Learning from Deaths Policy

Reference Number	Version	Status	Executive Lead(s) Name and Job Title	Author(s) Name and Job Title
374	2.0	Current	Dr David Hughes	A Gibson – Deputy Medical Director S Butler – Head of Patient and Healthcare Governance T George – Clinical Effectiveness Facilitator

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Associated Documentation:

Trust Controlled Documents: Quality Report

http://nww.sth.nhs.uk/STHcontDocs/STH_Pol/HealthAndSafety/IncidentManagementPolicy.doc

http://nww.sth.nhs.uk/STHcontDocs/STH_Pol/ClinicalGovernance/LastOfficesPolicy.doc

http://nww.sth.nhs.uk/STHcontDocs/STH_Pol/ClinicalGovernance/VerificationOfExpectedDeath.doc

http://www.rns.uk/sheffield

http://nww.sth.nhs.uk/STHcontDocs/STH_Pol/CorporateManagement/Complaint_SupportingStaffInvolvedInIncidentsComplaintsAndClaimsPolicy.doc

http://sharepoint.sth.nhs.uk/Collaboration/Wellbeing/SitePages/24hr%20confidential%20support%20service.aspx

External Documentation:

https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

https://www.rcplondon.ac.uk/guidelines-policy/mortality-toolkit-implementing-structured-judgement-reviews-improvement

https://improvement.nhs.uk/resources/serious-incident-framework/

Legal Framework:

For more information on this document please contact:- Dr Andrew Gibson
Version History

Version	Date Issued	Brief Summary of amendments	Owner's Name:
V1	11/04/2018	New policy	David Throssell
V2	04/03/2020	Amended in response to 360 Assurance Audit	David Hughes

(Please note that if there is insufficient space on this page to show all versions, it is only necessary to show the previous 2 versions)

Executive Summary

Learning from Deaths Policy

Document Objectives: To describe the process by which the deaths of patients under the care of Sheffield Teaching Hospitals are reviewed, any concerns identified and healthcare improvements enacted.

Group/Persons Consulted: Medical Examiner's Office ; Mortality Governance Committee: Trust Executive Group; NHSI Guidance July 2017

Monitoring Arrangements and Indicators: National Monitoring Requirements to be met.
Quarterly report to Board of Directors

Training Implications: Training in Structured Judgement Review (SJR) methodology undertaken by Multi-professional teams as described.
Training of additional Medical Examiners and Officers

Equality Impact Assessment: Initial analysis completed no potential or actual adverse impact on any relevant groups identified

Resource implications: Requirement to resource the infrastructure recognised.

Intended Recipients:
Who should:-

➢ be **aware** of the document and where to access it

All clinical staff

➢ **understand** the document

All SJR reviewer's, TEG, Trust Board, CD's ND's and OD's

➢ have a **good working knowledge** of the document

Mortality Governance Committee, Patient Safety Manager, Medical Director, Serious Incident Group, Medical Examiner's Office

Contents

1.1 Introduction

In December 2016, the Care Quality Commission (CQC) published its review on the way NHS acute trusts review and investigate the deaths of patients in England: *Learning, candour and accountability.* The CQC found that none of the trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

Daily mortality reviews have been conducted, as a pilot scheme funded by NHSI, by the medical examiner's system (MES) at Sheffield Teaching Hospitals NHSFT (STHFT) on approximately 80% of all deaths since 2009 until 2018. The funding for that scheme was withdrawn in March 2019 as the MES across England entered its non-statutory phase of development.

Executive approval has, as part of the further role out of the MES at the Trust, been given to extend the MES function to cover review of all deaths within the Trust and to recruit specialist reviewers to perform timely Structured Judgement Reviews on those hospital deaths that are mandated by the national guidance. The Trust has appointed a Lead Medical Examiner Officer (MEO) and a Lead Medical Examiner.

On March 21st 2017 the National Quality Board published "*National Guidance on Learning from Deaths*" which includes very specific guidance on the roles and responsibilities of the Board of Directors. It is essential that this guidance be read alongside the NHSI/E *Serious Incident Framework* (March 2015). Trust boards are accountable for ensuring compliance with both of these. The guidance clearly states that the learning from mortality reviews should be integral to a provider's clinical governance and quality improvement work.

Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in the Trust and provide necessary challenge. The guidance also directs all trusts to publish a Policy on how it responds to, and learns from, deaths of patients, who die under its management and care, including:

- How its processes respond to the death of an individual with a learning disability or mental health needs, an infant or child death and a stillbirth or maternal death.
- The Trust's approach to undertaking case record reviews. Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die. The Structured Judgement Review (SJR) case note methodology is one such approach and used at STHFT.
- Categories and selection of deaths in scope for case record review.

As a minimum and from the outset, Trusts should focus reviews on:

- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.
- All in-patient, out-patient and community patient deaths of those with learning

disabilities and severe mental illness.
- All neonatal and maternal deaths.
- All deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator).
- All deaths in areas where people are not expected to die, for example in relevant elective procedures.
- Deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.
- A further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.
- Following any linked inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths" in order to examine the effectiveness of their own review process.
- Deaths to be subject to a Serious Incident reporting and investigation.

Some deaths will be investigated by other agencies, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication are needed to avoid problems.

As these processes become more established, trusts should include cases of people who had been an in-patient but had died within 30 days of leaving hospital. Community trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach. The rationale for the scope selected by trusts will need to be published and open to scrutiny. Eventually it is envisaged that all deaths in England will be subject to a review of some type.

2.1 Purpose of Policy

The purpose of this policy is to describe the process by which STHFT reviews deaths that occur under its care, ensuring a consistent and coordinated approach by describing how:

- The process reports into the Trust's existing governance framework.
- Deaths that are of concern are appropriately escalated in a timely manner.
- Learning from every death is achieved by the end of the non-statutory phase of the national implementation of the MES.

- Learning is identified, shared and implemented appropriately.
- The process is quality assured.

In addition the policy will:

- Ensure clear reporting mechanisms are in place to escalate any concerns, so that the Trust is aware and can take appropriate and timely actions.
- Ensure openness and transparency including the appropriate application of the Statutory Duty of Candour.
- Further the organisational understanding of quality of care and clinical outcomes.
- Describe the reporting requirements.
- Describe how the deaths of patients falling within the mandated categories are reviewed and how the learning and outcomes are disseminated.
- Describe the additional support provided to families, carers and staff following investigations or reviews linked to the death of a patient.

3.0 New requirements for Trusts

Under the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017, trusts are required to:

3.1 Publish an updated policy from September 2017 on how their organisation responds to and learns from the deaths of patients who die under their management and care, including:

- How their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death.
- Their evidence-based approach to undertaking case record reviews.
- The categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed).
- How the trust engages with bereaved families and carers, including supporting and involving them in investigations.
- How staff affected by the deaths of patients will be supported by the trust.

3.2 Collect and report specific information every quarter on:

- The total number of inpatient deaths in an organisation's care.
- The number of deaths the trust has subjected to case record review (desktop review of case notes using a structured method).
- The number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents).
- Of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care.
- The themes and issues identified from review and investigation, including examples of good practice.

- How the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

3.3 Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

This policy sets out Sheffield Teaching Hospitals approach to meeting these requirements.

4.0 Roles and responsibilities

This section describes the specific responsibilities of key individuals and of relevant committees under this policy. Roles and responsibilities for incident management, complaints handling and Serious Incident management are detailed in various policies.

4.1 The individual roles and responsibilities are:

Role	Responsibilities
Chief Executive	Responsible for the statutory duty of quality and takes overall responsibility for this policy.
Chair of Healthcare Governance	Understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny. Championing quality improvement that leads to actions that improve patient safety. Assuring published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.
Medical Director	The Medical Director is the Executive Director with lead responsibility for implementing the National Guidance on Learning from Deaths; this includes ensuring that the directorates take responsibility for the governance of Learning from Deaths in their individual areas.
Learning disability lead Nurse Director, Head and Neck Care Group	Responsible for reporting appropriate organisational deaths to the national LeDeR Programme and assisting with the identification of LeDeR deaths subject to case record review.
Maternity lead Deputy Nurse Director, Obstetrics, Gynaecology and Neonatology	Responsible for ensuring maternal deaths are reported into the appropriate pathway.

Neonatal mortality lead Consultant Neonatologist, Obstetrics, Gynaecology and Neonatology	Responsible for ensuring neonatal deaths are reported into the appropriate pathway.
Head of Clinical Effectiveness & Patient Experience	Responsible for oversight and management of the day to day running of the case record review programme and is accountable to the Head of Patient and Healthcare Governance.
Senior Learning from Deaths Facilitator	Responsible for day to day running of the case record review programme and is accountable to the Head of Clinical Effectiveness and Patient Experience. This includes thematic analysis of learning and liaison with individual governance teams in directorates.

4.2 The committees through which these responsibilities are performed are:

Committee	Responsibilities
Trust Board of Directors	The *National Guidance on Learning from Deaths* places particular responsibilities on boards, as well as reminding them of their existing duties. Organisations must refer to Annex A of the *National Guidance on Learning from Deaths.*
Trust Executive Group	Reported to TEG.
Healthcare Governance Committee	Assurance provide to Healthcare Governance Committee.
Mortality Governance Committee (MGC)	To provide the oversight and review of all Trust activities in relation to the analysis of mortality and morbidity and reports to TEG and provides assurance to Healthcare Governance Committee.

5.0 Definitions of Terms within the Policy

The *National Guidance on Learning from Deaths* includes a number of terms. These are defined below.

5.1 Death certification
The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

5.2 Medical Examiner System
The MES will, in the statutory phase of its development, review each death in the hospital (and eventually the whole city) to allow for more accurate description of the causes of deaths and to enable a more accurate completion of the Medical Certification of the Cause of Death (MCCD). This review is fundamentally different from the more specific in depth Structured Judgment Review or case record review.

5.3 Structured Case record review (SJR)
A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any indications of problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist such as those raised by staff and families or when an external agency or audit process identifies concerns. The SJR is a validated tool used in case record review. The method used derives care scores across five phases of care and each phase is awarded a care score from one to five. The five scores of one to five denote, very poor care, poor care, adequate care, good and finally excellent care.

5.4 Serious Incident
Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm. Serious Incidents also encompass events where appropriate action/ intervention were not taken to safeguard against abuse. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

5.5 Investigation
A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw

on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

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

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

5.8 Patient safety incident
A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

6.0 The process for recording deaths in care

Full information with regards to care following death can be found in the Last Offices Policy. STHFT have bereavement teams who, following an in hospital death, capture details onto our locally held bereavement database. This includes but is not limited to: next of kin, cause of death and whether a case was referred to the coroner. All correspondence and further activity around this patient is then recorded on this bereavement database. Once the MES is fully implemented and is in the statutory phase of practice, each adult acute death at Sheffield Teaching Hospitals will undergo a timely review by the Medical Examiners' office to ascertain the cause of death and highlight any concerns regarding the care of the patient and as such inform further investigatory processes. It is intended that in time the MES will apply to all deaths in Sheffield both within the acute hospital setting and within other settings including deaths at home and in other environments within the community

The trust has access to HES data. This provides an effective system for capturing robust information on patient deaths automatically. Neonatal deaths and maternal deaths each have their own recording and reporting process' full details of which can be found in their respective policies.

7.0 Selecting deaths for case record review

Deaths that occur in STHFT are recorded in a number of ways and the total numbers of deaths are captured within the Trust Data Warehouse. This allows the Trust to publish accurate figures for the total numbers of deaths per quarter.

The selection of adult (except maternal) deaths that are to be the subject of a structured judgement review is summarised in Figure 1 and as suggested can be initiated by the outcome of a national alert, the MES, the mandated list of causes of deaths from national guidance or concerns raised by staff and families.

Figure 1
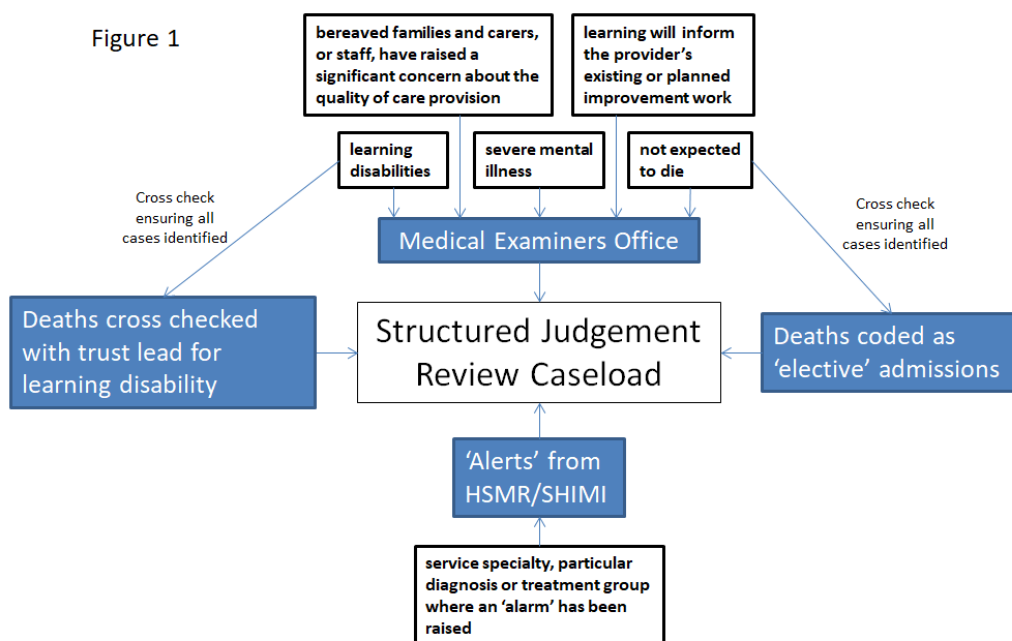
It is the ambition of the national programme once fully implemented to ensure that the MES is capable of reviewing all deaths that occur in the acute hospital setting in England. Those requiring further case record review using, in the case of STHFT, SJR will include all those that are mandated by the "*National Guidance on Learning from Deaths*" as discussed.

In addition, neonatal, stillbirth and maternal deaths are reviewed through separate processes in line with Child Death Statutory Guidance, Perinatal Mortality Review Tool (PMRT) and MBRRACE recommendations.

Figure 2 gives an overview of the neonatal, still birth and maternal processes.

Figure 2

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                        │  Paper A     │
                        │  SI          │
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┌──────────────┐   ┌──────────────┐   ┌──────────────┐   ┌──────────────┐   ┌──────────────┐   ┌──────────────┐
│  Neonatal    │→  │ Rapid Review │→  │ Investigation│→  │ Neonatal     │→  │ Neonatal ODN │→  │ Child Death  │
│  Death       │   │ (within 72   │   │ and          │   │ Mortality    │   │ Mortality    │   │ Overview     │
│              │   │  hours)      │   │ information  │   │ Meeting      │   │ Review Panel │   │ Panel        │
│              │   │              │   │ gathering    │   │              │   │              │   │              │
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│  Stillbirth  │→  │ Rapid Review │→  │ Investigation│→  │ Obs/NNU      │→  │ External     │
│              │   │ (within 72   │   │ and          │   │ PMRT meeting │   │ Reporting to │
│              │   │  hours)      │   │ information  │   │              │   │ PMRT         │
│              │   │              │   │ gathering    │   │              │   │ MBRRACE      │
│              │   │              │   │              │   │              │   │ Each Baby    │
│              │   │              │   │              │   │              │   │ Counts       │
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│  Maternal    │→  │ Rapid Review │→  │ Investigation│→  │ Obstetrics   │→  │ External     │
│  Death       │   │ (within 72   │   │ and          │   │ Morbidity and│   │ Reporting    │
│              │   │  hours)      │   │ information  │   │ mortality    │   │ MBRRACE      │
│              │   │              │   │ gathering    │   │              │   │ HSIB         │
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        ┌──────────────────────────────┐                    ┌──────────────┐
────────│ Support for family via       │───────────────────▶│ Reports      │
        │ Bereavement Team throughout  │                    │ shared with  │
        └──────────────────────────────┘                    │ family       │
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8.1 Case record review methodology

Case record review using the SJR method is used to determine whether there was any evidence of problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve healthcare outcomes even in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion that anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

An SJR is usually undertaken by an individual reviewing a patient's death and mainly comprises two specific aspects: explicit judgement comments being made about the care quality and care quality scores being applied. These aspects are applied to both specific phases of care and to the overall care received.

The phases of care are:

- Admission and initial care – first 24 hours
- On-going care
- Care during a procedure
- Perioperative/procedure care
- End-of-life care (or discharge care)
- Assessment of care overall.

While the principle phase descriptors are noted above, dependent on the type of care or service the patient received not all phase descriptors may be relevant or utilised in a review.

9.0 Staff training and support

Staff involved in the review of deaths, either through the MES or case record review have training and support as described below.

9.1 Medical Examiner's System (MES)

Medical Examiners (ME) Professional Requirements
Medical Examiners must hold a licence to practice with the General Medical Council (GMC) and must have at least five years' work experience as a fully registered medical practitioner. MEs should have up-to-date knowledge of causes of death and an understanding of legal frameworks associated with death certification processes. MEs will have professional independence in scrutinising deaths but will be accountable to the employing organisation's Board for achieving agreed standards or levels of performance. MEs will have an independent professional line of accountability to a regional structure of NHS Improvement/NHS England outside the employing organisation and immediate line management structure. MEs will comply with guidance issued by the National Medical Examiner when carrying out ME duties.

MEs Essential Training
All MEs must have successfully completed the mandatory 26 Medical Examiner e-learning modules developed by Health Education England prior to beginning the role. MEs must also attend a face-to-face training session developed by the Royal Society of Pathologists within the first three months in post. MEs are expected to take responsibility for their own continuing professional development in accordance with any standards for maintaining a GMC licence to practice and membership of any relevant professional body. The ME role should be included in the whole practice appraisal.

ME Staff Support
MEs can discuss individual cases and receive professional support from the Trust's Lead ME or from each other. MEs can also discuss professional issues with the regional or National lead ME.

9.2 Structured judgement reviewer training

Reviewers Essential Training
The National Mortality Case Record Review programme was a national programme running from 2016 -2019 and during this time delivered SJR training to over 140 hospitals in the UK. Training in the SJR methodology was delivered, and continues to be delivered to reviewers in STHFT by nationally accredited SJR trainers from the Royal College of

Physicians.

Reviewers On-going Development
Regular expert SJR meetings are held quarterly which gives reviewers chances to feedback to the chair of the MGC and in doing so refine aspects of the process in a timely fashion.

10.1 Selecting deaths for investigation

Cases highlighted as potential SIs are all reviewed by the trusts Serious Incident Group. These will then go through one of three pathways:
1. A Serious Incident is declared which initiates an investigation.
2. The group decides that it does not meet the criteria for reporting under the SI framework but a full internal investigation should take place and be overseen by SI group.
3. The group decides that it does not meet the criteria for reporting under the SI framework and that the directorate is to undertake a local investigation to be managed and overseen by local directorate arrangements.

SJR escalation to investigation:
Once cases have been reviewed by the expert SJR reviewers they are given an 'overall care' score. Those cases scoring a '1' (very poor) or '2' (poor) overall are subject to a second SJR review. Once the overall care score of '1' or '2' is corroborated (either by second review or arbitration by two different reviewers working together) further action is taken. The SJR reviews are returned to the directorate governance team. The task of governance team is to review the case in context. If the governance team declare the death as a potential SI they prepare a Paper A for the SI group. If the team feels the case does not warrant a consideration of an SI, the context of the case and an appropriate action plan is created to return to the mortality governance committee. The mortality governance committee then has oversight of this context and discusses each action plan at its monthly meetings. This process is described in Figure 3 below.

Figure 3
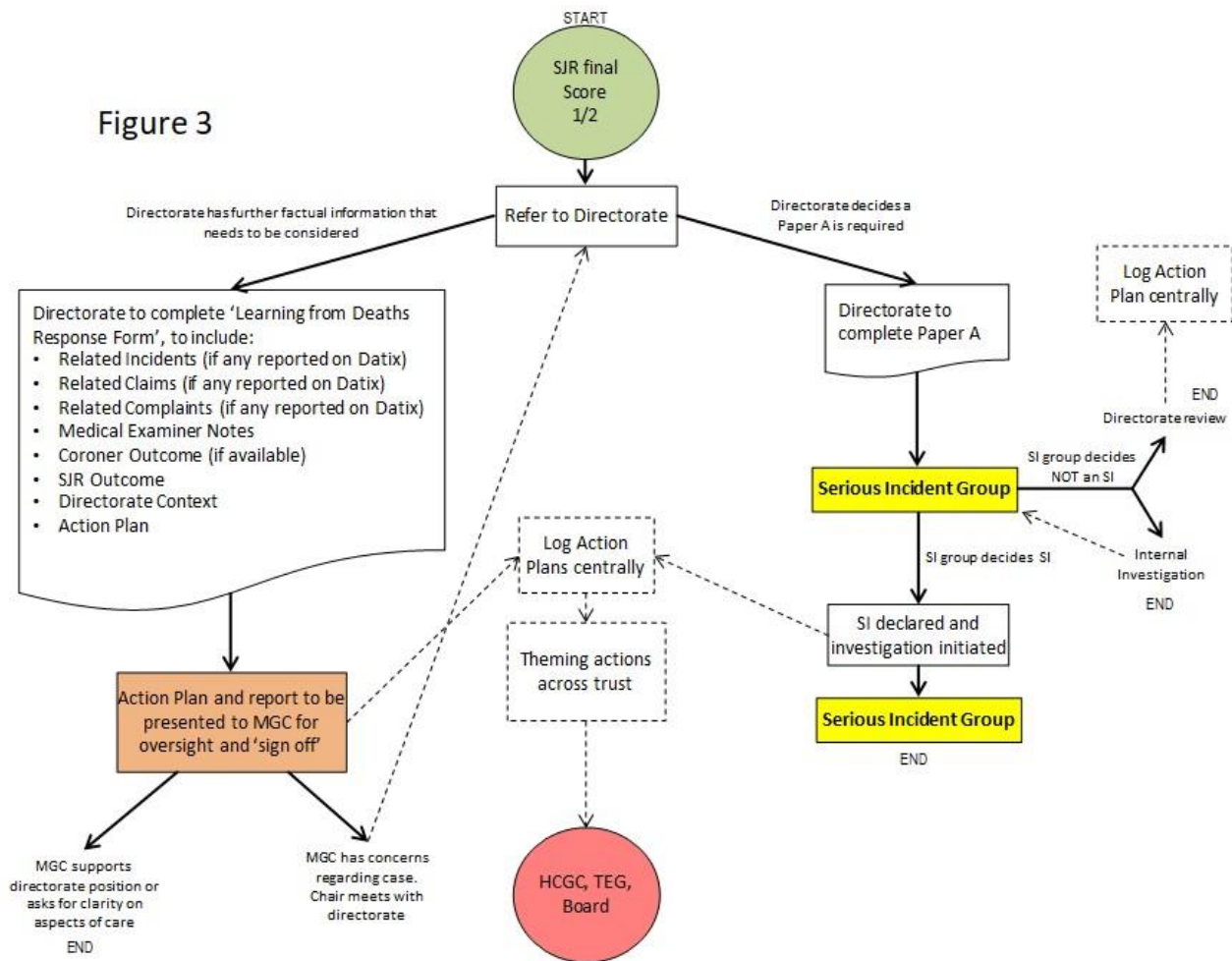
The mortality Governance Committee is comprised of:

- DMD (Chairperson)
- Head of Patient and Healthcare Governance
- Lead Medical Examiner Officer
- Neonatologist and neonatal/maternal mortality lead
- Trust lead for Learning Disability
- Head of CEU
- Medical Coding Manager
- ED Consultant
- Patient Safety Manager

The decisions of the Committee will be reported on a quarterly basis to Healthcare Governance and contribute to the Department of Health and Social Care Dashboard. The metrics to be included in the dashboard have been described and are included in the guidance published in March 2017. The information obtained will also be reported to the Board of Directors and published in the annual Quality Report as per the national guidance.

11.0 Reviewing outputs from review and investigation to inform quality improvement

The learning from each death, be it from an SJR, coronial inquest, SI investigation, MES or LeDeR review, will be collated by the Clinical Effectiveness Department and escalated/reported according to the individual themes. This will include escalation or
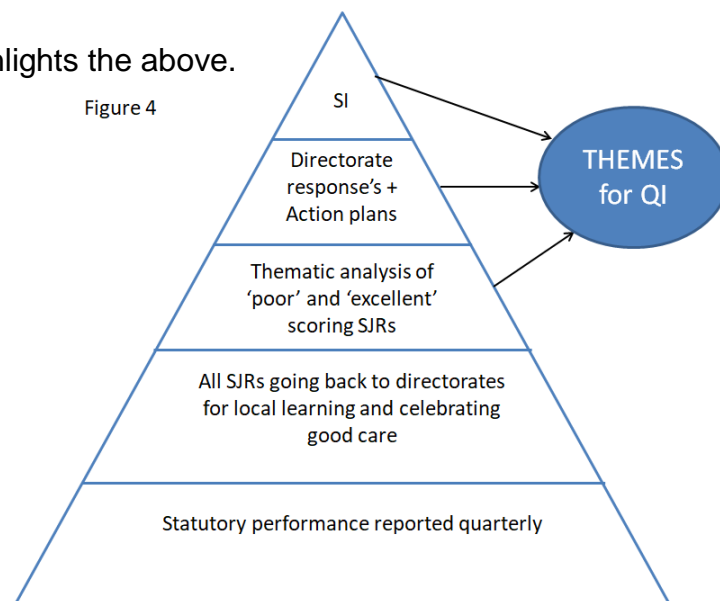
sharing, as appropriate, to:

- Trust Executive Group
- Patient and Healthcare Governance Department
- Medical Directors and Chief Nurses office
- Mortality Governance Committee
- Safety and Risk Committee
- Directorate Governance Leads
- Families

Results from SJR will be used on a variety of levels for local and trust learning, improvement and celebrating success:

- Every single case will be fed back to the directorate whose care the patient was under. This then allows the directorate to discuss individual cases at their local M&M meetings/ escalate cases as a SI or provide context to the care and action plans resulting from the SJR.
- SJR cases deemed as 'poor over all care' will be either escalated into the SI process or action plans be scrutinised by the Mortality Governance Committee.
- The action plans as described above will be thematically analysed to see if recurrent problems span multiple directorates across the hospital – this can then feed into wider trust improvement work.
- Where possible, SJR results and data will be fed into existing work streams for example within organisational development.
- Thematic analysis on different sections of the structured judgement review will highlight recurring problems at certain stages of care, for example first 24 hours of care or palliative care. These themes can then form the basis for directorate discussions and designing quality improvement projects.
- The above themes can also be presented at board level to highlight where extra resource may benefit patient care.

Figure 4 highlights the above.

Figure 4

SI

Directorate response's + Action plans

THEMES for QI

Thematic analysis of 'poor' and 'excellent' scoring SJRs

All SJRs going back to directorates for local learning and celebrating good care

Statutory performance reported quarterly

12.0 Presenting relevant information in board reports

As a result of the National Guidance on Learning from Deaths, the Trust will collect and publish, by quarter six months in arrears, specified statutory information on deaths via a paper to a public Board meeting. The Trust Executive Group and Healthcare Governance Committee (HCGC) will receive the papers prior to the Public Board meetings as part of the governance process. The data includes the total number of the Trust's in-patient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, the Trust is required to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

13.0 Supporting and involving families and carers

The Trust has in place guidelines for the inclusion of family and carers in the investigation of Serious Incidents. Where appropriate this guideline will be enacted to ensure involvement of family members following a death. This would also address any issues of candour arising.

Where a death does not involve a serious incident the below are in place for relatives/ carers:

- On the death of a patient a Bereavement leaflet is routinely provided.
- The last offices policy outlines the procedures for notifying relatives/ carers following a death.
- Following an ME review and agreement of the death certificate wording with the attending physician, the MEO will contact the next of kin (NoK) to discuss the content of the death certificate. The structure of this phone call also offers the NoK the chance to raise any concerns regarding care received which may instigate further signposting to support for NoK or instigate an SJR review.
- Feedback from families positive or negative is fed back to the directorates governance team for them to disseminate to local staff involved in care.

14.1 Supporting and involving staff

If staff members are affected by a patients' death they are able to access support from a number of sources:

- Ward manager/line manager – available for informal discussions and explore staff members concerns.
- Chaplaincy - available for informal discussions and explore staff members concerns.
- Vivup – the Trust's employee benefits provider. Vivup offers a 24/7 staff counselling telephone service and multiple self-help guides including a bereavement guide.
- The end of life team are available for reflective discussions.

Support around investigations:

- Support around investigations (SI) can be found in the supporting staff involved in incidents complaints and claims policy.
- Legal advice can be sought from the Trusts legal department.

15.1 Governance

The process as outlined above will be assured by the following mechanisms:

- A proportion of structured judgment reviews with an Overall score of 3 will undergo peer review within the process.
- It is planned that a proportion of Medical Examiner reviews that do not require a structured judgement review will be reviewed using the SJR methodology.
- An SJR will not be undertaken by an individual who has been involved directly or indirectly in the care that is being reviewed.
- The SJR reviewers will be appointed by the Trust for one year fixed term appointments and their reviews will be subject to a QA process described by the Royal College of Physicians.
- Mortality Governance Committee reports to the Trust Executive Group and provides assurance to the Healthcare Governance Committee.
- There is a named Non-Executive Director with responsibility for the oversight of mortality including learning from deaths.

16.0 Summary

This policy describes the processes by which STHFT will adhere to the NQB "Learning from Deaths" requirements of March 2017, and the prescribed schedule of timelines subject to the description of the metric required.

STHFT intend to enhance the function of the Medical Examiner's Office and thereby ensure that we are able to comment on, and potentially learn from, every death that occurs under the Trust's care using nationally aligned processes.

17.0 Equality impact assessment

Is there a potential or actual negative impact associated with this policy on people or individuals who share a 'protected characteristic'? i.e. does this policy directly or indirectly discriminate? - Can this policy be used to promote equality between people who share a protected characteristic and people who do not?		NOTES changes/additions/ further information or advice needed
RACE	No impact	
SEX **(I.E. MALE / FEMALE)**	No impact	
GENDER REASSIGNMENT	No impact	
DISABILITY(including consideration of the impact on carers of a disabled person)	Positive Impact	Selection of LeDeR deaths for review could provide improvements in inpatient care to this group
RELIGION OR BELIEF	No impact	
SEXUAL ORIENTATION	No impact	
AGE	No impact	
PREGNANCY or MATERNITY	Positive impact	As above but for maternal deaths.
	Does this Written Policy or Guidance impact on the following areas?	**NOTES** changes/additions/ further information or advice needed

HUMAN RIGHTS i.e. **Fairness** **Respect** **Equality** **Dignity** **Autonomy**	No impact	
SOCIAL DEPRIVATION **/ TACKLING HEALTH** **INEQUALITY**	No impact	