University Hospitals of North Midlands
NHS Trust

Policy No. RM14
Learning from Death Reviews Policy

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All Trust Staff**

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Ratified By:	**Quality and Safety Forum**
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Trust Contact:	**Head of Quality, Safety and Compliance**
Executive Lead:	**Medical Director**

Version Control Schedule (RM14)

Final Version	Issue Date	Comments
1	September 2017	Policy developed in response to national guidance issued in April 2017 and internal consultation.
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Statement on Trust Policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands NHS Trust aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation 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 Assessment tool is designed to help you consider the needs and assess the impact of your policy.'

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Act 1998 and the NHS Confidentiality Code of Practice
The Data Protection Act (DPA) provides a framework which governs the processing of information that identifies living individuals. Processing includes holding, obtaining, recording, using and disclosing of information and the Act applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers staff personnel records. The DPA provides a legal gateway and timetable for the disclosure of personal information to the data subject (e.g. health record to a patient, staff file to an employee).

Whilst the DPA applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates the requirements of the DPA and other relevant legislation together with the recommendations of the Caldicott report and medical ethical considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of complaint. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act
Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections
The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights
The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development
University Hospitals of North Midlands NHS Trust recognises the impact that its operations have on the environment as well as the strong link between sustainability, climate change and health. The trust is committed to continual improvement in minimising the impact of activities on the environment and expects all members of staff to play their part in achieving this goal. The Green Aware Campaign is designed to support you to do this. All trust policy should embed sustainability and refer to our Sustainable Development Management Plan where relevant. Further information and guidance can be obtained from the Trust Sustainability Manager.

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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 have 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 has updated its review processes.

The updated process will also address 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. STATEMENT

The policy has been written to provide guidance for all staff involved in mortality peer reviews including clinicians, clinical coding, governance, performance analysts, end-of-life and palliative care, and clinical audit and effectiveness staff.

The aim of the mortality peer review process is to:

- Identify and minimise 'avoidable' deaths in all Trust hospital sites
- Review the quality of end of life care and link with End of Life Group
- Ensure that relatives' 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 to hospital
- Enable informed reporting with a transparent methodology

- Promote organisational learning and improvement

3. 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

The mortality peer review process is applicable to:

- Identified minimum categories of in-hospital deaths in all specialties
- Diagnosis groups identified by CQC/Imperial College Dr Foster Unit
- Diagnosis groups identified by the Mortality Review Committee.

The minimum categories for review using the Trusts online version of the Royal College of Physicians Structured Case Review are:

- All Elective Surgical Deaths
- All Patients with learning disabilities 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
- Sample of other deaths (minimum 10%)

4. DEFINITIONS

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

4.2 **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.

4.3 **Serious Incident:** one where serious actual harm has resulted.

4.4 **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

4.5 **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 peer review process

4.6 **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.

4.7 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.

4.8 RCP Structured case review ; this 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.

5. ROLES AND RESPONSIBILITIES

Responsibilities

5.1 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.

5.2 Quality Assurance Committee (QAC)

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.

5.3 Quality and Safety Forum (QSF)

The QSF 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 QSF will receive quarterly Quality reports for safety, patient experience and 6 monthly for Claims

5.4 Mortality Review Group (MRG)

The MRG will be responsible for:

- Providing assurance to the Trust Board and QAC on patient mortality based on review of care received by those who die
- To receive report that meets National Quality Board reporting requirements identifying
  - total number of deaths,
  - number reviewed using the 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 any changes / amendments to the mortality review proforma
- 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.

5.5 Directorate / Specialty Mortality & Morbidity Meetings

Each 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

If there is any disagreement with the grading/classification of a death and this cannot be resolved locally then this will be escalated by the Mortality Lead to the Mortality Review Group.

5.6 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.

5.7 Non Executive Director

Trust Board appointed Non Executive Director with responsibility for ensuring that the Trust is learning from deaths and a robust process for review and reporting is on place

5.8 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.

5.9 Head of Quality, Safety & Compliance

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

Head of QSC will coordinate the notification of deaths for review, at least monthly, to ensure that deaths are reviewed and assessment on the care provided is completed using the online proforma.

Head of QSC will link with the Learning Disabilities Mortality Review Programme (LeDeR) in Staffordshire and report any deaths of patients with Learning Disability via the national reporting system – www.bristol.ac.uk/sps/leder/notify-a-death/

Head of QSC will produce the quarterly report on behalf of the Medical Director and Mortality Review Group.

- 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

Where a review carried out by the trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with the trust’s Adverse Incident Reporting and Investigation (including Serious Incident) (RM07)

5.10 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.

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.

5.11 Clinical Directors / Associate Directors / Associate Chief Nurses / Divisional Governance & Quality Managers

The Clinical Directors, Associate Chief Nurses, Associate Directors and Divisional Governance and Quality Managers are responsible for:

- Ensuring in hospital deaths are appropriately investigated within the Divisions; identifying any trends or reoccurring themes.
- Providing feedback to the Directorate and Divisional Governance meeting to ensure learning, improvements and risk reduction measures takes place.
- Discuss the quarterly Learning from Deaths Report at the Divisional Governance and Divisional Board 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.

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

Bereavement Services will provide Bereaved Families and Carers with support and information on the Trusts Learning from Death Review process.

Head of Quality, Safety & Compliance, in conjunction with Bereavement Services, will ensure that any cases that are identified as requiring review are notified and offered information and support about the review and to gather any views and share outcome of the review if requested by the bereaved families / carers. Outcome of the review will be shared by senior clinician from the Mortality Review Group.

7. EDUCATION TRAINING AND IMPLEMENTATION

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

7. MONITORING AND COMPLIANCE WITH THIS POLICY

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

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 Forum for approval.

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