Northern Lincolnshire and Goole NHS Foundation Trust

## Medical Director's Office

# MORTALITY IMPROVEMENT STRATEGY

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Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

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## 1.0 Introduction

**1.1** Every year in England and Wales over 500,000 people die (Office for National Statistics, 2017) and for approximately three-quarters of these people, death does not come suddenly. It is a process that may take days, weeks or even years, involving a progressive decline in functioning and frequent interactions with health professionals and hospitals (Hunter and Orlovic 2018). Most deaths that occur in hospital are unavoidable and are the end point of this process. It is therefore important to ensure that patients receive timely and appropriate care, so that any deterioration is picked up quickly, and also ensuring end of life plans if appropriate are in place and that the organisations learn from the deaths that do occur.

**1.2** Mortality rates (such as the Summary Hospital-level Mortality Indicator – SHMI, and Hospital Standardised Mortality Ratio – HSMR) are measures that are produced for all hospitals in an attempt to support all Trusts, and are used for benchmarking performance. Whilst the evidence suggests that a raised SHMI is not an indicator of the quality of care being provided in an organisation (Hogan et al 2015), it does normally act as a trigger factor for the initiation of a care review to investigate the reasons for this. Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) have raised SHMI and HSMR measures. Our Trust is thus committed to continuously and systematically reviewing patient outcomes to help improve the quality of care provided. There has been work carried out by clinicians to review the clinical care (from a review of medical records) which has identified a number of principle strands for improvement work within both the acute trust and also across the community. This strategy brings those improvement projects together to provide detail on our approach to increasing both the quality of care and the understanding of the factors that are leading to an increased SHMI. To ensure appropriate governance and to help drive and monitor this improvement work, a Mortality Improvement Group (MIG) has been set up, which reports to the Quality and Safety Committee (QSC) as a sub-group of the Trust Board, as well as the Quality Governance Group (QGG).

## 2.0 Purpose

**2.1** The purpose of this strategy is to provide oversight of the five principle strands of work to improve the quality of services and care that could lead to increased risk of harm or death, and therefore support a focus on reducing mortality within the Trust. These particular work-stream strands are:

- The provision of the acute medical assessment and care for patients attending the Trust (Medical model)
- The rapid detection of deterioration of patients receiving care within NLAG, with particular reference to Acute Kidney Injury (AKI) and Sepsis (Deteriorating Patient and Sepsis)
- The review of care that has been provided to a patient who dies after being in the care of the Trust (Learning from Deaths)
- Review of all current clinical coding methodologies and approaches used within the Trust, in order to explore all potential areas of improvement directly linking to (or influencing) the SHMI score. (Clinical Coding Improvements)

- Progression of a multi-disciplinary approach to patients on the End of Life Care pathway across all the wider health community. (*End of Life*)

**2.1.1** The principle overall outcomes and measures of these strands are:

| Outcome | Measure |
|---|---|
| Reducing the in hospital mortality rate over time and reduce the number of cases where death in hospital was not the most appropriate place.<br><br>Understand key data driving the SHMI and if possible reduce the SHMI so that the Trust is within the expected range. | Crude Mortality rate.<br><br>Reducing number of deaths $\leq$ 24 hours of admission (this being a proxy indicator for patients admitted at EOL) where advanced care planning could prevent hospital admission.<br><br>Improved coding quality indicators, specifically the increased capture and coding of higher risk Charlson co-morbidities, as well as palliative care codes when applicable.<br><br>SHMI / HSMR score.<br><br>Reduced disparity between the Trust's two main hospital sites of 'expected deaths' vs. 'observed deaths'. |
| Reduction in Serious Incidents (SIs) relating to deaths within the Trust. | Number of SIs relating to deaths. |
| Improvement in cross-organisational working to address over-arching Mortality issues across the wider healthcare footprint. | Minutes of relevant Mortality group meeting demonstrating discussion, challenge and agreement across organisations. |

## 2.2 Strand One: Medical Model

**2.2.1** Close liaison with, and the direct support of, emergency medicine by in-taking specialties will be essential. Site-specific rules should be agreed that set timescales, expectations and processes for how Emergency Departments (EDs) can access specialist services, particularly during periods of escalation. There are issues with flow through the acute trust, particularly on the Diana Princess of Wales (DPOW) site where length of stay can be longer than expected, as there are many outliers, patients having multiple moves, and the current model of care does not lend itself to allow prompt speciality in-reach and review. However, within the last year ambulatory care units have been set up, and a frailty service began in July 2018. The proposed plan for the medical model includes the full implementation of this frailty unit, the introduction of a short stay ward (72 hours), change to the speciality bed base, and also work programmes of the medical staff to enable a more consistent review of patients.

**2.2.2** Full utilisation of alternative pathways to admission (such as clinically supported community services across the health locality) should be fully considered for their potential role in any patient pathway. Key to this shall be the correct and appropriate use of advanced care plans for End of Life patients who may be inappropriately admitted to hospital without use of/adherence to such care plans. It is also crucial to encourage continued multi-discipline working across the whole locality with all potential providers of care to any patient.

**2.2.3** It should be noted that the SHMI (and other Standardised Mortality Ratios) are risk adjusted for a variety of case-mix factors including the type of admission. Therefore, any changes in admission pathways or profiles, particularly for patients admitted as an emergency (which carries the highest risk-adjusted weighting) will likely influence the SHMI calculation which compares the number of 'observed' deaths (numerator) to the number of risk adjusted 'expected' deaths (denominator). This is why crude mortality rates will also be measured.

**2.2.4** Milestones and Progress: tracked through the Access and Flow part of the Improving Together programme. For project outcomes and measures please see Appendix A.

### 2.3 Strand Two: Deteriorating Patient and Sepsis

**2.3.1** There is evidence to suggest that the combination of early detection, timeliness of response, and competency of the clinical response, is critical to defining clinical outcomes in the deteriorating patient. (Smith et al 2006; Groarke et al 2008). The National Institute for Health and Care Excellence (NICE) and the RCP's Acute Medicine Task Force have highlighted the importance of a systematic approach and advocated the use of 'early warning scores' (EWS).

**2.3.2** The identification and management of the deteriorating patient within the hospital has been the prime focus for over a year. The work is closely managed and monitored through a Deteriorating Patient and Sepsis group which is overseen through QGG. The specific aim of the work-stream is to ensure that a deteriorating patient is recognised and escalated appropriately, through the use of an Early Warning score. Corfield et al (2104) highlighted that as the NEWS (National Early Warning score) went up in septic patients there was a simultaneous increase in mortality rates. Using NEWS, NEWS2, and the obstetric and paediatric versions can therefore better facilitate triage and allow for involvement of a senior clinician at an earlier stage in the treatment pathway. To achieve this there has been a change in the training provided to staff, as well as the use of electronic media to enable rapid calculation of NEWS2 once observations are recorded. There is also a prompt on the electronic screen (when NEWS2 is high) to ensure consideration of sepsis. In addition, the escalation process is being redesigned to ensure quick access to senior medical support and there is a review of the critical care outreach and hospital at night teams to ensure that everyone has appropriate skills to deliver care to the patient who is deteriorating. Acute Kidney Injury (AKI) will also be incorporated into this project.

**2.3.3** Milestones and progress: tracked through the Deteriorating Patient and Sepsis Group and reporting into both MIG and QGG; for details see Appendix B.

### 2.4 Strand Three: Learning from Deaths

**2.4.1** To enable continued focus on education and learning, there needs to be renewed impetus in the ability to learn from deaths through timely Structured Judgement Reviews (SJR). Based on a body of evidence (Hutchinson et al, 2010a&b; Hutchinson et al, 2013), the SJR process supported by training has been used in a number of hospitals in the NHS Yorkshire and the Humber region since 2014 (Hutchinson et al, 2015) and subsequently the Royal College of Physicians National Mortality Case Record Review Programme in 2016. The SJR needs to be conducted in a timely manner to enable any learning points to be picked up early. The process for undertaking mortality reviews within the Trust has been reviewed and strengthened. To assist in the administration of this process, there is now a mortality analyst in place which will better enable feedback to the teams and collation of themes – both speciality specific as well as more generic applicable to the Trust as a whole. There is also monitoring and oversight of CQC outlier alerts (via the Dr Foster Unit) which will continue, as outlined within the Mortality Improvement Group terms of reference.

**2.4.2** Milestones and progress: being developed currently with oversight through MIG, for outcomes and measures see Appendix Ci.

### 2.5 Strand Four: Clinical Coding Improvements

**2.5.1** The SHMI score attributed to the Trust on a monthly basis is directly linked to the clinical coding that occurs following each episode of care is concluded. The SHMI is influenced strongly by the admitting diagnosis (during the first and second consultant episode) and any pre-existing comorbidities, which are weighted against the Charlson Comorbidity index.

**2.5.2** A review of the Trust's mortality statistics during 2019 identified that the Trust's level of 'expected mortality' (a statistically calculated denominator on which the SHMI is calculated, based on coded information) was unexpectedly different between the Trust's hospital sites and could be a result of a lack of accurate/relevant coding at the initial diagnosis and then limited review of coding for subsequent care.

**2.5.3** To improve the overarching SHMI score, including the expected death score, work is required to not only improve the coding at the initial diagnosis, but also the review of coding as part of a wider piece of work around review upon patient death.

**2.5.4** One key area of focus should also be the improvement in the recording of the Charlson high comorbidity diagnoses in a secondary position during first episodes and as relevant comorbidities (position 2-20). This will require improvements in the recording facilities (both in electronic and paper format) but will also require increased awareness and education of the Medical teams involved in patient care undertaking the recording of these diagnoses.

**2.5.5** Another key element will be the clinical validation of coding with the intention of updating the coding appropriately upon clinician review, and clarification (if needed) of the primary condition being treated for on admission and any omitted comorbidities.

**2.5.6** Milestones and progress: tracked through the Mortality monthly report which feeds into the MIG meetings. Dynamic KPI's to be developed via the MIG.

### 2.6 Strand Five: End of Life

**2.6.1** The impact of End of Life patient admissions into hospital towards the SHMI cannot be underestimated, nor can the impact on patient experience when inappropriately admitted. For both elements to be improved, a renewed multi-agency approach is required towards managing patients on an End of Life pathway within the wider health locality.

**2.6.2** For this to be achieved, the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) will be required to be fully embedded with all multi-agency providers of care across the heathcare locality. The full introduction and adherence to this will help ensure that the wishes of End of Life patients are met, as well as reducing pressure on hospital services to provide End of Life care in an acute setting.

**2.6.3** A multi-agency approach will ultimately require not only shared learning from any reviews but also addressing of any training issues for staff working in the community on End of Life patients.

**2.6.4** Further work that will be required under the End of Life strand will link in with the aforementioned coding work to ensure that follow up episodes of care are recorded, regardless of the speciality they are recorded in.

**2.7** A multi-discipline agreed End of Life pathway will be required to be embedded across the health locality for the above factors to be fully introduced and successful, this will also help with shared learning and addressing barriers in the system.

## 3.0 Area

This policy applies to all staff whether they are employed permanently or temporarily, through and agency or bank arrangement and all areas of care.

## 4.0 Duties

**4.1** Mortality Improvement Group (MIG)

**4.2** The Mortality Improvement Group will oversee the development and implementation of clinically led improvement plans to tackle concerns raised in connection with clinical and non-clinical systems and processes that affect patient care.

**4.3** Quality Governance Group

**4.4** The Quality Governance Group will receive relevant highlight reports from a number of relevant clinical domains influencing Mortality, as well as receiving specific reports from the MIG and Deteriorating Patient and Sepsis Group.

**4.5** Quality & Safety Committee (Sub-Group of the Trust Board)

**4.6** The Q&S Committee will provide assurance to the Board that all aspects of the strategy are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board.

**4.7** Trust Management Board

**4.8** Medical Model Sub Project Group; Deteriorating Patient Sub Project Group; End Of Life Sub Project Group; Clinical Coding Sub Project Group; Learning from Deaths Sub Project Group,

**4.9** The purpose of these proposed subgroups shall be the delivery of the respective work-stream improvement projects. Working with colleagues and other members of the Trust's Mortality Improvement Group will implement the changes required to make the improvements that are needed. They also are responsible for escalating to QGG when those changes cannot occur due to an organisational issue.

## 5.0 Monitoring Compliance and Effectiveness

**5.1** Medical model scorecard.

**5.2** Deteriorating Patient scorecard.

**5.3** End of life scorecard.

**5.4** Mortality scorecard.

**5.5** Monthly Mortality Report: SHMI; Crude Mortality; Deaths within 24 hours of admission (a proxy EOL indicator).

**5.6** Public Health Data relating to deaths in own home.

**5.7** Mortality meeting minutes will be reviewed to ensure learning has been shared.

## 6.0 Associated Documents

Mortality Improvement Group Terms of Reference (DCT133).

## 7.0 References

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**7.10** National Institute for Health and Clinical Excellence. (2007) Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital. NICE clinical guideline 50. London: NICE. https://www.nice.org.uk/guidance/cg50

**7.11** NHSi (2017) Good practice guide: Focus on improving patient flowhttps://improvement.nhs.uk/documents/1426/Patient_Flow_Guidance_2017___13_July_2017.pdf https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/

**7.12** Nolan JP, Soar J, Smith GB, Gwinnutt C, Parrott F, Power S, Harrison DA, Nixon E, Rowan K; National Cardiac Arrest Audit.(2014) Incidence and outcome of in-hospital cardiac arrest in the United Kingdom National Cardiac Arrest Audit, Resuscitation, Aug;85(8):987-92. doi: 10.1016/j.resuscitation.2014.04.002. Epub 2014 Apr 15. https://www.sciencedirect.com/science/article/pii/S0300957214004699

**7.13** Office for National Statistics [ONS] (2017) 'Deaths registered in England and Wales: 2016'.https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredinenglandandwalesseriesdr/2016

**7.14** Royal College of Physicians (2016). National Mortality Case Record Review (NMCRR) programme resources https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme

**7.15** Smith GB, Prytherch DR, Schmidt P et al (2006). Hospital-wide physiological surveillance – a new approach to the early identification and management of the sick patient. Resuscitation; 71:19–28. https://www.sciencedirect.com/science/article/pii/S0300957206001286

**7.16** Professor Mohammed's report to the Trust on mortality statistics

## 8.0 Definitions

**8.1** **Crude mortality rate** – number of deaths for every 100 patients.

**8.2** **Summary Hospital-level Mortality Indicator** – the ratio of 'observed' to 'expected' deaths given the characteristics of the patients treated.

## 9.0 Consultation

**9.1** Medical Director.

**9.2** Mortality Improvement Group.

**9.3** Trust Management Board.

## 10.0 Dissemination

**10.1** Available on the Trust website.

**10.2** Raising awareness of strategy through:

- Trust communications
- Lesson of the week
- Twitter

## 11.0 Implementation

Through the Mortality Improvement Group (or proposed subgroup).

## 12.0 Equality Act (2010)

**12.1** 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.

**12.2** 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.

**12.3** 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.

**12.4** 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).

## 13.0 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 document, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Trust's Freedom to Speak Up Policy and Procedure (DCP126). 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. 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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**The electronic master copy of this document is held by Document Control, Trust Secretary, NL&G NHS Foundation Trust.**

## Appendix A

| Outcomes | Measure | Frequency of reporting | Who reports |
|---|---|---|---|
| Improved treatment times in ED | Number and % of patients assessed within 15 minutes from arrival in ED | Monthly | Information Services |
| Improved treatment times in ED | Number and % of patients reviewed by clinician within 60 minutes from arrival in ED | Monthly | Information Services |
| Better care for frail patients | Number of frail elderly patients<br>• admitted to Frailty ward<br>• transferred to Frailty ward<br>• discharged from Frailty ward within 12hrs and 72hrs<br>Number of admissions avoided through FEAST | Monthly | Information Services |
| Reduction in emergency length of stay | Emergency average length of stay | Monthly | Information Services |
| Reduction in admissions from ED | ED admission conversion rate | Monthly | Information Services |
| Increase in numbers of patients treated in ambulatory care | Number of patients admitted to Medical Ambulatory Care | Monthly | Information Services |
| Increase in patients discharged home from ambulatory care | Patients discharged from Medical Ambulatory Care rate | Monthly | Information Services |
| Reduction in length of stay | Medicine emergency average length of stay | Monthly | Information Services |
| Reduction in length of stay | Number of stranded patients (7 days) | Monthly | Information Services |

## Appendix B

| Outcome | Measure | Frequency of reporting | Who reports |
|---|---|---|---|
| Reduction in cardiac arrests to be within expected levels. Nolan et al (2014) found the overall incidence of adult in-hospital cardiac arrest was 1.6 per 1000 hospital admissions with a median across hospitals of 1.5 (interquartile range 1.2-2.2), the incidence varied seasonally, peaking in winter | Number and rate of cardiac arrest<br>• patient characteristics;<br>• cardiac arrests attended by the team;<br>• location of arrest;<br>• status at team arrival; and<br>• presenting/first documented rhythm. | Quarterly | Data submitted for National Cardiac Arrest Audit (NCAA) |
| Increase in NEWS2 Conducted on time | Number of and % of NEWS2 Conducted on time | Monthly | WebV – Currently supplied for DP dashboard |
| Increase in OEWS conducted on time | Number of and % of OEWS conducted on time | Monthly | WebV– Currently supplied for DP dashboard |
| Improved Paediatric monitoring | Number of and % of PEWS conducted on time | Monthly | Audit data to be supplied to Information Services |

## Appendix B (continued)

| Outcome | Measure | Frequency of reporting | Who reports |
|---|---|---|---|
| Appropriate and consistent use of DNACPRs | DNACPR audit which will focus more on the timing and appropriateness of DNACPR's being put in place. Also the documentation of the patient's mental capacity and discussions surrounding the decisions for DNACPR will be assessed. | Monthly | Trend data from Deteriorating Patient ward scorecards,<br><br>EOL Information services |
| To reduce the incidents and complaints related to DNACPR decisions | Datix and complaints | Monthly | Clinical Governance |
| Improved sepsis care | Number of and % of patients who correctly receive the sepsis bundle | Monthly | CQUIN audit/WebV Adele |
| Reduction in patients' needs emergency admission to critical care | Number of and % of patients who need emergency admission to critical care | Monthly | Information services |

## Appendix C(i)

| Outcome | Measure | Frequency of reporting | Who reports |
|---|---|---|---|
| Effective Learning From Deaths process in hospital | Number (and %) of staff trained to review notes | Monthly | Jeremy Daws |
| Increase in number of SJR reviews | Number (and %) of notes reviewed | Monthly | Available from learning from deaths scorecard |
| Sharing of learning from SJR | Evidence from meetings where learning shared, looking for<br>**1.** themes identified from SJR reviews<br>**2.** evidence themes identified and shared with consultant team<br>**3.** evidence themes identified and shared with GP (where relevant) | Quarterly | Available from learning from deaths scorecard |
| Learning organisation | Evidence of implementation of learning – meetings, safety huddles, lesson of the week. | Monthly | Measures to be determined |

## Appendix C(ii)

| Outcome | Measure | Frequency of reporting | Who reports |
|---|---|---|---|
| Have effective transparent patient pathways with referral criteria and clear documentation standards | Number of discharge letters with addition of standardised information for EoL / Fast Tracked patients | One off audit | EoL project group and Improving together |
| | Patients who died in hospital and had an EOL audit | Monthly | Information services |
| | Patients died in hospital and number who had care in the last days of life document used | Monthly | Information services |
| | Of those above number who had Preferred place of death documented and achieved it | Monthly | Information services |
| | Of those above who had a DNACPR in place | Monthly | Information services |
| | Of those who had an end of life audit tool completed but were not commenced on the last days of life document how many had a DNACPR form in place | Monthly | Information services |
| | % End of life audit tool completed | Monthly | Information services |
| Improved bereaved relatives/carers feedback | Bereaved carers/relatives feedback | 6 month audit period | EoL project group |

**Appendix D**

Northern Lincolnshire and Goole NHS Foundation Trust

## Medical Director's Office

# LEARNING FROM MORTALITY POLICY

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## 1.0 Executive Statement

**1.1** This policy is designed to ensure that the Trust is learning from mortality through the development of a strong mortality governance framework, with a clear focus on improving the quality of clinical care within the Trust and reducing avoidable patient death and harm.

**1.2** Mortality is an indicator often used to help understand an organisation's performance, and the development of Standardised Mortality Ratios (SMRs) like the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-Level Mortality Indicator (SHMI) have sought to standardise for variables such as patient case-mix, admission type and disease. The prevalence of such indicators, as well as the NHS Digital publication of SHMI on a monthly basis using a standard and transparent methodology, has led to increased public awareness and scrutiny.

**1.3** High-profile investigations into NHS organisations, such as the Francis Enquiry, highlighted that organisational response to mortality rates deemed to be 'higher than expected' had not been used effectively by Trusts to understand if care quality had been a factor in these deaths.

**1.4** The process of learning from mortality was strengthened by the Care Quality Commission's (CQC) publication of the 'Learning, Candour and Accountability' review in December 2016, describing how organisations review and investigate mortality. The Secretary of State for Health accepted the recommendations from this and commissioned the National Quality Board (NQB) to develop a framework for the NHS to use to firstly identify, report, investigate and then learn from deaths in care.

**1.5** The National Quality Board issued this national guidance in March 2017, which included some specific requirements, including:

- From April 2017, collect new quarterly information on deaths, reviews, investigations and resulting quality improvement.
- By September 2017, publish an updated strategy / policy on how the Trust responds to and learns from the deaths of patients in its care.
- From Quarter 3 of 2017 onwards, publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings including information on reviews of the care provided to those with severe mental health needs or learning disabilities.
- From June 2018, publish an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews / investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

**1.6** This policy outlines the steps to be taken within Northern Lincolnshire & Goole NHS Foundation Trust to support an ongoing focus on learning from deaths, in line with the NQB requirements. This document is linked to additional guidance documents, including the policy for the engagement with bereaved families and carers and the Trust's reducing mortality strategy.

## 2.0 Aims

**2.1** The overall aim of this policy is to ensure that the organisation is learning from deaths in its care through an effective mortality governance framework, with a clear focus on improving the quality of clinical care, preventing avoidable patient harm, and engendering a culture of clinical excellence.

**2.2** This policy will seek to support the Trust and the wider healthcare system to learn from deaths, understand mortality performance, and where further improvements in service planning and care outside of the acute Trust could be made.

**2.3** The Trust will implement clear mortality governance arrangements to better enable executive and non-executive directors to understand the issues affecting mortality in the Trust and provide necessary challenge as and when required.

## 3.0 Links to the Trust's Strategic Objectives

This area links strongly to the Trust's Strategic Objective: "To give great care".

## 4.0 Policy Objectives

**4.1** The key objective of this policy is to ensure that the organisation is learning from mortality which will impact positively on the quality of care and treatment delivered to patients.

**4.2** The policy further aims to outline:

- Embed the existing learning from deaths process within the Trust
- Increased Consultant engagement in Mortality. This is linked to (and informs) consultant appraisals and revalidation, and can engender a culture of clinical excellence
- Outline for reviewing increasing numbers of deaths within the current process, and how this will be further supported and underpinned through the Medical Examiner role appointment
- Improvements in mortality learning through more consistent and effective working with community and primary care stakeholders, and to understand full learning from deaths outside of the acute hospital following discharge

## 5.0 The Current Review Processes in Place

**5.1** The Trust has been working to embed the mortality review process, using the Structured Judgement Review Methodology. The current process is detailed as follows.

**5.2** Priority case reviews (NQB (National Quality Board) cases) are undertaken for those patients who meet one or more of the following indicators:

- Learning disabilities (reviewed as part of the LEDER process)
- Severe mental health
- Deaths in patients aged <18 (links to Perinatal Mortality Review Tool (PMRT) and Child Death Overview Panel (CDOP) processes)
- PALS/Complaint cases where mortality review is felt to be of benefit to the bereaved relatives/carers (see separate policy for engagement with bereaved relatives/carers)
- Elective deaths
- Unexpected deaths (DATIX incidents)
- Specific areas of concern (i.e. outlier alerts) or where targeted improvement work is underway

**5.3** All in-hospital deaths in the General Surgery, Trauma and Orthopaedics and within Gynaecology specialties.

**5.4** Review all Critical Care deaths meeting the criteria based on Intensive Care National Audit & Research Centre (ICNARC) scores.

**5.5** Aim to complete a minimum of 20 cases of in-hospital mortality within the Medicine division (i.e. a minimum of 10 per site) each month, with the intention of increasing the proportion of cases reviewed.

**5.6** Aim to ensure effective Morbidity and Mortality Meeting (M&M) arrangements with the respective Divisions, with effective governance arrangements to discuss learning and agree sharing of key points.

**5.7 Learning from deaths policy: Next steps**

**5.7.1 Step 1: Embed existing learning from deaths process:**

- Further work required in following areas:
  - <18 years of age deaths – greater assurance of mortality reviews undertaken and understanding of the learning emerging
  - Gynaecology specialty deaths – greater assurance of process
  - General Surgery reviews of all deaths at DPoW – further work to embed
  - Trauma and Orthopaedic reviews of all deaths – further work to embed
  - Severe Mental Health diagnosis – widening of inclusion criteria required

- Cobra system to support SJR reviews alongside development of a mortality screening tool to review greater numbers of deaths and identify cases requiring more detailed review and investigation
- Greater focus on SJR training
- Improved process for internally identified mortality outlier data and appropriate response with divisions

**5.7.2 Step 2: Review increasing numbers of deaths:**

- Screening tool development – to screen a greater % of deaths with links to the SJR process / SI process as necessary
- General Surgery / Trauma and Orthopaedics / Gynae increased / wider remit to look at deaths within 30 days of discharge
- Medical Examiner Role – outline plans of how this will support existing mortality review processes and learning from.
- Cobra system to support screening tool / SJR reviews

**5.7.3 Step 3: Increased learning through greater collaborative working with the wider system:**

- Include here details for a more joined up learning from deaths processes across the system:
  - EOL KPIs (deaths <24 hours)
  - Links to EOL strategy group
  - Link to Out of Hospital Mortality Group and key priorities / action plan (NEL and NL)
  - Greater understanding for the reason for hospital admission and in instances where admission considered inappropriate, what service was needed to prevent the admission
  - Arrangements and shared ownership for collaborative reviews of deaths – especially in other CCG areas (i.e. ERoY, Lincolnshire)
  - Probe the role for a wider strategy around reviews of deaths in the community potentially linking in with GPs and taking a more targeted approach
  - Make better use of CCG incident reporting to ensure the feedback loop is more consistent when problems in care are identified in primary or community care settings when care quality reviewed by Hospital Healthcare Professionals

## 6.0 Stakeholder Analysis

**6.1** Mortality Improvement Group.

**6.2** Directorate of Operations (Speciality governance, audit and M&M groups).

**6.3** End of Life Care Teams.

**6.4** Community & Therapy Teams (North Lincolnshire).

**6.5** NHS North East Lincolnshire CCG.

**6.6** NHS North Lincolnshire CCG.

**6.7** Care Plus Group.

**6.8** Patient Experience Group.

**6.9** NAVIGO.

**6.10** Rotherham, Doncaster & South Humber (RDASH).

**6.11** East Midlands Ambulance Service (EMAS).

**6.12** EROY CCG.

**6.13** Lincolnshire CCGs.

## 7.0 Scope

**7.1** This policy and delivery plan is intended to inform and support all staff working within Northern Lincolnshire and Goole NHS Foundation Trust.

**7.2** Whilst focussed primarily on the learning possible from in-hospital deaths, this document will also relate to and provide greater structure to some of the existing collaborative work streams in place within the local healthcare community, whereby the Trust, supported by local partners and other NHS organisations, have been reviewing pathways of care as they interlink.

## 8.0 Consultation

**8.1** This policy and delivery plan was originally developed following discussion at the Learning, Candour and Accountability working group, overseen by the Mortality Assurance & Clinical Improvement Committee (MACIC).

**8.2** This policy refresh will be reviewed further by the Mortality Improvement Group (MIG) which has membership from the local CCGs and the Care Plus Group.

## 9.0 References

**9.1** NHS England (2015), Mortality Governance Guide

**9.2** Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England

**9.3** National Guidance on Learning from Deaths. National Quality Board.