Learning from Healthcare Deaths Policy

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

- To prioritise and enable consistently effective, meaningful engagement and compassionate support between family, friends, carers and staff that is open and transparent and that allows them to raise questions about the care provided to the service user.
- 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, Third Sector, Safeguarding, Health, and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximize learning from deaths.

All staff working at LYPFT 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 actions are taken.

This policy may refer to staff as qualified/registered professional or other such term to describe their role. These terms have traditionally referred to individuals in a clinical role at band five or above. Please note that the use of these terms **may or may not** include nursing associates or associate practitioners (band four). For clarification on whether a nursing associate or associate practitioner is an appropriate person to take on the identified roles or tasks in this policy, please refer to the job description and job plan for the individual, or local risk assessment.

DOCUMENT SUMMARY SHEET

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2.0	Review date extended	Policy review date extended 31 March 2023
3.0	Review of procedure	Update to reflect changes in National Guidance. Simplified reporting process
4.0	Review of procedure	• Alignment to PSIRF • Increase accessibility of policy content • Removal of Mazar's based elements in favour of the RCP full guidance on Learning From Death

This policy should be read in conjunction with:	
Being Open and Duty of Candour Policy	C-0060
Patient Safety Incident Response Policy	RM-0012
Patient safety incident response plan	Available on Staffnet

Contents

SECTION 1

Introduction

Learning from deaths of people in the care of LYPFT will improve the quality of the care provided to patients and their families and and identify where more could be done to prevent future deaths.

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, reviews or investigates and learns following a patient's death.

The policy sets out the Trusts approach to applying the National Quality Boards, *National Guidance on Learning from Deaths* (2017). The guidance builds on the CQC report 'Learning, Candour and Accountability publication' (Dec 2016), the "Using the Care Review Tool for mortality reviews in Mental Health Trusts" and the Learning Disabilities Mortality Review (LeDeR) process managed by NHS England.

The Five Year Forward View for Mental Health completed in February 2016 identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people and included recommendations to address this. This was also highlighted in the NHS Long Term Plan in 2019. The Confidential Inquiry into premature deaths of people with learning disabilities showed parallel patterns, in terms of early deaths.

People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy and are therefore dying earlier than they should. The learning from deaths, people with a learning disability and autistic people (LeDer) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally improve the health of people with a learning disability and reduce health inequalities. (NHSE)

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. It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

Scope

The policy sets out the procedures for identifying, recording, reviewing, investigating and learn from the deaths of people in receipt of care from the Trust or who have been discharged within the last six months from the time of the death occurring. 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. The core objectives of this policy are:

- To support staff to be open, transparent and compassionate in their engagement with family, friends and carers, including the opportunity to share information to support our review process, utilising a Just Culture approach.
- To standardise approaches to reviewing deaths, to gather relevant information and identify key learning and ensure that learning is shared as wide as possible.
- To understand how learning is improving patient experience.
- To respond to the death of a person living with autism or a learning disability, serious mental illness (SMI), an infant or child, supporting the identification of quality improvement processes, where applicable, to reduce the inequality in the life expectancy of people with the aforementioned conditions.
- To enhance learning at a personal, team and organisational level.
- To support staff wellbeing following the death of a patient (CrISSP).
- To ensure the Trust engages with other stakeholders (Acute Trusts, Primary care, public health, Safeguarding, Health, Coroners, Wellbeing Boards, etc.) to work collaboratively, sharing relevant information and expertise to maximize learning from deaths.
- To produce six monthly reports to be presented to the LYPFT Trustwide Clinical Governance meeting and subsequently to the LYPFT Quality Committee.

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.

1.4.1 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 support cultural change. The Medical Director for Mental Health Legislation and the Director of Nursing and Professions have 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. Bereaved families, friends and carers (including staff), following a death of a patient, are engaged and supported.
- There is evidence of learning from deaths, both internally and with our external partners, and quality improvement is championed.
- Processes focus on learning and can withstand external scrutiny, by providing challenge and support and assurance of published information.

1.4.2 Clinical Directors, Medical Staff, Senior Managers, Modern Matrons, Psychology Professionals, Ward and Team Managers and all Registered Nurses and Allied Healthcare Professionals

In conjunction with the Clinical Governance Team:

- Ensure staff have the right level of skill through training and experience.
- Promote a culture of 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 and shared amongst relevant trust staff.

1.4.3 Patient Safety Team

The Patient Safety Team ensures the following:

- Oversees the Trust's Datix system, including data analysis and performance reporting and ensuring the Datix incident reporting system is used to record deaths in accordance with Trust policy.
- Administration of patient safety alerts
- Leadership and advice for incident reporting and learning responses
- Support patient safety investigation teams for conducting patient safety incident reviews and investigations, including leading on these, when required.
- Provision of training and guidance around patient safety and patient safety events reviews and investigations to support staff at all levels.
- Support learning processes at local level as requested and gather findings and reccomandations of accrued learning trustwide.
- Continuously supporting clinical teams in the review, investigation and learning processes, as directed by the Learning from Incidents and Mortality Meeting (LIMM) and any other applicable forum.
- Update policies in line with changes with national and local guidance.
- Maintain and develop networks with external Trusts to support a cooperative and learning culture around deaths.
- Communicate with the Coroners regarding ascertaining causes of death, as required.
- Respond to external Trust safety queries on care delivered under LYPFT.

1.4.4 Learning from Deaths Quality and Safety Medical Lead

The post holder will work closely with the heads of clinical governance to identify themes arising from the analysis of deaths and near misses and to ensure that the organisation is learning from these and implementing quality improvements aimed at avoiding their repetition.

1.4.5 Death Certification – Role of Medical Examiner

LYPFT does not have a Medical Examiner assigned within the trust. The Medical Examiner service is entirely provided by Leeds Teaching Hospitals NHS Trust. Referral to medical examiners will be sent to the email (only via NHS.net email addresses) leedsth-tr.communitymedicalexaminer@nhs.net .

The governance process around the referral to the Medical Examiner can be found at appendix 2.1.7

The case notes should be passed to the Medical Examiner for review if the death has been:

- certified by a physician as a natural cause, *and*
- the death has not been reported to the coroner, *and*
- the patient did not die whilst under Mental Health Act (MHA) at time of death.

The medical examiner role is to examine deaths, to:

- agree the proposed cause of death (COD) and the overall accuracy of the "Medical Certificate of Cause of Death" (MCCD) with the physician 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.

Policy Details

1.5.1 Engaging and involving patients, families and carers following a death

When a service user dies, there is clear expectation that contact will be made with bereaved family, friends or carers of the service users to offer condolences, support, and opportunities to comment on the care the Trust provided, in line with the Duty of Candour Policy.

All staff should be familiar with requirements and actions required. Responding respectfully, sensitively and compassionately when someone has died is crucially important, as this is a sensitive matter for families, friends, carers and staff.

It is important to acknowledge that **apologising for an event that** occurred to a service user **does not automatically translate in an admission of liability** on the part of the clinician, worker or the Trust itself.

Through developing staff confidence in engaging with service users' family, friends and carers, LYPFT is seeking to create an open culture that hears the voice of family, friends and carers. LYPFT will ensure to learn from and share good practice, alongside areas the Trust need to consider for action and improvement.

Family, friends and carers may have questions or concerns they would like an answer to in relation to the care and treatment the service user received. This request should be clearly documented on appropriate records (e.g. Datix – preferably - or Care Director) and made part of the investigation or review process, aiming to answer to the concern in the most accurate and truthful way achievable at the time of the review or investigation.

To support family, friends and carers, LYPFT will provide a range of information for relatives that explain these processes and what they can expect. Further guidance can be found on NHSE website.

Please also refer to the "Duty of Candour Policy C-0060", the "DoC Flow chart of procedure" and the "Duty of Candour Staffnet page" for further information.

1.5.1.1 Initial Conversation

NHS England has provided guidance and a framework which outlines the national standard for engaging with those affected by a patient safety incident and their subsequent involvement in any learning responses. During an initial contact with the relatives of a deceased patient, staff should ensure they:

1. offer condolences
2. obtain a name and contact details for the family member or carer.
3. sensitively ask about the circumstances and cause of the death, where appropriate.
4. ask if they have any questions about the care their family member received from the Trust, note comments of request they have made (Preferably on Datix, or on Care Director if not possible to upload information on Datix). This will make part of the investigation process and will be explored and included in their report by the lead reviewer.
5. offer support and signpost to sources of support, e.g. GP, third sector organisations etc.

1.5.1.2 Unable to contact/contact declined

Attempts to make contact should be recorded (e.g. Datix - preferably - or Care Director). Where a service user could not identify family, friends or carers, or their details are not recorded on the clinical system, the reasons for no contact should be recorded. If the family, friends or carer do not wish any contact about the process or findings, this should be honoured, and staff should clearly record their wishes on appropriate records.

1.5.1.3 Sharing findings with family, friends and carers

Ideally this should be undertaken in a face-to-face meeting with a staff member talking to the family member/carer through the report, where this is appropriate, or summary of the same can be posted over to the most appropriate family member. This can be achieved following the Duty of Candour Policy for the final letter, where findings and improvement works are shared.

1.5.2 Identification of safety events requiring further review or investigation

1.5.2.1 National Guidance

The NQB National Guidance on Learning from Deaths provides the context to the review or Investigation of deaths and establishes several “must do’s” in terms of case notes reviews and investigations.

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 conditions such as: schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

For further context, GOV.UK identifies SMI as: people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as a SMI.

It is acknowledged that there is substantive criticism of the above definitions; 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. As there is no agreed definition of SMI, the Trust will ensure every case is reviewed with a case-by-case approach.

The Patient Safety Incident Response Plan (PSIRP) highlights the national requirements to conduct investigations or reviews when a service euser pass away. The national priorities to investigate are described in Appendix 1 – Events requiring a specific type of response as set out in policies or regulations (national) of this document.

1.5.2.2 Local Guidance

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

- Described in the LYPFT Local Priorities indicated in the Patient Safety Incident Response Plan (PSIRP)
- Where a family member, carer, friend or LYPFT staff flag or raise a concern on care provided, or in areas where one was flagged already.
- All patients with a diagnosis of psychosis or eating disorder during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within six months prior to their death.
- All patients who were an in-patient in a mental health unit at the time of death or who had been discharged from in-patient care within the last month.
- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.
- In instances where treatment delays were identified, such as when an assessment was conducted or a GP referral was made, but care and treatment were not provided, or where there was a gap in services.
- Causes of death such as epilepsy, fall from heights, self-harm incidents, abuse (any type), where medications with known risks (red class medications[1], such as Clozapine) played a significant part of the treatment regime.
- Where the service user had been subject to a care intervention where death would not have been an expected outcome, such as Electroconvulsive Therapy (ECT), rapid tranquilisation and others.
- “Deaths in Distress”, which might include drug and alcohol related deaths, or deaths of people who might not be in crisis but needing support, and from whose experience there may be learning from a specialist thematic review (STR).
- Where the initial assessment of a death identified a deterioration in the physical health of a service user that wasn’t responded to in a timely manner.

[1] Drugs considered to be specialist medicines and prescribing responsibility for these medicines should normally remain with the consultant or specialist clinician. These are associated with suspected adverse drug reactions from misuse, overdose, medication errors, or use of unlicensed and off-label medicines.

1.5.3 Information gathering and scope of reportable deaths

The Trust has systems that identify and capture the deaths of its service users on its electronic patient record (e.g. Care Director) and on its risk management systems (e.g. Datix). In addition, a weekly review of all deaths recorded via the NHS Spine system is completed, alongside a weekly joint review of concerns raised about care by a family member, carer, friend or LYPFT staff with the trust Complaints Team. The Patient Safety Team is responsible for these processes. In addition to, the Trust can 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 a death
- coroner's requests or via other care providers

1.5.3.2 Data Collection around deaths

The Trust collects data on all known deaths and has processes in place to determine the scope of deaths which require to be reported on datix and whether requiring further review (these are separate processes), in line with the "Patient Safety Incident Response Framework" and the "Learning from Deaths" NHS guidelines 2017. A breakdown of the deaths that are in scope for LYPFT, based on identification of the main provider of care, can be found in "Appendix 3 – Deaths in scope for LYPFT decision-making stratification table", box A. The Patient Safety Team is responsible for these processes.

LYPFT staff **must report deaths** that they are made aware of, including coroners reported death, **on Datix within 24 hours of being informed** and provide within the Datix the cause of death, if known. This duty includes temporary workers of any kind.

For all deaths where LYPFT cared for a service user, **up to the six months prior to the death occurring**, a Datix must be reported as soon as the information is acquired.

There is one **exception** to this: **Liaison Psychiatry should not report deaths that occur for inpatients at Leeds Teaching Hospitals NHS Trust (LTHT)** on the LYPFT Trust's DATIX system, **unless there is a specific concern in relation to mental health**. These deaths are reported on the LTHT incident reporting system.

1.5.3.3 Review Process of Reportable Deaths on Datix

All Datix reported deaths are reviewed daily by the Patient Safety Team and all service user deaths are considered through the review of patient safety event process and the approved PSIRF Policy and Plan, alongside this policy. All Deaths reported on Datix are subject to an initial review by the Patient Safety Team, in conjunction with a Fact Find completed by the Clinical Team Manager of the service where the patient died and a weekly report of concerns raised about care provided from complaints team.

The Fact Find must be available on Datix within 72 hours of the death occurring in an SBAR format (Situation-Background-Assessment-Recommendation). A Fact Find allows us to quickly identify learning, and the necessary learning response required for incidents causing harm to patients. The Patient Safety Team offers to all services in LYPFT training and support in the completion of Fact Finds. A Fact Find checklist can be found on Staffnet in the Patient Safety Incident Response Framework (PSIRF) staffnet page.

The Patient Safety Managers present all reviewed deaths at the weekly Learning from Incidents and Mortality Meeting (LIMM), highlighting cases with potential for further learning. These cases are then discussed in a multidisciplinary format (MDT). The purpose of LIMM is to facilitate a collaborative conversation among key stakeholders from all LYPFT services, determining whether a case warrants further review and to what extent. Following LIMM, where this is appropriate and proportionate, allocation to a trained staff member of a case notes review (SJR) learning review (AAR or STR) or a patient safety incident investigation (PSII) is arranged in a just manner.

1.5.3.4 Additional review requirements

There are occasions when the Trust is notified of the death of a former service user who was discharged from the Trust **over six 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 directly to teams or via the Trust's Clinical Governance Team (inquests). In such 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 Fact Find is required in this occasion**, but other reviews of the care provided may be required.

1.5.3.5 Liaison with other organisations

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 uncertainty as to who is responsible for the reporting and investigating of a patient's death and the risk of duplicating reports and reviews. To support staff in their decision-making, they should refer to the "Appendix 3 – Deaths in scope for LYPFT decision-making stratification table". However, if there is any doubt staff should contact their line manager via their preferred communication method or the patient safety team for advice at: patientsafety.lypft@nhs.net.

Where opportunities for learning 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 actions**. The Patient Safety team will be responsible for this process and clinical teams should collaboratively cooperate to complete this task.

All relevant stakeholders involved should work collaboratively to undertake one single investigation wherever this is possible and appropriate. A culture of compassionate curiosity should be adopted, and the following questions could be asked:

- Which deaths can be reviewed with a joint approach?
- What could we have done better between us?
- Could have we done anything differently?
- Where was care delivered well?
- Did we look at the care from a family and carers perspective?

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 levels of involvement and potential for learning.

Information will be shared with partners if the death is outside LYPFT's scope.

Where the death meets our review criteria, the clinical team manager will ensure the death is reported on Datix and the standard process followed.

Where a response involving multiple providers and/or services across a care pathway is too complex for a single provider to manage, the local Integrated Care Board (ICB) should support the co-ordination of cross-system response. The ICB lead will consult with relevant providers (and other ICBs if necessary) to agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

In "Mental health related homicides" incidents, as per PSIRF National Priorities, these will always be referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII.

1.5.4 Decision making process and levels of review

1.5.4.1 Levels of Review

To provide assurance of consistent, robust and aiming at learning from the event review, a stratified approach to safety events is the preferred choice in LYPFT. Once a patient safety event is reported, where this involved a service user death, the clinical teams are expected to follow the PSIRF learning response map.

All patients deaths that are in scope for LYPFT, will be subject to an initial fact find and discussed at Learning from Incidents and Mortality Meeting (LIMM) if further review or investigation is deemed necessary. There are instances where it is evident that no further review or discussion at LIMM is required and the PSMs will work with service lines to agree the most appropriate course of action. For example, a death of a patient with a learning disability where a referral to LeDeR has been completed and a factfind has found no concerns in care will be closed on the initial review by the patient safety team.

Within the discussion at LIMM, the group will decide if a review or an investigation is required and convene on the correct and proportionate level of review or investigation. The review or investigation will then be commissioned to an identified lead reviewer, with the support of a second reviewer and establishing collaboratively the Key Lines of Enquiry (KLoE) / Terms of Reference (ToR).

A service user's death that aligns with national or local priorities will always be discussed at LIMM. The case will receive a proportionate level of review, determined by the severity of the case and the potential learning outcomes. Any level of review, such as a Structured Judgement Review (SJR) or After-Action Review (AAR), can be escalated to a Patient Safety Incident Investigation (PSII) at any time, where a more in depth understanding of the care provided prior to death is required. **This decision will always be taken at LIMM.**

For people living 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 this website.

1.5.4.2 Types of Review and Investigations

To learn from a death, the LIMM group may grant several different types of review of the patient safety event, as stated below:

Structured Judgment Review (SJR)
A Structured Judgment Review is a standardised, yet not rigid, case notes review methodology usable across services, teams and specialties. SJR blends traditional, clinical judgement-based review methods with a standardised format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. **To undertake an SJR, staff are required to be trained in the use of this tool.** In LYPFT, SJRs are used to review care provided to service users who passed away while or within six months of receiving care. SJRs are then presented at the relevant service's local Clinical Governance (CG) meeting. Any actions would be agreed and monitored through the service or team Clinical Improvement Forum (CIF) and/or Clinical Governance (CG) or Risk Management Meeting and cascaded through the operational management structure, as appropriate. The SJR report will also be signed off at local CG or CIF meeting level. All actions from SJRs will be uploaded to and monitored via Datix system, alongside any other action monitoring system in place.

After Action Review (AAR)
An After-Action Review (AAR) is a structured discussion that is used when outcomes of an activity or event have been successful or unsuccessful. It is founded on four core questions, and it aims to quickly capture learning from describing work as imagined against work as done by all the professional who cared for a service user. **To facilitate an AAR, staff are required to be trained in the use of this tool.** After Action Reviews are then presented within the relevant service's Clinical Governance meeting. Any actions would be agreed and monitored through the service or team Clinical Improvement Forum (CIF) and/or Clinical Governance (CG) or Risk Management Meeting and cascaded through the operational management structure, as appropriate. The AAR report will also be signed off at local CG or CIF meeting level. All actions from AARs will be uploaded to and monitored via Datix system, alongside any other action monitoring system in place.

Specialist Thematic Review (STR)
An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, exploring a safety theme, pathway, or process. This tool is to be used after several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability. STRs use the SEIPS model to review processes. All actions from STRs will be uploaded to and monitored via Datix system, alongside any other action monitoring system in place.

Patient Safety Incident Investigation (PSII)
A Patient Safety Incident Investigation (PSII) is an in-depth review of a single patient safety incident to understand what happened, how it happened and why it happened. A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning, where a **systematic approach** is required to reduce or eliminate (where possible) risks. PSIIs use the SEiPS model

for improvement, alongside other models for improvement, such as the Yorkshire Contributory Factors Framework.

To undertake a PSII, staff are required to be trained in the use of this tool.

A PSII will be commissioned by the Learning from Incidents and Mortality Meeting (LIMM), where the incident is aligned with either a national or local priority, as identified in the Patient Safety Incident Response Plan (PSIRP). A PSII is undertaken by a trained patient safety investigator who collates data, conducts interviews, undertakes analysis and writes the recommendations, to which an improvement project and a change implementation phase will follow. A PSII report will be presented first at the Quality Assurance Group (QAG) and then signed off at the Trust Incident Review Group (TIRG). Actions will be monitored both locally and at TIRG levels.

All actions from PSIIs will be uploaded to and monitored via Datix system, alongside any other action monitoring system in place.

1.5.4.3 Other Investigations

The Trust is an active member in Safeguarding adult's board, safeguarding children's partnership and the community safety partnership. Should a death require an Investigation through the Safeguarding process, the Trust will work through that process in line with the trust Patient Safety Incident Response Plan (PSIRP).

1.5.4.4 Learning Disability and Autism Deaths

All deaths of individuals with a Learning Disability and/or an Autism diagnosis should have a fact find completed within 72 hours of the death occurring and uploaded on Datix, to enable potential learning at all levels to be identified. Alongside the Fact Find, a Structured Judgement Review (SJR) may be completed and, if appropriate, also refer to the West Yorkshire ICB to request a "Learning from Life and Death Review" (LeDeR).

1.5.4.5 Actions for improvement and investigation process conclusion

All PSIIs commissioned via LIMM for deaths are shared at (in chronological order):

1. Tier 3 Clinical Governance Meetings; for discussion and review of planned actions.
2. Tier 2 Quality Assurance Group (QAG); for review, comment and further development of planned actions.
3. Tier 2 Trust Incidents Review Group (TIRG); for discussion and final sign off.

All groups will aim to actively listen to the findings and recommendations of the investigator, have a constructive conversation aiming at either approve or require further details or insights around the incident or the planned actions for improvement.

The Patient Safety Team aims to offer support to the lead investigators across the whole review or investigation journey.

1.5.4.6 Continuos Improvement

Improvement and service transformation efforts play a crucial role in positively impacting patient safety within LYPFT. By fostering a culture of continuous improvement, implementing evidence-based practices, and leveraging technology, LYPFT can work to enhance the quality and safety of care delivered to patients. "Appendix 6 - Current improvement and transformation work within LYPFT" displays the current improvement and transformation work within LYPFT, where outcomes of investigations will feed into, as appropriate.

1.5.5 Data reporting

Trusts are required to publish information on deaths, reviews and investigations via a six-monthly agenda item and paper to its public Board meetings. Learning from Deaths reports will include the following points:

- Overall deaths reported in the ongoing and past financial years, including Total Number of Deaths in scope
- Total number of deaths considered to have contributory care delivery factors to the death, at any level of the service user experience with LYPFT (admission, risk assessment, care delivered, medical assessment, discharge processes, ongoing care, etc.)
- Focus on deaths that meet the PSIRF National Priorities
- Total Number of Deaths Reviewed under the SJR methodology

- Thematic breakdown of actions taken for each death.
- A chart highlighting the current cumulative trajectories of the current and past financial years of recorded death, with related analyses.
- Role of LIMM, QAG and TIRG.
- Highlights on concluded and ongoing investigations
- Focus on learning obtained from investigations
- Focus on areas for improvement and ongoing trust wide work on these
- Focus on safety training and investigation training around deaths
- Thematic review of known and emerging risks
- Horizon scanning
- Data on LeDer Reviews – how many deaths in scope, total deaths analysed via LeDer methodology, deaths considered to have contributory care delivery factors to the death and subsequent actions

1.5.6 Dissemination and Implementation

The prime objective of a "Learning from Death Policy" is for LYPFT to improve services and the users experiences of these. As a learning organisation, LYPFT consider how to share learning to a broad audience. Learning will be shared trust wide via a number of media, such as:

- Quarterly safety bulletins – regular bulletins describing the highlights of the cases reviewed in the past quarter and the lessons learnt from them, including deaths of service users.
- Upload safety information and lessons learnt on the Patient Safety Staffnet intranet page.
- The annual "Patient Safety Day" (occurring every September)

Furthermore, the Library and Knowledge Services can support with queries by providing a search of the evidence base, horizon scanning, and networking with other organisations for examples of best practice. Library and Knowledge Services can also offer a more extensive search of knowledge and evidence, and an information or evidence consultancy role where appropriate.

LYPFT has implemented a robust framework for reviewing reported deaths, as outlined above. This framework ensures that any potential learning opportunities are thoroughly explored and discussed during LIMM meetings, where the appropriate level, type, and scope of review or investigation are determined.

Each review and investigation mentioned in section 1.5.3.2 is designed to analyse the events leading up to a safety incident resulting in the loss of a patient's life, producing a S.M.A.R.T. (Specific, Measurable, Achievable, Realistic & Relevant, Timed) action plan highlighting the areas for improvement (this will also aid future thematic reviews), aiming to reduce the likelihood of the incident recurring, increasing at the same time service user's experience of the services delivered by LYPFT and wider health network.

To ensure the above, each Service Line should maintain an accurate record of all incidents being reported and investigated, highlighting:

- Incident identifications (Datix ID/Reference number, Date and Time of incident)
- Total Number of Deaths in scope
- Total Number of Deaths Reviewed under the SJR methodology
- Total number of deaths considered to have contributory care delivery factors to the death, at any level of the service user experience with LYPFT (admission, risk assessment, care delivered, medical assessment, discharge processes, ongoing care, etc.)
- Data on LeDer Reviews – how many deaths in scope, total deaths analysed via LeDer methodology, deaths considered to have contributory care delivery factors to the death.

1.5.7 Compliance and Monitoring

LYPFT will continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define what quality improvement work we need to undertake. This plan remains flexible and considers improvement planning as needed where a risk or patient safety issue emerges from our own ongoing internal or external insights.

The oversight of the outcomes of all PSIIs, as well as ongoing and emerging themes in LYPFT, would be the responsibility of the Trust Incident Review Group (TIRG). This is to ensure that actions are S.M.A.R.T., have a systems thinking based approach and all areas for improvement are identified; the above will feed into the LYPFT Improvement Team stream of work.

LYPFT's Trust Incident Review Group (TIRG) will maintain overall oversight of such processes and will challenge decision making to ensure that the Trust Board can be assured that the true intent of PSIRF and learning from deaths is being implemented within the organization and that we are meeting the national patient safety incident response standards.

1.5.7.1 Thematic monitoring

Thematic reviews will be carried out routinely and the monitoring activity of emerging themes will have oversight from the Trust wide Incident Review Group (TIRG).

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 several specialty meetings including, but not limited to, Falls and Pressure Ulcer Group, Positive and Safe Group, Sexual Safety Group, Trust wide Safeguarding Committee.

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

SECTION 2

APPENDIXES

2.1.1 Appendix 1 – Events requiring a specific type of response as set out in policies or regulations (national)

Event	Approach	Lead Body
Deaths thought more likely than not due to problems in care* (Incidents meeting the Learning from Deaths criteria for patient safety incident investigation (PSII))	• Locally led patient safety incident investigation (PSII)	The organisation in which the event occurred
Deaths of patients detained under the Mental Health Act or where the Mental Capacity Act (2005) applies (where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria).	• Locally led PSII.	The organisation in which the event occurred

Incidents meeting the Never events criteria.	Locally led PSII.	The organisation in which the never event occurred
• **Mental health related homicides.**	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally led PSII may be required.	As decided by the RIIT
• **Child deaths**	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Child death overview panel
• **Deaths of persons with learning disabilities**	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	LeDeR Programme

• **Safeguarding incidents in which:**
  • **babies, children, or young people are on a child protection plan; looked after plan or a victim of harm or abuse.**
  • **adults (over 18 years) who have care and support needs.**
	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	Refer to your local designated professionals or child and adult safeguarding

• **the incident relates to FGM, Prevent, modern slavery, human trafficking, or domestic abuse/violence.**		
• **Deaths in custody** • **e.g., police custody, in prison, etc where health provision is delivered by the NHS.**	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so.	PPO or IOPC
• **Domestic homicide**	• A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case CSP 23 | Guide to responding proportionately to patient safety incidents Event Action required Lead body for the response Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and	CSP

	requirements of organisations and commissioners of health services in relation to DHRs.	

2.1.2 Appendix 2 – Events requiring a specific type of response as set out in policies or regulations (local)

Patient Safety Incident Type	Planned Response and Rationale	Service
Self-Harm – suicide by overdose **Our data tells us that we have a high level of attempted suicides by overdose. Any incident relating to an overdose by a patient in our care will receive a proportionate response.**	• After Action Review • Patient Safety Incident Investigation	All services
Violence and Assault incidents – patient on patient **Our data tells us that we have a high number of patient-patient incidents with varying degrees of harm. Any incident of violence and assault from patient to patient will receive a proportionate response.**	• Specialist Thematic Review to capture lower levels of harm in respect of patient well-being • After Action Review • Patient Safety Incident Investigation	All services
Sexual Safety - any **At LYPFT we recognise that there is improvement work needed around how we record and respond**	• Specialist Thematic Review to capture low level harm and/ or several incidents pertaining to the same individual • After Action Review	All services

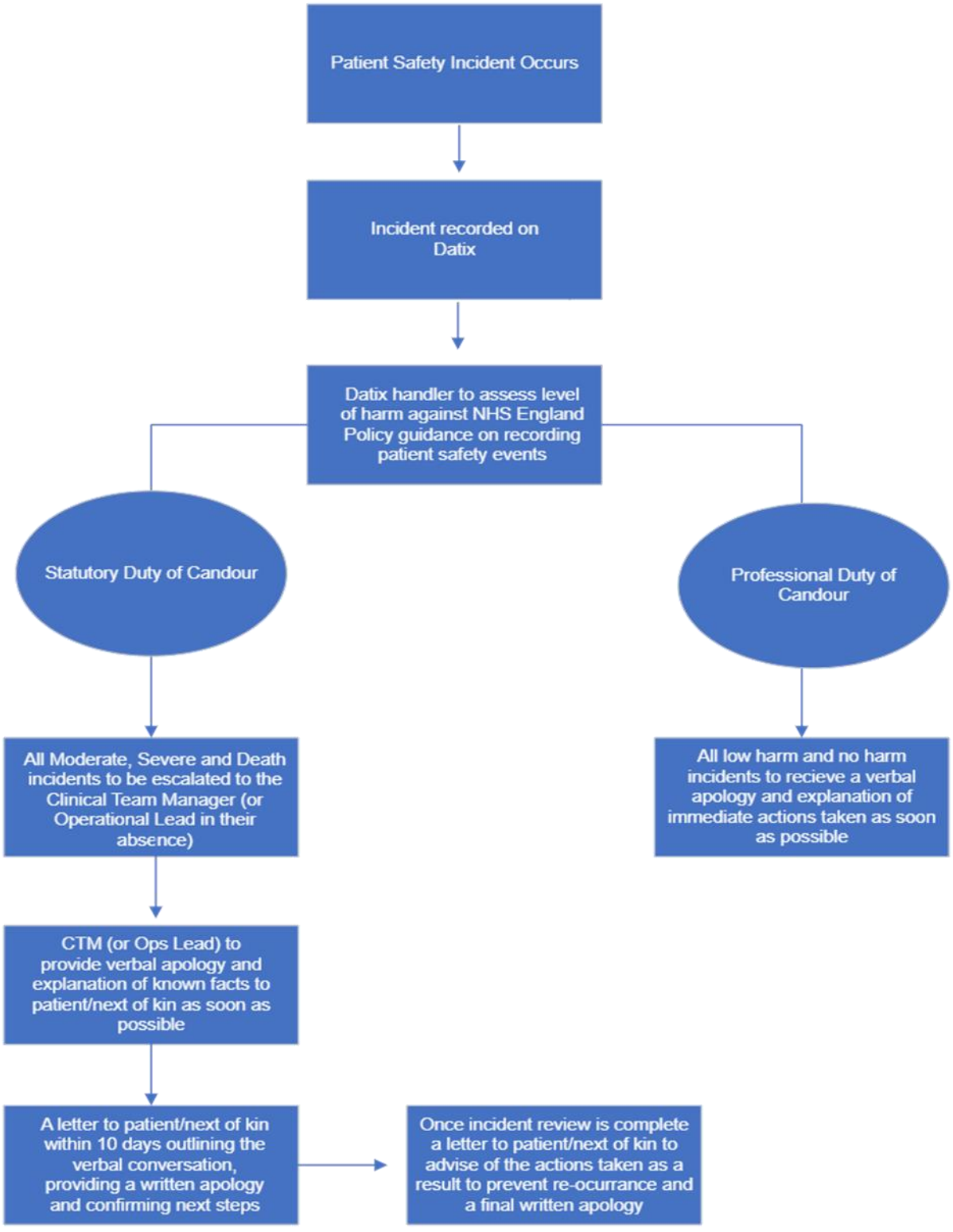
to sexual safety incidents. Making this a local priority will enable us to gather qualitative and quantitative data to inform our practice.	• Patient Safety Incident Investigation **Learning from these responses will be shared with the Sexual Safety Improvement Group to help inform practice across LYPFT.**	

2.1.3 Appendix 3 – Deaths in scope for LYPFT decision-making stratification table

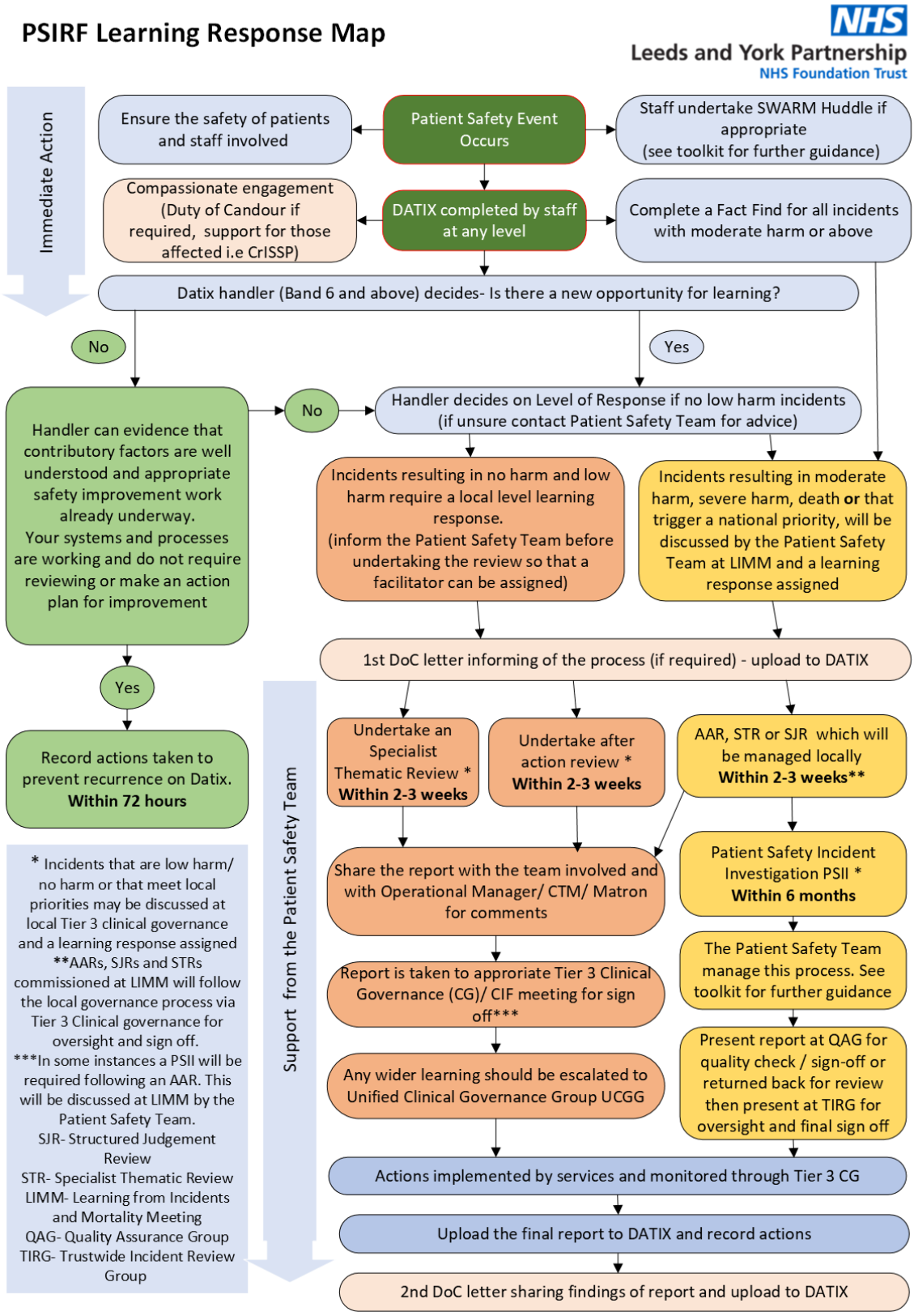
A	LYPFT is the main provider if at the time of death if the patient was subject to:
• An episode of inpatient care within our service. • An episode of community treatment due to identified mental health needs. • An episode of community treatment due to identified mental health, learning disability or substance misuse needs. • A Community Treatment Order (CTO). • A conditional discharge. • An inpatient episode or community treatment package within the 6 months prior to the date of their death (Mental Health services only). • Guardianship	
B	Service users who meet the criteria as in box A, 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. Said organisation will also exercise the responsibilities under Duty of Candour. However, there will be a collaborative discussion between the service providers to agree the scope of the review or investigation (this will be determined by the cause of death) and who the lead organisation will be. The Patient Safety Team shall be included within said 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 LYPFT is 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' General Practitioner (GP), therefore LYPFT will only participate, if indicated, in these reviews, but will not commence a review as not main provider of care. For these teams or services, they should only report deaths on Datix where there are concerns regarding the care provided (see point D below) • Dietetics (primary care and LCH are usually the main providers of care) • “Admiral” services • The Drug and Alcohol Shared Care Services	

• Care Home Team • Memory Services Team • Acute Hospital Liaison - In reach services for inpatients at LTHT • Community Physiotherapy/Occupational Therapy (primary care and LCH and LCC usually main providers of care) • Palliative care Team • Acute Liaison Psychiatry – if incidents occurred over six months of last contact/discharge. • Young People with Dementia	
D	**Exception/s**
In addition to the above, if any act or omission on the part of a member of staff, where LYPFT is not classed as the main provider, is identified to have in any way contributed to the death of a patient, an investigation will be undertaken by the Trust.	

2.1.4 Appendix 4 - Flow chart of Duty of Candour procedure



2.1.5 Appendix 5 – PSIRF Flowchart response map

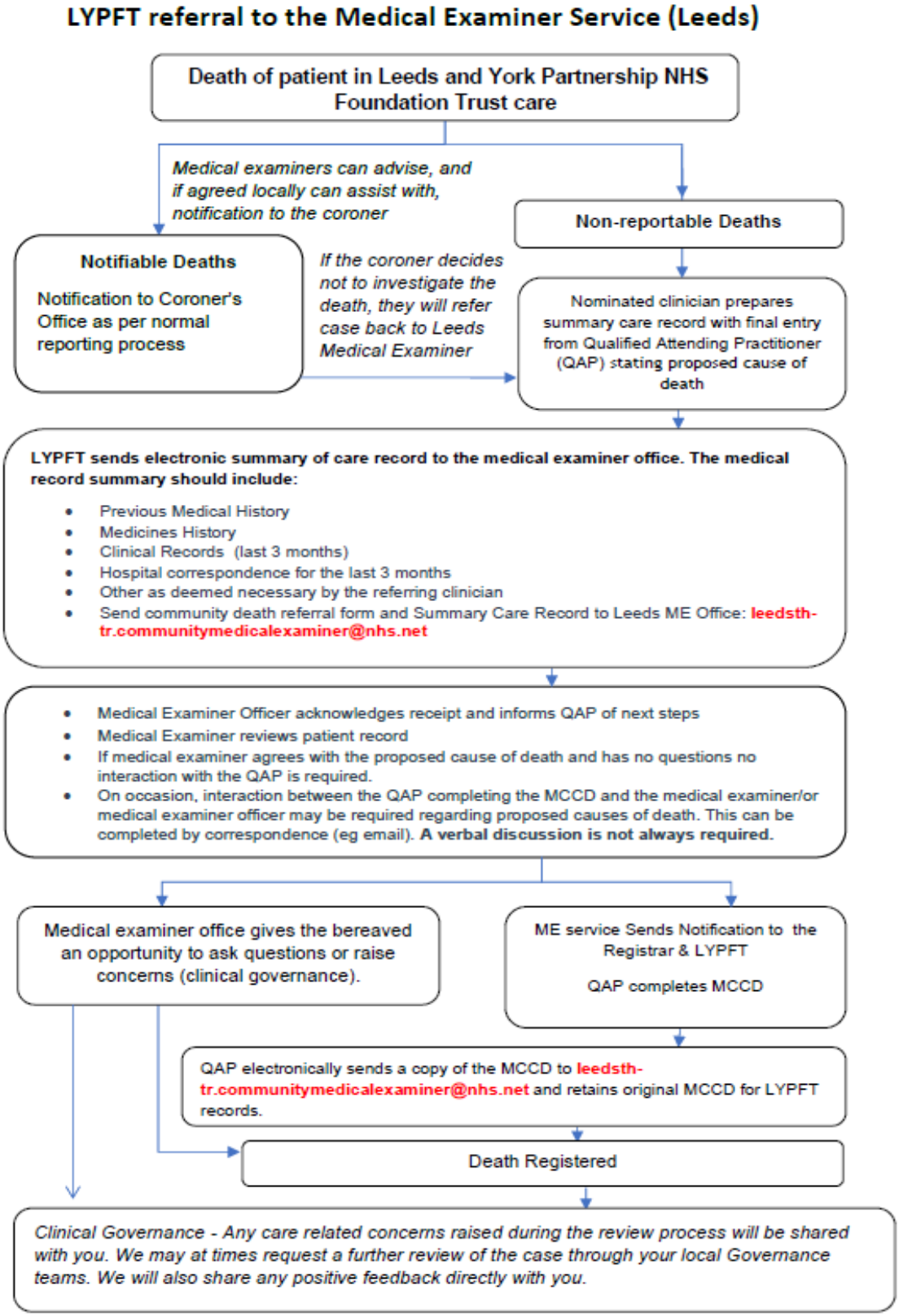


2.1.6 Appendix 6 - Current improvement and transformation work within LYPFT:

Patient safety incident type or issue	Service area	Anticipated improvement route
Sexual Safety Group	Nursing Directorate	Aims to increase the percentage of service users and staff who feel safe from sexual harm within LYPFT services and roll out Sexual Safety Standards across all inpatient services by April 2024 and across all Community/outpatient services by December 2024. Learning from Sexual Safety Incidents will be shared with the Sexual Safety Group to help inform practice.
Risk assessment and Safety Planning	All services	LYPFT will move away from the use of FACE and SAMP towards one standardised risk assessment template which is streamlined, simplified, and encourages a more flexible and personalised approach to assessing and managing peoples' safety, with safety planning being integral to this.
Falls and Pressure Ulcer Improvement Forum	All services	The forum is a multi-disciplinary group responsible for developing specific improvement goals in relation to reducing the number of reported falls and pressure ulcers, promoting safety and well-being for service users, and demonstrating our ability to learn from incidents.

Medicines Safety and errors	All services	Objectives of the committee include, improving reporting and learning of medication error incidents in the organisation. Prioritising and addressing medication risks to minimise harm to patients. Developing and promoting best practice for medication safety and planning.
CMHT Mental Health Teams Transformation	CMHT	A partnership of NHS organisations, Leeds City Council, the Voluntary, Community and Social Enterprise (VCSE) sector, and service users/people with lived experience and we are attempting to reshape the care offer for the adult Serious Mental Illness population, with more joined up and holistic care, with more timely interventions and with attention to the impact of wider determinants on people's mental health and recovery.

2.1.7 Appendix 7 – LYPFT Referral to the medical examiner service (Leeds)



Definitions

Term	Definition
After Action Review (AAR)	An After Action Review (AAR) is a structured discussion that is used when outcomes of an activity or event have been successful or unsuccessful. It is founded on four core questions and it aims to quickly capture learning from describing work as imagined against work as done by all the professional who cared for a service user. The key four components are: What was expected? What actually happened? Why was there a difference? What can be learned?
Being Open	The nurturing of an environment where families, carers and staff feel supported to question and raise concerns, to identify what went well, and what needs to be done differently to improve the quality of patient, carer and staff experience. This applies to all practices and incidents – not just those relevant to the Duty of Candour. This Learning from Deaths Policy fully aligns with the principles and practices set out in the Trust's Duty of Candour Policy.
Case record review **(Structured Judgement 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. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care. The Royal College of Psychiatrists Structured Judgement Review methodology provides an agreed template for this.

Contributory service delivery factor/s	A death that has been clinically assessed using one or more recognised methods of case record review, where the reviewers perceive that the death is more likely than not to have resulted from contributory service delivery factor/s (Note, this is not a legal term and is not the same as 'cause of death').
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.
Deaths in scope	Deaths that the Trust have determined require further review under this policy.
Just Culture	The Just Culture Guide, developed by NHS Improvement, helps NHS managers ensure staff involved in a patient safety incident are treated fairly. It supports a culture of openness to maximise opportunities to learn from mistakes.
Learning from Incidents and Mortality Meeting (LIMM)	Fortnightly meeting to review all severe and fatal harm incidents, identifying any potential opportunity for local and/or organisational learning.
Learning from Life and Death Review. **LeDeR**	LeDeR reviews will be completed for all individuals aged 4 and above with a learning disability and for individuals over the age of 18 who have been diagnosed by a registered and trained professional that they are autistic and had this clearly documented 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.
LFPSE	The Learn from Patient Safety Events (LFPSE) service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. The service introduces a range of innovations to support the NHS to improve learning from the over 2.5 million patient safety events

	recorded each year, to help make care safer (see 'How LFPSE will improve patient safety learning').
LYPFT	Leeds and York Partnership NHS Foundation Trust
Medical Examiner Role	Medical examiners are senior medical physicians 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.
Main provider of care	The identified Trust that is the main provider of care. This can be public, private, NHS based or others.
Patient Safety Incident Investigation (PSII)	A Patient Safety Incident Investigation (PSII) is an in-depth review of a single patient safety incident to understand what happened, how it happened and why it happened. A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning, where a systematic approach is required to reduce or eliminate risks. PSII use the SEiPS model for improvement, alongside other models, such as the Yorkshire Contributory Factors Framework.
PSIRF	The Patient Safety Incident Response Framework (PSIRF), which replaces the Serious Incidents Framework (SIF), is a core element of the NHS Patient Safety Strategy – establishes the NHS's approach to the development and maintenance of mechanisms for responding to patient safety incidents (PSIs) to maximise learning and improvement.
PSIRP	Patient Safety Incident Response Plan
Quality Assurance Group (QAG)	QAG will oversee all PSIIs commissioned at LIMM or by external agencies and will assure the quality of the action plan created to support findings and reccomandations.

Severe Mental Illness	National guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness should be subject to SJR or other higher level of evidence-based, structured reviews. The Royal College of Psychiatrists guidance states that this would include all patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death. The term is generally restricted to psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis, and schizoaffective disorder.
Specialist Thematic Review (STR)	An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. This tool is to be used after several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability. STRs use the SEIPS model to review processes.
StEIS	The 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. StEIS will be decommissioned with the Introduction of the LFPSE framework.
Service User (SU)	The person receiving care under LYPFT regulations.
Trust Incidents Review Group (TIRG)	The aim of TIRG is to review and approve the whole report produced around a patient safety event and the related action plan.

SECTION 3

IDENTIFICATION OF STAKEHOLDERS

Key Individuals / groups consulted in development of the document:

Stakeholder (job title or group name)	Date Sent	Date Response Received	Modification suggested? Y/N	Modification made? Y/N
Interim Head of Clinical Governance, Patient Safety	10/07/2024	10/07/2024	yes	yes
Head of Clinical Governance & Quality	12/07/2024	None received		
Head of Clinical Governance and Regulation	12/07/2024	None received		
Head of Patient Experience, Complaints & Legal Services	12/07/2024	02/08/2024	yes	yes
Head of Medical Development and Operations	12/07/2024	24/07/2024	yes	yes
LYPFT Patient Safety Team	12/07/2024	17/07/2024	yes	yes
Clinical Director for Acute Services, Community & Wellbeing Services	12/07/2024	None received		
Medical Director - Mental Health Legislation	12/07/2024	None received		
Clinical Director for Learning Disability Services, Older People's Services,	12/07/2024	None received		

Clinical Director for Regional Eating Disorders & Rehabilitation Services, Regional and Specialist Services, Forensic Services	12/07/2024	None received		
Clinical Director for Children and Young People's Services and Perinatal & Liaison Services	12/07/2024	None received		
LYPFT Chief Nurse	12/07/2024	29/07/2024	yes	yes
LYPFT Deputy Chief Nurse	12/07/2024	30/07/2024	yes	yes
Clinical Lead for acute services	12/07/2024	None received		
Clinical Lead for Community & Wellbeing Services	12/07/2024	None received		
Clinical Lead for Learning Disability Services	12/07/2024	15/07/2024	yes	yes
Clinical Lead for Older People's Services	12/07/2024	None received		
Clinical Lead for Regional Eating Disorders & Rehabilitation Services	12/07/2024	None received		
Clinical Lead for Regional and Specialist Services	12/07/2024	None received		
Clinical Lead for Children and Young People's Services	12/07/2024	None received		

Matrons for Forensic Services	12/07/2024	None received		
Clinical Lead for Perinatal & Liaison Services	12/07/2024	None received		
Professional Lead for Dietetics	12/07/2024	None received		
Professional Lead for Psychological Professions	12/07/2024	16/07/2024	yes	yes
Consultant Clinical Psychologist	12/07/2024	30/07/2024	yes	yes
Professional Lead for Nursing	12/07/2024	08/08/2024	yes	yes
AHP Lead Adult and OPS Directorate	12/07/2024	None received		
Interim Deputy Head of Safeguarding	12/07/2024	None received		
Professional Lead Allied Health Professional's	12/07/2024	30/07/2024	yes	yes
Deputy Director for Allied Health Professions	12/07/2024	12/07/2024	yes	yes
Library and Knowledge Services Manager	12/07/2024	12/07/2024	yes	yes
Lead Nurse (RNLD) for learning disability services and for people who have a learning disability	12/07/2024	None received		

SECTION 4

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/have not* identified any potential negative impacts for any of the nine protected groups.

Print name: Luca Marinannio
Job title: Patient Safety Manager
Date: 17/09/2024

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

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	*Chris Hosker*	Date	*24 September 2024*
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	*Clare Edwards*	Date	*29 October 2024*