Royal Surrey County Hospital NHS
NHS Foundation Trust

Mortality Policy

Learning from Deaths

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Name of Review/ Development Body:	Mortality Review Group
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Associated Documents:

- Trust Incidents and Serious Incidents Management Policy September 2016
- Trust Being Open Policy 2016
- Mental Capacity Act Code of Practice
- Learning Disability Alert
- Learning Disabilities Mortality Review (LeDeR) Programme, Guidance for the conduct of local reviews of the deaths of people with learning disabilities,(HQIP)
- Trust Risk Management Strategy Policy 2016
- Trust Clinical Audit Policy 2016
- Trust Guideline for Pregnancy Loss: Miscarriage, Stillbirth and Neonatal Death Policy 2016
- Trust Complaints and Concerns Policy, 2015
- Trust Maternal Death Policy, 2016

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1 INTRODUCTION / BACKGROUND

Concern about patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures that have taken place in recent years. There is an increased drive for NHS Trust boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

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 statement, 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 actions in place as a response to that information, in Quality Accounts from June 2018.

In March 2017, the National Quality Board issued a guidance document which sets out the framework for NHS Foundation Trusts. In the foreword, it states:

"Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This policy is our response to the publication of this national guidance.

The Policy refers to three levels of scrutiny to be applied to the care provided when someone dies. These are:

1. Team Doctor Review & Consultant Review
2. Structured Judgement Review
3. Serious Incident Review

A standardised approach will be implemented, to facilitate identification of learning and make quality improvements in collaboration with our staff and patients and the wider healthcare system.

2 PURPOSE AND OBJECTIVES

This policy sets out our agreed process to ensure a consistent and coordinated approach for responding to and learning from deaths. We describe our arrangements for responding as required in the National Guidance on Learning from Deaths, National Quality Board, March 2017 Annex C. We describe our review process and the responsibilities aligned to it. We set out our commitment to learning.

2.1. Our Agreed Principles & Practice: Responding to Death

These are the standards we have agreed:

a) We will implement a framework for a comprehensive mortality review process which includes a scope for case selection as stated in Section 3.
b) Structured Judgement Reviews will be undertaken to a consistent standard with reviewers adopting a comprehensive approach which looks at the care provided from admission to death.
c) We will use a set of metrics to monitor the conduct of reviews, and report this performance to the Trust mortality review group on a monthly basis.
d) When an inpatient death occurs, the clinical team responsible for the care of the patient will identify if the death requires structured judgement review (SJR), according to a set of agreed criteria; and notify the Trust Mortality Coordinator thereby triggering the SJR process.
e) When someone who has a learning disability dies we will implement the LeDeR process and also include the case within the scope of SJRs.
f) When a patient flagged as having a Mental Health condition we will implement the appropriate process and also include the case within the scope of SJRs.
g) When a maternal death occurs, the Head of Midwifery will implement the agreed process for reporting and investigating the case and will ensure that a mortality (SJR) review is undertaken as part of this process.
h) When an infant or child dies the Chief of Service for Women & Children Services will implement the agreed process for reporting and investigating the case and will ensure that a mortality (SJR) review is undertaken as part of this process.
i) We will invite other providers to inform us of deaths which may have been influenced by the care we delivered, to an agreed protocol and via reciprocal information sharing agreements.
j) We will undertake periodic reviews of cases of patients not selected for SJR on the basis of concern regarding care. These cases will be reviewed using identical SJR methodology.
k) We will keep clear and transparent records of case selection for SJR review.
l) We will communicate with openness and transparency with bereaved families and carers: ensuring engagement is meaningful and compassionate at every stage; from notification of death to the investigation report, lessons learned and actions implemented.
m) We will identify and implement a mechanism for supporting the bereaved and our staff to obtain appropriate legal advice in accordance with national guidance.

3 SCOPE

This policy and supporting processes apply to all professional and administrative staff who deal with mortality cases and data under the auspices of the Trust.

This policy provides a method of implementing national guidance for learning from deaths and whilst the cases will span clinical specialties, the structured judgement reviews are distinct from any specialty reviews which are undertaken by clinicians as part of audit or other service improvement activity.

The policy allows for senior non-medical staff, where appropriately qualified and trained, to undertake SJR reviews alongside medical Consultant colleagues in the context of a supportive mortality faculty and assurance of review quality and consistency, with oversight from the mortality review group.

This policy should be read with the Trust's Incidents and Serious Incidents Management Policy; Complaints and Concerns Resolution Policy; and the Corporate Governance Handbook.

3.1 Inclusions

From 1 October 2017, the policy will be applied to all adult in-hospital deaths. Work will commence in earnest to better understand deaths occurring within 30 days of discharge.

Other groups

Maternal deaths and deaths of children and young people under the age of 18 years are governed by the principles in this policy and we will continue to use our current processes to review each death. Learning and outcomes of these reviews will be shared with the Mortality Review Group (MRG) via a formal report.

When a child dies unexpectedly we will follow the Surrey Safeguarding Children's Board "Child Death Review Guidance", contacting the police, the coroner, the safeguarding team and social services. For all child deaths we will contact the GP, the NHS safeguarding Team, community child health, named safeguarding lead (community) and the child death overview panel.

The recent launch of the Learning Disabilities Mortality Review (LeDeR) Programme for reviewing deaths in people with learning disabilities will be implemented alongside this policy. It is important to note that current guidance clearly states that there is an expectation that the organisation will continue to review deaths in this cohort of our population in accordance with local arrangements.

3.2 Scope of Structured Judgement Reviews

At implementation, the following cases will be selected for SJR review and these will be referred to as 'in scope' in board reports and other documents.

a) All deaths where bereaved families and carers, or staff, have raised a concern about the quality of care provision. This to include intelligence from the safeguard modules for complaints and PALS
b) All in patient, out-patient, and community deaths of those with a learning disability
c) Deaths where learning will inform our existing or planned improvement work
d) A further sample of deaths that do not fit the identified categories so that we can take an overview of where learning and improvement is needed most overall

Existing arrangements in Paediatrics and Maternity will be maintained.

4 DEFINITIONS

The following terms are used and apply to this policy:

a) Serious Incident (S.I.)

Are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

b) Issue of Medical Certificate of Cause of death (MCCD)

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

c) Structured Judgement Review (SJR)

A structured desktop review of a case record/note, carried out by a trained reviewer who is normally a senior clinician, to determine whether there were any problems in the care provided to a patient. SJR methodology is applicable whether or not there are pre-existing concerns regarding care and may detect problems where none were previously suspected.

d) Death due to a problem in care

A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

e) Learning Disabilities

A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with; a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development.

f) Severe Mental Illness (SMI)

The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

g) Datix

Datix is Trust-wide patient safety software application for the reporting / investigating of Trust adverse events, complaints, risks, mortality cases and claims.

h) Structured Judgement Reviewer

Usually reviewers are consultants, senior trainees or senior nursing staff but, in principle, anyone can train to be a reviewer provided they are consistent in approach and have the clinical knowledge required to assess the appropriateness of care provision.

5 DUTIES AND RESPONSIBILITIES

5.1 Trust Board

a) Are accountable for ensuring compliance with the "National Guidance on Learning from Deaths" and the "Serious Incident Framework" and should work towards achieving the highest standards in mortality governance.
b) 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.

Refer to Appendix B for key points the Board should ensure are in place, as outlined in the "National Guidance on Learning from Deaths" framework.

5.2 Chief Executive Officer (CEO)

a) Has overall responsibility for this policy and compliance with it.

5.3 Non-Executive Directors (NED) Mortality Lead

As a critical friend, they should hold their organisation to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been due to problems in care. They will:

a) understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support
b) champion and support learning and quality improvement
c) assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges (e.g. information presented in board papers)

5.4 Medical Director

a) Will provide assurance to the Board of Directors that there are effective arrangements for learning from deaths in place and that the mortality review process is functioning effectively
b) Will ensure that there is a clear process through which delegated leaders hold reviewers to account for their performance regarding the quality and timeliness of the reviews and the implementation of learning actions

5.5 Trust Mortality Lead

The Trust Mortality Lead will assist the Medical Director in the implementation of this policy by:

a) Leading on all actions which result in full implementation of the policy
b) Offering training and advice to colleagues involved with the mortality review process
c) Monitoring recommendations from SJR reviews and serious incidents that have been declared as a result of SJR reviews and report them to the Mortality Review Group for information, discussion and agreed actions.
d) Reviewing reports from SJR and Serious incidents that have been declared as a result of SJR reviews to capture learning to be shared at MRG and speciality Mortality and Morbidity meetings
e) Raising any identified risk onto the Trust Risk Register via the Mortality Review Group for review as part of the Trust risk management process
f) Ensuring that external mortality alerts are investigated and any associated concerns resolved
g) Providing formal reports to the agreed framework
h) Ensuring that any actions identified in relation to mortality reviews are recorded, progressed and monitored appropriately
i) Sharing learning from Departmental Mortality and Morbidity meetings at MRG
j) Preparing quarterly mortality reports to Board

5.6 Trust Mortality Co-ordinator

The mortality co-ordinator will:

a) Administrate the MRG and other groups to an agreed schedule
b) Administer the relevant documentation to support the mortality review process
c) Monitor the completion of reviews and escalate delays and issues to the Trust Mortality Lead in a timely manner
d) Contribute to regular reports to MRG by providing updates to the Trust Mortality Lead
e) Receive feedback and learning points from the MSG and shared learning outcomes and action points to the specialities
f) Share outcomes within the specialty and at divisional governance meetings
g) Support and monitor the timely investigation of mortality alerts, reporting delays and or barriers to the Trust Mortality lead
h) Facilitate the allocation of SJR cases ensuring fair allocation of workload and that allocation takes account of considerations of leave.
i) Take and disseminate contributions from family / carers into the mortality review process

5.7 Quality & Safety Group

a) Receive reports and minutes of meetings from the MRG
b) Discusses cross-specialty and cross-divisional issues relating to mortality
c) Review and monitors action plans action plans where appropriate

5.8 Mortality Review Group (MRG)

a) Oversees specialty mortality review structure, process and actions
b) Captures, understands, and responds to external and internal mortality trends
c) Ensures cross divisional learning from mortality review
d) Informs the Board of mortality outcomes and trends using the agreed reporting framework.
e) Maintain oversight of capacity of all elements of process, including availability of SPA time in job plans for SJR reviews, and capacity within mortality and quality governance teams; raising any concerns regarding capacity and resource availability where necessary

5.9 Divisional Management Teams (DMTs)

a) Support clinical staff to speak openly and raise any concerns regarding the care of someone who has died and inform the Mortality co-ordinator so that the case can be considered for review
b) Promote an enabling culture by training and supporting staff to positively communicate with the bereaved and, where necessary, take timely effective action to address any specific concerns/complaints
c) Monitor the performance of Mortality and Morbidity meetings within the division by reviewing attendance and performance on at least an annual basis
d) Establish a governance process for receiving regular mortality reports from specialty mortality and mortality meetings and ensuring that learning is captured and improvement actions progressed and so demonstrate compliance with Care Quality Commission (CQC) Regulation 17 'Good Governance'
e) Disseminate this policy to new starters and making sure all staff know of and positively support our commitment to learn from deaths
f) Enable staff to contribute to a review when this is indicated
g) Ensure that the findings from mortality review are reported and discussed as part of the divisional quality governance process

5.10 Mortality & Morbidity Groups (Governance & Outcomes)

a) Each Mortality Group Chair will provide a template report to the Mortality Review Group. This will inform a performance dashboard giving MRG transparent and reliable data on learning outcomes
b) Receive and disseminate learning from mortality reviews

5.11 Bereavement Manager / Staff

a) Support the Trust Mortality Lead by ensuring that case notes are processed
b) Complete/update the patient details on Datix following receipt of notification of death and alert Trainee Doctors to commence Mortality Review Workflow, in accordance with the flowchart at Appendix A
c) Flag any issues with the progressing of the mortality review
d) Using the Datix system, establish whether a Serious Incident Investigation is underway that is linked to the patient's death
e) Signpost family appropriately if they have concerns that require investigating

5.12 Trainee Doctors

a) Submit new mortality record using Datix Mortality Module and link patient details previously updated by the Bereavement Team
b) Conduct a Team Doctor Review for all deaths
c) Flag the name of the Lead Consultant to commence the Consultant Review
d) Notify Mortality Co-ordinator if there is concern that Mortality Review timescales may not be met
e) Using the Datix system, establish whether a Serious Incident Investigation is underway that is linked to the patient's death

5.13 Consultants

a) Conduct Consultant Review using the Datix Mortality Module, in accordance with the flowchart displayed in Appendix A
b) Use their best judgement to establish whether a structured judgement review is necessary
c) Using the Datix system, establish whether a Serious Incident Investigation is underway that is linked to the patient's death
d) Notify Mortality Co-ordinator if there is a concern that Mortality Review timescales will not be met
e) Change approval status of the Datix Mortality record to indicate progress made through the Consultant Review stage

5.14 Structured Judgement Review (SJR) Faculty

a) Review cases within agreed timescales
b) Examine both interventions and holistic care by reviewing the whole record, including nursing notes
c) Ask 'why?' questions about things that happen, to enable understanding, improvement and action where required
d) Provide written, short, explicit clinical judgements on safety and quality of phases of care, highlighting good care as well as poor care
e) Report suboptimal care or death due to problems in care on the Datix incident module
f) Document any learning points for dissemination and distribution

5.15 Coding Team

a) Ensuring the mortality review process can be completed within timescales by ensuring timely medical notes availability.
b) Ensure that clinical coding is of high quality in order to ensure accuracy in generation of mortality statistics by external bodies

5.16 Associate Director of Quality Governance & Risk

a) Report presentation regarding mortality process

b) Ensure Datix is kept up to date in line with national guidance

5.17 Quality Governance Facilitator

a) Ensure actions resulting from mortality reviews are monitored through to completion via the Quality Performance Reports and their divisional quality governance meetings
b) Pass concerns raised by the family of the deceased to the SJR reviewer & mortality co-ordinator
c) Assist in identification of cases where the bereaved relatives/ carers have stated or implied that they have a concern about the quality of care- and that consent is sought to share this so that the case can be considered for review
d) Assist in application of duty of candour according to Trust processes
e) Assist in the dissemination of learning from mortality review across divisions.

5.18 Information Team

a) Provide monthly mortality trend data to the MRG
b) Map monthly patient level data against the mortality indicators and ensure that possible signals are reported to the MRG
c) Provide mortality data and prepare reports to meet the Trust's board, divisional, performance, Department of Health and commissioner reporting requirements

5.19 Datix Administrator

a) Up keeping of Datix, including ensuring that all staff is adequately informed regarding the system.
b) Supporting the preparation of scheduled reports on a monthly / quarterly basis
c) Providing data on mortality to enable the production of reports for relevant groups and committees as required by the National Quality Board (NGB)

5.20 Audit Analyst

a) Analysis of mortality trend data reported to MRG as required by NQB

5.21 All Trust Staff

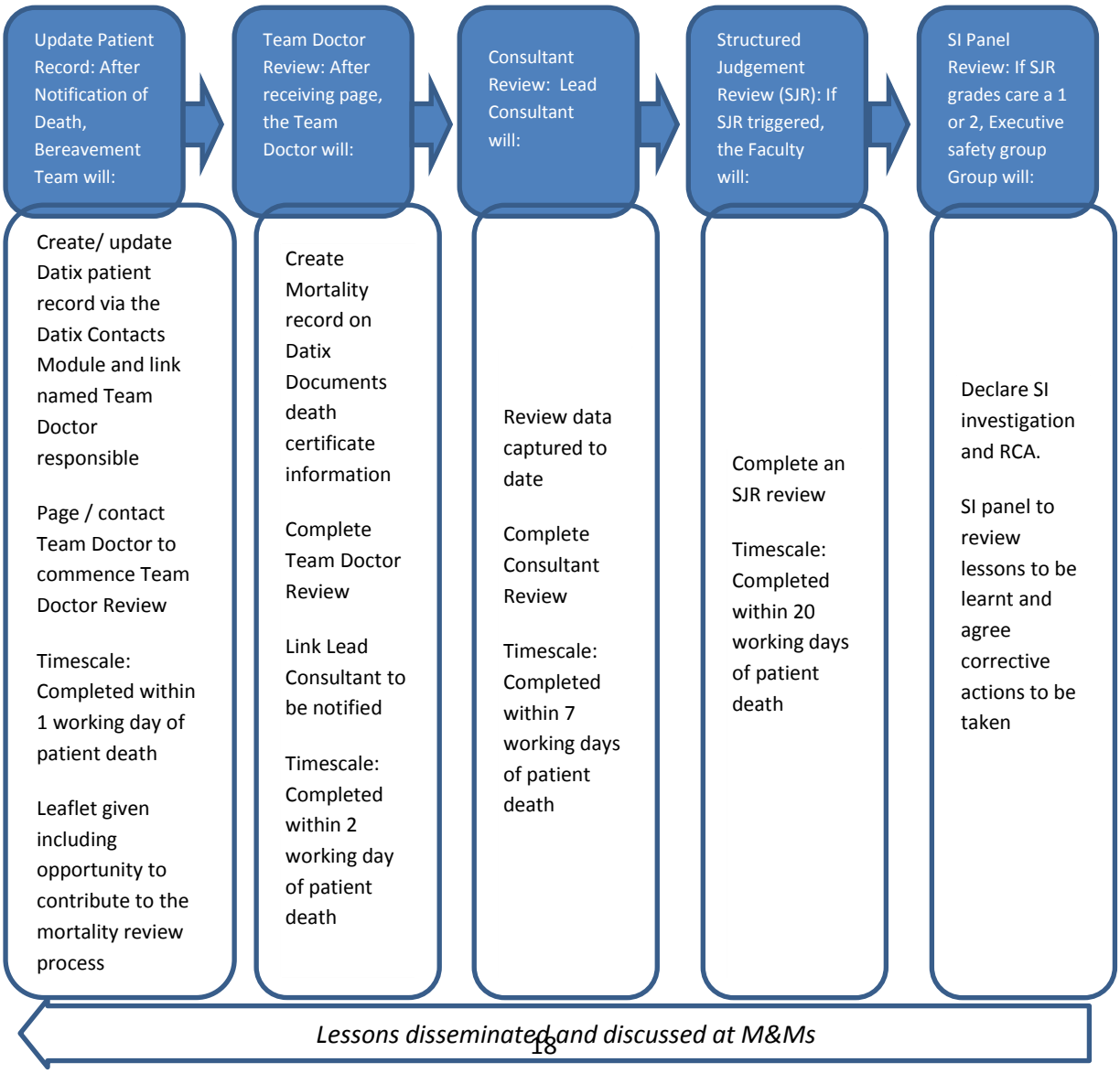
a) Flag any deaths which require further review with the mortality co-ordinator
b) Support compliance with the mortality review process, including:
    I. Helping ensure patient notes are available within the set timescales for the mortality process
    II. Completing any actions assigned to them as part of the mortality process

6 REVIEW METHODOLOGY

6.1 Mortality Review Process

The SJR mortality review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to escalate, learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

To support the review process a dedicated mortality module has been developed within the Trust's Datix System. All in-hospital deaths will be logged within the module by the Bereavement Teams; this will provide a platform to record the learning from all mortality reviews. The mortality review process has been outlined below and accommodates the need for relevant mortality reviews to be escalated. Please refer to Appendix A for more details.



6.2 Summary of methodologies used to review deaths (by patient)

Patient Group	Methodology
Adult inpatient	Structured Judgement Review
Mental health	Structured Judgement Review
Child (under 18)	Reviews will be undertaken in accordance with *Working together to safeguard children* [1] (2015) and the current child death overview panel processes.
Learning disability	The LeDeR method is used to review the care of individuals with learning disabilities Guidance for conducting reviews of deaths can be found here.[2] The Trust has systems in place to flag patients with learning disabilities so their care can be reviewed.
Perinatal and maternity	All perinatal deaths should be reviewed, using the new perinatal mortality review tool[3] once available. Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and if so, will be investigated accordingly.

7 TRAINING

Training is provided, and required for those who are allocated Structured Judgement Reviewers (SJR). SJR reviews will be undertaken during SPA (supportive programmed activities) time as part of an agreed Consultant job plan, or, where the reviewer is not a Consultant, during time dedicated to SJR review.

Advice and guidance for those completing part of the mortality process via the Datix Mortality Module is provided on the Intranet and within the Datix system on the user input screen.

8 IMPLEMENTATION

This document will be made available to all staff of the new Trust through the intranet site. To ensure that working documents are harmonised and kept up to date, work stream leads will ensure their individual policies comply with the requirements of this policy.

[1] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[2] http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf
[3] https://www.npeu.ox.ac.uk/pmrt

9 MONITORING OF COMPLIANCE & EFFECTIVENESS OF WORKING DOCUMENTS

Minimum requirement that is to be monitored	Monitoring Process e.g. review of incidents/ audit/ performance management	Job title(s) of individual(s) responsible for monitoring & for developing action plan	Minimum frequency of the monitoring	Name of committee that is responsible for review of the results & of the action plan	Job title of individual(s)/ committee responsible for monitoring implementation of the action plan
Board receives reports on compliance with the mortality process	Mortality reports provided to Board	Mortality Lead	Quarterly	Mortality Review Group	Board
SJR reviews completed within agreed timescales	Review of data from mortality module on Datix	Mortality Lead	Quarterly	Mortality Review Group	Quality and Safety
Learning/Action has been identified out of mortality review process	Review of actions arising from mortality review Review of Morbidity and Mortality meeting minutes	Mortality Lead	Quarterly	Mortality Review Group	Quality and Safety
Mortality trends are reviewed & actioned	Review of actions arising from mortality review Review of Morbidity and Mortality meeting minutes	Head of Patient Safety & Quality	Quarterly	Mortality Review Group	Quality and Safety

10 REVIEW, RATIFICATION AND ARCHIVING

This policy will be reviewed twice in the year after implementation at 6 months and 1 year. During this time, it will be necessary to monitor the impact of the process of the activity of Speciality Mortality and Morbidity Groups because they may need to evolve further.

Thereafter, it will follow the review and ratification process every 3 years, or earlier if national policy or guidance changes are required to be considered.

Within the three years, if the changes needed are of a minor nature the policy will not need to be subject to a review and re-ratification. Major changes are subject to review and re-ratification.

This policy will be archived in accordance with this document. The Central Policy Officer is responsible for ensuring that archived copies of superseded working documents are retained in accordance with the Records Management NHS Code of Practice, 2009.

11 DISSEMINATION AND PUBLICATION

Dissemination of the final policy is the responsibility of the author. They must ensure the policy is uploaded on the intranet via the Central Policy Officer who is then responsible for informing the Communications team to issue a trust-wide notification of the existence of the policy.

Clinical Directors, Divisional Management Teams, Specialty Business Unit (SBU) or supporting services management teams, ward managers and heads of department are responsible for ensuring that all relevant staff under their management (including bank, agency, contracted, locum and volunteers) are made aware of the policy.

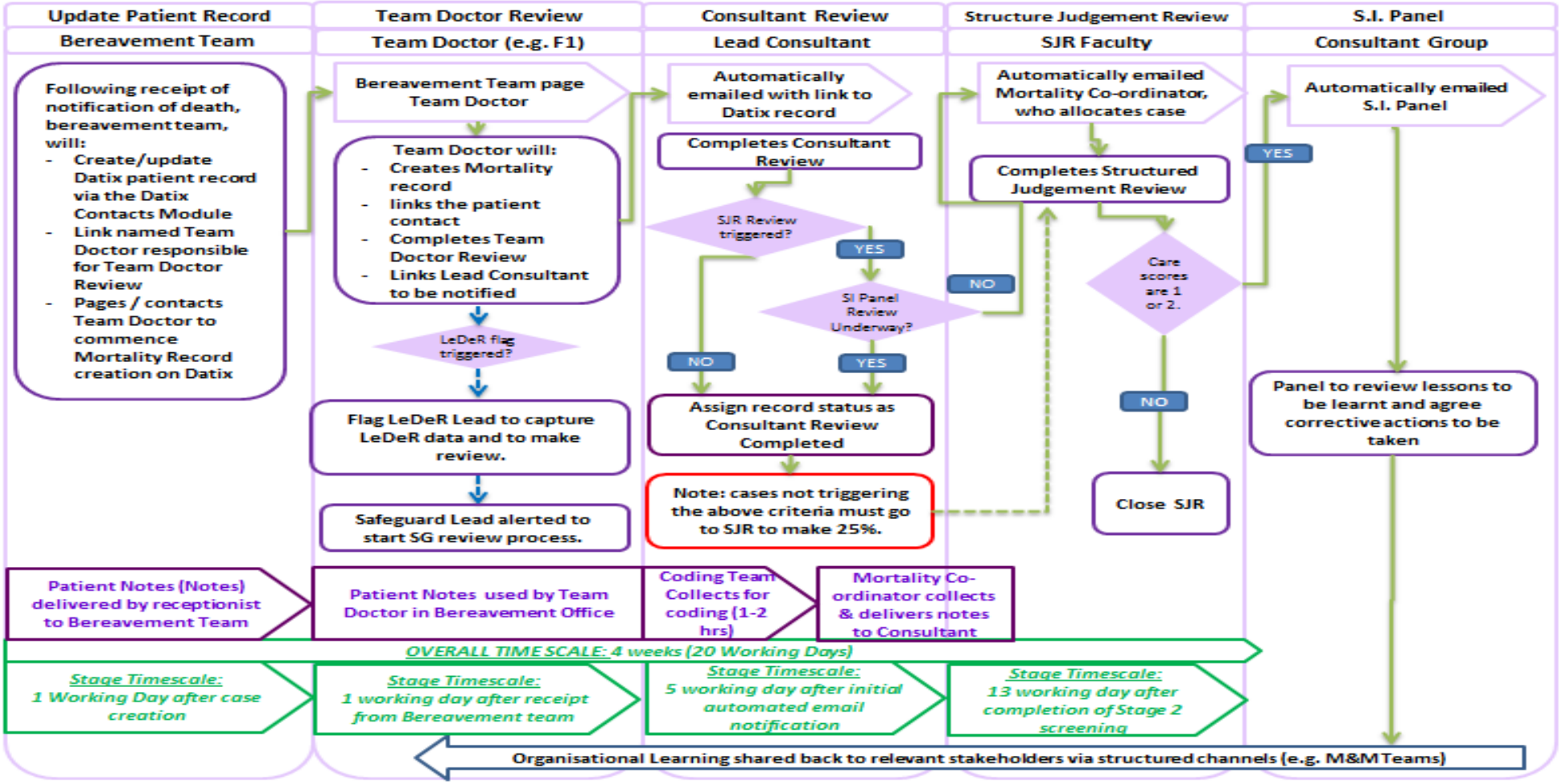
12 EQUALITY IMPACT ANALYSIS

The author of this policy has undertaken an Equality Impact Analysis and has concluded there is no impact identified. The analysis is available via the Central Policy Officer.

13 REFERENCES

a) National Guidance on Learning from Deaths. National Quality Board, March 2017
b) Learning Disabilities Mortality Review (LeDeR) Programme NHSE. 2015
c) CQC - Learning, candour and accountability, A review of the way NHS trusts review and investigate the deaths of patients in England, Dec 2016
d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance
e) Hutchinson, A Dr. Using the Structured Judgement Review method - A guide for reviewers, National Mortality case Record Review Programme, 2017
f) Gibson, A Dr, Frequently Asked Questions, National Mortality case Record Review Programme, 2017
g) Appalsawmy, U Dr. Training case notes guide, National Mortality case Record Review Programme,2017
h) Template Learning from Deaths policy, NHS Improvement, September 2017
i) Learning Disabilities Mortality Review (LeDeR) Programme, Guidance for the conduct of local reviews of the deaths of people with learning disabilities,(HQIP)

14 APPENDIX A – MORTALITY REVIEW WORKFLOW


Update Patient Record
Bereavement Team
Following receipt of notification of death, bereavement team, will:
- Create/update Datix patient record via the Datix Contacts Module
- Link named Team Doctor responsible for Team Doctor Review
- Pages / contacts Team Doctor to commence Mortality Record creation on Datix
Team Doctor Review
Team Doctor (e.g. F1)
Bereavement Team page Team Doctor
Team Doctor will:
- Creates Mortality record
- links the patient contact
- Completes Team Doctor Review
- Links Lead Consultant to be notified
LeDeR flag triggered?
Flag LeDeR Lead to capture LeDeR data and to make review.
Safeguard Lead alerted to start SG review process.
Consultant Review
Lead Consultant
Automatically emailed with link to Datix record
Completes Consultant Review
SJR Review triggered?
YES
NO
SI Panel Review Underway?
YES
NO
Assign record status as Consultant Review Completed
Note: cases not triggering the above criteria must go to SJR to make 25%.
Structure Judgement Review
SJR Faculty
Automatically emailed Mortality Co-ordinator, who allocates case
Completes Structured Judgement Review
Care scores are 1 or 2.
NO
Close SJR
YES
S.I. Panel
Consultant Group
Automatically emailed S.I. Panel
Panel to review lessons to be learnt and agree corrective actions to be taken
Patient Notes (Notes) delivered by receptionist to Bereavement Team
Patient Notes used by Team Doctor in Bereavement Office
Coding Team Collects for coding (1-2 hrs)
Mortality Co-ordinator collects & delivers notes to Consultant
OVERALL TIME SCALE: 4 weeks (20 Working Days)
Stage Timescale: 1 Working Day after case creation
Stage Timescale: 1 working day after receipt from Bereavement team
Stage Timescale: 5 working day after initial automated email notification
Stage Timescale: 13 working day after completion of Stage 2 screening
Organisational Learning shared back to relevant stakeholders via structured channels (e.g. M&M Teams)

15 APPENDIX B - BOARD LEADERSHIP - KEY POINTS

Trust board should ensure that the organisation:

a) 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;
b) pays particular attention to the care of patients with a learning disability or mental health needs;
c) has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
d) 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;
e) 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;
f) 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;
g) 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;
h) shares relevant learning across the organisation and with other services where the insight gained could be useful;
i) 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;
j) offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;
k) 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; and,
l) 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.