Brighton and Sussex University Hospitals

TW220 Learning from Deaths Policy:
Identifying, Reporting, Investigating and Learning from Deaths

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Contents

1   Introduction

For some people under the care of Brighton & Sussex University Hospitals (BSUH), death is an inevitable outcome. Many people experience excellent care from BSUH staff in the period leading up to their death. However, some patients experience poor quality care resulting from multiple contributory factors. By reviewing deaths we can ascertain whether the patient received the highest possible standards of care before they died. If not we can put in place actions to ensure future patients have a better experience. Moreover, it gives us the opportunity to thank staff and reinforce good practice when patients receive excellent care at the end of their lives.

In March 2017 the National Quality Board (NQB) published the [National Guidelines on Learning from Deaths](#) document, in order to improve standards of identifying, reporting, investigating and learning from deaths. In response, this policy describes three levels of mortality review with increasing levels of scrutiny depending on the concerns raised about the care leading up to death, and the opportunities for learning that this represents.

The policy requires the development of a number of new processes and enhancement of existing ones. Developing these processes will take time and at the time of writing this policy not all of the procedural elements required to deliver this policy are in place. Where this is the case this is made clear in the policy along with the actions required to fully embed these procedures. The policy will be updated in line with further developments in the organisation.

2   Purpose of this policy

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

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of BSUH. The scope of this policy refers to patients who are in-patients at the time of their death and those people who have died following recent treatment in BSUH whose deaths are notified to us by outside agencies. As part of a continuous improvement process for mortality review we would seek to broaden the scope of this policy to include review of deaths in patients who have recently received treatment at BSUH or are under active follow up by our services.

The policy also describes how BSUH will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the Trust supports staff who may be affected by the death of someone in the Trust's care.

It sets out how the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with the following Trust policies:

C018 Verification Certification and Notification of Death

TW018 Religion and Belief Policy

SQ005 Duty of Candour– Policy for communicating with patients or relevant persons following a notifiable patient safety incident, complaint or claim

SQ006 Investigation of Incidents, Complaints and Claims using Root Cause Analysis

SQ008 Policy and Procedure for the Internal and External Reporting of Incidents and Management of Serious incidents

HR010 Support arrangements for staff dealing with difficult situations

3   Definitions

The National Guidance on Learning from Deaths includes a number of terms. These are defined below.

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

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

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

Structured judgement review (SJR): A form of structured case record review developed by the Royal College of Physicians as part of the National Mortality Case Record Review Programme. It provides reviewers with a structured format for performing a case notes review ensuring that all relevant aspects of care are included. The SJR data collection form is attached in Appendix 1.

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

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

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

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

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

4 Responsibilities, Accountabilities and Duties

Trust Board
Responsibilities of the Board are to ensure that:

- there is **an identified executive director** to take responsibility for the learning from deaths agenda **and a non-executive director** to take oversight of progress;

- the **Trust has an effective policy** for identifying, reporting, investigating and learning from deaths;

- the Trust pays particular attention to the care of patients with a **learning disability or mental health needs**;

- the Trust has a systematic approach to **identifying those deaths requiring review** and selecting other patients whose care they will review;

- the Trust adopts a **robust and effective methodology for Structured Judgement Reviews (SJR) and that** LeDeR, CDOP and maternal death reviews are undertaken to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;

- **case record reviews and investigations are carried out to a high quality**, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;

- **mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board** in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised;

- **learning from reviews and investigations is acted on** to sustainably change clinical and organisational practice and improve care, and **reported in annual Quality Accounts**;

- **relevant learning is shared** across the organisation and with other services where the insight gained could be useful;

- sufficient numbers of **nominated staff have appropriate skills** through specialist training and protected time as part of their contracted hours to review and investigate deaths;

- the **Trust delivers timely, compassionate and meaningful engagement with bereaved families and carers** in relation to all stages of responding to a death;

- **where necessary an independent investigation** (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) **is carried out.** For example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and,

- the **Trust works with commissioners to review and improve their respective local approaches** following the death of people receiving care from their services.

Executive Director with responsibility for Learning from Deaths

- Provide executive leadership and take overall responsibility for delivering the Learning from Deaths agenda.

- Ensure that the Trust Board and relevant sub committees fulfil their duties in line with the policy

- Work closely with the appointed Non-Executive Director to carry out their responsibilities.

Non-Executive Director with responsibility for Learning from Deaths
Their responsibility is to take oversight of the processes surrounding the Learning from Deaths agenda:

- Understand the processes for learning from deaths, ensuring they are robust and can withstand external scrutiny, by providing challenge and support.

- Champion and support learning and quality improvement.

- Provide assurance around published information by ensuring that published information is a fair and accurate reflection of the Trust's achievements and challenges

Quality and Assurance Committee
Responsibilities of this Board sub-committee are to:

- Receive quarterly updates on mortality review from the Trust Mortality Review Group.

- Scrutinise and challenge reports and data in relation to mortality review and Trust mortality rates.

- Provide assurance to the Board on the adherence to this policy and the overall standards of clinical care to patients.

Trust Mortality Review Group (TMRG)
Responsibilities of this operational committee are to:

- Oversee the implementation of this policy

- Scrutinise national mortality data (HSMR/SHMI) for trends and concerns

- Decide and commission the appropriate level of mortality review in line with Trust Policy (Section 6)

- Ensure that **all departments have appropriate mortality review procedures** in place.

- **Review coroners Prevention of Future Deaths notices ('Regulation 28 letters')**, decide if any further review is required and to ensure there is an appropriate action plan in place

- **Ensure appropriate training** in mortality review techniques is available to relevant staff

- Receive reports from the **LeDeR programme**, **neonatal death reviews**, **maternal death reviews** and the **child death overview panel.** The committee will ensure that there is an appropriate action plan in place for any recommendations.

- Engage in **regular communications with Divisional management teams** and departmental mortality leads to share lessons emerging from mortality reviews

Medical Examiners (ME) [1]

Discuss all adult deaths with the referring doctor, review the case notes and speak to the bereaved in order to elicit concerns.

- Identify concerns about a death that require further review and escalate in line with Trust Policy (Section 6)

- Ensure that deaths requiring coronial review are appropriately referred

- To ensure accurate and complete recording of the cause of death on the Medical Certificate of Cause of Death

Divisional Mortality Meetings

- Ensure that all departments in the Division have a mortality review process in line with the guidance in this policy,

- Ensure that the actions arising from mortality reviews, incident investigations and coronial Prevention of Future Deaths notifications are carried out in a timely fashion.

- Ensure that all relevant staff are made aware of learning points arising from mortality review and where appropriate this information is disseminated to all departments in the Division

- Ensure that concerns arising from departmental mortality reviews are escalated for review by TMRG where appropriate.

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[1] At the time of writing the ME system is not yet fully functional at Princess Royal Hospital but recruitment to more ME posts are planned to develop this service. A small selection of deaths may be referred directly to the coroner.

Speciality Mortality Review Meetings

- Undertake departmental SJR reviews in line with guidance set out in Appendix 2.

- Appoint a senior doctor (consultant or Staff/Associate specialist) lead for Learning from Deaths/Mortality Review who will ensure the guidance in Appendix 2 is followed.

Speciality Mortality Lead

- Confirming that the departmental mortality review process ensures that SJRs are completed carried out

- Escalate any causes for concern to the divisional governance meeting for consideration of higher level review.

- Share any learning/recommendations arising from mortality review (either local reviews, those passed on by TMRG or arising from SI investigations) with relevant members of staff in their department.

- Provide the divisional governance meeting with monthly data on the number of deaths in that department and the number of deaths undergoing structured mortality review.

- Provide the TMRG with their departmental criteria for case selection for mortality review and the structured mortality review tool used by the department.

- DQSMAction recommendations for mortality review as requested by the ME or TMRG

- Maintain accurate records relating to outcome and number of SJRs

- Provide the divisional governance meeting with monthly mortality reports to include mortality statistics and alerts

- Provide data as requested on mortality for governance and assurance purposes

- Receive Datix® incident reports and escalate incidents where harm has been caused to the members of the SIRG

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[2] At the time of writing this team has not been formally created however a programme of training is underway.

Medico-Legal Team

- Co-ordinate responses to Regulation 28 notifications from HM Coroner

- Support the DMD S&Q to notify the HM Coroner where a death is considered to be preventable

- Notify the TMRG/SIRG where the HM Coroner has raised a concern regarding a death

- Liaise with MEs

Learning Disabilities Team

- Identify deaths of patients with a Learning Disability and refer the death to the LeDeR programme for further review.

Consultants and all registered professionals (nursing and AHPs)

- All consultants have a responsibility to take part in mortality review. This is a routine supporting professional activity and part of good clinical practice.

- Consultants who have a larger role in mortality review (ie: departmental mortality leads or those undertaking many structured mortality reviews) should have this work recognised in their job plans.

- MDT will be responsible for leading and supporting improvement work arising from mortality review in their department.

- Consultants are responsible for raising concerns about a death using the Datix® incident reporting system and discussing the concerns with their departmental lead consultant.

Staff

All staff are responsible for raising concerns in relation to a patient's death.

- Concerns should be reported using the Datix® incident reporting system or by reporting concerns to their line manager.

- Doctors involved in referring deaths to the Medical Examiner or coroner should inquire whether any of the staff involved in the patient's care have concerns that need to be raised during this referral process.

- Staff also have a responsibility to keep up to date and review any information about learning points arising from mortality review that is distributed by their departmental mortality lead or TMRG.

- All staff are expected to be actively involved with improvement plans put in place following the mortality review process.

5   Identification and recording of deaths

Deaths in in-patients are identified by ward staff and reported to the Bereavement Office as described in the Trust's Verification, Certification and Notification of Death Policy (C018). The Trust does not receive routine notification of deaths in patients who have been discharged from hospital or who are under out-patient follow up by the Trust's departments. Where the Trust receives notification from an outside agency of concerns relating to a death in a patient who has received care from BSUH these cases will be discussed at SIRG and reviewed in TMRG.

6   Review and investigation of deaths

The three level review process is summarised in in Figure 1. This does not need to be a sequential process; for example where serious concerns are raised an SI investigation may be recommended before even the ME review has occurred. Similarly, where an SI or coronial inquiry is underway there may still be merit in undertaking a departmental mortality review.

- **1st Level Review:** Medical Examiner (ME)

All deaths notified to the bereavement office will be discussed with the duty ME by a doctor from the deceased's medical team. This doctor should give a detailed account of the patient's medical history and any concerns about the deceased's care including any patient safety incidents and concerns raised by relatives or staff.

The ME will scrutinise the deceased's medical record to corroborate the referring doctor's account and confirm the proposed cause of death, if appropriate.

The ME will contact the deceased's next of kin, as detailed in the medical record, and discuss any concerns. Where the next of kin do not speak English or have other communication difficulties the Medical Examiners will utilise the Trust's interpretation services.

The ME will record their inquiries in a bespoke form within the Trust's Datix® incident reporting database. This form allows the ME to record their recommendations for further review which are automatically notified to a member of the Safety and Quality Team who will action those recommendations.
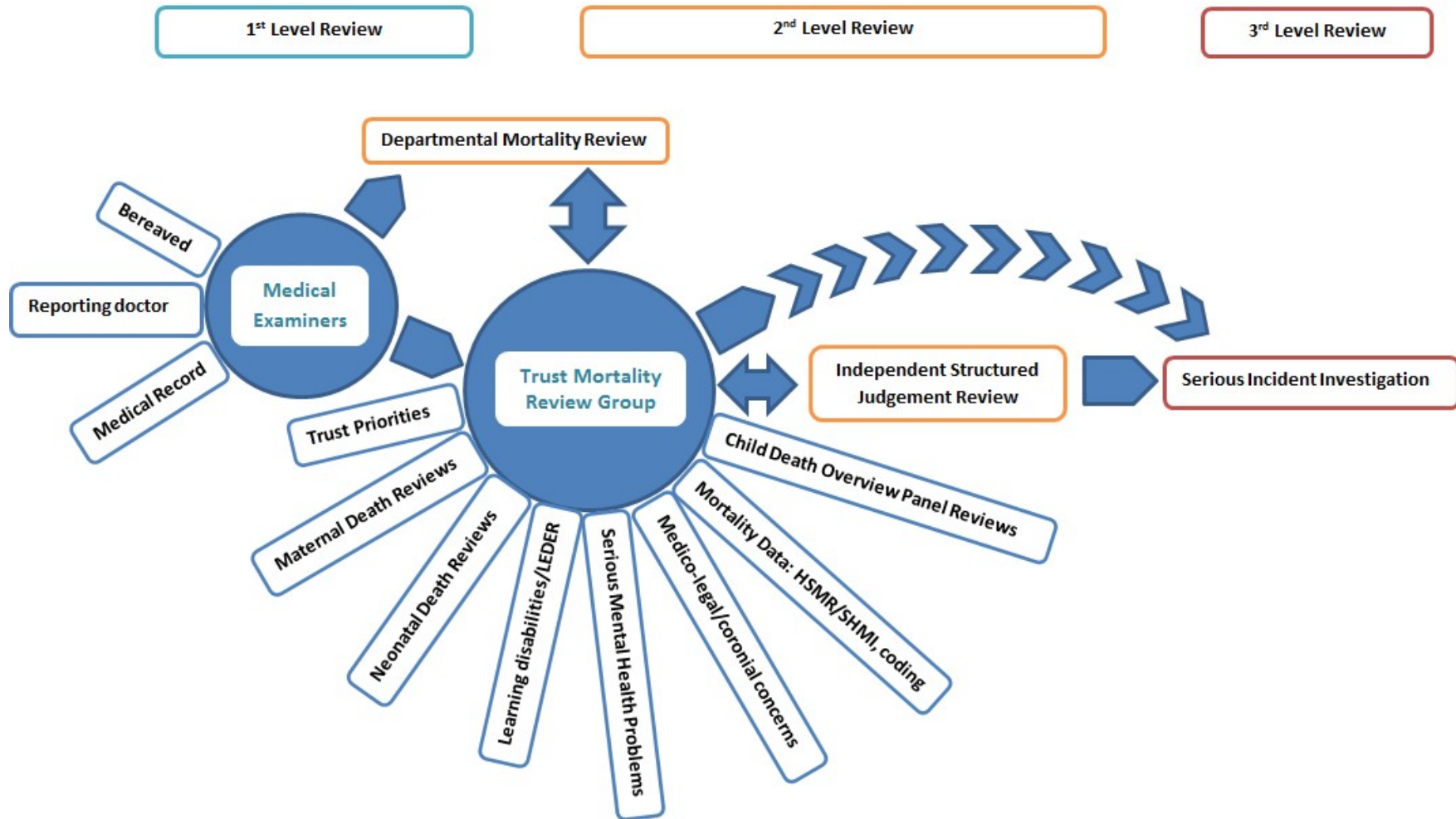
At the conclusion of their review the ME may advise coronial referral or issue of the Medical Certificate of Cause of Death (MCCD); **in addition** they may recommend the following:

- **No further review required:** where no concerns are identified, issue of the MCCD or coronial referral continues as usual. A department or TMRG may still choose to perform a 2nd level review even if no concerns are identified by the ME if the deceased fell into either the departmental or TMRG categories for review (for example: had a condition of educational interest or were part of a national mortality data alert).

- **Departmental Mortality Review:** where the ME has identified minor concerns, potential learning points for the department or areas of particularly good practice.

- **TMRG Review:** for more serious concerns, where there is wider organisational learning or the patient was in a predefined group of

interest (including those with learning difficulties and serious mental health conditions).

- **Completion of a patient safety incident report (Datix®):** where the ME believes there has been a patient safety incident this should be recorded as separate incident on the Datix® incident reporting system.

- **2nd Level Review:** Case Record Review
  There are two forms of second level review; Departmental Mortality Review and Independent Structured Judgement Review**.**

  - **Departmental mortality review**
    A guide for departmental mortality review is attached in appendix 2.

    Each department will publish their criteria for which deaths will undergo departmental review and report these to TMRG. Each department will use a structured format for mortality review. The Royal College of Physicians Structured Judgement Review (RCP SJR) Tool is the recommended format for mortality review but it is recognised that some departments already use other structured review tools. If a department wishes to use a format other than the RCP SJR this must be agreed by the TMRG. Training in use of the RCP SJR method will be offered to all departmental mortality leads. Results of departmental reviews will be shared with staff in that department at regular mortality meetings. Where a patient safety incident is identified as part of a departmental SJR this should be reported on the Datix® incident reporting system to allow a full investigation to take place.

Figure1: BSUH Mortality Review Process

- **Independent Structured Judgement Review**
Where significant concerns are raised or the death falls into one of the predefined categories of interest the TMRG will commission an independent SJR from a team of trained mortality reviewers. To ensure objectivity the reviewers will be instructed not to review deaths where they were involved in the patients care or where the patient had significant contact with the reviewer's department.
Categories where TMRG may request an independent SJR include

  – Concern raised by the bereaved, staff or Medical Examiner

  – Concern raised by the coroner or BSUH medico-legal team

  – Concern raised by external agency or other healthcare provider

  – Death in a patient with learning difficulties or severe mental health issues

  ▪ Mortality alerts arising from national mortality data (HSMR/SHMI)

  ▪ To support Trust priorities/'True North' objectives

  ▪ A random sample of deaths

  SJRs are recorded on a bespoke form within the PANDA patient clinical information database. Results of the SJRs are shared with the TMRG, relevant departmental mortality leads and Divisional Management teams. Where appropriate the reviews will be shared with other Trust committees or (suitably anonymised) with external agencies. It should be noted that any mortality review undertaken by the Trust is discoverable by HM Coroner to inform their inquiry.

  Examples of the learning generated and actions taken are presented to the Trust board on a quarterly basis. Themes arising from reviews will be shared with the Trust's Patient's First improvement programme to inform the wider quality improvement agenda.

  Where there are significant concerns or where concerns have been raised by the bereaved, the next of kin will be informed by the independent reviewer that a review is taking place and offered the opportunity to share any further concerns so that these can be addressed as part of the review. The bereaved will also be offered a summary of the final SJR and the opportunity to discuss it with the independent reviewer.

  Where significant concerns have been raised or there are challenging issues raised by a case, the independent reviewers may choose to ask for a second opinion from another trained reviewer and/or a multidisciplinary review by the TMRG members before finalising the review.

Where a patient safety incident is identified during an SJR this should be reported on the Datix® incident reporting system to allow a full investigation to occur.

- **3ʳᵈ Level Review:** Serious Incident Investigation and Coronial Inquiry

  - **Serious Incident Investigation**
    If, at any stage of the review process, it becomes clear that the patient's death was likely to have been due to a problem in care, the case will be referred for consideration of Serious Incident investigation in line with:

    - *Policy and Procedure for the Internal and External Reporting of Incidents and Management of Serious incidents (SQ008)*,

    - *Policy for Investigation of Incidents, Complaints and Claims using Root Cause Analysis (SQ006)*

    - *Duty of Candour– Policy for communicating with patients or relevant persons following a notifiable patient safety incident, complaint or claim (SQ005)*.

    Where any staff identify that a death was likely to have been preventable or due to a problem in care, then this must be reported as a patient safety incident using the Datix® incident reporting database and will be progressed in line with Trust policy as detailed above.

- **Coronial Inquiry**
  Deaths in certain circumstances will trigger a coronial inquiry and Inquest hearing. Whilst these occur independently of the organisation, the Trust has a duty to provide any information required to assist HM Coroner with an inquiry. This information will include any mortality review or incident investigation that has occurred in the Trust. Where HM Coroner raises further concerns as part of the judicial process or chooses to issue a Prevention of Future Deaths notification (Coroners' Regulation 28 (2013)), these concerns will be reviewed by the TMRG and consideration given as to how to respond to these concerns. Responses to Regulation 28 notifications will be co-ordinated by BSUH Medico-legal services and these recommendations reviewed by the TMRG.

7 Special situations

Learning disabilities
The NQB Learning from Deaths guidance describes the requirement for additional scrutiny for deaths in patients with learning disabilities. BSUH are actively engaged in the national LeDeR (Learning Disabilities mortality

Review) programme. All deaths in patients with a learning disability, as defined by the LeDeR programme, will be referred for LeDeR review using the online portal: https://www.bris.ac.uk/sps/leder/notification-system/. The death will be notified to LeDeR by a member of the BSUH Learning Disabilities Liaison Team (LDLT). The TMRG will notify the LDLT of any deaths in patients with learning difficulties that are identified by the MEs.

Completed LeDeR reviews will be fedback to TMRG for noting or further action as necessary.

Mental health
Another vulnerable group are those with significant mental health problems, whose deaths deserve close scrutiny. Medical Examiners will also be required to identify patients with significant mental health concerns. The NQB Learning from Deaths Guidance does not specifically define which deaths should undergo closer review but examples where closer scrutiny is required are:

- **Chronic mental health problems affecting daily living:** for example chronic schizophrenia resulting in homelessness or requiring supported living.

- **Patients receiving depot anti-psychotic medication** or second line antipsychotics, eg: Clozapine, at the time of death

- **Detention under any section of the Mental Health Act** at the time of death or in the period leading up to death. Deaths in this category will also need to be notified to the CQC.

- **Death as a direct consequence of mental health problems** ie: suicide, complications of self-harm, side effects of treatment.

- **Admission to the Trust from psychiatric in-patient care** eg: a patient developing pneumonia while a voluntary in-patient in a mental health hospital.

Some of these categories require referral to HM Coroner and an Inquest will be mandated. However, a local Independent Structured Judgement Review will also be carried out to identify any local learning points. Any Mental Health Trust involved in the patient's care will be informed of the death by the TMRG to enable them to carry out their own review. Where serious concerns are raised the relevant Clinical Commissioning Group (CCG) will be informed to enable a multi-agency review.

Children, young people and infants
Processes for mortality review in children, young people and infants are under review nationally following the Wood Review (2016). At the time of writing child deaths review processes for children, young people and infants remain the responsibility of the Local Children's Safeguarding Board who will convene a Child Death Overview Panel (CDOP) to scrutinise deaths. BSUH fully supports the CDOP and any recommendations the Trust receive via the

Children's Directorate or the Trust's Safeguarding Children Lead will be noted by TMRG and shared amongst the Children's Directorate.

While new regulations are awaited the Trust will review all deaths in children, young people and infants in a similar way to those in adults using a structured review tool. The national standardised [Perinatal Mortality Review Tool](#) (PMRT), developed by the National Perinatal Epidemiology Unit (NPEU), will be used to review all neonatal deaths. A similar tool will be developed locally for the review of all deaths in in-patients who are children and young people or infants.

In view of the complexity of child death reviews and in particular child safeguarding issues, the reviews of child deaths should be undertaken by specialists in Child Health. The Trust's team of independent mortality reviewers will not be expected to carry out mortality reviews on children unless they are from a Child Health background.

All deaths of children, young people and infants who are in-patients should be reported using the Datix® incident reporting system. Considerations around whether a child death requires 3rd level review (coronial referral and/or SI investigation) are the same as for all other in-patients.

Maternity
MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) reports have shown that there are frequently modifiable factors that lead up to stillbirth or maternal deaths. All stillbirths and maternal deaths in the Trust will undergo a structured review by a panel of specialists in maternal and fetal health. They will report data to MBBRACE-UK and will make recommendations which will be reviewed by TMRG and implemented by the Women's Directorate.

All maternal deaths will be reported using the Datix® incident reporting system. Considerations around whether a maternal death requires 3rd level review (coronial referral and/or SI investigation) are the same as for all other in-patients.

8 Support for the bereaved and involvement in the mortality review process

Support for the bereaved
- **Bereavement Office**: staff offer practical help and support for the bereaved in relation to death certification, the deceased's property, legal aspects and funeral arrangements.

- **Hospital chaplaincy service** offers religious and spiritual support. Where necessary the chaplaincy service will provide the bereaved with links to outside agencies or charities who can offer on-going support.

- **Patient Advice and Liaison Service (PALS)**: Where the bereaved have specific concerns or questions about the care their loved one received

they will be directed to PALs who will liaise with the relevant department/s in order to resolve concerns.

Involvement in Mortality Review Process

It is of the utmost importance that the bereaved are involved in the review process. Not only do they hold important information that will inform any investigation but they also have the right to understand in full what happened to their loved one. The bereaved will be involved in the mortality review process at the following points:

- **Medical Examiner Review**: MEs will speak to the next of kin of the deceased and ask if they had any concerns. If concerns are raised the ME will trigger the process outlined above. The ME will ask the relative if they have any objections to being contacted by a reviewer/investigator to discuss their concerns further. Where appropriate the ME will also advise the bereaved to contact PALS as a point of contact with the Trust.

- **Independent Structured Judgement Review**: when a SJR commences because serious concerns have been raised by the bereaved, they will be contacted by the reviewer to further establish the concerns and the circumstances of those concerns. The bereaved will be offered a summary of the SJR and given the opportunity to meet the reviewer to discuss the review.

- **Serious Incident Investigation/Coronial Inquiry**: in both circumstances there are well established pathways for involving the bereaved an eliciting their concerns. The bereaved will receive a copy of the final SI report and offered a meeting to discuss its findings with the investigator.

9 Support for staff

Training

Staff involved in mortality review will be offered training in Structured Judgement Review. At present we are utilising training from external bodies but we will develop an internal training programme as our mortality review processes mature.

Psychological support

Staff may be affected by the death of a patient in their care. The support offered by the Trust is detailed in policy HR010 Support arrangements for staff dealing with difficult situations. The Trust offers psychological support from the Health Employee, Learning and Psychotherapy (HELP) service. This service, which is accessible to all staff, offers group debriefing following distressing events and individual support.

In addition to caring for the bereaved, the chaplaincy team also offer religious and spiritual support to staff alongside the HELP service.
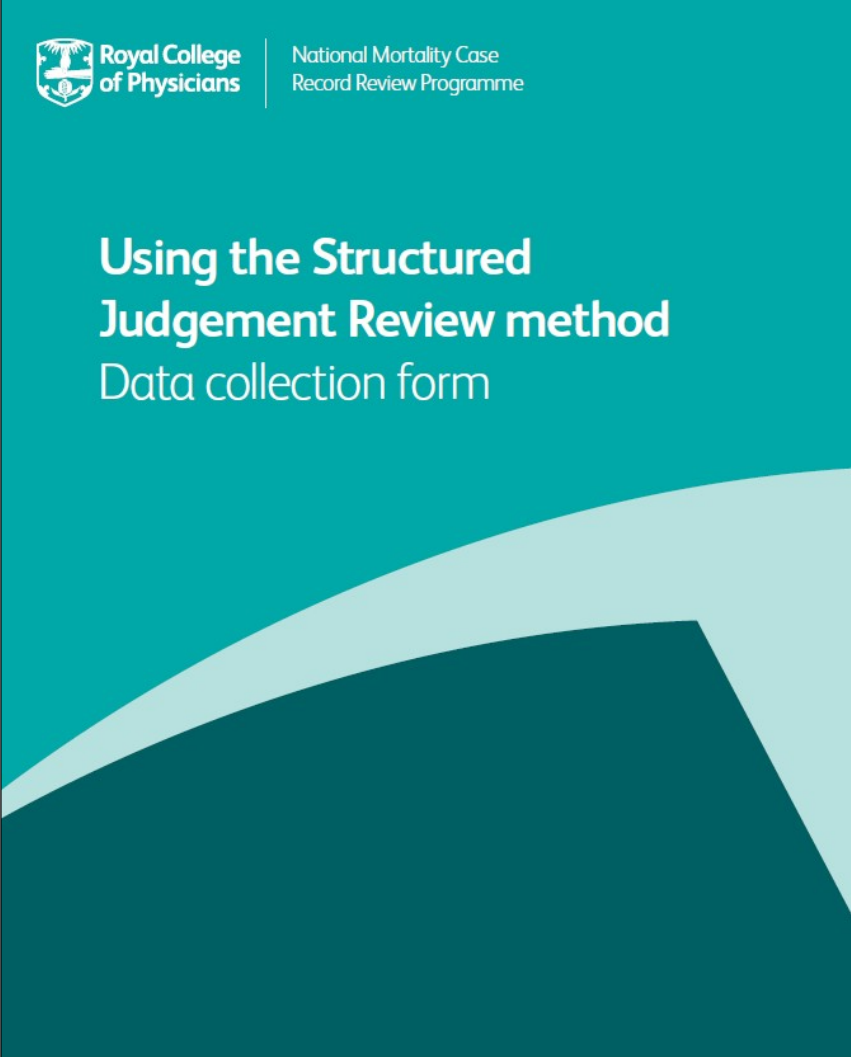
10   Data Collection and Reporting

The Learning from Deaths Guidance 2017 specifies the following data collection and reporting arrangements:

Data and learning points (suitably anonymised) arising from mortality review will be presented to the **public board on a quarterly basis**. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, an estimate will be presented of how many deaths were judged more likely than not to have been due to problems in care**.**

The **annual Trust Quality Account** will include details of learning points and actions taken as a result of mortality review.

A detailed review of nationally published mortality statisitics (ie: HSMR/SHMI) will occur in TMRG on a monthly basis.

Appendix 1

Royal College of Physicians | National Mortality Case Record Review Programme

Using the Structured Judgement Review method
Data collection form

In partnership with:
Improvement Academy
Part of the Yorkshire & Humber AHSN

Datix®
Software for patient safety

Commissioned by:
HQIP
Healthcare Quality Improvement Partnership

National Mortality Case Record Review Programme: structured case note review data collection

Please enter the following.

Age at death (years):

Gender: M/F

First 3/4 digits of the patient's postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:
Jan/Feb/Mar   Apr/May/June   Jul/Aug/Sept   Oct/Nov/Dec

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death if known:

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Guidance for reviewers

1   Did the patient have a learning disability?

- No indication of a learning disability.
  Action: proceed with this review.

- Yes – clear or possible indications from the case records of a learning disability.
  Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2   Did the patient have a serious mental health issue?

- No indication of a severe mental health issue.
  Action: proceed with this review.

- Yes – clear or possible indications from the case records of a severe mental health issue.
  Action: after your review, please refer the case to the hospital's clinical governance group.

3   Is the patient under 18 years old?

- No, the patient is 18 years or older.
  Action: proceed with this review.

- Yes – the patient is under 18 years old.
  Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Child Death Review Programme.

2

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care   2 = poor care   3 = adequate care   4 = good care   5 = excellent care

Please circle only one score.

3

Using the Structured Judgement Review method: data collection form

Phase of care: Ongoing care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care   2 = poor care   3 = adequate care   4 = good care   5 = excellent care

Please circle only one score.

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Using the Structured Judgement Review method: data collection form

Phase of care: Care during a procedure (excluding IV cannulation)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care   2 = poor care   3 = adequate care   4 = good care   5 = excellent care

Please circle only one score.

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Using the Structured Judgement Review method: data collection form

Phase of care: Perioperative care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care   2 = poor care   3 = adequate care   4 = good care   5 = excellent care

Please circle only one score.

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Using the Structured Judgement Review method: data collection form

Phase of care: End-of-life care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care   2 = poor care   3 = adequate care   4 = good care   5 = excellent care

Please circle only one score.

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Phase of care: Overall assessment

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this overall phase.

1 = very poor care   2 = poor care   3 = adequate care   4 = good care   5 = excellent care

Please circle only one score.

Please rate the quality of the patient record.

1 = very poor   2 = poor   3 = adequate   4 = good   5 = excellent

Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here)   Yes ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below. Please indicate whether it led to any harm and in which phase(s) of care the problem was identified. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* Yes ☐ No ☐

   Did the problem lead to harm? No ☐   Probably ☐   Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐   Ongoing care   ☐

   Care during procedure   ☐   Perioperative care ☐

   End-of-life care   ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)* Yes ☐ No ☐

   Did the problem lead to harm? No ☐   Probably ☐   Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐   Ongoing care   ☐

   Care during procedure   ☐   Perioperative care ☐

   End-of-life care   ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* Yes ☐ No ☐

   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐   Ongoing care ☐

   Care during procedure ☐   Perioperative care ☐

   End-of-life care ☐

4. **Problem with infection management** Yes ☐ No ☐

   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐   Ongoing care ☐

   Care during procedure ☐   Perioperative care ☐

   End-of-life care

5. **Problem related to operation / invasive procedure** *(other than infection control)* Yes ☐ No ☐

   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐   Ongoing care ☐

   Care during procedure ☐   Perioperative care ☐

   End-of-life care ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)* Yes ☐ No ☐

   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐   Ongoing care ☐

   Care during procedure ☐   Perioperative care ☐

   End-of-life care ☐

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7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* Yes ☐ No ☐

   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐   Ongoing care ☐

   Care during procedure ☐   Perioperative care ☐

   End-of-life care ☐

8. **Problem of any other type not fitting the categories above** *(including communication and organisational issues)* Yes ☐ No ☐

   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐   Ongoing care ☐

   Care during procedure ☐   Perioperative care ☐

   End-of-life care ☐

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Brighton and Sussex NHS
University Hospitals
NHS Trust

Appendix 2 - Guidance for Departmental Mortality Review

This guidance should be read in conjunction with the Trust policy TW220 Learning from Deaths.

It is acknowledged that most for most departments it is not practical to review all deaths. Therefore, there should be a clear method for selecting deaths for review and criteria should include:

- Concerns raised by staff or the bereaved
- Significant incidents/events
- Coronial Inquests (ideally mortality review should occur prior to the coronial inquest)
- Cases highlighted by a Medical Examiner
- Educational interest
- Issues of departmental interest eg: subject of improvement projects
- Random sample
- Cases highlighted by the TMRG in relation to a mortality outlier alert

Departments with a predominantly outpatient workload should review relevant deaths in patients known to their service. Again criteria for case selection must be published.

Where multiple specialities have been involved, the speciality in charge of a patient's care at the time of death will be responsible for co-ordinating the review. Other departments may be asked to take part in discussion or to take over the review depending on the circumstances of the death.

In some cases there may be higher level reviews (Eg: second level independent structured judgement review, SI investigation or coronial inquest) also in progress, however, departmental review should continue as it is likely that different issues will be identified by different reviewers. Points raised by departmental review will inform the recommendations of higher level reviews.

Method of review

Reviews should follow a structured format and should cover the most relevant sections of the patient's medical history. Usually this will be the whole final hospital admission but may need to cover other aspects. The review should cover all aspects of the hospital admission and not just the aspects relevant to the department

carrying out the review. It is acknowledged that staff may not have expertise in other specialist areas but they will be able to comment on the general aspects of care. If there are concerns raised about another department's care then the case should be referred to the relevant Departmental Mortality Review Lead and/or the Trust Mortality Review Group depending on the severity of the concerns.

It is recommended that the Royal College of Physicians Structured Judgement Review (SJR) Tool is used. However, some specialities have specific requirements in addition to those covered by the SJR. These departments may develop their own mortality review forms which incorporate the elements of the SJR. Any department not using the SJR should confirm with TMRG that their process is at least equivalent to RCP SJR.

Where there is concern that a death was likely due to a problem in care or potentially avoidable it should be referred to TMRG for second level review and/or Serious Incident Investigation. Where a patient safety incident has been identified then this should be reported using the Datix® incident reporting system.

Staff

Reviews may be carried out by any member of qualified healthcare staff. Often this will be medical staff but if there are concerns about nursing care or care by other healthcare professions then it may be relevant for these groups to carry out the review. Where a trainee doctor carries out the review they should be supervised by a Consultant. The reviews require a thorough review of the case record and so should be carried out prior to any Mortality Review meeting.

Departmental Mortality Review Meetings

The purpose of these meetings (also known as 'M&M' meetings) is to discuss the findings of case record reviews (SJR or equivalent), share learning, identify improvements and celebrate good practice. Meetings should be multidisciplinary, should be minuted and have a record of attendance. The frequency of these meetings will be dependent on the volume of deaths in a speciality. For most specialities a meeting coinciding with the10 annually assigned departmental Quality Safety and Patient Experience (QSPE meetings) would be a minimum frequency. TMRG will provide Departmental Mortality Leads with information arising from second level reviews and SI investigations and this should also be shared at Departmental Mortality Review meetings.

Training

Training in mortality review (SJR) is available from the Royal College of Physicians and will be offered to Departmental Mortality Leads. As the programme becomes more established training will be made available to other staff involved in mortality review

Appendix 3 - Due Regard Assessment Tool

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Age	**Yes**	Special scrutiny is applied to the deaths of children, young people and infants.
	• Disability	**Yes**	Patients with learning disabilities and serious mental health concerns are positively identified as vulnerable groups whose deaths need special scrutiny in order to improve the care of future patients with these problems
	• Gender	No	
	• Gender identity	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	**Yes**	Special scrutiny is applied to maternal deaths
	• Race	No	
	• Religion or belief	No	
	• Sexual orientation, including lesbian, gay and bisexual people	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	Yes	Evidence is detailed in the NQB Learning form Deaths Guidance 2017 explaining why deaths certain groups are subject to increased scrutiny
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**		
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**	N/A	
6.	**What alternative is there to achieving the document/guidance without the impact?**	N/A	

7.	Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?	N/A	
8.	Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)	Yes	

Appendix 4 - Version Control Sheet

Version	Date	Author	Status	Comment