Northern Devon Healthcare
NHS Trust

Learning from Mortality Strategy 2016-19

This strategy is designed to ensure that the organisation is learning from mortality through the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care and reducing avoidable patient death and harm

Corporate Governance
Final V2.0

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
1.0	21.10.16	Initial draft for comment	Corporate Governance Lead
1.1	25.11.16	Updated to include reference to National Mortality Case Record Review Programme	Corporate Governance Lead
1.2	25.11.16	Reference to Francis incorporated	Corporate Governance Lead
1.3	05.01.17	Updated following meeting with GT, CB, AD and to incorporate recent CQC publication on Learning, candour and accountability, published December 2016	Corporate Governance Lead
1.4	13.01.17	Additional section on patient advocacy and support added to address CQC requirements. References to electronic vital signs monitoring removed	Corporate Governance Lead
1.5	27.01.17	Incorporating comments from consultation	Corporate Governance Lead
1.6	06.06.17	Reviewed to incorporate the recommendations of the NQB National Guidance on Learning from Deaths	Head of Compliance
1.7	01.08.17	Presented to Trust Board for approval at August meeting 2017	Head of Compliance
2.0	02.08.17	Final version approved at Trust Board and Published on Trust Website.	Head of Compliance

For more information on the status of this document, contact:	Head of Compliance
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Reference	Learning from Mortality Strategy

CONTENTS

1. Executive Summary

1.1. This strategy is designed to ensure that the organisation is learning from mortality through the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care and preventing avoidable patient death and harm.

2. Links to Trust strategic objectives

2.1. This strategy supports the delivery of the following Trust Strategic Objectives:

✓	Highest Quality		Flexible and multi-skilled workforce
	Sustainable Services	✓	Efficient & Effective
	Integrated Health & Social Care	✓	Provider of Choice

3. Introduction

3.1. Hospital mortality has been used to assess quality of care since Florence Nightingale's comparisons of hospitals in the Crimea and London in the 19th century. Wide variations in hospital mortality have been a consistent finding, some of which can be explained by variables such as the case mix and acuity of patients being treated. However, much remains unexplained and may be reflective of variation in quality of care.

3.2. Concern about patient safety and scrutiny of mortality rates has intensified recently with high-profile investigations into NHS hospital failures. Findings from the Francis report showed that 'higher than expected' mortality rates were at worse ignored or manipulated and at best the subject of poorly functioning non-systematic mortality review meetings in which failings in the quality of care were not confronted or corrected.[1] The default position appeared to be that the deaths had been inevitable and there were no problems with the care of the patients.

3.3. The launch of the National Mortality Case Record Review Programme (NMCRR) in 2016 recognises these concerns and the importance of learning from mortality. The Trust is actively participating in the national roll-out of the programme which aims to develop and implement a standardised way of reviewing the case records of adults who have died by improving understanding and learning about problems and processes in healthcare associated with mortality, and to share best practice.

[1] Healthcare Commission, Investigation into Mid Staffordshire NHS Foundation Trust, March 2009

3.4. There is an associated increased drive for Trust Boards to be assured that deaths are reviewed and opportunities to improve care for future patients are not missed. The Care Quality Commission's publication in December 2016 of a review into the way NHS Trusts review and investigate the deaths of patients, 'Learning, candour and accountability' builds on the need to maximise learning from deaths.

3.5. The subsequent publication of the National Quality Board National Guidance on Learning from Deaths has further extended the recommendations made to Trusts on how undertaking clinical reviews and Learning from Deaths should happen to enable maximum learning takes place.

3.6. Concentrating attention on the factors that cause deaths through learning from mortality will impact positively on all patients, reducing complications, length of stay and readmission rates through improving pathways of care, reducing variability of care delivery, and early recognition and escalation of the deteriorating patient. There will also be an associated positive impact on the experience of patients' families and carers through better support and opportunities for involvement in investigations and reviews.

3.7. This strategy will provide a framework for aligning systems, processes and quality improvement initiatives for the purpose of ensuring that the organisation is learning from mortality and engendering a culture of clinical excellence. It is a dynamic document which will be reviewed and developed over time.

Status of this document

3.8. This is a first draft version of the strategy for consultation.

The scope of the strategy

3.9. The strategy applies to all clinical and corporate services delivered by Northern Devon Healthcare NHS Trust, and to all staff delivering those services to patients, their families and carers.

3.10. This strategy covers all in-hospital deaths in all departments and specialties across the Trust in the first instance.

3.11. As the development of place-based and care at home healthcare matures under the Five-year Forward View delivered through the Sustainability and Transformation Plan, community deaths where the organisation was involved in providing care to the patient will also be included in the scope. However, currently there is no process or method in place nationally to support the sharing of information between NHS Trusts or with other services such as primary care who have been involved in a patient's care before their death.

The overall aim of the strategy

3.12. The overall aim of the strategy is to ensure that the organisation is learning from mortality through the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care, preventing avoidable patient death and harm, and engendering a culture of clinical excellence.

3.13. We will seek to compare our performance across specialties and divisions, but also across health economies regionally and nationally and provide assurance to the Trust Board that the organisation has a robust culture of clinical excellence and processes in place to deliver and act on learning from the review of patient deaths in our care.

3.14. Implement Mortality Governance as a key priority for the Trust Board enabling Executives and non-executive directors to have the capability and capacity to understand the issues affecting mortality in the Trust and provide necessary challenge.

3.15. We will aim to develop multi-agency investigations with other providers who have provided care to patients who die in our care or within a specified time of discharge from our care.

3.16. We will aim to engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death. Involving families and their carers in the investigation and ensuring they received timely, responsive contract and support in all aspects of the investigation process through one point of contact.

The timescale of the strategy

3.17. The strategy aims to deliver improvements in mortality and the quality of patient care over the next three years to April 2020 and will be implemented from 1 March 2017.

The development process

3.18. The development of this strategy has been led by the Head of Corporate Governance in consultation with *patients, their families and carers*, the Trust Board, Medical Director, Deputy Medical Directors, Director of Nursing, Head of Quality & Safety, divisional teams, *NHS Improvement, the NEW Devon Clinical Commissioning Group*, and the Trust Mortality Review Committee.

3.19. In addition, specialist guidance and advice has been sought from the Trust Compliance team, Performance Analysts, Clinical Audit & Effectiveness Staff, End-of-Life Care Team, Resuscitation Service and Clinical Coding Team.

3.20. The strategy has been developed following discussions at the Mortality Review Committee to capture the direction and focus of the mortality governance agenda in the organisation and articulate a vision for the on-going work to learn from mortality, improve patient care and experience, and deliver a culture of clinical excellence.

3.21. In addition new provisional guidance on mortality reviews from NHS Improvement has been published following the Mazars independent review of patient deaths at Southern Health NHS Foundation Trust. This strategy will help to ensure the Trust is responsive to those requirements.

3.22. Also the publication of the National Guidance on Learning from Deaths published by the National Quality Board has provided a standardised approach to investigating deaths to be adopted by all Trusts. This process will be monitored as part of the Care Quality Commission inspection regime. A centralised reporting procedure of all deaths in all of the specific categories will ensure consistent reporting and learning from all deaths is embedded.

3.23. *Patients, their families and carers have been involved in developing the strategy through presentations to the Involving People Steering Group to seek their views. Their feedback has been incorporated into the document.*

3.24. The strategy will continue to evolve in line with published national, regional and local guidance and best practice.

3.25. The Strategy will be underpinned by the Mortality Peer Review Policy and the Standard Operating Procedure for Mortality and Morbidity meetings.

4. Stakeholder analysis

4.1. In order that this strategy meets the collective needs and expectations of the various stakeholders, the following have been consulted, engaged and involved throughout its development:

- *Patients and carers via the Involving People Steering Group*
- *NHS Improvement (NHSI)*
- *Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG)*
- Trust Board
- Mortality Review Committee
- Divisional management teams
- End-of-Life Care Team
- Customer Relations Team

5. Strategy vision and values

5.1. Perhaps the most fundamental goal in improving quality of care is to prevent avoidable deaths and harm. The concept of 'avoidable death' is a difficult one. However, current legislation and statutory responsibility has created a mandate to develop a robust and reliable method of identifying potentially avoidable deaths and to identify learning from them.

5.2. This has been reinforced through the Care Quality Commission's publication 'Learning, candour and accountability', a review into the way in which NHS trusts review and investigate the deaths of patients, which was published in December 2016. Further clarified by the National guidance on Learning from Deaths, prioritising the valuable opportunities for improvements in undertaking the clinical review of each death, involving the families and carers and identifying the learning that can be taken from each death.

5.3. Ensuring a clear mortality governance framework is in place supported by strong leadership and commitment from the Chief Executive and Trust Board will enable the alignment of clinical professionals and systems to improve understanding about the processes of care that may have contributed to a patient's death and thereby reduce 'avoidable' deaths.

5.4. The strategy supports the Trust vision to deliver high quality, safe care to our patients in a culture of clinical excellence which will result in a sustainable reduction in mortality, and excellent end of life care for those patients whose death is expected.

5.5. The core values which are central to this strategy and on which it is based are listed below. These will inform all the actions planned to deliver the objectives of the strategy as a result.

- Striving for excellence
- Demonstrating compassion
- Listening and supporting others

6. The current position

6.1. The Mortality Review Committee was established in August 2015 to work towards the prevention of all avoidable in-hospital deaths and provide assurance to the Trust Board that appropriate mortality governance processes are in place to ensure that the organisation is providing safe care and learning from problems that contribute to avoidable death and harm.

This strategy was drafted in early 2016, following discussions at the Mortality Review Committee, to build on the objectives of the Committee and to give clarity and direction to the Trust's aims.

Following the publication by the Care Quality Commission of their review into the way in which NHS Trusts review and investigate deaths (December 2016), the draft has been updated to reflect the new recommendations.

6.2. The Trust recognises that patient deaths fall into three categories:

- **Expected / unavoidable** (end-of-life care)
  These are cases where clinicians are focussed on getting end-of-life care right and providing patients, their families and carers with a good experience.
  (Patient / family experience – Head of Quality & Safety / End-of-Life Care Lead)
- **Unexpected / unavoidable**
  In these cases, it is important to establish whether the Trust is offering the most effective therapy in a timely way.
  (Clinical effectiveness – Deputy Medical Director (Effectiveness) / Clinical Audit & Effectiveness Team)
- **Unexpected / avoidable**
  These are cases where it is important that the Trust maximises the learning from deaths that may be the result of problems in care.
  (Patient Safety – Deputy Medical Director (Quality & Safety) / Head of Quality & Safety)

Mortality peer reviews

6.3. To provide assurance to the Trust Board a pilot was introduced early in 2016-17 to undertake structured mortality peer reviews looking at the care of patients who die in hospital. Findings were presented to the Trust Mortality Review Committee. The methodology uses the NCEPOD grading system to grade the overall care each patient received and assess the quality of care provided, and Hogan mortality scores to determine whether the death was preventable. A Policy has since been developed formalising the mortality peer review process. The document has been widely consulted on and will be approved through the Mortality Review Committee.

6.4. The Trust will use the tools the National Guidance for Learning from Deaths has identified in the deaths in specific categories as they are developed, such as reporting deaths of patients who have learning difficulties using the Learning Disabilities Mortality Review (LeDeR) programme and the Structured Judgement Reviews for patients with Mental Health.

Quality improvement

6.5. The Trust is part of the Sign up to Safety Campaign, one of a set of national initiatives to help the NHS improve the safety of patient care. The aim is to reduce avoidable harm by 50% and support the ambition to save 6,000 lives. This is demonstrated in the Trust's Quality Improvement Strategy, 2015-18 which links to the objectives of this strategy, and includes a three year safety improvement plan to support the national programme and local work streams and initiatives, including:

- Reduction in the rate of falls and harmful falls

- Reduction in the percentage of pressure damage acquired in our care per 1000 bed days, including zero preventable grade 3 and 4 damage
- Reduction in preventable cardiac arrests, avoidable acute kidney injuries, and avoidable sepsis
- Implementation of an electronic vital signs monitoring and handover system
- Reduction in patient harm incidents

6.6. The organisation's Quality Account for 2016-17 also describes areas for focussed improvement, including:

- Better care for people with dementia
- Keeping patients hydrated and promoting good nutritional health
- Mortality rate review

6.7. As part of the NHS Standard Contract, the organisation has a number of quality improvement aims under the Commissioning for Quality and Improvement (CQUIN) initiative. For 2016-17 these include:

- Acute kidney injury (AKI)
- Community diabetic foot care
- Dementia and delirium
- Falls
- Sepsis
- Paediatric 'Big 6' pathways (bronchiolitis/croup; fever; gastroenteritis; head injury; asthma; and abdominal pain)
- Patient flow through the Emergency Department
- Reducing the proportion of avoidable admissions

End of life care

6.8. Much work has been done over the past 12 months to improve end of life care for patients, including the development of a toolkit to help teams plan and deliver care for people in their last months, weeks and days of life. The results of regular Treatment Escalation Plan (TEP) audits are shared through the Mortality Review Committee.

7. Strategy Objectives

7.1. The key objective of this strategy is to ensure that the organisation is learning from mortality which will impact positively on the quality of care and treatment delivered to patients (including reducing variability, complications, readmission rates and lengths of stay), the experience of patients and their families when accessing services (including at the end of life), and hospital standardised mortality ratios.

7.2. The key performance results will include the following indicators:

- Reduction in 'unexpected/avoidable' deaths

- Better early recognition, escalation and management of the deteriorating patient demonstrated by a reduction in the number of in-hospital cardiac arrests that take place (with the exception of the Emergency Department), monitored through monthly audits and the learning from mortality peer reviews
- Demonstrable improvement in the prevention, recognition and management of acute kidney injury (AKI) measured through audits against the adult AKI care pathway and the results of mortality peer reviews
- Demonstrable improvement in sepsis recognition, diagnosis and early management leading to improved chances of survival and reduced complications, measured through audits against the sepsis pathway and the results of mortality peer reviews
- Improved end of life care that meets the needs and wishes of patients and their families and the 5 priorities for care identified by the Leadership Alliance for the care of dying people (LACDP)
- All in-hospital deaths that are reviewed use the mortality peer review proforma
- Accurate mortality information is linked to and informs consultant appraisals and engenders a culture of clinical excellence
- Mortality clinical coding audits routinely demonstrate >95% accuracy
- Reduction in the number of formal complaints received relating to patient deaths in our care
- Improved feedback from friends and family test (FFT) surveys of bereaved relatives and families
- Reduction in hospital standardised mortality ratio figures (HSMR), based on the standardised hospital mortality index (SHMI) which includes deaths within 30 days of discharge

7.3. There is clear evidence that achieving these strategic objectives will contribute to the overall objectives of the Trust as expressed in its mission, vision and values.

- People will be supported to live as healthily and independently as possible through timely recognition, diagnosis and management of their clinical condition
- The experience of patients and their relatives will be improved and the number of complaints associated with patient deaths reduced
- A significant and sustainable reduction in mortality will compare favourably with other Trusts both locally and nationally

8. Priorities for strategic change

8.1. The main areas where change is needed to enable us to achieve our key objectives outlined in this strategy are:

- The continued roll-out of the mortality review process to ensure that all in-hospital patient deaths in the relevant categories are peer reviewed

- Systems to ensure that there is appropriate support and advocacy in place for patients' families and carers to facilitate engagement in investigations and reviews and enhance learning, promote understanding and improve experience
- The sharing of mortality data and summaries of patient deaths across multi-disciplinary operational teams to improve monitoring and identification of non-random variation for further investigation and a better understanding of the processes of care that can be improved to reduce unnecessary deaths
- Strengthening of the governance framework to ensure that learning from deaths is better integrated into current systems to ensure it is shared and acted upon
- The development of system-wide processes with GPs, community teams and local residential care/nursing homes to enable patients to choose their place of death rather than automatically being admitted to hospital
- Enhance the skills and training of the medical staff to support this agenda as well as providing protected hour to review and investigate deaths to a high standard
- Develop a policy which details how the Trust responds to, and learns from death of patients who dies under its management and care. Specifically patients who have learning difficulties, mental health needs, an infant orchild and a stillbirth or maternal death.

8.2. The agenda for these changes is set out below and shown in more detail in the action plan at Appendix A.

Roll-out of mortality review process

- Implementation in 2017-18
- Lead = Andrew Davis, Deputy Medical Director (Quality & Safety)
- Impact on key performance outcomes:
  - All in-hospital deaths are reviewed using the mortality peer review proforma
  - Reduction in 'unexpected/avoidable' deaths
  - Reduction in the number of in-hospital cardiac arrests
  - Improvement in the prevention, recognition and management of acute kidney injury (AKI)
  - Improved sepsis recognition, diagnosis and early management
  - End of life care that meets the needs and wishes of patients and their families
  - Reduction in the number of formal complaints received relating to patient deaths
  - Reduction in hospital standardised mortality ratio figures (HSMR)

Engaging and supporting families and carers

- Implementation in 2017-18
- Lead = Sue Pilkington, Head of Quality & Safety
- Impact on key performance outcomes:

- Improved learning with associated reduction in 'avoidable' deaths
- Improved advocacy, support and experience for patients' families and carers following bereavement
- Reduction in the number of formal complaints received relating to patient deaths
- Improved feedback from friends and family test (FFT) surveys of bereaved relatives and families

Sharing of mortality data across multi-disciplinary teams

- Implementation in 2017-18
- Lead = Andrew Davis, Deputy Medical Director (Quality & Safety)
- Impact on key performance outcomes:
  - Reduction in 'unexpected/avoidable' deaths
  - All in-hospital deaths are reviewed using the mortality peer review proforma
  - Formalised and structured processes in place for mortality and morbidity meetings promoting shared learning
  - Mortality clinical coding audits routinely demonstrating >95% accuracy
  - Reduction in hospital standardised mortality ratio figures (HSMR)

Strengthening the governance framework

- Implementation in 2017-18
- Lead = Julie Poyner, Head of Compliance
- Impact on key performance outcomes:
  - Reduction in 'unexpected/avoidable' deaths
  - All in-hospital deaths are reviewed using the mortality peer review proforma
  - Formalised and structured processes in place for mortality and morbidity meetings promoting shared learning
  - Mortality clinical coding audits routinely demonstrating >95% accuracy
  - Reduction in hospital standardised mortality ratio figures (HSMR)
  - Compliance with the recommendations of the National Guidance for Learning from Deaths

Patient choice for place of death

- Implementation in 2017-18
- Lead = Diane Hollidge, End-of-Life Care Lead
- Impact on key performance outcomes:
  - Improved end-of-life experience for patients, their families and carers
  - Reduction in the number of formal complaints received relating to patient deaths
  - Improved feedback from friends and family test (FFT) surveys of bereaved relatives and families

9. Financial issues

Strategy financial implications

9.1. The key area in which there may be financial implications is the provision of advocacy and support for bereaved families/carers.

10. Risk issues

Management of risks associated with this strategy

10.1. Any risks associated with implementation of this strategy will be assessed and managed in accordance with the Trust's established risk management systems and processes.

Key risks associated with this strategy

10.2. The following key risks have been identified which may impact on the organisation's ability to deliver the objectives of this strategy:

- Capacity issues amongst medical and senior nursing staff to complete mortality peer reviews on all in-hospital patient deaths
- Resource and capacity issues in support services (e.g. Clinical Audit & Effectiveness, Clinical Coding, Performance, Governance) to support delivery of mortality peer reviews for every in-hospital death
- Lack of administrative support for specialty and divisional mortality and morbidity meetings
- Lack of process or method in place nationally to support the sharing of information between NHS Trusts or with other services (such as primary care) who have been involved in a patient's care before their death to ensure that the deaths of patients following discharge from Trust services are also reviewed.

11. Governance issues

11.1. No governance issues have been identified in terms of corporate governance, internal controls, risk management or financial controls and reporting.

Audit

11.2. Mortality peer review processes, acute kidney injury pathways, sepsis six bundle, TEP forms, etc., are routinely audited as part of the Trust's annual programme of clinical audit and effectiveness projects. Exceptions are reported through the Quality Assurance Committee.

12. Evaluation, learning and review

12.1. Progress against the action plan to implement this strategy will be monitored and the strategic objectives reviewed through regular updates to the Mortality Review Committee. This will include:

- On-going evaluation and review of the strategy throughout its life
- Performance monitoring over the lifetime of the strategy to ensure that the objectives are being met and actions completed in a timely fashion
- Where required, additional action plans will be developed to maintain progress against the key performance results and/or take corrective action where performance is below expected levels
- Learning and innovation identified as a result of implementation of the strategy will be recorded, acted upon and shared widely to promote improvement
- Expansion of the strategy to reflect the development of the guidance for all Trusts to learn from deaths
- Be aware and have knowledge of the developments of the Cross-system reviews and investigations being developed as a direct outcome of the National Guidance for Learning from deaths.

13. Communication plan

13.1. It is important that this strategy is communicated to all stakeholders to ensure shared objectives and understanding, timely implementation and feedback on progress.

- The content of the strategy and on-going progress will therefore be communicated to all stakeholder groups on a regular basis taking into account differing needs, expectations and levels of involvement.
- The frequency and type of communication and feedback will be agreed with the stakeholder groups:
  - *Patients and carers via the Involving People Steering Group*
  - *NHS Improvement (NHSI)*
  - *Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG)*
  - Trust Board
  - Mortality Review Committee
  - Divisional management teams
  - End-of-Life Care Team

14. Glossary

- HSMR – Hospital standardised mortality ratio: an indicator of healthcare quality that measures the mortality rate in a Trust and assess the risk of death based on a number of factors; diagnosis group, admission method, palliative care, comorbidities, deprivation, age group, gender, number of emergency admissions in the previous 12 months, etc. It is based on a group of 56 diagnosis groups which represent 80% of total inpatient deaths in England.
- SHMI – Standardised hospital-level mortality index: an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is 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. It covers in-hospital deaths and deaths that occur up to 30 days post-discharge for all diagnoses (excluding still births).

15. References

- NHS England (2015), Mortality Governance Guide
- Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England
- NHS Improvement (July 2016), The adult patient who is deteriorating: sharing learning from literature, incident reports and root cause analysis investigations
- Professor Sir Bruce Keogh (July 2013), Review into the quality of care and treatment provided by 14 hospital trusts in England
- NHS England (March 2015), Serious Incidents Framework
- Hogan, H et al (2012), Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study
- NCEPOD (2009), Acute kidney injury: Adding insult to injury
- NICE guidelines, CG169 (2013), Acute kidney injury: prevention, detection and management
- NICE guidelines, NG51 (2016), Sepsis: recognition, diagnosis and early management
- NHS England (2015), Improving outcomes for patients with sepsis: a cross-system action plan
- NICE guidelines, NG31 (2015), Care of dying adults in the last days of life
- National Guidance on Learning from Deaths. National Quality Board.

16. Associated documents

- Trust Patient Safety Improvement Plan, August 2015 – July 2018
- Trust Quality Account, 2016-17
- Standard Operating Procedure for Mortality Peer Review Process
- Standard Operating Procedure for Mortality & Morbidity Meetings
- Duty of Candour Policy

- Investigation, Analysis and Improvement Policy
- Patient Experience Strategy

APPENDIX A - YEAR 1 ACTION PLAN – TO BE DEVELOPED

- Detailed plans for actions to be implemented in year 1 to achieve the planned changes in key performance results/ operational indicators
- This should show, for each action point:
  - The resource implications (staffing, information, physical resources, technology, finance)
  - Who is responsible for delivering each action point
  - When it will be completed
  - Which key performance result(s) it is targeted at

APPENDIX B - YEAR 2/3 ACTION PLANS

- Future years' action plans will be developed as a result of
  - analysing key performance results and operational indicators, and setting appropriate targets for these in the year to come
  - assessing changes in the external environment affecting XYZ (e.g. new national targets, or changes in other health and social care organisations)
  - analysing innovation and learning relevant to XYZ
  - reviewing how this strategy fits with the Trust's overall direction