

Board of Directors (in Public)

Item 2.1

Subject: Learning from Deaths: Quarter 4 Report
Date of meeting: 1st May 2018
Prepared by: Dr Raphael Perry – Medical Director
Presented by: Dr Raphael Perry – Medical Director
Purpose of Report For Note

BAF Ref	Impact on BAF
3.2	No impact

1. Executive Summary

- New guidance on learning from deaths was published by the National Quality Board in March 2017 and was presented to the Board of Directors in May 2017
- Deaths are categorised as to the likelihood of being avoidable or not and the data collected centrally each quarter
- This quarterly report presents the mortality dashboard year to date (Appendix 1)
- The report also includes learning from deaths over the last year

2. Background

The new guidance has a strong emphasis on organisational learning from all deaths rather than from just preventable deaths. The definitions of preventable deaths have been revised. The threshold of defining preventable death is now on the basis of more likely than not encompassing the categories of definitely avoidable, strong evidence of avoidability and probably avoidable (greater than 50:50).

There continues good progress against the action plan (item 2.1a) and the Trust is on target implementing the new guidelines.

When cases have been reviewed by the MRG the action logs are sent to the divisions to review in divisional governance. The action log will include when the case is also to be reviewed during the relevant audit day. Since the end of Q3 the divisions have also been provided with an action spreadsheet derived from mortality data which will facilitate tracking and closure of action plans arising from learning points. This data will be triangulated with Dr Foster data.

All deaths have an initial review by the Deputy Director of Nursing to assess any issues raised by families and carers. The consultant in charge or an ITU consultant will invariably have spoken to families at the time of death. Further discussions with families unable to meet immediately after the time of death are offered the opportunity at a time convenient to the family. Any concerns raised by the families after a period of reflection are responded to and where appropriate investigated. If the death is considered avoidable or classed as an incident full duty of candour is exercised.

3. Key Issues

This is the 2017/18 Quarter 4 report and also the end of year report. There have been 215 deaths in the Trust since April 2017 with 65 deaths in Q4. For comparison the total number of deaths in the Trust for the period April 2016 – March 2017 was 183. Since April 2017 total 199 of the deaths have been through the mortality review process, 50 in Q4. There have been no deaths in patients with an identified learning disability.

In interpreting the attached spreadsheet it should be borne in mind that there may be an adjustment of the previous quarter's assessment of avoidability. This is because some of the returned full reviews will subsequently have been recalibrated by the mortality review group at their monthly meeting. Some cases rated by reviewer as less than 50:50 may have been deemed avoidable by the MRG and vice-versa.

There have been no deaths in Q4 classed as avoidable. For the year to date six deaths have been classified as greater than 50:50 chance of avoidability; three deaths were classed as probably avoidable (2.0%), two deaths classed as strong evidence of avoidability (1.0%) and one definitely avoidable (0.5%). Therefore a total of six deaths out of two hundred and fifteen (2.8%) had some evidence of avoidability during 2017/18.

Of those less than 50:50 in Q4 one death (2.0%) were classed probably avoidable but not very likely; seven deaths (14%) classed as slight evidence of avoidability; forty two deaths (84%) were classed as definitely not avoidable. The respective annual numbers for less than 50:50 chance of avoidability are twelve (6.0%); twenty one (10.6%) and one hundred and fifty nine (79.9%) – a total of 95.6% unavoidable deaths.

4 Organisational Learning from Deaths

There have been six deaths in the reporting period deemed to have been more likely than not avoidable.

One death was classed as definitely avoidable. This has been reported as an SUI and an RCA was carried out. The learning from this incident involved the creation of a Policy for Proctoring for the organisation.

The incident has been discussed at length and the need to speak out has been reinforced.

Two deaths were classed as strong evidence of avoidability. The first was a patient who had a PPCI for acute MI. He developed chest pain after the procedure on the ward and there was a delay in escalation. The learning from this involved reviewing and reinforcing the escalation process for staff on the ward and the medical teams.

The second was a mitral valve repair operation and there was the complication of bleeding from a tear in the ventricle.

Three deaths were classed as probably avoidable. The first was a referral for aortic surgery. The patient had a cardiac arrest in another trust and the transfer protocols were not followed as per the recommendations of the Critical Care Society. He was extremely unwell on arrival and did not survive surgery. The delays in and quality of transfer were considered as significant factors in his death.

The second patient presented to another hospital after collapse where an ECG change of evolving MI was missed. The patient was readmitted a short time later with an established MI and cardiogenic shock. PPCI was carried out but the patient did not survive. The missed diagnosis and delay in treatment was likely to have been significant contributors to the death.

The third case was a thoracic patient who was being treated for a haemothorax at another hospital. There was a delay at the referring hospital in recognising the drains needed changing

and a delay in transfer to LHCH. There were significant comorbidities and although a larger drain was inserted on arrival the patient did not survive.

These three incidents have been incident reported and shared with the referring Trusts for learning.

There have been a number of other deaths which were not deemed avoidable but have led to system and/or process change as well as individual reflection. These issues have been taken forward by the divisions, the learning hub meetings and the sharing and learning meetings.

The actions associated with the avoidable deaths are:

The development and implementation of a proctor policy. This defines the expectations and minimum standards for proctoring at LHCH.

The requirement for a minimum of two operators skilled or in training for any novel or innovative procedure.

Continued culture work and ensuring understanding of HALT process.

A review of the bleep filtering system to allow rapid escalation for urgent review.

Empowering nursing staff to call consultant staff direct if junior staff unavailable.

Personal reflection on operative technique reviewed in appraisal.

All of the delays in transfer or omissions of care from referring trusts have been shared with the trust concerned.

Other actions arising from deaths include a review of medicines administration; development of a rapid surgical pathway in high risk patients, both LHCH inpatients and transfer from DGH; feedback and personal reflection

The proctor policy has been used twice (thoracic and cardiac robotic surgery) with much stronger governance around the process.

Bleep filtering and escalation are under further review by the division of medicine. Impact not yet fully assessed.

Most of the other actions have not yet been formally evaluated as the changes/actions are recent.

Initial underlying trends have been explored. There are twenty nine deaths that the MRG has raised issues over since April 2017 the following possible themes have been identified. Six deaths were related to poor communication; nine deaths have led to suggested changes in policy and one to a combination of communication/policy; three deaths were due to rare and one off complications; three deaths were attributed to actions from referring hospitals; two deaths were secondary to technical issues and one each of choice of procedure, documentation, patient compliance and education.

Actions from the MRG are with the divisions to take forward and feedback will come through the Operations Board after divisional governance.


5. Conclusion


The Trust complies with national guidance and populates the mortality dashboard. There are six deaths with some evidence of avoidability during 2017/18 and actions from the MRG process have been taken forward by the appropriate division.

6. Recommendations

The Board of Directors is asked to note the dashboard data, the attached updated action plan and progress with the learning from deaths.

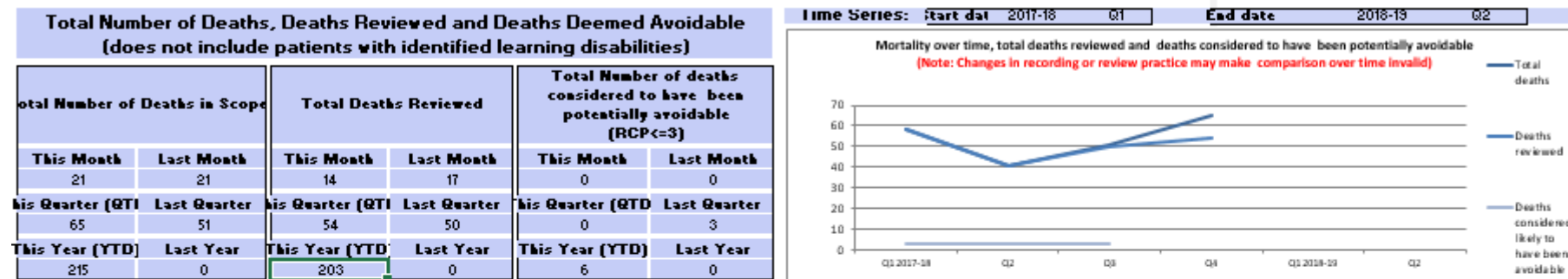
Appendix 1



Liverpool Heart and Chest NHS Foundation Trust: Learning from Deaths Dashboard - March 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 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 1 7.1%	This Month 2 14.3%	This Month 11 78.6%
This Quarter (QTI) 0 0.0%	This Quarter (QTI) 0 0.0%	This Quarter (QTI) 0 0.0%	This Quarter (QTI) 2 3.7%	This Quarter (QTI) 7 13.0%	This Quarter (QTI) 45 83.3%
This Year (YTD) 1 0.5%	This Year (YTD) 2 1.0%	This Year (YTD) 3 1.5%	This Year (YTD) 14 6.9%	This Year (YTD) 21 10.3%	This Year (YTD) 162 79.8%

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

