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| **Document name:** | Learning from Healthcare Deaths |
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| **What does this policy replace?** | Learning from Healthcare Deaths policy |
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| **Developed by:** | Assistant Director of Nursing, Quality and Professions  Patient Safety Manager |
| **Director leads:** | Director of Nursing and Quality |
| **Contact for advice:** | Deputy Director of Nursing, Quality and Professions  Associate Director of Nursing, Quality and Professions.  Assistant Director of Nursing, Quality and Professions  Patient Safety Manager |



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# Introduction

Most people will be in receipt of care from the NHS at the time of their death and experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, the experience is different and they experience poor quality provision for a number of reasons including system failure.

Learning from deaths is an essential part of quality improvement. It is the right thing to do to review and investigate deaths where care and service delivery problems occurred so that we can learn and prevent recurrence.

This policy is in line with the Trust values:

* We put the person first and in the centre
* We know that families and carers matter
* We are respectful, honest, open and transparent
* We improve and aim to be outstanding

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Therefore it is important that organisations widen the scope of deaths which are reviewed in order to maximise learning.

The Confidential Inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

We will make it a priority to work more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of the death of their family member through to actions taken following on from any investigation in line with the National Quality Board guidance on supporting bereaved families[[1]](#footnote-2).

The Trust will also look at a selection of cases where we can learn from examples of good care and share this through our learning from healthcare deaths reporting.

A report by independent auditors Mazars, commissioned by NHS England was published in December 2015. It commented on services run by Southern Health NHS Foundation Trust.

The report found:-

* Failings in the way the Trust investigated serious incidents.
* Too few deaths were investigated and some should have been investigated further.
* The Trust could not demonstrate a comprehensive systematic approach to learning from deaths

These findings were reinforced in the *Care Quality Commission (CQC) report Learning, candour and accountability[[2]](#footnote-3).* It revealed that in some organisations learning from deaths was not being given sufficient priority and that valuable opportunities for improvements were being missed. Importantly the CQC also point out that there is much more we can do to engage families and carers, and recognising their insights and experiences is vital to our learning.

The National Quality Board (NQB) guidance on Learning from Deaths[[3]](#footnote-4) was the starting point to initiate a standardised approach to the way NHS Trusts report, review, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning. These reviews will provide the Trust with valuable information in deciding how Executive Teams and Boards can use these findings.

The Trust fully supports the approach it has developed with mental health providers in the North of England Alliance as part of our collaborative approach to learning from deaths. The Trusts participating are:

* Bradford District Care NHS Foundation Trust
* Cumbria Partnership NHS Foundation Trust
* Humber NHS Foundation Trust
* Leeds and York Partnership NHS Foundation Trust
* Northumberland, Tyne and Wear NHS Foundation Trust
* Rotherham, Doncaster and South Humber NHS Foundation Trust
* Sheffield Health & Social Care NHS Foundation Trust
* South West Yorkshire Partnership NHS Foundation Trust
* Tees, Esk and Wear Valley NHS Foundation Trust

Working collaboratively will enable shared learning and good practice, and information suitable for comparison across organisations.

This policy sets out the principles that guide our work and how we will implement them.

South West Yorkshire Partnership NHS Trust provides a range of services alongside its mental health portfolio –including learning Disability Services, Physical Health services and these have been considered when writing the policy. We have and will continue to liaise with physical health colleagues.

This policy should be read in conjunction with:-

* [Being open](https://swyt.sharepoint.com/sites/Policy-Documents/Shared%20Documents/775.docx) policy
* [Incident reporting and management (including serious incidents)](https://swyt.sharepoint.com/sites/Policy-Documents/Shared%20Documents/425.docx) policy
* [Investigating and analysing incidents, complaints and claims to learn from experience](https://swyt.sharepoint.com/sites/Policy-Documents/Shared%20Documents/776.docx) policy

# Purpose and scope of the policy

Working with families/carers of patients who have died offers an invaluable source of insight to improve services. There is a need to ensure families are given the opportunity to comment on the care received, and ensure support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. Communication with families and carers should consider the Accessible Information Standards.

In line with the National Quality Board guidance on Learning from Deaths[[4]](#footnote-5), every Trust must have a policy in place that sets out how it identifies, reports, reviews, investigates and learns from a patient’s death and reviewing the care they received prior to death to consider if this could have been improved.

The Trust already does significant work with working with families following deaths where care delivery may be an issue. We also involve service users and families in the development of services and provide opportunities to provide feedback on all aspects of care and services delivery.

We will continue to educate staff and encourage a more open culture of listening to the views and opinions of families and carers following all deaths. Staff will become more confident in identifying what can be done differently and improve systems and share systems and processes that are working well.

This policy sets out roles and responsibilities relating to learning from deaths and promotes a culture of learning lessons.

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| MC900434750[1] | Learning from a review about the care provided to patients who die in our care is integral to the Trust’s governance and quality improvement work. |

**2.1 Purpose**

The Trust 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.

It will set out the Trust’s expectation / principles on how it responds to deaths in our care and identifies the scope of review for each death and how the Trust will learn from them.

This policy sets out how staff can support the involvement of families and carers when a death has occurred and how to engage with them to ensure there are easy opportunities to discuss or ask questions about the care received by their loved one to their preferred timescale.

**2.2. Objectives**

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.

The core objectives of this policy are:

* To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.
* To help to identify what can be improved to ultimately reduce the inequality in the life expectancy of people with a severe mental illness/learning disability.
* To standardise approaches to reviewing deaths across the northern cohort of mental health trusts in order to share information and key learning.
* To ensure there is a consistent and coordinated approach for undertaking mortality reviews for physical health care.
* To enhance learning at a personal, team and organisational level.
* To ensure the Trust engages with other stakeholders (Acute Trusts, Primary Care, Public Health, Safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximise learning from deaths.
* To support the evaluation of the Trust’s approach to learning from deaths in line with the northern alliance of mental health trusts agreed principles.

**2.3. Scope of the policy**

This policy applies to all Trust staff with a responsibility for patient care.

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| MC900434750[1] | The National Quality Board Guidance on Learning from Patient Deaths applies to all acute, mental health/learning disability and community NHS Foundation Trusts. |

# Definitions

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| **Term** | **Definition** | **Circumstances** |
| **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. | The Trust has two types of case record review.  The first stage case record review is the Manager’s 48 hour Review, with the second stage being a Structured Judgement Review – see definitions. |
| **Death certification** | The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner. | When a death has been certified, no further review process is required[[5]](#footnote-6). In the event of there being concerns about the care provided from management, governance or family, then a case would move into case record review or investigation. |
| **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’). |  |
| **Deaths in scope** | Deaths that the Northern Alliance of mental health trusts and the Trust for general community services have determined require further review under this policy. |  |
| **Investigation / Review** | The act or process of investigating or reviewing an incident; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies and 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.  Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first. | Investigations can include service level investigations, serious incident investigations, safeguarding reviews, learning disability reviews etc. Other internal review methods such as Significant Event Analysis are used at team level to systematically identify what happened, how it happened and why using human factors techniques. |
| **LeDeR** | The Learning Disabilities Mortality Review (LeDeR) programme has been commissioned by NHS England to support local areas in England to [review the deaths](http://www.bristol.ac.uk/sps/leder/about/reviews-of-deaths/) of people with a learning disability to:   * identify common themes and learning points and: * provide support to local areas in their development of action plans to take forward the lessons learned. | The LeDeR programme will be contacted regarding the death of a person with a learning disability. If the death has not been reported by another agency, the Trust will report the death. The Manager’s 48 hour review will also be completed internally to enable any local learning to be identified. In some cases, a Structured Judgement Review may be completed. |
| **Main provider of care** | When the Trust is the main provider of care as described in section 6. |  |
| **Manager’s 48 hour review** | Following the manager’s review of the clinical records against standards, the manager records their findings on the Manager’s 48 hour review on the Datix incident record. The aim is to provide a summary of the care provided and identify good practice and any areas for further review. | Where a death has not been certified, the Manager’s 48 hour review can be accepted as a first stage case record review. This is usually where the review is comprehensive, there are no concerns identified and care was provided as would have been expected. |
| 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. |  |
| **Serious Incident Investigation** | Principles as described under Investigation.  Serious incidents (SIs) usual involve serious injury, harm or death, which meet specific criteria defined in NHS England’s Serious Incident Framework. These incidents require additional external reporting to commissioning bodies on STEIS. Investigations are usually led by the Trust’s Lead Serious Incident investigators and medical investigators. | Some deaths meet the criteria for a Serious Incident investigation. They are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. |
| **Service Level Investigation** | A service level investigation is commissioned by the Service and the investigator identified by the service. Principles as described under Investigation. | Some deaths which do not meet the criteria for a Serious Incident investigation may require a Service level investigation where there are questions that are unanswered by the manager’s review or where learning could be significant. |
| **Severe Mental Illness** | The term is generally restricted to psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder |  |
| **Significant Event Analysis** | The Significant Event Analysis tool has been developed in the Trust to enable teams to review incidents as a team. It focusses on systematically identifying what happened, how it happened and why, using human factors techniques. This is used to identify learning and action promptly after the incident. This may lead to further investigation. This can be used as part of a service level investigation. |  |
| **STEIS** | Strategic Executive Information System is the national system for reporting Serious Incidents (SI) that enables electronic logging, tracking and reporting of Serious Incidents with NHS Improvement |  |
| **Structured Judgement Review (SJR)** | Reviewing case records to determine whether there were any problems in the care provided to the patient who died, in order to learn from what happened. The Trust uses the Royal College of Physicians Structured Judgement Review methodology[[6]](#footnote-7) and Royal College of Psychiatrists Mortality Review Tool for Mental Health Trusts[[7]](#footnote-8) | A Structured Judgement Review is undertaken when a more detailed, independent review of the care provided is required following review of the managers 48 hour review. This may be because there are questions remaining about the care provided. |

# Duties

This policy applies to all Trust staff with a responsibility for patient care as set out below:

Mortality governance is a priority for all Trust Boards and the Learning from Deaths Framework places a greater emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation.

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| **Role** | **Responsibility** |
| **Chief Executive, Executive Trust Board Directors and Non-Executive Directors** | Trust Boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remains a priority by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. They can do this by demonstrating their commitment to the work e.g. spending time developing Board thinking; ensuring a corporate understanding of the key issues around the deaths of service users and by ensuring that sufficient priority and resource is available for the work.  The Director of Nursing and Quality has been identified as the Board level ‘Patient Safety Director’ with responsibility for learning from deaths. Additionally a named Non-Executive Director has taken lead responsibility for oversight of progress to act as a critical friend, holding the organisation to account for its approach in learning from deaths.  The Board will ensure:   * That robust systems are in place for reporting, reviewing and investigating deaths * That bereaved families are engaged and supported * That there is evident learning from deaths both internally and with our external partners and quality improvement is championed * That processes focus on learning, can withstand external scrutiny, by providing challenge and support and assurance of published information |

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| **Directors, Medical Staff, Consultant Nurses, Business Delivery Management, Ward and Team Managers and all Registered Nurses & Allied Healthcare Professionals** | Staff should familiarise themselves with this policy and understand the process for learning from deaths. Identify the key changes required to implement this policy and ensure all appropriate action is taken.  When a member of staff is made aware of a death, the family should be contacted by the most appropriate person to offer condolences, support and the opportunity to comment on the care provided in line with Being Open, and Duty of Candour, when this applies.  Staff must record in a timely way information about deaths on clinical systems, including all details know about the cause and place of death.  Managers should review the clinical records to ensure care was provided in line with clinical standards, policies and procedures.  Staff must report any death on Datix if there are any concerns raised by family, clinical staff or through governance process or the Trust is a main provider of care (see flowchart in appendix D).    To support staff to review and investigate deaths ensuring they have the time to carry out this process in a skilled way to a high standard, and as part of that to:   * Ensure staff have the right level of skill through training and experience; * To promote learning from deaths; * That sufficient time is assigned in local governance forums to outline and plan for any lessons learned; * To ensure that learning is acted on.   Patient safety support team will provide support.  Manager’s should ensure the [Supporting staff involved in traumatic or stressful adverse events](https://swyt.sharepoint.com/sites/Policy-Documents/Shared%20Documents/777.docx) policy is followed and any staff affected by the death of a patient (or the death of a colleague) are offered support from Occupational Health in line with the above policy. |
| **The Patient Support Team, Performance and Information, Customer Services and Legal team** | These corporate Trust departments have a responsibility to ensure:   * Data is collected and published to monitor trends in deaths with Board level oversight of this process * Ensuring the Datix incident reporting system is used to its full potential to record deaths (as agreed by what is in scope/where the Trust is the main provider of care) in accordance with Trust policy. * Processing information consistently and precisely and in a meaningful way to fulfill governance processes required to ensure high standards in mortality governance are maintained.   Patient safety support team will provide support across the Trust |

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| C:\Users\flintoffj\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\XJK2M0E3\MC900434750[1].png | The Trust requires all staff to be open, honest and transparent about reporting deaths and for engaging with families and carers, actively enabling them to ask questions about care and identify if care can be improved. |

# Family engagement

In July 2018, the National Quality Board published guidance on supporting bereaved families[[8]](#footnote-9). The Trust will use the principles set out in the national guidance for how we will engage with and support bereaved families.

We will reinforce the importance of family engagement following deaths. Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times, families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but don’t always want to make a complaint.

The Trust will ensure that family involvement focuses on inclusivity, representation, non-discrimination and empowerment.

Bereaved families and carers should be treated as equal partners following a bereavement and take into account the following:

a. Be mindful of the imbalance of power represented by the finances, resources, information and knowledge available to them compared to families.

b. Try to lessen this inequality by ensuring families are listened to. They should use plain, understandable language to engage families. And they should provide information on how to apply for access to medical and other records.

c. Have a clear policy for engaging with bereaved families and carers. This should include a commitment to welcoming their questions or sharing concerns about the quality of care their loved one received.

**Families and Carers**

If you are reading this as a family member of someone who has recently died who received care from our Trust and you have anything you would like to discuss, you can contact the clinical team involved to discuss or you can contact customer services directly on Freephone 0800 587 2108. Further details on customer services are available on our [website](https://www.southwestyorkshire.nhs.uk/contact-us/customer-services/).

**First contacts**

When a service user dies, there is an expectation that contact will be made with bereaved families /carers of service users to offer condolences, support and opportunities to comment on the care the Trust provided.

The Trust may be informed of a death through various routes. For example an admin member of staff may receive a call from a family member to inform us of the death or a clinician may be told of a death on a planned visit, or an update from the clinical records. All staff should be familiar with what is required in these circumstances, ensuring they follow the Being Open Policy which includes Duty of Candour when this is required.

During an initial contact with the family of a deceased service user, staff should ensure they:

* offer condolences
* obtain a name and contact details for the family member
* sensitively ask about the circumstances and cause of the death
* ask if they have any questions about the care their family member received from the Trust
* offer support and signpost to sources of support, e.g. GP, third sector organisations etc.

The initial contact should be followed up in writing by the manager or appropriate person (e.g. care coordinator). This could take the form of a letter, or in some areas, a card may be more appropriate. A copy of the communication, whatever format, should be retained in the team. Other methods of communication should be considered in line with need and the [Accessible Information standards](https://swyt.sharepoint.com/sites/Intranet/Accessible-information-standard/Pages/Accessible-information-standard-.aspx).

The written communication should include:

* condolences for the death;
* The below points should be covered in the communication, but will also be available in a separate first stage leaflet that should be enclosed with the communication.
  + an explanation of how families can comment, ask questions or raise concerns about their relative’s care through the team manager or through the customer services team (further details will be included in a leaflet). The Trust needs to understand what families want to know, so these areas can be included in investigation terms of reference.
  + if they raise significant concerns, this would automatically prompt a review of the care received (further details will be included in a leaflet)
  + An overview of how we review the care of those who have died whilst under our care.
  + information about local and/or national bereavement support available to families (further details will be included in a leaflet)
* The content should be approved by a manager

The Trust has developed information to support families following bereavement. These are available on the Trust intranet under [Learning from Deaths](https://swyt.sharepoint.coms/sites/Intranet/learning-from-deaths).

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| **1) Leaflet - Support and information following a bereavement** | Provides details on how families can comment, ask questions or raise concerns about their relative’s care.  Includes a broad overview of our review processes.  Gives information on sources of support for grief and bereavement. Contact details for customer services |
| **2) Booklet -**  **Information for families following a bereavement** Details of review and investigation processes | Provides further information on our review processes.  Explanation of different types of review or investigation.  Aim of all reviews or investigations  Explain why there is an investigation  Where a case note review identifies potential problems with the care provided, how the trust will share the findings with the family  How a review findings can trigger an investigation  How families can get involved  Frequently asked questions egg how to access records, speaking with a staff member who cared for their relative  Contact details for customer services |

This early discussion enables us to ensure that deaths where families raise concerns are reviewed or investigated. If there are any concerns raised at all, this must be reported on Datix irrespective of if the Trust is the main provider of care.

There are some circumstances where the Trust may find out about the death of a service user after some delay. In these circumstances a discussion should take place between the Patient Safety Support Team and the clinical team involved to determine the best approach.

**Unable to contact**

There may be occasions where the Trust is not able to make contact with family or carers. Attempts to make contact should be recorded in the clinical record. Where a service user does not have family or carers, or their details are not recorded on the clinical system. The reasons for no contact with family should be recorded in the clinical record.

**Ongoing contact**

It is understood that dealing with the death of a relative is a sensitive matter for families, carers and staff and that all situations are different. Staff may need to offer the opportunity for on-going involvement in-keeping with the family’s needs and wishes.

**Involvement in reviews and investigations**

The Trust’s approach should be to treat the family/carer as an equal in the review/investigation process from the beginning taking their views and opinions into account at each stage.

For deaths that meet the requirement for review or investigation, we need to provide information to families regarding the opportunity to be involved in the review of the care. The flowchart in Appendix E sets out the different review processes that may be used following a death.

We will write to the family to inform them that a review or investigation is being undertaken. We will provide further information in the form of a booklet that explains the review/investigation process. The leaflet will include:

* information that every month the trust review a number of records of patients who die in its care, and that their relative’s case may be reviewed as part of this
* the review process we follow for all deaths of people who were under our care
* information about the different review/investigation processes including case note reviews and how they help the Trust take every opportunity to learn from the care it provides – both where care has been good and where there are opportunities to improve
* a statement that, where a case note review identifies potential problems with the care provided, the trust will share the findings with the family
* If a case note review identifies problems in care that the trust was previously unaware of, and which could have contributed to the death, an investigation will be triggered. Families should be told about the investigation and offered an opportunity to be involved
* How families can get involved in the review/investigation process
* Contact details for the customer services team will be included

Further information on our leaflets is available on the Trust intranet under [Learning from Deaths](https://swyt.sharepoint.coms/sites/Intranet/learning-from-deaths).

Families can choose how they wish to be involved, this may include:

* providing evidence / contributions to the review or investigation e.g. providing a pen portrait of the person, time-line of events
* agreeing the level of the review / investigation;
* contributing to the terms of reference for serious incident reviews;
* Commenting on report content.

When this is an investigation, families/carers should also be given the option of seeing a final report to ensure they are comfortable with any findings. Ideally this should be undertaken in a face to face meeting with a staff member talking the family member/carer through the report.

Further information and support can be accessed from the Patient Safety Support Team as this is already practice in serious incident investigations.

**Contact declined**

If the family member/carer decides they do not want to be involved in the review/investigation process, staff should make it clear they can contact us at any time should their decision change and that any relevant information can still be shared. If the family does not want contact at all about the process or findings, this should be honoured and staff should record their wishes.

**Unknown cause of death**

In some cases the cause of death may not be known when a death is reported. Where it is not possible to obtain information on the cause of death and circumstances from family or carers, teams should attempt to obtain this through other routes. The service user’s GP, care home or last care provider (e.g. acute hospital) may be able to provide information. When information is identified, the clinical record should be updated, and where reported on Datix, the Datix record updated.

In addition to this, the Patient Safety Support Team will liaise with the Legal Team to try to obtain cause of death/inquest conclusions from H M Coroner’s office.

**Family Bereavement Support**

In line with the guidance in the National Quality Board’s[[9]](#footnote-10) guidance for NHS trusts on working with bereaved families and carers, the Trust is exploring the development of a support network. Information on this network will be available on the Trust’s [learning from healthcare deaths intranet pages](https://swyt.sharepoint.coms/sites/Intranet/learning-from-deaths/Pages/Bereavement-Support.aspx) when available.

# Scope of reportable deaths

In order to support consistency in determining the scope of deaths for further review, the alliance of Northern Mental Health Trusts has agreed the core principles and the Trust has added to this to reflect the range of Trust services.

Where the Trust provides a wide range of clinical services across inpatient, community and other provider organisations this can lead to both a degree of confusion as to who is responsible for the reporting and investigating of a patient’s death and the risk of double reporting and investigation.

To support staff in their decision making, staff should refer to the flowchart in Appendix D which follows the principles below. They must consider any involvement of Trust teams outside of their own. However if there is any doubt staff should contact their line manager for advice.

**Core reporting principles:**

***A) The Trust is deemed the main provider of care, if at the time of death the patient was subject to:***

1. An episode of inpatient care within our service.
2. An episode of community treatment under CPA.
3. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
4. A Community Treatment Order.
5. A conditional discharge.
6. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
7. Guardianship
8. Deprivation of Liberties legislation (DOLS)
9. Patient discharged from SWYPFT inpatient bed in the 30 days prior to death.

***B) Patients who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.***

In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also offer condolences and exercise the responsibilities under being open and duty of candour if required.

However there will be a discussion to agree on if it is to be a joint or single agency review or investigation (this will be determined by the cause of death) and in the case of joint reviews/investigations who the lead organisation will be.

The Trust should still ensure the death is reported, to ensure we can review the care and treatment the Trust provided. In most cases, the certification and/or Manager’s 48 hour review will be sufficient to identify any local learning. Where there has been a long standing relationship with family members, condolences and support should be offered by the relevant staff.

***C) Services provided by the Trust where we are not classed as the main provider.***

The Trust is not usually classed as the main provider of care for a small number of teams. These teams usually provide a small component of an overarching package of care and the lead provider is usually the patients GP. For these teams, they should only report deaths where there are concerns regarding the care provided (see Appendix D). If, on review of the clinical records, it is identified that the deceased was on the caseload/waiting list of any of the listed teams but this was the incorrect pathway, the death should be reported so a review can take place.

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| **List C** |  |
| * Dietetics * The drug and alcohol shared care services * Care home liaison * Acute hospital liaison * Memory monitoring * Recovery college deaths * Support services, e.g. housing * Rapid Access | * Tissue viability * District Nursing * Community physiotherapy * Macmillan Nurses * Podiatry * Health and wellbeing * Tele-health * Long term conditions * End of life team * Primary care prevention services * 0-19 service |

***D) Exception.***

In addition to the above, if any act or omission on the part of a member of Trust staff where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, an investigation will be undertaken by the Trust. These MUST be reported on Datix.

**National guidance**

The above core principles are underpinned by the National Quality Board guidance[[10]](#footnote-11) which sets out certain types of death that must always be reported. These include:

* all in-patient, out-patient and community patient deaths of those with learning disabilities (this is through the LeDeR programme)
* deaths meeting the criteria within the Serious Incident Framework
* child (under 18) death reviews should be undertaken in accordance with national guidance, Working Together to Safeguard Children.
* maternity/perinatal deaths
* any death of a patient detained under the Mental Health Act is reported to the Care Quality Commission without delay
* 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
* 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;

In addition, the Northern Mental Health alliance has identified a number of potential triggers in a mental health setting for a Review / Investigation. These include deaths:

1. Patient deaths of people with severe mental illness (SMI)\*
2. Where medication with known risks such as Clozapine was a significant part of the treatment regime;
3. From causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data);
4. Where they had been subjected to a care intervention where death wouldn’t have been an expected outcome e.g. ECT, rapid tranquilisation;
5. Where the service user had no active family or friends and so were particularly isolated e.g. with no one independent to raise concerns;
6. Where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap in services;
7. Associated with known risk factors / correlations
8. Particular causes of death e.g. epilepsy;
9. Deaths in Distress which might include: drug and alcohol deaths, or deaths of people with an historic sex offence e.g. people who might not be in crisis but need support and from whose experience there may be learning from a thematic review;
10. Where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn’t responded to in a timely manner;
11. 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 - When identifying the numbers for sampling the Trust needs to consider that services such as Community Specialist Palliative Care Service already review and record significant data that is subject to analysis. They also provide minimum data sets for palliative care for the national council for palliative care.

**Severe Mental Illness\***

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

Further national guidance is expected to clarify expectations about mortality review in mental health and community services in the future however in the meantime, Trusts have been asked to use the above description of SMI.

These will be subject to a review of the case at the risk panel or Mortality review group and a decision made on an individual basis as to whether and what type of review is required.

***E) Additional reporting requirements***

There are occasions when the Trust is notified of the death of a former service user who was discharged from the Trust more than 6 months prior to their death. This is usually in the form of a request for information from HM Coroner because they require statements regarding the care we provided or where there are other legal processes. This contact could be made direct to teams or via the Trust’s Legal services team. In these cases, an incident should be recorded on Datix stating the nature of the request and detailing the length of time since discharge. The incident is required so that Legal services can use this record to manage the requested information. No Manager’s 48 hour review will be required.

**Liaison with other organisations**

Where problems are identified relating to other NHS Trusts or organisations, the Trust 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:

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

If the Trust receives 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 review the care provided on the clinical records in the first instance to establish our involvement. Information will be shared with partners if the death is outside the Trust’s scope. Where the death meets our reporting criteria the manager will ensure the death is reported on Datix and the normal process followed.

# Identifying and Reporting Deaths

**7.1 Identifying Deaths**

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration systems (PAS) and on its Datix system where the death requires reporting. This is to help ensure that the Trust Board has a comprehensive picture of the deaths of all its services users and the opportunities to learn from them.

The Trust’s Performance and Information team has also developed ways to triangulate deaths across Trust systems and link in information from some local registration of deaths services.

Where deaths are identified through enquiries from the coroner, teams should report the death on Datix.

The Trust will be informed of a service user’s death in a variety of ways. This could be by contacting to arrange an appointment or attending a planned visit, family contacting staff to inform them of the death, coroner’s requests, other care providers, through the clinical information system.

When the Trust becomes aware of a death, the **clinical team** should use the flowchart set out in Appendix D to ensure the process is followed when a death occurs. This initially includes contacting the family, and reviewing the clinical records. Appendix D helps teams identify which deaths should be reported on Datix.

**7.2 Responding to Deaths**

The first step that must happen in identifying a death is contacting the relevant family members to offer condolences. The team should agree who is the most appropriate person, ideally someone who has had previous contact. They should offer support to the family, and where possible, enquire about the circumstances and cause of death. They should be given the opportunity to raise any questions they may have about the care their family member received.

Attempts should be made to obtain further information from other providers, e.g. GP if information is limited.

The manager or deputy should be informed of the death as soon as possible.

The manager or deputy, should always review the care (minimum 6 months, and not limited to that team’s care) on the clinical information system to understand if the care provided was in line with what would be expected against clinical standards, policies and procedures.

**7.3 Reporting Deaths**

For some teams providing care, a death of a service user will always be reportable as an incident on Datix. The flowchart in Appendix D helps staff to identify which incidents should be reported. If a team is not usually a main provider of care, they would not routinely report deaths on Datix (see section 6). However if there were concerns raised by the family, management or governance, the death would be reportable so that review can take place. Staff should follow the guidance in Appendix D.

If the death is reportable the death should be reported on Datix within 24 hours of being informed. If there any doubts about whether a death should be reported or not, it should be reported so it can be considered.

Staff should provide details of the circumstances and cause of death where known. Where there has been an inpatient death, the recording should include certified cause of death or state whether this has been referred to the Coroner and why.

Information on the communication with the family should be recorded, including a summary of the conversation, the offer of condolences, who was contacted, when, any information about cause of death. If contact cannot be made with family members, this should also be recorded.

|  |  |
| --- | --- |
| C:\Users\flintoffj\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\XJK2M0E3\MC900434750[1].png | All deaths where we are the main provider of care or there are concerns from family, clinical staff or through governance processes, that staff are made aware of must be reported through the Datix system to start the process of learning from patient deaths. The Manager’s 48 hour review of care must be completed including any immediate action taken. |

**7.4 The decision to investigate or review**

All deaths reported on Datix are reviewed by the Patient Safety Support Team on a regular basis. A [flowchart](https://swyt.sharepoint.coms/sites/Intranet/learning-from-deaths/Pages/Reporting-deaths.aspx) has been developed to illustrate the mortality review process and categories of death which supports whether a review or investigation takes place. The [flowchart](https://swyt.sharepoint.coms/sites/Intranet/learning-from-deaths/Pages/Reporting-deaths.aspx) is available on the intranet and the Trust website.

To ensure there is consistency in recording, a number of categories have

been developed, used across the Northern Alliance. These have been added to Datix and the [flowchart](https://swyt.sharepoint.coms/sites/Intranet/learning-from-deaths/Pages/Reporting-deaths.aspx). The manager will record this when reviewing the death, being confirmed by patient safety support team from information given:

* Expected natural (EN1) – e.g. Terminal illness
* Expected natural (EN2) –e.g. cancer, expected but not in timescale
* Expected unnatural (EU) –e.g. death expected but not cause e.g. drug and alcohol
* Unexpected natural (UN1) –e.g. cardiac arrest, stroke, road traffic accident
* Unexpected natural (UN2) –e.g. alcohol dependency but care concerns
* Unexpected unnatural (UU) - e.g. suicide, homicide, abuse, neglect

The **patient safety support team** will prompt teams to ensure full and accurate information is recorded if this has not been already completed. The team will consider if the death meets the criteria for a serious incident. A death meeting the SI criteria will be reported as a serious incident and an investigation commissioned in line with the Trust’s Incident reporting and management (including serious incidents) policy.

The Patient safety support team will determine if the case is in scope or out of scope for the Trust mortality review process and to indicate the proposed level of scrutiny.

If this requires further discussion it is taken to the weekly risk panel that involves medical and nursing directors to make a final decision or agree next steps. In some cases, deaths may be reviewed for decision making in the mortality review group.

# Review methodology

Practice varies across Trusts in the northern alliance with regard to how deaths are reported and categorised.

Each Trust has core processes around:

* An initial screen of each death e.g. at a weekly Mortality review group, at a Huddle which will always necessitate the collection of core data around the service user and his or her death and sometimes the use of a structured tool;
* A way of making a judgement about which deaths are subject to further review which might be explicit and transparent against a set of criteria or sometimes more reliant on individual and clinical judgement;
* A way of deciding the level of further review; however this is described e.g. local review, clinical review, case record review, structured judgement review.

**Levels of Review**

The Trust has adopted the three levels of scrutiny suggested in the NQB guidance:

|  |  |  |
| --- | --- | --- |
| 1 | Death Certification | Details of the cause of death as certified by the attending doctor. |
| 2 | Case record review | Includes:  (1) Managers 48 hour review  (2) Structured Judgement Review |
| 3 | Investigation | Includes:  Service Level Investigation  Serious Incident Investigation (reported on STEIS)  Other reviews e.g. LeDeR, safeguarding. |

**8.1 Certification**

If the death has been certified by a doctor as a natural death and they have not reported the death to the coroner, no further review will usually be necessary unless the Trust is aware of any concerns expressed by family and clinical staff or through governance processes. The clinical team will normally review the case and make a note on Datix if they feel any further review may be required.

**8.2 Case Record Review**

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.

Some deaths will require further review to look at the care provided to the deceased as recorded in their case records in order to identify any learning.

The Trust has two types of case record review. The first stage case record review is the Manager’s 48 hour Review, with the second stage a Structured Judgement Review, as described below.

* + 1. **Manager’s 48 hour review**

Where a reportable death has not been certified, the Manager’s 48 hour review can be accepted as a first stage case record review.

The responsible manager records the findings of their case record review on the Manager’s 48 hour review on the Datix incident record. This aims to provide a summary of the care provided, identify if the care was provided within clinical standards, policies and procedures, identify areas of good practice and any areas for further review.

The completed Managers 48 hour review is considered (usually at risk panel) and where the review is comprehensive, there are no concerns identified and care was provided as would have been expected, this will be accepted as a first stage case record review.

* + 1. **Structured Judgement Reviews**

A Structured Judgement Review (SJR) blends a traditional clinical judgement based review with a standard format that enables reviewers to make safety and quality judgements over phases of care and which provides explicit written comments and a score for each phase. The Trust uses nationally agreed review toolkits. The first, issued by the Royal College of Physicians, has been in use in the Trust since April 2017. In November 2018, the Royal College of Psychiatrists published a toolkit focused on learning from patient deaths for NHS Mental Health Trusts. (see Structured Judgement Review in Definitions).

A SJR provides a 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. The Trust has trained a number of staff to be able to undertake these reviews.

Following a SJR being completed, it will be second reviewed, usually by a member of the mortality review panel to ensure consistency and completeness of the review. The second reviews and any recommendations are reported back into the Mortality Review Group.

* 1. **Investigations** 
     1. **Service level investigation/serious incident investigation requiring STEIS reporting**

Investigations are a review of care provided using recognised systems analysis tools. These are either undertaken at service level for a service level investigation/significant event analysis or through a central dedicated team for serious incidents. The aim of the review is for the Trust to learn and prevent recurrence.

When the family/carers wish to be involved, their preference regarding how, when and where they want to engage will be paramount and built on the principles of compassionate engagement. The findings will always be shared with the family subject to confidentiality requirements. We will always share the outcome and learning.

* + 1. **Joint investigations**

There are some instances when a joint approach is required with another organisation to investigate. The Trust has developed links with neighbouring acute Trusts to enable this to take place when needed. Either organisation can request this to take place.

* + 1. **Other investigations**

The Trust is an active member in Safeguarding Boards and should a death require investigation through the Safeguarding process the Trust will work through that process in line with serious incident framework. The manager’s 48 hour review would be completed in these cases.

* + 1. **Learning Disability Deaths**

All deaths of those with a Learning Disability diagnosis are reportable on Datix in the Trust. Each death will have the Manager’s 48 hour review completed to enable any local learning to be identified. In some cases, a Structured Judgement Review may be completed. Alongside this internal review, the Trust’s LeDeR lead managers will ensure the death is reported to the Learning Disability Mortality Review (LeDeR) programme.

# Governance process / ensuring learning

The prime objective of the Learning from Healthcare Deaths Policy is that we can improve services and the experience of those services for the people that use them.

We have worked with eight other mental health trusts and will work locally with services to develop a consistent framework around learning. This will focus on whether the activity we do under the guidance of this policy (i.e. talking to the families of those who died, the investigations, thematic reviews, the analysis of data, the review of case records including SJR) makes a difference.

How we measure the impact of the work will develop over time as the information we access improves, as we evaluate the policy overall including feedback from families.

We will all assess learning against a common framework that:

1. Identifies potential improvements;
2. Develops a shared understanding of what these improvements might be across the Trust;
3. Leads to a series of actions locally, that should be able to be measured;
4. Provides knowledge of the difference made by those actions.

We will take the opportunity to share learning with our partner Trusts and other, local stakeholders. For example, there may be common issues where we could commission thematic reviews.

The actual practice in each Trust will differ for a variety of reasons: different cultures, priorities and policies. This co-existence of cohesion and diversity will be a strength as we will have the opportunity (through our continued regional work) to share and learn from each other’s approaches and see which ones work best.

The Trust will ensure that lessons learnt result in change in organisational culture and practice by; identifying themes and trends in formal meetings and in the Quality Account; commissioning thematic reviews on a regular basis by the Mortality Review group and ensuring that associated action plans are implemented.

We will ensure learning is cascaded to frontline clinical staff on a regular basis by use of learning lessons events, learning reports and other methods being developed.

We will ensure transparency in decision making and accountability.

The Trust worked with the Northern Alliance of Trusts to develop the principles and policy. To ensure the Trust reviews the outputs from the reviews and investigations to inform quality improvements the Trust has developed a six monthly clinical mortality review group.

# Data reporting

From 1 October 2017, Trusts have been required to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings. The Trust publishes its [Learning from deaths reports](https://www.southwestyorkshire.nhs.uk/about-us/performance/learning-from-deaths/) on our website.

This report incorporates a dashboard of information. The Northern Mental Health Trusts alliance agreed the content of the dashboard to enable consistency of data presented across all the Trusts.

The dashboard will continue to develop over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths.

When counting ‘total number of deaths in scope’ and ‘total number of deaths reviewed (using the 3 levels of scrutiny on page x)’ it should be possible to see what percentage of deaths has been reviewed in a particular period. In other words, the number of deaths reviewed can be reported as a percentage of the number of deaths.

For reporting purposes, there is a natural lag with obtaining this information, therefore reporting is offset a quarter. For example Q1 data would be reported at the end of Q2.

We have developed an internal Business Intelligence Dashboard that bring together information on all known deaths from our clinical information systems and Datix. This work also includes information obtained from some local registrars.

Some Trust services such as End of Life Team provide separate reports to fulfil their own contractual requirements. These deaths are usually not in scope so would not be included in the breakdown of mortality figures. However, the figure would be included in overarching figure for all deaths obtained through our Business Intelligence Dashboard.

The Northern Alliance of Trusts has decided not to report initially on what are described in general hospital services as **“avoidable deaths”** in inpatient services.  This is because there is currently no research base for this in mental health services and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused.  We will continue to support work to develop our data and general understanding of the issues.

# Equality Impact Assessment

Equality Impact Assessment completed (see appendix A).

# Dissemination and implementation arrangements (including training)

* This policy will be disseminated on the intranet.
* A presentation will be prepared for BDUs to share on key points from the policy.
* Patient safety support team has already spent much time and resources setting up the collection of the recording deaths on Datix, this will be refined through implementation of this policy.
* Performance and information team are aware and continue to develop reports on all deaths recorded on PAS and working with local registrars.
* Customer services are aware they may have contacts from families but they do not see this as additional to what is already available.
* Serious incident investigators are within the Trust and this needs to remain.
* A number of staff have been trained in structured judgement reviews; further training will be arranged as needed to meet our needs.
* Training of staff by patient safety support team to undertake service level investigations/significant event analysis will need to continue.
* A clinical mortality review group to review and examine themes arising from reviews has been established. This will support the key messages for sharing and implementation of learning across the Trust.
* Continued review of the support requirements for the administration and coordination of learning from deaths agenda.

**12.1 Process for monitoring compliance and effectiveness**

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| --- |
| * This policy will be ratified by the Trust Board and published on the Trust’s intranet and external website. |
| * Line managers will disseminate this policy to all Trust employees through a line management briefing. This is mandated through The Brief. |
| * As and when further national guidance emerges, the Trust will review the policy and its implementation to ensure it continues to reflect best practice. |
| * The policy, procedures and processes will be audited on an annual basis by either the Quality Improvement and Assurance Team, Patient Safety Support Team or internal audit. The results of which will be considered at the Mortality Review group and/or Clinical Governance and Clinical Safety Committee. * The audit tool will be designed to capture both qualitative and quantitative data to demonstrate the lessons learned and how they have been shared and used to improve the quality of services. |

* 1. **Review and revision arrangements (including archiving)**

The policy will be reviewed as required in response to national and/or internal changes as defined on the front cover. Earlier versions of this policy will be available in the Trust’s document archive.

# References

This Policy document is to be read in conjunction with the Trust’s:

* [Incident reporting and management (including serious incidents)](https://swyt.sharepoint.com/sites/Policy-Documents/Shared%20Documents/425.docx) policy
* [Being open](https://swyt.sharepoint.com/sites/Policy-Documents/Shared%20Documents/775.docx) (incorporating Duty of Candour) policy
* [Investigating and analysing incidents, complaints and claims to learn from experience](https://swyt.sharepoint.com/sites/Policy-Documents/Shared%20Documents/776.docx) policy
* [Supporting staff involved in traumatic or stressful adverse events](https://swyt.sharepoint.com/sites/Policy-Documents/Shared%20Documents/777.docx) policy

Useful websites:

* [NHS Improvement website: Learning from deaths in the NHS](https://improvement.nhs.uk/resources/learning-deaths-nhs/)

And these national documents:

* [Care Quality Commission (CQC) (2016) Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England](https://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability)
* [National Quality Board (2017) National Guidance on Learning from Deaths](https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf)
* [NHSE Serious Incident Framework (2015): Supporting learning to prevent recurrence](https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf)
* [CQC Regulation 20: Duty of Candour (2014](http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour))
* [Working Together to Safeguard Children.](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf) (2015)
* [The Department for Education' forms for reporting child deaths](https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths)
* [National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers](https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/)
* [Royal College of Psychiatrists (2018) Care Review Tool for Mortality](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/care-review-tool-for-mental-health-trusts)
* [Royal College of Physicians (2018) Mortality toolkit: Implementing structured judgement reviews for improvement](https://www.rcplondon.ac.uk/guidelines-policy/mortality-toolkit-implementing-structured-judgement-reviews-improvement)

# Appendices

All policies should include completed versions of the following:

* Equality Impact Assessment (see appendix A);
* Checklist for the Review and Approval of Procedural Document (see appendix B);
* Version control sheet (see appendix C).

# Appendix A - Equality Impact Assessment

**Date of Assessment:** February 2020

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| --- | --- | --- | --- | --- |
|  | **Equality Impact Assessment Questions:** | | **Evidence based Answers & Actions:** | |
| **1** | **Name of the document that you are Equality Impact Assessing** | | Learning from Healthcare Deaths policy - The right thing to do | |
| **2** | **Describe the overall aim of your document and context?**  **Who will benefit from this policy/procedure/strategy?** | | The overall aim of the policy is to describe the Trust’s approach to Learning from Healthcare Deaths. The document sets out how we should ensure that patients, their families and carers feel supported when a patient dies.  Working with families/carers of patients who have died offers an invaluable source of insight to improve services. There is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. All communication with families and/or carers (verbally or written) should be in line with the [Accessible Information standards](https://swyt.sharepoint.coms/sites/Intranet/Accessible-information-standard/Pages/Accessible-information-standard-.aspx).  This assessment demonstrates that the policy will make an overall positive contribution to advancing equality in relation to Learning from Healthcare Deaths. We do not anticipate its implementation will have any negative impact on equality for people with protected characteristics. | |
| **3** | **Who is the overall lead for this assessment?** | | Director of Nursing | |
| **4** | **Who else was involved in conducting this assessment?** | | Julie Warren-Sykes (Associate Director of Nursing Quality and Professions and Emma Cox (Assistant Director of Nursing, Quality and Professions)  Helen Roberts, Patient Safety Manager  Previously developed by Julie Eskins (Assistant Director of Patient Safety) | |
| **5** | **Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?**  **What did you find out and how have you used this information?** | | The Trust worked with a northern alliance of other mental health trusts to develop this policy.  National guidance from the National Quality Board was issued in July 2018 providing guidance for NHS Trusts on working with bereaved families and carers. An assistant director within the Nursing and Quality directorate was a member of a carers and relatives involvement group for the mortality review programme facilitated by the Improvement Academy. Findings from this work was incorporated into the [National Guidance on working with bereaved families and carers](https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/).  The Trust has reviewed the national guidance and has developed support information for bereaved families in line with the guidance.  A recognised national figure ran a workshop with the northern alliance.  A discussion has taken place at a carers group in Kirklees  The Trust has also consulted with staff and families in developing policy and resources for undertaking investigations.  We have linked with one neighbouring acute Trust.  A Trust-wide Bereavement support development group has been in operation with staff from a wide range of services.  All of the key recommendations from national guidance have been added in this policy. | |
| **6** | **What equality data have you used to inform this equality impact assessment?** | | To inform this equality impact assessment the following data has been considered:  [Census 2011](https://swyt.sharepoint.coms/sites/Intranet/equality-impact-assessments/Pages/Resources.aspx) data for geographical areas  Equality monitoring data  [Apparent suicide analysis report](https://swyt.sharepoint.coms/sites/Intranet/incident-reporting/Pages/Incident-management-annual-report.aspx) – this includes data on apparent suicides and analysis of some of the protected characteristics. Annual data is reviewed and updated in reports.  Learning from Healthcare Deaths reports.  Learning Disabilities Mortality Review (LeDeR) programme reports.  Patient Safety Strategy 2019-21 Equality Impact Assessment.  This data will be reviewed regularly.  Data regarding those who have died is collected on Datix and data is available to the Mortality Review Group.  National information:  The [Five Year Forward View for Mental Health](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf) identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people.  Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities. | |
| **7** | **What does this data say?** | | The data informs us that there are significant differences in the communities that this organisation provides services to and as such this Learning from Healthcare Deaths policy needs to consider those differences.  We need understand and how information about harm can be relayed to all groups taking account of information requirements (which will be further enhanced through compliance with the Accessible Information Standard).  Culture is a huge determinant of the safety of the healthcare system. An environment where all staff feel supported and psychologically safe will be one that fosters inclusivity, with all staff confident to be open, honest and transparent when a death has occurred, ensuring families and carers are engaged with compassionately. Collectively, the initiatives to promote a patient safety culture as outlined in the Patient Safety Strategy and in this policy will have a positive impact on all staff, particularly those from BME backgrounds, and indirectly a positive impact on all patients and their families.  Data relating to a limited number of protected characteristics for individuals who have died (age, gender) is available on Datix. Other protected characteristics are not available reliably on the Datix system. This is because information on any protected characteristics of the patients or staff involved in an incident may not be immediately available to the reporter. Making its collection mandatory could act as a barrier to reporting and lead to fewer deaths being reported. We are developing how we can capture other protected characteristics at the review/investigation stage.  A new framework to review incidents (including deaths) will be introduced nationally that the Trust will adopt. This will replace the existing serious incident framework. This will bring more flexible approaches to investigation and review that may make it easier to address concerns specific to patients from minority cultural and language backgrounds, and those with disabilities. It will involve patients, families and carers more in the investigation of a death and should help them feel their concerns are being addressed. | |
| **8** | **Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:** | **Yes/No** | **Evidence based Answers & Actions. Where Negative impact has been identified please explain what action you will take to remove or mitigate this impact.** | |
| **8.1** | **Race** | **No** | We are aware that the Trust’s footprint varies greatly across the four regions.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | % average | White | Asian | Black | Mixed | Chinese & Other | | Kirklees | 79.1 | 15.7 | 1.9 | 2.3 | 0.7 | | Barnsley | 97.9 | 0.7 | 0.5 | 0.7 | 0.2 | | Calderdale | 89.6 | 7 | 0.9 | 1.3 | 0.6 | | Wakefield | 95.4 | 2.6 | 0.77 | 0.9 | 0.29 |   Also see narrative under item 7.  Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report (link above). This is updated annually.  The policy recognises theneed for compliance with the Accessible information Standards. Translation and advocacy services must be taken into account when planning to discuss a death and our review with families and carers. It notes seeking advice from an advocate or interpreter to understand the most sensitive way to discuss the information. Avoid using ‘unofficial translators’ and/or the service user’s family or friends as they may distort information by editing what is communicated. | |
| **8.2** | **Disability** | **No** | **Disability groups Day to day activities limited by disability**   |  |  |  |  | | --- | --- | --- | --- | | % average | Not at all | A little | A lot | | England % av. | 47.2 | 13.2 | 4.2 | | **Kirklees** | 45.5 | 12.5 | 13.7 | | **Barnsley** | 76.1 | 11.3 | 12.6 | | C**alderdale** | 56.5 | 12.2 | 13.8 | | **Wakefield** | 77.93 | 9.33 | 8.31 |   Also see narrative under item 7.  The policy recognises that some families and carers may have different communication needs. In these cases plans for communication should fully consider these needs. Knowing how to enable or enhance communications family members is essential to facilitating a process, focusing on the needs of individuals and their families and being personally thoughtful and respectful. All communication and information should be provided in line with [Accessible Information standards](https://swyt.sharepoint.coms/sites/Intranet/Accessible-information-standard/Pages/Accessible-information-standard-.aspx).  All deaths of those with a Learning Disability diagnosis are reportable on Datix in the Trust. Each death will have the Manager’s 48 hour review completed to enable any local learning to be identified. In some cases, a Structured Judgement Review may be completed. Alongside this internal review, lead managers will ensure the death is reported to the Learning Disability Mortality Review (LeDeR) programme.  Deaths of patients with severe mental illness conditions are reviewed on an individual basis. | |
| **8.3** | **Gender** | **No** | |  |  |  | | --- | --- | --- | | **Gender** | **Male** | **Female** | | England % av. | 49.2 | 50.8 | | **Kirklees** | 49.4 | 50.6 | | **Barnsley** | 49.1 | 50.9 | | **Calderdale** | 48.9 | 51.1 | | **Wakefield** | 49 | 51 |   Also see narrative under item 7.  Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report. (link above)  Mortality data is analysed by gender.  The consideration of special cultural needs must be taken into account when planning to discuss information. It would be worthwhile to obtain advice on the most sensitive way to discuss the information. | |
| **8.4** | **Age** | **No** | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **AGE** | **0-15** | **16-29** | **30-44** | **45-64** | **65+** | | England % av. | 18.9 | 18.6 | 20.3 | 22.4 | 16.9 | | **Kirklees** | 15.8 | 18.5 | 20.3 | 22.2 | 15.8 | | **Calderdale** | 19.6 | 16.4 | 20.1 | 24.2 | 16.6 | | **Wakefield** | 18.4 | 17.2 | 19.6 | 24.2 | 17.6 | | **Barnsley**  (2011 data) |  | 16-24 | 25-44 | 45-59 | 60+ | | % average | 18.5 | 10.8 | 26 | 20.9 | 23.8 |   Also see narrative under item 7.  Mortality data is analysed by age.  Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  It is known that people with learning disabilities can have early deaths. These are all reported and reviewed through the reported to the Learning Disability Mortality Review (LeDeR) programme. | |
| **8.5** | **Sexual Orientation** | **No** | |  |  | | --- | --- | |  | **Living in a civil partnership** | | England % av. | 0.01 | | **Kirklees** | 0.01 | | **Barnsley**  (2011 data) | 0.2 | | **Calderdale**(2011 data) | 0.3 | | **Wakefield** | 0.01 |   Also see narrative under item 7. | |
| **8.6** | **Religion or Belief –** | **No** | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | % average | **Christian** | **Buddhist** | **Hindu** | **Jewish** | **Sikh** | **Muslim** | | **Kirklees** | 67.2 | 0.2 | 0.3 | 0.1 | 0.7 | 10.1 | | **Barnsley** | 59.4 | 0.5 | 1.5 | 0.5 | 0.8 | 5 | | **Calderdale** | 60.6 | 0.3 | 0.3 | 0.1 | 0.2 | 7.8 | | **Wakefield** | 66.4 | 0.16 | 0.25 | 0.04 | 0.12 | 2.0 | |
| **8.7** | **Transgender** | **No** | As narrative under item 7. Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  You must enter a value in this field | |
| **8.8** | **Maternity & Pregnancy** | **No** | Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  As narrative under item 7. | |
| **8.9** | **Marriage & Civil partnerships** | **No** | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | **Married** | **Single** | **In a [registered] civil partnership** | **Divorced** | **Widowed** | **Separated** | | England % av. | 46.6 | 34.6 | 0.2 | 9.0 | 6.9 | 2.7 | | **Kirklees** | 48.4 | 32.4 | 0.2 | 9.3 | 6.8 | 2.8 | | **Barnsley** | 46.6 | 34.6 | 0.2 | 9 | 6.9 | 2.7 | | **Calderdale** | 46.7 | 32.1 | 0.3 | 10.5 | 7.3 | 3.0 | | **Wakefield** | 48.2 | 30.9 | 0.18 | 10.5 | 7.5 | 2.6 |   Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  As narrative under item 7. | |
| **8.10** | **Carers\***  **Our Trust requirement\*** | **No** | Service users who died who are carers:  There are around 160,000 unpaid carers across SWYFT. This is split across SWYFT is as follows :-   * Calderdale: 21,369 * Kirklees: 43,665 * Barnsley 27,167 * Wakefield: 36,621   We do not currently hold data to identify this.  Where patients have died, families and carers will be the primary recipient of communication with the Trust. Carers should be given information about how to raise concerns if they are not satisfied with the information they have been given. Further information to support bereaved families will be provided.  As narrative under item 7.  As a Trust we will ensure:   * work to engage with bereaved families and carers by recognising their insights and experiences is vital to our learning. * their involvement focuses on inclusivity, representation, non-discrimination and empowerment. * treat bereaved families and carers as equal partners following a bereavement * be mindful of the imbalance of power represented by the finances, resources, information and knowledge available to them compared to families. * try to lessen this inequality by ensuring families are listened to. use plain, understandable language to engage families. * provide information on how to apply for access to medical and other records. * have a clear policy for engaging with bereaved families and carers. * welcome questions or sharing concerns about the quality of care their loved one received.   Staff must report any death on Datix if there are any concerns raised by family, clinical staff or through governance process  When the family/carers wish to be involved, their preference regarding how, when and where they want to engage will be paramount and built on the principles of compassionate engagement. The findings will always be shared with the family subject to confidentiality requirements. We will always share the outcome and learning.  Communication with families and carers should be in line with need and the [Accessible Information standards](http://nww.swyt.nhs.uk/Accessible-information-standard/Pages/Accessible-information-standard-.aspx). | |
| **9** | **What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-** | | Monitoring the compliance with this policy is through the Mortality Review Group which reports to Clinical Governance and Clinical Safety Committee.  Other methods of capturing protected characteristics of those who have died will be explored. | |
| **9a** | **Promotes equality of opportunity for people who share the above protected characteristics;** | | This policy covers all reported healthcare deaths and each death is reviewed consistently, irrespective of characteristics. | |
| **9b** | **Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;** | | This policy does not condone any actions that would be perceived to be considered as discriminatory, harassing or bullying. The trust is committed to the values and vision as described within the introduction section of this policy. | |
| **9c** | **Promotes good relations between different equality groups;** | | All equality groups will be reviewed to the same standard. | |
| **9d** | **Public Sector Equality Duty – “Due Regard”** | | We are confident that the Trust healthcare deaths policy approach contributes to the effectivePublic Sector Equality Duty – “Due Regard” | |
| **10** | **Have you developed an Action Plan arising from this assessment?** | | **No** | |
| **11** | **Assessment/Action Plan approved by** | |  | |
|  | **(Director Lead)** | | **Sign: Mike Doyle Date: 17/2/2020**  **Title: Deputy Director of Nursing, Quality and Professions** | |
| **12** | ***Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Inclusion Team:***  [**inclusion@swyt.nhs.uk**](mailto:inclusion@swyt.nhs.uk)  **Please note that the EIA is a public document and will be published on the web.**  **Failing to complete an EIA could expose the Trust to future legal challenge.** | |  | |

# Appendix B - Checklist for the Review and Approval of Procedural Document

*To be completed and attached to any policy document when submitted to EMT for consideration and approval.*

|  | **Title of document being reviewed:** | **Yes/No/ Unsure** | **Comments** |
| --- | --- | --- | --- |
| **1.** | **Title** |  |  |
|  | Is the title clear and unambiguous? | Yes |  |
|  | Is it clear whether the document is a guideline, policy, protocol or standard? | Yes |  |
|  | Is it clear in the introduction whether this document replaces or supersedes a previous document? | Yes |  |
| **2.** | **Rationale** |  |  |
|  | Are reasons for development of the document stated? | Yes |  |
| **3.** | **Development Process** |  |  |
|  | Is the method described in brief? | Yes |  |
|  | Are people involved in the development identified? | Yes |  |
|  | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | Yes |  |
|  | Is there evidence of consultation with stakeholders and users? | Yes |  |
| **4.** | **Content** |  |  |
|  | Is the objective of the document clear? | Yes |  |
|  | Is the target population clear and unambiguous? | Yes |  |
|  | Are the intended outcomes described? | Yes |  |
|  | Are the statements clear and unambiguous? | Yes |  |
| **5.** | **Evidence Base** |  |  |
|  | Is the type of evidence to support the document identified explicitly? | Yes |  |
|  | Are key references cited? | Yes |  |
|  | Are the references cited in full? | Yes |  |
|  | Are supporting documents referenced? | Yes |  |
| **6.** | **Approval** |  |  |
|  | Does the document identify which committee/group will approve it? | Yes |  |
|  | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | N/a |  |
| **7.** | **Dissemination and Implementation** |  |  |
|  | Is there an outline/plan to identify how this will be done? | Yes |  |
|  | Does the plan include the necessary training/support to ensure compliance? | Yes |  |
| **8.** | **Document Control** |  |  |
|  | Does the document identify where it will be held? | Yes |  |
|  | Have archiving arrangements for superseded documents been addressed? | Yes |  |
| **9.** | **Process to Monitor Compliance and Effectiveness** |  |  |
|  | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | Yes |  |
|  | Is there a plan to review or audit compliance with the document? | Yes |  |
| **10.** | **Review Date** |  |  |
|  | Is the review date identified? | Yes |  |
|  | Is the frequency of review identified? If so is it acceptable? | Yes |  |
| **11.** | **Overall Responsibility for the Document** |  |  |
|  | Is it clear who will be responsible implementation and review of the document? | Yes |  |

# Appendix C - Version Control Sheet

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date** | **Author** | **Status** | **Comment / changes** |
| Draft 1 | Sept 2017 | J.Eskins /H.Roberts | Draft | For consultation with CGCSC, EMT |
| Draft 2 | Sept 2017 | J.Eskins /H.Roberts | Draft | Updated minimally from consultation ready for Trust Board |
| Draft 3 | Sept 2017 | J.Eskins /H.Roberts | Draft | Updated following Trust Board review of papers |
| Version 1 | Oct 2017 | J.Eskins /H.Roberts | archived | Approved by Trust Board |
| Version 2 | January 2019 | H Roberts/E Cox | current | Changes throughout to reflect development of processes  Updated flowcharts  Updated references  Additional definitions  Terminology updated  Links to new guidance |
| Version 3 | March 2020 | H Roberts | Current | Additional clarity regarding reporting deaths of former service users  Added Significant Event Analysis as additional review method  Reviewed and updated Equality Impact Assessment |
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# Appendix D - Death reporting requirements flowchart

To be read in conjunction with Learning from healthcare deaths policy, Being Open Policy, Investigating and the Analysing incidents, complaints and claims to learn from experience policy

The death of a service user is identified

**Initial review of care provided**

**Being Open and support for the bereaved**

Manager reviews clinical records to identify any concerns regarding care of the Trust (minimum 6 month period)

Ensure that the whole care experience is looked at, not just the individual team

Contact the Next of Kin/ family to offer condolences.

Seek any further information regarding the circumstances of death as appropriate

Enquire if there are any questions regarding the care provided by SWYPFT

Offer support, signposting as appropriate

Offer contact details in case of further questions

Follow up in writing with Bereaved families leaflet

**Are there any concerns related to SWYPFT care raised by family, clinicians or governance?**

This may include any act or omission on the part of a member of Trust staff where it is felt to have in any way contributed to the death of a patient

Record the contact/s, conversation and information gathered from the conversation/s with the family/carers in the clinical record.

No

Yes

**Mortality review processes commences**

Consideration of joint review where death occurred in another provider setting

**Report the death on Datixweb**

Record the outcome as death, and complete the Death of a service user questions.

Manager records findings of review of clinical records on Manager’s 48 hour review on Datix record.

# Appendix E - Review and Investigation levels and family involvement flowchart

Yes

***At the time of death, was the deceased person subject to any of the following?***

* A current inpatient in a SWYPFT ward/unit OR an inpatient in a SWYPFT ward/unit within the last 30 days
* Receiving care under Care Programme Approach (CPA)
* Under a Community Treatment Order (CTO)
* A Conditional Discharge
* Guardianship Order
* Receiving community treatment due to identified mental health, learning disability or substance misuse needs
* An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).

1. If Yes to above, the Trust is deemed a main provider of care.
2. Death in another provider setting, report on Datix so Trust care can be reviewed. Joint review may be beneficial.
3. Some teams are not usually a main provider, see list C in section 6
4. Exceptions that should be reported – eg all Learning disability deaths, child deaths - see full list from National guidance in Section 6 of the policy (page 16)
5. Discharged service user (6+ months) where HM Coroner or other legal process has requested information (record details of request and discharge dates in incident). \*Grade green. Managers 48 hour review not usually required.

No

**No further action**

No requirement to report the death on Datix.

\*Deaths reported for legal processes, no 48 hour review or further action required

Death reported, additional 48 hour information collated and reviewed\*

Ensure Initial Being Open conversation with family/carer has taken place and followed up in writing (see Appendix D and Being Open policy)

Death certified. Not usually any further review. However could go through a review process if concerns raised

Decision on level of review made (patient safety/ risk panel / mortality review group).

LEVEL OF REVIEW

LEVEL OF REVIEW

Service Level Investigation or Team Significant Event Analysis

Serious Incident Investigation

Manager’s 48 hour review

Structured Judgement Review

Other Review process e.g. LeDeR, Safeguarding

SI investigator writes to the family to explain their role and investigation process. SI process leaflet sent. Offers to meet to discuss any questions.

Help is at hand booklet given, face to face or posted

Ongoing family support from identified person

Ongoing family support from identified person

Ongoing family support from identified person

Manager contacts family/carer to update that care has been reviewed and shares any learning. Provide contact details in case of future queries.

Manager contacts the family/carer to explain their relative’s case has been selected for review.

Ask if any questions to consider in the review

Help is at hand booklet can be provided if relevant to circumstances, face to face or posted

Explain when contact will be made regarding the review process.

Follow up in writing, with bereavement booklet with more details regarding next steps

Investigation or Review process

On completion of the review/investigation, the manager contacts the family and offers feedback on the review/investigation process.

On completion of investigation, Investigator contacts the family and offers supported reading face to face where possible

Update Datix Being Open/Duty of Candour section.

1. National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers [↑](#footnote-ref-2)
2. Care Quality Commission (2016) Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England [↑](#footnote-ref-3)
3. National Quality Board (2017) National Guidance on Learning from Deaths [↑](#footnote-ref-4)
4. National Quality Board (2017) National Guidance on Learning from Deaths [↑](#footnote-ref-5)
5. In line with the National Quality Board - National Guidance on Learning from Deaths [↑](#footnote-ref-6)
6. Royal College of Physicians (2018) Mortality toolkit: Implementing structured judgement reviews for improvement [↑](#footnote-ref-7)
7. Royal College of Psychiatrists (2018) Care Review Tool for Mortality [↑](#footnote-ref-8)
8. National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers [↑](#footnote-ref-9)
9. National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers [↑](#footnote-ref-10)
10. National Quality Board (2017) Learning from Deaths guidance [↑](#footnote-ref-11)