NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
Paper number	Enclosure D1

Report provided:							
For approval:	√	For assurance:	√	To note:		For information:	

Quality Governance Committee Report

Accountable Director	Bill Tunnicliffe Non-Executive Director
Presented by	Bill Tunnicliffe Non-Executive Director
Author	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√
	Invest and realise the full potential of our staff to provide compassionate and personalised care		Ensure the Trust is financially viable and makes the best use of resources for our patients	
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability		Operational Performance	
	Quality of Care	√	Finance and use of resources	
	Strategic Change		Stakeholders	

Report previously reviewed by N/A		
Committee/Group	Date	Outcome

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF number(s)	R1.1, R1.2, R1.3,
Level of assurance and trend level			
Significant	Limited (level) √	None	

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Purpose of report	This paper provides the Board with the key achievements, issues, and risks discussed at the Quality Governance Committee on 27 July and 24 August 2017.
Summary of key issues	The discussion at QGC is becoming more focussed on providing assurance. The Clinical Governance Group (CGG) provides an excellent report to QGC from which a level of assurance can be gained. This month the Committee members used SQuID as an interactive way to view performance data and I am hoping that this approach will benefit the Committee's work in due course. From September, I am inviting the divisions on a month by month basis to undertake a deep dive into their key risks and issues. For the months of July and August, the Committee advises that limited assurance can be given in respect of the items discussed.
Recommendations	The Board is recommended to: • Approve the Policy on Learning from deaths • Note the update on the section 29a letter response • Note the assurance given within the report • Note that the QGC has approved the Safeguarding Annual Report and the Infection Control Annual Report

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT FROM THE QUALITY GOVERNANCE COMMITTEE

1 Introduction

This report provides the Board with key quality issues and risks discussed at the QGC meetings held on 27 July and 24 August 2017.

2 Background

The QGC is set up to give assurance to the Trust Board on issues affecting quality of care to patients. The membership consists of four non-executive directors and four executive directors plus a patient forum representative. HealthWatch will commence re-attending the meetings in September.

3 Issues discussed

3.1 Section 29A

The Chief Executive gave a comprehensive briefing to the Committee on the actions being undertaken with respect to the section 29a notice received in July 2017. The Chief Nurse had tested the thoroughness of the work being undertaken through an unannounced peer review to both Worcestershire Royal and the Alexandra Hospital on 22 August. A full report relating to this visit will be presented to the Committee at the next meeting.

There are nine sections of the improvement notice, all of which are reporting progress with the actions required.

Section 1	Learning from Incidents
Section 2	Assessing and responding to patient risk
Section 3	Medicines Management
Section 4	Infection and prevention control
Section 5	Safety of premises and equipment
Section 6	Bed capacity and patient flow management
Section 7	Safeguarding
Section 8	Fit and Proper Persons
Section 9	Fitness of equipment

Other actions include

- Approval of the Board development programme
- Risk and governance work including revision of the BAF, new performance management meetings and revised risk management strategy
- Patient confidentiality including changes to the electronic whiteboards
- Freedom to Speak Up guardian activity, including recruitment
- Work on the reduction of clinical vacancies

The areas which still need more progress to be made include VTE assessment. Mrs Morris will be undertaking further unannounced peer reviews in September and a full 'mock' CQC inspection led by NHS Improvement is also scheduled in September.

3.2 SQuID (Safety and Quality Information Dashboard)

As mentioned above, the Committee used SQuID for interactive live data. The

information is shown from ward to board and can be easily interrogated. The Divisions are beginning further developing the use of application within their meetings.

3.3 **Clinical Governance Group (CGG)**

The Chief Nurse spoke to the comprehensive CGG report. In summary the key issues and risks are shown below:

Specialist Clinical Services Division - The Group received a divisional report which identified the three top risks for the division for the month. It also discussed the WHO surgical safety checklist observational audit which shows improvement. The audit was seen to be of more value than the audit undertaken on the theatre system as this is retrospective and may give false assurance. The division is to explore how further observational audits might be undertaken.

Surgery Division- The top three risks to the division were reported and discussed. The performance against time to theatre for #NOF had dipped but this was due to a cohort of patients who have not been fit for theatre within the time scale. This KPI is starting to improve again. Health Education England (HEE) has undertaken a visit to the orthopaedic juniors and recommendations are being addressed within the division.

Medical Division – The top three risks for the division were identified and discussed. Concerns remain about the staffing and performance on the Silver Assessment Unit and these continue to be addressed through intensive support and a new ward leadership team. The Division continues to seek to address the backlog in complaints.

Women and Children Division: The top three risks were identified and discussed. The patient flow between delivery suite and maternity has been causing delays to the elective flow. This has been addressed with improvements in the system leading to improved flow and significantly earlier starts to the elective lists.

Other papers considered at the CGG included:

- Introduction of the new falls assessment and intervention paperwork
- Infection Prevention & Control Annual report and annual plan
- Safeguarding Annual Report and annual plan
- Update on VTE assessment
- Update on the delayed GP letters issue
- Update on external visits
- Update on Patient Safety Alerts

The CGG have embraced the discussion of risk and debating the levels of assurance for agenda items. This provides a positive position for the maturity of the risk and governance systems and processes.

Concern was expressed again by the Committee on the poor performance in relation to the management of complaints. The Committee felt that the learning from complaints was not taking place. Mrs Morris confirmed that the process was being reviewed within each division. I have agreed to visit the Complaints central function to support the staff in their work.

The Committee reviewed the individual division presentations. I have agreed to visit the Surgical Division to understand further the issue of cancelled operations which have a significant effect on patients and their families.

I will also visit Silver Unit.

The Committee expressed concern about mandatory training and the necessity for some managers to have manual records.

The level of assurance was confirmed as limited

3.4 Quality Improvement Board

The purpose of the Board is to monitor implementation of the Quality Improvement Plan, following Board approval of the Plan in July. The Committee was informed of the six work streams, each led by an executive director. The report contained high level objectives for each work stream. The Committee requested that assurance was now needed on the impact of the actions being taken.

The six work areas are:

- Deteriorating patient (CMO)
- Safe care (CNO)
- Governance (CNO)
- Operational Improvement (COO)
- Patient experience (CNO)
- Culture and Workforce (CEO)

The level of assurance was agreed to be limited as the process is being developed.

3.5 Mortality

The Committee considered the monthly mortality paper which showed a rise in crude mortality caused by the effects of winter. There is a difference between the mortality in the Alexandra Hospital and Worcestershire Royal, due to the difference in the case mix with a significant number of elderly people attending the Alexandra Hospital.

The number of reviews are still below trajectory, however the process is changing with the appointment of medical examiners to take forward the review process.

The policy for learning from deaths is attached and I commend it to the Board for approval.

The Committee agreed that limited assurance was given in respect of mortality.

3.6 GP letters issue

The Chief Medical officer gave an update on the letter backlog. The Trust has sent out 3000 letters. To date, one case of potential harm has been identified and is being reviewed in line with the agreed process. The issue is on the Board agenda for a further update. The serious investigation has commenced and the report will come to the Committee when completed. The Trust has instigated a review of clinical IT systems.

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3.7 Safeguarding Annual Report
Infection Control Annual Report
The Committee approved both of these reports which are on the agenda for today's meeting. I commend them to the board.

3.8 Items approved by the Committee

- BAF Quality risks
- Work plan

3.9 Items noted by the Committee
NHS I Patient Experience self-assessment; This provides a baseline for the development of a strategy with patients. Further actions will be bought back in quarter 4.
Care in the Corridor Survey Report: This report was compiled by HealthWatch. The Committee will consider an updated action plan at the next meeting. Thanks were expressed to HealthWatch for their work.

4 Implications
This Committee considers items which are under the framework of the Health and Social Care Act 2012. (Section 29A letter)

5 Recommendations
The Board is recommended to:

- Approve the Policy on Learning from deaths
- Note the update on the section 29a letter response
- Note the assurance given within the report
- Note that the QGC has approved the Safeguarding Annual Report and the Infection Control Annual Report

Compiled by
Kimara Sharpe
Company Secretary

Director
Bill Tunnicliffe
Chairman, QGC

Learning from deaths policy

Department / Service:	Corporate Governance
Originator:	S Graystone AMD Patient Safety
Accountable Director:	CMO
Approved by:	
Date of approval:	
First Revision Due:	February 2018
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All
Target staff categories	All clinical staff

Policy Overview:

This policy outlines the reason for and process of review of the care provided to patients who die whilst under the care of Worcestershire Acute Hospitals NHS Trust or within 30 days of discharge from the Trust.

The policy ensures that the Worcestershire Acute Hospitals approach to mortality reviews meets the standards required by the NHS National Quality Board.

This policy outlines how learning from reviews will be captured and the roles and responsibilities of those required to respond to care issues identified through the review process.

Latest Amendments to this policy:

New policy

Contents page:

- **Introduction**

  Learning from the care provided to patients who die is a key component of improving patient safety, experience and effectiveness, forming the building blocks of good governance and quality improvement work. Following recommendations by the CQC, the Secretary of State has made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die. The National Quality Board has produced a document outlining the standards to be achieved by all healthcare organisations in relation to the undertaking and outcomes from review of deaths. This policy sets out how the Worcestershire Acute Hospitals Trusts mortality review programme will meet these national standards.

- **Scope of this document**

  This policy applies to Trust clinical staff and those involved in the investigation of incidents and dissemination of learning.

  This policy covers the patient cohort as defined by the National Quality Board guidance published in March 2017 namely:

  - Any patient who dies in the emergency department
  - Any patient who dies whilst an in-patient
  - Any patient who dies within 30 days of discharge from Hospital
  - Any maternal death occurring within 42 days of delivery

  Patients who will not be subject to standard selection include those brought in dead (unless the patient had contact with this Trust within 30 days of death) and those patients transferred for care to another organisation/Trust; in which case, the Trust will participate in the review should the outside organisation/Trust suggest it.

The following selection of cases for in depth review is mandatory:

- All deaths where the family, carer(s) or staff have raised a concern about the quality of care provision. (This will include complaints, coronial inquests, serious incidents, litigation cases.)
- An infant, child, stillbirth or maternal death.
- All deaths where the patient was identified to be significantly disadvantaged, particularly all deaths of those with a registered learning disability and all deaths of those identified with severe mental illness.
- All deaths in a service specialty, particular diagnosis or treatment group, where an 'alarm' has been raised with the Trust through whatever means. For example, via a Hospital Standardised Mortality Ratio (HSMR) elevated mortality alert (CUSUM), concerns raised by audit work or by the Care Quality Commission or another regulator.
- All deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.

In addition, there is a requirement to screen all cases where there was evidence of sub-optimal care. These cases will include:

- All cases where a Datix was raised relating directly to the care of the patient.
- All cases where the patient's admitting diagnosis falls within groups identified by HSMR/SHMI analysis as being an outlying group
- All cases where the Trust is monitoring a service/diagnosis group, i.e. deaths where learning will inform the organisation's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths will be reviewed, as determined by the Trust.

Those cases meeting any of the above criteria will form part of the mandatory review.

- **Purpose**

  The purpose of this document is to provide a clear framework for a robust review process to ensure that learning is disseminated through the correct governance routes, that national mandatory reporting requirements are met, including reporting of incidents to the National Reporting and Learning System (NRLS) and to ensure that staff are aware of their responsibilities.

- **Definitions**
  - **LeDeR** – Learning Disabilities Mortality Review, a data gathering programme.
  - **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.
  - **SJR** - Structured Judgement Review, a tool developed by the Royal College of Physicians.
  - **Investigation** - the act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
  - **Death due to a problem in care** - a death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

- **Responsibility and Duties**

The Chief Executive

- Is responsible for ensuring meaningful and compassionate engagement with bereaved families and carers in relation to all stages of responding to a death occurs. See appendix 1
- Will ensure families/carers are advised of their right to request a mortality review if they have a significant concern about the quality of care provision.
- Will inform the Clinical lead for Mortality if a concern has been raised or request for review has been received from the family/carer.
- Will raise a scrutiny panel to review a series of incidents/internal investigations/SIs where learning has not been achieved/processes have not been put in place to mitigate risks to patients.

The Chief Medical Officer – Executive Lead for the Learning from Deaths Agenda

- Is responsible for the Learning from Deaths agenda.
- Pays particular attention to the care of patients with a learning disability or mental health needs.
- Ensures a robust and effective methodology for case record review with a view to identifying lapses in care and possible areas for improvement.
- Ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the Trust rather than individual errors in the problems that generally occur.
- Will address any non-compliance with staff where reviews are not completed, or the standard of completion is poor, or reviews are completed consistently after the deadline.
- Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board and is discussed at the public section.
- Will evaluate a case record review following any linked inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths" in order to examine the effectiveness of the Trust review process.
- Ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care.
- Ensures the sharing of relevant learning across the Trust and with other services where the insight gained could be useful.
- Ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths.
- Works with independent investigators where cases warrant external review.
- Works with commissioners to review and improve their respective local approaches following a death due to a problem in care.
- Ensures that the information the provider publishes is a fair and accurate reflection of its achievements and challenges.
- Will ensure that any information shared or published adheres to Caldicott principles.

Non-Executive Director – Responsible for oversight of progress

- Will play a crucial role in bringing an independent perspective to the boardroom and will scrutinise the performance of the Trust's management in meeting agreed goals and objectives and monitor the reporting of performance.
- Should be satisfied as to the integrity of clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.
- Will monitor that the information the Trust publishes is timely and a consistent, fair and accurate reflection of its achievements and challenges, seeking comparison data to help challenge potential for improvements whilst understanding direct comparison limitations.
- Will hold the Trust to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable.
- Will champion and support learning and quality improvement by understanding how learning is translated into sustainable effective action and monitor that learning and improvements are reported to the board and relevant providers.

- Will monitor that the Trust can demonstrate to stakeholders that "this is what we said we would do, and this is what we did" (learning and action), and explain the impact of the quality improvement actions.
- Will monitor that families and carers are involved in reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes.

The Director of Nursing

- As head of quality, the Director of Nursing will ensure that learning from case record review is reported in the Quality Account according to the standard template.
- Will ensure that nursing staff engage in the mortality review process.
- Will support the medical director in promoting the mortality review process.
- Will ensure that any nursing issues identified during review are addressed by nurse leads within the specialty, or more widely if appropriate.

The Medical Examiners for Mortality (MEM)

- Will, using the screening tool, identify the deaths for mandatory review e.g. vulnerable patient groups and cases where the family/carer has raised significant concerns about the quality of care provision, as described in the publication 'National Guidance on Learning from Deaths March 2017'.
- Will also select cases for review falling outside of mandatory categories as identified by mortality surveillance, Trust improvement priorities or other intelligence from external bodies or internal governance processes.
- Will work with the Medical Director to determine cases for peer review.
- Will inform the relevant service leads of the outcome of cases reviewed.
- Will identify any deficiencies in care/learning points, for the whole final admission period, or an earlier admission, if it was identified that the care delivered had impacted on the final admission.
- On identifying that a potential incident has occurred that requires action, will consider the following:
    - Is immediate action required? If yes ensure the relevant divisional directors and CMO/CNO are informed
    - Is anyone in immediate danger? If yes, ensure the relevant divisional directors and CMO/CNO are informed to ensure actions are taken to maintain safety.
    - Complete a Datix incident form, identifying that the incident has been raised following a mortality review, to facilitate tracking. If this meets the definition of the patient safety incident, it will be sent to NRLS (National Reporting and Learning System). If raised as a Safeguard, it will be reviewed within the safeguarding framework.
    - Will record the Datix number on the review form.

  (please refer to xxx Procedure for the Reporting and Management of Incidents and Serious Incidents Requiring Investigation (SIs))
- Will escalate serious concerns immediately to the Patient Safety Team
- Will raise concerns should they suspect that support given to the patient by other providers (e.g. Ambulance Service, Social Services, residential care, other healthcare providers) by completing a Datix incident choosing 'Other Healthcare Service Provider'.

- Will ensure that documentation is a true and accurate reflection of the patient's condition and treatment. If errors/the need for clarification are identified, they will provide an addendum in the health record or complete the 'comorbidity app' available through the eZnotes portal
- Will monitor the compliance with review completion and report to the Medical Director.
- Will send a standard review form to GPs for completion for all patients who die within 30 days of discharge.
- Will review case record findings and collate reports based on the SJR scales, summarise learning, and provide timely and accurate information for the quarterly public board report.
- Will liaise with leads and services not using the standard review tool (e.g. maternity, children's) to collate review summaries, learning and action points.
- Will provide reports to the Mortality Review Group and divisions, summarising case record review key learning points, themes and data relating to the SJR scales for patients accessing Trust services.
- Will review Datix incidents raised following a mortality review, bringing together the actions and learning.
- Will maintain a log to demonstrate action, learning and improvement.
- Will maintain a log recording where concerns have been raised by bereaved families and carers.
- Will work with the Medical Director and nominated Non-executive Director to ensure that systems are robust and accurate.

Divisional Medical Directors

- Ensure that the divisional structure for governance makes provision for learning from mortality review incorporating multidisciplinary review.
- Attend the mortality review group each month or send a deputy who is able to effectively represent the division.
- Develop a culture of learning from deaths within the division including Datix reporting where deficiencies in care are identified.

Investigation Officers (SI and Internal Investigation)

- Will follow the procedure as outlined in the Procedure for the Reporting and Management of Incidents and Serious Incidents Requiring Investigation (SIs) WAHT-CG-009, including implementing the Duty Of Candour guidance (Policy for Being Open and the Duty of Candour WAHT-CG-567) ensuring that bereaved families and carers have as much involvement in the review process as they wish, subject to respecting the expressed wishes of the deceased with regards to confidentiality.
- Will work with the identified action plan lead to compile a comprehensive action plan that meets the recommendations of the report.

The Divisional Governance Teams

- Will review concerns escalated to them by the Medical Examiners for Mortality and determine, in consultation with the appropriate director, whether the case requires the raising of a Datix and/or formal investigation and action.
- Where the incident is not deemed to be an SI/internal investigation, will ensure that bereaved families and carers are kept informed of progress should they wish to be. (It will be the responsibility of the SI/internal investigation team to provide family liaison support.)

- Will assist with the appointing of a staff member as a single point of contact, if this is required.
- Following the investigation, will inform the patient's GP of the outcome.
- If the investigation was prompted by a serious concern raised by the family or carer, they will assist in ensuring that the family/carer is as involved as much as they wish to be and treated in accordance with the Policy for Being Open and the Duty of Candour WAHT-CG-567
- Where a decision is made that a full investigation is not required following the review of concerns raised by the bereaved family/carer, will advise the CNO of the rationale behind this.
- Will provide a monthly report to the Mortality Review Group summarising learning and actions from mortality review investigations.

The Patient Safety Team

- Will ensure that where an SI is raised/internal investigation occurs for a patient who dies during that admission/or occurs as a result of mortality review, the summary produced from the 24-hour review/3-day report/7-day report is shared with the MEM team.
- Will advise the MEM team of any learning/actions following the completion of the 42/60-day review that will require monitoring through the mortality review process.
- Will work with the MEM to ensure that they are aware of patient safety themes that would warrant the mandatory review of a group of cases.
- Will receive themed actions from divisions to ensure that these are dovetailed with any existing actions to provide a consistent programme of action.
- Will liaise with the Clinical Commissioning Group where there is a multi-agency SI.

The Learning Disabilities Health Liaison Team

- Will support the LeDeR (Learning Disabilities Mortality Review) programme by registering all deaths where the patient had a learning disability on the LeDeR website, whether inpatient, out-patient or community.
- Will ensure, through spot checks, that patients with a confirmed learning disability are flagged on the Trusts PAS.
- Will participate in the peer review of patients with a learning disability who die in hospital or shortly after admission.
- Will escalate concerns to the Chief Medical Officer where deficits in care are identified and support the development, implementation and embedding of improvement methodology to improve patient care and reduce the number of avoidable deaths.
- Will identify care/safeguarding concerns, raising a Datix incident form as appropriate. Where the incident has the potential to be an SI, the team will ensure the Patient Safety Team are made aware of the incident.

Audit Midwife - Maternity MBRRACE

- A maternal death is defined internationally as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy.

- The audit midwife is responsible for recording the deaths of mothers, and babies on the MBRRACE website.
- The audit midwife will provide a quarterly report to the Mortality Review Group from the MBRRACE website for inclusion in the board report.
- The Bereavement Midwife will ensure that families are given a personalised letter from the Chief Executive expressing condolence and inviting comment about the care delivered.
- In addition to statutory reporting, the maternity team will undertake a review of care using an appropriate review tool.

The Bereavement Services Manager

- Will give the family/carer attending the bereavement suite a personalised letter from the Chief Executive/CMO expressing condolence and inviting feedback about the care received by the deceased.
- Will ensure that bereaved families are supported and sign-posted to services, (e.g. Leaflet 'What do I do now?').
- Will record any cases referred to the coroner on a shared data base.
- Will record all cases where cremation is the preferred option.

The Associate Medical Director for Patient Safety as lead for mortality reviews

- Will be responsible for training colleagues in the Structured Judgement Review methodology
- Will fulfil the role of Medical Examiner for Mortality if required to ensure completion of screening and reviews.
- Will review cases where the family/carer has raised a concern, completing a Datix incident report where substandard care is identified, escalating to the Patient Safety Team where appropriate.
- Where no issues in care are identified, will be responsible for summarising findings in line with Caldicott principles as part of a letter from the Chief Executive in response to the original request from the family carer.
- Will liaise with the Divisional Governance Manager(s) to ensure that the family/carer is kept informed as to progress at all points.

The Palliative Care Team

- Will submit a Datix incident form where lapses in care at the end of life are identified, including where a preferred place of care was not achieved/the patient experienced discharge delays.

Local Mortality & Morbidity Meetings/Divisional Governance meetings

- These meetings will normally be monthly, unless there are fewer on average than one death per month, in which case the meetings may be held every two months or quarterly, unless issues are identified, in which case, meeting frequency will be increased.
- Membership will be multidisciplinary, including nursing staff and professions allied to medicine such as pharmacy, nutrition and dietetics, physiotherapy.
- A summary of the meeting and attendance record will be kept in line with governance arrangements.
- Will review the speciality specific aspects of care in all patients whose outcome is death to ensure speciality specific standards are met.

- Will review the findings of all case record reviews in their specialty and identify actions and learning points for sharing both locally and Trust wide.
- Will ensure that learning is translated into sustainable effective action that measurably reduces risks to patients.
- Will ensure that overall learning and evidence of effective action from mortality discussions are reported to the Mortality Review Group. These reports should include evidence of both good as well as substandard care.
- Will pay attention to best practice and how this can be more broadly implemented.
- Will ensure that any internal investigation of a death which is not deemed to be an SI is discussed by a multi-disciplinary team with the findings minuted in a formal meeting.
- Will address any concerns where a team consistently fails to raise a Datix incident form at the time where issues in care are identified in the later SJR review.

The Mortality Review Group (MRG)

- Will receive the reports from the Divisions and pursue non-submission via the divisional structure.
- Will escalate concerns where teams consistently fail to raise Datix incident forms where harm or the potential to cause harm is identified by the SJR review process in consultation with the Divisional Management teams.
- Will decide whether the learning points have cross-specialty relevance and feed back to divisions where shared learning would be appropriate.
- Will monitor the actions of divisions to ensure that learning and change has occurred.
- Will monitor recurring themes and decide whether they should form part of additional training for staff during for example 'huddles', board rounds and other educational opportunities such as Grand Rounds, Journal Club, Multidisciplinary Governance Half Days and FY1 training.
- Will receive feedback from the board for dissemination to the relevant groups.

The Trust Board

- Will ensure that 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 by providing challenge and support.
- Will work with commissioners who are accountable for quality assuring the robustness of Trust systems so that the Trust develops and implements effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.
- Will receive quarterly reports from the Mortality Review Group for discussion and publication at the public board.
- Will review the information provided, raising any concerns with the Mortality Review Group.

The Clinical Governance Group and the Quality Governance Committee

- Will receive monthly reports from the Mortality Review Group detailing the outcomes of case record reviews and investigations, themes from incidents where lapses in care have been identified and a summary of actions.

In all cases where deficits in care have been identified, there will be an open and just culture across all service areas, where staff are supported during all stages of review.

- **Policy Content**

Bereaved Families and Carers

The needs of patients and their family/carers will be made the first priority. The Trust will engage 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. We will ensure a consistent level of timely, meaningful and compassionate support and engagement, from notification of the death to an investigation report and its lessons learned and actions taken.

Bereaved families and carers:

- Will be treated as equal partners following a bereavement
- Will always receive a clear, honest, compassionate and sensitive response in a sympathetic environment.
- Will receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.
- Will be informed of their right to raise concerns about the quality of care provided to their loved one.
- Will be given the opportunity to help inform decisions about whether a review or investigation is needed.
- Will receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.
- Will, where they want, be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations.
- involved in the investigation process will be supported to work in partnership with trusts in delivering training for staff in supporting family and carer involvement where they want to.

Where the family/carer raises a concern:

- The MEM undertaking the review will seek the advice of specialist colleagues, where appropriate, in determining whether there were any deficiencies in care.
- Where harm is identified the reviewer will raise a Datix incident report so that the case can be assessed by the Patient Safety Manager/Patient Safety Team to ascertain if this might be an SI or require an internal investigation.
- The MEM team will liaise with the Divisional Clinical Governance Manager to ensure that the family/carer is kept informed as described below, ensuring that Duty of Candour requirements are met.
- Where the MEM finds no issues in care, they will be responsible for summarising their findings (in line with Caldicott principles) in a letter which will be sent to the family/carer by the Chief Executive.

Where the Trust decides that the patient death requires investigation:

- Early contact will be made with bereaved families and carers so that their views help to inform the decision.
- Specially trained staff will explain to bereaved families and carers:
    - what happened;
    - how;
    - to the extent possible at the time, why it happened; and what can be done to stop it happening again to someone else.
- Provided the family or carer is willing to be engaged with regarding the investigation, an early meeting will be held to explain:
    - the process,
    - how they can be informed of progress,
    - what support processes have been put in place,
    - what they can expect from the investigation,
    - realistic timescales and outcomes.

  There will be a named person as a consistent link for the families and carers throughout the investigation.
- Bereaved families and carers will:
    - be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held;
    - be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation;
    - have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided;
    - have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings.
    - have an opportunity to be involved in setting any terms of reference for the investigation;
    - be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case;
    - have an opportunity to respond on the findings and recommendations outlined in any final report; and,
    - be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

  This may disclose confidential personal information for which consent has already been obtained, or where patient confidentiality is overridden in the public interest. This should be considered by the organisation's Caldicott Guardian and confirmed by legal advice in relation to each case. (See legal support)

Legal Support

The National Quality Board states that trusts should offer guidance, where appropriate, on obtaining legal advice for families, carers or staff. This should include clear expectations that

the reasons, purpose and involvement of any Trust lawyers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates. The Trust cannot advise families/carers as to how to seek legal support except to recommend that contact is made with the Citizens Advice Bureau.

Advising Staff

If a staff member is concerned about potential legal action, or if a family member suggests they are contemplating taking legal action, advice can be sought from the Trust's Legal Services Department. Early notification of a potential claim can be of assistance to the Trust's Legal Services Department so that early investigations can be carried out before a formal claim is received.

If a clinician is concerned that they have a conflict of interest with the Trust and/ or they want independent legal advice, they should consult their Medical Defence Union

Advising patients

Legal advice cannot be provided to family members by the Trust as there is a conflict of interest. The Trust can, however, provide generic guidance as to which external bodies the family can approach for advice/assistance. These bodies include:

- Local Ombudsman
- Citizen's Advice Bureau;
- AvMA (Action Against Medical Accidents) – 44 High Street, Croydon, Surrey, CR0 1YB (tel: 0845 1232352)
- The Law Society (020 7320 5650)

Alternatively, the family may want to seek advice from a local solicitor. The Trust will not recommend specific Claimant Solicitor firms.

If family members indicate they are contemplating making a claim, it may be of assistance, in some instances, to explain the relevant tests/standard of proof required to establish medical negligence. See appendix 2

The Process for Reviewing and Learning from Deaths

The bereavement office will identify all deaths occurring in the ED or whilst the patient was an inpatient. The PAS will be used to identify deaths occurring within 30 days of discharge (or 42 days of the end of the pregnancy). Following national guidance, there will be a proportion subject to mandatory review (see scope); the findings from these will be reported in the quarterly public board reports.

Cases where the patient had a learning disability, or where the patient was under the age of 19, or a was a maternal death, will be reviewed using additional methodologies to patients falling outside of those categories owing to separate national reporting requirements.

For all remaining cases, patients will be reviewed using the Royal College of Physicians' Structured Judgement Review (SJR) template.

- The reviewer will complete the form in its entirety, reviewing all care delivered from first presentation to discharge; advice will be sought from clinical colleagues where appropriate.
- The review will not be confined to the final admission if it is discovered that care in a previous admission contributed to the final admission.
- The reviewer will also consider care delivered by other providers, such as the patient's GP, the ambulance service, or acute care delivered by another organisation.
- Where substandard care is identified (delivered by this Trust/partner organisation) that caused or had the potential to cause harm, it is the responsibility of the reviewer to raise a Datix incident form (DIF1). The Divisional Governance Manager will be advised of any cases where there may be concerns about a lack of escalation, for further consideration by the division.
- Where a death is already being reviewed as part of an SI this review will replace the SJR. The reviewer will record on the SJR form that this is the case.
- The Divisional Governance team reviewing the Datix incident, with support from the Patient Safety team, will determine the level of investigation. The rational for this decision will be recorded in Datix. (See also appendix 3 for more information about cross-system reviews and investigations.)
- In all cases, where harm is identified, Policy for Being Open and the Duty of Candour WAHT-CG-567 will be followed.
- Every quarter, the Trust will publish the total number of in-patient deaths (including Emergency Department deaths) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review/investigation estimates will be provided, using nationally agreed criteria, of how many deaths were judged more likely than not to have been due to problems in care accompanied by relevant qualitative information and interpretation. This information will be subject to appropriate reporting restrictions laid out the Trusts information sharing protocols.
- Changes to the Quality Accounts regulations will also require summary information to be included in Quality Accounts from June 2018.

Severe Mental Illness

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

For the purposes of this policy, any patient under the care of secondary mental health services at the time of their death will be reviewed. Reviewers will be required to identify whether patient's mental health had any impact on the care delivered.

Learning Disabilities (patients aged 4 to 74)

The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so.[ii]

The Learning Disabilities Health Liaison Team (LDHLT) will be responsible for monitoring that patients with a diagnosed Learning Disability (LD) are appropriately flagged by staff on the patient administration system. Where a patient with an LD dies in the ED, hospital or community, the LDHLT will register the deaths with LeDeR, the Learning Disabilities Mortality Review Programme. The review will be conducted using the LeDeR template and the findings reported in the quarterly board report. The LDHLT will then assist with the coordination of any training relating to actions. The LDHLT will be responsible for reviewing deaths in other organisations and supporting the review of deaths in this Trust.

Deaths within 30 Days of Discharge

Where the Trust was notified of a death within 30 days of discharge in addition to an SJR review, the patient's GP will be sent a short review form to gather more information. Questions will include:

- Was the patient seen recently by a member of your practice?
- Did your practice see the patient between discharge and death?
- From a primary care perspective did you view the patients' death at the time it occurred as unexpected?
- Are you aware or any deficiencies in care delivered across the health community?
- Did the patient/family/carer raise any concerns about the care given in the months leading up to death?

Infant, Child, Young Person

- All deaths (community and inpatient) involving a child/young person will be recorded on the Worcestershire Safeguarding Children Board Child Death Reviews, form 'Notification of a Child Death'. Any unexpected death triggers the Child Death Review Rapid Response Service.
- Children's services will continue to register child deaths until the national register is rolled out. In addition, they will continue with the clinical review of patients in their care unless the patient had a learning disability, in which case, the review will be undertaken by a Learning Disability Healthcare Liaison Team.
- In addition to statutory reporting, the paediatric team will undertake a review of care using the methodology advised by the National Child Death Programme.

Maternal Death & Still Birth

'MBRRACE-UK' (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome

Review Programme (MNI-CORP) which hosts the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

All deaths are recorded on the MBRRACE website. The review questions include demographics, questions about care and cause of death which calculate the risks to the patient, delivering a decision about preventability.

In addition, the Trust uses SCOR (standardised clinical outcome review), a web-based tool which examines perinatal mortality. This tool helps clinicians to review the circumstances preceding and surrounding their stillbirths and neonatal deaths in a standardised way, and derives a taxonomy of substandard care factors which can lead to a systematic action plan.

In addition the Trust will commit to the NHS Resolution (NHSLA) Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury (RRR) scheme which proposes a system of consistent, robust, and independent investigations for all instances where there may be severe avoidable birth injury; and for eligible babies and their families, the option to join an alternative system of compensation that offers support and regular payments without the need to bring a claim through the courts.

- All maternal deaths will automatically be treated as an SI.
- Any suboptimal care identified will be incident-reported on Datix and subject to a 24 hour review.
- Datix incidents are reviewed by the senior midwife/obstetric group with any significant issues in care investigated.
- A national reporting tool is under development and will be used once released (possibly autumn 2017).
- All Datix incident reports are reviewed at the Divisional Risk Management meeting.
- Any learning identified is included is communicated to the maternity team via the divisions governance communication processes.
- All themes from mortality review will be included in the annual training programme, draft guidance updates, induction and audit meetings.
- Incidents will be discussed at Service Governance meetings.

Learning and Actions

The judgement of whether a problem may have contributed to a death requires careful review of the care that was provided against the care that would have been expected at the time of death. Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems, none of which would be likely to have caused the death in isolation but which in combination can contribute to the death of a patient (Hogan et al). Some of these elements of care are likely to have occurred prior to the admission and the Trust will support other organisations, for example in primary care, to understand and act on areas where care could be improved.

Learning will be gathered from the mortality review forms, SIs, Internal Investigations and Datix reviews. This will be recorded on a learning and actions log.

Learning will be disseminated through various communication forums.

All incidents meeting patient safety criteria will be uploaded to the NRLS.

Reporting

Each quarter, the Trust will be required to report data from case record reviews, investigations and SIs for all patients who die in hospital or within 30 days of discharge. This will be through a paper and an agenda item to the public Board meeting. This data will include the total number of the Trust's in-patient deaths (including Emergency Department deaths) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, the Trust will provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

Owing to the numbers of patients that may be involved, the reporting will be subject to the Trust's Information sharing protocols. This will seek to maintain confidentiality where reported numbers, diagnosis-types or patient profiles are very low.

A summary of the data we publish will be provided in our Quality Account from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that the trust has taken.

Training

Staff undertaking mortality reviews will be trained in the SJR review process by the Associate Medical Director for Patient Safety, to ensure that a standardised approach is used.

- **Implementation**
  1. **Plan for implementation**
     See attached Implementation plan
  2. **Dissemination**
     This policy will be shared with the divisional management and governance groups during the drafting process for agreement.
     The policy will be available on the Trusts intranet via document finder and will also be accessible through the mortality review web page.
  3. **Training and awareness**
     Medical Examiners for Mortality will be trained in the Structured Judgement Review (SJR) methodology by the AMD for Patient Safety.
     Corporate and Divisional Governance team members will be made aware of the policy during implementation.
     New members to these teams will be made aware of this policy through their induction programme.

- **Learning and Dissemination**

  Where serious concerns are identified through the mortality review process (death occurring as a direct consequence of the care provided or a lapse in care, or where the care provided is

deemed very poor) the issue will be logged as a clinical incident by the Medical Examiner and the incident managed in line with the Trusts serious incident management policy.

The data collected will be analysed by the Medical Examiner team on a quarterly basis and emerging themes for improvement reported into the Trusts quality improvement programme board as a formal report from the Mortality Review Group.

The Mortality Review Group will produce a lesson of the month as one of the groups routine outcomes.

- **Monitoring and compliance**

  External reporting of compliance with this policy is requires as set out in the NQB document 'National Guidance on Learning from Deaths'.
  In summary the Trust is required to report on a quarterly basis via a Board meeting held in public the following data:

  - Total number of patient deaths (including those occurring in the ED)
  - The number of deaths subject to case record review
    - Number of these patients with a learning disability
  - An estimate of the number of deaths judged more likely than not to have been due to problems with care.
  - A summary of the learning and improvements resulting from the mortality review process.

  These metrics will be collated using the NQB Dashboard. These metrics will be reported monthly to the Clinical Governance Group and Quality Governance Committee and quarterly to the Trust Board.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**

- **Policy Review**

This policy will be reviewed 6 months after approval then annually. The policy will also be reviewed in line with further guidance issued on mortality reviews issued by the NQB.

- **References**

References: Code:

National Quality Board Guidance on Learning from Deaths	
Royal College of Physicians National Mortality Case Record Review Programme – reviewers guide for using the structured judgement review	

- **Background**

.1 Equality requirements

There are no equality issues identified

.2 Financial risk assessment

The Medical Examiner for Mortality role will be funded through the monies accrued from the completion of the second part of the 'Approval to cremate' form. A Business case for this change was approved at Trust Leadership Group on xxx

.3 Consultation

This policy has been reviewed by divisional management teams, the Learning Disability Health Liaison Team, the Worcestershire CCG's and the Worcestershire Acute Hospitals Health Information team

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Dr Suneil Kapadia - CMO
Vicky Morris - CNO
Dr Julian Berlet DMD Specialised Clinical Support Division
Dr Sally Millet – Deputy DMD Specialised Clinical Support Division
Stephanie Beasley – DDN Specialised Clinical Support Division
Dr Andrew Short DMD Women and Children Division
Fay Baillie – DDN&M Women and Children Division
Dr Gary Ward DMD Acute medicine
Dr Jasper Trevelyan DMD Specialist Medicine
Stephen Jezard – DDN Medical Division
Mr Graham James DMD Surgical Division
Sarah King – DDN Surgical Division
Katherine Leach – Patient safety team lead
Jane Clavey – Head of legal services
Pamela Mariga – Learning disabilities health lead

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Mortality Review Group
Clinical Governance Group
Quality Governance Committee

.4 Approval Process

This policy has been produced by the mortality review group and will be reviewed by the Clinical Governance Group for recommendation for approval by the Quality Governance Committee. The Key Documents Approval Group will also approve the document before publication on the Trusts web site.

The Policy will also be discussed in the public section of the September Trust Board meeting.

.5 Version Control

Date	Amendment	By:

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the Policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	N	
	• Ethnic origins (including gypsies and travellers)	N	
	• Nationality	N	
	• Gender	N	
	• Culture	N	
	• Religion or belief	N	
	• Sexual orientation including lesbian, gay and bisexual people	N	
	• Age	N	
2.	**Is there any evidence that some groups are affected differently?**	N	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the Policy/guidance likely to be negative?**	N	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the Policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	N
2.	Does the implementation of this document require additional revenue	Change in funding stream required to support Medical Examiner for Mortality role
3.	Does the implementation of this document require additional manpower	Y
4.	Does the implementation of this document release any manpower costs through a change in practice	N
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	N
	Other comments:	OBC reviewed and agreed by Trust Leadership Group on..

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

[i] The Five Year Forward View For Mental Health (NHS England, 2016) is available at: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf

[ii] Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Needleman D, Russ L. (2013) Confidential Inquiry into premature deaths of people with learning disabilities. Bristol: University of Bristol.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
Paper number	Enclosure D2

Report provided:							
For approval:		For assurance:	√	To note:		For information:	

GP Letters – Update on Incident

Accountable Director	Suneil Kapadia Chief Medical Officer
Presented by	Suneil Kapadia Chief Medical Officer
Author	Vicky Morris Chief Nursing Officer

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	
	Invest and realise the full potential of our staff to provide compassionate and personalised care		Ensure the Trust is financially viable and makes the best use of resources for our patients	
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability		Operational Performance	
	Quality of Care	√	Finance and use of resources	
	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Quality Governance Committee	24 August 2017	Received for assurance

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF number(s)	R1.3
Level of assurance and trend			
Significant	Limited level	None	

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
Paper number	Enclosure D2

Purpose of report	To brief the Board on the serious incident in relation to GP letters.
Summary of key issues	Through a series of Strategic meetings with Partners and regulators we have reviewed the priority cohorts of letters and templates which are being then reviewed by GP's. Cohort 1 of these templates went out to GP colleagues at the beginning of August and to date 1 potential harm has been identified and this is being reviewed by a Clinical Commissioning group representative (beg of Sept) and the Acute Trust will be briefed if a full Root cause analysis is required. The Chief Medical officer has written to Internal clinicians (multi professional)and has requested that they undertake a Quality assurance process to provide clarity on whether the templates all need to go to the GP's. This process is needed to be completed by the 15th September 2017. Cohort 2 of required information will then be released for GP review. The strategic partnerships continue to monitor the process so that emerging risks are understood as well as effectively managing internal and external communication. The Risk rating will be reviewed after the first cohort of letters have been reviewed by GP's.

Recommendations	The Trust Board are asked to note
	• the verbal and written briefing on this Serious Incident and future briefings will be provided to Quality Governance Committee in between Trust Board meetings.
	• that a Serious Incident Investigation will be commencing once the initial clinical reviews have been undertaken. The Term of Reference has been agreed between the CMO and the Deputy Company Secretary who has agreed to lead this Investigation
	• the commissioning of a review of all system and processes across the organisation to understand the:
	  • Quality assurance processes which exist to support electronic systems and processes
	  • The Governance framework to support such systems

Date of meeting	14 September 2017
Paper number	Enclosure D2

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

GP letters

1 Introduction

In July 2017, the Trust was alerted by the Clinical Commissioning Group that a number of overdue letters and templates had been received by a number of GP practices in late June. The GPs raised concern and brought this to the attention of the Clinical Commissioning Group.

2 Background

This initial concern was raised with the Chief Nursing Officer (Acute Trust) and was reviewed and an initial investigation undertaken by the Division, which led to a serious incident being reported.

However, over and above this Incident which related to 607 letters, the CNO asked if there was any indication that there could be more letters held on the system. This further investigation identified that a significant number of letters and templates have been sitting on the Bluespier system for a number of years. These letters and templates were either waiting further action/ review or should have been sent to the General Practitioner.

Therefore a further Serious Incident report was logged onto STEIS to outline the extent of the system and process issues and discussions held with commissioners and regulators.

3 Current situation

To manage the situation and determine the management and subsequent investigation, the key stakeholders have formed an Incident strategy group with clear terms of reference and joint decision making process, to ensure a very considered and measured way of managing this significant issue.

Regular strategy meetings have been held and through those meetings clarity and consensus formed about the technical side of managing information quality assurance processes and information release in order to understand the potential or actual harm.

Please note that this also involves the Health and Care Trust who also use Blue Spier, they have been involved in the Strategy meetings since the second meeting.

The way forward is clear in so far as there needs to be a review of these letters to determine:

- What further action is required?
- Whether the patient has suffered harm or not?

We are working with GP colleagues and Consultants and other professionals internally to identify the relevant letters and the details of the patients which are held on a spreadsheet for subsequent audit purposes. A first Cohort of letters and

templates was released to GPs at the beginning of August and from that cohort, one potential harm has been identified from the review, which the Clinical Commissioning group are reviewing to identify whether a full root cause analysis investigation is required.

Internal review and Quality assurance of templates on the Blue spear system prior to sending the second cohort of templates to GPs is being closely monitored and due for completion by the 15th September.

The process we are following is with the support of our Clinical Commissioning Group, Local Medical Committee, NHS E, NHS I and the CQC. All letters dated after 1 March 2017 can be treated normally and require no further assessment.

It is important that this significant backlog is dealt with as soon as possible and due to annual leave in August the Internal review has not progressed as quickly as anticipated, so further communication has been sent out to all Consultants and Practitioners. We will continue to keep the Trust Board briefed.

4 Implications

None.

5 Recommendations

The Trust Board are asked to note

- the verbal and written briefing on this Serious Incident and future briefings will be provided to Quality Governance Committee in between Trust Board meetings.
- that a Serious Incident Investigation will be commencing once the initial clinical reviews have been undertaken. The Term of Reference has been agreed between the CMO and the Deputy Company Secretary who has agreed to lead this Investigation
- the commissioning of a review of all system and processes across the organisation to understand the:
  - Quality assurance processes which exist to support electronic systems and processes
  - The Governance framework to support such systems

Compiled by
Vicky Morris
Chief Nursing Officer

Director
Suneil Kapadia
Chief Medical Officer