The Hillingdon Hospitals NHS
NHS Foundation Trust

Learning from Deaths, Mortality Review Policy

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Author name and Job Title :	Dr Cheryl Messer, Clinical Director Quality and Safety Anita Maudsley, Clinical Audit and Effectiveness Manager
Sponsor Name and Job Title	Abbas Khakoo, Medical Director
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Scope	This policy applies to all staff involved in the Learning from Deaths Process
This policy has been Equality Impact Assessed	Yes

Uncontrolled once printed.

It is your responsibility to check against the intranet that this printout is the most recent version of this document.

This policy is also published on the Trust's public website

Record of changes to this document

Version & Section Number	Amendment	Date of Change	Change/ Addition	Reason
V1.0		August 2017		Gap analysis v NQB Report March 2017 Learning from Deaths recommendations

Dissemination and Consultation with Stakeholders

Disseminated to (either directly or via meetings, etc.)	Position of Stakeholder or Name of Endorsing Committee	Format (paper or electronic)	Date
Dr Cheryl Messer	Mortality Surveillance Committee	Electronic	
Dr Abbas Khakoo	Quality and Safety Committee	Electronic	

Contents

Operational Summary

Policy Aim
To provide guidance to all staff involved in Learning from Death reviews and to comply with all the recommendations set out in the National Quality Board: National Guidance on Learning from Deaths March 2017.

Policy Summary
This policy documents how the Trust will ensure its governance arrangements and processes are in place to facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. The policy will identify how the Trust will ensure staff share and act upon any learning derived from these processes. It sets out the standards expected of the Trust board including the requirement of an Executive with responsibility and a Non-executive director with oversight of the process.

The policy documents how the Trust will ensure that staff reporting and reviewing and investigating deaths have appropriate skills through specialist training and protected time under their contracted hours to deliver these to a high standard.

It sets out the process for engagement with bereaved families and carers including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one and to ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

The policy documents how the Trust responds to and learns from deaths of patients who die under its management and care including those with learning disability, mental health needs, an infant or child and a still birth or maternal death.

The policy sets out the criteria for selection of deaths to be reviewed. These are clear and open to scrutiny and documented later in this document including but not limited to all of those published in the NQB National Guidance. In particular contexts, and as these processes become more established, reviews will include cases of people who had been an in-patient but had died within 30 days of leaving hospital.

What it means for staff
Increased awareness of how review of deaths can have an impact on quality and safety of care and how staff can learn from feedback both from review of case notes after death and from family and carers' input.

Responsibility of Trust Employees
All Trust employees are responsible for reading the new/revised policies to maintain current awareness of changes which impact on their roles.

1. INTRODUCTION

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death.

However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures.

In response to concern about patient safety and increased scrutiny of mortality rates there is a drive for Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe. With the publication of the Care Quality Commission (CQC) document Learning, Candour and Accountability, December 2016 and the subsequent document from the National Quality Board (NQB): National Guidance on Learning from Deaths March 2017, the Trust Mortality Review Process has been reviewed and is now the Trust Learning from Deaths (LFD) process.

The purpose of reviews and investigations of deaths in which problems in care might have contributed to the death is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon. **The transformation required in response to the Learning from Deaths framework is first and foremost about the way carers and families are engaged after a death.** The Trust LFD process will drive this as part of wider clinical governance processes.

The Trust Quality and Safety Improvement Strategy 2016-2021 has 'Working towards no Preventable Deaths - positive improvement in mortality rates and outcomes from mortality review processes' as a quality priority for the next 5 years.

2. PURPOSE

This policy sets out the process to be followed in the Trust to ensure all patient deaths undergo appropriate review, and learning is acted upon to improve the care and experience of our patients and their carers.

Mortality review is a means of identifying problems in healthcare and identifying areas of care which could be improved such as early recognition and escalation of the deteriorating patient, and appropriate and timely end of life care. Reviews often highlight aspects of excellent care as well as poor care and it is important that learning from both areas of excellence, as well as those in need of improvement, is shared across the Trust.

National Guidance on Learning from Deaths was published by the National Quality Board in March 2017 including use of the Structured Judgement Review (SJR) case note tool as developed by the Royal College of Physicians (RCP), which is a core element of the guidance.

This document sets out how the Trust will conduct mortality review and learning from deaths, as per the requirements of the NQB guidance and as part of wider clinical governance processes, including but not limited to:

- deaths where the bereaved or staff raise significant concerns about the care
- deaths in a specialty, diagnosis or treatment group where an 'alarm' has been raised (for example, an elevated mortality rate, concerns from audit, CQC concerns)

- deaths where the patient was not expected to die, for example, in elective procedures
- deaths where learning will inform the provider's quality improvement work
- deaths of those with learning disabilities or severe mental illness

3. DUTIES AND RESPONSIBILITIES

Chief Executive:
The Chief Executive has overall accountability for ensuring there are appropriate processes in place for mortality review including involving family and carers, identifying, reviewing, investigating and learning from deaths.

Medical Director
The Medical Director has executive director responsibility for the Learning from Deaths process, specifically ensuring that information on deaths, investigations and learning is reviewed at the Patient Safety Committee and Public Trust Board - this will be via a quarterly report. The MD will ensure learning is acted upon and reported in the annual Quality Report

Non-Executive Director
The Non-Executive Director provides leadership on mortality and learning at Board level and attends the Mortality Surveillance Group Meetings. The NED will ensure

- They have a good understanding of the process and provide challenge and scrutiny
- The LFD processes are robust and meet national requirements
- That information published reflects challenges and achievements
- They oversee that carers and families are engaged after a death
- Learning and improvement remains the purpose of the exercise and that meaningful and effective actions are implemented to improve patient safety and experience.

Mortality Surveillance Group Chair
The Mortality Surveillance Group Chair is responsible for:

- Providing professional expertise and ensuring that Learning from Deaths policy and guidance is consistent with NQB guidance and based on best practice.
- Providing leadership within the Trust for Learning from Deaths Review
- Working with staff, both clinical and administrative, to improve patient care in response to learning from deaths
- Working with medical colleagues to ensure that NQB guidance is followed.
- Being a point of contact for the Trust Executive.
- Presenting the Mortality Report to the Patient Safety Committees
- Overseeing a report to Trust Board quarterly
- Providing a point of contact for, and liaising with, external bodies concerning LFD process.

Mortality Leads
Mortality Leads represent all clinical specialties and professional groups within the Trust involved in patient care; including medical, nursing and allied health professionals. Their responsibilities are to:

- Provide leadership for the LFD process within their specialty or professional group
- Attend MSG meetings

- Support the review process ensuring reviews are conducted as per timescales agreed.
- Enable and support the learning from reviews is being effectively disseminated within their specialty or professional group so that it reaches all frontline staff
- Assist in identifying those cases where use of the SJR may be required (when the Trust has SJR capability)

Mortality Lead Nurse
The Mortality Lead Nurse will support the overall LFD process ensuring all appropriate cases receive the required review.

- Support the review process ensuring all cases that require LFD review are identified.
- Attend MSG meetings and present the Trustwide report
- Review specific cases, for example, where a shortfall in care has been identified
- Enable and support the learning
- Liaison with families and carers as part of the LFD process

Managers (including Assistant Director of Operations, Assistant Director of Nursing and Divisional Directors)
Managers have responsibility to ensure that:

- LFD process is followed within their area/s of responsibility.
- Ensure engagement with bereaved families and carers, including supporting and involving them in investigations where relevant.
- Job plans reflect time required for involvement in the LFD
- All relevant staff are made aware of this policy,
- Consultant Staff receive appropriate training to perform mortality review of case notes as the Trust adopts the SJR as advised by RCP
- All staff have access to education and training as appropriate to their area of practice either to participate in the LFD process or in the light of learning needs identified by the process

Consultants
Consultants are responsible for ensuring that they:

- Engage with the LFD Process undertaking reviews in a timely manner as detailed in this document
- Support implementation of improvement and learning
- Engage with bereaved families and carers, including supporting and involving them in investigations where relevant.
- Attend training for the SJR as appropriate
- Perform SJR reviews when provided with training and time to do so
- Clearly document the SJR reviews as per training provided
- Identify, report and share any shortfall of care
- Learn from the review and take appropriate action

All clinical staff
All clinical staff are responsible for ensuring that:

- They comply with this policy to learn from review of deaths
- Lessons learnt from LFD Process are disseminated
- Lessons learnt result in an action plan to change so that future shortfalls are avoided

- They access education and learning resource opportunities as appropriate to their practice as may be identified by the review process
- They attend training as may be identified by the process
- Family and carers are proactively supported to express concerns about care given to a patient who has died
- They engage with bereaved families and carers, including supporting and involving them in investigations where relevant.
- Family and carers are involved in the review process as much as they may desire

Clinical Audit Team

The Clinical Audit Team, which includes the LFD Administrator, will

- Co-ordinate the LFD process
- Escalate concerns with the process to the Mortality Surveillance Group
- Ensure notes are processed for review
- Provide reports to MSG, PSC, Governance Boards, Trust Board
- Take minutes of Clinical Forum, Morbidity and Mortality Meetings to evidence discussion and agreed learning
- Ensure lessons learnt are recorded and actioned

The Mortality Surveillance Group

The Mortality Surveillance Group (MSG):

- Is the operational group to ensure the LFD process: provides assurance that mortality is proactively monitored, reviewed, investigated and; drives improvements.
- Will escalate areas of concern with the process, to the Patient Safety Committee.
- Will review specific cases escalated for further discussion
- Reports to the Patient Safety Committee
- Convenes bimonthly
- Has multi-disciplinary and multi-professional membership
- Reports to the Board via the Medical Director at the public section of the meeting quarterly with data suitably anonymised
- Communicates outputs of the mortality governance process including investigations of deaths to frontline clinical staff.
- Terms of Reference are attached in Appendix 1.

The Patient Safety Committee

The Patient Safety Committee:

- Receives reports from the Mortality Surveillance Group
- Drives Learning from Deaths process within the areas of responsibility of those attending
- Has oversight of Divisional responsibility to ensure areas of concern, highlighted by the MSG are addressed.

Trust Board

The Trust Board:

- Has overall responsibility for ensuring an appropriate Learning from Deaths Strategy is in place
- Is responsible for receiving and reviewing a quarterly report from the Mortality Surveillance Group
- Takes a systematic approach to the issue of potentially avoidable mortality and has robust mortality governance processes.

Clinical Quality Commissioning Group
The Clinical Quality Commissioning Group:

- Reviews the quarterly report from the Mortality Surveillance Group, after it has been presented at Trust Board
- Takes forward any findings and learning identified which is not within the remit of the Trust

Clinical forum, Morbidity and Mortality Review meetings

- Participation in mortality and morbidity (M&M) meetings and other Clinical Forums should be considered a core activity for all clinicians. Whilst it is recognised that different departments will have different requirements and aims in relation to M&M meetings, the main principles are that they should be a forum for discussion of deaths and other clinical adverse events.
- The overall aim is to learn lessons from clinical outcomes and drive improvements in service delivery. These meetings have a central function in supporting services to achieve and maintain high standards of care.
- Key learning from these meetings will be included in the LFD reports

Governance Boards
Governance Boards will:

- Ensure LFD process is embedded within their Division/Specialty
- Support the LFD process by dealing with areas of concern, both LFD process and clinical care, ensuring improvements are made
- Support the sharing of learning from deaths within their Division/Specialty
- Ensure LFD reports are a quarterly agenda item

4. EXPLANATION OF TERMS

- **Crude Mortality**
  Crude mortality is found in iREPORTER. This gives the mortality rate percentage of deaths during each month. Crude mortality identifies the patient level detail of deaths that occur in the Trust and is used as the mechanism for identifying patients for the LFD process.

- **HSMR - Hospital Standardised Mortality Ratio**
  The HSMR scoring system works by taking the crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc. By taking these factors into account, it is possible to calculate a ratio from the two scores – the mortality rate actually observed and the mortality rate that would be expected for any given hospital

- **SHMI - Summary Hospital-level Mortality Indicator**
  The SHMI is a score that reports on mortality rates at trust-level across the NHS in England, using a standard and transparent methodology. It is produced and published quarterly as an official statistic NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. SHMI includes deaths following a patient's discharge within 30 days.

- **Serious incident**
  Serious incidents (SI) are events in health care where the potential for learning is so

great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents; every incident must be considered on a case-by-case basis.

- **CEDSI**
  Is a tool for classification of care provided around time of death
  As described in the Confidential Enquiry into Stillbirths in Infancy – this is an evidence based tool used to classify deaths: Grade 0 - Unavoidable death, no suboptimal care; Grade 1 - Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome; Grade 2 - Possible avoidable death, suboptimal care, but different management *might* have made a difference to the outcome; Grade 3 - Probable avoidable death, suboptimal care , different care *would reasonably be expected* to have affected the outcome.

- **TARN**
  This refers to patients admitted to the Trust with injury due to trauma as defined by the Trauma Audit and Research Network

5. DEATH CERTIFICATION, CASE RECORD REVIEW and INVESTIGATION

5.1 Process for determining which patients, under our care, are to be included for case record review when they die

In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

In The Hillingdon Hospitals NHS Foundation Trust, all deaths will be identified via Crude Mortality, for both admitted patients and Emergency Department. The Learning from Death Administrator will undertake review of this to identify patients who have died. The death will be recorded on the centralised system and the process detailed in the flowchart in Appendix 2 will be followed.

For patients who die within 30 days of discharge from the Trust, if notified, these patients will be subject to the hospital LFD process. Further work, to identify all 30 day deaths, will be taken forward in conjunction with Hillingdon Clinical Commissioning Group.

The Trust will also review deaths where the care provided to patients was elsewhere at the time of death, but where another organisation suggests we review the care provided to the patient in the past (within 30 days). The Trust will need to do the same for other organisations.

5.2 Learning from Death Review Process

The Clinical Audit Team will review all casenotes to identify patients that require review under the LFD process. Criteria for inclusion include:

Mental Health
Learning Disability
Infant or child death
Stillbirth or maternal death
Carer/family concerns identified
Sepsis
Hip fracture
Acute Pancreatitis
DVT (deep vein thrombosis)
MRSA (Methicillin-resistant staphylococcus aureus)
TARN patient (see explanation of terms Paragraph 4)
Unexpected death
Coroner cases
Weekend admission
Re-admissions, including A&E
Patients awaiting placements
Death following an operation
Death following an endoscopy
Incidents, Claim, Complaint, Duty of Candour

Alongside this the Trust will introduce a sample of other deaths to review to clarify where further learning and improvement might be gleaned, this will include a review of the care provided to patients whose death may have been expected, for example those receiving end of life care.

Where a case does not fit directly within these criteria the Lead Mortality Nurse will undertake further review of the case-notes, to determine if LFD review is required.

Once identified for LFD review, the case-notes are issued to a consultant in a specialty who would be cognizant of appropriate care in the case under review but not a Consultant who had been involved in the immediate past care of the patient. The consultant will complete the LFD proforma in Appendix 3.

A subset of case-notes will be subject to SJR as the training for this and the Datix electronic support becomes available.

5.3 Outcome of LFD review

The Trust uses the CEDSI methodology for assessing the degree to which the care of the patient affected the outcome:

Grade 0: Unavoidable Death, No suboptimal care

- If Grade 0 is recorded from the LFD the findings will be included in the overall reporting for the LFD process.

Grade 1: Suboptimal care, but different management would not have made a difference to the outcome

- If Grade 1 is recorded, the Mortality Lead Nurse will review the case to determine what further action may be required e.g. case presentation to appropriate Clinical Governance Forum. Any learning points and actions for required change will be identified and shared as part of reporting process to MSG and PSC.

Grade 2: Suboptimal care, but different care MIGHT have affected the outcome, (possibly avoidable death)

- If Grade 2 is recorded, the case will require in depth review and presentation by the consultant (or member of their team) who cared for the patient to an appropriate multiprofessional Clinical Governance Forum where learning can be shared and any actions for required change agreed. This presentation, learning points and actions will be included in LFD reporting to MSG and PSC.

Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome, (probable avoidable death).

- If Grade 3 is recorded, this will have immediate escalation to the Divisional Director for potential SI investigation (see section 5.4)

For Coroner cases the Consultant will be asked to make a provisional review using the LFD proforma which can be included in the board report in a timely manner and then subsequently adjusted if necessary in the light of the coroner's report.

Themes and trends from LFD reviews will be collated and if any concerns are identified, for example, increased number of avoidable infections, bed availability issues, they will be reported to MSG to consider further action.

Positive practice will also be identified and reported across the Trust.

5.4 Process for decision on which deaths require an investigation under the Serious Incident framework.

The Trust will apply rigorous judgment to the need for deaths to be subject to Serious Incident reporting and investigation. For example, there may be instances where deaths clearly meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken).

Equally, problems identified in case record review may lead to the need for investigation whether this is an investigation under the Serious Incident Framework or other framework/procedure.

The **Policy for the Management and Investigations of Incidents Including the Management of Serious Incidents** will be used to ensure all cases are investigated where they should be.

5.5 LFD Reporting

- Overall reports on LFD will be provided to MSG and PSC ahead of the report to Board
- Specialty/Division specific reports will be provided to Governance Boards
- Quarterly reporting to Trust Board at a public meeting.
- Quarterly reporting to Clinical Quality Board (joint Trust and CCG quality meeting)
- The format of the reports will be based on the Learning from Deaths Dashboard for NHS Providers

- Data for inclusion in the Quality Report for 2017/18 will be agreed during the coming year

5.6 Involvement of family and carers

The Trust will engage meaningfully and compassionately with bereaved families and carers as part of the LFD process. The Trust will ensure our LFD process provides:

- A high standard of timely bereavement care
- Families and carers with information of their right to raise concerns about the quality of care provided to their loved one
- For family and carer views to be taken into account in deciding whether mortality review is indicated
- For families and carers to receive clear, honest and sensitive response to concerns
- For Families and carers, who have experienced the investigation process, to be invited to work with the Trust to improve the process.

Within the Trust the LFD process is one that will develop over time and will include:

When a bereaved family or carer raises significant concerns this will trigger a review (using the LFD proforma) and a subsequent investigation by the appropriate team as identified by the mortality lead nurse/mortality lead. Once this decision has been made:

- the bereaved family will be made aware in person and in writing as soon as possible of the purpose, rationale and process for the investigation by the relevant clinician
- be kept fully and regularly informed, in a way that they have agreed, of the process for the investigation.
- be asked their preference as to how and when they contribute to the process of the investigation including agreement to the terms of reference
- be provided with a single point of contact to provide timely updates including delays
- have an opportunity to respond to the findings and recommendations in any final report and be informed of what processes have changed in the provision of future care.

Where families and carers are already dealing with clinicians responsible for the care of the patient or locally within specialty/division, the details will be captured centrally for onward reporting to share findings and learning. As soon as families raise concerns, the completion of the LFD proforma can be started immediately – this must be by a clinician not directly involved in the care of the patient.

If the care given has been declared an SI, this will be noted within the centralised LFD process and will be updated as the investigation is completed.

Initial contact with family/carers, is often managed by the clinicians responsible for the care of the patient. This can be seen as a barrier to raising concerns. To ensure family /carers are able to raise concerns, a standard leaflet will be provided to them notifying them of the process for raising concerns about the care of the patient. The leaflet will include contact details to obtain legal advice.

CESDI Grade 2 and Grade 3 cases will trigger informing the family/carers of findings that require further review or investigation into the care provided to the patient. This will be co-ordinated by the Lead Mortality Nurse and will ensure that families/carers will be involved to the extent that they wish to be involved.

Any findings identified within the LFD process, that meet the requirements of the Duty of Candour policies will be subject to that process.

5.7 Learning Disability Deaths

The Trust will respond to the death of an individual with a learning disability and will submit cases to the Learning Disabilities Mortality Review (LeDeR) Programme. This will be overseen by the Lead Nurse for Safeguarding. Further details can be found via the following link: http://www.bristol.ac.uk/sps/leder/

5.8 Mental Health Needs

Cases identified where the patient had mental health needs will be reviewed as part of the LFD process and there will be a collaborative approach to review involving the Mental Health Trust caring for the patient, for example, Central and North West London NHS Foundation Trust.

5.9 Infant or Child Death/Stillbirth

This process will be covered within the Guideline for the Review of Deaths in Infants.

5.10 Maternal Death

All maternal deaths are subject to the Serious Incident process.

6. TRAINING REQUIREMENTS

Structured Judgement Review Training will be delivered/accessed as this becomes available.

7. MONITORING COMPLIANCE

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Key Performance Indicator	Lead responsible for monitoring	Evidence	Reviewed by/ frequency	Lead responsible for required actions
The Trust will collect and publish specified information on deaths	MSG chair	A paper and an agenda item to a public board meeting in each quarter	Report to the Mortality Surveillance Group, Patient Safety Committee and exception report to the Quality and Safety Committee Report to Trust Board quarterly Report to CQG quarterly	MSG Chair
The Trust will publish data and learning points	MSG chair	.	As above	MSG Chair
Uptake of training in the Structured Judgment Review	MSG chair	Consultants undergoing Structured Judgement review training	MSG Quarterly	Divisional Directors

8. EQUALITY IMPACT ASSESSMENT

The Trust is committed to promoting an environment that values diversity. The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. This document has been equality impact assessed and this can be found in **Appendix 4.**

9. NHS CONSTITUTION

The Trust is committed to the principles and values of the NHS constitution and this document takes in to account these principles and values.

10. REFERENCES

Care Quality Commission Report - Learning, candour and accountability, A review of the way NHS trusts review and investigate the deaths of patients in England, December 2016

National Guidance on Learning from Deaths, A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, March 2017

First Mid & South Essex Mortality Review Policy, July 2017

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

11. LIST OF ASSOCIATED DOCUMENTATION

Policy for the Management and Investigations of Incidents Including the Management of Serious Incidents

Quality and Safety Improvement Strategy 2016-2021

Appendix 1

Terms of Reference of the Mortality Surveillance Group

1. MEMBERSHIP

Clinical Director for Quality and Safety (Chair)
Non Executive Director (NED) Responsible for Mortality (Deputy Chair)
Corporate Nursing Representative
Governance Representative
Mortality Leads from Medicine, Emergency Department, Surgery, ITU, Anaesthesia, Trauma & Orthopaedics, Obstetrics and Gynaecology (as required), Paediatrics (as required), Nursing
Clinical Coding Manager
Information Department Representative (as required)
Mortality Lead Nurse
Clinical Audit Representation
Junior Doctor Representative
Palliative Care Representative
LD Specialist Practitioner – As required
Representative from Clinical Commissioning Group – As required

2. PURPOSE

The purpose of the Mortality Surveillance Group is to support the Trust Board in providing assurance that mortality is proactively monitored, reviewed, reported and where necessary investigated to ensure appropriate lessons are learned and actions implemented to improve outcome.

It acts as the principal source of advice and expertise on mortality, via the Patient Safety Committee, to the Trust Board. The Mortality Surveillance Group will provide updates on the status of any areas of concern and actions plans arising to the Patient Safety Committee and by exception to Quality and Safety Committee.

3. QUORUM

3.1 The meeting will be quorate if 5 members of the group are present, one to be the Chair or Deputy Chair with a minimum of two additional clinicians that should include Specialty/Divisional representation.

4. ACCOUNTABILITY

4.1 The Group is accountable to the Patient Safety Committee which reports to the Quality and Safety Committee.

5. DUTIES

5.1 General

5.1.1 To develop and oversee implementation of the process for effective mortality review to drive continuous improvement.

5.2 Specific duties

5.2.1 To ensure policies and procedures are in place to support effective mortality review meeting the requirements of national guidance. This will include but not be restricted to deaths in patients with mental health disorders, patients with Learning Disabilities, Stillbirths and patients undergoing elective surgery.

5.2.2 To ensure policies and procedures are in place to support effective review of in hospital deaths and escalation of concerns identified, including those raised by bereaved families / patient representatives.

5.2.3 To encourage proactive review of mortality in all clinical areas on a regular basis.

5.2.4 To ensure policies and procedures are in place for Divisional teams to systematically review a proportion of all deaths and particular those deaths flagged as unexpected.

5.2.5 To monitor nationally reported mortality outcomes such as SHMI and HSMR, and ensure that improvement plans are in place to implement national recommendations where mortality is reported to be an outlier;

5.2.6 To identify case specific mortality trigger groups for review by divisions in the next month through analysis of mortality data and alerts.

5.2.7 To identify causes of potential avoidable mortality and escalate to the Patient Safety Committee for development and implementation of action plans;

5.2.8 To maintain links with HM Coroner to ensure findings from Coronial investigations are made available to the MSG.

5.2.9 To ensure effective education and training provision is established and requirements and lessons learned are communicated across the Trust.

5.2.10 Process to ensure that LFD findings are reported and actioned appropriately, for example, that the substandard care is apportioned to the correct Healthcare organisation.

5.2.11

6. FREQUENCY

6.1 Meetings will be held bi-monthly.

7. REPORTING ARRANGEMENTS

7.1 The following reports will be provided to each meeting:

- Specialty specific reports, provided by Clinical Audit, produced in conjunction with the Mortality Lead – this report will be provided to Governance Meetings

- Mortality Lead Nurse will provide a Trustwide report to each meeting, including where another organisation needs to review the care they provided.

- Public board report in each Quarter

Appendix 2 – Learning From Deaths Process Flowchart

If, at time of death, an issue is identified by carers or clinicians the completion of the LFD proforma can be started immediately.

Casenotes obtained by clinical audit – within 2 weeks of patient death

Notes reviewed by clinical audit and Mortality Lead Nurse to check if should be issued for LFD review (see criteria below)

If no, reasons will be recorded in centralised system and included in onward reporting.

If yes, casenotes will be issued to a consultant for LFD review using the proforma in Appendix C. Within 4 weeks, the completed LFD proforma & casenotes, to be returned to clinical audit.

If case has already been identified as an SI, this will be recorded in the centralised system and await outcome of the investigation

If carer/ family concern identified - see section 5.7

CESDI Grade 0

CESDI Grade 1

CESDI Grade 2

CESDI Grade 3

Findings to be included in reports – case to be closed

Review by Mortality Lead Nurse to agree action

Case presentation within 4 weeks

Immediate referral to DD as potential SI. If declared an SI will be investigated by SI process and await outcome of the investigation

Improvements and outcomes from learning to be shared

Actions and learning to be monitored and implemented

Specific cases and outcomes of learning/actions to be presented at:
Surgery Audit Days,
Medicine Governance Forum
Obs and Gynae Audit Days

Overall reports on LFD will be provided to MSG and Governance Boards Quarterly

Quarterly reporting to Patient Safety Committee

Exception reporting to Quality and Safety Committee

Quarterly reporting to Trust Board

Report to Clinical Quality Group

Criteria for LFD review

Mental Health
Learning Disability
Infant or child death
Stillbirth or maternal death
Carer/family concerns identified
Sepsis
Hip fracture
Acute Pancreatitis
DVT
MRSA
TARN patient
Unexpected death
Coroner cases
Weekend admission
Re-admissions, including A&E
Patients awaiting placements
Death following an operation
Death following an endoscopy
Incidents, Claim, Complaint, DOC

Appendix 3

The Hillingdon Hospitals NHS
NHS Foundation Trust

Learning from Deaths Proforma

Patient Number		**Age:**		**Notes to be audited by:**			
Day patient admitted: **Date:**	☐ Mon ☐ Tues ☐ Wed	☐ Thur ☐ Fri	☐ Sat ☐ Sun	**Day patient died:** **Date:**	☐ Mon ☐ Tue ☐ Wed	☐ Thur ☐ Fri	☐ Sat ☐ Sun

Clinical Summary/ Learning to be Shared/Comments:

Contributory Factors/Categories (please select all required)			
Failure to rescue deteriorating patient	☐	Concerns raised by family/carers	☐
Communication issues	☐	Patient not in appropriate environment	☐
Avoidable infection	☐	Staffing issues	☐
Unanticipated complication in procedure	☐	Bed Availability issues	☐
Delay in diagnosis or diagnosis not suspected	☐	Delay in discharge to appropriate care facility	☐
Delay in procedure	☐	Problems following established protocol	☐
Delay in consultant/delegated review/actions	☐	Drug error	☐
Delayed transfer - within hospital	☐	Delay in transfer - between hospitals	☐

Was there evidence of collaborative care with patient, family/carers?		Yes ☐	No ☐
Was this person cared for using the Individual Care Plan for Excellent Care in the Last Days of Life?		Yes ☐	No ☐
Was there an opportunity to consider a DNACPR order? If so was this performed?	N/A ☐	Yes ☐	No ☐
Was the patient receiving palliative care team support?	N/A ☐	Yes ☐	No ☐
Was the death notification accurate?	N/A (coroner) ☐	Yes ☐	No ☐
Was the coding accurate? (if not, return notes to Coding with comments for review)		Yes ☐	No ☐

Please select appropriate category of care below:	
Grade 0: Unavoidable Death, No suboptimal care ☐	**Grade 2:** Suboptimal care, but different care MIGHT have affected the outcome, (possibly avoidable death). ☐
Grade 1: Suboptimal care, but different management would not have made a difference to the outcome ☐	**Grade 3:** Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome, (probable avoidable death). ☐

Consultant caring for patient:

Appendix 4

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Name of Policy or Service: Learning from Deaths, Mortality Review Policy	
Name of Author: Dr Cheryl Messer, Clinical Director Quality and Safety Anita Maudsley, Clinical Audit and Effectiveness Manager	
Who is the policy or service aimed at? (Staff, Patients/Carers, Visitors/Public)	Healthcare Practitioners
Description and aims of the policy/service	To enable healthcare practitioners to review deaths of patients, make improvements and share learning.
What outcomes are wanted from this policy/service?	Increased awareness of learning from deaths within the Trust and 30 days from discharge.
Are there any factors that might prevent outcomes being achieved?	Policy non-compliance

You must assess each of the 9 areas separately and consider:

1. Where you think that the policy/service could have a **NEGATIVE** impact on any of the equality groups, i.e. it could disadvantage them
2. Where you think that the policy/service could have a **POSITIVE** impact on any of the equality groups like promoting equality and equal opportunities or improving relations within equality groups
3. Where you think that this policy/service has a **NEUTRAL** effect on any of the equality groups listed below i.e. it has no effect currently on equality groups.

Equality Groups	Positive impact	Negative impact	Neutral effect	If negative, please state why and the evidence used in your assessment
Age?			X	
Sex (Male and Female)?			X	
Disability (Learning Difficulties / Physical or Sensory disability)?			X	
Race or Ethnicity?			X	
Religion, Faith or Belief?			X	
Sexual Orientation (gay, lesbian or heterosexual)?			X	

Pregnancy and Maternity?			X	
Gender Reassignment (the process of transitioning from one gender to another)?			X	
Marriage and Civil Partnership			X	
Mental Health			X	
Homelessness, Gypsy/Travellers, Refugees/Asylum seekers			X	

If you have identified a negative impact to any of the above, you must complete a full Equality Impact Assessment (See Appendix B)

Summary
I declare that I have paid **due regard** to equality (i.e. promote equality of opportunity between communities/staff, eliminate discrimination that is unlawful, promote positive attitudes towards communities/staff) for this policy / service. **I declare that in assessing the proposed policy / service I have identified that there is unlikely to be an adverse impact on different minority groups**

Name: Dr Cheryl Messer	Date: 23rd August 2017
Post: Clinical Director Quality and Safety	Contact Number: ext. 3238

Appendix 5

Checklist for the Review and Ratification of Trust Policy Documents

Policy Title: Learning from Deaths, Mortality Review Policy

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	committee/group will approve it?		
	If appropriate, have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Has the consultation record been completed?	Yes	
	Is there an implementation action plan identifying how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPI's to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	

Minor Amendments Ratification Chair Approval			
If as ratification committee/group chair you are happy to acknowledge and approve this document, please confirm this by email to the document author. Please enter your name and date of your approval in the box below. NB: A copy of the confirmation email must be sent to the Information Governance Team as evidence of approval before the document can be placed on to the intranet			
Name		Date	
Ratification Committee/Group Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the document author with responsibility for disseminating and implementing the document and the Governance Information Team who are responsible for maintaining the organisation's database of approved documents. A copy of the minutes demonstrating ratification has been agreed must also be sent as evidence of completing the process.			
Name	Trust Board	Date	27/09/2017

Acknowledgement: NHSLA Policy Template/Cambridgeshire and Peterborough Mental Health Partnership NHS Trust