Kent and Medway
NHS and Social Care Partnership Trust

Learning from Deaths Policy

Document Reference No.	KMPT.CliG.156.03
Replacing document	KMPT.CliG.156.02
Target audience	All clinical staff, Patient Safety staff, Trust Board
Author	Head of Patient Safety
Group responsible for developing document	Trust-wide Patient Safety and Mortality Review Group
Status	Approved
Authorised/Ratified By	Trust Wide Patient Safety and Mortality Review Group
Authorised/Ratified On	January 2021
Date of Implementation	January 2021
Review Date	September 2022
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	January 2021
Number of Pages	23
Contact Point for Queries	kmpt.policies@nhs.net
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DOCUMENT TRACKING SHEET

Learning from Deaths Policy

Version	Status	Date	Issued to/approved by	Comments
0.1	Draft	October 2017	Trust Wide Patient Safety and Mortality Group	
0.2	Draft	14/11/2017	Quality Committee	Review and approved.
1.0	Final	23/11/2017	Trust Board	Ratified.
1.1	Draft	24/04/2018	Trust Wide Patient Safety and Mortality Group	
2.0	Final	15/05/2018	Quality Committee	Ratified.
2.1	Draft	05/07/2019	Head of Patient Safety to Medical Director and Deputy Director Quality and Safety	First draft
2.2	Draft	30/08/2019	Head of Patient Safety to Medical Director, Deputy Director Quality and Safety and TWPS&MRG	Added LeDeR appendix (B) Added to sections 13 – 16 Minor additions.
2.3	Draft	24/09/2019	Head of Patient Safety to Medical Director, Deputy Director Quality and Safety and TWPS&MRG	Amended 4.4.1 to be more specific.
2.4	Draft	06/12/2019	Head of Patient Safety to Director of Nursing and Quality	Added to monitoring section
2.5	Draft	24/03/2020	Mortality Review Manager	Added to points
3.0	Final	07/01/2021	Trust Wide Patient Safety and Mortality Review Group	Ratified

REFERENCES

Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. CQC December 2016. https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

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. https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

Horgan H, Healey F, Neale G, et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. BMJ Quality and Safety (2012). Doi:10.1136/bmjqs-2012-001159

Healthcare Commission, Investigation Into Mid Staffordshire NHS Foundation Trust, March 2009

The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report, February 2013)

Hogan et al. Avoidability of hospital deaths and association with hospital-wide mortality ratios: a retrospective case record BMJ 2015; 351:h3239

The five year forward view for mental health (NHS England, February 2016)

Learning Disabilities Mortality Review (LeDeR, Bristol University, June 2015)

The Royal College of Psychiatrists Mortality Review Tool

Using the Care Review Tool for mortality reviews in Mental Health Trusts - Guidance for reviewers (The Royal College of Psychiatrists)

Thank you to East Kent Hospitals University Foundation Trust for permission to adapt their Learning from Death policy (March 2019) and to The Royal College of Psychiatrists for the use of Using the Care Review Tool for mortality reviews in Mental Health Trusts - Guidance for reviewers.

Learning from deaths: a dashboard for providers https://improvement.nhs.uk/resources/learning-deaths-nhs/#h2-mental-health

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Management and Investigation of Serious Incidents Policy	
Policy and Procedure for Listening and Responding to Concerns and Complaints	KMPT.CorG.019.06
Duty of Candour – Being Open Policy	KMPT.CorG.018.05
National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and Learning from Deaths om Care.	National Quality Board, 2017
Learning Candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England	Care Quality Commission, 2016
The Learning Disabilities Mortality Review (LeDeR) Programme	Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England
Learning from Experience Policy	KMPT.CorG.011
Death of an Inpatient Policy	KMPT.CliG.114

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
08/12/2020	Mortality and Review Manager		This policy has been reviewed and updated throughout
		1, 3, 4, 6	Minor amendments
		2	Patient safety statement added
		3	Associated policies added
		5	Added to section 7
		7, 8	Added section relation actions post-review
		9, 10	Added to section relating to involving the family
		11 - 14	Added reporting and monitoring sections and exceptions
		23	Added flowchart (appendix A)
			Removed appendix D

CONTENTS

1 INTRODUCTION

1.1 Learning from deaths of people under our care can help us improve the quality of the care we provide to patients and their families, and identify where we could do more.

1.2 Findings from the Francis Inquiry report show that 'higher than expected' mortality rates were at worse ignored or manipulated and at best the subject of poorly functioning non-systematic mortality review meetings in which failings in the quality of care were not confronted or corrected. Essentially, there are three levels of scrutiny that a provider can apply to the care provided to someone who dies; death certification; case record review; and investigation. They do not need to be initiated sequentially and an investigation may be initiated at any point. A review of deaths of patients already takes place within the Trust through the incident reporting system (Datix) and identification of STEIS reportable incidents involving mortality.

1.3 The five year forward view for mental health in February 2016 (NHSE) identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people.

1.4 Additionally, reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities. The NQB guidance specifies that all inpatient, outpatient and community patient deaths of people with learning disabilities should be reviewed to enable learning and thereby contribute to service improvements.

1.5 The Learning Disabilities Mortality Review (LeDeR), commissioned by HQIP (Healthcare Quality Improvement Partnership), has an established and well-tested methodology for reviewing the deaths of people with learning disabilities. Trusts should notify all deaths of people with learning disabilities to the LeDeR programme. All deaths of people with learning disabilities should be investigated using the LeDeR methodology by LeDeR (see Appendix B).

1.6 The National Quality Board (NQB) guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review. In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

1.7 The national bodies are working to clarify expectations about mortality review in mental health and community services in general. In the meantime, it is a requirement that the above description of SMI is used. You can also review the care provided to patients with other significant mental health issues such as those mentioned above, where this can be done proportionately and effectively.

1.8 Additionally, a Care Quality Commission (CQC) review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England found that some providers were not

giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care.

1.9 Following on from this in March 2017, the NQB introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. That report required trusts to undertake a number of actions to ensure a systematic approach to identifying those deaths requiring review and a systematic, standardised approach to the performance, reporting and learning from those reviews following the death of people receiving care. Since September 2017 all Trusts in England have been required to have a process in place for mortality reviews.

1.10 The Royal College of Psychiatrists has subsequently issued guidance and a tool to be used for mortality reviews within mental health services.

1.11 Kent and Medway NHS and Social Care Partnership Trust (KMPT) believes that concentrating attention on the factors that cause deaths will impact positively on all persons who use services, and is required to demonstrate how it responds to, and learns from, deaths of people who either die while in our care or whose subsequent death may be attributable to our care. The aims are:

1.11.1 To support staff to review and learn from deaths and then take effective action to embed improvements and

1.11.2 To enable families and carers to raise and have answered questions or concerns about the care of patients who have died.

1.12 This policy describes our approach to learning from deaths and should be followed in conjunction with the Serious Incident Policy and Duty of Candour policy.

2 WHO DOES THIS POLICY APPLY TO?

2.1 The policy applies to all clinical staff whether they are employed by the Trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

3 PURPOSE

3.1 The Trust is required to demonstrate how it responds to, and learns from, deaths of people who either die while in our care or whose subsequent death may be attributable to our care.

3.2 This should be by identifying:

3.2.1 Areas of good care that can be further developed, and

3.2.2 Areas where care can be improved.

3.3 This policy outlines the minimum number and the categories of deaths that should be reviewed, and who participates in the review.

3.4 Additionally, this policy takes account of how to involve service users, their families and/or carers.

3.5 This policy will also guide staff on the appropriate process to be used for a mortality review.

3.6 It will ensure a consistent approach in the quality of patient mortality reviews, which will be clearly documented and archived on Datix;

3.7 There are clear reporting mechanisms for learning from poor and good practice, with escalation of any areas of concern, ensuring appropriate action is taken.

4 ASSOCIATED TRUST POLICIES/PROCEDURES

- Management and Investigation of Serious Incidents Policy
- Concerns and Complaints Policy
- Learning by Experience Policy
- Duty of Candour Policy

5 DUTIES

5.1 The Board of Directors

5.1.1 The Board of Directors has overall responsibility for monitoring and learning from deaths across the Trust.

5.1.2 A non-executive director will be responsible for the oversight of the programme and to ensure that progress is made against the national recommendations.

5.2 The Medical Director

5.2.1 The Medical Director is responsible for ensuring the Trust complies fully with all national requirements for the programme.

4.2.1 The Medical Director is responsible, with the Mortality Review Manager, to ensure allocation of a clinician to complete a Section 2 review.

5.3 The Trust-Wide Patient Safety and Mortality Review Group

5.3.1 This group, under the chairmanship of the **Director of Nursing and Quality**, will be responsible for the review and monitoring of Trust learning from avoidable deaths.

5.3.2 This group has the required multi-disciplinary and multi-professional membership and will meet monthly to oversee the process.

5.4 The Serious Incident and Mortality Panel

5.4.1 The Serious Incident and Mortality Panel will be responsible for ensuring all deaths are reviewed. Every incident is considered on a case-by-case basis. The Panel will determine when a Section 2 review is required and escalate via the Mortality Review Manager.

5.5 Consultants and clinicians

5.5.1 Consultants and clinicians nominated as clinical leads for the learning from deaths programme are responsible for ensuring the programme is delivered and functioning in line with national recommendations.

5.5.2 Senior medical staff (ST4 and above) and senior members of other professional groups will be trained and participate in the process of case note review to support a thorough review process.

5.6 **Mortality Review Manager**

5.6.1 The Learning from Deaths Manager will be responsible for managing the process of learning from deaths within the organisation and will report into the Trust-wide Patient Safety and Mortality Review Group as well as produce reports required at a national level.

5.6.2 That person will also be responsible for ensuring the section 1 review is completed, and will also be responsible for liaising with the Medical Director to allocate Section 2 reviews.

5.7 **The role of Medical Examiners**

5.7.1 The introduction of the Medical Examiner role is expected to provide further clarity about which deaths should be reviewed by actively identifying and allocating appropriate cases as per Trust policy.

5.7.2 A national network of medical examiners was recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries and in March 2016 the Secretary of State announced a consultation for their introduction from April 2019.

5.7.3 The proposed role of the Medical Examiner will be to:

a) Scrutinise every death not requiring a Coroner investigation, provide expert advice and to confirm the doctor's Medical Certification of Cause of Death ensuring the cause of death is accurate;

b) Discuss the cause of death with the family and address any concerns they may raise;

c) Identify patterns of causes of death; where indicated refer the death of any patient for review by the most appropriate provider organisation(s).

5.7.4 The exact role of the medical examiner will be clarified by research commissioned by NHS Improvement and the Department of Health. It is planned that the medical examiner service will cover all deaths, wherever they occur, by March 2021.

6 PRINCIPLES

6.1 All deaths are appropriately reviewed to assess if there is potential for organisational learning.

6.2 The deaths selected for further review have a structured judgement review completed.

6.3 The review of deaths is undertaken in a spirit of openness and transparency, and organisational learning, rather than blame.

6.4 The review of deaths will involve families and those close to the deceased, where possible.

7 INITIAL REVIEW FOLLOWING A DEATH (STRUCTURED JUDGEMENT REVIEW SECTION 1)

7.1 All deaths of patients who have been under KMPT within the year before their death will have the death reported on Datix. The manager of the service (or deputy) under which the death occurred should complete the 48 hour management report on Datix, This report is then discussed and scrutinised at the Serious Incident and Mortality Panel.

7.2 All deaths of service users should be identified, for example using NHS Spine, through information from families, information received from Her Majesty's Coroner or other agencies such as the police. This review should take place to support the identification of the individual deaths which will require a more detailed review.

7.3 The Serious Incident and Mortality Panel will determine cases that require a Structured Judgement Review.

The tool (section 1) will be used as a brief screening instrument. It will be completed by the Mortality Review Manager.

7.4 Section 1 covers demographic details, past medical history, past psychiatric history and treatment, past medical history, medication, and a background history in addition to relationships. The diagnosis is the primary diagnosis that the patient was receiving treatment for, covering both mental and physical health.

7.5 Patients would be classed as being within the last 12 months of life if there was a documented discussion about end of life care planning or it was documented that palliative care processes were utilised, for example the Gold Standards Framework was applicable.

7.6 Those cases that then meet the mandatory criteria ("red flags") (see section 7), should be subject to section 2, if they are not already subject to a clinical review or a serious incident investigation.

8 SECTION 2 REVIEW: STRUCTURED JUDGEMENT REVIEW

8.1 The following criteria would automatically require a structured judgement review (SJR) (section 2 see appendix B):

8.1.1 All patients where family, carers, or staff have raised concerns about the care provided;

8.1.2 All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death;

8.1.3 All patients who were an in-patient in a mental health unit at the time of death or who had been discharged from in-patient care within the last month;

8.1.4 All patients who were under a Crisis Resolution and Home Treatment Team at the time of death;

8.1.5 There may also be locally determined 'red flags', identified by KMPT on a regular or ad hoc basis. On occasions, there may be a need to complete an SJR to review deaths of patients with e.g. a substance misuse diagnosis, or quality of end of life care in people with dementia, or when a change to

service is planned. When this occurs, a decision should be made through the Trust-wide Patient Safety and Mortality Review Group about whether to complete a care review tool for all of these patients, or whether a sample of this patient group should be selected. This may be requested by the SI and Mortality Panel, through groups or committees, care groups, Care Quality Commission or other regulators, audits or by other means when this is concern or when learning could be developed through good care.

8.1.6 A random sample of case notes should also be selected to be reviewed.

8.2 In cases where the serious incident criteria are met, the serious incident process should be followed and the mortality review process (section 1 and 2) would not be necessary. There may be cases that begin as a mortality review and it becomes clear that the death should have been reported as a serious incident. The serious incident process should be triggered at that stage. The serious incident investigation supersedes the mortality review processes.

8.3 It is also important to note that there are currently recognised processes and programmes which focus on deaths of children deaths of people with learning disabilities, and homicides linked to mental disorder. The Care Review Tool should therefore not be used in these circumstances as the other processes should be followed. NB Learning disability was not included as a red flag as all deaths of people with learning disability are reviewed by the LeDeR programme.

8.4 Staff completing an SJR must be trained in the process. The review must be completed by a senior clinician who was not involved in the patient's care.

8.5 The SJR form (section 2 – see appendix B) should be used. In this section, judgements should be made about different phases of care. Not all phases of care will be relevant in individual cases and only the relevant sections need to be completed. Phases of care include:

- The allocation and initial review or assessment of the patient;
- The ongoing care of the patient, including both physical health and mental health;
- Care during admission;
- Care at the end of life and
- Discharge planning.

8.6 In the text boxes in section 2, the reviewers should make explicit judgements about the relevant area of care and then rate the overall quality of the phase of care in question. The judgement should be based on current professional standards, such as the National Institute for Health and Care Excellence guidelines, or the reviewers' professional perspective based on their own experience.

8.7 It is important that the person conducting the review has the appropriate expertise to make such judgements. Additional expertise may need to be sought at times, for example input from a pharmacist. Ideally, these explicit judgement statements should be short and to the point. Examples include:

- "Physical observations were not completed regularly";
- "A significant deterioration in physical health was not recognised"

- "The patient's blood sugars were monitored appropriately and appropriate action was taken when issues were identified"
- "There was evidence of good multidisciplinary working to support the individual's needs and wishes"

8.8 Reviewers must also specify if care was judged to be excellent, good, adequate, poor, or very poor for each phase of care, as well as for the overall care. There are a wide range of situations which the reviewers will need to judge the care on. Care that covers the essential aspects of what is required would be adequate care. Where the team have gone above and beyond the usual care, the care may be rated very good or excellent. Poor care will be rated when the overall issues in that section were below the standard expected.

8.9 It is important to consider whether there was any harm that occurred to the patient, to note areas of good practice, and to identify areas where learning may occur from the deaths. The learning may be identified from areas of good practice as well as from poor practice.

8.10 Determining which point in care to commence the care review from is a clinical decision, and there is no timescale set nationally. For example, the review could commence from the point of referral to services, the last relapse of the patient's illness, the lead up to a hospital admission, or a point of deterioration or change in the patient's health.

9 ACTIONS FOLLOWING THE REVIEW

9.1 The review will be completed on Datix.

9.2 The recommendations from the SJR will be reviewed by the Head of patient Safety, the Mortality Review manager and the Serious Incident and Complaints Investigation Lead. They will determine if any of the recommendations will be added to the Trust-wide SRJ action plan. If so this will be disseminated to the patient safety care group leads for information and action.

9.3 If no Trust-wide action is required, the SJR and recommendations will be shared by the Mortality Review manager with the appropriate care group patient safety team who will pass to the team involved. The team involved will develop actions from the recommendations and will then send them to the Mortality Review Manager who will add them to Datix.

9.4 The actions will be monitored by the Mortality Review Manager who will escalate to Trust-wide Patient Safety and Mortality Review Group as required.

10 INVOLVING THE FAMILY

10.1 The "Learning from deaths" Guidance for NHS Trusts on working with bereaved families and carers should be followed, which includes an expectation that Trusts should explain to the families of all deceased patients that they routinely carry out case note reviews on a proportion of all deaths.

10.2 Families and carers should be given information on how to raise concerns (see Concerns and Complaints Policy). These concerns should be addressed and, if

new or additional concerns are raised by use of the Care Review Tool, the family should be informed. The decision on who will inform the family will be made in conjunction with the investigator, Mortality Review Manager and the care group Patient Safety and Risk Manager.

10.3 The SJR Tool has been designed to support Trusts in being able to respond to concerns from carers, families and staff about any aspect of the patient's care. It is anticipated that the review will be completed by experienced staff with the relevant experience.

10.4 When families have raised concerns these concerns should be addressed and, if new or additional concerns are raised by use of the SJR Tool, the family should be informed.

11 WORKING WITH OTHER ORGANISATIONS

11.1 There is a recognition that patients with mental illness may have physical healthcare needs that are looked after by their GPs and other secondary healthcare teams. Social services and other organisations may also be involved in their care. Consideration should be given to arranging meetings with other local organisations to support the process of learning from deaths.

11.2 Acute Hospital Trusts may also be reviewing the deaths of the same patients, and collaborative working would be appropriate in these cases. When themes emerge relating to cross-organisational working, or another team would be more able to address a particular issue, then agreement should be reached with the other organisation to support joint working or review of those aspects of care, as deemed appropriate.

12 TRAINING AND SUPPORT

12.1 All staff undertaking a Structured Judgement Review must be trained in the process. SJR reviewers should understand the process and the escalation process if issues are identified.

12.2 Support will be provided by the Mortality Review Manager. The SJR SOP provides further information about SJRs.

13 REPORTING

13.1 The Mortality Review Manager will produce a quarterly report on themes, trends and analysis from Structured Judgement reviews. This will feed into the Mortality report for TWPSMRG and Quality Committee.

13.2 The learning from deaths: a dashboard for NHS providers will be used for monitoring and reporting purposes https://improvement.nhs.uk/resources/learning-deaths-nhs/#h2-mental-health

13.3 Datix will be used to maintain records of cases reviewed.

14 RECORD RETENTION

14.1 Records will be maintained on Datix.

15 EQUALITY IMPACT ASSESSMENT SUMMARY

15.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

16 HUMAN RIGHTS

16.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the 14.1protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

17 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

17.1 The Mortality Review Manager track progress of action implementation, escalating any concerns through the Trust Wide Patient Safety and Mortality Review Group (TWPS&MRG)

What will be monitored	***How will it be monitored***	***Who will monitor***	***Frequency***	***Evidence to demonstrate monitoring***	***Action to be taken in event of non compliance***
The policy process	Data and information will be provided in a report to TWPS&MRG via Mortality Report	TWPS&MRG	Quarterly	Data collection of types of SJR cases reviewed produced to TWPS&MRG in Mortality Report	Escalate to TWPS&MRG meeting
Numbers of STEIS cases reported following SJR process	Data and information will be provided in a report to TWPS&MRG via Mortality Report and Patient Safety report	TWPS&MRG	Quarterly	Mortality Report	Escalate to TWPS&MRG meeting
Learning and concerns highlighted from Structured	Reporting through TWPS&MRG via Trust-wide	TWPS&MRG	Quarterly	Mortality Report and Patient Safety Report	Escalate to TWPS&MRG meeting

What will be monitored	*How will it be monitored*	*Who will monitor*	*Frequency*	*Evidence to demonstrate monitoring*	*Action to be taken in event of non compliance*
Judgement Reviews	mortality action plan				

18 EXCEPTIONS

18.1 Cases are not subject to Structured Judgement Review if the patient had a diagnosis of a learning disability as these are reviewed by the Learning Disabilities Mortality Review Group (LeDeR), and if serious incident criteria is met as this will be investigation by means of a Root Cause Analysis.

APPENDIX A STRUCTURED JUDGEMENT REVIEW FLOW CHART

STRUCTURED JUDGEMENT REVIEW FLOW CHART
(NOVEMBER 2020)

1.

Initial review

- Patient's death is reported on Datix as a serious incident
- The team responsible completes the 48 hour management report
- The case is reviewed either in Trust-wide SI and Mortality Panel, by Datix death notifications, by downgrade requests outside of the Panel, or by a complaint.
- If the case meets serious incident criteria, it is reported on STEIS to be investigated by means of a Root Cause Analysis (RCA).
- If no care and service delivery problems identified or learning was not contributory to the death, the incident is downgraded depending on the level of harm caused by any acts or omissions
- If the patient had a diagnosis of a learning disability, The Learning Disabilities Mortality Review (LeDeR) will need to be informed and an SJR will not be required.

2.

Criteria for Structured Judgement Reviews/Allocation

- The "red flag" criteria will be measured against each incident in Trust-wide SI and Mortality Panel:
- All patients where family, carers or staff have raised concerns about the care provided
- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of KMPT services prior to their death, or who had been discharged within the six months prior to their death.
- All patients who were an inpatient in a mental health unit at the time of their death or who had been discharged from inpatient care within the last month
- All patients who were under a Crisis Resolution and Home Treatment Team (CRHT) at the time of their death

If SJR criteria is met, the Mortality Review Manager will proceed with allocation to SJR trained staff. A sample of randomly selected cases will be chosen by the Mortality Review Manager and allocated accordingly.

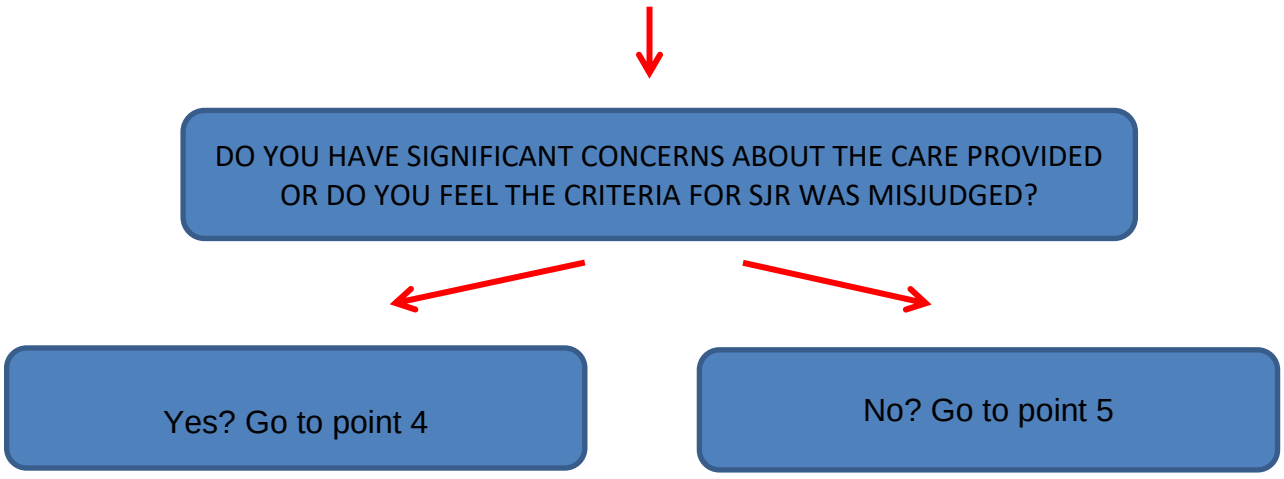
3.

Structured Judgement Review form

- **Please type your findings in the form provided when allocated as the information will need to be transferred to Datix.**
- Start at Section 1. This includes patient demographics and “red flag” tick boxes to evidence why SJR is required. The Mortality Review Manager will advise you why SJR is required for each case.
- Once section 1 is complete, move onto section 2. Fill in each box where relevant (some may not apply to the case you are reviewing).
- Remember to make explicit judgements about the relevant area of care followed by the rating of care for each phase.

TOP TIPS

- Explicit judgement statements in each section should be short and to the point.
- For each explicit judgement statement you may rate the level of care, for example; “Physical health observations were not completed regularly- this is poor care”
- Remember to include good practice, we can learn from this too!
- Care that covers the essential aspect of what is required is usually deemed as adequate care. Anything below this should be rated as poor or very poor.
- Your review of care quality should be based on the current professional and national standards, such as NICE guidelines, and should be based on your professional perspective and understanding of how services are run, including your own experience.
- Your review should be unbiased and should **NOT** include opinions, presumptions or blame.
- Remember, Structured Judgment Reviews are very different to RCA investigations and should be treated as such. There may be times where you require the expertise from another colleague and/or professional, such as a pharmaceutical review. This is acceptable however you do not need to delve into why the issue occurred.



4.

- You may identify acts or omissions in care that could have contributed to the patient's death or may feel as though the "red flag" previously identified is incorrect.
- If you have significant concerns about the care provided, and feel serious incident criteria is met, please **stop** the Structured Judgement Review process **immediately** and inform Mortality Review Manager or Head of Patient Safety in her absence.
- If you come to learn that the patient had a diagnosis of a learning disability, please also **stop** the Structured Judgement Review Process immediately and:
  - Report the death to the Learning Disabilities Mortality Review (LeDeR) by following the link. Learning Disabilities Mortality Review Programme | School for Policy Studies | University of Bristol
  - Inform Mortality Review Manager or Head of Patient Safety in her absence.

5.

Recommendations

- Learning identified during a Structured Judgement Review should lead to recommendations for the treating team and care group, and in some cases a Trust-wide recommendation will be required to address the concern.
- Recommendations should be concise and clearly documented in the review.

6.

What happens when you have completed the SJR

- Once you have completed the Structured Judgement Review form, please send to Frances Lowrey, Mortality Review Manager, frances.lowrey@nhs.net
- The information is then transferred to Datix under the Structured Judgement Review section of the incident.
- The review will be shared with the Serious Incident and Complaints Investigation Lead to determine if there are recommendations to be added to Trust-wide action plans.
- The responsible team will also receive the review and create actions from each local recommendation (those not included in Trust-wide action plans) to ensure learning is embedded. These must be shared with the Mortality Review Manager, who will add to Datix.
- If the patient's family was informed that a review would be completed, the findings from the SJR will need to be shared with them by the team involved.

7.

Monitoring

Monitoring of the Trust-wide actions will be completed by the Serious Incident and Complaints investigation Lead and the Mortality Review Manager.

Monitoring of local actions will be completed by the Mortality Review manager.

The Mortality Review manager will produce quarterly mortality reports for Trust-wide Patient Safety and Mortality Review Group and Quality Committee.

8.

Advice and support

If you require any support please contact Frances Lowrey, Mortality Review Manager either by email frances.lowrey@nhs.net or phone 07747862097.

APPENDIX B FORMS

Care review tool for mortality reviews (The royal College of psychiatrists)

https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/care-review-tool-for-mental-health-trusts

Guidance: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych_mortality_review_guidance.pdf

Section 1

This section should be completed as soon as is possible.
If it is deemed appropriate to complete Section 2, it should be completed within 60 days of selected patients' deaths.

Patient identification number:		**Gender:**	
Date of birth (dd/mm/yyyy)		**Age:**	
Social deprivation index (first 3–4 letters of postcode)		**Ethnicity:**	
Date of death		**Time of death:**	
Location of death			
Was the patient identified as being within the last 12 months of life?			
Cause of death (if known)			
Primary diagnosis, including ICD-10 code			
Co-morbidities			
Learning disability (if present, this death should be reviewed through the LeDeR process)			
Healthcare teams involved in the patient's care at the time of death			
Dates of last admission to a psychiatric hospital (where relevant)			
Patient summary (can be completed by the clinical team)			
Concerns from family members or carers about the patient's care (please outline concerns, or state if there were no concerns)			
Concerns from staff about the patient's care (please outline concerns, or state if there were no concerns)			
Red flags indicating further review where the death is not being investigated by other means (please indicate):			
Family, carers or staff have raised concerns about the care provided ☐			
Diagnosis of psychosis or eating disorders during the last episode of care ☐			
Psychiatric inpatient at time of death, or discharged from inpatient care within the last month ☐			
Under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death ☐			
Other locally determined criteria for review (please state): …… ☐			
Case selected at random ☐			

If a red flag is identified, or it has been agreed this death is for a review of care, please proceed to completion of Section 2.

Trusts may add additional red flags and should choose an additional random sample of other cases to review.

Time taken to complete Section 1 of this form (minutes): ……

Date of completion: ……

Name of person completing Section 1: ……

Job title of person completing Section 1 ……

Section 2

Please state the information sources used for the review, including the names of the electronic systems accessed:

2.1. Phase of care: Allocation and initial assessment or review (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐
2.2. Phase of care: Ongoing care (where relevant) • **Was mental health monitored adequately?** • **Was physical health monitored adequately?** • **Please list medication if known and relevant, and comment on medication**

monitoring where appropriate

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.3. Phase of care: Psychiatric Inpatients – comment on care during admission (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.4. Phase of care: End of life care (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒ Section not applicable ☐

2.5. Phase of care: Discharge plan of care (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.6. Other area of care (please specify) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.7. Overall care
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:
5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.8. If care was below an acceptable standard, did it lead to harm? If yes, please provide details and state an action plan (consider whether a serious incident investigation or another Trust process is required).

2.9. Was the patient's death considered more likely than not to have resulted from problems in care delivery or service provision? If yes, please provide details and state an action plan (consider whether a serious incident investigation is required).

2.10. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required. If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

2.11. Were the patient records adequate for the purpose of the review?	Yes ☐ No ☐
Please outline any difficulties in accessing appropriate information:	

Time taken to complete Section 2 of this form (minutes): ……

Date of completion: ……

Name of person completing Section 2: ……

Job title of person completing Section 2: ……

APPENDIX C LEARNING DISABILITIES MORTALITY REVIEW (LEDER)

http://www.bristol.ac.uk/sps/leder/

The Learning Disabilities Mortality Review (LeDeR) Programme was a world-first. It was the first national programme of its kind aimed at making improvements to the lives of people with learning disabilities. Reviews are carried out with a view to improving the standard and quality of care for people with learning disabilities. People with learning disabilities, their families and carers have been central to developing and delivering the programme.

The LeDeR programme reviews all deaths of people with learning disabilities. The death will be reported on Datix and reviewed by the SI and Mortality Panel and a LeDeR death notification will be made via:
http://www.bristol.ac.uk/sps/leder/notify-a-death/?_ga=2.4265911.589001362.1531124673-1987643447.1528363357

The responsible person to notify LeDeR will be agreed at the above panel.

These cases will not require reviewing via the SJR process.