Wrightington, Wigan and Leigh NHS Foundation Trust

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AT ALL TIMES, STAFF MUST TREAT PATIENTS WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.

1 INTRODUCTION

In March 2017 the National Quality Board published National Guidance on Learning from Deaths, a framework for NHS Trust's and NHS Foundation Trust's on identifying, reporting, investigating and learning from deaths in care. All Trusts are required to have a Mortality Review Framework or Policy in place which can be publically accessed. The Trust has had a Mortality Review Framework in place since November 2015.

2 MORTALITY REVIEW FRAMEWORK STATEMENT

2.1 This framework outlines the requirements for mortality case record review and investigation at Wrightington, Wigan and Leigh NHS Foundation Trust. This framework includes the following:

2.1.1 How processes respond to the death of an individual with a learning disability, a neonatal or child death and a stillbirth or maternal death;

2.1.2 The Trust's approach to undertaking case record reviews;

2.1.3 Categories and selection of deaths in scope for case record review.

3 KEY PRINCIPLES

3.1 There are three levels of scrutiny that an NHS Trust can apply to the care provided to someone who dies: death certificate; case record review; and investigation. They do not need to be initiated sequentially and an investigation may be initiated at any point in time, whether or not a case record review has been undertaken.

3.1.1 Death certificate: Deaths by natural causes are certified by the attending Doctor. Doctors are encouraged to report any death to HM Coroner that they cannot readily certify as being natural causes.

3.1.2 Case record review: Some deaths are subject to further review by the Trust, looking at the care provided to the deceased as recording in their case records in order to identify any learning.

31.3 Investigation: The Trust may decide that some deaths, where healthcare concerns have been identified and the death has been identified as potentially preventable, may warrant an investigation and should be guided by the circumstances for investigation under the serious incident framework.

3.2 This framework outlines the circumstances and methodology for case record review and investigation.

4 RESPONSIBILITIES

4.1 **Chief Executive** has overall responsibility for ensuring the Trust has a framework in place to review and monitor mortality.

4.2 **Medical Director** assures the Trust Board that the framework to review and monitor mortality is effective and that arrangements are in place for all clinical staff as appropriate to be aware of their responsibilities to contribute to the process. The Medical Director chairs the Mortality Committee and acts as 'Patient Safety Director', taking responsibility for the learning from deaths agenda.

4.3 **Chair of Quality and Safety Committee (Non-Executive Director)** takes oversight of the learning from deaths agenda in accordance with the responsibilities of Quality and Safety Committee.

4.4 **Associate Medical Director (Mortality Clinical Lead)** and his nominated team has designated responsibility to support the implementation and further development of the Trust's morality review framework. This includes management of the Trust's corporate mortality review and ensuring that national and regional mortality data is monitored and acted upon as necessary.

4.5 **Divisional Medical Directors. Clinical Directors and Governance Leads** ensure that appropriate multi-disciplinary mortality review takes place is all specialities and learning is acted upon and documented.

4.6 **Medical Staff** are expected to participate fully in the divisional mortality review processes.

4.7 **Nurses, Allied Health Professionals and other Clinical Staff** should be involved in divisional morality review as part of their clinical practice. This involvement could be acting on learning from mortality reviews that affects their practice.

4.8 **Trust Board** receives oversight of the monthly performance report which includes HSMR and SHMI data, quarterly reports in accordance with the National Quality Board Learning from Deaths Guidance and details of incidents submitted to STEIS, including unexpected deaths.

4.9 **Quality and Safety Committee** receives the quarterly SEC (Safe Effective Caring) report which includes HSMR and SHMI data, quarterly reports in accordance with the National Quality Board Learning from Deaths Guidance and details of incidents submitted to STEIS, including unexpected deaths. The Committee also receives the annual Corporate Mortality Review report. The Committee is responsible for ensuring that actions are completed to address concerns raised. The quarterly mortality updates are escalated to Trust Board.

4.10 **Mortality Committee,** chaired by the Medical Director is responsible for providing assurance to the Quality and Safety Committee on effective structures and systems in place for mortality review, assurance that actions are progressing to monitor mortality data and address any concerns or learning and to advise the Quality and Safety Committee on issues not resolved or that require escalation for action.

5. CORPORATE MORTALITY REVIEW

5.1 Aim and Methodology

5.1.1 The aim of the corporate mortality review is to undertake a case record review of approximately 400 deaths annually to identify patterns, themes or errors occurring endemically.

5.1.2 The reviews are undertaken by a doctor, nurse and clinical coder. The corporate review of deaths is undertaken throughout the year with the aim to achieve a review of approximately 400 deaths annually, which is just under half of all deaths that occur in hospital.

5.1.3 The corporate mortality review focuses on 'Box 4' deaths defined as:

5.1.3.1 Deaths shortly after admission (admitted to die);

5.1.3.2 Deaths where care of dying would have been appropriate or death was predicted;

5.1.3.3 Deaths not or easily predicable;

5.1.4 Deaths are reviewed against the following standards of care:
- 5.1.4.1 Charts with no major drug omissions
- 5.1.4.2 Patients on Correct ward
- 5.1.4.3 Thrombo-prophylaxis given
- 5.1.4.4 Seen within 24 hours by a Senior Doctor
- 5.1.4.5 Post take checklist completed
- 5.1.4.6 Ward round checklist completed
- 5.1.4.7 Sepsis Six
- 5.1.4.8 Acute Kidney Injury

5.1.5 The reviews also include an audit of cardiac arrests and a report on current inpatients with a length of stay over 30 days.

5.2 Learning Lessons

5.2.1 Learning from the mortality reviews is circulated to almost 1000 staff including all consultants, and a number of nurses and managers. If particular concerns regarding a death are highlighted in the review this information is disseminated to the relevant team or specialty for further discussion. A log of issues and actions discussed following dissemination of corporate mortality reviews is maintained and shared at Quality and Safety Committee (QSC) as part of a quarterly update.

5.2.2 An annual report is produced which summaries performance against the standards of care outlined above and highlights themes identified during the year. The annual report includes the percentage of deaths reviewed during the year that are potentially preventable.

5.3 Escalation of Concerns Identified (Potentially Preventable Deaths)

5.3.1 If a potentially preventable death is identified the Corporate Review Team will contact appropriate senior clinicians to undertake a rapid review into the death dependent on the nature of the concern, for example, Chief Pharmacist or Consultant Physician. The death is also escalated to the Corporate Governance Team. If healthcare concerns are confirmed and the death is deemed to be potentially preventable, an incident is submitted to Datix and the death is submitted to STEIS and investigated under the serious incident framework.

5.3.2 Lead investigators for serious incidents (including unexpected deaths) receive specialist training which includes a focus on 'human factors', acknowledging the primary role of system factors with or beyond the organisation rather than individual.

5.4 Engagement with Bereaved Families and Carers

Following the commencement of serious incident processes a single point of contact is identified, which in the event of a death, is usually the Trust's Bereavement Nurse. Engagement is in accordance with being open and duty of candour requirements. The Trust is committed to engaging with bereaved families and welcomes their questions or sharing concerns about the quality of care their loved one received.

5.5 Reporting

5.5.1 The Trust's performance for HSMR and SHMI is reported monthly to the Trust Board in Performance Report. The data presented includes benchmarking against other Trust's in Greater Manchester. HSMR and SHMI is also reported quarterly in the Trust's SEC (Safe, Effective, Caring) report presented to Quality and Safety Committee (QSC) and the Quality, Safety and Safeguarding Committee (QSSG), a joint forum with Wigan Borough Clinical Commissioning Group.

5.5.2 The annual corporate mortality review report is also presented to QSC and QSSG. Incidents submitted to STEIS are reported monthly to QSC, Trust Board and QSSG.

5.5.3 The Trust Board and Quality and Safety Committee receive quarterly mortality reports in accordance with the National Quality Board Learning from Deaths (March 2017) Guidance which includes:

5.5.3.1 The total number of the Trust's inpatient deaths (including Emergency Department deaths for acute Trust's);

5.5.3.2 Deaths subjected to review: Trusts are required to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

6. REVIEW OF DR FOSTER, IMPERIAL COLLEGE LONDON AND CARE QUALITY COMMISSION ALERTS AND OUTLIER STATUS

6.1 Aim

The aim of this review is to facilitate early identification of Dr Foster mortality alerts and learning for further review by the relevant specialties and to co-ordinate the Trust's response to the receipt of Imperial College London and Care Quality Commission mortality alerts.

6.2 Dr Foster Relative Risk and CUSUM Alerts

6.2.1 Methodology

A monthly summary of data from Dr Foster (Relative Risk and CUSUM Alerts) is circulated to Executive Directors, Associate Director of Governance and Divisional Clinical Governance Leads by Business Intelligence.

A review of the monthly data is undertaken by a doctor, nurse and clinical coder. Mortality alerts highlighting coding concerns are identified. Diagnostic groups are identified as having potential problems with raised mortality leading to the further review of individual cases within those groups being reviewed utilising the identical methodology as the corporate mortality review. A report summarising the findings from the review of each individual case record review is produced.

6.2.2 Learning Lessons

The report summarising the findings from the review of each individual care is disseminated to the Executive Team and the relevant Divisional Medical Director and Clinical Director(s). The report is also disseminated with the corporate mortality review information. The reports should be reviewed and utilised to develop improvement plans by the divisions to address issues raised.

6.2.3 Reporting

Dr Foster Relative Risk and CUSUM mortality alerts that required further review are reported to the Quality and Safety Committee (QSC) as part of a quarterly update.

6.3 Imperial College London and Care Quality Commission Alerts

6.3.1 Methodology

Imperial College London and Care Quality Commission mortality alerts are received by the Chief Executive's office and circulated to relevant divisional Director of Operations and Performance, Divisional Medical Director and relevant Clinical Director, Medical Director, Associate Director of Governance and Mortality Clinical Lead.

A review of the data triggering the alert is undertaken by a doctor, nurse and clinical coder. Mortality alerts highlighting coding concerns are identified.

Diagnostic groups are identified as having potential problems with raised mortality leading to the further review of individual cases within those groups being reviewed utilising the identical methodology as the corporate mortality review. A report summarising the findings from the review of each individual case is produced.

6.3.2 **Learning Lessons**

The report summarising the findings from the review of each individual care is disseminated to the Executive Team and the relevant Divisional Medical Director and Clinical Director(s). The reports should be reviewed and utilised to develop improvement plans with the divisions to address issues raised.

6.3.3 **Reporting**

Imperial College London and Care Quality Commission alerts are presented to the Mortality Committee. The Committee is responsible for ensuring that an appropriate response is received by Imperial College London or the Care Quality Commission where appropriate and improvement plans are completed.

7. DIVISIONAL MORTALITY REVIEW

Clinical Coding provide Consultants with weekly information on the deaths of patients under their care. Case record mortality reviews in the divisions are undertaken by specialities, led by senior clinicians. Summaries of the divisional mortality review meetings are escalated to the Mortality Committee. Clinical Coding provide Consultants with weekly information on the deaths of patients under their care.

8. DEATHS OF PATIENTS WITH A LEARNING DISABILITY

8.1 The deaths of all patients with a learning disability are subject to case record reviews by the corporate review team. There is a requirement to inform the learning disability mortality review programme (LeDeR) and document this in the patient's notes.

8.2 The deaths of all patients with a learning disability will be reviewed by the corporate review team. There is a requirement to inform the learning disability mortality review programme (LeDeR) and document this in the patient's notes.

8.3 The LeDeR is notified of the death of a person between 4-74 years with a learning disability via the LeDer website. The following steps are taken following the notification of a death:

8.4 The National LeDeR team will inform Greater Manchester learning disability mortality review programme that a death has been notified and provide the GM local co-ordinator with all of the information collected regarding the individual:

8.4.1 The person who has died.
8.4.2 The person reporting the death.
8.4.3 A person who knew the person who died well.
8.4.4 Any known health conditions or problems.
8.4.5 Whether they were registered with a GP.
8.4.6 Where they died and whether the cause of death is known.

8.5 The local co-ordinator will ensure that a professional known to the family/carers speaks to them to provide information regarding the review and to identify if they want to be involved in the process.

8.6 A locally devised form is then used to collect further information regarding the deceased from the individuals GP practice, Community Learning Disability Team and from social care. This information is collated and used to review the circumstances around the death and to identify any potentially contributory factors around the death within a multi-agency panel.

8.7 The purpose of the GM learning disability mortality review is to ensure modifiable factors which could have contributed to a preventable death are used to identify service improvement plans through the Transforming Care Partnership Board.

9. MATERNAL DEATHS

9.1 A maternal death is defined as the death of a pregnant woman or death of a woman within 42 days of delivery, miscarriage, termination or ectopic pregnancy providing the death is associated with pregnancy or its treatment.

9.2 Every death meeting the definition of a maternal death is submitted to Datix and a rapid review is undertaken. All maternal deaths are submitted to STEIS and investigated under the serious incident framework. Engagement with bereaved families and carers is in accordance with being open and duty of candour requirements.

9.3 All maternal deaths are reported to MBRRACE-UK and this includes all women who die during pregnancy or within 12 months of giving birth (for causes of death not related to the pregnancy). Annual reports are received highlighting any trends and lessons learned to inform future maternity care.

10. STILLBIRTHS

10.1 A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks. All stillbirths are submitted to Datix and reviewed by the divisional Governance Team, an Obstetric Consultant and a Midwife. If healthcare concerns are identified, incident management processes are followed. Engagement with bereaved families and carers is in accordance with being open and duty of candour requirements. They are reported every six months at Obstetrics and Gynaecology Clinical Cabinet.

10.2 All stillbirths and late fetal losses (sometimes referred to as late miscarriages) are reported to MBRRACE-UK and data collated nationally. Annual retrospective reports are received demonstrating individual Borough rates and comparisons with others.

11. NEONATAL DEATHS

11.1 A neonatal death is a baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born. The Trust's Neonatal Unit review every death and produce bi-monthly reports presented at a regional Greater Manchester Neonatal Network Clinical Effectiveness Group. If healthcare concerns are identified, incident management processes are followed. Engagement with bereaved families and carers is in accordance with being open and duty of candour requirements.

11.2 All neonatal deaths are reported to MBRRACE-UK and data collated nationally. Annual retrospective reports are received demonstrating individual Borough rates and comparisons with others.

12. CHILD DEATHS

12.1 All child deaths are submitted to Datix and a rapid review is undertaken. If healthcare concerns are identified, incident management processes are followed. Engagement with bereaved families and carers is in accordance with being open and duty of candour requirements.

12.2 All unexpected child deaths trigger a SUDC (Sudden Unexpected Death in Childhood) investigation. A Safeguarding investigation will also be undertaken as appropriate.

12.3 Quarterly Paediatric mortality meetings, chaired by a Consultant Paediatrician, review all child deaths. Minutes are circulated to Child Health Clinical Cabinet. Quarterly joint perinatal morality meetings for Paediatrics and Obstetrics are held, chaired by a Consultant Paediatrician or Obstetrician. Minutes are circulated to Paediatric and Obstetric Clinical Cabinets.

13. FURTHER TRIGGERS FOR CASE RECORD MORTALITY REVIEW

13.1 There are further triggers for a case record mortality review of a death which include:

13.1.1 Concerns raised following an incident related to a death submitted to Datix which may not have been subject to a case record mortality review previously. Incident Management processes and the Serious Incident Framework (where applicable) apply.

13.1.2 Identification of a concern raised during preparations in advance of an inquest for deaths which may not have been subject to a case record mortality review previously.

13.1.3 When bereaved families and carers, or staff, have raised a significant concern about quality of care following a complaint, family statement provided to HM Coroner in advance of inquest or raising concerns processes;

13.1.4 Following receipt of a Regulation 28 Report on action to prevent future deaths, issued by HM Coroner.

13.2 In all cases engagement with bereaved families and carers is in accordance with being open and duty of candour requirements.

14. INDEPENDENT INVESTIGATION OF DEATHS

There may be occasions where an independent investigation, commissioned and delivered separately from the Trust) may in some circumstances be warranted. The Trust has a framework to facilitate independent investigations of deaths. Executive Scrutiny Committee, chaired by the Director of Nursing, is responsible for agreeing when an independent investigation into a death is warranted.

15. ANNUAL MORTALITY REVIEW EVENT

Annual Mortality Review Events are held (themed SIRI Panels), chaired by the Medical Director and attended by clinicians from across the organisation. The purpose of the event is to review the learning from unexpected deaths reported as serious incidents and learning from the corporate review of deaths. Priority areas for action are identified and included as part of the Mortality Committee work-plan.

16. QUALITY ACCOUNTS

Changes to Quality Accounts regulations will require that the Trust publishes following presentation to Trust Board is summarised in Quality Accounts from June 2018 which will include evidence of learning and action as a result of this information and an assessment of the impact of actions that the Trust has taken.

17. HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

18. INCLUSION AND DIVERSITY

The document has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and, as far as we are aware, there is no impact on any protected characteristics.

19. MONITORING AND REVIEW

Appendix 1 outlines how this Mortality Review Framework is monitored.

20. ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd. For more details, please contact the HR Department on 01942 77 3766 or email equalityanddiversity@wwl.nhs.uk

Appendix 1

REFERENCES

National Quality Board Learning from Deaths Guidance (March 2017)

Appendix 2

Equality Impact Assessment Form

STAGE 1 - INITIAL ASSESSMENT

For each of the protected characteristics listed answer the questions below using **Y** to indicate Yes and **N** to indicate No	**Protected Characteristics**														**Reasons for negative / positive impact**
	Male / Female	**Age**	**Ethnicity**	**Learning Disability**	**Hearing Impairment**	**Visual Impairment**	**Physical Disability**	**Mental Health**	**Gay / Lesbian / Bisexual**	**Transgender**	**Religion / Belief**	**Marriage / Civil Partnership**	**Pregnancy & Maternity**	**Carers**	
Does the policy have the potential to affect individuals or communities differently in a negative way?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	
Is there potential for the policy to promote equality of opportunity for all / promote good relations with different groups – Have a positive impact on individuals and communities.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	If Yes, please state how you are going to gather this information.

Job Title	**Associate Director of Governance**	**Date**	19th September 2017

IF 'YES an NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp

Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an EIA. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation.

Appendix 3

POLICY MONITORING AND REVIEW ARRANGEMENTS

Para	Audit / Monitoring requirement	Method of Audit / Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
3.5	HSMR and SHMI data	Dr Foster	Business Intelligence	Monthly	Trust Board	Performance Report	Trust website
			Compliance Lead	Quarterly	Quality and Safety Committee	SEC Report	Corporate Nursing and Governance
	Annual Corporate Mortality Review	Summary of Weekly Corporate Mortality Reviews	Mortality Clinical Lead	Annual	Quality and Safety Committee	Annual Corporate Mortality Review Report	Corporate Nursing and Governance
	Quarterly Mortality Reviews in accordance with the Learning from Deaths Guidance	Summary of quarterly mortality activity	Associate Director of Governance and Mortality Clinical Lead	Quarterly	Trust Board	Quarterly Mortality Review Report	Trust website