Lincolnshire Community Health Services
NHS Trust

Learning from Deaths
Mortality Review Policy

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Chair: Elaine Baylis QPM
Chief Executive: Maz Fosh

Learning from Deaths: Mortality Review Policy

Version Control Sheet

Version	Section / Para / Appendix	Version / Description of Amendments	Date	Author / Amended by
1		New Policy	August 2017	Kim Todd
1.1		Minor Update	October 2017	Kim Todd
2	Whole policy document	Changed throughout adding learning from deaths with mortality review panel changed to mortality review group	May 2019	Kim Todd
3	Page 5	Expected deaths definition to include the fact that if the patient has not been seen 2/52 prior to death, then the doctor issuing the death certificate is required to view the body prior to sign off and release of death certificate	May 2019	Kim Todd
4	4.7	Clinical Governance manager changed to Quality Assurance manager	May 2019	Kim Todd
5	5.1	Addition of the	May 2019	Kim Todd

		Virtual Review Process		
6	6.0	Collaborative working narrative updated to include purpose points	May 2019	Kim Todd
7	7.0	Policy list updated to include Sepsis Screening and ReSPECT policies	May 2019	Kim Todd
8	Appendix 1	Changed to the new template	May 2019	Kim Todd
9		LeDER form removed	May 2019	Kim Todd
10	Appendix 4	Monitoring form updated	May 2019	Kim Todd
11	Appendix 4	Equality analysis updated	May 2019	Kim Todd
13	Policy formatted onto Policy and Procedural Document 2020 template		April 2021	Kim Todd
14	Throughout policy	Replace EPAG with CSEG throughout	April 2021	Kim Todd
15	Page 7	Procedural document statement now includes monitoring and equality statements	April 2021	Kim Todd
16	Page 12	Change Sepsis Screening Policy to Sepsis	April 2021	Kim Todd

		Recognition Policy		
17	Page 12	LCHS Policy to Support staff during a traumatic incident, event or claim no longer exists, removed from reference list	April 2021	
18	Page 13 Appendix 1	Changed to latest version of template	April 2021	Kim Todd
19	Page 19 Appendix 2	Updated Equality Analysis to reflect new format	April 2021	Kim Todd
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Procedural Document Statement

Background Statement	This policy confirms the process for reviewing deaths within Lincolnshire Community Health Services (LCHS) to provide assurance that deaths are reviewed effectively, systematically and with candour and transparency and that both lessons are learned and improvements are made and areas of good practice are highlighted.
Responsibilities	All LCHS staff involved with deceased patients are required to adhere to this policy
Training	Stage one review process will be cascaded within service areas. Stage 2 review process will be cascaded through learning from deaths mortality review meetings
Dissemination	Website/Intranet
Resource implication	This policy was developed in line with the CQC Learning , candour and accountability (2016) recommendations and the National Guidance on Learning from Deaths Quality Board Framework (March 2017)
Consultation	This policy has been developed in consultation with LCHS staff members
Monitoring	Monthly Learning from Deaths meetings are held which will monitor policy compliance
Equality Statement	As part of our on-going commitment to promoting equality, valuing diversity and protecting human rights, Lincolnshire Community Health Services NHS Trust is committed to eliminating discrimination against any individual (individual means employees, patients, services users and carers) on the grounds of gender, gender reassignment, disability, age, race, ethnicity, sexual orientation, socio-economic status, language, religion or beliefs, marriage or civil partnerships, pregnancy and maternity, appearance, nationality or culture.

1. **Introduction** This policy confirms the process for reviewing deaths within Lincolnshire Community Health Services (LCHS) to ensure a consistent approach is followed in order to identify if the patient's needs were met during the end of life phase and that relatives and carers were supported appropriately.

2. **Purpose** The aim of the mortality review process is to identify any areas of practice that require improvement and to identify areas of good practice. This process ensures that mortality within LCHS is managed and reviewed in a systematic way. Deaths of patients under the age of 19 all subject to review within the Child Death Overview Panel (CEDOP). A death of a patient (over the age of 4) with learning difficulties, whilst subject to the CEDOP/ LCHS mortality review process, these cases are also reportable for inclusion in the NHSE Learning Disabilities Mortality Review Programme (LeDER).

   In a death where a safeguarding concern is raised, this case may then be subject to a serious case review in line with the Lincolnshire Safeguarding Adults Board (LSAB) process.

3. **Definitions of death -** definitions taken from the LCHS Verification of Death Policy

Expected Death This is defined as death following on from a period of illness that has been identified as terminal, and where no active intervention to prolong life is ongoing. If the deceased has not been seen in the preceding two weeks prior to death, then the doctor issuing the death certificate is required to view the body of the deceased prior to sign off and release of the death certificate.

Unexpected Death This is any death that does not fit the definition of an expected death, where there is clearly no chance of survival and or where resuscitation would be both futile and distressing.

Suspicious Death A suspicious or unexplained death may include unnatural causes such as manslaughter, signs of violence, poisoning, suicide or safeguarding concerns such as neglect or abuse

4. Scope

All deaths from the following areas will be subject to mortality review:

- The four community hospital ward areas
- The Butterfly Hospice
- Transitional Care Beds

In addition, the learning from deaths mortality review group will also consider:

- Any deaths within an Urgent Care setting

- Any death reported as a Serious Untoward Incident
- Any death subject to a Coroners Enquiry regardless of the timeframe

5. Duties

5.1 Trust Board

It is the responsibility of the board to have oversight of all aspects of the learning from deaths mortality review process. They need to ensure that there is a systematic approach for identifying the deaths for review and further investigation and be assured that these are carried out to a high quality. This will be through the provision of a quarterly learning from deaths report to the board
Reporting of mortality review data is a statutory requirement and the board also need assurance that the mortality review data is reported in line with This information will then be reflected in the LCHS annual Quality Account.

5.2 Non Executive Director

Has a key role in ensuring that the learning from deaths mortality review processes that are in place are robust, focus on learning and quality improvement and can withstand external scrutiny, by providing challenge and support via the LCHS Quality and Risk Committee.

5.3 Medical Director

The Medical Director has overall Trust responsibility for ensuring that deaths within LCHS are monitored, reviewed and any actions required identified and acted upon. The Medical Director will act as Chair of the Learning from Deaths Mortality Review Group

5.4 Learning from Deaths Mortality Review Group

The aim of the group is to provide assurance that the Trust has a robust internal quality assurance process that ensures patient safety, clinical effectiveness and user experience form the core practice and principles of services by monitoring and reviewing mortality related issues. The group will undertake reviews of all deaths within scope and report findings and recommendations to the Clinical Safety and Effectiveness Group

Findings and recommendations will then be reported to the Quality and Risk Committee and the Trust Board as part of the assurance process. Additionally, findings will be disseminated to the service areas via the Heads of Clinical Services, Clinical Team Leads and Quality Assurance managers.

5.5 Clinical Areas

Are responsible for the completion of a Stage 1 review template to be completed for deaths that occur within the 4 community hospital ward areas, Butterfly Hospice and Transitional Care beds (Appendix 1). These will then be submitted to the learning from deaths mortality review group. If a coroner's referral is

required this will also be undertaken by these areas at the time of patient death and this fact will be recorded on the template.

Urgent Care areas will inform the mortality group via the practitioner performance manager of any deaths that occur within this area and submit and investigation to identify root causes to the group for discussion.

5.6 Practitioner Performance Manager /Learning from Deaths Lead

Is responsible (with administrative support) to ensure the production of the monthly agenda, monthly meeting minutes and a quarterly report. The practitioner performance manager will also act as a conduit for coroners enquiries.

5 .7 Quality Assurance Managers

Will liaise with the practitioner performance manager to ensure that all reports into deaths that are investigated as serious untoward incidents are submitted to the learning from deaths mortality review group.

Where a case record review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported via local risk management systems to the National Reporting and Learning System (NRLS).

6 . Process for Stage 1 and 2 review

6.1 Stage 1 Template completed within service area for each death and submitted to the Practitioner Performance Manager. The template will then be either virtually reviewed by the group (if it is clear that the patient was end of life and there were no concerns identified in relation to the final outcome) or added to the monthly agenda for further discussion.

6.2 Stage 2 Conducted virtually or case discussed by the learning from deaths mortality review group at which stage a grade is awarded to indicate if the case demonstrated:

- Unavoidable death, no suboptimal care (Grade 0)
- Unavoidable death, suboptimal care but different management would NOT have affected the outcome (Grade 1)
- Suboptimal care, but different management **MIGHT** have affected the outcome (possibly avoidable death) (Grade 2)
- Suboptimal care, different care **WOULD REASONABLY BE EXPECTED** to have affected the outcome (probable avoidable death) (Grade 3)

If a case is awarded a Grade 2 or Grade 3, a further indepth review will be requested by the mortality review group to be undertaken by the service area concerned.

If multiple agencies were involved in the patients care, where safeguarding concerns are identified, the case should be considered for referral for a serious case review.

6.3 Serious Untoward Incident Investigations

The investigation report is submitted to the group to ensure that all questions in respect of the death are answered and that the action plan is robust and evidence is available to provide assurance of actions completed. If the case is subject to a coroners enquiry, once signed off by the Quality and Risk Committee, a copy of the investigation report and action plan may be sent to the coroner with any supporting evidence to assure actions identified are complete.

6.4 Open and Honest/ Duty of Candour

LCHS recognise that any death, expected or unexpected is a difficult time for all involved and are committed to embedding a culture of early engagement with those affected, particularly where the death is unexpected. When there is a requirement to hold an investigation to identify root cause(s) into a death, the service area will inform the relatives/carer's of the deceased of the impending investigation and enquire if they wish to attend the investigation meeting. It is recognised that this needs to be handled sensitively and in a timely manner. Where the relatives/carers do not wish to attend the investigation in person, they should be offered the opportunity to receive the investigation findings.

7. Collaborative Working

NHS England and the Care Quality Commission have encouraged provider organisations and commissioners to work together to review and improve their local approach following the death of patients receiving care from the health system as a whole. As a result a Lincolnshire Mortality collaborative, of which LCHS is a member, is held six weekly with representatives from primary and secondary care and partner organisations such as LPFT, LCHS and St Barnabas.

The purpose of these meetings are to:

- Conduct discussions in order to aggregate common themes and findings from the reviews and to report these appropriately.

- To take action county-wide where there has been considered systematic failings and learning, within both Secondary and Primary Care

- Provide a platform for positive challenge within the Lincolnshire health care system for shared learning to be identified and improvements to be made to improve the end of life phase for patients and their families.

8. Associated Policies

This policy should be read in conjunction with the following policies:

LCHS Verification of Death by an Emergency Care Practitioner, Autonomous Practitioner or Registered Nurse
LCHS Open and Honest Care Policy (incorporating Duty of Candour)
LCHS Incident Reporting Policy
LCHS Serious Incident Policy
LCHS Complaints Policy
LCHS Procedure for the Investigation of Incidents, Complaints and Claims
LCHS Resuscitation Policy
LCHS Mental Capacity Act (including Deprivation of Liberty Safeguards)
LCHS Safeguarding Adults Policy
LCHS Safeguarding Child Policy
LCHS Sepsis Recognition Policy
LCHS Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Policy

9 . References

- Learning, Candour and Accountability: A review of the way NHS Trusts Review and Investigate the deaths of patients in England, December 2016, Care Quality Commission

- National Guidance on Learning from Deaths- A Framework for NHS Trusts and Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (March 2017) National Quality Board

- Care of dying adults in the last days of life, December 2015, NICE/NG31

- The Learning Disabilities Mortality Review Programme (LeDeR), 2015, NHS England

Appendix 1

MORTALITY REVIEW REPORTING TEMPLATE **Updated April 2021**

National Mortality Case Record Review Programme; Royal College of Physicians

Patient NHS Number		Patient Age	
GP Practice			
Was the GP record accessible?			
Medical History *(Significant active conditions only)*	**1**	**2**	**3**
	4	**5**	**6**
Admitted from			
Date of Admission		Time of Admission	
When was bed requested?		When did bed become available?	
Was a care package required and were there difficulties in obtaining? (provide detail)			
Date of Death		Time of Death	
Time & date last seen by medical practitioner/ACP prior to death	Time	Date	
Name of Unit(s) *(e.g. LCHS unit /hospital / care home)* *(Date order most recent first)* *(LOS = Length of stay in previous units)* **WITHIN THE LAST 6/52**	**1**	**2**	**3**
		LOS:	**LOS:**
	4	**5**	**6**
	LOS:	**LOS:**	**LOS:**
Main diagnosis on admission			
Main reason for admission If patient is palliative or EoL please ensure this is reflected in the S1 journal	.		

Phase of care: **Admission and initial management (approximately the first 24 hours)**	

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
Please circle only one score

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

- Please circle only one score
-

Phase of care: **Ongoing care**

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
Please circle only one score

Phase of care: **End of Life Care**

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
Please circle only one score

End of Life Planning:

Please answer all of the questions below:

Was this patient known to other services prior to admission e.g. Macmillan, Marie Curie, Community Nursing ? **PLEASE LIST**	
Was a DNA CPR in place before admission?	
If yes to above Was the DNAR valid and when was it put in place?	
If there was no DNACPR form in place when was one completed?	
Was there a RESPECT form?	
Is it scanned onto the patient record?	
When was it put in place? Was CPR recommended?	
Was the ReSPECT form revised? If so date of revision ?	
Was the palliative care /EPACCS template completed?	
What date was it commenced?	
Did any escalating action take place? If so, what?	
Was this the patients preferred place of death?	
Was this patient's choice?	
If the patient was admitted for active treatment when was the decision made to limit treatment?	
Was a DATIX completed and the death escalated as a STEISS?	
Has a complaint or concern been lodged regarding this patient's death?	

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.

From your assessment were there any problems with the care of the patient?

If NO stop here **If YES** (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below. Please indicate whether it led to any harm and in which phase(s) of care the problem was identified. Please indicate yes or no for all questions and where the answer is yes complete the rest of the of the question, if no pass onto the next question (8 in total)

1.Problem in assessment, investigation or diagnosis *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)*

YES	NO

Did the problem lead to harm?

In which phase(s) did the problem occur?

Admission and initial assessment Ongoing care Care during procedure End-of-life care

2. Problem with medication / IV fluids /syringe driver/ electrolytes / oxygen

YES	NO

Did the problem lead to harm?

In which phase(s) did the problem occur?

Admission and initial assessment Ongoing care Care during procedure End-of-life care

3.Problem related to treatment and management plan *(including prevention of pressure ulcers, falls, VTE)*

YES	NO

Did the problem lead to harm?

In which phase(s) did the problem occur?

Admission and initial assessment Ongoing care Care during procedure End-of-life care

4. Problem with infection management?

YES	NO

Did the problem lead to harm?

In which phase(s) did the problem occur?

Admission and initial assessment Ongoing care Care during procedure End-of-life care

6.Problem in clinical monitoring *(including failure to plan, to undertake, or to recognise and respond to changes)*

YES	NO

Did the problem lead to harm?

In which phase(s) did the problem occur?
Admission and initial assessment Ongoing care Care during procedure End-of-life care

7.Problem in resuscitation following a cardiac or respiratory arrest *(including cardiopulmonary resuscitation (CPR)*

YES	NO

Did the problem lead to harm?

In which phase(s) did the problem occur?
Admission and initial assessment Ongoing care Care during procedure End-of-life care

8.Problem of any other type not fitting the categories above *(including communication and organisational issues)*

YES	NO

Did the problem lead to harm?

In which phase(s) did the problem occur?
Admission and initial assessment Ongoing care Care during procedure End-of-life care

Specific Questions related to Patient Care:	
Was this patient known to have a learning disability? If so has the case been referred for LeDeR review ? Was this patient known to have mental health problems (excluding dementia)? Was this patient known to have dementia?	
Please rate the quality of the patient record **1 = very poor 2 = poor 3 = adequate 4 = good 5 = excellent**	

Please circle only one score			
Cause of death *(taking all information into account including Post Mortem if known)* If unobtainable “same as admission diagnosis” is acceptable		1a	
		1b	
		1c	
		II	
Was the Coroner informed / consulted?			
Template Completed and Case Reviewed by:			
	Designation:		
	Date Completed:		
	Time To Complete:		
Submitted to: Matron/ PP Manager	**Name:**	**Date:**	

10.Review of document

As per policy schedule

Appendix 2 **Equality Analysis**

NB - It is the responsibility of the author / reviewer of this document to complete / update the Equality Analysis each time it has a full review and to contact the Equality Diversity and Inclusion Lead if a full equality impact analysis is required

Equality Impact Analysis Screening Form

Title of activity	Policy Update- Learning from Deaths: Mortality Review Policy		
Date form completed	19/04/2021	Name of lead for this activity	Kim Todd

Analysis undertaken by:		
Name(s)	Job role	Department
Kim Todd	Practitioner Performance Manager/Learning from Deaths Lead	Quality

What is the aim or objective of this activity?	To ensure a consistent approach of reviewing deaths within LCHS
Who will this activity impact on? *E.g. staff, patients, carers, visitors etc.*	To ensure quality service delivery within LCHS and working with external partners to highlight concerns

Potential impacts on different equality groups:

Equality Group	Potential for **positive** impact	**Neutral** Impact	Potential for **negative** impact	Please provide details of how you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered)
Age	☒	☐	☐	
Disability	☒	☐	☐	
Gender reassignment	☒	☐	☐	
Marriage & civil partnerships	☒	☐	☐	

Pregnancy & maternity	☒	☐	☐	
Race	☒	☐	☐	
Religion or belief	☒	☐	☐	
Sex	☒	☐	☐	
Sexual Orientation	☒	☐	☐	
Additional Impacts ***(what other groups might this activity impact on? Carers, homeless, travelling communities etc.)***	☒	☐	☐	

If you have ticked one of the above equality groups please complete the following:

Level of impact

	Yes	No
Could this impact be considered direct or indirect discrimination?	☐	☐
If yes, how will you address this?		

	High	Medium	Low
What level do you consider the potential negative impact would be?	☐	☐	☐

If the negative impact is high, a full equality impact analysis will be required.

Action Plan

How could you minimise or remove any negative impacts identified, even if this is rated low?
How will you monitor this impact or planned actions?

Future review date: As per policy schedule