The Royal Wolverhampton NHS Trust

OP87

Death Certification & Learning from Deaths Policy

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[1] National Chemotherapy Board

1.0 Policy Statement (Purpose / Objectives of the policy)

Mortality reviews are used, in conjunction with other measures, to assess the quality of care provided by a hospital. All acute Trusts in England are required to implement a standardised approach[2] to mortality reviews and ensure learning identified supports quality improvement initiatives. Trusts must have robust governance systems for mortality surveillance and review, and evidence must be gathered and reviewed in a structured way. Learning from a review of the care provided to patients who die is integral to the Trust's clinical governance and quality improvement framework.

Death certification serves several functions. A MCCD (medical certificate of cause of death) enables the deceased's family to register the death. This provides a permanent legal record of the fact of death and enables the family to arrange disposal of the body and to settle the deceased's estate. Where a death requires a referral to the Coroner (refer to the guidance https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner), follow the instructions on the following page (http://trustnet.xrwh.nhs.uk/departments-services/e/emergency-services/emergency-department/clinicians/online-coroners-referrals/).

Information from the death certificate is used to measure the relative contributions of different diseases to mortality. Statistical information on deaths by underlying cause is important for monitoring the heath of the population, designing and evaluating public health interventions, recognising priorities for medical research and health services, planning health services, and assessing the effectiveness of those services.

Central to the implementation of the Learning from Deaths & Death certification framework is the appointment 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. They will also have responsibility for identifying cases for detailed mortality review according to this policy.

The main objective of the policy is to improve quality and consistency of review, enhancing learning from deaths by identifying areas to improve the safety of care for patients using a structured methodology.

The Trust takes the view that the accurate completion of a death certificate is fundamental to any process which attempts to understand mortality matters. Inaccurate completion of a death certificate can lead to rejection by the Registrar and cause unnecessary distress to families.

To achieve the main objective, the aims of the policy are as follows.

1. Provide a standardised process based on the national guidance (including appropriate escalation) for reviewing and assessing deaths in a consistent and co-ordinated way and to establish a robust reporting framework throughout the Trust.
2. Define the criteria to select which deaths are reviewed through the implementation of a Medical Examiner role in the Trust.
3. Identify areas of phases of care that are poor and those that are excellent. This policy aims to ensure that gaps are monitored, and good practice is shared and where necessary issues are escalated appropriately.

[2] National Guidance on Learning from Deaths (1st Edition – March 2017)

4. Provide assurance to the Mortality Review Group (MRG) that mortality reviews are robustly undertaken, and the learning is captured and shared across the Trust.
5. Define links with the Duty of Candour and signpost processes on how to engage with bereaved families.
6. To identify and implement quality improvement plans where care and, or services can be improved.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy (OP109) must be considered and addressed. In the case of any inconsistency, the Conflicts of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

2.1 **Avoidable mortality – a death that would not have occurred** if different clinical or organisational management had been in place and, or if care had been delivered differently. It is a death within an organisation that is considered more than likely (excess of 50% probability) due to problems in healthcare.

2.2 **Death certification** – an official statement, signed by a doctor, of the cause, date, and place of a person's death.

2.3 **Structured Judgement Review** (SJR) – a process developed by the Royal College of Physicians by which the care of a patient who died during hospitalisation is systematically examined and reported.

2.4 **SMART Actions** – refers to ensuring that actions identified are: Specific, Measurable, Achievable, Realistic and Timely

2.5 **Sub-Optimal Care** – care which has not followed evidence-based practice and, or which a responsible body of medical opinion would not consider acceptable (e.g. if a clinical pathway or guidance or best practice has not been followed, with no documented rationale).

2.6 **Unexpected death** in context of this policy means death occurring rapidly and earlier than anticipated.

3.0 Accountabilities

3.1 **Executive and non-executive directors** will **e**nsure the following.

a) The processes in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support.
b) Quality improvement is the purpose of the exercise by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change.
c) The information published is a fair and accurate reflection of the Trust's achievements and challenges.

3.2 **Deputy Medical Director or Nominated Deputy**

a) Have responsibility for the learning from deaths agenda, chairing the Mortality Review Group (MRG), overseeing the implementation of the revised policy, and ensuring clinical staff are aware of their responsibilities and the requirement to conform to this policy.

3.3 Medical Examiners

a) Undertake early scrutiny of hospital deaths (except for where early release is required and deaths post 30 days of discharge) and complete an assessment form.
b) Refer appropriately where further action is required e.g. to the Coroner, PAL(s) with concern, or for detailed SJR case note review.
c) Engage with doctors completing MCCD to review and agree cause of death.
d) Actively engage and support bereaved families and carers.
e) Engage and support Trust's LfD process.

3.4 Mortality Reviewer

a) Undertake reviews of selected deaths as per the agreed criteria. This must not be on patients who have been in their care.
b) Conduct reviews within the timescale agreed using the designated tool in place. This is currently the SJR methodology and, or RCA to identify learning (areas for improvement and good practice) from each of those reviews.
c) Liaise with nominated specialty advisers when required as part of mortality reviews for clarification and, or input.
d) Undertake review of selected deaths for quality assurance purposes as per the agreed criteria.
e) Provide support on thematic analysis of data and outcomes collected through the SJR and RCA processes

3.5 Mortality Review Group (MRG)

a) Ensure that the learning from reviews and investigations is acted on at Trust level (where appropriate) to change clinical and organisational practice to achieve sustained and improvements in care, and to submit information for reporting in Quality Accounts.
b) Monitor overall mortality in the Trust and its departments using the tools available.
c) Request mortality data from directorates and direct case note reviews into specific areas of concern, as necessary.
d) Receive and review reports collated from outcomes of directorate reviews, identify learning, and share outcomes across the Trust.
e) Combine mortality data with other indicators and assign actions as appropriate.
f) Provide regular reports to the Quality & Safety Assurance Group
g) Share across the Trust any learning about trends and themes identified by the reviews.
h) Identify quality improvement opportunities.
i) Respond to mortality alerts and ensures appropriate investigation undertaking for alerting diagnosis groups and are reported within the required timescales.

3.6 Clinical Pathway Group

a) Monitor overall Trust mortality issues using the tools available.
b) Respond to mortality alerts and ensure appropriate investigations are undertaken for alerting diagnosis groups and are reported within the required timescales (e.g., HQIP alerts/alarms, SHMI Alerting Diagnosis etc.).
c) Request mortality data from directorates and direct case note reviews into specific areas of concern, as necessary.
d) Receive and review reports collated from outcomes of directorate reviews, triangulate mortality data with other indicators, and assign actions as appropriate.

e) Provide assurance to the Mortality Review Group (MRG) that mortality reviews are robustly undertaken, and the learning is captured and shared across the Trust.
f) Identify quality improvement opportunities. Clinical pathway improvement is managed using continuous quality improvement methodology and is an important part of the Trust's Continuous Quality Improvement (CQI) strategy.
g) Receive regular reports and, or presentations on clinical pathways where specialities have had previously significantly elevated Standardised Mortality Ratio SMR's e.g. (sepsis, pneumonia, stroke, acute kidney injury (AKI) etc.).

3.7 Quality & Safety Assurance Group

a) Receive assurance reports with regard to learning from deaths and highlight and escalate to Quality Governance Assurance Group (QGAC) any areas of concern/improvement.

3.8 Mortality Leads (all Directorates)

a) Attend at least 60% of MRG regularly meetings or send a nominated deputy instead.
b) Disseminate and share information and learning relevant to their specialty from MRG to the directorate and division using appropriate meetings and other forums.
c) Review the outcomes of completed SJRs to identify local learning and actions following discussion at local governance and Mortality and Morbidity meetings.
d) Complete relevant documentation to demonstrate learning and progress with actions.
e) Report to MRG on a regular basis the outcome of SJR reviews to support trust-wide learning.
f) Provide 'expert' support as a 'specialty advisor' to Mortality Reviewers as required.
g) Update the Learning from Deaths Platform with learning identified following SJRs to enable Trust learning.

3.9 Divisional Management Team

a) Monitor the compliance with the mortality review process in their directorates, identifying quality improvement opportunities for the division and monitoring the progress of directorates' actions to closure.

3.10 Central Governance Team (Compliance Unit)

a) Monitor deaths that require SJR reviews and completion rates.
b) Disseminate directorate data packs monthly.
c) Upload to the Learning Disabilities Mortality Review Programme (LeDeR) database those patients whose SJR mortality reviews a learning disability.
d) Facilitate the function of the Mortality Review Group.
e) Support learning from deaths by collating information from the directorates and complete the Learning from Deaths Platform with identified learning.

3.11 Bereavement Office and Bereavement Nurse

a) Support the Death Certification process linking directorate doctors with a Medical Examiner, families and the Registrar to facilitate the swift completion of a Death Certificate.
b) Develop and implement the bereavement pathway supporting families and relatives in line with the National Guidance "*Learning from Deaths – Guidance for NHS trusts on working with bereaved families and carers*".

3.12 Medical Examiner Officer (MEO).

a) With the Lead Medical Examiner and Lead Bereavement Nurse, the MEO will lead on the development of the medical examiner services within the Trust and deaths that occur out in the community, supporting the integration and implementation of systems and processes relating to the medical examiner role as part of the Learning from Deaths strategy and national Medical Examiner initiatives.

b) MEOs coordinate and support the ME's and Bereavement Nurses in their role in scrutinising the circumstances and causes of deaths that incur in hospital and out in the community.

c) To act as an intermediary between the bereaved, clinicians (hospital and general practitioners), and community teams to establish and resolve any concerns relating to the death of a patient.

d) Ensure systems are in place to provide the statutory information and reports to the National Medical Examiner Team reporting through to NHS England and Improvement.

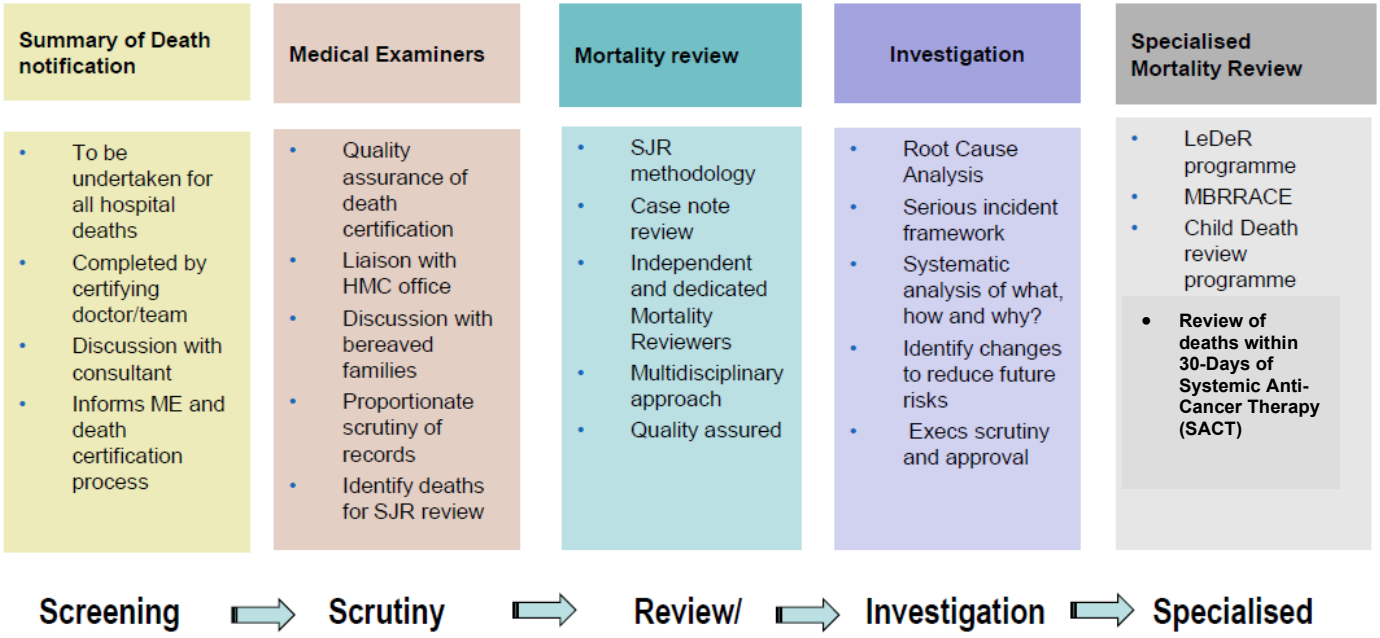
4.0 Policy Detail

This policy applies to all specialties and directorates, and any local processes must reflect the requirements of the standardized approach for both learning from deaths and death certification.

To support and facilitate the Learning from Death process, the Trust has developed and implemented a bespoke Learning from Death IT Platform.

The Trust's mortality review structure consists of the following stages.

Mortality Review Structure - Overview



Screening

Where a death occurs in hospital, this policy sets out the processes and requirements for a summary of death notification to be completed for all hospital deaths. This summary must be completed by the certifying doctor. The completion of this document must be done either during or following a discussion with the consultant to agree the cause of death. This document informs the Medical Examiner and supports the death certification process.

Scrutiny
The Medical Examiner (ME) will examine deaths to agree the proposed cause of death and accuracy of the medical certificate cause of death with the specialty; they will discuss the cause of death with relatives and establish if they have any concerns with the care that could have led to death. They will inform the Trust process of any cases that require further review by identifying those cases to go through the SJR process.

Review
The Trust Mortality Reviewers, who are multi-disciplinary clinicians and nursing professionals, will undertake SJRs of those deaths that meet the current Trust criteria (identified within Learning from Deaths pathway flow chart). The methodology used to standardise reviews undertaken is the structured judgement review methodology (SJR). The Trust has also implemented a process for quality assurance of SJRs, which is undertaken by the Mortality Reviewers; this involves reviewing a sample of all SJRs completed (regardless of outcome): the current criteria for QA is also identified within the Learning from Deaths pathway flow chart. Directorates must hold regular mortality and morbidity meetings in order to review deaths in their specialties and identify learning and action to improve care.

Investigation
If there has been an incident identified during the last episode of care of a patient who has died, the case must be highlighted as a potential incident and managed through the Trust's incident reporting process (OP10). If an RCA is being undertaken, a determination of whether the death has been caused due to a problem in care is undertaken by the RCA Lead; the result of this is presented and agreed at the Executive Significant Event Review Group (ESERG).

Specialised Mortality Review
It must be recognised that the Trust also complies with other national requirements for monitoring of mortality for specific patient groups. These processes are well embedded and reported both internally and externally to the Trust. The specialties that lead on these areas for the Trust also regularly report to the MRG; they are:

- CDOP Child Death Overview Panels, (i.e., Baby Deaths and Child Deaths up to 18YRs)'
- MBRRACE-UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, and
- 30-Days of Systemic Anti-Cancer Therapy (SACT).

Appendices

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c) Review of deaths 30-Days following Systemic Anti-Cancer Therapy (SACT)[3]

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	Yes – No
2	Does the implementation revenue resources of this policy require additional	Yes
3	Doe the implementation of this policy requires additional manpower	Yes
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

The policy does not target any specific group and meets the criteria laid down in the equality impact assessment.

7.0 Maintenance

The Mortality Review Group (MRG) will on any changes to national guidance direct changes to this policy and/or where there are minor changes. The Policy will be routinely reviewed in 3 years from the date of approval.

[3] National Chemotherapy Board

8.0 Communication and Training

Mortality Reviewer training is trained peer to peer when reviewers are new in post. Training for the Learning from Death Platform is provided via user guides and face to face where required.

Communication of the new policy will be via the Mortality Leads, intranet and the Learning from Deaths intranet page and all user bulletins.

The Trust will maintain a 'Learning from Deaths' intranet page where all outcomes and improvements identified will be available to all.

Training will be provided to all reviewers to use the Royal College of Physicians (RCP) Structured Judgment Review case note methodology. Tier 1 trainee will roll out Training to other Stage 2 reviewers within the Trust.

Training and guidance on how to complete a Structured Judgment Review (initial review) is in Appendix 2.3.

The policy will be available on the intranet.

The policy will be distributed to the Divisional Medical Directors, all Mortality Leads, and Clinical Directors and all Divisional and Directorate Governance Leads.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee/ Group
SJR Reviews completed using the MRG agreed criteria. (LfD Report)	Compliance Manager	LfD Platform and SharePoint (or other Trust approved system)	Monthly	Mortality Leads Divisional Management Mortality Review Group
Quality Assurance Process using the MRG approved criteria i.e. via SJR2 (Mortality Reviewers Report)	Compliance Manager	LfD Platform and SharePoint (or other Trust approved system)	Annual	Mortality Leads Divisional Management Mortality Reviewers Group
NNU Report to MRG on all deaths reviewed and learning identified.	NNU Lead	Via MRG agenda/minutes.	Bi-Annual	MRG
Stillbirths Report to MRG (including learning)	Obstetric Mortality Lead	Via MRG agenda/minutes.	?	MRG
Maternal Deaths (including learning)	Obstetric Mortality Lead	Via MRG agenda/minutes	Quarterly	MRG

Criterion	Lead	Monitoring method	Frequency	Committee/ Group
Child Deaths (paeds) (including learning)	Paediatric Mortality Lead	Via MRG agenda/minutes	Quarterly	MRG
Review of deaths 30-Days following Systemic Anti-Cancer Therapy (SACT)4	Oncology Mortality Lead	Via MRG agenda/minutes	Quarterly	MRG
Divisional Mortality Reports (LfD Report)	Compliance Manager/ Mortality Governance Support Officer	Report circulation to Divisional HCGMs or via other Trust approved repository	Quarterly	Divisional Governance
Death Certificate completion	Medical Examiner Officer (MEO)	ME Assessment form/Death Cert register, or other Trust approved repository	Annual	Mortality Review Group
Alerting diagnosis groups – responded to within timescales	Clinical Lead/ Specialty	Presentation/Reports and/or action plans	As required	Clinical Pathway Group/ MRG
Assurance/Activity reports (inc. learning)	Business Managers (CMO)	Via minutes of appropriate group.	Quarterly	QGAC/QSAG/ CQRM

10.0 References - Legal, professional, or national guidelines

- Professor Sir Bruce Keogh, KBE. (July 2013). Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Department of Health, NHS England. London: NHS.
- Care Quality Commission (CQC). (Dec 2016). Learning, candour, and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. Care Quality Commission. CQC.
- National Quality Board. (First Edition March 2017). National Guidance on Learning from Deaths: A Framework for NHS Trusts on identifying, reporting, investigating, and learning from deaths in care. National Quality Board.
- OP10 – Risk Management and Patient Safety Reporting Policy
- OP60 – Being Open Policy

[4] National Chemotherapy Board

Part A - Document Control

Policy number and Policy version: OP87 Version 4.1	Policy Title Death Certification and Learning from Deaths Policy	Status: Final	Author: Compliance Manager Chief Officer Sponsor: Chief Medical Officer

Version	Date	Author	Reason
FINAL V2.0	17/09/15	Compliance Manager	Final update following comments at Policy Group
FINAL V2.0	07/10/15	Compliance Manager	Update following TMC approval subject to constitution of MDT included in Policy.
FINAL V2.1	June 2016	CCI Analyst/ Compliance manager	Update to appendices – structure proforma for review of paediatric deaths
DRAFT V2.2	June 2017	Consultant in Elderly Care/Compliance Manager	Full review following Learning from Deaths national guidance. Including name change to policy. Comments following MRG 3/8/17
Draft V2.3	Aug 2017	Consultant in Elderly Care/Compliance Manager	Comments received (MRG members) incorporated.
Draft v2.4	Aug 2017	Consultant in Elderly Care/Compliance Manager	Comments received from Mr. Badger incorporated.
Draft v3.0	Nov 2018	Chair MRG /Compliance Manager	Full review following Learning from Deaths national guidance update and implementation of Medical Examiner role. Also combined OP89 Death Cert policy within this review.
Draft V3.1	Dec 19	Chair MRG /Compliance Manager	Change to SJR process agreed Nov 19 at MRG, addition of process for maternal deaths, mortality reviewers responsibilities and SJR assurance process, removal/update of templates/guidance. Addition of Maternal deaths to

				section 9.0 and typo's Removal of specific SJR criteria, removal of templates no long required and update to section 9.0 Addition of child death pathway (protocol 2a) and removal of assessment templates appendix 2.1 and 2.2 addition of LfD intranet page under section 8.0 Addition to appendicies: Mortality Review structure (Appendix 4.1) Update following comments from Dr A Viswanath Updated policy detail with structure and organised appendices to reflect mortality review structure.
	Final V3.2	Jan. 2021	Chair MRG /Compliance Manager	Minor update: Specialised Mortality Review (SACT).
	Final V3.3	March 2022	Chair MRG /Compliance Manager	Reviewed by Deputy Chief Medical Officer – Extended to May 2022 pending full review
	V4.0	June 2022	Chair MRG /Compliance Manager	Planned review
	V4.1	Sept. 2024	Chair MRG /Compliance Manager	Updates within section 4.1 Screening: a) Death Certification process with Medical Examiners replaced with attachment OP87 Appendix 1a. Overview process for death certification. b) Administration process in the event of a Death replaced with attachment OP87 Appendix 4.1b Administration process in the event of a Death incorporating the Medical Examiner Service c) Summary of Death (SoD) form replaced with attachment OP87 Appendix 4.1c Summary of Death (SoD) Form 2024 d) Authorisation for rapid

				release of a deceased patient from the SWAN suite replaced with attachment OP87 Appendix 4.1d Authorisation for the Rapid Release of a Deceased Person from the Ward or Swan Suite (out of hours) e) Out of Hours rapid release of deceased patient replaced with attachment OP87 Appendix 4.1e Out of Hours Rapid Release Procedure

Intended Recipients: All staff	
Consultation Group / Role Titles and Date: Mortality Review Group – 7th April 2022 (Mortality Leads/Members)	
Name and date of Trust level group where reviewed	Mortality Review Group Trust Policy group – July 2022 Trust Policy Group Virtual Approval – September 2024 – V4.1
Name and date of final approval committee	Trust Management Committee - July 2022
Date of Policy issue	September 2024
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	July 2025 - 3 Yearly
Training and Dissemination: Mortality Review Group, Mortality Reviewers Group, Communication through All User bulletin, intranet.	
Publishing Requirements: Can this document be published on the Trust's public page: **Yes / ~~No~~** If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.	
To be read in conjunction with: OP10 Risk Management and Patient Safety Reporting Policy and OP60 Being Open	
Initial Equality Impact Assessment (all policies): Completed Yes / No Full Equality Impact assessment (as required): Completed Yes / No / NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator8904	
Monitoring arrangements and Committee	Monitoring is identified within section 9.0 of the Policy. Mortality Review Group.

Document summary/key issues covered.

The main objective of the policy is to improve the quality and consistency of reviews, enhancing learning from deaths by identifying areas to improve the safety of care for patients using a structured methodology.

The Trust takes the view that the accurate completion of a death certificate is

fundamental to any process which attempts to understand mortality matters. Inaccurate completion of a death certificate can lead to rejection by the Registrar and cause unnecessary distress to families.

To achieve the main objective the aims of the policy are as follows.

1. Set accountabilities for staff/groups across the Trust.
2. Provide a standardised process based on the national guidance (including appropriate escalation) for reviewing and assessing deaths in a consistent and co-ordinated way and to establish a robust reporting framework throughout the Trust.
3. Define the criteria to select which deaths are reviewed through the implementation of a Medical Examiner role in the Trust.
4. Identify areas of phases of care that are poor and those that are excellent. This policy aims to ensure that gaps are monitored, and good practice is shared and where necessary issues are escalated appropriately.
5. Provide assurance to the Mortality Review Group (MRG), that mortality reviews are robustly undertaken, and the learning is captured and shared across the Trust.
6. Define links with the Duty of Candour and signpost processes on how to engage with bereaved families.
7. To identify and implement quality improvement plans where care/services can be improved.

Key words for intranet searching purposes	Mortality, learning, death certification, medical examiner, mortality reviewer, bereavement, scrutiny
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g., contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is high risk, it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**Yes / No (delete as appropriate)** If Yes include the following sentence and relevant information in the Intended Recipients section above – In the event that this is policy is made available to the public the following information should be redacted:

Part B **Ratification Assurance Statement**

Name of document:

Name of author: Sue Hickman Job Title: Compliance Manager

I, Sue Hickman the above named author confirm that:

- The ~~Strategy~~/Policy/~~Procedure/Guidelines~~ (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines(OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document, and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: 

Date: 27 May 2022

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

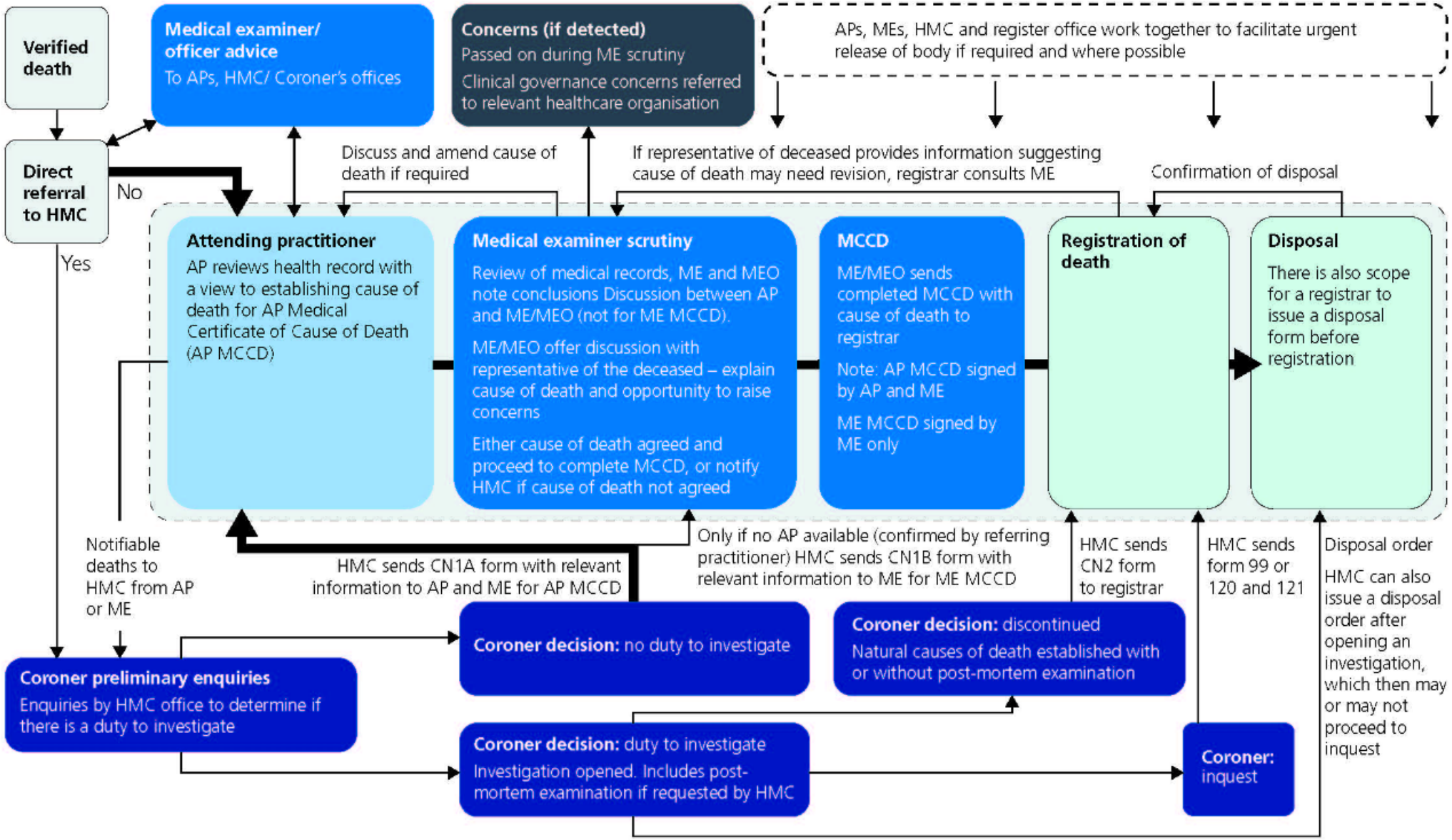
Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version	**Policy Title** **Death Certification & Learning from Death Policy**	
Reviewing Group	Mortality Review Group	**Date reviewed: May 2022**
Implementation lead: Print name and contact details		
Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.	N/a N/a	Flow chart included in policy.
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	N/a	Guide included in policy. Training for User guides available for LfD platform
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed	N/A	LfD Platform holds all information in relation to SJRs
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	Yes	Will be included in Trust Communications
Financial cost implementation Consider Business case development		
Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation		

Overview process for death certification



Key processes carried out by:

- AP (attending practitioner)
- Registration services
- HMC (HM Coroner's office)
- Medical examiner office: MEs (medical examiners) and MEOs (medical examiner officers)

Concerns – further action or review by relevant healthcare provider depends on nature of concern. Referral by ME/MEO to established clinical governance processes where appropriate

From 9 September 2024

The Royal Wolverhampton NHS Trust

Administration process in the event of a Death incorporating the Medical Examiner Service

Hospital death

Ward issue bereavement folder to relatives advising that they need to contact the Bereavement Centre the next working day between 10am and 4pm on 01902 695091.
Ward update PAS that the patient is deceased **(if out of hours this can be done via AMU staff)**
Ward sends deceased patient transfer form (top copy) with the patient to the Swan Suite (bottom copy filed in patient notes)
Skinny file to be standardised as per OP07 and contain correct skinny file label- Ward must track on PAS.
Ward doctor completes Summary of Death (SOD) form and places within skinny file, identifying a Qualified Attending Practitioner (QAP) who can complete the Medical Certificate of Cause of Death (MCCD). For deaths in the Emergency Department the SOD form can be emailed to rwh-tr.bereavement-centre@nhs.net

Patient received into Swan Suite. Swan Suite send email to the Bereavement Centre at 9am and 3pm with a list of deceased patients that have arrived in their care.

Patient Skinny file **must** be taken to Bereavement Centre by the ward staff as soon as possible, **no later than 10am the next working day.**

Relatives contact Bereavement Centre and are advised of next steps and to provide contact details. Relatives are asked if they are planning a cremation or burial and if they have chosen a funeral director.

Bereavement Officer records deceased patient on NHS spine

Bereavement Officer identifies QAP from SOD form and any eligible doctors who have attended the patient from the patient's file and sends an email to all to request that a doctor attends the Bereavement Centre to meet with the Medical Examiner (ME) as soon as possible (and **no later than 3 working days after the patient's death**). Emails copied to LfD Platform. Bereavement Officer escalates delays as per local escalation procedure. ME Office submit Datix if delayed.

Coroner decision not to investigate- HMC sends CN1a form.

Doctor has discussion with ME Service and agree to issue the MCCD or advise the QAP to refer to the coroner. ME advice section completed on SOD form and ME scrutiny/assessment completed on LfD for non-coronial deaths.

Coroner decision to investigate.

Skinny file tracked and sent to scanning.

QAP completes MCCD, ME signs MCCD.

Bereavement Officer emails the completed MCCD to Wolverhampton Register Office: register.office@wolverhampton.gov.uk (including the relatives contact details in the email)

ME Service contacts the patient's relative to explain cause of death and discuss any concerns. Relative is informed to make a face-to-face appointment to register the death at Wolverhampton Register Office on their website:

https://www.wolverhampton.gov.uk/births-marriages-and-deaths/register-birth-or-death/register-a-death

Or on 01902 551234

Send skinny file to scanning department within 48 hours of receipt of file – skinny file returned same or next day.

Bereavement Officer updates MCCD section on LfD IT Platform and GP notification is sent.

Patient released to Funeral Director

Bereavement Officer completes patient on LfD Platform

ME Service raises any concerns in care for escalation and highlights case for SJR if required.
Discussion with relatives is documented by ME Service either in ME assessment or on the Bereavement Centre Dashboard on LfD IT Platform

For out of hours bereavement process for Rapid Release of Deceased Patients please see separate process in OP87

Summary of Death

This form must be completed by the attending doctor after discussing with the consultant independently to the review by the Medical Examiner. Section 4 **must** be completed so that a record of the attending doctor's (team) view on the primary cause of death is recorded to ensure transparency of the process.

URGENT Faith Burial?
Yes ☐ No ☐
(Please refer to OP87)

1.	**Name of deceased person and the date, time, and location of death**	
	Full Name:	
	Hospital Number:	Ward:
	Date & Time of death: / / at:	
	Consultant:	
2.	**Have you seen the patient before death and able to issue the Medical Certificate of Cause of Death (MCCD)?** Yes ☐ No ☐ If no, please provide the name and GMC number of an Attending Dr able to complete the MCCD: Name…… GMC number ……... **(to be eligible to issue a MCCD the doctor must have attended the patient during their life)**	
3.	**Synopsis of circumstances, medical history and preliminary view of the cause of death** *This information is to provide information to support your proposed cause of death or referral to the coroner. Please include information regarding any concerns raised*	

Previous Medical History -

4.	**Cause of Death**
1a	……
1b	……
1c	……
1d	……
2	……

5. Could this admission have been avoided if appropriate out-of-hospital/community support/service was available? Yes ☐ No ☐
6. Do you have any concerns about the quality of care this patient received? Yes ☐ No ☐
7. Was the death unexpected (natural death occurring suddenly and earlier than anticipated)? Yes ☐ No ☐

8. Decision and action

☐ I feel able to complete the MCCD with no need for coroner referral *(Only valid for a doctor that attended the deceased)*

☐ I feel this case requires referral to the coroner for further action for the following reason (discuss with Medical Examiner before informing the coroner).

- ☐ The death was due to poisoning including by an otherwise benign substance
- ☐ The death was due to exposure to, or contact with a toxic substance
- ☐ The death was due to the use of a medicinal product, the use of a controlled drug or psychoactive substance
- ☐ The death was due to violence, trauma or injury
- ☐ The death was due to self-harm
- ☐ The death was due to neglect, including self-neglect
- ☐ The death was due to a person undergoing any treatment or procedure of a medical or similar nature
- ☐ The death was due to an injury or disease attributable to any employment held by the person during the person's lifetime
- ☐ The person's death was unnatural but does not fall within any of the above circumstances
- ☐ The cause of death is unknown
- ☐ The registered medical practitioner suspects that the person died while in custody or otherwise in state detention
- ☐ There was no attending registered medical practitioner, and there is no other registered medical practitioner to sign a medical certificate cause of death in relation to the deceased person
- ☐ The attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death
- ☐ The identity of the deceased person is unknown
- ☐ Other (please detail) _

9. Medical practitioner's name and contact details

Full name *(print)*: ______________________________ GMC No.: ____________

Designation: ____

Location/department: ____

Personal phone/bleep No.: ____________ Alternative/out-of-hours contact No.: _________

Signature: ____Date: __ / __ / ___

*The Doctor signing this form must either place it in the patient's notes or email it to the Bereavement Centre rwh-tr.bereavement-centre@nhs.net An eligible doctor must then attend the Bereavement Centre at the earliest opportunity to discuss the patient with the Medical Examiner and complete the Medical MCCD/ Coroners referral if applicable. Medical Examiner Office Hours- Monday to Friday 09:00-17:00 contact on **EXT 85091**

For urgent faith burials **out of hours** please email this form to rwh-tr.medicalexaminerservice@nhs.net and refer to OP87 for Rapid Release procedure. Out of hours Medical Examiner available weekends and Bank Holidays (excluding Christmas Day and Easter Sunday) 09:00-11:00 for **urgent faith burials only** (available via switchboard)

10. Advice from Medical Examiner Service *(To be completed by Medical Examiner's office)*

Spoken with: _________________________ Date and time: __/__/__ at ______

Notes:

____

____

____

____

Outcome:

____

____

____

Name of Medical Examiner/Medical Examiner Officer ____________________________

Signature ______________

Stamp _______________

Authorisation for the Rapid Release of a Deceased Person from the Ward or Swan Suite (out of hours)

Section 1 Doctor	**To be completed by the Doctor** Patient's name …… NHS number…… Ward…… Date of Death …… Time of Death…… Certificate number…… To the best of my knowledge and belief the above-named patient does not require referral to the coroner, and I am able to determine their cause of death. I can confirm that I have sent the required SOD form, patient records and MCCD to the Medical Examiner (ME). Name of Doctor: …….. GMC Number:…… Signature of Doctor…….
Section 2 Relatives	**To be completed by the relative (or other authorised person) who will be registering the death** I ……authorise …… To collect the body of …… From New Cross Hospital. I will register the death of the above-named person at the earliest opportunity. Relative's Name …… Relative's Telephone Number…… Relationship to deceased…… Address…… ……... Signature ……
Section 3 Funeral Directors/ Person collecting the body	**To be completed by the Funeral directors or family member receiving the deceased** Name of Funeral Directors/ family member …….. Address to which the deceased is to be taken to …… ……... Date …… Time…… Signature ……
Section 4 Nurse in charge/On call Manager	**To be completed by the Nurse in charge and on-call manager authorising Rapid Release** All sections above have been completed and I have discussed with the On-call Manager who has authorised the release of this patient. Name of On-call Manager…… Name of Nurse in Charge…… Designation …… Signature …… Stamp…… Date…… Time……
Section 5 Medical Examiner (ME)	**To be completed by the Medical Examiner** Name of the ME…….. GMC Number…… Signature of ME …….. Date and time countersigned MCCD emailed to Register Office ……..

Please ensure Care After Death (NCP-01) is undertaken prior to the patient being transferred into the care of the funeral director/family.

Out of Hours Rapid Release Procedure for urgent faith burials.

- It is a legal requirement that all non-coronial deaths must be reviewed by a Medical Examiner (ME), or they cannot be registered. Any doctor who has looked after the Deceased at any time during their life, and who can offer a cause of death to the best of their knowledge and belief, will be eligible to complete the MCCD (Medical Certificate of the Cause of Death).
- Some faith traditions require the deceased person to be buried as soon as possible after death. If urgent faith burial is requested by family within the hours of 09:00-17:00 then please contact the Bereavement Centre on ext. 85091. The Rapid Release procedure only applies outside of these hours.
- There is a ME available on call between the hours of 09:00-11:00 on weekends and bank holidays (except for Christmas Day and Easter Sunday) to support the rapid release procedure for urgent faith burial. The ME can be contacted via Switchboard within these hours.
- The eligible doctor/ward team will be required to scan and email the patients notes to allow for the ME to provide proportionate scrutiny of the patient's notes.
- The eligible doctor will need to complete the MCCD (available in the Bereavement Centre (C51), which will need to be scanned and emailed to the ME once completed on rwh-tr.medicalexaminerservice@nhs.net
- The completed MCCD must be countersigned by an ME before it is sent to the Registrar of Deaths by the ME.
- The family will be contacted by the ME to discuss the cause of death, and the family will be asked to contact Wolverhampton Register Office, therefore please ensure the contact details of the NOK are also included in the email to the ME.
- If the ME is unavailable, and there is an eligible doctor able to determine a natural cause of death for the patient, and no coroner's referral is required, then the patient can still be released into the care of the funeral directors/family once the patient notes, summary of death (SOD) form and MCCD is emailed to the ME. The ME will then need to be contacted via Switchboard at the next available opportunity (i.e. 09:00 the following morning). Please refer to below information relating to deaths requiring notification to the coroner.

Notification of Deaths requirements (Ministry of Justice, 2022)

A death under the circumstances set out as follows should always be notified to the coroner. If the below applies the patient will be required to be transferred into the care of the SWAN Suite pending Coroners permission to release the patient, and the rapid release policy can not be applied.

- The death was due to poisoning including by an otherwise benign substance
- The death was due to exposure to, or contact with a toxic substance

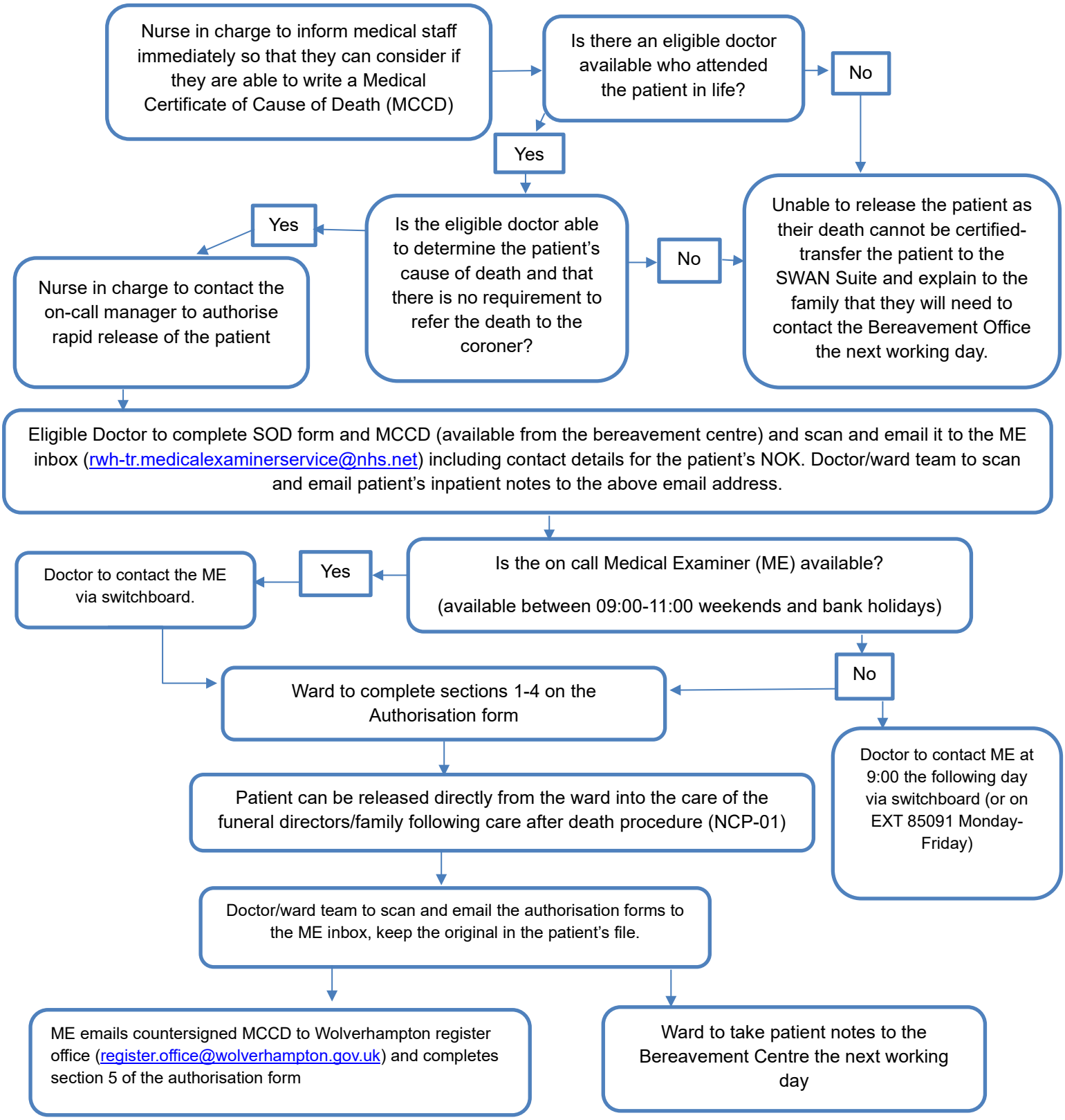
- The death was due to the use of a medicinal product, the use of a controlled drug or psychoactive substance
- The death was due to violence, trauma or injury
- The death was due to self-harm
- The death was due to neglect, including self-neglect
- The death was due to a person undergoing any treatment or procedure of a medical or similar nature
- The death was due to an injury or disease attributable to any employment held by the person during the person's lifetime
- The person's death was unnatural but does not fall within any of the above circumstances
- The cause of death is unknown
- The registered medical practitioner suspects that the person died while in custody or otherwise in state detention
- There was no attending registered medical practitioner, and there is no other registered medical practitioner to sign a medical certificate cause of death in relation to the deceased person
- The attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death
- The identity of the deceased person is unknown

If unsure then please refer to the guidance for medical practitioners: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1062499/registered-medical-practitioners-notification-deaths-regulations-25-march-2022.pdf

The Royal Wolverhampton NHS Trust

Out of Hours Rapid Release Flow Chart

- This procedure applies **out of hours only**
- This procedure only applies for urgent faith **burials**
- This procedure only applies to deaths **not** reportable to the coroner



Authorisation for the Rapid Release of a Deceased Person from the Ward or Swan Suite (out of hours)

Section 1 Doctor	**To be completed by the Doctor** Patient's name …… NHS number…… Ward…… Date of Death …… Time of Death…… Certificate number…… To the best of my knowledge and belief the above-named patient does not require referral to the coroner, and I am able to determine their cause of death. I can confirm that I have sent the required SOD form, patient records and MCCD to the Medical Examiner (ME). Name of Doctor: …….. GMC Number:…… Signature of Doctor…….
Section 2 Relatives	**To be completed by the relative (or other authorised person) who will be registering the death** I ……authorise …… To collect the body of ……. From New Cross Hospital. I will register the death of the above-named person at the earliest opportunity. Relative's Name …… Relative's Telephone Number…… Relationship to deceased…… Address…… …….. Signature ……
Section 3 Funeral Directors/ Person collecting the body	**To be completed by the Funeral directors or family member receiving the deceased** Name of Funeral Directors/ family member …….. Address to which the deceased is to be taken to …… …….. Date …… Time……. Signature ……
Section 4 Nurse in charge/On call Manager	**To be completed by the Nurse in charge and on-call manager authorising Rapid Release** All sections above have been completed and I have discussed with the On-call Manager who has authorised the release of this patient. Name of On-call Manager…… Name of Nurse in Charge…… Designation …… Signature …… Stamp…… Date…… Time……
Section 5 Medical Examiner (ME)	**To be completed by the Medical Examiner** Name of the ME…….. GMC Number…… Signature of ME …….. Date and time countersigned MCCD emailed to Register Office ……..

Please ensure Care After Death (NCP-01) is undertaken prior to the patient being transferred into the care of the funeral director/family.

The Royal Wolverhampton NHS Trust

Guidance on the completion of a death certificate following a diagnosis of Clostridium difficile

1.0 Overview

1.1. Medical staff have a legal duty under The Health and Social Care Act: Code of Practice for the Prevention of Healthcare Associated Infection (2008 rev. 2012) to record Clostridium difficile infection (CDI) on a death certificate if it was part of the sequence of events leading to, or contributing to the death of a patient.

2.0 Guidance for death certification

2.1 All cases where CDI is intended to be recorded in Part 1 of a death certificate must be discussed with a Consultant Microbiologist prior to doing so.

2.2 If a patient with CDI dies, the death certificate must state whether CDI was part of the sequence of events which led to the death or whether it was the underlying cause of death. If either case applies this must be recorded on part 1 of the death certificate.

2.3 If CDI was not part of the sequence of events leading directly to death but contributed in some way to, this must be recorded on the death certificate in Part 2.

2.4 If any doctor completing the death certificate is in doubt of the contribution of CDI to the death they must discuss this with either a Consultant Gastroenterologist or Microbiologist.

Death Occurs in hospital

Summary of Death notification

- To be undertaken for all hospital deaths
- Completed by certifying doctor/team
- Discussion with consultant
- Informs ME and death certification process

Urgent body release (MCCD issued)

NB: Out of Hospital Deaths (Death Occurs post 30 days of discharge)

Primary Care Review
**** Identifies criteria***

Medical Examiner Review

- **Proportionate case note review**
- **Discussion with relatives**
- **Scrutiny and Death Certification**

Outcome after ME review

- SJR Review* → Add to Mortality Review Worklist
- Incident reporting refer Governance process → See below
- **Specialised review process**
  Child Death Overview Panel (CDOP)
  LeDER programme
  MBRRACE Review
  Maternal Deaths
- Referral to PaLS process instigated
- No concern → No further action required.

Criteria for Structured Judgement Review (adults) by Mortality Reviewers

- Elective admission
- Mental Health ICD code*
- Unexpected deaths* (e.g., Cardiac Arrest)
- LD deaths*
- Autism flag deaths*
- DATIX incident (exc. Pressure Ulcer & Falls incidents[1])
- 20% Random selection (In Hospital Deaths)
- 10% Random selection (Community Deaths) *
- HACI[2] Covid Deaths
- Deaths with low mortality risk
- Directorate request/ Primary Care request*

where scope for potential for learning is identified.

Outcome after SJR Completed by Mortality Reviewers

SJR Overall Care outcome:
1 - very poor
2 - poor care

Incident reporting if applicable → Governance process to determine SUI reporting → RCA undertaken for Serious Untoward Incidents → 'Problem in Care' judgement and RCA outcomes reviewed by MRG

Feedback given to Directorate Mortality Lead/Speciality

Departmental M&M meetings
- Review and discuss findings from SJRs and investigations
- Implement actions to address problems in care
- Identify themes/QI opportunities

Directorate Gov Mtgs
Report findings/actions and monitor actions to closure

Divisional oversight through Quality/ Performance meetings

SJR stage 2
1. SJR Quality Assurance (Random 5% of SJRs)
2. Requested by Mortality reviewer
3. Manage disagreement (MR/Dir)

Learning – Reported to Mortality Review Group – capture on Learning from Death Platform to identify Themes for QI Opportunities/Learning

1 Pressure Ulcer and Falls incidents are scrutinised through weekly meetings: Pressure Ulcer Lessons Learnt Agreement (PULLA) & Falls Accountability.
2 Health Care Acquired Infection (HCAI) due to Covid i.e., those deaths where Covid identified as Part 1a/1b or 1c of death certification and meet the national criteria for HCAI.

Community Medical Examiner and Mortality Review Standard Operating Procedure for the RWT PCN

1.0 Strategic Aim

This document provides a foundation for the Royal Wolverhampton NHS Trust (RWT) to undertake Medical Examiner scrutiny of deaths that occur in the community and following Medical Examiner scrutiny a specific criterion has been set for Mortality Reviews to be undertaken for deaths that occurred in the community. The aim is to roll-out the current Learning from Deaths process out into the community for on-going surveillance, review and to provide assurance regarding the quality of care provided. This process will also support identifying learning to further improve the quality of care provided to patients.

1.1 Background

At present all in hospital deaths are subject to Medical Examiner scrutiny. Medical Examiners undertake early scrutiny of hospital deaths (with the exception of where early release is required and deaths post 30 days of discharge) and complete an assessment form. The Medical Examiners refer appropriately where further action is required e.g. to the Coroner, PALs with concerns or for detailed Structured Judgement Review (SJR) case note reviews. Medical Examiners actively engage with Doctors completing MCCD to review and agree the case of death. Medical Examiners and Bereavement Nurses / Medical Examiner Officers actively engage and supported bereaved families and carers to identify any causes for concern.

Following Medical Examiner scrutiny, the Mortality Review process commences. Mortality Reviewers undertake SJRs of selected deaths as per an agreed criterion and the process is set-up to ensure that the reviews are independent. Mortality Reviewers conduct reviews within the timescale agreed using the SJR methodology to identify learning (areas for improvement and good practice) for each of those reviews. Mortality Reviewers also undertake reviews of selected deaths for quality assurance purposes as per the agreed criteria.

In September 2020, Wolverhampton along with other CCGs within the Black Country STP undertook Mortality Reviews for community deaths during the peak of the first wave of the Covid-19 pandemic. The process was established locally and reviews were completed over a short period of time. The findings of the mortality reviews were presented to the STP Clinical Leadership Group where the learning from mortality review of community deaths was endorsed with a view to establish such a review process on a more permanent basis.

In June 2021, NHS England and Improvement informed all NHS Trusts that the current Medical Examiner scrutiny undertaken for all in hospital deaths would be rolled out into the community in order for all deaths in Wolverhampton to undergo medical examiner scrutiny.

In response, RWT have developed a pilot to be undertaken at the RWT Primary Care Network (PCN) for Community Medical Examiner Scrutiny and Mortality Reviews for all deaths which take place at the following GP practices that form the RWT PCN:

- Alfred Squire Medical Practice
- Lea Road Medical Practice
- Warstone Health Centre
- Coalway Road Surgery
- Penn Manor Medical Centre

- Thornley Street Surgery
- West Park Surgery
- Dr Fowlers Surgery (Oxley)

This is to ensure there is a consistent approach for reviewing deaths across Vertically Integrated practices in Wolverhampton and subsequent learning is actioned. The principle aim is to learn from aspects of care that could have been improved even when the death was inevitable to identify areas of good practice and achieve the following outcomes:

- Improving quality of care and safety across the health economy
- Improving end of life pathways

1.2 Scope

Initially the pilot for Medical Examiner scrutiny and Mortality Reviews will be undertaken with the RWT PCN. The aim is to extend the process based on the learning from the pilot. The STP Learning from deaths group is currently undertaking a scoping exercise to establish a standardised review process across the STP that the pilot will inform.

2.0 Medical Examiner Process for Assessment and Outcomes of Assessment

Outline of the process detailed in **Appendix 1 for Medical Examiner Assessment and Appendix 2 for Outcomes of Medical Examiner Assessment**

Essentially, Medical Examiner's Office will be notified of all community deaths by the GP practices. Similar to hospital deaths Medical Examiner will support the death certification process for non-coronial deaths and will help identify deaths that require reporting to the Coroner's office. In addition, Medical examiner will contact the bereaved family/NOK and based on proportional scrutiny of records determine of deaths should be subject to more detailed mortality review**.**

2.1 Mortality Review Process - Selection of deaths to review

When patients die in the community, these deaths are recorded on the EMIS system. The Governance Administrators will identify the deaths that have occurred within the community.

The community mortality review selection criteria applied will be as follows:

1. Deaths identified by Medical Examiners after initial scrutiny
2. Learning Disability deaths
3. Deaths in people with Significant Mental Health issues (excluding suicidal deaths)
4. Deaths where bereaved families / carers or staff have raised concern
5. Unexpected death
6. Deaths where primary care team identify scope for potential for learning
7. 5-10% random selection of deaths that have occurred within the community

Mortality Reviewers will be able to access GP systems to undertake SJR reviews for deaths which occur within the community. If care home records are required then the relevant agreements and processes will need to be put in place to gather this information.

The Royal Wolverhampton NHS Trust Governance Administrators will provide administration support in the allocation of reviews to mortality reviewers and ensure all required care records are available for the review to take place.

Mortality Reviewers will have access to the EMIS GP Practice system which is auditable therefore reviewers will only be accessing the patient record for the case they are reviewing.

2.2 Mortality Reviewers

The identified cases that require review will be allocated to individual Mortality Reviewers by the Governance Administrator.

The team of mortality reviewers will consist of;

- Primary Care Physicians (GPs)
- Advanced Nurse Practitioners

Mortality reviewers within the Royal Wolverhampton NHS Trust will have undertaken SJR training, however, for Primary Care Physicians who are new to the process orientation/introduction to the process and the use of the mortality review template will be provided. The session will be provided by a consultant from The Royal Wolverhampton NHS Trust who helped oversee the introduction of the SJR process in the acute setting. The session will include how to approach a review using SJR methodology and accessing various records.

2.3 Undertaking Mortality Reviews

During the review, mortality reviewer(s) will

- Undertake review of selected deaths as per the agreed criteria on patients who have not been in their care to ensure independent and objective view
- Reviewers should look at the last three months care provided and beyond if required to identify learning
- Conduct reviews within timescale agreed using the designated tool/proforma **(Appendix 5)**
- Undertake review using available documented information and have option of requesting second reviewer (if needed)
- It is anticipated that 1-1.5hours is sufficient to undertake a mortality review. However, in exceptional circumstances this may be longer due to complexity of the case.

Following the mortality review,

- Reviewers should identify learning (areas for improvement and good practice) and learning should be shared with primary care practice and other relevant teams involved in the patient care
- In cases where overall care is deemed very poor or poor, primary care (or relevant team) should identify learning and actions to address problem/s in care.
- Incident reporting via existing governance structures (where relevant)

The Governance Administrator will facilitate in the collection and retrieval of relevant care records to be available for the mortality reviewer and will monitor timely completion of the mortality reviews.

All reviews will be held securely in Sharepoint.

2.4 Learning & Sharing

Following mortality reviews, reviewers should identify learning (areas for improvement and good practice) and learning should be shared with primary care practice and other relevant teams involved in the patient care. In cases where overall care is deemed poor or very poor, primary care (or relevant team) should identify learning and actions to address problem/s in care.

All reviews and associated analysis will be stored on a secure IT network at the Royal Wolverhampton NHS Trust for 2 years.

Thematic review and analysis of all mortality reviews should be completed with outcomes reviewed at the RWT Mortality Review Group.

2.5 Governance Processes and Structure (Appendix 4)

Mortality Review Group (MRG) based at RWT has robust governance set-up and will provide oversight for mortality review of community deaths. MRG in turn reports to trust compliance and monitoring committees including TMC and Trust Board**.**

All deaths where overall care is deemed poor or very poor, identified by the mortality review process will be presented at MRG and learning identified will be shared.

2.6 Data Protection Act 2018

Whilst the Data Protection Act 2018 does not apply to patient records to be shared as part of this process, the common law of confidentiality applies and records will be shared in line with these requirements and relevant guidance (including the GMC guidance on managing and protecting confidential patient information).

Sharing of confidential information is justified for the following purposes: -

- Disclosure is justified in the public interest to protect others from a risk of death or serious harm
- For public health surveillance
- When it is necessary to support the reporting or investigation of adverse incidents, or complaints, for local clinical audit, or for clinical outcome review programmes.

2.7 Data Sharing

Data sharing agreements will be signed by each practice within the RWT PCN. Further, The Royal Wolverhampton NHS Trust and the multiple care providers is also in line with the principles outlined in the notice issued under the Control of Patient Information Regulations relating to Covid-19 (Covid-19 Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002). All records held will be destroyed after 3 months.

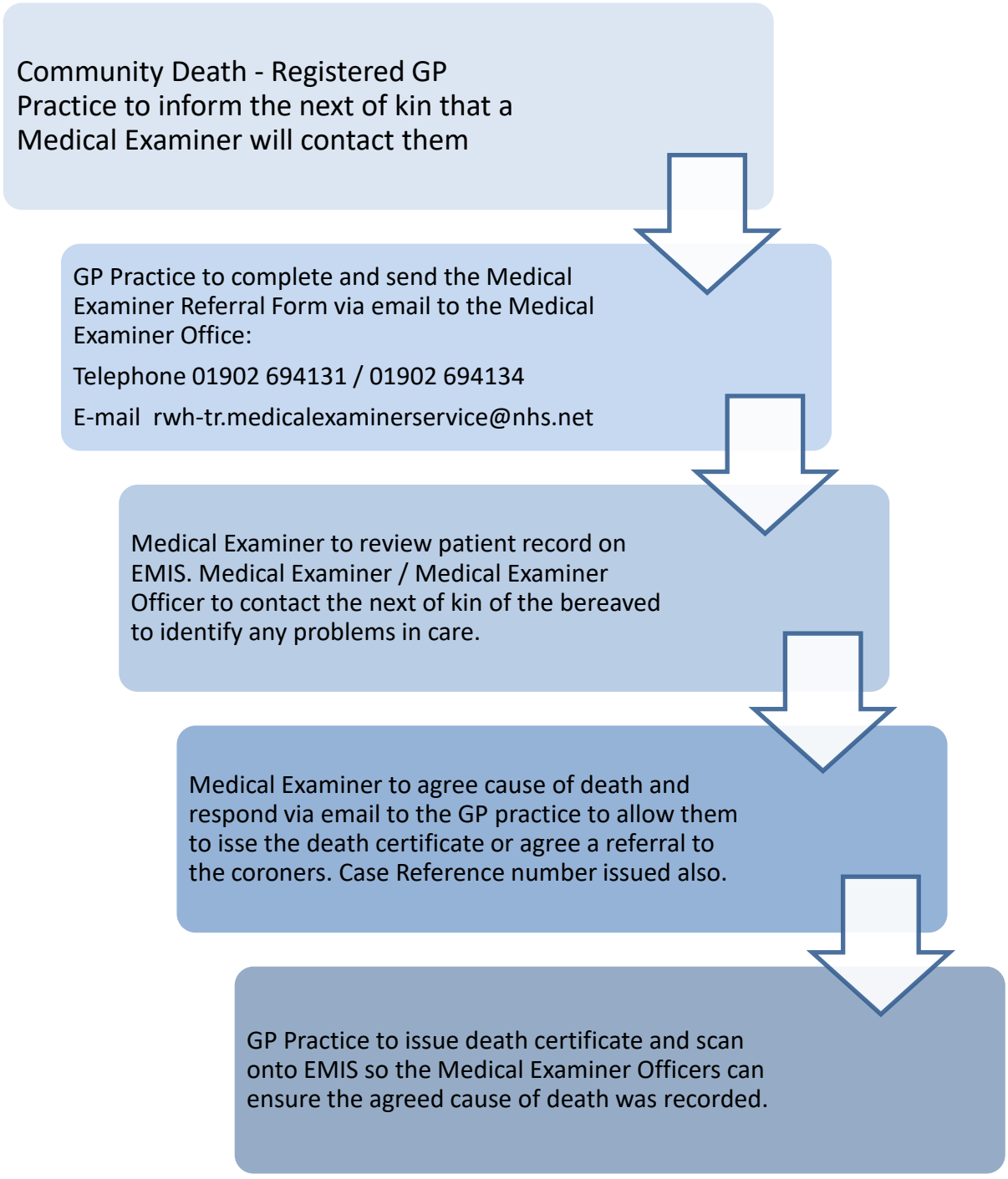
2.8 Safe Guarding

Safeguarding concerns that have not previously been identified should be reported via the local process which can be found at https://www.WOLVERHAMPTONsafeguarding.org.uk/index.php/safeguarding-adults/i-work-with-adults-with-care-and-support-needs/recognising-abuse

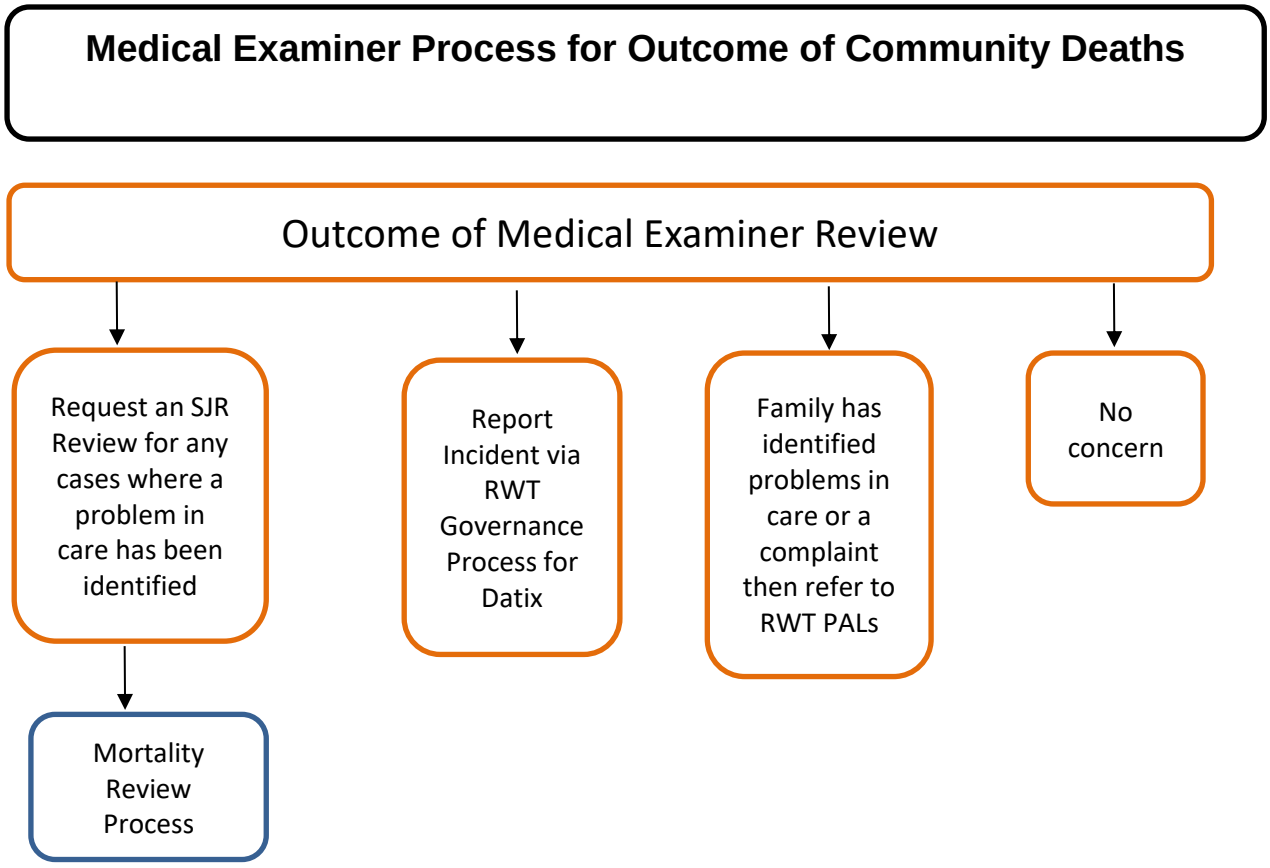
Oversight of all reviews and outcomes should be monitored via the RWT Mortality Review Group

Appendix 1

Medical Examiner Process for Assessment of Community Deaths



Appendix 2


Medical Examiner Process for Outcome of Community Deaths
Outcome of Medical Examiner Review
Request an SJR Review for any cases where a problem in care has been identified
Mortality Review Process
Report Incident via RWT Governance Process for Datix
Family has identified problems in care or a complaint then refer to RWT PALs
No concern

Appendix 3

Mortality Review Process for Community Deaths

RWT PCN

Selection criteria for community mortality review:

1. Deaths requested by Medical Examiners after initial scrutiny
2. Learning Disability deaths
3. Deaths in people with Significant Mental Health issues (excluding suicidal deaths)
4. Deaths where bereaved families / carers or staff have raised concern
5. Unexpected death
6. Deaths where primary care team identify scope for potential for learning
7. 5 % random selection of deaths that have occurred within the community

Mortality Reviewers:
Team of mortality reviewers to consist of;

1. Consultants
2. Nurses
3. Primary Care Physicians (GPs)

Mortality review:

1. Selected cases allocated to mortality reviewer
2. Mortality review completed using agreed template based on SJR methodology on Sharepoint.
3. Each death allocated to one reviewer who has option of requesting second reviewer (if needed)
4. Mortality reviewer ideally should not be the health care worker routinely involved in the care of the patient for an independent and objective view.
5. Mortality review is not an 'investigation' and should be undertaken with available documented information.

Outcome:

1. Following mortality review, the outcome and learning should be shared with primary care practice and other relevant teams.
2. Where overall care is deemed poor or very poor, primary care (or relevant team) should identify learning and actions to address problem/s in care.
3. Incident reporting via existing governance structures (where relevant)

Learning & Sharing:

1. All reviews should be stored in a secure place at RWT
2. In cases where overall care is deemed poor or very poor, primary care (or relevant team) should identify learning and actions to address problem/s in care.
3. Thematic review and analysis of all mortality reviews
4. Outcome of mortality reviews/thematic analysis reviewed at RWT Mortality Review Group (MRG).

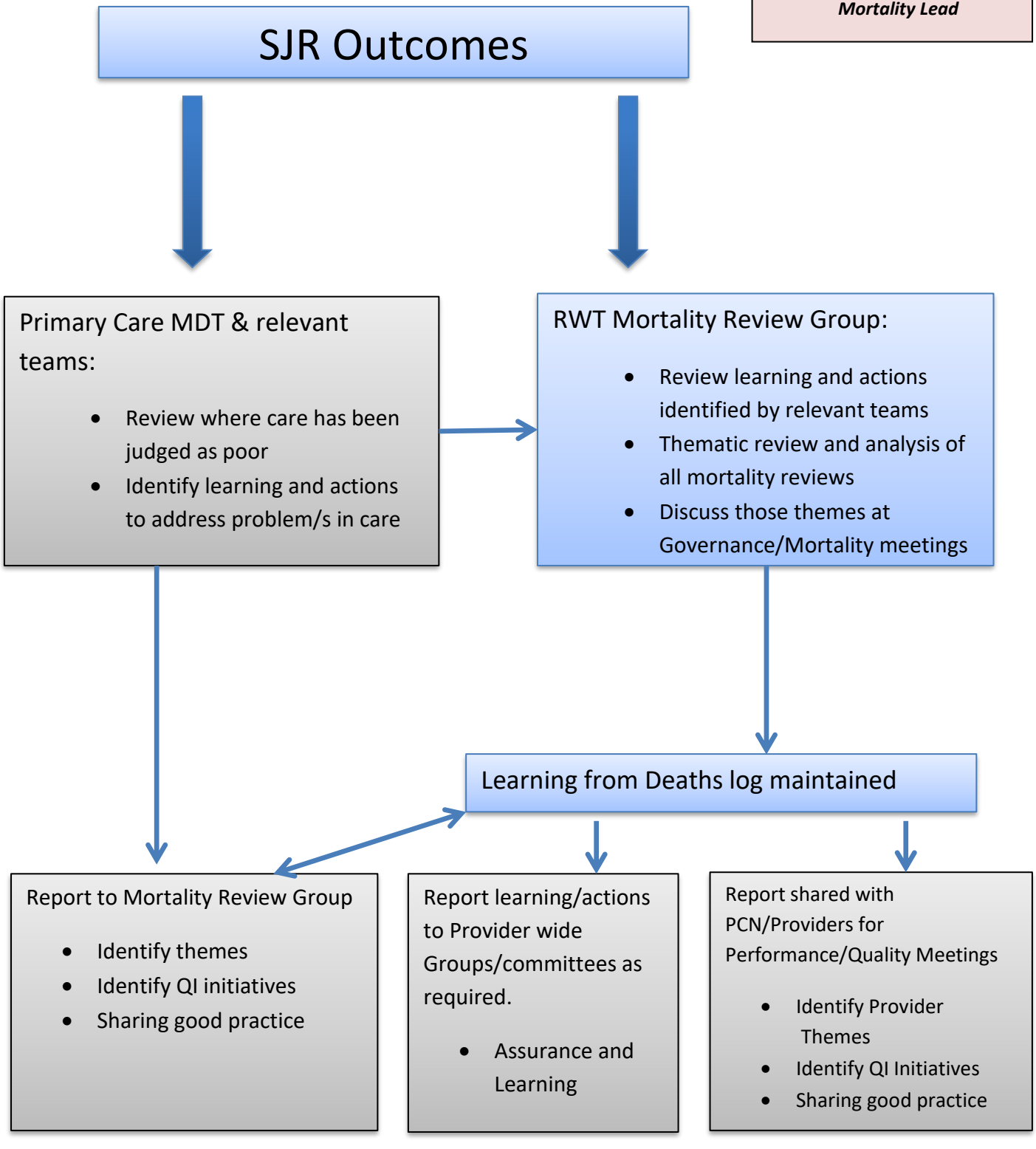
Appendix 4

Mortality Reviews – Sharing the Learning

Governance Structure

RWT Mortality Review Group

- ***CMO***
- ***Mortality Lead***
- ***Lead Medical Examiner***
- ***Governance***
- ***Directorate / PCN Mortality Lead***



Appendix 5

Mortality Review Template- Community Death

Patient ID:

Demographic details:

Age……Gender……..Ethnicity: ……

Primary care practice details:……

Date of Death: …… Place of deaths:……

Date of discharge (if <30 days): Hospital/directorate……

Date of review:

Reviewer 1 ……..(Designation)……

Reviewer 2……..(Designation)……

Indication for Mortality Review : (please select)

- ☐ Death where bereaved families/carers or staff have raised significant concern about the quality of care provision (complaint/DATIX)
- ☐ Death in person with Significant Mental Health issues
- ☐ Unexpected death (death occurring rapidly and earlier than anticipated)
- ☐ Death identified by Medical Examiner
- ☐ Deaths in person with Learning disability
- ☐ Deaths where primary care team identify scope for potential for learning
- ☐ Random sample of 5 % of deaths

Cause of death:

1a……

1b……

1c……

Was recorded cause of death reasonably accurate (given the available information):

Yes ☐ No ☐

Additional Information:

EOL practice register: Yes/No

Advanced care plan in place: Yes/No

DNACPR: Yes/No

Community Specialist Palliative care team involvement: Yes/No

Safeguarding concerns: Yes/No

Assessment of care:

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

A. End-of-Life care (if applicable)

(Free Text box for explicit comments) Please rate the care received by the patient during this phase. **1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care**

B. Care provision by Primary Care team (if applicable)

(Free Text box for explicit comments) Please rate the care received by the patient during this phase. **1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care**

C. Care provision by Community team (if applicable)

(Free Text box for explicit comments)

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

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

D. Care provision in Care Homes(if applicable)

(Free Text box for explicit comments)

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

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

E. Assessment of Overall Care

(Free Text box for explicit comments)

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

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

Assessment of problems in healthcare

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

A. Were there any problems with the care of the patient? (Please tick)
No (please stop here) **Yes** (please continue below)

B. Did the problem lead to harm**? No/Uncertain/ Yes**

Problem types

1. Problem in assessment, investigation or diagnosis**: Yes/ No**
2. Problem with medication*:* **Yes/ No**
3. Problem related to treatment and management plan (including transfer to hospital): **Yes/ No**
4. Problem with infection management: **Yes/ No**
5. Problem with hospital discharge**: Yes/ No**
6. Problem in clinical monitoring: **Yes/ No**
7. Problem in escalation and resuscitation (where indicated): **Yes/ No**
8. Problem of any other type not fitting the categories above *(including communication and organisational issues)* **Yes/ No**

Areas of good practice:

(Free Text box for comments)

Learning identified

(Free Text box for comments)

Outcome:

- ☐ No further action
- ☐ Incident Reporting (governance process)
- ☐ Feedback:
  - Feedback to Discharging team (hospital): Y/N Comment (free text)
  - Feedback to Community team: Y/N Comment (free text)
  - Feedback to Primary care practice: Y/N Comment (free text)
  - Feedback to Care Home: Y/N Comments (free text)

(Free Text box for comments)

Quality of clinical records:

- ☐ Records were adequate to make reasonable judgement
- ☐ Some deficiency
- ☐ Major deficiency

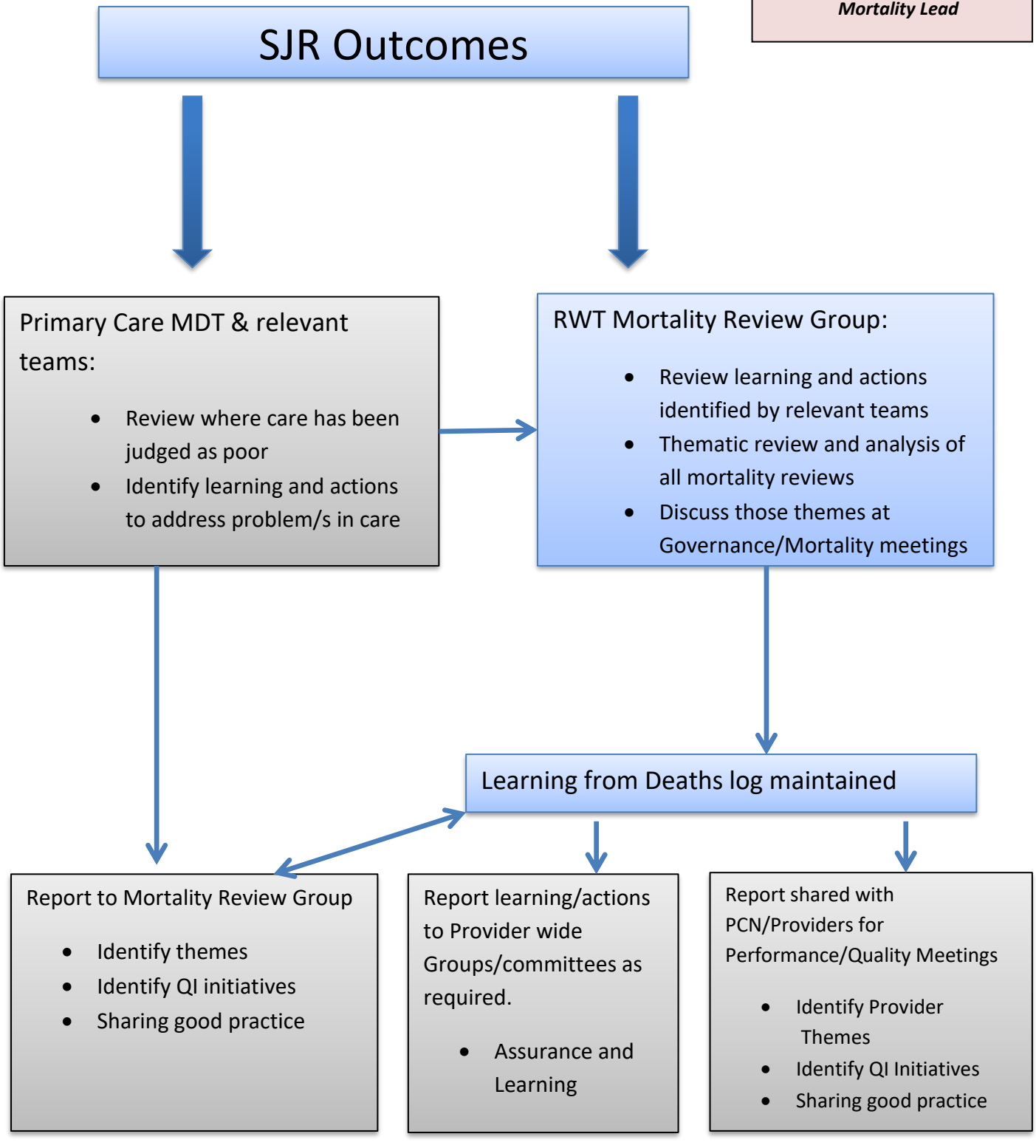
Appendix 4

Mortality Reviews – Sharing the Learning

Governance Structure

RWT Mortality Review Group

- ***CMO***
- ***Mortality Lead***
- ***Lead Medical Examiner***
- ***Governance***
- ***Directorate / PCN Mortality Lead***



The Royal Wolverhampton NHS Trust

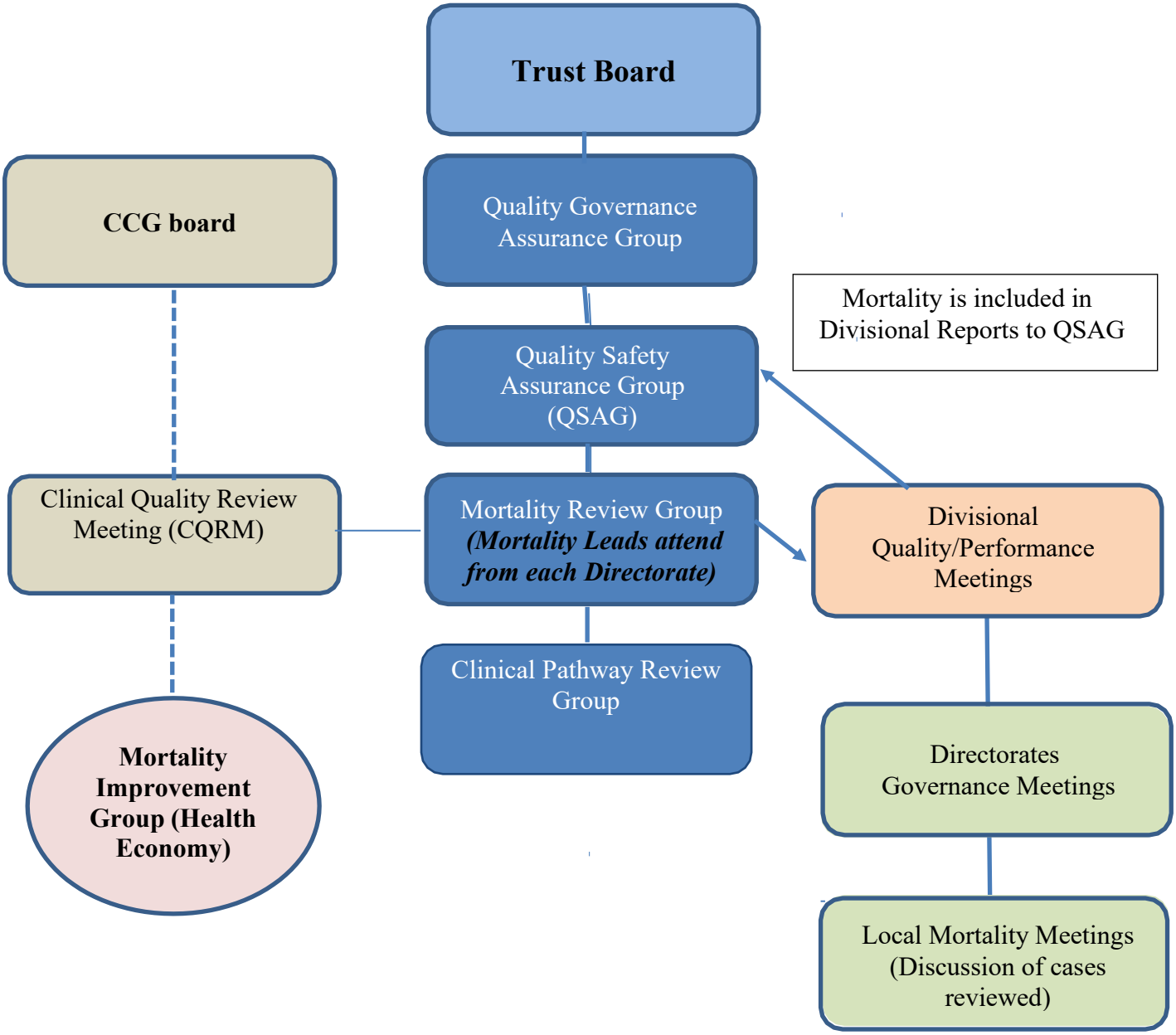
Mortality Review Structure

Summary of Death notification	Medical Examiners	Mortality review	Investigation	Specialised Mortality Review
• To be undertaken for all hospital deaths • Completed by certifying doctor/team • Discussion with consultant • Informs ME and death certification process	• Quality assurance of death certification • Liaison with HMC office • Discussion with bereaved families • Proportionate scrutiny of records • Identify deaths for SJR review	• SJR methodology • Case note review • Independent and dedicated Mortality Reviewers • Multidisciplinary approach • Quality assured	• Root Cause Analysis • Serious incident framework • Systematic analysis of what, how and why? • Identify changes to reduce future risks • Execs scrutiny and approval	• LeDeR programme • MBRRACE • Child Death review programme • Review of deaths within 30-Days of Systemic Anti-Cancer Therapy (SACT)

Screening ⇨ **Scrutiny** ⇨ **Review/** ⇨ **Investigation** ⇨ **Specialised**

Appendix 4.3b

Mortality Governance Structure



Key:
Internal Reporting
External Reporting

Royal College of Physicians

National Mortality Case Record Review Programme

Using the structured judgement review method

A guide for reviewers

(England version)

Supported by:

Improvement Academy
Part of the Yorkshire & Humber AHSN

Datix®
Software for patient safety

Commissioned by:

HQIP
Healthcare Quality Improvement Partnership

Dr Allen Hutchinson

Emeritus professor in public health
University of Sheffield

Date	Version number	Document owner	Review date
15 March 2017	One	Clare Wade – programme manager	September 2017

Structured judgement review

1 Background to the method and its strengths

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, review methods need to be standardised, yet not rigid, and usable across services, teams and specialties.

Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.[1] The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions.

Structured judgement case note review can be used for a wide range of hospital-based safety and quality reviews across services and specialties, and not only for those cases where people die in hospital. For example, it has been used to assess the care provided for people who have had a cardiac arrest in hospital, to review safety and quality of care prior to and during non-elective admission to intensive care settings and to review the care provided for people admitted at different times of the week.

An important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that has been judged to be problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

2 How the structured judgement review method works

2.1 Who does what and when?

There are two stages to the review process. The first stage is mainly the domain of what might be called 'front line' reviewers, who are trained in the method and who undertake reviews within their own services or directorates, sometimes as mortality and morbidity (M&M) reviews, sometimes as part of a team looking at the care of groups of cases. This is where the bulk of the reviewing is done and most of the reviews are completed at this point.

A second-stage review is recommended where care problems have been identified by a first-stage reviewer and an overall care score of 1 or 2 has been used to rate care as very poor or poor. This second-stage review is usually undertaken within the hospital governance process and normally uses the same review method. At this stage the hospitals may also choose to assess the potential avoidability of a death where harms due to care have been identified (see Section 4 below and *A clinical governance guide* (RCP 2016) associated with the review guide).

2.2 Phases of care – the 'structure' part of the method

The phase of care structure provides a generalised framework for the review and also allows for comparisons among groups of cases at different stages of care. The principal phase descriptors are shown in Box 1. However the use of the phase structure depends on the type of care and service being reviewed – not all phase of care headings will be used for any particular case. Thus the procedure-based review section may only be required in a few medical cases (eg a lumbar puncture, a chest drain or non-invasive ventilation) but are likely to be used in many surgical cases. It is up to the reviewer to judge which phase of care forms are appropriate in a particular case.

Box 1 Phase of care headings

- Admission and initial care – first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/ procedure care
- End-of-life care (or discharge care)*
- Assessment of care overall

*Note that discharge care is included because this method is just as applicable for the review of care for people who do not die during an admission.

2.3 Explicit judgement comments – the core of the method

The purpose of the review is to provide information from which teams or the organisation can learn. Explicit judgement commentaries serve two main purposes. First, they allow the reviewer to concisely describe how and why they assess the safety and quality of care provided. Second, they provide a commentary that other health professionals can readily understand if they subsequently look at the completed review.

When asked to write comments on the quality and safety of care, clinical staff often tend to write a resume of the notes or make an *implicit* critique of care. This is not helpful when others try to understand the reviewer's real meaning. So the central part of the review process comprises short, written, *explicit* judgement statements about the perceived safety and quality of care that is provided in each care phase.

This review guide does not include a glossary of explicit terms that reviewers might choose from, because this approach would inevitably be constraining or would fail to cover all eventualities in the complexities of clinical practice. Instead, reviewers are asked to use their own words in a way that explicitly states their assessment of an aspect of care and gives a short justification for why they have made the assessment.

Explicit statements use judgement words and phrases such as 'good', 'unsatisfactory', 'failure' or 'best practice'. See Box 2 and Box 3 for examples.

Box 2 Examples of phase of care structured judgement comments

- Continued omission to provide oxygen and respiratory support – poor care.
- Team still failed to discuss potential diagnosis with patient – unsatisfactory.
- Referral to intensive treatment unit (ITU) was too late.
- There was some evidence of good management by the overnight team, with prompt review and intervention.
- Although patient discussed with a consultant once and a specialist registrar (SpR) once, for 4 days they were only seen by junior doctors – this is completely unsatisfactory.
- Very good care – rapid triage and identification of diabetic ketoacidosis with appropriate treatment.

Additionally, these judgement words are accompanied by short statements that provide an explicit reason why a judgement is made – eg 'unsatisfactory because, etc' and 'for example, resuscitation and ceiling of treatment decisions made far too late in course of admission – poor care'. The purpose here is not to write long sentences but to encapsulate the clinical process in a few explicit statements.

Judgement comments should be made on anything the reviewer thinks is important for a particular case. Among other things, this will include the appropriateness of management plans and subsequent implementation together with the extent to which, and how, care meets good practice. In some cases, there may be care in a phase that has both good and poor aspects. Both should be commented on.

Commentary on holistic care is just as important as commentary on technical care, particularly where complex ceiling of treatment and end-of-life care discussions might be held. Judgements should be made on how the teams have managed end-of-life decision making and to what extent patients and their relatives have been involved. Thus, for example, a judgement comment might be couched as 'end-of-life care met recommended practice, good ceiling of treatment discussion with patient and family'. Similar approaches and levels of detail are required when care is thought not to have gone well, or where aspects of care are judged to be only just acceptable. Then words such as 'unsatisfactory', 'poor' or 'doesn't meet good practice standards' might be necessary.

Sometimes it is just not clear what has been happening during part of the process of care, where there appears to be a lack of decision making or guidance. Here, judgement words such as 'delay', 'poor planning' and 'lack of leadership' etc may be used. Or if this lack of clarity is due to the level of documentation, comments such as 'inadequate record keeping' may apply.

Overall, phase of care comments are intended to bring a focus to the review by asking for an explicit, clear judgement on what the reviewer thinks of the whole care episode, taking all aspects into consideration. It is not necessary to repeat all of what has been commented on before, although it is sometimes useful to repeat some key messages – that is a reviewer's choice. Again, however, it is important to make clear and explicit what the overall judgement is and why. Examples are given in Box 3.

Box 3 Examples of overall care structured judgement comments

- Overall, a fundamental failure to recognise the severity of this patient's respiratory failure.
- Good multidisciplinary team involvement.
- On the whole, good documentation of clinical findings, investigation results, management plan and discussion with other teams.
- Poor practice not to be aware of the do not attempt resuscitation (DNAR) status of the patient, especially when it has been discussed with family, clearly documented when first put in place and reviewed later on.

Cause of death information should form part of the review framework. If, on review, the certified cause of death causes the reviewer some concern, this should be explicitly stated, because there may be a clinical governance question involved.

So, the overall message about review language is that it should be explicit and clear, in order that you, the reviewer, feel you have made the points clearly and that others who read the review will be able to understand what you have said and why.

2.4 Giving phase of care scores

Box 4 Phase of care scores

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Care scores are recorded after the judgement comments have been written, and the score is in itself the result of a judgement by the reviewer. Only one score is given per phase of care: it is not necessary to score each judgement statement.

Scores range from 'Excellent' (score 5) to 'Very poor' (score 1) – see Box 4 – and are given for each phase of care that is commented on and for care overall.

These scores have a number of uses. For the individual reviewer, scores help them to come to a rounded judgement on the phase of care, particularly when there may be a mix of good and unsatisfactory care within a phase. The reviewer must judge what their overall decision is about the care provided for each phase and for care overall. Scoring makes this very explicit.

Overall care scores are particularly important in the review process. A score of 1 or 2 is given when the reviewer decides that care has been very poor or poor. Research evidence suggests that this might happen in upwards of 10% of cases in some circumstances, but less in others. A score at this level should trigger a second-stage review through the hospital clinical governance process (see Section 4).

2.5 Judging whether problems in care have caused harm

Problems in care take many forms and may have a range of impacts, some of which are potential rather than actual. Some of these events cause harms, but many do not.

The first-stage reviewer has an important role here in assisting the hospital to identify both actual and potential threats to patient safety. Using the assessment sheet at Appendix 1, reviewers are asked three questions in relation to problems identified in care. These are in the following format.

A) Were there one or more problems in care during this admission? Yes or no

B) If so, in which area(s) of the care process did this/these occur?

C) And for each of these problems, did any cause harm?

While the results of this assessment will be of importance in clarifying the issues in each review, it is the information aggregated across reviews that may pick up more fundamental care process issues that require attention.

2.6 Judging the quality of recording in the case notes

Case note review of course depends critically on the content and the legibility of the records. Safety of care also depends to some extent on good record keeping. Therefore, as part of the overall care assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records, again using a score of 1–5.

3 The review in practice

Case note review takes up expensive clinical resource so that the time spent on establishing the purpose and desired outcome of the review is important.

In some hospitals, the majority of mortality reviews take place in an M&M context and so they are often already being considered to be potentially problematic cases. Structured judgement review has been found to be of value in providing a reproducible process for M&Ms.

However the challenge for hospitals has often been the gathering together of the material from the reviews so that it can be used to examine care processes. Data from M&M cases should be entered into the hospital reviews database. Aggregated information is more powerful in the longer term than the data from individual cases.

Screening deaths for possible problems is another means of indicating where focused reviews are necessary. Valuable information about specific issues can be gained in this way, although generalising messages from complex cases can produce ‘solutions’ that may themselves have unintended consequences.

Another approach is to evaluate care for all or some patients who come to a particular service, or to explore the care provided for the majority of people who die in hospital over a particular time period in particular services; for example, all elective surgery deaths or people who die from acute kidney injury might require review. This aspect is covered in some detail in the *governance guidance* which forms part of the overall guidance materials.

Given the constraints on reviewer availability and the need to produce usable information from the reviews, the principle of 'less is more' applies.

A simple time-based longitudinal sample of around 40–50 cases will produce a rich source of quantitative and qualitative information on what goes right and what is not working properly. Timely review, rather than review after a delay, provides better information.

Time spent on the analysis and information presentation outweighs the benefit of adding a few more cases to the sample. The textual information allows for themes to be developed that then allows a focus for the next improvement steps. Such an approach also has the benefit of enabling individuals to learn from, and celebrate, the cases where care has gone well.

4 Second-stage review

In the context of the National Mortality Case Record Review Programme, second-stage review takes place within the hospital governance framework when the first-stage 'front line' reviewer judges care overall to be very poor (score 1) or poor (score 2), or when harms have been identified, or if concerns have been raised about a case.

Second-stage review is also undertaken using the structured judgement method and is effectively a process of validation of the first reviewer's concerns. If the second-stage reviewer broadly agrees with the initial case review (with poor or very poor overall scores and/or where actual harm(s) is judged to have occurred), the hospital governance group may decide on an additional assessment concerning the potential avoidability of the patient's death.

Judging the level of the avoidability of a death is a complex assessment that can be challenging to undertake. This is because the assessment goes beyond judging safety and quality of care by also taking account of such issues as comorbidities and estimated life expectancy. Recent evidence suggests the levels of agreement can be very low when assessing potential avoidability of death.

The judgement is framed by a six-point scale (6 – no evidence of avoidability, to 1 – definitely avoidable). This scale has been used in a number of recent national mortality review studies in Canada, the Netherlands and England.[2] Additionally, the national review process, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made.

The avoidability scale is shown in Box 5, together with an example of an 'avoidability of death' judgement comment. A score of 1, 2 or 3 on the avoidability scale would indicate a governance 'cause for concern'.

Box 5 'Avoidability of death' scale

Score 1 Definitely avoidable

Score 2 Strong evidence of avoidability

Score 3 Probably avoidable (more than 50:50)

Score 4 Possibly avoidable, but not very likely (less than 50:50)

Score 5 Slight evidence of avoidability

Score 6 Definitely not avoidable

Example structured judgement commentary

Non-invasive ventilation management was sub-optimal, but ultimately it was the patient's wish not to continue treatment. There may have been an alternative cause of breathlessness that was not fully explored or treated, which is why there may have been some avoidability.

Score 5 – slight evidence of avoidability

Appendix 1 – Assessment of problems in healthcare

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

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

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

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

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

4. **Problem with infection control:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

5. **Problem related to operation/invasive procedure** (*other than infection control)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

8. **Problem of any other type not fitting the categories above:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

Editorial note

This document has been adapted with permission from: Hutchinson A, McCooe M, Ryland E. *A guide to safety, quality and mortality review using the structured judgement case note review method*. Bradford: The Yorkshire and the Humber Improvement Academy, 2015. (Copyright The Yorkshire and the Humber Improvement Academy.)

The case note review methods discussed in this guide were primarily developed in a research study published as: Hutchinson A, Coster JE, Cooper KL, McIntosh A, Walters SJ, Bath PA *et al*. Comparison of case note review methods for evaluating quality and safety in health care. *Health Technol Assess* 2010;14(10):1–165.

All clinical examples and structured judgement comments in this document are taken from hypothetical scenarios.

Please note that this guide is subject to change following conclusion of the pilot phase of the programme.

References

1. Hutchinson A, Coster JE, Cooper KL, Pearson M, McIntosh A, Bath PA. A structured judgement method to enhance mortality case note review: development and evaluation. *BMJ Quality and Safety* 2013;22:1032–1040. DOI: 10.1136/bmjqs-2013-001839.
2. Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239.
3. Royal College of Physicians. *Using the structured judgement review method – a clinical governance guide to mortality case record reviews*. London: RCP, 2016.

Protocol 3

Learning from Deaths – Alerting Processes

SHMI Alerting Diagnosis identified

Reported at Mortality Review Group

Identified through SHMI data (adults)
- Mortality update standing agenda item (HED) data.

HQIP Outlier Alarms & Alerts

Identified by NCAPOP to Lead Clinician
- Receipt of alert/alarm from HQIP following data submission.

Actions taken by MRG

Coding Review undertaken

Lead identified to undertake review

Case Note Review
Timescale: **8 Weeks**
Appendix 6

Report to MRG
Timescale **12 Weeks**
Appendix 7

Clinical Pathway Group

- Respond to mortality alerts and ensures appropriate investigation undertaking for alerting diagnosis groups and are reported within the required timescales.
- Request mortality data from Directorates and direct case note reviews into specific areas of concern as necessary.
- Receive and review reports collated from outcomes of Directorate reviews, triangulate mortality data with other indicators and assign actions as appropriate.
- Identify quality improvement opportunities Clinical pathway improvement is managed using continuous quality improvement methodology and is an important part of the Trusts CQI strategy.
- Provide assurance to the Mortality Review Group (MRG), that mortality reviews are robustly undertaken, and the learning is captured and shared across the Trust.
- Receive regular Clinical Pathway updates from previously alerting diagnostic groups

Learning – captured and reported to MRG

Communicate Findings /Learning

Departmental M&M meetings
Review and discuss findings from case note reviews and investigations
- Implement actions to address problems in care
- Identify themes/QI opportunities

Directorate Gov Mtgs Report findings/actions and monitor actions to closure

Divisional oversight through Quality/ Performance meetings

Incident (case basis)
SUI (case basis)
(If identified)

Existing processes triggered for cases identified

Findings/learning shared with Trust existing specialist group/workstream as appropriate e.g., Deteriorating Patient Group/End of Life Care Steering Group/Patient Safety etc.

Appendix 4.4b

MORTALITY REVIEW PROFORMA (CASE NOTE REVIEWS)

Patient ID/hospital number _____

Age _____

Gender _____

Date of review _____ /_____ /_____

Reviewer 1_____

Reviewer 1 speciality and grade _____

Reviewer 2 _____

Reviewer 2 speciality and grade _____

Admission from Home ☐ Residential/ Sheltered Accommodation ☐ Nursing home ☐

Admission type: Elective ☐ Non-elective ☐

Was this an unplanned readmission within 30 days of a previous hospital discharge?

Yes ☐ No ☐

Was the patient seen in the Emergency department (ED) prior to admission? Yes ☐ No ☐

Date and time of initial admission to ED _____

Dates and times of ward admissions and names of admitted wards until date of death (may be multiple wards so please complete)

_____

_____

Date, time and place of death _____

Cause of Death

Details from death certificate

1(a) Disease or condition directly leading to death

_____

(b) Other disease of condition, if any, leading to 1(a)

_____

(c) Other disease of condition, if any, leading to 1(b)

_____

Other significant condition CONTRIBUTING TO THE DEATH
but not related to the disease or condition causing it

_____

Post mortem performed? Yes ☐ No ☐

Documentation of Do Not Attempt Resuscitation in case notes? Yes ☐ No ☐

DNAR Date _____

Was the patient on an End of Life Care Pathway? Yes ☐ No ☐
Comments

_____

_____

_____

Pre-Admission

Was this an avoidable admission (could the patient be cared in a community setting with appropriate support) Yes ☐ No ☐

Initial Assessment

Speciality and Grade _____

Where assessment was carried out:

Was the history and examination appropriate? Yes ☐ No ☐

If history and examination were not appropriate please specify why

_____

Was diagnosis/differential diagnosis appropriate? Yes ☐ No ☐
If diagnosis/differential diagnosis inappropriate please specify why

Were investigations appropriate? Yes ☐ No ☐
If investigations were not appropriate please specify why

Any other comments on initial assessment

First Review by (Non ED) admitting team

Time of review _____ hours following admission

Where patient was reviewed:

First review speciality and grade _____

Were history, diagnosis and investigations appropriate? Yes ☐ No ☐

If no specify why

Comments on first review

Time of Consultant review _____ hours following admission

Comments on first Consultant review (*especially if patient problems were identified and management plan made*)

Primary Diagnosis

Secondary Diagnoses

Comorbidity and Coding Review

Please list relevant comorbidities below. Indicate if it was coded or not coded. Indicate if patient was on treatment for comorbidity
e.g. Atrial Fibrillation : coded: Not on treatment
Asthma : not coded : On treatment

Any issues about clinical coding Yes ☐ No ☐
Please specify

Deterioration response

Was the EWS score recorded appropriately? Yes ☐ No ☐

Frequency of observations prescribed? Yes ☐ No ☐

Clinical deterioration recognised? Yes ☐ No ☐

Appropriate graded response to deterioration with clear documentation? Yes ☐ No ☐

Time from recognition of deterioration to Consultant review _____ hours

Was this timely given the clinical situation? Yes ☐ No ☐

Did the deterioration culminate in a cardiac arrest? Yes ☐ No ☐

Did the patient receive CPR/Resus? Yes ☐ No ☐

Was the patient referred to Critical Care? Yes ☐ No ☐

If no, reason why

_____

Clinical Management

Are there any aspects of this patients management which could/should have been handled differently? Yes ☐ No ☐

If yes please specify

_____

_____

_____

Are there any lessons to be learned from this case? Yes ☐ No ☐

If yes please specify

_____

_____

_____

Final comment on the overall management of this case

_____

_____

_____

Problems in care

Were there any problems with the care of the patient? (Please tick)
No ☐ (please stop here) Yes ☐ (please continue below)

Problem types

1. Problem in assessment, investigation or diagnosis *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)***:** Yes ☐
Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

2. Problem with medication / IV fluids / electrolytes / oxygen *(other than anaesthetic)***:** Yes ☐
Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

3. Problem related to treatment and management plan *(including prevention of pressure ulcers, falls, VTE)*: Yes ☐
Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

4. Problem with infection control: Yes ☐
Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

5. Problem related to operation/invasive procedure (*other than infection control)***:** Yes ☐
Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

6. Problem in clinical monitoring *(including failure to plan, to undertake, or to recognise and respond to changes)***:** Yes ☐
Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

7. Problem in resuscitation following a cardiac or respiratory arrest *(including cardiopulmonary resuscitation (CPR))***:** Yes ☐
Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

8. Problem of any other type not fitting the categories above: Yes ☐
Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

Reference:

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h32392

Review Outcome

NCEPOD
1 Good practice ☐
2 Room for improvement
Aspects of **clinical care** that could have better ☐
3 Room for improvement
Aspects of **organisational care** that could have better ☐
4 Room for improvement
Aspects of **clinical and organisational care** that could have better ☐
5 Less than satisfactory
Several aspects of clinical and/or organisational care which were
below acceptable standards ☐

Please give a brief clinical resume (narrative) of the care review

_____

_____

_____

_____

Considering all you know about this patient, how would you rate the overall quality of healthcare received by the Trust?

Hogan Quality Scale

Excellent ☐
Good ☐
Adequate ☐
Poor ☐
Very poor ☐

Avoidability scale:

1 Definitely not preventable ☐
2 Slight evidence for preventability ☐
3 Possibly preventable but not very likely, less than 50-50 but close call ☐
4 Probably preventable, more than 50-50 but close call ☐
5 Strong evidence of preventability ☐
6 Definitely preventable ☐

SHMI Alerting Diagnosis Group

Report outline

Methodology

- Patient selection
- Detail of reviewers

Results

- Demographic and admission details
  - ?avoidable admission
  - Source of admission
- Presentation and Interventions @ ED and/or upon admission
- Diagnosis and ongoing care
  - Consultant input and care during deterioration if relevant
  - compliance with national standards/local guidelines
- End of line care
  - Documentation of DNAR
  - ?Unexpected death
- Coding review:
  - Accuracy of primary diagnosis and reason for deviation (documentation, coding or both)
  - Capture of secondary diagnosis and co-morbidities

Overall Assessment of Care Provision

- Problems in health care
- Hogan score
- NCEPOD score
- Avoidability judgement

Discussion:

Summary/Conclusion:

Areas for improvement:

Action plan:

Appendix 1 - Mortality review proforma

Appendix 2 – Case review narrative

Case 1

Hogan score
NCEPOD

Case 2

Hogan score
NCEPOD

Case 3
.

Hogan score
NCEPOD

Case 4…….

The Royal Wolverhampton NHS Trust

Determination of mortality due to problem/s in health care

DATIX incident: ……

Date of review: ……

Reviewer/s	

Modified scale (Using Quality Account terminology)		Please choose
Score	Description	
6	Definitely not due to problems in health care	
5	Slight evidence that problems in health care was an issue	
4	Possibly due to problems in health care but not very likely, less than 50:50	
3	Probably due to problems in health care, more than 50:50	
2	Strong evidence that there were problems in health care	
1	Definitely problems in health care	

Please include your reasons for the judgement including any learning you have identified.

Determination of mortality due to problem/s in health care

Definition: OP 87 (Learning from Deaths) defines death due to problem/s in healthcare as a death that would not have occurred if different clinical or organisational management had been in place and, or if care had been delivered differently. In other words, it is 'death more likely than not to have been due to problems in the care provided to the patient'

Determining death due to problems in health care is a subjective assessment and Structured Judgement Review methodology used for case note reviews is not validated for this purpose. Within an organisation, such a determination should be limited to serious incidents, and scrutinised at an executive level by senior staff members. The following guidance may help.

In determining death due to problems in health care the reviewers should consider:

1. If there were problems in the way healthcare was delivered to the patient (the processes of care). Problem in healthcare is defined as 'any point where the patient's healthcare fell below an acceptable standard and led to harm'.

   Problems include:
   a. An omission or inaction such as failure to diagnose and treat or
   b. An act of commission or affirmative actions related to the delivery of care such as incorrect treatment or management.

2. For each case where a 'problem in care' that contributed to death is identified, mortality due to problem/s in healthcare is based on:

   a. If the problem in care that contributed to death was preventable
   b. Life expectancy at the time of admission taking into account admitting diagnosis, functional state and degree of urgency of the admission
   c. Associated co-morbidities and patients' overall condition (severity and complexity of concurrent illness) at that time

The following questions can be useful in helping to determine death due to problem/s in health care:

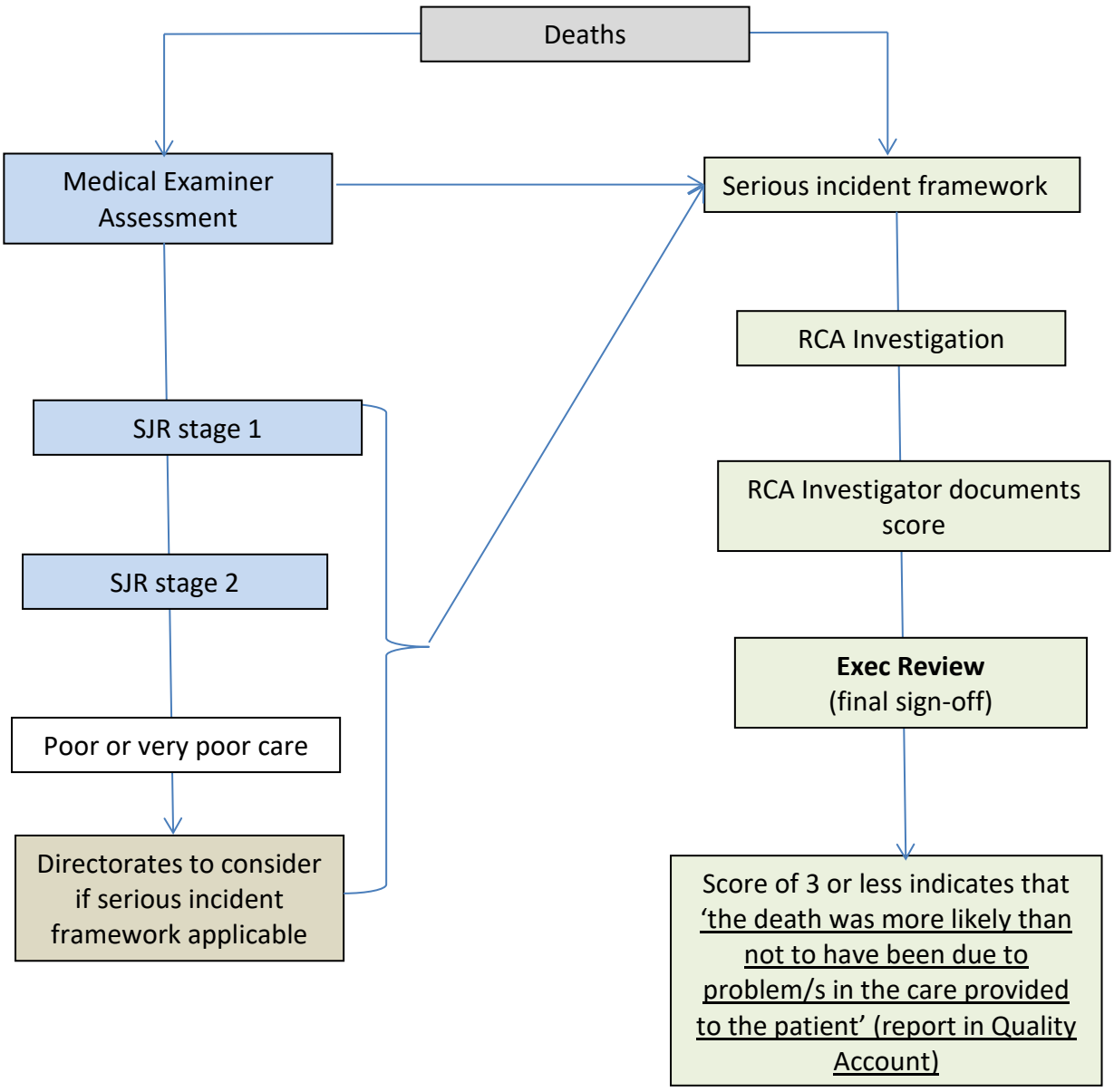
- Was the death expected or unexpected at the outset?
- Was the death related to a healthcare intervention rather than the natural progression of the patient's disease?
- Was there a deviation from the accepted norms of practice?
- Consider if better care had a reasonable chance of preventing the patient's death?
- Is there enough evidence to justify your decision?

<u>Reference:</u>

Adapted from Preventable Incidents, Survival and Mortality Study 2 (PRISM)
Medical Record Review Manual, Dr Helen Hogan, Jan 2014.

Hogan 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 Qual Saf 2012:21:737-Death.

Determination of mortality due to problem/s in health care



Process for upload of LD deaths to LeDER programme

http://www.bristol.ac.uk/media-library/sites/sps/leder/notify_a_death_flyer_for_website.pdf

SJR Mortality Review

- Patient identified with LD (SJR to be completed)
- SJR completed by mortality reviewers

SJR Complete

- Case upload to LeDeR Programme (by Mortality Governance Support)

**confirm with Learning Disability Nurse that patient is LD patient prior to upload.*

Regional Review

- Case allocated by LeDeR Area Contact to panel for review

Outcome

- Outcomes reported to Learning Disabilities Nurse - who presents to MRG for learning (individual cases)
- All findings included in LeDER annual report
- Gap analysis undertaken and presented to MRG

Learning identified

- Report and findings Included on learning page
- Cascade learning across Trust

Protocol 2a – Child Death reviews (following ME Scrutiny)

Baby Death Occurs

NEONATAL TEAM

- >22 weeks born alive
- Neonatal Deaths in NNU

OBSTETRIC TEAM

Fill MBRRACE **surveillance notification**

- Still Births >24 weeks to term
- Neonatal Deaths 0-28 days

Immediate decision making by Consultant by on Call consultant for Child Deaths

Discuss with ME

Outcome after ME scrutiny

Able to issue MCCD

Refer to Coroner

Incident Reporting (refer to Governance process)

No further action

Outcome:

- MCCD to be issued by consultant.
- Coroner issues MCCD
- Investigations accepted

SUI Process instigated – complete RCA

HSIB >37 weeks (0-6 days)

CO-ORDINATING PROCESS TO BE FOLLOWED

- Allocate Key Worker to support the family. Ie Bereavement Nurse/Consultant.
- Notification is submitted via eCDOP within 24-48 hours www.ecdop.co.uk/BlackCountry/Live
- Inform CHIS (Child Health Information system)
- Medical and Nursing staff to complete unit bereavement check list (24-48 hours) Ward clerk to notify relevant people: GP, Obstetrician local/referring, Midwife, Health Visitor, Risk Manager.
- Please include all Clinicians/agencies (police, social service/transport) involved in notification form.
- Follow SUDI guidance if appropriate.
- Support Staff – Debrief.

Offer Hospital PM to all deaths

Investigation & Info Gathering

- Fill PMRT (Perinatal Mortality Review Tool) by Neonatologist & Obstetricians within 1 month.
- CDOP administrator will distribute the reporting forms (form b) to all relevant people to fill in.

CDRM – Perinatal Mortality Review Meeting (ideally within 3/12 after death)

- Inform CDOP administrator – Jaki Bateman who will provide relevant reporting forms to enable hospital review. Jaki.bateman@wolverhampton.gov.uk 07942 24216 / 01902 558664 / 01922 654495
- **Core group in PMRT meeting:** Chair and vice chair. Scribe/IT/admin support, Obstetrician x 2, Midwife, Neonatologist, Neonatal Nurse, Risk Manager/or Governance team member eg Service Manager, Bereavement team x 1, external panel, Matron. Additional members, Pathologist – when PM was preform GP/community health care anaesthetics, Sonographer, safeguarding team etc. The evaluation form (form C) should be filled in highlighting modifiable factor and returned to Jaki Bateman.

Report learning and actions to family by Neonatologist

Report to MRG

CDOP/CDR Partners (independent review)

- Child death review overview panel.
- Considers draft analysis form (form c) submitted by PMRT chair.
- Learning and recommendations. Themes for actions are disseminated via CDOP Co-ordinator.

Protocol 2a – Child Death reviews (following ME Scrutiny)

Child Death (up to 18 years old)

Immediate decision following discussion with on-call consultant for Child Deaths

Unexpected death (SUDI/C)

Yes

No

Discuss with ME

Offer Hospital PM to all deaths

CO-ORDINATING PROCESS TO BE FOLLOWED

- Allocate Key Worker to support the family by the hospital. (eg Bereavement Nurse, Consultant)
- Notification is submitted via eCDOP within 24-48 hours. www.ecdop.co.uk/BlackCountry/Live.
- Notify CHIS (Child Health Information System)
- Please include all agencies involved in child's care ie Clinicians, ambulance, police, social service, school in notification form.
- Email LeDeR if appropriate
- (child with disability >4 years of age).
- Support staff – Debrief .

Joint Agency Response (Follow SUDI/C guidance)

Organised by Community Paediatrician (triggered within 24 hours of death)

- Death is or could be due to external causes
- Sudden with no apparent cause (incl. SUDI/C)
- Suspicious circumstances
- Still birth with no health care professionals in attendance

Outcome after ME scrutiny

Able to issue MCCD

Refer to Coroner

Incident Reporting (refer to Governance process)

PALS referral

Outcome:

- MCCD to be issued by consultant.
- Coroner issues MCCD
- Investigations accepted.

SUI Process instigated – complete RCA

HSIB if >37 weeks (0-6 days)

Investigation & Info Gathering

CDOP administrator will distribute the reporting form (form B) to all relevant people to fill in.

CDRM – Child Death Review Meeting (ideally within 3/12 after death)

- Inform CDOP administrator – Jaki Bateman who will provide relevant reporting forms to enable hospital review. Jaki.bateman@wolverhampton.gov.uk 07942 24216 / 01902 558664 / 01922 654495
- **Core groups in CDRM:**
  Chair – independent (Dr Copeman, Dr Williams, Hr Halahakoon), scribe/IT/admin support, Paediatricians involved in the care of child, (internal/external care). Paediatric Nurse. Bereavement Nurse, Risk Manager or Governance team members eg Service Managers. Additional members: Pathologist (when PM was due), GP/Community healthcare, anaesthetist, Safeguarding team. The evaluation form (Form C) should be filled in highlighting modifiable factors and returned to Jaki Bateman.

Report Learning and Actions to family by Paediatrician

Report to MRG

CDOP/CDR Partners (independent review)

- Child death Overview Panel
- Considers draft analysis form
- Learning and recommendations. These actions are disseminated via CDOP Co-ordinator

Learning from Deaths: Sharing and Learning

OUTCOME OF SJR (ONCE COMPLETED BY MORTALITY REVIEWERS)

SJR Overall Care outcome:
1 - very poor
2 - poor care

Mortality Reviewers email feedback to Mortality Lead/CD of appropriate speciality.

Discuss case through email to establish learning/actions.

Email to include:
- Whether incident report is recommended.
- Copy of SJR

cc email to:
- rwh-tr.learningfromdeaths@nhs.net
- Ananth.viswanath@nhs.net

MORTALITY LEAD/SPECIALTY ACTIONS & PROCESS

Mortality Lead to present case to MRG

- Incl. learning/actions identified by Specialty

Departmental M&M meetings
- Review and discuss findings from SJRs and investigations
- Implement actions to address problems in care

Directorate Gov Mtgs
Report findings/actions and monitor actions to closure

Divisional oversight
through Quality/ Performance meetings
Divisional report to QSAG to incl. oversight

MORTALITY REVIEWERS ACTIONS & PROCESS

Outcome to Mortality Reviewers Meeting
- Case review of Poor/V Poor cases
- Identify Trust themes for input to thematic reviews.
- Learning messages

Mortality Review Group:
- Thematic reports to MRG to include themes identified

MORTALITY GOVERNANCE ACTIONS & PROCESS

Capture feedback on SharePoint (or other Trust approved platform)

- Capture whether potential incident (SUI or otherwise)
- Capture discussion and learning points

Mortality Review Group (within 1 month of feedback)

- Agenda plan Case MRG for Mortality lead to present.
- Confirm with Mortality lead there attendance

Learning/Actions:

- Include learning/status within Directorate/Divisional reports.
- Exception report to be added to IGR
- Outcome added to Learning from Deaths Platform (LfD)
- Themes to be circulated to appropriate Trust group for consideration or
- Action agreed by MRG
- Outcome added Learning from Deaths Platform (LfD)