Board of Directors: **11.01.2018**
Agenda Item: **Bo.1.18.14**

LEARNING FROM DEATHS QUARTERLY UPDATE

Presented by:	Dr Bryan Gill – Medical Director	**Author:**	John Bellerby – Associate Director of Quality
Previously considered by:	The Quality Committee 29/11/2017		

Key points	**Purpose:**
1. The Trust is required from quarter three of this financial year to publish information on deaths, their reviews and investigations via a quarterly agenda item and paper to its public board meetings	To note and gain assurance
2. The Trust reports two mortality rates: the latest figures are a. Summary Hospital Mortality Indicator (SHMI) is 92.5 (as expected) b. Hospital Standardised Mortality Ratio is 87 (lower than expected)	To note and gain assurance

Executive Summary:

As part of the national guidance on learning from deaths the Trust is required from quarter three of this financial year to publish information on deaths, their reviews and investigations via a quarterly agenda item and paper to its public board meetings including information on reviews of the care provided to those with severe mental health needs or learning disabilities. This is the first of these quarterly reports.

The Board is asked to;

- Note the content of this report
- Note the progress being made around mortality reviews
- Be assured by the mortality rates for the Trust

Financial implications:

No

Regulatory relevance:

Monitor:	Quality Governance Framework

Equality

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Impact / Implications:	**Is there likely to be any impact on any of the protected characteristics?** (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights) Yes ☐ No ☒ If yes, what is the mitigation against this?

Other:	

Strategic Objective: *Reference to Strategic Objective(s) this paper relates to*	To provide outstanding care for patients
	To deliver our financial plan and key performance targets
	To be a continually learning organisation
	To collaborate effectively with local and regional partners

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LEARNING FROM DEATHS QUARTERLY UPDATE

1.0 Background

As part of the national guidance on learning from deaths the Trust is required from quarter three of this financial year to publish information on deaths, their reviews and investigations via a quarterly agenda item and paper to its public board meetings including information on reviews of the care provided to those with severe mental health needs or learning disabilities. This is the first of these quarterly reports.

2.0 Learning from deaths dashboard – National Guidance

This report would not have been possible 18 months ago as the review of mortality and learning from deaths in Bradford Teaching Hospitals NHS Foundation Trust was not standardised. As a result of us working closely with the Yorkshire and Humber Academic Network we are now at the forefront of mortality reviews nationally. We were instrumental in developing and piloting the methodology and governance around structured judgement mortality case note review that has been adopted as the national standard. We feel we are ahead of the curve nationally on the quality and the implementation of the mortality review process.

We now trained over 120 individuals in the trust to be able to conduct mortality case note reviews. The methodology has also been used to help with case note reviews for internal investigations, Serious Incidents and investigation of internal and external alerts.

The feedback has been very useful, highlights areas where care could be improved allowing us to prioritise quality improvement projects but also demonstrates that this organisation can provide care that is good or excellent to over 90% of its patients.

This report represents a huge amount of investment in time by our reviewers and by the staff providing care.

The Trust continues to participate in regional learning events and will ensure that any changes to guidance are applied at the Trust.

The completed learning from deaths dashboard is in appendix 1 (this is a slightly amended version from the example dashboard provided by the national programme). This dashboard reflects the data from Q1 and Q2 of this financial year.

It is important to note that the national programme for mortality reviews as commissioned by HQIP (The Healthcare Quality Improvement Partnership - responsible for national work including the National Clinical Audit and Patient Outcomes Programme) are not advocating the marking of avoidability in mortality reviews on the primary review.

The Trust has reviewed approximately 10% of deaths that are in scope for this financial year, prior to implementation of EPR this had been closer to 20%. Whilst, with the implementation of EPR, this downturn in reviewing rate had been expected we have escalated this to all divisional leaders and clinical governance leads and they are reviewing their mortality review process. We will

continue to provide training sessions where applicable and giving mortality feedback to all specialities. The rate of mortality reviews will be monitored closely.

3.0 Trust standard learning from deaths dashboard

Appendix 2 shows additional information which is included in the Trust standard report regarding learning from mortality reviews. These standard reports go to the Mortality Sub-Committee every two months. There are also distributed to all divisions and specialities and we are developing abbreviated 'learning' reports for dissemination to all staff in the organisation.

4.0 Trust mortality data

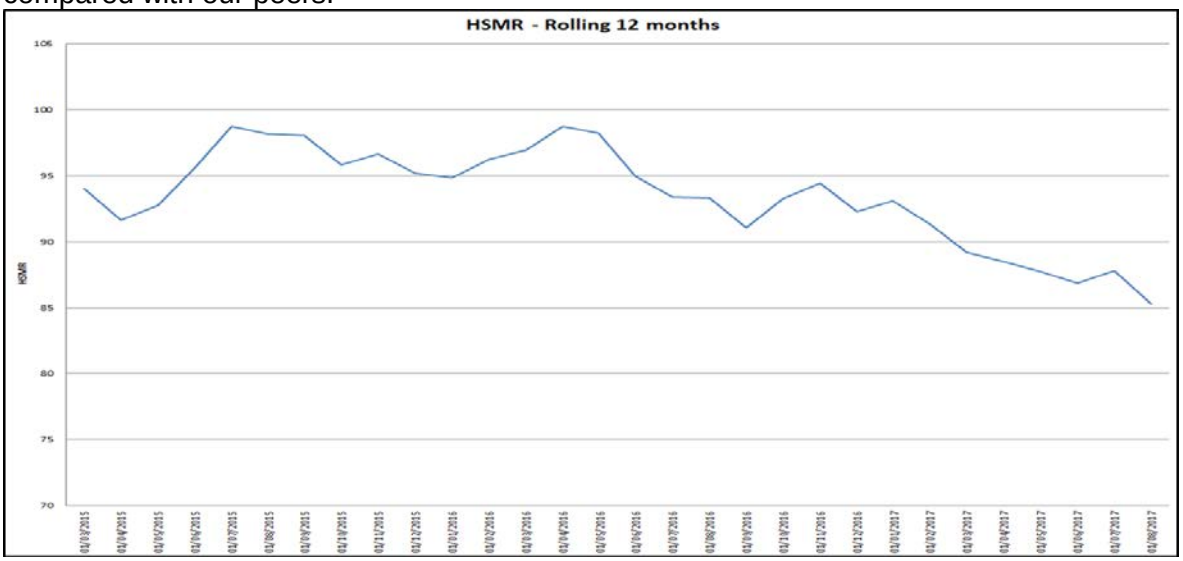
In addition to receiving reports relating to learning from mortality reviews the Committee also receives reports on our overall mortality data. These data have not been included in detail but the Committee is to be assured that the full NHS England guidance is followed on reporting mortality data to the Mortality Sub-Committee.

4.1 Headlines from mortality data

The most recent data made available to us by NHS digital for the Summary Hospital-level Mortality Indicator (SHMI) places the Trust in the "as expected" category with an outcome of 92.5. This refers to the twelve months July 2016 to June 2017.

The most recent data available for hospital standardised mortality ratio (HSMR) places the Trust in the "lower than expected" category with an outcome of 87. This refers to the twelve months October 2016 to September 2017. We have the lowest HSMR of any acute trust in West Yorkshire and one of the lowest in England.

The chart below shows the Trust HSMR as a rolling twelve month average (each point of data is an average of that month and the eleven months preceding it). It is useful to look at HSMR this way as it gives a more stable overview of the indicator (monthly values can vary making the chart difficult to interpret). It is also worth noting that a reduction in HSMR represents a faster continual improvement in mortality rates when compared with our peers.



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5.0 Recommendations

- Note the content of this report
- Note the progress being made around mortality reviews
- Be assured by the mortality rates for the Trust

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Appendix 1. Learning from death dashboard Q1 and Q2 data

NHS — Bradford Teaching Hsopitals NHS Foundation Trust: Learning from Deaths Dashboard - September 2017-18 — Department of Health

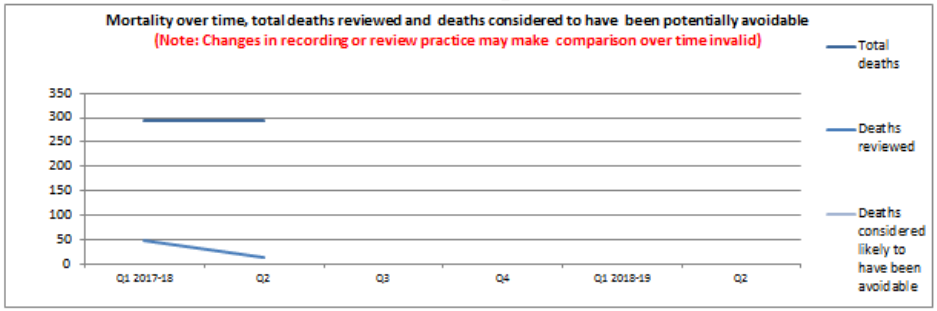
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
102	76	1	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
295	294	13	50	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
589	0	63	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q2

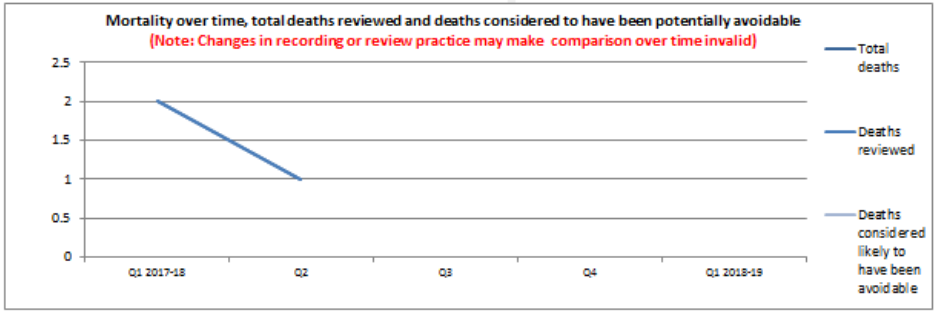


Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

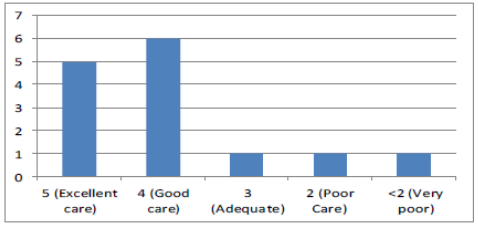
Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	2	1	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	0	3	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



Appendix 2. Learning from deaths information – Trust standard report (Covers July to September 2017)

Admission & Initial Care Score



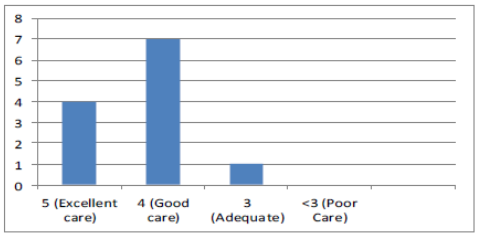
Seen and treatment commenced within 1 hour as per Sepsis bundle in A&E – good practice.

Able to access radiology quickly and reviewed in ICU by consultant surgeon and transferred to theatre – excellent care.

Medicines reviewed undertaken – diuretics stopped with AKI – good practice.

Poor care scores relate to delays in treating a patient with malaria, including availability of equipment for dialysis and problems setting up the equipment.

Ongoing Care Score

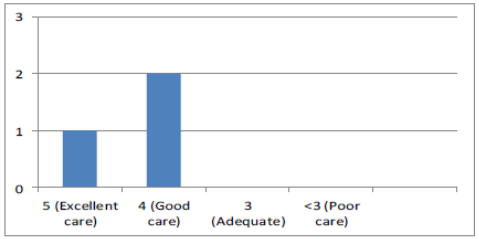


Family kept updated of progress and advanced care planning done – good practice.

Ward team continued to try various treatment options despite difficulties - good practice.

Acknowledged with patient that condition deteriorating and plan to refer to palliative care – this is good care but referral not received by palliative care team until 3 days later – this is not good care.

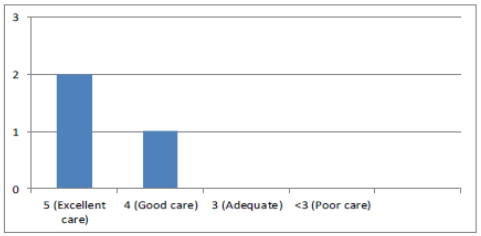
Care During a Procedure Score



WHO check and documentation filled out appropriately – example of good safe practice.

Well documented anaesthetic pre-assessment and conduct – good care.

Perioperative Care Score



Transferred to ICU post op. Full supportive care given. Good contemporaneous notes entered on Innovian (electronic system by nursing and medical staff. Twice daily consultant reviews. Conversations with family about deterioration and change to palliation – Good practice

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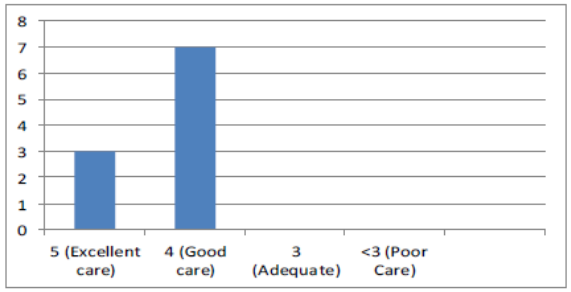
End of Life Care



Put on the palliative pathway appropriately.

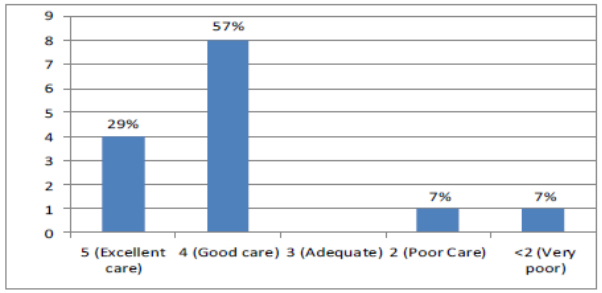
Continuous subcutaneous infusion commenced within 1 hour of being prescribed – this is very good care (standard is for within 2 hours).

Recognition that patient too unwell for transfer to hospice and discussed with patient and family – this is good care.

Patient died whilst palliative care nurse was there, support given to family.

Good care; given, patient wishes taken to account.

Overall Assessment of Care



The patient received excellent care from arrival to hospital with early recognition of the critically unwell patient and sepsis.

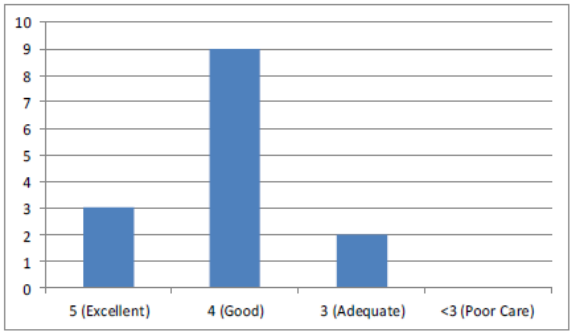
Good consistent communication and care throughout admission.

Breakdown in communication regarding diagnosis of malaria and then delay in treatment.

Failure to establish the patient on hemofiltration despite the documentation and the need to start this ASAP.

Poor care scores relate to delays in treating a patient with malaria (see two comments above). This case was subject to a second review, hence the score of '1' and subsequent score of '2' from the second review.

Quality of Patient Record Score



Key themes identified following a thematic analysis of the case note reviews completed

Good practice identified:

- Recognition of the sick patient seems to be good to excellent in many cases. There are still a few issues with NEWs scoring but on the whole this is good
- There is some excellent communication with patients and relatives identified which makes a real difference with planning for end of life
- Initial care within the first 24 hrs seems to be very good with good evidence of implementing relevant treatments on time
- Good multidisciplinary cooperation and communication is commented on making a difference to the patient care
- There is good use of palliative care and most times end of life care is put in place

Poor practice identified

- Note keeping and documentation is commented as being poor in places
- There are delays in care due to lack of equipment, beds or medications
- Delays in care due to lack of appreciation of urgency and poor communication
- Continuity of care and handover of information is poor at times
- At times palliative care and end of life planning could have been done sooner

Examples of comments suggesting some good care :

- "Lots of discussions with family very early on; tried to support family's wishes for her to return to care home to die but unfortunately care home couldn't meet needs."
- "Acknowledged with patient that condition deteriorating and plan to refer to palliative care – this is good care but referral not received by palliative care team until 3 days later – this is not good care."
- "Triaged promptly on arrival to A&E. Early recognition of sepsis with early administration of IV fluids and antibiotics. Surgeons appropriately called and senior reviewed patient- recognition of sepsis and need for CT thoracic, abdomen and pelvis and critical care input. All examples of good care. "

Examples of comments in Key learning points for improvement

- "Earlier move to theatres from ICU. Over an hour from decision to operate"
- "Referral to palliative care could have been made when initially planned on post-take ward round. If palliative care had had the opportunity to review earlier, a hospice bed may have been available sooner and the patient transferred prior to becoming too unwell to move. "
- "DNACPR form had review documented – this is good care, but no documentation in medical notes of discussion – this is not good care"
- "Better communication between lab/doctor/nurse regarding diagnosis of tropical disease."