Bradford Teaching Hospitals NHS
NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust

CP90 - Learning from Deaths Policy

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1. Introduction

In recent years increasing concerns about patient safety in the NHS has intensified the need to learn from the care we deliver.

It is important that Bradford Teaching Hospitals NHS Foundation Trust (the Foundation Trust) utilises a number of mechanisms to give assurance on the quality of patient care provided and to maximise learning.

The review of the care of patients who die under NHS care is paramount to this assurance.

The Foundation Trust is committed to improving the quality of care delivered and acknowledges that systematic review of patients who die in our care has a crucial part in learning from the care we give.

The Foundation Trust has an established mortality review process in place. Our Learning from Deaths process investigates both the quantitative and qualitative elements of mortality governance through scrutiny of hospital statistics, as well as individual case note reviews.

Mortality rates within the Foundation Trust are monitored using a number of different metrics, including the national Summary Hospital-level Mortality Indicator (SHMI) and crude mortality rates.

The Foundation Trust has developed a process to learn from all aspects of care. Case note reviews contribute to this wealth of knowledge, ensuring that any patterns, trends or themes are detected and that where necessary, all incidents are reported and investigated so that all learning opportunities are explored.

Deaths that are subject to HM Coroner's inquests, Patient Safety Incident Response Framework (PSIRF) and/or Patient Experience processes are subject to an intensive case review and learning process. As these are established, robust processes, they will be performed in lieu of the Learning from Deaths case note review process to avoid contradiction and duplication and provide the best response for families, carers and other authorities.

Completion of timely and proportionate mortality reviews will enable the Foundation Trust to identify recurring and emerging issues and to be able to quickly respond to any questions raised by external organisations, e.g. Integrated Care Board (ICB), Care Quality Commission (CQC), etc, in relation mortality trends.

As part of the Foundation Trust's legal duty to be open and honest with patients, and following their death, with their families and carers, information for the bereaved has been developed. This will inform them of the Trust's mortality review processes and give the opportunity to request a review of the death of their loved ones.

2. Purpose

2.1. The purpose of this policy is to describe the processes and the governance associated with the Foundation Trust's Learning from Deaths Programme. The Foundation Trust will learn from deaths that occur in line with the National Guidance on Learning from Deaths (*see Reference 1, Section 13*).

2.2. The policy describes how the Foundation Trust will provide a consistent and co-ordinated approach to undertaking mortality reviews, reporting on findings, and implementation of identified actions. It will also clarify how the process for mortality review interacts with other

investigation processes within the Foundation Trust, to facilitate a streamlined and co-ordinated interface with incident, complaint, inquest and claims investigations, where applicable.

2.3. The policy describes how the Foundation Trust will respond to and learn from bereaved relatives and carers.

2.4. The policy describes how the Foundation Trust will interact with external organisations and how the Foundation Trust will comply with the nationally mandated mortality review processes.

3. Scope

3.1. This policy applies to all adult patients and their bereaved relatives and carers who are under the care of the Foundation Trust and die whilst being cared for in hospital.

3.2. Further national work is being undertaken to explore how to develop process for the review of mortality in the community.

3.3. Paediatric, maternity and neonatal patients are subject to national review processes (MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) which are referred to in this policy but are not within the scope of this policy.

3.4. Patients with a learning disability are also subject to national review processes and are included in the scope of this policy under the Learning from Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) guidance.

3.5. The policy applies to all staff at the Foundation Trust.

4. Definitions/Glossary

4.1. **CDOP** – Child Death Overview Panel.

4.2. **HED** – Healthcare Evaluation Data, the commercial database/software application used by BTHFT for mortality data/statistics.

4.3. **Hospital Investigation** – refers to a process often triggered by an adverse event or outside request, e.g. complaints, PSIRF, HMC, CQC, etc, and involves an in-depth exploration of all the facts.

4.4. **LeDeR** – Learning from Lives and Deaths of People with a Learning Disability and Autistic People.

4.5. **MBRRACE-UK** – Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK.

4.6. **Mortality Review** – refers to the standard case note review triggered only by the death of a patient and will use the Structured Judgement Review (SJR) methodology.

4.7. **SHMI** – Summary Hospital-level Mortality Indicator is a ratio of the number of in-hospital deaths and deaths occurring up to 30-days post-discharge, in all clinical classifications against the number of 'expected' deaths (*calculated according to factors such as age band, sex, co-morbidities, deprivation etc.*).

4.8. **SJR** – Structured Judgement Review; this is the ratified methodology championed by the Royal College of Physicians presently used to perform mortality case note reviews at BTHFT.

4.9. **PSIRF** – Patient Safety Incident Response Framework; successor to the Serious Incident (SI) Framework.

5. Roles and Responsibilities

5.1. Bradford Teaching Hospitals Foundation Trust Board

5.1.1. Through the Chief Medical Officer, the Board is responsible for learning from mortality at the Foundation Trust.

5.1.2. The Board is represented at the Quality Committee (QC) to oversee the approach to learning from deaths.

5.1.3. The Board is responsible for ensuring a quarterly report is published containing the Trust's mortality figures and the emergent themes and learning from SJRs conducted in the given period.

5.1.4. Understand the review process: ensure the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.

5.2. Associate Medical Director for Learning from Deaths

5.2.1. Operational responsibility for the Learning from Deaths Programme, including reporting its findings and generating information for learning.

5.3. Quality Committee

5.3.1. Will seek assurance that all mortality at the Foundation Trust is reliably reviewed, monitored, and reported on. Receive reports from the Mortality Review Improvement Group (MRIG) and report to Board of Directors.

5.4. Mortality Review Improvement Group

5.4.1. Will seek assurance that mortality is reliably reviewed, monitored and reported. That all information is disseminated to all relevant staff and patient groups. That all learning is collated and recommendations on actions are made where applicable.

5.4.2. Has responsibility to implement, monitor and improve the mortality review process in line with the national directives whilst also contributing to the regional and national mortality review programmes.

5.5. The Learning from Deaths Team

5.5.1. Will review the hospital mortality data monthly, via the HED database and the Medical Examiner's Office statistics. It will monitor specifically the SHMI data, crude mortality rates and numbers of adult inpatient deaths, looking for changes and trends in mortality in all diagnostic groups. In areas of high mortality, internal investigations or observation regimes could be instigated. A monthly mortality dashboard will be produced and reviewed at the Quality of Care Panel (QuOC).

5.5.2. Working alongside the Associate Medical Director for Learning from Deaths, co-ordinate the mortality review process, maintaining up-to-date records of reviewers and cases. They will review and analyse the results of mortality reviews, producing a quarterly Mortality Outcomes Report displaying an overview of the data. They are responsible for escalating cases to the Quality Governance team, where appropriate.

5.5.3. Where concerns are identified from sources of mortality data, this will be escalated through the appropriate channels.

5.6. **The Clinical Coding Team**

5.6.1. Will ensure that the patient's care is coded appropriately.

5.7. **Clinical Directors, Associate Directors of Nursing and Heads of Nursing**

5.7.1. Will ensure and give assurance that the processes in this policy are implemented reliably in their respective clinical service units. Specifically, that mortality reviews are done using structured judgment methodology and that mortality statistics and the output from mortality reviews are discussed and learning is acted upon.

5.8. **Mortality Reviewers**

5.8.1. Will be identified individuals for most specialties. They will have the responsibility to ensure they are trained to perform SJRs and attend mortality review update sessions. They will report and escalate the reviews once completed in line with the process described.

5.9. **Business Intelligence**

5.9.1. Will have a responsibility to collate mortality data, help managers and clinicians understand the data and to help conduct investigations where applicable.

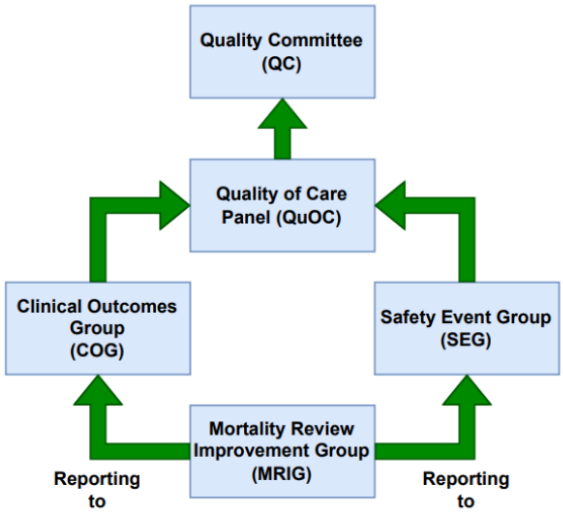
5.10. **The Quality Governance Team**

5.10.1. Are responsible for considering for investigation those cases which have been escalated by the Learning from Deaths Team where care has been deemed to be below an acceptable standard.

6. Mortality Governance

6.1. Governance and Reporting Structure

6.1.1. The BTFHT mortality review governance structure is displayed in the following diagram:



6.2. Mortality Review Improvement Group (MRIG)

6.2.1. This group has oversight of received updates from mortality reviews, including learning from Coroner's reports and case record reviews, as well as overseeing the Learning from Deaths programme. It provides assurance and learning to the Clinical Outcomes Group (COG) and Safety Event Group (SEG) before escalating findings to the Quality of Care Panel (QuOC) and Quality Committee (QC).

6.2.2. The Mortality Review Improvement Group is the initial conduit for learning from mortality. Representation is made from across the clinical service units.

6.2.3. MRIG will submit a quarterly report to COG, SEG, QuOC and QC reporting on the Foundation Trust's Learning from Deaths Programme.

6.2.4. MRIG has a standing agenda which is intended to help the Foundation Trust learn from mortality information from all sources:

- HED Mortality data (SHMI and Crude Mortality Rate);
- Learning from Coronial investigations;
- Mortality review improvement work and SJRs;
- Learning Disability reviews and the LeDeR national programme;
- National guidance on Learning from Deaths;
- Regional/national mortality programmes.

6.2.5. Membership includes, and is open to, all specialty mortality leads, staff trained in the structured judgement review method and any others involved in mortality review or have an interest in mortality. Members also support the Stage 2 Multidisciplinary Review process when triggered.

6.2.6. This meeting is held monthly and chaired by the Associate Medical Director for Learning from Deaths.

6.2.7. If the Associate Medical Director for Learning from Deaths is unavailable, then chairing duties fall to the Patient Safety Manager for Learning from Deaths.

7. Bereaved Families and Carers

7.1. The Foundation Trust has a bereavement policy which will outline how carers and the bereaved will be informed and consulted in a meaningful and compassionate manner.

7.2. In summary:

7.2.1. Carers and family will be given the opportunity and encouraged to raise any concerns of the care their loved one received in hospital either directly with the consultant or nursing staff in charge, the Bereavement Office, Medical Examiner or Patient Experience Team through the complaints process.

7.2.2. When there is a hospital investigation into a death (e.g. complaints process, PSIRF, HM Coroner inquest etc.), the relatives/carers will be informed, asked for comment and will be involved if they wish to be.

7.2.3. When a SJR is being conducted as part of the SJR process, the relatives/carers will not necessarily be informed.

7.2.4. All bereaved relatives/carers receive a letter within the bereavement pack which informs them of the possibility that their relative's care may be subject to a SJR.

8. Mortality Review

8.1. Mortality Review Process

8.1.1. When a patient dies whilst an inpatient of the Foundation Trust, their care will be eligible for review using our mortality review process. The established mortality review process as described in Appendix 1 is:

- The Independent Medical Examiner Service scrutinises all deaths within the Foundation Trust.
- If there are no concerns raised then the process ends.
- If the Medical Examiner feels the death should be subject to a SJR then the ME-1 scrutiny form is issued and a SJR request raised with the Patient Safety Manager for Learning from Deaths.
- The Patient Safety Manager for Learning from Deaths will identify a reviewer to conduct a Stage 1 SJR on the death.
- The SJR reviewer will conduct the Stage 1 SJR and return the completed Stage 1 SJR to the Patient Safety Manager for Learning from Deaths.
- If the Stage 1 SJR has an overall Care Score of 3 or above (indicating adequate to excellent care) the Patient Safety Manager for Learning from Deaths identifies any learning and escalates to MRIG.
- MRIG will discuss the findings and disseminate learning via CSU reporting structures and SEG/QuOC.

- If the Stage 1 SJR has an overall Care Score of 2 or below (indicating poor or very poor care) the Patient Safety Manager escalates the findings to MRIG in order for a MDT Stage 2 review to take place.
- MRIG will conduct the MDT Stage 2 review is this has an overall Care Score of 3 or above (indicating adequate to excellent care) then MRIG will discuss the findings and disseminate learning via CSU reporting structures and SEG/QuOC.
- If the MRIG MDT Stage 2 review has an overall Care Score of 2 or below (indicating poor or very poor care) then MRIG will discuss the findings and disseminate learning via CSU reporting structures. Meanwhile the Patient Safety Manager will escalate the case to SEG for discussion.
- Following discussion at SEG if it is deemed necessary, a referral will be made to QuOC to consider whether to declare a PSII.
- If QuOC declares a Patient Safety Incident Investigation (PSII) then the incident will be handed over the Quality & Patient Safety Facilitator for the CSU involved in order to conduct the PSII.

8.1.2. Not all patients who die in hospital will have their care reviewed. Reviewing large numbers of case notes is often not possible nor does evidence support that it increases opportunities for learning.

8.1.3. Deaths of patients that are the subject of a PSIRF, Patient Experience investigation or Coronial investigation (where a post-mortem cannot be gained) will be exempt from the Learning from Deaths SJR process. The act or process of investigating is a systematic analysis of what happened, how it happened and why. Investigations draw on evidence including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation in order to identify problems in care or service delivery that preceded an incident to understand how and why it occurred.

8.1.4. Patients who die in hospital will have their care scrutinised by the independent medical examiner who may select a review based on the following criteria:

- Deaths where carers/relatives or staff have raised concerns about the quality of care;
- Deaths of patients with learning disabilities, learning disabilities and autism, or autism with no learning disability (LeDeR);
- Deaths of patients where severe mental health illnesses have been identified;
- Deaths of patients who were not expected to die or were elective admissions to hospital;
- Deaths of patients in diagnosis groups where ‘alerts’ have been raised (e.g by the CQC);
- Deaths of patients where quality improvement programmes are in place and mortality reviews are deemed essential to learning;
- Deaths of patients in specialties with small numbers of deaths per annum (<100).

8.2. **Structured Judgement Review**

8.2.1. The Foundation Trust will use the Structured Judgement Review (SJR) methodology for the mortality review process. This is a nationally recognised methodology, championed by the Royal College of Physicians, which is known to provide good quality information regarding health care.

8.2.2. The SJR case note review enables a reviewer to examine and evaluate care. The review method combines structured reviewer comments with quality of care scores to assess the care of people who die in hospital.

8.2.3. The SJR method encourages reviewers to identify and celebrate good care as well as identify poor care. It helps to facilitate the identification of actions for improvement and suggests lessons that may be learned.

8.2.4. It is different from the traditional case note review approach as the process encourages the reviewer to rationalise their clinical assessment/judgement of the care received by the patient using positive and/or negative commentary to describe the quality and standard of care.

8.2.5. The safety and quality information that arises from this method provides a rich source of learning and will be used for governance purposes and for quality improvement initiatives.

8.2.6. Regular SJR training will be available for all mortality reviewers. Update training for existing reviewers will also be available.

8.3. **Collaboration with Other Organisations**

8.3.1. Many of our patients will be cared for or involved with other organisations (e.g. nursing homes). Where necessary or when requested to, we will review the care of patients who came through our organisation but did not necessarily die on Trust property or as an inpatient. We will use the same governance process and mortality review methodology as for our inpatients.

8.3.2. As required, we will work closely with other organisations to develop processes for sharing learning from mortality.

8.3.3. For certain categories, collaboration with other organisations is mandated.

8.4. **Medical Examiner**

8.4.1. The Department of Health announced that a national system of Medical Examiners was to be introduced from April 2019. Medical Examiners will have a separate professional line of accountability, allowing for access to information in the sensitive and urgent timescales surrounding death registration – but with independence necessary for the credibility of the scrutiny process. This independence is overseen by a National Medical Examiner, providing leadership to the system.

8.4.2. As of November 2020, BTHFT introduced the Medical Examiner role along with death scrutiny.

8.4.3. As of October 2021, the Medical Examiner office was fully staffed and has been scrutinising 100% of adult inpatient deaths at BTHFT.

8.4.4. As of September 2024, the Medical Examiner Service was made mandatory across England and Wales, with the expectation that the Service will scrutinise all deaths within acute Trusts and in the community.

8.5. **Working with Priority Areas**

8.5.1. **Learning Disabilities and Autism**

- All patients with learning disabilities, learning disabilities with autism, or autism with no learning disability that die at the Foundation Trust will undergo a mortality review (as described in Appendix 2).
- All learning disability patient deaths will be reported to the national LeDeR (Learning from Lives and Deaths of People with a Learning Disability and Autistic People) programme via the West Yorkshire Integrated Care Board.
- The Foundation Trust has an established process to contribute to the mortality reviews in the LeDeR programme.
- Through the mortality governance process the Foundation Trust will receive and review the LeDeR programme reports when produced and implement relevant recommendations.

8.5.2. **Severe Mental Health Illness**

- Patients with severe mental health illnesses who die at the Foundation Trust will have their care reviewed as per our SJR process.

8.5.3. **Paediatric Deaths**

- Children who die at the Foundation Trust will have their care reviewed as directed in the national programme for child mortality review.
- The Foundation Trust will continue to comply with the Child Death Overview Panel (CDOP) process.
- The Foundation Trust will receive and review the national reports related to paediatric deaths, learning will be disseminated through the relevant clinical service unit channels and the relevant changed implemented.

8.5.4. **Stillbirth and Neonatal Deaths**

- The Foundation Trust will review all perinatal deaths and has adopted the MBRRACE-UK mortality review tool.
- All deaths are submitted to MBRRACE-UK contributing to a report containing national comparison.
- All intrapartum stillbirths over 37 weeks gestation are reported and investigated by the Maternity newborn safety investigation team who are a branch of Health Services Safety Investigation Body (HSSIB).
- Safety recommendations and safety prompts, if generated, will be reviewed and an improvement plan is generated. This is shared with the Health Care Partnership and monitored through the Women's clinical service unit governance channels.
- This process applies to any neonatal death in the first 7 days of life and if a baby is diagnosed with a severe brain injury.
- All investigations are subject to parental consent.

8.5.5. **Maternal Deaths**

- Patients who die whilst pregnant or within one year of delivery will be subject to nationally mandated maternal mortality review via MBRRACE-UK which the Foundation Trust continues to comply with.

- The MBRRACE-UK reports will be received and reviewed, with learning disseminated through the relevant clinical service unit channels to review the statistical representation of the data.
- Maternal deaths that meet criteria are investigated by the Maternity newborn safety investigation team who are a branch of Health Services Safety Investigation Body (HSSIB).
- Safety recommendation and safety prompts, if generated, will be reviewed and an improvement plan is generated and shared with the Health and Care Partnership and monitored through the Women's clinical service unit governance channels.

9. Capturing the Learning from Mortality

9.1. The requirements set out in the national guidance require that we publish information annually within our Quality Account, specifically on:

- Number of deaths in the Foundation Trust's care.
- Number of deaths reviewed by the Medical Examiner.
- Number of deaths subject to a case record review.
- Number of deaths investigated under the Patient Safety Incident Response Framework (PSIRF).
- Number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care.
- Themes and issues identified from review and investigation (including examples of good practice).

9.2. The Foundation Trust will comply with all the requirements of the Coroner's Office in terms of death certification, notification to the Coroner's Office and Coronial investigations where applicable.

9.3. The Foundation Trust will comply with the national requirement to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to public board meetings (including information on a review of the care provided to those with severe mental health needs, learning disabilities and/or autism).

9.4. As per national guidance, the Foundation Trust will not use the term "avoidable mortality" or derivatives of.

9.5. The Learning from Deaths Team will produce reports which are distributed widely through the Trust:

9.5.1. **Monthly Mortality Dashboard** produced using Healthcare Evaluation Data (HED) and providing an overview of mortality indicator figures and performance at Trust level. The dashboard will also include updates on internal and external mortality alerts as well as performance in the SJR process.

9.5.2. **Quarterly Mortality Outcomes Report** provides an overview of the quality of care scores and structured judgement commentary collated from all case note reviews submitted to the Patient Safety Manager for Learning from Deaths. It presents a summary of emerging themes, identified learning and areas for improvement.

9.6. There is an expectation that individual specialties will discuss and disseminate these reports, along with their own SJRs and ensure that any learning points are acted on appropriately.

10. Impact Assessment

10.1. **Financial Impact Assessment**

10.1.1. There are no financial impacts associated with this policy. This will be reviewed at the next review date.

10.2. **Privacy Impact Assessment**

10.2.1. The Privacy Impact Screening Tool was completed for this policy and no privacy implications were identified.

10.3. **Equality Implications/Impact Assessment**

10.3.1. This policy was assessed in March 2019 to determine whether there is a possible impact on any of the nine protected characteristics as defined in the Equality Act 2010. It has potential impact on:

- Age – There are different processes to be followed for patients aged up to 18 years.
- Disability – There are specific processes to be followed for reporting on patients with learning disabilities and/or mental health illnesses. Adjustments would need to be made to ensure that deaf people, blind people and those with learning disabilities are able to understand.
- Maternity/Pregnancy – There is a specific process to be followed for women who die within the first year following delivery.
- Race and ethnicity – Adjustments would need to be made to ensure that people unable to communicate in English understand the process.

10.3.2. It has been found not to have an impact on:

- Gender
- Gender reassignment
- Marriage and civil partnership
- Religion and beliefs
- Sexual Orientation

10.3.3. It has also been assessed to determine whether it impacts on human rights against the FREDA principles (Fairness, Respect, Equality, Dignity and Autonomy) and it is considered that it has a positive impact. This assessment will be reviewed when the policy is next updated or sooner if evidence of further impact emerges.

11. Policy Review

11.1. This policy will be reviewed in three years to ensure it is relevant and responsive to changing clinical practice.

12. Links to Other Policies

12.1. Bereavement Policy
12.2. Patient Safety Incident Response Policy

13. References

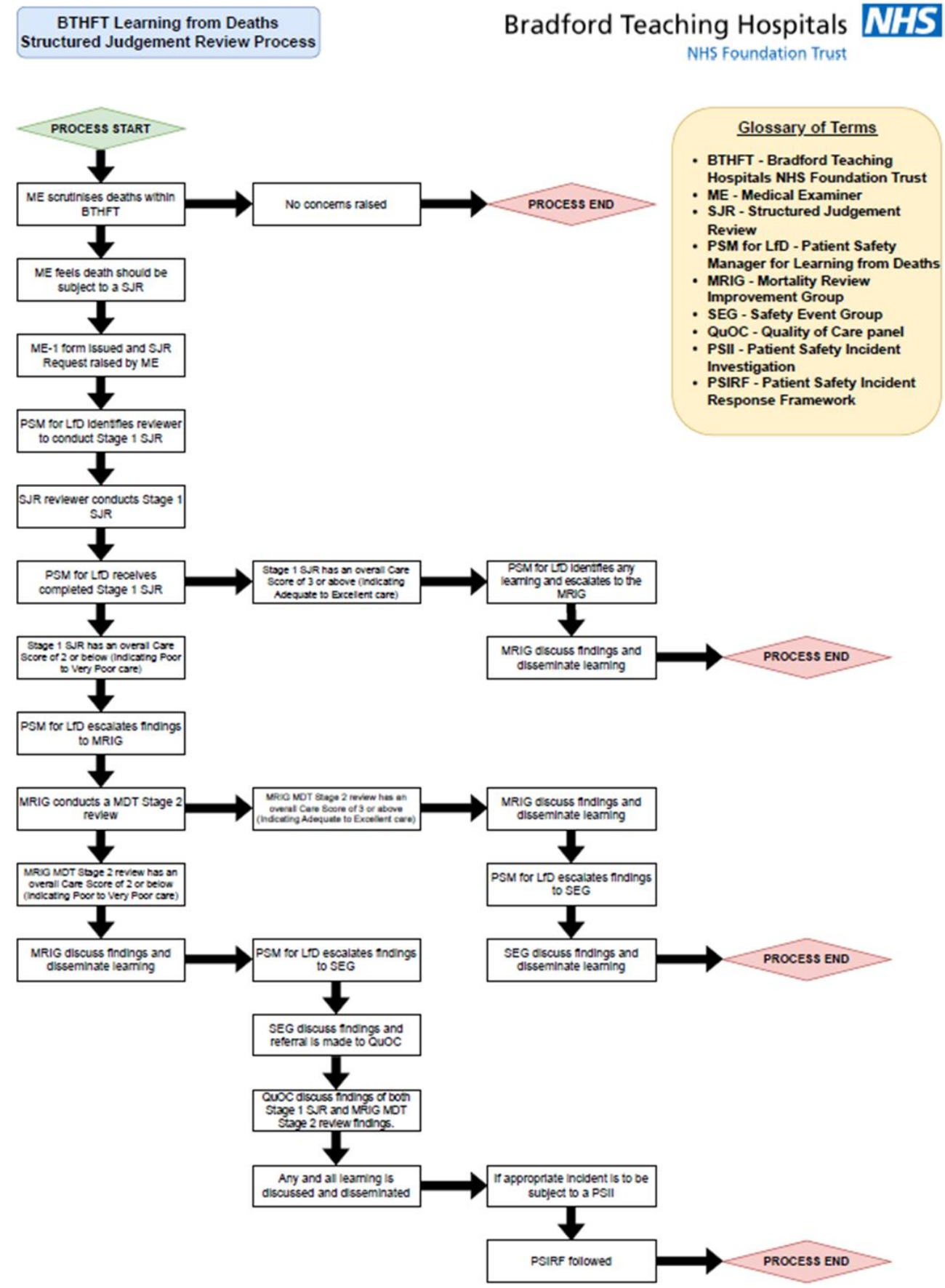
13.1. National Guidance on Learning from Deaths: https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/

13.2. Patient Safety Incident Response Framework: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/

13.3. Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) Policy 2021: https://www.england.nhs.uk/publication/learning-from-lives-and-deaths-people-with-a-learning-disability-and-autistic-people-leder-policy-2021/

13.4. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK: https://www.npeu.ox.ac.uk/mbrrace-uk

Appendix 1: Learning from Deaths Structured Judgement Review Process



Author: Nick Rushton Patient Safety Manager for Learning from Deaths at Bradford Teaching Hospitals NHS Foundation Trust, November 2023

Appendix 2: LeDeR/Severe Mental Health Illnesses SJR Process

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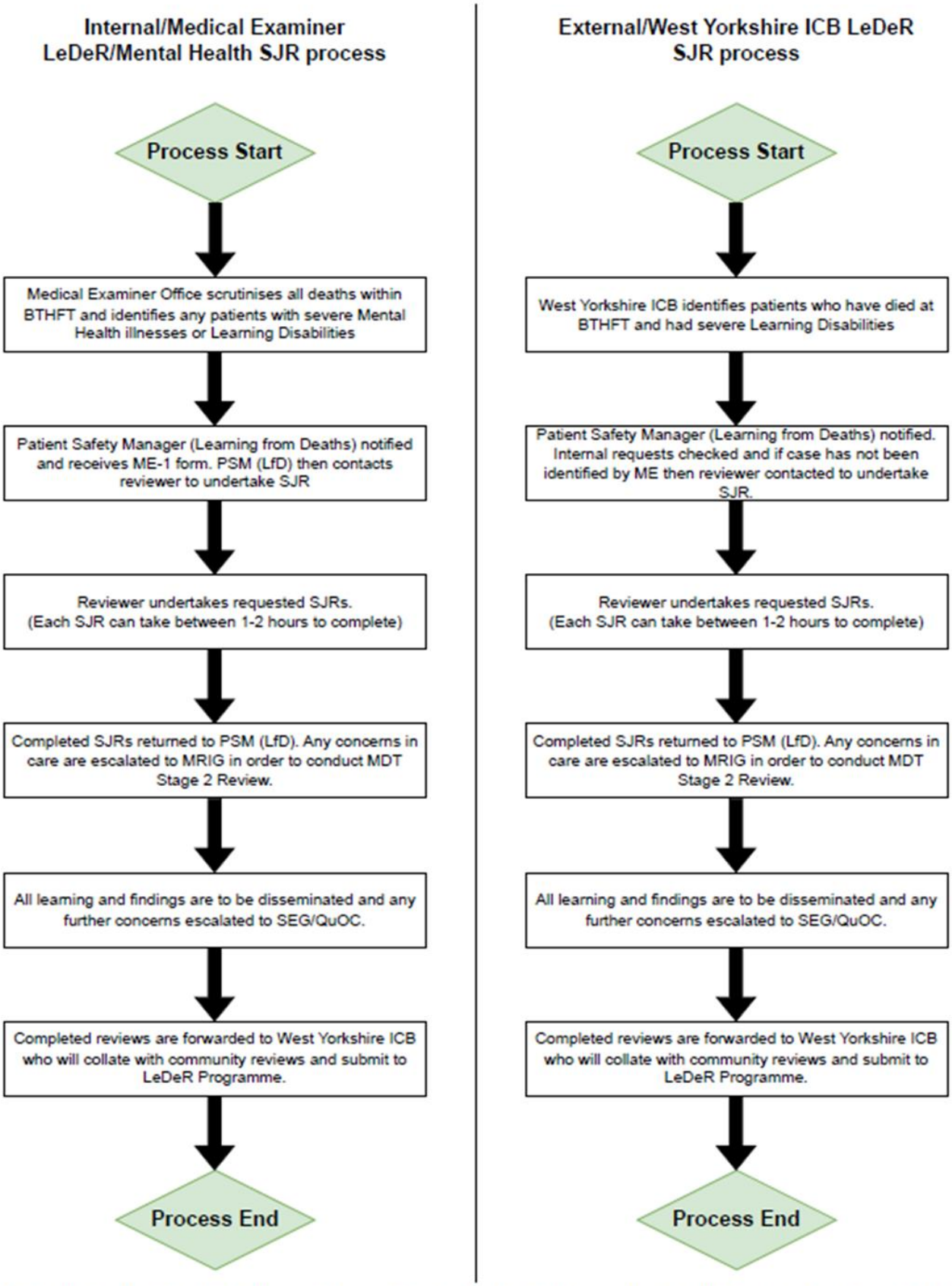

Author: Nick Rushton, Patient Safety Manager for Learning from Deaths at Bradford Teaching Hospitals NHS Foundation Trust, January 2024

Appendix 3: Medical Examiner Scrutiny and Wider Trust Investigation Processes