Somerset Partnership NHS
NHS Foundation Trust

LEARNING FROM DEATHS

(Mortality Policy)

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Applies to:	All Clinical Staff Groups

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DOCUMENT CONTROL

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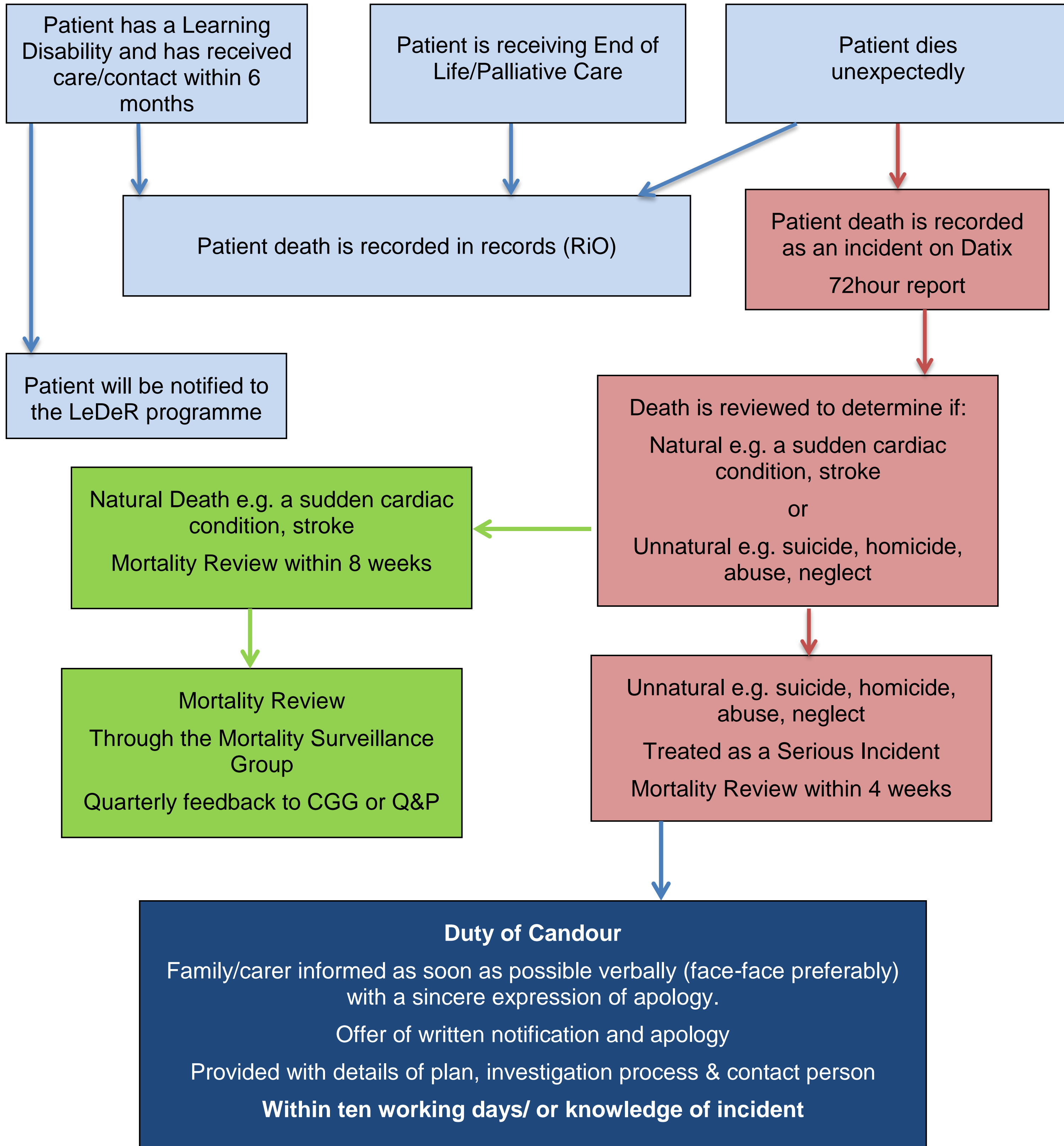
CONTENTS

Section	Sub-section	Summary of Section	Page
		Document Control	2
		Contents	3
		Mortality Process Flowchart	4
1		Introduction	5
2		Purpose & Rationale	5
3		Policy Statement	6
4		Definitions	6
5		Duties and Responsibilities	7
6		Recording, Reporting, Notification And Review Of Deaths	9
	6.1	Recording & reporting Deaths	
	6.2	Conducting Mortality Reviews (MSG)	9
	6.3	Engagement With Bereaved Families And Carers	9
	6.4	Case Record Review	9
	6.5	Feedback And Learning	9
7		Monitoring Compliance and Effectiveness	10
8		Training and Competency Requirements	11
9		References, Acknowledgements and Associated documents	11


Death of a service user
Patient has a Learning Disability and has received care/contact within 6 months
Patient is receiving End of Life/Palliative Care
Patient dies unexpectedly
Patient death is recorded in records (RiO)
Patient death is recorded as an incident on Datix
72hour report
Patient will be notified to the LeDeR programme
Death is reviewed to determine if:
Natural e.g. a sudden cardiac condition, stroke
or
Unnatural e.g. suicide, homicide, abuse, neglect
Natural Death e.g. a sudden cardiac condition, stroke
Mortality Review within 8 weeks
Mortality Review
Through the Mortality Surveillance Group
Quarterly feedback to CGG or Q&P
Unnatural e.g. suicide, homicide, abuse, neglect
Treated as a Serious Incident
Mortality Review within 4 weeks
Duty of Candour
Family/carer informed as soon as possible verbally (face-face preferably) with a sincere expression of apology.
Offer of written notification and apology
Provided with details of plan, investigation process & contact person
Within ten working days/ or knowledge of incident

1. INTRODUCTION

1.1 This policy describes the Trust framework for learning from deaths. It will ensure that all deaths of people with a learning disability, a mental health problem or receiving care for physical health, whether an inpatient or community patient (within six months of contact), who die unexpectedly or earlier than expected, and where the death is not subject to a serious incident investigation, will be considered for a mortality review.

1.2 The processes within this policy should provide assurance to the Trust board and public that patients are not dying as a consequence of unsafe clinical practices.

1.3 In 2013 a national review was undertaken of 14 hospitals conducted by the Chief Medical Officer. This followed the Mid Staffordshire NHS Trust Review. The hospitals chosen had nationally the highest mortality and the findings of the review showed that the focus given to mortality rates in Trusts distracted from the real requirement of learning and reducing genuinely avoidable deaths.

1.4 Following the guidance from NHS England (Serious Incident Framework 2015), only those deaths where the learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant will be reported as a Serious Incident for the NHS to review.

1.5 Following this the findings of the Care Quality Commission (CQC) report Learning, candour and accountability: *A review of the way NHS trusts review and investigate the deaths of patients in England*, found that learning from deaths was not being given sufficient priority in some organisations. Consequently valuable opportunities for improvements were being missed. This report also highlighted the need to engage with families and carers, and recognise the value of their insights as a vital source of learning.

1.6 The first edition of National Guidance on Learning from Deaths, published in March 2017, subsequently set the framework requirements for Trusts.

2. PURPOSE & RATIONALE

2.1 The aim of this policy is to:

2.1.1 Define the process for investigation of deaths in which problems or omissions in care might have contributed to.

2.1.2 Ensure there is consistency in the quality of patient mortality reviews and that these are clearly recorded.

2.1.3 Define the reporting mechanisms for the escalation of any areas of concern identified in mortality surveillance meetings.

2.1.4 Ensure the monitoring of mortality data is analysed and acted upon as appropriate.

2.1.5 Provide direction for learning in order to prevent recurrence.

2.1.6 Set out the standards expected of the Trust board, which includes having an existing executive director take responsibility for the learning from deaths agenda and an existing non-executive director take responsibility for oversight of progress.

2.1.7 Describes the level of engagement expected with bereaved families and carers. This will include the need for a consistent level of timely, meaningful and compassionate support and engagement at every stage; from notification of the death to an investigation report with the opportunity to raise questions or share concerns in relation to the quality of care received and the lessons learned and actions taken.

2.2 This policy applies to:

2.2.1 All clinicians in all specialities where patients receive care and treatment from the Trust.

2.2.2 The mortality review process for the following:

- The death of an individual with a learning disability (LD)
- The death of an individual with mental health (MH) needs
- The death of an infant or child
- The death of an individual who is cared for in the community – hospital or home

2.2.3 All MH/LD patients who have had contact with the Trust within the last six months.

3. POLICY STATEMENT

3.1 This policy will ensure that all deaths of people with a learning disability, a mental health problem or receiving care for physical health, whether an inpatient or community patient (within six months of contact), who die unexpectedly or earlier than expected, and where the death is not subject to a serious incident investigation, will be considered for a mortality review, in line with national guidance.

4. DEFINITIONS

4.1 **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.

4.2 **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.

4.3 **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.

4.4 **LeDeR:** The Learning Disabilities Mortality Review programme. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities. All deaths of people with learning difficulties aged 4 to 74 years of age are notified to the programme.

4.5 **Mortality**: For the purpose of this document, mortality relates to any patient who has died on Trust premises or any MH/LD death occurring within six months of contact with the Trust services. .

4.6 **Mortality Surveillance Group:** Where a multi-disciplinary group review and discuss clinical cases, outcome data and related information (e.g. serious incidents, complaints, benchmarking data).

4.7 **Mortality rate:** The mortality rate (or death rate) is a measure of the number of deaths that occurred during a particular time period divided by the total size of the population during the same time frame. It is typically expressed in units of deaths per 1,000 individuals per year.

4.8 **Regulation 28:** Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

4.9 **Structured Judgement Review (SJR):** The Structured Judgement Review is an evidence based methodology for reviewing the quality of care provided to those patients who die.

4.10 **Serious Incident (SI)** - serious injury, and or permanent harm, unexpected or avoidable death or where intervention occurs to prevent these.

5 DUTIES AND RESPONSIBLITIES

5.1 Trust Board

Responsible for:

- Nominating an existing Non-executive Director to oversee the progress of mortality reviews.
- Receiving assurance through the Quality and Performance Committee that the processes in place are robust and can withstand external scrutiny.

5.2 **Medical Director**

- Responsible for:
- The learning from deaths agenda.

5.3 **Non-executive Director**

Responsible for:

- Oversight of the progress of the learning from deaths agenda with direct report to Trust board.

5.4 **Clinical Governance Group (CGG)**

Responsible for:

- Maximising the learning from unexpected deaths of people in receipt of services.
- Providing assurance to Quality and Performance Committee in relation to learning from deaths.

5.5 **Mortality Surveillance Group (MSG)**

Responsible for:

- Establishing and maintaining the mortality governance processes in line with national guidance and regulation.
- Undertaking the mortality review processes.

5.6 **Head of Clinical Governance and Clinical Risk**

Responsible for:

- Producing reports based on information recorded in RiO and through the incident database on mortality figures.
- Analysis of the database to identify themes and trends
- Ensuring learning outcomes and action points are provided for inclusion in the Divisional Unit governance framework.

5.7 **Service Directors**

Responsible for:

- Ensuring that the analysis of deaths, within the scope of their service, forms part of the local and divisional governance framework.

5.8 **Senior Clinical Staff**

Responsible for:

- Participating in mortality reviews wherever possible, either in person or by nominated staff;
- Providing advice on clinical issues.

6 RECORDING, REPORTING, NOTIFICATION and REVIEW OF DEATHS

6.1 Recording and Reporting Deaths

	Expected Death	Responsibility & time	Unexpected Death	Responsibility & time
Recorded	RiO/patient record	Local service Within 24 hours	RiO/patient record	Local service Within 24 hours
Reported	N/A		Datix Incident Management System	Local service Within 24 hours
			'72 hour' report	Incident Handler Within 2 working days
Notified to	GP	Local service Within 1 working day	GP	Local service Within 1 working day
			CCG CQC (StEIS if SI)	H of CG Within 2 working days
Review level	Annual quality audit – end of life care. A proportion (random 10%) to be case-reviewed using SJR	MSG Every quarter	Natural e.g. a sudden cardiac condition, stroke	MSG Alternate months
			Unnatural e.g. suicide, homicide, abuse, neglect.	MSG Monthly
All deaths of patients/clients with learning disability aged 4-74 will also be notified to the LeDeR programme.				

6.2 Conducting Mortality Reviews (MSG)

6.2.1 The aim of the mortality review process is to:

- Identify and minimise 'avoidable' deaths for all Trust patients.
- Review the quality of end of life care for Trust patients.
- Improve the experience of patients' families and carers, through better opportunities for involvement in investigations and reviews.
- Promote organisational learning and improvement.

6.2.2 All deaths are expected to be subject to a mortality review, however due to the breadth of type of patient within the Trust the level of review may differ.

6.2.3 Learning Disability
All deaths of patients/clients with learning disability aged between 4 and 74years will be notified to the LeDeR programme who will assign reviewers.

6.2.4 End of Life Care/Palliative Care
Any patient that falls into this specified category will have the review undertaken by the End of Life/Palliative Care teams. The annual End of Life Audit will be provided for review at the MSG.

6.3 Engagement With Bereaved Families And Carers

6.3.1 This will include a consistent level of timely, meaningful and compassionate support and engagement at every stage; from notification of the death to an investigation report with the opportunity to raise questions or share concerns in relation to the quality of care received, and the lessons learned and actions taken.

6.3.2 A suitably able person should be identified to be the point of contact for the bereaved families and carers for each event of death, who can provide support and information, and ensure the voice of families and carers is noted and heard.

6.4 Case Record Review

6.4.1 The Trust will use the recommended case record review which looks at the quality of care provided to those patients who die. The tool for use is the Structured Judgement Review (SJR).

The cases to be reviewed will be:

- All serious incident classified deaths
- A proportion of expected deaths
- All unexpected but natural deaths

6.5 Feedback and Learning

6.5.1 Learning from the reviews will be shared with divisional governance units to ensure learning from deaths within the care group.
The findings from the reviews should identify areas of good practice and areas of learning for the team and Trust.

6.5.2 If during the review any concerns are discovered that have caused moderate harm and above and require duty of candour, this will be escalated to the Divisional Service Directors.

7 MONITORING COMPLIANCE AND EFFECTIVENESS

7.1 Compliance to the process will be reviewed on an annual basis and include
- The overview of meetings of the Mortality Surveillance Group, including attendance and case record review learning outcomes.
- The monthly report of mortality figures presented to the Trust Board.
- A review of the reports provided to Clinical Governance Group and to Trust Board for Public papers.

8 TRAINING REQUIREMENTS

8.1 There are no specific training requirements for this policy.
Staff who undertake the case reviews using SJR will be guided on the process.

9 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

9.1 References

National Guidance on Learning from Deaths; National Quality Board, March 2017.

Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England

9.2 Associated procedural documents

Serious Incident Requiring Investigation (SIRI) Policy
Mortality Surveillance Group terms of reference
Being Open and Duty of Candour Policy