**Learning from Healthcare Deaths Policy:**

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

**DOCUMENT SUMMARY SHEET**

ALL sections of this form must be completed.

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**1.** **THE PROCEDURE**

* 1. **Introduction**

Most people will be in receipt of care from the NHS at the time of their death and 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.

Learning from deaths is an essential part of quality improvement. 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.

This policy is in line with the Trust values:

* We have integrity – we treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.
* We keep it simple – we make it easy for the communities we serve and the people who work here to achieve their goals.
* We are caring – we always show empathy and support those in need.

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 maximise learning.

The Confidential Inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

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 family member through to actions taken following on from any investigation in line with the National Quality Board guidance on supporting bereaved families.

A report by independent auditors, Mazars, commissioned by NHS England was published in December 2015. It commented on services run by Southern Health NHS Foundation Trust.

The report found:-

* Failings in the way the Trust investigated serious incidents.
* Too few deaths were investigated and some should have been investigated further.
* The Trust could not demonstrate a comprehensive systematic approach to learning from deaths.

These findings were reinforced in the Care Quality Commission (CQC) report “Learning, candour and accountability.” It revealed 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 recognising their insights and experiences is vital to our learning.

The National Quality Board (NQB) guidance on Learning from Deaths was the starting point to initiate a standardised approach to the way NHS Trusts report, review, 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 Executive Teams and Boards can use these findings.

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

Leeds and York Partnership NHS Foundation Trust is the main provider of specialist mental health and learning disability services in Leeds. We also provide specialist services across York, the Yorkshire and Humber region, and some highly specialised national services.

This policy should be read in conjunction with:-

* Being Opan and Duty of Candour Policy C-0060
* The Management of Incidents Including Serious Incidents Procedure – RM-0002.

* 1. **Purpose and Scope of this policy**

Reviewing the deaths of patients who are or have recently been in receipt of our care provides the Trust with an opportunity to identify where good practice took place, to share and learn from. Through working with staff and families/carers of patients who have died we also gain information on where we can improve services.

In line with the NQB guidance on Learning from Deaths, each Trust must have a policy in place that sets out how it identifies, reports, investigates, and learns following a patient’s death. The initial review should include the care leading up to the patient’s death, considering if this could have been improved.

This policy informs the organisation of staffs’ roles and responsibilities relating to learning from deaths and how we identify learning opportunities.

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| C:\Users\flintoffj\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\XJK2M0E3\MC900434750[1].png | **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 how the Trust 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 families and carers involvement when a death has occurred, including how to ensure there are 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 support staff to be open, transparent and compassionate in their engagement with families and carers including the opportunity to share information to support our review process.
  + To standardise approaches to reviewing deaths in order to gather relevant information and identify key learning.
  + 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 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 Definitions**

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| **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 to learn from what happened. The Royal College of Physicians Structured Judgement Review methodology provides an agreed template for this. |
| **Death certification** | The process of certifying, recording, and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner. |
| **Medical Examiner Role** | Medical examiners are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. |
| **Learning from Incidents and Mortality Meeting (LIMM)** | Fortnightly meeting to review all deaths within scope and severity 4 incidents and other incidents with potential for organisational learning. |
| **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 – to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. |
| **Death due to a problem in care** | A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as ‘cause of death’). |
| **Deaths in scope** | Deaths that the Trust have determined require further review under this policy. |
| **Investigation / Review** | The act or process of investigating or reviewing an incident; 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.  Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first. |
| **LeDeR** | LeDer was originally introduced in 2015 in response to significant ongoing concerns about the likelihood of premature deaths of people with a learning disability. Since June 2021 deaths of adults who have a diagnosis of autism, but no learning disability will be included in the process. The name has changed from a Learning Disability Mortality review to **Learning from Life and Death Review.** LeDeR reviews will be completed for all individuals aged 4 and over with a learning disability and individuals over the age of 18 who have been told by a doctor that they are autistic and had this written in their medical record. All reviews of people who are autistic without a learning disability will be focussed reviews initially to develop data and learning. |
| **Main provider of care** | When the Trust is the main provider of care. |
| **Fact Find review** | Following review of the clinical records by the DATIX incident from handler, the fact find section is completed providing a summary of the care provided and identify good practice and any areas for further review. |
| **Patient Safety Incidents** | Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.  Current process is described in the Serious Incident Framework 2015, this will be replaced by Patient Safety Incident Response Framework by Autumn 2023. |
| **Severe Mental Illness** | The term is generally restricted to psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis, and schizoaffective disorder. |
| **StEIS** | Strategic Executive Information System is the national system for reporting Serious Incidents (SI) that enables electronic logging, tracking, and reporting of Serious Incidents with NHS Improvement. |
| **Structured Judgement Review (SJR)** | Reviewing case records to determine whether there were any problems in the care provided to the patient who died, in order to learn from what happened. The Trust uses the Royal College of Physicians Structured Judgement Review methodology[[1]](#footnote-1) and Royal College of Psychiatrists Mortality Review Tool for Mental Health Trusts[[2]](#footnote-2) |

**1.6 Duties**

**1.6.1 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 Trusts. |

**1.6.2 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.

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| **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. |
| **Clinical Directors, Medical Staff, Senior Nursing Managers, Modern Matrons, Ward and Team Managers and all Registered Nurses 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 Clinical Governance Team, to support staff to review and investigate deaths ensuring they have the time to carry this process out in a skilled way to a high standard, 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. |
| **Clinical Governance Team: Patient Safety, Quality & Regulations** | These corporate Trust departments have a responsibility to ensure:   * Data is collected and published to monitor trends in deaths with Board level oversight of this process every quarter. * Ensuring the Datix incident reporting system is used to record deaths (expected and unexpected) in accordance with Trust policy. * Information is processed in a consistent and accurate way to meet agreed governance processes and 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. Use in conjunction with Duty of Candour Policy. |

**1.7 Policy**

**1.7.1 Encouraging a learning from deaths culture**

Through developing staff confidence in engaging with families we are seeking to create an open culture that hears the voice of families and carers to identify learning. We will look to learn and share what we do well alongside areas we need to consider for action and improvement.

**1.7.2 Family engagement:**

Responding 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.

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. Further information is contained within policy C-0060 Duty of Candour. There may be times where there is a delay in the Trust being notified of the death of a service user. In these circumstances a discussion should take place between the Clinical Governance Team and the clinical team involved to determine the best approach.

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. 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 patient safety investigations or reviews.
* providing evidence / contributions to the review or investigation e.g., providing a pen portrait of the person, timeline 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.

**First contacts**

When a service user dies, there is an expectation that contact will be made with bereaved families/carers of service users to offer condolences, support, and opportunities to comment on the care the Trust provided.

The Trust may be informed of a death through various routes. For example, an admin member of staff may receive a call from a family member to inform us of the death or a clinician may be told of a death on a planned visit, or an update from the clinical records. All staff should be familiar with the Being Open Policy which sets out the requirements and actions required including if Duty of Candour applies.

During an initial contact with the family of a deceased service user, staff should ensure they:

* offer condolences
* obtain a name and contact details for the family member
* sensitively ask about the circumstances and cause of the death
* ask if they have any questions about the care their family member received from the Trust
* offer support and signpost to sources of support, e.g., GP, third sector organisations etc.

The Trust has developed information to support families following bereavement and also provides a copy of the “Help is at Hand” Booklet.

There are 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.

**Unable to contact**

There may be occasions where the Trust is not able to make contact with family or carers. Attempts to make contact should be recorded in the clinical record. Where a service user does not have family or carers, or their details are not recorded on the clinical system the reasons for no contact with family should be recorded in the clinical record.

**Ongoing contact**

Staff should offer the opportunity for on-going involvement in keeping with the family’s needs and wishes. Where an investigation or review has been agreed it should be agreed between the service, family/significant other and lead reviewer/investigator who will be the lead contact for LYPFT.

**Involvement in reviews and investigations**

The Trust’s approach is to seek early engagement with the family and/or carer taking their views and opinions into account to ensure they can, if they wish, be involved within the review/investigation process.

We will write to the family to inform them that a review or investigation is being undertaken. We will also provide further information in the form of a booklet that explains the review/investigation process and how they can be involved in the review. The flowchart in Appendix A sets out the different review processes that may be used following a death.

**Contact declined**

If the family or carer initially decides not to be involved in the review/investigation process, staff should make it clear they can change their decision at a later time. If the family does not want contact at all about the process or findings, this should be honoured, and staff should record their wishes.

**Unknown cause of death**

In some cases, the cause of death may not be known when a death is reported. Where information on the cause of death and circumstances is unknown to family or carers, teams should seek information relating to the death through other routes. The service user’s GP, care home or last care provider (e.g., acute hospital) may be able to provide information. As information is identified the clinical records and Datix, if recorded, should be updated with the required information.

In addition to this, the Patient Safety Managers will try to obtain cause of death/inquest conclusions from H M Coroner’s office.

**1.7.3 Scope of reportable 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. In addition, a weekly review of all deaths recorded via the NHS Spine, to identify any patients in receipt of LYPFT care in the 6 months prior to their death.

The Trust will be informed of a service user’s death in a variety of ways. This could be by contacting to arrange an appointment or attending a planned visit, family contacting staff to inform them of the death, coroner’s requests, other care providers, through the clinical information system.

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. Where deaths are identified through enquiries from the coroner, teams should report the death on Datix. There is one exception to this; Liaison Psychiatry should not report expected deaths that occur for inpatients at Leeds Teaching Hospitals on the Trust’s DATIX system unless there is a specific concern in relation to mental health. These deaths are reported on the LTHT reporting system.

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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 through the Datix system to start the process of learning from patient deaths.** |

All Datix reports for deaths are reviewed by the Patient Safety Team on a weekly basis and any unnatural unexpected deaths are considered through the Serious Incident process. A summary of all other reported deaths is taken to the Learning from Incidents & Mortality (LIMM) (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.

**1.7.4 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 (NHS England, Serious Incident Framework 2015: Supporting learning to prevent recurrence). This framework will be replaced by the Patient Safety Incident Response Framework in 2023. The decision is made at the fortnightly Learning from Incidents and Mortality Meeting (LIMM). All deaths reported are subject to a table top review initially and those who meet the criteria below will be subject to a further review at LIMM, and agreements made regarding coding the death and if appropriate allocation of an investigation.

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| LYPFT has a core process around:   * an initial screen of each death e.g., weekly review by Patient Safety Managers**.** * Learning from Incidents and Mortality Meeting which is held fortnightly.   The meeting considers deaths where further review may be indicated as it meets an agreed criteria or there are potential opportunities for organisational learning.   * Any initial review such as a Structured Judgement Review can be escalated to a comprehensive review, where appropriate, i.e., the review highlights significant concerns which requires a more in depth understanding of the care provided prior to death. |

The Patient Safety Managers present all deaths in scope to the fortnightly Learning from Incidents and Mortality Meeting. This is the decision meeting to ensure the correct coding of the death and if investigation is required. A death meeting the SI criteria will be reported as a serious incident and an investigation commissioned in line with the Trust’s Incident Reporting and Management (including serious incidents) Policy; of note is that this process will change with the implementation of PSIRF in 2023.

The codes are as follows:

* Expected natural (EN1) – e.g., Terminal illness
* Unexpected natural (UN2) –e.g., alcohol dependency but care concerns, multiple co-morbidities, including physical health
* Unexpected unnatural (UU) - e.g., suicide, homicide, abuse, neglect
* Not our Death (NOD) – not the main provider of care, therefore not in scope.

For people with a Learning Disability or autism the Trust supports the approach of the LeDer program with deaths subject to a fact find in the first instance to identify any immediate internal learning. The death is also reported to LeDer via the website: <https://leder.nhs.uk/report>

**National Guidance**

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:

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.
7. deaths meeting the criteria within the Serious Incident Framework.
8. child (under 18) death reviews should be undertaken in accordance with national guidance, Working Together to Safeguard Children.
9. maternity/perinatal deaths.
10. any death of a patient detained under the Mental Health Act is reported to the Care Quality Commission without delay.

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.

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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 due to identified mental health needs. * An episode of community treatment due to identified learning disability or substance misuse needs. * 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 between the service providers to agree the scope of the investigation (this will be determined by the cause of death) and who the lead organisation will be. The Patient Safety Team should be included within these discussions to ensure the management and governance of the review is agreed and in line with LYPFT requirements.  ***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.   * Dietetics * The Drug and Alcohol Shared Care Services * Care Home Team * Memory Services Team * Acute Hospital Liaison (In reach services for in patients at LTHT) * Community Physiotherapy/Occupational Therapy * Palliative care Team * Acute Liaison Psychiatry - **NB** *LIMM should always review the care provided to a person seen by ALPS in the 6 months prior to death to determine if a further review is required.*   ***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? |

**Local Guidance**

In addition, the Trust has identified a number of potential triggers for a review or investigation. These include deaths:

• Where a Family / clinical staff / clinical governance 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 the service user had been subjected to a care intervention where death would not have been an expected outcome e.g., ECT, rapid tranquilisation.

• Where the service user had no active family or friends and so was 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.

**Additional reporting requirements**

There are occasions when the Trust is notified of the death of a former service user who was discharged from the Trust more than 6 months prior to their death. This is usually in the form of a request for information from HM Coroner seeking statements regarding the care provided or other legal processes. This contact could be made direct to teams or via the Trust’s Clinical Governance Team (Inquests). In these cases, an incident should be recorded on Datix stating the nature of the request and detailing the length of time since discharge. This record will be used to manage the requested information. No Manager’s review will be required.

**Liaison with other organisations**

Where problems are identified relating to other NHS Trusts or organisations, LYPFT 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?

If the Trust receives requests from other organisations to review the care provided to people who are its current or past patients but who were not under its direct care at time of death, the Trust will review the care provided on the clinical records in the first instance to establish our involvement. Information will be shared with partners if the death is outside the Trust’s scope. Where the death meets our reporting criteria the manager will ensure the death is reported on Datix and the normal process followed.

**1.7.5 Levels of Review**

**Death Certification – Role of Medical Examiner**

Ifthe death has been certified by a doctor as a natural cause and the death has not been reported to the coroner, and patient did not die whilst under MHA at time of death, the case notes should be passed to the Medical Examiner for review.

Medical examiner offices in England are based at acute trusts (and a small number of specialist trusts).

The role is to examine deaths, to:

* agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it.
* discuss the cause of death with bereaved people and establish if they have questions or any concerns with care before death.
* act as a medical advice resource for the local coroner.
* identify cases for further review under local mortality arrangements and contribute to other clinical governance processes.

**Fact Find report**

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

Investigations are a review of care provided using recognised systems analysis tools. These are either undertaken at service level for a service level investigation/significant event analysis or through a central dedicated team for serious incidents. The aim of the review is for the Trust to learn and prevent recurrence.

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. The findings will always be shared with the family subject to confidentiality requirements. We will always share the outcome and learning.

* + 1. **Joint investigations**

There are some instances when a joint approach to investigation is required. The Trust has developed links with neighbouring Trusts and other NHS providers of care to enable this to take place when needed.

* + 1. **Other investigations**

The Trust is an active member in Safeguarding adult’s board, safeguarding children's partnership, and should a death require investigation through the Safeguarding process the Trust will work through that process in line with the Serious Incident Framework.

* + 1. **Learning Disability and Autism Deaths**

All deaths of individuals with a Learning Disability and/or an Autism diagnosis should have a fact find completed to enable any local learning to be identified. There is [**evidence from both before**](http://www.bristol.ac.uk/media-library/sites/sps/leder/LeDeR_2019_annual_report_FINAL2.pdf) and [**during the pandemic**](https://www.ons.gov.uk/releases/updatedestimatesofcoronaviruscovid19relateddeathsbydisabilitystatusenglandandwales2marchto20november2020) that deaths for people with disabilities and autistic people are  higher than they should be and that people die earlier than ought to be the case. Alongside the fact find a Structured Judgement Review may be completed and if appropriate also refer to the West Yorkshire ICB to request a Learning from Life and Death Review

**1.8 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 who use them.

We have developed a consistent framework to review deaths reported at LYPFT, ensuring where potential learning opportunities are identified that these are discussed at LIMM to agree the type and scope of review that is required. There are agreed processes in place as to where and how to share the findings and subsequent learning. As a learning organisation, we consider how to share learning to a broad audience.

Patient Safety Investigations commissioned via LIMM are taken through the service line Clinical Governance meeting and Quality Assurance Group for review, comment and development of appropriate actions. The report and action plan are taken through Trust Wide Clinical Governance for sign off. Thematic reviews will be carried out where appropriate and monitoring of emerging themes will have oversight from the Trust wide Incident Review Group.

Opportunities for Trust-wide learning can be shared at the Unified Clinical Governance Group and cascaded through service or service line Clinical Governance Meetings. There is also opportunity for information to be shared within a number of specialty meetings including, but not limited to, Falls and Pressure Ulcer Group, Positive and Safe Group, Sexual Safety Group, Trust wide Safeguarding Committee.

We share learning with our partner trusts through the Secondary Mental Health Suicide Prevention Group. We are currently piloting processes to share learning with clinical staff identifying any preferred methods.

Structured Judgement Reviews are presented within the relevant service’s Clinical Governance meeting. Any actions would be agreed and monitored through the service or team Clinical Improvement Forum and/or Clinical Governance or Risk Management Meeting and cascaded through the operational management structure as appropriate.

**1.8.1 Data reporting**

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

**2 Appendices**

**Mortality Review Process within LYPFT**

Table

Description automatically generated

**PART B**

**3 IDENTIFICATION OF STAKEHOLDERS**

The table below should be used as a summary. List those involved in development, consultation, approval, and ratification processes.

|  |  |
| --- | --- |
| **Stakeholder** | **Level of involvement** |
| Medical Director | Consultation |
| Deputy Director of Nursing and Quality | Consultation |
| Heads of Clinical Governance:  Patient Safety, Regulations and Quality | Consultation |
| Quality & Patient Safety Leads | Consultation |
| Deputy Director of Nursing Meeting | Consultation |
| Trustwide Incident Review Group | Consultation |
| Learning from Incidents and Mortality Meeting | Approval |
| Policies and Procedures Group | Ratification |

**4 REFERENCES, EVIDENCE BASE**

National documents:

* [Patient Safety Incident Response Framework](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/%23heading-1)
* [NHS England » Learning from deaths in the NHS](https://www.england.nhs.uk/patient-safety/learning-from-deaths-in-the-nhs/)
* [Care Quality Commission (CQC) (2016) Learning, candour, and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England](https://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability)
* [National Quality Board (2017) National Guidance on Learning from Deaths](https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf)
* [NHSE Serious Incident Framework (2015): Supporting learning to prevent recurrence](https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf)
* [CQC Regulation 20: Duty of Candour (2014](http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour))
* [Working Together to Safeguard Children.](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf) (2015)
* [The Department for Education' forms for reporting child deaths](https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths)
* [National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers](https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/)
* [Royal College of Psychiatrists (2018) Care Review Tool for Mortality](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/care-review-tool-for-mental-health-trusts)
* [Royal College of Physicians (2018) Mortality toolkit: Implementing structured judgement reviews for improvement](https://www.rcplondon.ac.uk/guidelines-policy/mortality-toolkit-implementing-structured-judgement-reviews-improvement)

**5 ASSOCIATED DOCUMENTATION (if relevant)**

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

C-0060 – Being Open and Duty of Candour Procedure

**6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)**

* Board oversight quarterly and annually
* Evidence of learning and implementation of recommendations/actions.

**7. EQUALITY IMPACT**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender, and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I have not identified any potential negative impacts for any of the nine protected groups.

Print name: Cath Wardle

Job title: Head of Clinical Governance, Patient Safety

Date: 14/02/2023

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; [diversity.lypft@nhs.net](mailto:diversity.lypft@nhs.net).

\*delete as appropriate

**CHECKLIST**

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This checklist is part of the working papers.

|  | **Title of document being newly created / reviewed:** | **Yes / No/** |
| --- | --- | --- |
| **1.** | **Title** |  |
|  | Is the title clear and unambiguous? | *Yes* |
|  | Is the procedural document in the correct format and style? | *Yes* |
| **2.** | **Development Process** |  |
|  | Is there evidence of reasonable attempts to ensure relevant expertise has been used? | *Yes* |
| **3.** | **Content** |  |
|  | Is the Purpose of the document clear? | *Yes* |
| **5.** | **Approval** |  |
|  | Does the document identify which committee/group will approve it? | *Yes* |
| **6.** | **Equality Impact Assessment** |  |
|  | Has the declaration been completed? | *Yes* |
| **7.** | **Review Date** |  |
|  | Is the review date identified? | *Yes* |
|  | Is the frequency of review identified and acceptable? | *Yes* |
| **8.** | **Overall Responsibility for the Document** |  |
|  | Is it clear who will be responsible for co-ordinating the dissemination, implementation, and review of the document? | *Yes* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Chair of the Committee / Group approving** | | | |
| If you are assured this document meets requirements and that it will provide an essential element in ensuring a safe and effective workforce, please sign and date below and forward to the chair of the committee/group where it will be ratified. | | | |
| Name | *Catherine Wardle* | Date | *09/02/2023* |
| **Name of the chair of the Group/Committee ratifying** | | | |
| If you are assured that the group or committee approving this procedural document have fulfilled its obligation, please sign, and date it and return to the procedural document author who will ensure the document is disseminated and uploaded onto Staffnet. | | | |
| Name | *David Syms* | Date | *21/03/2023* |

1. Royal College of Physicians (2018) Mortality toolkit: Implementing structured judgement reviews for improvement [↑](#footnote-ref-1)
2. Royal College of Psychiatrists (2018) Care Review Tool for Mortality [↑](#footnote-ref-2)