

## Northumbria Healthcare NHS Foundation Trust

### Clinical Governance Policies and Procedures

#### Policy on Learning from deaths

<b>Version</b>	2.0
<b>Sub Committee &amp; approval date</b>	Mortality and Outcomes Data Group – 27 April 2019
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<b>Name of policy author</b>	Jeremy Rushmer, Executive Medical Director
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<b>Review Date</b>	May 2022
<b>Target audience</b>	All clinical staff

**This Policy has been Impact Assessed against the Equality Act 2010**

## History of previous versions of this document:

Not applicable

<b>Date Approved by Sub Committee</b>	<b>Date Ratified by Assurance Committee</b>	<b>Version</b>	<b>Issue Date</b>	<b>Review Date</b>	<b>Policy Author</b>
Aug 2017	12 Sept 2017	1.0	15 Sept 2017	Sept 2020	Jeremy Rushmer, Medical Director

## Statement of changes made from version

<b>Version</b>	<b>Date</b>	<b>Description</b>
2.0	27/4/2019	<p>There have been changes to the flow chart and other elements of the policy to incorporate our current position with implementing Medical Examiners.</p> <p>The flow chart now refers to a 3 stage review process to include the 'light touch' Medical Examiner review.</p> <p>The executive lead has been changed from the Executive Director for Performance and Improvement to Executive Medical Director.</p> <p>Addition of information regarding an extra stage added to the SI/SLE template in the carer involvement section.</p> <p>EIA incorporated into document</p>

## Contents

1. Operational Summary.....	1
2. Introduction.....	4
3. Purpose .....	4
4. Duties .....	5
5. Definitions of Terms Used .....	6
6. Process in Response to an in-Hospital Death .....	8
6.1 Deaths in hospital.....	8
6.2 Reporting of Deaths which are of Immediate Concern .....	10
6.3 Second Stage (Independent) Case Record Review.....	11
6.4 Learning .....	12
6.5 Carer Involvement.....	12
6.6 Cross-system reviews and investigations .....	13
6.7 Working with Wider NHS.....	14
7. Training and Support.....	14
8. Process for Monitoring and Audit.....	14
9. References .....	15
10. Associated Documentation .....	15

Appendix 1 - Equality Impact Assessment

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# 1. Operational Summary

## Policy Aim

The purpose of the policy is to describe the process by which all deaths in hospital are identified, reported, investigated and learnt from.

## Policy Summary

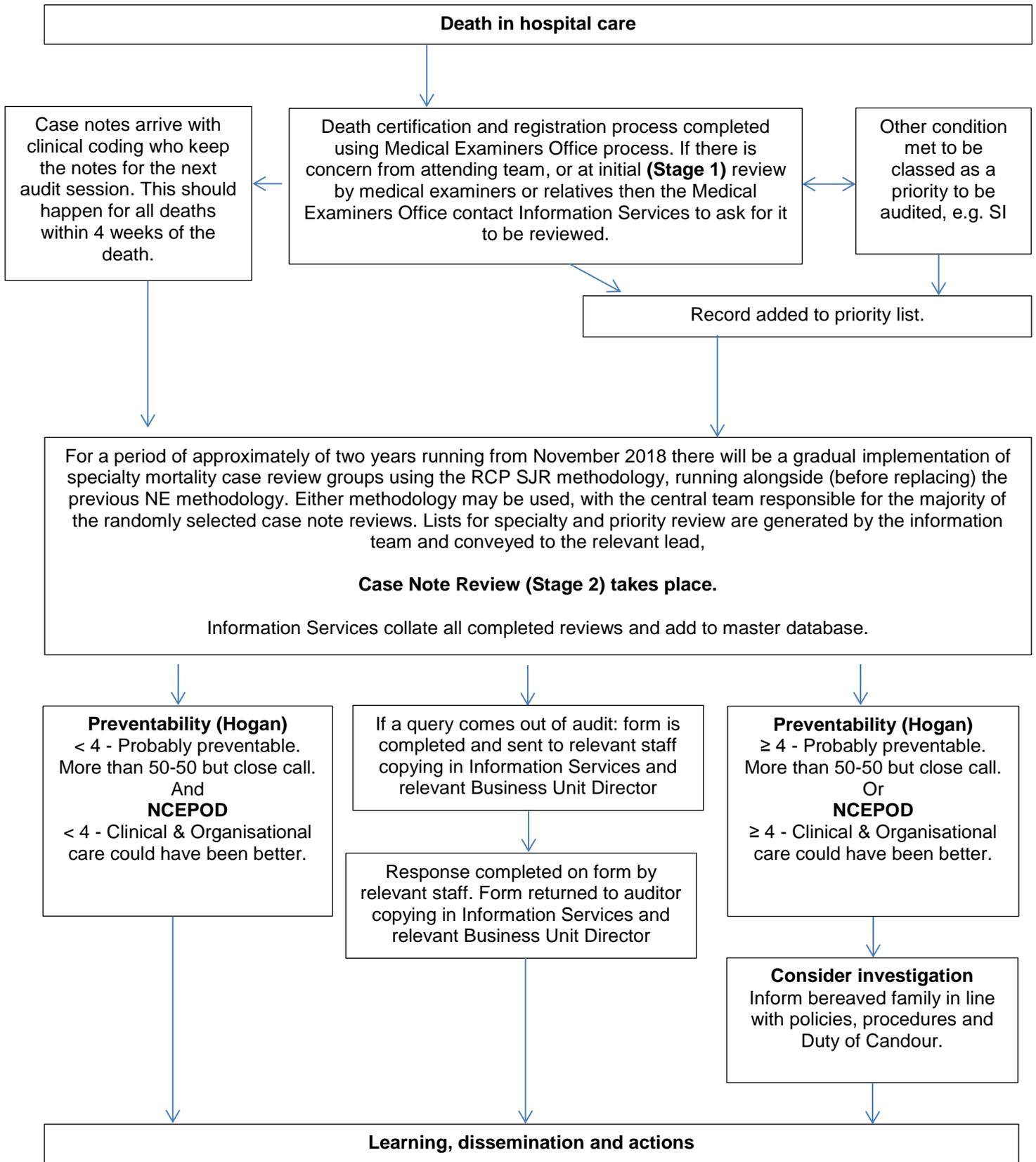
The flowchart on the next page provides a summary of the policy

## What it means for Staff

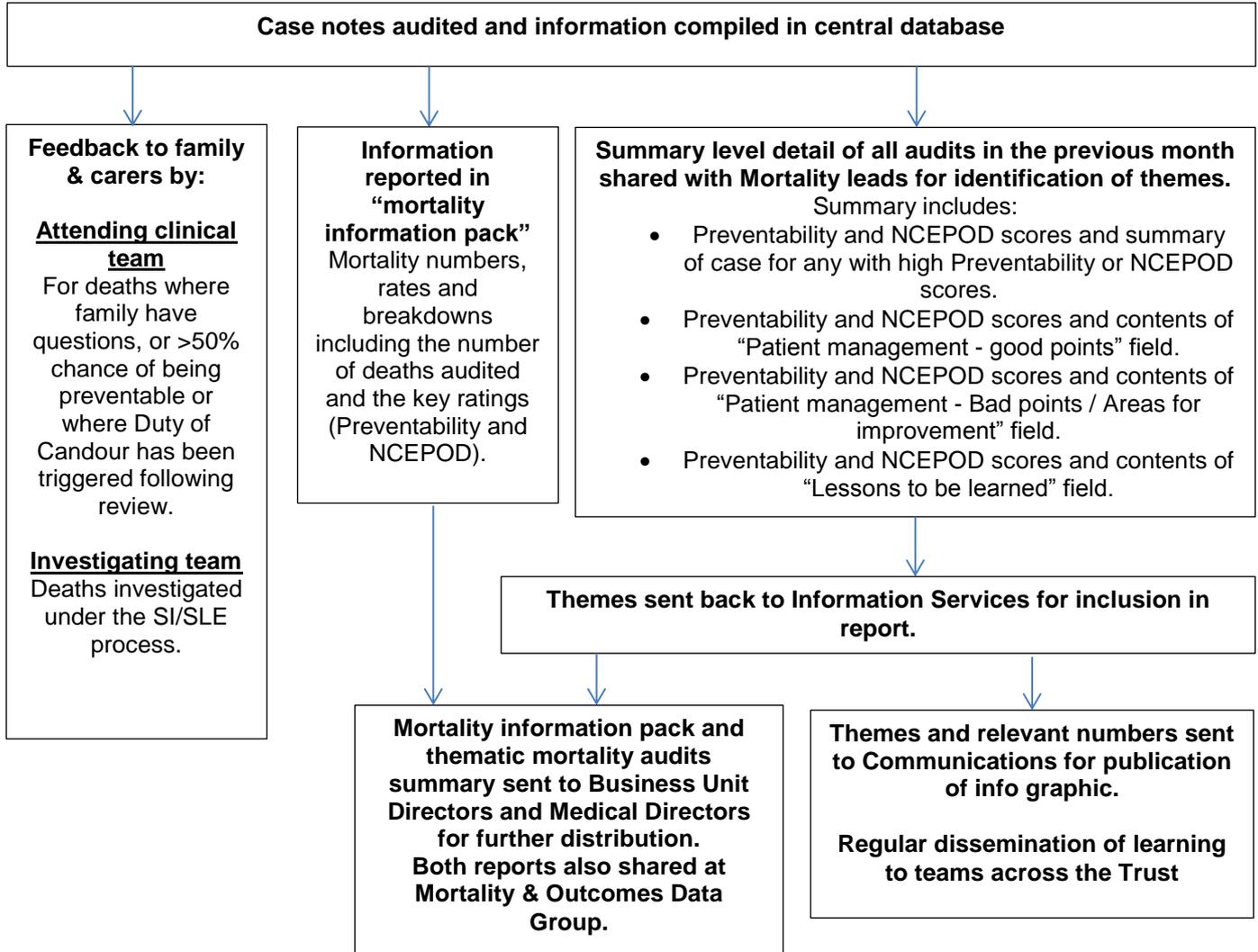
**Non-Executive and Executive Leads for Mortality** - To ensure that the Board is fully informed that the approved policy is implemented and that learning is appropriately delivered.

**Clinical Case Note Reviewers** – Responsible for reviewing the care leading to death and providing a clinical judgment.

## Overview of the Mortality Review Process



# Overview of the Process for Learning and Dissemination



## 2. Introduction

2.1 The National Quality Board published '*National Guidance on Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*'. The First Edition was released in March 2017. One of the regulations set out in this guidance (Chapter 1 sections 6, 12 and Annex C – Responding to Deaths) states that *"Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under their management and care."* This policy closely follows the detailed guidance set out in Annex C. NHS Improvement and the Care Quality Commission stipulate that the Responding to Deaths Policy should be approved and in place in Trusts by September 2017.

2.2 The national framework refers to key innovations, to Mortality Governance, not in place to meet the September 2017 deadline:

- A national training programme for case note reviewers by Royal College of Physicians covering how to complete a 'Structured Judgment Review' starting Autumn 2017
- A national programme for the implementation of learning from 'Medical Examiners' pilot sites, now delayed until 2019.

The framework also devotes a whole section to improvements in how better to involve families and carers in order to properly answers questions they have in relation to the deceased care.

2.3 In April 2019 the Department of Health implemented an instruction to undertake an implementation of a Hospital based Medical Examiner system based on the model piloted in the National program. The system has many benefits to the care of bereaved patients, but also provides access to a (Stage 1) clinical review of the notes that can identify cases that would benefit from (Stage 2) mortality review.

2.4 In February 2019 final approval of an investment in a Northumbria Medical Examiner system was approved, for implementation from April 2019. This means an increasing number of deaths will have a stage 1 review as the scheme rolls out during the year 2019/20.

## 3. Purpose

3.1 The purpose of this policy is to describe the process by which all deaths in hospital are identified, reported and investigated. It aims to strengthen arrangements, where appropriate, to ensure learning is shared and acted upon. It seeks to ensure the Trust engages meaningfully and compassionately with bereaved families and carers and supports staff to find all opportunities to improve the care the NHS offers by learning from deaths.

3.2 For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare.

When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in hospital might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

- 3.3 Because the timing of all national developments have not been completely aligned to the framework implementation, the policy also describes the process for the on-going improvement of learning from deaths. It is proposed that the success of any cycles of improvement be judged by favourable feedback from staff and patient/carers from the output of the learning system.

## 4. Duties

- 4.1 **Chief Executive** – Overall responsibility for the implementation of this policy.
- 4.2 **Executive Director of Nursing & Midwifery** – To ensure all nurses and midwives are supported to fulfill their duty to engage in responding to deaths; to identify specific nurses and midwives to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.
- 4.3 **Non-Executive and Executive Leads for Mortality** – To ensure that the Board is fully informed that the approved policy is implemented and that learning is appropriately delivered.
- 4.4 **Medical Directors** – To ensure all doctors are supported to fulfill their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.
- 4.5 **Executive Medical Director** - To be the Board lead for Learning from deaths; to take responsibility for the learning from deaths policy; to publish, through a quarterly paper to the public Board meeting, estimates of the number of avoidable deaths; to ensure that from June 2018 the annual Quality Account summarises the data published by the Board, including learning and action as a result of this information and an assessment of the impact of actions that the Trust has taken.
- 4.6 **Executive Director of Finance** – To ensure adequate resources are made available to enact the Responding to Deaths policy and other requirements such as set out in the Quality Account regulations.
- 4.7 **Human Resources Department** – Leading on the training needs analysis (TNA) and mandatory training policy. Training will be made available by the National Mortality Case Record Review Programme for those leading secondary case record review.
- 4.8 **Clinical Directors** – To ensure all doctors in their Clinical Directorate are supported to fulfill their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.

- 4.9 **All Staff** – To ensure all clinical staff have a duty to engage in responding to deaths; to be involved in case record reviews and investigations as required and to meet the Duty of Candour requirements.
- 4.10 **Clinical Case Note Reviewers** – Responsible for reviewing the care leading to death and providing a clinical judgment.
- 4.11 **Mortality and Outcomes Data Group** – Oversee the mortality review process and outcomes/learning from these reviews.
- 4.12 **Safety and Quality Committee** – To receive quarterly updates from the Mortality and Outcomes Data Group.
- 4.13 **Medical Examiner** - In the course of the medical review of the death necessary to inform the examiner process to identify and report cases where there are sufficient concerns of a governance nature that further investigation is merited or beneficial.

## 5. Definitions of Terms Used

- 5.1 **Death certification** - The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. The process includes identifying cases for referral to the Coroner and links to the Medical Examiner role.
- 5.2 **Medical Examiner** - Reforms envisaged by the government include the establishment of Medical Examiners, employed by Local Authorities, by April 2019. The Trust will fulfill this role until the national reforms are in place locally. The Medical Examiner will be involved in the certification and registration of deaths, have contact with bereaved families and staff in the immediate period after a death, improve the recording of cause of death, referral of cases to the Coroner and identify any concerns that suggest a case should receive a stage two case record review or investigation.
- 5.3 **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. The review should use a recognised methodology of case record review, for example Structured Judgement Review delivered by the Royal College of Physicians (RCP) or the PRISM (projects integrating sustainable methods) methodology. Often the output of these reviews are entered in databases and used to analyse trends. In addition to preventability and narrative descriptions of care attempts have been made to classify breaches in standards of care.

NCEPOD (National Confidential Enquiry into Patient Outcome and Death) have a well-established system they use in case note reviews:

## NCEPOD grading system for use by case reviewers

The grading system below is used by the case reviewers to grade the overall care each patient received. This system can be used locally at M&M reviews to aid the assessment of quality of care provided locally.

**Good practice:** A standard that you would accept from yourself, your trainees and your institution.

**Room for improvement:** Aspects of clinical care that could have been better.

**Room for improvement:** Aspects of organisational care that could have been better.

**Room for improvement:** Aspects of both clinical and organisational care that could have been better.

**Less than satisfactory:** Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.

**Insufficient data:** Insufficient information in the case notes to assess the quality of care.

This has been adapted in the RCP Mortality process:

Please rate the care received by the patient during this overall phase.

1 = very poor care    2 = poor care    3 = adequate care    4 = good care    5 = Excellent care

Please circle only one score.

None of these care or avoidability scales has been shown to have an advantage and despite their numerical nature offer sufficient consistency for comparative purposes. This is reflected in the national framework that recommends a tool, but is not didactic in its nature. The RCP toolset is much more narrative in construction, and claims, without (as yet) any evidence as such, that this will help the quality of learning from the casenote review process. Training in the use of this tool was received in 2017/2018, following this a trial of the tool has been undertaken and it has been adopted within the Trust.

- 5.4 **Preventable Death/'Preventability'** - The use of case record review by independent clinicians to determine an index of the likelihood that death was preventable. The key determinant is to identify those patients in whom a trained reviewer considers the possibility that the death was preventable to be more than 50/50. This is Hogan 4 or more and is equivalent to an avoidable death score of 3 or less using the RCP tool, see table below:

<b>HOGAN/Prism scale of preventability</b>	
1	Definitely not preventable
2	Slight evidence of preventability
3	Possibly preventable but not very likely, less than 50-50 but close call
4	Probably preventable, more than 50-50 but close call
5	Strong evidence of preventability
6	Definitely preventable
<b>RCP Scale of avoidability</b>	
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

- 5.5 **Death due to a problem in hospital care** - A death that has been clinically assessed using a recognised methodology of case record review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

- 5.6 **Investigation** - The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws 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 process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
- 5.7 **Duty of Candour** - Health and Social Care Act 2008 Regulation 20, this regulation infers a statutory duty to ensure that NHS providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- 5.8 **Serious Incident (SI)** - an accident occurring on NHS premises that resulted in serious injury, and or permanent harm, unexpected or avoidable death (ref to RMP03 'Reporting and Management of Incidents' policy for further details).
- 5.9 **Summary Hospital-level Mortality Indicator (SHMI)** - The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider and is the main mortality indicator reported nationally and is supported by the Department of Health. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping.

## 6. Process in Response to an in-Hospital Death

### 6.1 Deaths in hospital care

All patients who die following admission (including 'Escalation areas within ED) to any of the Trust's sites are regarded as 'deaths in hospital' and will be subject to this policy. Some deaths occur in patients who are under the care of the Trust but who are not admitted and over time more of these groups will be included under the remit of this policy. These groups include: patients who die before arrival in Emergency Department or who die in the emergency department prior to admission.

Deaths within a short period following admission, deaths under the care of community services but not whilst the patient is admitted, are all excluded, except in cases where they form part of criteria for a specialty mortality group (for example, they may look at all deaths within 30 days of surgery).

#### **Certification and Registration of a Death**

When a death occurs the consultant responsible for care (as either the "Attending Practitioner" or that doctor's supervisor) has a duty to decide whether the coroner needs to be informed and to oversee the process of completing the Medical Certificate of the Cause of Death (MCCD).

The MCCD should be completed within 24 hours for all deaths as circumstances allow. The Medical Examiner can provide guidance. When the attending team meet relatives to discuss MCCD they may refer the case for review if they or the family see fit.

**Cremation Forms Part 1** - for all deaths within the hospital, Part 1 of the Cremation Form (Cremation form 4) should be completed by the medical practitioner who attended the deceased at the same time as the MCCD within 24 hours as circumstances allow. Due to shift working the doctor writing the MCCD should complete a Cremation Part 1 at the same time. Best practice would be for the Family to collect MCCD from a bereavement suite or non-clinical location.

In normal circumstances, the consultant responsible for the care of the deceased will have an opportunity to discuss with the bereaved family the cause of death and at this stage the family should be asked whether they have any concerns about the care of the deceased patient. A second opportunity to identify any concerns about care will arise in many cases when a second doctor completes the confirmatory (Part 2) medical certificate for cremation.

**Cremation Forms Part 2** - this section may only be completed by a registered practitioner of at least 5 years' standing who is not either a relative of the deceased, the medical practitioner who issued the part 1 (Cremation form 4) or a relative or a partner or a colleague in the same practice or clinical team as the medical practitioner who issued that certificate. The Trust's Medical Examiner will normally complete this function and will undertake proportionate scrutiny of the case. This will usually involve examination of recent medical records and a discussion with a doctor who attended the deceased. It may involve an external examination of the body or conversations with other people, depending on the case. In every case the medical examiner will try to contact a representative of the family to ask whether they understand the proposed cause of death and whether they have any concerns that might justify further investigation. If the medical examiner concludes that the proposed cause of death is incorrect, s/he will contact the attending doctor and require that a replacement certificate is produced and that the incorrect certificate is cancelled.

When the medical examiner is satisfied that a natural cause of death has been correctly identified to an acceptable level of confidence, and that there is nothing to suggest that investigation by the coroner is justified, he/she signs a form to that effect and sends it to the Registrar. The attending practitioner is asked to add the date of this confirmation to the MCCD, making the MCCD ready for registration of the death.

The 'prescribed information about the deceased', supplied by the Attending Practitioner, should include any information about hazards associated with the body of the deceased, such as infections or implants (the latter being potentially hazardous during cremation). If the medical examiner becomes aware of such a hazard there is a duty to inform those concerned, such as funeral directors and crematorium staff.

A representative of the family takes the certificate of the cause of death to the Registrar, to register the death. The registrar checks that the information on the MCCD and the medical examiner's confirmation is all congruent.

If at any point during this process the medical examiner forms the opinion that the death should be investigated by a coroner, the medical examiner process must be stopped and the medical examiner must provide details of the case to the appropriate senior coroner. This does not preclude a referral for Stage 2 mortality review or further investigation via the Trust governance system.

Until the reforms are implemented the Trusts Medical Examiner(s) will support clinical teams in their duties by advising on the completion of the Medical Certificate of Cause of Death (MCCD) which is needed in order for the registrar of births deaths and marriages to issue a death certificate, advising on cases that should be referred to the Coroner, reviewing the case records, speaking to bereaved families and staff and identifying cases that require stage two case record review or investigation. The Trust's ME will develop a process to ensure that bereaved families are informed that the Trust reviews all deaths; that this does not mean that there has been a problem in care, but if a significant problem is identified that was not known about at the time of death that they can choose to be informed about this. Any family concerns and preferences about how much they would like to be involved in future will be recorded by the Bereavement Office team.

**First stage case record review:** The Medical Examiner will conduct a first stage case record review. They will identify whether there is any reason to conduct a more in-depth second stage review or investigation. It is intended that all deaths that occur whilst a patient is in receipt of care from the Trust also receive a first stage case record review from the specialty team responsible for their care at the time of death. In most cases, this will involve the wider specialty team, rather than just those directly responsible for the patient at the time of death. The case records should be reviewed briefly to see whether there is any reason why a more in-depth review would be potentially useful. On average, this first stage review will take about 10 minutes and should seek to identify any areas where there could be a problem in the care of the patient, such as a fall, potentially hospital-acquired infection, acute kidney injury, blood clot or other adverse event, problems in the recognition of deterioration, or in the care delivered as part of the end of life process (this list is indicative, it is not intended to be exhaustive – clinical judgement will always be required to identify when a second stage review would be potentially helpful). Brief details of the review should be recorded in the Trust's case record review system (see below). First stage reviews should consider whether a clinical or staff incident, a relative enquiry, an element of preventability, (with or without a decrement in care), or any combination of all these are the reason a more in depth second stage review is required. It is expected these reviews will normally be referred to the relevant specialty review group.

## 6.2 Reporting of Deaths which are of Immediate Concern

The following deaths fall within the serious incident framework should also be reported as incidents, escalated to the Business Unit Director for consideration of a Serious Untoward Incident:

- Deaths reported to Coroner where there were known problems with care;
- Maternal Deaths - deaths of women while pregnant or within 42 days of delivery, miscarriage, or termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (Serious Untoward Incident);

- Death of a neonate or child under the age of 19yrs which is a potential Serious Incident or Inquest (it is recognised that paediatric and neonatal deaths will also be subject to specific review process for example child death overview panel, however they must also be escalated to the Medical Director);
- Deaths during a surgical operation or endoscopy or before recovery of an anaesthetic, including conscious sedation;
- Any deaths where an incident has been raised and the clinical team have raised significant concerns about the care delivered to the medical or nursing director.
- Any death relating to a 'Never Event'.

There is a well-established process for investigating such events as described in RMP 03 'Reporting and Management of Incidents Policy'.

### **6.3 Second Stage (Independent) Case Record Review**

Those clinicians performing Case Record Review should be adequately trained, and experienced in the process as well as being entirely independent of the clinical care the patient received.

Notes may be selected for case record review from any patient who dies whilst an in-patient in the Trust. Sufficient resources currently allow for 17 case notes per week or 850 case notes per year. Each review takes approximately 30 minutes and is conducted by a trained, centralized team. This is a single stage review process and uses NCEPOD (National Confidential Enquiry into Patient Outcome and Death) and Hogan methodology.

The Trust has undertaken a pilot of the new RCP Structured Judgment Review Process for 2 stage review and is currently implementing specialty review groups for this purpose.

Not all patients will be reviewed, in order to make the best use of the limited record review resource notes will be sampled in the following way:

#### **Mandatory Sampling:**

- Deaths investigated as an SI (serious incident) or (less commonly) SLE (serious learning event), including falls and pressure ulcers.
- A patient has a Learning Disability (in-line with the national LeDeR process)
- Death during an elective admission
- Deaths referred to coroner with an inquest planned

#### **Discretionary Sampling:**

- Deaths referred by attending team or medical examiners consulting family as part of bereavement process
- Issues arising from deaths as a result of feedback in the relative feedback process.
- Deaths examined as part of other improvement processes: e.g. Surviving Sepsis, NELA, Hip Fractures
- Investigation of CQC mortality or other ALERTS (e.g. VLADs) as advised by Executive Directors on behalf of Board

The remainder of the review capacity should be made up of randomly selected case records, randomly selected notes (based upon site, date of death and availability) should not be less than 30% of the review total.

Maternal and neonatal deaths are reviewed in a robust process detailed in section 6.6 of this policy, as are deaths in children and young people.

## **6.4 Learning**

The weekly mortality audit uses an audit tool that has been developed over time and includes various questions including: Preventability score (Hogan), NCEPOD grade, Examples of good / bad practice, Lessons to be learned, Further questions to be addressed following this audit.

The questions from these audits are directed to the relevant person/team including the relevant session lead. Results of the mortality audits are regularly distributed to the site leads, Executive Lead for responding to deaths, Executive Director of Performance and Improvement and Head of Information and Statistics.

The collated learning output for one quarter should be sent to the executive lead for mortality, who is responsible for compiling a 'mortality' summary for onward cascade to clinical staff at least quarterly. The content of these letters should be surveyed at least twice yearly with a view to improving and developing the learning system.

All actions should be kept on a centrally held action log and completion captured by corporate or Business Unit governance systems. These completed actions should be collated centrally as part of the Mortality assurance framework, and included in the assurance reporting.

Lessons learnt and incomplete actions requested must be discussed at the Mortality and Outcomes Data Group, which meets bimonthly, who should ensure any necessary actions on the central log are captured and evidenced.

There must be a system of recording feedback given to relatives (including Duty of Candour) which must also be captured and assured by the mortality surveillance group.

A board paper summarizing cases reviewed, relative feedback and lessons learnt will be prepared quarterly (one quarter in arrears) for scrutiny at Safety and Quality Committee and subsequent Board. The Executive lead for responding to Deaths should be responsible for acting on the recommendations of these Board committees in response to the information provided.

## **6.5 Carer Involvement**

The Trust will extend its patient experience programme to include feedback from relatives of deceased patients. This feedback will be reviewed by the Mortality and Outcomes Data Group and used to inform decisions on improvements to the responding to deaths process. Bereavement officers will be invited to the Mortality and Outcomes Data Group so they may feedback directly to the reviewing team. There will be a pilot extension of the AMU practice of voluntary follow up with relatives by the attending team to discuss MCCD post death to include carer referral for, and discussion of a Case Record Review.

Feedback to carers must be recorded in the following circumstances:

- Significant harm ascribable to care requiring a Duty of Candour (i.e. all those deaths with a greater than 50% chance of avoidability, or patients whose EOL process was compromised, or length of stay increased by avoidable lapses) found on Case Record Review
- ALL patients referred for Case Record Review by relatives or carers, whether by discussion with attending clinicians or by medical examiner.

In these cases an appropriately anonymised version/summary of the Case Record Review should be discussed with the family by a member of the attending clinical team.

- All cases investigated as SI/SLE. This should be as per current arrangements within business unit investigating teams.

There will be a regular meeting of all those involved in the certification process, chaired by the executive lead for mortality, including a lead 'Medical Examiner' and a lead trainee. The purpose of the quarterly meeting is to ensure improvements required by the patient experience report are responded to and will ensure there is coordination, integration of the bereavement process.

A new section (3) will be added to the SI/SLE template to mandate the involvement of the carers and relatives of the bereaved in the terms of reference and output of the investigation.

## **6.6 Cross-system reviews and investigations**

### Deaths in children/young people

The Trust participates in the national (England & Wales) child death review process which has been in place for several years and developed as a multi-agency evaluation to standardize procedures and facilitate learning with the long-term aim of reducing child mortality. These processes were incorporated into "Working Together to Safeguard Children" and can be found in chapter 5 of the revised edition (2015). A child death review runs in parallel with any Coroner's or Police investigation and is overseen by the Designated Doctor for Child Death Reviews responsible for the child's usual place of residence – irrespective of where the death occurred.

All reviews are discussed by the North of Tyne Child Death Overview Panel (CDOP) which reports to the Local Safeguarding Boards (LSB). The cause of death is established by the doctor who signs the death certificate or by the Coroner whilst the aim of the CDOP is to classify the death, identify any modifiable factors and actions to address these. Any learning is shared within the Trust and reported via Child Health governance processes.

### Maternal and neonatal deaths

All maternal deaths will be investigated as SIs (Serious Incidents), all still births are investigated through the local perinatal mortality process (MBRACE – Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) which has a process to involve parents.

## 6.7 Working with Wider NHS

The Trust will work with partner NHS organisations to develop data sharing agreements to help partners identify patients for their own mortality review processes. Where partners have identified deaths occurring outside the Trust they will be able to refer for review patients previously not included in our review process. The NHCFT/NTW data sharing agreement will ensure improvement in learning from deaths for Northumberland population who have mental health disorders.

The Trust will also share learning in partner organisations where it has identified learning for other organisations. This will include sharing learning in the Trust from partner mortality reviews.

## 7. Training and Support

National RCP training was attended by staff in December 2017 (Carlisle) and January 2018 (Newcastle), which allowed a limited pilot to see if the RCP tool would offer benefits in the learning provided. Following receipt of this training and the pilot exercise a decision was made on future training requirements.

## 8. Process for Monitoring and Audit

Monitoring/audit arrangements	Methodology	Reporting		
		Source	Committee	Frequency
Quarterly Deep Dive report	A mortality information 'pack' including details of the lessons learnt from the audits will be circulated monthly. This pack will include the learning from deaths dashboard specified nationally.	Information Department	Mortality Outcomes Data Group	Bi Monthly
Quarterly report	Paper summarizing cases reviewed, relative feedback and lessons learnt will be prepared quarterly (one quarter in arrears) for scrutiny at Safety and Quality Committee and subsequent Board.	Information Department The Executive lead for responding to Deaths	SQC/ Trust Board	Quarterly

Wherever the monitoring has identified deficiencies, the following should be in place:

- Action plan
- Progress of action plan monitored by the appropriate Committee (minutes)
- Risks will be considered for inclusion in the appropriate risk registers

## 9. References

- Preventable deaths due to problems in care ;Charles Vincent and Nick Black Helen Hogan, Frances Healey, Graham Neale, Richard Thomson, BMJ Qual Saf 2012 21: 737-745

## 10. Associated Documentation

- **RMP 03** – Reporting and management of incidents policy
- **RMP 36** – Duty of candour and being open policy
- **RMP 05** – Handling of clinical and non-clinical claims and inquests policy
- **CG 23** – Bereavement policy

## Appendix 1 Equality Impact Assessment Template

***To be completed for all key policies. Cite specific data and consultation evidence wherever possible.***

### ***Duties which need to be considered:***

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

### **PART 1 – Overview**

Date of equality impact assessment:

27 April 2019

Name(s) and role(s) of staff completing the assessment:

Jeremy Rushmer, Medical Director

Overall, what are the outcomes of the policy?

This policy describes the process by which all deaths in hospital care in our Trust are identified, reported and investigated. It aims to strengthen arrangements, where appropriate, to ensure learning is shared and acted upon. It seeks to ensure the Trust engages meaningfully and compassionately with bereaved families and carers and supports staff to find all opportunities to improve the care the NHS offers by learning from deaths. The purpose is to ensure that any deaths in care are identified, reported and investigated in a consistent way.

## PART 2 – Relevance to different Protected Characteristics

Answer these questions both in relation to people who use services and employees as appropriate

Protected Characteristic	Does this characteristic have specific relevance to this policy?	If No –	If Yes –						
		Please state why:	What do you know about usage of the services affected by this policy by people in this protected group, about their experiences of it, and about any current barriers to access?	Could people in this protected group be disproportionately advantaged or disadvantaged by the policy?	Could the policy affect the ability of people in this protected group participate in public life? (E.g. by affecting their ability to go to meetings, take up public appointments etc.)	Could the policy affect public attitudes towards people in this protected group? (e.g. by increasing or reducing their presence in the community)	Could the policy, change make it more or less likely that people in this protected group will be at risk of harassment or victimisation?	If there are risks that people in this protected group could be disproportionately disadvantaged by the policy are there reasonable steps or adjustments that could be taken to reduce these risks?	Are there opportunities to create positive impacts for people in this protected group linked to this policy?
<b>Disability</b> <i>Note: “disabled people” includes people with physical, learning and sensory disabilities, people with a long-term illness, and people with mental health problems.</i>	Yes		Approximately 1.5million people in the UK have a learning disability (People with Learning Disabilities in England, 2011). Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities. The National Quality Board has therefore specified that all inpatient, outpatient and community patient deaths of people with learning disabilities should be reviewed in order that learning from these deaths can contribute to service improvements.	The policy makes a specific provision for the investigation of deaths of patients with a learning disability and states that patients with a learning disability are to be included in the compulsory sampling. In addition, it is acknowledged that within this policy there is reference to communicating with relatives. Due to a disability, some relatives may need additional support to participate fully in any meetings that are held with the Trust as a result of a patient death.	No	No	No	Provisions are in place to support people with a disability to communicate with the Trust and take part in any meetings that may be held as a result of a patient death.	The policy aims to support learning from deaths to make improvements in services for all patients, including specifically, those with a learning disability.
<b>Sex</b>	No	Policy applies regardless of sex							

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Protected Characteristic	Does this characteristic have specific relevance to this policy?	If No –	If Yes –						
		Please state why:	What do you know about usage of the services affected by this policy by people in this protected group, about their experiences of it, and about any current barriers to access?	Could people in this protected group be disproportionately advantaged or disadvantaged by the policy?	Could the policy affect the ability of people in this protected group participate in public life? (E.g. by affecting their ability to go to meetings, take up public appointments etc.)	Could the policy affect public attitudes towards people in this protected group? (e.g. by increasing or reducing their presence in the community)	Could the policy, change make it more or less likely that people in this protected group will be at risk of harassment or victimisation?	If there are risks that people in this protected group could be disproportionately disadvantaged by the policy are there reasonable steps or adjustments that could be taken to reduce these risks?	Are there opportunities to create positive impacts for people in this protected group linked to this policy?
Age	Yes		<p>Most deaths that occur in hospital are older people aged 75 and above. However, there are cases where younger people die including children and babies.</p>	<p>The policy stipulates that the death of a neonate or child under the age of 19yrs falls within the serious incident framework and should be reported as incidents, and escalated to the Business Unit Director for consideration of a Serious Incident.</p> <p>The policy states that paediatric and neonatal deaths will also be subject to a specific review process, for example child death overview panel, and must also be escalated to the Medical Director.</p>	No	No	No	<p>Patients of different ages will not be disproportionately disadvantaged by this policy. However, paediatric and neonatal deaths will be investigated in a different way to those of adults.</p>	<p>The policy aims to support learning from deaths to make improvements in services for all patients regardless of age.</p>
<p><b>Race</b></p> <p><i>Note: For the purposes of the Act 'race' includes colour, nationality and ethnic or national origins.</i></p>	Yes		<p>Information on the race of patients who have died in our care is not routinely analysed.</p> <p>According to the last census, in Northumberland, 98.5% of residents classed themselves as White and 1.5% (approximately 5,000) classed themselves as being part of another ethnic group.</p> <p>In North Tyneside, 96.6% classed themselves as White and 3.4% classed themselves as being part of another ethnic group.</p>	<p>Within this policy there is reference to communicating with relatives. Some people from non-White ethnic groups may not use English as their first language and may need additional support to participate fully in any meetings that are held with the Trust as a result of a patient death.</p>	<p>The Trust has arrangements in place to support people are not able to communicate in English to participate in meetings to discuss their relative's care.</p>	No	No	No	<p>The policy aims to support learning from deaths to make improvements in services for all patients regardless of race.</p>

Protected Characteristic	Does this characteristic have specific relevance to this policy?	If No –	If Yes –						
		Please state why:	What do you know about usage of the services affected by this policy by people in this protected group, about their experiences of it, and about any current barriers to access?	Could people in this protected group be disproportionately advantaged or disadvantaged by the policy?	Could the policy affect the ability of people in this protected group participate in public life? (E.g. by affecting their ability to go to meetings, take up public appointments etc.)	Could the policy affect public attitudes towards people in this protected group? (e.g. by increasing or reducing their presence in the community)	Could the policy, change make it more or less likely that people in this protected group will be at risk of harassment or victimisation?	If there are risks that people in this protected group could be disproportionately disadvantaged by the policy are there reasonable steps or adjustments that could be taken to reduce these risks?	Are there opportunities to create positive impacts for people in this protected group linked to this policy?
<b>Religion or belief</b> <i>Note: In the Equality Act, religion includes any religion. It also includes a lack of religion. Belief means any religious or philosophical belief or a lack of such belief.</i>	No	Policy applies regardless of religion or belief							
<b>Sexual Orientation</b> <i>Note: The Act protects bisexual, gay, heterosexual and lesbian people.</i>	No	Policy applies regardless of sexual orientation							
<b>Gender Reassignment</b> <i>Note: The Act provides protection for transsexual people. A transsexual person is someone who proposes to, starts or has completed a process to change his or her gender.</i>	No	Policy applies regardless of gender reassignment							

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		Please state why:	What do you know about usage of the services affected by this policy by people in this protected group, about their experiences of it, and about any current barriers to access?	Could people in this protected group be disproportionately advantaged or disadvantaged by the policy?	Could the policy affect the ability of people in this protected group participate in public life? (E.g. by affecting their ability to go to meetings, take up public appointments etc.)	Could the policy affect public attitudes towards people in this protected group? (e.g. by increasing or reducing their presence in the community)	Could the policy, change make it more or less likely that people in this protected group will be at risk of harassment or victimisation?	If there are risks that people in this protected group could be disproportionately disadvantaged by the policy are there reasonable steps or adjustments that could be taken to reduce these risks?	Are there opportunities to create positive impacts for people in this protected group linked to this policy?
<b>Pregnancy and Maternity</b> <i>Note: the law covers pregnant women or those who have given birth within the last 26 weeks, and those who are breast feeding.</i>	Yes		The Trust does not routinely publish information on how many patients in our care who died were pregnant.	The policy states that maternal deaths (deaths of women while pregnant or within 42 days of delivery, miscarriage, or termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes) fall within the serious incident framework and should be reported as incidents, and escalated to the Business Unit Director for consideration of a Serious Untoward Incident.	No	No	No	No	Other than the stipulation that maternal deaths fall within the serious incident framework, the process for investigating these deaths falls outside of this policy.
<b>Marriage and Civil Partnership</b> <i>Note: This applies to changes, decisions or proposals impacting on employees only. The Act protects employees who are married or in a civil partnership.</i>	No	Policy applies regardless of Marriage and Civil Partnership							
<b>Human Rights</b>	<b>Could the policy impact on human rights? (e.g. the right to life, the right to respect for private and family life, the right to a fair hearing)</b>								
	The policy supports the principles of human rights through incorporating the legal duty to be open and honest with patients about incidents that have caused or have the potential to result in significant harm.								

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### PART 3 - Course of Action

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Based on a consideration of all the potential impacts, tick one of the following as an overall summary of the outcome of this assessment:

<input checked="" type="checkbox"/>	The equality analysis has not identified any potential for discrimination or adverse impact and all opportunities to promote equality have been taken.
<input type="checkbox"/>	The equality analysis has identified risks to equality which will not be eliminated, and/or opportunities to promote better equality which will not be taken. Acceptance of these is reasonable and proportionate, given the objectives of the policy and its overall financial and policy context.