

MORTALITY REVIEW POLICY

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VERSION NUMBER	V2
KEY CHANGES FROM PREVIOUS VERSION	Amendments to reflect outcomes of review of processes in first year of policy implementation and national developments
AUTHOR	██████████, Project Co-ordinator
CONSULTATION GROUPS	Mortality Review Sub-Committee
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POLICY SUMMARY	
<p>The aims of this Mortality Review Policy are to provide a robust governance framework for undertaking mortality review to improve the quality and safety of services to our patients by:</p> <ul style="list-style-type: none"> • Ensuring that deaths that occur within the Trust are subjected to appropriate review based on the circumstances of the death which enables any good practice or conversely problems in care to be identified on an individual basis; • Ensuring that any problems in care for individual cases are addressed appropriately and appropriate actions taken in relation to that death; • Ensuring that any good practice and lessons learnt are shared across the Trust where appropriate and local actions taken to ensure that good practice is increased and improvements in care are implemented across the Trust where necessary; • Ensuring that the Trust has a corporate oversight of deaths of patients in its care and identifies any trends or themes of concern or good practice emerging which may require further investigation and action; and • Ultimately providing the Trust Board with assurance that there are robust processes in place in line with national guidance to review deaths appropriately which form part of the Trust processes for continually reviewing and ensuring that patients are receiving safe, high quality care. <p>This Mortality Review Policy has been developed from the learning of a number of national reports (referenced in the Introduction / Context Section) and complies with the NHS Quality Board's "National Guidance on Learning from Deaths" requirements. It sets out the governance framework for mortality review, a framework for the review of individual deaths and a framework for the surveillance of mortality across the Trust. It is supported by Procedural Guidelines.</p>	

The Trust monitors the implementation of and compliance with this policy in the following ways:

The Mortality Review Sub-Committee is responsible for ensuring that this Policy is appropriately implemented and for monitoring the effectiveness of this Policy.

A bi-monthly assurance report will be provided to the Quality Committee from the Mortality Review Sub-Committee which will include any hotspots and areas of positive assurance.

Appropriate data dashboards will be presented to various levels of group / committee involved in the mortality review process in order to enable them to undertake their role in the process effectively and to assure that the process is working effectively.

To support the Mortality Review Sub-Committee in their monitoring of effectiveness of the processes in place, a random audit of an appropriate sample size (to be determined by the Mortality Review Sub-Committee) of deaths designated as “Unexpected deaths” not referred for a detailed review by the Clinical Review Panel (ie closed at Level / Grade 1) will be undertaken on an annual basis to assess the appropriateness of the definitions and associated levels of scrutiny (grades of review / investigation) assigned. The relevant Mortality Review Form will be completed for the cases with a view to determining whether it was appropriate to close the case without further review. The outcomes of these audits will be presented to the Mortality Review Sub-Committee.

An independent assessment of the quality of SI investigations within EPUT will also be commissioned on an annual basis by the Executive Medical Director.

Services	Applicable	Comments
Trustwide	✓	
Essex MH&LD		
CHS		

**The Director responsible for monitoring and reviewing this policy is
Executive Medical Director**

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MORTALITY REVIEW POLICY

CONTENTS

- 1.0 INTRODUCTION AND CONTEXT**
- 2.0 AIMS OF MORTALITY REVIEW POLICY**
- 3.0 GOVERNANCE FRAMEWORK – INDIVIDUAL RESPONSIBILITIES**
- 4.0 GOVERNANCE FRAMEWORK – COMMITTEE RESPONSIBILITIES**
- 5.0 FRAMEWORK FOR THE REVIEW OF INDIVIDUAL DEATHS**
- 6.0 FRAMEWORK FOR THE SURVEILLANCE AND REPORTING OF MORTALITY ACROSS THE ORGANISATION**
- 7.0 IMPLEMENTATION**
- 8.0 MONITORING AND REVIEW**
- 9.0 REFERENCES**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

MORTALITY REVIEW POLICY

Assurance Statement

This Mortality Review Policy is intended to provide a robust governance framework for undertaking mortality review to improve the quality and safety of services to our patients. It supports the Trust in meeting the requirements of the requirements of the National Guidance on Learning from Deaths.

1.0 INTRODUCTION AND CONTEXT

- 1.1 The Chief Executive and Board of Directors are fully committed to the continuous development of a safety culture throughout the Trust, whereby the safety and health of all service users, residents, staff, carers and visitors is paramount.
- 1.2 The findings of the “Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 – March 2015” undertaken by Mazars (published December 2015) highlighted a number of concerns within that Trust about the oversight, management and review of deaths of people with mental health and learning disabilities.
- 1.3 Following the Southern Health review, the Secretary of State asked the Care Quality Commission to undertake a review of how NHS acute, community and mental health trusts identify, investigate and learn from the deaths of their patients, and how they involve bereaved families and carers. They looked at the deaths of all patients, with a spotlight on the deaths of people using learning disability or mental health services. The Care Quality Commission published their report of this review - “Learning, Candour and Accountability – A review of the way NHS trusts review and investigate the deaths of patients in England” - in December 2016.
- 1.4 This report identified that there was no single framework for NHS Trusts that set out what they needed to do to maximise the learning from deaths that may be the result of problems in care. This meant that there were a range of systems and processes in place, and that practice varied widely across providers. The CQC concluded that, as a result, learning from deaths was not being given enough consideration in the NHS and opportunities to improve care for future patients were being missed. Across the review the CQC was unable to identify any trust that could demonstrate good practice across all aspects of identifying, reviewing and investigating deaths and ensuring that learning was implemented.

- 1.5 Many complexities and inconsistencies were identified nationally in terms of the way organisations become aware of the deaths of people in their care and the way in which NHS Trusts are required to record when recent patients die after they have been discharged from a service. The CQC report also identified that there is inconsistency in the methods and definitions used across the NHS to identify and report deaths leading to decisions being taken differently across Trusts and that frameworks used in Trusts to inform decision making in terms of investigating deaths also varied across Trusts. The report therefore recommended that national solutions were progressed including the development of a new single national framework on learning from death and exploration of national system improvement in terms of the notification of deaths.
- 1.6 In March 2017, the National Quality Board issued the first edition of *“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”*. Its purpose is to help initiate a standardised approach across the NHS which it is intended will evolve as learning in terms of mortality review takes place nationally.
- 1.7 In July 2017, NHS Improvement issued supplementary guidance to support organisations in their implementation of the National Guidance on Learning from Deaths entitled *“Implementing the Learning from Deaths framework: Key requirements for Trust Boards”*.
- 1.8 Links to all of the above documents are included at section 12 of this Policy.
- 1.9 Any queries in terms of mortality review or this Policy should be directed to the Trust’s Serious Incident Team in the first instance.

2.0 AIMS OF MORTALITY REVIEW POLICY

- 2.1 One of the requirements of the National Guidance on Learning from Deaths issued in March 2017 was for all NHS organisations to have in place a policy by September 2017 on how it responds to and learns from deaths of patients who die under its management and care. The following policy and attaching procedural guidelines fulfil this national requirement and comply with the national guidance in terms of its content.
- 2.2 The aims of this Mortality Review Policy are to provide a robust governance framework for undertaking mortality review to improve the quality and safety of services to our patients by:
- 2.2.1 Ensuring that deaths that occur within the Trust are subjected to appropriate review based on the circumstances of the death which enables any good practice or conversely problems in care to be identified on an individual basis;
- 2.2.2 Ensuring that any problems in care for individual cases are addressed appropriately and appropriate actions taken in relation to that death;

- 2.2.3 Ensuring that any good practice and lessons learnt are shared across the Trust where appropriate and local actions taken to ensure that good practice is increased and improvements in care are implemented across the Trust where necessary;
- 2.2.4 Ensuring that the Trust has a corporate oversight of deaths of patients in its care and identifies any trends or themes of concern or good practice emerging which may require further investigation and action; and
- 2.2.5 Ultimately providing the Trust Board with assurance that there are robust processes in place in line with national guidance to review deaths appropriately which form part of the Trust processes for continually reviewing and ensuring that patients are receiving safe, high quality care.
- 2.3 This Mortality Review Policy has been developed from the learning of the above national reports and sets out:
- 2.3.1 Governance framework (sections 3 and 4)** – these sections set out the governance arrangements in place within EPUT to oversee, monitor, review and analyse deaths that have occurred within Trust provided services. Individual responsibilities are set out in section 3 of this document and the governance committee structure is set out in section 4.
- 2.3.2 Framework for the review of individual deaths (section 5)** – this section sets out the processes to be followed to ensure a consistent and coordinated approach for the review of deaths on an individual basis, to identify any areas of practice both specific to the individual case and beyond that could potentially be improved as well as good practice. This will enable the Trust to implement and share lessons learned and to ultimately ensure that services are as safe and effective as possible.
- 2.3.3 Framework for the surveillance of mortality across the Trust (section 6)** - this section sets out the reporting processes in place that will enable the Trust to analyse and understand the position in terms of numbers of deaths and any thematic issues arising; and to ensure that there are processes for escalation of any areas of concern identified so that the Trust can take appropriate action.
- 2.3.4 Implementation (section 7)** – this section includes details of the arrangements in place within the Trust for implementing this Mortality Review Policy and associating Procedural Guidelines.
- 2.3.5 Monitoring and review (section 8)** – this section sets out the arrangements for monitoring and reviewing the Mortality Review Policy and associating Procedural Guidelines.
- 2.3.6 Associating Procedural Guidelines (Appendix 1)** - this Policy is supported by Mortality Review Procedural Guidelines which have been developed by the Mortality Review Sub-Committee. These provide more detail in terms of the detailed operational processes to be followed to deliver the Mortality Review Policy.

- 2.4 This Mortality Review Policy links directly with other Trust policies including the Adverse Incident Policy (including Serious Incidents), policies relating to being open / Duty of Candour and the Risk Management and Assurance Framework.
- 2.5 This Mortality Review Policy applies to anyone involved in the mortality review process – this includes all staff employed within the Trust either permanent or on a temporary basis and to volunteers.
- 2.6 The overriding principle in developing this policy and attaching procedural guideline has been to ensure that the approach and processes outlined are compliant with the national guidance and are deliverable from the outset of implementation. Over time, as local and national systems develop and processes are evaluated, the Trust will continue to consider opportunities to further enhance and extend the coverage of the policy.

3.0 GOVERNANCE FRAMEWORK – INDIVIDUAL RESPONSIBILITIES

3.1 The following individuals within the Trust will undertake a role in relation to mortality review:

Chief Executive	The Chief Executive will ensure that this Policy is implemented across the organisation and that the necessary financial priority is allocated to maintain a safe system of care and work.
Designated Non-Executive Director	The Non-Executive Director designated as the lead NED for mortality review will maintain oversight of progress in accordance with the guidance contained at Annex B of the National Guidance on Learning From Deaths March 2017. This will include: <ul style="list-style-type: none"> • Understanding the process – ensuring the processes in place are robust and can withstand external scrutiny by providing challenge and support. • Championing and supporting learning and quality improvement. • Assuring published information – ensuring that information published is a fair and accurate reflection of the Trust’s achievements and challenges.
Executive Medical Director	The Executive Medical Director will be the lead Director responsible for ensuring that there is an appropriate mortality review policy and associating procedures in place within the organisation, including: <ul style="list-style-type: none"> • Chairing the Trust Mortality Review Sub-Committee; • Leading the process for mortality review and escalating any areas of concern to the Board of Directors (usually via the Quality Committee but directly should timescales require);

CP64 – Mortality Review Policy

	<ul style="list-style-type: none"> • Placing any identified risks onto the Trust Risk Register; • Ensuring that any mortality concerns raised by external bodies such as the Care Quality Commission are investigated and resolved; • Ensuring that any external guidance in terms of mortality review is reviewed within the Trust and appropriate action taken; • Ensuring that any lessons learnt are progressed through appropriate channels within the Trust; • Providing bi-monthly assurance reports to the Quality Committee; and • Ensuring that the mortality review work plan is progressed and monitored appropriately.
Director with responsibility for serious incident management (Executive Nurse)	<ul style="list-style-type: none"> • Support the Executive Medical Director in the full implementation of this Mortality Review Policy; • Maintain oversight of the serious incidents process and function; and • Ensure that lessons learnt are implemented across services.
Director with responsibility for Information	<ul style="list-style-type: none"> • Ensure that there are appropriate clinical data systems in place within the Trust to provide the necessary information to enable mortality review processes.
Director with responsibility for Risk Management	<ul style="list-style-type: none"> • Ensure that there are appropriate incident reporting systems in place within the Trust to provide the necessary information to enable mortality review processes. • Chair the Mortality Data Group which oversees this work.
Director with responsibility for clinical governance / quality	<ul style="list-style-type: none"> • Oversee the Deceased Patient Review Group that reports to the Mortality Review Sub-Committee with information / advice in terms of deaths requiring individual investigations. • Ensure that a monthly report is provided from the Deceased Patients Review Group to the Mortality Review Sub-Committee to provide assurance in terms of the review of individual deaths.
Mortality Review Lead	<ul style="list-style-type: none"> • Oversee the production of relevant data dashboards and reports for the Deceased Patients Review Group, Mortality Review Sub-committee, Quality Committee, Trust Board and others as required. • Co-ordinate delivery of the mortality review work plan, including co-ordination of the undertaking of mortality reviews and learning from the outcomes.
Operational Directors and Senior Management	<p>Directors and Senior Management will implement this Policy within their areas of responsibility through leadership, management systems and example. This will include:</p> <ul style="list-style-type: none"> • Ensuring their teams report and deal with deaths appropriately and follow the procedural guidelines

CP64 – Mortality Review Policy

	<p>including reviewing deaths.</p> <ul style="list-style-type: none"> • Monitoring implementation of this Policy within their areas of responsibility and take any necessary remedial action. • Ensuring that findings from mortality review are discussed as part of departmental clinical governance forums. • Ensuring that any organisational lessons learned are implemented within their area of responsibility. • Escalating any concerns identified for their area of responsibility to their local Quality and Safety Group for consideration and, if necessary, referral to the Mortality Review Sub-Committee.
<p>Managers and other Persons in Charge / Team Leaders / Nursing Home Managers</p>	<p>Managers and other persons in charge / team leaders / nursing home managers will:</p> <ul style="list-style-type: none"> • Ensure that all staff including new and temporary employees are made aware of the procedures and principles detailed within this Policy and that procedural guidelines are followed to meet all relevant guidance. • Ensure that staff are trained in the use of DATIX on-line web-based incident reporting system and have suitable access to Trust computer terminals to report deaths. In the event of the on-line DATIX system being unavailable, managers will decide whether the incident can wait to be reported according to severity and risk. Details in terms of subsequent reporting are included in the Adverse Incident Policy (CP3). • Feedback to and reflect on deaths with their staff to identify issues, support learning and reinforce a reporting culture. <p>The manager in charge is also responsible for ensuring all those involved in dealing with a death are offered appropriate support.</p>
<p>Investigating Officers and other officers with a responsibility in the Adverse Incident Policy (CP3)</p>	<p>Investigating Officers and other officers with a designated responsibility in the Adverse Incident Policy will ensure that they act in accordance with that policy.</p>
<p>Risk Management Team</p>	<ul style="list-style-type: none"> • Contribute to the production of relevant data dashboards for the Deceased Patients Review Group, Mortality Review Sub-committee and others as required. • Contribute to the production of mortality data and prepare any necessary reports, in partnership with the Clinical Governance and Quality Team, to meet Trust Board, performance, local service and commissioner reporting requirements.
<p>Serious Incident Team</p>	<ul style="list-style-type: none"> • Provide advice and guidance in terms of mortality review.

CP64 – Mortality Review Policy

	<ul style="list-style-type: none"> • Ensure the outcomes of the Deceased Patients Review Group, Clinical Review Panels and Mortality Review Sub-Committee are recorded onto Datix. • Retain a copy of all Grade 2 mortality review forms completed and the records of the summary discussions of Clinical Review Panel meetings. • Ensure appropriate sharing of any lessons learned through the mortality review process via the Learning Oversight Sub-Committee.
Information Team	<ul style="list-style-type: none"> • Contribute to the production of relevant data dashboards for the Deceased Patients Review Group, Mortality Review Sub-committee and others as required. • Contribute to the production of mortality data and prepare any necessary reports, in partnership with the Clinical Governance and Quality Team, to meet Trust Board, performance, local service and commissioner reporting requirements.
Patient Systems Development Team	<ul style="list-style-type: none"> • Produce regular reports from the National Spine of all deaths and compare against patient records to identify any deaths of EPUT patients. • Record such deaths appropriately on Trust clinical systems.
Chief Pharmacist / Medicines Management Team	<ul style="list-style-type: none"> • Provide advice in relation to medications issues in the context of mortality review, both on an individual and thematic basis.
All Staff, contractors and volunteers	<ul style="list-style-type: none"> • All staff, contractors and volunteers must ensure that the principles and processes contained within this Policy and associated procedural guidelines are followed at all times. This includes the timely and full reporting of deaths using the Trust's agreed reporting systems.
Whistle-blowing	<ul style="list-style-type: none"> • If staff have concerns regarding any deaths / delivery of clinical care, these concerns should be raised initially with their line manager. However staff can also raise concerns via the Trust Whistle Blowing Policy and procedural guideline or make contact with the Trust's Freedom to Speak Up Guardian.

3.2 Mortality review is a complex process with potentially many agencies involved directly or indirectly in incidents resulting in the death of an NHS patient – the roles and responsibilities of national bodies and commissioners in relation to mortality review are outlined in Annex I of the National Guidance on Learning from Deaths March 2017.

4.2 The role of these Committees / Groups will be as follows:

4.2.1 The Board of Directors

The Board of Directors is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust. It will therefore ensure that there is a safety culture within the organisation and maintain effective corporate oversight of mortality review within the Trust. This will be delivered via the receipt of regular assurance from the Quality Committee in terms of systems and processes in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care and outcomes of these systems. They will also ensure that activities relating to mortality review are adequately resourced. The Trust will ensure that Executive Directors and Non-Executive Directors have the capability and capacity to understand the issues affecting mortality in the Trust and to provide necessary challenge. The Board of Directors will ensure that there are robust governance arrangements supporting it in its delivery of effective mortality review. These arrangements will allow them to identify any areas of failure of clinical care and ultimately ensure the delivery of safe care. Detailed responsibilities of the Board of Directors are outlined at Annex A of the National Guidance on Learning from Deaths (link at Section 12 of this Policy).

4.2.2 Quality Committee

The Quality Committee will be responsible for maintaining oversight of the implementation of the Mortality Review Policy with a view to ultimately enabling the Board of Directors to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance processes and controls are in place throughout the Trust to promote safety and excellence in patient care; identify, prioritise and manage risk arising from clinical care; ensure the effective and efficient use of resources through evidence based clinical practice; and protect the health and safety of the Trust's employees.

The Quality Committee will therefore maintain oversight of the processes in place for mortality review, the monitoring and analysis of mortality rates and associated outcomes within the Trust and ensure that appropriate actions are taken and learning realised.

4.2.3 Mortality Review Sub-Committee

The Mortality Review Sub-Committee will be responsible for:

- Agreeing and overseeing the implementation of an agreed annual work plan.
- Overseeing the implementation and continued development of systems and processes for the delivery of effective mortality review across Essex Partnership University NHS Foundation Trust.
- Ensuring that all deaths that occur within the scope of this Policy are subject to sufficient review and analysis and presenting mortality data to the Board, the Executive Team and Trust Services as required.

- Monitoring and reviewing the minimum dataset required for the effective capture and analysis of deaths across all services and ensuring that reporting systems across the Trust are changed to reflect this requirement on an on-going basis.
- Keeping under review and continuing to develop where appropriate the systems and processes for recording and reporting deaths within the Trust to support this.
- Keeping under review and continuing to develop where appropriate monitoring and reporting standards across all Trust services, including the review of existing procedures for the reporting, recording and investigation of expected and unexpected deaths.
- Overseeing the implementation of recommendations as applicable to the Trust from national reports and guidance, including the Mazars Southern Healthcare report, the National Quality Board “National Guidance on Learning from Deaths” and other subsequent guidance.
- Undertaking mortality surveillance and identifying mortality trends, recommending a course of action to improve mortality where appropriate.
- Commissioning and overseeing completion of inquiries into the deaths where a trend has been identified.
- Commissioning and considering the outcomes of thematic mortality reviews.
- Ensuring that systems and processes are in place to consider and implement the learning from mortality review and that learning is implemented to improve quality of patient care.
- Agreeing the functions and scope of the Deceased Patients Review Group, the Mortality Data Group and the Suicide Prevention Group and receiving regular assurance reports from those Groups.
- Overseeing external reporting arrangements as required for mortality for inclusion within Board reports, national reporting templates and the annual Quality Report.
- Working closely with other relevant Trust Committees and Groups (eg , Physical Healthcare, Learning Oversight, local Quality and Safety Groups) to ensure a holistic approach to mortality review.
- Providing regular assurance reports to the Quality Committee.

4.2.4 Deceased Patients Review Group

The Deceased Patients Review Group/s will be responsible for reviewing and overseeing all reported deaths in scope across all Trust services in order to ensure that appropriate actions are taken in respect of each death; and to provide assurance to the Mortality Review Sub-Committee that all deaths have been subject to review and investigated to an appropriate level. The Deceased Patients Review Group/s will retain a record of decisions taken (usually via Datix) and provide a monthly assurance report to the Mortality Review Sub-Committee. The Deceased Patients Review Group may also perform the role of a Clinical Review Panel if / when appropriate.

4.2.5 Clinical Review Panels

Clinical Review Panels will be convened as and when required and will be responsible for undertaking scrutiny of detailed Grade 2 Clinical Case Record Reviews of individual deaths undertaken by reviewers utilising the Trusts agreed mortality review tools (see section 5). They will retain a record of decisions taken and the associating rationale via sign off of the Trust pro-forma mortality review tools, a summary of which will be presented to the Mortality Review Sub-Committee for review and assurance purposes.

4.2.6 Mortality Data Group

The Mortality Data Group will consider data issues relating to the delivery of an effective mortality review process and advise / present recommendations to the Mortality Review Sub-Committee for decision where appropriate. This will include overseeing the production of the monthly information for the Deceased Patient Review Group and quarterly dashboard information for the Mortality review Sub-Committee; detailed consideration of the dashboard information; reviewing data capture and analysis systems and advising the Mortality Review Sub-Committee appropriately on data issues.

4.2.7 Suicide Prevention Group

The Suicide Prevention Group will oversee, operationalise and implement EPUT's Suicide Prevention Strategy. This will include providing assurance to the Mortality Review Sub-Committee that clear standards for suicide prevention are in place; developing, implementing and reviewing specific pathways for high risk groups; and developing and reviewing appropriate Trust policies.

4.2.8 Task and Finish Groups (time limited)

Task and Finish Groups may be set up from time to time to support the Mortality Review Sub-Committee in the delivery of its functions. Clear terms of reference will be developed for any Task and Finish Groups.

4.2.9 Learning Oversight Sub-Committee

The Learning Oversight Sub-Committee will be responsible for ensuring that organisational learning from mortality review is implemented and that assurance is provided to the Mortality Review Sub-Committee that this is the case.

4.2.10 Local Quality and Safety Groups

Local Quality and Safety Groups will receive information on organisational mortality review as part of the regular Clinical Governance Reports considered by these Groups. This will ensure that any lessons learnt are shared and appropriate actions taken locally to ensure organisational learning is embedded.

5.0 FRAMEWORK FOR THE REVIEW OF INDIVIDUAL DEATHS

5.1 PURPOSE AND SCOPE

5.1.1 The purpose of this framework is to ensure a consistent and coordinated approach for the review of deaths on an individual basis, to identify any areas of practice both specific to the individual case and beyond that could potentially be improved as well as good practice. This will enable the Trust to implement and share lessons learned and to ultimately ensure that services are as safe and effective as possible.

5.1.2 In accordance with the National Guidance on Learning from Deaths March 2017, the Trust will as a minimum focus reviews on in-patient deaths. However, the guidance also indicates that Mental Health, Learning Disability and Community Health Trusts are required to also consider which categories of outpatient and / or community patient deaths are within scope for review taking a proportionate approach.

5.1.3 The following deaths will be in scope for consideration for mandatory individual mortality review in the Trust:

- All deaths that have occurred within Trust inpatient services (this includes mental health, community health, learning disability and prison inpatient facilities).
- All deaths in a community setting of patients with recorded learning disabilities. (All deaths of patients with recorded learning disabilities, whether in an inpatient or community setting, will be referred into the national LeDeR programme.)
- All deaths meeting the criteria for a serious incident, either inpatient or community based. (Any deaths deemed to meet the criteria for a serious incident will be automatically referred for an immediate Grade 4 serious incident investigation.)
- Any other deaths of patients in receipt of EPUT services not covered by the above that meet the national guidance criteria for a Grade 2 case note review. These will be identified on a case by case basis and appropriate actions taken to ensure these deaths are recorded via Datix and subjected to the individual death review process within the Trust commencing with consideration by the Deceased Patient Review Group. These deaths will be:
 - Any patient deaths in a community setting which have been the subject of a formal complaint and / or claim by bereaved families and carers.
 - Any patient deaths in a community setting for which staff have raised a significant concern about the quality of care provision.
- In addition, the information relating to any deaths of patients deemed to have a severe mental illness in a community setting will be considered by the Deceased Patient Review Group and consideration given to whether it would be appropriate to refer the death for a Grade 2 review. For the purposes of this policy, this will be deemed to be any patient with a psychotic diagnosis (schizophrenia or delusional disorder) recorded on electronic clinical record systems who is recorded as having been under the care of the Trust for over 2 years.

- Any deaths identified for thematic review by the Mortality Review Sub-Committee. This will include:
 - Deaths in a service speciality, particular diagnosis or treatment group where an “alarm” has been raised with the Trust through whatever means.
 - Deaths where learning will inform the Trust’s existing or planned improvement work.
 - A further sample of other deaths, as identified by the Mortality Review Sub-Committee, that do not fit the identified categories so that the Trust can take an overview of where learning and improvement is needed most overall.
- A random sample of 20 expected inpatient deaths per annum.

5.1.4 The nature and circumstances of deaths vary on a case by case basis and the grade of mortality review / investigation (ie “level of scrutiny”) will be dependent on and proportionate to the circumstances of each specific death. Details of the different levels of scrutiny to which these deaths will be subjected are included in Section 5.4 of this Policy.

5.1.5 As systems become increasingly established, the Trust will look towards the possibility of extending the coverage of consideration for individual case record mortality review. Work will continue to be undertaken within the Trust to keep under review the processes used for notification and recording of all patient deaths (those identified within the Trust and those identified via other national systems) in order to establish how the coverage of mortality review within the Trust can be appropriately and proportionately extended in the future. The Mortality Review Policy will be amended to reflect changes in the scope of coverage over time.

5.2 DEFINITIONS

5.2.1 Type of Death

In line with definitions used in a number of Trusts regionally / nationally, the following definitions for type of death will be used within EPUT in order to ensure appropriate and consistent systems are implemented across the organisation for mortality review:

Term – Type of Death	Definition
<i>Expected Natural (EN)</i>	Death that was expected to occur in an expected timeframe (e.g. terminal illness); OR Death that was expected but not expected to happen within the timeframe (eg cancer but dies earlier than anticipated).
<i>Expected Unnatural (EU)</i>	Death that was expected but not from the cause expected or the timescale (eg misuse of drugs, eating disorder).
<i>Unexpected Natural (UN1)</i>	Death from a natural cause (eg sudden cardiac arrest).

Unexpected Natural (UN2)	Death from a natural cause but didn't need to be (eg alcohol, drug dependency).
Unexpected Unnatural (UU)	e.g. suicide, homicide.
Under determination	This term will be assigned to any patient deaths for which it has not yet been possible to assign a type of death until further information is obtained.
Unknown – unable to obtain information from coroner / other health care provider to determine type of death.	This term will be assigned to any patient deaths for which it has not been possible to ascertain a type of death despite requests for information from the coroner / other health care provider.

The Trust's reporting system (Datix) allows each type of death category to be denoted as "suspected" until the point that the death type has been confirmed following full review / investigation.

Clinicians making the report of the death will initially categorise the type of death and record this on Datix. However, the Deceased Patient Review Group will review the category assigned and may amend the category at a later date as further information becomes available.

5.2.2 Assessing whether deaths are due to "problems in care" provided by EPUT

5.2.2.1 The definition included in the national guidance in terms of a "death due to a problem in care" is ***"A death that has been clinically assessed using a recognised methodology of care record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable"***. This definition will therefore be used by the Trust.

5.2.2.2 The national reporting template requires Trusts to denote the extent to which a death was due to a problem in care on a scale of 1 – 6. The Trust uses the following scale:

- 1 - Death **definitely more likely than not** to be due to problems in care provided by EPUT.
- 2 - **Strong evidence** – ie significantly more than 50:50 – that death more likely than not to be due to problems in care provided by EPUT.
- 3 - **Probably likely** – ie more than 50:50 – that death due to problems in care provided by EPUT.
- 4 - **Not very likely** – ie less than 50:50 – that death due to problems in care provided by EPUT.
- 5 - **Slight evidence** – ie significantly less than 50:50 – that death could be due to problems in care provided by EPUT.
- 6 - Death **definitely less likely than not** to be due to problems in care provided by EPUT.

This is outlined in more detail in section 8.10 of the attaching Procedural Guideline.

- 5.2.2.3 It should be noted that in accordance with national guidance, the term “avoidable mortality” will not be used in the Trust in the context of mortality review.
- 5.2.2.4 The judgement of whether a death was “more likely than not” to have resulted from problems in care will require careful review of the care that was provided against the care that would have been expected given the understanding of acceptable clinical practice at the time of the incident and the wider circumstances within which the incident occurred. This will be a clinical judgement, usually taken by the individual/s reviewing the death, based on the information available relating to the death.
- 5.2.2.5 The matter of whether a death should be defined as being “due to a problem in care” should be considered consistently at the final stage of mortality review (usually at the final stage of the Clinical Case Record Review) utilising the Trust’s mortality review tools. It will also be considered at an appropriate stage within Serious Incident processes to ensure consistency of categorisation. The agreement in terms of an appropriate “problems in care” score to assign can be made via a Panel meeting or virtually by a Panel using email where necessary.
- 5.2.2.6 In making its decision in terms of whether a death was “due to a problem in care”, EPUT can only reach a conclusion in terms of its own involvement with the patient and the care that has been provided by EPUT. Please refer to section 8 of this policy for information on cross-system and multi-agency reviews.
- 5.2.2.7 All deaths automatically closed by the Deceased Patients Review Group without referral for more detailed review will be automatically deemed as “**definitely less likely than not** to be due to problems in care provided by EPUT” (level 6).
- 5.2.2.8 It would appear that there is still no national consistency in terms of the methodology or approach to assigning “problems in care” scores for mental health and community health trust deaths. It is understood that work is still on-going nationally to agree a national methodology and approach which it is hoped will be launched in late 2018. The Trust will therefore keep abreast of national developments and adapt processes accordingly.

5.2.3 Critical Incidents and Serious Incidents

Critical incidents are defined as incidents which do not meet the criteria for reporting externally as a serious incident, however have been identified by the Trust as an event where the opportunity to learn from the incident and to take action is likely to result in an improvement in the safety and quality of health care or reduce risks to staff or Trust Property / premises.

Serious incidents (SIs) are "events in health care where the potential for learning is so great, or the consequences to patients, residents, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response."

5.3 IDENTIFYING, RECORDING AND REPORTING OF DEATHS

- 5.3.1 The CQC Report "Learning, Candour and Accountability – A review of the way NHS trusts review and investigate the deaths of patients in England" (see paragraph 1.5) identified that there is inconsistency in the methods and definitions used across the NHS to identify and report deaths, particularly across different health care providers.
- 5.3.2 This is consistent with the local position within EPUT whereby deaths may be identified by the Trust in a number of ways and from a number of sources. Processes are in place within the Trust to ensure that deaths that the Trust are made aware of are appropriately recorded onto the Trust's clinical (and, where appropriate, incident reporting) systems to ensure that patient data is accurate and that data in relation to mortality is available for analysis by the Trust.
- 5.3.3 Details of the notification, recording and reporting of deaths process to be followed by staff is outlined in Annexe A of the Procedural Guideline attaching to this Policy. This annexe also details the specific arrangements for reporting deaths of patients detained under the Mental Health Act / on a Community Treatment Order which are subject to specific prescribed requirements.
- 5.3.4 Due to the lack of national connectivity between clinical systems of different health providers, the Trust is not necessarily informed routinely of deaths of patients under its care based in the community and other health providers are not necessarily routinely informed if a death occurs within EPUT as there is not routine system connectivity across the NHS. National IT solutions are being progressed to address this situation. In the meantime, the local processes outlined in Annexe A of the Procedural Guideline will be followed until a national solution is agreed.
- 5.3.5 The CQC Report highlights that "Department of Health guidance permits the sharing of patient information if this is necessary, proportionate and justified in the public interest. There is a clear public interest to be served by sharing clinical information to support learning and improvement following a death in care. Investigation leads should seek the advice of their Caldicott Guardian, information governance leads and legal advisers on a case by case basis, and follow guidance on making public interest disclosures". This national guidance, as well as appropriate Trust policies and procedures appertaining to information governance and Caldicott, will be taken into account in all mortality review work undertaken by EPUT.
- 5.3.6 There are nationally prescribed processes in respect of reporting and investigating certain types of deaths which may occur within the Trust (eg homicides, an individual with a Learning Disability or Mental Health Needs (Detained or Prison) and an infant or child death).

5.3.7 The Serious Incidents Team will be responsible for identifying where a death reported on Datix falls within one of these categories and will ensure that the nationally prescribed processes applicable at that time are appropriately fulfilled by the Trust. Details of background information and nationally prescribed processes are appended as follows to the National Guidance on Learning from Deaths (a link to the national guidance is contained at Section 12 of this Policy):

Annexe D – Learning Disabilities

Annexe E – Mental Health

Annexe F – Children and Young People

A summary of the requirements is provided at Annexe C of the attaching Procedural Guidelines.

5.3.8 The fact that the death falls within the scope of one of the nationally prescribed processes will be recorded on Datix and thus reported to the Deceased Patient Review Group for consideration and assurance to the Mortality Review Sub-Committee.

5.3.9 In line with national guidance, where case record review identifies a problem in care that meets the definition of a patient safety incident (defined as “any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care”) then this will be reported via local risk management systems to the National Reporting and Learning System (NRLS).

5.4 LEVEL OF SCRUTINY (IE GRADE OF REVIEW / INVESTIGATION)

5.4.1 The nature and circumstances of deaths vary on a case by case basis and therefore the level of scrutiny (ie grade of review / investigation) should be dependent and proportionate to the circumstances of each specific death. The purpose of reviews / investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Such reviews / investigations are only useful for learning purposes if their findings are shared and acted upon. It should be noted that the Trust’s reviews / investigations are not conducted to hold any individual or organisation to account. Other processes exist for that purpose including criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation (eg GMC, CQC etc).

5.4.2 The Deceased Patient Review Group (DPRG) will undertake the initial review of information relating to every reported death in scope (with the exception of Serious Incidents which are detailed in paragraph 5.4.9 below). The DPRG will be notified on a monthly basis of an agreed dataset (appropriate dataset agreed by the Mortality Review Sub-Committee) for all patient deaths in scope recorded on Datix (produced by the risk team) and will assess this information to ensure that the appropriate level of scrutiny (ie grade of review / investigation) has been / is undertaken. The DPRG will recommend to the

Mortality Review Sub-Committee the grade of investigation required for each death given the circumstances.

5.4.3 The level of scrutiny (grade of review/investigation) will usually be as follows:

Type of death (definitions as section 4 above)	Level of scrutiny (as per national guidance)	Grade of review / investigation in EPUT
Expected Natural (EN)	<p>Level 1 – Death Certification: This applies to deaths by natural causes certified by the attending doctor. <i>(It should be noted that doctors are encouraged to report any death to the Coroner that they cannot readily certify as being due to natural causes – in these cases, consideration should be given to a Grade 2 – 4 review / investigation).</i></p>	<p>The DPRG will check that there is a DNACPR in place. If so, no further review will be undertaken and the record closed. This will be deemed to be a Grade 1 review. The fact that the record has been closed will be notified to the Mortality Review Sub-Committee. If no DNACPR is in place, the DPRG will seek further information prior to making a decision in terms of the appropriate level of review / investigation required.</p>
Expected Unnatural (EU) Unexpected Natural (UN1) Unexpected Natural (UN2)	<p>The level of scrutiny to which the death will be subjected may be any of the following:</p> <p>Level 1 – Death Certification This applies to deaths by natural causes certified by the attending doctor. Doctors are encouraged to report any death to the Coroner that they cannot readily certify as being due to natural causes.</p> <p>Level 2 – Case Record Review The application of a case record / note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. Those deaths that should be subjected to a minimum of Level 2 scrutiny are detailed in section 5.4.6 of this Policy.</p> <p>Level 3 – Investigation A systematic analysis of what happened, how it</p>	<p>The DPRG will determine the grade of review/investigation and will provide an assurance report to the Mortality Review Sub-Committee on a monthly basis of decisions taken. A decision will be sought from the Mortality Review Sub-Committee on any deaths about which the DPRG feels unable to make a decision without referral for advice / decision. Any recommendations by the DPRG for Grade 4 must be approved by the Executive Medical Director and Executive Director with responsibility for Serious Incidents.</p> <p>The grades of review/ investigation will range from:</p> <p>Grade 1 – Desktop review by DPRG and decision taken to close. <i>Level of scrutiny – Level 1 Death Certification.</i></p> <p>Grade 2 – Detailed desktop clinical review using the Trust’s mortality review tool and clinical records. <i>Level of scrutiny – Level 2 Case Record Review.</i></p> <p>Grade 3 – Full Critical Incident</p>

CP64 – Mortality Review Policy

Type of death (definitions as section 4 above)	Level of scrutiny (as per national guidance)	Grade of review / investigation in EPUT
	<p>happened and why. This will draw on evidence (including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation) in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The investigation process should aim to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events. Where appropriate, investigations should be guided by the framework in the national Serious Incident (SI) Framework.</p>	<p>Review by an Investigating Officer (as per the Trust's Adverse Incident Policy CP3). <i>Level of scrutiny – Level 3 Investigation.</i> Grade 4 –Full Root Cause Analysis and SI investigation by an Investigating Officer (as per the Trust's Adverse Incident Policy and in line with the national NHS Serious Incident Framework). <i>Level of scrutiny – Level 3 Investigation.</i> <i>Please note, unexpected deaths meeting the criteria for a Serious Incident (SI) will immediately be referred to an investigating officer by the SI team for a full Root Cause Analysis and SI investigation in accordance with the Adverse Incident Policy.</i></p>
<p>Unexpected Unnatural (UU)</p>	<p>Level 3 – Investigation A systematic analysis of what happened, how it happened and why. This will draw on evidence (including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation) in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The investigation process should aim to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events. Where appropriate, investigations should be guided by the framework in the national Serious Incident (SI) Framework.</p>	<p>Grade 4 –Full Root Cause Analysis and SI investigation by an Investigating Officer (as per the Trust's Adverse Incident Policy and in line with the national NHS Serious Incident Framework). <i>Level of scrutiny – Level 3 Investigation.</i> <i>Please note, unexpected deaths meeting the criteria for a Serious Incident (SI) will immediately be referred to an investigating officer by the SI team for a full Root Cause Analysis and SI investigation in accordance with the Adverse Incident Policy.</i></p>

Type of death (definitions as section 4 above)	Level of scrutiny (as per national guidance)	Grade of review / investigation in EPUT
Unknown – unable to obtain information from coroner / other health care provider to determine type of death.		A note will be made on the record by the DPRG that information has been requested but not secured, no further review will be undertaken and the record will be closed at Grade 1 review.

5.4.4 In making its decision about an appropriate grade of review / investigation, the Deceased Patients Review Group will take account of the details of each death recorded on Datix. Whilst the above table details the grade of review / investigation usually undertaken in given circumstances, the DPRG or Mortality Review Sub-Committee may legitimately decide to undertake a review / investigation at a different grade based on the circumstances of the death.

5.4.5 It should be noted that the grade of review / investigation may need to be reviewed and changed as new information or evidence emerges as part of the review / investigation process.

5.4.6 As a minimum, the following reported deaths will be subject to a minimum of level 2 scrutiny (ie Grade 2 case record review):

- a) All deaths (inpatient and community based) where bereaved families and carers or staff have raised a significant concern about the quality of care provision. For the purposes of this Policy, a “significant concern” from bereaved families and carers will be deemed to be a formal complaint / claim.
- b) All deaths (inpatient and community based) of patients with recorded learning disabilities. These will be subject to the national LeDeR programme review process. Advice in terms of the process for referral to the LeDeR programme will be provided by the SI team. These deaths will be considered by the DPRG and will usually be closed at Grade 1 in light of the fact that they will be considered via the national programme. However, the DPRG may refer the death for an internal review / investigation at a higher Grade should there be any concerns about the circumstances of the death.
- c) All deaths (inpatient or community based) of patients with “severe mental illness” will be considered for a Grade 2 case note review, dependent on the circumstances of the death. For the purposes of this Policy for the Trust, this is initially defined as any patient with a psychotic diagnosis (schizophrenia or delusional disorder) recorded on electronic clinical record systems who is recorded as having been under the care of the Trust for over 2 years.
- d) All deaths (inpatient or community based) in a service specialty, particular diagnosis or treatment group where an “alarm” has been raised with the Trust through whatever means (for example via an elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator). The Mortality Review Sub-Committee will be responsible for

considering and agreeing the need for such reviews; and for ensuring that appropriate reviews are then undertaken.

- e) All deaths in areas where people are not expected to die or had been subjected to a care intervention where death would not have been an expected outcome (eg ECT, rapid tranquilisation). For the purposes of this policy for the Trust, these deaths are defined as:
 - a. Any deaths of patients within CAMHS services (ie under age 18). These will also be subject to the national Child Mortality Review process (details included in Annexe C of the Procedural Guidelines associated with this policy).
 - b. Any deaths in in-patient services which are deemed by the Deceased Patient Review Group to warrant further detailed review within the following type of death categories :
 - i. Expected Unnatural (EU) – death that was expected but not from the cause expected or the timescale (eg misuse of drugs, eating disorder).
 - ii. Unexpected Natural (UN1) – death from a natural cause (eg sudden cardiac arrest).
 - iii. Unexpected Natural (UN2) – death from a natural cause but didn't need to be (eg alcohol, drug dependency).

Please note: Deaths categorised as “Expected Natural (EN)” will be closed by the Deceased Patient Review Group without further review beyond Grade 1. Deaths categorised as “Unexpected Unnatural (UU) – eg suicide, homicide” will be investigated via a Serious Incident Investigation – ie Grade 4 review.

- f) Deaths where learning will inform the Trust's existing or planned improvement work. To maximise learning, such deaths will be reviewed thematically. This may include for example deaths of patients where high risk medications were a significant part of the treatment regime, deaths of patients with identified risk factors, particular causes of deaths etc. The Mortality Review Sub-Committee will be responsible for considering and agreeing the need for such reviews; and for ensuring that appropriate reviews are then undertaken.
- g) A further sample of other deaths that do not fit the identified categories so that the Trust can take an overview of where learning and improvement is needed most overall. Again, the Mortality Review Sub-Committee will be responsible for identifying, defining and actioning reviews in this category.
- h) A random sample of 20 expected inpatient deaths (in accordance with the EN definition outlined above) per annum will be subjected to Level 2 scrutiny (i.e. case record review) on an annual basis to identify any lessons learned in terms of quality of care.

5.4.7 The above are additional to the requirements set out nationally for specific routes of reporting, review or investigations for specific groups of patient deaths such as deaths of patients detained under the Mental Health Act 1983. These are detailed in Annexe C of the associated Procedural Guidelines.

- 5.4.8 It should also be noted that doctors undertaking certification of death may refer cases for case record review to the most relevant organisation. This may therefore include EPUT doctors referring cases for case record review to other health providers or doctors in other organisations (including GPs) referring cases to EPUT for case record review (Grade 2). Any such requests will be considered via the Deceased Patient Review Group and taken through the normal mortality review governance process.
- 5.4.9 Any unexpected death of a patient currently under the care of EPUT or who had been under the care of EPUT within the previous 6 month period potentially meeting Serious Incident (SI) criteria will be notified to the Serious Incident team via Datix or via a telephone call. They will be referred by the SI team to the Executive Medical Director and Executive Director responsible for SIs for consideration and determination as to whether the death meets the criteria to be designated as a “Serious Incident”. In these cases, the Trust’s “Adverse Incident Policy including Serious Incidents” (CP3) will then be followed.
- 5.4.10 The detailed process for individual death review / investigation in accordance with the above levels of scrutiny / grades of review is outlined in the Procedural Guidelines attaching to this Policy.
- 5.4.11 Any deaths assessed as having a “problems in care” score of 1 – 3 will be automatically referred for a Critical Incident Review (Grade 3) or Serious Incident investigation (Grade 4) – see above section for definitions.
- 5.4.12 The grade of review / investigation undertaken for each death will be included in the summary dashboards analysed by the Mortality Review Sub-Committee to ensure that an overview can be maintained of grades of review / investigation undertaken and assurance provided that all deaths within scope are appropriately reviewed / investigated as part of organisational mortality surveillance (see section 9 below).
- 5.4.13 The Trust will review a case record review (Grade 2) or investigation (Grades 3 & 4) following any linked inquest and issue of a “Regulation 28 Report on Action to Prevent Future Deaths” in order to examine the effectiveness of internal review processes. The methodology for any such review will be agreed by the Mortality Review Sub-Committee and outcomes reported to the Mortality Review Sub-Committee.
- 5.4.14 Some deaths will be investigated by other agents, notably the coroner. For example, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. Care will be taken by the Trust to ensure that such investigations are not compromised whilst ensuring that internal review / investigation processes are progressed appropriately in the circumstances.
- 5.4.15 In circumstances where the actions of other agencies are required, the Trust will inform those agencies appropriately and follow relevant protocols.

5.4.16 It should be noted that case record review assessment is subject to significant inter-reviewer variation. As such it does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

5.5 STAFF SUPPORT

5.5.1 Support will be available to staff affected by the death of someone in the Trust's care or involved in the subsequent review / investigation of a death through the standard established Trust staff support processes. This includes support from immediate line managers and from services provided by the Trust's Occupational Health Service. Staff are advised to discuss any support needs with their line manager in the first instance.

5.6 ENSURING LESSONS ARE LEARNT AND IMPLEMENTED

5.6.1 The Serious Incident Team will ensure that any lessons learned from individual mortality reviews are appropriately shared across the organisation via established "lessons learnt" governance mechanisms. Please refer to section 9 of the Procedural Guideline associated with this Policy for further information on how the Trust will ensure that lessons are learnt and implemented from the mortality review process.

5.7 BEREAVED FAMILIES AND CARERS

5.7.1 Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients within the NHS is crucially important. In doing so, the Trust will ensure that the principles of openness, honesty and transparency, as set out in the Duty of Candour, are applied in engaging with bereaved families and carers.

5.7.2 The Trust will engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below:

5.7.2.1 Bereaved families and carers will be treated as **equal partners** following a bereavement;

5.7.2.2 Bereaved families and carers will always **receive a clear, honest, compassionate and sensitive response** in a sympathetic environment;

5.7.2.3 Bereaved families and carers will receive a **high standard of bereavement care** which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This will include providing, offering or directing people to specialist suicide bereavement support;

5.7.2.4 Bereaved families will be informed of their **right to raise concerns about the quality of care** provided to their loved one;

5.7.2.5 Bereaved families' and carers' views will **help to inform decisions about whether a review or investigation is needed**;

- 5.7.2.6 Bereaved families and carers will receive **timely, responsive contact and support in all aspects of an investigation process**, with a single point of contact and liaison;
- 5.7.2.7 Bereaved families and carers will be **partners in an investigation** to the extent and at whichever stages that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;
- 5.7.2.8 Bereaved families and carers who have experienced the investigation process will be supported to work in partnership with the Trust in **delivering training for staff in supporting family and carer involvement** where they want to.
- 5.7.3 Annexe B of the Procedural Guidelines associated with this Policy outlines how the Trust will ensure delivery of the above principles.
- 5.7.4 Should the Trust consider that it is appropriate to obtain legal advice in relation to a death under investigation, this will be communicated to the family and carer/s clearly from the outset so that they can understand the reasons for the involvement of lawyers and have the opportunity to arrange their own advocates in the process should they wish.

5.8 CROSS-SYSTEM REVIEWS AND INVESTIGATIONS

- 5.8.1 In many circumstances there will have been more than one healthcare provider organisation involved in the care of a patient who dies. This will apply both in the context of patients who die within EPUT services who will have been receiving services from other healthcare providers and to patients who die under the care of another healthcare provider but who were (or who had recently been) receiving services from EPUT. This is particularly likely for patients receiving mental health and learning disability services.
- 5.8.2 Case record reviews (ie Grade 2 reviews) typically rely on the records held by the organisation undertaking that review. However these records may provide indications of possible problems in care at earlier stages of the patient pathway with other providers.
- 5.8.3 Where the Trust identifies during a Grade 2 (or Grade 3 and 4) review the potential of problems in care with another healthcare provider, the Trust will take action to inform the other healthcare provider of its findings and suggest the healthcare provider undertakes a review of the care it provided.
- 5.8.4 Should another organisation suggest that the Trust review the care provided in the past to a patient who is not under the Trust's care at the time of death, the Trust will undertake a review utilising the most appropriate tool and methodology based on when the episode of care was.
- 5.8.5 Often in complex circumstances, separate investigations may be completed by the various different provider organisations. Where this is the case, a "lead provider" to coordinate the overall investigation should be identified. The "lead provider" will ensure that all organisations involved consider cross boundary issues such as gaps in services that may lead to problems in care

and will coordinate the findings of all investigations. Contributing factors and root causes of any problems identified will be fully explored by all organisations involved in order to develop effective solutions to prevent recurrence. The culmination will be the development of a single investigation report by the lead provider.

- 5.8.6 Where the provision of care by multiple providers, and particularly the coordination of that care, is thought to have potentially contributed to the death of a patient, the organisation identifying the death and potential need for a multi-agency review / investigation should contact the Clinical Commissioning Group to help facilitate discussions relating to which is the most appropriate organisation to take responsibility for co-ordinating the investigation process. This could include a local authority or other external body. Where no one provider is best placed to assume “lead provider” responsibility for co-ordinating an investigation, the commissioner may lead the process. If commissioners do not have the capability or capacity to manage this type of activity, the Clinical Commissioning Group will escalate this (for example through the relevant Quality Surveillance Group or through specific review panels and clinical networks) to ensure appropriate resources are identified.
- 5.8.7 As with managing oversight of serious incident investigations, should a number of different commissioners be involved in a multi-agency mortality review / investigation, a single “lead commissioner” will be identified to take responsibility for overseeing the review who will then liaise with the other commissioners as required. This is intended to facilitate continuity, remove ambiguity and reduce the likelihood of duplication.

6.0 FRAMEWORK FOR THE SURVEILLANCE AND REPORTING OF MORTALITY ACROSS THE ORGANISATION
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- 6.1 The purpose of mortality surveillance across the Trust is to enable the Trust to analyse and understand the position in terms of numbers of deaths and any thematic issues arising; and to ensure that there are processes for escalation of any areas of concern identified so that the Trust can take appropriate action to investigate further.
- 6.2 The Trust will undertake surveillance of mortality through the following means:
- 6.2.1 A minimum dataset has been agreed for recording deaths reported on Datix to allow for effective surveillance of mortality.
- 6.2.2 Staff are required to complete the minimum dataset for all deaths reported on Datix (in accordance with Notification and Reporting Protocol included as an annexe to the associating Procedural Guidelines).
- 6.2.3 A quarterly data dashboard comprising an agreed dataset (agreed by the Mortality Review Sub-Committee) for all deaths within the scope for consideration for individual mortality review will be produced and presented to the Mortality Review Sub-Committee on a quarterly basis for analysis. This will comprise a detailed dashboard containing information at an individual

death level as well as a summary sheet which is intended to assist the identification of any trends / themes.

- 6.2.4 The Mortality Data Group and Mortality Review Sub-Committee will analyse the information contained in the dashboard in order to determine whether there are any themes emerging which give rise to concern. Where possible and appropriate, national comparator data will be obtained for assessment purposes.
- 6.2.5 The Mortality Review Sub-Committee will notify the Quality Committee of any themes giving rise to concern, together with proposals for exploring the concerns further. This is likely to be in the form of an independent thematic review with recommendations in terms of actions required.
- 6.2.6 The outcomes of the further exploration will be presented in full to the Quality Committee.
- 6.2.7 Where the Mortality Review Sub-Committee have not identified any areas for concern, positive assurance in this respect will be provided to the Quality Committee.
- 6.2.8 Escalation to the Quality Committee will usually be via the bi-monthly assurance reporting from the Mortality Review Sub-Committee. However, should the issues identified require a faster escalation; the established process within the Trust for escalation will be followed by the Executive Medical Director.
- 6.2.9 The Quality Committee will report appropriately to the Board of Directors in terms of any issues identified and actions being taken. This process will enable the Board to be assured that surveillance is being undertaken, that issues of concern are being identified and that appropriate action is being taken.
- 6.2.10 The Board of Directors will also receive quarterly summarised information in terms of mortality within the Trust to enable it to be assured of the quality and safety of services the Trust is providing and to identify any issues which require further exploration / action. This information will comply with national guidance and will be meaningful, accurate, timely, proportionate and aim to support improvement.
- 6.2.11 The Serious Incident Team will ensure that any lessons learned from broader mortality surveillance are appropriately shared across the organisation via established “lessons learnt” governance mechanisms. This is detailed further in section 9 of the Procedural Guidelines associated with this Policy.

7.0 IMPLEMENTATION

- 7.1 The Mortality Review Sub-Committee will oversee effective implementation of this Policy and associated Procedural Guidelines. This will be done via delivery of an agreed work plan within the Sub-Committee.
- 7.2 Access to this Mortality Review Policy for all staff is through the Trust Intranet. This will be promoted via the Trust newsletter.

- 7.3 This Policy and associated Procedural Guidelines will be implemented and reinforced by the following means:
- Formal induction of new staff at corporate and local level.
 - Appropriate training and exercise of duties of staff, team leaders and managers to support effective mortality review.
 - Ongoing review of death reporting, investigation, action and learning at local, directorate and Trust level through normal governance and risk management processes.
 - Resources on the Trust intranet.
 - Trust communications such as Team Brief and Trust Today.
 - Advice and support from the Quality Team, Serious Incidents Team and Risk Management Team.
 - Oversight by the CCG and where appropriate regional groups of the Trusts mortality review process and reporting.
- 7.4 The Trust has a number of policies and procedural guidelines that have a direct impact on the mortality review process and should be consulted and followed as appropriate. These include the following specific policies as well as policies relating to Duty of Candour and Care of the Deceased Patients:
- Adverse Incident (including SI) Policy and Procedure (CP3)
 - Notifying the Care Quality Commission of the Death of a Detained Patient (MHA1 / MHAPG1)
 - Whistleblowing Policy and Procedure (CP53)
- 7.5 In undertaking the investigation of a death, a large number of Trust policies may become relevant and should always be consulted. A full list of Trust policies is held on the Trust intranet.

8.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE / REVIEW

- 8.1 The Mortality Review Sub-Committee is responsible for ensuring that this Policy is appropriately implemented and for monitoring the effectiveness of this Policy.
- 8.2 A bi-monthly assurance report will be provided to the Quality Committee from the Mortality Review Sub-Committee which will include any hotspots and areas of positive assurance.
- 8.3 Appropriate data dashboards will be presented to various levels of group / committee involved in the mortality review process in order to enable them to undertake their role in the process effectively and to assure that the process is working effectively.
- 8.4 To support the Mortality Review Sub-Committee in their monitoring of effectiveness of the processes in place, a random audit of an appropriate sample size (to be determined by the Mortality Review Sub-Committee) of deaths designated as “Unexpected deaths” not referred for a detailed review by the Clinical Review Panel (ie closed at Level / Grade 1) will be undertaken on an annual basis to assess the appropriateness of the definitions and

associated levels of scrutiny (grades of review / investigation) assigned. The relevant Mortality Review Form will be completed for the cases with a view to determining whether it was appropriate to close the case without further review. The outcomes of these audits will be presented to the Mortality Review Sub-Committee.

- 8.5 An independent assessment of the quality of SI investigations within EPUT will also be commissioned on an annual basis by the Executive Medical Director.
- 8.6 The Mortality Review Policy and associated Procedural Guidelines will be reviewed on an annual basis by the Mortality Review Sub-Committee, or earlier should changes in legislation or guidance require this. This frequency may be reviewed once national and local arrangements become more established.
- 8.7 Any amendments to the Policy will be submitted to the Mortality Review Sub-Committee for approval and ratified by the Quality Committee.

9.0 REFERENCES

- 9.1 The following national documents have been considered in the development of this Mortality Review Framework:
 - 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. *Mazar's December 2015* (**Link:** <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf>)
 - Learning, Candour and Accountability – A review of the way NHS trusts review and investigate the deaths of patients in England. *Care Quality Commission December 2016* (**Link:** <https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf>)
 - National Guidance on Learning from Deaths. *National Quality Board First Edition March 2017* (**Link:** <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>)
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