Learning from Deaths

Version	2.0
Designation of Policy Author(s)	Medical Director and Deputy Medical Director
Policy Development Contributor(s)	Deputy Medical Director Head of Governance
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Responsible Committee	Safety Senate Policy Guidelines and Procedures Group
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The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

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1 Executive Summary

1.1 Policy Scope

i. This policy applies to all clinical and nursing employees of the Trust including those employed on fixed, temporary and honorary contracts; including staff working on service level agreements at the Trust.

2 Introduction

i. Approximately 500 000 people die in the UK every year and of these, nearly half die in an NHS hospital.1 The CQC and NHS England have recently highlighted the need for NHS Trusts to learn from their experiences when someone in their care has died so that services can be optimised and clinical practice improved.2,3 Most of the adult deaths that are encountered at Liverpool Women's NHS Foundation Trust are the expected end point of a known disease process and significant deficiencies in care leading directly to perinatal deaths are rare in the organisation. Nevertheless, the need to learn is embraced by the Trust as an essential response to each and every death it encounters.

ii. The Trust's Adult Mortality Strategy and its Extended Perinatal Mortality Strategy describe the causes of mortality and the methods by which the risk of death can be minimised. The strategies also describe the ways in which learning should take place, through the processes of 'analysis' and 'response'. These learning processes are formalised into Trust Policy in the present document.

iii. This policy is relevant and applies to all of the Trust's clinical and managerial staff because the management of adult mortality and extended perinatal mortality is a shared responsibility.

3 Policy Objectives

3.1 Analysis

i. The Trust gathers detailed intelligence on all individual instances of adult mortality and extended perinatal mortality that it encounters in its patient population, identifying local issues and themes arising from those events.

3.2 Response

i. The Trust responds to its analyses by the production of SMART Action Plans, seeing those plans through to completion and disseminating the intelligence gathered to all relevant clinical and managerial groups. After completion of these action plans the Trust ensures that full benefit has been achieved by measuring relevant and related clinical outcomes.

4 Duties / Responsibilities

4.1 All Staff

i. It is the responsibility of all staff to minimise the risk of adult and extended perinatal mortality and to minimise its impact. To highlight areas for improvement, the Trust's risk management processes may be used. Issues may also be brought directly to the attention of Safety or Effectiveness Leads, Clinical Directors, senior nursing and midwifery staff, Divisional Managers, the Associate Medical Director for Clinical Governance, the Medical Director or the Director of Nursing and Midwifery for consideration, escalation and action.

4.2 Medical Director

i. The Medical Director sponsors the Adult Mortality Strategy and has lead responsibility for its delivery. The Deputy Medical Director presents the Quarterly Adult Mortality Report to the public meeting of the Board of Directors on behalf of the Medical Director for assurance. With respect to extended perinatal mortality, the Medical Director works with the Deputy Medical Director to agree the content of the Extended Perinatal Mortality Strategy and its delivery. More generally, the Medical Director has joint responsibility for clinical governance in the Trust and with respect to adult and extended perinatal mortality, provides the function of 'Patient Safety Director.'

4.3 Non Executive Director

i. The Non-Executive Director who chairs the meetings of Quality Committee, in conjunction with the Medical Director, takes oversight of the process for reviewing and reporting on adult and extended perinatal death in the Trust.

4.4 Director of Nursing and Midwifery

i. The Director of Nursing and Midwifery has joint responsibility for clinical governance, delegated authority for quality improvement and risk management and is the Executive Lead for infection control. The Director of Nursing and Midwifery supports delivery of the Adult Mortality Strategy and the Extended Perinatal Mortality Strategy. The Director of Nursing and Midwifery is the Executive Lead for Safeguarding and Learning Disabilities/Dementia with delegated responsibility sitting with the Associate Director of Nursing for Safeguarding.

4.5 Deputy Medical Director

i. The Deputy Medical Director assists the Medical Director and the Director of Nursing and Midwifery in delivering the commitments made in the Adult Mortality Strategy. The Deputy Medical Director also sponsors the Perinatal Mortality Strategy and has lead responsibility for its delivery. The Deputy Medical Director presents the Annual Extended Perinatal Mortality Report to Quality Committee and

ensures that it is also discussed and debated at the Maternity and Neonatology Clinical Meetings.

4.6 Head of Governance and Quality

i. The Head of Governance and Quality works with Medical Director, the Director of Nursing and Midwifery and the Deputy Medical Director, to support delivery of the Adult Mortality Strategy. The Head of Governance and Quality oversees the Quarterly and Annual Adult Mortality Report, presents it to Quality Committee and includes a summary of it in the Trust's Annual Quality Accounts. The Head of Governance and Quality also works with Deputy Medical Director, the Medical Director and the Director of Nursing and Midwifery, to support delivery of the Extended Perinatal Mortality Strategy. The Head of Governance and Quality assists the Deputy Medical Director in producing the Annual Extended Perinatal Mortality Report and includes a summary of it in the Trust's Annual Quality Accounts.

4.7 Safety Leads

i. Safety Leads are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold these posts. Safety Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Adult Mortality Strategy and the Extended Perinatal Mortality Strategy, including the promotion of incident reporting, identifying cases requiring Serious Untoward Incident investigations, ensuring completion of action plans after Serious Incident investigations, disseminating clinical lessons learnt and co-ordinating responses to national reports or initiatives. In conjunction with their Clinical Directors and the Effectiveness Leads, they assist the Deputy Medical Director in producing the Annual Extended Perinatal Mortality Report.

4.8 Effectiveness Leads

i. Effectiveness Leads are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold the posts. Effectiveness Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Adult Mortality Strategy and the Extended Perinatal Mortality Strategy, including the maintenance of clinical guidelines, formulation and delivery of clinical audit, benchmarking and horizon scanning. In conjunction with their Clinical Directors and the Safety Leads, they assist the Deputy Medical Director in producing the Annual Extended Perinatal Mortality Report.

4.9 Senior Managers

i. Senior managers take a leading role in the management of clinical risks in the Trust, including the management of risks relating to adult and extended perinatal mortality. Examples of their responsibilities include escalating clinical risks from the front line, identifying the actions needed to reduce the risk, assigning owners to elements of Action Plans and monitoring mitigating factors.

4.10 Committees and Meetings

4.10.1 Directorate Clinical Meetings

i. Standing items on the relevant Divisional Clinical meeting agenda of relevance to the Adult Mortality Strategy include review of the Divisional Risk Register, review of progress against the Clinical Audit Forward Plan, review of the actions detailed in SMART Action Plans after an adult death, review of the actions detailed in SMART Action Plans after a relevant clinical audit, horizon scanning and review of the Quarterly Adult Mortality Report. Standing items of relevance to the Extended Perinatal Mortality Strategy include review of the Divisional Risk Register, review of progress against the Clinical Audit Forward Plan, review of the actions detailed in SMART Action Plans, horizon scanning and review of the Annual Extended Perinatal Mortality Report.

4.10.2 Safety Senate

i. The Safety Senate monitors themes arising from clinical incidents that have been reported in the Trust, including those that have arisen following an adult or an extended perinatal death. In addition, after a Serious Incident, although the Divisional Clinical Meetings monitor progress against the SMART Action Plans produced, the Safety Senate provides monthly oversight and escalates unresolved risks to Quality Committee.

4.10.3 Effectiveness Senate

i. The Effectiveness Senate monitors progress against the Trust's Clinical Audit Forward Plan, which includes audit work in those clinical activities most closely related to the risk of adult mortality and extended perinatal mortality. In addition, although the Divisional Clinical Meetings monitor progress against the SMART Action Plans produced after their clinical audits, the Effectiveness Senate provides monthly oversight and escalates unresolved risks to Quality Committee.

4.10.4 Quality Committee

i. The Quality Committee is the sub-committee responsible for providing the Board of Directors with assurance on all aspects of quality of clinical care. Quality Committee therefore oversees all clinical governance activity relating to mortality. It meets on alternate months and receives, via the Effectiveness Senate and Safety Senate Chairs' Reports, risks relating to mortality that have not been resolved at divisional or senate level. In addition, it receives the Quarterly Adult Mortality Report and escalates unresolved risks relating to adult mortality to the Board of Directors. Since the Quarterly Adult Mortality Report is also provided directly to the Board of Directors, which meets monthly, it is accepted that the Board of Directors will occasionally receive an Adult Mortality Quarterly Report before it has been considered by Quality Committee. In addition, Quality Committee receives the Annual Extended Perinatal Mortality Report and escalates unresolved risks relating to extended perinatal mortality to the Board of Directors.

4.10.5 Board of Directors

i. The Board of Directors meets in public on a monthly basis. It has the overarching responsibility for activities relating to mortality in the Trust. It therefore receives the Quarterly Adult Mortality Report for direct consideration. It also receives assurance from Quality Committee with respect to the detailed elements of the report, via the Chair of Quality Committee's Report. The Board of Directors also receives assurance from Quality Committee with respect to the detailed elements of the Annual Extended Perinatal Mortality Report, via the Chair of Quality Committee's Report. In addition, the following items of relevance to adult mortality and extended perinatal mortality appear on the Board Assurance Framework: (i) the isolated site of Liverpool Women's Hospital, (ii) transport of adults across the critical care network, (iii) development and support of a comprehensive Clinical Audit Forward Plan, (iv) ensuring that lessons are learnt and change enacted from the reporting and investigation of incidents locally and across the NHS and (v) considering response to NICE Guidance.

5 Main Body of Policy

5.1 Analysis and Response in Adult Mortality

i. The Trust's policy for analysis after an adult death relies upon the following activities:

- Gathering detailed intelligence on all individual instances of adult mortality in the Trust
- Identifying local issues arising from each of those events individually
- Exploring themes that may be emerging from groups of events.

5.1.1 Intelligence-Gathering Process

i. Appendices A, B and C are flow charts that illustrate the intelligence-gathering processes that are followed after expected gynaecological deaths, unexpected gynaecological deaths and all adult deaths in obstetrics. Expected gynaecological deaths are those that arise as the predicted end point of a known disease process. In this Trust, most of these result from gynaecological cancers.

5.1.2 Adult Mortality Audit Sheet and Incident Reporting

i. All expected and unexpected adult deaths in the Trust, are reported on the Ulysses Risk management system as soon after death as practicable by the nurse or clinician providing care to the deceased patient. They will thereafter, complete an Adult Mortality Audit Sheet on Ulysses Risk Management System within 48 hours of the patient's death Appendix D). This records performance against a predefined set of standards, using the recognised and validated methodology detailed in PRISM studies. In each clinical area, the Clinical Director provides feedback to clinicians if individual errors or omissions in care have been identified by use of this audit tool. The forms are sent electronically to the Head of Governance and Quality, the Quality Improvement Lead and Governance Facilitator who analyse the data and identify any emerging Trust-wide themes. These are highlighted and reported in the Quarterly Adult Mortality Report. If any deaths are graded as NCEPOD 5 or <3

(very poor/poor care) on structured judgement review then a second stage review will be performed according to the RCP SJR process.

5.1.3 Root Cause Analysis

i. For unexpected gynaecological deaths and all maternal deaths, either a Level 2 or a Level 3 Root Cause Analysis is performed. One of the main aims of the Root Cause Analysis is to identify case-specific errors and systematic flaws. All Root Cause Analyses are scrutinised by the Head of Governance and Quality, who pools data and identifies any emerging Trust-wide themes. The lessons learnt and the SMART Action Plans are highlighted in the Quarterly Adult Mortality Report.

5.1.4 SMART Action Plans

i. After the analysis of events following an adult death areas of deficiency and opportunities for improvement are presently captured by the production of SMART Action Plans. Similarly, after completion of any clinical audit of relevance to adult death, areas of deficiency and opportunities for improvement are captured by the production of SMART Action Plans:

- Specific
- Measurable
- Agreed
- Realistic
- Time-based

ii. Each action in a SMART Action Plan has an assigned person responsible for its completion. This may for example be the Safety Lead, the Effectiveness Lead, a senior nurse or midwife or a manager. Progress against Action Plans is discussed as a routine agenda item at Divisional Clinical Meetings.

iii. The Head of Governance and Quality provides oversight and prompts the assigned person responsible if an action is overdue for completion. If a planned action relating to adult mortality has not been completed within one month of its agreed completion date, The Head of Governance and Quality escalates the matter to the Medical Director and the Director of Nursing and Midwifery, who pursue completion of the action.

iv. When any action in a SMART Action Plan is being closed relating to adult mortality, evidence must be attached to show how the requirements of that action have been met. In addition, beyond completion of a SMART Action Plan, the Trust ensures that full benefit has been achieved by measuring relevant and related clinical outcomes. These outcome measures are agreed at the Divisional Clinical Meetings and monitored at those same meetings with the assistance of the Head of Governance and Quality.

5.1.5 Quarterly Adult Mortality Report

i. The Head of Governance and Quality oversees the production of the Quarterly Adult Mortality Report, by the Quality Improvement Lead. As a minimum, this report contains data about:

- Number of adult deaths
- Number of women who had an Adult Mortality Audit Sheet completed
- Number of woman whose death lead to a Root Cause Analysis
- Number of deaths attributable to deficiencies in care
- Themes identified from the Adult Mortality Audit Sheets and Root Cause Analyses
- Actions being taken
- Progress against those actions
- Outcome measures identified for on-going scrutiny, beyond completion of action plans.

ii. In a broader sense, the Quarterly Adult Mortality Report contains information relevant to all of the activities outlined in the Adult Mortality Strategy, including activities around prevention, analysis, response and bereavement. The Head of Governance presents the Quarterly Adult Mortality Report to Quality Committee and The Medical Director presents the Quarterly Adult Mortality Report to the public meeting of the Board of Directors, to give assurance. A summary of the year's Quarterly Adult Mortality Reports is used by the Head of Governance and Quality to populate the Quality Accounts of the Trust.

5.2 Analysis and Response in Extended Perinatal Mortality

5.2.1 Neonatal Death

i. MBRRACE suggest that after all neonatal deaths, the Trust providing the clinical care should conduct a full review of the care provided, identify any local factors that might be responsible for high mortality rates and establish whether there are lessons to be learned to improve the quality of care. At Liverpool Women's Hospital, an initial assessment is made immediately after all neonatal deaths (including early neonatal deaths) by neonatal medical and nursing leads, at which time the following questions are asked:

- Does the death meet the threshold for triggering a SUDI investigation?
- (Sudden Unexplained Death in Infancy)
- Does the death require discussion with the Coroner?
- Does the death require reporting as a Serious Incident?

ii. If the death is a SUDI a police investigation takes place and this has precedence over all other investigatory work. Staff are required to make a written record of their involvement as soon as possible after the event and is converted into a police statement if required. The mothers/infants medical records are retained by the Safeguarding Team for the duration of the SUDI process. Liverpool Women's NHS Foundation Trust follows the Merseyside Joint Agency Protocol for SUDI.

iii. If the death is not a SUDI but the Coroner decides that a Coroner's Investigation is required, a post mortem examination will normally be carried out on the Coroner's direction. The Trust is provided with the post mortem result only after being given

permission by the Coroner. The Trust accepts that this can delay parallel in-house investigations that may be taking place.

iv. If a Serious Incident (SI) investigation is required, this can progress at a normal pace unless there is a SUDI, which takes precedence. If there is a Coroner's Investigation taking place in parallel with an in-house Serious Incident investigation, the Trust's investigators will normally reach a preliminary provisional conclusion while waiting conclusion of the Coroner's Investigation and complete their report thereafter. Each SI report includes a Lessons Leaned section and a SMART Action Plan, completion of which is monitored by the Neonatal Clinical Meeting. Importantly, SI reports are shared with the woman who has suffered a neonatal death and an opportunity is given for them to discuss the findings will a Consultant Neonatologist.

v. In addition to the above, a multi-disciplinary panel of doctors and nurses on the Neonatal Unit use a locally created standardised audit tool to review all neonatal deaths. The aim of these reviews is to agree the cause of death, to determine whether there were any deficiencies in care delivery and to decide whether these deficiencies were likely to have had any causal role in the death. A CEMACH code (CESDI no longer in use) is also determined at this meeting. Learning points arising from these panel reviews are communicated to the wider team by email, at daily handover meetings and at the Neonatal Clinical Meetings.

vi. Selected individual cases are presented to a Trust Bi-Annual Perinatal Mortality Meeting. Cases are selected for presentation that will be of interest to both the neonatal and maternity clinicians who are in attendance at those meetings.

vii. A summary of the data collected from the Trust's neonatal death reviews is reported to the Cheshire and Mersey neonatal network Clinical Effectiveness Group (CEG), along with any learning points generated. All deaths are also reported to the local Child Death Overview Panel (CDOP) and are discussed there. One of the neonatal Consultants from the Trust attends the CDOP to inform this discussion and to feed back any relevant points from the discussion to the Neonatal Clinical Meeting.

viii. An annual summary report of all neonatal deaths, including SUDI, coroner's cases, SIs and others, is compiled to demonstrate themes and these are used to drive targeted service change. The annual report is reviewed at the Neonatal MDT meeting and it is also presented to the Effectiveness Senate. The data generated after SUDIs, Coroner's Investigations and SIs are also included in the Trust's Annual Extended Perinatal Mortality Report - including Lessons Learned, SMART Action Plans generated and themes arising from early neonatal deaths.

ix. With respect to benchmarking, the Trust is involved in several initiatives in addition to the MBRRACE-UK report:

x. The Vermont Oxford Neonatal network collects data that allow us to benchmark our very low birthweight and extreme preterm in-hospital mortality against other neonatal units across UK and across the world, with risk adjustment for case mix.

xi. The Quality Account publishes data about neonatal mortality for babies born at the Trust, compared with the national neonatal mortality rates published by the Office for National Statistics, with adjustment for the gestation profile.

xii. The Neonatal Data Analysis Unit also produces an annual report on in-hospital mortality for preterm babies in UK neonatal units.

xiii. The Healthcare Quality Improvement Partnership is presently working with the RCOG and the British Association of Perinatal Medicine to developing a standardised Perinatal Mortality Review Tool (PMRT), for use when investigating perinatal deaths. The PMRT is due to be released by the end of December 2017 and after that time the Trust is committed to adopting it for local use. Data generated from use of the PMRT will be included in future editions of the Annual Extended Perinatal Mortality Report together with benchmarking data.

5.2.2 Serious Case Reviews (SCR)

i. When a child dies and abuse or neglect are known or suspected to be a factor in the death, local agencies should consider whether there are any lessons to be learnt about the ways in which they work together to safeguard children.

ii. Where this is the case the LSCB will conduct a review into involvement of agencies and the child and family. The LSCB will inform the National Panel within five days of the incident and their intention to undertake a Rapid Review. This review will be completed within twenty days. A decision will then be made as to whether a National or Local review is most appropriate and the National Panel notified. Agencies are required to be aware of the short deadlines (Working Together 2018).

iii. Additionally where a child has sustained a potentially life threatening injury, serious or permanent impairment or has been subjected to particularly serious sexual abuse the LSCB should consider whether a review should be conducted.

iv. The mothers/infants medical records are retained by the Safeguarding Team for the duration of the SCR process.

5.2.3 Stillbirth

i. The Trust has a well-embedded process for stillbirth review. The key steps are as follows:

ii. A central register of all stillbirths is kept locally by the Stillbirth Lead. The Clinical Coding department sends the Head of Midwifery a monthly update showing all coded stillbirths so that the local list and the external coding data correlate correctly, ensuring that there are no cases being missed from the investigatory process.

iii. All non-fetal abnormality stillbirths are recorded as adverse events using the Trust incident reporting system, Ulysses.

iv. All stillbirths undergo an initial incident review to ensure there are no patient safety concerns. They are then reviewed via the monthly perinatal mortality and morbidity review panel using the Perinatal Mortality Review Tool (PMRT). Copies of incident

report is sent to all staff involved in the delivery of care so that they can be discussed with Educational Supervisors and Senior Midwives as appropriate. The Lessons Learned are shared more widely via email and at the Maternity Clinical Meetings, in keeping with the Trust's Policy for Managing Incidents and Serious Incidents. A copy of the report is also sent to CCG and the CQC, who may choose to add scrutiny to the event. Importantly, SI reports are shared with the woman who has suffered a stillbirth and an opportunity is given for them to discuss the findings will a Consultant Obstetrician.

v. All Intrapartum stillbirths are declared SIs and in addition to SI reports, intrapartum stillbirths also undergo review using the Each Baby Counts review process. For these reviews, the Strategic Clinical Network provides an external panel member. The report generated is uploaded on to the Trust shared drive and is shared nationally.

vi. All stillbirths are discussed at a monthly meeting and MBRRACE grading is used and the national PMRT is completed.

vii. The Trust has previously published the results of its continuous stillbirth audit as an annual stand-alone report. The data generated from this continuous audit and the Lessons Learned and SMART Action Plans generated after SIs will be included in the Trust's Annual Extended Perinatal Mortality Report.

viii. With respect to benchmarking, the Trust receives yearly figures on its performance through MBRRACE-UK, in which an attempt is made to match local outcomes with national peers. The Trust's Deputy Medical Director produces a response to the annual MBRRACE-UK report at the time of its publication. This response takes into account local factors that have not otherwise been accounted for in the MBRRACE-UK document. This response is included in the Trust's Annual Extended Perinatal Mortality Report.

5.2.4 Annual Extended Perinatal Mortality Report

i. The Trust has been auditing stillbirth since 2004 and in recent years, this has taken the form of a continuous audit published as the Annual Stillbirth Audit. This included information about stillbirth rates, cause specific conditions and benchmarking data, measuring practice against our expected standards of care. Themes such as obesity, ethnicity, deprivation, reduced fetal movements and growth have been explored in the reports as mini-summaries.

ii. Early neonatal mortality rates have been reported and commented on annually since the Trust was founded, initially in the Neonatal Unit annual report and latterly in the Trust Quality Account. All neonatal deaths within the Trust in recent years have been subject to multidisciplinary team review using a standard methodology in order to identify areas for service improvement and ad-hoc reports if the data produced by this approach have been produced to inform service development priorities.

iii. The stillbirth and early neonatal death audit work are now incorporated into an Annual Extended Perinatal Mortality Report, additional elements of which are described in the Extended Perinatal Mortality Strategy. Production of the Annual

Extended Perinatal Mortality Report is the responsibility of the Deputy Medical Director in conjunction with the Clinical Directors, Safety and Effectiveness Leads from Maternity and Neonatology and the Trust's Head of Governance and Quality. The report is presented to meetings of Quality Committee, which is a sub-committee of the Board of Directors, on an annual basis.

5.3 Deaths involving people with Learning Disabilities

i. The Learning Disabilities Mortality Review (LeDeR) Programme was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England as a result of one of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD).

ii. CIPOLD reported that people with learning disabilities are three times more likely to die from causes of death amenable to good quality healthcare than people in the general population.

iii. The primary role of the LeDeR Programme is to make improvements in the quality of health and social care for people with learning disabilities, and to reduce premature deaths in this population.

iv. All deaths will be reviewed, regardless of the cause of death or place of death, in order to:

- Identify potentially avoidable contributory factors to the deaths of people with learning disabilities and ways of improving services to prevent early deaths of people with learning disabilities.
- Develop plans of action to make any necessary changes to health and social care services for people with learning disabilities

v. The local reviewer is either a health or social care professional who has received training in the agreed LeDeR methodology. Any LeDeR reviewer must be independent of the provider organisation they are nominated to review. The role involves:

- Receiving notifications of a death of a person with learning disabilities
- Completing an initial review of each death, based on a thorough understanding of the needs of people with learning disabilities and their families.
- Completing a multi-agency review of these deaths where this is indicated
- Maintaining communication with the Local Regional Contact and LeDeR Programme (as appropriate) during the course of the review to update on progress and highlight any problems
- Writing an accurate and concise report of the review and complete any associated action plan
- Submitting the completed paperwork of the review to the Local Area Contact and the LeDeR Programme

vi. For Trust guidance, please refer to Trust LeDeR SOP (**include link once live**)

5.4 Bereavement

i. The Macmillan Team provides bereavement support to family and carers after the death of an adult in the Trust. The team comprises six clinical nurse specialists (TWE 4.4), all of whom have advanced communications skills training. They draw upon guidelines from the Cheshire and Merseyside Palliative Care Network to underpin their work[1], in addition to in-house guidelines that are displayed on the Trust Intranet (Policies Procedures and Guidelines > Gynaecology > general Gynaecology > Bereavement Guideline).

ii. The Trust is committed to putting families and/or carers at the centre of the investigatory process in cases of unexpected adult deaths in gynaecology and all adult deaths in maternity. The Lead Investigator or deputy consults with the bereaved family and/or carers to inform them that an investigation is taking place and notes any questions that they would like addressed. On completion of the investigation, the Lead Investigator or deputy feeds back findings to the bereaved family and/or carers and gives them the opportunity to ask further questions. A copy of the investigatory report is provided to the bereaved family and/or carers at this time. A further opportunity is given to the bereaved family and/or carers to meet with the Lead Investigator or deputy at a later date, once they have had time to consider the content of the investigatory report.

iii. The Honeysuckle Team provides support for families and advice for women and their families following a pregnancy loss at any gestation and after an early neonatal death. We draw upon guidelines from SANDS (Stillbirth and neonatal death charity) and NBCP (National bereavement care pathways). One of the Honeysuckle bereavement midwives will liaise with parents prior to any internal investigations and will attend the PMRT (Perinatal Mortality Review Tool) meetings with the lead investigator and Quality & Safety midwife. Parents can submit questions prior to the investigation. A debrief is then arranged with a consultant and if requested by parents the bereavement midwife will also attend. Parents can attend at a later date or be telephoned if requested to discuss any more questions that may have arisen from the debrief.

6 Key Reference

i. Office for National Statistics, Death registrations summary tables – England & Wales for 2015

ii. Learning, Candour and Accountability: a review of the way NHS trusts review and investigate the deaths of patients in England (December 2016). Available online at www.cqc.org.uk

iii. National Guidance on Learning from Deaths. National Quality Board (2017) Available at www.england.nhs.uk

[1] North West Coast Strategic Clinical Network: Standards and Guidelines (2017). Available at www.cmscnsenate.nhs.uk/strategic-clinical-network/our-networks/palliative-and-end-of-life-care/audit-group/standards/

iv. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. Hogan H et al (2012) BMJ Qual Saf 21, 737-745.

v. Learning Disabilities Mortality Review (LeDeR) Programme (2017) Available at www.bristol.ac.uk/sps/leder

vi. North West Coast Strategic Clinical Network: Standards and Guidelines (2017). Available at www.cmscnsenate.nhs.uk/strategic-clinical-network/our-networks/palliative-and-end-of-life-care/audit-group/standards/

7 Associated Documents

i. Adult Mortality Strategy
ii. Extended Perinatal Mortality Strategy
iii. Adult and Perinatal Quarterly Reports
iv. Serious Incident Case Reviews
v. Adult Mortality Reviews
vi. Incident Management Reporting Policy
vii. Incident reporting SOP

8 Training

i. Individuals undertaking second stage mortality case reviews Tool specific training e.g. SJR

ii. Individuals undertaking first stage mortality case reviews Cascade training, peer support and buddy system

Who	What	Frequency	Monitoring
Individuals undertaking mortality case reviews	Tool specific training eg. Structured Judgement Review training by RCPCH	Once, before undertaking any reviews	Local department / Ulysses risk management system – mortality audit toolkit
Individuals undertaking mortality case reviews	Peer support and buddy system (experiential learning)	While undertaking the first few reviews	Local department / Ulysses risk management system – mortality audit toolkit

9 Policy Administration

9.1 Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment	PGP	27/03/2019	
GDPR	R. Cowell	09/11/2018	None
Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	Yes		
External Stakeholders			
Trust Staff Consultation via Intranet	Start date: October 2018		End Date: October 2018

Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)	By Whom will this be Delivered?
This policy will available on the Trust intranet. All staff will be notified that the policy is available on the intranet and will be notified by email if any amendments are made at a later date.	Policy Officer / Quality Improvement Lead

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
Oct 17	1.0	Medical Director	New Document
Oct 18	2.0	Quality Improvement Lead & Safety Manager	Minor updates (Dates and committee name changes), role changes. Updates to CESDI with CEMACH processes
Oct 18	2.0	Safeguarding Manager	Deaths Involving people with Learning Disabilities section, new to the policy.

9.2 Monitoring Compliance with the Policy

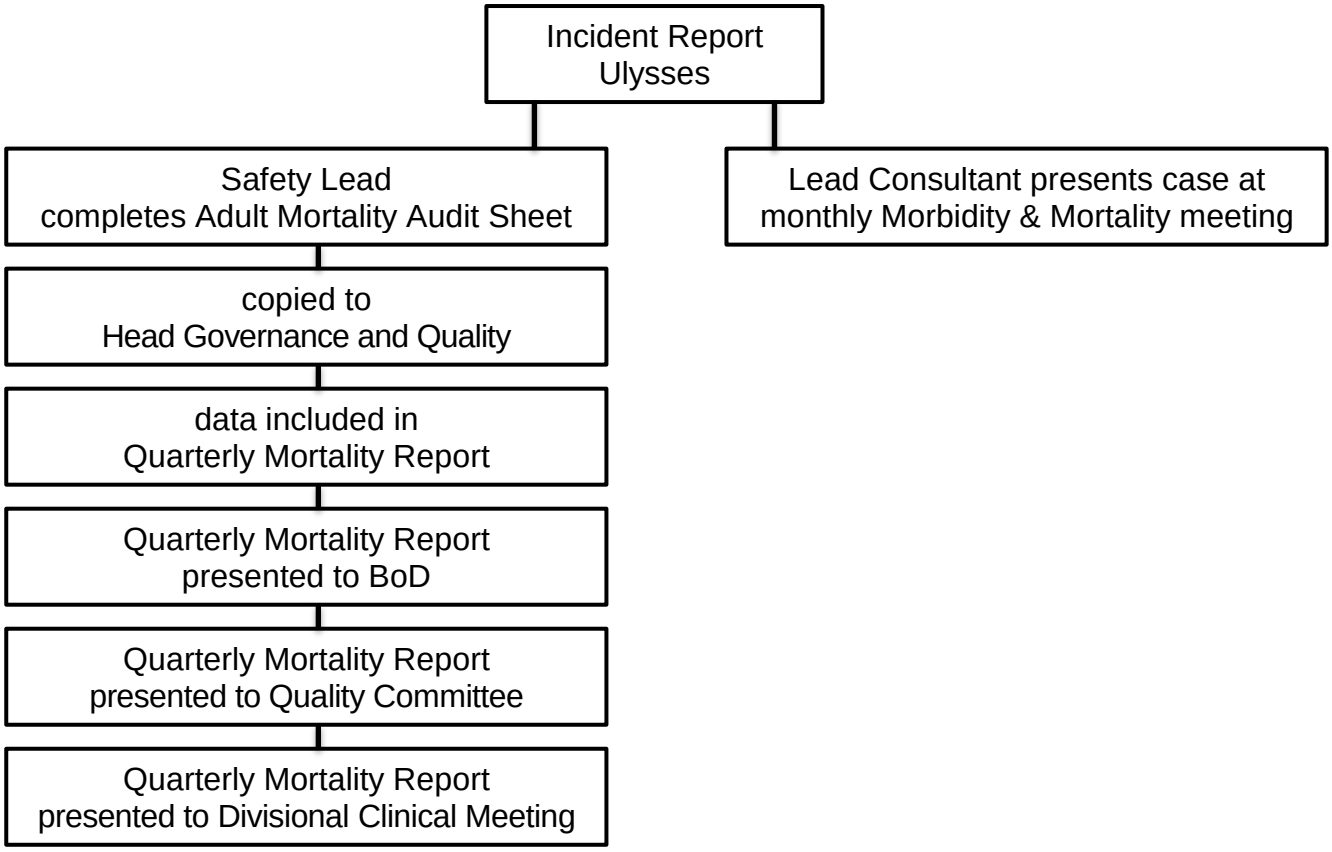
Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Compliance with the commitments made against adult mortality in this policy document will be monitored via the Quarterly Adult Mortality at Quality Committee and at the Public meeting of the Board of Directors.		will be monitored via the Quarterly Adult	Quality Committee / Public meeting of the Board of Directors.	Quarterly	
Compliance with the commitments made against extended perinatal mortality in this policy document will be monitored via the Annual Extended Perinatal Mortality Report at Quality Committee			Quality Committee	Annual	

9.3 Performance Management of the Policy

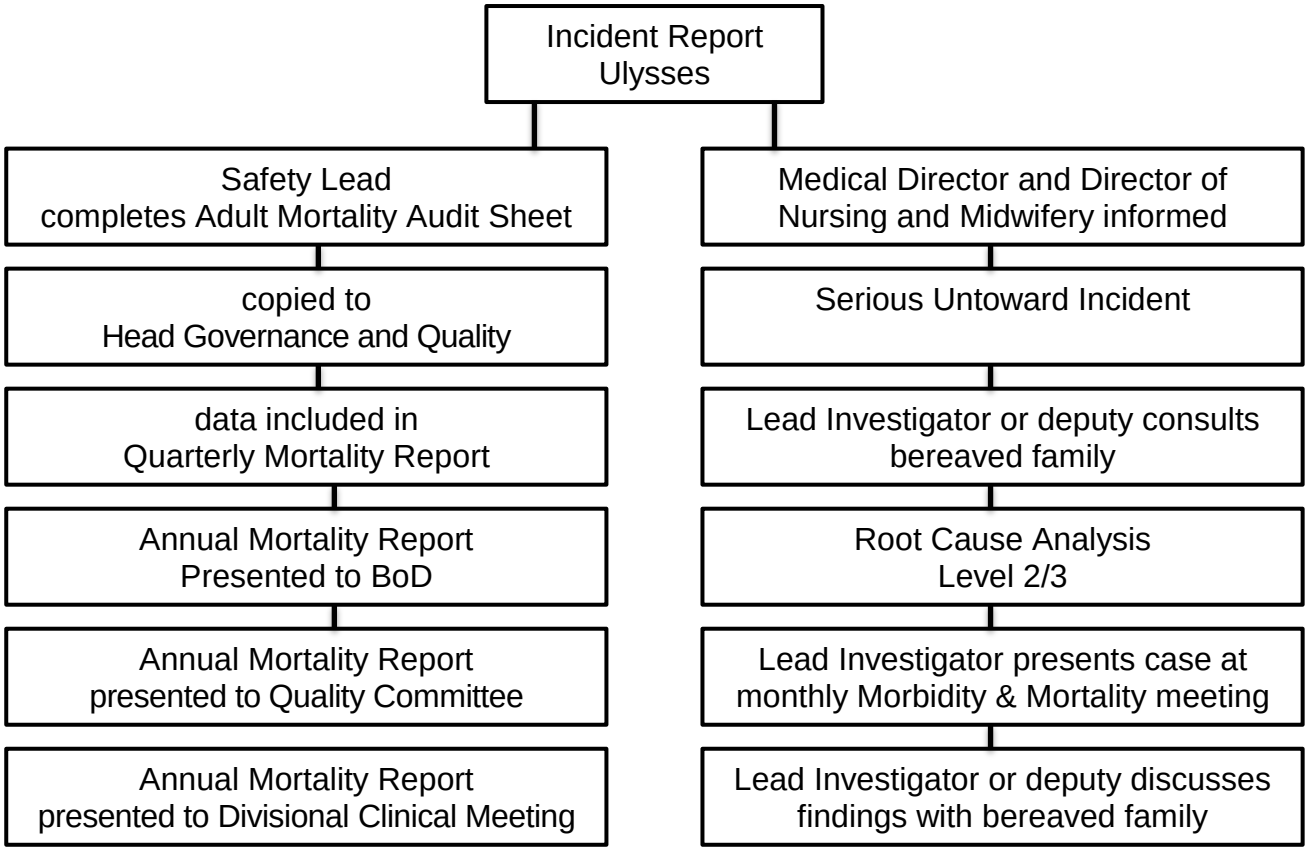
Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
This Policy will be reviewed and updated annually by the Medical Director and the Deputy Medical Director for Quality Committee	Quality Committee	Annually

10 Appendices

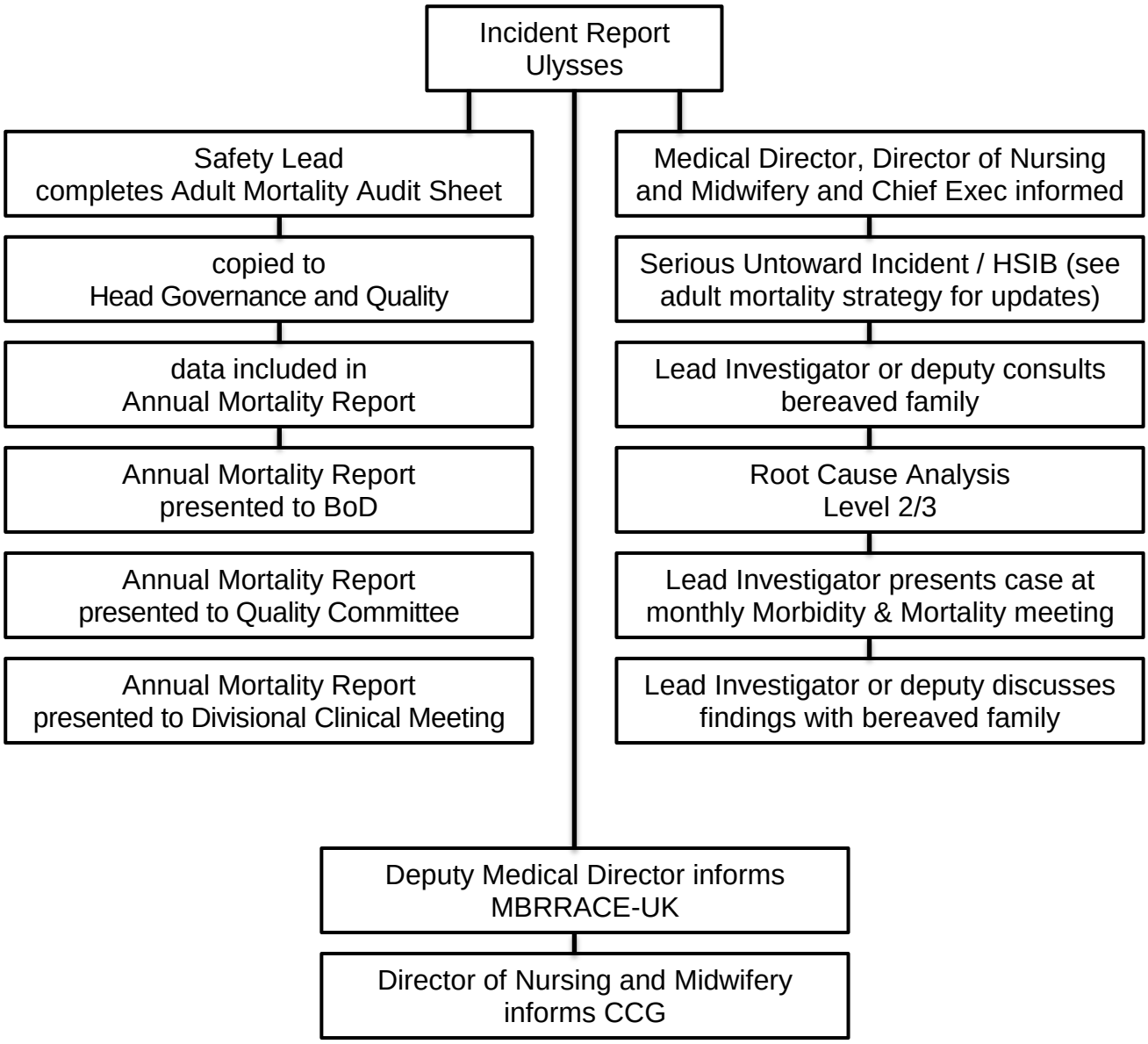
10.1 Appendix A: Response to an Expected Gynaecological Death (As per LeDeR SOP if patient has a diagnosis of Learning Disability then follow LeDeR process)



10.2 Appendix B: Response to an Unexpected Gynaecological Death (As per LeDeR SOP if patient has a diagnosis of Learning Disability then follow LeDeR process)



10.3 Appendix C: Response to a Maternal Death (As per LeDeR SOP if patient has a diagnosis of Learning Disability then follow LeDeR process)



10.4 Appendix D: Adult Mortality Audit Sheet (In addition to completing this form you should, as per LeDeR SOP if patient has a diagnosis of Learning Disability then follow LeDeR process)

The content of the Adult Mortality Audit Sheet is as follows (available on Ulysses once death is reported as an incident)

Date and time of admission:
Date and time of death:
Cause of death 1a: disease or condition directly leading to death
Cause of death 1b: other disease or condition if any, leading to 1a
Cause of death 1c: other disease or condition if any, leading to 1b
Cause of death 2: other significant disease or condition contributing indirectly to death
PM performed: Y/N
Documentation of DNAR in case notes: Y/N
Was the patient on an End of Life Care Pathway: Y/N
Did the patient receive any treatment prior to admission:
Was the patient seen in the emergency department prior to admission:
On initial clerking, were the history and examination appropriate: (If not, specify why)
Was the initial differential diagnosis appropriate: (If not, specify why)
Were the initial investigations (if any) appropriate: (If not, specify why)
Time of first review:
Number of hours after admission of first review:
Grade of doctor performing first review:
On first review, were the history and examination appropriate: (If not, specify why)
Was the differential diagnosis on first review appropriate: (If not, specify why)
Were the investigations on first review (if any) appropriate: (If not, specify why)
Time of first Consultant review:
Number of hours after admission of first Consultant review:
Was the NEW score recorded appropriately throughout:
Frequency of observations prescribed:
Clinical deterioration recognised:
Appropriate graded response to deterioration:
Clearly documented medical response to deterioration:
Did the deterioration result in cardiac arrest:
Did the patient receive CPR/resuscitation:
Did the separate location of LWH from an adult acute site contribute to the patient's death:
Did the separate location of LWH from an adult acute site reduce the quality of care provided: (If so, please specify)
Should the patient's management have been handled differently: (If so, please specify)

NCEPOD
1 Good practice
2 Room for improvement – some clinical care could have been better
3 Room for improvement – some organisational care could have been better
4 Room for improvement – some clinical & organisational care could have been better
5 Less than satisfactory – several aspects of care below an acceptable level

Explicit Judgement Comments

Here the reviewer makes explicit judgement comments on the phase/overall care reviewed which allows the reviewer to concisely describe and assess the safety and quality of care provided. Judgement comments can be made on anything the reviewer thinks is pertinent to a particular case, including technical aspects of care such as management plans, whether care meets good practice and the interventions undertaken. More holistic aspects of care such as end-of-life decision making and involvement of families are also reviewed. It is recommended that explicit statements use judgement words and phrases e.g. 'good', 'unsatisfactory', 'failure' or 'Best practice'.

RCP examples of explicit judgement comments:

Very good care – rapid triage and identification of diabetic ketoacidosis with appropriate treatment. Overall, a fundamental failure to recognise the severity of the patient's respiratory failure.

Phase of care scores once explicit judgement comments are made, the reviewer then applies a phase of care/overall care score. Only one score is given per phase of care and is not required for each judgement statement. This allows the reviewer to come to a rounded judgement on the phase of care being reviewed, which is particularly useful when there is a mix of good and poor elements of care. Therefore a phase of care could identify elements of poor care and still be rated a positive score overall if there were also elements of care that were very good.

The following care scores are used:

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Are there any lessons to be learnt from this case: (If so, please specify)

How would you rate the overall quality of care provided by the trust: Excellent / Good / Adequate / Poor / Very poor
Please give a brief clinical resume of the patient:

10.5 Appendix F: Glossary and Abbreviations

Action	A response to control or mitigate a risk
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted.
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available
BoD	Board of Directors
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit previously stated standards
Corporate Governance	The system by which Boards of Directors direct and control organisations in order to achieve their objectives
CQC	Care Quality Commission
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention
Quality Committee	Quality Committee
LeDeR	Learning Disabilities Mortality Review Programme
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
NHSLA	NHS Litigation Authority
NICE	National Institute for Health and Care Excellence
NPEU	National Perinatal Epidemiology Unit
RCOG	Royal College of Obstetrics and Gynaecology
Risk	The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance
Risk Management	The processes of identifying, assessing & judging risks, assigning ownership, taking actions to mitigate & anticipate them, monitoring and reviewing progress
Risk Register	A tool for recording identified risks and monitoring actions and plans against them
Strategy	A document that sets out the corporate approach and overview to a particular area or work activity.

11 Initial Equality Impact Assessment Screening Tool

Name of policy/ business or strategic plans/CIP programme: **Learning from Deaths**	**Details of policy/service/business or strategic plan/CIP programme, etc:** This policy document sets out the Trust's approach and a framework for the recording, audit and thematic review of care and treatment following instances of both expected and unexpected deaths of adults (gynaecology, gynaecology oncology and maternity) and of babies in the perinatal period. Adherence to the described framework ensures this is systematic and objective and results in the extraction of learning points, development of SMART and effective action plans, which are implemented and tested on completion to confirm change and improvement. Further, the described framework ensures this is applied without prejudice, discrimination or favour

Does the policy/service/CIP/strategic plan etc affect (please tick)

Patients ☐
Staff ☐
Both ☑

Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**Yes/No**	**Justification/evidence and data source**
Age	No	No discrimination / inequality identified, the document sets out the Trust's approach and a framework for the recording, audit and thematic review of care and treatment following instances of both expected and unexpected deaths of adults and of babies in the perinatal period. Adherence to the described framework ensures this is systematic and objective and results in the extraction of learning points, development of SMART and effective action plans, which are implemented and tested on completion to confirm change and improvement. Further, the described framework ensures this is applied with consideration only of clinical criteria and events and therefore without prejudice, discrimination or favour to any group of individuals or those characteristics listed.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?		**Justification/evidence and data source**
Right to life	No	No impact on human rights, the document is as described above; the aims being to reduce risks to the organisation and to improve the quality of care and treatment and delivery of its services and the safety
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	

		and well-being of patients, visitors, staff and the wider public. These aims are in keeping with upholding the human rights listed in the left hand column.
EIA carried out by: Quality assured by: Policies Guidelines and Procedures Group	Date 16/10/2018 27/03/2019	Contact details of person carrying out assessment: e-mail: Alan.clark@lwh.nhs.uk Tel: 0151 702 (4437)