Policy Document

Reference: RM14

University Hospitals of North Midlands NHS Trust

Learning from Death Reviews

Version:	**3**
Date Ratified:	**August 2023 by Quality & Safety Oversight Group**
Date Issued:	**September 2023**
To Be Reviewed Before:	**August 2026**
Policy Author:	**Head of Quality, Safety & Compliance Department**
Executive Lead:	**Medical Director**

Version Control Schedule

Version	Issue Date	Comments
1	July 2017	Policy developed in response to national guidance issued in April 2017
2	February 2019	Policy reviewed and updated job titles and committee reporting structures.
3	September 2023	Policy reviewed as part of formal review process. Included agreed permanent arrangements for nosocomial COVID-19 related deaths. Updated to reflect new Divisional Structure and job titles. Committee reporting structures updated Updated to COVID-19 section and included autism in LeDeR

Statement on Trust Policies

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed here

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NHS
University Hospitals of North Midlands
NHS Trust

Review Form / Equality Impact Assessment (EIA)

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Analysis Form is designed to help consider the needs and assess the impact of each policy. To this end, EIAs will be undertaken for all policies.

Policy Reference, Title and Version Number	RM14 Learning from Death Reviews Policy
Summary of changes made on this review	Policy reviewed as part of formal review process. Included agreed permanent arrangements for nosocomial COVID-19 related deaths. Updated to reflect new Divisional Structure and job titles.
Please list which service users, staff or other groups have been consulted with, in relation to this	Mortality Review Group on 30th May 2023
Were any amendments made as a result? If yes, please specify	
Does this policy involve the administration or control of medicines? If yes, have the Safe Meds Group been consulted with?	N/A
Which Executive Director has been consulted?	Medical Director

Does this policy have the potential to affect any of the groups listed below differently - please complete the below. Prompts for consideration are provided, but are not an exhaustive list

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	**Actions taken to mitigate negative impact** *(e.g. what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet to mitigate)*
Age (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)	N		
Gender (e.g. is gender neutral language used in the way the policy or information leaflet is written?)	N		
Race (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)	N		
Religion & Belief (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered)	N		
Sexual orientation (e.g. is inclusive language used? Are there different	N		

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	**Actions taken to mitigate negative impact** *(e.g. what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet to mitigate)*
access/prevalence rates?)			
Pregnancy & Maternity (e.g. are procedures suitable for pregnant and/or breastfeeding women?)	N		
Marital status/civil partnership (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)	N		
Gender Reassignment (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)	N		
Human Rights (e.g. Does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)	N		
Carers (e.g. is sufficient notice built in so can take time off work to attend appointment?)	N		
Socio/economic (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)	N		
Disability (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.	N		
Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? (e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)			**No**
Will this policy require a full impact assessment and action plan? (a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - please contact the Corporate Governance Department for further information)			**No**

1. INTRODUCTION

Concern about patient safety and scrutiny of mortality rates has intensified recently with high-profile investigations into NHS hospital failures combined with the Dr Foster report and patient safety rating for NHS Trusts. There is an increased drive for Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

Effective clinical audit and peer review processes incorporating analysis of mortality and morbidity contribute to improved patient safety. The specialty M&M meetings, established to review deaths as part of professional learning, also have the potential to help provide assurance that patients are not dying as a consequence of unsafe clinical practices.

Concentrating attention on the factors that cause deaths will impact positively on all patients, reducing complications, length of stay and readmission rates through improving pathways of care, reducing variability of care delivery, and early recognition and escalation of the deteriorating patient

Retrospective case note reviews help to identify examples where processes can be improved and gain an understanding of the care delivered to those whose death is expected and inevitable to ensure they receive optimal end of life care. UHNM has been undertaking reviews of in hospital deaths across all specialties since November 2015 and reporting to the QAC, Trust Board and Commissioners on outcomes of these reviews. In response to the CQC's Learning from Deaths Review (December 2016) and National Quality Board guidance (April 2017), UHNM updated its review processes.

The updated process also addressed the Care Quality Commission's publication in December 2016 of a review into the way NHS Trusts review and investigate the deaths of patients, 'Learning, candour and accountability' which builds on the need to maximise learning from deaths.

This standardised Trust-wide process integrating mortality peer reviews into the governance framework will provide greater levels of assurance to the Trust Board and help to ensure that the organisation is using mortality rates and indicators alongside others such as incidents and complaints to monitor the quality of care and share good practice and learning from mistakes.

This policy should be read in conjunction with the following:

- RM07 Adverse Incident Reporting and Investigation (including Serious Incident)
- RM12 Duty of Candour

An "Equality Impact Assessment" has been undertaken and no actual or potential discriminatory impact has been identified relating to this document.

2. SCOPE

The policy applies relates to the following staff groups who may be involved in the mortality review process:

- Medical Staff
- Senior Nursing Staff
- Clinical Coding Staff
- Clinical Audit & Effectiveness Staff
- Performance Analysts
- Quality Improvement Staff
- Governance Staff
- Bereavement and Medical Examiner Staff

The mortality peer review process is applicable to:

- Identified minimum categories of in-hospital deaths in all specialties

- Diagnosis groups identified by CQC
- Diagnosis groups identified by the Mortality Review Committee following review of Healthcare Evaluation Data (HED) system.

The minimum categories for review using the Royal College of Physicians Structured Judgement Case Review (SJR) are:

- All Elective Surgical / interventional procedure Deaths
- All Patients with learning disabilities, autism and severe mental health illness (excluding patients with dementia unless under MHA)
- All deaths where complaint raised serious concerns about the care provided
- All deaths within a Specialty where mortality alert has been received
- Infant / Child Death
- Stillbirth
- Maternal Death
- Random Sample of other deaths (minimum 10%)

Deaths within 30 days post discharge from UHNM
UHNM will focus reviews on in-patient deaths in line with the criteria specified by the National Quality Board. In cases highlighted to the Trust of people who had been an in-patient but die within 30 days of leaving hospital, UHNM will review these where concerns are identified.

In-patient deaths; Definite and Probable Hospital Onset COVID-19
In line with NHS E/I guidance all in-patients who have died with definite or probable hospital onset COVID-19 will have their care reviewed. COVID-19 associated deaths (hospital onset) are not an automatic trigger for an SJR. The Trust will continue to identify and review these deaths as part of ongoing M&M processes within specialties.

All completed SJRs that identify poor or very poor care at any stage in the patient's pathway must be subject to review at local M&M Meeting. In any case where there is a concern that a death might require investigation as a serious incident this must be escalated to both the Divisional Governance Team and the Quality, Safety & Compliance Department Team.

All adult deaths that occur within UHNM are reported to the Bereavement and Medical Examiner Service which oversees the death certification process and referrals to HM Coroner. The Bereavement and Medical Examiner Service staff have a pivotal role in liaising with families and carers and as part of this liaison role, will ask families if they have any concerns about the quality of care. Should any concerns be expressed these will be recorded by the Bereavement and Medical Examiner Service. Any significant concerns relevant to the quality of care of a deceased patient will be notified by the Bereavement and Medical Examiner service to the Quality, Safety & Compliance Department, any serious incidents will also be reported to HM Coroner for investigation

3. DEFINITIONS

Investigation: a detailed, thorough, systematic inquiry into an occurrence or omission.

Adverse incident: an event or omission, which caused physical or psychological injury to a patient, visitor or staff member or any event or circumstances arising during NHS care that could have or did lead to unintended or unexpected harm, loss or damage.

Serious Incident: one where serious actual harm has resulted.

Near miss: a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as a result of compensating action, thus preventing injury to a patient

Mortality rate: The mortality rate (or death rate) is a measure of the number of deaths that occurred during a particular time period divided by the total size of the population during the same time frame. It is typically expressed in units of deaths per 1,000 individuals per year.

Mortality Review Process: is a structured methodology for retrospective case note review following a patient's death to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care, and identify learning, plans for improvement and pathway redesign where appropriate.

Learning: The process of gaining experience or knowledge/skills from learning from incidents, complaints and claims in order to identify the root cause and prevent a reoccurrence.

RCP Structured case review: is a structured method of reviewing a death, looking at first 24 hours, then main part of hospital stay and then end of life care

4. ROLES AND RESPONSIBILITIES

Trust Board

The Trust Board has a responsibility to ensure that the review of identified deaths is undertaken and analysis of individual and aggregated deaths is undertaken to optimise the recognition of trends and themes and enable a swift response and sharing of learning.

Quality Governance Committee (QGC)

The QAC, on behalf and with delegated authority from the Trust Board, is responsible for ensuring that identification, reporting, investigating and learning from deaths is undertaken.
The QAC will seek assurance that any issues and themes identified are responded to and actions taken and receive a Quarterly Report which includes total number of deaths, number subject to case record review, numbers investigated as Serious Incident, Number of deaths where it is thought 'more likely than not' that problems in care contributed, themes and issues identified through review and changes that have been made as result of the process, lessons learnt.

Executive Quality & Safety Oversight Group (QSOG)

The QSOG will receive a quarterly report if an incident, complaint or claim trend is identified which represents a serious risk to patient safety. This group has the responsibility for ensuring that the Trust has an aggregated approach to the management of complaints, claims and incidents. The QSOG will receive quarterly Quality reports for safety, patient experience and 6 monthly for Claims

Mortality Review Group (MRG)

The MRG will be responsible for:

- Providing assurance to the Trust Board and QGC on patient mortality based on review of care received by those who die
- To receive report identifying
    - total number of deaths,
    - number subject to case RCP structured case review,
    - numbers investigated as Serious Incident,
    - number of deaths where it is thought 'more likely than not' that problems in care contributed,
    - themes and issues identified through review and changes that have been made as result of the process.
    - lessons learnt
- Agreeing and approving the Trust mortality review proforma and any subsequent amendments / revisions
- Review Trust HSMR and SHMI data and identify any potential 'hotpsots' for further review
- Reviewing M&M outcomes, audit data and action plans
- Identifying areas of high risk and agreeing and monitoring improvement plans

- Ensuring that feedback and learning points are shared with the divisions and specialties so that learning outcomes and action points are included in the specialty audit programmes as appropriate

Where there is disagreement at local Mortality & Morbidity Review Meetings on the grading of a death then these will be escalated to the Mortality Review Group for discussion and review to identify second independent review.

Directorate / Specialty Mortality & Morbidity Meetings

Directorate / Specialty, led by the agreed Mortality Lead, will undertake monthly M&M Meetings. Outcomes of the cases discussed and reviewed will be shared across the Directorate / Specialty and summary forwarded to Quality, Safety & Compliance to identify any learning and outcomes of the deaths reviewed.

Reviewed deaths will be entered on to the Trust's online review proforma, within Datix, to allow for collation of results and outcomes of deaths reviewed outside of the Mortality Peer Review Group.

Chief Executive

The Chief Executive is ultimately responsible for ensuring the safety of patients, visitors and staff within the organisation. It is therefore the Chief Executive's responsibility to;

- Ensure that there are robust systems in place to identify trends and themes from deaths and that measure are taken to ensure that the safety of patients, staff and visitors is not compromised.
- Ensure there are robust systems in place to learn lessons across the organisation and cross organisationally where possible.
- Ensure that this policy is implemented within all areas of the organisation through responsible Executive Directors, Clinical Directors and Associate Directors.

Medical Director

The Medical Director (or Deputy) is responsible for supporting the Chief Executive and Trust Board in their responsibilities. Through the Trust Quality, Safety & Compliance Department, the Medical Director is responsible for ensuring the production of the Learning from Deaths report and management of the review process.

Medical Examiner

Death Certification: In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when fully implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical Examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the Coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

UHNM will ensure that bereaved relatives are provided with a chance to express any concerns they may have around care associated with a death via the Bereavement and Medical Examiner Service (see section 5).

Quality, Safety & Compliance Department

Quality, Safety & Compliance Department is responsible for ensuring this policy is implemented by the Quality, Safety & Compliance Department and quarterly reports are submitted to MRG, QSOG, QGC and Trust Board.

Quality, Safety & Compliance Department will coordinate the notification of deaths for review on monthly basis with the support of the Outcomes Facilitator and Quality Systems Team to the Directorate / Specialty Mortality leads to ensure that deaths are reviewed and assessment on the care provided is completed using the online proforma.

Head of QSC will produce a quarterly and annual report on behalf of the Medical Director and Mortality Review Group to be presented at QSOG and Quality Governance Committee and included in report to the Trust Board

- total number of deaths,
- number subject to case record review,
- numbers investigated as Serious Incident,
- number of deaths where it is thought 'more likely than not' that problems in care contributed,
- themes and issues identified through review and changes that have been made as result of the process.
- lessons learnt

Directorate / Specialty Mortality Leads
Have a responsibility for the day-to-day implementation of this policy, ensuring that deaths within the individual specialties/directorates are reviewed in a systematic way, encouraging learning and promoting improvements via the local Mortality & Morbidity Meetings.

The Mortality Leads will ensure that deaths are reviewed by an independent Consultant from within the Specialty/Directorate who was not directly involved in the care and treatment of the patient.

Ensure the Directorate/Specialty are completing of the online version of the RCP Joint Structured Review Proforma for all adult deaths on the Trust Datix system and bespoke mortality review forms. The reviews will provide conclusion on the rating of the care provided and whether there were any problems with the care that may have resulted in harm to the patient.

Infant or child (under 18) death reviews should be undertaken in accordance with national guidance "Working Together to Safeguard Children". The Department for Education's 'Form C' should be used as a reporting template.

The Mortality Leads will present on an annual basis to the Mortality Review Group to provide assurance that meetings are being held, attendance, outcomes from meetings and learning identified and actions taken / planned.

They are supported by the Clinical Directors, Associate Directors, Head of Quality, Safety & Compliance and Divisional Governance & Quality Managers. The Datix electronic reporting system will be used to allow the information relating to mortality reviews to be collated and presented in monthly and quarterly mortality reports.

Directorate / Specialty Clinical Leads
The Clinical Leads will be responsible for ensuring that where a query is received from another Directorate / Specialty, the query is acknowledged and responded to within 4 weeks of the query being received.

Divisional Medical Directors / Divisional Operations Director / Divisional Nurse Director / Divisional Quality & Safety Manager
The Divisional Medical Director, Divisional Nurse Director, Divisional Operations Director and Divisional Quality & Safety Managers are responsible for:

- Ensuring in hospital deaths are appropriately investigated within the Divisions; identifying any trends or reoccurring themes.
- Providing feedback to the Divisional Governance meeting to ensure learning, improvements and risk reduction measures takes place.
- Discuss the quarterly Learning from Deaths Report at the Divisional Governance meetings.
- Assure the Risk Management Panel that lessons learned and risk reduction measures for incidents, complaints and claims are being implemented within the Divisions/Directorates as and when required.

5. SUPPORT, NOTIFICATON AND INVOLVEMENT OF BEREAVED FAMILIES / CARERS

Bereavement and Medical Examiner Service will provide Bereaved Families and Carers with support and information on the Trusts Learning from Death Review process and contact details to discuss reviews and further questions if required.

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

Identify clearly the arrangements for training and support etc. establishing how to ensure the policy is implemented. If training is required ensure the method of documenting the training is also included which should be recorded within the individual staff member's personal record, ideally within ESR.

Help and advice can be sought from the Head of Quality, Safety & Compliance.

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

Report will be provided to the Mortality Review Group, Executive Clinical Effectiveness Group and Quality Governance Committee which outlines the outcomes of the reviews undertaken and themes from the completed reviews.

Reviewing the effectiveness of the policy will be undertaken by the Mortality Review Group utilising:

- Directorate / Specialty M&M Presentations
- Monthly and quarterly reports on mortality outcomes and indicators including the completion rate of requested reviews.
- Monthly reports to M&M Leads, Divisional Clinical Governance Leads and Divisional Medical Directors will be provided on completion rates for each Directorate / Specialty.

The Trust reserves the right to change its monitoring method requirements subject to the needs of the Organisation. Where changes to methods are made, the Trust document should be reviewed and re-presented to the Quality and Safety Oversight Group for approval.

7.2 Review

This policy will be reviewed three yearly or earlier in light of new national guidance or other significant change in circumstances.

8. REFERENCES

Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England Care Quality Commissions 2016

National Guidance on Learning from Deaths National Quality Board 2017