Trust-wide Policy **Learning from Deaths; Mortality Policy & Operational Processes**	
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Version	**Brief summary of changes**
V3.0	**Transfer to new template. Minor typo changes. New process updates to section under investigation**

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1) Purpose and rationale

Purpose:

In December 2016, the Care Quality Commission (CQC) published its report *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'* (Ref 1). It found that most trusts undertake some form of mortality review however, there was some considerable variation in terms of methodology, and contribution to learning from deaths was not given sufficient priority therefore valuable opportunities for improvements were missed. The report also pointed out that there was more that could be done in relation to the care of vulnerable people and engaging more with families and carers to recognise and learn from their insights.

In response to this, the *'Learning from Deaths'* (Ref 2) framework was published by the National Quality Board in April 2017, which outlines a framework for trusts to adopt in order to standardise reviewing and investigating deaths across the NHS. It is expected that acute trusts and other health care organisations should incorporate the guidance, aligning mortality and morbidity reviews with their governance systems, in order to measure assurance of the provision of safe, effective care focusing on the systems and processes used in the service.

This policy has been developed in response to the 'Learning from Deaths' (LfD) (Ref 2) framework which states trusts are required to have an approved policy in place, outlining the operational processes for specific patient groups that must be subject to a mortality review and includes the following -

1. Elective Surgery
2. Learning Disabilities
3. Alerts via external monitoring bodies – i.e. CQC, Telstra Health (previously Dr Foster)
4. Family Concerns
5. Incidents
6. Local Safety Initiatives – i.e. in-patient falls
7. Other patient groups identified locally by Specialities

2) Scope

This document applies to all staff employed by The Great Western Hospitals NHS Foundation Trust (whether on a permanent, temporary or honorary contract).

This document sets out:

- How the Great Western Hospitals NHS Foundation Trust (the Trust) 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.
- The procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the Trust.
- How the Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further

action taken to review and/or investigate the death. It also describes how the Trust supports its employees that may be affected by the death of someone in the Trust's care.
- How the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with the following Trust policies:

1. Duty of Candour Policy (Ref 3)
2. Patient Safety Incident Response Policy (Ref 4)
3. Complaints Policy (Ref 5)

3) Definitions

The National Guidance on Learning from Deaths (Ref 2) includes a number of terms. These are defined below:

Death certification

The process of certifying, recording and registering death, specifically the cause(s) of death. This process includes identifying deaths for referral to the coroner.

Case record review

A structured desktop review of a case record/note, carried out by clinicians, to provide a subjective review of the care provided during the admission in which the patient died. The review may identify problems in the care provided to a patient, or alternatively may demonstrate excellent care. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be undertaken alongside patient safety processes where concerns do exist, though it should not be used as an investigative tool in this scenario.

A Structured Judgement Review (SJR) is a type of case record review based on nationally agreed methodology and will be the primary method of undertaken case record review at Great Western Hospital. Case record review will herein be referred to as "SJR".

Mortality 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.

Incidents

A patient safety incident is when something goes wrong in a patient's care or treatment that causes harm or has the potential to cause harm. The Trust manages patient safety incidents using the Patient Safety Incidents Response Framework (PSIRF) to support development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement

See the Patient Safety Incident Response Policy (Ref 4)

Learning response

Patient safety incident responses will be proportionate and undertaken using an approach that will maximise learning and opportunities for improvement. A systems approach to learning will be used to explore the human factors that impacted the situation. Not all patient safety incidents will trigger a Patient Safety Incident Investigation (PSII), other learning responses may be more appropriate and proportional. See the Patient Safety Incident Response Policy (Ref 4). Learning responses can be triggered by, and follow, SJR, or may be initiated without an SJR happening first, though it is likely an SJR will be requested if a patient safety incident has been identified (SJR mandatory category: "concerns raised by staff or relative"). It should be noted that an SJR is not a tool for investigation.

Death due to a problem in care

A death that has been clinically assessed using a recognised method of case record review e.g. SJR, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as the "Cause of Death"). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

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.

4) Duties

4.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

4.2 Trust Board

The Board should ensure that their organisation:

- Has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress
- Pays particular attention to the care of patients with a learning disability or mental health needs and ensures that mandatory processes to review these deaths are undertaken.
- Has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review
- Adopts a robust and effective methodology for case record reviews (SJR) of all selected deaths (identified using National Guidance on Learning from deaths (REF.2) reference required, and including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas to direct improvement work
- Ensures SJRs 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
- Ensure that where problems in care are identified, referral to the Patient Safety team for investigation is made for further investigation where required, and that SJRs are not used as a tool for investigation in such circumstance, but as a tool to be used alongside the patient safety process.

- Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board via quarterly and annual reports in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised
- Ensures that learning from reviews is acted on to sustainably change clinical and organisational practice and improve care and reported in annual Quality Accounts via the annual Learning from Deaths report.
- Shares relevant learning across the organisation and with other services where the insight gained could be useful
- Ensures a sufficient number of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths
- Offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to concerns regarding a death
- Acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted following the death of a patient, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved
- Works with the ICS to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers regarding deaths occurring whilst in their care, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involve bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.
- 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
- The information the provider publishes is a fair and accurate reflection of its achievements and challenges.

4.3 Non-Executive Directors

The Board of Directors are collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, and in the case of a Foundation Trust taking into consideration the views of the Council of Governors. Details of Board expectations can be found in section 5.2.

The role of the non-executive director with responsibility for mortality is to ensure oversight of progress regarding the Learning from Deaths agenda by constructively challenging the decisions of the board and helping to develop proposals on strategy.

As a critical friend, Non-executive Directors should hold their organisation to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable or where learning with the potential of improvement can be identified. The roles and responsibilities of Non-executive Directors related to Learning from Deaths include:

- Ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this
- Understanding the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support.

- Seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation's processes but understand limitations of any direct comparisons.
- Ensure timely and objective reviews/investigations, calibre of reviewer/investigator and quality of the review or investigation.
- Ensure appropriate selection of cases for review
- Ensure that deaths of people with learning disabilities are reviewed according to the LeDeR methodology
- Where problems in care are identified, ensure these are fed through the Patient Safety Incident Review Framework
- Ensuring that learning and improvements are reported to the board and relevant providers
- Supporting any changes in clinical practice that are needed to improve care resulting from this learning.
- Ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes.
- Paying attention to the provision of best practice and how the learning from this can be more broadly implemented.
- Ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement.
- Ensuring that reports are shared with the board and other providers or organisations where required

4.4 Chief Medical Officer

Executive lead for Learning from Deaths; to support the Trust Mortality Lead on –

- Ensuring a robust approach to Learning from Deaths within the trust
- Reviewing on a quarterly basis, the benchmarked mortality rates/trends in the form of quarterly reports provided by the trust mortality lead and the clinical audit, effectiveness and mortality team.
- Ensuring mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of learning and clinical excellence.
- Reporting on Mortality performance to the Board.

4.5 Deputy Chief Medical Officer

Deputy Executive lead for Learning from Deaths; to support the Trust Mortality Lead with –

- Regular review of Trust mortality activity and data with a view to identify areas of concern that require further exploration and/or investigation
- To advise, guide and support with workplan objectives and mortality related activity, for example Trust wide mortality reviews
- To encourage and support a robust approach to Learning from Deaths within the trust
- Reviewing on a monthly basis, the benchmarked mortality rates/trends in the form of internal reports and updates provided by the trust mortality lead and the clinical audit, effectiveness and mortality manager
- Ensuring mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of learning and clinical excellence.
- Support with Mortality Performance reporting to the senior management committees and the Board.
- Reviewing the engagement with, and effectiveness of, the Learning from Deaths agenda annually

4.6 Trust Learning from Deaths Lead

The Clinical Lead for Mortality and Morbidity; to support the Clinical Audit, Effectiveness and Mortality Team in the delivery the mortality agenda for the Trust, including –

- Compliance with mandatory SJR requests
- Provide clinical leadership and support the department M&M leads
- Support clinical teams with the action plans and methodologies that are designed to reduce mortality and morbidity across the trust
- Continual review and improvement of the learning from deaths process to make it accessible, without stigma, blame or bias and ensure support is available through relevant teams.
- Provide Trust Liaison with the Medical Examiner's Office
- Chair the Trust's Learning from Deaths Learning from Deaths sub-committee meetings and receive/review data and issues arising
- Chair the Trust's Learning from Deaths meetings and sharing of relevant learning from deaths identified at monthly Learning from Deaths sub-committee meetings
- Championing change in practice occurring as a result of learning from deaths
- Investigating any alerts or concerns received from within the trust or from external bodies (e.g. The Care Quality Commission (CQC), Telstra Health, the Integrated Care Board (ICB)).
- Signing off regulatory mortality responses.
- Supporting the patient safety agenda by identifying and escalating cases for concern for further investigation
- Support with the co-ordination and investigation and reporting from mortality alerts e.g. Telstra Health
- Monitoring of Trust mortality indicators e.g. standardised hospital mortality index (SHMI) outlining trends and associated learning outcomes to senior management committees
- Writing of, and presentation of (when appropriate), trust mortality reports to relevant committees and sub-committees (PQSC and Q&S)
- Reviewing the engagement with, and effectiveness of, the Learning from Deaths agenda annually.

4.7 Associate Medical Directors:

- To ensure that "Morbidity and Mortality" is a standing agenda item for divisional clinical governance meetings, i.e. to ensure that departments are fulfilling SJR requirements, M&M meetings are being held and learning from M&M meetings is being shared with divisional management where appropriate.
- To review internal mortality dashboard (provided by Clinical Audit, Effectiveness and Mortality Team) and where appropriate, minutes of departmental M&M meetings at divisional clinical governance meetings.
- To hold departments accountable for holding M&M meetings at least quarterly and demonstrating adequate learning.
- To ensure a comprehensive and up-to-date list of specialty M&M leads and SJR reviewers is available, and to ensure that vacancies within this role are addressed.
- To encourage and support departments to complete SJRs requested by the CAEMT.
- To ensure that departments have nominated members of their team to participate in the Mortality Review Programme (staff members participating in the MRP must have undergone SJR training and commit to completing one SJR per week during a 3-month period).
- To share relevant learning or themes identified with other divisions where appropriate.

4.8 Clinical Audit, Effectiveness & Mortality Team (CAEMT)

Supporting the implementation of a Learning from Deaths programme by –

- To be a central repository on behalf of the trust for mortality data and related activity
- To receive all relevant internal data related to mortality activity and maintain central electronic systems relating to deceased patients (e.g. Incidents, complaints, SJR's, Medical Examiner referrals)
- Use appropriate resources to identify and facilitate mandatory categories for Structured Judgement Review and support clinical teams in the completion of these
- To analyse, review, monitor mortality related activity to identify themes and trends that promotes good care and opportunities for improvement, this includes, the identification of concerns or queries regarding internally- and externally provided mortality rates, qualitative data from SJR and themed reviews, national audits, data from the Medical Examiner system, patient safety team, legal services team, PALS team or any other source of data regarding trust mortality
- Contribute to and present (where appropriate), trust mortality reports to relevant committees and sub-committees (PQSC and Q&S)
- Championing change in practice occurring as a result of learning from deaths.
- Benchmarking mortality process with local and national peers through analysis of internal and external data.
- Supporting the investigating any alerts or concerns received from within the trust or from external bodies (e.g. The Care Quality Commission (CQC), Telstra Health, the Integrated Care Board (ICB)).
- Supporting departments to engage in learning from deaths, by attending (where required) Mortality and Morbidity meetings, supporting in the co-ordination and facilitation of SJRs and themed mortality reviews.
- To provide specialist advice, guidance and support around the Trust processes for Structured Judgement Reviews, including specialist SJR training at department and trust-wide level.
- To provide administrative support for established Learning from Deaths Meetings.

4.9 Speciality M&M Lead

- To ensure that learning from deaths is part of the department clinical governance meeting agenda – this should include learning from M&M meetings, updates regarding SJR completion, review of dashboard from the Clinical Audit, Effectiveness and Mortality Team, and review of relevant alerts (could be at M&M, CG meeting or M&M lead can review and update at CG meeting).
- To agree a frequency of M&M meetings to reflect appropriate review of deaths within the department, to ensure M&M meetings are multi-professional and representative of those involved in patient care within the specialty, minutes are taken and shared within departmental and divisional clinical governance meetings, and to commit to holding a minimum of quarterly meetings (for some departments it may be appropriate to have more frequent meetings).
- To ensure that "Morbidity and Mortality" is a standing agenda item for departmental clinical governance meetings, i.e. to ensure that SJRs are being completed, that M&M meetings are being held and learning from M&M meetings is reviewed and shared accordingly within the department and to others for whom it may be appropriate (exact details for CG agenda to be decided at departmental level).
- To support department to complete requested SJRs (both mandatory category and random selection) and ensure training in SJR completion for appropriate members of the team.
- To nominate members of the department team to participate in the Mortality Review Programme. It is expected that departments will ensure they have one clinical member of staff available to participate at all times, and that SJR training is undertaken accordingly. The

member of staff taking part will be expected to complete one SJR per week for a 3-month period. More than one 3-month period can be completed if desired/appropriate.
- To participate in clinical audit and themed reviews for alerts raised through internal or external mortality data monitoring.
- To provide minutes of departmental M&M meetings, data regarding SJR completion and relevant mortality data to the Clinical Audit, Effectiveness and Mortality Team and divisional clinical governance meetings. Presentation of learning at divisional clinical governance meetings may be requested.

4.10 Safeguarding Lead

The Safeguarding Lead is responsible for the identification and appropriate review of Learning Disability deaths and ensuring compliance with the National LeDeR programme. (Ref 8).

4.11 Head of Midwifery/Maternity Lead

The Head of Midwifery/Maternity Lead is responsible for ensuring compliance with Perinatal Mortality processes/review programme, as required by Local and National requirements. (Ref 6).

4.12 Paediatrics/Children's and Young People Lead

The Paediatrics/Children's and Young People Lead is responsible for ensuring compliance with Child Death Review processes/review programme, as required by Local and National requirements. (Ref 7).

4.13 Medical Examiner

Medical examiners are senior medical doctors who are independently contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

The role of the Medical Examiner is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- discuss the cause of death with the next of kin/informant and establish if they have questions or any concerns with care before death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contribute to other clinical governance procedures

4.14 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

4.15 Target Audience – As indicated on the Cover Page of this Document

The target audience has the responsibility to ensure their compliance with this document by:

- Ensuring any training required is attended and kept up to date.
- Ensuring any competencies required are maintained.

- Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

5) Process

5.1 Requirements for Compliance with National Guidance on Learning from Deaths Findings

Under the National Guidance on Learning from Deaths, published by the National Quality Board in March 2017, trusts are required to:

- ❖ Publish an updated policy and made available on their website, on how their organisation responds to and learns from deaths of patients, who die under their management and care, including:
  - How their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death
  - Their evidence-based approach to undertaking case record reviews
  - The categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
  - How the trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
  - How staff affected by the deaths of patients will be supported by the trust.

- ❖ Collect specific information every quarter on:
  - The total number of inpatient deaths in an organisation's care
  - the number of deaths the trust has subjected to SJR. (NB: information relating to deaths reviewed using different methodologies e.g. inpatient adult deaths, child deaths, deaths of patient with learning disabilities – may be separated in the report to provide distinction/clarity where required)
  - Of those deaths subject to SJR or investigated otherwise, estimates of how many deaths were more likely than not to be due to problems in care
  - The themes and issues identified from review and investigation, including examples of good practice
  - How the findings from reviews have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

This policy sets out the Trust's approach to meeting these requirements.

5.2 Operational Process

The Operational Process has been designed to ensure that all aspects of the Learning from Deaths (LfD) guidance are fully implemented and is outlined in Appendix C.

- Doctor, qualified nurse or Advanced Clinical Practitioner (ACP) completes diagnosis of death on the ward.
- Nurse present completes notification of death and mortuary checklist.
- Ward Clerk updates deceased status on Electronic Patient Record (EPR).
- Deceased patient level data uploaded to the Trust's Mortality database daily.
- The Trust's Clinical Audit, Effectiveness & Mortality Team (CAEMT) identify mandatory cases for Structured Judgement Review (SJR).
- Mandatory cases for review are disseminated to the relevant speciality Mortality & Morbidity (M&M) Lead, or to a clinician enrolled in the Mortality Review Programme (MRP) for review and completion of SJR proforma.

- Non mandatory cases may also be disseminated to the relevant speciality M&M Lead, or to a clinician enrolled in the Mortality Review Programme (MRP) for review and completion of SJR proforma where cases can be selected for shared learning at local speciality M&M meeting.
- Completed SJR proformas are automatically submitted to the CAEMT using Microsoft Forms.
- Completed SJR's identifying further actions are facilitated where required by the CAEMT. i.e. 2nd speciality SJR, Higher Level Review (HLR) or Datix (if a patient safety concern is identified).
- CAEMT populate speciality M&M dashboards using data extracted from the Trust's Mortality Database.
- Departments arrange their own M&M meetings and review of deaths to inform local learning, including review of SJRs completed by department. Learning is reviewed via departmental clinical governance processes.
- M&M meeting minutes are shared with CAEMT.
- Mortality Data and department M&M outcomes are reviewed by the CAEMT for themes/trends analysis which informs local reporting to the LfD sub-group and the Trust's senior committees. i.e. Patient Quality Subgroup Committee (PQSC).
- Dashboards are shared with the Divisions for reporting and review at the monthly Divisional Governance Quality Meetings, alongside themes identified and reported by specialty M&M meetings. Divisions provide oversight of M&M activity occurring in specialties, ensuring that specialties not engaging as expected are challenged.

5.3 Identifying Deaths for Case Record Review

As per the Learning from Deaths Framework (2017), specific patient groups MUST be subject to mortality review and include the following -

1. Elective Surgery
2. Learning Disabilities – also reviewed as part of the LeDeR process
3. Alerts via external monitoring bodies – i.e. CQC, Telstra Health (previously 'Dr Foster')
4. Family Concerns
5. Incidents
6. Local Safety Initiatives – i.e. in-patient falls
7. Other patient groups identified locally by specialities

Please see Appendix C for inclusion and review process.

Note: there is a separate process for reviews that include stillbirths/maternal/infants' deaths. This is in line with the national framework specifically for these groups of patients. Please contact the Head of Midwifery/Maternity Lead for local information about Perinatal M&M and the Paediatrics/ Children's and Young People Lead for local information about Child Death review processes in the Trust.

5.4 Purpose and Objectives of Departments/Specialty Mortality & Morbidity Meetings

The purpose of the Mortality and Morbidity Meetings is to establish a consistent and robust process to identify learning and improvement opportunities following review of deaths occurring within specialties, and reduce avoidable in-hospital mortality by:

- Systematically reviewing care through a structured analysis of patient records
- Focusing on reducing complications
- Improving patient pathways (reducing variability of care)

- Improving early recognition and escalation of treatment for deteriorating patients
- Learning from problems that contribute to avoidable patient death and harm
- Learning from problems that contribute to poor experiences of patients and the bereaved
- Sharing the learning; promoting best practice and behaviours across the organisation

The Trust will take a collaborative approach when it comes to mortality reviews, for example, by participation with the Allied Academic Health Science Network (AHSN) Collaborative (Southwest).

5.5 Review Methodology

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service prior to their death. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion that anything has gone wrong. It can also be initiated when concerns have already been identified, but in this scenario, SJR should be undertaken alongside the PSIRF, and should **not** be used as an investigative tool, but as a subjective review of the care provided.

Patient Group	Methodology for Case note review in the Trust
Adult inpatient	Structured Judgement Review (Appendix G)
Mental health	Structured Judgement Review (Appendix G)
Child (under 18)	Reviews of these deaths are mandatory and should be undertaken in accordance with *Working together to safeguard children* (2015) (Ref 4) and the current child death overview panel processes.
Learning disability	All trusts should adopt the Learning Disabilities Review programme (LeDeR) (Ref 8) method to review the care of individuals with learning disabilities.
Perinatal and maternity	All perinatal deaths should be reviewed, using the new perinatal mortality review tool (Ref 6). Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly using the Trust's incident reporting processes (Ref 7)

Data from mortality reviews should be collected using an electronic tool which is based on identifying preventable incidents. Please refer to NHS England guidance. Appendix D

5.6 Selecting Deaths for Additional Investigation

Where a review carried out by the Trust under the processes above, identifies patient safety incident(s) that require further investigation, this will be reported as a Datix and managed via the Trust's PSIRF. (Ref 4)

The Structured Judgement Review Tool is designed to review the inpatient care delivered to the patient during the admission and prior to death. It is not designed to answer specific questions that may relate to patient/relative concerns, concerns raised around care, or the cause of any arising incidents.

Concerns arising around care, should be channelled through the Trust's internal routes for appropriate investigation and response, such as the PSIRF.

5.7 Reviewing Outputs from Review and Investigation to Inform Quality Improvement

Discussions and outcomes from M&Ms should be recorded including the conclusions around sub-optimal and/or outstanding care. Associated minutes should be produced for circulation and reporting to the Divisional Board and CAEMT.

5.8 Feedback to the Frontline

Clinical teams must be kept informed of the outcomes of their work if they are to learn and improve. There must be mechanisms in place for M&M discussions and learning to be fed back to employee as well as plans for improvement, lessons learnt and pathway re-design.

Examples of capturing and sharing information can include –

- Department/Divisional Dashboards.
- SWIFT.
- Email Alerts
- Quarterly Learning from Deaths Meetings
- Reports following mortality reviews which are shared at LfD meetings and with relevant working groups

6) Protected Characteristics Provisions

None

7) Consultation

Below is a list of consultees who supported the formulating of this document.

Job title and department	Date approved
Deputy Chief Medical Officer	21/01/2025
Associate Medical Director for Integrated & Community Care	29/01/2025
Mortuary Manager	31/01/2025
Associate Director of Nursing & Patient Safety Specialist	31/01/2025
Legal Services Manager	31/01/2025

8) Monitoring, compliance, and effectiveness of implementation

The arrangements for monitoring compliance are outlined in the table below:

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be taken if gaps are identified
Learning from Death Policy is in date and accessible on the Trust's Website.	Policy to be regularly reviewed at LfD Sub-Group to ensure it is up to date	Learning from Deaths Sub-Group	Annually	Patient Quality Sub-Committee	Escalation to Chief Medical Officer
Establish the total number of inpatient deaths	Data received into the CAEMT will be analysed regularly	CAEMT/ Trust Mortality Lead	Weekly	Weekly dissemination of reporting to Divisional Leads	Escalation to Trust Mortality Lead & Deputy Chief Medical Officer

			Quarterly	Data updates provided for inclusion in the quarterly reports for PQSC and Q&S Committees	Escalation to Chief Medical Officer and PQSC and Q&S Committees
Establish the proportion of deaths identified for mandatory category SJR	Data received into the CAEMT will be analysed regularly	CAEMT/ Trust Mortality Lead	Weekly Quarterly	Weekly dissemination of reporting to Divisional Leads Data updates provided for inclusion in the quarterly reports for PQSC and Q&S Committees	Escalation to Trust Mortality Lead & Deputy Chief Medical Officer Escalation to Chief Medical Officer and PQSC and Q&S Committees
Establish the proportion of deaths subjected to SJR	Data received into the CAEMT will be analysed regularly	CAEMT/ Trust Mortality Lead	Weekly Quarterly	Weekly dissemination of reporting to Divisional Leads Data updates provided for inclusion in the quarterly reports for PQSC and Q&S Committees	Escalation to Trust Mortality Lead & Deputy Chief Medical Officer Escalation to Chief Medical Officer and PQSC and Q&S Committees
Establish the proportion of SJRs where death was felt to have been >50% avoidable	Data received into the CAEMT will be analysed regularly	CAEMT/ Trust Mortality Lead	Monthly Quarterly	Weekly dissemination of reporting to Divisional Leads Data updates provided for inclusion in	Escalation to Trust Mortality Lead & Deputy Chief Medical Officer Escalation to Chief

				the quarterly reports for PQSC and Q&S Committees	Medical Officer and PQSC and Q&S Committees
Establish themes and issues identified from reviews including examples of good practice	Data received into the CAEMT will be analysed regularly	CAEMT/ Trust Mortality Lead	Monthly Quarterly	Monthly reporting at LfD Subgroup Committee Data updates provided for inclusion in the quarterly reports for PQSC and Q&S Committees	Escalation to Trust Mortality Lead & Deputy Chief Medical Officer Escalation to Chief Medical Officer and PQSC and Q&S Committees
Establish where findings from reviews have supported further quality improvement activity and any other actions taken, including progress in implementation.	Data received into the CAEMT will be analysed regularly	CAEMT/ Trust Mortality Lead	Monthly Quarterly	Monthly reporting at LfD Subgroup Committee Data updates provided for inclusion in the quarterly reports for PQSC and Q&S Committees	Escalation to Trust Mortality Lead & Deputy Chief Medical Officer Escalation to Chief Medical Officer and PQSC and Q&S Committees
Learning from Death activity, including adherence to local policy standards, review outcomes and improvements is captured and prepared for reporting in the Annual LfD Report.	LfD activity captured on the LfD workplan objectives/action tracker	CAEMT/ Trust Mortality Lead	Annually	Annual Report prepared for PQSC and Q&S Committees as well as Trust Board	Escalation to Deputy Chief Medical Officer, Chief Medical Officer, PQSC and Q&S Committees

9) Supporting documents

The following is a list of other policies, procedural documents, or guidance documents (internal or external) which employees should refer to for further details:

Ref No.	Document title	Link to document location
1	Learning, Candour and Accountability; A review of the way NHS trusts review and investigate the deaths of patients in England	http://www.cqc.org.uk
2	National Guidance on Learning from Deaths	https://www.england.nhs.uk
3	Duty of Candour Policy	T:\Trust-wide Documents\Incident, Clinical Risk, Duty of Candour, Complaints, Patient ID
4	Patient Safety Incident Response Policy	T:\Trust-wide Documents\Incident, Clinical Risk, Duty of Candour, Complaints, Patient ID
5	Complaints Policy	T:\Trust-wide Documents
6	Perinatal Mortality Review Tool	https://www.npeu.ox.ac.uk
7	Working together to Safeguard Children 2015	https://www.gov.uk
8	Learning Disabilities Review Programme (LeDeR)	http://www.bristol.ac.uk

Appendix A – Quality Impact Assessment Tool

Purpose - To assess the impact of individual policies and procedural documents on the quality of care provided to patients by the Trust both in acute settings and in the community.			
Process -The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives. Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained.			
Monitoring the Level of Risk - The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person. High Risks must be reported to the relevant Executive Lead.			
Impact Assessment Please explain or describe as applicable.			
1.	Consider the impact that your document will have on our ability to deliver high quality care.	The purpose of this document is to provide guidance for healthcare professionals in the process of Mortality Reviews. This in turn will provide opportunities for learning and encourage the drive for improvements and encourage the delivery of high quality care.	
2.	The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care).	Positive Impact. Quality Improvement is expected by the nature of the Structured Judgement Review Process.	
3.	Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall.	No service impact is expected.	
4.	Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is.		Not Applicable
Impact on Clinical Effectiveness & Patient Safety			
5.	Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm.	Positive impact. Implementing this Policy will support health care professionals to continuously review clinical practice and identify areas for improvements. Improving patient outcomes, safety and services delivered.	
Impact on Patient & Carer Experience			
6.	Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment.		As above
Impact on Inequalities			
7.	Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language).		None.

Equality Impact

Great Western Hospitals NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

Appendix B – Guidance on Data Collection and Review

NHS England has provided the following guidance on data collection and review:

Data from mortality reviews should be collected using a bespoke proforma created by the clinical team; ideally this should be electronic. The proforma should be based on identifying preventable incidents and initial assessment should include:

- Demographic details
- Mode of admission
- Initial clinical assessment
- On-going management
- Investigations
- Interventions
- Issues around – Infection, Venous Thrombo Embolism , Hydration and Nutrition
- Recognising deterioration
- Use of critical care services
- End of Life care and the appropriateness of DNAR assessment

Additionally, measurements and standards relating to NICE guidelines and the Royal Colleges should be included in order to focus the review to a specific area, for example;

- Acute medicine
- Stroke
- Fracture Neck of Femur
- End of Life

M&M review meetings should include a review of statistical information concentrating on relevant factors such as:

- Trends highlighted by hospital mortality indicators, for example:
- by speciality
- diagnostic group
- referral source; mortalities within 24-36hours of admission

Patient safety indicators for example: falls, unexpected return to theatres, post op infections

- Include specialist/high risk groups such as:
- Sepsis,
- Pneumonia,
- Stroke,
- Myocardial Infarction,
- Heart Failure,
- Acute Kidney Injury
- Fractured Neck of Femur

Link in relevant mortality data associated with National Audits to identify where needs to be improved, for example care:

- Intensive Care National Audit & Research Centre (ICNARC)
- Trauma Audit and Research Network (TARN)
- National Bowel Cancer
- Myocardial Ischaemia National Audit Project (MINAP)
- Sentinel Stroke National Audit Programme (SSNAP)

Departments/clinical teams should give M&M meetings and governance arrangements equal priority to other Multi-disciplinary Team meetings.

Appendix C – Department Mortality & Morbidity Review Meetings

Department Mortality and Morbidity Review Meetings
Established by Mortality Group
Reports and accountable to the Mortality Group
(Non-Statutory)

Overview

Concerns about patient safety and an increased level of scrutiny of hospital mortality rates have led to a drive for NHS Trusts to review and implement appropriate changes to ensure the delivery of safe, quality care.

In response to this, NHS England published the 'Mortality Governance Guide' in December 2015, which outlines general principles around mortality reviews; it is expected that acute trusts and other health care organisations should incorporate this guidance, aligning Mortality and Morbidity Reviews with their governance systems, in order to measure assurance of the provision of safe, effective care focusing on the systems and processes used in the service.

Purpose and objectives of Departmental/Specialty Mortality & Morbidity Meetings

The purpose of the Mortality Group meetings is to establish a consistent and robust process to identify and reduce all avoidable in-hospital mortality by:

- Systematically reviewing care through a structured analysis of patient records
- Focusing on reducing complications
- Improving patient pathways (reducing variability of care)
- Improving early recognition and escalation of care for deteriorating patients
- Learning from problems that contribute to avoidable patient death and harm
- Sharing the learning; promoting best practice and behaviours across the organisation

Note: this process does not include reviews for stillbirths/maternal/infants deaths. Please refer to the Terms of Reference for Perinatal Mortality and Morbidity which can be found on the Trust's intranet site.

Membership:

Core representation at Department M&M meetings should include:

- All consultants within the speciality
- Junior Doctors
- Senior nursing staff (Speciality specialist nurses, speciality ward and matrons where appropriate)
- Junior Nursing staff
- Key Allied Health Care Professionals – where relevant to department/speciality

Other invitees can include:

- Doctors– where relevant from other specialist groups (e.g. anaesthetics for surgical patients or ITU)
- Clinical Audit
- Clinical Coding
- Representation from the Information Team

Quorum

To be agreed by individual speciality M&M as this will vary depending on the size of each department and grades within each team.

For example, it could be agreed that for X department this will consist of the Speciality M&M Lead and XYZ members (of which, will include at least an agreed minimum number of consultants).

Frequency of Meetings

In general, to discuss deaths soon after they occur, meetings will be held monthly. For specialities with high numbers of deaths, more frequent meetings may be required to ensure a mechanism for good quality discussion and regular learning is in place.

For departments with low death rates, meetings may be held less frequently but they should still be held as they represent an opportunity to discuss morbidity and to learn and improve patient pathways. Meetings that are required less frequently could be incorporated in departmental governance meetings.

For the xxxxxxxx department, the meeting frequency will be xxxxxxxx (e.g. fortnightly, monthly, or quarterly)

Operational Functions:

To work towards the elimination of all avoidable in-hospital mortality.

The responsibility of department/clinical teams' mortality and morbidity reviews should be distributed amongst ALL consultants/senior members in order for them to understand the outcomes of their clinical practice. Each department/speciality should identify a Mortality and Morbidity Lead who will be the department/specialty representative and will be required to attend the monthly Mortality Group meetings.

- To share learning from department Mortality and Morbidity meetings across the wider system.
- To consider mortality data specific to the department in conjunction with case note review and identify areas for investigation and areas for improvement. For the xxxxx department this will include data from yyyyy and zzzz.
- To lead on in depth review where concerns are highlighted; with an identified lead for the review and writing up results
- To learn from reviews; develop ideas and formulate proposals for implementation.
- To develop M&M minutes/reports/dashboard; provide assurance to the Mortality Group / Division / Trust Board on patient mortality
- To ensure that the departmental M+M meeting is aligned with the operational functions of the Mortality Group as listed in the Terms of Reference for that group.

Roles and Duties of Department/ Team M&M Lead

- To support the alignment of department Mortality and Morbidity meetings for the purpose of reducing all avoidable deaths
- To provide senior leadership, support and overview of the Departmental/Team Mortality and Morbidity meetings
- To support the implementation of mortality reduction strategy that aligns hospital systems such as audit, information services and training
- Sign off action plans and methodologies that are designed to reduce Mortality and

Morbidity across the department/speciality
- Sign off regulatory mortality responses
- To report on Mortality performance to the Mortality Group
- To review the effectiveness of the Mortality and Morbidity Meeting annually.

Accountability/Reporting

Discussions and outcomes from the meeting should be recorded including the conclusions around sub-optimal and/or outstanding care. Associated minutes should be produced for circulation to the Divisional Board and Mortality Group.

There should be a standard scale to classify the care delivered for each mortality case reviewed and discussed. The NCEPOD (National Confidential Enquiries into Patient Outcomes and Death) Classification should be used as below:

- Good Practice – The standard you would expect from yourself, your trainees and your institution.
- Room for Improvement – Aspects of Clinical care could have been better.
- Room for Improvement – Aspects of Organisational care could have been better.
- Room for Improvement – Aspects of both Clinical & Organisational care that could have been better.

Less than Satisfactory – Several aspects of clinical and/or Organisational care that were well below what you would accept from yourself, your trainees and your institution.

Feedback to the Frontline

Clinical teams should be kept informed of the outcomes of their work if they are to learn and improve. There should be mechanisms in place for learning to be fed back to staff as well as plans for improvement, lessons learnt and pathway re-design.

Examples of capturing and sharing information can include –

- Department/Divisional Dashboards
- Safety Lesson of the Week
- Email Alerts

Review

These Terms of Reference will be reviewed and updated in conjunction with the scheduled review of this Policy.

Appendix D – Trust Learning from Deaths Group Meetings

Trust Learning from Deaths Group Meetings *Reports and accountable to the Trust board* (Non-Statutory)

Overview

Concerns about patient safety and an increased level of scrutiny of hospital mortality rates have led to a drive for NHS Trusts to review and implement appropriate changes to ensure the delivery of safe, quality care.

In response to this, NHS England published the 'Mortality Governance Guide' in December 2015, which outlines general principles around mortality reviews; it is expected that acute trusts and other health care organisations should incorporate this guidance, aligning Mortality and Morbidity Reviews with their governance systems, in order to measure assurance of the provision of safe, effective care focusing on the systems and processes used in the service.

Purpose and objectives of Mortality Group Meetings

The purpose of the Mortality Group meetings is to establish a consistent and robust process to identify and reduce all avoidable in-hospital mortality by:

- Systematically reviewing care through a structured analysis of patient records
- Focusing on reducing complications
- Improving patient pathways (reducing variability of care)
- Improving early recognition and escalation of care for deteriorating patients
- Learning from problems that contribute to avoidable patient death and harm
- Sharing the learning; promoting best practice and behaviours across the organisation

Note: this process does not include reviews for stillbirths/maternal/infants' deaths. Please refer to the Terms of Reference for Perinatal Mortality and Morbidity which can be found on the GWH intranet site.

Membership:

Core representation at the Trust wide Mortality Group meetings includes:

- Chair – Trust Mortality Lead
- Representation from leads of departments that conduct mortality and morbidity meetings:
    - Acute Medical Unit
    - Gastroenterology
    - Respiratory
    - Cardiology
    - Department of Medicine for the Elderly
    - Diabetes
    - Endoscopy
    - Obstetrics and Gynaecology
    - General Surgery
    - Urology*
    - ENT*
    - Haematology/Oncology
    - Emergency Department
    - Intensive Care Unit
    - Anaesthetics

- Junior Doctor Representative
- Nursing

Representative Other

invitees/specialities

include:

- Pathology
- Paediatrics* – where relevant

- Midwifery* – where relevant
- Palliative Care Medicine and nursing
- Clinical Audit
- Clinical Coding
- Representation from the Information Team

*denotes quarterly attendance or when deaths have occurred as they are rare in these departments.

Quorum

Six members plus the Trust wide Mortality Lead

Five clinical (medical or nursing staff and a governance representative)

Frequency of Meetings

Meetings will normally be held monthly

Reporting and Accountability

The Mortality Group is formally accountable to the Trust Board and reports to the Patient Quality Committee.

Operational Functions:

To work towards the elimination of all avoidable in-hospital mortality.

- To review monthly, the benchmarked mortality rates/trends for the speciality/service/high risk groups (Appendix A)
- To develop M&M minutes/reports/dashboard; to mirror department reporting to provide assurance to the Trust Board on patient mortality.
- To review themes or significant learning arising from departmental Mortality and Morbidity meetings reported by department/team M&M lead/s and to ensure mechanisms are in place to feedback, learn and improve practice from this learning.
- To consider the mortality data in conjunction with analysis of the case note review and identify areas for future investigation.
- To facilitate the use of Clinical Databases, run by various bodies including professional societies for the assessment of in-hospital mortality.
- To investigate any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems (e.g. Dr Foster, HED, etc.).
- To develop data collection systems to ensure the Trusts mortality data is timely robust and in line with national and international best practice.
- To ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of learning and clinical excellence.
- To develop an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
- To assign clinical leads to address increased mortality in particular clinical areas by the deployment of evidence-based interventions such as care bundles. The chair will receive

regular reports on implementation and the measurable impact of these interventions on hospital mortality.

- To review and monitor compliance with other Hospital policies including DNAR and Death Certification Policy through the process of case note review.
- To work with established groups to ensure each junior doctor intake receives the latest guidelines on M&M processes, care protocol implementation and clinical coding best practice.

Strategic Function:

- To act as the strategic hospital mortality overview group with senior leadership, support and overview of the Departmental/Team Mortality and Morbidity meetings
- To produce a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training and clinical divisions. This strategy will be reviewed on an annual basis by the Medical Director. Agree with Divisions and departments action plans that are designed to reduce Mortality and Morbidity across those departments/specialities
- Preparation of regulatory mortality responses for sign off by executive director(s)
- To report on Mortality performance to the Board
- To review the effectiveness of the Mortality Group annually

Feedback to the Frontline

Clinical teams should be kept informed of the outcomes of their work if they are to learn and improve. There should be mechanisms in place for learning to be fed back to staff as well as plans for improvement, lessons learnt and pathway re-design.

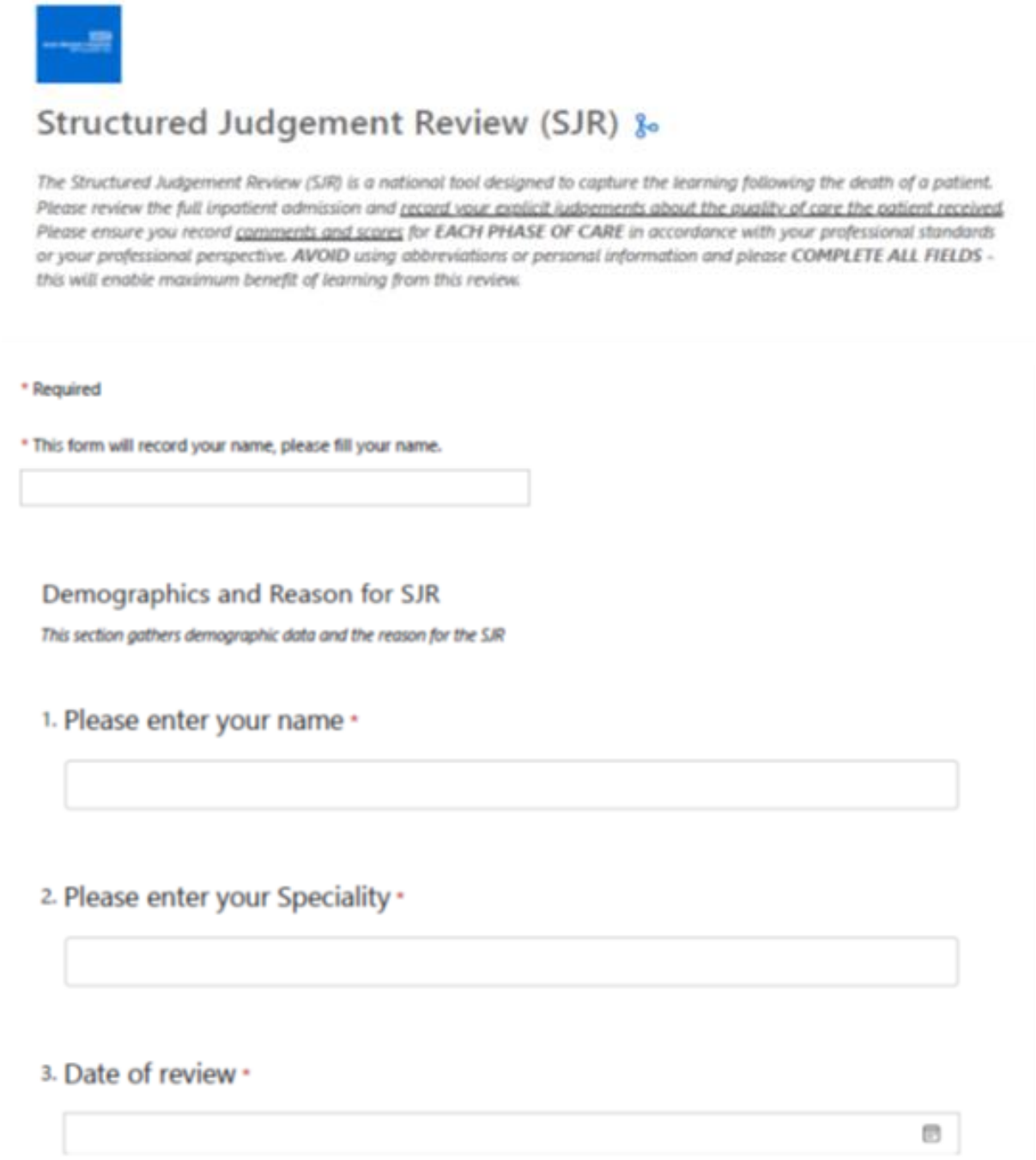
Examples of capturing and sharing information can include –

- Department/Divisional Dashboards
- Safety Lesson of the Week
- Email Alerts

Review

These Terms of Reference will be reviewed and updated in conjunction with the scheduled review of this Policy.

Appendix E – Structured Judgement Review Data Collection Form



Structured Judgement Review (SJR)

The Structured Judgement Review (SJR) is a national tool designed to capture the learning following the death of a patient. Please review the full inpatient admission and record your explicit judgements about the quality of care the patient received. Please ensure you record comments and scores for ***EACH PHASE OF CARE*** *in accordance with your professional standards or your professional perspective.* ***AVOID*** *using abbreviations or personal information and please* ***COMPLETE ALL FIELDS*** *- this will enable maximum benefit of learning from this review.*

* Required

* This form will record your name, please fill your name.

Demographics and Reason for SJR

This section gathers demographic data and the reason for the SJR

1. Please enter your name *

2. Please enter your Speciality *

3. Date of review *

7. **Reason for this SJR?** - What is the reason for completing this SJR. *

As indicated on the specific request from the Clinical Audit, Effectiveness & Mortality Team

- [ ] Mandatory Category - *(Should be reviewed as a priority)*
- [ ] Speciality Review - *(Part of your specialty M&M process)*
- [ ] Mortality Review Programme
- [ ] Trust Mortality Review - *(Part of a wider review)*

4. Please enter the patient's name *

5. Hospital number: *

6. Date of Death *

Structured Judgement Review

Please complete all fields

8. **Brief Case Summary/Synopsis**

Please use your professional judgement to record a concise overview of the events of the ***inpatient stay*** *and any other relevant information (background co-morbidities, significant past medical history etc).*

*

9. **Phase 1 of Care**: Admission and initial management (approx. first 24hrs)

Brief description *

10. Care during Phase 1 was: *

- 1 - Very poor
- 2 - Poor
- 3 - Adequate
- 4 - Good
- 5 - Excellent

11. Was the patient seen by a consultant within 12 hours of admission? *

- Yes
- No
- Unable to tell

12. Was patient death anticipated within 24 hours of admission? *

- Yes
- No
- Unable to tell

13. **Phase 2 of care**: Ongoing care

Brief description *

14. Care during Phase 2 was: *

- ◯ 1 - Very poor
- ◯ 2 - Poor
- ◯ 3 - Adequate
- ◯ 4 - Good
- ◯ 5 - Excellent

15. During admission, did any of the following occur? *

	Yes	No	Unable to tell
Sepsis	◯	◯	◯
Acute kidney injury	◯	◯	◯
Hospital acquired infection (Pneumonia, Covid, C-Diff etc.)	◯	◯	◯
Inappropriate use of non-invasive ventilation	◯	◯	◯
Inpatient fall	◯	◯	◯
Inappropriate ward transfers	◯	◯	◯
Unexpected return to theatre	◯	◯	◯
Signs of deterioration that were not acted upon	◯	◯	◯

16. Did the patient undergo a procedure during this admission? *

- ◯ Yes
- ◯ No

17. **Phase 3 of care:** Care during a procedure

Brief description *

18. Care during Phase 3 was: *

- 1 - Very poor
- 2 - Poor
- 3 - Adequate
- 4 - Good
- 5 - Excellent

19. **Phase 4 of care:** Perioperative care

Brief description *

20. Care during Phase 4 was: *

- 1 - Very poor
- 2 - Poor
- 3 - Adequate
- 4 - Good
- 5 - Excellent

21. **Phase 5 of care:** End of Life care

Brief description *

22. Care during Phase 5 was: *

- ○ 1 - Very poor
- ○ 2 - Poor
- ○ 3 - Adequate
- ○ 4 - Good
- ○ 5 - Excellent

23. During End of Life, were the following best practices in place? *

	Yes	No	Unable to tell
Regular consultant review	○	○	○
A Personalised Care Plan to support the patient's death	○	○	○
RESPECT form completed	○	○	○
Discussions with family/carers regarding deterioration	○	○	○
Evidence that the patient's end of life wishes were followed	○	○	○

24. Were there any problems with the care of the patient? *

- ○ Yes
- ○ No

25. **Problem Types:** Did the problem lead to harm?

Please indicate problems that occurred by ticking if they caused harm, and leaving problems that did not occur blank

	Yes	No	Unable to tell
Assessment, investigation or diagnosis	○	○	○
Medication/ IV fluids/ electrolytes/ oxygen	○	○	○
Treatment and management plan	○	○	○
Infection control management	○	○	○
Operation/invasive procedure	○	○	○
Clinical monitoring	○	○	○
Resuscitation following a cardiac or respiratory arrest	○	○	○
Any other issue	○	○	○

26. **Overall Assessment of Care**

Brief description *

27. Care overall was *

- ○ 1 - Very poor
- ○ 2 - Poor
- ○ 3 - Adequate
- ○ 4 - Good
- ○ 5 - Excellent

28. Was death considered to be over 50% avoidable? *

- ○ Yes
- ○ No

29. Standard of documentation was *

- ○ 1 - Very poor
- ○ 2 - Poor
- ○ 3 - Adequate
- ○ 4 - Good
- ○ 5 - Excellent

30. Order of the case notes was *

- ○ 1 - Very poor
- ○ 2 - Poor
- ○ 3 - Adequate
- ○ 4 - Good
- ○ 5 - Excellent

31. Please provide any additional comments that you feel are relevant to this review

32. Outcome of Structured Judgement Review *

Please select at most 3 options.

- ☐ **No further action/reviews required** - *overall score is 3 or above and no problems in care were identified*
- ☐ **Case to be discussed/presented** - at speciality M&M meeting for shared learning
- ☐ **Further Local Review** - by another speciality - *If this outcome is ticked, please indicate the speciality in the final question.*
- ☐ **Escalation to Higher Level Review** - *overall score is less than 3 or problems in care identified*

33. Specialty to carry out further review if required

34. Were there any problems in care that require an investigation?

If so, an incident should be raised via the Incident Management System (Datix). *

- ◯ Yes
- ◯ No