progress against actions proposed from 2018/19 and details the Group's response to the findings of the Trust's 360Assurance Mortality Audit which was published in July

2020.

We continue to review our HSMR and SHMI data and work closely with Dr Foster to understand what drives the changes in our data. A number of clinical case series reviews including fractured neck of femur (no longer a mortality outlier but still requiring understanding), upper GI haemorrhage and liver disease, alcohol related, have been undertaken by clinical teams this year. Further scrutiny of these findings by one of the Trust's Medical Examiners will be undertaken in 20/21as part of the MD Office deep dive investigative work.

The Learning from Deaths Group continues to receive the outputs of the Trust's Mortality review Process and Tool and is working with clinical teams to improve relevance of information and useability of the tool whilst aligning Learning from Deaths with other Governance processes and IT infrastructure. The role of the Trust Medical Examiner continues to be established and is a core member of the Learning from Deaths Group

The Board of Directors is asked to note:

- The content of the Report
- The 360Assurance mortality audit report which gives **significant assurance** and our responses to continue to improve learning from deaths.
- HSMR remains high but SHMI is within expected range
    - Reasons for this are not clear at the moment but are likely multifactorial
    - We are aware that may be related to our low palliative care coding rates remain in the lowest quartile nationally
    - The ongoing focus on the Fractured Neck of Femur, Upper GI Bleed and Alcohol-related Liver Disease mortality outlier status
- The performance of against the requirement to review 90% of all deaths and again our proposals to improve this performance and align our learning from deaths with other Governance processes.

1. COVID 19

The pandemic caused disruption to both reporting and functioning of the group and the impact on particularly elective activity resulted in some effects on our mortality data. Preliminary analysis reported in Q1 submission to board showed 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) 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).

Further analysis for COVID 19 patients is included in the Dr Foster Mortality Data section this report.

Colleagues who were unable to undertake their usual job roles, provided valuable additional support to the Bereavement Centre and structured judgement reviews were carried out on the majority of COVID-19 patients. No significant lapses in care were identified by this process

2. Progress on actions from 18/19

Specialties will be required to attend MSG at agreed intervals throughout the year to provide assurance about the effectiveness of local mortality meetings. A schedule of attendance has been drawn up.

Bespoke mortality reports are being agreed with individual services to support improved

understanding and engagement of clinical teams in the factors driving their own mortality.

This work continues as part of a more widespread **Governance reset** within the Trust, we are also establishing how Learning from Deaths fits in with other areas of Governance such as Serious Incident investigation and the Medical Examiner process

Particular focus will be given to three specific cohorts of patients (as defined in the April report to Board), not necessarily to reduce the overall mortality position but to provide an opportunity to improve pathways and treatment decision-making for vulnerable groups. These include:

- *Learning Disability*
- *Schizophrenia*
- *Acute Psychosis*
- *Bi-polar Disorder*
- *Fractured Neck of Femur*

A member of the Safeguarding team is a core member of the group to monitor Learning Disability and Mental Health mortality and a separate Learning disability (LeDER) summary forms part of the annual safeguarding Trust Board report. An invited speaker gave us an update on the Regional/ National picture at the September 2020 meeting.

As noted later in this report we are no longer an outlier for overall fractured neck of femur mortality. We are aware that we do not have a good understanding of what is driving these changes and we would like to see our mortality move further towards national average. An external MD Project Advisor has been appointed to work with this group and specialist clinical colleagues to further investigate this patient group.

Note the preparatory work undertaken through 2018/19 to ensure the successful implementation of the ReSPECT Tool in April 2019.

Progress has been delayed by COVID-19 but we are anticipating the beginning of implementation in November 2020. Our documentation has been adopted by the ICS for regional use.

3. Sherwood Forest Hospitals NHS Foundation Trust 360Assurance mortality audit report

Received in July 2020 reflecting the position at March 2020

Significant assurance	As a result of this audit engagement we have concluded that, except for the specific weaknesses identified by our audit in the areas examined, the risk management activities and controls are suitably designed, and were operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period under review.

Six findings with associated actions were identified

Finding 1:

- Although the Mortality Surveillance Group (MSG) has a specialty reporting schedule for the specialties to present patient stories and Structured Judgment Review cases to the MSG it is not clear how the MSG reviews the specialty level Mortality meetings to assure

consistency and compliance which is part of its remit as it does not receive meeting minutes.

Action: The specialty Mortality and Morbidity meetings to submit a copy of their Terms of Reference and meeting attendance log annually to the Mortality Surveillance Group.

Implementation date: 30 June 2021

Progress: **On Track**

Finding 2:

- Whilst meeting quoracy and membership is defined in the MSG's Terms of Reference (ToR) it is not clear which members are deemed core members. As the ToR state that core members must attend a minimum of 75% of meetings we were unable to identify true meeting attendance compliance. Only three out of 31 staff members had attendance greater than 75% of the meetings in our review period but we note that some of these staff members may not be core members.

Action**:** Core members of the Mortality Surveillance Group to be defined in its Terms of Reference and non-compliance with membership responsibilities to be escalated accordingly.

Implementation date: 30 September 2020

Progress: **Complete**. Core members defined and in, absence of a suitable deputy, submission of a written report has been agreed in Terms of reference and approved by Quality and Safety Cabinet.

Finding 3: We identified the following weaknesses with the Trust's Mortality Management Policy:

- The standard procedure for the review and reporting of adult deaths flowchart does not accurately describe current practice as the initial stage 1 review carried out by the junior doctor is not included in the flowchart.
- The Policy and flowcharts do not explicitly describe the timescales for undertaking and completing each stage of the process.
- The Trust standard for reviewing deaths is 90% of all deaths but this Key Performance Indicator (KPI) is not included in the Policy.
- The triggers for a Structured Judgment Review are not included in the Policy but we note they are included in the Mortality Review Tool.
- Care and avoidability ratings are not included in the Trust's Mortality Management Policy but we note they are included in the MRT.

Action: The Trust to review and update the Mortality Management Policy to:

- include the initial stage 1 review in the standard procedure for the review and reporting of adult deaths flowchart
- describe the timescales for undertaking and completing each stage of the process
- the Trust's Key Performance Indicators (KPIs) for mortality

- the triggers for a Structured Judgment Review
- care and avoidability ratings.

Implementation date: 30 September 2020

Progress: **Ongoing**. The policy has been reviewed. The group is not assured that the initial stage 1 review by junior doctors is suitably robust. Our performance against the 90% target remains low. A trial of stage 1 review by the Medical Examiners (who scrutinise 100% of deaths) has started. Additionally following the success of independent Structured Judgement Review by shielding colleagues we are exploring continuing this process. We feel a more considered review of the policy is required.

Finding 4: Two out of six of the specialties tested did not demonstrate learning from deaths within their Mortality and Morbidity or Governance meeting minutes.

Action: The Mortality Surveillance Group to be assured that the Stroke and Cardiology specialties document learning from deaths in their Mortality and Morbidity meeting minutes or governance meeting minutes.

Implementation date: 30 September 2020

Progress: **Complete.** Minutes of recent meetings have been submitted for scrutiny with documented evidence of discussion

Finding 5: We noted that the Trust is not reporting on compliance with SJR investigation timeframes.

Action: The Trust to include compliance with investigation timeframes in their Mortality Surveillance Group mortality reports or mortality dashboard

Implementation date: 31 March 2021

Progress: **On track.** A working group has been set up to investigate procedure and performance data within the mortality review process and tool.

Finding 6: The Trust is not currently carrying out formal mortality audits of compliance with policy, process and controls.

Action: The Trust to carry out regular formal audits of compliance with policy, process and controls.

Implementation date: 30 June 2021

Progress: **On Track.** The Trust has recently moved to a new audit platform (AMaT). Our current mortality review tool database has limited functionality. We have had a meeting with AMaT who can provide a mortality module which is compatible with the audit platform. There will be an additional cost for this module so we have also consulted NHIS colleagues to explore the possibilities of increasing the functionality of the existing platform. A business case outlining these options will be submitted this year. This will complement action 5 above.

We feel that these actions together with other work described in below will significantly improve

our ability to learn from deaths and integrate this learning into other sources of intelligence within the Trust.

4. **Dr Foster Mortality Data**

Figure 4.1 – HSMR 12 Month Rolling Trend

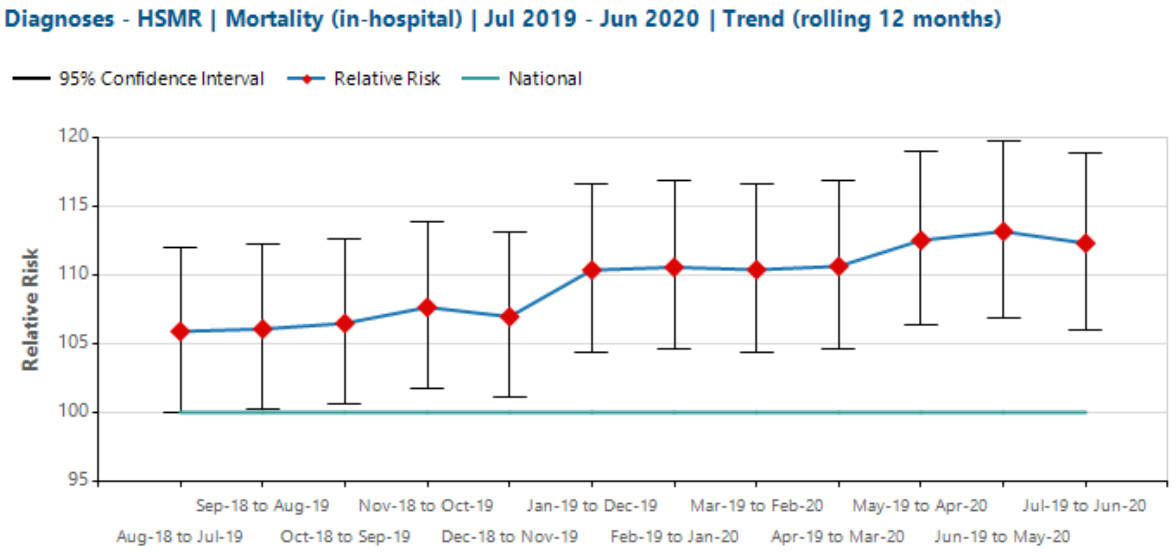
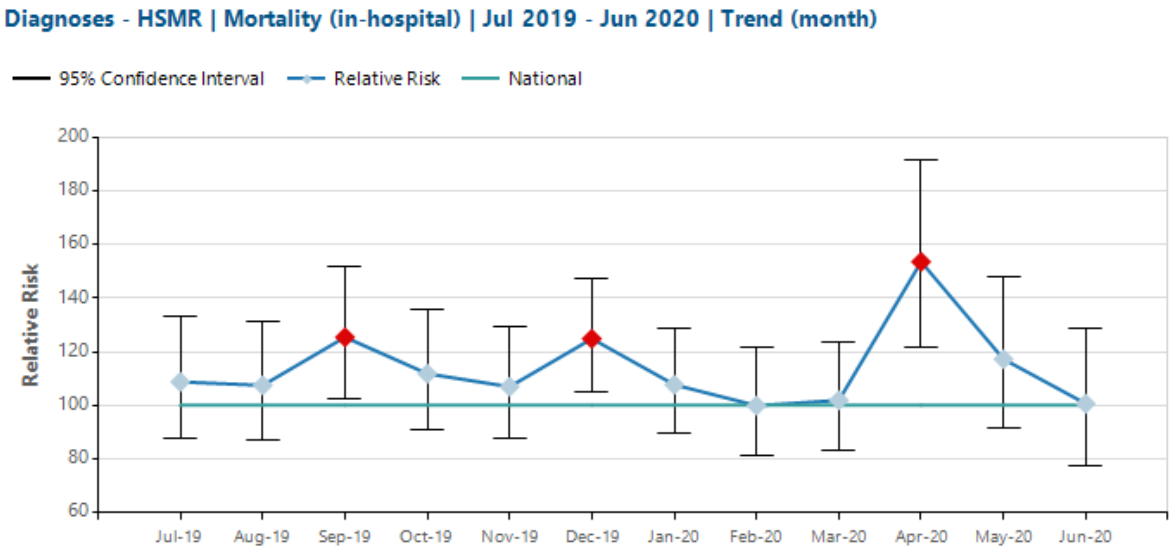


Figure 4.2 – HSMR Monthly Trend



The HSMR appears to have stabilised (Fig 2.0) and is now at **112.3** but remains statistically significantly high. However, the monthly point value has now dropped for the past two months with activity beginning to recover but in hospital mortality continuing to fall. The peak in April 20 relates very clearly to the fall in activity driven relating to the COVID pandemic. (Fig 1.0)

It is worthy of note that the Trust retains the highest crude and expected mortality rate across the regional peer group.

Comorbidity coding remains high (20+) 19.2% v 13.9% nationally

The risk profile however remains low 81.7% v 83.7% nationally of activity within the 0-10% band

In a reversal of the picture at the end of Q4 weekend mortality is now slightly higher with a subtly differing diagnosis profile at the weekend but a materially different crude rate: 7% weekend v 6% weekday. The coded case-mix across both weekday & weekend is broadly consistent in terms of Palliative care, Comorbidity and Age but with a difference in the diagnosis profile suggesting a higher proportion of Mental Health (Senility) & Injuries / poisoning admissions.

There are currently six identified outlying diagnosis groups including Viral Infections (COVID19):

- Abdominal pain
- Gastrointestinal haemorrhage
- Viral infection (Driven primarily by COVID-19 mortality)
- Liver disease, alcohol-related
- Peripheral and visceral atherosclerosis
- Cancer of liver and intrahepatic bile duct

Abdominal pain, Peripheral and visceral atherosclerosis and cancer of the liver are new and will continue to be observed.

Gastrointestinal haemorrhage and liver disease, alcohol related are known and internal case series investigations have been undertaken to be reported to Learning from Deaths group in November 2020.

Fractured neck of femur mortality is no longer significant although days to Theatre remains significantly high with the second highest crude rate across the region with a significantly high position following admission on a Friday or Saturday and for admissions with a comorbidity score of 10+. A review of these cases is underway following appointment of the external MD Project Advisor. An external review of the service has also been explored; initial contact has been made with the British Orthopaedic Association. The projected cost of this review is in excess of £20,000 and as such we wish to complete our MD Project Advisor review first to help clarify key lines of further enquiry, if required.

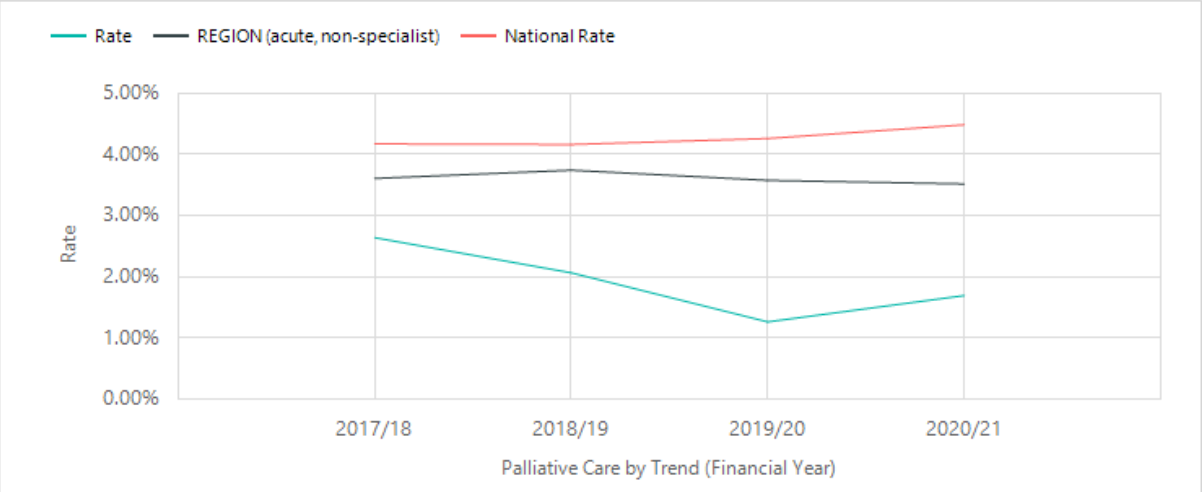
Following this review, dependent on establishment of a suitable reproducible process, further scrutiny of the case series investigations from Gastroenterology into upper GI haemorrhage and liver disease, alcohol related will be undertaken.

Figure 4.3 – FY Palliative Care Coding Rate Vs National

Organisation: **Sherwood Forest Hospitals NHS Foundation Trust** *Report Date:* **29 September 2020**

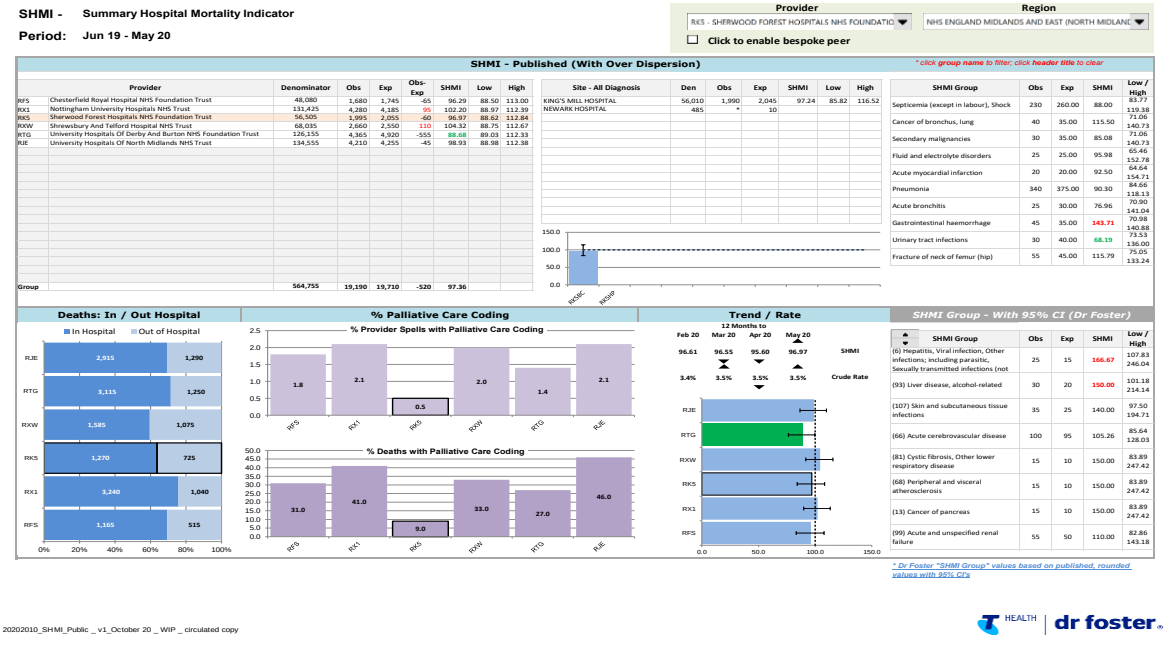
Basket: **Diagnoses - HSMR** *Peer group:* **REGION (acute, non-specialist)**

Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2017/18	17,800	470	2.64%	4.17%	3.61%
2018/19	18,540	383	2.07%	4.16%	3.74%
2019/20	20,473	259	1.27%	4.26%	3.58%
2020/21	3,304	56	1.69%	4.49%	3.52%



This position is under review by Clinical lead for End-of-life Care, Clinical Coding and Dr Foster.

Figure 4.4 SHMI The SHMI remains stable at 95.60



COVID-19 Data

Figure 4.5 Crude Mortality (All Patients)

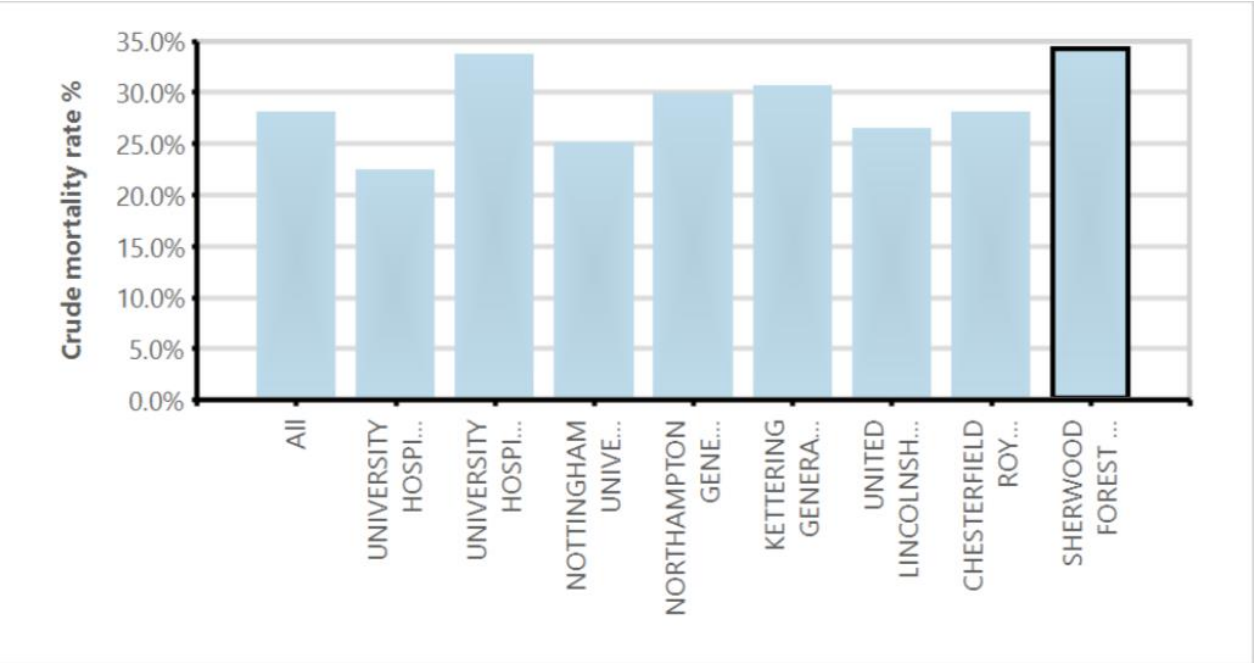
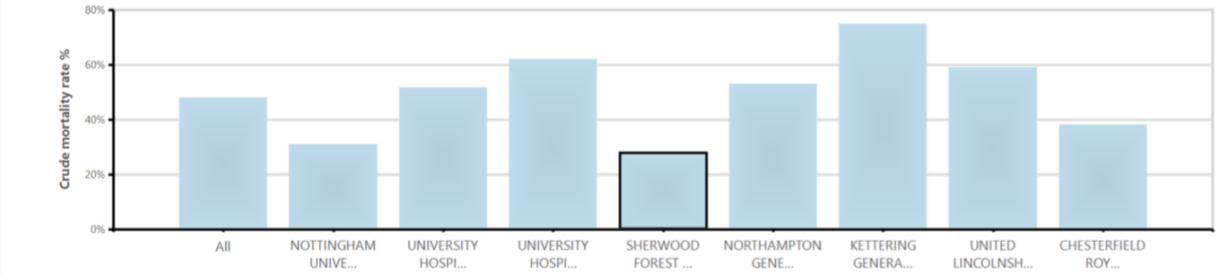


Figure 4.6 Crude mortality (Ventilated Patients)

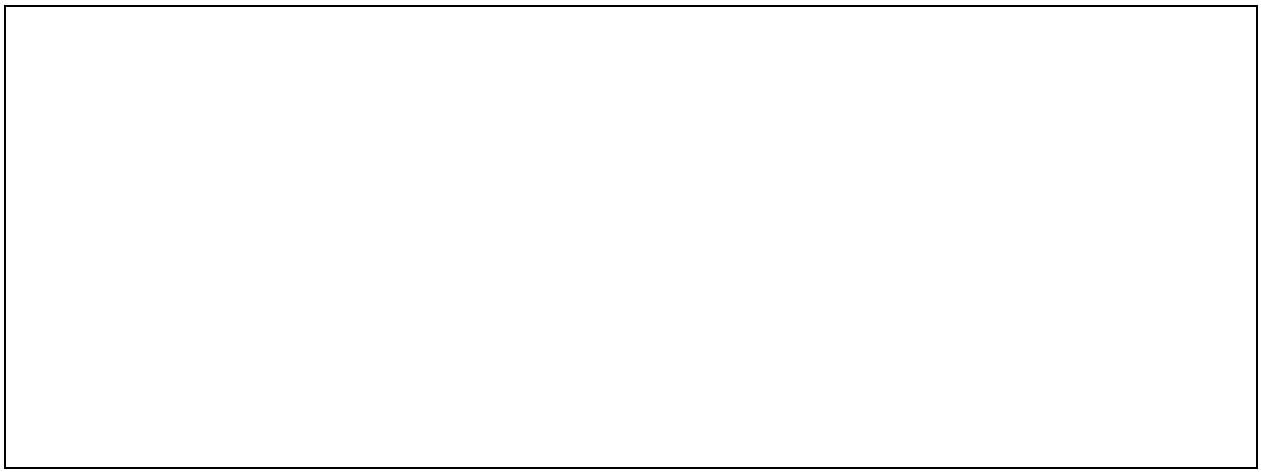


The mortality associated with COVID-19 particularly in ventilated patients is worth further analysis to understand.

Figure 4.7 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)

Figure 4.8 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)

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

Figure 5.1 Learning from Deaths Dashboard at Quarter 2 2020/21

Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Jul-20	94	67	71.28%	4
Aug-20	100	78	78.00%	5
Sep-20	113	72	63.72%	Not collected
Qtr 1	369	312	84.55%	25
Qtr 2	307	217	70.68%	9
Qtr 3				
Qtr 4				
Year 20/21	**676**	**529**	**78.25%**	**36**
Year 19/20	**1514**	**1314**	**86.79%**	**41**
Year 18/19	***1446***	***1267***	***87.62%***	***11***
Year 17/18	***1550***	***1300***	***83.87%***	***21***

As described in Figure 5.1 following a good performance in 19/20 just short of our 90% target we maintained this in Q1 during the COVID-19 surge but this has dropped in Q2. The number of avoidability assessments increased in 19/20 following a dip in 18/19. The number of avoidability assessments for Q1 and Q2 is already approaching the 19/20 figure.

It is difficult to interpret these numbers. As pointed out in the 360Assurance audit, we do not have a denominator for the number of SJRs and avoidability assessments that ***should have been done*** and we have no fixed timescales for completion of the reviews. Also there have been changes in the process with shielding colleagues undertaking mortality reviews during

the surge but returning to normal duties after. We anticipate that moving to a model where the Medical Examiners undertake the initial screening as part of the scrutiny will move our rate nearer 100%, reliably identify those cases that must have an SJR (e.g. learning disability and mental health deaths) to allow us to conduct meaningful audit. Medical examiners will trigger SJRs on cases where scrutiny raises questions and clinical teams will still be able to intiate SJRs through the regular morbidity and mortality review process. Establishing timeframes for completion of the reviews as recommended by the 360Assurance audit should make interpretation more straightforward.

6. Medical Examiner (ME) Role

Additional sessions have been recruited to, we now have 8PA with coverage of the bereavement centre on all weekdays and also project lead sessions to look at HSMR as described above. The MEs also liaise regularly with the Governance team to triangulate concerns with Datix reports (serious incidents involving deaths should have an SJR as part of the investigation). Additional ME sessions are currently out to expressions of interest.

7. Mortality Review Process and Tool Review

The Trust was an early implementer of National Learning from Deaths Guidance (2017) and the process continues to mature. Some of the processes and tools/ infrastructure which were developed to allow this early implementation may benefit from review and refinement.
As described above the group is continuing to undertake a review of the mortality management process, including its reporting structure and supporting IT infrastructure with the aim of aligning with other Governance processes to provide useful information to clinical colleagues and assurance. This ongoing work represents a significant undertaking for the year 20/21

8. Plans for 2020/21

- Complete outstanding actions from 360Assurance audit report including review of mortality management process together with strengthening the Medical Examiner role
- Continue to monitor both the HSMR & SHMI on a monthly basis and support MD Office deep dive investigative work.
- Review documentation and the coding, initially of Palliative care activity, given the impact it will potentially have on the Dr Foster models.
- Complete internal and possibly external reviews of those groups with outlying mortality
    - Dr Foster to complete further analysis at a diagnosis group level in conjunction with the Trust given that the crude rate for 4 out of the 6 identified groups the crude rate is the highest across the region (Except Abdominal Pain and Viral Infections). This work should focus on the higher volume groups.
- Dr Foster to complete further analysis to further understand the differences between weekend and weekday emergency admissions in terms of mortality focussing on associated metrics and case-mix.
- Develop the SJCR ‘faculty’.
- Continue to engage and learn from other local and buddy organisations with elevated HSMR.