North West Anglia
NHS Foundation Trust

Learning from Deaths report

January to March 2021 – Quarter Four

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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.

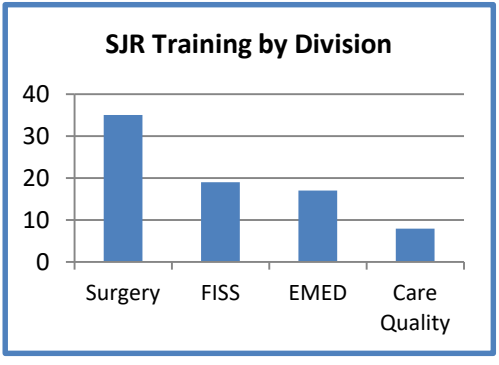
Structured Judgement Review Training

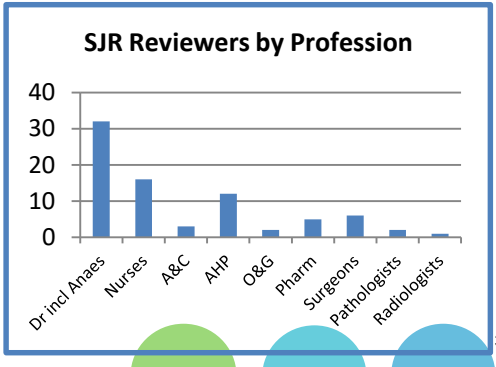
The Trust has six Tier One trainers, consisting of four clinicians and two non-clinicians.

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.

Online training will begin rolling out in May 2021.





Covid 19 Mortality Reviews – Learning from Deaths

The Learning from Deaths programme for non-Covid-19 deaths was resumed in Q3.

A total of 49 Covid-19 deaths from March 2020 to September 2020 were reviewed against temporary criteria to identify appropriate cases which yielded lessons learned and improved care for these patients.

A Root Cause Analysis of all Covid-19 deaths (where Covid-19 is listed on the death certificate) is carried out by the Infection Prevention & Control Team.

A Task & Finish Group has been set up to undertake case note reviews (using the SJR methodology and resources) of all nosocomial Covid-19 cases between February to May 2021. This is following newly published guidance from NHS England and NHS Improvement (NHSEI) outlining a minimum response to reporting, reviewing and investigating hospital onset Covid 19 and Covid 19 deaths.

SJRs completed/awaited

Month	Number of Adult, IP Deaths	Number of SJRs required	Number of SJRs undertaken (by month)*	Number of NCEPOD reviews undertaken	% of deaths subjected to NCEPOD	% of deaths subjected to mortality review	Referred to SCIG	Declared SI?
Jan	303	18	13	68	22%	27%	0	N/A
Feb	228	9	12	53	23%	29%	1	No
Mar	180	5	13	8	4%	12%	1	No
TOTAL	**708**	**32**	**38**	**129**	**18%**	**24%**	**2**	No

SJR's YTD	Number of deaths requiring SJR	Number of completed SJRs	Number of awaited SJRs	Awaited Covid-19 cases	Awaited ME referred cases
April 2020 – March 2021	161	128	41	0	15**
	TOTAL NUMBER OF SJRs AWAITED		**41**		

Mandatory SJRs against national framework criteria only, excluding Covid-19 deaths which are subjected to an RCA by the IPCT

*SJRs undertaken by month irrespective of month patient died.

** Figure is included in total number of SJRs awaited

Reviews by Methodology and by Special Focus Group

NCEPOD REVIEWS			
	HH	**PCH**	**TOTAL**
Jan	41	27	68
Feb	29	24	53
March	8	0	8
TOTAL	**78**	**51**	**129**

SJR's BY SITE			
	HH	**PCH**	**TOTAL**
Jan	5	8	13
Feb	8	4	12
March	7	6	13
TOTAL	**20**	**18**	**38**

Death by patient group/Type			
		QTR	**YTD**
SJR criteria	LD	8	20
	MH	14	35
	REPATS	2	7
	ELECTIVE	3	4
	OTHER CONCERNS	0	1
	CLINICIAN CONCERN	2	9
	COMPLAINT	2	2
	ME REFERRALS	7	11
Additional Covid-19 Criteria	BAME	0	10
	FRAILTY <5	0	8
	NOSOCOMIAL INFECTION	0	21
	TOTAL* note there are patients within multiple groups	**38**	**128**

Analysis of deaths, triages & reviews

41% of all inpatient deaths YTD have been subjected to either an NCEPOD or an SJR review

65% of the SJRs undertaken YTD identified a "Good" or "Excellent" standard of care

The Overall Assessment score determines what action is taken following the SJR. Since 1 April 2020, **26** SJR cases have been determined to have an overall quality of care provided to the patient ranked as "Poor" or "Very Poor". The reviewers were asked whether the care caused or contributed to the patient's death. Of these **26** cases, the reviewers felt that it did in **8** cases and the cases were referred to the Serious Clinical Incident Group (SCIG) with **3** being declared as Serious Incidents (SIs). Lessons learnt were discussed at the Trust-wide Education event on Teams and shared with the teams providing care to patients.

The Learning Disabilities mortality review programme (LeDeR)

8 patients with an LD had SJRs in Q4. Of these 8 patients, **2** received an "Excellent" standard of care, **5** were "Good" and **1** was "Poor". The reviewers identified delays in services offered/given. It was not considered necessary to refer this case to SCIG. Learning points will be fed back to the Division.

SJR outcome by phase of care

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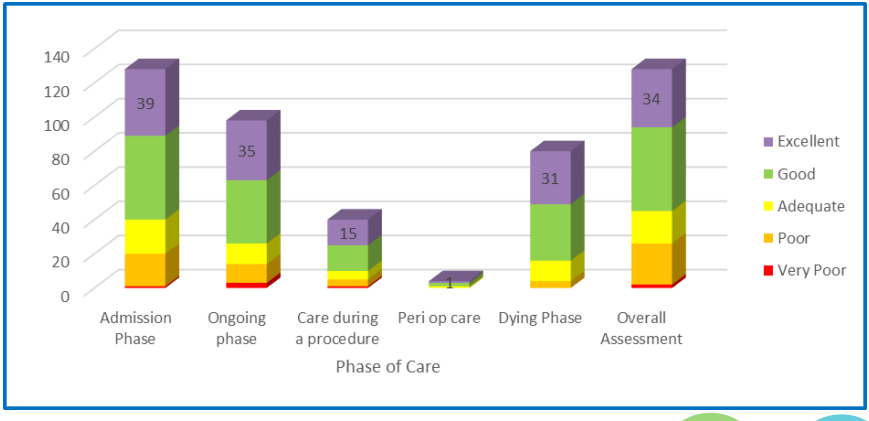
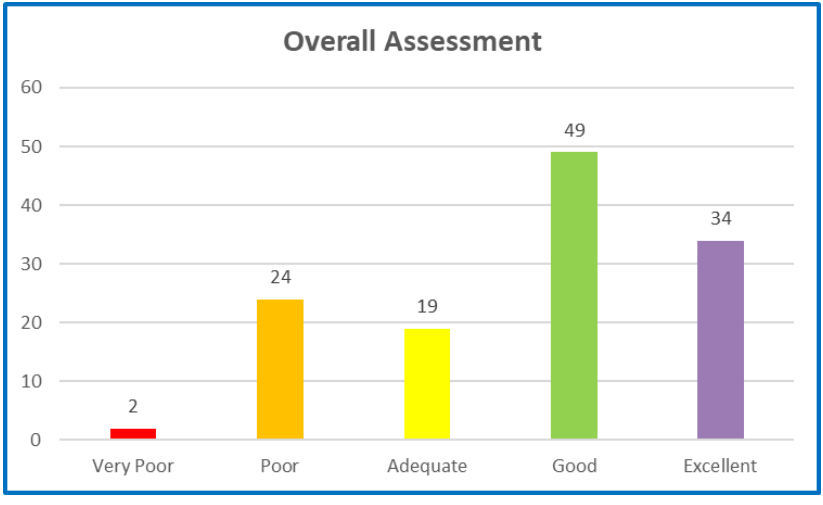
128 Structured Judgement Reviews have been carried out in **43** sessions across the Trust.



SJR Outcome by Overall Care Score



Issues in care that didn't go so well

- Poor communication with family/carers
- Tests/investigations results not acted on
- Amber Care not completed
- Delay in services offered/given
- Lack of nutritional support for patient
- Parkinsons medications not given
- Lack of nursing assessments
- Lack of specialist dementia or MH support/advocacy
- Incorrect tube insertion (ryles instead of NG, meaning patient could not receive enteral feeding)
- Medications weren't given based on the correct dx & ACS protocol not followed after abnormal ECG.

Specific areas for learning have been fed back divisionally to the relevant teams .

Highlighted from care that did go well

- Recognition of EOL patient
- Good documentation
- Good clinical decision making & rationale
- MDT approach to care
- Holistic care
- ReSPECT form completed
- Ceiling of care established
- Comprehensive care plan
- Regular senior review
- Good family/NOK involvement/communication
- Appropriate reviews and investigations
- Prompt and decisive action from post-op team
- Involvement of all relevant specialties
- Good communication with NOK despite language barrier & well-defined ceiling of care established
- Quick decisions/actions to escalate as needed.

Feedback including letters from the Deputy Medical Director are sent to staff where excellent standards of care are identified. - **15 letters in Q4**