TRUST POLICY AND PROCEDURE FOR LEARNING FROM DEATHS, CLAIMS AND INCIDENTS

<table>
<tr><td>Reference Number:
POL-CL/2187/17</td><td colspan="2">Version:
V4</td><td>Status
Final</td><td>Author: Aklak Choudhury
Job Title: Deputy Medical Director Quality and Safety</td></tr>
<tr><td rowspan="3">Version Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td>Reason</td></tr>
<tr><td>1</td><td>July 2017</td><td>Lorna Priestman, Associate Director</td><td>New Policy</td></tr>
<tr><td>4</td><td>September 2023</td><td>Aklak Choudhury, Deputy Medical Director Quality and Safety</td><td>Routine scheduled update with specific detail regarding triangulation of patient safety incidents and coronial referrals.</td></tr>
<tr><td colspan="5">Intended Recipients:
• Mortality Leads
• Clinical Governance Facilitators
• All Clinical Staff
• Legal Team
• Business Intelligence Team
• Bereavement Office
• Medical Examiner's Office
• Patient Safety Groups</td></tr>
<tr><td colspan="5">Training and Dissemination:
• Communication via Trust website NET-i
• Briefings at the Learning from Deaths, Claims and Inquests Group
• Educational content with use of animation videos and worked examples
• Downward cascading to divisional and Business Unit meetings via cascade learning.</td></tr>
<tr><td colspan="5">To be read in Conjunction with:
• Safeguarding Adults - Trust Safeguarding Policy and Procedure:
• Safeguarding Children Supervision - Trust Safeguarding Policy and Procedure Mental Capacity Act
• Healthcare Safety Investigation Branch - What we Investigate
• Incident Reporting, Management and Learning – Trust Policy and Procedure link here
• Child Bereavement - Trust Policy

Links to these materials are in Section 18.</td></tr>
<tr><td colspan="5">In Consultation with and Date:
• Learning from Deaths. Claims and Inquests Group - Date: 14th November 2023</td></tr>
<tr><td colspan="5">EIRA Stage one Completed N/A
Stage two Completed N/A</td></tr>
<tr><td colspan="3">Approving Body and Date Approved</td><td colspan="2">Trust Delivery Group / December 2023</td></tr>
<tr><td colspan="3">Date of Issue</td><td colspan="2">July 2017</td></tr>
<tr><td colspan="3">Review Date and Frequency</td><td colspan="2">December 2026 - every three years</td></tr>
<tr><td colspan="3">Contact for Review</td><td colspan="2">Lara Raworth - Medical Director's Office Manager</td></tr>
<tr><td colspan="3">Executive Lead Signature</td><td colspan="2"></td></tr>
</table>

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Appendices

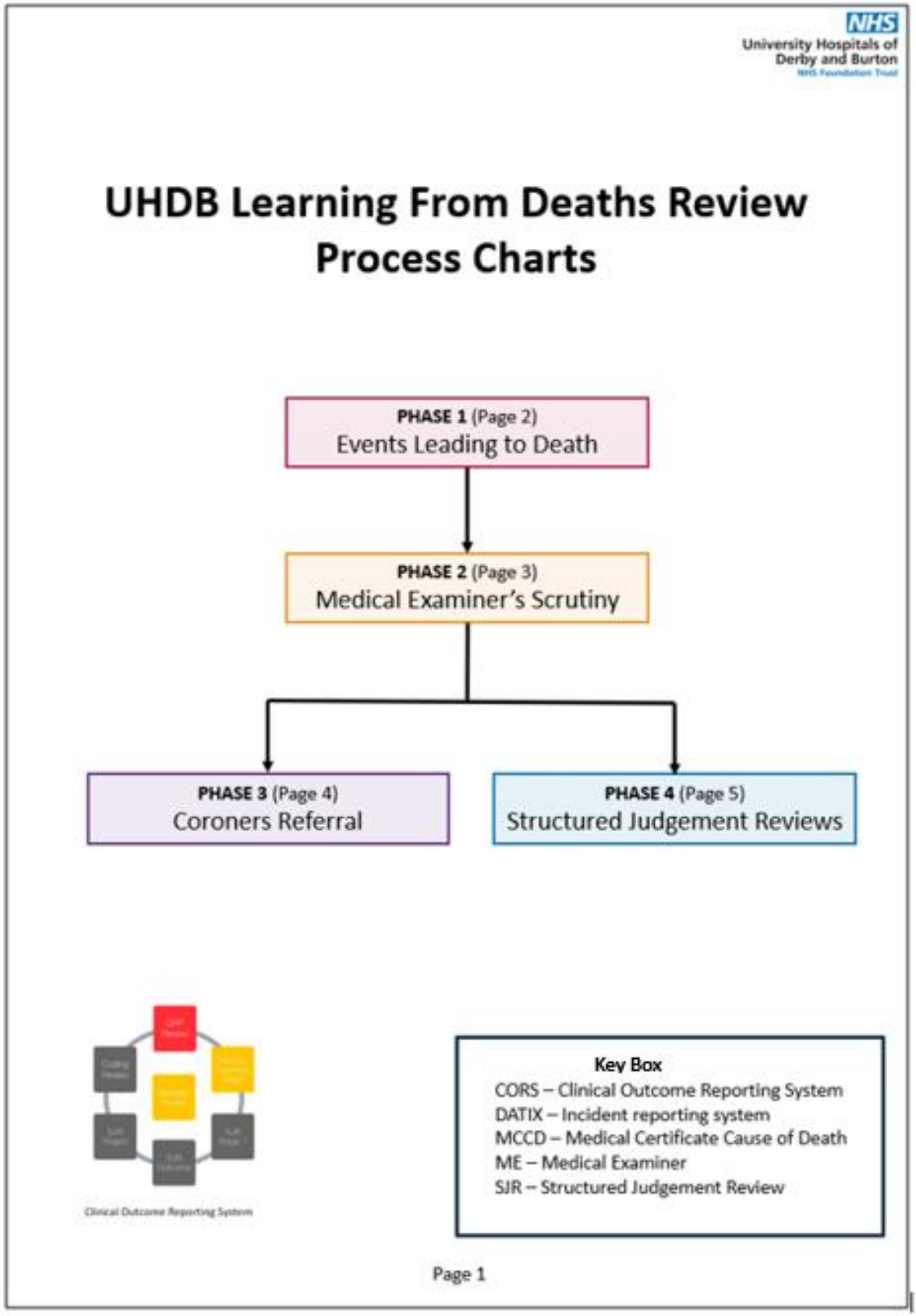
1. Introduction

Many people experience excellent care from the NHS in the months or years leading up to their death. However, some patients do not experience the quality of care that they expect and to which is aspired. This can result from multiple contributory factors, which may include poor leadership and system-wide failures. When lapses in care occur, health organisations working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths is to learn in order to prevent recurrence of sub-optimal care and share good practice when a death has been managed well. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

2. Purposes and Outcomes

It is compulsory to review all deaths of patients in the care of the NHS as stipulated by NHS England National Guidance on Learning from Deaths. When mistakes happen or poor care is delivered, there needs to be more done to understand the causes and make improvements. The purpose of reviews and investigations into patient deaths where there may have been problems, is to learn from this process, offer explanations to those who are bereaved and prevent recurrence in the future for other patients. Reviews and investigations can only be useful for learning purposes if their findings are valued, shared and acted upon in the spirit of transparency and improvement. This process can also acknowledge good practice and provide positive opportunities to share and help other teams. The NHS requirements for compulsory review of deaths in NHS care set out in policy by the National Quality Board, confirmed a decision by the government in June 2018 to implement the regulations 18-21 of the Coroners and Justice Act 2009 to establish a Medical Examiner (ME) role and service in England and Wales. This was in response to a number of high-profile criminal cases and a number of system failures as well as more recent events relating to infant deaths and “analgesia accelerated deaths”. The policy supports the operational procedure that clinicians must follow in reviewing and reporting information in clinical governance meetings in their specialty, Division and to the Trust Learning from Deaths, Claims and Inquests Group (LFDCIG). There will be a strong focus on learning from deaths. The Trust will develop mechanisms to encourage an open learning environment and culture with regards to deaths. The Trust shall collect and collate themes related to deaths that will instruct future improvement programmes and support triangulation across incidents and coronial referrals whilst ensuring consistent, constructive and fair evaluation of the actions of staff involved in related patient safety incidents.

3. Learning from Death Reviews Process Charts

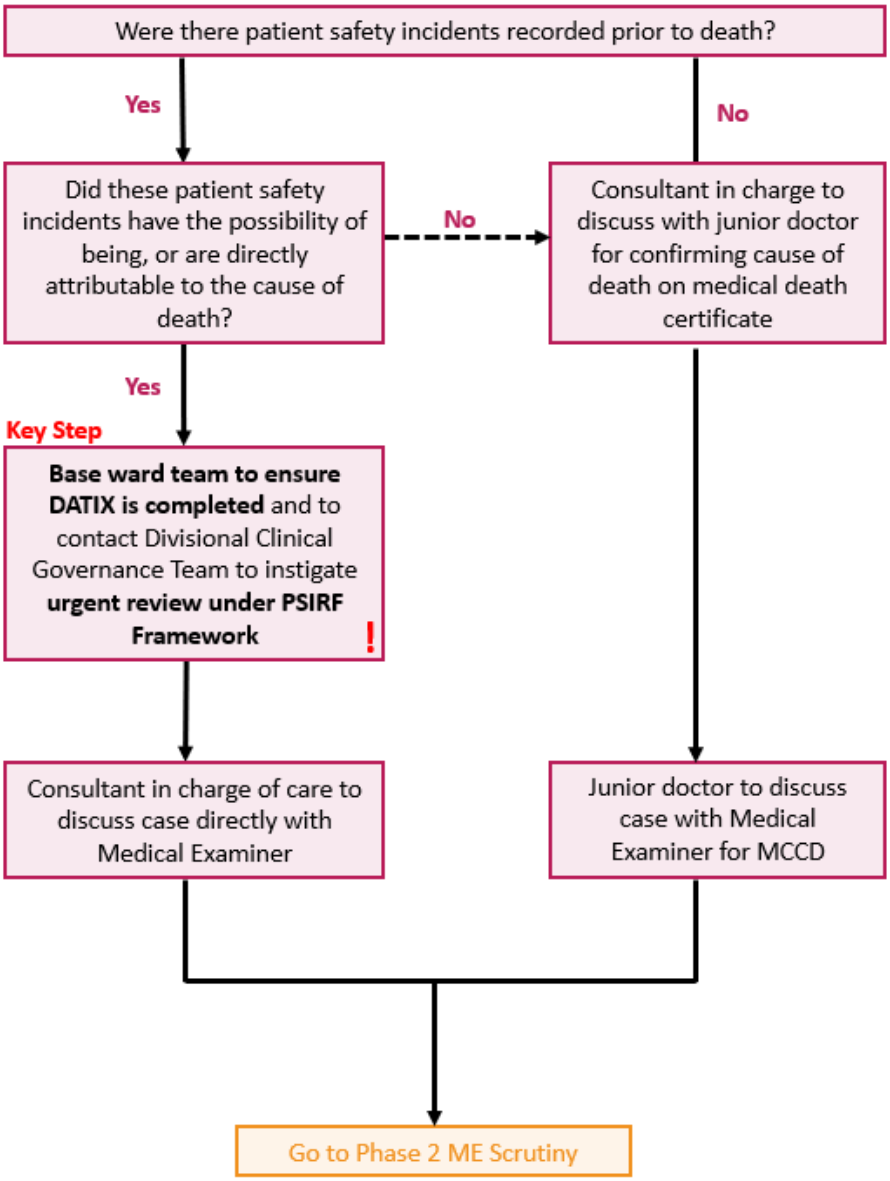


UHDB Learning From Deaths Review Process Chart

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Phase 1 – Events leading to death

PLEASE START HERE



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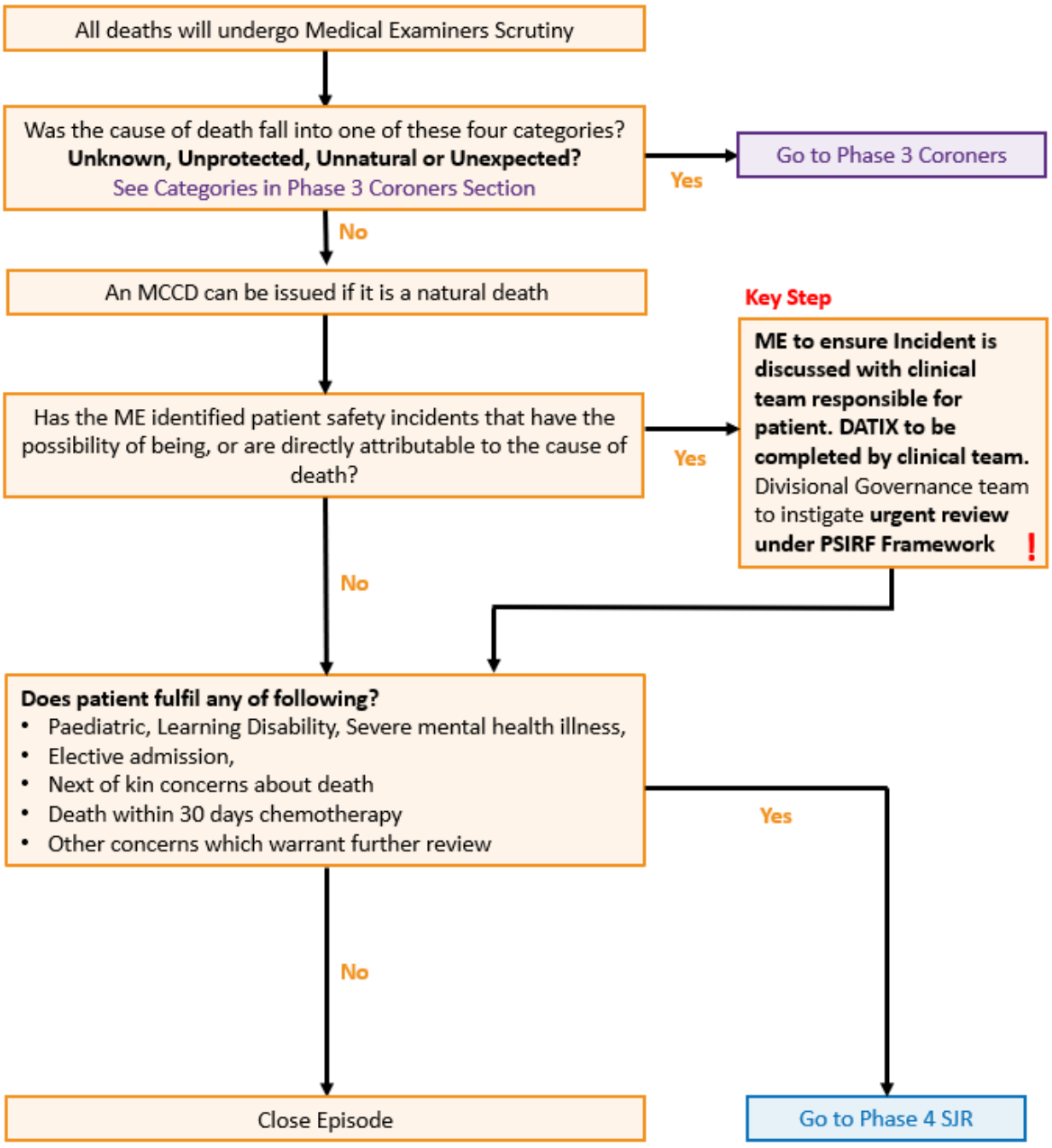
UHDB Learning From Deaths Review Process Chart

University Hospitals of Derby and Burton NHS Foundation Trust

Phase 2 – ME Scrutiny



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UHDB Learning From Deaths Review Process Chart

University Hospitals of Derby and Burton NHS Foundation Trust

Phase 3 – Coroners Referral

Confirm that the death fulfils one of the four Coronal referral categories below

Unknown
- Cause of death unknown /unexplained
- Deceased identity unknown
- GP unknown (for community deaths)
  Not attended in last 28 days or unable / refuses to sign MCCD

Unprotected
- In custody / state detention / on parole
- Significant care needs for learning disabilities
- Patient subject to S42Care Act (Safeguarding) processes
  Failure to provide care or delayed timely intervention

Unnatural
- Violent or traumatic death**
- Traumatic falls leading to death
- Poisoning / toxic substances
- Controlled drugs
  Medicine
  Psychoactive substances
- Death due to injury or disease attributable to Industrial Employment (in their lifetime)

Unexpected
- Post-operative or post-invasive procedure within last year if operation was contributory to cause
- Hospital Acquired Infections leading to death
  C Diff. / MRSA / Norovirus
- Medication errors
  Wrong dose / wrong meds
  Delayed treatment
  Incorrect / inappropriate treatment

Has the ME identified patient safety incidents that have the possibility of being, or are directly attributable to the cause of death?

Yes

Key Step

ME to ensure Incident is discussed with clinical team responsible for patient. DATIX to be completed by clinical team. Divisional Governance team to instigate **urgent review under PSIRF Framework** !

No

Coronial referral to be completed by junior doctor

Coroner's Decision

Information Box

1. ME will discuss patient safety incident with the clinical team. The discussion will be logged by MEO office and shared with the divisional clinical governance team. It remains the responsibility of the responsible clinical team for the patient to enter a DATIX incident form.
2. If a Coroner's Inquest is taking place, the referral to Coroner does not impact on the ME decision to request a Structured Judgement Review
3. All Coroner's Inquests and Fatal Claims must be discussed in Departmental Mortality and Morbidity Meetings

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UHDB Learning From Deaths Review Process Chart

University Hospitals of Derby and Burton NHS Foundation Trust

Phase 4 – Structured Judgement Reviews

Has case been identified for a Structured Judgement Review?
See all criteria in Box 1

Yes

All SJRs to be completed on
Clinical Outcome Reporting System **(CORS)**

Departmental Mortality Lead to allocate **SJR level 1** to clinicians NOT involved in patient's care
(12-week timeframe to completion)

SJR1 to be presented to **local departmental** Learning from Deaths meeting (i.e. Mortality and Morbidity meeting)
Learning themes and actions minuted for each case

Were there care problems identified by SJR1 review criteria?
Overall care score of poor or very poor
OR Avoidability of Deaths Scale 3 (CORS criteria – Box 2)

No → Departmental SJR Cases (using Learning From Deaths report template) to be discussed at Business Unit Mortality Review Meeting

Yes

Key Step

Consultant in charge of completing SJR1 to ensure **DATIX is completed if Avoidability of Death Score on CORS is 3** and to contact Divisional Clinical Governance Team to instigate **urgent review under PSIRF Framework** !

Departmental Mortality Lead to allocate **SJR level 2** to clinicians NOT involved in patient's care
(Additional 4-week timeframe to completion)

SJR2 to be presented again ay **local departmental** Learning from Deaths meeting (i.e. Mortality and Morbidity meeting)
Please invite representatives from other relevant departments for shared learning

Business Unit Learning From Death 'Alert, Advise, Assure' Report template to be discussed at Divisional Governance Board Meeting

SHARED LEARNING
Business Unit Learning From Death 'Alert, Advise, Assure' reports to be provided to Trust Learning From Deaths, Claims and Inquests Group

Box 1- Criteria for SJR Reviews

Group 1– Identified by ME for an SJR review (See Phase 2 – ME scrutiny section)
Group 2 – Agreed Departmental, Business Unit, Divisional Mortality Alert or National Audit SJR review requirement
Group 3 – Requirement to complete 20% allocation of SJR reviews within department

Box 2- CORS Avoidability of Death Scale

Score 3 – Suboptimal care, different care WOULD REASOBALY EXPECTED to have made a difference (probably avoidable)
Score 2 – Suboptimal care, different care MIGHT have made a difference (possibly avoidable)
Score 1 – Suboptimal care but different management would have made no difference to the outcome
Score 0 – No suboptimal care identified

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4. Definitions and / or Abbreviations Used

The Trust	Refers to University Hospitals of Derby and Burton NHS Foundation Trust.
Staff	Refers to all employees of the Trust including those managed by a third-party organisation on behalf of the Trust.
Case Record or Mortality Review	The application of a case record / note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review (SJR) delivered by the Royal College of Physicians model.
Medical Certificate Cause of Death (MCCD)	In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes.
Structured Judgement Review (SJR)	The application of a case notes review, by a clinician, to determine whether there were any problems or deficiencies in the care provided to the patient who died in order to learn from what happened. For the purposes of this document the Structured Judgement Review is the same as the one published at the Royal College of Physicians.
Investigation	The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation, in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar

	events. Cases referred to the Coroner should not be excluded from the review process but may require additional investigation and improvement actions following the Coroner's verdict. The NHS Patient Safety Strategy 2019 describes an updated process where patient safety will continue to be improved, building on the foundations of a safer culture and safer systems.
Death Due to a Problem in Care	A death that has been clinically assessed using a recognised methodology of case note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.
Avoidable / Preventable	These terms are used interchangeably in the NHS and for the purpose of this Policy 'preventable' or 'unpreventable' will be used with reference to whether anything could have been done to change the outcome.
Crude Mortality	The total number of deaths as a percentage of the total number of spells. Although this is not risk adjusted, monitoring trends in crude mortality can quickly highlight when things are going wrong.
Mortality	In-hospital deaths in patients under the care of a defined consultant.
Morbidity	Complications that occur causing the patient to need further intervention or a prolonged stay in hospital. Categories could include: (i) Specifically defined morbidities i.e. predefined complications (ii) Incidents or misadventures causing morbidities (iii) Any other unexpected morbidity, based on clinical judgement.

Mortality Review Meetings	A mortality meeting where a multi-disciplinary group review and discuss clinical cases, outcome data and related information (e.g. Patient Safety Incident Investigations, complaints or other benchmarking data). This will include development of themes and potential coordinated improvement work.
Clinical Outcome Review System	Abbreviated often to CORS, this is the online database used by the Trust to manage the Learning from Death Pathway including Medical Examiner scrutiny and Structured Judgement Review responses
Medical Examiner (ME)	ME are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

5. Key Responsibilities / Duties

The Trust Board will:

- Be satisfied that the Trust's arrangement for review of Mortality and Morbidity meetings is sufficiently robust to contribute to providing assurance that services are safe, and learning themes are identified, shared and lead to improvement.
- Ensure that learning from a review of patients who die is integral to the clinical governance and quality assurance framework
- Fulfil the standards and reporting requirements set out in national guidance
- Ensure governance arrangements and processes are in place to facilitate the review, investigation and reporting of deaths at corporate, Divisional, Business Unit and departmental levels, including those that are determined more likely than not to have resulted from problems in care
- Ensure that learning is shared with Divisions and patient safety teams with improvements made

- Ensure shared responsibility with the quality governance structures.

The Executive Medical Director will:

- Act as the Executive Lead for the Learning from Deaths, Claims and Inquests agenda and be accountable for the delivery of the review and learning process at Executive level

The Medical Director for Quality and Safety will:

- Be responsible for identifying and implementing a robust process for the systematic review of all mortality and to report thematic learning from deaths to the Quality Governance Steering Group (QGSG)
- Ensure appropriate processes between learning from deaths and patient safety incidents are robust and communicated.

The Deputy Medical Director for Quality and Safety will:

- Take responsibility for the Learning from Deaths, Claims and Inquests agenda
- Work closely with the Lead Medical Examiner (ME) for the Trust in sharing learning from the Trust mortality reviews and the Medical Examiner Office
- Via the Medical Directorfor Quality and Safety provide monthly reports on mortality denoting mortality trends and thematic learning
- Ensure case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the Trust rather than individual errors in the problems that generally occur
- Ensure that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care
- Report annually in the Quality Accounts
- Share relevant learning across the Trust and with other services where the insight gained could be useful.

Divisional Medical Directors (DMDs) and Business Unit Clinical Directors (CDs) will:

- Ensure and be responsible for supporting implementation and further development of the Learning from Deaths monitoring process. This includes the provision of support staff and infrastructure to assist the clinical teams conducting mortality reviews as well as ensuring national and regional mortality data is monitored and acted upon as necessary. Effective mortality monitoring will require the triangulation of multiple data

sources and groups. These may include; Trust mortality dashboards, CORS Database system, Structured Judgement Reviews (SJR), Child Death Outcome Panel (CDOP) and Healthcare Safety Investigation Branch (HSIB) for Maternity

- Provide assurance that mortality processes are consistent with the Learning from Deaths Review Process Flowcharts within their Division – Section 3
- Attend the LFDCIG as required on the forward plan or ensure a suitable deputy attends.

Associate Clinical Directors (ACDs) will:

- Support and oversee the completion of SJRs. These will include SJRs sent by the MEs, as well as a smaller randomly selected from deaths that month. SJR completion rate standard is set at 20% of all deaths in the department or a minimum of three cases a month, whichever is the larger number. This may be subject to yearly review
- Ensure adherence to the Learning from Deaths Review Process Flowcharts – Section 3
- Ensure their patients are discussed in local mortality and morbidity group. The ACD will either need to chair the mortality meeting or identify a mortality lead for their department to lead the meeting
- Provide a summary of cases reviewed to their CD by using the learning from deaths departmental template in Appendix 2. The CD will in turn surmise the departments findings in their Business Unit 3A report using the template in Appendix 3 to the LFDCIG in a timely manner in accordance to the schedule on the forward plan. A copy of the report is also sent to their Divisional Governance Team.

Doctors will:

- Have an organisational responsibility and professional duty (and where required a legal duty) to report any perceived concerns or deficiencies in treatment and care that may have cause or contributed to a patient death. This will include the appropriate use of incident reporting or coronial referral - please see appendices. Doctors must also co-operate with the review and investigation process, maintaining the highest professional standards.

Consultant and Associate Specialist staff will:

- Ensure all patients that have died in their care have the standard of the treatment and care and the mechanism of their death reviewed (as set out in the relevant standard

procedure)

- Offer support and review of death certificate to non-consultant medical / healthcare staff to complete this process in a timely and accurate manner complying to the information standards set out in the mortality reporting systems
- Correctly identify deaths that need to be subject to the different steps of review and where relevant escalate cases quickly where serious failings have been identified as per The NHS Patient Safety Strategy 2019
- Ensure the completion of SJR1on CORS within 12 weeks of death, and the completion of SJR2 within 16 weeks of death
- Ensure that a patient safety incident is raised through DATIX system when appropriate (see Section 9 for more details).

Non-consultant (trainees and locally employed doctors) staff will:

- Ensure that they have discussed the care of all patients that have died in their care with the relevant responsible consultant before discussing the case with the ME in order to correctly communicate any concerns regarding the standard of care.

Nurses, Allied Healthcare and Other Registered Clinical Staff are responsible for:

- Contributing to the process of care after death, the support for the bereaved and the timely involvement of other key groups or specific groups where relevant e.g. if there was a concern or complaint about the standard of care
- Being involved in working with the medical staff to offer information to support the review and report of a death (as set out in the procedure) as part of a multi professional approach
- where relevant being a representative at local departmental mortality and morbidity meetings.

Clinical Governance Facilitators will:

- Support the SJR process at Departmental / Business Unit level
- Report activity data to the Divisional Clinical Governance meetings
- Facilitate multi-disciplinary SJRs for cases escalated by the Specialty Mortality Lead or alerted by another route e.g. incident reporting system
- Support the ME or reviewer of the SJR to complete an incident form by providing education and training
- Support the implementation of improvement and dissemination of learning from

reviews undertaken

- Attend and provide support for local Mortality and Morbidity meetings
- May be required to attend the LFDCIG on request in relation to specific incidents related to death.

The Resuscitation Manager will:

- Review all cardiac arrest attendances by the Cardiac Arrest Team and, where the arrest resulted in death, identify any concerns regarding care for these patients
- Provide a six-monthly audit information on cardiac arrest calls to the LFDCIG
- Refer any cases of concern to the relevant specialty Mortality Lead for further review
- Provide a report of collated safety themes that occur during cardiac arrest attendances and provide assurance for improvement work for these themes.

The Medical lead for End-of-Life Care will:

- Attend LFDCIG meetings
- Work alongside the chair of the Trust's End-of-Life Care Programme Board to ensure relevant clinical issues are raised at LFDCIG
- By request, be available to colleagues for support/education if concerns are raised in LFDCIG (or End-of-Life Care Programme Board) about sub-optimal End-of-Life Care.

The Medical Directors Office will:

- Extract Learning from Deaths themes from Divisions to identify potential cross Divisional improvement programmes
- Ensure improvements that are identified by the LFDCIG is overseen, communicated and feedback on improvements returned to LFDCIG
- Collate data in relation to reviews undertaken and recorded on the electronic Clinical Outcomes Review System (CORS) for discussion at the LFDCIG
- Support the LFDCIG and Deputy Medical Director Quality and Safety role as required
- Support, collate and share learning themes from departmental report templates for SJR.

The Learning from Deaths Claims and Inquests Group (LFDCIG) will:

- Ensure the delivery of the mortality review process on behalf of the Clinical Effectiveness Group (CEG)
- Review the summary template of reviewed cases submitted by each Business Unit
- Commission targeted cases or diagnostic groups to be reviewed as a result of alerts from Care Quality Commission (CQC), or Health Evaluation Data (HED)
- Evaluate reports that will include mortality indicators for Hospital Standardised Mortality Ratio (HSMR), Summary Hospital-level Mortality Indicator (SHMI) and Crude Mortality. Identify learning themes and improvement plans for feedback to Divisions and for Trust wide dissemination improvement plans should consist of identifying the correct problems, understanding the problems, designing the improvements delivering the improvements and ensuring these improvements are sustained.

The Bereavement Office (BO) will:

- Collate required information to initiate the review process. A senior member of the BO team will attend the LFDCIG to provide a report in respect to any problems or opportunities related to medical death certification
- The BO will be responsible for ensuring an alert is sent within 24 hours to the general practice for a patient who has deceased at the Trust. The deceased patient list will be collected from the daily mortuary records at each acute site
- The BO will be responsible for a full list of patients that have been referred to the coroner. This list will include i) for advice but did not proceed to a post mortem or full inquest ii) patients that went to Coroner's Inquest iii) patients that had a post-mortem. This list will be collated and be sent to the senior clinical governance team for each Division. The Division will take responsibility to liaise with the departmental mortality lead whether a SJR is required for each case.

Specialty Mortality and Morbidity Groups will:

- Undertake a multi-disciplinary team review of all cases for which a SJR has been undertaken, to identify learning themes that show good practice and areas for improvement
- Discuss and review Fatal Claims and Coroner's Inquest outcomes from the Legal team
- Identify any cases where any phase of care was considered to be less than adequate in order for escalation to the Clinical Governance Facilitator. This may require the completion of an incident form on Datix and should be completed by an individual from

within the specialty where the incident occurred

- Identify points of learning for dissemination to the Specialty, wider Business Unit, Division and Trust
- Identify and proactively conduct improvement work on areas of concern and theme trends
- Ensure that the local mortality and morbidity meetings are minuted for each case discussed
- Ensure that the outputs of the meeting are transferred to the Departmental Learning from Deaths template (Appendix 2), and sent to the Business Unit Governance Team for discussion with a copy to uhdb.mortality@nhs.net .

The Legal Team will:

- Provide education, support and advice around the process for cases referred for Coroner's Inquest
- Send representation to attend the LFDCIG
- Support the Trust responses using the incident framework when a case has gone to the Coroner
- Will support the development of Learning Themes from Coroner's Inquests and Claims and share with the wider Trust.

The Medical Examiner Service will:

- Provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data.

The Medical Examiner Processes are summarised below:

1. Medical Examiner's Office (MEO) informed of death
2. QAP (Qualified Attending Practitioner) offers a report and discussion of case to ME
3. Independent 'proportionate' scrutiny of the medical notes by ME
4. Cause of death determined including natural vs. unnatural death evaluation

a. ME agrees a suggested cause of death with QAP
b. Advice is offered regarding coroner referral where appropriate
c. MCCD or coroner's referral done by QAP with help from BO
d. ME notes sent to Coroner if referred
e. If Coroners referral is severely delayed this is escalated

5. Case discussed with QAP, supported by MEO
    a. Referred back to ME if issues
6. MEO will contact deceased family. The cause of death is explained to next of kin, and opportunity is given to ask questions or raise concerns
    a. Referred back to ME if issues or concerns raised
7. Patient safety incidents are escalated by Datix. The ME is responsible for discussing with the responsible clinical team, and keeping a record of conversation with the MEO office. The responsibility and decision for Datix remains with the clinical team.
8. Quality incidents for learning escalated by SJR request
9. All cases are logged onto Clinical Outcome Review System (CORS). ME Scrutiny and SJR requests are logged onto CORS
10. MEO are responsible for collating and describing learning themes from ME reviews. A summary report to be sent to LFDCIG
11. Where the MEO has identified an immediate concern for an individual death or grouped series of deaths. These can be escalated through the extraordinary escalation pathway described in Section 12

RDH - MEOs receive patient notes from the BO and enter relevant details and any necessary triage onto CORS.

QHB - MEOs access patient notes via Meditech and enter relevant details and any necessary triage onto CORS.

6. Data Collection, Reporting of Mortality Indicators and Alerts

A report in relation to deaths reviewed will be provided to the Board on a monthly basis (public and confidential) via the Integrated Performance Report (IPR), in order that Executives remain aware and Non-Executives can provide appropriate challenge. Learning from reviews and investigations and actions taken to ensure sustainable change and improvements in care, will be reported in the Trust's annual Quality Account.

Mortality Indicator Definitions

There are four main nationally standardised measures to quantifiably evaluate deaths within acute Trusts. These are; crude mortality, HSMR, SHMI and a final measure is Observed / Expected death index. To assess these measures over time, rolling data is used over a year period. Comparison and benchmarking against comparable sized Trusts across the country are used in Trust reports. Definitions of mortality indicators is shown in Appendix 1.

The month mortality report provided by Business Intelligent to LFDCIG will report the following

- Crude mortality, SHMI and HSMR (or other methodology as appropriate) rates will be routinely monitored by the LFDCIG and also at a Trust and a Divisional level. The mortality data will be broken down by site, Divisional and Business Unit level where appropriate
- On an annual basis the LFDCIG will review all national benchmark mortality data i.e. Cardiology Myocardial Ischaemia National Audit Project (MINAP), ITU Intensive Care National Audit and Research (ICNARC), Surgery National Emergency Laparotomy Audit (NELA), Orthopaedics National Joint Registry (NJR). This information will be reported in the agreed format by the Information Department. The source of the information may vary according to publication and access to the appropriate benchmarking data
- Diagnostic clinical code groups (CCS) will be scrutinised against HSMR, SHMI and Observed / Expected Deaths and further separated by Hospital Site, Business Unit and Departments to help analysis mortality indicator trends
- Qualitative Themes from SJR reviews will be used to support evidence for potential trends in HSMR and SHMI.

Proactive Review of Mortality Outliers

HSMR and SHMI Red Mortality Alerts are derived from Health Evaluation Data (HED) via Trust Business Intelligence. Similarly the statistical Mortality CUSUM Alert is also derived from HED via Trust Business Intelligence.

In response to any NHS England HSMR and SHMI red alerts, the LFDCIG initiates case note reviews where appropriate following the process below:

1. Alert downloaded from the Mortality Dashboard and incorporated into the monthly LFDCIG Mortality Alert Report with recommendation of action to be taken
2. The decision to undertake a coding review will be made at the LFDCIG if a coding review is recommended, the Coding Department will undertake a coding audit on the patients identified. The auditor will re-code the patients' admission and identify and amend any errors that are found. A report is produced for the LFDCIG on the findings
3. Depending on the Coding findings, alerts where the difference between observed and expected deaths is statistically significant will go onto undergo clinical review
4. If a clinical review is required, the MDO will email the appropriate Mortality Lead requesting that they undertake a clinical review on the patients concerned and report back to the LFDCIG. It is expected that the mortality review will be completed within 6 weeks of request and presented to LFDCIG within 3 months. Any immediate escalation or concern regarding findings to be sent to Deputy Medical Director for Quality and Safety
5. The learning from the clinical reviews will be discussed at local mortality and morbidity meetings and Divisional governance meetings along with the LFDCIG.

Reactive Review of Externally Generated Mortality Outlier Alerts

Following receipt of a CQC for outlier mortality data, the Executive Medical Director will nominate a lead clinician to co-ordinate a review and produce a report within a determined timeframe. The process will be supported by the relevant department and clinical teams, Head of Clinical Coding and Information Department. Reports generated as a result of this process will be presented to the departmental mortality review meeting and monitored and approved by the LFDCIG. Improvement plan monitoring will be the responsibility of LFDCIG and these will be reported to the CEG.

7. Death Certification, Medical Examiner Scrutiny, Structured Judgement Reviews and Investigation

There are five levels of scrutiny that can be applied to the care provided to someone who dies:

- Death certification
- ME Scrutiny

- SJR
- Divisional or Trust investigation through incident reporting
- Coronial Investigation.

The above do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a SJR has been undertaken. An SJR is a formative process to enhance learning and share this learning amongst a wider group which may lead to improvement work. Although an incident form may be completed from the review of a SJR, the timeliness of recording patient safety incident through Datix is not ideal, as SJR1 completion timescale is 12 weeks and SJR2 completion timescale is 16 weeks from time of death. The relationship between recording patient safety incidents using Trust Datix system and SJRs is fully discussed in Section 9.

The majority of SJR requests to Divisions will be after scrutiny of a death from a ME. MEs may request an SJR in the following groups of patients:

- Paediatric patients
- Learning disability or autistic patient
- Severe mental health illness patient
- Elective admission
- Next of Kin concerns about death
- Death with 30 days of chemotherapy
- Other concerns which warrant further review.

In addition to the above, the Trust has identified the following categories for which a SJR will be undertaken.

- 20% of deaths within department with a maximum of up to 10 SJR cases per speciality per month, minimum 3 SJR cases per month. Focus is on those likely to yield learning. The SJR review thresholds will be reviewed on an annual basis
- Agreed Departmental, Business Unit or Divisional Mortality Alert from HED or National Audit SJR review requirement
- Deaths where learning will support Trust improvement work e.g. sepsis care.

8. Collecting Themes to Enhance Learning

Thematic learning will be used to better understand and respond to concerns related to death as well as share good practice. Themes from deaths will be further triangulated to themes developed from patient safety incidents, complaints and those from Coroner's Inquests and Claims.

A thematic learning framework for deaths will be developed and operational for the following groups.

- LFDCIG from themes cited from Departmental Reporting Templates for SJRs
- MEO from ME review of deaths
- Legal Team from final Coroner's Inquest and Claims reports
- Business Unit and Divisional Teams from Departmental Report Templates for SJRs.

Thematic learning will be described from creation of

- Initial themes – a short no more than 10 words describing the learning theme of the immediate issue
- Grouped themes – a short no more than 5 words describing a grouping of related initial themes.

Any single death may have more than one initial theme or grouped theme.

Grouped themes should have a consistent nomenclature to ensure that themes can be counted and triangulated consistently. An example of this is shown below.

Summary of case:

"*A 59 year old male was admitted a urinary tract infection. This was adequately treated in Medical Assessment Unit. He is known to have Parkinson's disease and epilepsy for which he was on treatment. Although medications were prescribed, a delay in ordering and arrival of Parkinson's and epilepsy medications may have led to worsening of his swallowing difficulties. He also suffered a seizure and vomiting on day three of his admission. He was treated for aspiration pneumonia and sadly passed away soon afterwards."*

Initial Theme	Grouped Theme
Epilepsy medications did not arrive on time lead to risk in seizures	Critical Drug Medication Error
Parkinsons medications did not arrive, worsening swallow and aspiration risk	Critical Drug Medication Error

An thematic database as part of CORS system is to be used to collate initial and grouped themes. Other key information such as location, department, hospital site and consultant should also be linked to each theme for future triangulation and creation of theme 'heat maps'.

9. Learning from Deaths and Link to Patient Safety Incidents

The Patient Safety Incident Response Framework (PSIRF) is the new national framework that will help support an appropriate and measured response to patient safety incidents.

The Learning from Deaths pathway enables the opportunity to report a Patient Safety Incidents that have the possibility of being, or are directly attributable to the cause of death through Datix at three opportunities. These are:

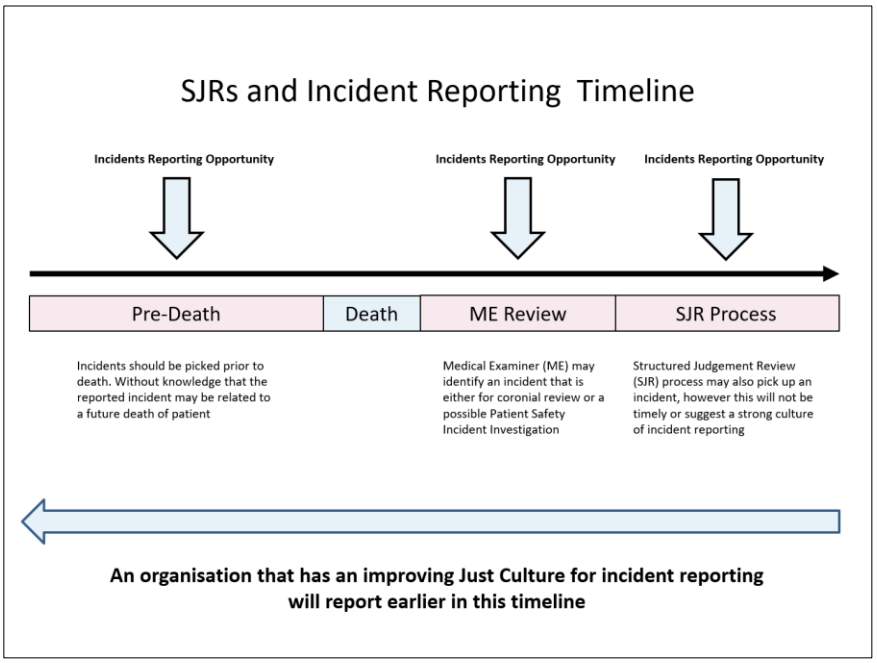
1. An incident reported prior to death. (Please note clinical team may not be aware of subsequent death).
2. An incident identified by a ME at time of death. The ME will discuss with the QAP or Consultant looking after the patient. The MEO will log the conversation that took place. The conversation log including ME name, who it was discussed with, discussion notes and outcome / next steps will be recorded by MEO. The MEO will share the conversation log with the lead Clinical Governance Facilitator for the Division. The responsibility of completing the Datix will remain the responsibility of the clinical team looking after the patient.
3. An incident identified at any point during the departmental Structured Judgement Process after the death – See Section 3, Phase 4.

Reporting patient safety incidents:

- It is mandatory that if a SJR avoidability of Death Scale is Grade 3 (Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have made a difference – probable avoidable), then an incident form must completed on DATIX

- Patient safety incidents that have the possibility of being, or are directly attributable to the cause of death should be reported immediately through DATIX, enabling the correct Trust governance response
- SJRs are for formative learning from a death and should not be used in isolation to manage Patient Safety Incidents that have the possibility of being, or are directly attributable to the cause of death
- If a patient safety incident was identified through SJR process, it is important to state 'Following ME Review / SJR' on description field on DATIX incident form
- If a Patient Safety Incident is reported through DATIX and has the possibility of being, or are directly attributable to the cause of death then an urgent review under PSIRF framework is investigated. A decision will then be made as to whether the incident requires a Local or National Patient Safety Incident Investigation (PSII).

Figure showing Datix Incident Reporting Opportunities for Learning from Deaths Pathway



The relationship between Learning From Deaths pathway and DATIX Incident Reporting are also clearly highlighted in the Learning from Deaths flowcharts in Appendix 2.

10. Responding to Deaths in Specific Groups

Responding to the Death of an Individual with a Learning Disability or Autism

The Trust will conduct local reviews of the deaths of people with learning disabilities and

autism and fully engage with LeDeR Learning Disabilities Mortality Review Programme (LeDeR) run by NHS England. This includes reporting all deaths to the national programme. All LeDeR deaths will require a Learning Disability / Autism Structured Judgement Review completed on CORS.

Responding to Deaths in Patients with Mental Health Needs

The Trust recognises that mental and physical health are closely linked. Reporting and reviewing the death of a patient with mental health problems should ensure that any patient detained under the Mental Health Act (1983) is reported to the CQC and the Coroner under the Coroners and Justice Act 2009. In circumstances where there is reason to believe the death may have been due to, or contributed to, by problems in care – including self-inflicted death – then the death must be reported to the Trust's commissioner(s) as an investigation and investigated appropriately. It should be recognised that the Trust cares and treats patients from the prison service and there are high incidence of mental or personality disorder, psychosis, anxiety, depression and substance misuse in this group of patients. Any death of a patient whilst in police or prison custody needs to be referred to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. The Trust will fully support any investigations as required.

Engaging with Bereaved Families and Carers

The Trust will inform family / carers as part of its Duty of Candour of any intention to formally review or investigate the care provided to a patient who has died. This will include details of how families / carers will be involved to the extent that they wish to be involved. The initial contact with relatives will depend on individual circumstances but may be managed by the clinicians responsible for the care of the patient or other appropriate person as determined at the time of the investigation. Families / carers must have the opportunity to express concerns about the care given to patients who have died and in certain circumstances involvement of clinicians responsible for care of the patient may be considered a barrier to raising genuine concerns.

11. Responding to Deaths in Maternity, Paediatrics and Neonates

Maternity Section for LFDCI Policy 2023

Maternal deaths are rare (11.7 women per 100000) (MBRRACE-UK 2023 2019-2021). MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) run the national Maternal, New-born and Infant Clinical Outcomes Review – and there are regular topic-specific confidential enquiries at set intervals (annually for stillbirths and neonatal deaths, triennial for Maternal deaths). Categorisation of a significant maternal event is as follows.

Maternal Death

A Maternal death of a mother while pregnant or within 42 days of the end of the pregnancy*, from any cause related to or aggravated by the pregnancy or its management, and not from accidental or incidental causes.

- Direct: deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above. This excludes cases of suicide.
- Indirect: deaths from previous existing disease or disease that developed during pregnancy, and which was not the result of direct obstetric causes, and which was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

  *Includes giving birth, ectopic pregnancy, miscarriage or termination of pregnancy.

Internal and external Learning from Maternal Deaths

The Trust will undertake the appropriate mortality review and investigation and reporting as required by the National Reporting Body. The Maternity and neonatal safety investigation (previously Healthcare Safety Investigation Branch (HSIB)) criterion for referral is outlined in the link: What we investigate (maternity) (hsib.org.uk). Summary findings from MNSI (HSIB) investigations will be presented to the LFDCIG.

The Trust's learning from Maternal deaths will follow that of adult death processes outlined previously. *See Section 3. Learning from Deaths Review Process Charts*. There will be a requirement for:

- A Darix Patient Safety Incident is to be completed, if an incident has occurred that has the possibility of being or was directly attributable to the cause of Maternal death
- All Maternal deaths to undergo ME scrutiny
- A Coronial referral meets the criteria (See Section 3)
- A SJR is to be done for all Maternal deaths that are routinely discussed at departmental Morbidity and Mortality Meeting
- Maternal deaths to be discussed at Business Unit and Divisional Governance meetings
- Maternal deaths are to be discussed jointly with paediatrics and neonatology at the LFDCIG if there is concomitant adverse neonatal outcome
- Thematic reviews from internal and external investigation bodies will be presented to the LFDCIG so that this can inform wider learning to the Trust
- Thematic review from MBRRACE-UK will be presented to the LFDCIG group to inform learning and inform policy changes to improve care.

Responding to death in Paediatrics and neonates

The response to all neonatal and paediatric deaths is led by senior clinicians and all deaths should be discussed with the ME or Coroner. The Coroner will need to be informed in cases where there is a statutory duty to report the death as per the notification of Deaths regulations 2019. Where this is not the case and the cause of death is natural and is an expected death the case should be referred to the ME for review prior to issuing the MCCD. All paediatric and neonatal deaths are on DATIX for governance purposes, but this does not necessarily indicate a patient safety incident.

All neonatal and paediatric deaths (children from birth to their 18th birthday) are reported to the relevant countywide CDOP (Child Death Overview Panel) within 24 hours. CDOP is a group of professionals and leaders from Health, Public Health, Police and Childrens Social Care. Information is gathered to systematically review the deaths of all children as per Child Death Review Statutory and Operational Guidance (England) Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk), with the intention of learning what happened and why, and preventing future child death. The Panel meets after all the information about the death has been gathered through the child death review process. Any relevant Trust governance reviews and minutes from the Child Death review or Mortality and Morbidity (M&M) meeting are shared with CDOP to inform the Panel discussion. Panel discussion will occur after Trust complaints and Governance investigations have been

completed and any Coroner's inquest has occurred.

Neonatal Deaths

All neonatal deaths in a midwifery unit, on delivery suite or in neonatal intensive care unit, will have a child death review meeting, known as a Perinatal Mortality Review Group Meeting. The review is assessed and reported on a national web-based tool (Perinatal Mortality Review tool (PMRT)) which supports standardised, systematic review of care in perinatal deaths. In all cases, the review meeting should generate an analysis form, which is to be sent to the local CDOP before CDRM (Child Death Review Meeting).

For early neonatal deaths of term babies (i.e. when the baby died within days 0- 6, after 37+0 weeks gestation) any NHS Patient Safety Incident Investigation will be the responsibility of the HSIB. The HSIB referral can be made through the HSIB website, and referrals are accepted from any source. The investigation is accomplished by working collaboratively with all involved in the incident, including patients and families. The investigation aims to establish the cause and make recommendations that enable system-wide change. HSIB also investigate NHS Patient Safety Incident Investigation cases of intrapartum stillbirth, early neonatal deaths and severe brain injuries from 37 weeks gestation. The HSIB report is forwarded to CDOP before the neonatal death is discussed at CDRM.

Neonatal care is also reviewed at local and Network Neonatal Mortality Group meeting. Learning generated from these meetings are disseminated locally and at network level. The report is forwarded to CDOP.

Paediatric Deaths

Following the death of a child there are numerous steps and decision making required by senior clinicians usually either the Consultant Paediatrician on call or Children's Emergency Department Consultant. Staff will access a Child Death pack available in the Children's Emergency Department and Paediatric wards, which has key guidance regarding the process required following a Child death. The practical steps required after a child dies flowchart helps guide clinicians about the decisions and steps required. Details for: Practical Steps required after a Child Dies - Paediatric Clinical Guideline - Derby only › Trust Policies Procedures & Guidelines catalog (koha-ptfs.co.uk)).

The Immediate decision proforma is completed which helps to decide whether the Sudden and Unexpected Death in an Infant / Child (SUDI/C) protocol should be initiated and a Joint Agency Response should be started.

A Joint Agency Response should be triggered if a child's death:

- Is or could be due to external causes
- Is sudden and there is no immediately apparent cause (incl. SUDI/C)
- Occurs in custody, or where the child was detained under the Mental Health Act
- Raised any suspicions in the initial circumstances that the death may not have been natural;
- Had no healthcare professional in attendance in the case of a stillbirth

The relevant SUDI/C countywide guideline should then be followed (Staffordshire and Derbyshire guidelines available on KOHA). The Child Bereavement Policy gives further information regarding the process for Child death review and bereavement care within the Trust.

Approach to Patient Safety Incidents and Deaths in paediatric / neonate group

The immediate decision proforma also asks senior clinicians to identify any care concerns or Duty of Candour requirements required on the day of the death. These concerns should be discussed with the Governance Team on the next working day and a 72-hour escalation report completed as necessary.

A 72-hour review process should be instigated if a patient safety incident has been identified which was directly attributable to the cause of death. A 72-hour review process should also be instigated if the child was reviewed in Children's Emergency Department or discharged from hospital within 3 days prior to death. When a death was unexpected or a patient safety incident was identified, the incident will be managed through our PSIRF framework, which may include a 72-hour review and Patient Safety Incident Investigation (PSII).

All children who die within the Trust will have a Child death review meeting or M&M meeting to review the death and establish the contributory and modifiable factors around the death (as per the Child Death Review process). The minutes, actions and learning from these meeting will be disseminated around relevant staff and shared with CDOP via the eCDOP system

(electronic CDOP mortality review system). Once all governance investigations and M&M meetings have been completed the death will go forward to CDOP Panel discussion and themes / factors around the death will be shared by CDOP to the National Child mortality Database.

At whichever stage a patient safety incident has been identified, then a DATIX should be raised and the PSIRF Framework used. This will include the initial review of the case, the later child death review meeting / M&M meetings, and subsequent CDOP panel review. The review and learning of all paediatric and neonatal deaths will be recorded,

12. Immediate Escalation Pathway

It is envisaged that the Learning from Deaths Policy and associated pathways outlined in Appendix 2 will be adhered to for the management of deaths at the Trust. There may be specific circumstances where an immediate escalation to the senior leadership team may be warranted. The immediate escalation pathway for learning from deaths is an 'extra-ordinary' pathway to facilitate the need for a rapid Trust response where patient safety is at immediate risk. The pathway can be triggered from either an individual case of death or a group of deaths. Examples of appropriate Immediate Escalation Pathway for Deaths referrals may include:

- Immediate patient safety concern related to death that cannot be resolved within department
- Immediate patient safety risk that could occur outside local department or Division and requires a Trust wide response
- Suspicious circumstance to death related to single or group of deaths requiring possible immediate investigation
- Continued departmental concerns for specific themes of care related to deaths
- Continued concerns for limited clinical, governance or team engagement in learning from deaths process.

The following steps are undertaken:

- The one-page Escalation Pathway for Deaths referral form is sent by immediate e-mail to the Divisional Director, Divisional Nurse and Divisional Medical Director with a copy to the Medical Director for Quality and Safety and Deputy Medical

Director for Quality and Safety

- A meeting takes place within two working days with above recipients, together with the referrer, for a structured discussion of escalation
- Any immediate risks to patient safety are identified with a plan to mitigate or eliminate the patient safety risk
- An initial communication strategy is formulated where needed
- The Executive Medical Director will be informed by report of the escalation and patient safety risk evaluation.
-

It is expected that Trust processes for Learning for Deaths and Incident Reporting must occur in parallel with this escalation.

13. Training for Learning from Deaths

Training will be provided for Learning from Deaths, Claims and Incidents through Divisional, Business Unit and Departmental educational sessions. This will be facilitated through the utilization of on-line and physical resources and attendance of mortality and morbidity meetings where appropriate.

Examples of training will include:

- Anonymous completed SJR forms for training
- Resources on how to develop and run a Mortality and Morbidity Meetings
- Video guides on the Trust's Learning from Deaths process charts
- Video on how to use the Learning from Death CORS database.

14. Claims and Inquests Related to Deaths

The Coroner has a duty to investigate a death where:

- The death is violent, including self-harm
- There is reasonable cause to suspect that the death is unnatural
- The cause of death is unknown
- The death occurred in custody or state detention, which will include deaths in prison or police custody and deaths while the deceased was detained under the Mental Health Act.

This will include deaths that were more than minimally contributed to by medical treatment or a procedure, for example:

- The death was due to a recognised complication of medical treatment
- The death was more than minimally contributed to by shortcomings in the medical treatment.

An inquest is a fact-finding inquiry to establish who has died, and how, when and where the death occurred. We usually know who has died and when and where the death occurred. For that reason, inquests usually focus on 'how' the person died. This goes beyond establishing the medical cause of death and the Coroner will scrutinise the circumstances surrounding the death. It is not the Coroner's role to apportion blame and the Coroner's Conclusion will not name any individual or organisation as being negligent or criminally liable for the death. However, during the evidence at the inquest the Coroner will scrutinise the medical treatment that the patient received and will seek to identify any shortcomings in care which more than minimally contributed to the death and this may feel like apportioning blame.

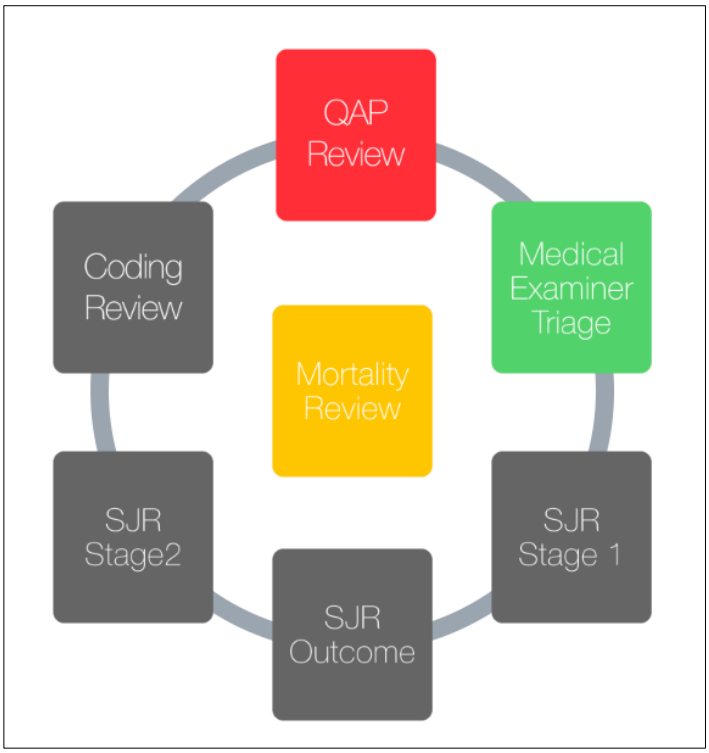
The in-house legal team are available to advise and support Trust staff through the inquest process, including report / statement writing and attending Court to give evidence.

The in-house legal team will be responsible for the dissemination of learning from fatal claims and Coroner's Inquests. Where themes / trends are identified by the in-house legal team, these will be reported to the LFDCIG.

15. Clinical Outcome Review System (CORS)

The Clinical Outcome Review System (CORS) is a secure database that encompasses recommendations from the Learning from Death initiative, as well as the most recent ME and SJR processes (Appendix 2 – Phase 4), in one streamlined and easy to use platform.

Stepwise approach to managing Learning from Deaths Pathway using CORS



The CORS steps are:

1. *QAP Review.* Area to be completed by the QAP from the team responsible for the episode of inpatient care
2. *MEs Triage* (Decision for Coronial Referral or SJR is made)
3. *SJR1* - Completed by consultant within department not directly responsible for episode of care (completion within 12 weeks of death)
4. *SJR Outcome* - To be completed after SJR1 case has been discussed at local departmental Mortality and Morbidity meeting
5. *SJR 2* – Only required where an incident attributable to death has been identified OR an SJR1 avoidable death score was 3 (Sub-optimal care, probably avoidable death). After SJR2, the case should be discussed again at local departmental Mortality and Morbidity Meeting
6. *Coding Review* – A final review of coding is made following SJR process consistent with final MCCD.

The Trust CORS SJR avoidability of Death scoring system has 4 levels. For information, the table below aligns this with the comparable RCP avoidability of death scale score (for information only).

Following Structured Judgement Review level 2 CORs - Avoidability of Death Scale	**RCP** - Avoidability of Death Scale
	Score 1 Definitely Avoidable
	Score 2 Strong evidence of avoidability
Grade 3 - Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have made a difference (probably avoidable)	Score 3 - Probably avoidable (more than 50:50)
Grade 2 - Suboptimal care, different care MIGHT have made a difference (possible avoidable death)	Score 4 - Possibly avoidable, but not very likely (less than 50:50)
Grade 1 - Suboptimal care but different management would have made no difference to the outcome (unavoidable)	Score 5 - Slight evidence of avoidability
Grade 0 - no suboptimal care (unavoidable)	Score 6 - definitely not avoidable

16. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

17. Monitoring Compliance and Effectiveness

Adherence with the Policy will be monitored through a quarterly review at the LFDCIG meeting and annual reporting to the Quality Governance Steering Group.

Audit – Six monthly record of departmental Mortality and Morbidity meetings, provision of Departmental and Business Unit LFDCIG reports, Attendance of Business Unit representative at LFDCIG according to yearly planning cycle and SJR completion rates.

18. Useful Links

Description	Link
Clinical Outcome Review System for UHDB.	Sign In (uhdb.nhs.uk)

Royal College of Physicians. Using the structured judgement review method A guide for reviewers.	RCP SJR Link
GMC Good Medical Practice Guide	https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice
Patient Safety Strategy 2019. NHS England	NHS England » The NHS Patient Safety Strategy
Patient Safety Policy for Incident Reporting, Management and Learning for UHDB	Details for: Incident Reporting, Management and Learning - Trust Policy and Procedure › Trust Policies Procedures & Guidelines catalog (koha-ptfs.co.uk)
PSIRF framework. NHS England	NHS England PSIRF Information
Learning from Deaths. National Guidance. NHS England	National Guidance for Learning From Deaths
Learning Disabilities Mortality Review (LeDeR) Programme	LeDeR - Home
Medical Examiner System. NHS England	https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/
Death Referral and Medical Examiners	Guidance-No.-31-Death-Referrals-and-Medical-Examiners.pdf (judiciary.uk)
Guidance for Medical Practitioners on the Notification of Death regulation	Guidance for registered medical practitioners on the Notification of Deaths Regulations (publishing.service.gov.uk)
Maternal Deaths Investigation Guidance - HSIB	What we investigate (maternity) (hsib.org.uk).
Child Death Review Statutory and Operational Guidance	Child Death Review Statutory and Operational Guidance (England)
Safeguarding Adults – UHDB Trust Safeguarding Policy and Procedure	Details for: Safeguarding Adults - UHDBFT Trust Safeguarding Policy and Procedure › Trust Policies Procedures & Guidelines

	catalog (koha-ptfs.co.uk)
Safeguarding Children – UHDB Trust Safeguarding Policy and Procedure	Details for: Safeguarding Children - UHDB Trust Safeguarding Policy and Procedure › Trust Policies Procedures & Guidelines catalog (koha-ptfs.co.uk)
Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) Policy 2021	B0428-LeDeR-policy-2021.pdf (england.nhs.uk)
Death of an Adult Patient Trust Policy	Details for: Death of an Adult Inpatient - Trust Policy and Procedure › Trust Policies Procedures & Guidelines catalog (koha-ptfs.co.uk)
Learning from Deaths in the NHS	NHS England » Learning from deaths in the NHS
The national medical examiner system	https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/
Patient Safety Incident Response Framework	NHS England PSIRF Information.
Learning Disabilities Mortality Review (LeDeR) Programme	LeDeR - Home.
UHDB CORS	Sign In (uhdb.nhs.uk)

Appendix 1 – HSMR, SHMI and Crude Mortality Indicators

1. Crude mortality - Crude mortality is a simple count of inpatient mortalities and a rate of mortality to inpatient stays. Stillbirth deaths are not counted in the analysis.
2. Hospital Standardised Mortality Ratio (HSMR) is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths for 56 diagnosis groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge. Please note, HSMR excludes days cases. The HSMR is calculated by Number of Deaths / Expected number of deaths multiplied by 100.
3. The Summary Hospital-Level Mortality Indicator (SHMI) is based on the latest Hospital Episode Statistics (HES) and HES-ONS datasets and is a ratio of the observed number of in hospital deaths at the end of a continuous inpatient spell and deaths within 30 days of discharge from the hospital as detailed in ONS dataset, to the expected number of in-hospital deaths (multiplied by 100) based on the standard SHMI methodology used by NHS Digital. Please note SHMI excludes day cases. SHMI includes all of the 260 Clinical Classification Software (CCS) diagnostic code groups whereas HSMR only maps to 56 CCS diagnostic code groups. SHMI therefore takes account of co-morbidity illness more robustly. The main differences between HSMR and SHMI Mortality indicators are highlighted on a table in Appendix 1.
4. A final simpler measure is Observed / Expected death index. This is the total observed number of deaths for that group minus the total number of expected deaths for that group derived from a national data set. A negative number denotes a favourable position for the Trust. The Observed / Expected Death index often correlates closely to HSMR and SHMI.

	HSMR (Hospital Standardised Mortality Ratio)	SHMI (Summary Hospital-Level Mortality Index)
Charlson comorbidity positions used in modelling	DIAG2 – DIAG14	DIAG2 – DIAG20
Indicator Owner	Telstra Health (previously Dr Foster Intelligence)	NHS Digital
Diagnosis groups used	56 of 260 CCS groups	SHMI (260 CCS groups that are grouped to 142 categories – known as "SHMI Diagnostic Groups")
Data Source	HES	HES - linked to ONS
Patient Classification used	1 – Ordinary, 2- Day Case & 5 – Mothers and Babies	1 – Ordinary, 5 – Mothers and Babies
Percentage of In-Hospital deaths covered	Approx. 80% including still-birth	100% excluding still-birth
Includes out-of-hospitals deaths?	N	Y
Calculation-level	Per Super-Spell	Per Spell
Attributed?	To all hospitals in super-spell	To last acute trust within 30 days
Rebased?	Monthly	Monthly
Over-dispersed	N	Y
Control limit to define 'outlier' status	99.8% (3σ) Poisson	Over-dispersed' random effects model: 95% (2σ)'OD'
Modelling period	10 years	3-year rolling
Case-Mix Adjustment		
Age	Y	Y
Sex	Y	Y
Admission method	Y	Y
Co-morbidity	Charlson score (continuous)	Charlson score in three groups (0, 1-5, >5)
Palliative Care (Z515 diagnosis or treatment specialty 315)	Y	N
Treatment Specialty	N	N
Deprivation	Y	N
Diagnosis sub-group	Y	N
Year of Discharge	Y	N
Rolling-year groups	N	Y
Month of admission	Y	Y
Emergency admission in previous 12 months	Y	N
Admission source	Y	N
Birth-weight (for diagnostic groups related to neonates only)	N	Y

Source – HED Mortality Overview Guide. www.hed.nhs.uk

Appendix 2 - Departmental Learning from Death Template

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

University Hospitals of Derby and Burton NHS Foundation
Learning from Deaths, Claims and Incidents Group Departmental Report

Departmental Report Completion Date: _____

Paper title: Learning from Deaths, Claims and Incidents report for [Insert your departmental]

Agenda item: Report to [Add your Business Unit] and LFDCIG

Author/exec lead: [Include author/presenter as appropriate], Executive Lead - Gisela Robinson

Paper type: For: ☐ Assurance ☒ Decision ☐ Information

Organisational objective:

- ☒ Putting patients and communities first
- ☐ Right first time
- ☐ Invest resources wisely
- ☐ Develop and nurture colleagues
- ☐ Ensure improvement through effective partnerships

Executive summary:
Write a succinct overview of the paper, ideally in no more than 60 words. Example: 'This paper provides an overview of X, following Y, covering the key actions and next steps.

Implications for:

- ☐ **Equality, diversity and inclusion** (if ticked, the paper content should outline how equity and health inequality implications for people from protected characteristics or who are under-represented have been considered)
- ☐ **Sustainability** (if ticked, the paper content should outline the impact on the environment)
- ☐ **Key risks** (including those on the Board Assurance Framework, or 'BAF'. If ticked, the paper content should outline these)

Recommendation
Insert your recommendation. This should be short and succinct (it should fit within the space of this box without expanding it).

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EXCEPTIONAL Care Together

Date:
Ref: MDO to include

Department	[Add your department here]
Business Unit	[Add your Business Unit here]

Summary of Structured Judgement Review (SJR) cases:

Hospital number	Which stage is the SJR currently?	Brief summary of case	Learning themes identified	Recommendations and actions
[Add here]	☐ SJR 1 complete ☐ 1st M&M meeting ☐ SJR 2 complete ☐ 2nd M&M meeting ☐ Discussed at BU Governance meeting?	[Add text here]	[Add text here, there may be multiple learning themes per case]	Avoidable harm? Yes ☐ No ☐ [Add text here]
[Add here]	☐ SJR 1 complete ☐ 1st M&M meeting ☐ SJR 2 complete ☐ 2nd M&M meeting ☐ Discussed at BU Governance meeting?			Avoidable harm? Yes ☐ No ☐
[Add here]	☐ SJR 1 complete ☐ 1st M&M meeting ☐ SJR 2 complete ☐ 2nd M&M meeting ☐ Discussed at BU Governance meeting?			Avoidable harm? Yes ☐ No ☐
Add more rows if needed…				

It is recommended that cases which have completed an SJR 1 or SJR 2 should be discussed at your local M and M meeting before being included in this report.

NB. The same case can be added again to a future departmental LFDGCI report, if there is new information or learning obtained.

Mortality and Morbidity Meeting Dates and Minutes

Meeting Date	M&M Meeting Name	Embed Minutes Here
[Add here]		[Embed Word File]
[Add here]		[Embed Word File]
Add more rows if needed…		

National or Local Audit Reports related to mortality:

Any National or Local Audit that has been undertaken with implications for Learning from Deaths. State any recommendations from the review.

Mortality alerts:

☐ No Mortality Alerts Issued ☐ Mortality Alert Issued (yet to do) ☐ Mortality Alert Review Completed

[Add details of Mortality Alerts here]

Patient safety incidents related to deaths

☐ Has there been any Patient Safety Incident Investigations (PSII) linked with a death during this reporting period?

If yes, please add details of PSII, including hospital number(s), in this section. If PSII completed, what were the key recommendations?

Coroners Inquests or Claims related to Deaths
☐ Has there been any completed Coroners Inquests or Claims related to death during reporting period? If yes, please add details, including the hospital number(s) in this section. What were the key findings, recommendations and actions undertaken from the coroners inquest or claim?
Updates on Active Improvement Work
Please add any departmental quality improvement work related to learning from deaths that you would like to share
Next Steps
Please return completed form by e-mail to your **Business Unit Governance Team** and to your BU **CD for discussion at their Divisional Governance Meeting and the next Learning From Deaths, Claims and Inquests meeting.** and Send copy to **uhdb.mortality@nhs.net**

Appendix 3 – Business Unit Learning from Death Template

University Hospitals of Derby and Burton
NHS Foundation Trust

University Hospitals of Derby and Burton NHS Foundation
Learning from Deaths, Claims and Incidents Group Business Unit Summary Report

Insert meeting date for LFDCI [leave blank - to be added by MDO team]

Paper title: [Insert paper title]

Agenda item: [Leave blank - this will be updated by the MDO team]

Author/exec lead: [Include author and presenter as appropriate], Exec. Lead. Gisela Robinson

Paper type:	For:	☐ Assurance	☐ Decision	☐ Information

Organisational objective:

- ☒ Putting patients and communities first
- ☐ Right first time
- ☐ Invest resources wisely
- ☐ Develop and nurture colleagues
- ☐ Ensure improvement through effective partnerships

Executive summary:
List a succinct overview of the paper, ideally in no more than 60 words. Example: 'This paper provides an overview of X, following Y, covering the key actions and next steps.

Implications for:

- ☐ **Equality, diversity and inclusion** (if ticked, the paper content should outline how equity and health inequality implications for people from protected characteristics or who are under-represented have been considered)
- ☐ **Sustainability** (if ticked, the paper content should outline the impact on the environment)
- ☐ **Key risks** (including those on the Board Assurance Framework, or 'BAF'. If ticked, the paper content should outline these)

Recommendation
Insert your recommendation. This should be short and succinct (it should fit within the space of this box without expanding it).

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EXCEPTIONAL Care Together

Date:
Ref: MDO to include

Report Date	[Date this report sent to LFDCI]
Business Unit	[Add your Business Unit here]

Alert

The Business Unit wishes to alert LFDCI that… Up to three or four matters. *These may include alerting key learning themes and recommendations from completed SJRs, Alerting Patient Safety Incidents related to mortality, Alert on audits and lack of governance structures to support mortality.*

Assurance

The Business Unit wishes to assure LFDCI that… Up to three or four matters. *These may include assuring that mortality and morbidity meetings are taking place regularly. Learning themes are being developed and shared. Recommendations from SJRs are being actioned.*

Advise

The Business Unit wishes to advise LFDCI that… Up to three of four matters. *These may include items that LFDCI wish to be informed and to be made aware of. e.g. The UKHSA Heat mortality monitoring report on July 2023, this may impact our more frail patients in our trust.*

Department Reports

State all departments within your Business Unit. Embed each report within this document. NB The details of SJRs should remain within the embedded departmental Word document report. Not to be copied on to this report.

Department Name	Report submitted to Business Unit?	Administration notes related to departmental submission	Embed Departmental Word Document Here
[Add here]	Yes ☐ No ☐	[Add text here]	[Embed Word File]
[Add here]	Yes ☐ No ☐	[Add text here]	[Embed Word File]
[Add here]	Yes ☐ No ☐	[Add text here]	[Embed Word File]
Add more rows if needed…			

Business Unit Mortality and SJR data for previous 3 months

This data will be supplied to you by LFDCI group 2 weeks before submission date. Please copy into your report.
Report from [Start Date] to [End Date]

Mortality Measure for Business Unit	Value
Total Deaths (n)	
Total Spells (n)	
Crude Mortality (%)	
HSMR (Hospital Standardised Mortality Ratios)	
SHMI (Summary Hospital Level Mortality Indicator)	
SJRs completed (n)	
SJR completion rate (%)	

Next Steps

Please copy to your **Business Unit Governance Team** for discussion at the next **Learning From Deaths, Claims and Inquests meeting.**

and

Send copy to **uhdb.mortality@nhs.net**