Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**26 February 2020**		

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**
Appendices:	**None**

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

- 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)

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
This report is submitted to Quality Board and Board of Directors on a quarterly basis.	

11.	Freedom of Information
Public.	

Royal United Hospitals Bath
NHS Foundation Trust

Learning From Deaths Quarterly Board Report 19/20 Quarter 3

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

Roughly 10% of cases are randomly allocated to undergo an SJR if they do not meet any of the criteria set out above.

A database to facilitate data entry relating to mortality review went live on July 9th 2018. The data in this report is derived from that database.

Administrative support has been available since mid-November 2018.

2.0 Results from Mortality Review since 09/07/2018 (data cut-off at 31/12/2019)

The results from Mortality Review activity are displayed in the table below.

- There have been just over 2000 deaths in the Trust since the database went active which equates to 1400-1450 per annum.
- SJRs are allocated to 15-20% of all patients
- Deaths deemed to be 'avoidable' i.e. patients whose death has been more likely than not due to problems with patient care are very uncommon. However, the reader should be aware that assessing if a death is avoidable is necessarily subjective as it is not possible to define 'avoidable' precisely in this context.

	2018-19 Q2	2018-19 Q3	2018-19 Q4	2019-20 Q1	2019-20 Q2	2019-20 Q3		
Period from	9/7/18	1/10/18	1/1/19	1/4/19	1/7/19	1/10/19		
Period to	30/9/18	31/12/18	31/3/19	30/6/19	30/9/19	31/12/19		
No. of days	83	92	90	91	92	92	Total	%
Awaiting completion of death certificate checklist	16	15	16	27	42	105	221	10.6%
Death certificate checklist completed, awaiting screening	6	18	26	38	40	96	224	10.8%
Screening completed, no further action required	203	269	247	228	194	169	1310	63.0%
Screening completed, awaiting SJR	10	22	20	31	16	21	120	5.8%
SJR completed	39	42	49	41	25	8	204	9.8%
Total deaths (per quarter)	274	366	358	365	317	399	2079	100.0 %

Table 2 documents progress made in the mortality review process for each of the quarterly cohorts. Please note that the process is expected to be incomplete for many of the patients who have died in the 3rd quarter of 2019/20. There is a small core of patients from earlier quarters who have not had the death certificate checklist completed. This reflects the way in which the process has been maturing over the 18 months since implementation. An improvement in performance is expected to come in April 2020 when the Medical Examiners will be performing the SJR screening process. This will mandate junior doctors to have entered the death certificate checklist details in advance of any discussion with the ME without which the process of issuing the medical certificate for cause of death (MCCD) cannot proceed.

The Rt Hon Jeremy Hunt, the previous Secretary of State for Health, is one of the people credited with initiating the process of learning from Deaths and was keen to define the rate of 'avoidable' deaths in our hospitals. An avoidable death is defined in the SJR that we use as where "care problems have been identified which most likely contributed to the patient's death". We need to consider whether this would be better defined as where "care problems have been identified that were the major contributor to the patient's death" or, as NHSI define it "the patient's death was more likely than not due to problems with patient care".

Since starting only 2% of deaths have been recognised to have 'avoidable' features possibly contributing to the death by the SJR reviewer. These are subjected to a second review. The Mortality Review Group reviews these cases and makes sure that the correct

steps have been taken eg referral to Coroner, duty of candour and RCA if and where appropriate.

With the implementation of the Medical Examiner System it will be easier to cross reference SJR findings with other governance processes and results of Inquests. This happens now but the system has to track back to points of cross over where as the ME system will be prospective and easier to track as cases progress.

The themes that have been identified from the patients cared for in the Division of Medicine include:

Delay in recognising deterioration.
Delay in accessing investigations.
The management of surgical problems while receiving medical care.
Communication between teams.

The vast majority of this learning is where care problems were identified but which were unlikely to have contributed to death

These findings are reviewed at specialty and divisional governance meetings. The difficulties in recognising and acting on deterioration is fed back into the deteriorating patient steering group. Prevention of avoidable harm is a True North priority and is being addressed through this work and the deployment of electronic observations and the expansion of the Critical Care Outreach team to become a 24/7 service. This is a good example of where learning from deaths has contributed to service improvement.

Phase of care ratings:

Each SJR mandates an evaluation of different phases of each patient's last hospital admission rated out of 5 (1 = poor; 2 = below average; 3 = average; 4 = good; 5 = excellent). The reader will note that no patient has, so far, been attributed a score of 1 for any phase of their care. However, the vast majority of scores are 4s and 5s.

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

2019-20 Q3 01/10/19-31/12/19			Rating (out of 5)				
	average rating	n=	**1**	**2**	**3**	**4**	**5**
Initial admission	**4.25**	8	0	0	0	6	2
Ongoing Care	**4.29**	7	0	0	1	3	3
Care during procedure	**4.50**	2	0	0	0	1	1
Return to theatre		0					
Peri-operative Care	**4.50**	2	0	0	0	1	1

EoL/Discharge Care	**4.50**	6	0	0	0	3	3
Overall Assessment	**4.50**	8	0	0	0	4	4
Patient record	**4.13**	8	0	0	1	5	2

Learning from the surgical SJRs

Surgical Patient SJR Process

- All deaths in surgery to undergo a SJR.
- Speciality governance leads to be informed when an SJR completed.
- If any section scores less than 3 a formal written response will be required from the speciality concerned after they have reviewed the case.
- Any case with an overall score of less than three will undergo a second review, if there is disagreement a third reviewer will be called upon.
- If an overall score of less than three is confirmed a serious incident will be triggered.

The Surgical Division has completed 58 SJRs between 9 July 2018 and 20 January 2020

Themes for learning:

- Optimising perioperative nutrition.
- Decision to operate on high risk cases.
- Standard of record keeping.
- Consistent documentation in relation to end of life care and resuscitation status.
- Medicines reconciliation.
- Earlier recognition of need for EOL care.
- Delay in escalating deterioration.
- Processes not always followed correctly for patients on medical wards when transferred to theatre.

Of these, the overall assessment ratings were as follows:

Score	Total
1	0
2	1
3	10
4	45
5	1
Total:	57*

*one SJR had no figures – all ratings were marked as ‘non-applicable’.

Five SJRs contained a subsection where the assessment score was less than 3 (all scored 2):

Subsection:	no.
Admission and initial management	2
End of life/discharge care	1
Patient record	1

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 every patient that dies here at the RUH and we are performing detailed reviews (SJRs) on approximately 10% of patients who die. Increasingly the focus is beyond the process and to see where there is learning. By far the majority of the learning is related to general care issues rather than issues that have directly contributed to the death.

The data shown above 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. Some care problems have been identified but none of these have been deemed to have contributed significantly to the patients' death.

5.0 Problems identified with Mortality Review Process

- A backlog of data entry built up over the first few months after the database went 'live'.
- Junior doctors are still not routinely entering the relevant data on the database in a timely fashion.
- Consultants challenged in their ability to engage completely with this process owing to work pressure.
- Balance of effort from the Mortality review Team is still too biased towards managing the process rather than analysing the learning.
- A lack of space in the database to allow detailed data entry – there is a limit of 8060 characters per patient.

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.
- The Mortality lead is starting a drive in areas that have got behind (Cardiology, ED, Respiratory, OPU, Acute Medicine and Stroke) to catch up with their data entry.
- The Mortality Lead is liaising with IT to build 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 M&M process.
- To identify where the Medical Examiner interacts with the Mortality Review process.

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