Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Learning from Deaths Group update	**Date**: 5th October 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	
Approved By:	David Selwyn	
Presented By:	David Selwyn	

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

Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
X	X	X	X		X

Principal Risk

PR1	Significant deterioration in standards of safety and care	X
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
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 Medical Managers and Patient Safety Committee. The HSMR update (appendix 1) was discussed in detail at Quality Committee on 3/10/2023.

Acronyms

- **SFH** Sherwood Forest Hospitals
- **HES** Hospital Episode Statistics
- **HSMR** Hospital Standardised Mortality Ratio
- **SHMI** Summary Hospital-Level Mortality Indicator
- **CuSUM** Cumulative Sum
- **ICB** Integrated Care Board
- **SJR** Structured Judgement Review
- **MCCD** Medical Certificate of Cause of Death
- **ME** Medical Examiner
- **PSC** Patient safety Committee
- **SPC** Statistical Process Control
- **MHA** Mental Health Act
- **LD/ LeDeR** Learning Disabilities/ Learning Disabilities Mortality Review
- **ReSPECT** Recommended Summary Plan for Emergency Care and Treatment
- **PSIRF** Patient Safety Incident Response Framework

Executive Summary

Sherwood Forest Hospitals NHS Foundation Trust (SFHT) has been challenged by a persistently elevated Hospital Standardised Mortality Ratio (HSMR) which remains “higher-than-expected” at 129.98. The Summary Hospital-Level Mortality Indicator (SHMI) remains “as-expected” at 108.64 but is trending upwards. This is in the national context of “excess deaths” observed across the region and England.

Work undertaken by the Learning from Deaths group to understand these metrics and the differences between then has not identified any new specific care or diagnosis concerns which will make any large difference to the numbers but has indicated several general areas for improvement in terms of documentation and coding.

The group continues to develop and refine other sources of mortality intelligence to complement these metrics and triangulate improvements in mortality intelligence.

The Mortality review process has been revised with clinical input, informed by changes made to mitigate the effects of industrial action. A trial of this process, which we anticipate will be more comprehensive, timely and efficient is planned for later in October.

The first element of the DCIQ (Datix) mortality management tool has been successfully implemented with further components expected soon. Potentially useful real-time data streams have been established.

The Trust continues to identify cases for further review using the Royal College of Physicians’ Structured Judgement Review methodology with support from our Medical Examiner Team. This system is generally working well although feedback around the timeliness and quality of some of the SJRs shows we still have room for improvement. We hope that time released by changes to other elements of the Mortality Review Process will help with this.

Conversations and documentation of decisions around end of life have been identified as an area for improvement in several ways. In addition to ongoing workstreams this has been identified as one of our themes for investigation in our PSIRF plan which launches on 2/10/2023. Whilst we have not identified any large, clear sources of avoidable death in the work of the Group we remain committed to improving the care at the end of those lives, where death is unavoidable.

Review of Deaths which met the serious incident (SI) threshold, the majority of which were hospital acquired Covid-19, identified no themes other than contact with community positive cases. Following discussions within PSC and following ICB discussions, future SI notifications and investigations in response to Covid-19, will be stood down.

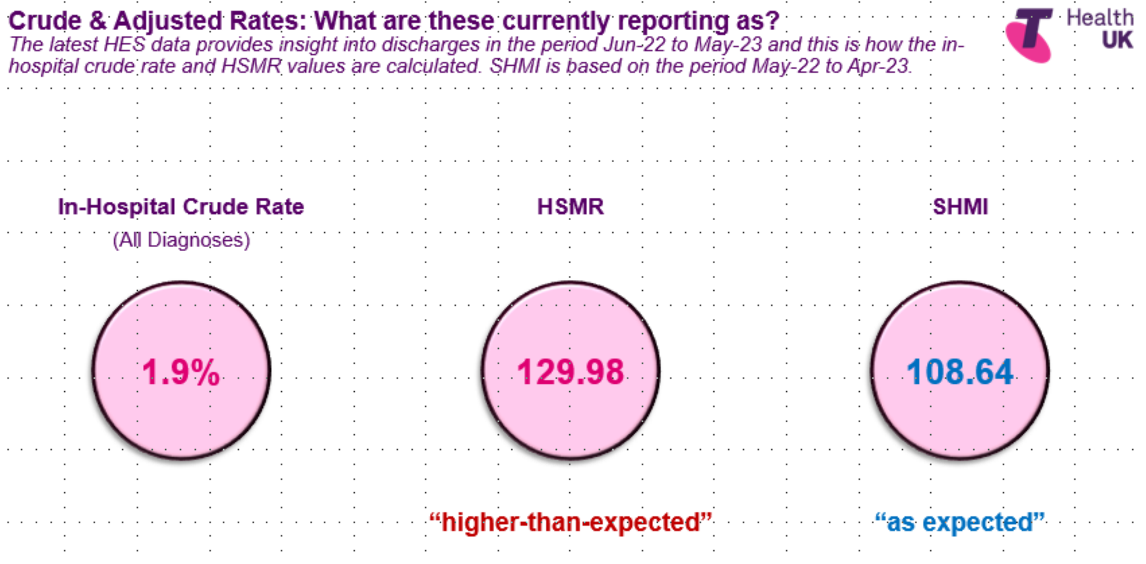
The Board is asked to note that we have received no new Regulation 28 notices from HM coroner.

In the next 6 months the Learning from Deaths Group plans to continue to develop and refine a broader range of mortality intelligence and communicate that to clinical teams to support ongoing improvements and learning, in patient care. We will also explore the possibilities for more integrated system working with our ICB and Regional NHS colleagues.

1 Mortality Surveillance Data

The most up-to-date high-level Trust mortality data is shown below.

Fig 1.1 Crude and adjusted SFH mortality rates



The paper attached in Appendix 1 was presented and discussed at Quality Committee on 3/10/23 with a presentation from our Dr Foster (Telstra) consultant dealing with derivation and interpretation of mortality metrics. This Appendix paper describes our current understanding and interpretation of this Trust-level data, offering explanations for the ongoing "higher than expected" HSMR and the "as expected" but rising SHMI.

Much of the analysis suggests this is due more to an ongoing under-estimate of our expected mortality according to the various models than a disproportionate increase in our number of deaths.

These data should be taken in context of a higher-than-expected number of deaths both regionally and nationally according to data from Office for Health Improvement and Disparities.

Fig 1.2 Excess Deaths East Midlands July 2021 to June 2023

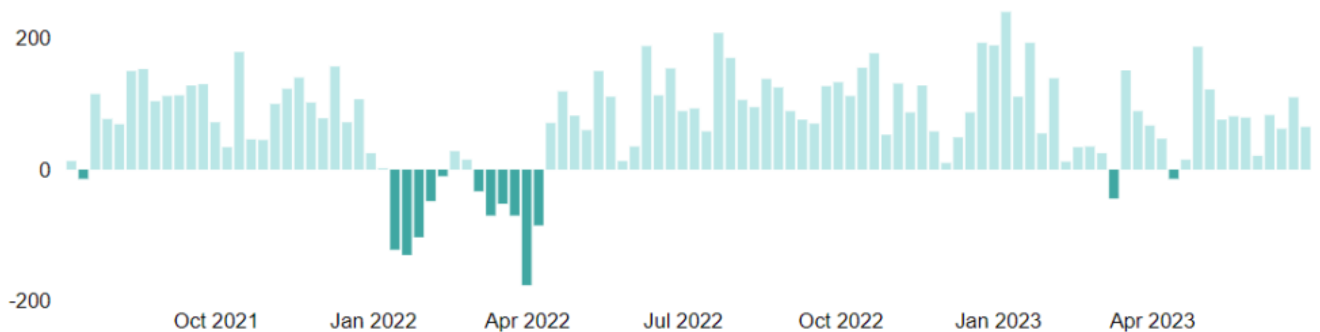


Fig 1.3 Total deaths East Midlands and England July 2021 to June 2023

Region	Registered deaths	Expected deaths	COVID-19 deaths	Excess deaths	Ratio: registered / expected
England	1,094,881	1,022,220	60,978	72,661	1.07
East Midlands	101,294	93,575	5,953	7,719	1.08

Source:
https://app.powerbi.com/view?r=eyJrIjoiOGNkMmY3NWMtMWM0MS00YTI1LWIyZTEtZjVhYTM0OTI3NmZiliwidCI6ImVlNGUxNDk5LTRhMzUtNGIyZS1hZDQ3LTVmM2NmOWRlODY2NiIsImMiOjh9

Adjusted mortality rates all have the same vulnerabilities in that:

1) they rely on quality of documentation and coding
2) they are produced by models based on a number of assumptions. Each model differs by more than one parameter which makes comparison difficult although we feel we have a robust approach for triangulating outliers in HSMR, CuSUM and SHMI reports. One of our biggest challenges is understanding impact of the fact that we are a national (low) outlier for palliative care coding which will increase our HSMR but not our SHMI. We have no further update regarding the Telstra consultation inclusion of palliative care in their model which was discussed in the last report to board.

Findings of recent clinical reviews instigated by the Learning From Deaths group (liver disease, sepsis and fractured neck of femur) have revealed variation between coded interpretation and clinical presentation occurring both at the documentation and coding stages. Further evidence has been provided by a recent coding audit across the whole department. In addition to coding errors there are a number of “missed codes” which are typically non-resolving chronic conditions which are not repeatedly documented in subsequent admissions (and therefore cannot be coded).

In addition to changes to the admission documentation referred to in previous reports, which is now ready for implementation, the Trust is looking at ways to

1) identify coding errors (by using digital solutions such as NerveCentre which can provide information before paper notes arrive) and capture them (possibly by including coders in the ward round teams) at the time of admission. Our primary concern is the impact this missing information has on decision-making in our clinical work
2) identify coding errors at the time of coding by increasing clinical input into the coding process to mitigate the effects on outcome data and ultimately our funding base for future care
3) Providing increased coding educational resource in our acute admission area

We have undertaken a broad educational approach emphasising the importance of good documentation, coding, understanding and interpretation of mortality metrics. This has included presentations at Medical Grand Rounds, meetings for governance leads, Medical Managers, Divisional Teams and Clinical Chairs. Further engagement events are planned. We anticipate inclusion of mortality indicators at Divisional Performance Reviews will increase the sense that these data are relevant to everyone’s work and we are making progress with providing data at diagnosis and specialty level to support these discussions and development of plans to address any clinical concerns.

At each clinical deep dive, we investigate signals from the data set. Some of these signals represent normal cause variation or overall system 'noise'. Each deep dive has an opportunity cost, and that work must compete with demands for patient-facing time against a background of increasing waiting list backlogs and on-going industrial action.

Our ongoing focus on HSMR has, however, resulted in learning that might have been missed had we solely been reassured by our historical SHMI. We are keen to ensure that our data is of the highest quality that we can achieve, to distinguish signal from noise and direct our resources most effectively and capture true learning.

1.2 Outlying diagnosis groups and progress on actions

Palliative Care
Work around reconfiguring the local palliative care provision is making slow progress but meanwhile we continue to work closely with our colleagues at John Eastwood Hospice, particularly in terms of education and understanding of Palliative, End-of-life and Last-days-of-life care, at multiple levels in the Trust and also in primary care. We hope that new appointments in both Nursing and Medical leadership in the Trust End-of-Life care team will build on this work. We are pleased to welcome these new colleagues to the Learning from Deaths Group.

1.3 External Mortality Intelligence Provider
We continue to use Dr Foster (Telstra) as our provider. We expect to undergo a re-tender process in the next year. Early discussions around potential advantages of commissioning these services at ICB level may be worthwhile.

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

Our concerns around the mortality metrics described to Board may be partially offset by other sources of mortality intelligence. We are making slow, but definite, progress in a number of other measures.

2.1 Mortality Review Tool

A new mortality process has been co-created with clinical teams and agreed at Clinical leadership groups and Patient Safety Committee. The aim is to launch this process as a trial in October- replacing the existing tool which we believe provides no useful information to Learning from Deaths. The model addresses the shortcomings of the previous MRT which is incompletely applied, retrospective (with a time lag often of several months) and conducted by those delivering the care and currently flagging up a very small number of cases for escalation to further review. Real-time reporting was not available. Building on learning from recent industrial action by Junior Doctors during which more senior members of the teams were involved in the Bereavement Centre and Medical Examiner (ME) processes the new tool asks a senior member of the team (ideally a consultant) to review and identify learning at the time of issue of MCCD alongside the independent ME scrutiny which captures 100% of hospital deaths. Based on experiences from the industrial action period and consultant with clinical staff this should improve both the quality and efficiency of the review. Real-time reporting will be available as this information will be supported on the DCIQ (Datix) platform. The outcome of this trial will be included in the next report to Board.

2.2 Data from Medical Examiner Service Office

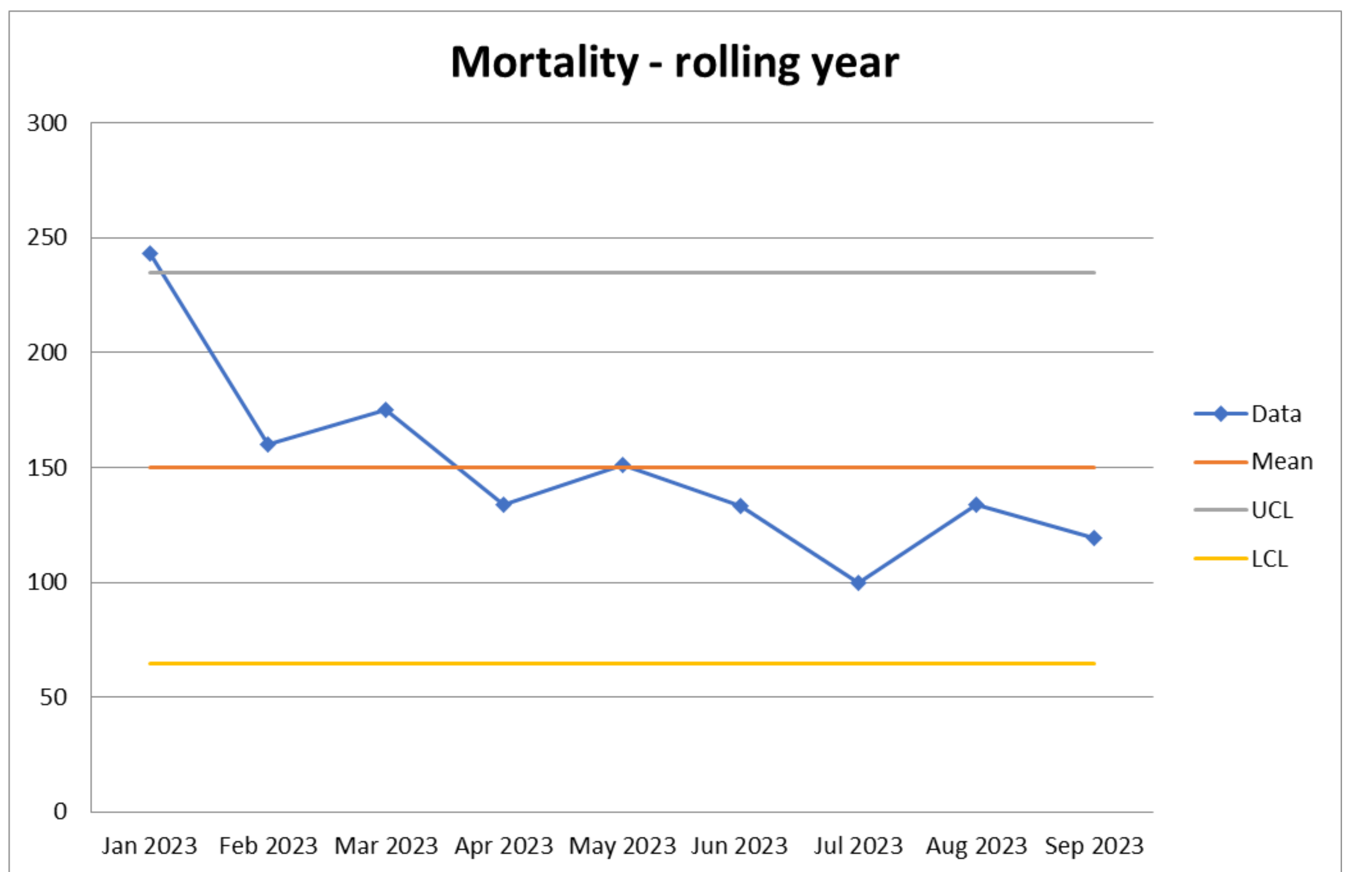
The service continues to scrutinise 100% of hospital cases.

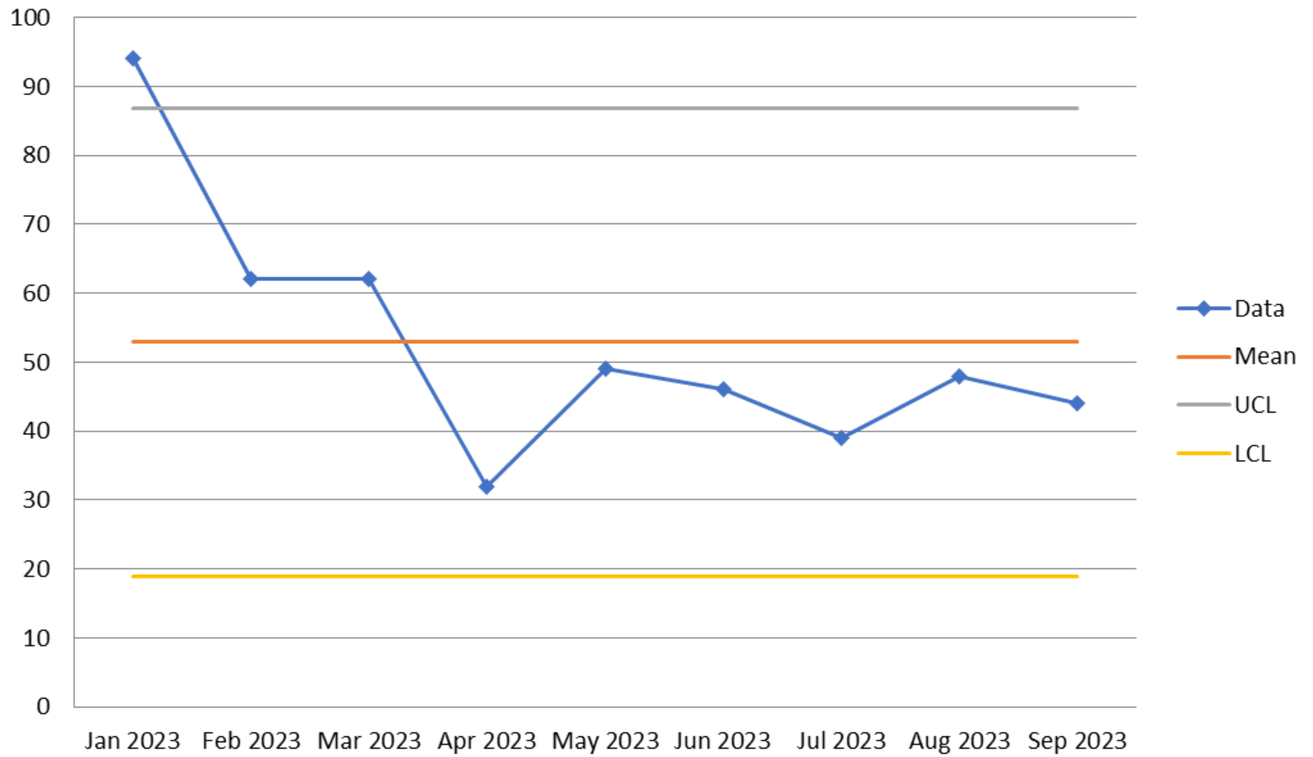
Since the last update to Board **989** deaths have been reported

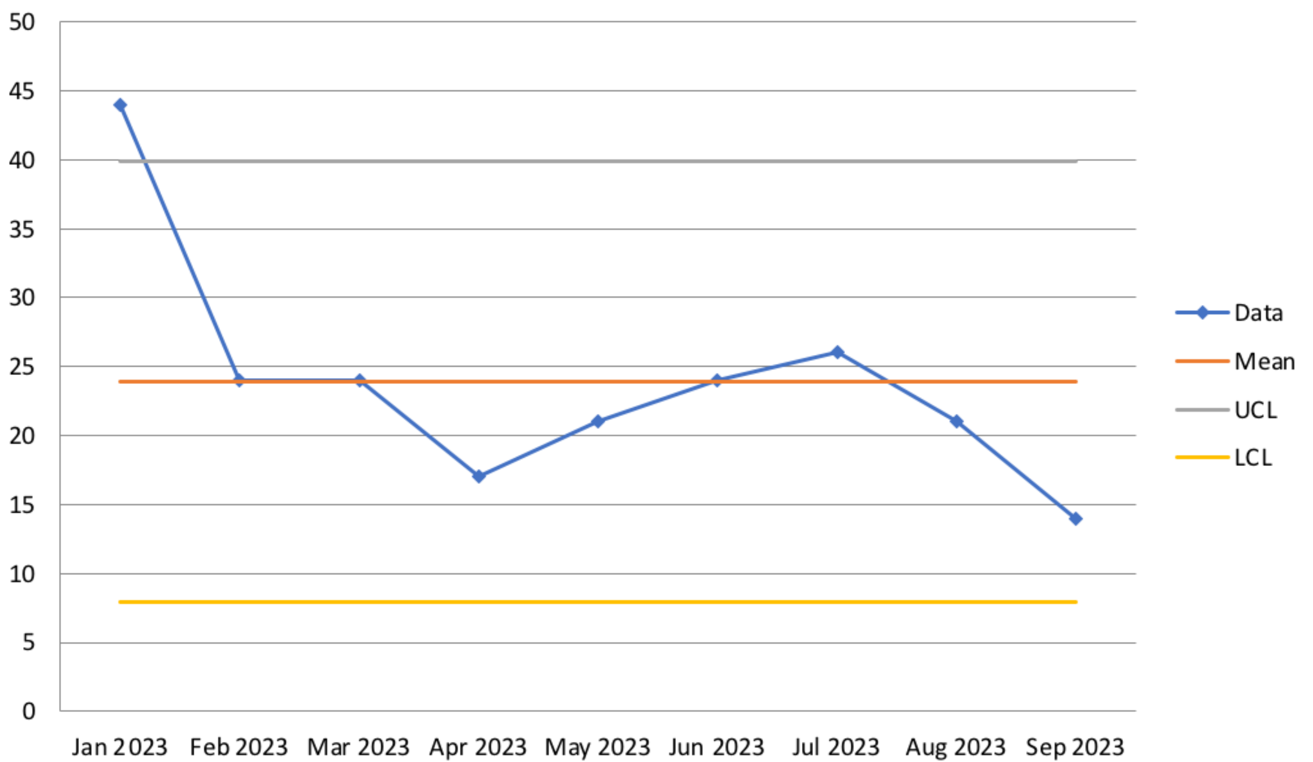
	2022-3 Q4	2023-4 Q1
Adult	568	414
Child	3	2
Stillbirth		2
Total	**571**	**418**

The new DCIQ (Datix) platform has successfully gone live for Bereavement Centre and Medical Examiner Office activities. This has enabled real-time reporting and creation of dashboards for Deaths, Coronial referrals (including type) and Structured Judgement Reviews. As these reports become established, we will be able to rapidly identify special cause variations in deaths or escalation using SPC charts without the many months' delay we see in our traditional mortality intelligence. Examples are included below.

Figure 2.2 Mortality trends







Of note, despite rising adjusted mortality indicators the number of deaths has been falling during the year.

Q1 Taken Over by Coroner - 63	
18x taken directly for Inquest-	8 x Industrial Related Disease 5 x Falls/Traumatic injury 2 x MHA/ LD 1 x Procedure 1 x Long standing Brain Injury 1 x Out of Hospital Cardiac Arrest
42 x cases taken for PM	9 x Occupational Related Disease 19 x Unclear COD/Out of hospital arrests 4 x Family Concerns 10 x Various – inc MH/LD/Recent Procedures
3 x cases for further investigation	1x LD 1x Family Concerns 1 x Occupation related

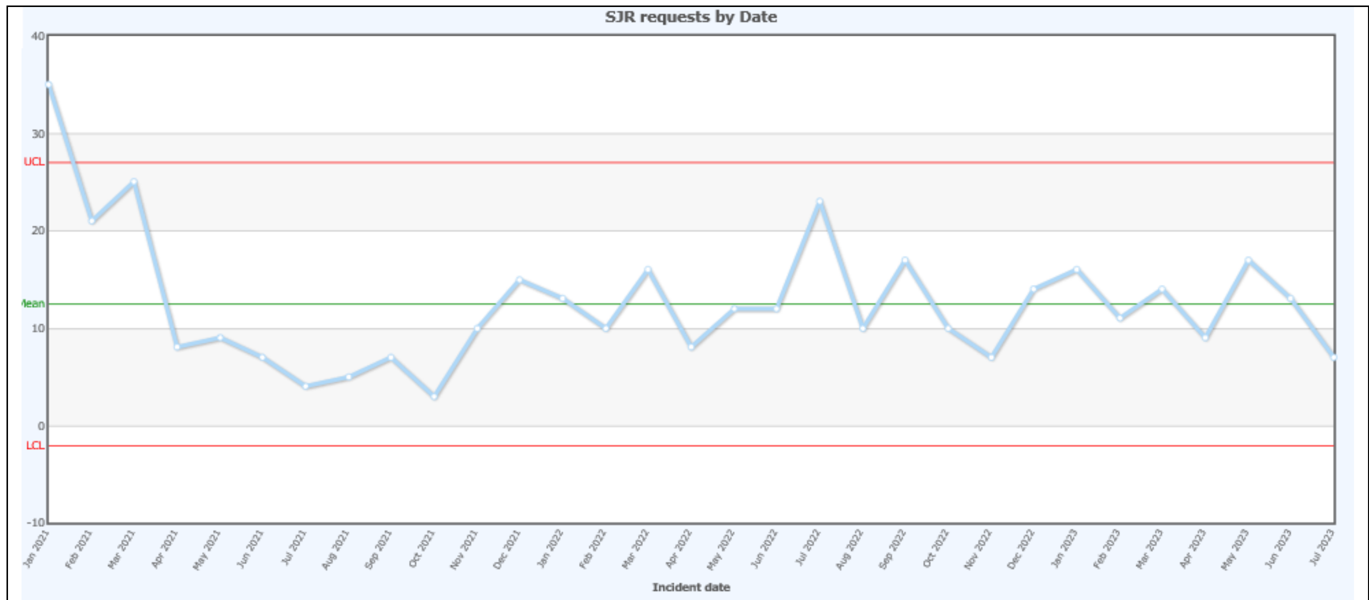
As our small cohort of medical examiners review all deaths, they are able to identify potentially outlying diagnosis groups (e.g. Primary PCI pathway patients which have been identified previously and which resulted in improvements to the pathway). We have not been made aware of any current concerns other than corroboration of known qualitative aspects of care such as End-of-life decision-making and communication which are identified elsewhere in this report. The Learning from Deaths group will seek to formalise the structure of reports from the Bereavement and Medical Examiner Teams in the next quarter to incorporate both quantitative and qualitative aspects.

2.3 Structured Judgement reviews

The ME team continue to assist learning from deaths by identifying cases for further review (including mandatory cases such as Learning Disabilities or patients detained under the Mental Health Act.) The average number of these cases being less than 10% of reported deaths. The system is working well and feedback from the lead ME is the responses appear qualitatively improved in general.

Feedback from Clinical Teams suggests that a number of reviews are requested to answer questions that do not require a full review, but information was not available within the timeframe given for the scrutiny process (5 days)- we anticipate improved senior involvement as outlined in 2.1 above will reduce theses requests.

Fig 2.3 Structured Judgement review requests at Q3 2022/23



2.4 Feedback from LeDeR reviews

Regionally aspiration pneumonia was the leading cause of death in this patient group. Autism, a recent addition to this category, remains poorly identified.

At SFH there have been 8 LeDeR deaths identified since the last update and we have received feedback from two cases which have had external review. There was no specific learning from the first case. The second case identified learning around communication of cause of death, discussion and documentation around ReSPECT and DNACPR (Do not attempt cardiopulmonary resuscitation). Also, from both, input from the family and review of the records. These have been communicated back to relevant clinical teams. Feedback around the timeliness and quality of some of the SJRs shows we still have room for improvement. We hope that time released by changes to other elements of the Mortality Review Process will help with this.

2.5 ReSPECT

We recognise that decisions and communication at the end of life are ongoing challenges in the Trust. Qualitative Audit of ReSPECT forms shows that processes are often started too late and the forms amount to little more than a de facto DNACPR. We have ongoing improvement workstreams and have identified this as an area that will benefit from a wide-ranging systems-based investigation and as such have identified it as one of our 5 PSIRF themes for the next year.

PSIRF launches formally in the Trust on 2/10/2023. Availability of a universally accessible “live” ReSPECT document remains a significant challenge. The solution is likely to be digital and is being addressed at ICB level. Easily- implementable coloured folders for respect forms to help location in the paper notes are being trialled as a temporary improvement.

3. Feedback and Learning Serious Incident Investigations and from Coroner.

We are required to report to the board an estimate of those deaths where a problem in care has contributed to a death. We believe that reviewing the cases subject to Serious Incident or Coronial

Investigation gives us the best insight into these rare cases.

We have received no new Regulation 28s (Prevention of Future Death orders) from HM Coroner. Some cases reported in the last 6 months are awaiting inquest or investigation and we will include in reports to Board as the outcomes become available.

11 deaths which met the Serious Incident Framework criteria were signed off in Q1 as detailed below.

April 2023

Medicine Division	5 Nosocomial Covid Deaths
U&EC Division	1 C. dif Death

May 2023

Medicine Division	1 Nosocomial Covid Deaths
	1 C. dif Death

June 2023

Medicine Division	2 Nosocomial Covid Deaths
CSTO Division	1 Missed posterior fossa stroke (investigation ongoing)

10 of these cases related to hospital acquired infection 8 of which were Covid. Thematic review of all our Nosocomial Covid Death cases was undertaken and showed the main theme identified was that the majority of patients had contact with a community positive case and all internal IPC precautions were adhered to. In response to changes in guidance from NHSE we were assured that no local learning would be missed in making a recommendation to stand down the full SI investigation process for Covid cases which was approved by Patient Safety committee.

4. Learning from Deaths meetings.

4.1 Attendance at meetings

The Learning from Deaths meetings continue to be well-attended and a venue for lively discussions which have stimulated Trust-wide actions as described in this report. Some changes in personnel, along with the updating of governance processes (which will be captured in a new version of the Learning from Deaths policy) has given us the opportunity to review our terms of reference. This will be in the context of discussions around an ICB-wide mortality surveillance and LFD programme. The Trust is represented at the Regional East Midlands Learning from Deaths Forum by Paula Arnold from the Governance Support Unit, who was recently appointed as Deputy Chair, and John Tansley who is the Co-chair of the Group.

5. Plans for Q1&2 2023/24

- Continue to develop sources of intelligence to complement the high-level metrics
- Communicate this information throughout the Trust to guide service improvement for our patients

• Review of Terms of Reference • Review Mortality Management (Learning from Deaths) policy • Complete migration of Mortality Review function onto DCIQ (Datix)