Birmingham and Solihull Mental Health NHS Foundation Trust

# Learning from Deaths Policy

| | | |
|---|---|---|
| **Policy number and category** | **C58** | **Clinical** |
| **Version number and date** | **3** | **December 2021** |
| **Ratifying committee or executive director** | **Clinical Governance Committee** | |
| **Date ratified** | **April 2022** | |
| **Next anticipated review** | **April 2025** | |
| **Executive director** | **Medical Director** | |
| **Policy lead** | **Head of Patient Safety** | |
| **Policy author *(if different from above)*** | **As Above** | |
| **Exec Sign off Signature (electronic)** |  | |
| **Disclosable under Freedom of Information Act 2000** | **Yes** | |

## Policy context

This policy sets out how the Trust will comply with the "National Guidance on Learning from Deaths", March 2017.

The Trust is committed to service improvement and acknowledges that systematic mortality review has a crucial part in delivering the clinical quality agenda and providing assurance of quality improvement.

## Policy requirement

The main purpose of this policy and the content is to promote learning and improve how the Trust supports and engages with the families and carers of those who die in our care.The Trust strives to improve the care provided to all of our its service users; the overall aim is to identify, understand and implement improvements where any issues are related to the provision of quality care. It is considered that if such improvements are initiated effectively and embedded, then the mortality statistics will naturally show improvement.

This policy provides details of how the Trust will ensure compliance with the requirements set out in the NQB guidance (2017).

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## 1. INTRODUCTION

### 1.1. RATIONALE

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality- noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This was reinforced by the findings of the Care Quality Commission (CQC, 2016) report "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England". It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

In March 2017, the National Quality Board (NQB) published national guidance "Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care". The guidance provides requirements for Trusts to implement as a minimum in order to ensure there is a focused approach towards responding to and learning from deaths of patients in our care; as required within the CQC report.

The Trust is committed to the fair treatment of all, regardless of age, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility or dependants, sexual orientation, trade union membership or non-membership, working patterns or any other personal characteristic. This policy and procedure will be implemented consistently regardless of any such factors and all will be treated with dignity and respect. To this end, an equality impact assessment has been completed on this policy Appendix 1.

### 1.2. SCOPE

This policy applies to all staff whether they are employed by the Trust permanently, temporarily though an agency or bank arrangement, are students on placement or are joint working through contract arrangements.

This policy applies to all deaths of service users who are being cared for at the time of their death or 30 days since their discharge from services.

## 2. THE POLICY

2.1 The main purpose of this policy and the content is to promote learning and improve how the Trust supports and engages with the families and carers of those who die in our care.

2.2 The Trust strives to improve the care provided to all of our its service users; the overall aim is to identify, understand and implement improvements where any issues are related to the provision of quality care. It is considered that if such improvements are initiated effectively and embedded, then the mortality statistics will naturally show improvement.

2.3 This policy provides details of how the Trust will ensure compliance with the requirements set out in the NQB guidance (2017). The policy sets out the process by which the Trust will:

- Identify and review deaths in care.
- Ascertain learning points to ensure these are used to support changes in practice.
- Provide support for bereaved families and offer them the opportunity to highlight any
- concerns they may have and to request a mortality review be completed.
- Support staff in collecting and using information to initiate quality service improvements and demonstrate learning.
- Describe how the Trust will report details in relation to completed mortality reviews and also the learning obtained through this work.

2.4 The purpose of reviews of deaths, which problems in care might have contributed to, is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

2.5 This policy should be read in conjunciton with:

- **The Management of Incidents (RS02)**
- **Duty of Candour (C25)**
- **NQB Guidnance (2017)**
- Enforcement Act (2018)

## 3. PROCEDURE

3.1 All deaths of service users expected and unexpected who currently receive care from BSMHFT services including HMP Birmingham, are to be reported on the Trust's incident management system Eclipse. Additionally, deaths of patients up to 6 months post discharge are also reportable. How to report an incident can be found in the Management of Incidents Policy (RS02)

3.2 Deaths which are reported on Eclipse will require completion of a Death Questionnaire. The person completing incident form will be expected to complete as much of the information as possible. When identifying cause of death, staff can review of Access Shared Care Record, documentation section on RIO for correspondence providing the detail.

3.3 Staff should be supported in line with the principles outlined in the Management of Incidents Policy (RS02)

3.4 Staff should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death in line with the following key principles as outlined in the National Guidance on Learning from Deaths (National Quality Board, 2017).

- Bereaved families and carers should be treated as equal partners following a bereavement
- Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment
- Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, cultures and beliefs, including being offered appropriate support.

- Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved ones
- Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed
- Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, which a single point of contact and liaison
- Bereaved families and carers should be partners in an investigation to the extent and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations
- Bereaved families and carers who have experienced the investigation processes should be supported to work in partnership with the Trust in delivering training for staff to support family and carer involvement where they want to.

The process for engaging with families and carers is outlined in appendix 2

3.5 In accordance with the requirements for Learning from Deaths, the Trust will systematically screen all deaths. This will be carried out by the Clinical Manager for Learning from Deaths.

3.6 All cases meeting the following criteria who have died whilst under our care or who have been discharged within the last 30 days will trigger a Mortality Case Note Review (MCNR) if a serious incident review has not been identified.

- If the family/carers have expressed a concern about the circumstances of the service users death
- Deaths of all service users with identified severe mental illness
- Deaths of all inpatient service users (where a serious incident review is not identified)
- If staff members have concerns about the circumstances of the patient's death
- Deaths of all service users with a diagnosis of learning disability

All reviews will adhered to the use of force act (2018) if appropriate

3.7 All deaths of people with learning disabilities aged four years and older will undergo a mortality review using the LeDeR methodology and reported to the national LeDeR programme. Refer to Annex D of the **National Guidance of Learning from Deaths.**

3.8 Whilst responding to the deaths of children who die under its care the Trust will work in line with the expectations described within Working Together to Safeguard Children (2015) and of NHS England's current review of child learning from deaths review processes. Refer to Annex F of the National Guidance on Learning from Deaths (2017). **National Guidance of Learning from Deaths.**

3.9 the Clinical Manager is responsible for writing to families to let them know we are undertaking an MCNR. The MCNR will be undertaken by a senior healthcare professional trained in the methodology and the review will be co-ordinated by the Trust lead for mortality.

3.10 The reviewer will assign scores for the quality of care including scores for overall provision of care (score1-5) and avoidability of death (score1-6) in line with the National Mortality Case Record Review Programme: A guide for reviewers.

3.11 All MCNR's that trigger a score of 1-2 for the overall provision of care or 1-2 for the avoidability of death score this should be escalated to the Head of Patient Safety for consideration of a Serious Incident Review.

3.12 Any safeguarding concerns highlighted within the review should be shared with the lead for Safeguarding.

3.13 If there is evidence of poor care or avoidable death and duty of candour has not been undertaken then the Clinical Manger for Learning from Deaths will undertake duty of candour as described in the Trust's Duty of Candour Policy (C25)

3.14 Regular MCNR update training is available for all mortality reviewers together with peer supervision.

3.15 Every month the Learning from Deaths Group, which is chaired by the Deputy Medical director for Safety and Quality will meet to assign a final score. The Terms of Reference for the Learning from Deaths group can be found in appendix 5

3.16 Every quarter the Trust will report on the following data:

- The total number of reported deaths
- The number of deaths the trust has subjected to case record review
- (The number of deaths investigated under the Serious Incident Policy (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.
- The Learning from Deaths Group will provide the Trust Board of Directors with assurance that the standards described in this section are being adhered to.

3.17 Dissemination of learning from reviews is outlined in Appendix 4

## 4. RESPONSIBILITIES

| Post(s) | Responsibilities | Ref |
|---|---|---|
| **All Staff** | | |
| **Service, Clinical and Corporate Directors** | Ensuring staff within their areas of responsibility are aware of their responsibilities in relation to the Learning from Deaths process | |
| **Policy Lead** | To review the policy and report on compliance with its contents to Board level | |
| **Executive Director** | Direct responsibility for the implementation of the policy | |

| | | |
|---|---|---|
| **Deputy Medical Director** | Direct day to day clinical leadership for learning from deaths and overseeing change | |

## 5: DEVELOPMENT AND CONSULTATION

| **Consultation summary** | | |
|---|---|---|
| **Date policy issued for consultation** | January 2022 | |
| **Number of versions produced for consultation** | 1 | |
| **Committees / meetings where policy formally discussed** | **Date(s)** | |
| Learning From Deaths Group | December 2021 | |
| PDMG | February 2022 | |
| CGC | April 2022 | |
| **Where received** | **Summary of feedback** | **Actions / Response** |
| | | |
| | | |

## 6. REFERENCE DOCUMENTS

- **Care Quality Commission (2016) "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England** [Accessed 2nd November 2021]
- **National Quality Board (2017) "National guidance on Learning from Deaths", National Quality Board, 2017**. [Accessed 2nd November 2021]
- **Royal College of Physicians mortality review materials**. [Accessed on November 2nd 2021]

## 7. GLOSSARY

**Mortality Case Note Review (MCNR).** This is a review undertaken following the death of a service user by a trained reviewer. The review looks at whether the death was avoidable and also the quality of care provided to the deceased service user.

## 8. BIBLIOGRAPHY

None

## 9. AUDIT AND ASSURANCE

| Element to be monitored | Lead | Tool | Freq | Reporting Arrangements |
|---|---|---|---|---|
| Family engagement | Clinical Manager | | Yearly | Patient Safety Advisory Group |

## 10. APPENDICIES

- **Appendix 1 -** Equality Analysis Screening Form
- **Appendix 2 –** Family Engagement Process Flowchart
- **Appendix 3 –** Learning from Deaths Process Chart
- **Appendix 4 –** Dissemination of Learning
- **Appendix 5 --** Terms of Reference for Learning from Deaths (LFD Advisory Group)

**APPENDIX 1**

## EQUALITY ANALYSIS SCREENING FORM

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

| | | | |
|---|---|---|---|
| **Title of Proposal** | Learning from Deaths Policy | | |
| **Person Completing this proposal** | Samantha Munbodh | **Role or title** | Head of Patient Safety |
| **Division** | Governance | **Service Area** | Corporate |
| **Date Started** | 4/1/22 | **Date completed** | 4/1/22 |

**Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.**

The policy sets out the purpose of Learning from Deaths within BSMHFT, who falls within the scope of LfD and how these will be monitored / reviewed

**Who will benefit from the proposal?**

All staff employed by BSMHFT and service users

**Impacts on different Personal Protected Characteristics –** *Helpful Questions:*

| | |
|---|---|
| *Does this proposal promote equality of opportunity?*<br>*Eliminate discrimination?*<br>*Eliminate harassment?*<br>*Eliminate victimisation?* | *Promote good community relations?*<br>*Promote positive attitudes towards disabled people?*<br>*Consider more favourable treatment of disabled people?*<br>*Promote involvement and consultation?*<br>*Protect and promote human rights?* |

**Please click in the relevant impact box or leave blank if you feel there is no particular impact.**

| Personal Protected Characteristic | No/Minimum Impact | Negative Impact | Positive Impact | Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics. |
|---|---|---|---|---|
| **Age** | | | X | Applies to all regardless of age |
| Including children and people over 65<br>Is it easy for someone of any age to find out about your service or access your proposal?<br>Are you able to justify the legal or lawful reasons when your service excludes certain age groups | | | | |

| | | | | |
|---|---|---|---|---|
| **Disability** | | | X | Applied to all regardless of disability |
| Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues<br>Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability?<br>Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families? | | | | |
| **Gender** | | | X | Applies to all genders |
| This can include male and female or someone who has completed the gender reassignment process from one sex to another<br>Do you have flexible working arrangements for either sex?<br>Is it easier for either men or women to access your proposal? | | | | |
| **Marriage or Civil Partnerships** | | | X | Applies to all |
| People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters<br>Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships? | | | | |
| **Pregnancy or Maternity** | | | X | Applies to all |
| This includes women having a baby and women just after they have had a baby<br>Does your service accommodate the needs of expectant and post natal mothers both as staff and service users?<br>Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity? | | | | |
| **Race or Ethnicity** | | | X | Apples to all ethnicities |
| Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees<br>What training does staff have to respond to the cultural needs of different ethnic groups?<br>What arrangements are in place to communicate with people who do not have English as a first language? | | | | |
| **Religion or Belief** | | | X | Applies to all religions and beliefs |
| Including humanists and non-believers<br>Is there easy access to a prayer or quiet room to your service delivery area?<br>When organising events – Do you take necessary steps to make sure that spiritual requirements are met? | | | | |
| **Sexual Orientation** | | | X | Applies to all regardless of sexual orientation |
| Including gay men, lesbians and bisexual people<br>Does your service use visual images that could be people from any background or are the images mainly heterosexual couples?<br>Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea? | | | | |

| | | | | |
|---|---|---|---|---|
| **Transgender or Gender Reassignment** | | | X | Applies to all |
| This will include people who are in the process of or in a care pathway changing from one gender to another<br>Have you considered the possible needs of transgender staff and service users in the development of your proposal or service? | | | | |
| **Human Rights** | | | X | Applies to all |
| Affecting someone's right to Life, Dignity and Respect?<br>Caring for other people or protecting them from danger?<br>The detention of an individual inadvertently or placing someone in a humiliating situation or position? | | | | |
| **If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)** | | | | |

| | | | | |
|---|---|---|---|---|
| | | **No** | | |
| **What do you consider the level of negative impact to be?** | **High Impact** | **Medium Impact** | **Low Impact** | **No Impact** |
| | | | | X |

| |
|---|
| If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.<br><br>If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.<br><br>If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.** |
| **Action Planning:** |
| How could you minimise or remove any negative impact identified even if this is of low significance? |
| |
| How will any impact or planned actions be monitored and reviewed? |

| |
|---|
| How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic. |
| |
| Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis. |

## Full Equality Analysis Form

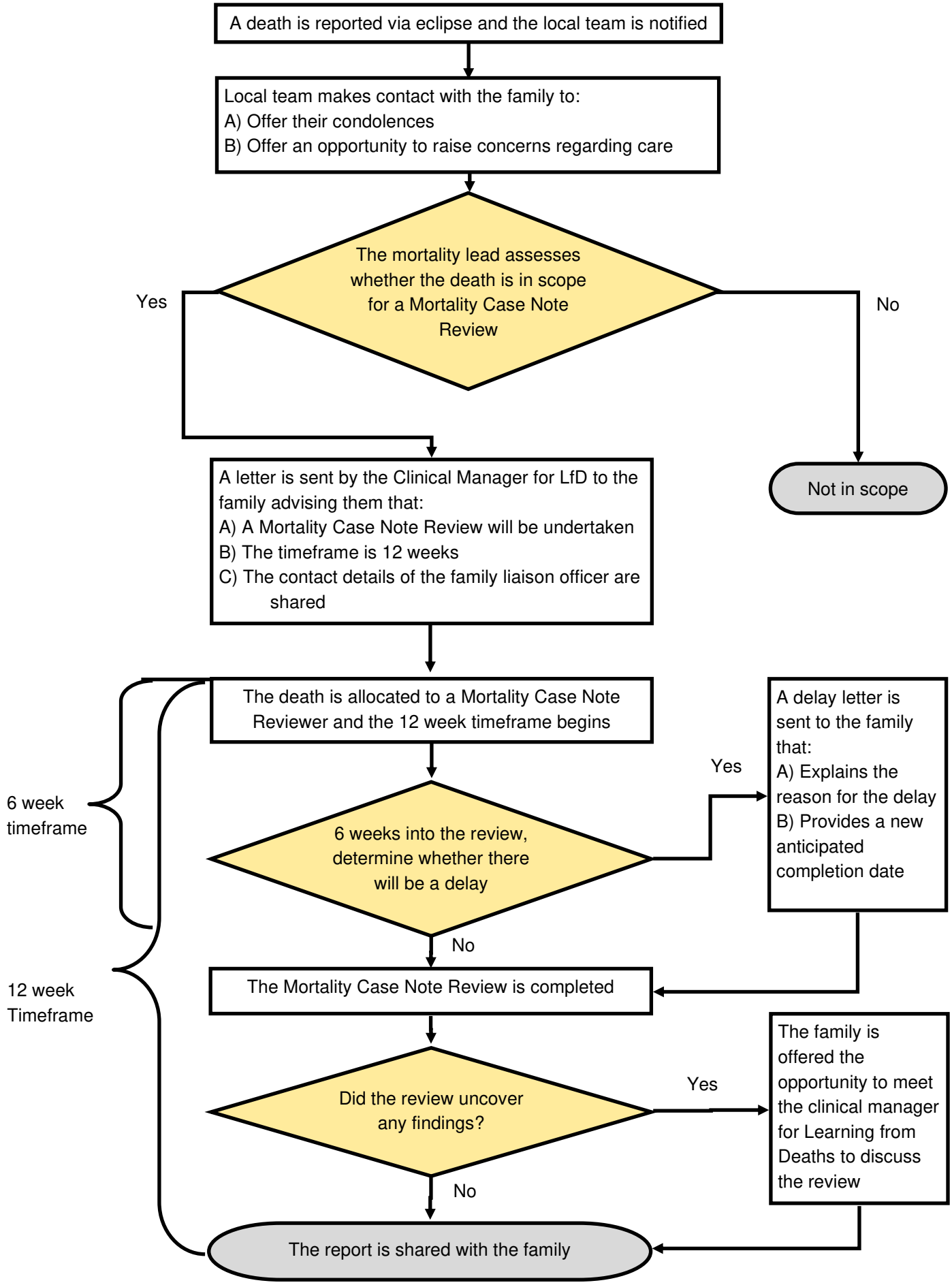
| | | | |
|---|---|---|---|
| **Title of Proposal** | | | |
| **Person Completing this proposal** | **Flair Birch** | **Role or title** | Clinical Manager |
| **Division/Department** | **Governance** | **Service Area** | Patient Safety Team |
| **Date Started** | **02-11-21** | **Date completed** | 02-11-21 |
| Looking back at the screening tool, in what areas are there concerns that the proposal treats groups differently, unfairly or disproportionately as a result of their personal protected characteristics? | | | |
| There are no current concerns as the policy applies to all | | | |
| **Summarise the likely negative impacts** | | **Summarise the likely positive impact** | |
| N/A | | N/A | |
| **What previous or planned consultation or research on this proposal has taken place with groups from different sections of the community?** | | | |
| | | **Please provide list of groups consulted.** | **Summary of consultation / research carried out or planned. If already carried out, what does it tell you about the negative impact?** |
| **Group(s) (Community, service user, stakeholders or carers** | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Staff Group(s)** | | | | | |
| **What up-to-date information or data is available about the different groups the proposal may have a negative impact on?** | | | | | |
| | | | | | |
| **Are there any gaps in your previous or planned consultations, research or information? If so are there any other experts, groups that could be contacted to get further views or evidence?** | | | | | |
| **Yes** | | **No** | x | | |
| **If yes please list below** | | | | | |
| | | | | | |
| **As a result of this Full Equality Analysis and consultation, what changes need to be made to the proposal? (You may wish to put this information into an action plan and attach to the proposal)** | | | | | |
| No changes are required at this stage | | | | | |
| **Will any negative impact now be:** | | | | | |
| **Low:** | x | **Legal:** | x | **Justifiable:** | x |
| **Will the changes made ensure that any negative impact is lawful or justifiable?** | | | | | |
| | | | | | |
| **Have you established a monitoring system and review process to assess the successful implementation of the proposal? Please explain how this will be done below.** | | | | | |
| | | | | | |
| **Action Planning: How could you minimise or remove any negative impact identified even if this is of low significance?** | | | | | |

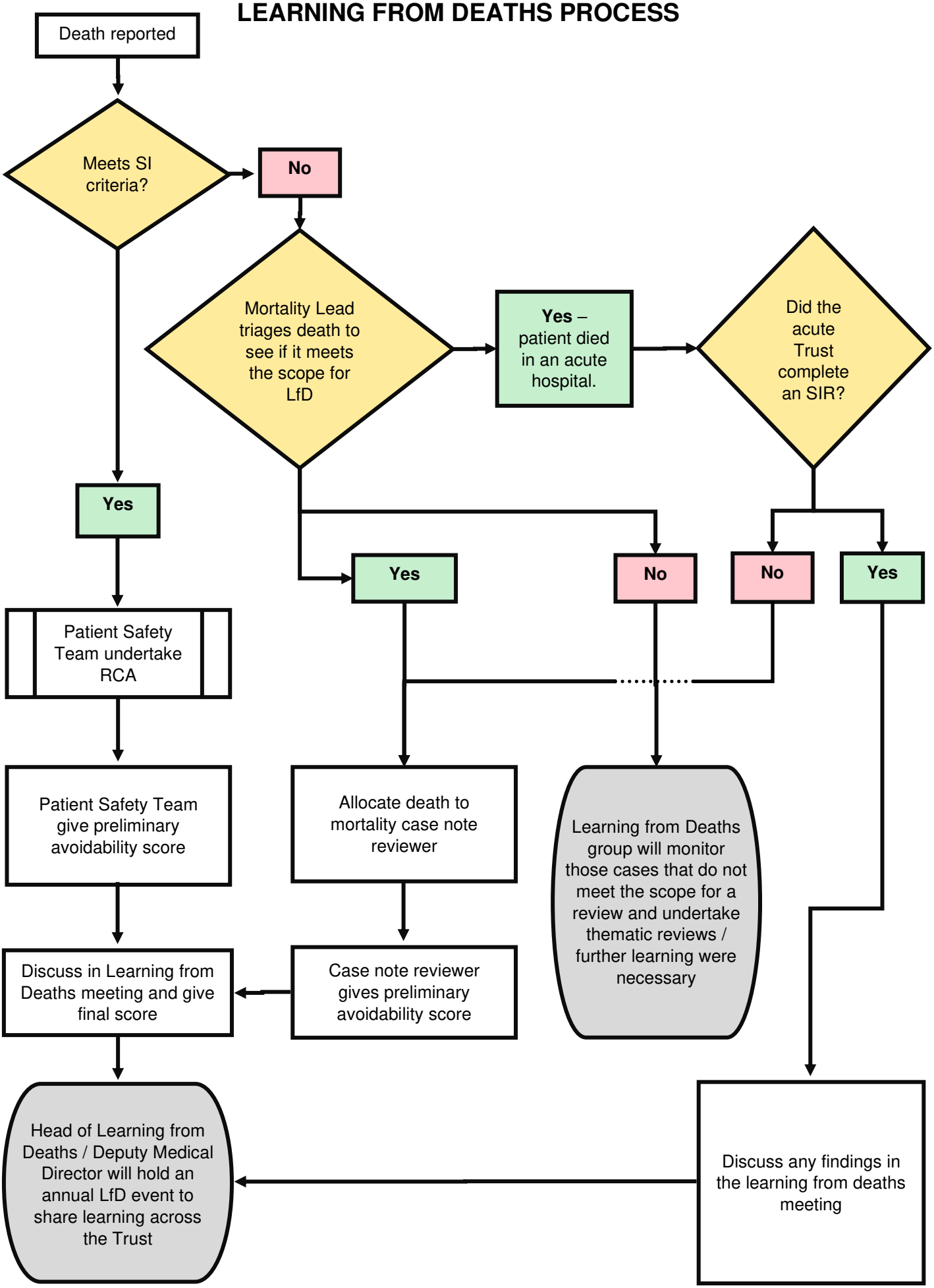
| |
|---|
| |
| **How will any impact or planned actions be monitored and reviewed?** |
| |
| **How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic?** |
| |

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

# FAMILY ENGAGEMENT PROCESS FOR LFD



# LEARNING FROM DEATHS PROCESS



**APPENDIX 4**

# DISSEMINATION OF LEARNING

The Trust has a commitment to organisational and local learning.

**Themes and Trends** - the Black Hole within the eclipse system on the trust intranet site (Connect) provides interactive reports for teams and service areas to learn from incidents data. The information on the Black Hole is updated daily and provides staff with in-depth incidents analysis to support learning**,** this includes a Mortality Dashboard for Learning from Deaths.

**Sharing the Findings of Mortality Review Case Note Reviews -** The Trust has a desire to be open and transparent with patients/service users, carers and staff to ensure that those involved have the opportunity to understand what has happened and learning can be shared. Information regarding how the Trust is going to improve practice and complete recommendations will also be shared with key stakeholders

**Sharing of Learning – alternative methods**

**Reflective practice –** To help learn from experience the Trust actively encourages reflective practice, whether this is individually or as a group. To help do this in a structured way Gibbs (1988) Reflective Cycle "Learning by Doing" is highly recommended**.**

**Kitchen Table/ Dare to Share** – Value based learning / Kitchen Tables – Value based learning involves sessions that are facilitated by the Patient Safety team. A Kitchen Table event is where people can talk openly and honestly, without judgment and above all be listened to. Informal discussions will take place around what is important to staff about keeping people safe and whether they have any suggestions on how patient safety can be improved within the Trust. The details of either one incident or a group of similar incidents are shared with staff who will then work on identifying the issues or concerns and recommendations to prevent reoccurrence.

**Thematic Review** - In order to prevent issues from being considered in isolation and common trends from being missed, review reports, action and improvement plans will be reviewed collectively by Trust and a yearly thematic review will be completed

**APPENDIX 5**

# TOR FOR LFD ADVISORY GROUP

## TERMS OF REFERENCE

| | |
|---|---|
| TITLE OF GROUP/COMMITTEE | LEARNING FROM DEATHS (LFD) ADVISORY GROUP |
| DATE TERMS OF REFERENCE RATIFIED | March 2021 |
| DATE OF NEXT REVIEW OF TERMS OF REFERENCE | March 2024 |

| | |
|---|---|
| 1. | Purpose and Aims of the Group/Committee |
| | 1.1 The primary role of the LFD Group is to provide assurance to the Trust Board on patient mortality. Mortality indicator statistics do not in themselves constitute evidence regarding the standard of care delivered. Therefore, assurance must be based on review of care received by those who die as well as understanding the statistics. This group should review data on service user deaths, including results and learning generated by local mortality review, and consider strategies to improve care and reduce avoidable mortality.<br><br>1.2 In addition to contextual information about quality of care the LFD Group should also receive statistical information about all deaths in the trust and should review areas of concern. This should include deaths by diagnostic group.<br><br>1.3 The group would form the primary assurance mechanism for the Trust Board to comply with Article 2 of the European convention on Human Rights in cases of deaths from all causes for detained patients and all other self-inflicted deaths of inpatients. |
| 2. | Duties/Core Delegated Responsibilities and Accountabilities |
| | i. To work towards the elimination of all avoidable mortality.<br>ii. There being a specific focus on deaths of those who are detained or liable to be detained under the Mental health Act 1983 and those other case where there is a trust responsibility under article 2 of European Convention on Human Rights.<br>iii. To review on a monthly basis, the mortality rates of the trust and to use benchmarking as and when national benchmarking is available.<br>iv. To consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation..<br>v. To investigate any mortality alerts received from the Care Quality Commission (CQC).<br>vi. To develop data collection systems to ensure the trust's mortality data is timely, robust and in line with national and international best practice.<br>vii. To ensure mortality information linked to responsible clinician/consultant appraisals is accurate, contextual and engenders a culture of clinical excellence.<br>viii. To address raised mortality in particular clinical areas by the deployment of evidence based learning and interventions. The group will receive regular reports on implementation and the measurable impact of these interventions on learning from deaths.<br>ix. To review and monitor compliance with other policies including DNACpR and Death Certification.<br>x. To receive all Regulation 28 Prevention of Future Death Reports from HM Coroner and seek to understand any aligned findings with the wider Learning from Deaths agenda.<br>xi. To monitor and consider the information from the electronic review of all deaths.<br>xii. Develop and govern the Learning from Deaths entry in the Annual Quality Account<br>xiii. To hold regular learning events linked to findings associated with mortality reviews<br>xiv. To identify opportunities for quality improvement from Mortality Case Note Reviews |
| 3. | Strategic Functions |
| | |

| | |
|---|---|
| | i. To act as the strategic mortality overview group with senior leadership and support to ensure the alignment of the trust's departments for the purpose of reducing all avoidable deaths.<br>ii. To produce a Learning From Deaths Strategy that aligns systems such as audit, information services, training and clinical service areas. This strategy will be reviewed on an annual basis by the Medical Director.<br>iii. To establish lessons learnt through mortality reviews and agree resultant improvement actions (locally and nationally).<br>iv. Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the trust.<br>v. Sign off of all regulatory mortality responses.<br>vi. To report on learning from deaths performance to the Integrated Quality Committee on a monthly basis and to the Trust Board on a quarterly basis. |
| 4. | Membership |
| | Chair – Deputy Medical Director<br>Business Manager/Lead Nurse – Learning from Deaths Mortality Case Note Reviewers<br>Family Liaison Officer<br>Medical lead for mental health legislation<br>Senior Nurse<br>Patient Safety Specialist<br>Clinical Commissioning Group representative<br>Nat Willetts – NR to pick up with NW out of here – think re whether nursing rep required **<br>Professional forums reps** - could invite Jane Clark/Alison Jowett<br><br>In attendance by invitation only:-<br>Doctor from each Service Area<br>Junior Doctor Representation<br>Research and Innovation Rep<br>Legal Services Rep |
| 5. | Quoracy |
| | 50% of membership must be present with either the Deputy Medical Director present or the Deputy Chair. |
| 5. | Meeting Arrangements |
| | i. The LFD will meet on at least 9 occasions during the year.<br>ii. Members are required to attend 70% of meetings throughout the course of the year.<br>iii. The LFD is accountable to the Trust Board via the Integrated Quality Committee. A quarterly written report will be provided to the Integrated Quality Committee. The Chair will escalate any risks to the Trust Board and risks will be entered onto the appropriate risk register. A quarterly report will be provided directly to the Trust Board.<br>iv. The agenda will be set by the Chair who will ensure administrative support is available to the meeting.<br>v. Joint working with CCG staff.<br>vi. Learning from acute trusts is to be brought back to this meeting. |
| 6. | Reporting Arrangements |
| | The Group will report on a quarterly basis into the Patient Safety Advisory Group, the Integrated Quality Committee and the Trust Board. |
| 7. | Effectiveness of the Group/Committee Function |
| | |

| | |
|---|---|
| | The Committee/Group will carry out an annual effectiveness review using a standardised trust template on an annual basis. |