Board of Directors

Subject:	'Learning from Deaths' – Mortality Report	**Date:** 26/10/17			
Prepared By:	Elaine Jeffers – Deputy Director of Governance & Quality Improvement				
Approved By:	Dr Andy Haynes, Medical Director				
Presented By:	Dr Andy Haynes, Medical Director				

Purpose

The purpose of this paper is to provide the Board of Directors with an overview of the current compliance with the 90% standard of reviewing all deaths as required through the National Learning from Deaths Guidance and to highlight the learning identified from Mortality Reviews for Q2.	**Decision**	
	Approval	
	Assurance	X

Strategic Objectives

To provide outstanding care to our patients	To support each other to do a great job	To inspire excellence	To get the most from our resources	To play a leading role in transforming health and care services
x	x	x	x	x
Indicate which strategic objective(s) the report support				

Overall Level of Assurance

	Significant	Sufficient	Limited	None
Indicate the overall level of assurance provided by the report -	External Reports/Audits	Triangulated internal reports x	Reports which refer to only one data source, no triangulation	Negative reports

Risks/Issues

Indicate the risks or issues created or mitigated through the report	
Financial	No financial implications are anticipated at this time
Patient Impact	Improvements to services and care will be realised through the timely and comprehensive review of each death to maximise learning opportunities
Staff Impact	Changes to practice and care will be identified through the Mortality Review Process
Services	Changes to service delivery will be identified through the Mortality Review Process
Reputational	Potential reputational damage

Committees/groups where this item has been presented before

This Report was presented to the Deteriorating Patient Group on 19/10/17

1. Executive Summary:

The National Guidance on Learning from Deaths setting out the new responsibilities for members of the Trust Board came into effect on 1st April 2017. The Guidance provides a framework to ensure Trusts give sufficient priority to learning from deaths so that valuable opportunities for improvements are not missed. In addition it points out the importance of engaging in an appropriate and supportive way with bereaved families recognising their insights as a vital source of learning.

The Care Quality Commission (CQC) are currently strengthening their assessment processes to cover the process by which providers identify patients who have died and decide which reviews or investigations are needed, with a particular emphasis on:

- Patients with a learning disability or mental health problem
- The quality of investigations carried out by trusts
- The reports provided to Trust Boards on learning from deaths
- The actions taken in response to learning from death
- How trusts have involved families and carers in reviews and investigations

A new Key Line of Enquiry (KLOE) has been developed to assess the progress of trusts:

- Well-led 8.3 ***'How effective is participation in and learning from internal and external reviews, including those relating to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?'***

This paper describes the current performance to date against the requirement to review 90% of deaths by 31st March 2018. It also highlights the current themes and trends identified from our Mortality Reviews and the subsequent learning.

1.1 The Board of Directors is asked:

- To note the content of this Report
- To note the current compliance rate of 84% in relation to the requirement to achieve the standard of reviewing 90% of all deaths by March 2018
- To note the learning from Mortality Reviews for Q2

2. Introduction

2.1 The Trust Mortality Surveillance Group (MSG) is well established. Meeting monthly, chaired by the Executive Medical Director, it is the focal point for understanding the safety and quality of care provided to patients in the days leading up to their death and importantly identifying the learning opportunities, ensuring the learning is shared across the wider clinical teams.

2.2 MSG previously reported to the Deteriorating Patient Group (DPG) but following the implementation of the National Quality Board 'Learning from Deaths' Guidance a monthly report, specifically highlighting progress towards the 90% standard for reviewing ***all*** deaths, including themes, trends and learning points is presented to the Patient Safety Quality Board. From October 2017 a quarterly report will be presented to the Quality Committee preceding the report to the Board of Directors.

3. Mortality Review

3.1 Mortality Review Tool (MRT) - The Trust had initiated a comprehensive Mortality Review process in 2016 by standardising the approach to local Mortality Reviews. An electronic screening tool was developed to capture initial data following the death of a patient and this has been subsequently expanded to include triggers to alert clinical teams that a more in-depth review is required. There is an expectation that all deaths are captured on the electronic Mortality Review Tool in the first instance with performance reported by way of a 'heat map' to MSG monthly.

3.2 Clinical Teams continue to receive training, encouragement and support to complete a MRT for every patient that passes away whilst under their care in order to identify where a more in-depth review is required. The accurate and timely notification of a death is key to enabling clinicians to commence the initial phases of mortality review.

3.3 Structured Judgement Review (SJR) - As previously reported the Trust has adopted the Royal College of Physician's Structured Judgement Review (SJR) methodology as the mandated process for conducting the following phases of mortality review if potential lapses in care are identified through completion of the MRT. This methodology has been widely used across a number of Acute Trusts nationally and our clinical teams are becoming more proficient with its use.

3.4 The SJR is divided into 2 phases:

(i) Case Record Review - looking specifically at 5 key phases of care with a requirement to initially rate each individual phase of care with a score of 1-5 (1 being very poor, 5 being excellent):

- Admission and initial management
- On-going Care
- Care during a Procedure
- Peri-operative Care
- End of Life Care

(ii) Avoidability Assessment - triggered when a case Record Review scores <2. The Avoidability Assessment considers the probability of avoidability with a score of (1-6 with 1 being high probability and 6 being low probability) A score of <3 indicates a more than 50% probability that avoidable factors were a contributory factor in the death.

Clinical teams are asked to make explicit judgements about the phase of care and identify the evidence to support the score.

3.5 The benefits of conducting a review using a consistent, validated methodology ensures that care is recorded in the same way whether it is good or bad. This will hopefully generate concise statements (both positive and negative), yielding a rich store of information to identify areas where there is excellent practice but also identify those areas for further improvements.

3.6 All cases resulting in an Avoidability Assessment are presented to the MSG for further challenge where agreement on the final probability of avoidability and any required actions and learning opportunities can be agreed.

4. Serious Incident Mortality Review

4.1 As part of the Trust Governance Framework the Trust holds a 3 x weekly Serious Incident Scoping meeting where concerns around care provided or potential harm to patients is presented to Executive Director Colleagues. This includes concerns around the death of a patient. A Serious Incident Investigation may be commissioned, however this does not negate the requirement to carry out a comprehensive Mortality Review, as the two processes complement each other.

4.2 The number of Serious Incidents involving the death of a patient – both internal investigations and those that meet the criteria for reporting on STEIS are included within the Mortality Dashboard. It should be noted however, that although a death may be the outcome this may not necessarily have been the trigger for the investigation.

5. Mortality Dashboard

5.1 The Trust is required to collect specific data to be included within the quarterly report to the Board of Directors. The data includes:

- Total number of deaths – to include number receiving the initial review via the MRT
- Number of deaths scoring <3 on the Avoidability Assessment following a Structured Judgement Review
- Number of Deaths investigated under the Trust Serious Incident Framework
- Themes and issues identified through review and investigation
- Changes that have been made as a consequence of this process

5.2 By 31st March 2018 all trusts are expected to show that they have reviewed 90% of all deaths. As indicated in the Dashboard the current compliance rate for the Trust is 84%, this is a 19% improvement from Quarter 1. We are confident that we will be in a position to meet the required 90% within the timeframe as there are the following monitoring arrangements in place:

- Monthly compliance Heat Map presented to the MSG. This will be circulated to Divisions 2 weeks prior to the MSG meeting in order for Divisions to validate the position and provide an exception report outlining their recovery plans where required
- Continued training and support of clinical teams in the effective application of the SJR methodology
- A collaborative working relationship established with the Governance Support Unit to ensure early notification of deaths that are subject to the Trust Serious Incident Framework
- A collaborative working relationship established with the Safeguarding Team to ensure early notification of deaths relating to patients with Mental Health or a Learning Disability
- A collaborative working relationship established with the Bereavement Centre to ensure timely notification to the clinical team of a death and confirmation of Coroner referral/acceptance
- Robust reporting arrangements are already in place from MSG through to PSQB to monitor progress on a monthly basis
- Progress on improving the quality of Mortality Reviews and ensuring learning is identified and shared is embedded within Programme 3 of the Advancing Quality Programme (AQP).

5.3 The Mortality Dashboard is attached at Appendix 1

6. Learning Disability – LeDer Programme

6.1 There have been a number of reports and case studies that have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities.

6.2 The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) raised concern that assumptions were sometimes made that the death of a person with a learning disability was ‘expected’ or ‘inevitable’.

6.3 Both CIPOLD and the 2016 CQC Report ***‘Learning, candour and accountability: A review of the way trusts review deaths of patients in England’.*** Identified deaths that should have been, but were not, reported to mandatory review processes, including safeguarding reviews or to the Coroner.

6.4 Additional scrutiny must be placed on the review of the death of a person with a learning disability. Consideration must be given to a cross-sector approach that includes families, primary and secondary care, social and third sector organisations.

6.5 The 'Learning Disabilities Mortality Review' (LeDer) Programme, commissioned by the Healthcare Quality Improvement Partnership (HQUIP) has already started this work. This programme will receive notification of all deaths of people with a learning disability. In addition it will support local teams in conducting standardised, independent reviews for persons with a learning disability aged 4-74 years.

6.6 The LeDer Programme has a well-established review methodology and will provide trained reviewers to ensure that the local reviews identify any potential avoidable factors that may have contributed to a person's death and to agree actions that will guide any necessary changes in health and social care services to reduce premature deaths in the future.

6.7 The Trust plans to align the adopted SJR process with the review methodology of the LeDer Programme. As the first step towards this, but primarily in response to concerns raised by a 'whistle-blower' about sub-standard care delivered to this patient group an internal independent investigation was commissioned to look at those deaths of persons with a learning disability that had occurred within the Trust between 01/04/16 and the 31/03/17

6.8 The Investigation looked at the overall quality of treatment and care, considering factors that might cause or contribute to their death.

6.9 14 patients with an established diagnosis of learning disability were included within the investigation. Both the LeDer mortality review and the Trust SJR processes were applied to determine the quality of care this patient group received.

6.10 Although areas of excellent and good practice were recognised there was enough evidence to cause concern and a number of areas for improvement were identified.

6.11 Using both review methods it was deemed that in 9 out of the 14 cases care was judged to be less than satisfactory and in 3 out of the 14 cases care was deemed to have at least a >50% probability that death had avoidable causal or contributory factors. A further independent review of these 3 cases has been requested.

6.12 The internal independent investigator noted that it had been useful to apply both the Trust SJR and the LeDer Review methods as the questions asked and scoring systems correlated. There was however, less detailed information derived from the LeDer System providing assurance that the SJR process adopted by the Trust will facilitate a detailed and constructive mortality review outcome.

6.13 The initial report has been presented to the Chief Nurse and Executive Medical Director with the further investigation to be overseen by the Director of Governance & Quality Improvement. Conclusions and recommendations from this report will be included within the Board of Director's Learning from Death Report in January 2018.

7. Bereaved families

7.1 The Trust must make it a priority to work more closely with bereaved families to ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered at every stage from notification of death to an investigation and lessons learned if

relevant. We must be able to provide a high standard of bereavement care, including support, information and guidance.

7.2 We must provide a clear, honest and sensitive response to bereavement in a sympathetic environment. We already work closely with bereaved families, offering them an opportunity to meet with the clinical team who cared for their loved one, in the days and weeks following their death to answer any questions and give them an opportunity to raise any issues.

7.3 However, to fully engage with families when potential lapses in care may well be identified some-time after a death will require a great deal of careful thought. The Trust has always been open and transparent when obvious lapses in care are identified at the point of death; however the new Structured Judgement Review process may well identify concerns that were not obvious until the SJR was completed. This could potentially be very distressing to families to have concerns raised with them when they are not expecting it. The National Quality Board is due to issue further guidance on this in January 2018.

8. Learning, themes and improvements

8.1 Learning from deaths should not be seen in isolation of other learning opportunities but should be an integral part of service and the wider Trust Governance Framework. Key issues identified as part of the Mortality Review process must be collated with themes and trends from other intelligence sources to aid the prioritisation of immediate and future improvement requirements.

8.2 The learning points from Mortality Reviews for Quarter 2 are set out in Appendix 2

9. Summary

9.1 The Trust recognises that learning from the care given to patients in their final days is about understanding what effective, sustainable improvements are needed but also where we provide excellent care and how we share good practice across the organisation.

9.2 The Case Record Reviews and Avoidability Assessments should not be used as a mechanism for determining how a patient died, that is for the Coroner to decide if appropriate, but to really understand how we can eliminate avoidable and contributory factors and ensure that when it is right the individual, their families and carers experience as good a death as possible.

9.3 It is important to recognise that improving mortality will improve that standard of care for all patients.

Reporting Learning from Deaths to Board

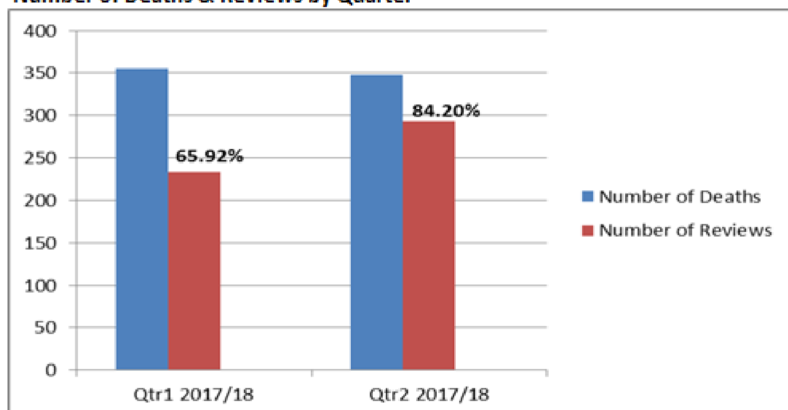
Learning from Deaths Dashboard Quarter 2 2017/18

Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Qtr 2	348	293	84.20%	5
Year to Date	703	527	74.96%	14

Deaths in groups under special focus Quarter 2

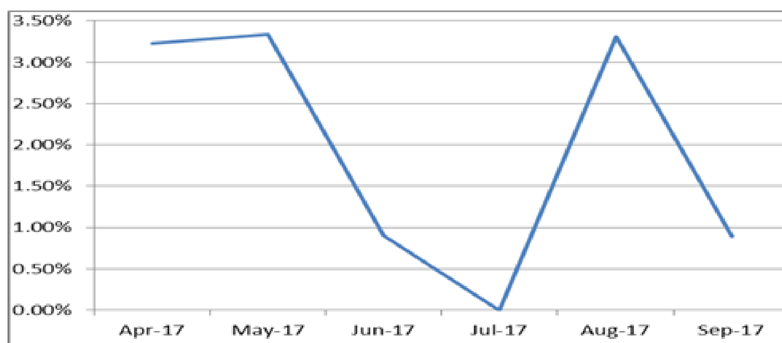
Group	Total
Learning Disability / Mental Health Patients	0
Deaths accepted by the coroner	45
Coroner's Inquest	5
STEIS SI	1
Internal Investigations	7

Number of Deaths & Reviews by Quarter



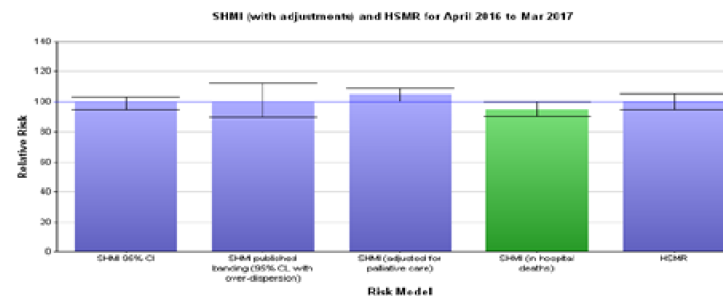
General Learning/Themes identified	
Ceilings of Care	A failure or reluctance to have timely and appropriate discussions with families and carers around Ceilings of Care.
Responding to the Deteriorating Patient	Failure to respond to an escalating NEWS score, early review by a senior doctor and failure to act on a deteriorating blood result.

% of deaths with Avoidable Factors



Summary Hospital Mortality Index (SHMI)

SHMI (with adjustments) and HSMR for April 2016 to Mar 2017



Appendix 2

Learning themes identified from Trust Mortality Review – Quarter 2 2017/18

Specialty	Issue	Learning identified
Paediatrics	Resuscitation Equipment Resuscitation Skills Did Not Attends (DNAs)	Delays and complexity in having timely access to resus equipment has been a theme over time. Paediatric and newborn Resuscitation Trollies have been designed and rolled out. A Resus Drug Chart has been developed and is due to be launched imminently. There had been a previous Morphine Never event and other difficult resuscitation issues that revealed team factors and a risk of mis-prescribing in high-stress resus situations. Simulation training has been introduced and recently appointed a Consultant and Practice Development Nurse to lead and embed a new style of learning Children not attending where there was already a safeguarding concern has led to an adjustment of the Trust cancellation Policy and the introduction of a Trust-wide 'was not brought' initiative
General Surgery	Abdominal Pathway	The new agreed Acute Abdominal pathway has been widely circulated and adhered to
Orthopaedics	Complex Orthopaedic Case	The complexity of this case necessitated multi-specialty, multi-disciplinary Structured Judgement Review. The logistics of facilitating such an event should not be underestimated, however the governance Support Unit will facilitate this at the earliest opportunity
Emergency Department	Inappropriate attendance at ED	10 deaths this quarter within the Emergency Department were reviewed and found to be expected, however it was clear that adequate care planning prior to attendance at the Department had not taken place . No advanced care planning was available either to EMAS or families to support decision-making. Often very traumatic for relatives.
General Learning Points/Themes	Ceilings of Care	A failure or reluctance to have timely and appropriate discussions around Ceilings of Care is a theme across a number of reviews. The implementation of the ReSPECT Tool will support the improvements required. The implementation of the ReSPECT Tool will be monitored through the Deteriorating Patient Group
	Responding to the Deteriorating Patient	Failure to respond to an escalating NEWS Score, early review by a senior doctor and acting on deteriorating blood results has featured in Mortality Reviews. In all cases of failure to escalate a 72 hour report is required for the Serious Incident Scoping meeting to determine the level of harm caused and the level of investigation required.

Q2 has seen a marked improvement and engagement of clinical teams in the Mortality Review process, with a much wider understanding of the value in the learning opportunities it offers.

A significant number of senior clinicians have been formally trained on the effective use of the Structured Judgement Review Tool with representatives from all specialties now able to facilitate the process within their teams. This training will continue, including refresher training where required. MSG plans to commission a retrospective audit in January 2018 of both Case Note Reviews and Avoidability Assessments to identify any further training and development necessary.

A number of teams are now reporting positively on the SJR experience, particularly in the involvement of multi-disciplinary colleagues. We have moved from a mortality review process that was largely medically led to a system that encourages a multi-disciplinary and where necessary a multi-specialty approach to determine the safety and quality of care delivered promoting a whole team solution to any learning or improvements.

It should be recognised though, that to undertake a comprehensive Structured Judgement Review is very resource dependent and this will pose a constant challenge to busy clinical teams. It is therefore imperative that teams are fully supported and can recognise the real value in undertaking this process to effect real change in the care they deliver to their patients.