# Learning from Deaths Policy

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| **POLICY NO & CATEGORY** | **C 58** | **Clinical Governance** |
| **VERSION NO & DATE** | **1** | **28/08/2017** |
| **RATIFYING COMMITTEE or EXECUTIVE DIRECTOR** | **Mortality Review Group** | |
| **DATE RATIFIED** | **December 2017** | |
| **NEXT ANTICIPATED REVIEW DATE:** | **December 2018** | |
| **EXECUTIVE DIRECTOR** | **Hilary Grant , Medical Director** | |
| **POLICY LEAD** | **Dinesh Maganty** | |
| **POLICY AUTHOR** *(if different from above)* | **Dinesh Maganty, Haider Al-Delfi, Michael Galvin** | |

** delete as appropriate*

## POLICY CONTEXT:

This Policy sets out the trust procedures to fulfil the standards and new reporting requirements set out in NHS National Quality guidance for acute, mental health and community NHS Trusts and Foundation Trusts 2017

## POLICY REQUIREMENT

This Policy forms part of the Trust governance arrangements and process to facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care.
The Trust seeks to ensure that it shares and acts upon any learning derived from these processes

This Policy sets out the learning from deaths process by which the Trust identifies patients who have died and decides which reviews or investigations are needed, with particular emphasis on:

a) patients with a learning disability or mental health problem
b) quality of investigations carried out by trusts
c) reports to trust boards on learning from death − action taken in response to learning from
d) death
e) how trust will involve families and carers in reviews and investigations

**Policy Structure:**

## 1. Introduction

### a. Rationa

Learning from a review of the care provided to patients who die is integral to BSMHFT clinical governance and quality improvement work.

Following events in Mid Staffordshire, and more recently Southern health care there is a growing National consensus to take very practical steps to reduce genuinely avoidable deaths in our hospitals and in the community.

This was reinforced by the recent findings of the Care Quality Commission (CQC) report learning, candour and accountability[1]: A review of the way NHS trusts review and investigate the deaths of patients in England. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning

This Policy forms part of the Trust governance arrangements and process to facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. The Trust seeks to ensure that it shares and acts upon any learning derived from these processes.

Establishing an evidence-based process of learning from avoidable deaths and having a continuous process dissemination of such learning within our trust and wider health economy in the West Midlands.

Embedding structured case note reviews and investigation of both mortality and near misses within the culture of the organisation by continuous process of training, to make the principle of reviewing a death and or learning from it as everyone's business.

### b. Scope and Purpose

This policy was developed to take forward the trusts Mission to provide excellent, high quality mental health services that are innovative and have an outstanding reputation for compassionate care and service user, carer and staff involvement.

[1] https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

This policy applies to all staff whether they are employed by the trust permanently, 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.
This Policy sets out the trust procedures to fulfil the standards and new reporting set out in NHS National Quality guidance for acute, mental health and community NHS Trusts and Foundation Trusts[2].

This Policy sets out the learning from deaths process by which the trust identifies patients who have died and decides which reviews or investigations are needed, with particular emphasis on:

a) Patients with a learning disability or mental health problem
b) Quality of investigations carried out
c) Reports to trust boards on learning from death − action taken in response to learning from death
d) How trust will involve families and carers in reviews and investigations

**Purpose**

BSMHFT 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.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of BSMHFT..

It describes how BSMHFT will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about 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.

It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with the Serious incident investigation policies and procedures already in place

### c. Principles: National Guidance

National guidance was issued on Learning from Deaths, A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care in March 2017

NHS National Quality guidance for acute, mental health and community NHS Trusts and Foundation Trust requires that each Trust should publish an updated policy by September 2017 on how it responds to and learns from deaths of patients who die under its management and care, including:

[2] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

i. How its processes respond to the death of an individual with a learning disability or mental health needs, an infant or child death .

ii. The Trust's approach to undertaking case record reviews, Individual case record reviews of deaths of people with learning disabilities by adopting the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme .

iii. Categories and selection of deaths in scope for case record review: This is to include all patients who are inpatients and carefully considered categories of outpatient and/or community patients within scope for review taking a proportionate approach. The rationale for the scope selected by Trust will be reviewed on a ongoing manner and open to scrutiny.

This Policy sets out to address the above requirements.

While BSMHFT did undertake mortality reviews for a number of years, there was as was the case nationally considerable variation in terms of methodology, scope, data capture and analysis, and contribution to improvement and learning. By establishing a consistent and robust process of Retrospective Review of case records (RCRR), in line with the guidance from NHS Quality Board BSMHFT aims to improve the quality of care by identifying and learning from problems in health care that contribute to avoidable patient death and harm.

Learning from mortality and avoidable deaths meets the Trust's Strategic Ambitions in:

1. Putting service users' needs first by improving the range of safe environments, treatments and care packages that deliver clinical excellence and enhanced outcomes

2. Achieving hope, recovery and opportunity through improved access to services and support opportunities for people with mental ill health in relation to physical wellbeing, especially by collaborating with acute hospitals to support them to learn from deaths of those with severe enduring mental illness and learning disability.

3. Providing evidence based help at the earliest opportunity to reduce the likelihood of escalation and distress by learning from cases where this did not occur

4. Embedding a culture of openness in learning from mortality throughout our organisation that drives leading edge advances in research, innovation and technology to improve care and sustainability for the future.

5. Listening to, families, carers, staff and stakeholders to continuously learn and improve our quality of care.

6. Being at the forefront of developing new care models based on learning from avoidable deaths with a range of NHS and other partners to improve consistency, coordination and quality of care and support people to lead fuller, happier lives.

## 2. Process

### Mortality Review Process Development

Mortality Surveillance Group for the Trust was established in shadow in the second half of 2016 with it Going live in 2017.

In the second half of 2016 we independently adopted the structured judgment and case record review process and adapted it to a mental health setting.

This currently is in keeping with the emerging national guidance via NHS Improvement and the Royal College of Physicians.

A template for the structured judgment based case note review process was developed in-house based on current available evidence (Annex 1). A small group of senior doctors carried out a validation process of the template.

The structured judgment based case note review process template was developed based on emerging national guidance and in line with the good practise principles set out below:

1. The process and review proforma should be simple and not onerous

2. It should not be rigid, restrictive or overly prescriptive

3. It should be adaptable by different specialties

4. It should be beneficial

Senior clinicians from the Trust were trained against this template (Annex 1) to conduct structured judgment based case record reviews as part of a Mortality Master Class 2017

In line with the structured case note review process a dashboard was developed in house which went live on April 1st. The structured case note review template has been integrated into Eclipse.

## 3. How Trust processes should respond to the death of an individual

The trust has established Structures and deployed its staff to respond to the death of an individual. This Policy Sets out the Procedures for operation of these structures and guide the staff involved.

1. Mortality surveillance group with Medical Director as chair, and Associate Medical Director patient safety/mortality, together with a lead Nurse for Mortality leading the mortality agenda have been established.

2. The Trust has developed a structured case record review process and is currently implementing a structured case record review programme to review deaths of those who suffer with l severe mental illness not subject to a serious incident review currently (e.g. death by natural causes in a community setting of a patient with schizophrenia).

3. Collaborative working relationships with acute and community hospital trusts to enable them to review by way of structured case note reviews those with severe enduring mental illness who die in acute and community hospital trust's care.

4. Mortality dashboard and Inclusion of Mortality Dashboard data into the Trust Quality accounts from June 2018.

5. Engaging with families and carers at a senior level in cases of mortality, specifically avoidable mortality, with Associate Medical Director for Patient Safety and Family Support worker taking a lead role.

6. Investigating in a collaborative manner with families/carers cases where they raise concern, from beginning to end.

7. Establishing a transparent, open and collaborative relationship in investigating and learning from mortality with Coroners, Medical Examiners/those Doctors who sign death certificates.

8. Establish a collaborative relationship with NHS Resolution in cases of mortality.

9. Look for and highlight exemplary practice in cases investigated and establish a reward/award system for the same.

10. Be in a "ready to bid" position for any nationally or regionally available funds for service improvement and innovation in this area.

**4. Cases In Scope for Mortality Case Note Review**

BSMHFT should be able to conduct a structured case record review in cases in scope. This would be two categories of cases, mandatory and discretionary:

Mandatory:

In cases which meet all the following criteria:

- Should be in receipt of services from BSMHFT currently or in the past 6 months.
- Should not have died in another provider's hospital
- Is not already subject to a BSMHFT Serious incident review
- Should have been diagnosed with a severe mental illness or be in contact with learning disability mental health services.

Discretionary
Structured case record reviews can be sought by the Chair of the Mortality Surveillance group in deaths who are not already subject to a mandatory structured case record review on a discretionary basis in cases of

- All deaths where family, carers or staff have raised a 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 Trust through whatever means. For example, via a Hospital Standardised Mortality Ratio (HSMR) elevated mortality alert, concerns raised by audit work or by the Care Quality Commission or another regulator;
- All deaths of patient's subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures such as ECT;
- Deaths where learning will inform the organisation's existing or planned improvement work, for example if work is planned on improving pulmonary embolism care, relevant deaths should be reviewed, as determined by the Mortality Surveillance Group;
- Further samples of other deaths may be selected that do not fit the identified categories, to ensure the Trust 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 day of the week;

## 5. Mortality Review operational procedure:

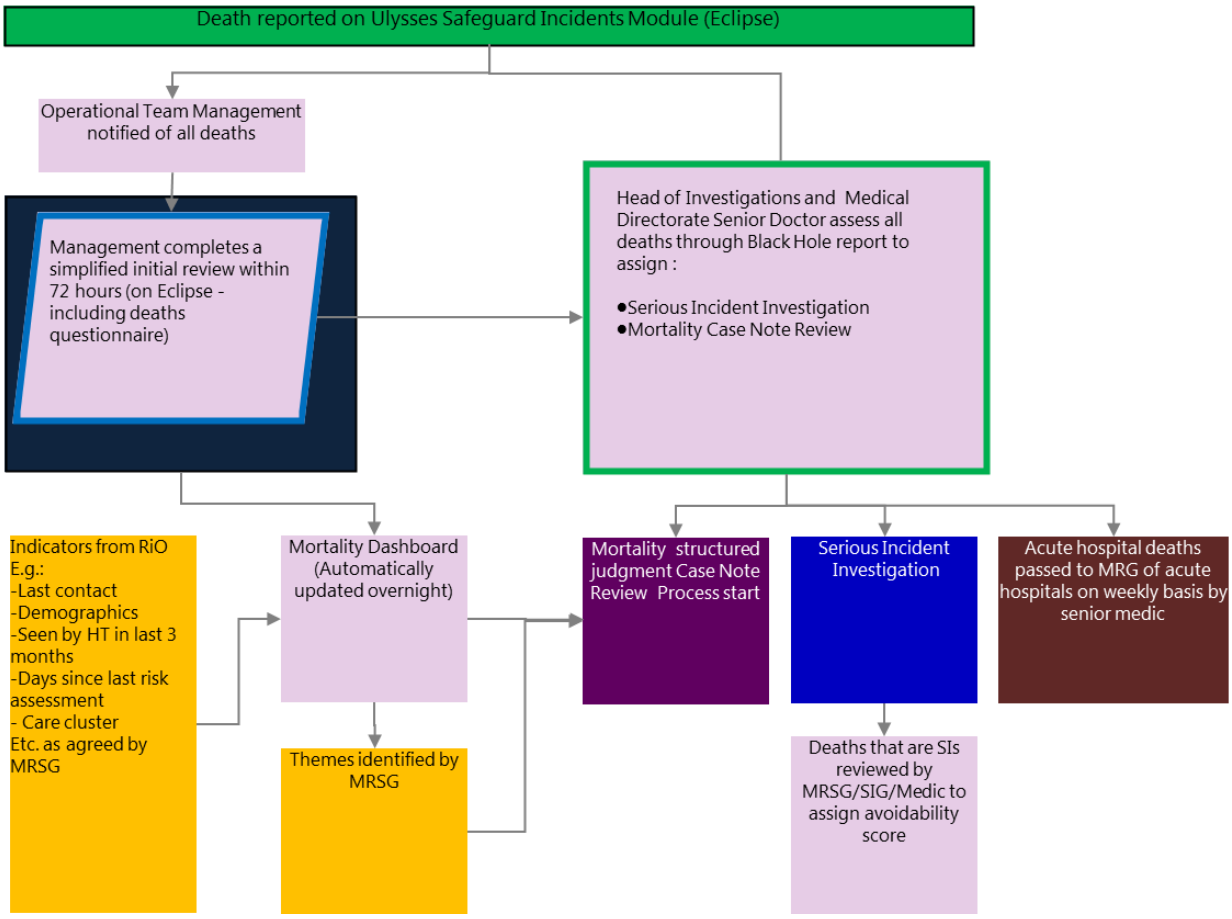
**5.1**
**5. Roles and responsibilities**
This section describes the specific responsibilities of key individuals and of relevant committees under this policy.
Roles and responsibilities for incident management, complaints handling and Serious Incident management, quality improvement are detailed in relevant BSMHFT trust Policies and need to be read in conjunction with this policy .

| Role | Responsibilities |
|---|---|
| Chief executive | **Overall responsibility for implementing the policy** |
| Non-executive director Chair of Integrated Quality committee | Non executive director with oversight<br>:<br>• . |

| | |
|---|---|
| Medical director* | Executive director with direct responsibility for the implementation of the policy and chair of the Mortality review group |
| Director of nursing* | Nursing lead for implementation of policy and National guidance |
| | |
| Associate Medical director for Quality and Risk | Direct day to day leadership and operational lead for implementation of the policy |
| | |

| Committee | Responsibilities |
|---|---|
| Trust board | Over  all responsibility for implementation of this policy inline with National guidance |
| Mortality review group/committee | Accountable committee for Day to day implementation and responsibility for this policy and implementation in line with National guidance |
| [ | |

## 5.2 The 6 steps process




**Step 1.** Death reported on Ulysses Safeguard Incidents Module (Eclipse)

**Step 2.** Operational Team Management notified of all deaths

**Step 3.** Care team Management member completes a simplified initial review within 72 hours (on Eclipse - including deaths questionnaire)

**Step 4.** Head of Investigations and Medical Directorate Senior Doctor/ lead nurse assess all deaths through Black Hole report to assign :

- Serious Incident Investigation
- Mortality Case Note Review

**Step 5.** Medical Directorate Senior Doctor/ lead nurse Inform Governance Intelligence Team to update Eclipse

**Step 6.** One of the three below processes commence:

**a.** Mortality Case Note Review Process start

**b.** Serious Incident Investigation and Deaths that are SIs reviewed by MRSG/ SIG/Medic to assign avoidability score and Information governance intelligence team update eclipse accordingly

**c.** Acute hospital deaths passed to MRG of acute hospitals on weekly basis by:

**5.2 Information captured from management report and deaths questionnaire is as follows:**

- Service user additional information:
- Service user diagnosis category (Dementia, Schizophrenia, Schizoaffective disorder, Bipolar disorder, Severe depression)
- Details of diagnosis (Narrative)
- Does the service user have a diagnosis of learning disability? (Yes/No/Unknown)
- Was the patient on CPA? (Y/N)
- Was the patient detained under MHA? (Y/N)
- Was the patient subject to DoLs? (Y/N)
- Patient Care Cluster (0-21, care cluster not allocated, care cluster unknown)
- Did the service have contact with the patient in the last 6 months? (Yes, No, if yes, please state date of last contact with service)
- Physical health: Did the patient have any known physical health problems/ conditions? (Yes/ No)
- Please state any physical health problems/ condition (Narrative)
- About the death
- Suspected cause of death to the best of your knowledge (Narrative)
- Are there any concerns regarding the quality of care provided (e.g. raised by staff or next of kin)
- Potential drug related death? (Y/N)
- Potential alcohol related death? (Y/N)
- If the patient died in acute hospital, please indicate which hospital
  (List of local hospitals, other) <- To redirect Mortality Case Note reviews.
- Referred to Coroner? (Yes/No/Unknown)
- Next of Kin □ NoK Name □ Address □ Telephone number □ Alternatively, provide details why NoK details are not available

## 6. Criteria for cases in scope for NQB national return dashboard

Patients who did not die in acute hospital (captured from Eclipse death questionnaire) who also meet one of the following criteria:

- All deaths with concerns regarding quality of care (e.g. Raised by staff or carer) (captured from Eclipse death questionnaire)
- All inpatient deaths
- Deaths for patient who had contact with service in the past 6 months who meet one or more of the following
- Patients on CPA (captured from Eclipse main form)
- Patients on Care Cluster (11-17) (captured from Eclipse death questionnaire)
- Patients with diagnosis of severe mental illness (captured from Eclipse death questionnaire)
- Patient with diagnosis of learning disability (captured from Eclipse death questionnaire)
- Patient detained under MHA in the community (captured from Eclipse death questionnaire) - Likely to be captured through CPA or Care Cluster too.
- Other deaths with an allocated Mortality Structured Case Note Review and HFAS questionnaire on Eclipse
- Commissioner reportable deaths that have been investigated through the Serious Incident Framework process (These will receive an avoidability score but not an additional case note review)
- Cases deemed as “Definitely not avoidable - Score 6” at the triage stage (These cases will not receive a Mortality Case Note review)

### 6.1 Black Hole reports to support the mortality review process that would be available

- A dynamic replica of the National Quality Board Learning From Deaths Dashboard updated on daily basis
- A dynamic report to highlight progress against the different stages of the mortality review process updated on daily basis.
- Data quality reports to assess validity of entries against alternative data sources like RiO.
- In collaboration with the information team, a local Mortality Dashboard utilising additional indicators from RiO.
- Acute hospital deaths passed to Mortality Review Lead of acute hospitals on weekly basis by
- Patients on Care Cluster (11-17) (captured from Eclipse death questionnaire)
- Patients with diagnosis of severe mental illness (captured from Eclipse death questionnaire)
- Patient with diagnosis of learning disability (captured from Eclipse death questionnaire)
- Any other cases the senior Medical Directorate medic and Head of Investigations consider appropriate

## BSMHFT Mortality Dashboard

BSMHFT Mortality Dashboard - April 2017 to date

**Total number of deaths triaged**

| Quarter | Month (Received date) | Deaths Triaged |
|---|---|---|
| FY 20172018 Q1 | 2017 Apr | ## |
| | 2017 May | ## |
| | 2017 Jun | ## |
| FY 20172018 Q2 | 2017 Jul | ## |
| | 2017 Aug | ## |

**Total number of deaths in scope**

| Quarter | Month (Received date) | NQB Cases in Scope |
|---|---|---|
| FY 20172018 Q1 | 2017 Apr | ## |
| | 2017 May | ## |
| | 2017 Jun | ## |
| FY 20172018 Q2 | 2017 Jul | ## |
| | 2017 Aug | ## |

**Total deaths reviewed (S.I. / M.C.N.R.)***

| Quarter | Month (Received date) |
|---|---|

**Total number of deaths considered to have been potentially avoidable (Score <=3)**

| Quarter | Month (Received date) |
|---|---|

**Cases pending triage by Medical Directorate**

##

**Cases pending completion of Deaths Questionnaire**

##

**Cases pending allocation of Mortality Case Note Reviews****

##

**Allocated Mortality Case Note Reviews pending completion**

##

**SIs pending avoidability scoring by Mortality Surveillance Group**

##

**Completed Mortality Case Note Reviews**

##

**RiO & Eclipse datasets comparisons (Up to 180 days post discharge) based on incident date / recorded date of death**

| Matching deaths | ## | On Eclipse but not RiO | ## | On RiO but not Eclipse | ## |
|---|---|---|---|---|---|

** Completed SI/M.C.N.R. cases where final avoidability score has been allocated*
*** Automatically generated by the system based on agreed Mortality Case Note Reviews criteria*

Indicators as extracted fro m Eclipse Deaths Questionnaire

**Deaths with diagnosis of Dementia**

##

**Deaths with diagnosis of Schizophrenia**

##

**Deaths with diagnosis of Schizoaffective Disorder**

##

**Deaths with diagnosis of Bipolar Disorder**

##

**Deaths with diagnosis of Severe Depression**

##

**Deaths with diagnosis of Learning Disability**

##

**Deaths of service users on CPA**

##

**Deaths of service users detained under MHA**

##

**Deaths of service users subject to DoLS**

##

**Deaths of service users on cluster 11-17**

##

**Deaths of SU with physical health problems / conditions**

##

**Deaths referred to Coroner**

##

**Deaths where N.O.K. or Staff expressed concerns**

##

**Deaths of service users with Alcohol use concerns**

##

**Deaths of service users with drug use concerns**

##

## Cases pending triage by Medical Directorate

The following cases will need one of the following options:
-Assign a Mortality Case Note Review Questionnaire
-Assign "Not applicable - not in scope" on the Deaths Avoidability Score (Final) questionnaire.
-Assign "Not applicable - transfer to Acute hospital" on the Deaths Avoidability Score (Final) questionnaire

| Incident Number | Death Q'naire | Death Location | Diagnosis Details | N.O.K. / Staff Concerns | Suspected cause of death to the best of management team knowledge |
|---|---|---|---|---|---|
| #### | Yes | Other - Solihull Hospital | Referred by RAID for assessment of mood - died before being seen by CMHT - was readmitted back to hospital. | None recorded on Questionnaire | Congestive Cardiac Failure, Ischaemic Heart Disease, Atrial Fibrillation, Diabetes Mellitus |
| #### | Yes | Sandwell General Hospital | Huntington's disease | None recorded on Questionnaire | Complications of Huntington's disease |
| #### | Yes | Other - Patient died in community following discharge from UHB. | Treated for depressive symptoms. | None recorded on Questionnaire | Not known. |

## Cases pending completion of deaths questionnaire

The following cases will need completion of deaths questionnaire

| Incident number | Team |
|---|---|
| #### | B3 Primary Care |
| #### | Criminal Justice Liaison & Diversion Service |
| #### | East HuB |

## Cases pending allocation of Mortality Case Note Reviews

The following cases will need to be assigned a Mortality Case Note Questionnaire on Eclipse with a Lead Reviewer.

| Incident number | Department | Allocation reason |
|---|---|---|
| #### | Team A | Death of patient seen in the past 6 months and is on Care Cluster 11-17 |
| #### | Team B | Death of patient seen in the past 6 months and was on CPA |
| #### | Team C | Death of patient seen in the past 6 months and Severe Mental Illness |
| #### | Team D | Concerns raised regarding quality of care and patient did not die in hospital |
| #### | Team E | Death of patient seen in the past 6 months and Severe Mental Illness |
| #### | Team F | Death of patient seen in the past 6 months and was on CPA |
| #### | Team G | Death of patient seen in the past 6 months and was on CPA |

## Allocated Mortality Case Note Reviews pending completion

The following cases have been assigned a Mortality Case Note Questionnaire on Eclipse with a Lead Reviewer. They will move to next stage once a final avoidability score has been recorded against the case.

| Incident number | SU has diagnosis of L.D. | Review Lead | Added | Started on Eclipse | Last Updated |
|---|---|---|---|---|---|
| #### | No | Staff A | 2017-05-26 | Pending | Pending |
| #### | No | Staff B | 2017-06-09 | Pending | Pending |
| #### | No | Staff C | 2017-07-31 | 2017-07-31 | 2017-07-31 |

## Serious Incidents pending avoidability scoring by Mortality Surveillance Group

The following cases will need to be assigned an avoidability score on the Deaths Avoidability Score (Final) questionnaire.

| Incident number | Investigation Lead | Department |
|---|---|---|
| #### | Staff A | RAID - UHB |
| #### | Staff B | Ladywood & Handsworth CMHT |
| #### | Staff C | Lyndon CMHT |

## 7. Structured Case Record Review and Judgment:

### Based on Human Factor analysis for Quality improvement in Mortality

The Royal College of Physicians (RCP) was awarded the contract by Healthcare Quality Improvement Partnership (HQIP) to deliver the first ever national Mortality Case Record Review Programme for the next 3 years (2016 to 2019).This covers only Acute Hospital trusts and Does not include Mental Health Trusts

This pioneering programme aims to develop and implement a standardised way of reviewing the case records of adults who have died in acute hospitals across England and Scotland. Its main aim is to improve understanding and learning about problems in care that may have contributed to a patient's death.

NCEPOD was commissioned to undertake a specification development exercise resulting in a guidance document for hospitals to improve the standardisation of, and learning from, case note review. It concluded that standardisation of case note review has been considered beneficial, but should be based on:

1. The process and review proforma should be simple and not onerous

2. It should not be rigid, restrictive or overly prescriptive

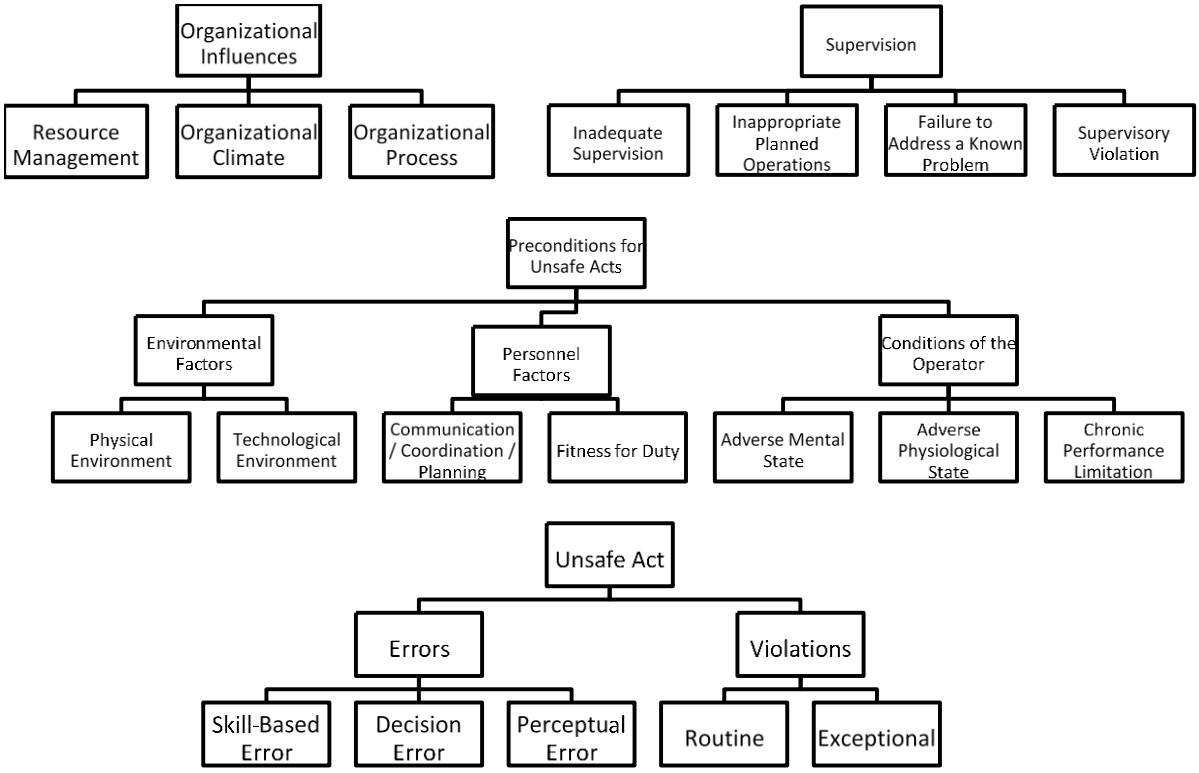
3. It should be adaptable by different specialties

4. It should be beneficial

5. Changes should be pursued with a consultation

BSMHFT aims to implement a pioneering RCRR process for a Mental health trust in line with the good practise principles set out above.

### 7.1 Human Factors Analysis Classification System (HFACS) Framework




**With use of the HFACS**

- **Actionable Common Causes identified**
- **Avoid unintended consequences**
- **Identify commonalities across departments/services/units – System solutions**

### 7.2 Structured Case Notes Review

In order to provide the benefits to patient care which are commensurate with the effort put into case note review, review methods need to be standardised, yet not rigid, and usable across services, teams and specialties.

There is now also recognition that mortality and safety review requires both training and guidance for reviewers.

Structured Judgement Review blends traditional, opinion-based, review methods with a standard format, requiring reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

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, to provide information about what can be learnt about the hospital systems where

care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

Most important in use of review language is that it should be explicit and clear, in order that the reviewer, feels they have made the points clearly and that others who read the review will be able to understand what has been said and why.

Where care is unsatisfactory the purpose of the review process is not to point to individuals but to ask questions of the system in which people work. Just as importantly, it is also to ask questions about why care goes so well in a complex institution and what can be learned from this.

In order to ask these questions there is a need to look at the whole range of care, at holistic care approaches and the nuances of case management, as well as at the outcomes of interventions. Structured judgement case note review can be used for a wide range of hospital - based safety and quality reviews, across services and specialties,

A very important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case and that good care is judged and recorded in the same detail as that care which has been problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from analysis of high quality care.

Much of the development and training in the structured judgement method has been concerned with enabling prospective reviewers to select and use their own phrases that express that judgement in a way that others can clearly understand. Thus the method moves away from descriptions of care that do not contain a judgement of whether care was good or poor, and away from comments or words where subsequent readers have to imply what the reviewer thought, to explicit statements that use judgement words and phrases such as ‘good’ or ‘unsatisfactory’ or ‘failure’ or ‘best practice’.

Additionally, these judgement words are accompanied by statements that provide an explicit reason why a judgement is made – e.g. unsatisfactory ‘because etc’. The purpose here is not to write long sentences but to encapsulate the clinical judgement in a few explicit statements

- **Use of one reviewer per case**: using a standardised approach following training, is often the most satisfactory approach

- **Consciously avoid hindsight bias**: by reminding and consciously bearing this in mind

- **Internal review as good or better**: well-trained internal reviewers can be as critical and reliable as external review teams. Furthermore, internal reviewers know something of the way the organisation is structured and the way care is delivered. They also know their way through the medical records system. Most importantly, perhaps, internal reviewers provide a continuing learning set for the organisation

**7.3 Structure of the review**:

- **Phase1**: last 7 days before incident
- **Phase 2**: day 30 to day 7 prior to the incident
- **Phase 3**: day 180 to day 30 prior to the incident

Grading the incident

Going forward from April 2017 we will incorporate Grading every inpatient

Using the National Mortality Case Record Review Programme: A guide for reviewers guidance.

Each phase of care will be graded as

1. Very poor care

2. Poor care

3. Adequate care

4. Good care

5. Excellent care

There would also be grading of overall all care

Overall care scores are particularly important in the review process. A score of 1 or 2 is given when the reviewer decides that care has been very poor or poor. Research evidence suggests that this might happen in upwards of 10% of cases in some circumstances, but less in others.

Those cases scoring 1 or 2, will be subject to a second Stage review (by another reviewer following the same process) and this reviewer would make a judgment

The judgement is framed by a six-point scale

6 = No evidence of avoidability

1 = Definitely avoidable.

This scale has been used in a number of recent national mortality review studies in Canada, the Netherlands and England.

| | |
|---|---|
| Score 1 | Definitely avoidable |
| Score 2 | Strong evidence of avoidability |
| Score 3 | Probably avoidable (more than 50:50) |
| Score 4 | Possibly avoidable, but not very likely (less than 50:50) |
| Score 5 | Slight evidence of avoidability |
| Score 6 | Definitely not avoidable |
| In addition, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made | |

Structured case notes reviews wil be conducted in each case of mortality identified as within scope with:

1. Care divided into phases
2. Each phase reviewed based on Human factor analysis classification system frame work being applied to the review overall and judgment reached over all
3. Grade Incident
4. Collation of data on all reviews based on HFACS

## 8. Liaison with Acute Hospitals:

BSMHFT Associate Medical director/Head of investigations/lead nurse will notify on a monthly basis to the acute Hospital Mortality review group chair a list of patients who meet all the following criteria:

a. has severe mental illness
b. have died in the acute hospital
c. Whose cases are not being reviewed by BSMHFT as they do not fall into scope for BSMHFT

BSMHFT will Designate a Consultant Psychiatrist working within the RAID team at the designated Acute hospital to be a point of contact to support the Acute Hospital review process

The role of this consultant Psychiatrist will be to offer expert advice if sought into the mental health aspects of the Mortality case note review which the acute hospital will carry out .

This advice will be via face to face/telephone consultation or email.

This Expert advisory role would not involve carrying out a Mortality review or routine attendance at the Mortality review meetings or being part of the Acute hospital mortality review group

## 9. Family /Carer Involvement

### Supporting and engaging bereaved families and carers when someone dies

BSMHFT has developed its engagement procedures in the context of:

- Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 also referred to as Mazars report 2015

- Learning, Candour and accountability: CQC December 2016 (8 recommendations, all accepted by Secretary of State)
- Family involvement in, and experience of, death investigations by the NHS : George Julian 2016
- A review of family involvement in investigations conducted following a death at Southern Health NHS Foundation Trust: Stephanie Carolan 2016
- National Guidance on learning from deaths: National Quality Board March 2017
- How can we assess how well providers review, investigate and learn from deaths? CQC June 2017 (Survey which families and carers could contribute to, closed 14 July 2017)

**The Guiding principles for Family /Carer engagement for all BSMHFT Staff involved with bereaved families will be:**

- Compassion and humanity
- Recognition of the uniqueness of every family
- Early involvement, clarity on what will happen
- Honesty and detail
- Support, family liaison, advocacy
- Equal value placed on family perspective
- Ethical practice
- Focus on learning lessons, reducing risk, taking demonstrable action
- Recognition of the different phases and stages of bereavement with options at each stage, that can also be taken up later

**When a death occurs:**

All trust staff involved will engage meaningfully and compassionately with bereaved families and carers - this should include informing the family/carers if the trust intends to review or investigate the care provided to the patient.
In the case of an investigation, this should include details of how families/carers will be involved, this will be guided by the extent that they wish to be involved.

Initial contact with families/carers will be managed by the clinicians responsible for the care of the patient.
BSMHFT will offer families/carers the opportunity to express concerns about the care given to patients who have died, under these circumstances the involvement of clinicians who cared for the patient may be considered a barrier to raising concerns, therefore every bereaved family or carer who wishes to raise concerns will have access to a Senior clinician independent of the care team and a family/carer support worker in addition to the normal complaints procedure information.

where appropriate the Family/carer support worker will offer signposting advice on obtaining legal advice for families

BSMHFT will keep involvement of its own legal team in the reviewing deaths process to a minimum and avoid it in most cases.
When NHS Resolution or the BSMHFT trust lawyers become involved the families/carers will be informed with the reasons, purpose and involvement of any lawyers being communicated clearly from the outset, by the Senior most member of the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates

**Some practical things that matter to families which should guide our staff**

- Early communication, saying sorry for loss
- Single point of contact
- Not receiving information on a Friday before the weekend and when no one is there to support where ever possible
- Not receiving the possessions of the lost relative in a bin bag and in the middle of a busy ward or building
- Sign posting to counselling support: for now or later on
- Kept informed of impact of investigation and given evidence of actions taken over time

**What should happen when things go wrong – will be linked to what happens in the daily and routine engagement of families and will extend from that point .**
The trust will work towards a consistent and recorded stepped process involving:

- Identify family members and carers straight away
- Standardised welcome
- Assess and support
- Intervention
- Transition

Good practice should be already firmly in place with the majority of families and carers. There should be an existing relationship with the care team to at least form the basis of an understanding around the family . **Mortality related engagement , should be an extension of spine of good practice of involving and engaging families** .

**Key aspects of family engagement and support after someone dies**

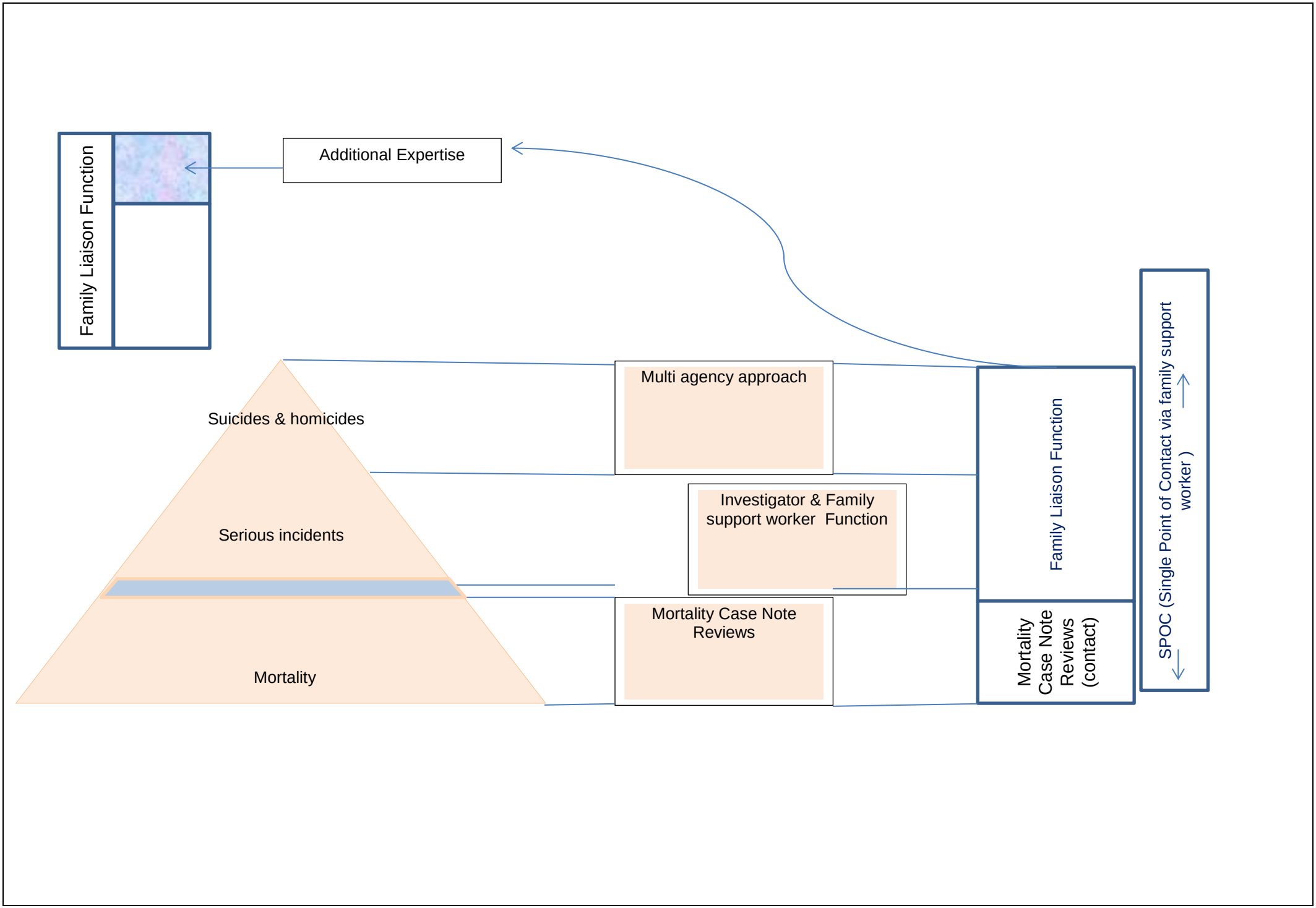
- Starts at the point the Trust learns of death
- Provides immediate information for family that can support
- Goes beyond Duty of Candour communication but should meet the duty of candour requirements
- Staff trained in bereavement support being consulted or involved where possible
- reporting using first name of the deceased, maintaining the focus on the person
- Reports shared ahead of inquest
- Legal involvement kept to minimum as seen as unhelpful to families overall

**Protocol after a death**

- Clear expectation that family will be contacted immediately by the team member who knows them best , if this is not possible by the senior Most clinician
- An overall assessment of the way forward being made with the family by a senior clinical member of staff (either internal or external to the organisation)
- An assignment of the family support worker, whose brief is based on the assessment made by the senior clinical member of staff, (to include risk, clarity around disclosure, forward /strategic view, specific wishes and wants of the family). This person will in essence be the single point of contact or family support worker.
- The role of this individual family support worker , and their brief, is set by the assessment above, is specific to the particular family, and is there for the family, up until the end point is agreed.
- Clear arrangements that ensure feedback to family extends beyond the life of the investigation and into the accountability for actions
- An understanding of different ways in which the family voice can be heard: different options at different points of the bereavement process

**Staff training internal to Trusts**

- Will have a tiered approach
- Training will include basic training on what everyone needs to know
- A small, dedicated group in more depth


Family Liaison Function
Additional Expertise
Suicides & homicides
Serious incidents
Mortality
Multi agency approach
Investigator & Family support worker Function
Mortality Case Note Reviews
Family Liaison Function
Mortality Case Note Reviews (contact)
SPOC (Single Point of Contact via family support worker )

- Who is the family
- Risk Assessment of family / staff
- Set criteria for contact
- Keep them informed
- Roles and accountabilities
- Rules re how much disclosure

# 10. Special Cases

## 10.1 Inpatients detained under Mental Health Act

- Regulations17 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.
- In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.
- 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.
- BSMHFT is also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983). All deaths of patients detained under the Mental health act or inpatients under DOLS provision will be reported as a Serious incident (SI) and investigated as a SI.
- In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) by the head of investigations of the Trust as a serious incident and investigated appropriately.
- Consideration should also be given to commissioning an independent investigation as detailed in the Serious Incident Framework.

## 10.2 People with Mental Health Disorders in Prisons

- Evidence shows that there is a high incidence of mental health problems in prisons: 72% of adult male and 71% of female prisoners may have 2 or more mental disorders.
- There have been large increases in the number of natural and non-natural deaths in prisons over the most recent five-year reporting period.

- The increase in recent years in non-natural deaths in prisons are due to a number of factors. Prisons contain a high proportion of vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of suicide or self-harm.
- The NHS Serious Incident Framework states that in prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations.
- BSMHFT will fully support these investigations where required to do so.
- The PPO (prison and probation ombudsmen) has clear expectations in relation to health involvement in PPO investigations into death in custody.
- Guidance published by the PPO will be followed by BSMHFT in cooperating with the PPO in investigating deaths in Prison custody where BSMHFT is the Provider

**10.3 Cases of death with Patients with learning disability: by adopting the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme**

All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology:

- The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017.
- If there is a death of a person with learning disabilities in BSMHFT and the ledr programme review is not available, the LeDeR initial review process and documentation availableat:**http://www.bristol.ac.uk/medialibrary/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf** will be used.
- BSMHFT will then submit that as an attachment to the LeDeR notification web-based platform once the review is completed
- Once the LeDeR review has been completed, a copy will be sent to the BSMHFT Mortality review group for action
- BSMHFT will encourage at least 2 senior clinicians to undertake LeDeR training and review processes
- Reviewers would be expected to conduct reviews independent of BSMHFT.

**10.4 Child death**

- BSMHFT whilst responding to the deaths of children who die under its care will work in line with the expectations described within Working Together to Safeguard Children (2015) and of NHS England's current review of child mortality review processes.
- Chair of the Mortality review group or clinical lead for the children's service will communicate with bereaved parents and carers and provide an honest and compassionate account of the reasons for death and knowledge of any potential problems in care that may need further review,
- Initial contacts will be managed by clinicians responsible for the care of the patient, and offering support to express concerns about the care given to patients who have died
- Efforts will be made to achieve independence (where relevant) and objectivity in the child mortality review process, as well as lay membership within wider clinical governance systems.
- Cross-system Reviews and Investigations: When the death of a child involves treatment across the health care pathway (primary: secondary: tertiary care) it is expected that child mortality review processes will not be duplicated and that a single overarching meeting will be convened. BSMHFT will participate and actively support such a process.
- Child mortality review processes should interface with existing organisational governance systems. The chair of the Mortality review group will lead on this process or nominate a suitable senior clinician .
- Working Together places the family at the heart of its processes. However it is recognised that the multitude of investigations that may unfold following a child's death can cause great confusion and distress to parents.

The national bereavement group and bereavement charities are closely involved with developing NHS England's child death review programme – both in the co-design of systems and public guidance that explains processes BSMHFT staff will follow this guidance

The national Child Death Review programme recognises the following principles:

1. Bereaved families and carers should be treated as equal partners both in the delivery of care and following a bereavement

2. Bereaved families and carers should receive a high standard of bereavement care, including being offered appropriate support

3. Bereaved families and carers must always receive an honest, caring and sensitive response

4. Bereaved families and carers should receive timely, responsive contact and support in all aspects of any review process, with a single point of contact and liaison

## 11. Training

Training for Doctors/RGNs who will conduct the Mortality structured case note reviews would occur through a process of Mortality master classes

This would include:

1. Training in the Structured judgment review process
2. Human factor Analysis
3. The mortality review process
4. Engaging with families
5. Learning lessons process

## 12. Learning lessons

**Learning lessons from the mortality reviews would involve**

a) Thematic reviews
b) Mortality learning lessons days for all clinicians
c) Trust Board report quarterly highlighting lessons learnt
d) Use of Mortality web page on the intranet , learning lessons bulletins
e) Joint learning of lessons with Acute hospitals

**Annex1**

**Structured Case Note Review and Human Factor Analysis for Quality Improvement in Mortality Template (stage one)**

Name

NHS Number

## 1. Phase1: Incident and 7 days before incident

Describe in your own words any significant features strengths and weaknesses in the caring process be explicit and clear (about 100 words maximum)

## 2. Phase 2: day 30 to day 7 prior to the incident

Describe in your own words any significant features strengths and weaknesses in the caring process be explicit and clear (about 100 words maximum)

## 3. Phase 3: day 180 to day 30 prior to the incident

Describe in your own words any significant features strengths and weaknesses in the caring process be explicit and clear (about 100 words maximum)

## 4. Conclusion:

## 5. Grade Incident

Circle as appropriate

- Very poor care
- Poor care
- Adequate care
- Good care
- Excellent care

## 6. Human factor analysis

Consider the below make a short summative comment.

You may not be able to comment on each of these factors due to lack of information or irrelevance

- Organisational Influences
- Resource Management:
- Organisational Climate:
- Organisational Process:

## 7. Supervision

- Inadequate supervision
- Failure to address known problems
- Supervision violation

## 8. Precondition to unsafe acts

- Environmental factors:
- Staff condition (mental state, training, seniority):
- Staff factors (communication, coordination, fitness):

## 9. Unsafe acts

- Errors:
- Deliberate violations of policies /procedures/Guidance:

**Annex 2: Structured Case Note Review and Human Factor Analysis for Quality Improvement in Mortality Template (stage Two)**

Only in cases where Stage one grading is 1/2

Name

NHS Number

1. **Phase1: Incident and 7 days before incident**

Describe in your own words any significant features strengths and weaknesses in the caring process be explicit and clear (about 100 words maximum)

2. **Phase 2: day 30 to day 7 prior to the incident**

Describe in your own words any significant features strengths and weaknesses in the caring process be explicit and clear (about 100 words maximum)

3. **Phase 3: day 180 to day 30 prior to the incident**

Describe in your own words any significant features strengths and weaknesses in the caring process be explicit and clear (about 100 words maximum)

4. **Conclusion**

5. **Grade Incident**

Circle as appropriate

1. Very poor care

2. Poor care

3. Adequate care

4. Good care

5. Excellent care

6. **Avoidability Grading circle as appropriate:**

**Score 1** Definitely avoidable

**Score 2** Strong evidence of avoidability

**Score 3** Probably avoidable (more than 50:50)

**Score 4** Possibly avoidable, but not very likely (less than 50:50)

**Score 5** Slight evidence of avoidability

**Score 6** Definitely not avoidable

**7. Human factor analysis**

Consider the below make a short summative comment.

You may not be able to comment on each of these factors due to lack of information or irrelevance

- Organisational Influences:
- Resource Management:
- Organisational climate:
- Organisational Process:

**8. Supervision**

- Inadequate supervision
- Failure to address known problems
- Supervision violation

**9. Precondition to unsafe acts**

- Environmental factors:
- Staff condition (mental state, training, seniority):
- Staff factors (communication, coordination, fitness):

**10. Unsafe acts**

- Errors:
- Deliberate violations of policies /procedures/Guidance:

## Annex 3.

## Definitions

The National Guidance on Learning from Deaths includes a number of terms. These are defined below.

**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.

**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.

**Mortality review**

A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

**Serious Incident**

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.

**Investigation**

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery

to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

**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’). The term ‘avoidable mortality’ should not be used, as this has a specific meaning in public health that is distinct from ‘death due to problems in care’.

**Quality improvement**

A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

**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