Above & Beyond
Fundraising for Bristol city centre hospitals

NHS
University Hospitals Bristol
NHS Foundation Trust

# Adult Mortality and Learning From Deaths Report

## April 2017 – March 2018

Dr M Callaway (July 2018)

# Contents

# Introduction

Since the beginning of April 2017 all adult inpatient mortality has been subject to review to enable learning from deaths. This annual report sets out the process by which all deaths are reviewed in UHBristol, the process of monitoring the outcome and learning from death, and documents the results from the first year of this process.

In April 2017 a grant was obtained from the charity, Above & Beyond, to enable the recruitment of a team to establish and develop processes for adult learning from deaths at UH Bristol. The team consists of the following:

### Non-Executive Director Lead

Julian Dennis

### Co-Leads

Dr Mark Callaway and Dr Emma Redfern

### Divisional Mortality Leads

**Medicine:** Dr Amanda Beale and Dr Rebecca Maxwell

**Surgery:** Mr Paul Wilkinson

**Specialised Services:** Dr Colette Reid

### Lead Mortality Nurse

Tina Whiting

### ITU Mortality Lead

Dr Sarah Sanders

### Learning Disabilities Lead

Helen Bishop (to May 2018)

### Mental Health Lead

Dr Nicola Taylor

### Mortality Clinical Fellow

Dr Sarah Kyle

## Background

In December 2016 the Care Quality Commission (CQC) published a review of how NHS trusts review and investigate deaths of patients in care. 'Learning, candour and accountability' provides helpful insight into the system level and local challenges to effective investigations, greater candour and transparency, and learning from deaths across the NHS.

The CQC's report made a number of recommendations, one of which (recommendation seven) is directed towards acute providers. This states that provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers. The CQC recommends that provider boards should ensure:

- Patients who have died under their care are properly identified
- Care records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented
- Staff and families/carers are proactively supported to express concerns about care given to patients who died
- Appropriately trained staff are employed to conduct investigations
- Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation
- Investigations are conducted in a timely fashion, recognising that complex cases may require longer than 60 days
- Families and carers are involved in investigations to the extent they wish
- Learning from reviews and investigations is effectively disseminated across the organisation, and with other organisations where appropriate
- Information on deaths, investigations and learning is regularly reviewed at Trust Board level, acted upon and reported in annual Quality Accounts
- Particular attention is paid to patients with a learning disability or mental health condition
- Provider boards should strongly consider nominating a non-executive director to lead on mortality and learning from deaths.

This document is the first annual report of the process from learning from adult deaths in UH Bristol. It describes the process at UH Bristol whereby all adult in-patient deaths are screened, investigated and reviewed. Learning from a review of the care provided to patients who die is now an integral part of our clinical governance and quality improvement work. UH Bristol is ensuring its governance arrangements and processes include, facilitate and give due focus to the reporting and investigation of all deaths.

This report describes the methodology behind the introduction of this process, and the structure by which the process is managed, it also reports on the outcomes from this process in the year 2017-2018.

UH Bristol has a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved ones. It is a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

Initial feedback at the start of the process suggested that the level of avoidable death in the inpatient environment would be in the region of between 3-10%. At UH Bristol our review has found that the majority of care provided is good or very good and the proportion of avoidable deaths lower than expected. Every organisation found a lower proportion of avoidable deaths than the figure expected at the introduction of this process.

However, several themes have been identified from the process. Where there has been care which is at a lower level than expected, there has often been inconsistent senior input leading to a slow introduction of the patient onto an end of life pathway. This is particularly important in order to move the patient onto a pathway which maximises the treatment of symptoms.

UH Bristol has been part of the wider collaborative within the healthcare community coordinated by the West of England Academic Health Science Network, and all eight acute providers within the region have been contributing results and sharing the learning from this process.

**Dr Mark Callaway**
**Interim Medical Director**
**July 2018**

## Adult Mortality Review Process

From April 1 2017 all adult inpatient deaths, excluding out of hospital cardiac arrests, were screened by the senior nurse leading the mortality process. If there were any aspects of care that triggered a further review, the notes were sent to the Mortality Leads in each of the adult bed holding divisions to co-ordinate a review using the Royal College of Physicians Structured Case Note Review (SCNR) process.

Criteria set by NHS England for deaths requiring an SCNR are;

- Unexpected death e.g. after an elective procedure
- Where the family/carer/staff raise concerns about the overall care
- Patients with learning disabilities
- Patients with a history of severe mental illness
- Patients aged between 16-18
- Where an alarm has been raised by the Trust regarding a service specialty
- Death is related to an area of planned improvement work.

In addition a local screening tool was developed to include deaths identified in local areas of potential concerns, such as multiple ward moves, queuing, or outlying could be factors that would trigger an SCNR.

All Intensive Therapy Unit (ITU) cases are reviewed by ITU consultants and if appropriate sent to the mortality team for a further review by SCNR.

Reviews for deaths of patients with learning disabilities are viewed by the Learning Disabilities Lead Nurse.

Reviews for patients with a serious mental health issue are undertaken by the Trust Mental Health Lead.

Following the structured case note review, if any aspects of care raise concern, or the reviewer felt the death was potentially avoidable, the case was referred for a second review undertaken by the Medical Director or Deputy Medical Director.

### The outcome of a Structured Case Note Review

The Structured Case Note Review results in two outcomes. The first is an overall score for the quality of the care provided; this is on a 1 to 5 scale with 5 representing excellent care and 1 poor care. The next is assessment of avoidability of death; this is on a 1 to 6 scale. These scores are also supported by statements from the case note reviewer that indicate the reasons behind the scoring and produce learning points from the review.

The SCNR is performed by a senior doctor, senior nurse or senior trainee who has undergone training in SCNR using the Royal College of Physicians' methodology. All consultants are eligible to be involved in SCNR once they have completed the appropriate training. This includes consultants in non-bed holding specialties, such as radiologists and anaesthetists.

- The co-ordination of the SCNR will be undertaken by the divisional mortality leads. It will be the responsibility of the divisional lead to distribute the review to the reviewers, co-ordinate the response and co-ordinate the learning and outcome from the review.
- All SCNRs that trigger a score of 1-2 for the overall provision of care or 1-3 on the avoidability of death score will undergo a second SCNR by a trained member of the Medical Director's team. This is so patients where the overall standard of care provided has been assessed as poor, or where there was a greater than 50% probability of avoidability, are subject to this further detailed review.

This process allows the senior medical team to be sighted on all deaths within the organisation where poor care has been identified, and to assess all potentially avoidable deaths. The themes and learning from this additional review are co-ordinated and fed back by the Medical Director's team to both the division and the mortality surveillance group. A judgement regarding the avoidability of death will be made following the Medical Director's review. The final judgement around the avoidability of death will be made following the second review by the medical director's team. This will be carried out in a timely way so that duty of candour can be undertaken as soon as possible where any issues have been identified.

- Where appropriate, the duty of candour will be carried out by the Medical Director's office, unless it has already been completed. If there is evidence of poor care or avoidable death, and duty of candour has not been undertaken, then the medical director's office will undertake duty of candour.

**Mortality Review Operational Group**

- The membership of the Mortality Review Operational Group is; the Deputy Medical Director, Associate Medical Director for Patient Safety, divisional leads for mortality (two in the division of medicine, one in specialised services, and one in surgery), the nurse lead for mortality screening, the leadership fellow for mortality and administrative support.
- The Mortality Review Operational Group is responsible for managing the review process. The group meets monthly and is responsible for the co-ordination of all the data surrounding the screening and review process. The data is held on the Mortality Dashboard. Every month the group reviews the total number of deaths, the total number of deaths which triggered a SCNR, the results of the reviews on a divisional basis, the total number of SCNR that triggered a second SCNR, and the total number of avoidable deaths. In addition, the group co-ordinates learning from any themes emerging from the SCNRs. These themes are then fed back to the divisions for integration into the divisional mortality and morbidity process. These themes are then fed into the Mortality Surveillance Group, which also receives a monthly report of these figures and actions for learning.
- The Mortality Review Operational Group is responsible for the training and co-ordination of case note reviewers. The list of trained reviewers will be held by this group and the number of reviews conducted by each reviewer noted. No reviewer should perform more than two reviews per month and no reviewer should go more than two months without undertaking a review. The number of reviews for an individual is recorded and on an annual basis fed back to the individual to inform the annual job planning process.

**Mortality Surveillance Group**

- The Mortality Surveillance Group is the governance group for co-ordinating all information regarding adult mortality and is responsible for the governance from the learning from death programme and reports to the Quality and Outcomes Group.
- The Mortality Surveillance Group is chaired by the medical director and its other members are the deputy medical director, the associate medical director for patient safety, the deputy chief nurse, the Trust lead for patients with learning disabilities, a representative from adult mental health, the divisional leads for mortality, the lead nurse for mortality screening, leads for mortality from ITU and the Children's Intensive Care Unit (CICU), the lead for child death review, and the lead for obstetric deaths.
- The Mortality Surveillance Group co-ordinates all reports into adult inpatient deaths within the organisation. Most of this information is obtained via the Adult Mortality Review Group but there are

further reports from investigations into maternal deaths, Serious Untoward Incidents (SUIs) and Root Cause Analyses (RCAs), adult mortality on ITU and CICU, and patients with learning disabilities via the Learning Disabilities Mortality Review programme (LeDeR) process.

- All deaths in patients in whom a Serious Incident (SI) has been initiated will be subject to a SCNR.
- Other sources of information will also feed into this group, such as coroner reports. This information will be co-ordinated by this group who will identify the most important learning points. This group will produce a quarterly report that will be presented to the Quality and Outcomes Group
- The role of this group is to co-ordinate and identify themes of learning from all the mortality data provided by various sources within the organisation, as described above and this group will produce a list of the most important areas for learning: this list will be shared with the divisions, who will need to demonstrate that practice has been changed and where appropriate actions will be incorporated into the organisation's Quality Improvement programme.
- In addition, it is likely that several themes will be cross-divisional in nature and may require changes in organisational practice such as induction for junior doctors. This work will be co-ordinated through the medical director's office.

# Mortality Review Results

## Statistics for 1 April 2017 to 31 March 2018

### Overview

There were 1,346 adult deaths in the organisation between April 1 2017 and March 31 2018. We have screened patient notes for 1,216 deaths (all but Out Of Hospital Cardiac Arrests [OOHCA]) and identified 327 cases (27%) that required a structured case note review according to the categories above. The majority of these cases were in the division of medicine (215 cases - 66%), with smaller numbers of cases within both the divisions of specialised services (64 cases) and the division of surgery (48 cases). The mandatory fields for investigation of learning from deaths generated 124 reviews whereas the additional fields added as part of the screening process developed in UH Bristol generated a further 205 reviews. A total of 16% of all inpatient deaths occurred on ITU.

***Table 1:*** *Adult inpatient deaths at UH Bristol from April 2017 to March 2018*

| Description | Number of deaths |
|---|---|
| **Total deaths** | **1,346** |
| **Out Of Hospital Cardiac Arrests (OOHCA)** | **130** |
| **Deaths in critical care** | **204** |
| **Case notes screened** | **1216** |
| **Deaths identified for review** | **327** |
| **Reviews allocated to Division of Medicine** | **215** |
| **Reviews allocated to Division of Specialised Services** | **64** |
| **Reviews allocated to Division of Surgery** | **48** |

**Screening: One year analysis**

Of the adult deaths that triggered a SCNR the group was broken down as follows; the largest group of cases reviewed were as a result of the local screening process. The following mandatory groups were reviewed:

***Table 2:*** *Screened deaths – Of the 1,346 deaths, 1,216 notes were screened. The following shows how many of these triggered a review – shown by category – note some cases triggered in more than one category.*

| Description | | Cases | Percentage |
|---|---|---|---|
| **Category 1** | **Family/carer/staff have highlighted concern over quality of care provision** | **52** | **4%** |
| **Category 2** | **Patient has learning disabilities** | **16** | **1%** |
| **Category 3** | **An alarm has been raised by the Trust regarding this service speciality via audit/CQC/HSMR mortality alert** | **0** | **0%** |
| **Category 4** | **Death is unexpected [Elective procedures and # NOFs]** | **30** | **2%** |
| **Category 5** | **Death is related to an area of planned improvement work [Invasive procedure never events, deteriorating patient: NEWS and escalation, sepsis, AKI, Insulin safety]** | **7** | **0.6%** |
| **Category 6** | **Age 16-18 years old** | **0** | **0%** |
| **Category 7** | **Other issue highlighted during screening process** | **218** | **18%** |
| **Category 8** | **Serious Untoward Incident** | **15** | **1%** |
| **Category 9** | **Patient with serious mental health issue** | **10** | **0.8%** |
| **SCNR not required** | **Deaths which did not trigger a SCNR** | **889** | **73%** |

***Chart 1 :*** *Breakdown of screened deaths.*

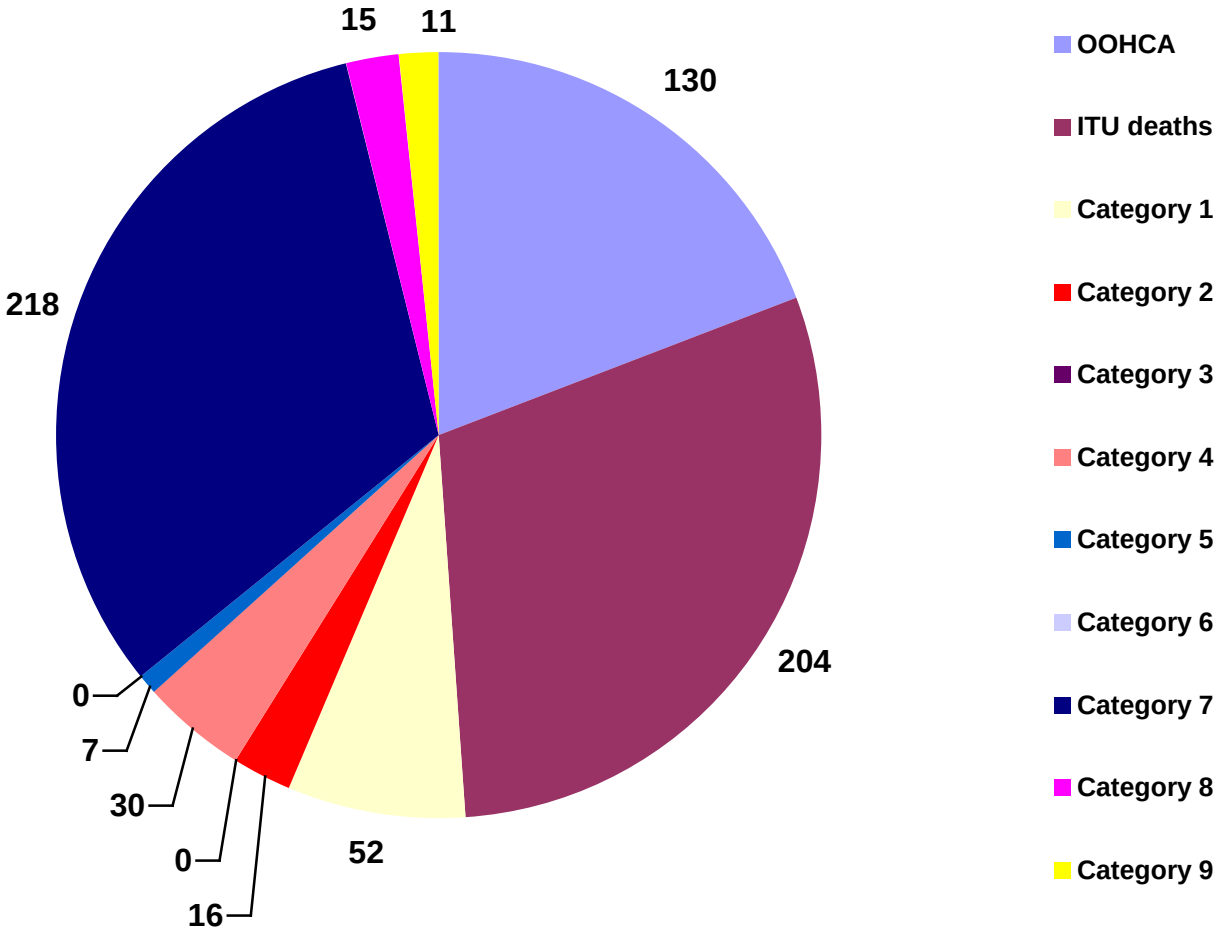
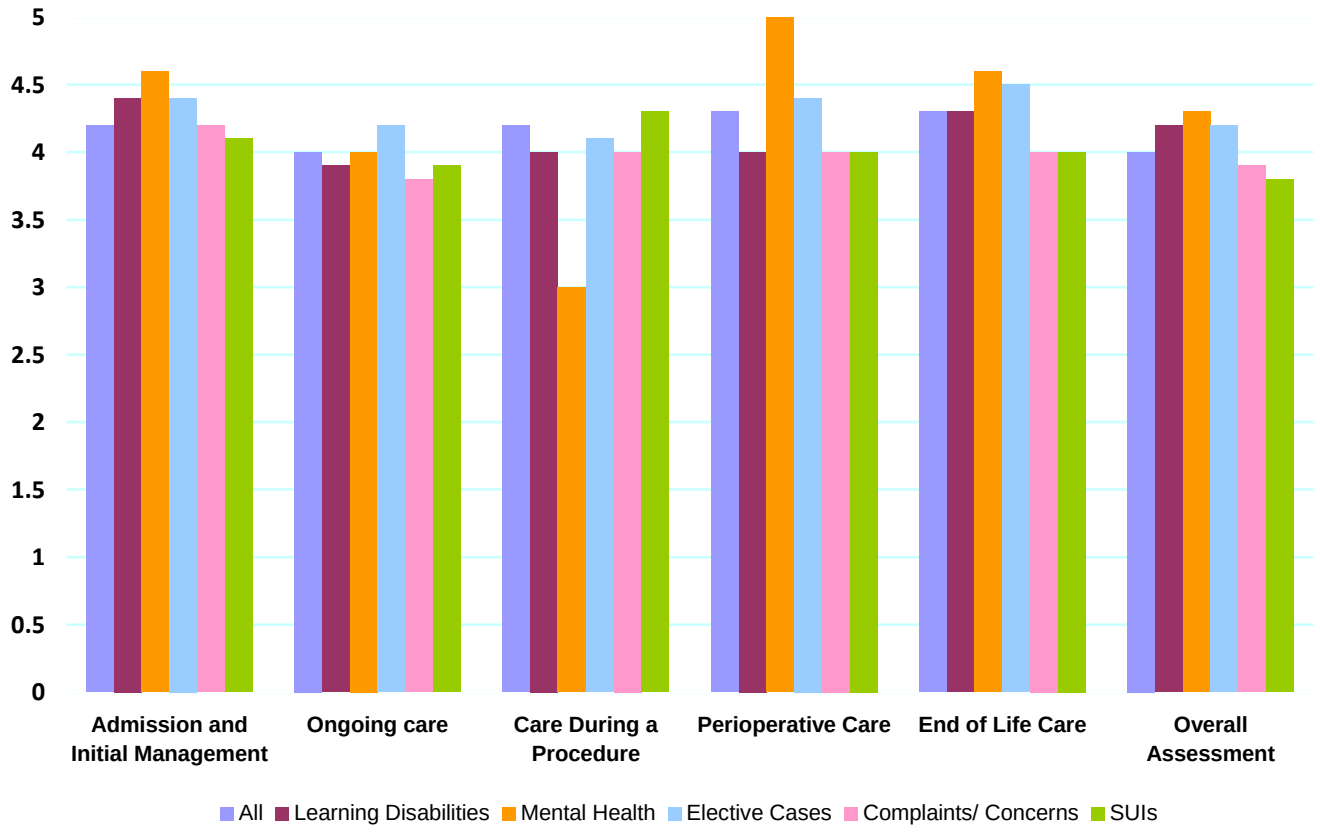


***Table 3 and chart 2:*** *Phases of care – mean scores by category of review*

| Score | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Definition** | Very poor | Poor | Adequate | Good | Excellent |

| SCNR Category | Admission and Initial Management | Ongoing care | Care During a Procedure | Perioperative Care | End of Life Care | Overall Assessment |
|---|---|---|---|---|---|---|
| **All** | **4.2** | **4** | **4.2** | **4.3** | **4.3** | **4** |
| **Learning Disabilities** | **4.4** | **3.9** | **4** | **4** | **4.3** | **4.2** |
| **Mental Health** | **4.6** | **4.0** | **3** | **5** | **4.6** | **4.3** |
| **Elective Cases** | **4.4** | **4.2** | **4.1** | **4.4** | **4.5** | **4.2** |
| **Complaints/ Concerns** | **4.2** | **3.8** | **4** | **4** | **4** | **3.9** |
| **SUIs** | **4.1** | **3.9** | **4.3** | **4** | **4** | **3.8** |

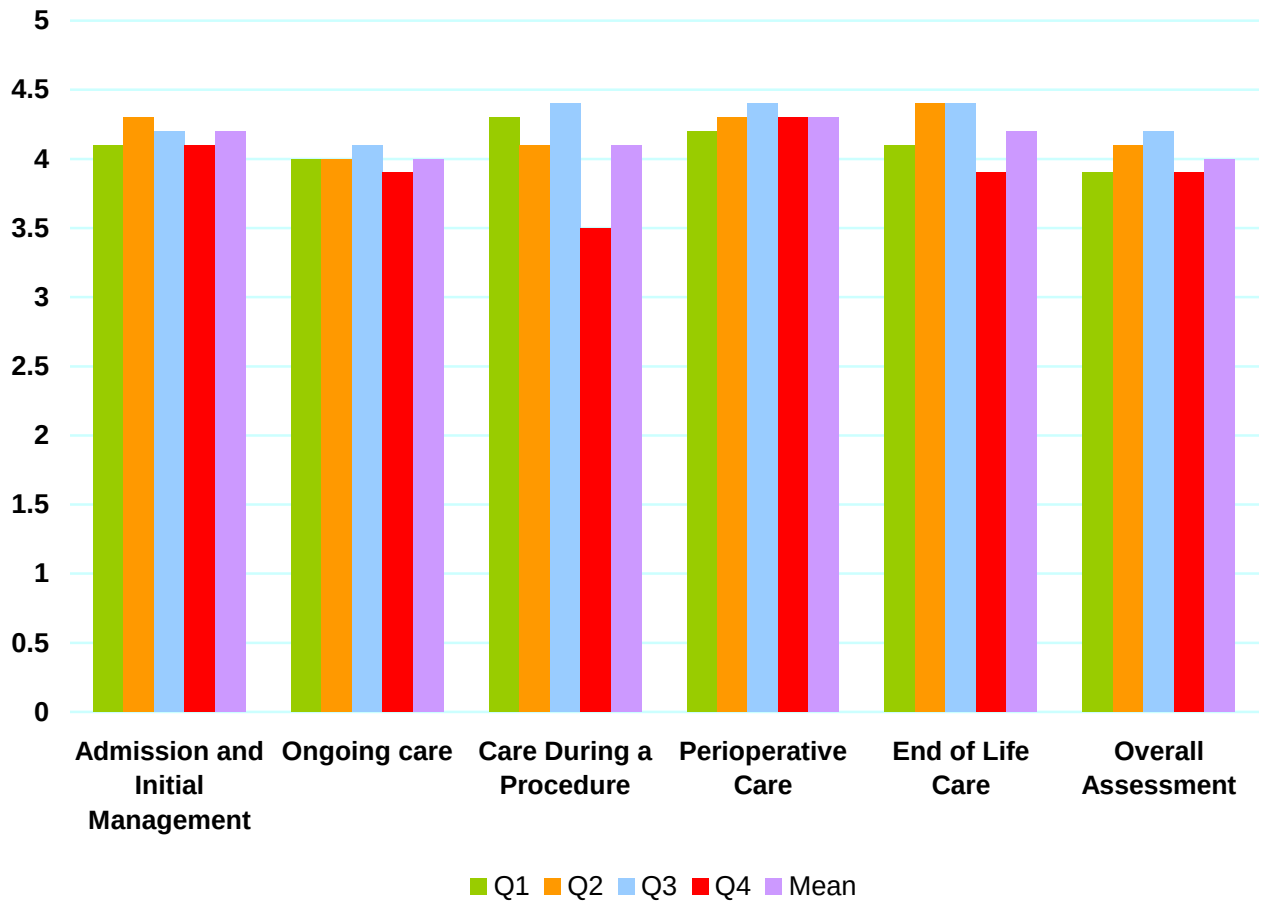


All deaths undergoing a SCNR have been grouped into quarters and the level of care assessed.

One of the aspects of care that raised a potential concern was whether there was an identifiable difference in the level of care provided in each quarter, particularly quarter 4 when the Trust faces increased demand due to the winter pressures. Although a slight drop in mean care ratings was found in all care phases for quarter 4, mean scores were between 3.5 (adequate- good) and 4.1 (good) for this period.

***Table 4 and chart 3:*** *Mean scores for each Phase of Care by quarter 2017 – 2018 - All deaths*

| Quarter | Admission and Initial Management | Ongoing care | Care During a Procedure | Perioperative Care | End of Life Care | Overall Assessment |
|---|---|---|---|---|---|---|
| **Q1** | **4.1** | **4** | **4.3** | **4.2** | **4.1** | **3.9** |
| **Q2** | **4.3** | **4** | **4.1** | **4.3** | **4.4** | **4.1** |
| **Q3** | **4.2** | **4.1** | **4.4** | **4.4** | **4.4** | **4.2** |
| **Q4** | **4.1** | **3.9** | **3.5** | **4.3** | **3.9** | **3.9** |
| | | | | | | |
| **Mean** | **4.2** | **4** | **4.1** | **4.3** | **4.2** | **4** |



# Avoidability of Death

**Second Review**

Eleven of the 212 completed review cases (data June 2018) underwent a second review by the medical director team, and four potentially avoidable deaths were identified. In three deaths anticoagulation was a factor; in two patients the review suggested that the anticoagulation was not sufficient, and in one patient over anticoagulation was a contributing factor. All these cases were reported at the time as incidents and underwent formal review as part of the Serious Incident Policy.

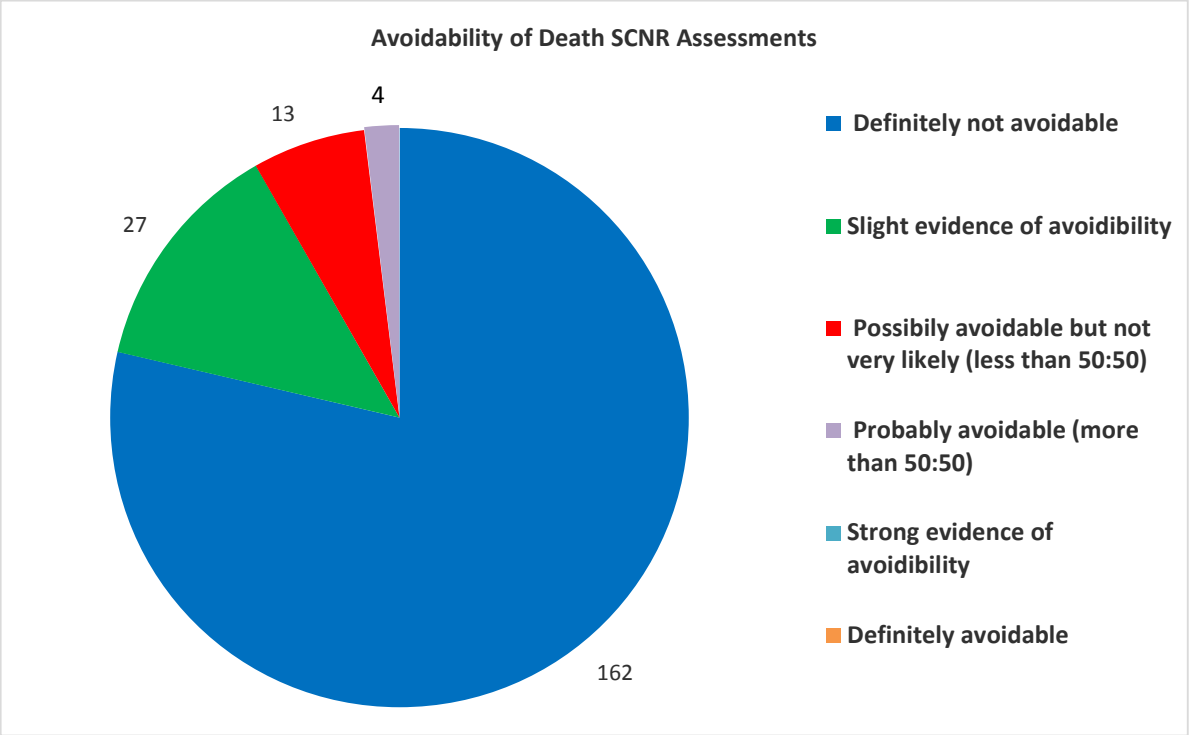
The second review also consolidated the learning from deaths, and highlighted areas where improvement could be undertaken. The two major areas requiring improvement were timely senior input and decision-making and the instigation of the patient onto the end of life pathway. These are two important aspects of end of life care as the decision to move to an end of life pathway means there is a move from physiological triggering of investigation to a symptom-based patient pathway.

A surgical case where a nasogastric tube was not placed in a patient with small bowel obstruction who was not suitable for surgical intervention found that whilst the placement of the tube would not have prevented the patient's death, this potentially could have relieved symptoms. This death was sent via the division's mortality and morbidity meeting to the surgical team responsible for the patient's care.

This information regarding senior input has been fed back to divisions who are reviewing processes and the work around the end of life pathway has been developed with the involvement of a quality improvement fellow.

***Table 5 and chart 4:*** *Avoidability of death (assessments for all deaths reviewed 2017-18)*

| | 6: Definitely not avoidable | 5: Slight evidence of avoidability | 4: Possibly avoidable but not very likely (less than 50:50) | 3: Probably avoidable (more than 50:50) | 2: Strong evidence of avoidability | 1: Definitely avoidable | Total |
|---|---|---|---|---|---|---|---|
| **Avoidability of Death (all)** | **162** | **27** | **13** | **4** | **0** | **0** | **206** |




## Cases where care could have been improved

The SCNR highlighted that only a small proportion of the deaths reviewed scored low in an aspect of care; 21 deaths scored either one (very poor) or two (poor) at some point during their care.

The major consistent finding in these cases was the lack of senior review and this information has been fed back to the divisions to direct an improvement in care:

- 11 of these were cases that were mandatory to review (priority category)
- 10 of these were picked up through our screening process
- One case scored 1 (very poor care) in 'Admission and Initial Management'
- In the division of medicine there were 10 cases that had poor scores (scores of 1 or 2); in specialised services there were four cases that had a score of 2; and in surgery there were seven cases that had a score of 2
- One of these patients had learning disabilities.

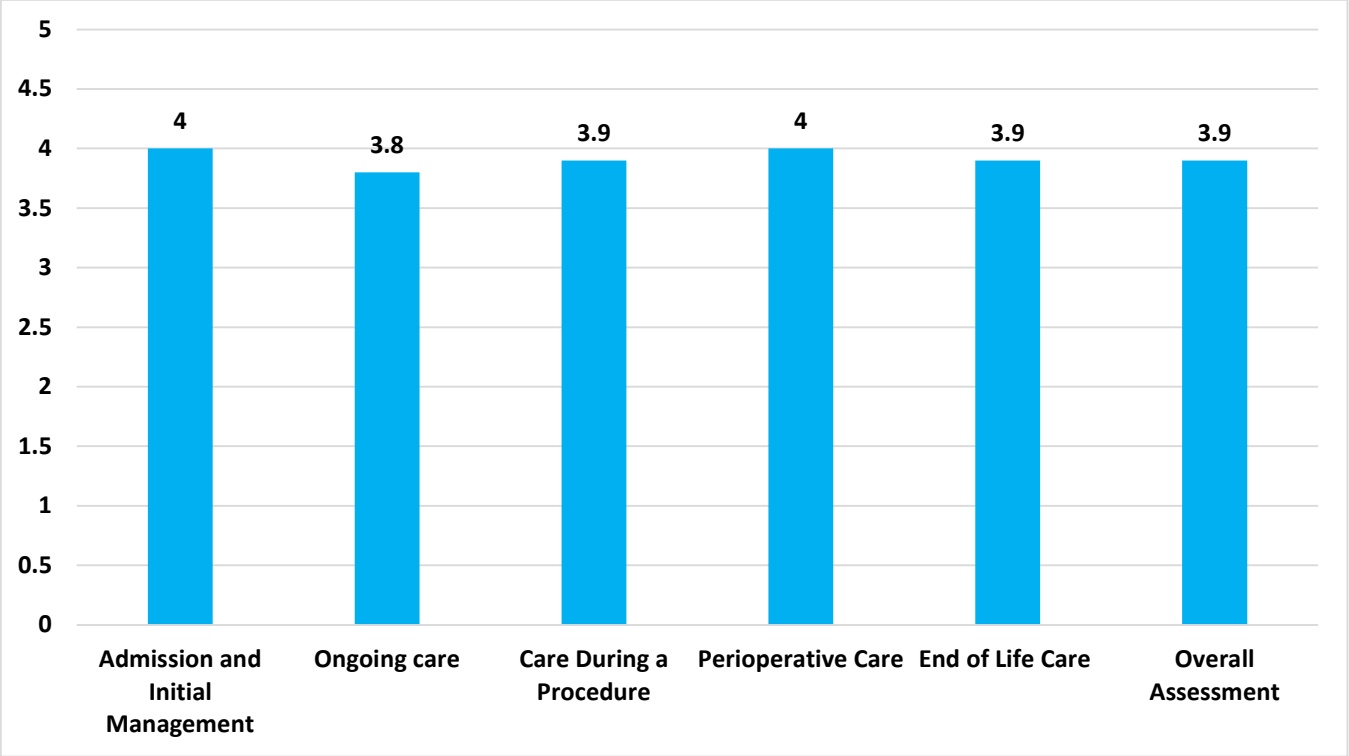
## Assessments of phase of care by review criteria:

### Category 1: Complaints or concerns raised by relatives or friends

This was the largest group of cases subject to SCNR and is defined as any case where concerns or complaints are raised. This occurs via the bereavement office. There has been a modification to the information leaflet supplied to families to facilitate this process.

Several common themes were identified, although there were no avoidable deaths in this group of patients. The consistent themes included a lack of senior decision-making at an early stage in patients' illnesses, and issues with movement of patients for such reasons as waiting for a cubicle or the movement of a patient at night. Several issues with the administration of medications including anticoagulation were raised, the perceived delay of transfer of patients to an appropriate end of life pathway with the associated management of symptoms, and most commonly, issues around communication and clarity regarding the patients' pathway.

***Chart 5:*** *Category 1 – Complaints / concerns (mean scores for phases of care)*

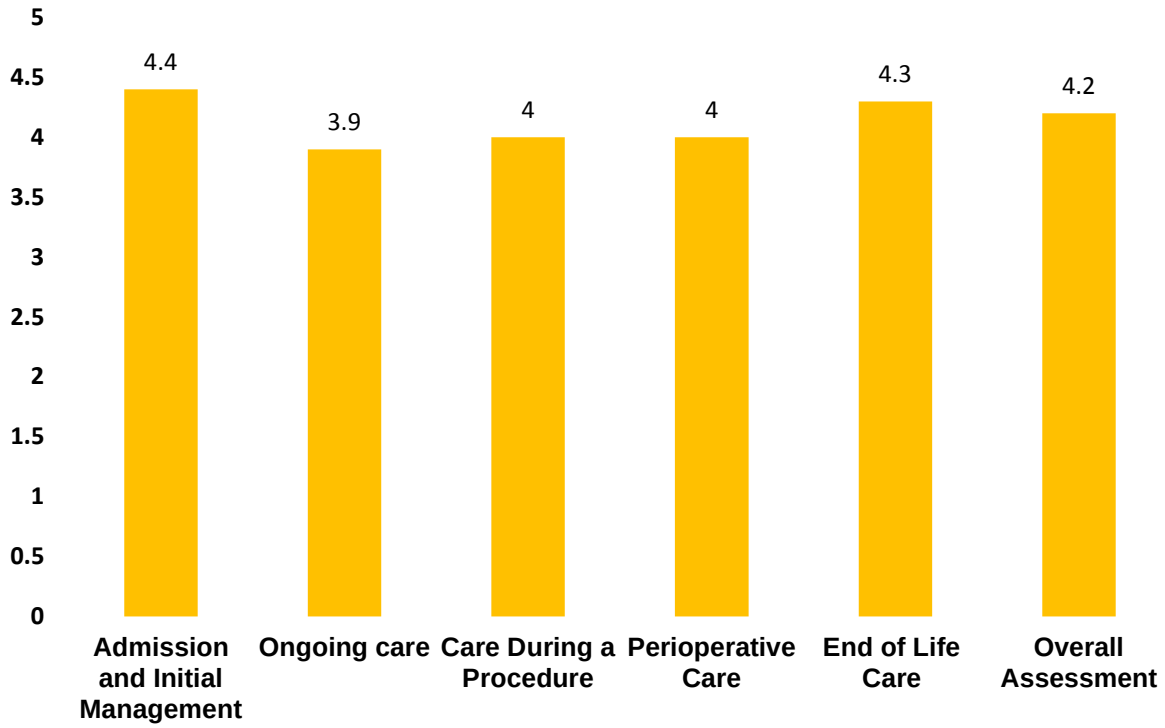


### Category 2: Learning disabilities

The definition used for a patient with learning disabilities is any patient who has a learning disability highlighted either on an alert through Medway and is known to the learning disabilities team, or who has a learning difficulty documented in their past medical history anywhere in their case notes

There have been 16 deaths in patients with learning disabilities. SCNR indicates the majority of the care care received for patients with learning disabilities was good or very good and no death in this category was defined as avoidable. There was evidence of poor care in one patient within this cohort where the patient's 'This is me' document was not brought in at admission which led to initial poor communication. This issue has been addressed.

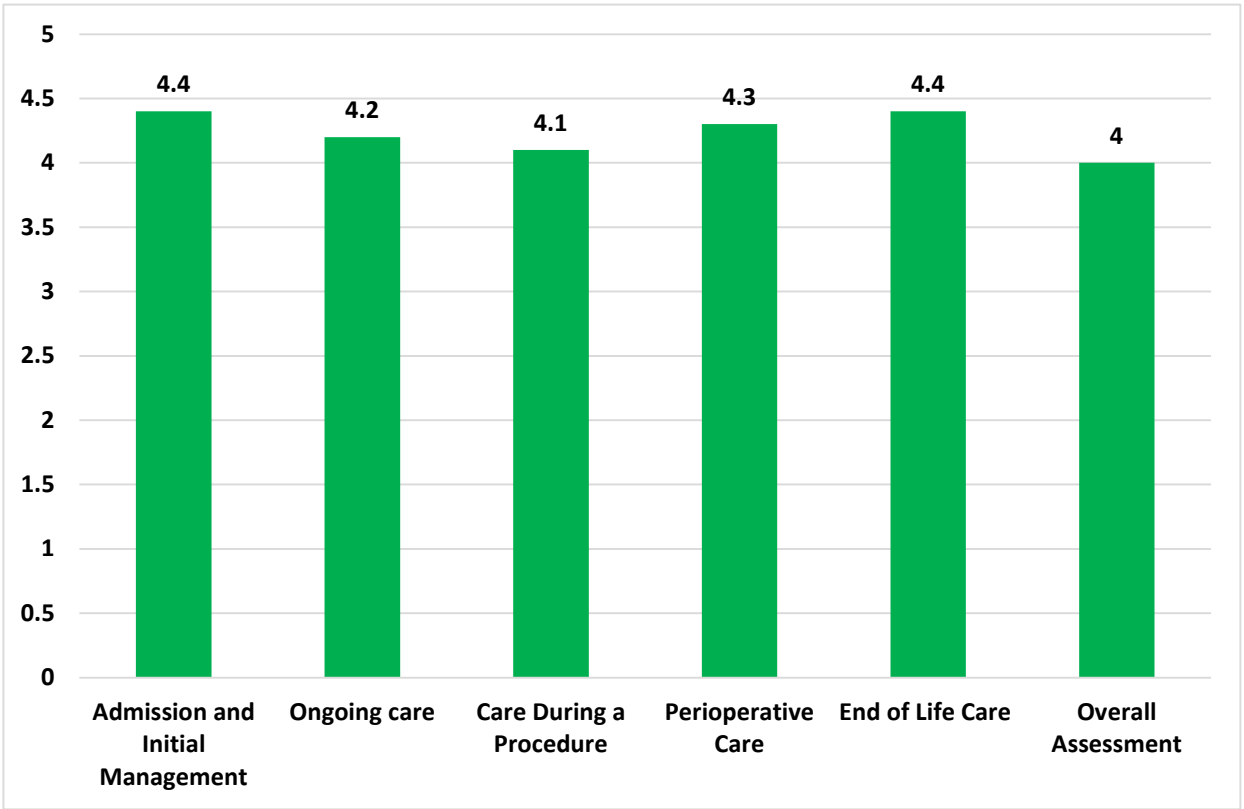
***Chart 6:*** *Category 2 – Learning disabilities (mean scores for phases of care)*



### Category 4: Elective Surgery Cases

All cases in which the death occurs following an elective procedure are reviewed using the SCNR. In this group 68% of these deaths following review were assessed as definitely not avoidable and no death following an elective procedure was considered avoidable. This was the largest category of deaths identified on the ICU and often occurred following complex surgery.

***Chart 7:*** *Category 4 - Elective Surgery Cases (mean scores for phases of care)*



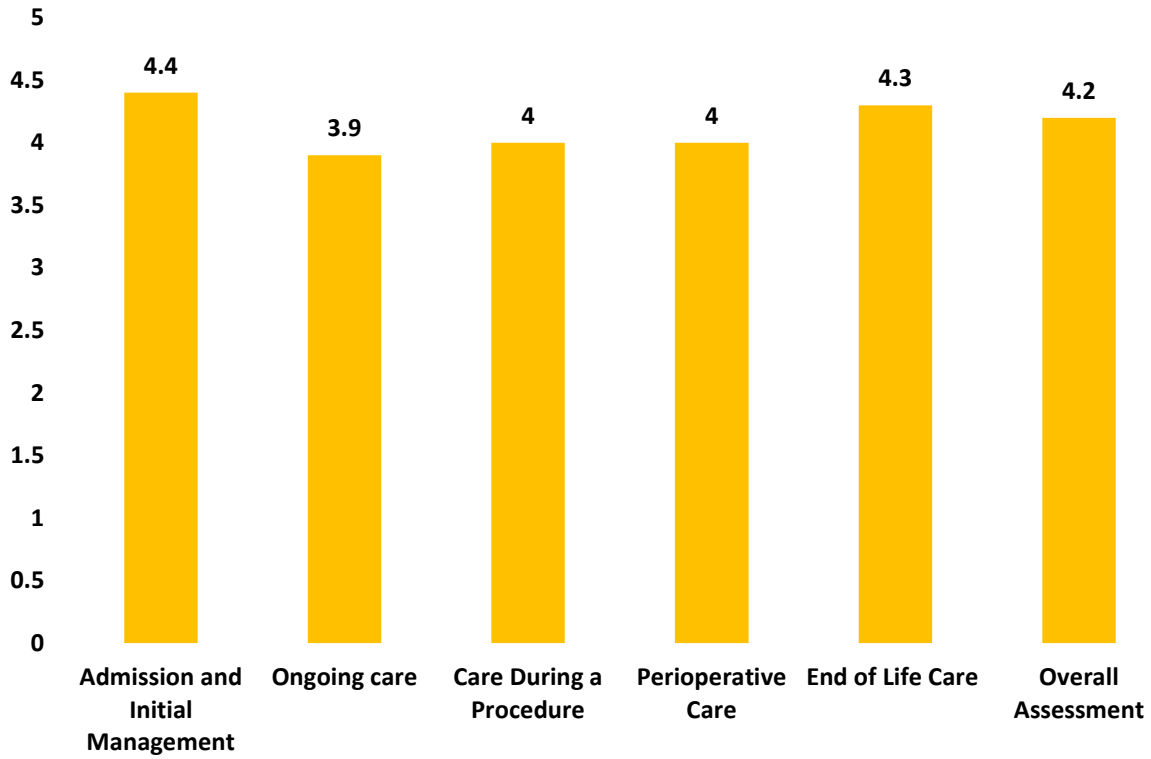
### Category 8 - Serious Untoward Incidents

There have been deaths associated with a Serious Untoward Incident (SUI) in 15 cases. In one of these cases the SUI was triggered by the mortality review and in this case the death was, on review, considered to be potentially avoidable.

The mortality review highlighted this death which occurred a short time after the patient's discharge and had not been identified by any other process within the organisation. Patients in whom a SUI is generated following their death also have a SCNR to assess the overall package of care during this last admission as an SUI often has a specific term of reference and does not review all aspects of the overall patient care

Several themes are consistent in this group of patients; there were several SUIs related to patient falls, to the use of anticoagulation and either over or under anticoagulation of a patient.

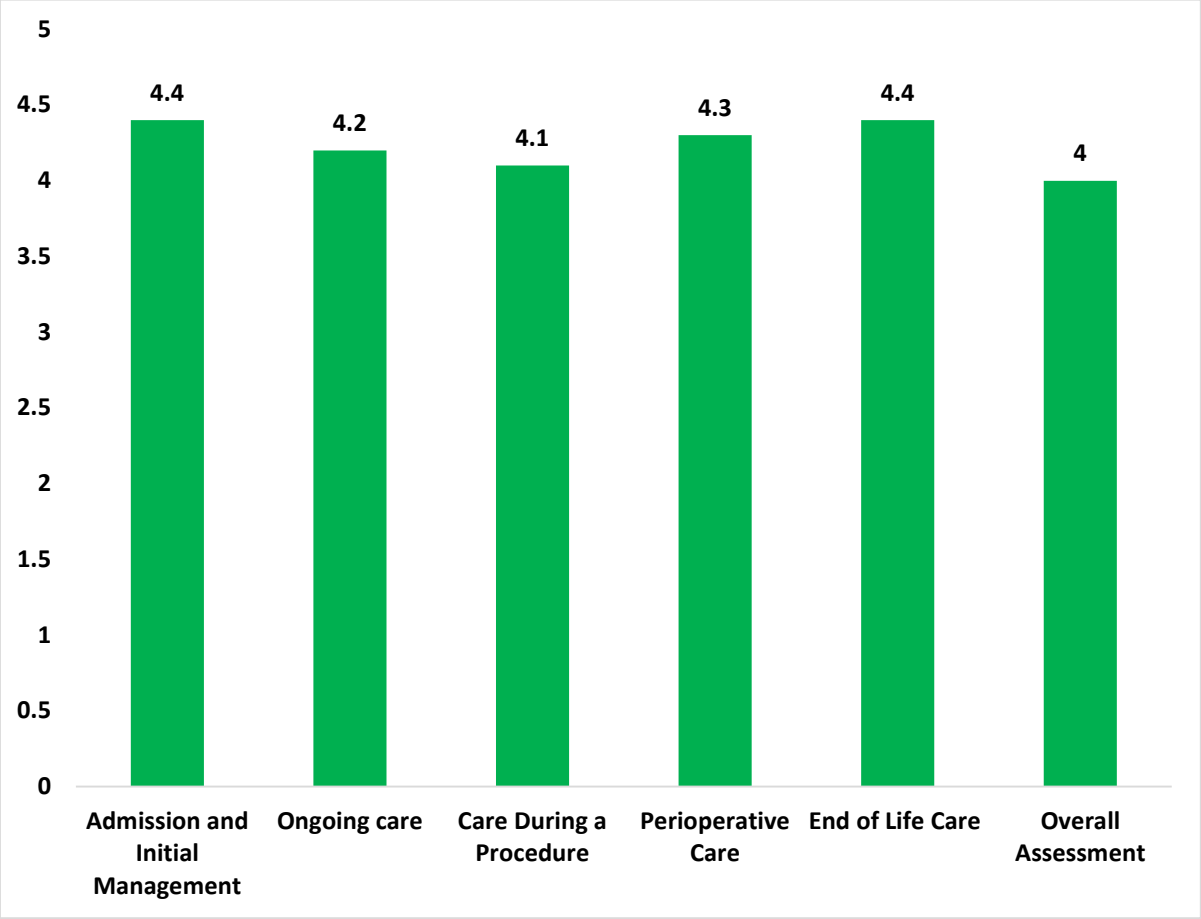
***Chart 8:*** *Category 8 - Serious Untoward Incidents (mean scores for phases of care)*



## Category 9: Mental Health

At UH Bristol a review of patients with a history of mental health is carried out if there is evidence of a current severe mental health issue that requires the input of mental health services during the patient's admission. This includes those under section. During the year there have been 10 deaths of patients who have had a severe mental health condition. No patient had evidence of scores in any domain on SCNR that caused major concern and there was no evidence of avoidable death.

***Chart 9:*** *Category 9 - Mental Health*



### Intensive Care

The Intensive Care Unit (ICU) has screened deaths on its unit in conjunction with the National Guidance On Learning From Deaths (NGOLD) document produced by NHS England which sets out the criteria to identify deaths that should undergo a mortality review. ICU reviews all deaths on the unit by a different process and does not use the SCNR proforma.

The following table shows the data the unit has collected from April 2017 to March 2018.

***Table 7:*** *ICU data 2017-18*

| Month | Admitted | Deaths | OOHCA deaths | Concerns pre- ICU admission care | Elective deaths | 16-18 deaths | Learning disabilities | Mental health | Complaints | Review score inadequate |
|---|---|---|---|---|---|---|---|---|---|---|
| **April 17** | 105 | 12 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **May** | 109 | 16 | 5 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **June** | 108 | 16 | 9 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| **July** | 98 | 15 | 7 | 1 | 1 | 0 | 0 | 0 | 0 | 0 |
| **Aug** | 124 | 22 | 9 | 3 | 2 | 0 | 0 | 1 | 1 | 0 |
| **Sept** | 96 | 24 | 8 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Oct** | 99 | 15 | 6 | 0 | 3 | | 1 | 0 | 1 | 0 |
| **Nov** | 109 | 18 | 8 | 4 | 1 | 0 | 1 | 0 | | 0 |
| **Dec** | 120 | 14 | 2 | 5 | 0 | 0 | 0 | 1 | | 0 |
| **Jan 18** | 112 | 22 | | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Feb** | 100 | 14 | 7 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| **March** | 106 | 16 | 8 | 1 | 3 | 0 | 0 | 0 | 0 | 0 |

**Deaths within 30 days of discharge from hospital**

One of the other areas of interest was the investigation of learning from the deaths of patients within 30 days of their discharge from hospital. This group initially provided a challenge in identification. However, we have developed a process that allowed us to identify these cases. These patients were subject to a review following their death.

This group proved to be larger than we had expected. The national guidance on learning from deaths advises that “trusts should include cases of people who had been an inpatient but died within 30 days of leaving hospital”. At present no other hospital in the South West has had the capacity to start looking at this subgroup yet.

We started to look at this in November 2017 to get a better understanding of what this group looked like and the numbers that were involved, with a view to setting up a process that would allow us to review these deaths. We include a summary of the findings.

See the flow chart on the following page.

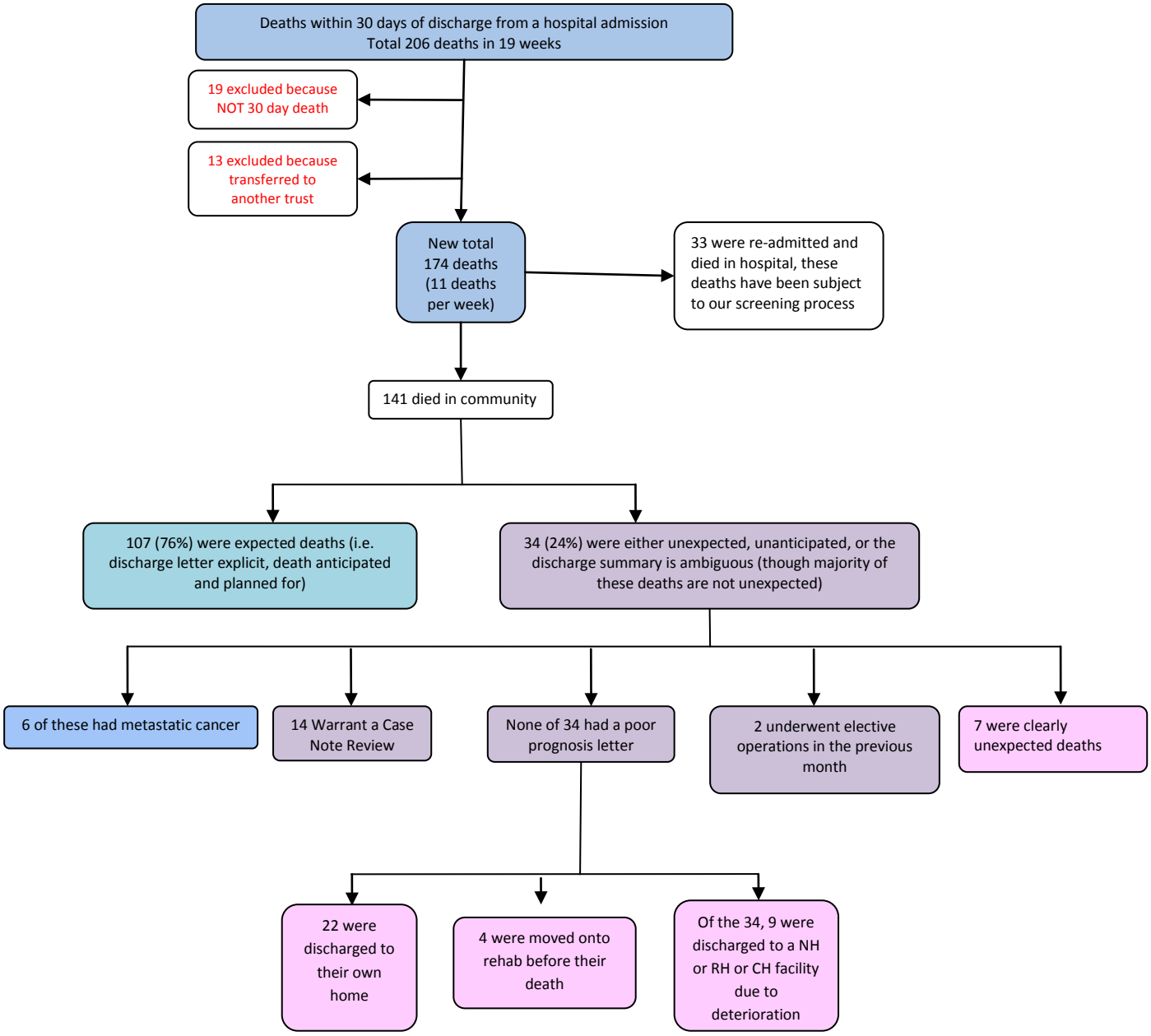
There were 206 deaths of patients within 30 days of discharge over the 19 week period of this review. This was a much higher number than had been expected. The deaths in patients in this group were then further reviewed and assessed to the number that fulfilled the criteria for SCNR.

There were 14 deaths that were identified as requiring a structured case note review. In one patient the death occurred in another trust, this was reviewed by the Emergency Department. Nine patients were medical cases which have had full structured case note reviews. Three patients were reviewed by Specialised Services, one patient with the Cardiothoracic Team (as this was a post Coronary Artery Bypass Graft death) and two patients have been reviewed by the Oncology Team because they were a chemotherapy related death. One patient of the 14 subsequently did not require a review on further investigation.

This short review highlighted several issues at the interface between primary and secondary care around the flow of patient information. Reviewing these patients has proved challenging due to accessibility to deceased patients’ notes in primary and secondary care.

The SCNR reviews highlighted the issue of discharge summaries and the use and integration of the poor prognosis letter.

***Chart 10:*** *Process for reviewing the deaths of patients who died within 30 days of discharge from hospital*



# Conclusion

Over the period April 2017 – March 2018, the mortality team has screened 1,281 deaths (all inpatient deaths except out of hospital cardiac arrests) and identified 25% that required a structured case note review according to the criteria set.

We have developed our own screening process which identifies more than 50% of these patients requiring a review.

Our report shows pleasing results: in the majority of cases that we reviewed the care given has been good or very good.

We have had four deaths that were probably avoidable (score 3: probably avoidable, more than 50:50). These cases have all had second reviews by the Medical Director's team.

The two major themes associated with patients subject to SCNR in all divisions were the instigation of the End of Life Pathway, and the early involvement of senior decision-making to adopt this pathway. The instigation of the End of Life Pathway is a major cross-divisional issue and has now formed the basis of an active and ongoing project within the Quality Improvement Academy for the year 2018/19.

This project will assess the integration of the End Of Life Pathway in the overall management of patients within the Trust. The Summary Hospital-level Mortality Indicator (SHMI) data is a year behind, and as such will start to impact on data collection from 2018/19.

As part of the West of England Academic Health Science Network collaborative we feedback all our results and the themes from learning from deaths, and these are the common areas for learning from all the hospitals within the region.

We have widened our training programme to increase the number of reviewers and plan an annual review of the process in May following the completion of the first year.

Another positive outcome of the process has been encountering the examples of truly excellent care found when reviewing patient notes. The Divisional leads have been able promote these elements of best practice by sharing with the teams and having those clinicians acknowledged by the Medical Director.

## List of reviewers

| Division of Specialised Services | |
|---|---|
| **Specialised Services Lead** | **Cardiac anaesthetists** |
| Colette Reid | Ian Ryder |
| | James Hillier |
| **Cardiac surgeons** | Richard Bateman |
| Hunaid Vohra | Tim Lovell |
| Cha Rajakaruna | |
| Umberto Benedetto | **Oncologists** |
| Alan Bryan | Charlie Comins |
| Franco Cuilli | Vivek Mohan |
| Raimondo Ascione | Jess Jenkins |
| Andrew Parry | Jilly McClean |
| Mark Yeatman | |
| | **Haematologists** |
| **Cardiologists** | Amanda Clark |
| Ihab Diab | Rachel Protheroe |
| Radwa Bedair | Laura Percy |
| Mark Turner | Lisa Wolger |
| Yasmin Ismail | |
| Mandie Townsend | **Oncology SpRs** |
| Tom Johnson | Philippa Closier |
| Julian Strange | Helen Brook |
| Ed Duncan | Hannah Reed |
| Steve Dorman | |
| Glyn Thomas | **Cardiac Matrons** |
| Palash Barman | Julie Crawford |
| Stephanie Curtis | |

| Division of Surgery | |
|---|---|
| Paul Wilkerson – Surgery Lead | David Messenger |
| Jane Blazeby | Jamshed Shabir |
| James Skipworth | Paul Sylvester |
| Jonathan Rees | Mike Thomas |
| Andrew Strickland | Rob Longman |
| Jon Randall | Evelyn Internullo |
| Dan Titcomb | Gianluca Casali |
| Paul Barham | Doug West |
| Chris Streets | Michael Schiller (OG fellow) |
| Andrew Hollowood | Elaine Toh (Thoracic Fellow) |
| Meg Finch-Jones | |

| Division of Medicine | |
|---|---|
| **Consultants** | **Juniors** |
| Rebecca Maxwell (Medicine Lead, ED) | Sophie James |
| Amanda Beale (Medicine Lead, Gastro-Hep) | Mark Houston Millet (SpR ED) |
| Jim Orr (gastro-hep) | Steve Dixon (SpR gastro) |
| Sarah Kyle (SpR lead – acute medicine) | Jodie Sabin (endo SpR) |
| Bushra Ahmad (Endo) | Hazel Morrison |
| Emma Kate Reed (COE) | Miranda Cole |
| Emily Bowen (COE) | |
| Katrina Curtis (respiratory) | **Learning Difficulties Lead** |
| Dave Wilson (radiology) | Helen Bishop |
| Louise Newell (dermatology) | |
| | **Matrons** |
| **Mental Health Lead** | Sally Wilson Medicine |
| Nicola Taylor | Karen Holliwell |
| | Lynne Myers |
| **Management Reviewers (third reviews)** | Sarah Jenkins |
| Mark Callaway | Jo Lloyd-Rees |
| Emma Redfern | |