Board of Directors Meeting in Public - Cover Sheet

Subject:	Learning from Deaths Group update	**Date: 4th April 2024**
Prepared By:	John Tansley, Clinical Director for Patient Safety & Chair for Learning from Deaths Group	
Approved By:	David Selwyn, Medical Director	
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 the ongoing resultant work to both respond to and improve that intelligence and consequent learning.	**Approval**	
	Assurance	**x**
	Update	**x**
	Consider	

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	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	**X**
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 have previously been presented to Quality Committee and form part of the Trusts Quality Account submission.

Acronyms

- **SFH** Sherwood Forest Hospitals
- **HES** Hospital Episode Statistics
- **HSMR** Hospital Standardised Mortality Ratio
- **SHMI** Summary Hospital-Level Mortality Indicator
- **CuSUM** Cumulative Sum
- **ICB/S** Integrated Care Board/ System
- **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

Trust Board is asked to note that the Summary Hospital-Level Mortality Indicator (SHMI) which remains "as-expected" at 108.2, this had been rising but appears to have stabilised.

That the Hospital Standardised Mortality Ratio (HSMR), which remains "higher-than-expected" at 127.7 but is trending back towards "as expected".

Both of these measures are in a context of a continuing picture of excess deaths in the East Midlands and nationally.

The Learning from Deaths group has seen changes in measures which we believe represent contributary factors in the persistently raised HSMR and worsening SHMI which have been key areas of focus (documentation and coding). The introduction of new paperwork to support our educational efforts has taken place but any effect will not be reflected in the data period in this report.

A key clinical review into fractured neck of femur has reported along with a wider ranging review. The Specialty have proposed some robust actions which the Division are supporting.

A competitive tendering process for mortality and other clinical intelligence is in the early stages from which we aim to increase our understanding and deliver some financial savings.

We had hoped to be able to report that our Mortality Review Tool would be fully implemented in this report. This has been delayed by a number of factors. We have made progress in both human and infrastructure elements which is beginning to deliver new insights. Aligning these two elements will reduce the workload associated with these key governance activities.

Qualitative information suggests that the significant majority of care received by patients in our Trust is of appropriate quality. Two instances where care has fallen below the standard we want to deliver have been identified and we have received criticism following challenging inquests at the Coroner's Court. We acknowledge these problems and are well placed to respond to them. This report contains some analysis and reflections on our ongoing relationship with our local Coroner Services.

The Board is also asked to note our plans for the next year:

Complete tender and contracting process for provision of Mortality Intelligence

Complete migration of Mortality Review function onto DCIQ (Datix)

Review Mortality Management (Learning from Deaths) policy

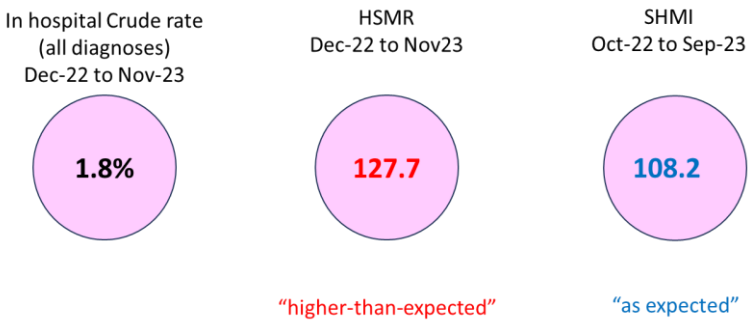
Develop relationships with other key stakeholders (e.g. HMC, ICB)

1 Mortality Surveillance Data

1.1 Mortality data

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

Fig 1.1 Crude and adjusted SFH mortality rates



HSMR (Hospital Standardised Mortality Ratio), SHMI (Summary Hospital-level Mortality Indicator)
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 Jan 2022 to Dec 2023, All Persons

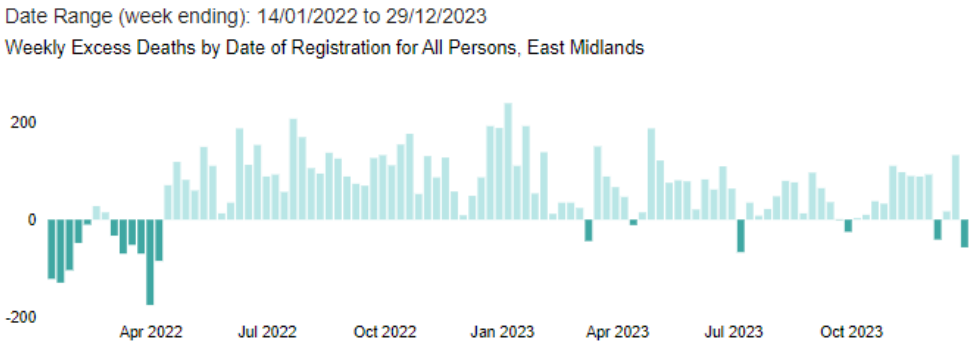


Fig 1.3 Total deaths East Midlands and England Jan 2022 to Dec 2023

Region	Registered deaths	Expected deaths	COVID-19 deaths	Excess deaths	Ratio: registered / expected
England	1,073,176	1,015,099	48,129	58,077	1.06
East Midlands	99,294	93,004	4,663	6,290	1.07

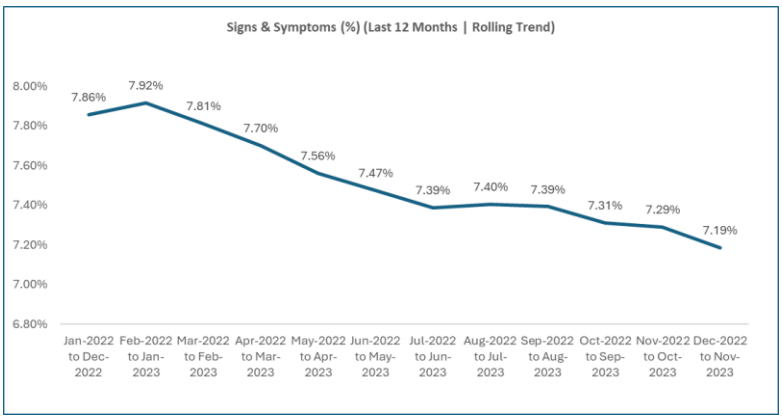
Source:
https://app.powerbi.com/view?r=eyJrIjoiOGNkMmY3NWMtMWM0MS00YTI1LWIyZTEtZjVhYTM0OTI3NmZiIiwidCI6ImVlNGUxNDk5LTRhMzUtNGIyZS1hZDQ3LTVmM2NmOWRlODY2NiIsImMiOjh9

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 triangulating outliers in HSMR, CuSUM and SHMI reports. One of our major challenges remains that we are a national (low) outlier for palliative care coding. Understanding the impact of this on HSMR (likely increase) and SHMI (likely neutral), remains. We are aware of national discussions from Telstra Healthcare around significant changes to their HSMR model including the removal of palliative care and methodological changes in the SHMI have also recently been announced. We will be interested to see how these changes influence our figures, if introduced, and whether this delivers any difference in our performance relative to peers and national benchmarks.

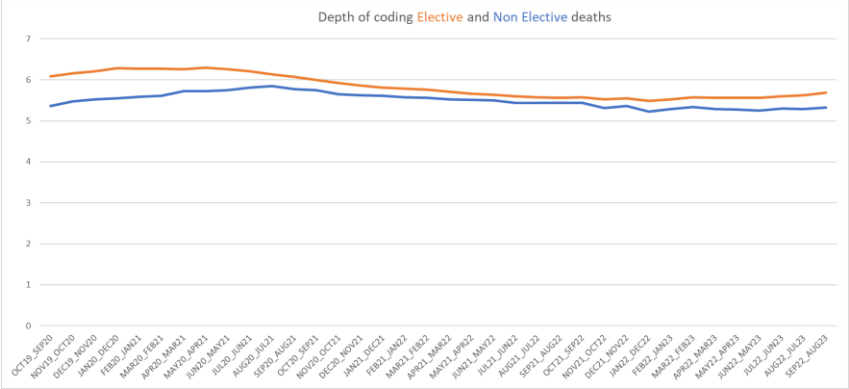
Our focuses of improvement have been process changes within coding and a wide-ranging educational approach, emphasising the importance of good medical documentation and coding. This includes discussions at medical Grand Rounds, meetings for governance leads, Medical Managers and Clinical Chairs. A marker of good documentation is the percentage of episodes which are coded as symptoms and signs rather than diagnoses (e.g. chest pain vs. angina)- lower is better.
Figure 1.4 shows a definite improvement in the form of trend downwards in this measure for HSMR data over the last year.

Fig 1.4 Percentage of Spells in Symptoms & Signs Chapter (Last 12 Months | Rolling Trend)



Looking at our SHMI data in Figure 1.5, the depth of coding (the mean number of additional codes above the acute diagnosis) which had been showing a decline appears to have plateaued for non-elective deaths and begun to reverse for elective deaths.

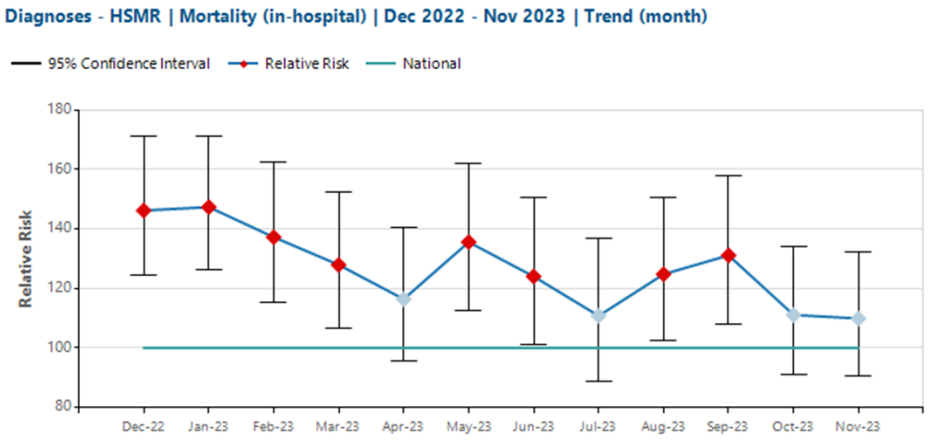
Fig 1.5 Depth of coding for Elective and Non-elective deaths (3-year trend)

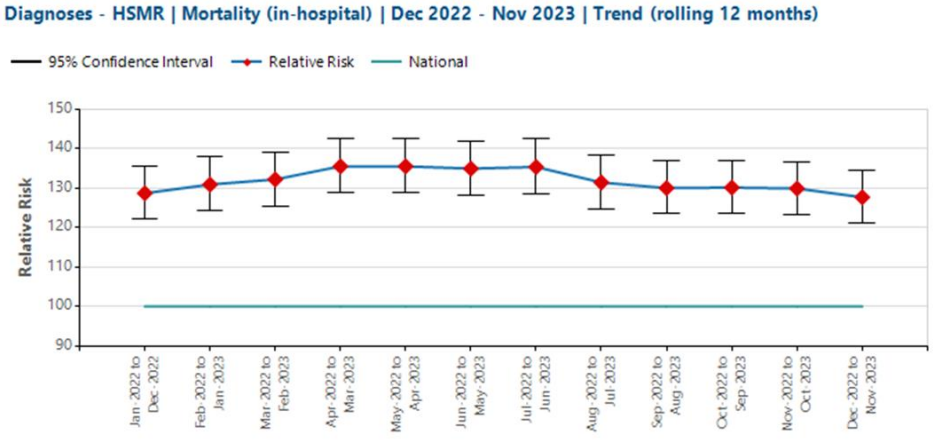


The new admission documentation was implemented in early November. Due to the analysis and reporting time lag any effects will not be seen in the current data but we will update in the next report.

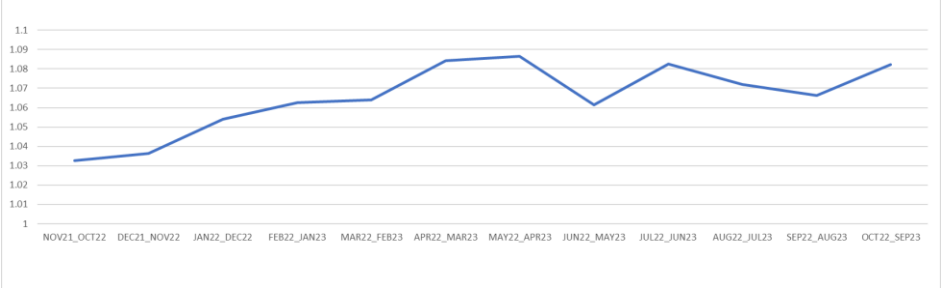
Over the same time periods Figure 1.6 shows an improvement in our in-month HSMR which is also reflected in the rolling 12-month trend for HSMR and the rising SHMI noted 6 months ago appears to have plateaued.

Fig 1.6 Annual Trends for HSMR (in-Month), HSMR (rolling 12-month) and SHMI (rolling 12-month)





Diagnoses- SMHI | Mortality |Oct 2022 – Sep 2023 |Trend (rolling 12 months)



1.2 Clinical review of outlying diagnosis groups and progress on actions

Palliative Care
Progress around system-level reconfiguring the local palliative care provision continues to be slow. 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.

Palliative care does not provide the whole explanation of our position against national benchmarks and we continue to look for signals for focussed clinical reviews using triangulation of signals from HSMR, SHMI and CuSUM alert. A small number of these reviews have taken place but of particular note:

Fractured neck of femur
An extensive clinical review of 1 year's cases reported in January. Of the 42 deaths in scope 1 was found not to be a fractured neck of femur and 10 of the remaining cases were managed non-operatively. Our relative mortality rates are therefore skewed by our lack of specialist palliative care provision but there are other underlying concerns. A wider review of all cases (not just deaths) was undertaken which revealed delays getting these patients to theatre. The Trauma and Orthopaedic specialty and have made robust proposals to address these concerns which are being overseen by Division.

1.2 External Mortality Intelligence Provider

A tendering process has begun with demonstrations from a range of providers and product specification is underway. As can be seen from data presented earlier in this report our high-level metric run significantly in arrears, an important factor in the new specification would be more timely availability of intelligence and better availability of information at divisional, specialty or even individual levels. At this stage we are looking to contract at Trust level and anticipate some financial savings over the next contract period.

1.3 Independent Validation

We believe we have a robust understanding of our high-level mortality metrics and the contributing factors influencing our position. We are actively seeking ways to externally validate these beliefs through colleagues in the ICS/ Region. This has yet to progress, but we will continue to explore options.

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

2.1 Mortality Review Tool

We have not been able to fully launch the new mortality tool as planned due to a number of factors including workforce pressure (recognising ongoing industrial action) and prioritising of our small Datix team to implementing the new Learning from Patient Safety Events (LFPSE) system which must be live by April 2024.
Pilots of Divisional dashboards have been created an example for the Medicine Division is shown in Figure 2.1.

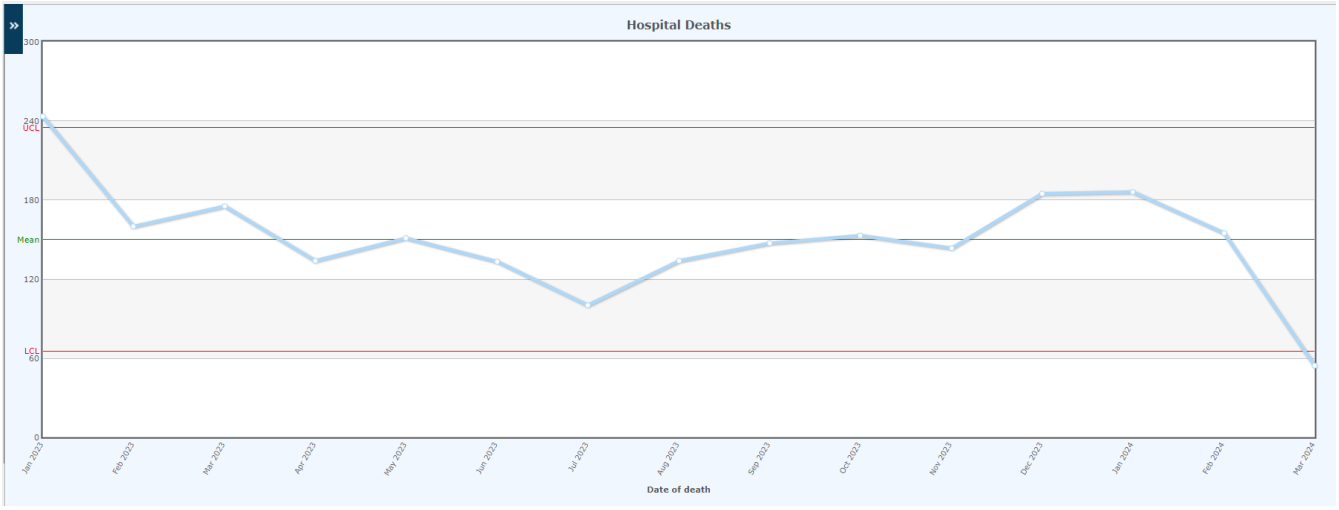
Fig 2.1 Suite of metrics for Medical Division

The human elements of the process are becoming embedded, we have welcomed some new clinical mortality leads to the group and we are optimistic that the digital platform will be in place during Q1 of 2024-5. Following this, the Trust's Mortality Management (Learning from Deaths) Policy will be updated to reflect these changes.

2.2 Data from Medical Examiner Service Office

Monthly mortality figures captured by the Medical Examiner service are shown in Figure 2.2. Since the last update to Board 948 deaths have been reported in Q2 and Q3 for which we have complete data. There have been no cases of special cause variation in the last 2 quarters. The service continues to scrutinise 100% of hospital cases.

Fig 2.2 Mortality trends- monthly hospital deaths 2023-4

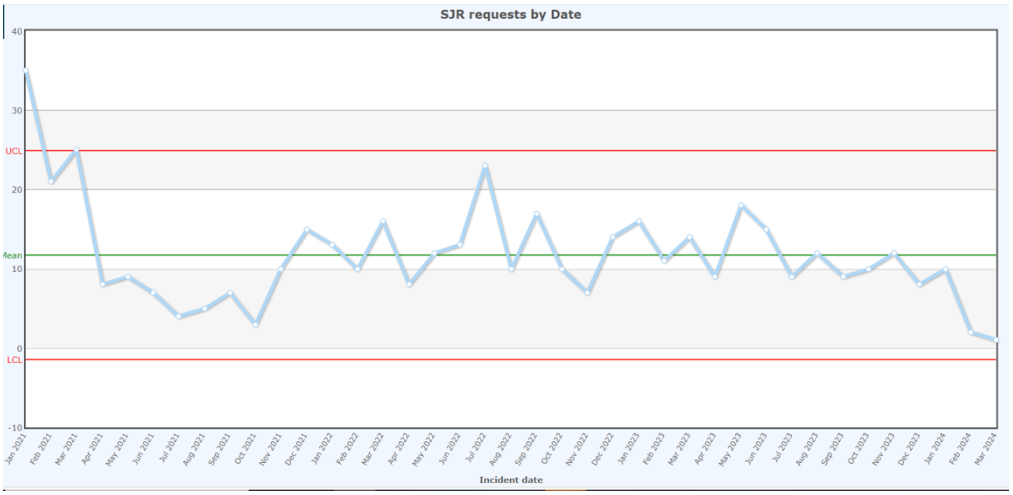


	2023-4 Q2	2023-4 Q3
Adult	372	471
Child	4	2
Total	376	473

2.3 Structured Judgement reviews

Further investigation following scrutiny of hospital deaths, using the Royal College of Physicians' Structured Judgement Review (SJR) Methodology remains stable as shown in Figure 2.3.

Fig 2.3 Structured Judgement review requests at Q4 2023/24



SJR was requested in 43 cases which includes mandatory cases such as Learning Disabilities or patient detained under the Mental Health Act. This is approximately 7% of deaths.

The number of deaths in each quarter for which a SJR has been raised is:

- 30 in Q3
- 13 in Q4 (at 13/3/24)

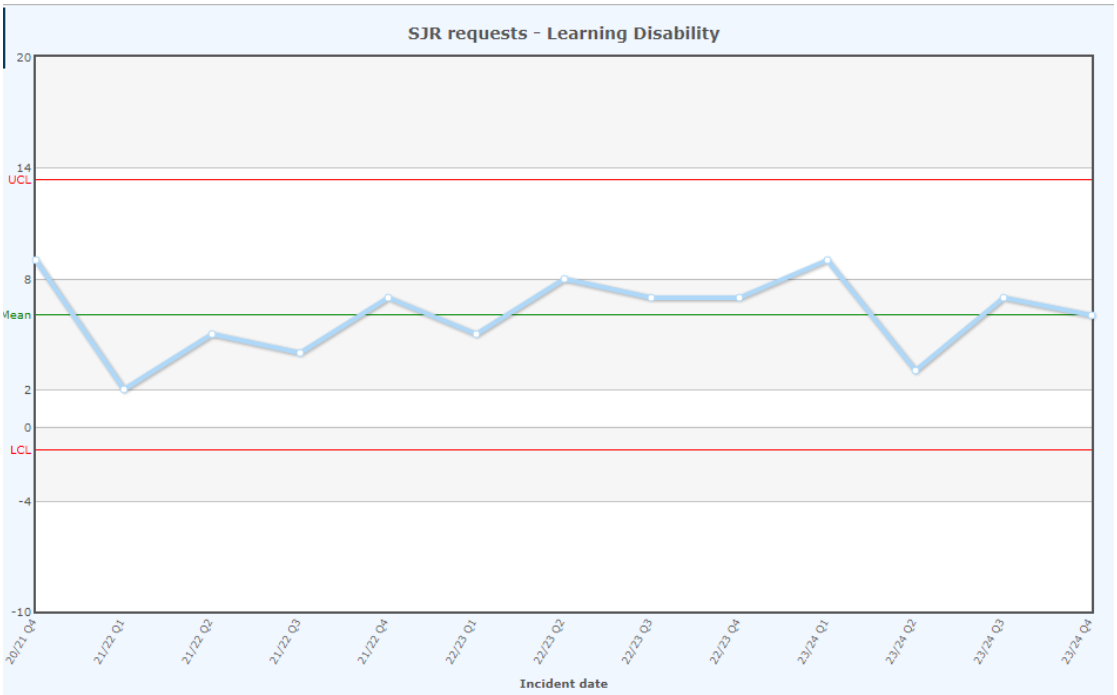
Clinical engagement in the SJR process has been good with both a reduction in the backlog in reviews and good qualitative feedback despite the challenges of clinical workload and industrial action. We hope this will be further facilitated by proposed migration of the full mortality review process onto the Datix system of which the Medical Examiner and Bereavement Centre components have been completed in the last year.

Following review, overall care was found to be generally acceptable or good. The small number of cases where poor care is identified by SJR are escalated through formal governance processes. These cases are then reviewed for further investigation under the Serious Incident Framework and more recently the Patient Safety Incident Response Framework (PSIRF) which went live in the Trust in October 2023. The Trust is currently working hard on the transition between these two frameworks. These cases are also typically subjected to coronial processes.

2.4 Feedback from LeDeR reviews

At SFH there have been 12 LeDeR deaths identified for review and reported to the group since the last update. The pattern of identification for the last 3 years is shown in Figure 2.4. Redacted reviews from the regional team are now being shared directly with us by email and we are working with them to identify learning specific to the Trust. No new specific issues have been identified. LeDeR are looking at ways to improve capacity to undertake the assessments and two band 6 nurses have been appointed on a full-time basis to complete the reviews. These posts have now commenced and the aim is to reduce the use of agency reviewers. The new reviewers now have access to GP records which should make the process easier and more efficient. The LD Nurse has been supporting the reviewers by providing additional information and inviting them to come in and review the paper records if required.

Fig. 2.4 SJR requests triggered by identification of Learning Disability



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. Two cases have reported in the last 6 months.

The First case was a child who attended ED with what was eventually identified to be group A streptococcus infection. The severity of her condition was not fully appreciated at the time, she went into cardiac arrest and died. The issues in this case were largely influenced by resources, with volume and complexity of patients overwhelming the available staff and leading to opportunities being missed.

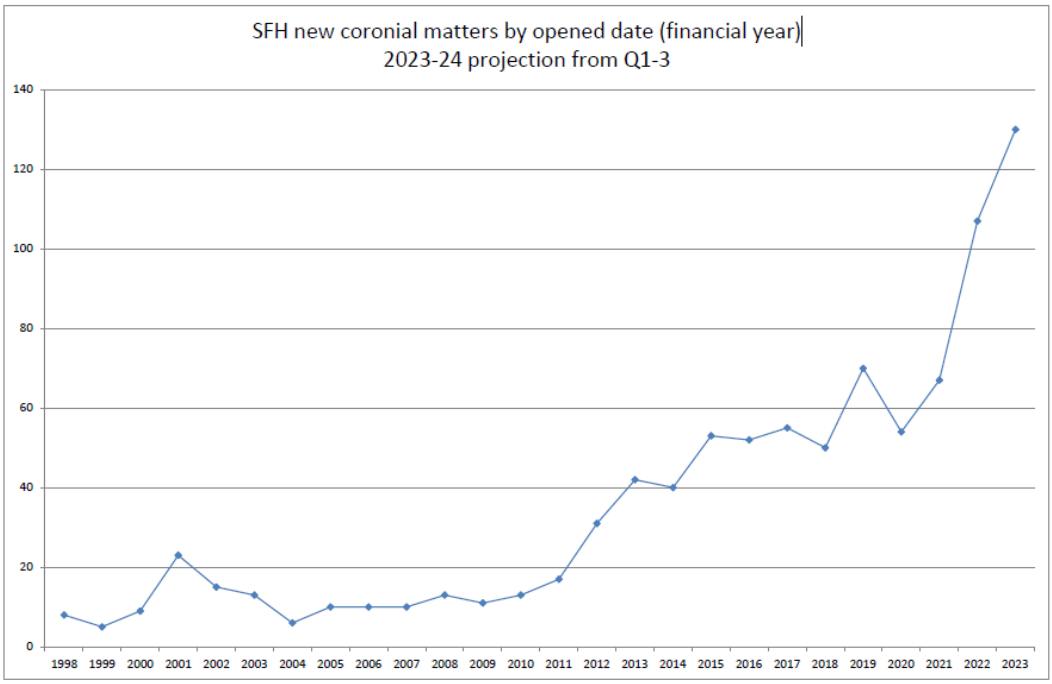
In this case, the coroner reached a narrative verdict and found that the acts/omissions of the Trust more than minimally contributed to the death. This was a finding we entirely expected and accept. Our own investigations have highlighted difficulties associated with variability in and useability of paediatric early warning scores and the Trust has taken the action of rationalising practice to a single scoring system PEWS. This action was completed before the inquest.

Following inquest into the second case the Trust received a Regulation 28 (Prevention of Future Deaths) order. Some of this was directed at our arrangements for managing Necrotising Fasciitis, a rare and difficult-to-diagnose condition but the case also highlighted weaknesses in our more generic processes, particularly in transferring patients between our Newark and King's Mill sites. The Trust was well on the way to implementing actions at the time of the inquest. The new approaches to incident response available under PSIRF were felt by the clinical teams to have facilitated better and more timely actions.

There has been a significant increase in the number of coronial cases over the last 15 years. The significant upward trend since 2018 has occurred over a similar timescale to our early roll out of the Medical Examiners System which will become mandatory from April 2024. Our current rate of notification is 34.4% for the last 12 months compared with the 36% most recently available national rate

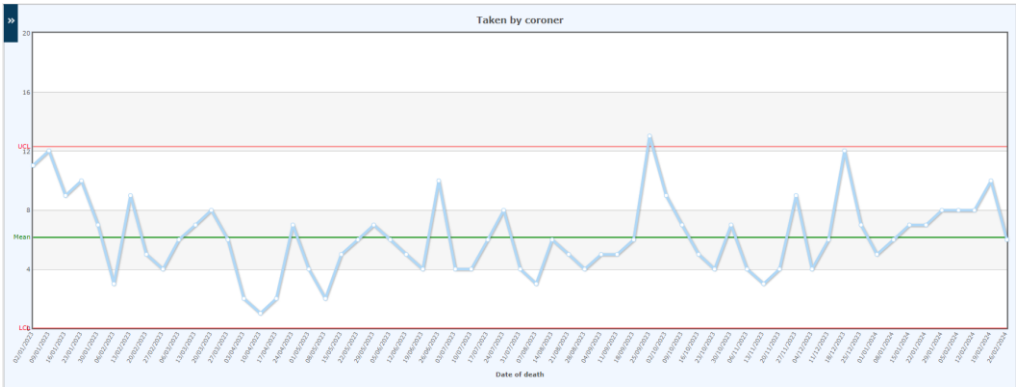
(Coroners statistics 2022: England and Wales - GOV.UK (www.gov.uk))

Fig 3.1 Long-term trend in coronial matters SFH



We are able to monitor variation in real time through the DCIQ platform as shown in Figure 3.2 Referral rates are fairly consistent but we are able to identify and investigate special cause variation. The peak in coronial matters opened in later September 2023 included 5 mining/ industrial/ notifiable (legionnaire's) diseases but no other obvious cluster of concern. The smaller peak in late December 2023 seems attributable to case mix. Occupational diseases are a frequent contibtor to our referrals as would be expected in our region.

Figure 3.2 New Coronial matters (weekly)



Preparation for inquests is time-consuming and the implementation of PSIRF may increase the gap between perspectives of our Trust and Coronial processes reducing the amount of evidence with will potentially serve both systems. This is something that affects all NHS Trusts in England but is nuanced by individual coronial relationships the Trust already engaging with our colleagues at NUH to discuss ways to mitigate any potential difficulties perceived by either side.This is not directly in the scope of the Learning from Deaths group but our role in triangulation of intelligence from many sources makes us a

key stakeholder.

The Trust has received some open court coronal criticism regarding preparation for a recent inquest (it was one of 5 in a single week). Attendance at inquests takes colleagues away from clinical duties which puts further pressure on an already stressed system. We are receiving feedback from colleagues and accounts of an increasingly adversarial approach during inquests. SFH is entirely committed to an open and transparent approach to providing and clarified case information and facts, including under direct questioning in coroner's court. However, we are becoming concerning regarding the impact and lasting effect that such experiences can have on our colleagues. We are also mindful of recent learned experiences from a variety of national regulators of the potential collateral impact which can occur. We plan to ask the ICB to guide us in how we sensitively provide this feedback.

The additional coronial workload has necessitated additional unfunded resource is provided as an urgent response.

4. Learning from Deaths meetings.

4.1 Attendance at meetings
Apart from one meeting which was stood down around industrial action the Learning from Deaths meetings continue to be well-attended and a venue for lively discussions which have informed Trust-wide actions as described in this report.

4.2 Learning from Deaths in a wider context
A consultation around Learning from Deaths at ICS level has taken place and we await the outputs of this which will also impact on regional learning from deaths which is currently not taking place during this consultation period. We have added a quarterly update from the ICS to our workplan and we are keen to incorporate intelligence from our local partners, especially as the scrutiny of all community deaths by the Medical Examiners embeds.

5. Plans for Q1&2 2023/24

- Complete tender and contracting process for provision of Mortality Intelligence
- Complete migration of Mortality Review function onto DCIQ (Datix)
- Review Mortality Management (Learning from Deaths) policy
- Develop relationships with other key stakeholders (e.g., HMC, ICB)