RESPONDING TO AND LEARNING FROM DEATHS POLICY

SUMMARY & AIM

This Policy sets out the process for the identification, recording, reviewing and investigating deaths of patients in the care of Airedale NHS Foundation Trust.
In addition it describes how the Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. (Being Open Policy)
It also describes how the Trust supports staff that may be affected by the death of someone in the Trust's care.
It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

TARGET AUDIENCE

- Medical staff
- Senior nursing staff
- Clinical coding staff
- Clinical Audit & Effectiveness Team
- Clinical Quality Analysist
- Quality & Safety Team
- Quality Improvement staff
- Bereavement Officer

TRAINING REQUIREMENTS

Train the trainer sessions to be sourced and delivered to the appropriate clinical reviewers

EVIDENCE OF IMPLEMENTATION

See section 10

KEY REQUIREMENTS

1. This applies to
   - All in-hospital deaths in all specialities
   - Maternal and child deaths
   - Diagnosis groups as identified by Quality Review Group, Mortality Surveillance Group and Executive Assurance Group.

2. It is everyone's responsibility to learn from the deaths occurring in the Trust.

3. All staff have a duty to raise concerns regarding patient care and follow Trust processes.

DOCUMENT CONTROL

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Approved documents related to this policy

Document name & hyperlink
Incident Management Policy
Being Open Policy
Complaints Policy
Safeguarding Adults Policy
Safeguarding Children & Young Persons Policy

Statement of changes made from version XX

Version	Date	Section & description
0.1	31/08/2017	New Policy

List of stakeholders who have been asked to review this document
(*list each person, a department or head of department with responsibilities)*

Name	Title	Date
Mr Karl Mainprize	Medical Director	20/09/17
Dr Sarah Stowe	Consultant & Mortality Lead	22/09/17
Mortality Review Group members		25/09/17
Dr Maggie Halliwell	Non-Executive Director	20/09/17

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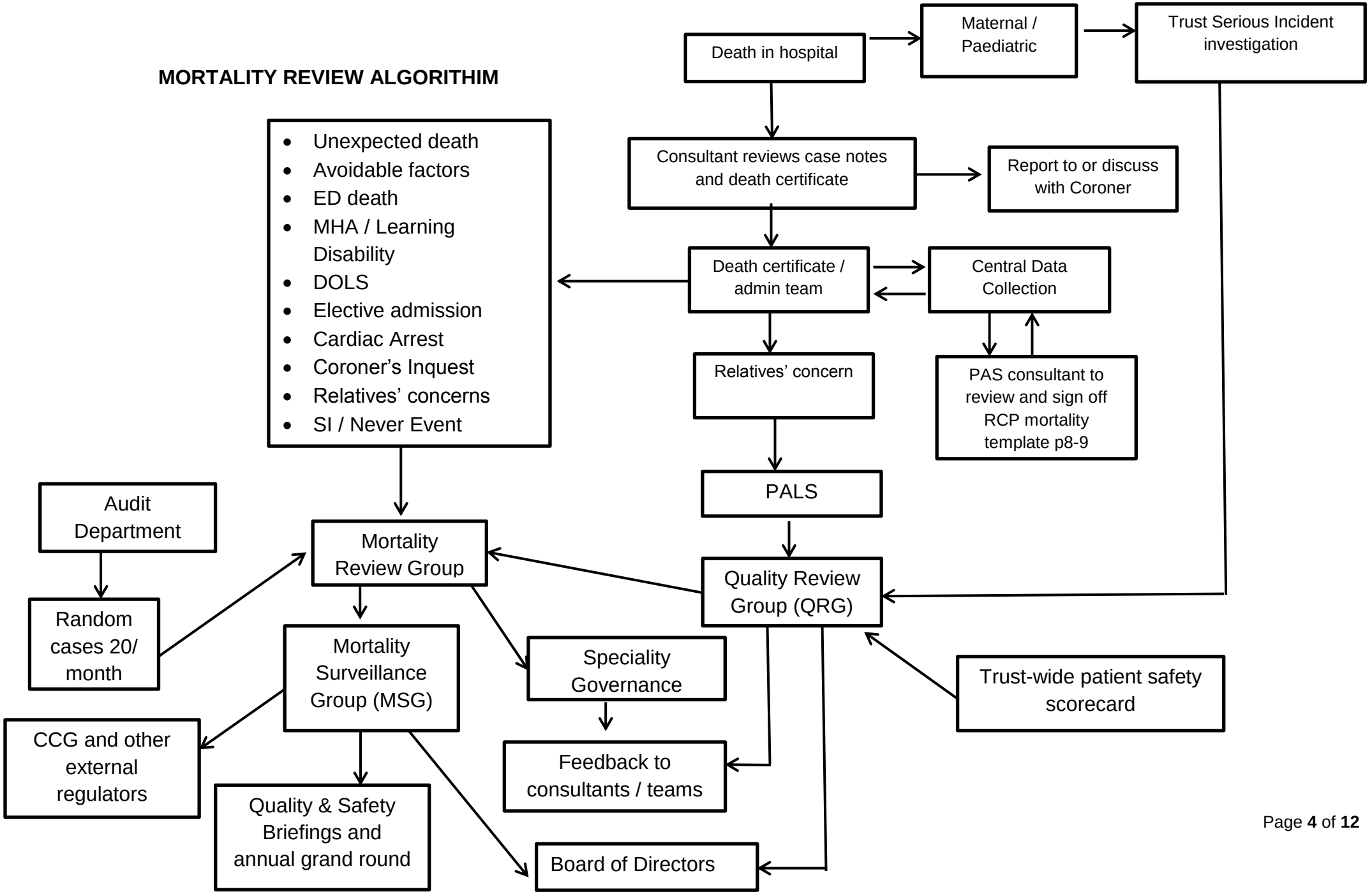
MORTALITY REVIEW ALGORITHIM



1. INTRODUCTION

The Care Quality Commission published their report "*Learning, Candour and Accountability; a review of the way NHS Trusts review and investigate the deaths of patients in England"* in December 2016, making recommendations regarding the approach to learning from deaths and how this could be standardised across the NHS.

The Trust had a mortality review in place but following a gap analysis it was deemed this could be strengthened to improve the identification, the standard of review along with the learning from deaths and in particular from those most vulnerable patient who die whilst in our care.

2. PURPOSE

The purpose of this policy is to implement and embed the requirements outlined within the Learning from Deaths Framework whilst making this business as usual and ensuring it forms part of current policies in place to continually learn and improve the quality of care provided to patients.

3. SCOPE

This document applies to all staff whether they are employed by the Trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

4. PROCESS FOR RECORDING DEATHS IN THE TRUST

All deaths occurring within the Trust must be recorded on SystmOne

The Consultant who last saw patient alive will review the case notes and approve the detail to be included within the death certificate.

The Consultant will ensure that the death does not require escalation to the Quality & Safety Team as a potential serious incident (SI) or require reporting to the Coroner or discussion with the Coroner's Officer. There is written guidance of information required before contacting the Coroner's office.

The causes of death as documented on the death certificate will be written in the case notes, along with any actions (eg referral to Coroner, record of discussions with relatives)

The death certificate once completed will be sent to the Bereavement Office along with the case notes.

As part of the Bereavement Officer's duties; a leaflet will be given to relatives outlining how they can report any concerns about their relative's care to the Trust.

5. SELECTING DEATHS FOR REVIEW

5.1 The Quality Review Group receives a list of all deaths on a weekly basis and those relating to an elective admission will be reviewed by the Medical Director and issued for a further review by the Mortality Review Group.

5.2 All infant or child, stillbirth and maternal deaths will be reviewed in accordance with the national policies and guidelines.

5.3 The Trust will review deaths in patients in the following categories:

- Infant or child (under 18) deaths
- Perinatal or maternal deaths
- Deaths of patients with learning disabilities or severe mental illness
- Deaths in areas where people are not expected to die
- All deaths where bereaved families and carers or staff, have raised a significant concern about the quality of care provision
- All inpatient, outpatient and community patient deaths of those with learning disabilities (the LeDeR review process outlined in Appendix 1 must be used in all aforementioned cases).
- All deaths in a service specialty, particular diagnosis or treatment group where an 'alert' has been raised with the Trust through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator)
- Deaths which should be investigated under the Serious Incident framework, including any inpatient detained under Mental Health Act in circumstances where there is reason to believe the death may have been due or in part due to problems in care. This includes suspected self-inflicted death which must be reported as a serious incident and investigated appropriately and via STEIS to the commissioner(s). Consideration will also be given to commissioning an independent investigation as detailed in the Serious Incident framework
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths will be reviewed, as determined by the Trust.
- A further sample of other deaths that do not fit the identified categories to provide an overview of where learning and improvement is required. This will be a random sample to ensure there is a minimum 20 sets of case notes reviewed each month. This may include patients whose death was expected and may have had an End of Life Care Plan in place.

5.4 For all other deaths, the consultant who last saw patient alive will review the case notes and approve the death certificate. He or she will ensure that the death does not require escalation to the Quality & Safety Team as a potential serious incident (SI) or require reporting to the Coroner or discussion with the Coroner's officer. The causes of death as documented on the death certificate will be written in the case notes, along with any actions eg referral to Coroner, record of discussions with relatives.

5.5 The death certificate will be sent to Bereavement office along with the medical records. As part of the bereavement officer's duties, a leaflet will be given to relatives outlining how they can report any concerns about their relative's care to the Trust (see point 8 below).

5.6 The death certificate will be scanned into SystmOne. The bereavement office will email a copy of the death certificate to the consultant responsible for the patient under PAS along with a template form / checklist to sign off (this will include a list of reasons to refer to the mortality review group, MRG). The consultant will return the completed, signed form back to the bereavement admin office

5.7 Any relative concerns will be directed to PALS (telephone, email, letter), then screened by the quality review group (QRG) weekly to determine further actions (eg escalated to Trust Board, refer to MRG, refer back to PALS).

5.8 The Quality Review Group meet weekly to review all incidents reported in the past week and any other concerns. All relatives' concerns relating to patient deaths will be screened and appropriate action taken. Any other issues relating to mortality will be referred to the MRG for further action

5.9 The MRG meets monthly and reviews all deaths in categories listed plus random cases supplied by the Clinical Audit Team, up to 20/month. The clinical reviewers will receive regular training, mentoring and feedback as part of the membership of the group. It will use the serious incident framework definitions to determine the level of investigation required for each case.

5.10 The MRG reports to the Mortality Surveillance Group (MSG) (via written minutes) and informs each specialty governance group and the clinical directors who will discuss cases at their governance meetings and feedback to individual consultants for learning / reflection.

5.11 The MSG is be chaired by the Trust medical director and reports to the Board of Directors on a quarterly basis and also by exception In addition there will be an annual report submitted to the Board of Directors.

5.12 The MSG will arrange an annual mortality grand round for whole hospital, with data, trends, themes, learning etc.

5.13 Learning from deaths will form part of the schedule of topics for the Quality & Safety Matters

6. PROCESS FOR REVIEW

6.1 Regardless of the type of review, its findings must form an integral part of and feed into the Trust clinical governance processes and structures. Findings from reviews should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust's wider strategic plans and safety priorities.

6.2 The mortality reviewers have three weeks to review their allocated case notes and the process must not delay any other process, for example the release of the deceased for burial or cremation.

6.3 The Trust will apply rigorous judgement to the needs for deaths to be subject to a Serious Incident reporting and investigation. This will be done according to the existing Serious Incident Policy and discussed within the Quality Review Group.

6.4 There may be instances where deaths clearly meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken). If at any stage of the mortality review process, it is suspected that the death may meet SI reporting criteria, the case will be referred directly for SI investigation in line with the Trust policy

6.5 Where possible all relevant information should contribute to the review; this may include the multi-disciplinary health record (all sources), reports prepared for HM Coroner, post-mortem examination reports, testimony of family, parents, loved ones or carers and incident / complaints information.

6.6 The Trust will report all deaths within the organisation and to other organisations who may have an interest (including the deceased person's GP), and early discussion must take place after death as to any other interested party to whom the death must be reported. This may include HM Coroner, another trust in which the patient may have been cared for, social services the patient may have been receiving, or the police.

6.7 The Trust will review a case record review or investigation following any linked inquest and issue of a 'Regulation 28 Report on Action to Prevent Future Deaths' in order to examine the effectiveness of the review and investigation process.

6.8 Learning Disability deaths

In addition to the Trust internal review, any death of a patient aged 4 and above with a recognised learning disability as defined by the Learning Disabilities White Paper 'Valuing People' (2001) will be referred to the Learning Disabilities Mortality Review (LeDeR) programme in line with national guidance.

6.9 Severe mental illness deaths

In line with national guidance, all deaths of patients with severe mental illness will be reviewed through the Trust mortality review process

7. ENGAGEMENT WITH BEREAVED FAMILIES AND CARERS

7.1 The Trust aims to engage meaningfully and compassionately with bereaved families and carers, this will include informing the bereaved families or carers if the Trust intends to investigate the care provided. In the case of an investigation, this will include details of how families / carers will be involved and to what extent they wish to be involved. Initial contact with families / carers should, where possible, be managed by the Clinicians responsible for the care of the patient.

7.2 If the care of a patient who has died is selected for review the Trust may have formed the decision based on the views of the family and carers. The Trust will review cases where family and carers have raised significant concern about the quality of care provision.

7.3 The Trust will communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed to the future in line with the Duty of Candour Policy.

7.4 The Trust will offer guidance, where appropriate, on obtaining legal advice for bereaved families, carers and staff.

7.5 The Complaints Management policy outlines the Trust's commitment to dealing with complaints about its services and provides information on how we manage, respond to and learn from complaints made about our services.

8. MORTALITY GOVERNANCE & LEARNING FROM DEATHS

8.1 The Trust recognises that mortality review does not replace the need to consider national mortality data (HSMR and SHMI). As such, the Trust Mortality & Morbidity group (MMG) provides assurance to the Trust regarding mortality indicators in addition to results of case record reviews.

8.2 The Quality Review Group will monitor national mortality indicators and review mortality reports from directorates and specialties regarding mortality reviews and learning from deaths.

8.3 In accordance with national guidance, the Trust will consider findings of reviews and investigations alongside other information and data including complaints, clinical audit information, mortality data, patient safety incident reports and data outcomes measures in order to promote learning.

8.4 The Clinical Quality, Learning and Improvement Group will ensure that learning identified at specialty and directorate level is shared appropriately to all relevant parties across the Trust through the Learning Forum.

8.5 Each specialty (where applicable) will conduct mortality and morbidity meetings on a regular basis. These should be multi-disciplinary in nature and seek to identify areas where learning can be identified. Minutes and action logs should be completed to capture outcomes of mortality review and resulting actions and learning.

8.6 Each specialty mortality review group will be chaired by an appropriate Consultant. The group will report to the Group governance meeting and highlight any issues that will improve care and reduce avoidable mortality.

8.7 The Medical Director will present information quarterly at the public meeting of the Board of Directors. This data will include the total number of the Trust's inpatient deaths (including Emergency Department deaths, maternal deaths, neonatal deaths and stillbirths) and those deaths that the Trust has subjected to mortality review. Of these deaths subjected to review, the Trust will provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

8.8 The required mortality data will also be published in the Trust Quality Account from June 2018, including evidence of learning and actions as a result of information and an assessment of the impact of actions that the Trust has taken.

9. TRAINING & SUPPORT

The reviewers will be provided with training to ensure there is a consistency in the approach and in addition there will be "train the Trainer sessions available to ensure the Trust can maintain the level of reviewer training in-house.

10. PROCESS FOR MONITORING COMPLIANCE

Standard to be monitored	Process for monitoring	Frequency	By whom	Assurance of compliance
Policy review	Review AireShare	Annually in the first year then 3 yearly	Mortality Review Group	Version control within AireShare, Minutes of MRG meetings
Number of deaths, including Learning Disability (LD) deaths specifically.	Mortality scorecard	At each Board of Directors public meeting	Medical Director	BoD minutes
Mortality review outcomes – avoidability score	Mortality Report	Quarterly	Medical Director	BoD minutes

Learning from deaths	Presentation slides	Quarterly	Clinical Quality, Learning & Improvement Group Learning Forum	Presentation slides, minutes and work programme for CQLIG
Engagement with families	Duty of candour, SI reports	Quarterly Patient Safety Review Report to the Board of Directors	Medical Director	Agenda, minutes and presentations

11. DEFINITIONS, ABBREVIATIONS & TERMS USED

Term	Meaning
Death certification	The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.
Case note review	A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.
Mortality review	A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.
Serious Incident	Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.
Investigation	A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.
Death due to a problem in care	A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.
Quality improvement	A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.
Patient safety incident	A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

12. DUTIES (ROLES & RESPONSIBILITIES)

Role	Duty
Chief Executive / Board of Directors	The Chief Executive and the Board of Directors are responsible for the monitoring and receipt of the requirements and receipt of assurance the new requirements are being met.
Executive Lead (Medical Director)	Has the delegated responsibility for providing assurance to the Board of Directors for them to discharge their duties in relation to this Policy. In addition this person chairs and leads the Mortality Surveillance Group and must ensure the collection and publication on a quarterly basis of specified information on deaths is received through a paper and an agenda item in the Public Board of Directors meeting.
Non-Executive Lead (NED)	The NED is responsible for • Understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny • Championing quality improvement that leads to actions that improve patient safety • Assuring published information fairly and accurately reflects the organisation's approach, achievements and challenges.
Executive Lead for Safeguarding (Director of Nursing)	Responsible for ensuring all safeguarding processes and legislation is in place within the Trust and any child or maternal death or still birth is notified to the Board of Directors at the earliest opportunity
Mortality Lead (Dr Sarah Stowe)	This person is responsible for chairing and leading the Mortality Review Group, conducting mortality reviews, preparing the information for issuing to the Board of Directors.
Assistant Directors of Operations (ADoOps)	These people are responsible for; • Ensuring mortality and learning from deaths is a standing item within their monthly governance meetings • Sharing any learning at the quarterly Learning Forum • Ensuring there is robust Clinical Group representation at the Mortality Surveillance Group • Ensuring M&M meetings take place in the specialities within the Clinical Group
Head of Midwifery (Mary Armitage)	Responsible for the identification and notification of still births and maternal deaths and reporting them via the trust incident reporting process (Ulysses). Instigating an immediate escalation to the status of Serious Incident and informing the relevant authorities of the death.
Assurance Group (Executive Assurance Group)	Responsible for the approval of the Policy prior to PDRG. To agree the data and detail to be reported to the Board of Directors and the public meetings.
Mortality Surveillance Group	This group is responsible for the oversight, implementation, monitoring and support of the Trust learning from deaths.
Mortality Review Group	• Providing assurance to the Board of Directors via the Mortality Surveillance Group on patient mortality based on review of care received by those who die • Agreeing and approving the mortality review proforma • Reviewing M&M outcomes, audit data and action plans • Identifying areas of high risk and agreeing and monitoring improvement plans • Ensuring that feedback and learning points are shared with the Clinical Group and specialties so that learning outcomes and action points are included in the specialty audit programmes as appropriate
Clinical Quality, Learning & Improvement Group (Learning Forum)	This group will receive a presentation on learning from deaths prior to this being reported to Executive Assurance Group and the Board of Directors.
Clinical Audit Manager (Sue Marshall) and clinical audit team	Responsible for the identification and provision/issuing of the clinical notes for the Mortality Reviewers to review. Along with the collation of the outcome of the reviews for further discussion at the Mortality Review Group. In addition to • Producing reports based on information recorded in AireShare • Maintaining a library of completed peer review forms and feeding back the reports and outcomes to the clinical leads for each area

	• Analysis of the database to identify themes and trends • Recording special reviews on AireShare
Quality & Safety Team	• Recording known incidents, inquests and post mortems on the list of Trust deaths received from the Performance Department and notifying the Clinical Audit & Effectiveness Team • Overseeing the process of mortality alert reviews and production of associated reports • Monitor identified learning outcomes and associated action plans • Support the review process with any identified duty of candour requirements
Mortality Reviewers	Responsible for reviewing the clinical records issued each month and completion of the electronic template. In addition escalating for further review any issue of concerns and good practice for identification of learning at the Mortality Review and Surveillance Groups.
Workforce Development Manager	Responsible for coordinating the Trust training needs analysis and must be consulted on all Procedural Documents where training needs are identified.