Ashford and St. Peter's Hospitals
NHS Foundation Trust

# Learning from Deaths Policy


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## Contents


1. Introduction 4
2. Scope 5
3. Purpose 5
4. Roles and Responsibilities 7
5. Definitions 10
6. Deaths Categories 13
7. The Process for Recording Deaths in care 13
   - 7.1 Step 1 – Initial screening 14
   - 7.2 Step 2 – Structured Judgement Review (1st and 2nd Stage) 15
   - 7.3 Step 3 – Root Cause Analysis Review 17
8. Selecting Deaths for Case record review 17
   - 8.1 Family Engagement 18
   - 8.2 Learning and Quality Improvement 19
9. Review Methodology 20
   - 9.1 Proposed Transitional Model 21
   - 9.2 Staff Training and Support 24
10. Selecting Deaths for Investigation 24
    - 10.1 Definition of a Serious Incident requiring Investigation (SIRI) 24
11. Reviewing outputs from review and investigation to inform quality improvement 25
    - 11.1 Presenting Relevant Information in Board reports 25
12. Supporting and Involving Staff 27
    - 12.1 Staff training for Bereavement Care 27
    - 12.2 Emotional and Psychological Support 27
    - 12.3 Debriefing Following Critical Incidents 28
    - 12.4 Training in Communication Skills 29

Appendices

Appendix 1 Mortality Review Flow Chart 30
Appendix 2 Trust Mortality review Form 31
Appendix 3 Equality Impact assessment Summary 32


For further information, please see our Learning from deaths webpage at http://www.ashfordstpeters.nhs.uk/about-us/quality-and-performance/learning-from-deaths

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## 1. Introduction

In response to the publication of the Learning from Deaths quality standard 2017 Ashford and St. Peter's Hospital NHS Foundation Trust has revised the current mortality review process to align with national requirements. The CQC report Duty, Learning and Candour[2] outlined the case for change to build standardisation and uniformity into the mortality process locally and nationally. Greater emphasis should be placed on independent review of all deaths, to promote objectivity and external scrutiny, with improved engagement with bereaved families/carers to ensure learning from deaths enables and informs quality improvements.

Central to the delivery of our quality objectives is being able to demonstrate that we are a learning organisation. Learning from deaths is important to the trust and resonates with our values of putting patients first, including families and carers.
It is important to the trust that when things do not go as planned resulting in poor outcomes for patients, that we can identify those problems early to be able to understand how and why they occurred, so that we may take meaningful action in order to prevent recurrence.
Retrospective case note reviews will help to identify examples where processes can be improved and gain an understanding of the care delivered to those whose death is expected and inevitable to ensure they receive optimal end of life care.

This standardised Trust-wide process integrating mortality reviews into the governance framework will provide greater levels of assurance to the Trust Board and help to ensure that the organisation is using mortality rates and indicators alongside others such as incidents and complaints to monitor the quality of care and share good practice and learning from mistakes. This document sets out how the Trust will learn from deaths that occur which were unexpected. This is in response to the National Guidance on Learning from Deaths (published March 2017).

The policy makes clear the procedure for responding to and learning from patient deaths across the Trust including:

- When and how the death of a patient should be reported.
- How deaths should be reviewed and investigated by the Trust.

- How the organisation should engage with bereaved families and carers.
- How the Trust learns from deaths to improve and inform clinical practice.

This document complements other Trust policies which are also concerned with the reporting, investigating and learning from incidents.

## 2. Scope

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

The mortality peer review process is applicable to:

- All Trust deaths for those patients who have had contact with the Trust in the last 12 months and where the Trust is the main care provider.
- Incidents subject to a Serious Incident review under the Trust policy 'Learning from Incidents and Serious Incidents' will be excluded.

## 3. Purpose

Ashford and St. Peter's Hospital NHS Foundation Trust (ASPH) will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of ASPH.

It describes how ASPH will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff who may be affected by the death of someone in the trust's care.

It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read with reference/links to relevant trust procedures: Reporting and managing incidents, Serious Incidents, Quality improvement, Complaints management and the existing Mortality governance processes, maternal death.

This policy has been written to provide guidance for all staff involved in mortality reviews including clinicians, governance, and clinical audit and effectiveness staff.

The outcomes that adherence to this policy will achieve include:

- That all deaths of people who have died and whose care are under the scope of this policy will be reviewed using at least one of the mechanisms identified.
- That all deaths in scope of patients with a diagnosed Learning Disability have been referred to the LeDeR process.
- That families of deceased patients will be involved as per Duty of Candour guidance once a Structured Judgement Review has identified that there are areas that require further exploration.
- The Trust's Board of Directors will receive information on the number of deaths that have occurred, number reviewed and learning points identified and actions taken.
- A summary of the findings of the mortality review process will be published in the Trust Quality Accounts from June 2018.
- How staff affected by the deaths of patients will be supported by the Trust.
- A learning from deaths data dashboard will be available within the Trust from Q3 2017/18 and used to provide information to the Board and its sub committees.

This dashboard includes:

- The total number of inpatient deaths in an organisation's care.
- The number of deaths the trust has subjected to case record review (desktop review of case notes using a structured method) (NB: information relating to deaths reviewed using different methodologies – eg inpatient adult deaths,

child deaths, deaths of patient with learning disabilities – may be separated in the report to provide distinction/clarity where required).

- The number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents).
- Of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care.
- The themes and issues identified from review and investigation, including examples of good practice.
- How the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

The aim of the mortality review process is to:

- Identify and minimise ‘avoidable' deaths within the entire Trust.
- Improve the experience of patients’ families and carers through better opportunities for involvement in investigations and reviews ensuring Duty of Candour.
- Enable informed reporting with a transparent methodology.
- Promote organisational learning and improvement.

The Trust will publish on a quarterly basis from December 2017 by taking a paper to public board meetings.
This policy sets out the approach by ASPH in meeting these requirements.

## 4. Roles and responsibilities

This section describes the specific responsibilities of key individuals and of relevant committees under this policy.
Roles and responsibilities for incident management, complaints handling and Serious Incident management, quality improvement are detailed in the following policies:

- Bereavement Policy
- Being Open Policy

- Concerns and Complaints Policy
- Freedom To Speak Up: Raising Concerns (whistleblowing) Policy
- Guidance for Doctors on Post Mortems Policy
- Handling of Deaths at Ashford Hospital Policy
- Incident Reporting policy
- Mortuary Viewing Policy
- Safeguarding Adults/Children Policies
- Supporting People with Learning Disabilities Policy
- Verification of Expected Death by Registered Healthcare Professionals Policy

All policies can be found at http://trustnet/documents/index.html

| Role | Responsibilities |
|---|---|
| Chief Executive | The Chief Executive is responsible for ensuring that the Trust has policies in place and complies with its legal and regulatory obligations |
| Non-Executive Director | The Trust is required by national guidance to have a nominated lead Non-Executive Director who will: -<br>• Understand the review process – ensure the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.<br>• Champion quality improvement – that leads to actions that improve patient safety.<br>• Assure that published information – fairly and accurately reflects the organisation's approach, achievement and challenges. |
| Medical Director | The Medical Director is the accountable director responsible for the development of this policy and to ensure that it complies with all relevant standards and criteria where applicable.<br>The Medical Director is responsible for trust-wide implementation and compliance with the policy.<br>The Medical Director will have overall responsibility for the learning from deaths agenda and main duties will include:-<br>• Oversight of the monthly Mortality Review Group<br>•Presenting reports to the Board and ensuring that national standards are met by the Trust.<br>• Ensuring that learning from mortality reviews is integral to the Trusts clinical governance and quality improvement work. |

| | |
|---|---|
| Chief Nurse | The Chief Nurse is responsible for ensuring that nursing and midwifery staff are trained in SJR and participate in reviews, and disseminating learning to the clinical ward teams. |
| Safeguarding Lead/ Learning Disability Lead | The Trust Safeguarding Lead on undertaking an internal management review (IMR) following the death /serious injury of a child. The Trust safeguarding leads represent the organisation on serious case reviews. |
| All staff | All staff are responsible for:<br>● The implementation of this policy and should familiarise themselves with its requirements and those of associated policies and procedures.<br>● Ensuring any Duty of Candour requirements are undertaken.<br>● Attending any training identified to fulfil the requirements of this and associated policies and procedures.<br>● Working collaboratively with their colleagues, patients, families and carers to promote an open culture of reporting and learning from deaths. |
| Divisional Triumvirate | The Divisional triumvirate have responsibility for ensuring staff are aware of the procedures to be followed in the event of a death whether expected, unnatural, unexpected, unexplained or violent and that these procedures are followed.<br><br>However the general principles to be followed are stated here:<br>• Ensure effective immediate action following the death, which will include actions by members of the clinical team and duty staff. The responsibility thereafter for ensuring completion of procedures and dealing with issues arising from the Patient's death rests with local managers and members of the Clinical Team.<br>• Immediate action must be taken to collect, secure and safeguard all records (both electronic and paper).<br>• Ensure prompt and sensitive notification to the deceased Patient's friends and family, and those staff who were involved in his / her care and treatment. In general this is the responsibility of the Responsible Clinician in charge of the care of the deceased patient.<br>In practice, senior nursing staff after discussion with medical staff may carry out this role. |

| Committee | Responsibilities |
|---|---|
| Trust board | The Trust Board has an existing board-level leader acting as patient safety director and an existing non-executive director to take oversight of progress;<br><br>The Board pays particular attention to the care of patients with a learning disability or mental health needs; |
| Mortality review group/committee | The Mortality Review Group will be chaired by the Mortality Governance Lead.<br>The Mortality Review Group will: -<br>• Provide assurance to the Trust Board on patient mortality based on review of care received by those who die<br>• Agree and approve the mortality review screening proforma and Structured Judgement Review methodology<br>• Review Mortality, audit data and action plans<br>• Identify areas of high risk and agreeing and monitoring improvement plans<br>• Identify themes and trends and commission appropriate thematic reviews<br>• Ensure that feedback and learning points are shared with the divisions so that learning outcomes and action points are included in audit programmes as appropriate. |
| Quality & Performance Committee | This committee is a sub board committee and will receive assurance from the Mortality Review Group, on the delivery of the process and particularly relating to the data dashboard and learning. |

The Trust will work with commissioners to review and improve their respective local approaches following the death of people receiving care from their services.

## 5. Definitions

The *National Guidance on Learning from Deaths* includes a number of terms. These are defined below.

**Death certification**

The process of certifying, recording and registering a death. The causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

**Case record review**

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

**Mortality review**

A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care. To draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

**Serious Incident**

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.[1]

[1] https://improvement.nhs.uk/resources/serious-incident-framework/

**Investigation**

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

**Death due to a problem in care**

A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

**Quality improvement**

A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

**Patient safety incident**

A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

**LeDeR – Learning Disabilities Mortality Review**

Programme commissioned by Health Quality Improvement Partnership (HQIP) for NHS England. The aim of the programme is to drive improvement in the quality of health and social care service delivery for people with a learning disability in England through a local review of deaths of people with learning disabilities aged 4 years and over.

**Candour –** is classified by the CQC (2016) as 'to support sharing information with other, including families. This definition is fully detailed within the Trust's Being Open Policy

**Learning –** is defined within this context as 'to improve and change the way care is provided (CQC, 2016).

## 6. Deaths categories

To enable staff to understand the requirements to learn from deaths the following categories will be used throughout the document.

**Unexpected unnatural death (UU)** An unexpected death from unnatural causes e.g. suicide, abuse, neglect.

**Unexpected natural death (UN1)** A death from a natural cause e.g. a sudden cardiac condition or stroke.
**Unexpected natural death (UN2)** A death from a natural cause but didn't need to be e.g. where there were may have been care concerns.

**Expected natural death (EN1)** The death was expected to occur in an expected time frame. e.g. people with terminal illness or within palliative care services.
**Expected natural death (EN2)** The death was not expected to happen in the timeframe. e.g. someone with cancer or liver cirrhosis who dies earlier than anticipated.

## 7. The process for recording deaths in care

Following the unexpected death of a patient within ASPH a Datix will be completed immediately. The patient record should be updated accordingly and internal reporting (including notification to the family or carers) should be undertaken in line with local protocol.

All unexpected deaths should also be reported to the CQC. This can be done by emailing (via NHS.net) Michelle.king@nhs.net.

**Mortality review investigation process**

The draft process for the conduct of mortality reviews is outlined in the flow chart at Appendix 1.

Key steps are described below

7.1 Step 1 – Initial Screening

Notification of a reported unexpected death is sent to the Chief of Patient Safety via the Trust's risk management system (Datix).
If the patient did not have contact with services within a 12 month period of the date of contact recorded on the Trust's risk management system, the incident is closed with no further action.
If the patient did have contact with services within a 6 month period, the Chief of Patient Safety will use the Mortality Screening Tool (Appendix 2) to complete an initial review of the care provided to the patient. This will be done using the patient record and any other current information available at the time for example post mortem/inquest results.
Each screening where possible will consider where inequalities may have occurred or discrimination that has led/ been a factor in the death.

The following Care Score will be given:

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

If Score 1 or 2 is indicated a Structure Judgement Review will be undertaken and Step 2 will be commenced. This will be recorded on the Trusts risk management system.

If Score 3, 4 or 5 is indicated the incident will require no further action and this will be recorded on the Trusts risk management system.

## 7.2 Step 2 – Structured Judgement Review Methodology (1st and 2nd Stage)

### 7.2.1 **What is Structured Judgment review (SJR)**

- Blends traditional clinical judgement based review with a standard format.
- Reviewers made safety and quality judgements over phases of care.
- Explicit written comments for each phase and score for each phase.
- Result - relatively short but rich set of information about each case in a format that can be aggregated to provide knowledge about clinical services and systems of care.

### 7.2.2 **What is the purpose of SJR**

- The review system can be used for individual cases and for identified groups of cases.
- The information allows units or organisations to ask 'why' questions about things that happen, to enable learning and action where required.
- Results show good care as well as poor care (and good care is much more frequent). It is designed to complement current good practise, rather than replace it.

### 7.2.3 **What is special about this review method**

- It examines both interventions and holistic care.
- Reviewers give written explicit judgements on safety and quality of phases of care [the structure].
- Reviewers give overall care and phase of care scores to accompany judgements.
- It is an internal review process usually based on one reviewer's judgement, with a second stage review where there is cause for concern at first review.

7.2.4 **The Structured Judgement Review:** /T:/Mortality%20Reviews/2017/NMCRR%20data%20collection%20sheet%20England_0_0%20(1).pdf will be used on all incidents that have received an initial screening care score of 1 or 2.

The review will focus on the following phases of care:

- Risk Assessment.
- Allocation/Initial Review.
- Ongoing care – Handover, Care Planning and Interventions.
- Care during admissions (if applicable).
- Follow up management/discharge or end of life care.
- Assessment of care overall.

This will be facilitated within a 10 day period by the Chief of Patient Safety and should involve other senior clinician/s to ensure objectivity,

Review of case records and other sources of evidence should, wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge.

Care Score 1 or 2 is still indicated following completion of the 1st stage then the 2nd Stage of the Structured Judgement Review should be undertaken.

This will involve making a decision on if the death was avoidable or not using the following scale:

1. Definitely Avoidable
2. Strong Evidence of Avoidability
3. Probably Avoidable
4. Possibly Avoidable but not very likely (Less than 50/50)
5. Slight Evidence of Avoidability
6. Definitely Not Avoidable

If Score 1, 2 or 3 is indicated this should be escalated immediately to the Medical Director, the appropriate Divisional Director and a STEIS report should be considered if appropriate.

At this stage immediacy of actions should be considered to prevent any potential of further harm. The Trust risk assessment procedure should be utilised to guide this decision and further actions.

This should be recorded on the Trusts risk management system. Step 3 should then be undertaken.

Score 4, 5 or 6 is indicated an action plan for improvement and further learning should be considered if appropriate and the incident closed. This should be recorded on the Trusts risk management system ensuring a full rationale for the decision not to review any further.

Copies of completed Structured Judgement reviews will be shared with the Responsible Clinician. They will be encouraged to share more widely with the MDT and use as part of their annual appraisal.

7.3 Step 3 - Root Cause Analysis Review

A full Root Cause Analysis (RCA) Review should be commenced according to Trust policy and procedure. The Trust policy on Being Open which includes Duty of Candour should be fully implemented. This should be recorded on the Trusts risk management

## 8. Selecting deaths for case record review

This section relates to case record review as set out above and not to patient safety incidents or incidents covered by the Trust Serious Incident Policy.

The CQC report 'Care Quality Commission – Learning from Deaths' states that every Trust must review the following cases:

- All deaths where family, carers or staff have raised a significant concern about the quality of care provision.
- All deaths of patients who are identified to have a learning disability and/or severe mental illness.
- Deaths involving children or infants, including still births
- All maternal deaths
- Deaths where learning will inform the Trusts existing or planned improvement work
- All deaths in areas where people are not expected to die – for example, in certain elective procedures
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- All deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example, via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the Care Quality Commission or another regulator)

A further sample of other deaths that do not fit the identified categories, so that the Trust can take an overview of where learning and improvement is needed most overall. This will be determined by the Mortality Governance Group.

In addition the Trust will review deaths where they have had requests from other organisations to review the care provided to people who are its current or past patients but who were not under its direct care at time of death.
The Trust will collaborate with others to carry out reviews and investigations when a person has received care from several health and care providers.

8.1 <u>Family engagement</u>

The Trust will engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below:

- Bereaved families and carers should be treated as equal partners following bereavement.
- Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment.
- Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.

This includes providing, offering or directing people to specialist bereavement support.

- Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one.
- Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed.
- Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.
- Bereaved families and carers should 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.
- Bereaved families and carers who have experienced the investigation process should be supported to work in partnership with the Trust in delivering training for staff in supporting family and carer involvement where they want to.

## 8.2 Learning and Quality Improvement

The Trust will ensure that lessons learnt from mortality reviews and analysis of mortality data will result in change in organisational culture and practice by:

- Identifying Themes and Trends at the Mortality Review Group and alerting clinical services when appropriate.
- Learning points identified within the Quality Report are actioned within an agreed timescale
- Thematic Reviews are commissioned on a regular basis by the Mortality Review Group and associated action plans implemented.
- Action plans from Mortality Related RCA Reviews are fully implemented.
- Ensuring learning is cascaded to frontline clinical staff and divisions on a regular basis through a Trust wide forum

Copies of completed Structured Judgement reviews will be shared with the Responsible Clinician. They will be encouraged to share more widely with the MDT and use as part of their annual appraisal

## 9. Review methodology

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.
The structured judgement review[2] (SJR) involves assessing the phases of care, writing explicit judgement statements and giving phase of care scores at stage 1:

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Each review will be undertaken by a trained individual – either a nurse (Band 7 and above) or a Consultant (of any speciality) - and is predicted to take up to one hour per case review.

It is proposed that 10 individuals are recruited to perform SJRs and will be adequately trained to undertake this role. The Trust will have a Lead individual who will oversee and partake in the mortality reviews.

Although not nationally mandated, it is the desired state that all deaths receive a stage one, full structured judgement review (SJR) within 30 days. Therefore, it is anticipated that approximately 110 deaths per month will be reviewed via the SJR process. This amounts to approximately 25 hours of Consultant/nursing time per week.

Specific time is to be made available within job plans to meet the requirements or where necessary will be remunerated through additional programmed activities for Consultants and supplemental income for nurses.

9.1 Proposed Transitional Model

Acknowledging that the process of recruiting and identifying a team of 10 staff to undertake full structured judgement reviews of all in-hospital deaths is likely to take a number of months to complete – a transition model is proposed in order to meet the requirements set out in the national guidance below:

*From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards).*

It is proposed that, from November 2017 the Trust lead for mortality will be appointed and will with existing resources in order to carry out full structured judgement reviews (SJR) on any deaths meeting the minimum national standards. These include:

*i. all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;*

*ii. all in-patient, out-patient and community patient deaths of those with learning disabilities…and with severe mental illness;*

*iii. all deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);*
*iv. all deaths in areas where people are not expected to die, for example in relevant elective procedures;*

*v. deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;*
*vi. a further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.*

It is anticipated that we start with approximately 5%-10% of deaths being reviewed via the SJR process using this model; increasing to 100% as the appropriate individuals are identified and trained.
This amounts to approximately 1.5 to 2.5 hours of Consultant/nursing time per week; increasing to approximately 25 hours per week.

| Patient group | Methodology | SRO | Frequency of review | Where info/outputs will be saved and shared |
|---|---|---|---|---|
| Adult inpatient | Mortality Screening Tool and when identified Structured Judgement Review | | | |
| Mental health | When applicable, the trust can use a modified SJR or another relevant method to review the care of those with severe mental illness. NHS England, NHS Improvement and the Royal College of Psychiatrists are developing a standardised methodology for case record review of the care of those who die with severe mental illness | | | |
| Child (under 18) | Reviews of these deaths are mandatory and should be undertaken in accordance with *Working together to safeguard children* [2] (2015) and the current child death overview panel processes. NHS England is leading work to update the latter | | | |
| Learning disability | All trusts should adopt the LeDeR method to review the care of individuals with learning disabilities, once it is available in their area.<br>Guidance for conducting reviews of deaths can be found here.[3]<br>Trusts must have systems to flag patients with learning disabilities so their care can be reviewed | | | |
| Perinatal and maternity | All perinatal deaths should be reviewed, using the new perinatal mortality review tool[4] once available. Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly | | | |

[2] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[3] http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf
[4] https://www.npeu.ox.ac.uk/pmrt

9.2 Staff training and support

The Trust is working with the Royal College of Physicians to provide staff with Tier 1 train the trainer courses. These peer trainers will be running training sessions for clinicians and senior nursing staff. The trained members of staff will have combined training updates to ensure the standards being taught are meeting the required output.
Training consists of the following:

- Face to face training with a tier 1 trainer to discuss theory of the SJR and its application.
- Support to complete a SJR on a mock patient record with peers in a supported training session.
- Peer review of the completed SJR with discussion on the process and scoring matrix.
- Discussion of the reviews of the mock case provided by the Royal College of Physicians.

There is further development from a wider group review session to allow staff to obtain peer and trainer support in terms of consistency in reviews and to ensure that explicit judgement is being used.

## 10. Selecting deaths for investigation

Where a review carried out by the trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with section 9 of the Trust's Managing Incidents Policy https://sph.surreyras.nhs.uk/trustpolicies/,DanaInfo=trustnet+RIS11.pdf

10.1 Definition of a Serious Incident Requiring Investigation (SIRI)

In terms of this policy, a serious incident requiring investigation is defined as an **incident** that occurred in relation to **NHS-funded services and care** resulting in the **Unexpected** or **avoidable** death of one or more patients, staff, visitors or members of the public.

On notification of an unexpected or avoidable death, the Chief of Patient Safety will decide in consultation with the SIRI core group, and the SIRI team whether the incident is to be classified as a Serious Incident Requiring Investigation (SIRI).

Section 9 of the Managing Incidents Policy details the process for commencing an investigation with a flow chart at appendix 3 of the policy. The requirements for an investigating officer are also detailed here. The SIRI process is detailed in appendix 14 of the same policy. The link to this policy is written above.
When an incident has been identified, actions will be taken as per the managing incidents policy.

## 11. Reviewing outputs from review and investigation to inform quality improvement

To ensure a co-ordinated approach to the sharing of learning identified through incident reporting, each Division reports and uploads the analysis of their deaths monthly. These are discussed at the Mortality Surveillance Group. Local governance groups review deaths and discuss learning. SIRIs are reported and monitored at the Quality Performance Committee (QPC) on a monthly basis.
Deaths captured monthly with minutes from the Mortality Surveillance Group meeting and quarterly reports will be presented to QPC. Trust Board reports will be generated every quarter to meet QPC reporting schedules.
The organisations committees support Trust learning, which is then shared locally through Divisions and throughout the organisation. The Trust will

place an emphasis on team to team learning through all levels of the organisation, from ward to Board. Larger platforms for sharing learning will include:

- Team Brief presentations.
- Demonstrations of Changes in Practice.
- Grand Round presentations
- Using after action review pieces to provide immediacy of feedback.

All action plans are recorded on a divisional action log tracker, which is monitored for compliance through Quality Governance Committee and Divisional performance meetings. Divisions have responsibility to ensure learning and changes in practice are disseminated locally through their governance/team meetings, and at mortality and morbidity meetings.
Wider sharing of learning is done by using the dedicated learning from deaths webpage on Trustnet. Deaths and mortality rates are also reviewed and discussed at Clinical Quality Review Meetings with the CCG.

11.1 Presenting relevant information in board reports

The minimum requirements for quarterly public board meetings are outlined under 'Improved data collection and reporting' in the executive summary of the *National Guidance on Learning from Deaths.* The Trust has determined that this information should be presented to the board as part of a wider mortality report, as long as it is clear on the board agenda that there will be a discussion on the data presented, the learning from this and what the board will do to lead the organisation in further improving quality of care under the Learning from Deaths framework.
The National reporting dashboard is available online.[5] This can be adapted for local use. ASPH will measure the following items:

[5] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-learning-from-deaths-dashboard.xlsx

- How the trust will share with relevant staff feedback received from families and carers to enable individual and team reflection on care provision and opportunity for improvement.
- How the trust will meet the duty of candour.
- Guidance that will be given to families and carers on obtaining legal advice (should they require it) or other support.

## 12. Supporting and involving staff

### 12.1 Staff training for bereavement care

Both clinical and non-clinical staff offering Bereavement care should be offered training appropriate to their level of involvement. It should be the responsibility of their line manager to ensure that such training is accessible to staff. The Trust should consider including Bereavement training in its “in house” training programme.

The Bereavement Officers and the Head of Pastoral Care participate in the Trust Induction programme. The Bereavement Officers also offer informal training to the medical staff in the completion of paperwork. One of the responsibilities of the Trust “End of Life Care” Group is to explore relevant training opportunities for staff. North West Surrey CRUSE offers regular bereavement training courses for their volunteer counsellors and may be willing to offer one or two places for members of Trust staff.

Other external agencies, such as SANDS, the Child Bereavement Trust and the National Association of Bereavement Services offer regular training events for NHS Staff.

### 12.2 Emotional and psychological support

Consideration should be given to the need for staff to access appropriate support following a death within their ward or clinical area. Some deaths are obviously especially hard for staff. These can include both sudden death (when staff can feel that they have not had time to build a rapport with the family so that caring for them in their bereavement has been particularly difficult) and the death of a long-term patient (when staff will have formed an important relationship both with the patient and his/her family.

Staff can also request that the Trust dedicates a Schwartz round to debrief and provide emotional support to staff. These rounds can be held in Chertsey House or provided as a ‘pop up’ round in the staff members working environment.

The death of a child or younger person can also be especially hard, and staff may be affected by a situation which is particularly close to their own personal circumstances (for example, the death of a patient who may be close in age to a family member).

The Ward/Unit Manager and the Unit Clinical Nurse Lead should try to exercise particular sensitivity and awareness in these situations. It is always possible to involve the Trust Chaplaincy Team, which operates a 24 hour “on call” service (Radio Page via Switchboard). The Specialist Palliative Care Team is also willing to offer additional support to staff. Staff themselves can be encouraged to access Occupational Health (ext 2404) or the Employee Assistance Programme. The latter is available 24 hours on 0800 282193.

12.3 Debriefing following critical incidents

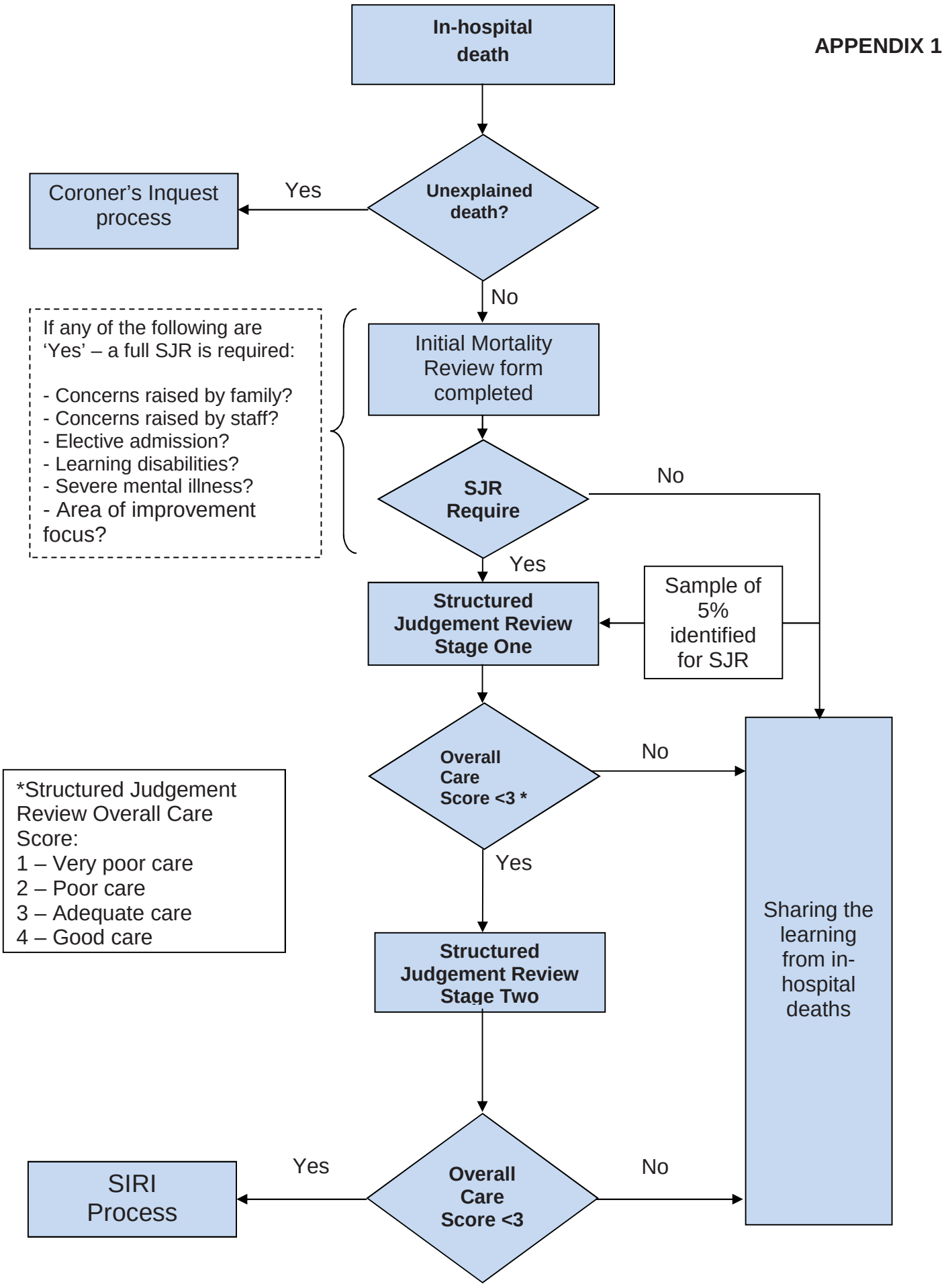
In certain circumstances (for example following unsuccessful attempts at resuscitation, particularly in the case of an infant or child) a more formal debrief for staff may be advisable. It should be the responsibility of the Ward/Unit Manager to facilitate this. The Resuscitation Training Officers

(Ext.3312) are often willing to lead a debriefing session. It might also be possible to involve the Chaplaincy/ Specialist Palliative Care Team as above.

12.4 Training in Communication Skills

Training in Advanced Communication Skills is no longer freely available to staff but can be accessed through NCAT and other networks. The Specialist Palliative Care Team on extension 2312 would be happy to advise.

**APPENDIX 1**


In-hospital death
Unexplained death?
Yes
Coroner's Inquest process
No
If any of the following are 'Yes' – a full SJR is required:
- Concerns raised by family?
- Concerns raised by staff?
- Elective admission?
- Learning disabilities?
- Severe mental illness?
- Area of improvement focus?
Initial Mortality Review form completed
SJR Require
No
Yes
Sample of 5% identified for SJR
Structured Judgement Review Stage One
Overall Care Score <3 *
No
Yes
*Structured Judgement Review Overall Care Score:
1 – Very poor care
2 – Poor care
3 – Adequate care
4 – Good care
Structured Judgement Review Stage Two
Sharing the learning from in-hospital deaths
Overall Care Score <3
Yes
No
SIRI Process

**Appendix 2**

# Adult Mortality Review Screening Tool

## Part 1 *to be completed by clinician at time of death*

| | |
|---|---|
| Patient ID | |
| Patient Name | |
| Date of Death | |
| Ward of Death | |
| Cause of Death (if available) | |
| Was this death reported to the Coroner? | ☐ Yes ☐ No |
| Consultant at Time of Death | |

| | Criteria for Case Record Review | Yes | No |
|---|---|---|---|
| 1 | Have family members or carers raised a significant concern about the quality of care provision? | ☐ | ☐ |
| 2 | Have any staff members raised a significant concern about the quality of care provision? | ☐ | ☐ |
| 3 | Did the patient have a learning disability? | ☐ | ☐ |
| 4 | Did the patient have a severe mental illness? | ☐ | ☐ |
| 5 | Is this a death in an area where people are <u>not</u> expected to die?<br>*(e.g. patients attending for a routine elective procedure)* | ☐ | ☐ |
| 6 | Do you have any other cause to think that this death would benefit from a mortality review?<br>*(Please indicate your reasons below)* | ☐ | ☐ |
| 7 | Please grade this death on the below scale of avoidability:<br>1. Definitely avoidable ☐<br>2. Strong Evidence of avoidability ☐<br>3. Some evidence of avoidability ☒<br>4. Definitely not avoidable ☐ | | |

**Completed by:** **Date completed:**

## Part 2 *to be completed by Divisional Governance Team*

| | Criteria for Case Record Review | Yes | No |
|---|---|---|---|
| 1 | Has a concern or red flag been raised in relation to an area which is already under investigation or subject to review? | ☐ | ☐ |
| 2 | Is there an incident recorded on Datix which directly relates to the death? | ☐ | ☐ |
| 3 | Is there a complaint/PALS concern relating to this case? | ☐ | ☐ |
| 4 | Is there a safeguarding concern relating to this case? | ☐ | ☐ |
| 5 | Has a CQC or other regulatory organisation raised a concern regarding this case? | ☐ | ☐ |
| 6 | Do you have any other cause to think that this death would benefit from a mortality review?<br>*(Please indicate your reasons below)* | ☐ | ☐ |

| Serious Incident Investigations | Yes | No |
|---|---|---|
| Is this case already being investigated under the SI process? | ☐ | ☐ |

# Outcome

| | |
|---|---|
| Is further review required? | ☐ Yes ☐ No |
| If 'Yes', which review process? | ☐ Mortality Review (SJR) ☐ Serious Incident |
| Date review requested | |
| Request sent to | |
| Request sent by | |

**Completed by:** **Date completed:**

**Job Title:**

# Equality Impact Assessment Summary

**APPENDIX 3**

**Name of Author** **Melanie Irvin-Sellers, Russell Wernham**

**Policy/Service:** **Learning from Deaths**

| **Background** |
|---|
| Aim of the policy is to<br><br>• Ensure that all deaths occurring in the Trust are reviewed and reported using a standard framework.<br>• Each death will be considered for a Structured Judgement Review (SJR). Alongside those mandated for review a further 5% will be taken at random for a SJR.<br>• Provide a framework for the identification and review of deaths, the process for reviewing and the identification of learning from these reviewed deaths.<br>• The circumstances surrounding each referral will vary; in all cases the Mortality Lead or Chief of Patient safety will be able to provide support.<br><br>The Equality Impact assessment was completed by Dr Melanie Irvin-Sellars and Mr Russell Wernham as part of the Mortality Review Group. |
| **Methodology** |
| This policy affects all patients regardless of race, ethnic origin, disability, gender, culture, religion or belief, sexual orientation or age.<br><br>Data and background information for this policy was taken from the National Learning from Deaths Framework.<br><br>Extra information was obtained from the Royal College of Physicians SJR process training and development pack. |
| **Key Findings** |
| People from all ethnic backgrounds, all religious groups, any sexual orientation, either gender, any culture or any social class are covered by the framework in this policy.<br><br>There are no adverse or potentially adverse impacts for any equality groups. |
| **Conclusion**<br>• Provide a summary of the overall conclusions |
| This Policy does not disadvantage any of the aforementioned groups. |
| **Recommendations** |
| |

| |
|---|
| No changes are required in light of the EIA process. |

**Guidance on Equalities Groups**

| | |
|---|---|
| **Race and Ethnic origin** (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment) | **Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration) |
| **Disability** (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people) | **Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs |
| **Gender** (consider care needs and employment issues, identify and remove or justify terms which are gender specific) | **Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior) |
| **Culture** (consider dietary requirements, family relationships and individual care needs) | **Social class** (consider ability to access services and information, for example, is information provided in plain English?) |