Learning from Deaths Policy and Standard Operating Procedure

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Specific staff groups to whom this policy **directly** applies	Likely frequency of use	Other staff who may need to be familiar with policy
• Medical staff • Matrons • Registered nurses on inpatient wards • Patient Safety, Assurance and Audit Service • Legal Team • Information Management & Technology Team	Weekly	This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf. Particular groups are: • Band 7 Registered nurses • Doctors in training

Owner:	**Seema Srivastava**
Consultation Route:	Mortality Review Group Quality Committee Quality and Risk Management Group Clinical Risk Operational Group Specialty Medical Leads Heads of Nursing Patient Safety, Assurance and Audit Service
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Approved by:	**Dr. Monica Baird (Chair of Clinical Effectiveness Committee)**
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1. **Introduction**

The National Health Service provides care up to patients until the end of life. Many people experience excellent care from the NHS in the months or years leading up to their death. However some patients do not experience the quality of care that they expect and to which we aspire. This can result from multiple contributory factors, which often include poor leadership and system-wide failures. When lapses in care occur, health organisations working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths is to learn in order to prevent recurrence of sub-optimal care. Reviews and investigations are only useful for learning purposes, if their findings are shared and acted upon.

2. **National Guidance Requirements**

Under the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017, trusts are required to:

- Publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patients who die under their management and care, including:

    - How their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death
    - Their evidence-based approach to undertaking case record reviews
    - The categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
    - How the trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
    - How staff affected by the deaths of patients will be supported by the trust.

- Collect specific information every quarter on:
    - The total number of inpatient deaths in an organisation's care
    - The number of deaths the trust has subjected to case record review (desktop review of case notes using a structured method)
    - The number of deaths investigated under the Serious Incident Requiring Investigation framework (and declared as Serious Incidents)
    - 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.

- Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

3. **Aim**

The aim of the mortality case note review process is to;

- Identify deaths where problems in care contributed to death and learn and act to reduce recurrence
- Review the quality of end of life care

- Ensure that patients' wishes have been identified and met
- Improve the experience of patients' families and carers through better opportunities for involvement in investigations and reviews
- Identify and minimise avoidable admissions or late presentation and to ensure that serious incidents are identified and investigated through the serious incident reporting process
- Enable informed reporting with a transparent methodology
- Identify good practice, promote organisational learning and links to the Trust Quality Improvement Programme as well as to the wider health community

4. Executive Summary

- All case notes of inpatients who died in the trust must undergo a review within 3 months of the death.
- All specialties will undertake mortality screening of all deaths in their service to identify which cases must undergo mortality case note review (MCR).
- Cases that are known **at the time of review** to be under investigation through the Serious Incident Requiring Investigation Framework process and cases going through Coroner's investigation and/or inquest process will not undergo a separate MCR review on the Trust electronic system but will be included as having been reviewed.
- Any MCR which concludes that the Overall Phase of Care is "Poor" or "Very Poor" will result in an automatic notification to the Patient Safety, Assurance and Audit Service (PSAAS). PSAAS will contact the Specialty Risk Lead who will arrange for an incident to be reported on Datix. The Division reviews the case to determine whether or not it meets the threshold of a SIRI; Datix Incident module will be updated to reflect the outcome.
- If the above review determines that the case meets the threshold of a SIRI, the SIRI policy will be followed.
- All Specialties must share learning from case note reviews with their teams and across other teams (where appropriate) through their specialty and divisional clinical governance processes and demonstrate where appropriate, actions for improvement.

5. Ownership and Responsibilities

5.1 The Trust Board will;

- Review monthly data from the mortality review process through the monthly Integrated Performance Report and quarterly board paper.

5.2 The Non-Executive Director Sponsor will;

- Ensure the processes in place for Mortality Review are robust, focus on learning and can withstand external scrutiny, by providing challenge and support.
- Ensure that quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change.
- Ensure the information the provider publishes is a fair and accurate reflection of its achievements and challenges.

5.3 The Medical Director will;

- Assure the Board that the mortality review process is functioning correctly.
- Ensure that arrangements are in place so that all clinical staff are aware of their responsibilities to contribute to the process.

5.4 The Trust Lead for Mortality Review will;

- Offer advice to colleagues involved with the mortality review process.
- Review numbers of completed case note reviews in each specialty and challenge the specialty leads in areas of low completion.
- Ensure that external mortality alerts are investigated and any associated concerns are resolved.
- Chair the Trust Mortality and Morbidity Review Group (MMRG) which will oversee the learning from deaths process.
- Feedback concerns raised at the MMRG to relevant specialties using the specialty governance processes.
- Ensure that learning themes from MCRs are linked to Quality Improvement and Patient Safety work.
- Ensure that deaths where learning will inform existing or planned improvement work are reviewed thematically to maximise learning.

5.5 Divisional Clinical Directors will;

- Ensure that mortality reviews are completed by nominated consultants. Individuals reviewing cases for which they had sole clinical responsibility should be avoided where possible; ideally, the case should be reviewed by a consultant not directly involved with the case although it is accepted that in some specialties this may not be achievable.
- Ensure that regular specialty mortality meetings are held to review all deaths, keeping a summary of the cases discussed, the findings and the management plan agreed upon.
- Ensure feedback to teams of key learning from Speciality mortality meetings across the Division.
- Receive feedback and learning points from the MMRG and ensure learning outcomes and action points are included in the specialty governance audit plans as appropriate
- Ensure that the specialty fully investigates mortality alerts as directed by the Trust Lead for Mortality Review and MMRG.

5.6 Specialty Mortality Leads will;

- Ensure that all cases of death occurring within their specialty are reviewed using the trust screening process and/or the MCR tool.
- Must become trained reviewers for their specialty.
- Ensure that the learning from speciality morbidity and mortality meetings is disseminated to their teams.
- Ensure that actions from these meetings are logged and updated as actions are closed.
- Review reports from speciality morbidity and mortality meetings to capture learning from mortality review within specialities.
- Ensure that the findings from mortality reviews are logged and discussed as part of the divisional clinical governance process.
- Raise any previously unidentified risk onto the Trust Risk Register, where it will be reviewed as part of the risk management process.

5.7 Reviewers will;

- Review routine cases using the MCR tool within 3 months of receipt of the case notes and priority cases within 4 weeks.
- Grade the management of inpatient care as indicated on the electronic Trust mortality review tool based on any concerns or good care highlighted.
- Use the Trust incident reporting system to report incidents identified during mortality review to enable review as part of the risk management process.

5.8 The Mortality and Morbidity Review Group (MMRG) will;

- Oversee specialty mortality review structure, process and actions.
- Capture and respond to external and internal mortality trends.
- Ensure cross divisional learning from mortality review.
- Ensure the board and executive is informed of mortality outcomes and trends.
- Ensure the delivery of the mortality review process on behalf of the Clinical Effectiveness and Audit Committee.

5.9 Patient Safety Assurance & Audit Service (PSAAS) will;

- Receive a daily list of in-hospital deaths from Information Services.
- Manage the electronic MCR tool.
- Collate information on post mortems, serious incidents, complaints and inquests and link with other mortality data.
- Allocate case notes to Reviewers.
- Provide updates to specialties, divisions and the MMRG on participation rates for mortality review and support in the identification of any gaps.
- Ensure that any death where overall care has been scored as Very Poor or Poor (based on the grading system on the mortality screening tool form) is recorded centrally..
- All MCRs that score poor or very poor are reviewed by the Division where the patient died as a possible serious incident. The Division will report on Datix as an incident and update the manager's investigation section with the outcome. If this review determines that the case meets the Serious Incident Requiring Investigation (SIRI) threshold, it will be discussed at EIRG and declared as a SIRI.
- Provide support to clinicians with any questions regarding the process.
- Provide monthly mortality trend data to the MMRG.
- Prepare monthly reports for Specialties, MMRG and Quality Committee.
- Provide mortality data and prepare reports to meet the Trust's board, divisional, performance and commissioner reporting requirements.
- To report externally to the overseeing national bodies.
- Provide information of deaths in hospital where a serious incident has already been identified and being currently investigated.
- Coordinate the Serious Incident process if a reviewer has identified a serious incident through the MCR tool.

5.10 Information Management and Technology Services will;

- Provide a daily list of in-hospital deaths to PSAAS.
- Provide a list of patients who die who have Learning Disability once the means of identifying such patients in the patient administration system is identified and implemented.

6. Mortality & morbidity meetings (M&M)

Participation in mortality and morbidity (M&M) meetings must be considered a core activity for all medical staff and senior nursing staff. Whilst it is recognised that different departments will have different requirements and aims in relation to M&M meetings, the main principles are that they must be a forum for discussion of deaths and other clinical adverse events.

In cases where a reviewer has given an Overall Care Score of Poor or Very Poor, the M&M will discuss the case and consider learning and any subsequent actions.

The overall aim is to learn lessons from clinical outcomes and drive improvements in service delivery. The M&M meeting has a central function in supporting services to achieve and maintain high standards of care. A log of learning and actions must be maintained and updated as actions are closed.

7. Feedback to staff

It is recognised that clinicians need to be kept informed of the outcomes of their work if they are to learn and improve. It is therefore essential that there is a mechanism for the outputs of the mortality governance process to be fed back to clinical staff including plans for improvement, lessons learnt and pathway redesign. Dashboards showing outcomes at individual / team / ward / department level will be developed and form part of the mortality review reports to specialties, divisions and the MMRG. Clinical teams must review these dashboards as part of their governance processes.

8. Supporting Families

Clinical teams must meaningfully and compassionately engage with bereaved families and carers - this should include informing the family/carers if the Specialty intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved. Bereavement Services will ask families if there are any concerns that they would like to raise about the patient's care. In the event of a concern, the consultant responsible for the patient's care must be informed and arrangements made to contact the family for further action.

In cases where Overall Care has been judged to be Very Poor or Poor, Duty of Candour must be applied and families supported through this process.

If families require support or advice in relation to a death then they can find further information at:-
https://www.gov.uk/after-a-death/overview

http://www.ageuk.org.uk/money-matters/legal-issues/what-to-do-when-someone-dies/what-to-do-first-when-someone-dies/

9. Maternal Deaths, Neonatal Deaths and Stillbirths

All maternal deaths and neonatal deaths are investigated as a Serious Incident through a Root Cause Analysis investigation route and reported to MBRRACE (Mothers and Babies: Reducing Risks through Audits and Confidential Enquiries) and CDOP (Child Death Overview Panel). The majority of stillbirth deaths will be reviewed under the Each Baby Counts tool.

10. **Children (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 processes.

11. **Learning Disability**

Any patient with Learning Disability who dies as an inpatient must be notified to the Patient Safety, Assurance and Audit Service and as a minimum undergo a full MCR.

Upon notification, details will be added to the LeDeR Portal to ensure the case is considered in line with the national LeDeR processes.

12. **Deaths Highlighted by Other Organisations**

If another organisation suggests that the Trust should review the care they provided to a deceased patient in the past where a patient has not died under the care of the trust at the time of death, an MCR will be undertaken.

13. **Communication to Other Organisations**

Where there is learning from a MCR that other organisations may benefit from, this must be communicated to those agencies, for example Primary Care or other hospitals where the patient received care prior to their death. This will be determined at Specialty Mortality Meetings.

14. **Standard Operating Procedure (APPENDIX A)**

The procedure to be followed can be seen in the flow chart. Please see Appendix A.
The process consists of the following stages:
- Screening of all deaths
- Mortality Case note Review (MCR) - detailed review of all deaths meeting the criteria following screening and a random selection of those not screened in relevant specialties
- Mortality Review Meeting discussion within each specialty
- Escalation using the incident reporting framework
- Reporting of outcomes and sharing of learning
- Link to LeDeR Portal

14.1 Screening

All deaths will be screened to identify if they meet the criteria for full mortality case note review. These cases must be screened with involvement from the consultant responsible for the patient's care.

Those deaths that meet any of the criteria in the screening tool require MCR and discussion at the specialty mortality review meeting. The screening process covers the following issues to ensure they are included for MCR:

- Deaths in elective care
- Deaths in patients with learning difficulties
- Deaths in patients with Serious Mental Illness (SMI)
- Deaths where there are significant family or staff concerns or complaints
- Deaths where there may be important lessons to be learned for the team or department (these lessons may be areas of excellence as well as areas to improve)

- Deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator)
- For deaths in a service specialty where at Coroner's investigation or inquest, a "Regulation 28 Report on Action to Prevent Future Deaths" is issued, any related MCR will be reviewed in order to examine the effectiveness of the screening and MCR process

14.2 Sampling

A sample of cases will be allocated for full mortality case note review to provide assurance and identify if any further learning can be gained from cases not meeting the criteria for full review.

14.3 Mortality Case note Review

The Patient Safety Assurance & Audit Service will upload and allocate cases to the relevant specialties.

MCRs require completion by a trained reviewer. All mortality leads must become trained reviewers, and each specialty must contribute to producing MCRs. Reviewers can be from different professions including consultants, Specialty Trainee grades 3+, Specialist nurses, advanced nurse practitioners, Registered Nurses Band 7+.
Cases must be reviewed within 3 months of the death.

If a death occurs in a specialty where there was delivery of care by another specialty either before or during the last care episode, which is relevant to the mortality review, the allocated specialty may do the following from the trust mortality review lead:
- Complete the MCR and send a report to the other specialty asking for the case to be discussed at their specialty mortality review meetings
- Request that the allocation of the case for mortality review be transferred to that specialty for completion
- Complete the MCR jointly with the other specialty (the online allocation will remain with the original specialty)

Requests are subject to the Trust mortality review lead's approval.

14.4 Escalation and Duty of Candour

The MCR has a scoring system for each phase of care from Very Poor to Excellent. Where a case is reviewed and overall care has been scored Very Poor or Poor, a clinical incident electronic form must be completed with consideration of whether the death should be reported as a serious incident for investigation. As with all incidents, processes described in the incident policies (including Being Open and Duty of Candour) must be followed where applicable.

14.5 Mortality Review Meetings

Specialty mortality review meetings must take place regularly, in the majority of cases, monthly, for specialties that have deaths most months. If deaths are less frequent than this, then a mortality review must take place at a specific meeting or general governance meeting to ensure that learning takes place as soon as possible after the death and no later than 3 months after the death has occurred. Mortality review meetings may form a component of a morbidity (M&M) meeting, and in specialties with very few deaths, may be part of the specialty governance meeting.

Mortality Review Meetings should meet the following processes:

- Be led by the designated mortality lead, responsible for the organisation of the meeting.
- Be multi-disciplinary, with attendance from consultants, junior doctors, nurses, therapists, and other staff where appropriate.
- Where necessary, be held jointly on a regular basis with other specialties e.g. anaesthetists and surgeons.
- Facilitate an open, honest and constructive discussion of cases with a no-blame culture
- Commence with a summary and update from action points that arose from the previous meeting.
- Review, and seek to understand, the numbers and causative factors of deaths in the specialty, looking at recent data and trends.
- The Mortality Lead and the person conducting the SCRs must decide which deaths should be allocated the most time for discussion.
- Cases must be presented including information about:
  - Phases of care; admission, ongoing care, peri-operative care (if appropriate), end of life care
  - Highlighting areas of good practice/excellence
  - Identifying areas for improvement
  - Use of literature review, where appropriate
  - Identifying points for discussion
  - Identifying potential learning points
  - Initial recommendations by reviewer
  - Opened up for discussion of potential action points
- The patient must only be identified by age, sex and hospital number.
- After discussion, action points should be made with clear timeframes, allocated to specific individuals and recorded in an action log.

15. Recording, Reporting and Sharing of Learning

Specialty Mortality Meetings
Specialty mortality review meetings must have meeting notes, summarising the cases discussed, whether they were MCRs, the main discussion points, and learning points and action points, and stored on a shared Division Drive.

- A register of attendance must be collected and stored with, or as part of, the meeting notes to provide evidence of who was present at the meeting.

A summary of learning from specialty mortality review meetings must be available to the MMRG.

16. Monitoring Compliance and Effectiveness

Monthly data on performance will be reviewed in the Trust-wide Integrated Performance Report. This report will show how many Screens and MCRs have been completed at a specialty level, how many cases reviewed were judged as having care delivery problems which contributed to death, how many cases of patients with Learning Disability or under the Mental Health Act were reviewed and how many deaths were investigated via the Serious Incident Framework (declared as Serious Incidents). This data will also be reported nationally.
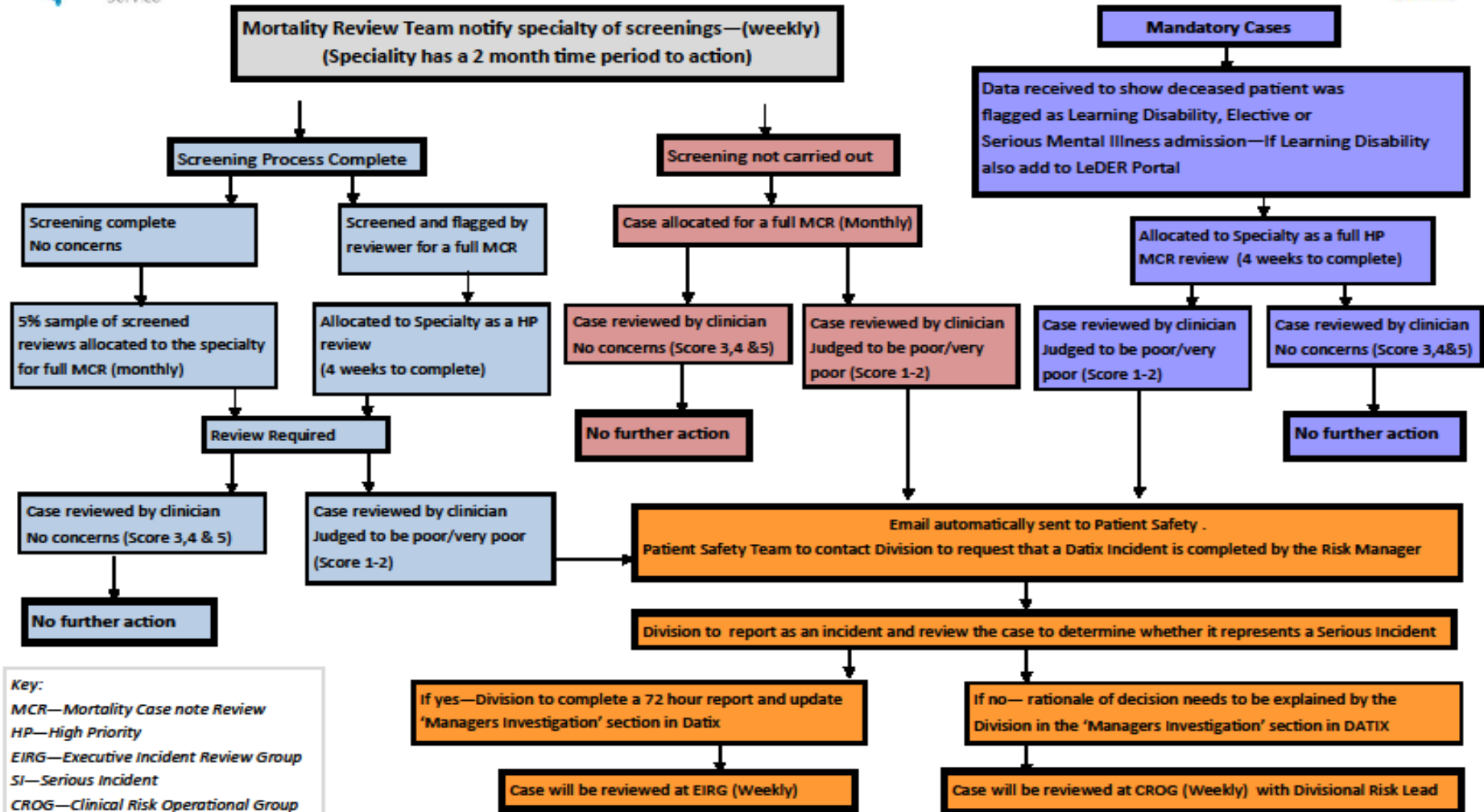
17. References

- NHS England, Mortality Governance Guide
- Morbidity & Mortality Meetings: A guide to good practice, Royal College of Surgeons (2015)
- Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England.

Mortality Review Screening Process

Patient Safety Assurance & Audit Service

NHS North Bristol NHS Trust

Mortality Review Team notify specialty of screenings—(weekly) (Speciality has a 2 month time period to action)

Mandatory Cases

Data received to show deceased patient was flagged as Learning Disability, Elective or Serious Mental Illness admission—If Learning Disability also add to LeDER Portal

Screening Process Complete

Screening complete No concerns

Screened and flagged by reviewer for a full MCR

Screening not carried out

Case allocated for a full MCR (Monthly)

Allocated to Specialty as a full HP MCR review (4 weeks to complete)

5% sample of screened reviews allocated to the specialty for full MCR (monthly)

Allocated to Specialty as a HP review (4 weeks to complete)

Case reviewed by clinician No concerns (Score 3,4 &5)

Case reviewed by clinician Judged to be poor/very poor (Score 1-2)

Case reviewed by clinician Judged to be poor/very poor (Score 1-2)

Case reviewed by clinician No concerns (Score 3,4&5)

Review Required

No further action

No further action

Case reviewed by clinician No concerns (Score 3,4 & 5)

Case reviewed by clinician Judged to be poor/very poor (Score 1-2)

Email automatically sent to Patient Safety . Patient Safety Team to contact Division to request that a Datix Incident is completed by the Risk Manager

No further action

Division to report as an incident and review the case to determine whether it represents a Serious Incident

If yes—Division to complete a 72 hour report and update 'Managers Investigation' section in Datix

If no— rationale of decision needs to be explained by the Division in the 'Managers Investigation' section in DATIX

Case will be reviewed at EIRG (Weekly)

Case will be reviewed at CROG (Weekly) with Divisional Risk Lead

Key:
MCR—Mortality Case note Review
HP—High Priority
EIRG—Executive Incident Review Group
SI—Serious Incident
CROG—Clinical Risk Operational Group

Please note—Perinatal Mortality go through their own mandatory process

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