Cambridgeshire Community Services NHS Trust

Learning from Deaths Policy 2.0

Document Type:	Policy		
Document no:	290		
Document Owner:	Dr David Vickers – Medical Director Liz Webb- Deputy Chief Nurse		
Document Service:	Quality Team		
Scope:	Trust wide		
Standards, legislation & key related documents:	• National Quality Board – National Guidance on Learning from Deaths March 2017 • NICE guidelines [NG31] Published date: December 2015 • This document supports Care Quality Commission Fundamentals of Care standards http://www.cqc.org.uk/content/fundamental-standards • Serious Incident Framework • Standards of Care for people living with HIV 2018 • NHSI Implementing the Learning from Deaths framework: key requirements for trust boards • End of Life Care Guidance • Verification of adult death policy		
Approved by:	Trust Board		
Date approved:	March 2019	**Review date:**	March 2022
Financial Implications:	Where a document has any financial implications on the Trust, the Local Counter Fraud Specialist (LCFS) has the authority to investigate and challenge this document in regards to current fraud and bribery legislation and to ensure appropriate counter fraud measures are in place. LCFS contact details are available on the Trust's Intranet.		
Equality & Diversity Impact:	Equality & Diversity Impact Assessment	Completed with no negative impacts	
Keywords:	End of life, deceased, mortality		

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VERSION CONTROL SUMMARY			
VERSION	**SECTION REFERENCE**	**DESCRIPTION OF CHANGE**	**DATE APPROVED**
1.0	N/A	First issue	September 2017
2.0	All	Multiple revisions. Introduction of a distinction in process for expected and unexpected deaths.	March 2019

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1.0 INTRODUCTION

1.1 Purpose of Document

The purpose of this document is to articulate the review process and dissemination of learning that the Trust will undertake in cases where a client aged over 18 dies. Section 4.2. details the deaths within the scope of this process.

Child deaths are investigated separately via Infant or child (under 18) death reviews undertaken in accordance with Working Together to Safeguard Children (2018). While these deaths do not fall into the scope of this policy and will be investigated under a different process e.g. Child Death Overview Panel, the Learning from Deaths Review Group will review the outputs from the Child Death Overview Panels to ensure any learning is embedded within the Trust.

Cases of adults and children over 4 years with identified Learning Disabilities (Definition appendix 2) who die will be investigated via the local Learning Disabilities Mortality Review (LeDeR) process. The trust will participate actively in such cases as required.

Mortality review is defined as a means of identifying problems in healthcare and identifying areas of care which could be improved such as early recognition and escalation of the deteriorating patient, and provision of appropriate and timely end of life care.

Reviews also often highlight aspects of excellent care, and it is important that learning from both areas of excellence, as well as those in need of improvement, is shared across the Trust.

1.2 Learning from the deaths of people in our care can help the Trust improve the quality of the care we provide to patients and their families, and identify where this care could be improved.

1.3 'Learning, candour and accountability: a review of the way Trusts review and investigate the deaths of patients in England' (A CQC review in December 2016) found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

1.4 This National Guidance required Trusts to:

- Have a Leaning from Deaths Policy approved and published by the end of September 2017 reflecting the guidance and setting out how the Trust responds to and learns from, deaths of patients who die under its management and care and includes deaths of individuals with a learning disability and children
- Publish information on deaths, reviews and investigations via an agenda item and paper to public Board meetings
- Have a considered approach to the engagement of families and carers in the mortality review process
- Publish evidence of learning and actions taken as a result of the mortality review and learning from deaths process in the Trust's Quality Account from June 2018

1.5 This Policy sets out how as a Community Trust, without in-patient beds the Trust will review deaths and describe our Learning from Deaths process; what the criteria is for review; how this will be reported and a commitment to provide quarterly reports from the Learning from Deaths Group to the Quality Improvement and Safety Committee and the Trust Board.

1.7 **This policy is about reflective learning from deaths that are considered within the remit of this policy. If a practitioner has immediate concerns regarding a patient death that was known to our service this should be escalated immediately to their line manager.**

2.0 OBJECTIVES

2.1

- To ensure that as a Community Trust we have in place a process for the monitoring of deaths that meet the criteria in 4.3 where an existing process is not already in place (e.g. CDOP Child Death Process; Learning Disability) The Trust will also review 10% of expected deaths in our community adult service.
- To ensure there is oversight and scrutiny of these deaths and that where identified lessons are learned and practice improved.
- To provide a clear process for obtaining information about deaths that is accurate and relevant to the Trust's Learning from Deaths process.
- To ensure that information provided quarterly can inform learning from an overview of deaths within the Trust and support changes to practice.
- To provide assurance to the Trust Board that any avoidable deaths or where problems in care are identified and where the Trust was in a position to influence the outcome brings about a change in practice.
- To provide an annual report based on quarterly reporting to the Quality Improvement and Safety Committee.
- To ensure the Trust meets with national best practice guidance – National Guidance on Learning from Deaths (03/17) where appropriate.
- To support external reporting as required under NHS Guidelines.

3.0 DUTIES, ROLES & RESPONSIBILITIES

3.1 The Board

The Trust's Executive Director (Medical Director) has responsibility within the Board of Directors for ensuring that the Trust has in place a robust process for Mortality Review. The Learning from Deaths Review Group supports this work and has oversight of cases that require a more in depth review and monitors any trends identified via data collation. NHSI guidance (July 2017) states that the Board has responsibility to ensure that the following takes place:

- Robust systems are developed for recognising, reporting and reviewing or investigating deaths where appropriate
- Teams learn from problems identified in healthcare provided from reviewing different sources of information
- Effective, sustainable action is taken where key issues are identified
- Provision of visible, effective leadership to support staff to improve
- Ensure that needs and views of patients and the public are central to how the Trust operates.

3.2 Non-Executive Members.

Non-Executive members of the Board have a particular role to be curious about the Trust's approach to delivery of healthcare, constructively challenge where improvements can be made and promote a culture of learning. A number of lines of enquiry for Non-Executive Directors are highlighted in the NHSI guidance (p14).

3.3 Quality Improvement and Safety Committee

The Quality Improvement and Safety Committee receives a quarterly report from the Learning from Deaths Review Group as well as an Annual Report which identifies learning and trends. The Chair of this committee is the nominated Non-Executive Director providing non-executive leadership and gives assurance to the Trust Board that the Trust is meeting its obligations and reports any areas of concern.

3.4 Managers

Managers are required to understand the Trust's responsibilities in relation to Learning from Deaths and support the collation of this information and address actions identified through this process that will lead to improved patient care. They must make themselves aware of the relevant policies and guidance to ensure that all staff within their teams have access to:

- The appropriate means of recording a death that falls within the scope of the Trust's Learning from Deaths process (table 4.3) and understanding of how to ensure this data is captured. This is via DATIX.
- Additional relevant training that is service specific.
- Clinical Supervision and informal and formal support

3.5 Clinical Staff

All staff members are required to draw to the attention of their line manager any death that meets the criteria of this policy and to complete relevant electronic paperwork (DATIX) and take part in any review of the case to ensure any required improvement in practice is identified.

Staff are also required to participate fully in the review process of expected deaths and use the reflective discussion as an opportunity to learn and improve practice.

4.0 SCOPE OF POLICY

4.1 **Deaths that may highlight problems in care (table 4.3)**
As a Community Trust, without in-patient units the Trust has taken the view that it will investigate all deaths in services that meet the criteria described in **table in 4.3**. These are deaths where working with bereaved families and learning from any identified problems in care will improve practice.

Expected Deaths- Adult Services
In addition 10% of expected deaths in our adult services (Luton) will be reviewed jointly by the Head of Adult Services in Luton and the Palliative Care Lead. Using a reflective learning approach within the local team meetings. The learning will be shared with all relevant staff and presented to the monthly Quality and Risk Group (Luton Adults). Where elements of the care and death give cause for concern, these should be reported using the DATIX incident report and a root cause analysis undertaken. A quarterly report will be made to the Learning from Deaths Group.

For the purpose of this policy expected death is defined as death following on from a period of illness which has been identified as terminal, and where no active intervention to prolong life is on- going.

4.2 Deaths in under 18's (Children)
Infant or child (under 18) death reviews are mandatory and must be undertaken in accordance with Working Together to Safeguard Children (2018). These deaths *do not* fall into the scope of this policy and will be investigated under a different process e.g. Child Death Overview Panel. However, the Learning from Deaths Review Group will review the outputs from the Child Death Overview Panel to ensure any learning is embedded within the Trust.

4.3 Deaths in over 18's that require use of the screening tool and review.

For the purpose of this Policy the deaths that fall under the remit of the Trust's Learning from Deaths policy are those deaths where the client has been seen in the past month where any of the following criteria apply:

- Unexpected death: Unexpected Death

(A death can be described as Unexpected if it was not anticipated to occur in the timeframe in which the individual died. The following gives a definition of this:

a. cause of death is unknown
b. death was violent or unnatural
c. death was sudden and unexplained)

- There has been a complaint by the deceased's family either internally through the Trust complaint process or externally

- There was concern raised by staff about patient care
- Deaths where bereaved families have expressed a concern
- Deaths in any service area where concerns have previously been raised (e.g. through audit or CQC inspection)
- Deaths in patients with a learning disability
- Deaths in patients with HIV
- Any death where concern has been expressed about the quality of care delivered by the Trust including adult safeguarding concerns
- Any death occurring during delivery of care in a The Trust clinical setting (i.e. a patient dies in one of our clinical settings)
- Deaths declared as a Serious Incident by the Trust

Cases referred to a Coroner will be considered on an individual basis by review from the Medical Director and Chief Nurse.

5.0 OTHER REVIEWS

5.1 Staff should be aware that there are other reviews into both child and adult deaths that can take place. The purpose of this Policy is not to replace those existing processes but to ensure those cases which are not reviewed externally or which are but require attention by our own organisation are captured and reported as required.

5.2 The following may be used, due to the circumstances, to review a child or adult death to identify learning:

- The Coroner
- Child Death Overview Panel (CDOP)
- Serious Case Review (SCR)
- Safeguarding Adult Review (SAR)

6.0 REPORTING & RECORDING

6.1 *Initial screening of information:* **Deaths that meet the criteria in 4.3**
Staff and Managers are required to report via DATIX any death that has raised concerns. The criteria described in 4.3 and detailed in Appendix 1 can be used to aid discussion and reporting. Any complaint or concern received by the Trust where death was the outcome should also be reported.

A multi-professional discussion should take place (via a panel) to agree whether the death requires further investigation using a RCA approach. Terms of reference and a lead investigator should be appointed as per the trust Investigations policy.
The family should be included in the process as appropriate at all stages, and kept informed by the lead investigator.

6.2 Expected Deaths case review process

The number of expected deaths of people known to our community adult services will be provided as per 6.3 below. Cases that are reviewed will be summarised and learning or actions presented to the local Quality and Risk Group for local dissemination. A report will be provided to the Learning from Deaths group on a quarterly basis. Specific cases will be presented at the Learning from Deaths Review Group, to facilitate Trust wide sharing of learning.

6.3 The Trust's Informatics Team will provide a quarterly overview of all patient deaths notified to the trust in an individual aged over 18 years of age. This will provide context to the cases that are reviewed.

Data – data from Systm1 and Blithe Lilie will form part of the Trust Learning from Deaths data set. Where the client's record is not held on Systm1 this will be reported manually to the Trust Informatics Manager to ensure it is collated along with other data recorded. This will form the overall notification of deaths. Data collection within the process described in this policy will include:

a) The total number of deaths of patients within the trust. These are system-generated: with tasks automatically created on S1 if there's an open referral for care. A pop-up saying a person has died appears. The informatics team will provide reports from S1 and Blithe Lilie.
b)Number of deaths where the screening tool (Appendix 1) has been used
c)Number of deaths that trigger an RCA (see App 2 – reporting via Risk Management System)

6.4 Data will be recorded monthly for ease of collation at the end of each quarter.

6.5 Data will be reported via the Quality Improvement and Safety Committee as part of quarterly reporting and to the trust board.

7.0 FAMILY / CARER INVOLVEMENT

7.1 The Trust will actively promote and work with staff to enable them to fully engage with the family, where appropriate, when a family member has died whilst receiving care to ensure that they are able to contribute to the RCA process as an equal partner.

7.2 The approach that is expected from staff includes the following:

- Adopting an open and honest approach including early apology
- Include the family / carers in all appropriate aspects of the investigation including setting the terms of reference and explain the purpose of the investigation i.e. to identify learning so that improvements can be made
- Keep the family/ carers informed throughout the process
- Offer the opportunity for the family / carers to ask questions, raise concerns and provide evidence
- Ensure that a coordinated approach is undertaken if the investigation involves a number of agencies.

8.0 LEARNING FROM DEATHS REVIEW GROUP

8.1 This group is responsible for the oversight of all aspects of Mortality review including initial data, the outcome of the initial screening process and any investigations undertaken. This group will meet quarterly to ensure timely review of data and learning and reports to the Quality Improvement and Safety Committee and chaired by the Medical Director.
The group will receive reports and relevant case studies and review both learning for improvement and but also seek to hear and share good practice in end of care.

9.0 LEARNING FROM DEATHS REVIEW FORM

9.1 The Learning from Deaths Review Form at Appendix 1 is to be used to help shape decision making in regards to whether the death fits with the criteria of the Learning from Deaths Policy and, is to be used in all cases where the criteria at 4.3 is met. If use of the form identifies 'Yes' to any questions then an RCA needs to be initiated and the Trust's Safeguarding Adult Lead and Safety Team are made aware.

10.0 MONITORING AND AUDIT

10.1 An audit of the use of this policy and of actions taken to address identified areas of practise requiring improvement should be added to the Trust's annual audit plan.

10.2 To demonstrate a robust internal system of control and the adoption of a proactive approach to the review of those deaths that fit with this policies criteria. Governance for this process will be as follows:

- Quarterly meetings of the Learning from Deaths Review Group act to ensure the process of reporting and subsequent activity is imbedded within the organisation.
- Staff use DATIX- incident reporting system to ensure near misses / significant events are brought to the attention of the organisation and can be escalated where appropriate.
- Reports to Quality Improvement & Safety Committee annually highlighting thematic reviews, trends gaps and learning.
- Report good practice and patient stories as applicable
- Participation in statutory regulatory inspections e.g. CQC

11.0 TRAINING AND COMPETENCY

11.1 The Deputy Chief Nurse will take a lead for the application of this policy and ensure staff required to use the screening tool are supported in its use. The local, Heads of Services will be appointed the lead investigator in any review and will ensure that Learning from Deaths is integrated into care and meeting agendas. Regular review of how well the tool is being used and the process and quality of reporting will be undertaken via audit.

12.0 REFERENCES

12.1

- Working Together to Safeguard Children (2018) HM Government
- Learning Disabilities Mortality Review (LeDeR) Programme (2017)
- National Guidance on Learning from Deaths – National Quality Board 1st Edition, (March 2017)
- Implementing the Learning from Deaths framework: key requirements for trust boards -NHS Improvement (July 2017)
- Learning from deaths- Guidance for NHS trusts on working with bereaved families and carers (July 2018)
- Standards of Care for people living with HIV 2018

Appendix 1: Learning from Deaths Review Form

Learning from Deaths Tool Review Form To be submitted to Safety Team at The Trust for inclusion on Datix when an RCA has been initiated under the Learning from Deaths Review Policy	
Area where incident occurred	
Cambridgeshire	
Peterborough	
Bedfordshire	
Luton	
Norfolk	
Suffolk	
Type of review being undertaken	
Unexpected death as per 4.1 of the Learning from Deaths Policy. The following gives a definition of this: • cause of death is unknown • death was violent or unnatural • death was sudden and unexplained	
There has been a complaint by the deceased's family either internally through the The Trust complaint process or externally	
There was concern previously raised by staff about patient care	
Concerns had been raised about The Trust	
Deaths where bereaved families have expressed a concern	
Deaths in any service area where concerns have previously been raised (e.g. through audit or CQC inspection)	
Deaths in patients with a learning disability	
Any death where concern has been expressed about the quality of care delivered by The Trust including adult safeguarding concerns	
Any death occurring during delivery of care in a Trust clinical setting	
Deaths declared as an Serious Incident by The Trust	
Those cases referred to a Coroner will be considered on an individual basis.	
Details of review	
The Trust Lead Reviewer	
NHS number (or unique identifier)	
Incident date	
Incident description	
Action taken	
Anticipated date of The Trust RCA report	
The Trust RCA Report Author	
To be completed by Safety Team and returned to contact	
Datix reference	
Date added to Datix	

Appendix 2

Learning Disabilities Mortality Review (LeDeR) Definition of Learning Disability

A person with learning disabilities will have:
A significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence) and a reduced ability to cope independently (impaired social functioning) which started before adulthood, with a lasting effect on development (Valuing People, DH 2001).

Who will be included in the LeDeR review programme?
Deaths of all people with learning disabilities aged 4 years and over will be reviewed as part of the Learning Disabilities Mortality Review (LeDeR) Programme. In order to help identify those who might have learning disabilities we suggest the following inclusion criteria:

Adults may be considered to have learning disabilities if any of the following conditions are met:

1. They have been identified as having learning disabilities on locally held learning disabilities registers (e.g. registers held by a GP or Clinical Commissioning Group) or by relevant Read Codes in health information systems
   LeDeR Programme Briefing Paper 1. V 1.2
2. They are likely to screen positive for learning disabilities using a validated screening test
3. When a child they were identified within education services as having a Special Educational Need (SEN) associated with moderate, severe or profound learning difficulty
4. They attended a special school or unit for children with moderate, severe or profound learning difficulty or 'mental handicap'
5. As a child they scored lower than two standard deviations below the mean on a validated test of general cognitive functioning (equivalent to an IQ score of less than 70)
6. As an adult they scored lower than two standard deviations below the mean on a validated test of general cognitive functioning and there is good evidence to suggest that they have had difficulties in learning since childhood
7. In response to survey questions, they may identify themselves as having a long-term illness, health condition or disability associated with 'learning disabilities' and may have low educational attainment (equivalent to no GCSEs at grade C or above).

Children may be considered to have learning disabilities if any of the following conditions are met:

They have been identified as having learning disabilities on locally held learning disabilities registers (e.g. registers held by a GP or Clinical Commissioning Group) or by relevant Read Codes in health information systems

They have been identified within education services as having a SEN associated with 'moderate learning difficulty', 'severe learning difficulty' or 'profound and multiple learning difficulty', or have been at the School Action Plus stage of assessment for this.

They have scored lower than two standard deviations below the mean on a validated test of general cognitive functioning (equivalent to an IQ score of less than 70).

Appendix 2: Learning from Deaths Flowchart