

Learning from Deaths Policy

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| Policy authors | Trust Mortality Lead Clinical Effectiveness Facilitator (Mortality) |
| Accountable Executive Lead | Medical Director |
| Approving body | Trust Board |
| Policy reference | SWBH/ORG/06 |

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

- 1 - All Clinical staff**
- 2 - Group Directorate & Specialty Leadership teams**

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:

- 1 - Executive Team/General/Operational Managers**

POLICY APPROVAL DATE

February 2018

POLICY IMPLEMENTATION DATE:

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DATE POLICY TO BE REVIEWED:

August 2019

DOCUMENT CONTROL AND HISTORY

| Version No | Date Approved | Date of implementation | Next Review Date | Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.) |
|-------------------|----------------------|-------------------------------|-------------------------|---|
| 1.0 | Feb. 2018 | Feb. 2018 | Aug. 2019 | New Policy |
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Learning from Deaths

KEY POINTS

1. Sets out the SWBH Trusts policy for learning from deaths in accordance to the National Learning From Deaths Agenda launched by the National Quality Board in March 2017. The purpose of the guidance is to help initiate a standardised approach for learning from deaths across all organisations and providers of healthcare.

2. The policy sets out:-
 - How the review process will be conducted.
 - Who will be involved.
 - How the monitoring of mortality will be undertaken.
 - How relatives and carers of the deceased will be involved.
 - How the learning from the reviews will be reported and disseminated.
 - Procedures for responding to mortality alerts from internal and external investigation.

**PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS
A QUICK REFERENCE GUIDE ONLY AND IS NOT
INTENDED TO REPLACE THE NEED TO READ THE FULL
POLICY**

Learning from Deaths

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Learning from Deaths

1. BACKGROUND

Monitoring mortality data can help a health care provider to identify whether there are any quality or safety issues related to the care that they provide. It can also help to identify where best practice has been implemented and excellent care provided. Information from this monitoring and the themes arising from it can guide the quality improvement work that is required in response.

Sandwell & West Birmingham Hospitals NHS Hospital Trust ('The Trust') has had a structured mortality statistics monitoring and case review system in place since 2000. The recently launched National Learning from Deaths guidance produced by the National Quality Board (NQB) in March 2017, provides the Trust with the means to enhance its existing programme to ensure that it continues to learn from deaths.

The focus of the NQB guidance is:

- engagement with relatives and carers of the deceased
- ensuring timely, focused structured reviews of appropriate cases
- identifying good and poor care from which lessons can be learnt
- Identifying quality improvement from the learning and implement and share this quality improvement work with the public as well as with health care providers.

Central to the enhancing the local framework is the appointment of a number of Medical Examiners (ME). They will have a key role in ensuring the accurate medical certification of the cause of death and in engaging with relatives and carers from this time. They will also have responsibility for identifying cases for review according to this policy.

The processes for reviewing deaths that occur in the Trust and for reporting of the outcomes is summarised in the flowchart contained in Appendix 4.

2. OTHER POLICIES TO WHICH THIS POLICY RELATES

The Policy on the Completion of a 'Medical Certificate of the cause of Death' (ORG112)
Incident Reporting Policy (ORG109)
Complaints Handling Policy (ORG008)
Being open following a patient safety incident (RM01)
Death of infant or child 0-18 year's policy (ORG100)
Maternal Deaths Reporting- MBRRACE (MAT022)
Rapid release of deceased adult (ORG11)

3. AIM / PURPOSE OF THE POLICY

The purpose of the Trusts Learning from Deaths Policy is to describe the process by which patients who die in the Trust's care are identified, reported, investigated, learnt from and used to drive quality improvement. It aims to strengthen current arrangements, where appropriate, and to ensure that the learning and quality improvement is shared and acted upon.

It seeks to ensure that 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 deaths.

4. GLOSSARY & DEFINITIONS (See Appendix1)

5. SCOPE

This policy applies to all clinical staff working within the Trust in all of its locations.

It is important for Group, Directorate and Specialty Leadership teams to understand the processes and requirements of this Policy as it relates to their areas.

The processes set out in this policy do not replace the established systems for reviewing deaths in certain patient groups. These include the procedures for reviewing perinatal mortality and maternal and child deaths.

6. THE MORTALITY REVIEW PROCESS (See Appendix 2 & 3)

The components of reviewing deaths in the Trust are identified in the table contained in appendix 3 Appendix 2 consists of the details of the processes for identifying cases for review and investigation through initial screening of deaths by Medical Examiners and for conducting a review through the SWBH in house mortality review system (MRS) and later by a web based Subjective Judgemental Review (SJR)) and thematic analysis tool.

a) Initial screening by Medical Examiners (ME)

The Medical Examiner conducts an initial screening of deaths reported to the Cares Office and considers whether the death needs to be referred to the Coroner, includes a reportable incident or falls into the category of deaths which require a case review; either trust MRS or Subjective Judgemental Review (SJR) or a Specialist Review. (See Appendix 2). There is also the opportunity at this time to make contact with the bereaved family to enquire whether they have any concerns about the cause of death.

b) Cases for Structured Judgemental Review (SJR)

The ME will identify the deaths which require a review MRS or SJR (See Appendix 2). These cases will be reviewed by trained Case Reviewers who will consider the overall level of care provided and form an opinion whether the care provided was Very poor (1), Poor (2), Adequate (3), Good (4) or Excellent (5).

c) Cases requiring Specialist Case Reviews (See Appendix 2)

The deaths which are subject to review by specialist review are identified in Appendix 2. The outcomes from these reviews will be presented to the Learning from Deaths (LfD) Committee according to the schedule agreed at the commencement of each new financial year.

7. MANAGEMENT OF MORTALITY OUTLIERS AND ALERTS

a. Routine mortality surveillance

Crude mortality rates and standardised mortality ratios (HSMR, SHMI & RAMI) at a Trust, Group and Directorate level will be monitored by the Lf D Committee. This information will be included in standard reports to Trust committees and to the Trust Board.

b. Pro-active review of mortality outliers

When mortality outliers are identified from internal surveillance or from the review of standardised mortality ratios, this will generate a specialty level case-note analysis and case investigation as appropriate. This work will be commissioned by Lf D Committee through the existing processes and supported through screening conducted by the Medical Examiners.

c. Review of externally generated mortality outlier alerts

The Medical Director and mortality lead will identify an appropriate specialty to conduct a review and produce a report and recommendations within the timeframe prescribed by the agency (e.g. Care Quality Commission) publishing the alert. This process is supported by the LfD Committee and the Hospital Information Services. Reports generated as a result of this process will be reviewed at LfD Committee to confirm that the actions required are appropriate before this is then reported to the appropriate Executive Committee.

8. MORTALITY REVIEW SYSTEM (MRS) REPORTING

Reports from the Mortality Review System or the SJR process with thematic analysis when this is in place, will be produced by the Clinical Effectiveness Facilitator for Mortality and be presented monthly to the LfD Committee. The reports will identify:-

- Deaths allocated a preventable code and those that trigger from the screening questions from MRS.
- Deaths that require a second stage Judgmental Review or Tier 2 MDT review. This will be the case where both poor and excellent care is identified from first SJR.
- Deaths where a clinical incident or complaint has been raised.
- Lessons learnt from the MRS and SJR's with thematic analysis.

9. DEATHS SUBJECT TO EXTERNAL REVIEW

External reviews include those arising from Coroners Inquests, the National Learning Disability Review Programme (LeDeR) and from the CQC's Outlier alerts programme. All in hospital deaths subject to external review will have the outcomes monitored by the Learning from Death Committee.

10 INVOLVEMENT OF RELATIVES AND CARERS

The national guidance on Learning from Deaths highlighted that providers must engage meaningfully and compassionately with bereaved families and their carers in relation to all stages of responding to a death. This includes informing them of their right to raise concerns about the quality of care provided to a loved one and that their views help to inform decisions about whether a review or investigation is needed.

The consultant responsible for the patient at the time of death, Medical Examiners and Bereavement Officers will all have the opportunity to ask relatives and carers to comment on the deceased's care prior to and during admission.

Meaningful engagement also includes informing the family/carers that the Trust intends to review or investigate the care provided to the deceased patient. Processes are already in place in the Trust which reflects the requirements of 'Being Open' and complying with the 'Duty of Candour'. These ensure that families and carers are involved and informed with regard to their involvement in the investigation process.

Relatives, carers and the public will be made aware of the LfD programme, the processes employed, and the learning and quality improvement outcomes arising from it, through a variety of channels. This includes through information reported to the public sessions of meeting of the Trust Board, that contained in the Trusts Annual Quality Accounts and from information published on the Trusts Internet site.

11. OVERSIGHT, MONITORING & GOVERNANCE

- The Learning from Deaths Committee will oversee, monitor and report on the Learning from Deaths programme according to its terms of reference.
- The Committee will have oversight of and ensure that responses produced to internal and external mortality data, and to the alerts generated, are credible.
- The committee will also monitor the performance of the Medical Examiner Team in ensuring that appropriate cases are being referred for a review and/or investigation, MRS or Structured Judgemental Review.
- Group Triumvirates will be responsible for ensuring that appropriate multi-disciplinary mortality and mortality meetings take place in all specialities.
- Any death that occurs that has been declared a serious untoward incident (SUI) must also undergo a review. The findings from this review will be used to support the Root Cause Analysis investigation and development of any recommendations and the resulting action plan.
- If a review identifies very poor care or serious harm this must be reported as a clinical incident through Safeguard and escalated to the Head of Risk Management.
- A complaint linked to a patient's death must also undergo a review.
- Any mortality review highlighting very poor care which is linked to an inquest must be reported as a clinical incident.
- The national guidance requires that Trust Board receives regular reports on the deaths occurring, the reviews and investigations undertaken and the learning from these in order that the executives and non-executives can provide appropriate challenge. The reporting should be discussed at the public session of the Board meetings, with the data being suitably anonymised.
- Prior to submission to the Board, reports must be submitted to and scrutinised by the Executive Quality Committee and Quality & Safety Committee

12. ROLES AND RESPONSIBILITIES

Chief Executive

The Chief Executive has overall responsibility on behalf of the Trust Board for ensuring that robust processes are in place for monitoring mortality in accordance with Learning from Deaths Guidance (2017).

Designated Non-Executive Director for Learning from Deaths.

The Non-Executive Director for Learning from Deaths has responsibility for ensuring that a robust system is in place to allow for the learning from deaths. This includes ensuring that published information is accurate and a fair reflection of the achievements and challenges.

Medical Director

- The Medical Director has responsibility for assuring the Board that the mortality monitoring processes are robust and that they are functioning correctly.
- To ensure that processes and resources are in place to discharge the requirements to meet the Learning from Deaths agenda.
- To ensure that arrangements are in place so that all appropriate clinical staff are aware of their responsibilities to contribute to the process.
- To ensure that any serious concerns following a patient's death are brought to the attention of the Board.
- Responsible for ensuring that quarterly mortality reports are submitted to public Board meetings.
- To ensuring that the Annual Quality Account summarises the outcomes and learning from the Trusts mortality review processes.

Clinical Group and Directorate Triumvirates

- To ensure that appropriate multi-disciplinary mortality and morbidity meetings take place in all specialties.
- To ensure that summary records of meeting are produced and recorded. Currently a template for this is provided in the Trusts Clinical Systems Reporting Tool.
- To ensure that specialty reviews take place in response to requests by the Medical Director or LfD committee.
- To ensure that their directorates or specialties contribute to the case review team and that the quality improvement identified is implemented and monitored.

Learning from Deaths (LfD) Committee

- The LfD Committee has responsibility for overseeing the Learning from Deaths processes on behalf of the Medical Director. This includes ensuring that deaths are reviewed, appropriately referred for mortality system, Subjective Judgemental or Specialist review, and for ensuring that the recommendations from reviews are implemented and monitored.
- Responsible for reviewing mortality indicator data (RAMI, HSMR, SHMI) and for ensuring that there is appropriate investigation of statistical outliers based on diagnosis groups or on speciality based analysis.
- The committee also has responsibility for ensuring that the lessons learnt from the processes described above are shared, acted on and published.
- Provide reports to executive committees and Board as scheduled or requested.

Executive Quality Committee

- To receive regular scheduled reports from the LfD Committee.
- To report to Quality & Safety Committee.

Quality & Safety Committee

- To seek assurance on behalf of the Trust Board that processes for Learning from Deaths are robust and working effectively.
- To seek assurance that the lessons arising from reviews, thematic analysis and investigations are being disseminated and that appropriate action is being taken to enhance the quality and safety of care where this is indicated.
- To receive reports from the LfD Committee/Executive Quality Committee (EQC) on compliance with this policy and summary reports on the findings and learning from reviews and data on internal and external mortality indicators.

Medical Examiners

- Medical Examiners are responsible for actively engaging and supporting families/carers of the deceased through the LfD process.
- To ensure that deaths are categorised, coded and referred appropriately for review to internal departments or external agencies.
- To contribute to the training and development of appropriate staff in the processes relating to the death of a patient.

Case Reviewers

- Case Reviewers are responsible for undertaking thorough review of selected deaths occurring within the Trust. This must be on patients who have not been in their care.
- To conduct reviews of the cases referred to them using the designated tool in place at the time. This is currently the Mortality Review Proforma which included as part of the Trusts Mortality Review System. This will be replaced by the Royal College of Physicians Structured Judgemental Review and thematic analysis web tool when this is implemented.
- Reviewers are responsible for escalating to the LfD Committee where they have

concerns that the patient has not been managed appropriately and to complete a clinical incident form if one has not already been initiated.

Clinical staff

- All clinical staff are required to participate fully in quality improvement work resulting from Learning from Deaths
- All clinical staff are expected to participate fully in M&M meetings that are relevant to their practice.

Clinical Effectiveness Facilitator (Mortality)

- The detailed review, interrogation and analysis of hospital standardised mortality ratios, using proprietary software platforms to which the Trust subscribes at any given time.
- To review the data produced from internal sources, including information on crude mortality and from completed mortality reviews with associated analysis.
- To produce comprehensive reports for the LfD Committee relating to the above and including reporting on the detection and investigation of alerts.
- To produce scheduled reports for Executive committees, Board and Quality Accounts.
- To facilitate and support secondary reviews of cases as determined by the LfD Committee.
- To manage the LfD Committee meetings and schedules.
- To facilitate sharing, communication and publishing of LfD activity, outputs and performance to appropriate internal and external groups.

13. NON-COMPLIANCE WITH THE MORTALITY REVIEW PROCESS

Individually appointed and trained case reviewers will be expected to comply with training requirements and the procedure for conducting mortality case reviews through MRS or SJR's within the timescale set. The role as Case Reviewer will be terminated if there is persistent noncompliance with the requirements despite negotiation, training and support.

14. CONSULTATION

Consultation was undertaken with the Medical Director, the Non-Executive Director for Learning from Deaths, the Executive team, the Mortality and Quality Alert Committee (MQuAC) (now Learning from Deaths Committee), in order to ascertain the suitability and applicability of content.

15. AUDITABLE STANDARDS/PROCESS FOR MONITORING EFFECTIVENESS

The methods for assessing compliance, the frequency of assessment and the reporting arrangements are identified in the table contained in Appendix 5. The monitoring will include the evaluation of whether there is appropriate identification of cases for review, the levels of engagement with relatives and carers, levels of completion of requested mortality reviews, the learning and quality improvement outputs and the performance of LfD Committee and Directorates in addressing the Learning from Deaths agenda.

16. TRAINING AND AWARENESS

- Medical Examiners will be required to undertake training to ensure they remain updated and receive appraisal through Learning from Deaths Lead and the Lead Medical Examiner.
- Clinical staff carrying out mortality reviews, Structured Judgmental Reviews and Thematic

analysis will receive training in these processes and will be expected to attend for updates as and when required.

- All new medical staff will be informed of policy and processes at Trust induction by a member or representative of the LfD Committee.
- The Learning from Deaths national guidance and updates will be shared with all clinical staff through quarterly Learning from Deaths newsletter and in resources available on the Intranet.
- The learning and quality Improvement work arising from the Learning from Deaths programme will to be shared with all clinical staff, internal committees and the Trust Board as indicated in this policy. It will also be shared with other external stakeholders e.g. Commissioners.

17. EQUALITY AND DIVERSITY

The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the SWBH Equality Impact Assessment Toolkit, the results for which are monitored centrally.

18. REVIEW

This policy will be reviewed after one year or sooner if this is necessitated by the fast moving LfD agenda.

19. REFERENCE DOCUMENTS AND BIBLIOGRAPHY

1. Horgan H, Healey F, Neale G, et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. *BMJ Quality and Safety* (2012). Doi:10. 1136/bmjqs-2012-001159.
2. Higginson J, Walters R, Fulop N. Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety? *BMJ Quality and Safety* (2012). Doi:10.1136/bmjqs-2011-000603.
3. Healthcare Commission, Investigation Into Mid Staffordshire NHS Foundation Trust, March 2009.
4. Department of Health. The Keogh Mortality Review, Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, 2013.
5. <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>

Glossary, Definitions & Abbreviations

Avoidable/Preventable – These terms are used interchangeably and investigated in the NHS and for the purpose of this policy 'preventable' or 'unpreventable' will be used with reference to whether anything could have been done to change the outcome.

Crude Mortality – This is simply the total number of deaths as a percentage of the total number of spells. Although this is not risk adjusted, it is often a good idea to monitor trends in crude mortality as it can quickly highlight when things are going wrong.

Structured Case Review (SJR) - A review of the patient death using the Trust Mortality Review proforma initially and later Royal College of Physician's Structured Judgemental Review and thematic analysis web tool.

Thematic Analysis - Initially analysis of reviewed patient deaths by Mortality Review System Report later through RCP thematic analysis web tool.

Case Investigation - An root cause analysis investigation into appropriate identified cases.

CHKS/HED – Independent companies that provide healthcare comparison data and enable healthcare organisations to benchmark their performance against their peers nationally.

Clinical Systems Reporting Tool (CSRT)- A local database, where audit data pertaining to Mortality and Morbidity is captured and archived, which is accessible on the Trust intranet page.

Health and Social Care Information Centre (HSCIC) – An information and technology resource for the health and care system. They are responsible for compiling and monitoring national healthcare data and provide Summary Hospital-level Mortality Indicator (SHMI) on a quarterly basis.

Summary Hospital-level Mortality Indicator (SHMI) - The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider and is the main mortality indicator reported nationally and is supported by the Department of Health. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping.

HED- external information and benchmarking system for the provision of various mortality data. The mortality data derived from HED is primarily SHMI (Summary Hospital-level Mortality Indicator), which is usually subject to a slightly longer delay in its availability, due to alignment with data from ONS (Office for National Statistics), as SHMI includes data for deaths which occur within 30 days of discharge from hospital.

Mortality and Morbidity Review Meetings - A mortality and morbidity meeting is where a multi-disciplinary group review and discuss clinical cases, outcome

data and related information (e.g. Serious Incidents, Complaints, Dr. Foster/CHKS or other benchmarking data).

Hospital Standardised Mortality Ratio (HSMR)- The HSMR is a method of comparing health care provider mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in population structure. The ratio is of observed to expected deaths, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100.

The methodology used to calculate the expected number of in-hospital deaths is complex. It involves using a range of variables to adjust or standardise the data to reflect the risk or likelihood of death.

Risk Adjusted Mortality Indicator (RAMI) – This is a methodology developed by CHKS to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. It is a ratio of the observed number of deaths to the expected number of deaths that occur within a hospital. A standard logistic regression model is used to estimate the risk of death for each patient. This is done by weighting each patient record with the logistic regression coefficients associated with the corresponding terms in the model, and the intercept term.

Serious Untoward Incident (SUI) - An accident occurring to a patient on NHS premises or receiving NHS care that resulted in serious injury and/or permanent harm, unexpected or avoidable death.

MCCD – Medical Certification of Cause Death

Mortality Review System (MRS) - The mortality review system involves a qualitative overview of each death by a senior clinician who was not directly involved in the patients care. Each case is examined for errors or deficiencies in care and the death is categorised as expected or unexpected and whether the death was considered to be preventable. The system contains the Mortality Review Proforma which is the current tool that is in place to record the outcomes from case reviews. This will be superseded by the Royal College of Physician's Structured Judgemental Review and thematic analysis web too when implemented.

LfD – Learning from Deaths

CQC – Care Quality Commission

ME – Medical Examiner – A senior clinician appointed to the role who are responsible for conducting an initial screening of deaths to determine those requiring a Subject Judgmental or Specialist Review and for ensure that there is effective liaison with relatives and carers where problems with care are identified on initial screening.

THE MORTALITY REVIEW PROCESS (Case Reviews)

Initial screening by Medical Examiners (ME)

1. Death occurs in the Trust
2. Death is notified to the Cares Office
3. Death certification. The responsible consultant at the time of death ensures that the death certificate is completed in accordance with the Policy on the Completion of a 'Medical Certificate of the cause of Death (MCCD)'
4. ME enters the information onto the database for recording any subsequent action taken in each case
5. ME screens the case and decides whether the Coroner needs to be involved, if this is not already the case.
6. The bereaved family must be asked whether they would like to comment on the care of the deceased
7. ME screens for deaths which fall in to any of the following categories and these will require a **Specialist Mortality Review** or a **Structured Judgmental Review (SJR)**.

- Specialist Mortality Reviews
 - Death of patient with Learning Disabilities
 - Child death
 - Perinatal or Maternal Death
 - Coroner referrals

- Structured Judgemental Reviews
 - Severe Mental health needs
 - Cases where the relatives or carers are concerned about the care received.
 - The patient is a young person (18-25)
 - In hospital cardiac arrest
 - Death of an elective and/or day case patient
 - Any death of a patient where there are Safeguarding concerns.
 - Any death of a patient where there has been an incident or complaint
 - Patient had an In-hospital VTE

Categorise as specified for each quarter through the LfD Committee; for example

- Patient was in a Low risk Diagnosis group (to be defined)
- Proportion of Supportive Care Pathway deaths
- Alerted diagnosis or care pathway
- Deaths of patients admitted at weekends.

8. ME enters on to the mortality database the outcome of their screening, identifying those which require a specialist mortality review, structured judgemental review or other referral.

Cases for Structured Judgemental Review (SJR)

1. Cases requiring a mortality system review or SJR will be forwarded to appropriate group of trained Case Reviewers by the ME.
2. Case Reviewer performs case reviews currently through the Mortality Review System (MRS) and then using the new SJR process using the RCP. Structured Judgemental Review Tool when this is introduced from 2018.
3. Case Reviewer will escalate any concerns identified immediately and inform the Learning from Deaths Committee of any cases thought not to have been managed appropriately.
4. Case Reviewer to consider whether overall the care provided was Very poor (1), Poor (2), Adequate (3), Good (4) or Excellent (5).
5. If the Case Reviewer detects very poor care or serious harm then an IR1 must be completed if this has not already been done so and the investigation is managed in conjunction with the Clinical Risk Team.
6. If the Case Reviewer identifies cases where there has been very poor, poor or excellent care these needs to be escalated to the LfD Committee. The committee will then conduct a second stage SJR.
7. In addition to this process, Specialties are required to review and report actions resulting from any deaths that relate to them at regular Mortality & Morbidity meetings.

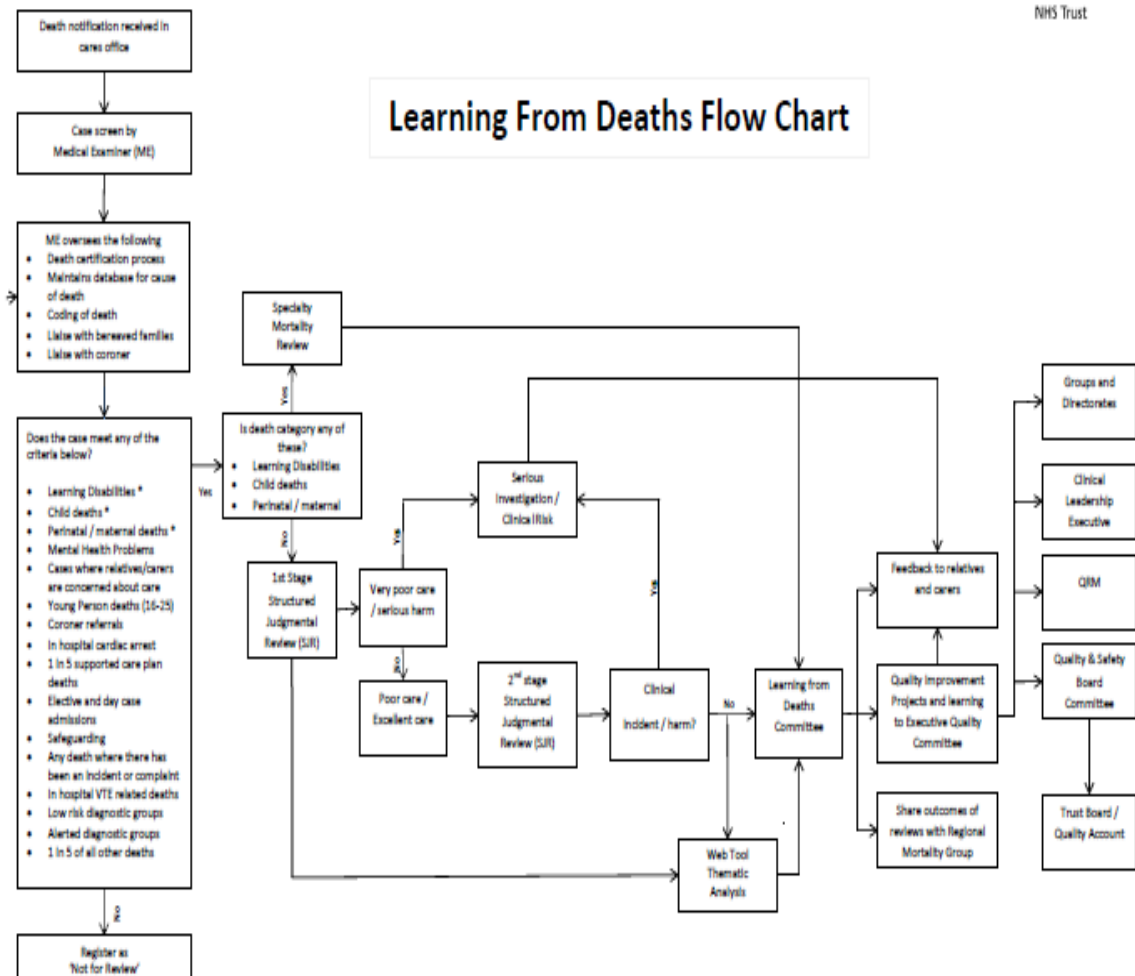
Components of the Mortality Review Process

| Components of the Process | Which Deaths | Method and Timing of Review |
|---|-------------------------------------|--|
| Component A Individual Case Review | Referred cases as defined in policy | <ul style="list-style-type: none"> <input type="checkbox"/> Mortality review within 10 working days <input type="checkbox"/> Complete full review of relevant documents; EPR and scanned case records <input type="checkbox"/> complete all sections of review proforma <input type="checkbox"/> Identify any problems in care and any good or excellent practice, <input type="checkbox"/> Complete incident report where appropriate <input type="checkbox"/> inform Learning from Deaths committee of any incident reported cases |
| Component B Clinical Team Review | Deaths relating to specialty | <ul style="list-style-type: none"> <input type="checkbox"/> Case Presentation of relevant deaths at the M&M meeting. <input type="checkbox"/> Discuss any concerns with patient care or opportunity for quality improvement <input type="checkbox"/> Define actions for clinical team <input type="checkbox"/> Complete M&M Template in the Clinical Systems Reporting Tool. <input type="checkbox"/> Report quarterly to Group and LfD Committee cases and actions. <input type="checkbox"/> Share trust LfD Quality Improvement projects from LfD |
| Component C Independent Reviews by the Learning From Deaths Committee (LfD Committee) | Tier 2 cases | <ul style="list-style-type: none"> <input type="checkbox"/> MDT 2nd Review of deaths identified from the MRS/initial review <input type="checkbox"/> Mortality performance data by Group/Directorate and identification of trends <input type="checkbox"/> Role to commission follow up actions or fuller investigation is required. <input type="checkbox"/> At next LfD Committee meeting <input type="checkbox"/> Refer for Root Cause Analysis Investigation (RCA) <input type="checkbox"/> Identify opportunities and make recommendations for improving the safety and quality of care |

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| <p>Component D</p> <p>External Review Group e.g. Coroner's Inquest, Police, Care Quality Commission, LeDeR Programme.</p> | <p>All in-hospital patient deaths identified or initiated for external review. Further scrutiny of care of patient death.</p> | <ul style="list-style-type: none"> □ All external reviews tabled at LfD Committee □ Monitor outcomes of investigations and implement recommendations from the review e.g. Coroners Regulation 28 reports □ Share learning and Quality Improvement implementation |
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Appendix 4

Flowchart summarising the review and reporting processes for deaths occurring in the Trust.



PROCESS FOR MONITORING EFFECTIVENESS

| Standard/Process | Monitoring and Audit | | | |
|---|--|---|---------------|-----------|
| | Method | By | Committee | Frequency |
| Identification of cases mandated for referral for review at Bereavement Office screening | Medical Examiners case referral database | Lead medical Examiner and Chair LfD Committee | LfD Committee | Monthly |
| Engagement with relatives and carers of deceased patients | Relative and carer feedback surveys | Bereavement office | LfD Committee | 6 monthly |
| Completion of Mortality Reviews through the Mortality Review System or RCP Structured Judgemental Review tool | Monitoring of number and timeliness of reviews allocated | Head of Performance | LfD Committee | Monthly |
| LfD Committee Meeting performance | attendance, reports, timeliness of actions | Chair of the LfD Committee | Q&S Committee | Annually |
| Convening of Mortality & Morbidity Meetings | Audit of Directorates/ Specialties quarterly reports to LfD Committee Mandatory completion by Directorates of the M&M Template in the Clinical Systems Reporting Tool | Clinical Effectiveness Facilitator | LfD Committee | Quarterly |
| Standard/Process | Monitoring and Audit | | | |

| | Method | By | Committee | Frequency |
|--|--|--------------------------|------------------|--|
| Feedback on learning from Mortality Reviews | Directorate reports detailing compliance with and outcomes and actions from Mortality and Morbidity review meetings | Individual Directorates | LfD Committee | Annually According to agreed schedule. |
| Management of Alerts and Detection of adverse trends | LfD Committee minutes and papers. Thematic analysis outcomes and Quality Improvement Projects actioned. LfD Reports to Q&S and Board | Clinical Governance Lead | Q&S Committee | Quarterly |