# BOARD OF DIRECTORS MEETING

| Agenda Item | P1/188/17 | | Date | 6<sup>th</sup> September 2017 |
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| Agenda Item | P1/188/17 | Date    6<sup>th</sup> September 2017 |
|---|---|---|
| **Subject /title** | **Mortality Review Policy** | |
| **Author** | **Kate Greaves, Associate Director of Quality** | |
| **Responsible Director** | **Helen Porter, Director of Nursing and Quality** | |

**Executive summary and key issues for discussion**

The National Quality Board published new guidance on learning from deaths in March 2017.  This guidance is supported by the CQC, NHS England and NHSI. NHSI will also monitor compliance against the Trust implementing the recommendations.

The guidance requires that each Trust should publish an updated policy on how it responds to, and learns from, deaths of patients who die under tis management and care.

From April 2017, Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards).

This paper ensures compliance with the requirements of Q2.

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| **Strategic context and background papers (if relevant)** |
|---|
| https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf |

| **Recommended Resolution** |
|---|
| • That the Trust Board approves the policy |

| **Risk and assurance** |
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| Provides assurance on compliance with the national guidance. |

| **Link to CQC Regulations** |
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| Regulation 12: safe care and treatment<br>Regulation 17: good governance |

| **Resource Implications** |
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| **Key communication points (internal and external)** |
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**Freedom of Information Status**

| FOI exemptions must be applied to specific information within documents, rather than documents as a whole.  Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.<br><br>**Application Exemptions:**<br>• **Prejudice to effective conduct of public affairs** | Please tick the appropriate box below:<br><br>[X]  **A. This document is for full publication**<br><br>[ ]   **B. This document includes FOI exempt information**<br><br>[ ]   **C. This whole document is exempt under FOI**<br><br>IMPORTANT: |
|---|---|

| • **Personal Information**<br>• **Info provided in confidence**<br>• **Commercial interests**<br>• **Info intended for future publication** | If you have chosen B above, highlight the information that is to be redacted within the document, for subsequent removal.<br><br>Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections. |
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## Equality & Diversity impact assessment

| Are there concerns that the policy/service could have an adverse impact because of: | **Yes** | **No** | |
| --- | --- | --- | --- |
| Age | | **X** | |
| Disability | | **X** | |
| Sex (gender) | | **X** | |
| Race | | **X** | |
| Sexual Orientation | | **X** | |
| Gender reassignment | | **X** | |
| Religion / Belief | | **X** | |
| Pregnancy and maternity | | **X** | |
| Civil Partnership and Marriage | | **X** | |

If YES to one or more of the above please add further detail and identify if full impact assessment is required.

## Next steps

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| |

## Appendices

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| |

## Strategic Objectives supported by this report

| Improving Quality | **x** | Maintaining financial sustainability | |
| --- | --- | --- | --- |
| Transforming how cancer care is provided across the Network | | Continuous improvement and innovation | |
| Research | | Generating Intelligence | |

## Link to the NHS Constitution

| Patients | | Staff | |
| --- | --- | --- | --- |
| Access to health care | | *Working environment*<br>Flexible opportunities, healthy and safe working conditions, staff support | |
| Quality of care and environment | x | *Being heard:*<br>• Involved and represented<br>• Able to raise grievances<br>• Able to make suggestions<br>• Able to raise concerns and complaints | |
| Nationally approved treatments, drugs and programmes | | | |
| Respect, consent and confidentiality | | | |
| Informed choice | | Fair pay and contracts, clear roles and responsibilities | |
| Involvement in your healthcare and in the NHS | | Personal and professional development | |
| Complaint and redress | | Treated fairly and equally | |

**CLINICAL POLICY**

# MORTALITY REVIEW:

# RESPONDING TO & LEARNING FROM DEATHS POLICY

**DOCUMENT REF:**
**(Version No. 1.0)**

| | |
|---|---|
| Name and designation of policy author(s) | Kate Greaves. Associate Director of Quality<br>Helen Wong. Quality Manager-CET |
| Approved by (committee, group, manager) | Trust Board |
| Approving signature | Minutes of Meeting |
| Date approved | |
| Review date | |
| Review type (annual, three yearly) | Three yearly |
| Target audience | All Clinical Staff |
| Links to other strategies, policies, procedures | Being Open And Duty Of Candour: Communicating Patient Safety Incidents with Patients & Their Carers<br>Incident Reporting policy<br>Complaints policy<br>Claims policy<br>Raising Concerns policy<br>Mortality Review SOP<br>Patient & Public Strategy |
| Protective Marking Classification | Public |

| This document replaces | n/a |
|---|---|

## Consultation:

| | Authorised by | Date Authorised | Comments |
|---|---|---|---|
| Impact Assessment | *To be completed by DCM* | *To be completed by DCM* | *To be completed by DCM* |
| Fraud Assessment | *To be completed by DCM* | *To be completed by DCM* | *To be completed by DCM* |

## Circulation/Dissemination:

| Date added into Q-Pulse | *To be completed by DCM* |
|---|---|
| Date notice posted in the Team Brief | *To be completed by DCM* |
| Date document posted on the intranet | *To be completed by DCM* |

## Version History:

| Date | Version | Author name and designation | Summary of main changes |
|---|---|---|---|
| 10.8.2017 | V1.0 | Kate Greaves. Associate Director of Quality Helen Wong. Quality Manager-CET | V1.0 |
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Table of Contents

## 1.0    Introduction

In December 2016 the CQC published *Learning, candour, accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England.* The National Quality Board has subsequently published their report *National Guidance on Learning from Deaths*, the purpose of which is to help initiate a standardised approach to learning and reviews of deaths. The national guidance provides details of actions all NHS and Foundation Trusts must take.

This policy outlines the systematic approach taken at CCC to the review and investigation of the deaths of people who use our services and die under our management and care. The reporting and monitoring of this approach facilitates organisational learning. Also recognition of whether opportunities for preventing a death have been missed and to identify any required improvements.

## 2.0    Purpose

This policy sets out the approach of this Trust in relation to mortality review and identifying, reporting, investigating and learning from deaths in care, in response to *National Guidance on Learning from Deaths*: *A framework for NHS Trusts and NHS Foundation Trusts*

The aim of this policy is to ensure:

• Consistency in the quality of patient mortality reviews within CCC

• The outcome of such reviews is clearly documented

• Clear reporting mechanisms are in place, to escalate any areas of concern identified in mortality review meetings, so that the organisation is aware and can ensure appropriate action is taken

• Mortality monitoring data is analysed and acted upon as appropriate.

• Organisational learning from deaths

## 3.0   Scope

This policy applies to all clinical staff in all directorates on all Trust sites. Implementation of the policy should be supported by administrative staff and managers as applicable.

*Maternal and still deaths are excluded from this policy because this hospital Trust does not provide a maternity service.*

*Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital level Mortality Indicator (SHMI) data sources are excluded from this policy as they are not applicable in the acute care setting of this cancer Trust.*

The Trust requirement is to review all Trust treatment related deaths as outlined in section 7.3.2

## 4.0    Responsibilities

### 4.1 Chief Executive

The Chief Executive has overall responsibility for monitoring mortality rates on behalf of the Board of Directors of the Trust, provides visible leadership and ensures reduction in mortality and increase in patient safety is a core strategic aim.

### 4.2 Medical Director

The Medical Director is responsible for

- Chairing the Mortality Surveillance Group (MSG) and provides assurance to the Board that the mortality review process is functioning correctly.

- Ensuring that arrangements are in place so that all clinical staff, as appropriate, are aware of their responsibilities to contribute to the process.

- The Medical Director, together with the Director of Nursing and Quality, is the executive director with responsibility for the learning from deaths agenda,

paying particular attention to the care of patients with a learning disability or mental health needs

- Responsible for appointing the medical chair of the Mortality Review Meetings (MRM) and ensuring appropriate time is allocated to support this function.

## 4.3 Non -Executive Director

An existing Non-Executive Director is responsible for oversight of the identifying, reporting, investigating and learning from deaths in care process and for providing constructive challenge as appropriate to support quality improvements in care.

## 4.4 The Director of Nursing and Quality

The Director of Nursing and Quality:

- Acts as Deputy Chair of the Mortality Surveillance Group and has joint responsibility for providing assurance to the Board that the mortality review process is functioning correctly.

- Responsible for ensuring all regulatory and legislative requirements are met in relation to mortality review and organisational learning is embedded.

- As patient safety Director, is responsible for the learning from deaths and quality improvement agenda, and the inclusion of learning from mortality reviews and investigations in the Trust's Quality Accounts.

- Responsible for liaising with Commissioners to review and improve local approaches to mortality governance arrangements

- The Director of Nursing and Quality, assisted by the Associate Director of Quality, is responsible for ensuring timely, compassionate and meaningful engagement with bereaved families and carers during all stages of responding to a death.

## 4.5 The Associate Director of Quality (Trust Mortality Lead)

The Associate Director of Quality:

- Has delegated responsibility to ensure appropriate governance is in place in relation to the mortality review process

- Supports the implementation and further development of the Trust's mortality monitoring process. This includes the provision of support staff and infrastructure to assist the clinical teams conducting mortality reviews.

- Ensures national and regional mortality data is monitored and acted upon as necessary.

- Responsible for having a systematic process in place for the identification and methodology for the review of deaths.

- Coordinates the Trust's mortality programme, ensuring that nominated staff have the appropriate skills and time to do this, and for providing assurance to the Board in relation to the management of mortality and reporting of learning outcomes at CCC.

- Responsible for ensuring effective internal/external communication and dissemination of actions and learning outcomes relating to care concerns and shared learning opportunities

## 4.6 The Quality Manager- CET

Responsible for:

- Providing detailed clinical data, clinical outcomes data and statistical mortality analysis to support the mortality review programme and associated processes, to include Consultant revalidation meetings.

- Ensuring the wider engagement of the Clinical Effectiveness Team in provision of mortality review meeting administrative support arrangements, ie case note reviews undertaken of deceased patients and discussed at meetings ,agenda setting, minutes taken and archived, collation of review

findings, learning points and actions for improvement for each mortality review meeting.

- Supporting requests for case note reviews following alerts/outlier notifications, and escalating up any areas of concern.

- Responsible for escalation of mortality related concerns and actions to appropriate committees (eg Risk Management, MSG)

### 4.7 Clinical Effectiveness Team :

The Clinical Effectiveness Team (CET) will monitor the mortality review process on behalf of the Associate Director of Quality as Trust Lead for Mortality Review, the Medical Director (Chair of MSG) and the Director of Nursing & Quality. They will:

- Identify and report monthly on in-patient and out-patient hospital deaths from the Trust EPR system, following weekly confirmation of date of deaths against the National DBS Database by the EPR and Information teams.

- Request internal and external clinical notes and post mortem reports, as appropriate, for deaths to aid completion of the Mortality Review screening Form (Appendix A)

- Receive monthly lists of serious incidents, complaints and inquests and link with other mortality data

- Retain copies of all completed Mortality Review Forms and maintain a log of the forms received and the review result category

- Provide updates to the MSG on participation rates for mortality review and support in the identification of any gaps

- Ensure that any death which has been identified as a concern (based on the Mortality Review Form screening tool) is recorded centrally and that any in-depth review using the Trust Mortality Review Form is reported through to Mortality Surveillance Group (MSG)

- provide support to clinicians with any questions regarding the process

- Provide administrative support to the mortality review process

- provide monthly mortality trend data

- Provide mortality data and prepare reports to meet the Trust's board, directorate performance and commissioner reporting requirements.

## 4.8 Directorate Managers and Clinical Directors

Directorate General Managers and Clinical Directors are responsible for ensuring that appropriate multidisciplinary mortality meetings take place and there is appropriate attendance by all relevant disciplines and professional groups. Responsible for ensuring organisational learning is embedded within the service areas.

## 4.9 Medical staff

All consultant medical staff are required to attend regularly and participate fully in the Mortality Review process. Consultants are required to attend a minimum of 50% of mortality review meetings annually. It is the responsibility of all registered medical practitioners to understand the outcomes of their clinical practice and to make changes as required from learning outcomes.

## 4.10 Nurses, allied health professionals and other clinical staff

All healthcare professionals should be involved in mortality reviews meetings, as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews in so far as they affect their area of practice, to full involvement in the production of data and implementation of learning recommendations

**4.11 Quality Team & Risk Management Facilitator**

Is responsible for providing support and guidance to staff and facilitating any meetings required to discuss any mortality related Serious Untoward Incident (SUI). They will also facilitate the investigation process, liaise with the family/Coroner/police and all other external agencies as appropriate, ensuring the production of a comprehensive investigation report, to include any required actions and organisational learning recommendations.

**4.12 Risk Management Committee**

The Committee is responsible for ensuring the Being Open and Duty of Candour processes are followed when mortality related patient safety incident occurs. It is responsible for reviewing mortality related patient safety incidents and monitoring that Trust policies and processes have been followed.

**4.13 The Mortality Surveillance Group (MSG):**

- Strategic oversight of the mortality review structure, process and actions
- Captures and respond to external and internal mortality trends
- Ensures cross directorate learning from mortality reviews
- Ensures the board and executive is informed of mortality outcomes and trends
- Ensures the delivery of the mortality review process, reporting into the Quality Sub- Committee

## 5.0   Laws & Regulations

https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

## 6.0   Definitions

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

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

**Mortality** – for the purpose of this document, mortality relates to any Trust in or out- patient death, and specifically any death occurring within 30 days of chemotherapy or within 30 or 90 days of receiving radiotherapy.

**Mortality Review Meetings (MRM)** - a mortality meeting is where a multi-disciplinary group review and discuss clinical cases, outcome data and related information

**Mortality Surveillance Group**- The primary aim of the Mortality Surveillance Group is to provide assurance to the Trust Board on patient mortality, through the review of care and statistical data on patient deaths, including results and learning from the Mortality Review Meetings. Also to consider strategies to improve care and reduce avoidable mortality. The MSG will report quarterly to the Public session of the Trust Board.

**Structured Judgement Review (SJR)** The Royal College of Physicians' structured judgement review methodology, intended for use in adult inpatients only.

**Severe Mental Illness (SMI) -** restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

**Serious Untoward Incident (SUI)** - an accident occurring on NHS premises that resulted in serious injury, and or permanent harm, unexpected or avoidable death

**Site Reference Group (SRG)-** a Consultant lead, cancer site specific multidisciplinary group of clinicians and health care professionals.

## 7.0   Main Body of Policy

In December 2016 the CQC published Learning, candour, accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England. This report found that learning from deaths is not being given sufficient priority in some organisations leading to opportunities for learning being missed.

The National Quality Board has subsequently published their report National Guidance on Learning from Deaths the purpose of which is to help initiate a standardised approach to learning and reviews of deaths. The report explains that whilst many patients receive excellent NHS care in the months and years leading up to their death there are some that don't experience good quality care which can be as a result of a number of factors including poor leadership and systems wide failures.

The national guidance acknowledges that when mistakes happen providers must work more with their partners to understand the cause and that reviews and investigations of deaths to establish if problems in care have contributed to the death are only useful for learning if their findings are shared and acted on.

## 7.1 Mortality Review at CCC

At CCC, there is a comprehensive mortality review programme. The aim of this process is to identify any areas of practice and or patient care, both specific to the individual case and beyond, that could potentially be improved, based upon peer group review. Areas of good practice and patient care are also identified and supported.

Each death in care will be subject to one or more of five levels of scrutiny based on The Royal College of Physicians, National Mortality Case Record Structured Judgement Review methodology (a quantitative retrospective analysis tool):

- Consultant independent review of mortality cases under their care using the mortality review proforma (Appendix A) to highlight areas of concern in care delivery
- Phase 1 initial structured case record review,
- Phase 2 full Mortality Review Meeting review,
- Specialist SRG or Specialist Committee (eg Safeguarding Committee) review
- investigation as per the Serious Incident Framework Policy

## 7.2 CCC Mortality Review Programme

| Frequency | Type of Review | Reporting Arrangements |
|-----------|----------------|------------------------|
| **Weekly** | <ul><li>Day of death confirmation against the DBS database</li><li>all Care Pathway inpatient deaths</li><li>review of preferred place of care deaths</li><li>weekend mortality rates for planned and unplanned admissions/expected (DNAR) & unexpected deaths</li></ul> | Quality Sub- Committee<br><br>MSG<br><br>Trust Board |

| | | |
|---|---|---|
| **2 weekly** | • Day after death mortality review narrative reports are compiled following relative/carer face to face interviews after every inpatient death and standards of care and support reviewed 2 weekly | Director of Nursing & Quality |
| **Monthly** | • 30 day mortality post chemo analysis<br>• 30 & 90 day mortality post RT analysis<br>• individual Cons review of own mortality data<br>• All inpatient deaths -Peer reviewed pre-mortality meeting of Mortality Review Form submissions and patient notes<br>• Mortality Review Meetings - multidisciplinary, peer review.<br>• IHI Oncology locally adapted Global Trigger Tool – inpatient case sheet review identifies possible harm events to include 30 day mortality from discharge & neutropenic sepsis mortality | Quality Sub- Committee<br><br>MSG<br><br>Site Reference Groups(SRGs)<br><br>Directorate meetings |
| **2 monthly** | • Mortality Surveillance Group meeting – strategic<br>• Quality Manager mortality action and learning report to MSG and Risk management Committee | Quality Sub- Committee<br><br>MSG |
| **3 monthly** | • Trust-wide mortality statistical analysis- internal benchmarking & identifies trends/areas for concern.<br>• Trust –wide quarterly mortality data and learning risks and assurance overview report | Quality Sub- Committee<br><br>MSG<br><br>Trust Board/<br><br>Board Quality Committee |
| **Annual** | • 12 months Trust-wide mortality statistical analysis- internal benchmarking & identifies trends/areas for concern.<br>• Site Reference Groups-audit of identified high risk diagnostic groups & recommendations as required for redesign of patient pathways<br>• Summary of mortality & learning action points | Consultant Appraisals<br><br><br>MSG<br><br><br><br><br>Quality Accounts |
| *Internal:*<br><br>*Recommendations for changes in practice to GMs/CDs/ Cons & their teams/SRGs/nursing staff*<br><br>*External:*<br><br>*Recommendations for review/changes in practice to GP or other treating hospital* | | |

## 7.3 Mortality Review Meeting (MRM) Process

*The Mortality Review Meeting frequencies are outlined in the above table and see Appendix A&B. Please also refer to the MRM SOP.*

The Mortality Review Meetings are intended as a forum for both improving practice as well as celebrating best practice. They form part of the existing Trust wide mortality review process and underpin the Trust's strategic goal to prioritise patient safety, prevent avoidable deaths and improve patient care through organisational learning from deaths. The MRM meeting is preceded by an initial Phase 1 structured case record review.

## 7.3.1 MRM Phase 1: Structured Case Record Review

The Mortality Review Form (Appendix A) enables much of the required data collection and supports the case record review process, an initial phase 1 desktop pre-MRM high-level screening of all in-patient, Chemotherapy and Radiotherapy 30/90 day deaths. This provides clinical teams with information relating to cases that may warrant a more in-depth review, to include where there are any concerns about standards of care, at the Phase 2 Mortality Review Meeting.

## 7.3.2 Deaths in Scope of MRM review

Cases are selected as per Flow Chart (Appendix B) by the pre-MRM independent clinician group based on The Independent Advisory Group to RCP recommendations, information from Mortality Review Proformas, and clinician queries/concerns relating to any aspect of treatment or care provided.

Deaths in scope are:

- 30 day chemo mortality
- 30 radical and palliative radiotherapy mortality

- 90 day radical radiotherapy mortality

- All inpatient deaths to include unexpected/injury related deaths and non-Care Pathway deaths

- Treatment related deaths

- Formal incident related deaths

- Concerns raised from the Global Trigger Tool extracted deaths

- Consultants, bereaved relatives or any Trust staff member may request for individual cases to be reviewed at the MRM where there are concerns about care, educational aspects or evidence of good practice that can provide shared learning and quality improvements.

- Deaths of all inpatients with learning disabilities or mental illness deaths will be selected for review

- Deaths in specialty, diagnosis or treatment group where an 'alarm' has been raised (eg elevated mortality rate, audit concerns, CQC concerns), unexpected deaths will be selected for review.

### 7.3.3 Phase 2: Mortality Review Meeting.

Cases are presented by the responsible Consultant or their teams at the MRM where independent interrogation of care, identification in lapses of care, actions required and organisational learning points are identified.

Members of the MRM must be objective, impartial and have a systemic focus on learning in order to improve and enhance current and future policy and practice. Resulting actions are disseminated Trust –wide, with action plans monitored by the MRM and reported into the Trust's strategic Mortality Surveillance Group.

Where the MRM review identifies a patient safety incident, this will be reported to the Trust Risk Manager and entered onto the Directorate Datix Risk Register, reporting into the National Reporting and Learning System (NRLS). All patient

safety incidents will be subject to internal and/or external investigation and review.

## 7.4 Responding to the death of an individual with learning disability, mental health needs, or child death

Deaths of patients with mental health problems, learning difficulties or child deaths, will be identified by clinicians on the Mortality Review Form (Appendix A) and through liaison with the Trust's Clinical Nurse Specialist for Additional Needs and Trust safeguarding lead, who will be involved in the mortality review and interrogation of care provided. Where appropriate, external representation will be invited to jointly review such deaths as active members of the MRM and provide expert opinion and challenge.

### 7.4.1 Learning Disability Deaths (aged 4 years and over)

All deaths of patients with learning disabilities will be notified to the LeDeR programme for specialist review. Deaths related to patients with learning difficulties will be externally reviewed using the NHS England Learning Disabilities Mortality Review (LeDeR) methodology to review care.

Internal mortality review will be undertaken in accordance with Trust policy for mortality review and reported into the CCC quarterly Safeguarding Committee for additional review to ensure optimal patient care, and family and carer support, was delivered.

### 7.4.2 Child Deaths (under 18)

Child Deaths (under 18) mortality reviews will be undertaken in accordance with Trust policy for mortality review and in line with national guidance, *Working Together to Safeguard Children,* supported by the Trust safeguarding lead, and reported into the CCC quarterly Safeguarding Committee for additional review to ensure optimal patient care, and family and carer support, was delivered.

The Department for Education's 'Form C' (Appendix C) will be completed as a draft reporting template and all such deaths will be reported to the Child Death Overview Panel (CDOP) to:

- evaluate information about the child's death;

- identify lessons to be learnt; and

- to inform an understanding of all child deaths at a national level.

**7.4.3 Deaths of patients with Mental health needs**

The National Quality Board guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

There is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder. The Trust will adopt this definition and scope for the identification, mortality review and subsequent learning from such deaths.

Mortality reviews for deaths of patients with mental health needs (SMI) will be undertaken in accordance with Trust policy for mortality review and reported into the CCC quarterly Safeguarding Committee for additional review, to ensure optimal patient care, and family and carer support, was delivered.

All inpatient deaths of patients detained under the Mental Health Act(1983) will be immediately reported to the Care Quality Commission.

## 7.5 Investigations of mortality related SUI

*Refer to the CCC Being Open and Duty of Candour: Communicating Patient Safety Incidents with Patients & Their Carers and the CCC Incident Reporting policy*

Deaths will be declared, investigated and reported as Serious Untoward Incidents in line with the Trust's Incident Reporting Policy and NHS England's Serious Incident Framework guidance. All mortality related SUIs will be recorded via the Trust's auditable incident management system DATIX. The decision whether an incident is declared as a SUI is the responsibility of the Director of Nursing & Quality or her appointed deputy.

Investigations using Root Cause Analysis (RCA) will be used to uncover the underlying causes of a mortality related patient safety incident. Investigations will focus on improving systems of care, which will then be reviewed for their effectiveness to prevent recurrence.

Both senior managers and senior clinicians must participate in the patient safety event investigation and clinical risk management.

Findings will be disseminated to staff so they can learn from mortality focussed patient safety incidents.

## 7.6 Open and Honest Communication with Families & Carers

*Refer to the CCC Being Open And Duty Of Candour: Communicating Patient Safety Incidents with Patients & Their Carers* which outlines the Trust's engagement and guidance policy with bereaved families and carers

For deaths investigated in the context of Serious Incidents at CCC, families are informed at the beginning of the investigation and invited to pose any questions they have about the care provided/events leading to the incident in person. The SUI Terms of Reference and final SUI Report is shared with them (where the family/carer wished) in all cases.

Being Open involves:

- Acknowledging, apologising and explaining when things go wrong

- Conducting an investigation into the patient safety event and reassuring patients, their families and carers that lessons learned will help prevent recurrence

- Providing support for all those involved

In the case of a patient death, communication with carers/relatives is sensitive, open and empathetic. It is important to consider the emotional state of the bereaved relatives and to involve them in deciding when it is appropriate to discuss what has happened. Practical support will be offered in all cases, to include legal advice, and a single point of contact lead at the Trust will be available to maintain regular contact with families/carers and provide interim updates on the investigation progress.

**7.7 Notification to External Bodies**

*Refer to Responsibilities Section 4.0 for Quality Team & Risk Management Facilitator responsibilities and the Trusts Incident Reporting Policy*

All cases of untimely, unexpected or unexplained death and suspected unnatural deaths need to be reported to the coroner. The Director of Nursing and Quality is responsible for reporting all serious incidents and any incidents resulting in

moderate or severe harm or death to the Commissioners in line with the contractual obligations and to the CQC.

## 7.8 Learning from Deaths

With a focus on quality improvement and patient safety, learning and outcomes of mortality reviews are captured on the Trust mortality reviews database, thematically analysed where possible, and fed through to all Trust frontline clinicians and staff groups via Directorate General Managers and Clinical Directors. The Mortality Surveillance Group (MSG) is responsible for the monitoring of all related action plans until completion, and for the wider dissemination of mortality related actions externally as appropriate.

Regular review of the Trust's mortality review process is carried out to ensure the effectiveness of the process, that any patterns and changes in mortality data are investigated and reported appropriately, and to meet the need to continuously improve the review processes to maximise learning and improve care to patients.

## 7.8.1 Shared Learning

Information about a mortality related concern or patient safety incident will be shared with other health care practitioners, as appropriate; to ensure optimal care in the future eg the patient's GP, other external hospital Trust's involved in the patient's care.

Where there are any concerns regarding the care or treatment of a CCC patient who has died in another hospital, the external hospital will be contacted to request a full review of care by their clinicians or Mortality Review Meeting, and a report provided, to be discussed at the CCC Mortality Review Meeting.

Where there is evidence of learning beneficial to the wider NHS, and taking account of data protection regulations, this will be shared through the appropriate forum.

### 7.8.2 Learning from Pro-active review of mortality outliers

Mortality outliers identified from internal surveillance in any patient group, or review of national audit data, will generate an SRG level case-note sample review with involvement of the clinical team. Reports following this type of review will establish appropriateness and category of clinical care and avoidability, using the National Mortality Case Record Review method of assessment. A written report will be presented to the MSG by the SRG Chair or a designated deputy.

### 7.8.3 Reactive review and learning from externally generated mortality outlier alerts

An appropriate lead clinician will be identified to conduct a multidisciplinary in depth case note review for a reasonable sample of patients, establish the appropriateness of the clinical care received, and to produce a report within the timeframe prescribed by the Care Quality Commission or other external body. The process is supported by the CET. Reports generated as a result of this process will be presented to the MSG.

### 7.9 Mortality Data Analysis & Reporting

### 7.9.1 CCC 3 monthly Analysis of 30 & 90 day mortality post chemotherapy & radiotherapy using Statistical Process Controls

This 3 monthly mortality data uses caseload adjusted data collection methodology to allow for internal benchmarking processes. Mortality data is analysed for all Trust Consultants by:

- treatment intent (palliative/radical)
- regime/toxicity
- individual consultant.
- number of cycles associated with death
- overall number of patient deaths

Resulting trend analysis is interrogated by the Associate Director of Quality, Quality Manager, lead clinicians and Clinical Directors to establish any areas of concern regarding overall and individual clinical practice. Actions plans are fed into the MSG and Medical Director, who will monitor progress until completion.

### 7.9.2 Routine mortality surveillance

Crude mortality rates will be routinely monitored both at a Trust and Directorate level and will be presented to the Quality sub -committee of the Trust Board on a monthly basis via the Quality Report and annually in the Quality Account.

### 7.9.3 Monitoring of Mortality Review Compliance and Effectiveness

The following elements will be monitored by CET and reported 2 monthly into MSG, to include completion of the Department of Health Learning from Deaths Mortality Dashboard requirements:

1) Directorate  and clinical participation rates in mortality reviews

2) Rates of Avoidable/non-avoidable death assigned by reviewers to the management of patient care, as indicated on the Trust mortality review form based on any concerns highlighted.

3) Levels of care assigned by reviewers to the management of patient care, as indicated on the Trust mortality review form based on any concerns highlighted.

4) Actions arising from the mortality reviews will be identified and thematically analysed, to include staffing levels, seasonal variations and external hospital-linked themes, by CET and monitored by the MSG led by the Trust Mortality Lead and the Medical Director (Chair of MSG).

5) Change in practice and lessons to be shared- Learning and recommendations will be identified and disseminated by the Trust Mortality Lead and the Medical Director (Chair of MSG).

### 7.9.4  Additional data collection and reporting

CCC, from April 2017, will collect and publish, on a quarterly basis at Trust Board, specified information on deaths. In line with National Guidance, the number of minimum requirements in relation to reporting and reviewing deaths for this quarterly report will include setting out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards).

A summary of this data and learning will be included in the Quality Accounts from June 2018


Specified information on deaths will be collected (from April 2017) and published (from September 2017) on a quarterly basis through a paper and an agenda item on the public Board meeting

The data collected will include:

- Total number of inpatient deaths

- Number subject to case record review

- Numbers investigated in the SUI framework

- Number of deaths where it is thought 'more likely than not' that problems in care contributed

- Themes and issues identified through review and investigation

- Changes that have been made as a result of these processes


### 7.10 Clinical Coding

Clinicians will receive education and training at Trust induction regarding clinical coding and how coders extract information from the clinical notes. This training will also inform clinicians of the correct methodology of annotation to support accurate clinical coding. Such education and training will also be available and provided on an ongoing, ad hoc basis to consolidate knowledge and skills of clinicians.

## 8.0   Training

No specific training is required for the implementation of this policy. However for advice relating to mortality monitoring techniques or for information on the statistical methods used nationally to monitor mortality please contact the Quality Department staff.

RCP Structured Judgment Review training for inpatient deaths is available through the Royal College of Physicians and clinical teams will be encouraged to access this and to attend internal specialist training opportunities to increase knowledge and skills around the Trusts mortality governance and process arrangements

## 9.0   Audit

The lead person responsible for monitoring compliance and developing and implementing action plans to rectify non-compliance with this policy is the Associate Director of Quality.

Where non-compliance is identified action plans will be developed by the service/Directorate lead assigned and progress against the action plan will be presented to the MSG monitoring committee at each meeting until the issue is resolved.

**9.1 Process for encouraging open communication between healthcare organisations, healthcare teams, staff, patients and/or their carers**

Lead: Risk Management Facilitator

Monitoring committee: Risk Management Committee

An annual audit will be undertaken to review all serious mortality related incidents in the previous 12 months to determine whether appropriate support and open communication took place, with the requirement for truthfulness, timeliness and

clarity of communication, and that the principles of being open process had been followed.

The review will involve determining whether the issue has been acknowledged/ discussed with the family/carer, that an apology has been given where appropriate and that the appropriate documentation had been completed.

The audit findings and any actions identified will be reported to and monitored by the Risk Management Committee until completion.

**9.2 Requirement for documenting all communication**
Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

The annual audit detailed in 9.1 above will also review documentation to ensure the compliance with the requirements
The report and any actions identified will be reported to and monitored by the Risk Management Committee until completion.

## 10.0  References

National guidance on Learning from Deaths
https://www.england.nhs.uk/wpcontent/uploads/2017/03/nqb-national-guidancelearning-from-deaths.pdf

Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England
https://www.cqc.org.uk/sites/default/files/20161213 -learning-candour-accountability-full-report.pdf

Learning from deaths dashboard
https://improvement.nhs.uk/resources/learningdeaths-nhs-national-guidance

Resources from the national patient safety team;
https://improvement.nhs.uk/resources/patientsafety-alerts

The Improvement Hub
https://improvement.nhs.uk/improvement-hub/

Developing people – improving care: A Framework for leadership and improvement https://improvement.nhs.uk/resources/developingpeople-improving-care/

Royal College of Physicians mortality review materials https://www.rcplondon.ac.uk/projects/nationalmortality-case-record-review-programme

Learning disabilities mortality review programme http://www.bristol.ac.uk/sps/leder/

Serious incident framework https://improvement.nhs.uk/resources/seriousincident-framework/

Root cause analysis tools and resources http://www.nrls.npsa.nhs.uk/resources/collections/r oot-cause-analysis/

Duty of candour http://www.cqc.org.uk/sites/default/files/20150327_ duty_of_candour_guidance_final.pdf

Being open guidance http://www.nrls.npsa.nhs.uk/beingopen/

DH Child Death Reviews https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths

## 11.0 Appendix A

The Clatterbridge Cancer Centre **NHS**
NHS Foundation Trust

### In-patient, Chemotherapy and Radiotherapy 30/90 day Mortality Review Proforma

| | Clinical Information | |
|---|---|---|
| **Reason for Discussion:** | | |
| 1 | Patient hospital number and name | |
| 2 | Age | |
| 3 | Gender | |
| 4 | Death of patient with mental health problems, learning difficulties or child death (ie below age 18 yrs)? | Mental health ☐   Learning Difficulties ☐<br>Child ☐   N/A ☐ |
| 5 | Primary Tumour | |
| 6 | Tumour Site | |
| 7 | Histology | |
| 8 | TNM & Overall staging / other staging | |
| 9 | Performance Status before treatment/admission | ☐0   ☐1   ☐2   ☐3   ☐4<br>☐Not known |
| | **In-patient Death** | |
| 10 | Date of admission / Episode Consultant | |
| 11 | Reason of admission | |
| 12 | Cause of death | |
| | **Chemotherapy 30 day Mortality Related Treatment** | |
| 13 | Chemotherapy Consultant | |
| 14 | Chemotherapy Regime | |
| 15 | No. of cycles | |
| 16 | Before each cycle of SACT which of these options were assessed? | ☐ Full blood count<br>☐ Urea and electrolytes<br>☐ Liver function tests |
| | **Radiotherapy 30/90 day Mortality Related Treatment** | |
| 17 | Radiotherapy Consultant | |
| 18 | Dose / Fractionation | / # |

| 19 | Anatomical treatment site | |
|---|---|---|

| **Prescriptions and administration** | | |
|---|---|---|
| 20 | Was there an assessment of toxicity<br>– since the previous cycle of SACT or<br>– during the course of radiotherapy treatment? | ☐ Yes  ☐ No  ☐ NA |
| 21 | Was a toxicity checklist used? | ☐ Yes  ☐ No  ☐ NA |
| 22 | Was there an assessment of response to treatment during the course of treatment? | ☐ Yes  ☐ No  ☐ NA |

| **Safety** | | |
|---|---|---|
| 23 | Did patient suffer any grade 3 /4 event following the most recent cycle of SACT/XRT?(CTC/RTOG grading) | ☐ Yes  ☐ No |
| 24 | If yes, was dose reduction or the use of prophylactic GCSF considered for SACT? | ☐ Yes dose reduction<br>☐ Yes use of GCSF<br>☐ No |
| | If No, please explain: | |

| **End of Life Care** | | |
|---|---|---|
| Was palliative care or appropriate support team involved? | ☐ Yes  ☐ No  ☐ NA | |
| Were all appropriate supportive care medicines prescribed? | ☐ Yes  ☐ No  ☐ NA | |
| Was patient on "End of Life Care and Communication Record" if patient was deceased as **CCC inpatient**? | ☐ Yes  ☐ No  ☐ NA | |

**Are there any concerns that you wish to raise with regarding this patient's death?**

---

\*\*If there is a gap in evidence, CET will contact the GP or other sources to gather further information unless you state otherwise.

**Mortality Review Meeting use ONLY**

| **Conclusion at Mortality Review Meeting (MRM)** | |
|---|---|
| 1 | Was appropriate dose of SACT/RT prescribed? | ☐ Yes ☐ No ☐ NA |
| 2 | Was toxicity managed appropriately? | ☐ Yes ☐ No ☐ NA |
| 3 | Was end of life care delivered appropriately? | ☐ Yes ☐ No ☐ NA |

| 4 | Avoidable death?<br><br>**Score 1**: definitely avoidable<br>**Score 2**: strong evidence of avoidability<br>**Score 3**: Probably avoidable (more than 50:50)<br>**Score 4**: Possibly avoidable but not very likely (less than 50:50)<br>**Score 5**: Slight evidence of avoidability<br>**Score 6**: definitely not avoidable | Score: …….. |
|---|---|---|
| 5 | Was optimal care provided by CCC? | ☐ Yes        ☐ No |

| **Learning & Actions arising from MRM** | | **Action by** |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| Any improvement can be suggested/reasons for judgement of level of avoidability/Comment: | | |

## Appendix B      Pre MRM Flowchart

CET Prepare MRM Forms for all patients fulfilling criteria:

- 30 day chemotherapy mortality
- 30 & 90 day radical and palliative radiotherapy mortality
- All inpatient deaths
- Formal incident related deaths
- Concerns raised from the Global Trigger Tool extracted deaths
- Any other mortality case concerns raised by individual Consultants

↓

MRM form and case notes returned to CET

↓

CET check cause and place of death when necessary. (i.e Home, Other Hospital, CCC). CET request copy notes from other trusts.

↓

Consultant reviews all cases at Pre MRM:

Chemo (non-exhaustive prompt list):
- Check decision to treat
- Appropriate consent (leaflets given, patient copy form)
- Correct dose given
- Day of Chemo – issues
- Assessment / Bloods / Performance Status

Post Chemo
- Triage Follow-up
- Clinical Assessments
- Neutropenic Sepsis – we do not always discuss at review but we <u>always document</u>

RT
- XRT Toxicity

Other (non-exhaustive prompt list):
- F/U
- EOL Management Issues at CCC and other trusts

**Common Reasons for review:**
- Toxicity / particular chemotherapy regimes
- End of Life care
- Triage advice
- Other reason

## APPENDIX C    Child Death Form C

**Form C - Analysis Proforma**

**CDOP Identifier (Unique identifying number)**

Child's age at death             Date of review                     Gender

## Analysis Proforma

This proforma is used by the Child Death Overview Panel (CDOP) to:

- o    evaluate information about the child's death;

- o    identify lessons to be learnt; and

- o    to inform an understanding of all child deaths at a national level.

Where prior to the CDOP meeting, a local case discussion is held, the local team may complete a draft Form C to be forwarded to the CDOP to inform their deliberations.

| Agencies represented at the meeting: | |
| --- | --- |
| Primary Health Care | Yes   No |
| Paediatrics | Yes   No |
| Hospital Services | Yes   No |
| Mental Health Services | Yes   No |
| Ambulance Services | Yes   No |
| Police | Yes   No |
| Children's Social Care Services | Yes   No |
| Schools | Yes   No |
| Other (Specify) | |

List of documents available for discussion

**Cause of death as presently understood**

**Case Summary**

A few paragraphs at most: a summary of the background and a factual description of events leading up to death.  This should be as short as possible.

**The CDOP should analyse any relevant environmental, extrinsic, medical or personal factors that may have contributed to the child's death under the following headings.**

For each of the four domains below, determine different levels of influence (0-3) for any identified factors:

0 - Information not available

1 - No factors identified or factors identified but are unlikely to have contributed to the death

2 - Factors identified that may have contributed to vulnerability, ill-health or death

3 - Factors identified that provide a complete and sufficient explanation for the death

This information should inform the learning of lessons at a local level.

## Domain - Child's needs

### Factors intrinsic to the child

Include any known health needs; factors influencing health; development/ educational issues; behavioural issues; social relationships; identity and independence; abuse of drugs or alcohol; note strengths and difficulties

### Please enter relevant information

| Please tick the following boxes if these factors were present or may have contributed to the death<br><br>**Condition:** | | Relevance (0-3) |
|---|---|---|
| Acute / Sudden onset illness<br>Specify: | Yes / No / NK | |
| **Chronic long term illness** | | |
| Asthma | Yes / No / NK | |
| Epilepsy | Yes / No / NK | |
| Diabetes | Yes / No / NK | |
| Other chronic illness<br>Specify: | Yes / No / NK | |
| **Disability or impairment** | | |
| Learning disabilities<br>Specify: | Yes / No / NK | |
| Motor impairment<br>Specify: | Yes / No / NK | |
| Sensory impairment<br>Specify: | Yes / No / NK | |
| Other disability or impairment<br>Specify: | Yes / No / NK | |
| | | |
| Emotional / behavioural / mental health condition in the child<br>Specify: | Yes / No / NK | |
| Allergies<br>Specify: | Yes / No / NK | |
| Alcohol/substance misuse by the child<br>Specify: | Yes / No / NK | |

| **Domain - family and environment** | | |
|---|---|---|
| **Factors in the family and environment**<br>Include family structure and functioning; including parental abuse of drugs or alcohol; wider family relationships; housing; employment and income; social integration and support; community resources; note strengths and difficulties | | |
| **Please enter relevant information** | | |
| **Please tick the following boxes if these factors were present or may have contributed to the death**<br><br>**Condition:** | | **Relevance (0-3)** |
| Emotional/behavioural/mental health condition in a parent or carer<br>Specify: | Yes / No / NK | |
| Alcohol/substance misuse by a parent/carer<br>Specify | Yes / No / NK | |
| Smoking by the parent/carer in household<br>Specify: | Yes / No / NK | |
| Smoking by the mother during pregnancy<br>Specify: | Yes / No / NK | |
| Housing<br>Specify: | Yes / No / NK | |
| Domestic violence<br>Specify: | Yes / No / NK | |
| Co-sleeping<br>Specify: | Yes / No / NK | |
| Bullying<br>Specify: | Yes / No / NK | |
| Gang/knife crime<br>Specify: | Yes / No / NK | |
| Pets/animal assault<br>Specify: | Yes / No / NK | |
| Consanguinity<br>Specify: | Yes / No / NK | |

| **Domain - parenting capacity** | | |
|---|---|---|
| **Factors in the parenting capacity**<br>Include issues around provision of basic care; health care (including antenatal care where relevant); safety; emotional warmth; stimulation; guidance and boundaries; stability; note strengths and difficulties | | |
| **Please enter relevant information** | | |
| **Please tick the following boxes if these factors were present or may have contributed to the death**<br><br>**Condition:** | | **Relevance (0-3)** |
| Poor parenting/supervision<br>Specify: | Yes / No / NK | |
| Child abuse/neglect<br>Specify: | Yes / No / NK | |

| **Domain - service provision** | | |
|---|---|---|
| **Factors in relation to service provision**<br>Include any identified services (either required or provided); any gaps between child's or family member's needs and service provision; any issues in relation to service provision or uptake | | |
| **Please enter relevant information** | | |
| **Please tick the following boxes if these factors were present or may have contributed to the death**<br><br>**Condition:** | | **Relevance (0-3)** |
| Access to health care<br>Specify: | Yes / No / NK | |
| Prior medical intervention<br>Specify: | Yes / No / NK | |
| Prior surgical intervention<br>Specify: | Yes / No / NK | |

**The CDOP should categorise the likely/cause of death using the following schema.**

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

| Category | Name & description of category | Tick box below |
|---|---|---|
| 1 | **Deliberately inflicted injury, abuse or neglect**<br>This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death. | |
| 2 | **Suicide or deliberate self-inflicted harm**<br>This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm.  It will usually apply to adolescents rather than younger children. | |
| 3 | **Trauma and other external factors**<br>This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors.<br>**Excludes** Deliberately inflected injury, abuse or neglect. (category 1). | |
| 4 | **Malignancy**<br>Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc. | |
| 5 | **Acute medical or surgical condition**<br>For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy. | |
| 6 | **Chronic medical condition**<br>For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause. | |
| 7 | **Chromosomal, genetic and congenital anomalies**<br>Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac. | |
| 8 | **Perinatal/neonatal event**<br>Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death.  It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week). | |
| 9 | **Infection**<br>Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby.  This would include septicaemia, pneumonia, meningitis, HIV infection etc. | |
| 10 | **Sudden unexpected, unexplained death**<br>Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age.<br>**Excludes** Sudden Unexpected Death in Epilepsy (category 5). | |

**The panel should categorise the 'preventability' of the death – tick one box.**
Preventable child deaths are defined in paragraph 11 of *Working Together to Safeguard Children (2015).*

| | | |
|---|---|---|
| **Modifiable factors identified** | The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths | |
| **No Modifiable factors identified** | The panel have not identified any potentially modifiable factors in relation to this death | |
| | Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.* | |

---

**Issues identified in the review**

List the issues identified by the review group.  This list may include the absence of certain key persons from the discussion or the lack of key documents.

---

**Learning Points**

List the learning points that emerge.  These may well overlap with the issues and with recommendations.

**Recommendations**

List any recommendations, even if already picked up as learning points or 'issues'

Specific agency

LSCB

Regional

National

---

**Follow up plans for the family, where relevant**

---

**Possible Actions**

Should this death be referred to another agency or Authority (e.g. Police, Coroner, Health and Safety Executive, Serious Case Review panel) for further investigation or enquiry? If so, please state

    Yes              No             Already done

If yes please
specify;