Ashford and St. Peter's Hospitals NHS Foundation Trust

Trust Board
31 May 2018

AGENDA ITEM	15.2
TITLE OF PAPER	Learning from Mortality Reviews – Q4 Board Report
Confidential	**No**
Suitable for public access	**Yes**
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED	
Mortality Committee	

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 4 of 2017/2018 there were 348 adult inpatient deaths across both Trust sites, of these 269 had initial screening completed (77%)

A SJR was identified for 39 patients, of which 14 have been completed at the time of writing this report (36%).

The Trust currently has 24 professional staff trained to complete SJR's with a further 16 allocated to a training session.

In Q4 2017/2018, no avoidable deaths have been identified through the SJR process. Problems with care were identified in 5 cases but there were no cases of avoidable harm that led to death.

Two deaths occurred in patients identified as having learning difficulties of which one has a completed structured judgement review with no identifiable problems in care. The other is currently undergoing the review process.

There are three deaths undergoing investigation as part of a serious incident (SIRI) process and reported in Q4. Two of these cases involve inpatient deaths and in one case the mortality screening tool identified some evidence or avoidability, this is being investigated through the SIRI process.

A summary of the findings and learning from these cases and the organisational learning processes are described in this paper.

RECOMMENDATION:	Receive for assurance
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PRESENTED BY DIRECTOR(s)	David Fluck, Medical Director and Sue Tranka, Chief Nurse
DATE	14 May 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.

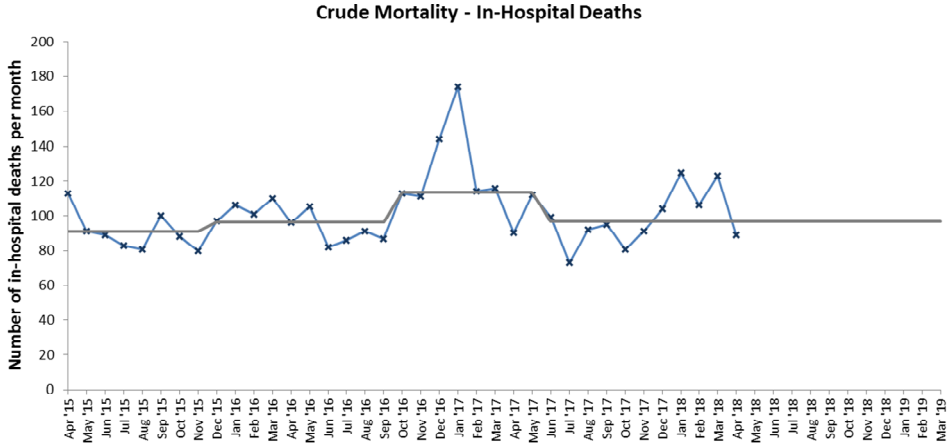
The structured judgement review (SJR) involves assessing different phases of care, writing explicit judgement statements and giving scores (from '*very poor care'* to *'excellent care'*). Each review is undertaken by a trained individual – either a nurse (Band 7 and above) or a Consultant (of any speciality) - 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 and since 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 Q4, 40 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

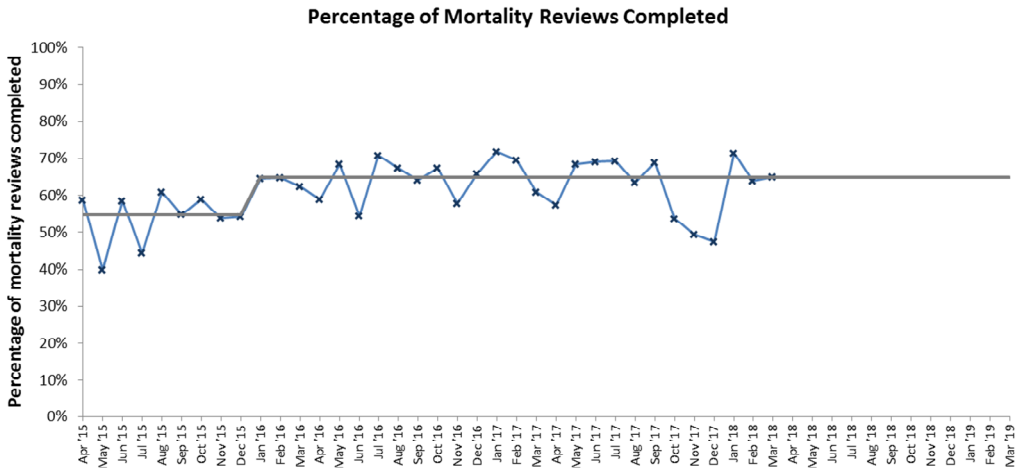
From October 2017, full structured judgement reviews (SJR) have been carried out on any deaths meeting certain minimum criteria. These include any death where bereaved families and carers, or staff, have raised a concern about the quality of care provided; any deaths of patients with learning disabilities 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 Q4 and the number of initial screening forms completed:

	Q4 2017 / 2018		
Division	In-hospital, adult deaths	Screening forms completed	% Screening forms completed
Medicine	304	236	78%
TASCC	34	33	97%
Orthopaedics	10	0	0%
Women's Health	N/A	N/A	N/A
All	348	269	77%

There has been an improvement in the completion of the screening forms in Q4 and measures to further improve the identified of cases for SJR will be discussed at the Mortality Committee in future months.



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).

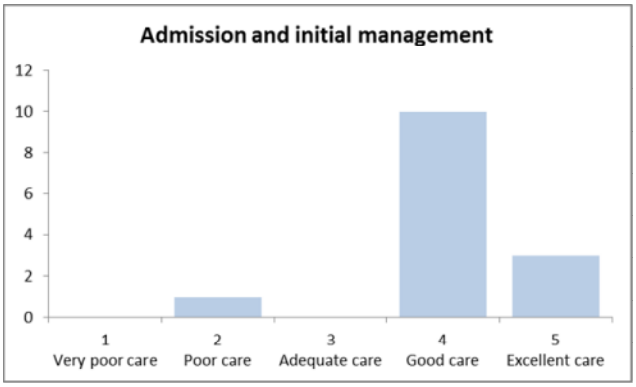
In Q4, 39 cases were identified for SJR and 14 have been completed to date.
A table showing the rate of completion of SJRs and other data is provided as Appendix B.

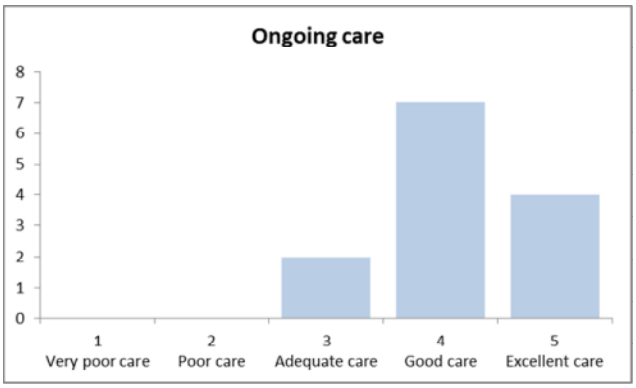
4. PHASES OF CARE SCORES

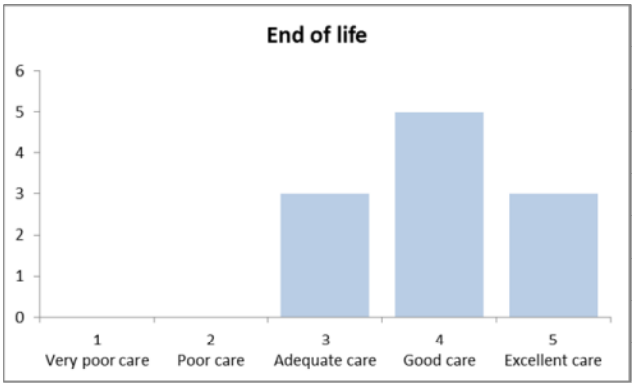
The SJR requires recording explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Care is rated during each phase on a scale of 1 to 5.

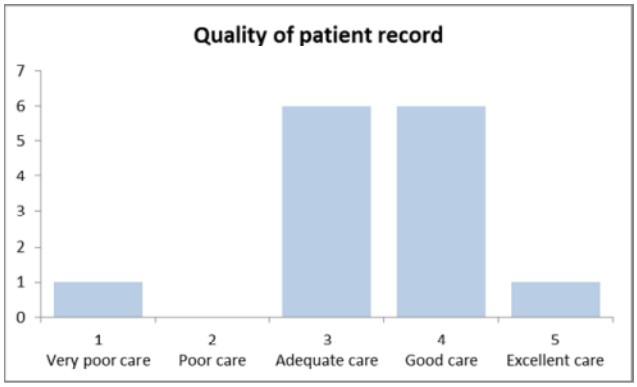
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

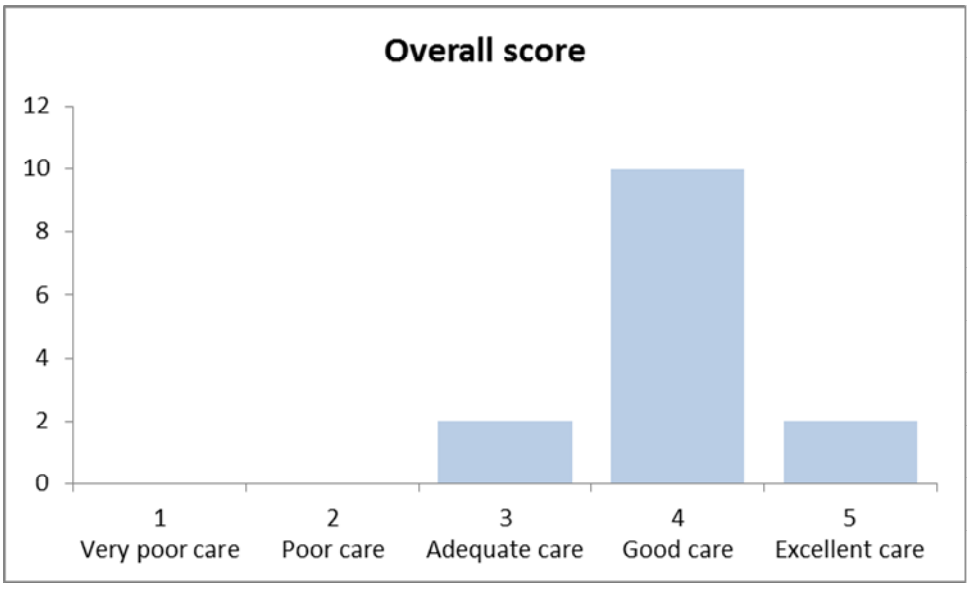
The charts below show the ratings recorded for the SJRs completed in Q4:











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.

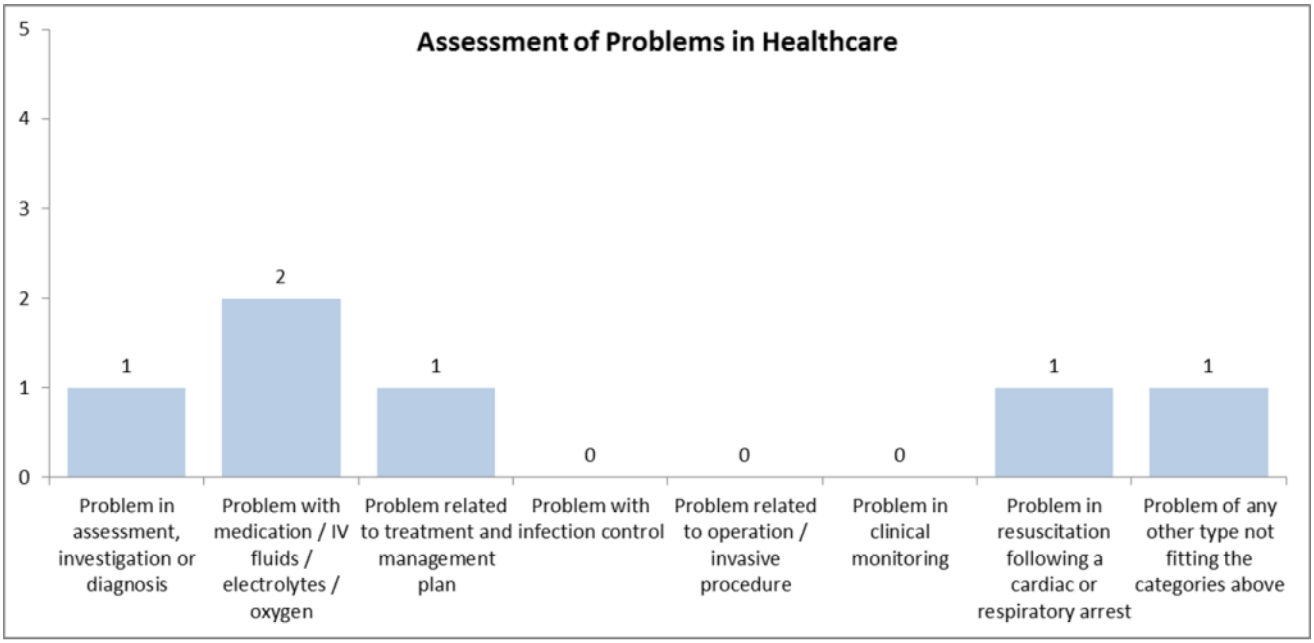
5. ASSESSMENT OF PROBLEMS IN HEALTHCARE

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 Q4 2017/2018 there were 5 cases in which problems with the care of the patient were identified, 1 patient had 2 problems of care identified.

In 4 cases these problems did not lead to harm.
In 1 case, the problem did lead to patient harm but not to avoidable death.

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



Two deaths occurred in patients identified as having learning difficulties of which one has a completed structured judgement review with no identifiable problems in care. The other is currently undergoing the review process.

There are three deaths undergoing investigation as part of a serious incident (SIRI) process and reported in Q4. Two of these cases involve inpatient deaths and in one case the mortality screening tool identified some evidence or avoidability; this is being investigated through the SIRI process.

A summary of the learning from these cases and the organisational learning processes are described below.

6. LEARNING FROM DEATHS

In Q4 2017/2018, no avoidable deaths have been identified through the SJR process. Problems with care were identified in 5 cases but there were no cases of avoidable harm that led to death.

No patients were found to have received *poor* or *very poor* care, and one patient was found to experienced problems with care that could have led to harm. However, there are a number of learning points to be shared from the SJRs completed in this period, these included:

- Learning relating to the decisions to resuscitate when a documented DNACPR is in place for a patient

- Learning about clearly documenting the discussions and decisions relating to suitability and fitness for transfer between hospitals for a patient

- Learning relating to moving a patient between acute medical wards shortly before death

In all cases where the SJR has identified problems with care, these have been shared with specialty governance team and a selected number of the cases will be put forward for discussion at the next medical QASH day.

Any case of an inpatient death found to be as a result of Sepsis, will take into account whether there was timely identification and treatment of Sepsis in-line with the Trust protocol; however, cases of patients with Sepsis that have led to death are not currently routinely subject to SJRs.

Following discussion at Mortality Committee it was agreed that both a retrospective review of cases of inpatient deaths with Sepsis will be coordinated by the Chief of Patient Safety and cases with Sepsis will also be added to the criteria for inclusion in the SJR process for the first part of 2018/2019.

One case was reported as a serious incident (SIRI) in Q4 of an inpatient death in December 2016 where the mortality screening tool identified some evidence or avoidability; this is being investigated through the SIRI process.

SHARING LEARNING IN THE ORGANISATION

Since Q3, some changes have been made to the process for collating and sharing the learning from completed SJRs, including:

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

- The DATIX platform provided by the Royal College of Physicians is now being used as the repository for completed SJRs, which provides the ability to analyse and summarise learning

- An agenda item has been added to the Quality and Performance Committee that provides monthly assurance that feedback is being given and learning from this is shared.

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.

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 – SUMMARY OF MORTALITY AND SJR DATA

Summary total deaths and total number of cases reviewed under the Structured Judgement Review Methodology												
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Total number of deaths in organisation	91	117	100	74	93	97	81	95	106	127	106	123
Total number of deaths in scope	89	113	98	73	92	95	81	91	104	126	103	119
% of deaths receiving initial review	57%	69%	68%	70%	64%	69%	85%	85%	88%	83%	79%	70%
Number of cases requiring an SJR							14	15	13	17	12	10
Total deaths receiving structured judgement review	n/a	n/a	n/a	n/a	n/a	n/a	12	15	10	9	3	2
Percentage of SJRs completed							86%	100%	77%	53%	25%	20%
Total Number of reviewed deaths considered more likely than not due to problems in care	n/a	n/a	n/a	n/a	n/a	n/a	0	0	1	1	0	0
Number of deaths of people with learning disabilities	n/a	n/a	n/a	n/a	n/a	n/a	1	0	1	0	1	1
Number of deaths of people with learning disabilities that have been reviewed	n/a	n/a	n/a	n/a	n/a	n/a	1	0	1	0	1	awaiting review
Number of deaths of people with learning disabilities considered more likely than not to be due to problems in care	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	awaiting review
Number of deaths investigated under the serious incident framework and declared as serious incidents	2	0	1	1	1	3	0	0	1	1	1	1