Guy's and St Thomas'
NHS Foundation Trust

Learning from Deaths Policy

The Learning from Deaths Policy sets out the minimum acceptable standards of the national learning from deaths programme and the Child Death Review Statutory and Operational Guidance.

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1 Scope

This policy covers the roles and responsibilities of Guy's & St. Thomas' NHS Foundation Trust in implementing national guidance following the death of adults and children in the organisation's care. The policy applies to all adults, babies, children and young people, regardless of the cause of death, across all sites and sectors, including maternity, acute and community.

2 Rationale

Guys and St Thomas' NHS Foundation Trust (GSTT) is committed to identifying, reporting and learning from deaths that occur in the organisation's care. Research suggests that preventable deaths due to problems in care make up 1-5% of deaths.

The publication *learning, candour and accountability* from the Care Quality Commission (CQC), made specific recommendations, largely focused on maximising learning from deaths and the involvement of carers and families. This led to the National Quality Board publishing *National Guidance on Learning from Deaths* in March 2017 which is a framework for trusts to identify, report and learn from deaths. It requires trusts to collect and publish, on a quarterly basis, information on the deaths of patients in their care.

The *Child Death Review Statutory and Operational Guidance (England)* published by HM Government in October 2018 states that deaths of children should be reported as set out in the *National Guidance on Learning from Deaths*, however, trusts should follow the statutory child death review process when reviewing the death of a child.

Mortality review enables the organisation to learn and continually improve the quality of care provided to all patients. This policy sets out the procedures for identifying, recording, reviewing and where necessary investigating the deaths of patients in the care of GSTT. Additionally it sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

It describes how GSTT will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff who may be affected by the death of someone in the trust's care.

This policy should be read in conjunction with the Trust Reporting and Responding to Incidents Policy, Patient Safety Incident Response Plan (PSIRP) the Trust Mortality Surveillance Group Terms of Reference, the Trust Complaints Policy and the existing mortality governance processes.

All areas are expected, as part of the minimum national requirements, to adopt the overarching principles of routine and systematic mortality reviews, which include a standardised approach to reviewing all deaths.

3 Policy objectives

The objectives of this policy are:

- To provide a framework for learning from deaths across all GSTT sites
- To ensure that learning from deaths at GSTT meets statutory responsibilities
- To ensure that processes are in place for shared learning and support for families, carers and staff
- To provide a framework for managing mortality alerts

4 Duties

Role	Responsibilities
Chief executive	Overall responsibility for implementation of the policy
Non-executive directors (including the role of a lead non-executive director in taking oversight of progress in implementing the Learning from Deaths agenda)	Trusts should refer to Annex B of the *National Guidance on Learning from Deaths* In summary, non-executive director responsibilities relating to the framework include: • 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
Chief Medical Officer (CMO)	The responsible director and lead for the learning from deaths agenda who provides assurance to the Trust Board that the processes are functioning correctly; the CMO must also ensure that arrangements are in place so that clinical staff are aware, as appropriate, of their responsibilities to contribute to and implement the policy

Lead for Trust Mortality Review and Surveillance	• Ensure a standardised approach is embedded across the Trust, including that Structured Judgement Reviews (SJR) are undertaken for deceased patients where criteria are met
	• Chair of the Trust Mortality Surveillance Group (TMSG) Agenda set and ensure minutes are taken and archived
	  • Appropriate attendance by all relevant disciplines and professional groups
	  • Collation of findings, learning points and actions for improvement from each meeting
	• Escalate any areas of concern to the CMO for action
	• Overall responsibility to ensure learning from deaths is shared across the Trust and beyond as appropriate
	• Ensure compliance with reporting of data
	• Ensure an appropriate entry in the Trust Annual Quality Account

Directors of Quality and Assurance	Delegated responsibility to support the implementation and further development of the mortality review process; this includes the provision of support staff to assist the clinical teams conducting the mortality reviews as well as ensuring the mortality data are monitored and acted upon as necessary
Quality & Assurance Directorate	• Ensuring adherence to policy and associated processes including expert support and advice for clinical group and directorate staff • System administration of the system for reporting deaths and undertaking mortality reviews • Secretarial support for the Trust Mortality Surveillance Group (TMSG)
Clinical Group Executives, Directorate Managers and Clinical Directors	Ensure that local mortality review processes are being adhered to, including appropriate multi-disciplinary mortality meetings, SJR performance, outlier mortality review alerts are responded to and that learning is shared with required local actions being implemented

Role	Responsibilities
Local Mortality Leads (LML)	To deliver the mortality review process at service / directorate level; to monitor and record within RADAR the mortality review; to deliver multidisciplinary mortality meetings and ensure documentation; to report learning identified locally and to report thrice yearly to TMSG
Clinical Governance Facilitator (CGF)	To support the LML in delivering their responsibilities with regard multidisciplinary mortality meetings, mortality review and reporting
Medical Examiner's Office (MEO)	Confirm cause of death where possible, identify if coronial referral is required, conduct proportionate independent 'scrutiny' review' and to support bereaved families The MEO will share the ME scrutiny review with the Trust and will escalate if concerns or criteria are identified to indicate that an SJR should be considered
Evelina London Medical Director	Delegated responsibility from the CMO to be the lead for learning from Child Death; to provide line management for the Clinical Lead for Child Death and also assurance to CMO and the Trust via TRAC that the processes for Child Death are functioning correctly and that arrangements are in place so that clinical staff are aware, as appropriate, of their responsibilities to contribute to and implement the Child section of the Learning from Deaths Policy
Clinical Lead for Child Death	• Ensure a robust, standardised approach to child death reviews in the Evelina London/GSTT, in order to fulfil the statutory functions required and maximise learning across the organisation from reviewing the deaths of children in the organisation • Provide senior clinical leadership, oversight, expertise and guidance in conducting child death reviews within the Evelina London Clinical Network and partner organisations • Represent Evelina London at TMSG and in engagements with external stakeholders relating to the review of child deaths
Evelina Child Death Review Specialist Nurses	• Work with the Clinical Lead for Child Death to ensure a robust, standardised approach to child death reviews in the Evelina London/GSTT • Ensure adherence to policy and associated processes including expert support and guidance for colleagues within the trust and in partner organisations • Ensure all child deaths are notified to child death review (CDR) partners as per statutory guidance • Facilitate child death review meetings (CDRMs) and ensure records are maintained and sent to CDR partners • Ensure complete and up to date records are maintained relating to all child deaths to support reporting of child deaths within GSTT • Support bereaved families in the Key Worker role where appropriate, guiding them through the CDR process and signposting to relevant resources

5 Policy implementation – Adults

GSTT uses RADAR, an electronic system, to record all adult inpatient and community deaths and the associated data pertaining to mortality review.

5.1 Initial mortality review – Stage 1a. Mortality review will be initiated by reporting an event within the RADAR system. Within this workflow, the outcome of the ME review will be recorded (scrutiny review + outcome of family discussions if appropriate) to inform subsequent local mortality review and signpost any concerns identified by the ME. Any potential criteria for detailed case record review (hereafter referred to as structured judgement review (SJR)) will be recorded (see below).

5.2 Attribution of specialty for mortality review. The death will be assigned to a primary specialty / directorate, usually based on the location of death. In many cases, multiple specialties will have been involved in the care of a patient who has died, in which case second or third additional specialities may be added, however responsibility for the subsequent steps rests with the primary speciality. Emergency Medicine will be routinely added as an additional speciality for patients who have been admitted through the Emergency Department and who die within 7 days. The LML may wish to discuss with other speciality leads and reassign by mutual agreement. Where this is not clear or there is discrepancy of opinion, the Trust Mortality Lead should be consulted.

The principle is for ownership to sit where there is the *greatest validity and opportunity for learning from mortality review.* The following is a guide:

- In most instances the service with primary responsibility for the patient at the time of their death will conduct the review, however:
- Where the SJR is triggered by a discrete concern, the service responsible for the patient at the time the concern arose should conduct the review
- Elective or planned cases where the admitting / operating / procedural specialty should conduct the review
- Where there was a substantive episode of clinical care that preceded transfer to another service in the last hours of life, the former service should conduct the review

5.3 Initial mortality review – Stage 1b. The primary specialty LML is responsible for conducting a local review. Typically this will be a team based review within a structured multidisciplinary mortality and morbidity meeting or other appropriate quality / safety / clinical governance meeting. In some specialties the review may be led individually by the LML. A brief review of the case and any learning points will be documented. Reference should be made to the outcome of the ME review to address any concerns raised. If potential criteria for SJR have been identified at Stage 1a, then these should be reviewed, with reference to 5.4 below. If the LML does not uphold the indication for SJR, the reason why should be documented. For example, some deaths may have been attributed as 'elective' when the LML can justify why these were in fact high risk cases (e.g. planned oncological admissions in patients with advanced malignancy) OR in light of the LML specialty knowledge or known conversations with family.

5.4 Criteria for SJR

The Trust will undertake case note review by SJR for the following indications:

- **Learning disabilities:** The National Learning Disability Mortality Review (LeDeR) Programme conducts a multi-agency review of all deaths of people with learning disabilities and known autism, aged four years and above, regardless of whether the death was expected or not. The team responsible for the patient's care at the time of death should notify safeguarding team when a patient with a learning disability has died by emailing gstt.learningdisabilities@nhs.net. Where appropriate the SJR will form part of the wider LeDeR project review when undertaken. SJRs are not routinely required for autism, unless a patient with autism also fulfils the criteria for SJR based on confirmed learning disability diagnosis or severe mental illness.
- **Severe Mental Illness:** defined as patients being actively treated for a severe mental illness; requiring registered mental health nurse (RMN) supervision and detained under the Mental Health Act (MHA).

- **Concerns about quality of care:**
  - Bereaved families and carers have raised a significant and credible concern about the quality of care
  - Clinical team has raised an actual or potential significant concern about the quality of care
  - ME identifies actual or potential significant concern about the quality of care (if concerns with care provided by other organisations, ME to escalate to that organisation)
  - Other organisations/providers have expressed concern with GSTT care
- **All deaths where people are not expected to die:** this may include elective procedures, deaths coded as "low risk" and inpatients where sudden unexpected cardiac arrest occurs. Patients presenting unwell to the ED who die do not necessarily need to be considered unless specific issue such as previous recent ED attendance.
- **Deaths in a service or specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means:** this may be through external matrices (for example diagnosis HSMR or other elevated mortality alert or concerns raised by the Care Quality Commission or another regulator) or internal audit and review.
- **Deaths where learning will inform the provider's existing or planned quality improvement work / PSIRF priorities):** Examples include deaths where there is evidence of concerns relating to GSTT care in the following areas: acute deterioration or sepsis; medicines safety; Inter-hospital transfers; missed diagnostic results management; administration safety (loss to follow up); falls / pressure ulcers; surgical safety.

NB. If a Patient Safety Incident Investigation (PSII) or other learning response including After Action Review (AAR) is already known to be required or has been undertaken, where that review *relates to the death*, an SJR is not also necessarily required. If the PSII / AAR, etc. are not related to the death itself, an SJR may still be required. In this case the outcome of the PSII or other learning response should be appended to the RADAR system as evidence of a mortality review having occurred.

5.6. SJR methodology

SJR is structured case record review, carried out by clinicians, to determine whether there were any problems with systems or processes and / or in clinical practice. This is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. Good practice, care issues and learning should also be identified. It is recognised that there will be inter-rater variability and SJR should not be used to compare organisations. SJR will be conducted within 2 months of determining that the review is required.

The reviewer will make a series of explicit statements regarding a) evidence of good practice b) opportunities for learning in the following domains:

- Admission and initial care
- On-going care
- Perioperative or procedural care
- End of life care
- Overall

Under each heading a rating of quality of care will be proposed. Finally, a statement will be made as to whether a problem or problems in care contributed to death using a six-point ordinal scale of probability, allowing nuance for reviewer judgements:

1. Definitely contributed
2. Strong evidence that contributed
3. Probably contributed (more than 50:50)
4. Possibly contributed but not v likely (less than 50:50)
5. Slight evidence that contributed
6. Definitely did not contribute

The judgement should be made by the SJR reviewer, and where appropriate also reflect the views of local mortality review and second opinion. Note, the term 'avoidable mortality' should not be used.

5.7. Problem(s) in care contributing to death

All cases where there is the potential for problems to have contributed to death (rated 1-4) will be reviewed with the Trust Mortality Lead (TML). Where there is agreement the case will move to the next stage. Any disagreement will be resolved by discussion between the SJR reviewer and TML to form a final shared view. Outcomes will be presented as the distribution of probabilities (1-6); where required for reporting this will be dichotomised so that cases rated 1-3 will be reported as 'more likely than not that problems in care contributed to death'.

Then following steps will apply following verification of 'more likely than not that problem(s) in care contributed to death'. Note that in many instances, these cases will already have beem reported as incidents and/or referred to the Coroner.

1) The Medical Examiner's Office will be notified for consideration of referral to the Coroner if not already, as per current policy.
2) Q&A team cross check RADAR for any evidence of an incident report related to the patient's death and any additional Patient Safety Incident Response Framework (PSIRF) Learning Response (LR) that have already occurred.
3) If an incident has not been reported this will be created by the local directorate governance team to log the event. The incident will be reported as 'No harm' (Physical and Psychological) with the Clinical Outcome box recording Death. The level of harm can be reviewed and amended if required following the Incident Review Meeting (IRM) and/or PSIRF Learning Response. An incident review meeting (IRM) will be held locally to review the SJR and any existing review completed. LR. The IRM will consider if a PSIRF Learning Reponse is required and if so, the type of Learning Response (Information on PSIRF LR's can be found in the LR Toolkit on GTi).
4) Priority will be given to ensuring maximal learning and transparency, whilst avoiding duplication of review. In making judgements the IRM will consider:
    1. The focus and quality of the existing SJR
    2. learning and actions already identified
    3. if learning already aligns to existing patient safety priorities and PSIRPs
    4. existing review and any other incident or PSIRF Learning Response and the extent to which they have addressed the problems identified by the SJR.
5) The reported incident should be linked to the Mortality record on Radar.
6) Safety Actions associated with SJRs will be added to Radar and tagged as 'Mortality Action'. Safety Actions from a subsequent PSIRF LR will be added to Radar and tagged as the relevant Learning Response that has been completed, e.g Patient Safety AAR Action if an After Action Review (AAR) is completed.
7) Safety Actions will routinely be managed locally (Directorate / Clinical group), however, where it is identified as a cross cutting action, this may be escalated to another appropriate owner (e.g. Trust safety committee).
8) TMSG will focus discussion and shared learning on cases where problems in care contributed to death.
9) Safety Actions in response to 'problems contributed to death' are also required to be reported to the Trust board and externally.

6 Policy implementation – Maternity

A maternal death is defined as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy. Deaths are subdivided on the basis of cause into: direct deaths, from pregnancy-specific causes such as preeclampsia; indirect deaths, from other medical conditions made worse by pregnancy such as cardiac disease; or coincidental deaths, where the cause is considered to be unrelated to pregnancy, such as road traffic accidents.

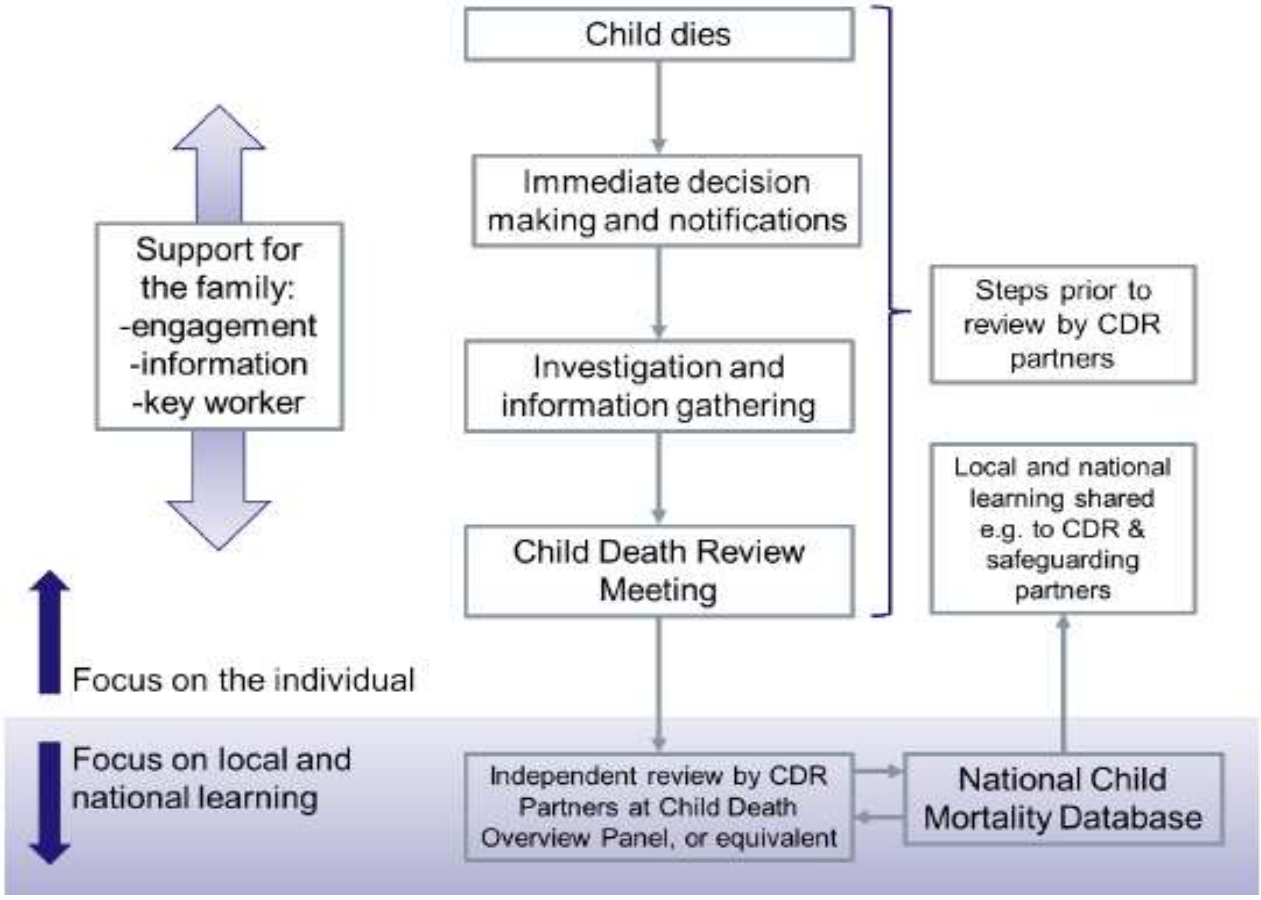
Maternal deaths will undergo an initial mortality review from the ME as per section 5.1. The death will be recorded on RADAR to facilitate aggregated management and reporting of trust deaths. An appropriate local mortality review / investigation will occur. Additionally a submission will be made to the national audit: Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBRRACE-UK).

7 Policy implementation – Children

The Child Death Review Statutory and Operational Guidance (England) sets out the key features of a robust child death review process, combing best practice with statutory requirements (under the Children Act 2004 the Children and Social Work Act 2017 and as set out in Working Together to Safeguard Children 2023). The purpose is to ensure that outputs from reviews are standardised as far as possible and of a uniform quality to enable effective thematic learning – at local, regional and national levels.

A child death review must be carried out for any live-born person under the age of 18 years, regardless of the cause of death.

The flow chart below sets out the main stages of the child death review process:



7.1. Immediate decision making and notifications

As soon as a child dies the following decisions need to be made:

- Whether the death meets the criteria for a Joint Agency Response, and if so, initiate the process by contacting on-call representatives from police and children's social care. If the case meets criteria for a Sudden Unexpected Death in Infancy/Childhood (SUDI/C), the relevant samples should be taken and guidelines followed. For the STH site see the relevant MoU with the Inner South London Coroner.
- Whether any actions are necessary to ensure the health and safety of others, including family, members of the community, other patients or staff.

As soon as possible after a child dies (or out-of-hours where expedited burial or repatriation has been requested by the family), the following notifications need to be made:

- Notification of Child Death – create note on EPIC, print and email to gstt.childdeathnotifications@nhs.net. The CDR team will use the information provided to complete the child death notification form for the relevant child death review partner team and inform other professionals as appropriate (including GP, other local/specialist medical teams, community midwives, health visitor, school nurse, social care).
- All deaths discussed by a senior clinician with the duty Medical Examiner (ME), who will also contact the family independently.
- Referral to the coroner if relevant. For STH site – Inner South London Coroner. For RBH site – Westminster Coroner. Support and guidance for completing the referral can be provided by the ME team. After making the referral, the form is saved and a copy sent to gstt.bereavement@nhs.net (GSTT) or gstt.rbhh-bereavements@nhs.net (RBHH) and gstt.childdeathnotifications@nhs.net.

If possible, and only after discussing and agreeing the cause of death with the ME, a senior clinician should complete the medical certificate of cause of death (MCCD). Note that there are two versions of the MCCD for child deaths: a neonatal certificate, up to 28 days, and a standard certificate thereafter.

When a child dies the family is appointed a Key Worker – a person who acts as a single point of contact for the bereaved family, providing them with information on the child death review process and signposting them to sources of support. In most cases this will be one of the Evelina Child Death Review Clinical Specialist Nurses, but may be another health professional within or outside of the trust better placed to support the family.

7.2. Investigation and information gathering

Investigations and information gathering will depend on the circumstances and may run in parallel, with varying timescales. These include:

- **Coronial investigation.** If the coroner accepts the referral, an investigation into the death is open. This may require a coronial post mortem examination (PME)/autopsy and/or inquest. The family will be contacted directly by the coronial team to explain the process and the Key Worker will provide additional support.
- **Joint Agency Response**. Following the initial information sharing meeting, plans for cross-agency working will be agreed and run in parallel with any additional investigations.
- **Patient safety investigation.** This may be a Trust investigation – either internal to GSTT or external, initiated and led by another organisation e.g. hospital of origin, ambulance/transport service, following the PSIRF framework, or subject to an independent investigation, via Maternity and Newborn Safety Investigations (MNSI),
- **Clinical information gathering.** Out with or in association with these investigations, there may be outstanding clinical information that can assist in the investigation of and learning from

a death. This can include hospital (i.e. non-coronial) PME and results from laboratory tests of tissue samples, including infectious diseases, metabolic and genetic investigations.

7.3. Child Death Review Meeting (CDRM)

The CDRM is a multi-professional meeting in which all matters relating to an individual child's death are discussed by the professionals directly involved in the care of the child during life and their investigation after death. It is scheduled once all outstanding investigations and information gathering have been completed. In the case of a coronial investigation, the CDRM should ideally take place before the inquest so as to inform the coroner's investigation. CDRMs are usually hosted by ELCH for any child who dies under the care of the organisation. Exceptions are where the majority of a child's care has occurred in another trust and/or where the majority of the learning/actions will be held elsewhere.

The aims of the CDRM are to review the clinical aspects of the case, ascertain contributory and modifiable factors associated with the death, identify any learning arising from the death and any actions that should be taken by any of the organisations involved, and to review the support provided to the family and staff involved. Following the meeting, notes are finalised and a draft Analysis Form submitted to the Child Death Overview Panel (CDOP). A summary of the CDRM is completed and sent to relevant stakeholders who are best placed to help share learning and who hold actions identified at the meeting.

7.4. Independent review by Child Death Review partners: the Child Death Overview Panel meeting

CDR partners have a legal responsibility to ensure that the deaths of children normally resident in their local authority area are reviewed, and may also review the death of a non-resident child who has died in their area. The CDOP is a multi-professional panel established by CDR partners to conduct a secondary review of each death, informed by the draft Analysis Form completed following the CDRM. The role of the CDOP is to analyse independently the information provided and determine any contributory factors; identify learning; make recommendations to relevant organisations; provide specified data to the National Child Mortality Database; produce an annual report for CDR partners on local patterns and trends in child deaths, lessons learned and actions taken and the effectiveness of the wider CDR process; and to contribute to local, regional and national initiatives to improve learning for child death reviews. GSTT may receive requests from CDOP seeking clarification/assurance regarding any actions identified pertaining to the organisation in the review of a child's death that may prevent future deaths.

7.5. Neonates <28 days

The death of any baby before 28 days of age is reported to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). This is a national data collection system that collates national data on perinatal loss, triangulates with data from the Office for National Statistics (ONS), publishes annual reports and undertakes in-depth analysis of trends in maternal and perinatal deaths. The MBBRACE dataset submitted is assessed for completeness and accuracy. Perinatal deaths should be reported as soon as possible, and within seven days – as per the Maternity Incentive Scheme (MIS).

Any perinatal death under 28 days can be reviewed using the standardised Perinatal Mortality Review Tool (PMRT): a web-based tool that supports standardised, systemic review of maternity care in perinatal deaths. In practice this should be used alongside and aligned with the CDR process, and

the CDRM should generate an analysis form which is sent to the relevant CDOP with the narrative report.

7.6 Reporting child deaths at GSTT

A report regarding Learning from Child Death is presented to the Evelina London Clinical Governance Committee on a quarterly basis and informs the regular report of Learning from Deaths to the Trust Risk and Assurance Committee (TRAC).

8 Policy implementation – older children and young adults

Following the death of a 16 or 17 year old admitted to an adult area of the Trust (i.e. outside of a paediatric area), the death should be reviewed in the same way as for adult patients (Section 5). In addition, the Child Death Review Team should be contacted as soon as possible, and certainly by the next working day, in order that any specific actions relating to reviewing child deaths can be initiated. This can be done by emailing gstt.childdeathnotifications@nhs.net.

Following the death of a patient older than 18 who is admitted to a paediatric area of the Trust, the death should be reviewed in the same way as for adult patients (Section 5).PALS and complaints Triangulation with Patient Advice and Liaison Service (PALS) / complaints may be helpful. Especially where the mortality review identifies 'family concerns', the service / directorate CGF should cross check within RADAR for more information. A response to a complaint does not replace the need for case record review / SJR, but SJR may assist with the response to a complaint.

9 Disclosure of mortality review

It is Trust policy that the mortality review (including SJR) is disclosable, either to families or to the coroner upon request. If the mortality review identifies any problems with care and / or if any lessons have been learnt, these should be proactively shared with the family. When disclosure is to the coroner, this will usually be for their use only. However, they may request that it is released to the family. Whenever the SJR is being shared with families, a covering letter should be provided explaining the SJR methodology and outcomes, and where appropriate offering a face to face meeting to discuss the findings.

10 Staff training and support

Appropriate training will be provided for all staff undertaking mortality reviews. The Trust Mortality Lead and Quality and Assurance Directorate will provide training to local service / directorate mortality leads, thereafter a cascade approach will be utilised for further training to ensure the workforce is competent to achieve the goals of this policy.
Staff affected by the death of patients will be supported by the trust and respective line managers and educational supervisors.
Trust guidance and support for staff:

- Support for staff involved in a complaint, incident, inquest or claim
- Engaging and involving patients, families and staff following a patient safety incident
- Clinical legal services

11 Learning from mortality review

LMLs and service level clinical directors are responsible for ensuring that local learning is disseminated within service and appropriate actions completed. The learning and actions will then be presented at TMSG and will be used to inform developments of systems and processes of care, and specific quality improvement where appropriate throughout the Trust. The lessons learnt and actions taken will be communicated across the organisation using appropriate channels. Where possible, linkages will be identified with existing patient safety improvement priorities and programs /

committees, utilising the PSIRF framework. Where new safety themes are identified these will be escalated through the Patient Safety Committee.

12 Supporting and involving families and carers

Guys and St Thomas' NHS Foundation Trust is committed to meaningful engagement with bereaved families and carers in all stages of responding to a death. The organisation will follow the recommendations as laid out in the 2018 NQB document entitled "Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers" and therefore will ensure that bereaved families and carers will:

- Be treated as equal partners following a bereavement
- Always receive a clear, honest, compassionate and sensitive response in a sympathetic environment
- Receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support.
- Be informed of their right to raise concerns about the quality of care provided to their relative. A representative from a bereaved family, or carers if appropriate, will be contacted by the ME following the death to facilitate them raising concerns (unless they request not to be contacted).
- Be reassured that their views will help to inform decisions about whether a review or investigation is needed
- Will, where a death is subject to a PSII, receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison. Bereaved families and carers will be partners in an investigation to the extent and at whichever stages that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations.
- Be supported to provide feedback where they have experienced the investigation process, which will help in delivering training for staff in supporting family and carers in future.

Guidance on informing, supporting and involving families is also detailed in:

- Statutory Duty of Candour
- Saying Sorry

Within 2 months of the death of their relative, families and carers will be sent a bereaved carers survey to capture their experiences and concerns as part of the NACEL, process. The survey will be accompanied by a covering letter which will include a contact telephone number for the Patient Experience Team should they prefer to highlight an issue or raise a concern verbally. This is in addition to the PALS service and complaints service. This approach is under regular review by the Patient Experience Team, End of Life Care Leads and TMSG.

13 Responding to mortality outlier alerts

An 'outlier' can be described as a result which is outside the expected range of performance. A mortality outlier alert can be generated by an external organisation or internally where data shows that the trust performance in relation to mortality is below the expected level. Commonly this will be in the form of a relative risk or CUSUM alert from Telstra Health UK (THUK). Where a mortality outlier alert is received the following is a summary of the process that will be followed:

1. A clinical lead will be identified (either the service / directorate LML or the service lead / clinical director). They will co-own the alert with the Head of Clinical Coding, supported by the Trust Mortality Lead and Quality and Assurance Directorate.
2. The patient cohort relating to the alert is anonymised and cannot be reidentified directly. However, an approximate cohort will be extracted from THUK using the Re-ID tool using the date range and diagnosis group(s) filter
3. For the patient cohort identified, the Quality and Assurance Directorate will conduct a review and summarise data from RADAR for incidents, complaints and mortality reviews (including SJR) outcomes

4. The outlier alert will then be undergo a two stage review:
   4.1. The first stage will be a review of coding / data quality by clinical coding. This will examine the appropriateness of primary diagnosis codes, admission type and depth of coding. If coding improvements are identified they will be proposed and an action plan made for future sustainable improvement in coding
   4.2. The second stage will be by the clinical lead and will identify of there have been any internal concern with respect to this patient group (e.g. internal audit, Speaking Up, Morbidity and Mortality process; Learning from Deaths, inc. d/w Medical Examiner; PSIIs, complaints) OR if there is any external data or review (e.g. national audit; peer review process; coroner's investigations, HSIB reports) that would reflect this patient group or the attributable service and if so if there been any concern identified
5. Based on 4.1 and 4.2 a determination will be made on whether there are data quality concerns (no concerns, possible, definite) and if there are clinical concerns (no concerns, possible, definite)
6. If unable to attribute alert to data quality, if alerts persist despite data quality action plan and / or if unable to positively confirm 'no clinical concerns', additional review is recommended:
   6.1. Additional bespoke analysis from THUK, for example to review the relative inclusion of different codes and risk within a diagnostic group AND/OR
   6.2. Retrospective mortality review of the patients using an appropriate and proportionate methodology AND/OR
   6.3. Prospective review by SJR of subsequent deaths under this diagnosis or procedural group for an appropriate period.
7. The outcome of the two stage response will be presented back to TMSG to provide assurance that any concerns identified have been addressed and there are no concerns about outlier mortality status.
8. The status and outcome of outlier alerts will be included in reports to TRAC until resolved.

14 Monitoring and assurance

The implementation of this policy, the reporting and subsequent review of deaths and the dissemination of learning will be monitored through the following internal and external groups and committees.

Committee	Responsibilities
Trust Mortality Surveillance Group (TMSG)	This meeting will meet monthly and oversee, monitor and support the Directorates/Specialties with the implementation of the Learning from Deaths policy. Directorates will report to TMSG to present their mortality trends and learning on a rolling rota basis. Compliance with first stage reporting of a death and detailed SJR or SI reviews will be monitored by TMSG, and escalated to TRAC as necessary.
Trust board	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.* The Trust Lead for Mortality Surveillance and Review supported by the Quality and Assurance Team will report quarterly to the TRAC and the Patient Safety Committee This report will include: • The total number of inpatient deaths in the organisation's care. • The number of adult deaths the trust has subjected to case record review / SJR • The number of deaths investigated as Patient Safety Incidents. • Of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care.

	• The themes and issues identified from review and investigation, including examples of good practice. • How the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.
Patient Safety Committee	Summary of thematic learning from deaths and detailed SJR, RCA and SI reviews and the implementation of change and/or sharing of the learning will be monitored by PSC
SEL ICB Mortality Review Group	The Trust Lead for Mortality Surveillance and Review supported by the Quality and Assurance Team will attend the ICB meeting quarterly. This report will address any specific questions raised by the CQRG prior to the annual report, along with updates on the: • Overall Trust level mortality indices (such as SHMI and HSMR) and comparison with other organisations • Thematic learning from the mortality deaths and the sharing/implementation of change based on this learning • Engagement in LeDeR project and sharing of learning from these reviews • Involving bereaved families and carers following a death
Lambeth, Southwark & Bromley Child Death Overview Panel (CDOP)	The panel meets monthly to analyse independently the information provided and determine any contributory factors; identify learning; make recommendations to relevant organisations; provide specified data to the National Child Mortality Database; produce an annual report for CDR partners on local patterns and trends in child deaths, lessons learned and actions taken and the effectiveness of the wider CDR process; and to contribute to local, regional and national initiatives to improve learning for child death reviews.

15 References

Document title	Publisher	Date	Comments
Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers	National Quality Board	2018	Supporting and involving carers and families
National Guidance on Learning from Deaths	National Quality Board	2017	Throughout the policy
Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England	Care Quality Commission	2016	Throughout the policy
Child Death Review: Statutory and Operational Guidance (England)	HM Government	2018	Throughout the CDR policy
Working together to safeguard children: statutory guidance	HM Government	2023	
Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation	Royal College of Pathologists & Royal College of Paediatrics & Child Health	2016	Due for update