The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
6 May 2021

Agenda item	109/21			
Report	Learning from Deaths Report			
Executive Lead	Medical Director			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery		Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:	Quality Operational Committee 20/04/21 Quality Assurance and Safety Committee 28/04/21			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	The Trust has seen a spike in both the Hospital Standardised Mortality Ratio (HSMR) and Risk Adjusted Mortality Index (RAMI) mortality indicators through January. This is most likely linked to the wave 3 cohort of COVID-19 deaths seen at the beginning of the year. The February and March predictions indicate performance returning to within expected parameters. Further guidance is expected in May 2021 from NHS England/Improvement in relation to the requirement of all healthcare providers to formally report hospital acquired COVID-19 as a Serious Incident via National Reporting and Learning System (NRLS). Once the guidance has been received a briefing note will be presented to the Executive Team outlining the implications for the Trust.			
Appendices	Appendix 1: Criteria for determining whether Covid-19 is hospital acquired: Appendix 2: Medical Examiner and Bereavement Service Report			

1.0 Introduction

1.1 The Learning from Deaths Guidance (2017) stated that 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.

1.2 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. Improvements as a result of this learning will in turn provide better care for our living patients.

1.3 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.

1.4 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.

2.0 Mortality Performance

2.1 The Trust has a monthly Learning from Deaths Group. As a standing agenda item Comparative Health Knowledge System (CHKS) provide information relating to a number of mortality metrics, indicating the performance of the Trust against a defined set of national mortality metrics. These are reported, by exception to the Board of Directors via the Integrated Performance Review report.

2.2 HSMR – Hospital Standardised Mortality Ratio. Chart 1 indicates the Trust HSMR performance to March 2021. The Trust's HSMR position is slightly below the peer average, but the index was higher than the peer in some months. There was an increase in HSMR in November and January in line with waves 2 and 3 of COVID-19 deaths. The forecast for February and March indicates HSMR is returning to within the expected range.

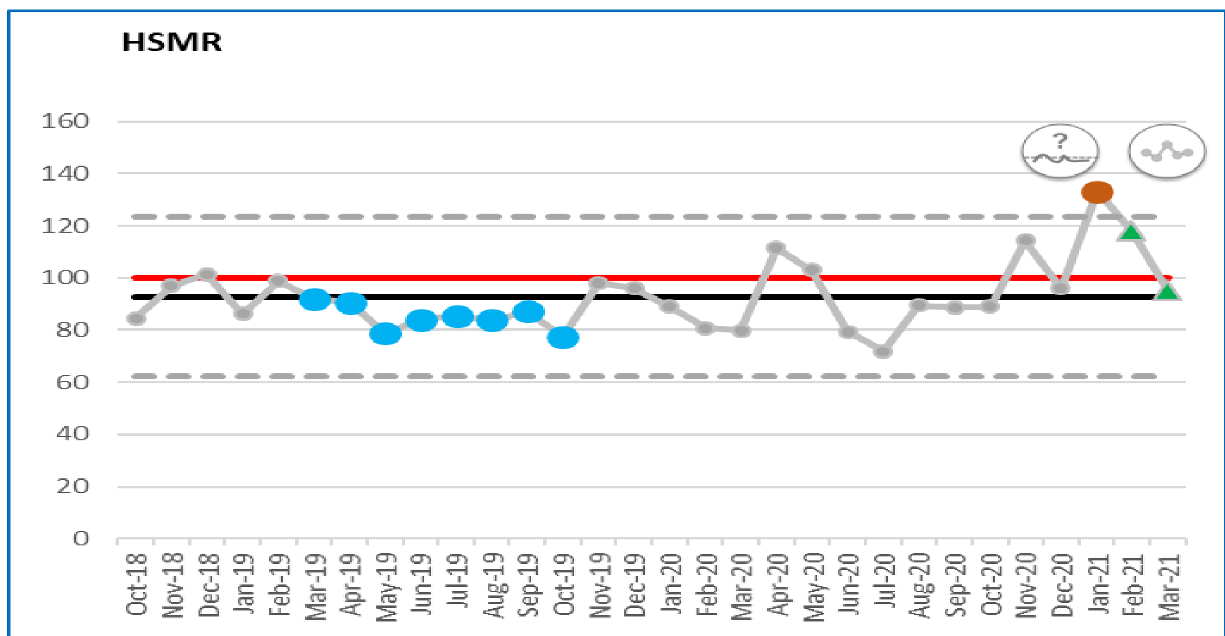


Chart 1.

2.3 HSMR is adjusted to account for patients with a primary diagnosis of COVID-19 in the first or second episode of care. These patients will be excluded from HSMR. For patients where the COVID-19 coding appears elsewhere in the spell or subsidiary diagnosis may well be included.

2.4 A number of diagnosis codes have been highlighted to the Learning from Deaths Group that warrant further investigation as individually they are out with the expected HSMR range, having the largest numbers of excess deaths. These are – urinary tract infection, respiratory failure, acute bronchitis and congestive heart failure, all of which are high compared to the peer group and have increased since the previous CHKS report.

2.5 A function of the Learning from Deaths Group is to identify specific conditions that may well be a potential mortality outlier – these are identified via the cusum alert where the number of actual deaths exceeds the expected. Once identified a further review takes place of the cohort of patients to determine whether there are any issues of concern and/or learning opportunities. An outcome report will then be presented to the Learning from Deaths Group. This report may well pre-empt a formal mortality outlier notification from CQC or other regulatory body.

2.6 RAMI – Risk Adjusted Mortality Indicator. Chart 2 indicates the Trust RAMI performance to March 2021. RAMI increased in January, again in line with the 3rd wave of COVID-19 deaths. This is in line with the performance in March/April 2020 during wave one of COVID-19. The index for PRH was higher than the peer. The RAMI indicator excludes COVID-19 patients.

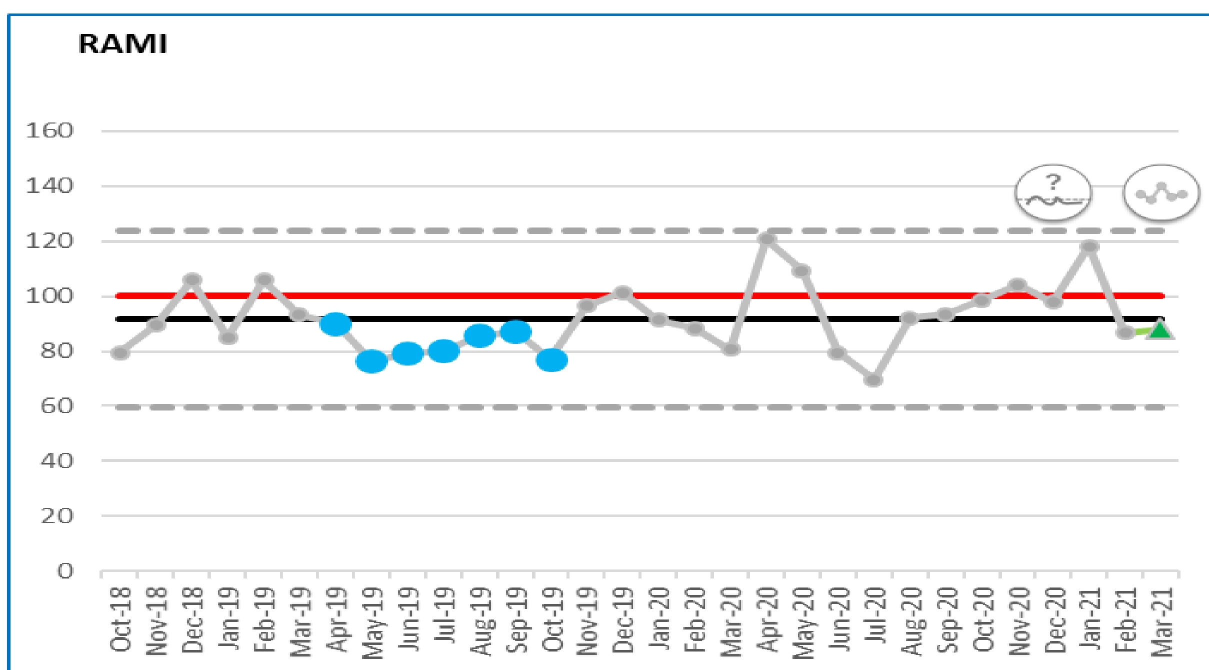


Chart 2

2.7 The current position could be due, in part to incomplete coding; however there are three diagnosis conditions that are an outlier for RAMI – Urinary Tract Infection, Respiratory Failure and Aspiration Pneumonitis with the latter being significantly raised in January on the Princess Royal Site.

2.8 Quarter three performance – 544 deaths were reported during quarter three. 100% of deaths have been scrutinised by a Trust Medical Examiner. It should be noted that following the 2017 Learning from Deaths Guidance where the standard was for ≥ 90% of all deaths to be reviewed and the subsequent introduction of the Medical Examiner service across the country, we are now confident that 100% of all deaths have an opportunity to be looked at independently by a qualified clinician. The purpose is to a) determine the cause of death, b) refer appropriately to the Coroner where required and c) identify any immediate concerns raised either through the scrutiny process or from the bereaved family.

2.9 Of the 544 deaths in quarter three all (100%) were scrutinised by the Medical Examiner. 180 have undergone a review by the relevant specialty and of these 160

had a CESDI Score of 0, 8 had a CESDI Score of 1, 11 had a CESDI Score of 2, and 1 a CESDI Score of 3. The cases scoring 2 and 3 are being considered for a second stage review and discussed in conjunction with Patient Safety and other specialist teams – i.e. Sepsis Lead Nurses.

2.10 There were five deaths of patients with a known Learning Disability. These will also be reviewed through the external LeDER process.

3.0 Learning from Deaths

3.1 Trust Learning from Deaths Group – the monthly meeting is now well established with good attendance from core members. Further work is required to ensure appropriate and timely attendance from Divisional and sub-specialty areas will be a focus through April.

3.2 Mortality Review process – in line with the 2017 Learning from Deaths Guidance the Trust is moving from the use of the CESDI Form as the primary mortality review mechanism to a structured judgement review model. The Structured Judgement Review Plus (SJRPlus) tool developed by NHSE/I has been selected as the tool of choice. This is a significant change in the way in which mortality reviews will be carried out moving forward and the transition should not be underestimated. The proposal has initiated considerable debate, which has been positive and productive in the main, but has highlighted a number of areas for improvement in the current process that the central learning from deaths team are working through.

3.3 Two training sessions for the use of the SJRPlus tool were provided on 23 February and 2 March. These were well attended by a cross section of clinical staff. The tool is web-based and currently uses the Oris Platform. To date a small number of clinicians who attended the training have requested their login details to start using the tool to review their mortality and it is expected that more will follow. Further training sessions are being agreed.

3.4 To support a more robust and comprehensive review process a list of mandated cases that will automatically trigger a Structured Judgement Review has been proposed. It includes:

- Sepsis 1a
- Death post elective procedure
- Death in Theatre
- Learning Disability
- Covid/Hospital acquired (to be reviewed in light of Public Health England document)
- Non-invasive therapy
- Dr Foster Mortality Outlier

3.5 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.

4.0 COVID-19 Mortality Review

4.1 A retrospective review has been taking place for patients who had COVID-19 recorded on their Medical Certificate on Cause of Death (MCCD) between 01/03/2020 and 30/08/2020 (Wave 1). This has been undertaken to understand how positive and potential COVID-19 patients were managed in the early phase of the pandemic and to identify any learning opportunities.

4.2 The total number of cases in the wave 1 cohort was 174, of this 65 cases were identified as having either probable (n40) hospital acquired COVID-19 or possible (n25) hospital acquired COVID-19.

4.3 Mortality reviews have been carried out on 20 of the probable cases to date with outcomes as follows: 12 = CESDI Score 0, 1 = CESDI Score 1, 6 = CESDI Score 2 and 1 = CESDI Score 3. The cases scoring 2 and 3 have been reviewed through the Trust Incident Management process. Reviews of the remaining cases continues.

4.4 The criteria for determining whether COVID-19 has been acquired as a consequence of the hospital admission is in line with national recommendations and is attached at Appendix 1.

4.5 Further reviews are being conducted by the Patient Safety Team on the cases where a patient passed away on a ward where a known COVID-19 outbreak had been declared. This review will pick up a significant number of cases of patients who died during wave 2 – 01/09/2020-31/12/2020.

4.6 Plans were underway to determine the process for reviewing cases for the wave 3 cohort; however Public Health England issued a document *'Reporting, reviewing and investigating hospital-onset COVID-19 cases and COVID-19 deaths'* in February 2021 providing guidance for providers as to how to determine which cases are to be reviewed during quarter 4 and 2021/22. Further guidance is expected in May 2021 which will indicate that all suspected or actual deaths resulting from hospital acquired COVID-19 must be reported as a Serious Incident via NRLS. A briefing note will be presented to the Executive Team outlining the implications for the Trust as this will significantly increase the number of serious incidents being reported.

5.0 Medical Examiner and Bereavement Centre update

5.1 The Medical Examiner and Bereavement Service are managed in line with Trust, Regional and National policy and links in with the Trust's monthly Learning from Deaths Committee and monthly and quarterly Regional Medical Examiner forums.

5.2 The Trust continues to work under the emergency COVID-19 legislation, with Medical Examiners completing the MCCD and part 1 cremation paperwork, following discussion with a qualified attending physician (QAP) involved in the patient's care. In some circumstances the Medical Examiner has the authority to super certify a death if they are unable to contact a QAP, as long as a cause of death can be established and is natural. In cases where there is concern around establishing a cause of death or that it is not natural, a referral to the Coroner will be made.

5.3 The Medical Examiner and Bereavement Service Report is attached at Appendix 2.

6.0 Next steps

6.1 The Learning from Deaths Group will continue to develop the approach to mortality review and plan to rollout the SJRPlus training to a wider audience with a plan to implement across the Trust by June 2021.

6.1 An external review of mortality was commissioned by the CCG in 2020 with the first report (Phase 1) due for publication imminently. The first draft of a second report (Phase 2) looking at mortality across the wider system is also due to be received shortly. It is hoped that the recommendations from these reports will further strengthen the Learning from Deaths Agenda.

6.2 The Trust Learning from Deaths Policy is under review and will be ratified in June 2021.

6.3 It is also necessary to measure the impact the current measures to manage COVID-19 are having on deaths from other causes. The largest impact is likely to be in the medium to long term due to delays by the public accessing GP, out-patient and diagnostic services, and cannot yet be known.

6.4 Excess deaths, from a 5 year average, have been cited as one measure to calculate any increase in all cause deaths. Within SaTH, as a measure of the immediate impact, this could be measured using a crude number of deaths, however between 2015 and 2019, average monthly activity increased by 2,500 spells, so crude numbers alone may be misleading. A comparison of a 5 year average mortality rate may be more accurate, as this will also take into account the reduction in elective surgery and day case activity in March and April 2020.

Medical Director
May 2021

Appendix 1

Criteria for determining whether Covid-19 is hospital acquired:

Probable Trust acquired:
- >8 days from admission to being positive
- Known outbreak area/contact
- Multiple ward moves
- Multiple previous (close to time) admissions - <one month since last contact

Possible Trust acquired:
- Positive within 3-8 days of admission (may change due to new variants)
- Known outbreak area/contact
- Recent admission <2 weeks (look at swab history)

Unlikely Trust acquired:
- Positive in under 3 days
- Consider low number of ward contacts
- Not in outbreak area prior to positive result
- Has had contact with Trust but length of time makes it unlikely and/or had a negative swab within 48 hours prior to previous discharge

Not Trust acquired:
- No recent Trust contact
- First presentation and positive swab on admission to ED/ward

Appendix 2

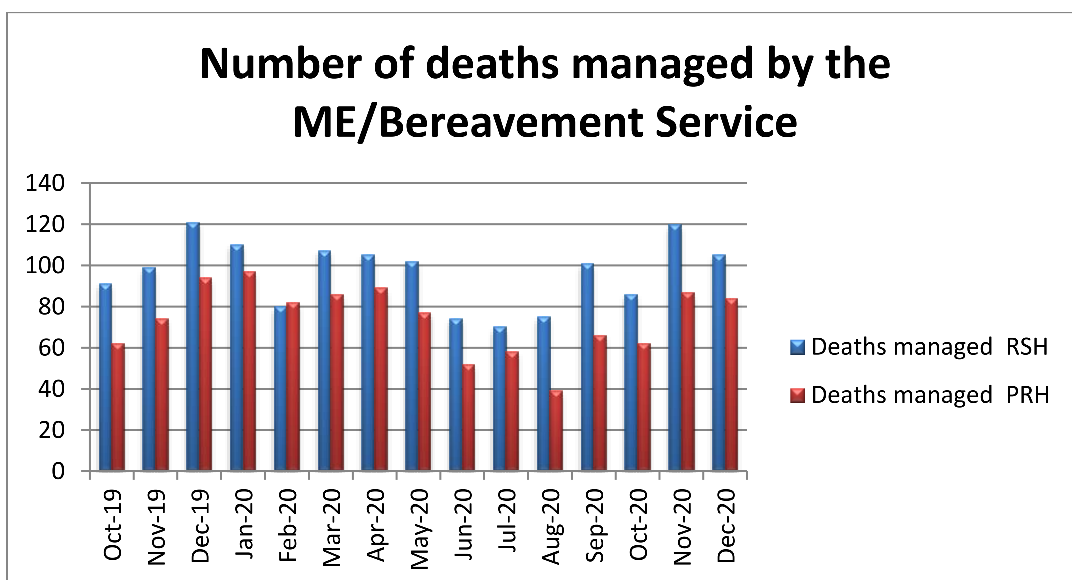
MEDICAL EXAMINER & BEREAVEMENT SERVICE REPORT
QUARTER 3 – OCTOBER –DECEMBER 2020

1. Introduction

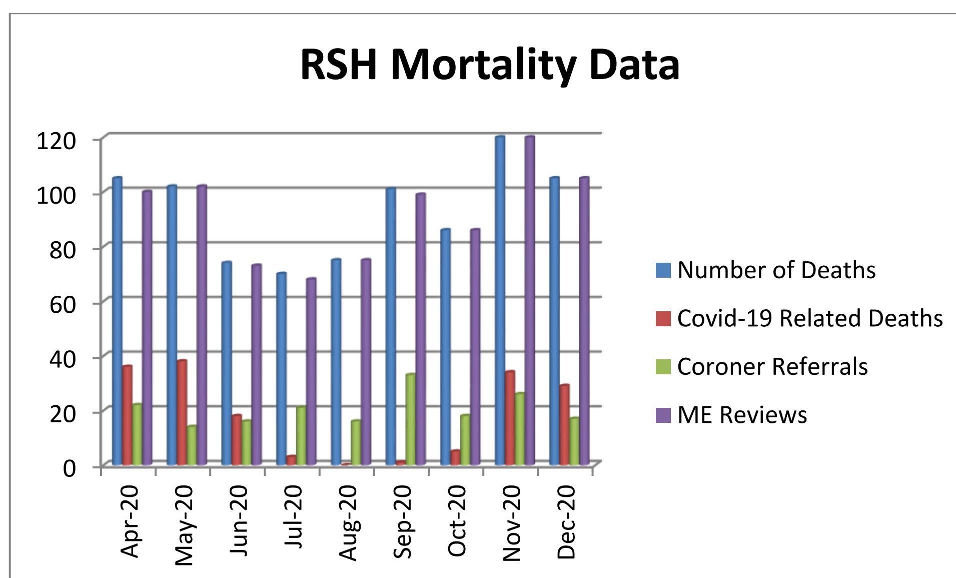
The purpose of this report is to provide the Trust Board with an overview of the hospital deaths managed by the Medical Examiner Service during quarter three (October-December 2020).

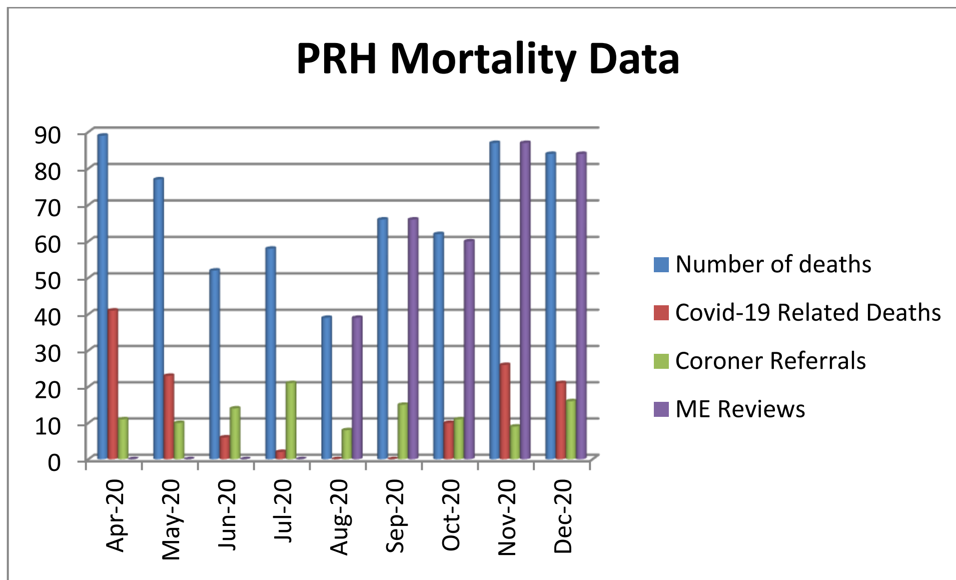
2. Hospital Deaths

During quarter three, there were 544 deaths across both of our hospitals, which is an increase of 135 deaths from quarter two of 2020 and a small increase than in the same period of 2019/2020 seeing only 3 more deaths than in that period.



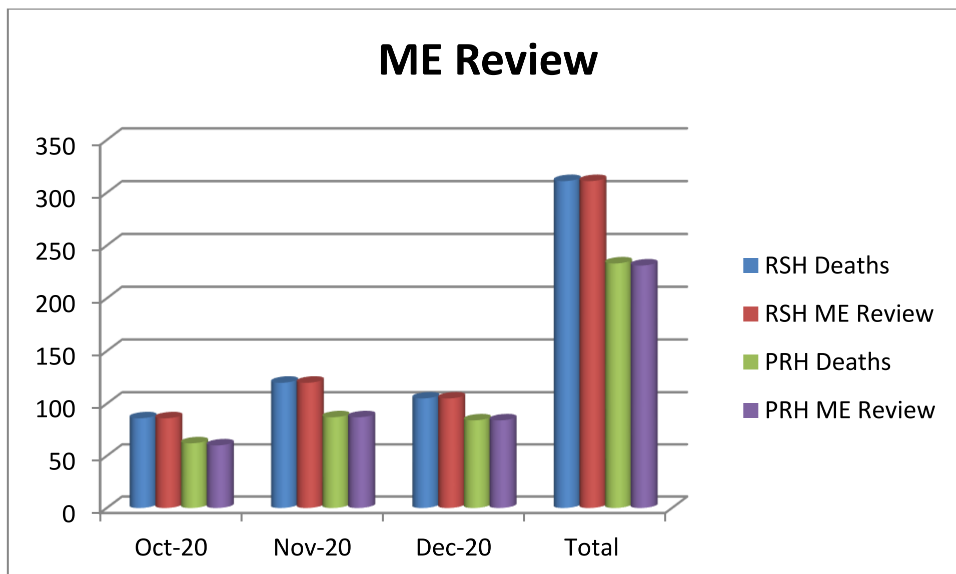
On reviewing the impact of the Covid-19 pandemic over the three quarters of this year, we can see the mortality data for each hospital below and will note the increase in covid-19 related deaths on each site in quarter three. The Bereavement service reported 68 covid-19 related deaths for RSH and 57 for PRH. These are deaths in a patient who died within 28 days of a positive PCR test for SARS-Cov-2.



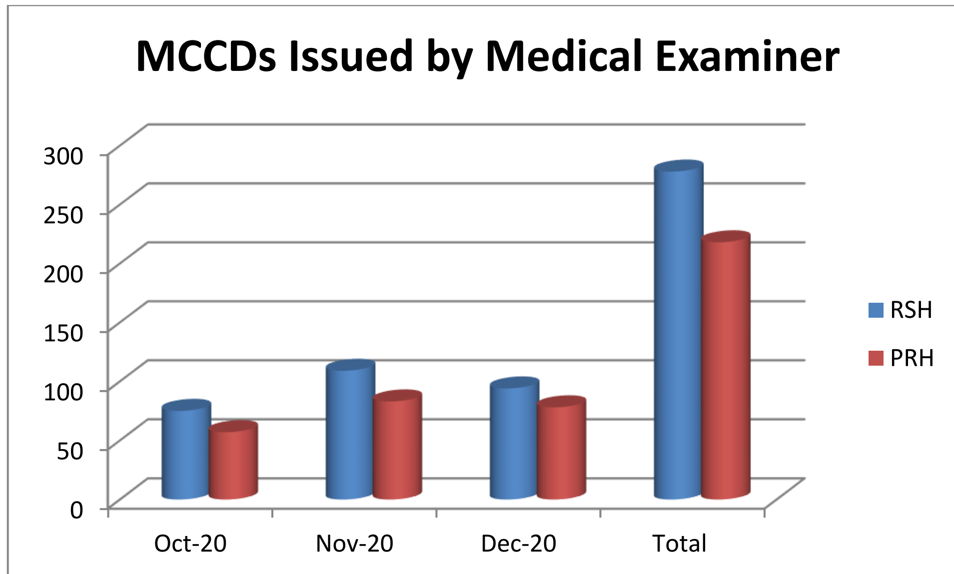


125 patients died in our care with Covid-19 during quarter three which is a significant increase from what was reported in quarter two with the Bereavement Service reporting only 6 cases during that period. 110 of these deaths were reported to NHS England by the Bereavement Service with the remaining cases being reported by Incident Command Centre as they started to support us with reporting deaths at the weekend mid-way through November. This support has been a significant help to the Bereavement Service.

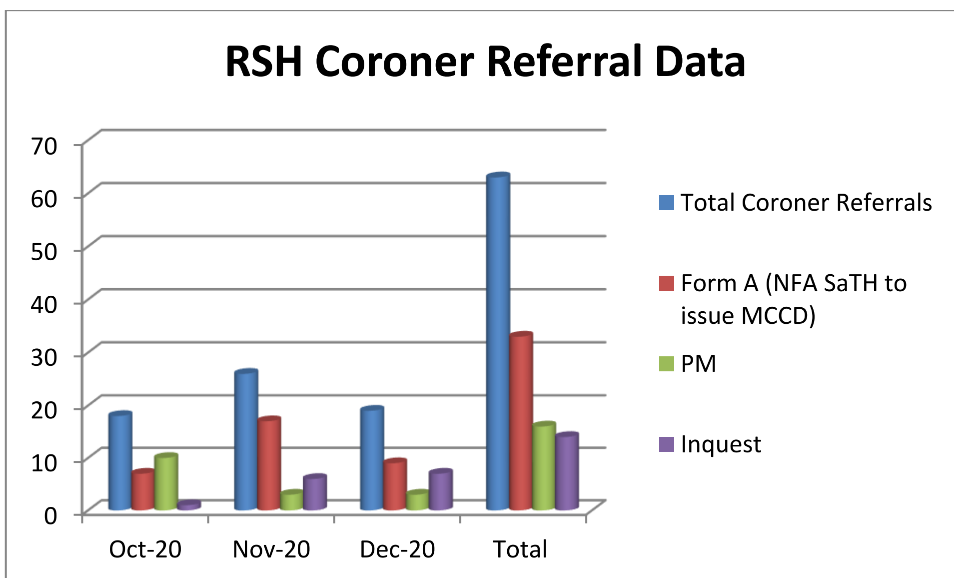
Of the 544 deaths that occurred in quarter three; our Medical Examiner (ME) service reviewed 542 deaths. The other 2 deaths were referrals to the Coroner that were made directly from the clinical area. The ME service in PRH was introduced in August 2020 and has been very successful and well received, particular by bereaved families who welcome the opportunity to discuss their relative's care with an independent doctor and have the circumstances and cause of death explained to them.

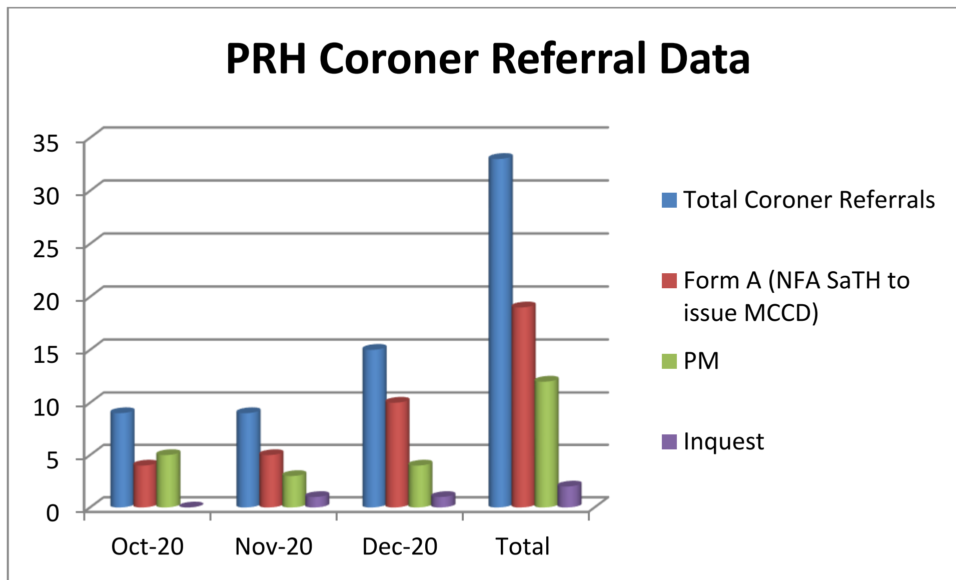


The Medical Examiner service continue to work under the emergency Covid legislation which allows any medical healthcare professional to complete the Medical Certificate of Cause of Death (MCCD) providing they have spoken with a qualified attending physician (QAP). We have been working in this way since April 2020 to relieve the operational pressures of the clinical teams and so they can maintain their presence on the ward and with clinical duties. In some circumstances it is at the discretion of the ME that they can super certify a death if they have been unable to locate and speak with a QAP. This is to prevent any delay to the bereaved relatives in registering the death, but can only be used if the ME is able to determine a cause of death, on the balance of probability. In quarter three 469 certificates were written and issued by the Medical Examiner.

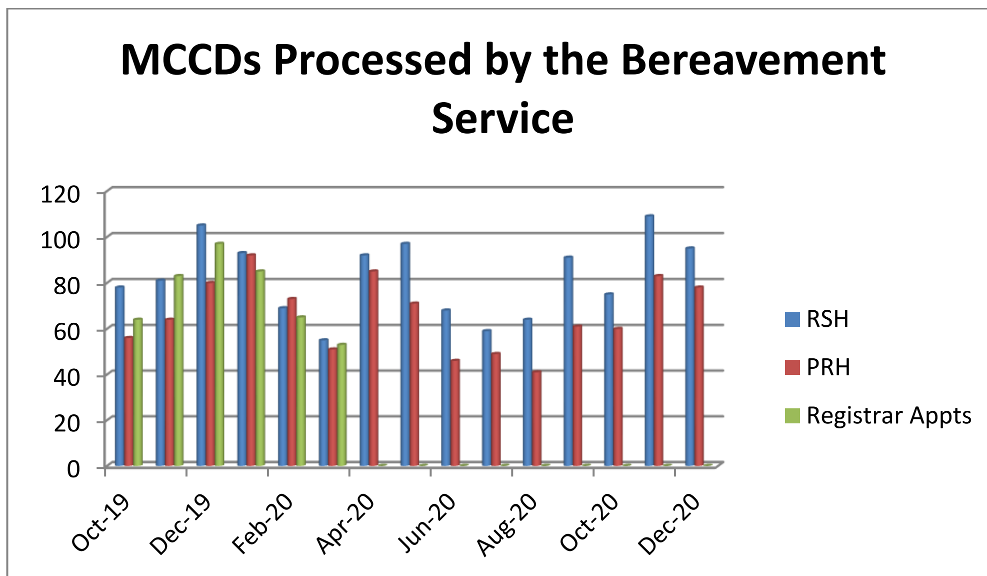


In quarter three we referred 96 deaths to the Coroner which is a reduction of 18 referrals from quarter two. The outcome of referring to the Coroner can vary between no further action being taken (Form A), to an inquest and requesting a post mortem. A breakdown of the outcomes from these referrals for each hospital is below.





The Bereavement Service remains unable to invite bereaved relatives in to collect the MCCD or personal belongings and therefore relatives were not able to register the death on site at RSH. In partnership with Shropshire and Telford & Wrekin Registrar Services, the Bereavement Service processed 500 MCCDs by sending these electronically to the Registrar Services so that telephone registration could be facilitated for the bereaved.



Medical Examiner and Bereavement Services Review

The ME and Bereavement Service has maintained the processes of supporting bereaved relatives, whilst not in person, by maintaining contact with them over the phone and ensuring they know what action we are taking in respect of their relative's death. Families continue to receive our swan bereavement folders via the post to help provide ongoing support and we are still open to receive enquiries from bereaved relatives and provide ongoing support to them. Medical Examiners are continuing with their reviews of all deaths and an important part of this is the support they offer to the bereaved.

The ME service has been in place at PRH since the beginning of August and has been well received, by the medical teams and the bereaved relatives.

At the end of December it was made possible that all deaths that require a referral to the Coroner are now done by the Medical Examiner Service and directly to the Coroner's Portal. This is working well and supports the process for ensuring appropriate referrals to the Coroner are made. The exceptions to this are referrals made by the Neonatal & Paediatric Department whereby they have been given access to refer cases over themselves. The Medical Examiner Service does not review infant or paediatric deaths and so these departments needed to maintain access for referring where necessary.