

Learning from Deaths Policy

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Document Abstract
<p>This policy describes how the Trust manages its mortality reviews in response to the Care Quality Commission publication 'Learning, candour and accountability'. The purpose of these reviews is to consider individual cases and trends, to identify and embrace opportunities for learning and improvement.</p> <p>This policy will also cover the transition period of adolescents aged between 16-18, recognising these individuals are also subject to a separate, well established Child Death Review Process .</p> <p>This policy also defines the process by which all adult inpatient deaths are screened in UH Bristol and the process of monitoring the outcome and learning from deaths. This process was introduced in April 2017.</p> <p>There is a separate process outlining the traditional Mortality and Morbidity Review meetings which occur within the Trust.</p> <p>This policy references a number of other documents regarding the support and engagement of bereaved families in investigatory processes should they wish.</p>

¹ Divide number of words (2920) by 240 for average reading time and add 25% for specialist content.

Document Change Control				
Date of Version	Version Number	Lead for Revisions	Type of Revision	Description of Revision
30 th September 2017	1.0	Medical Director	New Policy	Approved

Do I need to read this policy?

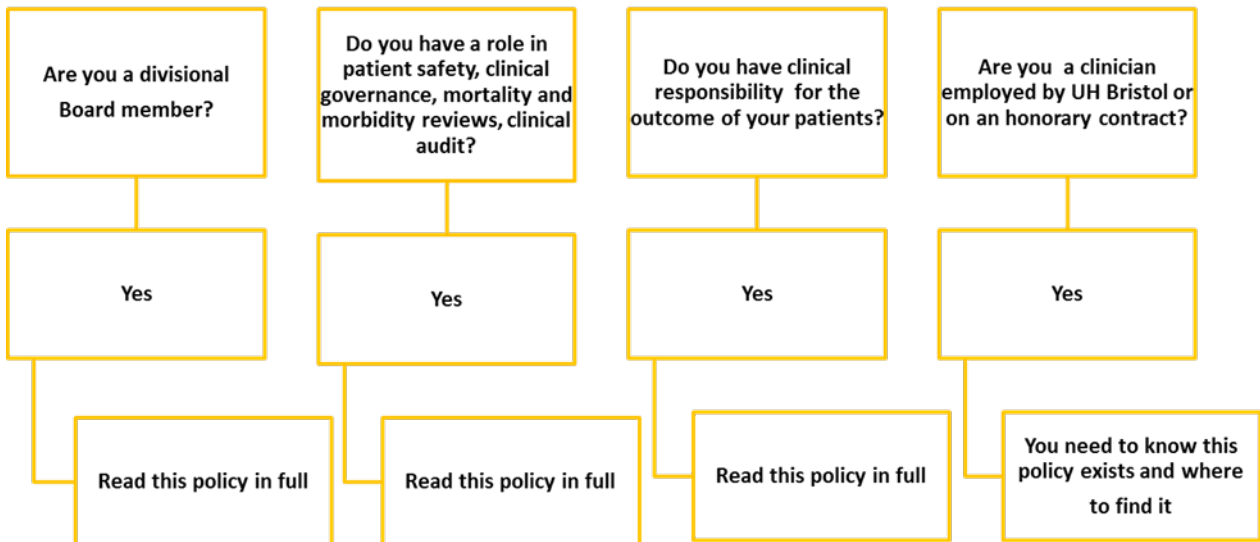


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1. Introduction

1.1 Learning from deaths

- (a) In December 2016, the Care Quality Commission published a review of how NHS trusts review and investigate deaths of patients in care. ‘Learning, candour and accountability’ provides helpful insight into the system level and local challenges to effective investigations, greater candour and transparency, and learning from deaths across the NHS.
- (b) The ability to learn from deaths is an established part of the provision of high quality clinical care. The Board of University Hospitals Bristol NHS Foundation Trust (UH Bristol, the Trust) regards learning from deaths as an essential element of clinical governance and a key practice in continuous quality improvement. The process of learning from deaths can help improve the care for all patients by identifying common themes and problems associated with poor outcomes, and working to understand how and why these occur so meaningful action can be taken.
- (c) Mechanisms for learning from deaths must be robust and effective to identify learning from death to identify changes in practice that would, in the future, prevent a death or reduce morbidity.
- (d) The process of learning from deaths is mandatory. The expectation is that learning from deaths data will be reviewed as a matter of routine and learning shared within the specialty and the division.
- (e) It is a priority for the Trust to engage with bereaved families and carers, giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. This process will allow the Trust to work more closely with bereaved families and careers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.
- (f) Cross-divisional learning will be shared through upward thematic reporting of the outcomes of learning from deaths reviews via the Trust Mortality Surveillance Group. This group will co-ordinate the learning from deaths throughout the organisation.
- (g) This policy recognises the new mortality review process and replaces the Trust’s previously established mortality review process.
- (h) Any incidents identified from learning from deaths should be reported in line with the Trust’s [Policy for the Management of Incidents](#).
- (i) Any risks identified from learning from deaths should be risk assessed in line with Trust’s [Risk Assessment Standard Operating Procedure](#).

2. Purpose

2.1 This policy:

- (a) describes the procedures for identifying, recording, reviewing and investigating the deaths of adults in the care of the Trust
- (b) describes 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.
- (c) references associated documents about how people who have been bereaved by a death at the Trust should expect to be informed about and involved in any further action taken to review and/or investigate the death

3. Scope

3.1 This policy covers learning from death in adults.

3.2 This policy will also cover the transition period of adolescents aged between 16-18, recognising these individuals are also subject to the Child Death Review Process.

3.3 There is a separate, well established [Child Death Review Process](#) which is to also be followed for all child deaths including adolescents aged 16 or 17 years.

3.4 There is also a separate policy which describes the Trust's processes for managing [National Confidential Enquiries](#) some of which could relate to mortality studies for specific groups of patients e.g. the national Confidential Enquiry into Maternal Deaths.

3.5 This policy applies to all bed holding divisions and those which carry out day case interventional procedures.

4. Definitions

The following definitions are used in this policy:

4.1 *Mortality*

In-hospital deaths of patients under the care of a specified consultant

4.2 *Structured Case Note Review (SCNR)*

A structured case note review (SCNR) is the methodology by which patient notes are reviewed to assess quality of care and the potential avoidability of death. The SCNR is performed by trained reviewers using a validated methodology designed by the Royal College of Physicians.

The following definitions apply for the purposes of this guidance:

- (i) Case/record review:

The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.

(ii) Investigation:

The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision to reduce the risk of future occurrence of similar events.

5. Duties, Roles and Responsibilities

5.1 Trust Board of Directors

- (a) The Trust Board of Directors has overall responsibility for quality of care in the Trust and a duty satisfy itself that the Trust's arrangements for learning from deaths are fit for purpose.
- (b) The Board will nominate a non-executive director who will oversee governance processes relating to review of mortality and morbidity, working closely with the Medical Director.
- (c) The Board will receive a quarterly report from Mortality Surveillance Group. This report will co-ordinate all the intelligence from reviewing in patient adult death and will establish the common themes associated with learning from deaths

5.2 Medical Director

- (a) The Medical Director is the lead executive director for learning from deaths responsible for putting appropriate systems in place to learn from deaths, resulting in shared learning to improve patient outcomes. This includes personal oversight of arrangements for systematic screening of adult inpatient deaths, subsequent review and investigation of appropriate cases, and Chairing the Trust's Mortality Surveillance Group
- (b) The Medical Director is also responsible for ensuring that the Trust has systems in place to enable it to receive regular mortality and morbidity data, benchmarked against other NHS providers, highlighting and enabling the investigation of, any potential areas of concern via the Trust's Quality Intelligence Group.
- (c) The Medical Director will chair the Trust's Mortality Surveillance Group, ensuring co-ordination and dissemination of common themes and learning throughout the organisation. The Medical Director will also chair the Quality Intelligence Group and will co-chair the Clinical Quality Group.
- (d) The Medical Director's team is responsible for undertaking secondary reviews where the SCNR has highlighted either concerns around the care of a patient or raised the potential that the death was avoidable

- (e) The Medical Director's team is responsible for ensuring sufficient numbers of medical staff are formally trained in SCNR. These staff should represent a cross section of all specialties.

5.3 Deputy Medical Director for Patient Safety

- (a) The Deputy Medical Director for Patient Safety is responsible for preparing, on behalf of the Medical Director, regular reports to the Trust's Clinical Quality Group describing thematic learning from the screening, review and investigation of adult inpatient deaths (see Appendix D).

5.4 Clinical Chairs and Divisional Directors

Clinical Chairs and Divisional Directors are responsible for:

- (a) Ensuring arrangements for learning from deaths within their division meet the requirements of this policy and are sufficiently robust to contribute to providing assurance that their services are safe, that learning from mortality and morbidity reviews is identified and shared to improve patient outcomes.
- (b) Ensuring the Divisions of Medicine, Surgery and Specialised Services have designated mortality leads; one each in Specialised Services and Surgery and joint leads in Medicine.
- (c) Designating consultant leads for learning from deaths for the division or sub-specialties.
- (d) Ensuring any incidents identified from mortality and morbidity reviews are reported in line with the Trust's [Policy for the Management of Incidents](#).
- (e) Ensuring any risks identified from mortality and morbidity reviews are risk assessed in line with Trust's [Risk Assessment Standard Operating Procedure](#) and entered on the departmental or divisional risk register and escalated in accordance with the Trust [Risk Management Policy](#) if of sufficient magnitude.
- (f) Monitoring the effectiveness of these arrangements within the division.
- (g) Ensuring that medical staff participate in the systematic screening and review of adult inpatient deaths.

5.5 Designated Divisional leads for mortality reviews

Designated consultant divisional leads for mortality are responsible for:

- (a) Ensuring SCNR in the patients identified by the Mortality Screening Nurse are carried out within the division/ specialty that meet the requirements of this policy. The Divisional mortality leads are responsible for coordinating the feedback from the SCNR within the Division, reporting the learning from deaths themes to both the Divisional board and the Mortality Surveillance Group.

- (b) Divisional Mortality leads are responsible for identifying and reporting to the Medical Directors Office any cases where significant concern regarding patient care or there is a potential the death was avoidable for a second review.
- (c) Producing reports from reviews for the Mortality Surveillance group
- (d) Co-ordination of SCNRs within their division/specialty.

5.6 Medical staff

- (a) Medical staff should not review cases in which they have been directly involved. When performing a SCNR, the medical staff should complete and return them to the Divisional mortality leads in a timely fashion.

5.7 All clinicians

- (a) All clinicians should participate in division-based learning from deaths 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.
- (b) Participation should take the form of open and transparent review of individual cases in the spirit of learning and continuous improvement.
- (c) Clinicians should review, and adjust if appropriate, their personal and team clinical practice in response to learning from such reviews.
- (d) Clinicians who attend mortality and morbidity meetings should:
 - (i) contribute their knowledge and experience to those meetings
 - (ii) openly look for prevention strategies, without resorting to blaming others
 - (iii) help colleagues to deliver safer care on the basis of what has been learned, by building safeguards into existing practice and challenging practice that has been demonstrated to be unsafe
 - (iv) look to improve and standardise care for patients and their families

5.8 Clinical Quality Group

The Clinical Quality Group is responsible for:

- (a) Receiving assurance reports on outcomes and learning from systematic screening and review of adult inpatient deaths, and the Child Death Review process.
- (b) Receiving assurance reports from the Mortality Surveillance group regarding learning from deaths

5.9 Quality Intelligence Group

The Quality Intelligence Group is responsible for receiving and acting upon benchmarked mortality data, provided by an agreed external contractor, describing the Trust's performance in relation to its peers and other NHS providers.

5.10 Mortality Surveillance Group

The Mortality Surveillance Group is responsible for ensuring that specific mortality reporting requirements, as set out by NHS England, are implemented.

5.11 Quality and Outcomes Committee

The Quality and Outcomes Committee is responsible for:

- (a) On behalf of the Trust Board, receiving summary assurance reports on the outputs from mortality and morbidity monitoring within the Trust
- (b) Appraising the Board of any concerns regarding mortality or morbidity identified from the information received

5.12 Divisional Management Boards

Divisional Management Boards are responsible for:

- (a) Supporting the designated lead consultant(s) for mortality reviews for the division or sub-specialties by ensuring this responsibility is reflected in job plans and to ensure administrative support is available for mortality and morbidity meetings.
- (b) Ensuring there is provision for storage of anonymised information relating to mortality reviews within their division on the Trust's intranet e.g. minutes and papers of mortality and morbidity meetings
- (c) Receiving regular reports from divisional mortality leads including action plans and recommendations arising from the mortality and morbidity review process.
- (d) Publishing evidence internally to provide assurance that lessons are being learned such as policies and training programmes, and preventative measures are effective

5.13 Divisional Governance Groups

Divisional Governance Groups are responsible for:

- (a) Ensuring that the standards described in section 7.1 are being adhered to.
- (b) Receiving reports of mortality review outcomes, and ensuring learning is shared appropriately within the division and systemic changes in practice are implemented if required
- (c) Considering future audit requirements for changes in practice and feed these into the division's clinical audit plan

- (d) Identifying and reporting any new incidents or risks arising from mortality and morbidity review outcomes within the division

6. Policy Statement and Provisions

6.1 Policy statement

- (a) The Trust is committed to taking every possible opportunity to learn from reviews of the quality of its services from a range of sources, and to implement changes, either locally or systematically for continuous quality improvement. The various reviews of mortality and morbidity described in this policy are intended to identify changes in practice that could, in the future, prevent a death or reduce morbidity.
- (b) In specialties, teams that provide direct care to patients must be sufficiently involved in mortality and morbidity reviews so as to enable staff to understand what the underlying causes for mortality and morbidity are for patients in their care.
- (c) The overarching reporting of mortality and morbidity is shown in Appendix D

6.2 Systematic mortality screening and review

- (a) In accordance with NHS England's expectations, the Trust will screen all adult inpatient deaths, carrying out SCNR where indicated.

6.3 The process of learning from deaths

- (a) The Trust will systematically screen all adult in-patient deaths. Cases meeting the criteria set out in section 7.1 of this policy will trigger a Structured Case Note Review (SCNR) to identify concerns and possible areas for improvement, and the outcome will be documented.
- (b) The Structured case note review will be undertaken by a senior healthcare professional trained in the methodology and the review will be co-ordinated by the Divisional mortality lead
- (c) Where the SCNR raises concerns about a the management of a patient or the avoidability of a death are identified, a further second review of the case will be undertaken by the Medical Director team
- (d) Learning from reviews and investigations will be co-ordinated by the Divisional mortality leads and fed back to the Trust Mortality Surveillance Group where the learning from deaths themes can be disseminated effectively across the organisation and with other organisations where appropriate
- (e) Information on deaths, investigations and learning will be regularly reviewed at board level, acted upon and reported in annual Quality Accounts
- (f) The Medical Director is responsible for ensuring that an effective system is in place; the operational lead for this system is the Associate Medical Director for Patient Safety

- (g) The process for conducting screening deaths and conducting case reviews is described in Appendix G.
- (h) The findings of systematic mortality reviews are reported at least annually to the Clinical Quality Group and, from there, to the Senior Leadership Team and Quality and Outcomes Committee and Trust Board as shown at Appendix D.

7. Standards and Key Performance Indicators

7.1 *Applicable standards for systematic screening and review of adult inpatient deaths*

- (a) All adult inpatient deaths will be screened by the Mortality Screening Nurse, except in patients who have suffered an out of hospital cardiac arrest.
- (b) All cases meeting the following criteria will trigger a Structured Case Note Review (SCNR):
 - (i) Deaths after an elective procedure
 - (ii) Deaths where the family raise concerns about the overall care
 - (iii) Patients with learning difficulties who have died
 - (iv) Patients who have died with a history of severe mental illness, this is defined as patients receiving on-going care from secondary mental health services or were detained under the Mental Health Act 2007 at the time of their death
 - (v) Patients aged between 16-18 years
 - (vi) Patients who die and have triggered a Serious Incident review
 - (vii) Deaths that occur following an alert that has been raised with the organisation
 - (viii) Patients who have died within 30 days of discharge from hospital
- (c) The co-ordination of the SCNR will be undertaken by the divisional mortality leads.
- (d) All SCNRs that trigger a score of 1-2 for the overall provision of care or 1-3 for the avoid ability of death score will trigger a second SCNR by a member of the Medical Director's team. A judgement regarding the avoid ability of death will be made following the second review.
- (e) If there is either evidence of poor care or avoidable death and duty of candour has not been undertaken then the Medical Director's office will undertake duty of candour.
- (f) If the review suggests the care should warrant a SI review and this has not occurred, this should be fed back via the Trust governance process

7.2 *Measurement and Key Performance Indicators*

- (a) Every quarter the Trust will collect the following data:

- (i) The total number of inpatient deaths in an organisation's care
 - (ii) The number of deaths the trust has subjected to case record review
 - (iii) The number of deaths investigated under the Serious Incident Policy (and declared as Serious Incidents)
 - (iv) Of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
 - (v) The themes and issues identified from review and investigation, including examples of good practice
 - (vi) How the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.
- (b) The Mortality Surveillance Group will provide the Trust Board of Directors with quarterly assurance that the standards described in section 7.2 are being adhered to. This information will also be reported to NHS England.

8. References

- 8.1 Care Quality Commission [Learning, candour and accountability](#), December 2016
- 8.2 National Quality Board [National Guidance on Learning from deaths](#) March 2017

9. Associated Documentation

- 9.1 Child Death Review Process
- 9.2 Risk Assessment Standard Operating Procedure
- 9.3 Policy for the Participation in National Confidential Enquiries
- 9.4 Serious Incident Policy
- 9.5 Policy for the Management of Incidents
- 9.6 Complaints and Concerns Policy
- 9.7 Link between Serious Incidents and other investigatory procedures
- 9.8 Guidance for supporting and working with families after unexpected death of an adult or a Serious Incident involving an adult
- 9.9 Patient information leaflet: Guide for adult patients and families about investigations of unexpected events and incidents
- 9.10 Guidance for the preparation and conduct of meetings with parents/families to discuss concerns and/or adverse event feedback

10. Appendix A – Monitoring Table for this Policy

- 10.1 This policy will be monitored via quarterly reporting from the Mortality Surveillance Group to the Board as set out in section 7.2 and a two yearly audit against the standards in section 7.
- 10.2 The outcome of the two yearly audit will be reported into the Clinical Quality Group

11. Appendix B – Dissemination, Implementation and Training Plan

11.1 The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Mark Callaway
This document replaces existing documentation:	Yes
Existing documentation will be replaced by:	Mortality and Morbidity Policy
This document is to be disseminated to:	Executive Directors, Divisional Boards and the Trust Patient Safety Group
Training is required:	Yes
The Training Lead is:	Training for mortality reviewers is provided by Medical Director Team

Additional Comments
[DITP - Additional Comments]

12. Appendix C – Document Checklist

12.1 The checklist set out in the following table confirms the status of ‘diligence actions’ required of the ‘Document Owner’ to meet the standards required of University Hospitals Bristol NHS Foundation Trust Procedural Documents. The ‘Approval Authority’ will refer to this checklist, and the Equality Impact Assessment, when considering the draft Procedural Document for approval. All criteria must be met.

Checklist Subject	Checklist Requirement	Document Owner’s Confirmation
Title	The title is clear and unambiguous:	Yes
	The document type is correct (i.e. Strategy, Policy, Protocol, Procedure, etc.):	Yes
Content	The document uses the approved template:	Yes
	The document contains data protected by any legislation (e.g. ‘Personal Data’ as defined in the Data Protection Act 2000):	Not Applicable
	All terms used are explained in the ‘Definitions’ section:	Yes
	Acronyms are kept to the minimum possible:	Yes
	The ‘target group’ is clear and unambiguous:	Yes
	The ‘purpose and scope’ of the document is clear:	Yes
Document Owner	The ‘Document Owner’ is identified:	Yes
Consultation	Consultation with stakeholders (including Staff-side) can be evidenced where appropriate:	Yes
	The following were consulted:	Medical Director, Mortality Review Group
	Suitable ‘expert advice’ has been sought where necessary:	Yes
Evidence Base	References are cited:	Yes
Trust Objectives	The document relates to the following Strategic or Corporate Objectives:	Patients will be kept safe from avoidable harm
Equality	The appropriate ‘Equality Impact Assessment’ or ‘Equality Impact Screen’ has been conducted for this document:	Not Applicable
Monitoring	Monitoring provisions are defined:	Yes
	There is an audit plan to assess compliance with the provisions set out in this procedural document:	Yes
	The frequency of reviews, and the next review date are	Yes

Learning from Deaths Policy - Reference Number

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
	appropriate for this procedural document:	
Approval	The correct 'Approval Authority' has been selected for this procedural document:	Yes

Additional Comments
[DCL - Additional Comments]

13. Appendix D – Mortality Review process

