Meeting Title:	**Quality Committee**
Date of Meeting:	**17th August 2021**
Document Title:	**Mortality Report: Learning from deaths Qtr 1 2021/22**
Responsible Director:	Prof. Alastair Hutchison, Medical Director
Author:	Prof. Alastair Hutchison, Medical Director

Confidentiality:	Public
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	11th August 2021	None specific

Purpose of the Paper	To inform the Quality Committee of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.
Summary of Key Issues	The Trust's SHMI reported during Q1 (5 months in arrears - rolling years to Dec 2020/Jan & Feb 2021) rose each month to just above the expected range in February at 1.138 vs 1.132. This is almost certainly due to delays in coding (see below). No other local or national indicators suggest that standards of in-patient care are resulting in excess unexpected deaths at DCH. Structured Judgement Reviews are being used to examine the care of an appropriate sample of people who died whilst in-patients, and to learn from any lapses in care that are identified. The DCH Medical Examiners review every death and highlight any obvious causes for concern.
Action recommended	The Quality Committee is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website 3. **Not publish** appendices 1 and 2 which are for internal discussion only

Governance and Compliance Obligations

Legal / Regulatory	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Financial	Y	Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.
Impacts Strategic Objectives?	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that an elevated SHMI is not a result of lapses in care requires regular scrutiny of a variety of data and careful explanation to staff and the public. An elevated SHMI can have a negative impact on the Trust's reputation both locally and nationally.
Risk?	Y	• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care • Clinical safety issues may be reported erroneously or go unnoticed if data quality is poor

Decision to be made?	N	
Impacts CQC Standards?	Y	An elevated SHMI would raise concerns with NHS Improvement and the CQC. NHS-I undertook a review in March 2019 and produced a report which has resulted in an action plan. This plan was presented to Trust Board in July 2019 and is complete, but work continues. The reduction in SHMI and improvements in coding are acknowledged.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning. See appendix 1 and 2 for full reports.

1.1 Division of Family Services & Surgery Q4 Report

Structured Judgement Review Results:
The Family Services & Division had 58 deaths in quarter 4 that require SJR's to be completed, with 22 having had a SJR completed. Between January to March, 37 SJR's have also been completed form previous months.

SJR Backlog: The outstanding SJR's for the Division as at 28/04/2021 is 32:

November	December	January	February	March
1	1	9	14	7

The available notes have been allocated to Clinical staff to ensure that these are completed.

Feedback from SJR's completed in quarter 4:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	3	12	31	46	9	0
1 Very Poor	0	0	1	0	0	0
2 Poor	2	0	0	0	0	1
3 Adequate	5	7	3	1	8	8
4 Good	26	19	20	6	28	27
5 Excellent	23	21	4	6	14	23

Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
4	1	2	6	28	18

- Common themes: Loose notes not filed. Incomplete or unclear documentation

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	2	10	47

Report completed by:
Richard Jee – Divisional Mortality Lead
Laura Symes – Quality Manager

1.2 Division of Urgent & Integrated Care Q4 Report

Structured Judgement Review Results:
The Urgent and Integrated Care Division had 208 deaths in quarter 4, 32 SJR's were requested with 13 having had a SJR completed. Between January and March, 14 SJR's have also been completed from previous months.

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	6	20	25	4	1
1 Very Poor	0	0	0	0	0	0
2 Poor	1	1	0	0	2	2
3 Adequate	3	7	1	0	1	6
4 Good	15	7	2	1	14	13
5 Excellent	8	6	4	1	6	5

Overall Quality of Patient Record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
2	0	1	5	13	6

Poor handwriting and filing. Evidence on electronic systems of failure to capture relevant clinical information, but hasn't caused poor care.

No times or dates attached to several of the entries making it very unclear when the patient was discharged and re-attended.

Avoidability of Death Judgement Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	2	4	21

SJR Backlog
The outstanding SJR's for the Division as at 19/04/2021 is 6:

January	February	March
1	0	5

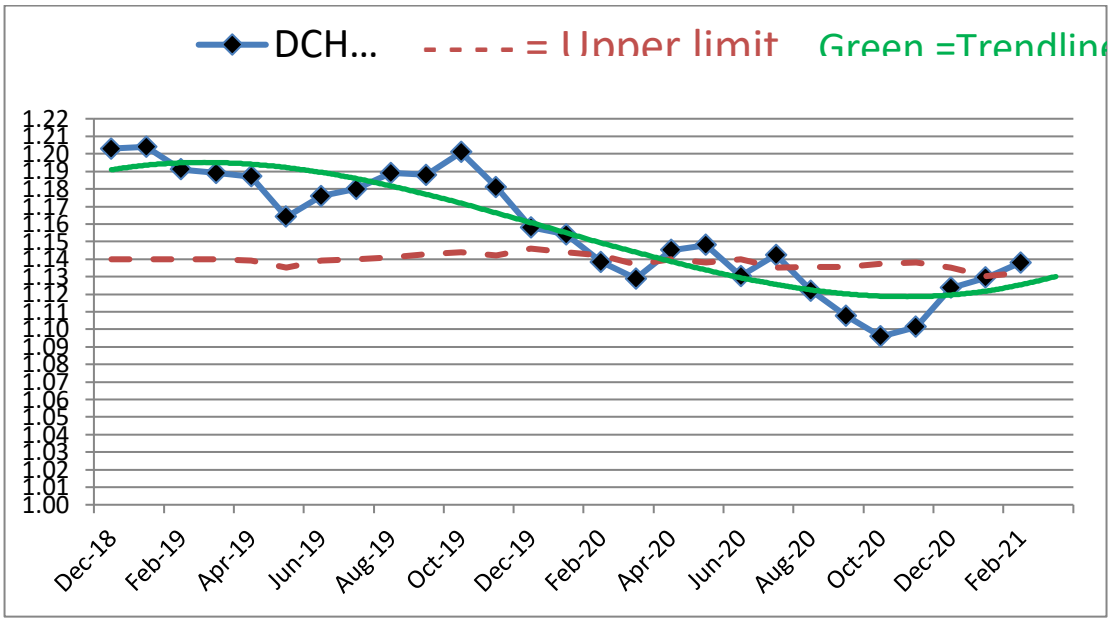
12 Nosocomial COVID-19 deaths require review and investigations are ongoing with the IPC team.

Stacey Notley, Quality Manager,
Sonia Gamblen, Divisional Head of Nursing & Quality
James Metcalfe, Divisional Director

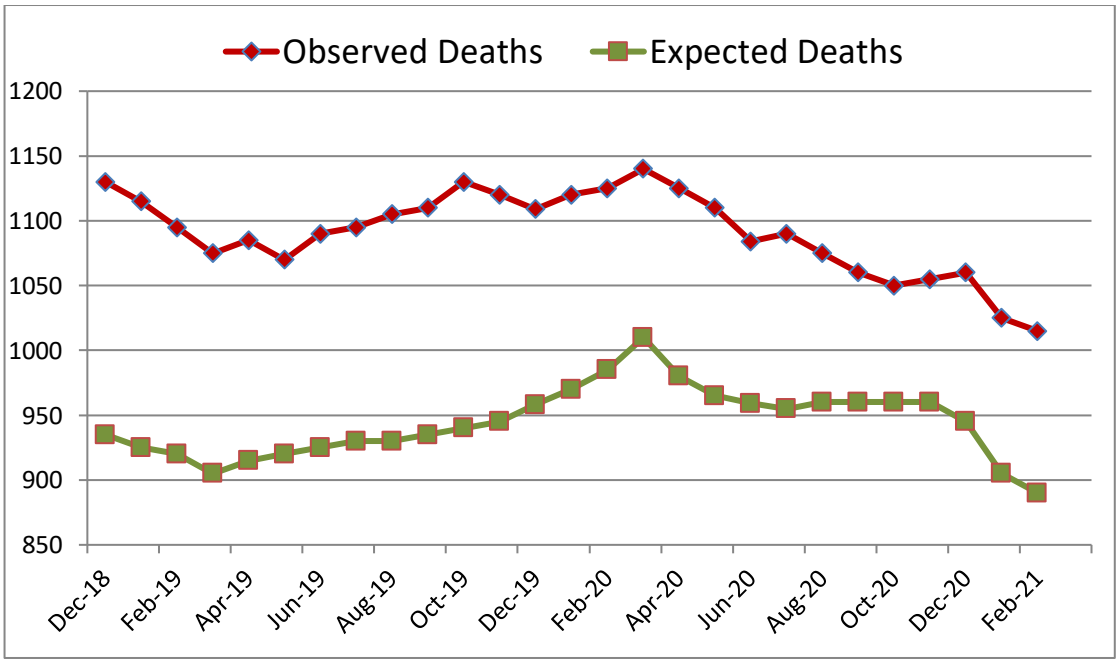
2.0 NATIONAL MORTALITY METRICS

2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and occurring within 30 days of discharge. The SHMI for the rolling years from October 2019 to date shows a clear trend to improvement. The latest SHMI remains within the expected range, but has risen slightly.



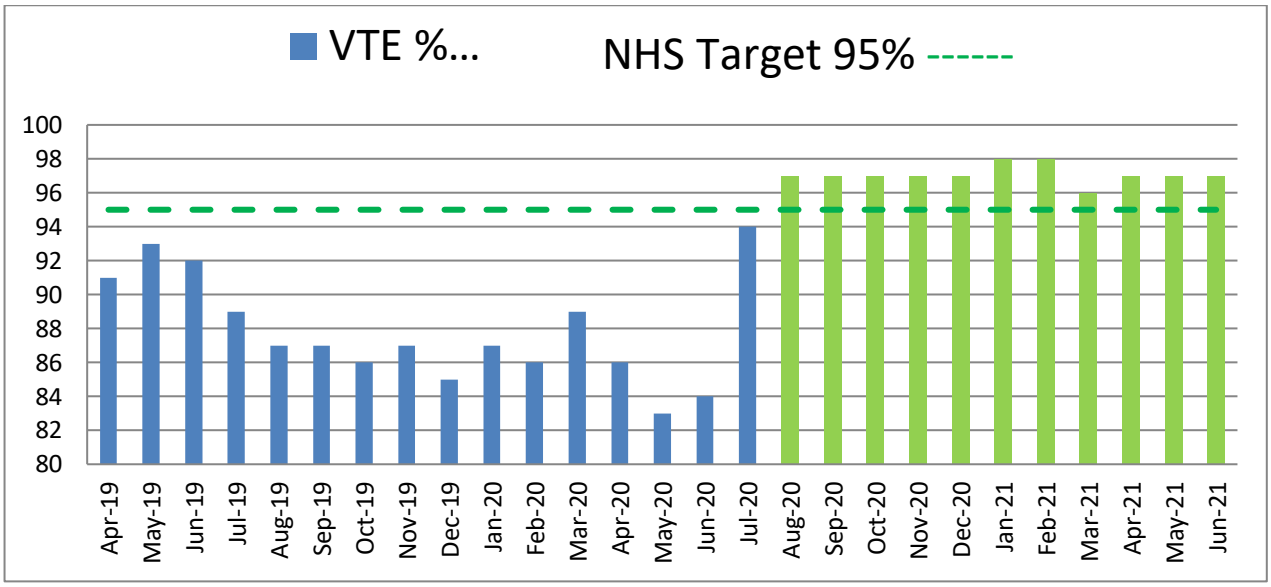
SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding data). As part of the NHS recovery from Covid-19, Trusts were financially incentivised to demonstrate that they were achieving at least 85% of the elective activity levels for 2019. This required the coding department to concentrate on returns for elective activity, resulting in a risk that non-elective data (which makes up the vast majority of SHMI data at DCH) might not be coded in time to be included in SHMI. Unfortunately this is what happened, and has resulted in a misleading fall in our 'Expected Death Rate'. The chart below shows observed and expected deaths over the past 2+ years (rolling years from March 18 to Nov 20), and whilst our observed (actual) deaths continue to reduce, the expected deaths have reduced disproportionately faster, increasing the SHMI ratio.



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group regularly examines any other data which might indicate changes in standards of care, and has continued to meet on a monthly basis throughout the COVID-19 crisis. The following sections report data available from various national bodies who report on individual Trusts' performance.

For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Director of Nursing. DCH VTE risk assessments reached 97% in August with the introduction of a more accurate reporting system, and have exceeded the 95% target for every month since then.



3.1 NCAA Cardiac Arrest data

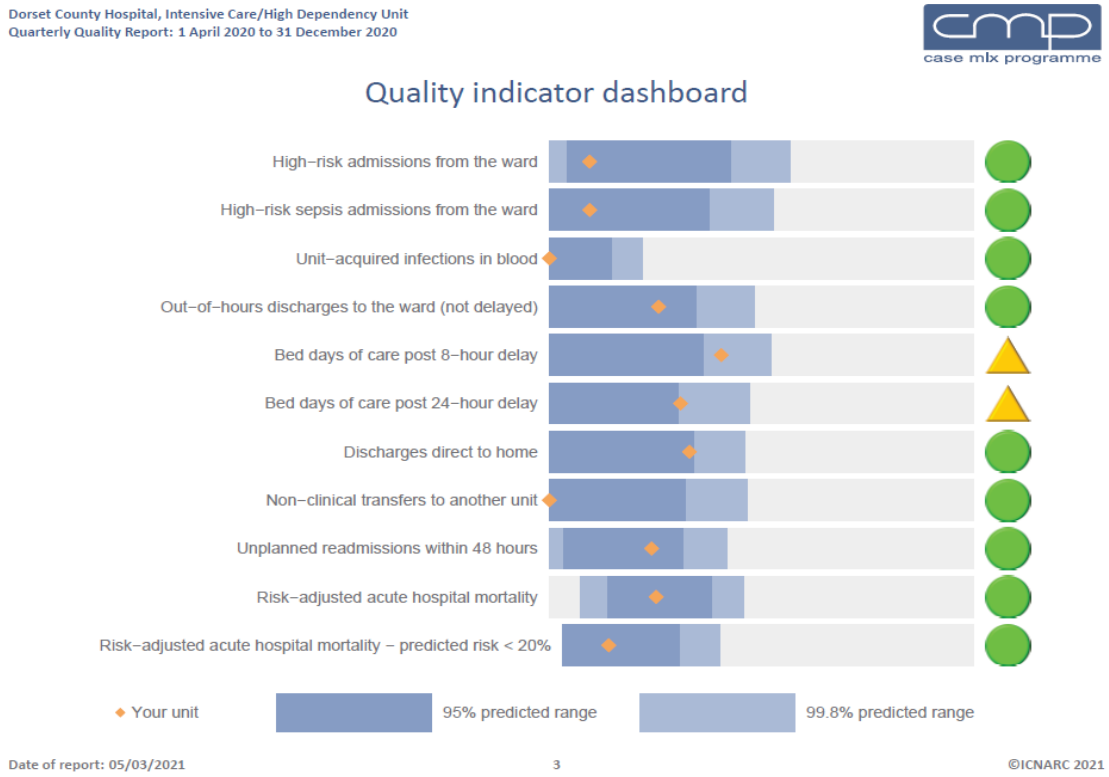
12 month Cardiac Arrest data for April 2019 to March 2020 was published in June 2020, and included in the previous Q1 report. The next data was expected in Nov 2020, but has not yet been published.

3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019

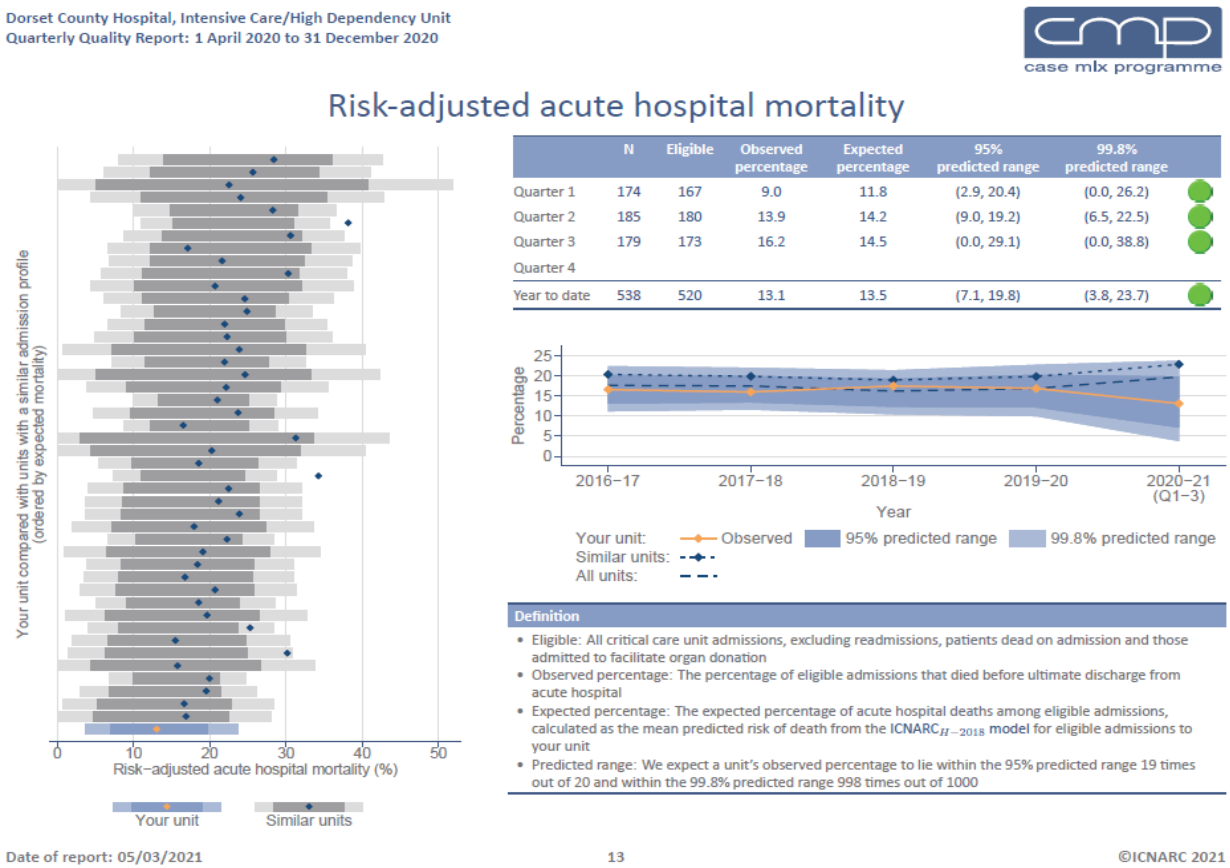
Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%	10%
Length of stay (discharged patients)	Median in days	3	5
Critical care admission	Yes - proportion	2%	5%
Readmission	Yes - proportion	8%	13%

The results suggest that patients admitted to DCH 2018/19 tended to be more ill than the national average, but had a lower death rate and shorter length of stay, with fewer readmissions.

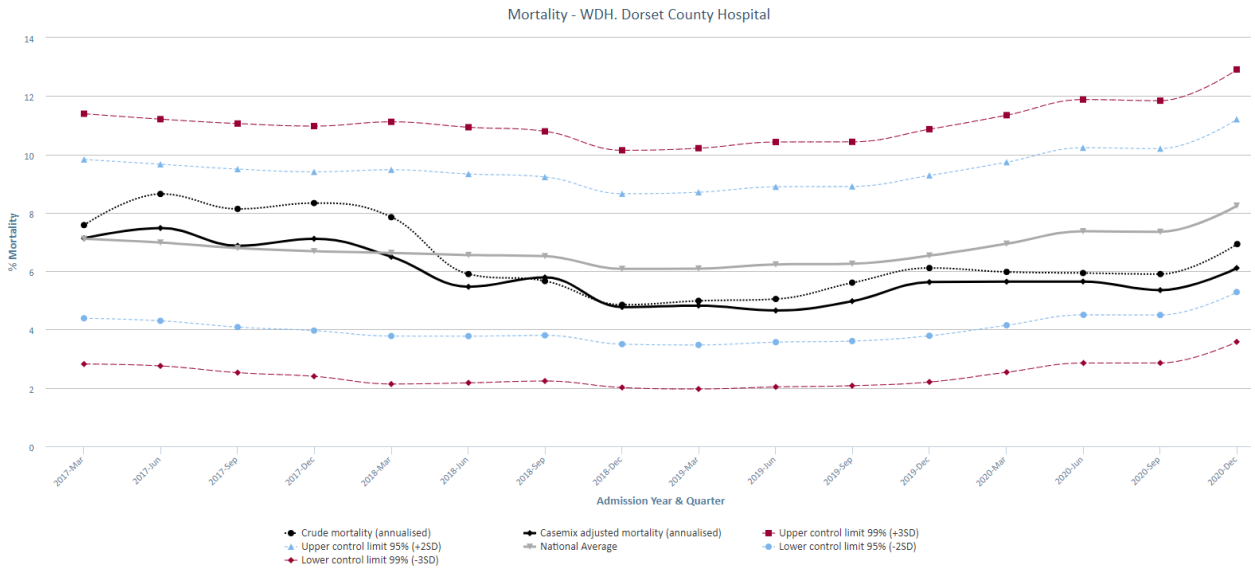
3.3 ICNARC Intensive Care survival latest data published 05 Mar 2021



The charts below show the “risk adjusted acute hospital mortality” following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.



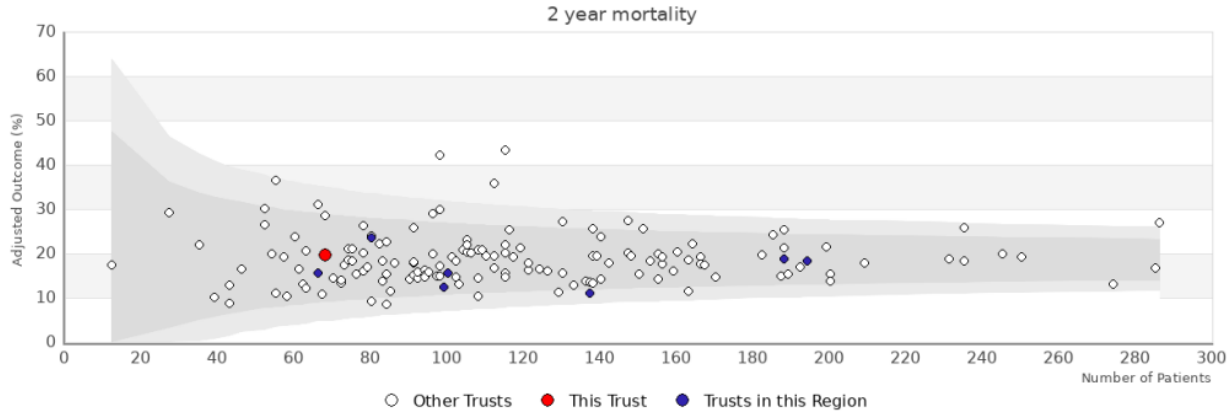
3.5 National Hip Fracture database to December 2020



The national average annualised mortality for hip fracture is 8.1%, with DCH's annualised mortality at 6.1%.

3.6 National Bowel Cancer Annual audit

No new data as yet this year - graph below shows latest available 2 year survival data for patients admitted in financial year 2018/19, compared to all other NHS Trusts, with other Wessex Trusts in dark blue.



Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	68	19.7%	19.3%

3.7 Getting it Right First Time; reviews in Q4

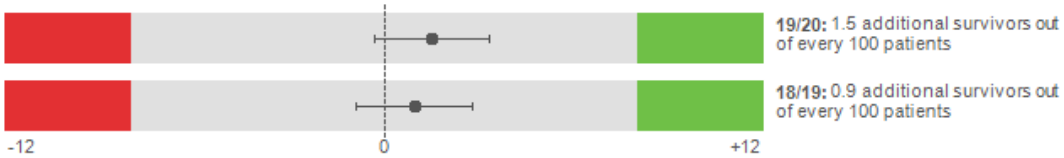
One shortened virtual GIRFT review was undertaken at DCH during this quarter – Gastroenterological Medicine. The full report is available within DCH from this link. As a result of COVID waves 2 and 3, all other visits were postponed for Q4.

Full reports from all previous GIRFT visits are available, and feedback from each review has previously been very positive. Action plans have been developed and are being worked through at present.

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. A summary of the latest published data (totals for 2018/19 and 2019/20, updated April 2021) is shown below. Data for 2020/21 is as yet incomplete:

Rate of Survival at this Hospital: Yearly Figures



Note: Data for the following years is not shown due to missing or incomplete data: 20/21

Rate of Survival Breakdown at this Hospital

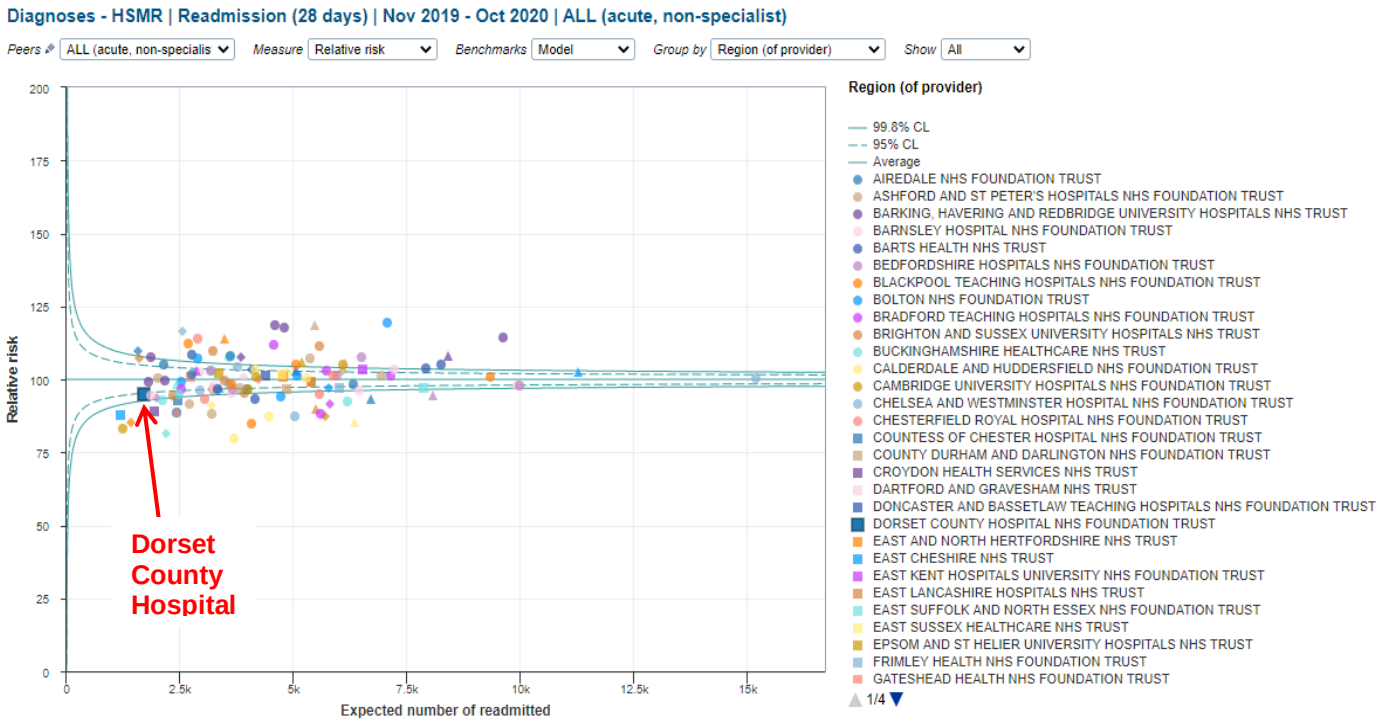
Survival band %	Number in group	Expected survivors	Actual survivors	Difference*	Adjusted difference**
95 - 100	532	522	529	1.2	0.8
90 - 95	177	164	165	0.4	0.1
80 - 90	103	87	89	1.1	0.1
65 - 80	46	34	33	-2.4	-0.1
45 - 65	15	8	11	17.1	0.4
25 - 45	7	2	3	3.6	0.1
0 - 25	5	0	0	-13.5	-0.2
Total	**885**	**820**	**830**	**1.0**	**1.1**

Unexpected deaths in minor/moderate injury
Usually due to poor management of co-morbidity and/or complications

Unexpected survivors with more serious injury
Usually indicates good initial resuscitation and the treatment of head injury in Neurological Centres

The first column categorises patients by percentage likelihood of survival, followed by the total number of patients seen at DCH, the calculated likely number of survivors and then the actual number of survivors.

3.9 Readmission to hospital within 30 days, latest available data (Dr Foster); lower is better



Readmission to hospital within 30 days suggests inadequate initial treatment or a poorly planned discharge process. However DCH's latest readmission rate is lower than the majority of other acute Trusts.

3.10 Dr Foster Safety Dashboard

This dashboard compares DCH with other England and Wales Trusts for a variety of complications that might occur during an in-patient stay or during childbirth. Where the confidence intervals (horizontal T bars) overlap the national mean there is no statistical difference from the national average. DCH has a higher number of decubitus (pressure) ulcers (264 versus 226; significant difference), but fewer deaths in low-risk diagnosis groups (24 versus 44; significant difference).

Patient Safety Indicators

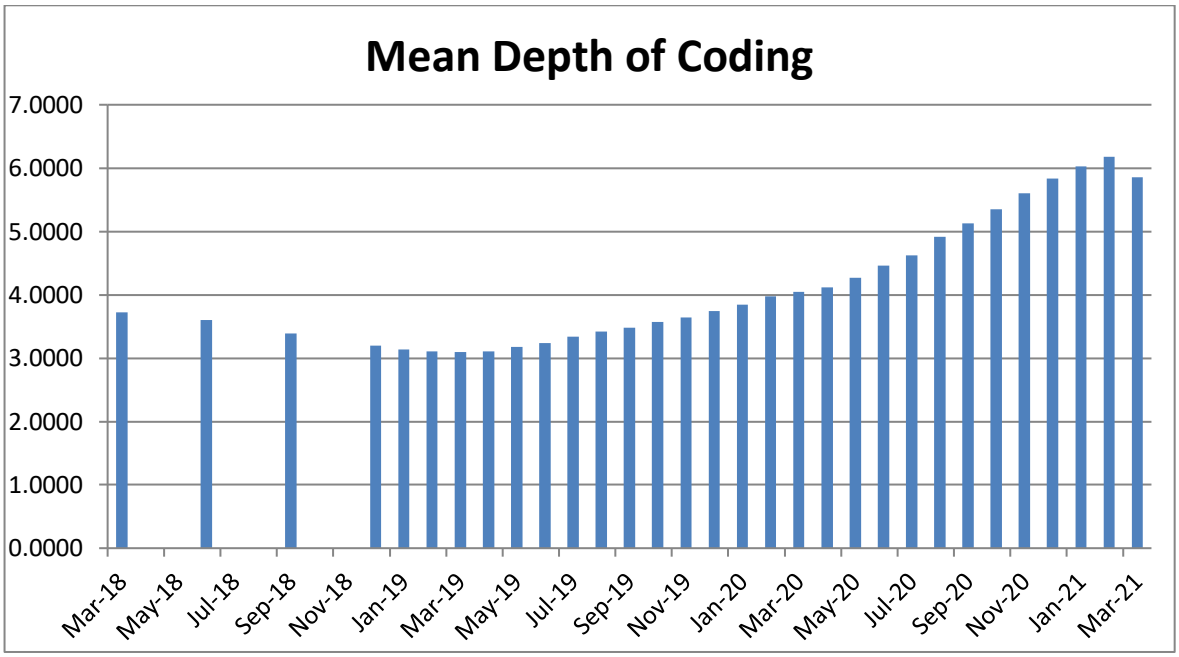
Period: 12 months (Feb 20 to Jan 21) | Data lag: No lag

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk	Compare
Accidental puncture or laceration	28524	53	45.3	1.9	1.6	116.9	
Deaths after surgery	195	9	14.7	46.2	75.2	61.3	
Deaths in low-risk diagnosis groups	12626	24	44.2	1.9	3.5	54.3	
Decubitus ulcer	3785	264	225.9	69.7	59.7	116.9	
Infections associated with central line	5431	0	0.3	0	0.1	0.0	
Obstetric trauma - caesarean delivery	383	2	1.7	5.2	4.5	115.4	
Obstetric trauma - vaginal delivery with instrument	108	8	7.3	74.1	67.9	109.0	
Obstetric trauma - vaginal delivery without instrument	678	21	19.9	31.0	29.3	105.7	
Postoperative haemorrhage or haematoma	10920	4	4.1	0.4	0.4	98.1	
Postoperative physiologic and metabolic derangement	9377	0	1.7	0	0.2	0.0	
Postoperative pulmonary embolism or deep vein thrombosis	11005	33	30.3	3.0	2.8	109.0	
Postoperative respiratory failure	8572	5	8.8	0.6	1.0	56.6	
Postoperative sepsis	110	1	1.7	9.1	15.6	58.2	
Postoperative wound dehiscence	375	0	0.3	0	0.8	0.0	

4.0 CODING

4.1 Depth of coding

The DCH depth of patient coding for Charlson Co-morbidities has improved steadily from one of the lowest four in the UK, and is now above the mean value for all UK Trusts, at 5.83. As a result, the Trust's expected death rate had been rising to a level which more accurately represents the co-morbidities of admitted patients. The graph below plots the improvement in depth of coding over the past 3 years. The latest month data reflects the diversion of staff to focus on coding elective cases.



5.0 QUALITY IMPROVEMENT ARISING FROM SJRs

The following themes have been previously identified from SJRs and are being translated into quality improvement projects:
1. Poor quality of some admission clerking notes, particularly in surgery
2. Morbidity and Mortality meetings - standardization and governance

6.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers.

Specialty	Contact	April	May	June	July	August
Cardiology	Helen Dell,	13.04.21	11.5.21	8.06.21	13.07.21	10.08.21
Renal	Kathleen O'Neill	05.05.21	02.06.21	30.06.21	28.07.21	28.08.21
Vascular	James Metcalfe	Weekly	Weekly	Weekly	Weekly	Weekly
Oncology	Abi Orchard				16.07.21	tbc
ED &Acute Medicine	Tamsin Ribbons & James Ewer	15.04.21	----------	Cancelled	----------	19.08.21
Respiratory	Marianne Docherty	27.4.21	25.5.21	Cancelled	27.07.21	24.08.21
Elderly Care & Stroke	James Richards Harold Proeschel	21.04.21	----------	----------	21.07.21	----------

7.0 LEARNING FROM CORONER'S INQUESTS

DCH has been notified of 22 new Coroner's inquests being opened in the period January 2021 – March 2021. All Inquests that were listed in this quarter were adjourned by the Coroner due to CoVID-19 restrictions.

17 other inquests were held during Quarter 4. Nine inquests were heard as Documentary hearings, not requiring DCH attendance. None were attended at Court as this was the clinician's preference. Eight required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 52 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 6 pre-inquest reviews were listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings, an increasing number of which will be attended virtually. The virtual court room set up within Trust Headquarters appears to be working well, and Ms Mandy Ford (DCH) liaises with the coroner's officer to improve the technology and its use.

8.0 LEARNING FROM CLAIMS Q4

Legal claims are dealt with by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs. The latest scorecard will report on the past financial year and will be included in the next Quarterly Learning from Deaths report.

Claims pattern this Quarter:

New potential claims	2 (1 Orthopaedic, 1 ED)
Disclosed patient records	10 (2 Obst, 3 unknown, 1 colorectal, 2 ED, 1 IBD, 1 Ophthalmology)
Formal claims	6 (1 Max-facs, 1 Gen Med, 1 Obst, 1 Orthopaedics, 1 Urology, 1 ED)
Settled claims	3 (1 Obstetrics, 1 ED/Cardiology, 1 Orthopaedics)
Closed no damages	3 (1 Colorectal, 1 Haematology, 1 Orthopaedics)

9.0 SUMMARY

SHMI remains within the expected range, with evidence of a clear trend to improvement over the past 14 months. No other metrics of in-patient care suggest that excess mortality is occurring at DCH, and much of the national data suggests better than average mortality.

Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths continue to improve.