NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(18)053

DATE OF MEETING	**27 February 2018**
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	**Dr Kate Wood, Acting Medical Director**
CONTACT OFFICER	**Jeremy Daws, Head of Quality Assurance**
SUBJECT	**Quarterly Learning from Deaths Progress Report**
BACKGROUND DOCUMENT (IF ANY)	**Monthly Mortality Report**
PURPOSE OF THE PAPER:	**For Assurance**
EXECUTIVE SUMMARY **(PLEASE INCLUDE A BRIEF SUMMARY OF THE PAPER, KEY POINTS & ANY RISK ISSUES AND MITIGATING ACTIONS WHERE APPROPRIATE)**	**The paper outlines an update with the following:** **1. Case review process performance & key issues** **A new process for delivery case notes to enable mortality reviews to take place timely and more efficiently has started during January 2018, agreed with the mortality clinical lead. More work is needed to embed this process alongside greater communication with clinicians from other specialties and across the Trust – the focus to date has been medicine at DPoW.** **This will form a large part of the Mortality Improvement Oversight Group's agenda, and this meeting will be rescheduled as soon as possible following the need to cancel during February as a result of OPEL 4 pressures.** **2. Key themes / lessons emerging** **Key lessons are emerging both from ward based M&M meetings and received completed mortality reviews. Key themes are:** • **Fluid balance not well documented** • **Implementation of end of life care not considered / delayed** • **Hospital admission could have been avoided / death in hospital was the wrong location for the patient** • **Monitoring and escalation could have been sooner.** **3. Learning from deaths dashboard** **Included is the most recent dashboard providing at a glance details of total deaths, and the numbers reviewed by clinicians to date.** **The Trust continues to participate in LEDER (mortality reviews for those patients with LD), however, this is a joint exercise with local partners and due to methodological challenges with this process, no cases have yet been reviewed. Some narrative to accurately explain current participation in LEDER will be agreed with the lead nurse and this will be added to this section of the dashboard.**
HAVE STAFF SIDE BEEN CONSULTED ON THE PROPOSALS?	**NOT APPLICABLE**
HAVE THE RELEVANT SERVICE USERS/CARERS BEEN CONSULTED ON THE PROPOSALS?	**NOT APPLICABLE**
ARE THERE ANY FINANCIAL CONSEQUENCES ARISING FROM THE RECOMMENDATIONS?	**NO**
IF YES, HAVE THESE BEEN AGREED WITH THE RELEVANT BUDGET HOLDER AND DIRECTOR OF FINANCE, AND HAVE ANY FUNDING ISSUES BEEN RESOLVED?	**NOT APPLICABLE**

ARE THERE ANY LEGAL IMPLICATIONS ARISING FROM THIS PAPER THAT THE BOARD NEED TO BE MADE AWARE OF?	**NO**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO THE NHS CONSTITUTION IN ANY DECISIONS OR ACTIONS PROPOSED?	**NOT APPLICABLE**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO SUSTAINABILITY IMPLICATIONS (QUALITY & FINANCIAL) & CLIMATE CHANGE?	**NOT APPLICABLE**
THE PROPOSALS OR ARRANGEMNTS OUTLINED IN THIS PAPER SUPPORT THE ACHIEVEMENT OF THE TRUST OBJECTIVE(S)	**YES – LINKS TO QUALITY & SAFETY**
THE PROPOSAL OR ARRANGEMENTS OUTLINED IN THIS PAPER ENSURE COMPLIANCE WITH THE REGULATORY OR GOVERNANCE REQUIREMENTS LISTED	**NOT APPLICABLE**
THE PROPOSALS OR ARRAGEMENTS OUTLINED IN THIS PAPER TAKE ACCOUNT OF REQUIREMENTS IN RESPECT OF EQUALITY & DIVERSITY	**NOT APPLICABLE**
ACTION REQUIRED BY THE BOARD	**The Board is asked to note the contents for assurance purposes.**

Medical Director's Office

Northern Lincolnshire and Goole NHS Foundation Trust

Quarterly Learning from Deaths Progress Report

Key points to update on:

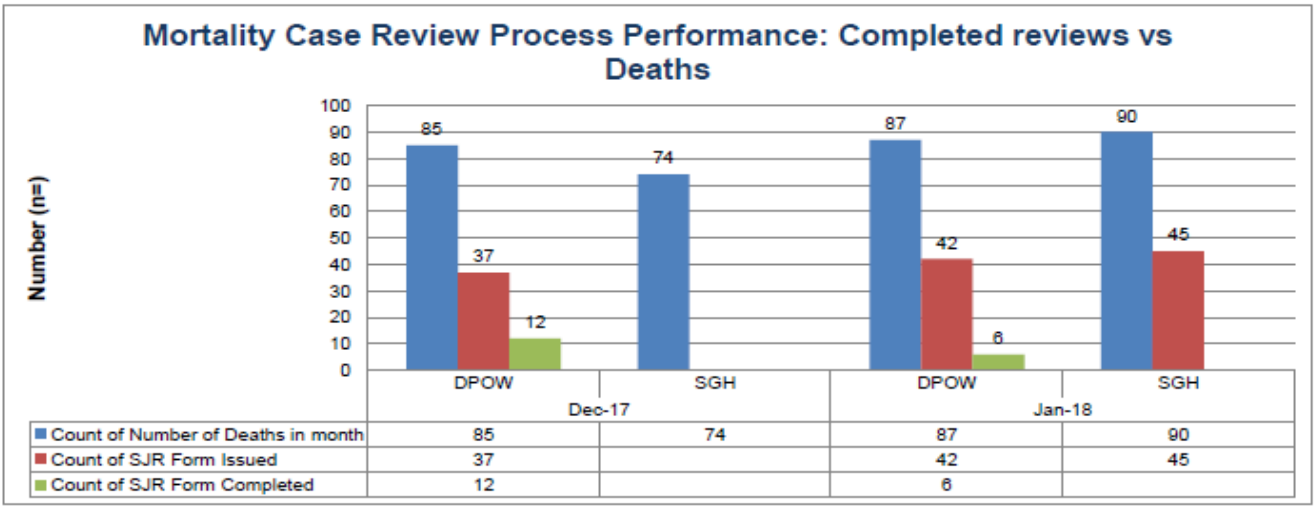
1. Case Review Process Performance & Key Issues
2. Key themes / lessons emerging
3. Learning from deaths dashboard

1. Case Review Process Performance & Key Issues

The Trust has appointed a mortality clinical lead. Dr Kamath has now taken up this post. Working with Dr Kamath and Dr Menon, on the DPoW site, the process for delivering case notes for review by clinicians has been changed in an attempt for reviews to be done in the same month as the death, ensuring the team involved in the care of the patient can review the care quality in as timely and as efficient manner as possible. Communication of this process has predominantly been focussed on the DPoW site, within the Medical Specialty. This is good as this is the area of focus for the Trust, but wider communication is now needed across the Trust/other specialties to ensure colleagues are aware of this process and action needed to support.

This is one of the main items on the Mortality Improvement Oversight Meeting's agenda. The first meeting was to be held on the 15 February but had to be cancelled due to OPEL 4 pressures.

To date, the following chart demonstrates progress with the new process of delivery of case notes to clinicians from the beginning of January 2018.



	Dec-17 DPOW	Dec-17 SGH	Jan-18 DPOW	Jan-18 SGH
Count of Number of Deaths in month	85	74	87	90
Count of SJR Form Issued	37		42	45
Count of SJR Form Completed	12		6	

Key Recommendations for the Mortality Oversight Group regarding the process are as follows:

- Greater communication across the Trust/specialities of the process
- Agree the proportion/target being aimed for regarding numbers of deaths to be reviewed
- Strengthening of sample identification to ensure it includes groups recommended by the National Quality Board paper
- Assurance that ward based M&M meetings are taking place and ensure linkages between these and group governance arrangements are robust

2. Key themes / lessons emerging:

From ward based M&M Meetings:
During the month of January, 2 ward based M&M meetings have been attended by members of the central team. Both ran well and identified, for the whole team present, opportunities for learning, these included:

- Implementation / consideration of end of life pathways / care did not happen or was delayed
- Patient admission to hospital was not appropriate or that the death in hospital was not the right place for the patient
- Patients felt to be on the wrong specialty ward
- No copy of discharge letter or cause of death documentation
- Appropriateness of antibiotic duration challenged

Assurance is needed that the above model of ward based M&M meetings is happening and consistently across the Trust. Further work is needed to gain this assurance.

From completed structured judgement review forms:
Whilst the number of completed forms is still few in number, the following themes/lessons have emerged from the completed mortality reviews to date:

- **Positive:**
- Evidence that regular reviews have taken place
- Good documentation
- Clear diagnosis
- Clear plans in place

- **Improvement opportunities:**
- Poor fluid documentation (a work stream in the improvement plan)
- Lack of cohesion within teams
- Lack of documentation
- Poor palliative care links to external providers
- Poor monitoring, clinical review needed sooner

Further work is needed to ensure that these themes feed into the Trust's ongoing focus on learning lessons.

3. Learning from deaths dashboard:

In line with the National Quality Board's recommendations, the Trust have been publishing the following learning from deaths dashboard monthly, within the Board received monthly mortality report. Key points:

- The 'avoidable' death indicator has been included, but it should be noted that this indicator was designed to be used to support learning and improvement. Concerns have been raised by the RCP that this data could be used for performance purposes, a purpose that this data was not designed for. Work is ongoing to determine how other Trust's publish this information.
- The LEDER review process. Work is underway to include greater narrative regarding the process that the Trust is a part of in connection with LEDER and also to ensure that the data reported within this dashboard is the same as used operationally when identifying cases for review.

Northern Lincolnshire and Goole NHS Foundation Trust: Learning from Deaths Dashboard - December 2017-18

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities or patients from A & E)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
162	122	12	6	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
437	348	32	25	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1218	1647	112	167	1	-

Time Series: Start date 2016-17 Q1 End date 2017-18 Q4

Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	37	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	1.0%	This Year (YTD)	2	1.9%	This Year (YTD)	1	1.0%	This Year (YTD)	99	96.1%

Avoidable deaths data: This is an assessment of whether the death was felt to be avoidable or not, using a Likert-type 6 factor scale. This is the initial reviewer's assessment from the retrospective assessment of the medical record. Any case reviews completed that identify that further understanding is needed is reviewed a second time by another clinician. This process links into the Trust's Serious Incident Framework if necessary. It should be stressed that this data is not a reliable measure of deaths that were avoidable, rather it is designed as an indicator to support local review and learning processes with the aim of helping improve quality of care.

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	2	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	18	0	0	0	0

Time Series: Start date 2016-17 Q1 End date 2017-18 Q4