Ashford and St. Peter's Hospitals
NHS Foundation Trust

Trust Board
28 July 2022

AGENDA ITEM NUMBER	15.4	
TITLE OF PAPER	Learning from mortality review report Q4 2021-22	
Confidential	**No**	
Suitable for public access	**Yes**	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
Quality of Care Committee July 2022		
STRATEGIC OBJECTIVE(S):		
Quality of Care	✓	This report provides details and assurance on mortality at Ashford and St Peter's Hospitals NHS Foundation Trust. Learning from deaths is a key aspect of our Quality objective to become a learning organisation.
People		
Modern Healthcare		
Digital		
Collaborate		
EXECUTIVE SUMMARY		
	This report gives details on mortality for the months of January-March 2022 which is Q4 2021-2022. Included within this is a review of the screening and structured Judgement reviews (SJRs) of in-hospital deaths, with analysis of the findings and phases of care. The report also provides detail of the learning and the plans for sharing of this learning throughout the organisation. In Q4 2021-2022 there were 325 inpatient deaths, this includes two paediatric deaths and two neonatal deaths. There were a further 33 adult deaths in ED and one paediatric death, bringing the total in hospital deaths to 359. This resulted in a total of 354 adult deaths (inpatients and ED) within the scope of the SJR process. The RAMI chart shows that the Trust continues to track above our peers. Historically we have always had a slightly higher RAMI than our peers, but still remained with a median below the RAMI 100. The sustained increase above our peers from October 2021 coincides with occurrences of deaths on Willow Palliative Ward, we are looking as this in greater detail to include a review of data and coding. This ward houses patients who would previously have been discharged and had their palliative care in the community. Nonetheless the Trust's RAMI remains at a median of 86.28 at end of Q4 2021-2022.	

	During Q4 2021-2022 the Trust recorded 53 COVID-19 deaths. An up to date (end of June 2022) report of COVID-19 mortality is contained within the Quality Report going to board this month. Of these deaths 71.9% in January, 78.2% in February and 65.0% in March have had an initial screening completed. 27 cases have been identified for an SJR. At the time of writing this report, of the total Q4 2021-2022 SJRs, eight have been completed. Three of the required four SJR's for patients with learning disabilities have been completed with no issues in care. Where we are able to identify such factors the SJRs of patients with additional vulnerabilities, inclusion groups and those at risk of health inequalities are prioritised.
RECOMMENDATION:	
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	YES
Patient impact	YES
Employee	
Other stakeholder	
Equality & diversity	YES
Finance	
Legal	
Link to Board Assurance Framework Principle Risk	
AUTHOR	Yvonne Jones, Head of Clinical Effectiveness
PRESENTED BY	David Fluck, Medical Director
DATE	21 July 2022
BOARD ACTION	Receive for assurance

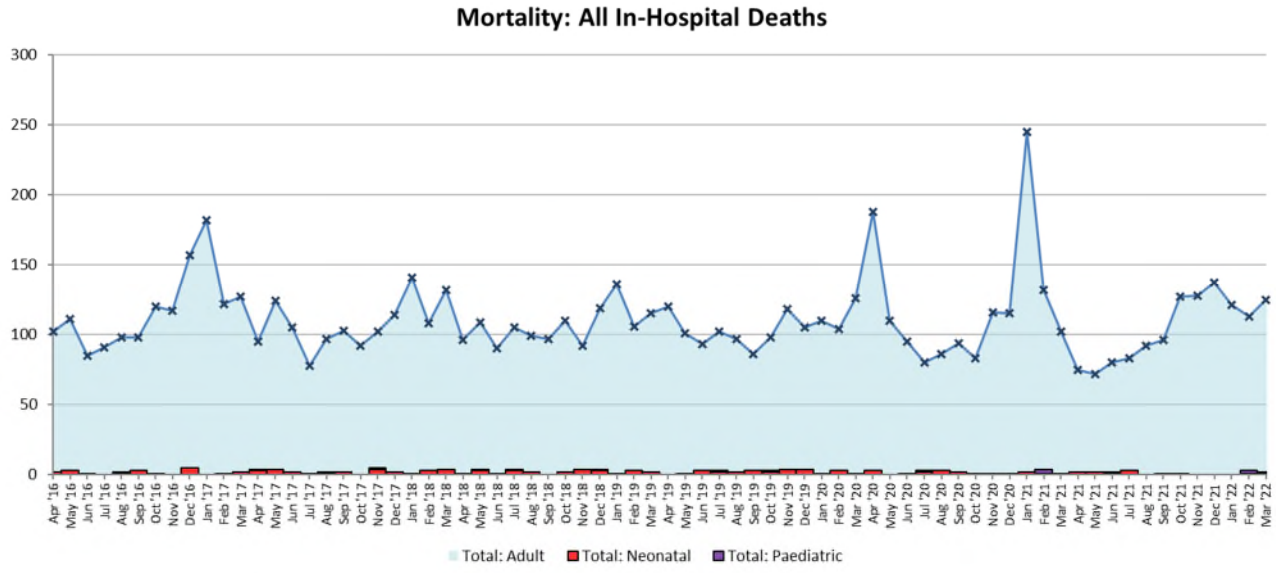
1. BACKGROUND

In March 2017, the National Quality Board released the first edition of the 'National Guidance on Learning from Deaths' which aims to adopt a standardised approach to the review of and learning from deaths. In response to this, the Royal College of Physicians have been leading the National Mortality Case Record Review (NMCRR) programme which provided clear guidance on the resources required to carry out an adequate programme of mortality reviews, including the use of a Structured Judgement Review (SJR) tool to be used to review some in-hospital deaths.

In-line with this guidance, ASPH has an objective within the Quality of Care strategic objective to ensure that there is a timely review of all relevant deaths through the Structured Judgement Review (SJR) process by specifically trained healthcare individuals; and to ensure there are robust methods and environments created within the Trust by which sharing of learning and actions for improvement can be made.

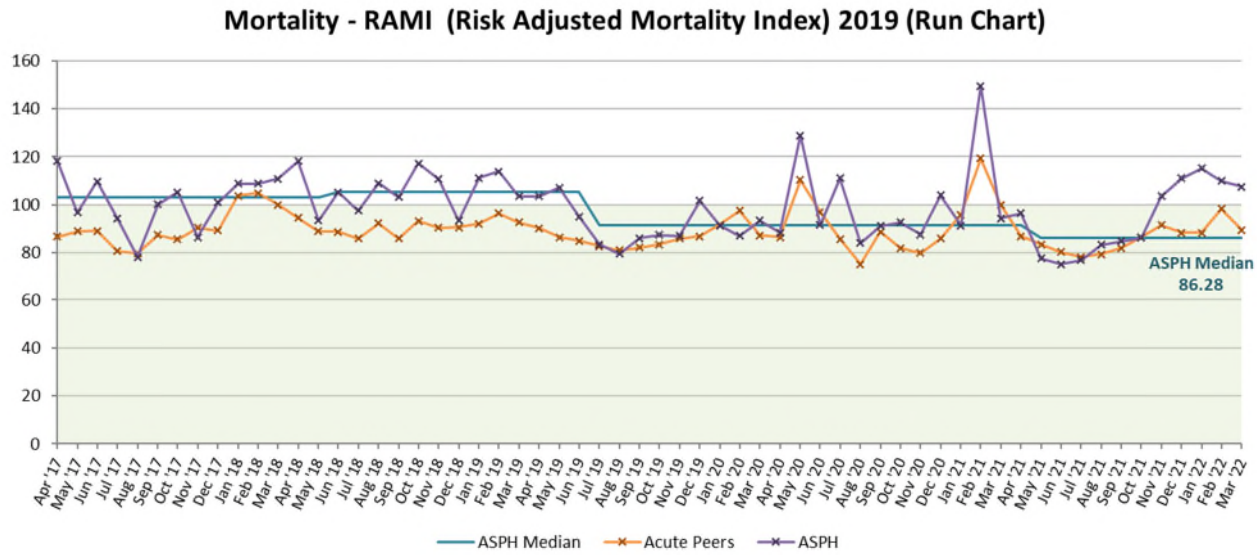
2. MORTALITY DATA

In Q4 2021-2022 there were 359 in-hospital deaths. To compare, in Q4 2020-2021, there were 479 in hospital deaths, in Q4 2019-2020 there were 340 deaths.



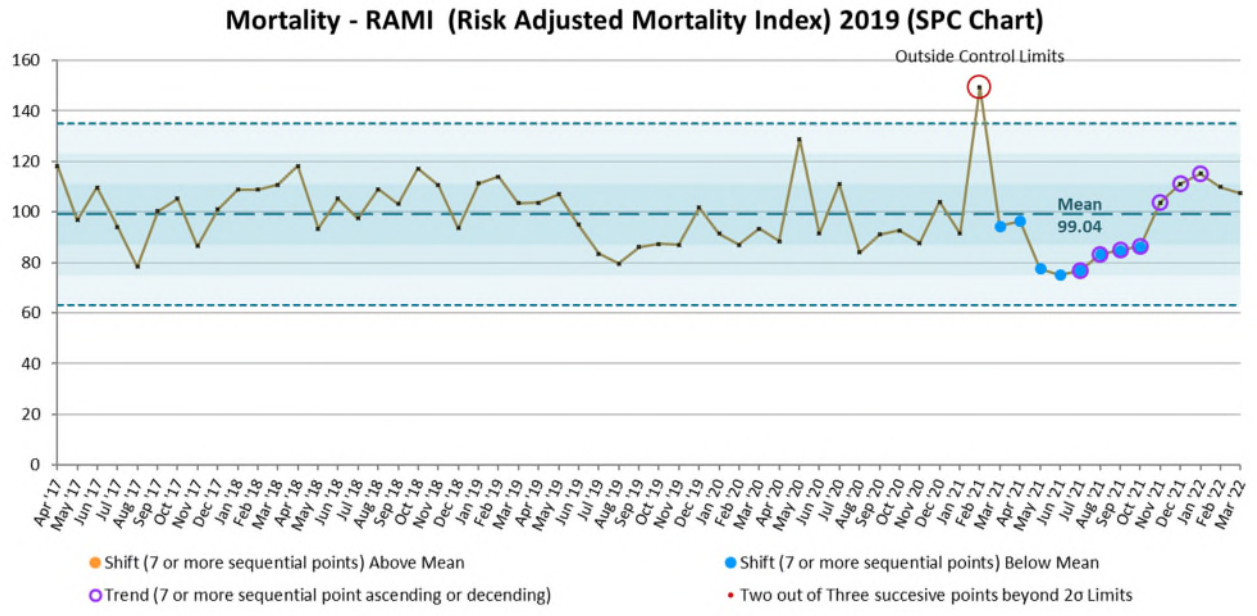
The in-hospital deaths comprised of 321 adult inpatient deaths, two inpatient paediatric deaths and two inpatient neonatal deaths (325 total inpatient deaths). There were a further 33 adult deaths and one paediatric death in ED. This resulted in a figure of 354 adult deaths (inpatients and ED) within the scope of the SJR process.

The Risk Adjusted Mortality Index (RAMI) is shown below. This excludes deaths 30 days post discharge, zero length of stay, palliative care code Z51.5 and maternity. The RAMI remains within common cause variation. The Trust's median trend line was at 91.40 at end Q1 then dropped to 89.79 at end Q2, and then dropped further to 84.13 for Q3, it has risen slightly to 86.28 for Q4 2021-22. This remains below the standardised RAMI 100 level. Whilst we are using RAMI to benchmark against our peers it is not considered a good indicator of quality of care; by definition 50% of hospitals will have a RAMI above 100. More significant is the percentage of deaths which are avoidable, and this is not benchmarked nationally.



The sustained increase above our peers from October 2021 coincides with occurrences of deaths on the newly instated Willow Palliative Ward. This houses patients who would previously have been discharged and had their palliative care in the community. Deaths coded as palliative should be excluded from the RAMI. Death data has been downloaded from CHKS from Jan 2022 to June 2022 and cross checked against the Trust's mortality file. There are 286 deaths on Willow in the period, of which 192 are listed in CHKS as spells against the RAMI measure. Based on this data there is a concern that patients receiving end of life care are being recorded in our RAMI. Further work to validate this data has started and will be reported to the committee once complete.

The mortality SPC chart below only tracks Trust data but shows that the recent increasing trend in deaths was preceded by shift of 8 points below the mean indicating a period of lower deaths.



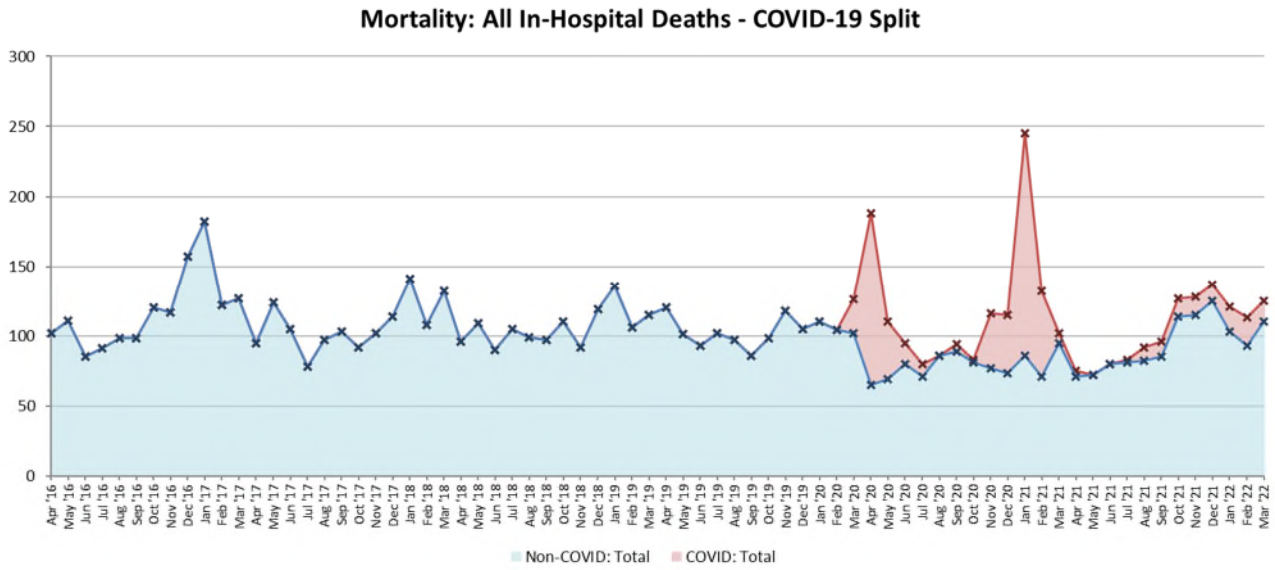
Four of the deaths in Q4 (three in January, and one in February), were people identified as having learning difficulties. Three of these reviews have been completed and scored as adequate or good care. In the fourth case there has been a delay in the notes being uploaded on to the electronic record (Evolve). The SJR's on patients with learning disabilities are being prioritised in the plan to address the SJR backlog. We also prioritise SJRs in groups at risk of health inequalities where we are able to identify such cases from the demographic information held. We did not identify any SJRs required in patients in inclusion groups for Q4, however one patient with additional vulnerabilities was identified.

From October 2017, full structured judgement reviews (SJR) have been carried out on any deaths meeting certain minimum criteria (described in Appendix A). These include any death where bereaved families and carers, or staff, have raised a concern about the quality of care provided; any deaths of patients with learning disabilities or with severe mental illness; any deaths following elective procedures; as well as a further sample of other deaths. From Q3 2018-2019 we have not routinely conducted SJRs on a random sample of deaths as an audit of reviews up until that point demonstrated no evidence of poor care. We have thus chosen to only perform SJRs on those triggered via the initial mortality review or any other raised concerns. Additionally, all Hospital acquired COVID-19 deaths are subject to a review using SJR methodology and reported as Serious Incidents.

3. COVID-19

In Q4 2021-2022 the Trust recorded 53 COVID-19 deaths, an increase from Q3 2021-2022 when the Trust recorded 38 COVID deaths. A further up to date review of COVID-19 deaths is contained within the Quality Report going to Board this month.

The split between COVID-19 and non-COVID deaths is shown below.

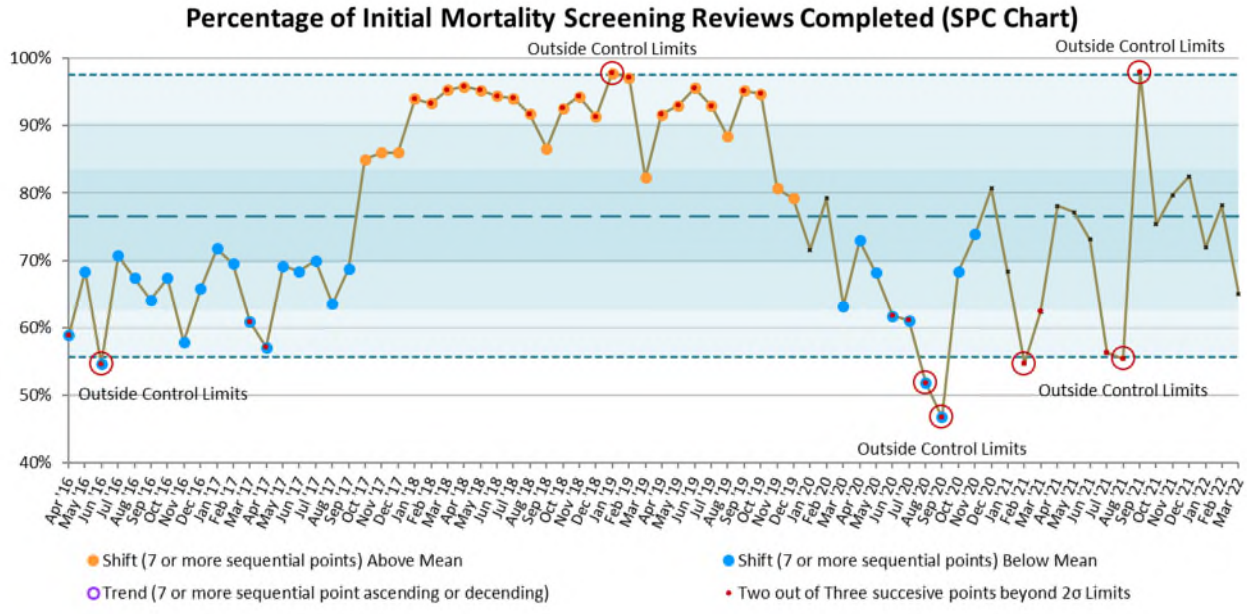


4. STRUCTURED JUDGEMENT REVIEWS AND INITIAL SCREENING

The Trust uses the methodology set out in the National Mortality Case Record Review (NMCRR) programme to perform structured judgement reviews (SJRs) of some in-hospital deaths. As part of the Quality of Care strategic objective the Trust aims to perform timely reviews of all relevant deaths identified by this methodology. Sharing of learning and actions for improvement is a key element of the approach which is facilitated through the Mortality Review Panel.

As at 17/6/2022 initial screening review completion via Mortality Review Form (MRF) stands at 72.7% in January, 78.2% in February and 65.9% for March, performance against the quality priority of completion within 48 hours has not seen an increase. Figures for overdue MRFs are now included in the speciality governance reports to aid escalation and discussed at Mortality Review Panel. Additional measures remain in place to identify cases that may need an SJR; these include checking Datix for staff or patient concerns, checking cases that require a post-mortem and scrutiny by the Medical Examiner. Furthermore, death of a patient with likely hospital acquired (HA) COVID infection (a new positive COVID swab result after 8 days in hospital), is an automatic trigger for an SJR. There are 11 potential cases of HA COVID which are being examined further to determine whether they are definite HA cases.

The SPC chart below shows total completion rate for MRF and is regularly updated to reflect the latest position of total screening completed. For the 2022-2023 quality priorities there is a continuation of the target that 95% of in hospital deaths will have an initial review within 2 days. The latest figure for this is reported in the Quality Report to QCC this month

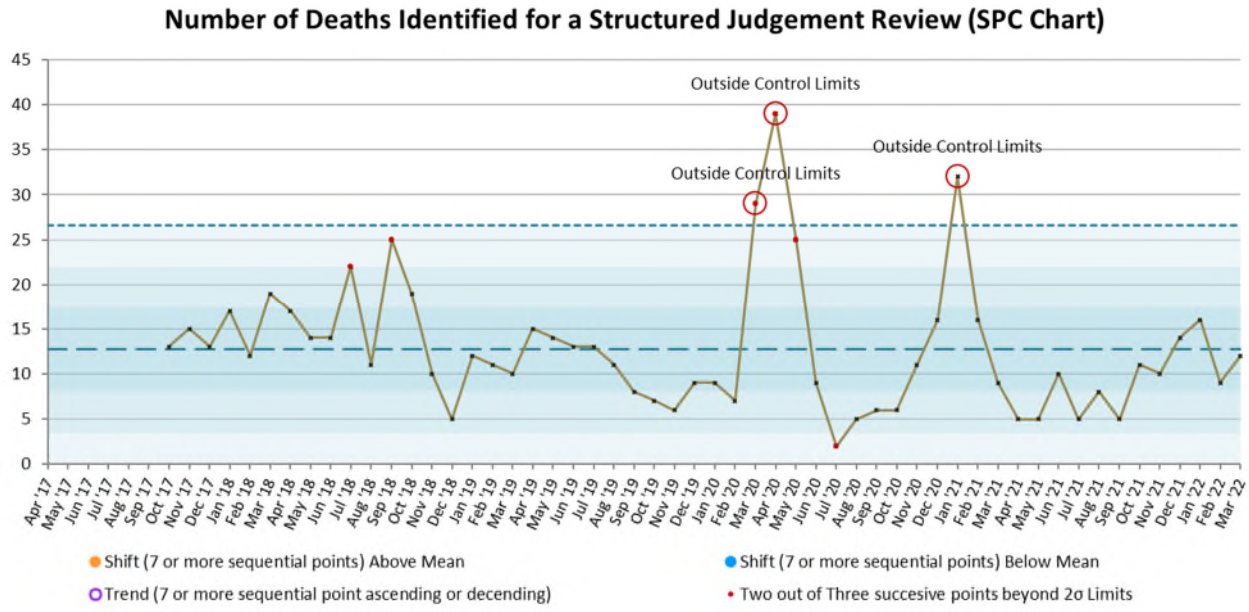


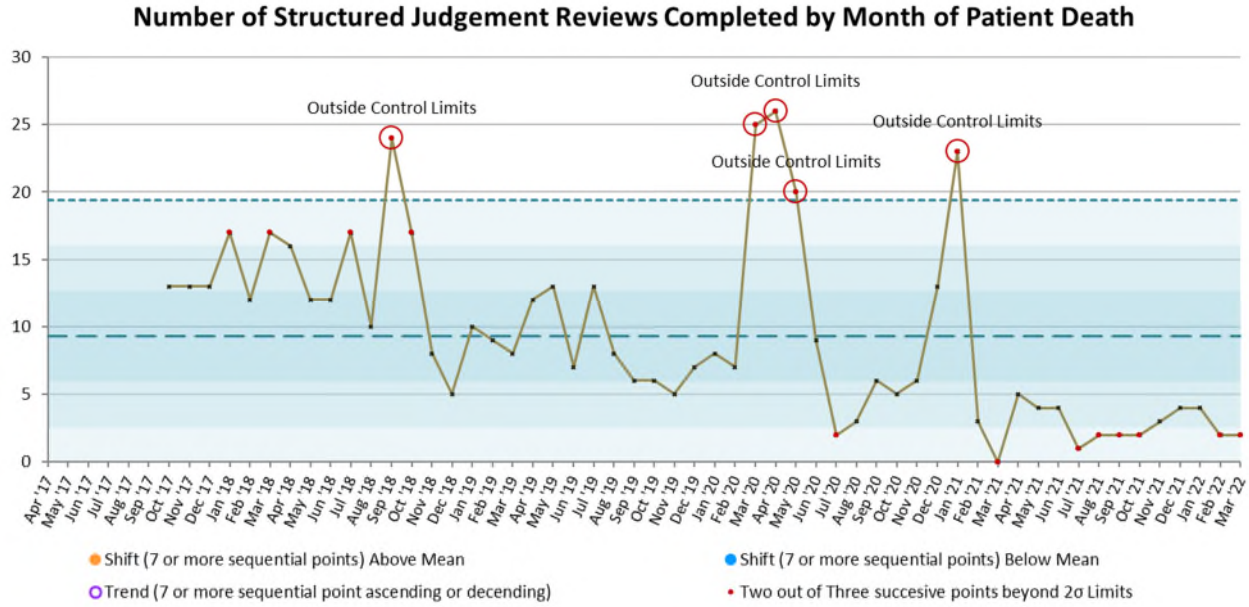
STRUCTURED JUDGEMENT REVIEWS COMPLETED

The SJR involves assessing different phases of care, writing explicit judgement statements and giving scores (from *'very poor care'* to *'excellent care'*). Each review is undertaken by a trained individual – either a nurse (Band 7 and above), AHP (Band 7 or above) or a Consultant (of any speciality). We are also taking steps to train Registrars to complete reviews as guidance from the Royal College of Physicians suggests that doctors in the later stages of training are appropriate, and often perceptive, reviewers.

There is usually a time lag with SJR completion, and the rate of completion has significantly increased and will be seen in the next report. In the previous LfD report, Q3 completion stood at three completed reviews, this has now risen to nine reviews which is 26%.

For Q4 2021-2022, 37 cases were identified for SJR. Of the total Q4 2021-2022 SJRs, eight (21.6%) have been completed to date. Nine additional SJR's have been completed during the Q4 period which relate to deaths in preceding reporting periods.



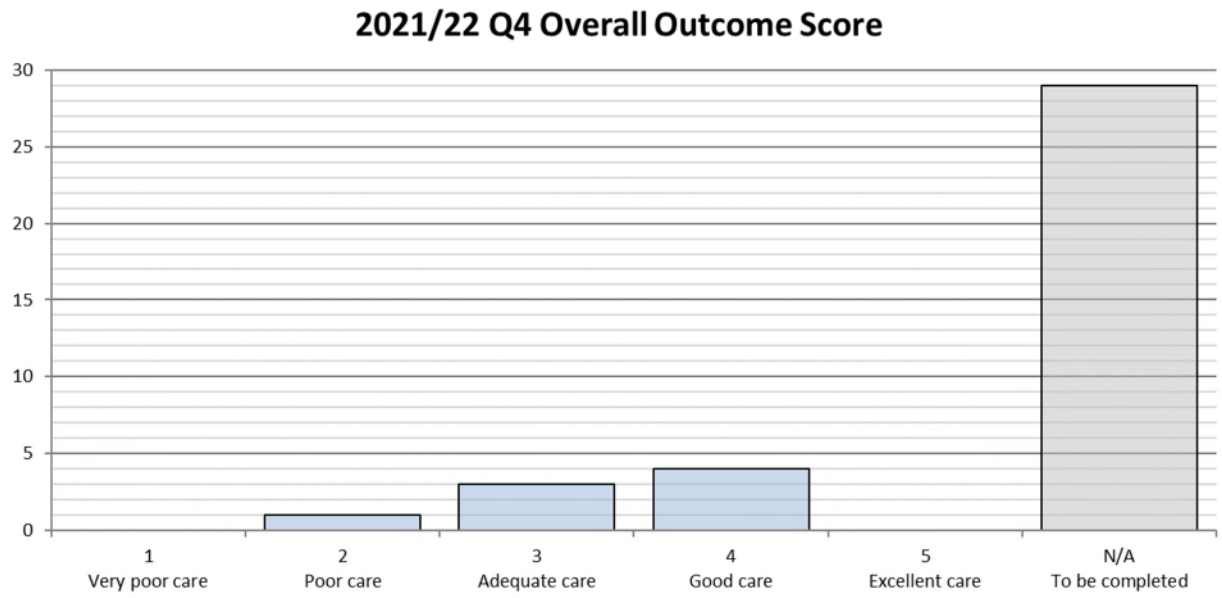


The new Mortality Improvement Lead post has been recruited to after the previous successful candidate withdrew, they are expected to start 1 September 2022. This new role is expected to reinvigorate the mortality review process, ensuring better engagement and involvement of families, ensure that reviews are carried out in a timely manner and to promote shared learning across the Trust and with our partners. A key part of the role, and contained within the business case for mortality improvement, will be a recruitment drive for further SJR reviewers now that there is agreement for them to be allocated paid sessions to complete their SJR work. There have been four new SJR reviewers trained since the Q3 report, with four more awaiting training. Additionally, three speciality registrars have also expressed an interest in being trained. In total there are now 22 trained SJR reviewers however, some of the existing reviewers have limited availability to take on SJR work.

4.1 PHASES OF CARE SCORES

The SJR requires recording explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Care is rated during each phase on a scale of 1 to 5.
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

To date, there are eight completed SJR for Q4.



The case that scored a 2 for poor care has had a second stage review which gave an outcome score of "Possibly avoidable but not very likely, less than 50:50". A summary of the case is included below.

5. ASSESSMENT OF CARE

This case involves a patient who re-attended ED as an emergency after having been seen the previous week and discharged with a plan of community heart failure review. The patient was found to have a high potassium and treatment was started to correct this which was successful. They were seen promptly by the Medical Registrar on -call and the Cardiology Consultant in the morning. Observations show the patient was stable but had an increased heart rate. Later in the day the patient collapsed whilst mobilising and resuscitation was unsuccessful.

The patient had previously indicated that they did not wish to be resuscitated but that they wanted to discuss this with family before completing a ReSPECT form to formally document this and this was never completed.

The stage one review found that there was some incomplete documentation and difficulty in ascertaining the events from the notes and because of this lack of clarity could not be sure whether there were missed opportunities. Due to the lack of evidence recorded, a grade 2 'poor care' score given.

The stage two review noted that it was unclear whether community follow up had occurred in between attendances. The reviewer also noted the lack of documentation after initial admission and in the few hours before cardiac arrest. It was felt that this may be because the patient appeared 'well' and was mobilising independently, including leaving the department to go outside. However, the reviewer had also found the notes during the first admission lacking in detail around treatment following a possible episode of deterioration.

Overall, because of the lack of detail across both admissions the conclusion was drawn that the death may have been avoidable, but was unlikely to be, due to an overall deteriorating picture of health.

6. LEARNING FROM DEATHS

Learning from SJR's is a standard agenda item for speciality governance meetings. A selected number of the cases are put forward by the speciality for discussion at the relevant Quality and Safety Half (QuaSH) Days. Departments and Divisions also hold regular Morbidity & Mortality (M&M) meetings throughout the year to allow time to review and reflect on learning from cases. Part of the new Mortality Lead role will be to facilitate a standardised approach to recording M&M meeting that records shared learning and ensure this is fed back into the governance processes and that deaths reviewed through M&M meetings are collated and contribute to figures for the total number of deaths reviewed by the Trust.

After the success of the Learning from Death events these are now linked with the Patient Safety Team and their similarly successful monthly Serious Incident learning events in order to provide a more consistent monthly / bi monthly combined learning event. The learning events continue virtually on MS Teams.

From Q3 2019-2020 the Mortality Committee had been incorporated into the bi-monthly Safety and Quality Committee (SQC). The Chief of Patient Safety chaired this meeting and presented a regular LfD gap analysis report within this meeting as a live document.

In place of this a separate Mortality Review Panel has since been established in Q4 2021-2022. The aim of the panel is to collate mortality reviews from the different sources and identify themes and learning and ensure this is more robustly disseminated both within the Trust and across the wider system. The Mortality Review Panel will report into SQC.

LeDeR
Learning from deaths of people with a learning disability and autistic people (LeDeR) was set up as a service improvement programme by NHS England. The aim was to investigate the reasons why people were dying and consider what changes were required both locally and nationally to improve people's health and reduce health inequalities. Reviews are conducted regionally, and Surrey Heartlands have shared their annual report for 2021/2022 with key findings and learning points:

- Women with learning disabilities, in Surrey, die 20 years sooner than women who do not have learning disabilities.
- Men with learning disabilities, in Surrey, die 14.7 years sooner than men who do not have learning disabilities.
- In 40% of the reviews completed, the person died as a result of aspiration pneumonia. This was a significant increase from last year where 7% of the deaths were due to aspiration pneumonia. A deep dive will be carried out by Surrey Heartlands ICS.
- In the last 3 years there were 5 choking deaths in Surrey. The LeDeR team were working with local speech and language therapists and safeguarding teams to review the learning from LeDeR and safeguarding enquiries, review the local training content / policies and develop a system action plan around choking. There were no choking deaths for patients with learning difficulties or for autistic patients in our Trust.

The Trust reported cases directly to the LeDeR programme and used a range of measures to ensure all applicable patients were identified. This included a coding check for deceased patients with autism which was previously not in place. The findings from LeDeR reviews are disseminated into the Trust via the Mortality Panel.

The LeDeR reviews shared provided both general feedback and learning for acute Trusts, as well as specific feedback in some cases. At the Trust's April 2022 Mortality Review Panel discussions noted there had been issues at acute Trusts with correct completion of ReSPECT forms and copies of advance care plans not being available in the hospital notes.

The Trust has received positive feedback from the LeDeR reviews in three specific cases. All involved good communication with family and/or carers and involving them in decisions and discussions around care. Positive feedback around reasonable adjustments such as increased visiting and placing a patient in a side room was received, and there have been no specific issues with care or actions for improvement for the Trust highlighted in the reports received in this period.

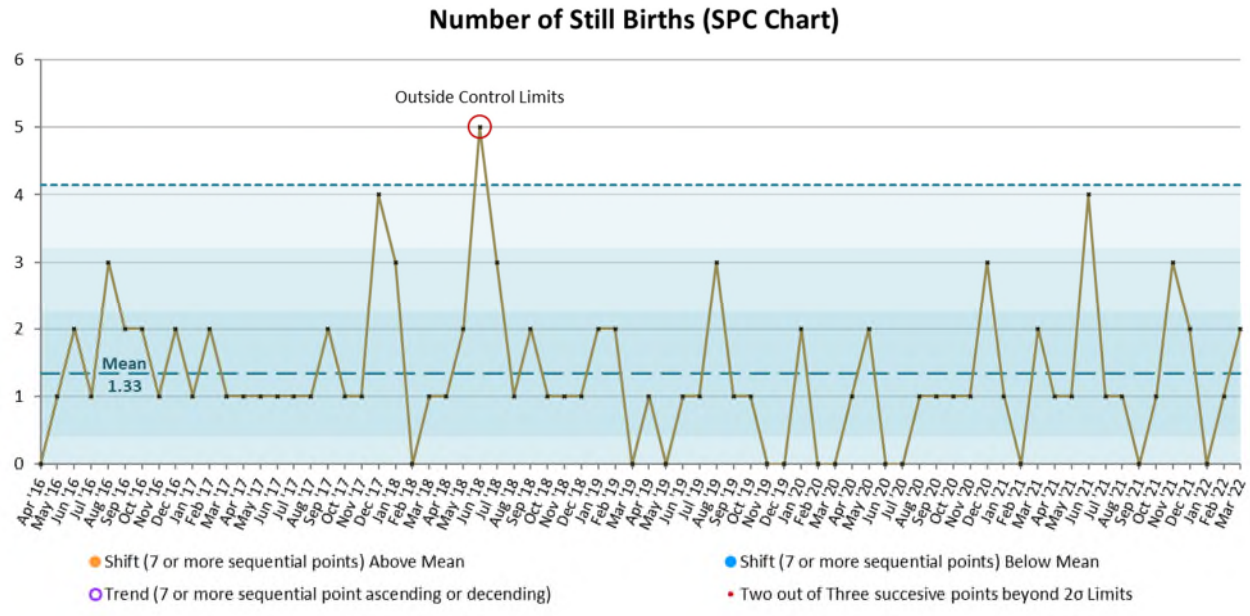
Triangulation with Serious Incident (SI) cases involving death

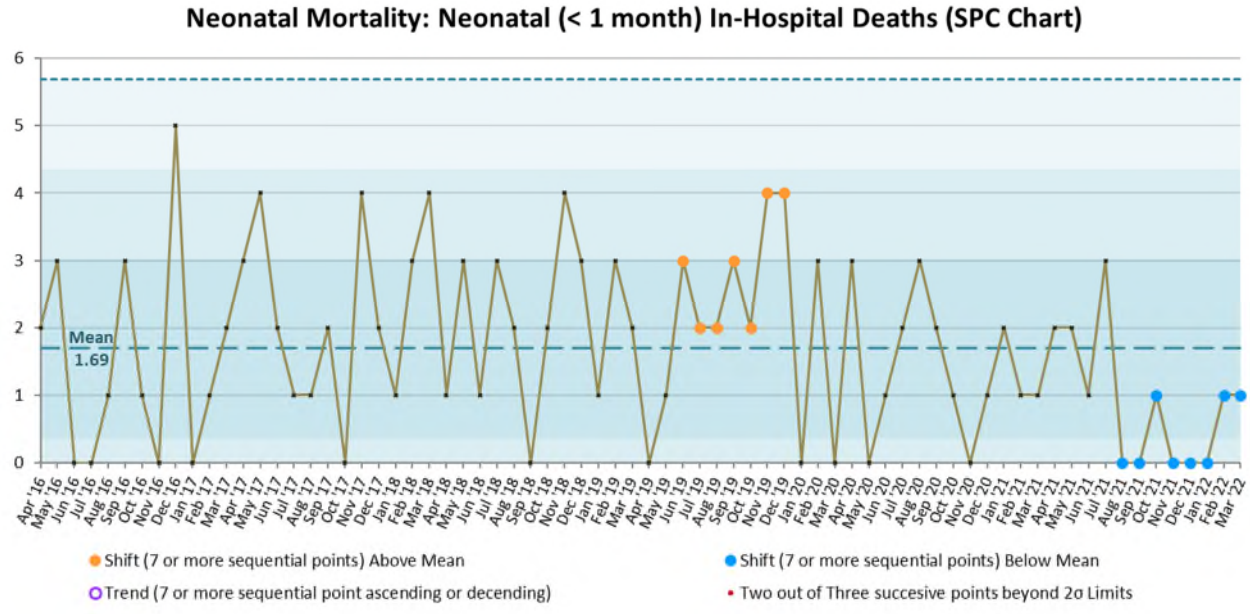
To aid monitoring and triangulation of potentially avoidable deaths, SI's relating to a patient death have been recorded in the table below. There have been two deaths in Q4 2021-2022 raised as SI's. It had been identified that some deaths were being subject to both SI and SJR reviews duplicating work. It has been agreed that any cases within the incident investigation framework, where the investigation centres on the death, do not also require an SJR. Whilst the SJR is different and can be complimentary to the SI investigative process it is felt that at present we should direct limited reviewer resource to other cases at this time.

Incident	Description	SI outcome	Outcome of SJR/ comments
W79211 July 2021	39-week gestation IUD	Report completed by HSIB. SI completed; mother presented with intrauterine death.	Not within scope of SJR process
W81789 Sept 2021	Psychiatric patient discharged from ED. Deceased following day.	SI completed. Patient died in the community, brought to ED deceased.	Not within scope of SJR process
W83375 Nov 2021	40-week gestation IUD	SI completed; mother presented with intrauterine death.	Not within scope of SJR process
W83309 Nov 2021	Unexpected potentially avoidable death	SI completed, arrived in ED in cardiac arrest.	Flagged as an incident by Medical Examiner's Office.
W81456 Nov 2021	Unexpected cardiac arrest	SI report is overdue to CCG	Unexpected cardiac arrest
W83081 Nov 2021	Treatment delay meeting SI criteria-died whilst awaiting surgical review	Investigation underway	Straight to SI
W83812 March 2022	Treatment delay-learning disability patient (death Nov 2021)	Investigation underway	SJR identified issues in care and as a result case escalated to SI.
W86892 March 2022	Treatment delay-diabetic Keto-acidosis	Investigation underway	Straight to SI

7. PERINATAL DEATHS

During Q4 2021-2022, there were three stillbirths and two perinatal deaths. There is now a separate Perinatal Mortality Review Tool (PMRT) report that is submitted to QCC by Women's Health and Paediatrics division which details learning from cases reviewed.

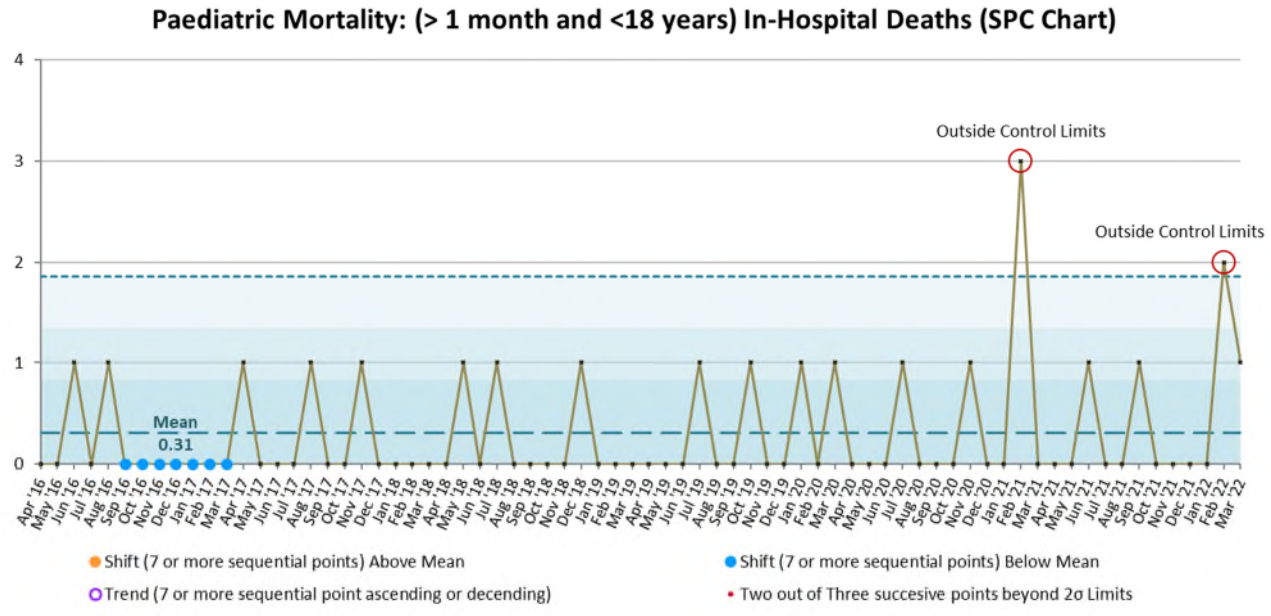




8. PAEDIATRIC MORTALITY

There were three paediatric deaths in Q4 2021-22. One of these was a baby on NICU who died at greater than one month old. The other paediatric inpatient death was in a child admitted with seizures on a background of a life limiting condition. This case has been referred for Child Death Review.

The child recorded as having died in ED had an advance care plan for end of life and was not for resuscitation. However, an ambulance was called when patient became unresponsive at home and resuscitation was started by the family and carer. The child had no signs of life on arrival at ED.



9. MEDICAL EXAMINER (ME)

The Medical Examiners team have provided the following update:

Due to the Community roll out, interviews were conducted before Christmas to recruit Medical Examiners (MEs) and Medical Examiner Officers (MEOs). MEOs were recruited on 7th March 2022 and they were later joined by three additional MEs. Community roll out was quite slow at the beginning of the year. Surrey Heartlands Primary Locality team experienced some technical difficulties with the eRS (electronic referral service) protocol, and this did have an impact on our GP pilot with The Grove Medical Practice. However, the ME office onboarded Chertsey Health Centre and the protocol has since been corrected.

The ME Office hope to start working with Southview Practice towards the end of April 2022. This means successful achievement of a referral base over all three areas of the North West Surrey GP Practice catchment, SASSE 3, Thames Medical and Woking. The ME office predicts 3-4 referrals per practice, per week and hope to roll out the eRS service further in the next few months.

The ME Office have been invited to join the pilot known as 'Consultant Connect' which is a smart communication tool for local GPs, which is being explored. The financial year ended with the "Spring Meeting" where we talked through Coroner referrals (mesothelioma and how we can provide supplemental information when referring) and the repeal of the Coronavirus Act 2020 and how this will affect every day working.

APPENDIX A

A full description of the criteria being applied to select the cases for SJR is below:

Criteria for SJR case selection	Details
Any death where bereaved families and carers have raised a concern about the quality of care provided.	Any adult, inpatient death where a complaint or PALS contact has been raised as identified by the Divisional Governance teams Any adult, inpatient death where 'Have family members or carers raised a significant concern about the quality of care provision?' is indicated on the mortality screening form as identified by the Ward team
Any death where a member of staff has raised a concern about the quality of care provided.	Any adult, inpatient death where a DATIX incident has been raised as identified by the Divisional Governance teams Any adult, inpatient death where 'Have any staff members raised a significant concern about the quality of care provision?' is indicated on the mortality screening form as identified by the Ward team Any adult, inpatient death which has been identified as either 'Definitely avoidable', 'Strong Evidence of avoidability or 'Some evidence of avoidability' by the Consultant completing the mortality screening form
Any death of a patient with learning disabilities or with severe mental illness.	Any adult, inpatient death of a patient with learning disabilities or with severe mental illness as identified by the Divisional Governance teams Any adult, inpatient death where 'Did the patient have a learning disability? or Did the patient have a severe mental illness?' is answered positively on the mortality screening form as identified by the Ward team
Any deaths following an elective admission.	Any adult, inpatient death with a spell coded with admission method of 11, 12, or 13 Any adult, inpatient death where 'Is this a death in an area where people are not expected to die? (e.g. patients attending for a routine elective procedure)' is answered positively on the mortality screening form as identified by the Ward team
A further sample of other deaths.*	A 5% random sample of all other deaths occurring in the month Any adult, inpatient death where 'Do you have any other cause to think that this death would benefit from a mortality review?' is answered positively on the mortality screening form as identified by the Ward team

* From Q3 2018-2019 we have not conducted SJRs on a random sample of deaths as an audit of reviews up until that point demonstrated no evidence of poor care. We have thus chosen to only perform SJRs on those triggered via the initial mortality review or any other raised concerns.

APPENDIX B - AVOIDABILITY OF DEATH JUDGEMENT SCORE

As part of completing a second stage, the reviewer is asked to make a judgement on the 'avoidability of death' in the case.

This is based on the Royal College of Physicians Structured Judgement Review Data Collection Form.

Mortality Review Form
Stage 2 - Structured Judgement Review

Avoidability of Death Judgement Score

We are interested in your view on the avoidability of death in this case.

Please choose from the following scale (tick one score).

☐ **Definitely avoidable**

☐ **Strong evidence of avoidability**

☐ **Probably avoidable (more than 50:50)**

☐ **Possibly avoidable but not very likely (less than 50:50)**

☐ **Slight evidence of avoidability**

☐ **Definitely not avoidable**

APPENDIX C: STRUCTURED JUDGEMENT REVIEWS COMPLETED BY MONTH DUE update chart

Updated 6th June 2022

Summary total deaths and total number of cases reviewed under the Structured Judgement Review Methodology													
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Cumulative (2021/2022)
Total number of adult inpatient deaths	67	69	73	77	86	88	116	123	126	110	96	115	1,146
A&E deaths (in scope from July 18)	6	1	5	3	6	7	10	5	11	11	14	8	87
Total number of deaths in scope	73	70	78	80	92	95	126	128	137	121	110	123	1,233
% of deaths receiving initial review	78%	77%	73%	56%	55%	98%	75%	80%	82%	72%	78%	65%	75%
Number of cases requiring an SJR	5	5	10	5	8	5	11	10	14	16	9	12	110
Total deaths receiving Structured Judgement Review	4	4	4	1	2	2	2	3	4	4	2	0	32
Percentage of SJRs completed	80%	80%	40%	20%	25%	40%	18%	30%	29%	25%	22%	0%	29%
Percentage of SJRs completed (by quarter)		60%			28%			26%			16%		
Total Number of reviewed deaths considered more likely than due to problems in care	0	0	0	0	0	0	0	1	0	0	0	0	1
Number of deaths of people with learning disabilities	2	0	0	0	1	3	1	2	2	3	1	0	15
Number of deaths of people with learning disabilities that have been reviewed	2	N/A	N/A	N/A	1	2	1	2	1	2	1	N/A	12
Number of deaths of people with learning disabilities considered more likely than not to be due to problems in care	0	N/A	N/A	N/A	0	0	0	1	0	0	0	N/A	1