Mortality Governance: Learning from Deaths of Patients in our Care Policy and Procedure (M-005)

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1. INTRODUCTION & BACKGROUND

The preventable death of Connor Sparrowhawk in July 2013, led to a number of investigations and enquiries into practice at Southern Health NHS Foundation Trust where he died. This led to the independent review of the deaths of people with a learning disability or mental health problem in contact with Southern Health (Mazars 2015). The majority of people do receive excellent care from the NHS, with staff working tirelessly under increasing pressures to deliver safe, high-quality healthcare. However some people do experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. It is important therefore that when people die in our care that NHS reviews practice and works with others to understand what can be learned from the death in order to prevent recurrence where possible. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon (National Quality Board 2017).

Research has shown that people with learning disability (PLD) and People with Mental Health (PMH) problems have greater health care needs than the general population and often suffer unnecessarily with untreated or poorly managed conditions. People suffer with at least 2 or more co-morbidities and die 15-20 years earlier than the general population (Hollins 2014). It is recognised that if you have a learning disability or a mental health problem, you may not seek advice and support for a physical health concern from primary care or that when you do, that this may go unrecognised with the misunderstanding that the presentation is part of the diagnosis of learning disability, also known as diagnostic overshadowing (Mencap 2011). Achieving parity of outcomes for people with learning disability and mental health problems has been outlined within the recent paper 'recognising the importance of physical health in mental health and intellectual disability (Board of Science 2014).

Following guidance from NHS England (Serious Incidents 2015), only those deaths where the learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant will be reported as a Serious Incident for the NHS to review. The Care Quality Commission (CQC) (2016) in their report 'Learning, Candour and Accountability reviewed the way that NHS Trusts review and investigate deaths in England. It showed that there was limited understanding of deaths and in some organisations learning from deaths was not being given sufficient priority; valuable opportunities for improvements were being missed. The CQC suggest that there is much more the NHS can do to engage families and carers and recognise their insights and experiences as being vital to our learning.

In line with the NQB guidance on Learning from Deaths, this policy will set out how Humber NHS Foundation Trust (HFT) will identify, report, investigate and learn from a patient's death. This will include the care leading up to the patient's death, considering if this could have been improved, even when the care may have had no direct link with the patient's death. HFT will make it a priority to work more closely with families/carers of patients who have died.

HFT is working closely with other mental health trusts in the north of England supporting the approach to learning from deaths within Humber and across the North of England.

2. DEFINITIONS

- **Expected death** – any death occurring at a stage in the patients' disease pathway at which death is inevitable and no active intervention to prolong life is planned or on-going

- **Unexpected death** – Any death which has not been expected

The Trust has adopted the coding as outlined by Mazars as detailed below, the reporter of the death will initially code the death and this will be peer reviewed and confirmed in the weekly Clinical Risk Management Group (CRMG).

2.1. Expected natural death – (EN1)

A death that occurred in an expected time frame, e.g. people with terminal illness, or within palliative care services. These deaths may not be investigated but could be included in a mortality review of early deaths. These deaths are unlikely to be preventable.

2.2. Expected natural death – (EN2)

A death that was expected but was not expected to happen in the timeframe, e.g. someone with cancer or liver cirrhosis who dies earlier than anticipated. These deaths should be reviewed and in some cases would benefit from further investigation. Some deaths may be preventable.

2.3. Expected unnatural death – (EU)

A death that was expected but not from the cause expected, or timescale, e.g. some people, who misuse drugs, are dependent on alcohol or with an existing disorder. These deaths should be investigated. Some may have been preventable.

2.4. Unexpected natural death – (UN1)

Any unexpected death from a natural cause e.g. a sudden cardiac condition or stroke
These deaths should be reviewed and some may need an investigation. Some of these deaths may have been preventable.

2.5. Unexpected natural death – (UN2)

An unexpected death from a natural cause but didn't need to be e.g. some alcohol dependence and where there were may have been care concerns. These deaths should be reviewed and a proportion will need to be investigation.

2.6. Unexpected unnatural death – (UU)

An unexpected death from unnatural causes e.g. suicide, homicide, abuse, neglect.
These deaths will be reviewed for consideration of a serious incident in line with guidance from NHS England. Reference should be made here to any other associated relevant Trust policies or documents.

2.7. Investigation

The act or process of investigating (either a Serious Incident investigation or a Significant Event Analysis); a systematic analysis of what happened, how it happened and why. This draws on evidence, which can include physical evidence, witness accounts, policies and procedures, guidance, good practice and observation in order to identify the problems in care and or service delivery that preceded the death to understand how and why the death occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence where possible.

2.8. Single Point of Contact for Serious Incidents and Significant Events Analysis

This is an identified individual who is independent from the investigation team. This person is agreed as the point of contact for the family/carers that are affected by the death. The single point of contact will be available to offer support, clarify the process of the investigation, and be available to develop the terms of reference and or respond to queries raised by the patient or the family. The single point of contact will usually be the senior manager who is supporting the serious investigation.

2.9. Case Record Mortality Review

This is a structured review of a case record/note carried out by clinicians to determine whether there were any problems in care provided to a patient, Case record review can be undertaken in the absence of any particular concerns about care, to learn and improve. This is because it can help to find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when the bereaved or staff raise concerns about care. Case

record mortality reviews utilise the Structured Judgement Review methodology (SJR) as described in section 2.10 below.

Consideration should be given regarding the involvement of the patient's family and/or carers in the process of a mortality review. As with an investigation, families will be asked if they have any concerns regarding the care their loved one received and offered support throughout the review process as appropriate. This should be dealt with in a sensitive manner and may not be appropriate in all cases however; if significant concerns that resulted in or contributed to harm are identified during the course of the review then the Trust has a duty to share these concerns with the family/carer in line with the Trust Duty of Candour Policy.

2.10. Structured Judgement Review – (SJR)

SJR blends traditional clinical judgement review methods with a standard format. It requires reviewers to make safety and quality judgments over phases of care, to make explicit written comments for each phase of care and to score each phases of care, the result is a relatively short but rich set of information about each case in a form that can be aggregated to produce knowledge about clinical services and systems of care.

2.11. Learning Disability Mortality Review (LeDeR)

This is a programme to review all deaths of people with learning disability commissioned by NHS England. The LeDeR programme is the first of its kind in the world and is managed by the Norah Fry Research Centre at the University of Bristol, under contract to the Healthcare Quality Improvement Partnership (HQIP). All deaths in Learning Disability are now reported to the LeDeR programme. All deaths in Learning Disability services should also be reported via DATIX and subject to Humber Teaching NHS Foundation Trust internal investigation/review processes.

2.12. Death due to a problem in care

This is a death that has been clinically assessed using a recognised methodology of case note review and determined more likely than not, to have resulted from problems in care and therefore to have been potentially avoidable.

3. SCOPE

This policy applies to all deaths that occur for a patient who has used the services of the Trust in the 6 months preceding the death. This policy is applicable to all clinical staff working within Humber Teaching NHS Foundation Trust on a permanent or fixed-term contract or on the bank or subcontracted to work in the Trust who have a responsibility for patient care.

4. POLICY STATEMENT

This policy will outline the Trusts principles on how it processes, responds to and learns from deaths in our care. This will include people with a learning disability or mental health need, an infant or child and our approach to undertaking case record reviews.

Mortality governance is a priority for the Trust, ensuring that learning from deaths becomes embedded within the organisation. The Trust will have an understanding of all deaths that occur whilst people are using its services. This policy will work alongside the Serious Incident and Significant Events policy to enable the Trust to achieve the highest standards in mortality governance.

Working with families/carers of patients who have died whilst in our care is a priority for the Trust and we will work closely with bereaved families/carers as equal partners in the process of review and or investigation into their care and treatment within our services. We recognise that families/carers can offer an invaluable source of insight to the life lived by the person and how services can be improved or may need to work differently.

The Trust will actively seek questions from both family/carers and its own staff to ensure that the care and treatment provided, was at the standard expected in line with NICE guidelines and or Trust policies and procedures.

This policy and procedure will ensure that all deaths of people who die unexpectedly or earlier than expected, where the death is not subject to a serious incident (SI) or significant event analysis (SEA) investigation who are in-patient or using services within the community will be considered for a mortality review using structured judgement review methodology (SJR). The mortality review will seek to understand the life lived by the person, reviewing in detail the care and treatment provided by services prior to their death.

All deaths within in-patient services will be reported to the public board on a quarterly basis and will provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

A wider review of deaths will be undertaken in any service where 3 or more deaths have occurred in any quarter. All deaths will be reviewed using an evidence based methodology for each review.

Learning from deaths will be shared at the Learning the Lesson events and through the bi-monthly quality newsletter.

5. DUTIES AND RESPONSIBILITIES

5.1. Trust board – Chief Executive, Executive Directors and Non-Executive Directors

- Trust Boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change.
- Both the Executive and Non-Executive Directors will understand the issues affecting mortality in this Trust. They will challenge where necessary, to ensure high standards in mortality governance are maintained and that the care provided to patient's who die is integral to the Trust's governance and quality improvement work, ensuring robust systems are in place for recognising, reporting, reviewing and investigating deaths.
- The Medical Director is the Executive lead for Mortality

5.2. Non-Executive Director (NED)

- An identified NED has been appointed as the lead for mortality and will hold the organisation to account for its approach and attitude to patient safety and that there is evident learning from all deaths. The identified NED will review the mortality governance processes to ensure that the focus is on learning and can withstand external scrutiny, by providing challenge and support to the Board. Please contact board support in order to identify the named NED for mortality

5.3. Medical/Nursing Director

- Executive lead/s for Patient Safety.
- To ensure this policy is fully implemented and suitable training programmes for staff are in place.
- To oversee the commissioning of reviews and learning dissemination.

- Ensures that evidence of Duty of Candour/communication with family/carers is fully completed in line with the statutory requirements following all deaths.

5.4. The Care Group Director/Clinical Care Director/Associate Medical Director

- To ensure the implementation of this policy within their areas.
- To ensure that staff are trained in the structured judgement review for use in Mental Health and Learning Disability Mortality reviews (LeDeR).
- Undertake an initial review of all expected natural deaths (EN1) and confirm no further action unless the reporting of the death identifies concerns or if there are concerns raised from family or staff involved.
- To ensure that staff engage with families/carers from initial the notification of the death and thereafter throughout any level of investigation or review, supporting families/carers in their bereavement.
- A single point of contact within the care group is identified to support the family/carers alongside any investigation (if required).

5.5. Medical Staff, Service Managers, Modern Matrons, Ward and Team Managers

- To ensure the effective implementation of the policy.
- To ensure staff report all deaths via DATIX, that are known to have occurred whilst patients have been in receipt of care of the Trust or have died within 30 days of discharge from in-patient services or have died following use of services within the past 6 months.
- To ensure staff reporting deaths have the skills and training to engage with families/carers and support the investigation/review processes.
- To ensure that staff that have the necessary skills through training e.g. Root Cause Analysis, Human Factors, Structured Judgment case note Review (SJR) and LeDeR review, ensuring they have the time to carry this process out in a skilled way to a high standard.
- To promote learning from deaths by:
    - Ensuring that the investigation is shared with the team/s and there is a facilitated discussion following every unexpected death
    - Identifying the areas for learning for the team and ensuring that these are acted upon.
    - Ensuring sufficient time is assigned in governance forums within the care groups to outline and plan for any lessons to be learned from deaths in the care groups.

5.6. The Risk Management Team, Business Intelligence, Information Management; have a responsibility to ensure:

- An insight report is developed and published to monitor trends in deaths (April 2017 onwards) with both Mortality Steering Group and Quality Committee/Board oversight of this process.
- DATIX incident reporting system is used to its full potential to record deaths (expected and unexpected) in accordance with Trust policy.

5.7. All Staff

- Are responsible for following the policy and procedure and report all deaths of people currently using services or have used services in the last 6 months that are either expected or where the person has died unexpectedly from either a natural or unnatural cause.
- Are part of facilitated learning sessions held within the team and or across the organisation.
- Ensure that areas for learning are acted upon.

6. WORKING IN PARTNERSHIP WITH FAMILIES/CARERS

6.1. Working in partnership with families/carers

Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients within the Trust is crucially important. We will work closely with the bereaved families/carers throughout the review or investigation, inviting the family to ask questions about the care and treatment provided. We endeavour to have an open culture where families feel supported to question and raise concerns, working in partnership to identify what could be done better or what needs to be done differently to improve the quality of our patient and carer experience.

6.1.1. When a patient dies under the care of the Trust, families and carers should be informed by someone who knew the patient best, to offer condolences and, inform the family/carer of the level of investigation/review to be undertaken; explaining the process if appropriate.

6.1.2. Family/carers should be offered the opportunity to be involved in the review of their family members care leading up to when they died. There are however some circumstances where the Trust may find out about the death of a patient after some delay (i.e. via an update from the national spine) or where the death took place in another provider (i.e. in an acute trust). In these circumstances, the care group director will confirm who will make contact with the family to offer condolences and confirm if an investigation is going to take place.

6.1.3. Communication at the time of the death, and thereafter, should always be clear, sensitive and honest. Bereaved families and carers should be given information in language they understand and without jargon, in line with the Duty of Candour at the time the information is known. It is recognised that families/carers may respond differently to the death and the information offered at the initial point may need to be revisited at a later date with the family/carer.

6.1.4. Bereaved family/carers may have questions about the care provided within the trust. Families/carers will be asked if they have any questions and or concerns about the quality of care received; this will inform the decisions about the level of investigation or review to be undertaken.

6.1.5. Inform the family/carers that an investigation is to take place. This can be by telephone or face to face were appropriate and will always be followed up in writing. The family/carers will be asked if they would like to inform the terms of reference.

6.1.6. Offer the family/carer a single point of contact to enable the family to ask questions, to provide timely updates, share the findings of the investigation and factual interim findings.

6.1.7. If the family member/carer decides they do not want to be involved in the investigation process, always make it clear they can contact us at any time should their decision change.

6.1.8. Always ask the family/carer if they would like either a summary of any findings and or the final report. If the family does not want contact at all about the process or findings, this will be respected and documented within the final report in line with Duty of Candour.

6.1.9. Bereavement support should be offered to the family, which should include support, information and guidance that should help with the practical aspects following the death of a loved one. Offer ‘help is at hand’, this is a resource for people bereaved by suicide and or other sudden, traumatic death.

6.1.10. When reviewing or investigating possible problems with care, in line with Duty of Candour, families and carers must be informed and this must begin with a genuine apology. A senior member of staff should be identified to explain what went wrong promptly, fully and

compassionately. If there are a number of organisations involved, contact should be coordinated and agreed with the family.

6.1.11. Families/carers can also be involved in reviewing draft reports or even providing a pen portrait of what the person was like or their timeline of specific events. Families/carers should also be given the option of seeing a final draft report to ensure they are comfortable with any findings. Ideally this should be undertaken in a face-to-face meeting with a staff member talking the family/carer through the report.

6.1.12. Consideration should be given regarding the involvement of a patient's family and/or carers in the process of a Case Record Mortality review as outlined in Section 2.9.

7. PROCEDURE

7.1. Identifying and reporting deaths

All expected and unexpected deaths will be reported via DATIX as soon as practicable or within 24 hours of becoming aware of the death. Staff will share what information is known about the death and will make a judgement on the death, using the definitions (Mazars) within section 2.

Once the DATIX is completed, the most senior staff on duty must attempt to engage with the family/carers. Any death out of hours of an in-patient must be reported to the Director on call, who will advise on contact with family.

For all deaths of a person whilst an inpatient, the care group directors or on call director if the death occurred between 5pm-9am, must be informed and they will support staff with contacting the family.

7.2. The decision to investigate or review

All reports of any unexpected unnatural deaths (UU) are shared immediately with executive directors and a senior team for consideration of a serious incident. The Director of Nursing or the Medical Director are the two individuals in the Trust who can confirm an incident as an SI. This duty is delegated from the Chief Executive who has overall accountability for declaring a serious incident.

The Clinical or Care Group Director and or Associate Medical Director will review all DATIX reports where a death has been reported, including expected, natural deaths. This is to ensure that the care provided met the standard expected and to identify if any issues have been raised from the family/carers/staff members involved in the patient's care. If there are no issues raised, the Care Group Director will confirm that no further action is required.

In addition all deaths will be peer reviewed by the Patient Safety Team initially within the daily patient safety huddle where categories of death will be reviewed and a weekly report will be presented to CRMG where decision to commission a review or investigation will be agreed and minuted. Types of investigations and reviews are as follows:

- Serious Incident: death reported on STEIS and to the CCG as Serious Incident and investigation undertaken
- Significant Incident: death reviewed using Significant Event Analysis (with chronology)
- Mortality Review using Structured Judgement Review methodology
- If the person had a diagnosis of Learning Disability, the death has been notified to LeDeR
- If a child death, the death will be reviewed by Child Death Overview Panel

Where the death did not meet the criteria for an SI or SEA, consideration should be given to a mortality review, using SJR.

The Trust is working closely with the Northern Trusts who have agreed the following approach to determining the level of investigation for the following deaths – see appendix 1.

7.2.1. Decision to investigate – The main provider of Care

The Trust recognises that people may receive services from a range of providers; this can cause confusion as to who is responsible for reporting and or investigating the death. The Trust considers itself to be the main provider of care if the patient was subject to:

- An in-patient episode of care or has died within 30 days of discharge from an in-patient facility
- An episode of treatment in the community under the Care Programme Approach (CPA)
- An episode of treatment in the community due to identified mental health, learning disability, or substance misuse needs
- A community treatment order (CTO)
- A conditional discharge
- Any of the above within 6 months prior to their death
- Guardianship

The Trust will work closely with the local commissioner of services to facilitate and support where needed.

7.2.2. People meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.

In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. The organisation will lead the statutory requirements under Duty of Candour. There will be a discussion to confirm if the investigation is to be a joint or single agency investigation (this will be determined by the cause of death) and in the event of joint investigations who the lead organisation will be.

7.2.3. Services provided by the Trust where we are not classed as the main provider.

For the following services the Trust is only providing a small component of an overarching package of care and the lead provider is the patient's GP.

- Tissue Viability
- District nursing
- Dietetics
- The drug and alcohol shared care services* (East Riding)
- Care home liaison
- Community physiotherapy
- Macmillan Nurses
- Podiatry

*Trust addiction services will be required to report drug and alcohol deaths in line with locally determined processes.

7.2.4. Exception

In cases where the Trust is not considered to be the main provider of care, but an act or omission has occurred during the course of care provided by Humber Teaching NHS Foundation Trust, an

investigation will be undertaken by Humber Teaching NHS Foundation Trust, if it is felt to have in any way contributed to the death of a patient.

It is recognised that there may be deaths which do not meet any of the above criteria but require investigation. Confirmation of the level of review/investigation will be discussed and agreed within the weekly CRMG.

7.2.5. Potential triggers for a review or investigation

- Where a family/clinical staff/operational/corporate staff flag or raise a concern
- Diagnosis of severe mental illness
- Where medication with known risks such as clozapine was a significant part of the treatment regime
- From causes or in clinical areas where concerns have already been flagged (from Board, complaints or data held from the insight report)
- Where a patient had been subject to a care intervention where death wouldn't have been an expected outcome e.g. ECT or rapid tranquilisation
- Where the patient had no active family or friends and so were particularly isolated e.g. with no independent person to raise concerns
- Where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided or where there was a gap in services; associated with known risk factors
- Deaths caused by epilepsy
- Deaths in distress which might include; drug and alcohol deaths or deaths of people with an historic sex offence e.g. people who might not be in crisis but need support. Deaths could be reviewed as part of a thematic review
- Following a rapid deterioration in the physical health which was not responded to in a timely manner

7.3. Local review

7.3.1. An initial review (see appendix 2) will be completed for all unexpected deaths, or where any of the above red flags are triggered, to understand the issues surrounding the death in order to inform the level of review/investigation required.

7.3.2. Levels of investigation/Reviews

- **Concise Serious Incident investigations** will be undertaken which only involve Trust services. This investigation is completed by two members of staff, one of whom must be trained in Root Cause Analysis. The family/carer will be contacted and invited to inform the terms of reference for the investigation. Families/carers will always receive a letter outlining the investigation to be undertaken and be invited to contact the lead investigator to be part of informing the terms of reference. The investigation will be completed within 12 weeks.

- **Comprehensive Serious Incident investigations** are for incidents, which involve other agencies in addition to those of the Trust. This investigation is completed by at least two members of staff, one of whom must be trained in Root Cause Analysis. Medical staff and or others may be invited to be part of the investigation team or be available for further advice. The family/carer will be contacted and invited to inform the terms of reference for the investigation. Families/carers will always receive a letter outlining the investigation to be undertaken and be invited to contact the lead investigator to be part of informing the terms of reference. This investigation should be completed within 12 weeks.

- **External Serious Incident investigations.** External investigations are required where the integrity of the investigation is likely to be challenged or where it will be difficult for an

organisation to conduct an objective investigation internally. This is due to the size of the investigation or the capacity/capability of the available individuals and or number of organisations involved. These should be completed within 6 months from the date the investigation was commissioned and will have an independent neutral investigator lead the investigation.

- **Significant Event Analysis (SEA) – Comprehensive** – This will be undertaken following an incident to a person who was receiving care from the Trust that has not met the criteria for a serious incident and therefore not been reported as an SI, but where the Trust feels there is an area for learning. The coroner will require this report, if involved. This will be completed within 9 weeks.

- **Case Note Mortality Reviews** – using **S**tructured **J**udgement case note **R**eview (SJR) methodology. Mortality review are considered if the death did not meet the criteria for either an SI or an SEA, but where the Trust still considers there are areas for learning. The coroner will require this report, if involved.

7.3.3. Mortality Reviews are undertaken by clinical staff who are trained in the SJR methodology

- The family will be asked if they have any questions or concerns about the care provided.
- A reviewer will be allocated from within the Care Group. The reviewer will have undertaken SJR training.
- A mortality review will be undertaken within 20 working days from the receipt of the records.
- The reviewer will make structured judgements on all the phases of care and then score the phases of care.
- Good practice found within the review will be shared back to the relevant team/service and or care group
- The mortality review will be reviewed at CRMG with confirmation of the scoring within the phases of care.
- A second stage review occurs where care problems have been identified in the initial review. This is undertaken by a further independent reviewer
- If the concerns are confirmed and any death scoring 1 or 2 in the overall care score will be escalated to CRMG for consideration of a second review or escalation to a serious incident
- Findings from the mortality reviews will be shared with the family by the reviewer or the single point of contact.
- Findings will be discussed at CRMG and the Mortality Steering Group (MSG). The Mortality Governance Team will ensure the final report is shared through the Care Group Clinical Networks who will be responsible for sharing with teams and services.
- The Mortality Governance Team will be responsible for sharing learning from deaths through learning the lessons events.
- The Care Groups will be responsible for ensuring actions are completed within the agreed timeframes.

7.3.4. Deaths in Learning Disability

- Will be initially reported via DATIX and reviewed in line with all deaths for consideration for investigation as a serious incident.
- Will be reported to the National Learning Disability Deaths Review (LeDeR) programme with confirmation of any local investigations to be undertaken
- Reviewed by staff trained in the LeDeR methodology
- Family are contacted and informed of the review to be undertaken by the reviewer or the Clinical Care Director.
- LeDeR review reported via the electronic tool on the website

- Feedback from the review of the death shared with the family (should they wish) at CRMG in order to identify local learning. Any concerns raised in the review will be shared at the MSG

7.4. Child Deaths

All Safeguarding children serious incidents child deaths are initially reported as a Serious Incident. The safeguarding team will always review the reporting of the child death with the CCG prior to reporting on the Strategic Executive Information System (StEIS) to determine which organisation will declare the incident as a serious incident.

All child deaths will be reviewed as part of the Child Death Overview Panel (CDOP)

The functions of the CDOP include:

- reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible
- identifying patterns or trends in local data and reporting these to the LSCB
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required
- agreeing local procedures for responding to unexpected deaths of children
- co-operating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths

The CDOP has a fixed core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate http://www.workingtogetheronline.co.uk/chapters/chapter_five.html

7.5. Governance Processes; ensuring learning across the organisation

7.5.1. Deaths investigated as a serious incident

The findings from the investigation will be shared with the family prior to the submission (where appropriate) of the final report being submitted to agree and confirm areas for learning. The findings, areas of good practice and learning from the final report will be shared with the team and the wider clinical network to ensure learning from deaths within the care group, demonstrating compliance with Care Quality Commission (CQC) Regulation 17 ‘Good Governance’. The Trust will also work with local commissioners to ensure learning across the wider system

7.5.2. Deaths reviewed using significant event analysis (SEA)

The report will be shared with the family to agree areas for learning. The findings will be discussed within the team prior to presentation of the report to the care group. This will be discussed and an action plan for learning, agreed within the care group clinical network.

7.5.3. Mortality reviews

The report will be reviewed within CRMG, identifying any lessons to be learnt and confirming scoring of the phases of care. Any actions required would be agreed and monitored in the first instance through the CRMG and cascaded through the Care Group structure as appropriate. Lessons learnt from deaths will be shared within the learning the lessons newsletter and learning the lessons events.

A quarterly report of all Mortality Reviews undertaken using SJR will be presented to the Mortality Steering group; providing a summary of:

- All deaths report via DATIX
- Deaths reported as an SI
- Deaths reviewed as an SEA
- Deaths reviewed as a mortality review; all scores for phases of care will be aggregated for mortality reviews
- Deaths of people with learning disability notified to the national programme
- Feedback on the scoring of the phases of care
- Learning from the mortality reviews

7.5.4. Areas of concern that are discovered during the mortality review, SEA or SI which trigger Duty of Candour will be escalated to the Care Group Director (patient safety incident that have caused moderate harm and above and or had the potential to cause severe harm). Please see Duty of Candour Policy for further information. Any areas of concern for immediate action will be addressed via a practice note for clinical staff.

7.5.5. A quarterly report will be presented to the public board, detailing the total number of in-patient deaths and those deaths subject to a case record review. The report will estimate the numbers of deaths judged more likely than not to have been due to problems in care. The report will outline the learning from the review of the deaths.

7.6. Mortality Steering Group (MSG)

- The Medical Director will chair the mortality steering group (MSG) to provide assurance that the mortality review process is functioning correctly ensuring that mortality meetings occur regularly. The MSG will receive an insight report of all deaths, including the detailing of all in-patient deaths categorised using the agreed definitions, with confirmation of an outcome from all.
- The MSG will ensure that individuals reviewing cases have not have been the sole clinician responsible for the case. The case will be reviewed by a professional not directly involved with the case. Any case where concerns have been raised will be discussed at the MSG following discussions within the relevant care groups, areas for learning will be shared as part of the themes and trends report.
- Governance and monitoring of all deaths and death reviews (SIs, SEAs, and SJRs) will be conducted through CRMG.

7.7. The Quality and Patient Safety Group (QPaS), on behalf of the Trust Board, will:

- Receive quarterly reports from the Mortality Steering Group identifying themes and trends from the mortality reviews undertaken.
- Discuss care group and primary or secondary care issues relating to mortality review and develop action plans where appropriate.

8. EQUALITY & DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust approved EIA.

9. MENTAL CAPACITY

The application of the statutory requirements of the Act will be addressed at all times in the review throughout the care and treatment of all deaths.

- There will be a presumption of Capacity; every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- The right for individuals to be supported to make their own decision – people must be given all appropriate help before anyone concludes that they cannot make their own decision.
- Best interests; anything done for or on behalf of people without capacity must be in the person's best interests.
- Individuals must retain the right to make what might be seen as eccentric or unwise decisions.
- Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

10. BRIBERY ACT

The Bribery Act applies to this policy.

11. IMPLEMENTATION

This policy will be disseminated by the method described in the Document Control Policy (November 2017). The implementation of this policy requires additional financial resources with more people to be trained in the use of SJR and Root Cause Analysis and Human Factors.

12. TRAINING

Staff will receive training in:

- Structured Judgement case note Review in order to carry out Quality and Safety reviews as part of record keeping and Mortality Reviews
- Root Cause Analysis and Human Factors in order to carry out Serious Investigations and Significant Event Analysis

13. MONITORING & AUDIT

All deaths will be shared as part of a quarterly report to the Mortality Steering Group, Quality Committee and the public section of the Board. This report will detail the learning from all deaths and any themes. The report will detail aggregate the scoring and avoidability from Mortality reviews.

14. RELEVANT HFT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Serious Incident and Significant Event Policy
Duty of Candour Policy
CQC Regulation 20 – Duty of Candour
Working together to safeguard children: A guide to inter agency working to safeguard and promote the welfare of children March 2015

15. REFERENCES AND BIBLIOGRAPHY

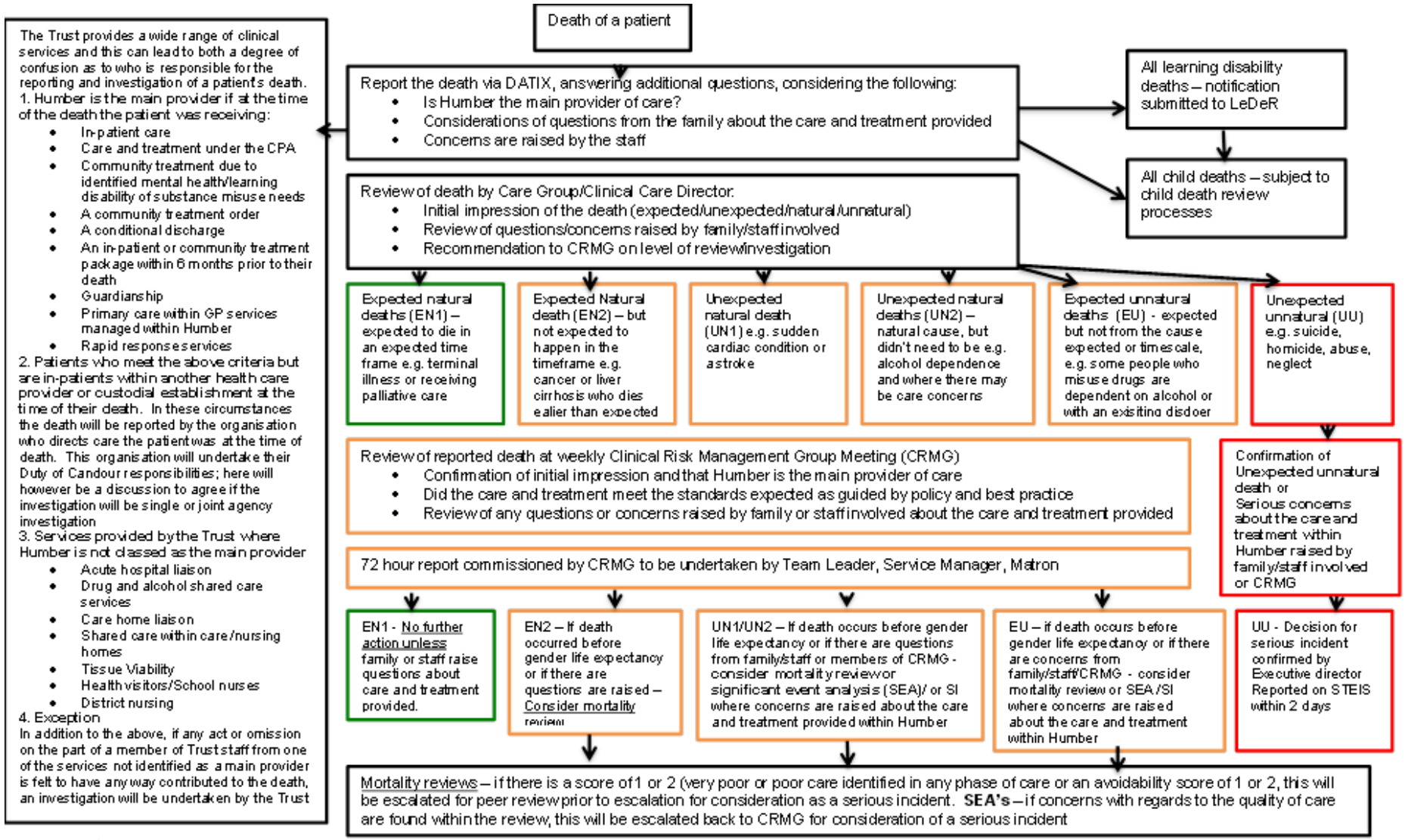
NHS England (2015) Serious Incidents, London, NHSE

CQC (2016), Learning, Accountability and Candour, London, CQC

NQB (2017), Learning from Deaths, London, NQB

NHS Improvement (2017) Implementing the learning from deaths framework: key requirements for trust boards, London, NHSI

Appendix 1 – Death of a Patient



Appendix 2 – Initial Incident Review for Potential Serious Incidents

INITIAL INCIDENT REVIEW FOR POTENTIAL SERIOUS INCIDENTS

This review should be completed by a team manager/clinical lead and returned to the Patient Safety Team HNF-TR.IncidentReporting@nhs.net & the Relevant Clinical Care Group Director. Should there be learning or further follow up, this document may be shared more widely within the Trust.

Reviewer's Details			
Reviewer's Name		**Reviewer's Job Title**	
Reviewer's Tel. no		**Reviewer's E-mail**	

DATIX Web Reference (includes link to DATIX)	
Date of Incident	
Date Incident Reported	
Care Group / Directorate	
Location of Incident Unit / Team / Department	
Type of Incident (e.g. self-harm, death)	

Provide details of patients involved / harmed / affected by the incident (if necessary copy the table below if more than one patient involved).

NHS Number	
Date of Birth	
Age	
Gender	Choose an item.
MHA Status at the time of the incident (if applicable)	
Name of GP	
Address of GP Practice	
Name of Next of Kin	
Relationship of Next of Kin	
Address of Next of Kin	

Duty of Candour – The patient / family / carer must be informed of the incident when the level of harm to the patient is moderate or above.	
Degree of Harm (Degree of harm caused by the Trust)	Click this space & select an Item from the dropdown box
Being open - Has the incident been discussed with the Patient / Relative / Carer?	Yes ☐ No ☐
If No - please state the reason below for not informing the patient / relative / carer:	
If Yes - please answer the following:	
When was the patient / family / carer informed:	
How was the patient / family / carer informed:	☐ Face-to-Face ☐ Over the telephone ☐ Letter
Details of patient / family / carer who was informed:	

Lead up to incident and description of what happened
Immediate actions taken to maintain safety (If required)
Are there any Safeguarding issues (Adult or Child)? If so what action have you taken?
Are there any staffing concerns that appear to have contributed to this incident?

Humber Teaching Foundation Trust Involvement (if necessary copy the table below)			
Team		**Referral Date**	
Frequency of Contact		**Discharge Date**	
Named worker/professional		**Date Last Seen**	
Summary of involvement			
Team		**Referral Date**	
Frequency of Contact		**Discharge Date**	
Named worker / professional		**Date Last Seen**	
Summary of involvement			

Involvement of other Agencies (add additional rows as necessary)	
Agency (include the name of the key person(s) involved)	**Summary of Involvement**

Media Interest?	Choose an item.
If so, is Communications Team aware?	

Summary of Clinical History (include all patients involved)

Please provide a summary of relevant events and contacts in the immediate period preceding the incident.

Medication at the Time of the Incident		
Drug	**Dose**	**Frequency**
Any Further Details		

Care and Treatment Review (please refer only to pre-incident reviews; any post-incident reviews can be referred to in the Immediate action/learning section below)

Question	Yes/No	Supporting Information
Is the documentation up to date and of the standard you would expect? For example, care plan and risk assessment completed and up to date.		
Was there appropriate liaison/communication with other teams in FT or externally?		
Was there appropriate liaison with other teams externally?		
Have the carer/relatives raised any concerns about the service user's care and treatment?		

Is there any other information about the service user's care that causes concern or that you would like to highlight?

Outcome of the Preliminary Review

Immediate actions / learning already implemented

	Action/Learning	By Who & When
1		
2		
3		

Further recommendations and issues identified from this preliminary review

	Further issues that required escalation outside of the teams /service responsibility
1	
2	
3	

Appendix 3 – Mortality Review – Structured Case Note Review Data Collection

Reference number:		**Team involved at time of death**	
Author – Name & Job Title			
Biographical details			
Age:	**Gender:**	**Years of Life Lost:**	
Recorded cause of death			
Marital status			
Employment		**Social Deprivation Indicator** (first part of postcode)	
Housing			
Lifestyle	**Weight**	**Smoker**	
	Physical activity	**Drug and Alcohol use**	
Diagnosis – Mental Health/Learning Disability			
Co – Morbidities			
Date of admission:	**Day:**	**Time:**	**Length of stay:**
Duty of Candour			
Pen Portrait			
Phase of Care – Risk Assessment			
Please rate the care received by the patient during this phase. Very Poor 1 2 3 4 5 Excellent			

Phase of care – Allocation/Initial Review
Please rate the care received by the patient during this phase. Very Poor 1 2 3 4 5 Excellent
Phase of Care – Ongoing Care
Please rate the care received by the patient during this phase. Very Poor 1 2 3 4 5 Excellent
Phase of Care – Care during admssions (if applicable)
Please rate the care received by the patient during this phase. Very Poor 1 2 3 4 5 Excellent
Phase of Care – Follow Up Management/Discharge/End of Life Care
Please rate the care received by the patient during this phase. Very Poor 1 2 3 4 5 Excellent
Phase of Care – Assessment of Care Overall
Please rate the care received by the patient during this phase. Very Poor 1 2 3 4 5 Excellent

What has been learned from this review?

Outcome of Mortality Review			
Issue	**Action**	**Accountable Person**	**Date for Completion**
Good practice			
Areas for Learning			
Conventional audit is required			
Immediate change			
Further investigation			
Sharing the learning			

Appendix 4 – Document Control Sheet

Document Type	Policy - Mortality Governance: Learning from Deaths of Patients in our Care Policy and Procedure (M-005)		
Document Purpose	This policy will outline the Trusts principles on how it processes, responds to and learns from deaths in our care. This will include people with a learning disability or mental health need, an infant or child and our approach to undertaking case record reviews		
Consultation/ Peer Review:	Date:	Group / Individual	
list in right hand columns consultation groups and dates	May 2018	Medical Director – Dr John Byrne	
	May 2018	Allyson Kent – Assistant Director of Nursing	
	May 2018	Care Group Directors and Clinical Care Directors	
	31 May 2018	QPaS Group	
Approving Committee:	N/A minor amends	Date of Approval:	31 May 2018 (QPaS)
Ratified at:	Director Sign-off	Date of Ratification:	
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	Training in SJR (Half day) and RCA (full day) for staff to enable them to conduct investigations and mortality reviews	Financial Resource Impact	Training is ongoing through internal processes
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	Policy will be disseminated via the Intranet and the Trust Weekly Global		
Monitoring and Compliance:	Monitored through Mortality Governance Steering Group and Clinical Risk Management Group.		

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
V1.0	New guideline	22 November 2016	Mortality guidelines developed following the Mazars report into the review of deaths of Southern Health.
V2.0	Changed from a guideline to a policy	July 2017	Guidelines developed into mortality governance policy following National Quality Board (2017) Learning from Deaths Approved and ratified at QPaS
V2.1	Review	25 July 2017	Updated following consultation at QPaS and Mortality Steering Group
V2.2	Review	31 May 2018	Minor process amendments Approved at QPaS (Director sign off)

Appendix 5 – Equality Impact Assessment (EIA)

Humber Teaching NHS Foundation Trust

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name:
   Mortality Governance: Learning from Deaths of Patients in our Care Policy and Procedure

2. EIA Reviewer (name, job title, base and contact details)
   Sadie Millington, Patient Safety Manager, Trust HQ (01482) 389135

3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?
   Policy and Procedure

Main Aims of the Document, Process or Service
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	No adverse impact identified Child deaths will be reviewed via the Child Death Overview Panel
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (and including cancer, HIV, multiple sclerosis)	Low	No adverse impact identified Learning Disabilities deaths will be reviewed by LeDeR
Sex	Men/Male Women/Female	Low	No adverse impact identified
Marriage/Civil Partnership		Low	No adverse impact identified
Pregnancy/ Maternity		Low	No adverse impact identified
Race	Colour Nationality Ethnic/national origins	Low	No adverse impact identified
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	No adverse impact identified

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Sexual Orientation	Lesbian Gay Men Bisexual	Low	No adverse impact identified
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	No adverse impact identified

Summary

Please describe the main points/actions arising from your assessment that supports your decision.	
EIA Reviewer: Sadie Millington, Patient Safety Manager	
Date completed: 24 May 2018	Signature: Sadie Millington