Lincolnshire Partnership
NHS Foundation Trust

Learning from Deaths

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1.0 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 is not being given sufficient priority in some organisations leading to opportunities for learning being missed.

Subsequently, in March 2017, The National Quality Board has 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 policy 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

Each Trust has been required to publish an updated policy by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care.

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.

- By end of Quarter 2 2017/18 Trusts must publish a paper and policy (this document) which sets out the approach to learning from deaths and;

- From Quarter 3 2017 /18 onwards quarterly publication of the data and learning points presented at public Board meetings.

- From June 2018 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 2017/18 it is anticipated that further developments 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 which is received via the Coroner.
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.
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 (concise) or Level 2 (comprehensive) 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.

- **Case Record Review** 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.

- **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 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].

6. Learning from Death Process

6.1 Reporting Deaths

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, including a list provided by the Registrar's Office on a monthly basis.

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.

- 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 (concise) or Level 2 (comprehensive) 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:

- Bereaved families and carers, or staff have raised a significant concern about the quality of care provision
- Any clinical area where Trust mortality surveillance has identified a concern
- Inpatient (informal)
- Suspected safeguarding concerns e.g. abuse or neglect
- The Coroner has issued a Regulation 28 Report on Action to Prevent Future Deaths (and the death has not already been investigated or reviewed by the Trust)

- In the community / outpatients:
- Under the care of a Crisis Team or open to the Community Mental Health Services within the 4 Divisions

- Exacerbation of life threatening long-term condition where Trust had input into managing – stepped up care
- Rapid deterioration in physical health – stepped up care
- Have a diagnosis of a learning disability
- Someone cared for under CPA
- Someone who has died within 30 days of discharge from an LPFT unit.
- Someone with a diagnosis of a learning disability see section 7
- Death of a child/young person see section 8

If the above criteria in Outcome 2 apply, a Case Notes Review should be conducted. The final format of the Case Note Review is being developed by the Mortality Surveillance Committee and when approved 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. Case Notes 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 standardise template which is based on recognised methodology.

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.

A written report will be produced which will clearly identify the issues raised and make recommendations for action. This will be signed off by the Medical Director and shared with relevant service areas.

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 Learning the Lessons Bulletin which is produced bi-monthly 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.

Further guidance is expected to be published by NHS England in 2018 concerning the engagement of bereaved families and carers.

In the interim, additional work will also be undertaken by the Trust to engage key families / carers in the development of this policy; and provide updated guidance regarding bereavement support for families / carers.

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 (from 1st April 2017) 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 Childrens 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 has been available for consultation the Trust acknowledges additional collaboration with carers in ongoing development of this policy is essential. The Trust plans to undertake further consultation during the first year of implementation with these key stakeholders, this will ensure the voice and perspective of bereaved families / carers and Governors enhances learning in an open and compassionate way.

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

The policy will be implemented as detailed below:

Action	Date
Policy approval via Board of Directors	September 2017
Email to be sent to Divisional Managers, Clinical Directors and Quality Assurance Leads informing of new policy	September 2017
Divisional Leads to cascade policy and expectation of employees to familiarise themselves with content.	October 2017
Communication to all staff via SHARON	October 2017
Development of Case Note Review by Mortality Surveillance Committee	December 2017

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
Implementation complete within designated timescale	Identified actions complete	Head of Quality and Safety	After proposed implementation period	MSC	
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. Available via –

   https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

3. NHS England: Serious Incident Framework 2015. https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf

4. Care Quality Commission: Regulation 20: Duty of Candour March 2015 http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

15. Associated Documentation

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

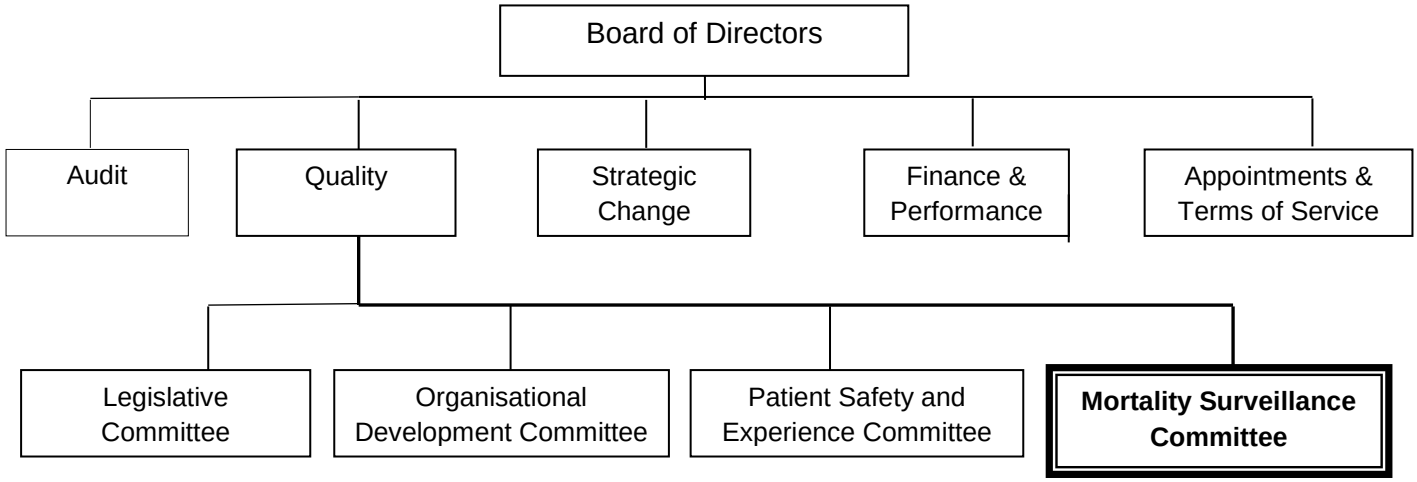
1. Clinical Care Policy – Section 21. Death of a Service User
5. Risk, Quality, Escalation, Candour, and Governance
6. Mental Health and Mental Capacity Policies

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)

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.

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……..