COUNCIL OF GOVERNORS
11th May 2017

Paper Title:	Mortality Review Update
Lead Director:	Medical Director
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Agenda Item:	9
Presented For:	Assurance

1. Purpose of this Report:

The purpose of this paper is to provide the Council of Governors with assurance that there is strong Board leadership of mortality review processes, within BDCFT, including a named NED to ensure that those processes are developing, in line with national guidance and informed by close collaboration with regional mental health Trusts and local NHS organisations.

2. Summary of Key Points

- BDCFT has named Executive and Non-Executive lead Directors for mortality review (Dr McElligott and Dr Butler).
- The Northern Alliance of mental health Trusts is well established and has put us all 'ahead of the game' in relation to mortality review processes.
- The BDCFT Mortality Review Group is established and reviews all deaths within LD services plus a significant proportion of deaths within mental health services.
- Early learning points are beginning to emerge from our mortality review process.
- Recent data suggests BDCFT death rates for mental health service users are below regional and national averages.
- Public reporting of mortality data will be required from July 2017.

3. Recommendations:

That the Council of Governors:

- Notes the progress made in relation to mortality review processes and associated early learning; and
- Confirms it is assured that there is strong, non-executive oversight of progress in respect of local process and national reporting requirements.

Mortality Review Update

1. Background

We have known for decades that people with a learning disability and those with mental health problems are dying prematurely.

The 2015 Mazars inquiry revealed very low numbers of investigations or reviews of deaths at Southern Health NHS Foundation Trust where, over a four year period, fewer than 1% of deaths within learning disability services and 0.3% of deaths in mental health services were investigated as a serious incident (SI).

These figures and the lack of interest in patient safety and learning from deaths reflected the reality as described by families of patients at Southern Health. As a result, there has been significant national focus on how Trusts identify, investigate and learn from the deaths of their patients.

From July 2017 all Trusts must publish, on a quarterly basis, specified information on deaths, including those that are assessed as more likely than not to be due to problems in care, and evidence of learning and action that is happening as a consequence of this information.

This paper aims to provide assurance that the Trust is taking all necessary action to ensure high quality mortality review processes are in place and that we will be in a position to publish accurate synopses, including how learning is being disseminated.

2. National Developments

In December 2016, the CQC published its review 'Learning, candour and accountability'.

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

In response, the Secretary of State accepted the report's recommendations and made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die.

Fundamental to the commitments are strengthened governance and capability, increased transparency through improved data collection and reporting, and better engagement with families and carers.

A national 'Learning from Deaths' conference was attended, on March 21st, by Dr McElligott and Dr Butler.

As outlined above, we know already that from April 2017 we must collect and publish, on a quarterly basis (initial publication in July), specified information on deaths, including those that are assessed as more likely than not to be due to problems in care, and evidence of learning and action that is happening as a consequence of this information. CQC/NHSI have suggested that best practice would be an agenda item and a paper to the public Board meeting in each quarter.

All deaths within learning disability services must be reported through the 'Learning Disabilities Mortality Review' (LeDeR) Programme which is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and delivered by the University of Bristol. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

3. Local process

Following publication of the Mazars report, an alliance of mental health trusts from Yorkshire, Cumbria and the North-East was formed, (the Northern Alliance), which is supported by the individuals from Mazars who undertook the Southern Health investigation. The alliance meets on a quarterly basis with a remit to share current, mortality review practice (including innovations and challenges), hear the latest national thinking and developments, share Trust-level mortality data and develop a common approach to mortality review across the region. BDCFT representation is via the Medical Director and the Serious Incident Manager and we have attended and contributed to every alliance meeting held so far.

Comparative mortality data across the Northern Alliance trusts has previously been presented to Quality and Safety Committee and to Board. This showed BDCFT to be above average at identifying deaths via the incident reporting system but to have a relatively low number which then proceeded to level 1 local review. This is now being addressed by the Mortality Review Group (MRG).

More recently Mazars has produced a draft data pack, based on Office of National Statistics and Mental Health Minimum Data Set returns, which shows BDCFT service users to have lower death rates (both crude and standardised) and lower premature death rates in comparison to other Northern Alliance Trusts.

The BDCFT Mortality Review Group was established in December 2016 and meets for one hour, every week, chaired by the Medical Director. Other attendees include the Head of Mental Health Services, Serious Incident Manager and representatives of the Safety, Risk and Resilience team.

The MRG reviews the deaths of all mental health and LD service users which have been identified by services (and therefore reported as an 'incident' as per Trust policy) with numbers averaging around 10 per week. The electronic records of each service user are scrutinised at MRG and cases are either closed, kept open awaiting further information (usually cause of death information from a Coroner), referred for local review (level 1 investigation), referred for LD-specific review (for every LD death) or agreed to be an SI requiring level 2 investigation (full case review incorporating 'root cause analysis' methodology).

Following local/LD reviews, the investigating officers attend MRG to outline their findings and any associated learning/actions taken.

One MRG also looked at all deaths, within mental health and LD, of which we became aware by searching the national spine (i.e. those deaths of which teams were unaware and had not, therefore, been reported as incidents). The number of these deaths is roughly equal to the number reported as incidents and, although some learning was identified, the MRG felt that we currently lack the capacity to undertake case note review on all of these. The majority of these deaths were in older people with whom the Trust had had very limited contact (e.g. assessed once and discharged by the liaison team or assessed and discharged by memory assessment).

All deaths within Learning Disability services are also reported to the LeDeR programme as described above.

An important learning point to emerge has been the lack of information exchange between local NHS organisations (trusts, CCGs, GPs) following a death. This has been recognised, both nationally and locally, as an area for improvement and the Medical Directors of the three local Foundation Trusts met earlier this week (May 8th), along with senior CCG representatives, to discuss how to address this.

4. Local results and learning

The following figures and narrative were reported to **Quality and Safety Committee** in March and give an indication of the early, emerging learning:

From 01/12/16 – 19/02/17 **93 deaths** were reported and reviewed by MRG.

- 24/93: Deaths of residential/nursing home patients
- 2/93: Deaths of hospice patients
- 9/93: Deaths investigated and reviewed as an SI
- 6/93: On watching brief awaiting further information
- 3/93: Local review completed and outcomes reviewed by MRG
    - 1/3 local reviews identified a learning opportunity
- 4/93: Ongoing local review
- 4/93: Death of person with learning disability
    - 3/4 LD deaths with a completed local review
    - 1/3 local reviews identified a learning opportunity
    - 1/4 LD deaths with a local review ongoing

Excluding the Serious Incidents, so far, no potentially avoidable deaths have been identified but learning opportunities have been identified in seven of the remaining 84 deaths as follows:

- Two cases where the same mistake by an individual administrator led to delayed assessment. The individual has been advised of correct procedure.
- One case where a referral, from a community mental health team to psychological therapies, went missing without an audit trail; this case has led to a review of our internal referral pathways which is ongoing.

- One case where a research nurse found a patient, who had been discharged from our care, very ill at home; this case has resulted in a concern, about the homecare provider, being raised with the Adult Safeguarding team.
- One case, where a patient with learning difficulties, experienced delays in treatment and a number of moves to different wards whilst at a local acute trust. Findings of review flagged with acute trust.
- Two cases within the older people's liaison service where the need for a follow up visit was documented but appeared not to have happened. Both examples have been shared with the team who are looking at improved internal communication and documentation.

5. Assurances in Place

This paper provides assurance in relation to CQC's 'safe' and 'responsive' Key Lines of Enquiry because a proactive response, to the learning opportunities offered by a robust mortality review process, should improve patient experience and safety.

Further assurance is provided by BDCFT membership of the Northern Alliance, ensuring consistency of practice and early insight into national thinking allowing for rapid response.

6. Monitoring and review

Quarterly reporting required from July 2017 in the public Board meeting.

7. Recommendations

That the Council of Governors:

- Notes the progress made in relation to mortality review processes and associated early learning; and
- Confirms it is assured that there is strong, non-executive oversight of progress in respect of local process and national reporting requirements