

Board of Directors (in Public)

Item 3.4

Subject: Learning from Deaths: Implementing the New National Guidelines

Date of Meeting: 30th May 2017

Prepared by: Dr Raphael Perry, Medical Director

Presented by: Dr Raphael Perry, Medical Director

BAF Ref	Impact on BAF
1.1	None

1. Executive Summary:

- LHCH has had a robust mortality review process in place since 2011 and a focus on organisational learning.
- New guidance on learning from deaths was published by the National Quality Board in March 2017
- This paper will highlight the key areas of the guidance and the attached action plan will outline the trusts response and progress in implementing the guidance

2. Background:

The Trust has had a well-established review process for all deaths since 2011. The mortality review process has been improved and brought up to date with national guidance issued in January 2016.

In line with the new recommendations TORs has been updated. There is a significant emphasis on actions and review of all potentially avoidable deaths.

In addition to discussions at audit days MRG results with recommendations are sent to the relevant division to manage through divisional governance. From the end of 2015 additional time has been set aside quarterly at the Operations Board for cross divisional learning from the MRG and from other governance issues. Also quarterly there is a cross divisional Quality and PFEC governance meeting chaired by the Medical Director. As well as addressing common themes from the divisional monthly governance meetings (which this replaces once per quarter) there will be opportunity to share outcomes from the MRG.

The 28 day target for completing mortality reviews has been difficult to achieve, in part due

to pressures on consultant staff time. Further work to increase the timeliness of returns was carried out in 2015/16. This includes proactive measures by the medical director and the lead administrator of the MRG group. In October 2016 a system of screening of forms was introduced with a core group of seven consultants doing a brief overview to establish whether an in depth review was necessary. To date 63% of cases needed an initial screening only with 37% going on to full screening by other members of the consultant body. Initial screening of cases was complete in seven days in 85% of cases; the Trust target is 95%. In terms of the overall thirty day reviews medical staff are reviewing 62% year to date (83% in month) against a target of 80%.

The reduction in the need for full reviews has led to a reduction in the number of cases exceeding the thirty day target.

Nursing review of cases is carried out in parallel now to ensure a multidisciplinary approach. The reviews cover all aspects of care during the patient's journey, including system wide and individual errors. Nurses are reviewing 59% within thirty days year to date (67% in month); again against a target of 80%

A multidisciplinary MRG meets at least monthly and selects those reviews which suggest areas for improvement that should be shared with the rest of the organization. These are then sent for presentation at audit days in surgery and cardiology, with the principle and reviewing consultant discussing the case.

The MRG process has also contributed to a culture of individual accountability within the clinical body, with the awareness that all clinical care is subject to independent scrutiny.

The Chair of the MRG summarises the key learning points every 3 months for the Directorates and presents an annual review to the Trust's Quality and patient experience committee. In the past one area of poor performance in the process is in actioning recommendations. There has been a significant improvement allied to the organisational learning strategy.

2. Key Issues

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 preventable, probably preventable and possibly preventable.

The CQC plan to strengthen their assessment process of mortality review and learning from deaths.

A Board of Director's masterclass with Hill Dickinson has been arranged for 23rd June 2017

The attached action plan defines the requirements and the progress the trust is making in implementing the new guidelines. Significant changes to our process include

- Updating the local policy in line with guidance by September 2017

- Clear structures demonstrating learning from deaths through the organisation.
- Ensuring systems are in place for deriving learning and acting upon findings and conclusions
- Evidencing processes to review learning around disability and learning disability
- Updating the present mortality documentation into a structured judgement review
- Completing and reporting externally quarterly the dataset and regular reporting to operations board, quality committee and board of directors
- Treating bereaved families as equal partners and supporting the right to raise concerns. Reviewing arrangements for bereavement support and keeping GPs informed of outcomes.
- Appoint a patient safety director at exec level and a NED for oversight
- Exercising appropriate and timely duty of candour and honesty
- Triangulating learning from deaths with complaints, claims and incidents.

4. Conclusion:

LHCH has an established mortality review process which was updated in 2016 in line with previous guidance.

There is an action plan to implement the new guidance on learning from deaths (attached).

The trust is making good progress with implementation.

5. Recommendations:

The Board is asked to note the guidance and progress with the implementation plan.

Identify issues to be addressed in Hill Dickinson masterclass

Also to consider the extent of future quarterly board reports.

How will the information / assurance presented impact on the BAF – note any recommendations for updating the BAF re gaps in controls / assurances (or closure) or BAF risk rating

Note: **Do not use names or identify individual patients or employees.**
 Do not include information that is commercially sensitive.

Your paper will be in the public domain unless there is a clear reason for the Board to consider the item in private.