



Policy for Reporting, Investigation and Learning from Deaths in Care

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Approving body	Trust Board
Policy reference	ROH/XXX/NNN [Assigned by Governance Team]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

- 1 – Medical workforce**
- 2 – Governance Team**
- 3. All other staff AHP, Nursing**

POLICY APPROVAL DATE:
August 2017

POLICY
IMPLEMENTATION DATE:
August 2017

DATE POLICY TO BE
REVIEWED:

August 2020

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
1	6-09-2017	Sep-2017	Aug-2020	New policy

Reporting, Investigating and Learning from Deaths in Care Policy

KEY POINTS

1. Organisations should be able to identify when deaths have occurred through a failure of processes and systems.
2. Requirement for organisations to have a forum which has oversight of patient deaths where discussion occurs and learning points are identified and addressed.
3. Numbers of deaths must be presented at Public Trust Board by the executive lead which would ordinarily be the Medical Director from Quarter 3 2017 onwards.
4. Cumulative numbers to be presented in the Annual Quality Accounts.
5. Clinicians identified who have undergone the appropriate training to allow them to undertake a case *Structured Judgement Review* (see appendix 4) and complete the required assessment of cause and avoidability making this available to the Clinical Audit and Effectiveness Committee which is charged with ensuring organizational learning occurs.

Reporting, Investigation and Learning from Deaths in Care

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1.0 INTRODUCTION

- 1.1 As an NHS Organisation we are required to put in place a framework that provides assurance and demonstrates we are learning from deaths that are deemed 'avoidable'. Avoidable has been defined as 'death due to a problem in care' (NQB, 2017) This policy aims to describe the steps required for The Royal Orthopaedic Hospital NHS Foundation Trust (ROHFT) to meet the required standards as laid out within 'A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting ,Investigating and Learning from Deaths in Care (NQB, 2017).Professor Keogh at a conference in March 2017 stated that the aim of the policy is to focus on process driven avoidable mortality he further clarifies this by adding:

'Something that we did that we shouldn't have done or something that we should have done but didn't '

2.0 SCOPE

- 2.1 The principles of identifying, reporting, investigating and learning from Deaths in care applies to all persons working within The Royal Orthopaedic NHS Foundation Trust including locums, GPs with specialist interest, agency staff (medical and nursing) and volunteers.

Categories and selection of deaths in scope for case record review:

- 2.2 The Royal Orthopaedic NHS Foundation Trust will focus reviews on in-patient deaths in line with the criteria detailed below. The rationale for the scope selected by the Trust will need to be published and presented at the Public Board quarterly.
- All deaths where bereaved families and carers, or staff, have raised a **significant concern about the quality of care provision.**
 - The National Quality Board suggests that, Trusts should include cases of people who had been an in-patient but had **died within 30 days of leaving hospital**
 - All in-patient and out-patient deaths of those with **learning disabilities** (the LeDeR review process outlined in app 1 should be adopted in those regions where the programme is available otherwise Structured Judgement Review or another robust and evidence-based methodology should be used) and with severe mental illness.
 - All deaths in a **service specialty, particular diagnosis or treatment group where an 'alarm' has been raised** with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator).
 - All deaths in areas where people are **not expected to die.**
 - Deaths where **learning will inform the provider's existing or planned improvement work**, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.
 - **A further sample of other deaths** that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

- 2.3 The above minimum requirements are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the Mental Health Act 1983 (App 2).
- 2.4 Providers should consider a case record review following any linked inquest and issue of a “Regulation 28 Report on Action to Prevent Future Deaths” in order to examine the effectiveness of their own review process.
- 2.5 Guidance relating to deaths in children and young adults is referred to in appendix 3.

3.0 OTHER POLICIES TO WHICH THIS POLICY RELATES

- Serious Incident Policy
- Incident Reporting Policy
- Duty of Candor Policy

4.0 GLOSSARY AND DEFINITIONS

- 4.1 **Case record review:** The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.
- 4.2 **Investigation:** The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
- 4.3 **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.

5.0 PRINCIPLES

5.1 Context

In December 2016, the Care Quality Commission (CQC) published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

The Secretary of State for Health accepted the report’s recommendations and in a Parliamentary statement⁴ made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

5.2 Accountability

Mortality governance should be a key priority for Trust boards. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

This *National Guidance on Learning from Deaths* should be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks. They should work towards achieving the highest standards in mortality governance. However, different organisations will have different starting points in relation to this agenda and it will take time for all Trusts to meet such standards. Over time this guidance is likely to be updated to include wider providers of NHS care and whole healthcare systems.

5.3 Responding to Deaths

Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care. The standards expected of Trusts are set out in the appendices.

Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of failure of clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, regular mortality reporting to the Board at the public section of the meeting with data suitably anonymised, and outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff.

6.0 ROLES AND RESPONSIBILITIES

6.1 Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to report and manage the requirements of Identifying, Reporting, Investigating and Learning from Deaths in Care (NCB, 2017). The Chief Executive delegates responsibility for the Trust's governance arrangements to the Director of Patient Services.

6.2 Trust Board

The board should ensure that their organisation:

- Has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress.
- Pays particular attention to the care of patients with a learning disability or mental health needs.
- Has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review.
- Adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented.
- Ensures case record reviews and investigations are carried out to a high quality,

acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur.

- Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised.
- Ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts.
- Shares relevant learning across the organisation and with other services where the insight gained could be useful.
- Ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths.
- Offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death.
- Acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved.
- Works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services.
- Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

6.3 Non-Executive Directors

- The boards of directors at the Royal Orthopaedic NHS Foundation Trust are collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, taking into consideration the views of the board of governors.
- Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

6.4 **Quality and Safety Committee**

The Quality and Safety Committee is the designated sub- committee of the Trust Board with responsibility for overseeing all governance and learning from deaths activity within the Trust. The committee will oversee the activity of the Clinical Audit and Effectiveness Committee. The Quality and Safety Committee will be responsible for:

- To provide assurance and upward report to the Trust Board
- Ensuring appropriate policies are in place for the identification, reporting, investigating and learning from deaths in Care and those carers and families are included within the process
- Receive monthly reports providing a synopsis of any deaths and that any patient that has been reported as a serious incident or unexpected death as a detailed case review and lessons learnt clearly actioned and communicated internally and externally to the organisation.

6.5 **Clinical Audit and Effectiveness Committee**

It is the responsibility of the Clinical Audit and Effectiveness Committee to ensure that all deaths are reviewed.

- An assessment has been made to establish that the categories and selection of deaths in scope for case record review has robustly been applied
- Those lessons are learnt from any deaths resulting in a case record review and communicated internally and externally to the Trust
- Ensure that carers and families are involved in the investigations of investigations into deaths that require a case record review.
- To provide a quarterly report into any deaths to the Quality and Safety Committee. This should include: total number of in-patient deaths and the number of those deaths that are subject to a case record review and the number of deaths judged to have been due to problems in the care provided.

6.6 **Medical Director (Executive lead)**

The Medical Director is responsible to the Trust Board and Chief Executive and has a pivotal role in supporting the Trust to deliver and embed the structural approach to learning from deaths through a process of investigation and case note reviews.

- To provide a paper and agenda item to the public Board meeting each quarter
- To oversee the establishment of a case record review process using evidenced based methodology for reviewing the quality of care provided to those patients who die
- The National Quality Board (2017) recommends the Structured Judgement Review (SJR) as the methodology. The Medical Director is responsible for ensuring that Consultants have the necessary training to carry out case record reviews

- To ensure that the quarterly reports are available in the public domain on the Trust website
- To ensure that a summarised account of learning and action taken as a result is provided in the Quality Accounts for 18/19 report

6.7 **Executive Director of Patient Services**

The Executive Director of Patient Services is responsible to the Trust Board and Chief Executive in providing a governance framework is in place and act upon any clinical risk and safety information.

6.8 **Governance Manager**

It is the responsibility of the Governance Manager to:

- To ensure that robust system for reporting, investigating and analysis is in place
- Provide advice on incident reporting and investigations to staff
- Ensure appropriate external reporting of incidents
- Provide advice and guidance to staff in the contractual application of Duty of Candour and in being open with carers and families when errors have occurred or patients have been harmed

6.9 **Responsible Consultant for the patient**

It is the responsibility of the Responsible Consultant to:

- Undertake a review of any death of patient within their care to establish if the death meets the criteria for further investigation and a SJR
- Ensure that families and carers are involved within any investigations
- Consider and report to the Medical Director and the Governance Manager any deaths that full into the category of a serious incident
- Where indicated ensure that a comprehensive investigation and that a SJR is completed within four weeks of the patients death
- Any serious concerns during the investigation to be escalated to the Medical Director and Governance Manager with a completed clinical incident form marked red.

6.10 **All staff**

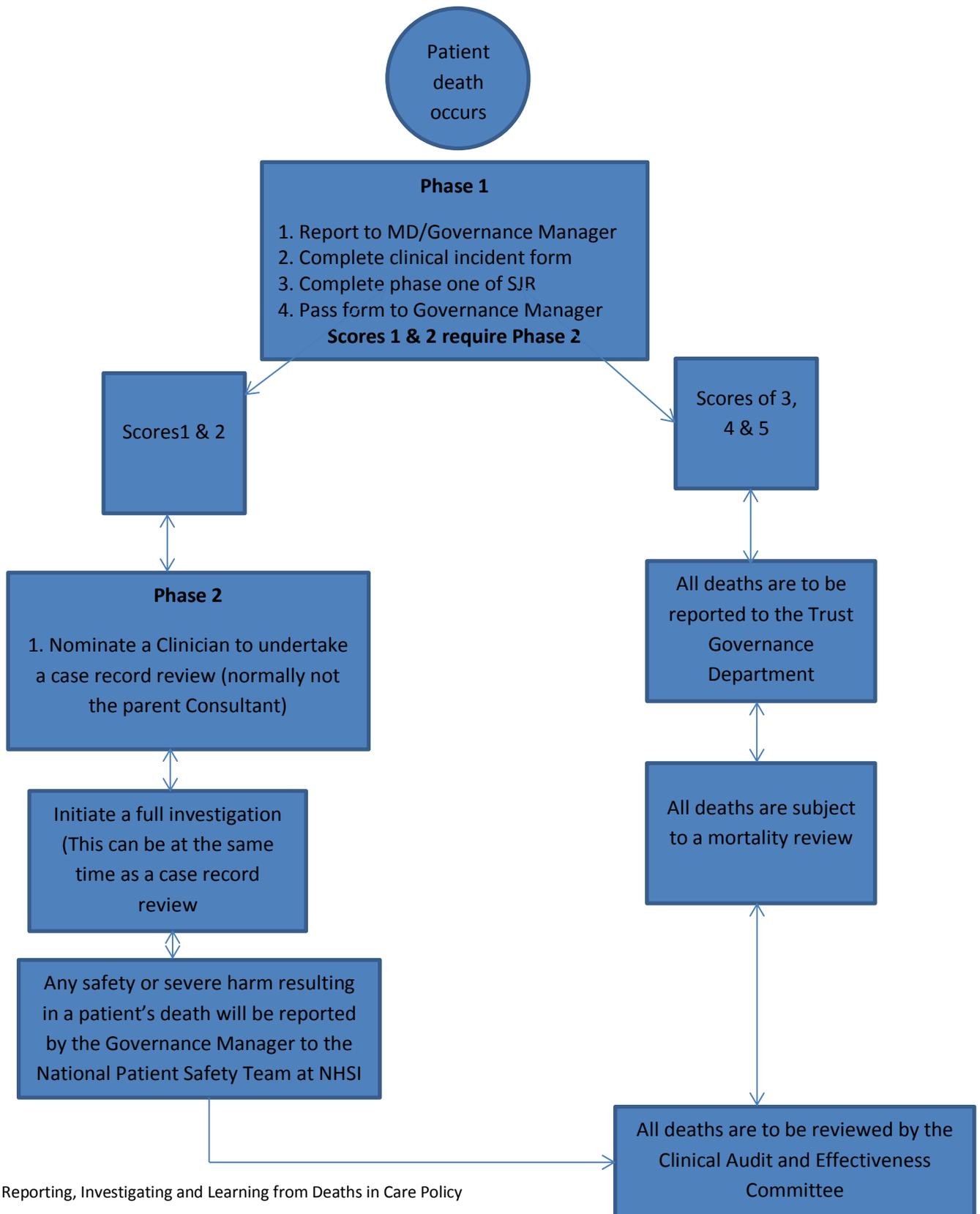
All staff are required to:

- Report any concerns they may have relating to the death of a patient immediately to their line manager
- Report any concern through the Trust clinical incident reporting system
- To assist and co-operate in any investigation process

- Report accurate factual details only regarding the circumstances surrounding an incident
- For all incidents relevant clinical records, documentation, equipment etc. should be secured. Staff are required to ensure that these remain as they were when the incident occurred

7.0 PROCEDURE (refer to appendix 4) –

N.B. Use of the Structured Judgement Review Template (appendix 5) is mandated



8.0 CONSULTATION

- 8.1 This policy has been reviewed by the Medical Director as chair for the Clinical Audit and Effectiveness Committee with oversight by the Quality and Safety Committee a committee of the Trust Board.
- 8.2 An initial draft of this policy was shared with the Executive Team, key clinical and corporate leads and stakeholders for comment and input. Amendments based on feedback received have been included where possible and deemed appropriate.

Individuals whose feedback is ESSENTIAL (role names)	Feedback received (Y/N)	Comments made (where applicable) including nil returns
Medical Director	Y	
Executive Team	Y	Minor comments on process
Deputy Director of Nursing & Clinical Governance	Y	Minor comments on process
Clinical Quality Group	Y	Open discussion and were supported over carers' involvement in the decision making and study days would be needed for medical workforce
Paediatric matron	Y	Minor comments on process
Paediatric Associate Medical Director	Y	Minor comments on process
Individuals whose feedback is DESIRABLE (role names)	Feedback received (Y/N)	Comments made (where applicable) including nil returns

9.0 AUDITABLE STANDARDS/PROCESS FOR MONITORING EFFECTIVENESS

- 9.1 This policy will be monitored through the Clinical Audit and Effectiveness Committee, with quarterly reports submitted to the Quality and Safety Committee. In addition the Trust is required to make available the quarterly reports within the public domain.

10.0 TRAINING AND AWARENESS

10.1 It will be identified which Consultants require further training in Structured Judgment Review methodology and this will be provided by the Trust.

11.0 INCLUSION

11.1 The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriate to their needs. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this.

12.0 REVIEW

12.1 This policy will be reviewed after three years or sooner if significant new information deems it necessary to do so.

13.0 REFERENCE DOCUMENTS AND BIBLIOGRAPHY

1. Royal College of Physicians. National Mortality Case Record Review Programme. Oct 2016. Available at: <https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme>
2. Care Quality Commission. Learning, candour and accountability. 2016. Available at: <https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf>
3. National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting and investigating and learning from deaths in care, National Quality Board (2017).

14.0 APPENDICES

APPENDIX 1 – Guidance for providers for deaths that occur with patients with learning disabilities

Key points to note are:

- All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology
- The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017. If there is a death of a person with learning disabilities in an acute setting in an area that is not yet covered by the LeDeR programme, Trusts are recommended to use the SJR process or a methodology of equivalent quality that meets the requirements for the data that must be collected as an interim measure
- If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: <http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf> The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed
- If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: <http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf> The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed
- Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred
- Trusts are encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Reviewers would be expected to conduct reviews independent of the Trust in which they work

APPENDIX 2 - Deaths in patients with Mental Health Issues

1. Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems.
2. Reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

Inpatients detained under Mental Health Act

1. Regulations require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.
2. Under the Coroners and Justice Act 2009, Coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).
3. In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the *Serious Incident Framework*.

APPENDIX 3 - Children and Young People

1. Infant and Child Mortality

Over the last 20 years, the UK has gone from having one of the lowest mortality rates for 0 to 14 year olds in Europe to one of the highest. In 2014, 4,419 children and young people aged 0 to 18 years old died in England and Wales. 24% of deaths in children and young people are thought to be preventable. In the year ending March 2016, 68% of all deaths occurred in hospital, 22% in the home, 4% in a public place, and 4% in a hospice. In the year ending March 2016, 32% of all deaths occurred following a perinatal or neonatal event, 26% in children with chromosomal, genetic and congenital anomalies, 8% in children with 'sudden unexpected and unexplained' death, 7% in children with malignancy, 6% in children with acute medical or surgical illnesses, 6% in children with infection, 5% in children suffering trauma, 3% in young people taking their life, and 2% following deliberately inflicted injury, abuse or neglect.

In child mortality review, professionals have moved away from defining 'avoidability' to instead using the language of 'a preventable death' where the latter is defined as a death in which 'modifiable factors may have contributed to the death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths'. In the year ending March 2016, 54% of deaths in hospital and 31% of death in the home were identified as having modifiable factors. Most modifiable factors are found in children dying from perinatal/neonatal events, followed by trauma, followed by those with chromosomal, genetic and congenital anomalies'.

2. Children (1-9 years)

The main factors that contribute to death during childhood are different to those that contribute to death during infancy or adolescence. The common causes of death amongst 1 to 9 year-olds are cancer, injuries and poisonings, congenital conditions and neurological and developmental disorders. Injuries and poisonings from external causes are the leading cause of death in boys aged one to four years, whilst cancer is the leading cause of death leading cause of death in girls of the same age. For both girls and boys five to nine years of age, cancer is the leading cause of death. Very early life also still has an impact on mortality in later childhood; children who were born preterm remain more likely to die before age 10 years compared to children born at term.

In the period 2012-2014, the mortality rate in children aged 1-9 years in the U.K. was 12.1 per 100,000 population. Although the mortality rate has declined across the UK since the 1970s, the UK's recent progress has been significantly lower than in other wealthy European countries, and concerning the incidence of death due to diseases such as asthma and diabetes is higher than equivalent high-income countries. The scale of difference between the UK child mortality rate and the average suggests there are around 130 excess deaths of 1- to 9-year-olds each year in the UK.

Many childhood deaths are preventable. As with infants there is a strong association between deprivation, social inequality, and mortality. Causes amenable to interventions include environmental and social factors as well as health service factors and key actions include the following:

- creating safe environments, including access to information and safety equipment schemes to promote safety in the home
- reduce road speed limits in built-up areas to 20mph
- ensuring that clinical teams looking after children with long-term conditions such as asthma, epilepsy and diabetes deliver care to the highest standards, incorporating good communication, open access for patients and families, use of established tools such as the epilepsy passport and asthma plan, adherence to the components prevalent in the best practice tariff for diabetes, and address early the optimal conditions for safe transition to adult services. Implicit in this is teaching self-management and ownership of the condition
- Increasing the provision of high-quality end-of-life care and access to appropriate palliative care; delivering integrated health systems across primary and secondary care; whilst providing the optimal configuration of specialist services for children with complex conditions needing tertiary care, such as cardiac, renal conditions and children's cancer

3. Young People (10-19 years)

After the first year of life, adolescence is the life stage when children are most likely to die. The factors leading to death in adolescence are different to those in earlier childhood, and differ between males and females. The most common causes of death in this age group are injuries, violence and suicide, followed by cancer, substance misuse disorders and nervous system and developmental disorders.

Although the mortality rate in young people has decreased across the UK since the 1970s, progress recently has been slower than that seen in other wealthy countries. The UK's 'average' adolescent overall mortality today is a mixed picture. Whilst our injury mortality rate is amongst the lowest, we have a higher rate of deaths due to 'non-communicable diseases' such as asthma than other equivalent wealthy countries. Social inequalities are important since injury and illness are associated with poor environmental conditions and hazards such as smoking, alcohol, and drug use.

Many deaths are preventable and key actions include:

- reducing deaths from traffic injuries through the introduction of graduated licensing schemes
- improving adolescent mental health services
- improving services for children with long term conditions, and especially those transitioning to adult care
- increasing the involvement of young people and their families with rare and common long-term conditions in developing guidelines, measuring outcomes, service design and research trials

Underpinning all efforts to reduce child mortality in England lies an urgent need to collect high-quality data to better understand the reasons why children die, to allow accurate international comparisons, and to inform health policy. This requires a national system for the analysis of child mortality data, as well as improved child death review processes.

Historical Background to the Process of Child Mortality Review

Since 1 April 2008, Local Safeguarding Children's Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such

responsibility is enshrined in the Children's Act 2004 and applies to all children under 18 years of age. The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document, *Working Together to Safeguard Children*. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths. *Working Together* describes two interrelated processes:

1. a "Rapid Response" multi-professional investigation of an individual unexpected death
2. a Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CDOP is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process.

Drivers for Change including new legislation

The review of child deaths has been, to date, far more comprehensive than that for adults. However the following drivers for change exist:

1. **Variation in process.** There is significant variation across the system in how child deaths are reviewed, which deaths are reviewed, and the quality of the review.

Specifically:

- 'unexpected' deaths in the community are generally reviewed as per the Sudden Unexpected Deaths in Infancy (SUDI) process. However there is variation in when a death is considered "unexpected" and in the timing of triggering investigations
 - hospital deaths are usually reviewed at a Mortality and Morbidity (M&M) meeting. However there is wide variation, across the NHS, in how these meetings are convened, no standardisation on terminology, and a confused array of investigations (root cause analysis, serious incident inquiry, and mortality review) that follow certain types of deaths
 - there is wide variation in CDOP processes (size, structure and functioning) and CDOP panels are dislocated from governance processes within their local children's hospital.
2. **The Wood Review.** In 2016, Alan Wood recommended that national responsibility for child death reviews should move from the Department for Education to the Department of Health, that DH should re-consider how CDOPs should best be supported within the new arrangements of the NHS, and that DH should determine how CDOPs might be better configured on a regional basis with sub-regional structures to promote learning. He also recommended that child deaths be reviewed over a population size that allowed a sufficient number of deaths to be analysed for patterns and themes. He went further to recommend that the NHS consider the role CDOPs should play in the process for achieving a common national standard for high quality serious incident investigations. Finally, he supported the intention to introduce a national child mortality database, and urged DH to expedite its introduction.
 3. **The National Adult Case Review** programme. This programme uses a very different structured judgment review (SJR) methodology to that used in child mortality review. It focuses on problems in health care processes within an organisation rather than trying to understand the cause of death. Cases in which care is judged to be poor are scored according to an 'Avoidability of Death' scale. It is important to recognise that many 16 and 17 year olds die in adult ITU's and therefore it is important to understand what processes should take precedence in the review of such

patients.

4. **Medical Examiner process.** The Medical Examiner will be introduced across England. This appointee will link with bereaved families as well as the Coroner and their involvement will affect all mortality review processes.
5. **CQC report: Learning, Candour, and Accountability.** This report identified inconsistencies in: the involvement of families and carers; the process of identifying and reporting the death; how decisions to review or investigate a death was made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions.
6. **Legislative change (*Children and Social Work Bill 2017*).** The Wood Review recommendation that national responsibility for child death reviews should move from the Department for Education to the Department of Health is being enacted through the Children and Social Work Bill 2017. Under the new legislation, local authorities and clinical commissioning groups are named as 'child death review partners' and must make arrangements for the review of each death of a child normally resident in the local authority area. They may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. The proposed legislation also states that the 'child death review partners' must make arrangements for the analysis of information about deaths reviewed and identify any matters relating to the death or deaths in that area a) relevant to the welfare of children in the area or to public health and safety and b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

National Child Mortality Programme

NHS England is undertaking a national review of child mortality review processes both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life. Central to the programme is the creation of a National Child Mortality Database, which is currently being commissioned. The effective functioning of the national database requires high-quality, standardised data arising from simplified and standardised local mortality and CDOP review processes. NHS England have therefore established 3 work streams:

- the simplification and standardisation of mortality review processes in the community and hospital;
- a review of the governance arrangements and standardisation of CDOP processes;
- the creation of the national child mortality database.

The goals of the NHS England's child mortality review programme are to:

- establish, as far as possible, the cause or causes of each child's death
- identify any potential contributory or modifiable factors
- provide on-going support to the family
- ensure that all statutory obligations are met
- learn lessons in order to reduce the risk of future child deaths

- establish a robust evidence base to inform national policy across government to reduce avoidable child mortality across the UK nations

NHS England, the Department of Health and the Department for Education are working together to produce new statutory guidance for child death review. This guidance will cover the processes which should take place following the death of a child, and in particular how the death should be reviewed at local mortality meeting and child death overview panel. This new guidance will be published in late 2017.

Reporting

The definitions used within the adult Case Review programme for record review and to identify problems in care are not recognised within *Working Together*. NHS England's work programme intends to identify best practice and standardise processes across deaths in hospital and the community, to improve the experience of families and professionals. The deaths of children who are treated in acute, mental health and community NHS Trusts should be included by Trusts in quarterly reporting from April 2017. The information should come from child death review processes, and should include reporting problems related to service delivery.

APPENDIX 4

Structured Judgement Review

Background to the method and its strengths

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, methods need to be standardised, yet not rigid, and usable across services, teams and specialists.

Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase and to score care for each phase¹. The result is a relatively short but rich set of information about each case in a format that can also be aggregated to produce knowledge about clinical services and systems of care.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions.

Structured judgement case note review can be used for a wide range of hospital-based safety and quality review across services and specialities and not only for those cases where people die in hospital. For example, it has been used to assess the care provided for people who have had a cardiac arrest in hospital, to review safety and quality of care prior to and during non-elective admission to intensive care settings and to review the care provided for people admitted at different times of the week.

An important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that has been judged to be problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

How the Structured judgement review method works

1. Who does what and when?

There are two stages to the review process. The first stage is mainly the domain of what might be called 'front line' reviewers, who are trained in the method and who undertake reviews within their own services or directorates, sometimes as mortality and morbidity (M&M) reviews, sometimes as part of a team looking at the care of groups of cases. This is where the bulk of the reviewing is done and most of the reviews are completed at this point.

A second-stage review is recommended where care problems have been identified by a first-stage reviewer and an overall care score of 1 or 2 has been used to rate care as very poor or poor. This second-stage review is usually undertaken within the hospital governance process and normally uses the same review method. At this stage the hospitals may also choose to assess the potential avoidability of a death where harms due to care have been identified (see Section 4 below and *A clinical governance guide* (RCP 2016) associated with the review guide).

2. Phases of Care – the ‘structure’ part of the method

The phase of care structure provides a generalised framework for the review and also allows for comparisons among groups of cases at different stages of care. The principal phase descriptors are shown in Box 1. However the use of the phase structure depends on the type of care and service being reviewed – not all phase of care headings will be used for any particular case. Thus the procedure-based review section may only be required in a few medical cases (e.g. a lumbar puncture, a chest drain or non-invasive ventilation) but are likely to be used in many surgical cases. It is up to the reviewer to judge which phase of care forms are appropriate in a particular case.

Box 1 Phase of care headings

- Admission and initial care – first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/procedure care
- End-of-life care (or discharge care)*
- Assessment of care overall

*Note that discharge care is included because this method is just as applicable for the review of care for people who do not die during an admission

3. Explicit judgement comments – the core of the method

The purpose of the review is to provide information from which teams or the organisation can learn. Explicit judgement commentaries serve two main purposes. First, they allow the reviewer to concisely describe how and why they assess the safety and quality of care provided. Second, they provide a commentary that other health professionals can readily understand if they subsequently look at the completed review.

When asked to write comments on the quality and safety of care, clinical staff often tend to write a resume of the notes or make an *implicit* critique of care. This is not helpful when others try to understand the reviewer’s real meaning. So the central part of the review process comprises short, written, *explicit* judgement statements about the perceived safety and quality of care that is provided in each care phase.

This review guide does not include a glossary of explicit terms that reviewers might choose from, because this approach would inevitably be constraining or would fail to cover all eventualities in the complexities of clinical practice. Instead, reviewers are asked to use their own words in a way that explicitly states their assessment of an aspect of care and gives a short justification for why they have made the assessment.

Explicit statements use judgement words and phrases such as ‘good’, ‘unsatisfactory’, ‘failure’ or ‘best practice’. See Box 2 and Box 3 for examples.

Box 2 Examples of phase of care structured judgement comments

- Continued omission to provide oxygen and respiratory support – poor care.
- Team still failed to discuss potential diagnosis with patient – unsatisfactory.
- Referral to intensive treatment unit (ITU) was too late
- There was some evidence of good management by the overnight team, with prompt review and intervention.
- Although patient discussed with a consultant once and a specialist registrar (SpR) once, for 3 days they were only seen by junior doctors – this is completely unsatisfactory.
- Very good care – rapid triage and identification of diabetic ketoacidosis with appropriate treatment.

Additionally, these judgement words are accompanied by short statements that provide an explicit reason why a judgement is made – e.g. ‘unsatisfactory because, etc.’ and ‘for example, resuscitation and ceiling of treatment decisions made far too late in course of admission – poor care’. The purpose here is not to write long sentences but to encapsulate the clinical process in a few explicit statements.

Judgement comments should be made on anything the reviewer thinks is important for a particular case. Among other things, this will include the appropriateness of management plans and subsequent implementation together with the extent to which, and how, care meets good practice. In some cases, there may be care in a phase that has both good and poor aspects. Both should be commented on.

Commentary on holistic care is just as important as commentary on technical care, particularly where complex ceiling of treatment and end-of-life care discussions might be held. Judgements should be made on how the teams have managed end-of-life decision making and to what extent patients and their relatives have been involved. Thus, for example, a judgement comment might be couched as ‘end-of-life care met recommended practice, good ceiling of treatment discussions with patient and family’. Similar approaches and levels of detail are required when care is thought not to have gone well, or where aspects of care are judged to be only just acceptable. Then words such as ‘unsatisfactory’, ‘poor’ or ‘doesn’t meet good practice standards’ might be necessary.

Sometimes it is just not clear what has been happening during part of the process of care, where there appears to be a lack of decision making or guidance. Here, judgement words such as ‘delay’, ‘poor planning’ and ‘lack of clarity is due to the level of documentation, comments such as ‘inadequate record keeping’ may apply.

Overall, phase of care comments are intended to bring a focus to the review by asking for an explicit, clear judgement on what the reviewer thinks of the whole care episode, taking all aspects into consideration. It is not necessary to repeat all of what has been commented on before, although it is sometimes useful to repeat some key messages – that is a reviewer’s choice. Again, however, it is important to make clear and explicit what the overall judgement is and why. Examples are given in Box 3.

Box 3 Examples of overall care structured judgement comments

- Overall, a fundamental failure to recognise the severity of this patient’s respiratory failure.
- Good multidisciplinary team involvement.
- On the whole, good documentation of clinical findings, investigation results, management plan and discussion with other teams.
- Poor practice not to be aware of the do not attempt resuscitation (DNAR) status of the patient, especially when it has been discussed with family, clearly documented when first put in place and reviewed later on.

Cause of death information should form part of the review framework. If, on review, the certified cause of death causes the reviewer some concern, this should be explicitly stated, because there may be a clinical governance question involved.

So the overall message about review language is that it should be explicit and clear, in order that you, the reviewer, feel you have made the points clearly and that others who read the review will be able to understand what you have said and why.

4. Giving phase of care scores

Box 4 Phase of care scores

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

Care scores are recorded after the judgement comments have been written, and the score is in itself the result of a judgement by the reviewer. Only one score is given per phase of care: it is not necessary to score each judgement statement.

Scores range from 'Excellent' (score 5) to 'Very poor' (score 1) – see Box 4 – and are given for each phase of care that is commented on and for care overall.

These scores have a number of uses. For the individual reviewer, scores help them to come to a rounded judgement on the phase of care, particularly when there may be a mix of good and unsatisfactory care within a phase. The reviewer must judge what their overall decision is about the care provided for each phase and for care overall. Scoring makes this very explicit.

Overall care scores are particularly important in the review process. A score of 1 or 2 is given when the reviewer decides that care has been very poor or poor. Research evidence suggests that this might happen in upwards of 10% of cases in some circumstances, but less in others. A score at this level should trigger a second-stage review through the hospital clinical governance process (see Section 4).

5. Judging whether problems in care have caused harm

Problems in care take many forms and may have a range of impacts, some of which are potential rather than actual. Some of these events cause harms, but many do not.

The first-stage reviewer has an important role here in assisting the hospital to identify both actual and potential threats to patient safety. Using the assessment sheet at Appendix 1, reviewers are asked three questions in relation to problems identified in care. These are in the following format.

- A. Were there one or more problems in care during this admission? Yes or no
- B. If so, in which area(s) of the care process did this/these occur?
- C. And for each of these problems, did any cause harm?

While the results of this assessment will be of importance in clarifying the issues in each review, it is the information aggregated across reviews that may pick up more fundamental care process issues that require attention.

6. Judging the quality of recording in the case notes

Case note review of course depends critically on the content and the legibility of the records. Safety of care also depends to some extent on good record keeping. Therefore, as part of the overall care assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records, again using a score of 1-5.

7. The review in practice

Case note review takes up expensive clinical resource so that the time spent on establishing the purpose and desired outcome of the review is important.

In some hospitals, the majority of mortality reviews take place in an M&M context and so they are often already being considered to be potentially problematic cases. Structured judgement review has been found to be of value in providing a reproducible process for M&Ms.

However the challenge for hospitals has often been the gathering together of the material from the reviews so that it can be used to examine care processes. Data from M&M cases should be entered into the hospital reviews database. Aggregated information is more powerful in the longer term than the data from individual cases.

Screening deaths for possible problem is another means of indicating where focused reviews are necessary. Valuable information about specific issues can be gained in this way, although generalising messages from complex cases can produce 'solutions' that may themselves have unintended consequences.

Another approach is to evaluate care for all or some patients who come to a particular service, or to explore the care provided for the majority of people who die in hospital over a particular time period in particular services; for example, all elective surgery deaths or people who die from acute kidney injury might require review. This aspect is covered in some detail in the *governance guidance* which forms part of the overall guidance materials.

Given the constraints on reviewer availability and the need to produce usable information from the reviews, the principle of 'less is more' applies.

A simple time-based longitudinal sample of around 40-50 cases will produce a rich source of quantitative and qualitative information on what goes right and what is not working properly. Timely review, rather than review after a delay, provides better information.

Time spent on the analysis and information presentation outweighs the benefit of adding a few more cases to the sample. The textual information allows for themes to be developed that then allows a focus for the next improvement steps. Such an approach also has the benefit of enabling individuals to learn from, and celebrate, the cases where care has gone well.

8. Second-stage review

In the context of the National Mortality Case Record Review Programme, second-stage review takes place within the hospital governance framework when the first-stage 'front line' reviewer judges care overall to be very poor (score 1) or poor (score 2), or when harms have been identified, or if concerns have been raised about a case.

Second-stage review is also undertaken using the structured judgement method and is effectively a process of validation of the first reviewer's concerns. If the second-stage reviewer broadly agrees with the initial case review (with poor or very poor overall scores and/or where actual harm(s) is judged to have occurred), the hospital governance group may decide on an additional assessment concerning the potential avoidability of the patient's death.

Judging the level of the avoidability of a death is a complex assessment that can be challenging to undertake. This is because the assessment goes beyond judging safety and quality of care by also taking account of such issues as comorbidities and estimated life expectancy. Recent evidence suggests the levels of agreement can be very low when assessing potential avoidability of death.

The judgement is framed by a six-point scale (6 – no evidence of avoidability, to 1 – definitely avoidable). This scale has been used in a number of recent national mortality review studies in Canada, the Netherlands and England ². Additionally, the national review process, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made.

The avoidability scale is shown in Box 5, together with an example of an ‘avoidability of death’ judgement comment. A score of 1, 2 or 3 on the avoidability scale would indicate a governance ‘cause for concern’

Box 5 ‘Avoidability of death’ scale

Score 1	Definitely avoidable
Score 2	Strong evidence of avoidability
Score 3	Probably avoidable (more than 50:50)
Score 4	Possibly avoidable, but not very likely (less than 50:50)
Score 5	Slight evidence of avoidability
Score 6	Definitely not avoidable
Example structured judgement commentary	
Non-invasive ventilation management was sub-optimal, but ultimately it was the patient’s wish not to continue treatment. There may have been an alternative cause of breathlessness that was not fully explored or treated, which is why there may have been some avoidability.	
Score 5 – slight evidence of avoidability	

Appendix 1 – Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick) No

(please stop here) Yes (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls): Yes

Did the problem lead to harm? No Probably Yes

2. Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic): Yes

Did the problem lead to harm? No Probably Yes

- 3. Problem related to treatment and management plan** (including prevention of pressure ulcers, falls, VTE): Yes
- Did the problem lead to harm? No Probably Yes
- 4. Problem with infection control:** Yes
- Did the problem lead to harm? No Probably Yes
- 5. Problem related to operation/invasive procedure** (other than infection control): Yes
- Did the problem lead to harm? No Probably Yes
- 6. Problem in clinical monitoring** (including failure to plan, to undertake, or to recognise and respond to changes): Yes
- Did the problem lead to harm? No Probably Yes
- 7. Problem in resuscitation following a cardiac or respiratory arrest** (including cardiopulmonary resuscitation (CPR)): Yes
- Did the problem lead to harm? No Probably Yes
- 8. Problem of any other type not fitting the categories above:** Yes
- Did the problem lead to harm? No Probably Yes

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

Editorial note

This document has been adapted with permission from: Hutchinson A, McCooe M, Ryland E. *A guide to safety, quality and mortality review using the structured judgement case note review method*. Bradford: The Yorkshire and the Humber Improvement Academy, 2015. (Copyright The Yorkshire and the Humber Improvement Academy.)

The case note review methods discussed in this guide were primarily developed in a research study published as: Hutchinson A, Coster JE, Cooper KL, McIntosh A, Walters SJ, Bath PA *et al*. Comparison of case note review methods for evaluating quality and safety in health care. *Health Technol Assess* 2010; 14(10):1-165.

All clinical examples and structured judgement comments in this document are taken from hypothetical scenarios.

Please note that this guide is subject to change following conclusion of the pilot phase of the programme.

References

1. Hutchinson A, Coster JE, Cooper KL, Pearson M, McIntosh A, Bath PA. A structured judgement method to enhance mortality case note review: development and evaluation. *BMJ Quality and Safety* 2013;22:1032– 1040. DOI: 10.1136/bmjqs-2013-001839.
2. Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239.
3. Royal College of Physicians. *Using the structured judgement review method – a clinical governance guide to mortality case record reviews*. London: RCP, 2016.

ROH STRUCTURED JUDGEMENT REVIEW

(to be completed with reference to appendix 4 of *Policy for Reporting, Investigating and Learning from Deaths in Care*)

Hospital Number:
Reviewer:

STAGE ONE (Front Line Review)

a) Phase of Care

Phase of Care	Care Score
Administration & initial care in first 24 hours	
Ongoing care	
Care during a procedure	
Perioperative/procedure care	
End-of-life/Discharge care	
Assessment of overall care	
TOTAL SCORE	

b) Explicit Judgement Statement(s):

Level of Care	Score
Very Poor	1
Poor	2
Adequate	3
Good	4
Excellent	5

c) Overall Care Structured Judgement Comments:

d) Was harm caused through problems in care? YES / NO

e) Were there one or more problems in care during this admission? YES / NO
(use questions in appendix 1 to make this judgement)

f) If so, in which area(s) of the care process did this/these occur? Complete in table below

g) For each problem did any cause harm?

Problem	Harm Caused	
	Yes	No

h) Judging recording in the case notes – quality and legibility

Quality of Medical Records	Score	Tick
Very poor	1	
Poor	2	
Adequate	3	
Good	4	
Excellent	5	

Do you consider that:

- 1) Care overall was very poor (score 1) or poor (score 2) YES / NO
2) Harm has been identified YES / NO
3) Concerns raised YES / NO

If the answer to any of these 3 questions is YES, a SECOND-STAGE review is required by the Trust Governance Manager

i) Avoidability of Death

Avoidability	Score	Tick
Definitely avoidable	1	
Strong evidence of avoidability	2	
Probable avoidability (more than 50:50)	3	
Possible avoidability (less than 50:50)	4	
Slight evidence of avoidability	5	
Definitely not avoidable	6	

*****PLEASE PASS TO TRUST GOVERNANCE MANAGER ONCE COMPLETED*****

Appendix 1 : Assessment of Problems in Healthcare

Were there any problems with the care of the patient? (Please tick)

No (please stop here) Yes (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

9. Problem in assessment, investigation or diagnosis (*including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls*): Yes

Did the problem lead to harm? No Probably Yes

10. Problem with medication / IV fluids / electrolytes / oxygen (*other than anaesthetic*): Yes

Did the problem lead to harm? No Probably Yes

11. Problem related to treatment and management plan (*including prevention of pressure ulcers, falls, VTE*): Yes

Did the problem lead to harm? No Probably Yes

12. Problem with infection control: Yes

Did the problem lead to harm? No Probably Yes

13. Problem related to operation/invasive procedure (*other than infection control*): Yes

Did the problem lead to harm? No Probably Yes

14. Problem in clinical monitoring (*including failure to plan, to undertake, or to recognise and respond to changes*): Yes

Did the problem lead to harm? No Probably Yes

15. Problem in resuscitation following a cardiac or respiratory arrest (*including cardiopulmonary resuscitation (CPR)*): Yes

Did the problem lead to harm? No Probably Yes

16. Problem of any other type not fitting the categories above (state problem): Yes

Did the problem lead to harm? No Probably Yes



Equality Impact Assessment

Initial Assessment form

The Initial Equality Impact Assessment (EIA) is a quick and easy screening process. It should:

1. Identify those policies which require a full EIA by looking at:
 - Negative, positive or no impact on any of the protected characteristics.
 - Opportunity to promote equality for the protected characteristics.
 - Data/feedback to prioritise if and when a full EIA should be completed
2. Justify reasons why a full EIA is not going to be completed

Division or Corporate area:

Division 1 & 2

Speciality/Service Area

Clinical

Executive Lead (name and designation):

A Pearson – Executive Medical Director

Title of Policy:

Reporting, Investigating and Learning from Deaths in Care Policy

Q1) What is the aim of your Policy?

Ensure a culture of learning from deaths is embedded in the Trust

Q2) State to which Trust strategic objective this Policy relates:

Safe patient care

Q3) Who benefits from your Policy?

Patients and Staff

Q4) Do you have any feedback data that influences, affects or shapes this Policy?

Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>
Please complete below.	Please go to question 5

What is your source of feedback?

- Monitoring Data
- Previous EIAs
- National Reports
- Internal Audits
- Patient Surveys
- Complaints / Incidents / Claims / Litigation
- Focus Groups
- Equality & Diversity Training
- Other (please state)

What does this source of feedback reveal?

Q5) Thinking about each group below does or could the Policy have a negative impact on members of the protected characteristics below?

Protected Characteristic	Yes	No	Unclear
Age	<input type="checkbox"/>	X	<input type="checkbox"/>
Disability	<input type="checkbox"/>	X	<input type="checkbox"/>
Race	<input type="checkbox"/>	X	<input type="checkbox"/>
Sex	<input type="checkbox"/>	X	<input type="checkbox"/>
Gender Reassignment	<input type="checkbox"/>	X	<input type="checkbox"/>
Sexual Orientation	<input type="checkbox"/>	X	<input type="checkbox"/>
Religion or belief	<input type="checkbox"/>	X	<input type="checkbox"/>
Pregnancy & Maternity	<input type="checkbox"/>	X	<input type="checkbox"/>
Marriage & Civil Partnership	<input type="checkbox"/>	X	<input type="checkbox"/>

Other socially excluded groups	<input type="checkbox"/>	X	<input type="checkbox"/>
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If the answer is “yes” or “Unclear” please complete a full EIA

Q6) Who was involved in the EIA and how?

<p>Medical Director</p> <p>Deputy Director of Nursing & Governance</p>
<p>How were they involved?</p> <p><input type="checkbox"/> Surveys</p> <p><input type="checkbox"/> Team Meeting</p> <p><input type="checkbox"/> Group Review</p> <p>X Other</p> <p>Please specify: Corporate leads for NHS Improvement required action</p>

Q7) Have you identified a negative/potential negative impact (direct /indirect discrimination)?

No	X	yes	<input type="checkbox"/>
----	---	-----	--------------------------

Q7a) If ‘No’ Explain why you have made this decision?

There is no discriminatory impact of applying the principles of learning from deaths to assess if avoidable

Q7b) If ‘yes’ explain the negative impact – you may need to complete a full EIA

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If a negative impact has been identified please continue to undertaking a full impact assessment. If no negative impact has been identified please submit your Initial Equality Impact Assessment to roh-tr.governance@nhs.net

Justification Statement:

As member of ROH staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete this EIA by law. By stating that you have not identified a negative impact, you are agreeing that the organisation has not discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Completed by:

Name:	A M Pearson
Designation:	Medical Director
Date:	22.08.17
Contact number:	0121 685 4166

This EIA has been approved:

Name:	
Designation:	
Date:	
Contact number:	



POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Reporting, Investigating and Learning from Deaths in Care
ACCOUNTABLE EXECUTIVE LEAD:	Andrew Pearson – Medical Director
POLICY AUTHOR:	Andrew Pearson
APPROVED BY:	
DATE OF APPROVAL:	

An implementation plan must be developed for all policies. This will ensure that a systematic approach is taken to the introduction of policies in order to secure effective working practices.

The following template provides a list of activities to consider as a starting point for thinking about implementation in a systematic manner

Policy Implementation Plan

Monitoring body (Internal and/or External):	Trust Board/ NHS Improvement
Reason for action plan:	NHS Improvement request
Date of action plan approval:	6 September 2017
Executive Sponsor:	Mr Pearson, Executive Medical Director
Operational Lead:	Mrs Jo Wakeman, Deputy Director of Nursing & Clinical Governance
Frequency of review:	Monthly
Date of last review:	Not applicable
Expected completion of action plan:	October 2017

REF	ACTION	SENIOR/EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
1	The NQB launched its Learning From Deaths policy in March 2017. The policy set out several key requirements including:						
	From April 2017, trusts must collect new quarterly information on deaths including: the total number of patient deaths; the number of deaths subject to case record review; the number investigated as SIs; an estimate of the number	AP	JW			Completed	

REF	ACTION	SENIOR/EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
	thought more likely than not to have been caused by problems in care; the main themes and trends emerging from review and investigation; and what the trust is doing to address those themes and trends in order to improve care.						
	By September 2017, trusts should publish an updated policy on how they respond to and learn from the deaths of patients in their care.	AP	JW	Sept 17		Completed	
	From Q3 2017 onwards they must publish information on deaths, reviews and investigations quarterly via an agenda item and paper to their public board meetings.	AP	JW	Dec 17		Structure in place monitored through CAEC .	
	From June 2018, trusts must publish an annual summary of this data in their quarterly accounts.	AP	JW	18/19		Monitored as part of the quarterly updates through CQG. One of the key deliverables for 16/17 quality Accounts.	
	Publish a Learning from Deaths policy	AP	JW	Sept 17		Completed	
	Ensure that the web address for the policy is communicated to NHS Improvement	AP	SGL				
	Trust Board meeting considers the first published data required by the Learning from Death policy	AP		6 September 17		28 th June 2017 – Q & S Executive sign off 22 August 2017	

Key to initials of leads

AP	Andrew Pearson, Executive Medical Director
JW	Jo Wakeman, Deputy Director of Nursing & Clinical Governance
SGL	Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary

