Ashford and St. Peter's Hospitals
NHS Foundation Trust

TRUST BOARD
26 September 2019

AGENDA	15.3	
TITLE OF PAPER	Learning from Mortality Reviews Q1 Report	
Confidential	No	
Suitable for public access	Yes	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
Quality of Care Committee 19th September 2019		
STRATEGIC OBJECTIVE(S):		
Quality of Care	/	This report provides details and assurance on the mortality review and reporting process for Ashford and St Peter's Hospitals NHS Foundation Trust and forms part of the Quality objectives to become a learning organisation.
People		
Modern Healthcare		
Digital		
Collaborate		
EXECUTIVE SUMMARY		
	This report gives details on the screening and Structured Judgement Review (SJR) of in-hospital deaths from Q1 2019/20120 (April, May, June 2019), with further analysis on the findings of the SJR and phases of care. The report also provides detail of the learning and the plans for sharing of this learning throughout the organisation. In Q1 of 2019/2020 there were 294 inpatient deaths across both hospital sites, 4 of these deaths were neonatal (less than 1 month old). There have been no Paediatric deaths (1 year -18 years old) reported in Q1 2019/2020. There were a further 20 adult deaths in ED in Q1 resulting in a total of 310 adult deaths (inpatients and ED) in the scope of the SJR process. Of these, 270 had an initial screening completed and 40 cases were identified for an SJR. At the time of writing this report, 17 of the cases identified in Q1 have been completed (43%). Overall we are maintaining our 10% review rate of in-scope mortality with SJR methodology. Of the cases identified in Q1 2019/2020, one case has been found to have received 'poor care' following a stage one and second stage review. The details of this case and the initial learning associated is summarised in this report. One patient identified as having learning difficulties was recorded in Q1, which is	

	outstanding at the time of writing. The case is known to the Surrey and Borders Mental Health Trust team and will be subject to LeDeR reviews. Three patients from previous quarters were identified as having received poor care during Q1, of which all have been confirmed with a second review. A further poor care identified from a first review is awaiting a stage two review. None of these four cases of poor care subject to a second review have shown evidence of significant avoidability. This report also includes a summary of the six perinatal deaths which occurred in Q1 and met the criteria for a perinatal mortality review; along with learning and actions from previous perinatal mortality reviews.
RECOMMENDATION:	The Board is asked to receive the report.
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	
Patient impact	
Employee	
Other stakeholder	
Equality & diversity	
Finance	
Legal	
Link to Board Assurance Framework Principle Risk	
AUTHOR	Dr Paul Murray, Chief of Patient Safety
PRESENTED BY	Sue Tranka, Chief Nurse; David Fluck, Medical Director
DATE	19 September 2019
BOARD ACTION	Receive for assurance

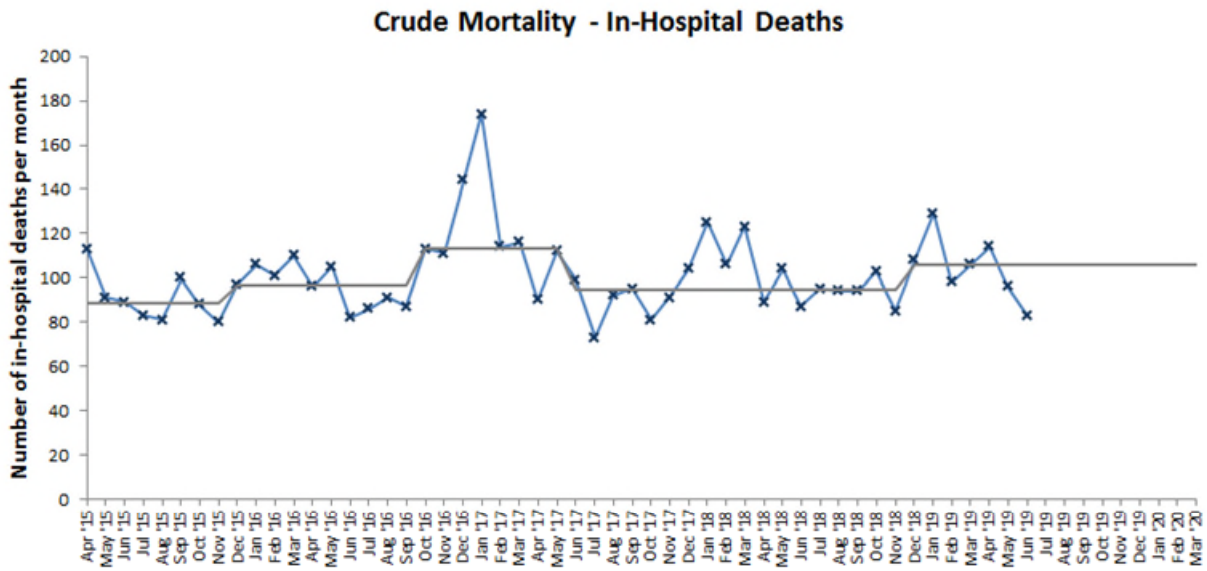
BACKGROUND

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 has an objective within the Quality of Care strategic objective 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 of learning and actions for improvement can be made.

1. MORTALITY DATA

In Q1 2019/2020 there were 290 inpatient deaths, including 4 neonatal deaths.

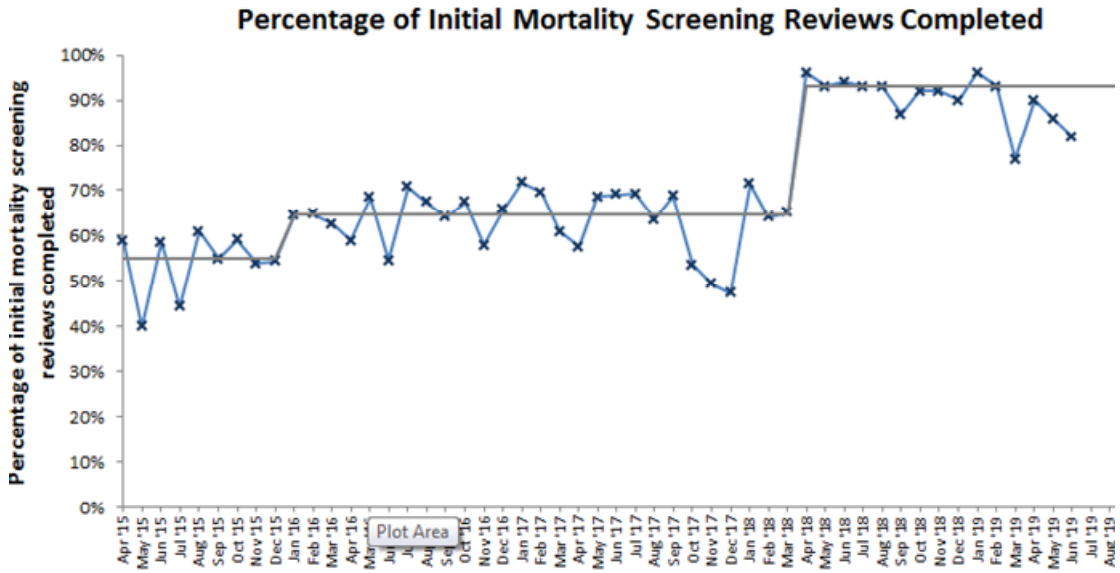


There were a further 20 deaths recorded in the Emergency Department (ED) in Q1. From October 2017 full structured judgement reviews (SJR) have been carried out on adult inpatient and ED deaths that meet certain minimum criteria (described in Appendix A).

One patient identified as having learning difficulties were recorded in Q1, of which is awaiting a structured judgement review at time of writing. The case is known to the Surrey and Borders Mental Health Trust team and will be subject to LeDeR review.

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. From Q3 2018/2019 we have not conducted SJRs on a random sample of deaths as an audit of reviews up until that point demonstrated no evidence of poor care. We have thus chosen to only perform SJRs on those triggered via the initial mortality review or any other raised concerns.

A list of the criteria for identification of cases for SJR is provided in Appendix A. A new Mortality Review Screening form was implemented in 2017/2018, which acts as a screening tool to help identify patients requiring SJR.



There was an improvement and special-cause variation in the completion of screening forms in 2018/2019 with 86% completed for Q1 2019/2020.

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), AHP (Band 7 or above) or a Consultant (of any speciality).

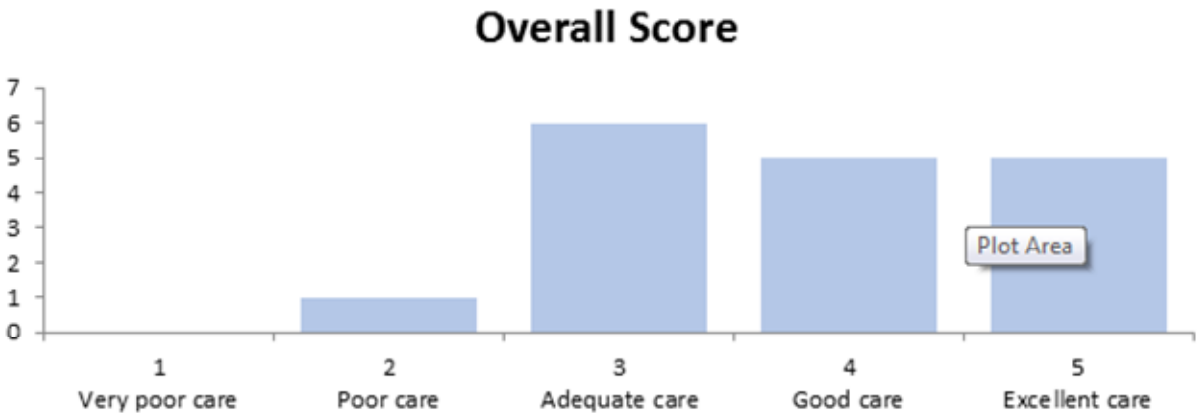
In Q1, 40 cases were identified for SJR and 17 have been completed to date (43%).

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 chart below shows the ratings recorded for the SJRs completed in Q1:



Of the cases identified in Q1 2019/2020, one case has been found to have received 'poor care' following completion of a stage one and two SJR review. The details of these and the learning associated is summarised in the section below.

2. ASSESSMENT OF CARE

POOR CARE

In Q1 2019/2020, four cases identified earlier in 2018/2019 had SJRs completed in this quarter and were found to have received 'poor care' at initial SJR and confirmed with stage two SJR review. There is a further one case awaiting stage two.

A description of the cases and the learning associated with them so far (pending the outcomes of the full investigations) is summarised below.

The first case highlighted concerns over impression of lack of escalation to deteriorating patient. A community DNAR being in place may have affected the decisions not to escalate. Patient was acutely unwell on arrival to A&E with poor health prior to admission. The initial antibiotics prescribed for suspected sepsis, one given in the golden hour, two later on. There was poor communication between staff and patients family with no clear recognition of dying.

The second case highlights concerns of a relatively high anaesthetic dose given for frail patient with host of medical comorbidities with a complicated periprosthetic fracture with an associated delay pre-operatively necessary due to frailty and need to optimise.

The third case showed a lack of senior review for consecutive days and failure to review results of tests ordered, insufficient pain control along with attention to basic needs and an overnight stay in the Emergency Department occurring in the early part of 2019.

The final case was a patient with severe end-stage lung disease that whilst the potential to decline during admission was high likely there was no pre-emptive discussions or ReSPECT type discussions had so when patient deteriorated they were initially inappropriately resuscitated.

No cases were found to have evidence of more than 50/50 avoidability.

If any such poor care is also associated with evidence of more than 50/50 avoidability* then the case(s) will be fed into the Serious Incident Framework for a more formal investigation along with a duty of candour to ensure any care and service delivery problems are identified, recommendations and learning points extracted and used to inform appropriate improvement work.

The outcomes and learning from both these incidents will form the basis of focussed improvement work involving the relevant teams and organisational as a whole. The outcome of all the SI investigations will be reported through usual methods and to the Quality of Care Board sub-committee.

* As part of completing a second stage SJR, the reviewer is asked to make a judgement on the 'avoidability' of the death and the options available are based on the Royal College of Physicians Structured Judgement Review Data Collection Form (Appendix B).

3. LEARNING FROM DEATHS

There are a number of learning points to be shared from the SJRs completed in this period as described in the section above. In all cases where the SJR has identified problems with care, these have been shared with a specialty governance team and a selected number of the cases will be put forward for discussion at the relevant Quality and Safety Half (QuaSH) Days.

The most recent, Trust-wide learning event was held in July 2019. This forum explored learning from three SJR cases during 2018/2019 which showed harm to patients due to poor management of anticoagulation. This was triangulated through a presentation linking the mortality concerns with SIRI investigations, an internal investigation along with overall Datix incident reporting and the medication safety work showing the overall theme of management issues of anticoagulation.

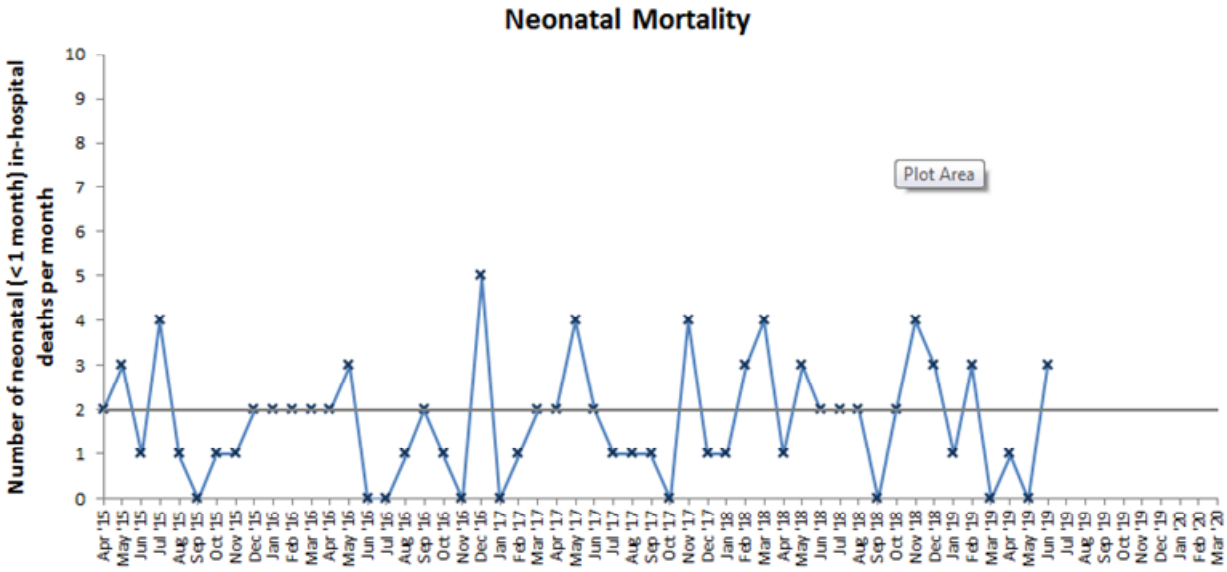
One of these SJR cases was discussed in more detail, again along the anticoagulation theme, which highlighted that it was documented the haemoglobin had dropped from 125 to 103 but took no action. This was is in a patient on an oral anticoagulant, who had not had their INR checked for several days and there was no review in respect to the continuation of anticoagulation.

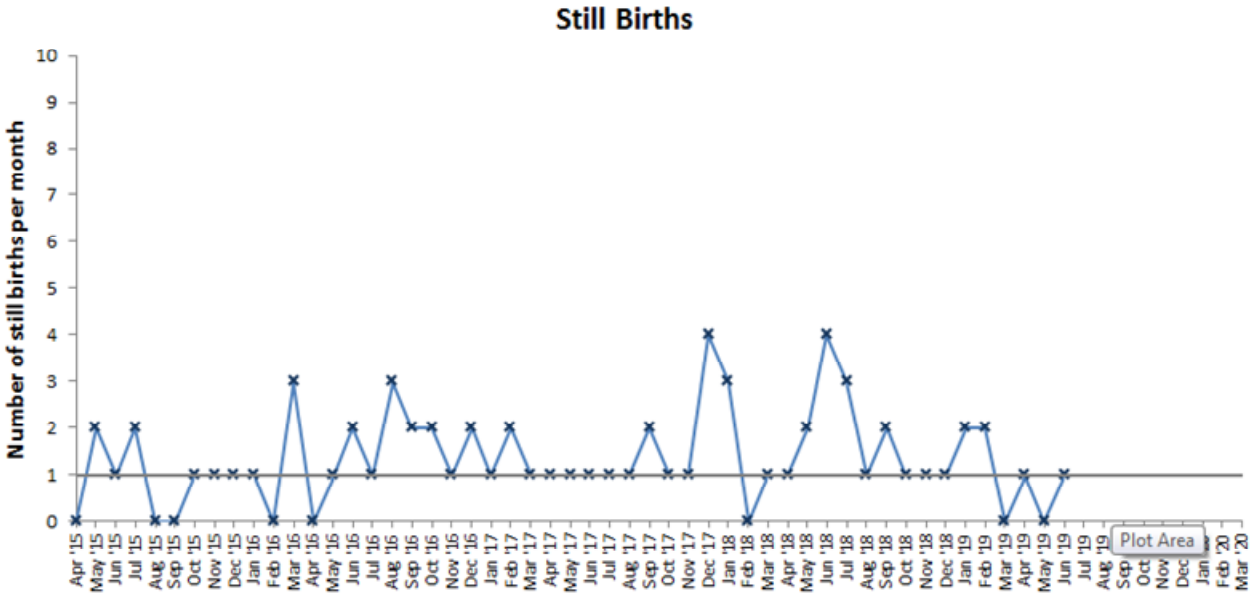
With a multidisciplinary audience of approximately 40 including staff and patient advocates, a small panel of those involved with the care of the patient and the reviewer discussed the care of the patient.

After the success of this event we are now linking with the Patient Safety Team and their similarly successful monthly SIRI learning events in order to provide a more consistent monthly learning event for the rest of 2019 into 2020.

5. PERINATAL DEATHS

During Q1, six perinatal deaths occurred that met the criteria for a perinatal mortality review to be undertaken.





During Q1, six perinatal deaths occurred that met the criteria for a perinatal mortality review to be undertaken. The following criteria are used by MBRRACE -UK to guide which babies require a perinatal mortality review to be undertaken.

- Terminations of pregnancy - resulting in a pregnancy outcome from 22+0 weeks gestation onwards, plus any terminations of pregnancy from 20+0 weeks which resulted in a live birth ending in neonatal death.
- Stillbirths – the baby is delivered from 24+0 weeks gestation showing no signs of life.
- Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.

	Gestation	Category of death	In/ex utero transfer	Cause of death
April	39+3	Intrapartum stillbirth	no	Severe Hypoxic Ischaemic Encephalopathy
May	29+1	Neonatal death day 4	In-utero transfer	Prematurity and Pulmonary Hypoplasia
June	39+2	Antepartum stillbirth	no	Indeterminable stillbirth
June	40+1	Neonatal death day 2	Ex-utero transfer	Severe Hypoxic Ischaemic Encephalopathy
June	26+3	Neonatal death day 7	In-utero transfer	Extreme prematurity, Persistent Pulmonary Hypertension and severe Respiratory distress syndrome.
June	23+1	Neonatal death day 5	In-utero transfer	Extreme prematurity and Gram Negative Sepsis

Five of the six babies were born and died at St Peter's Hospital, one baby was an ex-utero transfer and died at St Peter's Hospital. Three mothers were not booked at St Peter's hospital, but care was transferred for the purposes of accessing level three neonatal intensive care services.

83.3% of cases received a neonatal review and 66.7% (4 out of 6) of cases received an obstetric review. Two cases are being investigated by the Healthcare Safety Investigation branch (HSIB), whose timescales for investigation are longer than those set by CNST, therefore these have been excluded for the purpose of CNST compliance. PMRT will be completed once HSIB have concluded their review into these cases.

Actions implemented as a result of learning identified during the reviews:

- To ensure correct notification pathway is in place to alert the booking hospital when a neonatal loss occurs
- To enhance existing processes is in place to ensure BAPM and other important communications are effectively disseminated to the whole team and any recommendations are adopted into practice.
- Refresh team on the early signs of neonatal sepsis

6. MEDICAL EXAMINER

The National Guidance on Learning from Deaths, published in March 2017, set out a framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in their care.

The DoH accepted the conclusion of the Shipman inquiry third report that the existing arrangements for death certification are confusing, provide inadequate safeguards, and there is no mechanism that allows the NHS to see patterns, take action and learn from them. Further to this, inquiries into deaths and practices at Mid Staffordshire showed that improved reporting and investigations could have prevented many unnecessary deaths.

Alongside our present mortality review work the DoH have mandated the requirement to have a Medical Examiner (ME), along with Medical Examiner Officers (MEOs) working in each Trust to support the reforms enabled in the Coroners and Justice Act 2009. This will be a statutory requirement by April 2020

This whole system will then provide independent safeguards and checks to highlight patterns both through a review of relevant medical records and by making sure that the family has a chance to raise any concerns. This independent review will make the identifying of malpractice easier, provide opportunities for the NHS to learn and address system failures earlier.

The outcome of this whole system approach will provide:

- Replace the point of initial mortality review which will ensure 100% compliance
- Increase communication with and transparency for bereaved families
- Improve the quality and accuracy of medical certification of cause of death (MCCD)
- A system of effective medical scrutiny applicable to all deaths that do not require a coroner's post mortem or inquest
- Report matters of a clinical governance nature to support learning and changes to practice and procedures
- Information on public health surveillance requested by PHE

This new system will need to achieve these outcomes without imposing undue delays on bereaved families or unacceptable burdens on medical practitioner or others involved in the process. The new system will be transparent, proportionate, consistent and affordable.

The ASPH Medical Examiner role is progressing and after attendance at a ME event at Woking Coroners Court in July with attendance from Frimley and SASH (who both have MEs in post) we have reviewed our proposal. With a timeline to advertise for this role by end of October 2019 whilst will still be looking for 1WTE this will be most likely divided into five part-time roles along with a MEO to follow these other Trusts successful models which have been found to provide both excellent cover and sufficient flexibility.

At present the post is progressing through the Commercial Group and WOD processes with the support of the Medical Director and Chief Nurse.

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

* From Q3 2018/2019 we have not conducted SJRs on a random sample of deaths as an audit of reviews up until that point demonstrated no evidence of poor care. We have thus chosen to only perform SJRs on those triggered via the initial mortality review or any other raised concerns.

APPENDIX B - AVOIDABILITY OF DEATH JUDGEMENT SCORE

As part of completing a second stage, the reviewer is asked to make a judgement on the 'avoidability of death' in the case.

This is based on the Royal College of Physicians Structured Judgement Review Data Collection Form.

Mortality Review Form
Stage 2 - Structured Judgement Review

Avoidability of Death Judgement Score

We are interested in your view on the avoidability of death in this case.

Please choose from the following scale (tick one score).

☐ **Definitely avoidable**

☐ **Strong evidence of avoidability**

☐ **Probably avoidable (more than 50:50)**

☐ **Possibly avoidable but not very likely (less than 50:50)**

☐ **Slight evidence of avoidability**

☐ **Definitely not avoidable**

APPENDIX C – SUMMARY OF MORTALITY AND SJR DATA

Summary total deaths and total number of cases reviewed under the Structured Judgement Review Methodology													
	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Cumulative
Total number of adult inpatient deaths	95	93	94	101	81	105	129	95	104	114	95	80	1555
A&E deaths (in scope from July 18)	6	3	3	7	7	11	8	8	9	5	5	11	105
Total number of deaths in scope	101	96	97	108	88	116	137	103	113	119	100	94	1663
% of deaths receiving initial review	93%	93%	87%	92%	92%	90%	96%	93%	77%	90%	86%	82%	
Number of cases requiring an SJR	22	11	25	19	10	5	12	11	8	13	14	13	208
Total deaths receiving structured judgement review	17	10	24	16	7	1	8	9	7	8	7	2	151
Percentage of SJRs completed	77%	91%	96%	84%	70%	20%	67%	82%	88%	62%	50%	15%	73%
Percentage of SJRs completed (by quarter)		88%			71%			77%			43%		66%
Total Number of reviewed deaths considered more likely than not due to problems in care	0	0	1	0	0	0	0	0	0	0	0	0	2
Number of deaths of people with learning disabilities	N/A	N/A	2	1	N/A	N/A	N/A	2	N/A	N/A	N/A	1	8
Number of deaths of people with learning disabilities that have been reviewed	N/A	N/A	2	1	N/A	N/A	N/A	2	N/A	N/A	N/A	0	7
Number of deaths of people with learning disabilities considered more likely than not to be due to problems in care	N/A	N/A	0	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	0

Note: The data in previous months will be updated each month as new cases are identified and structured judgement reviews are completed. Data is correct at the time of writing (06/09/2019).