LEARNING FROM DEATHS - ADULTS POLICY

Summary

Learning from a review of the care provided to patients who die is integral to a provider's clinical governance and quality improvement work. To fulfil the standards and new reporting set out for acute, mental health and community NHS Trusts and Foundation Trusts, Trusts now need to ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trusts should also ensure that they share and act upon any learning derived from these processes.

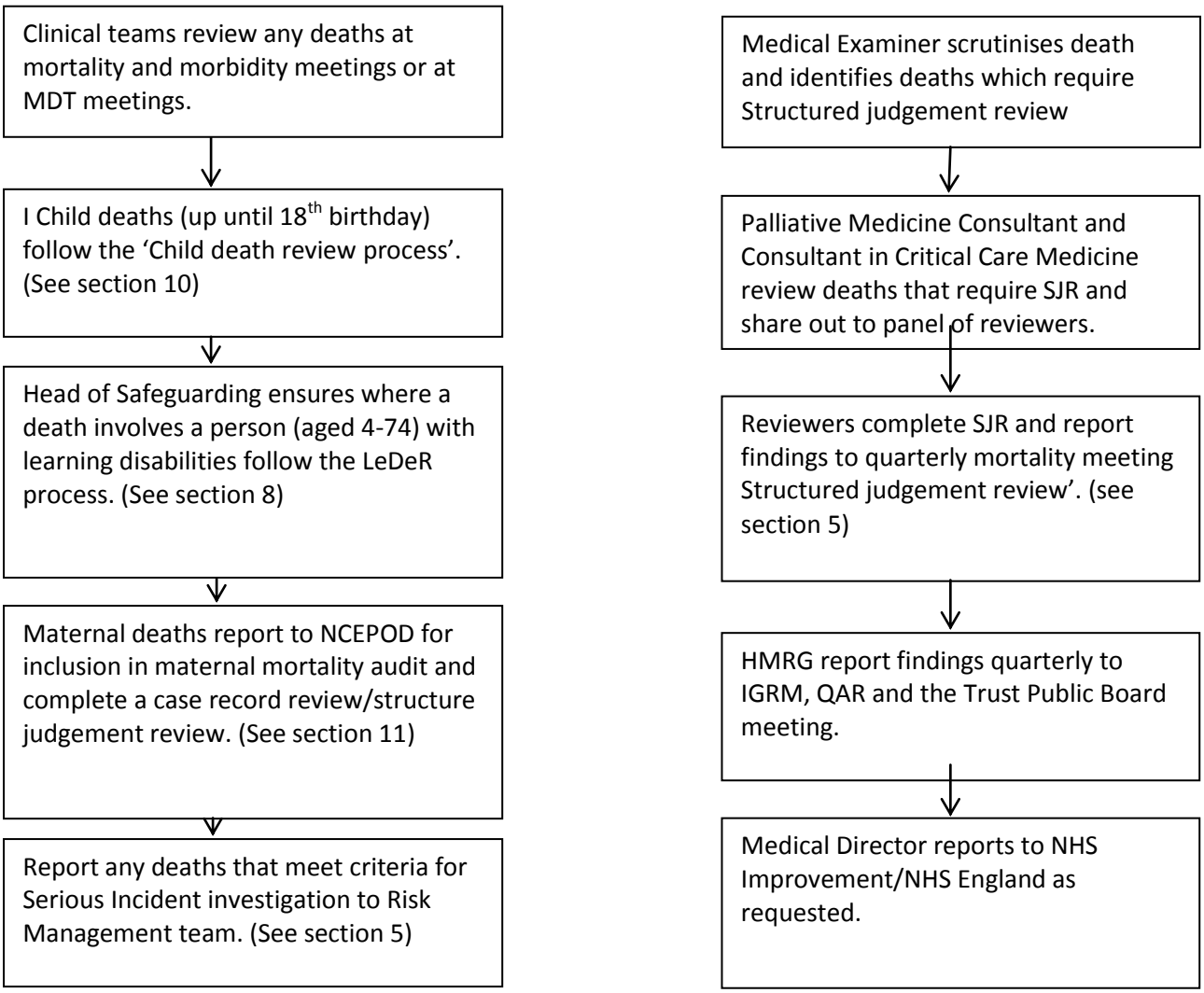
This policy outlines how The Royal Marsden NHS Foundation Trust (the Trust) responds to, and learns from, deaths of inpatients who die under its management and care, including:

i. How inpatient deaths in the Trust are reviewed and reported
ii. Categories and selection of deaths in scope for case record review using the structure judgement review
iii. The Trust's approach to undertaking case records reviews using the structure judgement review
iv. How the Trust's processes respond to the death of an individual with a learning disability or mental health needs, an infant, child, or maternal death
v. Approach to the issue of potentially avoidable mortality and the Trust's mortality governance processes.

Also outlined in this document is a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.

CONTENTS

1. FLOWCHART OF REVIEW OF DEATHS IN THE TRUST



2. INTRODUCTION

2.1 In March 2017, the National Quality Board issued a framework for NHS trusts on identifying, reporting, investigating and learning from deaths in care called "National Guidance on Learning from Deaths"[1]. In accordance with this document, this policy was developed.

Deaths within The Royal Marsden NHS Foundation Trust are an inevitable consequence despite the complex treatment and care delivered to patients with advanced cancer. The quality of care patients experience before those deaths and bereaved relatives experience afterwards must be reviewed in order to learn from any mistakes that may have occurred. This scrutiny is overseen both within Clinical Units but also at Trust wide level with direct report to the Board.

3. DEFINITIONS

3.1 The following definitions apply for the purposes of this policy:

(i) **Case record review** (as defined by the National Quality Board): The application of a case record review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. The template used is the **Structured Judgement Review** recommended by the Royal College of Physicians 2017 (Appendix A).

(ii) **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.

(iii) **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.

iv) **Case note review/Review of deaths**: Each clinical team in the Trust will review a patient's death in a variety of ways. This review is often presented at morbidity and mortality meetings or at multidisciplinary team meetings. In addition the Hospital Mortality Review Group reviews all deaths as detailed in section 3 below.

v) **Reasonably Expected Death**: A death that is reasonably expected is one which given the overall clinical condition, the patient is unexpected to survive. All attempts at treating reversible conditions will have been attempted and the death is due to irreversible progressive disease.

4. HOW INPATIENT DEATHS ARE REVIEWED AND REPORTED BY THE HOSPITAL MORTALITY REVIEW GROUP

4.1 Patient lists of inpatient deaths every quarter are obtained by the Trust's Quality Improvement Auditor and the Clinical Auditor.

4.2 Relevant electronic patient records are then reviewed and data summarised in an Excel spreadsheet.

4.3 Data collected by the Quality Improvement Auditor and Clinical Auditor include hospital site, ward, admissions date, date of death, length of hospital stay prior to death, cancer diagnosis and stage, admission reason, elective/emergency, palliative care referral date, palliative care review date, , evidence of metastatic disease, prognosis, preferred place of death, place of death, cause of death, reason for death at The Royal Marsden, information on whether the death was reasonably expected considering overall patient clinical condition, information on whether the patient was expected to die at The Royal Marsden, whether the patient had a learning disability, whether the patient had any mental health issues, whether the patient was an infant or child, maternal death, number and outcomes structured

case reviews undertaken, any failures of care identified, letters of condolences written, any queries/concerns highlighted from family or carers.

4.4 Medical Examiners when scrutinise record whether a structured judgement review is required.

4.5 Review of all inpatient deaths undertaken by a panel of reviewers led by Consultant in Critical Care Medicine and Consultant in Palliative Medicine.

4.6 Consultant in Critical Care Medicine; Palliative Medicine Consultant, SJR reviewers Head of Adult Safeguarding; Deputy Director of Patient Safety and Clinical Assurance; Quality Improvement Auditor; Clinical Auditor (Hospital Mortality Review Group) and PALs and Bereavement Lead meet quarterly to discuss the cases.

4.7 Data summarised against the following standards for care:

- **Standard 1:** 100% of in-hospital deaths should either be expected given the patient's overall clinical condition, or should have a clear identifiable irreversible reason for death that could not have been prevented by clinical intervention.
- **Standard 2:** 100% of patients who died in hospital with a documented preferred place of death that was not "hospital" should have a clear, identifiable reason outside the control of RM as to why their preferred place of death was not achievable. (Clear, identifiable reasons could include: patient too unwell to move elsewhere, hospice bed not available or family/care home unable to facilitate home death).
- **Standard 3:** A discussion with the Symptom Control and Palliative Care team takes place in 80% of the admissions which resulted in patient death in hospital, where the death was reasonably expected as per Standard 1.
- **Standard 4:** 100% of patients for whom the Structured Judgement Review is undertaken have no failures of care identified.

4.8 Findings are reported quarterly to the Trust's Integrated Governance and Risk Management Committee, Quality, Assurance and Risk committee and the Trust Board.

Finding and conclusions are rated:

- If Standards 1 and 4 are red then overall is red.
- If Standards 1 and 4 are green and at least one of Standards 2 & 3 is green, then green.
- All else, amber.

Report Standards	
Standard 1	100% of in-hospital deaths should either be expected given the patient's overall clinical condition, or should have a clear identifiable irreversible reason for death that could not have been prevented by clinical intervention.
Standard 2	100% of patients who died in hospital with a documented preferred place of death that was not "hospital" should have a clear identifiable reason outside the control of The Royal Marsden as to why their preferred place of death was not achievable.
Standard 3	A discussion with the Symptom Control and Palliative Care team takes place in 80% of the admissions which resulted in patient death in hospital, where the death was reasonably expected as per standard 1.
Standard 4	100% of patients for whom the Structured Judgement Review is undertaken have no failures of care identified.

Ratings	
GREEN	100% for Standards 1, 2 and 4 or >80% for Standard 3
AMBER	80-99% for Standards 1, 2 and 4 or 65-79% for Standard 3
RED	<79% for Standards 1, 2 and 4 and <64% for Standard 3

5. CATEGORIES AND SELECTION OF DEATHS IN SCOPE FOR CASE RECORD REVIEW USING THE STRUCTURED JUDGEMENT REVIEW

5.1 Case note review takes place routinely across the Trust within department mortality and morbidity meetings. All deaths are reviewed in a multidisciplinary forum with discussion on circumstances leading up to the death and review of any learning from the death.

5.2 For case record review within the Hospital Mortality Review Group, the group will specifically focus reviews on inpatient deaths within the following categories:

a. Inpatients with learning disabilities
b. Inpatients with mental health needs (those detained under the Mental health Act, those detained in a prison)
c. Inpatients who are under an urgent or standard authorisation of Deprivation of Liberty Safeguards (DOLs)
d. In maternal deaths
e. In a service specialty, particular diagnosis or treatment group where an alarm has been raised to the provider through whatever means (e.g. Summary of Hospital level Mortality indictors, concerns raised by audit work, mortality and morbidity meetings, CQC or another regulator)
f. Inpatients where patients were not expected to die, i.e.. cardiac arrest or following elective/emergency admission for surgery
g. Inpatients where concerns have been raised by families or carers either during admission or after death

h. Inpatients who have raised concerns regarding their care during admission prior to death.
i. Inpatients who have an E. coli bacteraemia identified during their final admission
j. Inpatients who have a definite/probable hospital acquired COVID-19 infection that leads to or contributes to their death (Hospital-Onset Probable Healthcare-Associated (HO.pHA) - positive specimen date 8-14 days after hospital admission; Hospital-Onset Definite Healthcare-Associated (HO.dHA) - positive specimen date 15 or more days after hospital admission)

5.3 Findings from the case record reviews undertaken within the Hospital Mortality Review Group are reported quarterly to the Trust's Integrated Governance and Risk Management Committee, the Quality, Assurance and Risk committee and the Trust Board. Actions will be taken if any failures of care identified.

6. APPROACH TO UNDERTAKING REVIEW OF DEATHS

6.1 There are three levels of scrutiny that the Trust applies to the care provided to someone who dies; (i) Medical Examiner review of death certification; (ii) case record review; and (iii) investigation. They do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a case record review has been undertaken.

- **Death Certification: Medical Examiners within the trust now review the medical notes after discussion with the attending doctor to agree the cause of death and whether coroner referral is necessary.**
- **Case Record Review using the Structured Judgement Review:** Some deaths should be subject to further review as outlined above, looking at the care provided to the deceased as recorded in their case records in order to identify any learning.
- **Investigation:** The Trust may decide that some deaths warrant an investigation and should be guided by the circumstances for investigation in the Serious Incident Framework. When a death meets Serious Incident criteria there is no need to delay the onset of investigation until case record review has been undertaken. Refer to the Trust policy 'Accident/Incident and Patient Safety Incident Reporting Policy Including Serious Incidents Requiring Investigation'.
- Some deaths will be investigated by other agents, notably the coroner. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay.

6.2 The purpose of the case record review is to provide information from which teams or the organisation can learn. Explicit judgement commentaries serve two main purposes. First, they allow the reviewer to concisely describe how and why they assess the safety and quality of care provided. Second, they provide a commentary that other health professionals can readily understand if they subsequently look at the completed review

6.3 The format of the case note review is based on the Structured Judgement Review method recommended by the Royal College of Physicians (Appendix A).

6.4 It is recognised that case record reviews are a fine balance and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

6.5 To ensure objectivity, case record reviews should wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge. Objectivity of reviews should be a component of clinical governance processes.

6.6 Where case record review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported to the Trust Risk Management Team.

6.7 All patient safety incidents reported as resulting in death or severe harm to a patient that meet the criteria for Serious Incident (SI) reporting will be clinically reviewed by the National Patient Safety Team at NHS Improvement to determine if there are implications for national learning and if a response is appropriate. Any deaths that are identified via case record review as due to problems in healthcare would meet the criteria for SI reporting which includes reporting to the NRLS. More information on the national process is available at https://improvement.nhs.uk/resources/patient-safety-alerts. The Risk Management Team coordinates the internal and external SI reporting processes.

7. FORUMS WERE INPATIENT DEATHS ARE REVIEWED IN THE TRUST

7.1 Forums where inpatient deaths are reviewed within the Trust and may be considered as part of the first stage case notes review.

7.1.1 30 day post Systemic Anti-cancer Therapy

The list of all deaths that occur inside and outside the Trust in the 30 days following systemic anti-cancer therapy is sent every quarter to the Consultant Medical Oncologist (GI) in Sutton and the Consultant Medical Oncologist (Lung/AOS) and the Consultant Medical Oncologist (Breast/AOS) in Chelsea. These deaths are formally reported quarterly to the Trust's Integrated Governance and Risk Management Committee in the quarterly Integrated Governance Monitoring Report and to the Clinical Audit Committee. The mortality data and learning from deaths are shared at the Chemotherapy mortality meetings (solid tumour only) which are chaired by the Consultant Medical Oncologist (GI) and at the Medical Oncology Consultants meetings which take place three times a year and are chaired by the Consultant Medical Oncologist (Lung).

7.1.2 Haematology

All haematology deaths both inside and outside the Trust are reviewed at a quarterly mortality and morbidity meeting, chaired by the Consultant Haemato-oncology. The multidisciplinary team reviews the circumstances leading up to the death and are formally reported quarterly to the Trust's Integrated Governance and

Risk Management Committee in the quarterly Integrated Governance Monitoring Report.

7.1.3 Paediatrics

All paediatric deaths are reviewed through the child death review panels which report through Children's safeguarding.

7.1.4 Critical Care Unit

Deaths in critical care are reviewed quarterly as part of the morbidity and mortality review group, chaired by a CCU Consultant and presented at the Critical Care Unit multidisciplinary team meetings, chaired by the Clinical Lead of Critical Care. Case mix adjusted standardised mortality ratios are reported externally to the Intensive Care National Audit and Research Centre and benchmarked against other critical care units.

7.1.5 Palliative Care

The hospital specialist palliative care team reviews all inpatient deaths weekly at the palliative care multidisciplinary team meetings, chaired by a Palliative Care Consultant/Nurse Consultant on each site. The review of death is recorded and learning shared with the team. All deaths are reviewed as a rolling audit of compliance with the principles of care document.

7.1.6 Surgery

Peri-operative deaths are discussed at the two-monthly joint Surgical and Anaesthetic Audit Meetings.. The minutes of this report are circulated to the Senior Surgeons and Anaesthetics group, chaired by the Chief of Surgery and the Trust's Integrated Governance and Risk Management Committee in the quarterly Integrated Governance Monitoring Report.

7.1.7 Safeguarding Adults

The safeguarding adult's team should be notified of any death where a patient with care and support needs dies as a result of suspected or known abuse or neglect and there is a concern that partner agencies could have worked more effectively to protect the adult. The safeguarding adult's team will then review and consider referral to the relevant Safeguarding Adults Board for consideration of a safeguarding adults review (SAR) under Section 44 of the Care Act 2014.

7.2 Should any of these forums highlight any concerns about care during the first stage review, the case should be referred to the Risk Management Team and the Hospital Mortality Review Group for second stage review using the Structured Judgement Review.

8. GOVERNANCE STRUCTURE

8.1 Mortality governance is a key priority for The Royal Marsden Trust Board. Executives and non-executive directors must have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

8.2 The Executive Director for mortality review is the Medical Director. There is also an appointed Non-Executive director. The Executive Director for End of Life Care is the Chief Nurse. Their roles are to ensure that:

i. Robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care.

ii. The Trust is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support; quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; and the information the provider publishes is a fair and accurate reflection of its achievements and challenges.

iii. Case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur.

iv. Mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the Board in order that the executives remain aware and non-executives can provide appropriate challenge.

v. That learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts.

8.3 The systematic approach outlined in this document enables the issue of potentially avoidable mortality to be identified and facilitates a robust mortality governance processes. This allows the Trust to identify any areas of failure of clinical care and ensure the delivery of safe care. This includes a Hospital Mortality Review Group with multidisciplinary and multi-professional membership which includes a Consultant Anaesthetist; Palliative Care Consultant; Head of Adult Safeguarding; Deputy Director of Patient Safety and Clinical Assurance; Quality Improvement Auditor; Clinical Auditor, and quarterly mortality reporting to the Integrated Governance and Risk Management Committee, the Quality, Assurance and Risk committee and the Trust Board, outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff.

8.4 Information on deaths are reported quarterly to the Trust's Integrated Governance and Risk Management Committee and includes the total number of the Trust's inpatient deaths, those deaths that the Trust has subjected to case notes review and whether the set standards have been met (standards 1-4). A summary will be published in the Trust's Annual Quality Account.

8.5 Failings of standards or failings of care identified during case notes review must be investigated in a timely manner with actions and learning disseminated to staff. Feedback to bereaved families and carers is also an important part of this process.

9. DEATHS OF PATIENTS WITH LEARNING DISABILITIES

9.1 The Learning Disabilities Mortality Review (LeDeR) programme was established in response to the recommendations of the Confidential Inquiry into the premature deaths of People with learning disabilities (CIPOLD) and was commissioned by NHS England and is managed by the Healthcare Quality Improvement Partnership (HQIP).

9.2 Recommendation 7 of the report states: Provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated, when appropriate and that learning from deaths is shared and acted on.

9.3 The LeDeR programme uses White Paper '*Valuing People'* (2001) definition of learning disabilities which is;

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- a reduced ability to cope independently (impaired social functioning)
- which started before adulthood, with lasting effect on development

9.4 As a result, the Trust must report all deaths of people with learning disabilities aged over 4 years old to the LeDeR programme. This includes the deaths of both children and adults with learning disabilities.

9.5 All deaths must first be reviewed to determine whether there are potential safeguarding concerns and whether it meets the criteria for a serious incident and further discussion held at local levels about how this will relate to the LeDeR review process.

9.6 The purpose of the LeDeR review is to;

- Identify any potential avoidable factors that may have contributed to the persons death and
- Develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities

9.7 To report a death of a person with learning disabilities, the Trust safeguarding team should be notified and they will take the lead responsibility to complete the *Notification of Death* to the programme via the programme's secure web portal or via telephone (0300 7774 774). A decision will then be made by the LeDeR programme about whether this meets the criteria and whether a LeDeR review is required.

9.8 Learning from LeDeR reviews will be agreed by local LeDeR steering groups and shared internally within the Trust's mortality audit committee and Trust Safeguarding Adults and Children's Boards and other relevant groups within the Trust. Externally, the learning will be shared with the relevant Safeguarding Adults and Children's Partnership Boards.

10. DEATHS OF PATIENTS WITH MENTAL HEALTH NEEDS

10.1 Physical and mental health are closely linked. People with severe and prolonged mental health problems are at risk of dying on average 15 to 20 years earlier than other people. In addition, people with long term physical health problems suffer more complications if they also develop mental health problems.

10.2 Reporting and reviewing of any death of a patient with mental health problems should consider these factors, i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

10.3 Inpatients detained under Mental Health Act: Regulations 17 require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.

10.4 Under the Coroners and Justice Act 2009, coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

10.5 In circumstances where there is reason to believe the death may have been due, or in part due, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the Serious Incident Framework.

10.6 Points 9.3 to 9.5 are satisfied within existing Royal Marsden Hospital systems. Death of a Royal Marsden inpatient detained under the MHA is an extremely rare occurrence. The Trust Safeguarding lead and Consultant Liaison Psychiatrist must ensure the CQC are informed without delay. The Trust Legal Team must inform the Coroner. An inpatient suicide, or problem in care contributing to the death, would be reported via Datix and investigated as a Serious Incident and a case notes review should be undertaken by the Hospital Mortality Review Committee in conjunction with the Adult Psychological Support Service. The findings should be reported to the Trust's Integrated Governance and Risk Management Committee. Consideration should also be given to commissioning an independent investigation to draw on the expertise of a Mental Health Trust.

11. DEATHS OF INFANTS AND CHILDREN

11.1 The Royal Marsden Hospital is a specialist tertiary cancer service for children and young people aged 1-19 years. The process for review of child deaths and the

learning from the death of children and young people will be outlined within the Trusts separate 'Learning from Deaths - Childrens Policy'.

12. MATERNAL DEATHS

12.1 The Trust occasionally cares for pregnant and breast feeding mothers. A maternal death is defined as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or birth).

12.2 If deaths occur within this patient group, a full case record review using the **Structured Judgement Review** should take place by the treating clinical unit and the report shared with the Hospital Mortality Review Group.

12.3 All maternity incidents investigated by The Healthcare Safety Investigation Board (HSIB) should be reported on the Strategic Executive Information System (StEIS) The HSIB investigate maternity incidents that meet the Each Baby Counts and the MBRRACE criteria for maternal deaths, as per HSIB's defined criteria. Current HSIB investigation criteria align closely with expectations of the Serious Incident Framework. All maternity incidents investigated by HSIB should also be reported on the Strategic Executive Information System (StEIS) - this will ensure CCGs and NHS England and NHS Improvement remain fully informed of ongoing investigations. Organisations should continue to undertake an immediate review (72- hour report) to identify urgent safety concerns.

12.4 These deaths would be reported to NCEPOD for inclusion in the maternal mortality.

12.5 All maternal deaths must be included in the Trust's Integrated Governance and Risk Management Committee Report.

13. STAFF TRAINING AND SUPPORT

13.1 Staff reviewing and reporting deaths must have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard. This may involve attendance of relevant external and internal courses.

13.2 If staff are affected by the death of a patient they should seek support from line managers in the usual way and through Staff Support/ Occupational Health services. Further guidance is also available in the policy for supporting staff involved in potentially traumatic or stressful incidents, complaints, claim or attendance at an inquest or employment tribunal [2039].

13.3 Skills for Health and NHS Health Education England have made available an e-learning resource for staff entitled 'Learning from deaths' this will be available on the trust's Learning Hub for staff to access.

14. BEREAVED RELATIVES AND CARERS

14.1 The Trust should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death. The staff member conveying the news of a death should be able to give as much information as they can about the circumstances of the death and if appropriate and answer any questions raised by the relatives or carers.

14.2 The principles of openness, honesty and transparency as set out in the Duty of Candour should always be applied when dealing with bereaved relatives.

14.3 All wards should give relatives or friends of the deceased the leaflet 'My relative or friend has died in hospital: *What do I need to do?'* (If this leaflet is required please contact PALS/bereavement advisors). This gives practical information about registering a death and arranging an appointment with the bereavement service.

14.4 All relatives or friends of the deceased will be invited to a bereavement meeting. The purpose of these meetings is twofold: to talk through the necessary administrative processes when a person dies including reviewing the death certificate; and providing support which includes signposting to appropriate bereavement support services and listening to their experience. The PALS/bereavement advisors will also enquire if there are any concerns the relatives/friends wish to discuss about the care or medical management of the diseased, as part of the meeting. Any issues that can't be resolved informally at the meeting will be referred to the lead clinician/case review process as detailed below

14.5 If concerns are raised within the meeting, this should lead to an automatic case record review using the structured judgement review undertaken within the Hospital Mortality Review Group.

14.6 If a risk management investigation takes place as per Trust policy following the death of a patient in the Trust, bereaved relatives and carers should receive timely, responsive contact and support in all aspects of the investigation.

14.7 Bereaved relatives should have a single point of contact and liaison with the Trust which is the nominated person within the PALS/ Bereavement team or the risk management team.

14.8 Bereaved relatives should have an opportunity to respond to the investigation and report findings and be made aware of the processes that have changed following the investigation.

15. LINKED DOCUMENTS

This policy should be read alongside the following policies.

Care of Dying and Deceased Patients in Hospital Policy: 115
Concerns and Complaints Policy and Procedure: 160
Being Open and Duty of Candour Policy: 1760
Accident/Incident and Patient Safety Incident Reporting Policy Including Serious Incidents Requiring Investigation: 0482
Children/Young People's Palliative Care Operational Policy: 0457
Child Protection and Safeguarding Children Policy: 0140
Safeguarding Adults Policy and Procedures: 1623
Policy for supporting staff involved in potentially traumatic or stressful incidents, complaints, claim or attendance at an inquest or employment tribunal: 2039

16. REFERENCES

1. National Guidance on learning from Deaths - A framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care: National Quality Board March 2017

2. Learning disabilities mortality review (LeDeR) programme - www.bristol.ac.uk/sps/leder

3. Duty of Candour: CQC: Regulation 20: duty of candour March 2015

4. Using Structured Judgement Review method: A guide for reviewers. Royal College of Physicians; National Mortality Case Review Programme; March 2017

5. Using Structured Judgement Review method: data collection form. Royal College of Physicians; National Mortality Case Review Programme; May 2017

6. Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. BMJ 2015; 351:h3239. DOI: 10.1136/bmj.h3239

7. Care Act 2014 c. 23 Part 1, Safeguarding adults at risk of abuse or neglect, Section 44. http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

8. Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Russ L. (2013) *The Confidential Inquiry into premature deaths of people with learning disabilities. Final Report*. University of Bristol. Bristol http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf

9. Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/250877/5086.pdf

10. University of Bristol and NHS England; Guidance for the conduct of reviews of the deaths of people with learning disabilities (2017) http://www.bristol.ac.uk/medialibrary/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf

11. Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers. National Quality Board. July 2018, first edition.

12. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children 2018 Department for Education

Appendix A: Template for Structured Judgement Review

1. Baseline information- Patient Hospital Number

Name of Reviewer:
Date of Review:

Age at death (years):
Gender: M/F
First 3/4 digits of the patient's postcode:
Day of admission/attendance:
Day of death:
Number of days between arrival and death:
Specialty team at time of death:
Specific location of death:
Type of admission:
Cause of death:

2. Phase of care: Admission and initial management (first 24 hours)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase. 1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care Please circle only one score.

2. Phase of care: Ongoing care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

3. Phase of care: Care during Procedure or Peri-operative care

Please rate the care received by the patient during this phase.
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care
Please circle only one score.

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care
Please circle only one score.

4. Phase of care: End of life care

Please rate the care received by the patient during this phase. 1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care Please circle only one score.

5. Phase of care: Overall care

Please rate the care received by the patient during this phase.
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care
Please circle only one score.

6. Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

6.1 Were there any problems with the care of the patient? (Please circle)

No Yes

6.2 If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please circle all that relate to the case.

Problem types:

a. Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)

No Yes

Did the problem lead to harm? No / Probably / Yes

b. Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic)

No Yes

Did the problem lead to harm? No / Probably / Yes

c. Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)

No Yes

Did the problem lead to harm? No / Probably/ Yes

d. Problem with infection management

No Yes

Did the problem lead to harm? No / Probably / Yes

e. Problem related to operation / invasive procedure (other than infection control)

No Yes

Did the problem lead to harm? No / Probably / Yes

f. Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)

No Yes

Did the problem lead to harm? No / Probably / Yes

g. Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))

No Yes

Did the problem lead to harm? No / Probably / Yes

h. Problem of any other type not fitting the categories above

No Yes

Did the problem lead to harm? No / Probably / Yes

7. Your view on avoidability of death. Please choose one of the following (circle):

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

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular that you have identified.

[End of Document - Do Not Delete]