CARING FOR YOU

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Neill Hepburn
Date:	7th November 2017
Healthcare standard	

Title:	Implementing Learning from deaths framework

Author/Responsible Director: Medical Director/ Bernie Gallen

Purpose of the Report:

To provide a summary and actions arising from the national guidance on learning from deaths: A framework for NHS Trusts on identifying, reporting, investigating and learning from deaths.

The Report is provided to the Board for:

Decision	√	Discussion	
Assurance	√	Information	

Summary/Key Points:

The focus of the new framework is on improving governance processes around patient deaths including new board leadership roles, a new system of 'case record reviews', quarterly reporting of specific information about deaths in care and a new Trust policy on how individual organisations will be implementing all this and on ensuring the families/carers of patients who have died in care are properly involved at every stage.

Recommendations: To support the implementation of the recommendations from the national guidance on learning from deaths: A framework for NHS Trusts on identifying, reporting, investigating and learning from deaths.	
Strategic Risk Register	**Performance KPIs year to date**
Resource Implications (eg Financial, HR)	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact	
Information exempt from Disclosure	
Requirement for further review?	

INTRODUCTION

In December 2016 the CQC published Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England. This report found that learning from deaths is not being given sufficient priority in some organisations leading to opportunities for learning being missed.

The National Quality Board has subsequently published their report National Guidance on Learning from Deaths, the purpose of which is to help initiate a standardised approach to learning from and reviewing of deaths. ULHT completed a gap analysis and produced an action plan addressing any areas identified as needing to be addressed.

The national guidance acknowledges that when mistakes happen providers must work with their family / cares to understand the cause and that reviews and investigations of deaths to establish if problems in care have contributed to the deaths and learning is shared.

The Learning from death guidance places particular responsibilities on executive and non-executive directors:

- Boards must ensure robust processes are in place for recognising, reporting, reviewing or investigating deaths were appropriate
- Both executive and non-executive directors have a key role in ensuring the Trust is learning from problems identified by reviewing and investigating deaths
- A specific non-executive should be identified to oversee the approach to learning from deaths. They have 3 overarching responsibilities:

- Understand the review process ensuring processes are in place for reviewing and learning from deaths are robust and can withstand external scrutiny
- Champion and support Quality Improvement that leads to meaningful and effective actions to improve patient safety
- Assure published information is an accurate reflection of the organisations approach, achievements and challenges.

The Learning from death guidance sets out key principles for how families and carers should be treated following a death in our care. These are:

- Provide a clear, honest and sensitive response to bereavement in a sympathetic environment
- Offer a high standard of bereavement care, including support, information and guidance
- Families and carers know they can raise concerns which will be considered
- Involve families and carers from the start and throughout any investigation
- Offer to involve families and carers in learning as appropriate

REPORTING

Learning Disability Deaths

There is unequivocal evidence that demands additional scrutiny be place on the deaths of people with learning disabilities. The Learning Disabilities Mortality Review (LeDeR) programme, commissioned by the Healthcare Quality Improvement Partnership (HQUIP) for NHS England has requested all patients who have a learning disability to be referred to LeDeR. They will then decide if a detailed review is required by a group of trained reviewers.

Mental Health Deaths

All patients with a diagnoses of mental health have to have a mortality review completed. This cohort of patients are incorporated within our 'must do' reviews.

Data collection and reporting to Trust Board

From April 2017, Trust are required to collect and publish through a Trust Board report the following on a quarterly basis:

- Total number of deaths –separated by Learning Disabilities and mental health
- Total number of reviews completed
- How many were judged more likely than not to have been due to problems in care

RISKS TO DELIVERY

Reforms to death certification, when implemented in England, will result in all deaths being either scrutinised by a medical examiner or investigated by the coroner in certain circumstances. Additionally, medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to coroner any death appearing to involve serious lapses in care.

The introduction of the medical examiner's role, expected to be in April 2019, should therefore further clarify which deaths should be reviewed. This also enables a review to be completed within 7 days which the guidance is mandating. ULHT currently permits the consultants 4 weeks to complete the review. The Quality & Safety Manager is currently completing a business case to employ medical examiners at ULHT.

SUMMARY

The focus of the new framework is on improving governance processes around patient deaths including new board leadership roles, a new system of 'case record reviews',

quarterly reporting of specific information about deaths in care and a new Trust policy on how individual organisations will be implementing all this and on ensuring the families/carers of patients who have died in care are properly involved at every stage. The Trust has progressed with the recommendations from the Learning, candour and accountability report, however, there are still some areas that require greater scrutiny and discussion on how the Trust is going to fulfil the recommendations for shared learning and involving families and carers.

CURRENT POSITION

The table below details how we are progressing with the requirements from the national guidance:

Key Points	ULHT Process	Action Required	Compliant
Patient Safety Director	Medical Director/Associate Medical Director	None	
Non-exec Director	Penny Owston		
Nominated staff have appropriate skills / specialist training	Prof Hutchinson provided training to a core group of consultants. ULHT have attended the Train the Trainer mortality review programme hosted by the Royal College of Physicians.	In house training for reviews amalgamate with Human Factors Training/ an example of a good review / Coding & Mortality Masterclass/ Junior Doctor Training annually/ Engagement with EAU's QG to attend governance meetings	
Proforma for case note reviews	Own electronic proforma- On review of the Standard Judgement review, it was deemed that to gather themes through narrative this would be difficult. It was decided that our own electronic proforma provided valuable learning from themes.	Agreement to continue with ULHT proforma as ULHT proforma allows greater analysis and interrogation of data to enable lessons learnt and themes. To update proforma with MHCA and in line with LeDeR recommendations	
Preventable deaths reporting & grading	Trust report highlights preventable deaths	To continue with ULHT grading as it is a nationally accepted grading criteria and is already reported to TB	
Initial review escalated for further in-depth review	Currently all deaths are referred for review.	Bereavement services have a checklist and they will liaise with QG for MUST DO reviews and QG will liaise with Risk and complaints relating to death to ensure all MUST DO reviews are being completed	
High quality reviews/mortality surveillance group	Quality Assurance from MoRAG/Grading/ Consultants do not review deaths if they are part of the patients pathway		

Complaints, IR1's, SI's included in reviews	These are reviewed by MoRAG and a Datix report is generated to ensure compliance. Risk are informed of impending SI from the review		
Care of Learning Disabilities	Not in proforma	Add to current ULHT proforma	
Engagement with LeDeR Programme	Not in proforma & reporting to LeDeR	Add to current ULHT proforma. QG staff will complete & submit the LeDeR proforma for all patient with Learning Disabilities.	
Care of Mental Health	Not in proforma	Add to current ULHT proforma	
Care of Stillbirth/maternal death	W&C review all deaths through the SI process	W&C process to be added to the Trust policy	
Care of infant or child	W&C review all deaths through the SI process		
Maternal, neonatal, mental health, learning disability deaths	Should be reported quarterly from April 2017	W&C will be incorporated within the Trust report	
Assessment against NICE care of the dying	Baseline assessment	100% compliant on Baseline assessment	
Mortality reporting deaths, reviews investigation to the board	Reported to Patient Safety Committee, Quality Governance, Board	BG to produce a briefing paper November 2017	
Reported in Annual Quality Account	Reported in Quality Account	Action for 2018 QA- include preventable deaths	
Reporting to GP-Patients death	Varied process at the moment	EDD deceased template live from 21st Sept 2017	
Working with commissioners to review and improve services	Lincolnshire mortality collaborative to review deaths within 30 days of discharge and 48 hours of admission		
Reporting of deaths	In house mortality tracker, trust Reports, specialty governance, upward reporting to Trust Board		
Updating policy	Policy currently in place	By September 17 the Trust policy must be aligned. Completed and on intranet and internet	

Shares relevant learning	MoRAG sends out presentation and learning via Bi-monthly briefings sharing MoRAG cases and Mortality learnings. Speciality Governance.	Briefings s to be published monthly to go to MAC, CEC, CMB, senior nurses forum, email, webpage and comms. More robust Specialty governance learnings To have other avenues of sharing of learning	
Bereavement services	Bereavement in place in Boston, Lincoln is due to open October 2017 Lincoln acting as a satellite for GDH.	Bereavement Services and QG have devised a checklist for the Bereavement services to complete to highlight all MUST DO reviews which includes family concerns. To still progress the involvement of patients families and carers.	

Green – completed

Amber – in progress