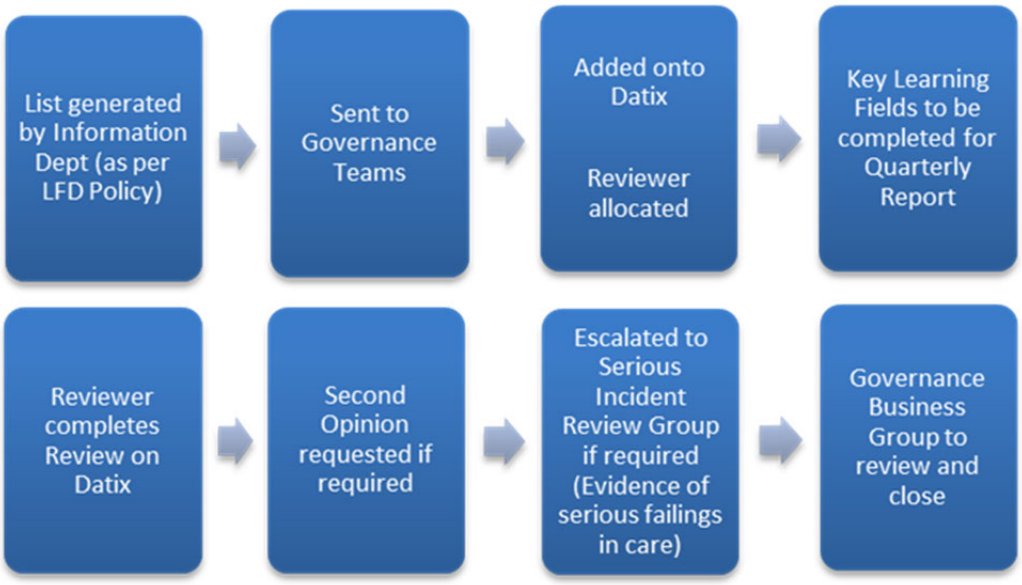
LEARNING FROM DEATHS REVIEW GUIDELINE

GUIDELINE CONTENTS

THE PROCESS – AT A GLANCE



EXECUTIVE SUMMARY

This guideline outlines the structures and processes for mortality review following deaths of patients cared for by Stockport NHS Foundation Trust ('The Trust'). This routinely includes deaths in hospital, but may also include some deaths in the community after discharge from hospital.

The process is referred to as Learning from Deaths (LFD) and is based on the document published by the National Quality Board (NQB) in March 2017 entitled National Guidance on Learning from Deaths. The purpose of the process is to ensure that any opportunities to learn from the care received by patients dying in our organisation are recognised, analysed and publicised; that appropriate actions are taken to improve the quality and safety of patient care going forward; and that these actions are audited for their clinical effectiveness.

National standards of investigation and of data collection and publication supporting this process must be met. As such, The Trust uses a data collection form based on the Structured Judgement Review (SJR) methodology published in conjunction with the National Mortality Case Record Review programme (NMCRRP).

There are three key priorities;

1. Learning to improve and change the way care is provided.
2. Duty of Candour to support sharing information with others which may include families.
3. Accountability, if failures are found.

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
- Medical Examiner Policy (ME SOP-BW-V5)

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.

THE SCOPE OF THE GUIDELINE

The content of this guideline applies to all staff who are involved in the review of patient deaths. This includes:
- Members of the Mortality Review Group (MRG).
- Learning from Deaths (LFD) Chair (Trust MD or LFD Lead Clinician)
- LFD Lead Clinician
- LFD reviewers
- Deputy Director of Quality Governance
- Clinical Governance Leads
- IT representative
- Bereavement Office Manager
- Medical Examiners
- Medical Examiner Officers

ROLES AND RESPONSIBILITIES

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 guideline 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 and implementation of the LFD guideline.

Deputy Director of Quality Governance

- The Deputy Director of Quality Governance is to ensure that the mortality review process, compliments the Trust's Incident reporting and management, and Trust's 'Being open and Duty of candour policy'.

Mortality Information Lead

- The Mortality Information Lead is to ensure development and delivery of a robust means of numerating deaths, and displaying the output of mortality reviews on a national dashboard.

Learning from Deaths Lead Clinician

- To develop and oversee implementation of the LFD process Trust-wide, including appointing LFD reviewers and ensuring they are appropriately trained in SJR methodology; to provide second opinions of cases referred by LFD reviewers to consider whether or not escalation is required; to publish a quarterly LFD report to be submitted to the MRG and a LFD newsletter for wider dissemination.

Learning from Deaths Reviewers

- To learn/receive training on the SJR methodology; to review all deaths flagged up by LFD using the approved reporting method; to liaise with the relevant M&M lead when clinical management has been assessed as suboptimal and lessons could be learned; to escalate more serious failures of clinical management to the LFD lead clinician; to write a quarterly summary LFD report.
- To supervise and delegate reviews to suitably trained (SJR methodology) staff where appropriate.

Medical Examiners

- Medical Examiners must report concerns that are identified as part of their role, so that LFD reviewers are able to complete the appropriate review

DEFINITIONS

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 introduced by the Royal College of Physicians and adopted by the NMCRRP.

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.

SELECTION OF DEATHS FOR CASE NOTE REVIEW

- All inpatient deaths will be considered for case note review
- Any patients who die after discharge from our hospital, but in whom significant concerns relating to their death are raised, will also be subject to case note review

Case note selection

- Prioritisation will be given to review where the following ‘red flags’ exist;
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of patient care and where there is a prima facie case for further investigation, usually via the Medical Examiner
- All surgical deaths (including death from GI haemorrhage)
- All obstetric deaths
- All paediatric, neonatal and stillbirth deaths
- All deaths within the remit of the LeDeR programme
- All deaths within the critical care unit (including ICU, HDU, theatre recovery and operating theatres)
- All cardiac arrest deaths
- One (randomly chosen if no specific reason) palliative care death per week
- All deaths within the ED

All of the above categories account for only about 10% of the total number of hospital deaths, with medicine accounting for the residual large majority. As it is not possible to review all of the medical deaths within current resource constraints, a selected subset of medical deaths will be subjected to LFD review according to the following “red flag” criteria:

Refractory epilepsy
Acute asthma
DKA
Within 24 h of an invasive procedure

The current target number of medical deaths for LFD review is 8 per week with current resources. (This number may change going forward with any increase in resource). It is likely at least 8 per month may be generated via the Medical Examiner process.

At least 8 deaths per month on the AMU will also be reviewed, including the above conditions, Medical Examiner cases and random cases to make up numbers, if needed.

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 SJR, irrespective of whether the patient dies or survives the resuscitation attempt.

Patients who suffer a cardiac arrest on the ICU or HDU may be considered an exclusion on the judgement of the relevant LFD reviewer in consultation with the Lead Clinician for LFD.

If the patient survives the cardiac arrest, case note review of the arrest will be led by the LFD reviewer covering the location/specialty in which the patient was being cared for at the time of the cardiac arrest. However, if the patient later dies, the cardiac arrest review will be included in the LFD review by the relevant reviewer at the time/place of death.

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

Mental health

The 'Five Year Forward View' for Mental Health 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.

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, 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 and will be subjected to LFD review.

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.

The Trust has adopted the Structured Judgement Review (SJR) methodology published in conjunction with the National Mortality case Record Review program (NMCRRP) methodology for data acquisition and mortality review.

Mortality review needs to be completed in a timely fashion. In normal circumstances, all cases flagged for mortality review should be reviewed within one month of the death.

Mortality cases outstanding beyond one month will be escalated to the Business Group Associate Medical Director for action.

Mortality review cases outstanding beyond two months will be escalated to the MD for action.

All reviews will be recorded on Datix.

MATERNAL DEATHS, STILLBIRTHS, NEONATAL AND PAEDIATRIC DEATHS

All neonatal deaths and stillbirths are reviewed using an online perinatal mortality review tool managed by MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK). Quarterly reports are presented to the maternity safety champions (Executive team led).

All term neonatal deaths have a rapid review and are reported to SIRG and considered for escalation as a serious incident, as well as being reported to HSIB.

Almost all neonatal deaths are reported to the Coroner and in almost all cases an inquest is opened.

Paediatric deaths, if unexpected, are reportable to the Coroner, if a hospital death. If the death occurs in the community, the SUDI(sudden and unexpected death in infancy) process is commenced and again reported to the Coroner.

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.

At least one palliative care death should be subjected to LFD review each week.

FAMILY INVOLVEMENT

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

All next of kin are given the opportunity to report any concerns about their relative's death at the time they meet with the Medical Examiner. The Medical Examiner may choose to refer to the Coroner's Office, refer the family to Patient Advice and Liaison service, or recommend an LFD, depending on the nature of their concerns. Referral for LFD is via the Trust Datix reporting system.

When reviewing or investigating possible problems with care, involvement of bereaved families is crucial. Our duty of candour responsibilities also dictate that the results of any mortality review investigation should be fed back to the next of kin, using a letter informing them of the key findings.

The appropriate staff member should be identified for each case to explain what may have gone wrong promptly, fully and compassionately. Where shortfalls in care are identified, a sincere apology should be offered. This feedback may include clinicians involved in the case but this may not always be appropriate 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 Divisional level. Duty of candour responsibilities will be led by the Divisional Governance teams.

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

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.

COMPARATIVE DATA AND LIMITATIONS OF MORTALITY REVIEW

The LFD review is a time limited overview of the case by an experienced clinician. The goal is to identify any deficiencies in care to promote learning. The LFD review is a finely balanced judgement based upon a relatively brief case examination of the case notes and the primary goal is to facilitate learning and to improve future patient care. It is therefore an educational rather than a forensic investigative tool.

Case note review alone may lead to inter-individual variation of conclusions and any conclusions drawn will be relatively subjective. The conclusions drawn from LFD review do not have the forensic credibility of a full investigation and must therefore be considered in this context. LFD reviews are a relatively insensitive tool for identifying suboptimal clinical practice. Conclusions will not be as consistent or as valid as that reached were a formal case investigation is undertaken.

The case note review is, however, 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 (usually the LFD Lead Clinician) will examine the case notes/SJR independently to support or challenge the conclusion.

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

RELATIONSHIP WITH SERIOUS INCIDENTS

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 LFD review has already been undertaken). Further to this, any LFD reviewer can report a ‘possible SI’ by completing a Datix report on the case in question. The case will then be considered by the Serious Incident Review Group, and a full SI investigation triggered as required.

Problems identified in LFD 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 LFD reviewer, to the 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.

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 will be required. Those agencies must be appropriately informed and relevant protocols must be followed.

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 Division must ensure that they have a robust process for cascading the learning from mortality reviews conducted in their Division.

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

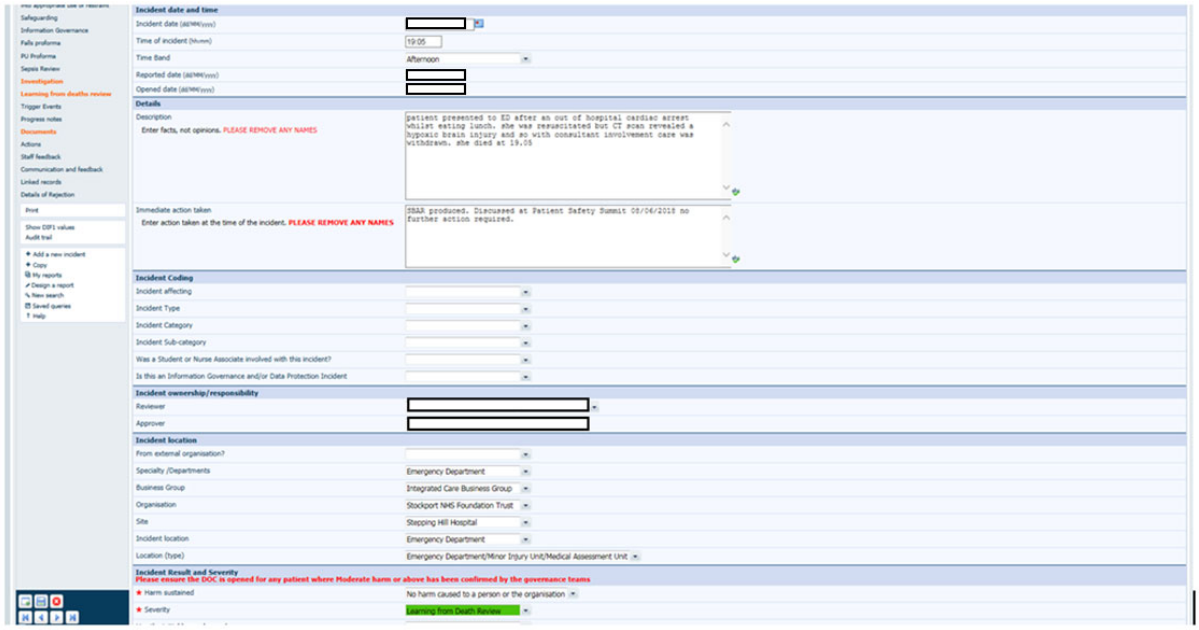
The mortality review group will ensure that key themes across the organisation are fed into this process.

A Quarterly review report will be produced and presented at the Mortality Review Group Meeting that is held quarterly. This will then be disseminated through to the Divisions

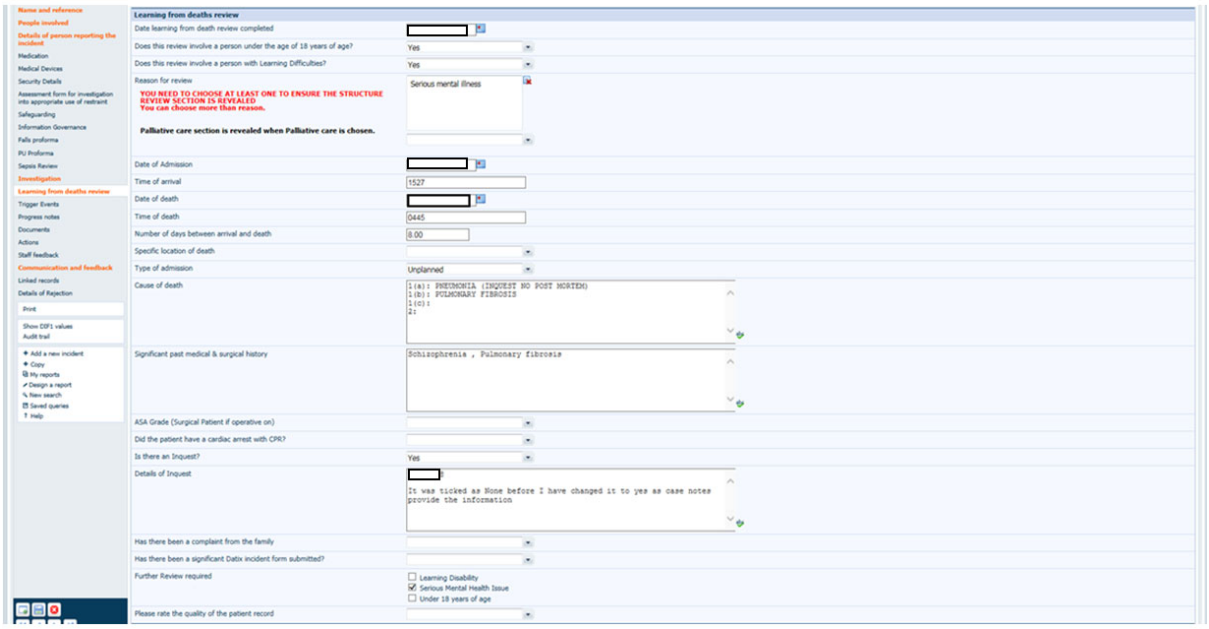
A Mortality Group Report is produced for presentation quarterly at the Patient Safety Group and for review at Trust Board meetings as appropriate.

DATIX

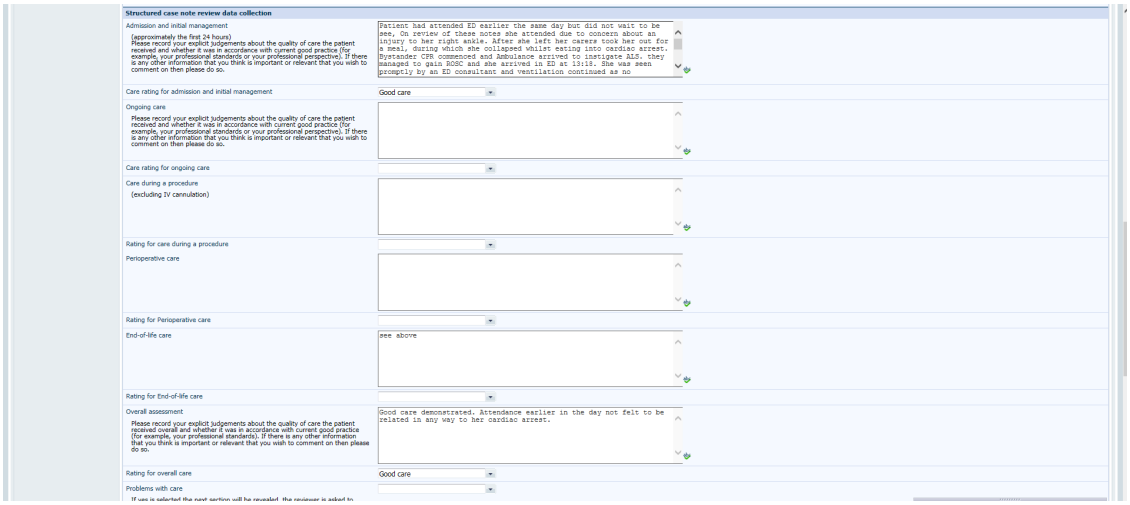
Learning from Death reviewers will have a different profile to other reviewers of Incidents as it has only the Learning from Death Review incidents

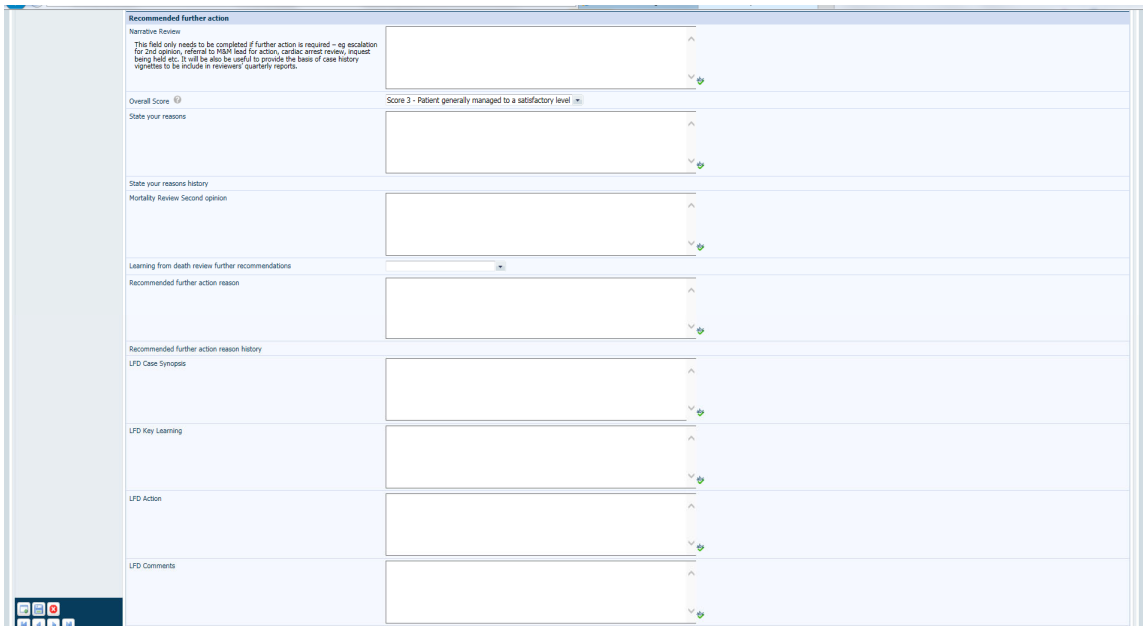


To access the Learning from Death review – click on the Section on the side.



The form follows the structured review format





REVIEW

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

MONITORING COMPLIANCE

The Trust is committed to ensuring compliance with documents and will actively monitor the effectiveness of such documents.

Process for monitoring compliance with this guideline

CQC Regulated Activities	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
17	Report	Mortality Group	Quarterly	Patient Safety Group	Mortality Group	Patient Safety Group

DOCUMENT LAUNCH AND DISSEMINATION

Launch
Once approved the document will be launched at the next Mortality Review Group

Dissemination
Once approved the document will be circulated to all LFD Reviewers, Governance Teams and Medical Examiner Officers

EQUALITY IMPACT ASSESSMENT

Office Use Only

Submission Date:	18 August 2021
Approved By:	N Baynham
Full EIA needed:	No

Equality Impact Assessment – Policies, SOP's and Services not undergoing re-design

1	**Name of the Policy/SOP/Service**	Learning from Deaths Review Guideline	
2	**Department/Business Group**	Governance	
3	**Details of the Person responsible for the EIA**	**Name:** **Job Title:** **Contact Details:**	Suzy Collins LFD Lead Reviewer Suzy.collins@stockport.nhs.uk
4	**What are the main aims and objectives of the Policy/SOP/Service?**	To provide and outline of the Learning from Deaths process within the Trust	

For the following question, please use the EIA Guidance document for reference:

5	**A) IMPACT** **Is the policy/SOP/Service likely to have a differential impact on any of the protected characteristics below? Please state whether it is positive or negative. What data do you have to evidence this?** **Consider:** • What does existing evidence show? E.g. consultations, demographic data, questionnaires, equality monitoring data, analysis of	**B) MITIGATION** **Can any potential negative impact be justified? If not, how will you mitigate any negative impacts?** ✓ Think about reasonable adjustment and/or positive action ✓ Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints. ✓ Assign a responsible lead. ✓ Produce action plan if further

	complaints. • Are all people from the protected characteristics equally accessing the service?	data/evidence needed ✓ Re-visit after the designated time period to check for improvement. **Lead**	
Age	Workforce Data: Average age 44.5 Stockport Population Data: Largest age band 40 – 49	There are not considered to be any specific impacts with regards to different age groups.	
Carers	The 2011 Census showed there are 31,982 unpaid carers in Stockport. 6,970 (22% of all carers) provide 50+ hours of care per week. Signpost for Carers estimate the total value of unpaid care in Stockport is £570 million a year. Trust Workforce: No Data	There are not considered to be any specific impacts with regards to individuals as carers.	
Disability	The 2011 census indicates that 18.4% of Stockport residents are living with a limiting long-term illness Trust Workforce: 3.32% report disability. 11.94% not declared	The LeDeR review process will identify those individuals with a Learning Disability, in whom all cases receive an LFD review. There are not considered to be any specific impacts in those with a physical disability.	
Race / Ethnicity	Stockport's Black & Minority Ethnic (BME) population has risen from just 4.3% in 2001 to around 8% at the 2011 Census Trust Workforce: BAME make up 16.18%	There are not considered to be any specific impacts with regards to Race or Ethnicity.	
Gender	Stockport's population is split almost equally by gender (51.1% female, 48.9% male), which mirrors the national trend. Trust Workforce: 79.9% female	There are not considered to be any specific impacts with regards to Gender.	
Gender Reassignment	It is estimated that 1% of the UK population is gender variant, based on referrals to and diagnoses of people at gender identity clinics. This would equate to 3,000 people in the borough Trust Workforce: No Data	There are not considered to be any specific impacts with regards to Gender Reassignment.	
Marriage & Civil	38% married 0.2% of people in the 2011 census were	There are not considered to be any specific impacts with	

Partnership	in a civil partnership – a figure which is consistent across Stockport, the North West and nationally. Trust Workforce: 54.9% married & 0.7% Civil Partnership	regards to Marriage and Civil Partnership.	
Pregnancy & Maternity	2% fertility rate On average there are over 3,300 births to Stockport resident mothers each year. Trust Workforce: 2.14% on maternity or adoption leave*	All maternal and neonatal deaths are reviewed in line with national policies, as outlined in Section 8.	
Religion & Belief	The majority of Stockport residents are Christian (63.2% - down from 75% at the last census), which is 4% greater than the national average. Trust Workforce: 52.47% Christian	There are not considered to be any specific impacts with regards to Religion or Belief.	
Sexual Orientation	It is estimated that 5-7% of the UK population is LGB, which would equate to 15-21,000 people in the borough. Trust Workforce: 2.12% LGBT 20.09% did not want to declare	There are not considered to be any specific impacts with regards to Sexual Orientation.	
General Comments across all equality strands			

EIA Sign-Off	**Your completed EIA should be sent to Equality, Diversity & Inclusion Manager for approval:** equality@stockport.nhs.uk

Quality

(Clinical & Quality Impact Assessment please record 'No Impact' if this is the case)

Date of initial review	06/12/2021	Date of last review	6/12/2021

Area of Impact		Consequence	Likelihood	Total	Potential Impact	Impact (Positive or Negative)	Action	Owner
Quality	Duty of Quality			0	How does it impact adversely the rights and pledges of the NHS Constitution?	Positive	None	
					How does the impact affect the organisations commitment to being an employer of choice?	No impact	None	
					What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individuals access to services and experience of the service?	See EIA	None	
	Patient Safety			0	How will this impact on the organisation's duty to protect children, young people and adults?	Positive	None	
					How will it impact on patient safety? • infection rates • medication errors •significant untoward incidents and serious adverse events •Mortality & Morbidity •Failure to recognise a deteriorating patient •Safe staffing levels	Positive	None	
					How will it impact on preventable harm? (eg slips, trips, falls)?	Positive	None	
					How will it impact upon the reliability of safety systems? (eg WHO checklist)	Positive	None	
					How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	Positive	None	
					How will this impact on workforce capability, care and/or skills?	Positive	None	
Experience	Patient Experience			0	What impact is it likely to have on self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	Positive	None	
					How will it impact on choice?	No Impact	None	
					Will there be an impact on waiting times?	No Impact	None	
					How will it impact upon the compassionate and personalised care agenda?	Positive	None	
	Staff Experience			0	How will it impact on recruitment of staff	No impact	None	
					What will the impact be on staff turnover and absentee rates	No impact	None	
					How will it impact on staff satisfaction surveys	No impact	None	
Effectiveness	Clinical Effectiveness and Outcomes			0	How does it impact on implementation of evidence based practice?	Positive	None	
					How will it impact on patient's length of stay?	No impact	None	
					Will it reduce/impact on variations in care? (eg readmission rates)	Positive	None	
					What will the impact be upon clinical and cost effective care delivery?	Positive	None	
					How does it impact upon care pathway(s)? Eg mortality	Positive	None	
					How will it impact on target performance?	No impact	None	
Other	Please use this section to detail any other impacts to clinical and quality that are not listed in the questions			0				

Data Protection Impact Assessment

DPIA Screening Questions

		Yes	No	Unsure	**Comments** *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
a)	Will the process described involve the collection of new information about individuals?		no		
b)	Does the information you are intending to process identify individuals (e.g. demographic information such as name, address, DOB, telephone, NHS number)?		no		
c)	Does the information you are intending to process involve sensitive information e.g. health records, criminal records or other information people would consider particularly private or raise privacy concerns?		no		
d)	Are you using information about individuals for a purpose it is not currentlyused for, or in a way it is not currently used?		no		
e)	Will the initiative require you to contact individuals in ways which they may find intrusive[1]?		no		
f)	Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		No		
g)	Does the initiative involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		no		
h)	Will the initiative result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		no		
i)	Will the initiative compel individuals to provide information about themselves?		no		

1. Intrusion can come in the form of collection of excessive personal information, disclosure of personal information without consent and misuse of such information. It can include the collection of information through surveillance or monitoring of how people act in public or private spaces and through the monitoring of communications whether by post, phone or online and extends to monitoring the records of senders and recipients as well as the content of messages.

If you answered YES or UNSURE to any of the above you need to continue with the Privacy Impact Assessment. Giving false information to any of the above that subsequently results in a yes response that you knowingly entered as a NO may result in an investigation being warranted which may invoke disciplinary procedures

Document Information

Type of Document	Guideline
Title	‘LEARNING FROM DEATHS REVIEW’ GUIDELINE
Version Number	1
Consultation	Mortality Group Patient Safety Group
Recommended By:	Mortality Group
Approved By:	Patient Safety Group
Approval Date	December 2021
Next Review Date	August 2024
Document Author	Learning from Deaths Lead
Document Director	Medical Director
For use by:	All Trust employees
Specialty / Ward / Department (if local procedure document)	N/A

Version	Date of change	Date of release	Changed by	Reason for change