Board of Directors - February 2016

Independent Review of Deaths at Southern Health NHS Foundation Trust and Trust Mortality Information

1. Introduction

A paper was presented to the Board of Directors in January outlining the findings of the Mazar's Independent Review of Deaths at Southern Health NHS Foundation Trust published in December 2015, the Trust's initial response and actions required.

The paper also outlined the Trust's current processes for reviewing deaths and managing incidents. This included the role of each division's Critical Incident Review Creating a Learning Environment (CIRCLE) Group and the establishment of a Trustwide CIRCLE which will also act as the Trusts Mortality Surveillance Group.

This report provides an update on progress with those actions, a more detailed analysis of deaths of patients and service users, the outcome of the NHS England data request submitted on 28th January and further improvements identified.

2. Overview of Findings from the Southern Health Report & Implications for the Trust

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

An action was agreed in January to undertake a detailed review of the 23 recommendations made for SHFT to identify the Trusts current position and identification of any areas for improvement. This has been undertaken and the outcome reported to the Trust CIRCLE on 18th February for consideration. Key issues for the Trust that require action are:

- Improve Board and Quality Committee oversight of deaths
- Implement an improved framework for reporting, classifying and investigating deaths - see section 5 below
- Agree standardised content of reports from the three division CIRCLEs to Trust CIRCLE to ensure consistency
- Agree standardised content for a mortality dashboard for the Quality Committee and Board of Directors

- Following completion of the human factors project with the East Midlands Patient Safety Collaborative, review incident investigation processes and undertake regular thematic reviews
- Undertake an analysis of deaths, particularly community natural cause deaths to identify any trends and any further review required. This will include Mental Health Services for Older People and Learning Disabilities.
- Develop clear data recording and extraction methodologies for deaths on clinical information systems such as RiO, PC-MIS and SystmOne. See section 4 below.

The specific actions the Trust will need to take will be incorporated into a Quality Improvement Plan which will be presented to the Quality Committee in March.

3. Trust Response to the Mazar's Report

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 had been reviewed or investigated
- How many deaths had been reported on STEIS as a Serious Incident Requiring Investigation (SIRI) in accordance with NHS England's Serious Incident Framework.
- How many deaths had been reported to the National Reporting and Learning System (NRLS) as a 'degree of harm 5', i.e. death was attributable to the patient safety incident.

It should be noted that SHFT have created 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.

An action was agreed in January to undertake a more detailed review of Trust data. The tables below using Trust data from Ulysses provides information on deaths recorded on Ulysses for the Local and Forensic Services Divisions, including directorates from April 2011 to March 2015. Data for Health Partnerships is shown for the whole division. This includes:

- The number of deaths recorded on Ulysses
- The number categorised as 'unexpected' which includes suspected suicide
- The number reported on STEIS as a SIRI
- The number categorised as 'degree of harm 5'

TRUST	2011-12	2012-13	2013-14	2014-15	TOTAL
Total Number of Deaths	533	691	533	629	**2383**
Number of Unexpected Deaths	77	74	85	132	**366**
Number of Deaths regarded as a SIRI	66	65	72	87	**290**
Number of Deaths Degree of Harm 5	203	41	49	75	**368**

LOCAL SERVICES	2011-12	2012-13	2013-14	2014-15	TOTAL
Total Number of Deaths	517	672	502	578	**2269**
Number of Unexpected Deaths	66	65	68	102	**301**
Number of Deaths regarded as a SIRI	50	54	54	61	**219**
Number of Deaths Degree of Harm 5	191	35	41	63	**330**
AMH					
Total Number of Deaths	57	54	55	73	**239**
Number of Unexpected Deaths	36	33	34	56	**159**
Number of Deaths regarded as a SIRI	34	29	32	45	**140**
Number of Deaths Degree of Harm 5	33	22	27	40	**122**
MHSOP					
Total Number of Deaths	424	574	405	466	**1869**
Number of Unexpected Deaths	11	13	15	23	**62**
Number of Deaths regarded as a SIRI	6	9	8	8	**31**
Number of Deaths Degree of Harm 5	138	6	7	7	**158**
SSD - Total (see breakdown of services below)					
Total Number of Deaths	36	44	42	38	**160**
Number of Unexpected Deaths	19	19	19	23	**80**
Number of Deaths regarded as a SIRI	10	16	14	8	**48**
Number of Deaths Degree of Harm 5	20	13	7	16	**56**
SMS					
Total Number of Deaths	35	31	36	30	**132**
Number of Unexpected Deaths	19	10	17	15	**61**
Number of Deaths regarded as a SIRI	10	9	12	5	**36**
Number of Deaths Degree of Harm 5	20	5	6	11	**42**
IDD					
Total Number of Deaths	1	2		1	**4**
Number of Unexpected Deaths				1	**1**
Number of Deaths regarded as a SIRI		1			**1**
Number of Deaths Degree of Harm 5	0	0		0	**0**
CAMHS/Looked After Children					
Total Number of Deaths		1		1	**2**
Number of Unexpected Deaths		1		1	**2**
Number of Deaths regarded as a SIRI		1		1	**2**
Number of Deaths Degree of Harm 5		1		1	**2**
IAPT/ PT					
Total Number of Deaths		10	5	6	**21**
Number of Unexpected Deaths		6	3	5	**14**
Number of Deaths regarded as a SIRI		5	2	2	**9**
Number of Deaths Degree of Harm 5		7	1	4	**12**

The decrease in the number of deaths recorded on Ulysses as 'degree of harm 5' can be explained by a change in policy. Natural cause deaths from 2012/13 have been reported as 'degree of harm 1', i.e. no harm.

HEALTH PARTNERSHIPS	2011-12	2012-13	2013-14	2014-15	TOTAL
Total Number of Deaths	0	5	11	24	**40**
Number of Unexpected Deaths	0	2	6	13	**21**
Number of Deaths regarded as a SIRI					**0**
Number of Deaths Degree of Harm 5					**0**

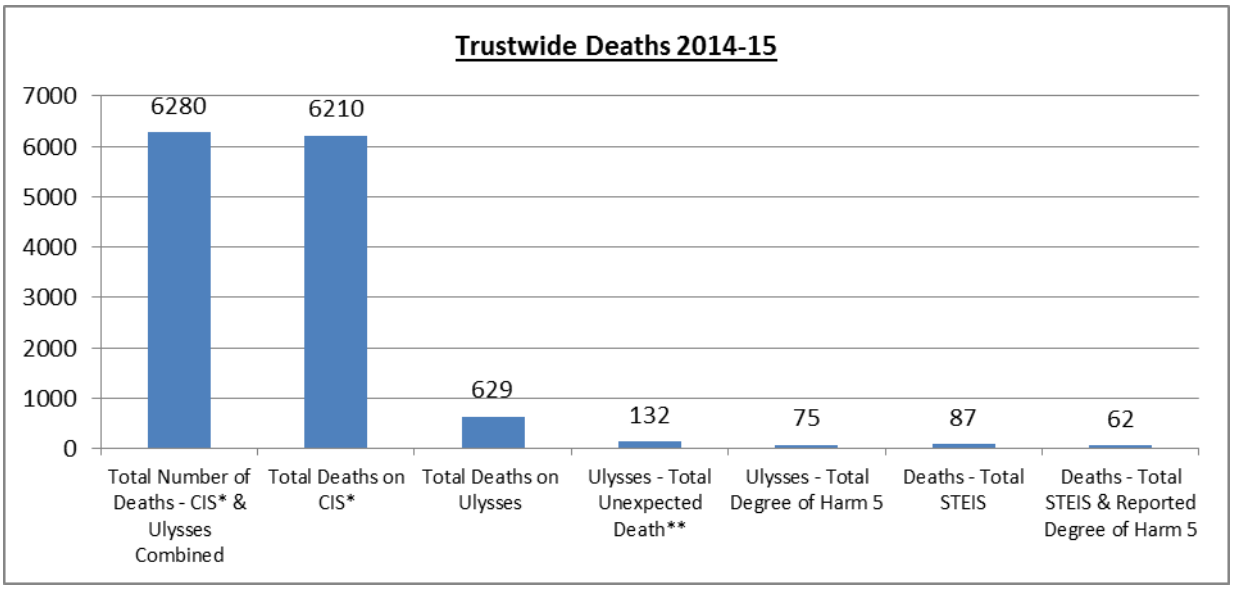
Health Partnerships data is not available for 2011/12. Incidents at this time were reported on a separate system.

FORENSIC SERVICES - Excluding Offender Health	2011-12	2012-13	2013-14	2014-15	TOTAL
Total Number of Deaths	1	5	4	2	**12**
Number of Unexpected Deaths	1	4	1	2	**8**
Number of Deaths regarded as a SIRI	1	5	4	2	**12**
Number of Deaths Degree of Harm 5	1	3	1	1	**6**
Rampton Mental Health					
Total Number of Deaths		1	1		**2**
Number of Unexpected Deaths					**0**
Number of Deaths regarded as a SIRI		1	1		**2**
Number of Deaths Degree of Harm 5		0	0		**0**
Rampton Women's					
Total Number of Deaths		2	2		**4**
Number of Unexpected Deaths		2			**2**
Number of Deaths regarded as a SIRI		2	2		**4**
Number of Deaths Degree of Harm 5		2	0		**2**
Community/Low Secure					
Total Number of Deaths	1	1	1	1	**4**
Number of Unexpected Deaths	1	1	1	1	**4**
Number of Deaths regarded as a SIRI	1	1	1	1	**4**
Number of Deaths Degree of Harm 5	1	0	1	0	**2**
Medium Secure					
Total Number of Deaths		1		1	**2**
Number of Unexpected Deaths		1		1	**2**
Number of Deaths regarded as a SIRI		1		1	**2**
Number of Deaths Degree of Harm 5		1		1	**2**

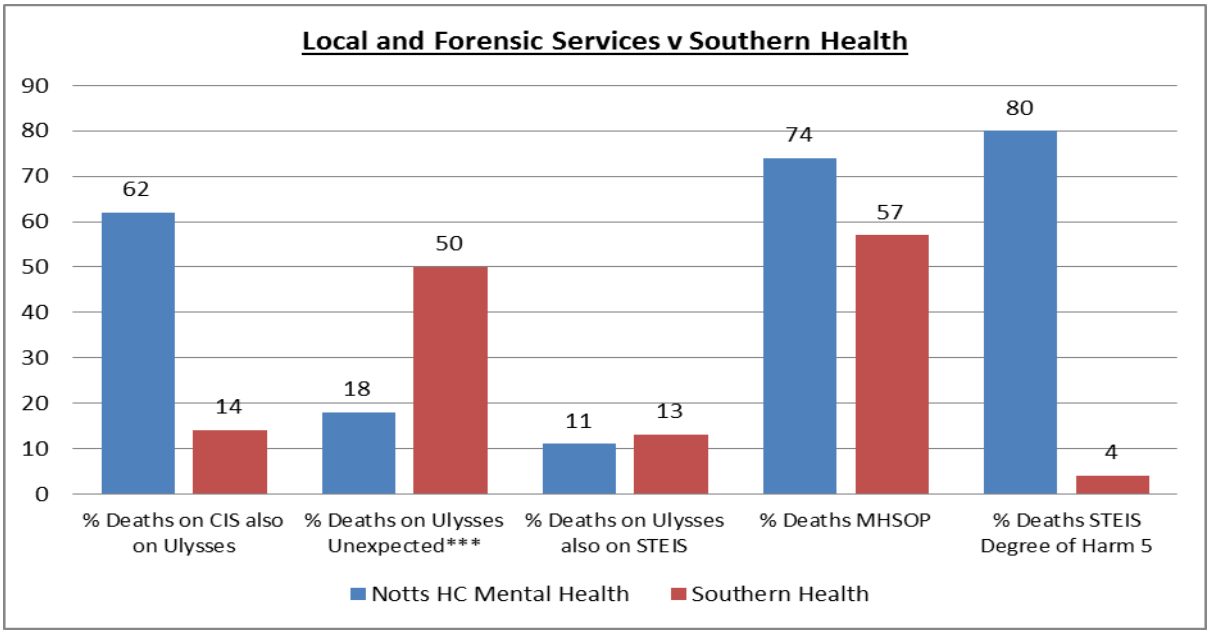
FORENSIC SERVICES - Offender Health	2011-12	2012-13	2013-14	2014-15	TOTAL
Total Number of Deaths	15	9	16	25	**65**
Number of Unexpected Deaths	10	3	10	15	**38**
Number of Deaths regarded as a SIRI	15	6	14	24	**59**
Number of Deaths Degree of Harm 5	11	3	7	11	**32**
HMP Doncaster					
Total Number of Deaths	3	1	1	4	**9**
Number of Unexpected Deaths	2			2	**4**
Number of Deaths regarded as a SIRI	3			4	**7**
HMP Hatfield					
Total Number of Deaths	1			1	**2**
Number of Unexpected Deaths	1			1	**2**
Number of Deaths regarded as a SIRI	1			1	**2**
HMP Lincoln					
Total Number of Deaths				2	**2**
Number of Unexpected Deaths				2	**2**
Number of Deaths regarded as a SIRI				2	**2**
HMP Lindholme					
Total Number of Deaths	1	1		1	**3**
Number of Unexpected Deaths	1	1		1	**3**
Number of Deaths regarded as a SIRI	1			1	**2**
HMP Moorland					
Total Number of Deaths			3	2	**5**
Number of Unexpected Deaths			1		**1**
Number of Deaths regarded as a SIRI			3	2	**5**
HMP New Hall					
Total Number of Deaths	1				**1**
Number of Unexpected Deaths	1				**1**
Number of Deaths regarded as a SIRI	1				**1**
HMP Nottingham					
Total Number of Deaths	3	1	5	3	**12**
Number of Unexpected Deaths	2		5	3	**10**
Number of Deaths regarded as a SIRI	3		5	3	**11**
HMP Ranby					
Total Number of Deaths			4	3	**7**
Number of Unexpected Deaths			4	3	**7**
Number of Deaths regarded as a SIRI			4	3	**7**
HMP Stocken					
Total Number of Deaths	2	1		1	**4**
Number of Unexpected Deaths	2	1		1	**4**
Number of Deaths regarded as a SIRI	2	1		1	**4**
HMP Wakefield					
Total Number of Deaths			1	1	**2**
Number of Unexpected Deaths				1	**1**
Number of Deaths regarded as a SIRI					
HMP Whatton					
Total Number of Deaths	4	5	2	7	**18**
Number of Unexpected Deaths	1	1		1	**3**
Number of Deaths regarded as a SIRI	4	5	2	7	**18**

Mazar's review of Southern Health data included a review of how many deaths were recorded on their clinical information system, e.g. RiO and how many of these were reported as an incident on Ulysses. They did not undertake any review of those not reported as an incident to determine whether they should have been. The table and graph below provide further information on Trust data for 2014/15 only. An analysis of 2015/16 data is currently on-going and will be reported to Trust CIRCLE in May.

2014/15	Local Services	Forensic Services	Offender Health	Health Partnerships	Trustwide
Total Number of Deaths - CIS* & Ulysses Combined	971	3	30	5276	6280
Total Deaths on CIS*	918	3	16	5273	6210
Total Deaths on Ulysses	578	2	25	24	629
Ulysses - Total Unexpected Death**	102	2	15	13	132
Ulysses - Total Degree of Harm 5	63	1	11	0	75
Deaths - Total STEIS	61	2	24	0	87
Deaths - Total STEIS & Reported Degree of Harm 5	50	1	11	0	62
*Clinical Information System (CIS) = RiO, PC-MIS, SysmOne					
**Ulysses - Unexpected Death includes Suspected Suicide but excludes natual causes					



The chart below using percentages compares Southern Health data from April 2011 to March 2015, whereas Trust data is 2014/15 only. The large number of deaths of patients in the wider community recorded on SystmOne who have been in contact with our services through Health Partnerships is not comparable with Mazar's findings at Southern Health and is therefore excluded, as is Offender Health. Although this is not a direct comparison is more accurate.



***It is unclear what definition Southern Health use for unexpected deaths

This shows that the Trust has reported significantly more deaths as an incident but proportionally less have been classified as unexpected. We report more deaths of service users from Mental Health Services for Older People (MHSOP), the majority of which are not considered to be unexpected. 80% of deaths of our service users that are reported on STEIS are also categorised 'degree of harm 5' compared to only 4% at SHFT.

MHSOP and Learning Disability Deaths

A concern raised in the Mazar's report related 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 is not directly comparable.

MHSOP - Our data does show that the majority of MHSOP deaths are reported as natural causes, have not met the threshold for reporting as a serious incident and have therefore not been investigated. In 2014/15 there were 742 deaths of MHSOP patients recorded on RiO, of which 466 were reported as an incident, 23 reported as unexpected and 8 reported as a SIRI.

Learning Disability - Four deaths of services users with a learning disability have been reported during the four years examined. Three were reported as natural causes and one as a cardiac arrest. These are being reviewed to ensure the initial review was appropriate and early indications are they were. There were however 36 deaths of patients with a learning disability recorded on RiO for 2014/15 and these will also be reviewed.

4. NHS England Information 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 was submitted on 29th January. The returns used 2014/15 data combining the number of deaths on clinical information systems with Ulysses. Information requested is outlined below with actions the Trust needs to take to respond to some issues that were identified and will be considered by the Trust CIRCLE on 18th February.

- *Number of Deaths?* – see section 3 above (Offender Health were excluded). This identified some issues with the accuracy of dates of deaths reported on clinical information systems which will be addressed. In particular for Health Partnerships, there is a complexity where multiple providers access SystmOne, e.g. GPs and it is not accurately known how many patients died when in actual receipt of Trust services.

- *How many potentially preventable deaths did Trust mortality review processes identify & how many deaths reported on STEIS were potentially preventable?*
  A retrospective review of investigation reports was undertaken and 9 out of 63 were considered to have been preventable. The question of preventability needs to be considered at the conclusion of each investigation in the future.

- *What percentage of deaths were reviewed using local mortality review processes?*
  All in-patient and mental health community patient deaths that met the threshold for reporting as a SIRI were reviewed.

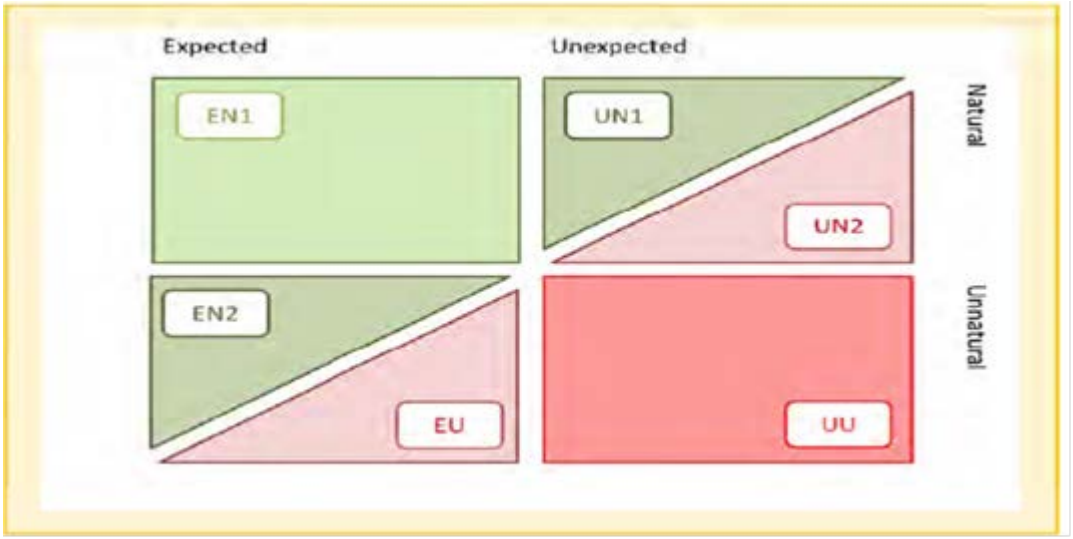
  The percentage of all deaths of mental health community patients and those who died following discharge that were not considered to be reportable as a SIRI was 5% No patient deaths in Health Partnerships were considered to be a SIRI and no deaths were reviewed. Implementation of a new framework for reporting and investigating deaths as define in section 5 below will provide clarity on this.

- *How many were reported to the National Reporting and Learning System that were classified as 'potentially preventable'?*
  This is the number recorded as 'degree of harm 5' on Ulysses. See section 3 above.

5. 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 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. If these proposals are accepted, categories on Ulysses will require amendment.



Type	Description
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and in some cases would benefit from further investigation
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.
Unexpected Natural (UN1	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke These deaths should be reviewed and some may need an investigation.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect These deaths are likely to need investigating

6. Future Board Reporting and Oversight of Deaths of Service Users

Trust CIRCLE will receive and review detailed mortality information and also receive reports from the division CIRCLEs quarterly with the outcomes of investigations following deaths. Trust CIRCLE will identify themes and actions required and will report to the Quality Committee quarterly via the Patient Safety Sub-Committee.

The report to the Quality Committee will provide an overview of themes, trends and details of any outliers and action being taken. The Board of Directors will receive a report 6 monthly which will include a focus on learning lessons from serious incidents, complaints and claims and will include patient stories.

In addition, the Mazar's report includes a suggested framework for Boards to use as assurance relating to systems regarding unexpected deaths of its service users. This framework will be used in future reporting and includes: identifying and reporting deaths, investigation, learning and meeting our obligation to others.

7. Recommendations

The Board of Directors is asked to:

- Note the number of deaths reported, how these are categorised and reported
- Note the issues identified and support the proposed actions
- Support the proposals for future reporting outline above
- Support implementation of the Emerging Framework for Classifying Deaths and Levels of Investigation

Dr Julie Hankin
Executive Medical Director
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