Item 3.iii Appendix 1

Report to:	**Quality and Risk Committee**	**Date: 25 June 2020**
Report from:	**Dr Stephen Webb, Deputy Medical Director**	
Principal Objective/ Strategy and Title:	**Learning from Deaths 2019-20 Annual Report**	
For:	**Information**	

Learning from Deaths framework

In 2017, the National Quality Board 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. The *Learning from Deaths* framework placed a number of new requirements on Trusts. The Trust complied with the new requirements of the *Learning from Deaths* framework and retrospective case record reviews of patients who died in hospital commenced in Q1 2017.

Medical Examiner service

Subsequently the Medical Examiner service at Royal Papworth commenced in Q2 2019 providing an additional level of scrutiny for all inpatient deaths. The Medical Examiner provides a rapid review of all inpatient deaths in discussion with the attending doctors and relatives of the deceased to ensure the accuracy and consistency of the content of death certificates and that appropriate referrals are made to the Coroner's Service.

Comprehensive review of inpatient deaths

There are now several processes which work in parallel to comprehensively review all deaths in Royal Papworth to identify issues and improve quality and safety for patients. These processes include:

- Medical Examiner Scrutiny Review
- Retrospective Case Record Review
- Morbidity & Mortality Meeting case discussion
- Serious Incident Investigation

Learning from Deaths Report 2019-20

From 1 April 2019 to 31 March 2020, 167 patients died in Royal Papworth Hospital. The following table sets out the number of deaths reviewed by Medical Examiner Scrutiny Review, Retrospective Case Record Review, Morbidity & Mortality Meeting case discussion and Serious Incident investigation. The table also includes the number of deaths considered 'more than 50% likely to have been potentially avoidable' as required by the Learning from Deaths framework.

Royal Papworth Hospital: Learning from Deaths Annual Report - 2019-20

Requirement for data collection & reporting	Number (%)
Total number of adult inpatient deaths	167
Total number of deaths reviewed by Medical Examiner Scrutiny Review	91
Total number of deaths reviewed by Retrospective Case Record Review	46
Total number of deaths discussed at M&M meetings	149 (89)
Total number of deaths investigated by Serious Incident investigation	3 (1.8)
Total number of deaths considered more than 50% likely to have been potentially avoidable	0

The tables below set out the number of patients who died in each quarter in 2019-20, 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: Learning from Deaths Quarterly Report - Q1 2019-20	
Requirement for data collection & reporting	**Number (%)**
Total number of adult inpatient deaths	37
Total number of deaths reviewed by Medical Examiner Scrutiny Review	0
Total number of deaths reviewed by Retrospective Case Record Review	21
Total number of deaths discussed at M&M meetings	33 (89)
Total number of deaths investigated by Serious Incident investigation	0
Total number of deaths considered more than 50% likely to have been potentially avoidable	0

Royal Papworth Hospital: Learning from Deaths Quarterly Report - Q2 2019-20	
Requirement for data collection & reporting	**Number (%)**
Total number of adult inpatient deaths	46
Total number of deaths reviewed by Medical Examiner Scrutiny Review	25 (54)
Total number of deaths reviewed by Retrospective Case Record Review	4

Royal Papworth Hospital: Learning from Deaths Quarterly Report - Q2 2019-20	
Total number of deaths discussed at M&M meetings	43 (93)
Total number of deaths investigated by Serious Incident investigation	1
Total number of deaths considered more than 50% likely to have been potentially avoidable	0

Royal Papworth Hospital: Learning from Deaths Quarterly Report - Q3 2019-20	
Requirement for data collection & reporting	**Number (%)**
Total number of adult inpatient deaths	47
Total number of deaths reviewed by Medical Examiner Scrutiny Review	40 (85)
Total number of deaths reviewed by Retrospective Case Record Review	3
Total number of deaths discussed at M&M meetings	40 (85)
Total number of deaths investigated by Serious Incident investigation	0
Total number of deaths considered more than 50% likely to have been potentially avoidable	0

Royal Papworth Hospital: Learning from Deaths Quarterly Report - Q4 2019-20	
Requirement for data collection & reporting	**Number (%)**
Total number of adult inpatient deaths	37
Total number of deaths reviewed by Medical Examiner Scrutiny Review *	26 (70) *
Total number of deaths reviewed by Retrospective Case Record Review	18
Total number of deaths discussed at M&M meetings	33 (89)
Total number of deaths investigated by Serious Incident investigation	2
Total number of deaths considered more than 50% likely to have been potentially avoidable	0

* The Medical Examiner Service was paused during Q4 due to redeployment of the Medical Examiner in response to COVID-19, to the East of England NHS England Critical Care Cell.

Lessons Learnt & Actions Taken in 2019-20

- *Lesson learnt from Medical Examiner Service*:

  - In 2019-20 the introduction of the Medical Examiner service has provided additional scrutiny for all inpatient deaths and allowed a more selective approach for case record reviews following criteria recommended by the Independent Advisory Group to Royal College of Physicians' *National Mortality Case Record Review Programme.*
  - The Medical Examiner service has provided additional support for bereaved families and has indentified operational difficulties with the Bereavement Service provided for Royal Papworth by a neighbouring organisation. The Bereavement Service has been reviewed with a plan to deliver the service directly by Royal Papworth.

  - The Serious Incident Executive Review Panel set up in 2018 has continued to meet weekly in 2019-20 to discuss deaths in the previous week and now links to ME scrutiny reviews as well as case record reviews and incident investigations.

- *Lesson learnt from Retrospective Care Record Reviews:*

  - The Clinical Audit team and Patient Advice & Liaison Service team jointly administer the mortality database and ensure that all patient details are recorded on a weekly basis. Some technical issues have been encountered using the spreadsheet leading the risk of data loss and the need for a comprehensive digital platform has been identified. A review of all mortality processes supported by the Business Intelligence team will help improve data collection and analysis.

  - The introduction of the Retrospective Case Record Review process has acted as an additional safety net to identify patient safety concerns in the Trust. In 2019-20 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 from Mortality & Morbidity Meetings*:

  - In 2019-20 case discussions at Mortality & Morbidity meetings have improved through the additional collective judgement of the overall quality of care using the NCEPOD grading tool in Surgery, Cardiology, Critical Care and ECMO M&M meetings.

  - Patients who die deaths after transfer from Royal Papworth to another hospital are not easily captured using our existing processes. We will work with other organisations in the region to improve our ability to learn lessons from patients who die in other hospitals.

- *Lesson Learnt from Serious Incident Investigations:*

  Q2 - SUI-WEB30910
  This SI was in relation to audible alarm settings from the central cardiac monitoring system to alert staff of a patient's cardiac rhythm change. The investigation concluded that appropriate resuscitation was provided promptly on the ward by the attending medical and nursing staff. Actions taken were in relation to alarm settings and clinical training in appropriate alarm setting subject to specific patient need.

Q4 - SUI-WEB32645
This SI was in relation to an increase in Mycobacterium abscessus infections exploring the likely source of the outbreak. Changes in infection control practice and engineering solutions have been introduced to protect subsequent patients from the risk of infection. One patient experienced a rare complication from treatment of the infection and died. This case is subject to a Coroner's inquest.

Q4 - SUI-WEB34717
A patient suffered an unexpected deterioration and a witnessed cardiac arrest on the ward needing emergency re-sternotomy on the ward due to suspected cardiac tamponade and immediate transfer to the operating theatre. The SI is currently investigating the circumstances leading up to cardiac arrest. This case is also subject to a Coroner's inquest.