Agenda Item 3.ii Appendix 2

Report to:	**Quality and Risk Committee**	**Date: 23rd May 2019**
Report from:	**Dr Stephen Webb**	
Principal Objective/ Strategy and Title:	**Learning from Deaths 18/19 Annual Report**	
For:	**Information**	

LEARNING FROM DEATHS

In March 2017, the National Quality Board (NQB) published *National Guidance on Learning from Deaths* which introduced new guidance for NHS providers on how they should learn from the deaths of patients in their care.

Implementation of *Learning from Deaths* at Royal Papworth Hospital

The *Learning from Deaths* framework placed a number of new requirements on trusts. Royal Papworth Hospital NHS Foundation Trust is committed to improving quality of care and to learning lessons from patients who die in hospital. The Trust has complied with the new requirements of the *Learning from Deaths* framework and retrospective case record reviews of patients who died at Royal Papworth Hospital commenced in April 2017.

Mortality Case Record Review Report 2018-19

From 1 April 2018 to 31 March 2019, 163 patients died in Royal Papworth Hospital. The table below sets out the total number of patients who died in 2018-19, the total number of deaths reviewed by retrospective case record review, the total number of deaths investigated by incident investigation and the total number of deaths considered more than 50% likely to have been potentially avoidable.

Royal Papworth Hospital : 2018-19 : Mortality Case Record Review Report	
Requirement for data collection & reporting	**Number (%)**
Total number of adult inpatient deaths	163
Total number of deaths reviewed by case record review	61 (37)
Total number of deaths investigated by incident investigation	5 (3.1)
Total number of deaths considered more than 50% likely to have been potentially avoidable	1 (0.6)

The tables below set out the number of patients who died in each quarter in 2018-19, the number of deaths reviewed by retrospective case record review, the number of deaths investigated by incident investigation and the number of deaths considered more than 50% likely to have been potentially avoidable.

Royal Papworth Hospital : Quarter 1 2018-19 (Apr-Jun 2018) : Mortality Case Record Review Report	
Requirement for data collection & reporting	**Number (%)**
Number of adult inpatient deaths	40
Number of deaths reviewed by case record review	4 (10)
Number of deaths investigated by incident investigation	0
Number of deaths considered more than 50% likely to have been potentially avoidable	0

Royal Papworth Hospital : Quarter 2 2018-19 (Jul-Sep 2018) : Mortality Case Record Review Report	
Requirement for data collection & reporting	**Number (%)**
Number of adult inpatient deaths	28
Number of deaths reviewed by case record review	10 (36)
Number of deaths investigated by incident investigation	1 (3.6)
Number of deaths considered more than 50% likely to have been potentially avoidable	0

Royal Papworth Hospital : Quarter 3 2018-19 (Oct-Dec 2019) : Mortality Case Record Review Report	
Requirement for data collection & reporting	**Number (%)**
Number of adult inpatient deaths	44
Number of deaths reviewed by case record review	26 (59)
Number of deaths investigated by incident investigation	2 (4.5)
Number of deaths considered more than 50% likely to have been potentially avoidable	1 (2.3)

Royal Papworth Hospital : Quarter 4 2018-19 (Jan-Mar 2019) : Mortality Case Record Review Report

Requirement for data collection & reporting	Number (%)
Number of adult inpatient deaths	51
Number of deaths reviewed by case record review	21 (41)
Number of deaths investigated by incident investigation	2 (3.9)
Number of deaths considered more than 50% likely to have been potentially avoidable	0

Mortality Case Record Review process

- The Royal College of Physicians' *Structured Judgement Review* methodology has been adopted as the agreed method for all case record reviews at Royal Papworth Hospital.

- Responsibility for case record reviews lies with the Clinical Directors, Clinical Leads and Mortality & Morbidity Leads overseen by the Clinical Governance Manager and Associate Medical Director.
- The case record review process sits alongside existing clinical governance processes including Serious Incident investigations and Mortality & Morbidity meeting case discussions. If a patient's death is considered *more than 50% likely to have been potentially avoidable* following case record review, this is reported as a patient safety incident triggering an investigation process. The local procedure is set out in DN682 *Mortality Case Record Review Procedure.*

- Analysis of number of deaths by Clinical Directorate shows that most deaths in Royal Papworth Hospital occur in Cardiology and Surgery, with smaller numbers in Transplant, Thoracic Medicine and Respiratory ECMO.

Lessons learnt & Actions taken in 2018-19

- *Lesson learnt*: Following the introduction of the case record review process in April 2017 the Trust sought to review all inpatient deaths by case record review.
- *Action taken*: In 2018-19 a more selective approach for case record reviews has been taken based on criteria recommended by the Independent Advisory Group to Royal College of Physicians' *National Mortality Case Record Review Programme.*

- *Lesson learnt:* The need to record and discuss deaths on a regular basis was identified as well as linking deaths to case record reviews and incident investigations
- *Action taken*: In 2018-19 the Serious Incident Executive Review Panel (SIERP) was set up to meet weekly to discuss deaths in the previous week and link to case record reviews and incident investigations. The Clinical Audit team and Patient Advice & Liaison Service team jointly administer the case record review database and ensure that all patient details are recorded on a weekly basis.

- *Lesson learnt*: Following the introduction of the electronic health record in June 2017, some difficulties had been experienced in conducting case record reviews. A range of different sources currently need to be accessed to perform a case record review (Current Admission Folder, Lorenzo, Electronic Medical Record, Metavision) and it can be difficult to make clear judgements on the quality of care.

- *Action taken*: In 2018-19 there have been improvements in access to the Current Admission Folder and there is ongoing work to ensure that Lorenzo clinical records are saved and uploaded contemporaneously.

- *Lesson learnt*: The introduction of the case record review process has acted as an additional safety net to identify patient safety concerns in the Trust. It is important not to miss any patient safety concerns which have not been identified through the incident reporting system.
- *Action taken*: In 2018-19 the case record review process did not revealed any patient safety concerns which had not already been reported as an incident indicating a strong patient safety reporting culture in the Trust.

- *Lesson learnt*: Post-mortem reports may needed to make a full judgement of the quality of care in patients who have died. The post-mortem reports for deaths which are referred to the Coroner and proceed to Coroner's investigation or inquest may be difficult to access.
- *Action taken*: In 2018-19 agreement with HM Coroner for Cambridgeshire and Peterborough has been reached for post-mortem reports to be released earlier to the Trust when case record reviews or incident investigations are being conducted.

- *Lesson learnt*: In addition to the case record review process deaths are also discussed at specialty Mortality & Morbidity meetings. The need to improve the standard of Mortality & morbidity meetings has been identified to ensure cases are discussed openly in a multidisciplinary forum, lessons are learnt and actions are taken.
- *Action taken*: In 2018-19 specialty Mortality & Morbidity meetings the quality of case discussions has been improved through the additional collective judgement of the overall quality of care using the NCEPOD grading tool.

- Lesson Learnt: In 2018-19 one patient's death was considered more than 50% likely to have been potentially avoidable. This case was identified and investigated through the Serious Incident investigation. Lessons learnt included the need to clearly assess and communicate the introduction of new clinical equipment into a clinical area.
- Actions taken: New processes have been set up for the risk assessment of new clinical equipment, appropriate training, correct storage and labelling and communication to clinical teams.

Impact & Developments in 2019-20

- Local training updates will be arranged for all case record reviewers in the *Structured Judgement Review* methodology
- A business case is being developed for funding to implement a system for case record reviews which links with the current *Datix Incident Reporting & Risk Management System*.
- The regional *East of England Learning from Deaths Forum* (chaired by the Associate Medical Director) which is supported by the supported by Eastern Academic Health Science Network and NHS Improvement will continue to meet providing a network to learn and share practice from other organisations in the region.
- Appointment of a Medical Examiner for Royal Papworth will support the *Learning from Deaths* agenda and the case record review process and incident investigation process by providing an initial rapid assessment of all deaths to identify patient safety concerns with staff and relatives.