Harrogate and District
NHS Foundation Trust

Date of Meeting:	29 May 2019	**Agenda item:**	6.4
Report to:	Board of Directors		
Title:	Learning from deaths report Q4 2018/19		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	Board to note quarterly report of learning from deaths process. During Q4 2018/19 five structured judgement reviews (SJRs) were completed. 100% (5/5) patients reviewed had good or excellent overall care. 60 SJRs were completed during 2018/19, 31 related to deaths that occurred during 2017/18 and many of these relate to the review of orthopaedic cases previously reported. 58/60 (97%) were found to have good or excellent overall care. No problems in care were identified in four of the cases in Q4. One case identified issues relating to end of life care although this was graded as no harm. The 2018/19 data shows two cases with problems in care associated with uncertain harm, and two cases where problems in care resulted in harm. These were included in previous reports. The deaths were both recognised and investigated as serious incidents. There was one death of a patient with learning disabilities that underwent a SJR during Q4. All relevant phases of care were judged as being good or excellent (4 or 5). All cases of a patient with learning disabilities dying in hospital are automatically referred to the national Learning Disabilities Mortality Review (LeDeR) programme, and five cases were referred during 2018/19. In general the structured judgement reviews contained numerous detailed descriptions of good practice. The results of case notes reviews of in-hospital cardiac arrests confirmed that the most prevalent reason to deem resuscitation inappropriate remains “patient had life limiting illness so a DNACPR should have been considered”. This is the focus of the Appropriate Resuscitation and Escalation Operational (AERO) Group. General problems and themes are reported to Improving Patient Safety Steering Group to discuss and agree any appropriate actions. Themes and learning are shared		

	across the organisation using the #ChatterMatters newsletter.

Related Trust Objectives

To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	The learning from deaths process aims to identify areas where improvements can be made to patient care which will reduce clinical risk.
Legal / regulatory:	There is a requirement to collect and publish specified information on deaths including learning points every quarter with a paper and agenda item to public Board meetings from Q3 2017/18 onwards.
Resource:	There is a time resource required to undertake the case note reviews, data collection and analysis.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	HDFT Learning from Deaths Policy
Assurance:	Learning from quarterly reports are reviewed at the Improving Patient Safety Steering Group.

Action Required by the Board of Directors:

It is recommended that the Board:

- **Notes** items included within the report;

For those patient deaths meeting the criteria for a detailed review of case notes, the Medical Director appoints a clinician with appropriate expertise to undertake a structured judgement review (SJR). The Trust has a number of clinicians trained to undertake the structured judgement review. Whenever possible, the clinician will not have been involved in the care of the patient who died.

A case note review is to determine not only examples of good practice, but also whether there were any problems in the care provided to the patient who died in order to learn from what happened.

The Trust has adopted the RCP National Mortality Review Tool which is hosted on Datix. This enables easy access to the information gathered but is not yet proving useful to prepare data for this report. We are communicating with Datix about this. We are also close to testing an in-house platform that will enable us to implement a screening process for all in hospital deaths, to prioritise early review of deaths that would or might benefit from a SJR.

The date of death is the date that we aim to use for the data analysis rather than the date that the SJR was undertaken. However this is currently difficult in that there is not a date of death field on Datix – only the quarter in which the death occurred – without the relevant year. This introduces the potential for error when some historic cases are being reviewed at the same time as current cases.

All case note reviews undertaken during Q4 2018/19 have been included in this report, and summary data for 2018/19 has also been included.

All hospital cardiac arrests are reported to the National Cardiac Arrest Audit (NCAA) to monitor and report on the incidence of, and outcome from, in-hospital cardiac arrest in order to foster improvements in the prevention, care delivery and outcomes from cardiac arrest. It is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) and is included in the Department of Health Quality Accounts. Further learning is sought by case notes reviews of all in-hospital cardiac arrests which are reviewed by the Resuscitation Committee to identify any areas of learning to share and determine whether the resuscitation is deemed appropriate or inappropriate; this information is also included in this report.

Results of structured case reviews

Summary of inpatient deaths and structured case note reviews

		Quarter or year in which the death occurred													
					2017/18					2018/19					
		2014/15	2015/16	2016/17	Q1	Q2	Q3	Q4	2017/18	Q1	Q2	Q3	Q4	2018/19	Total undertaken
	No of inpatient deaths				145	140	167	205	657	142	140	177	182	641	
Number of structured judgement reviews (SJRs)	SJRs previously reported	4	27	40	3	8	14	6	31	N/a	N/a	N/a	N/a	N/a	102
	SJRs undertaken during Q1 2018/18				5	4	9	7	25	8	N/a	N/a	N/a	8	33
	SJRs undertaken during Q2 2018/19				1	0	0	3	4	2	5	N/a	N/a	7	11
	SJRs undertaken during Q3 2018/19				0	0	0	1	1	0	7	3	N/a	10	11
	SJRs undertaken during Q4 2018/19				0	0	1	0	1	0	0	2	2	4	5
	Total SJRs undertaken during 2018/19 by year of death								31					29	60
	Total number of SJRs undertaken relating to deaths in the period	4	27	40					62	10	12	5	2	29	162

This table shows the number of inpatient deaths by quarter during 2017/18 and 2018/19, and the number of structured judgement reviews (SJRs) undertaken since 2014/15.

For 2018/19 the number of SJRs is given by quarter that the review was undertaken, and by the quarter and year that the death occurred. 60 SJRs were completed during 2018/19, 31 related to deaths that occurred during 2017/18 and many of these relate to the review of orthopaedic cases previously reported. During Q4 2018/19 five SJRs were completed.

Assessment of care

The table below shows the assessment of care for the identified stages of care provision for each of the five case reviews completed during Q4. 100% (5/5) patients reviewed had good or excellent overall care. The care is rated for each of up to seven phases of care. Out of 35 possible phases of care, 8 were not applicable, and 26/27 (96%) were rated as good or excellent.

Care scores summary: 2018/19 Q4

	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	5	0	0	0	5
On-going care	4	1	0	0	5
Care during procedure	1	0	0	4	5
Peri-operative care	1	0	0	4	5
End of life care	5	0	0	0	5
Overall assessment of care received	5	0	0	0	5
Overall assessment of patient record	5	0	0	0	5

The table below shows the assessment of care for the identified stages of care provision for each of the 60 case reviews completed during 2018/19. 58/60 (97%) were found to have good or excellent overall care. There were 9 identified stages of care where the standard of care provided was judged to be poor. The reasons for the poor care have been included in previous reports. As each patient may have up to seven stages of care, there are a total of 420 phases of care, of which 64 stages were not applicable. 325/356 stages of care (91%) were judged to be good or excellent.

Care scores summary: 2018/19 total

	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	49	6	5	0	60
On-going care	53	3	1	3	60
Care during procedure	30	2	0	28	60
Peri-operative care	24	3	0	33	60
End of life care	55	4	1	0	60
Overall assessment of care received	56	3	1	0	60
Overall assessment of patient record	58	1	1	0	60

As previously reported, the review of deaths included in the orthopaedic HSMR for the period Feb-17 to Jan-18 confirmed that the main theme was of good or excellent care with 96% (24/25) scoring 4 or 5 for overall care.

Problems with care

The SJR proforma has a section that enables the identification of problems in care. No problems in care were identified in four of the cases in Q4, and one case identified issues relating to end of life care and disagreement of cause of death between the coroner and the clinical teams although this was graded as no harm.

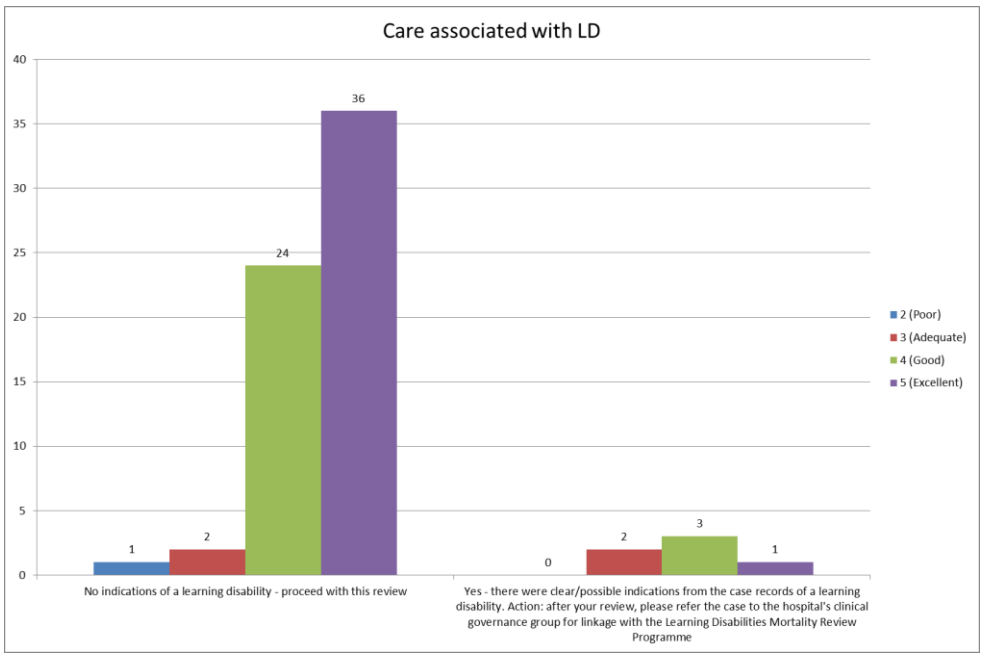
Problems with care: 2018/19 Q4				
	Degree of harm if problems identified			Total
	No harm	Uncertain harm	Harm	
No problems with care identified				4
Problems in care identified	1	0	0	1
Total				5

The 2018/19 data shows two cases with problems in care associated with uncertain harm, and two cases where problems in care resulted in harm. These were included in previous reports. The deaths were both recognised and investigated as serious incidents, with the outcome reported to the families involved, the Board of Directors, commissioners, HM Coroner and the Care Quality Commission. Detailed recommendations, including change of clinical practice and policy have been agreed and action plans produced in order that appropriate steps are taken to address problems in care and to share learning. Discussions are ongoing as to how learning is most effectively shared across acute trusts within the integrated care system.

Problems with care: 2018/19 Total				
	Degree of harm if problems identified			Total
	No harm	Uncertain harm	Harm	
No problems with care identified				45
Problems in care identified	11	2	2	15
Total				60

Deaths of patients with learning disabilities

There was one death of a patient with learning disabilities that underwent a SJR during Q4. All relevant phases of care were judged as being good or excellent (4 or 5).



The graph above shows the overall assessment of care for patients with learning disabilities (no=5) and without learning disabilities (no=63) from all HDFT SJRs recorded on Datix (n=68). There is no theme identified from this data but it is being regularly monitored.

All cases of a patient with learning disabilities dying in hospital are automatically referred to the national Learning Disabilities Mortality Review (LeDeR) programme, and five cases were referred during 2018/19. This is the national multi-agency programme for review of death in patients with learning disabilities commissioned by NHS England.

Specific learning points identified

There were no specific learning points identified from the Q4 SJRs. Any specific learning identified during 2018/19 has been addressed.

Results of case notes reviews of in-hospital cardiac arrests

This report includes the case note reviews for Q3 and Q4.

	2017/18						2018/2019					TOTAL
	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	**2017/18 Total**		Q1	Q2	Q3	Q4	**2018/19 Total**	
No of inpatient cardiac arrests	8	11	16	9	**44**		12	7	17	13	**49**	93
No of case note reviews	8	11	16	9	**44**		12	7	17	13	**49**	93
No of appropriate cardiac arrests	4	3	13	4	**24**		10	3	12	6	**31**	55
No of inappropriate cardiac arrests	4	8	3	5	**20**		2	4	5	7	**18**	38

The cardiac arrest case note reviews show that the care provided prior to and during resuscitation calls is of a high standard, following national guidelines and hospital policy.

The Resuscitation Committee deemed 40% of Q3 and Q4 and 37% of 2018/2019 resuscitation attempts as inappropriate. This is a slight improvement compared to 45% in 2017/2018. The reasons for deeming resuscitation inappropriate are detailed below for Q3 and Q4:

Patient had a DNACPR decision in place but not known of or not found	Resuscitation stopped quickly due to futility therefore DNACPR should have been considered pre arrest	Patient had life limiting illness so a DNACPR should have been considered	DNACPR put in place post arrest therefore should have been considered prior to arrest
3	1	9	1

The total number of reasons is greater than the number of cases as there have been more than one reason for being deemed inappropriate in some case note reviews.

Reflection and learning identified

The numbers of deaths in hospital that can be unequivocally shown to be truly avoidable are fortunately rare. The mortality review process is reproducible and provides a rich seam of learning which, albeit not necessarily affecting outcomes, will allow us to improve end of life care for many patients.

The SJRs continue to emphasise the increasing frailty and complexity of medical elderly patients in particular, and confirm the excellent care received by the great majority of patients whose death in hospital is expected. In a smaller number of cases during 2018/19, examples of where practice could be improved were documented. The great majority of these did not affect the eventual outcome. For example:

- Ensuring patients assessed in ED as having a stroke are not given oral intake prior to swallow assessment;
- Ensuring patients with a stroke are admitted to the stroke unit, not other medical wards;
- Ensuring patients transferred back from other hospitals have a timely medical assessment;
- Considering input from orthogeriatric colleagues at the pre-assessment clinic to manage frailty and start advanced care planning;
- Ensuring correct procedures regarding certification of death, and correct Coronial procedures are followed;
- Improving Neurosurgical advice available when the online referral system is not sufficient and holistic and contextual decision-making is indicated;
- Ensuring delays related to percutaneous endoscopic gastrostomy (PEG) tube insertion to feed patients who need this are minimised;
- Ensuring post mortem examination is considered in all relevant cases;
- Improving recognition of the dying phase at end of life to enable unnecessary treatments to be stopped at an appropriate time.

The results of case notes reviews of in-hospital cardiac arrests confirmed that the most prevalent reason to deem resuscitation inappropriate remains “patient had life limiting illness so a DNACPR should have been considered”. This is the focus of the Appropriate Resuscitation and Escalation Operational (AERO) Group to help clinicians to identify which patients they should be having these discussions with and to provide an easy to use platform to document this on and communicate with the MDT in the Trust and across community specialties. The Resuscitation Department are working with the Clinical Effectiveness Department to produce a survey for patients and carers to understand how we can improve the way we discuss treatment escalation and resuscitation with our patients.

Once the AERO group has agreed an appropriate tool to use to guide discussions and documentation, work can progress to provide education on this and a RPIW is planned to improve the culture and willingness to start and document discussions and decisions regarding treatment escalation and resuscitation.

Actions taken

The following actions have been taken during 2018/19 as a result of the learning identified to date:

1. Local dissemination through feedback to teams and across the organisation where appropriate. This is led through the Improving Patient Safety Steering Group. We have used our #ChatterMatters newsletter to share findings;
2. At national level through the implementation of a web based methodology for documentation of SJR which will enable more effective identification of themes and further opportunities for learning;

3. Combining outcomes and learning from reviews of deaths following attempted cardio-pulmonary resuscitation to inform resuscitation training, and resuscitation decision making training materials.

The impact has been:

- Increased awareness of the mortality review process and the benefits of reviewing deaths to inform learning;
- Further education of doctors in training within the Trust regarding Coronial processes and correct certification of deaths;
- Amending our SJR process to encourage the clinician completing the case review to report any specific problem regarding care that is identified as an event on Datix, so this can be followed up. General problems and themes continue to be identified following the SJRs and in-hospital cardiac arrests are reported to the Improving Patient Safety Steering Group where appropriate actions are agreed and progressed.