Mortality Report
Learning from Deaths

Quarter 2 2017

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

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

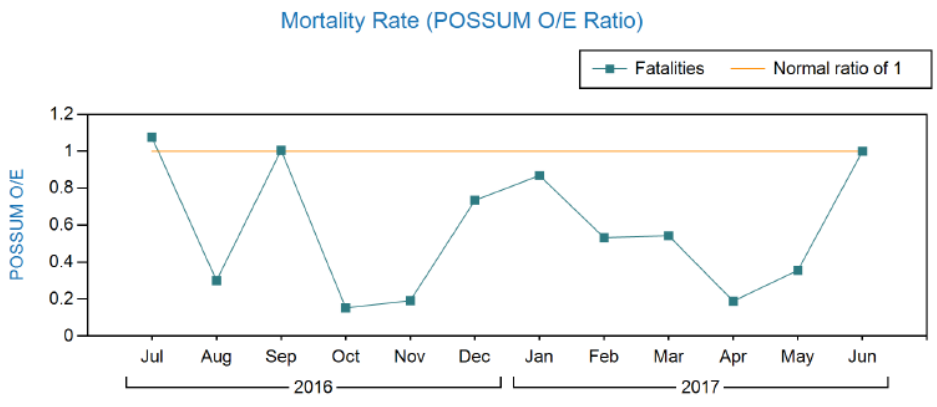
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Our latest SHMI covering 12 months October 2015 to December 2016 is **1.0060**, the next data release was scheduled for September 2017 but this data is not yet available.

CRAB data also 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.

Risk Adjusted Mortality



The Trust has changed its external mortality alert system and now uses the Copelands Risk Adjusted Barometer (CRAB) to provide outcomes data. The Clinical Outcomes Committee monitors outlier reports produced by CRAB and is gaining experience in analysing consultant and specialty level data. The mortality data provided by CRAB also informs the regular mortality and morbidity process.

Mortality Review

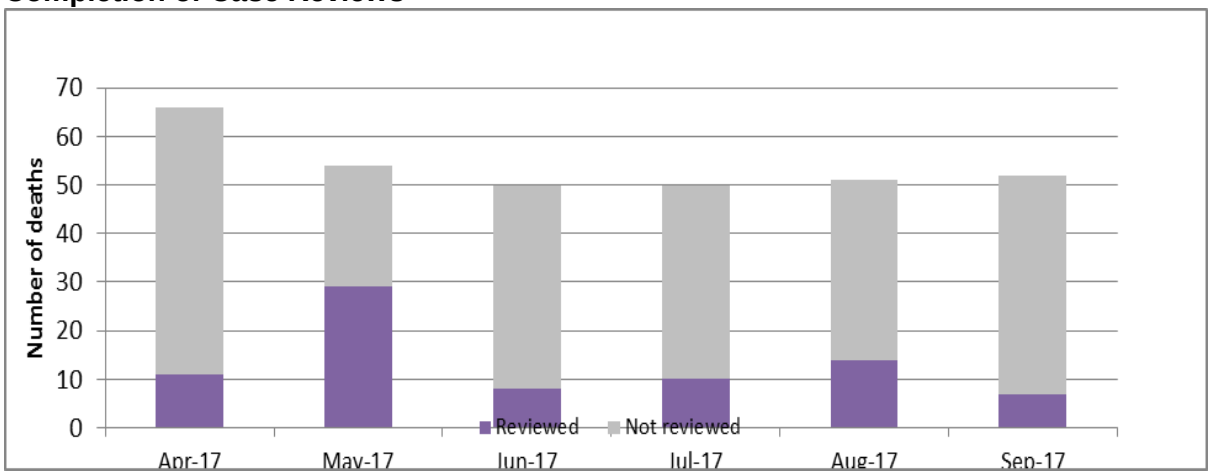
The Trust has changed its external mortality alert system and now uses the Copelands Risk Adjusted Barometer (CRAB) to provide outcomes data. The Clinical Outcomes Committee monitors outlier reports produced by CRAB and the newly formed Mortality Review group monitors speciality mortality reviews and undertakes a review of all deaths with more than 4 triggers. The Structured Judgement Review (SJR) tool from the Royal College of Surgeons has now been adopted throughout the Trust to standardise this process.

2017/18	April	May	June	Q1 Total	Jul	Aug	Sept	Q2 Total
Number of deaths in the Trust (including ED deaths)	66	54	50	**170**	50	51	52	**153**
Total number of deaths subject to a case review	6	21	6	**33**	10	14	7	**31**
Total number of deaths investigated under the serious incident framework	1	1	2	**4**	2	1	1	**4**
Number of deaths thought more likely than not to be due to problems with care	0	1	0	**1**	1	1	1	**3**

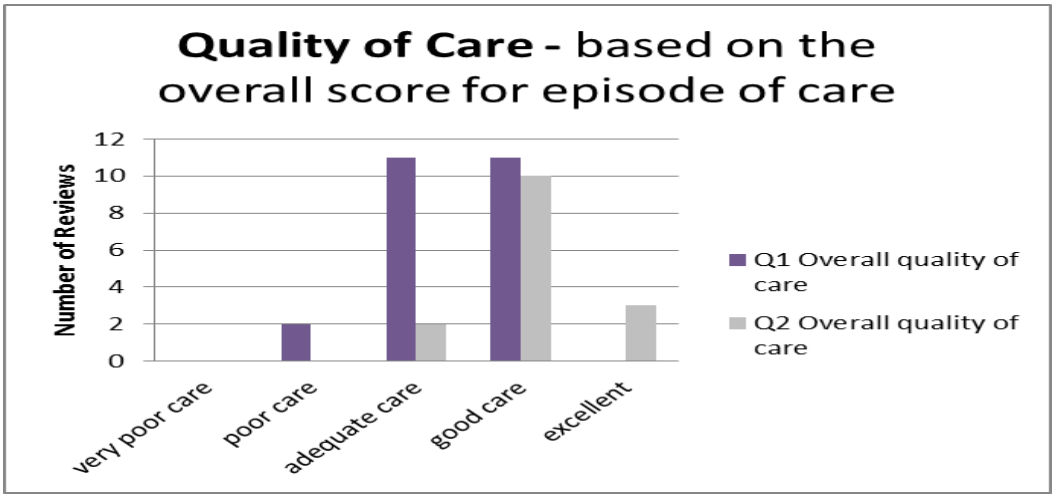
Of the 31 deaths subject to a case review:

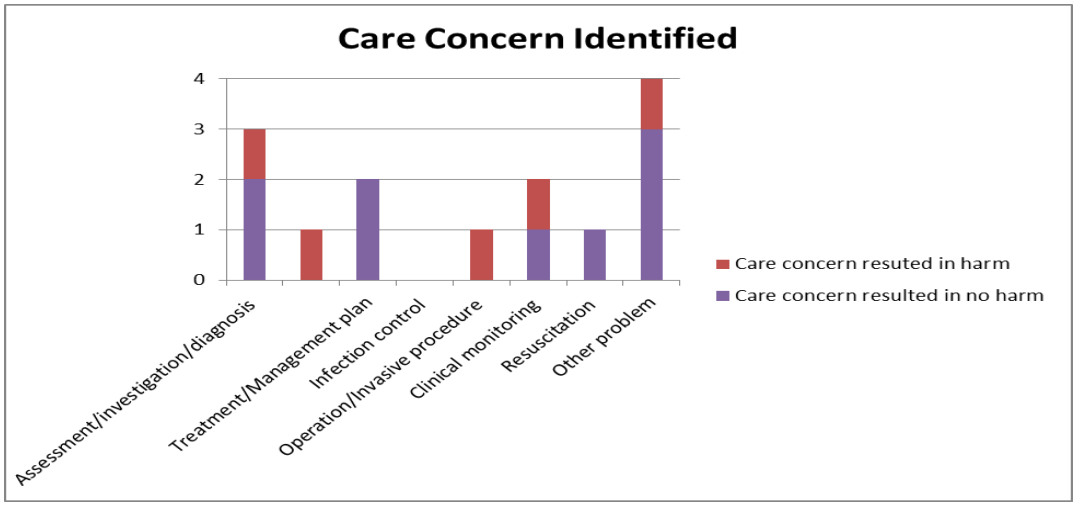
- 18 were subject to a SJR
- 4 were investigated under the serious incident framework (level 2 investigation)
- 9 were reviewed as a bereavement concern was raised

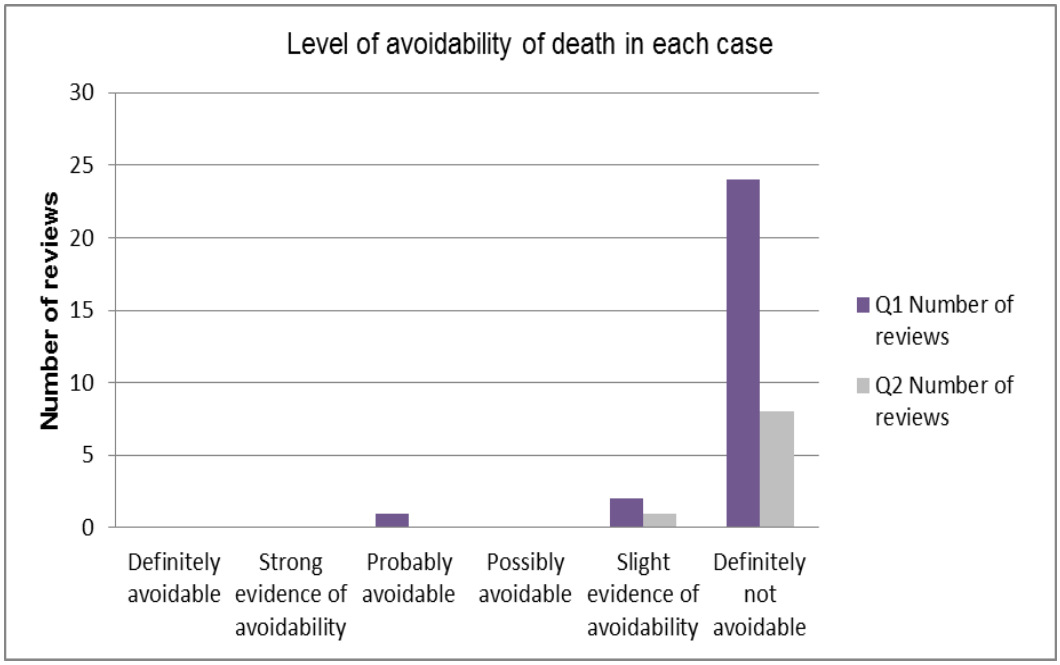
Completion of Case Reviews



Overall findings of SJRs







Themes from reviews and investigations

Of the 18 deaths with a SJR completed:

- 1 case was probably avoidable
- 2 cases were considered as having slight evidence of avoid ability
- Treatment/Management Plan and Clinical Monitoring were flagged as areas for improvement

2 reviews were undertaken in response to concerns from Bereaved Relatives.

The findings demonstrated a lack of consistent communication with relatives and a lack of continuity of care for patients.

Lessons Learned, Actions Taken

- Early discussion with patients and their families on treatment escalation and resuscitation status - case discussed at Medical Governance Meeting to inform decision making
- Recognition of pancytopenia and presenting complaints to ensure timely diagnosis and treatment – case shared with clinical team and feedback provided
- Early catheterisation and accurate fluid balance monitoring in patients with Acute Kidney Injury – reinforce implementation of AKI Care bundle to ensure timely intervention and appropriate management
- The wards have introduced observations before each transfer and before discharge to community hospitals to ensure patients are safe to transfer.
- Discussions with families will take place and be documented to ensure all staff are aware of discharge plans and can communicate this to relatives
- Feedback has been provided to the Trust's MDT, ward staff and other relevant staff.