Quality Committee

Meeting details

Committee:	Quality Committee
Date of Meeting:	21st January 2025
Title of Paper:	Quarterly Mortality Review (Quarter 3 2024/25)
Author:	Frances Lowrey, Mortality Review Manager
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Approval
Submission to Committee:	Regulatory requirement for each financial quarter

Overview of Paper

The Mortality Review report includes patient mortality incidents reported in Q3, 2024/25. The data includes natural causes and unexpected deaths, including suspected suicides.

Mortality data is reviewed monthly and presented at the Mortality Review Group for discussion. Actions are assigned to members when required.

Issues to bring to the committees attention

- Mortality incidents reported between September and November 2024 remained consistent. There was a noticeable dip in December 2024 (110). With Death Notification numbers not seeing a decrease in Q3, further exploration to review the rates of all incidents reported to InPhase in December 2024 is planned, which will identify any shortfalls and action accordingly. There are indications that the rate of all incidents reported in December 2024, may have reduced.

- Progress has been made to improve the SJR process across the trust. The main focusses have been to identify staff for training and to review 25% of the backlog of cases, as agreed. The learning from mortality incidents risk (7668), remains poorly controlled with risk mitigation status not met. However, this will improve as SJR progresses in Q4 2024/45.

- Suspected suicides reported in December 2024 were at their lowest over the 15 month period. A review of the mortality data in December has shown no indications of this data being incorrect, however could be linked to the reduction in mortality incidents reported, and once explored may alter the figures. Cause of death is also being review with Legal Services to ensure alignment of mortality and inquest data.

- Gaps in ethnicity recording in healthcare records (RiO) need to be explored as a trust, in order to better understand our data and patient cohort.

Governance

Implications/Impact: Patient safety
Risk recorded on: Trust Risk Register
Risk IDs: 7668. **Current Rating:**12. **Target rating:**6
Assurance/Oversight: Mortality Review Group and Trust Wide Patient Safety and Mortality Review Group

1. INTRODUCTION

1.1 The purpose of the report is to fulfil the expectations in relation to reporting, monitoring and the Board's oversight of mortality incidents, as set out in the National Quality Board's 'Learning from Deaths' guidance (March 2017). This builds on the recommendations made by the MAZARS investigation into Southern Health (Dec 2015), the CQC report 'Learning, Candour and Accountability publication' (Dec 2016) and the Learning Disabilities Mortality Review (LeDeR) which is managed by NHS England. This is further reflected in our local policies and procedures to ensure we discharge our duties effectively, and as such the Committee would be familiar with the report history and purpose.

2. HOW MORTALITY IS REVIEWED IN KMPT

2.1 The Patient Safety Incident Reporting Framework (PSIRF) was introduced by the NHS to improve how we learn from patient safety incidents or events. We'll also learn from good practice when things go well.

2.2 The Patient Safety Incident Response Framework (PSIRF) sets out how the NHS responds to these patient safety events so we can learn from them and improve patient safety.

2.3 There are national and local PSIRF priorities that KMPT are guided by.

2.3 KMPT implemented PSIRF on 30th September 2024. A weekly patient safety incident decision panel was set up, to replace the Serious Incident and Mortality Panel. Mortality is reported and reviewed by the Directorate Governance teams. The purpose of the group is to review incidents (including mortality) that may require further exploration, such as a thematic review, After Action Review (AAR) or Patient Safety Incident Investigation (PSII).

2.4 In addition to this panel and PSIRF processes, the trust has a monthly Mortality Review Group meeting, chaired by Interim Director of Quality and Safety or appointed Deputy. In this meeting, a monthly mortality report is presented to enable discussion relating to local and National mortality data. This group is made up of various Governance leads, Heads of Nursing, Complaints, Legal, and medical representation.

2.5 The trust also has a learning review group, that meets once a month, chaired by the Chief Nurse, where learning from deaths can also be discussed.

3. ANALYSIS OF INFORMATION

Figure 1: Mortality reported cases

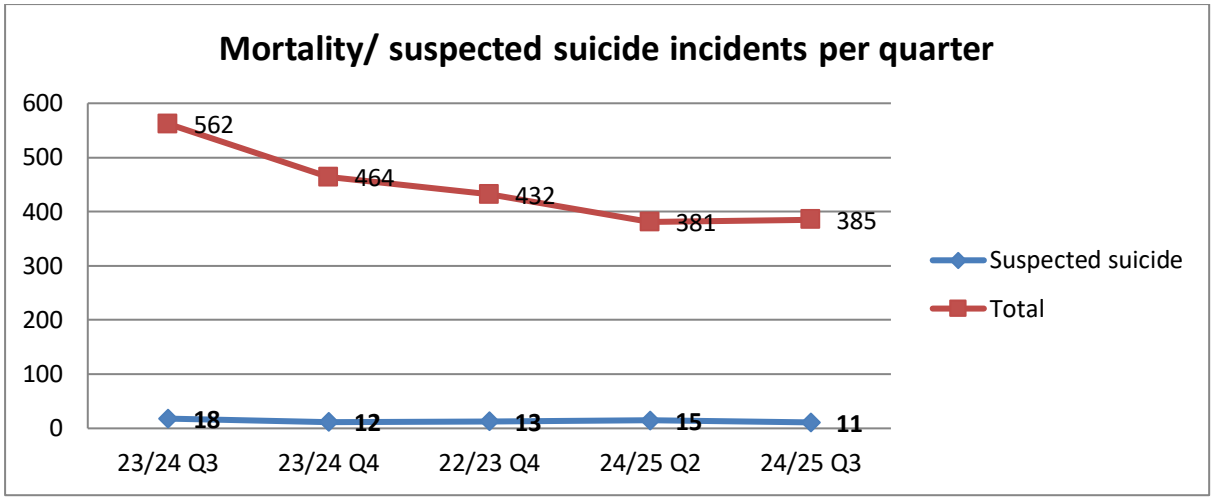
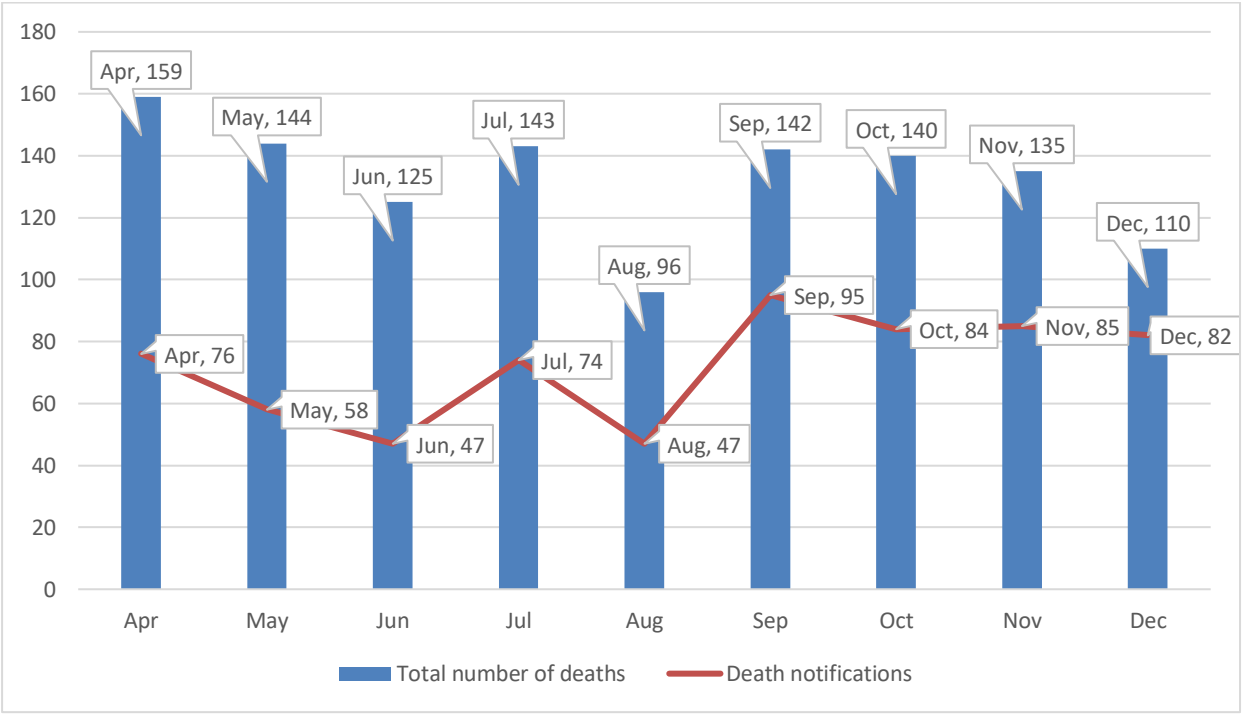


Figure 2: Mortality rates compared to death notifications



3.1 As previously explained to the Board, the number of mortality incidents reported was significantly higher in Q2 2023/24, due to the historic death backlog. Processes have been strengthened since this time, through Power BI to ensure timely and accurate reporting of mortality. 65% (252) of the mortality incidents reported in Q3, are recorded as Death Notifications. 87% (220) of all Death Notifications relate to deaths of patients over the age of 65.

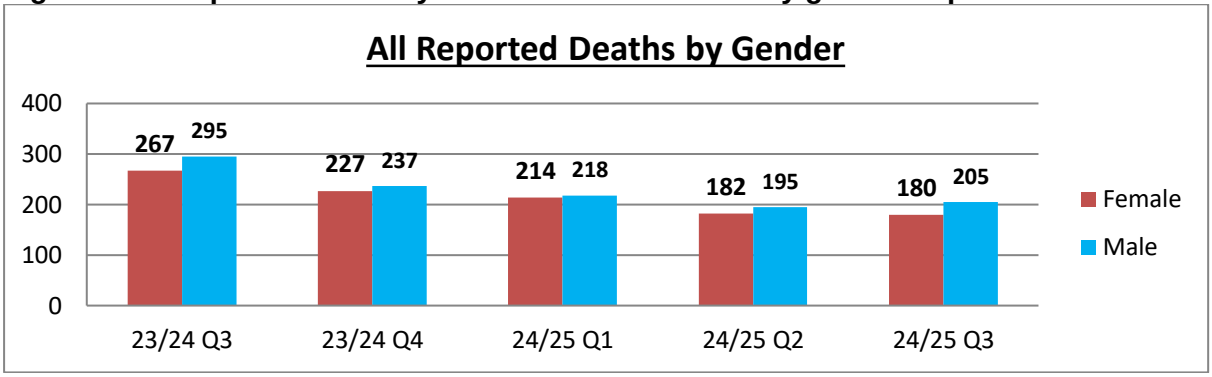
3.2 385 mortality incidents were reported on InPhase in Q3. This is a 1% increase when compared to Q2 data. There was a reduction in mortality in December 2024 as shown in Figure 2. The data indicates that death notifications have remained consistent in Q3.

3.3 303 of the 385 deaths reported, are of patients over 65 years of age.

3.4 There are initial indications that overall incident reporting reduced in December 2024. The reduction will be explored by the patient safety team, by means of a review of all incidents reported on InPhase in December 2024.

3.5 KMPT are currently benchmarking mortality and suicide data against other organisations. This is an ongoing piece of work and findings will be shared through the Trust Board.

Figure 3: All reported mortality incidents within KMPT by gender of patients



3.6 KMPT continues to mirror the local and national rates of mortality in males and females. Mortality rates in males does tend to be marginally higher, as demonstrated in Figure 5.

Mortality review by ethnicity
Figure 4: Deaths by ethnicity

	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2	24/25 Q3	Total
Asian or Asian British - Any other Asian background	3	2	0	0	1	6
Asian or Asian British - Bangladeshi	0	0	0	0	1	1
Asian or Asian British - Chinese	0	0	0	1	0	1
Asian or Asian British - Indian	4	2	1	2	4	13
Asian or Asian British - Pakistani	0	1	0	0	0	1
Black, African, Caribbean or Black British – African	0	1	0	1	2	4
Black, African, Caribbean or Black British – Caribbean	0	0	0	3	2	5
Mixed or Multiple groups - White and Asian	1	1	2	0	0	4
Mixed or Multiple groups - White and Black Caribbean	0	2	0	1	1	4
Mixed or Multiple groups - Any other mixed or multiple ethnic background	1	1	0	0	1	3
Not stated / Unknown	81	117	83	60	77	418
White - British	466	329	341	297	286	1719
White - Irish	0	2	2	0	1	5
Any other ethnic group	0	0	1	2	2	5
White - Any other White background	6	6	2	10	7	31

3.7 The findings regarding ethnicity are unchanged from previous mortality reports. 74% relate to people who are from a white–British background, which is consistent with the local population profile being predominantly white-British, and what national data tells us.

3.8 We continue to see low numbers of deaths of patients of ethnic minority.

3.9 20% (77) are recorded as ethnicity not known or stated according to the InPhase record.

3.10 The monthly mortality report reviewed all deaths reported in November 2024 where ethnicity was recorded on InPhase as not known or stated. The review of healthcare records found that out of the 31 deaths, 74% did not have an ethnicity recorded in the RiO record (52% ‘Not requested- not known. 22% ‘Unable to request- not known).

3.11 Discussions with the trusts Business Intelligence team has confirmed that it is each organisations responsibility for recording ethnicity, as this is not an element that is part of the synchronisation with GP records or the Spine.

3.12 The project to link InPhase and RiO is set to launch in January 2025. Although this will improve elements of data recording, we may not see noticeable improvement of ethnicity data recording in InPhase, if data is recorded as not requested or known in the healthcare record.

3.13 This finding will link into existing work on improving Equality, Diversion and Inclusion (EDI) data. Discussions are to be taken to the EDI Steering Group.

4 STEIS REPORTED DEATHS

4.1 Two deaths were reported on STEIS in Q3 2024/25. One in West Kent and one in North Kent. Both are subject to a PSII under PSIRF.

4.2 The number of STEIS reported deaths has significantly reduced since the implementation of PSIRF on 30th September 2024. This is expected as the trust has adapted processes to work in line with the Patient Safety Incident Response Plan (PSIRP), national and local priorities.

4.3 The impact of PSIRF is still to be determined and the trust are in the early stages of working in line with this new national framework. This work is monitored via the PSIRF workshops, Patient Safety Incident Decision Panel and the Learning Review Group.

4.4 Learning from patient safety events under PSIRF is determined through methods such as Rapid Reviews (RR), After Action Reviews (AAR) and Thematic Reviews (TR). A PSII will be undertaken if the death meets the national or local PSIRP.

5 KMPT SUSPECTED SUICIDES

Figure 5: Suicide by directorate/quarter

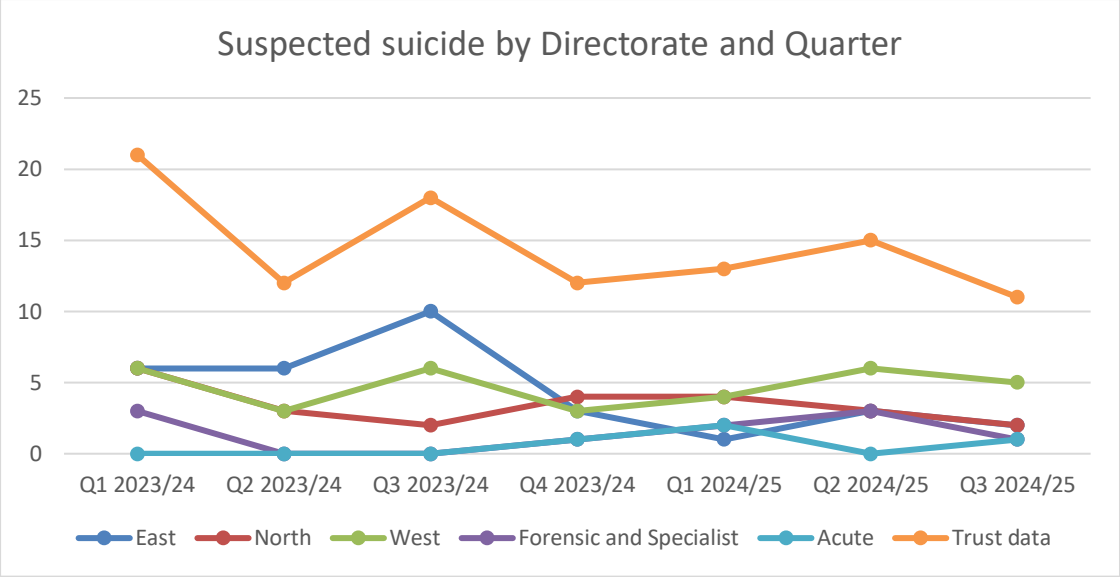
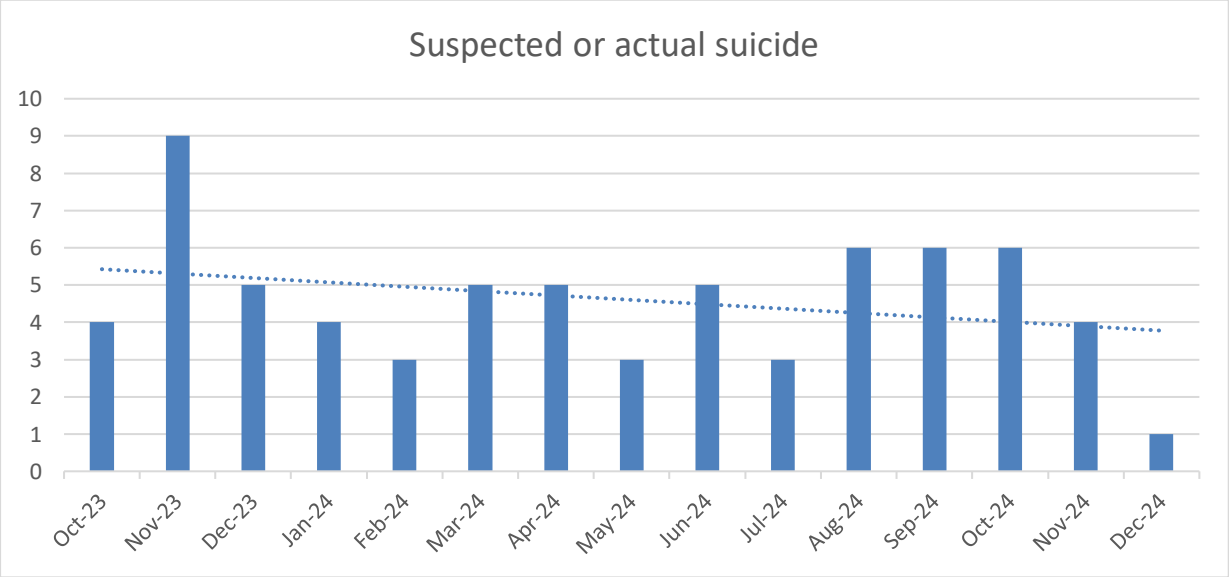


Figure 6: Suspected suicide by month



5.1 The most recent ONS stats for the period 2021-2023 placed the Kent (11.7) and Medway (12) rates at slightly higher than the average for England (10.7).

5.2 Suspected suicides reported in Q3 2024/24 were lower than previous quarters, with December reporting 1 (lowest over the 15 month period). The mortality review manager and Inphase team have examined the December 2024 mortality data and there are no indications at this stage that suspected suicides were under reported. This may change once the reduction in incident reporting for December is explored.

5.3 As InPhase is a live system, it is possible that incident categories are amended once cause of death is known and inquest conclusions are received. Therefore, number of suspected suicides may rise if information known indicates suicide at a later date.

5.4 Data will be continued to be monitored via the Mortality Review Manager and Mortality Review Group. A scoping exercise with Legal services will also be undertaken to compare suicide data across the two Inphase systems.

5.5 A review of the trust suicide prevention aims one year post implementation of the approach (December 2023) will be undertaken by suicide prevention colleagues. Where rates of suicide will be considered.

Figure 7:Suspected suicides by age and gender

	Q1 2024/25		Q2 2024/25		Q3 2024/25	
	Male	Female	Male	Female	Male	Female
18-19	1	0	1	0	0	0
20-29	1	0	0	1	2	0
30-39	1	2	2	0	2	0
40-49	0	1	2	0	2	1
50-59	1	0	3	3	1	1
60-69	1	2	2	0	0	1
70-79	0	3	0	0	0	1
80-89	0	0	0	1	0	0
90-99	0	0	0	0	0	0
Total	**5**	**8**	**10**	**5**	**7**	**4**

5.5 As shown in Figure 7, the common age of suspected suicide for males and females has varied each quarter. The Q3 suspected suicide data is represented by a younger demographic compared to Q2. This will be explored through the suicide prevention network. as nationally, it is known that suspected suicides in middle-aged males (40-54 years) is typically higher than any other age category.

5.6 KMPT have applied to become members of the National Suicide Prevention Alliance (NSPA). This is an exciting opportunity to connect with other agencies across the country, working collaboratively in the prevention of suicide.

5. STRUCTURED JUDGEMENT REVIEW

5.1 There remains a number of outstanding, unallocated Structured Judgement Reviews. A review of 25% (approximately 25) of the backlog of cases will be completed by trained reviewers over the course of January.

5.2 Progress has been made to improve the SJR process across the trust. This has involved:

Organising Structured Judgement Review training for senior clinicians and medical staff (aim for 5 representatives from each Directorate). Two in-person workshops planned for 13th and 23rd January 2025. (Approximately 30 members of staff have volunteered for training).

Overtime arranged for colleagues to review 25% of the SJR backlog. Four senior nurses have agreed to review approximately 25 outstanding SJRs as overtime. Training is being delivered to staff in order to complete the reviews.

Allocation of Structured Judgement Reviews will begin once training has been delivered (January 2025).

Development of a Structured Judgement Review Standard Operating Procedure (SOP), that includes guidance for staff on how and when to complete an SJR. This is draft SOP is currently in the review process before ratification.

Discussion with Mortality leads across the systems, through Communities of Practice and the Mortality System Learning group in how we learn from SJRs, how learning is shared, and how we evidence improvements from learning from death.

Figure 8: Risk ID (7668) actions:

Action	Owner	% Complete	Start Date	Due Date	Completion Date (est)	Comments
Mortality App report *(within InPhase to monitor progress of SJR's)*	Mortality Review Manager	*Cancelled*	21/06/2024	30/08/2024	30/08/2024	18/12/2024- Action cancelled- Agreement to discontinue Mortality App. SJR is now managed through the incident app.
Mortality Review Group Terms of Reference	Mortality Review Manager	100%	21/06/2024	31/07/2024	31/07/2024	Complete and agreed by the group
To reduce and remove the Structured Judgement Review backlog	Mortality Review Manager	10%	21/06/2024	02/01/2025	02/01/2025	Training sessions planned for 13th and 23rd January, with additional ad-hoc sessions arranged for some staff. SJRs will be allocated once training has been received.
Training of staff to undertake Structured Judgement Reviews (Total 10)	Mortality Review Manager	100%	24/04/2024	30/08/2024	01/08/2024	
Additional actions set – December 2024						
Structured Judgment Review SOP to be produced	Mortality Review Manager	50%	18/12/2024	31/01/2025	31/01/2025	Draft SOP shared with Chief Medical Officer and Deputy Chief Medical Officer

Structured Judgement Review training	Mortality Review Manager	0%	18/12/2024	31/01/2025	31/01/2025	Training sessions planned for 13/01/2025 and 23/01/2025.

5.3 Risk ID 7668 will continue to be monitored by the Mortality Review Manager. Training is the main focus to progress with completion of SJRs. There is an aim for the backlog to be cleared by the end of January 2025.

6 THE MEDICAL EXAMINER

6.1 KMPT have worked with the Medical Examiner Officers in Kent and Medway to agree process. KMPT will only need to refer a death to the ME if the death occurred on a KMPT ward and was expected (not referred to the Coroner).

6.2 A Medical Examiner Standard Operating Procedure (currently in draft) has been developed to guide staff through the process of referring to the Medical Examiner and for completion of the Medical Certificate Cause of Death (MCCD).

6.3 Work has been achieved in Q3 to promote this process via Doctors CPD, and the Mortality Review Group.

6.4 **Next steps are:**

- Medical Examiner SOP to be ratified and disseminated
- Visit wards to determine staffs understanding of the ME process and if they are aware of the MCCD location
- Add a dedicated Medical Examiner section to Resilience Direct (pending approved ME SOP).
- Additional MCCDs to be obtained by the Department of Health and Social care, so that each ward has their own copy. (Next roll out is April 2025).

6.5 From implementation (9th September 2024) to the date of this report (January 2025), there have been no KMPT deaths that has required a referral to the Medical Examiner.

6.6. Deaths will continue to be monitored via the Directorate Governance teams and Mortality Review Manager, and referrals to the Medical Examiner will actioned accordingly as and when required.

7 RECORDING DEATHS AS OUTCOMES

7.1 NHS England have highlighted that KMPT are an outlier for the number of fatal harm graded incidents, picked up by the clinical review team.

7.2 Events, once the level of harm is amended, are updated on the LFPSE portal, however, NHS England have advised that deaths of no concern should not be recorded as an incident type.

7.3 To ensure fatal harm graded incidents are accurately recorded, NHS England have suggested the trust record deaths as outcomes, rather than incidents, with guidance that

“expected deaths” can be recorded, and changed in the system to become PSIs if it is decided there may be elements of a PSI.

7.4 As of Monday 2nd December 2024, the trust adopted this process. A briefing paper was agreed by key colleagues, outlining the proposed process, which includes a flowchart for staff to follow.