Key message

The purpose of this policy document is to describe how West Suffolk NHS Foundation Trust responds to, and learns from, the deaths of people who die under our management and care.

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1. INTRODUCTION

West Suffolk NHS Foundation Trust (WSFT) endeavours to provide outstanding quality care to all our patients, their relatives and carers.

However, international research shows that problems in healthcare arise and that in some cases those problems cause harm. In a very small percentage of cases, the harm caused is unfortunately serious enough that it hastens or precipitates the patient’s death.

WSFT has had a system of mortality case record review in place for some time. In March 2017, NHS Improvement and the Care Quality Commission jointly launched the national Learning from Deaths programme, to standardise the way NHS trusts and foundation trusts do this important work.

This policy document lays out how WSFT will update its approach to learning from deaths to meet the recommendations in the new national guidance¹.

2. SCOPE

This policy applies to:

- All staff involved in patient care, quality and governance
- Deaths as defined in paragraph 5.1

3. DEFINITIONS

3.1 Case record review

The application of a case record review to determine whether there were any problems in the care provided to the patient who died, in order to learn from what happened.

3.2 Investigation

An investigation under the Serious Incident Framework².

4. RESPONSIBILITIES

The Medical Director is responsible for the learning from deaths agenda within the trust and therefore is responsible for ensuring that this policy is implemented.

The nominated Non-Executive Director is responsible for Board-level oversight of implementation.

The policy author is responsible for ensuring the policy is up to date and complies with national guidelines and legislation. The author will monitor the policy against the key performance indicators and maintain the Equality Impact Assessment. The policy author is responsible for bringing non-compliance issues to the Learning from Deaths group for action. The policy author will ensure the policy is reviewed at the date stated.


² Available at https://improvement.nhs.uk/resources/serious-incident-framework/ Accessed 11/07/2017
5. **WSFT PROCESS FOR LEARNING FROM DEATHS**

5.1 **Deaths in scope**

WSFT will review the quality of care given to all patients who die under our care and management. We will define patients under our care and management as comprising:

- all inpatients in West Suffolk NHS Foundation Trust
- all patients attending West Suffolk Hospital emergency department

People who are receiving care as outpatients or on our community services case list will not routinely be considered in scope, pending specific guidance from the National Quality Board on learning from deaths in community trusts. We will, however, willingly conduct a case record review for any patient who has died outside hospital, for whom another care agency, or the patient's relatives or carers, would like us to review the care the patient received from us.

In all cases, deaths which require investigation will be managed by that process and a separate case record review will not be performed.

5.2 **Method for mortality case record review**

WSFT will use a single-stage version of the Royal College of Physicians' Structured Judgment Review (SJR) method. The method will be introduced during 2017/18.

5.3 **Process for mortality case record review**

When a death is documented in the electronic patient record it is reported to the bereavement office and the Learning from Deaths coordinator.

Senior clinicians will perform the case record reviews. The post of Medical Reviewer will be introduced in 2017/18 to create protected time and develop the necessary expertise. Medical reviewers will be trained to use the SJR method and data will be collected on an electronic database. The process will be supported by the Learning from Deaths coordinator.

The case record review will be performed promptly after a patient has died. The review will be informed by conversations with the clinical team who looked after the patient, the patient’s relatives or carers, and any other agencies who were involved in the patient’s care immediately preceding their death.

Medical reviewers will liaise closely with the hospital bereavement service and the patient advice and liaison service to offer relatives and carers the opportunity to give feedback on the quality of care received at a time which suits them. This need not be straightaway.

Medical reviewers will identify any problems in care which they judge to have arisen and inform the clinical team of their judgment. They will also consider whether the problems had a material impact on the time or circumstances of the patient’s death and make a judgment about whether, on balance, the death was potentially avoidable.

5.4 **Deaths in people in groups under special focus**

The following five groups of patients will be subject to special focus for mortality review.
a. People who have a learning disability
Any patient who dies and who has been identified as having a learning disability by themselves, a relative or carer, or any agency involved in their care, will be referred for full review by the national Learning Disabilities Mortality Review Programme (LeDeR). WSFT will cooperate fully with the LeDeR process.

b. People who have severe mental illness
The trust’s response to some deaths in people who have severe mental illness is already determined under the Care Quality Commission (Registration) Regulations 2009, the Coroners and Justice Act 2009 and the Serious Incident Framework.

If a patient who dies has been identified as having a severe mental illness by themselves, a relative or carer, or any other agency involved in their care, and the response to their death is not already governed by one of these instruments, the trust will undertake a case record review internally and will also willingly contribute to a multi-agency review with other agencies involved in the patient’s care.

We will define severe mental illness as equal to serious mental illness as described by NHS Digital in the NHS Outcomes Framework3 (indicator 1.5i Excess under 75 mortality rate in adults with serious mental illness). That is, any person who has been in contact with secondary mental health services in the current or last two financial years.

c. Infants and children
The trust will continue to participate in the full multi-agency reviews conducted by the Suffolk Safeguarding Children Board Child Death Overview Panel. A separate case record review will only be undertaken in the case of a young person aged 16-18 who has died after being cared for in one of our adult inpatient wards.

d. Babies who are stillborn
The maternity service will continue to conduct a local review of the care received when a baby is stillborn.

e. Women who die during or after pregnancy or childbirth
The care provided to women who die during or after pregnancy or childbirth will be subject to full review using the SJR method.

5.5 Process for learning

Medical reviewers will provide a copy of their case review report and verbal or written feedback to the responsible clinician in every case. Where problems in care have been identified, the responsible clinician will be required to demonstrate that the case has been discussed and reflected upon at the appropriate ward, departmental or divisional governance meeting. The medical reviewer will be informed of any learning which is identified during the discussion and any actions which have been agreed.

Medical reviewers will meet regularly to identify themes in learning which have arisen over time.

A multidisciplinary Learning from Deaths group will meet monthly. The group’s terms of reference are appended to this policy.

The Learning from Deaths group will receive reports on deaths in the following categories:

- Every death where the Medical Reviewer’s judgment is that a problem in care has led to a potentially avoidable death
- Every death in a patient in a group under special focus (paragraph 5.4)

The Learning from Deaths group will also consider:

- learning and actions which have been identified by clinical teams and progress towards their implementation
- themes which the Medical Reviewers have identified as common across multiple cases.

The Learning from Deaths group will identify learning which has relevance to other parts of the trust and will advise the quality team of actions which will require support for implementation. The Learning from Deaths group will also identify learning which should be shared beyond the trust, with partner agencies or with fellow NHS trusts.

The group, through its chair, will be responsible for facilitating shared learning which may include, but not be limited to, a regular newsletter and learning events for staff and the wider system.

The reports, views and decisions of the Learning from Deaths group will be considered alongside other sources of information about care quality by the Quality Group under the trust’s Quality Assurance Framework.

### 5.6 Engagement with families and carers

Families and carers will be offered information on the progress and conclusion of the mortality case record review for each deceased patient. They will be able to receive this in the format of their choice, including by telephone, face to face or in writing. The information, as requested, will be provided in plain English so medical terminology does not act as a barrier to understanding. The trust will not make an assumption that families and carers wish to receive information about the mortality case record review and will respect their privacy following their bereavement.

The conclusion of the case record review will also be communicated in writing to the deceased patient’s GP.

Families’ and carers’ involvement in the learning process and implementation of actions which are identified will be welcomed and encouraged. This will be facilitated by the quality team and the patient advice and liaison team.

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4 Defined as an avoidability of death judgment score of 1, 2 or 3 in the structured judgment review
If families or carers wish to obtain legal advice about the circumstances of the deceased patient’s death, the patient advice and liaison team or the legal services team will be able to provide initial guidance. If the trust wishes to obtain legal advice about the risk of legal action concerning possible clinical negligence or professional misconduct, the legal services team or the human resources team respectively will inform the family or carers.

5.7 Data collection and reporting

The Learning from Deaths group will collect and report the results of the case record reviews, including the number of deaths which are judged to be more than 50% likely to be due to a problem in care. This information will be reported to the trust Board in public on a quarterly basis, effective December 2017.

The Learning from Deaths group will also report the ways in which it has acted on its learning from deaths, and how those actions have improved quality of care and patient safety, in the annual Quality Account, effective April 2018.

6. CONSULTATION

This policy has been prepared in consultation with:

- the members of the Learning from Deaths group
- the Learning Disability Liaison Nurse
- the Bereavement Officer
- the Patient Advice and Liaison Service manager
- the Information Governance and Legal Services manager
- a family representative
- the Acting Head of Midwifery
- the Senior Midwife for Risk Management

7. EQUALITY IMPACT ASSESSMENT

An equality impact assessment of this policy has been completed. No unfavourable impact on any group or individual with a protected characteristic has been identified.

8. APPROVAL PROCESS

This policy has been considered and approved by:

- the Trust Executive Group
- the Learning from Deaths group
- the Clinical Safety and Effectiveness Committee
- the Trust Board

9. IMPLEMENTATION & MONITORING

The policy will be implemented and monitored as described in section 5.

10. REVIEW

The policy will be reviewed every three years. An earlier review will be conducted if changes or additions are made to the national Learning from Deaths guidance.
### Appendix: EQUALITY/DIVERSITY ASSESSMENT TOOL

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<td><strong>Division</strong></td>
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<tr>
<td><strong>Completed by</strong></td>
<td>Dr Helena Jopling, Public Health Registrar</td>
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| Does this document affect an individual’s human rights? | No |

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<td><strong>File name:</strong></td>
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Source: Dr Helena Jopling, Public Health Registrar
Issue date: Aug 2017
Review date: Aug 2020
Document reference PP(17)350
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Learning from Deaths group
Terms of Reference

1. Aim

The Learning from Deaths group exists to ensure that West Suffolk NHS FT learns from, and acts upon, the quality of care provided to people who die under our management and care.

2. Responsibilities

The Chair of the committee will convene the group for monthly meetings. The Chair will report the group’s outputs to the Clinical Safety & Effectiveness Committee or Patient Experience Committee as appropriate, and to the Trust Board. The Chair will escalate identified risks to quality of care to the Quality Group.

All members will promote and contribute to the identification of problems in care associated with a patient’s death, and participate in securing meaningful action to reduce the likelihood of those problems recurring. All members of the group will also promote and advocate for the celebration of good care which is apparent in case record reviews.

All members of the group must adequately prepare for the meeting by reading the papers and provide effective challenge to the issues under discussion. If a member is unable to attend a suitable deputy should attend instead.

3. Core Responsibilities

- To enact the Learning from Deaths policy
- To synthesise the information arising from case record reviews to understand problems in care which have caused or contributed to the time or circumstances of a patient’s death
- To ensure that learning from these problems in care occurs and that meaningful actions which will reduce the likelihood of the problems recurring are identified
- To recognise when these actions are likely to need support in order to be implemented, and secure it
- To pay particular attention to the care received by people with learning disabilities or severe mental illness, to make sure it is equitable and matches the standard the Trust aspires to for all its patients
- To advocate for the involvement of families and carers in quality improvement
- To report on a quarterly basis to the Trust Board, information on the number and nature of problems in care which are associated with a patient’s death
- To report in the annual Quality Account, how the actions taken in response have improved quality of care

4. Composition

The membership will be as set out below:

- Executive Medical Director (Chair)
- Executive Chief Nurse
- Deputy Medical Director
- Associate Chief Nurse & Head of Patient Safety
• Clinical Directors for all Divisions
• Director of Medical Education
• Public health registrar
• Heads of Nursing
• Medical Reviewers (once appointed)
• Consultant general surgeon
• Consultant in palliative care medicine
• Resuscitation & Outreach Service Manager
• Mortuary manager
• Clinical Coding Manager
• Senior Information Analyst
• Learning Disability Liaison Nurse
• Senior Midwife for Risk Management
• Non-Executive Director
• Family representative

A quorum will be 7 members of the Committee. At least one of the following must be present: the Executive Medical Director, Executive Chief Nurse, Deputy Medical Director or a Head of Nursing/Associate Chief Nurse; plus a Clinical Director.

5. Accountability

- The group is accountable to the Clinical Safety & Effectiveness Committee.
- The group will escalate issues of concern to the Quality Group.

6. Authority

- The group will have authority to establish subgroup.
- The group will have authority to approve relevant policies and procedures.
- The group will escalate risks, it determines as appropriate, to the Quality Group.

7. Review Arrangements

The terms of reference are to be reviewed on an annual basis at the first meeting in the new financial year.