East Lancashire Hospitals NHS Trust TRUST WIDE DOCUMENT	
	Policy
DOCUMENT TITLE:	**Learning from Deaths**
DOCUMENT NUMBER:	**ELHT / C143 V1**
DOCUMENT REPLACES Which Version	**N/A**
LEAD DIRECTOR	**Medical Director**
AUTHOR(S): Note should not include names	**Deputy Medical Director**

TARGET AUDIENCE:	**All staff employed by ELHT**
DOCUMENT PURPOSE:	To outline the Trust's strategy and procedure for learning from deaths and to provide guidance for all staff involved in mortality reviews to ensure that deaths are reviewed appropriately and enable learning from the service provided to deceased patients prior to their death are reported into the organisation to promote continuous improvement in care.
To be read in conjunction with (identify which internal documents)	This policy should be read in conjunction with ; • C002 Risk Management Strategy • C003 Incident Management Policy • C007 Complaints • C009 Claims Policy • C012 Root Cause Analysis Policy and Protocols • C066 Policy for Care After Death and Support of the

	Bereaved • C075 Openness and Honesty Policy • CP30 Care of the Dying Policy • C087 Guidelines for the Care of Adults with Learning Disabilities • Procedure for Supporting Staff – Appended in policies C03, C07,C09,C75
SUPPORTING REFERENCES	• National Guidance on Learning from Deaths (National Quality Board – March 2017) • Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (Care Quality Commission – December 2016) • National Mortality Case Record Review (Royal College of Physicians 2016) • Incident Investigation Policy • Being Open Policy • Child Death Review Statutory Guidance (HM Government October 2017) • Template Learning from Deaths Policy NHSi – September 2017

CONSULTATION		
	Committee/Group	**Date**
Consultation	Mortality Steering Group Patient Safety and Risk Assurance Committee Quality Committee Policy Council	
Approval Committee	Policy Council	
Ratification date at Policy Council:	**May 2018**	
NEXT REVIEW DATE:	**April 2021**	
AMENDMENTS:	**NA**	

Contents

Introduction

This policy outlines this Trust's strategy for application of the CQC report "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England" (Care Quality Commission – December 2016). This Trust is committed to ensuring that learning from in-patient deaths supports our ethos of delivering Safe Personal and Effective Care. We are also committed to ensuring that families and carers are involved in and given compassionate support where it is identified that poor care may have contributed to a patient's death.

1. Scope

This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

2. Purpose

ELHT will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of ELHT.

This policy describes how ELHT will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff that may be affected by the death of someone in the trust's care.

It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with the policies and documents listed at the front of this document.

This policy replaces the previous process of Primary and secondary mortality review

and formalises the process of learning from deaths in accordance with national requirements as referenced at the front of this policy.

This policy aims to provide guidance for all staff involved in structured judgement (SJR) and mortality reviews in the process of and purpose of conducting these reviews.

The aim of the policy is to:

- Identify and minimise avoidable deaths within the entire Trust
- Review the quality of end of life care
- Ensure that patients' wishes have been identified and met
- Improve the experience of patients' families and carers through better opportunities for involvement in investigations and reviews ensuring Duty of Candour
- Identify and minimise avoidable admissions or late presentation
- Enable informed reporting of deaths within a transparent methodology
- Promote organisational learning and improvement.

3. ROLES AND RESPONSIBILITIES

3.1 Medical Director and Medical Director's Office

The Medical Director will have overall responsibility for the learning from deaths process and duties will include:

- Revision and review of this policy
- Ensuring appropriate audit of the processes set out in this policy
- Ensuring appropriate resources are in place to support the review of mortality processes set out in this policy
- Presenting reports to the Board and ensuring that national standards associated with this policy are met across the organisation
- Ensuring that learning from these processes is integral to the Trust's clinical and corporate governance and quality and safety work and is appropriately disseminated across the organisation.
- Undertaking Mortality Reviews where the criteria set out in this policy are met
- Chairing the Mortality Steering Group and ensuring it meets its approved Terms of Reference
- Liaising with the Associate Director of Quality and Safety to ensure appropriate Quality Improvement Programmes are initiated in response to

the finding of the mortality review processes

- Liaising with the Associate Director of Quality and Safety to ensure that the Trust's Incident Policy and Learning from Deaths Policy are congruent
- Ensure that there are appropriate arrangements in place to support staff involved in the death of patients or in the investigation of patient deaths

3.2 Board of Directors

The Board ensures that:

- There is a Board level Director acting as a Patient Safety Director who takes responsibility for learning from deaths
- The Trust a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review
- The Trust particular attention to the care of patients with a learning disability or mental health needs or is a child
- The Trust adopts a robust and effective methodology for case record reviews of all selected deaths to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented
- Reviews and investigations are carried out to a high standard, acknowledging the role of system and human factors in lapses in care or service provision where appropriate

3.3 Medical Director

The medical director ensures that;

- Learning from the mortality review processes is regularly provided to the Board in order that members remain aware of how learning is disseminated and improvements in care are implemented across the Trust and Non-Executive members provide appropriate challenge to the implementation of this policy and learning from it
- Has sufficient numbers of nominated staff with the appropriate skills to undertake the mortality review processes and implement learning from the mortality review processes
- Offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death
- Ensures that the appropriate independent external review of deaths falling within the scope of this policy are performed

- Cooperates appropriately with regulators and commissioners in the investigation of deaths and the dissemination of learning from mortality review processes

3.4 Associate Director of Quality Safety

- The post holder is responsible at an operational level for the implementation of agreed policies and procedures on the management of mortality within the Trust and for ensuring that they are congruent with the Trust's Incident Investigations policy which includes Duty of Candour.
- They are responsible for raising risks and trends with the Medical Director and his office to ensure that appropriate risk mitigation plans are put in place and that quality improvement projects are implemented in response to learning from mortality review processes.
- To ensure that patient's families and carers are given an opportunity to be engaged with the investigation and mortality review processes, including providing feedback on investigations and reviews where appropriate.
- To ensure that the outcomes and learning from reviews are recorded and action plans for improvement are developed where required by Divisional Quality and Safety teams and reported through Divisional Quality and Safety structures.

3.5 Structured Judgement Reviewers

The team are responsible for:

- Completion of Structured Judgement Reviews in accordance with the training and guidance provided by the Deputy Medical Director and for recording of the reviews on the appropriate module of the Trust's Datix system
- Secondary reviewers are responsible for reviewing any cases where care has been identified as poor or very poor whether or not that led to a patient's death. The detail of these secondary reviews will be reported by divisional Quality and Safety leads to Mortality steering group and divisional quality meetings.
- Secondary reviewers are responsible for ensuring that an incident is raised through Datix if it is felt that poor care has contributed to a patient death in order that a full RCA investigation is triggered

3.6 Quality and Safety Unit

The team are responsible for:

- Identifying through complaints triage processes cases where a family or carers have raised a concern that care provision could have contributed to a patient's death
- Act on information provided by the Bereavement Care Team if family or carers have raised a concern that care provision could have contributed to a patient's death
- Identifying diagnostic groups where quality improvement work is ongoing or planned and where mortality review could support the work stream
- Maintaining the mortality review module on Datix and ensuring appropriate clinical records are provided to the Structured Judgement Reviewers

3.7 Information Department Staff

The team are responsible for:

- Identifying alerting groups which require a detailed death review
- Identifying "low risk" deaths for review
- Identifying deaths following readmission within 30 days

3.8 Coding Department Staff

The team are responsible for:

- Identifying deaths occurring following an elective procedure
- Identifying deaths occurring as a result of a serious complication

3.9 Mortality Steering Group

The group is responsible for:

- Reviewing mortality trends including crude, HSMR and SHMI
- Ensuring that this policy is implemented and for monitoring of compliance with the policy
- Reviewing divisional responses to learning and monitoring action plans
- Identifying with commissioners who attend the meeting where joint working on pathways could improve the care and experience of patients as identified through mortality reviews

3.10 Quality Committee and its subcommittees

The Committees are responsible for:

- Receiving assurance reports on effectiveness of this policy and its interaction with other Trust policies
- Ensuring high priority and urgent learning from the mortality review process are escalated to the Trust Board as appropriate

3.11 Divisional Quality and Safety Teams

The teams are responsible for ensuring:

- Divisional action plans arising from mortality review processes are developed, progressed and appropriately monitored to provide assurance through the Trust's quality and safety structures and for escalating should the required input not be received from divisions.

4.0 The process for recording and reporting deaths in Care

4.1 The Trust will collate and report on a quarterly basis;

- The total number of inpatient deaths in the Trust's care
- The number of deaths the Trust has subjected to case record review
- The number of deaths investigated under the Serious Incident framework and declared as Serious Incidents
- Of those deaths subject to case record review or investigated, estimates of how many deaths where problems in care may have contributed to
- The themes and issues identified from review and investigation, including examples of good practice
- How the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation of those work-streams.

4.2 The process for recording deaths in care

a) The process for certification and verification of deaths

- The Bereavement Care team located in the General Office assist staff and families in the process for certification and registration of deaths.
- Medical staff report all deaths to the Bereavement Care Team who also provide advice on whether any death requires notification to the Coroner.

The bereavement care team maintain a list of patients who have died in the in-patient care of the Trust. Further details of the processes for care of a deceased person and support for families and carers are provided in C066 Policy for Care After Death and Support of the Bereaved.

- The Bereavement Care team will report to the Trust's Customer Relations Team should any family raise concerns that the care provided by the Trust contributed to the patient's death.
- The Customer Care Team will notify the wider Quality and Safety team in order that the patient details will be loaded onto Datix in order that an SJR is requested. The family will receive a letter confirming to them that a review is being undertaken and that they will be provided with feedback.

5.0 The selection of patient's for mortality review

This section details how the Trust identifies cases for review

5.1 There is a specific subset of patients detailed below for whom there is specific national guidance on the review process which the Trust adheres to:

- Deaths of people with learning disabilities are reported through the Learning Disabilities Mortality Review (LeDeR) programme Trust's Learning and Disability Group. Quality and Safety Unit staff will ensure that deaths of patients with Learning Disabilities are notified to the Chair of the Learning Disabilities Group
- Deaths of patients with mental health needs are reported to the Care Quality Commission in accordance with Annex E of National Guidance on Learning from Deaths (National Quality Board 2017 pg 33).
- Deaths of children and young people are reported in accordance with national guidance Child Death Review Statutory Guidance (Oct 2017) and in line with the Child Death Overview Panel Process.
- Maternity deaths are reported and investigated in line with Annex G of the National Guidance on Learning from Deaths (National quality Board 2017, pg 46)

5.2 The Trust has determined in accordance with national guidance that the mortality review process used in ELHT is based upon the Royal College of Physicians Structured Judgement Review (SJR) process (National Mortality Case

Record Review Royal College of Physicians 2016). This has been built into a Datix system developed by the Trust which is where SJR's will be recorded.

The Trust has determined that in-patient deaths as detailed below will be subject to the SJR process:

- All deaths after an elective procedure
- All deaths in an alerting diagnostic group
- Death following a serious complication
- All death categorised as low risk after coding
- Death where family, carers or staff have raised a concern about the quality of care provided because they feel it contributed to the patient's death
- Death where learning will inform the Trust's existing and planned improvement work
- A sample of deaths following readmission to hospital within 30 days of discharge
- Dependent upon the amount of cases generated by the above, the Trust may undertake random/targeted sampling of other deaths. This will be determined by the mortality steering group
- Deaths within the Critical Care Unit will be reviewed on a weekly basis at the Critical Care MDT and if necessary an SJR triggered

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The operational management of the SJR process is detailed in Appendix A

6.0 Learning and Quality

Learning from all mortality reviews (Learning Disabilities, Child Deaths, Mental Health patient deaths, Critical Care Unit deaths and those having undertaken the SJR process) will be reported to the Associate Director of Quality and Safety and the Deputy Medical Director for amalgamation and reporting of learning themes and monitoring of resultant action plans. These will be reviewed in line with the Trust's Risk Management Strategy, Incident Reporting Policy and Openness and Honesty Policy.

The Trust's Quality and Safety Unit in conjunction with the office of the Medical Director will review the investigations and outcomes of deaths reviewed by the Trust under this policy and will incorporate the findings into its Quality Improvement and Clinical Strategies to ensure there is continuous improvement in the quality of care

provided to our patients. The outcomes of Quality Improvement and Clinical strategies are reported on an annual basis in the Quality Account, Annual Report/ Review and a variety of internal and external publications to ensure learning from improvement work is shared as widely as relevant. In addition a report will be presented to the Trust Board on a quarterly basis as part of the Integrated Performance Report.

6.1 – Direct learning from SJR process

When a structured judgment review is undertaken the reviewer will indicate the quality of care provided using the following scale:

5 – Excellent Care

4- Very good care

3 - Adequate Care

2 – Poor Care

1 – Very Poor Care

(a) A score of 1 – 2 will trigger a secondary structured judgement review. If the secondary reviewer finds that the care provided contributed to a patient's death an incident report will be generated and the case will be StEIS reported and an investigation using root cause analysis methodology will be undertaken. In accordance with Duty of Candour requirements, family will be informed that an investigation is taking place.

(b) Where poor or very poor care is identified at SJR2 which did not contribute to the patient's death, divisional teams will liaise with the directorate responsible to arrange for an improvement plan to be generated and implemented. This will be reported to mortality steering group and divisional quality meetings.

7.0 Training and Support

The Trust will ensure that staff involved in the mortality review process have the appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard. Staff involved in the death of patients will be supported in line with the Trust's Procedure for Supporting Staff

8.0 Monitoring Compliance

Standard/ Process/ Issue	Method of monitoring/ audit	By	Committee/ Group	Frequency
Process and outcomes	Divisional Reports	Q and S Leads	MSG	Monthly
Overview of process and progress	Performance report	Informatics	MSG Trust Board	Monthly

Appendix A

Operational Process for SJR and conduct of review Initial Screening

(a) Deaths falling within the categories for SJR will be notified to the Mortality inbox on a weekly basis by the appropriate staff

(b) Quality and Safety Unit staff will ensure that the details of the notified deaths are appropriately identified on the mortality module within Datix

(c) Each notified death will be allocated to a reviewer by Quality and Safety Unit staff and will arrange for the medical notes of the deceased to be provided to the nominated reviewer

(d) Quality and Safety Unit staff will ensure that deaths of patients on the Critical Care Unit at the time of their death are referred to the Clinical Director for Anaesthetics and Critical Care.

(e) Quality and Safety Unit staff will liaise with the Trust's Inquest Co-ordinator to identify any cases that have been referred to the Coroner which will then be excluded from this process and will be dealt with in accordance with the Trust's Incident Investigation Policy as appropriate.

Structured Judgement Review

(a) On receipt of the deceased's clinical records, and in any event within 10 working days of allocation to a reviewer, the Structured Judgement Reviewer will examine the notes to complete the SJR module on the Trust's Datix system grading the care provided at

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent Care

(b) The SJR module will indicate areas of good practice and areas for improvement in practice.

(c) A score of 3 or above indicates that the death will require no further action save for the dissemination of good practice.

Secondary SJR

A score of 1 or 2 on an SJR will trigger a secondary mortality review led by the Deputy Medical Director and may include a multidisciplinary review panel. The panel could consist of a senior clinician, senior nurse and trainee doctor depending upon the issues under review. The panel will assess the case and determine if the identified concerns mean that the death was potentially avoidable.