Harrogate and District NHS Foundation Trust

LEARNING FROM DEATHS POLICY

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1. INTRODUCTION

1.1. Purpose

The vast majority of people who die under the care of the NHS have experienced excellent care in the months or years leading up to their death. In a small percentage of cases, and usually for a variety of reasons, the care provided is less good. The purpose of mortality reviews is not only to identify and share examples of best practice, but also to identify lapses in care which can be shared widely across the NHS for collective learning.

The National Quality Board published National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care (March 2017). The aim of the framework is to standardise an approach to learning from deaths, and the case is made for ensuring that learning from a review of the care provided to patients who die is integral to a provider's governance and quality improvement work. This policy outlines how that will be done within HDFT.

1.2. Scope

This policy and the processes described currently apply to patients who have died whilst an inpatient in HDFT. There are no specific exclusions and other deaths may be identified for detailed review e.g. if concerns are raised about the death of a patient:

- Within (but not necessarily limited to) 30 days of discharge;
- Whilst under the care of community services;
- Within a particular service specialty;
- In the Emergency Department;
- By another organisation in relation to care provided by the Trust in the past.

This policy and the processes described will link to existing processes for reviewing, investigating and learning from deaths.

1.3. Definitions

Case note review: A structured scrutiny of case notes alone to determine whether there were any lapses in the care provided to the patient who died in order to learn from what happened. It is anticipated a judgement of avoidability of death will form part of the review. Examples of good care should be highlighted. The Structured Judgement Review (SJR) method delivered by the Royal College of Physicians will be adopted locally.

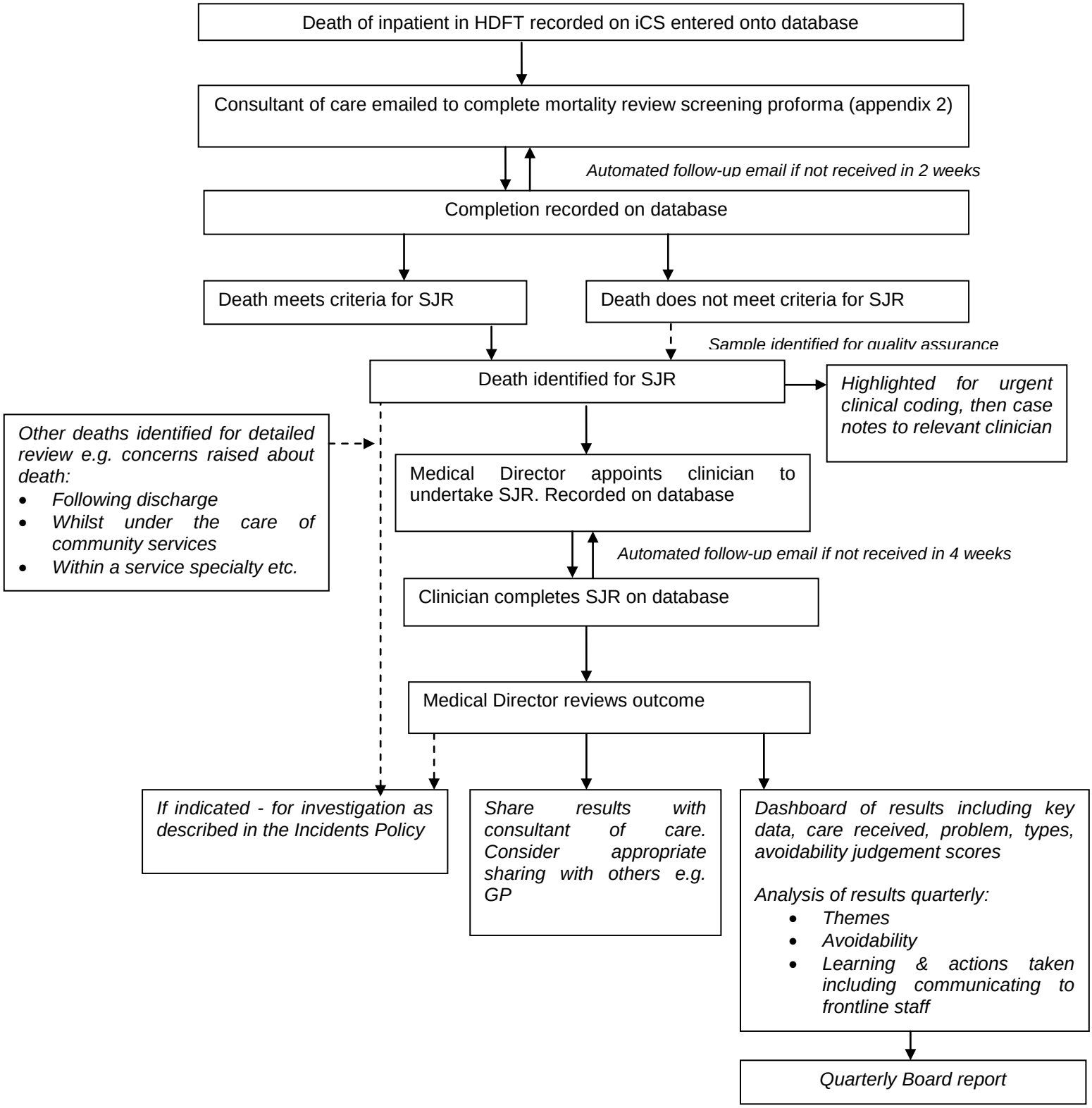
Investigation: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

Death due to a problem in care: A death that has been clinically assessed using a recognised methodology of case note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

2. LEARNING FROM DEATHS POLICY

The policy details a process for identifying, reviewing and learning from deaths and this is summarised below.

2.1. Learning from deaths process



The patient administration system (iCS) is used to identify the death of a patient whilst an inpatient in HDFT for the learning from deaths process. Coded data regarding diagnoses during the preceding episode of care and flagged data e.g. patient flagged as having learning disabilities, is used to identify patient deaths that meet any of the categories identified in 2.2. A screening process is being implemented to capture early feedback from the consultant of care about whether any of these categories are relevant.

Deaths that fulfil any of the above categories will trigger a case note review. HDFT has adopted the methodology for this developed by the National Mortality Case Record Review (NMCRR) programme and clinicians have been trained to use the Structured Judgement Review method (SJR).

The Medical Director will appoint a clinician with appropriate expertise to undertake a SJR. Whenever possible, the clinician will not have been involved in the care of the patient who died. The outcome of the SJR will highlight good practice, as well as identify any lapses in care and system failings. The aim is to identify and share learning, and to implement effective and sustainable changes to practice to improve quality of care.

There is clear reference to existing processes within the governance arrangements for investigation, and engagement with families and carers when this is appropriate, and quality improvement.

2.2. Categories and selection of deaths in scope for case note review

The processes described aim to identify deaths that meet any of the criteria below:

- Deaths where bereaved families and carers, or staff have raised a significant concern about the quality of care provision;
- Inpatient deaths of those with learning disabilities (LD) and severe mental illness. Note: there is a requirement to investigate any death in a person detained under the MHA;
- Deaths in a service specialty, diagnosis or treatment group where an alarm has been raised e.g. SHMI, audit, concerns from CQC or other regulator;
- Deaths in areas where people are not expected to die e.g. relevant elective procedures;
- An infant or child death, and a stillbirth or maternal death;
- Deaths where learning will inform existing or planned improvement work e.g. sepsis.

A mortality review screening proforma (appendix 2) has been developed to collect feedback from the consultant of care in order to identify cases that meet these criteria as quickly as possible. Some deaths that meet the criteria may be identified through other processes such as:

1. Self-reported by clinicians;
2. Flagging of vulnerable patients through iCS;
3. Concerns raised by staff / family through the Patient Experience Team;
4. Feedback to HDFT from Coroner's Officer;
5. Monitoring of standardised mortality rates using the Healthcare Evaluation Data (HED) tool;
6. Communication from Care Quality Commission.

Deaths identified as meeting any of the criteria will trigger a case note review as described below.

2.3. Case note review

A case note review is to determine not only examples of good practice, but also whether there were any problems in the care provided to the patient who died in order to learn from what happened. For those patient deaths meeting the criteria for a detailed review of case notes, the NMCRR data collection sheet is used. This is available from National Mortality Case Record Review (NMCRR) programme resources | RCP London.

This SJR methodology has been validated and used in practice within a large NHS region and is in the process of being rolled out in England and Scotland. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

In order to ensure deaths are investigated to a high standard, staff using the SJR methodology are expected to have received training, and to have the skills to undertake the structured judgement review appropriately. A cohort of clinicians at HDFT have been trained by the NMCRR programme. Regional tier one trainers are a resource for trusts to access to train in-hospital reviewers.

The Medical Director will appoint a clinician with appropriate expertise to undertake a SJR. Whenever possible, the clinician will not have been involved in the care of the patient who died. In some circumstances, the appropriate mental health provider will be invited to participate in the SJR of deaths of patients with known severe mental health needs. The case note review may take the form of a multidisciplinary review in selected cases.

A sample of deaths identified by the screening process as *not* requiring detailed review will be included for case note review. This will provide some quality assurance of the screening process as well as ensuring that a proportion of expected deaths are also reviewed. This will include some patients receiving end of life care. There is no recommended process for identifying such cases. A number of methods are available. The results of the case note review will be shared with the consultant of care. If it is considered to be relevant, the result may also be shared with other organisations that have been involved in the patient's care, including the patient's GP. It is anticipated that wider system learning will be available using online data analysis methodology.

2.4. Investigation

If through the course of screening or case note review, concerns are identified regarding the provision of care, consideration will be given to whether the case should be reported as a patient safety incident, meaning, any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care in accordance with the Incidents Policy. This policy sets out the framework for reporting and investigation of Patient Safety Incidents including identification and investigation of Serious Incidents (SIs). In a small number of cases it is possible that the Statutory Duty of Candour process will be triggered.

Investigation is more in-depth than case note review as it gathers information from additional sources. The investigation process provides a structure for considering how and why problems in care occurred so that actions can be developed that target the causes and prevent similar incidents from happening again.

HM Coroner may request reports for any matters referred whereby an investigation is required and the liaison point for any request will be via the head of Risk Management. It is expected that the Trust will cooperate fully with parallel Coronial processes.

2.5. Engagement with bereaved families and carers

The Care of the Dying Adult and Bereavement Policy provides guidance to staff regarding the management of death and the relevant information that must be provided to patients, relatives and carers. If concerns are raised by the bereaved family or carers about patient dignity and choice, or detrimental care provision, the policy specifically encourages reporting of this as an incident in order to enable learning and improvement.

If concerns are raised about the death of a patient by relatives, carers, or staff, that death will be subject to a case note review. If as a result of case note review lapses in care are identified, an appropriate investigation will be undertaken in accordance with the Incidents Policy. In such circumstances, the family and carers will have an opportunity to ask questions and raise any concerns, and will be supported through the investigation as described in the Incidents Policy, Investigating, Learning and Supporting Guide, HDFT Being Open and Duty of Candour Policy and Making Experiences Count Policy.

2.6. Reviewing and investigating infant or child deaths

The processes for investigating deaths in childhood are defined in the HDFT Expected and Sudden Unexpected Death in Childhood Policy. It relates to infants and children from birth to 18 years. All deaths in childhood should be notified to the Child Death Review Team whether expected or not. There is a statutory requirement for all Safeguarding Children's Boards to have in place systems for reviewing all child deaths from April 2008. Notification should be made to the Local Safeguarding board:
http://www.safeguardingchildren.co.uk/notification-cdop.html

A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. A SCR should take place if abuse or neglect is known, or suspected, to have been involved and:

- a child has died (including deaths by suspected suicide); or
- a child has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child; or
- the child dies in custody.

Local Safeguarding Children Boards (LSCB) follow statutory guidance for conducting a serious case review. The decision to conduct an SCR should be made within one month of the notification of the incident. The LSCB must then notify the National Panel of Independent Experts and Ofsted of this decision.

The LSCB should appoint one or more reviewers to lead the SCR. The lead reviewer must be independent of the LSCB and any organisations who are involved with the case. The LSCB should submit the names of these reviewers to the National Panel of Independent Experts.

For the review process, the LSCB should make sure there is appropriate representation of the different professionals and organisations who were involved with the child and the family. The LSCB may decide to ask them to give written information about their involvement with the child. The LSCB should aim to complete an SCR within 6 months and agree how the learning will be disseminated.

In selected cases, it may be appropriate for an internal SJR to take place in parallel with the above processes. This would be at the discretion of the Chief Nurse, Medical Director and Risk Management lead.

2.7. Reviewing and investigating stillbirths

Stillbirths are investigated using the stillbirth investigation toolkit, in order to systematically review the case and identify any lapses in care.

2.8. Reviewing and investigating maternal deaths

Maternal deaths are investigated as defined in the Maternal Death Guideline. The Trust reports to MBRRACE-UK for the National Confidential Enquiry into Maternal Deaths and national surveillance of late fetal losses, stillbirths and infant deaths. See www.mbrrace.ox.ac.uk

The existence of these policies, guidelines and processes for infant or child deaths, stillbirths and maternal deaths does not exclude a structured case note review in selected cases where concerns are raised. This will usually be at the discretion of the Chief Nurse and/or Medical Director.

2.9. Deaths of people with learning disabilities

The death of any inpatient in HDFT known to have learning disabilities and flagged as such on the patient administration system (iCS), will trigger a detailed review of case notes using the structured judgement review.

In addition the Acute Liaison Nurse - Learning Disabilities will automatically refer the death to the Learning Disabilities Mortality Review (LeDeR) Programme About the programme | School for Policy Studies | University of Bristol which aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere. LeDeR has produced guidance for conducting local reviews. Reviews of deaths | School for Policy Studies | University of Bristol. See also the LeDeR process flowchart in appendix 3.

2.10. Deaths in the Emergency Department

The Emergency Department regularly review patients who attended the Emergency Department, were admitted and died within 48 hours of admission. Case notes are reviewed and care analysed for timeliness, measurement and escalation of early warning score, diagnosis, omissions or learning points, demonstration of good care, consideration of palliative care, recent admission (within 14 days) and whether patient came from their own home or a care facility. Good practice, lessons to learn and actions are shared with the department staff and with the Medical Director.

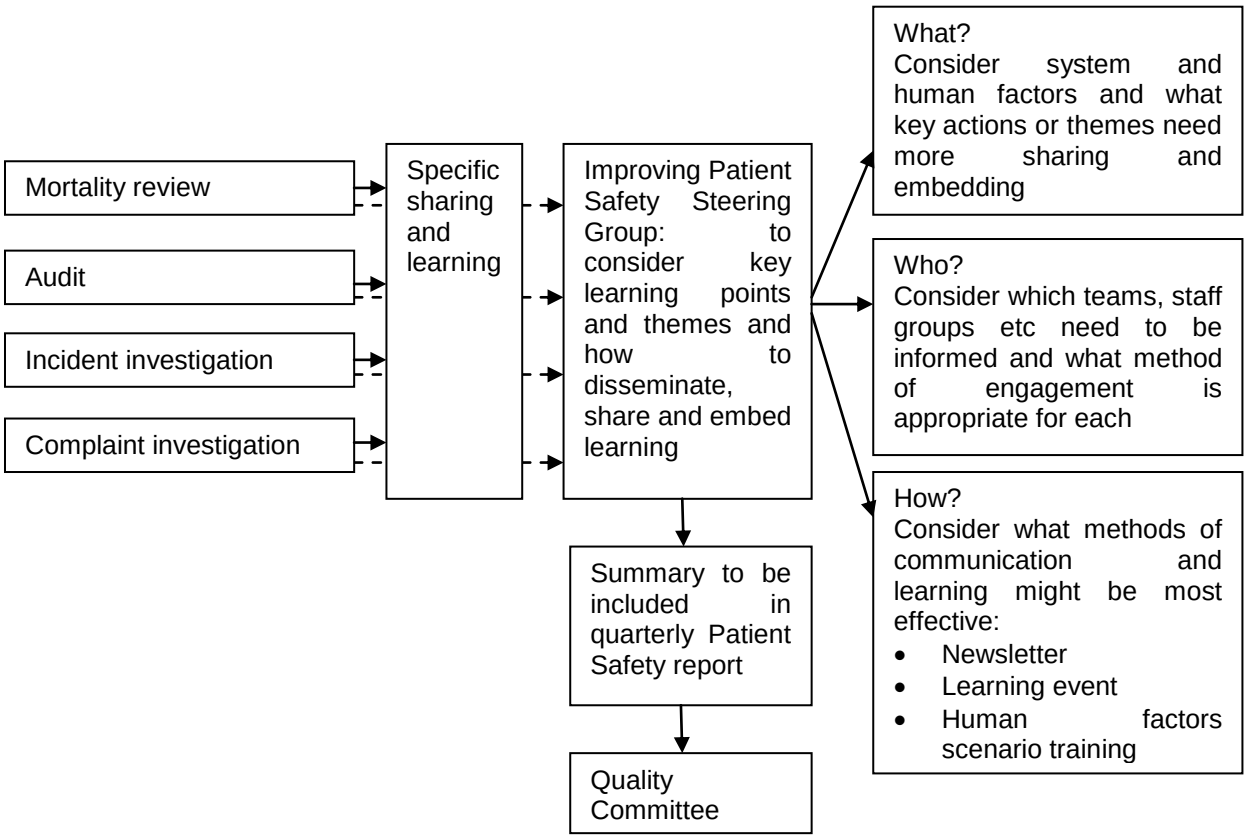
2.11. Sharing and implementing learning from deaths

Any specific areas for learning that are identified by a SJR will be shared with the patient's consultant of care and any other relevant staff involved in the patient's care.

However, regarding lapses in care, the Trust acknowledges the primary role of system factors within or beyond the organisation rather than individual errors. The aim of the review and learning process is to prioritise effective and sustainable changes to practice,

underpinned by human factors approaches, systems thinking and quality improvement methodologies.

The themes and learning points identified from the responding to deaths process will also be shared at a quarterly meeting of the Improving Patient Safety Steering Group. This group has multi-disciplinary and multi-professional input. The group will be engaged in reviewing learning from deaths alongside learning from incidents, complaints and good practice. They will identify key themes and actions for sharing, focusing on system and human factors. The group will be responsible for identifying and reviewing methods of disseminating learning, and ensuring these feed into the directorate and Trust governance structures. Processes and tools for communicating the output of investigations, themes, good practice and learning to frontline clinical staff will be established.



Specific learning may be shared with other organisations if appropriate. It is anticipated that the development of the national mortality review programme will facilitate future learning regionally and nationally.

2.12. Reporting

Sharing the data and information from this process supports an open and honest organisational culture.

The Medical Director will report data and learning points to the public Board every quarter. The information is to include:

- Total no of inpatient deaths (including ED deaths);
- Number of deaths subject to case note review;

- Number of deaths investigated under the SI framework;
- Number of deaths that were reviewed / investigated;
- Themes and issues identified from review and investigation, including examples of good practice;
- Actions taken in response, actions planned and an assessment of the impact of actions taken.

In these ways the results and the learning will be highlighted and reported to the Quality Committee and the Board of Directors, to be considered alongside other information and data. This will enable learning to be incorporated into the Trust's long term strategic plans and quality priorities.

A dashboard of data will be prepared based on the NHS England national guidance on learning from deaths dashboard. NHS England » National Guidance on Learning from Deaths. The quarterly dashboard and report will be shared with commissioners.

3. ROLES AND RESPONSIBILITIES

3.1. Trust Board

The Board is responsible for the quality of the healthcare the Trust provides. The Board has specific responsibilities for:

1. Ensuring the Trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate:
2. Ensuring the Trust learns from problems identified by reviews or investigations as part of a wider process that links different sources of information to provide a comprehensive picture of their care. In this context 'learning' means taking effective, sustainable action (via appropriately resourced quality improvement work) to address key issues associated with problems in care;
3. Providing visible and effective leadership to support their staff to improve what they do;
4. Ensuring the needs and views of patients and the public are central to how the Trust operates.

3.2. Executive Directors with responsibility for learning from deaths

Dr David Scullion (Medical Director) is the Trust Executive Director with responsibility for learning from deaths, and Mrs Lesley Webster is the Non-Executive Director Lead.

3.3. Medical Director

The Medical Director is the Trust Executive lead for mortality and is responsible for ensuring the Trust has a policy and processes in place to ensure a standardised approach is in place in the Trust to learn from deaths. This must meet the content of national guidance and must be integrated with the Trust's governance and quality improvement work.

They are responsible for ensuring sufficient clinicians at HDFT have been trained by the NMCRR programme.

The Medical Director will oversee the structured judgement reviews, discussing outcomes with relevant clinicians and ensuring the application of other policies such as the Incidents Policy and the HDFT Being Open and Duty of Candour Policy.

3.4. Improving Patient Safety Steering Group

The Improving Patient Safety Steering Group will approve this policy. The group will also be responsible for considering the learning points and actions identified by this process alongside other evidence, ensuring themes, system and human factors are identified and appropriate dissemination and quality improvement methodologies are adopted.

3.5. Head of Performance & Analysis, Information Services

The Head of Performance and Analysis is responsible for ensuring the completion of a quarterly dashboard to aid the systematic recording and reporting of deaths and learning from the care provided.

3.6. Acute Liaison Nurse - Learning Disabilities

The Acute Liaison Nurse - Learning Disabilities will notify the LeDeR programme of deaths of inpatients known to have learning disabilities.

4. POLICY DEVELOPMENT AND EQUALITY

This policy was developed using the references listed below and with input and advice from the staff listed in appendix 1. An equality impact assessment stage 1 has been completed. The need for a stage 2 impact assessment is being considered.

5. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

The initial consultation was undertaken as part of the policy development as above. The draft policy will be taken to Improving Patient Safety Steering Group for approval. The first version of this policy will then be presented to the Quality Committee for ratification and the Board of Directors for information.

6. DOCUMENT CONTROL

The current version of this policy will always be available from the intranet. Previous versions will be archived within the intranet as evidence of previous Trust policy. Paper copies may not be the most up to date version.

7. DISSEMINATION AND IMPLEMENTATION

This policy will be highlighted to key staff during the development of the policy and processes. The final version will be uploaded to the intranet and key staff will be notified of the location by email.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

The processes within this policy will be monitored regularly and the results included in a quarterly report to Quality Committee, the Board of Directors and relevant commissioners. Any concerns about compliance with the policy and processes will be addressed with relevant staff.

9. REFERENCE DOCUMENTS

National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care (March 2017). NHS England » National Guidance on Learning from Deaths

Implementing the Learning from Deaths framework: key requirements for trust boards. NHS Improvement (July 2017)

National Guidance on Learning from Deaths dashboard. NHS England » National Guidance on Learning from Deaths

Mortality Review Programme: Yorkshire and Humber AHSN Improvement Academy. Improvement Academy - Mortality Review Programme

National Mortality Case Record Review Programme: Royal College of Physicians. National Mortality Case Record Review Programme | RCP London

National Mortality Case Record Review (NMCRR) programme resources: Royal College of Physicians. National Mortality Case Record Review (NMCRR) programme resources | RCP London

10. ASSOCIATED DOCUMENTATION

HDFT Incidents Policy

HDFT Being Open and Duty of Candour Policy

HDFT Expected and Sudden Unexpected Death in Childhood Policy

Care of the Dying Adult and Bereavement Policy

Investigating, Learning and Supporting Guide

Making Experiences Count Policy

NMCRR data collection sheet from National Mortality Case Record Review (NMCRR) programme resources | RCP London.

11. APPENDICES

Appendix 1: Consultation Summary
Appendix 2: Mortality Review Screening Proforma
Appendix 3: LeDeR process flowchart

11.1. Appendix 1: Consultation Summary

	List Groups and/or Individuals Consulted
Those listed opposite have been consulted and any comments/actions incorporated as appropriate. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	Dr David Scullion, Medical Director
	Dr Sylvia Wood, Deputy Director of Governance
	Rachel McDonald, Head of Performance & Analysis
	Paul Nicholas, Deputy Director of Performance and Informatics
	Jolyon Ingle, Head of Information Systems Development
	Lesley Webster, Non-executive Director with responsibility for overseeing progress with learning from deaths
	Ben Haywood, Acute Liaison Nurse - Learning Disabilities
	Janet Farnhill, Senior Nurse-Adult Safeguarding
	Ian Cannings, Clinical Lead Paediatrics
	Kat Johnson, Clinical Director Planned and Surgical Care and Consultant Obstetrician
	HDFT / TEWV Engagement meeting
	Noreen Hawkshaw, Macmillan Lead Nurse for Cancer and End of Life Care (and End of Life Steering Group)
	Alison Pedlingham, Head of Midwifery
	Sue Oxendale, Bereavement Midwife
	Improving Patient Safety Steering Group
	Neil McLean, Non-executive Director with responsibility for children
	Jill Foster, Chief Nurse
	Andrea Leng, Head of Risk Management
	Mel Jackson, Patient Safety Manager
	Rebecca Wixey, Clinical Effectiveness & NICE Manager
	Dave Earl, Deputy Medical Director

11.2. Appendix 2: Mortality Review Screening Proforma

The aim of this review is to contribute to identifying learning from deaths of patients to improve future patient care.

Patient demographics

Date of admission: Time of admission: Date of death:		
Type of admission:	Acute / elective If acute: from GP / ED / other	
Did the patient have: Learning disabilities? Significant mental health illness? An elective procedure during this admission? Sepsis? Was this a maternal, neonatal or paediatric death? Are you aware of concerns about the care provision from staff, family, carers or advocates? *If yes to any of the above – this case will require a structured judgement review. You can stop and SUBMIT, or complete the remainder of the review if you wish to provide more information.* *If no to all of the above – please complete the remainder of this review.*		Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐
Did the patient have appropriate reviews? Y ☐ N ☐	How many ward moves during episode of care?	
Was the patient under the care of the appropriate clinical speciality?		Y ☐ N ☐
What was the admitting diagnosis?		
What was the main condition being treated if different from admitting diagnosis?		
Was key treatment initiated promptly and according to protocols / pathways where appropriate (e.g. antibiotics / fluids / chest drain)?		Y ☐ N ☐ N/A ☐
Is there evidence of appropriate clinical decision making and communication?		Y ☐ N ☐ N/A ☐
Were agreed pathways followed where appropriate? (e.g. Trust Guidelines / Care Bundles for Stroke / Sepsis / Pneumonia etc.)		Y ☐ N ☐ N/A ☐
Was there any failure to recognise deterioration? Y ☐ N ☐	Was there any failure to escalate?	Y ☐ N ☐
Was a DNACPR in place? Y ☐ N ☐	Was a ceiling of care defined?	Y ☐ N ☐
Surgical procedure? If yes: Y ☐ N ☐ Date ……	If yes: Elective Non-elective	Y ☐ N ☐ Y ☐ N ☐

Procedure ……	
Procedure carried out by:	Name of surgeon Grade
Anaesthetic carried out by:	Name of anaesthetist Grade
What was the certified cause of death?	
Do you agree with the certified cause of death?	Y ☐ N ☐
If not, please indicate the cause of death in your opinion:	
Was the death referred to the coroner? Y ☐ N ☐	If no, would this have been appropriate? Y ☐ N ☐
Was a post mortem examination undertaken?	Y ☐ N ☐

Overall care judgement - please score overall care using the scale below:

1 ☐ Poor care – may have led to harm(s) and / or patient / family distress. Indicate reasons below	**2** ☐ Adequate care	**3** ☐ Good care

Things that could be improved:	Things that went well:
Do you think this case would benefit from a structured judgement review by an independent clinician to highlight any learning?	Y ☐ N ☐
Any additional comments	

Name of person completing form:	
Signature:	Date review completed:

SUBMIT

11.3. Appendix 3: LeDeR process flowchart