Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**6 March 2024**		

Title of Report:	**Quarterly Learning from Deaths Report (Q2)**
Status:	**For Noting**
Board Sponsor:	**Andrew Hollowood, Chief Medical Officer**
Author:	**Heather Boyes, Lead for Claims and Inquests**
Appendices	**None**

1.	**Executive Summary of the Report**
84% of SJRs completed in the last quarter rated care as either good or very good and 3% SJRs completed in the last quarter rated overall care as poor. Issues relating to communication, observation or review, end of life care and documentation were identified as the causes of reduced quality of care in patients who died. Any specialty having care rated poor or very poor received a copy of the SJR to ensure that lessons are learnt from every element of care that appears to be substandard. No new emerging themes are emerging that sit outside of our patient safety improvement priorities. 16 inquests were opened and 35 were concluded. The Trust received one Regulation 28 Report.	

2.	**Recommendations (Note, Approve, Discuss)**
To note.	

3.	**Legal / Regulatory Implications**
The Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements/learning were being missed.	

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)**
There is a risk lessons will not be learnt from avoidable deaths due to SJRs being completed long after the SI and Inquest process has concluded.	

5.	**Resources Implications (Financial / staffing)**
Transfer of SPA activity to clinical time has had an impact on timely review. Return to appropriate SPA activity to allow review.	

6.	**Equality and Diversity**
n/a	

7.	**References to previous reports/Next steps**
Q1 Learning From Deaths Report	

8.	Freedom of Information
Public	

9.	Sustainability
N/A	

10.	Digital
N/A	

Royal United Hospitals Bath
NHS Foundation Trust

Learning From Deaths Quarter 2

July to September 2023

1.0 Introduction

The Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements/learning were being missed.

A process for mortality review for the RUH was devised in mid-2017 which required screening of all patients who have died in order to decide on whether a formal review of the patient's care in their final admission was required. The Royal College of Physicians had devised the Structured Judgement Review (SJR) as a means of standardising the way in which the review was conducted, which we adopted. It was not felt to be proportionate to conduct an SJR on every patient who died under the care of the Medical Division. 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 as follows:

- 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 in various diagnostic or procedure-specific groups flagged by Dr Foster or other clinical outcomes measures as being an area of concern

This report firstly considers how effectively and efficiently the Mortality Review Process is operating, and secondly reviews what lessons have been learnt as a result of the data generated by that process.

2.0 Performance of the Process

It is essential that each step of the Mortality Review process occurs in a timely manner. Delays risk the continuance of issues that are a risk to patient safety and potentially deprive subsequent processes, such as inquests, complaints and incident investigations of a useful source of information. The risk of duplicating work also increases.

The performance of the Medical Examiners is considered in greater detail in the quarterly Medical Examiner Office Reports.

2.1 Checklists

The commencement of the work of the Medical Examiners on 1st April 2020 has significantly decreased the number of patients awaiting the completion of Mortality Review checklist – the first step of the mortality review process.

At the time of writing this report, there were no outstanding checklists for patients who died in 2023.

2.2 Screening

Review of the checklists and the selection of cases for structured judgement review was previously completed by a consultant from the specialty last responsible for the patient's care. This function is now completed by the Medical Examiners. A standard proforma is used to ensure greater consistency and thoroughness of approach. The Medical Examiner Office report states that an average of 97% of patient deaths during the quarter received Medical Examiner scrutiny. Throughout the quarter, 100% of patients with a checklist were also screened

The Medical Examiners are also tasked with contacting the patient's family to confirm whether they have any concerns, helping to ensure that worries and queries are identified at an early stage. Medical Examiner data states 100% of patient families were appropriately contacted.

2.3 Structured Judgement Reviews

Each speciality is allocated a proportion of the SJRs to be completed, based on the number of consultants available to complete them.

Figure 1 illustrates that the number of SJRs completed has increased from 46 in Q1 to 54 in Q2. In Q1 and Q2 22/23 119 SJRs were completed compared to this year's 100.

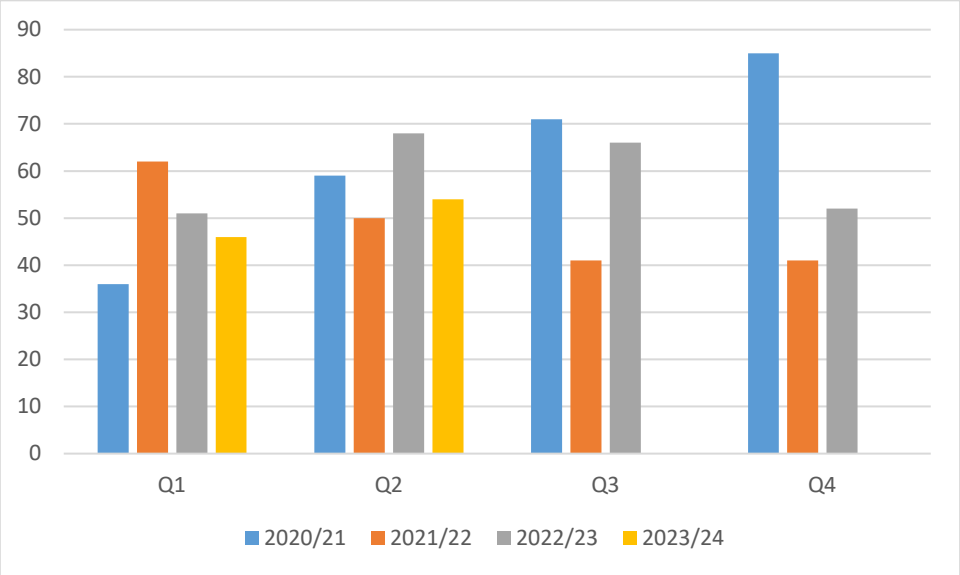

Figure 1: Number of completed SJRs

Figure 2 shows the number of outstanding SJRs. Medicine, in particular, have had a real focus on completing historic SJRs but the number being completed across the Trust each quarter is not sufficient to keep up with the new SJRs being requested and significantly reduce the number outstanding from previous quarters.

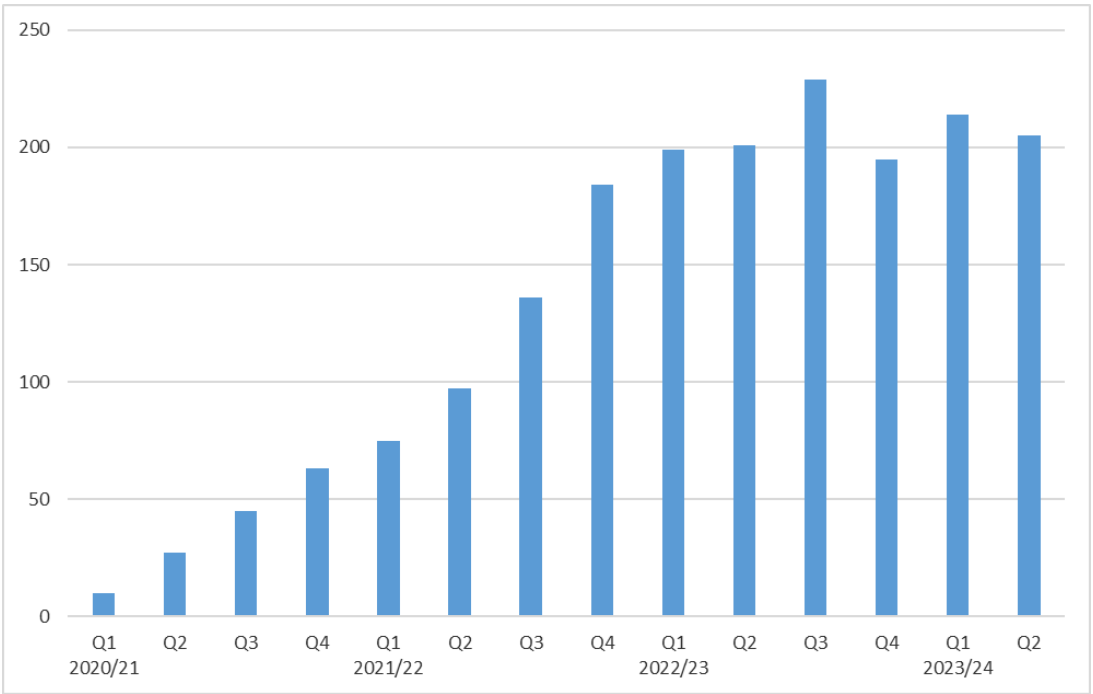

Figure 2: Number of outstanding SJRs

SJRs are allocated in batches of 100 i.e. for every 100 SJRs, ED will receive a fixed number based upon how many consultants they have. Of the last 200 SJRs allocated, 80 (an increase from 69 in Q1) are still outstanding. Of those, 24 (30%) are waiting for a Gastroenterology Consultant to complete them; 15% are waiting for an Oncology Consultant to complete them. The Oncology Team have recently been in contact with Legal Services, asking that the SJRS waiting for completion be reallocated due to a lack of consultant staff availability.

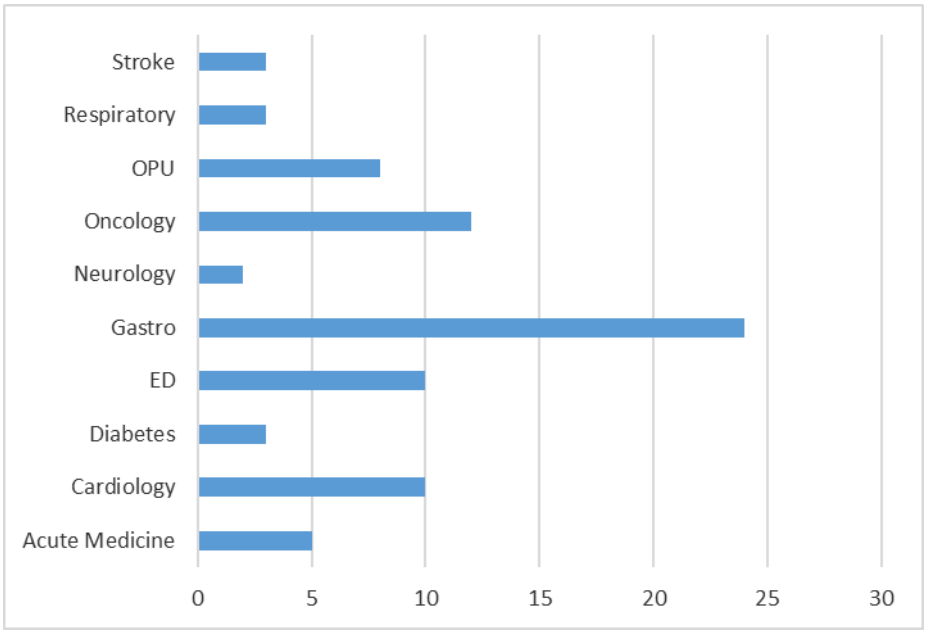

Figure 3: Outstanding SJRs by allocated speciality

The Trust aims to complete SJRs within two months of the patient's death. This is to ensure the conclusions of the review are available before the completion of a serious incident investigation or inquest. Compliance with this target is monitored and set out below. The Trust is yet to meet its target of completing 95% of SJRs within two months since monitoring commenced in April 2020. Whilst efforts to complete outstanding SJRs from 2022 will have made some impact, it is clear little progress is being made overall. Only 65% of SJRs were completed within six months of the death therefore significant work is required in this regard.

To support improvements in timeliness Legal Services have recruited to a vacant band 2 administrator post. This will help to minimise any delays in SJRs being allocated. In addition, Legal Services and the Medicine Division are working with a volunteer (who worked formerly as a healthcare solicitor) to offer bespoke training and support to those areas with a significant backlog.

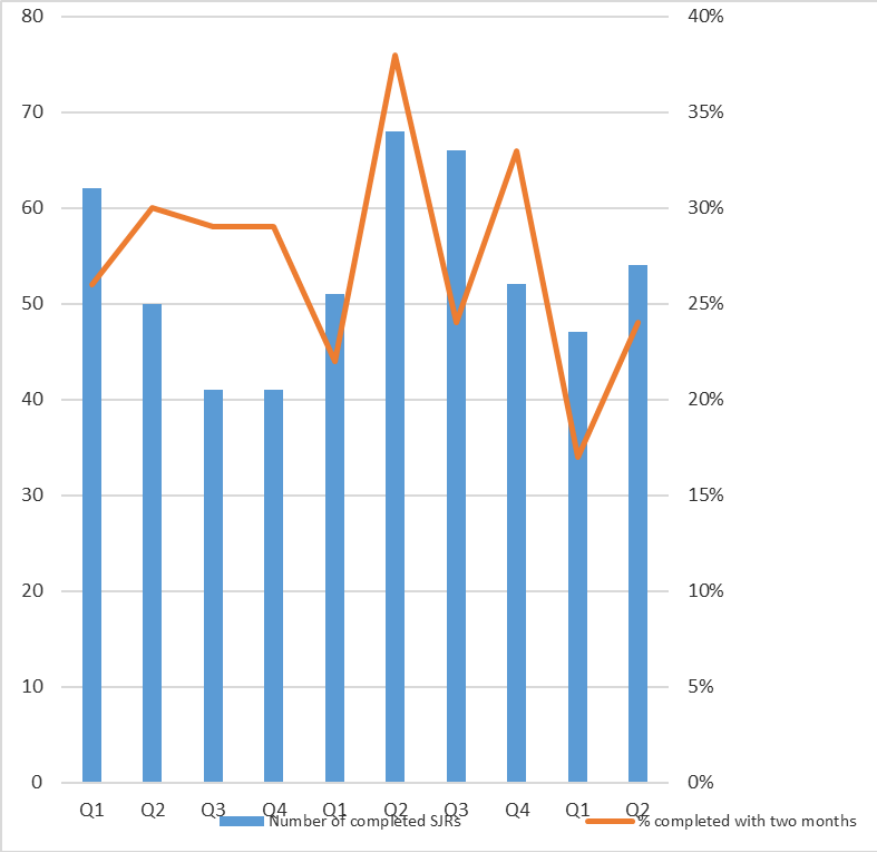

Figure 4: Number and percentage of SJRs completed within two months of patient death within Medicine

2.4 SJRs and Serious Incidents

The completer of the SJR is asked to consider the quality of the care delivered and whether any care problems identified are likely to have contributed to the patient's death. A score of 1 or 2 (very poor or poor care) or concluding that the care problems contributed to death will result in the SJR being highlighted in a Serious Case Report within the Mortality Review Database. These are scrutinised on a monthly basis by the Lead for Claims and Inquests.

Each case is reviewed to ensure a corresponding Datix incident report has been submitted, either at the time of the incident or following SJR completion. This is the process via which the matter is flagged to the relevant speciality and division. If a Datix report has not been submitted, the Lead for Claims and Inquests will write one.

If the mortality review process and the serious incident process are functioning well, only a small number of incidents should previously have gone unrecognised i.e. not have been reported on datix. Firstly because incidents are being recognised and

reported at the time and secondly, that the SJR process is not erroneously flagging issues that do not require investigation.

Four SJRs completed during Q2 raised queries about the quality of the care the patient received. One had already been reported as an incident and investigated as an SI. Three had not previously been reported; one has been reviewed and it has been concluded the death was unavoidable. The Medicine and Surgery divisions are in the process of reviewing the other two.

The introduction of the SJR process brought with it concerns about the duplication of work already being completed within the coronial and incident reporting process. The three previously unreported matters do suggest the mortality process is resulting in additional scrutiny of the circumstances surrounding the deaths of patients.

Given the relatively brief nature of the review, and the fact that the reviewer will, by design, not work within the specialty caring for the patient, there will always be some SJRs that raise concerns that subsequently transpire not to need investigation. Regular monitoring to ensure the queries being raised are reasonable will continue.

When the divisions receive a datix report as a result of a concerning SJR and harm is found, this report recommends that one of the terms of reference of any subsequent investigation should be why the matter was not identified and reported at the time it occurred.

3.0 Learning from Mortality Reviews

A quarterly report is submitted to the Mortality Review Committee for consideration of the trends appearing in the feedback generated by SJRs. As the committee is attended by the governance leads for each division and discussed at divisional governance committees this data is accessible to each part of the hospital. However, it has been recognised, similarly to the serious incident process, that there is still a gap in terms of reviewing not only whether actions have been put in place, but 1) the completion of those actions and 2) whether those actions have successfully brought about change. This forms part of a bigger, on-going piece of work, led by the Risk Management Team and the mortality review process does not seek to duplicate the process.

3.1 Overall Quality of Care

The table below sets out the ratings of care for each element of an inpatient admission. Of the SJRs completed during the quarter, 48 (84% - an increase from 79% last quarter) assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5).

One patient was marked as having received very poor ongoing care; this was identified as an Serious Incident by the division and appropriately investigated. There were two instances of the overall care being poor; one was the patient identified as having received very poor ongoing care (the subject of an SI investigation). The second is currently under review by the relevant division.

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.30	57	0	0	7	26	24
Ongoing Care	3.96	49	1	1	9	26	12
Care During	4.45	11	0	0	0	6	5
Return To Theatre		0					
Perioperative Care	3.86	7	0	0	2	4	1
End Of Life	4.26	43	0	0	6	20	17
Overall	4.09	57	0	2	7	32	16
Patient Record	4.00	56	0	0	15	26	15

Table 1: Phase of Care Ratings

Any specialty receiving a 1 or a 2 will receive a copy of the SJR, even if the patient did not die whilst under their care, or the overall standard of the care during admission was good. This is to ensure that lessons are learnt from every element of care that appears to be substandard, even if it did not ultimately affect the outcome.

3.2 Emerging Themes

The below shows the most commonly occurring themes arising from completed SJRs. It is important to recognise that in the majority of cases, either no additional learning was identified or it was recognised that the care delivered was of a good or excellent standard.

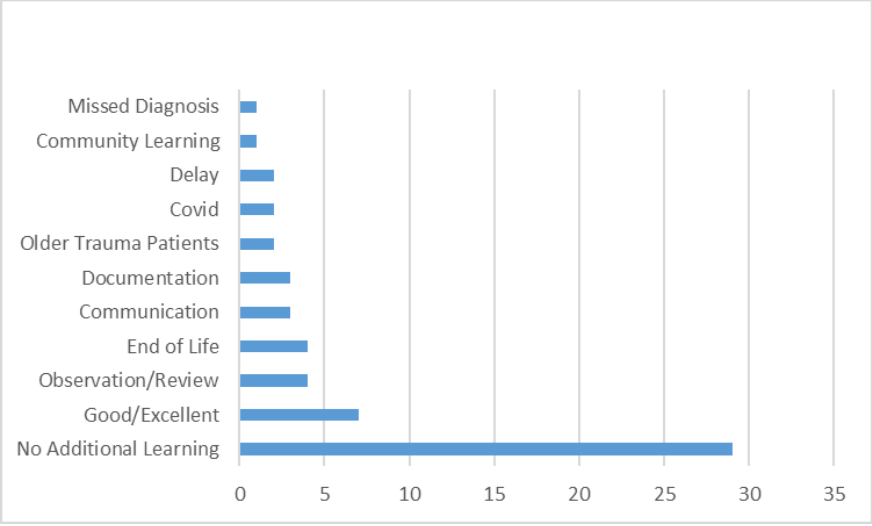

Figure 5: SJR themes

3.2.1 Observation or Review

Four SJRs raise queries about monitoring. The first queries whether the patient was sent to the correct ward from ITU. Whilst they no longer needed ITU level care, they could have been sent to a ward with telemetry. It has been concluded that the outcome would have been the same.

Two SJRs raise concerns about deterioration in the patients' condition not being detected in a timely manner. It is concluded that the outcome would not have changed but it would have allowed for earlier communication with the family.

The final SJR suggests a patient's blood sugar could have been monitored more closely. The patient's care is currently under review by the division.

3.2.2 End of Life

Three SJRs state the care provided was good but comment that it was the patient's or family's wishes that they die at home. This is reported to have been difficult to organise. It is presumed that attempts were ultimately unsuccessful as the death would not be recorded as a hospital death if a move had been achieved.

The final SJR comments that pain control could have been optimised.

3.2.3 Communication

Two SJRs conclude that communication about the patient's poor prognosis could have been improved.

The third states the discharge summary was not clear which was particularly important because the patient was in the process of changing GP. Continuing medication may have been omitted as a result although this is unlikely to have made a difference to the outcome.

3.2.4 Documentation

Two SJRs note that the patient's frailty score was not documented.

The final SJR comments that no falls risk assessment was documented despite the patient being admitted having suffered a fall.

3.3 Summary

84% of SJRs completed in the last quarter rated care as either good or very good and 3% of SJRs completed in the last quarter rated overall care as poor. Issues relating to communication, observation or review, end of life care and documentation were identified as the causes of reduced quality of care in patients who died. Any specialty having care rated poor or very poor received a copy of the SJR to ensure that lessons are learnt from every element of care that appears to be substandard.

4.0 Inquests

Sixteen inquests were opened during Q2 and 35 were concluded.

Trust witnesses were only required to attend one inquest in person; the other 34 were concluded on the basis of the written statements provided.

The attended inquest related to a patient who sustained significant pressure damage during his admission. The Coroner concluded there was a causal relationship between the tissue damage and the patient's death. Both the inquest and the Trust's serious incident report found there were significant deviations from trust guidelines in relation to how patients should be repositioned. The conclusion was one of Natural Causes contributed to by Neglect.

Whilst the Coroner heard a significant amount of evidence in relation improvements made, a Regulation 28 (Prevention of Future Deaths) Report was issued. The Trust's response sets out the details of targeted and detailed training that has been provided to staff subsequently and the ongoing monitoring of the quality of patient care being delivered.

5.0 Summary and actions

5.1 SJR process

A backlog of structured judgement reviews is developing which will impact on our ability to understand the quality of care delivered to patients who have died and to generate learning from deaths.

Action:

- Recruitment of band 2 administrator to optimise the process of SJR allocation and reduce unnecessary delay
- Monitoring through mortality surveillance group

5.2 SJR outcomes

The themes emerging from the structured judgement reviews and inquests are aligned with our identified patient experience and patient safety improvement priorities;

Preventing infections, preventing medication errors, preventing falls, early identification of deteriorating patients and self-discharge. Learning is being fed into the evolving improvement workstreams aligned to each priority and reported through the Trust Quality and Safety Group to Quality Governance Committee.

Action:

- Ongoing monitoring of themes through Trust Quality and Safety Group