Bradford District Care
NHS Foundation Trust

BOARD MEETING

25th January 2018

Paper Title:	Learning From Deaths
Section:	Public
Lead Director:	Dr. A McElligott, Medical Director
Paper Author:	Dr. A McElligott, Medical Director
Agenda Item:	**15**
Presented For:	Assurance
Paper Category:	Quality

Executive Summary:

BDCFT has named Executive and Non-Executive lead Directors for mortality review.

The Northern Alliance of mental health Trusts is well established and has agreed a consistent approach to learning from deaths in mental health and learning disability services, including how mortality data will be presented to boards.

The BDCFT Mortality Review Group is well established and reviews all deaths within LD services plus all deaths within mental health services which have been reported on the incident management system.

Learning points are beginning to emerge from our mortality review process but these are mainly around pathways of care rather than the potential to avoid deaths.

Recommendations:

That the Board

- Notes the continuing progress made in respect of mortality review processes
- Notes the numerical mortality data presented and confirms that assurance is provided of important learning and actions taken in response.

Governance/Audit Trail:

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

This report supports the achievement of the following strategic aims of the Trust: (*please mark those that apply with an X):*	
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	

This report supports the achievement of the following Regulatory Requirements: (*please mark those that apply with an X):*	
Safe: People who use our services are protected from abuse and avoidable harm	**x**
Caring: Staff involve people who use our services and treat them with compassion, kindness, dignity and respect	
Responsive: Services are organised to meet the needs of people who use our services	**x**
Effective: 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.	
Well Led: 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.	**x**
NHSI Single Oversight Framework	

Freedom of Information:
Publication Under Freedom of Information Act This paper has been made available under the Freedom of Information Act

Learning From Deaths

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.

All Trusts must now publish, on a quarterly basis, specified information on deaths 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 are required to have a, Board approved, Learning From Deaths Policy; our policy was approved at the September 2017 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 and that we are now able to publish accurate synopses, including how learning is making a difference to service provision.

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, in March 2017, by Dr. McElligott and Dr. Butler, at which the 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 those which require all Trusts to publish a 'Responding to Deaths' policy and to collect and publish, every quarter, specified information on deaths, and evidence of learning and action that is happening as a result. 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. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities but it remains very much a 'work in progress' and, in the meantime, local commissioners and providers are considering the development of our own multi-organisational overview process (based around similar principles to the Child Death Overview Panel which already scrutinizes the deaths of all children across the district). 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.

As set out, in our Board-approved policy, deaths currently 'in scope' for potential further review include those where BDCFT is defined as the main provider of care but not those where the Trust is only providing a small component of an overarching package of care (e.g. district nursing).

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 slightly lower proportion which then proceeded to local review. This is now being addressed by the Mortality Review Group (**MRG**).

The MRG was established in December 2016 and meets, for at least one hour, every week, chaired by the Medical Director. Other attendees include the Head of Mental Health Services and the Serious Incident Manager.
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). 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 local 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 developed a generic 'Learning From Deaths' policy, to which all Trusts contributed and then modified to reflect specific local practice.

The final BDCFT policy, approved last September, 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.

Board is reminded that the Northern Alliance has identified a number of potential triggers for a review / investigation. These include deaths:

1. Where family / clinical staff / risk management staff flag or raise a concern;
2. Where medication with known risks such as clozapine was a significant part of the treatment regime;
3. From causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data);
4. Where they had been subjected to a care intervention where death wouldn't have been an expected outcome e.g. ECT, rapid tranquilization;
5. Where the service user had no active family or friends and so were particularly isolated e.g. with no-one independent to raise concerns;
6. Where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap in services;
7. Associated with known risk factors / correlations
8. Particular causes of death e.g. epilepsy;
9. Deaths in Distress which might include: drug and alcohol deaths, or deaths of people with an historic sex offence e.g. people who might not be in crisis but need support and from whose experience there may be learning from a thematic review;

10. Where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn't responded to in a timely manner;

11. Random sampling.

Structured Judgment Review (SJR) is a formal, structured methodology for reviewing clinical notes, developed by the Royal College of Physicians, and has become the standard methodology for local mortality reviews in acute Trusts. Some mental health providers are attempting to adapt the methodology to suit and we are considering whether to adopt such an approach within BDCFT.

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 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. Discussions with AFT are ongoing. The Medical Director has been asked to provide a 'learning from deaths' presentation, next month, to the Health and Wellbeing Board, alongside Medical Directors from the acute trusts and the CCGs.

4. Local results and learning

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from *all* deaths. Working with the eight other mental health trusts in the Northern Alliance we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking in to some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur. The Trusts of the Northern Alliance have decided to not initially report on what are described in general hospital services as "avoidable deaths" in inpatient services. This is because there is currently no research base on this for mental health services and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. We will review this decision not later than April 2018 and will continue to support work to develop our data and general understanding of the issues.

Learning from deaths dashboard - data taken from risk management system Reporting Period Quarters 1 – 3 (1st April – 31st December 2017)

Total number of deaths within mental health services (excluding service users with identified learning disabilities)

Total number of deaths	Total number of deaths reviewed at MRG	Total number of deaths subject to further local review	Total number of deaths reviewed as a Serious Incident (SI)	Total number of in-patient deaths	Total number of significant learning points (excluding learning from SIs)
Q1	Q1	Q1	Q1	Q1	Q1
66	66	3	5	2	3
Q2	Q2	Q2	Q2	Q2	Q2
40	40	1	7	0	1
Q3	Q3	Q3	Q3	Q3	Q3
49	45	3	1	0	0
Q4	Q4	Q4	Q4	Q4	Q4
-	-	-	-	-	-
YTD	YTD	YTD	YTD		YTD
155	151 (100%)	7 (4.6%)	13 (8.6%)	2	4

*4 Death's awaiting review from MRG

Total Number of Learning Disability Deaths, and total number reported through LeDeR

Total Number of LD Deaths	Total number of LD deaths reviewed at MRG	Total number of LD deaths subject to further local review	Total number of deaths reported through LeDer	Total number of LD deaths reviewed as a Serious Incident (SI)	Total number of in-patient LD deaths	Total number of significant learning points (excluding learning from SIs)
Q1	Q1	Q1	Q1	Q1	Q1	Q1
8	8	8	8	0	0	0
Q2	Q2	Q2	Q2	Q2	Q2	Q2
5	5	5	5	0	0	0
Q3	Q3	Q3	Q3	Q3	Q3	Q3
5	5	5	5	0	0	0
Q4	Q4	Q4	Q4	Q4	Q4	Q4
-	-	-	-	-	-	-
YTD	YTD	YTD	YTD	YTD	YTD	YTD
18	18 (100%)	18 (100%)	18 (100%)	0 (0%)	0	0

The detail of Serious Incidents and associated action plans is already reported through Quality and Safety Committee.

Excluding the Serious Incidents, so far, only one potentially avoidable death has been identified (relating to clozapine monitoring) and this death was subject to a detailed, level 2 investigation but wider learning is emerging and being fed back into individuals, services, business units or Trust-wide, as appropriate.

The most significant learning points, referred to in the above table, were as follows:

There was a lack of clarity regarding how abnormal physical health parameters, (eg tachycardia), for patients on clozapine should be followed up. As a result, a detailed protocol is being developed by pharmacy and local cardiologists to ensure a clear escalation pathway from clozapine clinic.

A&E staff referred a service user to Trust drug and alcohol services but they did not engage. A new drug and alcohol signposting pathway was developed enabling signposting to non-statutory, community-based, drug and alcohol services, where appropriate, which are easier to access and do not require a formal referral.
There was no pathway to follow when patients rang up to be referred to the Haven and it was full. The service has now devised a pathway for staff to follow which describes how we deal with service users who cannot attend diversion services. This ensures no urgent cases are missed and that service users are booked into the next available slot or offered a same-day, face-to-face with Trust staff should the risks be high.

We recently found that some staff were writing requests for blood tests and physical health checks in ‘progress notes’ which, as result, might be missed and not acted upon. Services are currently producing a new protocol.

5. Monitoring and review

Quarterly reporting to the public Board meeting is now mandatory but it may be appropriate to provide this information within the body of the Integrated Performance Report rather than as a separate paper every time.