Learning from Deaths Policy:

The right thing to do

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

The core objectives of this policy are:

1   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.

2   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.

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

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

5   To ensure the Trust engages with other stakeholders (Acute Trusts. Primary Care, Public Health, Third Sector, Safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximize learning from deaths

6   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.

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ALL sections of this form must be completed.

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![Leeds and York Partnership NHS Foundation Trust]

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1.   THE PROCEDURE

1.1   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.

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 The Management of Incidents Including Serious Incidents Procedure – RM-0002.

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.

1.2 Why we need this 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 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.**

1.3 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.

1.4 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.

1.5 Scope

1.5.1 Who this policy applies to

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

> ⚠️ The National Quality Board Guidance on Learning from Patients Deaths applies to all acute, mental health/learning disability and community NHS Foundation Trusts.

1.5.2 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.

Role	Responsibility
Chief Executive, Executive Directors and Non-Executive Directors	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 having Board level responsibility for learning from deaths. Additionally a named Non-Executive Director has 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
Associate &Clinical Directors, Medical Staff, Senior Nursing Managers, Modern Matrons, Ward and Team Managers and all	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 Clinical Governance 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,

Registered Nurses Allied Healthcare Professionals	and as part of that to: • Ensure staff have the right level of skill through training and experience; • Promote learning from deaths; • That sufficient time is assigned in local governance forums to outline and plan for any lessons learnt; • Ensure that learning is acted on
The Clinical Governance Team, Complaints, PALS	These corporate Trust departments have a responsibility to ensure: • New data is collected and published to monitor trends in deaths (April 2017 onwards) with Board level oversight of this process • Ensuring the Datix 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

⚠️ 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.

1.6 Policy

1.6.1 Encouraging a learning from deaths culture

Through the Trust 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.

1.6.2 Family engagement:

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 who has received care from our Trust and you have anything you would like to discuss, you can contact us at 0113 8555962.

Where clinicians have had close contact with a service user and their family/carer, they will often be the first to offer condolences and support and to give appropriate information to those involved regarding the opportunity to be involved in the review of the care. (C-0060 Duty of Candour) 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 Clinical Governance Team 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 1.6.5);
- 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 explain these processes and what they can expect. This information will be available on staffnet.

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 Clinical Governance Team.

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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.

1.6.3 Identifying and reporting deaths

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (PAS) and where appropriate on its risk management systems. This is to help ensure that the Trust Board has a comprehensive picture of the deaths of all its services users and the opportunities to learn from them.

Trust staff must report deaths that they are made aware of on Datix within 24 hours of being informed and provide the cause of death where known. Once the Datix is completed staff must immediately 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.

⚠️ **All deaths that staff are made aware of must be reported through the Datix system to start the process of learning from patient deaths.**

All Datix reports for deaths are reviewed by the Clinical Governance Team on a daily basis and any unnatural unexpected deaths are taken forward through the Serious Incident process. A summary of all other reported deaths are taken to the Learning from Incidents & Mortality (LIM) (which is a multi-disciplinary forum) where each death is reviewed using the Mortality Review coding methodology (Appendix 1) to establish the category of death and the level of review required.

1.6.4 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 (NHSE Serious Incident Framework 2015: Supporting learning to prevent recurrence)

For people with a Learning Disability the Trust supports the approach of the LeDer program.

The NQB National Guidance on Learning from Deaths provides the context to the review or investigation of deaths and establishes a number of "must dos" in terms of investigations. These include:

i. all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;

ii. all in-patient, out-patient and community patient deaths of those with learning disabilities

iii. all deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means

iv. all deaths in areas where people are not expected to die, for example in relevant elective procedures;

v. 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;

vi. 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.

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

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 patients GP.

- Tissue viability
- Dietetics
- District Nursing
- The drug and alcohol shared care services
- Care home liaison
- Acute hospital liaison
- Community physiotherapy
- Macmillan Nurses
- Health Visitors
- Podiatry

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 carers 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:

- Where a Family / clinical staff / risk management staff flag or raise a concern;

- Where medication with known risks such as Clozapine was a significant part of the treatment regime;

- From causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data);

- Where they had been subjected to a care intervention where death wouldn't have been an expected outcome e.g. ECT, rapid tranquilisation;

- Where the service user had no active family or friends and so were particularly isolated e.g. with no one independent to raise concerns;

- 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;

- Associated with known risk factors / correlations

Also:

- Particular causes of death e.g. epilepsy;

- 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;

- Where a proactive initial assessment of a death has potentially identified that there was deterioration in the physical health of a service user which wasn't responded to in a timely manner;

- Random sampling.

1.6.5 The types of review

Practice varies across Trusts with regard to how deaths are reported and categorised. Each trust has core processes around:
- an initial screen of each death e.g. at a weekly LIM, at a Huddle which will always necessitate the collection of core date around the service user and his or her death and sometimes the use of a structured tool;
- 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.

72 hour report

An initial incident review to confirm whether a serious incident has occurred and if applicable the level of investigation required and to outline immediate action taken.

Concise/ Local review

This is suited to less complex incidents which may be managed by individuals or small group at a local level, to be completed within 6 weeks

Comprehensive/ Serious Incident review

This is suited to complex issues to be completed within 60 working days

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 LIM any non-SI deaths that require a review will be discussed with the service and the 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. See Flow Chart appendix 3

1.6.6 Governance process/ ensuring Learning

The prime objective of a Learning from Death 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 round 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 organisational culture and practice by; identifying themes and trends in formal meetings and in the Quality Account; commissioning thematic reviews on a regular basis by the Trust Incident Review Group (TIRG) 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: Learning reviews, lessons learnt bulletins, Clinical Governance Forums

The structured case review identifying any lessons to be learned will be presented to LIM as a standard agenda item to be reviewed and approved. Any actions required would be agreed and monitored in the first instance through the LIM and cascaded through the operational management structure as appropriate. This could take the form of a formal request for a review of a particular theme or topic or more general learning in the Lessons learnt bulletin

We will ensure transparency in decision making and accountability.

1.6.7 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.

1.7 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.

2 Appendices

Leeds and York Partnership NHS
NHS Foundation Trust

Mortality Review within LYPFT NHS Foundation Trust

Death of a patient in our care or has used services with the last 6 months – Complete a DATIX for all deaths

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Expected Natural death – (EN1): a death that was expected to occur in an expected time frame e.g. people with terminal illness or within palliative care services.
- These deaths may not be investigated but could be included in a mortality review of early deaths

Expected unnatural death – (EU): A death that was expected but not from the cause expected or timescale. e.g. some people who misuse drugs, are dependant upon alcohol or with and existing disorder.
- These deaths should be investigated

Expected Natural death – (EN2): A death that was expected but was not expected to happen in the time frame. e.g. someone with cancer or liver cirrhosis who dies earlier than anticipated.
- These deaths should be reviewed and in some cases would benefit from further investigation

Unexpected natural death – (UN2): An unexpected death from a natural cause but did not need to be e.g. some alcohol dependence and where there may have been care concerns.
Level 3 – DATIX
- These deaths should be reviewed and a proportion will need to be investigated

Unexpected natural death – (UN1): any unexpected death which are from natural cause e.g. a sudden cardiac arrest condition or stroke.
- These deaths should be reviewed and some may need an investigation

Unexpected unnatural death – (UU): An unexpected death from unnatural causes e.g. suicide, homicide, abuse, neglect.
- These deaths are likely to need investigation
- These deaths are likely to follow the Serious Incident process

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Discuss at weekly Learning from Incidents and Mortality Group (LIM)

Being open – make contact with the family/ significant others to offer condolences and offer support to the family.

Outcome of LIM
1. Expected natural death – no action needed.
2. Meets Serious Incident threshold – death reported to Clinical Commissioning Group as Serious Incident and investigation undertaken
3. Meets significant incident threshold – level 3 - comprehensive review by service
4. Review of expected natural, expected unnatural, expected natural, unexpected natural for consideration for review using structured case note methodology.

Feedback to LIM
1. 72 hour report – 1 week
2. Concise report/ Local review – 6 weeks
3. Comprehensive report/ SI report – 60 working days
4. Structured Judgement Review – 2 weeks

Trust Incident Review group
Will receive all Comprehensive reports
Quarterly feedback on all SI's and Level 3 and mortality reviews identifying themes and trends.

Duty of Candour
1. Be Open – meet with the family and explain what has happened as soon as reasonably practicable (within 10 working days of the death occurring or becoming aware of the death_ - Offer condolences and document within the patient records.
2. Explain to the family how the death will be investigated. Follow this explanation up in writing to the family (letter template available) and the date this will conclude. Upload a copy of the letter within DATIX.
3. Meet with the relevant person/s to discuss the findings of the investigation. Be open and honest about the areas for learning and actions to be taken to prevent reoccurrence.
4. follow up the meeting in writing, confirming the finding and areas for learning/ actions to be taken following the death.