Saving lives, Improving lives

Northern Care Alliance NHS Group

Salford Royal NHS Foundation Trust (SRFT) & the Pennine Acute Hospitals NHS Trust (PAT)

Title of Report	Group Learning from Deaths Report

Meeting	Group Risk Assurance Committee
Authors	Roger Prudham, Director of Professional Standards and Mortality Lead for the Northern Care Alliance NHS Group Rheanne Laybourn, Mortality Improvement Project Lead, Northern Care Alliance NHS Group Alison Talbot, Head of Legal Services, Northercare Care Alliance NHS Group
Presented by	Roger Prudham, Director of Professional Standards and Mortality Lead for the Northern Care Alliance NHS Group
Date	July 2019

Executive Summary	This paper represents the Northern Care Alliance (NCA) scheduled Group 'Learning from Deaths' report in compliance with National Guidance requirements. This report provides: • The Q4 report for 2018/19; • Provides a dashboard report for awareness and scrutiny in line with National Guidance and the required National Reporting Criteria; and • Sets out how Salford Care Organisation and the North East Sector (NES) Care Organisations systematically review and learns from deaths. **Key points:** • In Q4 85% of SJR have been completed across the NCA. The focus for Q4 2018/19 for the NES Care Organisations was; (1) improve learning outputs by using data and business intelligence , and; (2) switching to the Datix Mortality Module to streamline current systems. • Business intelligence from Dr Foster, CHKS and NHS Digital has been shared with the NES Care Organisation Mortality Oversight

Groups to assist with the development of a bespoke mortality Learning from Deaths Agenda and mortality improvement strategy.

- SJRs have been completed electronically in Q4 2018/19 using the Datix Mortality Module.

  The Module has assisted with quality improvement controls on the quality of SJRs and will assist with audits of the governance models at each Care Organisation with evidence of the process from Structured Judgement Review; Mortality and Morbidity Meetings, and; Care Organisation Mortality Overview Groups.

  The roll out of the Datix mortality module has caused a delay to completion of the SJR's as additional training and demos were required for staff trained in Structured Judgement Review methodology across the NES Care Organisations. As a result of the delay in completion, the embedded evidence of the governance model and embedded learning for Q4 2018/19 will be available in Q1 2019/20.

- The NCA continues to increase the uptake of trained SJR reviewers across the multi-disciplinary team by offering training sessions across all sites. The number of Consultants, Nurses and Allied Health Professional trained in SJR case records review methodology has increased at the NCA to 133.

Mortality Alerts

- Salford Care Organisation is in the **below expected range** on the HSMR and SMR rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard.

- HSMR across the NES Care Organisations remains within the **as expected range** for HSMR and SMR on the rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard.

Oldham Care Organisation

- **HSMR** at the Oldham Care Organisation has increased since the last quarterly report. The HSMR is above the peer group average, at 107. Whilst the HSMR confidence interval remains in the as expected range; the increase is being closely monitored by Oldham Care Organisation's Oversight Mortality Group and a focus group convened by the Medical Director,

with the aim to improve HSMR to within acceptable variation limits (below 100).

Clinical reviews of targeted CCS Diagnostic Basket Groups and Patient Safety Indicators using Structured Judgement Review Methodology continue to be completed alongside coding and standards assurance audits performed by NHS Digital approved clinical coding auditors from Salford Care Organisation. Corrections addressing data quality and coding have been submitted to SUS, however, the effect on HSMR will not be processed by Dr Foster intelligence until August 2019.

Clinical improvements in service delivery will not have an immediate effect on HSMR due to the reporting process used by Dr Foster. Dr Foster uses a rolling 12 month trend relative risk methodology, published 5 months in arears. Improvement work in clinical service delivery may not have an effect on HSMR for at least 6 months.

- **SHMI** for the Oldham Care Organisation, available from NHS Digital on a rolling 12 month period February 2018 to January 2019 and published 5 months in arears, is at 1.02.

- Whilst it is recognised that there are issues with Oldham Care Organisations relative risk HSMR profile on the Dr Foster Scorecard, specifically the use of palliative care coding. It is recognised by Oldham Care Organisation that there is an upward trend in relative risk and an outlier present on both HSRM and SHMI mortality indices.

  SHMI differs from HSMR in that it includes deaths within 30 days of discharge and no adjustment is made for palliative care. The data is produced by NHS Digital and is calculated using Hospital Episode Statistics (HES) data linked to Office for National Statistics (ONS) death registrations data.

Bury and Rochdale Care Organisation

- **HSMR** at Fairfield General Hospital has continued to increase and is now at 97. Whilst the HSMR confidence interval remains in the as expected range; the increase is being closely monitored.

- **SHMI** for Fairfield General Hospital, available from NHS Digital on a rolling 12 month period February 2018 to January 2019 and published 5 months in arears, is at 1.08.

	• This has been discussed at the Bury and Rochdale Mortality Oversight Group and a focus group convened by the Medical Director will be addressing HSMR and SHMI and an action plan will be implemented for Q1 2019/20. • The learning from deaths event has been confirmed for 21st September 2019 with key note speakers including the National Medical Examiner (provisional) and a former National Mortality Case Record Review Manager & Patient Safety Programme Manager at The Royal College of Physicians.
Annual Plan Objective	**Corporate Priorities supported by this paper:** 1. To pursue quality improvements, to assure safe, reliable and compassionate care. 3. To support our staff to deliver high performance and improvement. 4. To improve care and services through integration and collaboration. 5. To demonstrate compliance with mandatory standards.
Associated Risks	Lack of embedded learning from patient safety incidents, inquests and mortality will increase risk to patient safety and impact negatively on the reputation of the Northern Care Alliance NHS Group. Non-compliance in reporting and learning from deaths as per the National Guidance may result in additional performance monitoring being implemented, and the organisations ability to identify and address themes to improve patient safety.
Recommendations	The committee is asked to note and approve the content for submission to Committees in Common (Board) and subsequent dissemination throughout the Northern Care Alliance NHS Group, commissioning organisations and the general public. The committee is asked to note progress on the action plan devised by Oldham Care Organisation to support with HMSR.
Public and/or Patient Involvement (including equality related impact) None	

Communication: The report should be shared internally with the Care Organisations, and following approval at Group Executive Assurance and Risk Committee, submitted to Committees in Common, and subsequently shared with external partners and the public.

Freedom of Information

Please 'cross' one of the boxes below:

a) This document does not contain confidential information and Can be made available to the public.	x
b) This document contains some confidential information that would Need to be redacted before the document was made available to the public.	
c) This document is entirely confidential, as the redaction of confidential Information would render the document meaningless.	

1. Introduction

The NCA is committed to learning from both positive and negative aspects of patient's care, with a clear process for completing mortality reviews and providing a clinical judgement on areas of preventability. Learning identified during mortality reviews allows specialities to review and improve their processes, with collated learning providing corporate themes for larger quality improvement projects. The NCA is committed to systematically investigating, reporting and learning from deaths and delivering a clinical quality improvement agenda.

2. Scope

The purpose of this report is to inform the Board and the general public of the progress of, and findings from, mortality reviews for Q4 2018/19 data and learning.

3. Mortality Review Process

Each reported death is reviewed in line with three levels the NCA has adopted in line with the National Quality Board guidance:

1. Death certification.
2. Case record review, through SJR methodology or other nationally indicated reviews LeDer, MBRRACE or Child Death Review.
3. Investigation – service level, serious incident (SI) reported on StEIS or safeguarding.

The three levels of review are not systematic and any deaths identified at Stage 1 or 2 will be immediately escalated to Stage 3 investigations if they are identified as meeting the StEIS or safeguarding criteria.

The Care Organisations report quarterly on the number of deaths that are considered to have been "preventable". A Hogan score of 4+ will trigger a more detailed review by the Clinical Division to determine if the declaration to an SI is required.

If a cause for concern is identified about the care provided this must be escalated for discussion at the Mortality & Morbidity Meetings (M&M) and/or reported as a clinical incident.

3.2 Developments in the Mortality Review Process

The NES Care Organisations are working towards implementing a revised mortality process that aligns with Salford Care Organisation. Each death will be reviewed using a four step process:

1. Death Certification, GP Summary and Clinical Coding.
2. Care Quality Review.
3. Case record review, through SJR methodology by an independent Consultant or other nationally indicated reviews LeDer, MBRRACE or Child Death Review.

4. Investigation – service level, serious incident (SI) reported on StEIS or safeguarding.

The NES Care Organisations face unique structural challenges in comparison to Salford Care Organisation who benefits from an electronic patient system (EPR) and health information system (HIS) with systems interoperability. Oldham Care Organisation has been piloting the revised mortality process on wards F7 (Respiratory), F9 (Medical) and AMU with plans to expand into the other NES Care Organisations in Q4 2018/19.

An electronic Deceased Handover of Care that includes a care quality review has been developed by Oldham Care Organisation in Q4 2018/19 and the form is expected to go live for Q2 2019/20.

The delay in the launch of the electronic form is due to unexpected user surface technicalities with Healthviews that are expected to be resolved by the IM&T Department within the next quarter. In the interim, a paper death summary and screening tool will be rolled out across the NES Care Organisations. This should assist with the total number of deaths being reviewed and put the NES Care Organisations on an improved trajectory towards the aim of 100% of deaths being reviewed by March 2020 pending the launch of the electronic form.

4. SJR Methodology

The NCA will continue to review all deaths using case record review methodology that are triggered in line with the National Guidance on Learning from Deaths:

- Learning Disability (SJR & LeDer);
- Serious Mental Illness (SJR);
- Perinatal and maternal deaths (MBRRACE);
- Child Deaths (Child Death Overview Process);
- Unexpected deaths; elective admissions and certain cardiac arrests (SJR);
- Care concern and/or complaint and/or ‘alarm’ (SJR);
- Planned improvement work (SJR);
- Regulation 28 Report on Action to Prevent Future Deaths (SJR); and
- Random selections of deaths.

4.2 Developments in the SJR Methodology

The criteria for SJR methodology for Q4 2018/19 included additional triggers:

- All care organisations within the NCA reviewed deaths where an SI was being undertaken to triangulate all elements of learning from deaths;

- In Q4 2018/19 Oldham Care Organisation reviewed a random selection of deaths aligned with mortality alerts from Dr Foster and CHKS intelligence as part of the HSMR mortality improvement action plan.

Each Care Organisation within the NCA will continue to develop bespoke triggers that are individual to the patient population and services to understand prime mortality factors and help plan improvement work. This will be in addition to the minimum requirements of the National Guidance on Learning from Deaths and will be led by the Clinical Mortality Lead and overseen by the Care Organisation Mortality Oversight Group/Committee.

4.3 Challenges to completing SJR's and Learning from Deaths

A key focus for Q4 2018/19 was to enhance opportunities for learning across the NCA and improve the quality of SJR's complete. The roll out of the Datix mortality module has caused a delay to completion of the SJR's as additional training and demos were required for staff trained in Structured Judgement Review methodology. As a result of the delay in completion, the embedded evidence of the governance model and embedded learning for Q4 2018/19 will be available in Q1 2019/20.

Whilst these delays have caused the compliance to decrease it is important ot note the Datix mortality module has allowed:

- Joint Nursing and Medical Reviews;
- Learning Disability Deaths being reviewed by the Medical and Learning Disability and Autism Team;
- Quality improvement audits regarding the quality of the Structured Judgement Reviews completed with an attached record of the documentation and records used and internal communications;
- Quality improvement audits of the governance model with evidence of the process from Structured Judgement Review; Mortality and Morbidity Meetings; Care Organisation Mortality Overview Group; and
- Embedded evidence of key themes and learning using SMART (specific, measurable, achievable, realistic, and timed) actions.

5. Mortality Review Data Q4 2018/19

The below data (**Figure 1**) shows the total number of deaths with number and percentage of mortality reviews completed for each Care Organisation and preventability scoring allocated.
Key points:

- In Q4 2018/19 1296 deaths were recorded of which 11 patients were known to have Learning Disabilities.

- 16 of the 1296 deaths were investigated as Serious Incidents (SIs).

- 64 of 75 **(85%)** of deaths triggering an SJR mortality review methodology have been completed across the NCA.

- Salford Care Organisation continues to review 100% of all cases that are indicated within the National Guidance minimum requirements.

Preventability scoring:

- In Q4 2018/19 mortality reviews were undertaken for 426 cases with 425 confirmed as non-preventable deaths. There was 1 possibly preventable death identified.

  A further possible preventable death was identified during Q4 2018/19 from reviews pending in Q3 2018/19 at the time of publication of the quarterly Learning from Death Report from Salford Care Organisation.

- **The current total number of potentially preventable deaths due to problems in care identified across the NCA to date for 2018/19 is 8 (0.4% of all reviewed deaths n= 1952).**

Fig. 1 Q4 2018/19 Mortality Review Data for the Northern Care Alliance NHS Group

CO	Total	Total LD Deaths	Total Deaths SI	SJR	Number of SJR Reviews		Total Deaths Reviewed including those reviewed by SJR		Preventability scoring
North Manchester Care Organisation	240	2	3	**14**	Q3 18 (100%)	**Q4 12 (85%)**	Q3 62 (30%)	**Q3 44 (18%)**	44 Non-preventable deaths 0 Possibly preventable death
Oldham Care Organisation	356	3	2	**24**	Q3 18 (81%)	**Q4 16 (66%)**	Q3 59 (19%)	**Q4 63 (17%)**	63 Non-preventable deaths 0 Possibly preventable death
Bury & Rochdale Care Organisation	338	1	1	**6**	Q3 7 (70%)	**Q4 5 (83%)**	Q3 61 (23.7%)	**Q4 48 (14%)**	48 Non-preventable deaths 0 Possibly preventable death

Salford Care Organisation	362	5	10	**31**	Q3 35 (81%) **100% of national min. requirement*	**Q4 31 (100%)**	Q3 273 (75%)	**Q4 283 (74%)**	271 Non-preventable deaths 1 Possibly preventable death in review **6 in review*
NCA	1296	11	16	75	Q3 78 (83%)	**Q4 64 (85%)**	Q3 455 (40%)	**Q4 426 (32%)**	425 Non-preventable deaths 1 Possibly preventable death **6 in review*

*** Outstanding cases at the NES Care Organisations that are within the minimum requirements of the National Guidance on Learning from Deaths from Q3 & Q4 2018/19 have been allocated and are awaiting completion. It is anticipated these will be completed by publication of the Q1 2019/20 Learning from Death Paper***

Phase of care scoring:

Fig. 2a North Manchester Care Organisation
Of the 8 independent SJR reviews performed (72% of cases flagged) during Q4, care was rated as:

Phase of care *	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	1	1	5	3	2
Ongoing care	1	6	2	1	2
Care during procedure	-	-	3	-	-
Peri-operative care	-	-	2	2	-
End of life Care	3	2	3	2	2
Overall care	1	5	3	2	1

- 2 elective admissions triggered for Structured Judgement Review were not completed due to the deaths being reviewed under the formal complaints process.
- 2 Learning Disability Deaths: 1 case where overall care was judged to be poor and 1 case where overall care was judged to be adequate.
- 4 cases where overall care was judged to be poor, death was judged to be non-preventable.

Fig. 2b Oldham Care Organisation
Of the 8 independent SJR reviews performed (47% of cases flagged) during Q4, care was rated as:

Phase of care *	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	-	1	5	4	4
Ongoing care	-	1	2	8	2
Care during procedure	-	-	-	-	-
Peri-operative care	-	-	-	-	-
End of life Care	-	1	3	9	-
Overall care	**-**	1	5	8	**-**

- 1 SI triggered for Structured Judgement Review was not completed due to the death being reviewed under the formal complaints process.
- 3 Learning Disability Deaths; overall care was judged to be good in 2 cases and adequate in 1 case.
- 1 case where poor care was identified, death was judged to be non-preventable.
- 2 cases from the CCS Group 'Peri- *endo- and myocarditis cardiomyopathy*' have been forwarded to the Coding Team for coding and standards assurance following a front line review, an SJR has not been completed.

Fig. 2c Bury and Rochdale Care Organisations
Of the 5 independent SJR reviews performed (83% of cases flagged) during Q4, care was rated as:

Phase of care	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	-	-	1	2	2
Ongoing care	-	-	2	2	1
Care during procedure	-	-	-	2	-
Peri-operative care	-	-	-	1	-
End of life Care	-	-	3	1	1
Overall care	-	-	-	4	1

- 1 Learning Disability Death; overall care was judged to be good.

Fig. 2d Salford Care Organisation
Of the 31 independent SJR reviews performed (100% of cases flagged) during Q4, care was rated as:

Phase of care	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	1	5	1	12	12
Ongoing care	-	8	4	7	6
Care during procedure	-	-	1	-	-
Peri-operative care	-	1	1	-	2
End of life Care	-	3	10	6	12
Overall care	-	9	6	6	10

- 1 case death was judged to be possibly preventable and 6 are still in review.

6. Learning from Deaths

The below describes the learning taken following recent deaths. In addition, the NCA has a planned learning from deaths event will take place on 21st September 2019 with key note speakers including the National Medical Examiner (provisional) and a former National Mortality Case Record Review Manager & Patient Safety Programme Manager at The Royal College of Physicians.

A key focus for Q1 2019/20 will be translating learning from Mortality and Morbidity Meetings into SMART actions. A training session from the Quality Improvement Division will be showcased at the 'Learning from Death' event and support will be provided to Mortality and Mortbidity Leads.

North Manchester Care Organisation

Learning from Structured Judgment Reviews

SJR 1554 highlighted a late delay in the diagnosis of HIV. Incident and Inquest Data have identified the same theme and a NICE CG 60 Implementation Task and Finish group has been established to ensure that HIV screening practices are reflective of the needs of the local population and commissioned appropriately.

SJR 1282 highlighted poor care for patients with Learning Disabilities who transition into adult services. The SJR was discussed at the Bury and Rochdale Care Organisation and a Focus Group led by the Assistant Director of Quality Improvement has been established to investigate this further.

SJR 1512 & 1558 identified poor documentation and late referral to specialist multidisciplinary mental health teams. Both cases have been shared with the relevant Clinical Directorates to raise awareness and ensure cross speciality learning can be

facilitated and shared amongst colleagues.

SJR 1348, SJR 1511, SJR 1470 and **SJR 1771** highlighted poor end of life and/or specialist palliative care by the parent medical team. Cases have been shared with the relevant Clinical Directorates to raise awareness of specialist palliative care input and ensure cross speciality learning can be facilitated and shared amongst colleagues.

SJR 1348 and following investigation **R48395** a Patient Care Alert has been circulated that Oxygen cylinders valve will be checked to be in the full open position manually by the administering clinician.

SJR 3201 and following investigation **R39619** a Patient Care Alert has been reminding staff about handovers and making sure there is ownership of this in radiology so that referring teams have a point of contact. A Standard Operating Procedure for on-call referrals to the General Surgery Team has been developed by the Clinical Lead for Surgery.

Good practice themes identified from SJR	The following good practice has been identified from SJR during Q4: 1st 24hr of care: • Excellent teamwork with speciality teams; • Evidence of early senior Consultant review. Ongoing care: • Prompt multi-disciplinary involvement for patient with severe mental illness. Peri-operative care • Evidence of thorough work-up and multi-disciplinary involvement in optimising patient for surgery; • Evidence of good medical and nursing team-work and communication; • Pathways completed. End of life care: • Good recognition of end-of-life and family discussions with use of care plans to support holistic management.

Bury and Rochdale Care Organisation

SJR 1282 highlighted poor care for patients with Learning Disabilities who transition into adult services. The SJR was discussed at the Bury and Rochdale Care Organisation and a Focus Group led by the Assistant Director of Quality Improvement has been established to investigate this further.

Good practice themes identified from SJR	The following good practice has been identified from SJR during Q4: 1st 24hr of care • Prompt triaging; • Excellent teamwork with speciality teams; • Evidence of early senior Consultant review; • Prompt antibiotic administration. • DNACPR completed with patient and family for acutely unwell and high mortality risk presentations. Ongoing care: • Prompt multi-disciplinary involvement; • Prompt escalation of patients with elevated NEWS scores for assessment; • Evidence of regular senior medical review; Peri-operative care • Evidence of thorough work-up and multi-disciplinary involvement in optimising patient for surgery; • Evidence of good medical and nursing team-work and communication; • Pathways completed; • Clear instructions for post-op fluids, antibiotics and analgaesia. • Excellent documentation. End of life care: • Good recognition of end-of-life and family discussions with use of care plans to support holistic management.

Oldham Care Organisation

Learning from Structured Judgment Reviews

Following **R38962** a Patient Care Alert has been circulated reminding staff of the Policy for the Prescription and Administration of Oxygen in Adults in the Acute Setting, compliance with the Observation Policy/NEWS, recording of blood gases for patients with oxygen requirements and compliance with the clinical record keeping policy. A formal complaint from the family was partially upheld and assurances have been given to prevent reoccurrence.

HSMR CCS Diagnostic Group *'Septicaemia (except in labour)'*
SJR 1665, SJR 1666, SJR 1667, SJR 1668 and **SJR 1671** evidenced prompt antibiotic administration supported by microbiology advice. Improvements in care around end of life and specialist palliative care input were indicated.

HSMR CCS Diagnostic Group *' Peri- endo- and myocarditis cardiomyopathy'*
SJR 1685, SJR 1684 and **SJR 1680** evidenced early recognition of clinical symptoms and markers of infection. On call Cardiology opinions were appropriately sought. Two cases have been escalated to the Coding Team for coding and standards assurance.

SJR 1698 highlighted incomplete nursing documentation. This has been shared with the relevant Clinical Directorates to raise awareness and ensure learning can be facilitated and shared amongst colleagues.

SJR 1573 identified the need for staff to document care after death in detail in relation to family needs.

SJR 1473 identified clinical decision making out of hours was complicated by working culture and highlighted the importance of good communication and teamwork with NCA clinical colleagues. This has been shared with the relevant Clinical Directorates for cross organisational learning.

SJR 1474 identified unnecessary transfers for a patient who had been identified for palliative care. Clinical staff should be mindful of liaising with the specialist palliative care service for guidance on clinical management. This has been shared with the relevant Clinical Directorates to raise awareness of specialist palliative care input and ensure cross speciality learning can be facilitated and shared amongst colleagues.

Good practice themes identified from SJR	The following good practice has been identified from SJR during Q4: 1st 24hr of care: • Excellent teamwork with speciality teams; • Evidence of early senior Consultant review; • Evidence of prompt antibiotic administration supported by microbiology advice; • Good recognition of end-of-life and family discussions with use of care plans to support holistic management. Ongoing care: • Multi-disciplinary involvement in optimising high-risk patients; • Evidence of prompt antibiotic administration supported by microbiology advice; Peri-operative care • Evidence of thorough work-up and multi-disciplinary involvement in optimising patient for surgery; • Pathways completed.

	End of life care: • Good recognition of end-of-life and family discussions with use of care plans to support holistic management.

Salford Care Organisation

Co-ordinating patient care between the inpatient specialty area and community
Salford Care Organisation is working collaboratively with catchment CCG partners to explore the possibility of a wider GM solution for the long-term management of this patient group.

Optimising use of acute non-invasive ventilation (NIV)
There has been a submission to EPR for a series of digital tools to be installed as a long term adjunct to caring for patients requiring NIV.

There is ongoing educational work being undertaken to develop the skillset of the hospital at night team to potentially deliver temporary acute NIV at the ward bedside when needed to minimise delay to initiation. The necessary scoping is being undertaken to ensure that the necessary supports are in place for this to be conducted with an emphasis on patient safety.

Meeting infection control standards in a time-critical emergency
Following investigation **R129690** a "Take 5" bulletin has been circulated to re-emphasise that urgent/emergency situations may mean that there has to be compromise of infection control policy.

Learning from Structured Judgment Review
SJR M3307 was associated with investigation **41435** led by group diagnostics and radiology with specialist input from the MCCN division. This case highlights the importance of considering blunt/ligamentous spinal injury where initial CT imaging may not show any initial gross traumatic injury. Clinical staff should be particularly mindful where the picture maybe confounded by:

- **CT with a large degree of degenerative changes** which may make detection of subtle changes such as disc space widening more difficult to identify. Where there is sufficient doubt, this may benefit from maintenance of spinal precautions until expert interpretation by a neuroradiologist can be obtained.

- **Patient confusion/agitation or potential other distracting injuries** that may cloud the clinical assessment of the neck. Any unexplained focal change in neurology in the context of ongoing neck pain despite previous normal CT imaging

should warrant urgent reassessment of the patient and consideration given to re-instituting spinal precautions and obtaining further investigations.

SJR M3393 reviewed the acute care provided to a patient with learning difficulty. This case identified the need for staff to help support patient decision-making specifically where declining a recommended treatment even where the patient may appear to have capacity by attempting to identify:

- What the patient's specific concerns and reasons are to decline advice given?
- Have these concerns been addressed sufficiently?
- Are there significant others that may help the patient understand and weigh-up the advice being presented?

SJR M3735 and M3783 highlighted the need for medical staff to be mindful of the potential for serious underlying pathology where patients develop newly emergent severe pain disproportionate to clinical findings such that it requires strong opiate pain relief.

SJR M3735 highlighted the value of being vigilant and taking a full drug history including OTC medication and considering key risk groups where relevant such as analgesics (NSAIDS), anticoagulants and immunosuppression.

Good practice themes identified from SJR	The following good practice has been identified from SJR during Q4: 1st 24hr of care • Excellent teamwork demonstrated during difficult resuscitation effort following the sudden unexpected death of a child presenting to ED. There was excellent bereavement support provided including arranging an appointment for parents to attend the mortuary over the weekend. Ongoing care: • Several instances of prompt antibiotic administration supported by excellent and timely microbiology advice; • Prompt escalation of patients with elevated NEWS scores for assessment; • Good clear language being entered into patient discharge summaries to support better user experience; • Excellent support and follow-up provided by specialist nurses including Epilepsy and Diabetes nurse specialists; • Evidence of regular senior medical review and senior specialty review on-call over weekends. Peri-operative care • Many examples of thorough work-up and multi-

	disciplinary involvement in optimising high-risk patients for surgery (surgical/anaesthetic/renal); • Evidence of good team-work and communication during unexpected operative deterioration that required necessary discontinuation; • Excellent duration and frequency of assessment of high-risk patients post-operatively in recovery. End of life care: • Good recognition of end-of-life phase supported by timely referral to palliative care and use of care plan to support holistic management; Excellent family discussions by surgical consultant following an unexpected death.

7. NHS priorities for improvement in care for patients with Learning Disabilities

The following conditions have been highlighted as a focus for future improvement to close the gap in reduced life expectancy for patients with Learning Disabilities and will be considered in the ongoing review of patient deaths within the NCA as part of our commitment to the LeDer review process:

- Sepsis: timely identification and treatment;
- Respiratory conditions;
- Pneumonia including uptake of the flu vaccine;
- Constipation and bowel management;
- Uptake of cancer services.

8. Mortality Indicators – Dr Foster Data Source

The HSMR is calculated each month for each hospital in England. It includes deaths of patients with the most common conditions in hospital which account for around of 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by a 100, from 56 baskets of the 80% most common diagnoses. If the HSMR is above 100 then there are more observed deaths than expected deaths. Upper and lower confidence intervals are applied to HSMR. HSMRs with values between the confidence intervals are consistent with random or chance variation. To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

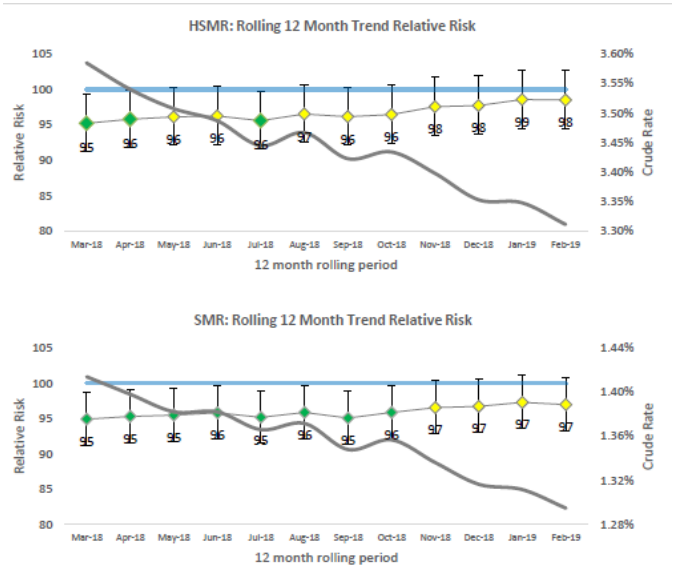
It is important to note that while the mortality indices from the Dr Foster data source are important, the frequency of risk groups (both in the treatments and operations that each hospital offers and the make-up of its local population) vary widely between Trusts. Whilst the HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors such as frequency of risk groups; local weightings such as lack of community-based hospice services and clinical coding errors may have an impact on HSMR as well as the quality of clinical services.

HSMR should be closely monitored alongside SHMI and RAMI mortality indices with intelligence from Dr Foster, CHKS and NHS Digital and internal intelligence from risks, incidents and complaints data forming part of the mortality strategy.

8.2 The NES Care Organisations

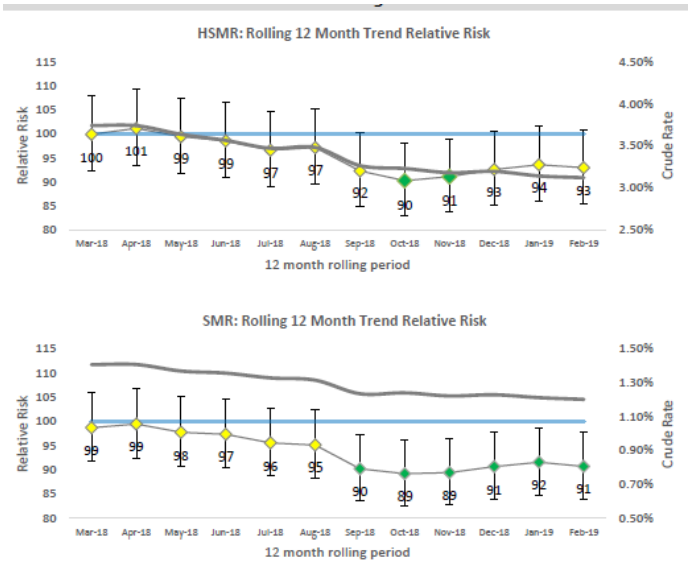
The confidence interval is in the **as expected range on the HSMR** and **SMR** on the rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard. HSMR data has slightly increased from 97 to 98 and is now above peer group average, **RR 98:94**.

The peer group average in the most recent Dr Foster scorecard since the last quarterly report has moved from 98 to 94 and this may be due to improvements in other Trusts relative risk profiles and/or a national benchmark change incorporated into the latest data update.



8.2.1 North Manchester Care Organisation

The confidence interval is in the **as expected range** on the HSMR and **the below expected range** on SMR rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard. HSMR data remains lower than the peer group average, **RR 93.**



4 CUSUM alerts were noted on the Dr Foster Scorecard. A clinical coding and standard data assurance exercise was completed for 2 of the 4 CUSUM alerts and no coding errors were reported. A low threshold for expected deaths was noted on all of the CUSUM alerts with no significant variation from the expected number. However, the Clinical Mortality Lead will be performing a front line review to assess whether the deaths should be escalated for further review using Structured Judgement Methodology in Q1 2019/20.

3 CCS Diagnostic Baskets were noted as possible mortality outliers with significant variation when reviewed further using CHKS Intelligence. A clinical coding and standard data assurance exercise was completed for 2 of the 3 CCS Diagnostic Baskets. The 1st CCS Diagnostic Basket 'Cancer of liver and intrahepatic bile duct' was found to have a significant amount of coding errors and it was determined no further action was indicated. A partial review of the 2nd CCS Diagnostic Basket 'Cancer of the Colon' found no coding errors and this alert will be escalated to NCA cancer quality improvement groups.

The 3rd CCS Diagnostic Basket 'Liver Disease – Alcohol Related' has been selected for further clinical review using Structured Judgement Review methodology as part of the Learning from Deaths agenda. The data will be available in Q1 2018/19.

No patient safety indicator was noted on the Dr Foster Scorecard.

8.2.2 Bury and Rochdale Care Organisation

The confidence interval for Fairfield General Hospital and Rochdale Infirmary is in the **as expected range on the HSMR** and **SMR** rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard. HSMR data remains lower than the peer group average, **RR 97** and **RR 82**.

The HSMR has slightly increased at both the Fairfield General Hospital and Rochdale Infirmary.

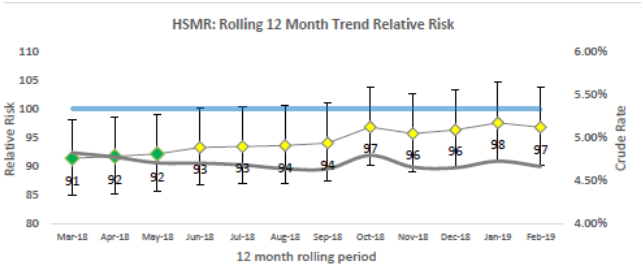
There is an upward trend in relative risk at Fairfield General Hospital on the Dr Foster Scorecard.

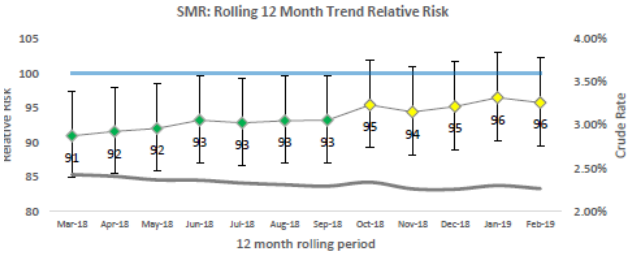
No CUSUM alerts or Patient Safety Indicators are noted.

CCS Diagnostic Basket '*Coma stupor and brain damage'* has been noted as a potential mortality outlier. This basket has been data assured and no coding errors were found. A random selection of deaths falling into this basket will be reviewed using SJR methodology as part of the Bury and Rochdale Care Organisation 'Learning from Deaths' agenda.

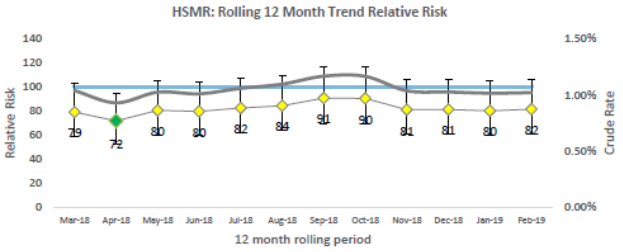
A focus group convened by the Medical Director will be addressing HSMR and SHMI and an action plan will be implemented for Q1 2019/20 and will be published in the next quarterly Learning from Death Report.

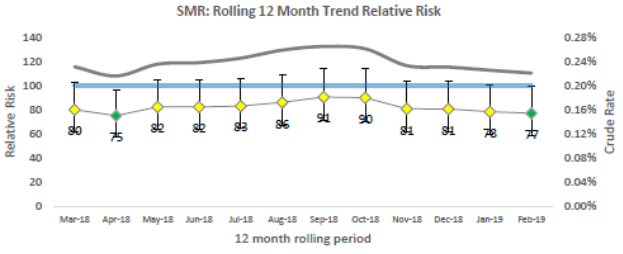
8.2.2.1 Fairfield General Hospital





8.2.2.2 Rochdale Infirmary

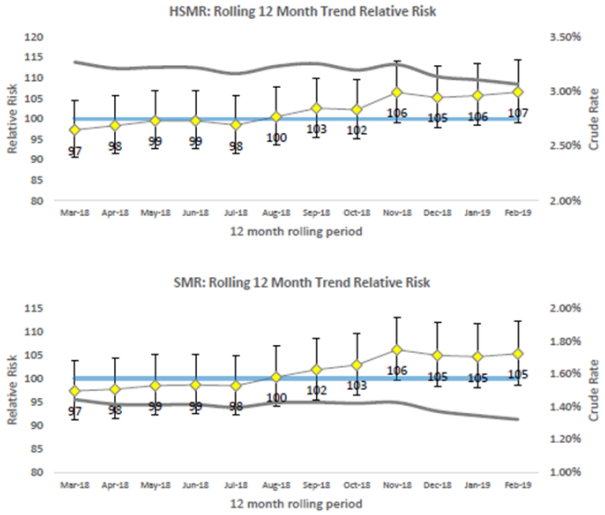




8.2.3 Oldham Care Organisation

The confidence interval is in the **as expected range on the HSMR** and **the SMR** on the rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard. HSMR data remains significantly above the peer group average, **RR107.**

As part of the HSMR action plan HSMR influencers from the Dr Foster Scorecard were investigated to understand the impact on Oldham Care Organisations relative risk profile.



8.2.4 Oldham Care Organisation - HSMR Action Plan

HSMR Influencer – Palliative Care Coding
It is noted that the palliative coding HSMR influence is significantly below the national average for both non-elective spells and non-elective deaths with specialist palliative care involvement (SPC). Oldham Care Organisation is performing at 1.71% for non-elective spells and 13.7%; the national average is 4.07% and 31.97%. Compared to other sites within the Northern Care Alliance using data from CHKS intelligence, Oldham Care Organisation is significantly underperforming and this will be contributing towards an increased relative risk profile for HSMR as the expected death denominator will be under estimated. Finished Consultant Episode (FCEs) deaths with palliative care code Z515 at Salford Care Organisation for March 2018 to February 2019 is 44.5%.

Finished Consultant Episode (FCEs) deaths with palliative care code Z515 at Fairfield General Hospital and Rochdale Infirmary for March 2018 to February 2019 is 32.8% and 8.3%, respectively. Finished Consultant Episode (FCEs) deaths with palliative care code Z515 at North Manchester Care Organisation for March 2018 to February 2019 is 31.9%. Finished Consultant Episode (FCEs) deaths with palliative care code Z515 at Oldham Care Organisation for March 2018 to February 2019 is 15.6%.	
Action	A focus group was convened by the Medical Director to investigated specialist palliative care services at the Oldham Care Organisation. It was noted that telephone consultations with the specialist palliative care team had not been allocated with a Z515 code. The clinical coding team have completed a further review of the deaths and allocated a Z515 code where this is documented in the clinical notes. Corrections addressing data quality and coding have been submitted to SUS, however, the effect on HSMR will not be processed by Dr Foster intelligence until August 2019. It is recognised that there is not a standard definition of what constitutes as 'specialised palliative care', and each Trust's palliative care team will differ, it strongly recommended that the clinical coding department works closely with the Trust's specialist palliative care team to identify when palliative care/specialised palliative care has been administered. The Clinical Coding team will continue to work with the specialist palliative care team to standardise the documentation and coding of palliative care and publish a policy on palliative care coding by September 2019. The focus group will continue to convene to discuss whether improvements are indicated in clinical service delivery with a business plan for a 7 day service at the Oldham Care Organisation scheduled for presentation in September 2019.

HSMR Influencer – Charlson Comorbidity Scoring	
The Charlson Index scores on the Dr Foster HSMR scorecard is above the national average for % of spells with a comorbidity score of 0 at 52.1%; the national average is 47.9%. The Charlson index scores on the Dr Foster HSMR scorecard is below the national average for % of spells with a comorbidity score of 20+ at 8.5%; the national average is 9.1%. Coding feedback has indicated that there is a potential weakness in clinical documentation. Coding relies upon explicit documentation of each individual condition that informs the Charlson Index. The Charlson Index will be underscored if the comorbidities are not listed. Although, only marginal differences are observed, this will be contributing towards an increased relative risk profile for HSMR as this will reduce the likelihood of expected death and therefore increase mortality for the site.	
Action:	A focus group was convened by the Medical Director and a revised Clerking Proforma has been designed by the Clinical Mortality Lead. The document has been circulated at the Medicine Mortality and Morbidity Meeting for review and feedback and will be presented at the July Mortality Oversight Group. It is anticipated that the document will be live by August 2019. Clinical Coding will be attending educational seminars to share best practice around documentation of comorbidities and performing ward walk rounds to raise the profile of the importance of recording comorbidities in clinical documentation.

HSMR Influencer – Weekend Admissions
It is noted that weekend admissions at the Oldham Care Organisation on the January 2018 – December 2019 Dr Foster Scorecard was an outlier. Site performance for Saturday was below the national average at 99.3; the national average was 101.6. However, site performance for Sunday was above the national average at 110; the national average was 101.

Intelligence from CHKS would indicate that the weekend admissions is an amber mortality alert, albeit, caution is advised as the trend is unpredictable.	
Action	A selection of weekend deaths have been randomly selected for review by the Mortality Lead for the Northern Care Alliance to understand any mortality trends and assess whether there are a patient safety concerns in service delivery. This review will be completed by September 2019 and findings will be available for the Q1 2019/20 quarterly report.

CCS Diagnostic Basket Groups	
Aspiration pneumonitis/food/vomitus A review of this diagnostic group was completed by a member of the Oldham Clinical Coding Team and a Consultant Physician. It was determined that there were errors with coding. ***Peri- endo- and myocarditis cardiomyopathy*** A selection of 6 cases was reviewed. No care concerns were noted following the review. ***Septicaemia (except in labour)*** A selection of 5 cases was reviewed by the Clinical Lead for Sepsis using Structured Judgement Review Methodology. No care concerns were noted following the review. It was noted that all of the patients had presented with a high risk of mortality. Although there were some minor delays it was concluded that this did not have an effect on the outcome for the patient. It was noted that there was no palliative care involvement in all 5 cases selected for review.	
Action:	***Aspiration pneumonitis/food/vomitus*** No further clinical action was indicated. The observed to expect deaths was no longer an outlier following identification of the coding errors. It was noted that impressions were being used instead of The Triangle Sign so that information cannot be coded. This was shared with relevant clinical teams and the Oversight

Mortality Group.

Peri- endo- and myocarditis cardiomyopathy
2 cases have been escalated to the Coding Team for coding and standards assurance.

Septicaemia (except in labour)
Dr Foster Intelligence has published a briefing on sepsis. One of the recommendations is that the Trusts' coding departments should work with their clinical teams to agree a clear internal process to identify which patients have sepsis. Part of this collaborative effort should include a clear agreement on how to distinguish between an identified local infection, such as a chest infection or urinary infection. A guidance document has been developed and shared with the clinical coding team.

The Clinical Lead for Sepsis has been leading improvement work on sepsis identification and management in the care organisation. Due to the reporting process used by Dr Foster (Dr Foster uses a rolling 12 month trend relative risk methodology, published 5 months in arears) this may not be reflected in the most recent HSMR scorecard.

Oldham Care Organisation is working towards a target of a minimum of 90% patients with red flag sepsis to be given antibiotics within 1 hour of identification by September 2019. Highlight reports on improvement work are forwarded to the Clinical Effectiveness Committee. The outlier will continue to be monitored by the COMOG with input from the Clinical Lead for sepsis.

The Clinical Sepsis Policy is being reviewed and an updated version is estimated to be completed by the end of July 2019.

The sepsis microsystem model is ongoing and this consists of a core group of the medical and nursing sepsis leads, QI representatives, nursing representatives from ED (inc paeds), and audit representatives along with other stakeholders when required who meet two weekly to drive changes and improvement in sepsis care. This group reports back

	to the sepsis steering group.

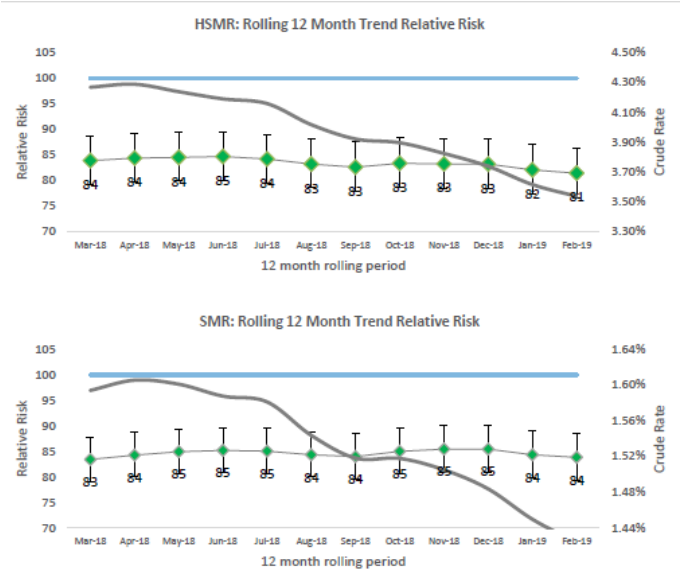
Patient Safety Indicators on Dr Foster and Incident and Risk Data	
Data from incidents and risks has been reviewed in line with Patient Safety Indicators from Dr Foster. A deep dive exercise is being undertaken led by the Northern Care Alliance Mortality Improvement Lead.	
Action	Deaths after surgery and deaths in low diagnostic groups were selected for a deep dive exercise. 20 cases have been selected from Gastroenterology, General and Colorectal Surgery for review by the Northern Care Alliance Clinical Lead for Mortality. A working task group is being convened led by the Clinical Lead for Mortality and surgeons trained in Structured Judgement Review methodology to complete the reviews by September 2019. The Northern Care Alliance Clinical Lead for Mortality has been providing support to the Gastroenterology team. The Gastroenterology Directorate has committed to providing a seven day service at the earliest opportunity. An outline business case is in development lead by the Clinical Director and the Directorate Manager. As mortality work has identified that there have been greater than expected numbers of deaths in HRGs within Gastroenterology and that HSMR by day of admission has been greater than expected for patients admitted on a weekend on the Oldham Care Organisation site to which Acute Gastroenterology cases are admitted, then the expectation is that the development of a seven day Gastroenterology service will contribute to improving patient experience, outcomes and ultimately mortality. A selection of deaths occurring on the discharge ward have also been selected for review by the Clinical Mortality Lead for Oldham Care Organisation using structure Judgement Review methodology to complete the reviews by September 2019.

	The Medical Director has been trained in Structured Judgement Review methodology and will be reviewing a random selection of Haematology deaths. Support will be provided to the Haematology Mortality & Morbidity Meeting by the Medical Director and Northern Care Alliance Mortality Lead in next quarter.

8.2.5 Salford Care Organisation

The confidence interval is in the **below expected range** on the HSMR and SMR rolling 12 month period January 2018 – December 2018.

HSMR data remains significantly lower than the national average, **RR 81: 98**.



Appendix 1: Oldham Care Organisation - HSMR Action Plan

Actions	Owner	Due by / Update
Review of harm allocated to incidents reported at Oldham CO. Exercise to be undertaken to provide assurance regarding ratios of harm reported within Datix. (Increases in harm levels would provide an initial indication of concerns regarding practices).	Medical Director, Head of Legal Services, Associate Director of Governance	COMPLETED
To quality assure the diagnosed outliers in the HSMR basket to determine if there are any coding errors.	Clinical Coding	COMPLETED
To measure staff mix on acute medical wards to determine mix between substantive and locum medical staff and triangulate against mortality – disparities to be escalated by medical division.	Re-allocated to Divisional Managing Director for Medicine and Urgent Care	OUTSTANDING 30 April 2019 Revised completion deadline of 12 July 2019
A sample audit of the diagnosis group (*within the HSMR basket) 'septicaemia (except in labour)' to be reviewed using SJR case record review methodology to determine quality improvement areas and opportunities for learning.	Clinical Mortality leads for medicine	COMPLETED
A sample audit of the diagnosis group (*within the HSMR basket) 'aspiration pneumonitis/food/vomitus' to be reviewed using SJR case record review Methodology to determine quality improvement areas and opportunities for learning.	Consultant Physician	COMPLETED
A sample audit of the diagnosis group (*within the HSMR basket) 'Peri- endo- and myocarditis cardiomyopathy' to be reviewed using SJR case record review methodology to determine quality improvement areas and opportunities for learning.	Consultant Cardiology	COMPLETED
Patient Safety Indicators on Dr Foster Dashboard to be data assured and reviewed using SJR case record review methodology to determine quality improvement areas and opportunities for learning.	Clinical Mortality Lead for the Northern Care Alliance	30 June 2019 Frontline review completed and working task group created to complete the clinical review by 30 September 2019.
Coding process will be reviewed with input from the North East Sector Clinical Palliative Lead to improve the current under coding of specialist palliative care	Clinical Palliative Lead and Coding	30 June 2019 Frontline review

patients.		completed and working task group created to complete by 30 September 2019.
Develop guidance for coding on specialist palliative care.	Clinical Palliative Lead and Coding	30 June 19 Frontline review completed and working task group created to complete by 30 September 2019.
To develop a business case to enable 7 day services for specialist palliative care patients.	TBC	30 September 2019
Scope changing the ward clerking Proforma to include the Charlson index; explicitly discourage recording of 'complex frailty' as a diagnostic term.	Clinical Mortality Lead	30 September 2019
To develop a business case to enable 7 day service on Gastroenterology.	CD Gastroenterology Medical Director/Associate Director of Governance	30 September 2019
Right patient right ward walk round to be included in the SJR reviews to determine if there is learning around patient transfers.	SJR reviewers	30 September 2019
To review volume and acuity trends for Oldham Care Organisation admissions.	Associate Director of Governance	30 June 2019
Coding ward walk rounds to educate Consultants on FCE1 and FCE2 and the importance of correct documentation.	Clinical Coding	On- going
A sample audit of weekend mortality to be reviewed using Structured Judgement Review Methodology	Clinical Mortality Lead	30 September 2019