Policy Reference: 317

MORTALITY REVIEW (LEARNING FROM DEATHS) POLICY

Version: 02

Name and Designation of Policy Author(s)	Mike Ellard, Deputy Medical Director
Ratified By (Committee / Group)	Patient Safety and Quality Board (PSQB)
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Review Date	4th October 2022
Target Audience	All Trust staff involved in caring for patients, or have responsibility for the quality of patient care and reviewing deaths
Other Associated Strategies, Policies, Procedures, etc.	291 - Risk Management Strategy & Policy 041a - Incident Reporting & Management Policy & Procedure 159 - Maternal Death Policy 149 - Management of Adult Patients Admitted with a Learning Disability 057 - Safeguarding Children Policy & Procedure 023 - Concerns and Complaints Handling Policy 007 - Duty of Candour 032 – Adult Death Administration Policy & Procedure 223 – Verification of Expected Death 217 Deprivation of Liberty Safeguards Policy 003 Safeguarding Adults Procedure and Guidance

Key Points for Staff

- National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigation and learning from Deaths in care' was published by the National Quality Board in 2017 setting out the process that all hospitals should now follow

- This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of Wirral University Hospital Trust – it must be read in conjunction with the relevant policies listed on the front cover

- All inpatient deaths will have a primary review unless they are subject to external or internal enquiry, they are identified as requiring a Structured Judgement Review (as detailed within section 4.1), or they have been referred through to the Serious Incident process

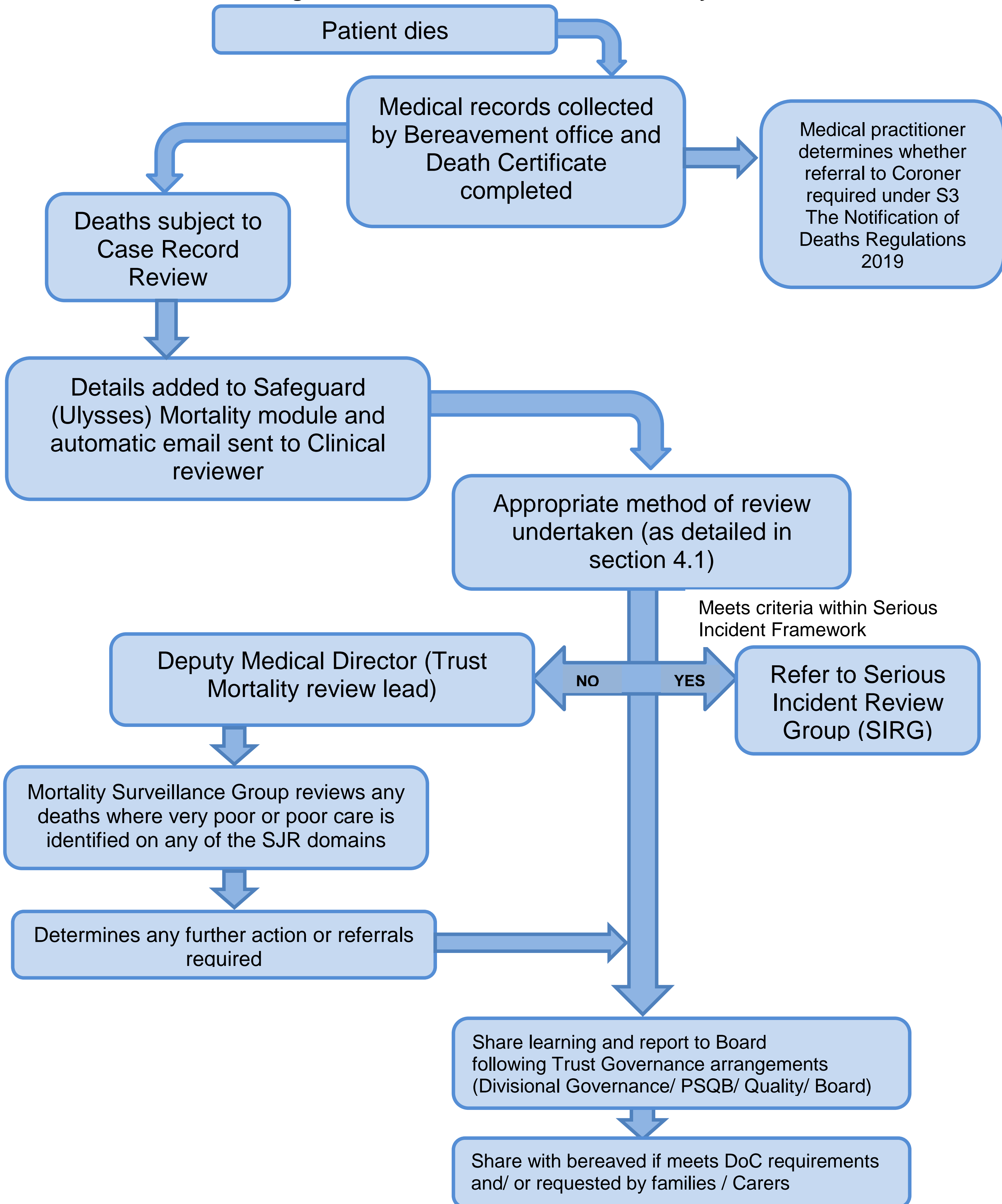
- The death and review process will be monitored through the Ulysses Safeguard mortality module

- Learning from deaths and ensuring continued improvement will be delivered through to the Trust's governance framework; with a quarterly report being presented to the Board

- The Trust is committed to engaging meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and will follow the principles as outlined in the National Guidance on Learning from Deaths (as detailed in section 4.3)

- The policy does not replace the requirements for full investigation of unexpected deaths or deaths following harm to patients in our care as described in the Incident Reporting Policy (041a).

Flow Chart Illustrating the Procedure Detailed Within the Policy



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1 Introduction

In 2016, a review carried out by the CQC identified that, in some Trusts, learning from deaths was not given sufficient priority and therefore valuable opportunities for learning and improvements were being missed. As a result, in March 2017, the National Quality Board published 'National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigation and learning from Deaths in care' was published setting out the process that all hospitals should now follow.

At Wirral University Teaching Hospitals (WUTH) we place patients, families and carers at the centre of everything we do and are committed to ensuring treatment and care is provided to the highest possible standard. Reviewing the care provided to people who have died can help improve care for all patients by identifying problems associated with poor outcomes, and working to understand how and why these occur so that meaningful action can be taken.

WUTH will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of WUTH.

It sets out how the trust will seek to provide learning at a personal, team, organisational level and where applicable and for the wider care system and outlines the evidence-based methodology for each review and the governance process in place to ensure maximum learning.

While a focus on process is important, everything that is done should focus on the outcomes from the learning from deaths. With this in mind the core objectives of this policy are to ensure that the Trust:

- Prioritises and enables meaningful engagement between families/carers and staff, that is open and transparent at whatever stage the engagement takes place to raise questions or share concerns about the care provided at every stage from notification of death to the review report,
- Establishes the expectations of the Trust in its approach to the provision of support to people who have been bereaved by a death, and to staff who may be affected by the death of someone in the trust's care.
- Supports effective learning from deaths, where there are problems in care identified and thus reducing avoidable deaths, ensuring the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) stay within acceptable limits.

This policy should be read with the policies and procedures listed on the cover sheet. There may be other local policies and procedures within specific specialties and therefore this list is indicative only.

2 Scope

This policy applies to all Trust staff involved in caring for patients, or who have responsibility for the quality of patient care, to feel more confident in answering questions and reviewing deaths to identify how we can learn from them and improve care provided.

The policy does not replace the requirements for full investigation of unexpected deaths or deaths following harm to patients in our care as described in the Incident Reporting Policy (041a).

3 Duties & Responsibilities

Chief Executive, Executive Trust Board Directors and Non-Executive Directors	Trust Boards are accountable for ensuring compliance with the National Guidance on Learning from Deaths, alongside NHS England's Serious Incident Framework 2015 and working towards achieving the highest standards in mortality governance. They are also responsible for ensuring quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions that improve patient safety and experience, and supports cultural change. The Board is required to ensure that its organisation has a board-level leader to take responsibility for the learning from deaths agenda. Within WUTH this is the Executive Medical Director. Additionally, a Non-Executive Director is nominated to take responsibility for oversight of progress and act as a critical friend holding the organisation to account for its approach in learning from deaths. Both the Executive and Non-Executive Director leads will have the capability and capacity to understand the issues affecting mortality in this Trust. They will challenge where necessary, to ensure high standards in mortality governance are maintained and that the care provided to patients who die is integral to the Trust's governance and quality improvement work. In addition to the above the Non–Executive Directors are responsible for: • Ensuring that the processes in place focus on learning and can withstand external scrutiny, by providing challenge and support. • Holding the organisation to account for its approach and attitude to patient safety and that there is evident learning from all deaths.
Medical Director	The Medical Director has overall responsibility for providing assurance to the Board that this policy is being delivered and lessons learnt from any suboptimal practices identified and actions are taken to improve care defects identified. They are accountable for the Mortality Review Steering Group. Supported by the Director of Quality and Governance they will ensure data is collected and published to monitor trends in deaths from April 2017 onwards, with Board level oversight of this process. Ensuring the Safeguard (Ulysses) reporting system is used to its full potential to record deaths and the circumstances of individual deaths. Information is processed consistently, precisely and in a meaningful way to fulfil the governance processes required to ensure high standards in mortality governance are maintained.
Mortality Review Lead Clinician (Deputy Medical Director)	The post holder is responsible for ensuring this process works at an operational level. They will manage the screening process, ensure reports are provided in a timely way and lessons learnt are disseminated across the Trust. They are responsible for updating this policy and process. They will chair the Mortality Review Steering Group.
Clinical Reviewers	Clinical reviewers will undertake the primary review and, if trained, SJR reviews. Those completing SJR reviews, will be expert by experience and training (once available). When they identify an unreported clinical incident, they are responsible for reporting it in line with the incident reporting policy.
Clinical leaders	Clinical leaders will:- • Foster a culture of responding to the deaths of patients who die/under our care and ensure staff reporting deaths have the skills and training to support the review process. • Participate in the review and investigation of patient deaths as required • Support staff that are to review and investigate the deaths ensuring they have the time and correct level of competency to carry this process out in skilled way and to a high standard, • To promote learning from deaths through facilitating and giving focus to the review, investigation and reporting of deaths. • To ensure that all learning from the process of review and investigation is shared and learning is acted upon. • Provide support for staff affected by the deaths of patients

All Staff	The Trust requires all staff to be open, honest and transparent about reporting deaths and for engaging with families and cares of the deceased to be their priority. Enabling them to ask questions about care and identify if care can be improved. All Healthcare professionals need to acquaint themselves with this policy and understand the process for learning from deaths.
Mortality Review Steering Group	The Mortality Review Steering group is a multidisciplinary and multi professional group, membership. The Mortality Review Steering Group is responsible for providing the required oversight within the Trust and reviews the outcomes of the process as gathered by the mortality lead clinician. The group will receive and review information from both internal and external sources to identify emerging themes, track trends over time and ensure that learning is identified and shared. This data and analysis is presented to the mortality steering group and subsequently follows the Trust governance process up to the Board
Serious Incident Review Group	SIRG is a sub-group of the Patient Safety Quality Group established to ensure that all serious adverse events are actively investigated and improvement plans are delivered to ensure lessons are learnt and risks reduced. SIRG will review serious adverse patient events that result in death and will share information and learning with the Mortality Review Steering group

4 Process

4.1 Selecting deaths for case record review

All patient deaths that occur in the Trust are notified to the Bereavement Team. The death and review process will be monitored through the Ulysses Safeguard mortality module. Clinicians will be notified of the requirement to conduct a review through an automatic email generated by the system.

All inpatient deaths have a primary review screen unless:

- they are identified as requiring a structured judgement review (SJR) as designated below
- maternity, paediatrics and neonates (as they are subject to alternative review processes)
- the patient refused access to their information prior to their death outside of direct patient care

A primary review is used to identify deaths that require a SJR.

In addition the following deaths will also be subject to a structure judgement review:

- deaths where the bereaved or staff raise significant concerns about the care
- deaths in a specialty, diagnosis or treatment group where an ‘alarm’ has been raised (for example, an elevated mortality rate , concerns from audit , CQC concerns, outlier alerts)
- deaths where the patient was not expected to die, for example, in elective procedures
- people detained under section 2 or 3 of the MHA (in conjunction with CWP)
- deaths where learning will inform the provider’s quality improvement work
- deaths where the doctor completing the death certificate believes a review should occur
- deaths of any patient from Wales (in line with contractual obligations)
- within Women’s services not undergoing external/ peer review
- within Paediatric services not undergoing external /peer review

All Infant and child (under 18) deaths will be reviewed in accordance with Working Together to Safeguard Children. Adult deaths where there is a known safeguarding concern identified may require review as per The Care Act 2014. Additionally any adult patient subject to a Deprivation of Liberty will only require discussion with the coroner, if the restrictions in place are thought to have contributed to that death. Please refer to safeguarding policies.

All perinatal deaths will be reviewed by the perinatal mortality review tool. Maternal deaths are reviewed by the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) in addition to being reviewed by the Healthcare Safety Investigation Branch (HSIB) if they meet the criteria (direct and indirect maternal deaths in the perinatal period). These deaths may meet the definition of a Serious Incident and will be investigated accordingly.

The death of a patient with a confirmed diagnosis of a Learning Disability is reported through the Learning Disabilities Mortality Review Programme (LeDeR). A review will be undertaken by the Learning Disability Nurse and identified clinician to facilitate learning at the earliest opportunity.

Any death where there is concern will be referred for a structured judgement review. However, if the care given is considered very poor, it will be reported in line with the incident policy and investigated through the risk management process to avoid further delay.

SJRs will be undertaken by staff that have been trained and are independent of the case. However, if specialist knowledge is required and the treating clinician is the only source of expertise they can be part of the reviewing team.

4.2 Methodology for making judgements on the standard of care

The Trust will use the Royal College of Physicians SJR tool (RCP, 2017) for case record review. This will include making a judgement on the standard of care:-

Score	Finding
Score 1	Very poor care
Score 2	Poor care
Score 3	Adequate
Score 4	Good
Score 5	Excellent

Where very poor or poor care is identified on any of the SJR domains, the case is reviewed at the Mortality review steering group to determine the level of avoidability.

If the Trust identifies that a cross-system review is required a Trust lead for the review will be identified. The lead will be responsible for identifying which organisations need to be involved in the review and for liaising with these organisations to complete the review. Learning will be shared with all involved.

The Trust will also co-operate with requests for cross-system review from other organisations to assist with investigations and ensure appropriate learning from deaths. This may include a review of the care provided to a patient in the past in cases when a patient was not under the Trust's care at the time of their death.

4.3 Bereaved families and carers

The Trust is committed to engaging meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death.

The Trust has a Duty of Candour Policy which outlines the formal approach required for notifiable patient safety incidents resulting in moderate, severe harm or death.

The Trust is committed to the following principles as outlined in the National Guidance

on Learning from Deaths (National Quality Board, 2017):

- Bereaved families and carers should be treated as equal partners following a bereavement
- Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment
- Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, cultures and beliefs, including being offered appropriate support.
- Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved ones
- Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed
- Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, which a single point of contact and liaison
- Bereaved families and carers should be partners in an investigation to the extent and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations
- Bereaved families and carers who have experienced the investigation processes should be supported to work in partnership with the Trust in delivering training for staff to support family and carer involvement where they want to

Bereavement support for families and carers of people who die under the management and care of the Trust will be provided by the Bereavement Team.

Families and Carers will be explicitly asked whether they were happy with the care provided to their relative when they attend the Bereavement office. Where concerns are highlighted the bereavement service will advise the bereaved of the Trusts processes for acting on any concerns. The bereavement service will follow the most appropriate process for the concern raised which may include the mortality review process.

4.4 Governance and arrangements for sharing learning

Findings from the mortality review process will be shared across the hospital through governance mechanisms as set out below in **Flowchart 1: Trust Governance arrangements.** Speciality meetings, special alerts and other communication mechanisms will also be utilised where necessary.

Where a specific theme is identified by the Mortality review team (including the Mortality Review Steering Group) an action plan will be developed and agreed with the appropriate specialty.

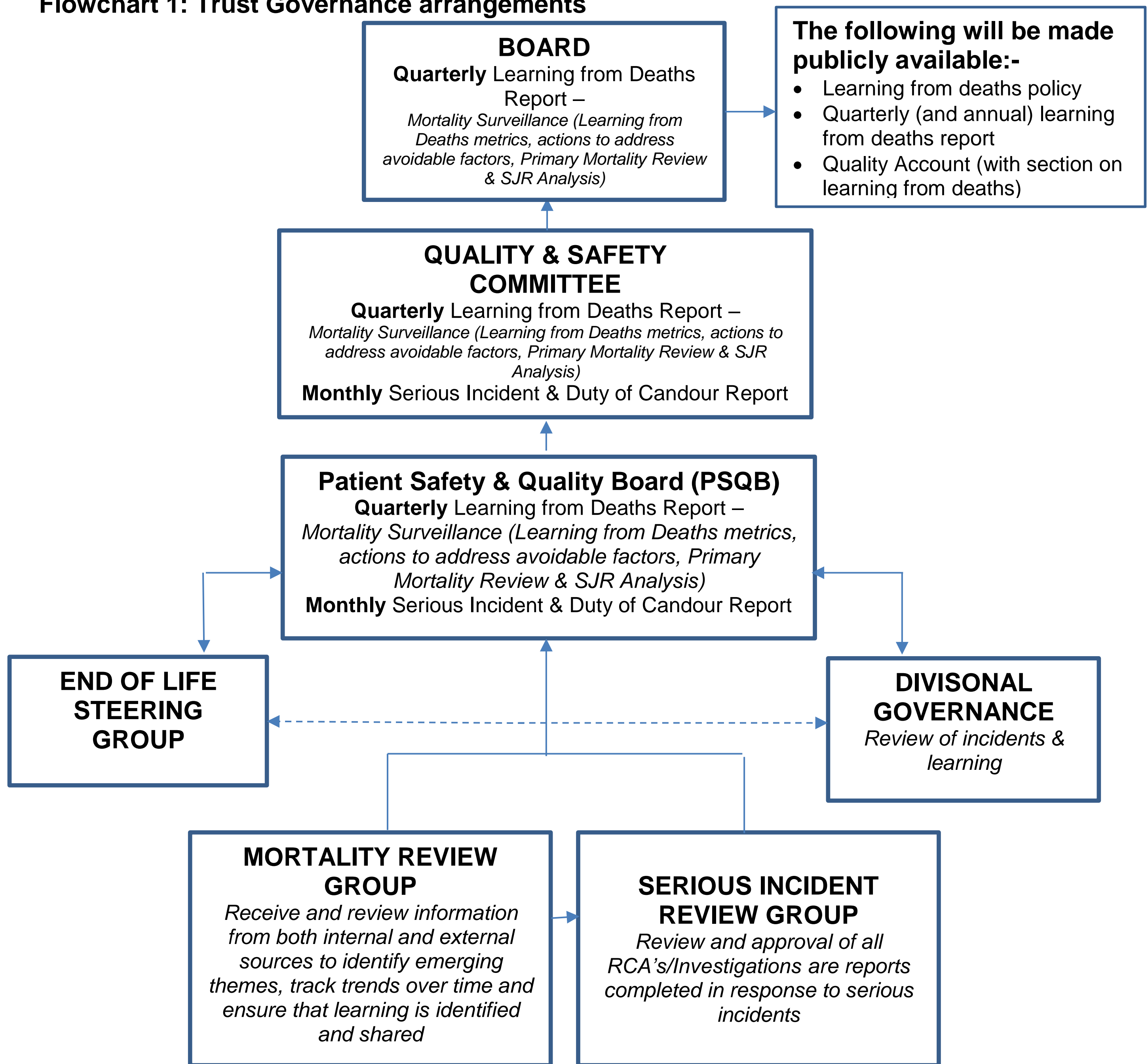
In addition, HSMR, SHMI and percentage of PMR's completed are included in the trust's Quality Performance Dashboard.

Quarterly reports to the Patient Safety and Quality Group, which will also be provided to the Public Board learning from the mortality review process utilising the learning from deaths dashboard (Appendix 2).

Summary information will be published in the Quality Account on annual basis.

Outcomes of inquests are shared at SIRG and issues will be escalated to the Mortality Review Steering Group as required. This may include a request to review the mortality review process effectiveness. For all inquests that result in a "Regulation 28 Report on Action to Prevent Future Deaths" a review of the case record review will be undertaken to assess the effectiveness of the review process.

Flowchart 1: Trust Governance arrangements



Sharing Learning and implementing actions for improvement:
In addition to sharing learning through the Trusts Governance arrangements, mechanisms such as the Safety Summit and Safety Bites bulletin will be employed. Actions will be tracked through the quarterly learning from deaths report and/ or incorporated into improvement work streams.

5 Definitions

Hospital Standardised Mortality Ratio (HSMR)
The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality. This helps compare an NHS Trust's actual number of deaths to its expected or predicted number of deaths. HSMR is a statistical number that enables the comparison of mortality rates between hospitals.

This prediction takes account of factors such as the age and sex of patients, their primary diagnosis and complicating factors. Standardisation of mortality rates allows comparison between different hospitals, serving different communities.
If a Trust has an HSMR of 100, this means that the number of patients who died is exactly as would be expected. Values above 100, suggest a higher than expected mortality and those below reduced expected mortality. However, the standard deviation must be noted to obtain significance for higher or lower mortality.

SHMI
The 'Summary Hospital-level Mortality Indicator (SHMI)' is another mortality measure. SHMI looks at factors such as the patient's age, method of admission and underlying medical conditions. The SHMI is a ratio of the observed deaths over a period of time divided by the expected number given the characteristics of patients treated by that Trust.
The data used to calculate the SHMI includes all deaths in hospital, and occurring within 30 days after discharge from hospital. The SHMI only attributes a death to the hospital which last treated the patient prior to death.

Death certification
The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review
A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review
A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident
Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

Investigation
A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care

A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

Quality improvement

A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident

A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

6 References

Care Quality Commission (2016) *Learning, candour and accountability: a review of the way NHS Trusts review and investigate the deaths of patients in England*. {Online}.
Available at https://www.cqc.org.uk/sites/default/files/20161213-learning-candouraccountability-full-report.pdf (

Hogan et al (2012) Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study, *BMJ Quality and Safety* 21 (9), 737-45

Hogan et al (2015) Avoidability of hospital deaths and association with hospital-wide mortality ratios: a retrospective case record review, *BMJ* [Online] 351: h3239 Available at http://www.bmj.com/content/bmj/351/bmj.h3239.full.pdf

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Available at http://www.bristol.ac.uk/medialibrary/sites/sps/leder/Initial%20review%20(Blank)%20V2.0.pdf

NHS Digital (2017) *SHMI: guidance for trusts* [Online]. Available at http://www.content.digital.nhs.uk/media/22828/SHMI-trustguidance/pdf/SHMI_guidance_for_trusts.pdf

NHS England (2016) *The five year forward view of mental health*. [Online]. Available at https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

National Quality Board (2017) *National guidance on learning from deaths: a framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care.* [Online]. Available at https://www.england.nhs.uk/wp content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Royal College of Physicians (2016) National Mortality Case Record Review Programme resources. Using the structured judgement review method. Available at https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-reviewnmcrr-programme-resources

Equality Analysis

Equality Analysis (EA) Form

The Equality Analysis (EA) form should be completed in the following circumstances:

- **All new policies**
- **All policies subject to renewal**
- **Business cases submitted for approval to hospital management impacting on service users or staff**
- **Papers submitted to hospital management detailing service redesign/reviews impacting on service users or staff**
- **Papers submitted to Board of Directors for approval that have any impact on service users or staff**

Please note the results of this Equality Analysis will be published on the Trust website in accordance with the Equality Act 2010 duties for public sector organisations

Section 1 should be completed to analyse whether any aspect of your proposal/document has any impact (positive, negative or neutral) on groups from any of the protected characteristics listed overleaf.

When considering any potential impact you should use available data to inform your analysis such as PALS/Complaints data, Patient or Staff satisfaction surveys, local consultations or direct engagement activity. You should also consult available published research to support your analysis. For further support with this, please refer to the Library and Knowledge Service accessible via the Trust's intranet site or switchboard.

Section 1 – Initial analysis

What is the impact on the equality groups below?		
Positive: • Advance equality of opportunity • Foster good relations between different groups • Address explicit needs of equality target groups	**Negative:** • Unlawful discrimination, harassment and victimisation • Failure to address explicit needs of equality target groups	**Neutral:** • It is quite acceptable for the assessment to come out as Neutral impact • Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Group	**Any potential impact?** **Positive, negative or neutral**	**Comments / Evidence** (For any positive or negative impact please provide a short commentary on how you have reached this conclusion)
Disability (Inc. physical and mental impairments)	Positive	Specific requirement to undertake SJR on 'at risk' groups
Age	Neutral	
Race (all ethnic groups)	Neutral	
Religion or belief	Neutral	
Sexual Orientation	Neutral	

Pregnancy & Maternity	Neutral	
Gender	Neutral	
Gender Re-assignment	Neutral	
Human Rights	Neutral	
Other e.g. Carers	Neutral	

If you have identified any **negative** impact you should consider whether you can make any changes immediately to minimise any risk. This should be clearly documented on your paper cover sheet/policy document detailing what the negative impact is and what has changes have been made.

If you have identified any **negative** impact that has a high risk of adversely affecting any groups defined as having a protected characteristic then please continue to section 2.

In all cases - you should submit this document with your paper and / or policy in accordance with the governance structure with copies to wih-tr.EqualityWUTH@nhs.net for monitoring purposes.

Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Equality Analysis	Mike Ellard	September 2019	This document is embedded within the Policy template
Other Stakeholders / Groups Consulted as Part of Current Version Development	Medical Director Interim Associate Director of Nursing for Safeguarding Clinical Governance Matron - Women and Children's Services Head of Quality & Governance Deputy Director of Nursing Deputy Head of Patient Experience and Bereavement Services Manager		
Trust Staff Consultation via Intranet	N/A		

Date notice posted in the News Bulletin.	N/A	**Date notice posted on the intranet**	October 2019

Describe the Implementation Plan for the Policy / Procedure (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc.)	**By Whom will this be Delivered?**

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
Sept 2017	1	Dr Mark Lipton, Deputy Medical Director	New Policy to replace Mortality Review Framework
Sept 2019	2	Mike Ellard, Deputy Medical Director	Update to existing policy

Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Trust Board quarterly reports as open agenda item	4 pa	Trust Board agenda	MRSG/ PSQB	Quarterly	Deputy Medical Director
Annual Learning from Deaths report	1 pa	Trust Board agenda	MRSG/ PSQB	Annually	Deputy Medical Director

Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Deputy Medical Director	MRSG/ PSQB	Quarterly