Leicestershire Partnership NHS Trust

# Learning from Deaths Policy

Learning from Deaths process and governance arrangements

| | | |
|---|---|---|
| Key Words: | Mortality, death, learning | |
| Version: | 5.1 | |
| Adopted by: | Trust Policy Committee | |
| Date this version was adopted: | 17 December 2019 | |
| Name of Author: | Professor Mohammed Al-Uzri and Jo Nicholls | |
| Name of responsible Committee: | Clinical Effectiveness Group | |
| Date issued for publication: | August 2022 | |
| Review date: | November 2023 | |
| Expiry date: | 31 January 2025 | |
| Target audience: | Senior Clinicians | |
| Type of Policy | Clinical<br>**X** | Non Clinical |
| Which Relevant CQC Fundamental Standards? | Regulation 17 Good Governance | |

## Key individuals involved in developing the document

| Name | Designation |
|---|---|
| Professor Al-Uzri | Consultant Psychiatrist & Associate Medical Director |
| Kate Dyer | Head of Assurance |
| Jo Nicholls | Interim Head of Patient Safety |

## Circulated to the following individuals for comment

| Name | Designation |
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| Jennie Palmer-Vines | Clinical Governance AMHLD |
| Anne-Maria Newham | Director of Nursing |
| Tracy Ward | Head of Patient Safety |

**Contents**

| Version number | Date | Comments (description change and amendments) |
|---|---|---|
| 1 | August 2017 | New Policy for consultation |
| 2 | December 2017 | Addition to cross organisation section (12) |
| 3 | January 2018 | Amended terms of reference and reporting arrangements |
| 4 | January 2019 | Complete refresh of policy. |
| 5<br>5.1 | December 2019<br>September 2024 | Formatting and accuracy amendments<br>Ext agreed at PSIG Meeting – 3 months |

For further information contact the Executive Medical Director.

## Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

## Due Regard

An analysis on the impact on equality (Due Regard) has been included in Appendix

## Definitions that apply to this Policy

| | |
|---|---|
| AMHLD | Adult Mental Health Learning Disabilities Directorate |
| Case Record Review (CRR) | A structured desktop review of a case record 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 that would initiate an SI Investigation, to learn and improve. The Trust uses a locally designed template (the morbidity & mortality structured judgement review form) in place of the Royal College of Physicians Structured Judgement Review methodology. |
| CDOP | Child Death Overview Panel |

| | |
|---|---|
| CHS | Community Health Services Directorate |
| Expected death | A death where the patient's demise is anticipated in the near future, and the patient has been seen by a clinician within the Trust in the last 14 days before death. |
| ISMR | Initial Service Management Review |
| FYPC | Families, Young People and Children's Directorate |
| The Learning Disabilities Mortality Review<br><br>(LeDeR) | This programme requires notification of all deaths of people with learning disabilities aged 4 to 74 years of age, and subsequent independent review. |
| LLR | Leicester, Leicestershire and Rutland |
| Mazars | Independent review of deaths of people with a Learning Disability or Mental Health problem |
| MHSOP | Mental Health Services for Older People Services |
| MSG | Mortality Surveillance Group |
| Serious Incident investigation | The process of investigation; 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. |
| Serious Incident | 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. |
| Sudden or Unexpected Death | A death that occurs suddenly or earlier than anticipated. |
| The Strategic Executive Information System (StEIS) | The national database for reporting and learning from the most serious incidents in the NHS. The Patient Safety Team is responsible for recording serious incidents on to StIES. Via this system, Commissioners and the CQC are informed of all serious incidents that are reporting in accordance with the NHS England Serious Incident Framework. |

| | |
|---|---|
| Ulysses | The Risk Management Software used at Leicestershire Partnership Trust. |

## 1.0 Purpose of the Policy

The purpose of this Policy is to set out the Trust's expectation on how it processes, responds to and learns from deaths of patients where the Trust is the main provider of care. This includes the scope of review for deaths and how the Trust ensures that learning is identified and shared.

## 2.0 Introduction

The effective review of mortality is an important element of the Trust's approach to learning and ensuring that the quality of services is continually improved.

Concern about patient safety and scrutiny of mortality rates has intensified recently with high-profile investigations into NHS hospital failures. There is an increased drive for Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

In July 2017 NHS Improvement produced a document titled "Implementing the Learning from Deaths framework: key requirements for trust boards". This framework placed a number of new requirements on trusts which are now in place:

- A policy which sets out the approach to learning from deaths.
- System in place to report, review and report all deaths from services in scope so that the organisation can learn from these leading to quality Improvement.
- Publish information on deaths, reviews and investigations via a quarterly agenda item and paper to public board meetings.
- Publish an annual overview of this information in Quality Accounts.

## 3.0 Recording Deaths

Where clinical services receive notification of a death of a patient (where the Trust is the main care provider), an eIR1 form is completed. There are a number of exceptions to this, these are detailed within the flow diagram in Appendix E.

There are three cause types on Ulysses for deaths:

- Expected Death
- Suspected suicide (Actual)
- Sudden / Unexpected Death

Expected Death

Where there is an expected death, the Services complete a Mortality Screening Proforma. This is generated automatically by the Ulysses System when an expected death is entered.

Sudden/Unexpected Death

Where there is an unexpected death an ISMR is completed.

Suspected Suicide (Actual)

This category is completed once and if a Suicide verdict is given by the Coroner. In the event of a narrative verdict the cause will remain sudden unexpected death.

All Mortality Screening Proformas and ISMR's are sent monthly for review at the Directorate mortality groups.

The Trust may become aware of a patient death via a number of different sources, including notifications provided by University Hospitals of Leicester NHS Trust where patients have been known to LPT services.

## 4.0 Review Process

### 4.1 In-scope

Those deaths within scope for mortality review are those where, at the time of death the patient was subject to:

- Any inpatient setting – including community hospitals
- CHS: anyone discharged from a community hospital within 30 days where known.
- AMH patients on active caseloads or were discharged from the service in the last 6 months.

### 4.2 Out of scope deaths

- Deaths that have been sent to LeDeR or CDOP for specialist review (see sections 4.6 and 4.7).
- Where LPT is not classed as the main provider.
- If a death is out of scope it may become in scope if the family or Coroner raise concerns about the death.
- Deaths investigated as part of the SI process will be considered out of scope for a case note review.

### 4.3 Patient Safety Team

The Patient Safety Team conducts a daily review of all incidents recorded on Ulysses.

If at any point it is known that the criteria of a Serious Incident has been met, the Patient Safety Team reports the death onto STEIS. The relevant manager is notified and an ISMR is required. Subsequent serious incident investigation is undertaken (see SI Policy).

A list of all deaths reported on STEIS is provided to the Care Quality Commission weekly, with any available 72 hour reports, SI reports (once signed off by Commissioners) and where relevant, any letters from the Coroner.

Monthly reports are produced by the Patient Safety Team from the Ulysses System. These reports contain all deaths subject to an SI process, all those in-scope which require mortality review, and all those which do not warrant further investigation. These are sent to the Directorate Clinical Directors monthly.

### 4.4 Directorates

The relevant Clinical Director should nominate reviewers to carry out the case record reviews.

The reviewer(s) should ensure that the patient's family and/or carers have been contacted and given an opportunity to contact the Trust. The Trust will develop a standard letter to be sent out to relatives informing them that a review of the death is being undertaken and asking them if there are any issues or concerns they would wish to raise or if they would like to input into the review.

The Directorates are required to provide a list of all those deaths not reviewed within timescale to the MSG where applicable.

### 4.5 Case Record Review

A Case Record Review is undertaken for all deaths in scope. The Trust's 'Morbidity and Mortality Structured Judgement Review' form is used to capture the pertinent information.

The Trust aims to complete Case Record Review's within 3 months of the death. This does not apply to LeDeR or CDOP reviews.

A summary of the outcomes are reported to the MSG.

Once the case review has been completed this needs to be attached to the incident on the Ulysses system

### 4.6 Learning Disabilities Mortality Review

For all deaths for patients with a Learning Disability, a LeDeR notification form is completed by the service treating the patient.

The LeDeR programme has been live since 01 October 2017 with trained and active reviewers in place across LLR.

From 01 February 2019 all deaths of Learning Disabilities Service patients are subject to a LeDer review and are not part of the Trust's Mortality Screening

### 4.7 Child Death Overview Panel

For all unexpected deaths of children aged 18 and under, a notification form is and submitted to the Child Death Overview Panel (CDOP)

### 4.8 Sharing Learning

Each directorate has its own key learning forum:

- The CHS Learning Forum
- The AMHLD Learning Forum
- The FYPC Learning Forum

Learning from all child deaths is included within the CDOP process.

Cases where there is wider learning are shared within the Directorate and directly with the clinical team; These are recorded on the mortality surveillance form presented to the Mortality Surveillance Group for sharing across the Directorates.

The Mortality Surveillance Group is where overall learning is highlighted and shared across the directorates.

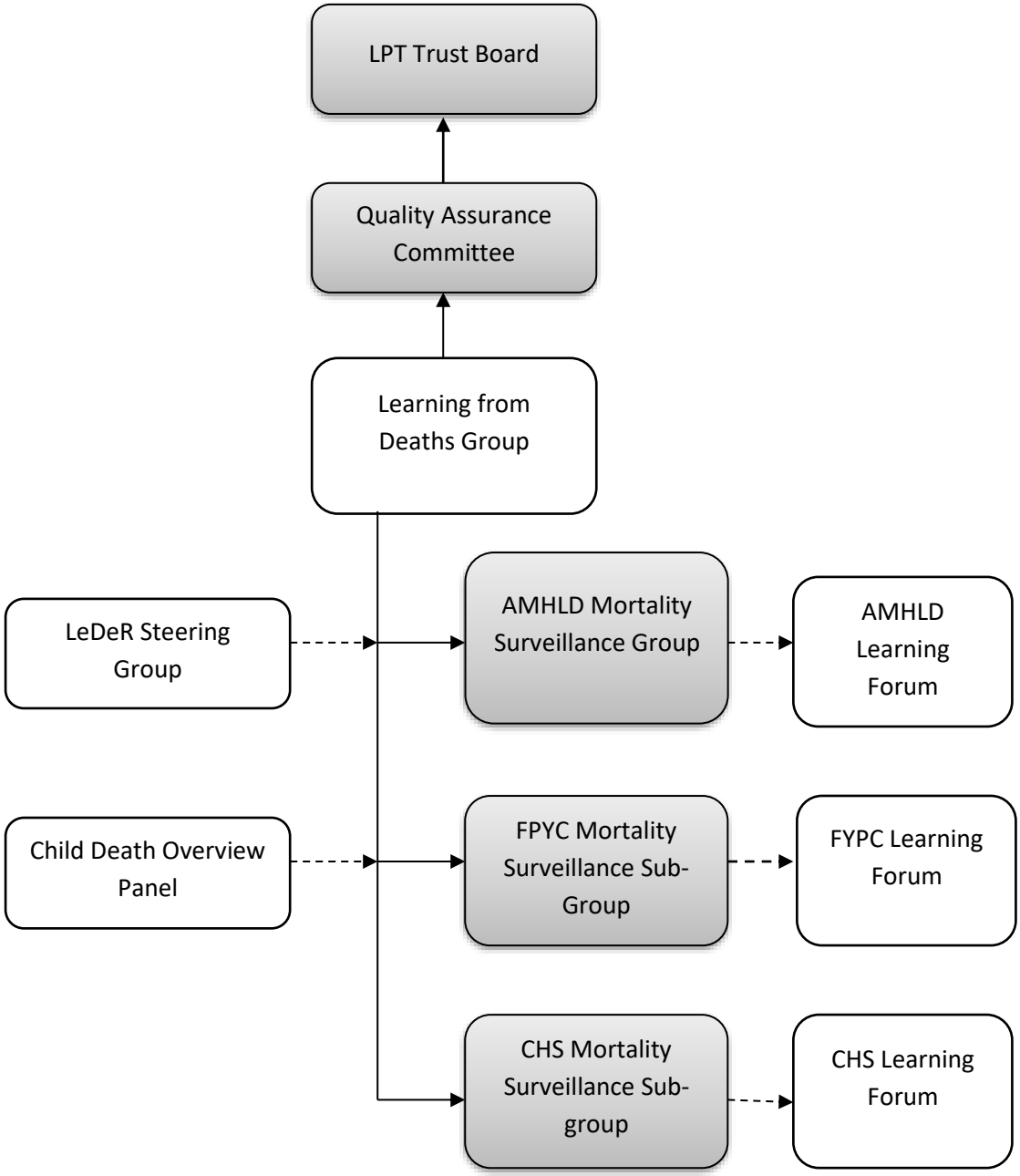
University Hospitals Leicester and Leicester partnership Trust have an agreed arrangement to share learning where patients have been seen by both providers.

## 5.0 Duties within the Organisation

The governance structure within the Trust allows for the reporting of deaths from ward to board, in a consistent, comprehensive and timely manner. It also supports the

capturing and sharing of learning from mortality review within the Directorates and across the Trust.

## 5.1 Governance Structure



### 5.2 Board of Directors

The Board is responsible for ensuring that robust systems are in place for recognising, reporting and reviewing or investigating deaths where appropriate.

### 5.3 Executive Medical Director

Overall accountability for the learning from deaths process sits with the Executive Medical Director. Roles and responsibilities include:

- Overall oversight and regular review of the learning from deaths process
- Ensuring case record reviews are carried out to a high quality.
- Ensuring that any risks identified during the review process are escalated accordingly to the Trust Risk Register.

### 5.4 Patient Safety Team

The Patient Safety Team is responsible for ensuring that:

- Data is collected and published to monitor trends in deaths, with Board level oversight of this process.
- Ensuring that the Ulysses reporting system is used to its full potential to record deaths and the circumstances of individual deaths
- Information is processed consistently, precisely and in a meaningful way to fulfil the governance processes required to ensure high standards in mortality governance are maintained.

It is the responsibility of the above staff:

- To foster a culture of responding to the deaths of patients who die/under our care and ensure staff reporting deaths have the skills and training to support the review process.
- To participate in the review and investigation of patient deaths
- Support staff that are to review and investigate the deaths ensuring they have the time to carry this process out in skilled way to a high standard, and as part of that to.
- Ensure staff have the right level of skill through training
- To promote learning from deaths through facilitating and giving focus to the review, investigation and reporting of deaths.
- To ensure that all learning from the process of review and investigation is shared and learning is acted upon.

### 5.5 Responsibility of All Staff

All Healthcare professionals need to acquaint themselves with this policy and understand the process for learning from deaths.

### 5.6 Responsibility of Clinical Staff

Clinical staff must ensure that deaths are reported in a timely manner with all relevant details in the incident description.

### 5.7 Learning from Deaths Group

The Learning from Deaths Group will be held quarterly and is chaired by the Medical Director. The Group is overseen by the Quality Forum.

The group will ensure learning from deaths take place in line with national guidance to enhance care provided for our service users. In particular, it will provide assurance that robust system and reliable data are in place to facilitate effective review of deaths of patients under the care of the Trust.

Reports to the Quality Committee will include:

- Directorate lists of all deaths, detailing those in scope and those subject to the SI process.
- Summary of the number of completed mortality reviews for those in scope, and the number of deaths considered likely to be due to problems in care.
- Analysis of thematic learning within Directorates.
- Assurance over the consistency of approach to collating the data and undertaking mortality reviews.
- Discussion around cross-directorate learning

The Directorate information reviewed by the Learning from Deaths Group contains the following fields

- Quarter
- The total number of deaths meeting the threshold (this includes all those 'in-scope').
- The number of deaths subject to a case record review (a review of case notes using the Trust's Mortality and Morbidity Structured Review form).
- Number of cases reviewed within the Quarter (ie the number of in-scope case record reviews undertaken within the quarter).
- Number of deaths subject to an SI investigation.
- Number of deaths reviewed / investigated and as a resulted considered more likely than not to be due to problems in care.
- Themes and issues identified as part of the review/investigation including examples of good practice. This column is related to the deaths subject to desktop review and does not include learning from SI's.
- Actions taken in response to identified themes and issues, actions planned and an assessment of the impact of actions.

### 5.8 Directorate Mortality Surveillance Sub-Groups

All three Directorate Mortality Surveillance Groups will receive the Terms of reference from the Trust's Learning from Deaths Group to inform the Directorate Groups Terms of Reference.

The three Directorate Mortality Groups will receive a full list of deaths in scope.

The Groups will provide the following standards of operation:

- Minutes which include how learning will be shared.
- Quoracy to be documented.

- Action log for recommendations emerging from mortality reviews
- Uptake of role specific training
- Completion of the morbidity & mortality structured judgement review form
- Review of the Mortality Screening Proforma.
- Incident numbers will be used to cross check with list of all deaths in scope to ensure that all relevant mortality reviews have been completed.
- Learning and actions to be included in minutes.

AMH/LD

The LeDeR methodology is adopted for the formal mortality review process. Learning from LeDeR is shared with the AMH/LD Directorate.

FYPC

The FYPC Directorate only reviews those deaths which are not covered by CDOP or the SI process. These are likely to be those adult deaths of patients known to the Directorate. Learning from CDOP is shared with the AMH/LD Directorate.

## 6.0 Relevant Policies

Duty of Candour

Where the Trust is the main provider of care, the principles of being open are to be applied following all deaths. If the death was as a direct result of a patient safety incident whilst the patient was under our care, or had been in receipt of our services in the 6 months following discharge from our services, Duty of Candour' applies. The Trust's Duty of Candour Policy is available for all staff on the intranet.

## 7.0 Family Liaison

The Trust is committed to supporting families and will comply with the 'Being Open' process for the death of any patient in the care of LPT. More detailed guidance is available in the Trust's Duty of Candour Policy – see link above in section 6.0.

## 8.0 Monitoring Compliance and Effectiveness

| Ref | Minimum Requirements | Evidence for Self-assessment | Process for Monitoring | Responsible Individual / Group | Frequency of monitoring |
|---|---|---|---|---|---|
| P8 | Directorate reports to MSG | 5.7 | MSG | Directorate mortality groups | Quarterly |
| P8 | Standards of operation | 5.8 | MSG | Directorate mortality groups | Quarterly |

| Ref | Minimum Requirements | Evidence for Self-assessment | Process for Monitoring | Responsible Individual / Group | Frequency of monitoring |
|---|---|---|---|---|---|
| P9 | Training | 6.0 | Training Data | Directorate mortality groups | Quarterly |

## 9.0 Standards/Performance Indicators

| TARGET/STANDARDS | KEY PERFORMANCE INDICATOR |
|---|---|
| NHSI Guidance | Annual review at the Mortality Surveillance Group |

## 10.0 Training Requirements

There are no specific training needs in relation to this policy, but all clinical staff will need to be familiar with its contents. All staff are familiar with the incident reporting system for reporting deaths. The Mortality Screening Pro-forma is attached to Ulysses and is automatically generated once the expected death cause group is chosen. Staff will be made aware through:

- Team Brief
- Team Meetings
- Supervision

Leicestershire Partnership NHS Trust

## The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

The principles that apply in this policy are:

| | |
|---|---|
| Shape its services around the needs and preferences of individual patients, their families and their carers | ✓ |
| Respond to different needs of different sectors of the population | ☐ |
| Work continuously to improve quality services and to minimise errors | ✓ |
| Support and value its staff | ☐ |
| Work together with others to ensure a seamless service for patients | ☐ |
| Help keep people healthy and work to reduce health inequalities | ☐ |
| Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance | ✓ |

Leicestershire Partnership NHS Trust

# Due Regard Screening Template

| Section 1 | |
|---|---|
| **Name of activity/proposal** | Learning from Deaths Policy refresh |
| **Date Screening commenced** | February 2019 |
| **Directorate / Service carrying out the assessment** | Medical Directorate |
| **Name and role of person undertaking this Due Regard (Equality Analysis)** | Professor Al-Uzri, Consultant Psychiatrist & Associate Medical Director |
| **Give an overview of the aims, objectives and purpose of the proposal:** | |
| **AIMS:**<br>The policy aims to describe the trust-wide process for reviewing and learning from deaths. | |
| **OBJECTIVES:**<br>To set out clear responsibilities for staff and groups in relation to the recording, review, scrutiny and oversight of death reviews and the sharing of learning. | |

| Section 2 | |
|---|---|
| **Protected Characteristic** | **If the proposal/s have a positive or negative impact please give brief details** |
| Age | The policy does not have an impact on any particular equality group. |
| Disability | No |
| Gender reassignment | No |
| Marriage & Civil Partnership | No |
| Pregnancy & Maternity | No |

| | |
|---|---|
| Race | No |
| Religion and Belief | No |
| Sex | No |
| Sexual Orientation | No |
| Other equality groups? | No |

## Section 3

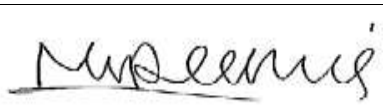
**Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.**

| Yes | | No | |
|---|---|---|---|
| High risk: Complete a full EIA starting click here to proceed to Part B | | Low risk: Go to Section 4. | ✓ |

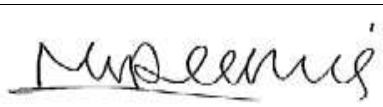
## Section 4

**If this proposal is low risk please give evidence or justification for how you reached this decision:**

Full statement of commitment to policy of equal opportunities is included in the policy.

| | | | |
|---|---|---|---|
| **Signed by reviewer/assessor** |  | **Date** | February 2019 |

*Sign off that this proposal is low risk and does not require a full Equality Analysis*

| | | | |
|---|---|---|---|
| **Head of Service Signed** |  | **Date** | February 2019 |

## Appendix C – Privacy Impact Assessment

**PRIVACY IMPACT ASSESSMENT SCREENING**

**Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment.**

**The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.**

| | | | |
|---|---|---|---|
| **Name of Document:** | Learning from Deaths Policy | | |
| **Completed by:** | Professor Al-Uzri and Jo Nicholls | | |
| **Job title:** | Consultant Psychiatrist & Associate Medical Director Trust Lead for Patient Safety | **Date** | February 2019 |

| | **Yes / No** |
|---|---|
| **1.** Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document. | No |
| **2.** Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document. | No |
| **3.** Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document? | No |
| **4.** Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used? | No |
| **5.** Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics. | No |
| **6.** Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them? | No |
| **7.** As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private. | No |
| **8.** Will the process require you to contact individuals in ways which they may find intrusive? | No |

**If the answer to any of these questions is 'Yes' please contact the Head of Data Privacy**
**Tel: 0116 2950997 Mobile: 07825 947786**
**Lpt-dataprivacy@leicspart.secure.nhs.uk**
**In this case, adoption of a procedural document will not take place until approved by the Head of Data Privacy.**

| | |
|---|---|
| **IG Manager approval name:** | Sam Kirkland |

| | |
|---|---|
| **Date of approval:** | **XX** |

# Morbidity and Mortality Screening Review Tool

| | |
|---|---|
| NHS Number | |
| Post Code | |
| Age | |
| Sex | M F |
| Ward / Team | |
| Date/Day and Time of Admission | |
| Date/ Day and Time of death | |
| No of days between admission and death | |
| Diagnosis on Admission | |
| Poor Communication Identified Y/N | Please state |
| Unidentified deterioration | |

| | |
|---|---|
| Delay in Treatment Y/N | Please state |
| Contributing Iatrogenic event Y/N | Please state |
| EOL Paperwork in place | |
| PM Request | Y N |
| Care and Service delivery issues identified?<br><br>(Were any deemed likely to have been contributory to the death?) | Please state |
| Was duty of candour process followed? | Y N |
| Further Discussion | Board presentation<br><br>SI Investigation<br><br>No Further action |
| Reviewer | |

# Flow chart for Mortality Screening and Learning from Deaths.
# In-patient Deaths

In-patient deaths that are expected

An in-patient death that is expected and occurs in any in-patient setting. Staff complete an EIRF and pick expected death as the cause type this will automatically generate a Mortality Screening Proforma on Ulysses to be completed at the time the death is recorded. All these deaths that are in scope will be subject to an M&M review in the Directorate.

In-patient deaths that are unexpected or are potential suicides

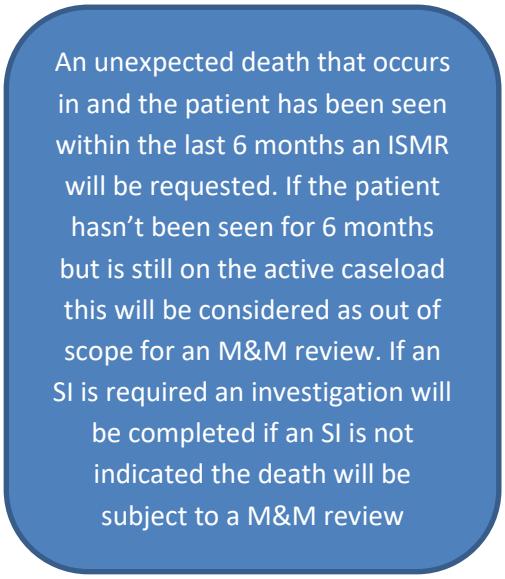
An unexpected death that occurs in any in-patient settings. Staff complete an EIRF and pick unexpected death as the cause type. The Patient Safety Team will then request an ISMR to be completed and request a cause of death from the Coroner. Dependant on the cause of death the Patient Safety Team will determine what level of investigation needs to be completed. For those that do not meet the criteria for an SI investigation and that are in scope these will be subject to an M&M review

**Community Deaths**

For purposes of Community Deaths that are in scope the following applies:

1. For Community Nursing and Therapy deaths these only need reporting if LPT staff arrive at a patients home and find them deceased or if the patient dies at the time of LPT staff carrying out care.
2. For MHSOP Community patient deaths these will only be in scope if patient's have been seen within the preceding 6 months.
3. For child deaths including CAMHS these will all be subject to the CDOP process. In addition those that meet the SI criteria will also be subject to an SI investigation.
4. For all LD deaths these will be reviewed via the LeDeR process.
5. For FYPC deaths that occur in PIER or Adult Eating disorders

**Community MHSOP deaths**




Community deaths AMH/LD and FYPC CAMHS, PIER and Eating Disorders