

## BOARD MEETING

**28th September 2017**

Paper Title:	Learning From Deaths Policy
Section:	Public
Lead Director:	Dr. A McElligott, Medical Director
Paper Author:	Dr. A McElligott, Medical Director
Agenda Item:	<b>12</b>
Presented For:	Approval
Paper Category:	Quality

### Executive Summary:

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.

Learning points are beginning to emerge from our mortality review process.

The Northern Alliance has developed a generic Learning From Deaths Policy which member Trusts have modified to reflect local circumstances; the BDCFT version of this policy is attached for Board approval.

Public reporting of mortality data will be required from Q3 of 2017/18.

### Recommendations:

That the Board

- Notes the continuing progress made in respect of mortality review processes
- Approves the new BDCFT Learning From Deaths Policy

**Governance/Audit Trail:**

<b>Meetings where this item has previously been discussed (please mark with an X):</b>					
<b>Audit Committee</b>		<b>Quality &amp; Safety Committee</b>		<b>Remuneration Committee</b>	<b>Finance, Business &amp; Investment Committee</b>
<b>Executive Management Team</b>	x	<b>Directors</b>		<b>Chair of Committee Meetings</b>	<b>Mental Health Legislation Committee</b>
<b>Council of Governors</b>					

<b>This report supports the achievement of the following strategic aims of the Trust: (please mark those that apply with an X):</b>	
Consolidation of Market Share : being great in our patch	
Manage the impacts of the whole system of reduced health and social care funding: working in partnership to develop cost effective out of hospital services and pathways to support the delivery of sustainable services	
Secure Funding for new or expanded services	

<b>This report supports the achievement of the following Regulatory Requirements: (please mark those that apply with an X):</b>	
<b>Safe:</b> People who use our services are protected from abuse and avoidable harm	<b>x</b>
<b>Caring:</b> Staff involve people who use our services and treat them with compassion, kindness, dignity and respect	
<b>Responsive:</b> Services are organised to meet the needs of people who use our services	<b>x</b>
<b>Effective:</b> Care, treatment and support achieves good outcomes, helps to maintain quality of life people who use our services and is based on the best available evidence.	
<b>Well Led:</b> The leadership, management and governance of the organisation make sure it's providing high-quality care that is based around individual needs, encourages learning and innovation, and promotes an open and fair culture.	<b>x</b>
<b>NHSI Single Oversight Framework</b>	

<b>Freedom of Information:</b>
<p><b>Publication Under Freedom of Information Act</b></p> <p>This paper has been made available under the Freedom of Information Act</p>

# Learning From Deaths Policy

## 1. Background and Context

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 an 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 Quarter 3, of 2017/18, 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.

As a precursor, to the publication of mortality data, all Trusts must have a Learning From Deaths Policy approved at a public meeting of the Board.

This paper aims to provide assurance that the Trust is taking all necessary action to ensure high quality mortality review processes are in place, that we will be in a position to publish accurate synopses (including how learning is being disseminated) and presents the new Learning From Deaths Policy for approval (see paper **12a**).

## 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 21<sup>st</sup>, by Dr. McElligott and Dr. Butler, at which the latest national guidance was launched.

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

The most important requirements of this guidance are that, by September 2017, all Trusts must publish a 'Responding to Deaths' policy and must collect and publish, every quarter, 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. The guidance suggests 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).

The MRG was established in December 2016 and meets for 90 minutes, 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.

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

All deaths within learning disability services are also reported to the LeDeR programme as described above.

The Northern Alliance has developed a generic 'Learning From Deaths' policy, to which all Trusts have contributed and which we have modified to reflect specific local practice.

The final BDCFT policy articulates which deaths are reviewed at MRG, which are selected for a local review, LeDeR review or SI review and how families and carers will be involved.

Structured Judgment Review (SJR) has become the standard methodology for local mortality reviews in acute Trusts. Some members of the Northern Alliance have adapted the methodology to suit mental health Trusts. Consideration must now be given to training a cohort of staff to undertake SJR (for comparison, BTHFT has over 100 trained staff from medical, nursing and risk backgrounds).

An important learning point to emerge, from local mortality reviews, 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, in May, along with senior CCG representatives, to discuss how to address this. A bipartite agreement has been reached, with BTHFT, to request a local review of any deaths occurring within the other Trust but about which we have questions. The results of those local reviews are being shared with the requesting organisation.

#### **4. Local results and learning**

Excluding the Serious Incidents, so far, one potentially avoidable death has been identified (currently subject to a level 2 investigation) but wider learning is emerging and being fed back into individuals, services, business units or Trust-wide, as appropriate. Learning from mortality reviews will form part of future, quarterly Board reports.

#### **5. Assurances in Place**

This paper provides assurance in relation to CQC's 'safe', 'responsive' and 'well-led' domains because a proactive response, to the learning opportunities offered by a robust mortality review process, should improve patient experience and safety and is carefully overseen by Board members.

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 Quarter 3 of 2017/18 in the public Board meeting.

A *draft, exemplar* mortality dashboard has been developed and is attached at **12b**.

## **7. Implications**

### **7.1 Legal and Constitutional**

All Trusts are required to have a Board approved 'Responding to Deaths' policy.

### **7.2 Resource**

All members of the Northern Alliance have contributed to funding Mazars' involvement in 2017/18.

Local review processes are currently being managed within existing budgets.

Formal staff training in SJR methodology would incur non-recurrent costs in line with the number of staff trained.

## **8. Communication and Involvement**

Following Board approval, the Learning From Deaths Policy will be disseminated via e-update.