Learning from Patient Deaths: Update on Implementation and Reporting of Data: 5th January 2018

Purpose

The purpose of this paper is to update the Trust Board on progress with implementing the mandatory framework on learning from in-patient deaths and includes the first 'Learning from Deaths Dashboard' under development by NHS Improvement and the Department of Health for publication within the public Board papers, until further guidance is received.

Background

Following on from the publication of the Care Quality Commissions (CQC) report "Learning, candour and accountability: a review of the way NHS trusts review and investigate deaths of patients in England" (December 2016); the Secretary of State made a range of commitments to improve how the NHS responds and learns from the care provided to patients who die.

This commitment was followed in March 2017 with guidance for trusts to identify, report, investigate and learn from in-patient deaths (published by the National Quality Board) and this guidance recommended trusts produce a quarterly 'Learning form Deaths Dashboard' to enable Trust Boards to examine their progress in delivery of this agenda. The guidance includes a number of standards and deadlines, giving guidance on the review methodology recommended Structured Judgement Review (SJR) and reporting requirements from Quarter 3 2017-18. Which includes the requirement to submit quarterly data externally, which populates a "learning from deaths" dashboard. This data is captured within the Learning from Deaths Dashboard, within Appendix A and this data is required within the Quality Account for 2017-18.

Prior to receiving the national guidance the Trust had established Mortality & Morbidity (M&M) Meetings and a mortality review process, which have now been amended and encapsulated within the recently published Learning from Patient Deaths Policy, to ensure compliance with the new national guidance.

Progress

Key milestones have been met to produce the data required within Quarter1 and Quarter 2 and the Trust was in a position to fully implement the framework and report on the required data set by Quarter 3 2017-18.

The Mortality Working Group, led by the Medical Director, supported by the Director of Corporate Affairs, Mortality Divisional Mortality Leads and Clinical Governance has made good progress to review all aspects of the learning from deaths framework and ensure Trust policies and processes

are compliant. The Mortality Working Group reports monthly to the Learning from Patient Deaths Group, which reports into the Clinical Excellence Committee quarterly.

A summary of the key areas of focus and progress with each is set out below:

Policy Review

The Trust developed and published a new 'Learning from Patient Deaths' policy was published at end of September 2017 in line with national requirements. The policy included the use of the SJR methodology, which was selected from the two national options available. A training programme is to be delivered for staff who will undertake SJR.

Process Review

A number of key principles have been agreed and are encapsulated within the Learning from Patient Deaths Policy including:

- All in-patient deaths will be initially reviewed by specialty Morality Leads, to assess the quality of care delivered, to select patients for in-depth SJR review and to gather information regarding any lessons learnt or action to be taken following the review.

- Any case may be referred for SJR, either at the discretion of the Mortality Lead or clinical staff member, because concerns have been raised, or because the case falls within pre-selected cohorts of patients as set out in the policy, which includes:

    - Any patient where bereaved families or carers have raised a significant concern about the quality of care provided
    - Any patient where a staff member has graded the care as 2 or 3 using the Confidential Enquiries into Stillbirths and Deaths in Infancy (CESDI) Classifications
    - Any patient with a Learning Disability
    - Any patient under a Mental Health Section
    - Any deaths within an service specialty or particular diagnosis or treatment group where an 'alarm' has been raised (e.g. via the Summary Hospital-level Mortality Indicator or other elevated mortality alert, the CQC or another regulator)
    - Any patients who were not expected to die
    - Any patients that are classified as Infant, Child, Young People, Still Birth or Maternal Deaths (as specified within the Trust Learning from Patient Deaths Policy)

In addition to the above national requirements, the Trust has selected the following criteria to trigger an SJR as these reviews, as these will contribute to the Trust's ongoing learning and will inform quality improvement work undertaken by Divisions:-

    - Any elective patients
    - Any patient who died within 30 days of leaving hospital (where possible to identify)
    - Any case being investigated by the Coroner.
    - Surgery on this admission, within 30 days and within 12 months.

- Quarter 3 2017-18 onwards: SJR will be completed in cases in the designated groups listed above.

- Mortality Leads have been recruited to all specialties, across all divisions and they are in the process of undertaking initial reviews of all in-patient deaths and assigning SJR's where needed, to team members using the Mortality module within Datix. It is estimated that initial reviews will take half an hour to complete and SJR's will take two hours to complete before being discussed during M&M meetings. On average the Trust has 200 initial reviews and 20 SJR's triggered each month.

- The Mortality Module within Datix was launched on Monday 27th November 2017 and this system captures all in-patient deaths within the Trust (data is initially entered by the Bereavement Team while Doctors are completing Death Certificates).

- SJR's will be completed under the guidance of Mortality Leads, within M&M meetings, for a collaborative approach to reviewing patient care.

- There has been no variation in the overall numbers in-patient deaths, numbers of avoidable deaths or deaths within any particular classification monitored by Dr Fosters (following established seasonal variations).

- The monthly High Level Mortality Report is used to monitor the Trust performance which continues to have low mortality rates, when judged using the three main national tools, Hospital Standardised Mortality Ratio (HSMR), Summary Hospital Mortality Indicators (SHMI) and Crude Mortality Rate. Despite the low levels of mortality, the Trust has plans in place to ensure that a selected number of patient deaths are reviewed using the SJR tool, to ensure service and Divisional learning.

- Mortality reporting metrics are included within the Dashboards submitted to the Clinical Quality and Risk Committee by Divisions, who report on their progress monthly.

- Training will be required for all staff undertaking SJR. The Royal College of Physicians "train the trainers" programme will be utilized in the first instance with members of the Mortality Working Group attending training in February 2018.

Involving families

A key focus of the guidance is the need to actively involve families including offering opportunities for them to raise questions or share concerns in relation to the quality of care received by their relatives.
The complexity of achieving this in a meaningful way both logistically, and also at an emotional and distressing time has been recognised nationally. A two-day workshop facilitated by NHS England was facilitated in November, which brings families together with clinicians involved in mortality review, as well as CQC, NHS Improvement, and the National Quality Board. Further guidance is due for publication in early 2018 and the Trust will review this in full. However, until then the Trust has included an area within the Mortality Module, within Datix, to allow the Bereavement Team to capture any comments made by families / carers and includes a trigger question for Bereavement staff to encourage families / carers to raise concerns and comment on the care given.

LeDeR – Learning Disabilities Mortality Review (LeDeR)

The trust is actively participating in the LeDeR programme; however the completion of reporting all deaths of patients with a Learning Disability to the national database is slow. All cases require an SJR to be completed, in addition to the external LeDeR. Cases that require an LeDeR are assigned by a national team, and involve a time delay, of approximately 6-8 weeks from death.

Not all regions in the UK have started carrying out LeDeRs. Where a patient resided out of the London region before their death the case will be reported however, if that region is not yet live, no separate LeDeR will take place. An SJR will always occur.

Reporting

Mortality data is reported monthly to the Learning from Patient Deaths Group via the High Level Mortality Report and the Learning Deaths Dashboard which is quarterly, both of which are reviewed by the Clinical Excellence Sub-Board Committee on a quarterly basis. The Learning from Deaths Dashboard will also be presented to the Trust Board on a Quarterly basis for publication.

The Learning from Deaths Dashboard must include the following information:-

- Number of in-patient deaths
- Number reviewed (and methodology)
- Number identified as receiving sub-optimal care or might responsibly expected to have contributed to patient's death
- Key learning and what contributed to good care

The dashboard showing data for in-patient deaths that occurred in Quarter 1-2 2017/18 is included in appendix A. This was developed using available guidance however the national dashboard remains under development by NHS Improvement and the Department of Health and the reporting portal is not yet available. Trusts have been asked to publish data in their public board papers until final guidance is released.

Review of Data

Key data is reported within the attached dashboard, appendix A and below is a commentary on performance against each measure:-

Data Field	Commentary
Total Number of In-Patient Deaths	Reported numbers are in line with previous Trust trends
Total Number of In-Patients Deaths Reviewed	Initial Reviews included an assessment of the quality of care received by patients and triggered a sub-set of patients to receive an In-Depth Review (now an SJR)
Total Number of Completed In-Depth Reviews / SJR	The Trust changed from In-Depth Reviews to SJR's, the In-Depth Reviews targeted a slightly different sub-set of patients as the national guidance had not been published when the In-Depth review criteria was established
Total Deaths Reviewed by NCEPOD Grade	National Confidential Enquiry into Perioperative Deaths (NCEPOD) grading system to classify patient care:- **Good practice:** A standard that you would accept from yourself, your trainees and your institution

Data Field	Commentary
	Room for improvement: Aspect of Organisational or Clinical care that could have been better. **Less than Satisfactory:** Several aspects of clinical care and / or organisational care that were well below that you would accept from yourself, your trainees and your institution.
Total Number of LD In-Patient Deaths	Number of in hospital deaths in which the patient had an identified Learning Disability. The Trust has reported 2 cases to LeDeR to date.
Total Number of LD In-Patients Deaths Reviewed	The Trust is awaiting allocation of cases for review from the LeDeR programme board on the portal. Once allocated these reviews will be completed within the mandatory time frames.

Key learning Identified in Quarter 1 & Quarter 2 2017-18

Out of the 29 completed in-depth mortality reviews, 14 made specific comments regarding the quality of care, as below which have been analysed using Thematic Analysis to place them under common themes.

Often these reviews made more than one comment about the quality of care. For instance both communication and educational points could be made from one review, therefore more than 29 entries are summarised below.

Thematic Analysis		
Theme	**Number of Instances**	**Commentary**
Good Communication	9	• Between patients and families • Between patients and the service • Between services • Families updated with patient information and progress
Communication Issues	3	• Difficult conversations with families • Clarity with Transplant Centre to be improved • Endoscopic Retrograde Cholangio-Pancreatography (ERCP) indication to be reviewed by services
Educational Points	3	• Earlier plans for deterioration to be clarified with senior members of team for ceilings of care to be established • Excellent learning for junior Ear Nose and Throat staff who may be unfamiliar with management of laryngectomy patients and their complications • Maintain high standards of competing Do Not Attempt Resuscitation (DNAR) forms. Not to use patient stickers & to include all information leading to the decision for DNAR
Contributions to Good Care	7	• High risk procedure with multiple co-morbidities • Correct procedures followed • End of Life Care delivered after discussions with patient • Excellent care provided with surgical input

Next Steps

- Continue to develop Trust Board reporting to including learning from SJR's completed and include positive feedback regarding the care that contributed 'good care'.

- Await publication of national guidance on involving families in the review process and develop processes and procedures to ensure the Trust complies with this guidance.

- Await confirmation of national reporting procedures, including all metrics once finalised.

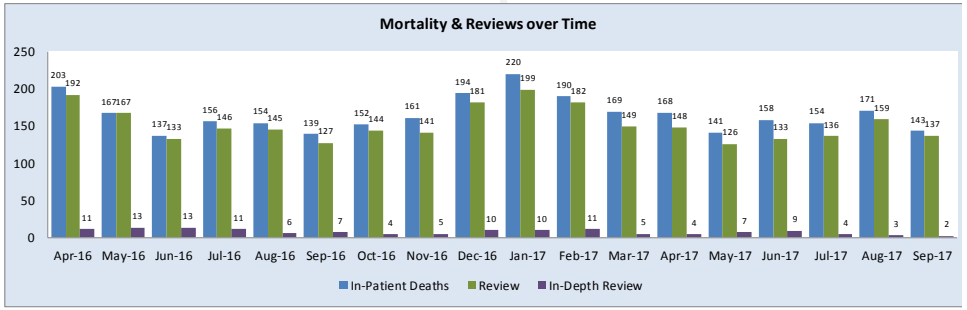
Appendix A: Learning Deaths Dashboard

London North West University Healthcare NHS Trust: Learning from Deaths Dashboard - September 2017-18

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review (SJR)Methodology

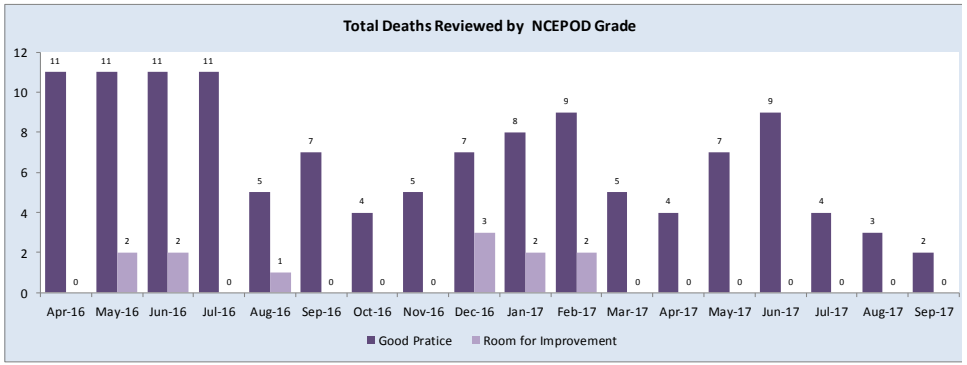
Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable.

Total Number of In-Patient Deaths		Total Number of In-Patients Deaths Reviewed		Total Number of Completed In-Depth Reviews / SJR	
This Month (Sept 17)	Last Month (Aug 17)	This Month (Sept 17)	Last Month (Aug 17)	This Month (Sept 17)	Last Month (Aug 17)
143	171	137	159	2	3
This Quarter (Q2)	Last Quarter (Q1)	This Quarter (Q2)	Last Quarter (Q1)	This Quarter (Q2)	Last Quarter (Q1)
468	467	432	407	9	20
This Year (2017-18)	Last Year (2016-17)	This Year (2017-18)	Last Year (2016-17)	This Year (2017-18)	Last Year (2016-17)
937	2042	839	1906	29	106



Total In-Patient Deaths Reviewed by NCEPOD Grade after In-Depth / SJR completed

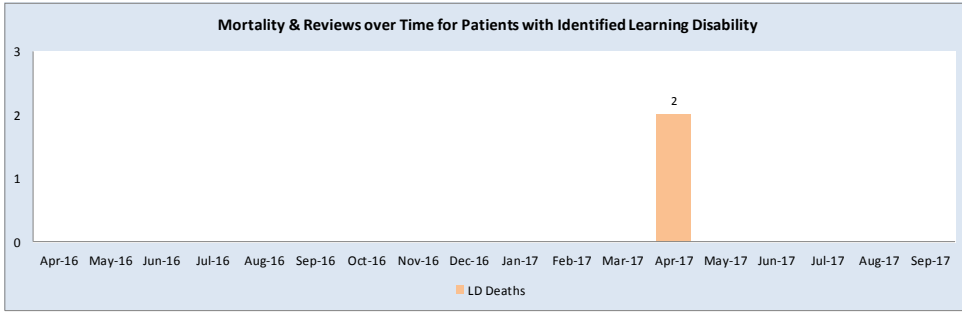
Good Pratice: A standard that you would accept from yourself, your tranees and your institution		**Room for improvement:** Aspect of Organisational or Clinical care that could have been better.		**Less than Satisfactory:** Several aspects of clinical care and / or organisational care that were well below that you would accept from yourself, your trainees and your institution.	
This Month (Sept 17)	Last Month (Aug 17)	This Month (Sept 17)	Last Month (Aug 17)	This Month (Sept 17)	Last Month (Aug 17)
2	3	0	0	0	0
This Quarter (Q2)	Last Quarter (Q1)	This Quarter (Q2)	Last Quarter (Q1)	This Quarter (Q2)	Last Quarter (Q1)
9	20	0	0	0	0
This Year (2017-18)	Last Year (2016-17)	This Year (2017-18)	Last Year (2016-17)	This Year (2017-18)	Last Year (2016-17)
29	94	0	12	0	0



Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths considered to involve sub-optimal care for patients with identified learning disabilities

Total Number of LD In-Patient Deaths		Total Number of LD In-Patients Deaths Reviewed		Total Number of LD In-Patient Deaths considered to have sub-optimal care	
This Month (Sept 17)	Last Month (Aug 17)	This Month (Sept 17)	Last Month (Aug 17)	This Month (Sept 17)	Last Month (Aug 17)
0	0	0	0	0	0
This Quarter (Q2)	Last Quarter (Q1)	This Quarter (Q2)	Last Quarter (Q1)	This Quarter (Q2)	Last Quarter (Q1)
0	2	0	0	0	0
This Year (2017-18)	Last Year (2016-17)	This Year (2017-18)	Last Year (2016-17)	This Year (2017-18)	Last Year (2016-17)
2	-	0	0	0	0



Raw Data for Learning Deaths Dashboard

Trust	London North West University Healthcare NHS Trust
Org Code	
Month	September
Year	2017-18

		Not LD Deaths			In-Depth Review / SJR Grading of Care			LD Deaths		
Financial Year	**Month**	**In-Patient Deaths**	**Review**	**In-Depth Review**	**Good Pratice**	**Room for Improvement**	**Less than Satisfactory**	**LD Deaths**	**LD Deaths Reviewed**	**LD Deaths Avoidable > 50%**
2016-17	Apr-16	**203**	**192**	**11**	**11**	**0**	**0**			
2016-17	May-16	**167**	**167**	**13**	**11**	**2**	**0**			
2016-17	Jun-16	**137**	**133**	**13**	**11**	**2**	**0**			
2016-17	Jul-16	**156**	**146**	**11**	**11**	**0**	**0**			
2016-17	Aug-16	**154**	**145**	**6**	**5**	**1**	**0**			
2016-17	Sep-16	**139**	**127**	**7**	**7**	**0**	**0**			
2016-17	Oct-16	**152**	**144**	**4**	**4**	**0**	**0**			
2016-17	Nov-16	**161**	**141**	**5**	**5**	**0**	**0**			
2016-17	Dec-16	**194**	**181**	**10**	**7**	**3**	**0**			
2016-17	Jan-17	**220**	**199**	**10**	**8**	**2**	**0**			
2016-17	Feb-17	**190**	**182**	**11**	**9**	**2**	**0**			
2016-17	Mar-17	**169**	**149**	**5**	**5**	**0**	**0**			
2017-18	Apr-17	168	148	4	4	0	0	2	0	-
2017-18	May-17	141	126	7	7	0	0	0	0	-
2017-18	Jun-17	158	133	9	9	0	0	0	0	-
2017-18	Jul-17	154	136	4	4	0	0	0	0	-
2017-18	Aug-17	171	159	3	3	0	0	0	0	-
2017-18	Sep-17	143	137	2	2	0	0	0	0	-