Trust Policy	Worcestershire Acute Hospitals NHS Trust

Learning from deaths policy

Department / Service:	Corporate Governance
Originator:	S Graystone, Lead Medical Examiner E Mitchell, Learning from Deaths Lead
Accountable Director:	Chief Medical Officer
Approved by:	Deterioration, Resuscitation, End of Life and Mortality Studies committee
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All
Target staff categories	All clinical staff

Policy Overview:

This policy outlines the reason for and process of review of the care provided to patients who die whilst under the care of Worcestershire Acute Hospitals NHS Trust or within 30 days of discharge from the Trust.

The policy ensures that the Worcestershire Acute Hospitals approach to mortality reviews meets the standards required by the NHS National Quality Board.

This policy outlines how learning from reviews will be captured and the roles and responsibilities of those required to respond to care issues identified through the review process.

Key Amendments

Date	Amendment	Approved by
March 2020	Document extended for 6 months due to current COVID-19 situation and emergency legislation likely to be passed	Steve Graystone
February 2021	Document extended as per Trust agreement 11.02.2021	
August 2023	Document revised to incorporate the implementation of the Medical Examiner system	

Contents page:

Introduction

Learning from the care provided to patients who die is a key component of improving patient safety, experience and effectiveness, forming the building blocks of good governance and quality improvement work. Following recommendations by the CQC in 2016, the Secretary of State made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die. The National Quality Board has produced a document outlining the standards to be achieved by all healthcare organisations in relation to the undertaking and outcomes from review of deaths. This guidance was published in 2017 and is the basis of this policy, and should be consulted if there is any discrepancy. This policy sets out how the Worcestershire Acute Hospitals Trusts mortality review programme will meet these national standards.

Scope of this document

This policy applies to Trust clinical staff and those involved in the investigation of incidents and dissemination of learning.

This policy covers the patient cohort as defined by the National Quality Board guidance published in March 2017 namely:

- Any patient who dies in the emergency department
- Any patient who dies whilst an in-patient
- Any patient who dies within 30 days of discharge from Hospital
- Any maternal death occurring within 42 days of delivery

Patients who will not be subject to standard selection include those brought in dead (unless the patient had contact with this Trust within 30 days of death) and those patients transferred for care to another organisation/Trust; in which case, the Trust will participate in the review should the outside organisation/Trust suggest it.

A review of care after a patient's death is mandatory in the following circumstances:

1. All deaths where the family, carer(s) or staff have raised a concern about the quality of care provision. (This will include complaints, coronial inquests, serious incidents, litigation cases.)

2. An infant, child, stillbirth or maternal death.

3. All deaths where the patient was identified to be significantly disadvantaged, particularly all deaths of those with a registered learning disability and all deaths of those identified with severe mental illness.

4. All deaths in a service specialty, particular diagnosis or treatment group, where an 'alarm' has been raised with the Trust through whatever means. For example, via a Hospital Standardised Mortality Ratio (HSMR) elevated mortality alert (CUSUM), concerns raised by audit work or by the Care Quality Commission or another regulator.

5. All deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.

6. In addition, there is a requirement to screen all cases where there was evidence of sub-optimal care. These cases will include:

a. All cases where a Datix was raised relating directly to the care of the patient.
b. All cases where the patient's admitting diagnosis falls within groups identified by HSMR/SHMI analysis as being an outlying group.

7. All cases where the Trust is monitoring a service/diagnosis group, i.e., deaths where learning will inform the organisation's 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.

Those cases meeting any of the above criteria will form part of the mandatory review.

Purpose

The purpose of this document is to provide a clear framework for a robust review process to ensure that learning is disseminated through the correct governance routes, that national mandatory reporting requirements are met, including reporting of incidents to the National Reporting and Learning System (NRLS) and to ensure that staff are aware of their responsibilities.

Definitions

- **LeDeR** – Learning Disabilities Mortality Review, a data gathering programme.
- **Case record review** - the application of a case record/note review to determine whether there were any problems in the care provided to the patient who died, in order to learn from what happened. In most instances this will be through an SJR as a structured process
- **SJR** - Structured Judgement Review, a tool developed by the Royal College of Physicians.
- **Investigation** - the act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
- **Death due to a problem in care** - a death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.
- **DREAMS meeting** – Deteriorating patient, Resuscitation, End of Life And Mortality Study group. The monthly forum in which concerns about patient care processes at the end of life are discussed.

Responsibility and Duties

The Chief Executive/Managing Director

- Is responsible for ensuring meaningful and compassionate engagement with bereaved families and carers in relation to all stages of responding to a death occurs. See appendix 1
- Will ensure families/carers are advised of their right to request a mortality review if they have a significant concern about the quality of care provision.
- Will inform the Lead Clinician for Learning from Deaths if a concern has been raised or request for review has been received from the family/carer.
- Will raise a scrutiny panel to review a series of incidents/internal investigations/SI/PSRE where learning has not been achieved/processes have not been put in place to mitigate risks to patients.

The Chief Medical Officer – Executive Lead for the Learning from Deaths Agenda

- Is responsible for the Learning from Deaths agenda.
- Pays particular attention to the care of patients with a learning disability or mental health needs.
- Ensures a robust and effective methodology for case record review with a view to identifying lapses in care and possible areas for improvement.
- Ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the Trust rather than individual errors in the problems that generally occur.
- Will address any non-compliance with staff where reviews are not completed, or the standard of completion is poor, or reviews are completed consistently after the deadline.
- Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board and is discussed at the public section.
- Will evaluate a case record review 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 Trust review process.
- Ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care.
- Ensures the sharing of relevant learning across the Trust and with other services where the insight gained could be useful.
- Ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths.
- Works with independent investigators where cases warrant external review.
- Works with commissioners to review and improve their respective local approaches following a death due to a problem in care.

8. Ensures that the information the provider publishes is a fair and accurate reflection of its achievements and challenges.
9. Will ensure that any information shared or published adheres to Caldicott principles.

Non-Executive Director – Responsible for oversight of progress

- Will play a crucial role in bringing an independent perspective to the boardroom and will scrutinise the performance of the Trust's management in meeting agreed goals and objectives and monitor the reporting of performance.
- Should be satisfied as to the integrity of clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.
- Will monitor that the information the Trust publishes is timely and a consistent, fair and accurate reflection of its achievements and challenges, seeking comparison data to help challenge potential for improvements whilst understanding direct comparison limitations.
- Will hold the Trust to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable.
- Will champion and support learning and quality improvement by understanding how learning is translated into sustainable effective action and monitor that learning and improvements are reported to the board and relevant providers.
- Will monitor that the Trust can demonstrate to stakeholders that "this is what we said we would do, and this is what we did" (learning and action), and explain the impact of the quality improvement actions.
- Will monitor that families and carers are involved in reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes.

The Director of Nursing

- As head of quality, the Director of Nursing will ensure that learning from case record review is reported in the Quality Account according to the standard template.
- Will ensure that nursing staff engage in the mortality review process.
- Will support the medical director in promoting the mortality review process.
- Will ensure that any nursing issues identified during review are addressed by nurse leads within the specialty, or more widely if appropriate.

The Medical Examiners

- Will, using the screening tool, identify the deaths for mandatory review e.g. vulnerable patient groups and cases where the family/carer has raised significant concerns about the quality of care provision, as described in the publication 'National Guidance on Learning from Deaths March 2017'.
- Will also select cases for review falling outside of mandatory categories as identified by mortality surveillance, Trust improvement priorities or other intelligence from external bodies or internal governance processes.
- Will work with the Medical Director to determine cases for peer review.
- Will inform the relevant service leads of the outcome of cases reviewed.
- Will identify any deficiencies in care/learning points, for the whole final admission period, or an earlier admission, if it was identified that the care delivered had impacted on the final admission.
- On identifying that a potential incident has occurred that requires action, will consider the following:
    - Is immediate action required? If yes, ensure the relevant divisional directors and CMO/CNO are informed
    - Is anyone in immediate danger? If yes, ensure the relevant divisional directors and CMO/CNO are informed to ensure actions are taken to maintain safety.
    - Complete a Datix incident form, identifying that the incident has been raised following a mortality review, to facilitate tracking. If this meets the definition of the patient safety incident, it will be sent to NRLS (National Reporting and Learning System). If raised as a Safeguard, it will be reviewed within the safeguarding framework.
    - Will record the Datix number on the review form.

  (please refer to Trust Procedure for the Reporting and Management of Incidents and Serious Incidents Requiring Investigation (SIs)/PSIRF framework)
- Will escalate serious concerns immediately to the Patient Safety Team and/or Coroner
- Will raise concerns should they suspect that support given to the patient by other providers (e.g. Ambulance Service, Social Services, residential care, other healthcare providers) by completing a Datix incident choosing 'Other Healthcare Service Provider'.
- Will ensure that documentation is a true and accurate reflection of the patient's condition and treatment. If errors/the need for clarification are identified, they will provide an addendum in the health record
- Will send a standard review form to GPs for completion for all patients who die within 30 days of discharge.
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- Will maintain a log recording where concerns have been raised by bereaved families and carers.
- Will work with the Medical Director and nominated Non-executive Director to ensure that systems are robust and accurate.

Divisional Directors

- Ensure that the divisional structure for governance makes provision for learning from mortality review incorporating multidisciplinary review.
- Attend the DREAMS meeting each quarter or send a deputy who is able to effectively represent the division.
- Develop a culture of learning from deaths within the division including Datix reporting where deficiencies in care are identified.

Investigation Officers (SI and Internal Investigation)

- Will follow the procedure as outlined in the Procedure for the Reporting and Management of Incidents and Serious Incidents Requiring Investigation (SIs) WAHT-CG-009, including implementing the Duty Of Candour guidance (Policy for Being Open and the Duty of Candour WAHT-CG-567) ensuring that bereaved families and carers have as much involvement in the review process as they wish, subject to respecting the expressed wishes of the deceased with regards to confidentiality.
- Will work to the Patient Safety Incident Review Framework when it is established (anticipated late 2023).
- Will develop a comprehensive action plan that meets the recommendations of the report.

The Divisional Governance Teams

- Will review concerns escalated to them by the Medical Examiners and determine, in consultation with the appropriate director, whether the case requires the raising of a Datix and/or formal investigation and action.
- In all instances a review of the patient's care and treatment should be undertaken.
- Where the incident is not deemed to be an SI/internal investigation, will ensure that bereaved families and carers are kept informed of progress and the results of any case note review should they wish to be. (It will be the responsibility of the SI/internal investigation team to provide family liaison support.)
- Will assist with the appointing of a staff member as a single point of contact if this is required.
- Following the investigation, will inform the patient's GP of the outcome.
- If the investigation was prompted by a serious concern raised by the family or carer, they will assist in ensuring that the family/carer is as involved as much as they wish to be and treated in accordance with the Policy for Being Open and the Duty of Candour WAHT-CG-567
- Where a decision is made that a full investigation is not required following the review of concerns raised by the bereaved family/carer, will advise the CNO of the rationale behind this.
- Will provide a quarterly report to the DREAMSGroup summarising learning and actions from mortality review investigations and Mortality and Morbidity meetings.

The Patient Safety Team

- Will ensure that where an SI is raised/internal investigation occurs for a patient who dies during that admission/or occurs as a result of mortality review, the Learning from Deaths lead clinician is informed.
- Will advise the Learning from Deaths lead clinician of any learning/actions following the completion of the review that will require monitoring through the mortality review process.
- Will work with the Learning from Deaths lead clinician to ensure that they are aware of patient safety themes that would warrant the mandatory review of a group of cases.
- Will receive themed actions from divisions to ensure that these are dovetailed with any existing actions to provide a consistent programme of action.

- Will liaise with the Integrated Care Board (ICB) where there is a multi-agency patient safety concern or investigation.

The Learning Disabilities Health Liaison Team

- Will support the LeDeR (Learning Disabilities Mortality Review) programme by registering all deaths where the patient had a learning disability on the LeDeR website, whether inpatient, out-patient or community.
- Will ensure, through spot checks, that patients with a confirmed learning disability are flagged on the Trusts PAS.
- Will participate in the peer review of patients with a learning disability who die in hospital or shortly after admission.
- Will escalate concerns to the Chief Medical Officer and Learning from Deaths lead clinician where deficits in care are identified and support the development, implementation and embedding of improvement methodology to improve patient care and reduce the number of avoidable deaths.
- Will identify care/safeguarding concerns, raising a Datix incident form as appropriate. Where the incident has the potential to be an SI, the team will ensure the Patient Safety Team are made aware of the incident.

Audit Midwife - Maternity MBRRACE

- A maternal death is defined internationally as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy.
- The audit midwife is responsible for recording the deaths of mothers, and babies on the MBRRACE website.
- The audit midwife will provide a quarterly report to the DREAMS group from the MBRRACE website for inclusion in the board report.
- The Bereavement Midwife will ensure that families are given a personalised letter from the Chief Executive expressing condolence and inviting comment about the care delivered.
- In addition to statutory reporting, the maternity team will undertake a review of care using an appropriate review tool.

The Bereavement Services Manager

- Will give the family/carer attending the bereavement suite a personalised letter from the Chief Executive/CMO expressing condolence and inviting feedback about the care received by the deceased.
- Will ensure that bereaved families are supported and sign-posted to services, (e.g. Leaflet ‘What do I do now?’).
- Will record any cases referred to the coroner on a shared data base.
- Will record all cases where cremation is the preferred option.

The Learning from Deaths Lead Clinician

- Will be responsible for promoting and leading on the review methodology.
- Will review cases where the family/carer has raised a concern, completing a Datix incident report where substandard care is identified, escalating to the Patient Safety Team where appropriate.
- Will liaise with the Divisional Governance Manager(s) to ensure that the family/carer is kept informed as to progress at all points.

- Will review case record findings and collate reports based on the SJR scales, summarise learning, and provide timely and accurate information for the quarterly public board report.
- Will liaise with leads and services not using the standard review tool (e.g. maternity, children's) to collate review summaries, learning and action points.
- Will provide reports to the Mortality Review Group and divisions, summarising case record review key learning points, themes and data relating to the SJR scales for patients accessing Trust services.
- Will review Datix incidents raised following a mortality review, bringing together the actions and learning.
- Will maintain a log to demonstrate action, learning and improvement.
- Will chair the quarterly DREAMS group with the Learning from Deaths agenda, and attend the DREAMS group meetings that focus on deteriorating patient and end of life issues.

The Palliative Care Team

- Will submit a Datix incident form where lapses in care at the end of life are identified, including where a preferred place of care was not achieved/the patient experienced discharge delays.

Local Mortality & Morbidity Meetings/Divisional Governance meetings

- These meetings will normally be monthly, unless there are fewer on average than one death per month, in which case the meetings may be held every two months or quarterly, unless issues are identified, in which case, meeting frequency will be increased.
- Membership will be multidisciplinary, including nursing staff and professions allied to medicine such as pharmacy, nutrition and dietetics, physiotherapy.
- A summary of the meeting and attendance record will be kept in line with governance arrangements.
- Will review the speciality specific aspects of care in all patients whose outcome is death to ensure speciality specific standards are met.
- Will review the findings of all case record reviews (SJRs) in their specialty and identify actions and learning points for sharing both locally and Trust wide.
- Will come to a view as to whether the death was, at that particular time, avoidable or not avoidable.
- Will ensure that learning is translated into sustainable effective action that measurably reduces risks to patients.
- Will ensure that other governance processes are used as needed e.g. entry of a particular issue onto the Directorate Risk Register.
- Will ensure that overall learning and evidence of effective action from mortality discussions are reported to the Mortality Review Group. These reports should include evidence of both good as well as substandard care.
- Will pay attention to best practice and how this can be more broadly implemented.
- Will ensure that any internal investigation of a death which is not deemed to be an SI is discussed by a multi-disciplinary team with the findings doxcumented in a formal meeting.
- Will address any concerns where a team consistently fails to raise a Datix incident form at the time where issues in care are identified in the later SJR review.

The DREAMS Group (Deteriorating patient, Resuscitation, End of life AND Mortality Study Group)

- Will receive the reports from the Divisions and pursue non-submission via the divisional structure.
- Will escalate concerns where teams consistently fail to raise Datix incident forms where harm or the potential to cause harm is identified by the SJR review process in consultation with the Divisional Management teams.
- Will decide whether the learning points have cross-specialty relevance and feed back to divisions where shared learning would be appropriate.
- Will monitor the actions of divisions to ensure that learning and change has occurred.
- Will monitor recurring themes and decide whether they should form part of additional training for staff during for example 'huddles', board rounds and other educational opportunities such as Grand Rounds, Journal Club, Multidisciplinary Governance Half Days and FY1 training.
- Will receive feedback from the board for dissemination to the relevant groups.

The Trust Board

- Will ensure that robust systems are in place for recognising, reporting, reviewing, or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care by providing challenge and support.
- Will work with commissioners who are accountable for quality assuring the robustness of Trust systems so that the Trust develops and implements effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.
- Will receive quarterly reports from the Mortality Review Group for discussion and publication at the public board.
- Will review the information provided, raising any concerns with the Mortality Review Group.

The Clinical Governance Group and the Quality Governance Committee

- Will receive monthly reports from the Mortality Review Group detailing the outcomes of case record reviews and investigations, themes from incidents where lapses in care have been identified and a summary of actions.

In all cases where deficits in care have been identified, there will be an open and just culture across all service areas, where staff are supported during all stages of review.

• Policy Content

Bereaved Families and Carers

The needs of patients and their family/carers will be made the first priority at every opportunity. The Trust will engage with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. We will ensure a consistent level of timely, meaningful and compassionate support and engagement, from notification of the death to an investigation report and its lessons learned and actions taken.

Bereaved families and carers:

- Will be treated as equal partners following a bereavement.
- Will always receive a clear, honest, compassionate and sensitive response in a sympathetic environment.
- Will be offered face to face, verbal communication and (*virtual is acceptable if this is the preference of the family) meetings as well as written correspondence.

- Will receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.
- Will be informed of their right to raise concerns about the quality of care provided to their loved one.
- Will be given the opportunity to help inform decisions about whether a review or investigation is needed.
- Will receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.
- Will, where they want, be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations.
- Will be involved in the investigation process will be supported to work in partnership with trusts in delivering training for staff in supporting family and carer involvement where they want to.

Where the family/carer raises a concern that is not locally resolved and brought to the DREAMS meeting:

- The Lead Clinician for Learning from Deaths will seek the advice of specialist colleagues, where appropriate, in determining whether there were any deficiencies in care.
- Where harm is identified the reviewer will raise a Datix incident report so that the case can be assessed by the Patient Safety Manager/Patient Safety Team to ascertain if this might be an SI or require an internal investigation.
- The Learning from Deaths Lead Clinician will liaise with the Divisional Clinical Governance Manager to ensure that the family/carer is kept informed as described below, ensuring that Duty of Candour requirements are met.
- Where the MEM finds no issues in care, they will be responsible for summarising their findings (in line with Caldicott principles) in a letter which will be sent to the family/carer by the Chief Executive via the Divisional Management Structure as appropriate.

Where the Trust decides that the patient death requires investigation:

- Early contact will be made with bereaved families and carers so that their views help to inform the decision.
- Specially trained staff will explain to bereaved families and carers:
    - what happened.
    - how.
    - to the extent possible at the time, why it happened; and what can be done to stop it happening again to someone else.
- Provided the family or carer is willing to be engaged with regarding the investigation, an early meeting will be held to explain:
    - the process,
    - how they can be informed of progress,
    - what support processes have been put in place,
    - what they can expect from the investigation,
    - realistic timescales and outcomes.

  There will be a named person as a consistent link for the families and carers throughout the investigation.
- Bereaved families and carers will:
    - be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held.

- be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation.
- have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided.
- have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings.
- have an opportunity to be involved in setting any terms of reference for the investigation.
- be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case.
- have an opportunity to respond on the findings and recommendations outlined in any final report; and,
- be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

This may disclose confidential personal information for which consent has already been obtained, or where patient confidentiality is overridden in the public interest. This should be considered by the organisation's Caldicott Guardian and confirmed by legal advice in relation to each case. (See legal support)

Legal Support

The National Quality Board states that Trusts should offer guidance, where appropriate, on obtaining legal advice for families, carers or staff. This should include clear expectations that the reasons, purpose and involvement of any Trust lawyers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates. The Trust cannot advise families/carers as to how to seek legal support except to recommend that contact is made with the Citizens Advice Bureau.

Advising Staff

If a staff member is concerned about potential legal action, or if a family member suggests they are contemplating taking legal action, advice can be sought from the Trust's Legal Services Department. Early notification of a potential claim can be of assistance to the Trust's Legal Services Department so that early investigations can be carried out before a formal claim is received.

If a clinician is concerned that they have a conflict of interest with the Trust and/ or they want independent legal advice, they should consult their Medical Defence Union or Professional Indemnity Organisation.

Advising patients

Legal advice cannot be provided to family members by the Trust as there is a conflict of interest. The Trust can, however, provide generic guidance as to which external bodies the family can approach for advice/assistance. These bodies include:

- Local Ombudsman
- Citizen's Advice Bureau.
- AvMA (Action Against Medical Accidents) – 44 High Street, Croydon, Surrey, CR0 1YB (tel: 0845 1232352)
- The Law Society (020 7320 5650)

Alternatively, the family may want to seek advice from a local solicitor. The Trust will not recommend specific Claimant Solicitor firms.

If family members indicate they are contemplating making a claim, it may be of assistance, in some instances, to explain the relevant tests/standard of proof required to establish medical negligence. See appendix 2

The Process for Reviewing and Learning from Deaths

The bereavement office will identify all deaths occurring in the ED or whilst the patient was an inpatient. The PAS will be used to identify deaths occurring within 30 days of discharge (or 42 days of the end of the pregnancy). Following national guidance, there will be a proportion subject to mandatory review (see scope); the findings from these will be reported in the quarterly public board reports.

Cases where the patient had a learning disability, or where the patient was under the age of 19, or a was a maternal death, will be reviewed using additional methodologies to patients falling outside of those categories owing to separate national reporting requirements.

For all remaining cases, patients will be reviewed using the Royal College of Physicians' Structured Judgement Review (SJR) template.

- The reviewer will complete the form in its entirety, reviewing all care delivered from first presentation to discharge; advice will be sought from clinical colleagues where appropriate.
- The review will not be confined to the final admission if it is discovered that care in a previous admission contributed to the final admission.
- The reviewer will also consider care delivered by other providers, such as the patient's GP, the ambulance service, or acute care delivered by another organisation.
- Where substandard care is identified (delivered by this Trust/partner organisation) that caused or had the potential to cause harm, it is the responsibility of the reviewer to raise a Datix incident form. The Divisional Governance Manager will be advised of any cases where there may be concerns about a lack of escalation, for further consideration by the division.
- Where a death is already being reviewed as part of an SI/PSIRF investigation this review will replace the SJR. The reviewer will record on the SJR form that this is the case.
- The Divisional Governance team reviewing the Datix incident, with support from the Patient Safety team, will determine the level of investigation. The rational for this decision will be recorded in Datix. (See also appendix 3 for more information about cross-system reviews and investigations.)
- In all cases, where harm is identified, Policy for Being Open and the Duty of Candour WAHT-CG-567 will be followed.
- The Divisional or Directorate Governance Teams/Leads will collate SJRs and use them as the basis for further discussion in the mortality and morbidity meetings.
- Following a discussion at the Mortality and Morbidity Meetings, the meeting should conclude that, on the balance of probabilities, the death was avoidable (at that particular time) or not avoidable.
- Every quarter, the Trust will publish the total number of in-patient deaths (including Emergency Department deaths) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review/investigation estimates will be provided, using nationally agreed criteria, of how many deaths were judged more likely than not to have been due to problems in care accompanied by relevant qualitative information and interpretation. This information will be subject to appropriate reporting restrictions laid out the Trusts information sharing protocols.
- Changes to the Quality Accounts regulations will also require summary information to be included in Quality Accounts from June 2018.

Severe Mental Illness

People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems.[i] Reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

For the purposes of this policy, any patient under the care of secondary mental health services at the time of their death will be reviewed. Reviewers will be required to identify whether patient's mental health had any impact on the care delivered.

Learning Disabilities (patients aged 4 to 74)

The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so.[ii]

The Learning Disabilities Health Liaison Team (LDHLT) will be responsible for monitoring that patients with a diagnosed Learning Disability (LD) are appropriately flagged by staff on the patient administration system. Where a patient with an LD dies in the ED, hospital or community, the LDHLT will register the deaths with LeDeR, the Learning Disabilities Mortality Review Programme. The review will be conducted using the LeDeR template and the findings reported in the quarterly board report. The LDHLT will then assist with the coordination of any training relating to actions. The LDHLT will be responsible for reviewing deaths in other organisations and supporting the review of deaths in this Trust.

Deaths within 30 Days of Discharge

Where the Trust was notified of a death within 30 days of discharge in addition to an SJR review, the patient's GP will be sent a short review form to gather more information. Questions will include:

- Was the patient seen recently by a member of your practice?
- Did your practice see the patient between discharge and death?
- From a primary care perspective did you view the patients' death at the time it occurred as unexpected?
- Are you aware or any deficiencies in care delivered across the health community?
- Did the patient/family/carer raise any concerns about the care given in the months leading up to death?

Infant, Child, Young Person

- All deaths (community and inpatient) involving a child/young person will be recorded on the Worcestershire Safeguarding Children Board Child Death Reviews, form 'Notification of a Child Death'. Any unexpected death triggers the Child Death Review Rapid Response Service.
- Children's services will continue to register child deaths until the national register is rolled out. In addition, they will continue with the clinical review of patients in their care unless the patient had a learning disability, in which case, the review will be undertaken by a Learning Disability Healthcare Liaison Team.
- In addition to statutory reporting, the paediatric team will undertake a review of care using the methodology advised by the National Child Death Programme.

Maternal Death & Still Birth

'MBRRACE-UK' (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which hosts the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

All deaths are recorded on the MBRRACE website. The review questions include demographics, questions about care and cause of death which calculate the risks to the patient, delivering a decision about preventability.

In addition, the Trust uses SCOR (standardised clinical outcome review), a web-based tool which examines perinatal mortality. This tool helps clinicians to review the circumstances preceding and surrounding their stillbirths and neonatal deaths in a standardised way, and derives a taxonomy of substandard care factors which can lead to a systematic action plan.

In addition the Trust will commit to the NHS Resolution (NHSLA) Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury (RRR) scheme which proposes a system of consistent, robust, and independent investigations for all instances where there may be severe avoidable birth injury; and for eligible babies and their families, the option to join an alternative system of compensation that offers support and regular payments without the need to bring a claim through the courts.

- All maternal deaths will automatically be treated as an SI.
- Any suboptimal care identified will be incident-reported on Datix and subject to a 24 hour review.
- Datix incidents are reviewed by the senior midwife/obstetric group with any significant issues in care investigated.
- A national reporting tool is under development and will be used once released (possibly autumn 2017).
- All Datix incident reports are reviewed at the Divisional Risk Management meeting.
- Any learning identified is included is communicated to the maternity team via the divisions governance communication processes.
- All themes from mortality review will be included in the annual training programme, draft guidance updates, induction and audit meetings.
- Incidents will be discussed at Service Governance meetings.

Learning and Actions

The judgement of whether a problem may have contributed to a death requires careful review of the care that was provided against the care that would have been expected at the time of death. Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems, none of which would be likely to have caused the death in isolation but which in combination can contribute to the death of a patient (Hogan et al). Some of these elements of care are likely to have occurred prior to the admission and the Trust will support other organisations, for example in primary care, to understand and act on areas where care could be improved.

Learning will be gathered from the mortality review forms, SIs, Internal Investigations and Datix reviews. This will be recorded on a learning and actions log.

Learning will be disseminated through various communication forums.

All incidents meeting patient safety criteria will be uploaded to the NRLS or its successor (anticipated 2023/4).

Reporting
Each quarter, the Trust will be required to report data from case record reviews, investigations and SIs for all patients who die in hospital or within 30 days of discharge. This will be through a paper and an agenda item to the public Board meeting. This data will include the total number of the Trust's in-patient deaths (including Emergency Department deaths) and those deaths that the Trust has subjected to case record 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.

Owing to the numbers of patients that may be involved, the reporting will be subject to the Trust's Information sharing protocols. This will seek to maintain confidentiality where reported numbers, diagnosis-types or patient profiles are very low.

A summary of the data we publish will be provided in our Quality Account from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that the trust has taken.

Training
Staff undertaking mortality reviews will be trained in the SJR review process by reference to the guidance documents produced by the Royal College of Physicians to ensure a standardised process is used. This information will be disseminated by the Divisions.

Implementation
1. Plan for implementation.
This policy supersedes the 2017 Policy. The changes within this policy have largely been reflective of the implementation of the medical examiner system.
The focus for the Trust will be in the following three areas.

a) Implementation and timely review by SJR of deaths referred to the Trust by the Medical Examiners
b) Establishment and Quality Assurance of monthly Morbidity and Mortality meetings within the Directorates
c) Learning from, and implementing necessary changes as a result of learning from deaths.

2. Dissemination
This policy will be shared with the divisional management and governance groups during the drafting process for agreement.
The policy will be available on the Trusts intranet via document finder and will also be accessible through the mortality review web page.

3. Training and awareness
Corporate and Divisional Governance team members will be made aware of the policy during implementation.
New members to these teams will be made aware of this policy through their induction programme.

- **Learning and Dissemination**

Where serious concerns are identified through the mortality review process (death occurring as a direct consequence of the care provided or a lapse in care, or where the care provided is deemed very poor) the issue will be logged as a clinical incident by the Medical Examiner and the incident managed in line with the Trusts serious incident management policy/PSIRF as necessary.

The data collected will be analysed by the Lead Clinician for Learning from Deaths on a quarterly basis and emerging themes for improvement reported into the Trusts quality improvement programme board as a formal report from the DREAMS Group.

- **Monitoring and compliance**

External reporting of compliance with this policy is requires as set out in the NQB document 'National Guidance on Learning from Deaths'.

In summary the Trust is required to report on a quarterly basis via a Board meeting held in public the following data:

- Total number of patient deaths (including those occurring in the ED)
- The number of deaths subject to case record review
  - Number of these patients with a learning disability
- An estimate of the number of deaths judged more likely than not to have been due to problems with care.
- A summary of the learning and improvements resulting from the mortality review process.

These metrics will be collated using the NQB Dashboard. These metrics will be reported monthly to the Clinical Governance Group and Quality Governance Committee and quarterly to the Trust Board.

Policy Review

This policy will be reviewed 6 months after approval then annually. The policy will also be reviewed in line with further guidance issued on mortality reviews issued by the NQB.

References: Code:

National Quality Board Guidance on Learning from Deaths	
Royal College of Physicians National Mortality Case Record Review Programme – reviewers guide for using the structured judgement review	

Background

.1 Equality requirements

There are no equality issues identified

.2 Financial risk assessment

The Medical Examiner for Mortality role will be funded through the monies accrued from the completion of the second part of the 'Approval to cremate' form. A Business case for this change has been approved at Trust Leadership Group

.3 Consultation

This policy has been reviewed by divisional management teams, the Learning Disability Health Liaison Team, the Worcestershire ICB and the Worcestershire Acute Hospitals Health Information team.

Contribution List

This key document has been circulated to the following individuals for consultation.

Designation
Dr Suneil Kapadia - CMO
Vicky Morris - CNO
Dr Julian Berlet DMD Specialised Clinical Support Division
Dr Sally Millet – Deputy DMD Specialised Clinical Support Division
Stephanie Beasley – DDN Specialised Clinical Support Division
Dr Andrew Short DMD Women and Children Division
Fay Baillie – DDN&M Women and Children Division
Dr Gary Ward DMD Acute medicine
Dr Jasper Trevelyan DMD Specialist Medicine
Stephen Jezard – DDN Medical Division
Mr Graham James DMD Surgical Division
Sarah King – DDN Surgical Division
Katherine Leach – Patient safety team lead
Jane Clavey – Head of legal services
Pamela Mariga – Learning disabilities health lead

This key document has been circulated to the chair(s) of the following committee's / groups for comments.

Committee
Mortality Review Group
Clinical Governance Group
Quality Governance Committee

.4 Approval Process

This policy has been produced by the mortality review group and will be reviewed by the Clinical Governance Group for recommendation for approval by the Quality Governance Committee. The Key Documents Approval Group will also approve the document before publication on the Trusts web site.

The Policy will also be discussed in the public section of the September Trust Board meeting.

APPENDIX 1 – CEO LETTER

Date

Re:

Dear

I am writing to offer my sincere condolences to you, your family and all t hose who will miss *first name of deceased* following his/her death here at the Worcestershire Royal Hospital/Alexandra General Hospital.

At the Trust we strive to provide excellent healthcare to all our patients and I hope the standard of care we gave *first name of deceased* met with your expectations.

We are very keen to improve the services we provide to people at the end of their lives and therefore we would welcome your comments. If you have any worries or you feel we could have done things better, I would encourage you to let us know.

I realise the days and weeks ahead may be difficult, so please do not feel you have to contact us immediately, but when you and your family have had time to reflect we would welcome the opportunity to address any concerns you have.

I hope your experience of Worcestershire Acute Trust has been a good one, but if you have feedback that will help us improve our services please contact me using the details above.

Yours Sincerely

APPENDIX 2 – LEGAL ADVICE

Generic guidance that can be provided below:

Under English law, an individual may be entitled to compensation if they have been injured as a result of the negligence of another person or organisation. In order for a patient to obtain financial compensation when something goes wrong in the NHS, the following criteria must be met:

1. The doctor (or other health professional caring for the patient) must have acted in a way which fell short of acceptable professional standards. The test is whether the actions of the health professional in question could be supported by a "responsible body of clinical opinion". It will not be enough to show that other health professionals might have done something differently if a "responsible body" of health professionals would support the action taken.

2. The harm suffered by the patient must be shown, on the balance of probabilities, to be directly linked with the failure of the health professional to meet appropriate standards. If, for example, there was a good chance that the patient would have suffered the harm even if the health professional had acted differently, then the claim is unlikely to succeed.

If you are successful in establishing the above, you will be entitled to recover compensation in an attempt to put you in the position you were in prior to the alleged negligence.

You will then need to formally particularise your claim by providing a Letter of Claim confirming the allegations you are making and what injuries and losses you are alleging have been caused as a consequence of these allegations. It is not sufficient to request the Trust pays compensation without particularising your case as without confirmation of these allegations raised, the Trust cannot investigate your claim.

Please also note that the Trust is a member of NHS Resolution ("NHSR"), which assesses and responds to formal claims on behalf of the Trust. The NHSR will usually refuse to register a claim unless they receive a formal "Letter of Claim", setting out precise details of the particulars of the claim and negligence alleged. Further details of what is required in a Letter of Claim can be found in the Pre-Action Protocol for the Resolution of Clinical Disputes. The entire Pre-Action Protocol can be located on the justice.gov.uk website by heading to the following web address:

https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot_rcd.

Clinical negligence claims can, by their very nature, involve complex issues of law. We would recommend that you seek legal advice and obtain expert evidence before serving a Letter of Claim.

Appendix 3 Cross-System Reviews and Investigations

To facilitate better cross-community care, a mortality concordat will be established with partner organisations.

1. In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being primary care and acute care, ambulances services and acute care, or mental health services combined with any of these. Case record reviews typically have to rely on the records held by a single organisation, but even these records can provide indications of possible problems in earlier stages of the patient pathway.

2. Where possible problems are identified relating to other organisations, it is important the relevant organisation is informed, so they can undertake any necessary investigation or improvement.

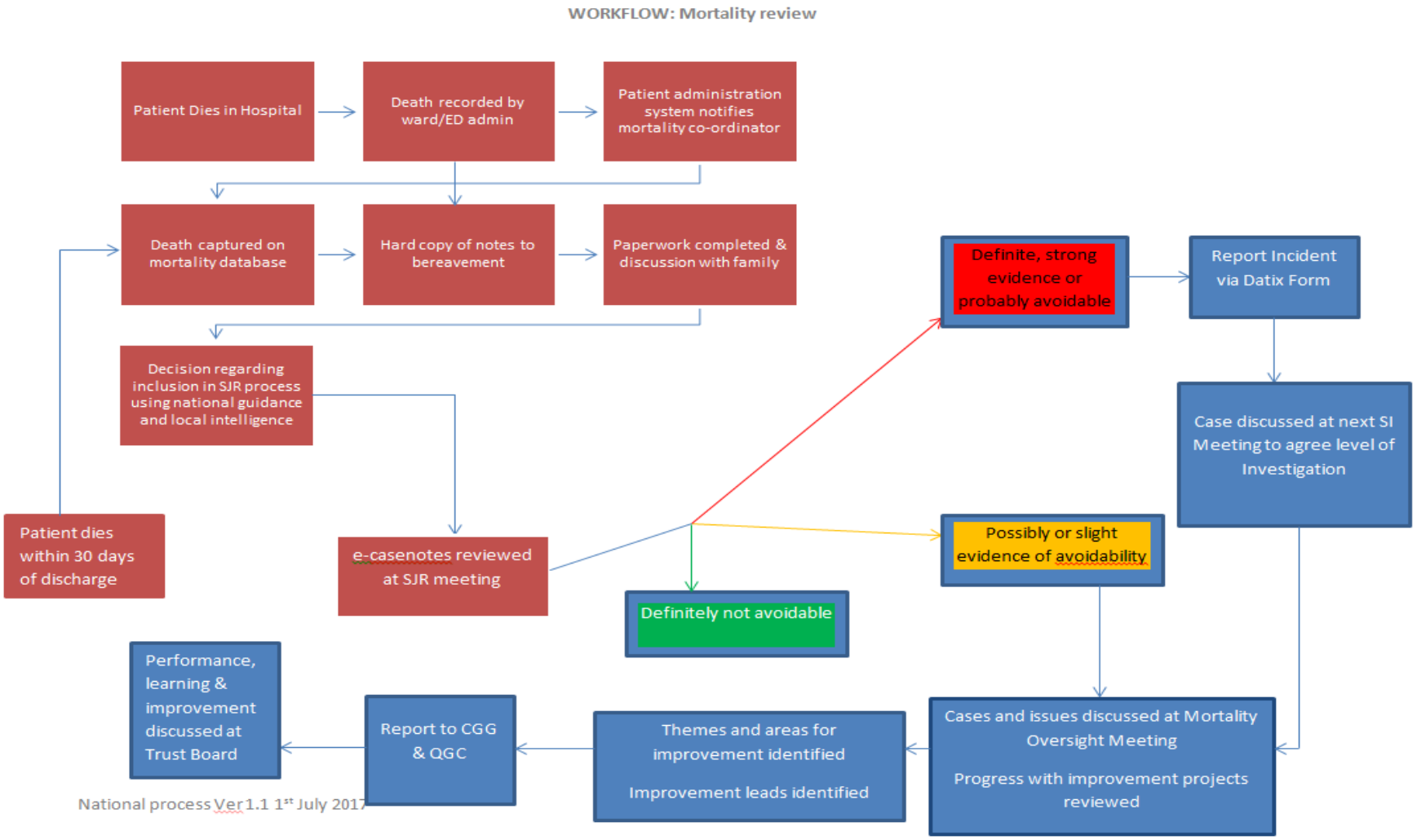
3. Trusts should consider whether they can routinely arrange joint case record reviews or investigations for groups of patients where more than one organisation is routinely providing care at the time of death - for example, for older people with dementia and frailty receiving frequent input from their GP and from community mental health nurses.

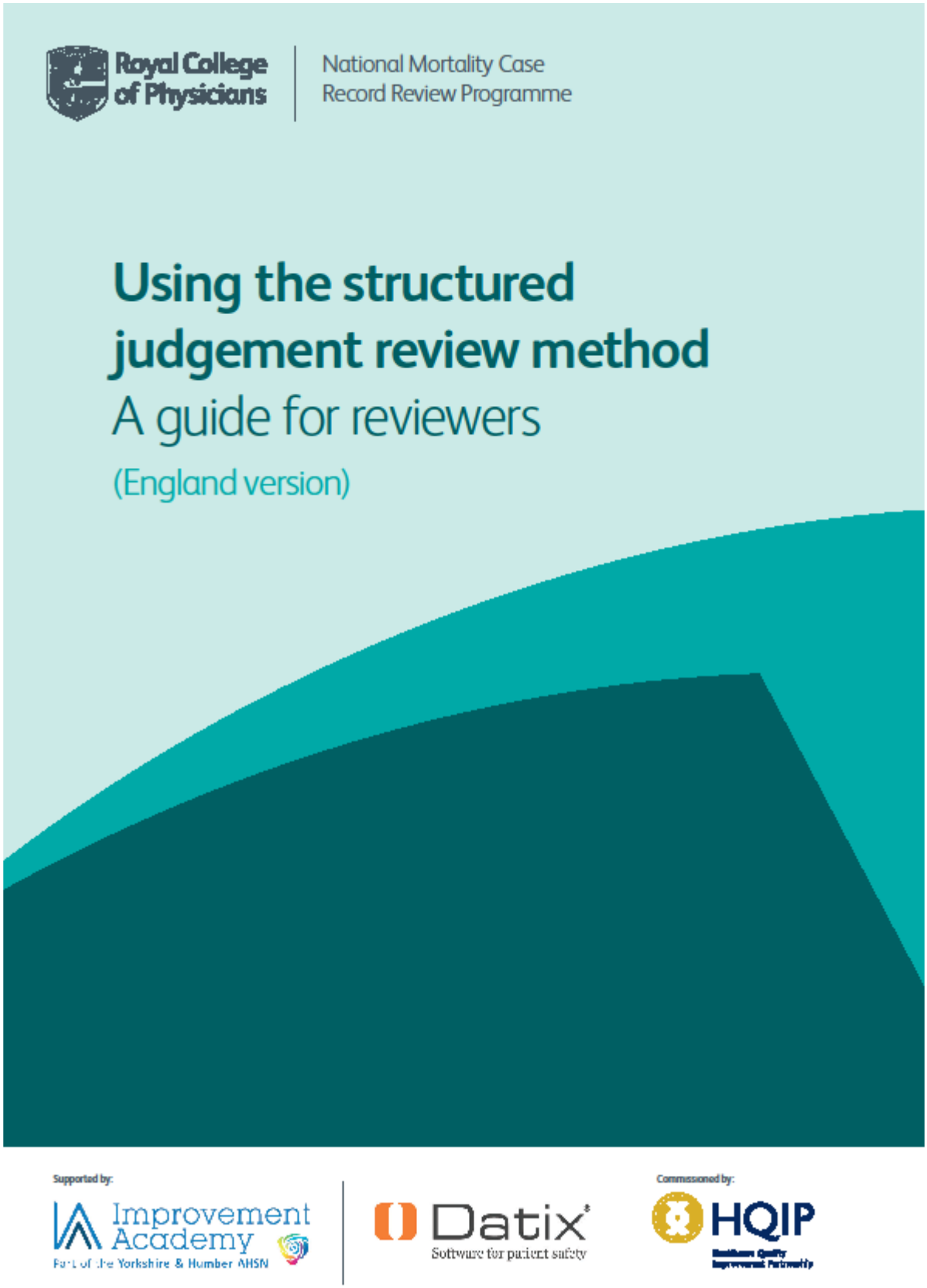
4. Where the provision of care by multiple providers, and particularly the coordination of that care, is thought to have potentially contributed to the death of a patient, investing the significant resources required to coordinate major and complex investigations must be considered. For example, the Serious Incident Framework outlines the principles which underpin a serious incident investigation process and the relevant content is set out in paragraphs 5 to 10 below.

5. The organisation that declares the serious incident is responsible for recognising the need to alert other providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.

6. All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate. Commissioners should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process. Commissioners themselves should provide support in complex circumstances. For example, where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this process. If commissioners do not have the capability or capacity to manage this type of activity this should be escalated to ensure appropriate resources are identified. This may be something to consider escalating through the relevant Quality Surveillance Group or through specific review panels and clinical networks. This will ensure the cumulative impact of problems with care can be resolved.

7. In some circumstances the local authority or another external body may be responsible for managing and co-ordinating an investigation process. Where this is the case, providers and commissioners will contribute appropriately and assure themselves that problems identified will be addressed.


WORKFLOW: Mortality review
Patient Dies in Hospital
Death recorded by ward/ED admin
Patient administration system notifies mortality co-ordinator
Death captured on mortality database
Hard copy of notes to bereavement
Paperwork completed & discussion with family
Decision regarding inclusion in SJR process using national guidance and local intelligence
Patient dies within 30 days of discharge
e-casenotes reviewed at SJR meeting
Definite, strong evidence or probably avoidable
Report Incident via Datix Form
Case discussed at next SI Meeting to agree level of Investigation
Possibly or slight evidence of avoidability
Definitely not avoidable
Performance, learning & improvement discussed at Trust Board
Report to CGG & QGC
Themes and areas for improvement identified
Improvement leads identified
Cases and issues discussed at Mortality Oversight Meeting
Progress with improvement projects reviewed
National process Ver 1.1 1st July 2017


Royal College of Physicians
National Mortality Case Record Review Programme
Using the structured judgement review method
A guide for reviewers
(England version)
Supported by:
Improvement Academy
Datix
Software for patient safety
Commissioned by:
HQIP

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the Policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	N	
	• Ethnic origins (including gypsies and travellers)	N	
	• Nationality	N	
	• Gender	N	
	• Culture	N	
	• Religion or belief	N	
	• Sexual orientation including lesbian, gay and bisexual people	N	
	• Age	N	
2.	**Is there any evidence that some groups are affected differently?**	N	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the Policy/guidance likely to be negative?**	N	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the Policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	N
2.	Does the implementation of this document require additional revenue	Change in funding stream required to support Medical Examiner for Mortality role
3.	Does the implementation of this document require additional manpower	Y
4.	Does the implementation of this document release any manpower costs through a change in practice	N
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	N
	Other comments:	OBC reviewed and agreed by Trust Leadership Group on..

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

[i] The Five Year Forward View For Mental Health (NHS England, 2016) is available at: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf

[ii] Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Needleman D, Russ L. (2013) Confidential Inquiry into premature deaths of people with learning disabilities. Bristol: University of Bristol.