Learning from Deaths Policy

1. Introduction

Reviewing the care provided to people who have died can help improve care for all patients by identifying problems associated with poor outcomes; working to understand how and why these occur; and then taking meaningful action. Learning from mortality reviews should be integral to clinical governance and quality improvement work.

On 21st March 2017 the National Quality Board published "*National Guidance on Learning from Deaths"* outlining practices to be introduced by trusts to ensure that robust systems are in place for the review of in-hospital deaths. This policy sets out Sheffield Teaching Hospitals approach to meeting these requirements.

2. Purpose

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.

3. Scope and exceptions

This policy applies to:

Setting	Trust-wide
Individuals	All clinical and governance staff. SJR reviewers. Mortality Governance Group. Medical Examiner System.
Speciality	All patients who have died while an inpatient at STH

This policy does not apply to:

Patients who have been under the care of STH but who die elsewhere.

4. Policy details

4.1 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. Implementation of the MES means that each adult acute death

at Sheffield Teaching Hospitals undergoes 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. From April 2024, it is intended that in the MES will cover 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.

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. Deaths should be recorded on the Trust EPR within 30 minutes of occurring. This allows the Trust to publish accurate figures for the total numbers of deaths per quarter.

4.2 Selecting deaths for case record review

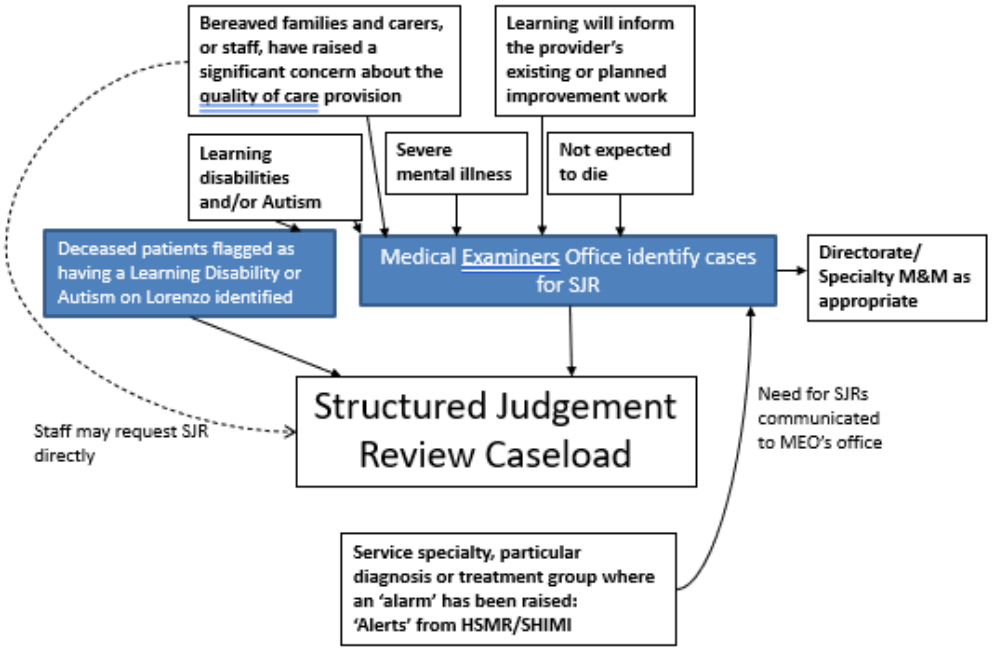
The "*National Guidance on Learning from Deaths" mandates that the following deaths should be subject to case record review:*

i. All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
ii. All deaths of those with learning disabilities or with severe mental illness
iii. 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).
iv. All deaths where people are not expected to die, for example relevant elective procedures
v. All deaths where learning will inform the provider's existing or planned improvement work
vi. 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.

In addition, LeDeR is now reviewing the deaths of people with Autism and there is a current agreement that STH will include these cases for SJR.

The selection of adult deaths that are to be the subject of a structured judgement review is summarised in Figure 1. All inpatient deaths are reviewed by an ME and selected for SJR if any of the above categories apply. Cases may also be referred in by the HSMR Review Group.

Figure 1



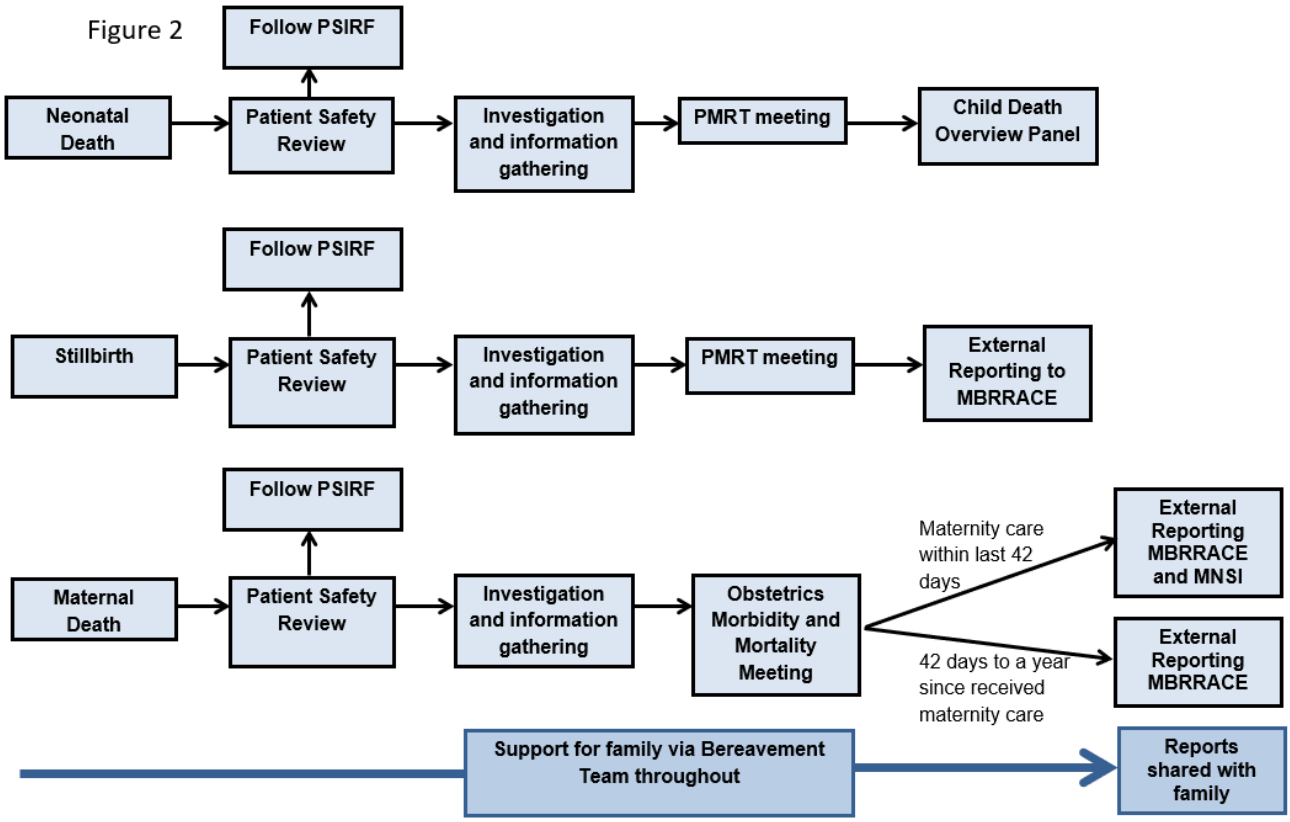
The Trust collaborates with the local LeDeR team in the review of deaths of people with Learning Disabilities. The Trust LeDeR lead notifies LeDeR regarding inpatient deaths of patients with Learning Disabilities and completed SJRs are sent to the ICB LeDeR Strategic Lead. In addition, the ICB LeDeR lead requests an SJR from the Trust for any deaths they have been notified of, where the individual may have died at the Trust, to ensure no reviews are missed.

Mental illness
Deaths of patients with a severe mental illness are identified by the Medical Examiners and referred for SJR. Data from these SJRs is sent each quarter for the Quality and Safety Monitor Report for the Mental Health Executive Committee.

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. Deaths of babies after 28 days of life are also reviewed in line with Child Death Statutory Guidance and using the PMRT but there is not a requirement for these deaths to be reported to MBRRACE.

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

Figure 2



Deaths of children under the age of 18 cared for by adult services are referred into local Child Death Review (CDR) processes.

4.3 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 principal 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.

4.4 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.

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.

Structured judgement reviewer training

Reviewers Essential Training
Training in the SJR methodology is delivered to reviewers in STHFT by nationally accredited SJR trainers from the Improvement Academy.

Reviewers Ongoing Development
Regular expert SJR meetings are held bi-monthly which gives reviewers chances to feedback to the chair of the MGG and in doing so refine aspects of the process in a timely fashion.

4.5 Selecting deaths for investigation

Cases highlighted as potential PSIIs through SJR, or at ME review, are reviewed by the Safety Panel. These will then go through one of two pathways:

1. A decision is made to initiate a PSII.

2. The group concludes that the death does not meet the criteria for a Trust led PSII but suggests an alternative learning response.

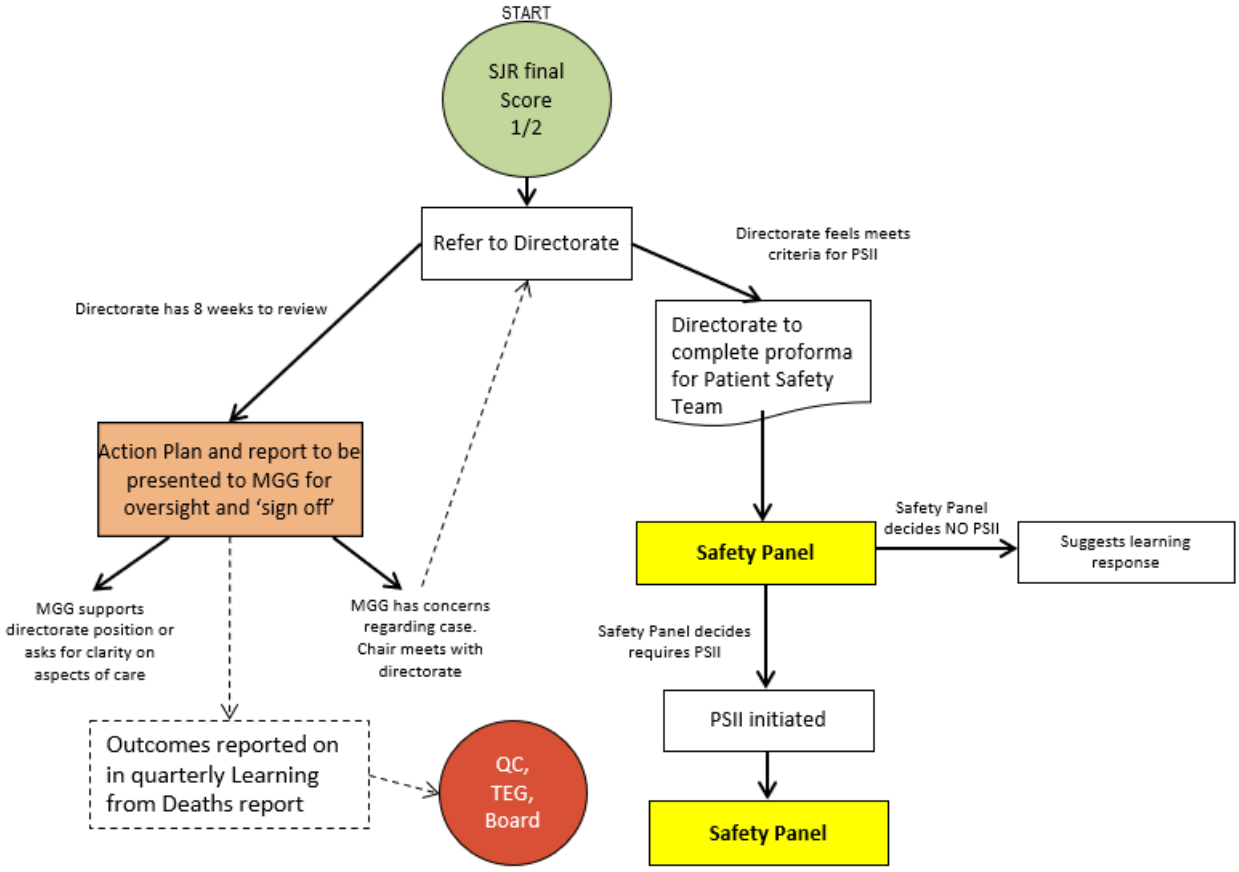
SJR escalation to investigation

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 to review the case in context.

If the governance team feel the case meets the national criteria for a PSII (a death more likely than not due to problems in care (incident meeting the learning from deaths criteria) they prepare a potential PSII proforma for the Safety Panel. Following the completion of a full investigation report and action plan, it is then the role of the Safety Panel to confirm whether care was more likely than not to have contributed to the death, consider discussion with the coroner and report this to the Mortality Governance Group.

If the SJR scored 3,4, or 5 and the Directorate Governance team considers that the case does not require the completion of a PSII, the context of the case and an appropriate action plan is created to return to the Mortality Governance Group. The Mortality Governance Group has oversight of this context and discusses each action plan at its monthly meetings. This process is described in Figure 3 below.

Figure 3



4.6 Mortality Governance Group

The Mortality Governance Group is comprised of:

- DMD (Chairperson)
- Quality Director
- Lead MEO
- Neonatologist and neonatal/maternal mortality lead
- Deputy Trust Lead for Learning Disability
- Deputy Chief Nurse (or representative)
- Clinical Effectiveness Lead
- Clinical Coding Manager
- Data Quality Engagement Lead
- Patient Safety Manager (or representative)
- Learning from Deaths Facilitator
- End of Life Care Clinical Lead
- Legal Services Manager (or representative)
- Directorate Mortality and Morbidity Leads on a rotational basis

Standing invitations: Medical Director (Operations), Head of Patient and Healthcare Governance, Performance and Information Director, Organisational Development Project Manager, Patient Complaints Manager, Clinical Coding Manager, Neonatal Mortality Lead, Maternal Mortality lead, and SJR Expert Group members.

The decisions of the Group will be reported on a bi-monthly basis to the Quality and Safety Executive Committee. The information obtained will also be reported to the Board of Directors and published in the annual Quality Report as per the national guidance.

4.7 Reviewing outputs from review and investigation to inform quality improvement

The learning from each death, be it from an SJR, coronial inquest, PSII, 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:

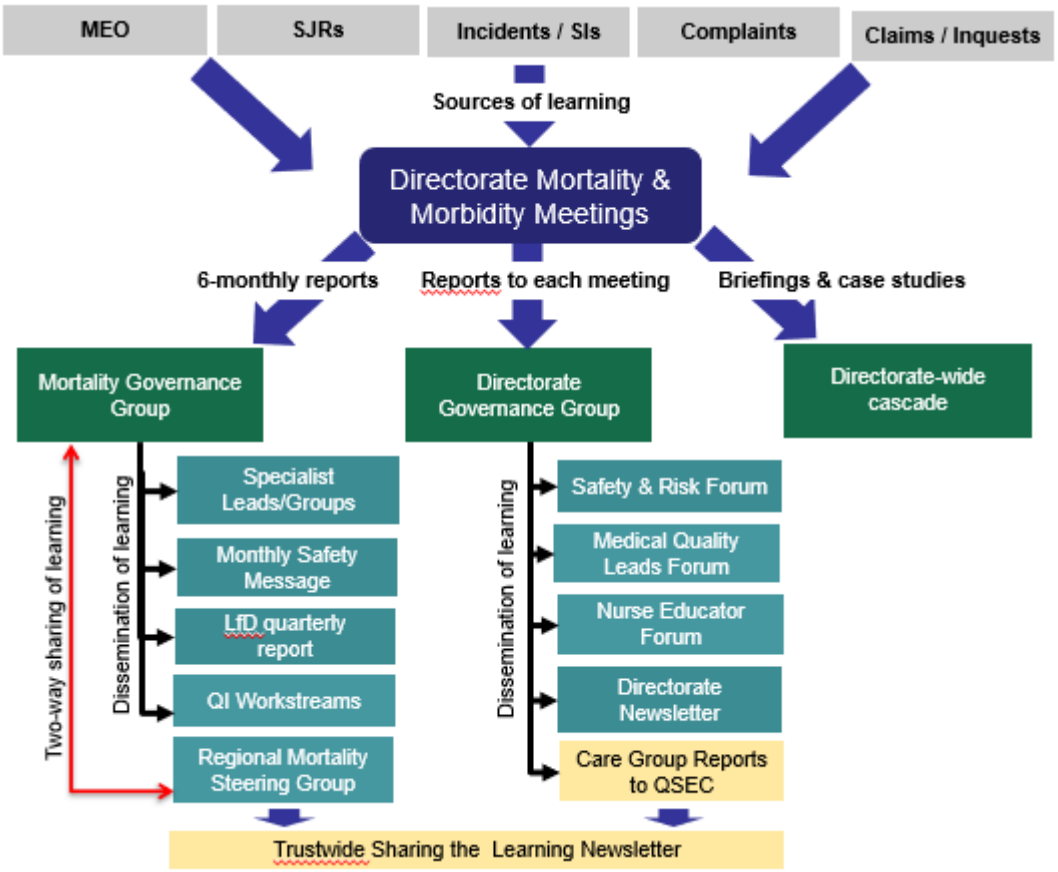
- Trust Executive Group
- Quality & Safety Executive Committee
- Mortality Governance Group
- Safety and Risk Forum
- Medical Quality Leads Forum
- Patient and Healthcare Governance Department
- Medical Directors and Chief Nurses office
- Directorate Governance Leads
- Families

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 PSII 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 PSII process or action plans be scrutinised by the Mortality Governance Group.
- The SJR comments will be thematically analysed to see if recurrent problems span multiple directorates across the hospital. This may include analysis of different sections of the structured judgement review, highlight recurring problems at certain stages of care, for example first 24 hours of care or palliative care; analysis of a specific patient group, time period or other criteria. These themes can then form the basis for directorate discussions and designing quality improvement projects.
- Where possible, SJR results and data will be fed into existing work streams for example within organisational development.
- The above themes can also be presented at board level to highlight where extra resource may benefit patient care.

Figure 4 illustrates further how learning from mortality will be shared within the Trust:

Figure 4



4.8 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 Quality Committee 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. The report will also include the number of deaths judged by the Safety Panel to be more likely than not to be due to problems in care.

4.9 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.

4.10 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 (PSII) can be found in the supporting staff involved in incidents, complaints and claims policy.
- Legal advice and support for attendance at inquests can be sought from the Trusts legal department.

4.11 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 Group reports to the Quality and Safety Executive Committee and provides assurance to the Quality Committee.
- There is a named Non-Executive Director with responsibility for the oversight of mortality including learning from deaths.

4.12 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.

5 Roles and responsibilities

Role	Responsibility
Individuals	
Chief Executive	Responsible for the statutory duty of quality and takes overall responsibility for this policy.
Chair of Quality Committee	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 (Operations)	The Medical Director (Operations) 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 Mortality Lead, Obstetrics, Gynaecology and Neonatology	Responsible for ensuring maternal deaths are reported into the appropriate pathway.
Neonatal Mortality Lead, Consultant Neonatologist, Obstetrics, Gynaecology and Neonataology	Responsible for ensuring neonatal deaths are reported into the appropriate pathway.
Clinical Effectiveness Lead	Responsible for oversight and management of the day to day running of the case record review programme and is accountable to the Head of Quality Governance.

Learning from Deaths Facilitator	Responsible for day to day running of the case record review programme and is accountable to the Clinical Effectiveness Lead. This includes thematic analysis of learning and liaison with individual governance teams in directorates
Committees/Groups	
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.*
Quality Committee (QC)	Provide assurance to the Board of Directors.
Trust Executive Group (TEG)	To receive and approve quarterly Learning from Deaths Reports for review at the Trust QC.
Quality and Safety Executive Committee (QSEC)	To receive and approve quarterly Learning from Deaths Reports for review at the TEG.
Mortality Governance Group	To provide oversight and review of all Trust activities in relation to the analysis of mortality and report to QSEC/TEG and provide assurance to the QC.
Directorate/Specialty Mortality & Morbidity Meetings	To discuss individual deaths in detail to identify areas for improvement and share good practice and learning. To identify themes and escalate issues to the Mortality Governance Group.

6 Monitoring

Standard, process or issue to be monitored	Monitoring method	Monitored by	Reported to	Frequency
	Learning from Deaths report			Quarterly
Mortality Governance Group	Summary report	QSEC	QC	Bi-monthly
Structured Judgement Reviews scoring 1 or 2	Response in Datix	Mortality Governance Group	QSEC (in summary report)	As cases occur

7 Definitions

Term	Description
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.
Medical Examiner System (MES)	The MES will 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.
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.
Patient Safety Incident Investigation (PSII)	A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.
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’.
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.

8 References / standards and statutory legal requirements

See section 9.

9 Associated Trust and external documents

Trust Controlled Documents

Quality Report: Microsoft Word - STHNHSFT 2022 Quality Report-final

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

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/SuppStaffInIncidentsCompClaims.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/ngb-national-guidance-learning-from-deaths.pdf

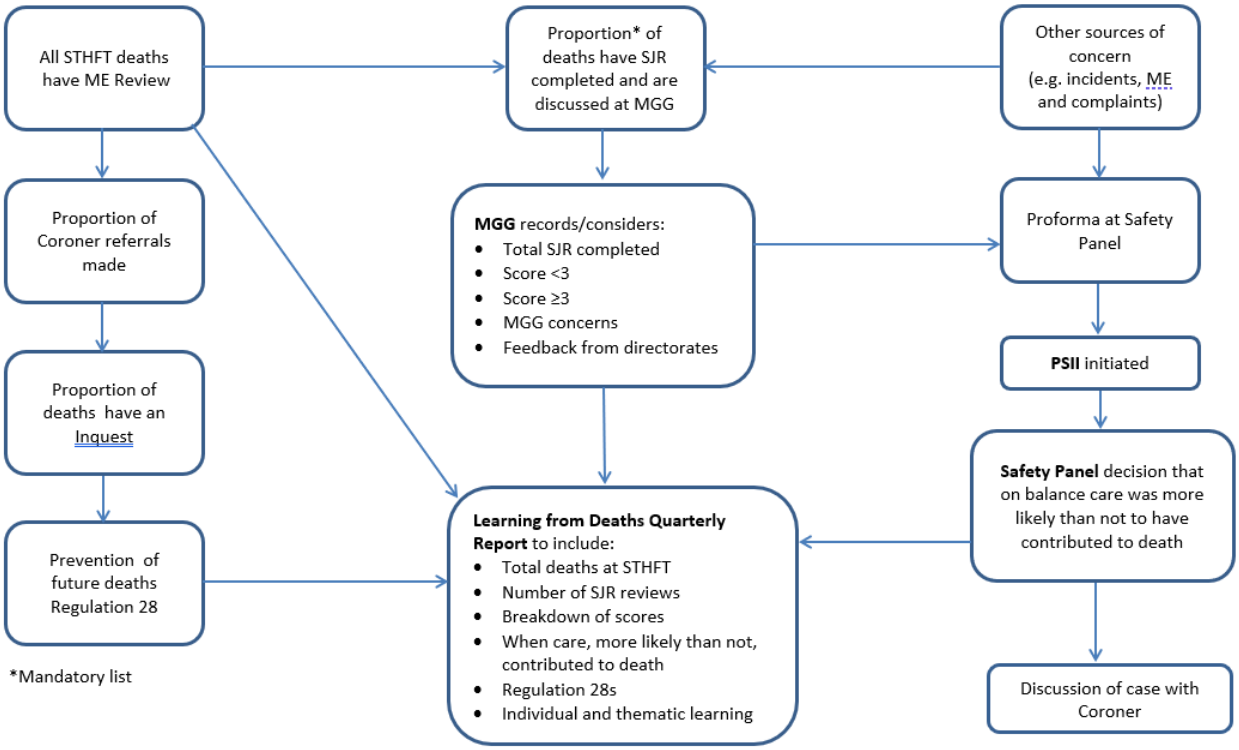
https://www.rcplondon.ac.uk/guidelines-policy/mortality-toolkit-implementing-structured-judgement- reviews-improvement

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

10 Appendices

Appendix A:

Appendix A: Deaths at Sheffield Teaching Hospitals and Learning from Deaths Quarterly Report



11 Document control

Ref	374
Version	4.0
Status	Current
TEG sponsor	Dr Jennifer Hill, Medical Director (Operations)
Controlled Document Lead / Author*	Mr Simon Buckley, deputy medical Director Janet Brain, Head of Clinical Effectiveness Rachel Honeywood, Learning from Deaths Facilitator
Approval body	Mortality Governance Group
Date approved	March 2024
Ratification body	Trust Executive Group
Date ratified	29/05/2025
Issue date	04/06/2024

Review date	31 March 2027

12 Version history

Version	Date issued	Brief summary of changes	Author
V1	11/04/2018	New Policy	David Throssell
V2	04/03/2020	Amended in response to 360 Assurance Audit	David Hughes
V3	24/03/2022	Amended in response to Serious Incident Group change of responsibility	Jennifer Hill
V4	04/06/2024	Amended in response to the introduction of PSIRF	Simon Buckley

13 Consultation and review

Groups / persons consulted	Date
Medical Examiner's Office	19/03/2024
Mortality Governance Group	19/03/2024
Trust Executive Group	31/05/2024
NHSI Guidance July 2017	

14 Intended recipients

Essential reading for	All SJR reviewers, TEG, Trust Board, CDs, NDs and ODs
Information for	All clinical staff, Mortality Governance Group, Patient Safety Manager, Medical Director, Serious Incident Group, Medical Examiner's Office

15 Rapid equality impact assessment

What relevant quantitative and qualitative information (data) do you have? This may include national or local research, surveys, reports or research; workforce / patient data; complaints and patient experience data, etc.

	Positive Impact[#]	Negative Impact[#]	Neutral Impact[#]	Advances equality of opportunity	Eliminates unlawful discrimination	Fosters good relations between people
Race (including nationality)	×	×	✓	×	×	×
Religion/belief and non-belief	×	×	✓	×	×	×
Disability	✓	×	×	×	×	×
Sex	×	×	✓	×	×	×
Gender Reassignment	×	×	✓	×	×	×
Sexual Orientation	×	×	✓	×	×	×
Age	×	×	✓	×	×	×
Pregnancy and Maternity	×	×	×	×	×	×
Marriage / Civil Partnership	×	×	✓	×	×	×
Human Rights (FREDA principles)	×	×	✓	×	×	×
Carers	×	×	✓	×	×	×
Other groups E.g. Travellers, vulnerable adults/children, homeless, care leavers, asylum seekers or refugees	×	×	✓	×	×	×

[#]Extent of impact

Positive Impact - This will actively promote or improve equality of opportunity or address unfairness or tackle discrimination

Negative Impact - This will have a negative or adverse impact which will cause disadvantage or exclusion

Neutral Impact - There is no likely impact on any of the protected groups

List any specific equality issues and information gaps that may need to be addressed through engagement and/or further research
Nationally there is a gap around information on gender reassignment.

15.1 Analysing the equality information

In this section record your assessment and analysis of the evidence. This is a key element of the EIA process as it explains how you reached your conclusions, decided on priorities, identified actions and any necessary mitigation.

Analysis of the effects and outcomes
By identifying all deaths of patients with a learning disability for SJR review and sending these for inclusion in the LeDeR process, it is intended that resultant learning will improve care for patients with learning disabilities at the Trust. Reporting of SJR data may include information on numbers of deaths reviewed of people with learning disabilities but would not routinely include data on sex or age although this is collected as part of the SJR record.

15.2 Outcome of equality impact assessment

No major change needed	Adjust Policy / proposal	Adverse impact but continue	Stop and remove policy / proposal
✓	×	×	×

15.3 Action plan

Give details of any actions required to remedy any negative impact(s) identified above:

Action to address negative impact	By whom	By when	Resource implication
None required			

15.4 Monitoring, review and publication

How will the policy be monitored?	See section 6. Monitoring
Manager signing off EIA	Date of next review
Rachel Salmon, Senior EDI Manager	Date
Approved by	Date sent to EDI Team sth.equalityanddiversity@nhs.net:

Please provide name of committee and date approved	14/05/24
	Date published (if applicable)
	Date

16 Other impacts

Financial implications	Requirement to resource the infrastructure recognised.
Training implications	Training in Structured Judgement Review (SJR) methodology undertaken by multi-professional teams as described. Training of additional Medical Examiners and Officers
Sustainability implications	None
Other	None

17 Document imprint

Policy template version 2.4