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Mortality Review Policy

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Worcestershire Health and Care NHS Trust

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Document Purpose	This policy outlines the framework for reviewing incidents of inpatient and community mortality.
Document Author	Richard Thomas- Quality and Safety Team Project Lead
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Responsible Group	Quality and Safety Committee
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Guideline / Policy on a Page – Summary of Key Points

- Revision of current Mortality Review policy to comply with the National Quality Board's March 2017 Learning from Deaths guidance:
    - Additional Trust mortality governance requirements – section 5
    - Revision of mortality review methodology to adapt the Royal College of Physicians' 2016 Structured Judgment (*mortality*) Review (SJR) methodology for Community and Mental Health Trusts for non-serious incident reported mortality. Section 10
    - Inclusion for assessing the degree of avoidability based on the RCPhys SJR methodology, as NHS providers are required to publish quarterly estimates of how many deaths were judged more likely than not to have been due to problems in care from quarter 3 in 2017_18. – section 10
    - Scope of deceased patients that should be subject to a Structured Judgment Review or Serious Incident Investigation – section 6
    - Participation in the national Learning Disability Mortality Review Programme (LeDeR)
    - Support for bereaved families and carers

Version History

Version	Circulation Date	Job Title of Person/Name of Group circulated to	Brief Summary of Change
V7	10.7.2017	Mortality Review Group Members Medical Director Consultants Palliative Care Deputy Medical Directors AMH & LD SDU Lead AMH Governance Lead AMH Quality Lead(s) AMH Clinical Lead LD Quality Lead LD Service Lead CC North SDU Lead CC North Quality Lead CC North Comm Services Manager CC South SDU Lead Clinical Nurse Lead Quality Lead CC South SDU Head of Integrated Comm Services Head of Comm Hospitals South Matron PoWCH Matron, Evesham Comm Hosp Matron Pershore Comm Hospital Matron OA Mental Health Inpatients Matron Tenbury Hospital Matron Malvern Hospital Matron Worcester City Unit Quality Lead SPC & CYP&F SPC & CYP&F SDU Lead	Revision reflecting March 2017 National Quality Board requirements

		SPC & CYP&F Qual Lead Finance dept. Information Managers Director of Quality & Nursing Head of Quality Governance Deputy to Head of Quality Gov Patient Safety Manager Quality & Safety Coordinator Quality Gov Information Lead Audit, Research and Clinical Effectiveness Manager Patient Relations Team Manage Clinical Studies Officer Quality and Safety Projects Officer Head of Stakeholder Engagement and Patient Involvement Head of Ed & Clinical Development Safeguarding Manager Lead for Allied Health Professional Chief Pharmacist Nurse Consultant IPC Deputy Directors of Nursing	
V7.2	18.07.2017		Meeting with the Patient Safety Manager to discuss the process by which Investigation Officers undertaking RCAs into Serious Incidents include the assessment of the quality of care and the degree of avoidability. Clarification to confirm procedures that should be considered in the Structured Judgment Review. Clarity to confirm patients in scope. Clarification to confirm the frequency by which the mortality review group reports to the Quality and Safety Committee and Trust Board. General feedback and formatting Clarification to confirm monitoring and implementation Clarification to confirm approach for completing Structured Judgement Reviews.
V7.3	25.07.2017	Clinical Policies Group	General feedback, appendixes 3 & 4, and formatting.

Accessibility

Interpreting and Translation services are provided for Worcestershire Health and Care NHS Trust, including:

- Face to face interpreting;
- Instant telephone interpreting;
- Document translation; and
- British Sign Language interpreting

Please refer to intranet page: http://nww.hacw.nhs.uk/a-z/services/translation-services/ for full details of the service, how to book and associated costs.

Training and Development

Worcestershire Health and Care NHS Trust recognises the importance of ensuring that its workforce has every opportunity to access relevant training. The Trust is committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.

Co-production of Health and Care – Statement of Intent

The Trust expects that all healthcare professionals will provide clinical care in line with best practice. In offering and delivering that care, healthcare professionals are expected to respect the individual needs, views and wishes of the patients they care for, and recognise and work with the essential knowledge that patients bring. It is expected that they will work in partnership with patients, agreeing a plan of care that utilises the abilities and resources of patients and that builds upon these strengths. It is important that patients are offered information on the treatment options being proposed in a way that suits their individual needs, and that the health care professional acts as a facilitator to empower patients to make decisions and choices that are right for themselves. It is also important that the healthcare professional recognises and utilises the resources available through colleagues and other organisations that can support patient health.

CONTENTS

1.0 INTRODUCTION

Death is an inevitable outcome of people's lives and some of these will occur whilst in the care of the NHS. NHS staff work tirelessly to deliver safe, high-quality healthcare. A few patients experience poor quality care, sometimes resulting from multiple contributory factors. It is therefore essential to:

- Review the quality of care nearing or at the time of death
- Assess if death in NHS care was avoidable due to problems in care, leadership or wider system failures.

Reviews and investigation must lead to actions and shared learning to prevent recurrence.

2.0 PURPOSE

The purpose of this policy is to describe the framework for reviewing incidents of patient mortality, undertaking actions to improve care and share learning and should be read in conjunction with the following policies, guidelines and commissioning intentions these include:

- Incident / Near-Miss Reporting and Investigation Policy (Includes Serious Incidents)
- Guidelines in the Event of Sudden or Unexpected or Suspicious death in Adults
- Being Open and Duty of Candour Policy

	• Policy for receiving, investigating, responding to and learning from Complaints, PALS enquiries, and Professional Enquiries • Rapid Response to Sudden Unexpected Death in Childhood • Worcestershire Clinical Commissioning Group Quality Contract The principles of this policy are: • The governance arrangements and processes include, 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. • Share and act upon learning derived from these processes. • Staff reporting deaths have appropriate skills and training to review and investigate deaths to a high standard. • A priority to work closely with bereaved families and carers to ensure consistent, timely, meaningful and compassionate support and engagement. • Being open and transparent in line with our Duty of Candour to disclose incidents, poor care practices and avoidable deaths. • Quarterly publication of incidents of mortality, learning and estimates of how many deaths were judged more likely than not to have been due to problems in care. • Publication of data and learning to be summarised in Quality Accounts from June 2017. • Seek similar data and trend information from peer providers to help identify improvements in the Trust's processes.
3.0	**SCOPE (STAFF)** This policy applies to all employees working within the Trust including: • Bank, Locum and Agency staff • Staff holding honorary contracts • Independent contractors
4.0	**TRAINING/COMPETENCIES** A range of training opportunities are available including investigation skills and Root Cause Analysis training. Guidance and support is also available from the Patient Safety Team and the Health and Safety Team throughout the process. All new members of staff will be introduced to the principles of risk management, including reporting serious incidents during the induction programme.
5.0	**RESPONSIBILITIES AND DUTIES**
5.1	**The Trust Board** has overall responsibility for ensuring compliance with all legal, statutory, best practice and quality requirements and for ensuring employees have good quality, ratified procedural documents to work with.
5.2	The Trust Board will ensure: • There are robust systems in place for recognising, reporting, reviewing or investigating deaths and actions are completed and the learning shared where there have been problems in care.

5.3	Ensure systems and processes are adequately resourced. This includes:	
	5.4	A mortality review group with multi-disciplinary and multi-professional membership, reporting quarterly to the Quality and Safety Committee and Trust Board.
	5.5	Designating an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda.
	5.6	Designate an existing non-executive director to take oversight of progress
	5.7	Pay particular attention to the care of patients with a learning disability and or mental health needs.
	5.8	A systematic and a proportionate approach to identifying deaths that should be reviewed or investigated.
	5.9	Adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the Learning Disability Review (LeDeR) programme.
	5.10	Ensures case record reviews and investigations are carried out to a high quality.
	5.11	Ensures that mortality reporting in relation to incidence of mortality, reviews, investigations and learning is on a quarterly basis provided to board in order that the executive remain aware and non-executives directors can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised.
	5.12	Ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in the annual Quality Accounts.
	5.13	Share and acts upon learning within the Trust and across the wider health economy including the independent healthcare and social care services.
	5.14	Staff reporting deaths have appropriate skills and training and to review and investigate deaths to a high standard.
	5.14	Offer timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death.
	5.15	Acknowledge that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved.
	5.16	Work with commissioners to review and improve approaches following the death of people receiving care from services.

5.17	**Executives and non-executive** directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.
5.18	The **Chief Executive** has ultimate responsibility for ensuring that the Trust has robust policies and procedures in place for reviewing all agreed categories and incidents of mortality in scope for review are appropriately reviewed and where required appropriate actions are taken and learning shared.
5.19	The **Service Delivery Unit Leads (SDU)** are responsible for ensuring there are arrangements for reviewing all agreed incidents of mortality in scope and where required appropriate actions are taken and learning shared.
5.20	**Inpatient and Community Clinical Managers** are responsible for ensuring all agreed incidents of mortality in scope are appropriately reviewed - see incidents of mortality in scope - and where required appropriate actions are taken and learning shared.
5.21	**Quality Leads** are responsible for the coordination and management of Serious Incidents and Significant Events into unexpected deaths, ensuring actions are taken and learning shared through their Service Delivery Unit Quality and Safety meetings.
5.22	**All staff authorised to add to the patient electronic records** are responsible for the completeness and contemporaneous of patient information as per each system's procedural guidance.
5.23	**All staff must** report or bring to the attention of the clinical team leader the death of a patient.
5.23	Where the death of a patient is in scope for a mortality review or investigation. **Team leaders** must ensure the appropriate review or investigation is undertaken. See section 6 below.
6.0	**SCOPE AND RATIONALE FOR MORTALITY PATIENT REVIEWS**
6.1	Worcestershire Health and Care NHS Trust provides a range of inpatient and community services for children, adults and older adults including services for people who experience mental ill health and learning disabilities in partnership with other NHS, statutory, independent and voluntary organisations. As a community and mental health trust we will undertake an approach which reflects all of our services in accordance with the National Quality Boards requirements to review:
	6.2 All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.
	6.3 All inpatient community deaths of patients with learning disabilities through the Learning Disability Review (LeDeR) process including patients whose residential care is commissioned outside of the county.
	6.4 All deaths in adult and older adult mental health inpatient services.
	6.5 All deaths of patients with severe mental illness.

	6.6	All deaths in community hospitals.
	6.7	Deaths of patients who had been an inpatient but died within 30 days of leaving hospital.
	6.8	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 Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator.
	6.9	All deaths in areas where people are not expected to die, for example in relevant elective procedures.
	6.10	All child 0 -18 deaths (expected and unexpected).
	6.11	Review deaths following any linked inquest and issue of a Coroner's Regulation 28 Report for the Prevention of Future Deaths where an investigation has not already been undertaken.
	6.12	Deaths where learning will inform the Trust's existing or planned improvement work.
6.13	The Mortality Review Group will continually review patients in scope to ensure reviews are appropriate and proportionate to the services that the Trust provides.	
6.14	Appendix one provides guidance to patients in scope for review or investigation.	
6.15	Staff should refer to the Medical Director or the Director of Quality and Nursing or the Head of Quality Governance for clarification whether a review or investigation is required if it appears to be outside of the scope of section 6.	
7.0	**LEARNING**	
	Learning is the critical process for improving the quality of patient care. The Trust will ensure it shares and acts upon learning from reviews and investigations within and across the Service Delivery Units and across the wider health economy including the independent healthcare and social care services.	
8.0	**SUPPORTING BEREAVED FAMILIES AND CARERS**	
	It is a priority to work closely with bereaved families and carers to ensure a consistent level of timely, meaningful and compassionate support and engagement at every stage - from notification of death, primary review or investigation and investigation report and lessons learned and actions taken. Bereaved family and carers must be given the **opportunity to raise questions or share concerns** in relation to the quality of care received by their loved one and be informed of their **right to raise concerns about the quality of care** provided. Appendix 2 provides further guidance to the support bereaved family and carers should receive.	

9.0 DEFINITIONS

Mortality Review	The process of reviewing the quality of care and assessing if the incident of patient death was avoidable against the Structured Judgement Review (SJR) methodology.
Structured Judgement Review methodology	Method of reviewing the quality of care and the degree of avoidability of patient death developed by the Royal College of Physicians 2016.
Patient Safety Incident	Any healthcare related event that was unintended, unexpected and undesired and which could have or did cause harm to patients as defined in the Serious Incident Policy
Serious Incident	Is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following: • Unexpected or avoidable death of one or more patients, staff, visitors or members of the public; • Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm • A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/ organisational information, damage to property, reputation or the environment, or IT failure; • Allegations of abuse; adverse media coverage or public concern about the organisation or the wider NHS; • One of the core set of **Never Events** defined by the National Patient Safety Agency (NPSA) as 'a *serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers'*. The NPSA maintains and publishes a list of never events: http://www.nrls.npsa.nhs.uk/resources/ Serious Incidents are subject to more rigorous scrutiny in terms of reporting, investigation and learning. They are reported on the Strategic Executive Information System (STEIS) which is a national system that enables electronic logging, tracking and reporting of SIs. When an incident is entered on STEIS it alerts NHS England who manage the system. The commissioning body of the service where the incident happened also have access, as do the CQC.
Death due to a problem in care	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

Significant Event	Unlike the other definitions, a significant event is not a nationally recognised classification of an adverse incident, but a classification within the Trust. This relates to incidents that do not meet the criteria for reporting as Serious Incidents, but where the trust identifies that a more in depth analysis of an incident may result in valuable learning for the organisation. The same investigation methodologies are used as for a Serious Incident however, the incident is internally managed and by monitored by the SDU and learning disseminated.
Learning Disability *Mortality* Review Programme	The Learning Disabilities (*Mortality)* Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. Its approach aims to clarifies any potentially modifiable social factors associated with a person's death, and works to ensure that these are not repeated elsewhere.
Duty of Candour	Duty of Candour is defined in The Francis report: *"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made*."
Being Open	Described by the National Patient Safety Agency as: *"discussing patient safety incidents promptly, fully and compassionately' adding that this 'can help patient and professionals to cope better with the after effects".*
PAS	Patient Administration System: Generic name to describe one of a number of IT systems to record patient care.
SDU	Service Delivery Unit. The services provided by the Trust are divided into Service Delivery Units.
HCP	Health Care Professional

10.0 STRUCTURED JUDGEMENT REVIEW METHODOLOGY

10.1 There are a number of national methods for calculating standardised mortality ratios. The two most commonly recognised national mortality indicators are:

- Hospital Standardised Mortality Ratio (HSMR)
- Summary Hospital Mortality Indicator (SHMI)

Although both of these indicators have significant value for measuring mortality rates in Acute Hospital settings, it is problematic to apply these methodologies to community trusts, as acute trusts typically have a high volume of short stay patients, with low risk of mortality in contrast to the nature of patients and clinical services of community trusts.

10.2	Worcestershire Health and Care NHS Trust provides a range of inpatient and community services for children, adults and older adults including services for people who experience mental ill health and learning disabilities in partnership with other NHS, statutory, independent and voluntary organisations. These services are delivered through the Trust's Service Delivery Units (SDU) who specialise in providing a range of inpatient and community services.
10.3	To support an appropriate and robust approach to mortality surveillance the Trust has adapted the Structured Judgement Review (SJR) methodology developed by Royal College of Physicians in accordance with the guidance from the National Quality Board.
10.4	The Structured Judgement (*Mortality*) Review is a five outcome scale for assessing the quality of care approaching or at the time of death.
10.5	<table><tr><td>1</td><td>Very Poor Care</td></tr><tr><td>2</td><td>Poor Care</td></tr><tr><td>3</td><td>Adequate Care</td></tr><tr><td>4</td><td>Good Care</td></tr><tr><td>5</td><td>Excellent Care</td></tr></table> See appendixes: 3 – Inpatient – Community Hospital Structured Judgement *(Mortality)* Review Proforma 4 – Community Services Structured Judgement *(Mortality)* Review Proforma **NB** An outcome of 1 or 2 must be recorded on the Ulysses incident reporting system and the relevant SDU Quality Lead informed for the appropriate management of the incident.
10.6	There are three routes by which investigations and reviews in scope are undertaken: • A primary Structured Judgement (*mortality)* Review where the death of a patient does not meet the criteria of an unexpected death as defined by Incident / Near Miss Reporting and Investigation (including serious incidents) policy. • A second stage review would be required where the overall judgement is 1 or 2. This must recorded on the Trust's incident reporting system for the appropriate management as either a Serious Incident or Significant Event through the Root Cause Analysis investigation process. • An unexpected death that meets the criteria of a Serious Incident, which must be recorded on the Ulysses incident reporting system and investigated through the Root Cause Analysis process as either a Serious Incident or Significant Event.

10.7	**Degree of Avoidability** Where an incident of mortality is investigated as a Serious Incident or Significant Event, the Root Cause Analysis process will need to consider the degree of avoidability as the Trust is required to publish on a quarterly basis estimates of how many deaths were judged more likely than not to have been due to problems in care. 1 Definitely avoidable 2 Strong evidence of avoidability 3 Probably avoidable (more than 50:50) 4 Possibly avoidable, but not very likely (less than 50:50) 5 Slight evidence of avoidability 6 Definitely not avoidable
10.8	**Outcome of Mortality Reviews and Investigations** The outcome of mortality reviews and investigations must be recorded on the Mortality Review database and a copy of the Mortality Review Guidance proforma attached to the database.
11.0	**PROCESS**
11.1	Mortality reviews and investigations must be assessed against the Trust's policies and procedures and professional standards. In many circumstances, more than one organisation maybe involved in the care of a patient and where possible problems are identified relating to other organisations, it is important the relevant organisations are informed, so they can undertake any necessary investigation and actions.
11.2	The Trust will consider as appropriate whether they can routinely arrange joint reviews or investigations for individuals or groups of patients where more than one organisation is providing care at the time of death.
11.3	Inpatient primary mortality reviews should be completed at the next multidisciplinary team meeting or within one week of the patient death.
11.4	Community mortality reviews should be completed within one week of when the team is notified of the patient's death.
11.5	A minimum of two registered Health Care Professionals, one of whom must minimally be working at a band 7 level or above are required to undertake a Structured Judgement (*mortality*) Review. In circumstances where a band 6 is working as a clinical team leader or deputy ward manger, this role can be delegated to a band 6 by the clinical manager.
11.6	The Mortality Review Group will regularly monitor the completeness and quality of all reviews and investigations.

11.7 For Non-Serious Incident or Structured Judgement *(Mortality)* Reviews

Inpatients	Reviews should be minimally undertaken by qualified medical and nursing staff
Community	**Multidisciplinary medical and non-medical team:** The team leader must review the caseload to allocate the most appropriate HCP(s) to undertake the review. ***NB*** • *See section 6 re patients in scope of reviews.* • *Where an adult community patient dies in a community hospital ward, the community ward review takes precedence for completing the review as the location of the patient death.*

11.8 If a MDT is unable to conclude or agree the grade of a mortality review, the MDT must refer to the team's clinical lead for guidance on how best to conclude the review.

12.0 REFERENCES

12.1
- Keogh B, Durkin M. Self-Assessment on Avoidable Mortality. Letter to NHS Medical Directors; 2015
- Worcestershire Clinical Commission Group. Quality Contract; 2016
- Mazars 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; 2015
- National Quality Board; National Guidance on Learning from Deaths; March 2017 Royal College of Physicians; Using the structured judgement review method – Data Collection Form (England Version) 2016
- Royal College of Physicians; Using the Structured Judgement Review Method – A Guide of Reviewers (England Version) March 2017

13.0 RELATED TRUST POLICIES AND PROCEDURES

- Incident / Near-Miss Reporting and Investigation (Includes Serious Incidents), Being Open
- Guidelines in the Event of Sudden or Unexpected or Suspicious death in Adults
- Being Open and Duty of Candour Policy
- Policy for Receiving, Investigating, Responding To and Learning from Complaints, PALS enquiries, and Professional Enquiries
- Rapid Response to Sudden Unexpected Death in Childhood
- Worcestershire Clinical Commissioning Group Quality Contract
- Quality Governance Strategy

14.0 MONITORING IMPLEMENTATION

Standards	Lead	Frequency	Committee
Completeness of inpatient Structured Judgement Reviews	Quality and Safety Team Projects Lead	Monthly	Mortality Review Group
Completeness of community Structured Judgement Reviews	Quality and Safety Team Projects Lead	Monthly	Mortality Review Group
Quality of Structured Judgement Reviews	Quality Leads	Ongoing	Service Delivery Units Quality Meetings & Mortality Review Group
Completeness and quality of Serious Incidents and Significant Events.	Chair of Serious Incident Forum	All Serious Incident investigations are scrutinised at the Serious Forum before they are signed off as complete. Commissioners provide further scrutiny before the incident is closed on STIES	Serious Incident Forum
Actions from serious incidents are completed and learning shared.	Quality Leads	Continually	Service Delivery Units Quality Meetings & Mortality Review Group
Staff have skills and training to complete Structures Mortality Reviews and investigate serious incidents	Learning and Development	Annually	Mortality Review Group
The trust to work closely with bereaved families and carers and ensure a consistent level timely, meaningful and compassionate support and engagement.	Medical Director	Annually	Mortality Review Group
Quarterly publication of incidents of mortality and learning.	Medical Director	Quarterly	Mortality Review Group
The Trust is open and transparent in line with the Duty of Candour to disclose problems in care.	Chair of Serious Incident Forum	Monitoring implementation will be undertaken by the Serious Incident Forum by when agreeing the closure of incident reports	Outcome of closed incidents is reported to the Quality and Safety Committee and Trust Board.
Seek similar data and trend information from peer providers to help identify improvements in the Trust's processes – acknowledging the limitation of comparison.	Quality and Safety Team Projects Lead	Annually	Mortality Review Group

Appendix One

Scope of Patient Death Requiring Mortality Review or Serious Incident Investigation

Inpatient Community Hospitals	Inpatient Adult and Older Adult Mental Health and Learning Disabilities	Community Adult and Older Adult Mental Health and Learning Disabilities.	Community Adult (Non-Mental Health and Learning Disability)	Children Young People and Families
Unless the incident of mortality meets the criteria for the Serious Incident policy, all community hospital inpatient mortality must have a Structured Judgement Review within one week of the patient death. **Appendix 3** In circumstances where a patient's death is investigated under the Serious Incident policy, the outcome of the Mortality Review is to be held pending until the completion of the RCA and closure of the incident at the Serious Incident forum.	All incidents of Adult, Older Adult Mental Health and Learning Disabilities inpatient mortality must be investigated under the Serious Incident policy and the outcome of the Mortality Review is to be held pending until the completion of the RCA and closure of the incident at the Serious Incident forum. **NB** Further guidance is pending for the implementation of the Learning Disability Review Programme (LeDeR).	All incidents of unexpected death must be investigated as per the Serious Incident policy unless they fall within scope of section **6.0** for Structured Judgement Review. **Appendix 4** **NB** Further guidance is pending for the implementation of the Learning Disability Review Programme (LeDeR)	All incidents of unexpected death should be investigated as per the Serious Incident policy unless they fall within the scope of section **6.0** for a Structured Judgement Review. **Appendix 4**	Unexpected deaths in children (0-18) follow a rapid response process, under the West Mercia SUDIC (Sudden Unexpected Deaths in Infant and Children) Protocol. If any of the unexpected deaths occurred as a result of any care provided by Worcestershire Health and Care Trust, the SI process will be instigated. All child deaths (0-18) (expected and unexpected) are reviewed at the Child Death Overview Panel (CDOP), which is a sub group of Worcestershire Safeguarding Children's Board. Unexpected Deaths from the SUDIC process and any SI reports completed are fed into CDOP.

1	**Support for Bereaved Families and Carers**
2	It is of prime importance to work closely with bereaved families and carers to ensure a consistent level of timely, meaningful and compassionate support and engagement at every stage - from notification of death, investigation, investigation report, lessons learned and actions taken.
3	Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients is crucially important. The principles of openness, honesty, and transparency as set out in the Duty of Candour must be applied in engagement and involvement with bereaved families and carers.

4	The key principles for supporting bereaved families and carers are:
	
	• To be treated as equal partners following a bereavement.
	• Must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment.
	• Provide a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support.
	• Informed of their right to raise concerns about the quality of care provided to their loved one.
	• Offer guidance, where appropriate, on obtaining legal advice.
	• Their views should help to inform decisions about whether a review or investigation is needed.
	• Receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact or liaison.
	• Should 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.
	• Support can include:
	  ○ Arranging completion of all documentation, including medical certificates.
	  ○ The collection of personal belongings.
	  ○ Post mortem advice
	  ○ Collection of the doctor's Medical Certificate of Cause of Death and information about registering a death at the Registrar's Office.
	  ○ Support during and following an investigation. This may include counselling or signposting to suitable organisations that can provide bereavement or post-traumatic stress counselling, with attention paid to the needs of young family members, especially siblings

5	People who are bereaved need others to recognise and acknowledge their loss. Recognition by professionals, appropriately expressed, may be particularly valued. Communication at the time of a death, and afterwards, should be clear, sensitive and honest. Bereaved families and carers should be given as much information as possible in line with the Duty of Candour for providers. Every effort should be made to hold these discussions in a private, sympathetic environment, without interruptions
6	When reviewing or investigating possible problems with care, involvement of bereaved families and carers begins with a genuine apology. Saying sorry is not an admission of

	liability and is the right thing to do. The appropriate staff member should be identified for each case, including to explain what went wrong promptly, fully and compassionately. This may include clinicians involved in the case but this may not always be appropriate and should be considered on a case by case basis.
7	Depending on the nature of the death, it may be necessary for several organisations to make contact with those affected. This should be discussed with the bereaved families and carers and a co-ordinated approach should be agreed with them and the organisations involved. If other patients and service users are involved or affected by the death, they should be offered the appropriate level of support and involvement.
8	The Trust should ensure that the deceased person's General Practitioner is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation.
9	Where a death is investigated under the Serious Incident policy, early contact should be made with bereaved families and carers so that their views help to inform the decision.
10	Bereaved families and carers will expect to know: what happened; how; to the extent possible at the time, why it happened; and what can be done to stop it happening again to someone else. If the Trust proceeds with an investigation, skilled and trained investigators need to be able to explain to bereaved families and carers the purpose of the investigation which is to understand what happened. If problems are identified, the investigation should be clear why and how these happened so that action can be taken to prevent the same problems from occurring again.
11	If a family wants to engage or contribute to an investigation, an early meeting should be held to explain the process, how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation. This should set out realistic timescales and outcomes. There should be a named person as a consistent link for the families and carers throughout the investigation.
12	Bereaved families and carers should: • Be made aware, in person and in writing as soon as possible, of the purpose, rationale and process of the investigation to be held. • Be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation. • Have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided. • Have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings. This may disclose confidential personal information for which consent has been obtained, or where patient confidentiality is overridden in the public interest. This should be considered by the organisation's Caldicott Guardian and confirmed by legal advice in relation to each case. • Have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date. • Be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case.

	• Have an opportunity to respond on the findings and recommendations outlined in any final report; and, • Be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

Appendix 3

Structured Judgement Review (SJR)
Inpatients
Community Hospitals & Older Adult Mental Health Wards
Unless patient death is reported on Ulysses as a Serious Incident

Worcestershire Health and Care NHS Trust

Adapted from the Structured Judgement Review Methodology (RCPhys) March 2017

Patient's Name		**NHS No:**	
Male / Female		**Age at Death**	
Source of Admission		**Date of Death**	
Ward		**SDU**	

Risk Factors Did the patient have a learning disability? Tick as appropriate	Yes		No	
If yes, complete review and forward the completed review to the Trust's Learning Disability Quality Lead for the management into the Learning Disabilities Mortality Review (LeDeR) programme. Details To be Confirmed				

Recorded Cause of Death	

Mental Health Act (MHA) Status				
Was the patient subject to the MHA / DOL? *Tick as appropriate*	Yes	No	If yes record status:	

Were there any problems with the care of the patient or incidents?				
Yes		No		*Tick as appropriate and comment is yes.*

Record your explicit judgement / statements about the quality of care the patient received and whether it was in accordance with Trust procedures / good practice. If there is any other information that you think is important or relevant that you wish to comment on then please do so.	
Admission: Assessment and Initial Management, Care Planning, Interventions and Ongoing Care	
Contact with Families and Carers	
End of Life Care	

Overall Assessment				
1 = Very Poor Care	2 = Poor Care	3 = Adequate Care	4 = Good Care	5 = Excellent Care
Circle as appropriate ***NB*** *Outcomes of 1 or 2 must be recorded on Ulysses and the Quality Lead informed for the appropriate management of the incident*				

Points for Shared Learning and Actions

Multidisciplinary SJR completed by: (*List all staff involved. Minimally must be **two** members of staff)*	
Team completing review	Date

Outcome of review must be recorded and attached on the mortality review database M:/TeamShare

Appendix 4

Structured Judgement Review (SJR)
Community Patients
Unless patient death is reported on Ulysses as a Serious Incident

Worcestershire Health and Care NHS Trust

Adapted from the Structured Judgement Review Methodology (RCPhys) March 2017

Patient's Name		**NHS No:**		**Known location of patient's death** *Tick as appropriate*	Home
Male / Female		**Age at Death**			Acute Trust
Date of Death		**Team**			Hospice
SDU					Residential / Nursing Home
					Out of County MH / LD Placement
					Other – *Name:*

Risk Factors Did the patient have a learning disability? *Tick as appropriate*	Yes		No	
If yes, complete review and forward the completed review to the Trust's Learning Disability Quality Lead for the management into the Learning Disabilities Mortality Review (LeDeR) programme. Details To be Confirmed				

Recorded Cause of Death	

Mental Health Act (MHA) Status				
Was the patient subject to the MHA / DOL? *Tick as appropriate*	Yes	No	If yes record status:	

Were there any problems with the care of the patient or incidents?				
Yes		No		*Tick as appropriate and comment is yes.*

Record your explicit judgement / statements about the quality of care the patient received and whether it was in accordance with Trust procedures / good practice. If there is any other information that you think is important or relevant that you wish to comment on then please do so.	
Assessment, Initial Management, Care Planning, Interventions and Ongoing Care	
Contact with families and carers	
End of Life Care	

Overall Assessment				
1 = Very Poor Care	2 = Poor Care	3 = Adequate Care	4 = Good Care	5 = Excellent Care

Circle as appropriate
NB *Outcomes of 1 or 2 must be recorded on Ulysses and the Quality Lead informed for the appropriate management of the incident*

Points for Shared Learning and Actions

Multidisciplinary Review completed by: *List all staff involved. Minimally must be **two** members of staff*	
Team completing review	Date

Outcome of review must be recorded and attached on the mortality review database M:/TeamShare

Title of Policy/Function (Function Includes: Services; Projects; Strategy; Processes; Systems; Practices; Procedures; Protocols; Guidelines; Care Pathways etc..)	New	Existing/Revised
Mortality Review Policy		Revised
Short description of Policy/Function (aims and objectives, is the policy/function aimed at a particular group if so what is the intended benefit):		
To comply with the National Quality Board's 2017 Learning from Deaths guidance and Worcestershire Clinical Commissioning Groups Quality Contract.		

Name of Lead/Author(s)	Job Title	Contact details
Richard Thomas	Quality and Safety Team Projects Lead	01905 681481

When the policy/function involves patients/staff/partners/stakeholders etc please where possible include them in the Equality Analysis to demonstrate openness, transparency and inclusion and particularly by those who this policy/function is most likely to have impact.

Does this Policy/Function have any potential or actual impact that is positive(+), neutral (N) or negative (-) impact on the following protected characteristics please indicate:				
	+	N	-	Please provide a rational/justification for <u>each</u> of the following regardless of impact
Age		✓		Includes all deceased patients except for those patients who mortality review is undertaken by the SUDIC process
Disability		✓		A mortality review is undertaken for all cases and within the review; the 9 protected characteristics are implicit in the care of patients prior to their death. Adjustments are made for recognising the 9 characteristics and then taken into consideration as part of the review
Gender Reassignment		✓		
Pregnancy & Maternity		✓		
Race		✓		
Religion & Belief		✓		
Sex		✓		
Sexual orientation		✓		
Marriage & Civil Partnership		✓		

Other Groups who could experience inequality, e.g carers, homeless, travelling communities, unemployed, people resident within deprived areas, different socio/economic groups eg low income families, asylum seekers/refugees, prisoners, people confined to closed institutions or community offenders, people with different work patterns eg part-time, full-time, job-share, short-term contractors or shift workers - *Access, location and choice of venue, timings of events and activities. Support with caring responsibilities*

Analysis conducted by: (minimum of 3 people)			
	Name	**Job Title**	**Contact details**
1	Richard Thomas	Quality and Safety Team Projects Lead	01905 681481
2	Sam Whitby	Audit, Research and Clinical Effectiveness Manager	01905 681514
3	Kathryn Rowe	Quality and Safety Team Project Support Officer	01905 733635

Start date of policy/function		**Period valid for : 3 Years**
Review date of policy/function		

Service Delivery Unit:		Quality and Safety Team						
Reference/Version:	7.2	**Date Equality Analysis completed**:	D	D	M	M	Y	Y
			1	8	0	7	1	7

If you have identified a potential discriminatory impact on the policy/function please refer it to the author together with suggestions to avoid or reduce the impact.

A copy of the completed Equality Analysis must be attached to the policy/function and a copy sent to:

Patrick McCloskey
Equality Inclusion Practitioner
Isaac Maddox House, Shrub Hill Road, Worcester, WR4 9RW
Tel: 01905 761324
patrick.mccloskey@nhs.net