Northumbria Healthcare NHS
NHS Foundation Trust

Clin Gov 108

Northumbria Healthcare NHS Foundation Trust

Clinical Governance Policies and Procedures

Learning from Deaths Policy

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This Policy has been Impact Assessed against the Equality Act 2010
http://intranet2.northumbria.nhs.uk/home/policies-and-procedures/files/2017/09/Clin-Gov-108-V01-EIA.doc

History of previous versions of this document:

Not applicable

Statement of changes made from version

Not applicable

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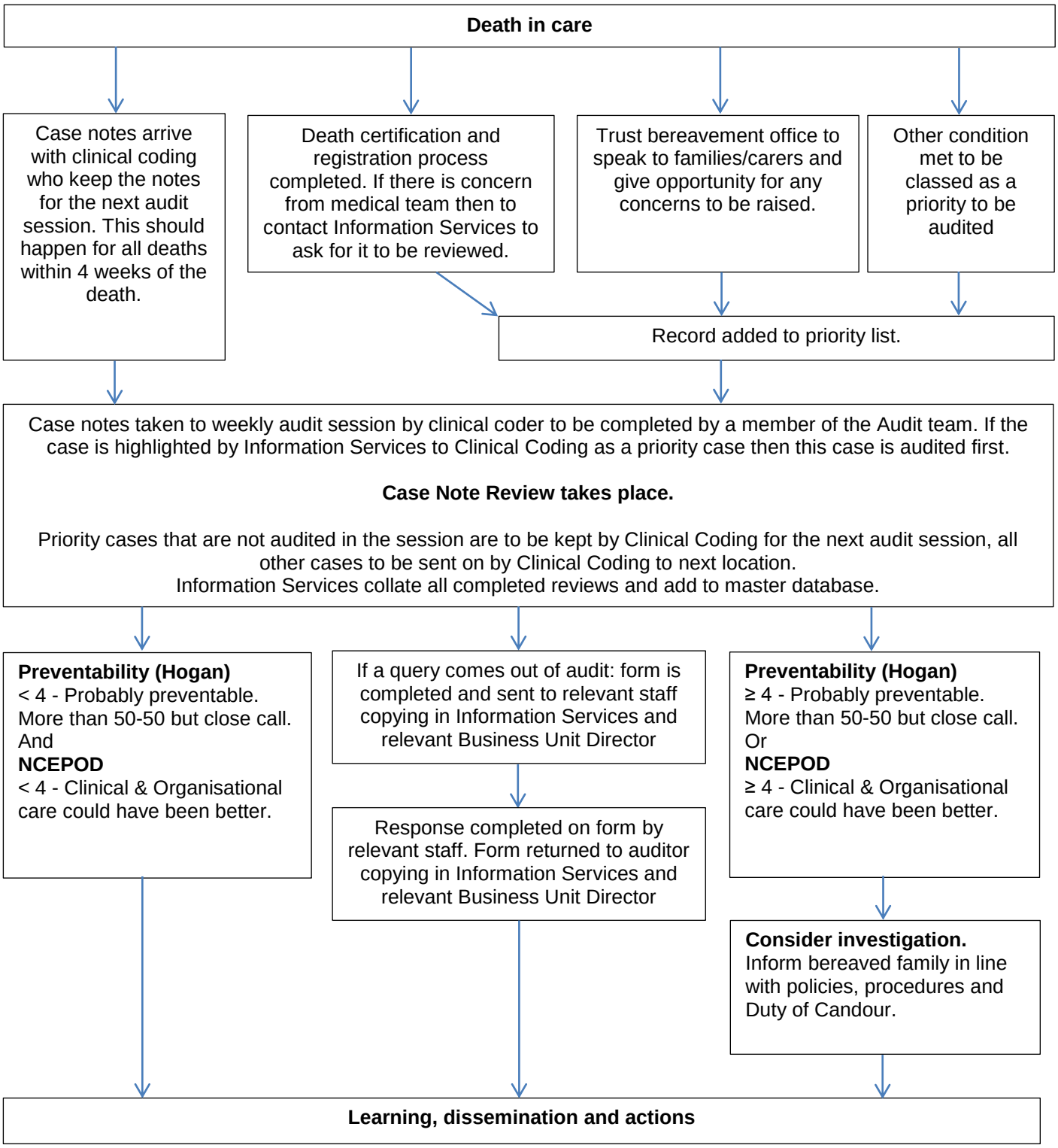
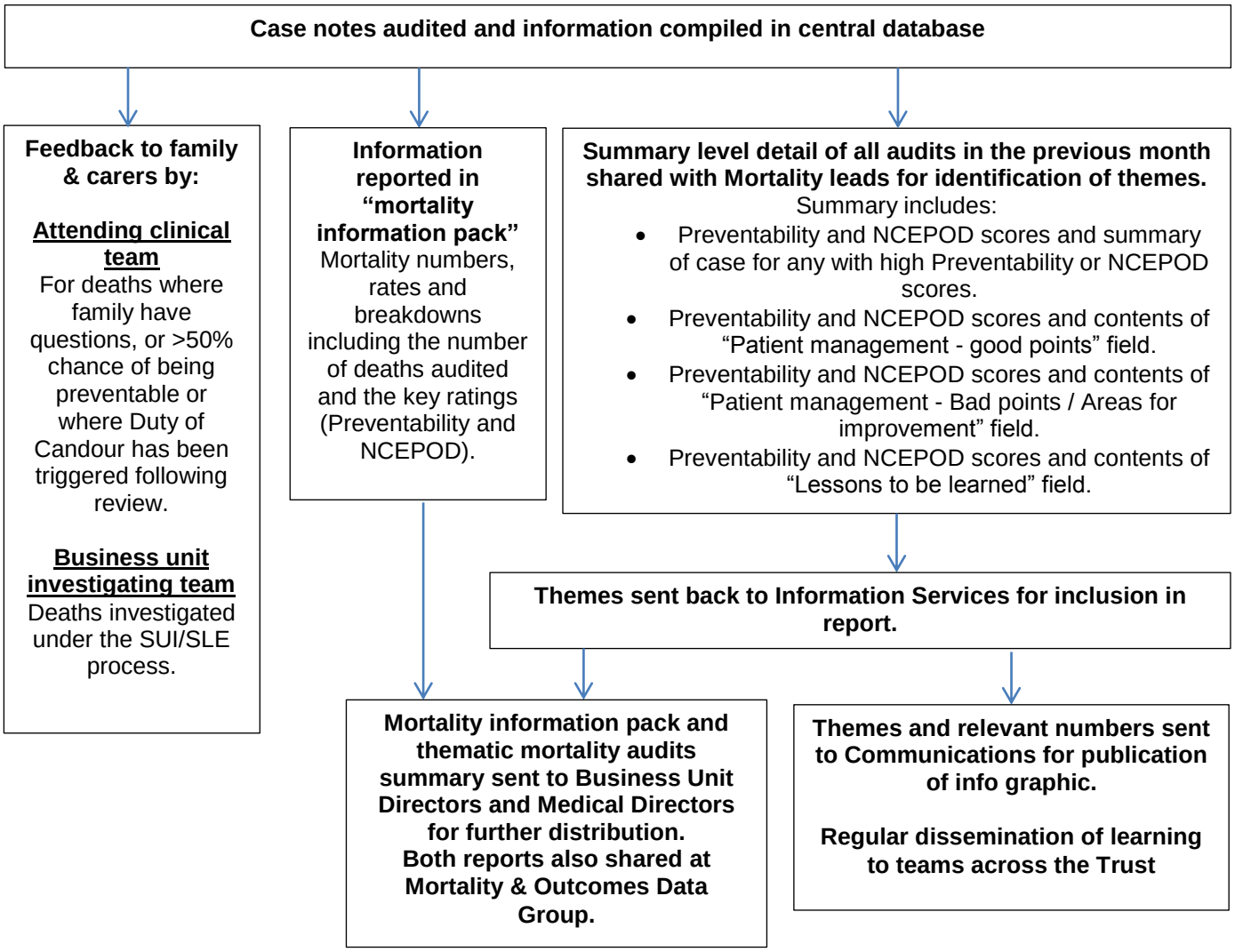
Clinical Case Note Reviewers – Responsible for reviewing the care leading to death and providing a clinical judgment

Overview of the Mortality Review Process



Overview of the Process for Learning and Dissemination



2. Introduction

2.1 The National Quality Board published '*National Guidance on Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'*. The First Edition was released in March 2017. One of the regulations set out in this guidance (Chapter 1 sections 6, 12 and Annex C – Responding to Deaths) states that *"Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under their management and care."* This policy closely follows the detailed guidance set out in Annex C. NHS Improvement and the Care Quality Commission stipulate that the Responding to Deaths Policy should be approved and in place in Trusts by September 2017.

2.2 The national framework refers to key innovations, to Mortality Governance, not in place to meet the September 2017 deadline:

- A national training programme for case note reviewers by Royal College of Physicians covering how to complete a 'Structured Judgment Review' starting Autumn 2017
- A national programme for the implementation of learning from 'Medical Examiners' pilot sites, now delayed until 2019.

The framework also devotes a whole section to improvements in how better to involve families and carers in order to properly answers questions they have in relation to the deceased care.

3. Purpose

3.1 The purpose of this policy is to describe the process by which all deaths in care are identified, reported and investigated. It aims to strengthen arrangements, where appropriate, to ensure learning is shared and acted upon. It seeks to ensure the Trust engages meaningfully and compassionately with bereaved families and carers and supports staff to find all opportunities to improve the care the NHS offers by learning from deaths.

3.2 For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

3.3 Because the timing of all national developments have not been completely aligned to the framework implementation, the policy also describes the process for the on-going improvement of learning from deaths. It is proposed that the success of any cycles of improvement be judged by favourable feedback from staff and patient/carers from the output of the learning system.

4. Duties

4.1 **Chief Executive** – Overall responsibility for the implementation of this policy.

4.2 **Executive Director of Nursing** – To ensure all nurses and midwives are supported to fulfill their duty to engage in responding to deaths; to identify specific nurses and midwives to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.

4.3 **Non-Executive and Executive Leads for Mortality** – To ensure that the Board is fully informed that the approved policy is implemented and that learning is appropriately delivered.

4.4 **Medical Directors** – To ensure all doctors are supported to fulfill their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.

4.5 **Executive Director of Systems, Strategy & Transformation** - To be the Board lead for Learning from deaths; to take responsibility for the learning from deaths policy; to publish, through a quarterly paper to the public Board meeting, estimates of the number of avoidable deaths; to ensure that from June 2018 the annual Quality Account summarises the data published by the Board, including learning and action as a result of this information and an assessment of the impact of actions that the Trust has taken.

4.6 **Executive Director of Finance** – To ensure adequate resources are made available to enact the Responding to Deaths policy and other requirements such as set out in the Quality Account regulations.

4.7 **Human Resources Department** – Leading on the training needs analysis (TNA) and mandatory training policy. Training will be made available by the National Mortality Case Record Review Programme for those leading secondary case record review.

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

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

4.10 **Clinical Case Note Reviewers** – Responsible for reviewing the care leading to death and providing a clinical judgment.

4.11 **Mortality and Outcomes Data Group** – Oversee the mortality review process and outcomes/learning from these reviews.

4.12 **Safety and Quality Committee** – To receive quarterly updates from the Mortality and Outcomes Data Group.

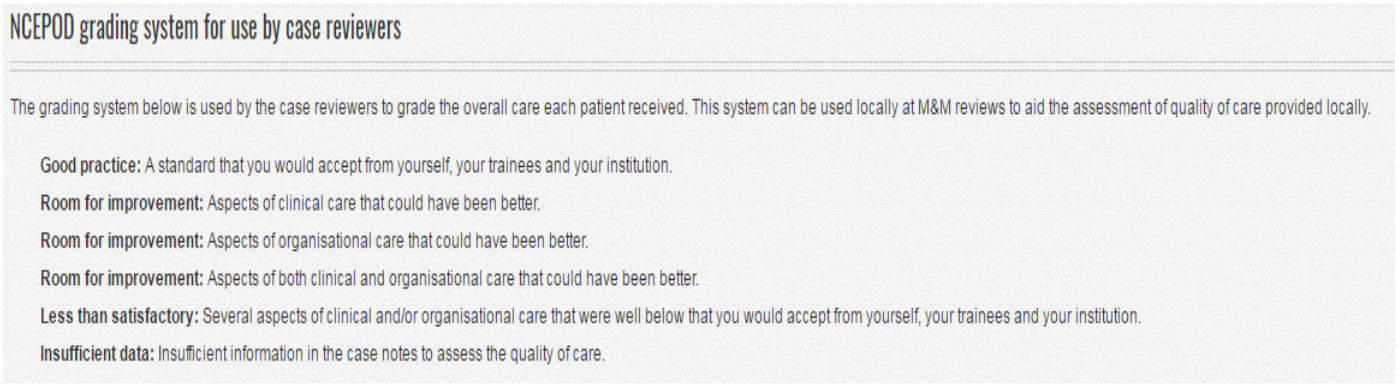
5. Definitions of Terms Used

5.1 **Death certification** - The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. The process includes identifying cases for referral to the Coroner and links to the Medical Examiner role.

5.2 **Medical Examiner** - Reforms envisaged by the government include the establishment of Medical Examiners, employed by Local Authorities, by April 2019. The Trust will fulfill this role until the national reforms are in place locally. The Medical Examiner will be involved in the certification and registration of deaths, have contact with bereaved families and staff in the immediate period after a death , improve the recording of cause of death, referral of cases to the Coroner and identify any concerns that suggest a case should receive a stage two case record review or investigation.

5.3 **Case record review** - The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. The review should use a recognised methodology of case record review, for example Structured Judgment Review delivered by the Royal College of Physicians or the PRISM methodology. Often the output of these reviews are entered in databases and used to analyse trends. In addition to preventability and narrative descriptions of care attempts have been made to classify breaches in standards of care.

NCEPOD have a well-established system they use in case note reviews:



NCEPOD grading system for use by case reviewers

The grading system below is used by the case reviewers to grade the overall care each patient received. This system can be used locally at M&M reviews to aid the assessment of quality of care provided locally.

Good practice: A standard that you would accept from yourself, your trainees and your institution.

Room for improvement: Aspects of clinical care that could have been better.

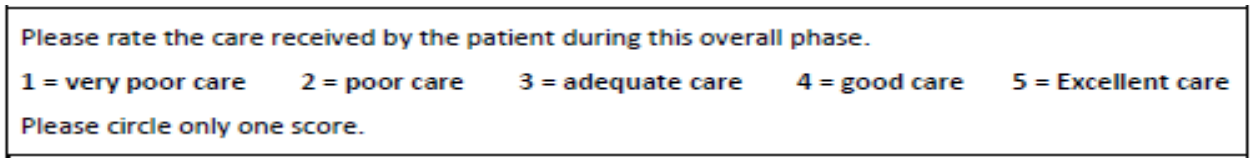
Room for improvement: Aspects of organisational care that could have been better.

Room for improvement: Aspects of both clinical and organisational care that could have been better.

Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.

Insufficient data: Insufficient information in the case notes to assess the quality of care.

This has been adapted in the RCP Mortality process:



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.

None of these care or avoidability scales has been shown to have an advantage and despite their numerical nature offer sufficient consistency for comparative purposes. This is reflected

in the national framework that recommends a tool, but is not didactic in its nature. The RCP toolset is much more narrative in construction, and claims, without (as yet) any evidence as such, that this will help the quality of learning from the case note review process. Training in the use of this tool will be received in later 2017/early 2018, following this a trial of the tool will be undertaken to consider whether it is adopted within the Trust.

5.4 **Preventable Death/'Preventability'** - The use of case record review by independent clinicians to determine an index of the likelihood that death was preventable. The key determinant is to identify those patients in whom a trained reviewer considers the possibility that the death was preventable to be more than 50/50. This is Hogan 4 or more and is equivalent to an avoidable death score of 3 or less using the RCP tool, see table below:

HOGAN/Prism scale of preventability	
1	Definitely not preventable
2	Slight evidence of preventability
3	Possibly preventable but not very likely, less than 50-50 but close call
4	Probably preventable, more than 50-50 but close call
5	Stong evidence of preventability
6	Definitely preventable
RCP Scale of avoidability	
1	Definitely avoidable
2	Strong evidence of avoidability
3	Probably avoidable (more then 50-50)
4	Possibly avoidable but not very likely (less than 50-50)
5	Slight evidence of avoidability
6	Definitely not avoidable

5.5 **Death due to a problem in care** - A death that has been clinically assessed using a recognised methodology of case record review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

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

5.7 **Duty of Candour** - Health and Social Care Act 2008 Regulation 20, this regulation infers a statutory duty to ensure that NHS providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

5.8 **Serious Untoward Incident (SUI)** - an accident occurring on NHS premises that resulted in serious injury, and or permanent harm, unexpected or avoidable death (ref to RMP03 'Reporting and Management of Incidents' policy for further details).

5.9 **Summary Hospital-level Mortality Indicator (SHMI)** - The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider and is the main mortality indicator reported nationally and is supported by the Department of Health. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping.

6. Process in Response to an in-Hospital Death

6.1 Certification and registration of a death

When a death occurs the consultant responsible for care (as either the "Attending Practitioner" or that doctor's supervisor) has a duty to decide whether the coroner needs to be informed and to oversee the process of completing the Medical Certificate of the Cause of Death (MCCD). The MCCD should be completed within 24 hours for all deaths as circumstances allow. The Medical Examiner can provide guidance. When the attending team meet relatives to discuss MCCD they may refer the case for review if they or the family see fit.

Cremation Forms Part 1 - for all deaths within the hospital, Part 1 of the Cremation Form (Cremation form 4) should be completed by the medical practitioner who attended the deceased at the same time as the MCCD within 24 hours as circumstances allow. Due to shift working the doctor writing the MCCD should complete a Cremation Part 1 at the same time. Best practice would be for the Family to collect MCCD from a bereavement suite or non-clinical location.

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

Cremation Forms Part 2 - this section may only be completed by a registered practitioner of at least 5 years' standing who is not either a relative of the deceased, the medical practitioner who issued the part 1 (Cremation form 4) or a relative or a partner or a colleague in the same practice or clinical team as the medical practitioner who issued that certificate. The bereavement office has a list of The Trust's medical staff who have undertaken training in completion of Part II. The bereavement officer will contact the relevant teams for part 1 and part 2 completion. The medical staff assigned will normally complete this function and will undertake proportionate scrutiny of the case. This will usually involve examination of recent medical records and a discussion with a doctor who attended the deceased. It may involve an external examination of the body or conversations with other people, depending on the case. In every case the medical examiner will try to contact a representative of the

family to ask whether they understand the proposed cause of death and whether they have any concerns that might justify further investigation. If the medical examiner concludes that the proposed cause of death is incorrect, s/he will contact the attending doctor and require that a replacement certificate is produced and that the incorrect certificate is cancelled. The medical examiner may refer the case to the case record review team for learning purposes. This should be done via the bereavement officer who will liaise with the information team that coordinate medical notes for the reviewers.

When the medical examiner is satisfied that a natural cause of death has been correctly identified to an acceptable level of confidence, and that there is nothing to suggest that investigation by the coroner is justified, he/she signs a form to that effect and sends it to the Registrar. The attending practitioner is asked to add the date of this confirmation to the MCCD, making the MCCD ready for registration of the death.

The 'prescribed information about the deceased', supplied by the Attending Practitioner, should include any information about hazards associated with the body of the deceased, such as infections or implants (the latter being potentially hazardous during cremation). If the medical examiner becomes aware of such a hazard there is a duty to inform those concerned, such as funeral directors and crematorium staff.

A representative of the family takes the certificate of the cause of death to the Registrar, to register the death. The registrar checks that the information on the MCCD and the medical examiner's confirmation is all congruent.

If at any point during this process the medical examiner forms the opinion that the death should be investigated by a coroner, the medical examiner process must be stopped and the medical examiner must provide details of the case to the appropriate senior coroner.

Cremation is very popular and in 2016 approximately 2/3 of all deaths required a cremation certificate.

Some wards (e.g. AMU) write to relatives after a patient's death to see if they would like to come in to discuss MCCD and other issues. This process will form the basis of a pilot into using case record review as part of this process.

6.2 **Reporting of deaths which are of immediate concern**

The following deaths fall within the serious incident framework should also be reported as incidents, escalated to the Business Unit Director for consideration of a Serious Untoward Incident:

- Deaths reported to Coroner where there were known problems with care;
- Maternal Deaths - deaths of women while pregnant or within 42 days of delivery, miscarriage, or termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (Serious Untoward Incident);
- Death of a neonate or child under the age of 19yrs which is a potential Serious Incident or Inquest (it is recognised that paediatric and neonatal deaths will also be subject to

specific review process for example child death overview panel, however they must also be escalated to the Medical Director);
- Deaths during a surgical operation or endoscopy or before recovery of an anaesthetic, including conscious sedation;
- Any deaths where an incident has been raised and the clinical team have raised significant concerns about the care delivered to the medical or nursing director.
- Any death relating to a 'Never Event'.

There is a well-established process for investigating such events as described in RMP 03 'Reporting and Management of Incidents Policy'.

6.3 **Independent Case Record Review**

Those clinicians performing Case Record Review, should be adequately trained, and experienced in the process as well as being entirely independent of the clinical care the patient received.

Notes may be selected for case record review from any patient who dies whilst an in-patient in the Trust. Sufficient resources currently allow for 17 case notes per week or 850 case notes per year. Each review takes approximately 30 minutes and is conducted by a trained, centralized team. This represents approximately 36% of all in-hospital deaths. This is a single stage review process and uses NCEPOD and Hogan methodology.

The Trust is committed to assessing a pilot of a 2 stage review process once national training is available.

Not all patients will be reviewed, in order to make the best use of the limited record review resource notes will be sampled in the following way:

Mandatory Sampling:
- Deaths investigated as an SUI or (less commonly) SLE, including falls and pressure ulcers.
- A patient has a Learning Disability (in-line with the national LeDeR process)
- Death during an elective admission
- Deaths referred to coroner with an inquest planned

Discretionary Sampling
- Deaths referred by attending team or medical examiners consulting family as part of bereavement process
- Issues arising from deaths as a result of feedback in the relative feedback process.
- Deaths examined as part of other improvement processes: e.g. Surviving Sepsis, NELA, Hip Fractures
- Investigation of CQC mortality or other ALERTS (e.g. VLADs) as advised by Executive Directors on behalf of Board

The remainder of the review capacity should be made up of randomly selected case records, randomly selected notes (based upon site, date of death and availability) should not be less than 30% of the review total.

Maternal and neonatal deaths are reviewed in a robust process detailed in section 6.6 of this policy, as are deaths in children and young people.

6.4 **Learning**

The weekly mortality audit uses an audit tool that has been developed over time and includes various questions including: Preventability score (Hogan), NCEPOD grade, Examples of good / bad practice, Lessons to be learned, Further questions to be addressed following this audit.

The questions from these audits are directed to the relevant person/team including the relevant session lead. Results of the mortality audits are regularly distributed to the site leads, Executive Lead for responding to deaths, Executive Director of Systems, Strategy and Transformation and Head of Information and Statistics.

The collated learning output for one month should be sent to the executive lead for mortality, who is responsible for compiling a 'mortality' learning letter to all clinical staff at least monthly. The content of these letters should be surveyed at least twice yearly with a view to improving and developing the learning system.

All actions should kept on a centrally held action log and completion captured by corporate or Business Unit governance systems. These completed actions should be collated centrally as part of the Mortality assurance framework, and included in the assurance reporting.

Lessons learnt and incomplete actions requested must be discussed at the Mortality and Outcomes Data Group, which meets bimonthly, who should ensure any necessary actions on the central log are captured and evidenced.

There must be a system of recording feedback given to relatives (including Duty of Candour) which must also be captured and assured by the mortality surveillance group.

A board paper summarizing cases reviewed, relative feedback and lessons learnt will be prepared quarterly (one quarter in arrears) for scrutiny at Safety and Quality Committee and subsequent Board. The Executive lead for responding to Deaths should be responsible for acting on the recommendations of these Board committees in response to the information provided.

6.5 **Carer Involvement**

The Trust will extend its patient experience programme to include feedback from relatives of deceased patients. This feedback will be reviewed by the Mortality and Outcomes Data Group and used to inform decisions on improvements to the responding to deaths process. Bereavement officers will be invited to the Mortality and Outcomes Data Group so they may feedback directly to the reviewing team. There will be a pilot extension of the AMU practice

of voluntary follow up with relatives by the attending team to discuss MCCD post death to include carer referral for, and discussion of a Case Record Review.

Feedback to carers must be recorded in the following circumstances:

- Significant harm ascribable to care requiring a Duty of Candour (i.e. all those deaths with a greater than 50% chance of avoidability, or patients whose EOL process was compromised, or length of stay increased by avoidable lapses) found on Case Record Review
- ALL patients referred for Case Record Review by relatives or carers, whether by discussion with attending clinicians or by medical examiner.

In these cases an appropriately anonymised version/summary of the Case Record Review should be discussed with the family by a member of the attending clinical team.

- All cases investigated as SUI/SLE. This should be as per current arrangements within business unit investigating teams.

There will be a regular meeting of all those involved in the certification process, chaired by the executive lead for mortality, including a lead 'Medical Examiner' and a lead trainee. The purpose of the quarterly meeting is to ensure improvements required by the patient experience report are responded to and will ensure there is coordination, integration of the bereavement process.

6.6 Cross-system reviews and investigations

Deaths in children/young people

The Trust participates in the national (England &Wales) child death review process which has been in place in for several years and developed as a multi-agency evaluation to standardize procedures and facilitate learning with the long-term aim of reducing child mortality. These processes were incorporated into "Working Together to Safeguard Children" and can be found in chapter 5 of the revised edition (2015). A child death review runs in parallel with any

Coroner's or Police investigation and is overseen by the Designated Doctor for Child Death Reviews responsible for the child's usual place of residence – irrespective of where the death occurred.

All reviews are discussed by the North of Tyne Child Death Overview Panel (CDOP) which reports to the Local Safeguarding Boards (LSB). The cause of death is established by the doctor who signs the death certificate or by the Coroner whilst the aim of the CDOP is to classify the death, identify any modifiable factors and actions to address these. Any learning is shared within the Trust and reported via Child Health governance processes.

Maternal and neonatal deaths

All maternal deaths will be investigated as SUIs, all still births are investigated through the local perinatal mortality process (MBRACE) which has a process to involve parents.

6.7 **Working with wider NHS**

The Trust will work with partner NHS organisations to develop data sharing agreements to help partners identify patients for their own mortality review processes. Where partners have identified deaths occurring outside the Trust they will be able to refer for review patients previously not included in our review process. The NHCFT/NTW data sharing agreement will ensure improvement in learning from deaths for Northumberland population who have mental health disorders. The Trust will also share learning in partner organisations where it has identified learning for other organisations. This will include sharing learning in the Trust from partner mortality reviews.

7. Training and Support

Two places (each) are booked for the national RCP training in December 2017 (Carlisle) and January 2018 (Newcastle), which would allow a limited pilot to see if the RCP tool offers benefits in the learning provided. Following receipt of this training and the pilot exercise a decision will then be made on future training requirements.

8. Process for Monitoring and Audit

Monitoring/audit arrangements	Methodology	Reporting		
		Source	Committee	Frequency
Monthly report	A mortality information 'pack' including details of the lessons learnt from the audits will be circulated monthly. This pack will include the learning from deaths dashboard specified nationally.	Information Department	Mortality Outcomes Data Group	Monthly
Quarterly report	Paper summarizing cases reviewed, relative feedback and lessons learnt will be prepared quarterly (one quarter in arrears). for scrutiny at Safety and Quality Committee and subsequent Board. The Executive lead for responding to Deaths	Information Department	SQC/ Trust Board	Quarterly

Wherever the monitoring has identified deficiencies, the following should be in place:

- Action plan
- Progress of action plan monitored by the appropriate Committee (minutes)
- Risks will be considered for inclusion in the appropriate risk registers

9. References

- Preventable deaths due to problems in care ;Charles Vincent and Nick Black Helen Hogan, Frances Healey, Graham Neale, Richard Thomson, BMJ Qual Saf 2012 21: 737-745

10. Associated Documentation

- **RMP 03** – Reporting and management of incidents policy
- **RMP 36** – Duty of candour and being open policy
- **RMP 05** – Handling of clinical and non-clinical claims and inquests policy
- **Clin Gov 23** – Bereavement policy