Learning from Deaths Policy

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Barnsley Hospital NHS Foundation Trust Policy Website.

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Contents

1. Introduction

The National Quality Board published National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (March 2017). This states "Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under their management and care."

This document sets out the process by which all deaths which occur in our care are reviewed, how learning is identified and shared, triangulation with mortality statistics and implementation of actions in response. It seeks to ensure the Trust engages meaningfully to find all opportunities to improve the care the NHS offers by learning from deaths.

2. Background:

2.1 Learning from Deaths:

A programme into reviewing deaths 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 a Medical Examiner could have played a vital role as a conduit for relatives' concerns (2).

In April 2008 the Child Death Overview Panel (CDOP) was established as a statutory function outlined in the Working Together to Safeguard Children (2006) guidelines.

In May 2015 the Learning Disabilities Mortality Review (LeDeR) programme was established with the aim of reviewing the deaths of people with learning disabilities to improve health and social care services.

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.

In 2022 the deaths of Autistic people were included within Learning from lives and deaths disability (and autistic people)(LeDeR) reporting

In September 2024 new death certification reforms became statutory. These require an independent review to be carried out for all deaths in England and Wales, without exception. This will either be provided by independent scrutiny by a medical examiner or by investigation by a coroner.

The primary legislation that underpins the statutory medical examiner system is the Coroners and Justice Act 2009. Since its passage, the act has been amended (most recently by the Health and Care Act 2022) to reflect changes to the health system.
The 3 sets of regulations made by the Department of Health and Social Care (DHSC) are:

- The Medical Certificate of Cause of Death Regulations 2024
- The Medical Examiners (England) Regulations 2024
- The National Medical Examiner (Additional Functions) Regulations 2024

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 who may investigate and hold an inquest.

The ME service is an independent service as detailed in section 8.8 and the Medical Examiner Scrutiny does not replace the Structured Judgement Review process but complements the process by informing cases that may require further review.

2.2 Mortality Statistics:

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. It is important the statistics are used to complement and triangulate learning from deaths and are not used as a measure of care.

3. 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.

4. Scope of Policy

4.1. 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 whereby a relative or patient representative has raised concerns with the medical examiner and the medical examiner agrees further investigation is indicated
- Deaths where Martha's rule was initiated during the final admission
- 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 complaints investigation, but often the complaints investigation will superseded the SJR.
- 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 complaint investigation or Patient Safety Incident Investigation (PSII). A PSII would always supersede an SJR

4.2. 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 5

4.3. 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 5.

4.4. Staff groups

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

- Associate Medical Director for Mortality.
- Patient Safety & Quality Improvement team;
  - Associate Director for Patient Safety & Quality Improvement
  - Patient Safety and Quality Lead
  - Patient Safety & Quality Improvement Officer
- Bereavement office staff
- Medical Examiners Service;
  - Medical Examiners
  - Medical Examiner Officers
- Medical Staff (all grades).
- Nursing Staff.
- Clinical Coding Staff.
  - Head of Clinical Coding
- Business Intelligence;
  - Head of Business Intelligence
  - Information Analyst
  - Information Development Analyst
- Quality Assurance & Effectiveness Staff.
  - Quality Assurance and Effectiveness Facilitator
- SJR Panellists
  - Anaesthetic Services Clerical Officer
- Safeguarding and Learning Disability and/or Autism team.
  - Learning Disability and Autism Acute Liaison
- Clinical Governance facilitators including women's and neonatal governance;
  - Clinical Governance & Compliance Manager
- Designated Doctor for Child Death;
  - Consultant Paediatrician

5 Process

5.1. Coronial and non-coronial adult deaths

- The Clinical Governance Administrator provides the bereavement team, Mortality Overview Group and Medical Examiner Service a list of incidents reported on Datix during the patient's current admission for all patients who have died the previous day
- The bereavement office staff notify the medical examiner service each day as and when deaths 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 Patient Advice and Complaints Team (PALs) or MOG
- All ME 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 and to facilitate an appropriate person to share a summary of the SJR findings
- 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.*
- 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.

5.2. Child 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.

5.3. Neonatal deaths

The following TAD guidance is followed within Maternity and Neonates following a death,

Late Miscarriage MTOP and early neonatal death from 20+0 to 23+6 weeks gestation (Late Miscarriage MTOP and early neonatal death from 20+0 to 23+6 weeks gestation.pdf)

Stillbirth MTOP and Early Neonatal Death from 24+0 weeks gestation (Stillbirth MTOP and Early Neonatal Death from 24+0 weeks gestation.pdf)

The deaths are reviewed at the Perinatal Mortality group, and follow the Perinatal Mortality Review Tool (PMRT) process. The PMRT is to support objective, robust and standardised local reviews of care when babies die. This is to provide answers for bereaved parents and their families about whether the care that they and their baby received was appropriately safe and personalised or whether different care may have changed the outcome. The second, but nonetheless important, aim is to ensure local and national learning results from review findings to improve care, reduce safety-

related adverse events, and prevent future baby deaths. The PMRT is designed to support the review of baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths, and neonatal deaths.

Definitions:

Pregnancy losses up to 23+6 are called Late Miscarriage rather than a stillbirth due to the birth occurring before the legal age of viability.

A Spontaneous Late Miscarriage is defined when women experience symptoms of abdominal pain and/or vaginal bleeding and recognisable signs of labour, with the process resulting in the unexpected birth of the baby.

An IUFD after 24+0 weeks gestation is classed as a stillbirth. The definition of "stillborn child" in England and Wales is contained in the Births and Deaths Registration Act 1953 section 41 as amended by the Stillbirth (Definition) Act 1992 section 1(1) and is as follows:

"a child which has issued forth from its mother after the twenty-fourth week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life, "

The world health organisation (WHO) defines "Live Birth refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born."

When signs of life are recognised at birth, at ANY gestation (including babies born as the result of Medical Termination Of Pregnancy), the subsequent death, must be managed as an Early Neonatal Death (A neonatal death is defined as a baby born showing signs of life, at ANY gestation during pregnancy, which dies within 28 days of being born

A Missed Miscarriage is one where the baby has died or not developed in utero, but labour does not commence spontaneously. In many cases, women are asymptomatic, with no indication of a problem with the pregnancy, until the fetal demise is identified by a health professional when attempting to auscultate the fetal heart or perform an ultrasound scan. In these instances, labour may be managed expectantly or may be induced.

Occasionally, medical termination of pregnancy (MTOP) for fetal abnormalities may be required to be performed after 24 weeks gestation. Termination of pregnancy is legal at any gestation following a diagnosis of a severe abnormality. The Royal College of Gynaecologists (RCOG) recommends that "for all terminations at gestational age of more than 21+6 weeks, the method chosen should ensure that the fetus is born dead"

5.4. 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 bereavement office staff will inform the LeDeR programme giving basic information so the death can have a full review. Following the SJR an escalation, if appropriate, 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.

5.5. PSII

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.

5.6. Referrals to HMC

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.

5.7. Remit of the SJR:

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 usually able to interrogate previous admissions or services outside the Trust such as community based advanced care planning issues. However, if a reviewer does find issues that warrant further investigation regarding a previous admission or community care, the MOG will review and escalate as appropriate to the PSP for further investigation. 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's 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 for mortality)

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 Finished Consultant Episodes (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 Sharing the learning:

Any SJRs with good or excellent care in all domains is shared via the good care events section in Datix

Information is collated and learning is shared via the learning from deaths bulletin.

CBU speciality level HSMR reports are available on IRIS

The Mental Health SJR report is shared quarterly with the Mental Health Steering Group

Learning Disabilities and/or Autism report is shared quarterly with the safeguarding lead

The end of life SJR findings report is shared with the end of life steering group

Thematic review of escalations to the PSP are reported on bi-annually to the LfMG and shared with the relevant governance group such the deteriorating patient group, medicines management group and End of Life Group.

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.

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 and learning from deaths 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.

8 Roles and Responsibilities

8.1. 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.

8.2. 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 from the Learning from Deaths and Mortality Statistics will go to the Trust Board via the Trust Governance Structure.

8.3. 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.

8.4. 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.

8.5. 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 learning is shared across the organisation and through the relevant governance groups
- Ensuring links with the regional groups are maintained and new developments reported to the LfMG.
- Preparing the Mortality and from Learning from Deaths report for Board.
- Ensuring the learning from mortality group, clinical effectiveness group, Quality & Governance Committee receive a bi-monthly and six monthly Mortality and Learning from Deaths reports (which is included in the chairs log to board and presented to board every six months).
- Ensuring communication between the external informatics provider, the coding department, the data quality team through the head of information, the variance group, the mortality statistics group and the mortality overview group
- The Associate Director for Patient Safety and Quality Improvement is accountable to the Medical Director for the Learning from Deaths process and Mortality Statistics

8.6. 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 including the variance meetings, mortality statistics meeting, learning from deaths group and any other meetings required by the Associate Director for patient safety & quality improvement.
- 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.

8.7. 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.

8.8. Medical Examiners Service

The medical examiner system is now a statutory requirement in England and Wales, meaning it is a mandatory part of the death certification process

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 :
- 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 MOG on compliments or any comments made regarding good care.

- 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.

8.9. 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.

8.10. 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

8.11. 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

8.12. Bereavement Office Staff

The bereavement office staff are 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.

8.13. 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.

8.14. Mortality Overview Group

The Mortality Overview Group will

- Comprises of a core group from patient safety and the AMD for mortality.
- Invite members as required such as, 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

8.15. 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.

9 Associated documentation and references

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- 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)World Health Organization. International statistical classification of diseases and related health
- problems. Tenth Revision. Vol 2. Geneva, Switzerland: World Health Organization, 1993:129.
- (Late Miscarriage MTOP and early neonatal death from 20+0 to 23+6 weeks gestation.pdf
- Stillbirth MTOP and Early Neonatal Death from 24+0 weeks gestation.pdf

9.1 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.

9.2 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

10 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.

10.1 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.		Yes	No	If staff, how many individuals/which groups of staff are likely to be affected?
	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.	Patients		x	If yes, who did you engage with? Please state below: Consultation of the mortality Committee
	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 sire where the service is provided have access to prayer and faith resources?	x	

EQUALITY IMPACT ASSESSMENT – STAGE 1 (PART 4)

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

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**

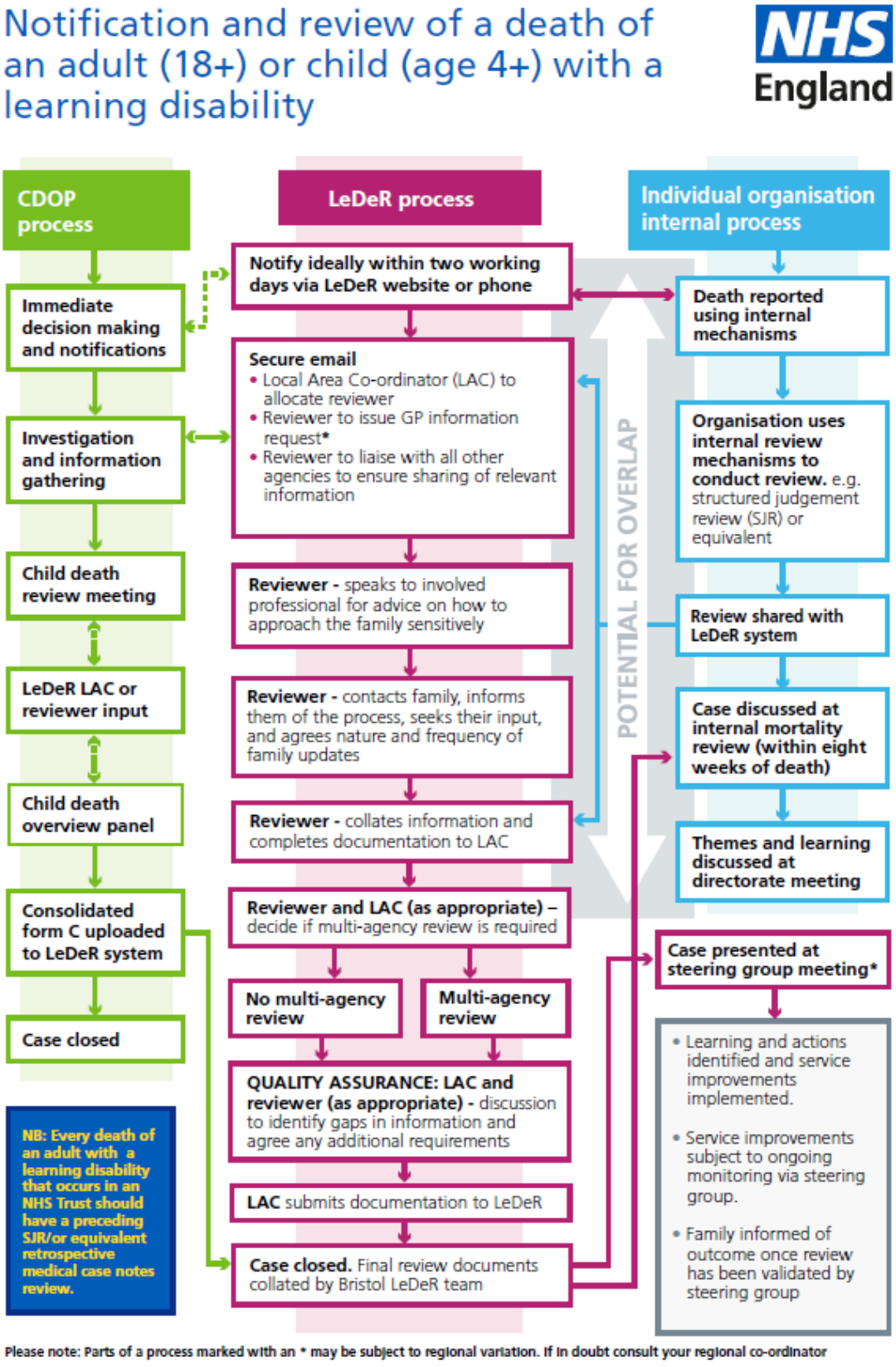
STAGE 2 – FULL ASSESSMENT & IMPROVEMENT PLAN
MUST be completed if any negative issues have been identified at stage 1

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
Men Younger People (17-25) and Children Older People (50+) Race or Ethnicity Learning Disability and/or Autism Hearing Impairment Visual Impairment Physical Disability Mental Health Need Gay/Lesbian/Bisexual Transgender Faith Groups (please specify) Marriage & Civil Partnership Pregnancy & Maternity Carers Other Group (please specify) Applies to ALL Groups				
How will actions and proposals be monitored to ensure their success? Which Committee will you report to? (i.e. Divisional DQEC / Governance Meeting).				
Who will be responsible for monitoring these actions?				

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
NHS England
CDOP process
LeDeR process
Individual organisation internal process
Immediate decision making and notifications
Investigation and information gathering
Child death review meeting
LeDeR LAC or reviewer input
Child death overview panel
Consolidated form C uploaded to LeDeR system
Case closed
NB: Every death of an adult with a learning disability that occurs in an NHS Trust should have a preceding SJR/or equivalent retrospective medical case notes review.
Notify ideally within two working days via LeDeR website or phone
Secure email
• Local Area Co-ordinator (LAC) to allocate reviewer
• Reviewer to issue GP information request*
• Reviewer to liaise with all other agencies to ensure sharing of relevant information
Reviewer - speaks to involved professional for advice on how to approach the family sensitively
Reviewer - contacts family, informs them of the process, seeks their input, and agrees nature and frequency of family updates
Reviewer - collates information and completes documentation to LAC
Reviewer and LAC (as appropriate) – decide if multi-agency review is required
No multi-agency review
Multi-agency review
QUALITY ASSURANCE: LAC and reviewer (as appropriate) - discussion to identify gaps in information and agree any additional requirements
LAC submits documentation to LeDeR
Case closed. Final review documents collated by Bristol LeDeR team
POTENTIAL FOR OVERLAP
Death reported using internal mechanisms
Organisation uses internal review mechanisms to conduct review. e.g. structured judgement review (SJR) or equivalent
Review shared with LeDeR system
Case discussed at internal mortality review (within eight weeks of death)
Themes and learning discussed at directorate meeting
Case presented at steering group meeting*
• Learning and actions identified and service improvements implemented.
• Service improvements subject to ongoing monitoring via steering group.
• Family informed of outcome once review has been validated by steering group
Please note: Parts of a process marked with an * may be subject to regional variation. If in doubt consult your regional co-ordinator

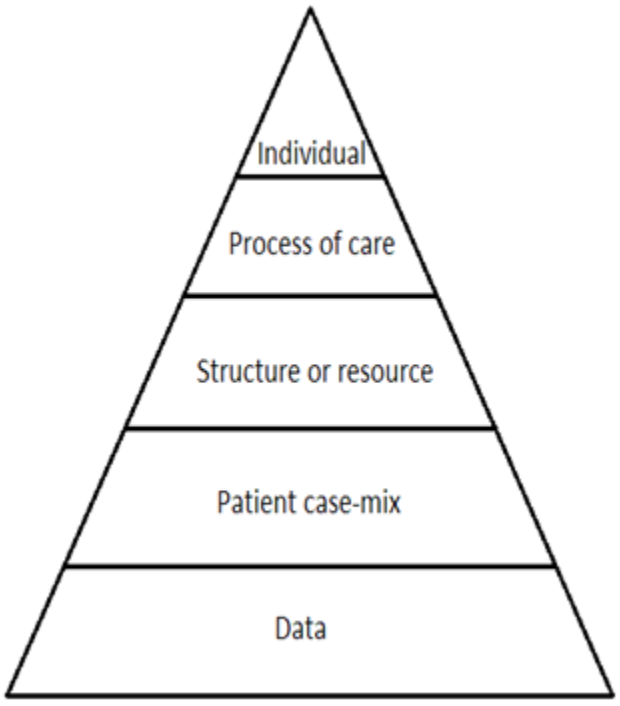
Appendix 4

- 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:



	have there been staff changes during the period under investigation, has a staff member gained additional skills which has led to improved outcomes, are the cases with adverse outcomes mostly associated with 1 clinician or team?
	have new treatment guidelines been introduced, have the appropriate care pathways been consistently followed, have there been any changes to admission or discharge practices?
	were there any changes to the structure and availability of resources e.g. availability of beds, equipment and staff?
	are there factors that particularly affect patients at the trust which are not considered by the national risk-adjustment e.g. patients admitted for end of life care?
	has the data been coded accurately, have all comorbidities been recorded and coded, have there been any changes in coding practice, is the data complete?

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

Appendix 6

Royal College of Physicians

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
7	10/09/2025	Statutory ME service 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
Learning from Mortality Group	10 September 2025