Airedale NHS
NHS Foundation Trust

Report to:	Board of Directors				
Date of Meeting:	27th January 2016				
Report Title:	Self-Assessment on Avoidable Mortality				
Status:	**For information**	**Discussion**	**Assurance**	**Approval**	**Regulatory requirement**
Mark relevant box with X				X	
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Executive Sponsor (presenting):	Karl S Mainprize, Executive Medical Director				
Appendices (list if applicable):					

Purpose of the Report

To present the new mandatory avoidable mortality review and the adjustments to the Airedale NHS FT Learning from Mortality Process.

Key points for information

The NHSE National Medical Director and the NHSE Director of Patient Safety wrote to the Executive Medical Director outlining a process that they wish to be followed around the scrutiny of mortality and avoidable mortality (Appendix 1 Mortality Governance Guide).

As part of the Quality Improvement Strategy we had already developed a new Learning from Mortality process, including guidance on the identification and extraction of learning from Potentially avoidable mortality, which was started in November 2015. This paper outlines a revision to that process to comply with the Mortality Governance Guide in appendix 2. The revised process is included as appendix 1.

It is proposed that we will set up a Mortality Surveillance Group which will scrutinize mortality and trends in mortality further and provide a report on a monthly basis to Board, attached as an appendix to the monthly Quality Account. This will be set up and start reporting in February 2016. The Terms of Reference are included in the Mortality Governance Guide.

The Mortality Governance Guide also outlines the type of questions that the non-executives are expected to ask of the executives around mortality.

Recommendations

That the Board approves the proposed revision of the Learning from Mortality process and is cognizant of the expectation placed upon it by the NHSE National Medical Director and the NHSE Director of Patient Safety.

Mortality Governance Guide

This document seeks to provide some basic guidance around mortality governance and how a focus on clinical care should be the Board's highest priority. This will also help prepare trusts for a programme of work underway in NHS England's Patient Safety Domain, around standardising retrospective case record review (RCRR) for in-hospital deaths. Whilst this guidance is largely applicable to acute trusts, there is clearly a need for similar processes in Community and Mental Health services and Ambulance Trusts in order to allow the Board to gain assurance on the quality of patient care. This is especially the case as the system moves towards greater integration of care delivery.

General Principles

While most hospitals undertake some form of mortality review, there is wide variation in terms of methodology, scope, data analysis, and contribution to learning. By establishing a consistent process of reviewing care through a structured analysis of patient records, we aim to improve the quality of care by helping hospitals to learn from problems that contribute to avoidable patient death and harm. NHS England has commissioned HQIP to manage procurement of development of a standardised methodology and training roll out to all NHS trusts in England. A supplier will be in place by January 2016, with a pilot expected to start in Q1 2016/17.

Whilst those that die will account for 3% or less of those admitted to an acute hospital, concentrating attention on the factors that cause those deaths will also impact positively on all patients, reducing complications, length of stay and readmission rates. This is through the mechanism of improving pathways of care, reducing variability of care delivery through the use of care bundles, and early recognition and escalation of care of the deteriorating patient. Retrospective case record review will identify examples where these processes can be improved and this information needs to be constantly fed back to clinicians. Furthermore, it will be possible to gain an understanding of the care delivered to those whose death is expected and inevitable. In many organisations this group of patients does not receive optimal care, often because the diagnosis (i.e. this person is dying) is not made or the necessary expertise is in short supply.

In time it will be possible to raise awareness amongst clinicians and managers of the need to promote best practice and behaviours, reduce variability, and make the focus on mortality everyone's business. It should become the subject of formal and informal conversations, from the Board room to the coffee room. Therefore, attention to the issues discussed in this document is relevant for all NHS providers, not just those for whom there are judged to be concerns around mortality.

Governance Processes

Mortality governance should be a top priority for trust Boards. Executive and Non-Executive Directors should have the capability and capacity to understand the issues affecting mortality and to provide appropriate challenge. It is recommended that Trusts have in place the following or similar processes in support of mortality governance, which will also help prepare for roll out of the national RCRR programme.

1) All trusts should have a mortality surveillance group (MSG), with multidisciplinary and multi-professional membership

The primary role of the MSG is to provide assurance to the Trust Board on patient mortality. Mortality indicator statistics do not in themselves constitute evidence regarding the standard of care delivered. Therefore, assurance must be based on review of care received by those who die as well as understanding the statistics. This group should review data on patient deaths, including results and learning generated by local mortality review, and consider strategies to improve care and reduce avoidable mortality. This should be chaired by a Board level clinician (i.e. the Medical Director or Director of Nursing). Serious consideration should be given to external membership from the local clinical commissioning group or NHS England area team and also a local service user/member of the public (e.g. a member of the local Healthwatch group). Attached at Appendix 1 is an example of Terms of Reference for an acute trust mortality surveillance group. Terms of reference for other types of provider would be broadly similar although the use of benchmark data would be different.

In addition to contextual information about quality of care the MSG should also receive statistical information about all deaths in the Trust and should track those in the highest risk groups. In most Acute Hospitals the largest numbers of deaths are in those patients admitted as acute medical emergencies with the diagnoses of sepsis, pneumonia, stroke, myocardial infarction, and heart failure. Other important diagnoses are Acute Kidney Injury and fractured neck of femur. The hospital information department or a commercial provider should be able to provide regular reports of overall crude mortality and numbers of deaths by diagnostic groups. Further detailed information on for example, deaths by ward, at weekends, Bank Holidays can be reviewed on a regular basis.

National audits providing information on mortality at Trust level, such as ICNARC, TARN, the National Bowel Cancer audit, and other aspects of care including stroke (SSNAP) and myocardial infarction (MINAP) should also be used to identify areas where care may need to be improved.

It may be useful to understand the source of referral for patients who die within 24-36 hours of admission. A significant proportion of these are people who are inevitably at the end of their lives and admission to an acute or community provider may not be in their best interest. Many will be referred from nursing homes or their own homes despite the presence of an appropriate care plan. This is easily achieved by tracking admissions by postcode. Undertaking this type of audit may provide rich information for engaging with commissioners and other LHE partners. It will also provide valuable insights into how these patients are managed in the acute trust, whether decisions, interventions and care are appropriate for this group of patients bearing in mind the recommendations of the review “One Chance to get it Right”.

If there are concerns about a cluster of cases or a distinct diagnostic group (for example fractured neck of femur) as identified by an elevated mortality rate, adverse audit report, complaints, Deanery feedback or information arising from a Morbidity and Mortality meeting then a process as described in the section “Response to a mortality alert” (below) should be followed.

2) Mortality reporting to the trust Board

Mortality reporting must be provided regularly in order that Executives remain aware and Non Executives can provide appropriate challenge. This should be at the public section of the meeting with the data suitably anonymised. We would expect the Non Executives to satisfy themselves that appropriate governance processes are in place, that the Trust is providing safe care and that systems exist to detect and reduce the level of avoidable deaths. The type of questions we expect to be asked of the Executives are:

- *What process exists for review of all deaths?*
- *How many people died in the Trust last month?*
- *What are the 3 biggest causes of death in the Trust and the current mortality rates for these?*
- *What is the Trust's current overall crude mortality rate, HSMR and SHMI?*
- *How does the Mortality Surveillance Group (MSG) function, what information does it consider, who are its members and chair?*
- *How will the MSG maintain oversight of avoidable mortality and identify outliers?*
- *Are there any specialities, sub-specialties, diagnostic codes or times of the week for which the data suggest elevated mortality levels? What further analysis and actions are you taking?*
- *How will the MSG keep the Board informed about the work it does?*
- *What steps is the Trust taking to implement the advice from the Academy of Medical Royal Colleges regarding daily senior review and 7 day working in the Hospital?*
- *Is support from Critical Care outreach available 24/7?*

3) In order to understand the standard of care being delivered to those who die there needs to be a high level assessment of all deaths

This is quite achievable if the responsibility is distributed amongst all consultants in those specialties with large numbers of deaths (e.g. acute medicine). It is the responsibility of all registered medical practitioners to understand the outcomes of their clinical practice so this should form a core element of SPA time. In specialties with fewer deaths (e.g. orthopaedics), case note review can be undertaken by a nominated individual. For those patients on a supportive care pathway where death should be judged unavoidable, assessment is still necessary in order to provide assurance of appropriateness and standard of care delivered.

The national RCRR methodology will include a standard review proforma and two-staged review process. Until rolled out, local mortality review templates (ideally electronic) may be used for this initial assessment of all deaths and include: demographic details, mode of admission, initial clinical assessment, ongoing management including investigations and interventions, issues around infection and venous thromboembolism (VTE), nutrition and hydration, recognition of deterioration, use of critical care services, end of life care and appropriateness of cardiorespiratory resuscitation (DNAR) assessment. This is not an exhaustive or exclusive list. In order to improve clinician engagement it is worth considering, in collaboration with the clinical teams, developing bespoke templates for different groups of patients e.g. acute medicine, acute abdomen, stroke, fractured neck of femur, end of life care as these patients will have different needs and their care should be informed by the relevant guidance from NICE, royal college or specialist association.

Standards from these guidance documents should be embedded into these review templates along with generic Trust standards for care. Please note: the national methodology will also include scope for local, specialist adaption to the review form.

If there is a desire to understand the level of avoidable mortality then deaths can be categorised using a stratification tool such as the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categorisation (see "Process for responding to a mortality alert" below). This is largely a subjective judgement which will also be supported by the national methodology, based on the PRISM studies.

If there are found to be concerns about the standard of care then the case must be reviewed in-depth by a multidisciplinary team. This should be at a regular departmental morbidity and mortality meeting with representation from senior and junior doctors and nurses, and other AHPs as appropriate for that specialty. These meetings should have equivalent priority, administrative support and governance as other MDT meetings that exist to decide care in for example all cancer disciplines. The outputs from these meetings need to be recorded, especially conclusions about outstanding care and suboptimal care, both of which should be captured and sent on to provide data for the **MSG.**

Furthermore it might also be prudent to undertake a case note review as described in a selection of high risk diagnostic groups (typically for most acute trusts pneumonia, heart failure, sepsis, stroke, AKI, #neck of femur) at least annually in order to provide ongoing assurance. Redesign of the pathway of care for the group of patients concerned should be considered making use of care bundles and including advice from NICE, Royal Colleges and other professional groups on current best practice.

Given the known association between staffing levels (doctors and nurses) and clinical outcomes including mortality rates the MSG should pay particular attention to these issues at all times when reviewing a service or circumstance where concerns have been raised.

4) Process for responding to a mortality alert

It is not the purpose of this document to provide detailed advice on this as there other publications which cover this ("Dying to Know" published by Association of Public Health Observatories October 2010).

In summary if there are concerns about mortality in any particular patient group then it is necessary to undertake an in depth case note review. It is important to identify the correct cohort of patients. This may be obvious depending upon the source of the concern (e.g. CQC alert or elevated SMR for a particular diagnostic group) or may require further investigation (e.g. global high weekend mortality). Once this has been established then a review of the case notes for a reasonable consecutive sample of the patients who died (say 30 – 40) by a relevant multidisciplinary group should be undertaken in order to establish whether the clinical care those patients received was appropriate or not. The review group should decide the criteria to be used for judging the standard of care much in the same way as the high level template described above although in this situation more detail may be required. This group will need adequate time and administrative support. There should be a lead person identified who will be responsible for the review and writing up the result.

The care should be categorised. The standardised RCRR methodology will include direction on categorisation, but in the interim, a useful approach is to employ the Confidential Enquiry into Stillbirths in Infancy (CESDI) mortality classification bandings. Deaths are classified according to CESDI as follows:

- Grade 0- Unavoidable Death, No Suboptimal Care,
- Grade 1- Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).

Alternatively, the NCEPOD grading of care can be used:

- 1 = Good practice: A standard that you would accept from yourself, your trainees and your institution.
- 2 = Room for improvement: Aspects of clinical care that could have been better.
- 3 = Room for improvement: Aspects of organisational care that could have been better.
- 4 = Room for improvement: Aspects of both clinical and organisational care that could have been better.
- 5 = Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.

In this way it is straightforward to determine if there is a problem. Assessment of coding should be part of the case note review but the primary focus should be to provide assurance on the quality of care. It is entirely possible that good care was provided to all patients and that all the deaths in the “alert” were unavoidable but experience in several Trusts shows 10-15% of cases will have elements of sub-optimal care. In any event following this approach will provide assurance to the Board that there is a formal process in place underpinned by sound documentary evidence.

5) Coding

Accurate clinical coding is essential in order that the correct information is collected in terms of activity and outcomes. This is necessary for a host of reasons not least that this constitutes the raw data upon which decisions are made about the Trust’s income. Clinicians need to be educated about how coders extract information from the hospital notes and how the way they record clinical findings and opinions support or hinder that process. Meetings and educational events between clinicians and coders can help build mutual understanding between these groups.

6) Feedback to the frontline

Clinicians need to be kept informed of the outcomes of their work if they are to learn and improve. It is essential that there is a mechanism for the outputs of the mortality governance process to be fed back to clinical staff as well as plans for improvement, lessons learnt and pathway redesign.

Dashboards depicting outcomes at individual / team / ward / department level can be used for these processes and are best devised in conjunction with the individuals

concerned. Other vehicles such as safety lesson of the week email alerts, cascading through governance groups using this data as part of appraisals should be considered.

Appendix 1

Example Terms of Reference for an Acute Hospital Mortality Surveillance Group

MEMBERSHIP

Chairman – Medical Director

Information Department Representation

Director of Nursing or Deputy

Senior Nurse

Doctor-Anaesthetist

Doctor-Acute Physician

Doctor – Care of the Elderly

Doctor – Respiratory /Cardiology

Doctor – Accident & Emergency

Doctor – General Surgery

Governance Representation

Junior Doctor Representation

QUORUM

Four members plus the Chairman (one nurse, two doctors and a governance representative).

FREQUENCY OF MEETINGS

The Committee will meet monthly.

Operational functions:

To work towards the elimination of all avoidable in-hospital mortality.

1. To review on a monthly basis, the benchmarked mortality rates of the Trust.
2. To consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation. To facilitate the increased use of Clinical databases, run by various bodies including professional societies in the fuller assessment of in-hospital mortality.
3. To investigate any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems e.g. Dr Foster, HED, etc.

4. To develop data collection systems to ensure the Trust's mortality data is timely robust and in line with national and international best practice.
5. To ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of clinical excellence.
6. To develop an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
7. To assign clinical leads to address raised mortality in particular clinical areas by the deployment of strong evidence based interventions such as care bundles. The MC will receive regular reports on implementation and the measurable impact of these interventions on hospital mortality.
8. To work with established groups to ensure each junior doctor intake receives the latest guidelines on care protocol implementation and clinical coding best practice.
9. To review and monitor compliance with other Hospital policies including DNAR and Death Certification Policy.
10. To monitor and consider the information from the electronic review of all in hospital deaths.

Strategic functions:

1. To act as the strategic hospital mortality overview group with senior leadership and support to ensure the alignment of the hospital departments for the purpose of reducing all avoidable deaths.
2. Strategic oversight of extant mortality review committee(s).
3. To produce a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training and clinical directorates. This strategy will be reviewed on an annual basis by the Medical Director
4. Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the trust.
5. Sign off of all regulatory mortality responses.
6. To report on Mortality performance to the Board.

ACCOUNTABILITY

The MSG would be formally accountable the Trust Board

Appendix 2: ANHSFT Learning from Mortality - Review Process

Patient dies

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Discussion with consultant responsible for inpatient care at next available working day opportunity

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Q1 Does the case need referring to the coroner (see guidance)? → Yes

↓ No

↓

Refer to coroner as per process

Q2 What should go in each section of the death certificate?

Q3 Is the death unexpected (and not coronial) or potentially avoidable

↓ Yes

↓

Refer to Mortality group for review
Is this a potential SI? If so, report.
If not, contact Paul Godwin's secretary
(extension 3475)

↓ Yes

↓

Are there any lessons to learn?

↓

Mandatory discussion and extraction of learning at group governance meeting and refer to mortality group

A potentially avoidable death is any death where there has been patient harm as a result of an act of omission (inaction) eg failure to diagnose or treat, or from an act of commission (affirmative action) such as incorrect treatment or management. These should be included both if they occur within the index admission or before the index admission, but led to harm within that admission. Then judge if there was a >50% chance that the death was preventable.

The Mortality review group will review all the potentially avoidable deaths, all unexpected deaths and a random selection of the unavoidable deaths as part of the assurance and learning process.

IDENTIFYING POTENTIALLY AVOIDABLE MORTALITY AND MAXIMISING THE LEARNING FROM MORTALITY IN AIREDALE NHS FOUNDATION TRUST

As part of the Quality Improvement Strategy it had been decided to evolve the current mortality review process within Airedale NHS Foundation Trust. The existing process involved a mortality review group reviewing a random selection of the deaths within the organisation (as many as could be done, averaging 60 to 80%) and then feeding back quality issues and learning to the consultants and groups involved as well as producing a quarterly report submitted to QSOG.

This had been identified as not extracting the maximum amount of learning and not identifying all of the potentially avoidable deaths, as well as demonstrating a potential lack of accountability by the clinicians delivering the care. It was felt that the death should initially be reviewed by the clinicians involved in delivering the care. Simultaneously there had been some problems with doctors understanding the rules around referral to the coroner (partly as a result of more junior members of the medical team making the initial decisions as to whether to refer) and the medical directorate worked with the coroner to devise a new process and a coronial referral policy.

On 17 December 2015, following the Secretary of State for Health's statement earlier in 2015 and the Mazar's report into Southern Health, a letter was received by the medical director outlining how the national leaders felt mortality should be reviewed by an organisation and the board should be made aware of its findings. The document outlining this is included as appendix 1. The ANHSFT medical director is reviewing the 254 page Mazars Report and is producing a summary and gaps analysis with action plan to close those gaps that will be presented to the executives in February 2016.

It is proposed that Airedale NHS Foundation Trust further adjusts its mortality review process to comply with the national guidance outlined in appendix 2. The proposition to deliver this is outlined below.

Mortality Review Process

When a patient dies the consultant looking after the patient, or if more appropriate the on call consultant, will be contacted usually within working hours to discuss and fill in the mortality review form (see appendix 2). This will guide them through the Airedale NHS Foundation Trust mortality review process. It will assist them in determining whether the patient should be referred to the coroner and will determine what is documented on the death certificate should the former not be necessary.

The mortality review process form will eventually be digitised to aid in audit, however the form itself will allow manual audit to ensure the process is working. Audit is outlined below.

This process was commenced within the organisation in November 2015 and is currently being embedded. A form is being developed to gather the information for audit, with the documentation currently expected to be written in the medical notes.

Mortality Surveillance Group

A mortality surveillance group will be set up using the terms of reference outlined in appendix 1. This is expected to 1st meet at the end of February 2016 and minutes of this group will be added as an appendix to the medical directors report to the Board of the monthly quality account.

Audit of mortality

The medical director is working with CHKS to develop a mortality dashboard that will look at many of the issues suggested in appendix 1. These data are already looked at through various different sources but pulling them into a single dashboard will make it much easier to identify problems and trends. This will be provided on a monthly basis to the Mortality Surveillance Group. That group will also be provided with the following data:

Crude mortality data
HSMR
SHMI
(the above will be split by clinical group and the whole trust)
Top 3 causes of death for the Trust by SHMI
Top 3 causes of death for the Trust from the Mortality Review Process forms (initially quarterly)
SHMI and crude mortality broken down by weekend v weekday admission
With SHMI broken down by clinical diagnosis
Numbers of deaths per month as recorded from the mortuary book including numbers per specialty
Quarterly trends in mortality and cause of death over the previous 2 years

The Mortality Surveillance Group will also need evidence/audit data from:

Learning from inquests
Learning from mortality SIs
Learning from AEFs that are not SIs
Mortality reviews via mortality group discussed at governance meetings
Unavoidable death lessons from governance meetings
Cause of death from death certificates

If issues are identified that need further investigation a task and finish group will be set up by the medical director.

Timescale

Mortality review group – already in place
Mortality review process v1 – launched November 2015 and being embedded
Mortality review process v2 – launch February 2016
Mortality surveillance group – first meeting planned in February 2016
First audit and review of process and learning/iterative development – June 2016