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HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST LEARNING FROM DEATHS POLICY

Broad Recommendations / Summary

In-hospital death occurs. Patient 18 years of age or above.

Child Death Review undertaken

YES   NO

Has the patient got a Learning Disability?

Yes → External LeDeR Review

No

Specialty < 10 deaths per month?

Yes → Review All Deaths
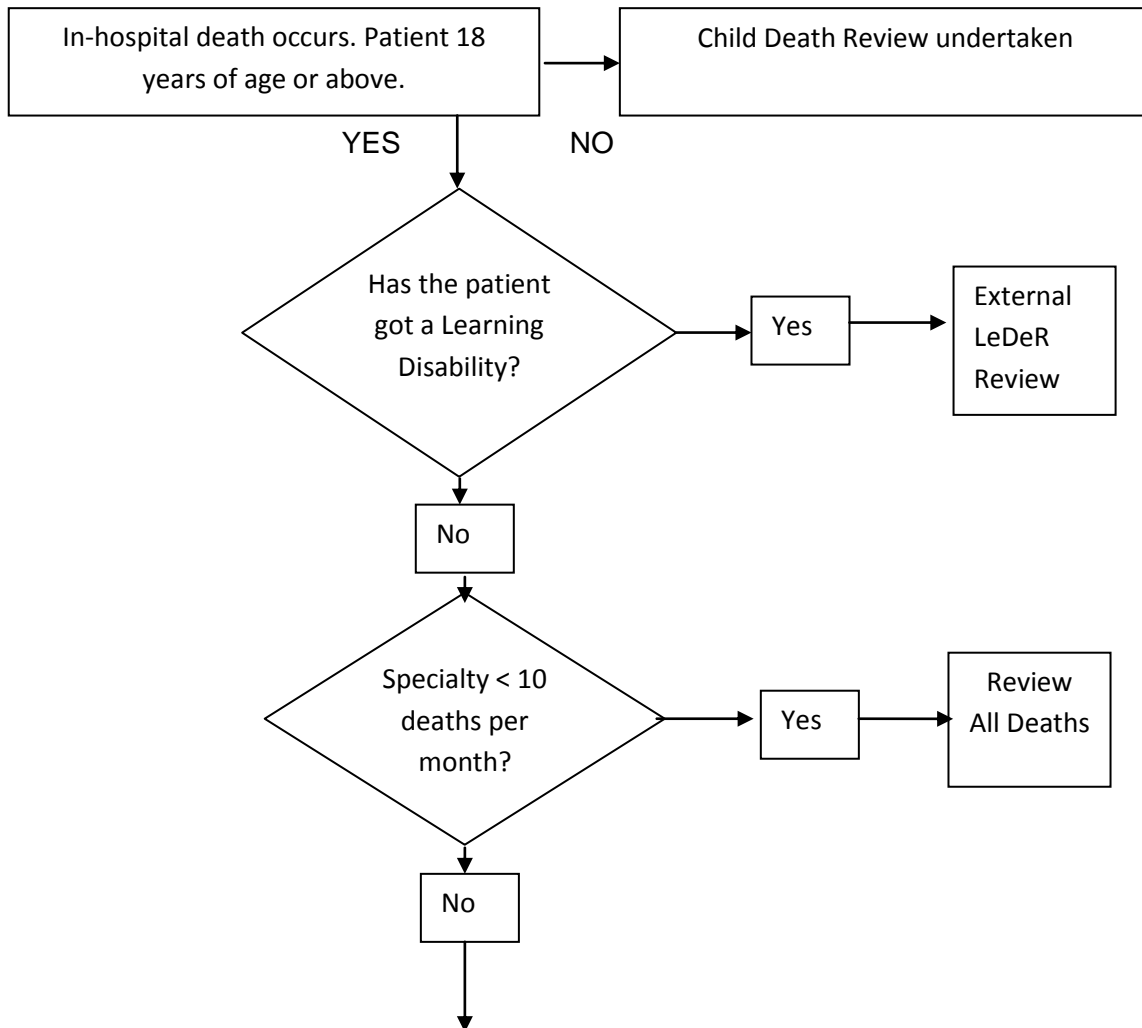
No

Screening Applied against NQB Recommendations.

Review death if the patient:

- Died unexpectedly
- Has a concern raised by family or carers relating to care delivered
- Had an elective procedure or procedure where death was unexpected
- Had a severe mental health condition

- In addition to the above - all deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means will require a review via the SJR method.

- Deaths where learning will inform the provider's existing or planned improvement work should be reviewed. The improvement areas are detailed within the Trust Quality Improvement Plan (QIP).

- A further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST LEARNING FROM DEATHS POLICY

1. BACKGROUND

In December 2016, the Care Quality Commission (CQC) published its review on the way NHS Trusts review and investigate the deaths of patients in England: *Learning, candour and accountability.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented. The review translates the CQC recommendations into 7 national work streams:

1. Delivering a new national Learning from Deaths framework
2. Improving how Trusts engage with and support bereaved families
3. Improving learning from deaths of service users with learning disabilities or serious mental illness
4. Improving the recording of information about patient deaths and sharing of this between organisations to learn from review of the care provided to patients who die.
5. Improving the quality and consistency of investigations into patient deaths
6. Supporting Trust Boards to implement the new requirements
7. Improving how the CQC assesses Trusts' learning from deaths

On March 21st 2017 the National Quality Board published "*National Guidance on Learning from Deaths*" which includes very specific guidance on the roles and responsibilities of the Board of Directors and the Non-Executive .It is essential that this guidance be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks.

The guidance clearly states that the learning from mortality reviews should be integral to a provider's clinical governance and quality improvement work.
Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

Purpose and Legal Requirements
- To confirm the process and ensure a consistent and coordinated approach for the scrutiny and review of hospital deaths.
- To consider mortality rates and national mortality indicators, available at diagnosis and individual ward/speciality level.
- To identify any areas of practice both specific to the individual case and beyond that could potentially be improved. Areas of good practice are also identified, acknowledged, supported and shared.
- To ensure clear reporting mechanisms are in place, to escalate any concerns via the proper channels, so that the Trust is aware and can take appropriate actions.
- To make families and carers aware of the Trusts approach to mortality review, and to engage and support families and carers who express concerns about the care given to patients who have died.

Duty of Candour will be applied to all mortality reviews where appropriate.

Deaths in hospital of patients under the age of 18 years and maternal deaths are excluded from this process document because they are reviewed under other established Trust processes, via reporting to Local Safeguarding Children Board/CDOP (Child Death Overview Panel). However, reviews using the structured judgement methodology may still be undertaken to allow local hospital level learning.

Documentation and administrative procedures following a death are detailed by a separate Trust policy. [1]

2. LEARNING FROM DEATHS

The Trust has adopted the Measuring and Monitoring Safety Framework and is applying it to various quality improvement projects, including learning from deaths. The principles of the framework are detailed in the diagram below.

The framework consists of five 'dimensions' and associated questions that the Trust can use to help understand the safety of its services. Used over time, this will help to give a rounded, accurate and 'real time' view of safety and will support efforts to identify those areas which present the greatest opportunity for safety improvement. The delivery will be monitored through the Trusts Quality Improvement Plan.

3. CRITERIA FOR SELECTING DEATHS TO REVIEW

The Trust will review, at a minimal, the following deaths as stated by the National Quality Board in the "*Learning from Deaths*" publication.[2]

The Trust will review the following deaths by the method detailed for each type:

1. all unexpected deaths, and deaths as a result of a relevant elective procedure;
   - To be reviewed by the Structured Judgement Review methodology.

2. all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
   - To be reviewed by the Structured Judgement Review methodology.

3. all in-patient, out-patient and community patient deaths of those with learning disabilities. (The LeDeR Review [3] is currently utilised by Hull and East Yorkshire

Hospitals NHS Trust, and is a robust review undertaken separately from the structured judgement review. See references for more information.)
- To be reviewed by the LeDeR Programme.

4. all deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);
- To be reviewed by the Structured Judgement Review methodology.

5. deaths where learning will inform the provider's existing or planned improvement work
- To be reviewed by the Structured Judgement Review methodology.

6. a further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall.
- To be reviewed by the Structured Judgement Review methodology.

7. All deaths where the patient had a severe mental health illness, identified by flagging system (attributed clinical diagnosis code);
- To be reviewed by the Structured Judgement Review methodology.

8. All deaths of infants and children;
- Referred to Child Death Overview Panel/Safeguarding. Structured Judgement Review optional addition.

9. All Stillbirths and Maternal deaths;
- Referred to MBRRACE and the Yorkshire Neonatal Network [4]

4. REVIEW PROCESS STEPS

All mortality reviews will be undertaken using the online mortality review form, based in the Lorenzo EPR system. This form is based on the Structured Judgement Review and meets the requirements of NHS I reporting.

In addition to the Trust internal review any death of a patient with a recognised Learning Disability as defined by the Learning Disabilities White Paper 'Valuing People'12 (2001) will be referred to the Learning Disabilities Mortality Review (LeDer) programme.

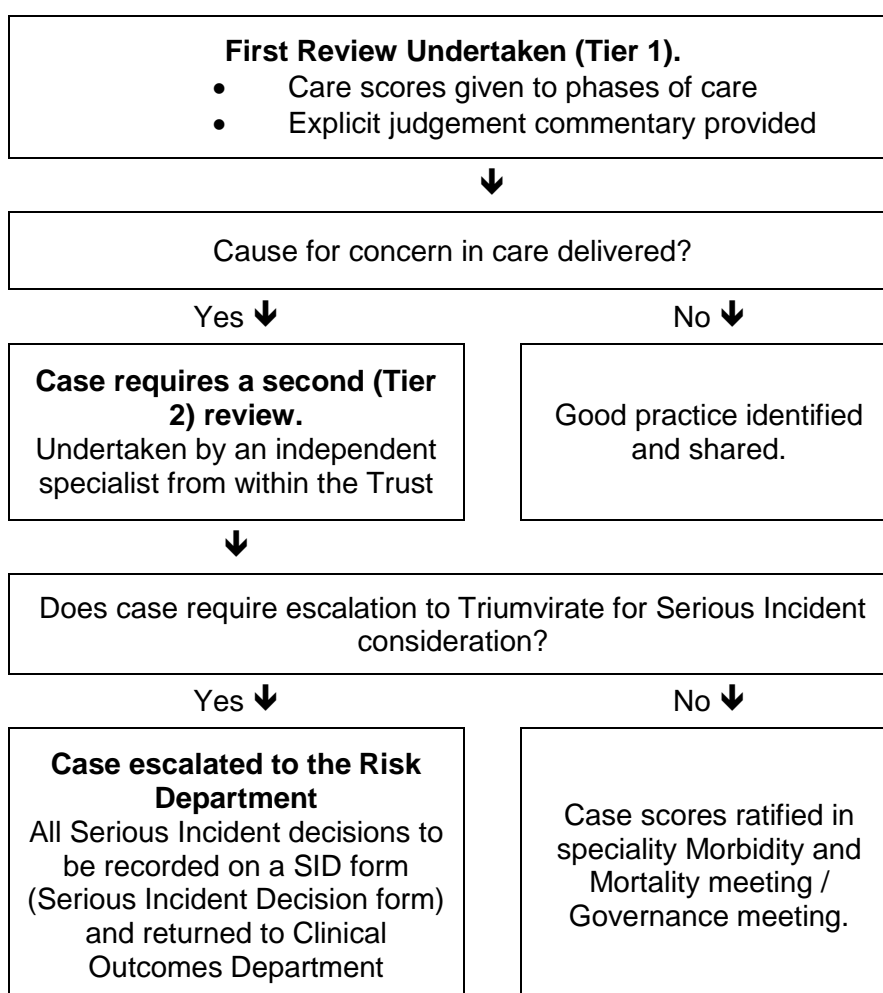In-hospital patient death occurs and is marked as deceased on the EPR system, Lorenzo.

1 If the patient deceased under a speciality that has less than an average of 10 deaths per month, a review will be undertaken. The Trust will review all deaths in specialties with less than an average 10 deaths per month.

2 If the patient deceased under a speciality with more than an average of 10 deaths per month, the National Quality Board minimal criteria is applied to identify which cases are reviewed, (See criteria for selecting deaths to review, and "*National Quality Board: Learning from Deaths*" publication)

3 The outcome of the review is then inspected by the Clinical Outcomes Manager, using the Trust Business Intelligence Analyser. A route of escalation is then decided, dependant on the scores given to the structured judgement review, as detailed by the flow diagram on the next page.

4.   SERIOUS INCIDENTS

The Serious Incident framework works collaboratively with the Trusts response to the death of a service user. Where a serious incident is declared in relation to the death of a patient (regardless of a structured review), a robust investigation process is implemented, detailed within the Trusts risk management policy. [5]

Cases that have undergone a stage 2 Structured Judgement mortality review will be escalated to the Risk Department if poor quality of care is identified at this level. The decision is then made by the Trust Triumvirate as to whether the case requires a Serious Incident declaration. A set criteria is used to decide if a case is declared as a Serious Incident or not.

All Serious Incidents relating to patient death will trigger a Structured Judgement mortality review that will co-exist alongside the full Serious Incident Investigation. The outcomes from the structured mortality review will be fed back to the Risk Department.

First Review Undertaken (Tier 1).
- Care scores given to phases of care
- Explicit judgement commentary provided

⬇

Cause for concern in care delivered?

Yes ⬇   No ⬇

| **Case requires a second (Tier 2) review.** Undertaken by an independent specialist from within the Trust | Good practice identified and shared. |

⬇

Does case require escalation to Triumvirate for Serious Incident consideration?

Yes ⬇   No ⬇

| **Case escalated to the Risk Department** All Serious Incident decisions to be recorded on a SID form (Serious Incident Decision form) and returned to Clinical Outcomes Department | Case scores ratified in speciality Morbidity and Mortality meeting / Governance meeting. |

A more detailed flow chart is available in *Appendix 1* showing the scoring system in relation to case escalation.

5.   ENGAGING BEREAVED FAMILIES AND CARERS

- Bereaved families and carers will be given an opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.

- Bereaved families and carers will be involved in the investigation of any death that is concluded to be avoidable as part of the Serious Incident investigation process. They will receive an investigation report including any actions taken to ensure lessons are learned.

- Families and carers will also be made aware of the Trusts approach to structured mortality review via the printed bereavement booklet that is handed to the families and carers by the Bereavement Team.

Upon recognition of a patient receiving sub-optimal care the Trust will:
- Begin with a genuine apology and early meeting with the family/carers
- All staff supporting the bereaved must have the necessary skills and knowledge of the incident.
- One person should be identified as the lead for liaison with the family/carer; consider the need for an independent advocate with the skills to work with bereaved individuals.
- Decide on a case-by-case basis the extent in which the responsible clinician will be involved in the investigations.
- Action being taken should be explained in person and in writing.
- Set out how the will be kept informed and supported.
- Describe what to expect from an investigation, including timescales and outcomes.
- Clearly explain the Serious Incident investigation's rationale and purpose: these investigations are conducted to support learning, not to hold anyone to account. Be clear: if wrongdoing is found, separate processes are followed.
- Inform the family/carers of any delays in the process
- Ensure there is a co-ordinated approach if multiple agencies need to contact the family/carer; for example, where regulators, coroners or the police are involved. A single point of contact with the family should be appointed to keep them engaged.

The Trust Duty of Candour policy details how the Trust is open and honest with its patients.[6]

6.   TRAINING AND SUPPORT
Structured Judgement Review training is being provided by the Trust Clinical Outcomes Manager, Clinical Mortality Leads and also via the Royal College of Physicians and NHS Improvement Academy (where available).

7. PROCESS FOR MONITORING COMPLIANCE

What is being Monitored	Responsibility	Frequency	Reporting
Specialties with <10 deaths per month to undertake SJR on all cases	Clinical Outcomes Department	Quarterly review of compliance, trends and themes.	Quarterly reports escalated to the Mortality Monitoring Committee, Operational Quality Committee and Board.
Specialties with >10 deaths per month to undertake SJR on 10 cases, all others to be screened against NQB recommendations (page 1)	Clinical Outcomes Department	Quarterly review of compliance, trends and themes.	
Identification of learning and action plans followed	Governance Leads	Annual	Quarterly reports escalated to the Mortality Monitoring Committee, Operational Quality Committee and Board.

8. ROLES AND RESPONSIBILITIES

The Chief Medical Officer will:
- Assure the Board that the mortality review process is in line with the National programme
- Ensure that arrangements are in place so that all clinical staff as appropriate are aware of their responsibilities to contribute to the process.
- Provide advice to the mortality review lead and maintain an oversight of the process.
- Chair the Mortality Monitoring Committee

The Non-Executive Director will:
- Have an oversight of the mortality review processes.
- Constructively challenge and support any systems and processes linked to the review, investigation and learning of deaths.
- Ensure the Trust Board of Directors receives on a quarterly basis, data for which they can be assured is accurate and consistent.

Speciality Governance Leads/Mortality Leads will:
- Promote the implementation of the Structured Judgement Review
- Ensure that cases are discussed within the Speciality Morbidity and Mortality meeting, ratifying any case review scores that require attention.
- Ensure action plans are in place where sub-optimal care is identified via themes and trends.

The Clinical Outcome Leads/Quality Safety Managers will:
- Offer training and advice to colleagues involved with the mortality review process
- Oversee the management of case-note tracking
- Ensure that any case where a relative or carer has expressed concern about quality of care has a full SJR undertaken
- Arrange for cases graded as a concern by the "first reviewer" (based on phases of care scores and avoidability of death scores of 3 and below) to go to MCNRG for further review and action.

- Feedback concerns raised at Mortality Monitoring Committee to relevant specialties using the specialty governance processes.
- Escalate cases for consideration of Serious Incident declaration
- Provide monthly reports to Quality Safety Managers on specialty compliance with process
- Provide quarterly reports to the Mortality Monitoring Committee to update on themes and trends identified, as well as overall progress with mortality review within the Trust
- Ensure learning points are identified, and ensure action plans are discussed and recorded at Governance meetings, and monitored for deliverance in collaboration with the Clinical Outcomes Manager.

The Clinical Coding Department will:
- Code deceased patient case notes within agreed timescales
- Provide support to the Mortality Monitoring Committee
- Work with the mortality review lead to ensure a workable process for Consultants to access notes

9. REFERENCES
1. Trust Policy CP330- Documentation and Administrative Procedures Following a Death
https://pattie.interactgo.com/Interact/Pages/Content/Document.aspx?id=3530&SearchId=

2. National Quality Board "National Guidance on Learning from Deaths" first edition published March 2017. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

3. LeDeR Review – Learning Disabilities Mortality Review, NHS England/HQIP , June 2016 http://www.bristol.ac.uk/media-library/sites/sps/leder/5.%20Briefing%20paper%20-%20Working%20with%20other%20investigation%20and%20review%20processes%20v1.pdf

4. MBRACE-UK https://www.npeu.ox.ac.uk/mbrrace-uk

5. Risk Management Policy and Procedures CP362
https://pattie.interactgo.com/Interact/Pages/Content/Document.aspx?id=3500
Serious Incident Framework: https://improvement.nhs.uk/resources/serious-incident-framework/

6. Duty of Candour

10. APPENDICES
APPENDIX 1 - Scoring Process
APPENDIX 2 Serious Incident Decision (SID) form

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Scoring Process

Stage 1 (Tier 1) review is undertaken

Any Phase of Care score given as 2 or less?

NO → Adequate to Good care is identified. Good practices recognised and shared. Discussed in Speciality M&M meeting.

YES

Case is escalated for Tier 2 review.

Avoidability of Death judgement score applied.

Any Phase of Care score given as 2 or less? Avoidable Death Score 3 or less?

NO → To be ratified within speciality M&M or Governance meeting and final score decided due to contrast in scores.

YES → Case escalated to the Risk Department.

Decision made by Triumvirate on status of Serious Incident.

Decision from Triumvirate recorded on SID form (Serious Incident Decision Form) *Appendix 2*

Analysis undertaken by Clinical Outcomes Department.

Themes and trends identified and shared with relevant clinical leads/governance leads/quality safety managers and learning shared. Action plans developed to improve care where necessary.

Serious Incident Decision (SID) form

Incident Details			
Health Group		**Specialty**	
Date of incident		**Date Incident Escalated for SI consideration**	
Incident Site		**Incident Location**	
'W' reference number		**Severity (as reported)**	
HEY no.			

Description of Incident :

What should have happened?

What actually happened?

Why the incident happened?

Actions now in place

Health Group Triumvirate decision (please mark box as appropriate)
Serious Incident ⬜
No Serious Incident ⬜
Does Duty of Candour still apply? (moderate severity) ⬜
Rationale for decision
Name of Triumvirate member sending decision ………………………..   **Signature**……………………………   **Date of decision**……………………………