C.11 SUBMISSION TO IHRD IN RESPECT OF DEATHS IN HOSPITAL

1. Deaths, expected and unexpected occur in hospital on a regular basis. Some of these deaths may be expected due to the nature of the underlying illness or disease process and some may not be expected. When a death does occur in hospital there are established processes for completing the Medical Certificate of Cause of Death (MCCD), referring deaths to the coroner where indicated and to provide support and information to the family of the deceased.

2. Following recommendations from the Human Organs Inquiry, a Regional Bereavement Co-ordinators network was established in February 2006. The five area bereavement co-ordinators have worked both within each Health and Social Care (HSC) Trust and together on regional projects including an audit of hospital end of life and bereavement care practices (2007/8), developing a Bereavement Care Strategy for Northern Ireland (issued 2009), revised post mortem examination consent forms and information booklets to ensure compliance with Human Tissue Authority (2009/10) and development of a public HSC Bereavement Network website to host guidance, e-learning, resources and news (2012/13).

3. Over a period of time there have been a number of developments in the manner in which deaths are investigated within the HSC. Various systems are in place to review or investigate death through the Serious Adverse Incident process, National Confidential Enquiries and Case Management Reviews.

4. Each of these is designed to ensure that the circumstances of the death are reviewed to establish whether lessons can be learnt for the future and to ensure dissemination of that learning.

5. Measurement to inform analysis and learning is an important part of improvement and deaths in hospital are often used as a proxy for the quality of care that is being provided. Crude death rates can however be misleading as they do not take account of differences in the age and sex profile of the populations served by different HSC Trusts or indeed the complexity or

disease severity of particular conditions. Therefore to allow comparative analysis across the UK, standardised death rates are used; Hospital Standardised Mortality Ratio (HSMR).

6. Given the complexities associated with such measurement, currently there is not uniform agreement on the best way to measure the number of deaths and there are several different methodologies in use across the UK.

7. The HSC in NI currently use the CHKS mortality measure which is called the Risk Adjusted Mortality Index (RAMI). As the name suggests the index is adjusted to take into account case mix. Some patients admitted to hospital will be more ill than others, or will have other underlying conditions or co-morbidities. This means their risk of death is higher.

8. It is widely accepted that a mortality measure on its own is not sufficient. It is a starting point but has to be used alongside other indicators. It is an important measure which cannot be ignored, but just like a smoke alarm there are many reasons it can 'go off' (appear high) – often not significant, but they must never be ignored. This is why CHKS also provide each Trust with more detailed analyses to underpin the RAMI data. The CHKS data is also provided regularly to the HSC Board.

9. Even when considering RAMI data, there can be many reasons for variation in mortality rates. A fundamental issue with this type of measure is that it is looking at what goes on inside a hospital and does not take account of the availability of services outside the hospital.

10. Some areas have much better end of life support for people to die at home, for example, Macmillan and Marie Curie Specialist Nurses. If community-based services are more limited in an area, or if a hospital has a specialist palliative care unit, more patients may be admitted for care at the end of their life.

11. Similarly it will depend on the policies of local nursing homes as to whether they send residents into hospital or support them through the last few days of life. "Hospitals" vary; some will provide hospice services which may be run by charities in other localities.

12. Inconsistencies in the recording of those patients receiving palliative care will have an effect on RAMI, as these deaths are excluded from the observed deaths in the measure.

13. To reduce the impact of deaths whilst receiving palliative care and following the publication of the Francis Inquiry into Mid Staffordshire Care, the Health and Social Care Information Centre (HSCIC) in England have developed a new Hospital Standardised Mortality Index (HSMI) to monitoring HSMR, which includes patients who died whilst receiving palliative care.

14. A high RAMI does not necessarily mean that there is a quality of care issue, or that unsafe services are being provided. It is not always possible to distinguish between deaths which could potentially have been preventable and those which were not. Therefore, a high HSMR is regarded simply as a trigger for further analysis and where necessary investigation of any variation.

15. Hospitals are complex organisations so there is inevitably variation between them due to many reasons. It is only of concern when a hospital has a RAMI that falls outside the upper confidence limit as this is used to show when there is a very low likelihood that such a pattern is just normal variation, in such circumstances variation of this nature requires further analysis and investigation.

16. The following narrative sets out some of the other developments and provides information on the proposed rollout of a regional system to investigate all deaths that occur in hospitals in Northern Ireland.

Luce Review and Shipman Inquiries

17. The 3rd Report of the Shipman Inquiry was published in July 2003 and dealt with death certification and the investigation of deaths by Coroners. At the same time the Home Office published the Luce Review - "*Death Certification and Investigation in England, Wales and Northern Ireland – The Report of a Fundamental Review 2003".*

18. Both reports had a bearing on the role of Coroners and the investigation of hospital deaths. A separate submission on Death Certification has been issued to the Inquiry.

Serious Adverse Incidents

19. In July 2004, the Department introduced guidance and advice for HPSS organisations and Special Agencies on the reporting and management of Serious Adverse Incidents (SAIs) and near misses.

20. This guidance highlighted the need for the Department to be informed immediately about incidents which are regarded as serious enough for regional action to be taken to ensure improved care or safety for patients, clients and staff. It contained guidance as to when a death in hospital should be regarded as a SAI, for example, when a patient has died in unusual circumstances or where there are clusters of unexpected or unexplained deaths.

21. Further information on SAIs has been included in the submission regarding Clinical and Social Care Governance, Quality and Patient Safety.

Clinical Outcome Review Programme

22. HSC organisations also contribute to Confidential Inquiries into death in hospital as part of the Clinical Outcome Review Programme. There are four Confidential Inquiries:

- Medical and Surgical
- Mental Health
- Maternal, Newborn and Infant
- Child Health.

23. Medical and Surgical – The National Confidential Enquiry into Patient Outcome and Death reviews medical and surgical clinical practice and makes recommendations to improve the quality of the delivery of care for the benefit of the public. They do this by undertaking confidential surveys and research

covering many different aspects of care and making recommendations for clinicians and management to implement.

24. Mental Health - As part of its core work the Inquiry examines suicide, and homicide committed by people who had been in contact with secondary and specialist mental health services in the previous 12 months. It also examines the deaths of psychiatric inpatients which were sudden and unexplained.

25. Maternal, Newborn and Infant - This programme investigates the deaths of women and their babies during or after childbirth, and also cases where women and their babies survive serious illness during pregnancy or after childbirth. The aim is to identify avoidable illness and deaths so the lessons learned can be used to prevent similar cases in the future leading to improvements in maternal and newborn care for all mothers and babies.

26. Child Health - This is a national programme of work to examine the incidence and associated features of mortality and serious morbidity in 1-18 year olds and aims to improve the delivery and outcomes of health care to children within the UK.

Case Management Reviews

27. Another example of where learning can be disseminated is in the use of Case Management Reviews (CMRs). The purpose of a CMR is to promote learning. They are undertaken not to find fault with individual practice but rather to examine organisational systems and processes that assist or allow individuals to make decisions or act in certain ways.

28. The focus of a CMR is on learning, to build on what has worked well and to determine how issues that have not worked well should be prevented in the future.

29. It is a statutory function of the Safeguarding Board for Northern Ireland (SBNI) to undertake a CMR in certain circumstances.

30. The SBNI aims to promote the highest standards of safeguarding practice within and across organisations. The CMR process is intended to assist the SBNI and its Represented Bodies to deliver that aim by creating a mechanism for reflecting on practice, identifying the learning from practice (what worked and did not work and why) and disseminating that learning for the purpose of improving practice and ultimately future safeguarding outcomes for children and young people. Of course, improvement must be sustained. This will require regular monitoring and follow-up by both the SBNI as a collective body but also by the SBNI's Represented Bodies as individual organisations. This will help to ensure that the findings from CMRs continue to have a real impact on children's lives.

Investigating All Deaths in Hospital

31. Arising from the recommendations of the Luce Review and the 3rd Report of the Shipman Inquiry, the Department took forward a programme of work in relation to Death Certification. A separate submission on Death Certification has been sent to the Inquiry.

32. In 2009 the Department and Coroner's service agreed that given the large number of deaths referred to the Coroner by doctors, it would be helpful to scope if medical support to the Coroner would be of benefit.

33. A Medical Officer was seconded on a part time basis and undertook a scoping exercise which indicated that around a quarter of all deaths referred to the Coroner were having active medical care, usually in hospital, at the time of death. A further 12% had reasons for the case to be referred to the Coroner because a MCCD could not be completed for legal reasons such as the person had not been seen in the preceding 28 days or there was a known industrial disease. Subsequently the Coroner's service has appointed a full time Medical Officer to assist the Coroners.

34. The Department has been seeking to develop a regional process to review all deaths that occur in hospital and in the community.

35. Monitoring of deaths in GP practices has been recommended as a way of providing data to assist quality improvement. A two-year pilot study carried

out by the Eastern Health & Social Services Board in 2003/2004 showed that practice age, gender or deprivation profiles provided sufficient assignable causes for mortality variations.

36. However, if necessary, further investigation would focus on levels of practice resources, then process of care such as differences in implementation or practice organisation, and then finally on the individual carers to identify factors associated with the individual.

37. Following this a Regional General Medical Data Analysis Project (RGMDAP) was established in 2006. This also showed that use of mortality data can identify practices with higher than expected mortality rates, allowing focused consideration of the data by the practice together with an external team. In several cases the rates are able to be explained due to population differences such as age, deprivation or nursing home care.

38. The RGMDAP was completed in 2011 and reaffirmed the findings from earlier work. The Department has considered the report and is integrating it into the reforms of Death Certification in Northern Ireland. In the interim, the HSCB are updating the data.

39. Although deaths were analysed by GP Practice, the death may have occurred in hospital rather than in the community. The work of the RGMDAP will be reviewed by the Death Certification Implementation Working Group to consider its applicability and the way forward.

40. A pilot scheme has also been developed within the Belfast HSC Trust to review all deaths that occur in their hospitals and discussions are ongoing on implementing this process across Northern Ireland. Essentially the process will record, review, monitor and analyse all hospital deaths.

41. At present, there is no systematic method of collecting the details entered onto the MCCD or reported to the Coroner and no HSC Trust-wide, guaranteed, routine assurance that every death is clinically reviewed. This is no different from other parts of the United Kingdom.

42. Among the recommendations from recent hospital inquiries such as the Mid Staffordshire NHS Foundation Trust Independent Inquiry (the Francis report) is that clinical teams review and learn from issues surrounding the deaths of their patients and the pilot scheme will ensure adherence to that recommendation.

43. The new "Morbidity and Mortality Review" (M&MR) system in the Belfast Trust was introduced in May 2013. It is accessed via the Trusts' Intranet system and is primarily a tool to be used by clinicians and multidisciplinary teams to record and learn from mortality and morbidity of their patients.

44. The M&MR system will allow the routine:

- Recording of details;
- Review by Consultant Medical Staff of the recording of deaths;
- Review of unexpected deaths at Mortality and Morbidity meetings;
- Recording of the discussion, and learning and action plans from these discussions; and
- Collection of information garnered at Mortality and Morbidity meetings for appraisal purposes.

45. The recording and reviewing sections of the M&MR process is divided into 3 stages:

1	At the time of death	**Record** details of the patient's death
2	By the next working day	**Review** of these details by the designated Consultant
3	Next Mortality and Morbidity meeting	**Review** of deaths and lessons learned at regular Mortality and Morbidity meetings

46. The monitoring and analysing of all deaths completes the process of review and learning.

Referral of Deaths to the Coroner

47. Information on when to refer a death to the Coroner has always been present on the MCCD. Teaching about the requirement to refer death to the Coroner, and how to complete a MCCD has been a long standing part of the under graduate training for medical students at Queen's University.

48. In 2005 a review of induction processes for junior doctors recommended that first day induction should include Coroner's issues. In recent years a presentation on death certification and referral to the Coroner has been included in the induction for foundation doctors, and they are also required to complete an e-learning module. Knowledge of death certification and referral to the Coroner is also included in the foundation curriculum.

49. In 2008 additional guidance on Death, Stillbirth and Cremation Certification was issued by the DHSSPS, Coroner's Service for Northern Ireland and the General Register Office (Northern Ireland). This provided information on the principles of certification and referral to the coroner as well as a step-by-step guide to completion of the forms.

50. In April 2012, the Department issued a letter re-iterating the guidance on Death, Stillbirth and Cremation Certification first issued in September 2008. It advised practitioners of their responsibilities to maintain their competence by updating their knowledge and reflecting on their practice and drew particular attention to the section on deaths that must be reported to the Coroner.

51. HSC organisations were reminded of their responsibility to promote good practice and governance by monitoring or regular audit of compliance with the guidance.

SQSD Meeting with QUB/UU to inform curricula

52. In order to promote safe and effective care, the Department also established an Undergraduate Forum in 2007. The purpose of this group was to provide a forum to facilitate discussion and action between the Department, educators

and the main training providers to improve patient safety and translate learning into the curriculum for the next generation of health professionals.

THERE ARE NO SPECIFIC DOCUMENTS FOR THIS SUBMISSION.

DOCUMENTS RELATING TO THE LUCE REVIEW AND SHIPMAN INQUIRY, AND THE GUIDANCE ISSUED ON DEATH, STILLBIRTH AND CREMATION CERTIFICATION HAVE BEEN INCLUDED IN THE SUBMISSION ON DEATH CERTIFICATION IN NORTHERN IRELAND.