Pennine Care NHS
NHS Foundation Trust

CO119, Learning from Deaths policy

Consultation Draft v.1*

September 2017

*Awaiting standardised Structured Judgement Review for Mental Health Trusts & wider consultation with workforce and stakeholder groups

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1. Introduction

In 2016 the CQC published its report – Learning, Candour & Accountability – *a review of the way in which NHS Trusts review and investigate deaths of patients in England* (2016)[1]. The report identified that there needed to be a much greater priority, emphasis and structure for NHS organisations to learn from the deaths of patients in their care.

In 2017 the National Quality Board published 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*. This set out a series of steps that NHS Trusts must take in order to demonstrate how learning from deaths is going to become an integral part of the Trust's approach to learning from deaths of their patients. The development of this policy is part of that structured approach.

Pennine Care NHS Foundation Trust is committed to learning from deaths and understands how important this is to develop and change services in the line with learning.

Pennine Care NHS Trust has set the following strategic goals

- Put local people and communities first;
- Provide high quality, whole person care;
- Deliver safe and sustainable services;
- Be a valued partner;
- Be a great place to work.

Learning from deaths fits with the trust's ethos about putting patients, families and carers at the centre of everything it does.

Pennine Care, in 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.

Pennine Care is committed to ensuring that the Board has a clear line of sight to mortality data, themes, trends and learning from deaths. Pennine Care's Trust Board has a clear role in providing visible and effective leadership to ensure the Trust addresses significant issues identified in reviews and investigations.

The Trust will ensure that our workforce, our patients, their carers and other stakeholders are consulted on this policy. The Trust is committed to ensuring that where the Trust decides after a review of a death, not to investigate, the family will have an opportunity to challenge that decision and to request an investigation. The Trust is committed to ensuring that when we decide to investigate a death, the investigating team will have access to this policy and will be held to account against it. It will be the role of the mortality review group

[1] https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

(MRG) to review and amend this policy in the face of sustained critical challenge from families or carer groups, the Board or the workforce.

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

Pennine Care NHS Foundation 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 Pennine Care NHS Foundation Trust.

It describes how Pennine Care NHS Foundation 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.

This policy should be read in conjunction with Incident Reporting, Management & Investigation Policy (CO10); Compliments & Complaints Policy (CO3); Safeguarding Families policy (CL22); the Trust's Quality Strategy and internal mortality review processes (for further information or support contact either the Patient Safety Lead or Risk Manager in the Risk Department – 0161 716 3076).

4. New requirements

Under the *National Guidance on Learning from Deaths*[2], published by the National Quality Board in March 2017, Pennine Care NHS Foundation Trust is required to:

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

[2] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

- 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*
- 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 – e.g. 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 Pennine Care NHS Foundation Trust's approach to meeting these requirements.

* 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

5. Roles and responsibilities

This section describes the specific responsibilities of key individuals and of relevant Committees and other groups/forums under this policy.

Roles and responsibilities for incident management, complaints handling and serious incident management, quality improvement are detailed in [CO10; CO3; CL122]. Overall responsibility for these processes, sit within the role of the associate director for Quality Governance.

Role	Responsibilities
Chief executive	The Chief Executive has overall responsibility for ensuring that the organisation adheres to the standards set out in this policy. This duty may be delegated to an executive/senior manager but accountability to the Trust Board remains with the chief executive.
Freedom to Speak up Guardian	Will ensure that any whistle-blowing case that involves evidence of poor care and treatment that could have meant the preventable or avoidable death of a patient is immediately escalated to the Chief Executive
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 within Pennine Care • assuring published information: that it fairly and accurately reflects Pennine Care's approach, achievements and challenges.
Medical director*	The Medical Director is responsible for ensuring a robust, open and transparent process is in place to learn from all deaths and for reporting on these to the Board of Directors

	and external bodies. Chair of the Performance Quality Assurance Committee (a sub-group of the Board). The role of the PQA Committee is to support effective and efficient decision making at Board of Director meetings based on assurance on the operational delivery and performance of the Trust, quality and effectiveness of service provision, opportunities available to ensure the long-term sustainable development of the Trust, delivery of the Trust's Quality Strategy, and the processes and control mechanisms established for monitoring and continuously improving the quality of service provision. Chair of the Mortality Review Group and report provide a summary of the report to Board. Work with other regional medical directors to support and promote the sharing of provider-led learning within the Greater Manchester Partnership. Chair the Trust's Serious Incident committee and communicate where appropriate to the Board. Chair the Suicide Prevention and Serious Self-harm group and promote working across the Greater Manchester Partnership to ensure that provider-led learning is shared.
Director of Nursing & Allied Healthcare Professionals	Provide support and deputy Chair responsibilities for the Mortality Review Group and Serious Incident committee. Chair the End of Life Steering group and ensure this is linked to the Mortality Review Group where necessary. Chair the Physical Health Matters steering group and ensure this is linked to the Mortality Review Group where necessary.
Learning disability lead	The operational lead for learning disability services will have direct oversight of how the Trust works with the LeDeR programme to ensure timely reporting to the programme and to take and embed learning from the programme into Pennine Care's learning disability services.
Head of Nursing & Safeguarding	The Head of Nursing & Safeguarding will have overarching responsibility for ensuring that Pennine Care works with partner agencies and Safeguarding Boards to ensure that participation and learning from Serious Case Reviews and any Safeguarding Adult Review death is communicated

	throughout the organisation's workforce. The Head of Nursing will also have direct responsibility for the End of Life steering Group's strategy and work programme within our community services and to ensure that the Learning from Deaths policy forms part of End of Life service delivery processes.
Patient Safety Lead & Risk Manager	Will have direct responsibility and oversight of all deaths reported to the Trust within the Risk Department. Will have direct responsibility and oversight of the processes for decision-making and central review of all deaths reported to the Trust Will have direct responsibility and oversight of serious incident reporting of deaths to the NHS Strategic Executive Information System (StEIS). Will have direct responsibility and oversight of the Patient Safety Improvement Group (PSIG) which will ratify the central decision-making process for the level of investigation into a death Will have direct responsibility and oversight of investigation reports into deaths that are investigated by the Trust, including lessons to be learned and action plans arising from the investigation reporting Will support the clinical governance leads across services with investigations, actions plans and learning Will have responsibility to support Trust-wide learning from deaths to improve services for our patients and carers. Will work in partnership with other providers within the Greater Manchester Partnership to ensure lessons learned cross NHS Trust boundaries for the benefit of the wider Greater Manchester population.
All staff	To be able to source this policy and to have support from their line manager to embed this into their front-line roles and responsibilities where appropriate.

* 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.

Committees & other forums	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	The purpose of the Group is to provide oversight of patient deaths, and to manage and monitor the Trust's response in relation to Investigations and provide assurance for those deaths not investigated: • To review mortality data across the Trust. • To sample and review deaths that are not investigated • To source and benchmark deaths that occur whilst in Trust care against other published data available (National Confidential Inquiry, National Reporting and Learning System, Mazars report) • To identify Trust areas additional focussed scrutiny and assurance in regards to incidents of unexpected patient deaths. • To identify and support strategies to reduce unexpected deaths including patient suicides and homicides. • To ensure investigation of patient deaths are conducted in line with the National SI Framework. • To provide assurance to the Trust Board that themes are identified and action plans are developed against key areas. • To provide Executive overview and assurance that deaths are monitored and themes identified. • Provide reports and statistical evidence to NHS England, DoH, CQC, CCG.
Serious Incident Panel	The purpose of the panel is to provide executive oversight of serious incidents subject to StEIS reporting and comprehensive investigation, manage and monitor the Trust's response in relation to the investigation and action planning,

	and monitor action plans developed as a result of external investigation and scrutiny.
Patient Safety Improvement Group	The Patient Safety Improvement Group (PSIG) has delegated responsibility from the Executive Directors to review all Pennine Care NHS Foundation Trust Serious Untoward Incidents (SUIs). The Group supports the Trust risk management policies and processes to improve patient safety following a patient safety incident. This weekly Patient Safety Improvement Group receives all Mental Health Incident reports (IRs) completed following Serious Untoward Incidents for Mental Health services.

The Patient Safety Lead and Risk Manager are invitees to our local Clinical Commissioning Group Serious Incident Panel where serious incident reports are reviewed for quality and assurances. The Trust is committed to working with CCG colleagues to continually improve the quality of services, processes and learning from deaths. The Trust will work with other stakeholder groups (e.g. *Healthwatch*) across the footprint to be receptive to concerns regarding service delivery and improvements.

The Trust's Corporate Governance team also work closely with HM Coroners to ensure learning identified for the Trust is reflected in an action plan for the service or the Trust. The Trust will also respond where it is issued instructions under Regulation 28.

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. 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.[3]

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

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

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 external procedures

Pennine Care NHS Foundation Trust will continue to utilise work with partner agencies and established procedures to continue to learn from deaths (e.g. NHS England and independent homicide reviews; Home Office and domestic homicide reviews; local safeguarding boards for child or vulnerable adult deaths. It will also begin to establish protocols for working with individual CCG learning disability mortality review groups.

8. The process for recording deaths in care

All patient deaths must be reported through the Trust incident reporting system (as an e-form via the Trust Electronic Incident Reporting System). This will require staff to provide information including:

- What happened and when
- Where the incident happened
- People involved in the incident
- What action have been completed
- If there has been Being Open communication
- The Incident grade and actual impact
- Police involvement

The Manager in Charge /Team leader is responsible for ensuring that an incident is completed and submitted on the electronic system by a member of staff that has sufficient knowledge and understanding of the incident. In order to meet national reporting requirements the recording of the incident must be completed within 24 hours of the incident occurring or being reported.

The notification rules set up in incident reporting system mean that the appropriate local manager is alerted to the incident. The manager is required to check the incident within the incident reporting system and 'sign off' the incident within 48 hours. This includes:

- Checking the detail of the information in the incident report.
- Confirming the correct cause group / code has been selected.
- Confirming the incident has been correctly graded.
- Ensuring that there has been appropriate communication with the patient and /or relatives.
- Ensuring that appropriate support is identified for service user/s and staff.
- Ensuring that action required maintaining the safety of service users, staff, and others have been identified and completed.
- Checking that appropriate immediate actions to reduce the opportunity for a similar incident to occur have been taken

Staff are required to complete ELearning training on a 3 yearly basis to support their competence to report an incident. Further detailed guidance on incident reporting and grading can be found on the Trust intranet http://portal/risk/Pages/ERS.aspx

Deaths of a person who is learning disabled – the service reporting the death of a patient who is learning disabled will be directed through the electronic incident reporting system to report the death to the LeDeR programme at Bristol University. The service (depending on the nature of the death) will be contacted by the LeDeR team to complete further questionnaires. Pennine Care NHS Foundation Trust is committed to supporting the improvement of services through learning from any death of a learning disabled person

and will ensure cooperation in the CCG Learning Disability Mortality review group processes, either by attendance or supplying of patient records.

Death of a person who is subject to the Mental Health Act (1983 – as amended by the Mental Health Act 2007)) – Pennine Care NHS Foundation Trust has systems and processes in place within the Mental Health Law administration network to report these deaths to the Care Quality Commission.

9. Selecting deaths for case record review

Pennine Care NHS Foundation Trust considers that any patient under our care at the time of their death will have their death reported onto our electronic incident recording system (Ulysses).

The Trust accepts that not all deaths will require investigation and will take a proportionate approach using a structured judgement process to assess whether or not further evidence is required; this is in the form of the following questions accompanied by the last care plan and risk assessment for the patient:

1. All Pennine Care Foundation Trust services involved
2. Any known concerns raised by family members or staff about the care received?
3. Diagnosis and CPA Level
4. When last seen by Pennine Care NHS Foundation Trust?
5. Any known risk factors prior to the incident?
6. Any Safeguarding concerns?
7. Were there any physical health issues?
8. What support was provided for physical health issues?
9. Any information suggesting intent to end life prior to the incident?
10. Any subsequent contact with services by the police?
11. Any subsequent contact with family and concerns raised by them?
12. Any alarm raised by another care provider or regulator (e.g. CQC) for that service?
13. Was the patient on an end of life care pathway?
14. Did the patient have a learning disability – if so have you reported the death to the LeDeR programme?

Pennine Care NHS Foundation 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*), after considering the central review of the death and 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, concerns raised by the Care Quality Commission or another regulator)
- all deaths that are apparently from **suspected suicide** and the patient was under the care of the Trust or within six months of their being discharged.

- 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; the Mortality Review Group will oversee this process.

Pennine Care NHS Foundation 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, and about which we did not have the death recorded. It will be the responsibility of the Risk Department to coordinate this response with support from clinical governance leads.

Pennine Care NHS Foundation Trust will collaborate and cooperate with others to carry out reviews and investigations when a person has received care from several health and care providers. As a Trust we are committed to a partnership approach with all stakeholders to learn lessons for our services when we have been involved in a patient's care.

Communicating with families and carers of the deceased is an essential part of the process for the Trust to understand their view point. Involvement begins with a genuine apology and condolences for the loss of their loved one and for the death of our patient. All staff working for the Trust will ensure that the principles of Being Open are reflected in their values and behaviours.

Pennine Care NHS Trust will ensure the deceased's relatives or carers are asked whether they have any significant concerns with the care provided by the team involved in their loved ones care, usually through the team manager of the service (this will then trigger a review or investigation). For investigations into deaths the Trust will ensure that carers and relatives are spoken to at the start of the investigation processes to inform and drive the terms of reference for the investigation. They will also be given draft copies of investigation reports to comment on before submission to the Trust's quality assurance processes.

The Trust recognises that certain forums or committees have a responsibility for mortality surveillance work (e.g. End of Life, Drugs & Therapeutics Committee, Suicide Prevention Group) and will escalate emerging themes or concerns to the Mortality Review Group.

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.

Pennine Care reviews all deaths reported to the Trust using the following process:

1. A death of a patient occurs who is under the care of the Trust (e.g. CMHT)
2. The death is reported onto the incident reporting system (Ulysses)
3. The member of staff is prompted to fill in as much information about the circumstances of the death and requested to complete the questionnaire (see above) as part of the incident process. The incident is then able to be viewed by the Risk Department.
4. The team member's manager reviews the incident and completes the Duty of Candour section (applies Yes/No)
5. The incident is then reviewed by the Risk Department to review and to decide if there is a need for a Level 1 investigation (CO10 Incident Reporting and Management Policy) to be completed by the team or not. In doing so the Risk Department will review the information in the incident, review the death questionnaire answers and request the patient's risk assessment and current care plan. If there are concerns raised from this initial review then the Patient Safety Lead and/or Risk Manager will review the electronic records where available or request that the clinical governance lead either review the paper-based patient record or ensure that they are sent to the Risk Department for further review.
6. If the death is to be investigated then this goes through our clinical governance systems and the team have 60 days to produce the report, send it back to the Patient Safety Improvement Group where it is critically reviewed.
7. If the death is not to be investigated then that decision is also taken to the Patient Safety Improvement Group for a multi-disciplinary review of the Risk Department's decision to not request an investigation.
8. The Risk Department will then produce a monthly summary for the Medical Director to have an oversight for the Trust Board meeting as necessary.
9. The Risk Department then produces a quarterly report for the Mortality Review Group in which it provides a summary of those deaths not investigated by the Trust. The Mortality Review Group will take a sample of deaths not investigated for case record review.

Pennine Care NHS Foundation Trust will use a modified SJR or another relevant method to review the care of those with severe mental illness when NHS England, NHS Improvement and the Royal College of Psychiatrists develop a standardised methodology for case record review of the care of those who die with severe mental illness. PCFT are

willing to work as part of a Greater Manchester Provider consortium to support development of this tool.

Pennine Care NHS Foundation Trust delivers Learning Disability services and as such will adopt the LeDeR method to review the care of individuals with learning disabilities, once it is available in their area and in consultation with CCG colleagues who are establishing Learning Disability Mortality Review Groups.

Pennine Care Foundation Trust has a system to flag patients with learning disabilities so their death is reported to the LeDeR programme and their care reviewed.

10.1 Staff training and support

Pennine Care NHS Foundation Trust will ensure that investigations are carried out by trained staff. Clinical Governance leads should maintain a record of trained staff.

The Risk Department and Clinical Ggovernance leads will support investigators in completing the work on behalf of the Trust. Training in the principle of investigations will be provided when required, to maintain sufficient capacity and expertise within the Trust to undertake this important work. Training on 'Being open' is available through an electronic e-learning tool which can be found via the link below:

https://report.npsa.nhs.uk/boatoolelearning/course/courselaunch.htm

Staff are also able to access further guidance on incident investigation via NHS England:

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

This includes a Root Cause Analysis (RCA) eLearning Programme (RCA Toolkit) which has been created as a tool for guiding NHS staff through the process of conducting an RCA investigation.

http://www.nrls.npsa.nhs.uk/resources/rca-conditions/

Opportunities for investigation training will be advertised via the Trust Learning and Development Department http://penn-web/training/course-list-3-2.asp

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 Incident Management and Reporting policy (CO10).

The Risk Management Team (in discussion with Executive Leads, Senior Managers and subject matter experts) will review the detail and circumstances of all grade 5 incidents to determine if the incident meets the criteria of a serious incident:

- Is the patient open / known to PCFT (or discharged within 6 months) Y/N
- Did the individual suffer any significant harm, or potentially have suffered significant harm? Y/N
- Is there any opportunity to learn significantly from this incident? Y/N
- Is there significant risk to the Organisational reputation (e.g. media interest) Y/N
- Any acts or omissions;
- Were the actions / plans intended Y/N
- Were any adverse consequences intended Y/N
- Were policies, protocols and safe procedures in place Y/N
- Did the individual /team follow agreed protocols/policies/procedures Y/N

Serious Incidents meeting the serious incident framework criteria (NHS England 2015), will be declared as soon as possible and immediate action will be taken to establish the facts, ensure the safety of the patient(s), other services users and staff, and to secure all relevant evidence to support further investigation. Serious Incidents should be disclosed as soon as possible to the patient, their family (including victims' families where applicable) or carers. The Commissioner will be informed (via STEIS and/or verbally if required) of a Serious Incident within 2 working days of it being reported; this will be completed via the Risk Management Team.

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

Cascading Learning

More than one method is used to cascade the outputs from review and investigation across the organisation and the development of these methods is in support of the Trust's Quality Strategy.

The 2-year Quality Strategy was approved by the Trust Board in May 2017. Objective 5 of the Strategy reads 'To learn by developing a portfolio of learning methods, deliver the elements of the portfolio in line with an agreed schedule and evaluate the impact and success of each element of the portfolio.' The portfolio will include the following learning methods:

- 7-minute briefing (Trust wide information shared across a service line)
- Continuous Learning Forum (return of front-line staff & managers alongside Executives to review an action plan arising from an SUI; review of efficacy and to revisit outstanding actions)
- Quality Summit (process of triangulating Safety, Experience & Effectiveness)
- Traffic light learning (due to be implemented from April 2018)
- Team level review and reflection.

Quality triangulation

The three strands of Quality Governance, Patient Safety, Patient Experience and Clinical Effectiveness hold a Quality Summit on a quarterly basis. The purpose of the Quality Summit is to use a robust approach to triangulate themes, trends and serious concerns arising across the strands. The outcomes of triangulation lead to learning; learning can be at any level of the organisation; e.g. team level, service level, organisational level. Learning is shared in the form of a question posed to senior management and responses collated are summarised into a report to give Executive Directors and CCGs assurance that quality concerns are managed and learned from appropriately, including those related to death.

Evaluating the impact of learning methods

The organisations Do We Learn workgroup lead the development, delivery, embedding and evaluation of the leaning methods sitting in the portfolio described earlier.

7-minute briefings and continuous learning forums have been in use since 2016 and the Do We Learn workgroup are responsible for the design of an evaluation study of both methods to determine the impact each method has had upon teams, services and the organisation in relation to learning and affecting reportable outcomes.

Evaluation studies of all other learning methods sitting in the portfolio will be completed once they have been in use for at least 9 months. Outcomes of all evaluation studies will be shared across the organisation through the Quality Governance Group.

Quality Improvement methodologies

The Health Foundation tells us that 'only around two-thirds of healthcare improvement [initiatives] goes on to result in sustainable change that achieves the planned objective' (The Health Foundation, 2013)[4]. It is therefore important that the approach chosen to create and sustain change is appropriate to the topic and culture of the organisation.

Clinical Audit is the preferred robust methodology to support quality improvement in the organisation and throughout the NHS. The Trust's Clinical Audit Programme is designed to capture Must Do, Should Do and Want To clinical audits. Must Do clinical audits include all projects mandated under the NHS Contract and must be reported in the Annual Quality Account. Should Do clinical audits include key priorities identified by the Quality Group, Service Directors and Commissioning Groups as well as Quality Reports published by the CQC and national influencers such as the Francis report and CQUIN. Want To clinical audits are topics that healthcare professionals wish to undertake; topics are not priority for the service and tend to focus on personal interests.

Clinical audits in response to serious incidents (including deaths) are captured in Section 6 of the Should Do section of the clinical audit programme and resources are reviewed on a regular basis by the Clinical Effectiveness & Quality Improvement Lead to ensure appropriate project management and data analysis resources are available at the right time.

Objective 2 of the organisations 2-year Quality Strategy reads 'To drive forward quality improvement by developing a Quality Improvement Programme (QIP), which is delivered using an agreed methodology, is monitored using standardised measures and reported on internally and externally within agreed governance arrangements.'

All projects will have a life cycle on the QIP and during 2017-19 the QIP will focus on the 15 emerging themes identified during deep analysis of the Quality report developed by the CQC following inspection in summer 2016.

Future projects, including any developed in response to a death, will be added to the QIP following proposal by the Quality Governance Team and agreed by the Quality Group.

All projects on the QIP will have an implementation plan completed considering the following factors.

[4] http://www.health.org.uk/publication/quality-improvement-made-simple

Goal	Why	Where	When	Who	How
	External driver *Organisational driver* *Team driver*	*External* *Organisational*	*Milestones* *Completion date*	*Team resources* *Other department's resources* *External resources*	*Engagement* *Communication* *Training needs* *Resources* *Embedding* *Evaluation*

Showcasing quality improvement

The Annual Quality Account is used to showcase organisational learning and successful quality improvement initiatives and projects. Individuals, teams, services and senior managers are able to submit projects and initiatives to be showcased in the Annual Quality Account (Part 3), including any relating to the review and investigation of a death.

To enable a consistent and standardised approach to showcasing within the Quality Account a template is available for completion and submission to the Clinical Effectiveness & Quality Improvement Lead. A multi-disciplinary panel are responsible for the review of all submissions for showcasing and projects and initiatives are selected using agreed high-quality criteria.

Objective 3 of the Quality Strategy aims to 'Showcase quality, promoting best practice, share innovation and recognise quality care, stimulating a culture of improvement and innovation based on recognition of what we do best.'

A showcasing programme makes use of existing performance and quality assurance arrangements as well as creating a repository of ideas and materials. The programme developers are members of the Quality Governance Team and the Innovation to Improvement delivery group; these two work streams work collaboratively to maximise knowledge and skills.

12.1 Presenting relevant information in board reports

It is the intention of Pennine Care NHS Foundation Trust to apply the dashboard template suggested by NHS Improvement once the Structured Judgement Tool has been standardised for use across mental health trusts.

The Mortality Review Group will consider the data ahead of the Trust Board and provide the qualitative data required.

In the interim timeframe the Risk Department will provide the Board with a report against the recommended matrices: data will include the total number of the Trust's in-patient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Pennine Care will provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The Board report will be accompanied by relevant qualitative information and interpretation.

13. Supporting and involving families and carers

Chapter 2 of the *National Guidance on Learning from Deaths* specifies that Pennine Care NHS Foundation Trust 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: see Section 4 page 35
- Being Open framework[5]
- Saying sorry.[6]

Communicating effectively with service users and/or their carers is a vital part of the process of dealing with errors or incidents. The needs of those affected should be a primary concern for those involved in the response to and the investigation of serious incidents. It is important that affected patients, staff, victims, perpetrators, patients / victims' families and carers are involved and supported throughout the investigation.

Involvement begins with a genuine apology, or in instances when an act or omission has not been identified, an expression of sympathy for the outcome of the incident e.g. condolences for the patient's death.

All staff can refer to the Trust's Incident Reporting Management and Investigation Policy (CO10), where there is clear guidance at paragraph 8 for involving and supporting those affected, including Duty of Candour responsibilities. Staff who are working with patients

[5] http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726
[6] http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

who are coming to the end of their life, must be aware of the Trust's End of Life Strategy document and if necessary seek advice and support from their line manager.

The Trust has a dedicated Family Liaison Officer (FLO) role which is mandated to contact families after serious untoward incidents. The Trust is currently looking at the depth and breadth at that role, and how it can better support families who are bereaved (especially, as not all will be as a result of an SUI). The Trust does run Initial Access to Psychological Treatment (IAPT) services and where appropriate families are signposted to these services.

The Trust has an established Triangle of Care meeting that collates and shares concerns raised by the carers of patients. The Trust-wide Triangle of Care Board is directly accountable to the Operational Management Group for the implementation and delivery of its agreed work plan. The work plan consists of priorities which represent a significant way forward for the involvement of the carer group within all aspects of care delivery within our mental health services. The work plan priorities include the strategic planning and then involvement and implementation of the Triangle of Care principles across the whole provision within Mental Health services in Pennine Care NHS Foundation Trust.

A large part of the TOC remit is, for Pennine Care NHS Foundation Trust as an organisation, to listen to their carer experiences. As the co-chair of the TOC, I recently met with the bereaved carer of someone who had used the Trust's services. Having listened to her "story" and provided support and information on the TOC work stream, she was keen to support Pennine in trying to improve the experiences of carers. She has told her story via video which will now be used in the carer awareness training for staff. She now attends the TOC co-trainer meeting and is a member of the Bury TOC Group.

14. Supporting and involving staff

It is important to recognise that serious incidents can have a significant impact on staff who were involved or who may have witnessed the incident. Like victims and families they will want to know what happened, why and what can be done to prevent the incident happening again.

Pennine Care NHS Foundation Trust has a responsibility to support all staff who are affected by the death of a patient and where appropriate will involve them in the investigation processes. The Corporate Governance department will also use its systems and processes to support all staff who are required to be involved in any Coronial processes.

The need to arrange debriefing for staff and support for other service users affected by the incident should be considered. Staff involved in the investigation process should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with information about the stages of the investigation and how they will be expected to contribute to the process.

For any staff in training including trainee doctors/ student nurses and other health care professional's appropriate educational contacts should be notified as appropriate. Following any serious incident, managers should ensure healthcare teams and staff are informed of outcomes of investigations. Where an incident investigation report has been produced, this should be fed back to staff as soon as possible by the service manager.

In the case of training doctors this will be via the use of a nominated individual within the borough selected by the Medical Education Lead. The nominated individual will be the lead support for that Training Doctor ensuring continuity if they have moved to another organisation. This nominated individual will then contact the Training Doctor once an internal investigation is completed to arrange a face to face meeting to discuss the finding and any learning from the incident including reflective practice. This will be the responsibility of the nominated person.

In the case of non-medical students this will be via the mentor or clinical educator with the support of the practice education facilitator (PEF) and the relevant college or higher education institution where required. When a non-medical student's placement within the Trust has ended, the PEF will liaise with the student's college or university link lecturer to ensure feedback is given, the college/university can also request that a PEF attend.

15. References

1. Learning, Candour & Accountability – *a review of the way in which NHS Trusts review and investigate deaths of patients in England* (2016).

   https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

2. *National Guidance on Learning from Deaths*

   https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

3. Serious Incident framework

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

4. Quality improvement made simple - *What everyone should know about health care quality improvement* (2013)

   http://www.health.org.uk/publication/quality-improvement-made-simple

5. Being Open framework

   http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726

6. Saying sorry

   http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

16. Equality impact assessment (see Appendix 1)

Equality Impact Analysis

As part of its development, this policy was analysed to consider its effect on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there are any unintended consequences for some groups, and to consider if the policy will be fully effective for all protected groups. This analysis has been undertaken and recorded using the trust's analysis tool, and appropriate measures will be taken to remove barriers or advance equality in the delivery of this policy.