North West Anglia NHS Foundation Trust

Learning from Deaths report

April-June 2020 – Quarter One

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Introduction

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In March 2017, the National Quality Board published National Guidance on Learning from Deaths. This guidance sets out the framework for NHS Trusts on identifying, reporting, investigating and learning from deaths in care.

Learning from a review of the care we provide to our patients who die should be integral to our clinical governance and quality improvement work.

To fulfil the standards and new reporting set out in this guidance, we had to ensure our governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care.

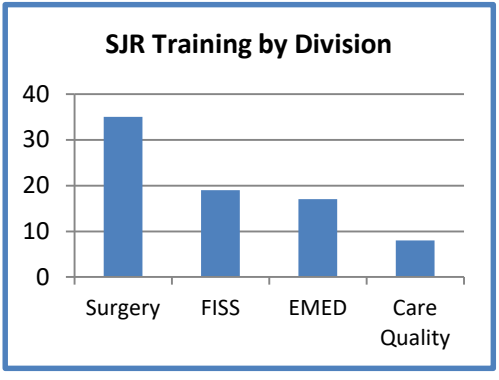
We have a duty to ensure that we share and act upon any learning derived from these processes.

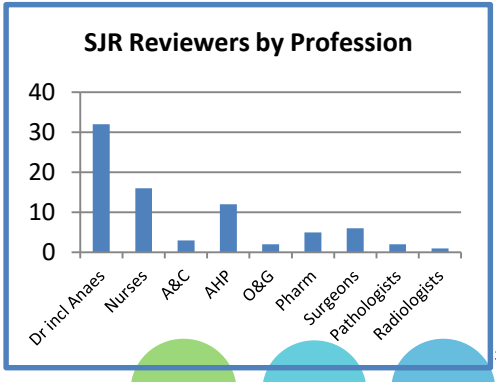
Structured Judgement Review Training

The Trust has six Tier One trainers, consisting of four clinicians and two non-clinicians.

Since the Tier One training was undertaken by the Royal College of Physicians in 2017, a programme of training has been and continues to be undertaken.

The Trust now has 79 staff trained to carry out Structured Judgement Reviews. A further programme of training will be considered during for 2020/21.





Covid 19 Mortality Reviews – Learning from Deaths Q1

The Learning from deaths programme for non Covid 19 deaths was temporarily suspended to meet the challenge of the Covid 19 pandemic. However all Covid 19 deaths from March, April, June have been reviewed against temporary criteria for SJR to identify appropriate cases and learn lessons in order to improve care for these patients. SJR sessions to review cases that meet the below criteria were established. All Covid19 mortality data has been and is continuing to be reviewed for overarching themes. In addition Covid 19 analysis and reporting is being provided for the Trust by Dr Foster

- Black or minority ethnic group
- Mental health condition
- Learning disability
- Frailty score <5
- Nosocomial infection

The recovery plan is in place and full Learning from deaths triaging is completed for April, and for the majority of May and June cases. A higher proportion of patients than usual are being reviewed due to the extra criteria in place. Additional sessions are being put in place to work through the additional SJR cases which need review and a secondment band 6 is due to start within the next few weeks and plans for a temporary/seconded band 5 for mortality are underway to fill gaps in the team and assist with the mortality workload

SJRs completed/awaited

Month	Number of Adult, IP Deaths	Number of SJRs required	Number of SJRs undertaken (by month)	% of deaths subjected to SJR	Number of NCEPOD reviews undertaken	% of deaths subjected to NCEPOD	% of deaths subjected to mortality review	Referred to SCIG	Declared SI?
Apr	238	49	11	22%	113	47%	**52%**	0	0
May	215	30	16	53%	109	51%	**58%**	0	0
Jun	119	15-TBC	12	80%	33	28%	**38%**	0	0
TOTAL	**572**	**94**	**39*** 2 x March deaths	41%	**255**	46%	**51%**	**0**	**0**

SJR's awaited	Number of deaths in scope	Number of deaths requiring SJR	Number of completed SJRs (for month of death)	Number of awaited SJRs
Apr-19	238	49	30	19
May-19	215	30	7	23
Jun-19	119	15	0	15
	TOTAL NUMBER OF SJRs AWAITED			57

Reviews by Methodology and by Special Focus Group

NCEPOD REVIEWS			
	HH	PCH	TOTAL
Apr	39	74	113
May	49	60	109
Jun	13	20	33
TOTAL	101	154	**255**

SJR'S carried out by site			
	HH	PCH	TOTAL
Apr	0	11	11
May	6	10	16
Jun	10	2	12
TOTAL	16	23	**39**

Death by patient group/Type- includes Trust Covid 19 review criteria		
	QTR	YTD
LD	2	2
MH	7	7
REPATS	0	0
ELECTIVE	0	0
CONCERNS	1	1
BAEM	10	10
Frailty <5	8	8
Nosocomial infection (probably/definite)	15	15
TOTAL* note there are patients within multiple groups	43	43

Analysis of deaths, triages & reviews

51% of all inpatient deaths YTD have been subjected to either an NCEPOD or an SJR review

74% of the reviews undertaken identified a "Good" or "Excellent" standard of care (against 47% Q4 2019/20)

Of the deaths reviewed, there were no cases which have identified care "more likely than not" to have caused or contributed to the patient's death

The Overall Assessment score determines what action is taken following the SJR. Since 1 April 2020, 5 SJR cases have determined that the overall quality of care provided to the patient was Poor or Very Poor. The reviewers were asked whether the care caused or contributed to the patient's death. For these 5 cases the reviewers did not feel this was the case and the cases were not referred to the Serious Clinical Incident Group (SCIG), with local learning being sought instead. Lessons learnt were discussed at the Trustwide Education event on teams and shared with the teams providing care to patients.

The Learning Disabilities mortality review programme (LeDeR) – This programme went live from 1 May 2017.

Four patients with an LD died in Q1 and SJRs of two patients identified that they received a good standard of care (4), two reviews are awaited

SJR outcome by phase of care

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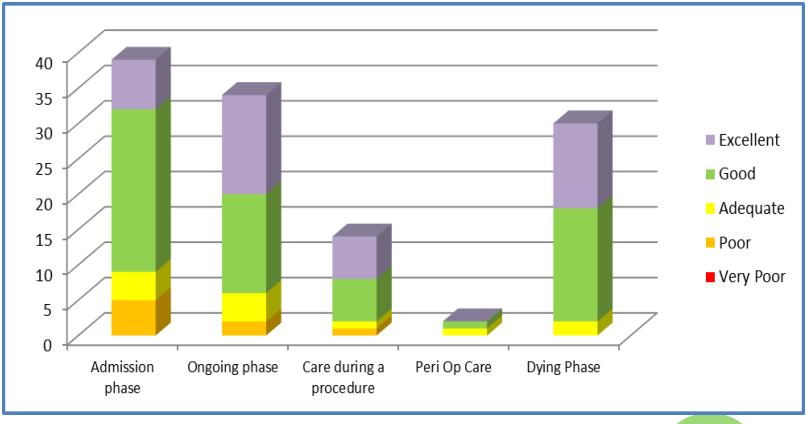
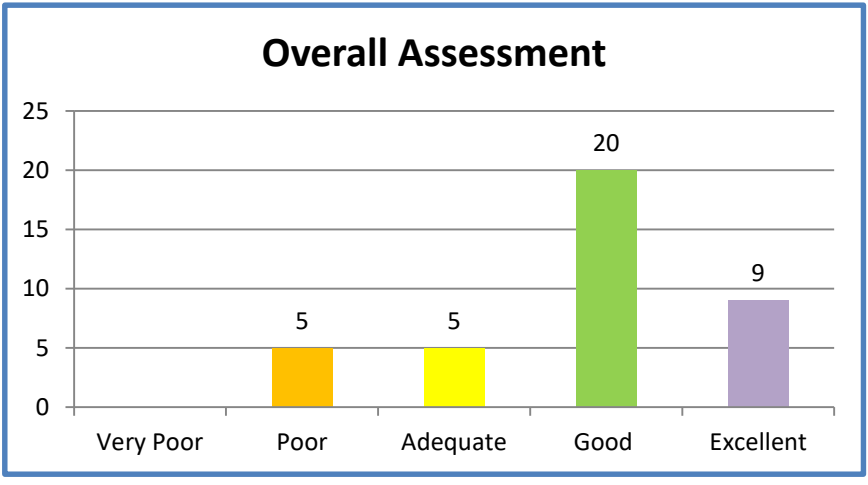
39 Structured Judgement Reviews have been carried out in 16 sessions across the Trust.



SJR outcome by Overall care score



Lessons from care that didn't go so well

Themes have been discussed at the Trustwide Educational event on Teams and with the clinicians providing care

- Some PTWR's failed to document severity of patients condition and plan for this. There often isn't the opportunity to review the patient again after the PTWR as the Covid 19 patient can deteriorate quickly and die before this happens. Relevant information to make a decision about management of the patient should be acted on at the outset
- Reviewers queried whether more frequent senior reviews are needed for Covid19 cases as the patients are dying more quickly
- Overall reduction in Sepsis screening noted and Sepsis team aware
- Lack of use of external interpreters, a paragraph to be added to the communications bulletin to state interpreters are still available
- Poor documentation of escalation/de escalating
- Patient with Autism transferred to and then from A4, for a patient with Autism any change can be distressing and this patient was moved to two new environments which also increased infection risk
- A chest X-ray wasn't done until after the PTWR. It should have been done before the patient goes to the ward due to the delay, disturbance of another move for an elderly patient and the infection risk.
- Lack of recognition of the deteriorating patient
- In a case of sudden deterioration there were very few notes, reviewers felt an event such as PE may have occurred
- Lack of involvement of the palliative care team where necessary– for example one patient became more hypoxic and was in the dying phase but this wasn't done. The fact that the team were struggling with the patients management should have triggered palliative care team review to help make the patient comfortable.

Lessons from care that did go well

Feedback including letters from the Deputy Medical Director are sent to staff where exceptional care is identified

- Prompt Sepsis screening for those that received this
- Detailed PTWR was completed within the first 14 hours and ReSPECT forms also completed at this time
- Clear documentation of the plan for the patient
- Consultant input throughout, avoiding any confusion
- LD nurse involvement
- Good conversations with families about patients condition
- Good involvement of the family in decisions regarding patient care and documentation of this including discussions about withdrawal of treatment.
- Evidence of Amber care plan progressing to PCP where required
- Evidence in the case notes of two/three consultants involved in decisions to step down care
- Plan for withdrawal of treatment made the night before which was excellent
- Appropriate Palliative team involvement
- In one case the Doctor facilitated husband to see dying patient who was on the same ward