Ashford and St. Peter's Hospitals NHS Foundation Trust

TRUST BOARD
25 January 2017

AGENDA ITEM NUMBER	14.3
TITLE OF PAPER	Learning from Mortality Reviews – Q3 Board Report
Confidential	**No**
Suitable for public access	**Yes**
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED	
Mortality Review Group	
EXECUTIVE SUMMARY	

This report provides details and assurance on the mortality reporting process for Ashford and St Peter's Hospitals NHS Foundation Trust.

The report gives details on the screening system and progression to a full Structured Judgement Review (SJR), with further analysis on the findings of the SJR and phases of care. The report provides detail on the learning and the plans for sharing of this learning throughout the organisation.

In quarter 3 of 2017/2018 there were 275 adult inpatient deaths across both Trust sites, of these 159 had initial screening completed.

A SJR was identified for 42 patients, of which 19 have been completed.

The Trust currently has 18 *professional staff* trained to complete SJR's with a further 10 allocated to a training session.

RECOMMENDATION:	
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PRESENTED BY	David Fluck, Medical Director and Sue Tranka, Chief Nurse
DATE	22 January 2018
BOARD ACTION	Assurance

1. BACKGROUND AND SCOPE

In March 2017, the National Quality Board released the first edition of the 'National Guidance on Learning from Deaths' which aims to initiate a standardised approach to the review of and learning from deaths. In response to this, the Royal College of Physicians have been leading the National Mortality Case Record Review (NMCRR) programme which provided clear guidance on the resources required to carry out an adequate programme of mortality reviews, including the use of a Structured Judgement Review (SJR) tool to be used to review some in-hospital deaths.

In-line with this guidance, ASPH have been reviewing and revising our own policies and processes and our aim is to ensure that there is a timely review of all relevant deaths through the Structured Judgement Review (SJR) process by specifically trained healthcare individuals; and to ensure a there are robust methods and environments created within the Trust by which sharing, learning and actions for improvement can be made.

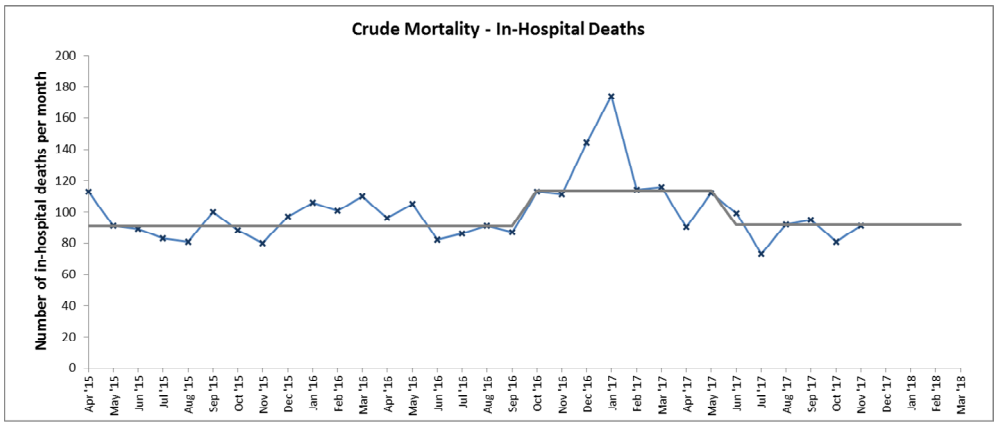
The structured judgement review (SJR) involves assessing different phases of care, writing explicit judgement statements and giving scores (from '*very poor care'* to *'excellent care'*). Each review is undertaken by a trained individual – either a nurse (Band 7 and above) or a Consultant (of any speciality) - and usually takes around one hour per case review.

Following approval of the changes to the process of reviewing adult, in-hospital deaths at TEC in September, the team working on implementation of necessary changes have set out to recruit a team of individuals from across the Trust to carry out SJRs and to work with them to ensure they are adequately trained to undertake this role.

ASPH has two tier-one trainers who have received training as part of the Royal College of Physicians national programme (Peter Wilkinson and Russell Wernham) and in Q3 the team have set out to recruit a team of individuals from across the Trust to carry out SJRs and to work with them to ensure they are adequately trained to undertake this role. At the end of Q3, 23 members of staff have been trained, or have volunteered to be trained, to undertake SJRs.

From October 2017 we have started to carry out full structured judgement reviews (SJR) on any deaths meeting certain minimum criteria. These include any death where bereaved families and carers, or staff, have raised a concern about the quality of care provided; any deaths of patients with learning disabilities or with severe mental illness; any deaths following elective procedures; as well as a further sample of other deaths.

At the current rate of in-hospital deaths, approximately 15 cases per month are subject to an SJR.



This paper provides an update on the reviews completed to date and a summary of the findings; as well as an update on the progress on the changes to process made to date and planned to support the completion of the reviews.

2. SCREENING FORM COMPLIANCE

From October 2017, full structured judgement reviews (SJR) have been carried out on any deaths meeting certain minimum criteria. These include any death where bereaved families and carers, or staff, have raised a concern about the quality of care provided; any deaths of patients with learning disabilities or with severe mental illness; any deaths following elective procedures; as well as a further sample of other deaths.

A full description of the criteria being applied to select the cases for SJR is included as Appendix A. It is anticipated that, by using these criteria, approximately 10%-15% of deaths will be reviewed initially via the SJR process.

A new Mortality Review Screening Form has been implemented, which acts as a screening tool to help identify patients requiring SJR. Below is initial analysis of in-hospital, adult deaths in Q3 and the number of initial screening forms completed:

	Q3 2017 / 2018		
Division	In-hospital, adult deaths	Screening forms completed	% Screening forms completed
Medicine	218	131	60%
TASCC	48	28	58%
Orthopaedics	9	0	0%
Women's Health	0	0	N/A
All	275	149	54%

A significant improvement in the rate of completion of the screening forms is required in order to ensure the correct cases are being identified for SJR. This has been discussed at the Mortality Committee and some measures are being taken to improve this compliance.

3. STRUCTURED JUDGEMENT REVIEWS COMPLETED

The structured judgement review (SJR) involves assessing different phases of care, writing explicit judgement statements and giving scores (from '*very poor care'* to *'excellent care'*). Each review is undertaken by a trained individual – either a nurse (Band 7 and above) or a Consultant (of any speciality).

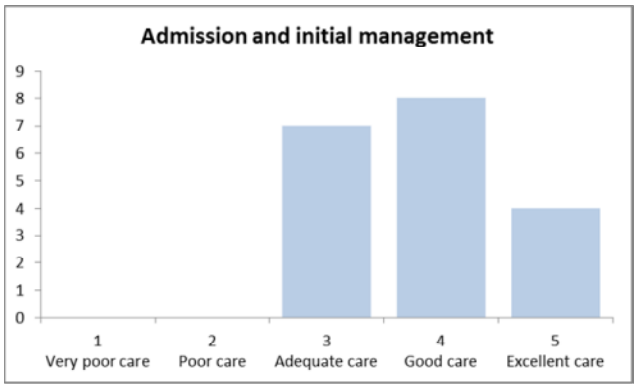
In Q3, 42 cases were identified for SJR and 19 have been completed to date.

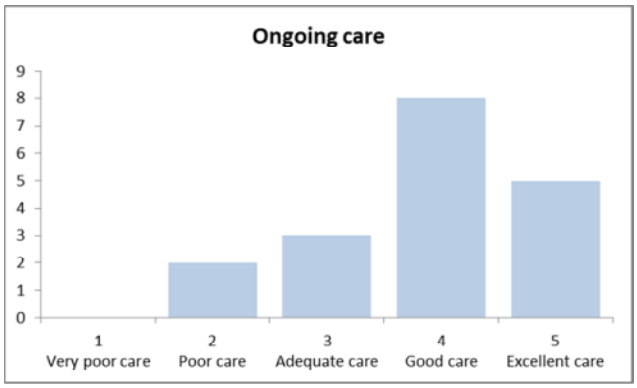
4. PHASES OF CARE SCORES

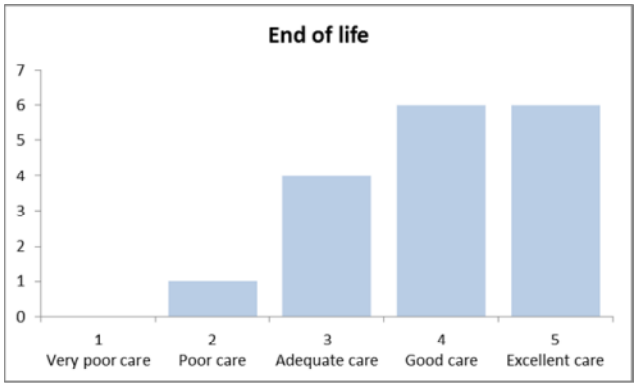
The SJR requires recording explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Care is rated during each phase on a scale of 1 to 5.

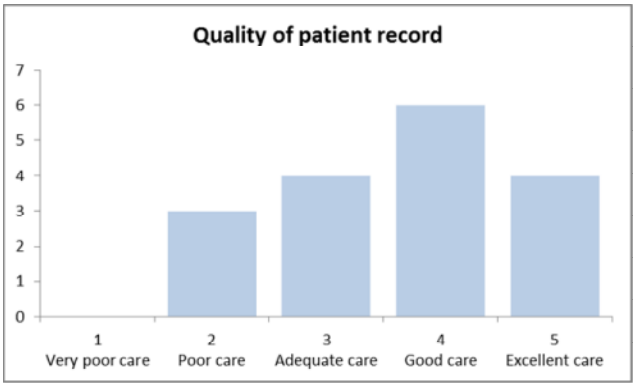
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

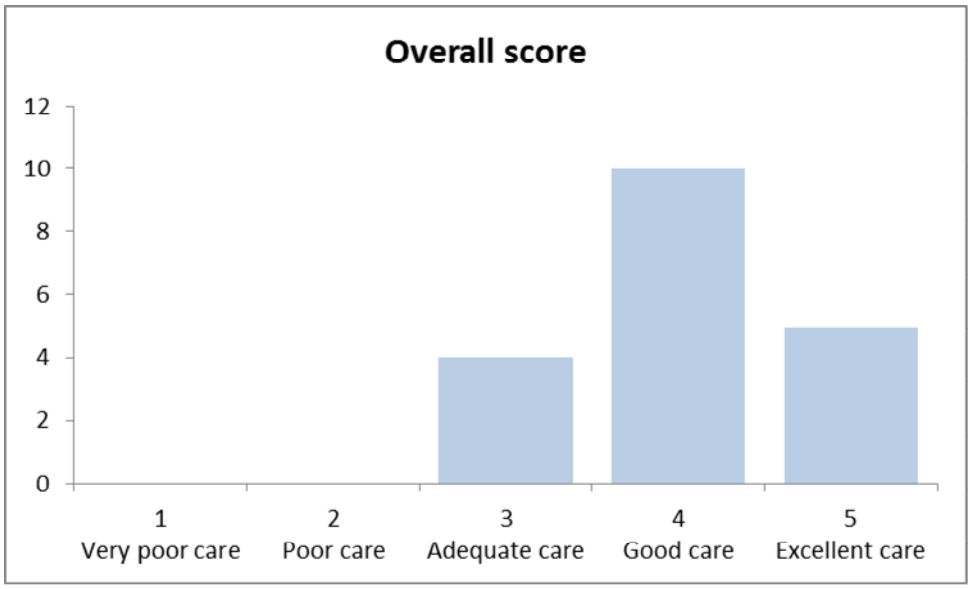
The charts below show the ratings recorded for the SJRs completed in Q3:











One case was identified to have received 'poor care' following the first stage SJR. Following a second stage SJR this was revised to reflect 'good care' and feedback and learning has been shared with the initial reviewer. Training for members of staff who have volunteered to carry out SJRs continues on an on-going basis.

5. ASSESSMENT OF PROBLEMS IN HEALTHCARE

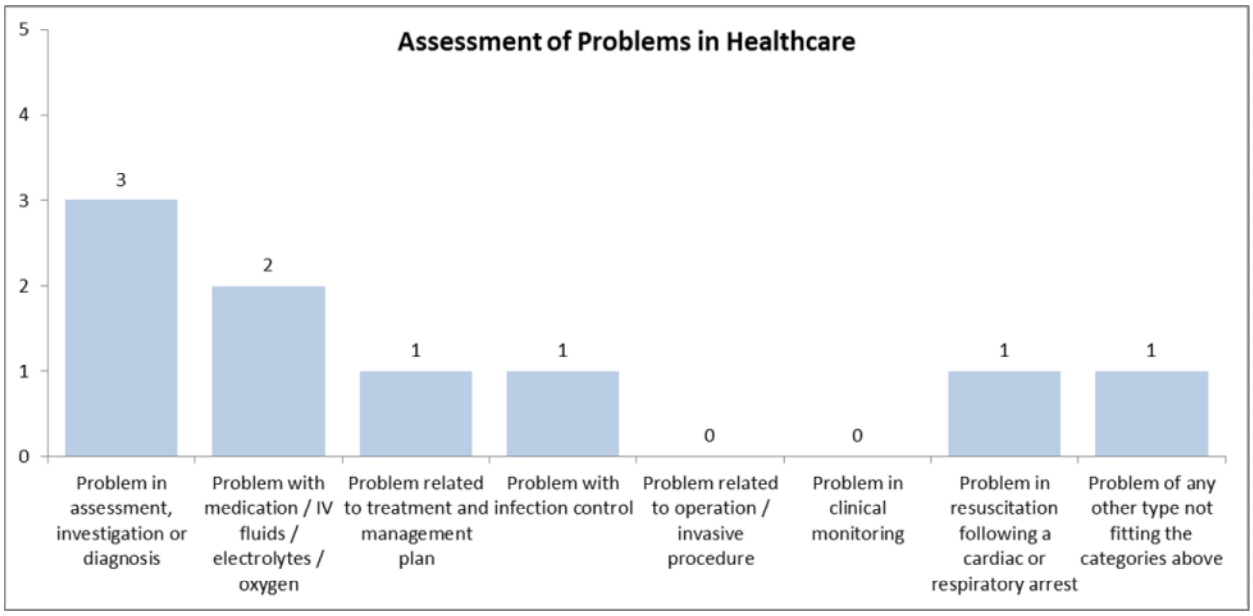
As part of the SJR, reviewers are asked to identify if there were any problems with care and if they could have led to harm to the patient. For clarity, in cases where patients have been found to have received good or excellent care, problems with care are still identified and shared as part of the learning processes.

In Q3 2017/2018 there were six cases in which problems with the care of the patient were identified.

In five cases, these problems did not lead to harm.
In one, the problems 'probably' led to patient harm.

In the one case where the problems with care 'probably' led to some patient harm, the overall care was found to be adequate.

A breakdown of the individual problems with care identified is below:



All problems in care are subject to review as part of the organisational learning process described below.

6. LEARNING FROM DEATHS

Although no patients were found to have received *poor* or *very poor* care, and only one patient was found to experienced problems with care that could *probably* have led to harm, there are a number of learning points to be shared from the SJRs completed to date.

All SJRs completed to date have been fed-back to the specialty teams in order to share the learning from the case reviews.

More plans underway to share learning from in-hospital deaths and these are summarised below.

The plans for extending the learning from mortality reviews throughout the organisation, and the methods for supporting mortality meetings that provide the opportunity to both make improvements and share good practice in patient care, have been discussed at length at the month Mortality Committee.

Creating a culture and environment in which such reflections are possible in an open and supportive way, which is oriented to improvement for the future, is important. A number of changes to the way the learning from deaths is shared throughout the organisation and beyond are planned for 2018.

The existing specialty mortality and morbidity review meetings provide an opportunity for peer review, collective learning and quality improvement, and this is an integral part of local clinical governance systems. In addition, each Divisional team is reviewing their plans for sharing learning from deaths within their governance structures.

7. NEXT STEPS

The Mortality Committee have recently reviewed and discussed a number of suggestions and recommendations for the testing of a Trust-wide learning process, which include:

- Open learning events (Based on learning from the Schwartz Round model and examples of good practice from elsewhere, we are proposing an initial testing of a Trust-wide ‘learning from deaths’ forum. The forum will aim to review one or two cases from the previous month and include reflections from families)
- ‘Aspire’ videos and messages
- The decision between a written report, or a more visual report will be discussed at the next Mortality Review Group.
- A learning mobile app
- The DATIX platform provided by the Royal College of Physicians as the repository for completed SJRs will provide the ability to analyse and summarise learning.
- The Mortality Review Group will review and provide a process for the maintaining of standards and good practice for those who undertake SJR’s.
- An agenda item will be added to QPC that provides monthly assurance that feedback is being given and learning from this is shared. The process of this sharing is still under discussion.

APPENDIX A

A full description of the criteria being applied to select the cases for SJR is below:

Criteria for SJR case selection	Details
Any death where bereaved families and carers have raised a concern about the quality of care provided.	Any adult, inpatient death where a complaint or PALS contact has been raised as identified by the Divisional Governance teams Any adult, inpatient death where 'Have family members or carers raised a significant concern about the quality of care provision?' is indicated on the mortality screening form as identified by the Ward team
Any death where a member of staff has raised a concern about the quality of care provided.	Any adult, inpatient death where a DATIX incident has been raised as identified by the Divisional Governance teams Any adult, inpatient death where 'Have any staff members raised a significant concern about the quality of care provision?' is indicated on the mortality screening form as identified by the Ward team Any adult, inpatient death which has been identified as either 'Definitely avoidable', 'Strong Evidence of avoidability or 'Some evidence of avoidability' by the Consultant completing the mortality screening form
Any death of a patient with learning disabilities or with severe mental illness.	Any adult, inpatient death of a patient with learning disabilities or with severe mental illness as identified by the Divisional Governance teams Any adult, inpatient death where 'Did the patient have a learning disability? or Did the patient have a severe mental illness?' is answered positively on the mortality screening form as identified by the Ward team
Any deaths following an elective admission.	Any adult, inpatient death with a spell coded with admission method of 11, 12, or 13 Any adult, inpatient death where 'Is this a death in an area where people are not expected to die? (e.g. patients attending for a routine elective procedure)' is answered positively on the mortality screening form as identified by the Ward team
A further sample of other deaths.	A 5% random sample of all other deaths occurring in the month Any adult, inpatient death where 'Do you have any other cause to think that this death would benefit from a mortality review?' is answered positively on the mortality screening form as identified by the Ward team