Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**21**
Date of Meeting:	**6th July 2022**		

Title of Report:	**Learning from Deaths and Inquest Report**
Status:	**To discuss and approve**
Board Sponsor:	**Bernie Marden Medical Director**
Author:	**Heather Boyes, Lead for Claims and Inquests**
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.

This is a report to summarise the mortality review process and learning from completed SJRs.

Any SJR raising the possibility of issues with care contributing to the patient's death will have been the subject of divisional scrutiny.

Where an SJR outcome reports that there are identified care problems likely to have contributed to death, it is important to remember that this is an individual's subjective assessment. A further stage of review or SI investigation is undertaken to establish any detailed concerns and to identify any additional appropriate actions.

2. Recommendations (Note, Approve, Discuss)

To discuss and approve

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.

The learning from deaths process has a number of steps. The first is scrutiny of all deaths via a checklist to determine appropriate certification and to identify any need

for additional attention, which may include a structured judgement review (SJR), referral to Coroner, or highlighting to internal clinical governance system eg possibility that an incident has not been previously recognised and flagged. Performance on this part of the process is very strong and is performed by the Medical Examiner who also makes sure that there is involvement of the family.

The next step is the SJR and this is where a more detailed review takes place by a senior clinician not directly involved in the care that has been provided. Performance in achieving this in a timely manner is challenging and the report highlights where this has slipped and what action is being taken to improve this. This is largely taking a more tactical approach to distributing the work to be more in line with available consultants in each specialty.

The SJR reviewer scores different parts of the patient pathway using a phase of care score. A score of 1 is very poor and 5 is very good. There is no score of 1 recorded and 5 scores of 2. The majority range from 3 to 5. Any low scoring areas of care are reviewed by the treating team even when not directly related to overall outcome in order to maximize the opportunity for feedback and learning. The reviewer also makes a subjective overall assessment of care. This is an opinion of a single professional and is moderated through the specialty and divisional governance scrutiny that follows any concerns being raised.

The learning is collated by the Risk Management Team and fed back to the organisation in a number of ways. Through oversight at the Mortality Review Group, Divisional Governance meetings and also triangulated along with complaints, incidents and inquests to inform the strategic quality improvement work overseen by the Patient Safety Steering Group. There a number of key themes currently. The quality and accuracy of documentation is something that is a recurring theme. Some elements of this such as dating and signing will be solved by a full electronic patient record, other elements such as the importance of contemporaneous note taking are being managed through education. End of Life care particularly around communication, discharge and admission is also an area where opportunities for learning have been identified. Quality Board has commissioned a multidisciplinary piece of work with the palliative care team and community colleagues to look at how this may be improved.

The process is an additional activity to be performed by already stretched clinicians and therefore we are continuously looking for ways to support this work and speed up the process to make any learning available as soon as possible. The involvement of the Medical Examiner at the first stages of the process strongly mitigates missing significant concerns and they have the authority together with the Divisional Governance leads to prioritise and expedite reviews where necessary.

It needs to be stressed that the Learning from Deaths process sits alongside and supports other governance processes and that the majority of cases demonstrated good or very good care. There are also opportunities to learn from episodes that have gone very well.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
What are the risks arising or identified in the report. Risks need to be added to the risk register in advance of submitting the report and the risk number stated.	

5.	Resources Implications (Financial / staffing)
The learning from deaths case review process is relatively resource intensive for clinicians.	

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

7.	References to previous reports
Quarterly Learning From Deaths Report	

8.	Freedom of Information
Public	

Learning From Deaths Quarter 4
January to March 2022

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, however since Q2, 2021/22 has been tracking at a higher level than 2020/21. Please see chart 1.

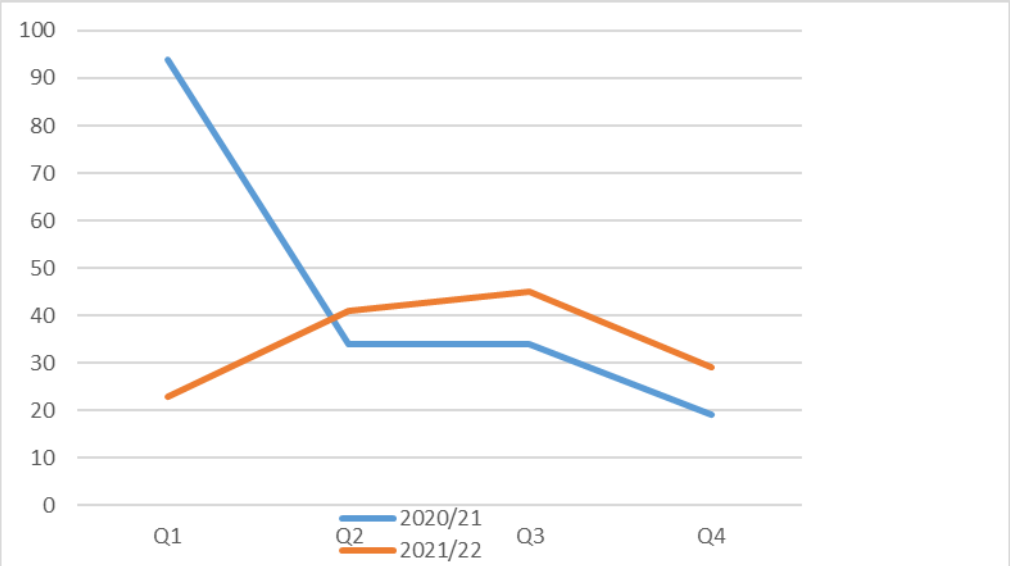

Chart 1: Number of outstanding checklists

The Lead Medical Examiner has completed a number of checklists that, for a variety of reasons, including a higher number of patient deaths in Q3 (see table 1) had not been completed by the relevant clinical team. This has resulted in the number outstanding decreasing from 45 to 29.

15 of these checklists relate to patients who died in 2020.

	Q1	Q2	Q3	Q4	Total
2018-19	dna	est. 300	366	358	dna
2019-20	365	318	404	429	1516
2020-21	275	274	374	390	1313
2021-22	280	324	412	351	1367

Table 1 – number of deaths per quarter

Chart 2 below illustrates decreases in the number of outstanding checklists during Q4 in all Specialities except Respiratory Medicine (increase from two to three).

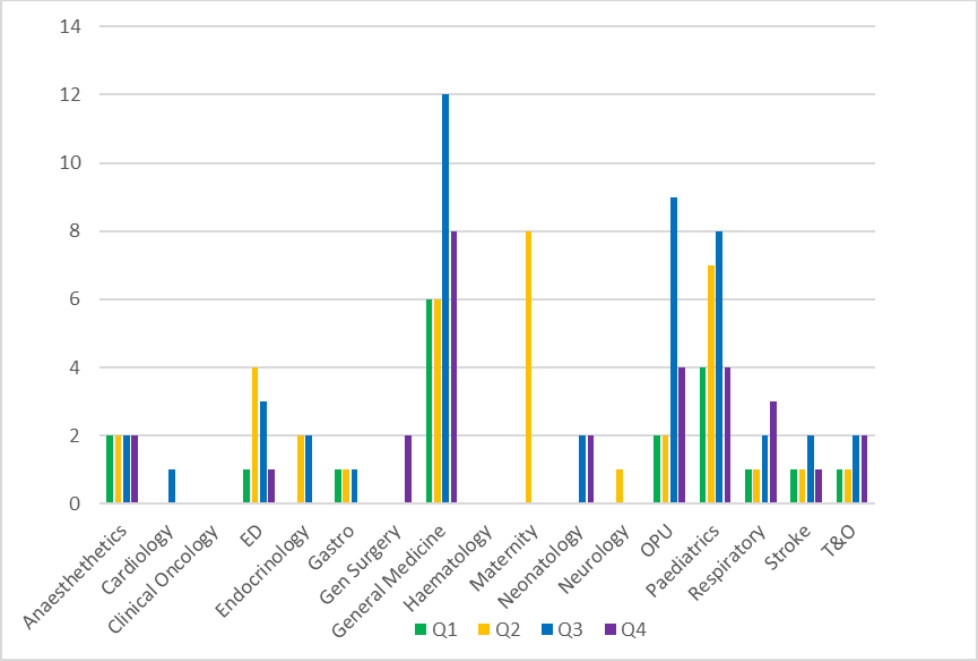

Chart 2: Outstanding checklists by specialty

Concerns have been raised previously that a failure to update the consultant responsible for a patient results in a patient death being allocated to an incorrect speciality. The chart bellows shows outstanding checklists by ward. This illustrates that MAU (6), Children's Centre (3), Midford (3) and Respiratory (3) have the highest number of outstanding checklists. It should be noted that death in children follows a separate statutory process, Child Death Review, which supersedes the checklist requirement.

If the Mortality Review Committee conclude this is a more accurate data set, the Learning from Deaths report will utilise this alternative methodology of recording by ward throughout from Q1 2022/23.

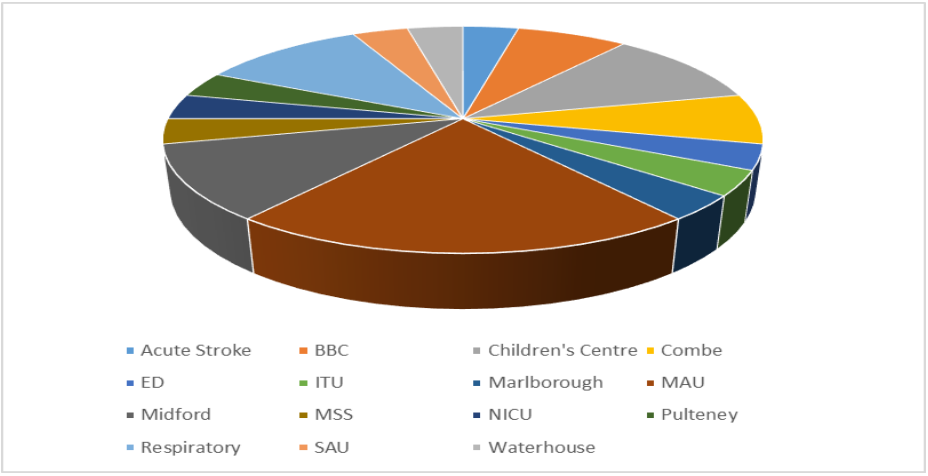

Chart 3: Outstanding checklists by ward

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 98% of patient deaths during the quarter year 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 97% 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.

Chart 4 illustrates that the number of SJRs completed has decreased during the financial year to date despite the number of cases being selected remaining high (65 deaths were selected for an SJR during Q4).

Chart 5 shows the number of outstanding SJRs is increasing at a rapid rate.

There are likely three potential explanations: 1) competing demands on clinical time 2) staffing in clinical areas and 3) depletion of staff within Legal Services resulting in it taking considerably longer to allocate Medicine and Family and Specialist Services' (Surgery allocate their own) SJRs to reviewers. Allocation of SJRs has been prioritised but at the time of writing, there are 48 SJRs waiting to be allocated to a reviewer.

The Claims and Inquests Officer, who is responsible for the allocation has reported that some clinical areas are more challenged with completing SJRs due to reduced consultant numbers. They are in the process of requesting consultant levels from each speciality to ensure SJR allocation remains fairly distributed.

The Mortality Review Committee will consider what steps can be taken to support the completion of SJRs.

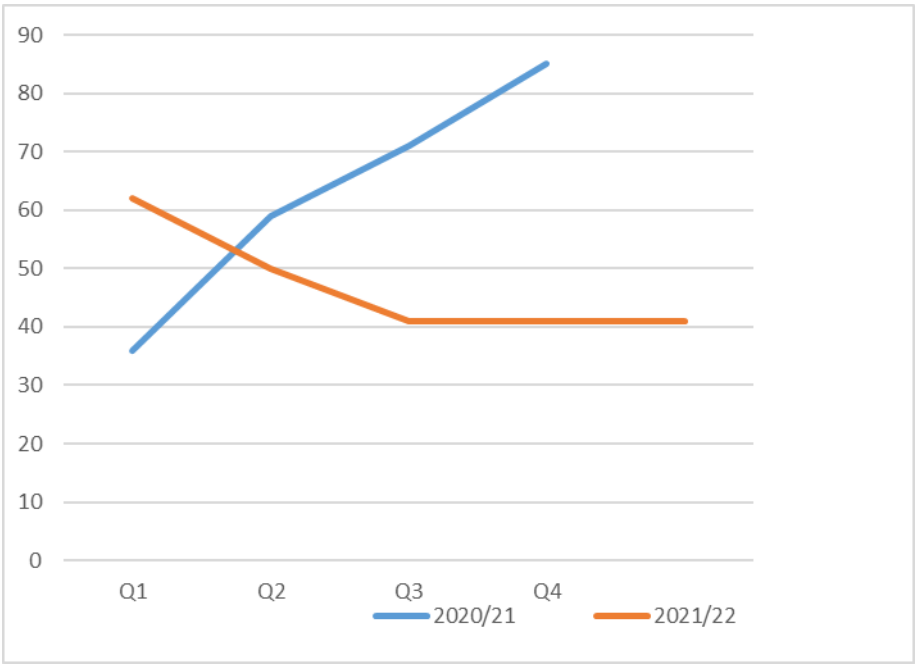

Chart 4: Number of completed SJRs

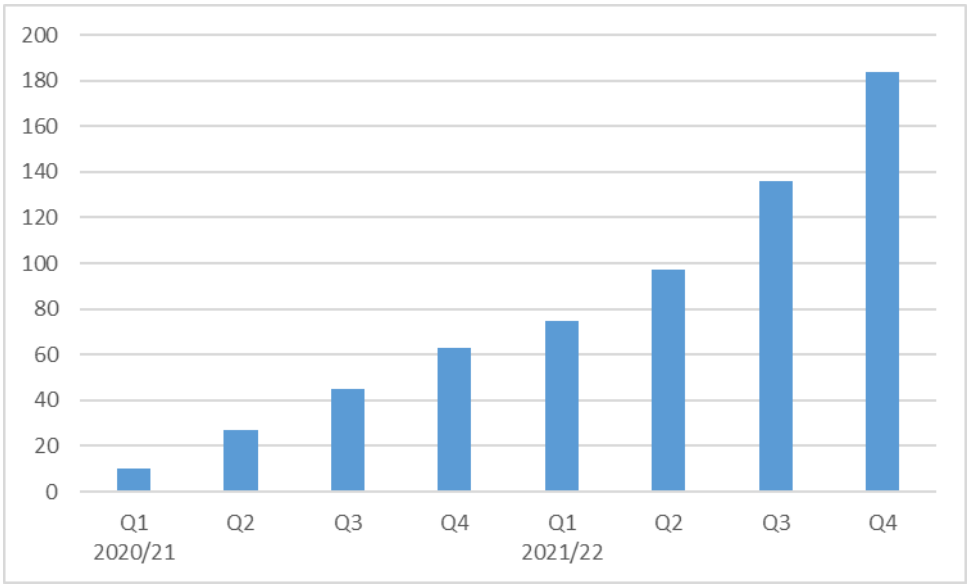

Chart 5: Number of outstanding SJRs

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, 52 are still outstanding. The chart below shows the speciality the outstanding review has been allocated to.

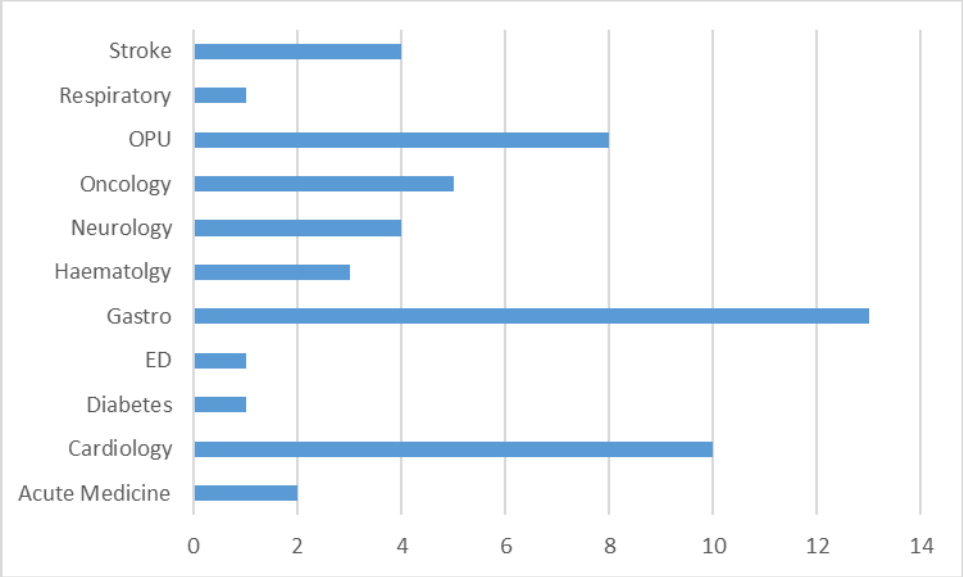

Chart 6: Outstanding SJRs by allocated speciality

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. It does need to be recognised that the Trust has never had the opportunity to operate under "normal" circumstances and it is hoped performance will improve once an element of stability has been achieved.

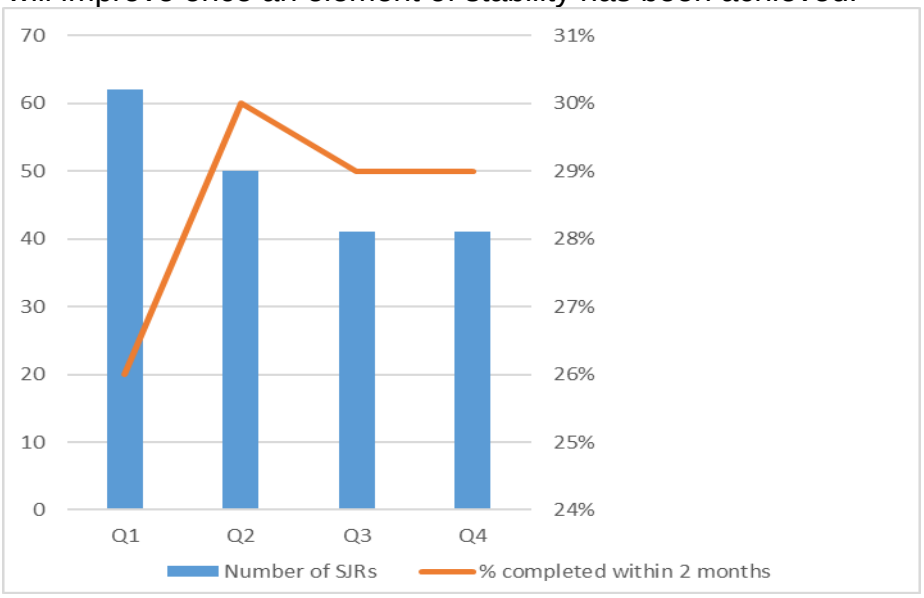

Chart 7: Number and percentage of SJRs completed within two months of patient death

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.

The table below shows two Medicine SJRs raising concerns related to incidents that had not previously been reported on Datix. Both have been subjected to review and been found not to meet SI criteria. This shows that in general there is good contemporaneous awareness of issues as they arise, and appropriate reporting and initiation of investigations happening in a timely manner. The SJR process adds an additional safety net.

Division	Specialty	SI?	Outcome of Review?
Medicine	OPU	No	Unavoidable Death
Medicine	Gastroenterology	No	Unavoidable Death

Table 2: Critical SJRs not previously reported as incidents

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. Whilst the two SJRs above were not found to meet SI criteria, they have resulted in greater scrutiny.

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 (Medicine also discusses the dashboard at their Divisional Governance meeting) 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.

3.1 Overall Quality of Care

The table below sets out the ratings of care for each element of an inpatient admission. Of the 41 SJRs completed during the quarter, 30 (73%, an improvement on Q3's 61%, but still a significant decrease from the 82% recorded for the last financial year) assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5).

No element of the care reviewed was found to be Very Poor (a score of 1) however, there were three (a reduction from 8 in Q3) instances of elements of the care provided being poor (score of 2), with two patients assessed as having received poor care overall.

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	3.90	41	0	1	8	26	6
Ongoing Care	3.91	35	0	2	7	18	8
Care During	4.00	14	0	0	2	10	2
Return To Theatre	4.00	3	0	0	1	1	1
Perioperative Care	4.00	12	0	0	1	10	1
End Of Life	4.11	35	0	0	3	25	7
Overall	3.83	41	0	2	9	24	6
Patient Record	3.63	40	0	0	21	13	6

Table 3: Phase of Care Ratings

ED received a 2 for Initial Admission, Ongoing Care and Overall Care. All related to the same patient. The patient's care has been reviewed by the division and it has been concluded that the SI threshold has not been met. Orthopaedics also received a score of 2 for Ongoing and Overall Care – these again related to the same patient. The score of 2 was given as a result of the patient experiencing an inpatient fall that resulted in a frail patient requiring surgery.

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.

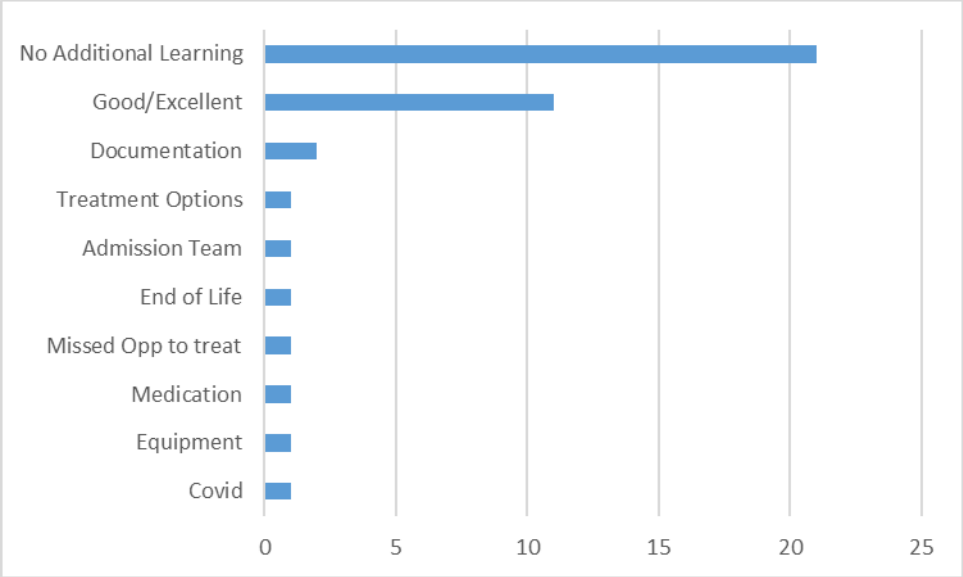

Chart 8: SJR themes

3.2.1 Documentation

Two SJRs comment in relation to the standard of documentation. The first comments on the need for staff to record their profession and grade on each occasion they write in the records. There is also reference to no documented evidence of the patient's next of kin being identified and contacted.

The second refers to the need to record conversations with relatives contemporaneously.

Documentation features in every quarterly report.

3.2.2 End of Life

Whilst only one SJR this quarter refers to end of life care, this is a theme that has appeared regularly. In this instance, reference is made to the distress experienced by family members who did not understand why IV fluids had been withdrawn. The SJR queries whether escalation to a more senior member of staff would have avoided some of this upset.