James Paget University Hospitals NHS Foundation Trust

Learning from Deaths Policy

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Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document: Head of Clinical Effectiveness and Compliance, Chief Medical Officer, Deputy Chief Medical Officer

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

The following acronyms have been used within this document:

Abbreviation	Definition
CDOP	Child Death Overview Panel
CEG	Clinical Effectiveness Group
CMO	Chief Medical Officer
CMRG	Clinical Mortality Review Group
CQC	Care Quality Commission
DCMO	Deputy Chief Medical Officer
DMD	Divisional Medical Director
ENS	Early Notification Scheme
HSIB	Healthcare Safety Investigation Branch
JPUH	James Paget University Hospital NHS Foundation Trust
LeDeR	Learning Disabilities Review programme
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
ME	Medical Examiner
M&M	Mortality and Morbidity meeting
MSG	Mortality Surveillance Group
NHS	National Health Service
NQB	National Quality Board
PMRT	Perinatal Mortality Review Tool
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PSQ	Patient Safety and Quality Committee
SJR	Structured Judgement Review

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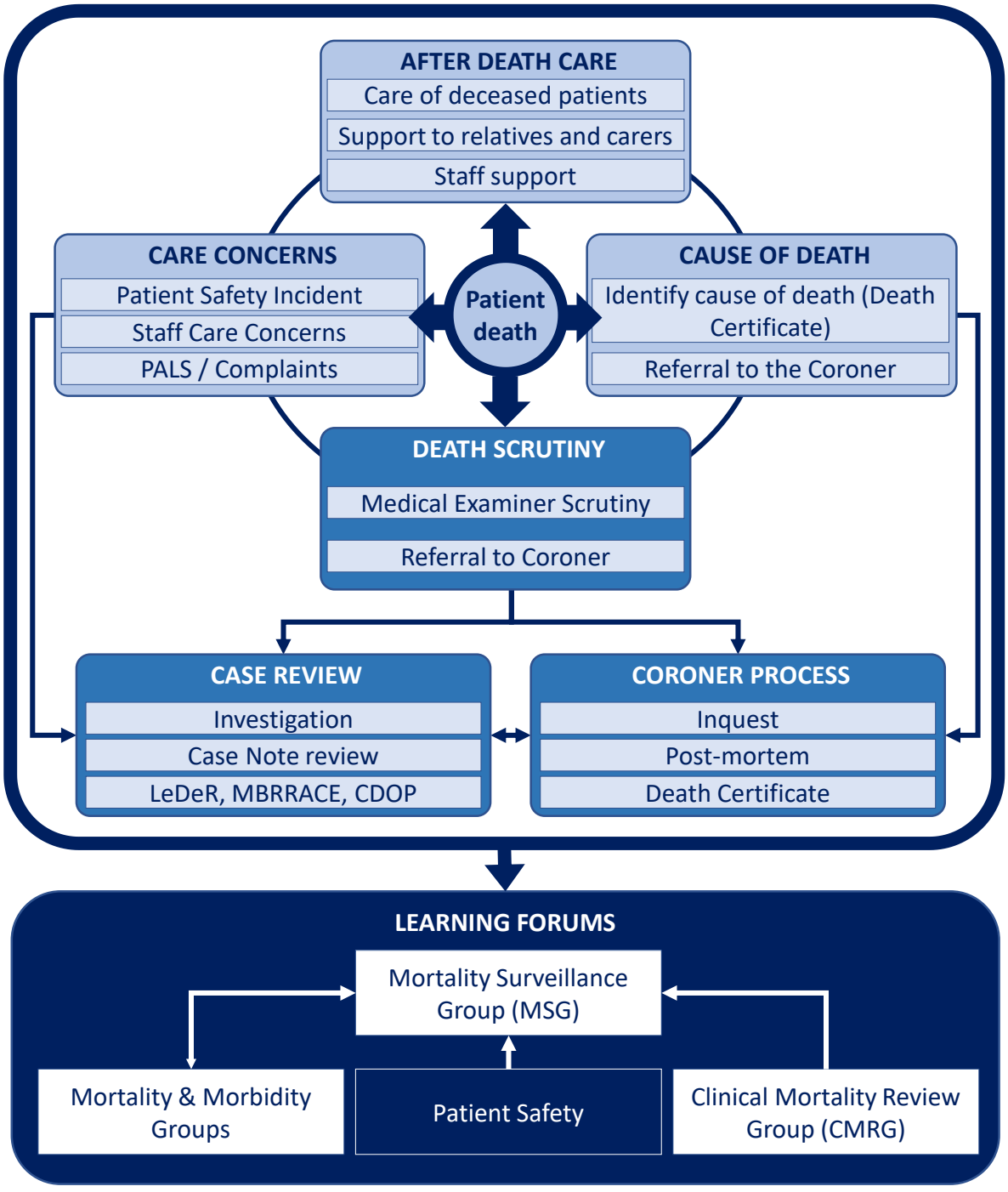
Quick reference: Learning from Deaths Process



1. Introduction

1.1. Rationale

The James Paget University Hospital (JPUH) puts patients, families, and carers at the centre of everything we do. Reviewing the care of patients who died can help to improve the care for all patients by identifying problems associated with poor outcomes, and working to understand how and why these occur so meaningful action can be taken.

The Care Quality Commission's report 'Learning, candour and accountability' (December 2016)[1] stated that "there is a real opportunity for the NHS to become world leaders in the way learning and investigations are completed and changes are made when a person dies". In 2017, the National Quality Board published a framework for learning from deaths titles 'National Guidance on Learning from Deaths'.[2]

This policy sets how the JPUH implements the Learning from Deaths framework, from visible and effective Board leadership to the ability of staff, patients, and families to raise questions or concerns. The policy benefits from close collaboration with the Medical Examiner, who the JPUH hosts following creation of this role by the Coroner's and Justice Act 2009[3].

1.2. Objective

The objective of the policy is to set out effective processes and systems to enable:

- The identification, review, investigation and reporting of patient deaths.
- Learning from the death of patients in the care of the Trust.
- Internal and external sharing of good practice and learning following the death of a patient.
- Providing support to bereaved relatives and carers following the death of a loved one.
- Providing support to staff who may have been affected by the death of a patient.

1.3. Scope

This policy applies to all 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 trust's behalf.

[1] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2021%2F07%2F170921-Template-Learning-from-Deaths-policy-final.docx&wdOrigin=BROWSELINK

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

[3] https://www.legislation.gov.uk/ukpga/2009/25/contents

1.4. **Glossary**

Term	Definition
Case Review	A structured desktop review of a case record carried out by clinicians, to determine whether there were any problems in the care provided to a patient. A care record review is undertaken routinely to learn and improve in the absence of any 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 when bereaved families or staff raise concerns about the care provided.
Death Certification	The process of certifying, recording and registering death, the causes of death and any concerns about the care provide. This process includes identifying death for referral to the coroner.
Death due to a problem in care or service delivery	A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery and/or service provision. This is not a legal term and is not the same as the 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'.
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 observations, 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, 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.
Mortality Review	A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems that may need action to improve care within a setting or for a particular group of patients.
Patient Safety Incident	A patient safety incident is any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS care.
Quality Improvement	A systematic approach to achieving better patients' outcomes and system performance by using defined change methodologies and strategies to alter provider behaviours, systems, processes and/or structures.

2. Responsibilities

2.1. Trust Board

The Board must:

- Ensure effective governance structures are in place to understand and monitor the Trust's practice and performance (including risks, issues and concerns) in relation to the management of patient deaths and the learning derived from them.
- Ensure compliance with this policy and that the policy is fully aligned with all relevant Guidelines (e.g. NQB guidance on Learning from Deaths).
- Assign responsibility to a nominated lead Non-Executive Director who has oversight on mortality and acts as a 'critical friend' holding the Trust to account for its learning form deaths approach.
- Assign responsibility for learning from deaths to a nominated Executive Director (Chief Medical Officer).
- Ensure that robust systems and processes are in place for identifying, recording, reviewing, investigating and reporting on deaths.
- Ensure that systems are in place for the engagement and support of bereaved families, carers and friends of deceased patients.
- Champion and support learning that leads to effective and meaningful actions to continuously improve the quality of care, patient safety and patient experience.
- Ensure that lessons learnt will be shared internally and externally with system partners to improve the quality care to patients living within Norfolk and Waveney.

2.2. Non-Executive Directors

The board nominates a lead Non-Executive Director, whose key responsibilities are to:

- Ensure processes focus on learning and can withstand external scrutiny, by providing 'check and challenge' as well as support to clinical colleagues.
- Provide independent scrutiny and challenge to ensure actions identified from patients who die in our care are implemented and improvements in quality of care are made in a timely manner.

2.3. Chief Medical Officer (CMO)

The CMO is the Board level nominated Executive Director with responsibility and remit for learning from deaths. The CMO must:

- Provides assurance to the Board that there are effective arrangements for learning from deaths.
- Present a quarterly mortality update report to the Patient Safety and Quality Committee and an annual report to the Trust Board.
- Ensures there are clear systems and processes to identifying, recording, reviewing, investigating and reporting deaths in a timely manner.
- Ensure there is a robust system for monitoring the timely and effective implementation of learning actions to improve the quality of care to patients at the Trust.

- Ensure good practice, key trends, themes and quality improvements are shared with other system partners.

2.4. **Patient Safety and Quality Committee (PSQ)**

PSQ is a Committee of the Trust's Board. The main responsibility of this Committee is to obtain assurance on behalf of the Board that the systems in place for the management and learning from deaths, including the Trust policy, are effective and consistently applied.

2.5. **Clinical Effectiveness Group (CEG)**

The key responsibilities of this group are listed below. Further detail is included in its Terms of Reference.

- To provide check, challenge, and scrutiny of the published mortality information, including cross-specialty and cross-divisional issues relating to mortality data presented to the CMO.
- To gain assurance that reviews/investigation output action plans are being monitored (where relevant) to improve the quality of care to our patients.
- To provide assurance to the PSQ Committee and the Board

2.6. **Mortality Surveillance Group (MSG)**

The detail of the aims of this group and its operation are included in its Terms of Reference. The key responsibilities of this group are listed below:

- Chaired by the Deputy Chief Medical Officer, this group leads on operational compliance with this policy.
- Responds to external and internal mortality trends by the regular review and scrutiny of the mortality data being presented to it monthly.
- Responds to alerts and statistical flags by commissioning pathway reviews/CQC format, monitoring outcomes and scheduling further reviews or re-audits. The purpose of this is to prevent avoidable deaths and reduce mortality rates.
- Ensures Trust wide learning from mortality reviews and investigation through various stakeholder events e.g. Grand Rounds, FY1 and FY2 mandatory training etc.
- Provides assurance to CEG about mortality outcomes and trends using the agreed reporting framework.

2.7. **Deputy Chief Medical Officer (DCMO)**

The responsibilities of the DCMO in relation to this policy are listed below:

- Chairing the MSG.
- Supporting the CMO in all responsibilities associated with the management of patient deaths and learning processes associated.
- Reporting relevant mortality and learning from deaths information to CEG.
- Considering and approving the need for additional mortality reviews based on identified risks, issues or concerns identified by the analysis of mortality data or requested by specific departments (e.g. patient safety).

- Supporting the effective and timely completion of mortality reviews.

2.8. **Clinical Mortality Review Group (CMRG)**

All details about this group are included in its Terms of Reference. Key highlights of the group are listed below:

- Chaired by the Trust's Clinical Mortality Lead.
- Consolidates and triangulates information from multiple sources to create learning.
- Ensures that learning is embedded within the organisation.
- Check and challenge case note reviews and investigation reports meeting the agreed criteria for learning from deaths.
- Provides regular progress reports and decision log to the MSG for assurance to demonstrate improvements in the quality of care are being made following case reviews or investigations.

2.9. **Clinical Mortality Lead**

The key responsibilities in relation to this policy are listed below:

- Support the CMO to strengthen and embed a culture of learning from all deaths with the purpose of preventing all avoidable deaths and reduce mortality rates.
- Liaise with specialty mortality groups and clinical staff of all disciplines as appropriate.
- Manage the Structured Judgement Review (SJR) process.
- Provide training and advice to colleagues involved with the Structured Judgement Review (SJR) and investigation process.
- Support the effective and timely completion of mortality reviews.

2.10. **Departmental Mortality and Morbidity Meetings**

The key highlights of these meetings are listed below:

- Chaired by the Clinical Lead for each specialty.
- Identifying and sharing relevant learning.
- Report learning to the MSG.

2.11. **Chief Nurse**

The general responsibilities in relation to the Learning from Deaths policy are listed below:

- Provide leadership support to the CMO to strengthen and embed a culture for learning from deaths.
- Actively encourage nursing, midwifery and Allied Health Professionals (AHPs) colleagues to be an integrated part of any review and investigation process following a death of a patient.

2.12. **Medical Examiner**

The main function of the Medical Examiner service in this policy is described below:

- The Medical Examiners screen all deaths and identify opportunities for learning that may not have otherwise met the SJR criteria.
- Work with medical colleagues to improve the accuracy of the information recorded on death certificates.
- Work with local Coroners to ensure consistency of referral.
- Works with the bereavement team to speak with families, carers and friends as part of the scrutiny process, to help them understand the cause of death and identify any concerns they may have.
- Administer the notification of death process, meeting the criteria within the Trust's incident reporting system (QSAFE) to ensure all deaths are reported within 24 hours and entered onto the mortality register.

2.13. **Head of Midwifery**

The Head of Midwifery is responsible to ensure the following processes are in place and effectively applied:

- Ensures the Trust follows the incident review and investigation processes in the event of a maternal or perinatal death.
- All Maternal and Neonatal Deaths are to MBRRACE.
- Patient safety incidents that meet the reported criteria are reported to the Healthcare Safety Investigation Branch (HSIB).
- Perinatal Mortality Review Tool (PMRT) is utilised in the review of all mortality cases from 22 weeks gestation until 28 days postnatal. Parents should be invited to attend this review along with external reviewers.
- Patient safety incidents that are eligible are reported to the NHS Resolution, Early Notification Scheme (ENS).

2.14. **Named Doctor for Safeguarding and Child Death Overview Panel**

The key responsibilities under this policy are listed below:

- Ensures that the Trust complies with the statutory requirements in case of death of a child as set out in 'Working together to safeguard Children' (2023)[4].

2.15. **Learning Disability/Mental Health Lead**

- The Learning Disability/Mental Health Lead is responsible for the identification of Mental Health or Learning Disability deaths and ensuring compliance with the National LeDeR programme.

[4] https://assets.publishing.service.gov.uk/media/65cb4349a7ded0000c79e4e1/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf

2.16. **Divisional Medical Directors**

The key responsibilities under this policy are listed below:

- The Divisional Medical Directors will collaborate with the Trust's Clinical Mortality Lead and Medical Examiners to meet the requirements of this policy.
- Present, share and discuss Learning from Deaths at speciality and divisional governance meetings.
- Receive feedback and learning points from the MSG and ensure learning outcomes and action points are included in the specialty governance audit plans as appropriate.

2.17. **Head of Clinical Effectiveness and Compliance**

The list below includes the key responsibilities of this role:

- Support the CMO with embedding this policy.
- Monitoring intelligence from learning opportunities such as patient safety incidents and share these with the MSG for information, discussion and agreed actions to improve the quality of care.
- Adding identified risks from the reviews or investigations onto the Trust's Risk Register via the MSG where these risks will be monitored and reviewed as part of the risk management process.
- Ensure external mortality alerts are investigated and any associated concerns are resolved or raised at the monthly MSG.
- Provide formal reports in line with the agreed framework.
- Ensure any actions identified in relation to mortality reviews are recorded, progressed and monitored appropriately.

2.18. **Mortality Administrator**

The Mortality Administrator function is undertaken by colleagues within the Clinical Effectiveness and Compliance department. The key responsibilities of this role are listed below:

- Provide administrative support to the Mortality Surveillance Group (MSG) and the Clinical Mortality Review Group (CMRG).
- Administer the relevant documentation to support the mortality review and investigation processes.
- Add all of the deaths selected for review onto the Trust's Mortality Register.
- Manage the process for requesting, monitoring and escalating Structured Judgement Reviews.
- Contribute to regular mortality reports.
- Support and monitor the timely investigation of mortality alerts, reporting delays and or barriers to the Clinical Mortality Lead.
- Report to the LeDer programme all relevant cases.

2.19. **Divisional Governance**

The key responsibilities of the triumvirate team for each division are as follows:

- Establish an effective governance process for receiving regular mortality reports and ensuring that learning is captured, and improvement actions progressed.
- Support all staff to speak openly and raise any concerns regarding the care of someone who has died.
- Promote an enabling culture for learning from deaths by training and supporting staff to positively communicate with the bereaved and, where necessary, take timely effective action to address any specific concerns/complaints.
- Disseminate this policy to new starters and making sure all staff know of and positively support the Trust commitment to learn from deaths.
- Enable people, including staff to contribute to a review when this is indicated.
- Ensure the findings from mortality review are reported and discussed as part of the divisional clinical governance process.

2.20. **Head of Analytics**

Key responsibilities under this policy for the role include:

- Analyse and report on related mortality data to enable MSG to monitor trends and identify areas for further investigation.
- Map monthly patient level data against the mortality indicators and ensure that possible flags or statistical alerts are reported to the MSG.
- Prepare reports to meet the requirements of Divisions, CEG, PSQ Committee, Trust Board and Commissioners.
- Ensure the Clinical Coding Engagement Lead is an active participant in developing the relationship between clinical coders and clinical staff as well as leading on training as required.

2.21. **Patient Safety Team**

The responsibilities of the Patient Safety Team are the following:

- Maintain and manage the Trust's incident reporting system (QSAFE).
- Provide continuous training, support, and communication to staff on the principles of good mortality governance.
- Ensure that deaths are reported onto QSAFE within 24 hours if a concern about quality of care is raised by staff members or families and follow the Patient Safety Incident Response Framework (PSIRF) protocol for such deaths.
- For deaths associated with a safety incident, ensure that bereaved relatives and carers are part of the resulting investigation.
- Support and manage the notification of relevant deaths to the regulator or other organisations.

2.22. **Mortuary Service Manager**

The key responsibilities of this role under the Learning from Deaths policy are listed below:

- Provide all of the information for bereaved relatives and families following a death of a loved one in our care.
- Work collaboratively with the Medical Examiner to enable proper scrutiny and communication with staff members and bereaved families.

3. Processes to be followed

3.1. Overview

Several JPUH processes take part in the system to extract learning from each individual patient death. This figure illustrates the systems in place for the management and learning from deaths in the Trust.

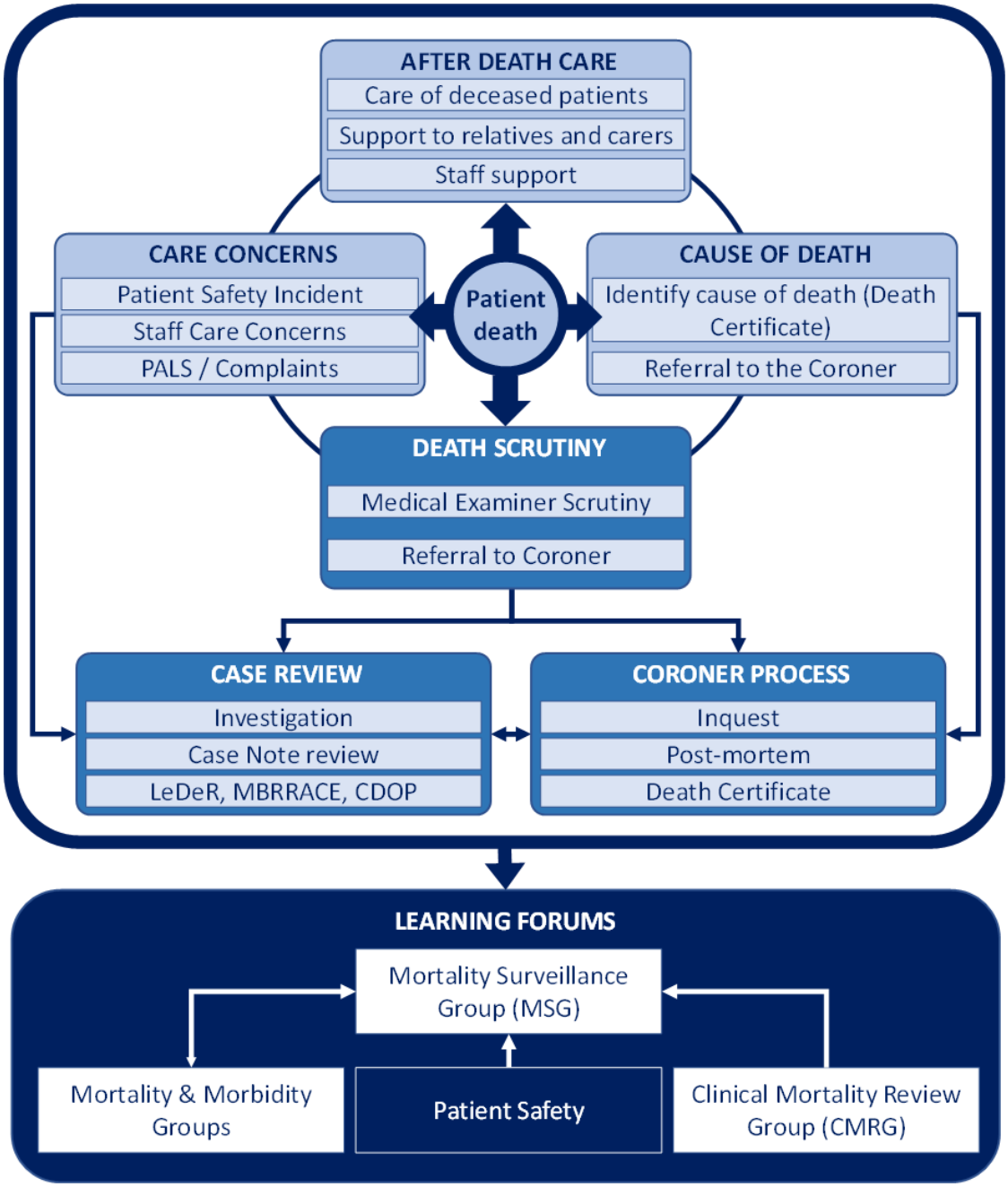


Figure 1: Learning from Deaths System

3.2. **After-death care:**

The Trust is committed to manage the death of a patient meaningfully, compassionately, respectfully and with dignity. This commitment focusses primarily on patients and their families or carers, but also ensures those members of staff impacted receive appropriate support.

In addition, all relevant organisations, authorities and regulatory bodies are informed about patient deaths following the appropriate procedures in each case. One of the key reasons for reporting deaths is to facilitate the intervention of these relevant parties in the learning process.

3.2.1. Care of deceased patients

The Trust has developed and implemented specific policies[5,6,7] to ensure continuation of care after the death of a patient. These policies establish the processes for the care of the body, notification of the death to relevant services and relatives or carers, patient identification, viewing of the patient by relatives or carers, spiritual needs, transference of the patient to the mortuary, etc.

3.2.2. Support for relatives and carers

The death of a loved one is always a traumatic event. When dealing with families and carers of deceased patients, the Trust is committed to fully apply the principles of openness, honesty, and transparency as set out in the Being Open/Duty of Candour Policy.

Relatives and carers are informed immediately after the death of a patient. Information provided is clear and as complete as possible, appropriately and sensitively expressed by a health professional. These discussions are always held privately and in a sympathetic environment. Staff taking part in these conversations have the necessary skills, expertise and knowledge.

Relatives and carers are encouraged to share any detail about the patient and the care received, including questions and concerns (informing them explicitly of their right to raise concerns – PALS, complaints, etc.). Any information, question or concern is acknowledged and considered carefully as they can be an invaluable source of insight to inform decisions about the need for case review or investigation and also to implement improvements in the quality of care. Within this context, bereaved families and carers are informed of the progress and findings of any case review and investigation in a timely manner and are offered the opportunity to be involved in the process. To this effect, a single point of contact is provided to relatives and carers.

Bereavement support is offered to relatives and carers. This support includes help with the completion of documentation, collection of patient's belongings, post-mortem advice and counselling, information about coroner's procedures and registering a death, access to advocate, appropriate transport, and communication/language aids, etc. Bereavement support provided always respects confidentiality, values, culture and beliefs. The Chaplaincy team offers a key service for bereaving relatives, carers and staff.

[5] Care After Death (Adults) Policy
[6] Care After Death Infant/Child Policy
[7] Transportation of Deceased Patients from Wards

3.2.3. Support for staff

The Trust is committed to providing the relevant support to any member of staff affected by a patients' death at the Trust with access to support being made widely available on Trust's intranet under the Health and Well-being page. Other specific support is detailed below:

- Ward managers/line managers are available for informal discussions and to explore staff members concerns. De-brief sessions are offered to teams involved in serious incidents.
- Support with the investigation process is arranged by the Patient Safety Team including opportunity to attend Safety Action and Assurance Group (SAAG) meetings, which provides a safe environment to discuss the events and identify early learning and support required by staff.
- Legal advice can be sought from the Trust's Complaints and Legal Services Team.
- The Chaplaincy team are available for informal discussions and to explore staff members concerns, providing signposting to other relevant internal and external services available.
- Attendance at the Good Grief Bereavement Café.
- Access is also available to our Health and Well-being champions at the Trust.

3.3. **Cause of death**

Understanding the cause of death is essential for relatives and carers to be able to register the death and subsequently to arrange disposal of the body, and to settle the estate of the deceased patient. It is also very important for monitoring and analysing the health of the population in England and in the areas local to the Trust. This information is used to develop policies and strategies for improving and setting specific health preventing and care effectiveness strategies.

3.3.1. Medical Certificate of Death Certificate (MCCD)

An MCCD needs to be issued as soon as possible after the decease of a patient. The doctor looking after the patient during the last episode of care (Qualified Attending Practitioner – QAP) has the statutory duty to complete a MCCD and arrange for the delivery of it to the relevant registrar as soon as possible. This is because the doctor is familiar with the patient's history, investigations and treatment, and has access to the relevant records and investigation results. If several doctors have been involved in the care of the patient, the ultimate responsible for completing the MCCD is the consultant in charge.

The death of the patient is required by law to be registered within 5 days of its occurrence unless there is to be a coroner's post-mortem or an inquest.

3.3.2. Referral to the coroner

In some cases, it is not possible to complete a MCCD immediately after the patient's death:

- The attending doctor has not seen (face-to-face or video consultation) the patient within the 28 days preceding death.
- The doctor has not seen the person after death.
- Unnatural or violent death is suspected.
- Cause of death is unknown.
- The death occurs in custody or otherwise in state detention.

- Although the death seems natural, there are some concerns about neglect or poor standards of care.

Any doctor referring the case of a deceased patient to the coroner provides a comprehensive account of the case. With this information and any other requested subsequently, the coroner will decide whether a referred death needs to be investigated further. The most common decisions from a coroner include to practice a post-mortem investigation, to hold an inquest or to complete a MCCD.

If the coroner decides that a MCCD needs to be completed, the registrar will request the certificate from the doctor who attended the deceased.

3.4. **Care concerns**

Every death in the Trust has potential for learning. All members of staff who provided or witnessed the care of a deceased patient can contribute to identifying opportunities for improvement. The contribution of relatives and carers in the identification of beneficial changes in practice and services is fundamental.

3.4.1. Patient Safety Incident

When concerns are raised by staff, family, carers or friends that the quality of care or the service may have contributed to the patient's death, this is reported into the Trust's incident management system (QSAFE) and is managed as per the Trusts Patient Safety Incident Response Plan (PSIRP)[8], which is based on NHSE's Patient Safety Incident Response Framework[9].

Deaths which may be related to problems with care trigger a level 1 learning response. This consists of an immediate review by the Executive-led Safety Action and Assurance Group (SAAG) which meets thrice-weekly, followed by a Patient Safety Incident Investigation by a trained level 1 investigator, when appropriate. The deceased patient's family and carers are an integral part of the investigation.

3.4.2. Patient Liaison Service (PALS) and complaints

Those close to the deceased patient are encouraged to report any additional information or concern they may have. They are made aware of their right to raise these concerns confidentially through formal processes (PALS and Complaints) by contacting PALS on 01493 453240 or pals@jpaget.nhs.uk.

3.5. **Scrutiny of the death**

All patient deaths in JPUH are scrutinised to identify clearly the cause of death and to identify any opportunity for improvement of the care and treatment provided.

3.5.1. Medical Examiner (ME) scrutiny

The ME service scrutinises every death in JPUH except those referred to the coroner. The scrutiny process is completed within 72h of the decease. During the scrutiny the ME

[8] https://jamespaget.interactgo.com/Interact/Pages/Content/Document.aspx?id=7761
[9] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-1.-PSIRF-v1-FINAL.pdf

requests information from members of staff that were involved or witnessed the care of the deceased patient. The ME also communicates with the relatives and carers to collect any additional information that may inform the examination of the case. This information will have a direct impact on the Medical Examiner's decision whether to recommend the completion of a Structured Judgement Review (SJR).

The ME's advice and scrutiny report includes the following:

- Type of death: whether the death was expected or not, including whether the patient had an end-of-life care plan in place.
- Potential learning: whether there are lessons to be learned.
- Structured Judgement Review: whether an SJR is recommended and why.
- Cause of death. Outcomes of discussion between ME and the qualified attending practitioner (QAP).
- Outcomes of discussion between ME and coroner/coroner's office (if required).
- Outcome of discussion of cause of death between ME and informant/next of kin or another appropriate person.

3.5.2. Structured Judgement Review (SJR) - indications

An SJR is carried out for all deaths in the following categories:

- Deaths where a significant concern about the quality of care provided is raised by bereaved families and carers
- Deaths where a significant concern about the quality of care provided is raised by medical examiner or staff
- Deaths of those with learning disabilities and with severe mental illness
- Deaths in a service speciality, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means
- 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 or end of life care

The Deputy Chief Medical Officer can commission an SJR for deaths that might satisfy one of these criteria but where the ME has not made a clear recommendation.

3.6. **Coroner's process**

The coroner, when referred a case, may authorise an MCCD to be issued, or may decide to proceed to inquest and may order a post-mortem.

3.7. **Case review**

Reviews and investigations aim to identify any problems in the care provided to a patient and to learn and improve from them. The deceased patient's families and carers are an integral part of the review or investigation processes. The Trust's open culture underpins these

processes. A fundamental element of this approach is listening to the views and opinions of those close to the patients.

3.7.1. Investigation

As described in section 3.4.1, SAAG commissions a Patient Safety Incident Investigation for incidents that trigger a Level 1 Learning Response according to PSIRP, including when death may have been associated with problems in care. An investigation can also be requested by CMRG and MSG. All investigations are carried out by a trained level 1 investigator.

3.7.2. Structured Judgement Review (SJR)

Please see **Appendix 1** for the SJR process map. A structured judgement case note allows reviewers to identify, describe and allocate a score to the quality of care received and to the estimated preventability of the death. This methodology has been adopted across the NHS for adult inpatient deaths. Section 3.5.2 lists the indications for an SJR. In addition, SJRs can be requested by the Deputy CMO, CMRG, MSG and SAAG for cases not automatically triggering an SJR (e.g. death of a homeless person, cases listed for a coroner's inquest).

SJRs are carried out by medical assessors (consultants and experienced doctors) using a standardised national electronic system (SJR Plus). The electronic SJR Plus system is linked to the Trust's mortality dashboard and enables identification of emerging themes and potential concerns.

Reviewers are allocated an SJR if they:

- Have not been involved in the care of the deceased patient.
- Work in the same Service or Division where the patient received care at the time of death.
- Have not completed another SJR in the last three months (unless there are reasons to allocate a particular reviewer, e.g. the only suitable person available).
- Are employed by the Trust (unless there is a specific reason to allocate reviewers that collaborate with the Trust although they are employed by another trust).
- Are permanent staff of the Trust (unless there is a specific reason to allocate temporary/agency staff –preferably long term staff).

SJRs are to be completed within 21 days of allocation. Reviewers are reminded at least one day before the due date. The main purpose of the reminder and escalation process is to identify any difficulty or barrier to the completion of SJRs and to provide support when required, and to ensure that learning is not unduly delayed. Reviews breaching the deadline are escalated to the Clinical Mortality Lead and then to the Deputy CMO if required. This monitoring and escalation process is illustrated in **Appendix 2.**

3.7.3. Review methodology for each patient group (including LeDeR, MBRRACE and CDOP)

This table summarises the process for different mortality groups:

Patient group	Review Methodology
Adult inpatients and community deaths within 30 days of discharge from hospital	Structured Judgement Review (SJR)
Mental Health	All deaths of patients with mental health needs are reviewed using the SJR methodology, in collaboration with clinical colleagues at the Norfolk and Suffolk Foundation NHS Trust.
Child under 18	The death of infants or children under 18 is reported to the Child Death Overview Panel (CDOP), which completes a Child Death Review in accordance with the 'Working Together to Safeguard Children' national guidance[10]. SJR methodology is not suitable for reviewing paediatric mortality.
People with learning disability and autistic people	The death of patients with learning disability and autistic people are reviewed using the SJR methodology. The Safeguarding team notifies the death and sends the SJR report externally to the LeDeR programme. As described in the LeDeR policy (2021)[11], this mortality review informs the wider LeDeR review.
Perinatal and Maternity	All perinatal deaths are reviewed using the national perinatal mortality review tool (PMRT) as per 'Mothers and Babies: Reducing Risk though Audits and Confidential Enquiries' (MBRRACE) guidelines. Maternal deaths are also reported through the MBRRACE reporting system. Maternal deaths and many perinatal deaths are very likely to be considered a Patient Safety Incident and be managed as per the Adverse Events Policy as well. Every maternal death is also be reviewed by the Maternity Governance Committee.

3.8. **Learning Forums**

The learning from deaths process starts from the moment a patient is recognised as deceased. The Trust is committed to provide opportunities for staff to learn from deaths. These include various forums and events such as the Grand Round, Specialty Governance Meetings and Foundation Year Doctors' mandatory lectures, where learning is shared.

The process includes everyone involved in the care of the patient, families and carers, and relevant external bodies. Every component of the process, from reflection to scrutiny, review, and investigation, is directed towards identifying lessons to be learnt. This means that

[10] https://norfolklscp.org.uk/people-working-with-children/child-death-overview-panel#:~:text=The%20Child%20Death%20Overview%20Panel,aim%20of%20preventing%20future%20deaths.
[11] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf

opportunities to provide better care and to prevent recurrence of ineffective ways or working and errors are identified and acted upon.

Ultimately, the formal management of this learning is led by three governance forums, which are interrelated to each other as illustrated in Figure 1 above.

The aims, operational mechanisms and strategic functions of these forums are detailed within their individual Terms of Reference.

3.8.1. Mortality and Morbidity Groups (M&M)

Each Specialty in the Trust has an M&M meeting chaired by the specialty lead consultant. During these meetings, the mortality and morbidity data and relevant individual cases are discussed. The aim is to identify learning that could be applied to the specialty or widely within the Trust.

Relevant learning, identified risks and changes implemented in the specialty, derived from M&M discussions are reported to the Mortality Surveillance Group at least quarterly. This includes the M&M group discussing deaths of children.

3.8.2. Clinical Mortality Review Group (CMRG)

CMRG is chaired by the Clinical Mortality Lead it reviews all cases whose SJR score for overall care is 3 or lower, and/or if preventability score is 4 or lower:

SJR Stage	Scores	CMRG review
Overall assessment rating	1= very poor care	✓
	2= poor care	✓
	3= adequate care	✓
	4= good care	
	5= excellent care	

Preventability scale	1= definitely preventable	✓
	2= strong evidence for preventability	✓
	3= possibly preventable, greater than 50-50	✓
	4= possibly preventable, less than 50:50	✓
	5= slight evidence for preventability	
	6= definitely not preventable	

The individual SJRs are discussed and, if necessary, challenged and revised. All learning identified is acted upon and reported to MSG. The SJR reviewer receives feedback from the Clinical Mortality Lead, for continuous improvement of reviewer skills.

3.8.3. Mortality Surveillance Group (MSG)

MSG provides assurance to the Clinical Effectiveness Group (CEG) on patient mortality. This assurance is based on the analysis of relevant mortality statistics, a review of care received by deceased patients and on the identification and escalation of risks, issues and concerns. Analysis of local review results and learning (provided by the different M&M groups) are included in the information considered by MSG.

All the information discussed during MSG meetings is used to identify opportunities for improvement and to determine specific interventions to address them. The implementation and effectiveness of these improvements is monitored by the group.

At least once a year MSG prepares a Learning from Mortality report highlighting the areas identified as benefiting from improvement or enhancement and a brief description of how this was acted upon. This report is shared with all Specialties within the organisation and with external organisations if appropriate.

Any relevant learning discussed during MSG meetings is considered for cascading to the appropriate clinical and non-clinical departments within JPUH. MSG decides the message and the communication channel most appropriate to each case.

The Clinical Mortality Lead share relevant mortality information and learning during the participation in external forums (e.g. Mortality ICS meetings).

3.8.4. Patient Safety Team

Opportunities for improvement are identified as part of the processes for the management of patient safety incident, and these are addressed through action plans. These action plans are monitored and reviewed as per the patient safety specific governance arrangements and as per other relevant divisional and Trust wide governance fora.

At least quarterly, the Head of Patient Safety and Quality provides a report to the MSG including an analysis of all the incidents of the relevant period involving patient deaths. This report includes lessons learnt.

4. Training & Competencies

4.1. SJR Plus

Training on the methodology and on SJR Plus is regularly provided to consultants by the Clinical Mortality Lead. In addition, support materials (guidance and training video) are available for all reviewers to access. Reviewers receive formative feedback from the Clinical Mortality Lead after their review is discussed at CMRG.

5. Related Documents

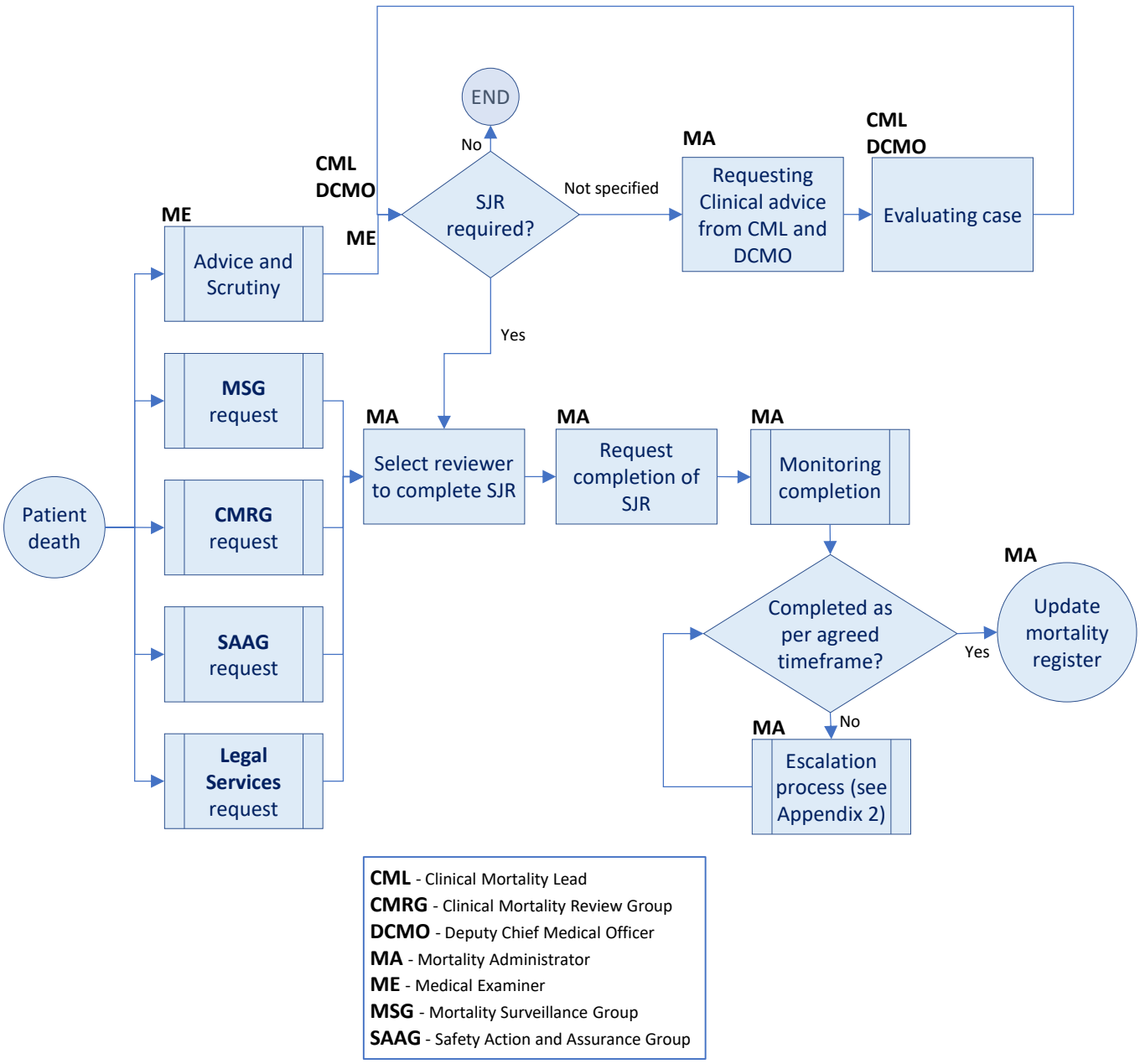
- Learning, candour and accountability: a review of the way NHS trusts review and investigate deaths of patients in England. Care Quality Commission, December 2016. 20161213-learning-candour-accountability-full-report.pdf (cqc.org.uk)
- National Guidance on Learning from Death. National Quality Board, March 2017. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
- Coroner and Justice Act 2009. https://www.legislation.gov.uk/ukpga/2009/25/contents
- Working Together to Safeguard Children 2023. HM Government, December 2023. https://assets.publishing.service.gov.uk/media/65cb4349a7ded0000c79e4e1/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf
- Care After Death (Adults) Policy. JPUH Policy. Care After Death (Adults) Policy - James Paget Hospital intranet (interactgo.com)

- Care After Death Infant/Child Policy. JPUH Policy. Care After Death Infant/Child Policy - James Paget Hospital intranet (interactgo.com)
- Transportation of deceased patients from wards. JPUH Policy. Transportation of Deceased Patients from Wards - James Paget Hospital intranet (interactgo.com)
- Patient Safety Incident Response Plan. JPUH Plan. https://jamespaget.interactgo.com/Interact/Pages/Content/Document.aspx?id=7761
- Patient Safety Incident Response Framework. NHS England, August 2022. B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)
- Child Death Overview Panel. Norfolk Safeguarding Children Partnership, 2023. Child Death Overview Panel | Norfolk Safeguarding Children Partnership | PWWC (norfolklscp.org.uk)
- Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021. NHS, March 2021. B0428-LeDeR-policy-2021.pdf (england.nhs.uk)

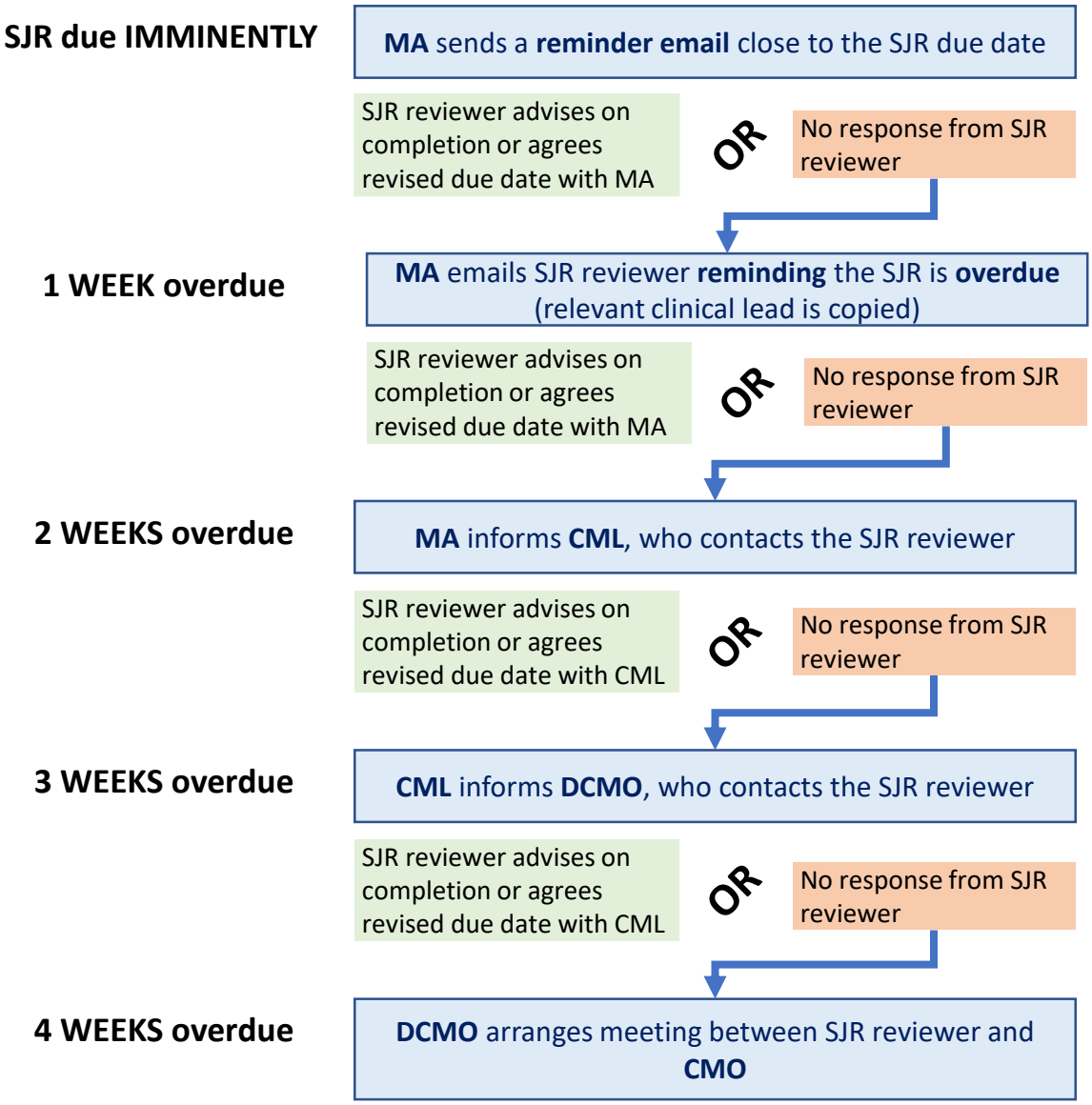
6. Monitoring Compliance

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Mortality benchmarking	SHMI and crude mortality rate	CEG	PSQ	Monthly
Alerts and Outliers	Statistical alerts and low-risk deaths	CEG	PSQ	Monthly
Learning from deaths quality	SJR assessor training rates	CMRG	PSQ	Monthly
Learning from deaths process	SJR completion rate	CEG	PSQ	Monthly
Learning from deaths outcomes	Thematic analysis	MSG	PSQ	Quarterly

7. Appendix 1: Structured Judgement Process



8. Appendix 2: Escalation process for non-completion of SJR



After discussing reasons for non-engagement with SJR reviewer, the CMO determines actions (including impact on revalidation in consultation with the Responsible Officer Advisory Group)

CML - Clinical Mortality Lead
CMO – Chief Medical Officer
DCMO - Deputy Chief Medical Officer

9. Equality Impact Assessment (EIA)

Policy or function being assessed: **Department/Service:**
Assessment completed by: **Date of assessment:**

1.	Describe the aim, objective and purpose of this policy or function.		
2i.	Who is intended to benefit from the policy or function?	**Staff x Patients x Public x Organisation x**	
2ii	How are they likely to benefit?		
2iii	What outcomes are wanted from this policy or function?		
For Questions 3-11 below, please specify whether the policy/function does or could have an impact in relation to each of the nine equality strand headings:			
3.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **race/ethnicity?**	**y/n**	
4.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **gender?**	**y/n**	
5.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **disability?** Consider Physical, Mental and Social disabilities (e.g. Learning Disability or Autism).	**y/n**	
6.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **sexual orientation?**	**y/n**	
7.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **pregnancy or maternity?**	**y/n**	
8.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **religion/belief?**	**y/n**	
9.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **transgender?**	**y/n**	
10.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **age?**	**y/n**	
11.	Are there concerns that the policy/function does or could have a	**y/n**	

	detrimental impact on people due to their **marriage or civil partnership?**		
12.	Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this policy/function?	**y/n**	
13.	Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.	**y/n**	
14.	**Specific Issues Identified**		
	Please list the specific issues that have been identified as being discriminatory/promoting detrimental treatment	Page/paragraph/section of policy/function that the issue relates to	
	1. N/A	**1.**	
15.	**Proposals**		
	How could the identified detrimental impact be minimised or eradicated?	**N/A**	
	If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11?	**N/A**	
16.	Given this Equality Impact Assessment, does the policy/function need to be reconsidered/redrafted?	**N**	
17.	**Policy/Function Implementation**		

14.	**Specific Issues Identified**	
	Please list the specific issues that have been identified as being discriminatory/promoting detrimental treatment	Page/paragraph/section of policy/function that the issue relates to
	1. N/A	**1.**
17.	**Policy/Function Implementation**	
	Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the policy/function should be adopted by the Trust. Please print: **Name of Director/Head of Service: Title:** **Date: Name of Policy/function Author: Title:**	

	Date: (A paper copy of the EIA which has been signed is available on request).
18.	**Proposed Date for Policy/Function Review**
	Please detail the date for policy/function review (3 yearly):
19.	**Explain how you plan to publish the result of the assessment?** *(Completed E.I.A's must be published on the Equality pages of the Trust's website).*
	Standard Trust process
20.	**The Trust Values**
	In addition to the Equality and Diversity considerations detailed above, I can confirm that our Trust Values are embedded in all policies and procedures. **C**ollaboration We work positively with others to achieve shared aims. **A**ccountability We act with professionalism and integrity, delivering what we commit to, embedding learning when things do not go to plan. **R**espect We are anti-discriminatory, treating people fairly and creating a sense of belonging and pride. **E**mpowerment We speak out when things don't feel right; we are innovative and make changes to support continuous improvement. **S**upport We are compassionate, listen attentively and are kind to ourselves and each other. I confirm that this policy/function does not conflict with these values. ☑