Learning from Deaths Policy

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1. Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is a specialist mental health trust based in north London, providing out-patient mental health services for children, young people, families and adults, as well as providing multi-disciplinary training and education. Unlike most other mental health trusts, it has no in-patient beds or psychiatric wards. The Trust does not provide physical health care in hospital or community settings.

2. Background

New requirements:

In December 2016 the Care Quality Commission published *A review of the way NHS trusts review and investigate the deaths of patients in England.* https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
Subsequently in March 2017 the National Quality Board published guidance based on the recommendations from the CQC report https://www.england.nhs.uk/wp content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf National Guidance on Learning from Deaths.

All trusts in England are now required to:

1. Publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patients who die under their management and care, including:

   – How their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death.
   – Their 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.

2. Collect specific information every quarter on:

   – The total number of inpatient deaths in an organisation's care.
   – 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.

3. Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

Further Developments:

The National Guidance on Learning from Deaths (2017) has advised that during 2017-18, there will be a number of further developments including that:

- The Care Quality Commission will strengthen its assessment of provider's learning from deaths including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.

- NHS England, led by the Chief Nursing Officer, will develop guidance for bereaved families and carers. This will support standards already set for local services within the Duty of Candour and the Serious Incident Framework and cover how families should be engaged in investigations.

- Health Education England will review training of doctors and nurses on engaging with bereaved families and carers.

- In addition, The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled particularly how providers and the wider care system may better capture necessary learning from these incidents

The National Guidance on Learning from Deaths (2017) gives specific details for 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 to be reported to the Learning Disabilities Mortality Review (LeDeR) programme.
- Mental health: refer to Annex E of the *National Guidance on Learning from Deaths*; 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*.

3. Scope

This policy sets out the Trust approach to meeting these requirements in the context of providing outpatient only services. The Trust Board is to be assured that all patient deaths in the Trust are reviewed and that changes are made in response to the lessons learned.

This policy applies to all clinical staff.

4. Purpose

The 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 the Trust.

It describes how the 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 who 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.

The aim of this process is to identify any areas of practice that could potentially be improved and to further support areas of good practice.

5. Roles and responsibilities

This section describes the specific responsibilities of key individuals and of relevant committees under this policy. Roles and responsibilities for incident management, complaints handling and serious incident management are detailed in associated policies and procedures.

5.1 Board of Directors

The Board is required to ensure that the Trust has a board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda. The National Guidance on Learning from Deaths (March 2017) outlines in Annex A that an executive director and in Annex B that a non-executive director will provide oversight of progress of implementing the Learning from Deaths agenda.

Non-executive director responsibilities relating to the framework include:

- 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 that published information fairly and accurately reflects the organisation's approach, achievements and challenges (refer to Annex B of the *National Guidance on Learning from Deaths).*

5.2 Chief Executive

The Chief Executive Officer has overall responsibility for patient safety and for ensuring that the appropriate policies, procedures and guidelines are in place to reduce risk and safeguard patients.

5.3 Medical Director

The Medical Director has overall responsibility for this procedure in role as lead for clinical risk. The Medical Director will oversee the Learning from Deaths Review Panel which will meet quarterly to review any patient deaths and

ensure that processes for responding to a patient death are complied with in full.

5.4 Associate Medical Director – Patient Safety and Clinical Risk

The Associate Medical Director will ensure that all unexpected patients deaths are externally reported and investigated according to the Trust Procedure for the
Investigation of Serious Incidents and also ensure that lessons learned are disseminated across all Trust services.

5.5 Service Leads / Managers are responsible for:

- ensuring that relevant individuals have been notified in person or by phone where a serious incident has been identified and an incident form has been subsequently completed
- ensuring that staff and patients receive adequate support (section 8). Advice should be sought from the Director of HR and/or head of discipline or Medical Director in the event that a member of staff is not fit to work after an adverse event or during an investigation
- undertaking an initial fact finding investigation
- ensuring that if confirmed as a serious incident that staff are aware an investigation will be conducted and understand what that process entails.
- ensuring that the Clinical Director and Associate Clinical Director are informed about any serious incident and involved, where appropriate, in the development of action plans emerging from investigations.

5.6 Clinical Directors

Clinical Directors are responsible for ensuring that the tasks of the service lead/managers are completed and that action plans with implications for the Directorate as a whole are implemented and lessons learnt. The Clinical Directors together with the Medical Director will ensure that action plans of relevance to the whole Trust are implemented including an annual review meeting for staff of lessons learnt from serious incidents.

6. Definitions – The National Guidance on Learning from Deaths (March 2017)

The *National Guidance on Learning from Deaths* (March 2017) includes a number of terms and for the purpose of clarity these are defined below but not all will apply to this Trust.

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.

As the Tavistock and Portman does not provided in patients services death certification does not occur.

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.[1]

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. 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.

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

7. Associated Trust Policy Documents

This policy should be read in conjunction with the following associated documents, all available on the Trust intranet/internet.

- Procedure for the Investigation of Serious Incidents

- Prevention of Suicide Policy

- Management of Self-harm Procedure procedure-self-harm-assessment-mana

- Clinical Risk Assessment Procedure procedure-clinical-risk-assessment.pdf

- Procedure for Rapid Transfer of an Acutely Unwell Patient Rapid_Transfer_Procedure_Dec_16.pdf

8. Skills and Training

In order to support the implementation of this policy the Trust will review the skills and training of clinical staff particularly in relation to investigation methodologies.

9. Reporting

As set out by The *National Guidance on Learning from Deaths (March 2017),* Trusts are required to publish information on deaths on a quarterly basis. As this Trust does not provide in patient care the data published will report on all unexpected patient deaths. Every death will have been investigated under the Trust Procedure for the Investigation of Serious Incidents using root cause analysis methodology. Also, as required by the National Guidance on Learning from Deaths (March 2017) the Trust will provide information on how many deaths were judged more likely than not to have been due to problems in care. Reports to the Trust Board will include evidence of learning and actions taken as well as an assessment of the impact of these actions.

10. The process of responding to deaths of patients in our care

Summary

- All unexpected patient deaths at the Trust are investigated under the Trust Procedure for the Investigation of Serious Incidents and an investigation team is appointed by the Medical Director.
- The Trust's contractual Duty of Candour obligations will be fulfilled with careful consideration of the needs of family members when suicide is the suspected cause of death (see section 12. Supporting and involving families and carers)
- The Trust ensures that the deceased person's GP is informed of the death. This is undertaken by the relevant service director.
- The death is reported to other organisations who may have an interest.
- The Trust works jointly with other health care providers to review the care provided to people who are current or past patients but who were not under the Trust's direct care at time of death.
- Clinicians who have been involved in the patient's care are offered support from their line manager/team colleagues. They can also access more formal support through the Staff Consultant Service.

Responding to the death of a patient with a Learning Disability

The death of a patient with a learning disability should be reported through the Learning Disabilities Mortality Review Programme (LeDeR). https://upload.leder.ac.uk/leder-notify/leder-notification.html

11. Case notes review

Under the Trust Serious Incident Procedure the case notes of a patient who has died will be reviewed by the appointed investigators. The methodology used for serious incident investigation including deaths is Root Cause Analysis. The Trust will review the relevance and suitability of alternative methodologies such as that being developed by NHS Improvement and The Royal College of Psychiatrists for reviewing the care of those who die with severe mental illness.

12. Supporting and involving families and carers

All unexpected patient deaths in the Trust are investigated under the Serious Incident Procedure. Following the death of a patient, the family of the deceased is contacted and offered support. This offer is followed up at various time points within the coming weeks/months. Specifically, families and carers are offered an opportunity to talk about the death and care in the time leading up to the death, and to raise concerns about any aspects of the person's care (verbal and written). The family is informed of the process of the investigation including their involvement should they wish and advised that they can have a copy of the investigation report.
Feedback from families and carers will be shared at lessons learned events and at the Learning from Deaths Review Panel.

13. The Learning from Deaths Review Panel

This panel meets quarterly. It is chaired by the Medical Director. The membership includes the Associate Medical Director, Director of Quality and Patient Experience, a non –executive director with responsibilities relating to the Learning from Deaths framework and a member of the Council of Governors.

14. Board of Directors

The Board of Directors is accountable for ensuring the Trust has robust mechanisms in place to promote and facilitate learning from incidents and reduce risk of harm.

The Medical Director, as chair of the Clinical Quality Safety and Governance Committee will provide the Board with an anonymised summary of serious incident investigations, the lessons learnt and the resulting action plan in Part 1 of the Board. Incidents requiring investigation but not yet completed will be raised in Part 2 of the Board.

15. Clinical Quality Safety Governance (CQSG) Committee

The CQSGC has delegated responsibility to lead on clinical and corporate governance, clinical quality and safety and to provide assurance to the Board of Directors that clinical quality, safety and governance are being managed to high standards. It is chaired by the Medical Director. Reports are received from a number of leads of work streams managing the collection of evidence to provide assurance.

The lead for the Patient Safety Clinical Risk work stream provides assurance to CQSGC that the Trust has followed its processes for serious incident investigation, whilst being open with patients and relatives and supporting staff directly involved, and that action plans have been implemented and lessons learnt for completed investigations. Completed SI investigation reports will be received by the committee.

16. Patient Safety Clinical Risk (PSCR) Work stream

The PSCR work stream is chaired by the Associate Medical Director who is responsible for monitoring the Trust's management of patient safety and clinical risk across all clinical areas of the Trust. Serious incident investigations will be reviewed along with the implementation of action plans and sharing lessons to be learned. Compliance will be monitored by way of analysis of all reported serious incidents. Learning from such incidents will inform further review of this policy.

17. Process for monitoring compliance with this policy.

Compliance will be monitored by way of analysis of all reported serious incidents. Learning from such incidents will inform further review of this policy.

18. Equality Impact Assessment

The impact of this policy on staff, potential or prospective staff of the Trust, service users and the wider community has been fully assessed with neutral impacts identified.

Appendix 1

LEARNING FROM DEATHS SUMMARY