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| **‘LEARNING FROM DEATHS’ POLICY** | | | |
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1. **INTRODUCTION**

This policy outlines the process for routine clinical review following deaths of patients managed by Stockport NHS Foundation Trust (‘the trust’, SNHSFT). This will include deaths in hospital, but also extend to some deaths and in the community, where the trust has been actively involved in care provision.

This process is referred to as ‘mortality review’ (MR) or ‘learning from deaths’. The purpose of this process is to ensure that opportunities to learn from the care received by patients dying in our organisation, or within 30 days of discharge. National standards of investigation and of data collection and publication supporting this process must be met.

There are three key priorities;

1. Learning to improve and change the way care is provided
2. Candour to support sharing information with others including families
3. Accountability if failures are found.
4. **ASSOCIATED DOCUMENTS**

Further sources of help and guidance are:

**Trust documents**

Being open and duty of candour policy

Incident reporting and management policy

Procedure for assisting HMC in the investigation of a death SOP

Investigating incidents, complaints and claims SOP

Management of SI SOP

**National documents**

Learning, Candour and Accountability – Care Quality Commission, December 2016.

National Guidance on learning from deaths – National Quality Board (NQB), March 2017.

Serious Incident Framework – NHS England, march 2015.

**3 DUTIES**

**The Board of Directors**

Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support.

Champion and support learning and quality improvement

**Medical Director**

To take overall responsibility to ensure processes outlined in this policy are robustly enacted. To ensure that national developments and policies in this area are duly considered.

**Mortality Review Group**

The mortality review group will offer oversight of the mortality review process.

**Trust Governance Lead**

To ensure that the mortality review process compliments the trust incident reporting and management and trust ‘being open and duty of candour policy’.

**Mortality information lead.**

To ensure development and delivery of robust means of numerating deaths, and displaying the output of mortality review on a national dashboard.

**Mortality reviewers**

The mortality reviewers must review the case notes to offer a view about the care that the patient received. The goal should be to ensure robust application of high clinical standards, and to apply challenge where care has fallen short of required standards. (see section 11 for the limitations of the role).

**4 DEFENITIONS**

**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, for example Structured Judgement Review delivered by the Royal College of Physicians.

**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.

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

**5. SELECTION OF DEATHS FOR CASE NOTE REVIEW.**

All adult inpatient deaths will be considered for case note review. Cases most likely to offer opportunities for learning or service development will be prioritised.

Any patients who die after discharge from our hospital, but in whom concerns relating to their death are raised, will be subject to case note review. These concerns, and a request for a mortality review can be raised by relatives or health professionals by contacting the governance and risk team, or through PALS.

In the future, this may be expanded to include all deaths within 30 days of hospital admission.

**Case note selection**

Prioritisation will be given to review where the following ‘red flags’ exist;

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| All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision; |

All surgical deaths

All obstetric deaths

All paediatric deaths

Deaths within 72 hours of admission

Deaths within 72 hours of invasive procedures

Deaths from; Refractory epilepsy or status epilepticus

Acute asthma

Diabetic ketoacidosis

Gastrointestinal bleeding

Clostridium difficile or MRSA septicaemia

All deaths from conditions where the trust has been highlighted by external agencies as a statistical outlier for mortality.

All deaths in patients with serious mental health issues or learning difficulties (see below)

20% of all case note reviews will be selected randomly.

**Review of in-hospital resuscitation attempts.**

Patients who suffer a cardiac arrest (with resuscitation attempt) in hospital, or after arrival in the emergency department are of particular interest for case note review, as one of the greatest sources of potential learning.

National cardiac arrest audit (NCAA) – definition of cardiac arrest.

All individuals (excluding neonates) receiving chest compression(s) and/or defibrillation and attended by the hospital-based resuscitation team (or equivalent) in response to the 2222 call

All patients who fulfil this definition after arrival in our Emergency Department (ED), or while an in-patient on one of our wards, will be subject to mortality ‘type’ review irrespective of whether the patient dies or survives the resuscitation attempt.

Mortality review after cardiac arrest will be led by the reviewer covering the ward in which the patient was being cared for immediately prior to the cardiac arrest (rather than the subsequent place of subsequent death, such as ICU)

The learning from these reviews will be fed into our mortality review process.

**Mental health**

The ‘[Five Year Forward View’ for Mental Health](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf) identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people.

The NQB guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness should be subject to case record review.

The process to identify these patients is to be established.

**Learning disabilities**

Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities.

The NQB specifies that all inpatient, outpatient and community patient deaths of people with learning disabilities should be reviewed in order that learning from these deaths can contribute to service improvements.

At present, NHS England is working with NHS Digital to explore the options and potential of ‘flagging’ the records of people with learning disabilities on the NHS Spine. Over time, this could provide an access point for identifying that a person who has died had learning disabilities. Until this is in place, patients with learning disabilities must be flagged for mortality review by clinicians, on a case by case basis.

The [Learning Disabilities Mortality Review (LeDeR) programme](http://www.bristol.ac.uk/sps/leder/), commissioned by HQIP, has an established and well-tested methodology for reviewing the deaths of people with learning disabilities.

All patients who die at the trust that are identified as having learning disability will be referred to the LeDeR program

Telephone **0300 777 4774 or http://www.bristol.ac.uk/sps/leder/notify-a-death/**

1. **PROCESS OF CASE NOTE REVIEW**

The NQB guidance recommends that all providers take a consistent and evidence-based approach to reviewing case records of adults who have died in acute hospitals.

Healthcare Quality Improvement Partnership (HQIP) have commissioned the Royal College of Physicians (RCP) to develop a standardised approach to case record review – referred to as Structured Judgement Review (SJR)

In the trust the SJR will be the default means of ensuring robust mortality review is carried out.

Where business group mortality review teams adopt a different methodology, a summary of that methodology, and rationale for omitting any key aspects of the SJR will need to be presented and ratified by the mortality review group.

Mortality review needs to be completed in a timely fashion, such that learning points can be be reinforced while recollection of the case remains recent. In normal circumstances, all cases flagged for mortality review should be reviewed within one month of the death.

All case note reviews will be submitted to the corporate governance team to be retained on a central archive for future use.

1. **MATERNAL DEATHS AND STILLBIRTHS**

All maternal deaths (within 42 days of delivery) and all stillbirths are already reported to ‘mothers and babies – reducing risk through audits and confidential enquiries’ (MBRRACE-UK). All such deaths are extensively peer reviewed.

1. **END OF LIFE CARE**

Good end of life care is a key marker of excellent healthcare. While ‘avoidable deaths’ are unlikely to feature, appraisal of the quality of care in this group of patients is a fundamental role of the mortality review process.

Approximately 50% of all deaths have undergone a significant period of formal palliative care. By ensuring that 20% of all deaths for review are randomly chosen, we can be confident that palliative care deaths will be captured. Half of the randomly selected mortality reviews will be reviewed by the palliative care team to ensure suitable standards of palliative care are being delivered.

1. **FAMILY INVOLVEMENT.**

Providers must offer families/carers the opportunity to express concerns about the care given to patients who have died.

All next of kin are given an information leaflet when they attend the trust to collect their medical certificate. This leaflet offers access to bereavement support, but also the opportunity to give feedback about the experience of clinical care. Where significant shortfalls in care are identified through this process, a mortality review will be triggered.

When reviewing or investigating possible problems with care, involvement of bereaved families is crucial. Our duty of candour responsibilities also dictate that significant shorftalls in care identified at mortality review investigation should be fed back to the next of kin.

The appropriate staff member to communicate with the family should be identified for each case. They should explain what went wrong promptly, fully and compassionately. A sincere apology should be offered for any significant shortfalls in care. Feedback may include clinicians involved in the case but this may not always be appropriate or possible and should be considered on a case by case basis.

The mortality review process is designed to identify and highlight deficiencies in care. Addressing these deficiencies will be undertaken at business group level. Duty of candour responsibilities will be led by the business group governance team.

The family or next of kin will be signposted to legal advice should it be required.

1. **INVOLVING OTHER ORGANISATIONS**

Where deficiencies in care are identified relating to other healthcare providers, they must be offered the opportunity to learn from the feedback.

Contact with a suitable governance team at the alternative provider, the medical director, or Clinical practice lead must be made. This contact must be documented in the case note review.

**11. COMPARATIVE DATA AND LIMITATIONS OF MORTALITY REVIEW**

The review assessment is finely balanced judgement based upon a relatively brief case note overview, and the primary goal is to facilitate learning and to improve future patient care.

The case note review is a time limited overview of the case by an experienced clinician. The clinician will not be an expert in all areas of care, but must make a judgement to the best of their abilities.

Case note review alone will lead to considerable inter-individual variation of conclusions, and the decisions made will be subjective. The conclusions drawn from case note review do not have the forensic credibility of a full case investigation, and must be considered in this context. Conclusions are unlikely to be as consistent or as valid as that reached were a formal case investigation is undertaken.

The case note review is a useful tool to facilitate learning and improve future patient care, in particular looking for possible system failings, and recurrent themes. These reviews should not be considered to be a thorough, formal, definitive professional opinion, about the quality of care delivered in individual cases (for litigation or inquest).

Where a death is felt to have been deemed potentially avoidable, a second reviewer should examine the case notes independently to support or challenge the conclusion.

Inter-organisational consistency in case note review does not currently exist. Comparison between organisations cannot and should not be used to make external judgements about the quality of care provided

**12 RELATIONSHIP WITH SERIOUS INCIDENTS**

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| Rigorous judgement must be applied to the need for deaths requiring escalation for a Serious Incident (SI) reporting and investigation.  **Serious Incidents**  Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using the additional resources required to undertake a comprehensive investigation.  There may be instances where deaths meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken). Further to this, any case note reviewer can report a ‘possible SI’ by completing a Datix report on the case in question. The case will then be considered by the Trust Incident Review Meeting, and a full SI investigation triggered as required.  Problems identified in case record review may not meet the criteria for Serious Incident, but require consideration and cascading on a more informal basis. Such cases should be fed back by the mortality reviewer, to the clinical director or Morbidity and Mortality lead for local investigation and departmental reporting.  Further information on the process for reporting and investigating serious incidents is available in the trusts incident reporting and management policy. |

**13. HOLDING TO ACCOUNT**

To generate learning for improvement in healthcare, clinicians and staff should engage in robust processes of retrospective case record review to help identify if a death was more likely than not to have been contributed to by problems of care.

Investigations are conducted to understand the cause of death and contributing factors, not to hold any individuals to account. Other processes exist for that purpose including criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, including the General Medical Council and the Care Quality Commission.

In circumstances where deficiencies of care identified at mortality review cause sufficient concern about individual or group performance, the actions of other agencies (outside of the mortality review process) will be required. Those agencies must be appropriately informed and relevant protocols must be followed.

**14. LEARNING FROM DEATHS**

The primary goal of the mortality review process is to improve future patient care. Facilitating learning from the deaths that are reviewed is a critical step in this process. Each business group must ensure that they have a robust process for cascading the learning from mortality reviews conducted in their business group.

Assuring a robust process for learning from mortality review must be a feature of the business group quality board / business group board. Compliance with this need will be appraised at the business group assurance meetings.

The mortality review group will ensure that key themes across the organisation are fed into this process.

**14. REVIEW**

This policy will be reviewed in 3 years or in light of further national guidance or legislation being issued.