

Responding To & Learning From Deaths Policy	
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Monitor/Finance/Performance	✓	Develop Acute services	
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Note: This document has been assessed for any equality, diversity or human rights implications			

Controlled document

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Executive Lead Signature: <i>(Applicable only to Trust Strategies & Policies)</i>	Executive Medical Director  Professor Adrian Harris

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1. INTRODUCTION

- 1.1 Concern about patient safety and scrutiny of mortality rates has intensified recently with high-profile investigations into NHS hospital failures combined with the Dr Foster report and patient safety rating for NHS Trusts. There is an increased drive for Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.
- 1.2 Effective clinical audit and peer review processes incorporating analysis of mortality and morbidity (M&M) contribute to improved patient safety. The specialty M&M meetings, established to review deaths as part of professional learning, also have the potential to help provide assurance that patients are not dying as a consequence of unsafe clinical practices.
- 1.3 Retrospective case note reviews help to identify examples where processes can be improved and gain an understanding of the care delivered to those whose death is expected and inevitable to ensure they receive optimal end of life care.
- 1.4 A formalised process will also address the Care Quality Commission's publication in December 2016 of a review into the way NHS Trusts review and investigate the deaths of patients, '[Learning, candour and accountability](#)', which builds on the need to maximise learning from deaths. (Care Quality Commission, 2016)
- 1.5 This standardised Trust-wide process integrating mortality reviews into the governance framework will provide greater levels of assurance to the Trust Board and help to ensure that the organisation is using mortality rates and indicators alongside others such as incidents and complaints to monitor the quality of care and share good practice and learning from mistakes.
- 1.6 **Failure to comply with this policy could result in disciplinary action.**

2. PURPOSE

- 2.1 The purpose of this policy seeks to apply a fair and consistent process to identifying, reporting, investigating and learning from deaths. This is in support of meeting requirements outlined in the [National Quality Board \(2017\) Guidance: National Guidance on Learning from Deaths](#). Key requirements include:
- 2.2 The requirements that NHS Trusts must implement, are described below:
 - Identification of a named executive and non-executive director to lead on identifying, reporting, investigating and learning from deaths.
 - Publication of a policy on how the Trust responds to, and learns from, deaths of patients who die under its management and care, to specifically include:
 - Processes for responding to the death of an individual with a learning disability, mental health needs, an infant or child death and a stillbirth or maternal death
 - The Trust's approach to undertaking case record reviews
 - Categories and selection of deaths in scope for case record review
 - Collection and publication on a quarterly basis of specified information on deaths through a paper and an agenda item on the public Board meeting.
- 2.3 The data collected must include:

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- Total number of deaths
 - Number subject to case record review
 - Numbers investigated in the Serious Incident Requiring Investigation Framework (SIRI)
 - Number of deaths where it is thought 'more likely than not' that problems in care contributed
 - Themes and issues identified through review and investigation
 - Changes that have been made as a result of these processes
- 2.4 Each death in care will be subject to one of three levels of scrutiny:
- Death certification (including scrutiny by the Coroner)
 - Case record review: A structured case review programme of deaths
 - SIRI Framework
- 2.5 A summary of data and learning must be presented annually in the Trust's Quality Report.
- 2.6 This policy summarises the Trust's response to this guidance with links to a number of other relevant policies, including:
- Incident Reporting, Investigating, Analysis and Learning Policy and Procedure
 - Safeguarding Vulnerable Adults Policy
 - Safeguarding Adults Policy
 - Safeguarding Children's Policy
 - Complaints Policy and Procedure
 - Risk Management Policy
 - Clinical Guideline for: The Care of Women Who Experience Stillbirth > 24/40

3. DEFINITIONS

- 3.1 **Mortality Rate** – The mortality rate (or death rate) is a measure of the number of deaths that occurred in a designated timeframe divided by the total size of the population during the same time period. It is expressed in units of deaths per 1,000 individuals.
- 3.2 **Mortality Review Process** – A structured methodology for retrospective case review following a patient's death to establish whether the clinical care the patient received was appropriate and provides assurance on the quality of care and identifies learning and opportunities for improvement or pathway redesign where appropriate. The Trust for central mortality reviews uses the Royal College of Physicians (RCP) Structured Judgment Review Process (SJR).
- 3.3 **Serious Incidents** – Adverse Events that can result in harm to the patient causing severe harm and death that require investigation under the National Incident Reporting Framework.
- 3.4 **Learning Disability** - A learning disability is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life (Mencap)

- 3.5 **Child Death Overview Panel (CDOP)** - A panel responsible for reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law.
- 3.6 **Maternal death** - Maternal death is defined as "The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes".
- 3.7 **Stillbirth**- A stillbirth is a baby born dead after 24 completed weeks of pregnancy. If the baby dies before 24 completed weeks, it is known as a miscarriage or late foetal loss.
- 3.8 **Neonatal Death** - The death of a baby within the first 28 days of life.

4. DUTIES AND RESPONSIBILITIES OF STAFF

- 4.1 The **Trust Board** is accountable for ensuring compliance with both the National Quality Board (NQB) 2016 [Guidance on Learning from Deaths](#) and the [Serious Incident Framework](#) (NHS England, 2015). The Board should work towards achieving the highest standards in mortality governance. Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Collection and publication on a quarterly basis of specified information on deaths will be received through a paper and an agenda item at the public Board meeting
- 4.2 The **Governance Committee** will, on a quarterly basis, receive specified information on deaths through a paper and an agenda item.
- 4.3 The **Safety & Risk Committee**, is responsible for the oversight, implementation, monitoring and support of the Trust's learning from deaths programme and as part of the Trust's Mortality Dashboard report will receive specified information as per the reporting schedule.
- 4.4 **The Patient Safety Mortality Review Group** is responsible for providing assurance to the Board Level Committees on patient mortality through review of the outcomes of the SJR process and review of the [Trust Mortality Dashboard](#) identifying areas for deep dive review and further scrutiny. This will include ensuring that feedback and learning points are shared with the Divisions and specialities so that learning outcomes and actions points can be monitored through to a conclusion.
- 4.5 The **Safeguarding Committee** is responsible for providing assurance for the learning from the [learning disabilities mortality review \(LeDeR\) programme](#).
- 4.6 **The Child Death Overview Panel (CDOP)** is responsible for the following:
- reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
 - collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
 - discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;

- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to the Local Children's Safeguarding Board (LSCB) or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the LSCB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required.

4.7 The **Chair of the Governance Committee** (nominated non-executive director) is responsible for ensuring progress made against the organisation's implementation of the learning from deaths programme. Specifically they are required to undertake the following:

- Gain assurance against progress with regard to the implementation and learning from death review process.
- Provide appropriate challenge and support around learning from deaths such that processes in place are robust and can withstand external scrutiny.
- Champion and support learning and quality improvement.
- Bring an independent perspective to the boardroom, scrutinising the performance of the provider's management in meeting agreed goals and objectives and monitor the reporting of performance.
- Be assured that published information is a fair and accurate reflection of the provider's learning, achievements and challenges.

4.8 The **Medical Director** is the nominated executive who is responsible for the learning from deaths agenda. Specifically the Medical Director is required to undertake the following:

- Take responsibility for effective leadership and implementation of the learning from deaths agenda in the organisation.
- Provide necessary response and challenge to the issues affecting mortality in the Trust.
- Take specific responsibility for the learning from child mortality processes.
- Ensure that learning from death reviews are delivered to a high quality, with sufficient numbers of trained staff to lead the mortality review process (including children)

4.9 The **Trust Mortality Lead** is responsible for the operational delivery of the SJR process. Specifically this will include the following:

- Ensuring that the designated number of deaths are reviewed using the SJR approach
- Supporting the central review team to complete the SJR reviews and input onto the Trust [electronic Mortality System](#)
- Ensuring patients families and carers are given an opportunity to be engaged in the review process, including providing feedback on the outcomes of reviews as appropriate
- Ensuring that outcomes and learning are recorded and action plans for improvement are developed and monitored
- Ensure findings are evaluated, triangulated and reported to the Patient Safety & Mortality Review Group and Divisional Governance Groups
- Promote organisational learning and improvement

4.10 **Divisional Directors**

Divisional Directors are responsible for:

- Sharing learning across and outside of their Division from learning from deaths.
- Providing feedback on how the learning from deaths agenda may be strengthened.
- Ensuring Divisional representation is identified in support of key mortality and learning from death groups and committees, including the Patient Safety Mortality Review Group.

4.11 **Trainee Medical Staff**

Trainee medical staff are required to support the learning from death process through the following:

- Completing the verification of deaths, coroner and mortality screening using the Trusts Mortality tool.
- Documenting verification of death has been completed in the medical notes.
- Engaging with Consultant colleagues in support of learning from the SJR and M&M processes.

- 4.12 **Governance Managers** are responsible for ensuring that ensuring that on the occasions that a second review is required that the family / carer is approached to understand the extent to which they wish to be involved in the review / investigation process and any duty of candour requirements will be fulfilled at this point.

5. **POLICY AND/OR PROCEDURAL REQUIREMENTS**

Determining which patients are considered to be under the care of the Trust and included for care record review if they die – (see flowchart in appendix 1)

5.1. **Inclusion criteria**

Please refer to Appendix 1 flow diagram for further guidance on the definition of cases that should be considered for a SJR. A SJR is not mandated as a precursor to declaring a Serious Incident. However, information and quality judgements elicited from a SJR as described as part of the second stage review process (Appendix 1) may well be useful in determining if a death should be investigated under the SI process.

5.2 **Scope**

A number of deaths mandate that a SJR is undertaken, including:

- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.
- All deaths of those patients with a learning disability.
- A proportion of deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means, for example via a statistically significantly elevated Summary Hospital-level Mortality Indicator or mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator. Reviews should include sufficient cases to support learning, rather than based on a calculated sample size.
- All deaths where the patient had a severe mental illness. In support of defining cases for review include those patients under the care of the Liaison Psychiatry Team / Mental Health Team whilst cared for at Trust.
- All maternal deaths (up to 42 days after the end of pregnancy).

- All Children (1 to 9 years) and Young People (10-19 years), regardless of whether cared for on a children's or adult ward.
- All term (+) stillbirths and neonatal deaths.
- Deaths highlighted by other organisations where that organisation suggests that the Trust should review the care provided to the patient.
- All elective deaths where the outcome of death was unexpected at the time of surgery.
- Cases where a concern during care prior to death has been identified through a mortality screening using the Trusts Mortality tool.
- In addition 20 randomly selected deaths will be reviewed per month using the SJR review process by the central mortality review team this will include deaths up to 30 days per discharge.

5.3 Deaths within 30 days post discharge

The Trust will focus reviews on in-patient deaths in line with the criteria specified by the National Quality Board. In cases highlighted to the Trust of people who had been an in-patient but die within 30 days of leaving hospital, will review these where concerns are identified. As local and national data sets mature, The Trust will develop its capability to identify patients who have died within 30 days of leaving the Trust in order to take a random sample in support of learning from deaths.

5.4 Recording the outcome of decision-making about whether or not to review or investigate a death

In cases where an associated clinical incident has been reported the decision as to whether or not to review or investigate a death should be documented in DATIX in the progress notes section and given the assignment of Mortality Review.

5.5 Management of SJR proformas

All completed SJR proformas will be completed and saved by reviewers via the electronic system. In cases where an associated incident has been raised the finalised SJR proforma must also be saved to DATIX in the documents section.

All completed SJRs that have identified poor or very poor care in the overall assessment section will undergo a second stage review. Where second stage review identifies that a case requires consideration as a potential Serious Incident this must be escalated to the Executive Lead.

5.6 SJR data analysis for internal and external learning and reporting

The Safety & Risk Team will complete a monthly return against mandated reporting and learning criteria.

The Trust Mortality Lead will collate a quarterly learning from deaths summary that meets internal and external reporting requirements, outlined in section 1.1.

6. RESPONDING TO THE DEATH OF AN ADULT WITH A LEARNING DISABILITY

6.1 The LeDeR programme

The learning disabilities mortality review (LeDeR) programme was established as a result of one of the key recommendations of the confidential inquiry into premature deaths of people with learning disabilities. The programme is run by the University of Bristol on behalf of NHS England and aims to make improvements to the quality of health and social care for people with learning disabilities.

The requirements of this programme are:

6.2 Initial review

An initial review of the death will be carried out by a trained LeDeR reviewer in consultation with the clinical team. The purpose of the initial review is to collect information to establish if there are any concerns relating to the care of the person who has died or if any further learning could be gained from a more in-depth review of the death.

6.2.1 The initial review will include inviting a person who knew the deceased well, to contribute their views, as well as a limited case note review and completion of a standard questionnaire.

6.2.2 The outcomes of all initial reviews will be routinely reported to the safeguarding committee for learning and sharing.

6.3 **In-depth or multi-agency reviews (local reviews)**

If there are any concerns identified about the death, or if it is felt that a fuller review could lead to improved practice, a more in-depth or multi-agency review will be initiated through the LeDeR process – see appendix 2.

6.4 **Priority themed reviews**

In addition to the local review process, there will be a fuller review of each death that is in a current NHS England themed priority area. These reviews will be led by panels convened by NHS England.

7. **RESPONDING TO THE DEATH OF AN INDIVIDUAL WITH MENTAL HEALTH NEEDS**

7.1 **Context**

The reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

7.1.1 Regulations require mental health providers to ensure that any death of a patient detained under the [Mental Health Act \(1983\)](#) is reported to the Care Quality Commission without delay.

7.1.2 Under the [Coroners and Justice Act 2009](#), Coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. In support of identifying cases please refer to the appendix 1 flowchart.

7.1.3 All patients with a severe mental health illness who are admitted to the Trust and subsequently die as an in-patient or within 30 days of transfer or discharge will be subject to a SJR.

7.1.4 Severe mental health illness in support of defining cases for review includes patients under the care of the Liaison Psychiatry Team / Mental Health Team whilst cared for at the Trust.

8. **RESPONDING TO AN INFANT OR CHILD DEATH**

8.1 **Reporting an infant or child death**

All infant and child deaths that occur within the Trust are reported to the child death review panel within one working day and to the children and young people's bereavement service which oversees the death certification process and referrals to

HM Coroner (all child deaths are automatically referred to HM Coroner). The staff from this team have a pivotal role in liaising with families which is part of the child death review process (described below). Through this liaison role, the staff will ask families if they have any concerns about the quality of care at the Trust. Any significant concerns relevant to the quality of care of a deceased infant or child will be notified by the children and young people's bereavement service to the Patient Safety Team.

8.2 Child death review process

The established multi-agency child death review process will be followed in all instances in line with the Children's Act 2004. Engagement with bereaved families and carers and other agencies will be in accordance with this process, which is either through the rapid response clinician in cases of unexpected deaths or, more usually, through the bereavement nurses.

- 8.2.1 The guidelines for the sudden unexpected death of an infant or adolescent/young person will also be followed. Families are given a leaflet explaining the child death review process as well as contact details for the child death overview panel (CDOP).
- 8.2.2 Any learning, recommendations and actions from these internal reviews will be shared with the CDOP in accordance with the statutory requirements.

9. RESPONDING TO A MATERNAL DEATH OR STILLBIRTH

9.1 Maternal deaths

The Trust guideline for dealing with maternal deaths will be followed in all instances. Engagement with bereaved families and carers will be in accordance with this guideline and any duty of candour requirement.

- 9.1.1 Any death which meets the StEIS threshold will be subject to a Serious Incident Requiring Investigation (SIRI). The Trust will report all known maternal deaths through the MMBRACE reporting system. Every maternal death will be reviewed by the Maternity Governance Group and the reports and actions plans from these deaths will be monitored through the established specialty, divisional and corporate governance processes.

9.2 Stillbirths

The Trust guideline for pregnancy loss in the second and third trimesters will be followed in all instances of stillbirth from these time periods. Engagement with bereaved families and carers will be in accordance with this policy and any duty of candour requirement.

- 9.2.1 An incident form must be completed for all unexplained stillbirths and early neonatal deaths. The reviewers will use a Trust-approved incident investigation screening tool. The Trust reports all stillbirths through the MMBRACE reporting system. The Head of Midwifery will escalate to the Head of Safety, Risk and Patient Experience if any stillbirth/early neonatal death meets the StEIS threshold and therefore be subject to a SIRI investigation.
- 9.2.2 Every stillbirth/early neonatal death will be reviewed at the Maternity Governance Meeting and actions plans from these deaths will be monitored through the established specialty, divisional and corporate governance processes.

10. REVIEWING THE CARE PROVIDED TO PATIENT'S NOT UNDER THE TRUST'S CARE AT THE TIME OF THEIR DEATH BUT WHERE ANOTHER ORGANISATION SUGGESTS THE TRUST SHOULD REVIEW THE CARE PROVIDED TO THE PATIENT IN THE PAST

- 10.1 All cases, as outlined in Appendix 1, highlighted by another organisation that suggest the Trust should review the care provided will be reviewed by the central mortality team for a SJR.

11. REVIEWING THE CARE PROVIDED TO PATIENTS WHOSE DEATH MAY HAVE BEEN EXPECTED

- 11.1 National Quality Board and Royal College of Physician guidance suggests a sample of patients whose death would have been expected (end of life and DNACPR) should be reviewed every year.
- 11.2 The Trust will adopt the principles of the national audit of care of the dying in hospital to confirm the quality of care provided in patients expected to have died at the end of life.

12. COMMUNICATING WITH BEREAVED FAMILIES AND CARERS

- 12.1 The Trust is committed to engaging in a meaningful and compassionate way with bereaved families and carers.
- 12.2 Where a SJR identifies that a second review is required (see Appendix 1) the family/carer will be contacted by the relevant Division and informed that the Trust intends to review the care provided to the patient. At this point the family/carer will be approached to understand the extent to which they wish to be involved in the review/investigation process and any duty of candour requirements will be fulfilled at this point.
- 12.3 In all cases where there is significant learning following review (SJR and or SI process) the outcome of the review, lessons learnt and how the review/investigation will result in changes to mitigate recurrence will be shared with the family/carer.

13. INTERNAL AND EXTERNAL REPORTING

13.1 Internal

- Divisional Governance Groups
- Patient Safety & Mortality Review Group
- Safety & Risk Committee
- Governance Committee
- Trust Board of Directors

- 13.1.1 At each meeting, the Patient Safety Mortality Review Group will review the Trust Mortality Dashboard and on a quarterly basis this group and the Safety & Risk Committee, Governance Committee and Trust Board will receive a learning from deaths report, to include:

1. Total number of deaths
2. Number subject to case record review
3. Numbers investigated in the SI framework

4. Number of deaths where it is thought 'more likely than not' that problems in care contributed
5. Themes and issues identified through review and investigation
6. Changes that have been made as a result of these processes

13.2 External

13.2.1 NHS Improvement (NHS I)

The Trust will, in line with national guidance, publish the required data (section 1.1) to NHS I on a quarterly basis.

13.2.3 Communicating with Other Care Providers, including General Practitioners

Where significant learning or concerns relate to another care provider outside of the Trust these will be shared via the Safety and Risk Team. Legal team or Medical Director with the partner organisation

13.2.4 Quality Account

The Trust will publish in its annual Quality Account learning and actions from reviews and investigations into deaths. This will include specific information where deaths assessed as more likely than not to have been due to problems in care.

14. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the Head of Safety, Risk and Patient Experience. An electronic copy will be maintained on the Trust Intranet, (A-Z) P – Policies (Trust-wide) – Responding and Learning. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

15. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

- 15.1 To monitor compliance with this policy/ strategy, the auditable standards will be monitored as follows:

No	Minimum Requirements	Evidenced by
1.	Collection and publication on a quarterly basis of specified information on deaths through a paper and an agenda item on the public Board meeting.	Paper on Board agenda
2.	A summary of data and learning must be presented annually in the Quality Report.	Quality report
3.	On a quarterly basis, Governance Committee receive specified information on deaths through a paper and an agenda item.	Paper on Governance agenda
4.	Mortality Dashboard presented to the Safety and Risk Committee	Paper on Safety and Risk Agenda
5.	20 randomly selected deaths will be audited monthly	Electronic Mortality Tool
6.	Quarterly learning from deaths summary	Paper on Safety and Risk,

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		Governance and Trust Board agenda's
7.	End of life and DNACPR to be reviewed annually	Annual End of Life Audit

15.2 **Frequency**

In each financial year, the Head of Safety, Risk and Patient Experience will provide an annual report to ensure that this policy has been adhered to and a formal report will be written and presented at the Safety & Risk Committee.

15.3 **Undertaken by**

Trust Mortality Lead

15.4 **Dissemination of Results**

At the Safety and Risk Committee.

15.5 **Recommendations/ Action Plans**

Implementation of the recommendations and action plan will be monitored by the Safety & Risk Committee.

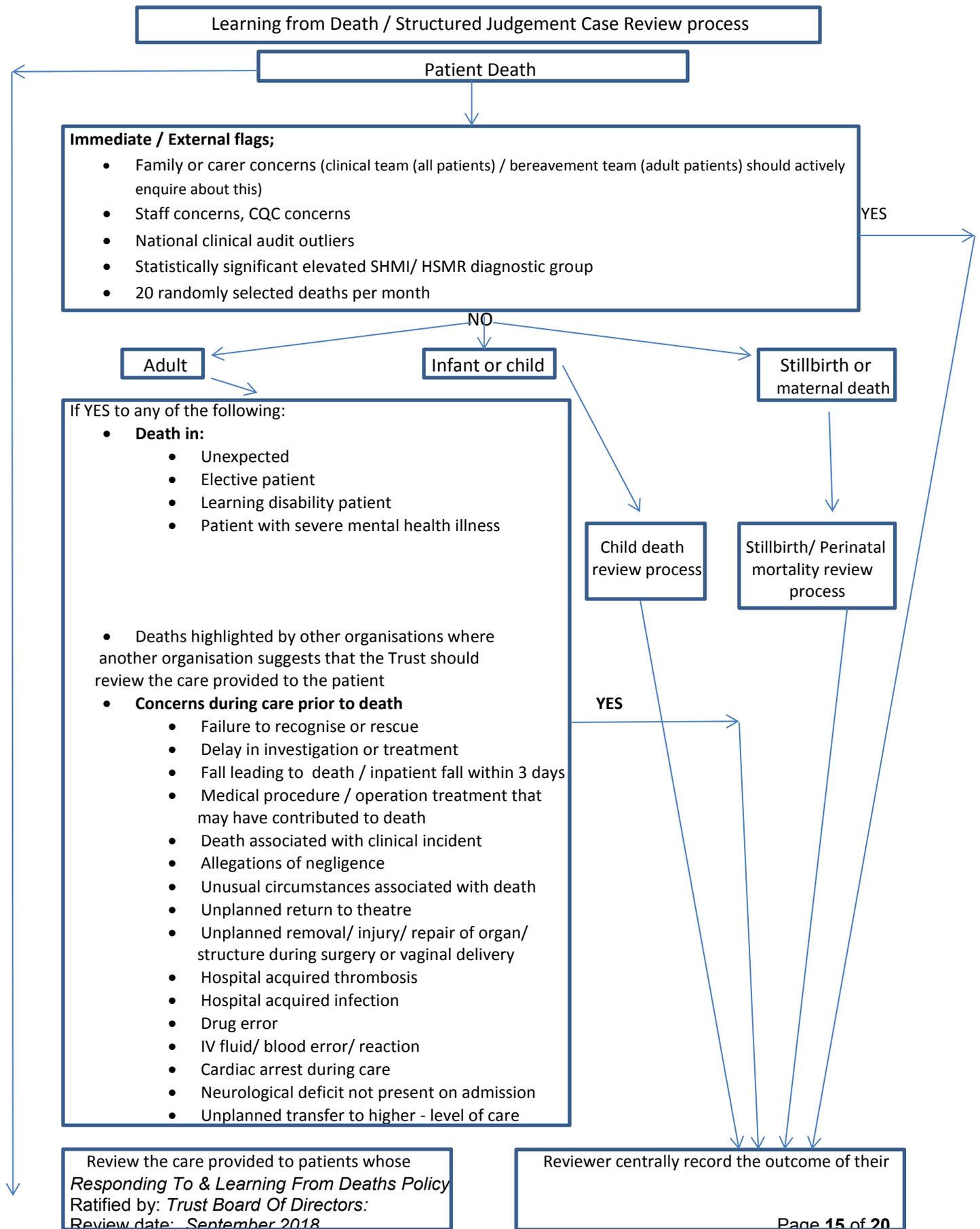
15.6 Any barriers to implementation will be risk-assessed and added to the risk register.

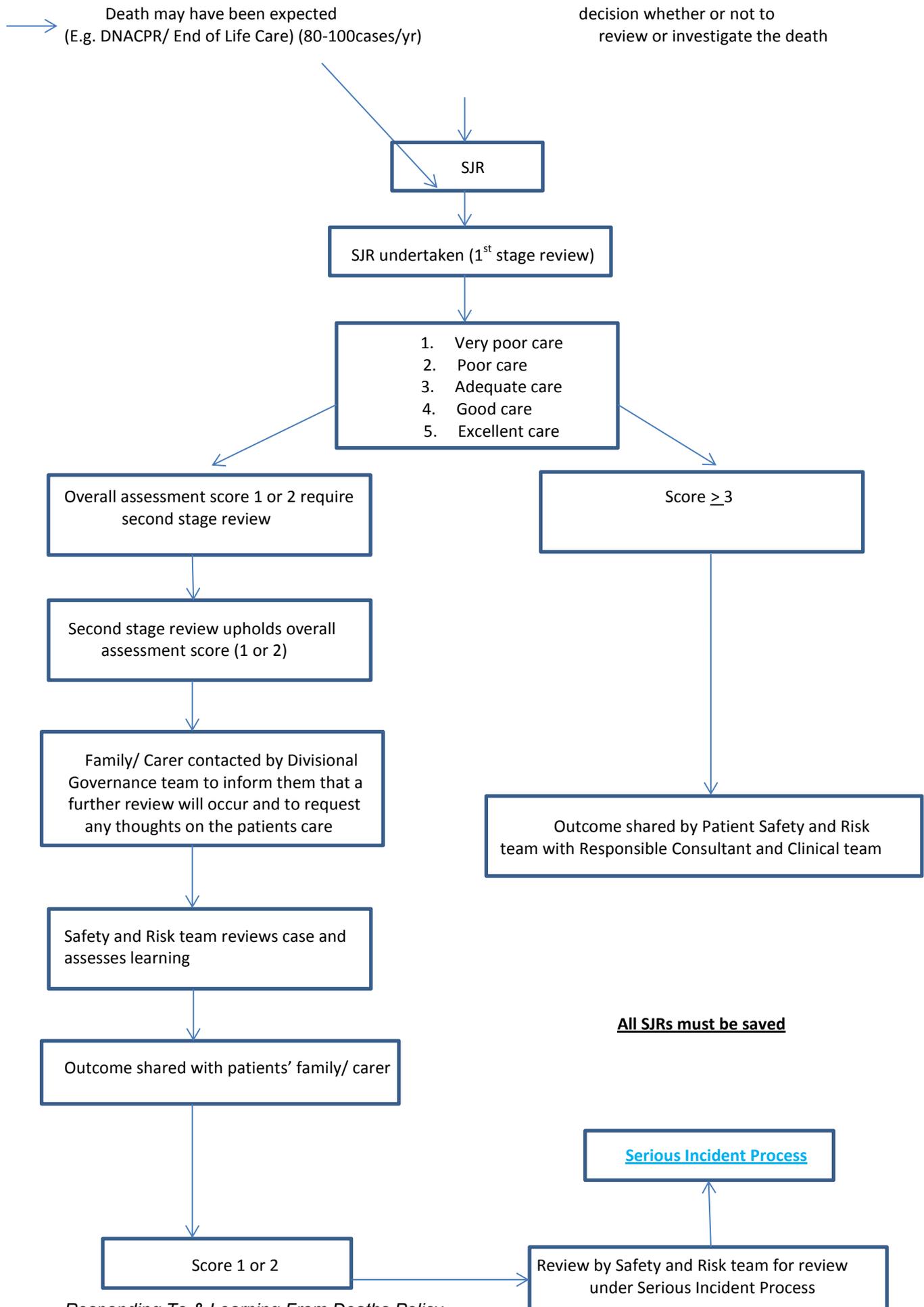
15.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers' cascade system.

16. **REFERENCES**

- Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England. <http://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability>
- Learning Disabilities Mortality Review (LeDeR) Programme (2017)
- National Guidance on Learning from Deaths, A Framework for NHS Trusts
- National Quality Board (2017) NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (National Quality Board, 2017).

APPENDIX 1: Structured Judgement Case Review Process/Flow Diagram





APPENDIX 3: COMMUNICATION PLAN

Royal Devon and Exeter
NHS Foundation Trust



COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	All staff members referred to in section 4.
The key changes if a revised policy/strategy	New policy to comply with National guidance
The key objectives	To have a systematic framework for Learning from Deaths
How new staff will be made aware of the policy and manager action	Through Governance framework
Specific Issues to be raised with staff	Changes through 2018 / 2019 to structured judgement review process
Training available to staff	Structured Judgement Review Training will be provided to appropriate individuals, either on a one to one basis or group training
Any other requirements	<i>None</i>
Issues following Equality Impact Assessment (if any)	<i>No negative impacts</i>
Location of hard / electronic copy of the document etc.	<i>Appendix of the policy/ procedural document will be on the Trust intranet and published on the Trust Website</i>

APPENDIX 4: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Responding to and Learning From Deaths Policy
Division/Directorate and service area	Corporate
Name, job title and contact details of person completing the assessment	Head of Safety, Risk and Patient Experience
Date completed:	3 rd September 2017

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

This standardised trust-wide process integrating mortality reviews into the governance framework will provide greater levels of assurance to the Trust Board and help to ensure that the organisation is using mortality rates and indicators alongside others such as incidents and complaints to monitor the quality of care and share good practice and learning from mistakes.

2. Who does it mainly affect?

Carers Staff Patients Other (please specify) Relatives

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box (x)

Protected characteristic	Relevant	Not relevant
Age	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Disability	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sex - including: Transgender, and Pregnancy / Maternity	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Race	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Religion / belief	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sexual orientation – including: Marriage / Civil Partnership	<input checked="" type="checkbox"/>	<input type="checkbox"/>

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to...** (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

<i>None</i>

5. **Do you think the document meets our human rights obligations?**

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
<ul style="list-style-type: none"> • Fairness – how have you made sure it treat everyone justly? • Respect – how have you made sure it respects everyone as a person? • Equality – how does it give everyone an equal chance to get whatever it is offering? • Dignity – have you made sure it treats everyone with dignity? • Autonomy – Does it enable people to make decisions for themselves?

6. **Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?**

Not applicable

7. **If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.**

“Protected characteristic”:	
Issue:	
How is this going to be monitored/ addressed in the future:	

Group that will be responsible for ensuring this carried out:	
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