Queen Victoria Hospital
NHS Foundation Trust

Responding to and Learning from Patient Deaths Policy

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2			**K Carter-Woods**
3	**2021**	**Updated to reflect current processes**	

Executive Summary

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.
'*National Guidance on learning from Deaths*'[1] outlines the principles that healthcare staff should use when a patient dies whilst in the care of the Trust or within 30 days following discharge or an Outpatient procedure. This should include all deaths where families/carers or staff have raised a significant concern about the death, all deaths of those with learning disabilities or severe mental illness and all deaths in areas where people are not expected to die (e.g. elective procedures).

It supports a culture of openness, honesty and transparency[2], incorporating the 'Duty of Candour' which was made a contractual obligation in April 2013 and reinforces the fundamental obligation to be open and honest in the event of an incident where patient harm has occurred.

It is not intended to replace the Serious Incident Framework; this process will affect a much broader range of cases than serious incident investigations, which will continue to be carried out in line with the existing *National Serious Incident Framework*[3] until the implementation of the Patient Safety Investigation Response framework (PSIRF)

Case record reviews will be required to determine whether there were any problems in the care provided to the patient who died and, if there were, whether the death is likely to have happened as result of those problems - i.e. whether it was a potentially avoidable death.

Reviews should be carried out using an evidence-based methodology such as the 'Structured Judgement Review' (Royal College of Physicians 2018): the guidance further specifies that case record reviews should, wherever possible, be conducted by clinicians who were not directly involved in the deceased's care.
The purpose of reviews and investigations of deaths, which problems in care might

have contributed to, is to learn in order to prevent recurrence, and enable the duty of candour with bereaved families.

Involving families / carers

The other key message from the new framework is that Trusts must make it a priority to work more closely with the families/carers of patients who have died to ensure meaningful support and engagement at all stages, from notification of the death right through to actions taken following investigation.

The guidance sets out key principles for Trusts to follow, including the need to treat bereaved families/carers as equal partners and recognising that paying close attention to what families/carers say can offer an invaluable source of insight to improve clinical practice.

[1]National Quality Board, March 2017 (First Edition)
[2]NPSA/2009/PSA003 19th November 2009 Being Open
[3]NHS England 'Serious Incident Framework': Updated March 2015

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1. Introduction

This policy was originally developed in direct response to the National Quality Board report: '*National Guidance on Learning from Deaths: a framework for NHS Trusts and Foundation Trusts on identifying, Reporting, Investigating and Learning from Deaths in Care'*, published 4th April 2017:

The focus of the recommendations within the report is improving clinical governance processes around patient deaths and ensuring the families / carers of patients who have died are fully involved at every stage of the investigation procedure.

1.1 The Trust has a responsibility to ensure that the death of any patient within their care, or within thirty days of discharge or an Outpatient procedure is reviewed and, if appropriate, fully investigated with the inclusion of relevant parties such as family / carers.

1.2 The Trust has a responsibility to ensure that appropriate and sufficient employees have access to adequate information, training and supervision to be competent to undertake such review and investigation thoroughly and to an acceptable standard.

1.4 This Policy is intended to:

- Provide information and guidance to staff to enable them to assist the Trust in analysing and investigating patient deaths in a systematic way
- Inform staff of the agreed procedures to follow when a patient dies in our care or within thirty days of discharge
- Outline requirements for engagement with bereaved families and carers
- Ensure that lessons are learned and appropriate action is taken, monitored and evidenced following a patient death to prevent, as far as is possible, a recurrence

1.5 This policy should be read in conjunction with the 'Duty of Candour Policy', 'Risk Management Policy, Incident Reporting and Investigation Policy' and 'Bereavement and Care after Death Policy' at the Queen Victoria Hospital, all available on Qnet.

2. Purpose

In December 2016 the Care Quality Commission published the report, '*Learning Candour and Accountability'*, a review of the way NHS Trusts review and investigate the death of patients in England; this was an NHS England commissioned review into the how NHS trusts investigate deaths across acute, community and mental health settings.

The review made 8 recommendations across five key areas:

- **Involvement of families and carers**
- **Identification and reporting**
- **Decision to review or investigate**
- **Reviews and investigations**
- **Governance and learning**

These reviews and investigations need to be carried out to a high quality, with a focus on system analysis rather than individual errors. Staff require specialist training and protected time to carry out investigations to help ensure that these identify missed opportunities for prevention of death and to improve care.

3. Scope

This policy applies to all workers of the Trust in all locations including temporary employees, locums and contracted staff, plus Non-Executive Directors.

4. Duties

The list below includes individual responsibility for responding to and learning from the death of a patient in our care, or within thirty days of discharge.

4.1 All Staff: (including: Trust bank, locum or agency staff, visiting consultants)

All staff have a responsibility to:

- contribute to the identification, reporting and where required investigation of such deaths
- familiarise themselves with relevant policies and maintain an awareness of relevant updates;
- be responsive to and share lessons learned from patient deaths

4.2 Medical Director

The Medical Director, (or the Deputy Medical Director in the Medical Director's absence) as Executive Patient Safety Lead is the nominated executive lead with overall responsibility for ensuring the trust responds to and learns from patient deaths; undertaking all preliminary reviews and SJR's – or delegation of the task to an appropriate clinician. This responsibility is alongside a named non-executive director who has a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny

4.3 Quality & Compliance Team

This team receive mortality data monthly: including patients who have died within 30 days of being an inpatient, day case or have received an outpatient procedure. This is reviewed monthly in arrears and the team:

- Inform the relevant consultant, speciality governance lead, Medical Director, Director of Nursing and Head of Risk & Patient Safety
- Ascertain and report, where possible, cause and place of death. This is from either the GP or coroner.
- Provide statistical information annually to the Medical Director confirming the total number of deaths in the Trust's specified scope (as a minimum, all adult inpatient deaths), total number of deaths subject to a case record review / SJR / SI
- Report mortalities in the Clinical Indicator Report (CIR) and distribute to a defined list of clinicians and relevant staff

4.4 Risk & Patient Safety Team

The main duties of the team, including the Head of Risk & Patient Safety, in relation to this policy are as follows:

- Supporting staff involved in the investigation
- Coordinating reviews and full investigations as required
- Where case review identifies a problem that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported via local risk management systems to the National Reporting and Learning System (NRLS) until the implementation of the national 'Learn from Patient Safety Events' system (LFPSE)
- Ensuring that, where there is organisational learning as a result of investigations, this is part of robust clinical governance processes and structures, and disseminated to all relevant staff and teams; including but not restricted to Joint Hospital Clinical Governance Group.

4.5 Patient Experience Manager

- To ensure that any patient death reported as a complaint or claim is notified to the Risk and Patient Safety Team through the Trust's electronic reporting system, if not already completed.
- To be a consistent point of contact available to bereaved families following any death, or during any investigation.

4.6 Administrative staff

Any member of staff could be informed of a patient's death prior to the monthly CIR being produced.
Staff should record on Patient Centre:

- date of death
- who has notified them of the death.
-

If they are unable to do so they should forward the information to the Health Records Team who will undertake this element

4.7 Committees and Groups with Overarching Responsibilities

The QVH Board of Directors is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, taking into consideration the views of the board of governors.

The Quality & Governance Committee (Q&GC) has delegated authority from the board as defined in the trust 'Reservation of powers and scheme of delegation' document. It will seek assurance that the policy and processes involved in Responding to and Learning from Patient Deaths are robust and complete.

It will receive a quarterly report from the Chair of the Clinical Governance Group (medical director) detailing the numbers of deaths, the numbers subject to case review and the numbers subject to 'Structured Judgement Review'.

Where there is any likelihood that care has contributed to the cause of death, the Committee will ensure that an investigation has been completed, and will review the findings and may well make recommendations to the Board about actions required or strategic review if indicated following conclusion of the investigation.

The Clinical Governance Group will ensure progress of investigations.

5. Review and Investigation

- All patient deaths within the QVH, along with those notified as being within thirty days of discharge from our care or Outpatient procedure, will be subject to an initial preliminary review (complete proforma **Appendix 1)**
- Where possible, the bereaved family and / or carers will be contacted by the Medical Director in relation to all deaths; with their views or concerns being sought to help inform the decision as to whether an investigation is appropriate.
- Investigation through Structured Judgement Review in the first instance, is recommended in following circumstances;

    - Unexpected death, for example in elective surgery
    - Any paediatric death
    - Any death of a patient with learning difficulties or serious mental

health disease
- Patients who are not under the care of QVH at the time of death but where another organisation suggests that the Trust should review the care provided to the patient previously.
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- All deaths where concerns have been raised internally or externally about the quality of care, or where service improvements are in progress
- All on-site deaths at QVH will be subject to SJR.

Upon death of patient / notification of death:

- Consider Duty of Candour requirements: complete Duty of Candour proforma if applicable and follow the guidance on the proforma.
- Obtain / secure the notes for initial preliminary review; <u>these notes must be kept and not sent for scanning onto the Evolve system.</u>
- As early as possible, engage meaningfully and compassionately with bereaved families and carers: see **Appendix 2** for key principles
- Regardless of the circumstances, any significant concern raised by families/carers should always trigger a case review
- Inform the patient's GP and any other interested parties i.e. referring acute trust patient came from / community trust / nursing home or any other relevant establishment: this should be discussed and agreed with the bereaved family / carers and a coordinated approach established.
- Where appropriate, a more formal structured judgement review (SJR) will be carried out, by someone trained in SJR methodology. This will be delegated by the Medical Director as appropriate if not undertaking it personally.
- Where an SJR reveals deficiencies in care, then those should be reported by the Datix system and be investigated as per the Incident Reporting and Investigation Policy. Duty of Candour applies.
- Where it is considered likely that any deficiencies in care have significantly contributed to the patient's death, or there is a greater than 50% possibility that the death could have been avoidable, then this should be treated as a Serious Incident; requiring full formal investigation, duty of candour and external reporting to commissioners and the CQC.
- The numbers of case reviews, SJRs, resultant incident reporting and SI's should be reported to Board by the Medical Director as part of the quarterly report, along with a log of actions required and completed.
- <u>No SJR's or investigation reports are to be sent externally without scrutiny from the HoN, MD and HoR</u>

6. Engagement with family / carers

Staff must engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death, following the principles in **Appendix 2** in addition to:

- Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients; openness, honesty, and transparency as set out in the Duty of Candour regulation should also be applied in all dealings with bereaved families and carers

- 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 Duty of Candour and every effort should be made to hold these discussions in a private, sympathetic environment, without interruptions.

- Involvement of bereaved families and carers begins with empathy and, where appropriate with a genuine apology; saying sorry is not an admission of liability, it is the right thing to do and, when appropriate, explaining what went wrong promptly, fully and compassionately and encouraging questions from the family / carers.

Where an initial review, or structured judgement review considers that the healthcare provided may have contributed to the death, then a more formal duty of candour meeting should be held as soon as possible with the bereaved family or carers to explain the process. This should include 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; as per Duty of Candour requirements, they should be provided with a named person as a consistent link throughout the investigation and should:

- have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process

- have an opportunity to respond on the findings and recommendations outlined in any final report

- 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.

7. Training and Awareness

This policy will be circulated to all ward managers and clinicians and be available on the Trust intranet for all staff.

8. Equality

This policy and protocol has been equality impact assessed in accordance with the Trust's impact assessment toolkit. Completed assessments are available upon request from qvh.eqia@nhs.net.

9. Review

This policy will be reviewed in 3 years: earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

10. Monitoring Compliance with this Policy

All hospital deaths are presented at specialty governance meetings, CGG and other forums as appropriate. Under the new framework, Trusts are now also required to comply with new data reporting requirements relating to patient deaths.

This includes publishing the following information each quarter:

- total number of deaths in the Trust's specified scope (as a minimum, all adult inpatient deaths),
- Total number of deaths subject to a case review

Activity being monitored	Methodology to be used for monitoring	Responsibility for monitoring	Frequency of monitoring and reporting	Process for review and improvement
Mortalities within QVH	Data produced by Informatics and Quality and Governance	Quality & Governance	Monthly report sent to CGG and clinicians.	• Preliminary Review (MD) • SJR if required • Full investigation if required • Peer review via the Joint Hospital Governance Meeting

Activity being monitored	Methodology to be used for monitoring	Responsibility for monitoring	Frequency of monitoring and reporting	Process for review and improvement
Mortalities elsewhere within 30 days of treatment (in/outpatient and day case)	Data produced by Informatics and Quality and Governance	Quality & Governance	Monthly report sent to CGG and clinicians.	• Preliminary Review (MD) • SJR if required • Full investigation if required • Peer review via the Joint Hospital Governance Meeting if required.
Learning Disabilities Mortality Review Programme (LeDeR)	Data produced by Informatics and Quality and Governance	Quality & Governance	Monthly sent to LeDeR by exception	Annual Report and Actions
Royal College of Physicians '*Structured Judgement Review'* (SJR) Deaths reviewed Avoidability score	Data taken from clinician mortality reviews	Quality & Governance and Risk	Monthly report sent to CGG and clinicians as part of the CIR	Review by Clinical Governance Group (CGG)

11. References

- National Guidance on Learning from Deaths: National Quality Board March 2017 (*First Edition*)
- NHS England 'Serious Incident Framework': updated March 2015
- NPSA/2009/PSA003 19th November 2009 'Being Open'

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Appendix 1

Responding to patient death: Preliminary Case Review

Guidance for all staff following:

1. The death of a patient in our care
2. Notification that a patient has died within thirty days of being discharged from our care or after an Outpatient procedure

Patient details:

Name:	Hospital number:
NHS number:	Date of birth
Date of death: Cause of death (if known)	Inpatient: Yes □ No □

Notes available: Yes □ No □

Reviewed: Yes □ No □

If 'yes' by whom: name and designation……..

Summary of findings:

Further investigation required: Yes □ No □

Appendix 2

BEREAVED FAMILIES AND CARERS - KEY PRINCIPLES:

- Bereaved families and carers should be treated as equal partners following a bereavement;
- Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
- Bereaved families and carers should receive 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;
- Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one;
- Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed;
- Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;
- Bereaved families and carers 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;
- Bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in delivering training for staff in supporting family and carer involvement where they want to.

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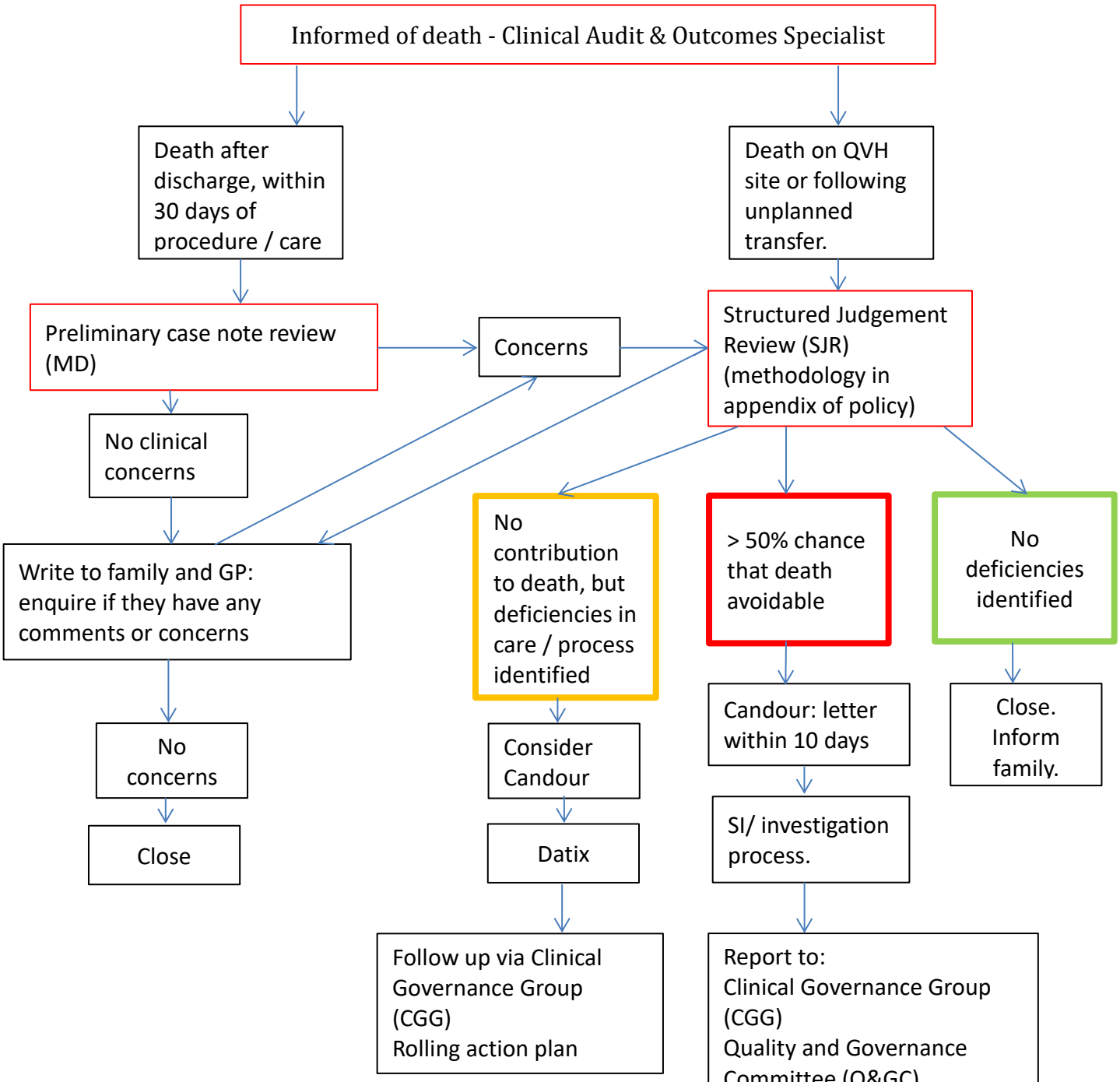
Appendix 3: RESPONDING TO & LEARNING FROM DEATHS FLOWCHART



Monthly Report to CGG, including action plan
Quarterly Report to Quality and Governance Committee
Annual report to Board of Directors

- Numbers of Deaths
- Numbers Subject to case review
- Numbers subject to SJR
- SJR results and learning