# Board of Directors

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|---|---|---|---|
| **Date:** | 29 May 2019 | **Attachment Number:** | **9(iv)** |
| **Title of Report:** | **Learning from Deaths from Q4 2018/19 including the Mortality Scorecards** | | |
| **Purpose of the report and the key issues for consideration/decision:** | To inform the Board of Directors of the outputs from the Mortality Review Group along with the learning from deaths identified during Q4 2018/19. In addition Appendix 1 outlines the currently available mortality data for April 2019 and provides assurance that the Trust remains within the acceptable range in line with national requirements.<br>Key issues:<br>• There remains the consistent theme regarding End of Life care within the mortality reviews.<br>• There are a number of examples of excellent care issues within the mortality reviews for Q4 2018/19.<br>• There have been a number of changes to strengthen the Mortality review Process following receipt of the Care Quality Commission Report.<br>• During April 2019 there were 50 in patient deaths, nine of which occurred within 'Day One' of admission.<br>• Peer benchmarking is current to February 2019.<br>• The latest published national data for the SHMI is provided – banded as expected. As a result of methodological changes to the indicator by NHS Digital, diagnosis breakdown is now also available with a banding. Selected groups correspond with the VLAD chart intelligence and are banded as expected with the exception of acute bronchitis where deaths are lower than expected.<br><br>Appendix 1 demonstrates further information. | | |
| **Prepared by:** | Ms Caroline Booton; Clinical Quality Analyst<br>Mrs Helen Kelly; Assistant Director Healthcare Governance | | |
| **Presented by:** | Mr Karl Mainprize; Medical Director | | |
| **Strategic Objective(s) supported by this paper:** | **Financial Sustainability** \| **Empower & Engage Staff**<br>**Quality of Care** \| X | | |
| **Is this on the Trust's risk register:** | **No** \| X \| **Yes** \| **If Yes, Score** | | |
| **Which CQC Standards apply to this report:** | Safe, Effective and responsive domains | | |

<table>
<tr><td>Have all implications related to this report been considered: (please X)</td><td>
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<tr><td>Finance Revenue & Capital</td><td></td><td>Equality & Diversity</td><td>X</td></tr>
<tr><td>National Policy/Legislation</td><td>X</td><td>Patient Experience</td><td>X</td></tr>
<tr><td>Human Resources</td><td></td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>Governance & Risk Management (BAF)</td><td>X</td><td>Other:</td><td></td></tr>
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<tr><td>Approve</td><td></td><td>Discuss</td><td></td><td>Receive for information</td><td>X</td><td>Decision</td><td></td></tr>
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<tr><td>Quality & Safety Committee</td><td>Date:</td><td>22/05/2019</td></tr>
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<tr><td>Recommendations:</td><td>The Board of Directors is requested to note the contents of this report and the detail within Appendices 1 and 2.</td></tr>
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# LEARNING FROM DEATHS

## 1. Context / Background

Following the publication of the National Guidance on Learning from Deaths in March 2017 by the National Quality Board, the Trust has implemented the recommendations required. The revised mortality process continues to facilitate greater learning from deaths as it becomes more robust and embedded.

## 2. Executive Summary

The Mortality Review Group continues to meet and the membership has expanded due to the increase in the number of reviewers. Our crude mortality rate remains below the national average and there appears to be more data to support the improvements made in the management of fractured neck of femur as our mortality has reduced to acceptable values.

## 3. Progress since last reporting and identified learning

### 3.1 Mortality Reviewer Training

The Mortality Reviewer Training will continue during 2019 in order to increase further the number of reviewers within the organisation.

At the time of reporting the Trust has provided another training session and there have been a further five reviewers increasing the Trust total to 35 trained mortality reviewers; training sessions will continue to be provided.

### 3.2 Statistics from reviews conducted during Q4 2018/19

Data has been collected in relation to in-patient deaths within the Trust along with outcomes from the mortality review processes. Table 1 below demonstrates the avoidability as scored by the Mortality Review Group. It is very important to note; the avoidability score is not a comparator nor can be used as a league table between specialties or other Trusts. It is simply an opinion of the reviewer from the detail available within the case notes.

| Score | Q1 Apr-Jun 2018 | Q2 Jul-Sept 2018 | Q3 Oct-Dec 2018 | Q4 Jan-Mar 2019 |
|---|---|---|---|---|
| **Number of recorded in-patient deaths** | 158 | 148 | 154 | 192 |
| **Score 1.** Definitely avoidable. | 0 | 0 | 0 | 0 |
| **Score 2.** Strong evidence of avoidability. | 0 | 0 | 0 | 0 |
| **Score 3.** Probably avoidable, more than 50-50, but close call. | 0 | 0 | 1* | 0 |
| **Score 4.** Probably avoidable, less than 50-50, but close call. | 0 | 0 | 1** | 0 |
| **Score 5.** Slight evidence of avoidability. | 10 | 14 | 4 | 8 |
| **Score 6.** Definitely not avoidable. | 48 | 58 | 52 | 51 |
| **Total Number of Cases Reviewed** | **58** | **72** | **58** | **59** |

### 3.3 Learning Identified

There were two main themes identified from the reviews undertaken during Q4 2018/19 relating to End of Life care and communication along with examples whereby the documentation could have been better. It must be noted there are many examples of early recognition of End of Life, swift implementation of patient centred pathways and excellent communications with the patients and their families. However this

is by no means universal through the Trust as there also examples of poor or late recognition of end of life and thus later than best practice of implementation of the pathway. It must be noted the examples of excellence outweigh the less good examples and whenever this is identified; it is raised with the speciality for cascade within their teams. There are no specific areas or specialisms where it is particularly good or poor.

There has been a number of excellent care examples noted relating to swift decision making and good team working within the ward nursing teams.

During the Mortality Reviewer training the attendees are encouraged to identify good practice either with aspects or the whole care as it is important we know how it can work well to support learning and increase the positive patient experience. Furthermore once their loved one has died it can be of great comfort to a family that the care they received was as good as it could have been.

### 3.4 Care Quality Commission Inspection conducted during November and December 2018

In the Care Quality Commission Quality Report published in March 2019; it was noted there needed to be greater clarity in relation to the Mortality Review Process in the Trust. There was comment made relating to clearer pathways, responsibility and accountability regarding the identified learning. As a result a piece of work was undertaken that resulted in the following

- Revision of the Learning from Deaths Policy – this remains out for consultation and it is anticipated will be approved at the next Mortality review Group scheduled for 24/05/2019.
- Revision of the flowchart for the management of mortality reviews within the Trust – complete
- Development and implementation of "feedback" forms to the Clinical Group Governance Leads for cascade to the relevant areas following the Mortality Review Group meetings. This ensures the Governance Lead is aware and can ensure there is feedback within the Clinical Group regarding learning and improvement. This has also been introduced for examples of excellence.
- The incorporation of the role of the Mortality Surveillance Group functions into the new Patient Safety Group; with reporting by the Mortality Review Group each quarter.
- The timeliness of the review taking place following the death was also commented upon as being "too long". There are a number of issues relating to this that are currentlty being worked on to demonstrate improvements.

This strengthening of the Trust process will be monitored and reported to the Patient Safety Group as part of the quarterly reporting.

## 4. Conclusions

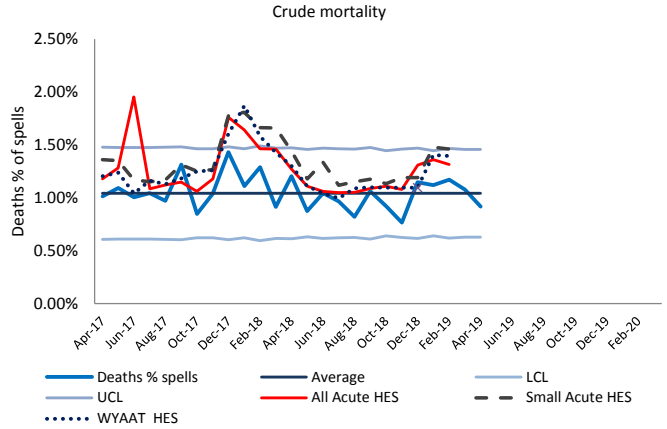
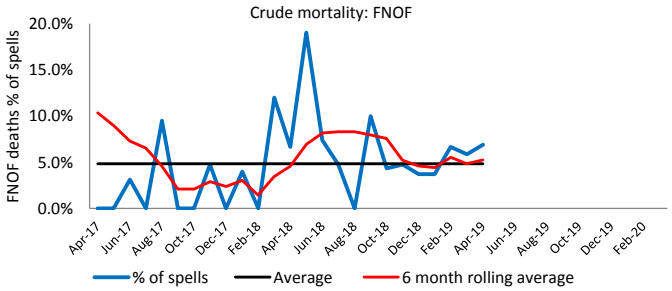
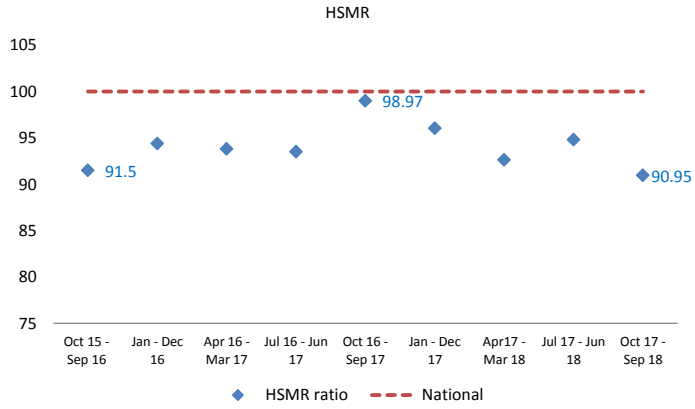
The improvements to the process and the evidence of shared learning will be monitored and reported as part of future reports.

## 5. Recommendations

The Board of Directors is requested to note the contents of this report and the detail within Appendices 1 and 2.

# Mortality Scorecard: to April 2019

NHS Airedale NHS Foundation Trust

| Description | Aggregate Position | Trend/ Special Process Control | Variation |
|---|---|---|---|
| **Crude Mortality** | | | |
| Crude mortality rate shows the number of deaths per 100 hospital episodes of care from admission to discharge (spell). | Crude mortality is consistently below the national rate for all providers. Peer benchmarking - **England, Small Acute & WYAAT -** is two months in arrears. In the UK there is a long-term downward trend in crude mortality; winter mortality was higher than usual in early 2017 and 2018.<br><br>Latest monthly rate is **0.92%** of all episodes of care. The rate is within control limits based on the local average for the period.<br><br>Source: CHKS icompare |  | **April 2019:**<br>Overall number of deaths: **50**<br>> Planned admissions: **0**<br>> Maternal death: **0**<br>> Neonatal and/or perinatal deaths [≤ 28 days]: **0**<br>> Paediatric death: **0**<br>> Clinical Coding Software [CCS] Group fracture neck of femur [FNOF]: **2** [see below for long- term trend] |
| **Crude Mortality - CCS FNOF** | | | |
| The chart opposite shows the number of deaths per 100 hospital episodes of care from admission to discharge (spell) and is based on the clinical coding software (CCS) diagnosis group for fracture neck of femur [FNOF]. In order to assess trends with a comparatively small number of events, a rolling average can be clearer (denoted by the red line). Each point on the following graph represents the average rate for the six months that precede the month on the 'x'-axis. | |  | In the last six months the rolling average is stable fluctuating on or around **4.8%** of applicable spells. |
| **Hospital Standardised Mortality Ratio - HSMR** | | | |
| The ratio of the actual number of patients who die following hospitalisation at a trust with the number that would be expected to die on the basis of average England figures for 56 diagnosis groups and given the characteristics of patients treated. It is estimated that around 80% of all deaths occur in these diagnosis groups. | The HSMR ratio from **Oct 17 to Sep 2018** shows an "as expected" relative risk when compared to other organisations nationally (denoted by the red dash line) .<br><br>Source: Dr Foster Intelligence |  | HSMR = **90.95** [Within expected range]<br>Total deaths = **577**<br><br>Emergency weekday HSMR = **87.59** [Within expected range]<br>Deaths following acute admission = **404**<br><br>Emergency weekend HSMR = **100.89** [Within expected range]<br>Deaths following acute admission = **143**<br><br>Mortality in low risk groups = **0.32** [Within expected range]. National: **0.49**<br>Deaths in this group = **7** |

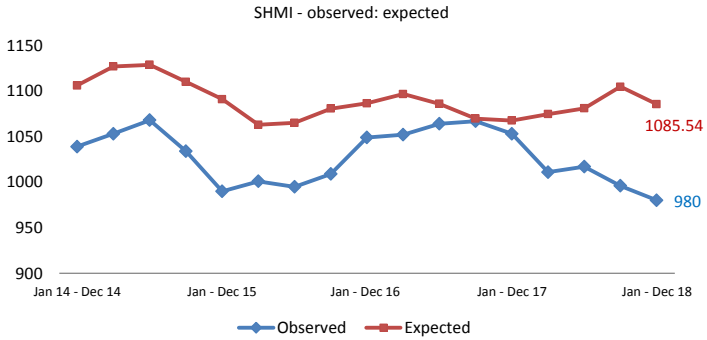
| Description | Aggregate Position | Trend/ Special Process Control | Variation |
|---|---|---|---|

**Summary Hospital level Mortality Indicator - SHMI**

The ratio of actual deaths and the number expected to die within 30 days of discharge from hospital on the basis of average England figures, given the characteristics of the patients treated. The indicator is updated quarterly and based on a rolling one year and released six months in arrears.

The SHMI ratio for **Jan - Dec 2018** is **0.90 and is banded 2 or as expected.** Values below one suggest a lower than expected number of deaths. A method of banding or control limit is used to help decide if a SHMI ratio exceeds expected limits.

Source: NHS Digital

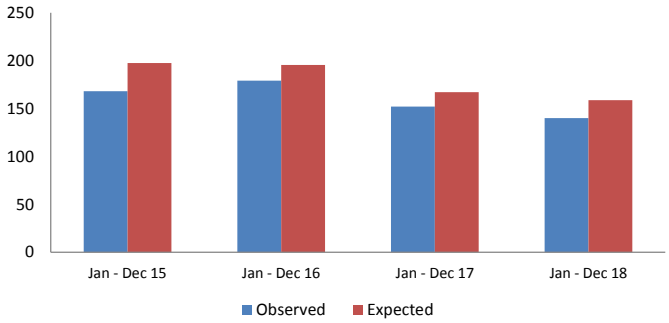



Where statistical models are considered to have sufficiently explained the expected variation in outcomes due to the case-mix adjustment NHS Digital Health generate diagnosis group breakdown and bandings. In the current period there were fewer deaths than expected for **acute bronchitis.**

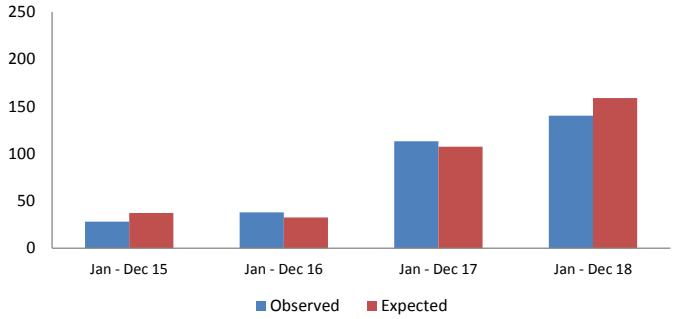
## SHMI: diagnoses groups with highest number of deaths January to December 2018

The following diagnosis groups account for around **41%** of the **980** deaths that occurred in the above period. In the latest period deaths are banded **2** or as expected for diagnoses **1 to 4**. The risk models for groups **5 & 6** should be factored into any appraisal of performance as they may not sufficiently explain variation [NHS Digital].

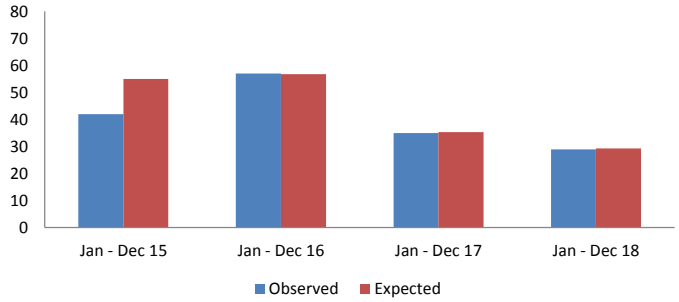
### 1. Pneumonia



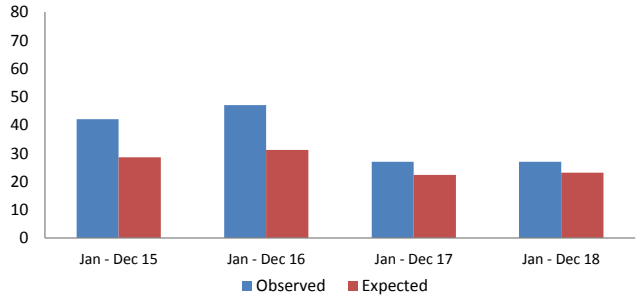

### 2. Septicaemia



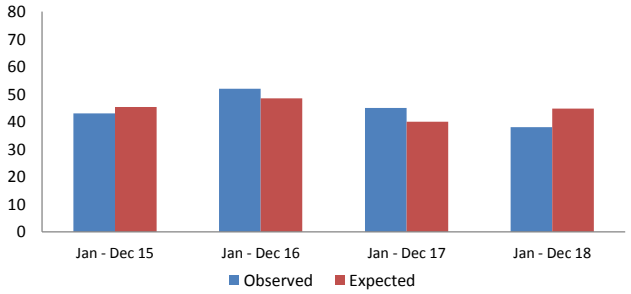

### 3. Urinary tract infection




### 4. Fracture neck of femur [FNOF]




### 5. Congestive heart failure




### 6. Acute cerebrovascular