Learning from deaths in hospices

Big Conversation
Wednesday 30th April 2025

HospiceUK

Our Big Conversation events are supported by:

MDDUS
Protecting professionals

Welcome and introductions

Anita Hayes, Clinical Quality Lead
Hospice UK

HospiceUK

Housekeeping

Please keep your mic muted unless you are asking a question

Please note that the presentations (excluding the Q&A) are being recorded.

The recording and slides will be shared with you after the event, and we'll notify you by email

Please use the Chat function to ask any questions

AI bots are not permitted in these meetings and will be removed

Agenda

11:00	Welcome and introductions	**Anita Hayes**, Clinical Quality Lead Hospice UK
11:05	Background	**Dr Samantha Edward,** Consultant Palliative Medicine & Medical Director North London Hospice
11:10	Implementing Structured Judgement Reviews (SJRs)	**Dr Grace Duffy**, Senior Registrar, Yorkshire and Humber Improvement Academy.
11:30	Learning from Deaths at St Gemma's Hospice	**Dr Mike Stockton**, Chief Medical Officer & Consultant in Palliative Medicine, who has led this work at St Gemma's Hospice
11:50	"Giving a voice to the bereaved": Medical Examiner Services	**Dr. Ben Lobo**, Consultant Geriatrician, End of Life Care and Medical Examiner Sherwood Forest Hospitals NHS Foundation Trust and Regional Medical Examiner (Midlands)
12:10	Turning data into improvement: National Audit of Care at the End of life (NACEL)	**Dr Mary Miller**, NACEL Clinical
12:20	Questions & discussion	All
12:30	Close	**Anita Hayes**, Clinical Quality Lead Hospice UK

Background

Dr Samantha Edward, Consultant Palliative Medicine & Medical Director
North London Hospice

HospiceUK

How to learn from structured judgement reviews in palliative care settings

Dr Grace Duffy
Palliative Medicine SpR and Clinical Fellow
30th April 2025

Contents

- What are structured judgement reviews?
- How can they be used to learn from deaths?
- What support is available when implementing SJRs?

Request from local hospice..

- How can we learn from deaths?

Structured Judgement Reviews

Overall care (**1.** Very poor care **2.** Poor care **3.** Adequate care, **4.** Good care, **5.** Excellent care)	**4**	Overall, Anna received good care. She was reviewed in a timely manner by the Community Palliative Care service who identified risk of further seizures and implemented a clear plan in case of this. There was good communication between the Community Palliative Care team, GP and District Nursing teams. Symptom control was prompt and appropriate. The family were well-supported throughout, allowing Anna to remain at home for end-of-life care.

- Standardised case note review methodology
  - Phases of care
  - Quality of care scores
  - Explicit judgement statements

Problems

- Help to identify risks to patient safety and identify themes

Problems in Healthcare

Problem **Were there any issues with:**	**Comment**	**Did the problem (s) lead to harm?** **Y/N**
The initial assessment, investigation or diagnosis? If so, please explain.		
Medicines management? If so, please explain.		
Treatment and management (including symptom control)? If so, please explain.		

Benefits and limitations of SJRs

Standardised

Quantitative and qualitative data- identifying themes

Good care is as important as poor care

Holistic

Versatile

Cost

Inter-rater variability

Other processes available

How do we learn from SJRs?

How we don’t learn from SJRs…

How do we learn from SJRs?

Phase of care scores

- Which phases go well?
- Which phases may need improvement?

Explicit judgement comments

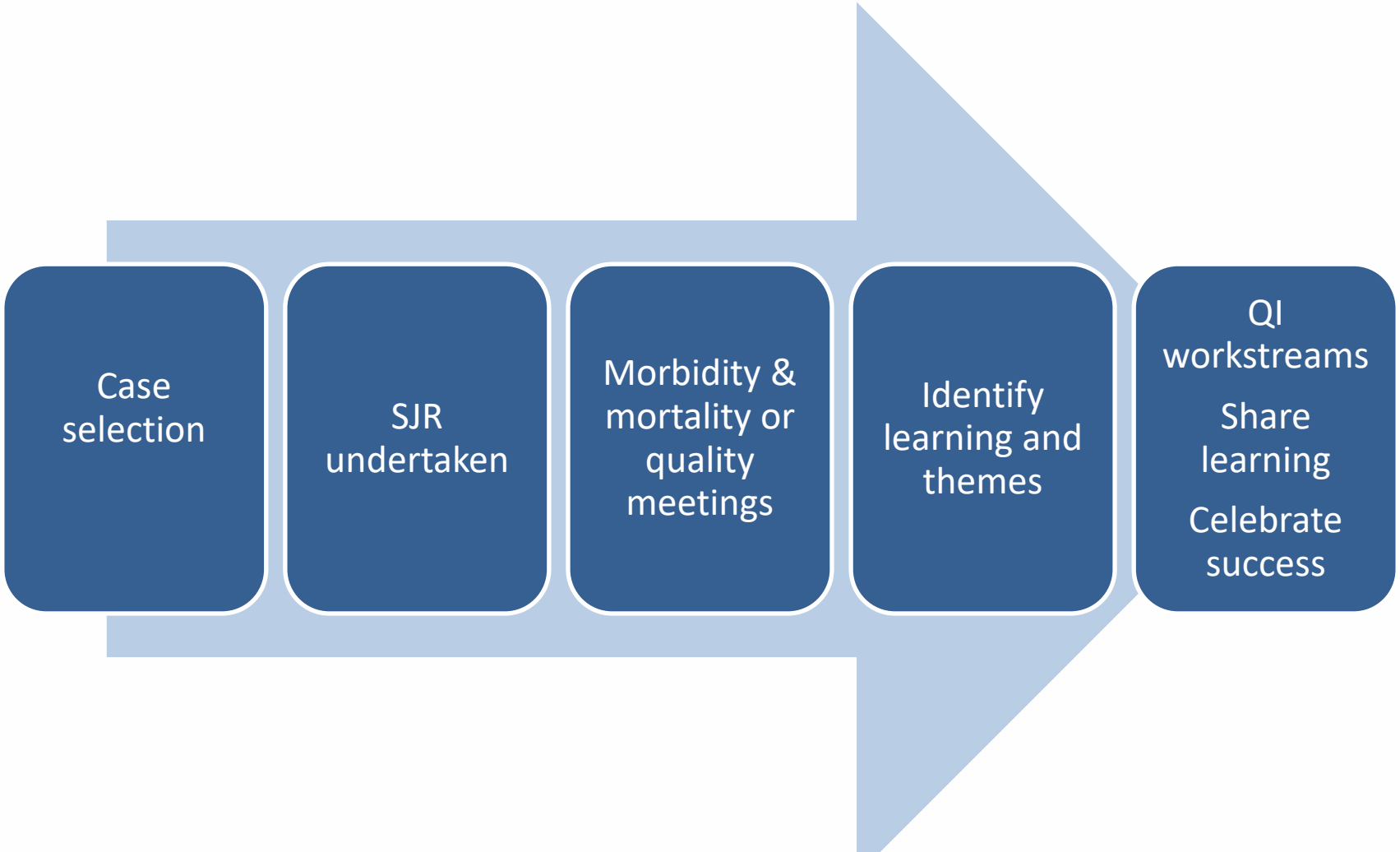
- What are we doing when care goes well?
- What's missing when care doesn't go well?

Problems

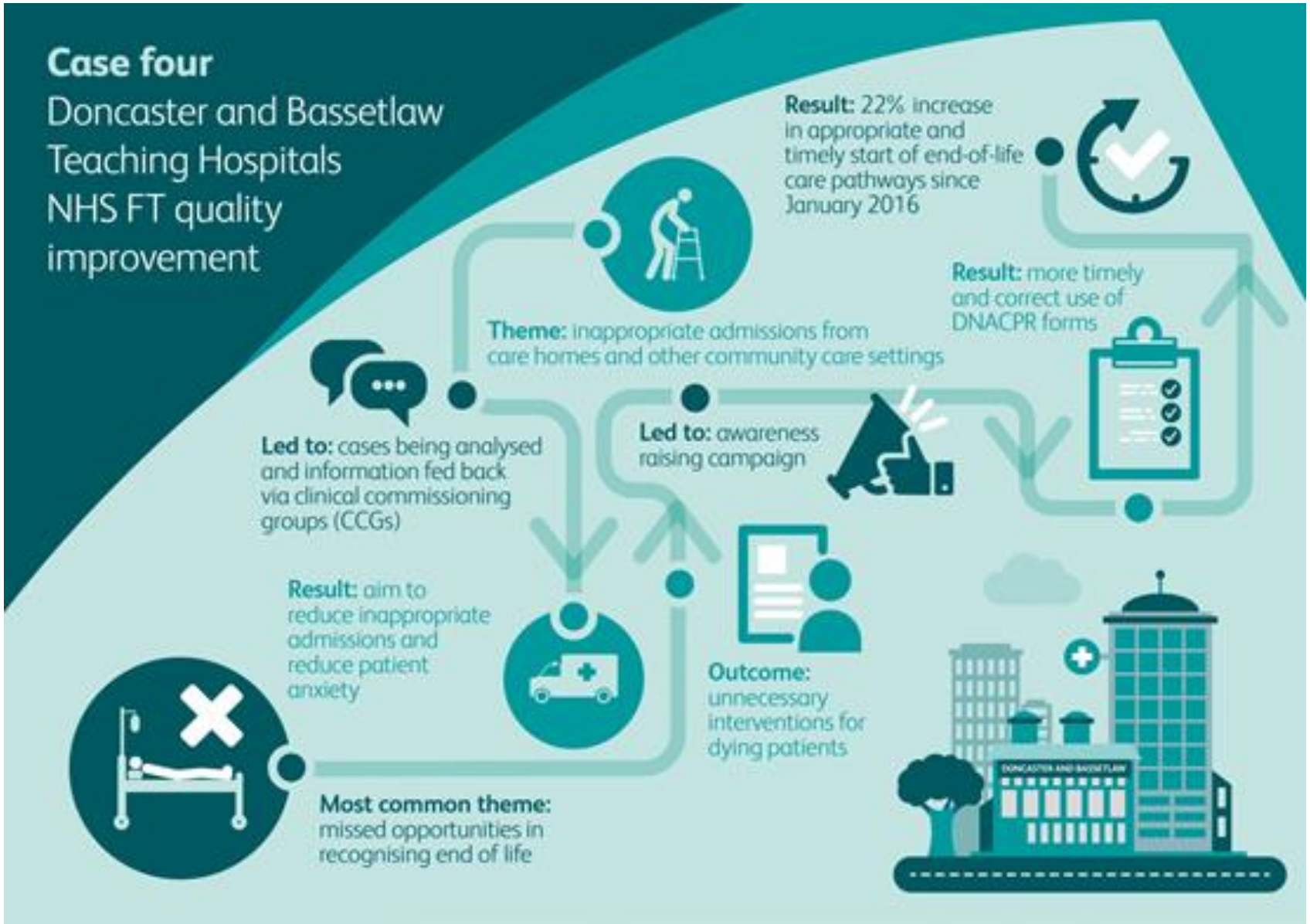
- Are any occurring frequently?

How do we learn from SJRs?

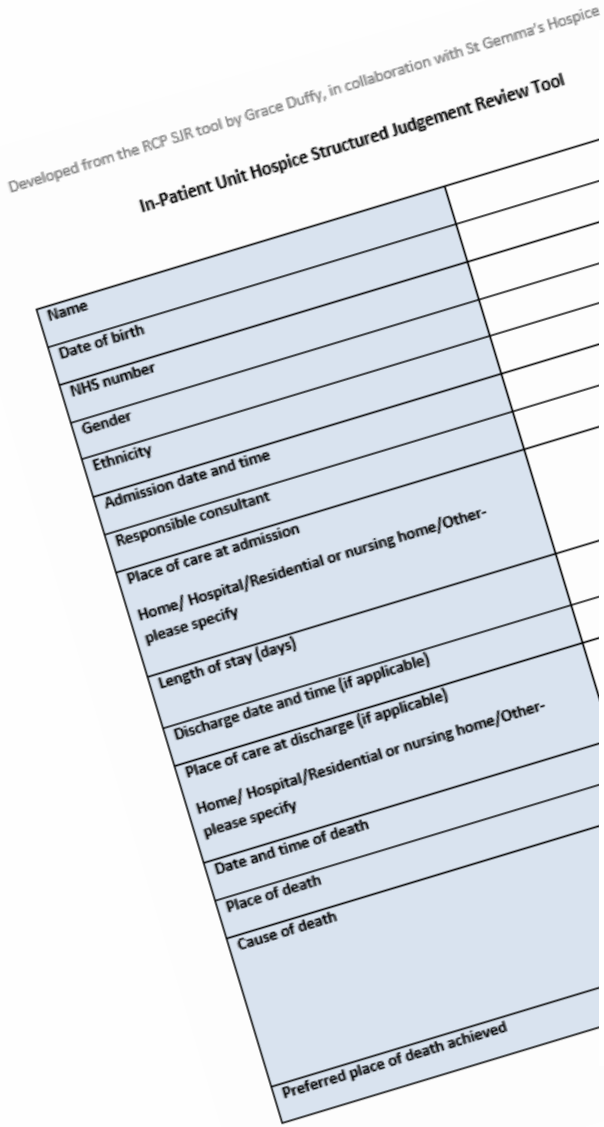
- Need governance processes in place



Impacts

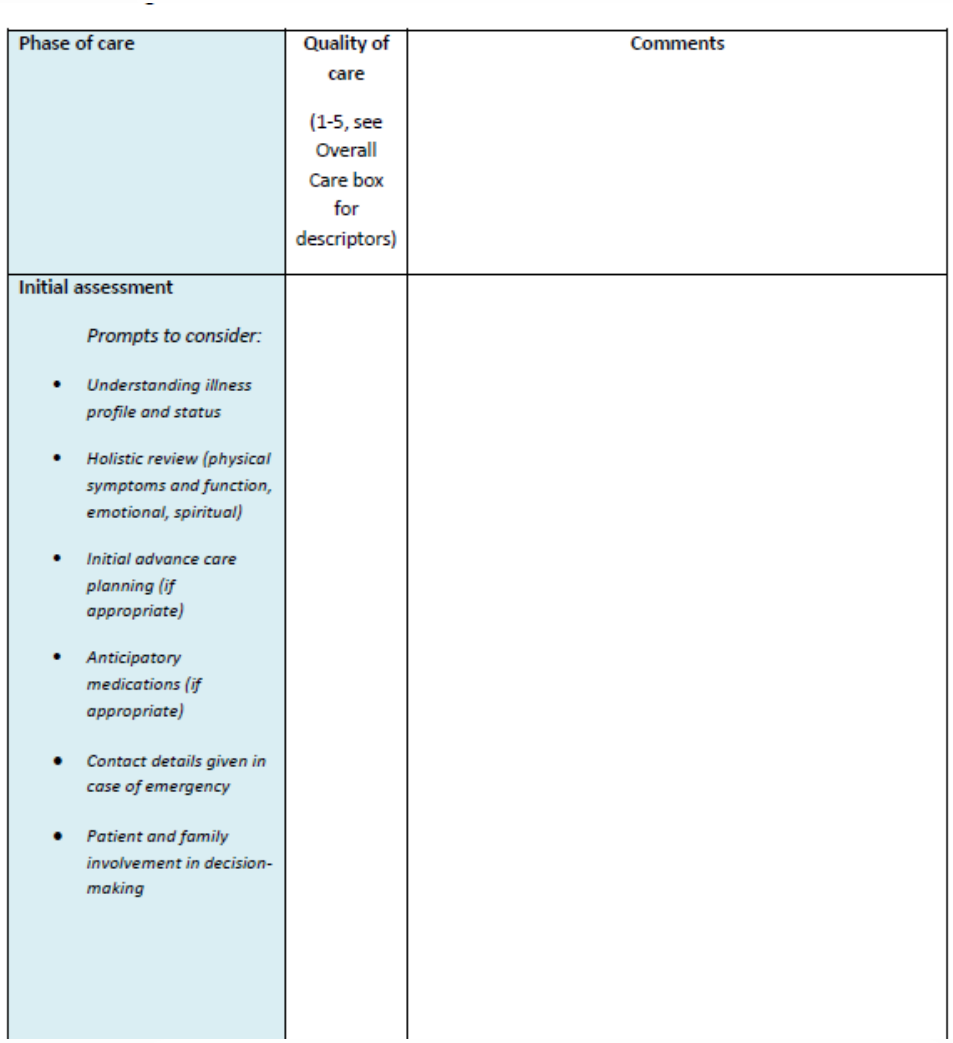

Case four
Doncaster and Bassetlaw Teaching Hospitals NHS FT quality improvement
Result: 22% increase in appropriate and timely start of end-of-life care pathways since January 2016
Result: more timely and correct use of DNACPR forms
Theme: inappropriate admissions from care homes and other community care settings
Led to: cases being analysed and information fed back via clinical commissioning groups (CCGs)
Led to: awareness raising campaign
Result: aim to reduce inappropriate admissions and reduce patient anxiety
Outcome: unnecessary interventions for dying patients
Most common theme: missed opportunities in recognising end of life

A tailored approach

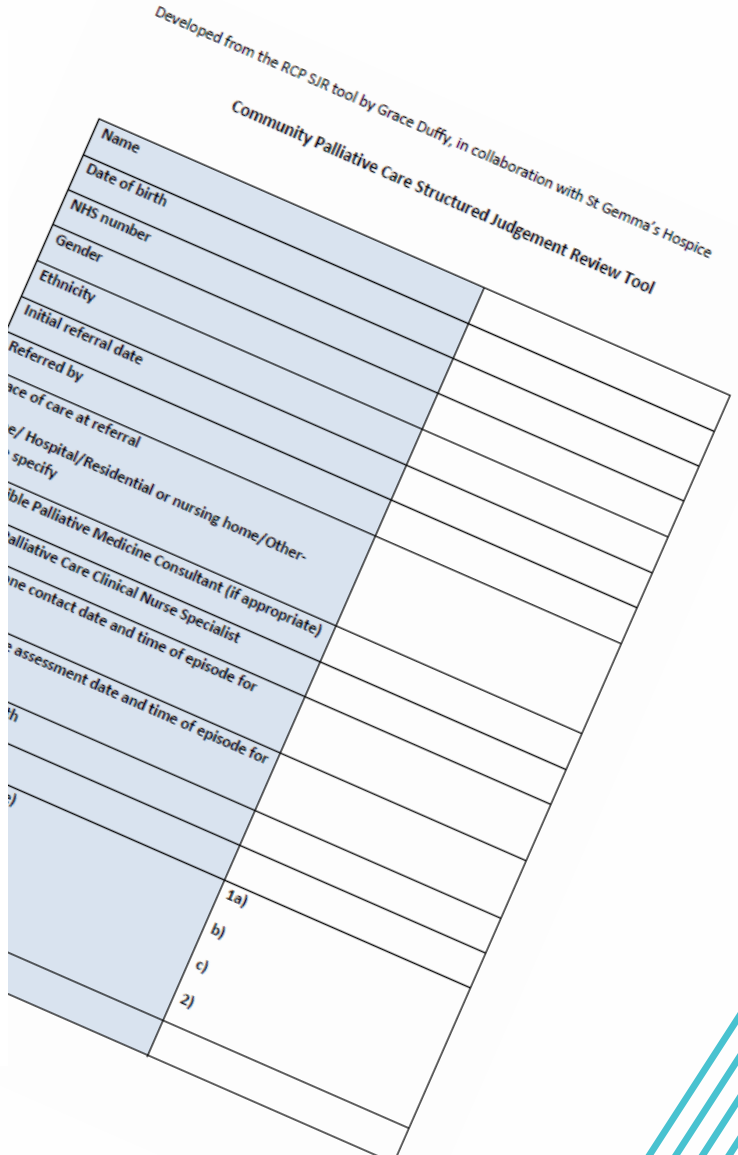

Developed from the RCP SJR tool by Grace Duffy, in collaboration with St Gemma's Hospice

In-Patient Unit Hospice Structured Judgement Review Tool

Name	
Date of birth	
NHS number	
Gender	
Ethnicity	
Admission date and time	
Responsible consultant	
Place of care at admission	
Home/ Hospital/Residential or nursing home/Other- please specify	
Length of stay (days)	
Discharge date and time (if applicable)	
Place of care at discharge (if applicable)	
Home/ Hospital/Residential or nursing home/Other- please specify	
Date and time of death	
Place of death	
Cause of death	
Preferred place of death achieved	



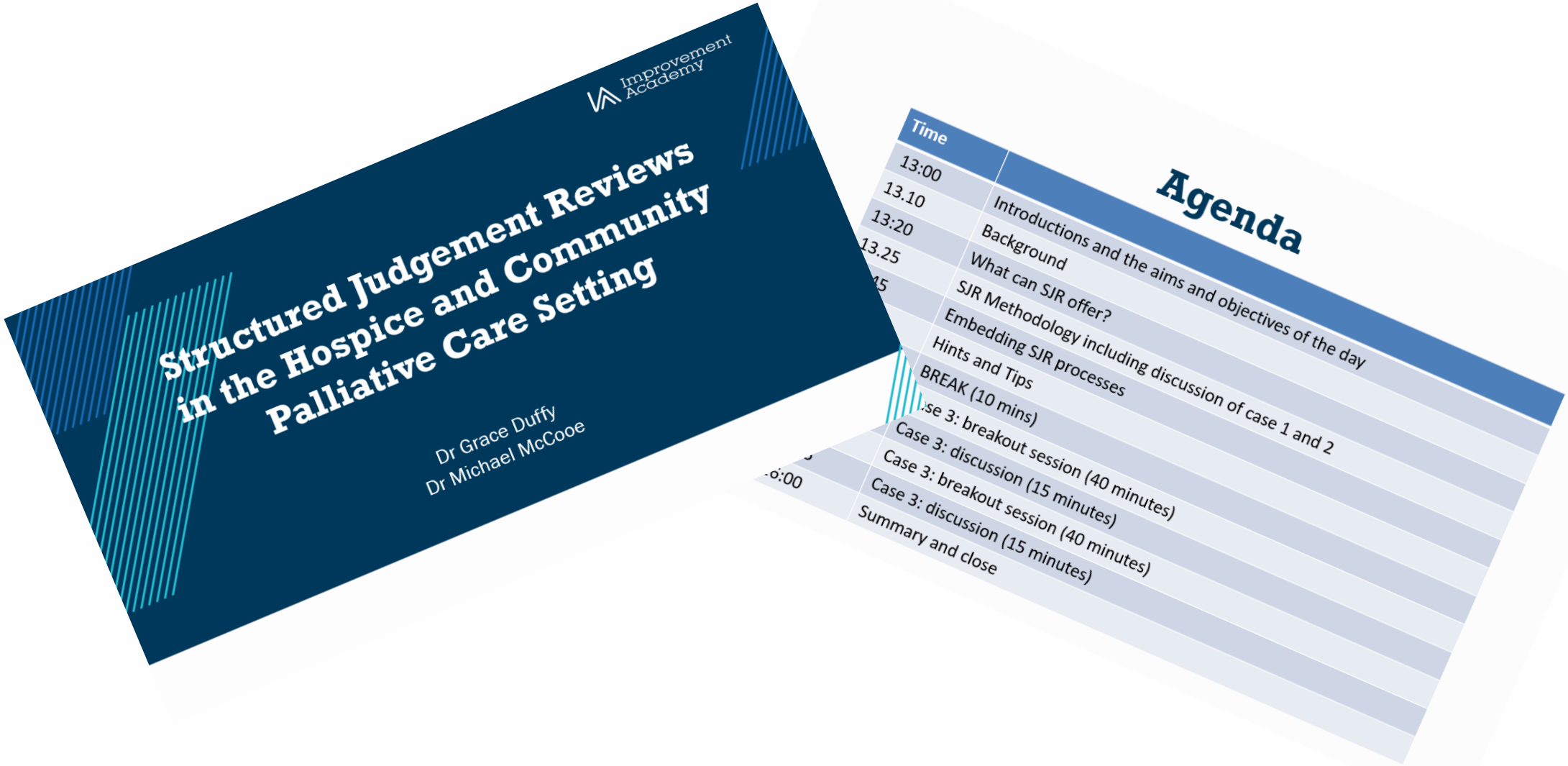
Phase of care	Quality of care (1-5, see Overall Care box for descriptors)	Comments
Initial assessment *Prompts to consider:* • *Understanding illness profile and status* • *Holistic review (physical symptoms and function, emotional, spiritual)* • *Initial advance care planning (if appropriate)* • *Anticipatory medications (if appropriate)* • *Contact details given in case of emergency* • *Patient and family involvement in decision-making*		


Developed from the RCP SJR tool by Grace Duffy, in collaboration with St Gemma's Hospice

Community Palliative Care Structured Judgement Review Tool

Name	
Date of birth	
NHS number	
Gender	
Ethnicity	
Initial referral date	
Referred by	
ce of care at referral	
e/ Hospital/Residential or nursing home/Other- specify	
ible Palliative Medicine Consultant (if appropriate)	
alliative Care Clinical Nurse Specialist	
ne contact date and time of episode for	
assessment date and time of episode for	
h	
)	
	1a)
	b)
	c)
	2)

Training Workshops



Training Workshops

Where to now?

IDENTIFYING AND DOCUMENTING BENEFITS AND CHALLENGES

REFINING THE PROCESS

WIDENING ADOPTION

CROSS-ORGANIZATIONAL LEARNING

References and reading

- Adams, C. (2023) 98 Saint Catherine's hospice mortality review; service development and audit. *BMJ Supportive & Palliative Care* 13:A45.
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Get in touch

Contact:

Grace Duffy

Grace.duffy@bthft.nhs.uk

Academy@yhia.nhs.uk

www.improvementacademy.org

@Improve_Academy

@ImprovementAcademy

Learning from Deaths Community Specialist Palliative Care Provider

Dr Mike Stockton
CMO & Medical Consultant
St Gemma's Hospice, Leeds

St. Gemma's Hospice

Content

- Why?
- What?
- How?
- So What?
- What's Next
- Key Takeaways

St. Gemma's Hospice

Why Do this?

The Drivers

- Improve quality of care and experience
- National Mortality Case Record Review (NMCRR) official launched 2016
  - Standardise mortality reviews in acute hospitals
- Multiple health enquiries:
  - Identify failings in care before irreversible harm or avoidable death
- Medical Examiner system
- Earlier identification of malpractice

The Considerations

- Death is (mostly) expected
- Care of the dying is our specialist area of practice
- What will we learn?
- How different will it be from acute care mortality review process?
  - Recognition of dying
  - ACP completion
  - Anticipatory medications

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What?

Objectives

Structure Judgement Review

Mortality Review Process

Universal Learning Log

What it isn’t

St. Gemma’s Hospice

Objectives

Develop a practical, sustainable, hospice-specific learning from deaths process

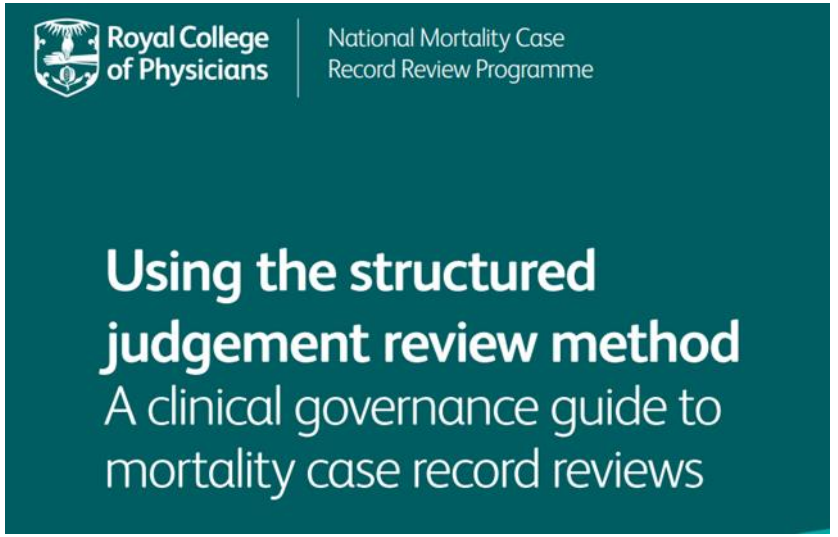
Multidisciplinary, structured, adaptable

Improve quality of care and experience

Integrate into existing clinical and academic governance structures

St. Gemma's Hospice

Structured Judgement Review



- **Why:**
  - Nationally adopted document
  - Aligns with wider processes: ME, LeDeR
  - Local training offer (NHS improvement academy)
  - Alternative tool for learning in PSIRF

- **Modifications for Hospice IPU and Community:**
  - Removal of redundant areas (simplify)
  - Holistic assessment
  - Documenting the reason for review (eg ME, family concern)
  - Ensure good practice highlighted

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Structure Judgement Review: Learning

Time and capacity challenges	• More time consuming than first estimated • Transposing EPR to review format
Clinical documentation-reality gap	
Clarify the time period	• Restrict to days to short weeks
Grading care provision (subjective clinical judgement)	• Some discomfort with this

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What: Mortality Review Process

All deaths: reviewed by senior clinical team

Selection Criteria (rank order):

- 1. Referral from the Medical Examiner (ME) or patients referred to LeDeR
- 2. Sudden or unexpected death
- 3. Family or staff concerns about care
- 4. Clinically complex or challenging cases
- 5. Random selection if no criteria are met

1 Selected death per month:

- Alternates between 2 wards and a community service
- Inch wide mile deep approach (interstitial issues)
- Balance between rigour, feasibility, and sustainability
- Rich discussion, debate and agreed learning

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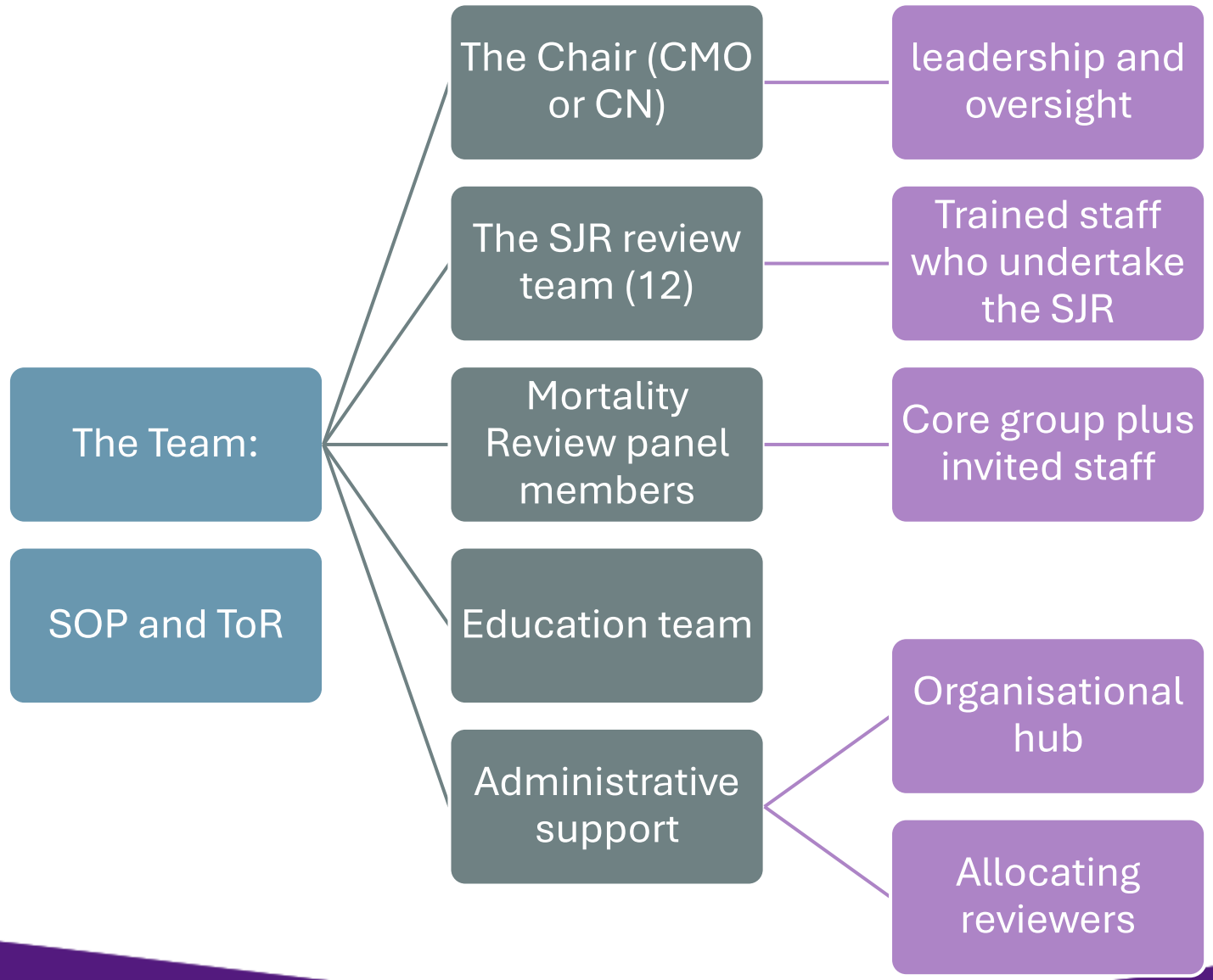
What: Mortality Review Process



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What it isn’t

FORMAL INVESTIGATION OF AN INCIDENT OR COMPLAINT

UNLIKELY TO IDENTIFY MALPRACTICE

THIS IS ONE WAY OF IDENTIFYING GOOD PRACTICE AND AREAS FOR IMPROVEMENT

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From Insight to Action

Cross Hospice Clinical Integrated Learning Log

- Draws from: SJR, incidents, complaints
- Tracks themes, actions, progress, completion
- Informs audit, SOPs, education and training plan
- Informs learning bulletin for staff

Theme of Learning
Not_following_process_or_policy
Medication
Falls
Security
Resources
Complaints_Concerns_Communication
Equipment
Manual_Handling
Pressure_Ulcer_Injuries
Infection_Control

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What did we learn about the care?

- Communication with families
- Documentation standards
- Legal guidance on recording consultations
- Escalation decisions
- Transitions of care
- Earlier referral opportunities
- End-of-life symptom control

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What did we learn about the process?

Culture of psychological safety essential

Valued, respected, senior-led, no-blame space

Encouraging openness and multiple perspectives

Time allocation and support

Learning linked to action via education, audits, policies:

Making a difference

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Governance and Visibility

- Visible in Quality Account and Business Plan
- Project-managed with lead, plan, and executive support
- Review at Clinical and Academic Governance Committee and Quality Assurance structures
- Demonstrates institutional commitment to learning

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What's Next?

01

Continue process refinement and embedding

02

Further connect themes with complaints and incidents

03

Explore regional collaboration or benchmarking

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Key Takeaways

One deep, SJR monthly provides rich and alternative learning.

Integrating learning into governance and practice is essential

Requires investment in people, systems, and culture

Still evolving – one hospice's approach, not a universal model

St. Gemma's Hospice

Thank You

Happy to share resources or continue the conversation

Dr Mike Stockton

Email: mikestockton@st-gemma.co.uk

Resources available on request

St. Gemma's Hospice

“Giving voice to the bereaved”

Medical Examiner Services

Presented by:
Dr Ben Lobo Regional Medical Examiner
NHS England

Thank you

- For inviting me to talk at your event.
- To all of you and your teams who have helped local ME services become established
- To all for your patience as we have evolved system and processes together
- To all of our teams who have had to cope during very difficult and dark times of COVID and beyond.
- Most of all thank you to all the bereaved families and friends who have and continue to trust us all, often sharing very private thoughts and fears at some of the lowest points in their lives.

Declarations and Promises

- I have no private practice or commercial interests
- I am presenting our own professional thoughts today
- I promise to be as open and honest as possible and answer your questions where we can.
- I may use anonymised examples during this presentation to demonstrate change or challenges
- I can't promise to be funnier, smarter, quicker than other presenters today.

Contact us: benjamin.lobo@nhs.net 07568344106

A quick poll

Question 1

Has the accuracy of death certification improved since the start of the ME programme in 2019?

Question 2

Has the accuracy of death certification improved from General Practice since 9th Sept 2024?

Question 3

In general, do you think that problems in treatment and care will be detected by your local ME service? Are problems in Palliative and EoL Care considered?

Question 4

Do you think that the bereaved have an opportunity to speak out if they have concerns?

Question 5

Do you think that the bereaved have a better understanding about the cause of the death?

Question 6

Has your local ME service had a beneficial impact on the work of coroner / registration services?

The ME service

Primary focus is to examine all non-coronial deaths (reasonable + proportionate scrutiny)

agree the proposed cause of death with the attending doctor and the ensure accuracy of the medical certificate cause of death (MCCD)

Discuss the cause of death with the next of kin or informant in lay terms and establish if they have concerns about the care that could have impacted or led to death (with the help of the MEO listen and signpost for further support / next steps)

Inform the selection of cases for further review under local mortality arrangements and other clinical governance procedures (5-10%) and or trigger coroner notification

support wider thematic learning and analysis of trends / variations

A medical advice / resource for the local coroner and for doctors liaising with the coroner

ME Services in England

- Locally managed and delivered, regional oversight
- DHSC Funding allocations calculated on expected deaths
- Enhancements for areas of expected to have out of hours urgent requests (11/20 in Midlands – extended working)
- Funding to the ICB and then to the host Trust

- Quarterly reporting on a national template from local service to regional team
- KPIs include workforce, activity and time to completion of scrutiny
- Qualitative information: trends and themes, escalations, complaints
- Regional sign off
- National collation

- Links to other Systems and Quality Governance – local, regional and national

After 5 years of operating ME services are they still necessary?

Coroner Notification Regulations 2019

Really useful start.

Work in progress as ME services continue to strengthen our confidence, supported by the local coroners to ensure the correct notification of cases and reduce unnecessary notifications

Feedback very positive from HM Cs

Reduce unnecessary notifications

Statutory Requirement Coroner or ME or both

Previous loop-holes	HM C Notifications Regs 2019
Poorly prepared, written MCCD	Statutory scrutiny by ME, CN1B
Poorly prepared / informed coroners notifications	More robust and predictable inter-agency working with ME, Registrar, Coroner
Professional Decisions of GPs not to engage (60-70% pre 9/9)	Registrars can’t be presented with an unchecked unsigned (ME) MCCD Almost all of the bereaved spoken

Occupational Risks and Cause of Deaths

Coroners and /or Medical Examiners will have scrutinised all deaths and taken responsibility to ensure no deaths are registered without due consideration. Registrars therefore do not need to reject for before clearance by a coroner.

This helps the bereaved understand better about the potential for claims and compensation

In attendance – qualified easements

Pre Covid	Within 14 days	Face to face (or visual confirmation)
During Covid	Within 28 days	ME Super Certifier role
Post Covid	Retention of 28 days	Loss of ME Super Certifier role

Statutory

- No specific time period
- Onus on the doctor to ensure they were suitably aware of the patient's illness and circumstances of their death
- Role of the ME (safety net to prevent inaccuracies and ensure probity)
- Role of ME to offer ME MCCD, supported by coroner – to mitigate against uncertified deaths

Information Sharing, Access to Records, Signing MCCDs

- Wide variation of especially Hospital systems with mixture of paper and electronic
- Remote access especially out of hours very variable.
- GP systems EMIS and SystmOne predominate
  - Opt out sharing presents barriers to our statutory right to access
  - Templates for GPs
  - Referral processes
- Communicating with Coroners
- Communicating with Registrars

- Lack of the national Case Management Tool
- Variety of locally based solutions
- Difficulty analysing trends and themes
- Data Security, Data Quality

Loss of Cremation forms 4 and 5

Pre Covid	Requirement for both
Covid	Requirement for only form 4
Post covid	Requirement for only form 4
Statutory	No form 4 and 5 – hurrah!

And no costs to the bereaved

New MCCDs to include extra details

ME co-signature

(Medical Referees)

Baby and Child Deaths

Previous provisions in the CDOP process now active

This has been a necessary and very significant change.

ME and MEOs have been nervous about these cases, especially where there has been little experience before.

Good engagement from clinical staff

Pivotal role of specialists

General Training (e-LFH, F2F)

Special Training

Forums

Peer support from specialist units

Regional Expert Speakers

Good Practice Guidance

Challenges

Evolution and Improvement

- An embedded and efficient system will take time, current delays
- Policy and political winds / pressures
- Improvements will be easier with collaboration
- Barriers need to change to enablers
  - Professional (not just GPs)
  - Information sharing
  - Technology
  - Feedback and Learning
- Sustainable staffing and service models
- Flexible and remote working and informal and formal partnerships

Resilience - Focus on our core purpose

Are ME services helping the learning from deaths?

Yes

MEs and MEOs highly motivated and specifically trained
ME programme has significantly enhanced the LFD process
Access to all relevant records with statutory powers
Closer interagency
Listen to the bereaved (and those close to the patient including staff)
More likely to detect problems in treatment and care and notify correct part
Last line of defence
Enhanced Transparency and Accountability
Positive Feedback too

But

Have we made the system more reliant on us?

Have professionals become less proactive and interested to review deaths and speak to the families themselves?

Turning data into improvement: National Audit for Care at the End of Life (NACEL)

Dr Mary Miller, NACEL Clinical Lead

About NACEL

- NACEL is a national comparative audit of the **quality and outcomes of care** experienced by the dying person (18+) and those important to them.
- Focuses on the last admission leading to death in a **hospital setting only**; acute, community and mental health hospitals in England, Wales, Jersey and Northern Ireland.
- **NHS Benchmarking Network** have delivered the audit since 2017, now undertaking the sixth round of data collection (2025).
- Commissioned by the **Healthcare Quality Improvement Partnership (HQIP)** on behalf of NHS England and the Government of Wales and Jersey.
- The audit is separately commissioned for Northern Ireland by the Public Health Agency.

NHS Benchmarking Network

Llywodraeth Cymru Welsh Government

HQIP

HSC Public Health Agency

the patients association

NHS England

Government of JERSEY

About NACEL

The role of audit

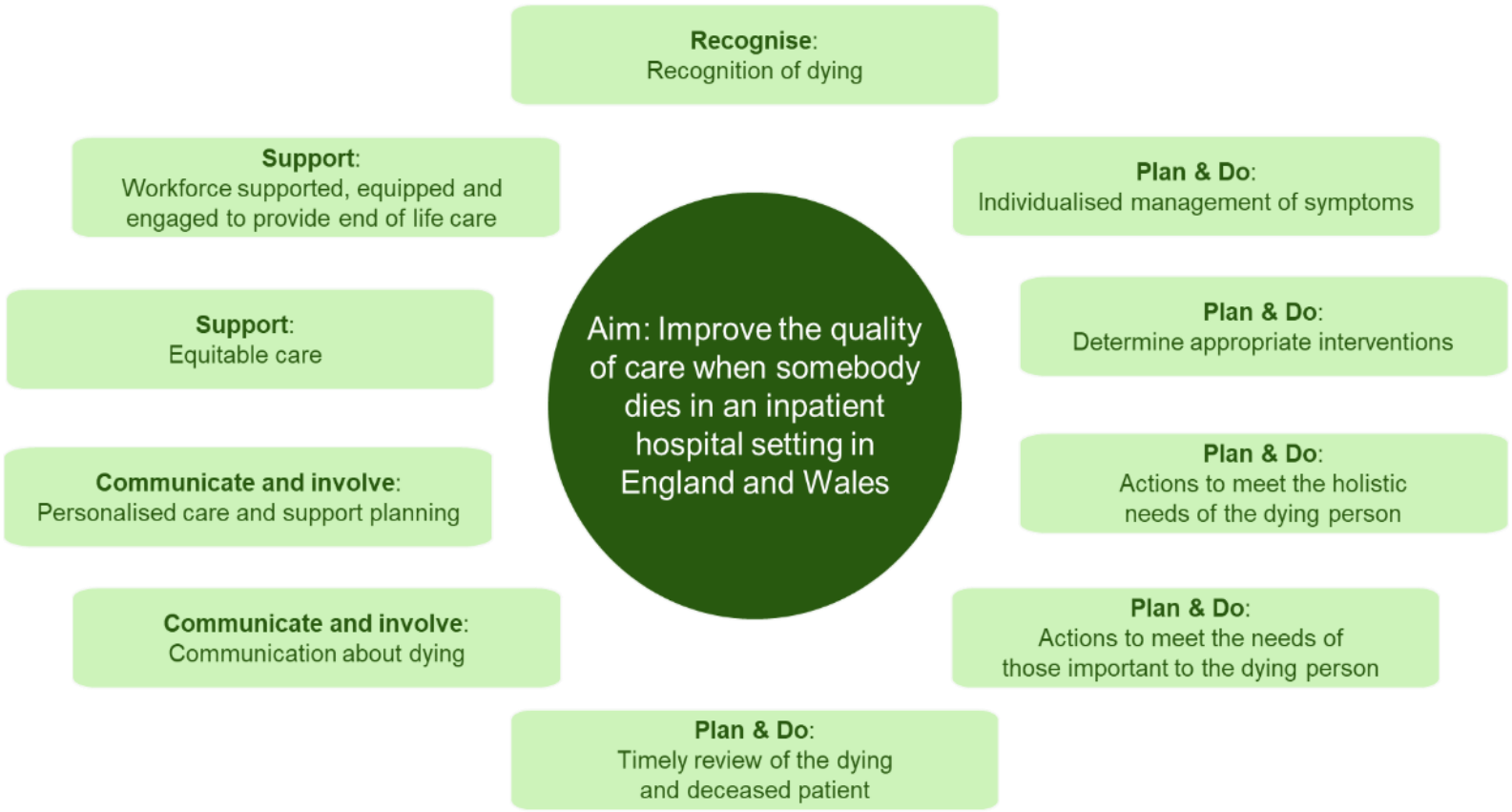
*"The role of a national clinical audit is to **stimulate healthcare improvement** through the provision of **high-quality information** on the organisation, delivery and outcomes of healthcare, together with tool and support to enable healthcare providers and other audiences to **make best use of this information**."*

(HQIP, 2022).

NHS Benchmarking Network

About NACEL

Drivers for supporting improvement



The four audit elements:

- Hospital/Site Overview
- Case Note Review
- Bereavement Survey
- Staff Survey

NHS Benchmarking Network

NACEL

Participation 2024

167 Trusts/Health Boards registered for NACEL 2024, across England, Wales and Jersey.

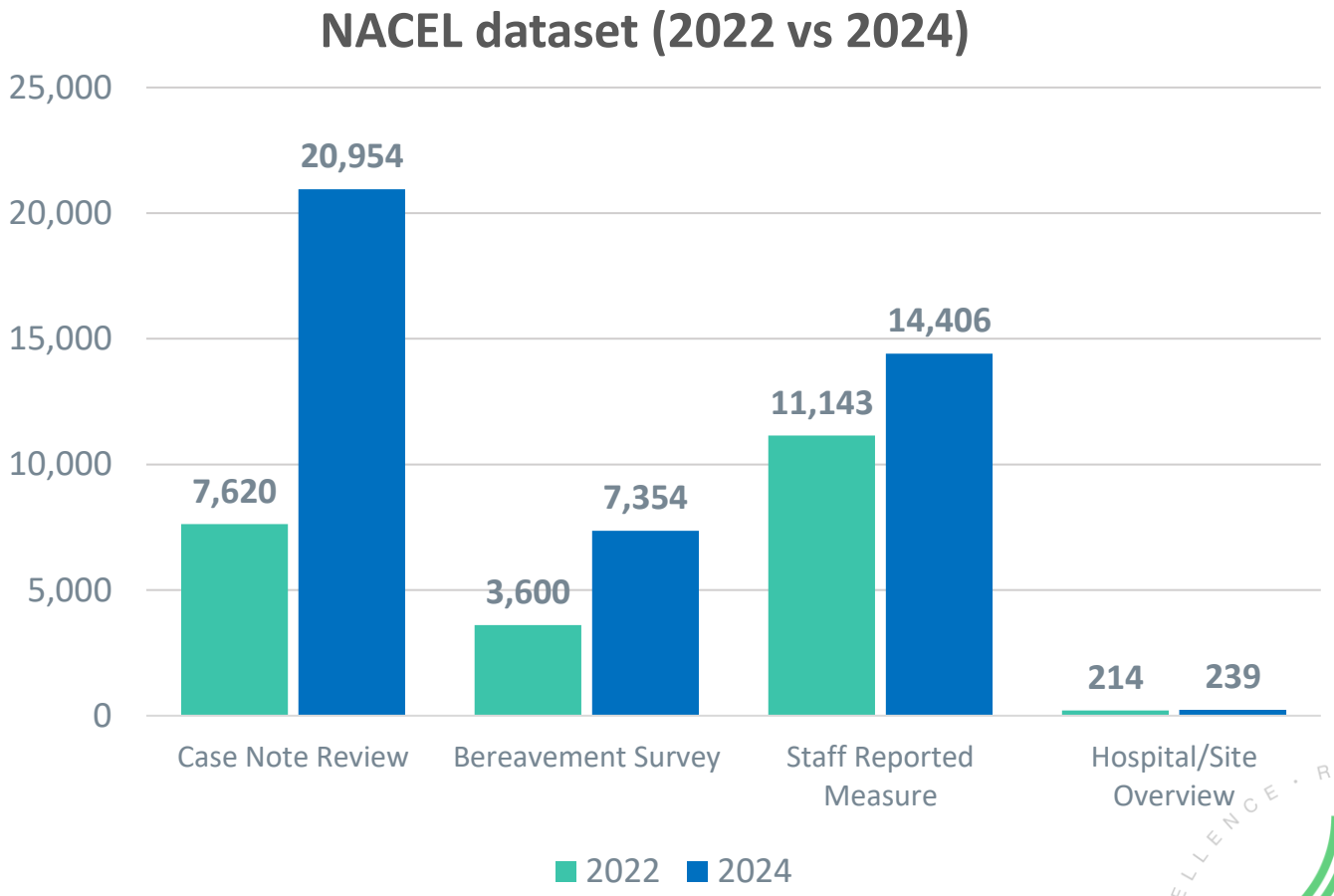
99% participation rate.

242 submissions (hospital/sites)

- 186 acute hospital providers
- 56 community hospital providers

Case Note Review accounts for 8% of hospital deaths across England and Wales

Bereavement Survey accounts for 3% of bereaved people in England and Wales



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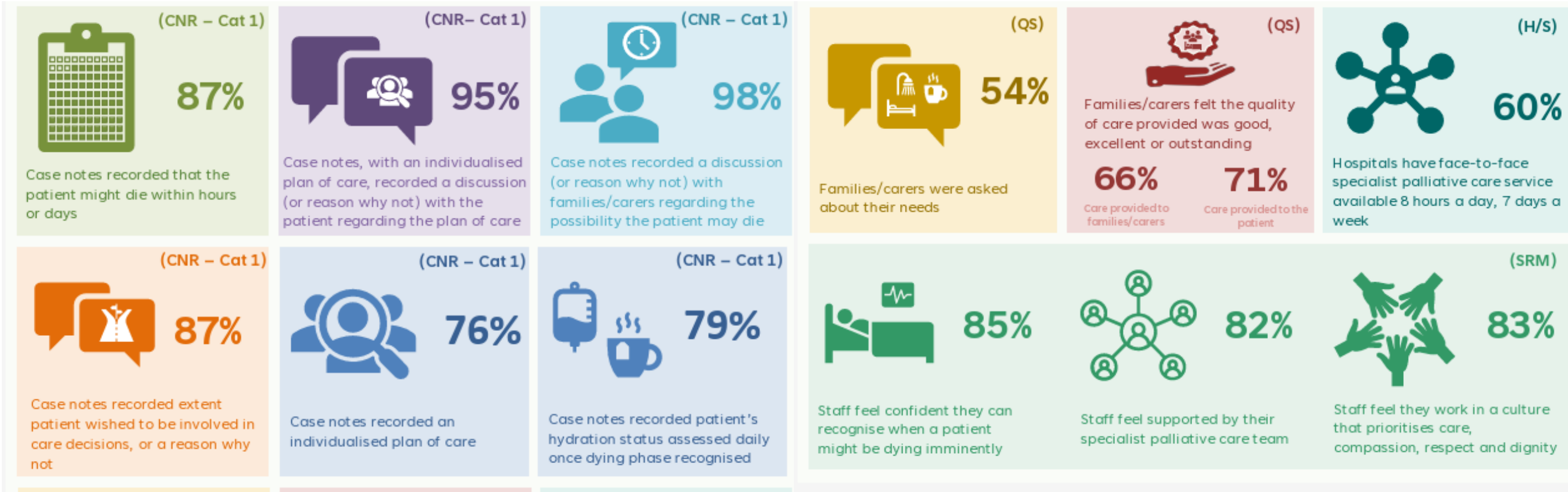
NACEL

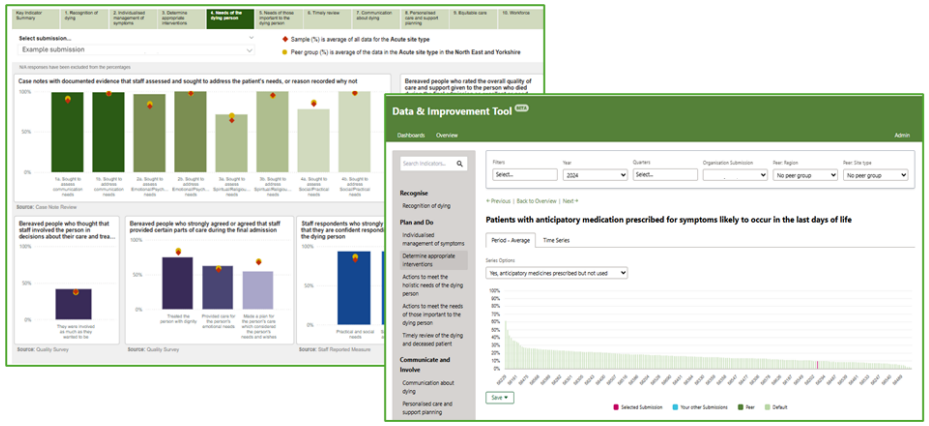
Findings from NACEL 2022



NHS Benchmarking Network

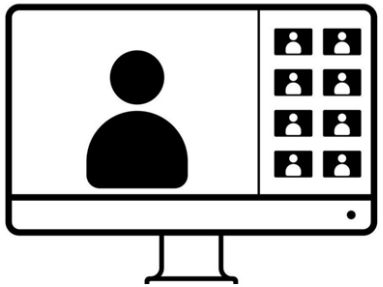
The NACEL 2024 findings are not yet published – State of the Nations Report to be published in August 2025.

NACEL QI Related Outputs



Data and Improvement Tool

Good Practice Compendium



QI webinars & huddles

Community of Practice

NHS Benchmarking Network

Impact of NACEL

Norfolk and Norwich University Hospitals NHS Foundation Trust

"NACEL's focus on coordination and communication within multidisciplinary teams has prompted us to enhance how we share information across care settings. Our work on shared care records and the new EPR system stems directly from these findings…"

Bradford Teaching Hospitals NHS Foundation Trust

"…following 2022 NACEL results a CNS in palliative care with a special interest in South Asian populations and religious needs has been appointed…identifying and meeting the needs of this group, which make up a significant proportion of the demographic the team see."

Manchester University NHS Foundation Trust

"NACEL has given us the opportunity to capture the experience of families and carers more clearly leading to us to expand and develop workstreams to improve their experience."

Essex Partnership University NHS Foundation Trust

"…Staff confidence increased, more accessible training opportunities."

Leeds Teaching Hospitals NHS Trust

"Development of action plans in response to NACEL results has led to board level support of changes in service delivery and processes."

NHS Benchmarking Network

Poll

Do you currently collect data on the quality of care within your hospice?

Yes/No

Would you consider taking part in a data collection aimed at understanding and improving the care provided to people at the end of life in a community setting (own homes, care homes, residential homes, hospices)?

Definitely interested / Possibly, depending on the details / Not at this time

NHS Benchmarking Network

Would you consider taking part in a data collection aimed at understanding and improving the care provided to people at the end of life in a community setting (own homes, care homes, residential homes, hospices)?

Do you currently collect data on the quality of care within your hospice?

Thank you for listening

You can get in contact with the NACEL team at:

nhsbn.nacelsupport@nhs.net

0161 521 8274

Visit the website at www.nacel.nhs.uk

Questions and Discussion

HospiceUK

Big Conversations

The Big Conversations series comprises webinars, workshops, and roundtables that enable our members to:

- learn more about key issues
- share knowledge and experience to inform our work
- discuss problems and solutions with peers
- get practical guidance to move work forward

Scan Me

We invite you to continue engaging with us in the months ahead, as we explore a range of important topics.

HospiceUK

Our Big Conversation events are supported by:

MDDUS
Protecting professionals

Hospice UK data collation 2025

Every year, Hospice UK collates, analyses and shares data about hospice services. This forms a key part of our work fighting for hospice care for all who need it, for now and forever.

This year we are asking our members to respond to the following surveys by **30th June 2025**.

more details

Workforce data collation

HospiceUK

Membership survey

Scan here for more details

HospiceUK

Feedback Survey

Learning form deaths in hospices - Big Conversation 30 April 25

Please consider sparing a few minutes to answer this survey, so that we can continue to improve future Big Conversation events:

https://forms.office.com/e/UbgUzRbT2g

Stay up to date

Scan me

Our Member Update page is updated regularly so you can keep up with our key work and priorities from week to week.

The page is hidden from the public and will not come up in web searches, so we'd recommend bookmarking it!

HospiceUK

Thank you

HospiceUK

Our Big Conversation events are supported by:

MDDUS
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