Learning from Deaths Policy
A Framework for Identifying, Reporting, Investigating andLearning from Deaths in Care.

Associated Policies / Guidelines / SOP

- Duty of Candour Policy CG10
- Clinical Incident Management Policy CG04
- Concerns and Complaints Policy and Procedure CG07
- Policy on the management of external reviews and assurances CG 02
- SOP Governance of Child Deaths in Shropshire Dec 2020
- Maternal Death Guideline August 2018
- Perinatal Deaths MBRRACE Reporting (096)
- Fetal Loss and Early Neonatal Death version 3.5
- Death and Seriously Ill Babies (041)
- Sudden Unexpected Death in Infants and Children (SUDIC) guideline v3
- SUDIC Supporting Bereaved Families – A Professional Response (050)
- When a Child Dies – Bereavement Care (173)

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Contents

1.0 Document Statement

1.1 In 2016 the Care Quality Commission (CQC) published its report 'Learning, Candour & Accountability – a review of the way in which NHS Trusts review and investigate deaths of patients in England'. The report advocated that there should be a much greater focus on NHS organisations learning from the deaths of patients in their care.

1.2 In 2017 the National Quality Board published National Guidance on 'Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. This set out a series of steps that NHS Trusts needed to take to demonstrate how learning from deaths is an integral part of their mortality surveillance.

1.3 The Learning Disability Mortality Review (LeDeR) Programme has been established to support local areas to review deaths of people with learning disabilities and autism and to use the lessons learned to make improvements to service provision.

1.4 This policy draws from these national documents and sets out how Shrewsbury and Telford NHS Trust (SaTH) learns from the deaths of patients in our care; it describes the systems and processes we use to ensure our approach provides a clear framework for patients and carers, Trust staff and our partner organisations.

1.5 Caring respectfully, sensitively, and compassionately for all patients, including in the remembrance of those who have died and their families, carers and loved ones, is at the heart of the services we provide.

1.5 In our mortality reviews we will look for examples of best practice and excellent care outcomes where staff have afforded outstanding care to patients and carers. We also commit to identifying where problems and associated poor outcomes have occurred to understand how and why these variances arise so that meaningful actions can be taken.

2. Purpose

2.1 This policy describes:

- The procedures for identifying, recording, reviewing and investigating the deaths of people in our care.
- How we learn from the care provided to patients who die, as part of our work to continually improve the quality of care we provide to all people who come into contact with our services.
- How we will support people who have been bereaved by a death within the Trust and how the bereaved should expect be involved in any further action taken to investigate the death of their loved one.
- How we will support staff who may be affected by the death of someone in their care.
- Specific reporting and review processes that are applicable to children who die in our care.
- Specific reporting and review processes that are applicable to deaths that occur within our obstetrics and neonatal specialities within the Trust.

3. Definitions

3.1 NHS governance processes for reviewing deaths include several terms and acronyms. Table 1 provides the definitions employed in this policy.

Table 1 – Definitions

Definition	Meaning
Expected death	A death that occurred in or was expected to occur near to or within an expected timeframe, and where the reason for the death was the expected cause. This may, for example, include people with a terminal illness or within palliative care services who were expected to die at or around the time death occurred. There will be some patients with frailty and multiple comorbidities in whom death was not unsurprising to the clinical team but where the definitive timeframes for death would have been very difficult to determine. These may also be described as 'expected'.
Unexpected death	A death that occurs suddenly or earlier than anticipated. Death was not expected to occur at or near to the time of the event, or where the cause of death was not an expected cause. This can be where the person has died as a result of a known health condition but was not expected to die at this time or in the near future, or where there is another cause of death not related to their known health condition e.g. a patient who was being treated for a serious mental illness but who dies unexpectedly due to a physical health condition. The unexpected death category includes deaths from suicide. Unexpected deaths must be reported on Datix and investigated / reviewed appropriately.
Datix	Incident reporting system available within SaTH
Medical Examiner scrutiny	Independent scrutiny of deaths consisting of: • Proportionate review of relevant medical records • Interaction with the doctor completing the Medical Certificate of Cause of Death (MCCD) • Interaction with the bereaved, providing an opportunity to ask questions and to raise concerns
Mortality screening	Locally developed online tool available within SaTH to facilitate the appropriate recognition of deaths which will benefit from a detailed review of care (SJR) to identify positive and negative learning
Mortality review / case record review	General term used to describe a review of care for patients who die
Structured Judgement Review (SJR)	Structured Judgement Review is a methodology introduced by the Royal College of Physicians (RCP) to review the care of patients who die. The SJR requires judgements to be made to determine if there were any problems or good practice in relation to the care provided to patients in order to identify learning to improve care for living patients. A need for an SJR may be flagged through Medical Examiner Services or through Mortality Screening
SJRPlus	Online tool designed by NHS England / Improvement which has been developed from the RCP methodology SJR
Patient Safety Incident	Any healthcare related event that was unintended, unexpected and undesired and which could have or did cause harm to a patient. Further information is available in the Trust's Incident Reporting policy.
Serious Incident (SI)	Adverse event where the consequences to patients, families and carers, staff or organisation are so significant and the potential for learning so

Definition	Meaning
	considerable, that a heightened level of response is justified. Include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and where incidents that cause widespread public concern can result in a loss of confidence in healthcare services.
Root Cause Analysis (RCA)	A systematic analysis of an incident to determine what happened, how it happened and why. An Investigating Officer undertaking an RCA for an unexpected death will draw on evidence, which can include case notes, witness accounts, the views of families and carers, reference to policies and procedures. This is to identify any problems in care that preceded the death and actions that will reduce the risk of future occurrence.
Just Culture	The Just Culture Guide, developed by NHS Improvement, helps NHS managers ensure staff involved in a patient safety incident are treated fairly. It supports a culture of openness to maximise opportunities to learn from mistakes.
Learning Disability Mortality Review Programme (LeDeR)	The LeDeR process strives to improve care, reduce health inequalities and prevent premature deaths for people with a confirmed learning disability or who are autistic. An individual LeDeR review looks at significant health and social care a person received that may have impacted on the overall outcome or that are examples of good practice. When the LeDeR review is completed, the decision is made as to whether a 'focussed review' will need to take place. This may be for example, when problems in care were identified. Information from LeDeR reviews is used to improve services.
Serious Mental Illness (SMI)	National guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness should be subject to SJR. The Royal College of Psychiatrists guidance states that this would include all patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death. In SaTH Health of the Nation Outcome Scales (HoNoS) will be used to guide which patients who have a Severe Mental Illness are in scope for SJR. Guidance will be sought from the Trust Mental Health Lead or the Mental Health Liaison Team to determine if a patient meets the criteria for mandated review based on serious mental illness.
Health of the Nation Outcome Scales (HoNoS)	A system for measuring the health and social functioning of people with mental illness. In order to have a consistent approach to undertaking SJRs into deaths of people who have a serious mental illness, SaTH will review patients who fall within HoNoS codes 10 – 17 (psychotic illness) and 20 (cognitive impairment or complicated dementia) which significantly impacts upon the patients' activities of daily living. Guidance will be sought from the Trust Mental Health Lead or the Mental Health Liaison Team to determine if a patient meets the criteria for mandated review based on serious mental illness.
Duty of Candour (DoC)	The volunteering of all relevant information to a patient who has been or may have been harmed as the result of an incident, whether or not the information has been requested by that patient. The Duty of Candour specifically applies to incidents where moderate harm, severe harm or

Definition	Meaning
	death has, or could have, occurred as the result of an incident.
Being Open	The nurturing of an environment where families, carers and staff feel supported to question and raise concerns, to identify what went well, and what needs to be done differently to improve the quality of patient, carer and staff experience. This applies to all practices and incidents – not just those relevant to the Duty of Candour. This Learning from Deaths Policy fully aligns with the principles and practices set out in the Trust's Duty of Candour Policy.
Patient Administration System (PAS)	Generic name to describe the IT systems used to record the administration aspects of patient care.
Safeguarding adults review	A multi-agency review process which seeks to determine what relevant agencies and individuals could have done differently that could have prevented harm or a death from taking place.
MBRRACE	Mothers and Babies; Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK). UK collaboration investigating maternal deaths and severe morbidity, stillbirths, infant deaths and morbidity
Perinatal Mortality Review Tool (PMRT)	A web-based tool within MBRRACE-UK to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.
CHKS	The SaTH chosen provider of healthcare intelligence including mortality data
Hospital Standardisation Mortality Ratio (HSMR)	Risk adjusted mortality measure used to monitor death rates in NHS Trusts. A score higher than 100 suggests more deaths than expected according to the model. The HSMR is based on a subset of fifty-six diagnoses which give rise to 80% of in-hospital deaths. HSMR are based on the routinely collected administrative data often known as Hospital Episodes Statistics (HES), Secondary User Service Data (SUS) of Commissioning Datasets (CDS)
Summary Hospital Mortality Indicator (SHMI)	Risk adjusted mortality measure used to monitor death rates in NHS Trusts. A score higher than 100 suggests more deaths than expected according to the model. It is produced and published quarterly as an official statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalization and the number that would be expected to die according to the model. SHMI includes 100% of in-hospital deaths and is the only model to include deaths following a patient's discharge within 30 days. This is the only measure therefore that may be sensitive to cases where the patient was potentially discharged early and then died.
Risk Adjusted Mortality Index (RAMI)	Risk adjusted mortality measure used to monitor death rates in NHS Trusts. A score higher than 100 suggests more deaths than expected according to the model.
Death rate	The number of deaths in hospital in relation to the inpatient activity. This measure is known as a crude death rate
Mortality Outlier Alert	A report on instances where the data indicate that the Trust's mortality rate has exceeded the national expected rate for one or more specific diagnosis or procedure codes. Alerts can be generated by: • SaTH Mortality Monitoring System (CHKS) • The Care Quality Commission (CQC) • SaTH Executive or Executive Level Committees • Dr Foster Data (Imperial College Dr Foster Unit)
Regulation 28 Report to Prevent Future	The Coroners and Justice Act 2009 allows a Coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or

Definition	Meaning
Deaths	government department and their agencies where the Coroner believes that an action should be taken to prevent further deaths
Maternal death	Deaths of women whilst pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or it's management, but not from accidental or incidental causes. Further defined as Direct and Indirect causes of death. Coincidental deaths are defined as deaths unrelated to but happen to occur in pregnancy or the puerperium
Stillbirth	A death of a baby occurring before or during birth once a pregnancy has reached 24 weeks.
Neonatal death	A baby born at any time during the pregnancy who lives, even briefly, but dies within 4 weeks of birth
Children and Young People	The definition being used in the Trust for this policy is: Children (1 to 9 years) and Young People (12/13-18 years). Under 16 or younger are admitted to the Children's Ward. Please note: the legal definition of child is under 16 and a young person is 16 or 17 and an adult is 18.
StEIS	Strategic Executive Information System that captures all Serious Incidents nationally.
HSIB	Healthcare Safety Investigation Branch

4. Roles and Responsibilities

Role	Responsibilities
Chief Executive	• Responsible for the statutory duty of quality and takes overall responsibility to ensure that the Trust abides by the standards defined within this policy • Accountable to the Trust Board of Directors.
Trust Board of Directors	• Collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust. • Specific accountabilities are set out at Annex A in the NQB Guidance for Learning from Deaths 2017.
Medical Director	• Overall responsibility for the Learning from Deaths process within the Trust lies with the Medical Director, who will ensure that the implementation of the policy meets with national requirements as well as the intended learning outcomes for the Trust. • Provides the Learning from Deaths report to the Trust Board of Directors at least 4 times per year. • Is the Trust Executive Lead for the LeDeR programme. • Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the Board in order that Executive Directors remain aware and Non-Executive Directors can provide appropriate challenge.

Role	Responsibilities
	• With support from other members of the Executive Team, will ensure external reporting requirements are met, and determine when an independent investigation may be warranted. The Executive team also liaise with Commissioners to review and improve their respective local approaches following the death of people receiving care from their services. • Has responsibility for ensuring neonatal, child and maternal deaths are reported in line with national requirements. (MBRRAC-UK, Child Death Review Statutory Guidance 2018).
Non- Executive Director (NED)	• The Trust has a nominated Non- Executive Director who has responsibility for oversight of the implementation of the Learning from Deaths process. • Specific NED responsibilities relating to this policy are set out within the NQB Guidance for Learning from Deaths 2017.
Freedom to Speak up Guardian	• The Trust's appointed Freedom to Speak Up Guardian will ensure any case that comes to their attention indicating evidence of poor care and treatment in relation to the death of a patient is immediately escalated to the Chief Executive.
Assistant Director of Nursing, Quality Governance	• Provides Quality Governance support for this policy • Attends (or provides deputy) the Trust Mortality Triangulation Group to provide Patient Safety perspective to cases discussed.
Chair of Learning from Deaths Group	• The Medical Director is the Executive Director who chairs the Learning from Deaths group where activity and outcomes from the investigation and learning from deaths is collated and discussed. The Trust Medical Mortality Lead is the Co-chair. The Chair: • ensures the processes for reviewing and learning from deaths are robust and can withstand external scrutiny • champions quality improvement that leads to actions that improve patient safety • assures published information accurately reflects the Trust approach, achievements, and challenges.
Trust Medical Learning from Deaths (Mortality) Lead	• Co-chair of the Trust Learning from Deaths Group in the Medical Director's absence. • Escalates any areas of concern to the Medical Director for action. • Supports the Medical Director in ensuring Divisional accountability for compliance with this policy. • Develops a framework of assurance for the Learning from Deaths process to the Trust Board. • Understands the national requirements within the Learning from Deaths agenda to ensure processes in place within the Trust are robust and can withstand external scrutiny, by providing challenge and support. • Provides Trust-wide strategic, policy and clinical leadership to maximise learning opportunities within the Learning from Deaths agenda.

Role	Responsibilities
	• Provides medical leadership to the change management process within the Trust to introduce a system whereby according to nationally or locally mandated requirements, Structured Judgement Reviews of care are undertaken for deceased patients. • Ensures compliance with reporting of data to meet national and local requirements. • Ensures that a standardised approach to mortality review using a nationally recognised methodology is embedded across the Trust.
Trust Learning from Deaths (Mortality) Lead	• In collaboration with the Trust Medical Learning from Deaths Lead, maintains oversight of the Divisional Learning from Deaths processes and supports the Medical Director in ensuring Divisional accountability for compliance with this policy • Develops a framework of assurance for the Learning from Deaths process to the Trust Board • Understands the national requirements within the Learning from Deaths agenda to ensure processes in place within the Trust are robust and can withstand external scrutiny, by providing challenge and support. • Coordinates and develops Learning from Deaths reports to meet statutory or internal requirements and provide assurance up to the Trust Board of Directors and external stakeholders. For example, Learning from Deaths Quarterly Report, Annual Quality Account, Integrated Performance Reports and other reports as required. • Ensures that information published externally is a fair and accurate reflection of the Trust's Learning from Deaths achievements and challenges. • Leads change management process within the Trust to introduce a system whereby Structured Judgement Reviews of care are undertaken for deceased patients according to nationally or locally mandated requirements, and identified learning is widely disseminated. • Supports integrated learning and quality improvements identified through Learning from Deaths across the Trust. • Identifies adequate resources to facilitate the Learning from Deaths agenda • Ensures robust systems are in place for recognising, reporting, reviewing or investigating deaths where problems or lapses in care provided within the Trust have contributed to the death. • Reviews external mortality data sources for example as provided by CHKS Healthcare Intelligence, and co-ordinates investigation into any issues unexplained by routine review processes. • Co-ordinates the monthly Trust Learning from Deaths meetings, including action tracker. • Collates findings, learning points and actions for improvement from the Learning from Deaths meetings. • Coordinate and Co-chair the Trust Mortality Triangulation Group (MTG). • Links with Mortality Leads within our strategic partnerships to develop a consistent approach to Learning from Deaths of patients across the

Role	Responsibilities
	system and maximise learning opportunities. • Links with Mortality Leads within both national and regional forums • Facilitate notification to the LeDeR programme of deaths of patients with learning disabilities within the Trust. • Support the independent external LeDeR reviews of patient care for patients with learning disabilities who die within the Trust
Medical Examiner / Lead Medical Examiner	• Undertakes an independent mortality scrutiny of the deceased patients care which may lead to the identification of potential learning and/or cases for Structured Judgement Review according to defined criteria. • Discusses and agrees with certifying doctors an acceptable cause of death. • Undertakes referrals and liaises with HM Coroner where indicated according to defined criteria • Communicates with bereaved relatives and, in doing so provides the opportunity for families to raise significant concerns about care provided within the Trust. • Ensure bereaved relatives are aware of the opportunity to provide feedback on the care their deceased relatives received within the Trust. • Ensure bereaved relatives are aware of the formal Trust Complaints process within the Trust where appropriate.
Medical Examiner Officer / Lead Medical Examiner Officer	• Provides support for the Medical Examiner Service in undertaking preparatory review of the patients' admission and advises on acceptable causes of death or the need to refer to the Coroner. • Is a point of contact and source of advice for relatives of deceased patients, healthcare professionals and coroner and registration services? • Ensures Medical Examiner Service data is submitted in accordance with national requirements. • Attends the weekly Mortality Triangulation Group. • Ensure bereaved relatives are aware of the formal Trust Complaints process within the Trust where appropriate.
Divisional Clinical Leads in Governance / Mortality	• Work closely with the Trust Bereavement and Learning from Deaths teams. • Be an active member of the Trust Learning from Deaths Group and attend relevant Trust Governance Groups as required. • Provide Divisional strategic, policy and clinical leadership with the support of the Divisional Quality Governance team. • Ensure that the mortality review process within the Division meets the requirements of the Learning from Deaths agenda and is implemented across the Division, including training for clinicians as required. • Support clinical teams with the mortality review process. • Coordinate the review of a defined cohort of patients within the Division for whom a Structured Judgement Review is mandated or recommended. • Ensure that the learning points from those reviews are disseminated

Role	Responsibilities
	through the Division and the organisation as needed. • Provide a regular update to Divisional Governance meetings on Learning from Deaths. • Chair the Divisional Mortality and Morbidity meeting which will be held as a minimum on a monthly basis. • Provide advice and support, working alongside the bereavement team for families and carers on issues and concerns raised at the point of death.
Specialty Clinical Leads in Governance / Mortality	• Supports the Divisional Leads with the Learning from Deaths agenda.
Clinicians	• Undertake mortality screening for cases within their area of expertise. • Ensures accurate diagnoses, comorbidities and significant history are recorded on the patients' notes. • Understands the correlation between documentation clinicians provide in the patients' medical records and wider mortality metrics. • Ensures that effective mortality reviews are undertaken identifying both positive and negative learning. • Takes appropriate action when required for suboptimal care identified. • Sharing lessons learned. • Using the lessons learned to improve patient care. • Undertakes SJR's as allocated within their Division and for the wider Trust as required. • Escalates areas for concern to the Quality Governance Teams for further review and action.
Nurses, allied health professionals and other clinical staff	• Contributes to mortality screening and Structured Judgement Reviews as required. • Involved with identification of actions plans and development of improvement work identified through the Learning from Deaths agenda.
Quality Governance Divisional Teams	• Provide Divisional support to the wider Learning from Deaths agenda with oversight from the Trust Learning from Deaths Leads, and in accordance with the Trust Learning from Deaths policy. • In collaboration with Divisional Clinical Leads for Learning from Deaths, provide assurance through the Quality and Safety Governance framework, which Learning from Deaths processes within the Divisions are in accordance with Trust Policy. • Facilitate and monitor timely completion of Structured Judgement Reviews as allocated within the Divisions, facilitating cross Divisional or cross Speciality reviews as required. • Provide an effective Divisional Quality Governance framework to support the findings and conclusions from Structured Judgement Reviews and escalate for further investigation as required either within the Divisions or the wider Trust. • Coordinate 'Potential Learning' actions from deaths as identified by the

Role	Responsibilities
	Medical Examiner Service. • Triangulate and share learning arising from the Learning from Deaths processes within the Divisions and the wider Trust assisted by the Corporate Learning from Deaths Leads • Escalate relevant concerns arising from the Divisional Learning from Deaths process to the Trust Learning from Deaths Leads. • Ensure that any deaths within the Division, following appropriate review or investigation that are determined more likely than not to have resulted from problems in healthcare are reported to the Trust Learning from Deaths Leads to facilitate subsequent reporting to the Trust Board of Directors through the appropriate Quality and Governance Framework

5. Quality Governance Framework Responsibilities

Committee	Responsibilities
Learning From Deaths Group	• This meeting meets monthly and oversees, monitors, and supports the Directorates/Specialties with the implementation of the Learning from Deaths policy.
Quality Operational Committee	• Requires assurance regarding Learning from Deaths programmes of work within the Trust
Quality, Safety and Assurance Committee	• Requires assurance regarding Learning from Deaths programmes of work within the Trust
Mortality Triangulation Group	• Meets weekly to provide oversight of deaths across the Trust and discuss cases identified for Potential Learning, SJR or referred to HM Coroner through Medical Examiner Scrutiny

6. Corporate Services

6.1 Bereavement Services

A Bereavement survey leaflet is offered to every Next of Kin as part of the Bereavement Service process. The survey includes an option for a telephone discussion with a Bereavement Officer if the family have any unanswered questions or concerns about the deceased's care.

Bereavement services and PALS will escalate any concerns raised by families and carers during the bereavement process. For simple queries and concerns, they will liaise with the Consultant in charge of care and the Ward Manager. Where concerns cannot be quickly and informally resolved, a formal complaint can be raised, and the Trust Complaints Procedure followed.

6.2 Legal Services

The Legal Services team provide liaison between the Coroner's office and the Trust. Members of the team will meet with the Coroner and the bereaved family during Pre-Inquest Reviews and co-ordinate requests for statements required by the Coroner and families as part of their Inquiries / Inquests.

The team co-ordinate the Trust's response to Regulation 28 reports and will provide feedback on learning from individual Inquests.

The Head of Legal Services (or deputy) attends the weekly Mortality Triangulation Group.

Will provide a regular update to the Trust Learning from Deaths Group the Trust Learning from Deaths Leads are aware of themes and trends noted through cases referred to the Coroner.

7. Scope

7.1 Staff in scope

This policy is applicable to all staff working within SaTH on a permanent or temporary basis including students, locums, sub-contracted and bank or agency staff. This policy also applies to any clinical services who are contracted to provide clinical services on behalf of SaTH. All healthcare professionals may be involved in mortality reviews as part of clinical practice. This involvement could range from simply being aware of the outcome of a review insofar as they affect their individual area of practice, to full or partial involvement in the undertaking of the SJR and implementing the recommendations and shared learning.

7.2 Patients in Scope for SJR

The SJR methodology is intended for use in adult patients only**.** Based on the National Guidance on Learning from Deaths (2017) an SJR is mandated in the following circumstances:

- Inpatient adult deaths where the case has been flagged for SJR through Medical Examiner scrutiny or online mortality screening
- Inpatient deaths identified for SJR through random sampling.
- Deaths of adult patients who are diagnosed with a serious mental health illness. Regulations require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay.
- Deaths of adult patients who meet the criteria for a LeDeR review.
- All unexpected deaths: To include certain elective procedures and those admitted where sudden unexpected cardiac arrest occurs.
- Deaths in any service where bereaved families, carers or staff, have raised a concern about the quality-of-care provision
- A case where the Coroner has issued a Regulation 28 Report for the Prevention of Future Deaths where an SJR and/or investigation has not already been undertaken.

- Deaths in a service or specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means. This may be through external matrices (for example specialty Summary Hospital-level Mortality Indicator or other elevated mortality alert or concerns raised by the Care Quality Commission or another regulator) or internal audit.

7.3 Patients Out of Scope for SJR:

- Children and Young People (age 0-18th birthday)
- Deaths which meet the criteria for referral to the Healthcare Safety Investigation Branch (HSIB) for investigation – intrapartum stillbirth of a term baby, babies who die within the first week of life, potential severe brain injury diagnosed in the first 7 days of life (according to defined criteria), direct or indirect maternal deaths
- Perinatal deaths and maternal reported to MBRRACE-UK
- Cases where a Serious Incident has been reported where an SJR has not already been undertaken
- Cases referred to the Coroner based on referral only. If a case has been flagged for SJR through Medical Examiner scrutiny, mortality screening or for any other mandated reason, the SJR will be completed unless it is already part of an SI investigation

8. Learning from Deaths Process for adult inpatient deaths

8.1 The Learning from Deaths process

The Learning from Deaths process within SaTH consists of 3 stages as defined in the Learning from Deaths Policy on a Page at Appendix A.

- Medical Examiner Scrutiny
- Mortality screening
- Structured Judgement Review (SJR)

When a case meets the criteria for investigation, this is carried out in accordance with the Trust Incident Management Policy

8.2 Medical Examiner Mortality Scrutiny Process

The Medical Examiner (ME) will review inpatient and emergency department adult deaths within SaTH assisted by the Medical Examiner Officers. Child deaths are referred directly to the Coroner as appropriate. The ME will complete the initial independent scrutiny of a case within 7 days of the patient's death. ME Scrutiny may identify the need for an SJR according to both national or local criteria including if there are any positive or negative lessons to be shared with the care given. Scrutiny may also identify 'Potential Learning' which does not require a detailed SJR, but still requires acknowledgement and potential action within Divisional teams. If an event is identified that meets the criteria for reporting through the Trust Incident Management process, a datix will be completed accordingly at this time.

8.3 Online Mortality Screening

An online tool is available within SaTH and is used to determine whether there were any issues in the care provided to a patient within a particular service. Such issues may lead to the recommendation for an SJR. Screening may also be used to identify positive examples of care and trigger an SJR to promote wider replication of good practice.

8.4 Structured Judgement Review (SJR) using the online SJRPlus

The primary focus of an SJR is to assist the identification of positive and negative learning to improve care for our living patients using a nationally recognised methodology developed by the Royal College of Physicians.

Only one SJR should be completed for each patient. If specialist opinions are required these should be added to the primary review and identified using the reviewers name, role, date and time.

The SJR should be completed by a clinician who has undertaken the Trust SJR training and who is deemed to have sufficient clinical knowledge to make valued judgments. SJR reviewers will be encouraged to attend SJR Masterclass sessions and to undertake regular SJR reviews to maintain competency.

The reviews will be undertaken using the medical records/case notes and any other relevant information and will be completed (including any secondary reviews) within an 8-week timeframe of the date of death. When this timeframe cannot be met, this will be escalated to the Trust Learning from Death Leads who maintain oversight of the process.

SJRs will be allocated to Divisions following discussion of cases at the Trust Mortality Triangulation Group. Monitoring compliance will be through use of a Divisional tracker held on a shared folder maintained by the Trust Learning from Deaths Leads.

Accountability for completion of SJRs within agreed timeframes will be within the Divisions and at Trust level through the Learning from Deaths Leads.

SJRs for patients who meet this criterion for LeDeR review will be undertaken in collaboration with the Trust Learning Disability team / MH Matron Lead.

SJRs for patients with a serious mental illness will be undertaken in collaboration with the Trust Mental Health Lead/Matron

Junior doctors are encouraged to participate in the Learning from Deaths process to establish a culture of learning and to enable involvement in the improvement journey.

8.5 Outcome of SJRs

On completion of the SJR a reviewer will have graded the care provided to a patient according to:

- Hogan score of preventability
- Expected vs unexpected death
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) rating
- Overall assessment rating
- Harm ratings relating to identified problems in healthcare

Qualitative text may provide additional context to the overall assessment of care. In line with good practice, a Datix will be completed for those cases that meet the following criteria:

- Hogan score 'Possibly preventable greater than 50:50 or above
- Unexpected death
- NCEPOD grade 'Less than satisfactory'
- Very poor or poor care
- Any problem in healthcare where harm / probable harm is identified
- Qualitative text that explicitly or indirectly implies that the care provided in a specific case may meet the criteria for reporting as a serious incident

The above datix categories will trigger an incident form to be submitted and the incident process followed for subsequent discussion at the weekly incident meeting. These cases will be discussed in the same manner as all other incidents to consider if the criteria have been met to report the case as a serious incident and reported externally through StEIS.

If a case is deemed to meet the criteria of a Serious Incident the Trust Serious Incident Management Procedure will be followed.

In addition a copy of the datix incident form will be automatically sent to the Trust Learning from Deaths Leads.

9.0 Mortality Triangulation Group

Coordination of the operational Learning from Deaths process has been centralised through the Trust Mortality Triangulation Group (MTG). MTG facilitates improved oversight and triangulation of cases for review and ensures that the appropriate pathway to manage individual cases is agreed. It aims to avoid duplication of reviews or investigations, ensure appropriate internal or external referral as required and to facilitate clarity for the bereaved. Cases within a defined timeframe are discussed in detail where the Medical Examiner has identified potential learning and / or flagged a case for SJR or when a death has been referred to the Coroner. Following discussion at MTG, cases for SJR or where potential learning has been identified through ME scrutiny are allocated to Divisions for further action and monitoring of compliance.

10.0 Internal and external reporting and dissemination of learning (adult deaths)

10.1 Learning identified following SJR

10.1.1 In line with best practice, the Divisions though their governance structure, will internally report and monitor the number of deaths, number of reviews, deaths where problems in healthcare were deemed more likely than not to have caused the death and a summary of learning identified through the mortality review process. The Divisions will be supported by the Corporate Learning from Deaths team to do this. See Appendix B

10.2. Learning from Deaths: Maternal Deaths.

10.2.2 Maternal **death** is defined as the deaths of a woman whilst pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

10.2.3 Direct - A death resulting from obstetric complications of the pregnant state (pregnancy, labour, and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.

10.2.4 Indirect - A death resulting from previous existing disease or disease that developed during pregnancy, and which was not due to direct obstetric cause, but which was aggravated by the physiological effects of pregnancy.

10.2.5 All direct and indirect maternal deaths are reported to HSIB for investigation and MBRRACE

10.2.6 **Coincidental** (Fortuitous) - A death that occurs from unrelated causes which happens to occur in the pregnancy or puerperium e.g., road traffic accident.

10.2.7 **Late** - A death occurring between 42 days and one year after termination of pregnancy, miscarriage or delivery that are due to direct or indirect maternal causes.

10.2.8 **Pregnancy related deaths** - A death occurring in women while pregnant or within 42 days of termination, irrespective of cause of death.

10.2.9 The Trust guideline 'Maternal Death' will be followed in all instances.

10.2.10 All maternal deaths will be reported using the Datix Incident Reporting system.

10.2.11 Individual cases will be referred for external investigation by HSIB in accordance with agreed criteria

10.2.12 The Trust reports all maternal deaths through the MBRRACE-UK reporting system in lone with national guidance.

10.2.13 Engagement with bereaved families and carers will be in accordance with the Trust Maternal Death guideline and any duty of candour requirement as detailed within CG34.

10.2.14 A Bereavement Specialist Midwife is available trust wide to provide essential expertise and support for woman and their families who suffer any fetal loss, maternal or neonatal death.

10.2.15 A summary of maternal deaths including learning identified, themes and trends will be shared will be with the Trust Learning from Deaths Group and reported within the quarterly Learning from Deaths reports to the Trust Board of Directors. This information will be used to help inform improvement work within the Division and the wider trust as appropriate.

11. Learning from Deaths: Stillbirth and neonatal death

11.1 The Trust guidelines for 'Fetal Loss and Early Neonatal Death' and 'Perinatal Deaths MBRRACE Reporting' will be followed

11.2 Engagement with bereaved families and carers will be in accordance with this guideline and any duty of candour requirement as detailed within CG34.

11.3 The Trust reports all stillbirths and neonatal deaths through the MBRRACE-UK reporting system. Referrals to HSIB for investigation will be made according to defined criteria.

11.4 A Bereavement Specialist Midwife is available trust wide to provide essential expertise and support for woman and their families who suffer any foetal loss or neonatal death.

11.5 A summary of stillbirths and neonatal deaths including learning identified, themes and trends will be shared will be with the Trust Learning from Deaths Group and reported within the quarterly Learning from Deaths reports to the Trust Board of Directors. This information will be used to help inform improvement work within the Division and the wider trust as appropriate.

12 Learning from Deaths: Infant or Child Death

12.1 The Trust should follow the child death review process set out in Child Death Review Statutory and Operational Guidance (England 2018) when reviewing the death of a child. The Trust SOP 'Governance of Child Deaths in Shropshire (080) and the Trust guideline 'When a Child Dies (173) will further enhance this process.

12.2 The SaTH SUDIC guideline will be adhered to for all sudden or unexpected deaths in children and young people 0-18yrs of age

12.3 Any concerns about the quality of care arising from these reviews will be reported as incidents on the Trust's Datix risk management system and reviewed against the criteria that define a Serious Incident; where those criteria are met, the Trust's Serious Incident Management Procedure will be followed.

12.4 All inpatient child deaths within the Trust will be notified via Datix Incident Reporting System.

12.5 All child deaths will be reported to the Child Death Overview Panel (CDOP)

12.6 All deaths of children aged 4 or over with a confirmed learning disability will be referred to the LeDeR programme for detailed review of care.

12.7 A summary of child deaths within the Trust including learning identified, themes and trends will be shared will be with the Trust Learning from Deaths Group and reported within the quarterly Learning from Deaths reports to the Trust Board of Directors. This information will be used to help inform improvement work within the Division and the wider trust as appropriate.

13 Mortality Diagnosis Alerts

13.1 Hospital Standardised Mortality Ratio (HSMR), Summary Hospital-level Mortality Indicator (SHMI) and Risk Adjusted Mortality Index (RAMI) should not be looked at in isolation; it is an indicator to prompt further investigation. A high HSMR / SHMI / RAMI or persistent trend is a signal for further investigation. A range of other information should be used to determine if there is a genuine quality problem and where to look further.

13.2 Any of the following scenarios, should be used as triggers for investigating a high mortality rate.

- An external mortality alert (Dr Foster Imperial or the Care Quality Commission)
- Condition where mortality metrics are above the national mortality benchmark of 100, especially when the index is above the peer group or when an amber or red CUSUM alert has been triggered.

- High Relative Risk alerts refers to an alert where there is a statistically significant difference between the observed number of deaths and the 'expected' number of deaths.

13.3 As a matter of good practice, in the event of an alert being identified on two consecutive months, the Learning from Deaths Group will inform the Lead that a case note review will be undertaken if a subsequent third alert occurs. This information will be obtained from the quarterly CHKS data.

13.4 There are several reasons for an alert and the following areas should be reviewed in the first instance:

- Discuss with the relevant Lead Clinician within the relevant specialty to identify any known concerns.
- Conduct a drill down exercise from CHKS.
- Review completed mortality reviews (SJRs) for outlier conditions as available.
- Discuss with the Clinical Coding Manager the accuracy of the primary diagnosis for outlier conditions and if necessary, request an audit of individual cases.
- Review findings with the relevant clinical teams to identify action plans and the requirement for further detailed reviews/audits/ education.
- Feed into the Trust Improvement work and enhance relevant clinical pathways in the light of the above findings.
- Review and report through Trust Governance processes.

14.0 Staff Support

Staff can be so involved in responding to the needs of families and carers that there is a risk their own feelings may go unrecognised. It may be particularly difficult for example if a staff member has recently experienced a bereavement of their own. The opportunity for debriefing should always be available for staff after a death. This can take the form of group supervision or individual clinical supervision. In clinical areas where deaths happen frequently, for example in end-of-life care settings, it may help for a debriefing to take place after exceptionally challenging deaths or when the cumulative effect of many deaths can be discussed. The Trust has guidance for support available for staff who have experienced a traumatic event at work check reference. The Just Culture Guide, developed by NHS Improvement, can help managers ensure staff involved in a patient safety incident are treated fairly, and supports a culture of openness to maximise opportunities to learn. The guide can be accessed here https://improvement.nhs.uk/resources/just-culture-guide

15.0 Training Needs

Ensure that the mortality review process within the Divisions meets the requirements of the Learning from Deaths agenda and is implemented across the Division, including training for clinicians to use the online SJRPlus.

16.0 Equality Impact Assessment

This document has been subject to an Equality Impact Assessment and is not anticipated to have an adverse impact on any group.

17.0 Review Arrangements

This policy will be reviewed after 5 years or following changes in national policy. In order that the document remains current, any of the appendices to the policy can be amended and approved

during the lifetime of the document without the document strategy having to return to the ratifying committee.

The Trust Learning from Deaths Group will ensure the policy is reviewed in line with changes in the national policy or when circumstances indicate that the policy requires review.

18.0 References/Bibliography

National Quality Board; National Guidance on Learning from Deaths (March 2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

National Quality Board: Guidance for NHS trusts on working with bereaved families and carers (July 2018)
https://www.england.nhs.uk/publication/learning-from-deaths-guidance-for-nhs-trusts-on-working-with-bereaved-families-and-carers/

Royal College of Physicians; Using the structured judgement review method – Data Collection Form (England Version) (2016)
https://www.rcplondon.ac.uk/guidelines-policy/mortality-toolkit-implementing-structured-judgement-reviews-improvement

Royal College of Physicians (March 2017) Using the Structured Judgement Review Method – A Guide of Reviewers (England Version)

Royal College of Psychiatrists (2018) Guidance on Using the Care Review Tool for mortality reviews in Mental Health Trusts https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh -policy/policy/rcpsych_mortality_review_guidance.pdf

CQC Learning, Candour and Accountability (December 2016)
https://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability

NHS Digital (2018) Health of the Nation Outcome Scales (HoNoS) (Working Age Adults).

AHSN Network Implementing Structured Judgement Reviews for Improvement (June 2018)
https://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability

Herefordshire and Worcestershire Health and Care NHS Trust (2019) Learning from Deaths Policy: Mortality Review Process and Procedures –

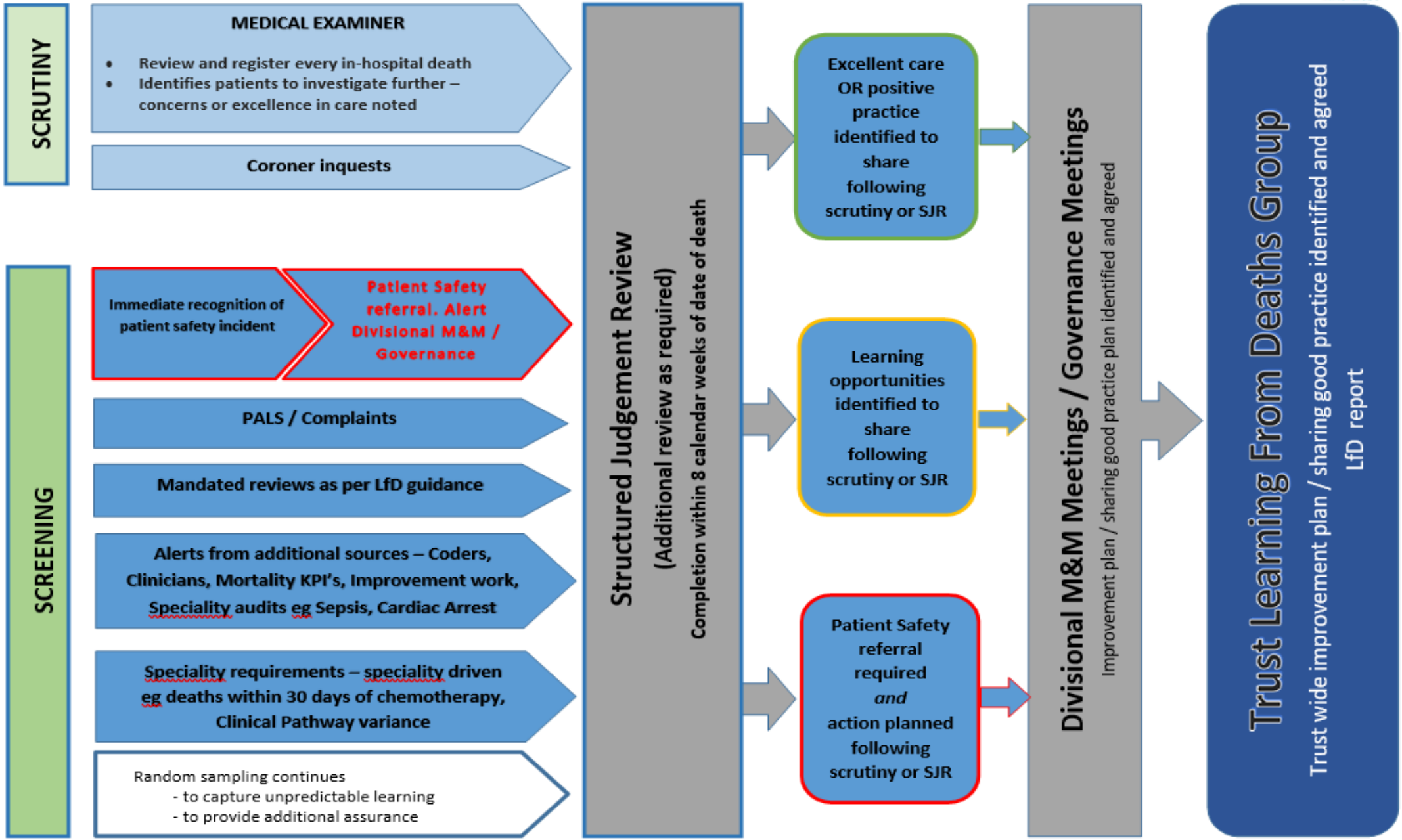
NHS England (2015) Serious Incident Framework: Supporting learning to prevent recurrence, NHSE, London

NHS Improvement (2018) The Future of NHS patient safety investigations, NHSI, London

Appendices A

Learning from Deaths Policy on a Page Jan 2022*

The Shrewsbury and Telford Hospital NHS Trust



FMcAree/JMac/TS April 2021

*excluding Obstetrics, Neonates and Paediatrics

APPENDICES B

INPATIENT MORTALITY REPORTING

DIVISION	MEDICINE & ED			
YEAR				
QUARTER	Q1 (reported September)	Q2 (reported December)	Q3 (reported March)	Q4 (reported June)
Total number of inpatient deaths				
Total number of ED deaths				
Total number of deaths considered more likely than not due to problems in healthcare				
Number of Learning Disability deaths				
Number of SJRs triggered				
Number of SJRs completed within agreed timescale				
Number of serious incidents reported by Division in quarter relating to patients who have died				
Number of complaints received by Division in quarter relating to patients who have died				

YEAR	
QUARTER (please circle)	1 2 3 4

Summary of learning, themes and trends:

DIVISION	**SACC**			
YEAR				
QUARTER	**Q1 (reported September)**	**Q2 (reported December)**	**Q3 (reported March)**	**Q4 (reported June)**
Total number of inpatient deaths				
Total number of deaths considered more likely than not due to problems in healthcare				
Number of Learning Disability deaths				
Number of SJRs triggered				
Number of SJRs completed within agreed timescale				
Number of serious incidents reported by Division in quarter relating to patients who have died				
Number of complaints received by Division in quarter relating to patients who have died				

YEAR	
QUARTER (please circle)	**1 2 3 4**
Summary of learning, themes and trends:	

DIVISION	**W&C**			
YEAR				
QUARTER	**Q1 (reported September)**	**Q2 (reported December)**	**Q3 (reported March)**	**Q4 (reported June)**
GYNAECOLOGY				
Total number of deaths in Gynaecology				
Total number of deaths considered more likely than not due to problems in healthcare				
Number of Learning Disability deaths				
Number of SJRs triggered				
Number of SJRs completed within agreed timescale				
Number of serious incidents reported by Division in quarter relating to patients who have died in Gynaecology				
Number of complaints received in quarter by Division relating to patients who have died in Gynaecology				
LEARNING, THEMES AND TRENDS **YEAR:** **Quarter (circle) 1 2 3 4**				

DIVISION	**W&C**			
YEAR				
QUARTER	**Q1 (reported September)**	**Q2 (reported December)**	**Q3 (reported March)**	**Q4 (reported June)**
PAEDIATRICS				
Number of inpatient child deaths				
Number of child deaths within ST&W				
Number of child deaths reported to and reviewed by the ST&W Child Death Overview Panel				
Number of unexpected child deaths reviewed under the Sudden Unexpected Deaths in Infancy (SUDIC) process				
Number of child learning disability deaths				
Number of serious incidents reported in quarter by Division relating to deaths within Paediatrics				
Number of complaints received in quarter by Division relating to deaths within Paediatrics				
LEARNING, THEMES AND TRENDS **YEAR:** **Quarter (circle) 1 2 3 4**				

DIVISION	**W&C**			
YEAR				
QUARTER	**Q1 (reported September)**	**Q2 (reported December)**	**Q3 (reported March)**	**Q4 (reported June)**
Obstetrics & Neonates (see below for definitions)				
Number of Stillbirths				
Number of ENND ≥ 24 wks				
Number of LNND ≥ 24 wks				
Number of MTOP ≥ 24 wks				
Number of NND < 24 wks				
Number of Maternal Deaths				
Number of serious incidents reported in quarter by Maternity relating to deaths within Division				
Number of complaints received by Maternity in quarter relating to deaths				
LEARNING, THEMES AND TRENDS **YEAR:** **Quarter (circle) 1 2 3 4**				

DEFINITIONS

Stillbirth: The death of a baby before or during birth at 24 or more weeks of pregnancy

Early Neonatal Death (ENND): The death of a neonate up to and including 6 days of life

Late Neonatal Death (LNND): The death of a neonate between 7 and 27 days of life inclusive

MTOP: Medical Termination of pregnancy

NND: Neonatal Death

Maternal Death: The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy

DIVISION	**CLINICAL SUPPORT SERVICES**			
YEAR				
QUARTER	**Q1 (reported September)**	**Q2 (reported December)**	**Q3 (reported March)**	**Q4 (reported June)**
Number of serious incidents reported by Division in quarter relating to patients who have died				
Number of complaints received by Division in quarter relating to patients who have died				
LEARNING, THEMES AND TRENDS **YEAR:** **Quarter (circle) 1 2 3 4**				