

Trust Board

Report Cover Sheet

Agenda Item: 14

Date of Meeting:	Wednesday 30th October 2019			
Report Title:	Quarterly Mortality Report			
Purpose of Report:	Present Quarterly Mortality report and proposed framework			
	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	Goal 3 In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs. Goal 4 All our services will have a high safety culture in which openness, fairness, accountability and learning from high levels of incident reporting and mortality reviews is the norm. Goal 5 All our services will be effective: we will reduce unwarranted variation, ensure our practice is consistent with recognised best practice 7 days a week, and improve outcomes for patients.			
Recommendations: (Action required by Board of Directors)	To receive the report for assurance			
Financial Implications:	Learning from deaths and reducing risk has the potential to reduce the volume of financial claims received by the Trust.			
Risk Management Implications:	Monitoring, review and learning from deaths is essential to ensure the Trust can identify areas of risk and reduce potential risk.			
Human Resource Implications:	No			
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	Objective 1 All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.			
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Presented by:	Mr Andy Beeby, Medical Director			

Quarterly Mortality Report

Executive Summary

The Trust SHMI is 1.03 placing the Trust with the banding of deaths 'as expected'.

The HSMR for Gateshead in the last 12 months (Jul-18 to Jun-19) is 106.9 placing the Trust with more deaths in the expected range. The Trust has the fourth lowest HSMR when compared to peer group performance of neighbouring Trust. Focused analysis has raised no concerns but suggests Gateshead Trust has lower figures for palliative care coding than other Trust in region.

Where mortality alerts have been triggered, case note review demonstrates that the majority of deaths have been reviewed, and were identified as definitely not preventable. Those cases that demonstrated evidence of preventability have been reviewed by the Trust Mortality Council where learning and actions has been identified.

A high proportion of deaths continue to be reviewed across the Trust, utilising the mortality database to identify learning themes and develop appropriate actions.

Work continues within the Trust to plan the development and implementation of the Medical Examiner Service, although it is anticipated to be challenging due to national funding allocations.

1. Introduction:

The purpose of this paper is to update the Board upon on going work in relation to mortality within Gateshead Health NHS Foundation Trust. Within the paper is an update on the Summary Hospital-level Mortality Indicator (SHMI) which is the national mortality ratio score developed for use across the NHS and the Hospital Mortality Standardised Ratio (HSMR) provided by Healthcare Evaluation Data (HED).

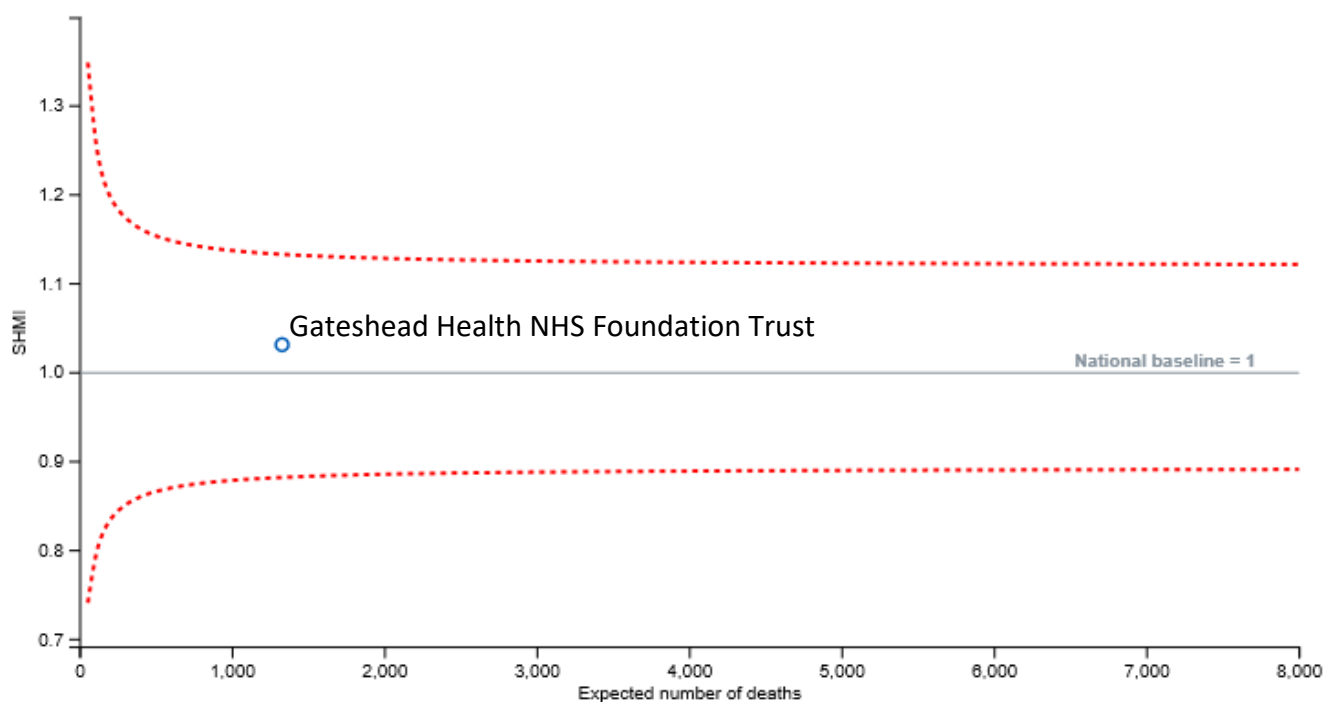
2. The National Picture:

The SHMI is currently published on a monthly basis. Each publication includes discharges in a rolling twelve-month period.

The SHMI compares 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, given the characteristics of the patients treated there.

For any given number of expected deaths, an upper and lower bound of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the trust in question is considered to have a higher or lower SHMI than expected.

The latest SHMI published for Gateshead Trust on the 19th September 2019 covering the period from May 2018 to April 2019 has a SHMI Banding of 'As Expected' with a score of 1.03

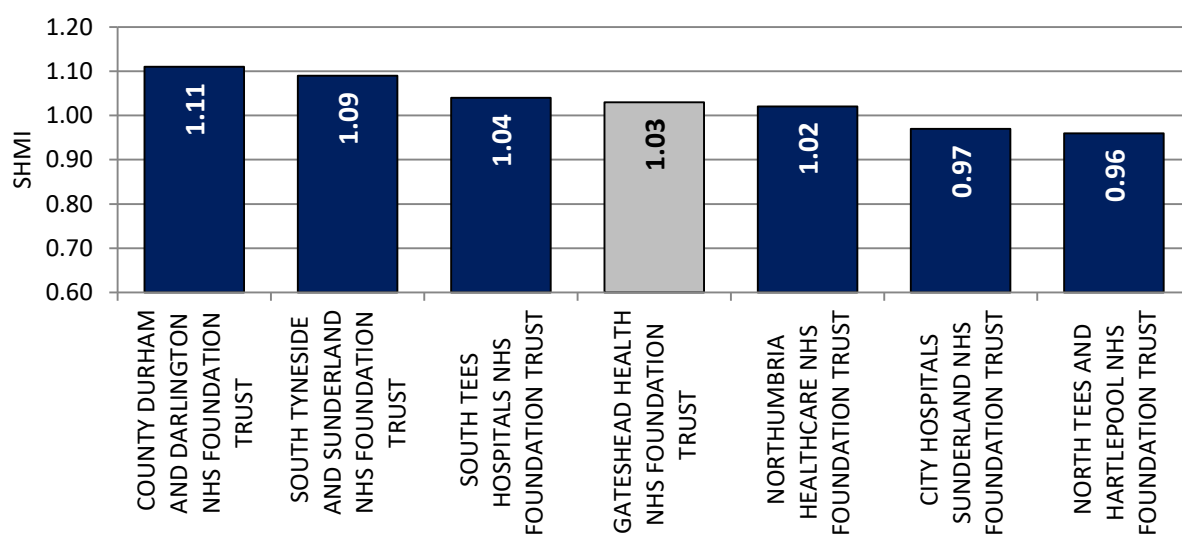


For the 130 Trust included in the SHMI from 1 May 2018 to 31 April 2019:

- 14 Trust had a higher than expected number of deaths.
- 103 Trust had a number of deaths within the expected range.
- 13 Trust had a lower than expected number of deaths.

Comparison to local Trusts, Gateshead Health NHS Foundation Trust has the fourth highest SHMI of North East Trust for the period. All Trust have a SHMI banding of deaths in the expected range.

SHMI - North East Trusts



3. Trust based data analysis:

The Hospital Standardised Mortality Ratio (HSMR) is a risk based assessment using a basket of 56 primary diagnosis groups which account for approximately 80% of hospital mortality.

The HSMR is the ratio between the number of patients who die in hospital compared to the expected number of patient deaths on the basis of average England figures given the characteristics e.g. presenting and underlying conditions, age, sex, admission method, palliative coding.

The HSMR covering the twelve month period July 2018 to June 2019 is 106.9, identifies the Trust as having deaths as expected when compared to Trust nationally, taking into account the Trust patient case mix.

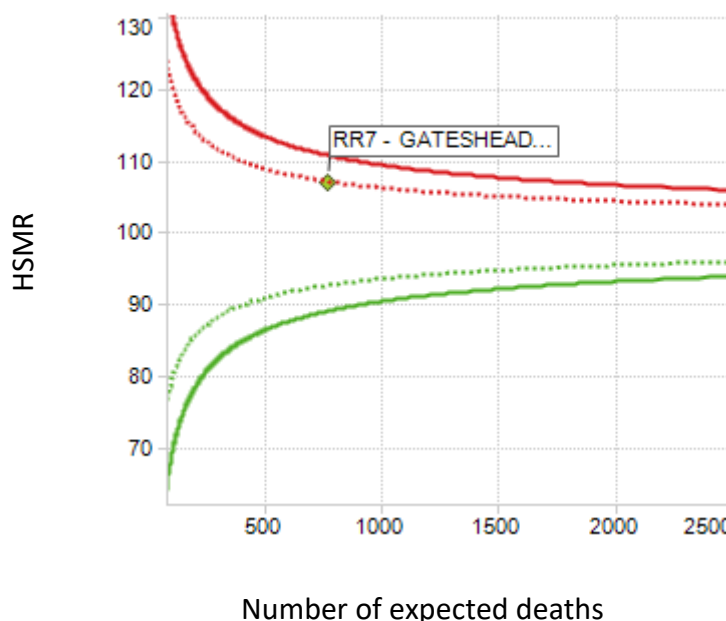
#	Trust	Score
1	RVW NORTH TEES & HARTLEPOOL	91.4
2	RTD THE NEWCASTLE UPON TYNE HOSPITALS	96.90
3	RXP COUNTY DURHAM & DARLINGTON	102.6
4	RR7 GATESHEAD HEALTH	106.9
5	RTF NORTHUMBRIA HEALTHCARE	108.3
6	RTR SOUTH TEES HOSPITALS	112.6
7	RLN CITY HOSPITALS SUNDERLAND	114.9
8	RE9 SOUTH TYNESIDE	118.5

Colour key:

Green: Represents that the trust is below or between the 95% Control limits

Amber: Represents that the trust is between the 95% and 99.8% Control limits

Red: Represents that the trust is above the 95% 99.8% Control limits

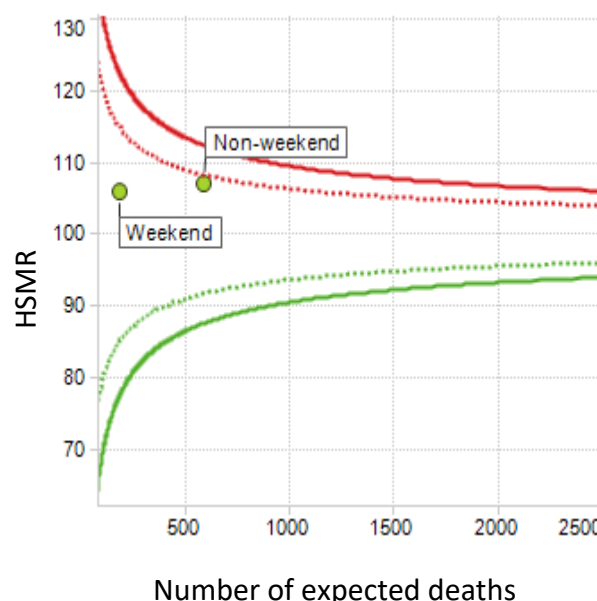


Previously, the Trust HSMR had been identified as higher than expected between June 2018 and April 2019. The latest figures see the HSMR return to the expected range. The HSMR is sensitive to palliative care coding (unlike the SHMI) for which the Trust is considered to have a relatively low palliative care coding. Section 4 comments on work to explore this further.

Comparison to regional Trusts, four Trusts (North Tees, Newcastle, County Durham and Gateshead) have an HSMR within the expected range for this period and four Trusts have a high HSMR (red) above the 99.8% control limit.

Inpatient deaths HSMR by day of admission

Data from HED shows that the HSMR for both deaths resulting from weekend admissions, and deaths resulting from weekday admissions are as within the expected range.



4. Acting on mortality & morbidity surveillance

The Assistant Director of Quality has recently met with NHSI to discuss and review this further analysis.

A review of the palliative care coding across the region was discussed and again highlighted that Gateshead is often lower than other surrounding Trust, however, NHSI did acknowledge confidence in our analysis and mortality report. Further actions taken have been to meet with coding managers and the consultants in palliative care to review our data and discuss any potential options for improvement in practice. The specialist team currently use sticker identification for coding if they have been involved in patient care at a specialist level. However the following actions were agreed with aim of improvement and consistency for coding;

- Raise importance within team of using colour coded sticker identification.
- Record all intervention/advice given by SPC team (tel. call advice received from St Bedes, ad-hoc ward request for advice when visiting a different patient).

- Recording of intervention into specialist areas such as chemotherapy day unit, (gynaecology and A&E- team advised currently capture this in their data).

Clinical classification diagnosis groups with more deaths than expected

Diagnosis Groups with significantly more deaths than expected for the period June 2018 to May 2019.

- Intestinal obstruction without hernia
- Skin and subcutaneous tissue infections

25 of 30 cases have been reviewed and the outcomes of those reviews were identified as definitively 'not preventable'.

	Number of Deaths	Number Expected By HSMR Model	Number reviewed	% reviewed	Hogan 1 Definitely not preventable
Intestinal obstruction without hernia	14	6.6	12	85.7%	100%
Skin and subcutaneous tissue infections	16	8.3	13	81.3%	100%
Total	30	14.9	25	83.3%	100%

Mortality Alerts from HED

There are currently no new mortality alerts identified in HED (the system used to monitor and analyse mortality indicators by the Trust.) The previous alerts still remain in place; however, the majority of cases have been reviewed and are identified as definitively 'not preventable'.

- HSMR - Abdominal Pain
- SHMI – Coagulation and Haemorrhagic disorders
- SHMI – Urinary Tract Infections

Indicator	Clinical Classification System (CCS) Group	Period	Observed	Expected	Value	Comments	Hogan 1 Definitely not Preventable
CUSUM	Peripheral and Visceral Atherosclerosis	June 2019	3	1.4	3.41	2 x Hogan 1 1 x Hogan 2*	66.7%
SHMI	Cancer of head and neck	Jun-18 to May-19	3	0.51	589.67	3 deaths; 2 deaths were inpatient deaths. Both Hogan 1 Definitely not preventable	100%
SHMI	Peripheral and visceral atherosclerosis	Jun-18 to May-19	17	7.86	216.30	17 inpatient deaths. 15 reviewed; 13x Hogan 1; 2 x Hogan 2*	86.7%
SHMI	Urinary Tract Infections	Jun-18 to May-18	70	44.8	156.26	70 deaths; 36 as inpatients. 30 deaths reviewed; All Hogan 1 Definitely not preventable.	100%

***Hogan 2 – Slight evidence of preventability case details**

There were three cases from alerts where slight evidence of preventability was identified. All three cases have been reviewed by the Trust Mortality Council and learning actions identified.

Case 1; related to a patient who required transferred from overseas to Critical Care. Care during transportation was considered unsatisfactory. The Trust provided appropriate care from admission to department however a CT scan identified ischaemic bowel which led to the patient's deterioration and subsequent death.

Case 2; related to a patient admitted as planned for total parenteral nutrition to be followed up with vascular surgery at the Freeman Hospital for treatment. However, the patient suffered a cardiac arrest and subsequently a DNACPR was completed. Surgical teams discussed expediting to the Freeman Hospital however this was declined by Newcastle due to an outbreak of norovirus on the receiving ward. The patient died prior to the procedure being rescheduled.

Case 3; related to a patient with a diagnosis of a thrombus in the coeliac axis, which was judged to be 'not likely amenable to any intervention and unsalvageable at outset. However the thrombus

was originally missed on the initial CT report. The case is to be discussed at the radiology discrepancy meeting.

5. Trust Mortality Database and Learning from Deaths

The Trust is required to provide figures relating to mortality review and preventability, these figures are provided below.

	Deaths in period	Deaths reviewed	%	Hogan 1	Hogan 2	Hogan 3	Hogan 4	Hogan 5	Hogan 6
All Deaths	1032	826	80.0%	97.8%	1.6%	0.4%	0.2%	0.0%	0.0%
Learning Disability Deaths	4	4	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Mortality Review Compliance

80.0% (826 of 1032) deaths have been reviewed and included deaths occurring between September 2018 and August 2019.

- 97.8% of cases are identified as being definitely not preventable.
- 79.5% of cases reviewed were identified as good practice.
- 17.9% of cases identified room for improvement.
- 0.2% (1 death) identified as potentially avoidable (Hogan score ≥ 4)

Learning Disability Deaths

Over the same period there were four deaths recorded as learning disability deaths. All were identified as definitely not preventable.

Learning Themes

Learning themes will be re-analysed in October to identify themes from mortality reviews for deaths between April and September 2019.

6. Update on the Learning from Deaths work stream / Medical Examiner Service

The final business case for the Medical Examiner Service has not yet been submitted, as confirmation of funding is still awaited. Correspondence has been received from NHS England/NHS Improvement, there is a lack of detail around the funding, and not enough to include in the business case.

Regional offices are being set up to support the implementation of the Medical Examiner at Trust level.

Following a meeting with the Medical Director, Associate Medical Director and Assistant Director of Quality, it was agreed to contact the National Medical Examiner office to obtain clarification and further detail regarding Trust level funding and timescales for regional office set up.

The improvement event in April 2019, identified that the audit of the 'Last Offices' process was no longer being undertaken. With the support of the Clinical Audit Manager, this has been reviewed, and reinstated as of September 2019. The conducting of 'Last Offices' is being audited in real time electronically by the Mortuary Team. Results will be fed back to ward sisters via their monthly meeting on a quarterly basis. In September, 75 cases were audited, the results identified varying compliance with the 'Last Offices' process. The ward level detail will be shared via the Ward Sisters meetings on a quarterly basis.

7. Recommendation

The Board is asked to receive this paper for information and assurance.

**Mortality & Morbidity Steering Group
Sub-Committee update**

1.	Number of meetings held during the last 6 months.
	Six meetings were scheduled and they all went ahead.
2.	Core Membership
	The core members are : • Medical Director (Chairperson) • Associate Medical Director or Associate Directors (Deputy Chair) • Director of Nursing & Midwifery • Assistant Director of Quality • Head of Risk and Patient Safety • Head of Service or nominated representative • Information Manager/Analyst • SafeCare Leads/ Clinical Risk Managers • Head of Pharmacy • Consultant Microbiologist • Bereavement Care Co-ordinator • Clinical Head of Service • Clinical Coding Manager • SafeCare Lead – Claims, Inquests & Duty of Candour • Strategic Safeguarding Lead • SafeCare Lead – Clinical Effectiveness
3.	Attendance
	The steering group has been well attended over the last six months, all six meetings were quorate.
4.	Review of Terms of Reference to ensure the committee/group is fully discharging its remit.
	The Terms of reference were reviewed and updated in February 2019, date of next review is February 2020.
5.	Summary of main issues dealt with during the last 6 months
	The Trust continues to deliver a SHMI within the ‘number of deaths expected range’ and receives mortality performance updates at every meeting. The Trust’s monthly HSMR remained above the 100 national average for 17 consecutive months from June 2017 – November 2018 and was identified as an outlier with more deaths than expected. The steering group commissioned NEQOS to undertake a review of the Trust’s HSMR. The findings were as follows:

- The high 'HSMR' at the Trust is largely explained by the low Palliative Care coding.
- Mortality review and the Serious Incidents process has only identified a small number of cases involving harm in 2018.
- The mean centred analysis highlights the winter peak for Dec 2017 / Jan 2018 which was seen across the NE and England.
- Looking at the deaths by CCS group doesn't reveal any problems with Pneumonia, Sepsis and COPD; it may be that there is some room for improvement in the coding for Primary diagnosis.
- High mortality for lung cancer is common to most of the NE. Proximity to Newcastle probably reduces spells but not deaths in Gateshead.
- The mortality indicators show the trust deaths relative to the expected deaths per the statistical models for HSMR and SHMI.
- The models are influenced by a trust's coding, in particular the Primary diagnosis, also the Secondary and Palliative Care (PC) coding.
- Trust PC coding is low which reduces the number of expected deaths, estimates for the impact for these factors on HSMR is approximate:
 - 8 points for Palliative Care coding
 - 4 points potentially relate to excess mortality in specific CCS groups (Some excess mortality relates to cancer, particularly lung cancer)
- No specific cause for the high HSMR, or concern about quality of care, has been identified.
- The data for Serious Incidents shows just 2 deaths for 2018.

Numbers of mortality reviews undertaken are monitored at each meeting, coupled with specialty level mortality reviews being presented throughout the year, to provide details of number of deaths undertaken, themes identified and actions taken.

Liaison with bereaved relatives/carers continues via the bereavement office in relation to mortality reviews, whereby any negative feedback received via the End of Life questionnaire is passed to the Mortality Council to undertake 2nd level review. The same process applies for any feedback received via formal complaints.

The steering group have received and monitored compliance with recommendations within reports published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and Clinical Outcome Review Programme.

Other work presented to the group includes:

Approval of the Rapid Release of Bodies Policy

Approval of the Treat as One Terms of Reference and presentation on the work undertaken in this project to date

Quarterly reports on learning from inquests and investigations

Updates on Bereavement Services

Presentation of the results from the National Audit of Care at the End of Life

Updates from the National Medical Examiners Office

Review of the national Learning Disability Mortality Review Report

Assurance on the work of the Organ Donation Committee and Trust performance in relation to

organ donation and transplantation Review of the National Guidance for Ambulance Trusts and Learning from Deaths Assurance on the Perinatal Mortality Review Tool and Saving Babies Lives Campaign	
6.	Summary of incidents reported and actions taken.
There have been no incidents reported in the last 6 months.	
7.	Assurance provided to the Board/Co-ordinating Sub-Committee that the Trust is in compliance with relevant legislation, guidance, governance issues and SafeCare issues.
An annual report was presented on all NCEPODs currently open on the system. The number of mortality reviews undertaken from September 2018 – August 2019 currently stands at 79.4%.	
As described in section 5, the steering group commissioned an external review from NEQOS to understand the high HSMR. The outcome of this review has provided assurance that there is no specific cause for the high HSMR, or concern about quality of care. This has been relayed through the Trust's committee structure. This findings were also discussed with NHS Improvement.	
The latest Trust HSMR for July 2018 to June 2019 is 106.9 placing the Trust with deaths in the expected range.	
8.	Identification of future issues that may impact on the Trust, i.e. new legislation, guidance, activity/demand issues, etcetera.
The National Quality Board published further guidance around learning from deaths, specifically for ambulance trusts. This guidance requires acute trusts to ensure processes are in place to notify ambulance trusts of any deaths of patients that had previously been in the care of the ambulance trust where a review by the ambulance trust may be warranted in relation to the care provided by them. This includes situations where the bereaved have a raised a concerns about the care provided by the ambulance trust along with any concerns raised by the trust mortality review system.	
The guidance also asks that the organisation be supportive of approaches from ambulance trusts in relation to learning from deaths, where they may be merit in undertaking a joint review of care.	
9.	Identification of any future significant initiatives/areas of work that the committee/group is looking to pursue in the forthcoming year.
Medical Examiner The implementation of the Medical Examiner System remains a significant piece of work.	
In April 2019 an improvement event was held to design and develop processes for the Medical Examiner Service. A model was developed, and a briefing provided to the Central Management Team in May 2019. However, the final business case has not yet been submitted, as confirmation of funding is awaited from the Department of Health and Social Care. The Department of Health and Social Care have committed to the medical examiner service being cost neutral to Trusts, based on their suggested model. Correspondence has been received from NHS England/NHS	

Improvement, however, there is a lack of detail around the funding, and not enough to include in the business case. The National Medical Examiner office have been contacted to obtain clarification and further detail regarding Trust level funding and timescales for regional office set up.

Job descriptions for a Lead Medical Examiner, Medical Examiner and Medical Examiner Officer are currently being drafted, with a view to commencing recruitment as soon as the business case is developed and approved.

Discussions with the Finance Department and the Mortuary have taken place and a process agreed for invoicing funeral directors for cremations.