Mortality Report
Learning from Deaths

Quarter 3 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.

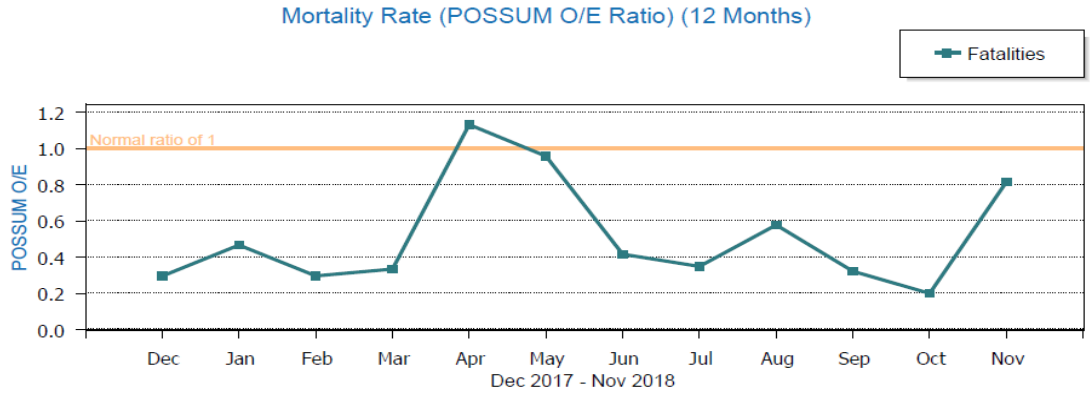
Mortality Rates

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 July 2017 to June 2018 is 0.9753. A review of data submissions which inform the SHMI will form a local indicator for the Quality Account for the current year.

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 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 for surgical patients 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.

Risk Adjusted Mortality



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 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.

Hospital Standardised Mortality Ratio (HSMR)

The Trust has recently procured Dr Foster to support analytical review of outcomes data. This includes reporting of the Hospital Standardised Mortality Ratio (HSMR), which is used in a basket of indicators to inform understanding of quality and improvements in clinical care. The Trust HSMR is reported at 91.5, rolling year as at September 2018, which is in the expected range against national benchmarks. A review of the previous position, and the resultant action plan has been shared with the CCH and NHSi. This will continue to be monitored and reported on a monthly basis.

The latest report from Dr Foster highlights an improved position in relation to palliative care coding and reports us as one of 10 trusts in the regional acute peer group with an HSMR in the expected range. The Dr Foster report also shows that we continue to maintain a high level of reporting of significant comorbidities.

There are no new Cusum alerts and a the quarter 2 report identifying 4 areas of increased relative risk have been subject to a table top audit with a drill down within each identified risk diagnosis. The four groups were deaths associated with oesophageal disorders, nutritional deficiencies, hypertension with complications and cancer of the female genital organs. The numbers of patients involved were small and no clinical issues identified. The latest Dr Foster data shows that these categories with a high relative risk have resolved with the exception of the diagnosis group, cancer of the female genital organs. This risk relates to 2 patients only and will continue to be monitored.

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 newly published toolkit has valuable information which will enhance the existing process for future mortality reviews.

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 has not identified 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 have increased in number. It is anticipated that the Mortality Review Group's role will continue to evolve into one of monitoring and defining the final judgement from the mortality review data submitted at specialty level.

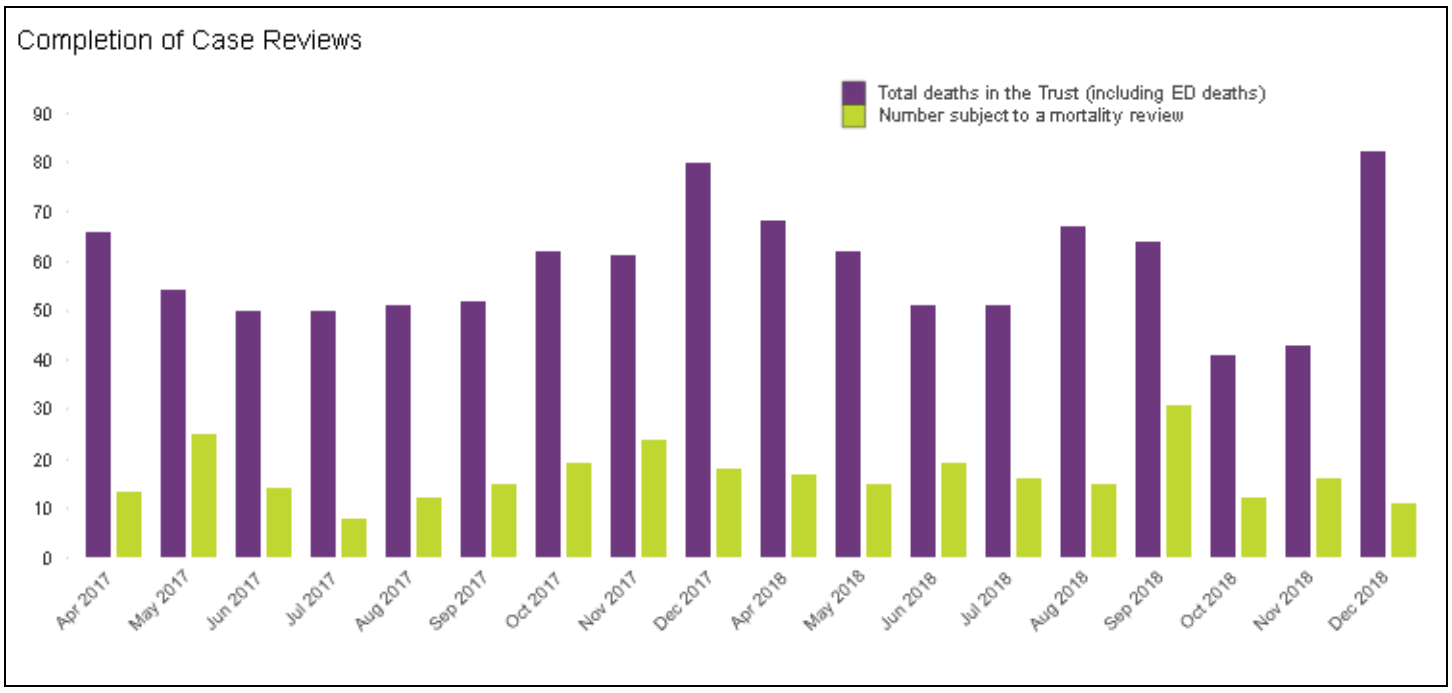
This table provides the number of deaths in month against the number reviewed and where concerns have been identified. Please note there is a delay in accurate reporting of in-quarter reviews due to the time frames of external surveillance data (CRAB and Dr Foster). This table will be updated quarterly.

2017/18													2018/19										
	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	April	May	June	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total
Total deaths in the Trust (including ED deaths)	50	51	52	**153**	62	61	80	**203**	89	94	95	**278**	68	63	51	**182**	51	67	64	**182**	41	43	82	**166**
Number subject to a mortality review	8	12	15	**35**	19	24	18	**61**	11	12	20	**43**	17	15	19	**51**	16	13	31	**60**	12	16	11	**39**
Number investigated under the serious incident framework	2	1	1	**4**	1	0	0	**1**	0	0	0	**0**	1	0	0	**1**	2	2	0	**4**	0	0	1	**1**
Number of learning disability deaths	1	0	2	**3**	0	0	0	**0**	1	0	1	**2**	0	1	0	**1**	0	0	0	**0**	1	0	0	**1**
Number of bereavement concerns	0	1	1	**0**	0	4	2	**6**	2	0	3	**5**	3	3	2	**8**	2	0	0	**2**	1	2	0	**3**
Number thought more likely than not to be due to problems with care	1	1	1	**3**	4	2	1	**7**	1	1	0	**2**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**

Of the 44 deaths subject to a case review so far in Q3:

- 39 were subject to a SJR
- One case has been referred for a LeDeR review (ED death)
- 3 were reviewed where bereavement concerns were raised

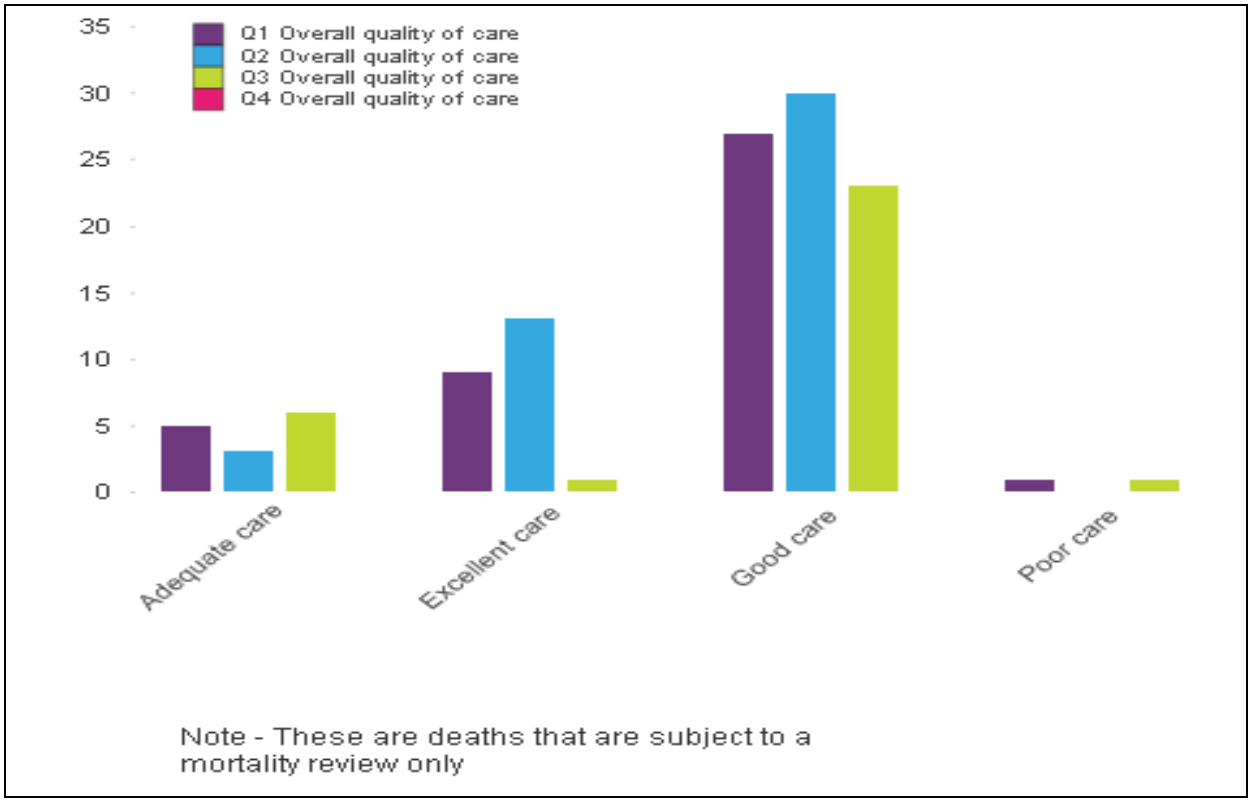
This data is summarised in the following charts:



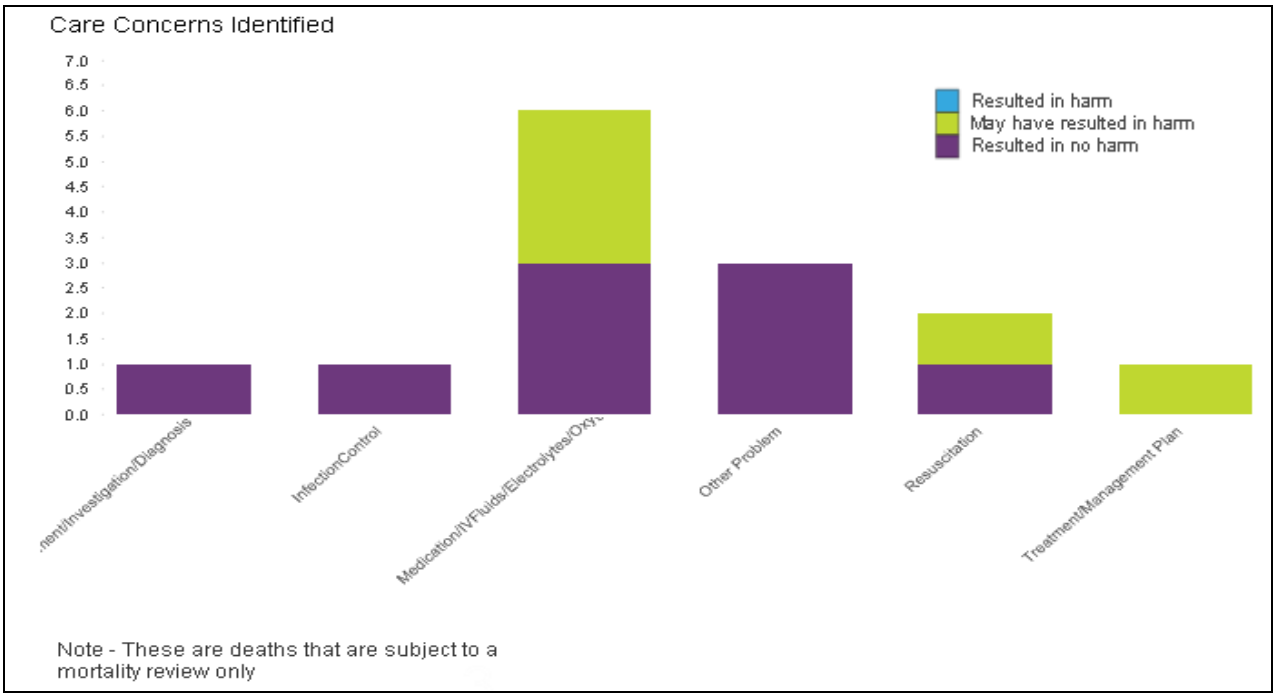
It should be noted that these figures relate to case reviews performed using the Structured Judgement Tool and does not include all reviews undertaken within the Trust.

Overall Findings from case reviews completed

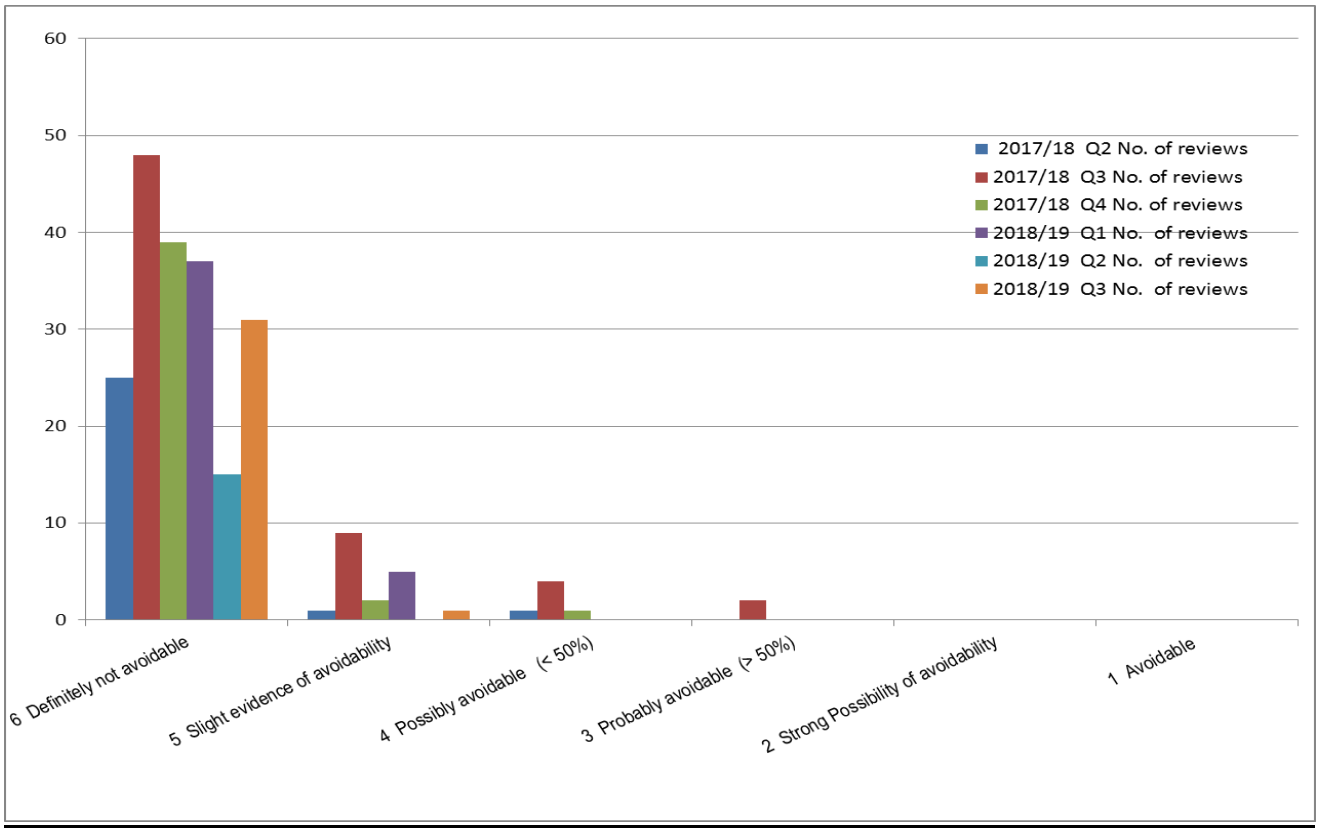
Quarter 3 2018/19- Quality of Care – Based on the overall score for episode of care



Rolling Year 2018/19 - Care Concerns Identified



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



Structured Judgement Tool Avoidability Score

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 so far in the quarter:

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

Issues positive and negative included:

- An improvement was noted in identifying and referral for advise in respect of end of life care
- Standard of documentation and assessment commended in some cases
- There has been an increase in the number of case reviews undertaken in particular by medical specialties and the data set now includes reviews of patients who died in the ED

Lessons Learned, Actions Taken

- An investigation for a coroner's inquest highlighted the need to identify and escalate any clinical changes in patient status and/or investigations undertaken between their pre-assessment appointment and admission for surgery. The Perioperative documentation has been reviewed and now includes specific questions about investigations and a section to record escalation prior to surgery taking place.

Learning Disability Deaths

There was one death of patients with a Learning Disability reported in the quarter. This occurred in the ED – Patient from nursing home attended TEP and DNAR with possible sepsis assumed to be from existing pressure sores despite. 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 or neonatal deaths reported in the quarter. All neonatal deaths are reviewed using the Perinatal Mortality Review Tool in line with national requirements.

Working with Families

The Trust reviewed the publication of national guidance to support its' work with Bereaved Families and agreed a number of actions. 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. The End of Life Steering Group, launched a Family Liaison Service in November 2018 and the positive outcomes from this extended service will be monitored.