North Tees and Hartlepool
NHS Foundation Trust

Policy Title: Learning from Deaths (Mortality Review) Policy
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Related Documents: RM 15 Incident Reporting and Investigation Policy RM14 Serious incident RM19 Supporting staff C40 Duty of Candour C82 Care after death policy National Guidance on Learning from Deaths, 2017.
This Policy is Intended for: **All Staff Groups.**

Policy Summary

This policy sets out how the Trust will comply with the "National Guidance on Learning from Deaths", March 2017.

The Trust is committed to service improvement and acknowledges that systematic mortality review has a crucial part in delivering the clinical quality agenda and providing assurance of quality improvement.

The Trust is committed to the fair treatment of all, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependants, sexual orientation, trade union membership or non membership, working patterns or any other personal characteristic. This policy and procedure will be implemented consistently regardless of any such factors and all will be treated with dignity and respect. To this end, an equality impact assessment has been completed on this policy.

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APPENDICES

1. Introduction

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This was reinforced by the recent findings of the Care Quality Commission (CQC, 2016) report "*Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England"*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

In March 2017, the National Quality Board (NQB) published national guidance "Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care". The guidance provide requirements for Trust to implement as a minimum in order ensure there is a focused approach towards responding to and learning from deaths of patients in our care; as required within the CQC report.

2. Aim

2.1 The main purpose of this policy and the content is to promote learning and improve how the Trust support and engage with the families and carers of those who die in our care; it is not in place to purely count and classify deaths.

2.2 The Trust strives to improve the care provided to all of our patients; the overall aim is to identify, understand and implement improvements where any issues are related to the provision of quality care. It is considered that if such improvements are initiated effectively and embedded, then the mortality statistics will naturally show improvement.

2.3 This policy provides details of how the Trust will ensure compliance with the requirements set out in the NQB guidance (2017). The policy sets out the process by which the Trust will:

- Identify and investigate deaths in care.
- Ascertain learning points to ensure these are used to support changes in practice.
- Provide support for bereaved families and offer them the opportunity to highlight any concerns they may have and to request a mortality review be completed.
- Support staff in collecting and using information to initiate quality service improvements and demonstrate learning.
- Describe how the Trust will report details in relation to completed mortality reviews and also the learning obtained through this work.

2.4 For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes.

2.5 The purpose of reviews and investigations of deaths, which problems in care might have contributed to, is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

3. Definitions

3.1 **Death certification:** The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. The process includes identifying cases for referral to the Coroner.

3.2 **Case record review**: A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be undertaken where concerns exist, such as when bereaved families or staff raise concerns about care.

3.3 **Mortality review:** A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

3.4 **Death due to a problem in care**: A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

3.5 **Investigation**: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

3.6 **Serious Incident:** Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. The Serious Incident Policy (RM14) details the process of investigation, including the different levels of investigations required in specific circumstances dependent on the overall outcome and level of harm.

3.7 **Duty of Candour:** Where case review identify that an incident has occurred this should be reported through the incident reporting system; the level of harm should be assessed in line with the Trusts Incident reporting and investigation policy (RM15). Duty of Candour regulations provide a framework to support the sharing of information when things go wrong; the Trusts policy C40, provides details on how these regulations are to be applied.

3.8 **Quality improvement:** A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

4. Responsibilities

4.1 **Chief Executive / Chief Operating Officer**
Have overall responsibility for this policy and compliance.

4.2 **Trust Board**
The Trust Board will receive Learning from Deaths reports and provide oversight in relation to the application of the learning across the organisation and in the wider health community.

4.3 **Non- Executive Directors (NEDs)**
Non-Executive Directors will understand the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.

They will champion quality improvements that lead to actions improving patient safety.

They will assure published information; that it fairly and accurately reflects the organisation's approach, achievements and challenges.

NHS Improvement have identified that Trust NEDs in particular have been identified as having a critical role to play in holding their organisations to account for: conducting robust case record reviews and serious incident investigations; and crucially for implementing effective and sustainable changes designed to improve safety and wider quality in response (NHSI, 2017).

4.4 **Medical Director / Director of Nursing, Quality and Patient Safety**
Carry overall responsibility for ensuring that this policy is applied consistently and comprehensively for both medical and nursing staff.

Ensure that all nurses, midwives and medical staff are supported to fulfill their duty to engage in the Trusts response to “Learning from Deaths”.

Ensure that Quality and Patient Safety initiatives supporting the findings of the reviews are implemented and improvements monitored.

4.5 **Deputy Medical Director / Mortality Lead**
Responsible for the provision of the quarterly Board Report outlining estimates of numbers of avoidable deaths and summarizing learning obtained through the Trusts mortality work.

To provide leadership in relation to the Trusts response to learning identified through systematic case reviews.

Utilise available data to identify key areas of focus in order to promote overall quality improvements; this will include working with stakeholders across the health economy to improve overall care pathways in primary as well as secondary care.

Ensure that the annual Quality Account provides a summary of the data provided to the Trusts Board, including details of any learning and improvements made as a result of this; provide an overall evaluation of the impact.

4.6 **Clinical Directors**
To ensure all clinicians in their Clinical Directorate are supported to fulfil their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.

To ensure specialties have local mortality reviews and results/learning are incorporated into central system and are used to inform quality improvement developments.

Ensure lessons learned are disseminated to their own directorate in order to obtain the maximum benefit from the reviews.

4.7 **Senior Clinical Matrons**
To ensure there is professional nursing / midwifery input in relation to case reviews in conjunction with the medical staff reviewing the case; identify specific staff to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.

4.8 **Head of Patient Safety**
Facilitate completion of appropriate case reviews at the Mortality Review Group meetings.

Work with administrative support to ensure that all reviews are recorded on the electronic mortality system.

Liaise with clinical teams in order to promote the completion of specialty reviews within the electronic mortality system; and provide support when analyzing overall learning points.

Liaise with Patient Safety Manager in relation to any cases where an incident investigation is required.

Where necessary, link with the Trusts Coroners Liaison Officer to identify any requirements from the Coroners officers.

4.9 **All staff**
All staff with clinical background have a duty to engage in responding to deaths; to be involved in case record reviews and investigations as required and to meet the Duty of Candour requirements.

Utilise learning from review processes to support involvement in quality improvements across the organisation.

5. Policy details

5.1 **Denominator Criteria -** This policy relates to all deaths of patients in Accident and Emergency department or receiving In-patient care within the Trust. This will be the denominator used to analyse data; over time this may be altered to include a wider range of deaths, for example deaths up to 30 days post discharge.

5.2 **Death certification -** When a death occurs the consultant responsible for care has a duty to decide whether the coroner needs to be informed and to oversee the process of completing the Medical Certificate of the Cause of Death (MCCD), see policy C82 Care after Death. The MCCD should be completed within 24 hours for all deaths as circumstances allow.

In normal circumstances, this is an opportunity to discuss with the bereaved family the cause of death and at this stage the family should be asked whether they have any concerns about the care of the deceased patient. A second opportunity to identify any concerns about care will arise in many cases when a second doctor completes the confirmatory (Part 2) medical certificate for cremation.

The Trust's Bereavement team provides ongoing sensitive, support for families through this difficult period and also use this opportunity to identify any concerns about care that are raised with them. These are escalated to the relevant clinical team for action at the earliest opportunity. The team also provides all families with a copy of the Trusts Bereavement survey; this survey gathers information about the overall care around the time of death but also allows families to request a review of the patient's case and the opportunity to meet with the clinical team to discuss any issues raised. The Bereavement survey follow up process is outlined in appendix 1.

5.3 **Compulsory case reviews:**

The following cases are to be included as compulsory:

- Where requests are made by families to undertake a case review.
- Where staff request a case review.
- All deaths in the Intensive Care Unit (ICU).
- All deaths linked to complaints about significant concerns in relation to clinical care.
- All deaths linked to Serious Incident investigations.
- All deaths where the patient was admitted for elective treatment.

Case reviews also linked with specific national review processes:

- All deaths where a patient has a registered Learning Disability (LD) – in conjunction with the Learning Disability Mortality Review Programme (LeDeR).
- All maternal deaths – in conjunction with M-BRRACE-UK.
- All deaths where the patient has a severe mental illness – in conjunction with local Mental Health Trusts as required; this definition to be agreed nationally and the identification of these cases will be agreed in partnership with local Mental Health Trusts.
- All child deaths (up to 18th birthday) – in conjunction with the Child Death Overview Panel (CDOP) process
- All stillbirths – in conjunction with nationally agreed Perinatal Mortality Review tool.

5.4 **Additional case reviews –** The Trust will also undertake additional case reviews on an ad hoc basis, for example:

- Where outlier alerts or alarms are received in relation to diagnostic groups i.e. Dr Foster or CQC.
- Where data analysis, quality or safety highlight an area for focus internally, in order inform existing or planned improvement work.
- Where cases are investigated by the Coroner, if not already a serious incident. This must not compromise any Coronial investigation and may need to be discussed with the Coroner in advance.
- Additional random case reviews will be undertaken either through central or specialty review processes.
- Where requests have been made by an external organisation, following a patient's death after leaving the care of the Trust, for the Trust to review the overall care and management.

5.5 Where a patient's death immediately raises concern this should be reported and escalated through the Trusts incident reporting process. This includes informing senior staff in relation to the case and the identified concerns; the details of the case will then be considered in line with the Serious Incident framework. A case record review should be completed as part of the investigation process; there should be no

delay in any required immediate action in order to await the outcome of a case record review.

5.6 **Case reviews**

5.6.1 Case reviews are undertaken to generate learning for improvement in healthcare, clinicians and staff should engage in a robust process of retrospective case record reviews to help identify if a death was more likely than not to have been contributed to by problems in care.

5.6.2 The review should use a recognized methodology of case record review, for example Structured Judgement Review delivered by the Royal College of Physicians or the PRISM (Hogan, 2015) methodology. The national guidance notes that assessment from case review can be subject to inter-reviewer variation, and advises that the results do not support comparison between organisations or to make external judgements around the quality of care provided.

5.6.3 The Trust is using a secure, on-line database (called Assure RCR) to facilitate the process of case record review. This has been developed in conjunction with the Academic Health Science network for the North East and other regional Trusts. The tool used for the reviews is adapted from the PRISM methodology. This tool provides a triage approach to the review and assists in identifying cases where there is the possibility of an avoidable death. The system records reviewers' judgements of the preventability of deaths and qualitative elements of the review that are suitable for identifying problems in care and opportunities for improving care. All case record reviews will, in time, need to be recorded in the system.

5.6.4 The PRISM methodology leads reviewers to identify a level of preventability on the following scale:

1. Definitely not preventable
2. Slight evidence for preventability
3. Possibly preventable less than 50-50
4. ***Possibly preventable greater than 50-50***
5. ***Strong evidence for preventability***
6. ***Definitely preventable***
7. Unable to grade

Where a death is graded "possibly preventable > then 50-50" or higher, grades 4, 5 and 6, this will then require a second review of care by a clinician external to the team who provided care. If necessary any specialist advice can be obtained from that team but the overall assessment, however the independent reviewer will finalise the assessment. If the case has not already been identified as being of concern then consideration will be made to review the cases through the incident investigation processes. This grading scale will allow the Trust to estimate the rate of preventable / avoidable deaths.

5.6.5 As part of the case records reviews, reviewers will also be asked to utilise the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading system:

1. Good practice: A standard that you would accept from yourself, your trainees and your institution.
2. Room for improvement: Aspects of clinical care that could have been better.
3. Room for improvement: Aspects of organisational care that could have been better.

4. Room for improvement: Aspects of both clinical and organisational care that could have been better.
5. Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.

Where any deficiencies in care are identified, reviewers are required to provide details of these in order to promote analysis of trends to support the identification of improvement developments to be actioned by the Trust and other organisations across the health economy.

5.6.6 When case record reviews are completed any positive learning points are also included, this allows areas of good practice to be identified and celebrated.

5.6.7 To ensure objectivity, case record reviews should wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge.

5.6.8 Engagement with colleagues in primary care will be arranged on an ad hoc basis in order to review deaths of patients where a patient's pathway may have included elements across primary and secondary care. This will support shared learning and improvement across care pathways. This is an area for further development that will be enhanced as collaboration activity increases.

6. Training and Support for staff

6.1 Any staff involved in a patient's management and death can raise concerns or request a mortality review; if they wish they can be involved in the subsequent review process. Regardless of this they will be provided with information relating to the outcomes.

6.2 Where staff members require support in relation to a specific case, this will be provided through the processes outlined in the Trust policy RM19 Procedure for Supporting Staff involved In Traumatic / Stressful Incidents, Complaints and Claims.

6.3 In order for staff to utilise the Assure system, local training and workshops are provided and can be accessed / arranged on request.

6.4 External training opportunities are also regularly in relation to mortality reviews; details of these will be circulated as when information is obtained.

7. Recording, monitoring and reporting

7.1 A report will be provided on a quarterly basis to the Patient Safety and Quality Standards Committee public Trust Board meeting outlining the overall mortality data collected over the previous quarter. This will be supported by use of a Mortality dashboard developed from the national tool.

The information provided overall will include:

- Current Trust mortality statistics such as Hospital Standardised Mortality Rate (HSMR) and Standardised Hospital Mortality Index (SHMI).
- Details of the overall number of deaths in the organisation (as described in section 5.1).

- Details of the number of cases reviewed using the structured case review process; where reviews are ongoing for compulsory reviews the numbers will be reported and updated in the following report.
- The number of deaths investigated through the Serious Incident framework; where investigations are ongoing, the numbers will also be included and updated in the following report.
- The number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care. Where investigations are ongoing, the numbers will also be included and updated in the following report.
- A summary of all trends identified, both positive and negative, to identify learning obtained and improvement measures being implemented to impact upon these.

7.2 The Trusts annual Quality Accounts will also provide a detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

7.3 Summary reports will be developed to provide clinical teams with summaries of the information logged in the Assure system following case record reviews. This will be interrogated further by the Trust Outcome, Performance and Delivery Operational Group, alongside any specialty information to initiate and enhance the Trusts overall learning and quality improvement work.

8. References, further reading and resources

"Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England"; CQC, 2016, Access via:
https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

"National guidance on Learning from Deaths", National Quality Board, 2017. Access via:
https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

"Implementing the Learning from Deaths framework: key requirements for trust boards", NHS Improvement, July 2017. Accessed on 06/09/2017 through:
https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf

"Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case review and regression analysis"; *BMJ* 2015; 351:h3239
Accessed on 06/09/2017 through: http://www.bmj.com/content/351/bmj.h3239

"Preventable Incidents, Survival and Mortality Study 2 (PRISM); Medical Record Review manual", Dr H Hogan, 2014. Accessed 06/09/2017 through:
https://improvement.nhs.uk/resources/learning-deaths-nhs/#prism

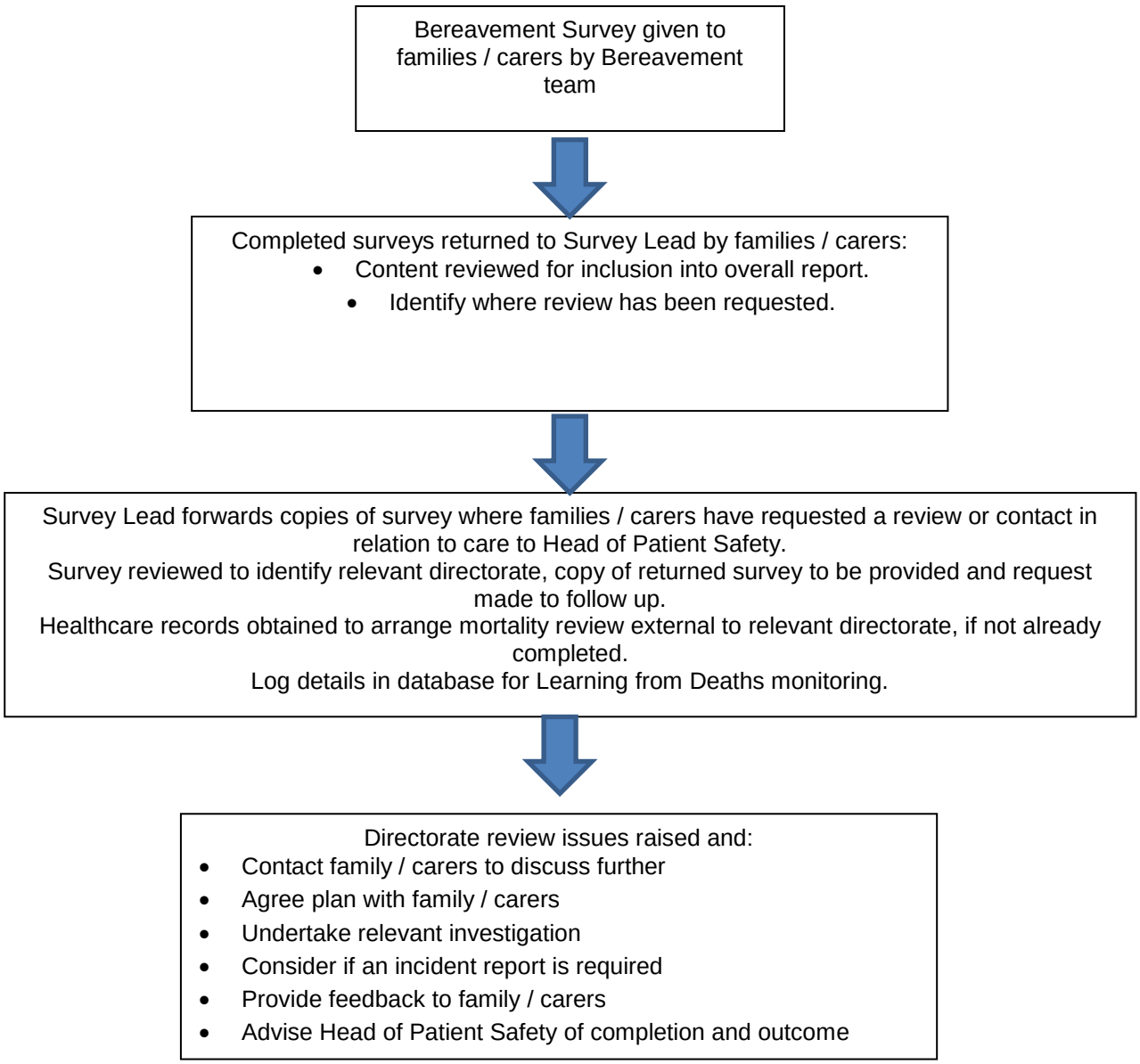
Mortality review resources:

Royal College of Physicians mortality review materials.
https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme

Learning disabilities mortality review programme http://www.bristol.ac.uk/sps/leder/

Appendix 1

Bereavement Survey follow-up process



At the time of the families / carers discussion with the Bereavement team, if the team recognise any concerns identified by the family, the Bereavement team will contact the relevant department / ward in order to provide appropriate response and reduce the need for a complaint to be made to the trust.

Appendix 2

Summary of Case Review Process