Cumbria Partnership NHS
NHS Foundation Trust

Learning from Deaths Policy

Document Summary

This policy applies to all staff working for Cumbria Partnership NHS Foundation Trust and describes the Trust arrangements for the reporting of deaths across all services.

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1 SCOPE

Cumbria Partnership NHS Foundation Trust (the Trust) recognises the importance of monitoring and reporting mortality in order to effectively target resources at learning lessons to improve the services that we deliver.
This policy applies to all staff employed by the Trust.

2 INTRODUCTION

Death is the inevitable end point in all of our lives. The Trust provides a wide range of services that care for people at all stages in their lives. As a result a high proportion of all people who die will have contact with our services. Most deaths are considered part of a natural predictable process, some are natural but unexpected, while less frequently we encounter patients who die unexpectedly, and rarely deaths occur that were not predicted and not from natural causes. This policy describes steps that will be taken to monitor and report on all deaths where we are the main service provider, and how we undertake investigations to identify where lessons can be learned in order to reduce avoidable deaths.

After the events of Mid Staffordshire, Professor Sir Bruce Keogh, NHS Medical Director for England reviewed 14 hospital trusts national mortality records. The investigation looked at the quality of care and treatment provided within these organisations and noticed 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.

This is reinforced in the recent 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 given significant priority and that valuable opportunities for improvements were being missed. Importantly the CQC also point out that there is more we can do to engage families and carers and recognise that their insights and experiences are vital to learning.

The National Quality Board National Guidance on Learning from Deaths is the starting point to initiate a standardised approach across the NHS to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning. Alongside the development of this policy, debates have been taking place at regional and local level in deciding which deaths to review and how and who will carry out the reviews. These reviews will 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.

Cumbria Partnership NHS Foundation Trust fully supports the approach to learning from deaths, and this policy in conjunction with the Duty of Candour Policy and Serious Incidents that Require Investigation (SIRI) Policy sets out how we will respond to and learn from patient deaths and make it a priority to work closely with families and carers of patients who have died.

This policy was developed in conjunction with the Northern Alliance of Mental Health Trusts.

3 STATEMENT OF INTENT

In line with the National Quality Board Guidance on learning from Deaths 2017 every Trust must have a policy that sets out how it identifies, reports, investigates and learns from a patient's death. This would include the care leading up to the patient's death, considering if this could have been improved, including when the care has no direct link with the patient's death.
The guide to determination of the appropriately proportionate level of investigation required as well as randomized reviews of deaths that fall within the more expected and natural classifications is described within CPFT's Incident and SIRI Policy (POL/002/006/001).

This policy describes the process of clinical staff reporting a patient death, how this information is collated, reported through quality and governance structures and through the Mortality Review and Surveillance Group to the Trust Executive board before being made available to commissioning and regulatory bodies.

4 DEFINITIONS

Mortality Monitoring enables the Trust to identify themes in order to target resources to areas in order to improve services

Mortality Reporting enables the Trust to be open and transparent both within the Trust and externally in order to demonstrate that we identify opportunities to learn lessons and improve services.

5 DUTIES

5.1 Chief Executive, Executive Trust Board Directors

Trust Boards are accountable for ensuring compliance with the National Guidance on Learning from Deaths, alongside NHS England's Serious Incident Framework 2015 and working towards achieving the highest standards in mortality governance. Ensuring quality improvements remains a priority by championing and supporting learning lessons that lead to meaningful and effective actions that improve patient safety and experience and support cultural change.
The Trust Board are required to identify an existing Executive Director to be the "Patient Safety Director" with responsibility for the Trust's learning from deaths.

Both the Executive and Non-Executive Directors will have the capability and capacity to understand the issues affecting mortality within the Trust. They will challenge

where necessary to ensure high standards in mortality governance are maintained and that the care provided to patient's who die is integral to the Trust's governance and quality improvement work.
Ensuring robust systems are in place for recognising, reporting, reviewing and investigating deaths.

5.2 Non-Executive Directors

The Non-Executive Directors will ensure that processes focus on learning and can withstand external scrutiny, by providing challenge and support. To hold the organisation to account for its approach and attitude to patient safety and that there is evidence of learning from deaths where deficits in service delivery have been identified.

5.3 Clinical Directors, Medical Staff, Service Managers, Care Group Triumvirate Managers, Ward & Team managers, All Registered nurses and Allied health care Professionals

Will foster a culture of responding to the deaths of patients who die under our care in line with CPFT Trust Values and an openness, transparency and willingness to learn, and ensure staff reporting deaths have the skills and training to support the review process.

To support staff that review and investigate deaths, ensuring that they have the time, resources and skills to carry out this process to a high standard, and as part of that to,

- Ensure staff have the right level of skill through training (see section 7 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.
- All deaths are reviewed accordingly ensuring that care group governance meetings assign sufficient time to consider and evaluate the implementation of action plans arising from investigations/reviews
- All healthcare professionals are required to be aware of this policy and understand the process for reporting deaths, understanding the process of review and learning from deaths.
- Senior Trust Triumvirate Care Group Managers receive real time alerts from the risk management system (Ulysses) and progress in line with CPFT Incident and Siri Policy.

5.4 Risk and Incident Team, Clinical Governance managers, Complaints, PALS and Legal Team.

These departments have a responsibility to ensure:

- New data is collected and published to monitor trends in deaths (April 2017 onwards) with Board level oversight of this process
- Ensuring the Ulysses reporting system is used to it's full potential to record data incidents including deaths and the circumstances of individual deaths.

- Risk Management Team ensures appropriate mapping of the risk management system (Ulysses) to internal governance reporting requirements to Senior Trust Triumvirate Care Group Managers.
- Processing information consistently and precisely and in a meaningful way to fulfil governance processes required to ensure high standards in mortality governance are maintained

5.5 Mortality Reporting and Surveillance Group

- To provide oversight of all deaths occurring amongst patients who the Trust is considered the main service provider.
- To support the consistent interpretation of the guidelines for investigating deaths based on the principles of identifying opportunities for learning and demonstrating accountability to the families of patients.
- Develop a mortality dashboard which is provided to stakeholders and reported in the annual report that provides a full picture of all data, themes, CIRs and serious incidents.
- To support the emerging Care Group incident Surveillance groups by providing appropriate confirmation and challenge.
- Monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10 chapters show any trend.
- Provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues.
- To ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings.
- The group must aim to improve the transparency of reporting levels of unexpected deaths in these service user groups.

6 POLICY

6.1 Learning from Deaths

We know that Trust staff work under increasing pressure to deliver safe, high quality care in challenging conditions, and we recognise that on occasions this care is not to the quality that we strive for. Rarely this failure is due to an individual, and more commonly this can be attributed to a systems or process failure. As a Trust we need to monitor and report on deaths of patients who use our services so that we can identify areas where we can do better, which will inform the Board on what resources and investments may be needed.

The Trust wishes to ensure that when an incident or serious incident occurs:

- There are systematic measures in place for safeguarding service users, carers, staff, the public, NHS resources and reputation.
- That the organisation learns from adverse incidents and in doing so prevents further harm.

6.2 Encouraging a learning from deaths culture

Encouraging a learning from deaths culture is about supporting staff to be confident in identifying what can be done better when delivering services to our patients. The Trust values of Kindness, Fairness, Ambition and Spirit should be foremost in the minds of all staff in monitoring, reporting and learning from deaths.

6.3 Family and Carer Engagement

Proactive, timely, sensitive and appropriate contact and engagement with families and carers maximises the learning opportunity for the Trust to enable it to learn lessons and improve services. It is also the right thing to do.
Family and carer engagement is described in detail within the trust policy Being Open and Duty of Candour Policy (POL/001/040) and Procedure.

Being Open - is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident.

Duty of candour - is the requirement to be open and honest when an ‘unintended or unexpected’ incident occurs and the patient experiences a significant level of harm (moderate, severe and death).

6.4 Reporting Deaths

Trust staff must report deaths on the Ulysses system within 24 hours of being informed. Guidance on reporting incidents and deaths are available (Ulysses incident and mortality reporting hyperlink)

The CPFT Director of Nursing and Medical Director receive notification of all red/high rated incidents giving real time notification of unexpected deaths.

Once the incident report has been completed, and a review is indicated, staff must immediately attempt to engage with the family and or carers unless there are exceptional circumstances.

When a death is reported on Ulysses, this is notified to the care group Senior Leadership Team who will then follow the Incident and SIRI Policy which includes a classification of death to help inform the decision around what level of review/investigation is appropriate.

Real time incident reports are sent by the Ulysses system to the care group senior leadership team, and weekly scheduled reports also go to the care group senior leadership team and the trust clinical governance team containing information including: incident number, date, department, StEIS number, care group, department, type of incident, name of patient, name of IO, trust incident management markers by date, incident detail, start and target investigation dates, date completed and date overdue.

The Clinical Governance Manager / Head of Clinical Governance sends an overarching monthly summary mortality report, including information containing the numbers of deaths and themes to the Trust Wide Clinical Governance Group. The care groups complete a quarterly highlight report, containing information from the previous 3 monthly period, as described below, and submits this to the Clinical Governance Manager / Head of Clinical Governance, who then uses the information to formulate a detailed report for the Quality and Safety Committee and Mortality Review Group.

Quarterly Mortality Surveillance Highlight Report data fields are as follows.

Mortality Statistics

- Total number of deaths reported in the care group:
- Total of these deaths that were categorised as unexpected:
- Total number of deaths
    - where the patient had a diagnosis of learning disability / autism:
    - where the patient was on an end of life care pathway
- For patients who are on an end of life care pathway, did the patients have clear agreed plans in place to ensure that their preferences were met:
- Was Duty of Candour applied appropriately in cases of death reported:
- Total number of deaths that that were declared as a SIRI:
- Total number of deaths that were StEIS reportable:
- Total number of 72 hr reports completed on deaths that were then not SIRI declarable:

Mortality Analysis - service level

- By service line / network, include the:
- Total number of deaths:
- Total number of deaths that were categorised as unexpected:

Thematic Review

- Initial themes / findings from completed incident / 72hr / investigation reports:
- Areas of notable practice:
- Any areas of concern:
- Numbers of Structured Judgement Reviews (SJR) undertaken
- Category of SJR under review

6.5 Reviewing deaths

The Trust provides a wide range of clinical services across inpatient, community and other provider organisations and this can lead to both a degree of confusion as to who is responsible for the reporting and reviewing (and investigation if necessary) of a patient's death, and the risk of double reporting and investigation.
To support Trust staff in their decision making staff should refer to the following guidelines in determining who is responsible for reporting and investigating.

A. The review will be undertaken by CPFT, and Trust services are considered the main provider, if at the time of death the patient was subject to:

- An episode of inpatient care within our service.
- An episode of community treatment under CPA.
- An episode of community treatment due to identified mental health or learning disability needs.
- A community Treatment Order
- A conditional discharge
- 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. However 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. Where services provided by the Trust are not classed as the main provider
Some services provided by the Trust only constitute a small component of an overarching package of care in such cases CPFT do not have a responsibility to investigate but will cooperate with other agencies who are taking the lead in such review/investigation to assist them in producing a review/investigation report.

D Exception.
An exception occurs if any act or omission on the part of a member of Trust staff from one of the services where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, or if a family member/carer expresses concern about Trust services, then a review will be undertaken by the Trust.

6.6 Levels of Review/Investigation

POL/002/006/001 Incident and Serious Incidents that Require Investigation (SIRI) Policy details the expectations and requirements for Trust staff in relation to the management of incidents including patient deaths. It describes the level of investigation needed and the reporting and governance structures to ensure that all incidents are reported, investigated and that lessons are identified and embedded in practice.

As a systemic quality and safety check, and to minimise the possibility of a missed opportunity of learning more widely from deaths, random reviews using evidence based methodology will be conducted on a sample of deaths that have been deemed as falling within the category of not requiring investigation.
In addition to investigations and reviews carried out in accordance with the CPFT Incident and SIRI Policy, the Mortality Reporting and Surveillance Group will request that reviews are carried out within the Care Groups of a random selection of patient deaths that have been deemed by the Care Group as not requiring reviews. This will typically be patient deaths that have been deemed as falling within the natural, expected deaths category. The review results will be made available to the Care Groups and the Mortality Reporting and Surveillance Group to enable thematic reviews.
All reported deaths not meeting the criteria for completion of a 72 hr report or SIRI investigation to be reported monthly to the Mortality Reporting & Surveillance Group (MRSG). The MRSG will select a random sample of reported deaths and notify Care Groups for completion of a review. There will be a maximum of 5 reviews required to be completed per care group each quarter period.

7 TRAINING

- Training is to be rolled out on the review methodology for undertaking the new system of case record reviews. Care Groups to release and support a minimum of 2 staff to undertake this training in order for them to be able to fulfil the Care Group's responsibilities in completing such reviews and ongoing participation in reviewer peer support and quality assurance groups

- Participating in LeDeR reviewer training for identified individuals to be supported by care groups.

8 MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trusts' monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	**Monitoring method**	**Individual responsible for the monitoring**	**Frequency of the monitoring activity**	**Group / committee which will receive the findings / monitoring report**	**Group / committee / individual responsible for ensuring that the actions are completed**
Quarterly Highlight reporting to the MRSG by each care group.	Highlight reporting templates are submitted as part of the meeting agenda.	Dr Andrew Brittlebank	Quarterly	MRSG	MRSG
Quarterly Reporting to the Quality and Safety Committee around deaths reported.	Quarterly report to be reviewed and ratified by the MRSG.	Dr Andrew Brittlebank	Quarterly	MRSG	MRSG
Findings from Quarterly reports to the Quality and Safety Committee are an agenda item as part of Board meeting.	Audit of minutes from previous Board Meetings	Dr Andrew Brittlebank	Bi-annual	MRSG for escalation to Quality and Safety Committee	Quality and Safety Committee

9 REFERENCES/ BIBLIOGRAPHY

1. Review into the quality of care and treatment provided by 14 hospital trusts in England: Professor Sir Bruce Keogh KBE, July 2013

2. Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. CQC, December 2016

3. National Guidance on Learning from Deaths
A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care: National Quality Board, March 2017

4. British medical journal. A structured judgement method to enhance mortality case note review: development and evaluation. Allen Hutchinson

10. RELATED TRUST POLICY/PROCEDURES

POL/001/040 Being Open and Duty of Candour Policy and Procedure

POL/002/006/001 Incident and Serious Incidents that Require Investigation (SIRI) Policy

Appendix 1

Mortality Report Review Process CPFT Draft 1.pub

Appendix 2 Quarterly Mortality Surveillance Highlight Report

Care Group	Reporting Period (previous qtr)	Completed by

Mortality Statistics

- Total number of deaths reported as expected in the care group:
- Total of these deaths that were categorised as unexpected:
- Age ranges of people who have died:
- Gender analysis of people who have died:
- Total number of deaths
    - where the patient had a learning disability / autism:
    - where the patient was on an end of life care pathway:
- For patients who are on an end of life care pathway, did the patients have clear agreed plans in place to ensure that their preferences were met:
- Was Duty of Candour applied appropriately in cases of death reported:
- Total number of deaths that that were declared as a SIRI:
- Total number of deaths that were StEIS reportable:
- Total number of 72 hr reports completed on deaths that were then not SIRI declarable:

Mortality Analysis - service level

By service line / network, include the:

- Total number of deaths reported as expected:
- Total number of deaths that were categorised as unexpected:

Structured Judgement Reviews (SJR) / LeDer Reviews

- Total number of completed SJR's:
- Total number of completed SJR's by service / network:
- Categories of SJR's under review:
- Number of LeDER reviews:

Thematic Review

- Initial themes / findings from completed incident / SJR / 72hr / concise or comprehensive investigation reports:
- Areas of notable practice:
- Any areas of concern: