

MORTALITY MANAGEMENT POLICY (Learning from Deaths)

		POLICY
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Author (Position & Name)	<ul style="list-style-type: none"> v3.0, Dr Ben Lobo, Consultant Physician/ Geriatrician and Trust Medical Lead for End of Life Care and Mortality v3.1, Amendments made by: Dr J Tansley, Clinical Director for Patient Safety, Chair Learning from Deaths Group v3.2, Amendments made by: Dr J Tansley, Clinical Director for Patient Safety, Chair Learning from Deaths Group 	
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Not Applicable	Not Applicable	
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1.0 INTRODUCTION

Many patients attend hospitals services every year and are discharged 'well', after effective treatment and care. A proportion of patients admitted to hospital will unfortunately die either because of a new and unexpected illness or the progression of a known or long term condition(s). It is hoped that all patients will have received excellent care and they and those family and friends close and important to them also report a positive experience of care. However some patients experience poor quality care as a result from sometimes single or multiple causal or contributory factors. These factors can include poor leadership, human factors and system-wide failures.

It is now compulsory to review all deaths of patients in the care of the NHS. When mistakes happen or poor care is delivered, it is important to do more to understand the causes and make improvements. The purpose of reviews / investigations into patient deaths where there may have been problems, is to learn from this process, offer explanations to those who are bereaved and prevent recurrence in the future for other patients. Reviews and investigations can only be useful for learning purposes if their findings are valued, shared and acted upon in the positive spirit of transparency and improvement. This process can also support and acknowledge good practice, and provide positive opportunities to share and help other teams.

Further to the NHS requirements for compulsory review set out in policy by the National Quality Board there has been a decision by the government in June 2018 to implement the regulations 18-21 of the Coroners and Justice Act 2009 to establish a medical examiner role and service in England and Wales. This has been as a response to a number of high profile criminal cases (Dr Shipman being the best known) and number of system failures (Mid Staffordshire) as well as more recent events relating to infant deaths and "analgesia accelerated deaths".

Healthcare systems and staff responsible for patients must also be "accountable" and this policy supports the operational procedure that clinicians must follow in reviewing and reporting information in clinical governance meetings in their Specialty, Division and to the Trust Mortality Surveillance Group.

This policy is issued and maintained by the Executive Medical Director as the sponsor on behalf of the trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions.

2.0 POLICY STATEMENT

Equality Impact Assessment

This policy is intended to be applied in a fair and consistent process to all patient deaths in the relevant clinical areas. The policy is expected to have its main impact in adult services and it will enhance existing strategies especially for patients / pathways for specific groups. These are identified in this policy.

The policy will help to identify any possible inequality or inequity of healthcare especially for those perceived to have specific protected characteristics and potential vulnerabilities. The policy promotes listen to and actively supporting bereaved families after death. This policy has been developed in keeping with existing policies in the Trust. It is informed by new national standard that guide the support and information to those that are bereaved by a death of a patient in the Trust's care.

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminates against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status.

An EIA of this policy/guideline has been conducted by the author using the EIA tool developed by the Diversity and Inclusivity Committee (see [Appendix D](#))

The correct application of this policy will help to identify patients and those close to them who may have been subjective to discrimination.

Privacy Impact Assessment (PIA)

The Policy has been subject to a detailed PIA which has been informed and supported by the Information Governance team.

This policy promotes a thorough examination of the patient's treatment and care during their admission. This process may require examination of other information, for example previous admissions or discussions with other health or social care providers.

This policy now requires an active consideration of the necessity to involve the bereaved family (as set in the National Quality Guidance, comply with the statutory requirement of the Duty of Candour and related information sharing procedures) and or those with specific legal / administrative relationships to the deceased. Where necessary and practicable, there will be a specific informed consent / assent with those close to the deceased patient.

This clinical document applies to:

Staff group(s)

- This is a Trust wide clinical policy, which focuses on those staff directly or indirectly providing a clinical service to the patients. It also applies to service managers, administrative and governance staff in the Trust. Specific responsibilities are identified in this policy.

Clinical area(s) and Patient group(s)

- This policy is intended to be applied in a fair and consistent process to all patient deaths in all clinical areas. The policy is expected to have main impact in adult services; there are clear and existing patients / pathways patient for specific groups.

3.0 DEFINITIONS AND/ OR ABBREVIATIONS

'The Trust'	Means the Sherwood Forest Hospitals NHS Foundation Trust
'Staff'	Means all employees of the Trust including those managed by a third party organisation on behalf of the Trust.
Case record or Mortality 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, for example Structured Judgement Review delivered by the Royal College of Physicians model.
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.
Death due to a problem in care	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable

4.0 ROLES AND RESPONSIBILITIES

The Board of Directors

1. The 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**.

2. The Board of Directors must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. The Trust should ensure such activities are adequately resourced. The Board of Directors must ensure the Trust works with commissioners and other providers to develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

3. All Trust Directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the Board and help develop proposals on strategy.

Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective and should scrutinise the performance of the Trust's management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

Learning from Deaths

Executive and non-executive directors have a key role in ensuring their Trust is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

- the processes are in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support;

- quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change
- the information the Trust publishes is a fair and accurate reflection of its achievements and challenges.
- there is a system to collect, publish and learn from new data to monitor trends in deaths. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, non-executive directors should hold the Trust to account particularly those deaths assessed as having been avoidable.

The roles and responsibilities of non-executive directors (as set out by the National Quality Board) include:

1. **“Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support.** This includes:
 - being curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust, are they sufficiently senior/experienced/trained?
 - seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation’s processes, but understand limitations of any direct comparisons;
 - ensure timely reviews/investigations , calibre of reviewer/investigator and quality of the review or investigation;
 - is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
 - how was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
 - are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
 - share data and patient records with external systems of confidential patient death reviews including but exclusively with the LeDeR system
 - confidentially report the process measures and outcomes of the scrutiny of deaths by local Medical Examiners to the Regional and National Medical Examiners
 - ensure the Trust keeps secure records of the local Medical Examiner Service for external scrutiny and or inspection where required by the Regional and National Medical Examiners, and other regulatory NNHS bodies as required.
 - for coordination of responses to reviews/investigations through the provider’s clinical governance processes, who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation’s Serious Incident processes?”
2. **“Champion and support learning and quality improvement” such as:**
 - ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this;
 - understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better;
 - understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients -

ensuring that learning and improvements are reported to the board and relevant providers;

- supporting any changes in clinical practice that are needed to improve care resulting from this learning;
- ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes;
- paying attention to the provision of best practice and how the learning from this can be more broadly implemented.
- assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges, such as:
 - ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement;
 - checking that relevant team are working towards a timely quarterly publication, in line with the Quality Accounts regulations and guidance;
 - checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter by quarter basis;
 - ensuring the organisation can demonstrate to stakeholders that "this is what we said we would do, and this is what we did" (learning and action), and explain the impact of the quality improvement actions."

Doctors must

All doctors have an organisational responsibility and professional duty (and where required a legal duty) to report any perceived concerns or deficiencies in treatment and care that may have caused or contributed to a patient death. Doctors must also cooperate with the review and investigation process, maintaining the highest professional standards.

Consultant staff must

- ensure all patients that have died in their care have the standard of the treatment and care and the mechanism of their death reviewed (as set out in the relevant standard procedure)
- offer support to non-consultant medical / healthcare staff to complete this process in a timely and accurate manner complying to the information standards set out in the mortality reporting systems
- correctly identify deaths that need to be subject to the different steps of review as set in the procedure and where relevant escalate cases quickly where serious failings have been identified (complying with the NHS Serious Incident Reporting Framework)

Non-consultant staff must

- ensure that they have discussed the care of all patients that have died in their care with the relevant responsible consultant before discussing the case with the Medical Examiner in order to correctly communicate any concerns regarding the standard of care.

Nurses, Allied Healthcare and other registered clinical staff are responsible for:

- contributing to the process of care after death, the support for the bereaved and the timely involvement of other key groups or specific groups where relevant e.g. if there was a concern or complaint about the standard of care
- being involved in working with the medical staff to offer information to support the review and report of a death (as set out in the procedure) as part of a multi-professional approach
- and be accountable for the standard of treatment they administer and the care they provide

Specialty and Divisional Clinical / Governance Leads are responsible for:

- ensuring that there is a system in place to deliver the clinical governance process as set in policy and procedure
- supporting these staff to perform and report reviews
- facilitating multi-professional forums to allow reviews and performance to be discussed and the lessons learned and shared in a confidential and professional manner
- working with other professional groups e.g. matrons, clinical nurse specialist / teams or specialty teams or services to ensure reviews and discussions are adequately supported, information is shared and the quality of learning outcomes is optimised.

Service Directors and Heads of Nursing (supported by General and Senior Management) are responsible for:

- ensuring the policy and procedure is implemented
- meeting the performance requirements set out in the policy and procedure and where there are system problems they are addressed.
- addressing any individual or professional under - performance or lack of competency, and where relevant any serious breaches of professional standards

Medical Examiner Service

This new service will comply with the legal requirements set out in the Coroners and Justice Act 2009 (CJA) and work in response to the government response to the consultation on the regulations / statutory instruments produced in accordance with CJA sections 18-21, providing an interim service whilst further statutory decisions are made. The service will comprise of locally appointed Medical Examiners and their Medical Examiner Officer /s and will be in full operation by the end of March 2020. Full details will be developed in parallel with local and national developments and updates to this policy will be expected.

This service will:

- scrutinise all deaths occurring within the Trust
- will liaise with the deceased's family or representative to
 - offer an explanation of the medical cause of death
 - to listen to and where necessary act on their concerns about the nature of the death and or the quality of the care provided to them relating to the cause or contributory facts
- will approve appropriate certification of the medical cause of death performed by the clinical team where an accurate cause of death has been proposed
- will provide support and advice where improvements may be appropriate to the cause of these death proposed by the clinical team and then approve amended submissions
- will support clinical teams in identifying those cases which according to nationally or locally agreed criteria require further review via
- the Trust's governance systems for investigation and action
- will identify cases that require coronial and or police referral and liaise between these agencies to ensure timely and accurate information sharing
- will work in partnership with the local coroner, registrar and other parties such as medical referees of crematoria to develop improved service arrangements to maximise the effectiveness and efficiency and deliver a high quality service
- will support the requirements of the Human Tissue Authority with specific regard to consent to Hospital Post Mortem

The service will report into the Trust's governance systems, primarily the Learning from Deaths Group on behalf of the Trust Board. This service must comply with the regulatory requirements set out by the National Medical Examiner and the regional deputies which must include the completion of timely reports and submission to the national information system.

5.0 APPROVAL

Following consultation, this policy has been approved by the Trust's Learning from Deaths Group.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

The introduction to this policy sets out the national mandate and now the NHS requirement to ensure all patient deaths are reviewed. This helps to identify good care as well as what could have been improved. This policy reflects the guidance set out by the National Quality Board which has been driven the collected learning from national reviews and through inspection and regulation by the Care Quality Commission. This policy now includes the requirements of the Coroners and Justice Act 2009 sections 18 -21 relating to the requirement for Medical Examiners and their officers, which is anticipated to be brought into force by April 2019.

This policy and the standard procedure sets out how the Trust and its staff must:

- determine which patients are considered to be under their care and included for case record review if they die
- respond to the death of an individual using the established and where required specific mechanisms with a learning disability; or mental health needs; an infant or child death and a stillbirth or maternal death and the Trust's processes to support such deaths; report the death within the organisation
- to ensure that:
 - all deaths that should be referred to the coroner are referred in a timely manner
 - the medical examiner service will scrutinise all non-coronial deaths; patients receive an accurate medical causation on their death certificate; detect cases where this is poor or very poor care which may also have contributed to harm or the patient's death; to offer a support and explanation to the bereaved family in the immediate period of loss
 - deaths which were initially considered "non-coronial" are referred to the coroner where there is an indication identified by the Medical Examiner or their Officer

This policy requires careful consideration of any staff in the review and discussion of any death where there is potential need for information sharing:

- to other organisations who may have an interest (including the deceased person's GP), including how they determine which other organisations should be informed
- review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past

This policy and the review procedures (which include specific information about the quality of palliative and end of life care) ensures there is a

- review the care provided to all deceased patients including those whose death may have been expected, for example those receiving end of life care

This policy and the implementation of the Medical Examiner Service requires sensitive and meaningful engagement with bereaved families and carers from all staff, through the specific process of medical scrutiny. The Medical Examiner Service must

- record the process of scrutiny of the Medical Examiner and their officer/s
- record the outcome from this scrutiny and actions that follow including communication with staff, the bereaved families and carers (where these people have significant concerns or complaints); other third parties or agencies.
- appoint a Medical Examiner Officer to work with the members of the Bereavement Centre and Patient Experience Team to be the initial and the on-going contact with the bereaved families and carer
- to facilitate listening and recording of any concerns or complaints
- to ensure the family/carers are informed if the Trust intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved
- to manage the involvement and discussions between the clinicians responsible for the care of the patient with the bereaved families and carers
- to offer guidance, where appropriate, on obtaining advocacy, legal advice for families carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by the Trust will be communicated clearly from the outset
- where relevant facilitate the undertaking of non- coronial post mortems ensuring that informed consent is taken by trained clinical or bereavement staff.

8.0 MONITORING COMPLIANCE AND EFFECTIVENESS

- The Trust has developed an electronic reporting tool for all deaths, this is in the process of being replaced due to the requirements to achieve scrutiny and reporting. As an interim measure cases identified as requiring further investigation will be identified by the Medical Examiners' Office on the Trust's incident reporting system (Datix)
- This system will automatically identify patients who have died from MedWay and trigger the mortality review process. 2nd stage and subsequent reviews will be monitored according to the same schedule as other incidents.
- The standard procedure for adults (see [appendix A](#)) reflects the current process and is detailed by the Flow Chart. This reflects modifications as a result of the Medical Examiner Service which along side a briefing between the responsible Consultant and that member of the team completing the MCCD forms the initial screen or 1st stage in scrutiny and review. The number (and %) of deaths scrutinised by the ME office will be reported monthly together with the number (and %) of those deaths which are not resolved within 5 working days. Where there are triggers have been detected for more detailed investigation this will lead on to the 2nd Stage review. The number (and %) of deaths referred for 2nd stage review (SJR) will be reported monthly together with the number (and %) of these reviews which have not been completed within 45 days. A 3rd stage review will be undertaken for quality assurance and to provide feedback to 2nd stage reviewers. Where care which is poor or worse or other concerns are raised further investigation though the incident or serious incident policy will occur. The number (and %) of these cases will be reported monthly.
- The findings of these reviews and any subsequent investigations will be fed back through specialty and divisional governance (ie morbidity and mortality) meetings and to the Learning from Deaths Group. The number (and %) of deaths where problems in care are found to be contributory by these reviews will be reported quarterly together with any learning points and recommended actions.
- The outcome of M&M meeting discussions with specific reference to learning will be reported to the Learning from Deaths Group at regular intervals according to an agreed work plan. In addition to the above areas of good practice should also be highlighted.
- The Medical Examiner Service will offer regular reports to the Trust, primarily reporting to the Learning From Deaths Group.
- [Appendix: B](#) sets the procedure for 'Still Births, Newborn, Infant, Child and Maternal' deaths
- [Appendix: C](#): sets out the Learning Disabilities (LeDeR) Mortality Review.
- Data will be collated, checked and analysed at each stage of the procedure by specialties and divisions. This electronic tool, will be updated to provide summary reports for the data to achieve the requirements set out in the national Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care set out below in the Department for Health dashboard. More detailed information from the electronic tool will also be available to start to provide clinical accountability, service level information, trends and themes.

There are existing frameworks and national audit process for specific to deaths of patients:

- Learning Disabilities
- Patients in Detention (which now excludes DOLS orders)
- Mental Health (and subject to specific detention under this Act)
- Maternal, Infant, Child and Young People

Specific other legal requirements remain the same. For most patients this relates to the reporting of a death to the coroner. There are established procedures in place for this, already subject to monitoring and audit.

From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths.

- This should be through a paper and an agenda item to a public Board meeting.
- Publication of the data and learning points should be from quarter 3 2017/2017 onwards.
- This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review.
- Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.
 - This will be established through the Trust's existing SI process



"This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. Trusts may use this to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Guidance on what should be recorded in individual fields is provided below, alongside instructions for completing and updating the dashboard. This guidance on individual fields complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP). The dashboard is not prescriptive and Trusts may set their own definitions according to local goals and data availability, although minimum requirements are set out in the framework"

This policy and the quality of the outcomes will be subject to clinical audit and independent audit as part of the Trust wide clinical audit plan. Information will be presented through the quality dashboard and be supported by detailed quarterly reports to the Board of Directors and delegated sub-groups.

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Specialty Governance Lead	See dash board. Also trends and themes and changes as a result of review must be reported.		monthly	Specialty
Divisional Governance Leads			monthly	Division
Chair of the Learning from Deaths Group			Monthly, Offering quarterly Board reports	Learning from Deaths Group

8.0 TRAINING AND IMPLEMENTATION

Supporting educational resources are available to support the implementation of this policy. The training has not previously been mandatory training but has been seen as important in the competency of especially all medical consultant staff. A quantitative and qualitative review of the mortality review process has indicated that 2nd and 3rd stage review would be better carried out by teams of dedicated reviewers. Arrangements to identify, train and allocate time to these teams will be addressed through job planning. Feedback to 2nd stage reviewers will be provided by the 3rd stage review process.

Training opportunities support and resources will be made available by this Trust to employees including any doctor performing the role of a Medical Examiner. Staff involved in the process of death certification and reporting to the coroner have a professional requirement to proactively seek to gain competency at this Trust or achieve this through other approved routes such as through training programmes, professional associations and accredited Colleges or membership of professional indemnity unions or societies.

9.0 IMPACT ASSESSMENTS

Delete/ amend as applicable:

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix D](#)
- This document is not subject to an Environmental Impact Assessment
- This document has been subject to an Environmental Impact Assessment, see completed form at [Appendix E](#)

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- **CQC report: Learning, Candour and Accountability – a review of the way NHS Trusts review and investigate the deaths of patients in England (Dec 2016)**
- **Royal College of Physicians: National Mortality Case Record Review Programme**
<https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme>
- **National Quality Board: National Guidance on Mortality Reporting (March 2017)**
<https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-learning-from-deaths-dashboard.xlsx>
- **Roll out of the Learning Disabilities Mortality Review programme (LeDeR) Important information for Acute General and Specialist Hospitals**
<https://www.england.nhs.uk/wp-content/uploads/2017/04/LeDeR-prog-secondary-briefing.pdf>
- **Guidance for NHS trusts on working with bereaved families and carers**
<https://www.england.nhs.uk/wp-content/uploads/2018/07/learning-from-deaths-working-with-families.pdf>
- **Government response to the consultation on Medical Examiners**
<http://qna.files.parliament.uk/ws-attachments/921296/original/180611%20Govt%20response%20to%20ME%20and%20Odeath%20certification%20consultation.pdf>
- **Perinatal Mortality Review Tool**
<https://www.npeu.ox.ac.uk/pmrt>

Related SFHFT documents

- Incident Reporting Policy, Procedures and Toolkit
- Risk Management Policy
- Last Days of Life for Adults Policy
- Protocol for the reporting of perinatal deaths
- Maternal death – standard operating procedure
- Verification of an Expected Adult Death by Registered Nurses Policy
- Emergency Department Record Sharing – ‘share in’ implied consent policy

11.0 KEYWORDS

- Death; HSMR; standard procedure for the review and reporting of adult deaths; medical examiners role;

12.0 APPENDICES

[Appendix A](#) – Standard Procedure for the Review and Reporting of Adult Deaths (including Medical Examiner Flow Chart)

[Appendix B](#) – Standard Procedure for the Review and Reporting of Still Births, Newborn, Infant, Child and Maternal Deaths (including Child Death Review Process and Rapid Response Process)

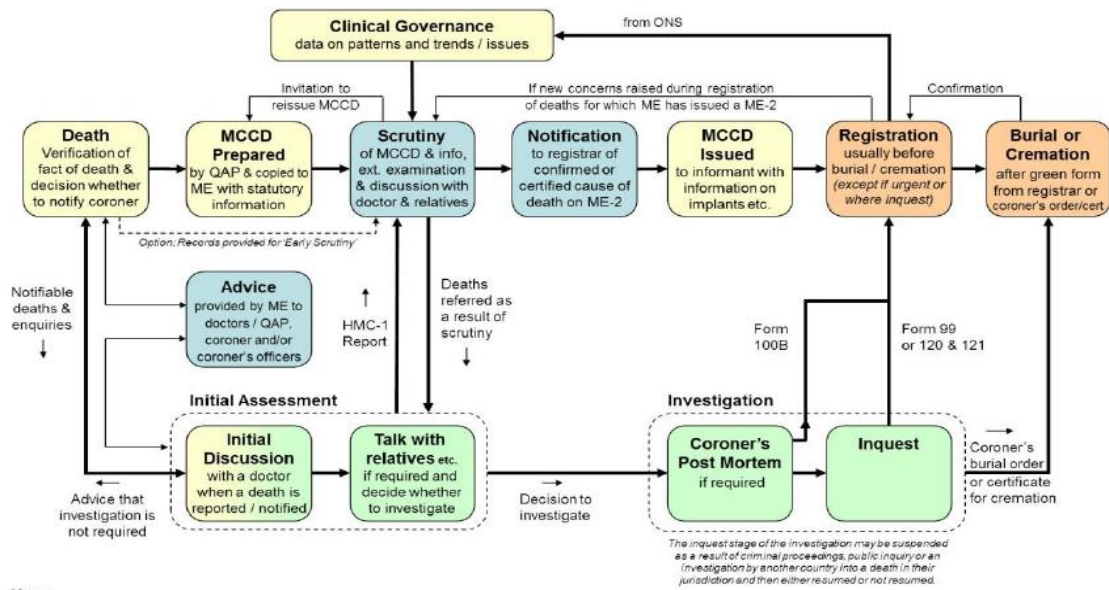
[Appendix C](#) – Summary Chart for Learning Disabilities Mortality Review Programme

[Appendix D](#) – Equality Impact Assessment

Medical Examiner Flow Chart

An overall flowchart of the new process of death certification is provided below.

Overview of Process for Death Certification



Key:

Process step(s) carried out by:	 Doctors, clinicians & other healthcare staff	 Medical Examiner's Service	 Coroners and their officers and staff	 Registrars, funeral directors & cemetery / crematorium staff
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Abbreviations & Notes: QAP = Qualified attending practitioner. ME = Medical examiner. Statutory information required with the copy of the MCCD may be documented in records. External examination may be delegated in certain conditions. The HMC-1 Report is issued by a coroner for deaths that have been reported, notified or referred but do not need to be investigated.

Appendix B: Standard Procedure for the Review and Reporting of Still Births, Newborn, Infant, Child and Maternal Deaths (including Child Death Review Process and Rapid Response Process)

SFH contributes to the national system of the reporting of these deaths and the information can be found at <https://www.npeu.ox.ac.uk/mbrrace-uk>.

'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

The aim of the MNI-CORP MBRRACE-UK programme is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

MBRRACE-UK achieves this by:

- Surveillance of all maternal deaths
- Confidential enquiries into maternal deaths during and up to one year after the end of the pregnancy
- Confidential enquiries into cases of serious maternal morbidity on a rolling basis
- Surveillance of perinatal deaths including late fetal losses (22-23 weeks gestation), stillbirths and neonatal deaths

Confidential enquiries into stillbirths, infant deaths and cases of serious infant morbidity on a rolling basis

The Trust must also comply with the new systems of Perinatal Mortality Review and use the approved review tool (PMRT).

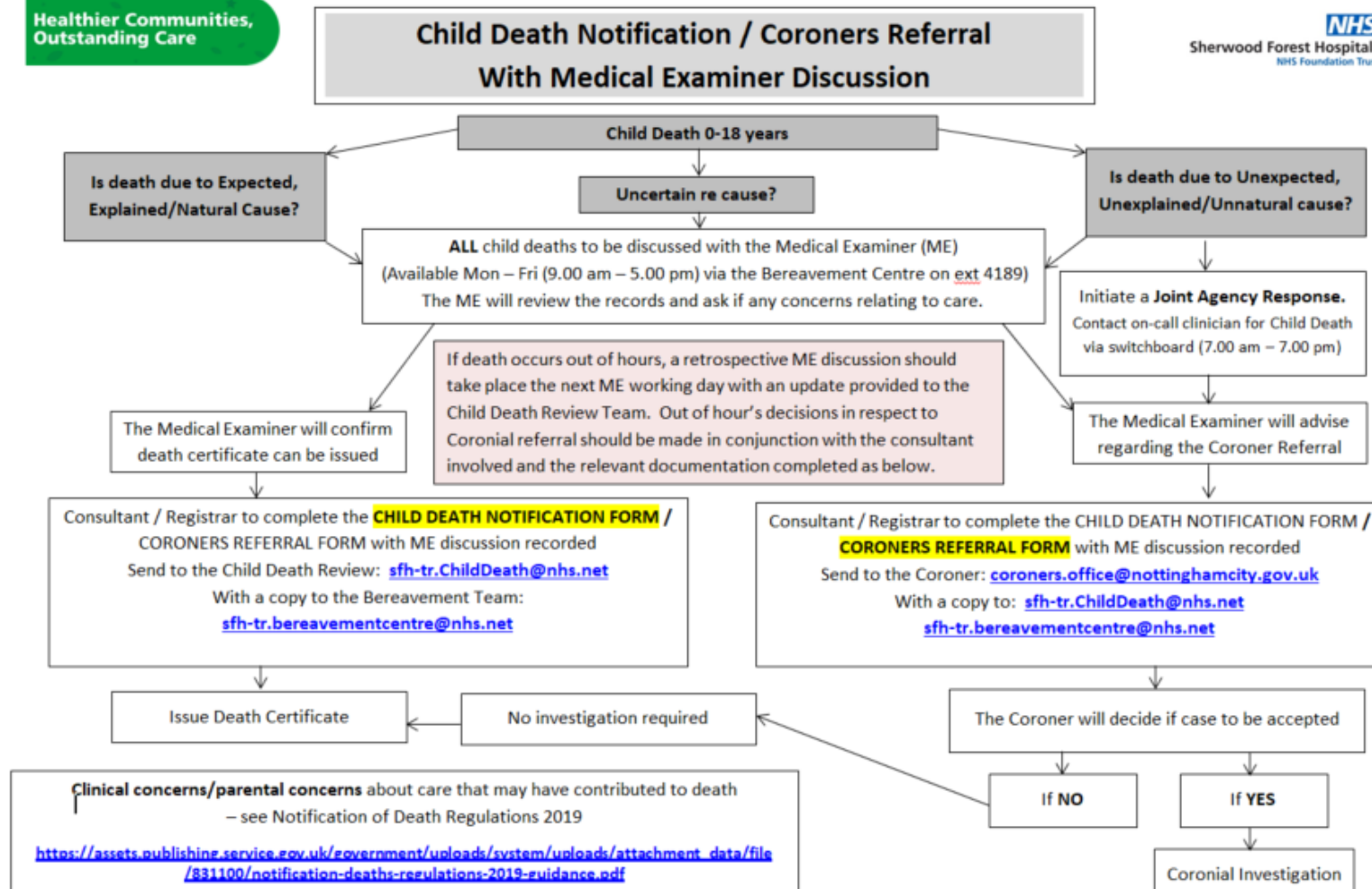
The Trust has a detailed and robust reporting and review system for deaths of children through the Nottinghamshire Safeguarding system, a summary of the process is included in figure 1 and 2 which set out the processes to be followed when a child dies in the Nottingham City and Nottinghamshire Local Authority areas as set out in Working Together to Safeguard Children (2010). There are two interrelated processes for reviewing child deaths (either of which can trigger a Serious Case Review (Chapter 8 in Working Together):

- a. rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
- b. an overview of all child deaths up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) in the LSCB area(s) undertaken by a panel.

The deaths are reported to the Coroner and supported by the Child Death Review Team. The deaths are reported to the Child Death Overview Panel a multi-agency group (for the appropriate local authority area) that informs reports to the Safeguarding Childrens Board.

Monthly mortality review meetings occur in the women and children's division (appropriately supported by other clinical team representatives) to ensure all cases are reviewed and understand and act upon any learning from any of the local or statutory review processes.

Healthier Communities,
 Outstanding Care



V7 – Flowchart (KMH) – March 2021

[Flowchart for Child Death Referral Process - V7](#)

Hosted currently here within trust intranet
<https://sfhnet.notts.nhs.uk/admin/webpages/default.aspx?ReclD=4473>

Appendix C Summary Chart for Learning Disabilities Mortality Review Programme

The Trust is now part of the national LeDer Programme with local systems in place. Local information will be collated and any LeDer outcomes be also considered by the (Trust internal) Safeguarding Steering group. Current case reviews are reported to this Group.

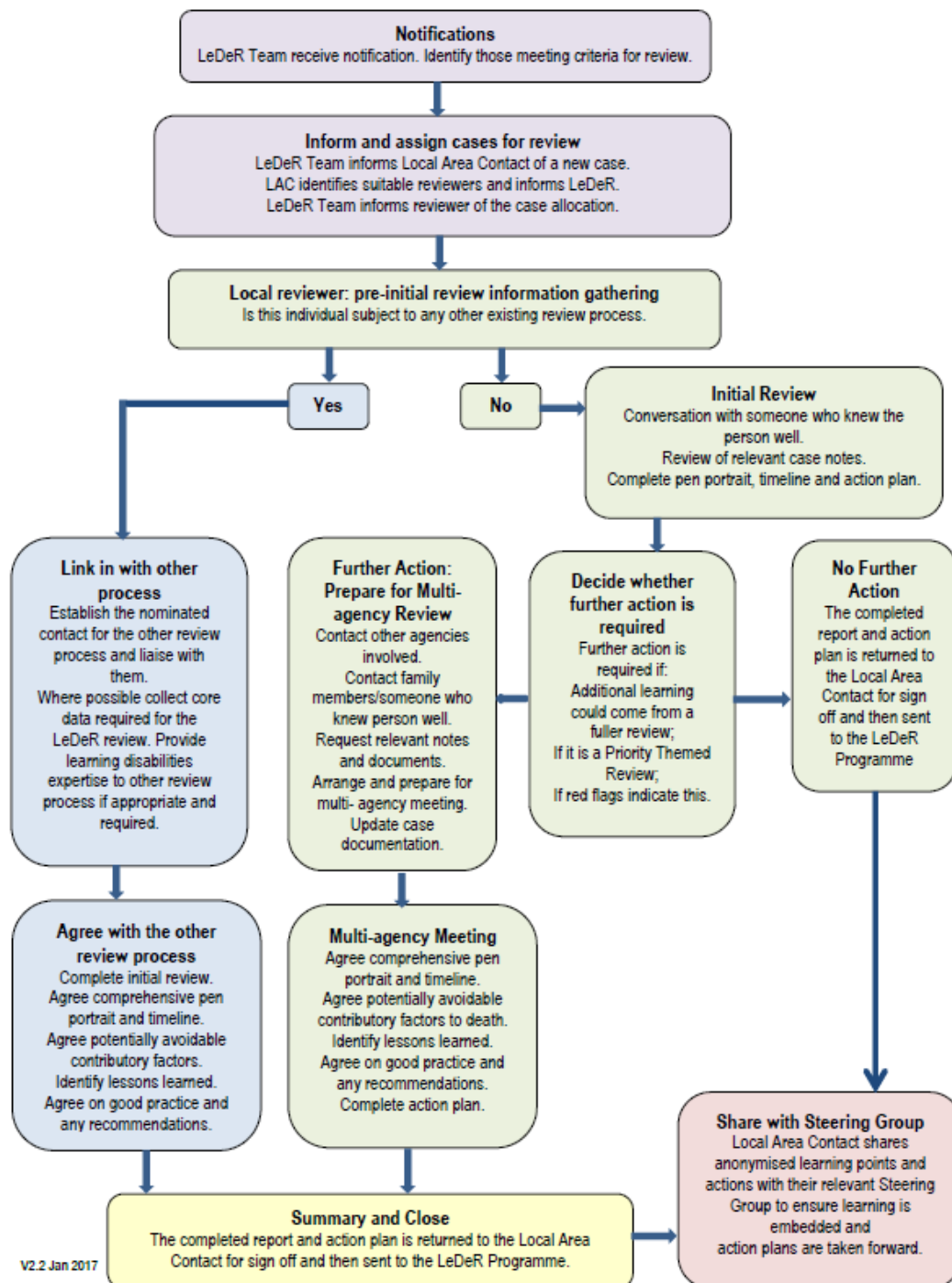


Learning Disabilities Mortality Review
(LeDeR) Programme



The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England.

LeDeR Process Flowchart



APPENDIX D - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Mortality Management Policy (Learning from Deaths)			
New or existing service/policy/procedure: Existing			
Date of Assessment: 28 th June 2017, updated 19/07/17			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
<p>This is a policy that looks at the standards and outcomes of treatment and care of patients that have died in this Trust. It does not directly affect these deceased patients and any impact on those important to the deceased patient (the bereaved) will be offered support by the patient experience team. This does not affect the legal or human rights of the deceased or those people close to them. This statement applies to all people with protected characteristics.</p>			
Race and Ethnicity	Please see other statements. Low impact policy with safeguards and controls in place.		
Gender			
Age			
Religion			
Disability			LeDer (national Learning Disabilities Mortality Review) systems are not fully established in this locality
Sexuality			
Pregnancy and Maternity			
Gender Reassignment			

Marriage and Civil Partnership		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)		
The implementation of this policy, data collection and analysis will help identify any potential inequality especially those who may have a protected characteristic. The establishment of a baseline of information will provide a comparison for trends and themes. This will be supported by information and reports for and by the Trust e.g. Dr Foster; Nottinghamshire Safeguarding and Children's Board		
What consultation with protected characteristic groups including patient groups have you carried out? <ul style="list-style-type: none"> There has been no external or public consultation at local level. Internal consultation is described on the front page 6 of this document. The national guidance which has been, to a greater extent prescriptive, has been through a formal route. 		
What data or information did you use in support of this EqIA? <ul style="list-style-type: none"> Please see above. 		
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? <ul style="list-style-type: none"> This is a positive policy approach to the national CQC report: Learning, Candour and Accountability – a review of the way NHS Trusts review and investigate the deaths of patients in England (Dec 2016). 		
Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: Low Level of Impact For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.		
Name of Responsible Person undertaking this assessment:		
Signature: Dr Ben Lobo		
Date: 28 th June 2017, updated 19/07/17		