NHS Improvement

Learning from deaths: case studies from trusts

December 2017

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We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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Foreword

A year since the Care Quality Commission published *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* and nine months since the National Quality Board issued *National guidance on Learning from Deaths* in March 2017, there has been a significant shift in expectation about how trusts should respond to, review and learn from the deaths of people in their care.

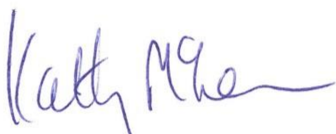
NHS Improvement has been supporting trust boards to embed the guidance in the work of their organisations. We have been clear that the change required of trust boards is one of culture and leadership, rather than one of process and counting. Crucially, it requires a commitment to the spirit and not just the letter of the guidance.

The requirement on organisations is clear. It is not simply to have a robust process for reviewing deaths in care, important though this is. Trusts need also to engage with and support bereaved families, to provide mechanisms for staff support and debriefing and to ensure active and robust board oversight. Perhaps most importantly learning needs to be translated into sustainable action to improve the way we look after the people in our care.

This collection of case studies demonstrates the range of actions that trusts are taking, as well as the challenges they face and how they are seeking to overcome these. We hope they provide inspiration and useful tips for other organisations.

We recognise there is more to do to ensure that the NHS truly draws on all possible learning from the deaths of those in its care. But these case studies serve to illustrate some of the important progress made since the national guidance was issued in March 2017.

I am grateful to all the trusts that have shared their work for this publication.



Kathy McLean

Executive Medical Director, NHS Improvement

1. Critical care memorial service

University College London Hospitals NHS Foundation Trust

University College London Hospitals NHS Foundation Trust (UCLH) is a large trust made up of five teaching hospitals. It has over 8,100 staff looking after more than a million patients every year.

UCLH has developed a comprehensive Learning from Deaths policy which it is in the process of implementing.

Supporting bereaved next of kin in critical care

To improve the support UCLH gives to bereaved relatives, in September 2017 the critical care team held its first memorial service for those who have died in its care. All relatives bereaved in the last year were invited.

At the service, the names of all those who had died on the unit over the last year were read out, the critical care nursing team sang a song, eulogies were given by family members or staff on their behalf, and families were asked to light a flame of remembrance and join in a minute's silence. Family members were also given a gift of remembrance – bulbs to plant at home.

Families shared stories of their loved ones, talked to other relatives about their loss and if they wished could seek emotional support from the multidisciplinary team members present at the service, one of whom was a clinical psychologist.

Families have since told the critical care team how much the service has helped them come to terms with their loss and to realise that they are not alone. Many said it had enabled a release of grief and that this had given them some closure to their loss.

Staff who took part in the service said it had helped them process their feelings about the deaths of patients in their care.

We plan to hold another memorial service next year.

Learning points

- The importance of including families in the development of bereavement support.
- Memorial services can be beneficial for families, carers and hospital staff.

Further information

Please contact:

Meenaxi Patel, General Manager: meenaxi.patel@nhs.net

John Welch, Nurse Consultant: john.welch@nhs.net

Trust policy:
http://www.uclh.nhs.uk/OurServices/Documents/Mortality%20Surveillance%20and%20Learning%20from%20Deaths%20Policy.pdf

2. Bereavement support through the intensive care unit

Royal Berkshire NHS Foundation Trust

Royal Berkshire NHS Foundation trust is one of the largest general hospital foundation trusts. It provides acute medical and surgical services to Reading, Wokingham and West Berkshire, as well as specialist services such as cancer, dialysis and eye surgery to a wider population across Berkshire and beyond.

The trust's bereavement services, both hospital-wide from the bereavement office and locally in the intensive care unit (ICU), have provided support to families and carers for many years.

Bereavement office

A dedicated bereavement team continually tries to improve care for families and carers, and has developed its services over the last five years. It increasingly provides support and advice to families and carers on complex financial issues.

The team asks the next of kin if they have any concerns about the care their loved one received. If they do, we tell the quality governance team, which may consider a full mortality review. A survey is given to the next of kin with the death certificate, to help monitor and improve services further.

Intensive care unit

The bereavement team on the ICU has provided support to relatives and carers since 2000. We started by compiling an information booklet specifically for ICU relatives. This incorporates practical information about death certification and registration, funerals, the role of the coroner and post-mortem examinations, as well as information about local bereavement support services.

Working with the hospital chaplains, the ICU team holds memorial services twice a year for relatives and friends of patients who died in its care; some 70 to 100 relatives and friends attend.

At six to eight weeks following a death, the bereavement team writes to the next of kin offering them a follow-up appointment. This can be a medically focused meeting with a consultant to go over what happened, or it can explore how they are feeling and what can be done to help. We do not offer counselling but can assess whether someone needs to be referred for this.

We review all deaths on the ICU, compiling a monthly list of morbidity and mortality that is presented at the clinical governance committee. If there are concerns that a death may be in some way due to care given, the case is presented to the mortality surveillance group.

Mortality surveillance group

Learning points and themes from the mortality surveillance group are reported to the clinical outcomes and effectiveness committee. These are recorded each month on a slide given to the specialty clinical governance meetings and published on the trust's intranet. To share learning across organisations, our medical director meets quarterly with the medical directors from local trusts to share themes and discuss issues.

Learning points

- It is important that the next of kin is asked what bereavement support they need.
- Learning should be spread as widely as possible.

Further information

Please contact:

Sheila Hill, Bereavement Care Sister, Intensive Care Unit: Sheila.Hill@royalberkshire.nhs.uk

Natalie Shaw, Bereavement Officer: rbft.bereavementoffice@nhs.net

Trust policy: http://www.royalberkshire.nhs.uk/learning-from-deaths.htm

3. Changing the Learning from Deaths process with rapid process improvement

Gateshead Health NHS Foundation Trust

Gateshead Health NHS Foundation Trust, known locally as QE Gateshead, provides a range of health services at Queen Elizabeth Hospital, Dunston Hill Day Hospital, QE Metro Riverside, Bensham Hospital, Blaydon Primary Care Centre, Washington Primary Care Centre, as well as a specialist unit in Houghton-le-Spring.

Approach

The mortality and morbidity council at QE Gateshead agreed that running a rapid process improvement workshop was the appropriate way to improve and change practice quickly throughout the organisation. A week was set aside for key internal stakeholders to meet members of the morbidity and mortality council. These stakeholders included surgeons, physicians, nurses and staff from coding, information technology, the bereavement office, secretarial and administration.

The current process for each of the business units was assessed. Processes were reviewed and refined where necessary to ensure that all deaths in the trust can be recorded in one place, using a database linked to the MEDWAY system. All processes associated with the Learning from Deaths policy were standardised and a standard operating procedure (SOP) was created; for example, a green box system on all wards for notes to be reviewed.

The trust recognises the importance of gaining the views of relatives and carers when learning from deaths. We now send a letter and feedback form to all bereaved relatives/carers six weeks after the death of the patient. Lessons learned will be shared via service lines, through the business unit safe care meetings as well as monthly at the mortality and morbidity steering group.

What has been achieved?

Since introducing the SOP for the first- and second-level reviews the approach to reviewing deaths has been consistent across the trust, with 76% of all deaths currently reviewed. By involving relatives in the Learning from Deaths process we have added a new qualitative dimension to our reviews. Much of the feedback from families is praise for care our staff have given. Where things have not gone well we are learning invaluable lessons and these are being used to shape future projects. Lessons so far concern how we communicate, including improving the DNACPR (do not attempt cardiopulmonary resuscitation) discussion, emergency care plans, breaking bad news or information about general care planning.

Learning points

- Lessons learned need to be used to target staff training, such as communication training for the ward teams in discussing DNACPR with carers and relatives.
- It is essential that the concerns raised by families and carers are shared with ward teams as well as the wider organisation.

Further information

Please contact: **Joanne Coleman**, Strategic Safeguarding Lead:
joanne.coleman5@nhs.net

Trust policy:
http://www.qegateshead.nhs.uk/sites/default/files/users/user10/OP93%20Reviewing%20and%20Learning%20from%20Deaths%20v1.pdf

4. Role of the family liaison officer

Southern Health NHS Foundation Trust

Southern Health NHS Foundation Trust provides community health, specialist mental health and learning disability services to people across the south of England. The trust employs around 5,500 staff over 200 sites, including community hospitals, health centres, inpatient units and social care services.

Southern Health has been undertaking work for several years as part of NHS England's commissioned review by Mazars – 'Independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust between April 2011 to March 2015', and our own commissioned external review, 'Experience of families in the investigation process'.

Family liaison officer role

In December 2016 Southern Health recruited an experienced family liaison officer (FLO) to support the families and carers of those who die while in our care. The successful applicant has previously worked as a coroner's officer and is Cruise trained in bereavement counselling.

The FLO supports all bereaved families and carers whether or not a Serious Incident investigation is ongoing. The FLO also supports those involved in non-death serious harm incident investigations and complex complaints.

All reported deaths, Serious Incidents and complex complaints are case reviewed using a 48-hour panel process and the initial referral for FLO involvement can be made at this point by any staff member. Some cases are referred later in the investigation process depending on the needs of individuals.

The FLO has received over 130 referrals and given support tailored to what an individual needs. This can include home visits, telephone calls, text messages, and support at meetings with investigating officers, clinicians and at inquests. The

length of time over which support is given also depends on the individual; the longest active case has lasted nine months.

What were the challenges?

The FLO was a new post for the trust and the need for it had to be proven. An independent consultant who reviewed families' experience of the investigation process advised against the role, stating that the responsibility was that of the investigating officer.

Members of the public have also raised concerns that the FLO is part of the quality governance team and is line managed by the head of patient safety, incident management and legal.

We strongly felt that an individual who was independent of any investigation but who understood the trust's processes was needed to guide and support families and carers through them.

What are the results?

Surveys of families and carers show the role has been positively received and highlight areas where the trust can improve its investigations.

The family liaison role is still evolving and our ongoing review will recommend next steps.

Learning points

- It is not just bereaved families and carers who need support but those participating in any Serious Incident or complainant investigation.
- There is very limited support externally for bereaved people and this can be difficult to access. The FLO has worked with the third sector to develop contacts for ongoing support to the people who require it.
- Families and carers value the support and information, independent from the investigation process, that the FLO provides. Feedback has been overwhelmingly positive.

Further information

Please contact:

Helen Ludford, Associate Director of Quality Governance:
helen.ludford@southernhealth.nhs.uk

Dr Sarah Constantine, Interim Medical Director:
sarah.constantine@southernhealth.nhs.uk

Elaine Ridley, Family Liaison Officer, would be happy to share any information regarding her role: elaine.ridley@southernhealth.nhs.uk

Trust policy:
http://www.southernhealth.nhs.uk/about/policies/?entryid41=100008&q=0%7edeath%7e

5. Debriefing sessions for staff

Lewisham and Greenwich NHS Trust

Lewisham and Greenwich NHS Trust was formed on 1 October 2013 through the merger of Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital. The trust provides healthcare for Lewisham, Greenwich, Bexley and other parts of south east London.

Regular staff debriefings in the intensive care unit

The intensive care unit (ICU) at Lewisham Hospital holds weekly Learning from Deaths debriefing sessions for its junior doctors. These sessions are facilitated by consultants, and members of the wider multidisciplinary team can also attend.

The debriefing sessions work as follows:

- no PowerPoint, no flipcharts and no minutes taken
- ground rules are stated at the start of each session to ensure it provides a confidential, non-threatening environment for learning
- the person who added the patient to the debrief list briefly summarises the case for the group and explains their reasons for raising the case – for example, difficult decision had to be made, near miss or complication, emotionally distressing case
- group members have an opportunity to share how they feel about the case and events surrounding it
- the group decides what points can be learned from the case.

After the session, brief learning points are noted on the shared drive. This informs colleagues not present at the debriefing and is useful for tracking progress.

One junior doctor said: “The debrief holds a tremendous amount of value following a stressful situation and acknowledges the impact of human factors on clinical practice”.

Learning points

- Consultants play an important role in ensuring staff debriefings become standard practice and in creating a safe environment for reflection and learning.
- The debrief is a critical part of the learning process, designed to highlight lessons learned, and provide an opportunity to reflect on performance and develop strategies to improve practice.
- The debrief also has an important role in supporting staff working on the unit.

Further information

Please contact: **Dr Ashraf Molokhia**, Consultant ICM and Anaesthetics: ashraf.molokhia1@nhs.net

Trust policy:
https://www.lewishamandgreenwich.nhs.uk%2Fdownload.cfm%3Fdoc%3Ddocm93jijm4n2133.pdf%26ver%3D2571&usg=AOvVaw1dTIaLnBeZszDX8hyZYz6

6. Embedding electronic death certification

King's College Hospital NHS Foundation Trust

King's College Hospital NHS Foundation Trust is a large trust comprising King's College Hospital (KCH) and several smaller sites including Princess Royal University Hospital, Orpington Hospital and Queen Mary's, Sidcup.

Process for systematic mortality review

Routine mortality monitoring underpins KCH's approach to patient outcomes surveillance and clinical quality improvement. We are developing and promoting a culture of systematic mortality monitoring across the organisation by requiring divisions to adopt a structured mortality review process for each of our care groups.

Electronic death certification

All deaths at KCH (Denmark Hill site) are recorded through electronic death certification (eDC) on the electronic patient record at the time the written death certificate is completed in the bereavement office. This platform for electronic death certification was developed in-house and all junior doctors are trained in how to complete the eDC shortly after induction.

This process has enabled the complete identification and record of all deaths in the hospital. Use of eDC has also enabled KCH to quantify consultant input into death certificate wording, increase consultant attribution to cases and improve our ability to audit the timeliness of paper death certification. We consider the latter particularly important to bereaved families and carers and for this reason it is an important quality measure for us.

The eDC is a first-stage review and a key function of it is to identify those cases needing a full structured judgement review. Use of the eDC has been transformative for KCH – for example, before its introduction KCH had limited ability

to identify those cases involving people with a severe mental illness or learning disability.

Next step and sustainability

KCH plans to roll out the eDC to the Princess Royal University Hospital. KCH will maintain clinician engagement by demonstrating to them the benefits of data collection to identify deaths and quality failings in this area and how this relates to improvements in patient care.

Other planned work in our Learning from Deaths strategy is ongoing joining up with other relevant policies and systems such as the duty of candour policy and patient safety systems. This should help avoid duplication of effort and improve timeliness.

Learning points

- Information technology support is integral to the development of systems such as the eDC.
- Gaining clinician engagement at all levels, both during development of processes and in the longer term, is critical.

Further information

Please contact: **Professor William Bernal**, Corporate Medical Director: william.bernal@nhs.net

Trust policy: http://www.kch.nhs.uk/about/corporate/care-standards/mortality-monitoring

7. Role of the bereavement office in co-ordinating review and support

St George's University Hospitals NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust employs nearly 8,500 staff and serves a population of 1.3 million across south west London. Some services – cardiothoracic medicine and surgery, neurosciences and renal transplantation – cover an additional 3.5 million people from Surrey and Sussex.

Consultant-led approach to learning from deaths

St George's has introduced daily consultant-level support for the bereavement office and daily 'independent' review of deaths. All reviewers are trained in the Royal College of Physicians' structured judgement review process. Most deaths are reviewed independently, with data and learning reported to the board.

Consultant support and mortality review in the bereavement office help improve the information and support given to families, and with escalating their concerns. These measures also support clinical teams with improved and timely death certification and with referral to the coroner. Importantly, they have helped identify clinical issues that are then fed into risk and/or quality improvement programmes.

An established direct link between the mortality review team and the risk team ensures all incidents of significant harm are rapidly identified to allow timely support for families and investigation either at local or trust level. There is also a direct link to the Child Death Overview Panel (CDOP) and the Learning Disability Mortality Review (LeDeR) programme.

IT solutions mean we can identify deaths in almost 'real' time and collate all reviews, enabling identification of themes and development work. We have

processes for raising concerns with other care providers and work is underway with another local trust to investigate care across hospitals and to share learning.

Challenges and how these were overcome

Staff capacity and resource are a challenge. Conducting mortality reviews well and providing timely support to families and clinical teams are resource intensive. But with board-level support, both executive and non-executive, we have managed the challenges of providing appropriate staff capacity and resource. St George's has resourced consultant time for daily bereavement office support and independent mortality case review. The trust has also created a new management post by reconfiguring the clinical effectiveness team, dedicated to mortality review.

Since publication of the national guidance on Learning from Deaths, we have continuously improved our mortality review processes with better support and improved cross-reference with other information.

Next step and sustainability

We will continue to strengthen our processes and the support we give to families and teams. The imminent appointment of a responsible manager should help to ensure reports and learning are disseminated well and embedded into practice. We plan to continue to strengthen the review process, train more reviewers and improve the learning across care providers. We will continue to work with CDOP and the LeDeR programme.

Learning points

- Board-level support is essential.
- IT solutions are essential to identifying deaths and accurate data reporting.
- Mortality review processes and outcomes need to fit seamlessly into other trust governance structures.

Further information

Please contact: **Dr Nigel Kennea**, Associate Medical Director:
learningfromdeaths@stgeorges.nhs.uk

http://blogs.bmj.com/bmj/2017/11/02/ollie-minton-et-al-learning-from-deaths

Trust policy: https://www.stgeorges.nhs.uk/wp-content/uploads/2013/06/Learning-from-Deaths-policy-app-PSQB200917.pdf

8. Embedding the learning disability mortality review process

North Tees and Hartlepool NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust (NTHFT) provides integrated hospital and community services to 400,000 people living in and around east Durham, Hartlepool and Stockton-on-Tees.

Approach

NTHFT has adopted a multidisciplinary team (MDT) approach to reviewing the deaths of people with learning disabilities under the LeDeR (Learning Disability Mortality Review) methodology. The team includes the named nurse for adult safeguarding (learning disability lead), the lead medical consultant with an interest in learning disability and the nurse advisor for learning disability and adult safeguarding.

The team meets monthly to review any deaths identified in the intervening period and to establish a chronology of the care provided to the deceased person across their lifespan.

The trust works in partnership with the Teesside LeDeR group, which is chaired by Hartlepool and Stockton-on-Tees Clinical Commissioning Group. Information collated internally is shared with the LeDeR group and our chronology of the person's care is merged with partner agency information to establish a complete picture of the care and support the person received.

What were the challenges?

- Tracking down the medical notes – to ensure notes are available before carrying out the review.

- Co-ordinating the MDT approach to the review – dates are now scheduled in advance with all appropriate staff involved, to ensure their involvement and to provide the correct level of clinical knowledge for effective review.

What are the results?

NTHFT now has monthly meetings planned with all relevant clinical staff. Our co-ordinated approach with medical and nursing staff ensures that lessons are learned and good practice is shared to improve and enhance patient care.

Learning points

- A co-ordinated approach to reviewing deaths – with a specific time and date for this each month – ensures all the relevant clinical staff are able to contribute and work together. It is a huge benefit that all the staff involved have a specific interest in learning disabilities, strive to share good practice and are motivated to make improvements where possible.
- The process highlights areas of good practice that would not have been identified without it.
- The value of taking a proactive approach; because the trust may be aware of a death sooner, the review can start as soon as possible.

Further information

Please contact: **Carley Ogden**, Nurse Advisor for Learning Disability and Adult Safeguarding: Carley.ogden@nth.nhs.uk

Trust policy: https://www.nth.nhs.uk/about/trust/how-we-are-doing/

9. Improving performance relating to hospital standardised mortality ratio

Sherwood Forest Hospitals NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust (SFH) provides healthcare services to 420,000 people across Mansfield, Ashfield, Newark, Sherwood, as well as parts of Derbyshire and Lincolnshire.

Mortality action plan

The trust had been an outlier with regards to the hospital standardised mortality ratio (HSMR) since 2013 and was among the worst performers nationally. Because of this we worked with Dr Foster to truly understand the mortality data and to develop a comprehensive mortality action plan. From identifying the necessary interventions we recognised that the position with regards to HSMR was likely to worsen before sustained and fully embedded improvements could be realised.

The mortality action plan included:

- ensuring an accurate mortality ratio that reflected the patient demographic
- changes to clinical coding processes to record the full complexity of patients and developing effective working relationships between coding and clinical teams
- redesign of patient pathways (including those for stroke, sepsis, acute kidney injury and GI bleed) to deliver safe and high quality care
- complete change in the culture of the trust's approach to mortality – the 4M mantra '**M**aking **M**ortality **M**ore **M**eaningful' – enabled clinical staff to review the care delivered to a patient in the days and weeks leading up to their death.

The trust has achieved a seismic shift in its performance – from a trust with one of the highest HSMRs to one that since April 2016 has consistently been within the expected range.

Mortality surveillance group

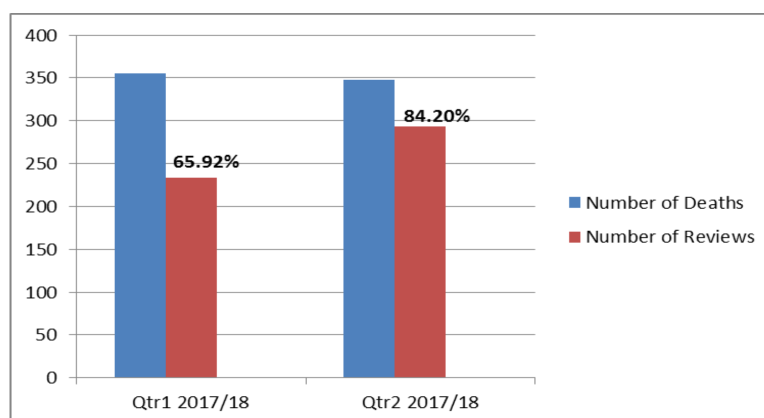
The trust had established a mortality surveillance group in our governance structure before publication of the Learning from Deaths national guidance.

In preparation for the launch of this guidance, the trust adopted the Royal College of Physicians' structured judgement review (SJR) methodology. Training was rolled out across the organisation and to date more than 75 consultant and senior clinical staff have been trained.

The trust decided to apply the SJR methodology to **all** cases that, following an initial review, triggered the requirement for an SJR, rather than specific patient or disease groups. This was not an insignificant challenge. The trust committed to meeting the required review of >90% of all deaths standard by the end of March 2018.

Implementation of the SJR methodology has radically changed the approach by teams. Their discussions now focus on the quality of care given by every member of the team. These also consider whether the experience of death – even if expected – could have been improved for the patient, their families and the staff involved.

We have seen a 19% increase between 2017/18 Q1 and Q2 in the percentage of all deaths initially reviewed.



The learning from the review of a death is shared through several mechanisms, from formal trust communications to local forums and learning events. Further work is needed to identify themes and trends across the organisation, and it is hoped that this work will inform the advancing quality improvement programme for 2018/19.

Learning points

- Have a plan – understanding and accepting the current position and agreeing the necessary actions and interventions with all stakeholders is crucial to success.
- Embed the right culture – the engagement of clinical staff, particularly medical staff, is vital. The Medical Engagement Scale survey was used across the organisation to measure the culture and demonstrate the level of engagement from medical teams.
- Implement good governance – a robust governance framework is needed to ensure delivery of the highest quality and safe care.

Further information

Please contact: **Dr Andy Haynes**, Medical Director: andrew.haynes@sfh-tr.nhs.uk

Trust policy: http://www.sfh-tr.nhs.uk/attachments/article/423/Learning%20from%20Deaths%20Policy.pdf

10. Role of the mortality review panel

Portsmouth Hospitals NHS Foundation Trust

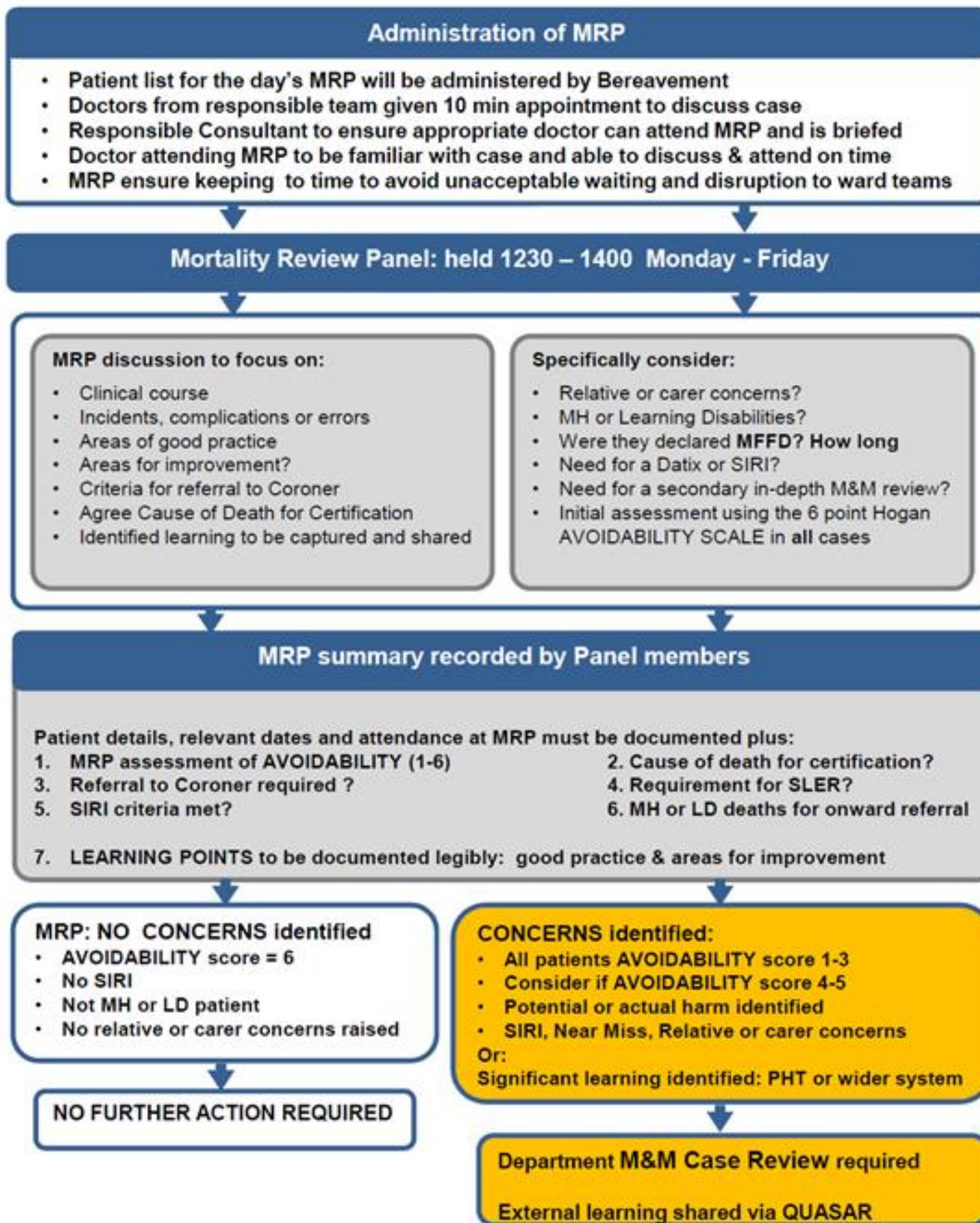
Portsmouth Hospitals NHS Foundation Trust is a single-site trust, Queen Alexandra Hospital, employing over 7,000 staff. The emergency department alone sees more than 132,000 patients every year.

Mortality review

The trust is committed to monitoring, understanding and learning from its mortality outcomes. In particular, we aim to:

- reduce and then maintain our hospital standardised mortality ratio below 100
- reduce our standardised hospital-level mortality index
- identify all deaths where avoidable harm may have occurred, aiming for no avoidable deaths
- improve learning from mortality reviews
- ensure robust and timely governance processes regarding mortality outcomes and reviews
- provide assurance of mortality processes in the trust.

To strengthen the trust’s mortality review process we established a mortality review panel (MRP) which meets every weekday to review deaths that have occurred in the previous 48 hours (see below). Clinicians on the panel from an independent specialty undertake a concise guided review of each death. They make an initial assessment of potential avoidability and identify areas of concern or opportunities for learning that may require further investigation.



The mortality processes and data are overseen by the trust's newly established mortality review group, chaired by the medical director, which meets monthly. This committee reports into the trust's governance and quality committee, a subcommittee of the board.

Learning points

- Regular MRP meetings increase oversight of factors involved in patient deaths.
- The Learning from Deaths policy needs to be tied into the trust's existing governance arrangements.
- Learning from reviews must be shared effectively across the organisation and the wider health system, and actions to address the findings must be implemented effectively.

Further information

Please contact: **Dr John Knighton**, Medical Director:
john.knighton@porthosp.nhs.uk

Trust policy: http://www.porthosp.nhs.uk/about-us/policies-and guidelines/policies/Clinical/Learning%20from%20Deaths%20policy.docx

11. Implementing and integrating a Learning from Deaths dashboard

West Suffolk NHS Foundation Trust

West Suffolk NHS Foundation Trust (WSFT) provides hospital and community healthcare services to the population of west Suffolk, a predominantly rural area with a population of around 280,000. It is an associate teaching hospital of the University of Cambridge.

Approach

From working through the changes needed to implement the Learning from Deaths national guidance, the trust identified that our learning from the mortality review process or indeed other incidents and investigations does not always achieve sustainable improvements in quality or safety. To address this, WSFT is developing a trust-wide quality improvement framework to build capability and capacity in improvement science, establish a solid improvement culture, increase service user and public involvement in improvements, and disseminate learning and successful improvements better. At the same time as writing our Learning from Deaths policy, we revised the terms of reference for the mortality surveillance group, gave it the new name of the Learning from Deaths group, and added a non-executive director and a family representative to the membership.

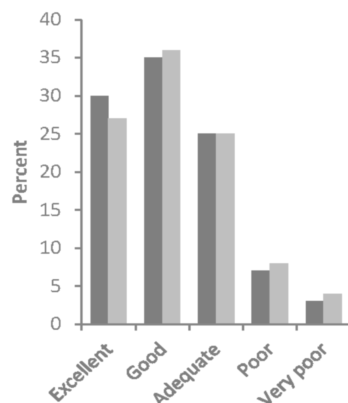
WSFT has designed a Learning from Deaths dashboard which is used in reporting to the trust board and the Learning from Deaths group (see below). Feedback from both audiences has been used to develop its content. The dashboard includes the summary hospital mortality index (SHMI), number of deaths and number of reviews. It highlights deaths of patients with learning disabilities or severe mental illness, maternal deaths, child deaths and stillbirths. The dashboard also summarises identified learning themes.

Learning from Deaths dashboard – Quarter 2 2017/18
Accurate 15th November 2017

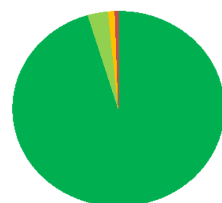
West Suffolk NHS
NHS Foundation Trust

Inpatient deaths	Total	Reviews completed
Quarter 2	217	194
Year to date	439	410

Overall quality of care
QX and YTD (grey), 20XX/XX

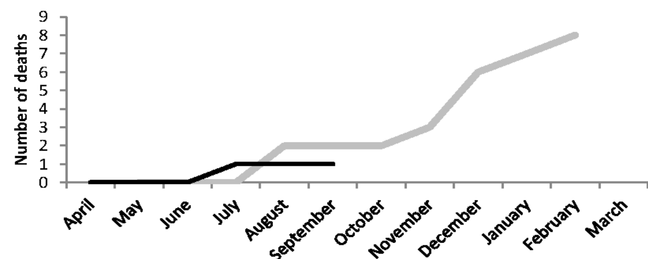


Outcomes of reviews
Quarter 2, 2017/18



- Definitely not preventable - 185
- Slight evidence of preventability - 6
- Possibly preventable - 2
- Probably preventable - 1
- Strong evidence of preventability - 0
- Definitely preventable - 0

Cumulative incidence of deaths judged to have >50% likelihood of preventability
2017/18 (black) compared to 2016/17 (grey)



Preventability benchmarks

3.0 – 4.3%
Research

0.5%
Real world

0.5%
Q2 WSFT

0.2%
YTD WSFT

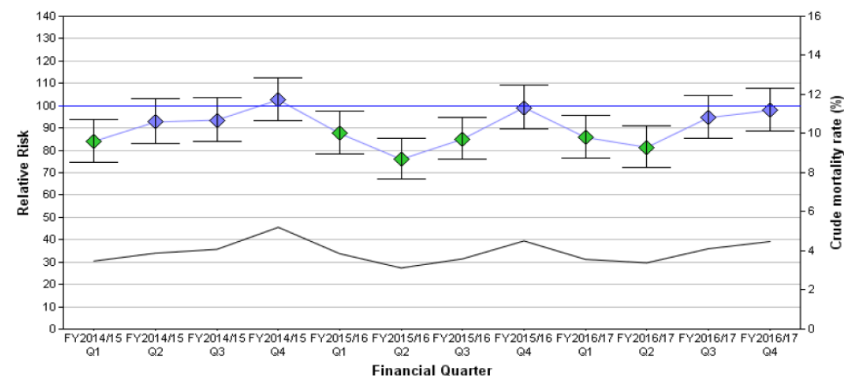
Deaths in people in groups under special focus – Q2 (YTD)

Group	Total	> 50% likely preventable
People with learning disabilities	1 (1)	1 (1)
People with severe mental illness	0 (1)	0 (0)
Maternal deaths, child deaths and stillbirths	Not governed through Learning from Deaths in this time period	

Learning themes identified

Contributing to preventable deaths	Reviews still in process – see board report
Not contributing to death	No new themes identified

Summary Hospital Mortality Index (SHMI)



What were the challenges?

One of the biggest challenges for the trust was the cultural change required for staff to be comfortable about details of care and deaths being made publicly available. The trust board sees overcoming this challenge as an important benefit from the Learning from Deaths programme, as well as central to what the trust is trying to achieve. The trust is fully committed to making its Learning from Deaths programme a success.

A public health registrar working at the trust has overseen the change programme associated with implementing the Learning from Deaths programme and has critiqued how the trust handles learning and acts in response to deaths. Stemming from this the trust has created a post for a consultant in healthcare public health whose role will include continuing to oversee the Learning from Deaths programme, managing the team, implementing the quality improvement framework and making sure learning is used well and shared effectively. We strongly encourage other trusts to consider whether this type of expertise is available to them and if not, whether they would benefit from exploring ways to obtain it.

Learning points

- Working collaboratively with the governance team, the bereavement office, the Patient Advice and Liaison Service and the mortuary ensures that the care pathway for relatives and carers after a patient dies is co-ordinated.
- It is imperative to move away from relying on quantitative data and to pay more attention to the narrative of what happens in individual cases.
- The cultural change needed alongside this programme, and which underpins its success, takes longer than the practical changes.

Further information

Please contact: **Dr Nick Jenkins**, Medical Director: nick.jenkins@wsh.nhs.uk

Trust policy: http://www.wsh.nhs.uk/CMS-Documents/Trust-policies/301-350/PP17350-Learning-from-Deaths-policy.pdf

12. Region-wide collaboration

West of England Academic Health Science Network

The West of England Academic Health Science Network (WEAHSN) is funded by NHS England and the West of England healthcare organisations, and brings together the health service community, industry, research, education, patients and the wider public to work in partnership to improve patient care. Hosting the patient safety collaboratives – commissioned by NHS Improvement – is an important part of the work of this network.

Collaborative regional approach to learning from deaths

In mid-2016 colleagues at WEAHSN and its associated trusts became aware of an initiative by the Royal College of Physicians to introduce retrospective mortality case record reviews across England. In keeping with this, WEAHSN is encouraging and supporting a collaborative approach to learning from deaths across its trusts, with the aim of standardising the mortality review process and sharing learning. WEAHSN also aims to co-ordinate outcome themes and facilitate region-wide quality improvement initiatives.

In October 2016, the National Mortality Case Record Review programme team trained 44 clinicians from across the collaborative in the Royal College of Physicians' structured judgement review (SJR). WEAHSN then facilitated rollout of training to nearly 100 trainers across the region who will support training of others and the rollout of the SJR process.

Our aim is for all trusts in the WEAHSN collaborative to implement SJR by March 2018. This will provide a rich pool of learning themes that will influence quality improvement work in the WEAHSN region.

Most trusts have now developed operational process maps for their SJR process, detailing mechanisms for feedback to staff, teams and the board. The identification

of family care concerns and informing families of review outcomes are areas in development across the collaborative.

Learning points

- The inclusion of non-acute trusts in the collaborative has enabled processes for shared learning across the system.
- The value of senior review and the importance of earlier identification of patients nearing the end of their lives have emerged as important themes.

Further information

Please contact: **Kevin Hunter**, Patient Safety Programme Manager: kevin.hunter@weahsn.net

http://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nacre-programme-resources

13. Working across Greater Manchester on mortality review

Pennine Care NHS Foundation Trust

Formed in 2002, Pennine Care NHS Foundation Trust employs over 5,000 staff and provides community and mental health services to 1.3 million people across six boroughs of Greater Manchester.

Our vision is to deliver the best care to patients, people and families in our local communities, by working effectively with partners to help people to live well.

Approach

As part of the Greater Manchester Partnership, Pennine Care NHS Foundation Trust has established a provider-based mortality review group with Greater Manchester Mental Health NHS Foundation Trust, its main partner trust. This is to ensure that lessons learned are shared between providers for the benefit of the population of Greater Manchester, identified as important in intra-trust work on suicide prevention and planning a forum for learning lessons from homicides. Both medical directors and patient safety leads firmly believed that learning lessons from deaths was not something that should be confined within individual trusts. The trust was also keen to establish a place for mental health within the wider Greater Manchester partnership's Learning from Deaths forum.

What were the challenges?

The first challenge was to overcome any barriers to how lessons learned by one organisation are shared more widely. The group established as a principle the ethos of the 'greater good' in that all persons receiving services from mental health teams across Greater Manchester would benefit from those services being improved by learning from each other.

A remaining challenge is to establish a protocol for sharing datasets, and that those datasets capture the correct and identical data. Doing this is complicated by the two trusts using different data systems (Datix and Ulysses). The trusts have set up a business intelligence group to work through these problems and, in the spirit of co-operation and collaboration, drive establishment of a protocol both are happy with.

What has been achieved?

A programme of Greater Manchester provider-based mortality review groups (MRGs) now links into the individual MRGs. It is early days and obstacles are anticipated, but the relationships and the driving principle of sharing data and lessons for the benefit of all our patients and carers are established.

Learning points

- Working with other trusts can yield wider unanticipated results for your own trust.
- Medical director sign-up is critical to ensure leadership at the highest level and for a clear line of sight between the partnership group, individual mortality review groups and individual boards.
- Establishing good working relationships at a level below medical director is critical to making the partnership work. It takes effort above and beyond the day job to ensure learning is effectively shared.
- Don’t be afraid to stumble or stutter – nothing worthwhile was ever achieved in a smooth linear fashion. We are engaged in an iterative process that hopefully will become established for the greater good of patients and carers in Greater Manchester.

Further information

Please contact:

Pennine Care NHS Foundation Trust

Dr Henry Ticehurst, Medical Director: henry.ticehurst@nhs.net

Matt Walsh, Patient Safety Lead: Matt.walsh@nhs.net

Greater Manchester Mental Health NHS Foundation Trust

Dr Chris Daly: Chris.Daly@gmmh.nhs.uk

Julie Bodnarec, Head of Patient Safety and Governance:
Julie.Bodnarec@gmmh.nhs.uk

North West Boroughs Healthcare NHS Foundation Trust

Dr Louise Sell: Louise.Sell@nwbh.nhs.uk

Kerstin Roberts: Kerstin.Roberts@nwbh.nhs.uk

Trust policy: https://www.penninecare.nhs.uk/media/496210/co119-learning-from-deaths-policy-v1.pdf

Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

Follow us on Twitter @NHSImprovement

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