MANCHESTER HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Report of:	Professor R C Pearson, Medical Director Miss Toli Onon, Medical Director
Paper prepared by:	Mrs S Corcoran, Director of Clinical Governance
Date of paper:	December 2017
Subject:	Learning from Deaths
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities	To improve patient safety, clinical quality and outcomes
Recommendations	The Board of Directors is asked to note this report.
Contact:	Name: Mrs Sarah Corcoran Tel: 0161 276 8764

Introduction

This paper aims to provide assurance to the Board of the work underway across the organisation to implement the National Quality Board's (NQB) National Guidance on Learning from Deaths (LFD).

Background

The Care Quality Commission (CQC) report '*Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The guidance released in March by the NQB aims to kick-start a national endeavour, helping to initiate a standardised approach to reviewing and learning from deaths.

Requirements of the guidance:

1. All Trusts to have a mortality policy in place by September 2017 on how organisations respond to and learn from deaths

2. All mortality policies should include a clear process for engagement with bereaved families and carers including giving them an opportunity to raise questions or share concerns in relation to the quality of care received by their loved ones.

3. From April 2017 - collection and publication of specified information on deaths through a paper and agenda item to a public board meeting set out in the Trust's policy (by end Q2) and publication of the dashboard and learning points (by end Q3). The dashboard data will also need to be summarised in the Trust's Quality Account from June 2018.

Mortality Review Policy

Both legacy Trusts had a Mortality Review Policy and CMFT had published on their public facing website as required by the guidance.

The legacy CMFT document is available here:

http://www.cmft.nhs.uk/media/1820267/mortality%20review%20policy%20final%20july%202017.pdf

The legacy UHSM document was ratified but not published.

Both documents are aligned with the guidance and the post transaction implementation plan details the aim of bringing these together and publishing as one policy by the end of January 2018.

The policies aim to ensure all deaths are reviewed in a consistent manner, ensuring that there is meaningful and compassionate engagement with bereaved families and carers in order to answer their questions then learn from and act on the information gathered. The policies define the process within the Trust for monitoring mortality indicators such as Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR).

Mortality Data Summary

At December 2017 the primary metrics for organisational mortality measurement stand at:

SHMI: 100[1]
HSMR: 91.7[2]
Crude death rate: 1.23[3]

All of these are as expected or below.

Whilst some assurance can be taken from these metrics, it is evident that each can be impacted on by issues other than quality of care, such as the translation of information into coding or the complexity of activity across the Trust. In order to learn and improve quality of care it is therefore important that deaths are subject to further review.

The Trusts aims to review deaths from the following cohorts, as set out in the Learning from Deaths guidance:

- All deaths where the patient is aged under 18
- All maternal deaths
- All neonatal deaths
- Any unexpected death
- Any death as a result of VTE
- All deaths where the patient has MRSA
- Any death where the circumstances are subject to a HLI
- Any death of a patient resulting from a 'Never Event'
- Any death deemed as avoidable following an EBM meeting
- All deaths where bereaved families and carers or staff, have raised a significant concern about the quality of care provision
- All inpatient, outpatient and community patient deaths of those with learning disabilities, in addition these deaths will also be submitted for LeDeR review.
- All deaths in a service specialty, particular diagnosis or treatment group where an 'alert' has been raised with the Trust through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator)
- All deaths in areas where people are not expected to die, for example in relevant elective procedures
- Inpatient detained under Mental Health Act
- Deaths where a theme has emerged
- A further sample of other deaths that do not fit the identified categories so that the Trust can take an overview of where learning and improvement is needed most

[1] NHS Digital Data Period – July 16 – June 17
[2] MFT internal data rolling year period
[3] MFT internal data last reported month

overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday. This must include patients whose death was expected and may have had an End of Life Care Plan in place

- The Trust will review a case record review following any linked inquest and issue of a 'Regulation 28 Report on Action to Prevent Future Deaths' in order to examine the effectiveness of the review process

The data are presented below split by the two legacy sites:

Currently the sites associated with the two legacy organisations use the same principles of review there are two different scoring methodologies.

The South sites use the Structured Judgement Review (SJR) which uses a 1-6 scoring methodology.

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

The central sites use a slightly different methodology:

Grade 0 – no suboptimal care
Grade 1 – suboptimal care but different management would not have prevented the death
Grade 2 – suboptimal care, different care might have made a difference (possibly avoidable death)
Grade 3 – suboptimal care, different care would reasonably have been expected to make a difference (probably avoidable death)

The methodologies will be brought together by March 2018.

Central Manchester & Trafford Sites

	Deaths (not Learning Disability)			Reviews				Learning Disability Deaths		
Quarter	Total	Reviewed	Avoidable > 50%	Grade 0 No Suboptimal Care	Grade 1 Suboptimal care did not contribute to	Grade 2 Suboptimal care may have contributed to death	Grade 3 Suboptimal care probably contributed to death	Total	Reviewed	Avoidable > 50%
17/18 Quarter 1	473	91	1	70	17	3	1	5	1	0
17/18 Quarter 2	420	81	0	67	12	2	0	8	0	0
Total YTD	**893**	**172**	**1**	**137**	**29**	**5**	**1**	**13**	**1**	**0**

Wythenshawe Sites

	Deaths (not Learning Disability)			Reviews						Learning Disability Deaths		
Month	Total	Reviewed	Avoidable > 50%	Score 6 Definitely not avoidable	Score 5 Slight evidence of avoidability	Score 4 Probably avoidable but not very likely	Score 3 Probably avoidable	Score 2 Strong evidence of avoidability	Score 1 Definitely avoidable	Total	Reviewed	Avoidable > 50%
17/18 Quarter 1	335	78	0	69	6	3	0	0	0	2	2	0
17/18 Quarter 2	316	88	3	73	7	5	3	0	0	3	3	0
Total YTD	**651**	**166**	**3**	**142**	**13**	**8**	**3**	**0**	**0**	**5**	**5**	**0**

In summary for the data period reported (April 2017 - September 17) 893 patients died and of those reviewed there was one death identified that was deemed as avoidable and a further eight where it was felt that sub-optimal care may have contributed to death.

Outcome of Reviews

The reviews have identified a number of themes; they are presented below.

Positive:

- Very few deaths of the total reviews defined as avoidable
- No identified risk of increased mortality by day of admission (slightly raised for the period on a Sunday but not statistically significant)
- Improvements to sepsis management, though further work still required
- Good end of life care
- Good management of complex surgery
- Good input from palliative care team

Improvements required:

- Failure to recognise deterioration
- Failure to respond
- Poor communication – particularly record keeping
- Medicines contraindication
- Pre-operative assessment
- Serious harm from falls
- Review of outcomes for patients discharged on a Saturday or Sunday which is statistically higher than for patients discharged during the week. This needs further exploration as it may include patients discharged on a rapid discharge pathway at end of life.

- Review of deaths of patients with a Learning Disability (Currently 22%, target 100%)
- Accuracy of coding and increase in capture of Charlson indices

Action Underway in Response to Learning

- Increased consultant presence on orthopaedic wards and improved ortho-geriatric support
- Sepsis Group operational
- Acute Care Team education sessions
- Emergency Bleep Review and dissemination of learning
- Continuation of Human Factors training, focus on communication and non-technical skills
- Falls Team review of all falls and sharing of learning
- Trust wide changes on nutrition support for patients who are nil-by-mouth
- Education for medical staff on the management of patients with Parkinson's Disease when nil-by-mouth
- Meeting between the Emergency department, ICU and Acute Medicine to discuss the identification of learning disability deaths and review of lessons learned
- Simulation sessions continue for Nurses on the management of tracheostomy
- Implementation of a group wide project on the electronic patient record and improvements to records management

- Review of pre-operative preparation processes
- Work on smoking reduction in pregnant women
- Improvements to end of life care
- Changes to the Obstetric Induction Policy

- Coding reviews and improvements to coding process
- Improvements to be made to reviews of deaths of patients with an identified learning disability
- Implementation of Divisional Mortality review Panel, chaired by a Non-Executive in order to drill down on local issues and action
- Review of cases of patients discharged at weekend

Recommendations

The Board of Directors is asked to receive the report and note the actions taken to further reduce avoidable harm.