Agenda item 9 iii)

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25 May 2016

Title and Author of Paper:

Update on actions undertaken and planned in response to the publication of the *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation* undertaken by Mazars.

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Executive Lead: Gary O'Hare

Paper for Debate, Decision or Information: Debate

Key Points to Note:

- The report by Mazars contains 39 recommendations covering twelve areas and applicable to several organisations.
- NTW has responded to the publication through a number of actions already undertaken, and further actions underway or planned.
- The Trust has robust systems in place for identifying, reporting and investigating deaths.
- Areas for improvement include introducing a review system for natural deaths and embedding learning across the organisation
- NTW is working with other partner Trusts in the North of England to enable cross organisational benchmarking and learning

Risks Highlighted to Board :

- Reputational risk of failing to investigate and learn from deaths

Does this affect any Board Assurance Framework/Corporate Risks?
Please state NO

Equal Opportunities, Legal and Other Implications:
None

Outcome Required:

- Debate and acknowledgement of work undertaken and planned

Link to Policies and Strategies:

- NTW(O)05 Incident Policy and associated PGNs

PURPOSE OF THIS PAPER

The purpose of this paper is to inform the Trust Board of the actions the Trust has taken, and is planning to take, in response to the publication in December 2015 of the *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation* undertaken by Mazars [1]. It includes the Trust response to the subsequent letter to Trust from Prof Sir Bruce Keogh and Dr Mike Durkin concerning data collection and a Mortality Governance Guide.

BACKGROUND AND CONTEXT

Mazars is an international audit, tax and advisory firm. They were commissioned by NHS England to review the culture of reporting and investigation of deaths within Southern Health following concerns identified during an independent investigation into the death of Connor Sparrowhawk, a young man with learning disability who drowned in a bath in an in-patient unit in July 2013.

The full report consists of 254 pages, and concludes with 39 recommendations. The report identified a range of issues and challenges for mental health and learning disability providers, as well as other health and social care providers, commissioners, regulators and local authorities.

The recommendations and learning points coved the following areas:

A. Leadership and Board assurance

B. Identification and reporting of deaths

C. Attrition in number from total deaths to investigations and external reporting

D. Management and oversight of report quality and timeliness

E. Learning from deaths and thematic reviews

F. The reporting of deaths of people with a learning disability

G. Family and carer involvement in investigations

H. The role of commissioners

I. System wide investigation and advocacy

J. Information and data management

K. The need to share information

L. Contextual and comparative information

[1] Full report available at https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

ACTIONS ALREADY UNDERTAKEN AND IN PROCESS

Since the report was published and received into the Trust a number of actions have developed, or are in the process of development. Each action has been referenced to the areas identified in the previous section.

✓ Initial benchmarking paper to CDT-Q (areas A-G).

A paper entitled *"Trust Response to the Mazars report into the numbers of deaths within Southern Health NHS Foundation Trust and the comparison to activity within Northumberland , Tyne & Wear NHS Foundation Trust"* was presented to the Quality subgroup of CDT in February 2016. Key points were as follows:

- Over the time period examined, there were 1,454 reports of deaths in Southern Health of which 722 (50%) were unexpected. Of these 195 (27% of all unexpected deaths) were fully investigated

- For NTW in the same timeframe the Trust reported 2,614 deaths of which 343 (13%) were classified as unexpected all of which were subsequently investigated with either an after action review (AAR) or full serious incident investigation.

- The attrition in reporting noted in Southern Health did not occur in NTW.

- There was evidence of Trust leadership, Board oversight of deaths and suitable management and oversight of death investigations, although improvements are being made in these areas (see below)

- Commissioners have always had the opportunity to be actively involved in the SI review process and are members of the SI panel. Reports on the epidemiology of deaths are presented to the relevant QRGs on a routine basis.

- Family and Carer Involvement has always been a feature of NTW investigation process, but was only seen in 64% of investigations undertaken by Southern Health.

- Two areas were identified as requiring attention: a review of the format and content of the safety reports going to Trust Board; and strengthening the Duty of Candour requirement in the investigation process.

✓ New Incident policy and framework (areas B, C, D, E, G).

Work on an updated Incident Policy was already underway, but has now been completed. This work brings the policy in line with developments in the investigation process and ensures a proportionate level of review and investigation depending on the nature of the incident. The whole process is overseen by Group Business Meeting (GBM) on a weekly basis where new potential serious incidents are reviewed and actions considered.

The policy reinforces the need for relatives and carers to be fully involved in the investigation process; this has been the case for several years. The Duty of Candour requirement is included to enhance this.

- ✓ **Annual reporting of unexpected, unnatural deaths to the Trust Board (areas A, B, E, F, J, L).**

The Trust Board has received, since 2010, regular presentations and/or reports on the epidemiology of unexpected unnatural deaths occurring amongst service users of the Trust. In 2015 a new schedule was developed with an interim analysis undertaken in April followed by a more detailed report presented in October which included benchmarking of the Trust against data obtained from the National Confidential Inquiry into Suicide and Homicide (NCISH) undertaken by the Centre for Suicide at the University of Manchester. These reports have tracked the number and classification of deaths across time in the major service lines. Over time, the number of unnatural deaths has been in line with the expected number of such deaths as estimated from the NCISH and data from the Office of National Statistics.

- ✓ **Review of reported deaths in service users in learning disability services (areas A, B, C, F, L).**

The Trust Board received a paper in February 2016 detailing a review of deaths occurring in service users in learning disability services. Key points were as follows:

- Over the period covered by the Mazars report (1st April 2011 to 15th March 2015), there were 57 deaths in NTW service users being treated in learning disability services at the time of death. Taking six month periods (as used in Mazars) the range of such deaths was from 5 to 10. Over the same period Southern Health reported 157 deaths and was criticized for a continual reduction in the number of such deaths reported into Ulysses over time. There has been no similar attrition in NTW.

- Natural cause accounted for 45 of these deaths (79%). There were 4 unnatural deaths; 3 service users died due to accident or misadventure and 1 was deemed to have killed themselves. Verdicts are recorded as pending for 5 cases.

- 5% of all learning disability deaths currently recorded on RiO were STEIS reported, and 9% were subject to review or investigation. By comparison, over the same period in Southern Health 157 deaths were reported of which only 2 were subject to a Serious Incident Requiring Investigation (SIRI) and a further 2 subject only to a Critical Incident Review (CIR). Thus only 2.5% of reported deaths resulted in a formal review process.

In addition, the Trust is exploring the feasibility of participation in the LeDeR programme which is due to be piloted within North East and Cumbria and will include all community health and social care services. It will seek to review all deaths of people with a learning disability age 4-75 and will link with local statutory review processes already in place for specific groups. This programme arose from a key recommendation of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD).

- ✓ **Establishment of a Mortality and Morbidity Group (areas A, B, C, D, E, F).**

Following the guidance issued in the letter issued by Mike Durkin and Prof Bruce Keogh advising the establishment of formal mortality and morbidity groups within Trusts, NTW has now formed such a group. The terms of reference have been approved and a multidisciplinary membership is being sought. The group has met on three occasions so far and is focussing initial work on reviewing the process by which deaths are reported into the Trust on each of the two main systems – RiO and SafeGuard. This group will be central in discussions about expanding the scope of the current review and investigation process to additional classes of deaths recommended by Mazars

- ✓ **Attendance at regional meeting hosted by TEWV Trust and Mazars (areas H, I, J, K, L).**

Our neighbour Trust, Tees, Esk and Wear Valley (TEWV) NHS FT, hosted a regional meeting on 21st April 2016 where the team from Mazars and a team from CQC both presented their previous and planned work. This was attended by representatives of ten Trusts form the North of England which provide mental health and learning disability services.

At the conclusion of the meeting there was unanimous agreement that there should be further work undertaken at a regional level to attempt to introduce a common language and some standardisation of processes to enable meaningful comparison and cross organisational learning. Mazars recognised the robustness of the NTW reporting and reviewing processes currently in place.

- **Developing assurance for the Trust Board (area A).**

Mazars has produced an information sheet to assist Trust Boards in seeking assurance around the mortality review processes in the organisation. This proposes that boards should ask five key questions:

- Do we identify and report deaths correctly?
- Do we review and investigate unexpected deaths properly and without delay?
- Do we meet our obligations to others?
- Do we learn from deaths?
- Do we learn from deaths? Are we being transparent and open in our reporting and investigating of deaths?

The Trust Patient Safety team is currently engaged in developing responses to theses questions, and the paper will be submitted to a future Board for debate.

- **Planned improvements to the current Incident review and investigation processes (areas B, C, E, F).**

To facilitate the identification of lessons in the Trust review and investigation process the Patient Safety team (assisted by an SpR in Public Health Medicine) is exploring the introduction of a formal human factors framework.

The Trust has previously considered how it could proportionately review deaths which were classified as being of natural cause, to attempt to identify learning around physical health and lifestyle factors. In line with recommendations from Mazars, the team is now exploring broadening the scope of the review process to include classes of death not currently included in the incident framework. This is likely to be included in the cross-organisational work across the North of England.

- **Improvement Through Learning (ITL) (area E).**

A key issue identified in the Mazars report was the need to identify and embed learning from incidents into everyday clinical practice. While there are examples of good practice in sharing and learning from lessons the Trust intends to build upon this. Therefore, The Trust is currently developing a programme to enhance opportunities to improve quality through learning from not only safety related incidents but also other activity and sources such as complaints, employment issues, inspections, audits.

- **Adoption as a Sign Up To Safety priority (areas A-G).**

At the CDT-Q meeting in May it was proposed that the Trust revisit its Sign Up To Safety plan and include within it learning from incidents in recognition of the central importance of this work to the Trust's safety and quality goal.

CONCLUSION

The Mazars report provides an important and valuable resource for the Trust to use as a yardstick for a self-evaluation of our mortality review and investigation processes. The Trust has responded through a series of action, and will continue to do so. An important ambition is the development of a regional approach to broaden the scope and potential learning across organisations.

Dr Damian Robinson
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May 2016