POLICY FOR THE IDENTIFICATION, INVESTIGATION AND LEARNING FROM DEATHS WITH THE TRUST
A) SUMMARY POINTS

• It is important for the hospital to learn from patients who die under our care

• Mortality reviews can occur at a number of different levels from Immediate Discharge Summary, Death Certification, Structured Case Record Reviews, Serious Incident Reviews, Coroner reviews and formal external review.

• All death in patients with learning difficulties must be investigated through the LeDeR process.

• Mortality governance is a key priority for the Trust board

C) DOCUMENT DETAILS

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1. INTRODUCTION

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. Reviews and investigations of deaths are only useful for learning purposes if their findings are shared and acted upon.

The Care Quality Commission (CQC) published its review Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. (2016). The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

The first edition of National Guidance on Learning from Deaths was published by the National Quality Board in March 2017 to initiate a standardised approach ensuring that learning from a review of the care provided to patients who die should be integral to a provider’s clinical governance and quality improvement work. To fulfil the standards and new reporting set out in this guidance for acute, mental health and community NHS Trusts and Foundation Trusts, Trusts should ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trusts should also ensure that they share and act upon any learning derived from these processes.

The standards expect providers to have a clear policy for engagement 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. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

2. MORTALITY GOVERNANCE

Mortality governance should be a key priority for the Trust board. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in the Trust and provide necessary challenge.

The Board should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of failure of clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, quarterly mortality reporting to the Board at the public
3. IDENTIFICATION OF DEATHS FOR REVIEW AND INVESTIGATION

There are three levels of scrutiny that can be applied to the care provided to someone who dies; (i) death certification; (ii) structured case record review; and (iii) investigation. Investigation can be internal or commissioned externally. They do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a case record review has been undertaken.

Algorithm for investigation of deceased patients (18 years or older)

Patient dies

Learning Disabilities?

Yes/ No

LeDeR

Expected

(e.g. admitted for EOLC, palliation)

Complete IDS and Death Certificate

Consider letter to GP

Offer family Bereavement Questionnaire

Unexpected

Refer to Coroner?

Serious Incident?

Yes

Datix and Investigation

No

Structured Case Record

Review on EPR
3.1 Death Certification

Deaths by natural causes are certified by the attending doctor. Trainee doctors are encouraged to discuss the cause of death and the certification details with their consultant prior to completing the certificate. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. The report should be made via email on the linked form available on the Poole Hospital intranet.

Bereaved relatives collect the death certificate from the Patient Affairs Manager. Bereaved relatives will be provided with a leaflet explaining that:

1. we review all deaths that occur in the Trust and inviting them to raise any questions or concerns that they might want answered.
2. includes the bereavement questionnaire that they can complete and return as and when they feel ready and able to do so.

Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

3.2 Structured Case Record Reviews

A weekly list of all deaths in the Trust is produced by the Information Department 4 weeks after the week in which the patient died. This allows time for the records to go for coding and to be scanned onto the electronic patient management system. This list is made available on the hospital network ‘s’ drive to all members of the mortality surveillance group to review remotely during the week. Each review is summarised on the Electronic Patient Record Mortality Review e-form.

The Trust mortality lead subsequently reviews the output from these reviews and identifies any deaths for discussion at the Mortality Surveillance Group. This will include all deaths deemed to have been avoidable or any deaths which the reviewer has concerns or areas of learning. A quarterly report is produced for the Quality and Safety Committee.

The e-form was produced from experience of the PRISM 2 study and from other local trusts but the Structured Judgement Review (SJR) case note methodology being rolled out by the Royal College of Physicians may replace this, in time.

In parallel with this review process, the department of medicine for the elderly undertake review of all deaths under their care and from March 2017 these will be recorded on the EPR form and not be reviewed by a member of the mortality surveillance group. Deaths under the care of gastroenterology are reviewed similarly.
3.3 Internal Investigation

Some deaths should be subject to reporting as Serious Incident and investigation. For example, there may be instances where deaths clearly meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken). Equally, problems identified in case record review may lead to the need for investigation whether this is an investigation under the Serious Incident Framework.

Review will include those deaths reported on the Datix Incident Reporting System when a member of staff has raised concerns about a patient's care.

In addition the following will be investigated either internally or externally:

- all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- all patients with learning disabilities (the LeDeR review process outlined below should be adopted) and with severe mental illness
- 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);
- all deaths in areas where people are not expected to die, for example in relevant elective procedures;
- 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.

3.4 External Reviews

There are separate arrangements for review of certain categories of deaths, for example suicides, homicides, and child and maternal deaths and the trust will cooperate in these.

Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication are needed to avoid problems.
4. LEARNING FROM REVIEWS

Learning from systematic case note reviews and bereaved carer surveys will be shared with the Mortality Surveillance Group to the Clinical Governance Group and reported to the Board. Important learning will be shared across the Trust through clinical governance meetings, Grand Rounds and through the trainee newsletter. Any learning for trainees will be shared with the individuals Educational Supervisors.

Important learning across services will be presented to the Dorset Mortality Review Group.

5. BEREAVED FAMILIES AND CARERS

The National Guidance on Learning from Deaths requires Providers to 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 a 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 suicide 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 Trusts in delivering training for staff in supporting family and carer involvement where they want to.

All bereaved families should be provided with written information informing them that all deaths are reviewed and asking them if they have any questions or concerns about the death of their relative. They should also be asked what feedback they might want following the review and any specific questions they would like answered.
6. MORTALITY REVIEW IN NEONATES AND CHILDREN

Since 1st April 2008, Local Safeguarding Children’s Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such responsibility is enshrined in the Children’s Act 2004 and applies to all children under 18 years of age. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths.

NHS England is undertaking a national review of child mortality review processes both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life. Central to the programme is the creation of a National Child Mortality Database, which is currently being commissioned. The effective functioning of the national database requires high-quality, standardised data arising from simplified and standardised local mortality and CDOP review processes. NHS England have therefore established 3 work streams:

- the simplification and standardisation of mortality review processes in the community and hospital;
- a review of the governance arrangements and standardisation of CDOP processes;
- the creation of the national child mortality database.

7. LEARNING DIFFICULTIES

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 disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.

The standardised review process involves discussing the circumstances leading up to the person’s death with someone who knew them well (including family members wherever possible), and scrutinising at least one set of relevant case notes. Taking a cross-agency approach, the reviewer develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death, identifies any best practice or potential areas of concern, and makes a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated.

A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18-24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas. A full multi-agency review is recommended if there have been any concerns raised about the death, if any ‘red flag alerts’ have been identified (potential problems with the provision of care e.g. no evidence that an assessment of mental capacity has been considered when this would have been appropriate; delays in the person’s care or treatment that adversely
affected their health) in the initial review, or if the reviewer thinks that a full multi-agency review would be appropriate. The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes.

8. SUMMARY

Many people reach the end of life whilst a patient in hospital and 25-30 patients die each week in Poole Hospital. Most of these patients have been recognised by family and hospital teams to be at the end of life but on occasions the death is unexpected. There is increased scrutiny of deaths that occur in hospital as this is an important quality measure and there is an expectation that bereaved families should be engaged in the process.

The process can take place at a number of levels starting with a discussion between the members of the clinical team who should ask whether the death was expected. The Immediate Discharge Summary (IDS) should record the cause of death accurately and ideally flag any death that is unexpected. If it is possible for the hospital team to complete the death certificate this should be agree by the consultant in charge of the patient and the detail should be accurate. If the cause of death is not clear then the patient will be referred to the Coroner. Regular Structured ase Note Reviews should be undertake.

Where there are concerns about the care of the patient, a datix should be completed and the pathway investigated as a potential SI. Patients with learning difficulties who die in hospital must be identified and the death investigated through the LeDeR process. In extreme circumstances a death may need to be investigated through an external process.