# Policy for responding to and learning from the death of a patient

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## Contribution List

Key individuals involved in developing this version of the document

| Name | Designation |
|---|---|
| Dr Anna Wood | Director Clinical Governance |
| Senior Clinicians | Level 2 mortality SJR group members |
| Michelle Hope | Associate Chief Nurse Quality Assurance |
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## Change of History

| Version | Date | Author | Reason for change |
|---|---|---|---|
| 1 | June 2017 | Dr. Anna Wood | New Policy with a 1 year formal review date agreed. |
| 2 | July 2018 | Dr. Anna Wood | Formal review as agreed and next review in 2 years |
| 3 | December 2021 | Dr. Anna Wood | Routine Updated Policy with a 3 year formal review date agreed. |

## Abbreviations and Acronyms

| Abbreviations and Acronyms | Description |
|---|---|
| MDT | Multidisciplinary Team |
| PGRG | Policy & Guideline Review Group |
| QSG | Quality & Safety Group |
| | |

**Contents**

## 1. Introduction

The Care Quality Commission (CQC) published a report, ***Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*** in December 2016 recommending that there should be a standardised approach to learning from deaths across the NHS. In response to this report the National Quality Board (NQB) published the new ***Learning from Deaths Framework*** in March 2017.

This is a revised Trust policy which was previously written to reflect the recommendations within the Framework and to set out how the Trust responds to and learns from the deaths of patients in our care. The trust's number one objective is to provide the best quality care and it is important that we review the care provided to people who have died which can help improve care for all patients by identifying problems associated with poor outcomes,and working to understand how and why these occur so that meaningful action can be taken. The revision reflects the key role which the Medical Examiner department undertakes within the SJR framework by the identification of cases for review.

This policy has been written considering the publication on ***Implementing the Learning from Deaths framework: key requirements for trust boards*** (NHS Improvement, July 2017) and sets out clearly how staff, patients, families and others can raise questions or concerns about the policy and how it is implemented.

## 2. Objectives

The purpose of this policy is to set out:

- The Trust's case record review process, including the methodology used and how potential review is determined.
- How the Trust responds to the death of someone with a learning disability or mental health needs, an infant or child, a stillbirth or maternal death.
- How the Trust decides which deaths, whether reviewed or not, require an investigation under the serious incident framework.
- How the Trust engages with bereaved families and carers, including how they are supported by the Trust and involved in investigations where relevant.
- How the Trust will promote learning from following the Framework.

## 3. Definitions

**Case record *review*:**

The application of a case notes review to determine whether there were any problems in the care provided to the patient who died using validated methodology such as Structured Judgement Review (SJR).

**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.

**Serious Incident:**

An incident that occurred in relation to NHS-funded services and care resulting in:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life -saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the National Patient Safety Agency definition of severe harm);
- Allegations of abuse/ neglect (safeguarding)
- One of the core set of ‘'Never Events"

- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure
- Adverse media coverage or public concern about the organisation or the wider NHS
- An incident which is considered to have considerable learning potential for the entire Trust.

**Death due to a problem in care:**

A death that has been clinically assessed with appropriate methodology and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

## 4. Scope

This policy applies to all our staff, whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trusts behalf.

## 5. Responsibilities

**Trust Board:**

Will have regular oversight of potentially avoidable deaths and learning from them, with responsibility for this being attributed to a named non-executive director and a named executive director (the medical director).

**Quality Committee:**

Will, as a sub-committee of the Board be responsible for overseeing the Learning from Deaths Framework, seeking assurance from the Quality and Safety Group (QSG) that the processes in place to learn from deaths are being adhered to.

**Quality and Safety Group (QSG):**

Will review and monitor information provided by the Divisional reports and ensure that there are robust plans in place to address issues identified through the key themes and trends identified from the case record reviews.

**Level 2 Mortality SJR group:**

Will provide information to the serious Incident panel in the first instance and then QSG on potentially avoidable deaths identified from case record review and learning from them, as well as highlighting any identified themes.

**Clinical Divisions:**

Will identify and conduct selected case record reviews as set out in this policy and provide requisite information to QSG by regular reports.

## 6. Procedure for responding to and learning from deaths

### 6.1 First stage review and process

**Selection of cases**

Identification of deaths for review may occur in 4 ways

1) Trust Medical Examiners are the most frequent source of identification of cases for review and this occurs immediately after death.
2) Specialities may identify cases at monthly Morbidity and Mortality meetings.
3) Ward and department level when raised as an incident.
4) The serious incident panel may refer a case for SJR if felt helpful in addition to the serious incident investigation.

Selection for case record review, as a minimum, should include those patients who have died in the month preceding the review and when the following criteria are fulfilled:

- When clinicians and/ or Medical Examiners are aware of suboptimal care
- Some cases of unexpected deaths
- Some cases which have been declared as a Serious Incident
- Those in whom a concern or complaint has been raised by the family about the care
- Patients with learning disabilities
- Patients with mental health problems
- All maternal deaths
- All neonatal and paediatric deaths
- All elective surgical patients and selected acute surgical patients
- SJR of cases after referral to the coroner if deemed appropriate by the medical examiner.
- A review of SJR should occur following any inquest and issue of a 'Regulation 28 Report on Action to Prevent Future Deaths' for quality assurance

**Number of Cases**

The absolute number or percentage of deaths for review is not stipulated, but as a minimum, the above criteria should be fulfilled. There may be other categories which may arise for example, a mortality outlier for a particular group of patients identified through mortality alerts or via the CQC, which should also undergo case note review.

Our objective should be appropriate selection, quality of review and not quantity.

### 6.2 Structured Judgement Review

The Trust will use the *structured judgement review (SJR)* method to analyse and document overall care scores.

There are trained Consultant SJR reviewers across all the Divisions and cases are allocated to them by the corporate governance team.

Cases requiring SJR will be allocated to a clinician (from a hospital pool trained in this methodology), who have not been involved in the patient's care.

The output of SJR is an overall care score as below:

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

### 6.3 Second stage review and process

Second stage review occurs within the hospital Governance team called the level 2 SJR mortality group and if the first stage overall care review has been scored 1 or 2.

#### 6.3.1 6 Point Scale

The purpose of the second stage review is to judge the level of avoidability of a death on a 6 point scale of a death as follows:

1 Definitely avoidable
2 Strong evidence of avoidability
3 Probably avoidable (more than 50:50)
4 Possibly avoidable, but not very likely (less than 50:50)
5 Slight evidence of avoidability
6 Definitely not avoidable

Those with an avoidability score of 1,2 and 3 are referred to the Serious Incident Panel and also sent to the responsible team for comments as well as to the Medical Examiner who has referred the case and the SJR reviewer.

The completed SJR irrespective of overall care score score is distributed to the Divisions and collated in a regular governance report for QSG.

Completed SJR's are not routinely sent to family members (as the purpose of SJR is for trust learning and not structured to answer complaints) but in exceptional circumstances, an SJR is shared with a family member after request and authorisation by the Clinical Director for Governance.

Completed SJR's are released to the Coroner at request and after authorisation by the Clinical Director for Governance but not routinely.

Completed SJR's are released to the Ombudsman at request.

## 7. Governance Framework

The Trust governance framework for mortality will remain as before which is that the outcomes of the reviews will be examined at Quality and Safety Group as well as at Quality Committee and Board. Those scoring 1 or 2 from second stage review will be considered as potential Serious Incidents and follow the Trust process of Root Cause Analysis Investigation including discharge of duty of candour.

The Board will have sight of this Policy and approach taken to responding to the death of patients, numbers considered potentially avoidable, the learning from this and any areas of concern by way of a quarterly standing agenda item and dashboard on board papers.

The potentially avoidable mortality data is published externally in the quality accounts on a quarterly basis.

## 8. Learning

Learning from the reviews will follow the same pathway as other aspects of learning from serious incidents and complaints which is by Divisional governance half days and newsletters. The themes will be analysed and articulated in the quarterly Trust Learning from Deaths paper which follows the governance route as above, from Quality and Safety Group to Quality Committee and then the Trust Board.

## 9. Cases involving multiple providers

If a patient has been managed by more than one acute provider there will be appropriate communication between the providers to ensure that any need for SJR or further investigation is coordinated. It may be appropriate in certain cases to commission an investigation by the Healthcare Safety Investigation Branch.

The Trust will consider SJR of case records of any patient which another provider considers our trust may be able to provide useful information regarding even if the care was not recent and even if the patient did not die in our care.

## 10. Responding to the death of someone with a learning disability, an infant or child or a still birth or maternal death

### 10.1 Learning Disability

The Trust uses SJR to review the care of individuals with learning disabilities. All patients with learning disabilities are identifiable on admission from their care record and trust systems and are therefore readily identifiable in the event of their death. Case notes of Patients with learning disabilities will be reviewed by the Trust named Safeguarding Consultant Lead by SJR methodology and the Safeguarding Team will notify and send SJR reports externally to the LeDer programme.

### 10.2 Infant or child under 18

Reviews of infants or a child under the age of 18 will be mandated in line with existing requirements set out in Working together to safeguard children guidance. The Department for Education **Form B** will be used for these deaths.
The Trust's Sudden Unexpected death in Infancy guideline (SUDI) and Sudden Unexpected Death in the older Teenager (SUDOT) must be adhered to.

### 10.3 Perinatal or Maternal Death

All perinatal deaths will be reviewed, using the perinatal mortality review tool and by a multidisciplinary panel including obstetricians, neonatologists, midwives and an external reviewer as per MBRRACE guidelines. The parents are invited to contribute and raise any concerns or questions they may have.

All perinatal cases have a rapid review (CIRG) and taken to Serious Incident Panel and if any care or service delivery issues are identified then an investigation will be undertaken – the level of the investigation to be determined by the SI Panel, not all of these will meet the definition of a serious incident (SI).

Maternal deaths meet the definition of a serious incident (SI) and will be investigated accordingly by HSIB (Healthcare Safety Investigation Branch) – an independent national body. If a family declines a HSIB investigation, then the hospital will investigate as an SI with the involvement of an external expert.

### 10.4 Serious Incident Investigations

The Trust has an Incident and Serious Incidents Policy. The policy is published on the intranet and defines what constitutes a Serious Incident along with the reporting and investigation processes for Serious Incidents (Sis).
In reference to this Learning from Deaths Policy all mortality reviews scoring 1 and 2 from the second stage review must be submitted for consideration to the Serious Incident panel.
If it is agreed that the incident is to be declared a Serious Incident the required response will be an effective root cause analysis investigation involving patients, families and others to the extent they wish to be, focused on learning why things

went wrong and identifying effective and sustainable changes to reduce the risk of recurrence. Serious incident investigations are not undertaken to hold individuals or organisations to account or to determine the cause of death.

If a patient's death is investigated immediately under the serious incident framework, a SJR will also be carried out if considered a helpful adjunct. (section 6.3.1 of this policy)

### 10.5 Bereaved Families and Carers

The Trust will ensure that any family concerns after a relative has died are taken seriously and dealt with promptly, sensitively and appropriately. Families will be considered as partners in respect to concerns and any subsequent investigations.

Family members should be informed immediately after the death.

Bereaved families and carers will be informed of their right to raise concerns about the quality of care provided. Trained staff in the Patient Affairs Office will enquire if the family has any concerns regarding the care provided and will sign post them to the relevant information provided within the Trust Bereavement booklet. The relevant paragraph states the following: *If you have any questions or would like to raise concerns about the quality of care received by your loved one in the lead up to, or at the time of their death, please contact the Patient Advice and Liaison Service, who are there to support and assist you with any concerns you may have. If you have any suggestions or compliments regarding the care provided to your loved one, the Patient Advice and Liaison Service would welcome the feedback.* If a concern is raised the response thereafter will be timely and coordinated by named individuals.

Any such concern raised by a family member will be followed by a letter from the Trust confirming the communication and subsequent action taken which may range from a phone call, setting up of a meeting, SJR to formal investigation according to SI framework.

The family member may ask to voice concern or just seek assurance to unanswered questions with a Medical Examiner and the outcome of this may be no further action or signposting to the relevant department or PALS.

If the outcome of the concern is SJR and/ or investigation then the family will be involved and their input outlined in the terms of reference as per current Trust practice.

If permission for a hospital post-mortem has been granted there must be an appropriate date set with the family to discuss the results and should be organised from the Bereavement Office at the time of request with the consultant.

The deceased person's General Practitioner (GP) will be informed of the death and provided with details as stated on the death certificate at the same time as the family. This will occur by electronic patient summary completed by the hospital doctor after death certification and in the Bereavement office. The GP will be informed of the outcome of any investigation.

The Trust will provide a bereavement service which encompasses support, information, guidance and signposting e.g. Specific bereavement counselling
The Trust will, if appropriate guide the family if there are requests for legal support

## 11. Monitoring & Compliance

| | | | |
|---|---|---|---|
| 1 | Following local and national policies and guidelines, what key elements require monitoring? | List elements to be monitored | a. Documented family concerns in terms of timeliness of response and outcome<br>b. The cases selected for SJR are appropriate selection according to policy |
| 2 | Who will lead/be accountable for monitoring? | Lead title and/or MDT | a. Head of Complaints, PALS and legal services<br>b. SJR clinical Lead |
| 3 | Describe how the key elements will be monitored? | List tools to evidence compliance | a. Audit<br>b. Constant Data capture |
| 4 | How frequently will each element be monitored? | List frequency of monitoring for each element | a. Annual<br>b. Monthly |
| 5 | Explain the protocols for escalation in the event of problems? | List the processes of escalation | a. Escalation to Associate Chief Nurse for Quality Assurance and then the Director of Clinical Governance |
| 6 | Which Committee/ Panel/ Group will reports go to? | List the Committee/Panel/ Group/Peer Review that the reports will go to | a. Quality Committee<br>b. Level 2 SJR Mortality meeting |
| 7 | Explain how the policy/guideline will be disseminated within the Trust? | List ways identifying how this document will be shared and how it will be recorded that appropriate staff have been made aware of the document and where to find it | a. By presentation at QSG which has representatives from all Divisions and at Quality Committee which has a broader representation from senior members of the Trust and by documentation in the minutes of both meetings. |

## 12. Safeguarding

This policy has direct links to the following Trust policies:

- Safeguarding adults from abuse (June 2021)
- Safeguarding children, young people and unborn babies (June 2021)

There is complimentary policy overlap with focus on the prevention of organisational failings leading to poor and unsatisfactory practice and subsequently to avoidable death, harm, or avoidable complications. There is particular focus on the most vulnerable patients, including those with learning difficulties, infants and children.

## 13. Patient & Carer Involvement

Reference any group/individual patient/carer involvement in developing this document

## 14. References


- CQC (December 2016) *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* *https://www.cqc.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf*
- National Quality Board (March 2017) *National Guidance on Learning from Deaths* https://www.england.nhs.uk/wp-content/uploads/2017/03.ngb-national-guidance-learning-from-deaths.pdf
- NHS Improvement (July 2017) *Implementing the Learning from Deaths Framework: key requirements for trust boards* https://improvement.nhs.uk/uploads
- Learning from deaths dashboard https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance
- The duty of candour: guidance for providers
- https://www.cqc.org.uk/news/stories/updated-guidance-meeting-duty-candour
- https://www.cqc.org.uk/sites/default/files/20210421%20The%20duty%20of%20candour%20-%20guidance%20for%20providers.pdf


## 15. Related Policies and Guidelines

- Incident and serious incidents policy (WHHT: G004)
- Safeguarding children, young people and unborn babies (WHHT: C301)
- Safeguarding adults from abuse (WHHT: C200)

## 16. Equality Impact Statement (EIA)

What is an equality impact assessment?

There are many benefits in conducting an equality impact assessment (EIA) prior to making business decisions about policies, clinical guidelines or any other work that may potentially impact on a wide range of people with protected characteristics. Equality impact assessments should not be seen as an afterthought once decisions have already been made.

Benefits:
- Improved capacity to consider equality, diversity and inclusion as part of business management
- Reduced costs as a result of not having to revisit a policy/project
- Take into account a diverse range of views and needs
- Enhanced reputation as a Trust that is seen to understand and respond positively and proactively to diversity.

Whatever approach you take to an equality impact assessment, case law has established that you should keep an accurate, dated, written record of the steps you have taken to analyse the impact on equality. This will help you to check whether you are complying with the duty and it will be useful if your decisions are challenged.

When completing an equality impact assessment you should consider:
- Treating a person worse than someone else because of a protected characteristic (known as direct discrimination)
- Putting in place a rule or way of doing things that has a worse impact on someone with a protected characteristic than someone without one, when this cannot be objectively justified (known as indirect discrimination)
- Treating a disabled person unfavourably because of something connected with their disability when this cannot be justified (known as discrimination arising from disability)
- Failing to make reasonable adjustments for disabled people.

**Equality impact assessment process**
Stage 1 (Screening)

This stage provides an opportunity to explore whether the policy decision may have a negative, neutral or positive impact on different groups of people.

- If yes, use the ‘comments’ column to describe what this impact could be.

- If no, outline how have you arrived at this conclusion.

- If unsure use the ‘comments’ column to describe what you need to do to find out.

Stage 2 (Full Assessment)
This should be carried out in compliance with policy HR028 Equality & Human Rights Policy.

| Does this policy/guideline affect one group less or more favourably than another on the basis of: | | | | |
|---|---|---|---|---|
| | | | | Comments |
| 1 | Age<br>(younger people & children& older people) | | no | |
| 2 | Gender<br>(men & women) | | no | |
| 3 | Race<br>(include gypsies and travellers) | | no | |
| 4 | Disability<br>(LD, hearing/visual impairment, physical disability, mental illness) | yes | | These groups are specifically selected for case note review but that is positive because there is historical context and evidence that there was previously insufficient scrutiny |
| 5 | Religion/Belief | | no | |
| 6 | Sexual Orientation<br>(Gay, Lesbian, Bisexual) | | no | |
| 7 | Gender Re-assignment | | no | |
| 8 | Marriage & Civil Partnership | | no | |
| 9 | Pregnancy & Maternity | | no | |
| | Is there any evidence that some groups maybe affected differently? | | no | |
| | Could this document have an impact on other groups not covered by a protected characteristic? (e.g.: low wage earners or carers) | | no | |
| | If '**NO IMPACT'** is identified for any of the above protected characteristics then no further action is required. | | | |
| | If '**YES IMPACT**' is identified a full impact assessment should be carried out in compliance with HR028 Equality & Human Rights Policy and linked to this document | | | |

| **Any other comments:** |
|---|
| *Please use this box to add any additional comments relevant to the assessment* |

| Assessment completed by: | *Dr Anna Wood* | Date completed: | 13/12/2021 |
|---|---|---|---|

If you have any queries or concerns about completing the EIA form, contact the Trust's Inclusion & Diversity Team at WestHerts.Inclusion@nhs.net