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Nottinghamshire Healthcare NHS
NHS Foundation Trust

**BOARD OF DIRECTORS**

**January 2016**

**Independent Review of Deaths at Southern Health NHS Foundation Trust**

## Introduction

An independent review of deaths of people with a learning disability or mental health problems in contact with Southern Health NHS Foundation Trust (SHFT) was published on 17th December. The investigation was triggered following a preventable death of a service user with learning disabilities and consisted of a review of deaths between April 2011 and March 2015. It did not include a case review of all deaths to identify whether they were clinically avoidable but did seek to establish the extent of unexpected deaths and identify themes, patterns or issues. The report also focussed on the responsibilities of the trust to report deaths and ensure the right level of review, enquiry or investigation was carried out.

SHFT provides mental health, learning disability, community and social care services to 250,000 patients each year. These are sub-divided into:

- Physical health and older people's mental health community services
- Adult mental health and specialised secure services
- Health visitors and district nursing
- Specialist support to adults with learning disabilities
- Social care services (learning disability, mental health, older people – there are 650 services uses of whom 400 are cared for full time)

This report to the Board of Directors provides an overview of the findings from the Southern Health report, an overview of deaths of our service users, proposals for further review and Trust arrangements for monitoring deaths of service users.

## Overview of Findings from the Southern Health Report

Key findings from the report include:

- Lack of leadership, focus and sufficient time reporting and investigating unexpected deaths of learning disability and mental health service users
- Inadequate response by the board regarding concerns raised, including from Coroners on the quality of reporting processes and investigations
- No effective systematic management and oversight of the reporting of deaths and investigations and issues with timeliness
- Could not demonstrate a comprehensive, systematic approach to learning from deaths and resultant service change
- Despite comprehensive data on deaths being available it was not used effectively to understand mortality

The report made 23 recommendations for the trust relating to:

| Recommendation Theme | Number of Recommendations |
|---|---|
| • Board leadership and oversight | 4 |
| • Monitoring mortality and unexpected deaths/ attrition | 2 |
| • Thematic reviews | 7 |
| • Reporting and identifying deaths | 1 |
| • Quality of investigation reporting | 1 |
| • Timeliness of investigations | 2 |
| • Involvement of families | 1 |
| • Multi-agency working | 1 |
| • Deaths in detention and in-patient deaths | 2 |
| • Information management | 2 |

A detailed review of these recommendations, the Trusts current position and identification of any areas for improvement will be carried out and reported to the Board of Directors in February. **Action**

In addition the report makes 9 recommendations for commissioners and 7 national recommendations.

## Overview of Analysis of Information on Deaths at Southern Health

Southern Health use RiO as a clinical information system for mental health and learning disability services and Ulysses as their risk management system; the same systems used by this Trust. The Mazar's investigation focussed on the analysis of deaths reported on Ulysses from April 2011 to March 2015. The investigation considered:

- How many deaths were reported on Ulysses
- How many deaths had been classified as unexpected
- How many deaths were reviewed or investigated

The NHS England's Serious Incident Reporting Framework provides a definition of a Serious Incident Requiring Investigation (SIRI). These are the incidents that are reportable through the STEIS system to commissioners and classed as a Serious Incident (SI). All these incidents are investigated and the reports submitted to commissioners. In addition to this, Southern Health have an additional category of Critical Incident Review, for incidents they don't regard as meeting the definition of a SIRI but warrant further investigation. This Trust does not have a similar level of investigation, however all incidents reported on Ulysses are reviewed by a manager.

## Trust Response to the Mazar's Report

The Mazar's review identified that:

- 14% of deaths recorded on clinical information systems such as RiO were reported as an incident on Ulysses
- 50% of deaths reported on Ulysses were categorised as unexpected
- 13% were identified as meeting the requirements of a SIRI, reported on STEIS and fully investigated
- A further 28% of deaths were subject to a Clinical Incident Review.
- 0.6% were recorded as 'degree of harm 5'

The Trust intends to replicate the methodology used by the independent review team using information on RiO, SystmOne, PC-MIS, Ulysses and STEIS. This will identify how many deaths of patients/ service users there have been, how many of these were reported as incidents (internally and externally to commissioners), how many were considered unexpected and how many were subject to an investigation. This process has commenced and early findings have identified that for the same reporting period:

- 43% of deaths reported on RiO (in 2014/15 only) were reported on Ulysses
- 15% are reported on Ulysses as an unexpected death. It should be noted that 78% of our deaths relate to MHSOP as opposed to 57% at SHFT and the majority of our MHSOP deaths are not classified as unexpected
- 12% were identified as meeting the requirements of a SIRI, reported on STEIS and fully investigated
- 16% of deaths were recorded as 'degree of harm 5'

A more detailed review of Trust data will be undertaken and reported in February. This will also consider the concern raised in the Mazar's report relating to the low number of deaths investigated in older people & learning disability services. It should however be noted that SHFT also provide social care to these groups and therefore there the data will not be directly comparable. **Action**

## Assurance on Trust Processes for Reviewing Deaths and Managing Incidents

The Trust has well established systems for reporting and investigating incidents including deaths. This includes each division having an Incident Review Creating a Learning Environment (CIRCLE) Group whose duties include: reviewing serious incidents, ensuring appropriate investigations are carried out, identifying learning to reduce recurrence and monitoring the implementation of action plans.

The CQC inspection report from April 2014 stated that 'the trust had good systems in place to report, record and learn from incidents and ensured that this was embedded in practice at all levels across the three divisions. Staff used past incidents as a means of learning to ensure the safety of people using services. This learning was shared with all staff'. Furthermore, no particular concerns have been raised by commissioners or the Coroner regarding the quality of investigation reports.

## Establishment of Trust CIRCLE Group

It was recognised that whilst the Trust has good systems for reporting and learning from incidents, improvements can be made. Therefore this is an enabling workstream of the Sign up to Safety Campaign to support the ambition to reduce harm by 50% in six core areas: medication errors, falls, pressure ulcers, assaults, suicide and self-harm and restrictive practice.

A review of how each Division's CIRCLE operates and how the Trust identifies learning and ensures effective cross-organisational improvements are implemented effectively was undertaken at a CIRCLE workshop on 29th October. It was identified that the Patient Safety Committee does not have the capacity to undertake these requirements fully, analyse all information relating to incidents and triangulate this with other sources of quantitative or qualitative information. In addition, it was also recognised that the Trust did not have a forum to specifically review mortality.

To address this, a Trust CIRCLE Group has been established, which met for the first time on 16th December. This will meet at least quarterly and will report to the Patient Safety Committee. This Group will have five main functions:

- Reporting and learning from incidents
- Mortality surveillance and production of a biannual mortality report to the Board
- Oversight of very serious incidents
- Oversight of relevant information systems, data quality and national returns
- Receive assurance from division CIRCLE's and escalation of concerns to the Patient Safety Committee, Quality and Risk Committee and Board of Directors.

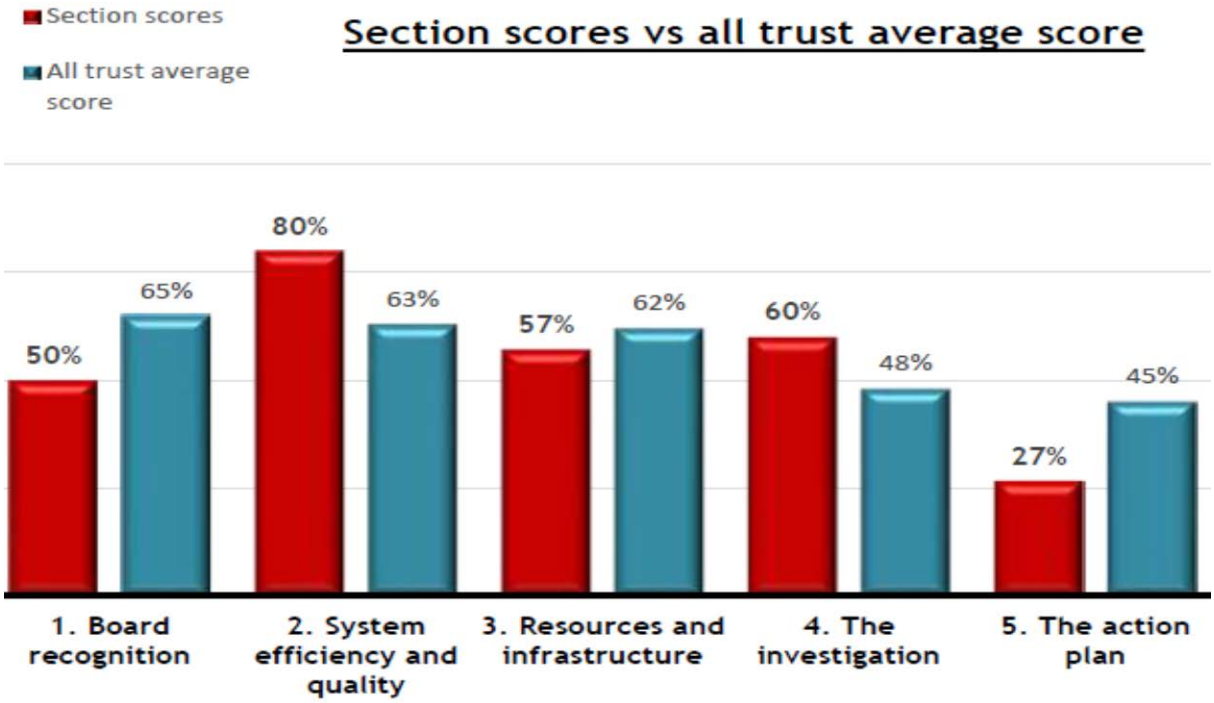
## Independent Learning Lessons Diagnostic Assessment

The Trust commissioned Verita, an organisation that specialises in conducting and managing independent investigations who also provide our incident investigation training to undertake a learning lessons diagnostic assessment. The assessment focussed on Adult Mental Health. They have developed a toolkit to assess trust processes against national best practice and focus on five areas with a score given for each:

1. Board recognition – What information do the board and executives see
2. Resources and infrastructure – Resourcing to put new improvements in place and engagement with clinical divisions and clinicians
3. System efficiency and quality – How are serious incidents triaged/allocated, timeliness, quality of the investigation reports and action plans?
4. The investigation - Terms of reference, clear chronologies, evidence benchmarked, identifying the issues that caused or contributed to the incident, involvement of patients and families

5. The action plan – Are recommendations SMART and does the action plan address all the point, systems to encourage systematic learning from serious incidents, analysis of trends analysed and translation into changes in practice

The draft report has been received. Overall the Trust scored 55% against the average score of 57% of all trusts Verita have reviewed. The graph below demonstrates how the Trust compares to other trusts in each of the five categories.




The report makes a number of recommendations where the Trust can make improvements and the final report will be considered by the Trust CIRCLE in February. **Action**

## Human Factors Analysis and Classification System

Through the East Midlands Patient Safety Collaborative the Trust is participating in a project with three other providers of mental health services in the East Midlands.
The aim of this work is to refine, test and evaluate the Human Factors Analysis and Classification System (HFACS) for use in mental health and community services.

Following development and validation of the new HFACS framework, the external human factors experts will code between 30-40 serious incident reports from the Trust, carry out an analysis of the findings, developing a profile of findings for each individual Trust and also identifying common features across the Trusts. They will then draft an individual report for each Trust which should be received in May.
The project also includes training for HFACS champions in each trust. Following the completion and evaluation of the project the Trust will then consider the next steps.

## Emerging Framework for Classifying Deaths and Levels of Investigation

Potential data quality issues relating to information on Ulysses, in particular classification of the degree of harm has been discussed in various Trust forums. Furthermore, the initial review of Trust data has identified that the current categories for recording deaths on Ulysses are not sensitive enough to clearly distinguish unexpected deaths from expected. The Mazar's report outlines an emerging framework for classifying deaths with 6 categories relating to unexpected versus expected deaths and natural versus unnatural. The report then provides a framework for determining the level of investigation based upon the death type. An initial examination of this framework shows that implementation would be helpful in ensuring greater consistency in deciding whether or not to investigate a death and would also improve data quality relating to the reporting of deaths. This framework will be considered by the Trust CIRCLE. **Action**

In addition, the Trust has a Ulysses Oversight Group which is in the process of reviewing the governance arrangements of the Ulysses system and processes for assurance of the quality of the data. Due to the large number of incidents reported this is challenging and therefore the focus for 2016/17 will be on deaths to ensure information received by Trust CIRCLE is accurate. **Action**

## NHS England Data Request

On 17th December, following the publication of the Mazar's report NHS England requested a self-assessment on avoidable mortality from all NHS trusts which is due to be submitted by 31st January. This includes information on the number of deaths, how many have been reviewed, how many have been reported on STEIS, how many reported to the National Reporting and Learning System and how many were potentially preventable. A tool has been provided for this and this data will also be used to inform the report to the Board of Directors in February.

## Recommendations

The Board is asked to:

- Note the findings of the Mazar's review and the early findings from the review of Trust data
- Support the proposed response to the independent review of Southern Health
- Note the assurances previously received and the ongoing improvements currently being implemented
- Consider whether the Board requires a full report on the outcome of the review of Trust practice against the recommendations of the Mazar's report and analysis of the Trust's mortality information, or whether a highlight report is required in February with full details submitted to the Quality Committee.

**Julie Hankin**
**Executive Medical Director**
**January 2016**