Northamptonshire Healthcare
NHS Foundation Trust

CRM012 - Identifying, Reporting, Investigating And Learning From Deaths In Care

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Why we need this Policy

Sometimes, when a person receiving care from the Trust dies, it is important for us to review the care and treatment we provided for them in greater detail. The purpose of the reviews and investigations of deaths is to identify any problems in care which might have contributed to the death and to learn in order to prevent a reoccurrence. This is to make sure we did everything we could for the person and, identify things that could have been improved and identify aspects of what went well. We can share this with our staff to ensure we learn; reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

In 2016, a national review by the Care Quality Commission (CQC) found that the NHS was missing opportunities to learn from patient deaths and that too many families were not being included or listened to when an investigation happened. A key recommendation from this review was that a national framework be developed, so that NHS Trusts have clarity on the actions required when someone dies in their care.

The *National Guidance on Learning from Deaths* published by the National Quality Board (NQB) in March 2017, recommended all Trusts to publish a policy on how the organisation responds to and learns from deaths of patients who die under their management and care. The frameworks purpose is to initiate a standardised approach for reporting, investigating and learning from deaths in care.

What the Policy is trying to do

This policy sets out the Trust's approach to meeting the *National Guidance on Learning from Deaths* (NQB 2017) and how we will seek to learn from the care provided to patients who die. This policy makes clear the procedure for responding to and learning from patient deaths across the Trust including:

- How the process will respond to the death of an individual
- Determine the categories and selection of deaths in scope for review
- How the Trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
- How staff affected by the deaths of patients will be supported by the Trust.
- How the Trust learns from deaths to improve and inform clinical practice
- The themes and issues identified from review and investigation, including examples of good practice
- How the findings, themes and issues from reviews and investigations will be used to inform and support quality improvement activity; any other actions taken, and progress in implementation.
- How the Trust collects specific information every quarter of those who die, outcomes of reviews of care and publish this information on a quarterly basis to public board meetings.

Which stakeholders have been involved in the creation of this Policy

- Trust Executive Team
- Non-Executive Director
- Patient Safety Team
- Mortality and Morbidity Forum
- Senior Operational Managers
- Quality Forum
- Learning from Deaths Steering Group

Any required definitions/explanations

Mazars - is a global audit, accounting and consulting group. Mazars can provide a range of audit and advisory services to NHS organisations. Following the notable death of Connor Sparrowhawk, in 2014 Mazars was commissioned by NHS England to review the deaths of people with a learning disability or mental health issue in contact with Southern Health NHS Foundation Trust. In line with definitions used in a number of Trusts regionally and nationally, NHFT has adopted Mazars classifications of deaths.

Datix – The Trust's incident reporting system.

Mortality Screening Tool – Applies a structured approach of screening an incident of death, to assess the requirement to undertake a Structured Judgement Review (SJR). The Mortality Screening Tool will enable the reviewer to score on the quality of care provided to the deceased.

Structured Judgement Review (SJR) – Applies an investigative methodology recognised by the Royal College of Physicians to determine whether there were any care delivery concerns provided to the patient who died in order to learn from what happened. The Structured Judgement Review will enable the reviewer to score the on the quality of care and the 'Level of avoidability' of the death.

Automatic Structured Judgement Review (SJR) – A selected group of deaths will be subject to a Structured Judgement Review automatically, irrespective of the circumstances or the quality of care.

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.

Death due to a problem in care - A death that has been clinically assessed using the Structured Judgement methodology, 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.

End of Life - People are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and coexisting conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events

Internal Assurance Meeting (IAM) - A weekly meeting where incidents brought to the attention of the Patient Safety Team, are discussed. A group that includes the Deputy Director of Nursing, Safeguarding Professionals, Head of Patient Experience, Patient Safety Manager, and Mortality Lead together with other relevant and specialist professionals consider the factors surrounding an incident. Based upon this discussion and comparison against the Serious Incident National Framework, a judgement is made as to what level of investigation is required, if any, or what further information is outstanding, to ensure that a sound decision can be made.

Learning Disabilities Mortality Review Programme (LeDeR) – Delivered by the University of Bristol, commissioned by Healthcare Quality Improvement Partnership (HQIP) on behalf of 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. The LeDeR programme will support reviews of all deaths of people with a Learning Disability aged 4 years and over, irrespective of the cause of death or place of death.

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 CRM006.

Key duties

The **Chief Executive** – has overall responsibility for the implementation of this policy.

The **Trust Board** will ensure that NHFT:

- Has an existing board-level leader acting as **Patient Safety Director** and an existing **Non-Executive Director** to take oversight of the progress in implementing the Learning from Deaths agenda
- Understand the process; ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support
- Champion and support learning and quality improvement that leads to actions that improve patient safety

- Assure published information; ensure that information published is a fair and accurate reflection of the organisations approach, achievements and challenges

The **Mortality Lead** will:

- Develop, manage and oversee the whole Trust mortality assurance processes ensuring robust governance is in place to allow the identification of any required improvement and good practice in care to facilitate the delivery of safe care.
- With the support of the Patient Safety Manager, ensure that Trust processes and policies, in relation to Learning From Deaths, is consistent and in keeping with National and Regional Guidance.
- Support clinicians and staff to engage in robust processes of reviews into those who die to help identify if the death was more likely than not to have been contributed to by problems of care.
- Determine which patients are considered to be under the Trust's care and included for Structured Judgement Review if they die (and which patients are specifically excluded).
- Report at board level on the Trust's compliance and performance with the national guidance on learning from deaths.
- Identify and facilitate the dissemination of learning for the Trust as part of the Structured Judgement Review
- Embed, co-ordinate and support The Learning Disability Mortality Review Programme into NHFT and facilitate the dissemination of learning for the Trust as part of the process.
- Support the Patient and Family Liaison Lead to engage with families and carers of patients that have died.
- Provide appropriate training as identified within clinical services.

The **Patient and Family Liaison Lead** will:

- Ensure the Trust meets it CQC regulation 20: Duty of Candour requirements.
- Develop and maintain the Trust's approach in Duty of Candour process in line with National guidance and aligned with the Trusts Being Open policy.
- Support and engage with families and carers following the unexpected (non-custodial) death of a patient, providing them with clear opportunities to ask questions, raise issues and provide feedback.
- Ensure that families and carers are as involved as they choose to be during the investigation process.
- Ensure that families and carers are signposted to appropriate support service as required.
- Provide appropriate training as identified within clinical services.
  (see Appendix 7 for flow chart of involvement)

The **Mortality and Morbidity Forum** will:

- Provide a forum of discussion that relates to incidents of Mortality and Morbidity in an environment that promotes dissemination of information and learning from incidents.
- Provide a forum of discussion that relates to the *Learning form Deaths* agenda, provide scrutiny of reviews into care and ensure compliance and effectiveness in the process

The **Learning from Deaths Steering Group** will:

- Review on a bi-monthly basis the mortality rates, avoidability of deaths and learning from reviews
- Consider mortality data against other qualitative clinical data and identify areas for further investigation
- To develop data collection systems to ensure the Trusts mortality data is robust and presented in line with national best practice
- The Deputy Medical Director will chair the Learning from Deaths Steering group.
- Monitor and ensure that mortality reviews are undertaken using the Mortality Screening Tool and where applicable, Structured Judgement Review templates

The **Service Managers/Senior medics** will**:**

- Support the implementation of the Learning from Deaths framework, its governance and processes within the organisation.
- Ensure data in relation to their services is accurate and reported promptly to support the organisational needs of the Learning form Deaths agenda.
- Work in collaboration with the Patient Safety Team and Mortality Lead to identify and share the learning from deaths.
- Ensure that all staff within their area understand and are aware of this policy.
- Ensure that all deaths are reported and investigated according to this policy, working collaboratively with internal and external stakeholders when required.
- Allocate and support staff to complete investigations as required
- Have accountability the Structured Judgement Review will be completed within 10 working days once allocated to a reviewer.
- Support investigation processes and be part of the investigation team as needed.

All staff are responsible for:

- The implementation of this policy
- Ensure Duty of Candour requirements are undertaken
- Engage in and promote an open culture or reporting and learning form deaths

Policy detail

Categorising a death (Mazars) (Appendix 1)

In line with definitions used in a number of Trusts regionally and nationally, NHFT has adopted the Mazars classification of death scale in order to ensure appropriate and consistent systems are implemented across the organisation for mortality review.

	Code	Type	Description	Example
	EN1	Expected Natural - Type1	A death that was expected to occur and occurred within an expected time frame	A person receiving end of life care
Datix Deaths in these categories	EN2	Expected Natural - Type 2	An expected death that occurred sooner than the expected timeframe	A person with a terminal illness diagnosis dies much earlier than anticipated
	EU	Expected Unnatural	A death that was expected, however not within the expected timeframe as well as not being form the expected cause	A person who dies as a result of associated complications of unnatural addictions / habits / choices (e.g Alcohol dependency, chronic substance use, eating disorder)
	UN1	Unexpected Natural - Type 1	An unexpected death by a natural cause	A death of a male in his 30's that dies from a stroke or heart attack
	UN2	Unexpected Natural - Type 2	A death that was unexpected caused by a complication of a known medical condition	A death of a person who is alcohol dependant or related to diabetes where there are concerns raised in these areas of care
	UU	Unexpected Unnatural	An unexpected death caused by unnatural means	Suicide, homicide, neglect, abuse

The Mazars categories will be used to determine the level of reporting required following a death.

If there is any doubt reporting a death on Datix, the default position is to report the death on Datix.

Identifying and reporting deaths

All service users considered to be under the care and management of the Trust can be considered for selection for a review into their care using the *Learning from Deaths* guidance.
Service users determined to be under the care and management of the Trust are those with an open referral to an NHFT service, receiving care from an NHFT service, had died no more than 6 months after discharge from an NHFT service. Deaths that do not meet these criteria will be assessed on an individual basis with support from the Mortality Lead and the Internal Assurance Meeting (IAM).

A Datix reporting the death will be raised when the specified the criteria is met as soon as practicably possible or within 24 hours of becoming aware of the death through whatever means. Staff will share what information is known about the death to inform the review process.

If the death is not reportable on Datix, the patient record should be updated accordingly.

The most appropriate member of staff will take responsibility in ensuring the Duty of Candour requirements are fulfilled.

Notification to the other professionals involved (including GP) will be considered and referrals or ward stays ended. This is to support the systemic process of closing the deceased patient's record to avoid prescriptions, appointments and letters being sent out incorrectly which may cause distress to bereaved families and carers.

The patient's clinical record is one of the key elements reviewed as part of any review or investigation; it is each individual's responsibility to ensure patient records are maintained in accordance to the standard required.

Services that have predominately 'Expected Natural – EN1' (for example, patients receiving End of Life care) will make a clinical judgement on the death, using the Mazars definitions, to establish if the death is reported onto Datix.

Clinical staff will make judgments as to whether the death is expected or otherwise. To ensure that there is a robust check on the quality of those judgments, there will be an audit process on a selection of those deaths. This audit will look at a sample of the deaths judged to be expected and review the patient's record using the Mortality Screening Tool (Appendix 4).

The leads involved will receive notification of deaths reported onto Datix and performance information reports and will start the review process where it is applicable to do so according to this policy.

Criteria for reporting a death on Datix

Service	What deaths are reported on Datix?
Adult Mental Health In-patient	All deaths, including deaths post discharge
Adult Mental Health Community	All deaths, including deaths post discharge
Older Adult Mental Health In-patient	All deaths, including deaths post discharge
Older Adult Mental Health Community	• Deaths assessed as unexpected (MAZARS EN2 or higher) • Significant concerns in relation to the quality of care raised by either family/carers, staff or safeguarding • The deceased had a diagnosis of Severe Mental Illness or Learning Disability • An 'alarm' has been against the service by whatever means
Learning Disability Services	• All deaths, irrespective of the cause or location of the death, including deaths post discharge
Hospice, Palliative and End of Life	• Deaths assessed as unexpected (MAZARS EN2 or higher) • Significant concerns in relation to the quality of care raised by either family/carers, staff or safeguarding • The deceased had a diagnosis of Severe Mental Illness or Learning Disability • An 'alarm' has been against the service by whatever means
Child and Adolescent Services	• All deaths
Community Hospitals	• Deaths assessed as unexpected (MAZARS EN2 or higher) • Significant concerns in relation to the quality of care raised by either family/carers, staff or safeguarding • The deceased had a diagnosis of Severe Mental Illness or Learning Disability • An 'alarm' has been against the service by whatever means
Community Nursing (District / ICT)	• Deaths assessed as unexpected (MAZARS EN2 or higher) • Significant concerns in relation to the quality of care raised by either family/carers, staff or safeguarding • The deceased had a diagnosis of Severe Mental Illness or Learning Disability • An 'alarm' has been against the service by whatever means
Prisons	• All deaths of those receiving, or had received NHFT care
Private Healthcare, Pilots and SLAs	• Deaths assessed as unexpected (MAZARS EN2 or higher) • Significant concerns in relation to the quality of care raised by either family/carers, staff or safeguarding • The deceased had a diagnosis of Severe Mental Illness or Learning Disability • An 'alarm' has been against the service by whatever means

Deaths subject to review

All deaths that meet the criteria for review will be undertaken using the Royal College of Physicians (RCP) Structured Judgement Review (SJR) methodology as recommended in the NQB guidance.

Not all deaths will have the same level of review and will be determined by the circumstances of the death and the Trusts statutory requirements. The Trust will apply rigorous judgement to the needs for deaths to be subject to a Serious Incident reporting and investigation. This will be done according to the existing Serious Incident Policy and review at the Internal Assurance Meeting (IAM).

Deaths of those with a Learning Disability - LeDeR (Flowchart Appendix 2)

All deaths of those with a recorded diagnosis of a Learning Disability, of any degree and open to any NHFT service will be recorded on Datix irrespective of the circumstance, cause or location of death.

Deaths of those with a Learning Disability, over the age of 4 years old, will be notified to the national Learning Disability Mortality Review (LeDeR) programme. The Mortality Lead will ensure this notification is made and record the date of LeDeR notification onto the Datix record.

Deaths of infants and children with a Learning Disability under the age of 4 years old will be included in the Deaths of Infants and Children process.

The LeDeR programme will provide a review of the death through nominated local reviewers and will feedback learning and action points at the local Learning Disability Mortality Review Steering Group attended by NHFT representatives.

Death of those with a Learning Disability will also be reviewed at the Internal Assurance Meeting (IAM) with support from the Mortality Lead to determine if the death meets the criteria for further investigation.

Deaths of Infants and Children

Infants and Children is determined by any person under the age of 18, irrespective of employment, residency, where they are receiving care from or diagnosis.

Deaths of Infants and children who were normally resident in Northamptonshire, died in Northamptonshire or died subsequent to an unexpected event in Northamptonshire will be reported to the Trusts Children Safeguarding Team who will ensure the notification is managed in line with local and national policy.

Deaths of infants and children will be reported as an incident on Datix and will be subject to review by the Internal Assurance Meeting (IAM) to determine if an investigation is required.

Reviewing deaths process (Appendix 3)

Some deaths may require the Mortality Screening Tool, the Structured Judgement Review and a full root cause analysis investigation (either Clinical Review or Serious Investigation) dependant on the circumstances of the death. Each element will complement the learning from a death.

Any review should identify any trends and learning that could improve service provision and clinical care not just from within that setting but for the organisation as a whole. Feedback from the review (as required) will be provided to the family/ carer by the most appropriate staff member. If the families/ carer's are not satisfied with the Trust's outcome the case will be referred to the Internal Assurance Meeting (IAM).

It should be noted that the Structured Judgement Review (SJR) assessment is subject to inter-reviewer variation. As such it does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

Some deaths will be investigated by other agents, notably the coroner. The coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. Care will be taken by the Trust to ensure that such investigations are not compromised whilst ensuring that internal review / investigation processes are progressed appropriately in the circumstances.

The Patient Safety Team, Mortality Lead and the Patient and Family Liaison Lead will monitor reporting systems regularly to ensure accurate and contemporary monitoring of reported deaths, ensure Duty of Candour standards are met and support reviewers through this process.

Step 1 – Mortality Screening Tool (Appendix 4)

- A death that meets the reporting on 'Datix criteria' is reported on Datix. This notifies the Mortality Lead and Patient Safety Team.
- If the death falls within the scope for review, the Mortality Lead will use the Mortality Screening Tool to complete an initial review of the care provided to the patient. This will be done using the clinical notes and any other current information available at the time.
- The decision regarding whether to review a death will be recorded on the screening form and this information will be recorded on the Datix incident report.
- 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 (SJR) will be required and **Step 2** will commence.

- If Score 3, 4 or 5 is indicated the incident will require no further action

Step 2 – Structured Judgement Review (Appendix 5 and 6)

- The Structured Judgement Review for Community Hospitals (Appendix 5) or Mental Health and Prisons Template (Appendix 6) will be circulated by the Mortality Lead to relevant Clinical Directors or Service Managers who will allocate a reviewer. The Structured Judgement Review will be used on all deaths that trigger a mandatory SJR or have received an initial screening care score of 1 or 2.

- The review will be completed and returned to the Mortality Lead and Patient Safety Team within a 10 working day period (National guideline) once allocated to the Reviewer. The SJR review should involve a medic or other healthcare professional in 'nurse-led' services. The case will be escalated to the Trust' Clinical Director leading on Mortality if the review is not completed within 10 working days.

- 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.

- The Structured Judgement Review template will allow the reviewer to make 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 Mortality Lead and Patient Safety Team for review.

- At this stage immediacy of actions should be considered to prevent any potential of further harm.

- If 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.

Deaths that require an Automatic Structured Judgement Review

The Trust will automatically review deaths from **Step 2** of the review process that occur the following circumstances using the Structured Judgement Review template, irrespective of the Care Score:

- All Adult, Older Adult and CAMHS in-patient mental health deaths, irrespective of age or cause of death
- All Community Hospital deaths that are unexpected or occurred sooner than the expected timeframe (MAZARS EN2 or higher)
- Deaths of those with a Serious Mental Illness in an in-patient setting
- Significant concerns in relation to the quality of care raised by either family / carers, staff or safeguarding
- All deaths in custody
- All deaths that occurred 30 days after discharge from a hospital or release from custody
- An 'alarm' has been against the service by whatever means (e.g concerns raised by audit work, concerns raised by the Care Quality Commission or another regulator)
- All deaths in areas/during procedures where people are not expected to die, for example elective procedures: Dentistry, ECT, Ketamine Infusion, Repetitive Transcranial Magnetic Stimulation (rTMS)
- A further sample of other deaths will be subject to a Structured Judgement Review (SJR) that does not fit the identified categories to provide an overview of where learning and improvement is required. For example patients whose death was expected and may have had an End of Life Care Plan in place. This does not have to be a random sample, and could use practical sampling strategies to inform quality improvement action.

Mortality reviews and investigations across different organisations

When a person has received care from several health and care providers, the clinical team notified of the death will report all deaths to other organisations who may have an interest (including the deceased person's GP), and early discussion must take place after death as to any other interested party to whom the death must be reported. This may include Her Majesty's Coroner, another trust in which the patient may have been cared for, social services the patient may have been receiving, or the police.

Where problems are identified relating to other NHS Trusts or organisations, the Mortality Lead or most appropriate staff, should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement.

A culture of compassionate curiosity should be adopted and the following questions should be asked:

a) Which deaths can we review together?
b) What could we have done better between us?
c) Did we look at the care from a family and carers perspective?
d) How can we demonstrate that we have learnt and improved care, systems and processes?

Identifying the 'lead' organisation in a review will be negotiated through the Mortality Lead. This process should be completed by the Mortality Lead within 10 working days of identifying the problem.

Where the Trust is not the 'lead' organisation in a review of care, the Trust will respond to requests from other organisations and co-operate to review the care provided to people who are its current or past patients but who were not under the Trusts direct care at the time of death.

Where a concern regarding sharing of confidential patient information is identified, the concerned party will contact the Trusts Information Governance Team for advice.

The Trust should ensure that every effort is made to work collaboratively with neighbouring NHS organisations in relation to the Mortality Agenda to encourage learning and improvement on a regional level.

Family and Carer Engagement

The phrase family/carer is used to include significant others in people's lives as it is recognised that some people may not have family but have sought their support from close friends.

Following a bereavement the clinical team/service involved should make contact with the family and/or carer as soon as practicable to offer condolences and to undertake any Duty of Candour requirements and offer a sincere apology. This should be undertaken by the most appropriate staff. An apology is not an expression of guilt; it is the right thing to do. Full and clear guidance on 'Duty of Candour' conversations is contained within CRM006 Being Open/Duty of Candour policy.

Where the death is the subject to an investigation, the Trust, with the support of the Patient and Family Liaison Lead, will engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death where an investigation is taking place, and operate according to the following key principles below: -

- The intention to formally investigate a death should always be communicated to the bereaved family and/or carers verbally and in written form. They should be supported to understand the process, given clear timelines for when to expect an outcome and invited to contribute to the investigation Information should be available in differing formats based on the needs of the family and/or carer.
- Information should be available in differing formats based on the needs of the family and/or carer.
- Bereaved families and carers should be treated as equal partners following bereavement.
- 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 must always receive information as **openly, honestly**, **transparently**, and **candidly** as the Trust powers and the law allows
- bereaved families and carers must always receive a 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
- Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed
- 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.

The purpose of the Patient & Family Liaison Lead is to engage and support families and carers through the difficult process of an investigation into care provided by NHFT. In most cases this will be the Patient & Family Liaison Lead however the role may be undertaken by any suitably qualified person, allocated by the Patient Safety Team. The process of family and carer engagement is outlined in **Appendix 7**. The Patient and Family Liaison Lead will support the family/carers throughout the investigation until conclusion, which may also include supporting beyond any internal investigation, for example Coroner's Inquest. The Patient and Family Liaison lead is not able to provide counselling or bereavement support or referrals to other health services but will signpost to other relevant support organisations.

Bereaved families and carers affected by deaths in custody will receive support from Family Liaison Officers (FLOs) through the Prison services.

In conjunction with feedback from a review or from clinical teams, The Patient Advice and Liaison Service (PALS) will inform the Mortality Lead and Patient and Family Liaison Lead where families and carers have raised a significant concern with care following a death.

Significant concerns in care raised by bereaved families or carers will be reviewed by the Mortality Lead and Patient and Family Liaison Lead and will trigger a review.

To further capture family and carer involvement in the review process, the Patient Advice and Liaison Service (PALS) with support from the Patient and Family Liaison Lead will ensure a letter offering condolences to families and carers is sent which also invites families and carers to raise any concerns they may have with the care provided.

Supporting Staff

Staff will be able to access advice in relation to this policy from the Patient Safety Team, Mortality Lead and Patient and Family Liaison Lead.

NHFT staff affected by the deaths of patients will be supported by the Trust. This support can be through several routes:

- Line manager / Clinical supervisor
- Occupational Health Department
- All NHFT staff have access to the Trusts' free and confidential counselling service, this can either be face to face or confidentially over the phone

If staff have concerns regarding any deaths and delivery of clinical care, these concerns should be raised initially with their line manager. However staff can also raise concerns via the Trusts' Whistle Blowing Policy and procedural guideline or make contact with the Trust's Freedom to Speak Up Guardian.

Governance and Oversight

The Trust Board will receive Learning from Deaths Assurance paper on a quarterly basis which will consider: -

- Any changes made to the national agenda or directions from NHS Improvement (NHSi)
- Trust response to national directions
- Progress with achieving targets for review h.
- Consideration of any inequality /discrimination issues

Data will be shared with an analysis on mortality management quarterly and reported to the Trust Board, this will be included as part of the Learning from Deaths Assurance paper.

This will include the number of deaths that have occurred across the Trust, the number of deaths that meet the scope for mortality review, those identified as avoidable /unavoidable (using the avoidability scale numbers 1 to 6) and the number reviewed at each stage of the Trust's processes: -

a)Mortality Review Screening
b) Structured Judgement Review
c) Learning Disability Mortality Review (LeDeR)
d) Child Death protocol
e) Root Cause Analysis Review (Serious Incident / Clinical Review)

In this paper, the themes and issues from reviews and investigations, including examples of good care will be shared along with how the findings from reviews and investigations have been used to inform actions and support quality improvement activity.

Learning and Quality Improvement

Regardless of the type of review into care of someone who has died, its findings must form an integral part of and feed into the Trust clinical governance processes and structures.

Findings from reviews should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust's wider strategic plans and safety priorities.

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 through data analysis
- Alerting clinical services when appropriate
- Learning points identified within the Learning from Deaths paper and actions taken within an agreed timescale
- Thematic Reviews are commissioned on a regular basis and associated action plans implemented
- Structured Judgement Reviews that determine the death to be 'Definitely Avoidable' and 'Strong Evidence of Avoidability' will be discussed at the Internal Assurance Meeting (IAM) and be subject to further review to assess the requirement for Serious Investigation
- Ensuring learning is cascaded to frontline clinical staff and services on a regular basis by use of: -
    - The Trusts intranet web pages
    - E-brief
    - Managers Need To Know bulletin
    - Team meetings
    - Significant learning fedback to clinical teams by the Mortality Lead or the Patient and Family Liaison Lead where appropriate
    - Learning from Deaths Steering Group
    - Morbidity and Mortality Group
    - Learning Disability Mortality Review Steering Group

The Trust will collect service specific and demographic data (such has age, cause of death, family and carer involvement) using the Suicide Data Collection Tool (Appendix 8) related to all deaths caused by suspected suicide to inform the Trusts' local Suicide Prevention Strategy and provide focus for quality improvement action or thematic reviews. The Suicide Data Collection Tool can be amended to incorporate any identified future learning needs or trends that require further exploration.

Any mortality surveillance work will be used to inform where reviews of care can be applied and to provide focus for quality improvement action.

Training requirements associated with this Policy

Training will be provided in relation to the Mortality Review process and the Structured Judgement Review process, this will be a requirement for all those that are undertaking the reviews.

Training will be provided to those staff that require support in communicating/working with bereaved families.

Completion of the Duty of Candour training module (via the Training Tracker) is mandatory for all clinical staff (doctors, nurses and AHPs) and patient facing staff

LeDeR local reviewers will be provided with external training in line with the national programme, this will co-ordinated by the University of Bristol and the Learning Disability Mortality Review Steering Group

How this Policy will be monitored for compliance and effectiveness

The following groups will share responsibility for monitoring the Learning from Deaths process for compliance and effectiveness

- Learning from Deaths Steering Group,
- Morbidity and Mortality Forum
- Learning Disability Mortality Review Steering Group
- Patient Safety Team
- Attendance at, or release of information from regional or national forums will inform compliance and effectiveness.

Equality considerations

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Policy changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of 'protected characteristics' including:

- Age;
- Disability;
- Gender reassignment;
- Marriage and civil partnership;
- Race;
- Religion or belief;
- Sexual orientation;
- Sex;
- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers and homeless people).

The author has considered the impact on these groups of the adoption of this Policy.

(a) Line Managers should ensure that staff returning from maternity or paternity leave are given time to update themselves on any changes made to the policy.

(b) Equality Considerations - Should the reader of this policy or any other group believe they are disadvantaged by anything contained in this policy, please contact the Equality & Inclusion Manager, who will then actively respond to the enquiry.

Reference Guide

National Quality Board (2017) *National Guidance on Learning from Deaths* [online] available from: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

CQC (2016) Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England.

NHSi (2016) Serious Incident Framework – annexe FAQ

Document control details

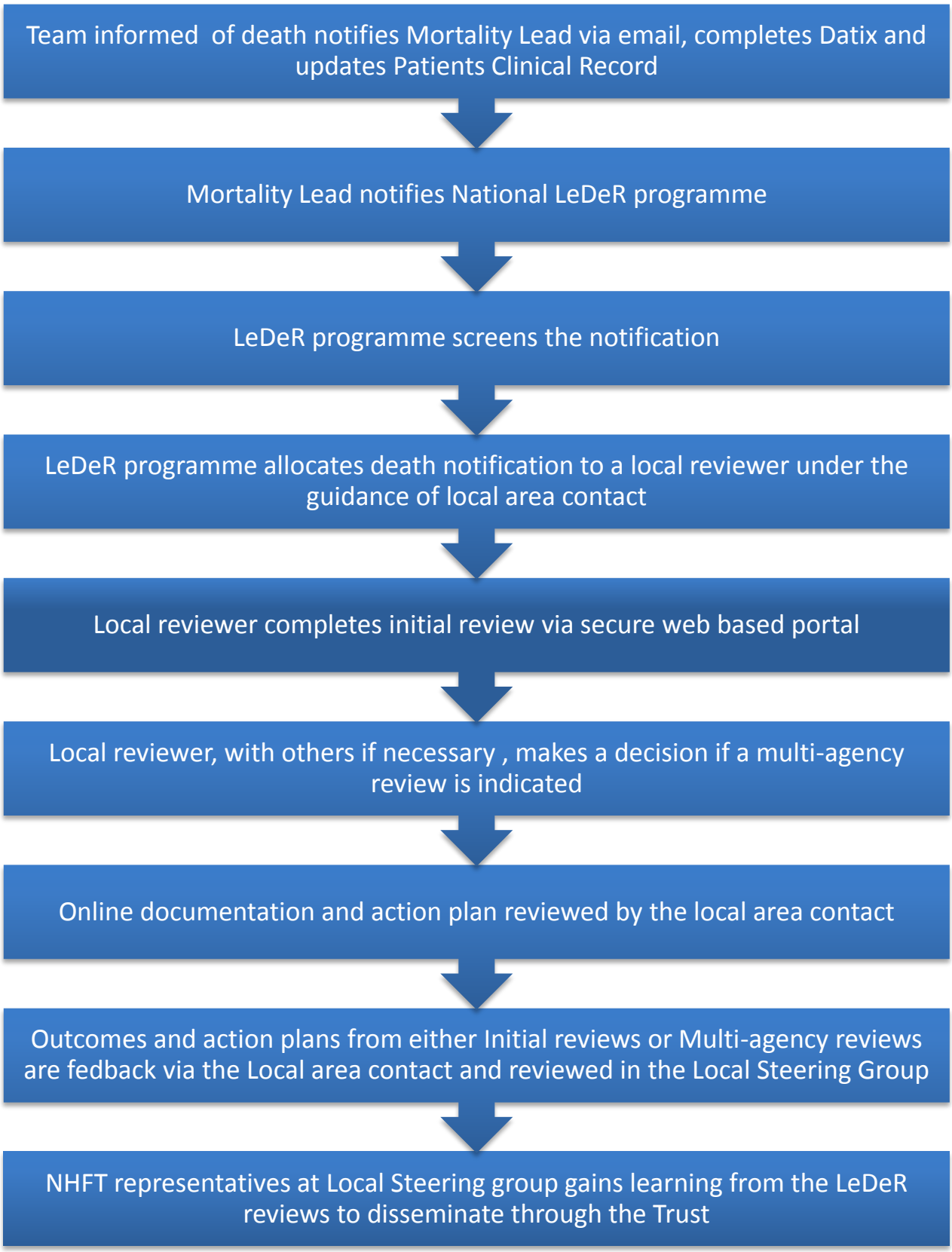
Author:	Mortality Lead
Approved by and date:	Trust Policy Board: 19 January 2018
Responsible committee:	Quality Forum
Any other linked Policies:	• Being Open/Duty of Candour policy (CRM006) • Incident policy (CRM002) • Investigation policy (CRM008) • Reporting and Management of Serious Investigations policy (CRM010) • Analysis, Improvement and Learning Lessons policy CRM005
Policy number:	CRM012
Version control:	2.0

Version No.	Date Ratified/ Amended	Date of Implementation	Next Review Date	Reason for Change (eg. full rewrite, amendment to reflect new legislation, updated flowchart, minor amendments, etc.)
1.0	27/07/2017	01/08/2017	01/08/2020	New Policy based on guidance from the National Quality Board.
2.0	19/01/2018	20/01/2018	19/01/2021	Changes in legislation and working practice. Training implications.

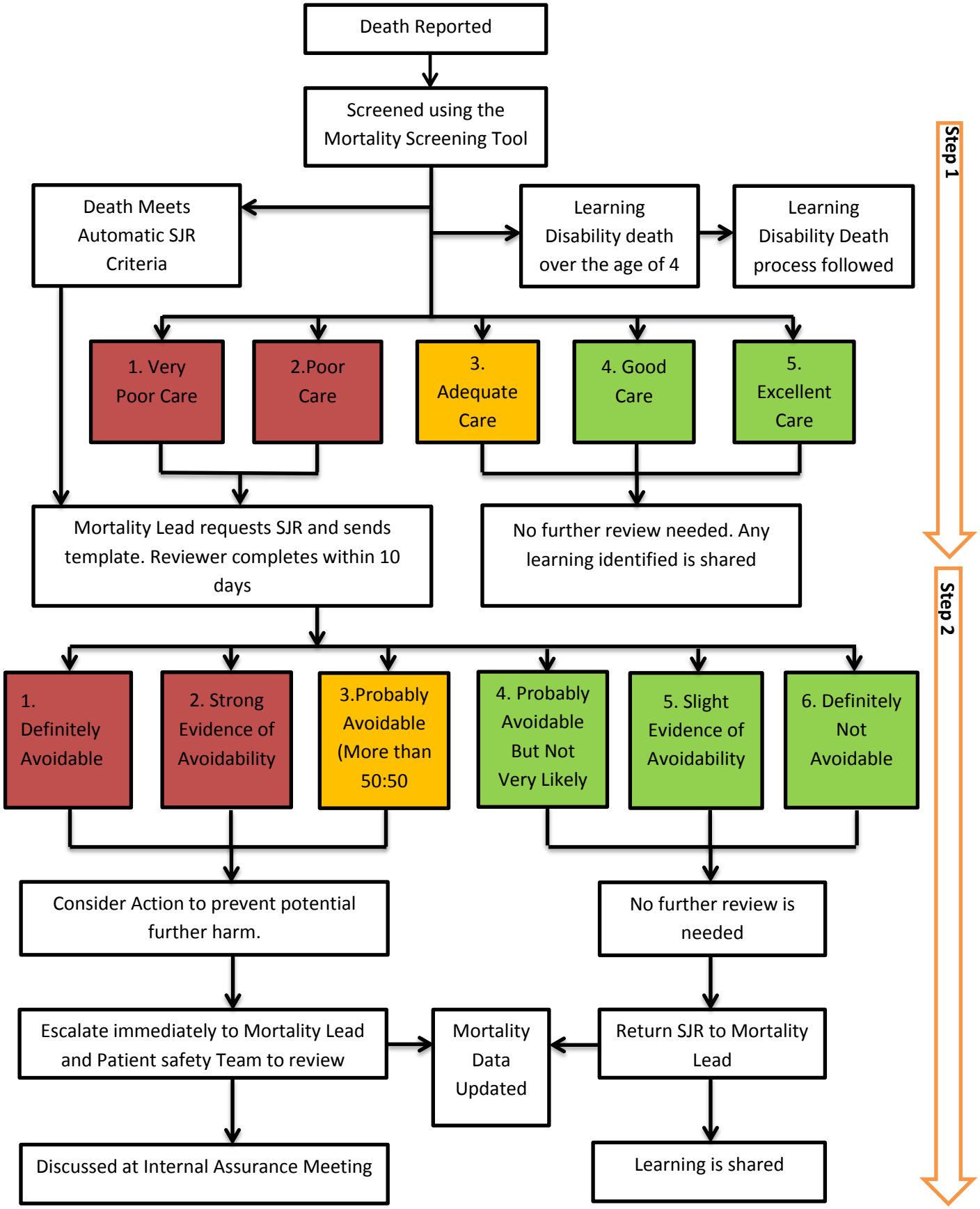
Appendix 1 - Categorising a death (Mazars)

	Code	Type	Description	Example
	EN1	Expected Natural - Type1	A death that was expected to occur and occurred within an expected time frame	A person receiving end of life care
Datix Deaths in these categories	EN2	Expected Natural - Type 2	An expected death that occurred sooner than the expected timeframe	A person with a terminal illness diagnosis dies much earlier than anticipated
	EU	Expected Unnatural	A death that was expected, however not within the expected timeframe as well as not being form the expected cause	A person who dies as a result of associated complications of unnatural addictions / habits / choices (e.g Alcohol dependency, chronic substance use, eating disorder)
	UN1	Unexpected Natural - Type 1	An unexpected death by a natural cause	A death of a male in his 30's that dies from a stroke or heart attack
	UN2	Unexpected Natural - Type 2	A death that was unexpected caused by a complication of a known medical condition	A death of a person who is alcohol dependant or related to diabetes where there are concerns raised in these areas of care
	UU	Unexpected Unnatural	An unexpected death caused by unnatural means	Suicide, homicide, neglect, abuse

Appendix 2 Learning Disability Death process (LeDeR)



Appendix 3 – Reviewing deaths process



Appendix 4 – Mortality Screening Tool

This form has been circulated due to the death of a service user meeting the local and national Learning from Deaths scope and is therefore subject to be screened to assess for a Structured Judgment Review (SJR).

Section 1 – Service User Information				
Patient Initials	Gender	Date of Birth	Name of Screener/s	Datix
NHS Number		Date of Death	Location of Death	Service Line
GP name and contact details		Date of Screen	Suspected / Known Cause of Death	

Classification of Death? (Mazars)											
EN1		EN2		EU		UN1		UN2		UU	

Section 2 – Learning Disability Screen			
Recorded diagnosis of Learning Disability and over the age of 4?	Yes (Notify LeDeR)	Date notified: ……	No (Continue Screen)

Section 3 – Lead Care Provider			
NHFT		Acute Trust	
NCC		HMP Service	
Other			
Comments…			

Section 4 – Automatic Structured Judgement Review?	Yes	No
Inpatient Mental Health death		
Community Hospital death ‘EN2’ or higher		
Diagnosis of Serious Mental Illness		
Significant concerns in relation to the quality of care raised by either family / carers, staff or safeguarding		
Death in custody (DIC)		
Death occurred 30 days after discharge from a hospital or release from custody		
An ‘alarm’ has been against the service by whatever means (e.g. concerns raised by audit work, concerns raised by the Care Quality Commission or another regulator		
A death in areas/during procedures where people are not expected to die, for example elective procedures; Dentistry, ECT, Ketamine Infusion, Repetitive Transcranial Magnetic Stimulation (rTMS)		
A further sample to provide an overview of where learning and improvement is required		

- **If the answer is Yes to any of the above, an Automatic Structured Judgement Review is required.**
- **If the death does not meet an Automatic Structured Judgement Review, continue screen.**

Section 5 – General care		
Did the care provided deviate from policy / good practice guidance?	Yes	No
Was there a delay in accessing appropriate resources / assistance?	Yes	No
Was there a delay in starting assessments?	Yes	No
Was there a delay in starting treatment?	Yes	No
Was there a delay in diagnosis?	Yes	No
Is there a medication error associated with this death?	Yes	No
Was there a lack or misuse of equipment associated with this death?	Yes	No
Were there sufficient nursing intervention reviews?	Yes	No
Were there sufficient Medic intervention reviews?	Yes	No
Were safeguarding issues identified and acted upon?	Yes	No
Section 6 - Communication		
Was there evidence of good communication between the team and the patient?	Yes	No
Were family / carers fully involved in the care?	Yes	No
Was there evidence of good communication between the team and other healthcare professionals	Yes	No
Comments…		
Section 7 - Risk Assessments		
Was there a risk assessment in place?	Yes	No
Was the risk assessment updated to changes in clinical presentation?	Yes	No
Did the Risk assessment mitigate identified risks?	Yes	No
Was there evidence of family and carer involvement in the risk assessment?	Yes	No
Comments…		
Section 8 – Care plans		
Were there care plans in place that addressed identified risks?	Yes	No
Was there evidence of co-production in the care plans?	Yes	No
Was there evidence of family and carers involvement in care plans?	Yes	No
Were care plans reviewed as indicated?	Yes	No
Comments…		

Section 9 – Physical Health monitoring		
Was any physical deterioration recognised and responded to in a timely manner (Use of NEWS etc.)	Yes	No
Were all applicable assessment tools completed?	Yes	No
Were there any examples of failure to respond to abnormal observations?	Yes	No
Was there a delay in starting any required treatment?	Yes	No
Were there any issues with accessing internal / external resources?	Yes	No
Comments…		

Section 10 – Record Keeping				
Rate the general content and organisation of the notes within the record				
Excellent	Good	Adequate	Poor	Very Poor

- **If RED to any of the above, potential learning is identified**

Section 11 –Care Score					
How would you judge the overall quality of care delivered?	Excellent care	Good care	Adequate	Poor care	Very poor care
	↓	↓	↓	↓	↓
Is an SJR required?	No	No	No	Yes	Yes

Section 12 – Learning		
What went well?		
What 3 main points could have been improved?		
	Aspect of care	Action to be taken
1.		
2.		
3.		

SJR indicated?	Yes Date requested:……	No

Identified Learning fedback to…	Senior Medic	Service Manager	Clinical Team	M&M / LfD Group	PST / IAM
	Other (Please Specify)				

Appendix 5 – Structured Judgement Review Template for Community Hospitals

Section 1 – Service User Information				
Patient Initials	Gender	Date of Birth	Name of Reviewer/s	
NHS number		Date of Death	Location of Death	Datix
GP details		Date of Screen	Suspected / Known Cause of Death?	

Section 2 – Admission Overview			
Emergency or Elective?	Day of Week of Admission?	Time of Arrival on Ward (24 hour)	Time of Admission on Ward (24 hour)
Length of stay in days?	Day of Week of death?	Time Death occurred (24 hour)	Family / Carer Involved

How soon was the First Physician Review?	< 2 hours after admission	2-4 hours after admission	< 12 hours after admission	> 12 hours after admission

Was the Patient Seen by Consultant in Ward Round review?	Yes	No	MDT

Was the admission in which the patient died a readmission within 28 days?	Yes	No
Was there a delay in Admission to the Ward?	Yes	No
Was the Admission for End of Life Care?	Yes	No
Did the patient have a DNACPR in place?	Yes	No
Section 3 – Specific Triggers for harm		
Complication of medication / adverse drug reaction	Yes	No
Complication of procedure	Yes	No
Complication of surgery?	Yes	No
Development of a pressure sore?	Yes	No
Hospital Acquired Infection (HAI)?	Yes	No

Comments…

Section 4 – Sequence of events
(Please give a summary of background information, clinical presentation, circumstances leading to service users death. Include frequency of contact, last contact, staff members contacted for review).

Section 5 – Medic and Nursing Reviews				
Were there daily entries in the patient's record?		Yes		No
Is there documented evidence of regular Medic review during the admission?	Daily	Every 2-3 Days	Weekly	More than weekly
Comments…				

Section 6 - Diagnosis		
What was the main condition treated during the admission?		
Was there a delay in reaching a diagnosis?	Yes	No
Was the diagnosis made clear in the patient's record?	Yes	No
Comments…		

Section 7 - Communication			
Was there evidence of good communication between the team and the patient?	Yes	No	N/A
Were there any concerns in care raised by family or carers?	Yes	No	N/A
Was there evidence of good communication between the team and other healthcare professionals?	Yes	No	N/A
Comments…			

Section 8 – Investigations and Monitoring		
Were there any delays in completing important investigations or starting treatment?	Yes	No
Were there any investigations omitted that should have been done?	Yes	No
Were the results documented clearly in the patient's record?	Yes	No
Were there any examples of failure to respond to abnormal observations?	Yes	No
Did the patient receive the appropriate level of monitoring?	Yes	No
Were there any issues with accessing internal / external resources?	Yes	No
Comments…		

Section 9 – Quality of record				
Rate the general content and organisation of the notes within the patient record				
Excellent	Good	Adequate	Poor	Very Poor
Comments…				

Section 10 – Quality of Care					
How would you judge the overall quality of care delivered?	Excellent care	Good care	Adequate	Poor care	Very poor care

Would the care provided be suitable for a member of your family?	Yes	No

If no, please explain why…

Section 11 – Death avoidability score (Please indicate below)					
Score 1 Definitely avoidable	**Score 2** Strong evidence of avoidability	**Score 3** Probably avoidable (more than 50:50)	**Score 4** Probably avoidable but not very likely	**Score 5** Slight evidence of avoidability	**Score 6** Definitely not avoidable

Section 12 – Learning from the death

What went well?

What 3 main points could have been improved?

	Aspect of care	Action to be taken
1		
2		
3		

SJR completed by…

Designation/s	Date :

Patient safety Team only

SJR reviewed by…					Date :	
Further learning identified?	No	Yes	IAM Review		M &M / LF D Groups	

Appendix 6 - Structured Judgement Review Template for Mental Health Services and Prisons

Section 1 – Service User Information			
Patient Initials	Gender	Date of Birth	Name of Reviewer/s
NHS number		Date of Death	Location of Death
GP name and contact details		Date of Screen	Suspected / Known Cause of Death?

Section 2 – Overview					
Diagnosis / Working Diagnosis (Include co-morbidities)					
Community	CTO	Inpatient	Detained	Prison	Remand
	Informal		Informal		Sentenced
Was there a delay in assessment/ admission/treatment?		Yes		No	
If yes, give further details…					

Day of Week of death?	Time Death occurred (24 hour)

Section 3 - Communication			
Was there evidence of good communication between the team and the patient	Yes	No	N/A
Were there any concerns in care raised by family or carers?	Yes	No	N/A
Were families and carers fully involved in the care?	Yes	No	N/A
Was there evidence of good communication between the team and other healthcare professionals	Yes	No	N/A
Comments…			

Section 4 – Sequence of events
(Please give a summary of background information, clinical presentation, circumstances leading to service users death. Include frequency of contact, last contact, were there any issues with accessing internal / external resources etc.)

Section 5 – Medic and Nursing Reviews		
Were medic and nursing reviews completed as expected?	Yes	No
Were medic and nursing reviews documented clearly within the patient's record?	Yes	No
Comments…		

Section 6 - Investigations and Physical Health Monitoring			
Were all applicable assessment tools completed?	Yes	No	N/A
Were there any examples of failure to respond to abnormal observations?	Yes	No	N/A
Were there any delays in completing important investigations or starting treatment?	Yes	No	N/A
Were there any investigations omitted that should have been done?	Yes	No	N/A
Were the results documented clearly in the patient's record?	Yes	No	N/A
Did the patient receive the appropriate level of monitoring?	Yes	No	N/A

Section 7 - Risk Assessments		
Was there a risk assessment in place?	Yes	No
Was the risk assessment updated to changes in clinical presentation?	Yes	No
Did the Risk assessment mitigate identified risks?	Yes	No
Was there evidence of family and carer involvement in the risk assessment?	Yes	No
Comments…		

Section 8 – Care plans		
Was there care plans in place that addressed identified risks?	Yes	No
Was there evidence of co-production in the care plans?	Yes	No
Was there evidence of family and carers involvement in care plans?	Yes	No
Were care plans reviewed as indicated?	Yes	No
Comments…		

Section 9 – Quality of Record				
Rate the general content and organisation of the notes within the patient record				
Excellent	Good	Adequate	Poor	Very Poor
Comments…				

Section 10 – Quality of Care					
How would you judge the overall quality of care delivered?	Excellent care	Good care	Adequate	Poor care	Very poor care

Would the care provided be suitable for a member of your family?	Yes	No

If no, please explain why…

Section 11 – Death avoidability score (Please indicate below)					
Score 1 Definitely avoidable	**Score 2** Strong evidence of avoidability	**Score 3** Probably avoidable (more than 50:50)	**Score 4** Probably avoidable but not very likely	**Score 5** Slight evidence of avoidability	**Score 6** Definitely not avoidable

Section 12 – Learning

What went well?

What 3 main points could have been improved?

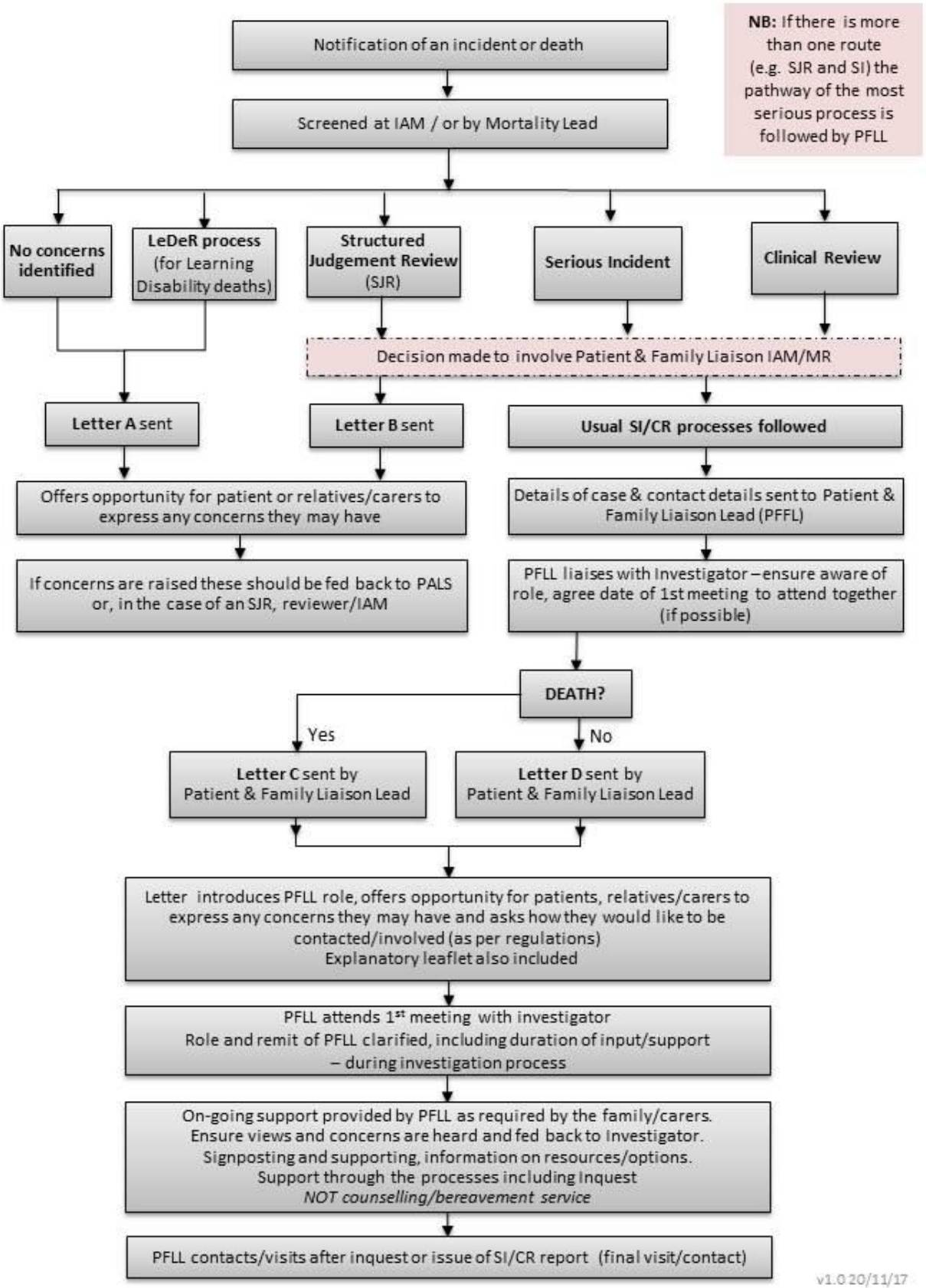
	Aspect of care	Action to be taken
1		
2		
3		

SJR completed by…

Designation/s	Date :

Patient safety Team only						
SJR reviewed by…					Date :	
Further learning identified?	No	Yes	IAM Review		M &M / LFD Groups	

Appendix 7 – Involvement of Patient and Family Liaison Lead flowchart



Appendix 8 – Suicide Data Collection Tool

Gender	Male				Female				Other			
Age Range	0-19		20-30		31-40		41-50		51-60		61-70	70+
Month of death	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Suspected Cause of Death	Ligature			Poisoning			Train			Drowning		
	Other (Please specify):											
Main Team Involved												
Primary Diagnosis	Depression		Depression and Anxiety		Psychotic Illness		Affective Disorder		Personality Disorder		ADHD / ASD	None
	Other (Please specify):											

Question	Yes	No
Access, Treatment and Monitoring		
Was there a delay in accessing treatment?		
Was Treatment being given and accepted as expected?		
Were there any issues with accessing internal / external resources etc.)		
Was the Service User being monitored as expected?		
Physical health/pain		
Was the client experiencing chronic or acute physical or neurological pain?		
Did the client have a co-existing physical health condition? (e.g. COPD, diabetes etc)		
Substance Use		
Was there evidence of alcohol misuse?		
Was there evidence of street drug misuse?		
Was there evidence of prescribed drugs misuse?		
Is there evidence of signposting / the substance use was being treated?		
Social problems and loses in the 6 months prior to suspected suicide		
Significant personal relationships		
Finances		
Significant work stressors / pressures / redundancy		
Housing		
Bereavement		
Help seeking behaviour – Contact In the month prior to suspected suicide		
Family		
Council / Housing		
Voluntary Agency		
GP / Out of Hours		
NHFT		
Suicidal behaviour		
Were there previous, significant attempts with intent to end their life?		
If multiple times, did the attempts use the same method?		
Was the suicide method the same method as previous attempts?		
Communication problems / System Issues		
Were family / carers fully involved in care decisions?		
DNA not followed up – or discharged without assessment or follow up		
Transfer between services		
Risk documentation not completed as expected		
Inadequate care / safety planning		