NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Learning from Deaths Quarterly Report (Q4 2018/19)	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 24 July 2019	**Item 1**
Responsible Executive Director: Prof Julian Redhead, Medical Director	**Author:** Shona Maxwell, Chief of Staff Ian Bateman, General Manager Clementine Burbidge, compliance and assurance improvement lead

Summary:

This paper provides a quarterly update on our Learning from Deaths programme to the Trust board. It includes an updated dashboard outlining activity undertaken as part of the programme up to and including Q4 2018/19. Since the mortality review process was implemented in 2017, there have been 3597 deaths at the Trust (to 31st March 2019). A level 1 review has been completed for 3523 deaths. To date, 480 of these cases have had SJRs completed with 29 avoidable deaths reported.

The report also provides an update on a number of actions we are taking to improve our learning from deaths processes, including strengthening and formalising the triangulation of our SJR and incident processes and the implementation of the medical examiner service.

The paper has been reviewed and discussed at executive quality committee (ExQu) and board quality committee, with the data being approved for submission and both committees supportive of the improvement plans described.

Recommendations:

The board is asked to note the data and learning from deaths dashboard for 2018/19 and progress with implementing actions to improve our learning from deaths processes.

This report has been discussed at (delete/tick as relevant):

☒ Executive Quality Committee
☒ Board Quality Committee

Quality impact:

This process supports improved learning from deaths which occur in the Trust, therefore supporting the safe, effective and well-led quality domains.

Financial impact:

There is no direct financial impact associated with this paper. The implementation of the Medical Examiner service is the subject of a corporate cost pressure (£300k) which was agreed at ExQu in March 2019. Clinical and administrative structures for the ME and Patient Affairs and Bereavement Service are currently being designed, and a final cost will be confirmed once this is completed.

Risk impact and Board Assurance Framework (BAF) reference:

There is potential for reputational risk associated with the ability to deliver reviews within the specified time periods, thus impacting on national reporting. Learning from Deaths is on the divisional risk register (no. 2439).

Workforce impact (including training and education implications):

Six staff received Tier 1 training provided externally by the Royal College of Physicians, the remaining staff were then trained internally in a mixture of individual or small group sessions, dependent on need. Training remains available via the Mortality Auditor.

What impact will this have on the wider health economy, patients and the public?

The aim of this work is to identify avoidable factors in the deaths of patients, provide learning opportunities, and guide future improvement works to reduce avoidable deaths.

Has an Equality Impact Assessment been carried out?
☐ Yes ☐ No ☒ Not applicable

Paper respects the rights, values and commitments within the NHS Constitution.
☒ Yes ☐ No

Trust strategic goals supported by this paper:

- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Learning from Deaths Quarterly report (Q4 2018/19)

1. Executive Summary

1.1. This paper provides a quarterly update on our learning from deaths programme to the Trust Board. It includes an updated dashboard outlining activity undertaken as part of the programme up to and including Q4 2018/19 and an update on a number of actions being taken to improve our learning from deaths processes.

1.2. The paper has been reviewed and discussed at executive quality committee (ExQu) and board quality committee, with the data being approved for submission and both committees supportive of the improvement plans described.

2. Background

2.1. In March 2017, the National Quality Board published a framework for NHS trusts on identifying, reporting, investigating and learning from deaths in care. We reviewed our established mortality review process and associated policy in line with these requirements and are fully compliant.

2.2. Our learning from deaths process can be summarised as follows:

- All deaths have a Level 1 review – a consultant uses a list of prompts on Datix to screen and then assign an initial avoidability score.
- The consultant decides whether the case then needs a Level 2 review which is a specialty based multi-disciplinary Mortality & Morbidity (M&M) meeting review. This review is recorded on Datix.
- The M&M (level 2) review follows the SBAR approach and should conclude with a judgement on the avoidability of the death. If concerns are raised the case is referred on for structured judgement review (SJR).
- SJR is a validated methodology and involves trained clinicians reviewing medical records in a critical manner and to comment on phases of care and ultimately assign an avoidability score.
- Cases are also automatically referred for an SJR from the following cohorts:
  - ❖ Concern raised by bereaved family;
  - ❖ Concern raised by staff involved in care;
  - ❖ 1st stage review avoidability score of 1-3 (more than probably avoidable);
  - ❖ Patient had a learning disability (LeDeR process);
  - ❖ Patient was detained under Mental Health Act;
  - ❖ Any case subject to a coroner's inquest or enquiry;
  - ❖ Any case subject to an SI where the patient died;
  - ❖ Deaths in patients aged 16-25 years old;
  - ❖ Any mortality alert raised via benchmarking systems.

3. Summary of data

3.1. The Trust has had a significantly low relative mortality risk across the last twelve consecutive months and has the lowest HSMR in England over that time period. Our SHMI trend is significantly lower than expected over the last three financial years. See appendix 1.

3.2. Since we implemented the mortality review process in 2017, there have been 3,597 deaths at the Trust (to 31 March 2019). A level 1 review has been completed for 3,523 deaths. To date, 480 of these cases have had SJRs completed with 29 avoidable deaths reported. The percentage of all deaths that have been deemed to be avoidable from SJR (score 1-3) is 0.81%. See appendix 2. We are required to submit data on learning from deaths to NHS England in the form of a quarterly dashboard. This is provided in appendix 3.

3.3. The graphs in appendix 4 show the number of triggers for an SJR by type, and the percentage of triggers based on the overall number.

3.4. The highest number of triggers are from coroner's inquests (n=197), followed closely by vulnerable groups (n=196) which include: patients with a learning disability, patients detained or liable to be detained under the Mental Health Act, children and young people (the SJR is conducted in addition to the Child Death Overview Panel process), and maternity cases including still births.

3.5. A total of 3.1% of SJRs have been triggered as a result of concerns from a family member, and a further 6.7% have been triggered following a serious incident investigation. It is interesting to note that only one of the cases that went on to be scored as being probably avoidable or more had concerns raised by the bereaved family.

3.6. Since the last quarterly report in March 2019, seven avoidable deaths have been confirmed. Of these, two deaths were judged to have strong evidence of avoidability (score 2) and the remaining five were judged to be potentially avoidable (more than 50:50 – score 3).

3.7. There have been a number of occasions where a SJR has found the death of a patient to be avoidable, but subsequent investigation has found otherwise. We have therefore made changes to our processes to ensure that these two investigatory processes, whilst independent of one another, are linked appropriately. These include presentation of all SJRs with a score of 1-3 at the MD panel, and a new decision making group chaired by the medical director being convened. This process will now be carried out for all cases previously declared as avoidable and the final decision reported in the next quarterly update.

3.8. Compliance with duty of candour for these cases is good. This meets the national guidance on learning from deaths which states that families should be contacted where concerns have been found, invited to be involved in the investigation and advised of the outcome.

4. Learning from SJRs

4.1. Themes from the SJRs for avoidable deaths link to a number of our safety streams: falls and mobility, responding to the deteriorating patient, medication safety and fetal monitoring. Additional themes include treatment delays and sepsis.

4.2. Case specific actions following SI investigations, and local and level one investigations, are recorded and tracked through the Datix actions module. Examples include:

- Review of the VTE protocols in renal

- Repatriation guidance in trauma patients to be considered
- MDT learning undertaken for management of hyperkalaemia
- ED exit checklist to be incorporated into Cerner
- Local teaching on treatment of PE
- Discharging patients with abnormal results to be included in local induction slides
- Transfer arrangements for renal patients to be discussed and clarified with other NHS organisations
- Changes to the Emergency Department safety rounds

4.3. Data fields are being incorporated into the online mortality module to facilitate thematic reporting into the future. These are expected to be embedded by Q3.

5. Update on the implementation of the Medical Examiner service

5.1. The implementation of the medical examiner (ME) service continues with Dr Kevin Lessey having been appointed in May 2019 as our senior ME and other ME posts in the process of being recruited.

5.2. The structure of the new bereavement and patient affairs service has been agreed. It is expected that this will be in place in September 2019.

5.3. We have been working through the end of life steering group to improve how we involve families in mortality review. Bereavement literature is being re-designed to include details of the SJR process with the aim of ensuring us that all families are engaged in the process. This will be led by the ME in the future, supported by the bereavement and patient affairs service.

6. Conclusion and Next Steps

6.1. We have a comprehensive learning from deaths process in place, however as we continually strive to improve our processes and our ability to learn from deaths that occur at our hospitals, it is appropriate that we review our processes and make changes and improvements.

6.2. A new decision making group chaired by the medical director has been convened which will review all cases where the SJR and investigation outcome differ. This process will now be carried out for all cases previously declared as avoidable and the final decision reported in the next quarterly update.

6.3. We continue to make the necessary changes to implement the ME service, including the appointment of a senior ME, and will work to ensure that this mandated development is exploited to its greatest potential when it comes to learning from and scrutinising deaths that occur in our hospitals.

7. Recommendations

7.1. The Board is asked to note the data and learning from deaths dashboard for 2018/19 and progress with implementing actions to improve our learning from deaths processes.

Author **Shona Maxwell, chief of staff**
Clementine Burbidge, compliance and assurance improvement lead
Ian Bateman, general manager

Date 17 July 2019

Appendix 1 – Mortality data
Appendix 2 – Learning from deaths data for 2017/18 and 2018/19
Appendix 3 – Learning from deaths dashboard – attached
Appendix 4 – Triggers for structured judgement reviews

Appendix 1 – Mortality data

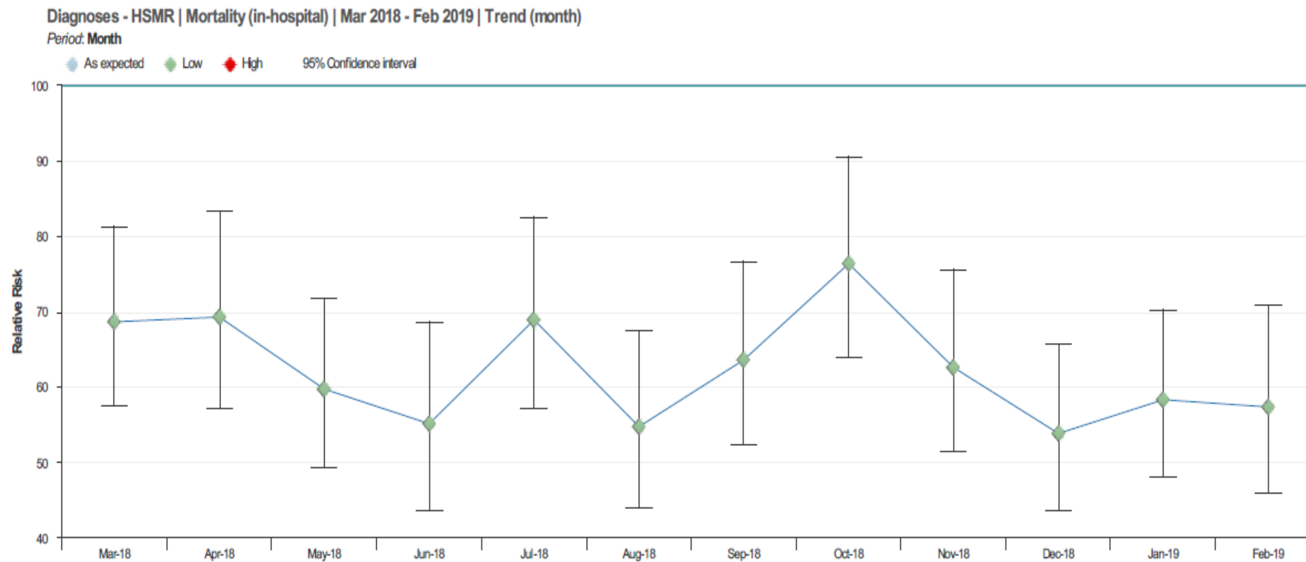


Figure 1 – HSMR trend by month from March 2018 to February 2019

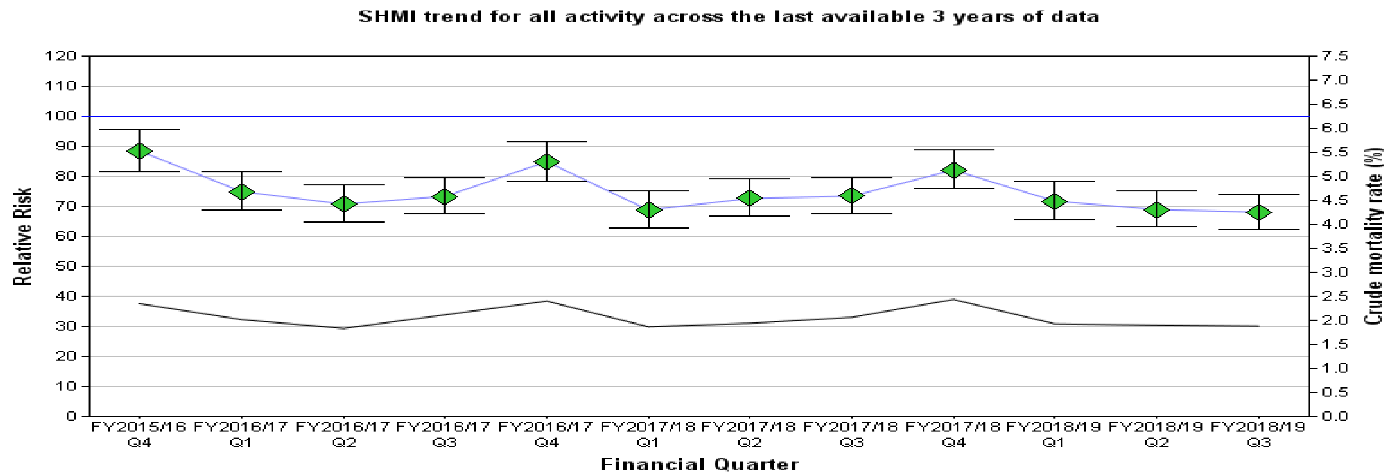


Figure 2 – SHMI trend from Q4 2015/16 to Q3 2018/19

Appendix 2 – Learning from deaths data for 2017/18 and 2018/19

Note that the avoidable deaths in the table are those that have been agreed by the monthly Mortality Review Group (MRG), hence there may be differences between these figures and the Divisional dashboards

**data accurate as of 07th June 2019*

Trust Total	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Total Deaths	120	152	137	138	163	151	161	167	161	191	176	178	**1895**
No. Level 1 Reviews Completed	120	152	137	138	163	150	161	167	161	191	176	178	**1894**
% Level 1 Reviews Completed	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	**100%**
No. of SJRs Requested	3	3	4	21	30	22	36	19	21	29	32	28	**248**
No. of SJRs Completed	3	3	4	21	30	22	36	19	21	29	32	28	**248**
% SJRs Completed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
No. of Avoidable Deaths (Score 1-3)	2	0	0	2	3	1	3	2	0	2	2	1	**18**

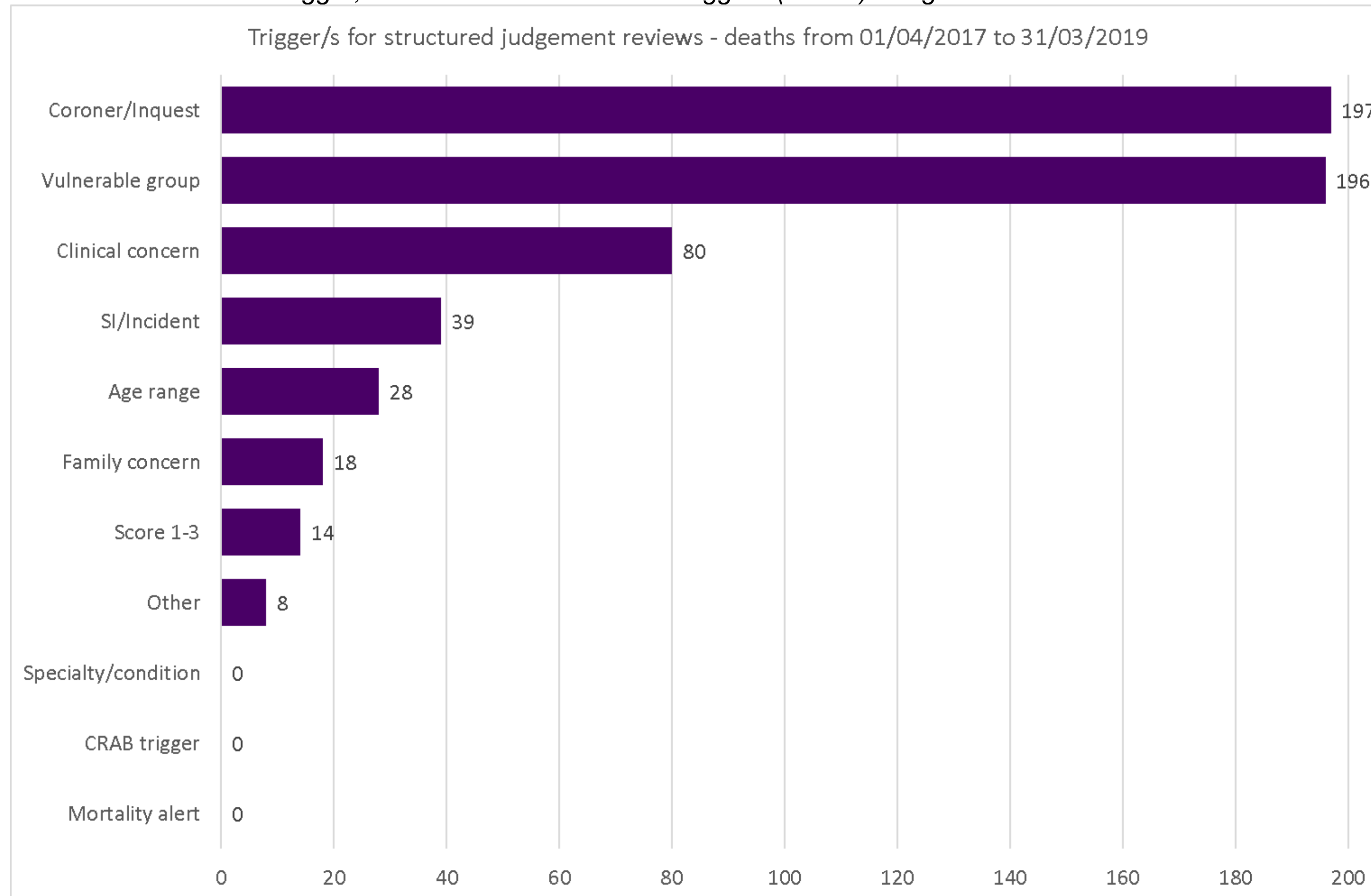
**data accurate as of 07th June 2019*

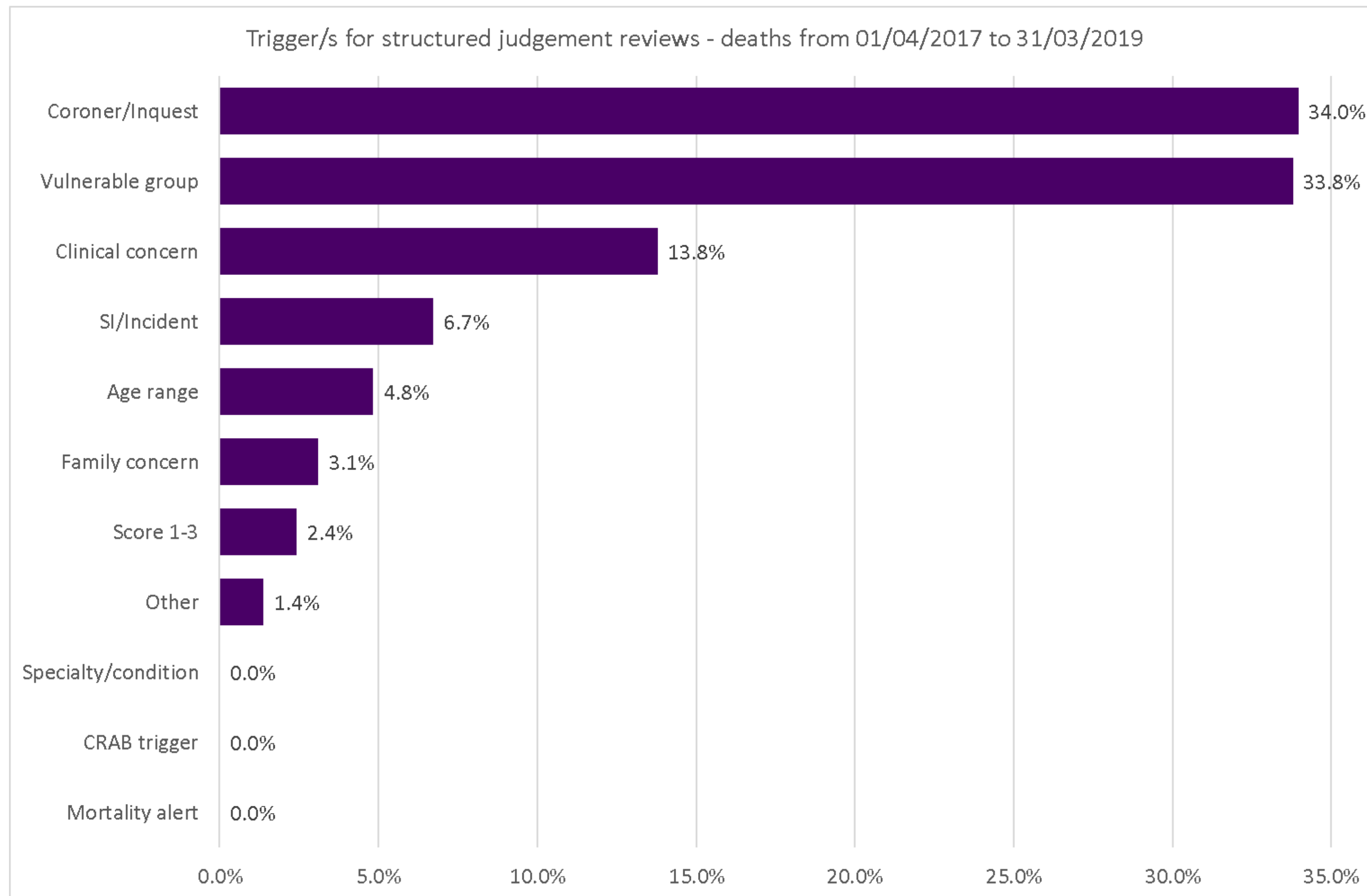
Trust Total	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	**YTD**
Total Deaths	155	136	122	159	118	131	162	133	145	153	124	164	**1702**
No. Level 1 Reviews Completed	155	136	119	159	116	126	159	129	139	147	109	135	**1629**
% Level 1 Reviews Completed	100%	100%	98%	100%	98%	96%	98%	97%	96%	96%	88%	82%	**96%**
No. of SJRs Requested	19	30	23	23	21	14	16	19	25	20	19	25	**254**
No. of SJRs Completed	19	30	21	23	21	13	16	18	22	19	13	17	**232**
% SJRs Completed	100%	100%	91%	100%	100%	93%	100%	95%	88%	95%	68%	68%	**91%**
No. of Avoidable Deaths (Score 1-3)	2	1	1	1	1	0	0	0	0	1	2	2	**11**

Appendix 3 – Learning from deaths dashboard – attached

Appendix 4 – Triggers for structured judgement reviews – deaths from 1st April 2017 – 31st March 2019 – by number of triggers and percentage of overall triggers

N.B. Some cases have more than one trigger, thus the overall number of triggers (n=580) is higher than the overall number of SJRs completed (n=480).




Trigger/s for structured judgement reviews - deaths from 01/04/2017 to 31/03/2019
Coroner/Inquest
34.0%
Vulnerable group
33.8%
Clinical concern
13.8%
SI/Incident
6.7%
Age range
4.8%
Family concern
3.1%
Score 1-3
2.4%
Other
1.4%
Specialty/condition
0.0%
CRAB trigger
0.0%
Mortality alert
0.0%
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
30.0%
35.0%

Imperial College Healthcare NHS Trust : Learning from Deaths Dashboard - March 2018-19

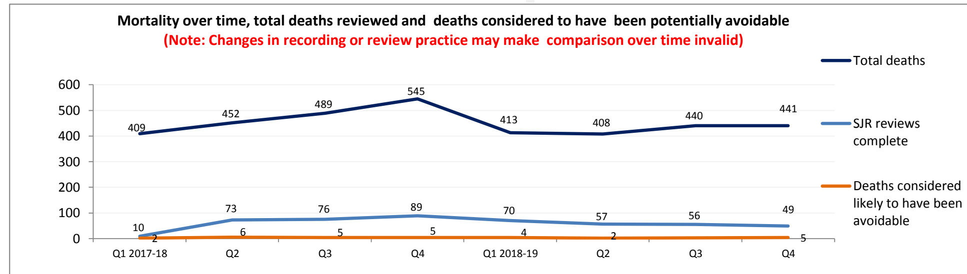
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
164	124	17	13	2	2
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
441	440	49	56	5	0
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
1702	1895	232	248	11	18

Time Series:	Start date	2017-18	Q1	End date	2018-19	Q4



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (FYTD)	0	0.0%

Score 2 Strong evidence of avoidability		
This Month	0	0.0%
This Quarter (QTD)	1	2.0%
This Year (FYTD)	2	0.9%

Score 3 Probably avoidable (more than 50:50)		
This Month	2	11.8%
This Quarter (QTD)	4	8.2%
This Year (FYTD)	9	3.9%

Score 4 Probably avoidable but not very likely		
This Month	2	11.8%
This Quarter (QTD)	5	10.2%
This Year (FYTD)	18	7.8%

Score 5 Slight evidence of avoidability		
This Month	3	17.6%
This Quarter (QTD)	7	14.3%
This Year (FYTD)	27	11.6%

Score 6 Definitely not avoidable		
This Month	10	58.8%
This Quarter (QTD)	32	65.3%
This Year (FYTD)	176	75.9%

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	3	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
5	1	0	0	0	0
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
13	12	0	2	0	0

Time Series:	Start date	2017-18	Q1	End date	2018-19	Q4