Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Learning from Deaths Policy

This procedural document supersedes: CORP/RISK 32 v.1 – Learning from Death Policy

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s)	Sewa Singh
Author/reviewer	Mandy Dalton, Mortality Review Lead
Date written/revised:	October 2017
Approved by:	Board of Directors
Date of approval:	October 2017
Date issued:	9 November 2017
Next review date:	November 2019 – **(extended to May 2020)**
Target audience:	Trust Wide

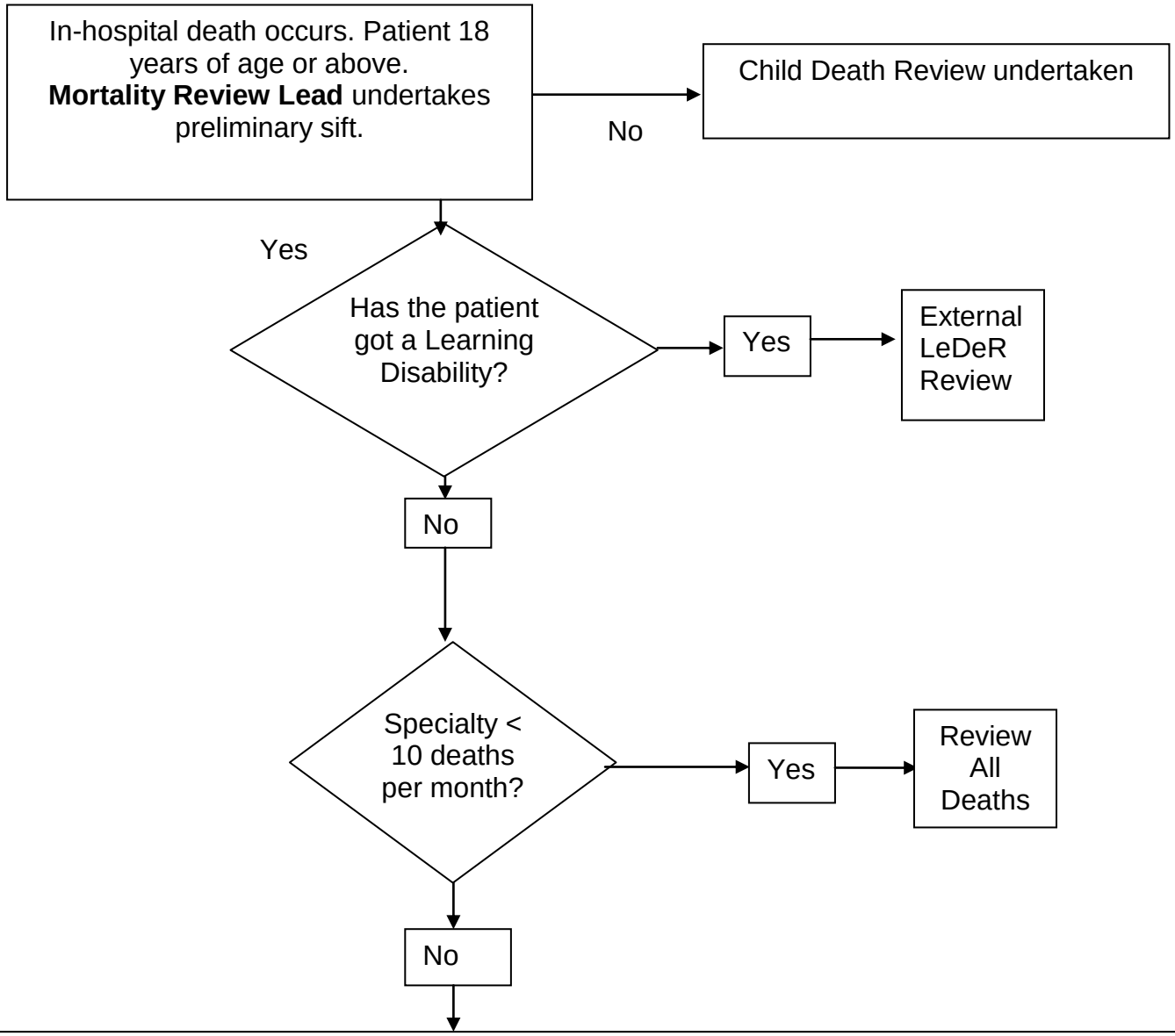
Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 2 [amended April 2019]	28 May 2019	• Appendix 2 – Mortality Review Screening Tool – has been amended/replaced with the new, agreed screening tool.	Mandy Dalton
Version 2	9 November 2017	Changes to the flowchart plus minor changes in line with NHSI template policy: • Definitions • Reference to Child death and Maternal death procedures • New requirements on reporting added • Selecting deaths for review and investigation	Mandy Dalton
Version 1	10 August 2017	• This is a new procedural document, please read in full	Mandy Dalton

Contents

Review of Death Process



Screening Applied against National Quality Board Recommendations by **Mortality Review Lead.**

Review death if the patient:

- Died unexpectedly, difficulty in identifying cause of death, clinician concern
- Has a concern raised by family or carers relating to care delivered
- Had an elective procedure or procedure where death was unexpected
- Had a severe mental health condition

- In addition to the above - all deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means will require a review via the SJR method.

- Deaths of patients on EOL care will be screened by the EOL team/Mortality review lead.

- A further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall.

1 INTRODUCTION

1.1 In December 2016, the Care Quality Commission (CQC) published its review on the way NHS Trusts review and investigate the deaths of patients in England: *Learning, candour and accountability.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

1.2 On March 21st 2017 the National Quality Board published "*National Guidance on Learning from Deaths"* which includes very specific guidance on the roles and responsibilities of the Board of Directors and the Non-Executive .It is essential that this guidance be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks.

1.3 The guidance clearly states that the learning from mortality reviews should be integral to a provider's clinical governance and quality improvement work. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

2 PURPOSE

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the Trust. It should be read in conjunction with the following policies:

- Serious Incident (SI) Policy - CORP/RISK 15
- Being Open and Duty of Candour Policy - CORP/RISK 14
- Equality Analysis Policy – CORP/EMP 27
- Fair Treatment for All Policy – CORP/EMP 4
- Complaints, concerns, comments and compliments – CORP/COMM 4
- Death of a patient – PAT T 60

2.1 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (The Trust) will implement the requirements outlined in the Learning from deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

2.2 To confirm the process and ensure a consistent and coordinated approach for the scrutiny and review of all hospital deaths, including those occurring in the Emergency department and how the process dovetails into existing governance structures.

2.3 To consider mortality rates and national mortality indicators, available at diagnosis and individual patient level.

2.4 To quality check the documentation and so ensure accurate and in depth clinical coding.

2.5 To identify any areas of practice both specific to the individual case and beyond, that could potentially be improved, based upon peer group review. Areas of good practice are also identified, acknowledged and supported.

2.6 To ensure clear reporting mechanisms are in place, to escalate any concerns, so that the Trust is aware and can take appropriate actions.

2.7 Statutory Duty of Candour will be applied to all mortality reviews as appropriate

2.8 Deaths in hospital of patients under the age of 18 years and maternal deaths are excluded from this process document because they are reviewed under other established Trust processes but learning and outcomes of these reviews are fed through to the Mortality Monitoring Group (MMG)

2.9 To engage and support families and carers who express concerns about the care given to patients who have died.

3 NEW REQUIREMENTS ON QUARTERLY REPORTING

Under the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017, the Trust is required to collect the following information every quarter :

- the total number of inpatient deaths
- the number of deaths that have been subject to case record review
- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
- the themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

This information will be published on a quarterly basis from December 2017 by taking a paper to public board meetings.

4 ROLES AND RESPONSIBILITIES

4.1 The Medical Director/ Deputy Medical Director will:

- Assure the Board that the mortality review process is in line with the National programme.
- Ensure that arrangements are in place so that all clinical staff as appropriate are aware of their responsibilities to contribute to the process.
- Provide advice to the mortality review lead and maintain an oversight of the process.
- Chair the Mortality Monitoring Group (MMG).

4.2 The Non-Executive Director will:

- Have an oversight of the mortality review processes.
- Constructively challenge and support any systems and processes linked to the review, investigation and learning of deaths.
- Ensure the Trust Board of Directors receives on a quarterly basis, data for which they can be assured is accurate and consistent.

4.3 The Trust Lead for Mortality Review will:

- Ensure diagnosis at time of admission and all co-morbidities are documented.
- Offer training and advice to colleagues involved with the mortality review process
- Chair the Mortality case note review group (MCNRG).
- Develop and maintain a robust and dynamic screening process ensuring all deaths are scrutinised.
- Ensure that any case where a relative or carer has expressed concern about quality of care has a full SJR undertaken.
- Liaise with the Trust lead for Learning disabilities to ensure accurate coding and involve them in the SJR.
- Report all deaths of patients with a learning disability to the Local Area Contact via http://www.bristol.ac.uk/sps/leder/notify-a-death/
- Arrange for cases graded as a concern by the “first reviewer” (based on phases of care scores of 3 and below) are referred to MCNRG for further review, to determine whether the death was due to a problem in care and agree any further actions.
- Feedback concerns raised at MMG to relevant specialties using the specialty governance processes.
- Ensure a random selection of “no concern ” deaths from other specialties have a 2nd review at 6 monthly intervals.
- Use the Trust incident reporting system (Datix) to report incidents identified as “serious” to enable review as part of the risk management process.

- In conjunction with the information department and clinical coding, scrutinise the HED data and ensure that external mortality alerts are investigated and any associated concerns are resolved.
- Provide monthly reports to MMG on specialty compliance with process and quarterly thematic analysis reports to specialty governance groups.
- Ensure that any actions identified in relation to mortality review are recorded, progressed and monitored.
- Ensure compliance with the Statutory Duty of Candour.

4.4 Care Group Management Teams/Clinical Governance Leads will:

- Ensure that those specialties with <10 deaths per month review ALL deaths using the Structure Judgement Review form **(Appendix 1**).
- Ensure those specialties with > 10 deaths per month can demonstrate that all notes are "screened" using the trust approved screening tool (**Appendix 2)** and at least 10 have a full SJR.
- Ensure that all findings from mortality review are reported and discussed as part of the Care Group clinical governance process, to demonstrate compliance with Care Quality Commission (CQC) Regulation 17 "Good Governance".

4.5 The Bereavement Team (DRI) and General Office (Bassetlaw Hospital) will:

- Identify all in hospital deaths.
- Ensure the first section of the mortality database is completed.
- Send all notes of patient's referred for post mortem and cremation to the mortuary (DRI patients) Post mortems for Bassetlaw Hospital patients are held at Nottingham Queens Medical centre. Notes will be sent with the body.
- Facilitate the death certification process.
- Send all notes of patients for burial to Clinical Coding once the family have received the death certificate.
- Inform the Patient Experience team of any concerns raised by families or carers who will action accordingly

4.6 The Clinical Coding Department will:

- Collect notes from mortuary twice a week.
- Code all "death notes" within agreed timescales.
- Complete the clinical coding section of the mortality data base.
- Provide support to the MMG and MCNRG.
- Work with the mortality review lead to ensure a workable process for Consultants to access notes.

4.7 Specialty Governance/Mortality Leads will:

- Be responsible for the dissemination of notes requiring mortality review. Individuals reviewing cases for which they had sole responsibility should be avoided; the case should be reviewed by a Consultant/senior clinician NOT directly involved with the case.
- Ensure that a summary of cases is discussed and minuted at the specialty clinical governance meeting and that action plans are completed and monitored.
- Provide feedback to MMG of any key learning.
- Provide reports and additional information on mortality reviews as requested by MMG.
- Receive feedback and learning points from MMG and ensure learning outcomes and action plans are included in the specialty governance and audit plans.

4.8 Reviewers will:

- Specialty reviewers will review cases within 4 weeks of receipt of the cases identified utilising the Trust's structured judgement case note review methodology and completing the Structured Judgement review form (SJR) and return it to clinical audit for data inputting.
- Mortality review group members will review those cases identified by the mortality review lead on a monthly basis.

4.9 End of Life Team will:

- Screen all case records of patients within the specialty of haematology and stroke and those who are on an individualised plan of care for the last hours/days of life and refer cases to MCNRG as indicated on the screening tool.
- Be a member of the MCNRG at DRI and Bassetlaw Hospital and participate at the monthly meetings.
- Provide input at MMG.

5 DEFINITIONS

- **Death Certification** : the process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to Coroner.
- **MMG :** Mortality Monitoring Group
- **MCNRG :** Mortality case note review group
- **Screening :** The initial review of a death against the National Quality Board's recommendations

- **SJR :** Structured judgement review is a systematic review of case notes using the agreed methodology to identify any problems in care, highlight learning opportunities to improve the care for other patients.
- **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. 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"

6 SELECTING DEATHS FOR REVIEW OR SCREENING

6.1 Child under 18

Reviews of these deaths are mandatory and should be undertaken in accordance with *"working together to safeguard children"* (2015) and the current child death overview panel.

6.2 Stillbirths, perinatal and maternal deaths

All still births and perinatal deaths will be reviewed using the current perinatal mortality review tool. All Maternal deaths will be investigated as per the Serious Incident Policy.

6.3 Adult inpatient with learning disability (LD) or serious mental health concern

The LeDeR process must be followed. All LD deaths will be reported via http://www.bristol.ac.uk/sps/leder/notify-a-death/ An external review will then be undertaken.

6.4 Elective admission deaths

All will be reviewed using the structured judgement review methodology at the Multi-disciplinary MCNRG meeting.

6.5 In patient death where a family member, carer or member of staff has raised a concern

All will be reviewed using the structured judgement review methodology (SJR) at the Multi-disciplinary MCNRG meeting.

6.6 In patient deaths within a speciality having < 10 deaths a month

All will be reviewed using the SJR by objective members of that speciality.

6.7 In patient deaths within a specialty having > 10 deaths per month

These will be screened by either the mortality review lead, End of Life team, clinical governance or mortality lead within that specialty using the agreed screening tool **(Appendix 2)** SJR then undertaken on those that trigger a review.

6.8 Deaths from a diagnosis or treatment group where an 'alarm' has been raised through HED data

These will decided on at MMG and have a SJR undertaken by the specific specialty.

7 SELECTING DEATHS FOR INVESTIGATION

Where a review carried out above identifies an overall assessment score of 1,2 or 3 the MCNRG will review the case and decide on whether a serious incident investigation should be carried out. This will be recorded onto Datix.

If an SI is not declared but the care indicates quality improvement/learning is required then this will be taken to MMG (see section 10 Learning, below)

8 SUPPORTING AND INVOLVING FAMILIES AND CARERS

- Bereaved families and carers will be given an opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.
- Bereaved families and carers will be involved in the investigation of any death that is concluded to be due to problems in care as part of the Serious Incident investigation process. They will receive an investigation report including any actions taken to ensure lessons are learned.

9 TRAINING/ SUPPORT

- Group training will be available three times a year.
- Care Group trainers will ensure that sufficient clinicians within each specialty are trained in the use of SJR.
- All reviewers will undertake at least 10 reviews per year.

10 LEARNING

- The Training and Education department will support development of educational tools to support any identified learning.
- Learning identified will be shared within the identified specialty and/or Trust wide, dependant on issue, following established clinical governance processes and structures.
- Themes will be identified as part of a quarterly thematic analysis and taken forward as Quality Improvement projects.

11 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Specialties with <10 deaths per month to undertake SJR on all cases	Mortality Monitoring group	Quarterly review of compliance	Report received at MMG and to form part of annual report to Trust Clinical Governance and Quality Committee (CGQC)meeting
Specialties with >10 deaths per month to undertake SJR on 10 cases, all others to be screened	Mortality Monitoring group	Quarterly review of compliance	Report received at MMG and to form part of annual report to Trust Clinical Governance and Quality Committee meeting
Receipt of review findings and identification of learning	Clinical Governance and Quality Committee	Annual	Care Group clinical governance report received by CGQC

12 EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 3).

13 REFERENCES

1. Hutchinson A, National Mortality Case Record Review programme. Nov 2016
2. Learning, candour and accountability. CQC. December 2016
3. National Guidance on learning from Deaths. NQB. March 2017

APPENDIX 1 – STRUCTURAL CASE NOTE REVIEW DATA COLLECTION FORM

National Mortality Case Record Review Programme: Structured case note review data collection

Please enter the following.

Age at death (years):

Gender: M/F

First 3/4 digits of the patient's postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:
Jan/Feb/Mar Apr/May/June Jul/Aug/Sept Oct/Nov/Dec

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death if known:

Guidance for reviewers

1) Did the patient have a learning disability?

1. No indication of a learning disability – proceed with this review.
2. Yes – clear or possible indications from the case records of a learning disability. Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2) Did the patient have a serious mental health issue?

- No indication of a severe mental health issue – proceed with this review
- Yes- clear or possible indications from the case records of a severe mental health issues. Action: after your review, please refer the case to the hospital's clinical governance group.

3) Is the patient under 18 years old?

- No the patient is 18 years or older – proceed with this review.
- Yes- the patient is under 18 years old. Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Child's Deaths review programme.

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Phase of care: **Care during a procedure (excluding IV cannulation)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this overall phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Please rate the quality of the patient record.

1 = very poor 2 = poor 3 = adequate 4 = good 5 = Excellent

Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here) **Yes** ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*

   Yes ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

4. **Problem with infection management Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

5. **Problem related to operation / invasive procedure** *(other than infection control)*

   Yes ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

8. Problem of any other type not fitting the categories above Yes ☐ No ☐

Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

APPENDIX 2 – MORTALITY REVIEW SCREENING TOOL

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Mortality Review screening tool

National Guidance on learning from Deaths (March 2017) mandates that when certain criteria are present, a structured judgement case note review (SJR) must be undertaken. This will help the Trust to identify the themes relating to mortality, in order to drive quality improvement work.

If "yes" is selected in any of the criteria below, your specialty governance/mortality lead will be informed. They should then facilitate the completion of an SJR.

Date of admission		Please affix patient label	
Source of admission			
Date of death			
Consultant			
GP		**Screening Completed by**	

Cause of death (as recorded on the Death Certificate if available)	
1a	
1b	
1c	
2	

Criteria for SJR		**YES**	**NO**			**YES**	**NO**
1	Do you believe the death was unexpected?			**5**	Was this death reported to the Coroner?		
2	Was the patient admitted for an elective procedure?			**6**	If the death was expected was there an absence of an individualised EOL care plan?.		
3	Did the patient have a learning disability or severe mental illness?			**7**	If the death was expected was there an absence of a "not for CPR recommendation" on a ReSPECT form?		
4	Have staff or the bereaved family raised concerns about care?			**8**	Was the admission potentially avoidable?		
If answered YES to any of the above, to go for full Structured Judgment Review							

Screening tool April 2019

APPENDIX 3 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Learning from Deaths Policy	Corporate Directorate	Mandy Dalton	Existing Policy	October 2017

1) Who is responsible for this policy? The Corporate Medical Directorate

2) Describe the purpose of the policy: To ensure scrutiny and learning following all in hospital deaths.

3) Are there any associated objectives? Compliance with best practice and CQC requirements

4) What factors contribute or detract from achieving intended outcomes? – Non-compliance with policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? NO

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	no	
b) Disability	no	
c) Gender	no	
d) Gender Reassignment	no	
e) Marriage/Civil Partnership	no	
f) Maternity/Pregnancy	no	
g) Race	no	
h) Religion/Belief	no	
i) Sexual Orientation	no	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

**If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: November 2019

Checked by: Mandy Dalton Date: October 2017