

Learning from Deaths Policy

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1 Introduction

Patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures leading to publication of the Keogh (2013) and Frances (2013) reports. It is essential that Barnsley Hospital NHS Trust Board have assurance that when patients have died in hospital the quality of care the patient received was in accordance with current good practice.

Measures of mortality such as Summary Hospital-level Mortality Indicator (SHIMI) and Hospital Standardised Mortality Ratio (HSMR) can be used as a useful indicator of mortality trends. These statistically modelled indicators provide information on deaths within certain clinical groups. If the actual number of deaths differs from the expected number of deaths, or the numbers move outside of the set confidence limits, it can trigger organisations to look at deaths in more detail.

The mortality indicator statistics used within Barnsley Hospital NHS Trust are:

- Hospital Standardised Mortality Ratio (HSMR). The HSMR is calculated each month for each hospital in England. It looks at deaths in the most common conditions in hospital which account for around 85% of deaths in hospital.
- Summary Hospital-level Mortality Indicator (SHMI). The SHMI score looks at all deaths in hospital and within 30 days of discharge from hospital.
- Crude Mortality data. The number of monthly recorded deaths.

Mortality statistics do not in themselves give evidence on the standard of care provided. This can be ascertained by reviewing the care episode of a patient who has died to identify any preventable factors that may have influenced the likelihood of death. Findings and learning from the mortality reviews can be used to make appropriate improvements to patient care. As well as ensuring there are surveillance processes in place within the Trust to promptly and accurately record deaths, and to interrogate and understand mortality indicators, it is also important to ensure that there are independent clinical reviews of deaths within the Trust to accommodate the complexity of modern healthcare.

In 2016 The Care Quality Commission (CQC) and NHS Improvement (NHSI) published guidance (applicable to adult patients) on learning from deaths.

In 2017 the National Mortality Case Record Review (NMCRR) programme introduced a standardised methodology for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland, known as the Structured Judgement Review (SJR).

In April 2018 the Department of Health announced the introduction of a national network of specifically trained independent senior doctors called medical examiners (MEs) to “independently review and confirm cause of death”. Overseen by a National ME, the emphasis of the role is to scrutinise all deaths across a local area that do not fall under HM Coroner’s jurisdiction but involve close liaison with the HM Coroner’s Office.

This is a national extension of the initial programme which began in 2005 following the Shipman Enquiry. Subsequent enquiries including the Francis Report into Mid Staffs (2013) and the Kirkup report on Morecambe Bay in 2015(1) found that the role of ME could have played a vital role as a conduit for relatives’ concerns (2).

The ME service also heralded much needed reform of the death certification process. The certification of death prior to the introduction of the ME role was often delegated to junior doctors. There is evidence that up to ten percent of death certificates are completed to a poor standard and just over half (55%) could be improved. A recent study by the Office for National Statistics found that if the death certificate is checked by a ME, the underlying cause of death is recorded differently in 22% of cases.

If there is any suspicion that ‘unnatural causes’ (such as accident, neglect, industrial disease, self-harm or link to a medical procedure) may have contributed to a death, or if the cause of death is unknown, the death must be reported to HM Coroner as currently happens. HM Coroner may investigate and hold an inquest.

The ME service is an independent service as detailed in section 7.8 and the ME role does not replace the Structured Judgement Review.

2 Objective

This policy recognises the need to consider mortality rates and national mortality indicators using information available at individual patient level. The objective is to review whether the quality of care the patient received was in accordance with current good practice and to identify any areas that could potentially be improved, based upon either the ME scrutiny process or the in-depth structured judgement review. Areas of good practice can also be identified and used to improve care.

In summary the objective is to:

- Identify and minimise poor quality care as identified in the ME scrutiny or in the SJR .
- Use learning to improve the experience of patients, their families and carers and clinical quality.

3. Scope of Policy

3.1. Coronial and non-coronial adult deaths

The National Guidance on Learning from Deaths (2017) makes recommendations on which cases should be reviewed but does not suggest that all deaths require an SJR. At BHNFT a Consultant led ME scrutiny takes place on all non-coronial adult deaths. The ME scrutiny suggests cases that may need a further in depth review and in addition a proportion of coronial deaths are reviewed as a random selection.

The following criteria is used to inform selection of cases for a more in-depth SJR and therefore provides the scope of this policy. This list is however not exhaustive and exceptions may occur:

- Death where the ME scrutiny has raised a concern.
- Deaths of those identified with a severe mental illness (SMI); there is no single NHS definition of SMI and the two most accessible definitions used on NHS sites are detailed in Appendix 5. For the purpose of this policy SMI includes all individuals who have received a diagnosis of schizophrenia, bipolar affective disorder or who have experienced an episode of non-organic psychosis or any individuals with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired.
- Deaths of those with learning disabilities and autism (see section 3.3).

- Deaths where the ME has identified a lack of compliance with policy which may have led to poor care.
- Deaths where the ME scrutiny has identified a lack of compliance with current good practice which may have led to poor care.
- Deaths of those who are identified in the ME scrutiny to be significantly disadvantaged in some way.
- Deaths subject to scrutiny from other processes may still have an SJR if further aspects of care need review.
- Deaths where there is a complaint investigation relating to the death or same patient episode if it supports the investigation.
- Cases referred to HM Coroner which may or may not be subject to an inquest
- A proportion of deaths referred to HMC for deaths related to occupation where an ME scrutiny hasn't taken place

A further sample of other deaths may be selected that do not fit the identified categories, for example to take learning from where excellent care has been delivered or where changes in the delivery of a care pathway could be improved.

Occasionally deaths may not be selected that do fit the criteria if it is already known that the concern raised by the reviewer is being (or recently has been) addressed in another group or process, for example the case is already subject to a Patient Safety Incident Investigation (PSII).

3.2. Child and Perinatal Deaths

Deaths of patients under the age of 18 years (Statutory and Operational Guidance England 2018 HM Government), maternal deaths and stillbirths are subject to separate review processes and will provide reports to the Learning from Mortality Group. The processes for this are detailed in section 4

3.3. Death of Patient with a Learning Disability and/or Autism

The Trust follows the guidance issued from the NHS Learning from lives and deaths disability and autistic people (LeDeR) policy 2021 (Version 1, 23 March 2021). The process for this is detailed in Section 4.

3.4. Staff groups

Who will be involved in the process include (list is not exhaustive):

- Associate Medical Director for Mortality.
- Medical Staff (all grades).
- Nursing Staff.
- Clinical Coding Staff.
- Quality Assurance & Effectiveness Staff.
- Information Analysts.
- Safeguarding and Learning Disability and/or Autism team.
- Bereavement office
- Patient Safety & Quality Improvement team.
- Medical secretaries (for case note tracking and return).
- Medical Examiners.
- Medical Examiners Officers.
- Governance Midwife.
- Designated Doctor for Child Death.
- SJR Panellists.

4 Process

4.1. Coronial and non-coronial adult deaths

- The bereavement office notifies the medical examiner service each day as and when they occur (Mon-Fri). The Medical Examiner Service supplies the Cause of Death following the completion of the MCCD and this is shared with the information team who import this on to the IRIS report - [Cause of Death IRIS Report](#).
- All completed ME Scrutiny forms for escalation and referral forms for coronial deaths are referred to the Mortality Overview Group (MOG) (bdg-tr.mortalityoverviewgroup@nhs.net).
- Any patient relative concern escalations from coronial deaths are referred to either PALs or MOG
- All Scrutiny forms are reviewed by MOG, prior to any further distribution within the Trust.
- Any ME Scrutiny forms that has been requested from other sources will be reviewed by the Lead Medical Examiner and discussed with MOG prior to any further distribution as a safety netting process.
- If requests are made by the bereaved to view any ME Scrutiny forms and SJR data forms, this request must be made to MOG ensure there is no conflict with any pending review by HM Coroner.

- The ME Scrutiny forms and SJR data forms do not form part of the patient’s medical records and are therefore subject to separate release arrangement. If requests are made direct to the ME Service or to MOG, they must be discussed at MOG prior to agreement for release.
- The MOG allocate any SJR’s required after review of the ME Scrutiny. If the concern can be answered from a further review and assurance found an SJR may not be requested.
- A Mortality Tracking Spread sheet filled in with ME Scrutiny completion dates and whether further escalation either for an SJR, Patient Safety Panel or other sources is updated by the Patient Safety & Quality Improvement Officer
- Where the MOG indicates an SJR is required, it will be conducted in line with the Royal College of Physicians documentation.
- Case notes for SJR will be reviewed by the SJR Panel who are individuals trained in the SJR process. The expected time to complete an SJR is about 2 hours and the maximum turnaround 20 Working days.
- If any SJR reviewer has difficulty in deciding what level to rate the care, or if on review the findings are that there were episodes of poor care, MOG will review and may escalate further to Patient Safety Panel for support.
- SJR data forms are screened and stored electronically to create a library of mortality information - [Structured Judgement Review Library](#)
- If any SJR reviewer has difficulty in deciding what level to rate the care, or if on review the findings are that there were episodes of poor care, MOG will review and may escalate further to Patient Safety Panel for support *or further action or investigation.*

4.2. Child and perinatal deaths

The death of a child is anyone under the age of 18 years and includes live births. Two local documents “Child Death Overview Policy” and Procedure “Assessment Pack and Check list Following the Death of an Infant/Child Under the Age of 18 Years Old” have been developed and embedded into practise. This is to support the Local Safeguarding Children Board, the Child Death Overview Panel and associated Rapid Response Process as per the statutory guidance highlighted in Chapter 5 of the government’s statutory guidance Working Together to Safeguard Children 2018. Dependent upon the circumstances there may also be a Safeguarding Practice

Review (formerly known as Serious Case Review). This information forms part of the National Child Mortality Database.

A monthly Paediatric Departmental Morbidity and Mortality meeting has been established as a forum for internal review of any unexpected child death and includes sharing of the monthly Child Death Report. It is attended by the wider MDT including external peer support by a representative from Embrace Transport service. There are both educational and governance aspects to the meeting. Relevant learning is actioned and reviewed within the paediatric departmental governance meeting and by the mortality overview group.

Perinatal deaths include babies who are live at birth from 22 weeks gestation until 28 days after birth. The Perinatal Mortality Review Tool (PMRT) is a national tool used to support the review of care of the following babies; All fetal losses 22+0 to 23+6, antepartum and intrapartum stillbirths and all neonatal deaths from 22+0 weeks gestation to 28 days of life.

Parents are asked for their perspectives in relation to the care they have received. This an MDT approach to the review with a monthly data input. Once the data input has been completed, the care is reviewed in the monthly Perinatal Mortality Meeting (PMM). This is again an MDT approach including external peer reviewers for review of the care and the grading of the care they received. Any care issues identified which require actions are followed up through our governance process to ensure the action is completed.

The data inputted through MBRRACE-UK facilitates a national report and also provides the trust with a local data report. The PMRT process has strict times set by CNST year five, safety action one. Parents receive full duty of candour through either letter or during debrief, which is dependent on when the review is completed and the debrief has been undertaken. Parents are supported throughout this process by the Bereavement Lead Midwife.

- For the avoidance of doubt, it does not include:
 - stillbirths - baby born without signs of life after 24 weeks gestation.
 - late foetal loss - pregnancy ends without signs of life before 24 weeks gestation.
 - or terminations of pregnancy (of any gestation) carried out within the law.

4.3. Death of Patient with a Learning Disability and/or Autism

Following the death of a patient with a Learning Disability and/or Autism a Structured Judgement Review (SJR) takes place internally within the Trust and this is followed by a Learning Disability and/or Autism Mortality Review (LeDeR). This is undertaken by a trained external LeDeR Reviewer. When a patient with a Learning Disability and/or Autism dies the Learning Disability Liaison Nurse (LDLN) will inform the LeDeR programme giving basic information so the death can have a full review. The LDLN will liaise with the LeDeR reviewer making sure all information from the individual's admission up until death is documented and if any learning can be taken from their care.

5 Sharing Learning

Information is collated and learning is shared via the learning from deaths bulletin. Individual feedback is given by email or in person by the AMD where appropriate.

Learning can also be reported via clinical governance meetings by the CBU representatives who attend the Learning from Mortality Group (LfMG), where appropriate actions to improve speciality care are generated and managed. Other relevant platforms to share learning are utilised as appropriate.

Discussions, outcomes and learning from the LfMG, including any conclusions about good or outstanding care and sub-optimal care, are formally recorded in a chairs log and shared using the Trust Governance Structure via the Clinical Effectiveness Group.

Themes of learning and good practice will be shared either in learning from deaths bulletins or as part of any investigatory findings. A bi-monthly mortality report is shared via the governance structure through to Board. This will include the HSMR and SHMI mortality statistics, updates from the ME service and compliance with the mortality process.

Sharing of learning from deaths with the bereaved is through the clinical governance processes with the Trust. This ensures consistency in the level of timely, meaningful and compassionate support and engagement delivered and is assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken. Sharing of ME Scrutiny forms and SJR data forms must be in a supportive environment with a qualified ME or SJR Reviewer who can explain the purpose and limitations of the reviews

that are carried out. An explanation of limitations and use is provided on the front cover of the SJR pro forma (see Appendix 6).

5.1. Escalation

BHNFT have an SJR panel; this panel consists of Consultants independent to the Mortality Process, who complete the SJR's. As the SJR process is for in-patients only a separate subjective review process takes place for deaths in ED whereby they are reviewed by the ED consultant with responsibility for clinical governance. If an SJR/ED review identifies one or more episodes of poor care (for the SJR this is out of the 5 SJR episodes and excluding overall care), the AMD and MOG will review the SJR/ED review and seek further clarity if needed. If appropriate an escalation will be presented to the patient safety panel for consideration of PSII or other type of learning response. If the learning response includes further review or investigation, the patient safety issues will be reported on Datix for the designated team to manage.

There is a national requirement that a PSII is undertaken for all deaths clinically assessed as more likely than not due to problems in care. If a PSII is commenced before an SJR is requested the SJR process will not take place as it would be superseded by the PSII. The Duty of Candour Policy should be followed. In relation to mortality the Duty of Candour regulation threshold is met if the patient's death is deemed to have been as a result of a notifiable safety incident.

Any referrals to HMC are shared with the Medical Examiner Service and Legal Services. The Medical Examiner Service forwards the referrals to the Mortality Overview Group to review and explore if any further investigation is required.

As the process for the review of in-hospital deaths has changed since the inception of the SJR process, it is important to reiterate the remit of the SJR process. The introduction of the ME service has been central to this change. The SJR concerns the final admission prior to death; it is not able to interrogate previous admissions or services outside the Trust such as community based advanced care planning issues.

There is a full ME service at the Trust. All non-coronial deaths are screened for potential harms through this process and concerns are raised through the weekly Mortality Group. If an SJR is appropriate to the query this will be requested and performed by the SJR reviewers. If there are issues around previous admissions or speciality specific issues additional investigation (outside of the SJR) can be requested, the narrative of which will support any escalation to the patient safety panel.

6 Mortality Alerts

If there are concerns about mortality in any particular patient group, for example a higher than expected HSMR for a particular diagnostic group, it may be necessary to undertake an in-depth review for assurance.

The review will follow the methodological order for investigation of a high HSMR which is: check coding; review case-mix and review care. More detail on investigating mortality alerts is provide by NHS Digital and is available in Appendix 4.

Any in depth reviews in any particular patient group that may be of concern must be reported to the Medical Director or in their absence to the Deputy Medical Director and reported to the Clinical Effectiveness group

A list of patients within the relevant diagnostic group will be produced by the Information Analyst with the date of last admission and coding of the FCE's that inform the HSMR. The list will be reviewed for coding accuracy by the Head of Coding and a desktop review of care undertaken by the AMD. Depending on the number of patient records and scope of the review the speciality team may need to support the desktop review.

Once the desktop review has been completed further investigation into care may be required using the SJR process. Any relevant findings and recommendations from the investigation should be collated into a report and shared via the same Trust governance structure as the monthly mortality report. The report should be constructed to demonstrate methodology, findings, learning and recommendations.

7 Roles and Responsibilities

7.1 Trust Board Executive and Non – Executive Directors

The Board of Directors must be assured that robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. The roles and responsibility of the Trust Board includes

- Understanding the Mortality Review process.
- Ensuring it can withstand external scrutiny.
- Championing and supporting learning and quality improvements.
- Ensuring published information is fair and accurate.

7.2 Medical Director

The Executive Medical Director is the overall Lead for Mortality within the Trust and will ensure that appropriate processes are in place to review mortality data and learning. This will be monitored through the Trust Governance Structure. The reporting outcomes and findings from the Learning from Deaths and Mortality Statistics will go to the Trust Board via the Trust Governance Structure.

7.3 Deputy Medical Director

The Deputy Medical Director will deputise as the overall Lead for Mortality in the absence of the Medical Director and as such will adopt the same responsibilities as the Medical Director.

7.4 Associate Medical Director for Mortality

The Associate Medical Director will be responsible for:

- Regular review of the mortality review process.
- With MOG members receive and act upon escalation from the ME service.
- Ensuring and supporting use of the SJR method, utilising the SJR panel.
- Ensuring training is available for staff to complete SJRs.
- Ensuring any speciality mortality statistics are available for the CBU triumvirate for discussion at CBU level.
- Initiating any speciality wide reviews in response to mortality indicators or themes from the mortality process.

7.5 Associate Director for Patient Safety and Quality Improvement

Associate Director for Patient Safety and Quality Improvement will be responsible for:

- Regular review of the mortality review process.
- Supporting the AMD and the ME Service with ensuring that ME Scrutinies, SJR's and learning and feedback from deaths takes place.
- Ensuring links with the regional groups are maintained and new developments reported to the LfMG.

- Ensuring the Quality & Governance Committee receive a bi-monthly report and the Board a quarterly report on Learning from Death and Mortality statistics.
- Ensuring communication between the external informatics provider, the coding department, the data quality team through the head of information and the mortality overview group

7.6 Patient Safety & Quality Improvement Officer

The Patient Safety & Quality Improvement Officer will be responsible for:

- Regular review of the mortality review process.
- Overseeing the processes of the MOG.
- Administration of the MOG action log.
- Overseeing the mortality tracker and identifying any issues to the MOG.
- Organisation of further escalation to the Patient Safety Panel.
- If a Patient Safety & Quality Improvement Officer is not available to support the above responsibilities members of the patient safety team will act up or down to fulfil the role.

7.7 Consultants

Consultants are responsible for participating in mortality case note reviews at either the request of the ME or the AMD. This may be to review points of patients in their care or to give a specialist opinion on areas such as:

- Timely consultant/medical reviews.
- Communication with families and/or carers.
- Use of ReSPECT plans.
- Timely escalations or referrals.
- Any non-compliance with trust wide policies (for example VTE assessment and Sepsis screening).
- Any learning from good or excellent care.
- The use of My Care Plan.
- Speciality Reviews in response to specific queries raised at the MOG.
- Clarification on specific points from either the ME service or from the SJR panel.

7.8 Medical Examiners Service

The ME service is hosted by the Trust with independent status to ensure the ME scrutiny is carried out without any undue influence on the outcome of the scrutiny . The independence underpins the integrity of the service. The ME's and MEOs have a trust contract which means they have to meet all Trust contractual obligations and adhere to Trust policies; however, the service is paid for in full by NHSE again underpinning the independence of the system.

There is bidirectional feedback and communication between The ME office and Mortality Overview Group in relation to overall mortality data, outcomes, clinical governance issues and trends identified within the Trust. They also feed into the Mortality Overview Group and Learning from Mortality Group. The ME office also reports quarterly to the National ME.

The role of the Medical Examiners Service is to review deaths in order to:

- Agree the proposed cause of death and the overall accuracy of the medical certificate cause of death.
- Discuss the cause of death with the next of kin/informant and establish if they have any concerns with care that could have impacted/led to death.
- Act as a medical advice resource for HM Coroner.
- Inform the selection of cases for further review under local mortality arrangements and contribute to other clinical governance procedures.

The Medical Examiner's Office will liaise with the Trust and :

- Attend the MOG meeting as requested, to provide an update for escalation of actions if required.
- Ensure good communication with the CDOP Lead and the Safeguarding and Learning Disabilities Team to ensure all child deaths and deaths of persons with learning disabilities and autism are recorded and the information reported weekly to the MOG.
- Provide a list of Trust deaths and the associated ME Scrutiny as requested by MOG.
- Provide feedback to the Trust on compliments or any comments made regarding good care. This feedback should be reported to the relevant Lead Nurses and Medical Teams and collated as part of the information provided for the monthly mortality report.
- Provide information to support mortality reporting within the Trust on the ME service including (but not exhaustive) the number of scrutinies carried out, number of referrals HM Coroner, number of escalations and number of compliments.

7.9 Other Medical and Nursing Staff

Will be responsible for:

- Checking coding accuracy against patient episodes when requested
- Giving specialist opinions.
- Participating in the mortality process wherever possible, either in person or by nominated staff being available for advice on medical and nursing issues.

7.10 Clinical Coding Staff

Clinical Coding staff will be responsible for:

- Participating in the MOG meetings if requested and the learning from deaths group.
- Ensuring episodes of care as identified in the review process are accurately coded.
- Reviewing any coded episodes that flag for review by the external informatics company (flex and freeze data)
- The head of coding or AMD should address issues arising from the reviews regarding clinical coding directly with the clinician concerned to promote learning and improvement.
- Attend monthly meetings with the external informatics providers
- Attend monthly data variance meetings

7.11 Information Analyst (Management Information)

The Information Analyst will be responsible for:

- The maintenance of a quantitative and qualitative database derived from mortality information.
- Timely production of mortality statistics and learning from deaths reports for the AMD (Mortality) and Associate Director for Patient Safety & Quality Improvement.

- Providing other related reports as required by the AMD and Associate Director for Patient Safety & Quality Improvement.
- Maintaining and producing mortality dashboards.
- Acting as liaison between BHNFT and the external health informatics team regarding mortality statistics.
- Acting as liaison between MOG and the wider informatics team to ensure data exported into SUS and HES is accurate, without duplication and without test patients.
- Attend monthly meetings with the external informatics providers
- Attend monthly data variance meetings

7.12 Bereavement Officer and Patients Relatives Officer

The bereavement officer is responsible for many aspects of communication with the bereaved and organisation between the trust and funeral directors but with regards to the learning from deaths policy the key functions are

- Providing written information to relatives or carers via the bereavement booklet.
- Explaining contact will be made with the bereaved by the ME service.
- Escalating to MOG any improvements recommended by the bereaved in the medical examiner or learning from deaths processes.

7.13 Quality Assurance & Effectiveness Team

The Quality Assurance & Effectiveness Team will be responsible for:

- Facilitating any audits that arise from the mortality review process.
- Ensuring reports are submitted and discussed at all relevant governance groups in line with local processes.

7.14 Mortality Overview Group

The Mortality Overview Group will

- Comprises of a core group from patient safety and the AMD with invited members as required, information analyst, clinical coding, MEO's or any other co-opted member.
- Raise any issues in coding with the head of coding (used to identify co-morbidities and expected deaths).
- Raise any issues with the head of information about data quality leaving the trust
- Meet weekly and review the recommendations from the ME scrutiny and completed SJR's in accordance with this policy.
- Allocate SJR's where required to the SJR panel.
- Request specialist information if needed from clinical leads.
- Complete any escalations to the Patient Safety Panel.
- Identify any training needs within the mortality process that become apparent from reviewing returned ME Scrutiny and/or SJR forms.
- Feed into the Learning from Mortality Group.
- Review and share mortality statistics with the CBU

7.15 Learning from Mortality Group

The Learning from Mortality Group will be responsible for:

- Providing assurance to the Trust Board via the Trust Governance Structure on patient mortality based on mortality statistics and findings from ME Scrutiny and SJR's.
- Identifying areas of high risk and escalating these to the CBU through the CBU representatives.
- Ensuring the CBU's are aware of any alerting groups via the HSMR section in the CBU information packs.
- Ensuring that feedback and learning points are shared with the trust and specialties via the group so that learning outcomes and action points are included in specialty audit programmes as appropriate.
- The group reports into the Trust Governance Structure through the Clinical Effectiveness Group.

8 Associated documentation and references

- NHS Improvement (2019) The National ME System.
- Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office. London: Department of Health.
- Keogh B (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. London: NHS England.
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- Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England.
- Higginson J, Walters R, Flop N, *BMJ Qual Saf* (2012), Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?.
- National Guidance on Learning from Deaths, National Quality Board (March 2017).
- Learning from lives and deaths – People with a Learning Disability and/or Autism (LeDeR) policy 2021.
- Severe Mental Illness definition – <https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care-annexes.pdf>.
- SMI Definition – <https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing#fn:1>.
- Child Death Overview Policy - <portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TADDocs/Child Death Overview.pdf>
- Assessment Pack and Check list following the death of an infant/child Under the age of 18 Years Old Procedure - [Assessment Pack and Check list Following the Death of an Infant or Child Under the Age of 18 Years Old.pdf \(trent.nhs.uk\)](#)

8.1 Training & Resources

- In order for SJRs to be completed the SJR Panel reviewers must have undertaken the formal training.
- Dedicated on-going trainers must be available to ensure consistency.
- Training will be recorded on the NLMS data base.
- The AMD requires job planned time to reflect their mortality review role.
- Time allocation for those supporting the process to carry out relevant duties.
- Support for the movement of medical records across the organisation.
- ME and MEOs training consists of a full day face to face training provided by the Royal College of Pathologists and e-learning modules.

8.2 Monitoring and Audit

Minimum requirement to be monitored	Compliance of ME scrutiny and SJR
Process for monitoring e.g. audit	Data collection on completed scrutiny's and SJR's where applicable Audit
Responsible individual/ group/ committee	MEO/Patient Safety Team/Management information team
Frequency of monitoring	Monthly
Responsible individual/ group/ committee for review of results	Learning from Mortality Group
Responsible individual/ group/ committee for development of action plan	Learning from Mortality Group
Responsible individual/group/ committee for monitoring of action plan and Implementation	Learning from Mortality Group

9 Equality and Diversity

Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy and procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness. Monitoring information will be collated, analysed and published on an annual basis as part Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact. The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

Appendix 1

EQUALITY IMPACT ASSESSMENT TEMPLATE

INITIAL ASSESSMENT STAGE 1 (part 1)

Department:	Quality / Governance	Division:	Corporate															
Title of Person(s) completing this form:	Deborah Firth	New or Existing Policy/Service	New															
Title of Policy/Service/Strategy being assessed:	Policy for the Review of Clinical Care following the death of a patient in Hospital	Implementation Date:	September 2017															
What is the main purpose (aims/objectives) of this policy/service?	The Structured Judgement Review (SJR) ensures a consistent and coordinated approach for the review of all deaths in hospital. This policy recognises the need to consider mortality rates and national mortality indicators available at diagnosis and individual patient level. That all preventable deaths are identified and patient safety improved																	
Will patients, carers, the public or staff be affected by this service? Please tick as appropriate.	<table border="1"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Patients</td> <td>x</td> <td></td> </tr> <tr> <td>Carers</td> <td></td> <td>x</td> </tr> <tr> <td>Public</td> <td></td> <td>x</td> </tr> <tr> <td>Staff</td> <td></td> <td>x</td> </tr> </table>		Yes	No	Patients	x		Carers		x	Public		x	Staff		x	If staff, how many individuals/which groups of staff are likely to be affected?	
	Yes	No																
Patients	x																	
Carers		x																
Public		x																
Staff		x																
Have patients, carers, the public or staff been involved in the development of this service? Please tick as appropriate.	<table border="1"> <tr> <td>Patients</td> <td></td> <td>x</td> </tr> <tr> <td>Carers</td> <td></td> <td>x</td> </tr> <tr> <td>Public</td> <td></td> <td>x</td> </tr> <tr> <td>Staff</td> <td>x</td> <td></td> </tr> </table>	Patients		x	Carers		x	Public		x	Staff	x		If yes, who did you engage with? Please state below: Consultation of the mortality Committee				
Patients		x																
Carers		x																
Public		x																
Staff	x																	
What consultation method(s) did you use?	Staff review at relevant meetings																	

DATA COLLECTION AND CONSULTATION

1a In relation to this service/policy/procedure – Do you currently record/have any of the following patient data?

Protected Characteristic	Indicate yes or No	If Yes – State where Recorded
Age	YES	On the screening tool
Sex	YES	On the screening tool
Ethnicity	NO	
Religion or Belief	NO	
Disability	YES	On the screening tool
Sexual Orientation	NO	
Gender Re-assignment	NO	
Marriage & Civil Partnership	NO	
Pregnancy & Maternity	Yes	On the screening tool
Carer Status	NO	

Please indicate Yes or No

Equality Impact Assessment Stage 1 PART 2

What does this data tell you about each of the above protected characteristics? Are there any trends/inequalities?

No inequalities – the screening tool is used to ensure deaths are reviewed correctly

What other evidence have you considered? Such as a 'Process Map' of your service (assessment of patient's journey through service) / analysis of complaints/ analysis of patient satisfaction surveys and feedback from focus groups/consultations/national & local statistics and audits etc.

National Guidance from the National Quality Board

Equality Impact Assessment Stage 1 PART 3

ACCESS TO SERVICES

What are your standard methods of communication with service users?

Please tick as appropriate.

Communication Methods	Yes	No
Face to Face Verbal Communication		x
Telephone		x
Printed Information (E.g. leaflets/posters)		x
Written Correspondence		x
E-mail		x
Other (Please specify)	X we may need to communicate with relatives or carers	

If you provide written correspondence is a statement included at the bottom of the letter acknowledging that other formats can be made available on request?

Please tick as appropriate.

Yes	No
	x

Are your staff aware how to access Interpreter and translation services?

Interpreter & Translation Services	Yes	No
Telephone Interpreters (Other Languages)	x	
Face to Face Interpreters (Other Languages)	x	
British Sign Language Interpreters	x	
Information/Letters translated into audio/braille/larger print/other languages?	x	

ACCESS

Please tick as appropriate

Is the building where the service is located wheelchair accessible?	Yes	No
Does the reception area have a hearing loop system?	x	
Does the building where the service is located have a unisex wheelchair accessible 'disabled toilet'?	x	
Does the building have car parking space reserved for Blue Badge holders?	x	
Does the building have any additional facilities for disabled people such as a wheelchair, hoist, specialist bath etc?	x	
Does the building/hospital site where the service is provided have access to prayer and faith resources?	x	

EQUALITY IMPACT ASSESSMENT – STAGE 1 (PART 4)

<u>Protected Characteristic</u>	<u>Positive Impact</u>	<u>Negative Impact</u>	<u>Reason/comments for positive Impact</u>	<u>Reason/Comments for Negative Impact</u>	<u>Resource Implication</u>
	High Low None	High Low None	<u>Why it could benefit any/all of the protected characteristics</u>	<u>Why it could disadvantage any/all of the protected characteristics</u>	Yes / No
Men	<u>Low</u>				Staff to complete the reviews
Women	<u>Low</u>				
Younger People (17 – 25) and Children	<u>Low</u>				
Older people (60+)	<u>Low</u>				
Race or Ethnicity	<u>Low</u>				
Learning Disabilities	<u>Low</u>				
Hearing impairment	<u>Low</u>				
Visual impairment	<u>Low</u>				
Physical Disability	<u>Low</u>				
Mental Health Need	<u>Low</u>				
Gay/Lesbian/Bisexual	<u>Low</u>				
Trans	<u>Low</u>				
Faith Groups (please specify)	<u>Low</u>				
Marriage & Civil Partnership	<u>Low</u>				
Pregnancy & Maternity	<u>Low</u>				
Carer Status	<u>Low</u>				
Other Group (please specify)					
Applies to ALL Groups	<u>Low</u>				

INITIAL ASSESSMENT (PART 5)

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following protected groups?

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'HIGH YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

(a) In relation to each group, are there any areas where you are unsure about the impact and more information is needed?

(b) How are you going to gather this information?

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary? NO

Assessment Completed By: Deborah Firth

Date Completed: 30/08/2017

Reassessed: 13/03/2019

Reassessed: 18/03/2020

Reassessed: 11/11/2020

Reassessed: 17/09/2021

Line Manager Tracey Radnall

Date...17/09/2021

Head of Department Tracey Radnall

Date...17/09/2021

When is the next review? Please note review should be immediately on any amendments to your policy/procedure/strategy/service.

1 Year	2 year	3 Year
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STAGE 2 – FULL ASSESSMENT & IMPROVEMENT PLAN

MUST be completed if any negative issues have been identified at stage 1

Protected Characteristic	What adverse (negative) impacts were identified in Stage 1 and which groups were affected?	What changes or actions do you recommend to improve the service to eradicate or minimise the negative impacts on the specific groups identified?	Lead	Time-scale
<p>Men</p> <p>Younger People (17-25) and Children</p> <p>Older People (50+)</p> <p>Race or Ethnicity</p> <p>Learning Disability and/or Autism</p> <p>Hearing Impairment</p> <p>Visual Impairment</p> <p>Physical Disability</p> <p>Mental Health Need</p> <p>Gay/Lesbian/Bisexual Transgender</p> <p>Faith Groups (please specify)</p> <p>Marriage & Civil Partnership</p> <p>Pregnancy & Maternity</p> <p>Carers</p> <p>Other Group (please specify)</p> <p>Applies to ALL Groups</p>				
<p>How will actions and proposals be monitored to ensure their success? Which Committee will you report to? (i.e. Divisional DQEC / Governance Meeting).</p>				
<p>Who will be responsible for monitoring</p>				

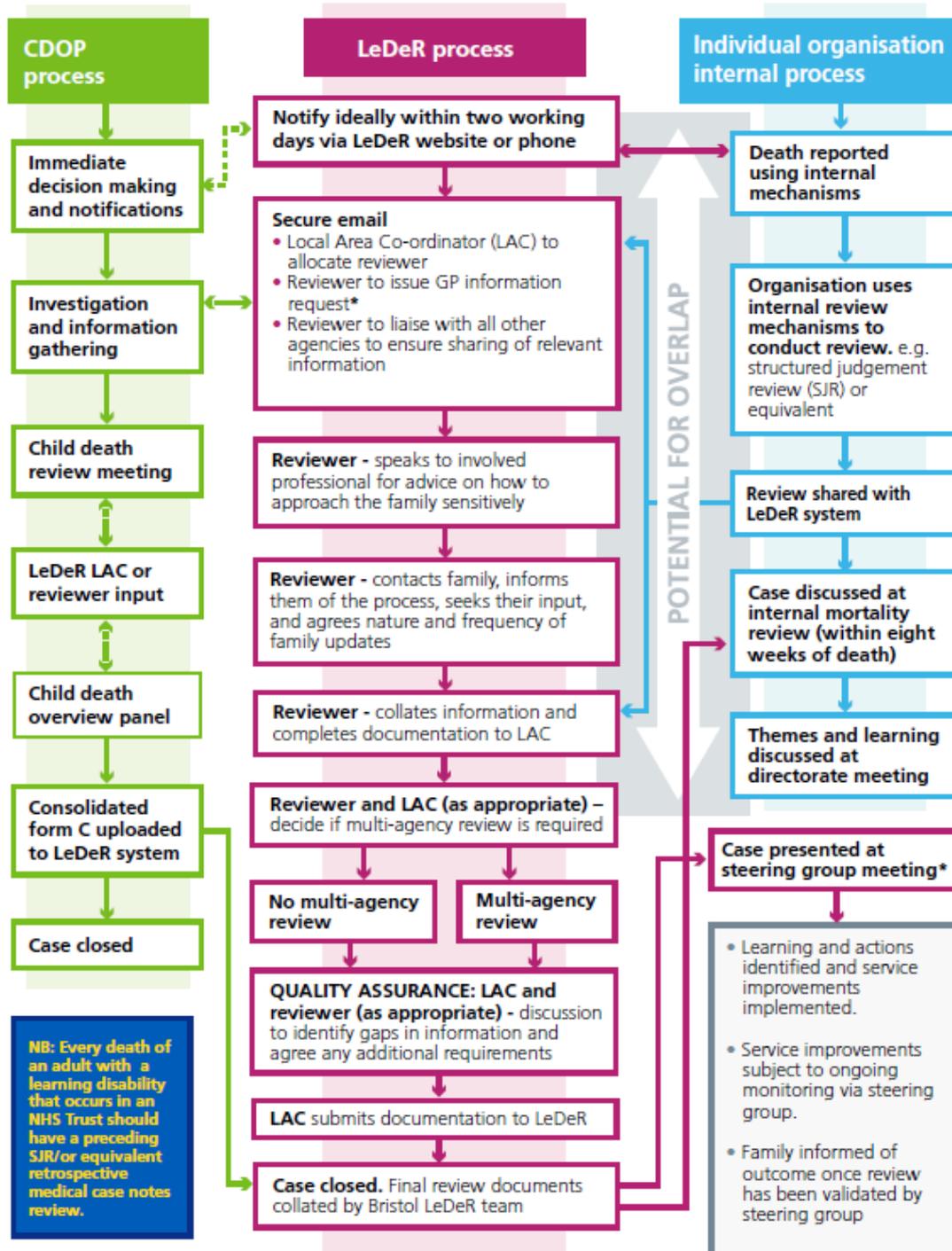
these actions?	
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Appendix 2
Glossary of Terms used within Policy

Term	Meaning
(SHMI)	Summary Hospital-level Mortality Indicator – A Mortality Indicator based on the analysis of deaths of patient in hospital and up to 30 days post discharge.
(HSMR)	Hospital Standardised Mortality Ratio – A Mortality Indicator based on the analysis of deaths of patient in hospital
(NHSI)	NHS Improvement (NHSI) is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
(VTE)	Venous thromboembolism (VTE) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE).
RCA	Root cause analysis (RCA) is a structured method used to analyse serious adverse events.
SI	The Serious Incident framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. DNACPR
“Do Not Attempt Cardiopulmonary Resuscitation” DNACPR	A DNACPR decision is a decision made in advance that attempted CPR would not be likely to be appropriate for a person in the event of cardiac arrest.
Sepsis	Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs.
Sepsis Screening	A screening tool for sepsis is a methodology used to identify sepsis early and lead to more timely diagnostics and treatment.

Appendix 3

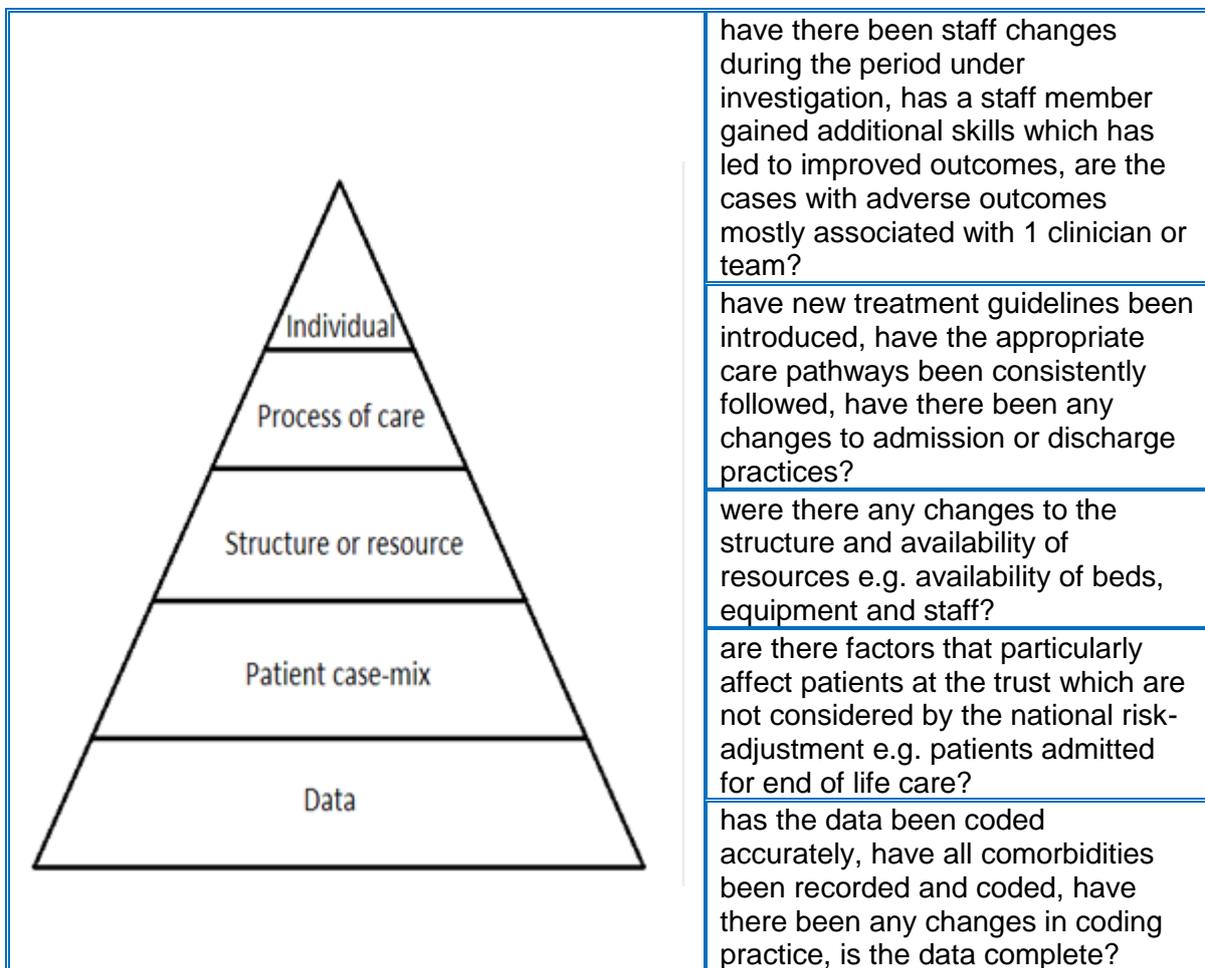
Notification and review of a death of an adult (18+) or child (age 4+) with a learning disability



Appendix 4

- NHS Digital information on how to manage alerts can be found at NHS Digital, 2020 SHMI interpretation guide available at: <https://files.digital.nhs.uk/BB/F7852B/SHMI%20interpretation%20guidance.pdf>
- Alerts should not be immediately interpreted as indicating good or bad performance, they are a smoke alarm that warrants a follow-up. It is recommended by NHS Digital that such follow-ups use a structure such as the pyramid of investigation for special cause variation to further investigate patient outcomes (see Figure 1).
- More likely explanations are listed towards the bottom of the pyramid, and so NHS Digital suggest these are investigated initially.

Figure 1: Pyramid of Investigation:



Appendix 5

Definition of the term Severe Mental Illness (SMI)

The definition of the term 'SMI' has been aligned to the existing definition used to construct the Quality and Outcome Framework (QoF) SMI register. The term SMI refers to all individuals who have received a diagnosis of schizophrenia, bipolar affective disorder or who have experienced an episode of non-organic psychosis. Diagnoses, including diagnoses of personality disorder (other than schizotypal personality disorder), substance misuse disorders without co-morbid psychosis, eating disorders or recurrent depression are not included in the definition.

<https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care-annexes.pdf>

"The phrase severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as an SMI"

<https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing#fn:1>



Using the Structured Judgement Review method

Learning and Signposting

Medical Examiner (ME) Scrutinies: ME Scrutinies are not routinely shared by the service but can be requested via the Mortality Overview Group and requests must be in line with Caldicott principles. The Lead ME has responsibility deciding if it is appropriate to share the scrutiny.

Structured Judgement Reviews (SJR) – shared for Learning and Signposting, not as an investigation or report in its own right.

All in-patient deaths are reviewed by the ME Service and where indicated, an SJR is requested by the Mortality Overview Group (MOG) for any care concerns (or for patients with a learning disability and/or autism or serious mental illness).

An SJR is designed to signpost for learning and further investigation rather than be considered as an investigation in its own right. A trained SJ reviewer will look critically at a set of medical records and using explicit judgements across a number of phases of care give their individual opinion on care received during a patient's final admission to hospital. The care score is derived and is described on a scale of 1 to 5 in each phase where 1 is very poor care and 5 is excellent care. Any care found to be poor or very poor is escalated to the Patient Safety Panel. Where the SJR does not trigger for escalation to PSP, there may still be learning which is shared with the teams and/or via a learning from deaths bulletin.

The reviews typically take about 1-2 hours to perform and look at all the available medical records. The process does not have the rigour of an investigation or the benefit of staff statements or an MDT review but neither does it involve the team of clinicians that delivered the care. It is essentially an independent clinical view of the care delivered but by a single trained reviewer. It does not contain wider patient, clinical or organisational context and in this respect is not suitable to use as a basis for a further investigation as it may create bias in the investigation, but it does act as a "flag" for concerns and possible future learning and this is its intended purpose.

An SJR or ME Scrutiny should not be shared in its raw format with the bereaved or patient representatives as it is meant for peer to peer learning and it is not part of the patients records. The 'findings' of an SJR can be shared in a recipient friendly format either by letter or in person with the support of the appropriate reviewer (arranged by the Lead ME or AMD Mortality as appropriate).

Requests for SJR's are made to MOG and any shared will have the reviewers name anonymised.

Anonymised versions of the SJ reviews (patient and reviewer details) are available in the SJR library and from April 2022 will indicate if further investigation is recommended by PSP.

Appendix 7

Version	Date	Comments	Author
1	27/09/2017	Approved by Quality & Governance	Tracey Radnall
2	20/03/2019	Minor Changes - Approved by Clinical Effectiveness Group	Tracey Radnall
3	13/05/2020	Minor changes – Approved by Learning from Mortality Group	Tracey Radnall
4	11/11/2020	Minor changes – Approved by Learning from Mortality Group	Tracey Radnall
5	08/09/2021	Learning from Mortality Group	Tracey Radnall
5.1	05/01/2022	Minor changes – Learning from Mortality Group	Tracey Radnall
5.2	02/03/2022	Minor changes – Learning from Mortality Group	Tracey Radnall
5.3	04/05/2022	Minor changes – Learning from Mortality Group	Tracey Radnall
5.4	02/11/2022	Minor changes – Learning from Mortality Group	Tracey Radnall
6	17/11/2023	Learning from Mortality Group	Tracey Radnall

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Quality & Governance	27 September 2017
Clinical Effectiveness Group	20 March 2029
Learning from Mortality Group	13 May 2020
Learning from Mortality Group	11 November 2020
Learning from Mortality Group	8 September 2021
Learning from Mortality Group	5 January 2022
Learning from Mortality Group	2 March 2022
Learning from Mortality Group	4 May 2022
Learning from Mortality Group	2 November 2022
Learning from Mortality Group	17 November 2023