CONTROLLED DOCUMENT

University Hospitals Birmingham NHS Foundation Trust

Reviewing Inpatient Deaths Policy

CATEGORY:	Policy
CLASSIFICATION:	Governance
PURPOSE	To set out the framework for reviewing inpatient deaths across the Trust.
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Distribution: • **Essential Reading for:** • **Information for:**	Medical Examiners Divisional Management Teams Clinical Governance and Patient Safety staff Medical Staff

Contents

1. Policy Statement

1.1 University Hospitals Birmingham NHS Foundation Trust (the 'Trust') is committed to learning from deaths of people in their care in order to improve the quality of care they provide to patients.

1.2 This policy and its associated documents detail the requirement for Trust Medical Examiners and individual clinical specialties to review inpatient deaths in line with national requirements.

1.3 The key objectives of this policy are to:

1.3.1 Set out the framework for the review and reporting of inpatient deaths;

1.3.2 Ensure all staff understand their roles and responsibilities in connection with the policy; and

1.3.3 Ensure compliance with national policy and requirements related to the review of inpatient deaths.

2. Scope

2.1 This policy applies to all areas and activities of the Trust and to all individuals employed by the Trust including contractors, volunteers, students, locum and agency staff and staff employed on honorary contracts.

2.2 The policy applies to patients who die whilst in the care of the Trust as outlined in the associated procedural documents.

3. Framework

3.1 This section describes the broad framework for the review of inpatient deaths. Detailed instructions are provided in the associated procedural documents.

3.2 The Chief Medical Officer shall approve all procedural documents associated with this policy, and any amendments to such documents, and is responsible for ensuring that such documents are compliant with this policy.

3.3 The Trust will ensure that all relevant inpatient deaths are subject to clinical review and outcomes of these reviews are used for learning and quality improvement.

3.4 Medical Examiners will complete a Stage 1 review for inpatient deaths apart from those which fall into the following categories:

3.4.1 Out of area deaths;
3.4.2 Forensic deaths;
3.4.3 Coronial referrals that are not returned to the hospital with a Form 100A (for hospital issue).

3.5 All cases which meet the escalation criteria referred to in section 2.2.3 of the Inpatient Death Review Procedure will require specialty Mortality and Morbidity review. In addition, those cases that are deemed more likely than not to have been due to problems with care will prompt a "Stage 2" review by a member of Clinical Governance and Patient Safety Team and the Assistant Medical Director – Clinical Governance. The outcomes of all cases escalated for further review will be presented to the Trust Executive led Clinical Quality Monitoring Group (CQMG) for assurance.

3.6 Where required, the Clinical Governance and Patient Safety Department will refer cases to the Clinical and Professional Review of Incidents (CaPRI) group which will review and decide which cases justify further review or independent investigation in line with the associated Policy for the Reporting and Management of Incidents including Serious Incidents.

3.7 The outcomes of reviews of deaths will be reported to the Board of Directors on a quarterly basis. This will include, as a minimum, the number of inpatient deaths occurring in the Trust, the number receiving a Stage 1 and Stage 2 review.

3.8 Each speciality will review their patient deaths at a relevant mortality and morbidity meeting in accordance with the associated 'Procedure for Mortality and Morbidity (M&M) review'.

3.9 Child deaths and those associated with maternity services will be reviewed as per the Child Death Review process

4. Duties

4.1 Chief Medical Officer

The Chief Medical Officer is responsible for:

4.1.1 Overseeing the implementation of this policy and its associated procedure;

4.1.2 Authorising independent formal investigations of relevant inpatient deaths; and

4.1.3 Receiving reports where Medical Examiner Stage 1 review triggers the requirement for further investigation.

4.2 Assistant Medical Director – Clinical Governance

4.2.1 Mortality lead for the Trust;

4.2.2 Liaison between Clinical Governance and Lead Medical Examiner in relation to any additional queries arising during a Stage 2 review following a Stage 1 Medical Examiner review.

4.2.3 Medical lead for Learning from Deaths reports to CQMG and the Board.

4.3 Trust Lead Medical Examiner

The Trust Lead Medical Examiner, who is directly responsible to the Chief Medical Officer, will:

4.3.1 Manage the Trust's Medical Examiner Service and team (ME consultants and non-clinical team), supported by Chief Medical Officer's Services;

4.3.2 Ensure independent scrutiny of care for eligible inpatient deaths, in accordance with national requirements and escalation of cases for review by Clinical Governance and Patient Safety.

4.4 Divisional Medical Directors, Managing Directors, Directors of Operations and Clinical Service Leads

Divisional Medical Directors, Managing Directors, Directors of Operations and Clinical Service Leads will:

4.4.1 Support the implementation of this policy and its associated procedure; and

4.4.2 Ensure clinical specialties undertake reviews of cases raised as requiring further review by the Medical Examiners.

4.5 Clinical Governance and Patient Safety Department

Members of the Clinical Governance and Patient Safety Department will:

4.5.1 Manage the process of review and escalation of outcomes of Medical Examiner reviews;

4.5.2 Coordinate and conduct Learning from Deaths reviews, including Stage 2 reviews and other mortality triggers and provide the associated reports to CQMG;

4.5.3 Produce information for the Chief Medical Officer to provide reports in line with national requirements to the Trust Board of Directors;

4.6 Bereavement Services

Members of Bereavement Services will support families and carers of patients who have died whilst in the care of the Trust.

4.7 Investigations Team

Where the case is being investigated as a Level 2 Serious Incident, members of the Investigations Team will maintain contact with families and carers and offer them the opportunity to meet and discuss their concerns or answer any questions they may have.

4.8 Lead Nurse for Vulnerabilities

The Lead Nurse for Vulnerabilities is responsible for ensuring all deaths are reported to the Learning Disabilities Mortality Review (LeDeR) programme as per National guidance. The lead nurse is also responsible for ensuring reports and associated action plans are enacted.

4.9 Clinical Compliance/Educator for Mental Health

Responsible for ensuring all deaths of patients detained under the Mental Health Act have been appropriately reported to the Coroner and Care Quality Commission.

5. Implementation and Monitoring

5.1 Implementation

This policy will be available on the Trust's Intranet. The policy will also be disseminated through the management structure within the Trust when practice changes or staff are to be reminded of this policy.

5.2 Monitoring

Appendix A provides full details on how the policy will be monitored by the Trust.

6. References

National Quality Board (2017) – National Guidance on Learning from Deaths

Care Quality Commission (2016) Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England

7. Associated Policies and Procedural Documentation

Reviewing Inpatient Deaths Procedure

Bereavement Care Services Policy and Procedures

Policy for the Reporting and Management of Incidents including Serious Incidents

Procedure for the Reporting and Management of Incidents Including Serious Incidents

Appendix A Monitoring Matrix

MONITORING OF IMPLEMENTATION	MONITORING LEAD	REPORTED TO PERSON/GROUP	MONITORING PROCESS	MONITORING FREQUENCY
Report of ME escalations and other mortality indicators	Head of Clinical Governance and Patient Safety, Assistant Medical Director – Clinical Governance	Clinical Quality Monitoring Group	Monthly CQMG Learning from Deaths report	Monthly
Trends and themes	Head of Clinical Governance and Patient Safety, Assistant Medical Director – Clinical Governance	Medical Examiner Meeting	Figures will be reported on any trends and themes to the ME group for consideration of further action.	Quarterly
Medical Examiner activity, escalations and stage 2 reviews	Head of Clinical Governance and Patient Safety, Assistant Medical Director – Clinical Governance	Trust Board	CMO Learning from Deaths (ME scrutiny and Child death review) report to the Board via the CMO (as per NQB requirements)	Quarterly
LeDeR Outcomes and progress on action plans	Lead Nurse - Vulnerabilities	Chief Nurse via Vulnerabilities Steering Group	Vulnerabilities Steering Group receives updates on LeDeR report outcomes and action plans monthly. This is reported to the Chief Nurse via the Care Quality Group (NB this is also included in CQMG reports)	Monthly