Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

NHS Improvement

Learning from Deaths Policy

September 2017

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1. Introduction

Avon and Wiltshire Partnership Mental Health NHS Trust (AWP) are committed to ensuring the safety of patients and service users. Working together with families and carers to identify and learn from problems associated with poor outcomes the Trust strives to learn from deaths through robust mortality review and quality improvement processes.

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence (National Quality Board 2017 CQC 2016).

Learning from deaths is a fundamental aspect of risk management. Sharing the learning of mortality review enables the organisation to implement changes to practice, processes and systems so that the risk of harm is reduced. In addition to the human costs, if lessons are not learned, they may result in a loss of public confidence in the organisation and a loss of assets.

2. Scope

This policy applies to all staff whether they are employed by the Trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

3. Purpose

Avon and Wiltshire Mental Health Trust will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of Avon and Wiltshire Mental Health Trust.

It describes how Avon and Wiltshire Mental Health Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the Trust supports staff that may be affected by the death of someone in the Trust's care.

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

This policy should be read with Guidance for Incident Management Policy (P057) and associated appendices Adverse Incident Management Procedure (appendix C1), Woking with Families (appendix C3), Supporting Staff After and Unexpected Death, Serious Incident Complaint or Claim (appendix C2) Duty of Candour Procedure, Procedure for Investigating Complaints and Concerns, Structured Judgment Review Process.

4. New requirements

Under the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017, the Trust will implement this policy to address how the organisation responds to and learns from deaths of patients who die under their management and care of the Trust, including:

- Processes to respond to the death of an individual with a learning disability, severe mental illness, a child death or a maternal death.
- An evidence-based approach to undertaking case record reviews
- The categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed).
- How the Trust engages with bereaved families and carers, including how the Trust supports them and involves them in investigations

– How staff affected by the deaths of patients will be supported by the Trust.

Collect specific information every quarter on:

- The total number of inpatient deaths in an organisation's care[1]
- The number of deaths the Trust has subjected to case record review (desktop review of case notes using a structured method)
- The number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents)
- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
- The themes and issues identified from review and investigation, including examples of good practice
- How the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

The Trust will publish this information on a quarterly basis from December 2017 by taking a paper to public Board meetings.

This policy sets out Avon and Wiltshire Mental Health Partnership approach to meeting these requirements.

5. Roles and responsibilities

Roles and responsibilities for incident management, complaints handling and serious incident management are detailed in Adverse Incident Management Procedure (appendix C1), Woking with Families (appendix C3), Supporting Staff After and Unexpected Death, Serious Incident Complaint or Claim (appendix C2) Duty of Candour Procedure, Procedure for Investigating Complaints and Concerns Structured Judgment Review Process.

Role	Responsibilities
Chief Executive	• Overall responsibility for implementing the policy. • Ultimately responsible for ensuring that the necessary resources and systems are in place to provide for the effective management of and learning from deaths.
Non-Executive Directors (including the role of a lead non-executive director in taking oversight of progress in implementing the Learning from Deaths agenda)	In summary, non-executive director responsibilities relating to the framework include: • Understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny. • Championing quality improvement that leads to actions that improve patient safety. • Assuring published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.
Medical Director*	• The Medical Director is the appointed Patient Safety Director, and has responsibility for development, implementation and on-going review of this policy.
Director of Nursing	• Responsibilities for directly ensuring resources are available to implement the quality aspects of the policy.
Executive Management Team	• Ensuring that appropriate systems are in place to respond in a timely manner to

	learning from deaths, to ensure that the appropriate level of investigation takes place and to ensure that controls are implemented as quickly as possible.
Clinical Directors	• Ensuring that the corporate systems for managing and investigating deaths are cascaded and implemented within their areas and that all staff are aware of their roles and responsibilities. • Overseeing the implementation of this policy in relation to learning from deaths.
Clinical Leads	• Clinical Leads are responsible for ensuring the learning and action points are presented and discussed at Locality Governance meetings as a standard agenda item. • They are additionally responsible for supporting the Clinical Director in ensuring that any agreed changes in practice are communicated into the wider workforce within the locality. • Providing a senior clinical contribution to the investigation and review of reported deaths. • Sharing learning from mortality reviews. • Ensuring lessons are learned from incidents and changes to practice are made.
Head of Patient Safety, Service User and Carer Experience	• Responsible for maintaining a central electronic record of all reported deaths. • Analysing review data and identifying

	trends. • Providing reports which highlight data, trends and learning. • Offering support and advice regarding the processes of reporting, managing and investigating deaths, linking with external investigations; and co-operating with the processes for sharing learning and implementing recommendations.
Patient Safety Systems Team	• Responsible for receiving individual reviews, challenging & clarifying avoidability and learning points for organisational implementation, identifying themes for improvement and ensuring acceptable performance of the process. • They act as the gatekeeper for raising concerns about patient care with other involved organisations, and receive concerns about the care of patients and service users of AWP who subsequently die elsewhere identified from an external mortality review.
All Managers	• Ensuring that all staff and relevant contractors are familiar with this policy. • They are responsible for ensuring that staff are appropriately supported following an adverse incident and through any complaint or judicial process that may follow on thereafter.
All Staff	• Every member of staff is responsible for reporting a death when it occurs and adhering to the requirements of this policy.

Quality and Standards Committee	• This Board reporting committee is responsible for receiving reports on learning from deaths activity and providing assurance to the Trust Board.
Critical Incident Overview Group	• The Critical Incident Overview Group is responsible for developing strategies and plans to encourage the reporting and learning from deaths, the development of a positive safety culture and for monitoring the implementation of this policy. It reports to the Executive Management Team, though has the authority to report directly to Board.
Local and Specialist Governance Groups	• Each locality has an integrated governance group. These groups have responsibility for reviewing mortality data and learning alongside other patient experience data and disseminating learning throughout their service. They are responsible for monitoring the implementation of action plans arising from mortality reviews.

Committee	Responsibilities
Trust Board	• The Trust Board has ultimate responsibility for risk management. It is responsible for engendering through its leadership the development of a strong learning culture. • The Board has a leader acting as a patient safety director who takes responsibility for learning from deaths and a non-executive director responsible for oversight

	of progress.
Quality and Standards Committee	• This Board reporting committee is responsible for receiving reports on learning from deaths activity and providing assurance to the Trust Board
Critical Incident Overview Group	• The Critical Incident Overview Group is responsible for developing strategies and plans to encourage the reporting and learning from deaths, the development of a positive safety culture and for monitoring the implementation of this policy. It reports to the Executive Management Team, though has the authority to report directly to Board, when circumstances deaths.
Local and Specialist Governance Groups	• Each locality has an integrated governance group. These groups have responsibility for reviewing mortality data and learning alongside other patient experience data and disseminating learning throughout their service. They are responsible for monitoring the implementation of action plans arising from mortality reviews.

6. Definitions

The *National Guidance on Learning from Deaths* includes a number of terms. These are defined below.

Death certification
The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review
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 to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review
A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident
Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.[2]

Investigation
A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided.

[2] https://improvement.nhs.uk/resources/serious-incident-framework/

Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care
A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

Quality improvement
A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident
A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

7. The process for recording deaths in care

Deaths should be reported on the Trusts incident reporting system, information can be found in Procedure for reporting Adverse Incidents (appendix B1), as soon possible following detection or knowledge of the death. This should include

- All current patients and service users.
- Someone who has been referred to a service provided by the Trust in the last month.
- Someone who has used services in the last 6 months.

A process is being developed to ensure that the Trust data is robust and will include comparison of HES data with incident reporting.

- There are recording processes relating to certain types of death for which review is mandated:

  - People with learning disabilities: refer to Annex D of the *National Guidance on Learning from Deaths*; all deaths will be reported to the Learning Disabilities Mortality Review (LeDeR) programme.
  - Mental health: under regulations, mental health providers are required to ensure that any death of a patient detained under the Mental Health Act is reported to the Care Quality Commission without delay.
  - Children and young people: refer to Annex F of the *National Guidance on Learning from Deaths*
  - Maternity: refer to Annex G of the *National Guidance on Learning from Deaths*.

- The clinical team are responsible for ensuring a nominated person undertakes the responsibility for informing other relevant persons, e.g.: GP.

- The process for certification of death remains the responsibility of the medical team.

- Responsibility for reporting deaths to the coroner remains with the clinician certifying the death.

- Recording of deaths notified to the Trust from other sources (for example, other care providers, coroners, families, etc.) should be via reporting of the death on the Trusts incident reporting system as the information is received.

- The Patient safety System Team will inform the coroner when this is a late report following a review which has identified possible problems in care.

9. Selecting deaths for case record review

This section relates to case record review and not to patient safety incidents or incidents that fall under the Serious Incident framework.

Inclusion & Exclusion Criteria

This policy covers the review of all in-patient and community patient deaths that are not being reviewed as a serious incident in line with the national serious incident framework.

- The following deaths must undergo a structured judgement review if not being investigated as a serious incident or incident of significant concern. All deaths occurring within 6 months of inpatient or community discharge are included.

    - A person who died whist an AWP inpatient.
    - A person who died following an incident on an AWP ward.
    - The death of person with an eating disorder.
    - The unexpected death of current service user of drug and alcohol services.
    - All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.
    - All deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example, via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the Care Quality Commission or another regulator).
    - Deaths where learning will inform the provider's existing or planned improvement work.

A structured judgement review will be undertaken for an agreed number of cases for the remaining cohorts who do not fit the identified categories. This will be a sample of all deaths that are reported each Friday.

The Trust will respond to specific categories of deaths as mandated in the Learning from Deaths framework, outlined in section 10 of this policy:

- Deaths of people with a learning disability

- Deaths of people with severe mental illness
- Child deaths
- Maternal deaths

- All deaths in areas where people are not expected to die – for example, in certain elective procedures, such as following ECT.

- The Patient Safety Systems Team will respond to requests from other organisations to review the care provided to people who are its current or past patients but who were not under its direct care at time of death. All requests will be reviewed by the Trusts Professional Review Meeting and agreed by the Medical Director and Director of Nursing and Quality. The Trust will fully engage in this process where requested and ensure a joined up approach to learning established within the jointly agreed term of reference of the review.

- When a person has received care from several health and care providers the Trust will collaborate with other to carry out the reviews and investigations, the Terms of Reference and lead organisation will be agreed by the Medical Director and Director of Nursing and Quality.

- For those patients under the direct care of AWP the deceased's relatives or carers should be given an opportunity by the clinical team raise any significant concerns with the care provided by the Trust (this will then trigger a review or investigation).

- Improvement work will inform where case record review should take place, for example the Sign Up to Safety work stream leads may request a focussed mortality review approach and receive the data for analysis to inform the Trusts improvement plan. Requests will be coordinated by the Patient Safety Team and agreed at the Trusts Professional review Meeting.

10. Review methodology

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is

undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

Methodology

Structured Judgement Review (SJR) will be utilised to conduct the majority of mortality reviews unless otherwise indicated. The review will incorporate a review of health care provided by AWP in relation to mental health, physical health and medication.

Patient group	Methodology	SRO	Frequency of review	Where info/outputs will be saved and shared
Mental health	Modified SJR. (NHS England, NHS Improvement and the Royal College of Psychiatrists are developing a standardised methodology for case record review of the care of those who die with severe mental illness).	Medical lead Medical Director Director of Nursing Non – executive Director	Monthly Monthly Quarterly Quarterly	Locality governance groups CIOG CQGG Quality and Standards Committee
Child (under 18)	Reviews of these deaths are mandatory and should be undertaken in accordance with *Working together to safeguard children* [3] (2015) and the current child death overview panel processes. (NHS England is leading work to update the latter).	Medical lead Medical Director Director of Nursing	Monthly Monthly Quarterly	Locality governance groups CIOG CQGG

[3] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

		Non – executive Director	Quarterly	Quality and Standards Committee
Learning disability	Modified SJR. (The Trust will adopt the LeDeR method to review the care of individuals with learning disabilities, once it is available). Guidance for conducting reviews of deaths can be found here.[4] Trusts must have systems to flag patients with learning disabilities so their care can be reviewed.	Medical lead Medical Director Director of Nursing Non – executive Director	Monthly Monthly Quarterly Quarterly	Locality governance groups CIOG CQGG Quality and Standards Committee
Perinatal and maternity	All perinatal deaths should be reviewed, using the new perinatal mortality review tool[5] once available. Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly	Medical lead Medical Director Director of Nursing Non –	Monthly Monthly Quarterly Quarterly	Locality governance groups CIOG CQGG Quality and Standards

[4] http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf
[5] https://www.npeu.ox.ac.uk/pmrt

executive Director		Committee

10.1. Staff training and support

The Trust has committed to ensure that staff are trained to undertake mortality reviews. The Patient Safety Systems Team will support the review process until sufficient medical staffs have completed training in structured judgement review (SJR) methodology.

11. Selecting deaths for investigation

Where a review carried out by the Trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with the Trust's Serious Incident policy, Guidance for Incident Management Policy (P057).

The identified patient safety incident will be raised by the lead professional responsible for the mortality review within three working days of identification, reporting as a patient safety incident via the Trusts electronic incident management system. The incident will reviewed and managed in line with the Trusts policy. Relevant records of how and whether or not to declare a serious incident will be documented within the Trusts professional review meeting minutes and stored as an attachment on the electronic incident.

12. Reviewing outputs from review and investigation to inform quality improvement

The findings of reviews and investigations will be used to Trust wide and locally to inform quality improvement work.

- Locality governance groups will discuss analyse the findings of investigations and reviews and develop local improvement plans.
- The patient safety systems team will aggregate the findings of investigations and reviews and report to CIOG. CIOG will, where required commission the

development of Trust wide improvement plan and report to CQGG and the Quality and Standards Committee.

- Where linked, key improvement work will be led by sign the safety work streams in conjunction with the localities.
- Locality and improvement plans will be uploaded to the relevant locality or Trust wide Quality Improvement Plan (QIP).
- Monitoring and completion of improvement plans will be overseen by the relevant locality governance group.
- High level monitoring and testing of improvement plans will be overseen by the Trust Quality Improvement Team and reported at CQGG.
- The Head of Quality Improvement will report improvement progress to the Quality and Standards Committee via the Clinical Executive report.
- Learning will be shared with staff across the organisation via Clinical Directors and Clinical Leads.
- Learning will be shared with the Trust Board and the public at open Board via the Quality and Standards Committee.
- Wider sharing will be led by the Head of Quality Improvement and Head of Patient, Service User and Carer Experience via the regional academic health science network (AHSN).

12.1 Presenting relevant information in board reports

Quarterly reporting of information will be presented quarterly to public board meetings via the information submitted in the clinical executive report to the Quality and Standards Committee using the national reporting dashboard. The report will provide:

- Number of reported deaths to include the number of inpatient deaths and deaths of patients with learning disability.
- Proportion of deaths declared and reviewed as a serious incident.
- Proportion of deaths reviewed using SJR methodology.
- Proportion of deaths where death has been identified as potentially avoidable or avoidable.
- Identified learning and resulting improvement work.

The Trust Board will report to the public board meeting:

- What the board will do to lead the organisation in further improving quality of care under the Learning from Deaths framework.

13. Supporting and involving families and carers

The Trust aims to engage meaningfully and compassionately with bereaved families and carers. Supporting families in the right way is essential and each family's requirements will be different. Arrangements for supporting families and carers following an unexpected death is located in within the policy for Reporting, Management and Investigation of Adverse Incidents (including serious incidents), appendix C3 http://ourspace/StaffServices/PtoT/RiskCompliance/Pages/GuidanceP057.aspx.

Specific information regarding families and carers after someone has taken their own life can be found on the Trust intranet site Ourspace suicide prevention page, user and family information. http://ourspace/StaffServices/PtoT/SuicidePrevention/Pages/Resources.aspx.

When an incident meets the threshold to invoke Duty if Candour information can be found to support staff in implementing this in the Trust Duty of Candour Procedure http://ourspace/StaffServices/PtoT/RiskCompliance/Pages/GuidanceP057.aspx.

Guidance on informing, supporting and involving families is also detailed in:

- Serious Incident framework:[6] see Section 4 page 35
- Being Open framework[7]
- Saying sorry.[8]

[6] https://improvement.nhs.uk/resources/serious-incident-framework/
[7] http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726
[8] http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

14. Supporting and involving staff

The death of a patient or service user can have a significant effect on members of staff and teams, staff are likely to be affected in different ways. Supporting staff at these times is a core part of all managers' roles, and most teams have well established systems for supporting their staff; further information can be found the policy for Reporting, Management and Investigation of Adverse Incidents (including serious incidents), appendix C2 http://ourspace/StaffServices/PtoT/RiskCompliance/Pages/GuidanceP057.aspx.

15. Equality impact assessment

Template to be added.

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