Policy Title: Learning from Deaths Policy	
Reference & Version No: C72 Version 3	
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Related Documents:	
RM15	**Reporting and Management of Incidents including Serious Incidents and Never Events Policy.**
Plan01	**Patient Safety Event Response Plan (PSERP) 2024-25**
HR71	**Supporting Staff Involved in Stressful Situations Policy**
C40	**Duty of Candour Policy**
C82	**Care after Death Policy**
This Policy is Intended for: All Staff Groups	

Policy Summary / Flowchart

The aim of this policy is to set out how we respond to deaths of inpatients within our care, with a focus on identifying areas of concern, understanding the issues, promoting learning and implementing improvements where needed. In all of this we will seek to engage compassionately with and support the families and carers of those who die in our care.

North Tees and Hartlepool Solutions and North Tees and Hartlepool NHS Foundation Trust is committed to the fair treatment of all, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependants, sexual orientation, trade union membership or non-membership, working patterns or any other personal characteristic. This policy will be implemented consistently regardless of any such factors and all will be treated with dignity and respect. To this end, an equality impact assessment has been completed on this policy.

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Please note: All contents and appendices are hyperlinked

1. Introduction/Purpose

1.1 The NHS cares for its patients from 'cradle to grave' and the Trust is committed to providing excellent care throughout our patient's lives.

1.2 Following the 2013 report[1] by Sir Robert Francis into the events in Mid Staffordshire the CQC produced a report[2] 'Learning, Candour and Accountability: A review of the way Trusts review and investigate the deaths of patients in England'. It recommends that learning from deaths is given priority in all NHS Trusts so that valuable opportunity for improvement is not overlooked. The report also points out that there is more we can do to engage families and carers as partners in reviewing and learning from the deaths of those within our care.

1.3 The National Quality Board (NQB) has since published 'Learning from Deaths: a framework for NHS Foundation Trusts on Identifying and Learning from Deaths in Care'[3] setting out minimum standards required to ensure there is a focused, compassionate approach to learning from deaths.

1.4 The aim of this policy is to set out how we respond to deaths of inpatients within our care, with a focus on identifying areas of concern, understanding the issues, promoting learning and implementing improvements where needed. In all of this we will seek to engage compassionately with and support the families and carers of those who die in our care.

1.5 The Trust will ensure compliance with the requirements set out in the NQB guidance by:

- Reviewing all relevant mortality data produced by NHS England, in particular the Standard Hospital Level Mortality Indicator (SHMI)[4]
- Identifying deaths which need further investigation
- Ascertain learning points to ensure these are used to support changes in practice.
- Ensuring bereaved families have the opportunity to highlight any concerns they may have and to request a mortality review be completed.
- Support staff in collecting and using information to initiate quality service improvements and demonstrate learning.
- Reporting findings to the Trust Board

1.6 The Learning from Deaths process will involve examining a range of available data, including mortality reviews (structured judgement reviews), patient safety events, inquests, complaints and compliments, audit, specialty mortality and morbidity data and bereavement surveys.

1.7 This policy sits alongside C82 Care after Death, which contains more detail around Certification of Death, The Medical Examiner Service and care of the bereaved.

2. Definitions

2.1 **Death certification**:
The process of certifying, recording and registering death, the causes of death and any concerns about the care provided.

2.2 **Medical examiner** (Elements of this service await statutory implementation[5])
Medical examiners are senior medical doctors who provide independent scrutiny of the causes of death. They are trained in the legal and clinical elements of death certification processes.

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the Coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased

- improve the quality of death certification
- improve the quality of mortality data.

2.3 **Structured Judgement Review (SJR):**
A validated tool to review the care a person has received during their last admission to hospital.

2.4 **Death due to a problem in care:**
A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

2.5 **Patient Safety Event / Incident**
A patient safety event / incident is when something goes wrong in a patient's care or treatment that causes them harm or has the potential to cause harm.

2.6 **Patient Safety Incident Investigation**
A patient safety incident investigation (PSII) is undertaken when an event or near-miss indicates significant patient safety risks and potential for new learning.

2.7 **Duty of Candour:**
Duty of Candour regulations provide a framework to support the sharing of information when things go wrong; the Trusts policy C40, provides details on how these regulations are to be applied.

2.8 **Quality improvement (QI)**:
A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

2.9. **Summary Hospital-level Mortality Indicator (SHMI)**
Produced by NHS England – the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

3. Roles and Responsibilities

3.1 **Chief Executive / Chief Operating Officer**
Have overall responsibility for this policy and compliance.

3.2 **Board of Directors**
The Board will receive Learning from Deaths reports and provide oversight in relation to the application of the learning across the organisation and in the wider health community.

3.3 **Non- Executive Directors (NEDs)**
Non-Executive Directors will understand the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.

They will champion quality improvements that lead to actions improving patient safety.

They will assure published information; that it fairly and accurately reflects the organisation's approach, achievements and challenges.

NHS Improvement have identified that Trust NEDs in particular have been identified as having a critical role to play in holding their organisations to account for: conducting robust case record reviews and serious incident investigations; and crucially for implementing effective and sustainable changes designed to improve safety and wider quality in response (NHSI, 2017).

3.4 **Chief Medical Officer**
Has overall responsibility for ensuring that this policy is applied consistently and comprehensively for both medical and nursing staff.

Ensure that all nurses, midwives and medical staff are supported to fulfil their duty to engage in the Trusts response to "Learning from Deaths".

Ensure that Quality and Patient Safety initiatives supporting the findings of the reviews are implemented and improvements monitored.

3.5 **Mortality Leads**
Responsible for the provision of the quarterly Board Report outlining estimates of numbers of avoidable deaths and summarizing learning obtained through the Trusts mortality work.

To provide leadership in relation to the Trusts response to learning identified through systematic case reviews.

Utilise available data to identify key areas of focus in order to promote overall quality improvements; this will include working with stakeholders across the health economy to improve overall care pathways in primary as well as secondary care.

Ensure that the annual Quality Account provides a summary of the data provided to the Trusts Board, including details of any learning and improvements made as a result of this; provide an overall evaluation of the impact.

3.6 **Care Group Senior Management Teams and Specialty Clinical Directors.**
To ensure all clinicians in their group or team are supported to fulfil their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.

To ensure specialties have local mortality reviews and results/learning are incorporated into central system and are used to inform quality improvement developments.

Ensure lessons learned are disseminated to their own directorate in order to obtain the maximum benefit from the reviews.

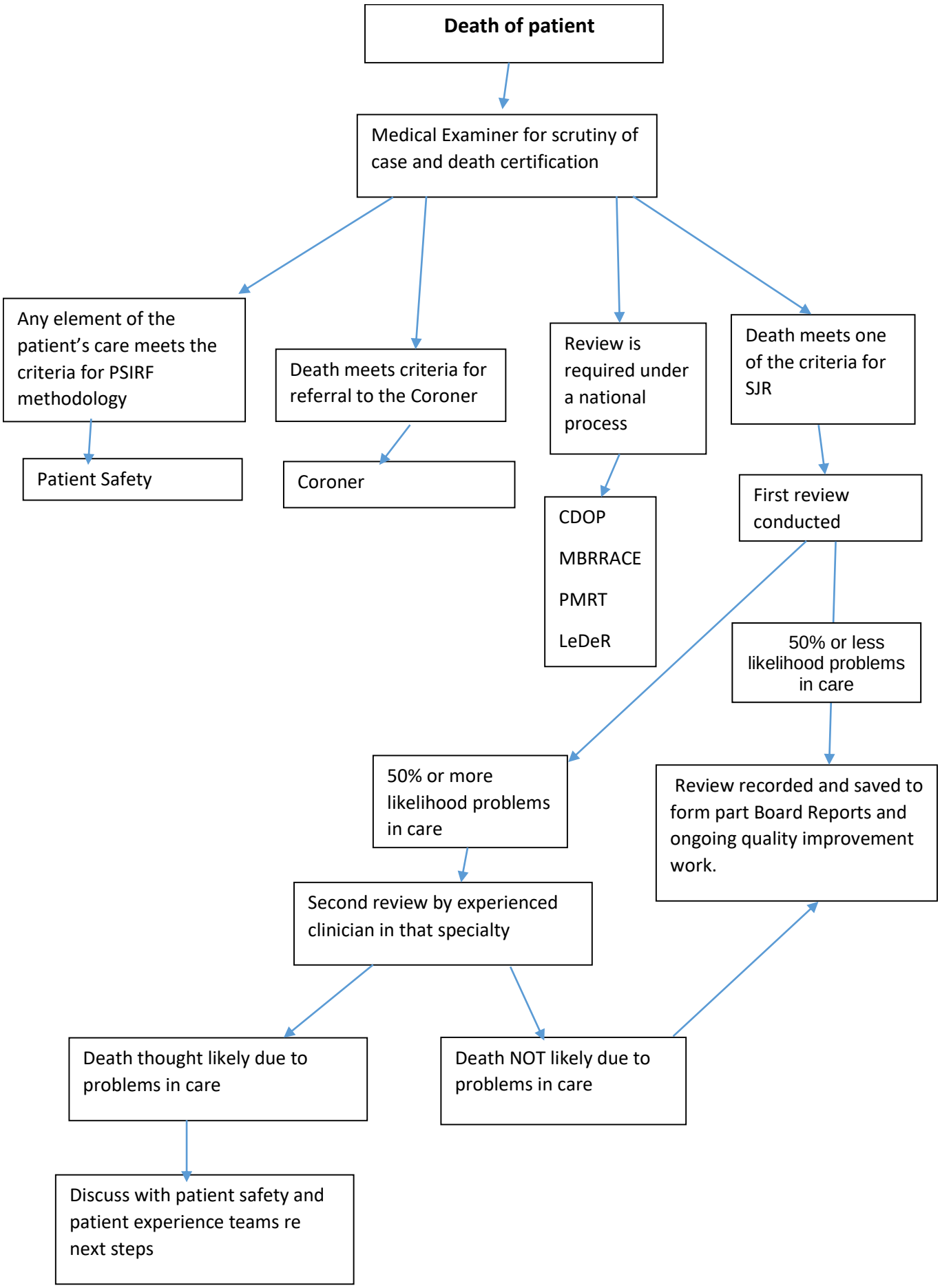
3.7 **Senior Clinical Matrons**
To ensure there is professional nursing / midwifery input in relation to case reviews in conjunction with the medical staff reviewing the case; identify specific staff to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.

3.8 **Medical Examiner Service**
Maintain close working links with patient safety and mortality teams to ensure identification of cases for further review

3.9 **All staff**
All staff with clinical background have a duty to engage in responding to deaths, to be involved in case record reviews and investigations as required and to meet the Duty of Candour requirements.

4. Policy and Process

4.1 Where a patient's death **immediately raises concern** this should be reported and escalated through the Trusts patient safety event reporting process. This includes informing senior staff in relation to the case and the identified concerns; the details of the case will then be considered in line with the PSIRF framework.


Death of patient
Medical Examiner for scrutiny of case and death certification
Any element of the patient's care meets the criteria for PSIRF methodology
Patient Safety
Death meets criteria for referral to the Coroner
Coroner
Review is required under a national process
CDOP
MBRRACE
PMRT
LeDeR
Death meets one of the criteria for SJR
First review conducted
50% or less likelihood problems in care
Review recorded and saved to form part Board Reports and ongoing quality improvement work.
50% or more likelihood problems in care
Second review by experienced clinician in that specialty
Death thought likely due to problems in care
Death NOT likely due to problems in care
Discuss with patient safety and patient experience teams re next steps

4.2 National review processes

Deaths falling into the following categories will be referred for further review in line with specific national review processes:

- Patients with Learning Disability – in conjunction with the Learning Disability Mortality Review programme (LeDeR)
- Maternal Deaths – in conjunction with MBRRACE UK
- Still Births – in conjunction with the Perinatal Mortality Review Tool
- Child Deaths (up to 18th Birthday) – in conjunction with the Child Death Overview Panel Process.

4.3 Structured Judgement Reviews (SJR)

4.3.1 In line with NQB guidance an SJR will be completed for deaths in the following categories as well as a random selection of deaths within the trust:

- Severe Mental Illness
- Elective procedures
- Family have expressed a concern
- Staff have expressed a concern
- To guide quality improvement work in specific areas
- To respond to an outlier alert eg in SHMI data
- Requested by ME office
- Requested by an external organization, as part of an overall review of that person's care.

4.3.2 SJR is a recognized method of retrospective case note review, undertaken to ascertain whether there have been any problems contributing to the person's death or to the quality of care received, and to identify good practice.

The Trust uses the InPhase system to record Structured Judgement Reviews and generate reports. The review incorporates PRISM methodology[6] to estimate the likelihood that the death was related to a problem in care. Reviewers can also record judgements about aspects of care provided during the patient's admission. Retrospective case note reviews are undertaken to ascertain whether there have been any problems contributing to the person's death or the quality of care received, and to identify good practice.

4.3.3 The PRISM methodology leads reviewers to identify a level of preventability on the following scale:

1. Definitely not preventable
2. Slight evidence for preventability
3. Possibly preventable less than 50-50
4. ***Possibly preventable greater than 50-50***
5. ***Strong evidence for preventability***
6. ***Definitely preventable***
7. Unable to grade

Where a death is graded "possibly preventable > then 50-50" or higher, grades 4, 5 and 6, this will then require a second review of care by a clinician external to the team who provided care. If the case has not already been identified as being of concern then consideration will be made to review the cases through the incident investigation processes. This grading scale will allow the Trust to estimate the rate of preventable deaths.

4.3.4 Reviewers will also be asked to utilise the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading system[7]:

1. Good practice: A standard that you would accept from yourself, your trainees and your institution.
2. Room for improvement: Aspects of clinical care that could have been better.
3. Room for improvement: Aspects of organisational care that could have been better.
4. Room for improvement: Aspects of both clinical and organisational care that could have been better.
5. Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.
6. Insufficient Data

Where any deficiencies in care are identified, reviewers are required to provide details of these in order to promote analysis of trends to support the identification of improvement developments to be actioned by the Trust and other organisations across the health system

4.3.5 When case record reviews are completed, any positive learning points are also included. This allows areas of good practice to be shared for learning.

4.3.6 SJR should not be conducted by clinicians involved in the patient's care (the second reviewer may have been involved in the patient's care if they are the only available person with the relevant clinical expertise)

4.3.7 Collaboration with other organisations such as primary care, mental health trusts, ambulance trusts and other acute trusts will support full understanding of a person's care and will promote shared learning. This is an area under development.

5. Training and Support for staff

5.1 Any staff involved in a patient's management and death can raise concerns or request a mortality review.

5.2 The Mortality Leads will maintain a panel of trained reviewers from a range of clinical backgrounds.

5.3 Staff interested in joining the SJR panel of reviewers will undergo training in using the SJR Plus Tool and will be supported by the Mortality Leads/experienced reviewers.

5.4 Participation in SJR sessions counts as CPD for appraisal purposes.

5.6 Where staff members require emotional support in relation to a specific case this will be provided through the processes outlined in the Trust policy HR71 Supporting Staff involved In Stressful Situations.

6. Recording, Monitoring and Reporting

Process Reference	Process	Lead Auditor	Scrutiny Committee	Frequency
Section 4 – Policy & process	Learning from Deaths report to provide assurance include, as a minimum: • Trust mortality statistics, namely the SHMI • The overall number of deaths in the organisation • The number of Structured Judgement Reviews completed • The number of deaths thought more than likely due to problems in care. • Thematic learning and agreed actions following SJR's; and the evaluation of impact on patient care or service provision. • Quality improvement work stemming from the LfD process. • The number of issues relating to patient deaths being reviewed under the PSIRF framework. • Relevant LeDeR MBRRACE, CDOP summary details. The report may also include: • Focus on particular areas eg specialties, departments. This may be on a rolling basis. • Other mortality data eg for specific diagnostic groups	Trust Mortality Leads	Quality Assurance Council Quality Committee Group Board – Public paper	Quarterly

Safety Events

This policy will be monitored primarily through exception reporting via the InPhase Reporting system as and when an event occurs. These references ARE NOT for safety events identified in relation to patient care; these should be reported under the appropriate category and adverse event codes on InPhase. .

If any deviation from the policy occurs, an InPhase event is created using the following categories:

InPhase

Category:	Peoples action / inaction (Human Agents)
Sub category:	Did not do something
	I don't know
Adverse Event:	Did not know the right thing to do
	Knew what to do but it did not happen
	Other

Please note: this is not a comprehensive list of InPhase categories.

7. References, further reading and resources

1. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK (www.gov.uk)
2. Learning, candour and accountability - Care Quality Commission (cqc.org.uk)
3. ngb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)
4. About the Summary Hospital-level Mortality Indicator (SHMI) - NHS England Digital
5. An overview of the death certification reforms - GOV.UK (www.gov.uk)
6. "Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case review and regression analysis"; *BMJ* 2015; 351:h3239
   Accessed on 01/05/2024 through: http://www.bmj.com/content/351/bmj.h3239
7. Grading system (ncepod.org.uk)

8. Policy Revisions Change Control

The table below identifies the areas where this policy has been reviewed; where these are minor changes staff should ensure that they take this opportunity to refresh knowledge of the whole policy and their responsibilities in relation to this and not just focus on the minor changes.

Policy Ref	Version Number	Revision to Page	Description of Revisions Made	Approved Date
C72	V3		Full policy review	