Northern Lincolnshire and Goole NHS Foundation Trust

Medical Director's Office

LEARNING FROM DEATHS POLICY

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Author / Contact:	Miss Pooja Balchandra, Consultant, Mortality Lead SGH & Goole

1.0 Introduction

1.1 Our Trust is committed to continuously and systematically reviewing patient outcomes to help improve care quality. This policy guides the development of a robust method of investigating deaths and demonstrates the process by which the Trust can learn from deaths. This follows our Trust ethos to keep patients, their families and carers at the heart of its core objectives.

1.2 A Mortality Improvement Group has been established to ensure robust governance processes are followed and learning from deaths is shared appropriately and effectively in a timely manner so as to continuously improve the services we provide to the patients and their families and to better engage with the family and carers of the deceased.

1.3 The findings of the Care Quality Commission (CQC) report 2016 "learning, candour and accountability: a review of the way NHS trusts review and investigate deaths of patients in England" showed that valuable opportunities for improvements were being missed due to lack of sufficient priority given to learning from deaths. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

1.4 The National Quality Board published 'National Guidance on Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. The First Edition was released in March 2017. One of the regulations set out in this guidance states that "Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under their management and care."

1.5 Immediate action is needed to learn from deaths in our care and with the aim of improving the quality of care being provided.

2.0 Purpose

2.1 The purpose of this policy is to describe the process by which deaths in our care are identified, reported, investigated and learnt from. This policy aims to provide assurances to the Board that effective processes are in place and that learning is shared and acted upon.

2.2 The trust will implement the requirements outlined in the Learning from deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients. This includes determining which patients are included for case record review if they die, reporting the death within our organisation and to other organisations who may have an interest (including the deceased person's GP), responding to the death of an individual with a learning disability or mental health needs, an infant or child death, a stillbirth or maternal death, reviewing the care provided to patients whose death may have been expected, for example those receiving end of life care.

2.3 It describes how our organisation will support people who have been bereaved by a death in our care and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how our trust supports staff who may be affected by the death of someone in the trust's care.

3.0 Area / Scope

This policy applies to all staff whether they are employed permanently or temporarily, through any agency or bank arrangement.

4.0 New Requirements

4.1 The National Guidance on Learning from Deaths, published by the National Quality Board (NQB) in March 2017, requires the Trust to publish updated policies on how the Trust responds to and learns from deaths of patients who die under its management and care.

4.2 The Trust needs to define processes to respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a still birth or a maternal death. An evidence based approach is needed when undertaking case record reviews. The Trust needs to engage with bereaved families and carers, support them fully and involve them in investigations along with supporting staff affected by the deaths of patients in their care.

4.3 The Trust needs to collect specific information every quarter on:

4.3.1 The total number of inpatient deaths in our care (including Emergency Department).

4.3.2 The number of deaths the trust has subjected to case record review using a structured method.

4.3.3 The number of deaths investigated under the Serious Incident framework and declared as Serious Incidents.

4.3.4 Assess how many deaths of those cases subject to case record review were more than likely than not to be due to problems in care.

4.4 The trust needs to publish this information on a quarterly basis by taking a paper to the public board meetings. Also to be included in this quarterly summary is publication of key learning points.

4.5 The Trust should review all deaths where:

4.5.1 Bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.

4.5.2 All inpatient, outpatient and community patient deaths of those with learning disability (LeDeR process).

4.5.3 All patients with severe mental illness who die as an inpatient or within 30 days.

4.5.4 All deaths in a particular diagnosis or treatment group where an “alarm” has been raised with the provider through whatever means (for example via summary Hospital-Level Mortality indicator or other elevated mortality alert), concerns raised by audit work, concerns raised by the CQC or another regulator.

4.5.5 All deaths where people are not expected to die for example in elective procedures.

4.5.6 Deaths where learning will inform the organisation's planned Improvement work for example "sepsis care".

4.5.7 All surgical deaths, as agreed locally following discussion of this methodology at the Trust's Mortality Improvement Group.

4.5.8 A random sample of other patients who die, that do not have any of the NQB factors described (sections 4.5.1 to 4.5.6), who have died within the medicine specialty. The Trust will aim to review 20% of all medical deaths initially and then aim to increase the sample size being reviewed, in line with the Royal College of Physicians guidance to review small samples on a frequent basis.

4.6 Assess the themes and issues identified from review and investigation, including examples of good practice. Oversight of this is provided by the Trust's Mortality Improvement Group and the meeting's terms of reference.

4.7 Define how findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken. This will be overseen and supported by the Trust's Mortality Improvement Group.

5.0 Duties and Responsibilities

5.1 The Mortality Improvement Group along with the Quality Assurance Team will ensure adoption of a robust and effective methodology of high quality for case record reviews of all selected deaths, including engagement with the Learning disabilities mortality review programme (LeDeR), as described previous in section 4.5.

5.2 The aim is to review a regular sample of deaths in hospital so as to identify any learning opportunities to allow continuous improvement, as described in section 4.5.

5.3 The team acknowledges the primary role of system factors within or beyond the organisation and will ensure that mortality reporting in relation to deaths, reviews, investigation and learning is regularly provided to the board.

5.4 The Mortality Improvement Group will ensure that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care. This will form the basis of the group's terms of reference and agenda. The group understands that each Division will approach sharing the learning from case reviews differently. The Mortality Improvement Group will seek assurance that processes are place and are effective. From this oversight, the group will make recommendations on an ongoing basis.

5.5 The Chief Executive will have overall responsibility for the implementation of this policy. Medical Director and Divisional Clinical Directors will ensure all doctors are supported to fulfil their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.

5.6 All clinical staff have a duty to engage in responding to deaths; to be involved in case record reviews and investigations as required and to meet the Duty of Candour requirements. Clinical Case Note Reviewers will be responsible for reviewing the care leading to death and providing a clinical judgement.

5.7 The Mortality Improvement Group will oversee the mortality review process and outcomes/learning from these reviews. The group will also provide proactive support where needed or requested, for example in provision of training to health care professionals in the review of deaths using the SJR methodology.

6.0 Actions

6.1 Review of Deaths -Mortality Case Note Reviews

6.1.1 The primary purpose of mortality case note reviews is governance and assurance to ensure that patients have not died because of suboptimal care. It allows identification of any underlying key themes about care quality and allows opportunities to learn and improve.

6.1.2 The policy details the processes which aim to identify issues to reduce avoidable deaths by ensuring case notes are systematically reviewed and recommendations are implemented. Working with the Clinical coding staff will allow positive learning of the value of coding expertise. Areas of good practice will be identified and championed for adoption by other departments as appropriate.

6.1.3 This will allow for clear reporting mechanisms in place to identify and escalate any concerns.

6.1.4 This mortality review will take the format of structured judgement review with comments regarding the care given at all stages of the patient journey. Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care. The objective of the review method is to look for strengths and weaknesses in the caring process. Training is available from the Trust to support healthcare professionals in undertaking mortality reviews using the SJR methodology.

6.2 Deaths in Patients with Learning Disability

6.2.1 The confidential enquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who dies from a cause of death amenable to good quality care, 3 people with learning disability would do so. Overall people with learning disabilities currently have a life expectancy of at least 15-20 years lesser than the general population.

6.2.2 Those with a learning disability have a multidisciplinary team looking after them and it includes families, primary and secondary healthcare, social and third sector care providers. Patients with learning disability will undergo a mortality review as per the Learning disabilities mortality review programme (LeDeR).

6.3 Learning from Deaths

6.3.1 The review meetings are a key component of work placed based learning and continuing professional development. The meeting structure must include presentation and review of patient death, review of the relevant literature to ensure evidence based practice is developed throughout the organisation. It must highlight recommendations made and clearly document learning points and action plans to prevent a similar problem in the future.

6.3.2 These meetings must be held regularly so learning points can be escalated promptly to avoid further patients being subjected to the same errors.

6.3.3 It is the responsibility of the Mortality improvement group to identify quality improvement projects using the themes and trends highlighted from mortality reviews. The clinical leads will be available to oversee and manage these projects within their area and this will be fed back to the organisation. The reports should be fed back to the Quality Assurance teams.

6.3.4 Learning from a review of the care provided to patients who die is integral to clinical governance and quality improvement work.

6.3.5 To ensure we fulfil the standards required of us by the National Quality Board, adequate governance arrangements and processes will be put in place to review, investigate and report these deaths.

6.3.6 The Trust is committed to sharing and acting upon the learning derived from these processes.

6.3.7 The learning from death reviews will be disseminated through various processes that include quality and safety days, audit meetings, governance meetings and morbidity and mortality meetings. Deaths that are deemed unavoidable and have no clinical or organisational issues will be discussed in individual departmental based morbidity and mortality meetings. However, if there are any learning points, they will be shared with all the teams. This process will be monitored by the Mortality Improvement Group.

6.3.8 Deaths deemed in any way avoidable or where the care was substandard will need escalation to governance leads/mortality leads so that appropriate investigation is undertaken and learning derived from such cases is shared appropriately. If the death is deemed unavoidable there may still be lessons to learn that can be shared amongst relevant teams.

6.3.9 Other processes for learning follow the serious incident framework where a death of a patient may be subject to a serious incident. The involvement with families and carers with this process follows the serious incident policy.

6.4 Bereaved Families and Carers

6.4.1 The Trust will do its utmost to engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death. Bereaved families and carers will be involved in all stages of investigation and review and receive clear, honest compassionate and sensitive response to a death of their loved one with learning, candour and accountability.

6.4.2 The Trust seek to enable bereaved families and carers to engage with this process either via their formal concerns or complaints being raised with the Trust, or through closer working with the Trust's Bereavement office and efforts to proactively include details of how they can get involved in this process.

7.0 Monitoring Compliance and Effectiveness

Number of cases reviewed per team will be audited and entered into the mortality dashboard. Mortality meetings will be reviewed regarding minuted agenda items to ensure learning has been shared.

8.0 Associated Documents

The Mortality Case Review flowchart and the Structured Judgement Review – Appendix.

9.0 References

9.1 Care Quality Commission (CQC) report 2016 "learning, candour and accountability December 2016 https://www.cqc.org.uk/.../20161213-learning-candour-accountability-full-report.pdf

9.2 National Guidance on Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care' March 2017 https://www.england.nhs.uk/wp.../ngb-national-guidance-learning-from-deaths.pdf

9.3 The Keogh report July 2013

9.4 CIPOLD Confidential Inquiry into premature deaths of people with learning disabilities www.bristol.ac.uk/cipold

10.0 Definitions

None.

11.0 Consultation

11.1 Medical Director.

11.2 Mortality Improvement Group.

11.3 Doctors and Nurses.

12.0 Dissemination

Available on the trust website.

13.0 Implementation

Structured judgement review will be part of mandatory training.

14.0 Equality Act (2010)

14.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

14.2 The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

14.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

14.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

15.0 Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this policy, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Trust's 'Speaking Out Policy' (Freedom to Speak Up Policy and Procedure (DCP126)) or by contacting the Human Resources Department. Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg.tr.ftsuguardian@nhs.net or by phoning 304141. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian or with one of the Associate Guardians can be found on the Trust's intranet site.

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