Lincolnshire Partnership NHS Foundation Trust

Learning from Deaths

DOCUMENT VERSION CONTROL	
Document Type and Title:	Policy & Procedure
Authorised Document Folder:	Risk, Quality, Escalation, Candour, and Governance
New or Replacing:	Replacing v1.1
Document Reference:	5F
Version No:	v2
Date Policy First Written:	August 2017
Date Policy First Implemented:	September 2017
Date Policy Last Reviewed and Updated:	April 2019
Implementation Date:	September 2017
Author:	Head of Quality and Safety
Approving Body:	Quality Committee
Approval Date:	02 May 2019
Committee, Group or Individual Monitoring the Document	Mortality Surveillance Committee
Review Date:	April 2020

Contents

1. Introduction

1.1 In December 2016 the CQC published Learning, candour, accountability [1]: A review of the way NHS Trusts review and investigate the deaths of patients in England. This report found that learning from deaths was not being given sufficient priority in some organisations leading to opportunities for learning being missed.

Subsequently, in March 2017, The National Quality Board published the report: National Guidance on Learning from Deaths[2] to introduce a national standardised approach to learning and reviews of deaths.

The national guidance acknowledges that whilst NHS staff aim to deliver safe, high quality healthcare, some patients may experience poor quality provision resulting from contributory factors. The reports advises that when mistakes happen providers must work with their partners to understand the causes, and conduct reviews and investigations of deaths to establish if problems in care have contributed to the death. It states however that reviews and investigations are only useful for learning if their findings are shared and acted on.

1.2 The national guidance provides details of action NHS Trusts and Foundation Trusts must take which are summarised in the following key points:

1.3 Governance and capability requirements:

- Trust Boards must ensure that robust systems are in place for recognising, reporting and reviewing or investigating deaths where appropriate.
- Trust Boards must ensure that they share and act upon any learning derived from reviews / investigations.
- An Executive director to take responsibility for the learning from deaths agenda.
- A Non- Executive Director to take responsibility for oversight of the process.
- Staff reporting deaths to have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.
- Clear guidance for engagement with bereaved families and carers, including giving them the opportunity to raise concerns or questions in relation to the quality of care. Bereaved families and carers to receive timely, meaningful and compassionate support and engagement throughout any investigation process.

1.4 Publication, Data collection, and reporting requirements:

1.4.1 Policy Publication

The policy includes:

- Trust processes for responding to the death of an individual with a learning disability, or mental health needs, an infant or child death and a still birth or maternal death.

- Trust approach to undertaking case record reviews using adapted evidence based methodology for example The Structured Judgement Review (SJR).

- Case record reviews of deaths of people with a learning disability by mental health Trusts should adopt the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme.

- Categories and selection of deaths in scope for case record review.

1.4.2 Data collection and reporting -

- From April 2017, Trusts have been required to collect, specified information on deaths.

- Trusts must have a policy (this document) which sets out the approach to learning from deaths and;

- Trusts must produce a quarterly publication of the data and learning points presented at public Board meetings.

- A summary of this data must be included in the Trust Quality Accounts, including evidence of learning and action as a result of the information and an assessment of the impact of the action that a provider has taken.

2. Purpose

2.1. This policy therefore details the requirements as stated above for reviewing all known deaths of patients, whether or not they meet the criteria for a Serious Incident in accordance with the National Quality Board's National Guidance on Learning from Deaths – "A Framework for NHS Trusts and NHS Foundation Trust on Identifying, Reporting, Investigating and Learning from Deaths in Care" published March 2017. Full report is available via the link below:
https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

2.2. During 2019/2020 it is anticipated that further developments (the new revised Serious Incident Framework was due to be published in Spring 2019) will take place and additional national guidance issued, therefore further review / amendment to this policy will be required.

3. Duties

Individual / Group	Duty and Responsibilities
Board of Directors	• Board is responsible for ensuring that robust systems are in place for recognising, reporting and reviewing or investigating deaths where appropriate.
Executive Medical Director	• Policy Lead and nominated executive director with accountability for learning from deaths agenda • Establish Learning from Deaths review panels and ensure cases are available to be reviewed by the panel. • Ensure Learning from Death reports are provided to the Trust Board. • Chair of Mortality Surveillance Committee. • Responsible for ensuring reviews are undertaken are a high quality standard using an appropriate template. • Ensure a robust review process which identifies learning for quality improvement programmes to address and issues.
Non-Executive Director (Chair of the Quality Committee)	• Responsibility for oversight of process with responsibility to hold Trust to account for its approach to case record review and implementing quality improvement work in response.
Head of Quality and Safety / Quality and Safety Team Leader	• Day to day operational responsibility for ensuring the appropriate application of this policy and processing the results of reviews / learning. • Regular review and update of this policy to reflect any new developments. • Ensure a mortality review data base is established and maintained. • Ensure any Duty of Candour issues are addressed via the responsible clinician.
Informatics Team	• Responsible for supplying / inputting into Datix routine mortality data.
Divisional Managers / Clinical Directors / Quality Improvement and Assurance Lead	• Day to day operational responsibility for ensuring the appropriate application of this policy. • Contribute to and participate in review process

	• Disseminate learning / implement quality improvement programmes.
All Trust Employees	• Duty to record on Datix if they become aware of a patient death as per Trust Incident Reporting Policy. • Apply the principles of being open and honest (Duty of Candour) and offer support to bereaved families / carers. • Have a duty to implement this policy
Learning from Deaths Investigator	• To facilitate the learning from deaths process. • A duty to ensure learning from all types of mortality review is shared across the organisation and results in sustained change and improvement.
Mortality Surveillance Committee (MSC)	• The MSC provides assurance to the Board of Directors, via the Quality Committee that deaths are identified and reported correctly, unexpected deaths are investigated properly without delay, obligations to others are met, lessons are learnt from all deaths and we are open and transparent in our reporting and investigations. • Full Terms of Reference are available in Appendix 1**.**

4. Definitions

- **Serious Incident (SI)** is defined in the NHS Serious Incident Framework (3). Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

- **Serious Incident Investigation** is the process of investigating; a systematic analysis of what has happened, how it happened and why. These will either be a Level 1 or Level 2 investigation.

- **The Strategic Executive Information System (STEIS)** is the national database for reporting and learning from the most serious incidents in the NHS. The Quality and Safety Team are responsible for recording serious incidents onto STEIS. Via this system Commissioners and the CQC are informed of all serious incidents that are reported in accordance with the NHS England Serious Incident Framework.

- **Structured Judgement Review** (SJR) is a structured desktop review of a case record /note carried out by clinicians to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely in the absence of any particular concerns about care, to learn and improve. 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 the bereaved or staff raise concerns about care. These reviews will also highlight good practice.

- **LeDeR** is the Learning Disabilities Mortality review programme. It requires notification of all deaths of people with learning disabilities aged 4 to 74 years of age, and results in a subsequent independent review.

- **SUDIC** (Sudden Unexpected Death in Infants and Children). An unexpected death of a child is defined as the death of an infant or child (less than 18 years old and excluding stillbirths). Lincolnshire Safeguarding Childrens Board is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by the Child Death Overview Panel (CDOP).

5. Development of Policies and Procedures

5.1 The policy has been developed by the Executive Medical Director / Head of Quality of Patient Safety / Quality and Safety Team Leader and members of the Mortality Surveillance Committee in consultation with key stakeholders.

5.2.1 The policy content is aligned to the requirements of the National Quality Board: National Guidance on Learning from Deaths - March 2017[2] and Learning from Deaths: Guidance for NHS trusts on working with bereaved families and carers-July 2018[3.]

6. Learning from Death Process

6.1 Reporting Deaths
All service users considered to be under the care and management of the Trust can be considered for selection for a review into their care using the Learning from Deaths guidance.

A Datix reporting the death will be raised when the specified criteria is met as soon as is practicably possible or within 24 hours of becoming aware of the death through whatever means. Staff will share what information is known about the death to inform the review process.

Service	**What deaths are reported on Datix**
Adult Mental Health In-patient	All deaths, including notifications deaths 6 months post discharge
Adult Mental Health Community	All deaths, including notifications deaths 6 months post discharge
Older Adult Mental Health In-patient	All deaths, including notifications deaths 6 months post discharge

Older Adult Mental Health Community	All deaths, including notifications deaths 6 months post discharge
Learning Disability Services	All deaths, including notifications deaths 6 months post discharge

All known deaths are to be recorded on Datix system. A death will be recorded using one of the following categories:

- Death Expected : Natural causes confirmed
  : Natural causes unconfirmed
  : Unnatural cause confirmed
  : Unnatural cause unconfirmed

- Death Unexpected : Natural causes confirmed
  : Natural causes unconfirmed
  : Suicide Coroner confirmed
  : Suicide suspected
  : Unnatural cause confirmed
  : Unnatural cause unconfirmed

The Trust may become aware of a patient death via a number of different sources, included a monthly national report extraction of all deaths pertinent to the Trust.

6.2 Initial Death Review

The associated Service Manager is alerted via the Datix system if a death has been recorded on the system. The Quality and Safety Team also conduct a daily review of all Datix reports submitted and will contribute to ensuring the following actions are taken:

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- Identify and provide assurance that any necessary immediate action to ensure the safety of staff, patients and the public is in place.

- Assess the death according to the criteria below and determine whether Outcome 1, 2 or 3 apply and propose the level of investigation or case note review required. This is a joint decision between operational senior management and the Quality and Safety team unless directed by any external body.

- If at any point it is known that the definition of a Serious Incident has been met the death must be reported onto STEIS. This will be undertaken by the Quality and Safety Team.

- The associated Team Leader gains details of communication with the family and ensures application of the Duty of Candour.

- Where an Initial Death Review Report is deemed as required should be sent to Quality and Safety Team and uploaded to Datix.

This review also acts as a triage to determine whether the death should be reported on STEIS as a Serious Incident and the level of investigation required. The outcome of the Initial Death Review will be either:

Outcome 1 – With the facts known it meets the definition of a Serious Incident – this would require reporting onto STEIS and completion of an Initial Review Report (IRR).

Or

Outcome 2 – The death does not appear to meet the definition of a Serious Incident but does need to be looked at in more detail

Or

Outcome 3 – There are no apparent issues that need to be explored.

6.3. Initial Death Review Outcome Criteria Investigation Requirements

Outcome 1 – The definition of a Serious Incident is met, as a minimum this relates to the following deaths:

- Apparent suicide/self-inflicted death/accidental overdose
- Apparent homicide – perpetrator or victim
- Deaths where abuse or neglect is known
- Deaths following a Never Event
- Death of a patient under the care of a LPFT In-Patient Service (reportable to CQC – please refer to link below for further guidance
- Deaths of patients detained under the MHA/CTO or subject to recall (reportable to CQC – please refer to link below for further guidance
- Death in custody (prisons)
- Deprivation of Liberty applied (including care home)

An Initial Review Report (IRR) will be sent for approval to the Divisional Manager and then the approved report will be sent to the Associate Director of Nursing, the Commissioners, relevant others.

Following the IRR the Divisional Manager and Associate Director of Nursing and Quality will agree whether a Level 1 or Level 2 investigation is required as per NHS England Serious Incident Framework (2015) or a case note review and provide rationale for this.

The Procedure for Management of a Serious Incident is then followed as detailed in the LPFT Reporting and Management of Risk Policy:

http://www.lpft.nhs.uk/assets/files/Accessing%20our%20information/Policies%20and%20Procedures/policy-5b-reporting-and-management-of-risk-policy-version-2.1.pdf

Outcome 2 – The definition of a Serious Incident has not been met, however the following apply:

- Anyone with a serious mental illness(on CPA)
- In contact with CRHT at time of death
- Inpatient on our wards within 1 month of discharge(ensuring physical healthcare needs are reviewed)
- Concerns raised by families
- Concerns raised by services
- Safeguarding concerns
- A sample of Older Adult Dementia pathway patients (10 every 6 months)

If the above criteria in Outcome 2 apply, a Case Notes Review should be conducted. The final format of the Case Note Review is evolving (at present the Trust is trialling the newly published Royal College of Psychiatrist's Mortality Review Tool) and when the Mortality Surveillance Committee approve and finalised will be appended to this policy.

Outcome 3 – The criteria for Outcome 1 and 2 have not been met, therefore no further investigation or Case Notes Review is required. Rationale for this will be provided. In these cases the final stage will be the completion of the Datix.

6.4. Structured Judgement Review

Nominated members of the Mortality Surveillance Committee or specific clinician who has the relevant skills / training will conduct a case note review of any identified Outcome 2 case. This will be conducted using a standardised template which is based on recognised methodology. These reviews should take no longer than 30 working days from allocation.

It is advised that case review is multidisciplinary.

The findings of the review will be presented at the next available Mortality Surveillance Committee to analyse the information that has been collected for the purpose of identifying the underlying causes and any improvements to services required.

6.5 Learning from Reviews of Deaths

Learning and Quality Improvement

The Divisional Manager or Equivalent (or their deputies) working in conjunction with the Clinical Director and Executive Director as necessary will agree an Improvement Plan.

The Learning and Quality Improvement plan will clearly state:

- What issues have been identified
- What outcome any improvements are intended to achieve
- What action is required to achieve the outcome and resolve the identified issue
- Who is leading the improvements
- Timescale for completion

As implementation of the Improvement Plan continues, this will be updated to:

- Provide a RAG rated progress rating
- Progress comments
- Evidence that the desired outcome has been achieved and ongoing monitoring arrangements

All improvement plans will be discussed and monitored via the Mortality Surveillance Committee.

Involvement of Other Providers

If recommendations have implications for the practice of staff employed by other provider organisations consideration will be given to providing a copy of the final report. This will first be agreed by the Mortality Surveillance Committee.

Where another agency is requested to engage and cooperate in processes to share learning as required following serious incidents but fails to engage this must be escalated to the Medical Director for information and appropriate action.

6.6 Sharing Learning

One of the key aims of the incident reporting and learning process is to reduce the risk of recurrence, both where the original incident occurred and elsewhere in the organisation or the NHS. The timely and appropriate dissemination of learning following a serious incident / case note review following death is core to achieving this and to ensure that these lessons are embedded in practice.

Divisions must have processes in place to identify lessons and disseminate them and ensure where appropriate these are embedded in practice. Some lessons will be

appropriate for dissemination to a wider audience and this may be done in the form of, for example, the Safety Matters bulletin which is produced by the Quality and Safety Team.

6.7 Support and Engagement of Bereaved Families / Carers

Duty of candour principles apply as per CQC Regulation 20: Duty of Candour 2015[4] and guidance from National Quality Board: National Guidance on Learning from Deaths - March 2017[2] which outlines the key principles for how families and carers should be treated following a death in care, Trusts should:

- Provide a clear, honest and sensitive response to bereavement in a sympathetic environment.

- Offer a high standard of bereavement care: including support, information and guidance.

- Ensure families and carers know they can raise concerns which will be considered when deciding to review or investigate.

- Involve families and carers from the start and throughout any investigation as far as they want to be.

- Offer to involve families and carers in learning and quality improvement as relevant.

It is essential that bereaved families and carers are offered support including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.

LPFT Duty of Candour Policy is followed to ensure timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

In July 2018 the National Quality Board published Guidance for NHS trusts on working with bereaved families and carers. The guidance advises trusts on how they should support, communicate and engage with families following a death of someone in their care. There are 8 key principles within the guidance:

1. Bereaved families and carers should be treated as equal partners following bereavement.
2. Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment
3. Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support
4. Bereaved families and carers who have experienced the investigation process should be supported to work in partnership with trusts in delivering training for staff in supporting family and carer involvement where they want to.

5. Bereaved families and carers views should help inform decision about whether a review or investigation is needed
6. Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process with a single point of contact and liaison
7. Bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations
8. Bereaved families and carers who have experience the investigation process should be supported to work in partnership with trust in delivering training for staff in supporting family and carer involvement where they want to.

The Learning from Deaths Investigator and Patient Safety Lead will work collaboratively with the operational services to ensure these key principles are embedded within the Trust.

7. LeDeR Programme

The Learning Disability Mortality Reviews in Lincolnshire (LeDeR) is overseen by the Steering Group of Lincolnshire County Council and Clinical Commissioning Groups under the governance of the Independent Chair of the Lincolnshire Adults Safeguarding Board.

LPFT will actively engage in the LeDeR reviews by providing named staff as LeDeR reviewers.

The Trust is required to report to Lincolnshire LeDeR for review the death of anyone 4 years of age and above with a learning disability. The Quality and Safety Team will forward the notification form to the Division to complete which will then be sent securely to the Lincolnshire LeDeR programme.

8. Death of a Child

Sudden Unexpected Death in Infants and Children (SUDIC). An unexpected death of a child is defined as the death of an infant or child (less than 18 years old and excluding stillbirths) which:

- Was not anticipated as a significant possibility for example 24 hours before the death; or
- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

Notification must be made to Lincolnshire Safeguarding Childrens Board via the form which will be forwarded to the Division by the Quality and Safety Team at the point of notification.

Ref: Lincolnshire Safeguarding Children Board Policy and Procedure for Child Death review Process ad Child Death Overview panel

9. Consultation, Approval and Ratification Process

The policy will be consulted upon, approved and ratified in accordance with the Trust's Corporate Documents and Policies Procedure. The relevant Executive Committee is identified in the appendices to that procedure.

Service user/patient, family and carer involvement is central to the Trusts values. Although this document was available for consultation the Trust acknowledges additional collaboration with carers in ongoing development of this policy is essential.

10. Review and Revision Arrangements including Version Control

This policy will be reviewed annually by the policy author in accordance with the Corporate Documents and Policies Procedure. Revision may occur earlier if relevant new legislation or guidance is issued.

The Executive Committee monitoring the effectiveness of the policy may also call for an early review on the basis of the reports it receives.

The Trust Secretary's Office will maintain a version control sheet, as per the Corporate Documents and Policies Procedure.

11. Dissemination and Implementation

This reviewed policy will be disseminated in accordance with the Corporate Documents and Policies Procedure.

12. Policy Control including Archiving Arrangements

Corporate and Legal Services will retain a copy of each policy for a minimum of 10 years in line with the recommendations contained within 'Records Management NHS Code of Practice' (2006).

Individuals wishing to obtain previous versions of this policy should contact Corporate & Legal Services.

13. Monitoring Compliance with and Effectiveness of Policies and Procedures

Systems	**Monitoring and/or Audit**				
Standard/ NHSLA criteria	Measurable	Lead Officer	Frequency	Reporting to	Action Plan/ Monitoring
Implementatio	Identified	Head of	After	MSC	

n complete within designated timescale	actions complete	Quality and Safety	proposed implementation period		
Systems in place to monitor deaths of patients/service users	Number and required data ranges	Head of Quality and Safety	Quarterly	MSC Board	MSC (Monitoring)
Systems in place to monitor implementation of service and practice improvements identified.	Number of service changes identified Implementation of improvements Audit of improvements made as a result of learning.	Divisional Quality Improvement and Assurance Leads and Clinical Directors.	Bi-monthly Monthly Annual	MSC Board	MSC (Monitoring)
Systems in place to report improvements to Board	Board report	Head of Quality and Safety	Quarterly	Board	MSC(Monitoring)
Systems in place to learn from national reports and enquiries	Reports received by MSC	Quality and Safety Team Leader	Quarterly Monthly	Board	MSC(Monitoring)

14. References

1. Care Quality Commission: Learning, candour and accountability. 2016. Available via - https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

2. National Quality Board: National Guidance on Learning from Deaths. March 2017. https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

3. Learning from Deaths-Guidance for NHS trust on working with bereaved families and carers.

https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

4. LPFT Duty of Candour Policy.
http://www.lpft.nhs.uk/assets/files/Accessing%20our%20information/Policies%20and%20Procedures/5c-duty-of-candour-policy_v1.2_february_2019.pdf

5. NHS England: Serious Incident Framework 2015.
https://improvement.nhs.uk/resources/serious-incident-framework/

6. Care Quality Commission: Regulation 20: Duty of Candour March 2015
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

15. Associated Documentation

The following Trust Policies must be read in conjunction with this policy:

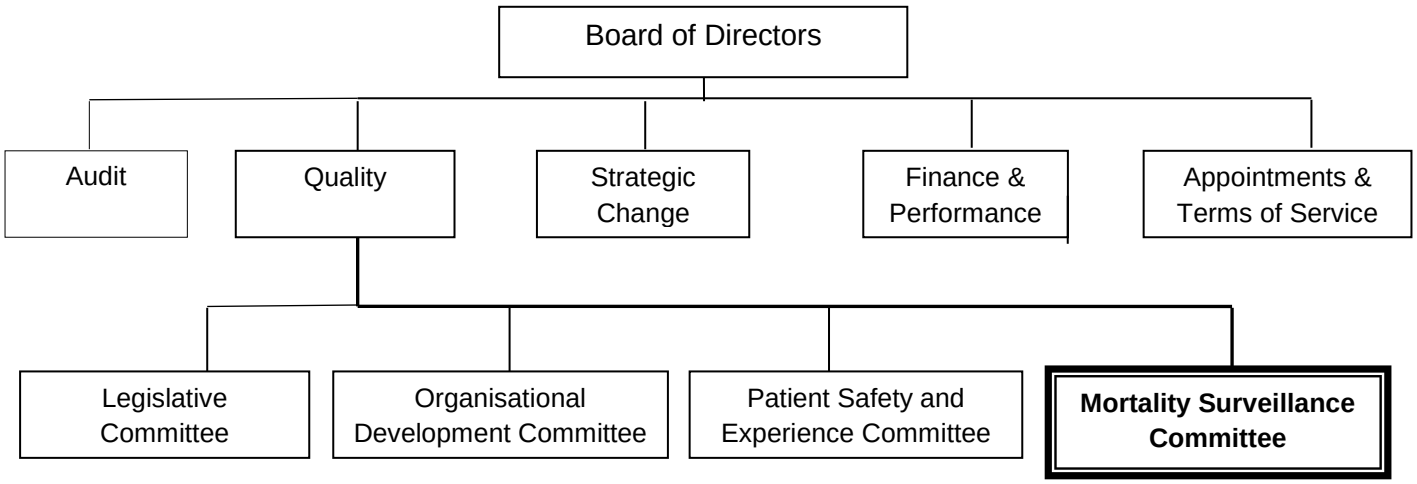
1. Clinical Care Policy – Section 21. Death of a Service User
5. Risk, Quality, Escalation, Candour, and Governance
6. Mental Health and Mental Capacity Policies

APPENDIX 1

MORTALITY SURVEILLANCE COMMITTEE

TERMS OF REFERENCE

STRUCTURE AND RELATIONSHIPS



1. CONSTITUTION

1.1 The Mortality Surveillance Committee (The MSC) will be appointed by the Quality Committee.

2. AUTHORITY

The Quality Committee authorises the MSC to fulfil its terms of reference. In doing so, the MSC is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the MSC.

The MSC is authorised by the Quality Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. PURPOSE

The MSC is the strategic overview group involving multi-professional clinical staff to:

3.1 Provide assurance to the Board of Directors, via the Quality Committee that deaths are identified and reported correctly, unexpected deaths are investigated properly without delay, obligations to others are met, lessons are learnt from all deaths and we are open and transparent in our reporting and investigations.

3.2 Establish the mortality governance processes within Lincolnshire Partnership NHS Foundation Trust.

3.3 Maximise learning from deaths which meet the required criteria of people in receipt of services within Lincolnshire Partnership NHS Foundation Trust.

4. SUMMARY OF ROLE

The MSC is authorised by the Quality Committee to ensure that:

- There are robust processes in place for the effective review and learning from deaths.
- Effective structures are in place to support quality and safety, that these structures operate effectively and that action is taken to address areas of concern.

5. MEMBERSHIP

5.1 The membership of the MSC will comprise:

- Medical Director (Chair)
- Director of Nursing and Quality or Associate Director of Nursing and Quality
- Head of Quality and Safety (co-chair)
- Quality Assurance and Improvement Leads (x4 divisions)
- Clinical Directors (x4 divisions)
- Medical quality leads (x2)
- Safeguarding representative
- Informatics representative
- Pharmacy representative

6. ATTENDANCE

6.1 Any member of the Board of Directors may attend the meetings of the MSC however, they will be recorded as being 'in attendance' and not as being 'present', unless they are formally deputising for a director colleague. No other party may attend without the specific invitation of the Committee.

6.2 The Lincolnshire Coroner or their nominated deputy will be invited to attend the meetings of the MSC.

6.3 The MSC has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose as set out on paragraph 3 above.

6.4 The Quality Committee has delegated authority to the Medical Director to chair the MSC and Head of Quality and Safety to act as nominated deputy.

6.5 Administrative support will be provided by the appointed administrator.

6.6 Members will be required to attend a minimum of 50% of meetings per year. A register of attendance will be maintained and reviewed by the MSC annually.

7. FREQUENCY OF MEETINGS

7.1 The MSC will meet monthly.

7.2 Agenda and papers will be circulated five days prior to each meeting.

8. QUORUM

A quorum shall be no less than 4 members of the group including one of: Medical Director, Director of Nursing and Quality, Head of Quality and Safety.

9. REPORTING

9.1 Draft minutes of the MSC meetings shall be included in the Quality Committee agenda and papers every 6 months. Once the MSC has approved the full minutes, a copy will be available to the Quality Committee.

9.2 The Chair of the MSC shall draw to the attention of the Quality Committee any issues that require disclosure to the full Quality Committee, or require executive action.

9.3 The MSC shall provide an Annual Report to the Board of Directors outlining the statistical information, themes, learning and actions taken.

9.4 The MSC will support the development of the Trusts Annual Quality Report.

10. RESPONSIBILITIES

10.1 To implement the mortality review pyramid of learning (Mazars, 2015)

10.2 To review all deaths that occur whilst in LPFT care or within a 6 month period following discharge from services.

10.3 To receive monthly reports of all the deaths within the Trust up to the end of the month preceding the date of the last meeting.

10.4 To develop supporting materials (e.g. guidance/policy)

10.5 The MSC will agree the format and process for identification and recording of improvement plans (both required and not required).

11. PARTNERSHIP WORKING

11.1 The MSC will support working with the Lincolnshire Coroner or their appointed deputy.

11.2 Where appropriate the MSC will work with any other bodies in support of its function.

11.3 The MSC will support working with the county-wide Mortality Surveillance Collaborative.

12. ASSURANCE FRAMEWORK

The MSC will provide assurance assessments to the Quality Committee for its areas of responsibility such that the Board Assurance Framework can be effectively maintained.

14. REVIEW

The MSC will review the effectiveness and, where appropriate, revise the MSC membership and terms of reference at least annually and more frequently where required.

15. BIBLIOGRAPHY

Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015; (2015); Mazars LLP.

Learning, Candour and Accountability; (2016); Care Quality Commission.

Signed…….
(Chair of the Board of Directors)

Date……..