



Learning from Deaths Policy

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Index

Section		Page
1.	Introduction	3
2.	Purpose	3
3.	Scope	4
4.	Definitions/Glossary	4
5.	Roles and Responsibilities	5
6.	Policy Implementation	6
7.	Mortality Governance	7
8.	Bereaved, Families and Carers	9
9.	Mortality Review Process	9
10.	Learning from Mortality	12
11.	Being Open Framework	13
12.	Impact Assessments	13
13.	Policy Review	
14.	Links to Other Policies	14
15.	References	14
Appendix 1	Mortality Case Note Review Governance Process	15
Appendix 2	How to Guide - Mortality Review process	16
Appendix 3	Learning Disability Mortality Review process	17
Appendix 4	Quality Oversight and Response System	18

1. Introduction

- 1.1. In recent years increasing concerns about patient safety in the NHS has intensified the need for us all to learn from the care we give.
- 1.2. It is important that BTHFT utilises a number of mechanisms to assure ourselves of the quality of patient care that we give and to make the most of any learning.
- 1.3. The review of the care of patients who die under NHS care is paramount to this assurance.
- 1.4. Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) is committed to improving the quality of care that we deliver and acknowledges that systematic review of patients who dies in our care has a crucial part in learning from the care we give.
- 1.5. BTHFT has an established mortality review process in place. This includes scrutiny of the hospitals statistics as well as individual case note reviews.
- 1.6. Mortality rates within BTHFT are monitored using a number of different metrics, these include the national Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality indicator (SHMI) and also our own local death rate.
- 1.7. Deaths that are subject to Coroner's inquests, serious incident investigations and complaints are subject to an intensive learning process.
- 1.8. Our case note reviews provide a wealth of information regards patient care.
- 1.9. BTHFT is developing a process to learn from all our care, Mortality data and reviews will contribute to this wealth of knowledge, ensuring that any patterns or trends are detected and that where necessary all incidents are reported and investigated in a way that we learn from what we have done and improve the care we give.
- 1.10. Completion of timely and proportionate mortality reviews will enable BTHFT to identify recurring and emerging issues and to be able to respond quickly to any questions raised by external organisations, e.g. CCG, CQC, in relation to mortality trends.

2. Purpose

- 2.1. The purpose of this policy is to describe the processes and the governance associated with BTHFT's learning from mortality programme. We will learn from the deaths that occur within BTHFT in line with the National Guidance on Learning from Deaths (see reference 1 in section 15).
- 2.2. The policy describes how we will provide a consistent and coordinated approach to undertaking mortality reviews, reporting on findings, and implementation of identified actions. It will also clarify how the process for

mortality review dovetails with other investigation processes within BTHFT, to facilitate a streamlined and coordinated interface with incident, complaint, inquest and claims investigations, where applicable.

- 2.3. The policy describes how we will respond to and learn from bereaved relatives and carers.
- 2.4. The policy describes how we interact with external organisations and how we will comply with the national mandated mortality review processes.
- 2.5. The policy recognises that this is an iterative process and will need to be reviewed as we learn from what we do, as clinical care changes and as national directives change.

3. Scope

- 3.1. This policy applies to all patients and their bereaved relatives and carers who are under the care of BTHFT and die whilst being cared for in hospital.
- 3.2. Further work is being undertaken to develop processes for the review of mortality up to 30 days post discharge. At present these patients are not within the scope of this policy.
- 3.3. For certain patients, those with learning disability, paediatrics and maternity are subject to national review processes which are referred to in this policy but may be outside the BTHFT episode of care and are subject to nationally mandated mortality review and learning processes.
- 3.4. The policy applies to all Staff in BTHFT.

4. Definitions/Glossary

- 4.1. **Mortality Review** – refers to the standard case note review triggered only by the death of a patient and will use Structured Judgement Review (SJR) methodology.
- 4.2. **Hospital Investigation** – refers to a process often triggered by an adverse event or outside request e.g. Coroner, CQC and involves an in depth exploration of all the facts. It may involve SJR of the clinical notes.
- 4.3. **HSMR** - Hospital Standardised Mortality Ratio is a ratio of the number of in-hospital deaths to the number of “expected” deaths (which is calculated according to factors such as age band, sex, co-morbidities etc) calculated for 56 specific clinical classification groups.
- 4.4. **SHMI** - Summary Hospital-level Mortality Indicator is published quarterly by the Department of Health. It is calculated in a similar way to HSMR, but includes deaths in all clinical classifications, and also deaths occurring up to 30 days after discharge.

- 4.5. **SJR** - Structured Judgement review; this is the methodology presently used to perform the mortality reviews.
- 4.6. **HED** - Hospital Episode Data, the commercial database/software application used by BTHFT.
- 4.7. **MBRRACE-UK** - Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK.
- 4.8. **CDOP** - Child Death Overview Panel.

5. Roles and Responsibilities

5.1. BTHFT Board

- 5.1.1. Through the Medical Director the Board is responsible for learning from mortality at BTHFT.
- 5.1.2. BTHFT has a named Non-Executive Director to oversee the approach to learning from deaths. This is the chair of the Quality Committee.

5.2. Non-Executive Director

- 5.2.1. Understand the review process: ensure the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.
- 5.2.2. Champion quality improvement that leads to actions that improve patient safety.
- 5.2.3. Assure published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.

5.3. Associate Medical Director for Quality Improvement (AMDQI)

- 5.3.1. Operational responsibility for the mortality review programme, including reporting its findings and implementing improvements.

5.4. Quality Committee

- 5.4.1. Will seek assurance that all mortality at BTHFT is reliably reviewed, monitored and reported. Receive reports from the Mortality sub Committee and report to the Board of Directors.

5.5. Mortality Sub-Committee

- 5.5.1. Will seek assurance that mortality is reliably reviewed, monitored and reported. That all information is disseminated to all relevant staff and patient groups. That all learning is collated and recommendation on actions are made where applicable.

5.6. Mortality Review Improvement Group

- 5.6.1. Has responsibility to implement, monitor and improve the mortality review process in line with the national directives whilst also contributing to the regional and national mortality review programmes.

5.7. HED (mortality data) Reporting Group

- 5.7.1. Will review monthly the hospital mortality data via the HED informatics system. It will monitor specifically the HSMR and SHMI data plus look for changes and trends in mortality in all diagnostic groups. In areas of high mortality internal investigations or observation regimes will be instigated. A regular HED report will be produced and disseminated.

5.8. The Quality Improvement team

- 5.8.1. Working alongside the AMDQI, co-ordinate the mortality review process, maintaining an up-to-date spreadsheet of reviewers and cases. They will review and analyse the results of mortality reviews, producing a quarterly Mortality Outcomes Report displaying an overview of the data. They are responsible for escalating cases to the Governance & Risk team, where appropriate.
- 5.8.2. The team are also responsible for reviewing national benchmarking tools such as HSMR and SHMI, provided by the Healthcare Evaluation Data (HED) and collating this information into a quarterly Mortality Dashboard. The AMDQI will initiate a co-ordinated review in to any areas of concern.
- 5.8.3. Any cases where there are concerns identified either through individual reviews or from sources of mortality data will be escalated to the Medical Director.

5.9. The Clinical Coding Team

- 5.9.1. Will ensure that the patient's care is coded appropriately.

5.10. Divisional Clinical Directors, Deputy Clinical Directors and Heads of Nursing

- 5.10.1. Will ensure and give assurance that the processes in this policy are implemented reliably in their respective divisions. Specifically that mortality reviews are done using structured judgement methodology and that mortality statistics and the output from the mortality reviews are discussed and learning is acted upon.

5.11. Mortality Reviewers

- 5.11.1. Will be identified individuals for most specialities. They will have the responsibility to ensure they are trained to perform SJRs and attend mortality review update sessions at least once per year. They will identify the relevant deaths to be reviewed and ensure these reviews are performed in the expected time frame. They will report and

escalate the reviews once completed in line with the process described.

5.12. All Medical Staff

- 5.12.1. Will have a responsibility to ensure all mortality reviews are done for the relevant patients in their care, that the learning from the reviews is collated and acted upon to improve the quality of care.

5.13. All Nursing Staff

- 5.13.1. Will have a responsibility to contribute towards the mortality reviews, understand the mortality data and contribute to any quality improvement projects.

5.14. Informatics

- 5.14.1. Will have a responsibility to collate mortality data, help managers and clinicians understand the data and to help conduct investigations where applicable.

5.15. The Governance & Risk team

- 5.15.1. Are responsible for investigating cases which have been escalated by the QI team where care has been deemed to be below an acceptable standard.

5.16. Learning Disability Forum

- 5.16.1. Are responsible for identifying those deaths in patients with a learning disability where review is required, and collating and disseminating any learning.

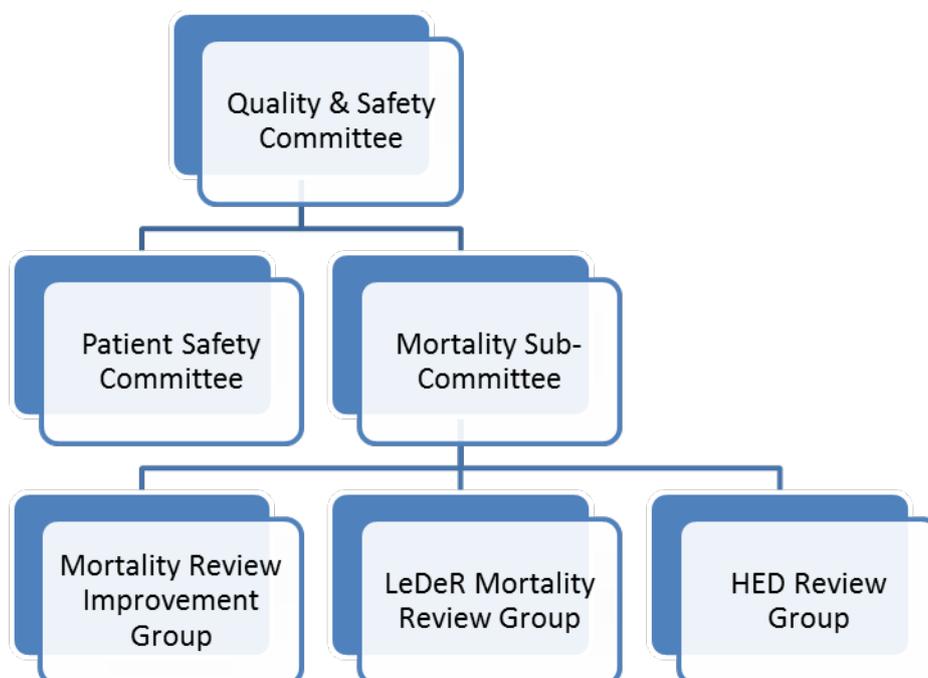
6. Policy Implementation

- 6.1. The policy will be ratified by the Medical Director. It will be disseminated via the Divisional Clinical Directors, Deputy Divisional Clinical Directors, Divisional General Managers and Clinical Governance leads.

7. Mortality Governance

7.1. Governance Structure

- 7.1.1. The established BTFHT mortality review governance process is described fully in appendix 1.



7.2. Mortality Sub- Committee

- 7.2.1. This group has oversight of mortality across BTHFT. Receives updates from mortality reviews including learning from Coroner's reports, serious incidents and 'other' risk incidents, mortality related national audits as well as overseeing the Mortality Review Improvement programme. It provides assurance to the Quality & Safety Committee and is chaired by the Associate Medical Director for Quality Improvement with the Associate Director of Quality as deputy. This meeting is held quarterly.

7.3. Mortality Review Improvement Group

- 7.3.1. Membership includes and is open to all specialty mortality leads, staff trained in the structured judgement case note review method and any others involved in mortality review or have an interest in it. There has also been interest from colleagues from Paediatrics who attend periodically. This meeting is held monthly and chaired by the Associate Medical Director (AMD) for Quality Improvement. Members also support the 'second reviewer' process when triggered.

7.4. HED Review group

- 7.4.1. This group meets monthly to undertake mortality surveillance using the HED (Healthcare Evaluation data) online system. This proactive approach to mortality monitoring is an essential part of assuring high quality clinical care and is currently managed by the Quality Improvement team.

7.5. Learning Disability (LeDer) Mortality Review group

- 7.5.1. This group has responsibility for reviewing all Learning disability patient deaths at BTHFT. Cases reviewed will also include mental health cases as identified by Bradford District care Foundation Trust colleagues or through our internal processes in place.

8. Bereaved, Families and Carers

- 8.1. The BTHFT has a bereavement policy which will outline how the carers and the bereaved will be informed and consulted in a meaningful and compassionate manner.
- 8.2. In summary:
 - 8.2.1. Carers and family will be given opportunity and encouraged to raise concerns or comment either directly with the consultant or nursing staff in charge, the bereavement office or through the complaints process on the care their loved one received in the hospital.
 - 8.2.2. When there is a hospital investigation into a death taking place the relatives/carers will be informed, asked for comment and will be involved if they wish to be.
 - 8.2.3. When a clinical case note review is being done, as part of our routine mortality review process, the relatives/carers will not necessarily be informed.

9. Mortality Review Process

- 9.1. When a patient dies whilst an inpatient in the BTHFT their care will be eligible for review using our mortality review process.
- 9.2. BTHFT will use Structured Judgement Review (SJR) methodology for the mortality review process. This is a nationally recognised methodology known to provide good quality information regards health care.
- 9.3. The SJR case note review method - enables a reviewer to examine and evaluate care. The review method combines structured reviewer comments with quality of care scores to assess the care of people who die in hospital.
- 9.4. The SJR method encourages reviewers to identify and celebrate good care as well as poor care and facilitates the identification of actions for improvement and suggests lessons that may be learned.
- 9.5. It is different to the traditional case note review approach as the process encourages the reviewer to rationalise their clinical assessment / judgement of the care received by the patient by using positive and / or negative commentary to describe the quality and standard of care received.
- 9.6. The safety and quality information that arises from this method provides a rich source of learning and will be used for governance purposes [including duty of candour issues] and for quality improvement initiatives.

- 9.7. The established BTFHT mortality review process is described in appendix 2.
- 9.8. All patients who die in hospital are eligible to have their care reviewed using SJR methodology. Those patients undergoing detailed investigation by external authorities or through the Serious Incident process may not be eligible but a SJR review may be requested.
- 9.9. Not all patients who die in hospital will have their care reviewed. Reviewing large numbers of case notes is often not possible nor does it increase the opportunities for learning. In specialities with large numbers of deaths (>100 per annum) it is expected that a selection of deaths will be reviewed. The selection process will be proposed by the specialty but approved by the mortality subcommittee.
- 9.10. However patients who die in hospital must have their care reviewed if they fall into the following criteria:
- 9.10.1. All deaths where carers/relatives or staff have raised concerns about the quality of care
 - 9.10.2. All patients with Learning Disabilities
 - 9.10.3. All patients who were not expected to die or were elective admissions to hospital
 - 9.10.4. All patients in diagnosis groups where 'alerts' have been raised (for example by the Care Quality Commission)
 - 9.10.5. All patients where quality improvement programmes are in place and mortality reviews are deemed essential to the learning
 - 9.10.6. Deaths in patients where severe mental illness has been identified
 - 9.10.7. All deaths in specialities with smaller number of deaths per annum (<100)
- 9.11. BTHFT's ambition is that a minimum of 25% of all the patients who die in hospital will undergo a detailed structured judgement review. There is little evidence to suggest reviewing all deaths increases the learning above a smaller number of good quality reviews.
- 9.12. Regular Structured Judgement Review training will be available for all mortality reviewers. Update training for existing reviewers will be available.

9.13. Collaboration with Other Organisations

- 9.13.1. Many of our patients will be cared for or involved with other organisations (for example nursing homes and Bradford District Care Trust). Where necessary or when requested to we will review the care of patients who came through our organisation but did not die. We will use the same governance process and mortality review methodology as for our inpatients.
- 9.13.2. As required, we will work closely with other organisations to develop processes for sharing learning from mortality.
- 9.13.3. For certain categories collaboration with other organisations is mandated, this includes maternal and paediatric deaths.

9.14. Working with Priority Areas

9.14.1. Learning Disabilities

- 9.14.2. All patients with learning disabilities who die at BTHFT will undergo a mortality review (process described in appendix 3).
- 9.14.3. All learning disabilities deaths will be reported to the national LeDeR programme (as required).
- 9.14.4. BTHFT has an established process to contribute to the mortality reviews in the LeDeR programme.
- 9.14.5. Through the mortality governance process BTHFT will receive and review the LeDeR programme reports when produced and implement relevant recommendations.

9.14.6. Mental illness

- 9.14.6.1. Patients with severe mental illness who die at BTHFT will be identified and their care reviewed as per our Structured Judgement Review process.

9.14.7. Paediatric deaths

- 9.14.7.1. Children who die at BTHFT will have their care reviewed as directed in the national programme for child mortality review.
- 9.14.7.2. BTHFT will continue to comply with the Child Death Overview Panel (CDOP) process but is aware that the national programme and recommendations are being reviewed.
- 9.14.7.3. BTHFT will receive and review the national reports related to paediatric deaths, learning will be disseminated through the relevant divisional channels and the relevant changes implemented.

9.14.8. Stillbirth and neonatal deaths

- 9.14.8.1. BTHFT review all perinatal deaths and will be adopting the MBRRACE-UK mortality review tool once it is made available. In addition there are perinatal multidisciplinary team mortality (and morbidity) meetings are held monthly with an annual summary each year.
- 9.14.8.2. All deaths are submitted to MBRRACE-UK contributing to a report containing national comparison.

9.14.9. Maternal deaths

9.14.9.1. Patients who die whilst pregnant or within one year of delivery will be subject to the nationally mandated maternal mortality review, MBRRACE-UK, which BTHFT complies with.

9.14.9.2. The MBRRACE-UK reports will be received and reviewed, learning will be disseminated through the relevant divisional channels and relevant changes implemented.

10. Learning from Mortality

10.1. The Mortality Sub-Committee is the initial conduit for learning from mortality. Representation is made from across the divisions and other corporate departments which can contribute to and learn from mortality, such departments include:

- 10.1.1. Bereavement
- 10.1.2. Palliative Care
- 10.1.3. Governance and Risk (as required)
- 10.1.4. Clinical Coding
- 10.1.5. Quality Improvement
- 10.1.6. Service Improvement

10.2. The requirements set out in the national guidance require that we publish information specifically on

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

10.3. The Mortality Sub-Committee has wide representation from across BTHFT.

10.4. The Mortality Sub-Committee submits a biannual report to the Quality and Safety Committee reporting on BTHFT's Mortality Improvement Programme.

10.5. The Mortality Sub-Committee meets every two months and has a standing agenda which is intended to help BTHFT learn from mortality from all sources:

- 10.5.1. Local Mortality surveillance and reporting
- 10.5.2. HED Mortality report
- 10.5.3. Mortality Outcomes report
- 10.5.4. Learning from Coronial investigations, Claims and Serious incidents
- 10.5.5. Mortality Review improvement work
- 10.5.6. Learning from reviews and action planning to improve practice
- 10.5.7. Learning Disability Reviews
- 10.5.8. National guidance on Learning from deaths

- 10.5.9. LeDeR – Learning disability mortality review programme (District wide position)
- 10.5.10. Regional / National Mortality Programme
- 10.5.11. Items to escalate to the Learning and Surveillance Hub

10.6. Learning from mortality will feed into the Quality Oversight System, this is described in appendix 4.

10.7. BTHFT will comply with all the requirements of the Coroner's office in terms of Death certification, notification to the Coroner's office and coronial investigations where applicable.

10.8. Where a death is deemed a serious incident the case will be referred to the Governance and Risk Team and will be dealt with as per BTHFT policy.

10.9. BTHFT will comply with the national requirement to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings (including information on reviews of the care provided to those with severe mental health needs or learning disabilities).

10.10. As per the national guidance BTHFT will not use the term "avoidable mortality"

11. Being Open Framework

- 11.1.1. There are no implications associated with the Being Open framework in relation to this policy.

12. Impact Assessments for this policy

12.1. Financial Impact Assessment

- 12.1.1. There are no financial impacts associated with this policy. This will be reviewed at the next review date.

12.2. Privacy Impact Assessment

- 12.2.1. The Privacy Impact Screening Tool was completed for this policy and no privacy implications were identified

12.3. Equality Implications/Impact assessment

- 12.3.1. This Policy was assessed in September 2017 to determine whether there is a possible impact on any of the nine protected characteristics as defined in the Equality Act 2010. It has potential impact on:

- Age - There are different processes to be followed for patients aged up to 18 years
- Disability - There are specific processes to be followed for reporting on patients with learning difficulties and mental health

issues. The SJR form is amended to include consideration of appropriate communication for deaf people and those with learning difficulties.

- Maternity/pregnancy - There is a specific process to be followed for women who die within the first year following delivery.
- Race and ethnicity - The SJR form is amended to include consideration of appropriate communication for those who are unable to communicate in English.

12.3.2. It has been found not to have no impact on:

- Gender
- Gender reassignment
- Marriage and civil partnership
- Religion and belief
- Sexual orientation

12.3.3. It has also been assessed to determine whether it impacts on human rights against the FREDA principles (Fairness, Respect, Equality, Dignity, Autonomy) and it is considered that it has a positive impact. This assessment will be reviewed when the policy is next updated or sooner if evidence of further impact emerges.

13. Policy Review

13.1. This policy will be reviewed in 12 months to ensure it is relevant and responsive to changing clinical practice.

14. Links to Other Policies

14.1. Bereavement Policy.

14.2. Risk Incident Reporting and Investigation Policy.

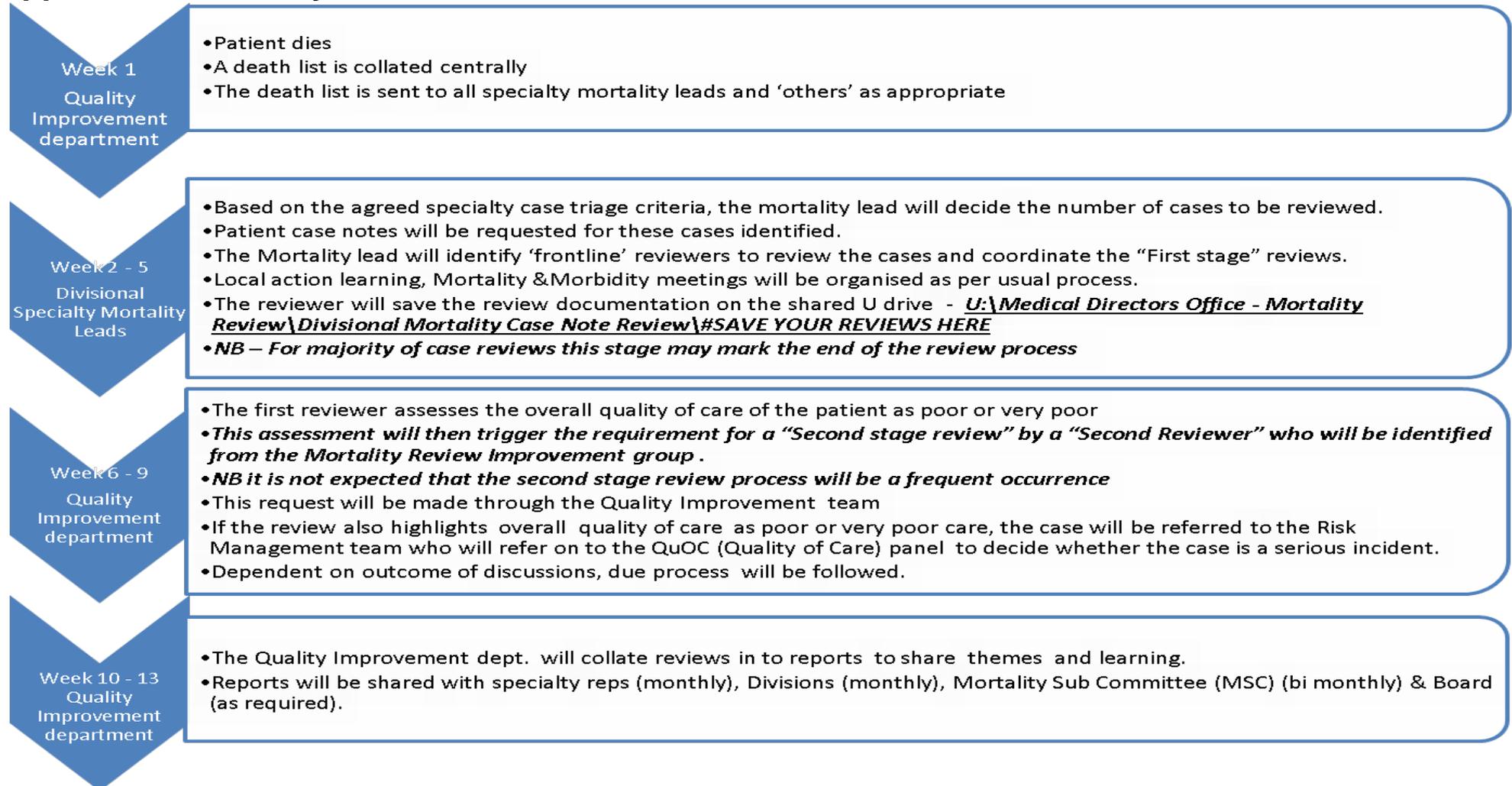
14.3. Serious Incident and Never Event Policy.

15. References

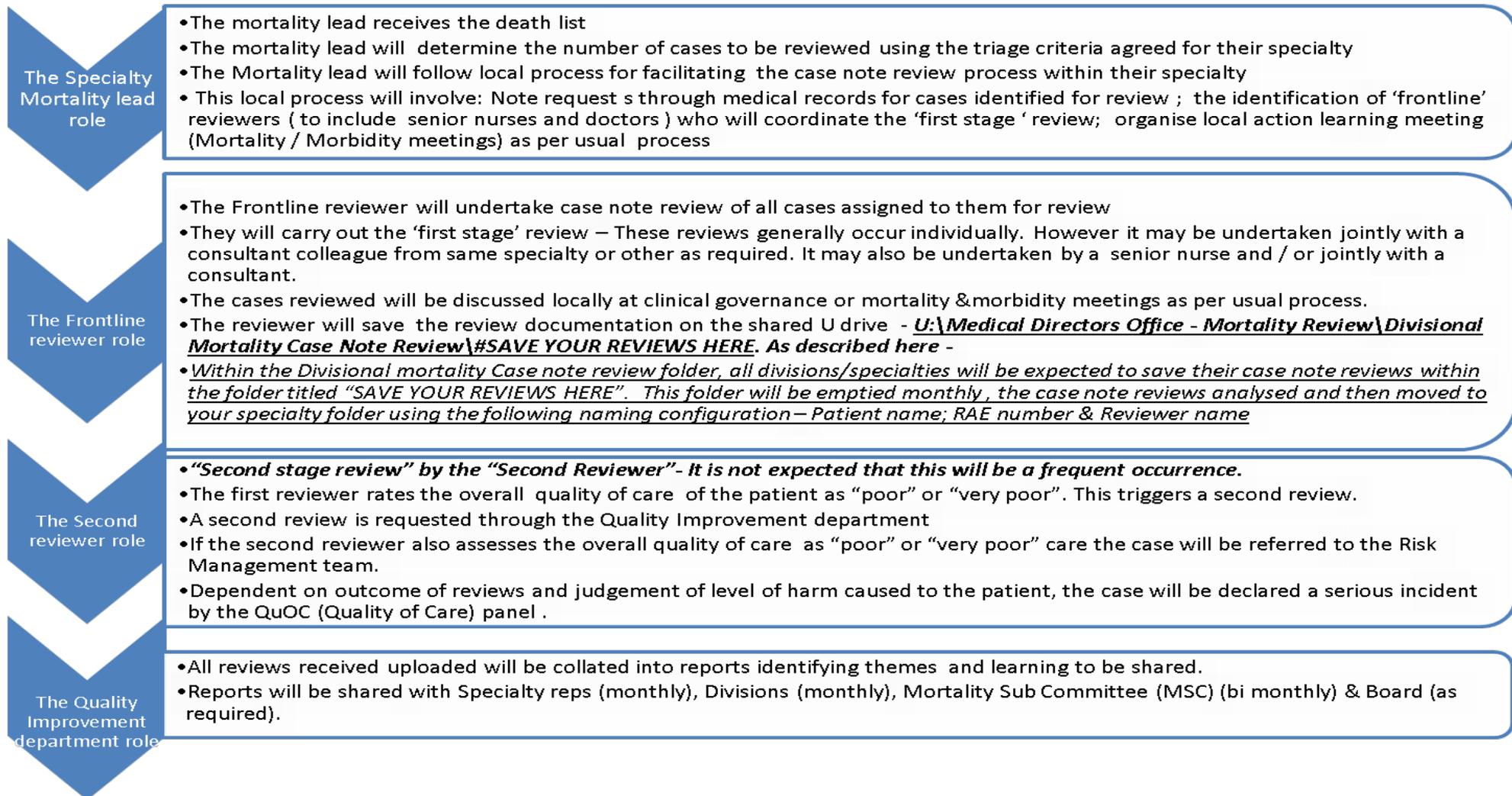
15.1. National Guidance on Learning from Deaths: <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>

15.2. Serious Incident Frame work:
<https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf>

Appendix 1: Mortality Case Note Review Governance Process



Appendix 2: How to Guide - Mortality Review process



Appendix 3: Learning Disability Mortality Review process

LD patient dies

- LD patient death is identified through a number of routes set up - Bereavement services, the BTHFT safe guarding team following the completion of the closing the gap assessment process on the admitting ward and through community partners at Waddiloves; any other eg Palliative care team.
- The LD core group is notified of the death

Review of the LD death

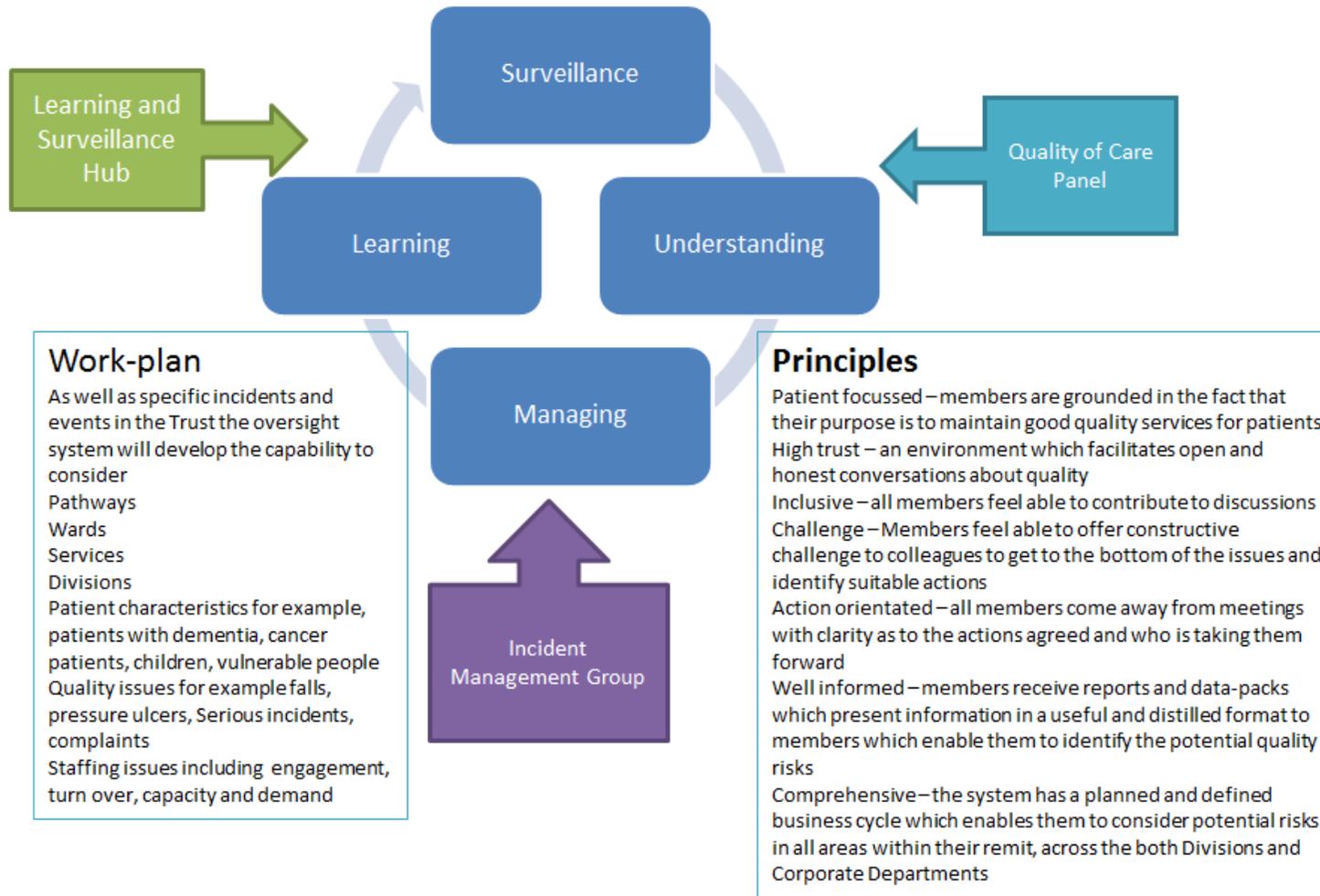
- The patient death is confirmed on iPM
- The patient's case notes are requested ensuring that the most recent episode of care is available
- If the review has not already been undertaken at specialty level, the initial case note review will be undertaken by the LD core group. This group consists of a Senior Nurse, the Safeguarding lead nurse and 2 Senior doctors. The Trusts standardised mortality review process will be used. NB: The mortality lead of the specialty of death should be notified of this review
- Where a second review is required, the mortality lead within the specialty of death will facilitate this review and then report back to the core group with their findings
- NB The review phase will also serve as confirmation of the patients' learning disability status before the death gets notified to the LeDeR team

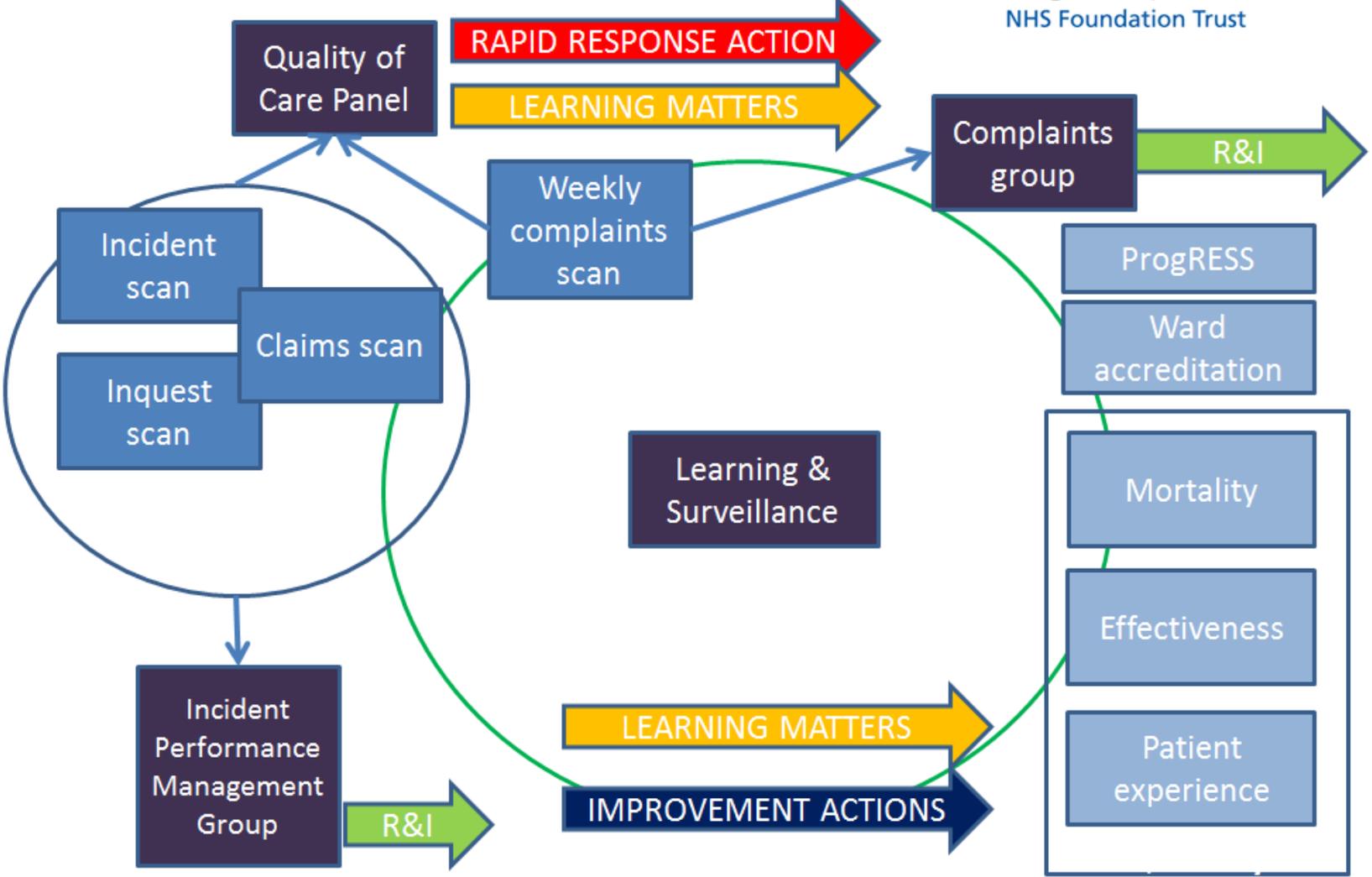
Notification of the LD death

- Once the case has been reviewed and the LD status confirmed, the death will be notified to the LeDeR team using the online system
- The notification process will be completed by the Assistant Chief Nurse

Appendix 4: Quality Oversight and Response System

Quality Oversight System





Learning and Surveillance Hub: Surveillance and Learning

Purpose

To act as a virtual team across the Foundation Trust, bringing together all Divisions and Corporate Departments and their respective information and intelligence, gathered through performance monitoring, and regulatory activities.

All members should feel ownership and responsibility for the effective operation of the group. By collectively considering and triangulating information and intelligence, members will work to safeguard the quality of care that people receive through learning and translation into practice activities

Members should be seen as a network of partners who work together and share information in the interests of patients and service users. This should not be confined to formal meetings. The Learning and Surveillance Hub can act as a virtual network in between meetings, with members interacting with each other in smaller groups where appropriate.

Information sources

Any information deemed relevant to the purpose of the group by its members including

- Mortality Sub-Committee
- Serious incident reports and action plans
- Datix reports
- Complaints
- Claims
- PALs
- External reports
- ProgrESS reports
- Leadership Walk rounds
- Quality Dashboards
- Ward accreditation

Mechanism

Monthly challenge and translation forum where those with the operational responsibility for informal and formal learning are able to challenge progress and identify best practice in formal and informal learning

Membership

- Associate Director of Quality*
- Assistant Director for Governance and Risk*
- Divisional and corporate directorate representation with operational management responsibility for learning and translation in their area of work
- Assurance and Regulation Manager
- Head of Effectiveness and Assurance

Agenda focus

- Are we learning?
- How are we learning?
- How do we know that we are?
- What more can we do?

Outputs

- Supporting the development of learning strategies for across the Trust
- Escalation of issues for immediate attention to the Quality of Care Panel
- Actions / investigations by individual members;
- Triggering a ProgRESS review –where further evidence/assurance of learning is required
- Identification of good practice in formal and informal learning
- Supporting assurance in relation to the effectiveness of action planning
- Supporting prioritisation within the Quality Improvement Programme

Quality of Care Panel: Surveillance and Understanding

Purpose

To ensure an executive leadership clear line of sight through the care provision and operational activities of the Trust, to ensure any past, present or future potential or actual unmitigated risk to the quality of our services has been captured, is understood and is being acted on and learnt from appropriately

Information sources

Serious Incident referral forms
Serious incident exception reports
Serious Incident investigation reports
Soft intelligence (internal/external)
Quality/Performance dashboard data
NPSAS alerts
Mortality Sub-Committee

Agenda focus

Review previous weeks harm, safety, risk
Take a 'temperature check' of current Trust position
'Horizon scan for anticipated risk/safety issues/pressure points in the Trust

Mechanism

Weekly quality focused decision making and discussion panel attended by executive and senior clinical and managerial leadership

Membership

Medical Director*
Director of Governance and Corporate Affairs*
Chief Nurse*
Deputy Medical Director
Associate Director of Quality
Deputy Chief Nurse
Assistant Director of Governance and Risk
* One of these executive directors should be present at each meeting

Outputs

Understanding of past harm: decisions associated with the declaration of Serious Incidents and the outcome of incident investigations
Understanding of latent risk: decisions associated with national alert compliance or exceptions escalated from Serious Incident/complaint investigation
Surveillance and decisions associated with the Trust's current position and defined actions associated with management of risk to quality
Surveillance and decisions associated with the Trust's current position and defined actions associated with management of risk to quality

Incident Management Group: Surveillance and Managing

Purpose

To review all incidents where a patient has died or there has been severe harm to ensure that the threshold for declaring a Serious Incident has not been reached and make recommendations as appropriate

To monitor the conduct and progress of all Serious Incident and Internal Investigations and escalate any concerns to the Quality of Care Panel (QuOC)

to review the content and quality of Duty of Candour disclosures following investigation of notifiable incidents and make recommendations where appropriate

To develop a work plan to ensure that thematic learning from incidents is identified and escalated/shared as appropriate with the QuOC or the Learning and Surveillance Hub

Information sources

Incident Reports (including RIDDOR)
Coronial referrals
Serious Incident/Internal Investigation Database

Agenda focus

Review previous harm, safety, risk through discussion
Review current position and any changing risk/issues with conduct
Engage with work plan

Mechanism

Bi monthly discussion, forum where those with the operational responsibility for the management of incidents are able to highlight concerns and identify best practice

Membership

Assistant Director for Governance and Risk*

Deputy Medical Director*

Risk Management team

Divisional representatives (quality leadership role)

Assurance and Regulation Manager

Risk Management Secretary

* One of these senior representatives should be present at each meeting

Outputs

Escalation of incidents and their sequelae to QuOC Panel

A consistent approach to the management of Serious Incidents and internal investigations

A consistent approach to the review of Duty of Candour disclosures

To provide intelligence to the Learning and Surveillance Hub