University Hospitals of Leicester NHS
NHS Trust

UHL Policy for
Learning from the Deaths
of Patients who have been in our Care

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Trust Lead:	**Head of Learning from Deaths**
Board Director Lead:	**Medical Director**
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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

2022/23 LfD Policy B31/2017 and Mortality and Morbidity Review Policy B48/2017 amalgamated and reference to Morbidity Review removed.

New UHL Specialty Mortality and Morbidity Review Guidelines (Bxx/2024) written to cover both mortality and morbidity review processes.

KEY WORDS

Medical Examiner, Death Certification, MCCD, M&M, Mortality Screening, Structured Judgement Review, SJR, Death Classification, Learning from Deaths, Bereavement Support,

1 INTRODUCTION AND OVERVIEW

1.1 UHL has had a standardised Mortality and Morbidity process since 2011 which has been reviewed and revised several times in response both national and local requirements.

1.2 In December 2016, the Care Quality Commission published its report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*[1]. The report identified that there were inconsistencies in the way Acute Trusts carried out mortality reviews and there was a need to improve learning from deaths reviewed.

1.3 The National Guidance on Learning from Deaths (Mar 17)[2] subsequently provided a framework for NHS Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. *Evidence shows that deaths caused by problems in care will occur in every single NHS trust and every hospital worldwide. The key is to learn from them as part of well-functioning governance processes*.[3]

1.4 This document provides details on how University Hospitals of Leicester NHS Trust (UHL) will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

1.5 UHL's framework for 'Learning from Deaths' involves:

- Bereavement Services Office
- Medical Examiner Process – both within UHL and across the LLR Healthcare System
- Bereavement Support Service
- Specialty Mortality Reviews using the national Structured Judgement Review tool
- UHL Child Death Reviews and Perinatal Mortality Review Group reviews using the national Review Tools
- Clinical Team reviews and reflections
- Patient Safety Incident Reviews, Investigations and Complaints
- Inquest findings and Prevention of Future Death letters
- Findings from External Reviews/Investigations of UHL deaths: for example Health & Safety Investigation Branch (HSIB); Child Death Overview Panels (CDOP); Mothers & Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK); HQIP Consultant Outcomes Programme

1.6 This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in our care and should be read in conjunction with the following supporting policies:

a) Last Offices and Care of the Deceased Patient Policy (B28/2010)
b) Medical Examiners' Process Policy (B49/2017)
c) Specialty M&M Guidelines (xx/xxxx)
d) Bereavement Support Service Guidelines (B4/2016)
e) Child Bereavement Support Services Guideline (C57/2021)
e) Incident and Accident Reporting Policy (A10/2002)

1.7 This policy is also supported by the:

a) UHL Child Death Paperwork and CDOP Process (0-18 years) (D3/2021)
b) Safeguarding Children Policies and Procedures (B1/2012)
c) Stillbirth and Late Fetal Loss – Bereavement Care (C275/2016)
d) Certification of Stillbirth and Neonatal Deaths on Labour Ward (C33/2010)
e) Maternal Death: Guidelines for the management of Maternal Death (C2/2007)

2 POLICY SCOPE

2.1 This policy applies to:
a) All deaths as inpatients and within the Emergency Department.
b) All adult, paediatric and perinatal deaths
c) Relatives and Carers who have been bereaved by a death in UHL

2.2 The principles of this policy and supporting guidelines also apply to deaths following discharge from UHL where potential learning or issues in care identified.

2.3 This policy applies to:
a) All staff involved in the care of patients

and specifically

b) Bereavement Services Officers
c) Medical Examiners and Medical Examiner Officers
d) Corporate Learning from Deaths Team
e) Doctors who have cared for deceased patients and who are eligible to complete the Medical Certificate of the Cause of Death (MCCD)
f) Specialty Mortality & Morbidity Leads
g) Mortality reviewers
h) Bereavement Support Nurses
i) Patient Safety Team

3 DEFINITIONS AND ABBREVIATIONS

3.1 **Medical Examiner** (ME) - The role of the UHL ME is to advise certifying doctors about the cause of death and undertake proportiate scrutiny (to include screening of the deceased's health care records and speaking to the bereaved relative/carer)

3.2 **Death certification** (MCCD) - The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

3.3 **Proportionate Scrutiny** - refers to the reading through of deceased patients' clinical records (electronic and paper) with a view to identifying if there are potential problems in care or lessons to learn. Scutiny by MEs will also include speaking to a bereaved relative/carer, usually the 'next of kin'.

3.4 **Case Record Review** – review of a case record carried out by clinicians to determine whether there were any prolems in the care provided to a patient.

3.5 **Structured Judgement Review** (SJR). A detailed review of the medical record, normally undertaken by a senior doctor not directly involved in the care of the patient but in the same medical specialty as that responsible for the deceased's final care. It is 'structured' because it follows an approach defined by the Royal College of Physicians.

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

3.7 **Clinical Review -** for the purpose of this policy this refers to where a clinician is requested to review a specific aspect of care and to reflect on whether there is any learning or actions required.

3.8 **Death Classification** –Whether or not a death is considered to be more likely than not due to problems in care

3.9 **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. (Note, this is not a legal term and is not the same as 'cause of death').

3.10 **Patient Safety Incident** (PSI) – Any unintended incident which could have led or did lead to harm for one or more patients receiving NHS care.

3.11 **Serious Incidents** (SI) - Adverse events in healthcare, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified.

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3.12 **Investigation** – Systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided.

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

3.14 **Bereaved Relatives and Carers** (Bereaved) – Someone who has a relative or close friend who has recently died.

3.15 **Severe Mental Illness (SMI) -** there is currently no single nationally agreed definition of which conditions/criteria would constitute SMI. For the purpose of this policy SMI will include psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

3.17 **'Fast Tracking cases for review'** for the purpose of this policy 'fast tracking cases for review' is where a Structured Judgement Review is urgently undertaken by the relevant Specialty M&M because the outcome of the review and death classification is needed to support a Coroner's Inquest or meeting with the Bereaved Relatives/Carers.

4 ROLES AND RESPONSIBILITIES

4.1 Board Level Lead - Medical Director

a) Overall responsibility for the Learning from Deaths Framework within UHL and for the Trust's adult, child and perinatal mortality review processes to include reporting to the Trust Board and publication of the Trust's 'death due to a problem in care' data
b) Ensuring reviews are delivered to a high quality, with sufficient numbers of trained staff to lead the mortality review process.

The Deputy Medical Director will have delegated responsibility for the above.

4.2 Non Executive Director - Chair of Quality Committee

Responsible for having oversight of the Trust's Learning from Deaths policy to include:

a) Understanding the review process
b) Ensuring robust processes are in place for the review and learning from deaths and for the taking forwards quality improvement actions to improve patient care
c) Seeking assurance that the UHL's published mortality information accurately reflects the organisation's approach, achievements and challenges

4.3 Mortality Review Committee (MRC)

Oversee all work-streams and governance processes related to mortality and the Learning from Deaths framework within UHL

4.4 Head of Learning from Deaths

a) The HoLfD is the Operational Lead for the Learning from Deaths framework within UHL and is responsible for development, review, implementation and monitoring of this policy and associated policies:
   - Last Offices Care of the Deceased (Last Offices) Policy
   - Medical Examiner Process Policy (ME Policy)
   - Mortality & Morbidity Review Process Policy (M&M Review Policy)
   - Bereavement Support Service Guidelines (BSS Guidelines)

b) Quality assurance of the mortality review processes within UHL – to include peer review of SJRs and internal and external reporting of SJR findings and death classification data
c) Overseeing the co-ordination of theming of Learning from Deaths outcome data for Quarterly and Annual Reporting both internally and externally

4.5 Senior/ Bereavement Services Officers are responsible for:

Being aware of the requirements of this policy and supporting implementation of the Medical Examiner Process
Implementation of the Last Offices Policy

4.6 Head of Patient Safety

Lead Officer for the Incident and Accident Reporting Policy (Incident Policy)

4.7 Patient Safety Team are responsible for

Being aware of the requirements of this policy and implementing the Incident Policy

4.8 Senior/Medical Examiners and Medical Examiner Officers are responsible for:

Being aware of the requirements of this policy
Implementation of the ME Process Policy Standards

4.9 Learning from Deaths (LfD) Administrative Team is responsible for:

Supporting implementation of this policy and the standards in the ME Policy and Specialty M&M Guidelines and the LfD Team Standard Operating Procedures

4.10 Lead/Bereavement Support Nurses are responsible for:

a) Being aware of the requirements of this policy and implementation/review of the
- Bereavement Support Service Guidelines (BSS Guidelines)
- Child Bereavement Support Services Guideline (Child Breavement)

b) Support Specialty M&M Leads / Clinical Teams with feeding back the outcome of Reviews and M&M discussions to bereaved relatives, where this has been requested

4.11 Learning Disability Acute Liaison Lead Nurse Practitioner is responsible for:

Ensuring that the deaths of patients with Learning Disability are registered with the Learning Disability Mortality Review Programme (LeDeR)
Being a point of contact for advice and support in respect of reviewing the deaths of patients with a Learning Disability

4.12 CMG Management Teams are responsible for:

a. ensuring that appropriate multi-disciplinary M&M Meetings take place in their CMG and that there are approved Terms of Reference for each Specialty M&M
b. ensuring that there is appropriate administrative support identified for the M&M processes within their CMG
c. ensuring M&M Leads are aware of any quality issues/data reported at the CMG Quality and Safety Board (QSB) relating to mortality or morbidity
d. confirming reporting processes between M&M Meetings to the CMG QSB and for escalating issues and areas of concern to the Mortality Review Committee (MRC) as appropriate
e. monitoring and surveillance of M&M Meeting outcomes/themes at a CMG level.
f. having oversight of externally reported mortality and other clinical outcomes, relevant to their CMG

4.13 Specialty Clinical Leads/Heads of Service: are responsible for

a. identifying an M&M Lead and reviewing their role as part of the annual job planning process (0.5 – 1.0 PA per week)
b. contributing to the facilitation of appropriate multi-disciplinary M&M Meetings for Specialty/service staff
c. being aware of M&M outcomes/themes at a specialty level and supporting M&M leads with effective dissemination of learning points and implementation of relevant actions.
d. Supporting the M&M lead with ensuring processes are in place for the timely and accurate collection, validation and submission of relevant externally reported mortality data and other clinical outcomes,

e. ensuring appropriate review, response and actions are taken in respect of relevant published mortality and other clinical outcomes, to include responses to mortality alerts, where applicable

4.14 Specialty M&M Leads are responsible for

Being aware of the requirements of this policy and the Specialty M&M Review Guidelines and specifically

a) Oversee the mortality and morbidity review process within their Specialty in order to meet the standards in Section 5.
b) Co-ordinate the Specialty M&M meeting schedule and agenda in order that Mortality SJRs are completed and Death Classification confirmed within 4 months of the death (or 6 months if there have been delays in receipt of relevant information)
c) Be a point of contact for the Corporate M&M team where delays are identified
d) Review proposed Death Classifications and Morbidity Classifications and confirm whether the case needs full discussion at the Specialty M&M
e) Ensure relevant Consultants and Ward Sisters/Matrons are aware of cases to be discussed where problems in care have been identified
f) Ensure cases thought to be more likely than not due to problems in care are reported as a Patient Safety Incident with Major Harm on Datix and that all other Patient Safety Reporting requirements are met as part of either Mortality or Morbidity Reviews.
g) Escalate cases thought to be more likely than not due to problems in care to MRC via the Corporate M&M team
h) Have oversight of Specialty process for responding to ME feedback, where SJR considered to have been inappropriately requested
i) Oversee dissemination of learning from deaths or from morbidity reviews –both within their Specialty and other areas where relevant
j) Ensure identified actions are Specific, Measurable, Achievable, Realistic and Timely (SMART) and escalate to relevant Head of Service, or other managerial leads as appropriate
k) Ensure learning and actions are appropriately documented and completed reviews are securely archived on the UHL M&M Drive.
l) Track actions against agreed timescales and escalate to Head of Service if not completed
m) Ensure their M&M process is in line with the Specialty M&M Process Guidelines and Terms of Reference (Appendices 5 and 6)
n) Being a point of contact for the Corporate M&M team in respect of any Mortality alerts and associated reviews

4.15 Child Death Review (CDR) and Perinatal Mortality Review (PMR) Leads are responsible for

Being aware of the requirements of this policy and the Specialty M&M Guideline and in collaboration with the relevant Specialty M&M Leads for

a) Supporting implementation/review of the guidelines:
    - Child Death and CDOP Process (CDR Lead)
    - Certification of Stillbirth and Neonatal Deaths on Labour Ward (PMR Lead)
    - Stillbirth and Late Fetal Loss - Bereavement Care UHL Obstetric Guideline (PMR Lead)
b) Overseeing the external reporting of child, perinatal and maternal deaths as per national requirements

4.16 Administrative Staff who support Speciality M&M Processes are responsible for

Being aware of the requirements of this policy and supporting implementation of the M&M Review Process Policy within their Specialty

4.17 Consultants, Ward Sisters and Matrons are responsible for:

a) Being aware of the requirements of this policy
b) Referring deaths for review by the Specialty M&M where potential problems in care identified or there could be lessons to learn
c) Reporting of relevant potential patient safety incidents where these are identified through mortality screening or completion of SJR in line with the Incident Reporting Policy
d) Supporting implementation of relevant standards in this policy and in the policies listed in Section 1.6
e) Reflecting on the care provided to patients who die in our hospitals and learning from this to inform future practice
f) Supporting the implementation of actions identified from reviews or investigations
g) Consultants/Clinicians undertaking Structured Judgement Reviews must not have had either overall responsibility or substantial direct involvement in the deceased patient's care during their last admission
h) Carrying out clinical reviews and taking forward identified learning and actions
i) Participating in the Specialty M&M process as per the Specialty M&M Guidelines and Terms of Reference

4.18 All Staff directly or indirectly involved in patient care are responsible for

a) Participating in the process for Learning from deaths
b) Being aware of learning from deaths identified as relevant to their specialty
c) Supporting the implementation of actions in response to learning from deaths within their specialty
d) Reporting patient safety incidents in line with the Incident Reporting Policy

5. POLICY STANDARDS

The process for Learning from Deaths within UHL is summarised in Appendices 1 & 2

5.1 Recording Deaths in Care

All deaths within UHL will be recorded on the Trust's Patient Administration System (InPatients/Theatres) and NerveCentre (Emergency Department deaths). This data is then uploaded into the Trust's Hospital Information Services System (HISS).

5.2 Death Certification, Post Mortem and Coroner Referral

All deaths (excluding stillbirths or deaths referred to the Coroner by the Police) will be discussed with the Medical Examiner to confirm if cause of death known, post mortem indicated or whether referral to the Coroner is required, in line with the ME Policy and Consent to Hospital Post Mortem Examination Policy.

5.3 Propotionate Scrutiny

All Deaths of patients under our care, either as an inpatient or in the Emergency Dept will be subject to 'proportionate scrutiny' as per the ME Policy.

5.4 Supporting and involving families and carers

a) Bereaved Relatives/Carers of all UHL deaths should be informed and supported in line with the 'Last Offices' Policy and Bereavement Guidelines

b) All Bereaved Relatives/Carers will be given an opportunity to raise concerns about the care provided to the deceased as per UHL's Bereavement Guidelines and Medical Examiner Policy

c) Practical and emotional bereavement support will be offered to the bereaved relative/carer by the Bereavement Services and Bereavement Support Nurses (see Last Offices Policy and Bereavement Support Guidelines – Adult & Child Deaths) or the Bereavement Midwife (Maternal and Perinatal deaths).

5.5 Supporting and involving staff

Support will be available for staff; affected by the death of someone who has been in the trust's care, from;

- Clinical and Operational Managers and senior colleagues
- Medical Examiners
- Bereavement Services Office Staff
- Bereavement Support Nurses
- Head of Learning from Deaths
- Corporate Teams – (Claims and Inquests, Patient Safety and Complaints) see Policy for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims (B28/2007)
- AMICA Staff Counselling and Psychological support services (contact telephone no. 0116 254 4388)

5.6 Selecting deaths for case record review (Structured Judgement Review)

a) A Structured Judgement Review and Death Classification (SJR & DC) must be undertaken,by the relevant Specialty, of all:
   - Infant and Child Deaths
   - Maternal Deaths
   - Deaths where the patient had a Learning Disability
   - Deaths where the patient had a Severe Mental Illness if indicated by the UHL Mental Health Lead
   - Deaths following an Elective Procedure

b) If Proportionate Scrutiny by the Medical Examiner (to include feedback from the Bereaved, or Members of the Clinical Team or Clinical Records Screening) identifies potential areas for learning or problems in care in line with the Medical Examiner Process Policy criteria; a Structured Judgement Review (SJR) will be undertaken as per the Specialty Mortality & Morbidity Process Guidelines

c) Members of the clinical team or the Specialty M&M Lead may also select cases for SJR, either due to concerns raised directly to the team or for potential learning

d) In addition to SRJs being undertaken where referred by the Medical Examiner or due to meeting the national criteria (as set out in 5.6a above) SJRs will be undertaken of a random sample of deaths or all deaths in line with agreed Specialty M&M Terms of Reference.

5.7 Learning Disability

a) The Trust's Special Register will be checked as part of the Mortality Screening process to identify deaths of patients with Learning Disability

b) All deaths of people with learning disabilities aged four years and older will be registered with the national Learning Disabilities Review Programme (LeDeR)

5.8 Severe Mental Illness

a) Where a patient is identified (either by the Medical Examiner screening process or the clinical team) as having a SMI (as defined in 3.15) which is requiring active treatment by a Mental Health Trust (which will usually by the Leicestershire Partnership Trust), the case will be reviewed by the UHL Mental Health Lead to determine whether a full structured judgement review is required

5.9 Undertaking Mortality Reviews and Responding to Mortality Alerts

a) UHL's crude and risk adjusted mortality rates will be monitored by MRC
b) Mortality Cluster Reviews will be undertaken of diagnosis/patient groups with a higher than expected risk adjusted mortality or a 'mortality alert' is received.
c) Mortality reviews may also be undertaken as part of a quality improvement inititive
d) Review findings, learning and actions will be reported to the relevant clinical team, Specialty M&M, CMG and MRC as applicable
e) Responses to mortality alerts will be overseen by MRC

5.10 Mortality Review Formats

a) Structured Judgement Reviews (SJRs) for adult patients will use the UHL SJR template based on the national Royal College of Physicians' National Mortality Case Record Review tool

b) SJRs for patients with a Learning Disability or Serious Mental Illness will include the LD/SMI sections

c) Child Death Reviews (CDRs) will be undertaken using the Child Death Review Template (CDRT)– in collaboration with other organisations as applicable

d) Perinatal Mortality Reviews (PMRs) will be undertaken using the national Perinatal Mortalitiy Review Tool (PMRT)

e) SJRs/CDRs/PMRs and Death Classifications will be completed within 4 months of the death (6 months where post-mortem result or coroner inquest outcome awaited)

f) SJRs will be completed within 2 months where the outcome of the review and death classification is needed to support a Coroner's Inquest or meeting with the Bereaved Relatives/Carers.

5.11 Clinical Reviews

a. Where problems in end of life care or patient experience are identified, either by mortality screening or bereaved relatives/carers feedback, this will be shared with relevant teams for clinical review, learning and action as per ME Policy.

b. Clinical Reviews should be completed within 2 months, particularly where the outcome of the review and death classification is needed to support a response for/meeting with the Bereaved Relatives/Carers.

5.12 Compliments

a) Compliments received from the bereaved will be shared with the relevant clinical teams as per the ME Policy

5.13 Recording and Disseminating Mortality Review Outcomes

a) Outcomes of reviews, to include details of any identified learning and actions should be recorded on the Review Template or captured in the Specialty M&M Minutes

b) All actions must have a clearly identifed Lead and agreed Completion Timescales

c) Dissemination of learning from SJRs/CDRs/PMRs and Mortality Screening will be via Specialty and Joint Speciality M&M meetings and also via the Trust-wide M&M Leads Forum

d) Outcomes, Learning and Actions, may be used to inform patient safety incident investigations and Coroner Inquests.

5.14 Learning from Deaths and other Organisations

a) Where other organisations requires a review of an adult UHL in-patient, ED or post discharge death, these will be screened by members of the Mortality Review Committee and referred for SJR by the relevant Specialty M&M as applicable.

b) Where potential learning is identified for non UHL organisations this will sent to their Learning from Deaths Lead or equivalent

c) Where a LLR cross-organisational review of a UHL in-patient, ED or post discharge death is indicated, the Corporate LfD Team will liaise with the 'Mortality / LfD Leads' for other relevant organisations

5.15 Trustwide Learning from Deaths

a) Learning themes identified through Proportionate Scrutiny and Specialty M&M Reviews/Discussions will be reviewed by the Mortality Review Committee to identify cross-specialty or trust-wide learning or themes.

b) Cross cutting themes will be shared with relevant Trust committees (eg; Thrombosis Committee; Deteriorating Patient Board)

c) Findings from mortality screening and SJRs will be used to inform the Trust's annual Quality Improvement programme

5.16 Sharing Mortality Review findings with Bereaved Relatives/Carers

a) Where bereaved relatives/carers request feedback following a review, this information will be shared with them via the Bereavement Support Nurse/Midwife with input from the Clinical Team as required

5.17 Selecting deaths for investigation

Where mortality screening or SJR/CDR/PMR identifies a problem in care that meets the definition of a patient safety incident this must be reported on Datix as per the **UHL Incident and Accident Reporting Policy** and Duty of Candour requirements met as per the Being Open (Duty of Candour) Policy.

5.18 Quality Improvement

a) Where a need for learning or action is identified via feedback from bereaved relatives/carers, ME proportionate scrutiny; Clinical Review; Feedback; or the SJR/CDR/PMR process, this must be taken forward by the relevant clinical team / Specialty M&M

b) Monitoring of actions resulting from SJR/CDR/PMR and M&M discussions will be via the Specialty M&M Action Tracker with oversight by the Corporate LfD Team

c) Monitoring of actions resulting from an SI investigation will be via the SI Tracker with oversight by the Adverse Events Committee (AEC).

d) Progress with implementation of actions resulting from deaths were considered to be more likely than not due to problems in care will be reported on a Quarterly basis to MRC (unless being tracked by AEC)

e) Where Actions are behind schedule relating to “deaths more likely than not due to problems in care” these should be risk assessed and reported on the Risk Register as applicable

5.19 Presenting UHL’s mortality data

a) The outcomes of all ME scrutiny, bereaved relatives/carers’ feedback, clinical reviews, SJRs/CDRs/PMRs, M&M discussions and Mortality Cluster Reviews will be recorded on the UHL Learning from Deaths Database

b) UHL’s Learning from Deaths data will be published via the Quarterly MRC report to the Trust Board and will include adult, child and infant, in-patient and ED deaths

c) Data will be published in the quarter after that in which the death occurred and will include -
   - number of deaths subject to case record review (desktop review of case notes using a structured method)
   - number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
   - number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
   - themes and issues identified from review and investigation (including examples of good practice)
   - actions taken in response, actions planned and an assessment of the impact of actions taken.
   - How many reviews or investigations are ongoing

d) UHL’s mortality and LfD data and details of learning and actions taken will be published in the Trust’s annual Quality Accounts

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 Details of additional training or education requirements and provision of such are set out in the associated policies and guidelines

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead Officer / Clinical Lead	Tool	Frequency	Reporting arrangements
Completion of Learning from Deaths Dashboard	Head of LfD /Deputy Medical Director	LFD Database	Quarter	Mortality Review Committee
Evidence of Learning and Actions	Head of LfD /Deputy Medical Director	Quality Account	Annually	Mortality Review Committee
M&M Terms of Reference and Meeting Frequency/Attenance	Head of LfD /Deputy Medical Director	M&M ToR & Minutes Audit	Annually	Mortality Review Committee

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

[1] **Learning, candour and accountability**; A review of the way NHS trusts review and investigate the deaths of patients in England, Care Quality Commission, December 2016

[2] **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

[3] **Implementing the Learning from Deaths framework**: key requirements for trust boards, NHS Improvement, July 2017

Template Learning from Deaths policy ; NHS Improvement Sept 2017

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This Policy will be uploaded into the Policies and Guidelines Library on INsite and will be available on the Trust's website.

The Policy will be reviewed in August 2027 by the Head of Learning from Deaths with support from Mortality Review Committee members.

LEARNING FROM THE DEATHS OF CHILDREN IN OUR CARE (0-18 YEARS) FLOW CHART APPENDIX 1

STILL BIRTHS, EARLY AND LATE NEONATAL DEATHS	CHILD / INFANT DEATHS IN THE EMERGENCY DEPARTMENT	DEATHS ON: GENERAL PAED ITU MEDICAL WARDS SURGICAL WARDS	DEATHS ON: CARDIAC PAED ITU; CARDIAC WARDS	CHILD DEATHS ON: ADULT WARD

Death recorded on Patient Centre / Nerve Centre. 'Notification of Death Form Completed and yellow copy taken to Bereavement Services Office

Cause of Death discussed with Medical Examiner[1] and Death Certificate (MCCD) Issued or Death Referred to the Coroner[2]

• Perinatal Death Process followed & CDOP Informed • 72hr Rapid Review by Risk Team if imm concerns • HSIB Informed if applic • PMRT undertaken • Case Presented to PMRG	• Child Death Process followed & CDOP Informed • Child Death Review facilitated – usually led by LLR CDOP • Clinical Review by ED Paeds • Case presented to ED M&M	• Child Death Process followed & CDOP Informed • Child Death Review undertaken – usually facilitated by UHL CDR Lead in collaboration with other Trusts as applicable • CDR findings presented to CH M&M	• Child Death Process followed & CDOP Informed • Child Death Review undertaken – usually facilitated by UHL CDR Lead in collaboration with other Trusts as applicable • CDR findings presented to EMCHC M&M	• Child Death Process followed & CDOP Informed • SJR undertaken by Specialty M&M (or Child Death Review) • SJR/CDR findings presented to M&M

Summary of Review Findings and identified reviewed and discussed at Specialty M&M / PMRG

- Death Classification Agreed as per Paed/Perinatal Mortality Review Policies
- Where problems in care identified – Incident Reporting Policy requirements met
- Learning and need for Actions considered – where Actions agreed - Leads and Timescales Confirmed
- Outcome of Reviews and M&M Discussion shared with CDOP

[1] Excluding Stillbirths
[2] Suspicious/Unexpected Deaths may be referred directly to the Coroner by the Police or sometimes by the Clinical Team without discussion with the ME

Learning Disseminated and Actions Tracked by Specialty M&M Leads / Heads of Service

All Deaths in Neonates/Children (0-18 years) reported to Child Death Overview Panel (CDOP) via the LLR CDOP Portal https://www.ecdop.co.uk/LLR/Live/Login

All Stillbirths, Deaths within 28 days of Life and Maternal Deaths (within 1 year of pregnancy, regardless of pregnancy outcome) reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquriies across the UK (MBRRACE-UK) via **UHL's W&C Patient Safety & Complaints Team**

Updates on actions sought by Corporate LfD Team and inputted on the UHL LfD Database for internal assurance; theming of Specialty learning/actions and reporting to both Children's Hospital Board; and UHLTrust Board via the MRC Quarterly Report and for feeding back to the LLR CDOP

Outcomes of CDOP Reviews, Additional Learning and/or Actions fed back to the Clinical Teams / Specialty M&Ms by UHL Members of the LLR CDOP

APPENDIX 2

LEARNING FROM THE DEATHS OF ADULT PATIENTS IN OUR CARE FLOW CHART