Kent and Medway
NHS and Social Care Partnership Trust

Learning from Deaths Policy

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DOCUMENT TRACKING SHEET

Learning from Deaths Policy

Version	Status	Date	Issued to/approved by	Comments
0.1	Draft	October 2017	Trust Wide Patient Safety and Mortality Group	
0.2	Draft	14 November 2017	Quality Committee	Review and approved.
1.0	Final	23 November 2017	Trust Board	Ratified.

REFERENCES

RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

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	National Quality Board, 2017
Learning, Candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England	Care Quality Commission,2016
NICE Guidance on Tackling premature Mortality (early death)	LGB25 2015
The Learning Disabilities Mortality Review (LeDeR) Programme	Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England
Management and Investigation of Serious Incidents, Incidents, Accidents and Near Misses Policy	
Learning by Experience Policy	KMPT.CorG.011
Death of an Inpatient Policy	KMPT.CliG.114

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)

CONTENTS

1 INTRODUCTION

1.1 Concern about patient safety and the scrutiny of mortality has been emphasised in recent years, following high-profile events in Mid Staffordshire, Southern Health NHS Trusts and the review of 14 hospitals with the highest mortality nationally. The Care Quality Commission's 2016 publication, 'Learning, candour and accountability' and the National Quality Board's 2017 publication, 'National Guidance on Learning from Deaths' focuses on the need to maximise learning from deaths. There is an increased drive for Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure people who use services are cared for and treated safely and effectively.

1.2 Kent and Medway NHS and Social Care Partnership Trust believes that concentrating attention on the factors that cause deaths will impact positively on all persons who use services, reducing complications, length of stay and readmission rates through improving pathways of care, reducing variability of care delivery, and early recognition and escalation of concerns.

1.3 Having a formalised retrospective review process will help the Trust to identify examples where processes can be improved and gain an understanding of the care delivered, including to those whose death is expected and inevitable, to ensure they receive optimal care. The standardised trust-wide process integrating mortality review process into the quality governance framework will provide greater levels of assurance to our Trust Board. This will help to ensure that the Trust is using mortality rates and analysis alongside other indicators such as incidents and complaints to monitor the quality of care and share good practice and learning.

2 PURPOSE

2.1 This policy provides guidance for all staff in mortality review process. The aim of the review process is to:

2.1.1 Review the quality of care delivered to persons who use our services.

2.1.2 Identify and minimise deaths where sub-optimal care has been delivered.

2.1.3 Promote organisational learning and improvement.

2.1.4 Improve the experience for people who use our services and their families through better opportunities for involvement in reviews. The role of the family liaison officer will be key in promoting people's involvement.

2.2 We will implement the requirements outlined within this policy as part of the organisations existing procedures to learn and continually improve the quality of care provided to all patients.

2.3 The policy describes how we will support people who have been bereaved by a death at the Trust, and also how those people should expect to be given information and involved in any further action taken to review and or investigate the death. It also describes how the Trust supports staff who may be affected by the death of someone in the Trust's care.

2.4 It sets out how the Trust will seek to learn from the care provided to people who die, having had contact with the Trust's services, as part of its work to continually improve the quality of care it provides to all.

2.5 This policy should be read in line with Management and Investigation of Serious Incidents, Incidents, Accidents and Near Misses Policy.

3 SCOPE

3.1 This policy applies to all staff whether they are employed by the Trust temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

3.2 **Associated Trust Policies/Procedures**

The mortality review process forms one component of the Trust's quality and safety improvement work, complementing information identified from other relevant Policies and Procedure such as:

- SI Policy
- Complaints Policy
- Learning by Experience

4 DEFINITIONS

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

4.2 **Mortality review process:** A structured judgement methodology for retrospective review following the death of a person who used services to establish whether the care of the person was appropriate, provide assurance on the quality of care, and identify learning, plans for improvement and pathway redesign where appropriate.

4.3 **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.

4.4 **Serious Incident:** Every incident is considered on a case-by-case basis. A serious incident is defined as an incident that occurred in relation to **NHS funded healthcare services and care** resulting in one of the following:

4.4.1 **Unexpected or avoidable death**: Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in Unexpected or avoidable death (Caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission) as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice) of one or more people.

This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past (This includes those in receipt of

care within the last 6 months but this is a guide and each case should be considered individually - it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously.).

4.4.2 **Serious harm;**

- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern-day slavery where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.
- This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS-funded care caused/contributed towards the incident.
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
- Property damage;
- Security breach/concern
- Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS) this needs to be reported to the CQC without delay;
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/unit closure or suspension of services); or
- Activation of Major Incident Plan (by provider, commissioner, or relevant agency).
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organization
- Absence without Leave: AWOL.

4.4.3 **Never Events:** are a sub-set of SIs and are defined as "serious, largely preventable patient safety incidents that should occur if the available preventative measures have been implemented by healthcare providers".

These incidents are serious and largely preventable such as inpatient suicide using non-collapsible rails or whilst being on 1:1 observations.

4.4.4 Serious incidents can extend beyond incidents which affect person/s' who use our services directly and include incidents which may directly impact patient safety or an organisation's ability to deliver ongoing healthcare.

5 ROLES AND RESPONSIBILITIES

5.1 **Trust Board:** has overall responsibility for Learning from deaths and monitoring mortality rates the Quality Committee will also be responsible for reviewing and monitoring the Mortality Reporting.

5.2 **Non-Executive Director (Mortality):** is the identified non-executive director for Quality and Safety has responsibility for;

- Understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny
- Assuring published information; that it fairly and accurately reflects the organisation's approach, achievements and challenges.

5.3 **Executive Director for Nursing and Quality:** is the Executive Lead for quality and safety with responsibility for ensuring that the approach to mortality review is implemented both consistently and comprehensively. In addition they are responsible for the following:

- Chairing the Trust Mortality Surveillance Group
- Identifying mortality risk
- Respond to external enquiries about mortality
- Ensure that safety initiatives supporting the findings of the reviews are implemented and improvements monitored
- Ensure the findings, analysis, outcomes and learning from mortality reviews are presented to the Board and in the annual Quality Account.

5.4 **Deputy Director Quality and Safety:** is the person with delegated responsibility for ensuring that the mortality policy is put into action. They are responsible for the following:

- Ensuring that there are appropriate governance arrangements, and adequate resources in place to deliver the mortality assurance work.
- Ensuring that all our staff receive appropriate training in order to be able to report deaths notified to them.
- Provide assurance to the mortality surveillance group, Operations, Executive and Trust Board.
- In the absence of the Executive Director for Nursing and Governance, chair the Mortality Surveillance Group.

5.5 **Executive Directors and Care Group Directors:** have responsibility for ensuring that there is Care Group representation at the relevant mortality review meetings and the Mortality Surveillance Group. They will ensure that findings/ learning from mortality reviews as relevant to their care group are embedded, shared and discussed at relevant meetings. Monitoring of identified actions will be monitored by the relevant care group meetings.

5.6 **Head of Patient Safety:** will manage the mortality work stream ensuring the day-to-day management of the process is in line with this policy. They will ensure that:

- Mortality reviews are conducted in a timely manner
- Ensure the reliability of the mortality data
- Ensure mortality review meeting run in line with the process
- Ensure the morality reviews and mortality surveillance group are run in accordance to the terms of reference
- They ensure that actions are implemented and tracked, including escalating any concerns through the TWPSRG and the relevant operational groups.

5.7 **Serious Incident and Quality Leads:** will have responsibility for ensuring that all incidents are investigated robustly. They will work closely with the Head of Patient Safety to ensure that all deaths reported via the incident reporting systems are screened and receive appropriate investigation.

They will support the development of reports showing analysis of the findings from the reviews in order to ensure there is appropriate sharing of learning across the Trust, both good practices as well as identified areas of improvement. They will ensure lessons learned are disseminated to their own care group in order to obtain the maximum benefit from the reviews.

5.8 **Mortality Assurance Coordinator:** will support the Deputy Director of Quality and Safety in ensuring the day-to-day management of the process is in line with this policy. They will ensure that:

- The mortality data is reliable
- Complete the initial mortality screening, having a discussion with the Associate Director of Risk and Safety post completion of the screening
- Mortality reviews are arranged with the relevant individuals present
- Actions are implemented and tracked, including escalating any concerns through the MSG and the relevant operational groups.
- Provide administrative support to the mortality work stream

5.9 **Mortality reviewers:** will review cases within 4 weeks of the death being notified. They will ensure that their expertise is provided during the mortality review process to ensure that any concerns in care are identified and corrective actions are taken.

5.10 **Trust wide Serious Incident and Mortality Panel** are the groups with responsibility for ensuring the mortality review process is delivered in accordance with the policy. See the terms of reference in Appendix B.

5.11 **Family Liaison Officer:** will be the lead contact for bereaved families/ carers when a serious incident or mortality review is instigated. They will ensure that any concerns or questions are addressed and that families/ carers' are involved in the investigation or review as they would like. This includes ensuring the investigation or review report is shared with the family and the 6 months post investigation of the report contact is maintained.

5.12 **All staff:** are responsible for identifying the death of persons who use our services and reporting the death via Datix.

6 MORTALITY REVIEW PROCEDURE

6.1 The process for conducting mortality reviews is outlined in the Mortality flowchart in Appendix A. Any member of staff can report a death through the Trust Datix incident reporting system, although it is preferable for this to be someone who was involved in the person's care at the time of death. Alternatively, this can be the member of staff who was informed of the death, if, for example, the person had not accessed our services for some time. All staff, particularly within the community setting, will ensure that any information they may receive on a death of a person is raised to their team management.

6.2 In order to report a death, Datix incident reporting system should be accessed as outlined below and in accordance with the Management and Investigation of Serious Incidents, Incidents, Accidents and Near Misses Policy:

All deaths are logged onto Datix even if they were not in contact with KMPT services in the last 6 months.
The person whom first knows about the death/incident is responsible for recording this on Datix

KMPT staff member is notified/becomes aware of death of person who has EVER used KMPT services. **When made aware LOG ONTO DATIX.**

THEN

Is it known which KMPT staff member/team had contact with service user?

NO → Include in initial Datix report when made aware of death.

YES

Contact team with information via telephone / email and document on Rio. Hand over Datix reference number to receiving

THEN

Receiving team to update Datix accordingly.

6.3 As shown in the flow chart, in order to report a death, Datix incident reporting system should be accessed by following the link on our intranet. All deaths meeting the criteria outlined in Appendix B must be reported. Currently, all deaths of persons who had contact with our services up to 6 months prior to the date of death are to be reported.

6.4 The Datix incident reporting form should be completed as soon as possible within the same shift. The cause of death of the person may not yet be known. The reporter will therefore be asked several addition questions when death is chosen as the incident category. If the cause of death is known, this should be included in the relevant field of the incident reporting form.

6.5 All reported incidents are reviewed on a daily basis to consider whether the incident needs to be:

- Referred to adult or children safeguarding or any other relevant experts
- Referred to Coroner to establish cause of death
- Investigated as a concise investigation or an SI

7 INITIAL MORTALITY SCREENING (IMS)

7.1 Any deaths which meet the criteria (outlined in Appendix B) for reporting onto Datix will require an initial mortality screening by the Serious Incident Lead using the Mortality Review Proforma and then discussed at the Serious Incident and Mortality Panel.

7.2 The IMS will be reviewed by a clinically-led mortality review panel meeting **within 4 weeks from when the death was notified**. Therefore, every attempt should be made to complete the IMS as quickly as possible and it must be completed prior to the mortality review panel meeting.

7.3 Deaths that meet the Serious Incident criteria must be reported and managed as per the Trust Incident Reporting Policy. The purpose of the IMS is:

- Identify any potential concerns about the care and service received by the person prior to their death.
- Identify key issues or risks that require immediate action.
- Identify any initial third party agency factors and considerations.
- Determine whether further investigation is required and whether the death meets the criteria to require a full root cause analysis and declared as a serious incident.
- Any reasons why a death may need to be potentially reported externally, including the Police. In these cases, advice should be sought from the Deputy Director Quality and Safety.

7.4 Post completion of the IMS, there will be a discussion between a clinician and the designated Care Group Director to determine whether a Formal Mortality review or a Serious Incident is required.

7.5 If during the IMS or meeting with the Care Group Director it is identified that the death meet the need for a serious incident investigation the case would be referred to the Serious Incident and Mortality Panel.

8 MORTALITY PANEL

8.1 Each completed IMS is required to be quality assured by a clinically-led mortality review panel within 4 weeks from when the death was notified to ensure that the findings and recommendations identified in the IMS are appropriate and sufficient. In particular, making recommendation as to whether to proceed to an SI investigation as per the Trust Management and Investigation of Serious Incidents, Incidents, Accidents and Near Misses Policy.

8.2 The mortality review methodology blends the traditional, opinion-based, review methods with a standard format, which requires reviewers to make safety and quality judgements over phases of care for each phase, make explicit written comments about care for each phase, and to score care for each phase.

8.3 It is the intention that the result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care. The object of the review method is to:

- Look for strengths and weaknesses in the caring process.
- Provide information about what can be learnt about Trust systems when care goes well.
- Identify points where there may be gaps, problems or difficulty in the care process.
- Actions identified as a result of a Mortality Review will be monitored by the relevant Care Group Quality Meeting, with updates against provided at Trust Wide Patient Safety and Mortality Group (TWPS&MG).
- Action plans will feed into the Quality Improvement process where appropriate and will be recorded on Datix.

8.4 After all the phases of care have been reviewed and 'judged' an overall summary judgement on whether the person who died received optimal or suboptimal care. A level of care should be graded accordingly:

- Grade 0 – No sub-optimal care
- Grade 1 – Sub-optimal care, but different care management would not have made a difference to the outcome
- Grade 2 – Sub-optimal care but different care MIGHT have affected the outcome
- Grade 3 – Sub-optimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome

8.5 The Deputy Director of Quality and Safety and the Head of Patient Safety, with the support of the designated Care Group SI Lead and clinician will identify the members of the clinical-led mortality review panel meeting and they will be responsible for completing the morality review proforma. The panel meeting can happen by remote access such as conference calling. The mortality review panel meeting will consist of:

- Deputy Director of Quality and Safety
- Deputy Director of Nursing and Practice
- Head of Patient Safety

- SI Lead (Relevant Care Group)
- Care Group Director
- Service Manager
- Lead Nursing (relevant Care Group)
- Social Worker (where relevant)
- Subject matter expert dependent on the death (safeguarding, HR, etc.)

8.6 The Mortality Group template will be used to capture the recommendations and actions and will ensure that action completion is monitored via the Prevention of Suicide and Homicide Group (PoSH.).

8.7 The completed mortality review Proforma will be presented at the Mortality Panel for scrutiny and closure.

8.8 The Mortality Review Action Plans will be monitored in line with the Incident Management Action Plans. They will be monitored by the Care Group Quality Meetings and in accordance with the Management and Investigation of Serious Incidents, Incidents, Accidents and Near Misses Policy. Identified actions will be linked where appropriate with Quality Improvement projects and processes.

9 LEARNING DISABILITY DEATHS

9.1 When the Trust is notified of the death of a person with a Learning Disability an internal Initial Mortality Screening (IMS) investigation will be undertaken to determine if the death meets criteria for a Formal Mortality Review, a Higher Learning (HLI) Investigation or a Serious Incident (SI) investigation.

9.2 The death will be registered on the LeDer Portal for the local area and a local area reviewer will be allocated to the Trust. If the Initial Screening indicates that the death does not meet either SI or HLI criteria then a Full Mortality Review will be under taken. At this point the Deputy Director of Quality and Safety will support the local LeDer Reviewer to lead the Mortality Review as per the Trust Mortality review process. The completed review will be submitted to the Kent LeDer Mortality review Programme Steering Group.

9.3 When the Trust is notified of a death that was not previously reported via Datix, for instance via the office for national statistics (ONS). The SI Lead will inform the lead clinician of the service the person was last in contact with that they have died. This includes informing any other health and/or social care professionals involved with the person who died. This information should be recorded in both the deceased person's care record and Datix.

10 COMMUNICATING WITH BEREAVED FAMILIES AND CARERS

10.1 Communicating with families and carers who have suffered bereavement should be with respect, sensitive and compassion. The principles of openness, honesty, and transparency as set out in the Trust Being Open and Duty of Candour Policy must be applied in all these dealings with bereaved families and carers.

10.2 In addition the Trust Guidance on Dealing with Bereaved Families and Carers must be followed as this will ensure effective communication within a structured approach with families and carers.

10.3 For all Learning Disability specific deaths this will be subject to our Duty of Candour approach as outlined in the Duty of Candour Policy.

11 SUPPORTING STAFF

11.1 Managers are responsible for ensuring that staff that may have been affected by the death are offered the opportunity of counselling, support or debriefing. They should be made aware of all internal and external support available as per our Supporting Staff Involved in Incidents, Complaints, Claims and Inquests Policy.

11.2 It is important for staff to be kept aware of the progress of an investigation or review with which they have had clear associations.

12 MONITORING

12.1 Implementation of recommendations and actions emerging from mortality reviews and signed off at the Mortality Group will be monitored through respective care group with assurance given to the Mortality Group, Executive Board and Trust Board. Mortality Reports will be submitted to the Executive and Trust Board monthly and quarterly.

12.2 The Head of Patient Safety will track progress of action implementation, escalating any concerns through the MSG and Operations Board.

What will be monitored	Methodology	Frequency	Lead	Reporting to	Deficiencies / gaps recommendations and actions
Initial Mortality Screen (Screening of all death notification received). Within 2 weeks following notification	Mortality Electronic System	Monthly	Mortality Team	Mortality Surveillance Group (MSG)	Serious Incident and Mortality Panel
Mortality Review Panel: Completed within 4 weeks of the death being notified	Mortality Electronic System	Monthly	Mortality Team	Mortality Surveillance Group (MSG)	Serious Incident and Mortality Panel

13 EQUALITY IMPACT ASSESSMENT

13.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

14 HUMAN RIGHTS

14.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.

15 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	***How will it be monitored***	***Frequency***	***Lead***	***Reported to***
Relevance and compliance with current legislation	Review by Trust wide Serious Incident and Mortality Panel	Annually or where legislation changes. Also, within three months of policy implementation and amend as appropriate.	Deputy Director of Quality and Safety	Trust Wide Patient Safety & Mortality Group

APPENDIX A MORTALITY REVIEW FLOW CHART

Mortality Review (Completed within 30 working days)
Manager acknowledges receipt of incident within 5 working days (if notified via Datix)
Initial mortality screening completed using Mortality review Proforma within 10 working days and discussed at the Trustwide Serious incident and Mortality Panel.
Learning Disability Specific SI Lead to update LeDer portal for all Learning Disability deaths
Completed screen discussed with the designated Service Manager to determine grade of investigation: Formal Mortality Review, No Further Review Required, concise investigation or an SI
Learning Disability Specific Allocated local area reviewer to lead on all Learning Disability death reviews.
SI Lead completes Mortality Review Proforma
Serious Incident and Mortality Panel completes analysis, findings, actions identified. Determine need for Duty of Candour
Escalate for SI investigation if criteria met
The completed Mortality Review Proforma is approved and signed off at the POSH Group
Learning Disability Specific Completed and signed off Mortality Review Proforma to be submitted to the Local LeDer Steering Group
Action plan implementation and completing is monitored via the relevant Care Group
Action plan implementation and completion assurance update provided to the TWPS&MRG

APPENDIX B OTHER RELATED INFORMATION

	Criteria
Adult Mental Health and Specialist Services	• Person who uses our services • Person who have been or had contact with the service in the last 6 months • Person dies following transfer to acute sector from Inpatient Unit
Learning Disability	• Person who uses our services • Person who have been or had contact with the service in the last 6 months • Person dies following transfer to acute sector from Inpatient Unit
Older People's Mental Health Services	• Person been discharged home from Trust Inpatient Unit in the proceeding 30 days and is still open to CMHT • Suicides or suspected suicides within 6 months of last contact (regardless of whether open referral or discharged) • Concerns raised by any individual or organisation as the circumstances surrounding death • Current open referral to safeguarding • Death referred to the Coroner • Deaths following transfer to the acute sector from an Inpatient Unit • Liaison where there has been a recent discharge from general hospital • Person dies following transfer to an acute sector from Trust Inpatient Unit.