Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**26 September 2018**		

Title of Report:	**Learning From Deaths Quarterly Update**
Status:	**Progress Update**
Board Sponsor:	**Dr Bernie Marden, Medical Director**
Authors:	**Dr Bernie Marden, Medical Director**
Appendices:	

1.	**Purpose of Report (Including link to objectives)**
The Trust is required to report quarterly on its activity relating to Learning From Deaths as mandated by Secretary of state for Health and Social Security and monitored by NHSI and the CQC.	

2.	**Summary of Key Issues for Discussion**
Update on methodology Latest reporting data Future plans for improving methodology	

3.	**Recommendations (Note, Approve, Discuss etc)**
Board of Directors is asked to note, support and approve the content of this report and any inherent actions within.	

4.	**Care Quality Commission Outcomes (which apply)**
Regulation 10 – Person-centred Care Regulation 12 – Safe care and treatment Regulation 17 – Good Governance	

5.	Legal / Regulatory Implications (NHSLA / ALE etc)

In December 2016, the Care Quality Commission (CQC) published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

The Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

6.	Risk (Threats or opportunities link to risk on register etc)

Resource implications

7.	Resources Implications (Financial / staffing)

While not dealt with explicitly in this report the Learning from Deaths program of work requires resourcing in terms of clinician time, IT support and administrative personnel and resources. This requires regular review against what the output of this work is able to achieve.

8.	Equality and Diversity

All services are delivered in line with the Trust's Equality and Diversity Policy.

9.	Communication

Reported to the Board of Directors via Quality Board

10.	References to previous reports

Last quarterly report submitted June 2018

11.	Freedom of Information

Public.

Learning From Deaths – Quarterly Report

Introduction

In December 2016, the Care Quality Commission (CQC) published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

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This report highlights the work which is being undertaken within the Trust in line with the expectations outlined above. NHS England mandates a quarterly report to the Board of Directors. The first report was in December 2017 and reflected the Learning from Deaths activity for Q3 17/18. This report is to reflect activity upto and including Q1 18/19. There is a variable lag in the data becoming available, which is also expressed in this report.

Methodology

There is a long history of specialties having an individualised approach to reviewing the deaths of patients occurring while under their care. The Learning from Deaths work described within this report has sought to standardise the approach as much as possible and to ensure that specialties without their own methodologies adopt this new standard method as quickly as is possible while trying to minimise disruption to specialties with established procedures.

One of the main drivers for standardising the process is to allow data to be available centrally and for any learning and themes to be more visible across specialties and to the wider organisation. Ultimately this enables a more coherent approach to how we report the data externally.

The methodology has recently been refined and updated to try and gain better traction and consistency across specialties.

The original methodology was as follows:

Mortality review checklist is filled out at time of Death Certification.

Mortality screen is conducted by senior clinician as member of core mortality review trained team to determine if a Structured Judgement Review (SJR) is required.

SJR completed by assigned member of core mortality review team.

The new methodology is as follows:

Mortality review checklist is filled out at time of Death Certification.

Mortality screen is conducted by a senior clinician from the team who the patient has been cared for at the time of the death. This should happen as soon as is practicable following the death. There is a fail safe whereby the consultant who is supervising the care of the patient at the time of death is notified and is ultimately responsible for ensuring that the process is complied with.

SJR completed by assigned member of core mortality review team.

The second step underlined above is the main change and it is expected that by maintaining ownership of the responsibility for screening with the specialty rather than a separate team will improve engagement and ease the process.

The change in process went live on 9th July 2018 to coincide with the launch of the new database. There have been some challenges with establishing the new process and the Divisional Governance Lead for Medicine together with the Medical Director has been working on solutions with IT, and liaising with the clinical teams to work through the problems. It is expected that the reporting of data for Q2 will reflect the benefit of these improvements.

There is an outstanding need to establish administrative support to help drive the Learning from Deaths work.

Update on Data available since last report.

There have been 178 deaths across the Trust.

Medicine
Medicine are currently reviewing their processes, consequently data is incomplete for Q2.

Period	Quarter	No. screened (Reported 06/18)	No of SJRs identified	No. of SJRs performed
2017-18	Q2	2	0	0
2017-18	Q3	243 (239)	21	14
2017-18	Q4	295 (186)	39	13
2018-19	Q1	21	2	2
2018-19	Q2	-	-	-
		561	62	29

The figures in brackets above represent the data reported in June 2018. The uplift demonstrates the lag sometimes seen in reporting but also that some momentum is building with the screening process.

Surgical

Surgery utilise a different process for screening than Medicine which reflects that they have much longer established methods for Mortality Review. There are 4 senior clinicians who undertake the screening and SJRs and the summary of their work is described below:

28 SJRs in total to date for 2018.

26 Emergency, 2 Elective

17 Male, 11 Female.
Mean age 74.8yrs

SRJ scores for overall care:

1. 0
2. 0
3. 7
4. 20
5. 1

Examples of learning identified from the above falls into the following themes but none of the issues were felt to have directly contributed to the death. The learning is discussed at the Surgical Governance Meeting and disseminated to the teams.

Improving Peri-operative nutrition.
Improving record keeping.
Better attention to transcribing admission medications.
Improved escalation of deteriorating NEWS.
Improving the earlier recognition of the appropriateness of end of life care.
Improving assessment of and perioperative documentation for emergency laparotomy patients who are on medical wards.

Women and Children's
All deaths of children are subject to the Child Death Review process. Additionally the trust undertakes RCA investigations. All neonatal deaths (infants less than 28 days) are taken through the perinatal mortality meetings and all deaths are discussed at the Divisional Governance Meeting. There are no reports ready for inclusion in this overarching report currently.

The Division have had 1 death in Q1 which has been subject to an RCA. Key learning identified was improvements regarding handover, observations and timing of antibiotics. None of these issues were directly contributory.

Learning Disability Mortality Review Update

LeDeR programme; this is a national programme that has been rolled out under NHS England in line with transforming care partnerships.

The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. It is being implemented at the same time of considerable scrutiny on the deaths of patients in the NHS, and the introduction of the national Learning from Deaths framework in England. The programme is led by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. (HQIP May 2018)

The programme has now been rolled out nationally, and the RUH has been involved in notifying patient deaths since September 2017.

Adult deaths notified by Learning Disability Liaison Nurse since September 2017:

	Number of notifications	CCG's	Comments
Sept 2017	2	1. South Glos 2. Wiltshire	
Oct – Dec 2017	3	3. Wiltshire	3 additional patient deaths discussed with LeDeR but not progressed as out of scope of the programme (did not have confirmed learning disability)
Jan – March 2018	4	1 Somerset 3 Banes	
April- June 2018	4	3 Wiltshire 1 Somerset	

The RUH is represented at the Banes CCG LeDeR steering group by Debra Harrison, Senior Nurse for Adult Safeguarding.

The LeDeR programme reviewers are now requesting copies of the patient's Structured Judgement Reviews as part of their review process.

<u>Update from the Mortality Surveilance Group (Reporting to Clinical Outcomes Group)</u>

<u>IT Support</u>

Data base launched on 9th July 2018. Under continuous review and receiving modification to establish it's reliable use.

Administrative and Managerial Support

Now that the database has been launched it is intended to recruit a Band 3 0.5 wte administrative support worker. The coordination of mortality review activity with other governance activity such as complaints, Inquests and SIs will be incorporated into the work of the Clinical Risk team.

Future Recommended Actions

Embed change in methodology with greater ownership of screening within the clinical teams.

Improving database to reliably capture all activity.

Medical Director has welcomed support from Executive Director Colleagues to include Learning from Deaths as a focused area of interest with the Divisional Triumvirates in Executive Performance Review meetings on a quarterly basis.