

HEALTH SCRUTINY COMMITTEE

11th September 2018

Title: Review of Mortality at Barking, Havering and Redbridge Hospitals NHS Trust	
Report of the Associate Medical Director and Lead for Learning from Mortality	
Open Report	For Information
Wards Affected: None	Key Decision: No
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Accountable Director: Dr Magda Smith, Acting Medical Director	
Accountable Strategic Leadership Director: Chris Brown, Interim Chief Executive Officer, BHRUT	
Summary <p>Barking, Havering and Redbridge Hospitals NHS Trust (BHRUT) is a busy acute care organisation with a catchment population of over 750,000. The Trust has over 2,000 deaths per annum and the demand placed on developing a Mortality Review Service has been considerable. The Trust has engaged and implemented a Lead for Mortality who directs the Trust's Learning from Mortality Strategy.</p> <p>This brief outlines the mortality governance process within the Trust.</p> <p>The Trust has previously demonstrated outlier status in respect to published mortality ratios. The current position now demonstrates that these mortality ratios are showing improving trends and are within the expected ranges.</p> <p>The Trust aims to review 100% of deceased patient records using an established checklist review. This is completed by the doctor at the same time as the death certificate. We have completed over 6,000 reviews since June 2015 with a current average completion rate of 75%.</p> <p>The BHRUT Mortality Faculty undertake a schedule of case record reviews following the Royal College of Physicians (RCP) methodology. This provides the Trust with a resource to deliver a baseline of mortality reviews. The purpose of these reviews is to identify areas of good and poor practice and to develop strategies for care quality improvement. Alongside this we are developing a Faculty of Junior Doctor mortality reviewers who will have the opportunity to use the review process as part of identified Quality Improvement projects, as well as developing the use of local mortality reviews in specialty Mortality and Morbidity meetings.</p>	
Recommendation(s)	

The Committee is recommended to note:

- (i) The BHRUT mortality indices are improved.
- (ii) The BHRUT mortality review process is driving a range of Quality Improvement projects and provides the Trust with greater assurance about the quality of care we provide for our patients.
- (iii) The Trust is facing a challenge with engagement with our community stakeholders. We would welcome opportunities for greater involvement in developing a more robust community engagement strategy.

Reason(s)

These issues fall under the Health Scrutiny Committee's remit, which includes the scrutiny of any matter relating to the planning, provision and operation of the health service in the borough or accessed by Barking and Dagenham residents.

1. Introduction and Background

- 1.1 Patients are at the centre of our work at BHRUT and our organisational objectives contain 5 commitments to enable the delivery of safe high quality care. Improvement through learning lessons is key to this commitment and directs our approach to providing a robust, evidence based method to review patient care and make necessary improvements. Caring for the families of patients that die with compassion and openness is central to this work and a new approach to family support was introduced following the published guidance by the National Quality Board in March 2017: 'Learning from Deaths'.

BHRUT has a long history of reviewing the care provided to patients and learning from findings. This work was initially led by individual members of Trust staff within department Morbidity and Mortality reviews and via specific pathway reviews led by the Chief Nurse and the Medical Director's team. This process was formalised in 2015 and resulted in the formation of a standardised review checklist completed after each patient death.

Reporting findings from data and care reviews to every level of the organisation ensures all can respond whether that is a member of medical staff ensuring timely prescribing of antibiotics or Trust board member or subcommittee responding to a reported trend and allocating resources to respond.

Combining mortality ratio data, published nationally with clinical review information the organisation enables the highlighting of best practice alongside areas for improvement. Examples of this type of work can be seen in reviews regarding Septicaemia and Pneumonia and development of new care pathways in these areas.

The Trust has a local 'Learning from Deaths' policy which brings together existing aspects of the Trusts governance structures, including incident reporting process to ensure effective support for patients and families, rapid identification of issues and a

high quality clinical review. Learning from findings is critical and central to drawing each of these aspects is harnessing the Trusts' improvement capabilities which are supported by the Trusts partnership with the Virginia Mason Institute. The translation of this technique, known as the 'PRIDEWAY' offers significant advantages to deliver robust improvements which can be measured and sustained. Each employee of BHRUT is able to access training for this approach to enable them to fulfil their obligation to improve the quality of care provided.

An important aspect of Learning from Deaths at the Trust includes broadening the patient and family involvement beyond current incident reporting and patient advice and liaison aspects. The Trust fully delivers responsibilities under the statutory duty of candour however more is possible and guidance based on the input from families and carers in the NQB guidance is a valuable source of support. To this end, we have introduced a formal family liaison role which will act as direct support or provide training and support to those working with patients and families to deliver effective support and information.

2. Proposal and Issues

2.1 Mortality Checklist.

Using various prompting questions we try to identify whether the patient had any significant concerns about problems in care that may have contributed to patient death. We have recently audited this to identify whether the checklist review correlates with patients where we have subsequently identified concerns about care quality following structured review of the patient's mortality or where concerns have been raised via other methods such as complaints and incident reporting.

2.2 Mortality Reviews.

The Committee is asked to note for assurance that clinical reviews undertaken by the Mortality Faculty have identified a majority of good practice and no avoidable death. Where we have identified areas of learning we have a central Faculty of Mortality Reviewers who undertake Structured Judgement Reviews (SJR) using the RCP methodology. This provides the Trust with a resource to deliver a baseline of mortality reviews. This has been found to be of particular help where a concern is raised of how a patient has died. The mortality review can be used to inform a Round Table discussion about concerns around patient care leading up to the death. As this is usually an impartial view it improves the quality and nature of discussion at the Round Tables. The Mortality Faculty also commit to delivering mandatory mortality reviews e.g. patients with learning difficulties, high risk groups and so on.

2.3 Mortality outliers and Care Quality Commission alerts

BHRUT was identified as being an outlier for mortality in patients with pneumonia and for patients with biliary sepsis. We have engaged the clinical teams responsible for the care of these patients to undertake the mortality reviews of the appropriate mortality groups and then develop a quality improvement strategy based on their learning from. In biliary sepsis, the reviews were then used to inform and develop a new biliary sepsis management strategy and a review of service provision of Endoscopic retrograde cholangio-pancreatography (ERCP).

The learning tools have then been developed using some of the cases we have encountered to illustrate the clinical issues and have then been presented to the appropriate clinical specialties. The ability to reach to all specialties in such complex pathways remains a challenge but the use of the mortality review process highlights the need for improving care pathways of care for these patients.

- 2.4 We have developed a Trust-wide tool for mortality review, this includes instructions for use, a template for reviewing the phases of care and some clear outcomes. In addition we have developed a template that enables presentation of the patient at local mortality meetings. This process is being developed alongside focussed training for FY1s and other Junior Doctors in how to undertake a mortality review.

3. Consultation

- 3.1 Mortality Assurance Group meets monthly with participants from clinical divisions and other relevant stakeholders. This group ratifies the monthly Mortality Assurance Report that goes via the Executive Committee to the Trust Quality Assurance Committee.
- 3.2 The actions in this report were considered and endorsed by the BHRUT Quality Assurance Committee at its meeting on 19th July 2018.

4. Financial Implications (Not applicable)

This paper is for information purposes.

5. Legal Implications (Not applicable)

This paper is for information purposes.

Public Background Papers Used in the Preparation of the Report: None

List of appendices: None