The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting

10 February 2022

Agenda item	024/22			
Report	How we learn from deaths Report Q2 2021/22			
Executive Lead	Dr John Jones, Acting Medical Director Mr Richard Steyn, Co-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	✓	BAF1, BAF 2	
Presented to:				
Executive summary:	This paper provides the Board of Directors with a quarterly update on inpatient and Emergency Department deaths, progress with implementing the Structured Judgement Review Plus tool (SJRPlus), the Trust's performance in line with national Mortality Key Performance Indicators, an update regarding COVID-19 mortality and a summary of learning that has been identified. In Quarter 2 of 2021/22 there were 417 inpatient deaths and 60 deaths in the Emergency Department. All deaths are independently scrutinised by a Medical Examiner. Just under 5% (target 15-20%) of deaths underwent a case review using the Structured Judgement Review Plus tool. The CESDI paper-based mortality review form will be withdrawn in January 2022 increasing available resource to complete the SJRPlus. A weekly Mortality Triangulation Group (MTG) has been established to improve oversight and triangulation of learning. A Mortality Dashboard is being developed, with assistance from NHSE/I. A total of 16 of 19 recommendations from the Shropshire Independent Review of Deaths and Serious Incidents (NICHE Phase 2 Review) commissioned by the Shropshire Clinical Commissioning Group, are complete.			
Lead Executive				

1.0 Introduction

1.1 The National Quality Board (NQB) guidance 'Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (2017)', provides the framework to support the Trust's Learning from Deaths process. All inpatient deaths are scrutinised either by a Medical Examiner or investigated by the Coroner in defined circumstances. Some deaths are subject to further review at speciality level where the review of care delivered to our patients in the days leading up to their death aims to maximise learning opportunities and improve care for our living patients. Patient Safety concerns that are identified during case record review are referred to the Patient Safety Team for investigation.

1.2 Mortality performance within The Shrewsbury and Telford Hospital NHS Trust is monitored using external CHKS data and through analysis of internal Trust data, which is detailed in the report. Feedback from bereaved families is used to further support this work.

2.0 Mortality Performance - CHKS

2.1 No Dr Foster Imperial alerts have been received during Q2 2021/2022.

2.2 HSMR - Hospital Standardised Mortality Ratio.

Chart 1 shows the Trust's HSMR performance from October 2018 to October 2021. The HSMR indicator is just above the national target of 100 demonstrating common cause variation. The Trust's HSMR long term trend position to this date follows a similar pattern to the peer group.

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. Patients where the COVID-19 coding appears elsewhere in the spell or subsidiary diagnosis, may be included.

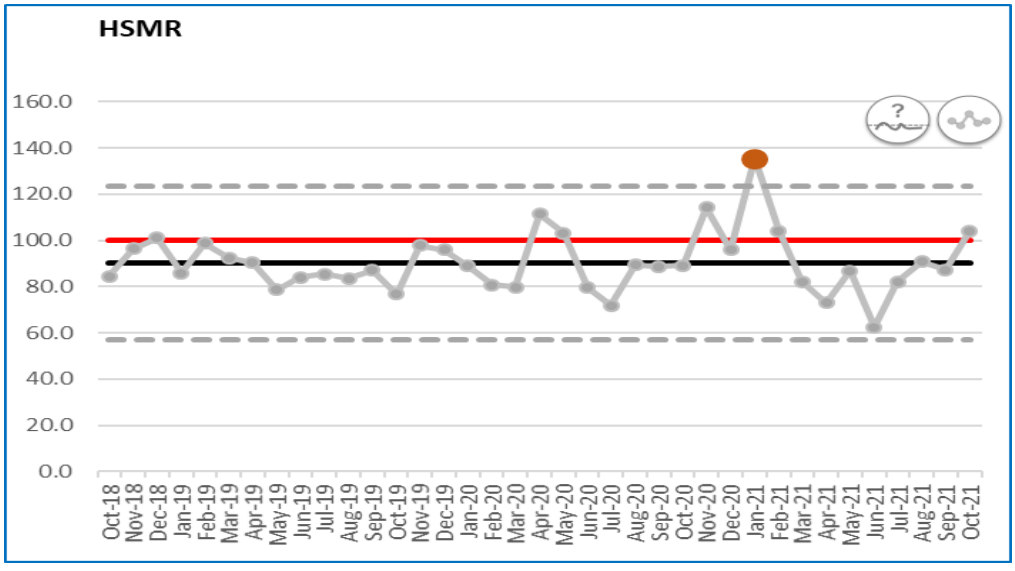

Chart 1

2.3 HSMR by condition

Across both sites, during the period October 2020 to September 2021 the top three conditions where the number of deaths is higher than expected (defined as 'excess deaths') within the HSMR model, remain consistent with previous months. These are pneumonia, urinary tract infections and acute and unspecified renal failure. This is

based on the primary diagnosis code from the first episode of care and does not consider the identified cause of death. All of these were higher than the peer average and an increase from the previous year 2020/2021.

2.4 An audit has been undertaken to review patients who died during the period September 2020 to August 2021 where the primary diagnosis code was urinary tract infection. The findings were presented at the December Trust Learning from Deaths meeting. As a result, two further audits have been agreed to review in more detail cases from this cohort of patients where sepsis was identified as a cause of death and those which involved a readmission to hospital. These will be undertaken in collaboration with the Clinical Audit team. On completion, learning will be collated and shared within the Trust.

2.5 Similar audit work is currently underway for patients who have died where the primary diagnosis code was pneumonia and acute and unspecified renal failure, which may be referred to by clinicians as acute kidney injury (AKI).

2.6 RAMI – Risk Adjusted Mortality Indicator.

Chart 2 indicates the Trust RAMI performance to October 2021. The indicator remains just below the national target of 100, demonstrating performance in the better-than-expected range. The RAMI indicator excludes COVID-19 patients.

The Trust's RAMI position is below the peer average.

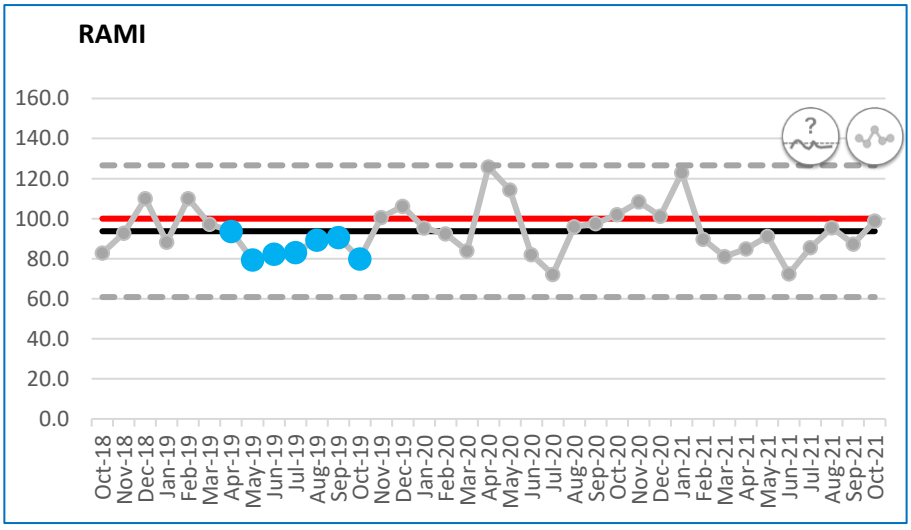

Chart 2

2.7 RAMI by condition

The top conditions where the number of deaths is higher than expected (defined as 'excess deaths') within the RAMI model, are consistent with the HSMR model - pneumonia, urinary tract infection and acute and unspecified renal failure although septicaemia is now seen as the condition with the second highest number of excess deaths. All except urinary tract infections have increased from the previous year and, other than pneumonia, were high compared to the peer. The recognition and escalation of sepsis and the deteriorating patient are incorporated within Care Quality Commission (CQC) action plans and Quality Standards.

2.8 HSMR and RAMI data for admission / attendance on a weekend versus weekday

The trend for both HSMR and RAMI indicators is higher for admissions and attendances at the weekend versus weekdays however this is a similar trend to the peer. The higher HSMR at PRH for admissions on a Saturday versus the peer group continues, however the latest data from CHKS shows a slight improvement. This remains under review and a plan to target mortality reviews for this group of patients is currently in progress.

2.9 SHMI – Summary Hospital-level Mortality Indicator.

SHMI data includes both deaths in hospital and those which occur within 30 days of discharge.

The Trust's SHMI long term trend from the latest available 12-month period up to the end of June 2021 is comparable to the peer average. There has been a decreasing trend in the Trust's SHMI since February 2021, with a particular decrease at RSH noted following the previous upward trend.

2.10 SHMI by condition

The condition groups with the highest number of 'excess deaths' within the SHMI model are consistent with both the HSMR and RAMI models – pneumonia, urinary tract infection and acute and unspecified renal failure. Additionally, work is planned to review deaths allocated to the SHMI condition group 'anaemia' as the latest CHKS data shows the number of 'excess deaths' in this condition to be higher than the peer.

3.0 Learning from Deaths

3.1 The existing paper based CESDI mortality review form will be withdrawn in January 2022. The Structured Judgement Review Plus (SJRPlus) tool will then be the exclusively available approach for clinicians to undertake mortality reviews. The expectation is that the Trust should then meet the target advised by NHSE/I where 15-20% of all deaths are reviewed using the SJRPlus. To support appropriate identification of cases for review, a screening tool has been developed with the Information Technology team within the Shrewsbury and Telford Hospital NHS Trust. This will be piloted with clinical teams prior to full implementation. A paper detailing the new operational process for Learning from Deaths was approved at the December 2021 Quality Operational Committee (QOC).

3.2 Mortality case reviews

In Q2 2021/2022 just under 5% of all deaths within The Shrewsbury and Telford Hospital NHS Trust received a mortality review using the SJRPlus. This percentage will increase when the existing paper based CESDI review tool is withdrawn and the available resource to complete the SJRPlus increases.

Q2 Total deaths (Inpatient and ED)	477
Deaths in Q2 flagged for mortality review by Medical Examiner	35
Completed mortality reviews from Q2 for cases flagged by Medical Examiner	14
Total number of mortality reviews undertaken for patients who died in Q2 (CESDI or SJRPlus)	111
Number of CESDI mortality reviews in Q2	89
Number of mortality reviews using the SJRPlus in Q2	22

Appropriate referral through the Trust Incident Management process is triggered based on preventability and harm ratings. Using the CESDI tool this is determined by a score of 2 or 3. The SJRPlus tool criteria is determined following recognition of any harm and by provision of a Hogan score relating to preventability and the NCEPOD grade relating to quality of care. These will be judged by the reviewer and it is expected that any referral for investigation through the Trust Clinical Incident Management process will be undertaken following discussion within Divisional / Speciality Governance and Mortality and Morbidity (M&M) meetings.

Number of cases with a CESDI score of 2 in Q2	3 - none of these cases have been referred for management through the Trust Clinical Incident Management process
Number of cases where a patient has died and there is an internal serious incident investigation in Q2	0
Number of cases where a patient has died, and an external serious incident has reported in Q2	6 - comprehensive investigations into each serious incident are undertaken with lessons learned and recommended actions identified

3.3 Deaths of patients with confirmed learning disabilities

During Q2 2021/2022 there were three deaths of patients with a confirmed learning disability. Two of these cases have undergone a mortality review and no concerns in care were identified. A mortality review is currently in progress for the third case. All three cases have been referred for a LeDeR review (Learning from deaths of people with a learning disability).

3.4 Mortality Triangulation Group (MTG) - originally referred to as Mortality Operational and Triangulation Group (M.O.T)

The Learning from Deaths Leads have established a weekly meeting to facilitate improved oversight and triangulation of learning. This will facilitate the operational Learning from Deaths processes and ensure that the appropriate pathway to manage individual cases is agreed. This aims to avoid duplication of reviews or investigations, ensure appropriate referral and facilitate clarity for the bereaved.

Current membership is the Trust Medical Mortality Lead (or deputy), Trust Mortality Lead (or deputy), Medical Examiner Service Manager (or deputy) and Head of Legal (or deputy). Membership will extend to include appropriate representation from the new Divisional Quality Governance Teams early in the new year. The meeting is evolving at pace, with the terms of reference, reporting structure and associated meeting templates being developed. Learning identified during Medical Examiner scrutiny has been shared with the Trust Learning from Deaths group and it is envisaged that the wider representation at divisional level will facilitate the sharing of learning directly with clinical teams.

Learning identified to date includes the following (the numbers are small and will therefore be monitored for themes and trends):

a. When a patient has been deemed fit for discharge but there is a delay to the discharge occurring, if the patient becomes more unwell, the patient must be seen medically.

b. Potential delays with the ambulance service attending the patient. These cases have been referred to West Midlands Ambulance Service for review.

c. Clinical teams to involve the Frailty Team when appropriate.

d. Earlier decision making to support patients to be able to die at home.

e. Early identification of the need for End-of-Life care especially with regards to the need to communicate with families.

3.5 Learning from Deaths dashboard

The Trust Mortality Lead and the Medical Examiner Service Manager are working with the Trust Informatics Team and NHSE/I to develop the mortality dashboard, incorporating both qualitative and quantitative data. It is hoped that this will be available early in 2022. Once the dashboard goes 'live', reports will be available for dissemination across the Trust so that learning opportunities will be maximised. The new Quality Governance framework now in place across the Trust will play a vital role to further support, maximise and evidence all available learning opportunities arising through the Learning from Deaths agenda.

3.6 NICHE recommendations

The action plan details 19 recommendations relevant to The Shrewsbury and Telford Hospital NHS Trust. The actions from 16 of these are complete. It is anticipated that the outstanding 3 actions will be completed by the end of March 2022.

4.0 COVID-19 Mortality

4.1 Throughout the first wave, second wave and to the end of December 2021, there have been 133 patients identified with probable or definite hospital acquired COVID-19 based on definitions provided by NHSE/I and Public Health England. All these cases have been uploaded to the National Reporting and Learning System (NRLS). One collective serious incident has been reported which is currently under investigation by the Patient Safety team with support from the Infection Prevention Control team using a combined thematic approach. Duty of Candour is being addressed. Reviewing these deaths collectively is in line with NHSE/I guidance and is an approach adopted by other Trusts.

Acting and Co-Medical Directors

January 2022