COVERSHEET	
Meeting	Board of Directors' meeting in PUBLIC
Paper Title	Learning from Deaths Report (Q1 & Q2 - 2020)
Date of meeting	5 November 2020
Date paper was written	23 October 2020
Responsible Director	Dr Arne Rose, Medical Director
Author	Elaine Jeffers, CQC Improvement Lead/Patient Safety
Presenter	Dr Arne Rose, Medical Director

EXECUTIVE SUMMARY

There has been a thorough review of the approach to how we optimise the learning opportunities from care prior to death and the purpose of this paper is to highlight how the Trust plans to move forward with this important work.

A Learning from Deaths report will be provided to the Board of Directors each quarter describing how we have learned and where our clinical practice has changed and improved as a consequence.

This report highlights the work underway in relation to the Trust Learning from Deaths Agenda for the period April – September 2020.

The Board of Directors' are asked to:

- Note the content of the report
- Acknowledge the current performance with regards to the external metrics of HSMR, SHMI and RAMI noting the Trust remains within the expected range
- Acknowledge the review of the current mortality systems and processes to bring the Trust in line with the requirements of the National Learning from Deaths Guidance
- Note the work underway to extract learning from the first wave of the Covid-19 Pandemic

Previously considered by	The Trust Mortality Meeting is scheduled for 19 November 2020. To meet the governance reporting requirements this report will be presented to the monthly Mortality Group in future prior to submission to the Board of Directors.

THE BOARD OF DIRECTORS' (Committee) ARE ASKED TO:			
☐ Approve	☐ Receive	☑ Note	☐ Take Assurance
To formally receive and discuss a report and approve its recommendations or a	To discuss, in depth, noting the implications for the Board or Trust	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

particular course of action	without formally approving it		

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	BAF 561 IF we do not have system-wide effective processes in place THEN we will not achieve national performance standards for key planned activity.

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	

MAIN PAPER
SITUATION

The National Quality Board Guidance on Learning from Deaths (2017) has driven a national endeavour to initiate a standardised approach to the way in which we review and learn from the care and treatment given to our patients prior to their death.

To fully support this agenda the Trust will continue to develop the wider mortality systems and processes to enable us to get a clear understanding of the care delivered to patients, their families and loved ones at what is a very emotional and difficult time.

This will strengthen the knowledge for specialty teams in understanding where they perform in terms of mortality, supporting them to identify areas of excellent practice but also areas of improvement and required changes to the way in which care is delivered.

Learning from Deaths is comprised of a number of elements and these are highlighted below:

1. Mortality Performance

1.1 Quarter One 2020/21

Table 1 indicates that during quarter one, there were 499 deaths across both sites, which is a reduction of 63 deaths from quarter four of 2020, but is up 30 deaths for the same period in quarter one of 2019/20 and could be a direct result of the Covid-19 Pandemic.

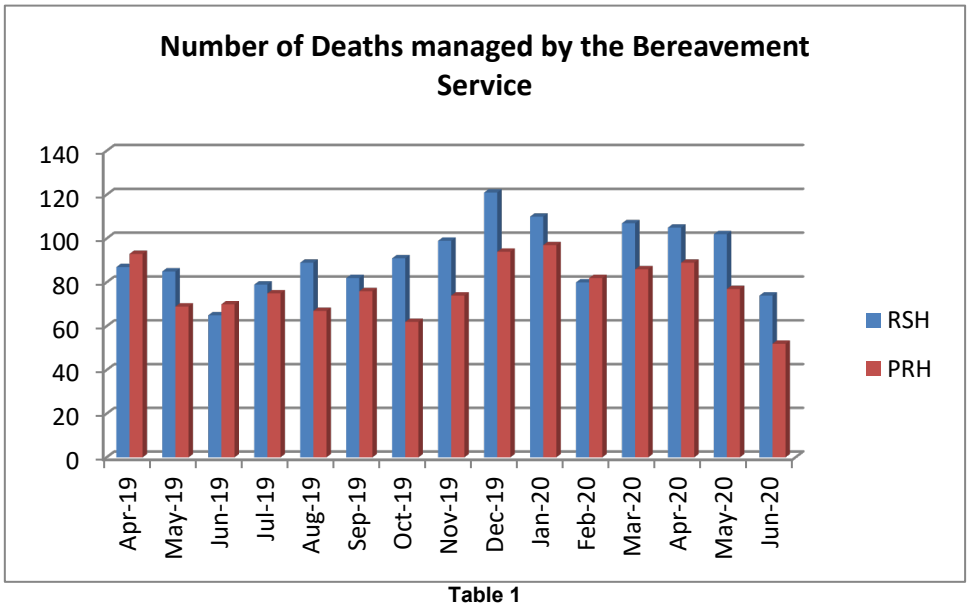


Table 1

Of the 499 deaths that occurred in quarter one, 162 were related to COVID-19. 92 of these deaths were at the Royal Shrewsbury Hospital (RSH) and 70 were at the Princess Royal Hospital (PRH).

The quarter two performance is included within the Bereavement and Medical examiner report to the November Board; however this will be included within the Learning from Deaths Report from quarter three.

1.2 CHKS

The Trust works in collaboration with CHKS who provide the external intelligence in relation to mortality. CHKS provide a monthly report highlighting performance against a number of indicators, including the Hospital Standardised Mortality ratio (HSMR), the Summary Hospital-level Mortality Indicator (SHMI) and the Risk Adjusted Mortality Index (RAMI).

The HSMR, SHMI and RAMI data provides an external overview of mortality and those risk adjusted factors that may contribute to a death enabling the Trust to benchmark mortality data nationally and locally by organisation and individual diagnosis code. Appendix A indicates the Trust performance HSMR and RAMI for the period April 2018 to August 2020 and SHMI April 2018 to May 2020.

The graphs indicate that for all three indicators the Trust remains within the expected range, both from a national position but also when compared to a selected peer group of similar organisations. CHKS provide a detailed report to the Mortality Group where in-depth discussion takes place as to specific diagnosis indicators where the Trust performs below the expected range (positive) and where a more focussed review would be of benefit to pre-empt any potential mortality outliers.

The aim for specialties through 2020/21 is to understand their own mortality position, particularly those factors driving either a good or poor performance. To facilitate this CHKS will work more closely with mortality leads to design bespoke mortality reports that specialties will be able to access to support local mortality and morbidity meetings.

2. Mortality Review

The purpose of reviews / investigations into patient deaths where there may have been problems, is to learn from this process, offer explanations to those who are bereaved and prevent recurrence in the future for other patients. Reviews and investigations can only be useful for learning purposes if their findings are valued, shared and acted upon in the positive spirit of transparency and improvement. This process can also support and acknowledge good practice, and provide positive opportunities to share and help other teams.

Learning from a review of the care provided to patients who die is integral to our overall clinical governance and quality improvement work. To fulfil the standards and the reporting set out in this guidance for our hospitals the Trust is carrying out a comprehensive review of governance systems and processes and in particular strengthening the wider learning from deaths agenda across the organisation.

This will give due focus to the review, investigation and reporting of deaths, including those deaths that are deemed more likely than not to have resulted from problems in care. A key focus of this work will be to ensure we share and act upon any learning derived from our review processes.

The current mortality review process is being re-designed in line with the National Learning from Deaths Guidance. The review process consists of three key elements –

a) Initial review (all deaths) to determine the cause of death and identify any immediate concerns that may indicate a more detailed review is required
b) Structured Judgement Review (SJR) – initiated if concerns are raised either by the bereaved family, the clinical team or medical examiner

c) Avoidability Assessment – initiated if deficits in care or potential avoidable factors are identified. This stage operates concurrently with the incident management process as it is likely a more formal investigation will be required.

3. Structured Judgement Review

The Trust will need to enhance the skills and training of clinical teams to support this agenda. We will need to ensure that staff reporting deaths have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.

To facilitate this the Trust will adopt the Royal College of Physician's Structured Judgement Review (SJR) methodology as the standardised Mortality Review mechanism. This is new to the organisation thus a programme of training is being developed to support timely and effective implementation and will be delivered through 2021/22.

The adoption of this methodology will ensure standardisation and consistency of the review process, allow for national and regional benchmarking and provide assurance that we provide the safest, highest quality of care patients deserve at this extremely difficult time.

Regardless of whether the care provided to a patient who dies is examined using case record review or an investigation, the findings should be part of, and feed into, robust clinical governance processes and structures. The findings will be considered alongside other information and data including complaints, clinical audit information, mortality data, patient safety incident reports and data and outcomes measures etc. to inform the Trust's wider strategic plans and safety priorities.

4. Engagement with Bereaved Families

The engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one is a vitally important element of how the Trust learns and improves the care for all patients.

The Trust endeavours to work closely with bereaved families and carers to ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.
The Learning from Deaths Guidance set clear expectations for how NHS Trusts should engage meaningfully and compassionately with bereaved families and carers prior to and following a death.

In July 2018 additional guidance to support the work with bereaved families was published by the National Quality Board. The guidance was developed by NHS England in collaboration with families who have experienced the death of someone in NHS care and have been involved in investigations, as well as with voluntary sector organisations.
There are eight principles that set out what bereaved families and carers can expect. These are:

- Being treated as equal partners.
- Receiving clear, honest, compassionate and sensitive response in a sympathetic environment.
- Being informed of their rights to raise a concern.
- Receiving help to inform decisions about whether a review or investigation is needed.

- Receiving timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.
- Being partners in an investigation as they offer a unique and equally valid source of information and evidence.
- Being supported to work in partnership with trusts in delivering training for staff in supporting family and carer involvement where they want to.

The Trust Bereavement Service has made great progress toward meeting all these expectations and the full implementation of the Medical Examiner service has further supported this.

5. Medical Examiner Service

The Trust complies with the legal requirements of having a Medical Examiner Service following the enforcement of the Coroners and Justice Act 2009. The requirements for acute trusts have been set out in parliamentary statements in 2018. These statements have committed the government to act on the many years of development in response to numerous national inquiries and system failures, such as Mid Staffordshire, Morecombe Bay and Gosport Memorial Hospital.

The Medical Examiner has an independent role in the Trust but remains professionally accountable to the Medical Director and is in the employment of the Trust. The independent nature of the role is of the upmost importance. Each local Medical Examiner is also accountable to the regional and national Medical Examiners.

The introduction of the Medical Examiner role provides further clarity about which deaths should be reviewed. Medical Examiners are able to refer the death of any patient for review with this mechanism ensuring a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient's death.

BACKGROUND

The Care Quality Commission (CQC) report *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (2016)'* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do as a healthcare provider to engage families and carers and to recognise their insights as a vital source of learning.

It is compulsory to review ***all*** deaths of patients in the care of the NHS. When mistakes happen or poor care is delivered, it is important to do more to understand the causes and make improvements. Implementation of the National Learning from Deaths guidance is key to the way in which the Trust can maximise the learning opportunities from the review of care delivered to our patients in the days leading up to their death, whilst an inpatient in one of our hospitals.

ASSESSMENT

6. Progress to date

Good progress has been made through quarters one and two of 2020/21 to strengthen the current mortality processes. Since July 2020 the following has been achieved:

- Review of the Trust Mortality Group – chaired by the Medical Director the group now meets monthly and reports directly to the Quality Operational Group with a quarterly Learning from Deaths Report to be provided to the Board of Directors
- Revised Terms of Reference and Membership in place
- Appointment of a Medical Lead for Mortality (1 x PA) in post
- Appointment of a Learning from Deaths Lead (Band 7) will take up full time post in January 2021 but currently providing 2 days/week support
- Plan for implementation of SJR Training in development to be rolled out from January 2021
- Pilot local mortality process using SJR methodology underway in Acute Medicine
- Improved reporting from CHKS presented to October Mortality Group

7. Next steps

To build on the overall mortality review process there are a number of specific groups of patients for whom a thorough review of their care is required regardless of whether the death was expected. These include, but are not limited to:

- Patients with a known learning disability
- Cases proceeding to Inquest or taken by the Coroner for further investigation
- Patients who die whilst undergoing surgical/interventional procedure (or within a specified timeframe)
- Patients where suspected hospital acquired Covid-19 is identified on the Medical Certificate of the Cause of Death (MCCD)

8. Covid-19

A retrospective review is taking place for patients who had Covid-19 recorded on their MCCD between April and September 2020 (Cohort 1) to identify any learning opportunities from the first wave of the pandemic in order to initiate any improvements to support he expected wave two and the winter period. One case is currently undergoing a rigorous review within the Patient Safety Team in response to concerns raised by a family member through the CQC. The outcome of this review will be reported in the quarter three report to the Board.

9. NICHE Project

The Trust has been participating in an external system-wide review of mortality, commissioned by the CCG in conjunction with the company NICHE. Phase one of the programme has concluded and the initial draft has been received for factual accuracy. Phase two is due to commence in November, which will focus on mortality across the system but specifically looking at primary care and the care sector rather than the acute sector. The outcome of the initial report will be provided within the quarter three Learning from Deaths Report.

10. Future reporting

Improved reporting will be in place for the quarter three board report, with a revised performance dashboard provided to include outcome metrics following mortality reviews, inquests, investigations, feedback from bereaved families and improvements and changes to practice where appropriate.

RECOMMENDATION
The Board of Directors is asked to acknowledge the work already undertaken and planned to strengthen and improve the approach to the mortality agenda across the Trust, bringing it in line with the requirements of the National Learning from Deaths Guidance.

Appendix A.

SHMI trend April 2018 to May 2020

Peer group: SaTH Trust Peer 2020

SHMI 12-month rolling trend April 2018 to May 2020

Peer group: SaTH Trust Peer 2020

HSMR trend April 2018 to August 2020

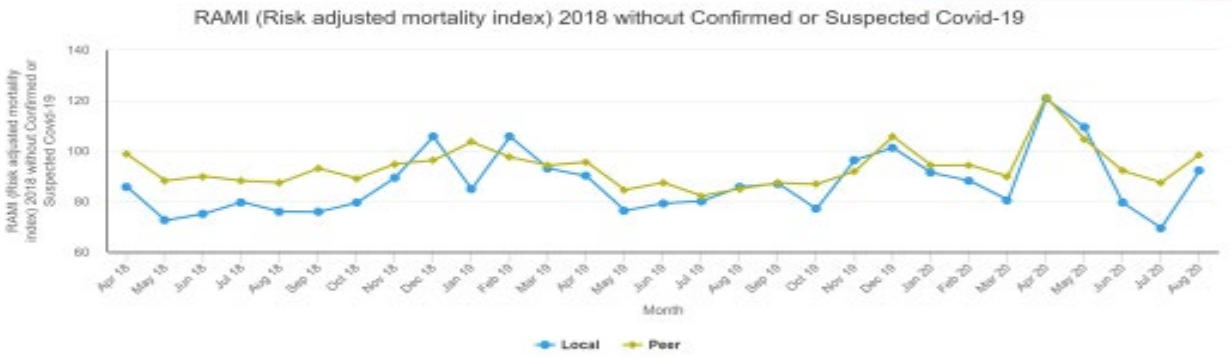
Peer group: SaTH Trust Peer 2020

HSMR 12-month rolling trend April 2018 to August 2020

Peer group: SaTH Trust Peer 2020

RAMI trend April 2018 to August 2020

Peer group: SaTH Trust Peer 2020



RAMI trend April 2018 to August 2020

Peer group: SaTH Trust Peer 2020