Shropshire Community Health NHS Trust

Policies, Procedures, Guidelines and Protocols

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Main points the document covers	This policy provides guidance on how the Trust reports, reviews and/or investigates deaths of patients who are under our care and how lessons learnt can be identified and disseminated. It includes details of the processes required and the engagement of families and carers
Who is the document aimed at?	Guidance for all medical and healthcare professionals who have delivered care and treatment to a patient who has died and are involved in the Learning from Deaths Review Process
Owner(s)	Alan Ferguson, Quality Facilitator (Learning from Deaths Facilitator)
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No	**Date**	**Amendment**
1	Nov 2014	Updates following Internal Audit recommendations including ensuring the reporting process includes reporting to relevant Trust committees and groups
2	Aug 2017	Community Hospitals Mortality Review Process superseded by this Learning from Deaths Policy which now covers a wider remit in line with the National Guidance Learning from Deaths (March 2017)
3	Jan 2017	Amendments to the Terms of Reference section to include specific reference to the Child Death Overview Panel and the review of child deaths identified as Serious Incidents
4	Sept 2019	Amendments to Learning from Deaths process and updating of supporting documentation (see appendices). Update of definitions to bring them in line with latest National guidance. Addition of a Support to Staff section, change to the term “learning from deaths” instead of “mortality”, change of title of the Mortality Group to the Learning from Deaths Group; Terms of Reference updated. Reference to the new Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process
5	Jan 2022	Minor amendments to Learning from Death Process including the addition of *Learning from Deaths Level 1 Review Report* to replace *Learning from Deaths Local Checklist.* These amendments were carried out as part of the agreed extension of a full review of Policy to April 2022. Consideration of amendments required during this initial extension revealed numerous evolving factors impacting on the update of this policy that will remain uncertain for several months. It was therefore agreed that these would be acknowledged now and developed for inclusion in a completed policy update by September 2022. These factors include both local (e.g. Organisational changes/governance and System establishment/Strategy) and national (e.g. Medical Examiners Function, Covid response regulation such as temporary MCCD completion)
6	Dec 2022	Further reviewed, update Medical Director. Full review further postponed until September 2023 due the impending introduction of the Medical Examiner Service within Non-Acute services including Community Hospitals.

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Learning from Deaths Policy

1 Introduction

1.1 National Guidance on Learning from Deaths

In line with the Care Quality Commission's (CQC) recommendations in its "Learning, Candour and Accountability" (Dec 2016) review of how the NHS investigates patient deaths, the National Quality Board (NQB) has published the national framework for NHS Trusts - 'National Guidance on Learning from Deaths' (March 2017).

The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths in order to lead to better quality investigations and more embedded learning within organisations.

The NQB guidance covers how Trusts should respond to deaths in their care generally, not just those amounting to 'serious incidents', which will continue to be dealt with under the existing 'Serious Incident Framework'.

The focus is on improving governance processes around patient deaths and on ensuring the families/carers of patients who have died in care are given the opportunity to be involved at every stage of any in investigations and/or reviews.

1.2 Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)

LeDeR (formally the Learning from Deaths Programme) is a service improvement programme that aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities and people with autism. It was established in response to one of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). LeDeR enables local areas to meet their requirements as laid out in the NHS Operational Planning guidance includes the following "must do" for NHS England:

> *"Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism"*

A key part of LeDeR is to facilitate local reviews of deaths of people with learning disabilities (aged 4 to 74 inclusive) and people with autism registered with a GP in England at the time of their death. All deaths will be reviewed, irrespective of the cause or place of death.

2 Purpose

This policy sets out how the Trust responds to and learns from patient deaths and has been developed to ensure that the Trust pays due attention to mortality of patients in our care and ensures that any lessons learned from care delivery and avoidability are clear and cascaded. The policy also aims to:

- Ensure that patients' wishes have been identified and met
- Improve the experience of patients' families and carers through better opportunities for involvement in investigations and reviews
- Promote organisational learning and improvement

3 Definitions

3.1 Certification of Death

Certification of death is the process of completing the 'Medical Certificate of the Cause of Death' (MCCD) which is completed by a medical practitioner in accordance with The Births and Deaths Registration Act 1953, underpinning the legal requirements for recording a person's death. Currently, in order to issue a MCCD a doctor must have attended a patient in their last illness, and either seen the patient in the 14 days preceding death or seen the body after death.

In the existing system of certification of death 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.

Note: Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety (National Guidance on Learning from Deaths – March 2017).

3.2 Case Record Review

The application of a case record/note review to determine whether there were any problems in care provided to the patient who died in order to learn from what happened (National Guidance on Learning from Deaths – March 2017)

3.3 Investigation

The act or process of investigating, in a systematic analytic way of what, how and why it happened. 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.

3.4 Death due to a problem in care

A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable (National Guidance on Learning from Deaths – March 2017).

3.5 Expected Death

An expected death can be defined as "*a death where a patient's demise is anticipated in the near future and the doctor will be able to issue a medical certificate as to the cause of death (i.e. the doctor has seen the patient within the last 14 days before the death)".* (Home Office 1971)

An expected death is the result of an acute or gradual deterioration in a patient's health status, usually due to an advanced progressive incurable disease. The death is anticipated, expected and predicted.

3.6 Unexpected Death

An unexpected death is: *"Any death not due to terminal illness or, a death the family was not expecting. It will also apply to patients where the GP has not attended within the preceding 14 days. Where there is any suggestion of suspicious circumstances, trauma, neglect or evidence of industrial disease in an expected death. Patients transferred from an Acute Hospital Trust to Intermediate Care Facilities with post-surgical conditions, or fractures"*.

Unexpected death is a death that is not anticipated or related to a period of illness that has been identified as terminal. Where the death is completely unexpected, and the healthcare professional is present then there is a requirement to begin resuscitation. The national resuscitation council has issued clear guidance for the circumstances where a patient is discovered dead and there are signs of irreversible death (Hospice UK, 2019).

It is recognised that some patients may die as a result of age or fragility consequences to suffering various co-morbidities'. Whilst their death might not have been imminently expected, it is nonetheless a natural consequence of their age and general condition.

3.7 Sudden or unexpected death within a terminal period

A patient with a terminal diagnosis can have a sudden death, e.g. an embolism. Death can be verified by an RN in these circumstances provided the DNACPR/ReSPECT form is completed and the circumstances are discussed with the doctor. The death can be verified even if the doctor has not seen the patient in the previous fourteen days (Hospice UK 2019)

3.8 Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

From the 31 October 2019 the ReSPECT form replaced the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Such emergencies may include death or cardiac arrest, but are not limited to those events. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop[1]

4 Duties

4.1 Trust Board

Mortality governance is a key priority for the Trust Board. As stated in the National Guidance on Learning from Deaths, Executives and Non-executive Directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge. Trust boards are accountable for ensuring compliance with both the National Guidance on Learning from Deaths and the Serious Incident Framework. They should work towards achieving the highest standards in mortality governance.

[1] Resuscitation Council: https://www.resus.org.uk/respect/health-and-care-professionals/

4.2 Directors

The Medical Director has overall Trust responsibility for ensuring that mortalities are monitored, reviewed and any actions required identified and acted upon. The Medical Director will act as Chair of the Learning from Deaths Group.

4.3 Non-Executive Director

A nominated Non-Executive Director is appointed to the Learning from Deaths Group in order to act as an independent member to oversee the Learning from death process on behalf of the Trust Board.

4.4 Learning from Deaths Group

The aim of the group is to provide assurance to the Quality and Safety Delivery Group (QSDG) that the Trust has robust internal quality assurance processes that ensure patient safety, clinical effectiveness and user experience form the core practice and principles of services by monitoring and reviewing mortality related issues. The group will undertake reviews of all deaths and report findings and recommendations to the Quality and Safety Delivery Group.

Findings and recommendations will be reported to the Quality and Safety Committee (QSC) and the Trust Board as part of the assurance around management of risk within the Trust. Additionally, findings will be disseminated to the Divisional Service Delivery Group Quality and Safety meetings, Locality Clinical Managers, Ward Managers and Team Leaders for further dissemination to medical and healthcare staff within each Services and Community Hospitals. The Learning from Deaths Facilitator and other Specialist Leads will provide any additional advice and guidance to support this process. (See Appendix 7 Learning from Deaths Group Terms of Reference)

4.5 Locality Clinical Managers, Team Leaders and Ward Managers

As the local managers and leads the Locality Clinical Managers (LCM) and the Ward Managers will instigate the necessary Local Learning from Deaths panel reviews involving the relevant staff to ensure mortalities are being monitored and reviewed.

For Community Hospitals in particular, Locality Clinical Managers are responsible for carrying out Learning from Deaths Reviews and liaising with the relevant staff and Community Hospital Medical Advisors/Clinical Leads. Monthly reports will be submitted to the Records Manager & Quality Facilitator for review at the Adult Service Deliver Group Quality and Safety meetings. The LCMs will also be responsible for reporting to the appropriate groups and instigating any identified actions.

They are to ensure all staff are aware of the learning from deaths review process and are involved in the learning from deaths local review process when it relates to a patient that has been in their care.

4.6 Quality Facilitator

The Quality Facilitator (Learning from Deaths Facilitator) will act as the Learning from Deaths Group co-ordinator and advisor to support and monitor the reporting process and, in liaising with the Risk Manager and relevant clinical managers / staff, escalate any matters to the appropriate managers and groups. He will also ensure that monthly reports are disseminates as required and update the monthly Performance Management Tool (InPhase) with expected and unexpected death information.

They will receive local learning from deaths reports from the Locality Clinical Managers/Team Leads to ensure mortalities are reviewed following the learning from deaths review process. Any actions required will be shared with all Community Hospitals as part of the monthly Learning from Deaths reporting and any issues escalated as required to the Learning from Deaths Group and/or the Quality and Safety Delivery Group.

4.7 Medical and Healthcare Staff

All medical and healthcare staff within Services and Community Hospitals are to be aware of the requirements of the learning from deaths review process and should feedback any relevant observations or concerns to the relevant Team Leaders. They are also responsible for being involved in the Local Learning from Deaths review panels to ensure that relevant medical and clinical aspects are highlighted and acted upon.

5 Criteria for Investigating/Reviewing Patient Deaths

As a Trust, we will carry out a review or investigation of the death of any patient under our direct care. We are also willing to be involved in the investigation of any patient death where that patient has been cared for by our staff but where that patient's direct care is the responsibility of another organisation. The Learning from Deaths Level 1 Review form is used for initial review of all deaths

It is acknowledged that, for patients not under our direct care, we will have to rely on those other organisations to notify us of a patient's death as there is currently no national system in place that will notify us directly.

Where a patient has died under our direct care but has been cared for by other organisations, we will ask them to be involved in any investigations and share any lessons learnt.

5.1 Patients who are Under our Direct Care

For the purpose of this policy, the following groups of patients are considered to be under our direct care:

- Patients who are being cared as inpatients in one of our Community Hospitals
- Patients who are in custody in HMP/YOI Stoke Heath where healthcare is provided by the Trust

5.2 Patients who are Under the Direct Care of another organisation

In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being primary care and acute care, ambulances services and acute care, or mental health services combined with any of these.

The following groups of patients are ones where we are delivering care but they are under the direct care of another organisation. In these cases we will rely on being informed by the appropriate organisation until a national notification process is in place.

- Patients within the community who have received care from staff employed by the Trust i.e. those under the care of the General Practice (GP)
- Patients who were transferred as an inpatient from our Community Hospitals into the Acute Hospital e.g. Shrewsbury and Telford Hospital

(SATH) but had died within 48 hours of transfer. A investigation such as this is referred to as a Superspell[2] Investigation

- In-patients who have died within 30 days of leaving a Community Hospital.

5.3 Criteria for a case record review

If a patient dies whilst under our direct care (as defined above), a case record review should always be undertaken by the Trust if any of the following criteria apply:

- The death was unexpected
- The bereaved family have expressed a concern about the care their relative received from the Trust
- Staff employed by the Trust have expressed a concern about the quality of care received by the deceased
- The death occurred whilst the patient was under the care of a service where concerns have previous been raised (e.g. through audit or CQC inspection)
- The deceased patient had a learning disability
- The deceased patient was a child
- The deceased patient was in custody

5.4 Criteria for an Investigation

If a death is reported as an Unexpected Death an investigation will be carried out. In other cases where it is felt an investigation is required staff should be guided by the circumstances for investigation in the Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner as the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication are needed to avoid problems.

If an investigation into a death is needed, early contact should have been made with bereaved families and carers so that their views helped to inform the decision.

6 Bereaved Families and Carers

The following are the key principles stated in the National Guidance for Learning from Deaths are to ensure staff engage in a meaningful and compassionate manner with bereaved families and carers in relation to all stages of responding to a death. Bereaved families and carers:

- should be treated as equal partners following a bereavement
- must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment

[2] An admission to a hospital is referred to as a “spell” or episode of care. Spells ending in transfer to another NHS hospital are linked together (“superspell”) allowing for a difference between discharge from the first Trust and admission to the next Trust of up to two days.

- should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support
- should be informed of their right to raise concerns about the quality of care provided to their loved one
- views should help to inform decisions about whether a review or investigation is needed
- should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison
- should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations
- who have experienced the investigation process should be supported to work in partnership with Trusts in delivering training for staff in supporting family and carer involvement where they want to

The National Quality Board has published a Learning from Deaths Guidance for NHS Trusts on working with bereaved families and carers

7 Patients Deaths Under the Direct Care of another organisation

Where a patient dies while under the care of another organisation but where members of our staff have been involved in the care and treatment of that patient we would expect to be informed of that death and to be involved in any review or investigation as required. If members of our staff have concerns relating to the patient death then this should be reported using the Trust's Incident Reporting system and relevant investigations will be instigated.

If a member of staff discovers a patient who has died in the community, e.g. in the patient's home, then they should contact the Emergency Services to ensure the appropriate actions are taken and authorities informed. They should also raise a Datix incident report to detail the actions they have taken and record as an "Informal Death" on the RiO Electronic Patient Record System. This will ensure other teams and services in the Trust are aware of the patient's death until the formal death notification is updated from the Patient Demographic Services.

8 Child Death Overview Panel

The CDOP Process covers all child deaths from birth up to 18th birthday (excluding still births and planned terminations). The CDOP considers the death of each child, and is required to complete a national proforma regarding its findings for each child. The proforma includes factors relating to the child and family, and service provision; categorisation of the cause of death; a judgment regarding whether there were modifiable factors; learning points and recommendations; immediate follow up actions for the family and whether the case should be referred to the LSCB Chair for consideration of a Serious Case Review.

9 People with Learning Disabilities and Autistic People

The death of any person with a learning disability and people with autism, must be reported and investigated as part of the LeDeR service improvement

programme which facilitates the local reviews of deaths of people with learning disabilities aged 4 to 74 (inclusive) and people with autism registered with a GP in England at the time of their death. All deaths will be reviewed, irrespective of the cause or place of death. Link: https://leder.nhs.uk/

The child death review (CDR) process reviews the deaths of all children who are aged 4-17. This will be the primary review process for children with learning disabilities and autistic children; the results are then shared with the LeDeR Programme.

10 Patient Deaths within Community Hospitals

Community Hospitals do not collect Summary Hospital-Level Mortality Indicator (SHMI) or Hospital Standardised Mortality Ratio (HSMR) data as acute trusts are required to do. Therefore following best practice in line with organisations that do have these measures, the Trust has implemented a process by which mortality within community hospitals in Shropshire Community Health NHS Trust (SCHT) is managed and reviewed in a systematic way.

All deaths of inpatients within Community Hospitals will be reviewed as part of the Learning from Deaths Review Process and are detailed in more detail later in the "Process following the death of a Patient in a Community Hospital" sections. In summary a Learning from Deaths Level 1 Review will be carried out on all inpatient deaths. If the death is reported as an Unexpected Death then a Learning from Deaths Investigation report will need to be completed. A case record review will be carried out for Learning from Deaths Investigations. See Appendix 2 Learning from Deaths Guidance for more details and flowchart of the process.

11 Deaths in Custody

"Deaths in Custody" from HMP Stoke Heath are linked into the Prison and Probation Office (PPO) Deaths in Custody process and as such will be investigated as part of that process. An Initial 48 Hour report will be produced and reported to the HM Prison Commissioners and any initial actions followed up. Final actions will be reported to the Trust following the PPO Investigation process. The Learning from Deaths Group will be kept informed of any aspects they need to be made aware of and will receive any investigation reports and actions required of the Prison Healthcare Department (see Appendix 1 for HM Prison Death in Custody Reporting Process flowchart)

12 Process following the death of an Inpatient in a Community Hospital

12.1 Learning from Deaths Local Review

Initially the Learning from Deaths Level 1 Review should be carried out by the team that cared for the patient. This should be carried out within seven working days of the patient death using the Learning from Deaths Level 1 Review report (Appendix 3). The key purpose of this review is to ensure all appropriate care was delivered in a timely manner. The Community Hospital Patient's Records (including the Medical Record, Patient Assessment and Plan of Care and Acute Hospital record where appropriate) should be reviewed as part of this process. With implementation of the Electronic Patient Record system, RiO, that system will also be referred to as part of the review.

A notification e-mail will be generated following the coding of a death on the clinical systems and the relevant Locality Clinical Manager (LCM), Ward Manager and the Learning from Deaths Facilitator will be notified by e-mail. The Learning from Deaths Level 1 review process will then be initiated by the LCM. The review should be led by the Ward Manager / Team Leader and include the medical and healthcare staff involved in the patient's care. It is seen as good practice to initiate a Local Review Panel of those concerned in order to fully discuss, understand and identify any learning from the death. These reviews should be reported to the LCM so that any further investigations or actions can be taken locally, with a brief summary of:

- Good practice points identified.
- Any gaps that may have been identified
- Any actions that have been identified with the name of a responsible person and time scales for completion of the required actions.

The LCM will use these Learning from Deaths Level 1 Review Report in order to complete their LCM Expected Death Monthly Summary (see Appendix 4). Any identified actions will be recorded in the Action Plan section of this monthly summary. The completed LCM Expected Death Monthly Summary will be reported to the Learning from Deaths Facilitator who will review and update the Master Learning from Deaths Database with the relevant information. They will also maintain an LCM Action Plan Tracker in order to monitor any actions identified and to note any trends.

12.2 Learning from Deaths Review Factors

The purpose of Learning from Deaths reviews are:

- To provide reassurance to families of the deceased, the care providers and Boards of NHS organisations that any particular death is not a cause for concern in terms of quality of care provided
- To identify areas for improvement in health care in the care and treatment environment and inform the appropriate individual who can deliver the necessary changes

The Local Learning from Deaths panel should consider the following factors. In reviewing these factors the following should be taken into consideration:

1. **Key domains of care:** Physical, Psychological, Social and Spiritual
2. **Key organisation governance requirements:** Clinical Decision Making; Management and Leadership; Learning and Teaching; and Governance and Risk

Key aspects to consider include (but not limited to): referral; initial assessment; diagnosis; ongoing assessments; day to day care; monitoring and response to e.g. early warning scores; escalation of care; quality of end of life care, including timely and appropriate completion of end of life care planning and ReSPECT forms and decisions, where appropriate; and care after death.

The information collected as part of the local LfD Level 1 Review should provide the Team Leads and LCMs with sufficient detail in order to identify any issues/concerns/trends that require further actions and to share learning and areas of good practice between staff in all Community Hospitals.

12.3 Support to staff

The Local Learning from Deaths Review/Panel should also give staff the opportunity to discuss any aspects of the patient death and seek any personal support from their line managers and/or Occupational Health.

The ***Stress and Staff Support at Work Policy*** gives more in-depth details and guidance on the recommended support process including: Immediate debriefing; Factors to consider when giving support; Group debriefings; Ongoing support and Support available.

If it is felt appropriate, the Network of Staff Supporters (NOSS) provides confidential counselling for staff and this can be accessed through a self-referral basis.

Contact details for NOSS are: Tel: 01978 780479, e-mail reception@noss.uk.com. For further information on NOSS: www.noss.uk.com

12.4 Learning from Deaths Local Review Recommendations and Findings

Recommendations, findings and actions identified from the Local Learning from Deaths reviews will be discussed at the Adult Service Delivery (Quality and Safety) Group and should be disseminated to appropriate staff by individual / team briefings or staff awareness events such as Ward and GP meetings. A consolidated Learning from Deaths Report will be sent to the Learning from Deaths Group each month. Any issues identified for escalation should be reported to this group by exception.

13 Unexpected Death

13.1 Learning from Deaths Review

If the death is an unexpected death this should be reported on the Trust's incident reporting system (Datix). If on initial investigation there is any evidence of service care or delivery problems or concerns that were considered to be a significant contributory factor then the Datix Incident should be escalated as a Serious Incident. The Risk Manager will liaise with the appropriate people to ensure this decision is made in a timely manner. Any unexpected deaths deemed as a Serious Incidents will be reported to the Trust Executives and Board and escalated as per the Serious Incident process.

All unexpected deaths will be reviewed by the Learning from Deaths Group. In order to assist in this process a Learning from Deaths Investigation Review (see Appendix 5) should be carried out by the Local Learning from Deaths panel to identify any care and service delivery issues associated with the unexpected death. This review should be led by the Locality Clinical Manager liaising with the Community Hospital Medical Advisor/Clinical Lead and include any other medical and healthcare staff involved in the patient's care. This investigation should be carried out within two working days. A report of this review, including initial findings, lessons learnt and actions proposed, will then be submitted to the Learning from Deaths Group to assist in the review and investigation process.

Note: the Datix Incident investigation will take place as a separate but related process.

Those involved in this review should consider SBAR (Situation, Background, Assessment and Recommendations) principles when carrying out this process.

The Community Hospital Patient's Records (including the Medical Record, Patient Assessment and Plan of Care and Acute Hospital record where appropriate)

should be reviewed including Transfer of Care/ Admission, Medical Management, Care Plans, Observation Charts, Evaluation and Communication Sheets and a chronology of events. The patient's electronic record (RiO) should also be included in this review.

On reviewing unexpected deaths any contributory factors should be identified, these could include:

- Patient Factors
- Staff Factors
- Task Factors
- Communication Factors
- Equipment Factors
- Work Environment
- Education and Training and
- Team Factors

The Global Trigger Tool (Acute Trigger Tool) should also be completed for each unexpected death (see Appendix 6).

13.2 Global Trigger Tool

The Global Trigger Tool is a case note review system which was designed for use within the Acute Hospital settings but can be adapted to the Community Hospital environment. The tool helps to identify any "triggers" which may them have resulted in harm to the patient. These harms are categorised as follows:

Category E: contributed to or resulted in temporary harm to the patient and required intervention

Category F: contributed to or resulted in temporary harm to patients and required initial or prolonged hospitalisation

Category G: contributed to or resulted in permanent patient harm

Category H: required intervention to sustain life

Category I: contributed to the patient's death

The tool is spilt into the following sections:

1. General care module
2. Surgical care module (not applicable to Community Hospitals)
3. Intensive care module (not applicable to Community Hospitals)
4. Medication module
5. Lab test module

The key aspects covered during this review process are:

- Coding summary
- Observations and fluid balance charts
- Blood / Laboratory reports
- X-ray reports
- Procedural notes
- Nursing notes
- Medical notes

Be cautious of “normalisation of the abnormal” i.e. a specialist saying that that harm would be expected if that procedure was undertaken.

13.3 Learning from Deaths Review Recommendations and Findings

Recommendations, findings and suggested action plan of the Learning from Deaths Review will be reviewed and agreed by the Learning from Deaths Group. These will also be reported to the Medical Director and the Adult Service Delivery (Quality and Safety) Group. As required, additional reporting will be made to the Quality and Safety Committee and Trust Board. Recommended actions and lessons learnt from the Learning from Deaths Review and the Datix Investigation will be discussed at the Adult Service Delivery (Quality and Safety) Group and disseminated to appropriate staff by individual / team briefings or staff awareness events such as Ward and GP meetings. Relevant learning from deaths factors will also be shared with the Community Hospital Medical Advisors/Clinical Leads Group and the End of Life (EOL) Group

14 Learning from Deaths

The Learning from Deaths Group will identify any lessons learnt from either Case Record Reviews or Investigations and these will be disseminated to staff via team meetings, staff briefings and face to face discussions with the individuals involved. In some cases the lessons learnt may be shared wider within the Trust or with agencies or organisations outside the Trust.

The Lessons Learnt should include:

- An overview of what happened, including any themes identified – putting safety first. Being honest
- Any System of Process Factors – adherence to policy and procedure
- Any Human Factors – be supportive and caring. Open and non-defensive culture
- What will we do? Learn and Act – preventative and risk reducing improvements. Continually learn. Share across services

In particular for Learning from Deaths Investigations an action plan will be agreed and specifics details of how lessons learnt are to be disseminated will be recorded and monitored by the Learning from Deaths Group.

15 Reporting

From April 2017, Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust’s policy and approach and publication of the data and learning points. This data should include the total number of the Trust’s in-patient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

15.1 Monthly Reporting

The Learning from Deaths Facilitator will co-ordinate the monthly reporting of Learning from Deaths and learning from deaths related information distributing relevant reports to the Learning from Deaths Group members, the Adult Service Delivery Group Quality and Safety meeting. Expected and Unexpected Death related data will be uploaded onto the Trust’s Performance Management

Reporting tool (InPhase) so it is included in monthly performance management reporting and available to those who need to refer to the mortality data. See Appendix 6: Learning from Deaths Reporting Flowchart.

15.2 Learning from Deaths Trends and Categories

The monthly reports will include additional mortality data/factors in order for trends to be identified, monitored and appropriate follow up actions taken as required. These factors include the deaths per community hospital; patient's age and gender; hospital admission source and preferred place of care. In addition the causes of death are reviewed and categorised as follows:

- Cardiovascular
- Frailty – Old Age
- Respiratory
- Malignancy
- Infectious Diseases
- Gastrointestinal
- Neurological
- Renal
- Other
- Awaiting Cause of Death Confirmation (*includes deaths referred to the Coroner for reasons such as: patient had not been seen by the GP in the last 14 days; patient had undergone surgery within the last 6 weeks at an acute hospital*)

15.3 Learning from Deaths Dashboard

The Department of Health have produced a Learning from Deaths Dashboard as a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care. This dashboard records deaths under the following six categories:

- Score 1 – Definitely avoidable
- Score 2 – Strong evidence of avoidability
- Score 3 – Probably avoidable (more than 50 – 50)
- Score 4 – Probably avoidable but not very likely
- Score 5 – Slight evidence of avoidability
- Score 6 – Definitely not avoidable

This dashboard is included in the Learning from Deaths Reports produced for the Trust Board.

15.4 Learning from Deaths Report

The Chair of the Learning from Deaths Group will provide a six-monthly learning from deaths report to the Quality and Safety Committee and a quarterly summary learning from deaths report as detailed above to the Trust Board

15.5 Quality Accounts

The Quality Accounts regulations require that the data providers publish be summarised in Quality Accounts from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken.

16 Training

Following the CQC Learning, Candour and Accountability report Health Education England (HEE) were to be tasked with engaging with relevant system partners, families and carers, and staff to understand broader training needs and develop approaches to ensuring that staff have the capability and capacity to carry out good investigations of deaths, with the focus on these leading to improvements in care. The Trust will monitor the developments in this training in order to ensure that staff can access suitable training when it becomes available.

The Trust currently offers the following training:

- Root Cause Analysis (RCA) Investigation Technique training which is co-ordinated and provided by the Risk Management Team
- Dealing with Important Conversations: training for Staff when talking to patients, carers and family members
- Key members of staff have undertaken the LeDeR training and they will be able to provide guidance based on the concepts covered during that training

17 Consultation

The following have been included in consultation for this policy, and the previous Community Hospital Learning from Deaths Review Process, have included the Medical Director, Associate Medical Directors, Non-Executive Director, Deputy Director Nursing and Quality, Risk Manager, Adult Services Divisional Manager, Community Hospital Locality Clinical Managers, Ward Managers, Clinical Lead for Community Hospitals, Head of Infection Prevention and Control, Records Manager and Quality Facilitator and Nurse Consultant.

18 Dissemination and Implementation

This process will be disseminated to all medical and healthcare staff via the Datix notification process and by Locality Clinical Managers, Team Leaders and Ward Managers.

19 Monitoring and Compliance

The Learning from Deaths Group will monitor compliance with this policy by:

1. Reviewing any related reported incidents
2. Feedback from staff involved in the process

20 References

- National Guidance on Learning from Deaths (NQB March 2017)
- CQC Learning, Candour and Accountability Review

- Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) Policy 2021
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (March 2013)
- Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report (Professor Sir Bruce Keogh KBE, July 2013). The Keogh Review
- IHI Global Trigger Tool (UK version)
- Using the Acute Trigger Tool
- Learning from Deaths Guidance for NHS Trusts on working with bereaved families and carers
- Hospice UK: 2nd Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance
- Resuscitation Council: Recommended Summary Plan for Emergency Care and Treatment
- Guidance for registered medical practitioners on the Notification of Deaths Regulations 2019

21 National Leads

The list below provides the lead role with overall responsibility for the learning from deaths programme at relevant national organisations:

- NHS Improvement - Executive Medical Director
- Care Quality Commission - Chief Inspector of Hospitals
- Department of Health - Director of Acute Care and Workforce
- NHS England - National Medical Director

22 Associated Documents

Trust policies, procedures and other record keeping related documents:

- Clinical Record Keeping Policy
- Consent to Examination and Treatment Policy
- Admissions and Transfer to Community Hospitals Policy
- End of Life Care After Death Policy
- Child Death Overview Process Community Health Professionals Guideline
- Verification of Death Policy
- Incident Reporting Policy
- Stress and Staff Support at Work Policy

These documents are available from the Policies section of the Trust's website: http://www.shropscommunityhealth.nhs.uk/

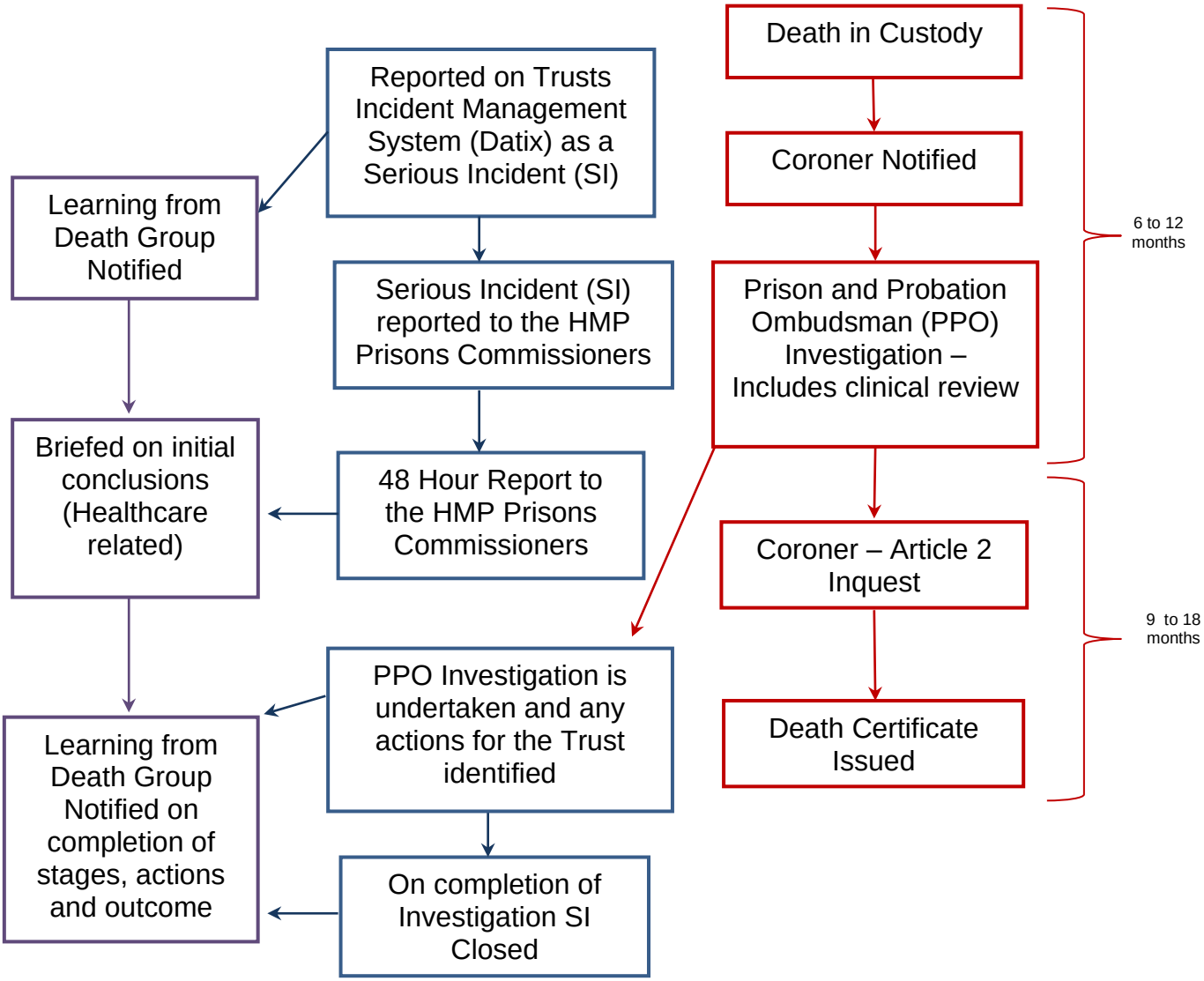
23 Glossary/Abbreviations

Term / Abbreviation	Definition / description
CHMA	Community Hospital Medical Advisor
CDOP	Child Death Overview Panel
CQC	Care Quality Commission
DNACPR	Do Not Attempt Cardio-pulmonary Resuscitation
EOL	End of Life
HSMR	Hospital Standardised Mortality Ratio
HMP/YOI	Her Majesty's Prison / Young Offenders Institute
LCM	Locality Clinical Manager
LeDeR	Service Improvement programme for people with a learning disability and autistic people
LfD	Learning from Deaths
MCCD	Medical Certificate of the Cause of Death
NOSS	Network of Staff Supporters
NQB	National Quality Board
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
SBAR	Situation, Background, Assessment and Recommendations
SHMI	Summary Hospital-Level Mortality Indicator

Appendix 1: HM Prison Death in Custody Reporting Process

HM Prison Death in Custody Reporting Process

The flowcharts below show the link between the Learning from Deaths Group and the standard Death in Custody required reporting process.



Note: The Prison and Probation Ombudsman (PPO) are responsible for the full investigation into Deaths in Custody and the Trust will receive their final report detailing any actions required by the Trust's Prison Healthcare Department. Any immediate actions identified in the 48 Hour report will be noted in that report followed up as a matter of priority

Appendix 2: Learning from Deaths Guidance

The National Learning from Deaths framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths in order to lead to better quality investigations and more embedded learning within organisations.

The Learning from Deaths Policy sets out how the Trust responds to and learns from patient deaths and has been developed to ensure that the Trust pays due attention to mortality of patients in our care and ensures that any lessons learned from care delivery and avoidability are clear and cascaded. The policy also aims to:

- Ensure that patients' wishes have been identified and met
- Improve the experience of patients' families and carers through better opportunities for involvement in investigations and reviews
- Promote organisational learning and improvement

Learning from Deaths Process: In brief all deaths of inpatients within Community Hospitals will be reviewed as part of the Learning from Deaths (LfD) Process. Deaths of patients within the Community come under the direct care of their GP but Community Services/Teams are encouraged to use the Learning from Deaths Process in order for the Trust to gather useful Learning from Deaths information from the Community.

The purpose of Learning from Deaths reviews are:

- To provide reassurance to families of the deceased, the care providers and Boards of NHS organisations that any particular death is not a cause for concern in terms of quality of care provided
- To identify areas for improvement in health care in the care and treatment environment and inform the appropriate individual who can deliver the necessary changes

Learning from Deaths Level 1 Review

The Learning from Deaths Level 1 Review Report form is used for any expected death reviews and will be carried out by the team that cared for the patient within seven working days of the death of a patient. When completing this Level 1 Review staff should consider all aspects of the patient's care including communication between healthcare professionals and/or with family/carers.

Key aspects to consider include (but not limited to): referral; initial assessment; diagnosis; ongoing assessments; day to day care; monitoring and response to e.g. early warning scores; escalation of care; quality of end of life care, including timely and appropriate completion of end of life care planning and ReSPECT forms and decisions, where appropriate; and care after death.

Undertaking this Level 1 Review will determine whether a more in-depth Learning from Deaths review/investigation is required.

Learning from Deaths Investigation/Review

If the death is reported as an Unexpected Death then it should be reported on Datix and a Learning from Deaths Investigation/Review report will need to be completed. This investigation takes the form of a Root Cause Analysis (RCA) and will look into the full details of the patient's care and treatment. A case record review will be carried out for Unexpected Death Investigations. See the Learning from Deaths Review Flowchart overleaf for more details of the process.

People with Learning Disabilities and People with Autism: The death of any person with a learning disability (aged 4 and above) and every adult (18 and over) with a diagnosis of autism is eligible for a LeDeR Review and must be reported and investigated as a LeDeR Notification of Death. The LeDeR programme facilitates the local reviews of deaths of people with learning disabilities and autistic people registered with a GP in England at the time of their death. All deaths will be reviewed by a LeDeR Assessor, irrespective of the cause or place of death.

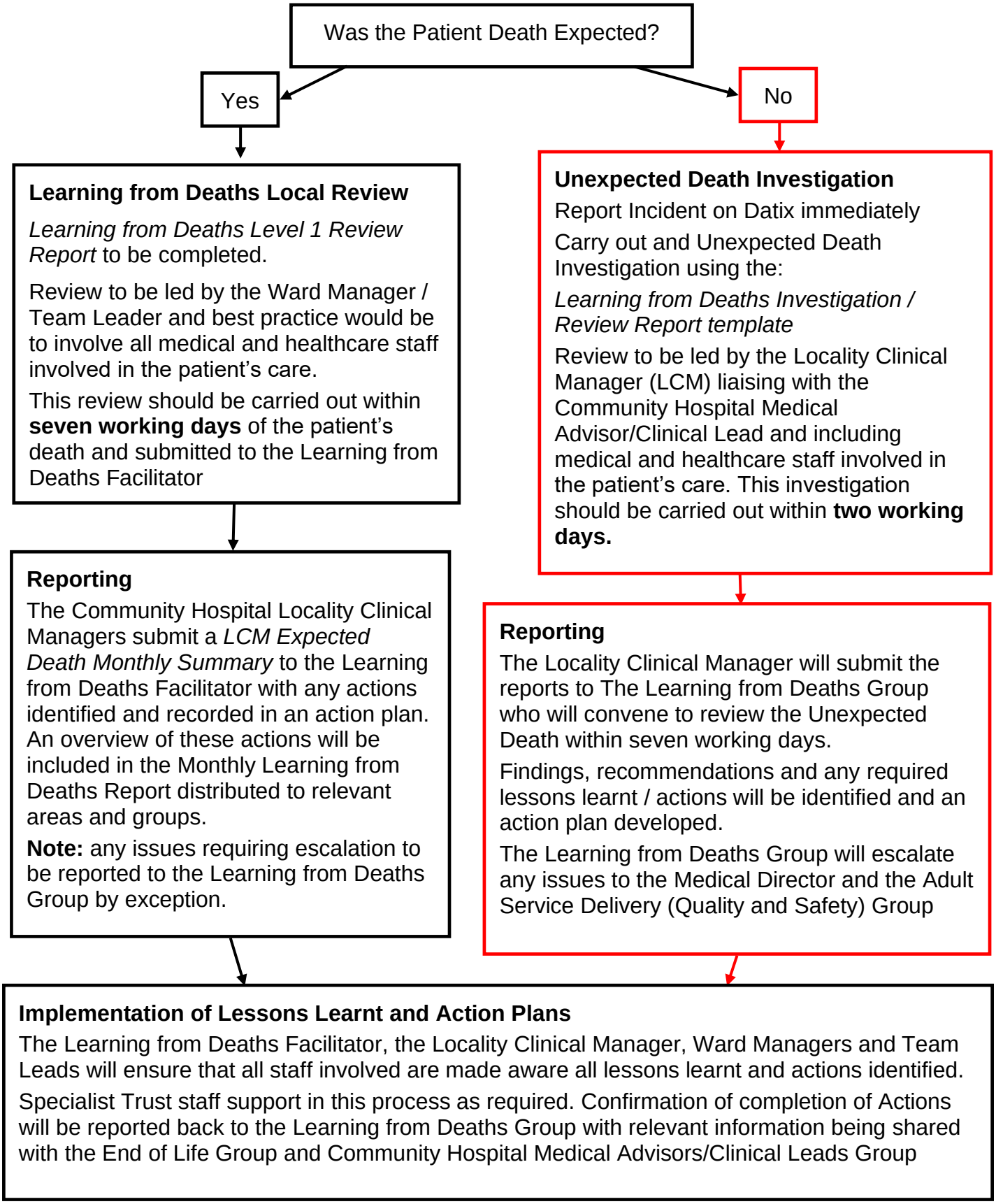
Definitions:

Expected Death: An expected death can be defined as *"a death where a patient's demise is anticipated in the near future and the doctor will be able to issue a medical certificate as to the cause of death (i.e. the doctor has seen the patient within the last 14 days before the death)"* (Home Office 1971). In short, a death where the patient was expected to die or their family or friends have been informed was terminally ill or likely to die. These are usually determined by the fact that the patient's GP will be able to complete a certification of death and the patient often has a DNACPR / ReSPECT form in place.

Unexpected Death: An unexpected death is: *"Any death not due to terminal illness or, a death the family was not expecting. It will also apply to patients where the GP has not attended within the preceding 14 days. Where there is any suggestion of suspicious circumstances, trauma, neglect or evidence of industrial disease in an expected death. Patients transferred from an Acute Hospital Trust to Intermediate Care Facilities with post-surgical conditions, or fractures"*.

Please note that it is recognised that some patients may die as a result of age or fragility consequences to suffering various co-morbidities'. Whilst their death might not have been imminently expected, it is nonetheless a natural consequence of their age and general condition and not an unexpected death under the above definition.

Learning from Deaths Review Flowchart



Note: the relevant learning from deaths process forms mentioned in this guidance are available on the Trust's Clinical Documentation Library SharePoint under the Community Hospital, Mortality and Learning from Deaths

Appendix 3: Learning from Deaths Level 1 Review Report

NHS
Shropshire Community Health
NHS Trust

First Name:
Last Name:
Date of Birth:
NHS Number:

Learning from Deaths
Level 1 Review Report

Patient Ref: i.e. Patient initials and last four of NHS Number		**Date of Review Report:**	
Gender:		**Datix Ref** (if applicable):	
Was this death an Unexpected Death? *(*If Yes please ensure a Datix is raised)*			Yes ☐* No ☐
Date and Time of Death:		**Patient's Age:**	
Cause of Death: (As listed on Death Certificate)			
Community Hospital (incl Ward) **/ Community Service** (Incl Team):			
The key purpose of this review is to ensure all appropriate care and treatment was delivered in an appropriate and timely manner and to identify any suggested areas for improvement.			
Background: *summary of key facts relating to patient's death*			
Admitted / Transferred / Referred from:			
Date of Admission / Start of Treatment:		**Length of Stay / Treatment:**	
Reason for Admission / Referral:			
Any Alerts recorded? (e.g. COVID 19 positive swab result)			Yes ☐* No ☐
**If Yes, please give relevant details:*			
Was the patient on an End of Life Care Plan?			Yes ☐ No ☐
If End of Life, was the patient's place of death their preferred one? **If No, please give relevant details below:*			Yes ☐ No ☐*
If relevant, has a ReSPECT form been completed for this patient?			Yes ☐* No ☐
**If Yes what was the date of this form?*			
Did the patient have any relevant Additional Needs? **If Yes, please consider and record all relevant additional identified needs, including any protected characteristics[1] factor(s), e.g. disability, religion or belief, in the review below*			Yes ☐* No ☐
Was the patient known to have a Mental Health condition or a Learning Disability? **If Yes, please consider and record all relevant Mental Health and/or Learning Disabilities factors in the review below*			Yes ☐* No ☐
Significant Medical History:			

Complete below with regard to patient, relatives, carers and staff:
What went well?
• <<Please list items in bullet points>>
What went less well?
• <<Please list items in bullet points>>
What could have gone better?
• <<Please list items in bullet points>>
Comments:
• <<Please list items in bullet points>>
Suggestions (these should be specific points relating to any concerns or issues)**:**
• <<Please list items in bullet points>>
Details of those involved in the Learning from Deaths Local Review

Name:	Signature:	Designation:

[1] *Protected Characteristics include age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. For further guidance see Equality and Human Rights Commission website*

Appendix 4: LCM Expected Deaths Monthly Summary

Shropshire Community Health NHS Trust

LCM Expected Deaths Monthly Summary

This form is to be completed by Locality Clinical Managers (LCM) following completion of the Learning from Deaths (LfD) Local Reviews undertaken following expected deaths. This monthly summary should include key aspects from the LfD Local Reviews undertaken in order to identify any trends and to highlight any concerns and to share areas of good practice between staff in all the Community Hospitals. This information is used for consolidated reporting to the Adult Service Delivery Group and the Learning from Deaths Group and onward reporting to the Quality & Safety Committee and the Trust Board.

Expected Death Details				
Community Hospital / Ward:				
Patient References: (Patient initials and last four of NHS Number):	**Date and Time of Death:**		**Date of LfD Local Review:**	
Total Deaths:		**For period**	**From:**	**To:**
Background: summary of key facts relating to each patient's expected death incl. confirmation of Cause of Death, End of Life care plan in place, DNACPR/ReSPECT Form reviewed/in place, note of patient's preferred place of death and involvement of family/carers. Also confirmation if any patient was known to have a Mental Health condition or a Learning Disability. Include any other relevant facts to understand the individual patient requirements and any additional needs around their care and treatment.				
Care or Service Delivery Issues / Concerns identified: In particular please note any care or service delivery problems on the ward that may have affected the care of the patient, including: staffing or acuity and dependency aspects. Record "no issues or concerns" where applicable.				
Recommendations: include any lessons learnt and/or shared training. Please note any specific learning to be shared with other Community Hospitals				
Actions Taken / Planned: For any actions identified from the Recommendations section, complete *Appendix 1: Action Plan* (ensure to include who is involved and timescales for completion.) In no actions please state so below				

Author:	
Role / Designation:	
Report Date:	

Appendix 1: LCM Expected Death - Action Plan:

Status Key: Red – overdue; Amber – on track / in progress; Green – action completed

Community Hospital:		**Date:**				
Action No	**Identified Issue / Area of Concern** (Care or Service Delivery Issues / Concerns identified)	**Action required** (Refer to Recommendations. Include what is required and who needs to be involved)	**By Who**	**By When**	**Progress** (include Monitoring and Evaluation Arrangements)	**Status RAG**
1.						
2.						
3.						
4.						
5.						

Appendix 5: Learning from Deaths Investigation/Review Report

Learning from Deaths Investigation/Review Report

During this review follow the **S**ituation, **B**ackground, **A**ssessment and **R**ecommendations tool principles

Situation		
Patient Ref: (Patient initials and last four of NHS Number)	Datix Ref No:	
Gender:	Was this an Unexpected Death? Yes ☐* No ☐ (*If yes please ensure a Datix is raised)	
Date of Birth:	Date and Time of Death:	Age:
Cause of Death: (to be completed when known)		
Community Hospital (incl. Ward) / Service (incl. team):		
Detection of incident:		
Involvement and support of patient relatives:		

Background	
Admitted / Transferred / Referred from:	
Date of Admission/Start of Treatment:	Length of Stay/Treatment:
Reason for Admission/Referral:	
Did the patient have any relevant Additional Needs? **If Yes, please consider and record all relevant additional identified needs, including any protected characteristics[1] factor(s), e.g. disability, religion or belief, in the review below*	Yes ☐* No ☐
Was the patient known to have a Mental Health condition or a Learning Disability? **If Yes, please consider and record all relevant Mental Health and/or Learning Disabilities factors in the review below*	Yes ☐* No ☐
Significant Medical History:	
Medication:	

Chronology (timeline) of events	
Date & Time	Event

Assessment
Review the patient's medical records including, Medical Assessments, Daily Charts, Rounding Tool, Evaluation and Communication Sheets and Care Plans to assess the care delivered. Ensure a Global Trigger Tool review has taken place and note any findings below.
Findings Summary:
Recommendations
Using the information above and any additional information found, what are the Care and Service Delivery problems associated with this incident?
What are the identified Contributory Factors? These could include: Patient Factors; Staff Factors; Team Factors; Communication Factors; Equipment Factors; Work Environment: Organisational; Education and Training:
Root Causes (the contributory factors that had the greatest impact, and which addressed will minimise the likelihood of re-occurrence):
Lessons Learned:
Conclusions / Recommendations:
Arrangements for Shared Learning:

Author:	
Role / Designation:	
Report Date:	

Learning from Deaths Investigation/Review Report Action Plan:

Status Key: Red – overdue; Amber – on track / in progress; Green – action completed

No	**Identified Issue / Area of Concern** (refer to Root Causes, Lessons Learnt)	**Action required** (Refer to recommendations. Include what is required and who needs to be involved)	**By Who**	**By When**	**Progress** (include Monitoring and Evaluation Arrangements)	**Status RAG**
6.						
7.						
8.						
9.						

Appendix 1: Global Trigger Tool (adapted for SCHT Community Hospitals)

Patient Ref: _____ **Length of Stay:** _____

(Patient Initials and last four of NHS Number)

		Number of Events	Event Description	Severity E – I (see Key overleaf)
General Care Module				
G1	Lack of early warning score or early warning score requiring response			
G2	Any patient fall			
G3	Decubiti			
G4	Readmission to hospital within 30 days			
G5	Shock or cardiac arrest			
G6	DVT/PE following admission evidenced by imaging +/or D dimmers			
G7	Complication of procedure or treatment			
G8	Transfer to higher level of care			
Medication Module				
M1	Vitamin K			
M2	Naloxone			
M3	Flumazenil			
M4	Glucagon or 50% glucose			
M5	Abrupt medication stop			
Lab Test Module				
Haematology				
L1	High INR (>5)			
L2	Transfusion			
L3	Abrupt drop in Hb or Hct (>25%)			
Biochemistry				
L4	Rising urea or creatinine (>2x baseline)			
L5	Electrolyte abnormalities Na+ <120 or >160			
L6	K+ <2.5 or >6.5			
L7	Hypoglycaemia (<3mmol/l)			
L8	Raised Troponin (>1.5 ng/ml)			
Microbiology				
L9	MRSA bacteraemia			
L10	C. difficile			
L11	VRE			
L12	Wound infection			
L13	Nosocomial pneumonia			
L14	Positive blood culture			

Total Events _____ **Complete any additional comments overleaf**

Global Trigger Tool (adapted for SCHT Community Hospitals) continued:

The Global Trigger Tool helps to identify any "triggers" which may them have resulted in harm to the patient. These harms are categorised as follows:

Severity Category Key:

E: contributed to or resulted in temporary harm to the patient & required intervention

F: contributed to or resulted in temporary harm to patients& required initial or prolonged hospitalization

G: contributed to or resulted in permanent patient harm

H: required intervention to sustain life

I: contributed to the patient's death

The key aspects to be covered during this review process are:

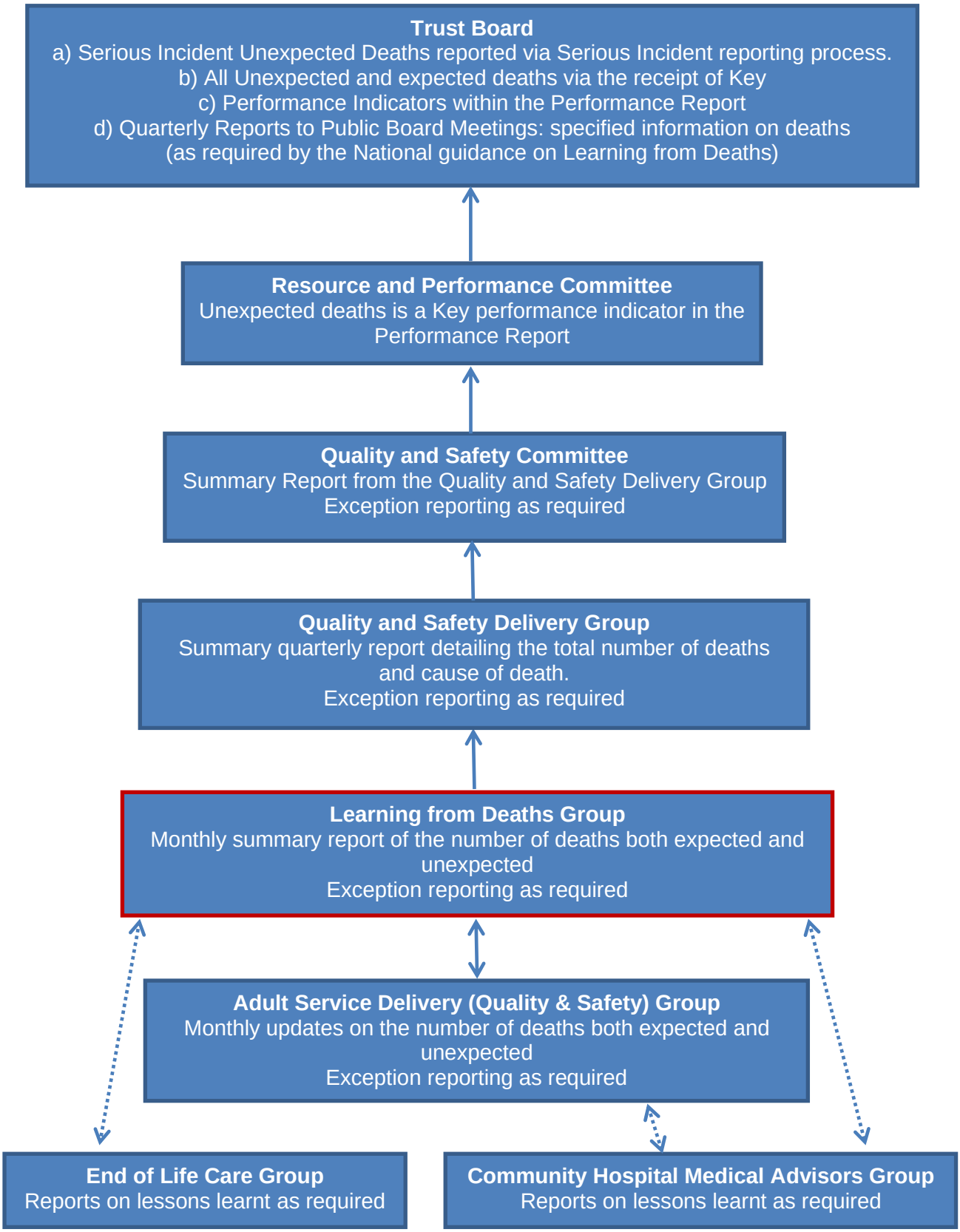
- Coding summary
- Observations and nutrition / hydration charts
- Blood / Laboratory reports
- X-ray reports
- Procedural notes
- Nursing notes
- Medical notes

Additional comments / notes:

Completed By:

Name:	**Designation:**
Signature:	**Date:**

Appendix 6: Learning from Deaths Reporting Flowchart



Appendix 7: Learning from Deaths Group Terms of Reference

Shropshire Community Health NHS Trust

Learning from Deaths Group
Terms of Reference

Version: 1.81

Approved by: Quality & Safety Service Delivery Group

Date 30 Jun 2021 (minor updates approved by Learning from Deaths group)

Date approved	
Date issued:	**30 Jun 2021**
Review date:	~~**30 November 2021**~~ **Extended to 15 Sept 2022 to bring in line with review of Learning from Deaths Policy**

Document History:	
Version:	**1.81**
Ratified by:	**Quality & Safety Service Delivery Group (LfD Group – 30th June 2021)**
Date ratified:	**30 June 2021**
Name of author(s):	**Dr Mahadeva Ganesh, Medical Director and** **Alan Ferguson, Quality Facilitator (Learning from Deaths Facilitator)**

Name of responsible committee/group/individual:

Quality and Safety Delivery Group,
Shropshire Community Health NHS Trust

Target audience: **Quality and Safety Committee**
Shropshire Community Health NHS Trust

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4.	Meetings and Quorum	3
5.	Authority	3
6.	Role and Duties of the Learning from Deaths Group	3
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1. Introduction

The Learning from Deaths Group (previously known as the Mortality Group) is a sub-group of the Quality and Safety Delivery Group. Its powers are delegated by that group and detailed in these terms of reference. The aim of the group is to provide assurance to the Quality and Safety Delivery Group that Community Health Services have robust internal quality assurance processes that ensure patient safety, clinical effectiveness and user experience form the core practice and principles of services by monitoring and reviewing Learning from Deaths related issues. The group will review mortality data and Learning from Deaths reports as part of the Trust wide Learning from Deaths processes. The Group will undertake reviews of unexpected deaths and report findings and recommendations to the Quality and Safety Delivery Group.

2. Constitution

The Learning from Deaths Group is a sub-group of the Quality and Safety Delivery Group and has no executive powers other than those specifically delegated in these Terms of Reference.

3. Membership

The membership will comprise representatives from clinical services and will be chaired by the Medical Director. The Vice Chair will be an Associate Medical Director

Group Members:

- Medical Director - Chair
- Associate Medical Director(s) – Vice Chair
- Head of Nursing and Quality (Adults)
- Non-Executive Director
- Corporate Risk Manager
- Head of Infection Prevention & Control

- Clinical Lead for Quality
- Learning from Deaths Facilitator/Quality Facilitator
- Community Hospitals Locality Clinical Managers (LCM) representative
- Nurse Consultant for Older People (EOL Group representative)
- Community Hospital GP Medical Advisor/Clinical Lead representative
- Nurse Specialist Child Death Reviews

Group members should nominate a deputy to attend on their behalf if they are unable to attend. Other staff members shall be invited to attend for discussions when the Group is discussing areas of risk or operation that are the responsibility of that staff member where they are not already represented.

4. Meetings and Quorum

Quorum: The quorum arrangements for the Learning from Deaths Group require the presence of at least the Medical Director or the Deputy Director of Nursing and Quality and representation from the Operations Directorate. There must be a minimum of representation from at least two other members.

If the Group is not quorate the meeting may be postponed at the discretion of the Chair/Vice Chair. If the meeting does take place and is not quorate, no decision shall be made at that meeting and such matters must be deferred until the next quorate meeting. Additional meetings will be scheduled to ensure any matters deferred or additional matters requiring discussion are dealt with in a timely manner.

Frequency: Meetings shall be held every three months or earlier if there is a requirement to review an unexpected death or an exception report.

Members are expected to attend all meetings. However, as a minimum, members should attend at least two thirds of all meetings per year.

5. Authority

The Learning from Deaths Group has no executive powers other than those specifically delegated in these terms of reference. The Group is authorised by the Quality and Safety Delivery Group to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Group. In addition, the Group is authorised to seek advice from external advisors via the Medical Director.

6. Role and Duties of the Learning from Deaths Group

The duties of the Group are to provide assurance to the Quality and Safety Delivery Group relating to the Implementation of the quality strategy and in addition delivery against key aspects of quality including:

Safety

- The management of clinical risks by carrying out reviews of deaths of patients under our direct care i.e. Community Hospitals and HMPYOI Stoke Heath, with specific focus on unexpected deaths.
- As well as reviewing deaths of patients in our direct care the Group will also review cases referred to them reference deaths of patients under the direct care of another organisation e.g. patient deaths within the community who have received care from staff employed by the Trust i.e. those under the care

of the General Practice (GP). In these cases the Group would liaise with these other organisations in order to carry out a joint review.

- The Group will also be involved in the review of child deaths identified as Serious Incidents and being investigated by the Child Death Overview Panel
- Receiving reports on all deaths within Community Hospitals from the Clinical Service Managers (via the Adult Service Delivery Group Quality and Safety meetings), to monitor and review mortality rates and identify any key issues / risks
- Liaising with the Corporate Risk Manager to ensure any reporting, analysing and learning from incidents related to unexpected deaths is in line with national guidance and best practice.
- Reporting on and providing assurance of mortality related risk and reporting to any other groups or committees as detailed in section 9.
- Reporting to the End of Life (EOL) Working Group any risks associated with EOL care that are identified by the Learning from Deaths Group through the local mortality review process and any subsequent reviews and/or investigations
- Agree and escalate key issues/ risks of concern that cannot be addressed by the Learning from Deaths Group to the Quality and Safety Delivery Group

Effectiveness

- To monitor, review and alert where appropriate.
- Compliance with aspects relating to the Care Quality Commission (CQC) Regulations.
- Measuring the effectiveness of clinical care through a related clinical audits.
- Receiving and reviewing national guidance relating to mortality topics and implications for the Trust.
- Provide regular feedback to the Quality and Safety Delivery Group on activity of the group to ensure appropriate assurance.

7. Monitoring Effectiveness

Through receipt of the minutes (on request) the Quality and Safety Delivery Group will monitor the effectiveness of the Learning from Deaths Group.

A record of the frequency of attendance by members, quoracy and the frequency of meetings will be maintained. Any areas of concern will be highlighted to the Chair of the Learning from Deaths Group.

The Group will monitor the delivery of the 6 monthly report to the Quality and Safety Delivery Group to ensure effective reporting of the Group's activities and any escalation of identified issues and trends.

The Group will also monitor the quarterly Trust Board Learning from Deaths report as part of the National Learning from Deaths Framework requirements.

Key risks will be highlighted to the Quality and Safety Delivery Group and reported to the Quality and Safety Committee and Trust Board.

8. Administrative Arrangements

The Group will receive appropriate administrative support. Duties will include:

- Preparing and circulating the agenda and papers with the Chair.

- Maintaining accurate records of attendance, key discussion points and decisions taken and issue necessary action logs within five full working days of the meeting.
- Drafting minutes for circulation to members within five full working days of the meeting.
- Maintaining a database of any documents discussed and/or approved and recall them to the Group when due.
- Organising future meetings.
- Filing and maintaining records of the work of the Group.

9. Relationships and Reporting

The Chair of the Learning from Deaths Group shall draw to the attention of the Quality and Safety Delivery Group any issues that require executive action.

The Learning from Deaths Group will receive monthly mortality reports from the Community Hospital Locality Clinical Managers. The Adult Service Delivery Group Manager will provide an overview of these reports in the Service Delivery Group report presented to the monthly Adult Service Delivery Group Quality & Safety Group meetings. The Learning from Deaths Group will also liaise with the Community Hospitals Practitioners (Medical Advisors/Clinical Leads) Group over relevant learning from deaths related issues.

The Nurse Specialist Child Death Reviews Group will provide regular update reports in relation to the work of the Child Death Overview Panel.

The Group will report to the Quality and Safety Delivery Group and the Quality and Safety Committee six monthly on its work in support of compliance with Care Quality Commission (CQC) Regulations. The Group will also report quarterly on the Learning from Deaths requirements set out in the National Learning from Deaths framework that should be presented to the public Trust Board meetings.

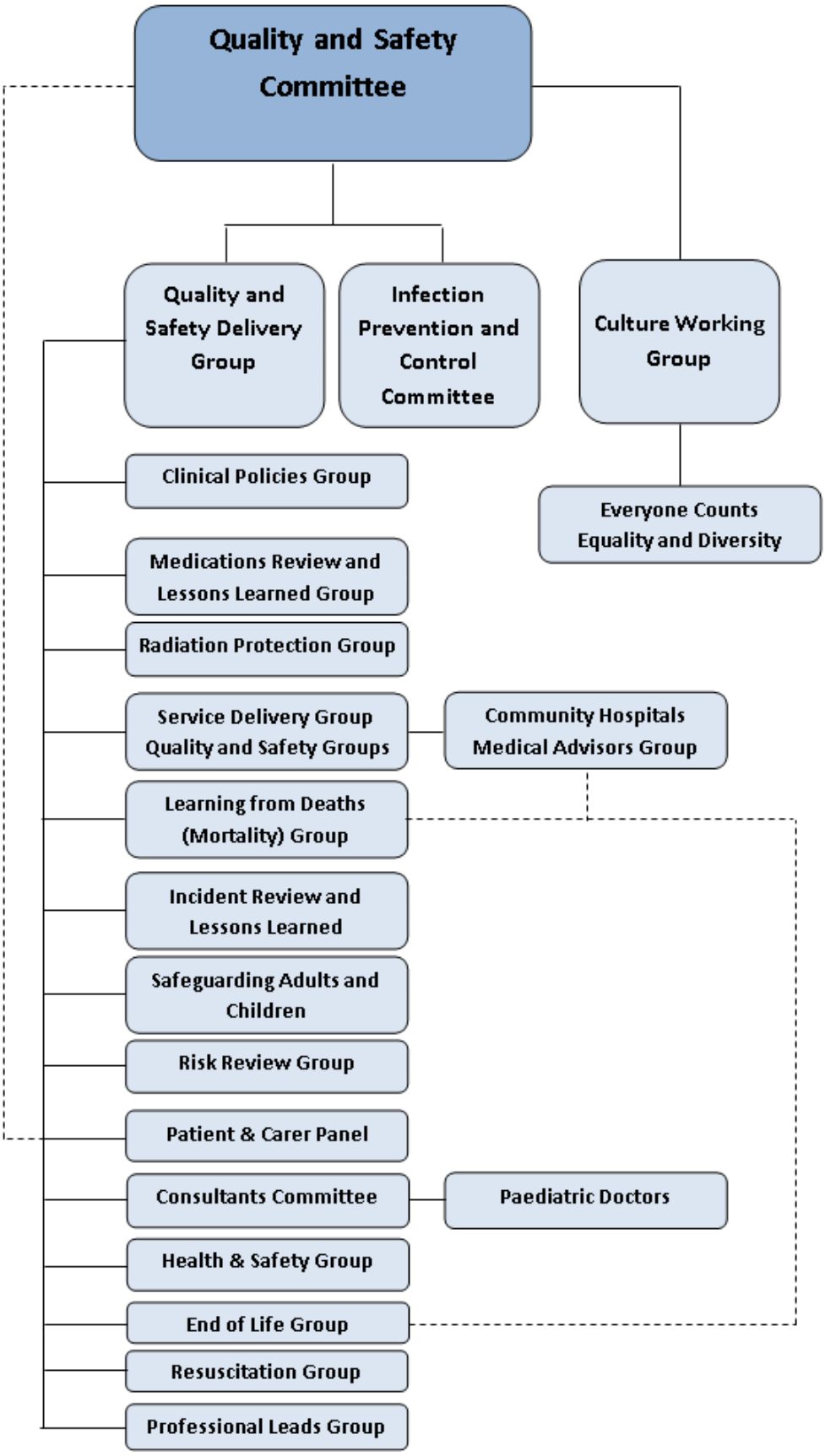
Following recommendations from the CQC review into how NHS Trusts review and investigate deaths of patients (Learning, Candour and Accountability December 2016), a Non-Executive Director has been appointed to the Learning from Deaths Group and will act as an independent member to oversee the learning from deaths process on behalf of the Trust Board to ensure we have effective governance arrangements to drive quality and learning from deaths of patients. This will include ensuring the involvement of families and carers in the relevant learning from deaths reviews and investigations (to the extent that they wish).

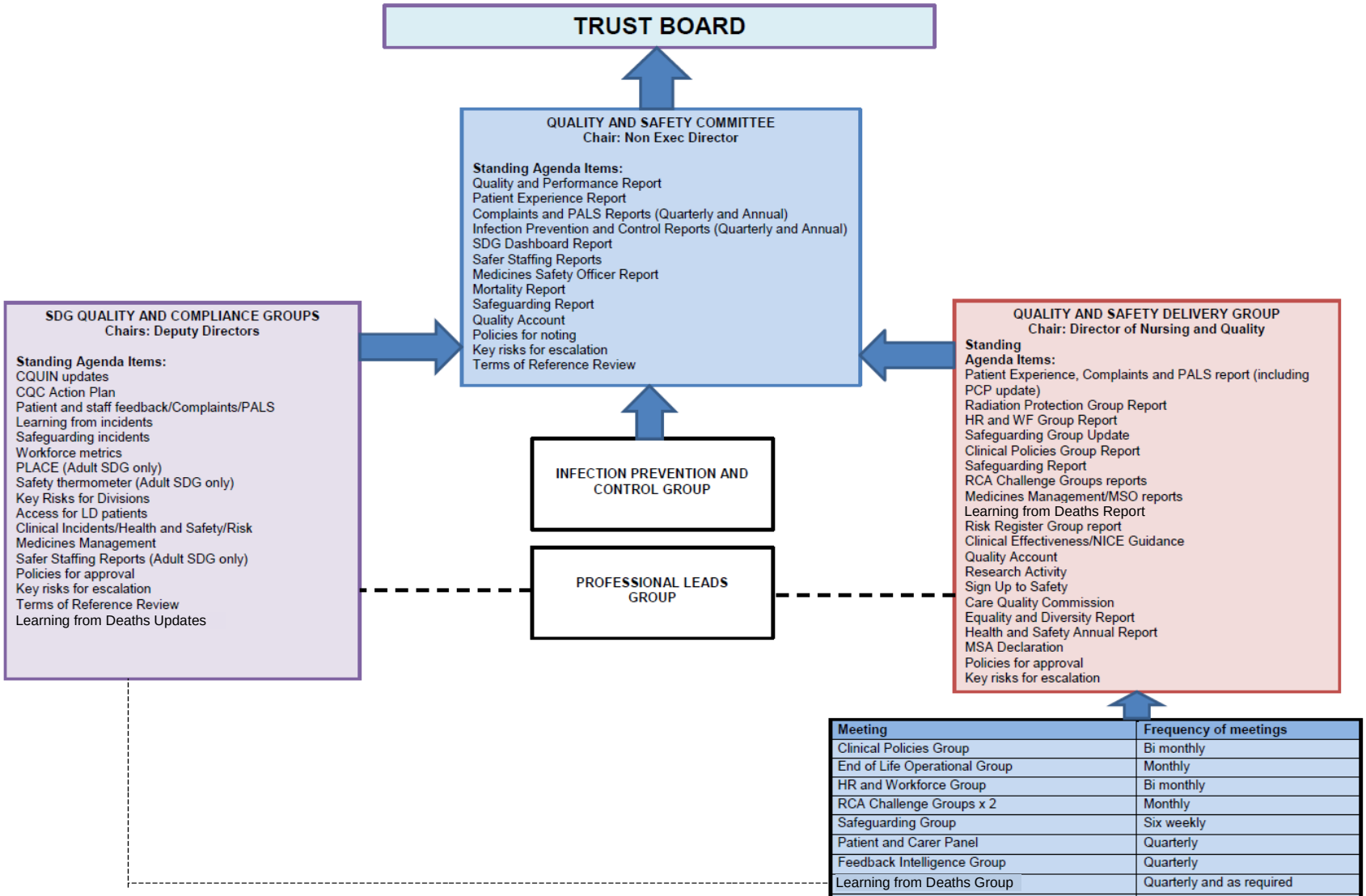
10. Review of Terms of Reference

This document will be reviewed annually or sooner if agreed by the Quality and Safety Delivery Group.

Any amended Terms of Reference will be agreed by the Learning from Deaths Group for recommendation to the Quality and Safety Delivery Group for its approval.

11. Reporting Structures





Meeting	Frequency of meetings
Clinical Policies Group	Bi monthly
End of Life Operational Group	Monthly
HR and Workforce Group	Bi monthly
RCA Challenge Groups x 2	Monthly
Safeguarding Group	Six weekly
Patient and Carer Panel	Quarterly
Feedback Intelligence Group	Quarterly
Learning from Deaths Group	Quarterly and as required
Risk Register Group	Quarterly
Radiation Protection Group	Annual