Learning from Deaths programme for Mental Health Trusts

Taster session

2024-25

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Advancing Quality Alliance

Housekeeping

We are recording today's session so that we can capture discussion.

Please feel free to use the chat box for comments or questions during the session.

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Agenda

Title	Additional Info
Joining via Teams link **Introduction – who's in the room?**	Chair – Paul Greenwood Slido to capture the details
SJRs and SJR*Plus*	
Population inclusion	
Addressing inequality	
Moving away from quantitative to qualitative	Jean MacLeod Tracey Sparkes
Information gathering and PSIRF	
System learning	
Wrap up and forward planning: if you could change one thing?	Paul Greenwood
Close	Thank you!

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learning from deaths, learning for lives

Slido

Who is in the room?

What *role* do you have in Learning from Deaths?

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Which organisation do you work for?

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What is your role?

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Where are you based?

About Aqua & Better Tomorrow

We are an NHS health and care quality improvement organisation working across the NHS, care providers and local authorities to identify, refine and embed sustainable strategies for high-quality care and regulatory excellence.

Established more than a decade ago, we provide improvement expertise, specialist learning and development, and consultancy services for health & care organisations through long-term membership and project-by-project consultancy.

We provide our customers with the skills, expertise, and trusted advice to deliver safe, high-quality care in any setting from an experienced team of public servants with an established UK-wide and international network.

Expertise

We are delighted to be able to provide the Better Tomorrow programme. We have worked with the team previously operating out of NHSE to co-design support and are confident that we will build on the considerable success and learning from the programme to date and offer value for trusts needing support on learning from deaths.

The Better Tomorrow programme originated from a passion for improving care and a respect for Learning from Deaths. The main aim of the programme is that we learn together and together we improve care for patients. Expertise includes providing intensive support to the trusts and systems the clinical and patient safety leadership, leading trusts to embed the quality improvement initiative and thus enhancing patient care services.

SJR Plus tool

As all users will be aware, Aqua recently took over running the SJR Plus app after NHSE's decision to stop supporting from the end of this fiscal year (2023/24).

Our expertise and experience: Aqua's Better Tomorrow

Aqua have worked with the Better Tomorrow team to design a package of products for Trusts or systems to commission to help them successful implement and sustain a learning from deaths approach. The Better Tomorrow team, have until recently been working for NHSE and have considerable experience and expertise.

The work is underpinned by good understanding of current state (diagnose) making the most of a tried and tested implementation approach (support) with a view to changing practices and cultures of learning (sustain).

Jean MacLeod (Clinical Lead)

Jean is a consultant in Internal Medicine and Lead Medical Examiner for North of Tees in North-East England. She has had a variety of clinical and patient safety leadership roles, all focussed on quality improvement, including long experience in incidence investigation and in undertaking mortality reviews, describing and learning from the good as well as not good enough.

Over 3 years within NHS I then NHSE she developed and led the Better Tomorrow programme with Tracey Sparkes. The programme spread well beyond the initial cohort of intensive Support for Challenged Trusts and Systems, with interest from acute mental health and community health providers, and moved to Aqua in 2023 to continue supporting organisations.

She has contributed to guidance for NICE, Diabetes UK and NCEPOD; worked as Clinical Ambassador for GIRFT in N East England and N Yorkshire; and served as Director of Quality for the Royal College of Physicians of Edinburgh. She continues to sit on the Northern Clinical Senate and Board of the Costing for Value Institute of Health Care Finance Managers Associations.

Tracey Sparkes (Programme Lead)

Tracey trained as a nurse and health visitor. Her career has focused on working with health and social care organisations to improve quality and efficiency through standards development, consultancy, training and audit. Her previous roles include Regional NHS Performance Lead at the Audit Commission, Primary Care Survey Manager at the King's Fund and Commissioning Lead for Children's Services in West Yorkshire. As a consultant, she has worked on various programmes for the Department of Health, NHS Wales, Local Safeguarding Children Boards, NHS Trusts and CCGs.

Tracey is an experienced report writer and has had four Serious Case Reviews published as an independent Author. Her academic publications have focused on multi-agency and system-wide learning, and include a chapter on Mental health promotion in old age In: Norman, I.J. and Redfern, S.J. (eds) Mental Health Care for Elderly People, Churchill Livingstone (1997)
Tracey has led two joint county-wide inspections of services for Older People. Her work on Learning from Deaths began when she led an external review across Leicestershire in 2017. As the programme lead for Better Tomorrow, she has applied her knowledge and experience of systems, quality improvement, audit and programme management to learning from deaths. This has involved working directly with Trusts in England as well as co-producing a suite of open access tools and materials to support organisations in learning from deaths and turning this into improvement in care.

Paul Greenwood
Programme Manager for Mental Health | **Mental Health Subject Matter Expert,** Aqua

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Lismy Cheripelli

Senior Improvement Advisor | **Programme Manager and Business Contact** for Learning from Deaths, Aqua

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Yiinubari Nwigbo

Principal Business Intelligence Analyst, Aqua

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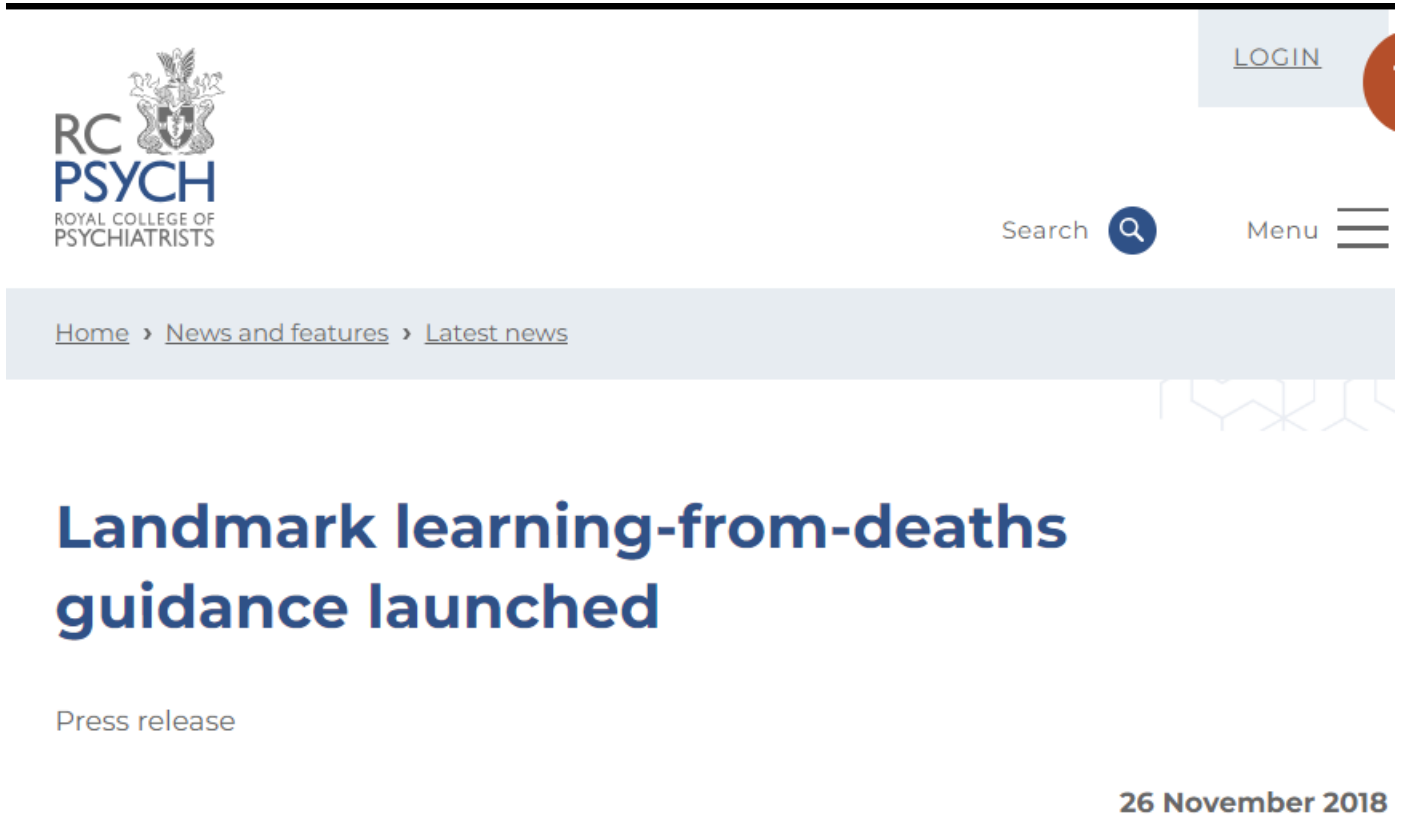
Slido result

Who is in the room?

Structured Judgement Review



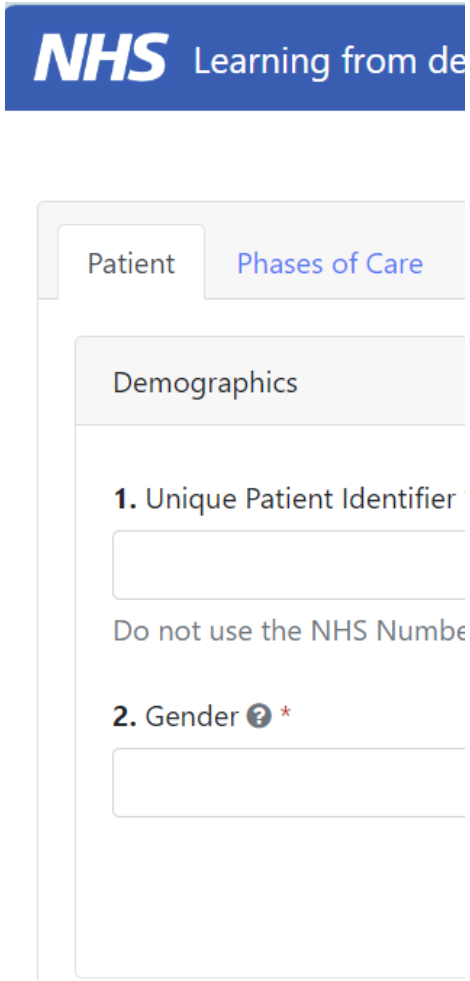
SJRs and SJR*Plus*

Principles of SJR

- Combines traditional, clinical-judgement based, review methods in a standard format
- Usable across services, multi-professional teams and specialties
- Relies upon trained reviewers looking at the patient record in a critical and holistic manner and commenting on specific phases of care and treatment
- Requires safety and quality judgements and a score for phases of care
- Uses free text and categorical variables to capture the quality of care delivered
- Identifying good practice and behaviours
- Identifying gaps, problems or difficulties in the care received

SJRs and SJR*Plus*

https://lfd.ardengemcsu.nhs.uk/MortalityReview



SJR*Plus* now hosted by Aqua

- Based on RCP and RCPsych mortality review tools
- Demographics
- Extended phases of care: Admission and Assessment, Ongoing Care, End of Life Care
- Includes Elixhauser comorbidity for complexity
- Standardised grading
- Drop down menus
- Problems in care and the Yes No Maybe
- Online data capture
- Exportable data and integrated reporting
- Integrated dashboard

SJRs and SJR*Plus*

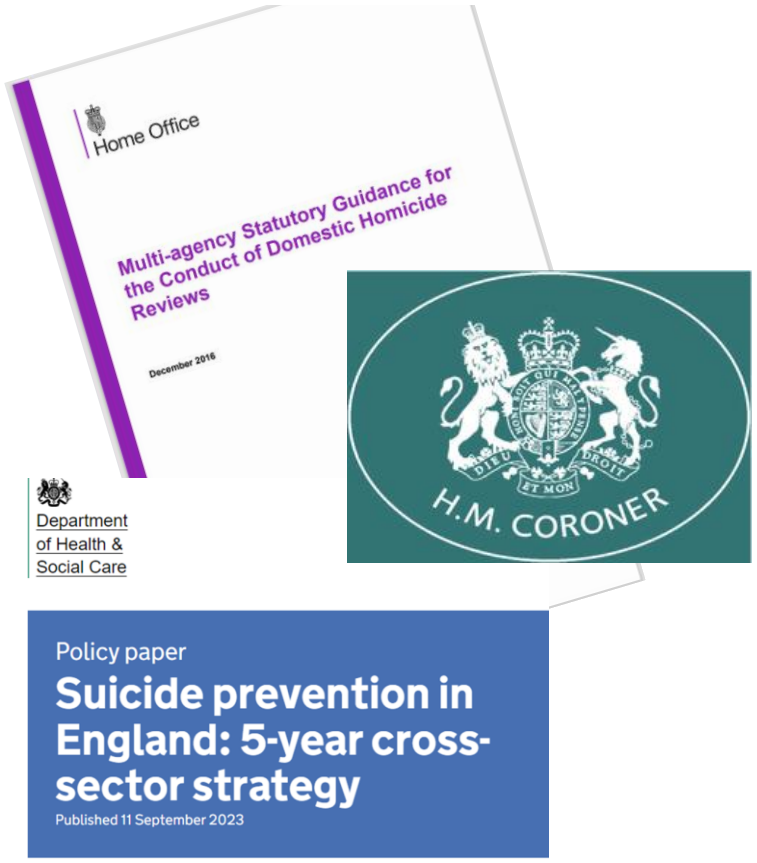
Capturing data about problems in care

Problem with care?	Yes/No/Maybe
Previous admissions to psychiatric hospital	
Inpatient or community death	
Detained under the mental health act	
Quality of patient record	
Family carer support	
Notable staff concerns	
Problem with management plan	
Problem with management plan (harm)	
Problems with community setting	
Problems with community setting (harm)	

How representative are your reviews?

Population inclusion

Finding cases and describing cases



in-patient in a mental health unit at the time of death
under the care of services at the time of their death

had been discharged from in-patient care within the last month
had been discharged within the 6 months prior to their death
under a Crisis Resolution and Home Treatment Team at the time of death

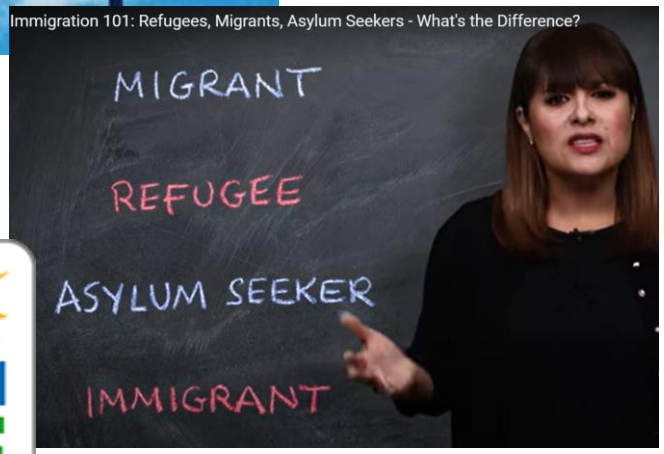
with a diagnosis of psychosis or eating disorders during their last episode of care

where family, carers, or staff have raised concerns about care

where family, carers, or staff have recognised exemplar care?

Addressing inequalities

Finding cases and describing cases



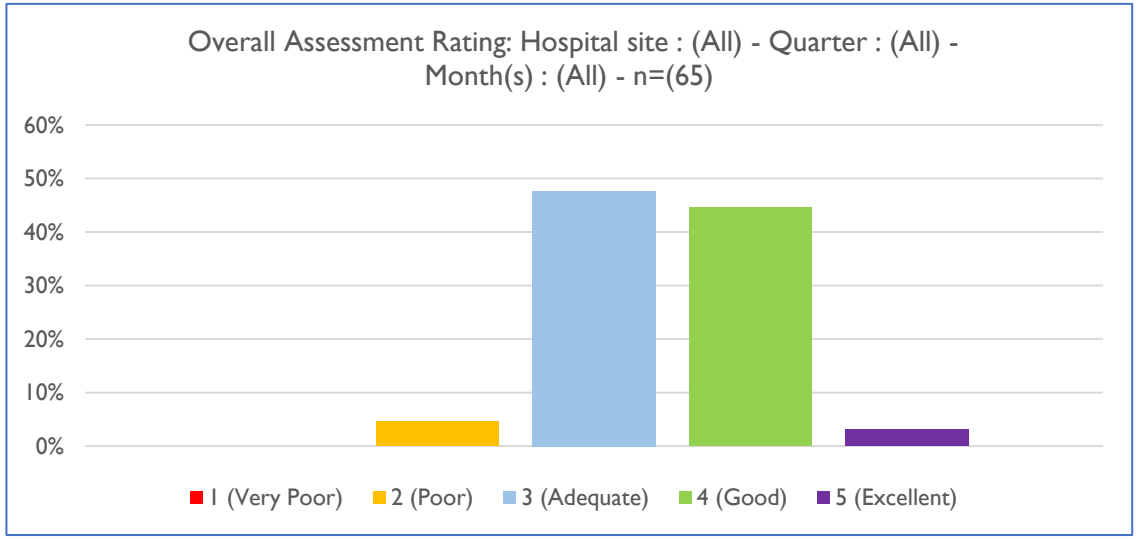
PEOPLE'S POSTCODE LOTTERY

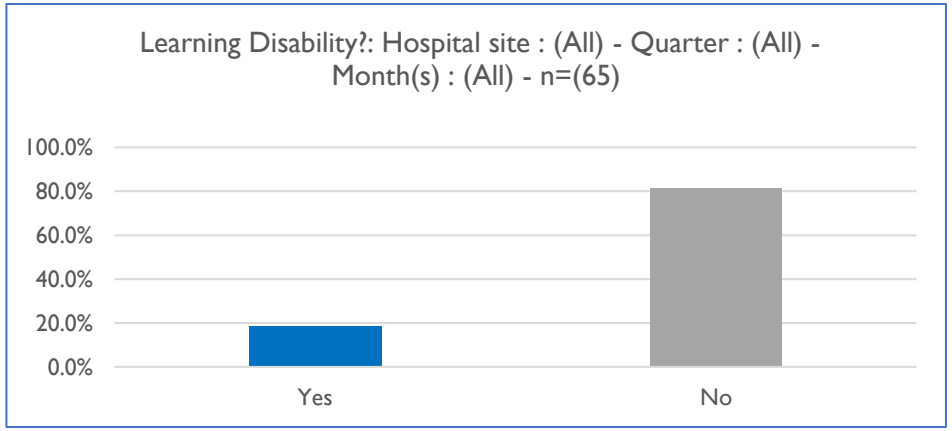
Discuss

How are you sharing information with your local Medical Examiner team?
How do staff prompt case reviews?

Moving from quantitative to qualitative

Quantitative data outputs on SJR*Plus* – high level to granular level





Overall care assessment rating for patients with learning disability

Patient with learning disability - overall assessment care rating
Learning Disability? Yes

Overall summary

	Admission and Assessment Care Rating	Ongoing Care Rating	End of Life Care Rating
1 (Very Poor)			
2 (Poor)			1
3 (Adequate)		1	1
4 (Good)	10	8	7
5 (Excellent)	2	2	1
Grand Total	**12**	**11**	**10**

Detailed summary

	Admission and Assessment Care Rating	Ongoing Care Rating	End of Life Care Rating
Patient 1	Good Care	Good Care	N/A
Patient 2	Good Care	Good Care	Good Care
Patient 3	Good Care	Good Care	Good Care
Patient 4	Excellent Care	Excellent Care	Excellent Care
Patient 5	Good Care	Good Care	Good Care
Patient 6	Good Care	N/A	Good Care
Patient 7	Excellent Care	Excellent Care	N/A
Patient 8	Good Care	Good Care	Adequate Care
Patient 9	Good Care	Good Care	Good Care
Patient 10	Good Care	Good Care	Good Care
Patient 11	Good Care	Adequate Care	Poor Care
Patient 12	Good Care	Good Care	Good Care

Moving from quantitative to qualitative

Using SJR captured narrative

Lessons learned: Hospital site : 4 - Quarter : (All) - Month(s) : Lessons learned

Back to contents

Negative lessons learned description	Count
possible suboptimal anticoagulation	1
notes very patchy, he had been moved between departments and sites on several occasions and some notes were definitely missing, others out of order.	1
Problems with anticoagulation compliance due to	1
Me: referred for learning after family expressed concerns:	1
Prolonged operative time using lots of irrigation in a high risk patient Difficulties in contacting Consultant Urologist	1
lack of dates and times in paperwork which was also out of order making narrative hard to establish. delay in palliative care being instituted - largely due to family disagreement	1
transfer of patient without documentation deterioration not recognised inappropriate resuscitation	1
if the intent of the ciprofloxacin was to prevent urosepsis then this was an oversight as she had resistance to it. It is still possible that even on a different antibiotic the outcome would have been the same. evidence that she was resistant to the antibiotic she was given (ciprofloxacin)	1

Positive lessons learned description	Count
Good end of life care	1
excellent multidisciplinary involvement good discussions with family who took a long time to accept the situation.	1
Communication particularly by junior doctors very good	1
good multidisciplinary involvement	1
excellent attempts to communicate with him (Arabic, non-English speaker)	1
good communication with family + their wishes heard. Good documentation + nursing care	1
good documentation particularly around patient's decision for conservative management, good multidisciplinary care.	1
Good sensible decision making involving patient and family	1

Where should these lessons be shared?	Count
Board Report	82
With the WARDS INVOLVED	1
Board Report	1
Board Report, Patient Safety	1
Board Report.	2
Fed back to North Tees	1
Board Report Patient Safety	1
Grand Total	89

Moving from quantitative to qualitative

Using SJR captured narrative

Drilling down to
End of Life Care phase

Judgement: Hospital site : (All) - Quarter : (All) - Month(s) : Jan-00

Question

End of Life Care Judgment	End of Life Care Rating	First 24-hour Care Judgement
First 24-hour Care Rating	Hogan Scale definitions	NCEPOD Definitions
Ongoing Care Judgement	Ongoing Care Rating	Overall assessment Judgment

Judgement detail	ID
Decision for palliation by patient and family after refusal of NG tube feeding. Attempts to discharge home rebuffed by patient and family. Fast discharge to nursing home / hospice planned but died before this could be done.	LFD003050
Patient only responding to voice, for palliation, very frail, medical assessment that the patient is ill enough to die completed. Seen by Consultant family discussion documented family in agreement to palliate. Care plan 25 commenced. syringe driver in place. Death verified 11/01/2024.	LFD003033
Discussion with family documented, being treated with antibiotics for pneumonia. Patient still been actively treated, anticipatory medications	LFD003274
Patient kept comfortable. Seen by the Specialist Palliative Care Team. End of life care plans in place, syringe driver insitu. Family discussions documented	LFD003111
ICU care of the dying pathway followed, family present pain free, death verified.	LFD003257
Family discussions documented, medical assessment that the patient is ill enough to die completed. No concerns.	LFD003039
19/03/2023 medical assessment that the patient is ill enough to die completed. Care plan 25 commenced. Anticipatory medications prescribed. Patient kept comfortable, family present, reviewed by Specialist palliative care Team. Verification of death documented.	LFD003037
	LFD003237
Had Oramorph prescribed, not yet formally on end-of-life care pathway, but palliative and death not unexpected Death verified.	LFD003317
Care of the dying patient ICU pathway completed. Appears to have passed away comfortably with family at his bedside. Death verified.	LFD003487
not formally on EOLCP patient not unexpectedly passed away, family present, death verified, anticipatory medications not required, rapid release	LFD003318
Specialist palliative care input, EOL care plans in place, EOL revoked when GCS improved, but patient deteriorated with high NEWs, death verified.	LFD003268
Good (but difficult) discussion with family, agreed transition to palliative care - delayed because of family disagreements.	LFD003054
Transition to end of life 18/03 following discovery of infarct.	LFD003114
After discussion with family agreed further active treatment not in his best interests and transition to palliative care.	LFD003110
NA	LFD003183

How easy it is to gather information from your reviews?

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Information gathering and PSIRF

Is this for an investigation or for structured judgement review? One interrogation not duplication of effort

Coroner Inquest

Collate factual statements for Coroner, document accurate chronology of events and investigate through internal process, capturing positive and negative lessons Use Duty of Candour if relevant. Ensure family &/or carers are aware of referral. Coroner will also liaise with family &/or carers for information gathering and let them know processes. Use feedback from Coroner Inquests to gather trends and inform improvement plans.

Coroner
Wants to know facts
Expects and values honesty
Appreciates improvement
Gives judgement

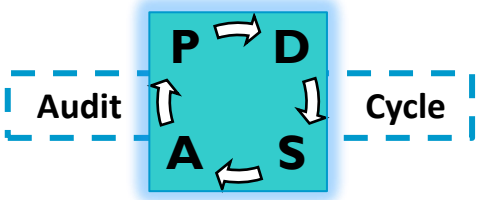
Patient Safety Incident, Complaint or Duty of Candour

Generate incident report to prompt information gathering. Collate factual information: chronology of events and circumstances; contributory factors; and any positive and negative lessons. Different learning approaches can be used depending on the information gathered.
Use Duty of Candour if it is needed. Liaise with family &/or carers to address their concerns, answering complaints directly with available information, involving clinical teams throughout investigation.

Patient Safety Incident Investigation, Multidisciplinary team (MDT) review or After Action Review
Refer to Patient Safety Incident Response Framework

Audit of care bundles or care processes

Review of care processes and care delivery against a standard operating policy or standard of practice, capturing positive and negative lessons. Use improvement methods to complete audit cycle and demonstrate progress. Involve family &/or carers in improvement planning based on audits.
Use an investigation of events and Duty of Candour if any failings influenced an individual outcome.



If none of above applies then consider case for:

Structured Judgement Review

Judgement based holistic review of care with narrative, ratings and grading which captures positive and negative lessons. If SI, Near Miss or DoC identified in case review, then investigate as above. Involve family &/or carers and system partners in discussion of trends and improvement planning.

Include random cases and exemplars for balance.

Insight and learning comes from sharing all of these

Information gathering and PSIRF

Learning from deaths

- Complaints
- PSIRF
- ME scrutiny
- Coroner
- Feedback
- SJR
- Peer review GIRFT
- LeDeR
- Audit
- Special reviews eg CDOP NCISH SARs HSSIB
- Coding
- Mortality metrics

Gathering a full picture of care

Thematic analysis

↓

Action, learning and improvement

Discuss

Who holds the data in and around your organisation?
How are you going to integrate it for deeper understanding?

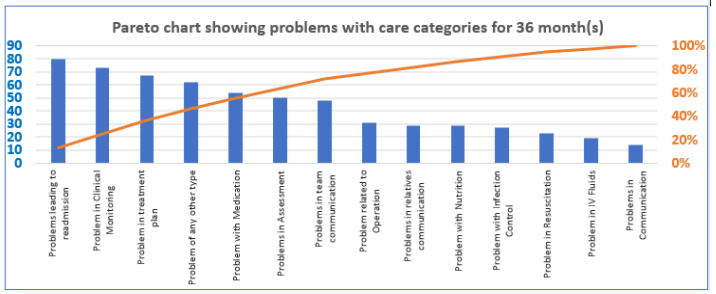
System learning

Sharing the output for impact

- Individual records
  - shared with second reviewer or a mortality review team
  - lived experience captures interest
- Collated records
  - shared within a report to understand common themes and findings
  - mapping changes over time to ensure organisational memory
- Dashboard
  - displaying information in context for wider audience
  - sharing information in structured way for system or regional learning

The story of Mrs B....

Patient demographic or shared underlying condition	
Same CoD	Same concern
Same place	Same team
Same drug	Same behaviour



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System learning

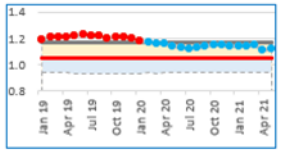
Northern Lincolnshire and Goole NHS Foundation Trust

Context

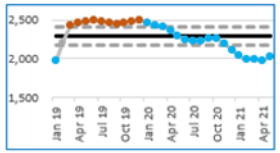
Detail

SHMI

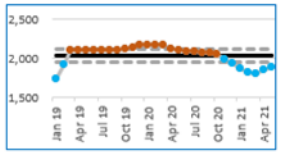
Latest month	May-21
SHMI	1.071
Observed deaths	2018
Expected deaths	1884



Trust SHMI - Observed deaths



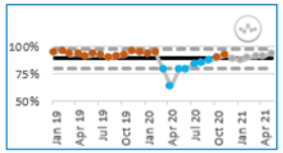
Trust SHMI - Expected deaths



Hospital Occupancy

Latest month	May-21
%	93.6%

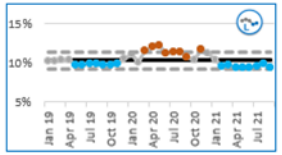
No significant change



% Patients with LoS > 7 day

Latest month	Sep-21
%	9.5%

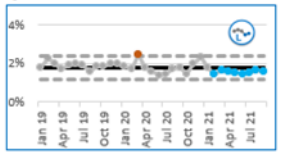
Improving decrease



% Patients with LoS > 21 days

Latest month	Sep-21
%	1.6%

Improving decrease



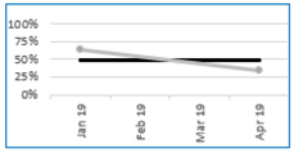
Scrutiny to SJR

Detail

% of deaths scrutinised by ME

Latest month	Sep-21
%	33.7%
Number	160

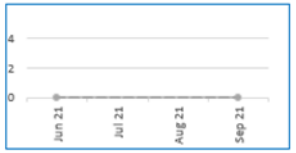
No significant change



No. MCCDs not completed within 3 calendar days of death - Q16

Latest month	Sep-21
Number	0

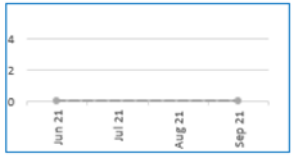
No significant change



No. Patient Safety Incidents notified by medical examiner office as a result of scrutiny - Q23

Latest month	Sep-21
Number	0

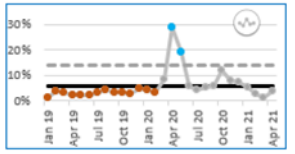
No significant change



SJRs (% of total deaths)

Latest month	Apr-21
%	3.8%
Number	7

No significant change



Care

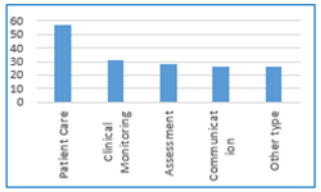
Detail

Good care identified

In 65 out of 80 cases (81.3%) positive lesson were learned.

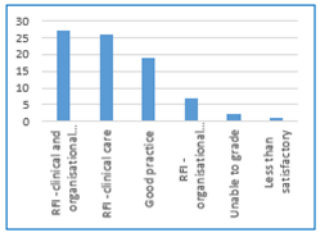
Problems with Care

Patient Care	57/82
Clinical Monitoring	31/82
Assessment	28/82
Communication	26/82
Other type	26/82



NCEPOD assessment

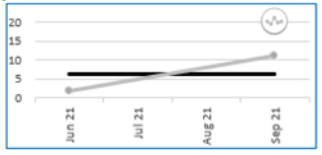
RFI -clinical and organisational care	27/82
RFI -clinical care	26/82
Good practice	19/82
RFI -organisational care	7/82
Unable to grade	2/82
Less than satisfactory	1/82



Deaths where a significant concern about the quality of care provided is raised by bereaved families and carers - Q20a

Latest month	Sep-21
Number	1

No significant change



System learning

Sheffield Health & Social Care NHS FT - MOCK UP - EXAMPLE ONLY

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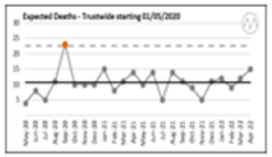
Context — Detail

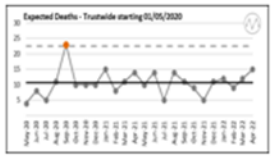
Deaths

Latest month	May 22
All Deaths	18
Of which, Unexpected Deaths (Suspected	5
Unexpected Deaths (not natural causes)	7

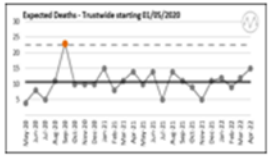
All Deaths



Unexpected Deaths (not natural causes)



Unexpected Deaths - Suspected Suicide



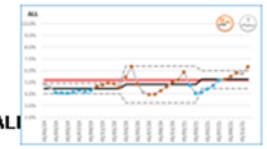
System Pressure — Detail

Demand (Referrals in)

	May 22
SPA	759
OA CMHT (SPA)	264
Liaison Psychiatry	147
TOTAL	1170

Demand (bed occupancy)

	May 22
Acute	98%
PICU	94%
Older Adult	86%
TOTAL	95%



Out of Area Bed Nights Used (ALL

	May 22
TOTAL	345
Equivalent beds occupied	11.1

Community Service Activity

Caseload (Open episodes)	4500
Countable Contacts (Activity)	24562

Scrutiny — Detail

SIs (% of total deaths)

Latest month

%

Number

SJRs (% of total deaths)

Latest month

%

Number

% deaths to Coroner

Latest month

%

Number

% deaths scrutinised by ME

Latest month

%

Number

Complaints about Deaths

Care — Detail

Good care identified

Narrative eg good care was identified in 3 of the 5 SJRs...

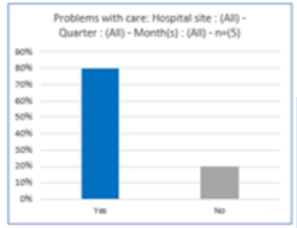
Problems with care (DATES)

	n.	%
Yes	4	80.0%
No	1	20.0%
Grand Total	5	20.0%

*number of incomplete records 0

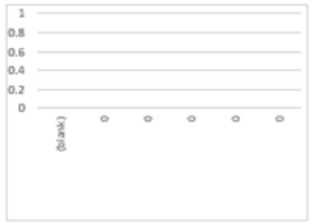
Ranked order

Problem area	Yes
Problem with Medication	4
Problem related to Treatment	3
Problem with Nutrition	1
Problem of any other type	1
Problems in Communication	1
Problem in Clinical Monitoring	1



NCEPOD assessment (DATES)

Good Practice	0
< satisfactory	0
RFI Clin and Org care	0
RFI Clinical care	0
RFI Organisational care	0
Unable to grade	0



Complexity & Co-morbidities

Elixhauser over 20?

?

Learning Identified	n.	%
Positive	2	40.0%
Negative	1	20.0%

- Common dataset approach
- Linking existing data streams
- Contextual data
- SJR data
- Longitudinal assurance

Discuss

Who are your stakeholders in Learning from deaths – who should be involved to help you make a difference?

aqua
Shape Change Inspire Quality Transform Care

Agenda

What did we touch on?

- ✓ SJRs and SJR*Plus*
- ✓ Population inclusion
- ✓ Addressing inequalities
- ✓ Moving from quantitative to qualitative
- ✓ Information gathering and PSIRF
- ✓ System learning
- ✓ Wrap up and forward planning: if you could change one thing?

How could we help?

If you want a further conversation with the team, please contact:

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