Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 22nd March 2017

Title and Author of Paper: Modification of current Safety processes to accommodate mortality reviews. Update on Board Safety Reporting Cycle Dr Damian Robinson, Deputy Medical Director – Safety Tony Gray – Head of Safety & Security

Executive Lead: Gary O'Hare, Executive Director of Nursing and Operations

Paper for Debate, Decision or Information: Information

Key Points to Note: In January 2017 the Board of Directors received a paper noting receipt of the recent report from CQC "Learning, candour and accountability" which includes recommendations arising from the CQC review of how Trusts investigate and learn from deaths. The Secretary of State accepted these recommendations and Dr Kathy McLean and Professor Sir Mike Richards detailed the new requirements for Trusts to review and learn from deaths in a letter sent from NHS Improvement to Trusts on 22nd February (see attached at appendix 1). These come into effect from April 2017. This report outlines internal proposals for integrating additional mortality reviews into the current serous incident processes and reporting to fulfil the responsibilities identified by NHS Improvement. Also included in this report is the updated Board Cycle of Safety Reporting, which will commence in April 2017, this is to bring all reporting both internal and external in line with transparent reporting, and sharing the learning with External Agencies such as our Commissioners as part of our contractual obligations.

Risks Highlighted to Board : • Failure to learn from deaths and prevent future incidents • Regulatory action from CQC • Reputational risk from non-compliance with guidance

Does this affect any Board Assurance Framework/Corporate Risks? NO Please state Yes or No If Yes please outline

Equal Opportunities, Legal and Other Implications:

Outcome Required: Discussion on proposals

Link to Policies and Strategies: Incident Policy - NTW(O) 05

MODIFICATION TO CURRENT TRUST SERIOUS INCIDENT PROCESS TO ACCOMMODATE MORTALITY REVIEWS

Background and context

The Secretary of State accepted these recommendations and Dr Kathy McLean and Professor Sir Mike Richards detailed the new requirements for Trusts to review and learn from deaths in a letter sent from NHS Improvement to Trusts on 22nd February (see attached). These come into effect from April 2017.

These requirements include:-

- Appointing an executive director to take responsibility for, and an executive director to oversee, the process.
- Ensuring staff have the skills to investigate deaths.
- Engaging with bereaved families and carers.
- Collecting and publishing information on deaths (the focus in the letter is on in-patient deaths and has an acute care focus).
- Publishing the Trust policy on undertaking case reviews.

Furthermore, the letter advises that new requirement for reviewing deaths should: -

- Complement existing processes and not replace current good practice.
- Be co-ordinated within existing governance processes which should be adapted to accommodate the review and reporting of deaths.

Further guidance will be forthcoming from the National Quality Board on learning from deaths, together with guidance on training and how Trusts should engage with families and carers.

The guidance is very much focussed on acute Trusts and further guidance for mental health Trusts is likely. In addition, there is a national conference to be held on 21st March which NTW will attend. This may provide additional information.

This report outlines internal proposals for integrating additional mortality reviews into the current serous incident processes and reporting to fulfil the responsibilities identified by NHS Improvement.

1. Identifying and reporting deaths

From April 1st all deaths of NTW service users, including those who have died within 6 months of last contact with NTW, will be reported to the Safeguard incident system through the web based portal. This is in addition to recording the death on RiO. This will allow a full and thorough quality check of all deaths that have occurred, and agree an appropriate response to the review of all deaths, with significant consideration given to post incident family support as appropriate. It is acknowledged that all Healthcare organisations will be commencing this work from the 1st April 2017, so it is important that there is cross pathway conversations taking place, with Acute Trust's, GP Practices and Ambulance Trust's who may also have provided care.

A review of both systems has indicated that there is already a high degree of concordance but that this can be further improved.

In addition to the standard incident report, staff reporting a death will be expected to complete a short web based questionnaire attached to the report. The purpose of this is to enable staff in the Safety Team to identify those deaths appropriate for a mortality review (see next section).

A revised web based reporting form will be in place from 1st April. Notification of the change will be communicated through the Chief Executive's Bulletin and a CAS alert prior to the implementation date.

2. Selecting deaths for SI investigation or mortality review.

All deaths which fulfil the requirements for a full serious incident investigation and reporting to STEIS will continue to have such an investigation. This will continue to be undertaken by the central Safer Care investigation team and review at the weekly Serious Incident review panel. These deaths will be predominantly, though not exclusively, those where self-harm is suggested. In the diagram below these are identified as category A deaths.

Deaths of other service users which fulfil additional criteria will be subject to a multi-disciplinary mortality review. Such deaths will include those previously classed as natural cause deaths which have been subject to statistical analysis but not individual review. The exact nature of the review is being discussed but will probably be based on the current multi-disciplinary after action review process enhanced to focus on physical health. The review will follow the principles for the review promoted by the LeDER initiative. These are category B deaths.

The criteria used to identify deaths appropriate for a mortality review have been selected to focus on deaths where the greatest learning is likely to be achieved.

Current proposal are:-

- Deaths of current inpatients, including those transferred to acute hospitals for management of health conditions.

- Deaths of service users detained under the Mental Health Act (but not those subject to Deprivation of Liberty).

- Deaths of all service users receiving care from learning disability services. When the information can be obtained this will also include those with a learning disability diagnosis.

- Deaths where the service users dies prematurely. The suitable age range for determining such deaths requires additional discussion as the number of such reviews will increase significantly as the age criteria increases.

- Deaths where the cause of death is one which the Trust feels requires particular focus. This might include diabetes, epilepsy and sepsis. Identification of such deaths requires additional information provided by the reporter.

- Other deaths as determined by the Directors at the weekly Business Delivery Group. It is proposed that details of selected deaths be reviewed weekly by the Directors.

- Deaths where family, carers or staff have raised a concern. This will mean expanding our Duty of Candour responsibilities to encompass consideration for all deaths.

- Deaths where a service user has been subject to an intervention such as ECT.

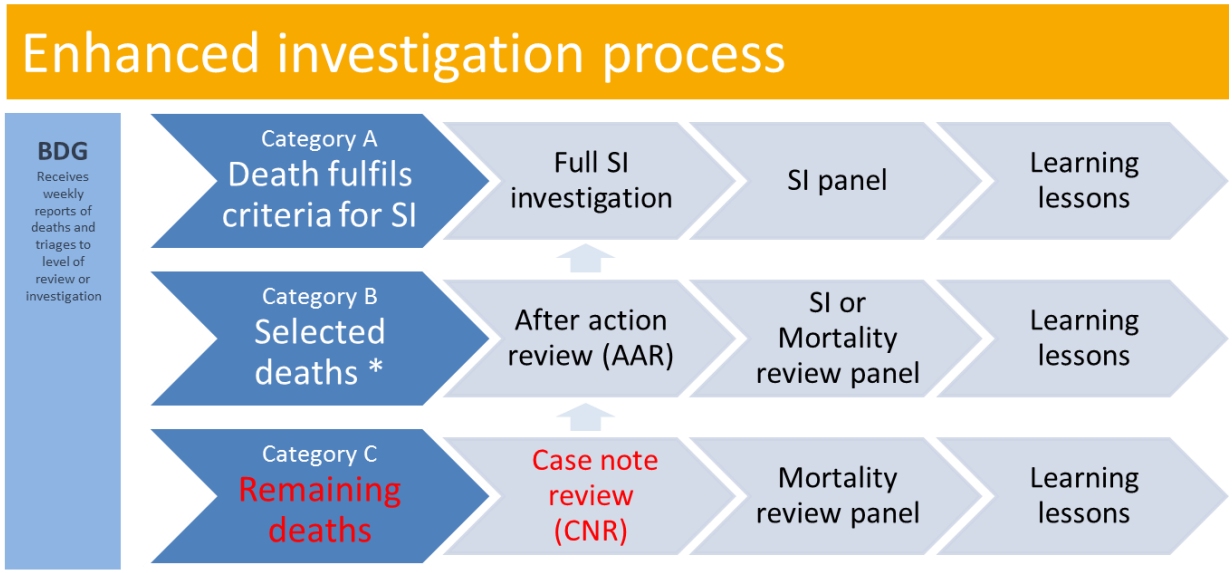
3. Case note review

The letter from NHS Improvement advises that the Structured Judgement Review methodology be used to review deaths, though this is in the context of in-patient deaths. The Safety Team have reviewed this tool and it is not felt to be useful in a mental health setting. It has been designed to review deaths in acute in-patient medical care and therefore is not appropriate for deaths in the community where the vast majority of NTW deaths occur. The letter acknowledges that mental health Trusts will need to adapt guidance to reflect patient and clinical circumstances, and that further guidance will be forthcoming, in advance of the April implementation date, at the time of writing this report, the guidance for mental health is not available.

It would be possible for deaths not fulfilling the criteria for a full serious incident investigation or proposed mortality review to be subject to a modified process of brief case note review though this would have implications for clinical (mainly

medical) staff asked to undertake these reviews. Such case reviews would be further reviewed as above to identify themes and lessons.

The Safety Team is currently in discussion with the North East Quality Observatory (NEQOS) and the developers of a software package called Clarity which is used by several acute care Trusts to collect case note reviews. This is an Academic Health Sciences Network (AHSN) funded project. It seems very likely that NTW could join this programme which has the advantage of ensuring that NTW service users who die in acute care are identified, reviews are undertaken jointly and lessons are shared. There is potential information sharing agreement issues to be overcome.



*Selected deaths include deaths which fulfil one or more of the following criteria (but not criteria for SI):

- In-patient death (including deaths in other hospitals or care homes while an in-patient)
- Deaths within three months of discharge from an NTW in-patient unit
- Deaths of people detained under the mental health act (but not DOLS)
- Death of a service user accessing specialist learning disability services
- Premature death
- (Deaths from a specified cause (e.g. diabetes, epilepsy – based on ONS list)
- Other deaths as agreed by BDG

4. Identification of themes and lessons.

The reports from these mortality reviews will be furthered reviewed by a Trust wide panel fulfilling the role of a Mortality Review Group. It is proposed that this role be subsumed within the current weekly serious incident panel, with specific time identified within the weekly agenda for such review and discussion.

The reasons for proposing this integrated approach are as follows:-

- The constitution of the current serious incident panel is also appropriate to review deaths arising from natural causes as it includes a pharmacist, doctors, nurses and representatives from the Safety Team. It also includes commissioners from the CCGs. While it would be advantageous to increase medical representation this is equally applicable to reviewing all serious incidents.

- The meetings are already scheduled and well established in the weekly timetable. Setting up additional meetings to review mortality reviews could create difficulties in identifying rooms and ensuring good attendance.

- The lessons to be learnt from natural cause deaths may well be applicable to those dying from unnatural causes, and *vice versa*. Having all deaths reviewed by the same panel will ensure that identification of themes and learning from deaths is comprehensive.

- It is envisaged that mortality reviews will be examined as a table top exercise and attendance by the clinical teams will not be routinely required. Therefore, each review should be shorter than one subject to a full serous incident review.

- This process would facilitate managing variation in numbers of each type of review and be more time effective that holding two different types of meeting.

  There is capacity within the current serious incident panel timetable to accommodate mortality reviews. This process will be trialled for six months to assess the impact on the time table for serious incident reviews (which are subject to a 60 working day target).

5. Annual statistical analysis

The open Board of Directors meeting has received a bi-annual analysis of deaths for several years which identify trends and provide a comparison with other published data such as the National Confidential Inquiry. While this has focussed on un-natural deaths in the past, it is proposed that there is an increased focus on all deaths, including natural deaths in future publications.

6. Publication

NHS Improvement indicate that Trusts must publish specific information on deaths on a quarterly basis, and suggest that a paper to the public Board meeting would be an appropriate way to achieve this.

It is therefore proposed that the new quarterly Safer Care report include a section on deaths and provide a composite view of all deaths, regardless of whether they have been investigated as a full serious incident or as a mortality review. It is anticipated that this report will be seen at CDT-Q prior to the Board.

The proposed schedule for receipt at Board is in July (Q1 data); October (Q2 data); January (Q3 data); and April (Q4 data). While the letter advises that first publication should be in June, this does not allow for collection of the first full quarter's data

In addition, the Trust must include a summary of the data and an assessment of the impact of actions taken in the annual Quality Account from June 2018.

With this in mind, there is a requirement to update the Board of Directors current Safety Reporting cycle which has been in place for the last year.

The following table gives a breakdown of the future Board of Directors – Safety Reporting Cycle to capture the current and future NHS Improvement / Care Quality Commission reporting requirements, whilst also creating and developing the current learning reports that have been produced and shared both internal and external to the organisation.

Following changes to the Board of Directors – sub committees in 2016 there was a need to review how incident and complaint information, flowed through the organisation from the clinical and operational teams, through the Quality and Performance committee and to the Board of Directors, before sharing with our Commissioners as part of our contractual obligations.

The Executive Director of Nursing and Operations and Executive Director of Commissioning and Quality Assurance and Deputy Director, with members of the Safety Team have met and agreed a new reporting structure to comply with all the required contractual and governance requirements , and the new reporting structure will commence on the 1st of April 2017.

The following information gives the detail of the reporting structure.

For the purpose of this report as the Trust is in transition from old reporting to new reporting this report is deemed as the forward plan that will be shared with the Board of Directors in March of each year, following a reflection of what has been reported and any further changes that have been required throughout the year.

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Internal													
	CDT	x	x	x	x	x	x	x	x	x	x	x	x
	CDT-Q	x	x	x	x	x	x	x	x	x	x	x	x
	Q&P		x		x		x		x		x		x
	Board	x	x	x	x		x	x	x		x	x	x
		Safer Care Quarterly Report	Annual Security Management	Positive & Safe Annual Update	Safer Care Quarterly Report		Mortality Report	Safer Care Quarterly Report	NHS Protect staff assaults		Safer Care Quarterly Report	Annual Lone working	Forward Plan
External													
	Monthly contract info	x	x	x	x	x	x	x	x	x	x	x	x
	CQC monitoring report	x	x	x	x	x	x	x	x	x	x	x	x
	QRG		x			x			x			x	
			Safer Care Quarterly Report			Annual Security Management			Mortality Report			NHS Protect staff assaults	
			Annual Lone working			Positive & Safe Annual Update			Safer Care Quarterly Report			Safer Care Quarterly Report	
			Forward Plan			Safer Care Quarterly Report							
	Quality Account	x	x										

Date:
22 February 2017

To:
Medical directors of acute, mental health and community foundation trusts and NHS trusts

Dear colleagues,

Learning from Deaths

In December last year, the Care Quality Commission published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England*. In response, the Secretary of State accepted the reports' recommendations and made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die.

This letter gives an initial indication of what these commitments mean for Trusts and Foundation Trusts, including new requirements that will come into effect from April this year. It is a reminder that in some areas, providers will need to make preparations now to be ready to fulfil their new responsibilities from April.

Fundamental to the commitments are strengthened governance and capability, increased transparency through improved data collection and reporting, and better engagement with families and carers. This letter covers each of these and concludes with next steps and further tools that will be available to support implementation by NHS Trusts and Foundation Trusts. A non-executive director along with an executive director responsible for mortality have been invited to a national *Learning from Deaths* conference on 21 March to discuss this agenda and to input into further development of guidance and associated tools.

Learning from the care provided to patients who die is, of course, a key part of clinical governance and quality improvement work. These new requirements are designed to complement your existing approaches, introducing minimum standards and reporting in some areas but not seeking to replace current good practice.

These new requirements are part of a broader programme of initiatives on learning from the care provided to patients who die that flows from the Secretary of State's commitments. This programme will be rolled out over the coming year, and will include new guidance, training and processes, the most immediate of which are covered in the last section of this letter.

Governance and capability

To fulfil these new expectations Trusts will need to adapt **governance arrangements and processes** to accommodate the review and reporting of deaths,

including those that are assessed as having been more likely than not to have been caused by problems in care, as well as sharing and acting upon the learning derived from this process.

An important early step is for each Trust or Foundation Trust to identify an **executive director** to take responsibility for this agenda and a **non-executive director** to be responsible for oversight of progress. Executive directors responsible for leading on mortality and non-executive directors responsible for quality oversight are likely to be well-placed to take on these responsibilities.

Providers should also review **skills and training** required to support this agenda. For example, this should include ensuring that staff reporting deaths have appropriate skills through specialist training to review and investigate deaths associated with problems in care. The Royal College of Physicians has been commissioned to provide training in case record review skills to all acute NHS providers and more information on this will be provided in due course.

The Care Quality Commission's report stressed the importance of **how providers engage with bereaved families and carers**, including enabling more effective learning from the care provided to their loved ones. Further guidance on this is being developed. In the meantime, Trusts and Foundation Trusts should ensure that they have appropriate engagement processes in place so that families and carers receive candid, sensitive and timely communications in the event of a family member's death, and are invited to express any concerns about the care their loved one received.

Improved data collection and reporting

From April, NHS Trusts and Foundation Trusts must **collect and 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 should cover the total number of the provider's in-patient deaths, the subset of these that the provider has subjected to case review and, following application of the Structured Judgement Review methodology, estimates of how many deaths were thought more likely than not to have been related to problems in care.
- A full version of the Structured Judgement Review methodology under development by the Royal College of Physicians will be provided to you as part of more detailed guidance, for imminent publication. This will be accompanied by a suggested dashboard.
- The data in the dashboard should be collected and published on a quarterly basis together with relevant qualitative information, interpretation of the data, and what learning and related actions your organisation has derived from it.
- This data should be collected from April for an initial quarterly publication in June. Our suggested best practice in publication would be a paper and an agenda item to a public Board meeting in each quarter.