Template Learning from Deaths policy

September 2017

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We have created this document to support trusts that are developing or updating their Learning from Deaths policy. It is intended to provide a high level outline of what needs to be covered in a Learning from Deaths policy and should be read with the [*National Guidance on Learning from Deaths*](https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf) published in March 2017.[[1]](#footnote-1)

Its use is entirely voluntary. Trusts should use their own discretion in adapting or making use of this template to fit their specific needs and local circumstances. Trusts may also choose to amend existing policies/procedures such as incident management policies, so that relevant information relating to Learning from Deaths is included within one overarching document.

|  |
| --- |
| We have used a colour code throughout the template to help trusts adapt it for their own purposes:  **Black text – This is content that can be directly lifted and used in a policy.**  **Red text – This is guidance about what the policy must include (to keep to the requirements outlined in the Learning from Deaths framework), which trusts can retain in the final document if they wish. However, trusts may choose to include this information in different sections or to present it in a different order.**  **Green text – This is suggested guidance about what different sections of the policy should include, but this text should be deleted from the final version of the document.** |

For further information, please see our [Learning from Deaths webpage](https://improvement.nhs.uk/resources/learning-deaths-nhs/).[[2]](#footnote-2)

To contact the NHS Improvement Patient Safety team directly, email [Patientsafety.enquiries@nhs.net](mailto:Patientsafety.enquiries@nhs.net)

## 1. Introduction

This might cover the following points:

Contextual reference to the [CQC’s report of December 2016](https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf).[[3]](#footnote-3)

A statement about why learning from deaths is important to the trust and how this fits with the trust’s ethos about putting patients, families and carers at the centre of everything it does. How reviewing the care provided to people who have died can help improve care for all patients by identifying problems associated with poor outcomes, and working to understand how and why these occur so that meaningful action can be taken.

The board’s role in providing visible and effective leadership to ensure the organisation addresses significant issues identified in reviews and investigations.

How staff, patients, families and others can raise questions or concerns about the policy and how it is implemented.

## 2. Scope

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

## 3. Purpose

[*Organisation’s name*] 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 [*organisation’s name*].

It describes how [*organisation’s name*] 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.

This policy should be read with [include reference/links to relevant trust procedures: for example, for reporting and managing incidents, Serious Incidents, quality improvement, complaints management and the existing mortality governance processes]. We recognise that the names of other relevant policies will differ across organisations and this list is indicative only.

## 4. New requirements

Under the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017, trusts are required to:

* 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.
* Collect specific information every quarter on:
  + the total number of inpatient deaths in an organisation’s care[[4]](#footnote-4)
  + the number of deaths the trust has subjected to case record review (desktop review of case notes using a structured method) (NB: information relating to deaths reviewed using different methodologies – for example, inpatient adult deaths, child deaths, deaths of patient with learning disabilities – may be separated in the report to provide distinction/clarity where required)
  + 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.
* Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

This policy sets out [*organisation’s name*] approach to meeting these requirements.

## 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, quality improvement [and other processes] are detailed in [state relevant policies].

This information could be presented in tabular form, as below, but does not need to be.

|  |  |
| --- | --- |
| Role | Responsibilities |
| Chief executive | For example, overall responsibility for implementing the policy |
| Non-executive directors (including the role of a lead non-executive director in taking oversight of progress in implementing the Learning from Deaths agenda) | Trusts should refer to Annex B of the *National Guidance on Learning from Deaths*  In summary, non-executive director responsibilities relating to the framework include:   * understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny * championing quality improvement that leads to actions that improve patient safety * assuring published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges. |
| Medical director\* |  |
| Director of nursing\* |  |
| Director of human resources |  |
| Mental health lead |  |
| Learning disability lead |  |
| Head of maternity/maternity lead |  |
| Paediatrics/children and young people |  |
| All staff |  |
| [Other roles to be added] |  |

\* The board is required to ensure that its organisation has a board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda. This section should specify which post-holder has this remit.

|  |  |
| --- | --- |
| Committee | Responsibilities |
| Trust board | The *National Guidance on Learning from Deaths* places particular responsibilities on boards, as well as reminding them of their existing duties. Organisations must refer to Annex A of the *National Guidance on Learning from Deaths* |
| Mortality review group/committee |  |
| [Other boards and committees to be added as relevant] |  |

This section could also detail:

how the trust will work with commissioners

how the trust will work with other health and care providers (for example, to review care across patient pathways).

## 6. Definitions

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

#### Death certification

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

#### Case record review

A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

#### Mortality review

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

#### Serious Incident

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation’s ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the [Serious Incident framework](https://improvement.nhs.uk/resources/serious-incident-framework/) for further information.[[5]](#footnote-5)

#### 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.

## 7. Links with existing procedures

This section might include how the Learning from Deaths policy links with the trust’s existing policies and procedures. However, trusts may find that they can simply incorporate this information in other sections.

## 8. The process for recording deaths in care

Where the trust already has electronic systems for capturing deaths, details of this should be recorded here. All organisations have access to HES data and the Spine, so even where interlinked data from NHS Digital is not available within the organisation, there should be effective systems for capturing robust data on patient deaths.

This section should also include details of any plans to improve systems to ensure that deaths are automatically captured so the need for review can be considered.

This section should also cover some or all of the following points:

* The process for certification and registration of deaths.
* Specific details (or reference to relevant guidance) 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*.
* The process and required timeframes for internal reporting of deaths, which system is used to record this information and how to use it. The process and required timeframes for identifying other organisations that may have an interest in a death (including the person’s GP) and making arrangements to inform them.
* The process for recording deaths notified to the trust from other sources (for example, other care providers, coroners, families, etc).
* The process for informing the coroner including at time of death and when this is a late report following a review which has identified possible problems in care.

Where organisations have not yet developed systematic methods for ensuring all deaths are automatically captured, this section might also include a flow chart which shows staff at a glance the process they need to follow when a death has become known to them and they need to ensure it is captured for review.

## 9. Selecting deaths for case record review

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

This section must include:

* How the trust will determine which patients are under its care (see page 6 in the guidance) and therefore should be considered eligible for selection for case record review in the event of their death.
* How the trust will respond to specific categories of deaths as mandated in the Learning from Deaths framework:
  + deaths of people with a learning disability
  + deaths of people with severe mental illness
  + infant or child deaths
  + stillbirths
  + maternal deaths.
* How the trust will determine which other categories of deaths to review (with due regard to the categories listed in the *National Guidance on Learning from Deaths*), including:
* all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
* all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example, via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the Care Quality Commission or another regulator)
* all deaths in areas where people are not expected to die – for example, in certain elective procedures
* deaths where learning will inform the provider’s existing or planned improvement work
* a further sample of other deaths that do not fit the identified categories, so that providers can take an overview of where learning and improvement is needed most overall; this does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

[Decision support tools are a useful approach and can be included in policies].

* How the trust will respond to requests from other organisations to review the care provided to people who are its current or past patients but who were not under its direct care at time of death.
* How the trust will collaborate with others to carry out reviews and investigations when a person has received care from several health and care providers.
* How the trust ensures the deceased’s relatives or carers are asked whether they have any significant concerns with the care provided by the trust (this will then trigger a review or investigation).
* How the information from mortality surveillance work will be used to inform where case record review should take place (for example, if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider).

## 10. Review methodology

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

This section must set out the methodology/ies that the trust will use to review deaths.

This could be in tabular format as set out below**.** The methodology notes are intended as information for the policy developer and should be deleted/adapted as appropriate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient group | Methodology | SRO | Frequency of review | Where info/outputs will be saved and shared |
| **Adult inpatient** | For example, SJR, PRISM, other evidence-based method |  |  |  |
| **Mental health** | Trusts can use a modified SJR or another relevant method to review the care of those with severe mental illness. NHS England, NHS Improvement and the Royal College of Psychiatrists are developing a standardised methodology for case record review of the care of those who die with severe mental illness |  |  |  |
| **Child (under 18)** | Reviews of these deaths are mandatory and should be undertaken in accordance with [*Working together to safeguard children* [[6]](#footnote-6)](https://www.gov.uk/government/publications/working-together-to-safeguard-children--2) (2015) and the current child death overview panel processes. NHS England is leading work to update the latter |  |  |  |
| **Learning disability** | Trusts must have systems to flag patients with learning disabilities.  All trusts should adopt the LeDeR method to review the care of individuals with learning disabilities, once it is available in their area. Guidance for conducting reviews of deaths can be found [here](http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf).[[7]](#footnote-7)  It is also strongly recommended that trusts conduct an initial case note review of all deaths of people with learning disabilities using structured judgement review or another robust and evidence-based methodology. |  |  |  |
| **Perinatal and maternity** | All perinatal deaths should be reviewed, using the new [perinatal mortality review tool[[8]](#footnote-8)](https://www.npeu.ox.ac.uk/pmrt) once available. Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly |  |  |  |

### 10.1. Staff training and support

This section could include details of the organisation’s process for ensuring that staff are trained and supported to undertake reviews. [Please see the [NHS Improvement website](https://improvement.nhs.uk/resources/learning-deaths-nhs/%5d) for details of training available to trusts.[[9]](#footnote-9)]

## 11. Selecting deaths for investigation

Where a review carried out by the trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with the trust’s Serious Incident policy [insert link to the relevant policy].

This section should also include details of how the decision about whether or not to declare a Serious Incident and initiate an investigation will be made, how this will be documented and how relevant records will be updated.

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

This section should explain how the findings of reviews and investigations will be used to inform quality improvement work, including:

* relevant roles and responsibilities of individuals and committees that can support quality improvement strategy development and implementation
* methodologies for undertaking quality improvement work
* mechanisms/approaches for monitoring the progress and adapting improvement strategies to deliver change and improvement
* investment and resources to support improvement work
* how the learning from improvement work (including challenges and successes) will be shared with others who can learn within the organisation and across the NHS more widely (for example, internal/external publications, networks, conferences, etc).

### 12.1 Presenting relevant information in board reports

This section must include how this information will be presented in board reports.

NB: The minimum requirements for quarterly public board meetings are outlined under ‘Improved data collection and reporting’ in the executive summary of the *National Guidance on Learning from Deaths.* It is for the trust to determine whether this information should be presented to the board as a standalone item or as part of a wider mortality report, as long as it is clear on the board agenda that there will be a discussion on the data presented, the learning from this and what the board will do to lead the organisation in further improving quality of care under the Learning from Deaths framework.

The example[National reporting dashboard](https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-learning-from-deaths-dashboard.xlsx) is available online.[[10]](#footnote-10) NB: this can be adapted for local use.

## 13. Supporting and involving families and carers

This section of the policy must include or reference guidance on supporting and involving families and carers. This policy should supplement existing documents where appropriate but does not need to repeat guidance available elsewhere.

Chapter 2 of the [*National Guidance on Learning from Deaths*](https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf)[[11]](#footnote-11) specifies that providers should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death, and details the key principles that trusts should follow.

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

[Serious Incident framework](https://improvement.nhs.uk/resources/serious-incident-framework/):[[12]](#footnote-12) see Section 4 page 35

* [Being Open framework](http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726)[[13]](#footnote-13)
* [Saying sorry](http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf).[[14]](#footnote-14)

If not covered elsewhere in the policy, this section might include:

* Reference to the trust’s policies and procedures for working with families and carers towards the end of a person’s life where it is expected that they are going to die.
* Arrangements to inform the family/carer about a death (where relevant) including who should do that, and in what formats information will be provided (verbal, written). Template communication materials should be provided.
* What practical and emotional bereavement support the trust will offer and how families will be connected with this.
* How the trust will offer families and carers 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 opportunities), and how the trust will respond to concerns (including initiating a review but also how a decision will be made about whether or not to investigate).
* How the trust will share with relevant staff feedback received from families and carers to enable individual and team reflection on care provision and opportunity for improvement.
* How the trust will meet the duty of candour.
* Guidance that will be given to families and carers on obtaining legal advice (should they require it) or other support.

## 14. Supporting and involving staff

This section should describe how staff affected by the death of patients will be supported by the trust where relevant. This policy should supplement existing documents where appropriate but does not need to repeat guidance/policies available elsewhere.

This section might include:

* The support available for staff affected by the death of someone who has been in the trust’s care.
* The opportunities available to staff individually and collectively (outside any formal review or investigation) to reflect on the care provided to people who have died and any learning from this to inform their practice and the way that care is organised.
* The support available to staff before, during and after any review or investigation, including recognition that most problems in care will derive from systems and processes, not individual negligence or reckless behaviour.
* How staff can get guidance on obtaining legal and other advice.

## 15. Equality impact assessment

[*Organisational template to be added*]

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1. <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf> [↑](#footnote-ref-1)
2. <https://improvement.nhs.uk/resources/learning-deaths-nhs/> [↑](#footnote-ref-2)
3. <https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf> [↑](#footnote-ref-3)
4. Trusts can define locally which patients are considered to be ‘in their care’ according to what makes sense for their services. At a minimum this must include all inpatients but, if possible, also patients who die within 30 days of discharge from inpatient services. Be aware that this means all inpatients are *in scope* for review, not that all inpatient deaths need to be reviewed. Mental health trusts and community trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach. The rationale for the scope selected by trusts needs to be published and open to scrutiny. [↑](#footnote-ref-4)
5. <https://improvement.nhs.uk/resources/serious-incident-framework/> [↑](#footnote-ref-5)
6. <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2> [↑](#footnote-ref-6)
7. <http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf> [↑](#footnote-ref-7)
8. <https://www.npeu.ox.ac.uk/pmrt> [↑](#footnote-ref-8)
9. <https://improvement.nhs.uk/resources/learning-deaths-nhs/>] [↑](#footnote-ref-9)
10. <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-learning-from-deaths-dashboard.xlsx> [↑](#footnote-ref-10)
11. <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf> [↑](#footnote-ref-11)
12. <https://improvement.nhs.uk/resources/serious-incident-framework/> [↑](#footnote-ref-12)
13. <http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726> [↑](#footnote-ref-13)
14. <http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf> [↑](#footnote-ref-14)