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EQUIP-2017-079
Review Date: September 2018
Review Lead: Associate Medical Director

Calderdale and Huddersfield
NHS Foundation Trust

Learning from Deaths Policy
Version 1

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Author	Associate Medical Director	
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Mortality Surveillance Group	Medical Director	11 August 2017
Clinical Outcomes Group	Medical Director	21 August 2017
Quality Committee	Non-Executive Director	4 September
Other Stakeholders Consulted		
Matron for Complex care		August 2017
Clinical Governance Midwife		August 2017

Does this document map to other Regulator requirements?	
Regulator details	*Regulator standards/numbers etc*

Document Version Control	
Version no	
1	The policy has been developed from the Mortality Review Protocol and considers the National Quality Board guidance published March 2017

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Contents

1. Introduction

Mortality data from each NHS trust is freely available in the public domain, and comparisons in rates between trusts are made and used as part of the overall assessment of the quality of care provided by a trust. The Keogh review (2013) examined the quality of care and treatment provided by 14 NHS trusts that had shown persistently high mortality rates over the previous two years, and as a result of the findings the 14 trusts were put into "special measures" by Monitor.

Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). In February 2017, the CQC set out new requirements for the investigation of deaths for all trusts to run alongside the local existing processes. This was followed by the publication by the National Quality Board in March 2017 providing further guidance for trusts entitled 'A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'.

The Trust has investigated a number of selected deaths since 2014, in order to learn from deaths, in addition to the formal investigation of deaths reported through the incident management process. Between November 2014 and April 2017, 1925 reviews have been carried out on the 4132 inpatient deaths.

Reviews on all still birth and neonatal deaths have been carried out for a significantly longer period.

2. Purpose

The purpose of this policy is to describe the process by which we learn from mortality reviews and how we will keep the Board informed of the learning. This will enable us to identify areas for improvements in patient care and experience and take appropriate action to bring about a reduction in the mortality rates at the Trust and where death is inevitable, we ensure quality of care.

The policy will ensure that there is a consistent and coordinated approach to undertaking mortality reviews, and reporting on findings, and implementation of identified actions. It will also clarify how the process for mortality review dovetails with other investigation processes within the Trust, to facilitate a streamlined and coordinated interface with incident, complaint, inquest and claims investigations, where applicable.

Completion of timely and proportionate mortality reviews will also enable the trust to identify recurring and emerging issues and to be able to respond quickly to any questions raised by external organisations, e.g. CCG, CQC, in relation to mortality trends.

3. Definitions

The definitions or explanation of terms relating to this document are:

HSMR Hospital Standardised Mortality Ratio is a ratio of the number of in-hospital deaths to the number of "expected" deaths (which is calculated according to factors such as age band, sex, co-morbidities, length of stay, admission category) calculated for 56 specific clinical classification groups.

SHMI Summary Hospital-level Mortality Indicator is published quarterly by the Department of Health. It is calculated in a similar was to HSMR, but includes deaths in all clinical classifications, and also deaths occurring up to 30 days after discharge.

CUSUM The CuSum is a statistical process control (SPC) technique which provides focus on the outcome trend of a series of consecutive procedures. It is designed to allow prompt detection of changes in performance reflected by persistent deviation to an acceptable and expected rate of adverse outcomes

StEIS Strategic Executive Information System is for reporting Serious Incident (SI) that enables electronic logging, tracking and reporting of Serious Incidents with the NHS Improvement

4. Duties (Roles and Responsibilities)

Duties within the Organisation

The Board of Directors ("BOD") will keep mortality under constant review. It will receive reports relating to mortality review findings, and request additional reviews and actions as a result.

The Medical Director has executive responsibility for the mortality review process and implementation of improvements. Operational responsibility for the mortality review programme, including reporting its findings and implementing improvements, is delegated to the **Associate Medical Director.**

The Coding Team will ensure that the patient's care is coded and completed within three working days of the month-end.

Health Informatics Team will review local data sources and national benchmarking tools, i.e. HSMR and SHMI provided by the Healthcare Evaluation Data (HED), and additional information provided by NHS Digital for early warning signs. Any area of concern flagged to the Associate Medical Director who will initiate a coordinated and proportionate investigation.

Mortality Reviewers must undertake the reviews that have been allocated to them within the designated timescale (usually within 4 weeks). Reviewers must flag any difficulties in undertaking reviews to the Governance Team.

The Governance Team coordinates the mortality review process, maintaining an up-to-date spreadsheet of reviewers and cases, and ensuring that cases are allocated appropriately. The team will review and analyse the results of mortality reviews and, together with the Associate Medical Director, produce a monthly report of findings for the Mortality Surveillance Group.

5. Process for conducting mortality reviews

5.1 Reviews of individual patients

Learning from individual deaths will be either by initial screening review or by a structured judgement review (SJR) using a retrospective case note review

5.1.1 Initial screening review

The initial screening reviews will be performed by senior medical and nursing staff using a retrospective case note review and a pre-set screening mortality review on-line proforma. The aim of this screening review is to establish whether the care and escalation, if required, was appropriate and in a timely manner.

These are performed by some specialities areas and include paediatrics, stroke, gastroenterology, general surgery and orthopaedics and emergency department. The rest of the cases, at the time of writing this policy, are allocated randomly each month by the Governance Team.

It is acknowledged that speciality specific reviews will vary in aspects of care investigated eg surgical outcomes such as decisions to operate or returns to theatre. However, as a minimum these speciality specific reviews must complete the online initial screening review tool and rate the overall quality of care given. A standard operating procedure has been developed to ensure standardisation of these speciality reviews (see Appendix 1)

The reviewer will be required to provide an overall score for the quality of the care provided. It is evident from our knowledge of reviewing mortality cases that on occasions the care has been sub-optimal but this has not resulted in the death

however, we also know that where there has been concerns over the avoidability of a death that the quality of care has always been assessed as poor.

The quality of care is scored on a scale of 1 to 5 as below (Royal College of Physicians 2016)

1	Very poor care
2	Poor care
3	Adequate care
4	Good care
5	Excellent care

Where the care is assessed as adequate, good or excellent then the reviewers will be asked whether any harm related to the patient's death for example a patient fall with harm. If harm is observed from the review this should be reported, if not already, on Datix.

5.1.2 Follow-up / escalation following initial screening

The follow up process following the initial screening review is managed according to the quality of care score is outlined in the flowchart in Appendix 1

Cases where the care is assessed as adequate, good or excellent but there was no harm related to the patient's death will result in no additional investigation unless raised through the complaints process.

Cases where harm was noted or the care was assessed as poor or very poor will result in the case been subject to a structured judgement review by one of the specialist reviewers.

5.1.3 Structured judgement reviews

The Structured judgement reviews (SJR) are performed by a small team of clinicians who are specially trained in SJR. The following cases will be referred for SJR although this list is not exhaustive (see flowchart Appendix 1)

- Deaths where families have raised a concern about the quality of care provision
- All deaths from patients with Learning Disabilities (in conjunction with the LeDer process) or significant mental health conditions
- Deaths following elective procedures
- Cases that have been escalated following initial screening reviews

Consideration will also be given to the following deaths

- SHMI/HSMR alerts or outliers
- Random samples of specific groups or conditions

- Deaths where the learning will inform improvement work
- Incidents with harm
- Inquests
- Claims
- Child, still born and perinatal and maternal deaths (in conjunction to the existing review processes)

When a case is flagged for a SJR the Governance Manager will allocate the case using a reviewer who is independent from the direct care of the patient. All SJR must be completed within four weeks of allocation.

The reviewer will grade the case according to the National (Improvement Academy) avoidable death score:

1. Definitely avoidable.
2. Strong evidence for avoidability.
3. Probably avoidable, more than 50-50 but close call
4. Possibly avoidable but not very likely, less than 50–50 but close call.
5. Slight evidence for avoidability
6. Definitely not avoidable

Cases assessed with an avoidability score 1 and 2 will be reported on Datix as a red incident and referred to the weekly serious incident (SI) panel to agree the level of further investigation. This will usually be either to refer for Divisional investigation or to investigate as an SI with reporting on the Strategic Executive Information System (StEIS) (see escalation flowchart – Appendix 1).

Cases assessed with an avoidability score of 3 and/or a quality score of 1 or 2 will be reported on Datix as an orange incident for Divisional investigation (see escalation flowchart – Appendix 1).

5.2 Family and carer involvement

Bereaved families and carers should be invited to be involved with the review of the death and kept informed of the process and outcome. They must be dealt with respect, sensitivity and compassion and should be treated as partners in an investigation, if they so wish, as they can offer a unique and equally valid source of information.

All deaths reported as serious incidents will inform the bereaved family or carer as part of the duty of candour requirements and will have the opportunity to have their concerns investigated. Further details are covered in the Being Open – Duty of Candour policy

Bereaved family and carers that choose to make formal complaints will have their concerns investigated which will include a mortality review. This is included in the Procedure for Handling Concerns and Complaints policy available on the intranet

Further processes will be developed as part of the End of Life Strategy in order to seek a suitable process to make contact with all bereaved families and/or carers. The aim will be to make contact during the period following death of their loved one to see if they had any concerns over the care irrespective of whether this was an expected or not expected death so that we can learn from their experience.

5.3 Reviews of clusters of cases as a result of alerts / horizon-scanning

5.3.1 Identification of cases

The Health Informatics team review the mortality database for early indications that mortality is rising in a specific clinical classification area. It also reviews CUSUM charts contained within the HED system, to identify early trends that may indicate a future alert may arise.

Anticipation of HSMR / SHMI cases that may go on to trigger will be identified within the regular monthly report on current HSMR and SHMI position.

5.3.2 Scope of review

The informatics team will notify the Medical Director via the MSG with relevant information regarding alerts. The MSG will agree the level of review, terms of reference, sample and time frames.

5.4 External Mortality Reviews

5.4.1 Child deaths

Deaths of all children from birth to 18 years in the area are notified to the Calderdale and Kirklees Safeguarding Children Boards Joint Child Death Overview Panel (JCDOP) including children in our care. Whilst all deaths are notified to the JCDOP and a core data set collected, not all deaths will be reviewed in detail. Particular consideration shall be given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention. The team will determine and review on a regular basis which deaths are to be reviewed in an in-depth manner.

5.4.2 Maternal deaths

All maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of residence. These cases are also reported on DATIX to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports are presented to the MSG. Further information can be found in the Maternal Death Guidelines.

5.4.3 Still born and Perinatal deaths

All still born and perinatal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. These cases are also reported on DATIX to ensure local governance and risk management structures are followed. Each case is subjected to a 1st and 2 level review processes using the NPSA review proforma. Quarterly reports are presented to the MSG. Further information can be found in the Still born and perinatal death SOP.

5.4.4 Learning Disabilities Mortality Review Programme (LeDer)

The LeDeR Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, and is overseen by the University of Bristol. It aims to make improvements in the quality of health and social care for people with learning disabilities, and to reduce premature deaths in this population.

LeDeR will support local areas in England to review the deaths of people with learning disabilities aged 4 upwards at the time of their death. All deaths in patient with learning disabilities will be reported externally and reviewed, regardless of the cause of death or place of death. This process will run alongside our internal mortality reviews and will not replace out internal process. Currently all deaths of people aged 18-25 and or if the person is from a Black and Minority Ethnic background will be subject to a full multi-agency review. Consideration needs to be given to red flag alerts (potential problems with the provision of care, for e.g. no evidence of consideration of mental capacity has been considered, or where delays in the persons care or treatment that adversely affected their health) for the potential of a multi-agency review for these deaths.
See appendix 3 for LeDeR reporting process.

In addition, all deaths are reviewed internally using a SJR. These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the MSG.

6. Reporting of findings

6.1 Datix reporting

Mortality cases following SJR that are assessed with an avoidability score of 2, 3 or 4 are reported on Datix as an orange incident for Divisional investigation.

Mortality cases following SJR that are assessed with an avoidability score of 1 are reported on Datix as a red incident and escalated to the Serious Incident Panel to determine the level of further investigation.

Mortality cases where the quality of care is assessed as very poor and scored 1 are reported on Datix as an orange incident for Divisional investigation.

In addition, any mortality case review where an incident resulting harm has been identified should be, if not already, reported on Datix.

6.2 Learning from Death Reports

6.2.1 The Governance Team, with the Associate Medical Director, will produce regular reports of trust-wide mortality review findings. These reports will include;

- The total number of deaths and the number of mortality reviews performed
- How many deaths were judged as more likely than not to have been due to problems in care
- Themes and trends arising in month from the reviewed cases
- A summary of the key findings of cases with a quality score of either poor or very poor
- Any learning points, recommendations and actions

The report is to be presented to the Mortality Surveillance Group (MSG), Divisional Patient Safety and Quality Boards, and Clinical Outcomes Group (COG), and findings escalated to the Quality Committee as appropriate.

In addition, a quarterly report will be presented to the Board of Directors to include the above information.

6.2.2 Findings of "cluster reviews" must be reported on the approved template (see appendix 3) and within the agreed time-scale. They will be presented to the committees / groups as above, and additionally to any other relevant speciality meeting as appropriate.

6.3 Action planning and learning

The MSG will approve any recommendations identified in the monthly report, and any action plan including timescales and action owners.

The Governance Team will ensure the action plan is circulated to the action owners, and will monitor progress and completion, which will be included in the ensuing reports.

Opportunities for learning will be sought including newsletters and learning from death summit events.

6.4 Real time data availability

Using the trusts Knowledge Portal platform, mortality review data is available in the Mortality Model. Mortality reviewers will have access to this and will be able to view the outcome of the reviews which have been undertaken. This data is made available one day following the input of the review into the database.

7. Training and Implementation

Training for initial screening reviewers: a number of short training sessions either in small groups lasting no more than 30 minutes or as part of clinical governance meeting will be provided. Staff who are experiencing difficulties in forming conclusions from their reviews may seek advice and support from a reviewer colleague, or from the Associate Medical Director.

Training for structured judgement reviews: this training will be provided by staff that have already received training from the Improvement Academy.

Implementation: On ratification this document will be available to all staff via the Policies page on the Trust's Intranet. The ratification of the document will also be communicated to staff via divisional communication routes.

Learning from Death: this will be included into the Effective Investigations training and the Complaints Management training.

8. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnerships.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

9. Monitoring Compliance

Compliance with this process will be evaluated from the monthly mortality reports, which will include a section on process and performance, as well as findings.

An annual review of mortality review compliance and findings will be prepared for the Quality Committee. An action plan will be submitted with the report, should any non-compliance with the process be identified.

10. Associated Documents

This document should be read in conjunction with the Incident Reporting, Management, and Investigation Policy.

11. References

This document was drafted with reference to the following documentation:

CQC (2016) *Learning, candour and accountability: A review of the way NHS Trusts review and investigate deaths of patients in England* http://www.cqc.org.uk/content/learning-candour-and-accountability

Hogan et al (2012) *Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study.* BMJ Quality & Safety 22 (2): 182

Keogh B (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf*

NHS England (2017) *National Guidance on Learning from Deaths. A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care* https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

Royal College of Physicians (2016) *National Mortality Case Record Review Programme. Using the structured judgement review method. A guide for reviewers (England)*

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Appendix 1

SOP for speciality specific Learning from Deaths – initial screening review

Purpose

The purpose of this SOP is to define the process by which specialty specific initial mortality reviews are completed. This is part of the trust's 'Learning from Deaths' policy. This SOP applies to initial reviews performed in all deaths within the following specialties:

- Critical Care (HDU and ICU)
- Gastroenterology (patients on ward 17 at HRI)
- General Surgery
- Orthopaedics
- Patients who have been admitted with acute stroke and
- Patients who die in the Emergency Department.

There is a trial underway looking at initial reviews in patients who have died whilst receiving chemotherapy but to whom this SOP, at present does not apply.

Agreed Procedure

1. All patients who die in hospital either under the care of a specialty with or with an admitting diagnosis as defined above will have an initial screening review performed within that specialty.
2. The name, hospital and NHS numbers of the deceased will be sent to the relevant specialty named consultant lead from the Governance team.
3. It will be the responsibility of the named consultant lead to ensure that the case(s) are distributed evenly across the consultant body in that specialty.
4. Allocation to the named consultant responsible for that patient's care should be avoided.
5. It is expected that the reviews are performed within four weeks of the patient's death irrespective day or date of death.
6. The review of the medical record may be delegated but it is the responsibility of the consultant who has been allocated the review to complete and sign off the initial screening review submission.
7. To this effect for each review an Initial Mortality Review screening tool must be completed. The online tool will be available from the Learning from Deaths icon on the trust's intranet home page.
8. Any reviews with an overall rating of either 1 or 2 will trigger a Structured Judgment review as per policy.
9. Any additional information relevant to the specialty should be held within that specialty and collated bi-annually.
10. Each specialty lead (or nominated representative) will submit and present the cumulative findings from that specialty to the Learning from Death's panel every six months. This should include progress on any specific actions or learning from these reviews. This will be integrated into the Learning from Deaths annual report.
11. Whilst it is acknowledged that consultants within the specialties mentioned above will perform initial reviews within their relevant specialty this will not completely exclude them from reviews needed from other specialties. However this will be taken into consideration so that all initial reviews are distributed evenly across the consultant body.

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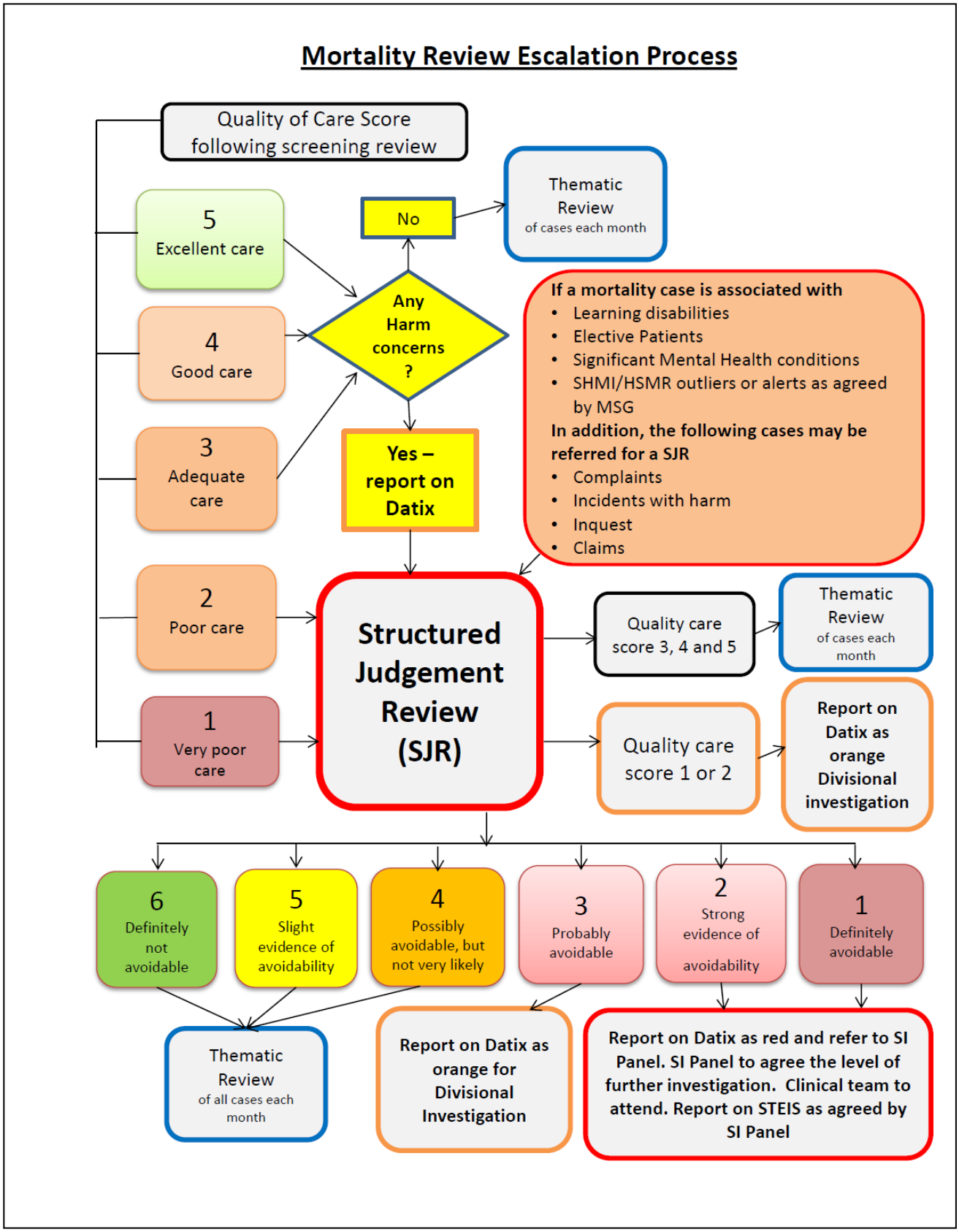
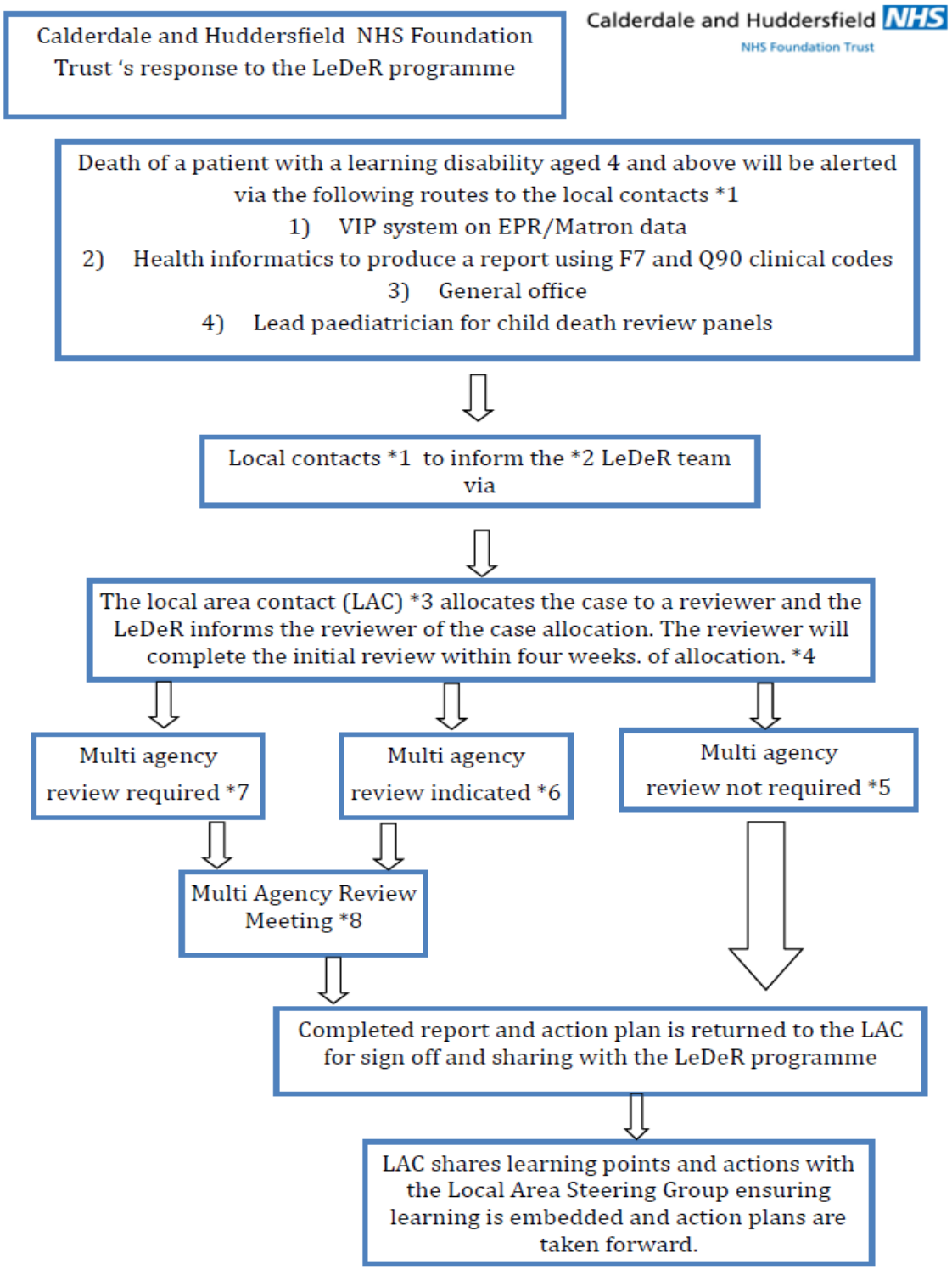
Appendix 2



Appendix 3


Calderdale and Huddersfield NHS Foundation Trust 's response to the LeDeR programme
Calderdale and Huddersfield NHS
NHS Foundation Trust
Death of a patient with a learning disability aged 4 and above will be alerted via the following routes to the local contacts *1
1) VIP system on EPR/Matron data
2) Health informatics to produce a report using F7 and Q90 clinical codes
3) General office
4) Lead paediatrician for child death review panels
Local contacts *1 to inform the *2 LeDeR team via
The local area contact (LAC) *3 allocates the case to a reviewer and the LeDeR informs the reviewer of the case allocation. The reviewer will complete the initial review within four weeks. of allocation. *4
Multi agency review required *7
Multi agency review indicated *6
Multi agency review not required *5
Multi Agency Review Meeting *8
Completed report and action plan is returned to the LAC for sign off and sharing with the LeDeR programme
LAC shares learning points and actions with the Local Area Steering Group ensuring learning is embedded and action plans are taken forward.

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Index for use

***1** Local contact Amanda Mckie—matron and Mandy Hurley—clinical governance

***2** LeDeR team telephone 03307774774 or email leder-team@bristol.ac.uk or web form https://leder.onlinesurveys.ac.uk/notify

***3** Local area contact (LAC)
Calderdale CCG - Louise Burrows louise.burrows@calderdaleCCG.nhs.uk
Kirklees CCG – to be agreed
NHE England - Tom Raines tom.raines@nhs.net

***4** Review at least one set of case notes, have a conversation with someone who knew the person well, complete a pen portrait, timeline and action plan.

***5** A multiagency review is required if additional learning could come from a fuller review, if it is a priority themed review or if a red flag indicates.

***6** If a multi-agency review is **NOT** required identify lessons learned; agree good practice and any recommendations; complete an action plan.

***7** If a multi-agency review **IS** required contact other agencies involved; contact family member, request relevant notes and documents. Arrange and prepare for the multi-agency review meeting; update case documentation (if another statutory review is not taking place).

***8** At the multi-agency meeting agree a pen portrait and timeline; agree potentially avoidable contributory factors; identify lessons learned. Agree good practice and any recommendations; complete action plan.

***9** Local area steering group is a regional group which provides support, scrutiny and oversight to the process.

Mortality Alert / Cluster review report template **Appendix 4**

Meeting:	**Report Author:**
Date of meeting:	**Sponsoring Director:**
Title and Brief Summary:	
Action required by the ********:** For discussion and noting	
Strategic Direction area supported by this paper: Keeping the base safe	
Forums were this paper has been previously considered: **********	
Governance requirements: **********	
Sustainability implications: **********	
EXECUTIVE SUMMARY	
APPENDIX	

Introduction and Background

Include how alert was raised, specific concerns, rationale, timeframes etc

Sample and method

State how the review was conducted

Findings

Information to be presented as appropriate. Include analysis / charts as necessary, and summarise themes,etc

Recommendations

Make recommendations as appropriate according to findings

Action Plan

SMART actions