

You & Your Care

**The 5 key messages the reader should note about this document are:**

*It is the right thing to do to review and investigate deaths where care and service delivery problems occurred so that we can learn and prevent recurrence*

*We make it a priority to work closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages*

*The Medical Director is the Board level Director with responsibility for learning from deaths and a named Non-Executive Director has lead responsibility for oversight of progress*

*All deaths, within mental health and learning disability services, that staff become aware of must be reported on Safeguard to start the process of learning*

*The Mortality Review Group, chaired by the Medical Director, meets weekly to review all reported deaths and determine which require further investigation in accordance with this policy*

**Learning from Deaths Policy:**

**The right thing to do**

This document has been approved and ratified. Circumstances may arise where staff become aware that changes in national policy or statutory or other guidance (e.g. National Institute for Health and Care Excellence (NICE) guidance and Employment Law) may affect the contents of this document. It is the duty of the staff member concerned to ensure that the document author is made aware of such changes so that the matter can be dealt with through the document review process.

**NOTE: All approved and ratified policies and procedures remain extant until notification of an amended policy or procedure via Trust-wide notification, e.g. through the weekly e-Update publication or global e-mail and posting on the Intranet (Connect).**

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# INTRODUCTION

After the events of Mid Staffordshire the then Prime minister asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review 14 hospital trusts national mortality records. The investigation looked broadly at the quality of care and treatment provided within these organisations and noted that the focus on combined mortality rates was distracting Boards from the practical steps that could be taken to reduce avoidable deaths in NHS hospitals.

These findings were reinforced in the recent Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England 2016. It showed that in some organisations learning from deaths was not being given sufficient priority and that valuable opportunities for improvements were being missed. Importantly the CQC also point out that there is much more we can do to engage families and carers and recognise their insights and experiences are vital to our learning.

The National Quality Board (NQB) guidance on Learning from Deaths (2017) is the starting point to initiate a standardised approach across the NHS to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning. These reviews will provide the Trust with valuable information in deciding how avoidable the death may have been and how Executive Teams and Boards can use these findings.

For most people, death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, the experience is different and they experience poor quality provision for a number of reasons including system failure.

It is the right thing to do to review and investigate deaths where care and service delivery problems occurred so that we can learn and prevent recurrence.

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people therefore it is important that organisations widen the scope of deaths which are reviewed in order to maximize learning.

We will make it a priority to work more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of the death of their loved one right through to actions taken following from an investigation (if deemed appropriate).

The Trust fully supports the approach it has developed with other mental health trusts in the north of England as part of our collaborative approach to learning from deaths. The trusts participating are:

• Bradford District Care NHS Foundation Trust

• Cumbria Partnership NHS Foundation Trust

• Humber NHS Foundation Trust

• Leeds and York Partnership NHS Foundation Trust

• Northumberland, Tyne and Wear NHS Foundation Trust

• Rotherham, Doncaster and South Humber NHS Foundation Trust

• Sheffield Health & Social Care NHS Foundation Trust

• South West Yorkshire Partnership NHS Foundation Trust

• Tees, Esk and Wear Valley NHS Foundation Trust

Working collaboratively will enable shared learning and good practice, valid comparisons across organisations and shared capacity.

This policy sets out the principles that guide our work and how we will implement them.

This policy should be read in conjunction with

* Being Open Policy
* Serious Incident Policy
* Incident Reporting and Management Policy
* Analysing, Learning From and Responding To, Inspections, Guidance and Internal/ External Reports Policy
* Investigation of Incidents, Complaints and Claims Policy

NHS Improvement is fully aware that many organisations, particularly mental health and community care providers, have less clarity on methodologies and scope for the new requirements of learning from deaths. Therefore it does not expect providers to have developed perfect processes by autumn 2017 and acknowledges that further support will need to be provided over the course of the next 12 months.

The Trust will therefore review the policy to ensure it continues to reflect best practice in April 2018.

# SCOPE

**Who this policy applies to**

This policy applies to all Trust staff with a responsibility for patient care as set out below:

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| C:\Users\flintoffj\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\XJK2M0E3\MC900434750[1].png | The National Quality Board Guidance on Learning from Patients Deaths applies to all acute, mental health/learning disability and community NHS Foundation Trusts. |

Working with families/carers of patients who have died offers an invaluable source of insight to improve services. Therefore there is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. In line with the National Quality Board (NQB) guidance on Learning from Deaths, every Trust must have a policy in place that sets out how it identifies, reports, investigates and learns from a patient’s death. This should include the care leading up to the patient’s death and considering if this could have been improved.

This policy informs the organisation of staffs’ roles and responsibilities relating to learning from deaths and promotes a culture of learning lessons.

Learning from a review about the care provided to patients who die in our care is integral to the Trust’s governance and quality improvement work.

Purpose

The purpose of this policy is to set out the Trusts expectation / principles on how it responds to deaths in our care and identifies the scope of review for each death and how the trust will learn from them.

This policy sets out how staff can support the involvement of families and carers when a death has occurred and how to engage with them to ensure there are easy opportunities to discuss or ask questions about the care received by their loved one to their preferred timescale.

Objectives

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.

The core objectives of this policy are:

• To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.

• To help to identify what can be improved to ultimately reduce the inequality in the life expectancy of people with a serious mental illness/learning disability.

• To standardise approaches to reviewing deaths across the northern cohort of mental health trusts in order to share information and key learning.

• To enhance learning at a personal, team and organisational level.

• To ensure the Trust engages with other stakeholders (Acute Trusts, primary care, public health, safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximize learning from deaths

• To support the evaluation of the Trust’s approach to learning from deaths in line with the northern cohort of mental health trusts agreed principles.

# 3 The policy

**3.1 Roles and responsibilities**

Mortality governance is a priority for all Trust Boards and the Learning from Deaths Framework places a greater emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation.

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| **Role** | **Responsibility** |
| **Board members** | Trust Boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. They can do this by demonstrating their commitment to the work e.g. spending time developing Board thinking; ensuring a corporate understanding of the key issues around the deaths of service users and by ensuring that sufficient priority and resource is available for the work.  The Medical Director has been identified as the Board level ‘Patient Safety Director’ with responsibility for learning from deaths. Additionally a named Non-Executive Director has taken lead responsibility for oversight of progress to act as a critical friend holding the organisation to account for its approach in learning from deaths.  The Board will ensure:   * That robust systems are in place for reporting, reviewing and investigating deaths * That bereaved families are engaged and supported * That there is evident learning from deaths both internally and with our external partners and quality improvement is championed * That processes focus on learning, can withstand external scrutiny, by providing challenge and support and assurance of published information |
| **Medical Staff, Deputy Directors, Heads of Service, Service Managers, Team Leaders, Ward Managers and all Registered Nurses and Allied Healthcare Professionals** | Staff should familiarise themselves with this policy and understand the process for learning from deaths. Identify the key changes required to implement this policy and ensure all appropriate action is taken;  In conjunction with the Serious Incident Team and Safety, Risk and Resilience Team, to support staff to review and investigate deaths ensuring they have the time to carry this process out in skilled way to a high standard, and as part of that to:  Ensure staff have the right level of skill through training and experience;  To promote learning from deaths;  That sufficient time is assigned in local governance forums to outline and plan for any lessons learned;  To ensure that learning is acted on  Staff should engage with families to offer condolences, in line with Being Open and Duty of Candour when this applies. |
| **Serious Incident Team, and Safety, Risk and Resilience Team** | These corporate Trust departments have a responsibility to ensure:  New data is collected and published to monitor trends in deaths (Quarter 3 of 2017/18 onwards) with Board level oversight of this process  Ensuring the incident reporting system is used to its full potential to record deaths (expected and unexpected) in accordance with Trust policy.  Processing information consistently and precisely and in a meaningful way to fulfill governance processes required to ensure high standards in mortality governance are maintained |

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| C:\Users\flintoffj\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\XJK2M0E3\MC900434750[1].png | The Trust requires all staff to be open, honest and transparent about reporting deaths and for engaging with families and carers, actively enabling them to ask questions about care and identify if care can be improved. |

**3.2 Encouraging a learning from deaths culture**

The Trust already does significant work with working with families following deaths where care delivery may be an issue.

We will continue to educate staff and encourage a more open culture of listening to the views and opinions of families and carers following all deaths. Staff will become more confident in identifying what can be done differently and improve systems and share systems and processes that are working well.

By educating staff and encouraging a more open culture of listening to the views and opinions of families and carers, staff will become more confident in identifying what can be done differently and improving.

**3.3 Family engagement:**

We will reinforce the importance of family engagement following deaths. Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but don’t always want to make a complaint.

If you are reading this as a family member of someone who has recently died, and has received care from our Trust and you have anything you would like to discuss, you can contact the clinical team involved to discuss or you can contact the Patient Advice and Complaints Department on 01274 251440

When a service user dies, staff will often be the first to offer condolences and support and to give appropriate information

They also need to ask if the families have any comments they may wish to make about the care provided. This early discussion supports ensuring that deaths were families raise concerns are reviewed or investigated. If there are any concerns this must be reported on the incident reporting system.

When staff make contact they should ensure they follow the Being Open Policy which includes Duty of Candour when this is required.

There are however some circumstances where the Trust may find out about the death of a service user after some delay. In these circumstances a discussion should take place between the Mortality Review Group and the clinical team involved to determine the best approach. We have begun a dialogue with families about how they would wish to be involved in reviews of a family member’s death or in an investigation. This work will inform the Trusts practice in the future as will anticipated national guidance\*.

It is understood that dealing with the death of a loved one is a sensitive matter for families, carers and staff and that all situations are different. Staff may need to offer the opportunity for on-going involvement in-keeping with the family’s needs and wishes.

The Trust’s approach should be to treat the family / carer as an equal in the review process from the beginning taking their views and opinions into account at each stage.

Families can choose how they wish to be involved, this may include:

* agreeing the level of the review / investigation (see 4.5);
* contributing to the terms of reference for serious incident reviews;
* providing evidence / contributions to the review or investigation e.g. providing a pen portrait of the person, time-line of events
* Commenting on a draft report.

Families / carers should also be given the option of seeing final reports to ensure they are comfortable with any findings. Ideally this should be undertaken in a face to face meeting with a staff member talking the family member / carer through the report.

To support families, we will provide a range of information for relatives that explains these processes and what they can expect.

If the family member / carer decides they do not want to be involved in the review process staff should make it clear they can contact us at any time should their decision change and that any relevant information can still be shared. If the family does not want contact at all about the process or findings, this should be honoured and staff should record their wishes.

Staff should be prepared for the types of questions that families may have such as:

* Why is there an investigation?
* Can I access the records for my relative?
* Can I speak to the staff who were caring for my relative?

One way to ensure that answers are provided to the questions that families / carers have is to ask them, at an early stage, what they want to know and to involve them in writing the terms of reference of any review or investigation. Further information and support can be accessed by the Serious Incident team as this is already in practice in serious incident investigations.

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| \*Note: The NQB guidance states that a *“*further development” in 2017 /18 will be: the development of “*guidance for bereaved families and carers. This will support standards already set for local services within the Duty of Candour and the Serious Incident Framework and cover how families should be engaged in investigations*”. The Trust will review this policy in this context and as part of the policies evaluation. |

**3.4 Identifying and Reporting Deaths**

The Trust has systems that identify and capture the known deaths of its service users on RiO and on the incident management system, Safeguard. This is to help ensure that the Trust Board has a comprehensive picture of the deaths of all services users and the opportunities to learn from them.

Trust staff must report deaths that they are made aware of on Safeguard within 24 hours of being informed and provide the cause of death where known. Once the incident report is completed staff should attempt to engage with the family and or carers unless otherwise instructed. In the first instance this would take the form of a condolence letter with contact numbers for contacting the service.

**This applies to the deaths of all patients open to BDCFT mental health or learning disability services.**

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| C:\Users\flintoffj\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\XJK2M0E3\MC900434750[1].png | **All deaths that staff are made aware of must be reported on Safeguard to start the process of learning from patient deaths.** |

All incident reports of deaths which appear to meet the threshold for a Serious Incident (SI) are taken forward through the SI process. A summary of all other reported deaths are taken to the Mortality Review Group (MRG) where each death is reviewed, by the Medical Director, the Serious Incident Lead, members of the Safety, Risk and Resilience Team and a representative from services (see Appendix 1) to establish the category of death and the level of review required.

**3.5 The decision to investigate or review**

The Trust collects data on all known deaths and has a process in place to determine the scope of deaths which require further review or investigation. The information below sets out these processes in addition to the existing Serious Incident Framework which remain • For people with a Learning Disability the Trust supports the approach of the LeDer programme.

For people with a Learning Disability the Trust supports the approach of the LeDeR programme.

The NQB National Guidance on Learning from Deaths provides the context to the review or investigation of deaths and establishes a number of circumstances where investigation is mandated. These include:

1. all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
2. all in-patient, out-patient and community patient deaths of those with learning disabilities
3. all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means
4. all deaths in areas where people are not expected to die, for example in relevant elective procedures;
5. deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;
6. a further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

The NQB guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

Further national guidance is expected to clarify expectations about mortality review in mental health and community services in the future however in the meantime, Trusts have been asked to use the above description of SMI. These will be subject to a review of the case at the Mortality Review Group and a decision will be made on an individual basis as to whether and what type of review is required.

In order to support consistency in determining the scope of deaths for further review, the cohort of Northern Mental Health Trusts has agreed the following approach:

Table 1

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| Where the Trust provides a wide range of clinical services across inpatient, community and other provider organisations this can lead to both a degree of confusion as to who is responsible for the reporting and investigating of a patient’s death and the risk of double reporting and investigation.  To support staff in their decision making staff should refer to the following guidelines. However if there is any doubt staff should contact their line manager for advice.  ***A We are the main provider if at the time of death the patient was subject to:***   * An episode of inpatient care within our service. * An episode of community treatment under CPA. * An episode of community treatment due to identified mental health, learning disability or substance misuse needs. * A Community Treatment order. * A conditional discharge. * An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only). * Guardianship   ***B Patients who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.***  In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also exercise the responsibilities under Duty of Candour. However there will be a discussion to agree on if it is to be a joint or single agency investigation (this will be determined by the cause of death) and in the case of joint investigations who the lead organisation will be.  ***C Services provided by the Trust where we are not classed as the main provider.***  For the following services the Trust is only providing a small component of an overarching package of care and the lead provider is the patient’s GP.   * Tissue viability * District Nursing, Community Matrons and Case Managers * Care home liaison * Acute hospital liaison * Palliative Care * Health Visitors * Podiatry * Speech and Language Therapy * Continence * Community Dentistry   ***D Exception.***  In addition to the above, if any act or omission on the part of a member of Trust staff where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, an investigation will be undertaken by the Trust.  Where problems are identified relating to other NHS Trusts, or organisations, the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement. A culture of compassionate curiosity should be adopted and the following questions should be asked:  • Which deaths can we review together?  • What could we have done better between us?  • Did we look at the care from a family and carer’s perspective?  • How can we demonstrate that we have learnt and improved care, systems and processes? |

In addition the Northern Mental Health trusts have identified a number of potential triggers for a Review / Investigation. These include deaths:

1. Where family / clinical staff / risk management staff flag or raise a concern;
2. Where medication with known risks such as Clozapine was a significant part of the treatment regime;
3. From causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data);
4. Where they had been subjected to a care intervention where death wouldn’t have been an expected outcome e.g. ECT, rapid tranquilization;
5. Where the service user had no active family or friends and so were particularly isolated e.g. with no-one independent to raise concerns;
6. where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap in services;
7. Associated with known risk factors / correlations

Also:

1. Particular causes of death e.g. epilepsy;
2. Deaths in Distress which might include: drug and alcohol deaths, or deaths of people with an historic sex offence e.g. people who might not be in crisis but need support and from whose experience there may be learning from a thematic review;
3. Where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn’t responded to in a timely manner;
4. Random sampling.

**3.6 The types of review**

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| Practice varies across Trusts with regards to how deaths are reported and categorized.  Each trust has core processes around:   * an initial screen of each death e.g. at a weekly MRG * a way of making a judgement about which deaths are subject to further review which might be explicit and transparent against a set of criteria or sometimes more reliant on individual and clinical judgement; * a way of deciding the level of further review however this is described e.g. local review, clinical review. In this practice around the use of SJR is still emergent. |

**3.7 Local review**

The Trust has adopted the three levels of scrutiny suggested in the NQB guidance.

1. Death Certification
2. Case record review
3. Investigation

Certification:

If the death has been certified by a doctor as a natural death and they have not reported the death to the coroner, no further review will usually be necessary unless the Trust is aware of any concerns expressed by family and clinical staff or through governance processes. The clinical team will normally review the case.

Of note is that once the reform of death certification comes into place, the medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical practice or patient safety.

**3.8 Case Note Reviews / Structured judgment Reviews:**

A Structured Judgment Review (SJR) blends traditional a clinical judgement based review with a standard format that enables reviewers to make safety and quality judgements over phases of care and which provides explicit written comments and a score for each phase. A SJR provides a relatively short but rich set of information about each case in a format that can be aggregated to provide knowledge about clinical services and systems of care

Following the Mortality Review Group any non-SI deaths that require a review are discussed with the service and the local review completed using an evidence based tool. Once this decision has been made then the family will be informed a review will be taking place and be asked how they would like to be involved.

When the family/carers wish to be involved, their preference regarding how, when and where they want to engage will be paramount and built on the principles of compassionate engagement. A summary of any findings will always be prepared with or for the family.

Service level investigation/serious incident investigation joint investigation

There are some instances when a joint approach is required with another organisation to investigate. The Trust has developed links with neighbouring acute Trusts to enable this to take place when needed. Either organisation can request this to take place.

Other investigations

The Trust is an active member in Safeguarding Boards and should a death require investigation through the Safeguarding process the Trust will work through that process in line with serious incident framework.

**3.9 Governance process / ensuring Learning**

The prime objective of a Learning from Deaths Policy is that we can improve services and the experience of those services of the people that use them.

We are working with eight other mental health trusts to develop a consistent framework around learning. This will focus on whether the activity we do under the guidance of this policy (i.e. talking to the families of those who died, the investigations, thematic reviews, the analysis of data, the review of case notes including SJR) makes a difference.

How we measure the impact of the work will develop over time as the information we access improves, as we evaluate the policy overall including feedback from families and as the national guidance emerges.

We will all assess learning against a common framework that:

1. Identifies potential improvements;

2. Develops a shared understanding of what these improvements might be across the Trust;

3. Leads to a series of actions locally, that should be able to be measured;

4. Provides knowledge of the difference made by those actions.

We will take the opportunity to share learning with our partner Trusts and other, local stakeholders. For example, there may be common issues we could commission thematic reviews of.

The actual practice in each Trust will differ for a variety of reasons: different cultures, priorities and ways of doing things. This co-existence of cohesion and diversity will be a strength as we will have the opportunity (through our continued regional work) to share and learn from each other’s approaches and see which ones work best.

The Trust will ensure that lessons learnt result in change in organizational culture and practice by; identifying themes and trends in formal meetings and in the Quality Report; commissioning thematic reviews on a regular basis by the Mortality Committee and ensuring that associated action plans are implemented.

We will ensure learning is cascaded to frontline clinical staff and divisions on a regular basis by use of

1. The Learning Hub
2. Quarterly learning events of SI, Complaints and Claims
3. Feedback of findings at Business units governance meetings
4. Learning is put onto Connect sites
5. Monthly, Quarterly and Annual reports on Themes from SI, Complaints and Claims are on the Complaints and SI Connect sites

The completed reviews identifying any lessons to be learned will be presented to the Mortality Review Group as a standard agenda item to be reviewed and approved. Any actions required would be agreed and monitored in the first instance through the Mortality Review Group and cascaded through the operational management structure as appropriate. We will ensure transparency in decision making and accountability.

**3.10 Data reporting**

From Quarter 3 trusts are required to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings.

The Northern Mental Health Trusts have agreed a common dashboard and will continue to develop this over the next 6 months.

When counting ‘total number of deaths in scope’ and ‘total number of deaths reviewed’ it should be possible to see what percentage of deaths has been reviewed in a particular period. In other words, the number of deaths reviewed should be reported as a percentage of the number of deaths. To do this means that it is helpful to have a time lag in the reporting period - for example Q1 data would be reported at the end of Q2.

The dashboard will include:

• Scope narrative

• Narrative on deaths not recorded on the Safeguard system

• Total deaths registered on RIO

• Total deaths on Safeguard system

• Total number of deaths in scope

• Community (MH, LD) and Inpatient (MH, LD)

• How many reviewed via Mortality Review Group and what level of investigation

• Explain rational for not reporting ‘avoidable’ and include root causes and contributory factors for SI deaths

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from ALL DEATHS.

Working with eight other mental health trusts in the north of England, we are developing a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking in to some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur.

The Northern Alliance of Trusts has decided not to report initially on what are described in general hospital services as “avoidable deaths” in inpatient services. This is because there is currently no research base on this for mental health services and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. We will review this decision not later than April 2018 and will continue to support work to develop our data and general understanding of the issues.

**3.12 How this policy will be implemented**

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| This policy will be ratified by the Executive Management Team and published on the Trust’s intranet and external website. |
| Line managers will disseminate this policy to all Trust employees through a line management briefing. |
| * As further national guidance emerges over the next 12 months, including family engagement, the Trust will review the policy and its implementation to ensure it continues to reflect best practice. |

**3.13 How this policy will be audited/evaluated**

The policy and processes and procedures will be audited by the clinical assurance team, initially following 6 months of implementation and then annually. The results of which will be considered at the Governance and Quality sub group.

The audit tool will be designed to capture both qualitative and quantitative data to demonstrate the lessons learned and how they have been shared and used to improve the quality of services

# 4 DEFINITIONS

|  |  |
| --- | --- |
| **Term** | **Definition** |
| **Case record review** | Reviewing case records/notes to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. The Royal College of Physicians Structured Judgement Review methodology provides an agreed template for this. |
| **Death due to a problem in care** | A death that has been clinically assessed using a recognized methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable. |
| **Investigation** | The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies and procedures, guidance, good practice and observation – in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. |
| **Certification** | A death that has been certified by a doctor at the time of death. |
| **LeDer** | The Learning Disabilities Mortality Review (LeDeR) programme has been commissioned by NHS England to support local areas in England to [review the deaths](http://www.bristol.ac.uk/sps/leder/about/reviews-of-deaths/) of people with a learning disability to:   * identify common themes and learning points and: * provide support to local areas in their development of action plans to take forward the lessons learned. |
| **STEIS** | Strategic Executive Information System is the national system for reporting Serious Incident (SI) that enables electronic logging, tracking and reporting of Serious Incidents with NHS Improvement |
| **Main provider of care** | When the Trust is the main provider of care as described in section 4.4. |
| **Deaths in scope** | Deaths that the Northern mental health trusts and the Trust for general community services have determined require further review under this policy. |
| **Severe Mental Illness** | The term is generally restricted to psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder |

# EQUALITY IMPACT ASSESSMENT

The Trust has no intent to discriminate and endeavours to develop and implement policies that meet the diverse needs of our workforce and the people we serve, ensuring that none are placed at a disadvantage over others. Our philosophy and commitment to care goes above and beyond our legal duty to enable us to provide high-quality services. Our Equality Analysis and equality monitoring is a core service improvement tool which enables the organisation to address the needs of disadvantaged groups. The aim of Equality analysis is to remove or minimise disadvantages suffered by people because of their protected characteristics.

An impact assessment has been undertaken to consider the need and assess the impact of this Procedural Document and is evidenced at Appendix A.

# TRAINING NEEDS ANALYSIS

The Trust is committed to high quality targeted training and effective communication to support this procedural document. The Trust recognises that training capacity can fluctuate and will depend on resources available. As such, based on an assessment of capacity and risk, the training needs analysis will identify the high priority groups for training. The objective is to implement this procedural document and meet the training needs of these groups over the time frequency stated. The focus of Trust monitoring will be on this group over the agreed period or lifetime of the procedural document.

# MONITORING COMPLIANCE AND EFFECTIVENESS

| **Criteria** | **Evidence identified to indicate compliance with policy** | **Method of monitoring, i.e. how/where will this be gathered?** | **Frequency of monitoring** | **Lead responsible for monitoring** |
| --- | --- | --- | --- | --- |
| Interim reivew of policy | BDCFT Dashboard | Report | Annually | Mortality Review Group |

# REFERENCES TO EXTERNAL DOCUMENTS

National Quality Board: National Guidance on Learning from Deaths 2017

NHSE Serious Incident Framework 2015: Supporting learning to prevent recurrence

CQC Regulation 20: Duty of Candour 2014

# ASSOCIATED INTERNAL DOCUMENTATION

This Policy document is to be read in conjunction with the Trust’s:

Serious Incident Policy

Duty of Candour Policy

Being Open Policy

Incident Reporting and Management Policy

Analysing, Learning From and Responding To, Inspections, Guidance and Internal/ External Reports Policy

Investigation of Incidents, Complaints and Claims

**Appendix A**

**Equality Analysis Screening Form**

|  |  |
| --- | --- |
| **Area** | **Response** |
| **Policy/Procedure** | Learning from Healthcare deaths – The right thing to do |
| **Manager** | Andy McElligott, Medical Director |
| **Directorate** | Governance |
| **Date** | 20 September 2017 |
| **Review date** | 01 April 2018 |
| **Purpose of Policy** | Working with families/carers of patients who have died offers an invaluable source of insight to improve services. Therefore there is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. In line with the National Quality Board guidance on Learning from Deaths, every Trust must have a policy in place that sets out how it identifies, reports, investigates and learns from a patient’s death. This should include the care leading up to the patient’s death and considering if this could have been improved. |
| **Associated frameworks e.g. national targets NSF’s** | CQC review December 2016, ‘Learning, candour and accountability |
| **Who does it affect** |  |
| **Consultation process carried out** | The Trust has worked with a northern alliance of other trusts to develop this policy.  A national policy regarding involving families is to be produced this year so the policy will be reviewed in light of this.  A recognised national figure ran a workshop with the northern alliance.  The Trust has also consulted with staff and families in developing policy and resources for undertaking investigations.  All of the key recommendations have been added in this policy. |
| **QA Approved by** | Andy McElligott |

| **Equality protected characteristic** | **Impact Positive** | **Impact Negative** | **Rationale for response** |
| --- | --- | --- | --- |
| Age |  | No |  |
| Disability |  | No |  |
| Gender Reassignment |  | No |  |
| Race |  | No |  |
| Religion or Belief |  | No |  |
| Pregnancy & Maternity |  | No |  |
| Sex |  | No |  |
| Sexual Orientation |  | No |  |

|  |  |  |
| --- | --- | --- |
| **Equality Analysis SIGN - OFF** | | |
| Have any adverse impacts been identified on any equality groups which are both highly significant and illegal? | | No |
| Are you satisfied that the conclusions of the EqIA Screening are accurate?  The Trust will publish a summary of the impact analysis carried out to meet the duty and make this available to the public on the Trust Internet site. | | Yes |
| Completed by Manager |  |  |
| Q A approved |  |  |
| Director approved | Andy McElligott |  |

**Appendix B**

When there is to be a structured case review under the Learning from Deaths process

|  |
| --- |
| Service becomes aware a patient has died |

|  |
| --- |
| IRE is completed by service including cause of death if known |

|  |
| --- |
| Service staff make contact with the family/carer and offer condolences and contact details |

|  |
| --- |
| Mortality Review Group to review all IREs where a death or serious harm has been reported. |

|  |
| --- |
| An incident is identified that meets the threshold to be reviewed under the Serious Incident Framework (SI process commences) or involves the death of a patient with a learning disability (local LD review and LeDeR process commences) |

|  |
| --- |
| Deaths are assessed for the mortality review/learning from deaths process. |

|  |
| --- |
| Local review takes place and learning shared at the MRG |

****

**Document control**

| ***Learning from Deaths Policy*** | | **Yes/No/ Unsure** | **Comments** |
| --- | --- | --- | --- |
| **1.** | **Title** | | |
|  | Is the title clear and unambiguous? | Yes |  |
|  | Is it clear whether the document is a policy or procedure? | Yes |  |
| **2.** | **Rationale** | | |
|  | Are reasons for development of the procedural document stated, e.g. in the Introduction or Scope sections? | Yes |  |
| **3.** | **Development Process** | | |
|  | Is the method described in brief e.g. in the Introduction or Scope sections? | Yes |  |
|  | Are people involved in the development identified, e.g. in the Production and Review Details (page 2)? | Yes |  |
|  | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | Yes |  |
|  | Is there evidence of consultation with stakeholders, service users, patients or carers, e.g. in the Production and Review Details (page 2)? | Yes |  |
|  | Have the requirements of the following been taken into account where applicable:  Mental Health Act  Mental Capacity Act  Care Programme Approach (CPA) Guidance | Yes |  |
| **4.** | **Content** | | |
|  | Is the objective of the document clear, e.g. in the Scope section? | Yes |  |
|  | Is the target population clear and unambiguous, e.g. in the Scope section? | Yes |  |
|  | Are the intended outcomes described, e.g. in the Core Content section? | Yes |  |
|  | Are the statements clear and unambiguous? | Yes |  |
|  | Are any amendments compared to a previous version of the document summarised or where appropriate listed in more detail, e.g. in the Production and Review Details (page 2)? | Yes |  |
|  | The Trust is transitioning services to agile working: please consider and include implications for agile workers and the management of agile within all policies and procedures. | Yes |  |
|  | **Accessible Information Standard.**  All organisations that provide NHS or adult social care are legally required to meet the standard law (Section 250 of the Health and Social Care Act 2012) and to ensure that people who have a disability, impairment or sensory loss are asked if they have any accessible information needs and if they do that these needs are met.  This might include making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email or that people get support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or advocate.  Under the Standard organisations must do the following five things. So please consider when writing your policy and any associated procedures how you will:   1. Ask people if they have any information or communication needs and how these needs might be met. 2. Record those needs clearly and in a set way in the appropriate clinical system. 3. Highlight or flag the person’s file or notes so it is clear that they have information or communication needs and how to meet those needs. 4. Share information about people’s information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so. 5. Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.   For more information and support with the Accessible Information Standard contact Fiona Sherburn, Deputy Director of HR & Workforce Development. | Yes |  |
|  | **Information Governance**  Insert something here about what the author of the procedure should consider in terms of information Governance and sharing information outside BDCFT plus a contact in the Information Governance Team for support.  For more information about Information Governance contact: Gaynor Toczek, Information Governance & Security Manager, Administration. | Yes |  |
| **5.** | **Evidence Base** | | |
|  | Is the type of evidence to support the document identified explicitly, e.g. in the References to External Documents, Associated Internal Documentation sections and Appendices? | Yes |  |
|  | Are key references cited? | Yes |  |
|  | Are the references cited in full? | Yes |  |
|  | Are supporting documents referenced? | Yes |  |
| **6.** | **Approval and Ratification** | | |
|  | Does the document identify which committee/group will approve it, e.g. in the Production and Review Details (page 2)? | Yes |  |
|  | If appropriate have the joint Human Resources/Staff Side Committee (or equivalent) approved the document, e.g. in the Production and Review Details (page 2)? | Yes |  |
|  | Does the document identify which committee/group will ratify it, e.g. in the Production and Review Details (page 2)? | Yes |  |
| **7.** | **Dissemination and Implementation** | | |
|  | Is there an outline/plan to identify how this will be done, e.g. in the Production and Review Details (page 2)? | Yes |  |
|  | Does the plan include the necessary training/support to ensure compliance, e.g. in the Training Needs Analysis section? | Yes |  |
| **8.** | **Document Control** | | |
|  | Does the document identify where it will be held, e.g. in the Production and Review Details (page 2)? | Yes |  |
|  | Have archiving arrangements for superseded documents been addressed, e.g. in the Production and Review Details (page 2)? | Yes |  |
| **9.** | **Process to Monitor Compliance and Effectiveness** | | |
|  | Are there measurable criteria, standards or KPIs to support the monitoring of compliance with and effectiveness of the document, e.g. in the Monitoring Compliance and Effectiveness section? | Yes |  |
|  | Is there a plan to review or audit compliance with the document e.g. in the Monitoring Compliance and Effectiveness section? | Yes |  |
| **10.** | **Review Date** | | |
|  | Is the review date identified, e.g. in the Production and Review Details (page 2)? | Yes |  |
|  | Is the frequency of review identified? If so is it acceptable, e.g. in the Production and Review Details (page 2)? | Yes |  |
| **11.** | **Overall Responsibility for the Document** | | |
|  | Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document, e.g. in the Production and Review Details (page 2)? | Yes |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Author Approval** | | | |
| The Author should complete, sign and date this Procedural Document Compliance Checklist then share it with the Responsible Director/Senior Manager. | | | |
| Author | Andy McElligott | Date | 20.9.2017 |
| Signature |  | | |
| **Responsible Director/Senior Manager** | | | |
| The Responsible Director/Senior Manager should complete, sign and date this then share it with the Responsible Director/Senior Manager.  If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation’s database of approved documents. | | | |
| Name | Andy McElligott | Date | 20.9.2017 |
| Signature |  | | |