Mortality Report
Learning from Deaths

Quarter 3 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

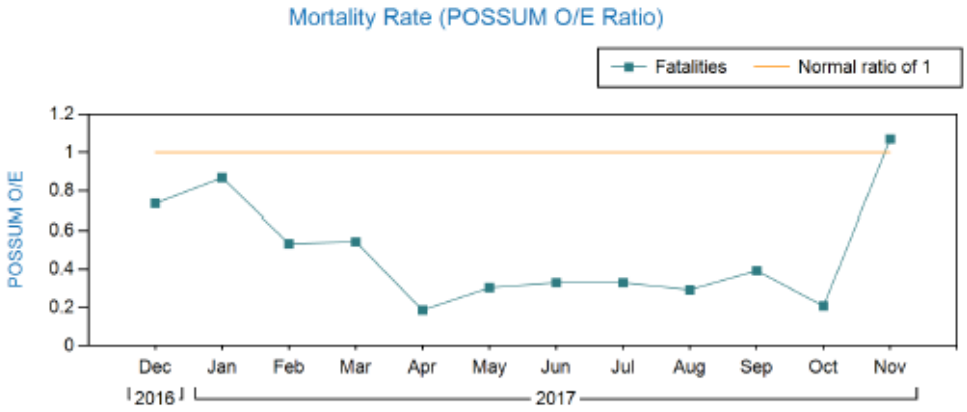
In hospital deaths per month

The number of deaths in hospital is captured through the Summary Hospital-level Mortality Indicator (SHMI). This 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 June 2016 to July 2017 is 0.9764.

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.

Risk Adjusted Mortality



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 Clinical Outcomes Committee monitors outlier reports produced by CRAB and the Mortality Review group monitors speciality mortality reviews and undertakes to review all deaths with more than 4 triggers which have occurred in the Trust.

It should be noted 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 114.0. A number of actions have been taken to provide assurance of the safety and quality of care and to make improvements accordingly. Actions include:

- Improved accuracy of clinical coding of patients being managed on a palliative care pathway
- Audit of patients with a primary diagnosis of urinary tract infection who have died
- Audit of patients with a primary diagnosis of anaemia and haemorrhage
- Introduction of a combined TEPDNAR document for all emergency admissions to improve and inform clinical management plans
- Increased focus on early conversations with patients and/or their families about wishes and ceilings of treatment if thought to be in the last year of life
- Improved recording and coding of Acute Kidney Injury in patients failing to respond to primary care treatment by the GP for urinary tract infections

An action plan has been drafted to ensure appropriate oversight and to provide assurance of the improvements planned and consequent impact. This will be monitored by the Clinical Outcomes Committee on an ongoing basis.

No care concerns were identified that were thought to contribute to patient deaths and a copy of the audit results have been shared with NHSi and CQC accordingly.

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.

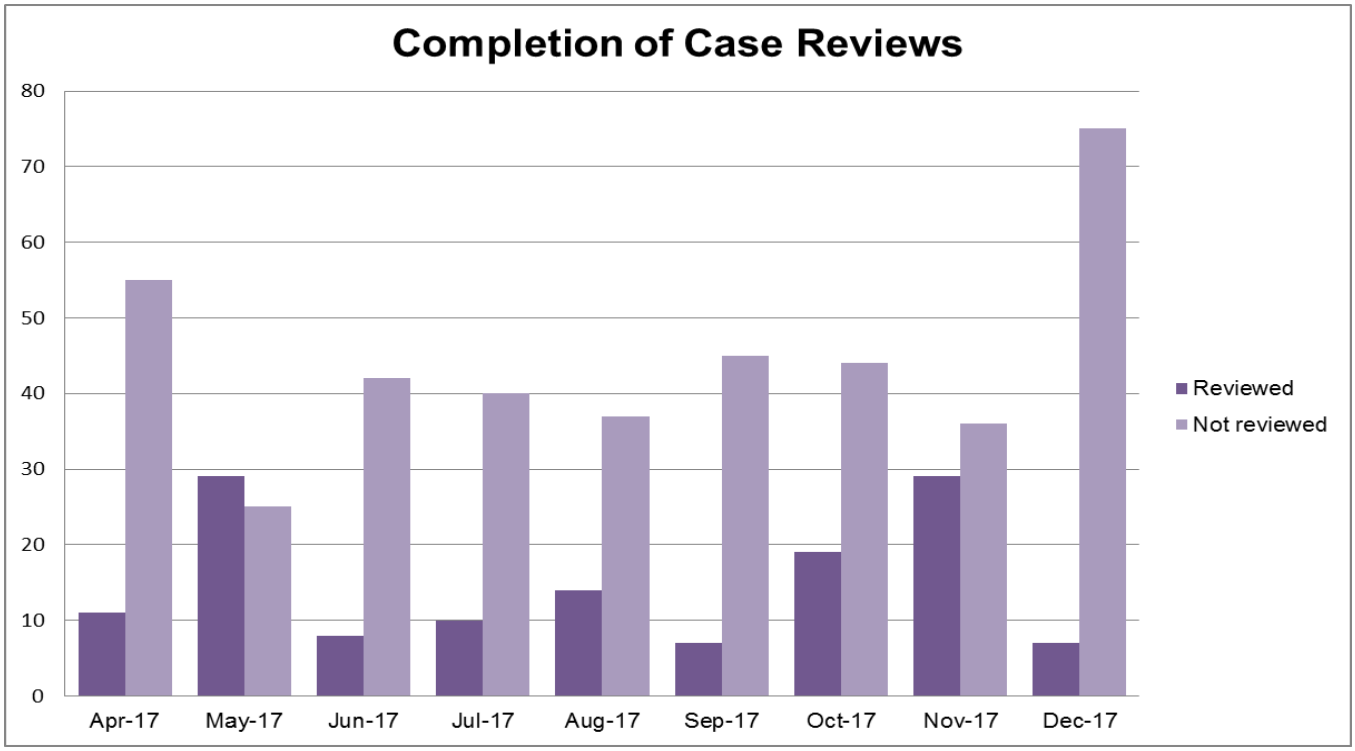
The Mortality Review Group did not identify any deaths in the patient cohort with greater than 4 triggers where concerns were thought to have contributed to the outcome for those patients. It should be noted this data includes deaths within 30 days of discharge. Speciality based reviews have been formalised 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.

The table provides the number of deaths in month against the number reviewed and where concerns have been identified. 27.5% of deaths were reviewed in Quarter 3 as follows:

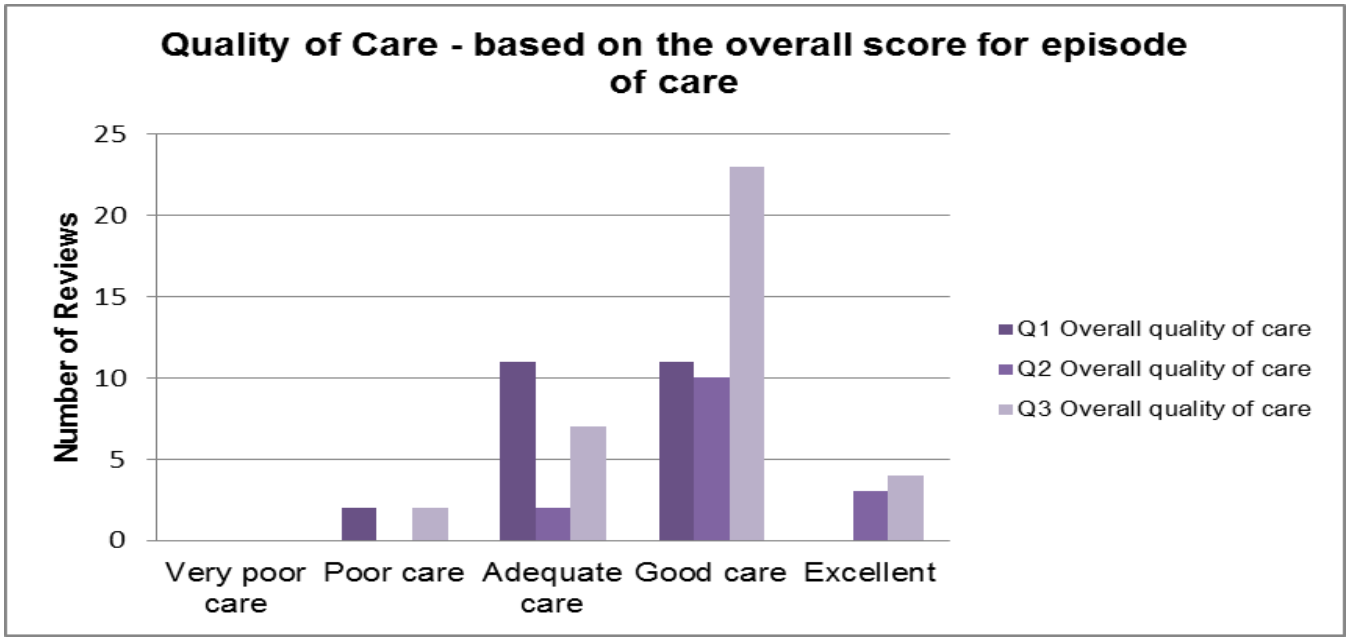
2017/18	April	May	June	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total
Total deaths in the Trust (including ED deaths)	66	54	50	**170**	50	51	52	**153**	63	61	80	**204**
Number subject to a mortality review	9	17	6	**32**	5	7	11	**22**	19	29	7	**49**
Number investigated under the serious incident framework	1	1	2	**4**	2	1	1	**4**	1	0	0	**1**
Number of learning disability deaths	0	1	0	**1**	1	0	2	**3**	0	0	0	**0**
Number of bereavement concerns	--	--	--	**--**	0	1	1	**0**	0	4	2	**6**
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**

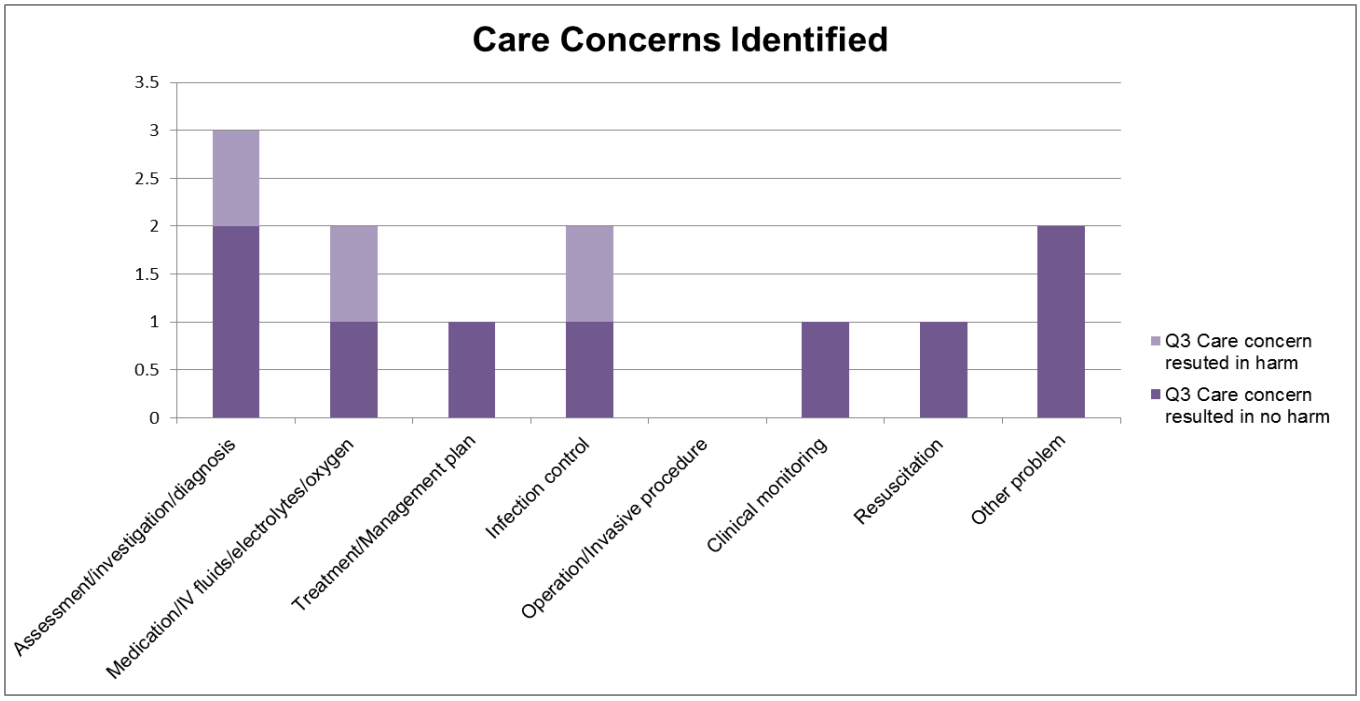
Of the 56 deaths subject to a case review in Q3:

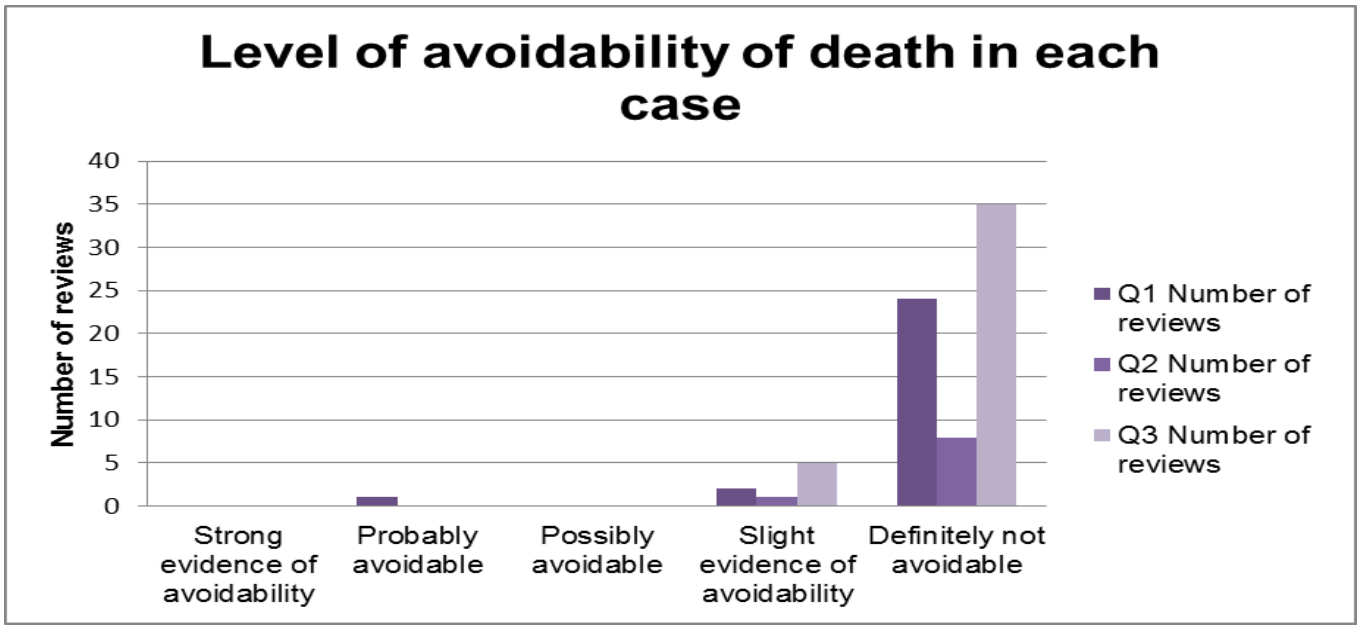
- 49 were subject to a SJR
- 1 was investigated under the serious incident framework (level 2 investigation)
- 6 were reviewed where a bereavement concern was raised



Overall findings







Themes from reviews and investigations

Of the deaths reviewed:

- No cases were identified where care concerns were considered to have directly contributed to death.
- 5 cases were considered as having slight evidence of avoidability using the RCP definitions
- Treatment/Management Plan and Clinical Monitoring were identified as areas for improvement
- Use of the Last Days of Life Communication Tool and the need to improve care planning at end of life
- Accuracy of death certificates

Lessons Learned, Actions Taken

- Excellent quality of record keeping in Cardiology
- Increased use of TEPDNAR in line with Trust policy – monthly audit in place and results being monitored at the Recognition and Rescue Group

- Early involvement and review of leg ulcers by the Tissue Viability Team and identification of sepsis risk factors
- Early involvement of Palliative Care Team in discussions with families

Learning Disability Deaths

No deaths of patients with Learning Disabilities were reported in the quarter. The Trust is fully compliant with the LeDer Programme and will report such cases to the Commissioners for appropriate review and investigation.

Neonatal and Maternal Deaths

There were no neonatal or maternal deaths reported in the quarter and no maternal deaths for the year to date. Three neonatal deaths were reviewed as part of a thematic review to consider modifiable risk factors and no themes or trends were identified. The outcome of the review and the individual learning points have been shared with the Southwest Neonatal Network to inform best practice across the region.

Working with Families

The Trust anticipates 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. This approach will be reviewed once the national standards have been issued.