Status Active PolicyStat ID 13937648

Harrogate and District NHS Foundation Trust

Origination	01 Sep, 2017
Last Approved	01 May, 2023
Effective	01 May, 2023
Last Revised	01 May, 2023
Next Review	30 Apr, 2026
Owner	DAVID EARL: Consultant Anaesthetics
Area	CS Medical Directorate Team
Document Types	Policy

Learning from Death Policy

Version	Date	Purpose of Issue/Description of Change	Review Date
1	Sept 2017	Initial Issue	Sept 2019
1.1	June 2018	Addition of Appendix 4: Process for HDFT involvement in LeDeR Programme	
2	July 2019	Review and update	Sept 2020
2.1	Sept 2019	Additional section re: safeguarding adult reviews	
3	My 2023	Major re-write	May 2023

Status	Open
Publication Scheme	Our policies and procedures
FOI Clasification	Release without reference to author
Document Type	Policy
Key Words	Learning; Deaths; Mortality; SJR
Executive Lead	Executive Medical Director

Policy Lead	**Deputy Medical Director (Quality and Safety)**	
Author (if different from above)	**D.Earl**	
Governance Group (that will oversee effectiveness of implementation)	**Patient Safety Forum**	
Approval Body	**Senior Management Team**	**Date/s**
Review Date (Usually 3 years from approval date)		

1. PURPOSE

The vast majority of people who die under the care of the NHS have experienced excellent care in the months or years leading up to their death. In a small percentage of cases, and usually for a variety of reasons, the care provided is less good. The purpose of mortality reviews is to identify and share examples of best practice and also to identify lapses in care which can be shared widely across the NHS for collective learning.

The National Quality Board published National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care (March 2017). The aim of the framework was to standardise an approach to learning from deaths, and that learning from a review of the care provided to patients who die is integral to a provider's governance and quality improvement work. This policy outlines how that is currently done within HDFT.

2. BACKGROUND/CONTEXT

The aim of the policy is to ensure the Trust reviews and learns from the deaths of people who have died whilst an inpatient in HDFT. Although deaths in certain patient groups may automatically be selected for review, it is recognised that there is potential learning from all deaths, enabling sharing of good practice and assurance, in addition to learning and further investigation if significant care lapses were evident.

3. DEFINITIONS

Case note review/Structured Judgemental Review (SJR) : A structured scrutiny of case notes to assess the standard of care provided to the patient, focussing on specific high-risk periods and procedures such as care in the first 24 hours, care during a procedure or the presence of complications such as infections or thromboembolism.

DMD (QS): Deputy Medical Director for Quality and Safety

Patient Safety Incident Response Framework (PSIRF): The trust policy and plan on how to respond to safety incidents across the trust.

LeDeR: Learning Disability Mortality Review Program

4. POLICY EFFECT

4.1. Case Selection

Certain mortality cases should always have an SJR performed:

The patient had learning disabilities

The patient had a diagnosis of autism

Death following an elective procedure

Cases may also be selected by the following routes:

The Medical Examiner has raised concerns and suggests an SJR

Incidents raised with the DMD (QS) by the Quality Team. These may include cases identified by Datix incident reports, 48 hour reviews, Patient Experience Team communication or as part of a patient/relative complaint.

Cases with a diagnostic code which have been raised as an area of possible concern via HSMR/SHMI data

Cases with a diagnosis or treatment code where it is felt further investigation may be warranted

Random cases selected to provide assurance to individual teams

4.2. Case Review Process and Outcomes

Cases for SJR will be allocated by the DMD (QS) to individual reviewers who have been trained in SJR methodology. The reviewer may or may not be from the same specialty responsible for the case, and can even be the consultant of care where appropriate.

Where concerns about care have been identified by SJR, such cases should be presented at the relevant Quality of Care meetings/Morbidity and Mortality meetings.

Overview of all SJR findings will be performed by the DMD (QS) and form part of the quarterly "Learning from Deaths" board paper. This paper is also shared at Patient Safety Forum, and any wider learning across the organisation taken forward from that meeting.

Where the overall score for care is recorded as a 1 or 2 (very poor or poor care), or when the reviewer feels the preventability of death was greater than 50:50, a second reviewer will undertake an SJR. Usually, one of the reviewers will be the DMD (QS) or another senior clinical leader. If both reviewers agree on the lapses of care, a more in-depth investigation will be recommended to the trust, in line with the PSIRF policy.

4.3. External Reviews

All cases with identified learning disabilities will receive an external review as part to the LeDeR process.

All childhood deaths, whether expected or not, are notified to the Child Death review team under the statutory requirement of Safeguarding Children's Board.

All fetal deaths over 22 weeks gestation, together with neonatal deaths up to 28 days postnatal are notified to MBRACE-UK via the online portal. Full details are in the document titled "Standard Operating Procedure - Maternity Services Stillbirth Reviews using the PMRT (Perinatal Mortality Review Tool)". These cases will also be reported to the Healthcare Safety Investigation Branch (HSIB).

Maternal deaths are also reported to MBRACE-UK and HSIB, as detailed in the trusts' "Maternal Death Guideline"

4.4. Reporting

Sharing the data and information from these processes supports an open and honest organisational culture and excellent opportunities for learning and improvement.

The Executive Medical Director will present a "Learning form Deaths report" to the public Board every quarter. The information in the paper will include:

- Total no of inpatient deaths (including Emergency Department deaths)
- Trust mortality indices (HSMR and SHMI) and a narrative explaining any trends
- Number of deaths subject to case note review and how they were selected
- Breakdown of key SJR scores
- Themes and issues identified from review and investigation, including examples of good practice

An annual summation of this data will be published in the trust's annual Quality Report.

5. ROLES AND RESPONSIBILITIES

Trust Board: The Board is responsible for the quality of the healthcare the Trust provides. The Board has specific responsibilities for:

- Ensuring the Trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate:
- Ensuring the Trust learns from problems identified by reviews or investigations as part of a wider process that links different sources of information to provide a comprehensive picture of their care. In this context 'learning' means taking effective, sustainable action (via appropriately resourced quality improvement work) to address key issues associated with problems in care;
- Providing visible and effective leadership to support their staff to improve what they do;
- Ensuring the needs and views of patients and the public are central to how the Trust operates.

Executive Medical Director:Lead Executive with responsibility for mortality

Deputy Medical Director (Quality and Safety): Operational oversight of the Learning from Death

policy and procedures, including managing the processes around SJRs Patient Safety Forum:Reviewing the Learning from Death reports and ensuring dissemination of learning (with input from the Quality Team)

6. EQUALITY ANALYSIS


EqIA for Learning from Deaths policy.pc

7. CONSULTATION, REVIEW AND COMMUNICATION

The draft policy was reviewed at Patient Safety forum and Quality Governance and Management Group, prior to ratification by Senior Management Team (with delegated responsibility from the Trust Board)

8. STANDARDS/KEY PERFORMANCE INDICATORS

Number of SJRs performed quarterly will be reported in the Learning from Deaths quarterly report.

9. MONITORING COMPLIANCE AND EFFECTIVENESS

This section, using the template below, must include details of how compliance and effectiveness of implementation of the Policy will be monitored. This will include monitoring for any adverse impact on different groups. This should include the role of the Policy Lead and overseeing Governance Group in reviewing assurance.

Where an audit is required in order to measure compliance or effectiveness, the audit should be included in the Trust Annual Clinical Audit Programme and an audit tool should be made available.

Policy element to be monitored	Standards and Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
SJR process	Number of SJRs completed per quarter	Data collected by DMD (Q&S)	Patient Safety Forum/ Trust Board	Quarterly	DMD (Q&S)	Patient Safety Forum

10. REFERENCES/ASSOCIATED DOCUMENTATION

National Guidance on Learning from Deaths. National Quality Board 2017

Annex 1: Consultation Summary

Those listed opposite have been consulted and any comments/actions incorporated as appropriate. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	**List Groups and/or Individuals Consulted** **Patient Safety Forum** **Quality Governance and Management Group**

Executive Lead	Executive Medical Director
Governance Group (that will oversee effectiveness of implementation)	Patient Safety Forum

Approval Signatures

Step Description	Approver	Date