Learning from Deaths Framework Policy

Profile	
Version:	*1.0*
Author:	*Dr Nigel Kennea, Associate Medical Director (Mortality)*
Executive/Divisional sponsor:	*Medical Director*
Applies to:	*All staff*
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Approval	
Approval person/Committee:	Patient Safety and Quality Board
Date:	*20th September 2017*

Contents

Policy Gateway

Please complete the checklist and tables below to provide assurance around the policy review process.

☒ I have involved everyone who should be consulted about this policy/guidance

☒ I have identified the target audience for this policy/guidance

☒ I have completed the correct template fully and properly

☒ I have identified the correct approval route for this policy/guidance

☒ I have saved a word version of this policy/guidance for future reviews and reference

Please set out what makes you an appropriate person to conduct this review:
AMD responsible for Mortality Monitoring

Please set out the legislation, guidance and best practice you consulted for this review:
National Guidance on Learning from Deaths (National Quality Board, March 2017); Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (CQC, December 2016)

Please identify the key people you involved in reviewing this policy why, and when:
Medical Director; Head of Governance – August 2017

Summarise the key changes you have made and why:
New policy required as per National Guidance on Learning from Deaths

Executive Summary

This policy sets out St George's University Hospitals NHS Foundation Trust processes for complying with the National Learning from Deaths Framework (March 2017) and outlines how the Trust responds to, and learns from deaths of patients who die under our management and care. It defines the categories of deaths in scope for case record review, the role of the Mortality Monitoring Committee in conducting and instructing case record review and in identifying and disseminating learning.

1. Introduction

The National Guidance on Learning from Deaths (March 2017) has driven a national endeavour to improve and further strengthen systems of mortality case review with emphasis on learning. At St George's Hospitals' NHS Foundation Trust, this has involved the strengthening of governance processes, skills and training in case review, with defined data collection and reporting to Board level. The framework also demands the need for a name non-executive board member with responsibility for this important work.

It has been acknowledged that risk-adjusted mortality statistics including HSMR and SHMI do not accurately reflect quality of care and that case note review is an important method to identify area where care may be improved, or learned from (Hogan et al, 2016). It is essential that problems of care are identified and actions taken to prevent reoccurrences, and that families are well supported in the process.

Within St George's Hospitals' NHS Foundation Trust, there is an expectation that all deaths should be reviewed by the responsible care group. Trust wide case note review, mortality monitoring and the management of mortality alerts are undertaken by the Mortality Monitoring Committee (MMC). The MMC coordinates case note review having identified deaths in near real time from the bereavement office and from the information team via tableau. Any mortality alerts identified through routine monitoring of published statistics and local benchmarking are also taken to the MMC where required actions are identified.

The role of the MMC is to establish if there are any factors that may have contributed to individual deaths or an increase in mortality within a specific area. The remit of the MMC is to identify areas where there may be an underlying problem that affects patient care, and to help pinpoint shortfalls in the management or care of particular patients via escalation of concerns to the risk team. In such cases a serious incident investigation is considered.

This policy describes the specific processes in the Trust to fully comply with the Learning from Deaths framework and is additional to, and complements local service mortality monitoring processes and other work undertaken by the MMC. It is anticipated that by adherence to the policy we will help achieve greater understanding of factors contributing to death, increased collaboration with the care groups, a greater degree of reflection on cases that have not proceeded according to plan, and better timely escalation of concerns to the risk and other teams. The policy will also support the identification of points of learning and also help support families with questions or concerns following death.

2. Status and Purpose

This document is part of the St George's Hospitals' NHS Foundation Trust policies and is applicable to all staff.

The purpose of this policy is to outline processes necessary to support the aims and ambitions of the Learning from Deaths framework (March 2017), and demonstrate how the Trust responds to, and learns from, deaths of patients under its management and care.

3. Definitions

Alert – data indicates that outcomes are significantly different to expected and therefore investigation is required to determine the cause of this difference.

Diagnosis group - each diagnosis group is made up of one or more ICD10 diagnosis codes. A patient's diagnosis group is assigned from the primary diagnosis, usually from the first episode.

Procedure group – each procedure group is made up of one or more OPCS procedure codes. A patient's procedure group is assigned from the dominant procedure in the patient's spell of care.

Hospital standardised mortality ratio (HSMR) – the ratio of the observed number of inpatient deaths to the expected number of inpatient deaths, for conditions accounting for approximately 80% of inpatient mortality.

Summary hospital-level mortality indicator (SHMI) - the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Structured Judgement Review (SJR) – a standardised approach to clinical-judgement based case record review.

Learning Disability Mortality Review Programme (LeDeR) - 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.

4. Scope

This procedural document applies to the activities of the Mortality Monitoring Committee in leading the review and scrutiny of deaths at a trust-wide level. It complements established mortality review and governance processes that occur at a local service level. Mortality governance is a key priority of the Trust Board. Processes should enable clinical teams, executive and non-executive directors to have the capability and capacity to understand issues affecting mortality enabling improvement work going forward.

5. Roles and Responsibilities

5.1 Board

The Board is responsible for identifying a board member (Medical Director) with responsibility for 'Learning from Deaths' and a named non-executive director to take oversight of progress. The Board is responsible for 'ensuring learning from reviews and investigations are acted on to sustainably change clinical and organisational practice and improve care', and this is reported in the annual quality accounts.

5.2 Patient Safety and Quality Board

The patient safety and quality committee (PSQB) oversees the outcomes of mortality reviews and monitors any necessary actions.

5.3 Risk Team

The risk team is responsible for discussing and documenting investigations directed as a result of concerns raised by case note review. Case note review processes are therefore aligned to other Trust risk management processes including Serious Incident declaration processes. There is a need to ensure all adverse incidents identified are recorded on DATIX and all moderate and severe harm incidents following Duty of Candour expectations.

5.4 Mortality Monitoring Committee

The Mortality Monitoring Committee (MMC) reports directly to PSQB, and is responsible for coordinating reviews of deaths, and mortality signals, and escalating concerns about potentially avoidable deaths directly to the risk team for urgent clinical review and possibly serious incident (SI) investigation.

The MMC support clinical teams in their local mortality governance processes to strengthen learning, and support directly the bereavement office in ensuring timely and accurate death certification, Coroner's referral and support of families where necessary. The clinical team, with bereavement services, are primarily responsible for supporting relatives at this time. All incidents identified as moderate severity or above are bound by Duty of Candour processes.

5.5 Named Non-Executive Director

This individual takes responsibility for oversight of mortality monitoring and progress related to actions and learning derived from casenote review.

5.6 Medical Director

This individual is the executive lead with a key role in ensuring learning from problems of healthcare identified through reviewing or investigating deaths. They are responsible for ensuring the organisation has robust processes with focus on learning by providing challenge and support. They are responsible for ensuring quality improvement is at the centre of these processes and that the Trust publishes a fair and accurate reflection of achievements and challenges.

5.7 Associate Medical Director (Mortality)

This individual chairs the MMC and is responsible for co-ordinating casenote review and collating learning in keeping with the Learning from Deaths framework and expectations. The AMD is responsible for identifying areas for learning and actions and escalates clinical concerns to the teams involved and to the risk processes of the trust. This individual will monitor and ensure notification of deaths to the national learning disability mortality review programme. The AMD will notify the service and risk team of concerns raised by families in order to promote better support and timely investigation/explanation.

5.8 Clinical Effectiveness Manager (Mortality)

This individual is responsible for monitoring raw mortality and casenote review data and provides operational support with mortality governance processes from case identification, to review, identification of learning, and dissemination of outcomes to individuals, teams and trust-wide.

6. Process

6.1 Categories of deaths in scope for case record review

In order to gain oversight of Trust care processes MMC carry out independent case note review of greater than 70 per cent of all deaths. This is in addition to, and feeds into, service lead mortality monitoring processes. All deaths are identified by Bereavement Services and confirmed by Information team data (daily Tableau report). The review is documented in a secure on-line abridged version of the Royal College of Physicians SJR.

The Trust undertakes full case record review of the following categories of deaths:

i. All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
ii. All in-patient and community deaths of those with learning disabilities and current mental health diagnoses;

iii. All deaths in a speciality, diagnosis or procedure group where an 'alert' has been identified, either internally or externally. Internal alerts may be generated through local analysis of risk-adjusted mortality data such as the SHMI or HSMR, or through other internal governance processes such as national clinical audits, or analysis of incidents/risk, complaints and inquest data. External alerts may be received from the CQC, national clinical audit projects, the Dr Foster Unit at Imperial or other stakeholders/regulators;

iv. All deaths in areas where people are not expected to die, for example in all patients following elective admission;

v. Deaths where learning may inform the Trust's existing or planned improvement work.

6.2 Methodology for case record review

The Trust has adopted the RCP SJR for case record review of the categories of deaths defined above. A number of fields have been added to the form in order to gather local intelligence and context to support the effective identification and sharing of learning.

For patients with a learning disability, in addition to completing an SJR locally, all eligible deaths of patients, over age 4 years of age, are reported to the national Learning Disability Mortality Review Programme (LeDeR). The LeDeR review process is managed by Clinical Commissioning Groups (CCGs) and appropriately trained staff from St George's will be required to lead or participate in mortality reviews as requested by the CCG. St George's has a named clinical lead for this process and are fully engaged with the local steering group.

The MMC receives service level mortality reviews and summaries of mortality meetings and use this data to develop greater understanding of quality and outcomes across the organisation. Issues identified by casenote review are fed directly to the service governance lead for inclusion in their mortality reviews and discussions.

Phase of Process	Mechanism	Commentary
Identification of Deaths	Bereavement Office Daily Report Information Team (tableau report)	These reports enable 'real time' identification of all inpatient deaths. Daily review of cases identified.
Death Certification and Referral to Coroner	Mortality Monitoring Committee daily support of bereavement services.	A trained consultant from MMC attends and performs case note review in the bereavement office each working day. They support Bereavement Services staff in ensuring timely and accurate Death Certificate completion, and advise clinicians where there is uncertainty. All Coroners' referrals are now emailed and placed in the clinical record. The case reviewers may inform clinical teams about the need to refer, or not, to the Coroner's services. The bereavement office database records all Coroners referrals.

Case note review	Daily case note review by trained consultants from Mortality Monitoring Group	Case note review occurs in the bereavement office within 48 working hours of death where notes are available. Full notes review is undertaken and outcomes recorded on an electronic 2 page review proforma for the majority of deaths rather than the full SJR. For selected cases, including those following elective admission, the review is documented on an electronic proforma developed to cover all SJR fields, as well as further local data. A preliminary judgement about avoidability is made on all cases reviewed; although such a judgement is known to be highly subjective it is used as a start of conversations to aid escalation and clinical improvements where necessary. This process identifies specific patients where records require further scrutiny by other processes e.g. vulnerable patients including those with learning disability (notification to National LeDeR process), current mental health diagnoses, children and young people (Child death overview panel and developing National Child Mortality Programme). There are currently planned national pilots of other groups (for example National Perinatal Mortality Programme) which the Trust will support if rolled out.

Support of families	Bereavement services and clinical teams	The bereavement team provide support to all bereaved families. With daily MMC support of the bereavement office, and case note review, the MMC may identify families at need of additional information and support. In such cases issues are referred back to the clinical team and Trust wide governance processes to provide families necessary support and information.

Data storage	Keypoint database	The case reviews are held on a secure database enabling easy further review of cases. It also enables calculation of numbers reviewed, numbers of patients with learning disability, and other specific patient groups. A further database collates case note review information from local M+M meetings, or other local review sources.

Mechanism of information sharing	Via reviewer and MMC Chair	All concerns about significant issues of care are documented and reported back to the service to review and consider in their M+M meetings. This is done on the day of review and email communication is stored. This rapid approach enables timely local investigation and support of families affected.

Escalation of concerns if significant care issues identified or death considered potentially avoidable.	Referral immediately to risk team for consideration, including serious incident declaration. Triangulation of DATIX adverse incident reports and learning. Triangulation with complaints process.	There is immediate escalation to the risk team of significant care issues identified, or potential avoidable factors. All deaths where first review suggests potential avoidable factors are referred to the risk team for a 72 hour review. All incidents that meet moderate or severe criteria are bound by Duty of Candour policy that involves appropriate openness and support of families affected.

Identification and escalation of deaths in vulnerable patients	Children, patients with learning disabilities, and those with mental health diagnoses are identified by this case note review process.	All deaths in patients with learning disability are referred to the National Learning Disability Mortality Review Programme. All child deaths are referred to CDOP panel by clinical teams. CDOP is represented on MMC. The direct and early case note review is essential for this as such patients may not be identified by clinical coding alone. Patients with mental health diagnoses are identified and care scrutinised. Cases where there are potential issues of care outside St George's will be discussed with the risk team, and concerns discussed with the relevant provider to promote cross-sector learning. The Learning from Deaths Framework acknowledges that in the future nationally processes need to be strengthened in this area once basic processes are more consistent across the UK.

Deaths following elective admission	Service-level information from deaths following elective admission is reviewed case by case at MMC	Cases are identified from hospital statistics on a weekly basis by the Clinical Effectiveness Manager. These are logged on the Trust's Mortality Database and given a unique reference number. The named managing consultant is contacted with a request to complete a SJR. If the form is not returned within 1 month of request, the case is escalated to the care group lead. Once completed this is cross-referenced with any SJR completed by the MMC. The case will then be presented at the next MMC meeting for discussion. Any queries arising from the discussion are addressed to the care group and any lessons learned are shared as appropriate.

Collation of findings and learning	Information and learning from reviews is returned to the clinical teams	The MMC will develop a quarterly trust-wide report summarising main learning points identified. This is addition to learning identified and published currently from risk management

	Information collated in MMC and learning identified	and governance teams.
	Learning from adverse or serious incident reports is collated and disseminated through current Trust and Divisional processes along with action plans.	

Reporting and quality improvement	The MMC reports into the Patient Safety and Quality Board (PSQB), the Quality Committee, and provides quarterly reports to the public board. The MMC is also invited to the Clinical Quality Review Meeting to report progress to commissioning colleagues regularly. The Trust is required to summarise learning and actions in the annual quality report.	These modes of reporting enable the outputs of this work to contribute to local, or trust-wide improvement activity, and be triangulated with other intelligence. The MMC will publish the mortality data as suggested in the draft template published in 'Learning from Deaths' including the provisional 'avoidable deaths data' for all deaths that have a case note review where a judgement is made. This will include cases who have a full SJR completed and also those where case note review is documented on the abridged proforma. This will be included in the Board report alongside summaries of issues identified and learning.

Monitoring of Actions	Actions are determined at local level, and trust-wide.	The monitoring of actions and outcomes occurs at several levels from care group to the Board. The Divisions are responsible for developing and monitoring plans and actions.

6.3 Data recording and storage

All deaths are recorded on a bespoke mortality database, maintained by the Clinical Effectiveness Manager. Each SJR is logged on the database with a unique reference number, with the full detail of any SJRs completed electronically stored in an additional Keypoint database.

All investigations are logged on the mortality database with a unique reference number. All reviews associated with the investigation are tagged to this reference number.

The MMC receives service level mortality reviews and summaries of mortality meetings and use these data to develop greater understanding of quality and outcomes across the organisation. Issues identified by casenote review are fed directly to the service governance lead for inclusion in their mortality reviews and discussions. Service level reviews which are shared with or available to MMC are logged on the mortality database with the unique identifier, and collated alongside independent review.

7. Dissemination and implementation

7.1 Dissemination:

This policy will be distributed to all divisions for dissemination. It will be made available on the SGH Policy Hub.

7.2. Implementation

The MMC will direct implementation of the policy and will monitor this monthly through MMC meetings.

8. Consequences of Breaching the Policy

Failing to follow this policy could lead to a failure in compliance with the Learning from Deaths framework (March 2017).

9. Monitoring compliance

The table below outlines the process for monitoring compliance with this document.

Monitoring compliance and effectiveness table					
Element/ Activity being monitored	**Lead/role**	**Methodology to be used for monitoring**	**Frequency of monitoring and Reporting arrangements**	**Acting on recommendations and Leads**	**Change in practice and lessons to be shared**
To complete independent review of 70% of deaths within 1 month of death, to enable timely scrutiny learning and reporting	Chair Mortality Monitoring Committee	PSQB, Quality Committee, and Board reports will include % deaths reviewed for each month Independent audit of this could be performed from the MMC database	Learning from Deaths Framework mandates Quarterly reports to the public Board.	Mortality Monitoring Group PSQB Quality Committee Trust Board	Changes in review methodology will be developed and shared in MMC reports
All deaths requiring full SJR are identified, and appropriate review documented within 1 month.	Chair Mortality Monitoring Committee	Audit of MMC database with denominator data derived from information team	Quarterly PSQB, Board Report	Mortality Monitoring Group PSQB Quality Committee Trust Board	Changes in review methodology or need for further support / resource escalated and developments documented in reports
Refer all LD deaths to the LeDeR programme	Chair Mortality Monitoring Committee Local LeDeR mortality lead with learning disability team	Quarterly MMC review and documentation of those patients identified with learning disability and those notified to the national programme.	Figures included in quarterly report	Mortality Monitoring Group PSQB Quality Committee Trust Board	
Services required to complete SJR for deaths following elective admission 15 working days of death	Chair Mortality Monitoring Committee to highlight issues to care group leads and divisional leads if necessary to ensure timely completion	% outside this timeline review at monthly MMC	Monthly	PSQB and escalation to Divisions	
Meet the necessary Framework Public Board reporting criteria with regard to learning from deaths, and data and learning published in annual quality accounts	Trust Board	Audit of Board reports Timetable for future Board reports	Annual		

10. Associated documentation

National Guidance on Learning from Deaths
National Quality Board (First Edition March 2017)

Duty of Candour (Being Open) Policy (January 2017)

Serious Incident Policy (March 2016)

11. References

National Guidance on Learning from Deaths
National Quality Board (First Edition March 2017)