# Learning from Deaths – the National Picture

## 17 October 2018

Matt Fogarty
Deputy Director of Patient Safety (Policy and Strategy)

# What we do

NHS Improvement

**Increasing our understanding of what goes wrong in healthcare**

- NRLS
- Serious Incident Framework
- LFD

**Enhancing the capability and capacity of the NHS to improve safety**

- Patient Safety Alerts
- PS Collaboratives
- PS leadership

**Tackling major barriers to widespread safety improvement**

- PSIMS
- Maternity and neonatal collaborative
- AMR

etc

# Background

CQC published *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* in December 2016


In their review, CQC found that:

- Families and carers are not treated consistently well when someone they care about dies.
- There is variation and inconsistency in the way that trusts become aware of deaths in their care.
- Trusts are inconsistent in the approach they use to determine when to investigate deaths.
- The quality of investigations into deaths is variable and generally poor.
- No frameworks are available that require boards to keep deaths in their care under review and to share learning from these.

NHS Improvement

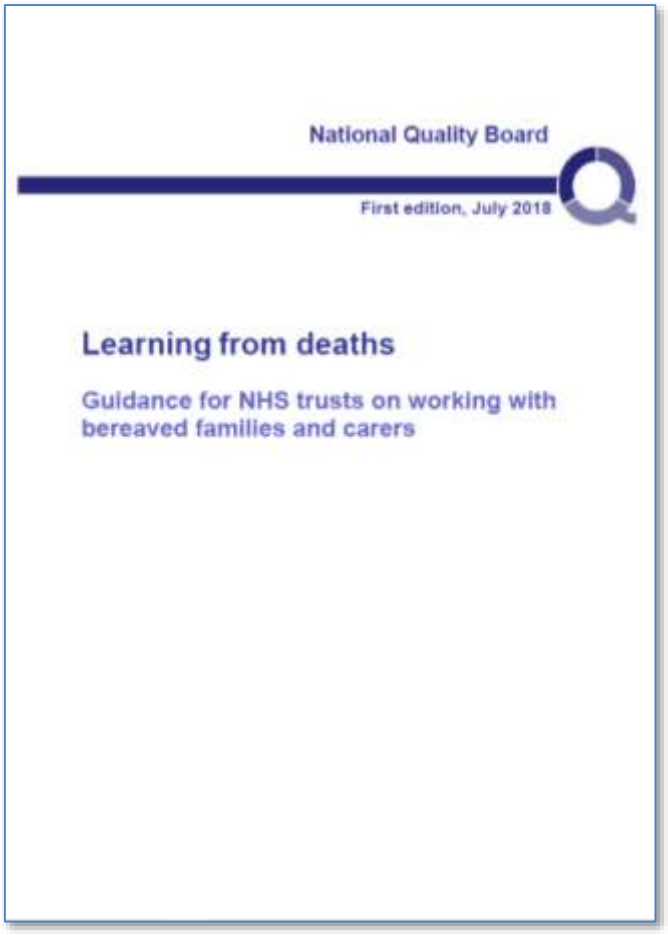
The Learning from Deaths Framework should not be viewed in isolation but as part of an overall direction of travel to:

- ✓Increase transparency
- ✓Provide candour
- ✓Involve people and their families in their care
- ✓Foster a culture of continuous learning and improvement
- ✓Strengthening leadership

# Key Messages

NHS Improvement

- ✓ Learning from Deaths is about providing clear and timely information to relatives/carers and allowing them to raise concerns



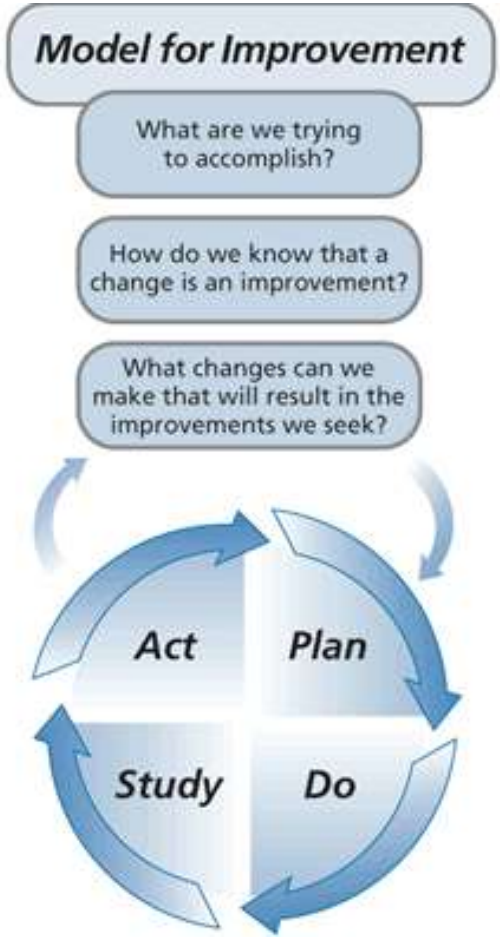

Published July 2018

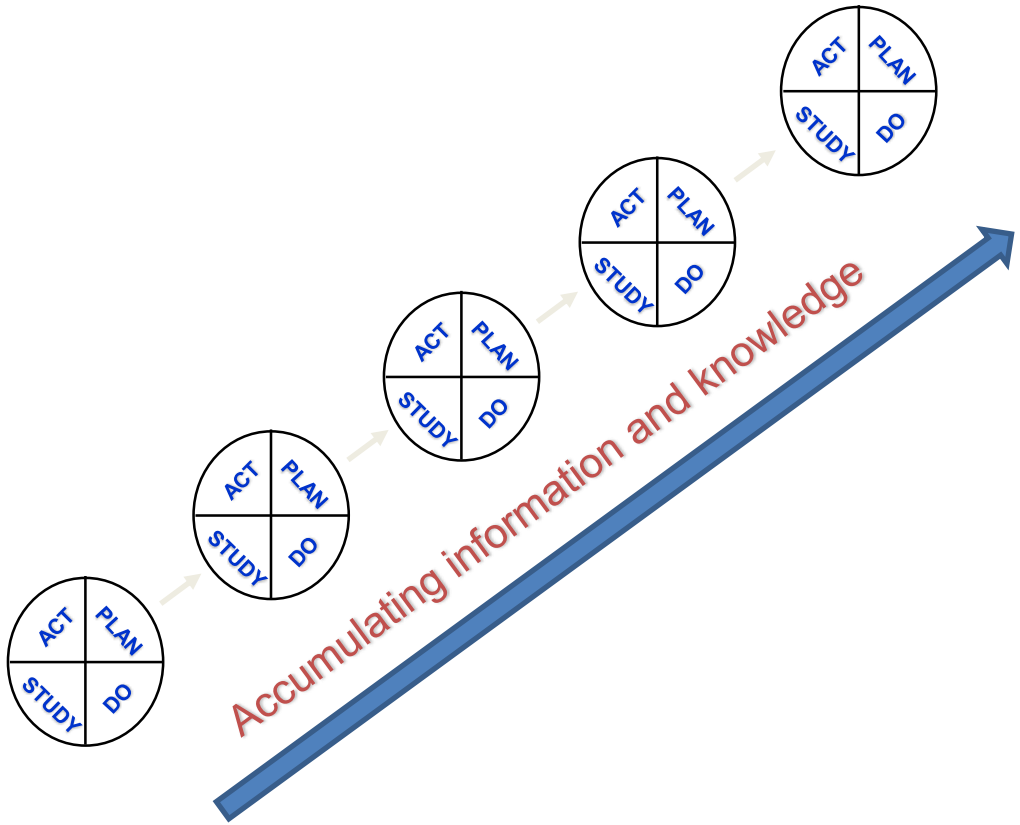
Co-produced with ~80 bereaved family members

# Key Messages

NHS Improvement

- ✓ Learning from Deaths is about undertaking effective, sustainable improvement



# Key Messages

- ✓ We use the term ‘deaths thought more likely than not to be due to problems in care’
- ✓ There is no standardised measure of ‘avoidable’ mortality at trust level.
- ✓ Case record reviews involve difficult judgements - the data is not comparable.
- ✓ Any publication that seeks to compare organisations on the basis of the number of deaths thought likely to be due to problems in care is actively misleading.

# Insight so far based on national analysis of Quality Accounts - qualitative

- 30 Quality Accounts analysed thematically
- Common clinical themes were;
  - Recognising end of life and providing good end of life care (half of QAs)
  - Detection of sepsis and recognition of deterioration
  - Fluid management
  - Suicide risk factors
  - Communication with MH patient families

- For EOLC specifically;
  - Early and documented discussion in relation to DNACPR.
  - Continuing family communication and discussing changes to their loved one's condition.
  - Avoiding unnecessary investigations
  - Improved pre-emptive prescribing.
  - Not moving patients between wards at the end of life
  - Unnecessary admission at the end of life because there was not a documented plan for their care in the community.
  - Delays in fast track discharge of patients at the end of life.

# Insight so far based on national analysis of Quality Accounts - qualitative

NHS Improvement

For sepsis and recognition of deterioration specifically

- Importance of early recognition and management of sepsis.
- Use of the sepsis 6 bundle
- Inconsistent recording of NEWS and the need to inducted agency staff
- Training records to include training staff had received in sepsis.
- Focused work on the management of sepsis in the emergency department.

For fluid and electrolyte management specifically

- Inadequate fluid replacement and balance.
- The importance of ward staff getting a second opinion on nutrition and fluid replacement.
- Identified need for guidance on prioritising certain electrolyte abnormalities over others.

# Insight so far based on national analysis of Quality Accounts - qualitative

NHS Improvement

For suicide risk assessment and documentation specifically;

- recognising suicidal risk factors and documenting these
- communicating with families and involving them in the development of care and safety plans

Generic (non-condition specific) themes

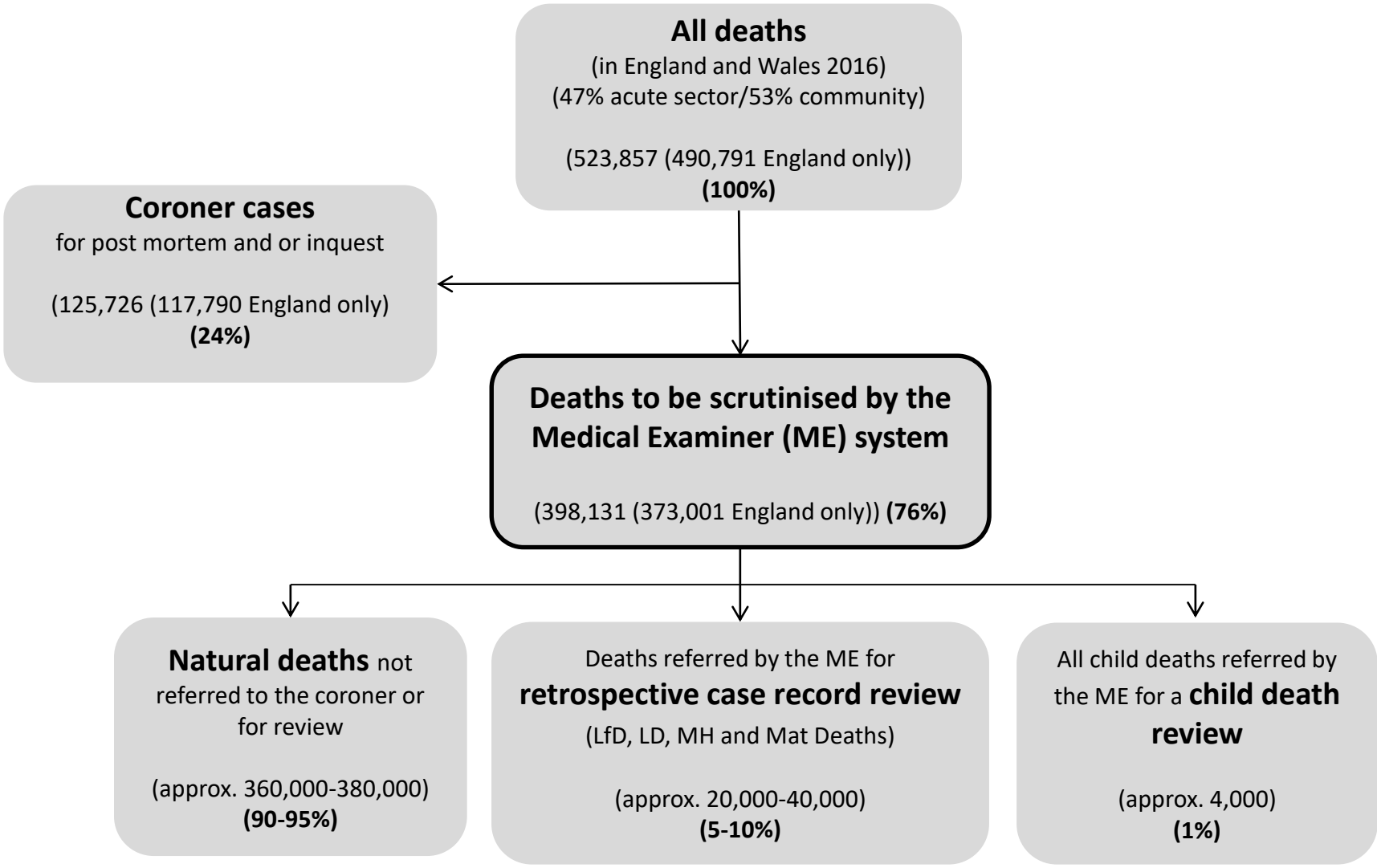
- discharge communication to GPs and community providers (including proper documentation, including in relation to patients with a mental health diagnosis)
- communication and joint working between providers where a patient is receiving care from both or all of them.
- Delays in discharge where a patient needs nursing care.
- Patients being moved around different wards in a hospital risking continuity and quality of care.

# Actions taken so far based on national analysis of Quality Accounts

NHS Improvement

| Type of action | Examples |
|---|---|
| Sharing what has been learned with others | Patient Safety and Learning from Deaths bulletins, targeting information about learning for particular groups of staff, presentation of a cases |
| Further information gathering | Doing case note reviews on all deaths involving a particular issue (e.g. biliary sepsis); carrying out a thematic review into an issue (e.g. how children's and adults' services communicate and share information); audit (e.g. on accuracy of fluid balance chart completion); surveys of families of patients. |
| Introducing new policies or adapting existing policies and procedures | One trust plans to make changes to its thrombopropylaxis policy; another trust is developing a LocSSIP for patients requiring a colonic stent. Another trust is developing a Standard Operating Procedure for care of patients in recovery following a gynaecological procedure. |
| Raising awareness | One. raising awareness and skills in communicating with patients and families at the end of life, ensuring staff aware of protocols prior to SACT (Systemic Anti-Cancer Therapy) administration. |
| Training | Providing refresher training on acute kidney injury, introduction of mandatory training on pneumonia management, training in medicines management for unfamiliar drugs. |
| Making immediate changes | Having a drug for agitation at end of life available on site, amended discharge processes to ensure GPs are made aware of critical issues. |
| Working groups, task and finish groups etc. | One trust has set up a task and finish group to set standards for care to be given the recently bereaved. |
| Quality improvement | Established quality improvement projects on fluid and electrolyte balance. |

# Number of deaths planned to be scrutinised through the medical examiner system



# Benefits of the medical examiner system

The introduction of the medical examiners will:

- ensure proper scrutiny of all non-coronial deaths
- enable the bereaved to raise any concerns direct to the medical examiner service
- improve the quality and accuracy of medical certificates
- Improve the quality of mortality data
- Support the appropriate direction of deaths to the coroner.

# Next steps for the introduction of medical examiners

- A National Medical Examiner will be appointed to set standards and provide guidance to medical examiners

- A full medical examiner service will be implemented providing an equal system to all non-coronial deaths whether cremated or buried. The medical examiner system will also build on Learning from Deaths and inform the mortality review process

- Medical examiners will be employed in the NHS system ensuring lines of accountability are separate from acute trusts, but allowing for access to information in the sensitive and urgent timescales to register a death.

- DHSC medical examiner pilots already scrutinise non-coronial deaths in the acute, primary care and community sector. We will continue with a phased approach post April 2019, aiming to roll out to cover all non-coronial deaths

# MH-Update

There is no widespread MH-specific methodology yet but…

RCPsych have developed and piloted a new tool

Similar to SJR and there is the potential for crossover between SJR and RCPsych tools depending on the patient

November launch

# Ambulance-Update

There is no requirement on Ambulances to undertake mortality review yet but…

NHSI are working with the National Association of Ambulance trust medical directors

Joint workshop planned for November

About half of ambulance trusts are already doing some kind of mortality review

Guidance for ambulance trusts in early 2019?

NHS Improvement


Email:
Patientsafety.enquiries@nhs.net
matthew.fogarty@nhs.net

# Resources

*National guidance on Learning from Deaths*
https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

*Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*
https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

Learning from deaths dashboard
https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance

Resources from the national patient safety team
https://improvement.nhs.uk/resources/patient-safety-alerts

The Improvement Hub
https://improvement.nhs.uk/improvement-hub/

*Developing people – improving care for leadership and improvement*
https://improvement.nhs.uk/resources/developing-people-improving-care/

## Mortality review resources

Royal College of Physicians mortality review materials
https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme

Learning disabilities mortality review programme
http://www.bristol.ac.uk/sps/leder/

Hogan et al Research on mortality review
http://www.bmj.com/content/351/bmj.h3239
http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159

## Related guidance and publications

Serious incident framework
https://improvement.nhs.uk/resources/serious-incident-framework/

Root cause analysis tools and resources
http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Duty of candour
http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

Being open guidance
http://www.nrls.npsa.nhs.uk/beingopen/