Weston Area Health Trust Learning from Deaths in Hospital Policy

Draft v 5 October 2017

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Directorate / Department responsible (author/owner):	Medical Director Clinical Effectiveness Group (CEG)
Contact details:	Peter Collins- Medical Director Peter Collins- MRG Chair
Brief summary of contents	Description of WAHT approach to learning from deaths in hospital
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This document replaces (exact title of previous version):	New policy
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Links to key external standards	National Quality Board March 2017 National Guidance on learning from deaths
Related Documents:	
Training Need Identified?	

Version Control Table

Date	V	Summary of changes	Author
01.07.17	1	Initial draft document	P Collins
01.09.17	2	Specialist additions	P Collins
03.10.17	3	Review of NHSI requirements	R Goddard

Document Amendment Form – minor amendments

No.	Date	Page no	Amendment	Authorised by
1				
2				
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10				

Ten or less minor amendments can be made before the document is revised.

Major changes must result in immediate review of the document

If printed, copied or otherwise transferred from the Trust intranet, procedural documents will be considered uncontrolled copies. Staff must always consult the most up to date version – located on the intranet.

Table of Contents

1. Introduction and purpose

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards “from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals”.

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

Trust boards have been issued guidance requiring them to ensure that there is clear governance about how learning from deaths in hospital is obtained (the collection of information) analysed (the determination of learning) shared (the communication of learning) and acted upon (learning leading to improvement).

2. Scope

This policy and its associated procedures and guidance documents are relevant to all clinical staff in Weston Area Health Trust as well as non-clinical staff involved in supporting quality and governance and all trust board members

The policy describes the processes the trust will use to collect and report information on and learning from deaths in hospital. It identifies those individuals who will be responsible for and accountable for the collecting reporting and dissemination of information and learning.

A robust process does not require all deaths to be subject to a case record review, although deaths in some circumstances must always be investigated.

3. Explanation of terms

Death certification

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Structured Judgment Review
A structured desktop review of a case record/notes, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. This is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

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

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

Investigation
A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care
A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

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

Patient safety incident
A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

Mortality Database
An access database that is automatically filled with all inpatient deaths by the Health Informatics team. This software is used to enter each structured judgment review and populates the Trust's mortality dashboard.

Mortality rate
The mortality rate (or death rate) is a measure of the number of deaths that occurred during a particular time period divided by the total size of the population during the same time frame. It is typically expressed in units of deaths per 1,000 individuals per year.

LeDeR
The Learning Disabilities Mortality Review programme will receive notification of all deaths of people with learning disability aged 4 to 74 years of age. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities. All deaths of people with learning difficulties are notified to the programme.

4. Roles and Responsibilities

Role	Responsibilities
Trust Board	• Ensures a systematic approach to the issue of potentially avoidable mortality and that robust mortality governance processes are in place. This allows the identification of any areas of failure of clinical care and ensures the delivery of safe care. • The Clinical Effectiveness Group will provide regular mortality reporting to the Board (at the public section of the meeting) and assurance that the outputs of the mortality governance process (including investigations of deaths) are being communicated to frontline clinical staff.
Medical Director	• Has overall responsibility for the mortality peer review process. • Reports outcomes and findings to the Trust Board. • Ensures that all staff understand their responsibilities to participate in the review of deaths in hospital and share learning with a view to improving care.
Nominated Non-executive Director	• Assures that the published information accurately and fairly reflects the organisation's approach, achievements and challenges and champions quality improvement which leads to improvements in patient safety.

Clinical Effectiveness Group	• Provides assurance to the Trust Board on patient mortality based on review of care received by those who die. • Reviews directorate M&M outcomes, audit data and incident reporting • Identifies areas of high risk, commissions audits and quality improvement and monitors effectiveness • Ensures that feedback and learning points are shared with relevant staff within the directorates and specialties so that learning outcomes are actioned in an effective way.
Associate Medical Directors	• Co-chair and attend the clinical effectiveness group • Ensure that all specialties are engaging with the second stage review of cases identified by the SJR • Ensure that all pertinent cases and findings from mortality reviews are presented by the appropriate clinical leads at minuted specialty Mortality & Morbidity (M&M) meetings • Ensure that outcomes and learning from M&M meetings are recorded and action plans for improvement are developed where required • Ensure that findings are evaluated and reported to specialty and divisional governance meetings to promote learning • Feedback findings from mortality peer reviews and M&M meetings to the Mortality Review Committee
Deputy Director of Safety and Quality	• Producing reports based on information recorded in Keypoint • Maintaining a library of completed peer review forms and feeding back the reports and outcomes to the clinical leads for each area • Analysis of the database to identify themes and trends • Recording special reviews on Keypoint • Ensuring learning outcomes and action points are included in the specialty audit programmes as appropriate • Ensuring the clinicians is alerted if the specific tools to be used if the patient falls under the specialty criteria
Medical staff	• Participate in mortality case reviews using the structured judgement tool • Be involved in quality improvement which leads to actions that improve patient safety

Senior Nursing Staff	• Participate in mortality peer reviews wherever possible, either in person or by nominated staff being available for advice on nursing issues
Clinical Coding Staff	• Attend Clinical Effectiveness Group • Participate in mortality peer reviews to advise on coding issues • Contribute to the identification of areas of concern/interest based on available data • Contribute to an active clinical coding improvement programme
Performance Analysts (including CHKS)	• Collating the learning from deaths dashboard monthly for the medical director and the Clinical Effectiveness Group • Compile monthly mortality report for the Clinical effectiveness group based on feedback from Medical director and
Bereavement Support Officer	• Is the initial point of contact for the bereaved family and carers • Informs the families of their right to request a learning from deaths review irrespective of whether they have concerns about the quality of care provided to their family member • Screens the case to establish whether the family or carers have a concern about care or whether there is a PALS complaint • Ensures that families and carers are involved in the investigation process, if they express a wish to be, and that they are provided with the report and any subsequent action plan. • Ensures that families and carers are involved in any recommendations for further training for staff • Provide bereavement support to the families and carers of any patient who has died whilst receiving care
Audit Team	• To highlight patients on the mortality database who have been identified by the mortality screening form • To review the DOLS register on a weekly basis to identify relevant deaths • To work alongside the clinical effectiveness group to identify categories of patients requiring structured judgment reviews • To co-ordinate themes and quality improvement projects relating to learning identified from structured judgment reviews

5. Policy details

There are three levels of scrutiny that a provider can apply to the care provided to someone who dies;

(i) death certification

(ii) case record review

(iii) Investigation

These do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a case record review has been undertaken (although a case record review will inform the information gathering phase of an investigation together with interviews, observations and evidence from other sources). For example, the apparent suicide of an in-patient would lead to a Serious Incident investigation being immediately instigated in advance of death certification or any case record review. The three processes are summarised below:

Death Certification:

In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

At the time of death certification the doctor completing the certificate with record on a standard form (see appendix 1) information about the death and concerns about care provided.

When bereaved families are given the certificate they will be provided with the opportunity to request a record review with a clear explanation of the difference between this and an investigation in response to a complaint (see information leaflet appendix 2).

At the point of completion of certification, a discharge notification to primary care should be completed by the same doctor and should include any information about an intention to formally investigate the death (via an external (e.g. police/coroner) or internal (e.g. serious incident) investigation).

Case Record Review:

Some deaths will be subject to a more thorough case review which will be coordinated by the trust governance and quality lead in conjunction with the chief registrar. This process will use a consistent methodology, looking at the care provided to the deceased as recorded in their case records in order to identify any learning.

Identification of deceased patients who require case record review:

All patients who die during an admission to Weston Area Health Trust will be considered for case record review. This includes patients who die in the emergency department.
Patients who die within 30 days of admission to hospital including patient who present and die in the emergency department will also be considered for review and could be identified by the registrar for deaths, local GP practices and by the coding department

The trust will perform a structured case record review on **all** of the following groups of patients:

- *Deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision (via a formal or informal complaint during or after the final care episode)*
- *Death where bereaved families and carers have requested a review*
- *In-hospital deaths of those with learning disabilities*
- *In-hospital deaths of those with mental health needs*
- *Infant or child death*
- *Stillbirth*
- *Maternal Death*
- *Deaths in a service or specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the trust via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or other regulator.*
    - *These groups will be determined by the Mortality Review Group and reviewed on a quarterly basis.*
- *Deaths in areas where people are not expected to die, for example in relevant elective procedures*

- *Deaths where learning will inform quality improvement work (for example, if work is planned on improving sepsis care, relevant deaths should be reviewed)*

- *Deaths where learning points have been raised from other organisations (e.g. community care, primary care or other Acute Trusts)*
- *A proportion of other deaths selected randomly from all of the identified deaths or as part of a systematic audit/quality improvement process*
    - *This will be determined by the Mortality Review Group and reviewed on a quarterly basis.*
    - *This will include periodical review of patients whose death was expected, for example those receiving end of life care*
    - *The mortality screening form will be tailored to identify patients relevant to specific quality improvement projects or in specific groups of interest*

The majority of these cases will be identified through the use of the Mortality Screening Form (appendix 1). The specific details for each scenario are laid out in the other appendices.

<u>The case record review process:</u>

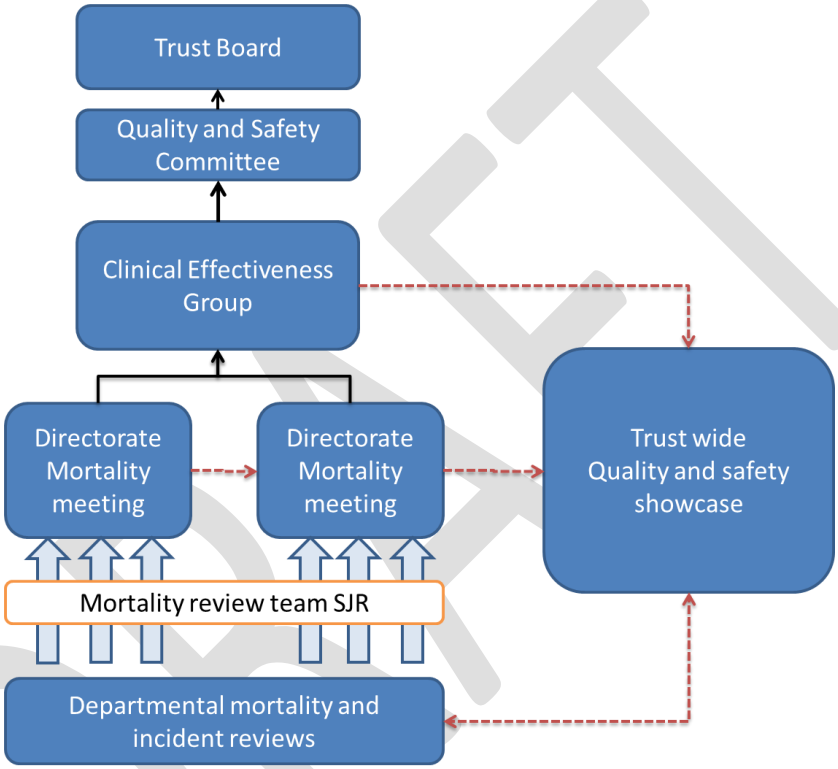
All cases identified as above will undergo a case record review using the Royal College of Physicians Structured Judgment Review (SJR) tool by a clinical team trained in this methodology and independent of the team caring for the patient at the time of death.

Each SJR will be discussed with multidisciplinary teams at departmental level and in a monthly directorate mortality meeting where any key learning points and trends will be described. Formal records and minutes of these meetings will be kept.

Key themes and learning at directorate level with feed into monthly clinical effectiveness group meetings to be combined with data from incidents and complaints, and external sources (e.g. SHMI data).

Learning will be fed back into the organisation through quarterly safety and quality showcase meeting as well as informing directorate- and trust-sponsored audit and quality improvement projects.

Each department in the hospital will continue to perform mortality reviews for cases which do not fit the mandatory review criteria nor are part of the control cases selected at random. The teams will receive training around implementing structured case review methodology and will use the same form to input data into the mortality database.
The departmental learning from these reviews will be fed into the relevant directorate mortality meetings, with key themes and learning to be reported to the clinical effectiveness group each month.



Investigation:

Some deaths warrant an in-depth investigation due to the magnitude of the concerns raised. These investigations should follow the methodology described in the Trust's Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication are needed to avoid problems.

The intention to formally investigate a death should always be communicated to the bereaved family and/or carers verbally and in written form. They should be supported to understand the process given clear timelines for when to expect an outcome and invited to contribute to the investigation. An individual staff member should be identified to act as a point of contact for information and updates.

Information sharing

Bereaved relatives and/or carers will be informed of the intention to carry out a case review and invited to a) contribute a statement b) receive feedback on completion of review including any actions taken and lessons learned. The Duty of Candour process should be followed.

Key themes and learning should be shared with other organisations (for example primary care, mental health trusts, community providers and other acute trusts) if this is considered to be appropriate.

The results of formal investigations (as opposed to SJRs) should always be shared with the deceased GP and any other relevant organisations.

Reporting

A mortality dashboard will be populated from the data gathered at the time of the SJR. From this, monthly data on total deaths will be published and available to the members of the clinical effectiveness group and the trust board (via the quality and safety committee).

A quarterly report will be compiled by the medical director on behalf of the Clinical effectiveness group including an overview of mortality in the trust, emerging trends, comparable data from other trusts, internal learning and actions with measures of success.

This will specifically detail:

- The total number of inpatients deaths in Weston General Hospital
- The number of deaths subject to case record review
- The number of deaths investigated as serious incidents
- Number of deaths more likely than not to be due to problems with care

- The themes and issues identified from review and investigation including examples of good practice
- How the findings have been used to inform and support quality improvement activity, and progress with this

The SJR has been designed to clearly identify cases in which learning points have been raised pertaining to other organisations – for example primary care, community care or other Trusts.

Where learning points have been raised relating to another acute trust the medical director's team will prepare a report which will be shared with the relevant team in order to feed the learning into their own mortality review system.

We are committed to sharing learning between organisations by promoting a two-way dialogue between community services and the hospital.

Coroner's Inquests:

In the case of a coroner's inquest where a *Regulation 28 Report on Action to Prevent Further Deaths* is issued, the Medical Director will be asked to respond within 56 days with:

a. details of any action that has been taken or which it is proposed will be taken whether in response to the report or otherwise and set out in a timetable of the action taken or proposed to be taken; or

b. an explanation as to why no action is proposed

This report should contain a review of the case's *Structured Judgement Review* in order to examine the effectiveness of the Trust's review process.

Support for family members

The bereavement team will provide support for family members, including:

- Arranging completion of all documentation, including medical certificates
- The collection of personal belongings
- Post mortem advice and counselling
- Deaths referred to the coroner
- Emotional support and signposting to relevant counselling

- Collection of the doctor's Medical Certificate of Cause of Death and information about registering a death at the Registrar's Office
- Details of the doctor's Medical Certificate of Case of Death (this is needed to register a death at the Registrar's Office)
- Offering support and guidance and obtaining legal advice for families and carers
- Timely access to an advocate (independent of the Trust) with necessary skills for working with bereaved and traumatised individuals

The bereavement team will ask the family if they have any concerns about the patient's care that they would like to raise. In the event of a concern, this will be recorded on the mortality screening form and the consultant responsible for the patient's care will be informed.

If the family require legal support it can be found here:

https://www.citizensadvice.org.uk/family/death-and-wills/

Families and other interested parties (e.g carers) may choose to seek legal support to represent their concerns and this should be facilitated by the trust without prejudice. Legal representation is not necessary for the normal trust processes used to investigate concerns about an individual death or the care a patient receives,
Cases heard in the coroners court will often involve the trusts legal team and it is important that families are aware of this fact in advance and given information about the purpose of a coroners inquest and advice on whether to secure their own legal representation.

6. Dissemination

The policy will be available internally on the trusts document management system and externally via the trusts public website.

The document will be referred to during structured judgment review training sessions and other relevant training and development programmes.

7. Implementation

This agreed policy supersedes all other agreements on this subject, and will be reviewed no later than 3 years of this agreement.

The Policy will be implemented through the Trust intranet, Email and via induction and training.

Each member of staff is responsible for maintaining up-to date awareness of existing policies and for adhering to those policies in the course of their daily work. All new staff joining the Trust should be made aware through line management of all current Trust wide documents.

8. Monitoring Compliance and Effectiveness

Table 1. Mandatory Elements of Monitoring Compliance.

Element to be monitored	Mortality Review	Learning from Deaths
Lead	Deputy Director for Quality and Patient Safety and Chief Registrar	Medical Director, chairs of the CEG
Tool	Mortality report and dashboards	Trust Mortality Report
Frequency	Monthly	Quarterly
Reporting arrangements	monthly report to Clinical Effectiveness Group	Quarterly report to public board
Acting on recommendations and Lead(s)	Clinical Effectiveness Group (CEG) Directorate governance leads	Relevant corporate and directorate teams
Change in practice and lessons to be shared	CEG and directorate governance leads	Corporate governance leads

9. Reference and bibliography

National Guidance on learning from deaths: National Quality Board 2017
www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

Guidance for the conduct of local reviews of the deaths of people with learning disabilities
NHS England 2017

Template Learning from Deaths Policy, NHS improvement, September 2017

10. WAHT associated records

- Mortality Review Template
- Mortality Database
- Mortality dashboard
- Mortality screening tool

11. Staff compliance statement

All staff must comply with the Trust-wide procedural document and failure to do so may be considered a disciplinary matter leading to action being taken under the Trust's Disciplinary Procedure. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual concerned.

12. Equality and Diversity statement

The Trust aims to design and implement services, policies and measures that meet the diverse needs of users of our services, population and workforce, ensuring that none are placed at a disadvantage over others. **Equality Impact Assessment Screening Tool**

To be completed for any procedural document when submitted to the appropriate committee for approval.

		Yes/No	Rationale
1	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	No	
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2	**Is there any evidence that some groups are affected differently?**	No	
3	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	No	
4	**Is the impact of the policy/guidance likely to be negative?**	No	
5	**If so can the impact be avoided?**	No	
6	**What alternatives are there to achieving the policy/guidance without the impact?**	No	
7	**Can we reduce the impact by taking different action?**	No	
8	**Actions identified following screening process**	None	

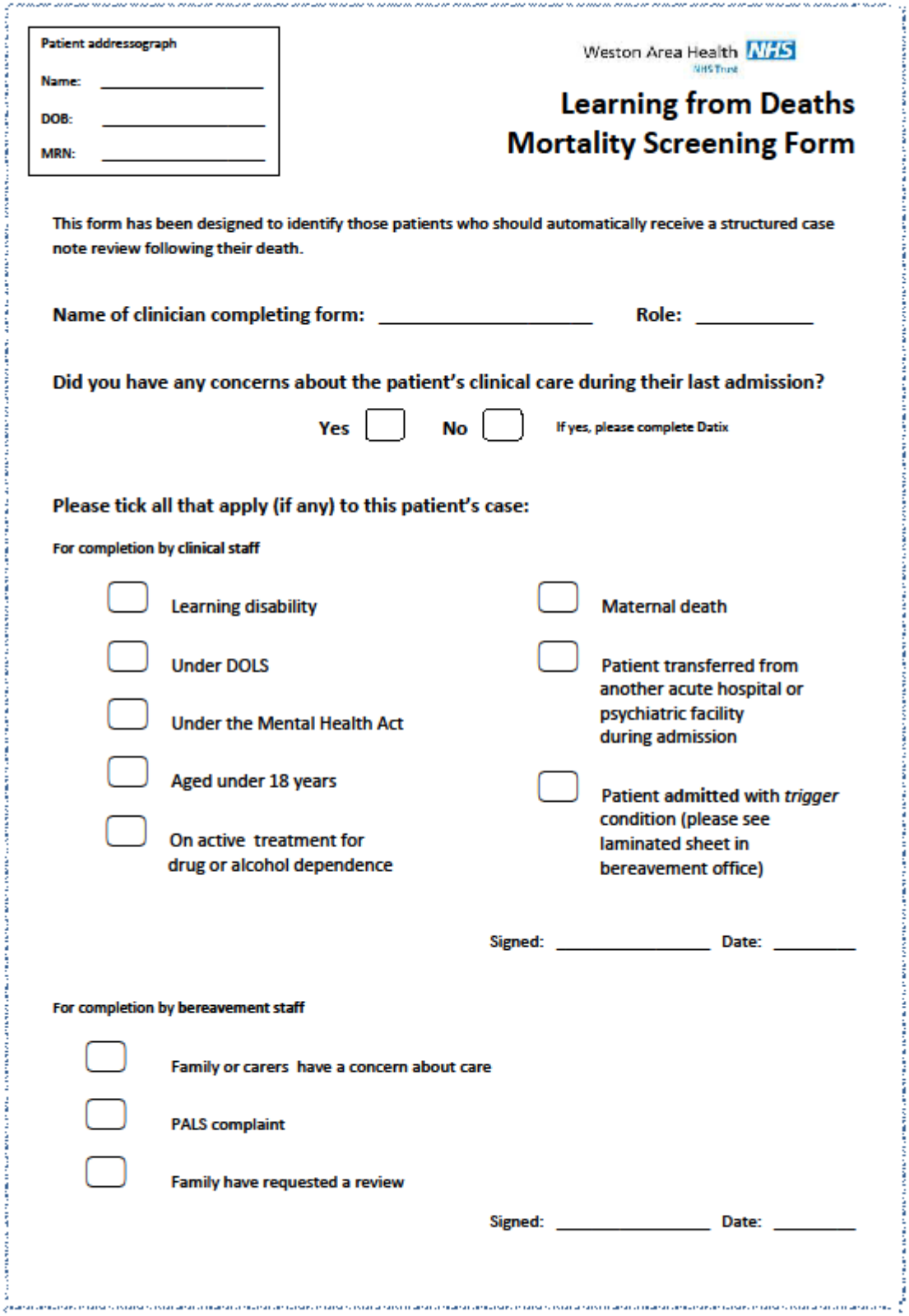
9	**Screening identified a full impact assessment.**	No

If you have identified a potential discriminatory impact of this policy/procedure, please refer it the appropriate Director in the first instance, together with suggested actions required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact the H.R Department. For advice on completion of this form please contact the Governance Team.

Appendix 1

Mortality Screening Form

A screening tool has been developed for use by the clinician completing the end of life paperwork. This has been designed to identify the patients whose notes should automatically undergo a case review.



Patient addressograph

Name: _____

DOB: _____

MRN: _____

Weston Area Health NHS

NHS Trust

Learning from Deaths
Mortality Screening Form

This form has been designed to identify those patients who should automatically receive a structured case note review following their death.

Name of clinician completing form: _____ **Role:** _____

Did you have any concerns about the patient's clinical care during their last admission?

Yes ☐ **No** ☐ If yes, please complete Datix

Please tick all that apply (if any) to this patient's case:

For completion by clinical staff

- ☐ Learning disability
- ☐ Under DOLS
- ☐ Under the Mental Health Act
- ☐ Aged under 18 years
- ☐ On active treatment for drug or alcohol dependence
- ☐ Maternal death
- ☐ Patient transferred from another acute hospital or psychiatric facility during admission
- ☐ Patient **admitted** with *trigger* condition (please see laminated sheet in bereavement office)

Signed: _____ Date: _____

For completion by bereavement staff

- ☐ Family or carers have a concern about care
- ☐ PALS complaint
- ☐ Family have requested a review

Signed: _____ Date: _____

All forms will be returned to the audit and quality improvement hub for review by the audit team. If the patient screens positive for **any** criteria they will be flagged up for structured judgment review on the mortality database.

The form will be adapted to screen for specific criteria such as those relevant to quality improvement work. These criteria will be decided by the clinical effectiveness group.

Appendix 2

Deaths where bereaved families, carers or staff have raised a significant concern about the quality of care provision

- Families or carers raising a concern:
    - The PALS team will identify deceased patients who have had a concern raised about the quality of their care
        - If this is known at, or shortly after, the time of death then it will be recorded on the mortality screening form.
        - If this becomes apparent at a later date the PALS team will inform the audit team who will flag the patient up for review on the mortality database
    - The bereavement officer will identify deceased patients whose relatives have raised a concern but do not wish to involve PALS . This will be recorded on the mortality screening form.
- Staff raising a concern:
    - The clinician completing the mortality screening form is able to identify whether they had any concerns about the patient's clinical care during their last admission
    - The governance team will review the mortality database on a weekly basis and highlight for review any patients who had a Datix attributed to the admission prior to death
    - The audit team will receive a weekly list of all Datixes pertaining to inpatient admissions received from community teams produced by the governance team; they will review this list for any deaths occurring within 30 days of discharge. If identified, these patients will be added to the mortality database and highlighted for review.

Appendix 3

In-hospital deaths of those with a learning disability

The deaths of patients with a learning disability will be identified for review in two ways:

1. The safeguarding team will review their learning disability database on a monthly basis to identify deaths within the population; if these are in-hospital deaths or deaths within 30 days of discharge they will flag them up on the mortality database for review

2. Via the mortality screening tool whilst completing the bereavement paperwork

Once identified, the structured case review should be done in conjunction with the lead nurse for Learning Disability Services to ensure mental capacity, reasonable adjustments, consent and communication needs are included.
Information-sharing protocols within North Somerset safeguarding Adults at Risk and the LeDeR programme will be implemented.

If the case is deemed a serious incident requiring investigation (SIRI) the Trust should continue to complete its own internal mortality review and any necessary investigations.

The Learning Disabilities Mortality Review (LeDeR) programme

The LeDeR programme will receive notification of all deaths of people with learning disability aged 4 to 74 years of age which are identified using the methods detailed above. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities. All deaths of people with learning disabilities will be notified to the programme *once active within the south west* via the clinical audit hub. Those meeting the inclusion criteria for mortality review will receive an initial review of their death by an independent, trained reviewer.

Learning and recommendations from LeDeR reviews will identify opportunities for improvement at the local, regional and national level. Governance structures that can support the cross-agency implementation of recommendations from mortality reviews are required at all levels, but in particular for the reviews of deaths of people with learning disabilities. Such structures exist in the form of regional steering groups for the LeDeR programme, and these are usually best placed within the safeguarding framework. Not all deaths of people with learning disabilities are safeguarding issues; however the existing multi-agency framework and statutory responsibility mean that this is a natural 'home' for governance of mortality reviews.

The initial structured case review can be submitted as an attachment to the LeDeR notification web-based platform once completed.

Appendix 4

In-hospital deaths of those with mental health needs

It is well recognised that people with significant mental health problems and/or substance misuse issues are at a higher risk of premature death. The deaths of any adult with a significant mental health diagnosis will be automatically subject to a detailed mortality review with the input of a mental health practitioner designed to focus particularly on learning centred around holistic care and any contribution that mental health and/or substance misuse to the decisions made about care. The definition of significant mental health will include (but not be confined to):

- Patients who die with a DOLS in place
    - The Audit Team will review the DOLS register weekly to look for deaths; if identified these will be flagged up on the mortality database
- Patients who die whilst under an aspect of the Mental Health Act
- Patients who were transferred for medical care from a mental health facility
- Patients being actively treated for drug or alcohol dependence

Patients transferred for medical care from a mental health facility
Patients treated for a major psychiatric illness within the last 10 years
Patients currently under the care of a CPN or Mental Health team
Patients being actively treated for drug or alcohol dependence

Appendix 5

Infant or child death, including adolescents aged 16 or 17 years

Weston Area Health Trust's Child Death Policy is available at http://nww.avon.nhs.uk/dms/download.aspx?did=19465 and provides full guidance on the processes surrounding child death in the hospital setting in North Somerset.

This process also applies to adolescents aged 16 or 17 years. These patients may not necessarily present to a paediatric facility and should follow the guidance set-out above.

The Local Safeguarding Children Boards are responsible for arranging a Child Death Review for each paediatric death; these are reviewed by the Child Death Overview Panel.

Appendix 6

Stillbirth

Working in conjunction with UH Bristol we follow the guidance below

- Patient Safety Midwife will complete a 72Hour report
- SIRI panel to agree if RCA required
- Duty of candour allocated

- Full guidance is provided in the following links below:
  - Child Death Review Process

    http://nww.avon.nhs.uk/dms/download.aspx?did=19488
  - Child Death Review Processes Information For Professionals

    http://nww.avon.nhs.uk/dms/download.aspx?did=7330

Appendix 7

Maternal Death

Working in conjunction with UH Bristol we follow this guidance:

- Patient Safety Midwife will complete a 72 Hour report
- SIRI panel will request an RCA to be completed by the Patient Safety Midwife
- Duty of Candour allocated for family – Head of Midwifery
- Maternal death will be reported to MBBRACE
- Full details are available here:

Maternal Death
Checklist updated 31

Appendix 8

Deaths within a group where an 'alarm' has been raised via a Summary Hospital-level Mortality Indicator (SHMI) or elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator.

Deaths where learning will inform quality improvement work

- These groups will be determined by the Clinical Effectiveness group on a quarterly basis based on information from SHMI and Central Healthcare Knowledge System (CHKS) along with any feedback from the CQC.

Appendix 9

Deaths where learning points have been raised by other organisations

There are a number of ways in which concerns or learning points can be raised:

- Following the receipt of a case record review by another Trust where learning has been identified relevant to Weston – this will be sent to the medical director who will instigate a case record review
- Following a letter of complaint received by the trust by another organisation – this will be sent to the medical director who will instigate a case record review
- Following a Datix raised by another organisation regarding the care a patient had by Weston Area Health Trust where the patient has died within 30 days of discharge.
    - The governance team will distribute a list of all patients who have had a Datix raised in the community highlighting a concern about hospital care to the Medical Director who will review the list for deaths within 30 days and instigate a case record review if appropriate.