Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	9
Date of Meeting:	30 May 2018		

Title of Report:	Learning From Deaths Quarterly Update
Status:	Progress Update
Board Sponsor:	Dr Bernie Marden, Medical Director
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Appendices	None

1. Executive Summary of the Report

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. Recommendations (Note, Approve, Discuss)

The Board of directors is asked to note, support and approve the content of this report and any inherent actions within.

3. Legal / Regulatory Implications

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.

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

Resource Implications

5. 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.

6. Equality and Diversity

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

7.	References to previous reports
Previously submitted and discussed at October and December 2017 Board of Directors. Learning from Deaths is also regularly monitored at the Mortality Surveillance Group and Clinical Outcomes Group.	

8.	Freedom of Information
Public	

Learning from Deaths

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 for Q4 17/18.

Methodology

Every death in the Trust is to be subjected to a review. Across the clinical divisions there is a difference in the scale of this activity and the approach that is taken. By far the majority of deaths occur within the Medical Division. The Surgical Division and Women and Children's Divisions have fewer deaths but also have well established systems for reviewing deaths through existing Mortality and Morbidity meetings. There are also existing statutory requirements to investigate deaths occurring in Maternity services and in Children. These areas have therefore maintained existing methodologies and this report largely references the work that is being undertaken within the Medical Division utilising the new systems, as well as applying the new SJR methodology to deaths in Surgical Division.

When a death certificate is issued in the Bereavement Office the clinician undertaking this task uses a screening tool to identify if a death needs to be subjected to a more in depth review. This does not replace the governance arrangements which exist where an obvious concern has already been identified or where a referral to the Coroner is mandated. It should be viewed a complimentary opportunity to triangulate information. Where a death triggers the need for a review then the case is put forward for a Structured Judgement Review (SJR), which is the tool developed by the Royal College of Physicians. This tool is designed to identify deficiencies in care and therefore learning. It should be noted that deficiencies in care may be identified which have not directly contributed to the death and that this needs to be given appropriate weighting and attention.

Update on Data available since last report

Medicine

Screening

Q2	2 patients
Q3	239 patients
Q4	186 patients
TOTAL	430 patients

SJRs

42 Selected for SJR
26 Allocated to Consultant for SJR (13 not yet allocated)
13 SJR completed & Returned (12 death deemed 'death definitely not avoidable'; 1 deemed 'slight evidence of avoidability')

Reasons for selection for SJR

12 Clinician (or screener) concern about quality of care
3 Early readmission
6 Family concerns about quality of care
5 Learning difficulties
2 Patients were MFFD at some stage during their admission
2 Elective admissions
1 Mental Health
11 Patients chosen at random

Surgical

17 cases selected for SJR (Result awaited)

Women and children's

2 cases undergoing Statutory Child Death review process.

Update from the Mortality Surveilance Group (reporting to Clinical Outcomes Group)

Training

A training session was delivered to a large multi-professional group in the use of the Structured Judgement Tool.

IT support

A database which links directly to the EPR in Millennium is nearing completion and will be rolled out imminently. A demonstration of the system was taken to the Mortality Surveillance Group meeting in May and it has been approved with some minor alterations. This will allow easier identification of cases requiring SJRs and better organisation of the clinicians required to undertake this activity. It will also allow easier collation of results and opportunities to recognise patterns and areas of learning. It will also support the generation of reports.

Administrative and managerial support

There is a clear commitment from the Risk Team within the Quality Improvement Centre to support the Learning From Deaths work stream by including this work as a priority area to support. The team is undergoing a review associated with some changes brought about as part of vacancies and recruitment. They will work closely with the Mortality surveillance Group and divisional Governance leads to coordinate this support.

Learning Identified to Date

It should be noted that learning is likely to become more prominent the more cases that are reviewed and as our ability to identify patterns therefore sharpens its focus. Of interest an Inquest into the death of a patient in August 2017 was strongly supported evidentially by an SJR while still in pilot phase. This SJR enabled learning to be identified into the design and utilisation of charts used for monitoring hydration and nutrition and the way in which clinical teams coordinate care. This has already led to changes in the way in which

dietetics coordinate care and into the use of the charts. The evidence provided helped the Coroner to reach a verdict of death by natural causes while at the same time allowing the Trust to demonstrate changes in practice supporting improvements in care.