Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**29 July 2020**		

Title of Report:	**Learning From Deaths Quarterly Update 19/20 Q4**
Status:	**Progress update**
Board Sponsor:	**Dr Bernie Marden, Medical Director**
Authors:	**Heather Boyes, Lead for Claims and Inquests**
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.	

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Learning From Deaths Quarterly Board Report 19/20 Quarter 4

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 31/03/2020)

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

- There have been just over 2500 deaths in the Trust since the database went active and 1511 during the financial year 2019-20.
- 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.

Table 2

	2018-19 Q2	2018-19 Q3	2018-19 Q4	2019-20 Q1	2019-20 Q2	2019-20 Q3	2019-20 Q4		
Period from	09/07/18	01/10/18	01/01/19	01/04/19	01/07/19	01/10/19	01/01/20		
Period to	30/09/18	31/12/18	31/03/19	30/06/19	30/09/19	31/12/19	31/03/20		
No. of days	83	92	90	91	92	92	91	Total	%
Awaiting completion of death certificate checklist	16	15	16	27	42	105	97	318	12.7%
Death certificate checklist completed, awaiting screening	6	18	26	38	40	96	97	321	12.8%
Screening completed, no further action required	203	269	247	228	194	169	204	1514	60.3%
Screening completed, awaiting SJR	10	22	20	31	16	21	18	138	5.5%
SJR completed	39	42	49	41	25	8	14	218	8.7%
Total deaths (per quarter)	274	366	358	365	317	399	430	2509	100.0%

Figures in parentheses are the figures presented on the previous quarterly report (Sept 2019) for comparison

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 4th 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 from April 2020 when the Medical Examiners will be performing the SJR screening process however the impact of the COVID19 pandemic is as yet unknown.

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 less than 1% of deaths have been recognised to have ‘avoidable’ features possibly contributing to the death by the SJR reviewer. All SJRs that identify avoidable

features, or conclude that a second review is required, are recorded on Datix to facilitate further scrutiny within the well-established incident investigation process.

The Trust Lead for Claims and Inquests has commenced the process of drawing together the themes and trends from Serious Incident, Inquests and SJRs and detailed reporting in relation to individual cases will be considered by the Mortality Surveillance Group and Operational Clinical Governance Committee.

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 Q4 01/01/2020 - 31/03/2020			Rating (out of 5)				
	average rating	n=	**1**	**2**	**3**	**4**	**5**
Initial admission	**4.00**	14	1	0	2	6	5
Ongoing Care	**4.09**	11	0	0	0	10	1
Care during procedure	**4.00**	2	0	0	0	2	0
Return to theatre		0					
Peri-operative Care	**4.00**	2	0	0	0	2	0
EoL/Discharge Care	**4.45**	11	0	0	0	6	5
Overall Assessment	**4.07**	14	0	1	0	10	3
Patient record	**3.79**	14	0	0	5	7	2

Learning from Medicine SJRs

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

- Falls risk assessments need to be repeated if a patient's condition changes
- Limitations in the provision of end of life care in the community results in some patients requiring an emergency admission to hospital

During Q4 no problems were identified that were felt likely to have contributed to death. The vast majority of the learning is being generated where care problems were identified but which were unlikely to have contributed to death

These findings are reviewed at specialty and divisional governance meetings. Prevention of

avoidable harm is a True North priority.

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 88 SJRs between 9 July 2018 and 27th April 2020

Themes for learning:

- Two SJRS indicated that a second review was required and therefore the key learning is still being considered.

- Good care was identified within several SJRS.

- Improvements could be made to documentation, including ensuring the ward and relevant consultant are noted within the history sheets.

Learning from the Women and Children SJRs

The women and Children Division did not complete any SJRs during Q4.

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. Whilst additional support will be available from Medical Examiners it

is still imperative that the team caring for the patient take ownership of this element of the process.
- 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.
- The COVID19 pandemic has hampered the functioning of the newly Medical Examiners.

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.
- To roll out the newly devised process for ensuring SJRs, Inquests and Incidents are properly aligned to maximise learning and minimise duplication of effort.

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