Learning from Deaths

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Date equality analysis completed.

Title sheet must be followed by a

Version Control Sheet

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<td>21/9/17</td>
<td>Stephen Powis</td>
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1 Introduction

1.1 Learning from the death of patients who have been treated in our trust is a vital component of improving the quality and safety of care we provide. It is a key part of our mission to provide world class care.

1.2 Mortality review, presentation and discussion is a long-standing component of clinical governance. Traditionally it has taken the form of specialty run morbidity and mortality (M&M) meetings within clinical divisions. More recently there has been a national drive to standardise this process and design systems which allow widespread learning case note reviews across specialties within a hospital site and across organisations.

1.3 A Care Quality Commission report published in December 2016 highlighted the need for trust’s to improve the processes by which deaths are reviewed, investigated and resultant learning disseminated and implemented. Subsequently, national mortality review guidance was published in March 2017 by the National Quality Board with the aim of standardizing mortality review processes in all trusts. This guidance has followed inspections, reports and academic studies prompted by well publicised problems in care and safety in the NHS over the last 5 years.

1.4 The vision of this national project is that learning and action resulting from mortality review will be more effective and visible; that there will be greater board oversight of this aspect of safety and quality improvement within trusts; and that there will be greater involvement of families and carers in investigations of deaths. Furthermore, there will be better communication and cooperation of different organisations within the health economy so that information after a patient’s death is shared appropriately and learning is spread as widely as possible.

1.5 The purpose of this policy is to standardise our approach to learning from deaths across all RFL NHS FT sites and to ensure the requirements of national guidance are met. It describes how the board ensures that the trust learns from significant issues identified through reviews of death, and how this influences the trusts quality improvement programmes.

1.6 The policy sets out the trusts framework for retrospective case record review (RCRR) within the trust to assess the clinical care we deliver in our hospitals. It allows us to find out where any problems in care lie so that they can be remedied and help us to prevent future harm. It also allows the identification of excellent care.

2 Policy Statement

2.1 Scope

2.1.1 This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust’s behalf.
2.2 Purpose

2.2.1. The Royal Free London NHS Foundation Trust is required to implement the requirements outlined in the Learning from Deaths (LfD) framework as part of the organisation’s existing procedures to learn and continually improve the quality of care provided to all patients.

2.2.2. This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the trust.

2.2.3. It describes how the trust 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.

2.2.4. 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.

2.3 This policy should be read with the policies and guidance listed in section 9.

3 Definitions of terms used

Patients in our care
Patients that are considered to be ‘in our care’ and therefore within scope for LfD review include all inpatients and, when possible, patients who die within 30 days of discharge from inpatient services. The Trust will lead the review of the care of a patient only when the trust is the healthcare provider best placed to do so.

Maternal death
A maternal death is defined as the death of a woman while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management and not from accidental causes (WHO 2010).

Paediatric / young person’s death
A paediatric / young person’s death is defined as the death of anyone up to the age of 19 years.

Unexpected Death
A death where natural causes are not suspected.

Stillbirth
A baby born without signs of life after 24 completed weeks of pregnancy

Likert Avoidability (RCP Methodology) Scores
1. Definitely avoidable
2. Strong evidence of avoidability
3. Probably avoidable, more than 50:50
4. Possibly avoidable, but not very likely, less than 50:50
5. Slight evidence of avoidability
6. Definitely not avoidable (unavoidable)

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.

**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.¹

**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

¹ [https://improvement.nhs.uk/resources/serious-incident-framework/]
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 Equality statement

4.1 The Royal Free London NHS Foundation Trust is committed to creating a positive culture of respect for all individuals, including job applicants, employees, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability (including HIV status), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. It is also intended to use the Human Rights Act 1998 to treat fairly and value equality of opportunity regardless of socio-economic status, domestic circumstances, employment status, political affiliation or trade union membership, and to promote positive practice and value the diversity of all individuals and communities.

4.2 The equality analysis for this policy is attached at Appendix 3.

5 Duties

5.1 This section describes the specific responsibilities of key individuals and of relevant committees under this policy.

<table>
<thead>
<tr>
<th>Individual</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Chief executive</td>
<td>Overall responsibility for implementing the policy</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>The chair of the Clinical Standards and Innovation Committee is the trust non-executive lead for mortality and the learning from deaths policy</td>
</tr>
<tr>
<td></td>
<td>Non-executives directors have responsibility for:</td>
</tr>
<tr>
<td></td>
<td>• understanding the review process and ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny</td>
</tr>
<tr>
<td></td>
<td>• championing quality improvement that leads to actions that improve patient</td>
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</table>
safety
• assuring published information that fairly and accurately reflects the organisation’s approach, achievements and challenges.

Further guidance on the role of non-executive directors is contained in Annex B of the *National Guidance on Learning from Deaths*.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Chief Medical Officer</strong></td>
<td>Board-level executive with overall responsibility for mortality review and learning from deaths agenda. Chair of the group Mortality Surveillance Group.</td>
</tr>
<tr>
<td><strong>Group Chief Nursing Officer</strong></td>
<td>Board-level executive with responsibility for patient safety and risk.</td>
</tr>
<tr>
<td><strong>Group Associate Medical Director for Clinical Performance</strong></td>
<td>Deputises for Group CMO as chair of the group Mortality Surveillance Group. Prepares board reports on mortality and learning from deaths. Directs communication with other organisations within the local health economy to facilitate joint review of patients treated jointly and to disseminate learning.</td>
</tr>
<tr>
<td><strong>Site Medical Director</strong></td>
<td>Chair the site based Mortality Review Group. Responsibility for the site mortality review and learning from deaths agenda. Ensure mortality reviews and reports arising from the learning from deaths policy are reviewed at site Patient Safety and Clinical performance Committees.</td>
</tr>
<tr>
<td><strong>Group Deputy Director for Patient Safety and Risk</strong></td>
<td>Ensure Datix management to support the review process, maintain the relevant data, and provide summary data for the reporting and learning processes. Co-ordination of the review process via the Divisional Governance teams.</td>
</tr>
<tr>
<td><strong>Group Deputy Director of Clinical Governance and Clinical Performance</strong></td>
<td>Provide administrative and expert support to the Group Associate Medical Director for Clinical Performance, the Mortality Surveillance Group and other relevant committees.</td>
</tr>
<tr>
<td><strong>Divisional Director</strong></td>
<td>Ensure mortality reviews and reports arising from the learning from deaths policy are reviewed at</td>
</tr>
</tbody>
</table>
### Divisional Quality and Safety Boards

Ensure adequate numbers of structured case note reviewers are identified and trained.

### Clinical Director

Ensure effective mortality and morbidity meetings are undertaken in specialties.

### Divisional clinical audit and governance team

Coordinate mortality reviews within their divisional specialties, including liaison with mortality and morbidity meetings. Provide support to the structured case note reviewers, including Datix administration and assessment of incident criteria.

### Structured case note reviewer

Undertake the structured case note review using the tool provided in a timely manner.  

Assessment of whether output of case review meets criteria for management under trust incident policy.  

Ensure Datix is regularly updated with the outputs of case reviews.

### All staff

Cooperate actively with mortality reviews in which they are involved.

## Committee Responsibilities

<table>
<thead>
<tr>
<th>Committee</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust board</td>
<td>The <em>National Guidance on Learning from Deaths</em> places particular responsibilities on boards, as well as reminding them of their existing duties. These responsibilities, detailed in Annex A of the <em>National Guidance on Learning from Deaths</em>, are reproduced in Appendix A of this policy.</td>
</tr>
</tbody>
</table>
| Clinical Standards and Innovation Committee | The non-executive director chaired board committee with responsibility for:  
- ensuring the learning for deaths policy is implemented  
- reviewing and discussing reports arising from the policy  
- setting criteria for certain aspects of the policy  
- reviewing the policy at least on an annual basis. |
| Mortality Surveillance Group | Chaired by the Group Chief Medical Officer, has operational responsibility for the learning for deaths process and for further development of the policy. |
Site Mortality Review Group

Chaired by the site Medical Director, has local site oversight of the learning for deaths process.

Site Clinical Performance and Patient Safety Committee

Receives and discusses reports arising from the Learning from Deaths process and ensures that learning is disseminated throughout the site.

Divisional Quality and Safety Boards

Receives and discusses reports arising from the Learning from Deaths process and ensures that relevant cases are discussed at appropriate specialty mortality and morbidity meetings.

Serious incident Review Panel

Receives and discusses completed LfD forms and determines levels of investigation, harm severity and avoidability.

5.1. Roles and responsibilities for incident management, complaints handling and quality improvement are detailed in the relevant policies listed in section 9.

6 Details of policy

6.1. The process for recording deaths in care

6.1.1. Trust coding data is used to identify all patient deaths on a monthly basis, and these data are then cross-referenced with other data sources to identify those deaths which meet the LfD criteria for review.

<table>
<thead>
<tr>
<th>Type of death</th>
<th>Process for identification</th>
<th>Timeframe</th>
<th>System data</th>
<th>National Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All deaths</td>
<td>Deaths coding dataset to be held by the Datix Team</td>
<td>Within 1 month of death</td>
<td>Coding data</td>
<td></td>
</tr>
<tr>
<td>People with learning disabilities</td>
<td>LD lead nurse will flag cases for review for LeDeR LD flags are captured via coding and are cross referenced with all deaths coding dataset</td>
<td>Within 1 month of death</td>
<td>LD lead nurse spreadsheet - LeDeR Coding data Datix incidents</td>
<td>National Guidance on Learning from Deaths Annex D LeDeR</td>
</tr>
<tr>
<td>Mental health</td>
<td>MH flags are captured via coding and are cross referenced with all deaths coding dataset</td>
<td>Within 1 month of death</td>
<td>Site Management Coding data Datix incidents</td>
<td>National Guidance on Learning from Deaths Annex E</td>
</tr>
</tbody>
</table>

9
6.1.2. The process and required timeframes for identifying other organisations that may have an interest in a death (including the person’s GP) and making arrangements to inform them is documented in section 9 of the trust Management of Deceased Patients policy.

6.1.4. The process for certification and registration of deaths and informing the coroner at time of death is documented in sections 9 and 12 of the Management of Deceased Patients policy.

6.1.5. The process for recording deaths notified to the trust from other sources (for example, other care providers, coroners, families, etc) will be coordinated through the RFL Group patient safety and risk team.

6.1.6. The process for informing the coroner including when this is a late report following a review which has identified possible problems in care is coordinated by the Legal Services Department.

6.2. Selecting deaths for case record review

6.2.1. The process for the identification of deaths for LfD case record review that are not reported as patient safety incidents or serious incidents is outlined below.

<table>
<thead>
<tr>
<th>Specific categories of deaths</th>
<th>Process identification</th>
<th>Eligibility</th>
<th>Timeframe</th>
<th>System data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillbirths</td>
<td>Maternity Management and then cross reference with all deaths coding dataset</td>
<td>All</td>
<td>Within 1 month of death</td>
<td>Datix incidents Datix LfD</td>
</tr>
<tr>
<td>All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision</td>
<td>All complaints where the patient has died are flagged. These are reviewed by RFL Group patient safety and risk team and where</td>
<td>All relevant</td>
<td>Within 1 month of death</td>
<td>Datix complaints</td>
</tr>
<tr>
<td>Concerns relate to care are then cross reference with all deaths data</td>
<td>All deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example, via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the Care Quality Commission or another regulator)</td>
<td>Mortality Surveillance Group to review and identify</td>
<td>All relevant</td>
<td>Within 3 months of death</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>All deaths in areas where people are not expected to die – for example, in certain elective procedures</td>
<td>Mortality Surveillance Group to review low mortality diagnosis-related groups and identify</td>
<td>All relevant</td>
<td>Within 1 month of death</td>
<td>Datix incidents</td>
</tr>
<tr>
<td>Deaths where learning will inform the provider’s existing or planned improvement work</td>
<td>Patient Safety Programme clinical workstreams</td>
<td>All relevant</td>
<td>Within 1 month of death</td>
<td>Datix incidents</td>
</tr>
<tr>
<td>A further sample of other deaths that do not fit the identified categories</td>
<td>Mortality Surveillance Group to review and identify</td>
<td>All relevant</td>
<td>Within 3 months of death</td>
<td>Deaths coding dataset</td>
</tr>
<tr>
<td>Patients who die within 30 days of discharge from inpatient services</td>
<td>To be reviewed</td>
<td>All relevant</td>
<td>Within 3 months of death</td>
<td>External data</td>
</tr>
</tbody>
</table>

### 6.3. Collaboration with other organisations

The RFL Group patient safety and risk team will coordinate collaborations with other organisations to carry out reviews and investigations when a person has received care from several health and care providers. This will include requests from other organisations to review the care provided to people who are its current or past patients but who were not under its direct care at time of death.
6.4. Review methodology

6.4.1. Retrospective case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

6.4.2. Relevant deaths will be identified as those meeting the specified national minimal criteria:

- all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- all in-patient, out-patient and community patient deaths of those with learning disabilities and with severe mental illness
- all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator)
- all deaths in areas where people are not expected to die, for example in relevant elective procedures
- deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider.
- a further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

6.5. The process of review

6.5.1. Relevant cases are identified for review by either meeting the minimal criteria or through the Mortality Surveillance Group

6.5.2. On identification, trained clinicians will review the case record using the LfD template. The current version of the template is shown in Appendix A.

6.5.3. If no concerns are identified, the LfD is logged in Datix, the review scanned and the relevant Datix fields completed, including lessons learnt.
6.5.4. If concerns are identified, the case is reported as an incident and logged as an LfD (and the two records linked).

6.5.5. The completed LfD review is submitted to SIRP for review and a decision made about Likert avoidability, level of investigation, harm severity and DoC requirements.

6.5.6. If the Likert score is 4-6 the LfD Datix record is completed and depending on the level of investigation the incident is investigated and the Datix incident closed.

6.5.7. If the Likert score is 1-3 (ie the death was avoidable) the incident is investigated and the Likert score reviewed during this process.

6.5.8. Once investigations and reviews are completed, the Datix incident/LfD records must be updated to capture the lessons learnt and the final Likert scoring.

6.5.9. Specialist Reviews:
- **Maternal Deaths**: These will be reviewed via the London Maternity SCN “Process for reporting and investigating a direct or indirect maternal death”. Once the report is finalised the Datix incident will be updated with lessons learnt and the Likert score.
- **Paediatric / young people’s deaths**: These will be reviewed via the Child Death Overview Panel. Once the report is finalised the Datix incident will be updated with lessons learnt and the Likert score.
- **Patients with learning disabilities**: These will be reviewed via the Learning Disabilities Mortality Review (LeDeR) programme. Once the report is finalised the Datix incident will be updated with lessons learnt and the Likert score.
6.6. Using outputs from reviews and investigation to inform quality improvement

6.6.1. Reports arising from the learning from deaths process will be:

- Presented to a trust board meeting held in public on a quarterly basis
- Presented as part of a wider mortality report to the Clinical Standards and Innovations Committee on a bi-monthly basis
- Presented as part of a wider mortality report to the site Clinical Performance and Patient Safety Committees on a bi-monthly basis
- Presented as part of a wider mortality report to each Divisional Quality and Safety Board

6.6.2. The findings of reviews and investigations will be used to inform quality improvement work within the trust. These include (but are not limited to):

- The trust patient safety programme: an existing programme that uses established improvement methodology in number of key areas identified through thematic reviews of past clinical incidents. These include sepsis, patient falls and acute kidney injury.
• The trust quality improvement programme: a new three year programme that has recently been established in collaboration with the Institute for Healthcare Improvement. This programme aims to train large numbers of staff in improvement methodology and to support them in a variety of specific improvement projects relevant to their own clinical areas.
• The trust clinical pathways programme: the development of clinical pathways, to embed best practice and remove unwarranted clinical variation, is a major component of the trust’s group operational model. This will be supported by the digitisation of pathways as part of our Global Digital Exemplar programme.

6.6.3. These programmes are designed to disseminate learning and improvement throughout the members of the Royal Free group

6.6.4. A lessons learnt bulletin will be disseminated more widely via Freenet on a quarterly basis.

6.6.4 Learning from improvement work will be disseminated outside the trust through a variety of mechanisms including:
• Presentations at conferences and meetings
• The UCLPartners Quality Forum
• Publications in academic and healthcare literature

6.7. Supporting and involving families and carers

6.7.1. Existing trust guidance can be found in the
• Policy and Procedure for the Management of Deceased Patients
• Incident Policy
• Duty of Candour Policy
• Being Open Policy

6.7.2. Bereavement support and advice is available via the Bereavement Office from the Bereavement Services Officer, the Lead Nurse for Bereavement Services, the Bereavement Services Officer and members of the multi-faith Chaplaincy-Spiritual Care Service.

6.7.3. In addition, the Mortality Surveillance Group will develop processes to ensure that all bereaved families and carers are informed of their right to raise concerns about the quality of care provided to their loved one, and the process through which this is done

6.7.4. Where a bereaved family or carer raises significant concerns regarding a death this will trigger a structured case note review under this policy. Once this decision has been made the bereaved family should be made aware in person and in writing as soon as possible of the purpose, rationale and process of the review.

6.7.5. If the need for an investigation is identified, the bereaved family should:
- Be kept fully and regularly informed in a way that they have agreed, of the process for the investigation.
- Be asked their preference as to how and when they contribute to the process of the investigation including agreement to the terms of reference
- Be provided with a single point of contact to provide timely updates including delays
- Have an opportunity to respond to the findings and recommendations in any final report be informed and be informed of what processes have changed in the provision of future care.

6.7.6. The requirements of the Trusts’ Duty of candour policies should be met

6.7.7. Where appropriate, the trust should offer advice on obtaining legal advice for bereaved families

6.8. Supporting and involving staff

6.8.1 It is recognised that staff may be affected by the death of someone who has been in the trust’s care and therefore may need support.

6.8.2. Existing trust guidance can be found in the
- Policy and Procedure for the Management of Deceased Patients
- Incident Policy
- Being Open Policy

6.8.3 Staff will be supported in line our arrangements set out in the trust management of deceased patients’ policy. It is the duty of the line manager of any staff member involved in a distressing death or inquest to support that staff member and to ensure that they are aware of other sources of support which they may access.

7 Monitoring

7.1. This is a new policy which will be reviewed and updated at least annually to ensure compliance with the national requirements.

Implementation of this policy will be monitored by the Clinical Standards & Innovation Committee.

8 References

- Serious incident framework: [https://improvement.nhs.uk/resources/seriousincident-framework/](https://improvement.nhs.uk/resources/seriousincident-framework/)

Trust Policies:
- Policy and Procedure for the Management of Deceased Patients (for BCF see Death and Bereavement Policy)
- Incident reporting and learning (including serious incidents and never events) policy
- Being Open Policy

9 Associated documentation

Information Leaflets:
- Information about you
- Information Governance for Patients

Trust Policies:
- Duty of Candour Policy
- Risk Assessment and Risk Management Policy
- Death and Bereavement Policy (for RF see Policy and Procedure for the Management of Deceased Patients)
- Complaints Policy and Procedure
- Patient Advice and Liaison Service (PALS) Policy (for BCF see Complaints and PALS Policy)
- Patient Confidentiality Policy
- Information Governance Overarching Policy
- Information Sharing Agreement

Related national guidance:
- Learning from deaths dashboard: [https://improvement.nhs.uk/resources/learningdeaths-nhs-national-guidance](https://improvement.nhs.uk/resources/learningdeaths-nhs-national-guidance)
- Resources from the national patient safety team: [https://improvement.nhs.uk/resources/patientsafety-alerts](https://improvement.nhs.uk/resources/patientsafety-alerts)
- The Improvement Hub: [https://improvement.nhs.uk/improvement-hub/](https://improvement.nhs.uk/improvement-hub/)

Mortality review:
- Royal College of Physicians mortality review materials: [https://www.rcplondon.ac.uk/projects/nationalmortality-case-record-review-programme](https://www.rcplondon.ac.uk/projects/nationalmortality-case-record-review-programme)
- Learning disabilities mortality review programme: [http://www.bristol.ac.uk/sps/leder/](http://www.bristol.ac.uk/sps/leder/)
• Hogan et al Research on mortality review
  http://www.bmj.com/content/351/bmj.h3239
  http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159

Related guidance and publications:
• Root cause analysis tools and resources
  http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/
• Duty of candour
• Being open guidance http://www.nrls.npsa.nhs.uk/beingopen/
Appendix 1: Royal Free London NHS Foundation Trust
Learning from Deaths Mortality Review Template

**DO NOT USE** this form for reviewing the following patient groups. Separate forms available:
- Maternal deaths - Please contact Carla Long/ Helen Swarbrick
- Paediatric deaths - Please contact Carla Long/ Helen Swarbrick
- Deaths within 30 days after chemotherapy - Please contact Derralynn Hughes
- Deaths of patients with learning disabilities - Please notify the Learning Disability Team (Tamara McNamara or Sarah Lally)

**Excluded patient group:**
- Patients who come in being resuscitated and die in the ED.

**Form MUST be used for reviewing the following:**
- Deaths of patients with severe mental illness and patients detained under the Mental Health Act, 1983
- Deaths within 30 days of leaving hospital
- Any deaths recorded as an incident on Datix
- Deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision via the complaints process
- Unexpected deaths e.g. during surgery
- Alarms raised by SHMI, CQC, national audit outcomes reporting
- Regulation 28 Report on Action to Prevent Future Deaths

### Section 1: To be completed for all deceased patients

<table>
<thead>
<tr>
<th>Directorate:</th>
<th>Patient’s age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty:</td>
<td>Patient’s NHS/hospital ID number:</td>
</tr>
<tr>
<td>Date of admission:</td>
<td></td>
</tr>
<tr>
<td>Date of death:</td>
<td>Name of reviewer and role:</td>
</tr>
<tr>
<td>Date of review:</td>
<td></td>
</tr>
</tbody>
</table>

### Section 2: Judgement Review
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 please do so.

**Admission and Initial management**
(approximately the first 24 hrs)

Please rate the care received by the patient during this phase as documented in the notes

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

**Ongoing care**

Please rate the care received by the patient during this phase as documented in the notes

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

**Care during the procedure**
(excluding IV cannulation)

Please rate the care received by the patient during this phase as documented in the notes

| 1 = very poor care | 2 = poor care | 3 = adequate care | 4 = good care | 5 = excellent care |
### Perioperative Care

Please rate the care received by the patient during this phase as documented in the notes

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

---

### End of Life Care

Please rate the care received by the patient during this phase as documented in the notes

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

1. Was there adequate discussion with the family regarding the patient’s outcome?
   - Yes
   - No
   - Don’t know

2. Did the family raise any concerns regarding care?
   - Yes
   - No
   - Don’t know

3. Was a timely referral made to palliative care?
   - Yes
   - No
   - Don’t know

4. Did the palliative care team see the patient?
   - Yes
   - No
   - Don’t know

5. Was the patients last days of life supported by the Palliative Care Plan; including was pain and suffering effectively controlled?
   - Yes
   - No
   - Don’t know

6. Was the GP and the referring doctor informed of the death?
   - Yes
   - No
   - Don’t know

---

### Overall Care:

Please consider:
- All relevant risk assessments: VTE/falls/pressure ulcers
- Clinical care and deterioration and any failure to escalate
- Management of perioperative/cardiac arrest (and appropriateness)
- Technical and non-technical elements – e.g. insertion of lines, team work, team leadership

Please rate the care received by the patient during this phase as documented in the notes

1 = very poor care  2 = poor care  3 = adequate care  4 = good care  5 = excellent care
### Section 3: Assessment of concerns during the patients admission

Please comment on whether one of more specific types of concern were identified, and if so, indicate whether any led to harm.

<table>
<thead>
<tr>
<th>Concern</th>
<th>Yes</th>
<th>No</th>
<th>Probably</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 If ‘Yes’, did this lead to harm?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 If ‘Yes’, did this lead to harm?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Treatment and management plan (including prevention of pressure ulcers, falls, VTE)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 If ‘Yes’, did this lead to harm?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4. Infection control?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 If ‘Yes’, did this lead to harm?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Operation/invasive procedure (other than infection control)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 If ‘Yes’, did this lead to harm?</td>
<td></td>
<td></td>
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<tr>
<td>6. Clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1 If ‘Yes’, did this lead to harm?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Failure to recognise or take appropriate action on ‘alerts’ e.g. MEWS&gt;3?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.1 If ‘Yes’, did this lead to harm?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Communication?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.1 If ‘Yes’, did this lead to harm?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Any concerns not fitting the categories above?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Section 4: This case must be logged as an incident on DATIX and flagged to SIRP for review if:

1. A score of 1 or 2 recorded for overall care in Section 2
2. Any concerns identified during the patient’s admission that led to harm or probably led to harm i.e. ‘Yes’ or ‘Probably’ recorded in Section 3

### Section 5: Main diagnosis on admission (If don’t know state reason i.e. not documented)

Confirmed main diagnosis (e.g. after tests):

Cause of death (taking all information into account including PM):

1a. 
1b. 
1c. 

2.

Patient death referred to Coroner? | Yes | No | Don’t know | reason: |
Post mortem undertaken? | Yes | No | Don’t know | reason: |

### Section 6: Learning and actions to improve

Name of meeting where the patient’s death reviewed? E.g. debrief, Specialty M&M, Governance Meeting.
Date of review/meeting:  
Chair of meeting (if applicable):  

**Excellent care examples:** Please document examples of excellent care and how we could share/learn.

**Improvements:** Please list any areas identified for improvement.

<table>
<thead>
<tr>
<th>Action to be taken</th>
<th>Person/ Group/ Committee responsible</th>
<th>Review date</th>
<th>Associated work streams/ groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Please scan/save completed form on the Learning from deaths (mortality review) part of Datix after local review at M&M
## Appendix 2 Publication and communication checklist

<table>
<thead>
<tr>
<th>Title of document:</th>
<th>Learning from Deaths Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date finalised:</td>
<td></td>
</tr>
<tr>
<td>Dissemination lead:</td>
<td>(print name and contact details)</td>
</tr>
<tr>
<td>Professor Stephen Powis</td>
<td></td>
</tr>
<tr>
<td>Previous document already being used?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, in what format and where?</td>
<td>N/A</td>
</tr>
<tr>
<td>Proposed action to retrieve out-of-date copies of the document:</td>
<td>N/A</td>
</tr>
<tr>
<td>To be disseminated to:</td>
<td>How will it be disseminated, who will do it and when?</td>
</tr>
<tr>
<td>Paper or electronic</td>
<td>Comments</td>
</tr>
<tr>
<td>All</td>
<td>Freenet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date put on register / library of procedural documents</th>
<th>Date due to be reviewed</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Disseminated to: (either directly or via meetings, etc)</th>
<th>Format (i.e. paper or electronic)</th>
<th>Date disseminated</th>
<th>No. of copies sent</th>
<th>Contact details / comments</th>
</tr>
</thead>
</table>
## Appendix 3 Royal Free London NHS Foundation Trust Equality Analysis for: Learning from Deaths Policy

<table>
<thead>
<tr>
<th>Name of the policy / function / service development being assessed</th>
<th>Learning from Deaths Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe its aims and objectives:</td>
<td>This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the trust. It describes how the trust 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.</td>
</tr>
<tr>
<td>Directorate and Lead:</td>
<td>Professor Stephen Powis</td>
</tr>
</tbody>
</table>
• Serious incident framework: [https://improvement.nhs.uk/resources/seriousincident-framework/](https://improvement.nhs.uk/resources/seriousincident-framework/) |
<p>| Is the Trust Equality Statement present?                          | Yes |</p>
<table>
<thead>
<tr>
<th>Protected Characteristic (Equality Act 2010)</th>
<th>Identify negative impacts</th>
<th>What evidence, engagement or audit has been used?</th>
<th>How will you address the issues identified?</th>
<th>Identifies who will lead the work for the changes required and when?</th>
<th>Please list positive impacts and existing support structures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Potential negative impact through use of complaints as trigger</td>
<td>Evidence from the trust's annual complaints report shows that there is a lower reporting rate for complaints from people with a protected characteristic.</td>
<td>Monitoring process and report will be reviewed by the Trust’s Equality Steering Group</td>
<td>Trust’s Equality Steering Group</td>
<td>To ensure the learning from deaths process is inclusive of all protected characteristics.</td>
</tr>
<tr>
<td>Disability</td>
<td>No negative impact</td>
<td></td>
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<tr>
<td>Gender Reassignment</td>
<td>Potential negative impact through use of complaints as trigger</td>
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<tr>
<td>Marriage and Civil Partnership</td>
<td>No negative impact</td>
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<tr>
<td>Pregnancy and maternity</td>
<td>No negative impact</td>
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<tr>
<td>Race</td>
<td>Potential negative impact through use of complaints as trigger</td>
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<tr>
<td>Religion or Belief</td>
<td>Potential negative impact through use of complaints as trigger</td>
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<tr>
<td>Sex</td>
<td>Potential negative impact through use of complaints as trigger</td>
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<tr>
<td>Sexual Orientation</td>
<td>Potential negative impact through use of complaints as trigger</td>
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<tr>
<td>Carers</td>
<td>Potential negative impact</td>
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<td></td>
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<tr>
<td>Protected Characteristic (Equality Act 2010)</td>
<td>Identify negative impacts</td>
<td>What evidence, engagement or audit has been used?</td>
<td>How will you address the issues identified?</td>
<td>Identifies who will lead the work for the changes required and when?</td>
<td>Please list positive impacts and existing support structures</td>
</tr>
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<td>--------------------------------------------</td>
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<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
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<tr>
<td></td>
<td>through use of complaints as trigger</td>
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</tbody>
</table>

It is important to record the names of everyone who has contributed to the policy, practice, function, business case, project or service change.

Equality Analysis completed by: (please include every person who has read or commented and approval committee(s). Add more lines if necessary)

<table>
<thead>
<tr>
<th>Role and organisation if appropriate</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard Chester          Deputy Director Patient Experience</td>
<td>21/09/17</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>