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Learning from Deaths Policy: The right thing to do

(Incorporating the Protocol for reporting Learning Disability deaths to the Learning Disabilities Mortality Review (LeDeR) Programme)

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1 Introduction

After the events of Mid Staffordshire, the then Prime minister asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review 14 hospital trust's national mortality records. The investigation looked broadly at the quality of care and treatment provided within these organisations and noted that the focus on combined mortality rates was distracting Boards from the practical steps that could be taken to reduce avoidable deaths in NHS hospitals.

These findings were reinforced in the Care Quality Commission (CQC) report Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England 2016. It showed that in some organisations learning from deaths was not being given sufficient priority and that valuable opportunities for improvements were being missed. Importantly the CQC also pointed out that there is much more we can do to engage families and carers to recognise their insights and experiences which are vital to our learning.

The National Quality Board (NQB) guidance on Learning from Deaths (2017) was the starting point to initiate a standardised approach across the NHS to the way NHS Trusts report, investigate, and learn from patient deaths. This approach has led to better quality investigations and more embedded learning. Mortality reviews provide the Trust with valuable information in deciding how avoidable the death may have been and how Executive Teams and Boards can use these findings to ensure that safe, high quality services are provided.

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people therefore it is important that organisations widen the scope of deaths which are reviewed to maximise learning.

The Trust 'Journey to Change sets out why we do what we do, the kind of organisation we want to be and the three big goals we're committing to within our business plan:

To co-create a great experience for our patients, carers and families, so you will experience:

- Outstanding and compassionate care, all of the time.
- Access to the care that is right for you.
- Support to achieve your goals.
- Choice and control.

To co-create a great experience for our colleagues, so you will be:

- Proud, because your work is meaningful.
- Involved in decisions that affect you.
- Well led and managed.
- That your workplace is fit for purpose.

To be a great partner, so we will:

- Have a shared understanding of the needs and the strengths of our communities
- Be working innovatively across organisational boundaries to improve services.
- Be widely recognised for what we have achieved together

The most important way we will achieve our goals is by living our values of respect, compassion, and responsibility, all the time. This Policy supports the delivery of safe and effective care in line with the trust values and the Trusts 5-year strategic goals .

In keeping with goal 1 of Our Journey to Change we will ensure that carers and families receive compassionate care following the loss of a loved one. We will make it a priority to work more closely with families and carers of patients who have died to ensure meaningful support and engagement with them at all stages, from the notification of death through to actions taken following an investigation. As part of goal 2, we will ensure our staff are trained to undertake thorough reviews of deaths to ensure that learning is identified and embedded into practice to improve the services we provide. Our 3rd goal will be to work collaboratively with other Trusts, as part of a Northern Alliance, and the Better Tomorrow Programme to facilitate shared learning/good practice and valid comparisons.

The experience of carers and families must be central in how we respond when care might not have been delivered to the standard expected by the trust. Families and carers can offer us an invaluable insight which can help us to identify how we can learn from these situations. If things do go wrong, families should be able to say:

- We were treated with respect, care, and compassion
- We were supported appropriately and did not feel further harmed by the process
- Our view and information were given the same credence and weight as that of your staff
- We were given meaningful, truthful, and clear answers and information in response to all our queries and concerns regarding the death of our loved one.
- Where our expectations were not met or we were not satisfied, we were given a meaningful, truthful, and clear explanation for why this was not possible.

This policy sets out the principles that guide our work and how we will implement them, it should be read in conjunction with the *Incident reporting and serious incident review policy (CORP-0043)*.

2 Why we need this policy

Working with families/carers of patients who have died offers an invaluable source of insight to improve services. There is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. In line with the NQB guidance on Learning from Deaths, every trust must have a policy in place that sets out how it identifies, reports, investigates, and learns from a patient's death. This should include the care leading up to the patient's death to consider if this could have been improved.

This policy informs the organisation of staffs' roles and responsibilities relating to learning from deaths and promotes a culture of learning lessons.



Learning from a review about the care provided to patients who die in our care is integral to the trust's governance and quality improvement work.

2.1 Purpose

The purpose of this policy is to set out the trust's expectation / principles on how it responds to deaths in our care and identifies the scope of review for each death and how the trust will learn from them.

This policy sets out how staff can support the involvement of families and carers when a death has occurred and how to engage with them to ensure there are opportunities to discuss or ask questions about the care received by their loved one.

2.2 Objectives

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.


The core objectives of this policy are:

- To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.
- To help to identify what can be improved to ultimately reduce inequality in the life expectancy of people with a serious mental illness/learning disability/Autism.
- To standardise approaches to reviewing deaths across the northern cohort of mental health trusts to share information and key learning.
- To enhance learning at a personal, team and organisational level.
- To ensure, in keeping with Our Journey to Change, that the trust engages with other stakeholders (Acute Trusts, Primary care, Public Health, Safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximise learning from deaths.

3 Scope

3.1 Who this policy applies to

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

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

The policy aligns to the trust values of compassion, respect, and responsibility.

We will respect bereaved relatives by listening to any concerns they may wish to raise, by treating them as equal partners during any review that takes place. All bereaved relatives/carers will be treated with compassion and staff will be responsible for being open and transparent during any review with a focus on learning

3.2 Roles and responsibilities

Mortality governance is a priority for all Trust Boards and the Learning from Deaths Framework places a greater emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation.

| Role | Responsibility |
|--|--|
| <p>Chief Executive, Executive Trust Board Directors and Non-Executive Directors</p> | <p>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.</p> <p>They must ensure quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. They can do this by demonstrating their commitment to the work, for example, spending time developing Board thinking; ensuring a corporate understanding of the key issues around the deaths of patients and by ensuring that sufficient priority and resource is available for the work.</p> <p>The Director of Nursing and Governance has been identified as the Board level 'Patient Safety Director' with responsibility for learning from deaths. Additionally, a named Non-Executive Director has taken lead responsibility for oversight of progress to act as a critical friend holding the organisation to account for its approach in learning from deaths.</p> <p>The Board will ensure:</p> |

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| | <ul style="list-style-type: none"> • That robust systems are in place for reporting, reviewing, and investigating deaths • That bereaved families are engaged and supported • That there is evidenced learning from deaths both internally and with our external partners and quality improvement is championed • That processes focusing on learning, can withstand external scrutiny, by providing challenge and support and assurance of published information |
| <p>Clinical Directors, Medical Staff, Heads of Service, Heads of Nursing Locality Managers, Modern Matrons, Ward and Team Managers and all Registered Nurses Allied Healthcare Professionals</p> | <p>Staff should familiarise themselves with this policy, understand the process for learning from deaths and identify the key changes required to implement this policy ensuring all appropriate actions are taken.</p> <p>In conjunction with the Patient Safety Team staff will be supported:</p> <ul style="list-style-type: none"> • to be involved in the different reviews and investigations of deaths ensuring they have the time to carry this process out in skilled way to a high standard • to have the correct level of skill through training and experience • to promote learning from deaths • to ensure that sufficient time is assigned in local governance forums to outline and plan for any lessons learned • to ensure that learning is acted upon |
| <p>The Patient Safety Team</p> | <p>This corporate Trust department has a responsibility to ensure:</p> <ul style="list-style-type: none"> • Data is collected and published to monitor trends in deaths with Board level oversight of this process • The Datix incident reporting system is used to its full potential to record deaths (expected and unexpected) in accordance with Trust policy. • Information is processed consistently and precisely to maintain high standards in mortality governance |



The Trust requires all staff to be open, honest, and transparent about reporting deaths and for engaging with families and carers, actively enabling them to ask questions about care and identify if care can be improved.

4 Policy

4.1 Encouraging a learning from death culture

By educating our staff and encouraging a more open culture of listening to the views and opinions of families and carers, staff will become more confident in identifying what can be done differently and improving patient experience in the future.

4.2 Family engagement

Dealing respectfully, sensitively, and compassionately with families and carers when someone has died is paramount. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received.

Where clinicians have had close contact with a patient and their family/carer, they will often be the first to offer condolences and support and to give appropriate information regarding the opportunity to be involved in a review of care their loved one received. Where there is a delay in the trust being informed about the death of a patient, a discussion should take place between the Patient Safety team and the clinical team involved to determine how best to approach families/carers.

The Trust acknowledges that coping with death of a loved one is a distressing time for those bereaved. Staff may need to offer the opportunity for on-going involvement in-keeping with the family's belief, needs and wishes. It may be that relatives/carers need help themselves. The trust's Family Liaison Officer (FLO) or the reviewer overseeing a case can arrange to either refer or signpost those bereaved to appropriate services. To support families, we provide information for bereaved carer's/relatives which explains the different levels of review, what they can expect from a review and different services available for support.

The trust's approach must be to treat families/carers as equal partners in the review process. Families can choose how they wish to be involved for example by contributing to the terms of reference, providing evidence, being involved in the review process, providing a pen portrait of their loved and/or a timeline of events and the opportunity to provide comments at different stages of the review process. Families/carers should also be given the option of seeing final reports to ensure they are comfortable with any findings. Ideally this should be undertaken in a face-to-face meeting. This would usually be with a member of the Patient Safety Team/Family Liaison Officer and a representative from clinical services with a staff member talking the family member/carer through the report. If the family member/carer decides they do not want to be involved in the review process, staff should make it clear they can contact us at any time should their decision change and that any relevant information can still be shared. If the family does not want contact at all about the process or findings, this should be respected, and staff should record their wishes.

Staff should be prepared for the types of questions that families may have such as:

- Why is there an investigation/review?
- Can I access the records for my relative?
- Can I speak to the staff who were caring for my relative?

4.3 Identifying and Reporting Deaths

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

Trust staff must DATIX report **all deaths** that they are made aware of, within 24 hours of being informed. This applies to all deaths of patients open to TEWV services. A cause of death should be provided where known. Once the Datix is completed, staff must immediately attempt to engage with the family and or carers unless otherwise instructed. In the first instance this would take the form of a condolence letter, in an appropriate format, with relevant numbers for contacting the service.

Datix reports should also be completed for deaths thought to be due to a patient safety incident for people who die within 6 months of being discharged from TEWV services.



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

All Datix reports for deaths are initially reviewed by the Central Approval (CAT) team. Any unnatural, unexpected deaths either in-patient or community services and any expected in-patient deaths are taken through the daily Patient Safety Team huddle. Depending on the facts of the case, completion of a Rapid Review Report by the clinical service is requested to identify any early learning as well as appropriate actions to address this learning. Upon receipt of the Rapid Review Report, if there is more significant, or trust-wide learning, the most appropriate level of investigation is determined. This could be a Serious Incident Investigation for deaths resulting from an unnatural, unexpected patient safety incident or a Structured Judgement Review (SJR) under the mortality review process for expected in-patient death. Each case will be reviewed on an individual basis to ensure the correct approach/level or review is requested. Expected and unexpected physical health deaths in the community follow the mortality review process. In these cases, the CAT team undertake an initial review and then forward these details to the Mortality Review Manager.

Mortality reviews are completed in-line with guidance from the Royal College of Psychiatrist. The mortality review tool used consists of a Part 1 and Part 2 review (see appendix 1). Part 1 is a review of the care records, if any red flags or concerns are noted a more in-depth Part 2 (Structured Judgement Review) will be carried out.

Evidence of “red-flags” to be considered during the Part 1 review are as follows:

- Family, carers, or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)

- Patients with a Learning Disability and (in the future autistic people, and people from Black, Asian and minority ethnic communities)
- Prescribed Clozapine or high doses of anti-psychotic medication

This criterion allows for greater learning from a more suitable selection of cases reviewed.

To prioritise the most significant cases for learning from unexpected and expected **physical** health deaths the following reviews take place:

- All in-patient deaths will have a Structured Judgement Review completed by a Senior Nurse with investigation skills. Clinical Teams and families will be involved where appropriate.
- All Learning Disability deaths are reviewed under Part 1 of the mortality review process. Where any concerns are identified a Structured Judgement Review is requested and completed by a Senior Nurse with investigation skills. Clinical Teams and families will be involved where appropriate. All these cases will also be referred to LeDeR for an external review.
- All community deaths for patients aged 64 and under are reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review will be carried out by a Senior Nurse with investigation skills. Clinical Teams and families will be involved where appropriate.
- 20% of community deaths for patients aged between 65 and 75 are reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review will be requested. This 20% is selected from deaths within Trust services as opposed to deaths within care homes or memory services, for example, where the Trust is not the main care provider.
- 10% of community deaths for patients aged between 76 onwards are reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review be carried out. This 10% is selected from deaths within Trust services as opposed to deaths within care homes or memory services, for example, where the Trust is not the main care provider.
- In the latter two categories, here there are any concerns about the use of psychotropic medication

4.5 Reporting Learning Disability Deaths

In addition to internally reporting and learning from Learning Disability deaths, there is also a requirement to report them externally. We need to ensure that throughout the Trust we report the death of a patient (aged four years and older) with a Learning Disability to what was previously known as the LeDeR Programme.

The Learning Disabilities Mortality Review (LeDeR) Process was originally introduced in 2015 in response to significant ongoing concerns about the likelihood of premature deaths of people with Learning Disabilities. The Learning Disabilities Mortality Review (LeDeR) Programme was initially delivered by the University of Bristol. It was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in

June 2015 for an initial three-year period, which is now embedded. The aim of reviews is to learn from deaths and lead to improvements in services.

In 2021, the LeDeR process changed. In response to stakeholder engagement the new name for the LeDeR programme is now the Learning from Life and Death Reviews. There is a new platform for reporting learning disability deaths. Please use the following link to register a notification:

[online form on the LeDeR website](#)

When a member of a team is informed about the death of a patient with a Learning Disability, over the age of four, who is receiving care and treatment from TEWV, they must follow the below steps as soon as practicable:

- Check whether the death has been reported to LeDeR, you should find this on PARIS, and if not, take responsibility of notifying LeDeR about the death. If in doubt, please report to LeDeR anyway (it's better to over report than under report).
- Report the death on DATIX. *For guidance on completing a Datix incident form, please follow the Incident Reporting and Serious Incident Review Policy or contact the Central Approval Team.*
- The Central Approval Team will log the death of every patient with Learning Disabilities to a spreadsheet, to keep a record of all Learning Disability deaths. The Central Approval Team will contact the reporter of the Datix Incident form to confirm that LeDeR has been notified of the death, and this information will be added to the spreadsheet.



Reporting the death of a person with a learning disability

Anyone can notify a death to the LeDeR programme. To report a death please use the following link

[online form on the LeDeR website](#)

Integrated Care systems (ICS) are now responsible for ensuring external reviews take place. TEWV staff may be asked to be involved with this process and it is important that they assist with this review and provide any information requested; the sharing of information in these cases is authorised under Section 251 of the Health Research Authorities Confidential Advisory Group. Support should be provided to staff by their line manager during this process.

Following the review, it will be agreed whether there are any contributory factors, lessons learned, good practice and recommendations. If any learning is identified through these external reviews, these will be shared with the Head of Service and should be taken to their local QUAG for discussion. The Mortality Review Manager will also meet up with the Regional Mortality Reviewers monthly to discuss learning and any potential themes that may need addressing trust wide.

Reporting autism deaths

For the first time, deaths of adults who have a diagnosis of autism, but no learning disability will be included in the process. LeDer reviews will be undertaken for all autistic people over the age of 18 who have been told by a Dr that they are autistic and had this written in their medical records.

Reporting deaths from BAME communities

The deaths of all people from BAME communities will also need to be reported externally to LeDeR to enable a review as there is evidence to suggest that health inequalities experienced by people from these communities are very significant.

NB: These latter two groups of deaths (autism and BAME) will require reporting once the external LeDeR reviewers have completed training. A notification will be sent out to clinical services Trust-wide once the trust needs to report these externally



Reporting deaths of people with a diagnosis of autism or people from BAME communities

Anyone can notify a death to the LeDeR programme.

To report a death please use the following link (this is envisaged to be from late 2021-early 2022)

[online form on the LeDeR website](#)

4.4 The decision to investigate or review

The Trust collects data on all known deaths and has a process in place to determine the scope of deaths which require further review or investigation. The information below sets out these processes in addition to the existing NHS England Serious Incident Framework (2015) which remain and are set out in the trust's Incident Reporting and Serious Incident policy.

The National Quality Board guidance on Learning from Deaths provides the context to the review or investigation of deaths and establishes several "must dos" in terms of deaths to be investigated.

These include:

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| i | all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision |
| ii | all in-patient, out-patient and community patient deaths of those with learning disabilities |

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| iii | all deaths in a service specialty, particular diagnosis, or treatment group where an 'alarm' has been raised with the provider through whatever means |
| iv | all deaths in areas or related to interventions where people are not expected to die, for example ECT, rapid tranquilisation |
| v | deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically; |
| vi | a further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample and could use practical sampling strategies such as taking a selection of deaths from each weekday. |

The NQB guidance requires that all inpatient, outpatient, and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis, and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

Where Trusts such as ours provide a wide range of clinical services across inpatient, community and other provider organisations this can lead to both a degree of confusion as to who is responsible for the reporting and investigating of a patient's death and the risk of double reporting and investigation.

It is recognised that people with mental health problems often access a range of health services and may be in receipt of care by multiple agencies at the time of their death. To support consistency in determining the scope of deaths for further review by the Trust as the main provider of care or to participate in the review with another provider, the cohort of Northern Mental Health Trusts agreed the following approach to provide further guidance and clarity to the definition in the NQB guidance:

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| <p>To support staff in their decision making regarding the investigation of deaths, staff should refer to the following guidelines. If there is any doubt staff should contact their line manager or the Patient Safety department for advice.</p> <p>A We are the main provider if at the time of death, the patient was subject to:</p> <ul style="list-style-type: none"> • An episode of inpatient care within our service. • An episode of community treatment due to identified mental health needs • An episode of community treatment due to identified learning disability or substance misuse needs • A Community Treatment Order. • A conditional discharge. |
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- An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
- Guardianship

B Patients who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.

In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also exercise the responsibilities under duty of candour. There will be a discussion to agree on if it is to be a joint or single agency investigation (this will be determined by the cause of death) and in the case of joint investigations who the lead organisation will be.

C Services provided by the Trust where we are not classed as the main provider.

For the following services the Trust may only be providing a small component of an overarching package of care and the lead provider is the patients GP.

- Tissue viability
- Dietetics
- Drug and alcohol shared care services
- Care home liaison
- Acute hospital liaison
- Community physiotherapy
- Memory clinic

D Exception.

In addition to the above, if any act or omission on the part of a member of Trust staff where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, an investigation will be undertaken by the Trust.

Where problems are identified relating to other NHS Trusts or organisations the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement. A culture of compassionate curiosity should be adopted, and the following questions should be asked:

- Which deaths can we review together?
- What could we have done better between us?
- Did we look at the care from a family and carers perspective?
- How can we demonstrate that we have learnt and improved care, systems, and processes?

In addition to the above, the Northern Mental Health trusts have identified several potential triggers for a Review / Investigation. These include deaths:

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

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

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| Where the service user had no active family or friends and so were particularly isolated, for example, with no one independent to raise concerns; |
| Where there had been known delays to treatment e.g., assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap or wait in services; |
| Also |
| Particular causes of death e.g., epilepsy; |
| Deaths in Distress which might include drug and alcohol deaths, or deaths of people with an historic sex offence e.g., people who might not be in crisis but need support and from whose experience there may be learning from a thematic review; |
| Where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn't responded to in a timely manner; |
| Random sampling |

4.5 Types of review

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| <p>Practice varies across Trusts in relation to how deaths are reported and categorised.</p> <p>In TEWV deaths are reported and categorised as follows:</p> <ul style="list-style-type: none"> • Incidents are reported on Datix by the service who first becomes aware of the death. • An initial screen of all deaths is carried out by the CAT team. • The CAT team will bring any inpatient deaths (expected/unexpected) and unexpected community deaths (cause unknown) or due to a suspected patient safety incident to the Patient Safety Team's daily huddle together with information around the circumstances of the death. • A decision is made by the Patient Safety Team about which deaths will be subject to further review. Each case will be considered on its own merits. On some occasions additional information will be required and clinical services will be asked to collate and present this at a PST huddle via a Rapid Review Report to identify any early learning • Unexpected in-patient deaths will usually commence with a Rapid Review meeting supported by the PST. This is to identify any early learning and to formulate an action plan. • Unexpected inpatient and community deaths, due to a suspected patient safety incident, will generally follow the Serious Incident Investigation process • Unexpected/expected physical health in-patient deaths will follow the mortality review process with a structured Judgement review being carried out. |
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| <ul style="list-style-type: none">• Unexpected/expected physical health community deaths, within scope, will be reviewed under the mortality review process. |
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4.5.1 Local review

The trust has a multi-disciplinary mortality review panel which meets monthly. The purpose of the mortality review panel is to review and discuss findings/learning from structured judgement reviews, seeking assurance that all elements of care have been reviewed and relevant learning/themes have been identified.

Learning points are captured and shared with clinical services as appropriate. Learning feeds into appropriate workstreams trust-wide, any areas of concern not covered by existing workstreams are fed into the Quality Assurance and Improvement Group for discussion and advice regarding potential next steps.

This process is in place for deaths which are **not** categorised as Serious Incidents.

4.5.2 Structured judgment Reviews

A Structured Judgment Review (SJR) blends a traditional clinical judgement-based review with a standard format that enables reviewers to make safety and quality judgements over phases of care and which provides explicit written comments and a score for each phase. A SJR provides a relatively short but rich set of information about each case in a format that can be aggregated to provide knowledge about clinical services and systems of care

When the family/carers wish to be involved, their preference regarding how, when and where they want to engage will be paramount and built on the principles of compassionate engagement.

4.6 Governance process / ensuring Learning

The prime objective of a Learning from Deaths Policy is to improve services and the experience of the people that use them. As a trust we have developed a consistent framework around learning by identifying areas for improvement, developing a shared understanding about what those improvements are, defining detailed action plans with SMART goals and to provide assurance that the impact of actions is making a difference to the quality and standard of services provided.

As a learning organisation, the trust will ensure that lessons learnt result in changes in organisational culture and practice. Thematic reviews will be carried out where appropriate and monitoring of emerging themes will have oversight from the Trust's Organisational Learning Group and the Quality Assurance and Improvement Group. Trust-wide Learning will be identified by the MDT Mortality Review Panel and will be cascaded to staff via Patient Safety Bulletins. All learning will be stored in the Learning Library. Evidence and assurance that actions from learning are having an impact on service improvement will be monitored via the learning database.

We can share learning with our partner trusts and other, local stakeholders. For example, there may be common issues we could commission thematic reviews of. This will be facilitated via the Northern Mortality Alliance group and attendance at the Better Tomorrow Programme group sessions.

4.7 Data reporting

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

5 Definitions

| Term | Definition |
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| Case record review | <p>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.</p> <p>The Royal College of Physicians Structured Judgement Review methodology provides an agreed template for this.</p> |
| Death due to a problem in care | <p>A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.</p> |
| Investigation | <p>The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies and procedures, guidance, good practice, and observation – to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred.</p> |
| Structured Judgement Review (SJR) | <p>A Structured Judgement Review is carried out by a Senior Nurse who is trained in investigation skills. The SJR considers the care and treatment the patient received and any lessons that can be learned</p> |

6 Related documents

This Policy document is to be read in conjunction with:

- Incident Reporting and Serious Incident Policy (CORP-0043)
- Duty of Candour Policy (CORP-0064)

7 How this policy will be implemented

[In this section, write about how the policy will be disseminated and implemented. Include an implementation action plan if required. Identify any training needs and who is responsible for its delivery.]

| |
|---|
| <p>This updated policy will be scrutinised by the Executive Management Team and published on the Trust’s intranet and external website.</p> |
| <p>Line managers will disseminate this policy to all Trust employees through a line management briefing.</p> |
| <p>As further guidance emerges over the next 12 months from the Better Tomorrow Programme, the Trust will review the policy and its implementation to ensure it continues to reflect best practice.</p> |

7.1 Training needs analysis

Not applicable

8 How the implementation of this policy will be monitored

| | Auditable Standard/Key Performance Indicators | Frequency/Method/Person Responsible | Where results and any Associate Action Plan will be reported to, implemented, and monitored; (this will usually be via the relevant Governance Group). |
|---|---|--|--|
| 1 | The audit tool will be designed to capture both qualitative and quantitative data to demonstrate the lessons learned and how they have been shared and used to improve the quality of services. | The policy and processes and procedures will be audited by the clinical audit team, annually. The results of which will be considered at the Clinical Effectiveness Group and Quality Assurance Committee. | The results will be considered at the Quality Assurance and Improvement Group and Quality Assurance Committee. |

9 References

National Quality Board: *National Guidance on Learning from Deaths 2017*

NHS Improvement: *Implementing the Learning from Deaths framework – key requirements for trust boards 2017*

NHSE Serious Incident Framework 2015: *Supporting learning to prevent recurrence*

CQC Regulation 20: Duty of Candour 2014

http://www.gmc-uk.org/DoC_guidance_english.pdf_61618688.pdf

People with a learning disability and autistic people (LeDeR) policy 2021

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

| | | |
|---|---|-------------------|
| Date of approval: | 15 December 2021 | |
| Next review date: | 15 December 2024 | |
| This document replaces: | CORP-0065-v1 AND REPLACES Protocol for reporting Learning Disability deaths to the Learning Disabilities Mortality Review (LeDeR) Programme | |
| This document was approved by: | Name of committee/group | Date |
| | SLG | 15 December 2021 |
| This document was ratified by: | Name of committee/group | Date |
| | SLG | 15 December 2021* |
| An equality analysis was completed on this document on: | 14 December 2021 | |
| Document type | Public | |
| FOI Clause (Private documents only) | N/A | |

Change record

| Version | Date | Amendment details | Status |
|---------|-------------|---|-----------|
| 1 | 27 Sep 2017 | New document | Withdrawn |
| 1 | 18 Jun 2020 | Review date extended from 27 September 2020 to 27 March 2021 | Withdrawn |
| 1 | 08 Mar 2020 | Review date extended to 27 September 2021 | Withdrawn |
| 2 | 15 Dec 2021 | Full review with minor changes. Including transfer to new template and with minor wording changes to reflect current practice. *= Ratified subject to OJTC being corrected, sent for publication March 2022. | Published |

11 Appendices

Appendix 1 – Care review tool for mortality reviews

PART 1 Review-

| | | | |
|---|--|----------------|--------------------------|
| Patient identification number: | | Gender: | |
| Date of birth (dd/mm/yyyy) | | Age: | |
| Social deprivation index (first 3-4 letters of postcode) | | Ethnicity: | |
| Date of death | | Time of death: | |
| Location of death | | | |
| Was the patient identified as being within the last 12 months of life? | | | |
| Cause of death (if known) | | | |
| Primary diagnosis, including ICD-10 code | | | |
| Co-morbidities | | | |
| Mental Health Medication | | | |
| Learning disability (if present, this death should be reviewed through the LeDeR process) | | | |
| Healthcare teams involved in the patient's care at the time of death | | | |
| Dates of last admission to a psychiatric hospital (where relevant) | | | |
| Patient summary (can be completed by the clinical team) | | | |
| | | | |
| Concerns from family members or carers about the patient's care (please outline concerns, or state if there were no concerns) | | | |
| Concerns from staff about the patient's care (please outline concerns, or state if there were no concerns) | | | |
| Red flags indicating further review where the death is not being investigated by other means (please indicate): | | | |
| 1. Family, carers, or staff have raised concerns about the care provided | | | <input type="checkbox"/> |
| 2. Diagnosis of psychosis or eating disorders during the last episode of care | | | <input type="checkbox"/> |

| | |
|--|--------------------------|
| 3. Psychiatric inpatient at time of death, or discharged from inpatient care within the last month | <input type="checkbox"/> |
| 4. Under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death | <input type="checkbox"/> |
| 5. Case selected at random | <input type="checkbox"/> |

If a red flag is identified, or it has been agreed this death is for a review of care, please proceed to completion of Review 2

Time taken to complete Section 1 of this form (minutes):

Date of completion:

Name of person completing Section 1:

Job title of person completing Section 1

Part 2 Structured Judgement Review

Please state the information sources used for the review, including the names of the electronic systems accessed:

2.1. Phase of care: Allocation and initial assessment or review (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care 4 Good care 3 Adequate care 2 Poor care 1 Very poor care

Section not applicable

2.2. Phase of care: Ongoing care (where relevant)

- Was mental health monitored adequately?
- Was physical health monitored adequately?
- Please list medication if known and relevant, and comment on medication monitoring where appropriate

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care 4 Good care 3 Adequate care 2 Poor care 1 Very poor care

Section not applicable

2.3. Phase of care: Psychiatric Inpatients – comment on care during admission (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care 4 Good care 3 Adequate care 2 Poor care 1 Very poor care

Section not applicable

2.4. Phase of care: End of life care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

| |
|--|
| |
| <p>Please rate the care received by the patient during this phase:</p> <p>5 Excellent care <input type="checkbox"/> 4 Good care <input type="checkbox"/> 3 Adequate care <input type="checkbox"/> 2 Poor care <input type="checkbox"/> 1 Very poor care <input type="checkbox"/></p> <p>Section not applicable <input type="checkbox"/></p> |

| |
|--|
| <p>2.5. Phase of care: Discharge plan of care (where relevant)</p> <p>Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.</p> <p>Please also include any other information that you think is important or relevant.</p> |
| |
| <p>Please rate the care received by the patient during this phase:</p> <p>5 Excellent care <input type="checkbox"/> 4 Good care <input type="checkbox"/> 3 Adequate care <input type="checkbox"/> 2 Poor care <input type="checkbox"/> 1 Very poor care <input type="checkbox"/></p> <p>Section not applicable <input type="checkbox"/></p> |

| |
|--|
| <p>2.6. Other area of care (please specify)</p> <p>Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.</p> <p>Please also include any other information that you think is important or relevant.</p> |
| |
| <p>Please rate the care received by the patient during this phase as:</p> <p>5 Excellent care <input type="checkbox"/> 4 Good care <input type="checkbox"/> 3 Adequate care <input type="checkbox"/> 2 Poor care <input type="checkbox"/> 1 Very poor care <input type="checkbox"/></p> <p>Section not applicable <input type="checkbox"/></p> |

| |
|---|
| <p>2.7. Overall care</p> <p>Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.</p> <p>Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.</p> <p>Please also include any other information that you think is important or relevant.</p> |
| |
| <p>Please rate the care received by the patient during this phase as:</p> <p>5 Excellent care <input type="checkbox"/> 4 Good care <input type="checkbox"/> 3 Adequate care <input type="checkbox"/> 2 Poor care <input type="checkbox"/> 1 Very poor care <input type="checkbox"/></p> <p>Section not applicable <input type="checkbox"/></p> |

| |
|---|
| <p>2.8. If care was below an acceptable standard, did it lead to harm? If yes, please provide details and state an action plan (consider whether a serious incident investigation or another Trust process is required).</p> |
|---|

| |
|--|
| |
|--|

2.9. Was the patient's death considered more likely than not to have resulted from problems in care delivery or service provision? If yes, please provide details and state an action plan (consider whether a serious incident investigation is required).

| |
|--|
| |
|--|

2.10. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required. If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

| |
|--|
| |
|--|

2.11. Were the patient records adequate for the purpose of the review?

Yes

No

Please outline any difficulties in accessing appropriate information:

| |
|--|
| |
|--|

Time taken to complete Section 2 of this form (minutes):

Date of completion: 2/11/21. Name of person completing Section 2:

Job title of person completing Section 2:

Appendix 2 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

| | | | | |
|---|---|-------------------------------------|-----------------------|------------------|
| Name of Service area, Directorate/Department i.e., substance misuse, corporate, finance etc. | Nursing and Governance - Quality Governance | | | |
| Policy (document/service) name | Learning from Deaths Policy | | | |
| Is the area being assessed a... | Policy/Strategy | <input checked="" type="checkbox"/> | Service/Business plan | Project |
| | Procedure/Guidance | | | Code of practice |
| | Other – Please state | | | |
| Geographical area covered | Trustwide | | | |
| Aims and objectives | The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people therefore it is important that organisations widen the scope of deaths which are reviewed to maximise learning. | | | |
| Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.) | Dec 2021 | | | |
| End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved) | Dec 2021 | | | |

You must contact the EDHR team if you identify a negative impact - email tevv.eandd@nhs.net

| | | | | | |
|---|----|---|----|--|----|
| 1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project, or Business plan benefit? Families and Carers; Trust Staff; | | | | | |
| | | | | | |
| 2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project, or Business plan impact negatively on any of the protected characteristic groups below? | | | | | |
| Race (including Gypsy and Traveller) | no | Disability (includes physical, learning, mental health, sensory and medical disabilities) | no | Sex (Men, women, and gender neutral etc.) | no |
| Gender reassignment (Transgender and gender identity) | no | Sexual Orientation (Lesbian, Gay, Bisexual and Heterosexual etc.) | no | Age (includes, young people, older people – people of all ages) | no |
| Religion or Belief (includes faith groups, atheism, and philosophical belief's) | no | Pregnancy and Maternity (includes pregnancy, women who are breastfeeding and women on maternity leave) | no | Marriage and Civil Partnership (includes opposite and same sex couples who are married or civil partners) | no |
| <p>Yes – Please describe anticipated negative impact/s</p> <p>No – Please describe any positive impacts/s</p> <p> Gives clarity and understanding around learning from deaths to families, carers, trust staff and external stakeholders. There is an acknowledgement that there could be a negative impact on the families and carers of patients who have died in relation to the protected characteristic of 'Disability' and the effects it could have on the families and carers mental health. The policy therefore identifies ways to ensure that families and carers are supported to access appropriate services via the Trusts Family Liaison Officer/reviewer and that the families and carers are given appropriate information and choice in relation to how they wish to be involved in the review process.</p> | | | | | |

| | | | | |
|--|--|--|--|--|
| <p>3. Have you considered other sources of information such as legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? If 'No', why not?</p> | <p>Yes</p> | | | |
| <p>Sources of Information may include:</p> <ul style="list-style-type: none"> • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports (LeDer) | <ul style="list-style-type: none"> • Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below) | | | |
| <p>4. Have you engaged or consulted with service users, carers, staff, and other stakeholders including people from the following protected groups? Race, Disability, Sex, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership</p> | | | | |
| <p>Yes – Please describe the engagement and involvement that has taken place</p> | | | | |
| | | | | |
| <p>No – Please describe future plans that you may have to engage and involve people from different groups</p> <p>No – however this has been based on discussions with Quality Assurance Improvement Group, Learning from Deaths report (to external stakeholders and the Trust Board of Directors) and Equality and Diversity team have been consulted.</p> | | | | |

| | | | | | |
|--|---|---------------|----|---------------------------------------|----|
| 5. As part of this equality analysis have any training needs/service needs been identified? | | | | | |
| No | Please describe the identified training needs/service needs below | | | | |
| A training need has been identified for; | | | | | |
| Trust staff | /No | Service users | No | Contractors or other outside agencies | No |
| Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so | | | | | |

Appendix 3 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

| | Title of document being reviewed: | Yes/No/ Not applicable | Comments |
|-----------|---|---------------------------|--|
| 1. | Title | | |
| | Is the title clear and unambiguous? | Y | |
| | Is it clear whether the document is a guideline, policy, protocol or standard? | Y | |
| 2. | Rationale | | |
| | Are reasons for development of the document stated? | Y | |
| 3. | Development Process | | |
| | Are people involved in the development identified? | Y | |
| | Has relevant expertise has been sought/used? | Y | |
| | Is there evidence of consultation with stakeholders and users? | Y | |
| | Have any related documents or documents that are impacted by this change been identified and updated? | n | However related docs are due for review in January when new guidance is due to be published. |
| 4. | Content | | |
| | Is the objective of the document clear? | Y | |
| | Is the target population clear and unambiguous? | Y | |
| | Are the intended outcomes described? | Y | |
| | Are the statements clear and unambiguous? | Y | |
| 5. | Evidence Base | | |
| | Is the type of evidence to support the document identified explicitly? | Y | |
| | Are key references cited? | Y | |
| | Are supporting documents referenced? | Y | |
| 6. | Training | | |
| | Have training needs been considered? | n/a | None at this time |
| | Are training needs included in the document? | n/a | |

| | Title of document being reviewed: | Yes/No/ Not applicable | Comments |
|------------|---|---------------------------|----------|
| 7. | Implementation and monitoring | | |
| | Does the document identify how it will be implemented and monitored? | Y | |
| 8. | Equality analysis | | |
| | Has an equality analysis been completed for the document? | Y | |
| | Have Equality and Diversity reviewed and approved the equality analysis? | y | |
| 9. | Approval | | |
| | Does the document identify which committee/group will approve it? | Y | |
| 10. | Publication | | |
| | Has the policy been reviewed for harm? | Y | |
| | Does the document identify whether it is private or public? | yes | public |
| | If private, does the document identify which clause of the Freedom of Information Act 2000 applies? | n/a | |