

Report to:	Public Board of Directors	Agenda item:	8
Date of Meeting:	24 April 2019		

Title of Report:	Learning From Deaths Quarterly Update
Status:	Progress update
Board Sponsor:	Dr Bernie Marden, Medical Director
Authors:	Dr Chris Knechtli, Consultant Haematologist, Mr Chris Gallegos, Consultant Urologist & Dr Clare Edmonds, Women & Children's Governance Lead
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
<ul style="list-style-type: none"> • Change in formatting and layout of report with greater emphasis on actual learning. • 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)
<p>In December 2016, the Care Quality Commission (CQC) published its review <i>Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England</i>. 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.</p> <p>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.</p>	

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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
	This is the first time this report has been submitted to Quality Board.
11.	Freedom of Information
	Public.

1.0 Introduction

It is vital that organisations continuously learn from all patients that they care for, not just those where issues are identified that trigger investigations.

National Guidance on Learning from Deaths: A framework for NHS Trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in care was published by the National Quality Board in March 2017.

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates (e.g. SHMR and SHMI) was distracting Trust boards “from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals”. This was reinforced by the recent findings of 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. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

2.0 The Mortality Review system devised for the RUH

Since mid-2017, the Divisional Governance Leads have been working through the Trust’s Clinical Outcomes Group and Mortality Surveillance Group meetings to design and establish a methodology for embedding Learning from Deaths across the Trust. In 2017 the Royal College of Physicians had piloted the use of the Structured Judgement Review (SJR) which is a standardised and validated tool to allow a detailed review of a patient’s case record. This has now been widely adopted as the standard tool to utilise for the Learning from Deaths work. After suitable training, it was estimated that an SJR should take between 45-90 minutes to conduct depending on the complexity of the case. Across the Trust there are approximately 120 deaths per month of which 85-90% are in patients admitted under the Division of Medicine. The Division of Surgery opted for a process that involved performing an SJR on any patient that died under their care and the Women and Children’s Division review deaths in patients under their care utilising existing statutory processes. However it was not felt to be proportionate to conduct an SJR on every patient who died under the care of the Medical Division. This is because the case mix is more strongly biased to expected deaths. every death still receives an initial screen as a partial review, As a consequence, a system was devised whereby each patient who dies is screened to decide on whether their death meets certain criteria that require an SJR to be enacted and maximise opportunity to identify any quality of care issues and learning:

- Learning difficulty
- Mental health issues contributing to the patient’s death (especially if patient sectioned under Mental Health Act)
- Concerns expressed by the patient’s relatives
- Concerns expressed by the medical/nursing team in charge of the patient’s care
- Death following an elective admission
- Surgical patient
- Patients declared ‘fit for discharge’ earlier in their last admission
- Patients in various diagnostic or procedure-specific groups flagged by Dr Foster (an independent organisation that collates and publishes benchmarked outcomes data that the Trust then takes account of in the work of the Clinical Outcomes Group) or other clinical outcomes measures as being an area of concern.

The following have been identified as key elements required to enable this to be successfully achieved:

- **Engagement** of medical and nursing staff with the process
- A **database** to collate the relevant information and allow regular reporting of mortality review activity
- **Administrative** support for the process

The Divisional Governance Leads started screening patients who had died and piloting the use of the SJR process in November 2017. 561 patients were screened and approximately 38 SJRs performed. The screening was based on an Excel spreadsheet and the SJRs were completed on a paper-based proforma. A training ½ day was provided on February 8th 2018 to establish a multi-professional team of clinicians able to continue the work of undertaking SJRs.

A database was subsequently devised and constructed by the IT Department and went live on July 9th 2018. Substantial effort was made to ensure that clinical teams were aware of this development and the need to contribute to it in a timely fashion. Teams are asked to ensure that their junior doctors complete the 'death certificate checklist' as early as possible and generally when they are in the Bereavement Office completing other paperwork relating to the patient's death. A consultant from the team looking after the patient is then responsible for:

- Deciding on whether a detailed SJR review of the patient's medical records is required according to the criteria noted above
- Documenting the reason for deciding that an SJR is required (if applicable)
- Documenting a brief summary of the nature of the patient's admission

SJR's are then allocated to a suitable reviewer by the Divisional Governance Leads for medical and surgical patient respectively.

Administrative support has been made available with the assistance of the Lead for Claims and Inquests and colleagues from the Quality Improvement Centre since November 2018.

3.0 Results from Mortality Review since 09/07/2019 (data cut-off at 11/02/19)

The results from Mortality Review activity are depicted in the table below:-

Avoidability as revealed by SJR assessments:

	2018-19 Q2	2018-19 Q3	2018-19 Q4
Period from	09/07/2018	01/10/2018	01/01/2019
Period to	30/09/2018	31/12/2018	11/02/2019
No. of days	83	91	41
Care problems identified which are likely to have contributed to death	0	0	0
Care problems identified which are <u>unlikely</u> to have contributed to death	5	1	1

No care delivery problems identified	23	24	2
Not known at this time - second review awaited	0	0	0
Total no. of SJRs completed	28 (10.4%)	25 (7.0%)	3 (1.2%)
Total deaths (per quarter)	269	357	173

There is a natural lag in completion of reviews and SJRs, which accounts for apparent differences in performance for completed SJRs moving across from Q2 and Q3 through to Q4. The Q4 data is also incomplete as not available at time of writing the report. In general, we expect to see 10% of deaths requiring an SJR. When the process has reached sufficient maturity is our intention to undertake reviews on randomly selected cases that haven't been triggered for an SJR through screening.

Learning and observations from Medical SJRs

- Changing frequency of observations when certain groups of medication are used.
- Difficulty in making diagnosis in rare conditions with unusual presentation.
- Delay in recognising deterioration.
- Risk of hospital acquired infection in already vulnerable patients (patient already receiving palliative care)
- General record keeping of variable quality
- Closer attention to dietary needs of vulnerable patients (learning difficulties)

These are observations from individual cases and as such do not form a consistent pattern or trend.

Learning and observations from the surgical SJRs

- Delayed recognition of deterioration
- Peri-operative nutrition.
- Decision to operate on high risk cases.
- Record keeping of variable quality
- Resuscitation decisions inconsistently documented
- Admission medications not continued on ward.
- Earlier recognition of need for EOL care.
- Risk assessment and boarding card not completed for emergency laparotomy patients on medical wards.
- Lactate and other results from blood gas analyser do not stream to Millennium

These are observations from individual cases and as such do not form a consistent pattern or trend.

These are observations from reviewing the case records that were found not to have directly contributed to the death of the patient. There is however, important learning that is extrapolated generally to clinical care. This is reported to the Mortality Review Group for more detailed analysis

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and findings disseminated to the Divisional Governance meetings.

The clinician conducting the SJR assigns a phase of care rating out of 5 to each reviewed element. The table below gives some detail about the scoring assigned.

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Phase of care ratings:

	2018-19 Q2		2018-19 Q3		2018-19 Q4	
	average rating		average rating		average rating	
	(out of 5)	n=	(out of 5)	n=	(out of 5)	n=
Initial admission	4.43	28	4	25	5	1
Ongoing Care	4.20	25	4.27	22	4	1
Care during procedure	4.25	4	3.75	4	3	1
Return to theatre		0		0		0
Peri-operative Care	4.50	4	4	3		0
EoL/Discharge Care	4.44	27	4.21	24	4	1
Overall Assessment	4.25	28	4.24	25	4	2
Patient record	4.36	28	4.08	25	5	2

Learning from Women and Children's Division

Gynaecology and Paediatric deaths

Date	Specialty	Age
November 2018	Gynae Oncology	76 years old
November 2018	Paediatrics	12 years old

On review in both of the cases the patients had life limiting illnesses which were appropriately managed and the deaths were anticipated.

Stillbirth and unexpected neonatal deaths

These cases are reviewed at the monthly multidisciplinary perinatal mortality and morbidity meetings. Learning from these cases includes:

Stillbirths

- To ensure re-education about the importance of women being placed on the correct care pathways at booking or at any stage in their care if this becomes necessary.
- Shared learning about the importance that individualised care is continually assessed at each antenatal appointment.
- For clinicians to be proactive in referring outside of guidelines if their clinical concern warrants this.

- The importance of good communication and information sharing when cross boundary working to include regular updates from neighbouring Providers to capture process updates.

Neonatal deaths

- A clinical process has been introduced that oxygen saturations required on all babies who show any signs of respiratory distress.
- Re-education of teams to have situational awareness to ensure IV antibiotics are given within 1 hour of suspected sepsis.
- Include neonatal team in discussion re early delivery and risks associated with this.

The learning from all of the cases has been shared both face to face at focused training sessions as well as via newsletters and maternity governance meetings.

4.0 Commentary

The focus has been to encourage and then establish data entry as a matter of routine for all patients who die whilst under the care of the RUH. It shows that we are effectively reviewing patients that die here at the RUH and we are performing detailed reviews (SJRs) on approximately 10% of patients who die.

The data shown above is somewhat crude but does demonstrate that, even in patients selected for the SJR process, the vast majority of the patients are judged to have received good quality care. Where care problems have been identified, none of have been deemed to have contributed significantly to the patients' death and opportunities to improve future quality of care have been gained.

5.0 Process problems identified

- A backlog of data entry built up over the first few months after the database went 'live'. This was due to:
 - Doctors not registering themselves on the system *before* they attended the Bereavement Office
 - A lack of a team-based approach to ensuring that junior doctors *and* consultants understood their responsibilities in entering death certificate checklist data and screening for the SJR process respectively
- Junior doctors are still not routinely entering the relevant data on the database in a timely fashion.
- Pressure on consultant's time is inhibiting ability to engage properly with this process.
- Too much of the Mortality Review Team's time is spent chasing staff to complete data entry at the moment.
- A lack of space in the database to allow detailed data entry – there is a limit of 8060 characters per patient which may not be enough to adequately describe issues that are identified.

6.0 Next steps

- To reach a place where *all* patients are having their death certificate checklists and SJR screens performed as a matter of routine within 2 weeks of the patient's death.
- Identify additional support for areas that have got behind (Cardiology, ED, Respiratory, OPU, Acute Medicine and Stroke) to catch up with their data entry.
- Liaising with IT to build a system that allows email alerts to be sent out to Consultants to

inform/remind them that patient has died under their care.

- Working with IT to see if there is a system that allows the sending of a copy of the final data from an SJR to the Specialty Governance Lead of the specialty under whose care the patient died to feed in to their specialty Mortality and Morbidity review process.
- To identify where and how the new National Medical Examiner role interacts with the Mortality Review process.