Learning from Deaths Policy

Policy Number	CGP005
Version:	V2.1
Purpose:	The aim of the policy is to outline the standard operating procedure for undertaking mortality reviews within Gloucester Health Care NHS Foundation Trust (GHC)
Consultation:	Medical Director Associate Medical Directors Director of Nursing, Therapies & Quality Associate Director of Patient Safety Mortality Review Groups
Approved by:	Clinical Policy Group
Date approved:	April 2021
Author:	Gordon Benson, Quality Lead (Mortality, Engagement & Development)
Date issued:	May 2021
Review date:	March 2023 This document will be reviewed as determined by changes in: ▪ Legislation ▪ National guidance ▪ Local Trust and system needs
Audience:	All Trust Employees
Dissemination:	Trust's policy section on the intranet, highlighted to managers and all colleagues via the weekly electronic news bulletin
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date	Reason for Change
1	June 2017	New Policy
V1.1	September 2019	Transferred to new template
V2	May 2021	Harmonised policy replacing CLP104 V1.1 Learning from Deaths Policy - Mental Health and CLP104 V1.1 Learning from Deaths Policy – Physical Health

V2.1	Dec 2021	Appendix C amended to include Charlton Lane Hospital

SUMMARY

In accordance with national guidance and legislation, the Trust currently reports all incidents and near misses, irrespective of the outcome, which affect one or more persons, related to service users, colleagues, students, contractors or visitors to Trust premises; or involve equipment, buildings or property. This arrangement is set out in the Trust policy on reporting and managing incidents.

Further guidance was published by the National Quality Board in March 2017 setting out mandatory standards for organisations in the collecting of data, review and investigation, and publication of information relating to the deaths of all patients under their care. This information is reported and published on a quarterly basis through the Trust Board.

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ABBREVIATIONS

Abbreviation	*Full Description*
GHC	Gloucestershire Health Care NHS Foundation Trust
MRG	Mortality Review Group
LeDeR	Learning Disabilities Mortality Review Programme
ICG	Improving Care Group
ME	Medical Examiner
PDL	Post Death Learning
EoL	End of Life
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
SIRI	Serious Incident Requiring Investigation
CD	Clinical Director

1. INTRODUCTION

1.1 A CQC review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England' found that some Trusts do not focus on the opportunity to learn and improve from deaths. Subsequently, in March 2017, the National Quality Board published its National Guidance on Learning from Deaths - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.

1.2 This policy relates to the collection, recording, investigating and reporting procedures adopted in respect of the deaths of people who are, or have been within a specified period, patients of GHC. The data generated is likely to provide an overview of the health outcomes for patients who have been seen or treated by providers within the Gloucestershire health and social care systems. The information will be used to inform internal quality and safety reports, but is intended also to engage with a wider systemic review of patient deaths across all providers, the scope and function of which is yet to be directed either locally or nationally.

1.3 While this data will include information concerning cases that have been reviewed through the serious incident process; that process will continue to run alongside the learning from deaths process and this policy will not affect the scope or purpose of the existing Incident Policy including Serious Incidents.

1.4 The Trust supports an active approach to reviewing patient deaths and places an emphasis on lessons learned, both internally, and within the wider NHS and social care systems in which it operates. The aim is to improve the quality of the care they provide to patients and their families, and identify where the Trust could do more.

1.5 GHC is mindful of its obligations to people with mental health problems and learning disabilities and recognises the considerable epidemiological information indicating that such people often find disadvantage within the wider health and social care community,

leading to their premature deaths, for a variety of reasons.

2. PURPOSE

The policy sets out the approach to be followed in publishing data relating to patient deaths, deriving and publishing learning, and reporting the information publicly through Board meetings.

3. SCOPE

This policy and procedure applies to all GHC colleagues. There are no limitations on its circulation within the Trust and the wider NHS community, and it can be made available to service users, their families and the public on request.

The Trust does, however, recognise that not all deaths of patients in contact with its services will be subject to review. The following categories of patient will be considered in scope for a mortality review process (including application of the serious incident process where appropriate);

- All inpatient deaths in community hospitals;
- All inpatient deaths mental health inpatient units or who had been discharged from in-patient care within the last month;
- All deaths of those with learning disabilities under our care;
- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death;
- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death;
- All perinatal/maternal deaths (perinatal mental health service for us);
- All deaths of patients where a complaint or significant concern about the quality of care provision has been raised (within 12 months of the date of death);
- All deaths of patients receiving care from a service where an 'alarm' has been raised with the Trust through whatever means (for example via an elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator). This will include situations where another organisation has reviewed a death and suggests that our Trust reviews its care processes;
- 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;

4. DUTIES

4.1 All Colleagues

- Take initial corrective actions (where safe) to prevent re-occurrence of any accident/incident leading to the death of a patient.
- Report all patient deaths, including those believed to arise from "natural causes", in a timely manner using the designated procedure via Datix.

- Ensure incident forms (in the event that Datix is unavailable) are given to the line manager as soon as possible after the incident is discovered (within 72 hours).
- Follow the procedure set out in the Policy on Reporting and Managing Incidents in respect of any suspected serious incidents.
- Ensure that learning from deaths is embedded within their practice.

4.2 Managers

- Review incident received and check the details for completeness.
- Authorise the Datix record (or countersign the completed paper form) and forward it, together with any supplementary documentation, to the safety department within five days.
- Escalate the incident immediately if it is serious or potentially serious or suspected to meet the criteria for a formal serious incident review.
- In respect of suspected serious incidents follow the procedure set out in the policy on reporting etc.

4.3 Director of Nursing, Therapies and Quality and Medical Director

- Have joint Board level responsibility for the development of this document and may delegate the authority to a subordinate.
- Provide the Quality Committee with quarterly reports of all data relating to learning from deaths prior to their submission to a public Board meeting.

4.4 The Executive Team

- The Chief Executive has overall responsibility to ensure the Trust has a robust coordinated response to publishing data and learning from deaths. The Chief Executive is supported in this role by all Executive Directors.
- The Medical Director, Director of Nursing, Therapies and Quality and the Director of Service Delivery have responsibility for ensuring that the policy in respect of serious incidents is followed and that appropriate processes are in place to review, where necessary investigate, and publish data relating to learning from deaths across the organisation.

4.5 The Board

- Take responsibility for receiving and reviewing information in respect of the deaths of patients through its public board meetings.
- Take responsibility for overseeing the measures in place and ensuring that these are understood and monitored at a board level.
- Nominate a non-executive director to take responsibility for oversight of the learning from deaths/mortality review process.
- Have 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.
- Pay particular attention to the care of patients with a learning disability or mental health needs.
- Have a systemic approach to identifying those deaths requiring review and selecting other patients whose care they will review.

- Adopt 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 involvement, with the outcome documented.
- Ensure 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 general occur.
- Ensure 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.
- Ensure 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.
- Share relevant learning across the organisation and with other services where the insight gained could be useful.
- Ensure sufficient numbers of nominated colleagues have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths.
- Offer timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death.
- Acknowledge 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.
- Work 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 investigation to inform quality improvement and contracts etc.

4.6 Clinical Director Leads for Learning from Deaths

- Two clinical directors have a joint lead for reviewing the data in relation to learning from deaths. One provides senior medical expertise into the mental health and learning disability Mortality Review Committee meetings; one provides senior medical expertise in the community hospital Mortality Review Group.
- Attend the relevant mortality review meetings at which data on patients who fall within the scope of this policy will be considered, categorised and reviewed.
- Together with the Quality Lead (Mortality, Engagement & Development) or Associate Director of Patient Safety and Mortality Review Officer, prepare a report to be submitted quarterly to the Trust Quality Committee prior to consideration at a public Board meeting.

4.7 Associate Director of Patient Safety and/or Quality Lead (Mortality, Engagement and Development)

- Produce the learning from deaths report, in conjunction with the clinical director leads for learning from deaths, and submitting this to the Quality Committee and Board as appropriate.
- Collate data relating to patient deaths from Datix, RiO, and any other appropriate sources.
- Responsible, with the Clinical Director leads for learning from deaths, for commissioning and reviewing any investigations considered to be appropriate.
- Chair the Mental Health Mortality Review Group and the Physical Health Mortality Review Group.
- These posts will be supported directly by the Mortality Review Officer.

4.8 Service Director – Hospitals Directorate

- Ensure that the matrons oversee the mortality review process within their respective hospitals (community hospitals, mental health and learning disability inpatient units), including multi-disciplinary team reviews.

4.9 Medical Examiner

- Support and challenge the certifying doctors to ensure the best quality and most accurate medical certificate of cause of death (MCCD) and associated mortality data.
- Provide proportionate scrutiny of all non-coronial deaths.
- Enabling the bereaved to raise any concerns through the ME system in a safe and transparent way.
- Supporting the appropriate direction of deaths to the coroner allowing the ME to act as a specialist resource.
- ME input is provided through Gloucestershire Hospitals NHS Foundation Trust; a Memorandum of Understanding has been agreed to define this. This are shown in Appendix B, supported by a Standard Operating Procedure shown in Appendix C.

5. POLICY DETAIL

5.1 In March 2017, the National Quality Board published its National Guidance on Learning from Deaths: a Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. This guidance sets out mandatory standards for organisations in the collecting of data, review and investigation, and publication of information relating to the deaths of patients under their care.

5.2 Concerns arising from Southern Health led to the publication of an audit by Mazars LLP, in November 2015, which suggested that the serious incident review process discriminated against patients with learning disability and elderly patients where their deaths were considered to be due to natural causes. This led to a review by the Care Quality Commission and a recognition of the need to understand and publish mortality data for all patients in contact with a provider.

5.3 The guidance specifies standards of governance and organisational capability to ensure that governance arrangements and processes include, facilitate and give due

focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. They are required to ensure that they act upon any learning. Providers are also required to review and, if necessary, enhance skills and training to support the agenda. Providers should also have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.

5.4 Trusts are required to ensure that their governance arrangements and processes "include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care". In respect of this, Trust boards are required to ensure that their organisation pays particular attention to the processes required in the guidance and that an appropriate policy and reporting arrangements are in place and acted upon. The requirements for Board leadership are set out in Annex A of the National guidance.

5.5 The Board is required to 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 the process.

5.6 In respect of governance and process, the Board is expected to have oversight of a systematic organisational approach to identifying deaths requiring review, effective methodology for case record reviews to ensure that these are carried out to a high quality, receive regular reports in relation to deaths, reviews investigations and learning, ensure that learning is acted upon and shared across the organisation, that families are appropriately engaged in a timely compassionate and meaningful way, that nominated colleagues have appropriate skills in respect of reviewing and investigating deaths, works with commissioners to review and improve their local approaches, and recognises the benefit of independent investigation in a small number of cases.

5.7 Trusts are expected to have a cohort of colleagues who have received training to develop specialist skills in the investigation and review of deaths. Provider Trusts are also expected to have a clear policy for engagement with bereaved families and carers.

5.8 The responsibility of Non-Executive Directors are set out in Annex B of the National guidance. This reinforces the guidance with regard to necessary board oversight and sets out the roles and responsibility of non-executive directors, including:

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.

5.9 The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, July 2019 makes clear the importance of using mortality review to understand the care provided to people at end of life.

6. IDENTIFYING PATIENT DEATHS FOR REVIEW

6.1 All GHC colleagues will be required to notify, using the Datix process, the deaths of any Trust patients. This comprises anyone who dies within 30 days of receiving care from GHC. Deaths recorded on Datix will be collated by the Trust's Mortality Review Officer for discussion at the relevant monthly Mortality Review Meeting chaired by the Quality Lead (Mortality, Engagement & Development).

6.2 The Mortality Review Officer will complete a table-top review for all deaths considered in scope and include the following information: cause of death (from e.g. GP or Coroner), location of death, who certified death, any family concerns, and any known details of health deterioration immediately prior to death.

6.3 Based upon the information gather, patient deaths will either be closed on Datix, subject to a case record review, or escalated to the Patient Safety Team for consideration for investigation as a serious incident or clinical incident. All those subject to case record review will be further sorted into those where there may be concerns and those where no concerns are identified.

6.4 A range of tools, classifications and mechanisms will be used to support this process including:

- Global Trigger Tools Methodology (The Health Foundation, April 2010) will be used as a sampling method to support the random audit of cases to ensure the methodology is robust;
- A modified version of the structured judgement review methodology defined by the Royal College of Physicians;
- Royal College of Psychiatrists Care Review Tool for mortality reviews;
- National Confidential Enquiry into Patient Outcome and Death, grading system for use by care reviewers;
- Classification of patient deaths as developed by Mazars following their report into Southern Health NHS Foundation Trust (2015)
- Feedback from Medical Examiner;

6.5 All deaths of patients with a learning disability will be also reported through the appropriate LeDeR process, and child death reviews are covered by the Statutory Child Death Review Process overseen by the Child Death Overview Panel.

6.6 All cases which meet the threshold for review will be presented to the appropriate Mortality Review Group for exploration of the care provided and identification of learning points.

7. MORTALITY REVIEW GROUPS

7.1 The Trust currently has 3 separate Mortality Review Groups to ensure that appropriate focus is directed into the review process, these are as follows:

- Physical Health Mortality Review Group
- Learning Disability Mortality Review Group

- Mental Health Mortality Review Group

7.2 Processes for each of these groups is seen in Appendix A.

8. OUTPUTS AND LEARNING

8.1 The data obtained will be subjected to a modified version of the structured judgement review methodology defined by the Royal College of Physicians and assigned to one of three categories:

Category 1: "not due to problems in care"

Category 2: "possibly due to problems in care within GHC"

Category 3: "possibly due to problems in care within an external organisation"

8.2 For those deaths that fall into Category 2, learning will be collated and an action plan developed that will be progressed through operational and clinical leads and reported to the Quality Committee.

8.3 Where deaths are identified in Category 3, the issues identified will be escalated to local partner organisations through the Clinical Commissioning Group lead for mortality review. For distant organisations, issues will be shared with the local lead for learning from deaths within the organisation.

8.4 The Mortality Review Groups will, through the Associate Director of Patient Safety, the Director of Nursing, Therapies and Quality and the Medical Director, provide a report to the Quality Committee and thence to the Trust Board on a quarterly basis

9. INVOLVING FAMILIES

9.1 The Trust will endeavour to:

- Provide a clear, honest and sensitive response to bereavement in a sympathetic environment
- Offer a high standard of bereavement care, including support, information and guidance
- Ensure families and carers know they can raise concerns and these will be considered when determining whether or not to review or investigate a death.
- Involve families and carers from the start and throughout any investigation as far as they want to be.
- Offer to involve families and carers in learning and quality improvement as relevant.

9.2 The process for involvement of families in the investigation following serious incidents is well tested within this organisation and will continue as set out in the Serious Incident Policy. This provision will be extended to provide a family liaison worker and full involvement, to the extent the family wishes, in any clinical incident investigation into the death of a patient.

10. SUPPORTING COLLEAGUES

10.1 Colleagues will be offered debriefing and support around incidents within their team and professional network. The availability of support for colleagues will be highlighted through the process, and colleagues will be reminded of their access to Freedom to Speak Up Guardians and the Raising Concerns Protocols.

11. PUBLICATION OF FINDINGS

11.1 The Trust Board will receive a quarterly (or as prescribed nationally) dashboard report to a public meeting, including:

- Number of deaths
- Number of deaths subject to case record review
- Number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
- Number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- Themes and issues identified from review and investigation (including examples of good practice)
- Actions taken in response, actions planned and an assessment of the impact of actions taken.

11.2 The Trust will publish an annual overview of this information in its Quality Report, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

12. RESOURCES

National guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf.

Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

Learning from deaths dashboard https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance

Resources from the national patient safety team; https://improvement.nhs.uk/resources/patient-safety-alerts

The Improvement Hub https://improvement.nhs.uk/improvement-hub/

Developing people – improving care: A Framework for leadership and improvement https://improvement.nhs.uk/resources/developing-people-improving-care/

Royal College of Physicians mortality review materials https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme

Learning disabilities mortality review programme http://www.bristol.ac.uk/sps/leder/

Hogan et al Research on mortality review http://www.bmj.com/content/351/bmj.h3239 http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159

Serious incident framework https://improvement.nhs.uk/resources/serious-incident-framework/

Root cause analysis tools and resources http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Duty of candour http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

Being open guidance http://www.nrls.npsa.nhs.uk/beingopen/

National Confidential Enquiry into Patient Outcome and Death Grading system (ncepod.org.uk)

The NHS Patient Safety Strategy NHS England » The NHS Patient Safety Strategy

13. DEFINITIONS

Table Top Review	A review by the Mortality Review Officer which potentially identifies some "red flags" that warrant further clinical review.
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.
Investigation	The act of all process of investigating; a systemic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
Death due to a problem in care	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in health care and therefore to have been potentially avoidable.
Clinical incident	An event or circumstance which could have resulted, or did result in unnecessary damage, loss or harm such as physical or mental injury to a patient, colleagues, visitors or members of the public which does not meet threshold associated with serious incidents requiring investigation.
Datix	The computer system used by the Trust to record and manage incidents.
NQB	National Quality Board.
CCG	Clinical Commissioning Group.
CQC	Care Quality Commission.
DOH	Department of Health.

Learning Disabilities Mortality Review (LeDeR) Program	A programme commissioned by the health care quality improvement partnership for NHS England to receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age.
National Child Mortality Program	A national review of child mortality review processes conducted by NHS England 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.
NCEPOD	National Confidential Enquiry into Patient Outcome and Death, maintains and improves standards of care for adults and children by reviewing the management of children, undertaking confidential surveys and research.
National Child Mortality Database	A national database central to the national child mortality programme.
Post Death Learning (PDL)	Description of the learning once a death is reported using the Datix electronic data submission form.
RiO	The electronic patient records system used within Trust mental health services.
SystmOne	The electronic patient records system used within Trust physical health services

14. PROCESS FOR MONITORING COMPLIANCE

This policy requires approval by the Clinical Policy Group with notification to the Quality Committee and Board. It will be reviewed bi-annually, and sooner if needed. The Trust Board is responsible for ensuring that compliance against the standards defined by the National Quality Board within the National Guidance is upheld by receiving a quarterly report from the Medical Director.

15. TRAINING

Colleagues receive training in incident reporting as part of statutory and mandatory training. Additional training is provided through Datix sessions run by the Datix Team.

16. REFERENCES

Implementing the Learning from Deaths framework: key requirements for trust boards (NHS Improvement, July 2017)

National Guidance on Learning from Deaths (National Quality Board, March 2017)

Mazars LLP. Independent review of deaths of people with a learning disability or mental health problem in contact with Southern health NHS Foundation Trust April 2011 to March 2015 (2015).

GHC Documents:

- *Policy on Reporting and Managing Incidents (including Serious Incidents)*
- *Raising Concerns Protocols*
- *Child Death Guidelines*

Reference Royal College of physicians. Using the structured judgement review method. A clinical governance guide to mortality case record reviews (2016).

Implementing Structured Judgement Reviews for Improvement - West of England AHSN 2018

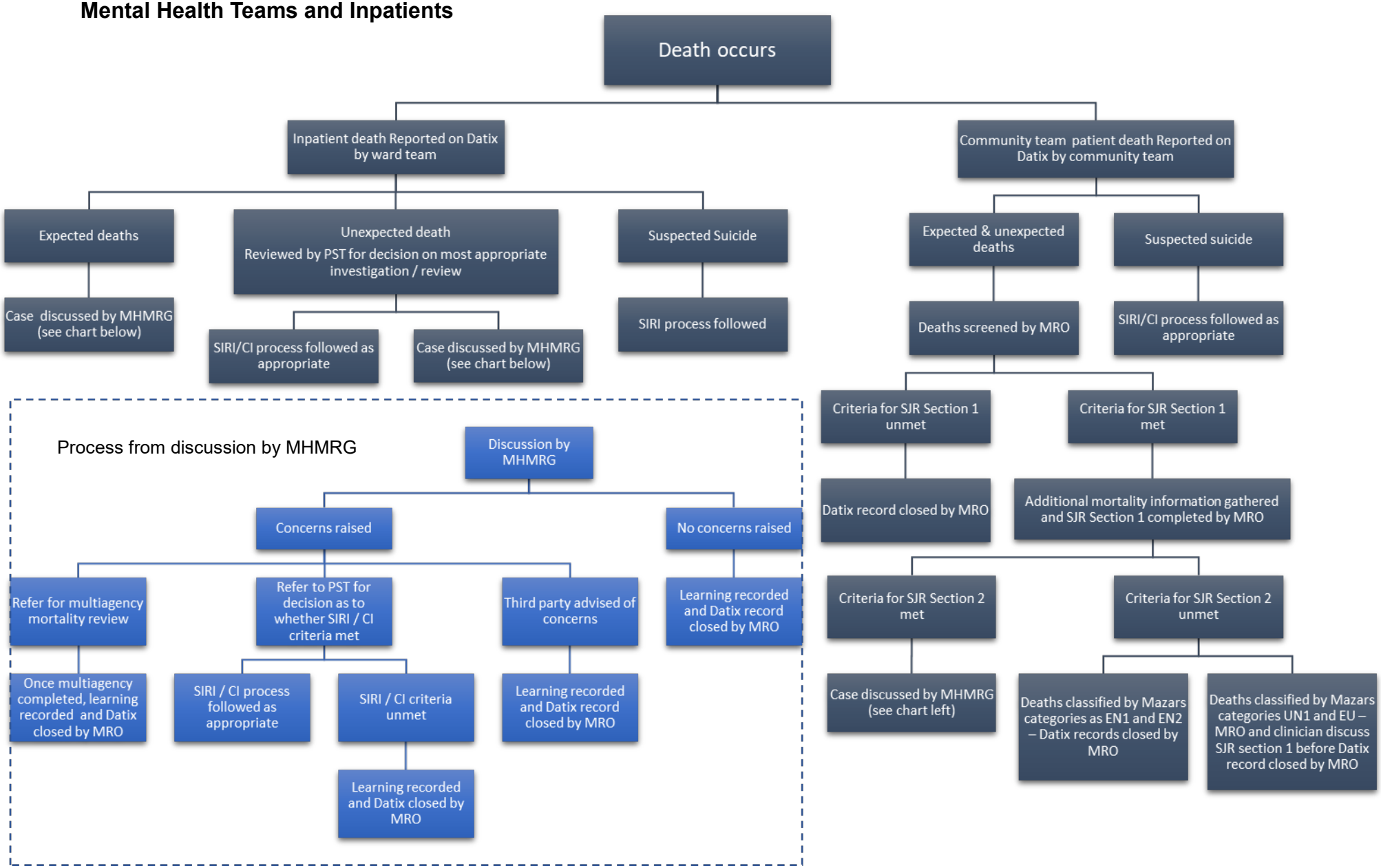
Care Quality Commission, December 2016: Learning, candour and accountability: A review of the way NHS trusts review and investigate

NHS Patient Safety Strategy (July 2019): Safer culture, safer systems, safer patients

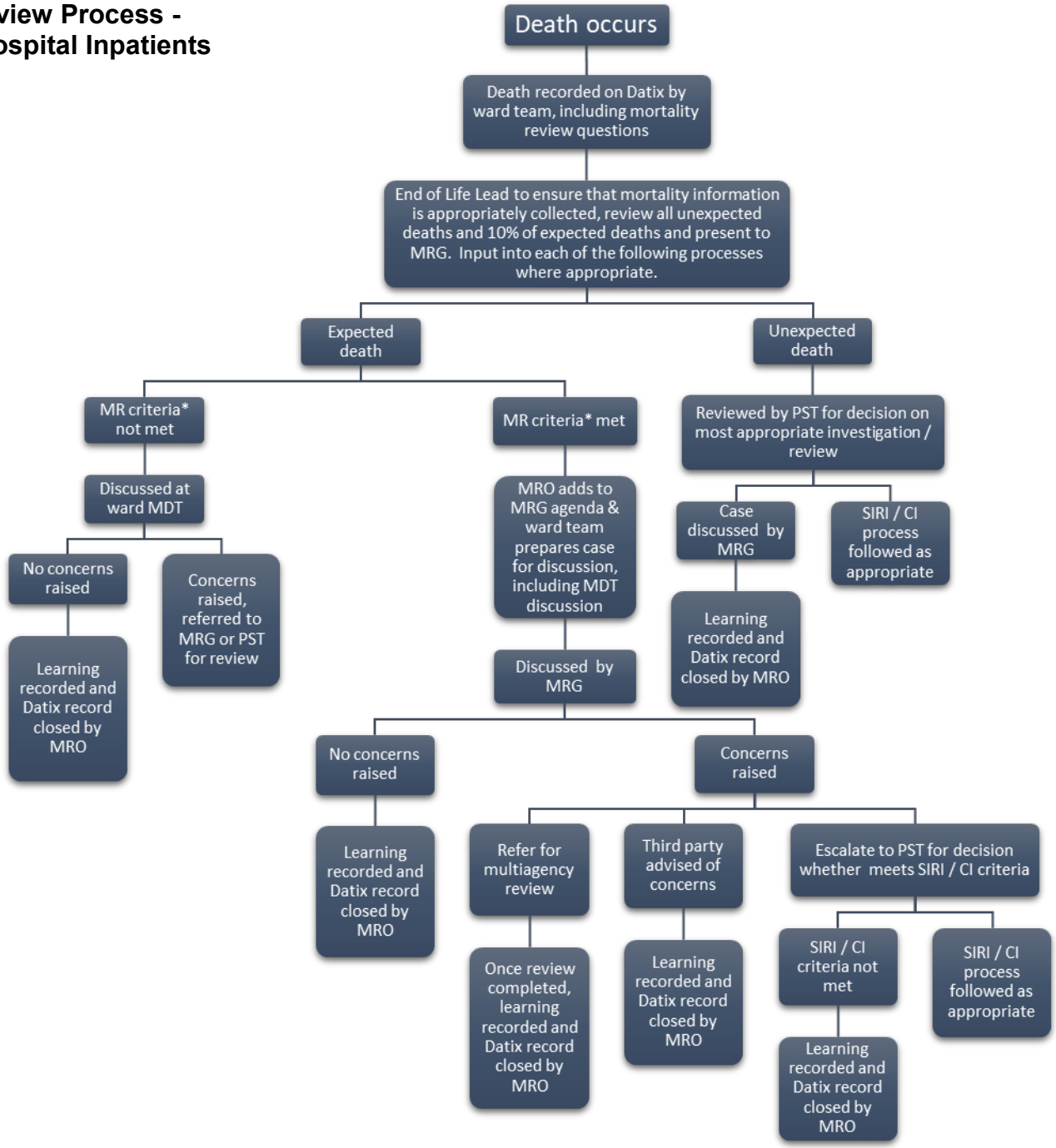
APPENDIX A

Mortality Review Process - Community LD Teams and LD Inpatients

Mortality Review Process – Community Mental Health Teams and Inpatients



Mortality Review Process - Community Hospital Inpatients



APPENDIX B

Memorandum of Understanding
Between
Gloucestershire Health and Care NHS Foundation Trust
and
Gloucestershire Hospitals NHS Foundation Trust (GHFT)
Medical Examiner Service

This Memorandum of Understanding (MoU) sets out the terms and understanding between Gloucestershire Heath and Care NHS Foundation Trust (GHCFT) and GHFT' Medical Examiner Service ahead of the Government's reforms to death certification processes becoming law. This interim period will allow both parties to test and shape a practical and seamless process for clinical staff to follow while being sensitive to the needs of the bereaved.

Background

The role of the Medical Examiner (ME) is set out in the Coroner & Justice Act (2009) following recommendations from the Shipman Inquiry (2004) and subsequently the Francis report (2013). The ME has a duty to review deceased patient records and speak to their relatives to ensure that the wording used on the medical certificate of cause of death (MCCD) accurately describes the circumstances leading to the death and is acceptable for release to the Registration Service. This includes:

- Support and challenge the certifying doctors to ensure the best quality and most accurate MCCD and associated mortality data
- Provide proportionate scrutiny of all non-coronial deaths
- Enabling the bereaved to raise any concerns through the ME system in a safe and transparent way
- Supporting the appropriate direction of deaths to the coroner allowing the ME to act as a specialist resource

Purpose

This MoU clarifies the expectations and obligations of both parties. It is designed to encourage productive and supportive engagement between the GHCFT and the ME Service. The overall aim is to allow seamless and timely scrutiny of all in-hospital patient deaths which are in scope of this pre-statutory phase of the Government's reforms. Furthermore, that the MCCD contains the best quality account of the circumstances leading to death which has been reached with respectful dialogue between the certifying doctor and the ME without causing additional delays in the death certification process. Above all to ensure that the bereaved families are supported at all stages of the process.

Mission, Values and Aims of GHFT Medical Examiner Service

It is the mission of GHFT's ME service to provide a compassionate, seamless and responsive service to GHCFT and the relatives of its patients who have died under their care. The ME

service team will commit to putting the various needs of the bereaved at the heart of the process at all times. This will include when the ME, or their officer, speaks to the nominated relative/carer about the proposed cause of death and in establishing if they have any concerns with care. This will be done in a sensitive, clear and non-alarmist or intrusive manner. The ME service will promote good governance with supporting identification of mortality trends and data. Furthermore, to screen the quality/accuracy of the MCCDs' completion in line with the General Register Office (GRO) standards.

The above aims will be achieved by undertaking the following activities:

GHC NHS Foundation Trust will:

- Inform the ME Service of the deaths of patients who die in their inpatient settings
- Consent and provide contact details of deceased person's Next of Kin to facilitate a telephone conversation with the ME or their officer
- Allow remote access to patient records on relevant clinical systems in order to allow proportionate scrutiny of the patient notes
- Provide a proposed cause of death and discuss with the ME, where requested, and agree the cause of death prior to issue/release of the MCCD

GHFT Medical Examiner Service will:

- Respond to requests to scrutinise patient records within 1 working day Monday to Friday excluding bank holidays
- Contact the deceased person's next of kin to discuss cause of death and address any concerns related to the death and proposed wording of MCCD
- Address any clinical concerns arising from the review of clinical notes or the conversation with next of kin in partnership with the patient's attending doctor and GHCFT hospital location
- Adhere to all applicable Information Governance guidance and recognized best practice in all aspects of accessing patient data and speaking to relatives using their personal contact details
- Provide advice to the Certifying doctor in terms of referral to HM Coroner where indicated
- Discuss any recommended changes to the MCCD with the certifying doctor
- Ensure that MCCD is accurate and reflects the precise cause of death as required by the Registrar of Births and Deaths

Evaluation and Monitoring of Service

Background

The Medical Examiner Service has been a flagship pilot site for the Department of Health and Social Care (DHSC) for over ten years and as such has extensive experience of running the ME system in a range of settings. This means that the ME team is fully competent in all aspects of the role(s) and routinely provides advice to other Trusts across England on the quality service standards necessary when setting up a service.

National Organisation Structure

Guidance on the role and responsibilities of the ME service is issued by the office of the National Medical Examiner (NME) which sits within NHS Improvement. Once the ME system is on a statutory footing NHSI will be able monitor both compliance with legal frameworks and that appropriate behaviours are demonstrated towards stakeholders. This is underpinned by an organisational structure which is made up of seven Regional MEs whereby Gloucestershire sits within the South West.

Local Evaluation of GHFT ME Service

Key Performance Indicators (KPIs) will include: -

1. Percentage of deaths generating MCCD resolved with the input of the ME service
    a. GHC inpatient deaths which do not go through this pathway should be subject to Datix.
    b. These will be identified monthly at the point of the Mortality Review meetings.

2. Number of times a MCCD is rejected by Registrar and reason this occurs

3. Percentage of potential Coroner referrals resolved with the input of the ME service
    a. These will be identified monthly at the point of the Mortality Review meetings.

4. Complaints made by bereaved relatives due to:

    - perceived delays to completion and release of MCCD (end to end timescales examined)
    - the discussion with the ME or their officer has added further distress
    - information was not clear or helpful, lacking in compassion, professionalism etc.
    - the cause of death did not match their understanding of what their relative died from

Evaluation of effective compliance with formal death certification protocols for both parties will be ongoing and findings will be published in a report as required. This will only be circulated to GHCFT and be anonymized for use in learning and development of the ME service as a whole.

Compliance with Data Sharing and Codes of Confidentiality

All data shared and processed as part of this Memorandum of Understanding will be done in line with the code of practice on confidential information and the common law duty of confidentiality. All processing must be in line with the Caldicott and Data Protection principles of fairness, transparency and lawfulness, Purpose limitation, data minimisation, accuracy, storage limitation and confidentiality.

Funding

This MoU is not an undertaking, on either side, to request or require transfer of funding.

Duration

This MOU is at-will and may be modified by mutual consent of the authorised officials from GHC NHS Foundation Trust and GHFT ME service. This MoU shall become effective upon signature by the authorized representatives and will remain in effect until modified or terminated by any one of the parties by mutual consent.

Contact Information

Partner name	GHC NHS Foundation Trust
Partner Representative	Dr Andrew Wheeler
Position	Clinical Director of Community Hospitals
Address	Gloucestershire Health and Care NHS Trust, Edward Jenner Court, 1010 Pioneer Ave, Brockworth, Gloucester GL3 4AW
Email:	andrew.wheeler@ghc.nhs.uk

_____ Date:
(GHC NHS Foundation Trust representative signature)

Contact Information

Partner name	GHFT Medical Examiners Service
Partner Representative	Ms Kathryn Griffin
Position	Head of Bereavement/Medical Examiners' Service, Gloucestershire
Address	Gloucestershire Royal Hospital, Great Western Rd, GL13NN
Email:	k.griffin@nhs.net

_____ _____ Date:
(GHFT Medical Examiner Service representative signature)

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

APPENDIX C

Standard Operating Procedure
for Medical Examiner Service Input with All Inpatient Deaths

From 1 December 2021, the Medical Examiner (ME) Service must be notified of <u>ALL INPATIENT DEATHS</u> occurring at Community Hospitals and Charlton Lane Hospital including potential referrals to the Coroner.

Death of patient

↓

Ward Staff to contact Next of Kin (NoK)
Advise NoK to expect contact from ME Service to review circumstances of death.

↓

Ward medical staff to contact Medical Examiner's Service on 0300 422 6982, and inform the Medical Examiner Officer of:

1. Date, time and place of death
2. The patient's last occupation
3. Proposed **cause**(s) of death for the Medical Certificate for Cause of Death
4. Any indication for referral to the Coroner
5. Contact details of NoK / nominated relative
6. Name, GMC number, phone / email of referring Doctor.

ME Officer will forward details to the Medical Examiners.

↓

Medical Examiners (typically available each weekday afternoon) will review the death remotely on the relevant clinical system, and after discussion with NoK will:

1. approve the cause of death, or
2. challenge and suggest alternative wording for the cause of death, or
3. need to speak further to the attending doctor.

The ME Service will provide a confirmatory phone call / email with the outcome of discussions.

↓

Ward medical staff to:
Issue the MCCD +/- Cremation Form 4, or refer the death to the Coroner.

<u>Out of hours,</u> an on-call ME is available via GHFT switchboard for **urgent** queries. Otherwise, leave a voicemail message with ME office and resolve when the ME office re-opens.

In **<u>exceptional circumstances</u>**, where a prompt service from the Medical Examiner's Office is not available, or deaths in cultures requiring prompt funeral arrangements, MCCDs can be issued where the cause of death is well understood. **This <u>does not</u> include deaths that must be referred to the Coroner**. **<u>Datix reports must be completed for all such exceptions</u>** and this activity will be audited.

Queries? Contact:

- Kathryn Griffin, Head of Bereavement and Medical Examiner Mortality Review Services, k.griffin@nhs.net, 0300 422 6982
- Dr Andrew Wheeler, Clinical Director of Community Hospitals, Andrew.wheeler@ghc.nhs.uk
- Dr Katie Kelly, Consultant Psychiatrist, Charlton Lane Hospital, katie.kelly@ghc.nhs.uk