The UHBristol Adult Mortality Report

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Summary

Since April 2017 all in patient adult mortality has been subject to review with the aim of learning from death. This report sets out the process by which all adult death is reviewed in UHBristol and the process of monitoring the outcome and learning from death.

Introduction

In December 2016 the Care Quality Commission published a review of how NHS trusts review and investigate deaths of patients in care. 'Learning, candour and accountability' provides helpful insight into the system level and local challenges to effective investigations, greater candour and transparency, and learning from deaths across the NHS. The CQC's report made a number of recommendations and recommendation number 7 is directed towards acute providers. This states that provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers. The CQC recommend that Provider boards should ensure:

- Patients who have died under their care are properly identified.
- Care records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.
- Staff and families/carers are proactively supported to express concerns about care given to patients who died.
- Appropriately trained staff are employed to conduct investigations
- Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.
- Investigations conducted in a timely fashion, recognising that complex cases may require longer than 60 days.
- Families and carers are involved in investigations to the extent they wish.
- Learning from reviews and investigations is effectively disseminated across the organisation, and with other organisations where appropriate.
- Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.
- That particular attention is paid to patients with a learning disability or mental health condition.
- Provider boards should strongly consider nominating a non-executive director to lead on mortality and learning from deaths.

This document describes the process at UHBristol whereby all adult in-patient deaths are screened, investigated and reviewed. Learning from a review of the care provided to patients who die is an

integral part of our clinical governance and quality improvement work. UHBristol will ensure its governance arrangements and processes include, facilitate and give due focus to the reporting and investigation of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. UHBristol will also ensure that sharing learning derived from review of deaths is effective.

UHBristol will ensure that staff have the necessary skills and training to support this mortality review process.

UHBristol has a clear policy for engagement with bereaved families and carerers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. It is a priority to work more closely with bereaved families and careers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

Board leadership

The process of The Adult Mortality Review, in UH Bristol, will be overseen by the Medical Director, acting as director for patient safety to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress;

The Board of UHBristol will;

1. Pay attention to the care of patients with a learning disability or mental health needs;
2. Have a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
3. Adopt a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR program) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
4. Ensure case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond UHBristol rather than individual errors in the problems that generally occur;
5. Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is provided to the Board in order that Trust executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed periodically at the public section of the board level with data suitably anonymised;
6. Ensure that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and is reported in the Trust's annual Quality Accounts;
7. Share relevant learning across the organisation and with other services where the insight gained could be useful;
8. Ensure sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths;
9. Offer timely, compassionate and meaningful engagement with bereaved families and careers in relation to all stages of responding to a death;

Mortality Review Process

1. All adult inpatient deaths will be screened

The notes of all adult in patient deaths will be screened for criteria that will trigger a Structured Case Note Review (SCNR). These criteria are;

i. deaths after an elective procedure

ii. where the family raise concerns about the overall care

iii. patients with learning difficulties

iv. patients with a history of severe mental illness, those patients who are under section of the mental health act

v. patients aged between 16-18

In addition, a random selection of deaths that would not have triggered a review by the above criteria will be selected and subjected to a SCNR.

If a death triggers a SCNR the Divisional lead will be informed and the case notes will be subject to a SCNR by a trained reviewer.

2. All deaths meeting the screening tool criteria will be subject to a SCNR

UH Bristol has developed a screening tool which allows additional criteria for triggering a SCNR to be assessed; factors such as multiple ward moves, queuing or outlying could be factors that would be used to trigger a SCNR.

The Mortality Operational Review group will monitor these factors and identify to both the Divisions and the Mortality Surveillance group any potential learning that review of these additional factors produces.

3 All deaths in patients with learning difficulties and severe mental illness

All patients with learning difficulties will be reviewed in association with the LeDeR process with representation on the Mortality Surveillance group

Patients with subject to a Deprivation of Liberty Safeguard (DOLs) with the last period of illness they will also be subject to a structured case note review

4. Patients who die but have triggered a Serious Incident Review

These patients will be subject to a Structured Case Note Review as the terms of reference of the serious incident may not cover the period of care around the patient's deaths and as such this group

of patients need to be included in the SCNR. The patient's safety office will co-ordinate with the mortality team informing the mortality team of all patients who die and are subject to serious incident investigation

5. Deaths within 30 days of discharge

This is a long term aim of learning from deaths but is presenting a challenge to the organisation on the best method of co-ordinating this information, the organisation is working with Academic Health Services Network collaborative and the community to develop the best method of system wide approach to the obtaining and reviewing this information

The outcome of a Structured Case Note Review

The Structured Case Note Review results in two outcomes, the first is an overall score for the quality of the care provided; this is on a 1 to 5 scale with 5 representing excellent care and 1 poor care. The next is assessment of avoidability of death; this is on a 1 to 6 scale. These scores are also supported by statements from the case note reviewer that indicate the reasons behind the scoring and produce learning points from the review.

The SCNR will be performed by a senior doctor, senior nurse or senior trainee who has undergone training in SCNR using the Royal College of Physicians' methodology

The SCNR will be performed by a Senior Clinician. All consultants are eligible to be involved in SCNR once they have completed the appropriate training. This includes Consultants in non-bed holding specialties, such as Radiologists and Anaesthetists.

1. The co-ordination of the SCNR

The co-ordination of the structured case note review will be undertaken by the Divisional mortality leads. It will be the responsibility of the Divisional lead to distribute the review to the reviewers, co-ordinate the response and co-ordinate the learning and outcome from the review.

2. All SCNRs that trigger a score of 1-2 for the overall provision of care or 1-3 on the avoidability of death score will trigger a second SCNR by a trained member of the Medical Director's team

All adult inpatient deaths which score a one or two for the overall provision of care, or 1-3 on the avoidability of death score on the initial review will trigger a second SCNR by the MD office. This is so patients where the overall standard of care provided has been assessed as poor or where there was a greater than 50% probability of avoidability are subject to a further detailed review. This process allows the Senior Medical team to be sited on all deaths within the organisation where concerns have been raised. This also allows the Medical Director's team to assess all potentially avoidable deaths. The themes and learning from this additional review will be co-ordinated and fed back by the Medical Directors team to both the Division and the mortality surveillance group

3. A judgement regarding the avoidability of death will be made following the second review

The final judgement around the avoidability of death will be made following the second review by the Medical Director's team. This will be carried out in a timely way so any issue arising from the avoidability of death result in a duty of candour can be undertaken as soon as possible following the death

4. Where appropriate, the duty of candour will be carried out by the Medical Director's office, unless it has already been completed.

If there is either evidence of poor care or avoidable death and duty of candour has not been undertaken then the Medical Directors office with undertake duty of candour

Mortality Operation Review Group

1. The membership of the Mortality Operational Review Group

The membership of the Mortality Operational Review Group is; the Deputy Medical Director, The Associate Medical Director for Patient Safety, The Divisional leads for Mortality (2 in the Division of Medicine, 1 in Specialised Services, 1 in Surgery and Head and neck), The Nurse lead for Mortality Screening, The Leadership Fellow for Mortality and Administrative support.

2. The Mortality Operational Review group will be responsible for managing the review process

The Mortality Operational Review Group meets monthly and is responsible for the co-ordination of all the data surrounding the screening and review process. The data is held on the Mortality Dashboard. Every month the group will review; the total number of deaths, the total number of deaths which triggered a SCNR, the results of the reviews on a Divisional basis, the total number of SCNR that triggered a second SCNR and the total number avoidable deaths.

In addition, the Mortality Operational Review Group will co-ordinate learning derived from any themes emerging from the SCNR. These themes will then be fed back to the Divisions for integration into the Divisional Mortality and Morbidity process. These themes will be fed into the Mortality surveillance group

This group will produce a monthly report of these figures and actions for learning that will be submitted to the mortality surveillance group

3. The Mortality Operational Review Group will co-ordinate the reviewers and the use of reviewers

The Mortality Operational Review Group will be responsible for the training and co-ordination of case note reviewers. The list of trained reviewers will be held by this group and the number of reviews conducted by each reviewer noted. No reviewer should perform more than 2 reviews per month and no reviewer should go more than 2 months without undertaking a review. The number of reviews for individual will be recorded and on an annual basis fed back to the individual to inform the annual job planning process

Mortality Surveillance Group

1. The mortality surveillance group is the governance group for co-ordinating all information regarding adult mortality

The Mortality Surveillance Group is the overall group with responsibility for the Governance from the learning from death programme and reports to the Quality and Outcomes group.

2. This group is chaired by the Medical Director and has the following members

The Mortality Surveillance group is Chaired by the Medical Director and has the following members; the Deputy Medical Director, the Associate Medical Director for Patient Safety, the Deputy Chief Nurse, the Trust lead for Patient's with learning Difficulties, Representative from Adult Mental Health, the Divisional leads for Mortality, the Lead nurse for mortality screening, leads for mortality from ITU and CICU, Lead for Child Death review, Lead for Obstetric deaths

3. This group takes reports from all aspects of adult mortality, including ITU, and deaths in patients with learning difficulties

The Mortality Surveillance Group will co-ordinate all reports into adult deaths within the organisation. Most this information will be obtained via the Adult Mortality Review Group but there are likely to be further reports from Investigation into Maternal deaths, SUI and RCA, adult mortality on ITU and CICU, patients with Learning Difficulties via the LeDeR process.

All deaths in patients in whom a SI has been initiated will be subject to a SCNR

Other sources of information will also feed into this group, such as Coroners report. This information will be co-ordinated by this group who will identify the most important learning points. This group will produce a quarterly report that will be presented to the Quality and Outcomes Group

4. This group needs to establish, and co-ordinate the main themes associated with learning from death

The role of this group is to co-ordinate and identify themes of learning from all the mortality data provided by various sources with the organisation, as described above and this group will produce a list of the most important areas for learning: this list will be shared with the Divisions, who will need to demonstrate that practice has been changed and where appropriate actions will incorporated into the organisations Quality Improvement project.

In addition, it is likely that several themes will be cross-divisional in nature and may require changes in organisational practice such as induction for junior doctors. This work will be co-ordinated through the Medical Directors office

Staff

1. The Medical Director chairs the Mortality Surveillance Group and there is a named Non-Executive Director with responsibility for the Mortality process. The review process is led by the Deputy Medical Director and the Associate Medical Director for Patient safety

2. Each Division has a Lead for Adult Mortality except Woman's and Children and Diagnostics and Therapeutics. These leads co-ordinate the review process within the Division once a death has triggered a review. The lead for Adult Mortality also co-ordinates the learning within the Division and will feed back the themes from the reviews into both the Divisional Boards and the Mortality Surveillance Group.

3. The Reviews are conducted by trained reviewers in the Royal College of Physicians methodology in SCNR and there is a requirement from all Consultants to support this process, including non-bed holding consultants

4. Once the process has been established, Senior Trainees and Nurses will be trained in SCNR

5. The screening process is undertaken by the lead mortality nurse, who has also been trained in SCNR methodology.

Current Results for the First Quarter 2017/2018

Quarter 1 – April – June 2017

Total Deaths **Number of patients not fully screened**	**299** **20**	
SCNRs	**Required**	**Awaiting completion**
Total	**55**	**14**
Medicine	34	5
Sp S	15	6
Surgery	6	1

During this period 3 patients were subject to a secondary review by the Medical Directors Office and one death was determined as avoidable. This death was already subject to both a Serious Investigation and Root cause analysis. The care of the patient was good throughout but a single medical error was identified as the avoidable cause of the patient death.

The learning from this case has already form the basis of a safety alert and been communicated with front line staff.

Two themes have emerged from the SCNR; appropriate and early involvement in end of life care, and senior decision making around end of life care.

These themes have been fed back to the end of life steering group and will form the basis of a QI project to develop further. Further communication with the Consultant body is planned using a safety update and direct feedback at the consultant awaydays.

Conclusion

This report outlines the new methodology by which the adult mortality review process will be undertaken, in line with the National Learning from Deaths Guidance. This report confirms this process has been established and indicates that already themes are emerging from this process, and appropriate action to ensure processes are established to learning fro death