

# Learning from Deaths Policy

The Learning from Deaths Policy sets out the minimum acceptable standards of the national learning from deaths programme.

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## Table of Contents

	<b>Page</b>
1. Introduction	3
2. Scope	3
3. Purpose	3
4. New Requirements	4
5. Duties	5
6. Definitions	7
7. The process for recording deaths in care	9
8. Selecting deaths for case record review	9
9. Review methodology	11
9.1 Staff training and support	11
10. Reviewing outputs from review and investigation to inform quality improvement	11
10.1 Presenting relevant information in board reports	12
11. Supporting and involving family and carers	12
12. Supporting and involving staff	13
13. References	14
14. Appendices	N/A

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## 1. Introduction

Guys and St Thomas' NHS Foundation Trust (GSTT) are committed to identifying, reporting and learning from deaths which occur in our care or following interventions and to enhancing the national learning in this field through engagement with carers and families and with our clinicians.

The recent 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 (NQB) releasing its guidance (March 2017) to act as a framework for identifying, reporting, investigating and learning from deaths in care. The Learning Disability Mortality Review (LeDer) Programme has been established to support local areas to review deaths of people with learning disabilities, and to use the lessons learned to make improvements to service provision.

The latest research suggests that preventable deaths due to problems in care make up around 5% of deaths and that the variation seen in the Summary Hospital Level Mortality Indicator (SHMI) is likely due to other factors.

The Board at GSTT are embracing their role and are providing visible and effective leadership to ensure the organisation addresses any significant issues identified in reviews and investigations. Board members are eager to hear from staff, patients, families and others and provide opportunities for questions or concerns to be raised about this policy and its implementation across all clinical services.

## 2. 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.

## 3. Purpose

Guy's and St. Thomas' Trust (GSTT) will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

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This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of GSTT.

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.

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.

This policy should be read in conjunction with the Trust Incident Reporting and Management Policy, the Serious Incident Framework, the Trust Mortality Surveillance Group Terms of Reference, the Trust Complaints policy and the existing mortality governance processes.

#### **4. New requirements**

Under the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017, trusts are required to:

- Publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patients who die under their management and care, including:
  - How their processes respond to the death of an individual with a learning disability, severe mental illness and a patient who is classified as homeless.
  - Evidence-based approach to undertaking case record reviews.
  - The categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
  - How the trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
  - How staff affected by the deaths of patients will be supported by the trust.
- Collect specific information every quarter on:
  - The total number of inpatient deaths in an organisation's care.
  - The number of deaths the trust has subjected to case record review (undertaken using the SJR methodology outlined below).

- The number of deaths investigated under the Serious Incident framework (and declared as Serious 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.
- Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

This policy sets out GSTT's approach to meeting these requirements.

## 5. Duties

Roles and responsibilities for incident management, complaints handling and Serious Incident management are detailed in the relevant policies mentioned under section 3.

Role	Responsibilities
<b>Chief executive</b>	Overall responsibility for implementing the policy
<b>Non-executive directors</b> (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 <i>National Guidance on Learning from Deaths</i>  In summary, non-executive director responsibilities relating to the framework include: <ul style="list-style-type: none"> <li>• Understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny</li> <li>• Championing quality improvement that leads to actions that improve patient safety</li> <li>• Assuring published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.</li> </ul>

<b>Medical director</b>	The responsible director and lead for the learning from deaths agenda who provides assurance to the Board that the process is functioning correctly. The Medical Director must also ensure that arrangements are in place so that all clinical staff as appropriate are aware of their responsibilities to contribute and implement the policy.
<b>Deputy Medical Director</b>	Also the Chair of the Trust Mortality Surveillance Group will ensure: <ul style="list-style-type: none"> <li>• Appropriate attendance by all relevant disciplines and professional groups</li> <li>• Structured Judgement Reviews (SJR) are undertaken of deceased patients and discussed</li> <li>• Collation of findings, learning points and actions for improvement from each meeting</li> <li>• Agenda set and ensure minutes are taken and archived</li> <li>• Escalate any areas of concern to the Medical Director for action</li> <li>• Overall responsibility to ensure learning from deaths is shared across the Trust and Nationally as appropriate</li> <li>• Ensure compliance with reporting of data</li> <li>• Ensure a standardised approach is embedded across the Trust</li> <li>• Ensure an appropriate entry in the Trust Annual Quality Account</li> </ul>
<b>Directors of Quality and Assurance</b>	Delegated responsibility to support the implementation and further development of the Learning from Death process. This includes the provision of support staff to assist the clinical teams conducting the mortality reviews as well as ensuring the mortality data is monitored and acted upon as necessary.
<b>Directorate Managers and Clinical Directors</b>	Ensures that carers and relatives are fully involved in the learning from deaths process particularly where learning has been identified or there is a need for an investigation. Directorate Managers and Clinical Directors are also responsible for ensuring appropriate multi-disciplinary mortality meetings are taking place in all specialties and meetings are recorded.
<b>Clinicians</b>	Required to participate fully in the learning from

	deaths process
<b>Nurses, allied health professionals and other clinical staff</b>	Involvement in mortality reviews, as part of their clinical practice - this involvement can range from simply being aware of the outcome of the reviews to full involvement in the production of data and implementation of recommendations.
<b>Committee</b>	<b>Responsibilities</b>
<b>Trust board</b>	The <i>National Guidance on Learning from Deaths</i> places particular responsibilities on boards, as well as reminding them of their existing duties. Organisations must refer to Annex A of the <i>National Guidance on Learning from Deaths</i> .
<b>Trust Mortality Surveillance Group (TMSG)</b>	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 the TMSG on a monthly basis, each directorate will be required to present their mortality trends and learning on a rolling rota basis.
<b>Trust Risk and Assurance Committee (TRAC)</b>	The TMSG will report monthly to TRAC and compliance with the policy will be monitored via the monthly update.

## 6. Definitions

The *National Guidance on Learning from Deaths* includes a number of terms. These are defined below.

### Death certification

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

### Case record review

A structured review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also

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be done where concerns exist, such as when bereaved families or staff raise concerns about care.

### Mortality review

A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

### Serious Incident

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation’s ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the [Serious Incident framework](#) for further information.

### 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 observation, 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 or 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.

### Death due to a problem in care

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/service provision. (Note, this is not a legal term and is not the same as ‘cause of death’). The term ‘avoidable mortality’ should not be used, as this has a specific meaning in public health that is distinct from ‘death due to problems in care’.



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### Quality improvement

A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

### Patient safety incident

A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

## **7. The process for recording deaths in care**

All areas are expected, as part of the minimum national requirement, to adopt the overarching principles of routine and systematic mortality reviews, which includes reviewing all deaths. It is vital that Guys and St Thomas' NHS Foundation Trust adopt a standardised approach to this.

GSTT use Datix, an electronic platform, to record all deaths and the associated data pertaining to the deaths e.g. localised service / Directorate review and Structured Judgement Review outcomes.

## **8. Selecting deaths for case record review (Mortality Review)**

This section relates to case record review and not to patient safety incidents or incidents that fall under the Serious Incident framework.

Based on National Guidance on Learning from Deaths from the National Quality Board, The Trust will undertake Mortality Review by Structured Judgement Review for patients who fall into the following categories:

### **1. Mandated Mortality Review Required**

- **Learning disabilities:** The National Learning Disability Mortality Review (LeDeR) Programme aims to review all deaths of people with learning disabilities aged 4 years to 74 years, regardless of whether the death was expected or not. The TMSG has regular representation from the safeguarding team. The safeguarding team should be notified if a patient with a learning disability has died. Where appropriate

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the internal Trust mortality review will form part of the wider LeDeR project review when undertaken

- **Severe Mental Illness:** Currently this group of patients will include patients being actively treated for a severe mental illness; require registered mental health nurse (RMN) supervision and detained under the Mental Health Act (MHA).
- **Concerns About Quality of Care:** All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.
- **All deaths where people are not expected to die:** to include certain elective procedures and those admitted where sudden unexpected cardiac arrest occurs.

## 2. Local Agreed Mortality Review

In addition to the mortality review of those deaths mandated above from the *National Guidance on Learning from Deaths*, the Trust will also undertake a mortality review on inpatient deaths in the following areas:

- **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 speciality Summary Hospital-level Mortality Indicator or other elevated mortality alert or concerns raised by the Care Quality Commission or another regulator) or internal audit and review (for example the Acutely Ill Patient Review Group).
- **Deaths where learning will inform the provider’s existing or planned improvement work:** Initially this will include the review of those patients who are street homeless at the time of death as part of local variation in terms of street homelessness in the local community.
- **External Concerns about previous care:** Deaths where other organisations/care providers have expressed concern with care given to its current or past patients but who were not under its direct care at the time of death.
- **Sample of deaths not fitting into any of the above categories:** This will enable review of cases to identify additional learning and potential improvement. To facilitate this there will be review of deaths occurring on a certain day of the week in the month (e.g. all deaths occurring on a Monday will be reviewed in January)

GSTT will make every effort to work with partner organisations to investigate deaths where there are concerns about a patient’s care which spans multiple organisations and pathways e.g.

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where patients are under the care of a tertiary specialist for part of their care and receiving care from their local acute Trust for other elements.

## **9. Review methodology**

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

GSTT will adopt the SJR review methodology. 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 be identified throughout the case review. Further information on this approach can be sourced [here](#). All deaths that are identified to require a mortality review by SJR in Section 8 above will have this mortality review undertaken within 2 months of determining that the review is required. Where a review carried out by the trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with the Trust's [Incident Reporting and Management Policy](#).

### **9.1. Staff training and support**

Appropriate training will be provided for all staff undertaking SJR mortality reviews. The Trust will access specialist external training for the Structured Judgement Review programme and LeDeR review programme. In addition, the Trust will provide a cascade approach to further training to ensure the workforce are competent to achieve the goals of this policy.

## **10. Reviewing outputs from review and investigation to inform quality improvement**

The issues and learning identified from the reviews presented at the TMSG will be used to inform quality improvement projects throughout the Trust e.g. Safety Signals, Grand Round

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discussion, Schwartz Round, Trust wide newsletter and through papers to various committee's and discussion at local governance meetings.

### **10.1 Presenting relevant information in board reports**

GSTT will present it's Learning from Deaths data to the Quality and performance committee, which is a subcommittee of the Board on a quarterly basis via the Trust Quality and Performance Meeting.

## **11. Supporting and involving families and carers**

Guys and St Thomas' NHS Foundation Trust are committed to meaningful engagement with bereaved families and carers in relating to all stages of responding to a death and will ensure:

- Bereaved families and carers will be treated as equal partners following a bereavement
- Bereaved families and carers will always receive a clear, honest, compassionate and sensitive response in a sympathetic environment
- Bereaved families and carers will 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.
- Bereaved families and carers will be informed of their right to raise concerns about the quality of care provided to their loved one
- Bereaved families and carers views will help to inform decisions about whether a review or investigation is needed

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- Bereaved families and carers will 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.
  - Bereaved families and carers who have experienced the investigation process should be supported to provide feedback which will help in delivering training for staff in supporting family and carers in future.

We will also consider:

- Timely access to an advocate (independent of the Trust)
- Support with transport and communication
- Support during and following the investigation

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

- [Being Open framework](#)
- [Saying Sorry](#)

Families and carers of the deceased will be written to shortly after their loved one's death. This letter will invite them to make contact if there have been any concerns relating to the care of their relative/friend. This letter will include a survey to capture their experience and concerns/issues. This is in addition to the PALS service and complaints service.

## **12. Supporting and involving staff**

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](#)
- [Guidance on obtaining legal and other advice](#)

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## 13. References

<b>Document title</b>	<b>Publisher</b>	<b>Date</b>	<b>Comments</b>
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
Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study.	British Medical Journal	2012	Introduction
Severe Mental Illness; Health outcome indicator	Department of Health	2000	Mandated reporting group