Policy Document Control Sheet

County Durham and Darlington NHS Foundation Trust

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	Trust-wide Guideline		Local Guideline			
Originating Directorate Or Care Group	Corporate					
Department	Medical					
Name of Document Author	Lisa Ward					
Name of Document Owner	Lisa Ward					
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Executive Sponsor's Signature	
Name & Job title of Executive Sponsor	Mr Jeremy Cundall, Executive
Master copy held at:	Corporate Records Office, Trust Headquarters, Darlington Memorial Hospital

Previously known as Responding to Deaths

Version Control Table

Date Ratified	Version Number	Status
21/8/17	1.0	Superseded
22/10/2019	1.1	Approved

Table of Revisions

Date	Section	Revision	Author
3/7/2017	Whole Policy	Full	L Ward
17/7/19	Amendments to reflect process changes		L Ward
Sept 2019		Clinical Effectiveness Committee requested name of policy changed from Responding to Deaths to Learning from Death's Policy	Clinical Effectiveness Committee

This Policy/Procedure/Guideline has been reviewed and updated to comply with the EU General Data Protection Regulations and Data Protection Act 2018.

Contents

1 Introduction

The National Quality Board published National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. The First Edition was released in March 2017. One of the regulations set out in the National Guidance on Learning from Death (Chapter 1 sections 6, 12 and Annex C – Responding to Deaths) states that "Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under their management and care." This policy closely follows the detailed guidance set out in Annex C of the National Guidance. NHS Improvement and the Care Quality Commission stipulate that the Responding to Deaths Policy should be approved and in place in Trusts by September 2017.

2 Purpose

The purpose of the Responding to Deaths Policy is to describe the process by which all deaths in care are identified, reported and investigated. It aims to strengthen arrangements, where appropriate, to ensure learning is shared and acted upon. It seeks to ensure the Trust engages meaningfully and compassionately with bereaved families and carers and supports staff to find all opportunities to improve the care the NHS offers by learning from deaths.

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

3 Scope

This policy covers the process for reviewing and learning from deaths. This policy will be updated as required in the light of changes to national and / or international guidance and practice or for trust specific changes.

This policy/procedure also applies to persons who, although not employed by The Trust, have authorised access to the Internet through the computers owned or managed by The Trust. This includes staff working for any affiliated organisations and includes County Durham and Darlington NHS Services (CDD NHS Services

4 Definitions

Death certification: The process of certifying, recording the cause of death and registering death. The process includes identifying cases for referral to the Coroner, either as a result of statutory requirement, or concerns have been identified regarding the care provided.

Case record review: The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn

from what happened, or indeed areas of good practice to be shared across the Trust. The review should use a recognized methodology for example Structured Judgement Review delivered by the Royal College of Physicians or the PRISM methodology.

Investigation: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events. The Serious Incident Policy details the process of investigation, including the different levels of investigations required in specific circumstances

Duty of Candour: Health and Social Care Act 2008 Regulation 20. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

5 Duties

Chief Executive	Overall responsibility for the implementation of this policy.
Non-Executive Director	The National Learning from Deaths Policy indicates that; 'Non-executive directors have a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that: The processes their organisation have in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support; Quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; The information the provider publishes is a fair and accurate reflection of its achievements and challenges. In line with this, the Trust have appointed Mr M Bretherick as the non-executive director mortality lead, who working with the Executive Medical Director, and Executive Director of Nursing will ensure that the above requirements are met.
Executive Medical Director	To be the Executive lead for Learning from deaths; to take responsibility for the Responding to Deaths policy; to publish, through a quarterly paper to the public Board meeting, estimates of the number of avoidable deaths; to ensure that from June 2018 the annual Quality Account summarises the data published by the Board, including learning and action as a result of this information and an assessment of the impact of actions that the Trust has taken.

	To ensure all doctors are supported to fulfil their duty to engage in responding to deaths; working with Care Group Directors to identify specific doctors to be involved in case record reviews and investigations and to meet the requirements of Duty of Candour legislation.
Director of Nursing	To ensure all nurses and midwives are supported to fulfil their duty to engage in responding to deaths; to identify specific nurses and midwives to be involved in case record reviews and investigations and to meet the requirements of Duty of Candour legislation.
Director of Finance	To ensure adequate resources are made available to enact the Responding to Deaths policy and other requirements such as set out in the Quality Account regulations.
Executive Medical Director and Executive Director of Nursing	To ensure policies make it clear that clinical staff have a duty to engage in learning from deaths, to contribute to case record review and investigations when required and to fulfil Duty of Candour requirements.
Care Group Directors, Clinical Directors and Clinical Leads	To ensure all doctors in their care group are supported to fulfil their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.
Mortality Lead	To co-ordinate the mortality review and learning from deaths process within CDDFT.
Medical Speciality Governance Leads	To receive information relevant to their speciality area; co-ordinating dissemination and discussion and ensuring that lessons are learnt where appropriate. To co-ordinate the development of actions plans to reduce future risk and providing assurance of action to the Care Group Governance Leads.
Learning Disablities Lead Nurse	To ensure that the cases of any patients who die within the Trust with Learning Disabilities have a Mortality Review.
Bereavement Officers	To ensure that any concerns from the family regarding the Quality of Care received by the deceased to be escalated to the Mortality Lead to ensure a mortality review is completed.
Learning and Development	Leading on the training needs analysis (TNA) and mandatory training policy. Training will be made available to those staff participating in case record review – this will be undertaken by the mortality lead and wider mortality group
All Staff	To recognize their duty to engage in responding to deaths; to be involved in case record reviews and investigations as required and to meet the Duty of Candour requirements.

6 Responding to deaths in care

6.1 Certification and registration of a death

When a death occurs the Consultant responsible for care has a duty to decide whether the coroner needs to be informed and to oversee the process of completing the death certificate, including the recording of the cause of death. The medical certificate of cause of death should be completed within 24 hours for all deaths as circumstances allow.

6.2 Bereaved Families

A high standard of bereavement support is provided to families via the specialist bereavement services. The family will beinformed as part of this support of their right to raise concerns about quality of care provided to their relative. Carers and relatives will be informed that the Trust reviews a proportion of it's deaths; that this does not mean that a there has been a problem in care, and is a mechanism to ensure the Trust continuously review the care provided to ensure this is of a high quality, and share best practice where identified. However if a significant problem is identified that was not known about at the time of death that they can chose to be informed about this. Any family concerns, and preferences about how much they would like to be involved in future, will be recorded by the team to whom the family can raise a concern on a standardised proforma and passed to the mortality team. The Mortality lead will ensure the case notes are referred to the Mortality Review team for a case record review (see Appendix B)

6.3 Case record review

An in-depth review of the notes will be carried out by the reviewers, either in their own care group or within the centralised mortality review team when:

- Any concerns have been raised by the bereaved family
- Any concerns have been raised by staff involved in the patients care.
- Any death where a serious incident was reported during the patients stay (see section on investigations below).
- A death occurs within 30 days of a procedure in theatres
- A patient has a Learning Disability (in-line with the national LeDeR process).
- A patient has a severe mental illness
- Deaths occur in patients aged between the ages of 18 and 50.
- Deaths occur following a 2222 Cardiac Arrest Call
- Any mortality alert from Care Quality Commission, via benchmarking systems including the HED system (for SHMI and HSMR) or the CRAB Clinical Informatics system.

Details of the patients who require a review will be provided to the identified body of staff responsible for mortality reviews by email or made available at the weekly mortality review group.

Maternal and neonatal deaths are reviewed in a robust process detailed elsewhere, as are deaths in children and young people.

6.4 The Trust Mortality Database.

The details of all mortality reviews completed will be stored on the Trusts Mortality Database; on a shared mortality drive, which is only accessible to key members

of the mortality team. Any mortality reviews carried out within care groups will be forwarded, by email, to the Mortality database administrator.

6.5 Investigations

All deaths must be cross referenced to the Trust's incident reporting system (Safeguard) to identify any death in which a serious incident was reported during the patient's hospital stay. Where an incident has been recorded, a case record review will be carried out in order to determine whether the incident was part of a problem in care that contributed to the patient's demise. Case record review is not a replacement for investigation, which includes Root Cause Analysis (RCA). A RCA includes a review of case records but goes beyond this by utilising other evidence (see definitions section) including discussions with staff.

Case record reviews may in themselves identify the need for incident reporting and subsequent investigation. In such a situation a safeguard will be raised by the mortality lead following discussion with the clinician undertaking the review and highlighted to the relevant care group governance team and Consultant.

6.6 Cross-system Reviews and Investigations

In many circumstances organisations other than the Trust are involved in the care of a patient who dies whilst in the care of the Trust, with the most common ones being primary care, ambulance services, other acute Trusts and mental health services. In the past, case record review has largely been restricted to review of records held by the Trust however it is sometimes possible to identify problems in care at earlier stages of care. Where this is the case, in the last few years, it has been possible to ask for reviews to be carried out by other organisations, however this has largely been restricted to other acute Trusts and the National Quality Board's regulations make it clear that the NHS needs to substantially strengthen arrangements. As these arrangements come into place, it is expected that Trust staff will engage with cross-system reviews and investigations as required.

6.7 Being Open/ Duty of Candour

In most cases, problems of care are known to the team managing the care of a patient at the time of their death and suitable discussions have been held with the bereaved family at the time. However case record review or investigation can identify problems that were not known about at the time and where it would be appropriate to inform families. If it is found that there is a moderate harm or above incident related to the care of the patient, then statutory Duty of Candour will apply and staff will follow due process in addition to full root cause analysis review.

6.8 Learning from deaths

The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon. It is beyond the scope of this policy to outline all the organisational and educational mechanisms that can be employed to do this. However, it is clear that case record reviews and investigations must include summaries of the lessons that need to be learnt and disseminated. The Trust will collate themes and report on action taken as a result. The reports will be provided to care group governance leads and presented at care group governance meetings. If there are any themes noted across the Trust these will also be disseminated across the Organisation.

6.9 Governance and Accountability arrangements

Board Leadership will be provided by a Non-Executive Director and the Executive Medical Director. The public section of the Trust Board will currently receive a quarterly report in relation to deaths, reviews, investigations and learning, and this will now include updates in respect to implementation of this policy in order that the executives remain aware and non-executives can provide appropriate support and challenge. Further detail will be included by virtue of the paper which includes a dashboard, as set out by the National Quality Board regulations, detailing the number of deaths for the previous quarter, the proportion reviewed and the percentage where a problem in care was identified and where reviewers judged that the death had a greater than 50/50 chance of being preventable. Patients with Learning Disabilities who die will be reported separately from other deaths and in time separate reporting for patients with severe mental illnesses will also be reported separately.

All aspects of the Trust's approach to learning from deaths will be overseen by the Mortality Reduction Committee which reports via Clinical Effectiveness Committee, to the IQAC and to the Board.

The annual Quality Account, from July 2018, will contain a section reporting how the Trust ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care.

7 Monitoring

7.1 Compliance and Effectiveness Monitoring

Compliance with this policy will be monitored as outlined in the table below.

7.2 Compliance and Effectiveness Monitoring Table

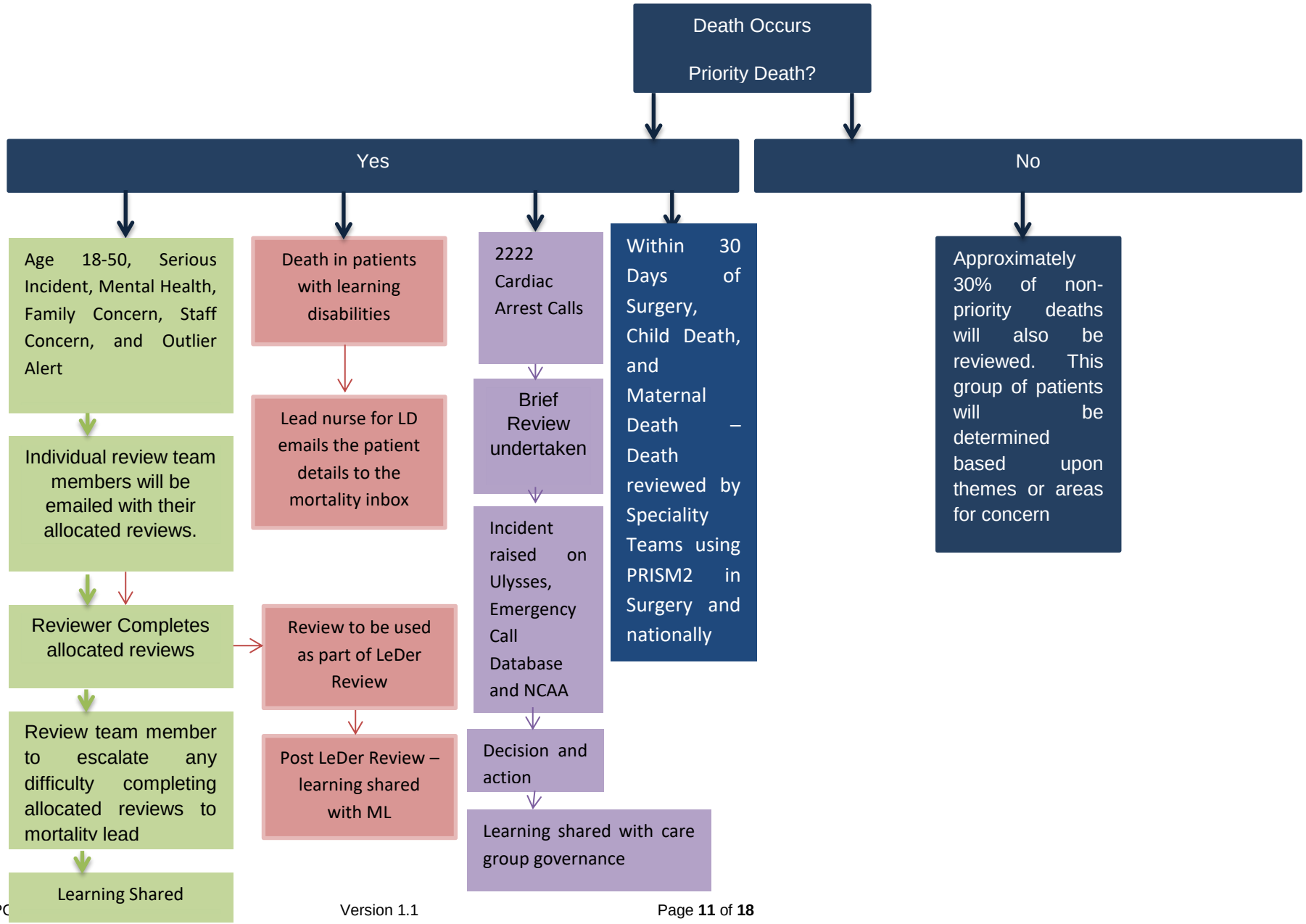
Monitoring Criterion	**Response**
Who will perform the monitoring?	Reports will be submitted by the Mortality Lead under the control of the Medical Director who will report to Mortality Reduction Committee and Trust Board. Data relating to Mortality Review will be reported to the public part of Trust board quarterly.
What are you monitoring?	Compliance with policy
When will the monitoring be performed?	Quarterly
How are you going to monitor?	On going surveillance to ensure all deaths with mandated case record reviews have completed reviews Peer review of mortality reviews with regional collegues
What will happen if any	Shortfalls will be escalated to medical governance leads, care group senior leadership teams and Mortality Reduction Committee

shortfalls are identified?	SMART Action plans will be developed and monitored
Where will the results of the monitoring be reported?	Care group Governance Teams via Care Group Medical Governance Lead will report to the Mortality Reduction Committee and the Medical Director will then report to the Trust Board.
How will the resulting action plan be progressed and monitored?	Care Group Governance Medical Leads will responsible for progressing any action plans and this will be monitored by the Trust Mortality Lead.
How will learning take place?	Trust-wide learning bulletins Key themes will be identified and included in training courses and department / ward specific targeted education Sharing with Individual Clinicians Sharing at care group governance meetings

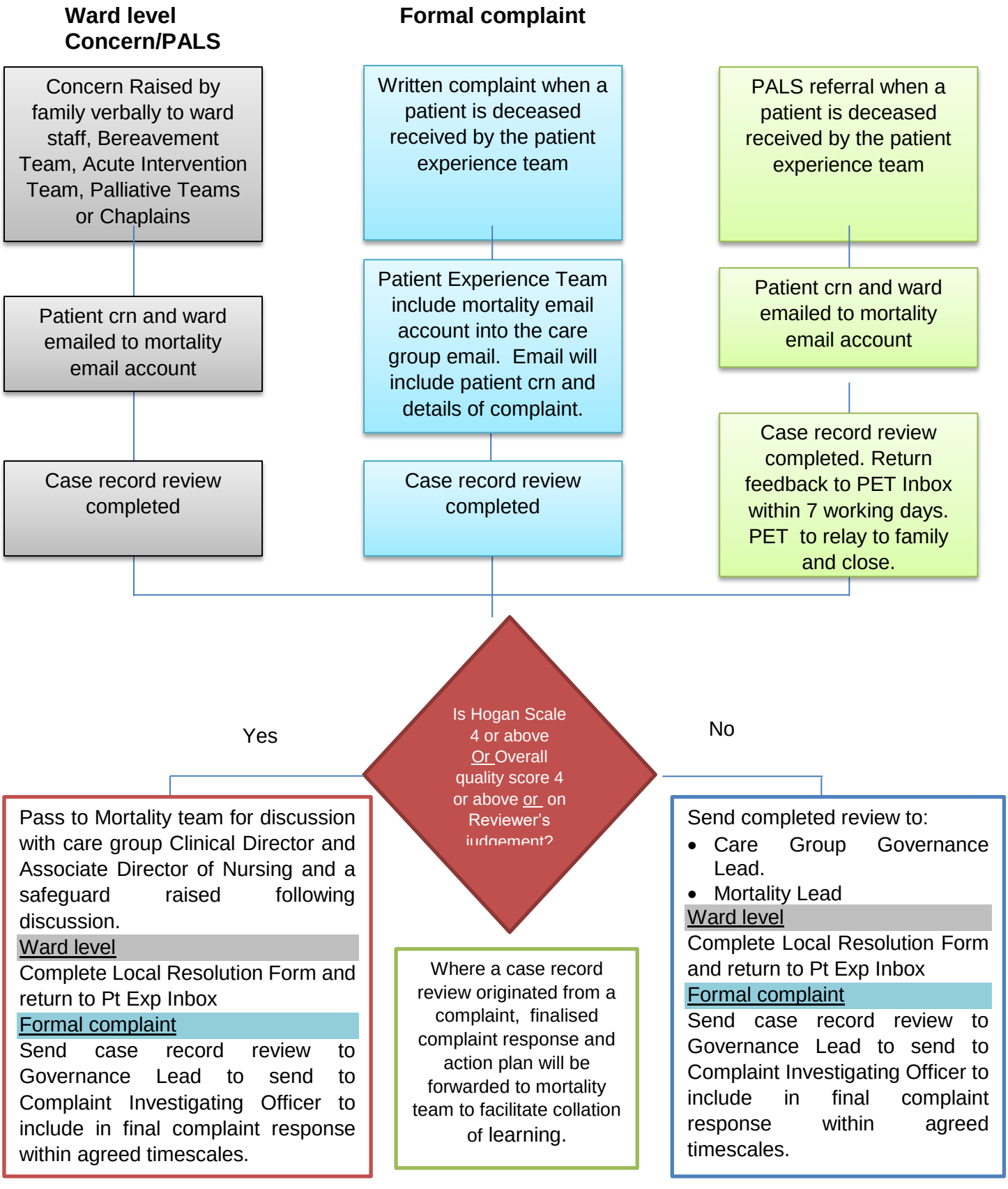
8 Appendices

Appendix A	Summary of Mortality Review Process
Appendic B	Opportunities and Process for Bereaved Relatives Raising Concerns or Complaints
Appendix C	
Appendix D	Equality Analysis / Impact Assessment

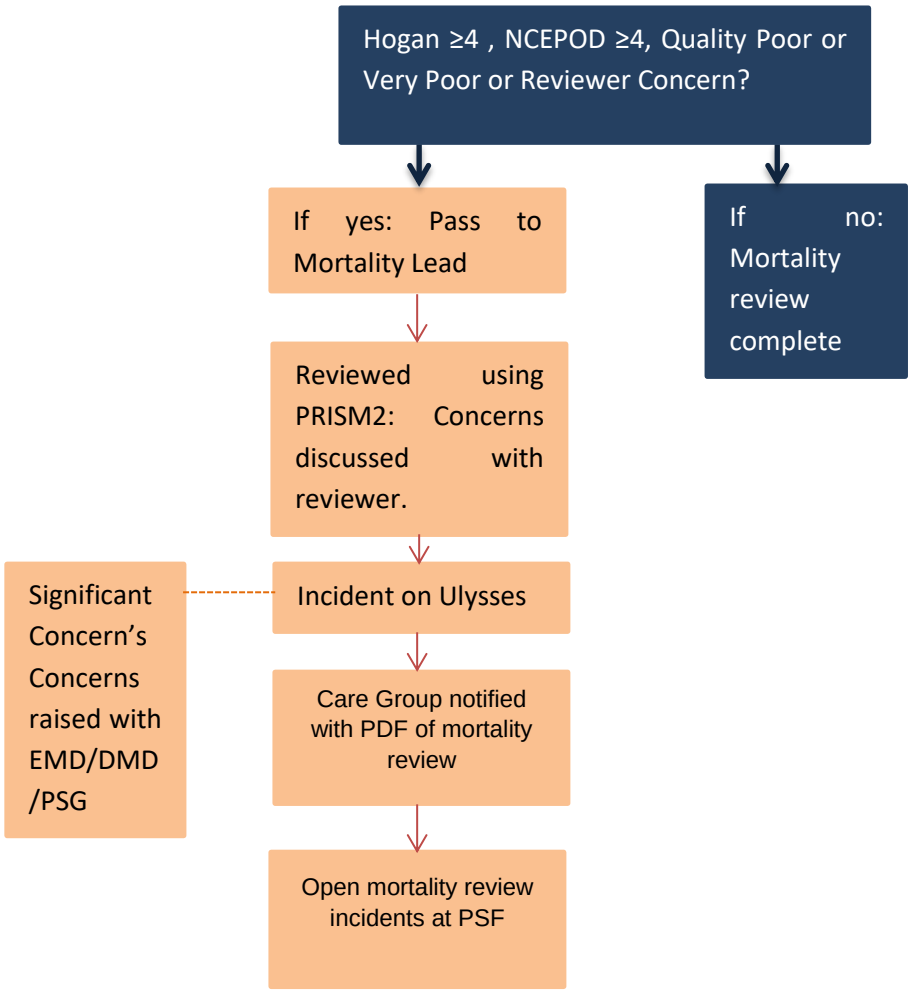
8.1 Appendix A - Summary of Mortality Review Process



8.2 Appendix B - Opportunities and Process for Bereaved Relatives Raising Concerns or Complaints



8.3 Appendix C



8.4 Equality Analysis / Impact Assessment

Division/Department:	Medical Director
Title of policy, procedure, decision, project, function or service:	Responding to Deaths Policy
Lead person responsible:	Executive Medical Director – Jeremy Cundall
People involved with completing this:	Lisa Ward, Donna Johnston

Type of policy, procedure, decision, project, function or service:

Existing	☒
New/proposed	☐
Changed	☐

Date Completed:	2nd August 2017

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

Provides policy statements and outlines process in relation to how Co Durham and Darlington NHS Foundation Trust responds to deaths.

Who is the policy, procedure, project, decision, function or service going to benefit and how?

The policy will benefit staff by having clear guidance about expectations in relation to responding to deaths.

What barriers are there to achieving these outcomes?

None

How will you put your policy, procedure, project, decision, function or service into practice?

Publication on the Trust intranet, communication on Trust bulletin and direct communication with key stakeholders.

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

Links to bereavement team, patient experience team. Not in conflict with other teams or policies.

Step 2 – Collecting your information

What existing information / data do you have?

Derived from national guidance on learning from deaths and in line with other policies in the region.

Who have you consulted with?

Associate Medical Director

What are the gaps and how do you plan to collect what is missing?

None

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

None

Sex/Gender

None

Age

None

Disability

None

Religion or Belief

None

Sexual Orientation

None

Marriage and Civil Partnership (applies to workforce issues only)

None

Pregnancy and Maternity

None

Gender Reassignment

None

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills etc.

None

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?
Yes ☐ **No** ☒

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

There is no evidence that introduction of the policy will impact staff in relation to any of the factors listed in step 3

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?