TRUST BOARD

AGENDA ITEM NUMBER	16.3
TITLE OF PAPER	Learning from Mortality Reviews – 2018/2019 Q2 Report
Confidential	**NO**
Suitable for public access	**YES**

PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED

Mortality Committee
Quality of Care Committee

STRATEGIC OBJECTIVES

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 Q2 2018/2019 (July, August and September 2018), 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 Q2 of 2018/2019 there were 287 inpatient deaths across both hospital sites, six of these deaths were neonatal (less than 1 year old). There have been no Paediatric deaths (1 year -18 years old) reported in 2018/2019. There were a further 12 adult deaths in ED in Q2 resulting in a total of 293 adult deaths (inpatients and ED).

Of these, 78% had an initial screening completed and 55 cases were identified for an SJR, which is an increase from 42 in Q1. At the time of writing this report, 33 of the cases identified in Q2 have been completed (60%).

Of the cases identified in Q2 2018/2019, 3 cases were found to have received 'poor care' following a stage one and stage two SJR. One further case was found to have received 'poor care' following a stage one review and is pending a second stage review. The details of these and the learning associated is summarised in this report.

Two deaths occurred in patients identified as having learning difficulties in Q2, of which one has received a structured judgement review and one is outstanding. Both cases are known to the Surrey and Borders Mental Health Trust team and are scheduled for case note reviews in January 2019.

A summary of the findings and learning from these cases is described in this paper, as well as the actions taken in the first part of this year to improve the sharing or learning from mortality reviews.

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PRESENTED BY	Sue Tranka, Chief Nurse; David Fluck, Medical Director
DATE	24 January 2019
BOARD ACTION	Receive for assurance

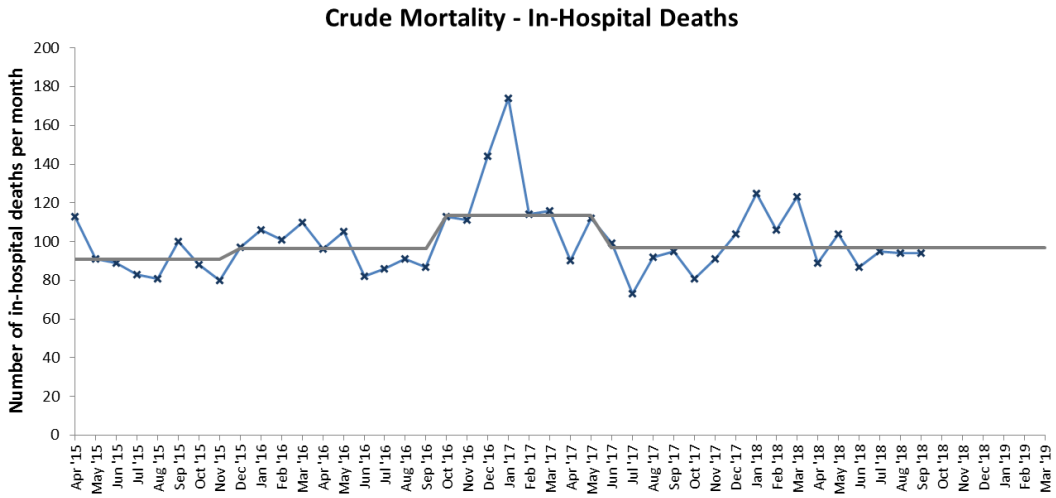
1. BACKGROUND

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, learning and actions for improvement can be made.

In Q2 2018/2019 there were 287 inpatient deaths, including 6 neonatal deaths. This represented a decrease from the previous two quarters but this remains within common cause variation.



There were a further 12 deaths recorded in the Emergency Department (ED) in Q2. 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).

Two deaths occurred in patients identified as having learning difficulties in Q2, of which one has received a structured judgement review and one is outstanding. Both cases are known to the Surrey and Borders Mental Health Trust team and are scheduled for case note reviews in January 2019.

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 FORMS AND IDENTIFICATION OF CASES FOR SJR

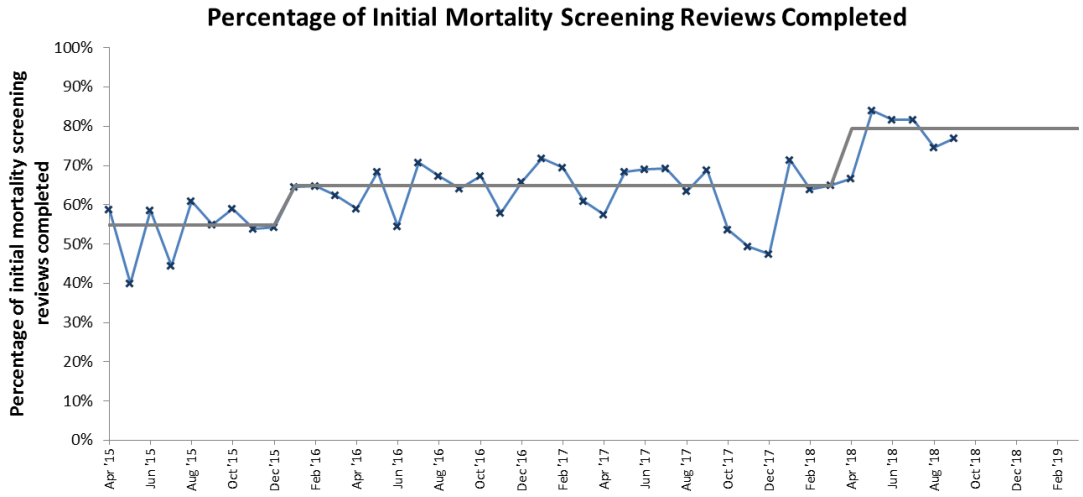
From October 2017, full structured judgement reviews (SJR) have been carried out on any deaths meeting certain minimum criteria. These include any death where bereaved families and carers, or staff, have raised a concern about the quality of care provided; any deaths of patients with learning disabilities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

A list of the criteria for identification of cases for SJR is provided in Appendix A. It is anticipated that, by using these criteria, approximately 15% of deaths will be reviewed initially via the SJR process.

Following discussion at the Mortality Committee it was agreed that a retrospective review of cases of inpatient deaths with Sepsis would be coordinated by the Chief of Patient Safety and that, during Q1 2018/2019, cases of deaths involving Sepsis would be included in the criteria for SJR.

Following the completion of this audit and presentation at Mortality Committee in November 2018, it was agreed that deaths involving Sepsis would not be included in the criteria for SJR from Q2 onwards. The audit of cases of patients who died in hospital with Sepsis in 2017/2018 was completed in Q2 and a summary of the work is presented to Board this month and summarised in section 7 below.

A new Mortality Review Screening form was implemented in 2017/2018, which acts as a screening tool to help identify patients requiring SJR.



There has been an improvement and special-cause variation in the completion of screening forms in 2018/2019 with 78% of adult deaths having a screening form completed, compared to 62% in the previous year. This increase has been as a result of efforts to make the completion of screening part of everyday work and incorporated into morning board rounds on medical wards.

Since October 2017, 188 cases have been identified for SJR, and average of 15 per month.

3. STRUCTURED JUDGEMENT REVIEWS COMPLETED

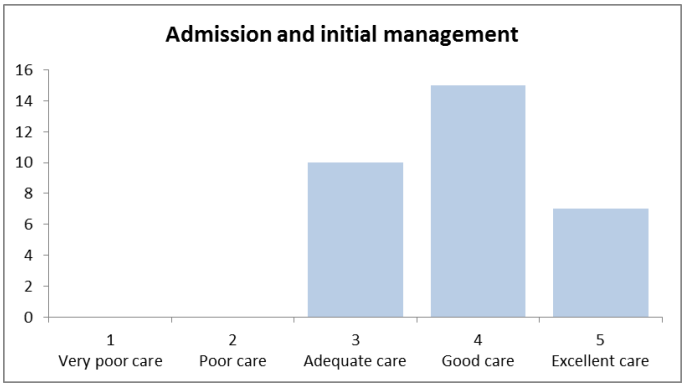
The structured judgement review (SJR) involves assessing different phases of care, writing explicit judgement statements and giving scores (from '*very poor care'* to *'excellent care'*). Each review is undertaken by a trained individual – either a nurse (Band 7 and above), AHP (Band 7 or above) or a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

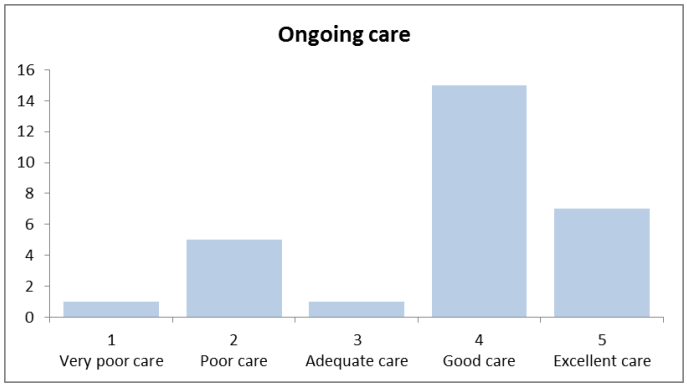
In Q2, 55 cases were identified for SJR and 33 have been completed to date (60%).

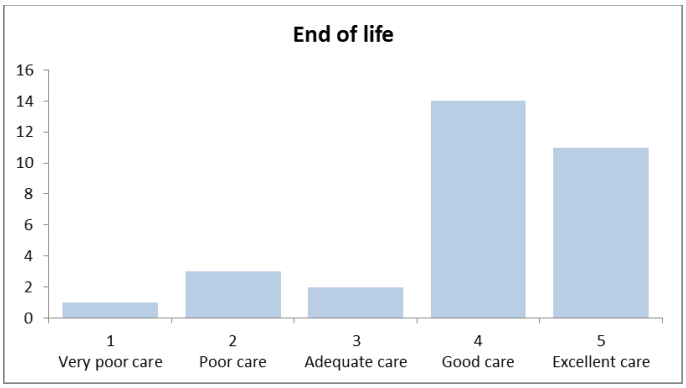
PHASES OF CARE SCORES

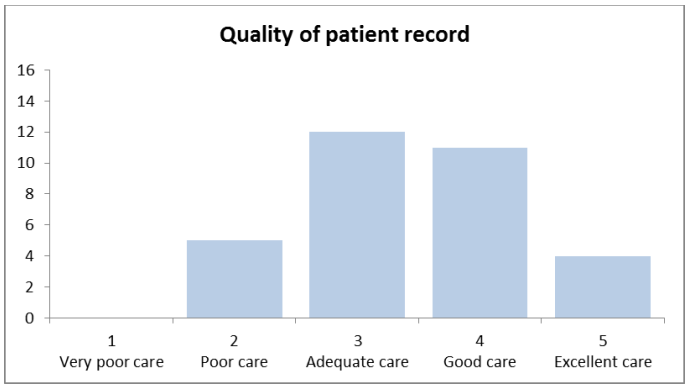
The SJR requires recording explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Care is rated during each phase on a scale of 1 to 5.
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

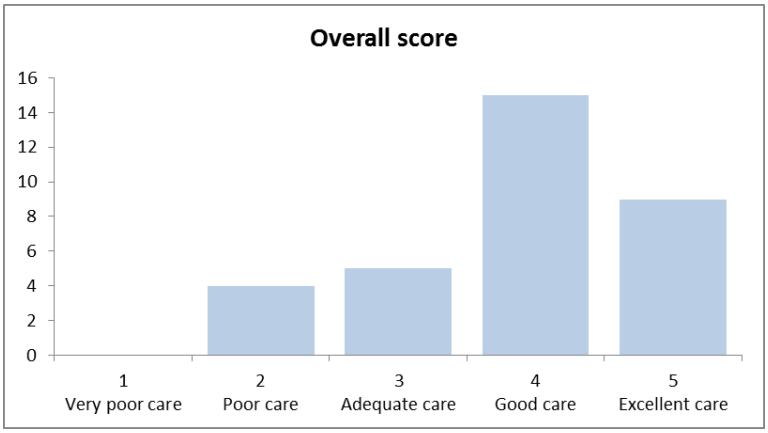
The charts below show the ratings recorded for the SJRs completed in Q2:











Of the cases identified in Q2 2018/2019, 3 cases were found to have received 'poor care' following a stage one and stage two SJR. One further case was found to have received 'poor care' following a stage one review and is pending a stage review. The details of these and the learning associated is summarised in this report. The details of these and the learning associated is summarised in the section below.

4. ASSESSMENT OF CARE

POOR CARE

In Q2 2018/2019, three cases were found to have received 'poor care' following a first and second stage SJR and all three cases are also subject to serious incidents (SI) investigations. In the three cases from Q2, two were found to be of 'less than 50:50 avoidable'* and one is still to be confirmed pending further investigation.

* 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).

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

- In September 2018 a 70 year old patient died on a medical ward, four days following admission to hospital. The SJR found that there was poor documentation in respect to a 'Do Not Attempt Resuscitation' (DNAR) status which initially led to inappropriate resuscitation attempts. The patient was also found to have had omitted doses of prophylactic clexane during her stay in hospital. The second stage SJR found the death to be 'less than 50:50 avoidable' however the case is also subject to an SI investigation. Initial learning has been identified relating to the use of the new ReSPECT form, which was not in use at the time of this case. The learning relating to the omission of clexane is aligned with that already being shared within the medication safety programme and this case will be used to make further improvements in this area.

- Also in September 2018, a 91 year old patient died on a medical ward, five days following admission to hospital. The second stage SJR confirmed that there was 'poor care' but found that there was 'less than 50:50 avoidable' in this case of a frail patient with dropping haemoglobin on oral anticoagulants. The case is subject to an SI investigation as concerns were highlighted relating to blood test monitoring and an urgent review by the Pharmacy team of anticoagulant protocols has been instigated alongside the investigation.

- In the final case, in September 2018, a 72 year old patient died on a surgical ward, four days following admission to hospital for elective surgery. The death of the patient following elective surgery triggered a SI investigation and an urgent SJR was completed to identify any immediate issues and learning at an early stage, evidence of avoidability has not been confirmed at this time.

Although all of the cases described above were from September 2018, there is no clear correlation between cases (location, etc.) however these will be reviewed for common root causes alongside other SI from the same period.

Two of the cases described above highlighted concerns over anticoagulation management. This was also highlighted through an SI investigation and through the routine review of medication safety issues reported during the same period. As a result of this triangulation of intelligence, an urgent review of protocols for the prescription and administration of heparin has been initiated. The outcomes of this review will be communicated throughout the organisation and learning will be disseminated to all stakeholders.

The outcome of all the SI investigations will be reported through usual methods and to the Quality of Care Board sub-committee.

EXCELLENT CARE

As part of the SJR, reviewers are asked to rate the care during each phase on a scale of 1 to 5, where 5 is 'excellent care'. In Q2, 9 cases were found to have experienced 'excellent care' overall. Some of the examples of excellent care provided to patients at the end of life include:

- Good communication with next-of-kin and family, specifically with regard to appropriate investigations and recognition of dying
- Recognition of dying and transfer in a timely fashion to an appropriate ward
- Good end-of-life care, involvement of palliative care and appropriate prescription of end-of-life drugs
- Multi-disciplinary involvement in developing management plans and referrals to specialist teams made at an appropriate time

7. 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.

Since Q1, there has been an on-going review of the various M&M (Mortality & Morbidity) arrangements and forums for sharing learning in specialty and divisional teams.

The review has been led by the Chief of Patient Safety with an initial focus on the Medicine and Emergency Services Division, which found that all but two areas have regular review meetings where SJRs are now fed-back for shared team learning via the Clinical Governance structure. This good practice is being spread throughout the Division to ensure a common approach is followed.

The review also found that the monthly Critical Care Mortality meetings demonstrated an excellent learning environment with accessibility to the ITU specific Electronic Patient Record system (Metavison) and could be a useful model to disseminate Trust-wide once we have a full EPR system. Such a model received high praise from our recent CQC inspection.

In addition to these local arrangements, the Learning from Deaths Project team has produced one-page learning Infographics which are designed to summarise and disseminate the key learning points from the SJRs on a quarterly basis.

Two Trust-wide learning from deaths events have now been held and the next event is scheduled for January 2019. The events are based on the successful Schwartz Round model and explore recent cases which have undergone a SJR with a learning panel sharing key messages and facilitating conversations with attendees from across the organisation.

In addition to the on-going completion of SJRs each month, a review of a sample of deaths from January 2017 was started in Q2 and the findings from this will be reported in the Q3 report.

The 'National Guidance on Learning from Deaths' (2017) aims to initiate a standardised approach to the review of and learning from adult deaths in hospital. A report detailing the rate of mortality in ASPH Maternity and Paediatric Services and the outline processes for learning from these cases is presented to the Closed Trust Board this month.

SEPSIS AUDIT

During Q1 2018/2019, cases of deaths involving Sepsis were included in the criteria for SJR and in Q2 2018/2019 a retrospective review of cases of inpatient deaths with Sepsis was coordinated by the Chief of Patient Safety. Following the completion of this audit and presentation at Mortality Committee in November 2018, it was agreed that deaths involving Sepsis would not be included in the criteria for SJR from Q2 onwards.

The audit of cases of patients who died in hospital with Sepsis in 2017/2018 was completed in Q2 and a summary of the work is presented to Board this month.

The audit set out to establish if the current process measures in place were an effective indicator for the timely and effective treatment of patients with Sepsis; and using the Structured Judgement Review (SJR) methodology, to identify if there were any 'poor care' or 'problems in care' experienced by the patients who died with Sepsis in the previous year.

The audit found that screening for, and timely treatment of, Sepsis in the ED for these patients was in-line with those reviewed in the monthly CQUIN audits. 76% of patients received antibiotics within one hour with the average time for these patients to receive antibiotics was 40 minutes. These results compare favourably with the national sepsis CQUIN measures. However, this was not the case for those patients who were diagnosed with Sepsis as inpatients; of which, only 27% received antibiotics within one hour of diagnosis.

The audit also found that 95% of the sample cases received 'adequate care' or better; as well as a number of potential areas for improvement in the timely identification and treatment of Sepsis.

This work has been shared at the Mortality Committee and will be share further within Divisional and Educational Forums, and the Learning from Deaths event in January 2019 will focus on the Sepsis theme and a presentation of a Sepsis case. This will lead to some focused work within IP clinical areas identified within the audit.

The Medical Director is leading work to test an approach to the timely care provided to patients who are diagnosed with Sepsis as inpatients utilising doctors in training and improvements in the treatment of Sepsis will form part of the infection prevention and control quality priority in the year ahead.

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

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												
	Oct-17	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**
Total number of deaths in organisation	91	102	114	140	108	133	96	109	91	105	97	97
A&E deaths (in scope from July 18)	10	7	8	13	2	10	7	5	4	6	3	3
Total number of deaths in scope	81	91	104	126	103	119	88	101	85	101	95	97
% of deaths receiving initial review	85%	86%	88%	94%	94%	93%	93%	90%	89%	85%	86%	79%
Number of cases requiring an SJR	13	16	13	17	12	18	16	12	14	21	10	24
Total deaths receiving structured judgement review	12	13	13	14	9	13	14	7	9	11	7	15
Percentage of SJRs completed	92%	81%	100%	82%	75%	72%	88%	58%	64%	52%	70%	63%
Percentage of SJRs completed (by quarter)	90%			77%			71%			60%		
Total Number of reviewed deaths considered more likely than not due to problems in care	1	0	1	0	0	0	0	0	0	0	0	1*
Number of deaths of people with learning disabilities	0	2	0	0	0	2	1	1	0	0	0	2
Number of deaths of people with learning disabilities that have been reviewed	N/A	1	N/A	N/A	N/A	2	1	1	N/A	N/A	N/A	1
Number of deaths of people with learning disabilities considered more likely than not to be due to problems in care	N/A	0	N/A	N/A	N/A	0	0	0	N/A	N/A	N/A	0

*One death is likely to have been due to problems in care but further investigation is required to confirm this.

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 (14/12/2018).