Bradford Teaching Hospitals
NHS Foundation Trust

Learning from Deaths Policy

Many current BTHFT policy documents contain references to the “Divisions” (Medicine, Surgery, Womens & Newborn) which were in place until 31st March 2019, when they were replaced by Clinical Business Units and Care Groups. Whilst the policies still remain valid, from 1st April 2019 all BTHFT policy should be applied in the context of the new organisational structure and its associated governance. Any queries about the application of the new governance to this policy document should be directed to the Director of Governance and Corporate Affairs.

Document control

Policy reference	*CP90*
Category	*HR/Finance/Clinical etc*
Strategic objective	To be a continually learning organisation

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Executive Lead:	Dr Bryan Gill, Chief Medical Officer
Approval Committee:	Executive Management Team
Ratified by:	Dr Bryan Gill
Date ratified:	16 May 2019
Date issued:	29 May 2019
Review date:	May 2024

Target audience	All clinical staff
Summary	BTHFT is developing a process to learn from all aspects of care. Mortality data and reviews will contribute to this wealth of knowledge, ensuring that any patterns or trends are detected and that where necessary all incidents are reported and investigated so that all learning opportunities are explored. This policy will articulate the governance framework for how this is being implemented in the organisation and also the scope of the work being covered.
Changes since last revision	Reorganisation of the sections Inclusion of the Medical examiner role Amendments to job roles within the role and responsibilities section Amendments to the appendices content to ensure are up to date.
Monitoring arrangements	The Central Mortality team routinely capture mortality data which includes mortality statistical information and qualitative data captured from mortality reviews completed by medical and nurse staff in the trust. These are extrapolated into quarterly reports which are circulated widely in the organisation. A death list is also maintained which captures all deaths in the Trust and this is circulated weekly to mortality leads and relevant staff to inform their specialty mortality and morbidity review processes as well as case selection for review.

	A tracker of all deaths reviewed using the structured judgement review method is maintained. All deaths screened using the Mortality screening tool are also captured centrally.
Training requirements	Formal classroom sessions and bespoke sessions tailored to need and teams
Equality Impact Assessment	This Policy was assessed in March 2019. It has potential impact on Age, disability, Maternity / pregnancy and Race and ethnicity. These will be managed through current governance processes which corporate governance will be responsible for.

Index

1. Introduction

1.1. In recent years increasing concerns about patient safety in the NHS has intensified the need to learn from the care we deliver.

1.2. It is important that Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) utilises a number of mechanisms to give assurance on the quality of patient care provided and to make the most of any learning.

1.3. The review of the care of patients who die under NHS care is paramount to this assurance.

1.4. BTHFT is committed to improving the quality of care delivered and acknowledges that systematic review of patients who die in our care has a crucial part in learning from the care we give.

1.5. BTHFT has an established mortality review process in place. This includes scrutiny of hospital statistics, as well as individual case note reviews.

1.6. Mortality rates within BTHFT are monitored using a number of different metrics, including the national Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) and also the Trust's local death rate.

1.7. Deaths that are subject to Coroner's inquests, serious incident investigations and complaints are subject to an intensive case review and learning identification process.

1.8. Case note reviews provide a wealth of information regards patient care.

1.9. BTHFT is developing a process to learn from all aspects of care. Mortality data and reviews will contribute to this wealth of knowledge, ensuring that any patterns or trends are detected and that where necessary all incidents are reported and investigated so that all learning opportunities are explored.

1.10. Completion of timely and proportionate mortality reviews will enable BTHFT to identify recurring and emerging issues and to be able to respond quickly to any questions raised by external organisations, e.g. CCG, CQC, in relation to mortality trends.

1.11. From April 2019 a new Medical Examiner led system will be introduced in England, with the expectation that it is rolled out within all NHS provider organisations. Options towards the implementation of this non-statutory requirement in BTHFT are being explored.

1.12. As part of BTHFT's legal duty to be open and honest with patients, and following their death, with their families and carers, information for bereaved carers and families has been developed. This will inform them of the Trust's mortality review process and give the opportunity to request a review of the death of their loved ones.

2. Purpose

2.1. The purpose of this policy is to describe the processes and the governance associated with BTHFT's learning from mortality programme. BTHFT will learn from deaths that occur in line with the National Guidance on Learning from Deaths (see reference 1 in section 14).

2.2. The policy describes how BTHFT will provide a consistent and coordinated approach to undertaking mortality reviews, reporting on findings, and implementation of identified actions. It will also clarify how the process for mortality review dovetails with other investigation processes within BTHFT, to facilitate a streamlined and coordinated interface with incident, complaint, inquest and claims investigations, where applicable.

2.3. The policy describes how BTHFT will respond to and learn from bereaved relatives and carers.

2.4. The policy describes how BHTFT will interact with external organisations and how BHTFT will comply with the national mandated mortality review processes.

2.5. The policy recognises that this is an iterative process and will need to be reviewed as learning is highlighted from what we do, as clinical care changes and as national directives change.

3. Scope

3.1. This policy applies to all patients and their bereaved relatives and carers who are under the care of BTHFT and die whilst being cared for in hospital.

3.2. Further national work is being undertaken to explore how to develop processes for the review of mortality up to 30 days post discharge. At present these patients are not within the scope of this policy.

3.3. Paediatric and maternity patients and those with a learning disability are subject to national review processes which are referred to in this policy and are subject to nationally mandated mortality review and learning processes.

3.4. The policy applies to all Staff in BTHFT.

4. Definitions/Glossary

4.1. Mortality Review – refers to the standard case note review triggered only by the death of a patient and will use Structured Judgement Review (SJR) methodology.

4.2. Hospital Investigation – refers to a process often triggered by an adverse event or outside request e.g. Coroner, CQC and involves an in depth exploration of all the facts. It may involve SJR of the clinical notes.

4.3. HSMR - Hospital Standardised Mortality Ratio is a ratio of the number of in-hospital deaths to the number of "expected" deaths (which is calculated according to factors such as age band, sex, co-morbidities etc) calculated for 56 specific clinical classification groups.

4.4. SHMI - Summary Hospital-level Mortality Indicator is published quarterly by the Department of Health. It is calculated in a similar way to HSMR, but includes deaths in all clinical classifications, and also deaths occurring up to 30 days after discharge.

4.5. SJR - Structured Judgement Review; this is the ratified methodology presently used to perform the mortality reviews.

4.6. HED - Hospital Episode Data, the commercial database/software application used by BTHFT.

4.7. MBRRACE-UK - Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK.

4.8. CDOP - Child Death Overview Panel.

4.9. LeDeR – Learning Disabilities Mortality Review Programme

5. Roles and Responsibilities

5.1. BTHFT Board

5.1.1. Through the Chief Medical Officer, the Board is responsible for learning from mortality at BTHFT.

5.1.2. BTHFT has a named Non-Executive Director to oversee the approach to learning from deaths. This is the chair of the Quality Committee.

5.1.3. The Board is responsible for ensuring a quarterly report is published containing the Trust's mortality figures and the emergent themes and learning from SJRs conducted in the given period.

5.1.4. Understand the review process: ensure the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.

5.2. Non-Executive Director

5.2.1. Understand the review process: ensure the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.

5.2.2. Champion quality improvement that leads to actions that improve patient safety.

5.2.3. Assure published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.

5.3. Associate Chief Medical Officer for Mortality (ACMO Mortality)

5.3.1. Operational responsibility for the learning from deaths programme, including reporting its findings and generating information for learning.

5.4. Quality Committee

5.4.1. Will seek assurance that all mortality at BTHFT is reliably reviewed, monitored and reported. Receive reports from the Mortality Sub-Committee and report to the Board of Directors.

5.5. Mortality Sub-Committee

5.5.1. Will seek assurance that mortality is reliably reviewed, monitored and reported. That all information is disseminated to all relevant staff and patient groups. That all learning is collated and recommendations on actions are made where applicable.

5.6. Mortality Review Improvement Group

5.6.1. Has responsibility to implement, monitor and improve the mortality review process in line with the national directives whilst also contributing to the regional and national mortality review programmes.

5.7. HED (mortality data) Reporting Group

5.7.1. Will review the hospital mortality data monthly, via the HED informatics system. It will monitor specifically the HSMR and SHMI data, looking for changes and trends in mortality in all diagnostic groups. In areas of high mortality, internal investigations or observation regimes will be instigated. A quarterly Mortality Dashboard will be produced and disseminated.

5.8. The Central Mortality Team

5.8.1. Working alongside the ACMO Mortality, co-ordinate the mortality review process, maintaining an up-to-date spreadsheet of reviewers and cases. They will review and analyse the results of mortality reviews, producing a quarterly Mortality Outcomes Report displaying an overview of the data. They are responsible for escalating cases to the Quality Governance team, where appropriate.

5.8.2. Will review national benchmarking tools such as HSMR and SHMI, provided by HED and collate this information into a quarterly Mortality Dashboard. The ACMO Mortality will initiate a co-ordinated review in to any areas of concern.

5.8.3. Any cases where there are concerns identified through individual reviews will be escalated through the Quality Governance team.

Where concerns are identified from sources of mortality data, this will be escalated through the appropriate channels.

5.9. The Clinical Coding Team

5.9.1. Will ensure that the patient's care is coded appropriately.

5.10. Clinical Directors, Associate Directors of Nursing and Heads of Nursing

5.10.1. Will ensure and give assurance that the processes in this policy are implemented reliably in their respective clinical business units. Specifically, that mortality reviews are done using structured judgement methodology and that mortality statistics and the output from mortality reviews are discussed and learning is acted upon.

5.11. Mortality Reviewers

Will be identified individuals for most specialities. They will have the responsibility to ensure they are trained to perform SJRs and attend mortality review update sessions. They will identify the relevant deaths to be reviewed and ensure these reviews are performed in the expected time frame. They will report and escalate the reviews once completed, in line with the process described.

5.12. All Medical Staff

5.12.1. Will have a responsibility to ensure all mortality reviews are done for the relevant patients in their care, that the learning from the reviews is collated and acted upon to improve the quality of care.

5.13. All Nursing Staff

5.13.1. Will have a responsibility to contribute towards the mortality reviews, understand the mortality data and contribute to any quality improvement projects.

5.14. Informatics

5.14.1. Will have a responsibility to collate mortality data, help managers and clinicians understand the data and to help conduct investigations where applicable.

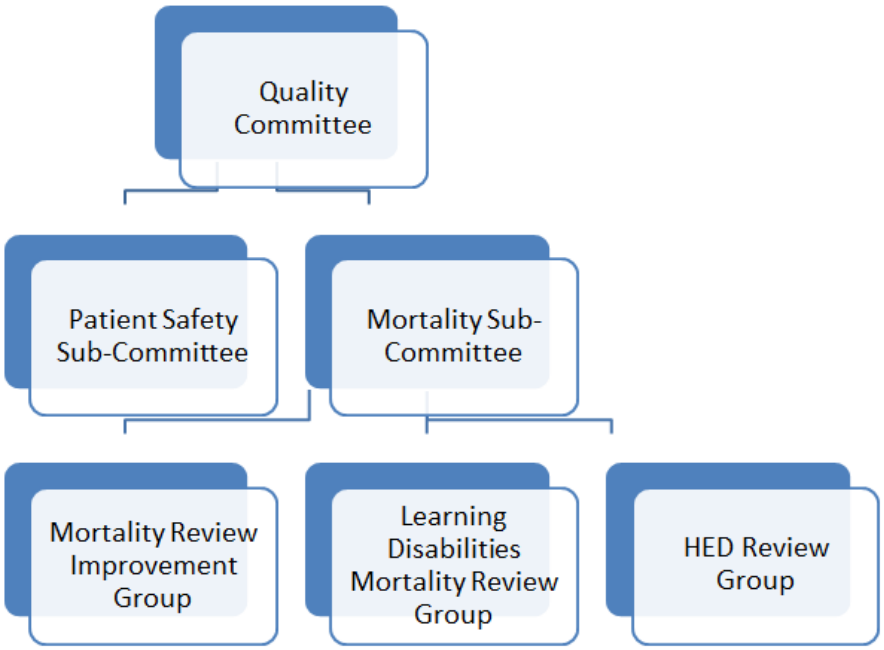
5.15. The Quality Governance team

5.15.1. Are responsible for considering for investigation those cases which have been escalated by the Central Mortality Team where care has been deemed to be below an acceptable standard.

6. Mortality Governance

6.1. Governance Structure

6.1.1. The BTFHT mortality review governance structure is displayed in the below diagram.



6.2. Mortality Sub- Committee

6.2.1. This group has oversight of mortality across BTHFT. Receives updates from mortality reviews including learning from Coroner's reports, serious incidents and 'other' risk incidents, mortality related national audits, CDOP, MBRRACE, as well as overseeing the learning from deaths programme. It provides assurance to the Quality Committee and is chaired by the ACMO Mortality. The meeting is held bi-monthly.

6.2.2. The Mortality Sub-Committee is the initial conduit for learning from mortality. Representation is made from across the clinical business units and other corporate departments which can contribute to and learn from mortality, such departments include:

6.2.2.1. Bereavement
6.2.2.2. Palliative Care
6.2.2.3. Quality Governance (as required)
6.2.2.4. Clinical Coding
6.2.2.5. Quality / Service Improvement

6.3. The Mortality Sub-Committee submits a quarterly report to the Quality Committee reporting on BTHFT's learning from deaths programme.

6.4. The Mortality Sub-Committee has a standing agenda which is intended to help BTHFT learn from mortality information from all sources:

6.4.1. HED Mortality Dashboard
6.4.2. Mortality Outcomes report
6.4.3. Learning from Coronial investigations, Claims and Serious incidents
6.4.4. Mortality review improvement work
6.4.5. Learning Disability reviews
6.4.6. National guidance on learning from deaths
6.4.7. LeDeR – Learning Disability Mortality Review programme (district wide position)
6.4.8. Regional / national mortality programmes
6.4.9. Items to escalate to the Learning and Surveillance Hub
6.4.10. Specialty update from paediatrics
6.4.11. Specialty update from maternity.

6.5. Mortality Review Improvement Group

6.5.1. Membership includes and is open to all specialty mortality leads, staff trained in the structured judgement case note review method and any others involved in mortality review or have an interest in it. This meeting is held monthly and chaired by the ACMO Mortality. Members also support the 'second reviewer' process when triggered.

6.6. HED Review group

6.6.1. This group meets monthly to undertake mortality surveillance using the HED online system. This proactive approach to mortality monitoring is an essential part of assuring high quality clinical care and is currently managed by the Central Mortality Team.

6.7. Learning Disability Mortality Review group

6.7.1. This group has responsibility for reviewing all Learning Disability patient deaths at BTHFT. Cases reviewed will also include mental health cases as identified by Bradford District Care Foundation Trust colleagues or through our internal processes.

7. Bereaved, Families and Carers

7.1. BTHFT has a bereavement policy which will outline how carers and the bereaved will be informed and consulted in a meaningful and compassionate manner.

7.2. In summary:

7.2.1. Carers and family will be given the opportunity and encouraged to raise concerns or comment either directly with the consultant or

nursing staff in charge, the bereavement office or through the complaints process, on the care their loved one received in the hospital.

7.2.2. When there is a hospital investigation into a death, the relatives/carers will be informed, asked for comment and will be involved if they wish to be.

7.2.3. When a SJR is being done as part of our routine mortality review process, the relatives/carers will not necessarily be informed.

7.2.4. All bereaved relatives/carers receive a letter within the bereavement pack which informs them of the possibility that their relative may be subject to a routine SJR. They are also invited to request a review if they feel there were problems in care.

8. Mortality Review

8.1. Mortality Review Process

8.1.1. When a patient dies whilst an inpatient of BTHFT, their care will be eligible for review using our mortality review process.

8.1.2. The established BTFHT mortality review process is described in appendix 2.

8.1.3. Not all patients who die in hospital will have their care reviewed. Reviewing large numbers of case notes is often not possible nor does evidence support that it increases the opportunities for learning.

8.1.4. Patients who die in hospital must have their care reviewed if they fall in to the following criteria:

8.1.4.1. All deaths where carers/relatives or staff have raised concerns about the quality of care;

8.1.4.2. All patients with learning disabilities;

8.1.4.3. All patients who were not expected to die or were elective admissions to hospital;

8.1.4.4. All patients in diagnosis groups where ‘alerts’ have been raised (for example by the CQC);

8.1.4.5. All patients where quality improvement programmes are in place and mortality reviews are deemed essential to learning;

8.1.4.6. All patients where severe mental illness has been identified;

8.1.4.7. All deaths in specialties with small numbers of deaths per annum (<100).

8.1.5. A screening tool is used to identify cases for review. The tool is completed during the death certification process and managed by the Central Mortality Team.

8.2. Structured Judgement Review

8.2.1. BTHFT will use Structured Judgement Review (SJR) methodology for the mortality review process. This is a nationally recognised methodology known to provide good quality information regards health care.

8.2.2. The SJR case note review method enables a reviewer to examine and evaluate care. The review method combines structured reviewer comments with quality of care scores to assess the care of people who die in hospital.

8.2.3. The SJR method encourages reviewers to identify and celebrate good care as well as poor care and facilitates the identification of actions for improvement and suggests lessons that may be learned.

8.2.4. It is different from the traditional case note review approach as the process encourages the reviewer to rationalise their clinical assessment / judgement of the care received by the patient by using positive and / or negative commentary to describe the quality and standard of care received.

8.2.5. The safety and quality information that arises from this method provides a rich source of learning and will be used for governance purposes (including duty of candour issues) and for quality improvement initiatives.

8.2.6. Regular Structured Judgement Review training will be available for all mortality reviewers. Update training for existing reviewers will be available.

8.3. Collaboration with Other Organisations

8.3.1. Many of our patients will be cared for or involved with other organisations (for example nursing homes and Bradford District Care Foundation Trust). Where necessary or when requested to, we will review the care of patients who came through our organisation but did not die. We will use the same governance process and mortality review methodology as for our inpatients.

8.3.2. As required, we will work closely with other organisations to develop processes for sharing learning from mortality.

8.3.3. For certain categories collaboration with other organisations is mandated, this includes maternal and paediatric deaths.

8.4. Medical Examiner

8.4.1. The Department of Health announced that a national system of Medical Examiners is to be introduced from April 2019. Medical Examiners will have a separate professional line of accountability, allowing for access to information in the sensitive and urgent timescales surrounding death registration – but with independence necessary for the credibility of the scrutiny process. This independence will be overseen by a National Medical Examiner, providing leadership to the system.

8.4.2. BHTFT is working towards introducing the Medical Examiner role.

8.5. Working with Priority Areas

8.5.1. Learning Disabilities

8.5.2. All patients with learning disabilities who die at BTHFT will undergo a mortality review (process described in appendix 3).

8.5.3. All learning disabilities deaths will be reported to the national LeDeR (Learning Disabilities Mortality Review) programme.

8.5.4. BTHFT has an established process to contribute to the mortality reviews in the LeDeR programme.

8.5.5. Through the mortality governance process BTHFT will receive and review the LeDeR programme reports when produced and implement relevant recommendations.

8.5.6. Severe Mental illness

8.5.6.1. Patients with severe mental illness who die at BTHFT will have their care reviewed as per our SJR process.

8.5.7. Paediatric deaths

8.5.7.1. Children who die at BTHFT will have their care reviewed as directed in the national programme for child mortality review.

8.5.7.2. BTHFT will continue to comply with the Child Death Overview Panel (CDOP) process but is aware that the national programme and recommendations are being reviewed.

8.5.7.3. BTHFT will receive and review the national reports related to paediatric deaths, learning will be disseminated through the relevant clinical business units channels and the relevant changes implemented.

8.5.8. Stillbirth and neonatal deaths

8.5.8.1. BTHFT review all perinatal deaths and will be adopting the MBRRACE-UK mortality review tool once it is made available. In

addition there are perinatal multidisciplinary team mortality (and morbidity) meetings held monthly with an annual summary.

8.5.8.2. All deaths are submitted to MBRRACE-UK contributing to a report containing national comparison.

8.5.9. **Maternal deaths**

8.5.9.1. Patients who die whilst pregnant or within one year of delivery will be subject to the nationally mandated maternal mortality review, MBRRACE-UK, which BTHFT complies with.

8.5.9.2. The MBRRACE-UK reports will be received and reviewed, learning will be disseminated through the relevant clinical business units channels and relevant changes implemented.

9. Capturing the learning from mortality

9.1. The requirements set out in the national guidance require that we publish information specifically on:

9.1.1. Number of deaths in BTHFT care
9.1.2. Number of deaths subject to case record review
9.1.3. Number of deaths investigated under the Serious Incident framework
9.1.4. Number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
9.1.5. Themes and issues identified from review and investigation (including examples of good practice)

9.2. BTHFT will comply with all the requirements of the Coroner's office in terms of death certification, notification to the Coroner's office and coronial investigations where applicable.

9.3. BTHFT will comply with the national requirement to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings (including information on reviews of the care provided to those with severe mental health needs or learning disabilities).

9.4. As per the national guidance, BTHFT will not use the term "avoidable mortality."

9.5. The Central Mortality Team produce two quarterly reports which are distributed widely throughout the Trust:

9.5.1. **Mortality Dashboard** produced using Healthcare Evaluation Data and providing an overview of mortality indicator figures and BTHFT performance against these at Trust level, as well as against a select number of diagnostic groups as recommended by NHS England guidance. Also includes updates on internal and external mortality alerts.

9.5.2. **Mortality Outcomes Report** provides an overview of the quality of care scores and structured judgement commentary collated from all the case note reviews submitted to the Central Mortality Team. It presents a summary of emerging themes and identifies key learning and areas for improvement.

9.6. There is an expectation that individual specialties will discuss and disseminate these reports, along with their own SJRs and ensure that any learning points are acted on appropriately.

9.6.1. These reports will also feed in to the Learning Hub (see appendix 4) and the Clinical Audit and Effectiveness Sub-Committee.

10. Duty of Candour which includes the Being Open Framework

10.1.1. There are implications associated with the Being Open framework in relation to this policy.

10.1.2. Where it is established during mortality reviews that problems in care identified contributed to moderate or severe harm to a patient whilst in hospital, it would be expected that the Duty of candour process will be triggered.

10.1.3. These cases will be reported on Datix and the Risk management team will also be notified. Depending on the level of harm assigned due process will be followed.

11. Impact Assessments for this policy

11.1. Financial Impact Assessment

11.1.1. There are no financial impacts associated with this policy. This will be reviewed at the next review date.

11.2. Privacy Impact Assessment

11.2.1. The Privacy Impact Screening Tool was completed for this policy and no privacy implications were identified

11.3. Equality Implications/Impact assessment

11.3.1. This Policy was assessed in March 2019 to determine whether there is a possible impact on any of the nine protected characteristics as defined in the Equality Act 2010. It has potential impact on:

- Age - There are different processes to be followed for patients aged up to 18 years
- Disability - There are specific processes to be followed for reporting on patients with learning difficulties and mental health issues. Adjustments would need to be made to ensure that

deaf people, blind people and those with learning difficulties are able to understand.

- Maternity/pregnancy - There is a specific process to be followed for women who die within the first year following delivery.
- Race and ethnicity - Adjustments to be made to ensure that people unable to communicate in English, understand the process.

11.3.2. It has been found not to have no impact on:

- Gender
- Gender reassignment
- Marriage and civil partnership
- Religion and belief
- Sexual orientation

11.3.3. It has also been assessed to determine whether it impacts on human rights against the FREDA principles (Fairness, Respect, Equality, Dignity, Autonomy) and it is considered that it has a positive impact. This assessment will be reviewed when the policy is next updated or sooner if evidence of further impact emerges.

12. Policy Review

12.1. This policy will be reviewed in 3 years to ensure it is relevant and responsive to changing clinical practice.

13. Links to Other Policies

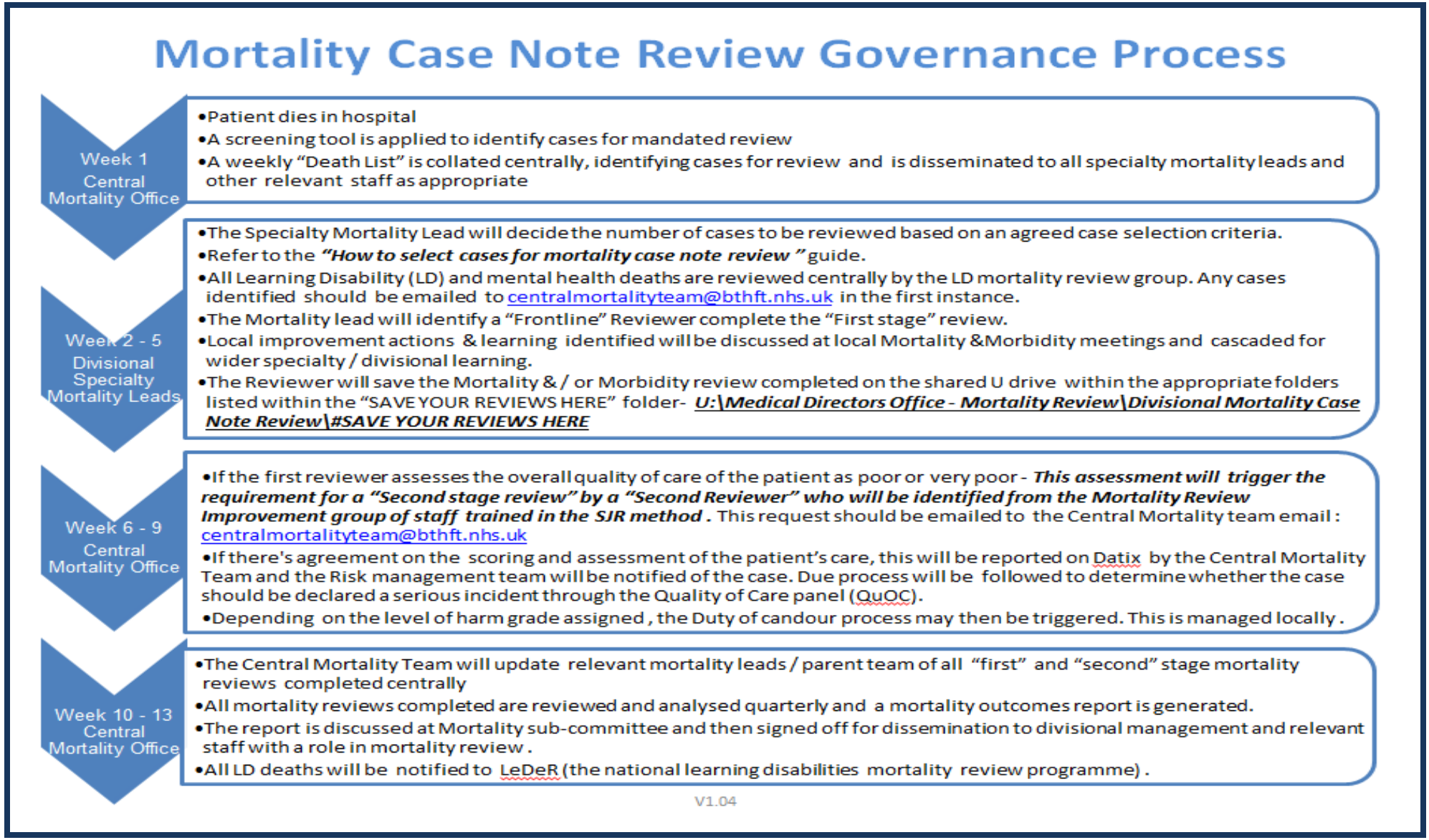
13.1. Bereavement Policy.
13.2. Risk Incident Reporting and Investigation Policy.
13.3. Serious Incident and Never Event Policy.

14. References

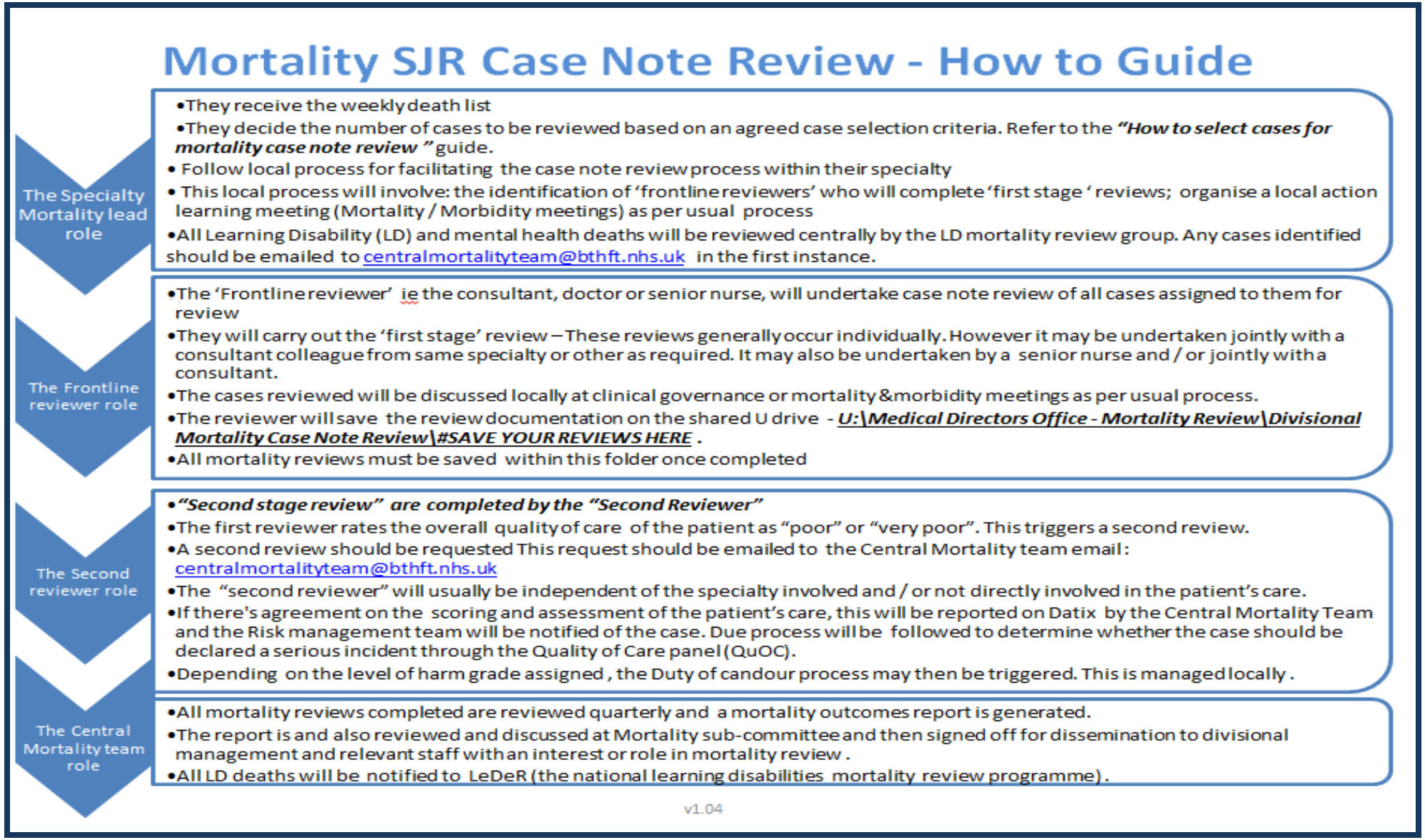
14.1. National Guidance on Learning from Deaths: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

14.2. Serious Incident Frame work:
https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf

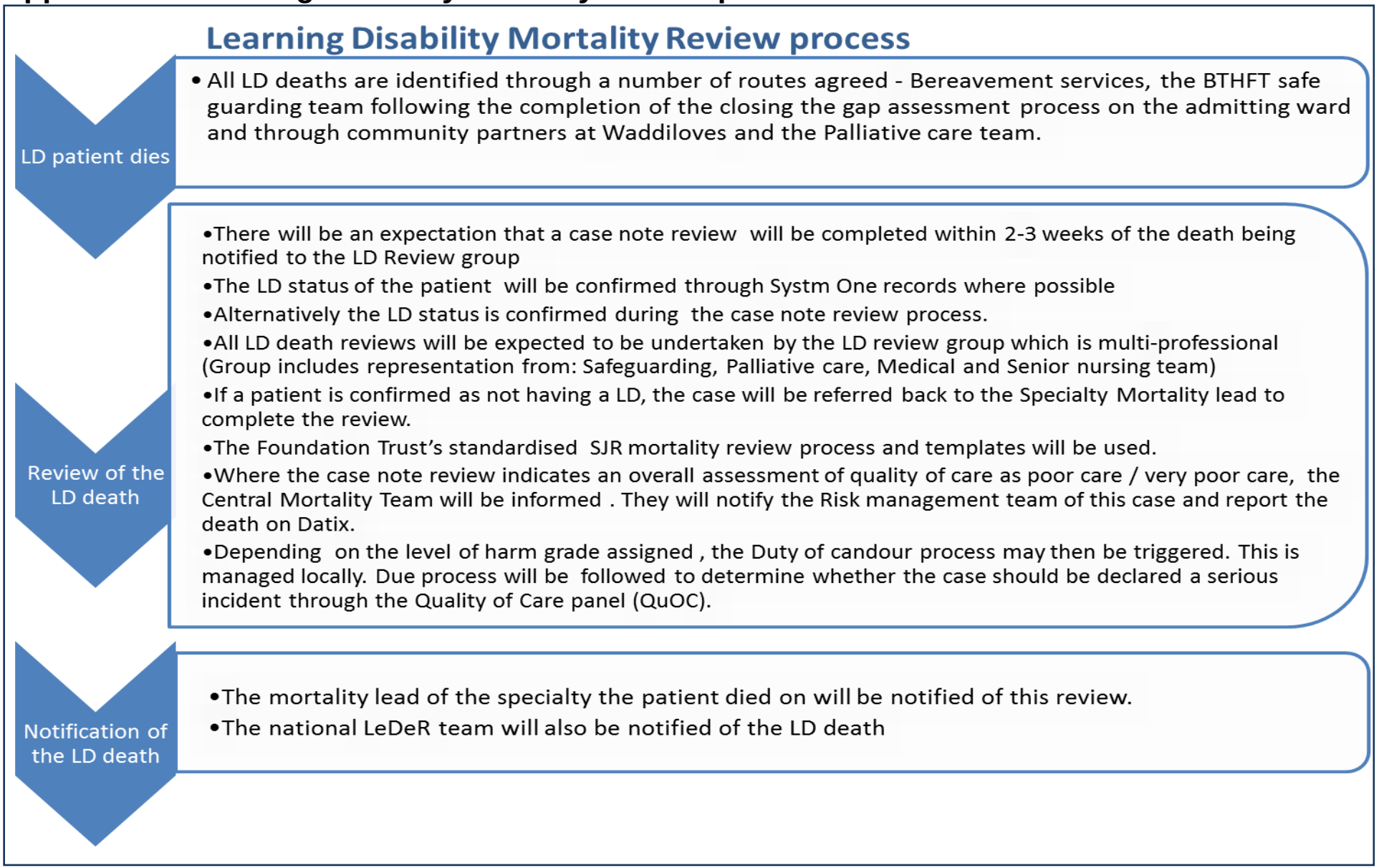
Appendix 1: Mortality Case Note Review Governance Process



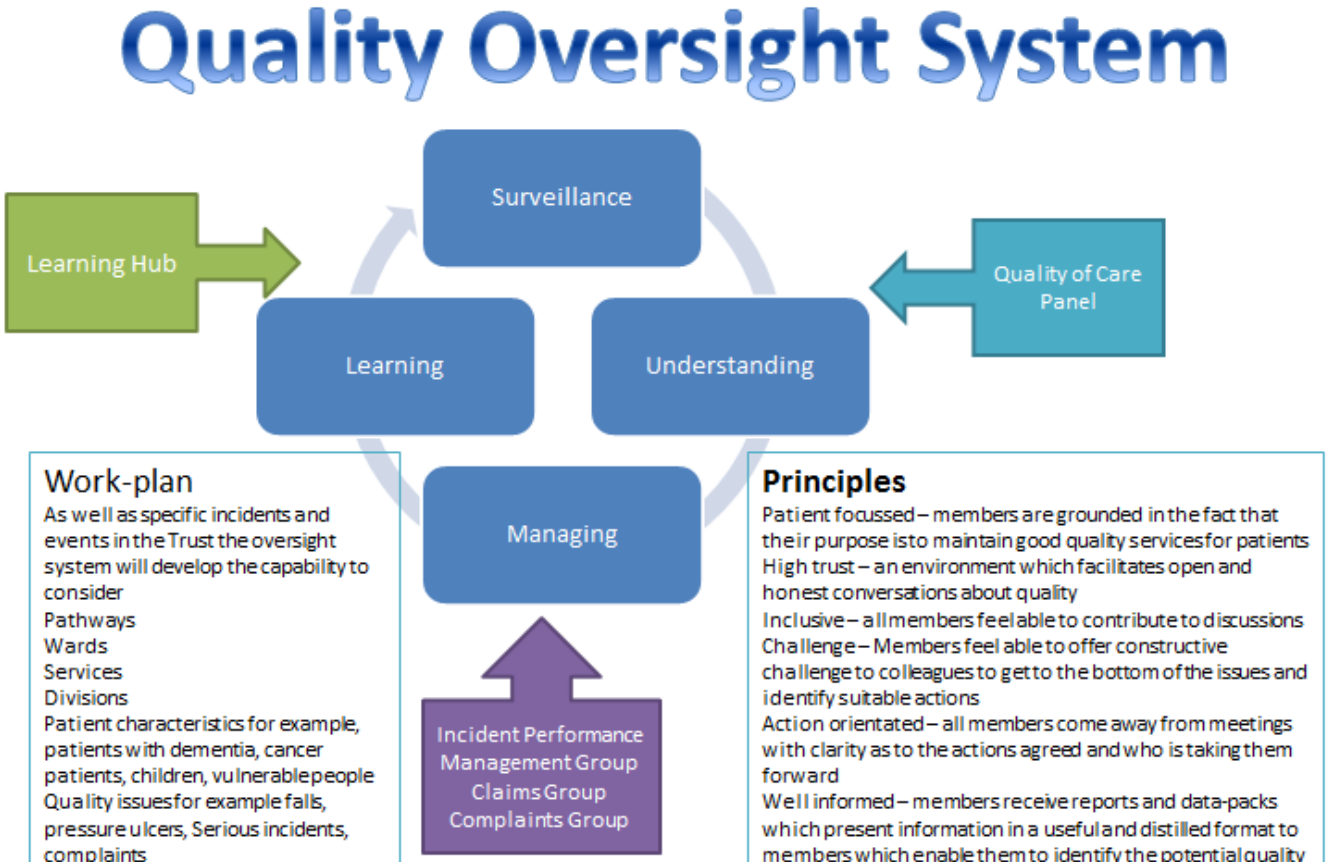
Appendix 2: How to Guide - Mortality Review process



Appendix 3: Learning Disability Mortality Review process



Appendix 4: Quality Oversight and Response System



Quality of Care Panel: Surveillance and Understanding

Purpose

To ensure an executive leadership clear line of sight through the care provision and operational activities of the Trust, to ensure any past, present or future potential or actual unmitigated risk to the quality of our services has been captured, is understood and is being acted on and learnt from appropriately

Information sources

Serious Incident referral forms
Serious incident exception reports
Serious Incident investigation reports
Soft intelligence (internal/external)
Quality /Performance dashboard data
NPSAS alerts

Agenda focus

Review previous weeks harm, safety, risk
Take a 'temperature check' of current Trust position
'Horizon scan for anticipated risk/safety issues/pressure points in the Trust

Mechanism

Weekly quality focused decision making and discussion panel attended by executive and senior clinical and managerial leadership

Membership

Medical Director*
Director of Governance and Corporate Affairs*
Chief Nurse*
Deputy Medical Director
Associate Director of Quality
Deputy Chief Nurse
Assistant Director of Quality Governance
* One of these executive directors should be present at each meeting

Outputs

Understanding of past harm: decisions associated with the declaration of Serious Incidents and the outcome of incident investigations
Understanding of latent risk: decisions associated with national alert compliance or exceptions escalated from Serious Incident/complaint investigation
Surveillance and decisions associated with the Trust's current position and defined actions associated with management of risk to quality
Surveillance and decisions associated with the Trust's current position and defined actions associated with management of risk to quality

Incident Performance Management Group: Surveillance and Managing

Purpose

To review all incidents where a patient has died or there has been severe harm to ensure that the threshold for declaring a Serious Incident has not been reached and make recommendations as appropriate
To monitor the conduct and progress of all Serious Incident and Internal Investigations and escalate any concerns to the Quality of Care Panel (QuOC)
to review the content and quality of Duty of Candour disclosures following investigation of notifiable incidents and make recommendations where appropriate
To develop a work plan to ensure that thematic learning from incidents is identified and escalated/shared as appropriate with the QuOC or the Learning and Surveillance Hub

Information sources

Incident Reports (including RIDDOR)
Coronial referrals
Serious Incident/Internal Investigation Database

Agenda focus

Review previous harm, safety, risk through discussion
Review current position and any changing risk/issues with conduct
Engage with workplan

Mechanism

Weekly discussion, forum where those with the operational responsibility for the management of incidents are able to highlight concerns and identify best practice

Membership

Assistant Director for Quality Governance*
Associate Medical Director*
Risk Management team
Divisional representatives (quality leadership role)
Assurance and Regulation Manager
Datix Manager
Risk Management Secretary
* One of these senior representatives should be present at each meeting

Outputs

Escalation of incidents and their sequelae to QuOC Panel
A consistent approach to the management of Serious Incidents and internal investigations
A consistent approach to the review of Duty of Candour disclosures
To provide intelligence to the Learning and Surveillance Hub

Learning Hub: Knowledge sharing and Learning

Purpose

To act as a virtual team across the Foundation Trust, bringing together all Divisions and Corporate Departments and their respective information and intelligence, gathered through performance monitoring, and regulatory activities.

All members should feel ownership and responsibility for the effective operation of the group. By collectively considering and triangulating information and intelligence, members will work to safeguard the quality of care that people receive though learning and translation into practice activities

Members should be seen as a network of partners who work together and share information in the interests of patients and service users. This should not be confined to formal meetings. The Learning Hub can act as a virtual network in between meetings, with members interacting with each other in smaller groups where appropriate.

Information sources

Any information deemed relevant to the purpose of the group by its members including

Serious incident reports and action plans
Datix reports
Complaints
Claims
PALs
External reports
ProgrESS reports
Leadership Walk arounds
Quality Dashboards
Ward accreditation

Mechanism

Monthly challenge and translation forum where those with the operational responsibility for informal and formal learning are able to challenge progress and identify best practice in formal and informal learning

Membership

Assistant Director for Governance and Risk*
Divisional and corporate directorate representation with operational management responsibility for learning and translation in their area of work
Members of the Quality Governance Team
Members of the QI and Transformation Team

Agenda focus

Are we learning?
How are we learning?
How do we know that we are?
What more can we do?

Outputs

Supporting the development of learning strategies for across the Trust
Escalation of issues for immediate attention to the Quality of Care Panel
Actions / investigations by individual members;
Triggering a ProgRESS review – where further evidence/assurance of learning is required
Identification of good practice in formal and informal learning
Supporting assurance in relation to the effectiveness of action planning
Supporting prioritisation within the Quality Improvement Programme