### Document Details

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<td>This policy provides guidance on how the Trust reports, reviews and/or investigates deaths of patients who are under our care and how lessons learnt can be identified and disseminated. It includes details of the processes required and the engagement of families and carers</td>
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<td>Who is the document aimed at?</td>
<td>Guidance for all medical and healthcare professionals who have delivered care and treatment to a patient who has died and are involved in the Mortality Review Process</td>
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<td>Owner(s)</td>
<td>Alan Ferguson, Records Manager and Quality Facilitator</td>
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### Approval process

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<tr>
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Learning from Deaths Policy

1 Introduction

1.1 National Guidance on Learning from Deaths

In line with the CQC's recommendations in its “Learning, Candour and Accountability” (Dec 2016) review of how the NHS investigates patient deaths, the National Quality Board (NQB) has recently published the first edition of a new national framework for NHS Trusts - ‘National Guidance on Learning from Deaths’ (March 2017).

The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths in order to lead to better quality investigations and more embedded learning within organisations.

The NQB guidance covers how Trusts should respond to deaths in their care generally, not just those amounting to 'serious incidents', which will continue to be dealt with under the existing 'Serious Incident Framework'.

The focus is on improving governance processes around patient deaths and on ensuring the families/carers of patients who have died in care are given the opportunity to be involved at every stage of any investigations and/or reviews.

1.2 The Learning Disability Mortality Review Programme

The Learning Disability Mortality Review (LeDeR) Programme (2015-2018) aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities. It was established in response to one of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). The LeDeR programme will enable local areas to meet their requirements as laid out in the NHS Operational Planning guidance 2017/2018 includes the following “must do” for NHS England:

“Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism”

A key part of the LeDeR programme is to facilitate local reviews of deaths of people with learning disabilities aged 4 to 74 (inclusive) registered with a GP in England at the time of their death. All deaths will be reviewed, irrespective of the cause or place of death.

2 Purpose

This policy sets out how the Trust responds to and learns from patient deaths and has been developed to ensure that the Trust pays due attention to mortality of patients in our care and ensures that any lessons learned from care delivery and avoidability are clear and cascaded. The policy also aims to:

- Ensure that patients’ wishes have been identified and met
- Improve the experience of patients’ families and carers through better opportunities for involvement in investigations and reviews
- Promote organisational learning and improvement
3 Definitions

3.1 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 (National Guidance on Learning from Deaths – March 2017).

3.2 Case Record Review
The application of a case record/note review to determine whether there were any problems in care provided to the patient who died in order to learn from what happened (National Guidance on Learning from Deaths – March 2017)

3.3 Investigation
The act or process of investigating, in a systematic analytic way of what, how and why it happened. 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.

3.4 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 (National Guidance on Learning from Deaths – March 2017).

3.5 Expected Death
An expected death can be defined as “a death where a patients demise is anticipated in the near future and the doctor will be able to issue a medical certificate as to the cause of death (i.e. the doctor has seen the patient within the last 14 days before the death)”. (Home Office 1971)

3.6 Unexpected Death
An unexpected death is: “Any death not due to terminal illness or, a death the family was not expecting. It will also apply to patients where the GP has not attended within the preceding 14 days. Where there is any suggestion of suspicious circumstances, trauma, neglect or evidence of industrial disease in an expected death. Patients transferred from an Acute Hospital Trust to Intermediate Care Facilities with post-surgical conditions, or fractures".
4  Duties

4.1 Trust Board
Mortality governance is a key priority for the Trust Board. As stated in the National Guidance on Learning from Deaths, Executives and Non-executive Directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge. Trust boards are accountable for ensuring compliance with both the National Guidance on Learning from Deaths and the Serious Incident Framework. They should work towards achieving the highest standards in mortality governance.

4.2 Directors
The Medical Director has overall Trust responsibility for ensuring that mortalities are monitored, reviewed and any actions required identified and acted upon. The Medical Director will act as Chair of the Mortality Group.

4.3 Non-Executive Director
A nominated Non-Executive Director is appointed to the Mortality Group in order to act as an independent member to oversee the mortality process on behalf of the Trust Board.

4.4 Mortality Group
The aim of the group is to provide assurance to the Quality and Safety Operational Group that the Trust has robust internal quality assurance processes that ensure patient safety, clinical effectiveness and user experience form the core practice and principles of services by monitoring and reviewing mortality related issues. The group will undertake reviews of all deaths and report findings and recommendations to the Quality and Safety Operational Group. Findings and recommendations will be reported to the Quality and Safety Committee and the Trust Board as part of the assurance around management of risk within the Trust. Additionally, findings will be disseminated to the Divisional Service Delivery Group Quality and Safety meetings, Clinical Services Managers, Ward Managers and Team Leaders for further dissemination to medical and healthcare staff within each Services and Community Hospitals. The Records Manager & Quality Facilitator and other Specialist Leads will provide any additional advice and guidance to support this process. (See Appendix 8 Mortality Group Terms of Reference)

4.5 Head of Nursing and Quality - Adults
The Head of Nursing and Quality Adults (Mortality Group Deputy Chair) will receive local mortality reports from the Clinical Services Managers as part of the Service Delivery Group Quality and Safety responsibilities to ensure mortalities are reviewed following the mortality review process. Any actions required will be shared with all community hospitals and any issues escalated as required to the Mortality Group and/or the Quality and Safety Delivery Group

4.6 Clinical Services Managers, Team Leaders and Ward Managers
As the local managers and leads the Clinical Services Managers (CSM) and the Ward Managers will instigate the necessary Local Mortality Group reviews
involving the relevant staff to ensure mortalities are being monitored and reviewed.

For Community Hospitals in particular, Clinical Services Managers are responsible for carrying out Unexpected Death Reviews and liaising with the relevant staff and Community Hospital Medical Advisors. Monthly reports will be submitted to the Records Manager & Quality Facilitator for review at the Adult Service Deliver Group Quality and Safety meetings. The CSMs will also be responsible for reporting to the appropriate groups and instigating any identified actions.

They are to ensure all staff are aware of the mortality review process and are involved in the local mortality review process when it relates to a patient that has been in their care.

4.7 Records Manager and Quality Facilitator

The Records Manager and Quality Facilitator will act as the Mortality Group co-ordinator and advisor to support and monitor the reporting process and, in liaising with the Risk Manager and relevant clinical managers / staff, escalate any matters to the appropriate managers and groups. He will also ensure that monthly reports are disseminated as required and update the monthly Performance Management Tool with expected and unexpected death information.

4.8 Medical and Healthcare Staff

All medical and healthcare staff within Services and Community Hospitals are to be aware of the requirements of the mortality review process and should feedback any relevant observations or concerns to the relevant Team Leaders. They are also responsible for being involved in the Local Mortality Group reviews to ensure that relevant medical aspects are highlighted and acted upon.

5 Criteria for Investigating/Reviewing Patient Deaths

As a Trust, we will carry out a review or investigation of the death of any patient under our direct care. We are also willing to be involved in the investigation of any patient death where that patient has been cared for by our staff but where that patient's direct care is the responsibility of another organisation.

It is acknowledged that, for patients not under our direct care, we will have to rely on those other organisations to notify us of a patient's death as there is currently no national system in place that will notify us directly.

Where a patient has died under our direct care but has been cared for by other organisations we will ask them to be involved in any investigations and share any lessons learnt.

5.1 Patients who are Under our Direct Care

For the purpose of this policy, the following groups of patients are considered to be under our direct care:

- Patients who are being cared as inpatients in one of our Community Hospitals
- Patients who are in custody in HMP/YOI Stoke Heath where healthcare is provided by the Trust
5.2 Patients who are Under the Direct Care of another organisation

In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being primary care and acute care, ambulances services and acute care, or mental health services combined with any of these.

The following groups of patients are ones where we are delivering care but they are under the direct care of another organisation. In these cases we will rely on being informed by the appropriate organisation until a national notification process is in place.

- Patients within the community who have received care from staff employed by the Trust i.e. those under the care of the General Practice (GP)
- Patients who were transferred as an inpatient from our Community Hospitals into the Acute Hospital e.g. Shrewsbury and Telford Hospital (SATH) but had died within 48 hours of transfer.
- Patients who were transferred as an inpatient from our Community Hospitals into the Acute Hospital e.g. Shrewsbury and Telford Hospital (SATH) but had died within 30 days of leaving hospital.
- In-patients who have died within 30 days of leaving a Community Hospital.

5.3 Criteria for a case record review

If a patient dies whilst under our direct care (as defined above), a case record review should always be undertaken by the Trust if any of the following criteria apply:

- The death was unexpected
- The bereaved family have expressed a concern about the care their relative received from the Trust
- Staff employed by the Trust have expressed a concern about the quality of care received by the deceased
- The death occurred whilst the patient was under the care of a service where concerns have previous been raised (e.g. through audit or CQC inspection)
- The deceased patient had a learning disability
- The deceased patient was a child
- The deceased patient was in custody

5.4 Criteria for an Investigation

If a death is reported as an Unexpected Death an investigation will be carried out. In other cases where it is felt an investigation is required staff should be guided by the circumstances for investigation in the Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner as 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.
If an investigation into a death is needed, early contact should have been made with bereaved families and carers so that their views helped to inform the decision.

6 Bereaved Families and Carers

The following are the key principles stated in the National Guidance for Learning from Deaths are to ensure staff engage in a meaningful and compassionate manner with bereaved families and carers in relation to all stages of responding to a death:

- 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

7 Patients Deaths Under the Direct Care of another organisation

Where a patient dies while under the care of another organisation but where members of our staff have been involved in the care and treatment of that patient we would expect to be informed of that death and to be involved in any review or investigation as required. If members of our staff have concerns relating to the patient death then this should be reported using the Trust’s Incident Reporting system and relevant investigations will be instigated.

If a member of staff discovers a patient who has died in the community, e.g. in the patient’s home, then they should contact the Emergency Services to ensure the appropriate actions are taken and authorities informed. They should also raise a Datix incident report to detail the actions they have taken and record as an “Informal Death” on the RiO Electronic Patient Record System. This will ensure other teams and services in the Trust are aware of the patient’s death until the formal death notification is updated from the Patient Demographic Services.
8 Child Death Overview Panel

The CDOP Process covers all child deaths from birth up to 18th birthday (excluding still births and planned terminations). The CDOP considers the death of each child, and is required to complete a national proforma regarding its findings for each child. The proforma includes factors relating to the child and family, and service provision; categorisation of the cause of death; a judgment regarding whether there were modifiable factors; learning points and recommendations; immediate follow up actions for the family and whether the case should be referred to the LSCB Chair for consideration of a Serious Case Review. Children who die aged 4 years up to 18th birthday with a learning disability already have their death reviewed via the CDOP Process and the Lead Nurse for CDOP has undertaken the LeDeR Reviewer Training and it is anticipated that the 2 review processes will interlink.

9 People with Learning Disabilities

The death of any person with a learning disability must be reported and investigated as part of the Learning Disability Mortality Review (LeDeR) programme. The LeDeR programme facilitates the local reviews of deaths of people with learning disabilities aged 4 to 74 (inclusive) registered with a GP in England at the time of their death. All deaths will be reviewed, irrespective of the cause or place of death.

10 Patient Deaths within Community Hospitals

Community Hospitals do not collect Summary Hospital-Level Mortality Indicator (SHMI) or Hospital Standardised Mortality Ratio (HSMR) data as acute trusts are required to do. Therefore following best practice in line with organisations that do have these measures, the Trust has implemented a process by which mortality within community hospitals in Shropshire Community Health NHS Trust (SCHT) is managed and reviewed in a systematic way.

All deaths of inpatients within Community Hospitals will be reviewed as part of the Mortality Review Process and are detailed in more detail later in the “Process following the death of a Patient in a Community Hospital” sections. In summary a Local Mortality Review will be carried out on all inpatient deaths with an Exception Report investigation being carried out if the need is identified in the Local Mortality Review. If the death is reported as an Unexpected Death then an Unexpected Death Investigation report will need to be completed. A case record review will be carried out for both the Exception Report reviews and Unexpected Death Investigations. See Appendix 2 Mortality Review Flowchart for more details of the process.

11 Deaths in Custody

“Deaths in Custody” from HMP Stoke Heath and are linked into the standard Death in Custody process and as such will be investigated as part of that process and the Mortality Group will be kept informed of any aspects they need to be made aware of and will receive any investigation reports (see Appendix 1 for HM Prison Death in Custody Reporting Process flowchart).
12 Process following the death of an Inpatient in a Community Hospital

12.1 Local Mortality Review

Initially the Local Mortality Review should be carried out by the team that cared for the patient and should be carried within seven working days of the death of a patient using the Local Mortality Review checklist (Appendix 3). The key purpose of this review is to ensure all appropriate care was delivered in a timely manner. The Community Hospital Patient’s Records (including the Medical Record, Patient Assessment and Plan of Care and Acute Hospital record where appropriate) should be reviewed as part of this process. With the planned implementation of the Electronic Patient Record system, RiO, that system will also be referred to as part of the review.

A notification e-mail will be generated following the coding on a death on the clinical systems and the relevant Clinical Services Manager, Ward Manager and the Records Manager & Quality Facilitator will be notified by e-mail. The local mortality review process will then be initiated by the CSM. The review should be led by the Ward Manager / Team Leader and include the medical and healthcare staff involved in the patient’s care. These reviews should be reported to the CSM so that any further investigations or actions can be taken locally, with a brief summary of:

- Good practice points identified.
- Any gaps that may have been identified
- Any actions that have been identified with the name of a responsible person and time scales for completion of the required actions.

Any findings and recommendations will be reported to the Adult Service Delivery (Quality and Safety) Group for further discussion and to identify any trends or concerns (see Appendix 4: Expected Death CSM Report). The Records Manager and Quality Facilitator will provide a monthly summary report compiled from all mortality reviews that have taken place in that month.

Any issue requiring immediate escalation should be reported by exception to Divisional Manager and the Chair of the Mortality Group for appropriate actions to be identified and agreed (see Appendix 5: Expected Death Exception Report).

12.2 Mortality Review Factors

The Local Mortality Group should consider the following factors:

1. Initial Assessment:
   - Referral / Transfer of Care Information
   - Admission Assessment
   - Communication
   - Facilities
   - Spirituality
   - Medication
   - Current Interventions
   - Nutrition
   - Hydration
• Skin Care
• Explanation of Care plan

2. Ongoing Assessments and Day to Day Care
• Review of current management plan (incl. reviews of DNAR and appropriate Care Plan reviews)
• Delivery of care

3. Care after Death
• Verification of Death (persons present, relatives, coroner likely to be involved…)
• Certification of Death (cause of death)
• Patient Care Dignity
• Relative / Carer Information
• Organisational Information (notified GP, Healthcare / Multi-disciplinary (MDT) Teams and other appropriate services

In reviewing these factors the following should be taken into consideration:

1. Key domains of care: Physical, Psychological, Social and Spiritual
2. Key organisation governance requirements: Clinical Decision Making; Management and Leadership; Learning and Teaching; and Governance and Risk

12.3 Local Mortality Review Recommendations and Findings
Recommendations and findings of the Local Mortality Group will be discussed at the Adult Service Delivery (Quality and Safety) Group and should be disseminated to appropriate staff by individual / team briefings or staff awareness events such as Ward and GP meetings. A consolidated Local Mortality Report will be sent to the Mortality Group. Any issues identified for escalation should be reported to this group by exception.

13 Unexpected Death

13.1 Unexpected Death Review
If the death is an unexpected death this should be reported on the Trust’s incident reporting system (Datix). If on initial investigation there is any evidence of service care or delivery problems or concerns that were considered to be a significant contributory factor then the Datix Incident should be escalated as a Serious Incident. The Risk Manager will liaise with the appropriate people to ensure this decision is made in a timely manner. Any unexpected deaths deemed as a Serious Incidents will be reported to the Trust Executives and Board and escalated as per the Serious Incident process.

All unexpected deaths will be reviewed by the Mortality Group. In order to assist in this process an Unexpected Death Investigation Review (see Appendix 6) should be carried out by the Local Mortality Group to identify any care and service delivery issues associated with the unexpected death. This review should be led by the Clinical Services Manager liaising with the Community Hospital Medical Advisor and include any other medical and healthcare staff involved in the patient’s care. This investigation should be carried out within two working days. A report of this review, including initial findings, lessons learnt and actions
proposed, will then be submitted to the Mortality Group to assist in the review and investigation process.

**Note:** the Datix Incident investigation will take place as a separate but related process.

Those involved in this review should consider SBAR (Situation, Background, Assessment and Recommendations) principles when carrying out this process.

The Community Hospital Patient’s Records (including the Medical Record, Patient Assessment and Plan of Care and Acute Hospital record where appropriate) should be reviewed including Transfer of Care/ Admission, Medical Management, Care Plans, Observation Charts, Evaluation and Communication Sheets and a chronology of events.

On reviewing unexpected deaths any contributory factors should be identified, these could include:

- Patient Factors
- Staff Factors
- Task Factors
- Communication Factors
- Equipment Factors
- Work Environment
- Education and Training and
- Team Factors

The Global Trigger Tool (Acute Trigger Tool) should also be completed for each unexpected death (see Appendix 6).

### 13.2 Global Trigger Tool

The Global Trigger Tool is a case note review system which was designed for use within the Acute Hospital settings but can be adapted to the Community Hospital environment. The tool helps to identify any “triggers” which may have resulted in harm to the patient. These harms are categorised as follows:

- **Category E:** contributed to or resulted in temporary harm to the patient and required intervention
- **Category F:** contributed to or resulted in temporary harm to patients and required initial or prolonged hospitalisation
- **Category G:** contributed to or resulted in permanent patient harm
- **Category H:** required intervention to sustain life
- **Category I:** contributed to the patient’s death

The tool is split into the following sections:

1. General care module
2. Surgical care module (not applicable to Community Hospitals)
3. Intensive care module (not applicable to Community Hospitals)
4. Medication module
5. Lab test module

The key aspects covered during this review process are:

- Coding summary
- Observations and fluid balance charts
• Blood / Laboratory reports
• X-ray reports
• Procedural notes
• Nursing notes
• Medical notes

Be cautious of “normalisation of the abnormal” i.e. a specialist saying that that harm would be expected if that procedure was undertaken.

13.3 Unexpected Death Review Recommendations and Findings

Recommendations, findings and suggested action plan of the Unexpected Death Review will be reviewed and agreed by the Mortality Group. These will also be reported to the Medical Director and the Adult Service Delivery (Quality and Safety) Group. As required, additional reporting will be made to the Quality and Safety Committee and Trust Board. Recommended actions and lessons learnt from the Unexpected Death Review and the Datix Investigation will be discussed at the Adult Service Delivery (Quality and Safety) Group and disseminated to appropriate staff by individual / team briefings or staff awareness events such as Ward and GP meetings.

14 Learning from Deaths

The Mortality Group will identify any lessons learnt from either Case Record Reviews or Investigations and these will be disseminated to staff via team meetings, staff briefings and face to face discussions with the individuals involved. In some cases the lessons learnt may be shared wider within the Trust or with agencies or organisations outside the Trust.

The Lessons Learnt should include:

• An overview of what happened, including any themes identified – putting safety first. Being honest
• Any System of Process Factors – adherence to policy and procedure
• Any Human Factors – be supportive and caring. Open and non-defensive culture
• What will we do? Learn and Act – preventative and risk reducing improvements. Continually learn. Share across services

In particular for Unexpected Death Investigations an action plan will be agreed and specifics details of how lessons learnt are to be disseminated will be recorded and monitored by the Mortality Group.

15 Mortality Reporting

From April 2017, Trusts are 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 in each quarter to set out the Trust’s policy and approach and publication of the data and learning points. This data should include the total number of the Trust’s in-patient deaths 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.
15.1 Monthly Reporting
The Records Manager and Quality Facilitator will co-ordinate the monthly reporting of mortality related information distributing relevant reports to the Mortality Group members, the Adult Service Delivery Group Quality and Safety meeting. Expected and Unexpected Death related data will be uploaded onto the Trust’s Performance Management Reporting tool (InPhase) so it is included in monthly performance management reporting and available to those who need to refer to the mortality data. See Appendix 7: Mortality Reporting Flowchart.

15.2 Quarterly Mortality Report
The Chair of the Mortality Group will provide a quarterly mortality report to the Quality and Safety Committee and a summary report as detailed above to the Trust Board.

15.3 Quality Accounts
Changes to the Quality Accounts regulations will require that the data providers publish be summarised in Quality Accounts from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken.

16 Training
Following the CQC Learning, Candour and Accountability report Health Education England (HEE) were to be tasked with engaging with relevant system partners, families and carers, and staff to understand broader training needs and develop approaches to ensuring that staff have the capability and capacity to carry out good investigations of deaths, with the focus on these leading to improvements in care. The Trust will monitor the developments in this training in order to ensure that staff can access suitable training when it becomes available.

The Trust currently offers the following training:
- Root Cause Analysis (RCA) Investigation Technique training which is co-ordinated and provided by the Risk Management Team
- Key members of staff have undertaken the LeDeR training and they will be able to provide guidance based on the concepts covered during that training

17 Consultation
The following have been included in consultation for this policy, and the previous Community Hospital Mortality Review Process, have included the Medical Director, Deputy Director Nursing and Quality, Risk Manager, Community Hospital and Outpatients Service Divisional Manager, Community Hospital Clinical Services Managers, Ward Managers, Clinical Lead for Community Hospitals, Records Manager and Quality Facilitator and Nurse Consultant.

18 Dissemination and Implementation
This process will be disseminated to the all medical and healthcare staff via the Datix notification process and by Clinical Services Managers, Team Leaders and Ward Managers.
19 Monitoring and Compliance

The Mortality Group will monitor compliance with this policy by:

1. Reviewing any related reported incidents
2. Feedback from staff involved in the process

20 References

- National Guidance on Learning from Deaths (NQB March 2017)
- CQC Learning, Candour and Accountability Review
- Learning Disabilities Mortality Review (LeDeR) Programme
  http://www.bristol.ac.uk/sps/leder/
- Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report (Professor Sir Bruce Keogh KBE, July 2013)
- IHI Global Trigger Tool (UK version)
- Using the Acute Trigger Tool -

21 National Leads

The list below provides the lead role with overall responsibility for the learning from deaths programme at relevant national organisations:

- NHS Improvement - Executive Medical Director
- Care Quality Commission - Chief Inspector of Hospitals
- Department of Health - Director of Acute Care and Workforce
- NHS England - National Medical Director

22 Associated Documents

Trust policies, procedures and other record keeping related documents:

- Clinical Record Keeping Policy
- Consent to Examination and Treatment Policy
- Admissions and Transfer to Community Hospitals Policy
- End of Life Care Strategy
- Child Death Overview Process Community Health Professionals Guideline
- Verification of Death Policy
- Incident Reporting Policy

These documents are available from the Policies section of the Trust’s website:
http://www.shropscommunityhealth.nhs.uk/
Appendix 1: HM Prison Death in Custody Reporting Process

HM Prison Death in Custody Reporting Process

The flowcharts below show the link between the Mortality Group and the standard Death in Custody required reporting process.

- Death in Custody
- Coroner Notified
- Serious Incident (SI) reported to Commissioners
- Prison and Probation Ombudsman (PPO) Investigation – Includes clinical review
- Coroner – Article 2 Inquest
- Death Certificate Issued

Mortality Group Notified

Briefed on initial conclusions (Healthcare related)

Mortality Group Notified on completion of stages and outcome

Reported on Trusts Incident Management System (Datix) as a Serious Incident (SI)

48 Hour Report to Commissioners

Investigation / RCA

On completion of Investigation SI Closed

6 to 12 months

9 to 18 months
Appendix 2: Mortality Review Flowchart

Was the Patient Death Expected?

Yes

Local Mortality Review
Local Mortality Group to carry out a review using the:
- Local Mortality Review Checklist
Review to be led by the Ward Manager / Team Leader and involve all medical and healthcare staff involved in the patient’s care
This review should be carried out within seven working days of the patient’s death

No

Unexpected Death Investigation
Report Incident on Datix immediately
Carry out and Unexpected Death Investigation using the:
- Unexpected Death Investigation Report template
- Global Trigger Tool
Review to be led by the Clinical Services Manager liaising with the Medical Advisor and including medical and healthcare staff involved in the patient’s care. This investigation should be carried out within two working days.

Reporting
The Clinical Services Manager to submit a report to the Mortality Group Facilitator for the Adult Service Delivery (Quality and Safety) Group.
Note: any issues requiring escalation to be reported to the Mortality Group by exception.

Implementation of Lessons Learnt and Action Plans
The Head of Nursing and Quality – Adults, the Clinical Services Managers and Ward Managers will ensure that all staff involved are made aware all lessons learnt and actions identified. Specialist Trust staff will support in this process as required. Confirmation of completion of Actions will be reported back to the Mortality Group.
## Appendix 3: Local Mortality Review Checklist

| First Name: __________________________ |
| Last Name: __________________________ |
| Date of Birth: ________________________ |
| NHS Number: ___________ ___________ ___________ |

### Community Hospital

**Local Mortality Review Checklist**  
*(Including End of Life Care 5 Whys appendix)*

#### Community Hospital:
- **Date and Time of Death:**
- **Date of Mortality Review:**

<table>
<thead>
<tr>
<th>Was this death an expected Death?</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>If No report as an Unexpected Death and complete an Unexpected Death Review</em></td>
</tr>
</tbody>
</table>

The key purpose of this review is to ensure all appropriate care was delivered in a timely manner. Review the patient’s Community Hospital Records assessing the aspects of care detailed below. The supporting comments section should be used to give additional details relating to the relevant aspect of care.

In reviewing these factors the following should be taken into consideration:
- Key domains of care: Physical, Psychological, Social and Spiritual
- Key organisation governance requirements: Clinical Decision Making; Management and Leadership; Learning and Teaching; and Governance and Risk

<table>
<thead>
<tr>
<th>Was the patient known to have a Mental Health condition or a Learning Disability?</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>If yes, please consider and record all relevant Mental Health and/or Learning Disabilities factors in the review below</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Completed</th>
<th>Supporting Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Assessment:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Referral / Transfer of Care Information</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Admission Assessment</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Communication (with all relevant parties)</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Facilities</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Spirituality</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Medication</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Current Interventions</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Nutrition</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Hydration</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Skin Care</td>
<td>Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>• Explanation of Care plan or</td>
<td>Yes □ No □</td>
<td></td>
</tr>
</tbody>
</table>
### Care Pathway

#### Initial Assessment Additional Comments:

<table>
<thead>
<tr>
<th>Ongoing Assessments and Day to Day Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review of current management plan (incl. reviews of DNAR and appropriate Care Plan reviews)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>• Were all appropriate observation charts completed and any variations noted and acted upon?</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

#### Ongoing Assessments and Care Additional Comments:

<table>
<thead>
<tr>
<th>Care After Death</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Verification of Death (persons present, relatives, coroner likely to be involved…)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>• Certification of Death (cause of death)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>• Patient Care Dignity</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>• Relative / Carer Information</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>• Organisational Information: Notified GP, Healthcare / Multi-disciplinary Teams (MDT) and other appropriate services</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

#### Care After Death Additional Comments:

<table>
<thead>
<tr>
<th>Details of those involved in the Local Mortality Review Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Signature:</td>
</tr>
</tbody>
</table>
Appendix 1: Root Cause Analysis – End of Life Care

To all Ward Managers/Hospital CSM

The purpose of carrying out this RCA process for patients admitted or transferred to Community Hospitals for End of Life Care is to identify the reason for admission, highlight any gaps in service provision within the health economy and any variation from the care pathway for that patient. The commissioners have specified that we should use the “5 Whys Technique”. It is important to note that you may ask “why” more often (or less) than five times. You should use the form below sheet for the analysis and can add rows if you need to. It would be helpful if you could add any other notes that you think would be useful.

<table>
<thead>
<tr>
<th>Why was this patient admitted or transferred to a Community Hospital for End of Life care?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Why?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Why?</td>
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<tr>
<td></td>
</tr>
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<td>Why?</td>
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<tr>
<td></td>
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<tr>
<td>Why?</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Further information:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
# Appendix 4: Expected Death CSM Report

Expected Death CSM Report

This form is to be completed by Clinical Service Managers (CSM) for consolidated reporting (to the Community Hospital and Out Patients Quality & Safety Group and the Mortality Group) of the local mortality reviews undertaken following expected deaths. This report should summaries key aspects in order to identify any trends and to highlight any concerns and to share areas of good practice.

<table>
<thead>
<tr>
<th>Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Hospital / Ward:</td>
</tr>
<tr>
<td>Patient References: (Patient initials and last four of NHS Number):</td>
</tr>
<tr>
<td>Total Deaths:</td>
</tr>
</tbody>
</table>

**Background:** summary of key facts relating to the expected death incl. confirmation of cause of death, End of Life plan, DNACPR and involvement of family.

**Care or Service Delivery Issues / Concerns identified:** record no issues where applicable

**Recommendations:** include any lessons learnt and/or shared training

**Actions Taken / Planned:** include who is involved and timescales for completion

**Author:**

**Role / Designation:**

**Report Date:**
# Appendix 5: Expected Death Exception Report

**Expected Death Exception Report**

This form is to be used for reporting exceptions identified from Community Hospital Local Mortality Reviews

<table>
<thead>
<tr>
<th>Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Hospital / Ward:</td>
</tr>
<tr>
<td>Patient Ref: (Patient initials and last four of NHS Number):</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Cause of Death:</td>
</tr>
<tr>
<td>Was the patient known to have a Mental Health condition or a Learning Disability?</td>
</tr>
<tr>
<td>*If yes, please consider and record all relevant Mental Health and/or Learning Disabilities factors in the review below</td>
</tr>
</tbody>
</table>

| Background: summary of key facts relating to the expected death |

| Care or Service Delivery Issues / Concerns identified: |

| Recommendations: include any lessons learnt and/or shared training |

| Actions Taken / Planned: include who is involved and timescales for completion |

<table>
<thead>
<tr>
<th>Author:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role / Designation:</td>
</tr>
<tr>
<td>Report Date:</td>
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</table>
## Unexpected Death Investigation Review

During this review follow the **Situation**, **Background**, **Assessment** and **Recommendations** tool principles

<table>
<thead>
<tr>
<th>Situation</th>
<th></th>
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<tbody>
<tr>
<td>Patient Ref:</td>
<td>Datix Ref No:</td>
</tr>
<tr>
<td>(Patient initials and last four of NHS Number):</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Date and Time of Death:</td>
</tr>
<tr>
<td>Cause of Death: (to be completed when known)</td>
<td></td>
</tr>
<tr>
<td>Community Hospital / Ward:</td>
<td></td>
</tr>
<tr>
<td>Detection of incident:</td>
<td></td>
</tr>
<tr>
<td>Involvement and support of patient relatives:</td>
<td></td>
</tr>
</tbody>
</table>

**Was the patient known to have a Mental Health condition or a Learning Disability?**

*If yes, please consider and record all relevant Mental Health and/or Learning Disabilities factors in the review below*

| Yes ☐* | No ☐ |

## Background

**Admitted / Transferred From:**

<table>
<thead>
<tr>
<th>Date of Admission:</th>
<th>Length of Stay:</th>
</tr>
</thead>
</table>

**Reason for Referral:**

<p>| |</p>
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<th></th>
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</table>

**Significant Medical History:**

<p>| |</p>
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<th></th>
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</table>

**Medication:**

<p>| |</p>
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<th></th>
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</thead>
</table>

## Chronology (timeline) of events

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Event</th>
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<tbody>
<tr>
<td></td>
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*Appendix 6: Unexpected Death Investigation Review*

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**Learning from Deaths Policy 1877-37421.doc**

**Datix Ref: 1877-37421**

**25**

**Aug 2017**
### Assessment

Review the patient's medical records including, Medical Assessments, Daily Charts, Rounding Tool, Evaluation and Communication Sheets and Care Plans to assess the care delivered. Ensure a Global Trigger Tool review has taken place and note any findings below.

**Findings Summary:**

### Recommendations

Using the information above and any additional information found, what are the Care and Service Delivery problems associated with this incident?

What are the identified Contributory Factors? These could include: Patient Factors; Staff Factors; Team Factors; Communication Factors; Equipment Factors; Work Environment: Organisational; Education and Training:

Root Causes (the contributory factors that had the greatest impact, and which addressed will minimise the likelihood of re-occurrence):

**Lessons Learned:**

**Conclusions / Recommendations:**

**Arrangements for Shared Learning:**

**Author:**

**Role / Designation:**

**Report Date:**
### Unexpected Death Investigation Review Action Plan

**Status Key:**
- Red – overdue;
- Amber – on track / in progress;
- Green – action completed

<table>
<thead>
<tr>
<th>No</th>
<th>Identified Issue / Area of Concern (refer to Root Causes, Lessons Learnt)</th>
<th>Action required (Refer to recommendations. Include what is required and who needs to be involved)</th>
<th>By Who</th>
<th>By When</th>
<th>Progress (include Monitoring and Evaluation Arrangements)</th>
<th>Status RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
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<td></td>
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<tr>
<td>3.</td>
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<td></td>
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<tr>
<td>4.</td>
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</tbody>
</table>
# Appendix 1: Global Trigger Tool (adapted for SCHT Community Hospitals)

<table>
<thead>
<tr>
<th>General Care Module</th>
<th>Event Description</th>
<th>Number of Events</th>
<th>Severity E – I (see Key overleaf)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1</td>
<td>Lack of early warning score or early warning score requiring response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G2</td>
<td>Any patient fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3</td>
<td>Decubiti</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4</td>
<td>Readmission to hospital within 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G5</td>
<td>Shock or cardiac arrest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G6</td>
<td>DVT/PE following admission evidenced by imaging +/- or D dimmers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G7</td>
<td>Complication of procedure or treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G8</td>
<td>Transfer to higher level of care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication Module</th>
<th>Event Description</th>
<th>Number of Events</th>
<th>Severity E – I (see Key overleaf)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td>Vitamin K</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2</td>
<td>Naloxone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td>Flumazenil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M4</td>
<td>Glucagon or 50% glucose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M5</td>
<td>Abrupt medication stop</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab Test Module</th>
<th>Event Description</th>
<th>Number of Events</th>
<th>Severity E – I (see Key overleaf)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haematology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L1</td>
<td>High INR (&gt;5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L2</td>
<td>Transfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L3</td>
<td>Abrupt drop in Hb or Hct (&gt;25%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biochemistry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L4</td>
<td>Rising urea or creatinine (&gt;2x baseline)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L5</td>
<td>Electrolyte abnormalities Na+ &lt;120 or &gt;160</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L6</td>
<td>K+ &lt;2.5 or &gt;6.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L7</td>
<td>Hypoglycaemia (&lt;3mmol/l)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L8</td>
<td>Raised Troponin (&gt;1.5 ng/ml)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microbiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L9</td>
<td>MRSA bacteraemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L10</td>
<td>C. difficile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L11</td>
<td>VRE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L12</td>
<td>Wound infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L13</td>
<td>Nosocomial pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L14</td>
<td>Positive blood culture</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Events**

Complete any additional comments overleaf
Global Trigger Tool (adapted for SCHT Community Hospitals) continued:

The Global Trigger Tool helps to identify any “triggers” which may them have resulted in harm to the patient. These harms are categorised as follows:

**Severity Category Key:**

- **E:** contributed to or resulted in temporary harm to the patient & required intervention
- **F:** contributed to or resulted in temporary harm to patients & required initial or prolonged hospitalization
- **G:** contributed to or resulted in permanent patient harm
- **H:** required intervention to sustain life
- **I:** contributed to the patient’s death

The key aspects to be covered during this review process are:

- Coding summary
- Observations and nutrition / hydration charts
- Blood / Laboratory reports
- X-ray reports
- Procedural notes
- Nursing notes
- Medical notes

**Additional comments / notes:**

**Completed By:**

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Appendix 7: Mortality Reporting Flowchart

Trust Board
- a) Serious Incident Unexpected Deaths reported via Serious Incident reporting process.
- b) All Unexpected and expected deaths via the receipt of Key Performance Indicators within the Performance Report
- c) Quarterly Reports: specified information on deaths (as required by the National guidance on Learning from Deaths)

Resource and Performance Committee
Unexpected deaths is a Key performance indicator in the Performance Report

Quality and Safety Committee
Summary Report from the Quality and Safety Delivery Group
Exception reporting as required

Quality and Safety Delivery Group
Summary quarterly report detailing the total number of deaths and cause of death.
Exception reporting as required

Mortality Group
Monthly summary report of the number of deaths both expected and unexpected
Exception reporting as required

Adult Service Delivery (Quality & Safety) Group
Monthly updates on the number of deaths both expected and unexpected
Exception reporting as required

End of Life Care Group
Reports on lessons learnt as required

Community Hospital Medical Advisors Group
Reports on lessons learnt as required
Appendix 8: Mortality Group Terms of Reference

Shropshire Community Health NHS Trust

Mortality Group
Terms of Reference

Version: 1.6

Approved by: Quality & Safety Committee  Date: 16 Feb 2017

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Document History:

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<td>Name of author(s)</td>
<td>Dr Mahadeva Ganesh, Medical Director and Alan Ferguson, Records Manager and Quality Facilitator</td>
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Name of responsible committee/group/individual:

Quality and Safety Delivery Group,
Shropshire Community Health NHS Trust

Target audience:  Quality and Safety Committee
Shropshire Community Health NHS Trust

Contents
1. **Introduction**

The Mortality Group is a sub-group of the Quality and Safety Delivery Group. Its powers are delegated by that group and detailed in these terms of reference. The aim of the group is to provide assurance to the Quality and Safety Delivery Group that Community Health Services have robust internal quality assurance processes that ensure patient safety, clinical effectiveness and user experience form the core practice and principles of services by monitoring and reviewing mortality related issues. The group will undertake reviews of unexpected deaths and report findings and recommendations to the Quality and Safety Delivery Group.

The definition for unexpected deaths is: *Any death not due to terminal illness or, a death the family was not expecting. It will also apply to patients where the GP has not attended within the preceding 14 days. Where there is any suggestion of suspicious circumstances, trauma, neglect or evidence of industrial disease in an expected death. Patients transferred from an Acute Hospital Trust to Intermediate Care Facilities with post-surgical conditions, or fractures.*

2. **Constitution**

The Mortality Group is a sub-group of the Quality and Safety Delivery Group and has no executive powers other than those specifically delegated in these Terms of Reference.

3. **Membership**

The membership will comprise representatives from clinical services and will be chaired by the Dr M Ganesh, Medical Director. The Vice Chair will be the Head of Nursing and Quality (Adults)

**Group Members:**
- Medical Director - Chair
- Head of Nursing and Quality (Adults) - Vice Chair
- Non-Executive Director
- Associate Medical Director
- Risk Manager
- Records Manager & Quality Facilitator
- Community Hospitals Clinical Services Manager representative
- Nurse Consultant for Older People (EOL Group representative)
- Community Hospital GP Medical Advisor representative

Group members should nominate a deputy to attend on their behalf if they are unable to attend. Other staff members shall be invited to attend for discussions when the Group is discussing areas of risk or operation that are the responsibility of that staff member where they are not already represented.

4. Meetings and Quorum

**Quorum:** The quorum arrangements for the Mortality Group require the presence of at least the Medical Director or the Deputy Director of Nursing and Quality and representation from the Operations Directorate. There must be a minimum of representation from at least two other members.

If the Group is not quorate the meeting may be postponed at the discretion of the Chair/Vice Chair. If the meeting does take place and is not quorate, no decision shall be made at that meeting and such matters must be deferred until the next quorate meeting. Additional meetings will be scheduled to ensure any matters deferred or additional matters requiring discussion are dealt with in a timely manner.

**Frequency:** Meetings shall be held every three months or earlier if there is a requirement to review an unexpected death or an exception report.

Members are expected to attend all meetings. However, as a minimum, members should attend at least two thirds of all meetings per year.

5. Authority

The Mortality Group has no executive powers other than those specifically delegated in these terms of reference. The Group is authorised by the Quality and Safety Delivery Group to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Group. In addition, the Group is authorised to seek advice from external advisors via the Medical Director.

6. Role and Duties of the Mortality Group

The duties of the Group are to provide assurance to the Quality and Safety Delivery Group relating to the Implementation of the quality strategy and in addition delivery against key aspects of quality including:

**Safety**

- The management of clinical risks by carrying out reviews of deaths in Community Hospitals with specific focus on unexpected deaths.
- Receiving reports on all deaths within Community Hospitals from the Clinical Service Managers (via the Adult Service Delivery Group Quality and Safety meetings), to monitor and review mortality rates and identify any key issues / risks
- Liaising with the Corporate Risk Manager to ensure any reporting, analysing and learning from incidents related to unexpected deaths is in line with national guidance and best practice.
- Reporting on and providing assurance of mortality related risk and reporting to any other groups or committees as detailed in section 9.
- Reporting to the End of Life (EOL) Working Group any risks associated with EOL care that are identified by the Mortality Group through the local mortality review process and any subsequent reviews and/or investigations
• Agree and escalate key issues/ risks of concern that cannot be addressed by the Mortality Group to the Quality and Safety Delivery Group

Effectiveness

• To monitor, review and alert where appropriate.
• Compliance with aspects relating to the Care Quality Commission (CQC) Regulations.
• Measuring the effectiveness of clinical care through a related clinical audits.
• Receiving and reviewing national guidance relating to mortality topics and implications for the Trust.
• Provide regular feedback to the Quality and Safety Delivery Group on activity of the group to ensure appropriate assurance.

7. Monitoring Effectiveness

Through receipt of the minutes (on request) the Quality and Safety Delivery Group will monitor the effectiveness of the Mortality Group.

A record of the frequency of attendance by members, quoracy and the frequency of meetings will be maintained. Any areas of concern will be highlighted to the Chair of the Mortality Group.

The Group will monitor the delivery of the 6 monthly report to the Quality and Safety Delivery Group to ensure effective reporting of the Group’s activities and any escalation of identified issues and trends.

Key risks will be highlighted to the Quality and Safety Delivery Group and reported to the Quality and Safety Committee and Trust Board.

8. Administrative Arrangements

The Group will receive appropriate administrative support. Duties will include:

• Preparing and circulating the agenda and papers with the Chair.
• Maintaining accurate records of attendance, key discussion points and decisions taken and issue necessary action logs within five full working days of the meeting.
• Drafting minutes for circulation to members within five full working days of the meeting.
• Maintaining a database of any documents discussed and/or approved and recall them to the Group when due.
• Organising future meetings.
• Filing and maintaining records of the work of the Group.

9. Relationships and Reporting

The Chair of the Mortality Group shall draw to the attention of the Quality and Safety Delivery Group any issues that require executive action.

The Mortality Group will receive monthly mortality reports from the Community Hospital Service Delivery Managers. The Service Delivery Group Manager will provide an overview of these reports in the Service Delivery Group report presented to the monthly Adult Service Delivery Group Quality & Safety Group meetings. The Mortality Group will also liaise with the Community Hospitals Practitioner (Medical Advisors) Group over relevant mortality related issues.

The Group will report to the Quality and Safety Delivery Group and the Quality and Safety Committee quarterly on its work in support of compliance with Care Quality Commission (CQC) Regulations.
Following recommendations from the CQC review into how NHS Trusts review and investigate deaths of patients (Learning, Candour and Accountability December 2016), a Non-Executive Director has been appointed to the Mortality Group and will act as an independent member to oversee the mortality process on behalf of the Trust Board to ensure we have effective governance arrangements to drive quality and learning from deaths of patients. This will include ensuring the involvement of families and carers in the relevant mortality reviews and investigations (to the extent that they wish).

10. Review of Terms of Reference

This document will be reviewed annually or sooner if agreed by the Quality and Safety Delivery Group. Any amended Terms of Reference will be agreed by the Mortality Group for recommendation to the Quality and Safety Delivery Group for its approval.
11. Reporting Structures

Quality and Safety

Quality and Safety Committee

Quality and Safety Delivery Group

Infection Prevention and Control Committee

Culture Working Group

Clinical Policies Group

Medicines Management Group

Radiation Protection Committee

Service Delivery Group

Quality and Safety Groups

Mortality Group

RCA Challenge

Safeguarding Adults and Children

Risk Review Group

Patient & Carer Panel

Consultants Committee

Community Hospitals Practitioners Group

Everyone Counts Equality and Diversity Group

Paediatric Doctors

CAHMS Doctors