The Shrewsbury and Telford Hospital NHS Trust

Learning from Deaths Policy

A Framework for Identifying, Reporting, Investigating and Learning from Deaths in Care.

Associated Policies

- Being Open and Duty of Candour policy CG10
- Clinical incident / near-miss reporting and investigation policy (including Serious Incidents and Never Events) CG04
- Concerns and Complaints Policy and Procedure CG07
- Policy on the management of external reviews and assurances CG 02
- Guidelines for Supporting Staff involved in Traumatic / Stressful Incidents, Complaints, or Claims (CG03)

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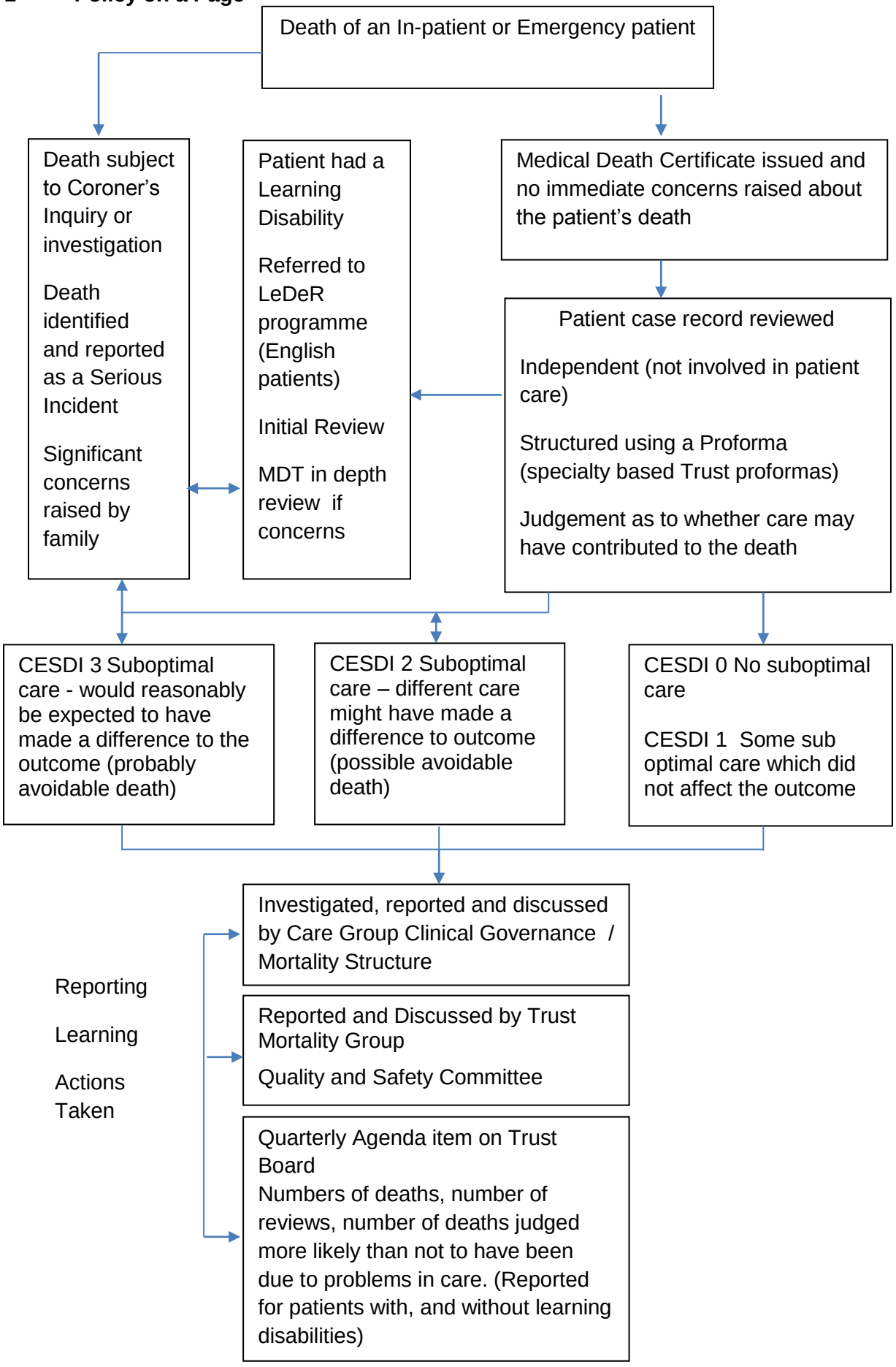


2 Document Statement

The purpose of this document is to describe the responsibilities and processes for reviewing, reporting and learning from the care of patients who have died at the Shrewsbury and Telford Hospital NHS Trust. (SaTH).

3 Overview

In December 2016, the Care Quality Commission (CQC) published its review ***Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England.*** The CQC made a number of recommendations to improve the consistency of investigations into patients' care, the publication of the outcomes of mortality reviews and, any learning or actions arising from investigations.

In March 2017, the National Quality Board published ***National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*****.** The framework set out in greater detail the standards and reporting requirements required by all Acute, Mental Health, Community NHS Trusts and Foundation Trusts in England:

- The Trust will offer timely, compassionate and meaningful engagement with bereaved families.
- The Trust has governance processes in place to allow for a systematic approach to mortality case record review, using a robust and effective methodology.
- Where problems in care are identified, that the appropriate external reporting and high level investigation takes place.
- That mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the Trust Board.
- The Trust will ensure that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and will be reported in annual Quality Accounts from June 2018.

Although the National Guidance is aimed at Trusts providing care in England, Welsh patients who die within the Trust will be subject to the same level of review. The only exception to this is that Welsh patients are not included in the Learning Disabilities Mortality Review (LeDeR) programme for patients with learning disabilities, and any patient with a learning disability who has a Welsh postcode, will only be subject to the Shrewsbury and Telford Hospital (SaTH) case record review.

4 Definitions

Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) grading system.

Grade 0 No Suboptimal care

Grade 1 Suboptimal care, but different management would have made no difference to the outcome

Grade 2 Suboptimal care - different care MIGHT have made a difference (possibly avoidable death)

Grade 3 Suboptimal care would reasonably be expected to have made a difference to the outcome (probably avoidable death)

In order to meet the requirements of the national framework, a grade of CESDI 3 will be interpreted and reported as 'a death more likely than not to have been due to problems in care'.

Learning Disability The LeDeR Programme will use the definition included in the 'Valuing *People'*, the 2001 White Paper on the health and social care of people with learning disabilities which states:

'Learning disability includes the presence of:

- significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- reduced ability to cope independently (impaired social functioning)
- which started before adulthood, with a lasting effect on development

5 Duties

5.1 Trust Board leadership

The Medical Director has responsibility for the Learning from Deaths agenda and a named Non-Executive Director has responsibility for oversight of progress.

The Medical Director is the Trust Executive Lead for the LeDeR programme, supported by the Associate Director of Quality and Patient experience.

The Medical Director will ensure that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the Board in order that Executive Directors remain aware and Non-Executive Directors can provide appropriate challenge.

The Medical Director, with support from other members of the Executive Team, will ensure external reporting requirements are met, and determine when an independent investigation may be warranted. The Executive team also liaise with Commissioners to review and improve their respective local approaches following the death of people receiving care from their services.

The Medical Director is chairman of the Trust Mortality Group, where activity and outcomes from the investigation and learning from deaths is collated and discussed.

5.2 Care Group Medical Directors and Specialty Leads

Care Group Medical Directors (CGMDs) are responsible to the Medical Director for ensuring that robust systems are in place within their Care groups for the identification and review of the care of patients who have died.

Where problems in care have been identified, the CGMD is responsible for ensuring that systems are in place to escalate concerns; those responsible for external reporting are informed where necessary, and, a robust investigation is commissioned.

The CGMD is responsible for ensuring that systems are in place for monthly reporting of the number of deaths within the Care Group, the number of deaths reviewed, the outcomes of those reviews, and, any learning or actions taken.

Case record review data will be a standing agenda item of the Care Group Board and Specialty reports will be provided to the Trust Mortality group.

The CGMD will ensure that lessons learnt and actions taken are disseminated to the clinical areas via the Care Group governance structure.

The CGMD will manage those instances where an individual clinician has difficulty completing the required number of reviews, or concerns have been raised regarding outcomes.

The CGMD can nominate Clinical Governance Leads, Specialty Clinical Leads, the Head of Nursing and senior Nurses to undertake some or all of these actions on his or her behalf.

Associate / Deputy Directors, Care group Directors and Business Managers are responsible for promoting an open, honest and fair culture within the organisation. They are responsible for making sure that local management arrangements are suitable and sufficient to allow for all aspects of the Being Open and Duty of Candour policy are implemented.

Where a family raises concerns, the CGMD will ensure that the systems are in place for the family to receive timely responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.

5.3 Consultants in charge of Patient care

Consultants are expected to deal respectfully, sensitively and compassionately with families and carers of dying or deceased patients and, as far as possible, ensure that they are kept informed and answer any concerns raised during the course of the patient's End of Life Care.

Where significant concerns are raised after the patient's death, or a Consultant has concerns following case record review, those concerns must be escalated to allow for independent investigation as per Trust policy.

It is initially the responsibility of the Consultant in charge of a patient's care to decide whether a death should be reported to the Coroner. The Legal Services Team will offer advice and support if a Medical Death Certificate has already been issued. Further decisions regarding referral may be initiated following case record review.

5.4 Corporate services

Patient services

A Bereavement survey leaflet is given to every Next of Kin as part of the Bereavement service process. The survey includes an option for a telephone discussion with a Health Care Professional if the family have any unanswered questions or concerns about the deceased's care.

Bereavement services and PALS will escalate any concerns raised by families and carers during the bereavement process. For simple queries and concerns, they will liaise with the Consultant in charge of care and the Ward Manager. Where concerns cannot be quickly and informally resolved, a formal complaint can be raised and the Trust Complaints Procedure followed.

Patient Safety Team

The Patient Safety Advisors will liaise with Clinical, Care Group and Corporate staff to support the decision as to what level of investigation is required into a death where there are concerns that an act or omission in the patient's care has contributed to, or caused harm. Serious Incidents will be reported and supported as per policy. (Appendix 1)

The Patient Safety advisors may contribute to the monitoring and reporting of review data within the Care Group they support.

The Mortality Lead is responsible for notifying the LeDeR programme of deaths of patients with learning disabilities within the Trust. She or he also acts as the main contact for the Trust to facilitate the independent external LeDeR reviews of patient care.

The Mortality Lead is responsible for co-ordinating the reporting of mortality case note review data to the Medical Director and Trust Board.

Legal Services

The Legal services team provides the liaison between the Coroner's office and the Trust.

Members of the team will meet with the Coroner and patients' families during Pre-Inquest Reviews and co-ordinate requests for statements required by the Coroner and families as part of their Inquiries / Inquests.

The team also co-ordinates the Trust's response to Regulation 28 reports and will provide feedback on learning from individual Inquests.

6 Case record review

6.1 Routine Casenote review processes for different patient groups.

The Trust commits to ensuring that all patient deaths within SaTH will be reviewed. Currently, further work will be required in order to achieve this.

Adults' case records will be reviewed using a Trust proforma specific to the specialty under which the patient died.

All cases will be graded in accordance with the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) grading system.

Patient reviews which are awarded a CESDI score of 2, will be subject to a High Risk case Review.

Patients which are awarded a CESDI score of 3 will be reported as a Serious Incident and discussions will be held with the Coroner.

Adult Medical specialties

Consultants will be paired with another Consultant from their specialty who will perform the review. After coding, the case record, with a copy of the Medical casenote proforma, will be sent to the 'partner' of the Consultant who last saw the patient. This will provide a form of independence to the review.

Adult Surgical Specialties

Case records are reviewed by a single reviewer within each specialty, using a specialty specific Trust proforma. The deaths will then be presented at Clinical Governance / Mortality meetings where the care is discussed and a CESDI outcome awarded.

Emergency Department

All deaths in the Emergency Department will be reviewed by the Clinical Governance (CG) Lead. Reporting is by exception where there are identified concerns in care. The CG Lead will also identify deaths in ED of patients who recently have been discharged from the Trust.

Deaths of patients with a Learning disability

All patients with a Learning Disability who die as in-patients will have a SaTH case record review appropriate for the specialty in whose care they died. SaTH participates in the national LeDeR programme, but it only applies to patients with an English post code, aged 4 years and over. Patients who fall outside the scope of LeDeR will be reported in the numbers of patients with a Learning Disability, but will only be subject to a SaTH case record review.

Deaths of patients with Mental Health needs

All in-patients who die whilst detained under the Mental Health Act are reported to the Coroner and CQC. At SaTH, deaths of patients with acute mental health needs, where those health needs may have been a factor in their death, are more likely to be voluntary patients who may, or may not be in

receipt of Mental Health services. Sudden or unexpected deaths will be investigated jointly with representatives of the Mental Health services.

Maternal Deaths.

Deaths of women during, or up to 42 days after the end of their pregnancy are subject to rapid review to identify:

a) whether the death was associated with, or exacerbated by, pregnancy, and

b) whether there were any act or omissions in care, including out-patient ante natal care, which may have contributed to the death.

Since 2015, maternal deaths only have to be reported as Serious Incidents (SI) if the SI inclusion criteria is met. Other deaths will be subject to high Risk case review. Details of maternal deaths are submitted to the MBRRACE programme.

Infant and Child deaths.

All child and infant deaths are subject to internal review. The Trust will notify the designated person of the Local Safeguarding Children Board of any child's death, and participate in the ensuing Child Death Overview Panel review. The CDOP review will also include review questions from LeDeR for children aged over 4 with Learning Disabilities.

Stillbirths and neonatal deaths.

All stillbirths and neonatal deaths are subject to peer rapid review to identify potential avoidable contributory factors. Where no immediate issues are found, the care is subject to simple case review. If any concerns are expressed, the death is reported as a Serious Incident and subject to a Root cause analysis. Families are supported throughout by the Bereavement Midwife. National guidance on a standardised investigation process is awaited following the publication of Better Births 2016.

See Women and Children's care group – Process for reviewing death for more details

6.2 Targeted case note review

Deaths in a diagnosis or treatment groups, where there is higher than expected mortality as reported by the national mortality tools or national audits.

The Medical Director will co-ordinate investigations into alerts received from the CQC, or any other monitoring body where SaTH mortality is reported as statistically significantly higher than peer.

The Trust Mortality Group will perform deep dive investigations, before an alert threshold is reached, where internal surveillance shows an unexplained trend in a particular diagnosis group. Outcomes will be reported to the Quality and Safety Committee and CQRM.

Deaths which had previously been reviewed, but need to be re-examined in light of findings from a subsequent Inquiry, Inquest, or, following the issue of a Regulation 28 report by the Coroner

The Legal Services Team will notify the Medical Director of any concerns raised by the Coroner. A decision will be made at the Trust Mortality group whether a deep dive is required to re-review patient deaths in similar circumstances to those identified by the Inquiry. The families of any affected patients would be notified and regular contact maintained until the outcome of the investigation was known.

Audit

Concerns surrounding individual patient care identified in retrospect through Audit will be subject to the same standards of openness as deaths reported concurrently. The Audit Lead will report concerns to the Specialty Clinical Governance Lead or Care Group MD in the first instance.

6.3 Reporting of mortality case note review data

Care Groups and specialties will report their Mortality Data in a standardised template to the Trust Mortality Group. The reports will include:

Metrics from CHKS

1. HSMR, RAMI, In-hospital and total SHMI figures for specialty
   Any significant variance from previous year or peer value
2. Any significant variance in any other indicators

Mortality Case record reviews

1. Number of deaths and Percentage of deaths reviewed by month.
2. Number of deaths by CESDI scores.
3. Deaths by day of week.
4. Deaths of electively admitted patients.
5. Deaths of patients with Learning Disabilities or severe mental illness.
6. Any deaths where family, carers or staff have raised a concern about the quality of care.
7. Themes or observations
8. Recommendations and learning to be shared

Coroner's cases, Serious Incidents and multi-agency reviews

1. Themes and conclusions
2. Recommendations and learning to be shared

Trust Board Reporting

Data on the number of deaths that have occurred within the Trust; the number of deaths reviewed, and, the CESDI outcome grade of those deaths will be presented quarterly as an Agenda item in the public section of the Trust Board.

6.4 Management of Mortality and Dissemination of Learning

See Appendix 2 for the flowchart summarising this.

7 Document Control including archiving arrangements

The policy will be available, and archived on the Trust Document Library. This policy will be reviewed after 5 years, or following changes in national policy. In order that the document remains current, any of the appendices to the policy can be amended and approved during the lifetime of the document without the document strategy having to return to the ratifying committee.

8 Dissemination and implementation

Mortality case record review has been a Clinical Governance process in the Trust for the last 5 years. This policy formalises the process in line with national requirements. The policy will be disseminated via the Trust Governance structure and Nursing and Midwifery Forum.

9 Training

There is no mandatory training associated with this guidance. If staff have queries about its operation, they should contact the Trust Mortality Lead in the first instance.

10 Equality Impact Assessment

Stage 1 EQIA assessment identified a positive impact for people with Learning Disabilities. A stage 2 assessment is not required.

11 Standards of Business Conduct

Due consideration has been given to the Bribery Act 2010 in the formation of this policy document and no specific risks were identified.

12 Process for monitoring compliance with the effectiveness of this policy

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring	Frequency of monitoring	Group or committee that will review the findings and monitor completion of any resulting action plan
The review of patient deaths in SaTH	Numbers of deaths identified and reviewed	Medical Director (Trust Mortality Lead)	Quarterly	Quality and Safety Committee. Trust Board

13 Review arrangements

This policy will be reviewed after 5 years, or following changes in national policy. In order that the document remains current, any of the appendices to the policy can be amended and approved during the lifetime of the document without the document strategy having to return to the ratifying committee.

The Trust Mortality Group will ensure the policy is reviewed in line with changes in national policy or when circumstances indicate that the policy requires review.

14 References / bibliography

Learning, Candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. Care Quality Commission, Dec 2016

National Guidance on Learning from deaths : A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. 1st Ed, National Quality Board, March 2017

Serious Incident Framework v2, Patient Safety Domain, NHS England, March 2015

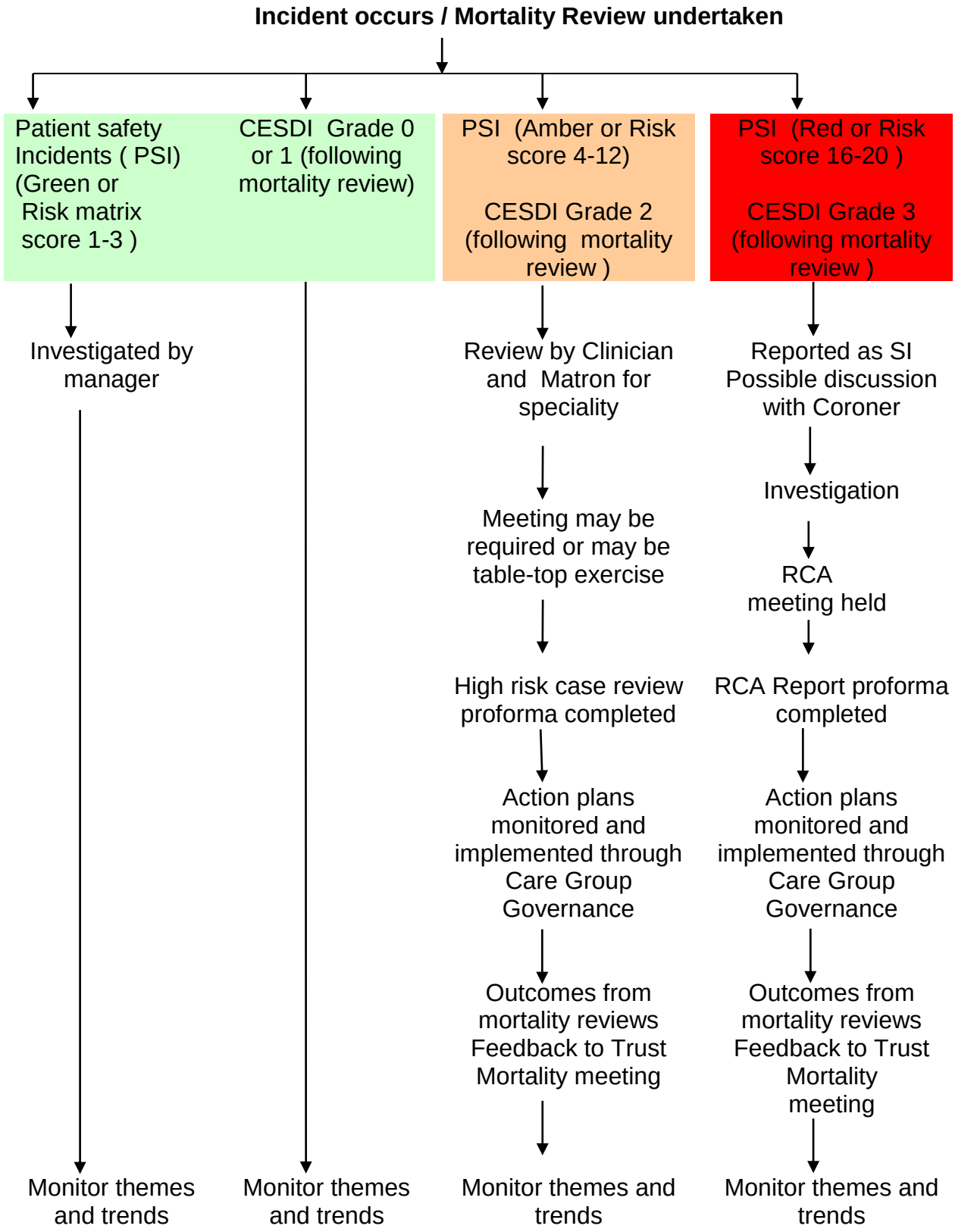
Better Births, Improving outcomes of Maternity services in England, National Maternity Review, NHS England February 2016

Royal College of Physicians. *Using the structured judgement review method – a clinical governance guide to mortality case record reviews*. London, Royal College of Physicians 2016

15 Associated Documents

Women and Children's Care Group – Process for reviewing Death

Appendix 1 Guidance Flow Chart for Patient safety Incidents / Mortality Review



Appendix 2 Management of Mortality at SaTH