Kingston Hospital NHS Foundation Trust

Trust Board	**Item: 11**
Date: 29th November 2017	**Enclosure: G**
Purpose of the Report: To provide the Board with information on the Learning from Deaths Policy and the processes that are followed in Kingston Hospital.	
For: Information ☒ Assurance ☐ Discussion and input ☐ Decision/approval ☐	
Sponsor (Executive Lead):	Jane Wilson, Medical Director.
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Risk Implications – Link to Assurance Framework or Corporate Risk Register:	N/A
Legal / Regulatory / Reputation Implications:	N/A
Link to Relevant CQC Domain: **Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒**	
Link to Relevant Corporate Objective:	N/A
Document Previously Considered By:	N/A
Recommendations: The Trust Board is asked to receive and note the content of this report.	

Mortality Review: Learning from Deaths

Introduction

The Board has previously received information regarding the National Mortality Review process, and the approved Trust Policy is published on the Trust website as required by NHS Improvement. The review process was originally prompted by the Francis Report into the MidStaffordshire NHS Foundation Trust, which found that mortality rates in that Trust had been significantly higher than the average, but that no action was taken. Professor Sir Bruce Keogh, the National Medical Director for the NHS in England, then undertook a review of Trusts with the highest mortality rates, putting eleven under 'special measures' in order to improve the governance of issues resulting from patient death. The review identified actions, which included the use by Trusts of mortality data to drive quality improvement; understanding the importance of genuinely listening to views of patients and staff; and involving junior doctors in Morbidity and Mortality meetings. It was noted that mortality in all NHS hospitals has fallen by around 30% over the last decade and that over 90% of deaths in hospital occur when patients are admitted as an emergency. However a further examination commissioned by NHS England of avoidable mortality, using case note review, suggested that approximately 4% of deaths in hospital were potentially avoidable.

In December 2016, the Care Quality Commission (CQC) published a review of the way that NHS Trusts review and investigate the deaths of patients in England called 'Learning, candour and accountability'. The review resulted in new requirements, which took effect from April 2017 and included *'strengthened governance and capability, increased transparency through improved data collection and reporting, and better engagement with families and carers'.* A key requisite is the collection and publication, on a quarterly basis, of specific information on patient deaths through the newly instituted National Mortality Case Record Review Programme. This report is the first to be received by the Board, and will be presented on a quarterly basis, and also annually within the Trust Quality Report, from 2017/18.

As a result of the 2014 Department of Health report on the recommendations made by the Confidential Inquiry into premature deaths of people with learning disabilities, the Trust is also required to support the Learning Disabilities Mortality Review (LeDeR) Programme. This information will be included in the Trust review process and reports. The purpose of the LeDeR programme is to review the deaths of people with a learning disability, to:

- Identify common themes and learning points and
- Provide support to local areas in their development of action plans, to take forward the lessons learned

The Trust also has a statutory duty to continue to support both the Child Death Review Process (for all deaths <18 years of age) and the National Maternal Mortality review process.

Mortality leads and responsibilities

- *Non-Executive Director responsible for learning from deaths* **(Dr Rita Harris)**. A specified non-executive director on the Trust Board is responsible for the oversight of the process of learning from the mortality review process and for ensuring that the Trust responds appropriately.
- *Medical Director* **(Jane Wilson)** is responsible for the overall Mortality and Morbidity agenda and for reporting to the Trust Board on a quarterly basis.

- *Trust Lead for Mortality and Morbidity* **(Farid Bazari)** is responsible for the process of reviewing deaths within the Trust and ensuring that records are kept of these reviews to inform the Trust Board via the Medical Director. They will also ensure that individuals undertaking reviews have the competence to do so, and will oversee the Structure Judgment Review Process.

- *Service Line Clinical Directors* are responsible for either chairing the M&M meetings or appointing a Chair, for instance the Service Line's Risk Lead, and for creating a robust system to ensure adequate discussion, action planning and serious incident (SI) reporting where necessary. They will also ensure that actions are put in place in their Service Lines in response to learning from the process.

- *The M&M Chair* is responsible for ensuring appropriate attendance by all relevant disciplines and professional groups at meetings, reporting M&M findings to service line governance meetings and to the Quality Improvement Lead for Patient Safety, escalating any areas of concern, ensuring SIs are reported where necessary, and disseminating learning points as required. They are expected to ensure that the discussions/decisions within M&M meetings are recorded according to the Trust mortality review policy.

Mortality Review Process

All patient deaths will be reviewed at local Service Line Mortality and Morbidity (M&M) meetings using a structured Trust-wide template. The likelihood of a death being avoidable or expected is determined for each case. Any death where the initial review indicates that the death was 'Avoidable' or 'Unavoidable with issues' will receive a second line review by a trained reviewer using the Structured Judgement Review method designed by the Royal College of Physicians. All deaths referred for investigation by the Coroner will also receive a second stage review. This data collected as part of the process will be discussed monthly at the Trust Mortality meeting and be reported to the Trust Board quarterly. This will include relevant qualitative information and interpretation of the data, including learning for the Trust, and actions taken.

The data for the year will then be summarised in the annual Quality Report and will also include an assessment of the impact that the actions taken have had within the Hospital.

Training

The Royal College of Physicians has been commissioned to provide training in case record review skills to all acute NHS providers. A cohort of clinical staff has been trained in the appropriate methodology and will now train their peers to provide capacity for the 'Second Stage' review.

Training of LeDeR reviewers is provided by NHS England. The Trust requires at least one staff member trained according to the LeDeR process.

Outcome of Mortality Reviews, including Learning from Structured Judgment Review and Serious Incident Investigations.

There were 169 deaths in the Trust during Quarter 2 2017. All deaths are reviewed within the service lines and 105 have been discussed at Mortality and Morbidity meetings. Since adopting the process described in this paper there have been 2 deaths reported as serious incidents which are being investigated through the Trust SI investigation process. There have also been 3 cases subject to the newly introduced Structured Judgement Review process.

To date the serious incident investigations are still in progress, but no immediate safety concerns requiring action have been identified. Actions arising from the completed investigations will be reported at the January 2018 Trust Board meeting.

One of the Structured Judgment Reviews has been completed; the remaining two reviews are still progressing.

The Structured review process reviews details of the care provided under five headings and then an overall score of the likelihood of a death being avoidable is determined. Each section is graded 1 to 5, each score determining whether care was very poor (score 1), poor (score 2), adequate (score 3), good (score 4) or excellent (score 5). The phases of care that are separately assessed are: admission and initial management, care during a procedure, perioperative care, end-of-life care and an overall assessment. The patient whose care was subject to this review process was a 76 year old lady who was admitted through the Emergency Department. Following the review it was concluded that, despite her death, care was good to excellent, with the diagnosis ultimately being an extremely rare condition not amenable to treatment at presentation and therefore the conclusion was that the death was definitely unavoidable.

It was noted through the review that vital signs and assessment were good, with appropriate investigations undertaken. There was evidence of multidisciplinary working and communication with the family and chaplaincy. A question was raised as to the appropriateness of continuing broad spectrum antibiotics when they were not effective. It was recognised that treatment was failing and the patient was dying; however this was not documented until the last 24 hours and the family appeared to have led the decision, even when retrospectively there was evidence of the futility of care at an earlier stage.

There are no actions directly related to this review as the Trust has an ongoing antibiotic stewardship and End of Life programme. The results of the review will be shared with those involved in delivery of care and discussed at the Trust mortality meeting.

Reporting Month	Q2 - 17-18

Total Number of Deaths	
Quarter 2	Quarter 1
169	207

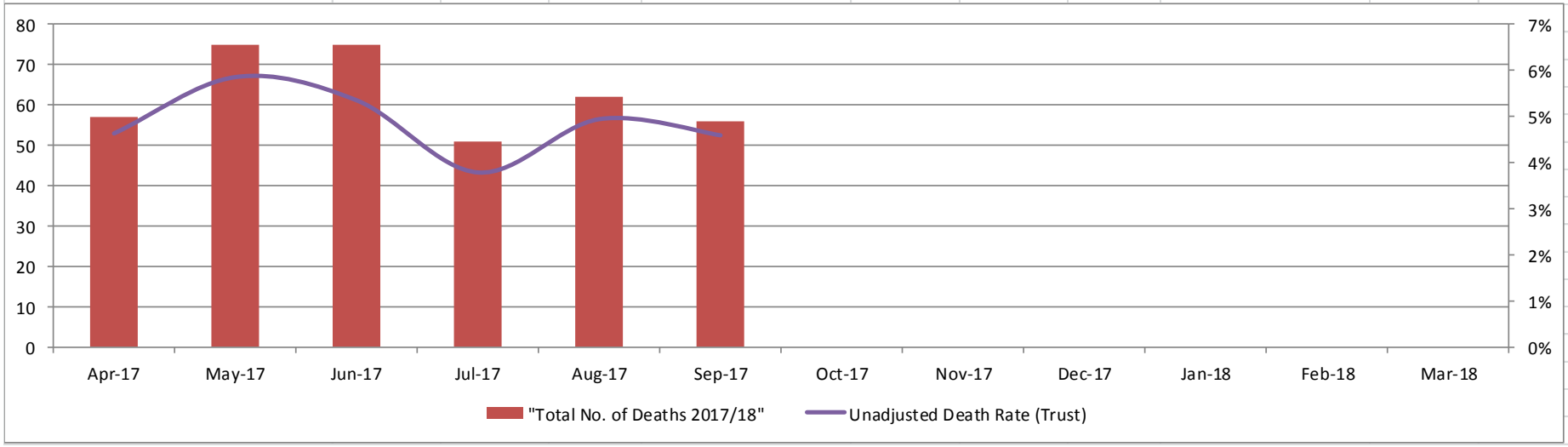
Total Deaths Reviewed	
Quarter 2	Quarter 1
105	5

Unadjusted Death Rate (Trust)	
Quarter 2	Last Quarter
4.43%	5.29%

SJR Outcome	
Avoidable deaths (SJR score 1-2)	0
Unavoidable deaths (SJR score >2)	1

Number of Investigations	
SI's	2
SJR's	3

SHMI (March 2016 - March 2017)	
Score	0.84
Excpected Deaths	1400
Actual Deaths	1179
Difference	221



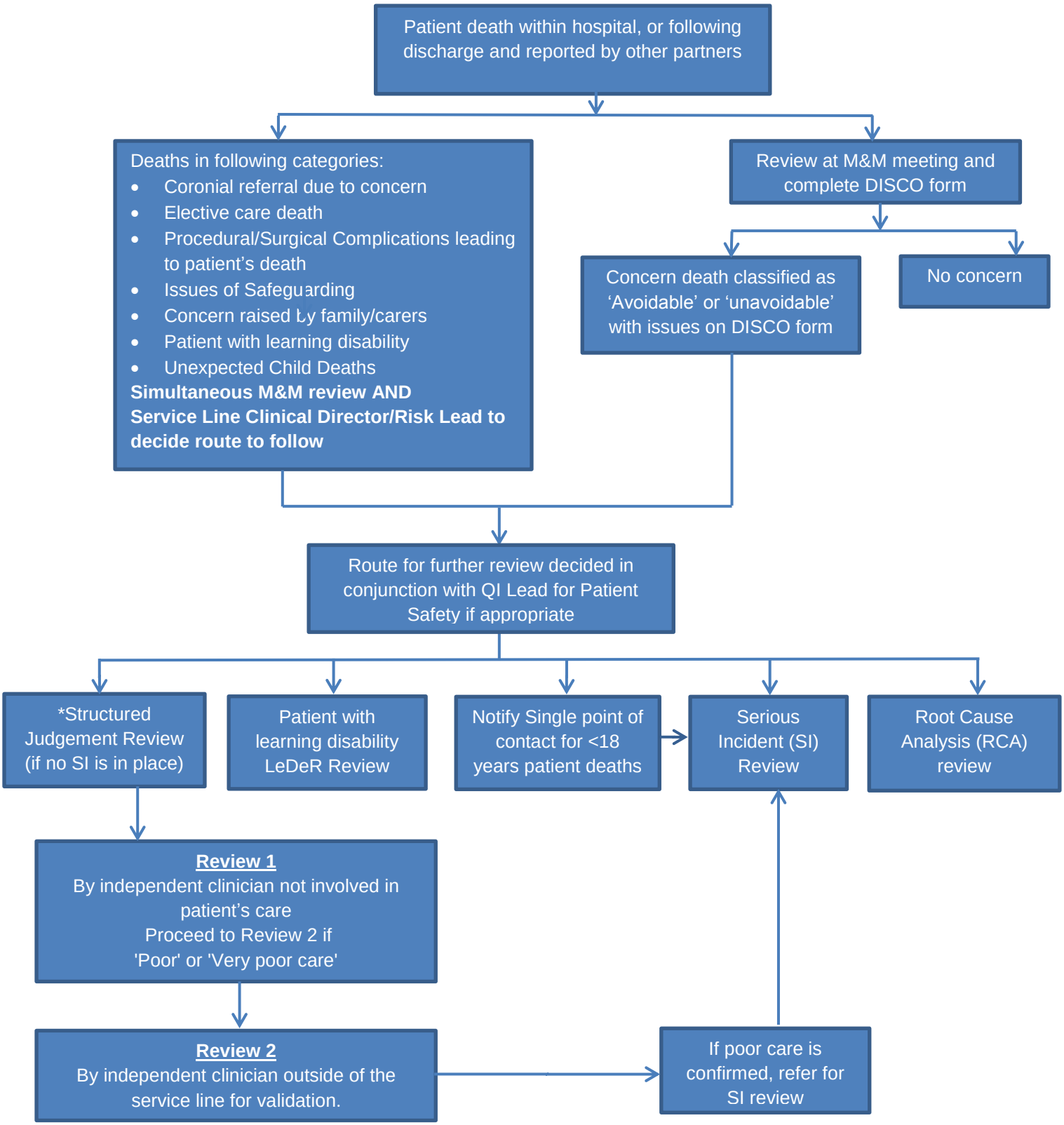
Appendix 1

The following table and flow cart describe the two-stage review process which has been adopted.

Stage	Type of Case	Responsibility	Process
Stage 1	Mortality - all patient deaths	Service Line M&M meeting	Completion of DISCO form for each patient. This is a structured review of diagnosis, coding, issues of care and treatment, death classification, adverse incidents, learning points and actions. Any patient death which is classified as 'avoidable' or 'unavoidable with issues' proceeds to a Stage 2 (SJR) review or alternatively an SI/RCA investigation (see flow chart).
Stage 2 SJR review	Mortality – potentially avoidable, or un-avoidable with care issues, death	Clinician(s) trained in SJR methodology	'Structured Judgment Review' in line with Royal College of Physicians methodology. If the care is judged to be poor or very poor, a second independent SJR review will occur and declaration of a Serious Incident will be considered.
		Clinician(s) trained in RCA methodology	Where an SI/RCA investigation is decided, this is carried out as per the procedure for the identification and management of Serious Incidents.
An LeDeR review and child death review (CDOP) will be informed by and run in parallel to the above process, until such point as the programme concludes or recommendations inform a change in practice.			

Appendix 2

Flowchart of learning from deaths review process



***Refer to Appendix 1**

Appendix 3

Structured Judgment Review Phases and Scoring Tables.

Phase of Care	**1**	**2**	**3**	**4**	**5**
Admission and initial management (approximately the first 24 hours)					
Ongoing care					
Care during a procedure (excluding IV cannulation)					
Perioperative care					
End-of-life care					
Overall assessment					

1 = Very Poor Care	**2 = Poor Care**	**3 = Adequate Care**	**4 = Good Care**	**5 = Excellent Care**

Avoidability of death judgement score

Score 1	Definitely avoidable	
Score 2	Strong evidence of avoidability	
Score 3	Probably avoidable (more than 50:50)	
Score 4	Possibly avoidable but not very likely (less than 50:50)	
Score 5	Slight evidence of avoidability	
Score 6	Definitely not avoidable	