City Hospitals Sunderland
NHS Foundation Trust

MORTALITY REVIEW & LEARNING FROM DEATHS POLICY

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Document status	Final
Target Audience	All clinical staff involved in mortality case record reviews and investigations and who have a role to play in learning from death
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Ratified by	Board of Directors
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Sponsor	Ian Martin, Medical Director

Version	Dates of amendment	Author	Update comments
1.0	Sep 2017	David Laws, Consultant & Chair Trust Mortality Lead and Gary Schuster, Clinical Governance Manager	New policy in response to national requirement under the National Quality Board 'Learning From Deaths' Programme
1.1	Sep 2017		Final amendments following feedback from Policy Committee/Board

1 INTRODUCTION

1.1 The Care Quality Commission (CQC) published a report, 'Learning, candour and accountability; a review of the way NHS trusts review and investigate the deaths of patients in England' in December 2016.

1.2 The report describes a review of the process of investigating deaths in a sample of NHS acute, mental health and community Trusts in England. This was undertaken in response to a review of mental health and learning disability deaths at Southern Health NHS Foundation Trust between April 2011 and March 2015. The CQC report identified that:

- families and carers are not treated consistently well when someone they care about dies;
- there is variation and inconsistency in the way that Trusts become aware of deaths of patients in their care;
- there was an inconsistent approach across Trusts to determine when to investigate deaths;
- the quality of investigations is variable and generally poor; and
- there are no consistent frameworks that require Boards to keep deaths in their care under review and share learning from these.

1.3 In their review, the CQC made a number of recommendations about how the approach to learning from deaths could be standardised across the NHS. These recommendations were accepted by the Secretary of State for Health, who asked the National Quality Board to produce a framework for the NHS on identifying, reporting, investigating and learning from deaths in care.

1.4 In March 2017, the National Quality Board published the first edition of the 'National Guidance on Learning from Deaths'. One of the key requirements for Trusts was to publish a policy on how they respond to, and learn from, deaths of patients who die under their management and care.

2 PURPOSE AND SCOPE

2.1 The purpose of the Trust's Mortality Review & Learning from Death Policy is to describe the process by which patients who die in the Trust's care are identified, reported and investigated. It aims to strengthen current arrangements, where appropriate, and to ensure that learning is shared and acted upon.

2.2 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 death.

3 DUTIES / RESPONSIBILITIES

3.1 **Board of Directors**

The Board of Directors is collectively responsible for ensuring the quality and safety of the healthcare it provides. The Board ensures robust systems are in place for recognising, reporting, and reviewing or investigating deaths where appropriate.

3.2 **Chief Executive**

The Chief Executive is responsible for the statutory duty of quality in the organisation and delegates responsibility for the implementation of this policy to the Medical Director.

3.3 **Medical Director**

The Executive lead for Learning from Death is the Medical Director. Responsibilities in respect of the Learning from Death programme include:

- working with the Executive Director of Nursing and Patient Experience all doctors and nurses are supported to fulfil their duty to engage in learning from deaths, participate fully in case record reviews and investigations where appropriate and fulfil the Trust Duty of Candour requirements,
- ensuring that the Trust is learning from problems in healthcare identified by the review or investigation of deaths,
- ensuring that any serious concerns following a patient death are brought to the attention of the Board,
- publishing quarterly mortality reports to the public Board meetings, and
- ensuring that the annual Quality Account summarises the outcomes and learning from the Trust mortality review process.

3.4 **Designated Non-Executive Director for Learning from Death**

The designated Non–Executive Director for Learning from Death oversees the Trust's approach to Learning from Death. Responsibilities in relation to the guidance include:

- ensuring the processes in place for reviewing and learning from deaths are robust and can withstand external scrutiny;
- championing and supporting effective actions that improve patient safety; and
- ensuring mortality review outcomes information shared with the public is presented in a meaningful and understandable way.

3.5 **Mortality Review Panel**

The Mortality Review Panel is responsible for providing assurance to the Board on patient mortality based on clinical review of care received by those who die in hospital.

3.6 **Specialty Mortality Meetings**

Specialty mortality meetings should be considered a core activity for all clinicians. Whilst it is recognised that different specialties and directorates will have different requirements, the main principles are that specialty mortality meetings are be a forum for discussion of patient deaths and the associated clinical events and act as a driver for improvement.

3.7 **Rapid Review Group**

The Rapid Review Group (RRG) reviews Directorate Initial Incident Review forms relating to adverse events reported to have had a moderate or more severe impact, and establishes which require investigation to identify their root cause. RRG then commissions the appropriate level of investigation, setting appropriate Terms of Reference. RRG monitors progress of commissioned investigations, considers completed root cause analyses received from directorates, and either approves them or requires their amendment as appropriate.

Once the relevant investigation processes involving a death have concluded, RRG is responsible for determining the appropriate level of avoidability and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) quality scoring before closure. They also ensure appropriate actions and notification processes are engaged.

3.8 **Clinical Directors**

Clinical Directors ensure that all doctors in their Clinical Directorate are supported to fulfil 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.

3.9 **Divisional General Managers / Directorate Managers / Heads of Department**

Divisional General Managers/Directorate Managers / Heads of Department are responsible for the proactive implementation of this policy within their business areas.

3.10 **Nurses, Allied Health Professionals and Other** C**linical Staff**

All healthcare professionals should be involved in mortality review meetings, as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews insofar as they affect their area of practice, to full involvement in the production of data and implementation of recommendations.

4. DEFINITIONS

4 Learning from Death offers a standardised framework for identifying, reporting, investigation and learning from deaths in care. The following definitions clarify the terms used in the national programme:

Avoidable / Preventable Death

These terms are used interchangeably in the NHS and for the purpose of this policy 'preventable' or 'unpreventable' is used with reference to whether anything could have been done during the admission associated with an in-hospital patient death to change the outcome.

Case Record Review

A case record review is a structured critical review of the case records to determine whether there were any problems in the care provided to the patient in order to learn from what happened. The review must use a recognised and credible approach, for example the Structured Judgement Review (Royal College of Physicians) or the PRISM (Hogan) methodology.

This policy identifies a concise **first stage 1a screening review** conducted by the clinical team responsible for the patient's care at the time of death which is designed to be used in all deaths. This screening review will identify any deaths that warrant subsequent structured in-depth reviews: a **departmental stage 1b review** conducted by an appropriate specialist not primarily responsible for the patient's care at the time of death and a **Mortality Review Panel stage 2 review** that will identify whether the death is due to problems in care. The stage 2 review will determine judgements on the quality of care and the avoidability of the death.

Death Certification
Death certification is 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.

Death Due to Problems 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 is described as due to problems in care.

To identify avoidable deaths it is important to establish whether there were problems in the way healthcare was delivered to the patient (the processes of care). If a patient is harmed by healthcare but the care was delivered to an acceptable standard, this harm is known as a complication. A death following a complication, such as intracerebral bleeding after appropriate administration of thrombolysis would not be regarded as avoidable.

PRISM 2 defines a problem in healthcare as **'any point where the patient's healthcare fell below an acceptable standard and led to harm'.** Problems include:

- An omission or inaction such as failure to diagnose and treat
- An act of commission or affirmative actions related to the delivery of care such as incorrect treatment or management

The term "problem in healthcare" is preferred to the traditional term "adverse event" as this latter term tends to be associated with discrete incidents and is more likely to identify acts of commission than omission. The term "problem/s in healthcare" allows a reviewer to broaden their perspective and assess the impact of multiple small events (usually omissions) across the patient journey.

It may be difficult to identify one clear cut problem or even identify the point at which things went wrong. Avoidable deaths are more likely to result from a combination of problems in healthcare.

Death Verification
Death verification is the process of formal confirmation of a patient death and documentation of the time, date and location of death.

Duty of Candour
Duty of Candour is a legal duty on healthcare organisations which applies if there have been mistakes in care that have led to moderate or more severe harm (definition given by NHS England). Duty of Candour aims to ensure patients/carers receive accurate and truthful information about what happened and why and what action and lessons have resulted from the investigation, along with an apology.

Investigation
An investigation is a systematic analysis of what happened, how it happened and why. 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. The Trust Incident Policy details the process of investigation, including the different levels of investigations required in specific circumstances.

Mortality Governance
The phrase "mortality governance" refers to a network of processes designed to monitor and challenge mortality performance and to set out the arrangements for investigating and learning from deaths.

Mortality Meetings
Mortality meetings involve reviewing patient deaths and complications in a structured manner. These meetings have the potential to identify improvements required for raising clinical standards and improving patient safety.

Root Cause Analysis (RCA)
A specific type of investigation conducted using a systematic methodology with a retrospective review of all the circumstances surrounding an incident, to find out which circumstances contributed to what happened. A good RCA identifies changes which will help to make sure that the risk of the incident happening again is reduced.

5. MORTALITY REVIEW & LEARNING FROM DEATHS – DEATH CERTIFICATION, CASE RECORD REVIEW AND INVESTIGATION

5.1 Levels of review

There are three levels of review which can be undertaken. These are described in the table below:

Level of review	Which deaths to include	Method
Stage 1 – Death Certification Process (clinical team screening review and, if indicated, structured Departmental Review)	All adult in-patient deaths	• Responsible Consultant at the time of death performs **stage 1a mortality screening review** • Completion of review document on Meditech V6 • Confirms accuracy of death certificate • Confirms completion of discharge letter • Records any involvement with the coroner • Identifies if there are any potential problems in care • Identifies if any other departments should perform a review of care provided • Identifies if the patient was in receipt of End Of Life Care prior to death – If **YES** – Patient death may be selected for End of Life audit to determine quality of end of life provision • Does the patient meet any of the criteria for structured mortality case record review – If **YES stage 1b departmental review** (ideally) conducted by specialist consultant not directly involved in the provision of the patient's care.

Level of review	Which deaths to include	Method
		Any learning points will be recorded at completion of this departmental review
Stage 2 – Mortality Review Panel (independent peer review)	Nationally set criteria	• Structured Case Record review by independent reviewer within the Trust Mortality Review Panel • Review death certificate for accuracy and completeness • Check reportable deaths have been referred to Coroner • If findings reveal the death should have been reported, report immediately • Identify learning opportunities • Liaise with departments to produce recommendations for improving the safety and quality of care
Stage 3 – Corroboration & collation (independent triangulation)	Patient deaths subject to: • Coroner's Inquest • Serious Incident Framework analysis	• Collating judgements from other sources through RRG – i.e. adjusting avoidability scores following departmental review post MRP, determining avoidability score based on coroner's reports, determining avoidabilty scores based on RCA findings, address Duty of Candour issues where avoidability of death is identified as more likely than not to have occurred

A flowchart summarising the levles of review can be found at **Appendix 1**.

5.2 Certification and Registration of a Death – Opportunities to Raise Concerns

5.2.1 When a death occurs the consultant responsible for care has a duty to decide whether the coroner needs to be informed and to oversee the process of completing the death certificate, including the recording of the cause of death. In normal circumstances, there 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. To assist the doctors in making this decision the Coroner has issued a Guide to Reportable Deaths which details which cases must be referred to the Coroner. Currently these guides can vary between Coroners however there is work underway, led by the Chief Coroner to introduce standardised guides.

5.2.2 If any concerns are identified at any stage of the certification or registration process, the death will receive a 'second stage case record review' (see below).

5.2.3 **Appendix 2** sets out the Standard Operating Procedure (SOP) for completion of Medical Death Certification and Cremation Forms.

5.3 Stage 1 Case Record Mortality Review

5.3.1 A concise **Stage 1a screening mortality review** (**Appendix 3)** conducted by the clinical team responsible for the patient's care at the time of death must be used in all deaths. This screening review identifies any deaths that warrant subsequent

structured in-depth reviews: namely, a **departmental stage 1b mortality review** conducted by a specialist not primarily responsible for the patient's care at the time of death and a **Stage 2 Mortality Review** conducted by an independent reviewer within the Trust's Mortality Review Panel team.

5.3.2 Wherever possible the ***Stage 1a mortality screening review*** should be completed by the ***responsible consultant at the time of the patient's death***. This stage will also ensure determinations and documentation after death is completed in a timely fashion and is satisfactory. The document must be completed after determination of the death certification process has been made. The document should be completed and saved on Meditech V6 within 5 days of the death. Foundation doctors must not conduct this review under any circumstances as high-level judgements and understanding are needed. The responsible consultant may delegate this task to a cross-covering consultant in their absence. A senior specialist trainee may be delegated this task under direct supervision as part of their training, but this must not form part of their service commitment on a routine basis.

5.3.3 If the Stage 1a screening mortality review identifies criteria have been met for a Stage 2 review, a departmental **Stage 1b case record mortality review (Appendix 4)** must be completed within **4 weeks** by a consultant. This should be conducted by a consultant within the same department who has (ideally) not been directly involved in the patient's care.

5.4 Stage 2 Case Record Mortality Review

5.4.1 An independent review of the notes will be carried out by the Mortality Review Panel. **Appendix 5** shows the content of the review which is carried out when:

- One or more criteria for a Stage 2 Mortality Review are met (**Appendix 6**) as determined at Stage 1a Mortality Screening review;
- Stage 1b Departmental case record review suggests an independent Trust-level review may be helpful or where the death is judged to have greater than 50:50 chance of being preventable.

Judgements on the quality of care and the avoidability of the death will be determined at this stage.

5.4.2 For certain groups of patients, there are already well-established processes in place to guide local mortality reviews and investigations. For reviewing the deaths of patients who had a **learning disability,** the Learning Disabilities Mortality Review Programme (LeDeR) is used (**Appendix 7**). **Maternal and neonatal deaths** are reviewed within an existing process which is described in **Appendix 8.** Similarly a robust process for the **review of deaths in children and young people** is in place and outlined in **Appendix 9.**

5.4.3 For the **death of an individual with mental health needs,** the Team Manager of the Sunderland Psychiatric Liaison Team (at Northumberland, Tyne and Wear NHS Foundation Trust) and the Head of Patient Experience and Practice Development (CHSFT) undertake reviews of patients who have died whilst detained or have an existing mental health problem. However, additional formal links.

5.5 Investigations

5.5.1 All deaths are cross referenced to the Trust's incident reporting system to identify any death in which an incident was reported during the patient's hospital stay. Where an incident has been recorded, a second stage case record review will be carried out in order to judge whether the incident was part of a problem in care that contributed to the patient's death.

5.5.2 Case record review is not a replacement for investigation, which includes root cause analysis (RCA). RCA involves reviews of case records reviews but goes beyond this by utilising other evidence including discussions with staff. Second stage case record reviews may identify the need for incident reporting and subsequent investigation.

5.6 Cross-system Reviews and Investigations (flowchart Appendix 10)

5.6.1 In many circumstances organisations other than the Trust are involved in the care of a patient who dies whilst in the care of the Trust, with the most common ones being primary care, ambulance services, other acute Trusts and mental health services.

5.6.2 In the past, case record review has largely been restricted to review of records held by the Trust, however it is sometimes possible to identify problems in care at earlier stages of the patient's contact with health services. Where this is the case, it has been possible to ask for reviews to be carried out by other organisations, however this has largely been restricted to other acute Trusts and the National Quality Board's regulations make it clear that the NHS needs to substantially strengthen arrangements. As these arrangements come into place, it is expected that Trust staff will engage with cross-system reviews and investigations as required.

5.7 Serious Incidents

5.7.1 The Trust should apply rigorous judgement on deaths subject to Serious Incident Reporting and investigation where the death clearly meets the Serious Incident Framework. The RRG will determine which reported incident meets the NHS England criteria of a Serious Incident. The Trust Incident Reporting Policy gives the definition of a Serious Incident and shows the guidance which RRG applies when considering whether an adverse event meets the national definition of a Serious Incident.

5.8 Meaningful Engagement with Bereaved families and Carers

5.8.1 Meaningful engagement includes informing the family/carers if the Trust intends to review or investigate the care provided to the deceased patient. When a death is being investigated as part of either a RCA or an inquest this should include details of how families/carers will be involved to the extent that they wish to be involved.

5.8.2 Processes are already in place in the Trust which reflect the requirements of Being Open and Duty of Candour. These ensure families and carers are involved and informed with regard to their involvement with any investigation process.

5.8.3 Nationally, there is ongoing work to determine what support bereaved relatives and carers can expect from Trusts. The policy will be reviewed once the outcomes from this important area of work are known.

5.9 Learning from Deaths

5.9.1 The purpose of reviews and investigations of death is to identify any learning in order to minimise the risk of recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon. It is beyond the scope of this policy to outline all the organisational and educational mechanisms that can be employed to do this. However, case record reviews and investigations must include summaries of the lessons that need to be learnt and disseminated. The Trust will collate themes and report on action taken as a result.

5.9.2 Lessons to be learned are shared on an individual, group and organisational level dependent upon the issue and relevance. Reports detailing lessons learned from deaths are provided to the Trust Bereavement Group on a monthly basis to inform its work and necessary action planning. Key learning is also identified within the quarterly report which the Mortality Review Group provides to Clinical Governance Steering Group and shares with the clinical governance leads to disseminate across their respective areas of responsibility.

5.9.4 A detailed narrative account of the learning from reviews and/or investigations and any actions taken and their impact are included in the annual Quality Account (Quality Report).

5.10 Deaths Referred to the Coroner

5.10.1 The Coroner is an independent judicial office holder, appointed by the Crown. Coroners investigate all deaths where the cause is unknown, where there is reason to think the death may not be due to natural causes, or deaths which need an inquiry for some other reason e.g. a death in police custody.

5.10.2 The role of the Coroner is to determine who the deceased person was, when, where and how (i.e. in what circumstances) they came by their death. When the death is suspected to have been either sudden, of unknown cause, violent, or unnatural, the Coroner decides whether a post-mortem examination is necessary and if warranted opens an inquest.

5.10.3 A post-mortem examination of the body will usually establish the cause of death. If the cause of death is found to be one of natural causes then the Coroner will close his investigation and a death certificate will be issued. However if the cause of death is found to be unnatural or cannot be ascertained then an inquest will be opened. An inquest is held in open court (this means members of the general public may attend should they wish) and seeks to establish who, when, where and how the person came about their death.

5.10.4 The place where death occurs will dictate which Coroner's jurisdiction will be involved and investigate the death. The patient may have received care at the Trust but then discharged to a residence in another local authority area and subsequently died. In these cases the death will be investigated by the Coroner from that local authority.

5.11 Inquest Process

5.11.1 The Inquest Team at the Trust will be notified by the Coroner that an investigation into a death has been opened and information is required from the Trust to facilitate it. Case notes are immediately secured and the originals maintained within the Inquest Offices ensuring chain of evidence, should it be required. Copies of both paper medical records and electronic records are provided to the Coroner to facilitate the investigation.

5.11.2 The Risk and Inquest Manager determines in conjunction with the Coroner which staff will be required to provide statements to assist with the investigation and ensures that these are provided in accordance with the required standards. The Risk and Inquest Manager also ensures that appropriate support is provided to staff involved in the process and if necessary external support services are accessed. If the case is complex (involving multiple specialties or has the potential for significant litigation) then the Risk and Inquest Manager will ensure that appropriate legal advice and support is obtained and will ensure that National Health Service Resolution (NHSR) are informed.

5.11.3 Once initial statements and records have been reviewed and the post mortem (if necessary) has been completed, the Coroner advises the Risk and Inquest Manager if an inquest is required. If so then additional statements may be required and the Risk and Inquest Manager will facilitate this and ensure staff are appropriately supported and prepared to attend court.

5.12 Police Investigations

5.12.1 The police will be involved in investigating a death if there is a suspicion that a crime has occurred. Generally, deaths should be reported to the police if it is suspected that assault, violence or other criminal act has caused or contributed to the death e.g. intentional poisoning

When the Coroner is notified of a death during working hours, a decision will be taken as to whether the case requires escalation to the police, in which case the Coroner will ensure that this takes place. If a death takes place out of hours and it is suspected that the death is due to a criminal act then the police should be contacted immediately and hospital staff should not wait for the Coroner's usual office hours. There is a 24/7 on call service in operation to deal with such matters.

5.12.2 Criminal investigation by the police takes priority over other enquiries which may be put on hold to avoid potentially prejudicing a criminal investigation and any subsequent proceedings.

5.12.3 The Trust is part of a multi-agency agreement between the Coroner, Northumbria Police, and the Health and Safety Executive which is known as a Memorandum of Understanding (MOU). This sets out the investigation processes that will take place and how they will be coordinated and managed. The Trust designated point of contact for the MOU is the Risk and Inquest Manager.

6. MONITORING COMPLIANCE / EFFECTIVENESS OF THE POLICY

Area for monitoring	Method	Frequency	Responsibility	Monitoring Assurance Group	Lead for developing action plan	Group responsible for monitoring action plan
Case selection and review method	Review of case review method used	Annual	Trust mortality lead / Clinical Governance Department	Mortality Review Group	Trust mortality lead / Clinical Governance Department	Clinical Governance Steering Group (CGSG)
How the Trust responds to the death of specific types of patients	Review of case selection	Annual	Trust mortality lead / Clinical Governance Department	Mortality Review Group	Trust mortality lead / Clinical Governance Department	CGSG
Engagement with families / carers – support and involve-ment in the investigation process	Review of adherence to current process	Annual	Trust mortality lead / Clinical Governance Department	Mortality Review Group	Trust mortality lead / Clinical Governance Department	CGSG
Learning from death	Trust Mortality Report	Quarterly	Trust mortality lead / Clinical Governance Department	Mortality Review Group	Trust mortality lead / Clinical Governance Department	CGSG
	Quality Report	Annual	Clinical Governance Manager	Mortality Review Group	Clinical Governance Manager	CGSG

7 DISSEMINATION, IMPLEMENTATION AND TRAINING

7.1 This policy will be implemented following ratification of the document by the appropriate committees. Dissemination of the policy requirements will be achieved through the following mechanisms:

- available on the Trust's intranet and brought to the attention of all clinical and healthcare staff by means of an intranet link;
- reference to it will be made across the network of local clinical governance groups and meetings, including the Clinical Governance Leads meeting;
- included as part of local Trust induction for new starters; and
- inclusion in Team Brief.

Training needs will be identified and assessed during the implementation of this policy and will be coordinated jointly by the Mortality Review Group, Clinical Governance Department and Risk and Inquest Team.

8 CONSULTATION, REVIEW AND APPROVAL/RATIFICATION

8.1 Consultation of the policy has included the following stakeholders:

- Trust Mortality Review Group and Panel
- Clinical Governance Steering Group
- Risk Management Team, Litigation and Inquest Services

- Bereavement and Chaplaincy Services
- Clinical Directors
- Clinical Governance Leads
- Matrons
- Operational Management Group
- Child Death Leads
- Learning Disability Leads
- Maternal Death Leads
- Clinical Governance Department

8.2 The policy will be reviewed after 3 years following ratification or earlier if any significant changes are required, either through changes in Trust processes or guidance (eg National Quality Board / Care Quality Commission / NHS Improvement.)

9 REFERENCES

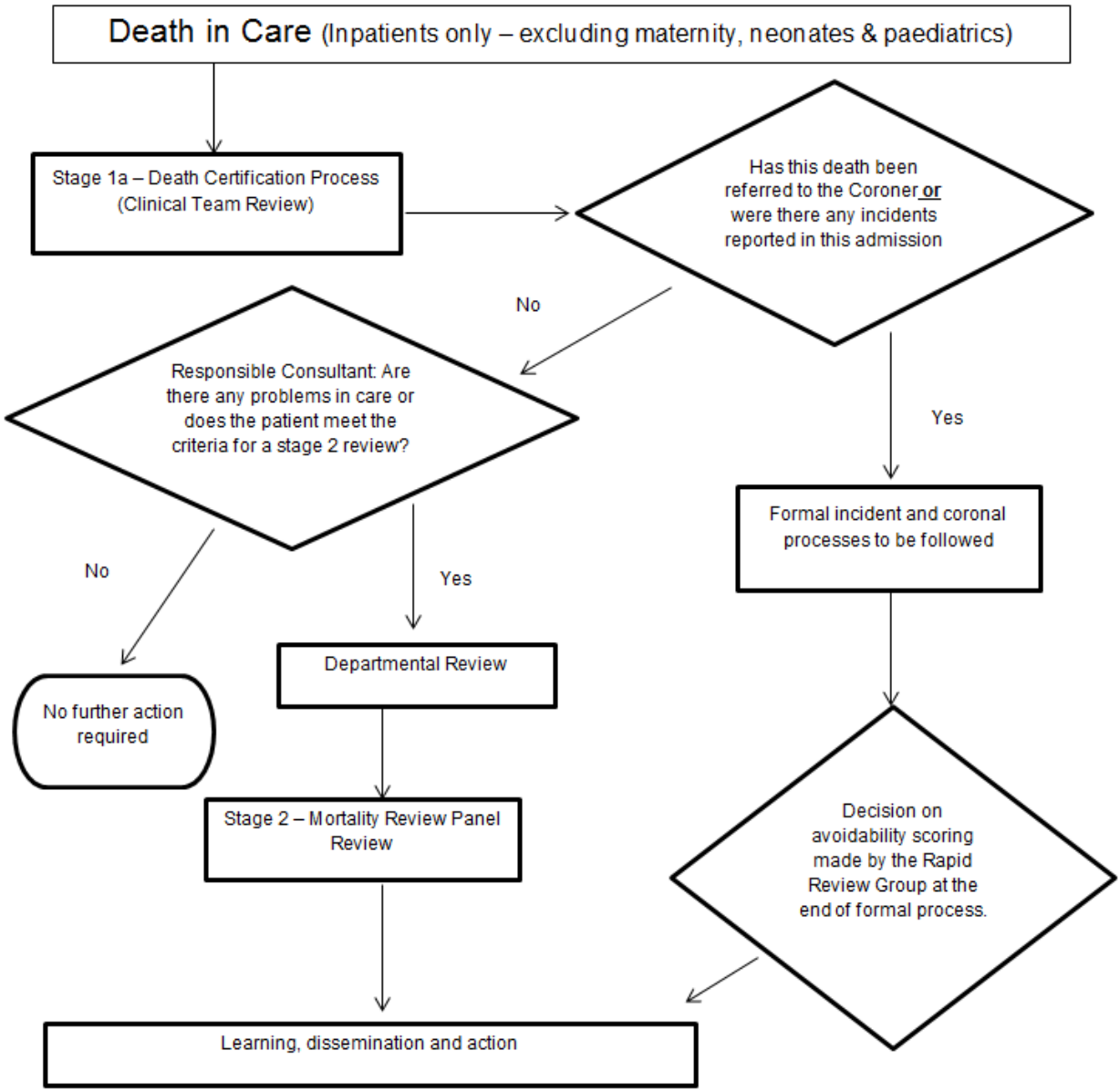
- Care Quality Commission (2016) Learning, Candour and Accountability: http://www.cqc.org.uk/content/learning-candour-and-accountability
- National Quality Board (2016) National Guidance on Learning from Deaths: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
- National Quality Board (2016) National reporting dashboard: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-learning-from-deaths-dashboard.xlsx
- Morbidity & Mortality Meetings: A guide to good practice, Royal College of Surgeons (2015)
- Health & Social Care Act (2008) Regulation 20 – Duty of Candour

10 ASSOCIATED DOCUMENTS

- Post Mortem Policy
- Do Not Attempt Cardiopulmonary Resuscitation Policy (DNACPR)
- Organ & Tissue Donation Policy
- Incident Reporting Policy
- Investigating and Learning from Incidents Policy
- Clinical Outcome Reviews Programme (Procedural document)

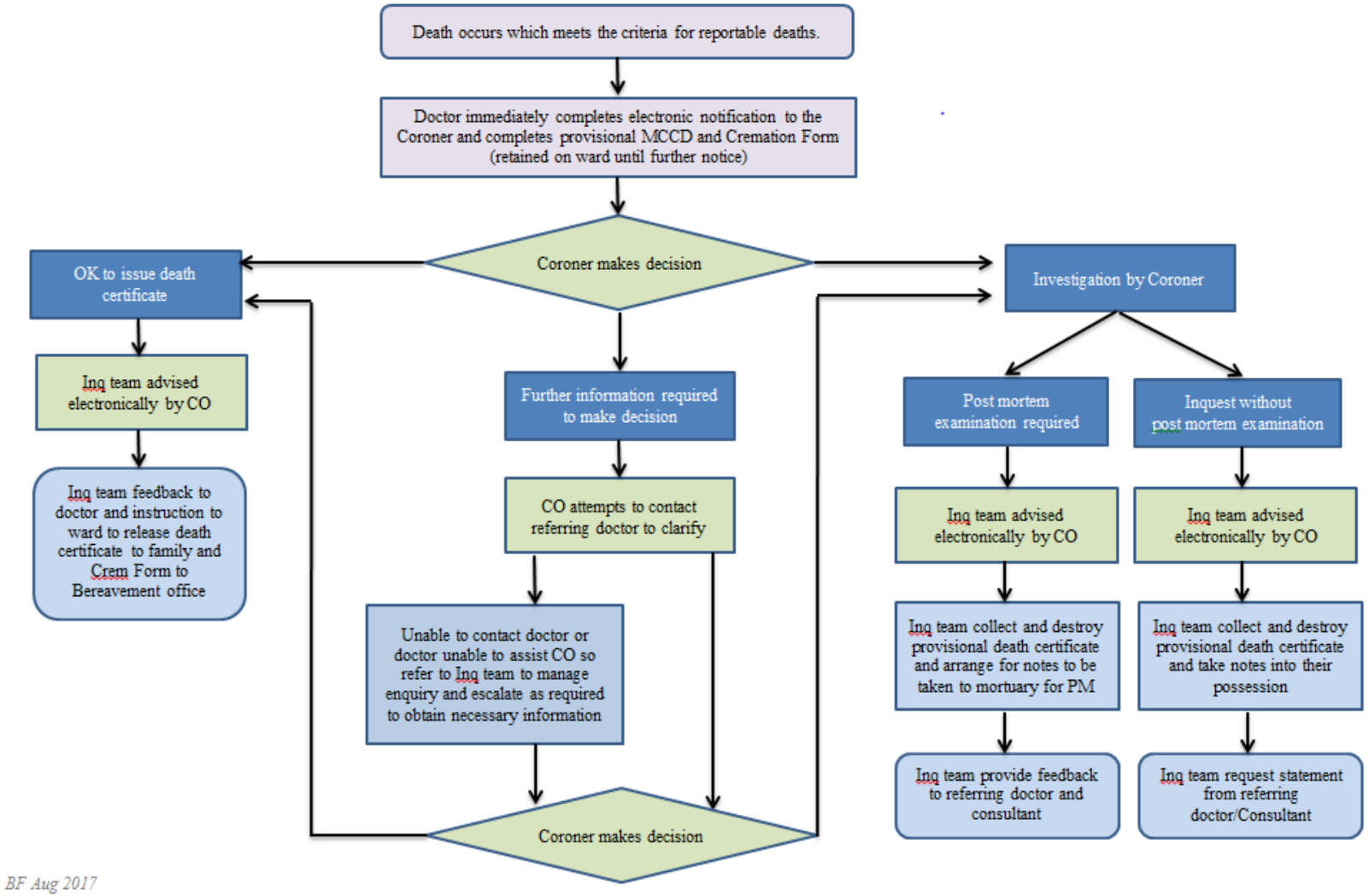
Appendix 1

Flowchart summarising levels of review



Standard Operating Procedure for completion of Medical Death Certificate and Cremation Forms

PROPOSED REVISED CORONIAL DEATH NOTIFICATION PROCESS



BF Aug 2017

Appendix 3

Stage 1a Screening Mortality Review (To be completed on V6)

Death certification to be reviewed by senior clinician (ideally responsible consultant at time of death - **not** Foundation doctor)

Stage 1a screening mortality review document (to be completed after death certification process has been determined):

To be completed by senior clinician, preferably consultant for all adult (non-Maternity patients) who die in hospital in patient care record.

Purpose is for 1) post death quality assurance, and
2) identification of patients for Stage 2 mortality review.

Q1. Were there any problems in care during the admission prior to death that may have had an impact upon this patient's death (e.g. acts of omission, commission, misdiagnosis, delays in diagnosis and/or treatment, recognition of deterioration or failings in response to deterioration, any poor quality care)?

Y/N If Yes, one sentence describing issue.

Q2. Death certificate options:

Select 1 option: Death certificate issued independently by hospital
Death certificate issued after discussion with coroner's office
Death certificate not issued: For coroner's inquest
Death certificate issuance not determined at this stage

Q3. Please affirm that a saved Discharge Summary (deceased) has been completed and is accurate

Y/N If No, state why…

Q4. Was the patient in receipt of end of life care prior to death?

Y/N If yes, was the palliative care team involved in provision of end of life care Y/N/ N/A

Q5. Does this patient meet any of the criteria for mandatory stage 2 review (see list of Criteria for Stage 2 Trust MRP Mortality review below)?

Y/N – select option(s)

Criteria for Stage 2 (Trust MRP) Mortality review;

- Deaths referred to the coroner where the death was unexpected
- Deaths referred to the coroner where the death is unexplained
- Deaths referred to the coroner which are associated with an invasive procedure
- Patients with a known Learning Disability who die in hospital (As part of the LeDeR process)
- Patients with a severe mental illness who die in hospital – Those patients formally receiving Mental Health Care provision during admission prior to death – i.e. Under care of liaison psychiatry services at time of death
- Deaths associated with a cardiac arrest call in hospital (death within 24 hours of cardiac arrest call)

- Deaths associated with a reported significant clinical incident relating to the quality of care
- Deaths associated with a concern about problems in care (acts of omission or commission leading to death)
- Deaths where bereaved families and carers have raised a significant concern about the quality of care provision
- Deaths associated with an active formal area of concern within the Trust (i.e. identified by external bodies – CQC alerts, SHMI data, audit data)
- Deaths within a designated clinical area of improvement e.g. sepsis
- Death associated with any other issue which in the opinion of the responsible consultant is worthy of further review

If any criteria for Stage 2 review are met please ensure a structured departmental mortality review is completed within 2 weeks

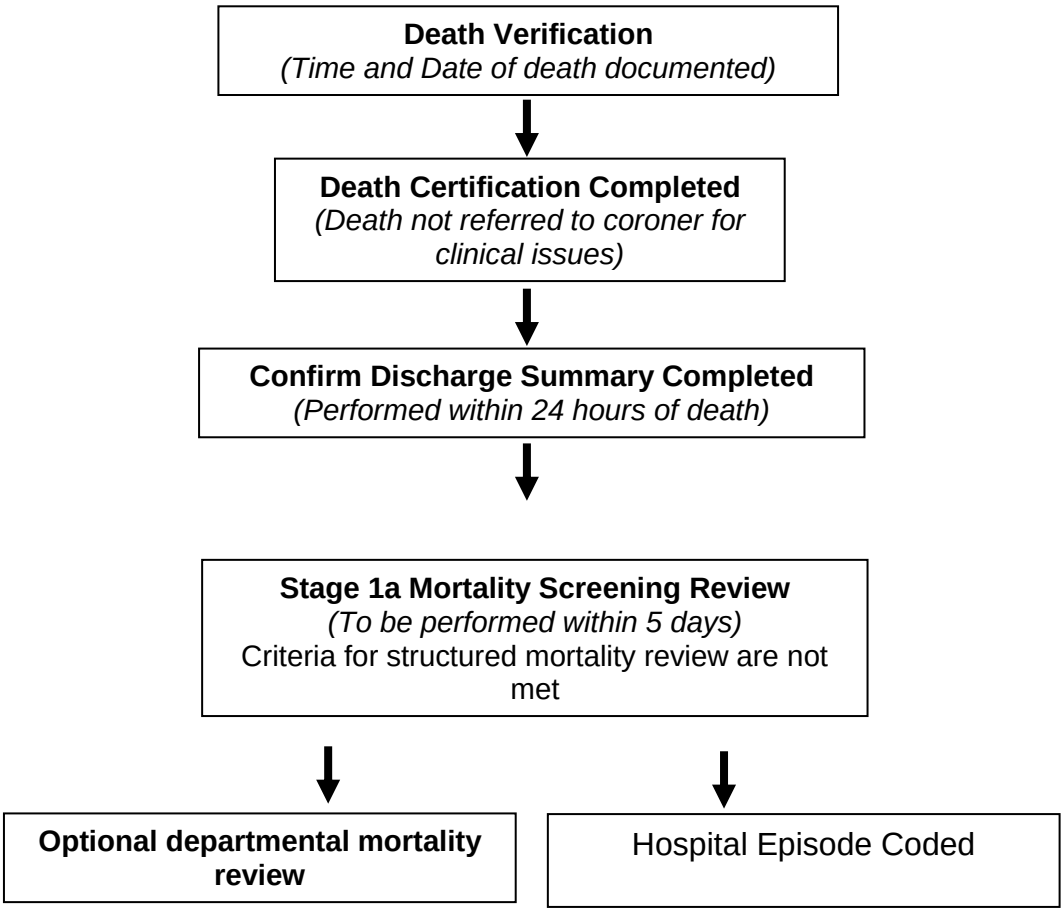
Q6. Is your department going to complete a departmental mortality review for this patient independent of the above criteria?

Y/N

Q7. Please select other departments that may wish to perform their own mortality review for this patient (during this admission)

List of departments – provides notification to nominated individual within each department (Departmental CG lead/mortality lead)

Flowchart of Process for mortality review for deaths NOT meeting Stage 2 review criteria



Appendix 4

Stage 1b (Generic) Departmental Structured Mortality Review (To be completed on V6)

All reviewed patients should be discussed at the next available Mortality meeting

Date of review [insert]

Pull through **Demographics** (as per MRP document)
(Patient details, age at death, sex, day of admission & death, Length of stay, specialty at time of death, type of admission)

Pull through **Recorded death certificate details**

1) Admission and initial management (first 24 hours)

Comments: *Note any problems in care in addition to excellence in care*

Rating: Excellent, Good, Adequate, Poor, Very Poor or Not applicable to department

2) Ongoing Care within department (Overview of reviews, investigations, treatments etc)

Comments: *Note any problems in care in addition to excellence in care*

Rating: Excellent, Good, Adequate, Poor, Very Poor

3) Review of relevant invasive procedure(s) (not iv cannulation)

Details:

Rating: Excellent, Good, Adequate, Poor, Very Poor, N/A

4) Any problems with monitoring or managing clinical deterioration (Recognition, Initial Response, Escalation)

Yes / No / N/A
Comments:

5) Any clinical event during last admission which has prompted a serious incident framework review (via RRG)

Yes / No / Unknown
Comments:

6) Overall assessment of care within department - mandatory

Rating: Excellent, Good, Adequate, Poor, Very Poor
Explanatory comment

7) **Brief Summary of care**

8) Note any learning points to be highlighted at Departmental Mortality meeting
Comments box:

9) Stage 2 review requested (in light of departmental review) Y/N

Appendix 5

Stage 2 Structured Trust Mortality Review (To be completed on V6)

Date of review [insert]

Pull through **Demographics** (as per MRP document)
(Patient details, age at death, sex, day of admission & death, Length of stay, specialty at time of death, type of admission)

Pull through **Recorded death certificate details**

1) Admission and initial management (first 24 hours)

Comments: *Note any problems in care in addition to excellence in care*

Rating: Excellent, Good, Adequate, Poor, Very Poor or Not applicable to department

2) Ongoing Care within department (Overview of reviews, investigations, treatments etc)

Comments: *Note any problems in care in addition to excellence in care*

Rating: Excellent, Good, Adequate, Poor, Very Poor

3) Review of relevant invasive procedure(s) (not iv cannulation)

Details:

Rating: Excellent, Good, Adequate, Poor, Very Poor, N/A

4) Any problems with monitoring or managing clinical deterioration (Recognition, Initial Response, Escalation)

Yes / No / N/A

Comments:

5) Any clinical event during last admission which has prompted a serious incident framework review (via RRG)

Yes / No / Unknown

Comments:

6) Overall assessment of care within department - mandatory

Rating: Excellent, Good, Adequate, Poor, Very Poor

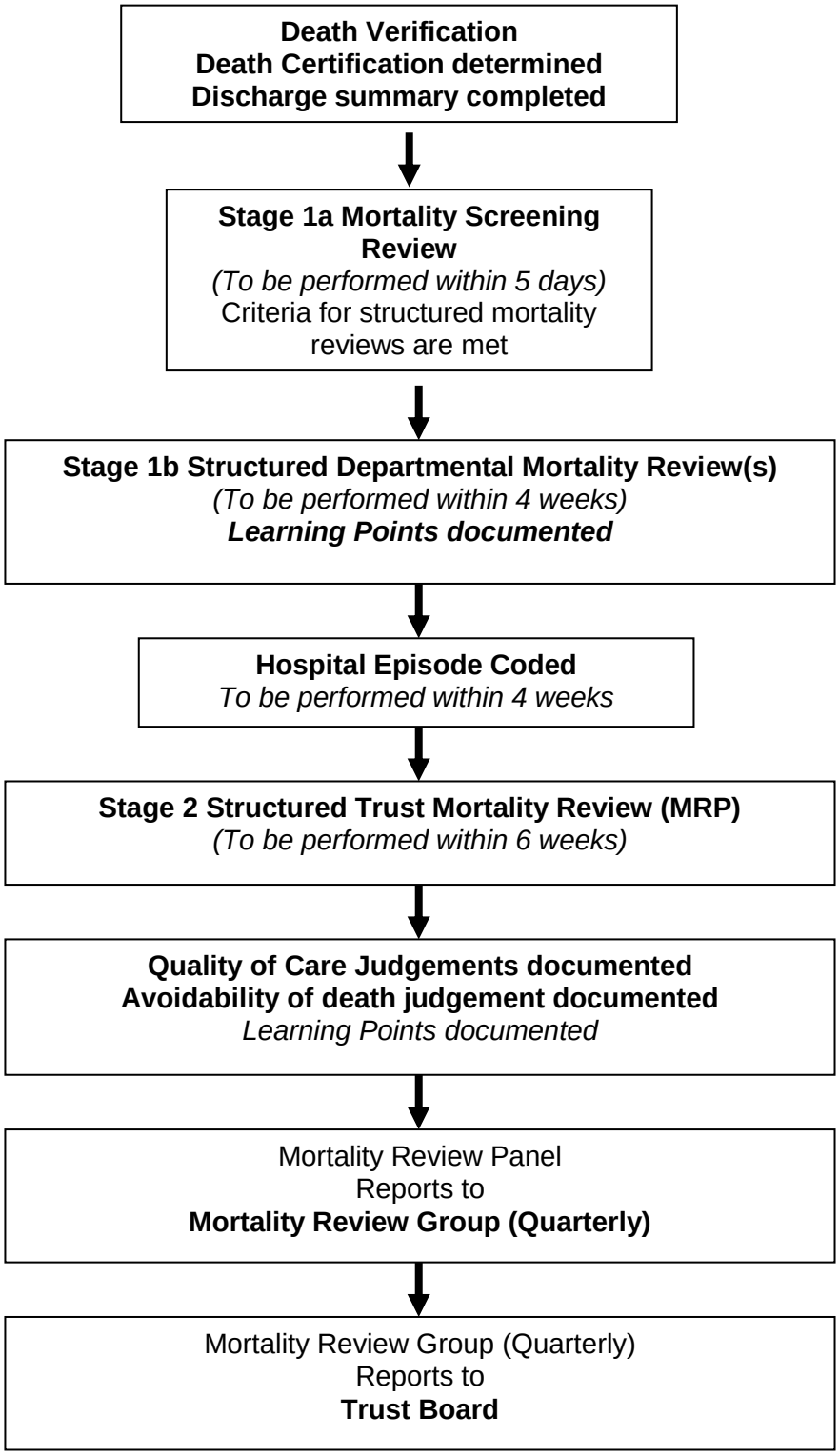
Explanatory comment

7) Note any learning points:

Comments box:

8) Judgements in Quality of Care and Preventability of Death (Hogan and NCEPOD)

Flowchart of Process for mortality review for deaths meeting Stage 2 review criteria



Appendix 6

Criteria for Stage 2 Mortality Review

- Deaths referred to the Coroner where the death was unexpected
- Deaths referred to the Coroner where the death is unexplained
- Deaths referred to the Coroner which are associated with an invasive procedure
- Patients with a known Learning Disability who die in hospital (As part of the LeDeR process)
- Patients with a severe mental illness who die in hospital – Those patients formally receiving Mental Health Care provision during admission prior to death – i.e. Under care of liaison psychiatry services at time of death
- Deaths associated with a cardiac arrest call in hospital (death within 24 hours of cardiac arrest call)
- Deaths associated with a reported significant clinical incident relating to the quality of care
- Deaths associated with a concern about problems in care (acts of omission or commission leading to death)
- Deaths where bereaved families and carers have raised a significant concern about the quality of care provision
- Deaths associated with an active formal area of concern within the Trust (i.e. identified by external bodies – CQC alerts, SHMI data, audit data)
- Deaths within a designated clinical area of improvement e.g. sepsis
- Death associated with any other issue which in the opinion of the responsible consultant is worthy of further review

Patients in receipt of End of Life Care prior to death will be selected for a Trust End of Life Audit review to determine the quality of end of life provision.

Appendix 7

Responding to the Death of an Individual with a Learning Disability using the LeDeR Process

INTRODUCTION

1. The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities and to take forward the lessons learned in the reviews in order to make improvements.

2. The purpose of the LeDeR reviews is not to hold any individual or organisation to account. Other processes exist for that, such as criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation. It is vital, if individuals and organisations are to be able to learn lessons, that reviews are undertaken in a trusted and safe environment that encourage honesty, transparency and sharing of information.

3. The Trust four clinical staff have been trained to review the deaths of patients who had a learning disability. The process involves;

    a. The notification of a death to the LeDeR team. This notification can be from anyone from a person involved in their care, their family or a member of the public.

    b. The national team assign the case to a local area contact (LAC). For CHSFT this is the Director of Nursing of Sunderland CCG. The LAC then assigns the case to a local reviewer and informs the LeDeR team.

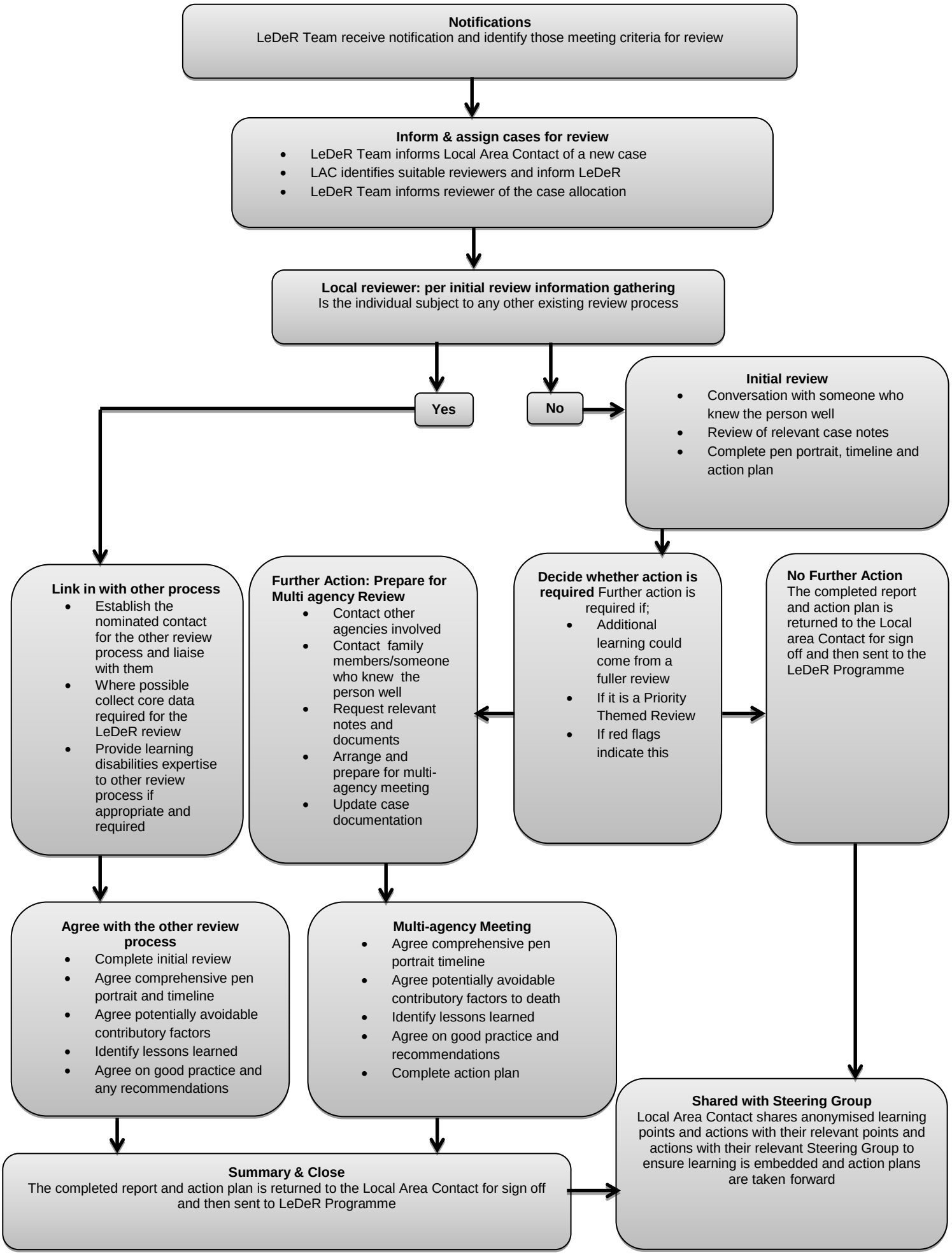
    c. The local reviewer gathers the initial information including whether any other review processes are underway. If there are other reviews in place the local reviewer will liaise with the contact for that review to agree the way forward, if not an initial review will be undertaken. If the person who died meets the criteria for a priority themed review ,or it is felt that there is further learning could be obtained from a more in depth analysis of the circumstances leading to the death, then a multi-agency review meeting must be held.

    d. In CHSFT there is an agreement that if the death raises concerns with regard to safeguarding the case will be sent to the Learning and Improvement in Practice (LIIP) subgroup of the Adult Safeguarding Board for scoping.

    e. Lessons learned to improve care are shared at ward/team level and the LAC shares learning points more widely with the relevant steering group.

    f. The following flow chart outlines the detail of the review process.

LeDeR Process Flowchart



Appendix 8

Responding to a stillbirth, neonatal death or maternal death

The Directorate 'trigger list' for incidents which must be reported through Ulysses includes maternal death, fetal loss from 16 weeks gestation, intrapartum stillbirth and neonatal death.

Maternal Mortality

All maternal deaths (regardless of the standard of clinical care provided) are reported through Ulysses and escalated to the Executive Director of Nursing and Patient Experience (or deputy) as documented in the maternity risk management strategy. The level of investigation is determined by the Trust Rapid Review Group (RRG) and will be completed either by the Directorate Risk Management Team, overseen by the Directorate Manager, or it may be subject to external review at the instruction of RRG. The Head of Midwifery is responsible for reporting all maternal deaths to **MBRRACE – UK** and sharing clinical records for inclusion in the national 'Confidential Enquiry into Maternal Deaths'.

Perinatal Mortality

All fetal losses over 16 weeks are reviewed and the severity rating upgraded or downgraded according to the review findings.

The following are escalated to the Executive Director of Nursing and Patient Experience (or deputy) as detailed in the Maternity Risk Management Strategy –

- The unexpected death of, or severe brain injury to, a baby born under the care of the Trust if it is felt that the clinical care provided may not have been of a reasonable standard

All Perinatal Mortality cases are discussed in the monthly Directorate Perinatal Mortality meeting held jointly with the Neonatologists and neonatal team.

All of the following are reported to MBRRACE-

- late fetal losses from 22+0 weeks gestation to 23+6 weeks gestation
- termination of pregnancy from 22+0 weeks gestation
- stillbirth from 24+0 weeks gestation
- neonatal death up to 28 days of age of all infants born at 20+0 weeks gestation or above and with birth weight >400g

MBRRACE reporting is mandated. MBRRACE publish a Perinatal Mortality report annually and the Directorate produce a joint response with the Neonatologists where indicated which is forwarded to the Trust Clinical Governance Steering Group for noting. The Neonatal team hold internal mortality reviews on a quarterly basis for all cases of neonatal death with an external reviewer present and report all mortalities and learning points to the Neonatal Network.

Additionally the Obstetrics and Gynaecology Directorate report the following to the Royal College of Obstetricians and Gynaecologists 'Each Baby Counts' (EBC) project,

- all term deliveries (≥37+0 completed weeks of gestation) following labour that resulted in one of the following outcomes: Intrapartum stillbirth, early neonatal death within the first week of life and severe neonatal encephalopathy

Reporting to EBC is voluntary rather than mandated but the Trust has signed up to the project along with all other Trusts in the UK. Root Cause Analysis investigations are completed for all cases meeting the EBC criteria and anonymised versions of RRG approved reports shared with EBC.

Appendix 9

Responding to the death of an infant or child (Child Death Review)

OVERVIEW

All deaths of children aged 0-18 years of age are currently reviewed at a local and regional level through the Child Death Overview Process. This process is outlined in Chapter 5 of *Working Together to Safeguard Children (2015)* guidance; (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2).

For children under 12 months of age additional guidance is provided within the report of the working group within the Royal College of Paediatrics and Child Health entitled *Sudden Unexpected Death in Infancy and Childhood;* (https://www.rcpath.org/discover-pathology/news/new-guidelines-for-the-investigation-of-sudden-unexpected-death-in-infancy-launched.html).

The South of Tyne Child Death Overview Panel (CDOP) is responsible for reviewing all child deaths in Sunderland, Gateshead and South Tyneside. Information from all professionals involved would be collected and collated by the local designated doctor and discussed at Local Child Death Review panel (LCDR) in Sunderland prior to discussion at CDOP. This would include information from health, social services, education and police to ensure that as much information is available to be able to evaluate whether the death is deemed preventable and to identify any modifiable factors. These might result in actions at a local, regional or national level to prevent further deaths.

The designated doctor for child death will ensure that families receive information on the Child Death Process and meet with them where possible to discuss any concerns or questions that they might have about their child's death. The purpose of the Child Death Overview Panel (CDOP) is:

- To establish, where possible, a cause or causes of death (in conjunction with the Coroner)
- To identify any potential contributory factors
- To provide ongoing support to the family
- To learn lessons in order to reduce the risks of future child deaths

The Trust has detailed information and documentation to use in the event of a child death which is available to paediatric staff via the Q drive (Paediatrics – Child Death).

The designated doctor for child death has produced a guide to the child death review process, entitled 'Responding to the death of an infant or child.

Responding to the death of an infant or

Appendix 10

Flowchart of Process for mortality review for deaths meeting Stage 3 review criteria