Yeovil Hospital Healthcare

NHS

Mortality Report
Learning from Deaths

Quarter 1 2018/2019

Introduction

In December 2016 the CQC report Learning, Candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England Identified that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. In March 2017 the National Quality Board published national guidance on Learning from deaths to initiate a standardised approach to learning from deaths which includes a number of recommendations to be included into Trust's governance frameworks.

These recommendations include having a Director responsible for the learning from deaths agenda, a non-executive director to take oversight of progress and implementing a systematic approach to identifying the deaths requiring review with a robust and effective methodology for case record reviews.

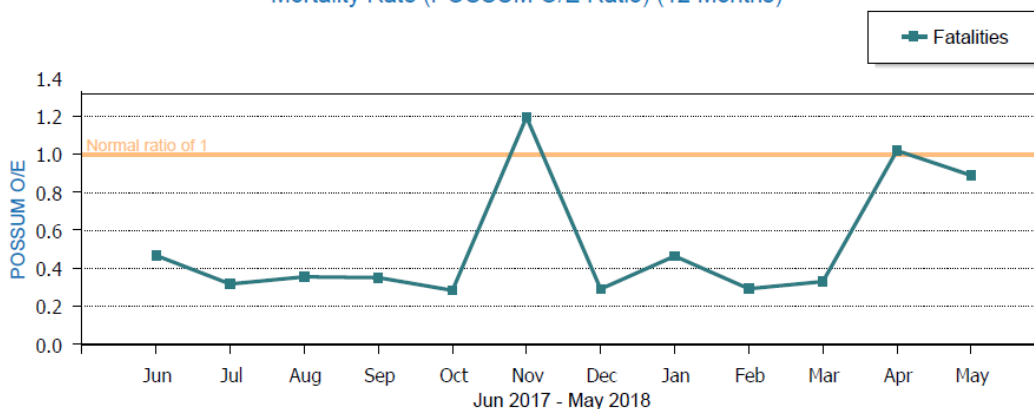
Mortality Rates

In hospital deaths per month

The number of deaths in hospital is captured through the Summary Hospital-level Mortality Indicator (SHMI). This reports mortality at trust level using a standard and transparent methodology which is published quarterly as a National Statistic by NHS Digital.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Our latest SHMI covering 12 months October 2016 to September 2017 is 0.9624

The Trust continues to use the Copelands Risk Adjusted Barometer (CRAB) to provide outcomes data. CRAB data defines the risk of mortality within certain groups of patients. The following table shows risk adjusted mortality data over the last year in patients who have undergone surgery. The normal mortality O/E (Observed number of adverse outcomes / predicted number of adverse outcomes) ratio is 1.00. The Trust has remained below this acceptable norm throughout the year. Drilling down into this data allows the Trust to identify any adverse outcomes and look at these in relation to volume of procedures performed.



The Clinical Outcomes Committee monitors outlier reports produced by CRAB and the Mortality Review group monitors speciality mortality reviews and undertakes a review of deaths with more than 4 triggers which have occurred in the Trust to identify opportunities for improvements in care.

It should be noted that the CRAB baseline data includes deaths within 30 days of discharge and is provided approximately six weeks after the patients' death. This means a percentage of these patients will have been reviewed as part of the routine mortality review process. Looking more closely at the greater than four trigger groups ensures that this cohort of high risk patients has been reviewed.

Mortality Outlier Alerts

The Trust HSMR is reported at 96.7 rolling year as at March 2018. A review of this position has been monitored and reported against on a monthly basis and a mortality action plan developed as a consequence. This action plan has been shared with Somerset CCG and NHSi for their information and assurance. A reduction in HSMR was set as a target and the Trust is on trajectory to achieve this. Ongoing actions include:

- Improved accuracy of clinical coding of patients being managed on a palliative care pathway
- Introduction of a countywide Somerset Treatment Escalation Plan to improve and inform clinical management of patients transferring between care settings

Actions continue to be monitored by the Clinical Outcomes Committee on an ongoing basis.

Learning from Deaths

The Structured Judgement Review tool from the Royal College of Physicians has been adopted throughout the Trust to ensure that formal mortality reviews are undertaken and that this data is available to inform improvements in care and reporting to the Board.

The Mortality Review Group continues to meet monthly to review those deaths flagged with four or more triggers to identify any concerns and to ensure learning for improvement. In addition, there has been in increase in the number of cases also reviewed via speciality Morbidity and Mortality meetings on a monthly basis. These cases are presented at the local Clinical Governance Meetings to share findings and inform improvements in care delivery.

The Mortality Review Group did not identify any deaths in the patient cohort with greater than 4 triggers where concerns were thought to have contributed to the outcome for those patients. It should be noted this data includes deaths within 30 days of discharge. Speciality based reviews have been formalised and it is anticipated that the Mortality Review Group's role will be one of monitoring and defining the final judgement from the mortality review data submitted at specialty level.

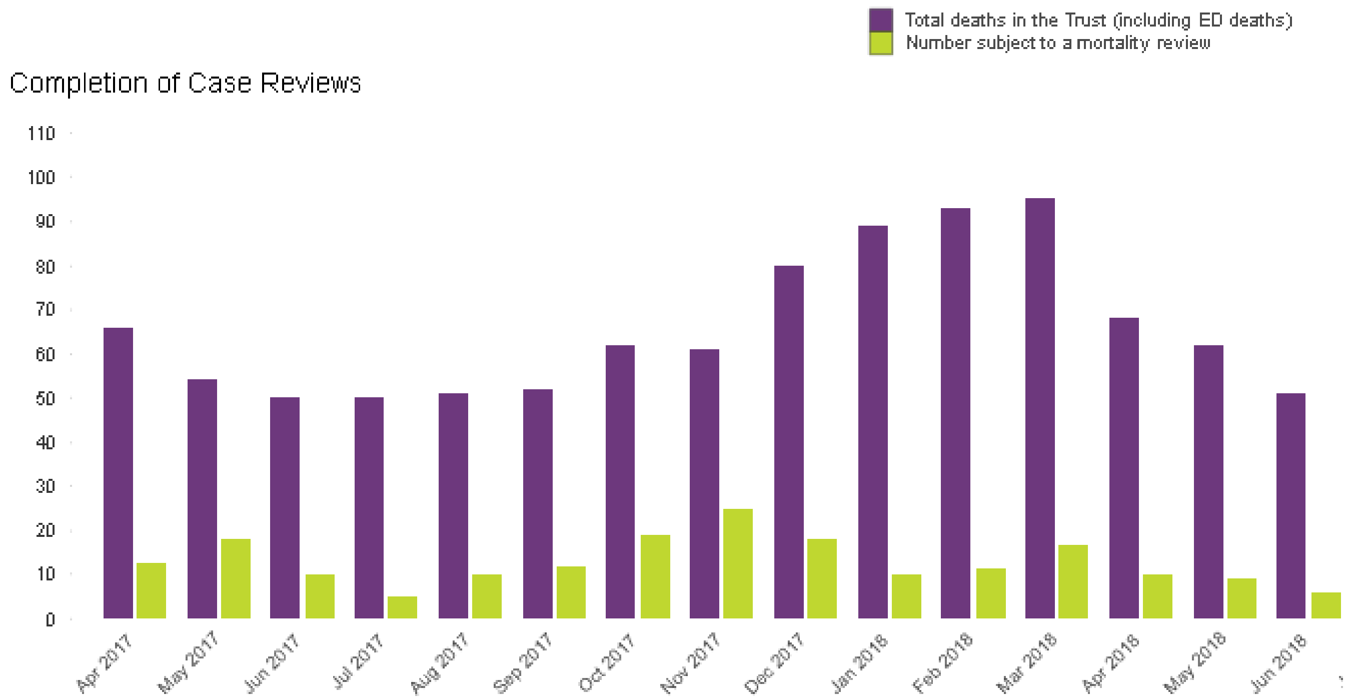
This table provides the number of deaths in month against the number reviewed and where concerns have been identified.

2017/18																2018/19			
	April	May	June	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	April	May	June	Q1 Total
Total deaths in the Trust (including ED deaths)	66	54	50	**170**	50	51	52	**153**	63	61	80	**204**	89	98	95	**282**	68	63	51	**182**
Number subject to a mortality review	9	17	6	**32**	5	7	11	**22**	19	29	7	**49**	10	11	20	**41**	11	10	8	**29**
Number investigated under the serious incident framework	1	1	2	**4**	2	1	1	**4**	1	0	0	**1**	0	0	0	**0**	1	0	0	**1**
Number of learning disability deaths	0	1	0	**1**	1	0	2	**3**	0	0	0	**0**	1	0	1	**2**	0	1	0	**1**
Number of bereavement concerns	--	--	--	**--**	0	1	1	**0**	0	4	2	**6**	2	0	3	**5**	3	3	2	**8**
Number thought more likely than not to be due to problems with care	0	1	0	**1**	1	1	1	**3**	4	2	1	**7**	1	1	0	**2**	1	0	0	**0**

Of the 39 deaths subject to a case review in Q1:

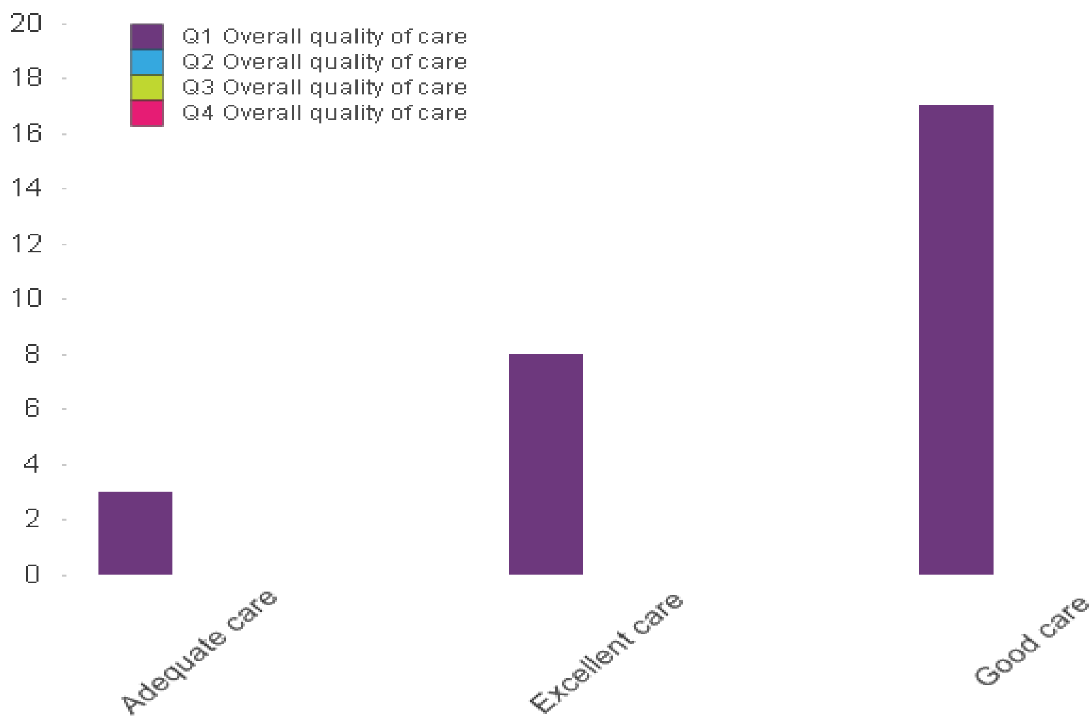
- 29 were subject to a SJR
- 1 will be subject to a LeDeR review
- 8 were reviewed where bereavement concerns were raised

This data is summarised in the following charts:

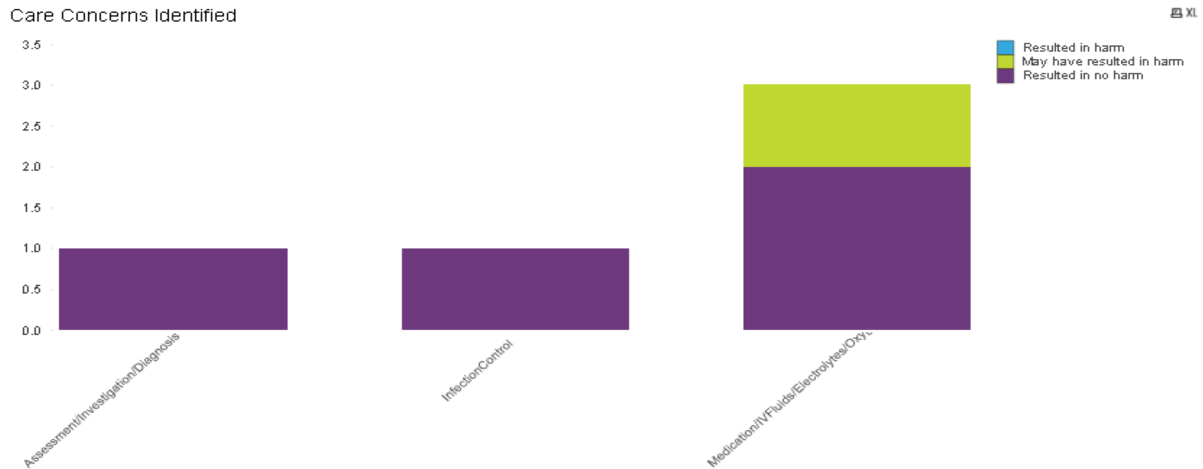


Overall Findings from case reviews completed

Quarter 1 2018/19- Quality Of Care – Based on the overall score for episode of care

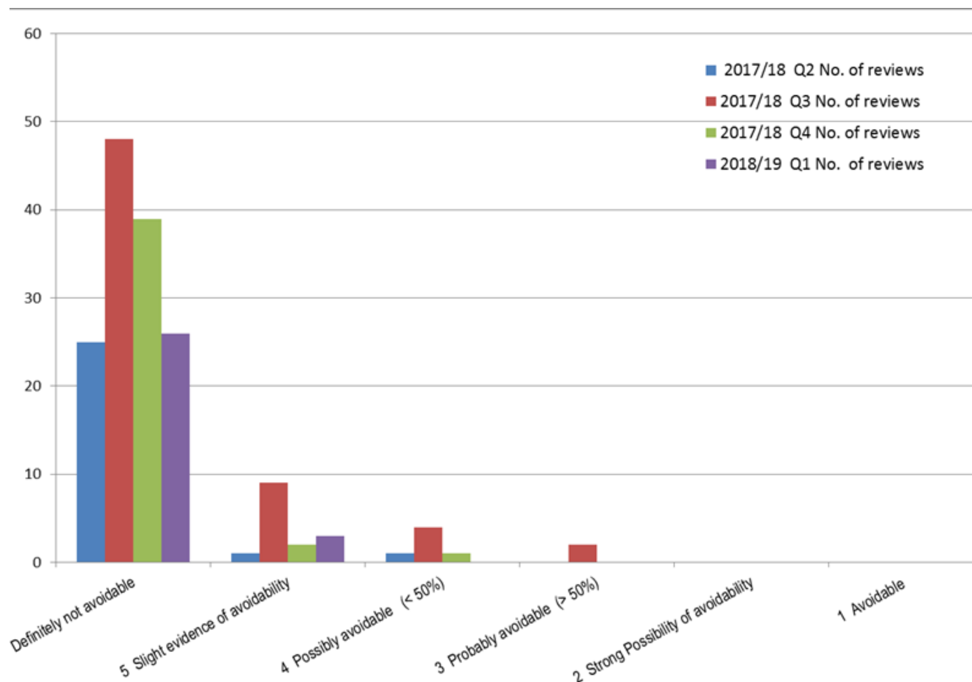


Quarter 1 2018/19 - Care Concerns Identified



Note - These are deaths that are subject to a mortality review only

Level of avoidability of death in each case reviewed - Rolling Year to date



<u>Structured Judgement Tool Avoidability Score</u>
1 – Definitely avoidable
2 - Strong possibility of avoidability
3 – Probably avoidable greater than 50%
4 - Possibly avoidable less than 50%
5 - Slight evidence of avoidability
6 - Definitely not avoidable

Themes from reviews and investigations

Of the deaths reviewed:

- No cases were identified where care concerns were considered to have directly contributed to a death.
- 3 cases were considered as having slight evidence of avoidability scoring 5 using the RCP definitions

Issues raised included:

- The need to improve care planning at the end of life was again highlighted
- Screening tools to identify early deterioration were not always implemented
- Quality of death certification has been questioned

Lessons Learned, Actions Taken

- The introduction of a countywide TEPDNAR has not yet had an impact due to the notes review period – A monthly audit is in place with results being monitored at the Recognition and Rescue Group
- Early escalation to the Critical Care Outreach Team, as well as junior doctors, when deterioration is first identified in a patient.
- Excellent quality of note keeping in many of the specialities
- Excellent use of the new Falls Assessment record which standardises the medical assessment and investigation of patients who have suffered an inpatient fall.
- Launch of a quality improvement project to improve hydration of patients across the Trust with the implementation of revised fluid balance charts, trial of an innovation drinking system and enhanced audit of fluid intake. The outcome of this work will be monitored by the Nutrition and Hydration group and reported via the Patient Experience and Engagement as well as Clinical Outcomes Committees.

Learning Disability Deaths

There was 1 deaths of patients with Learning Disabilities were reported in the quarter. Deaths are reported in line with national requirements and reviewed in the first instance for any immediate actions. The Trust is fully compliant with the LeDer Programme and will report such cases to the Commissioners for appropriate review and investigation. To date, no deaths have been identified as a consequence of concerns about hospital care.

Neonatal and Maternal Deaths

There were no maternal deaths reported in the quarter. Neonatal deaths are reviewed using the Perinatal Mortality Review Tool in line with national requirements. There was one death in the quarter.

Working with Families

The Trust is reviewing the publication of national guidance to support its' work with Bereaved Families. Bereavement support includes capturing concerns at the time a death is reported, issuing information to support those dealing with a death in the family and signposting the bereaved to ongoing bereavement support. Trust policies and procedures are in line with current national standards.