SOUTHERN HEALTH NHS FOUNDATION TRUST

Report

Committee:	**Portsmouth Health Overview and Scrutiny Panel**
Date:	**2 February 2015**
Title:	**Update following publication of the Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015**
Presented by:	**Dr Chris Gordon, Chief Operating Officer and Director of Performance, Quality and Safety and Dr Lesley Stevens, Medical Director**

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1. Executive Summary

1.1 This report seeks to update the Portsmouth Health Overview and Scrutiny Panel following the independent review of deaths of people with a learning disability or mental health need in contact with Southern Health NHS Foundation Trust at least once in the previous year, and provide details of measures the Trust is taking to make the improvements needed.

1.2 The report was commissioned by NHS England and carried out by accountancy firm Mazars. It covers a four-year period, from April 2011 to March 2015.

2. Recommendations

2.1 That the Portsmouth Health Overview and Scrutiny Panel notes the report and the comprehensive action plan Southern Health has in place.

3. Update following Independent Review of Deaths of People with a Learning Disability or Mental Health Problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

3.1 The report highlighted that Southern Health's processes for reporting and investigating deaths of people with learning disabilities and mental health needs could have been better. The Trust accepts this and acknowledges that it did not always involve families as much as it could have. The Trust apologises unreservedly. The report did not consider the quality of care provided by the Trust.

3.2 Substantial changes have already been made to the way in which Southern Health records and investigates deaths, including:

- Significantly strengthening executive oversight of the quality of investigations and ensuring appropriate measures are in place to address any issues identified, and that all learning is shared and implemented across the Trust. New executive level doctors and nurses joined the Trust Board from July 2014.

- Setting up a new central investigation team which is improving the quality and consistency of investigations and learning.
- Capturing conclusions of inquests more effectively to identify and act swiftly on areas for improvement.
- Launching a new system for reporting and investigating deaths in consultation with our commissioners to increase monitoring, scrutiny and learning.
- Providing every family with the opportunity to be involved in investigations relating to a death of a loved one.

3.3 Healthcare regulator Monitor has decided to take action against Southern Health, utilising its powers under section 106 of the Health and Social Care Act 2012. Monitor is providing expert support to improve the way the Trust investigates and reports deaths. Southern Health has agreed with Monitor to take a number of steps to show how the Trust is improving. These are:

- Implement the recommendations of the Mazars report through a comprehensive action plan (**attached as Appendix II**)
- Get assurance from independent experts on this action plan
- Work with an Improvement Director appointed by Monitor who will support and challenge the Trust as it makes the necessary changes

3.4 The Care Quality Commission (CQC) carried out a follow-up inspection of Southern Health services in January, focusing on improvements within mental health and learning disability services, in particular acute mental health inpatient wards, learning units for people with learning disabilities, crisis/community mental health teams and child and adolescent inpatient and secure services. The inspection also focussed on focusing on our progress against comprehensive improvement plans we have in place following publication of the review.

3.5 Southern Health fully accepts the need to continue to make changes and will continue to work closely with commissioners and regulators to make the improvements required. The Trust's focus continues to be on ensuring that everyone who relies on services provided by Southern Health receives the best possible care.

Appendix I

Link to the Independent Review into deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015: https://www.england.nhs.uk/south/our-work/ind-invest-reports/

Appendix II

Action Plan for: Mortality and SIRI Improvement

Version No: 4 ***Date:*** 14.01.16

Issue No.	What is the issue to be addressed?	Current Risk/ Priority Low, Med, High	Action/s to be taken	Evidence of the completion of each action	Action Timescale	Action Progress Blue=Complete Green=Begun & On Track Amber= Risk of slippage Red=Overdue
			Number			
1	Ensure that Serious Incident investigation reports adhere to national timescales.	high	1.1 Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation - this will be embedded into the Trust BI System.	1.1 Weekly Flash produced in new format.	1.1 Completed	1.1 Completed
			1.2 Executive team to review the governance 'flash' report every week.	1.2 Weekly Flash is reviewed by TEG every week	1.2 Completed	1.2 Completed
			1.3 Serious Incident Investigation Training to include the National timescale requirement.	1.3 Investigators training includes reporting timescales.	1.3 Completed	1.3 Completed
			1.4 Lead Investigators to be appointed for each Division who will track compliance to timescales and support investigators to achieve this. Job Description to be standardised with a 20% Corporate and 80% Divisional governance focus and an initial priority objective to deliver clearance of any SIRI backlogs which will be evidenced in the Flash report.	1.4 Centralised lead investigation team in post (register of names / divisions to be supplied) and role specification.	1.4 Completed	1.4 Completed

			1.5 Executive support to be sought and agreed to ensure that investigators are given sufficient time to investigate serious incidents as part of their job plans. If improvement trajectories are not being met a divisional review of capacity will take place.	1.5 Monitoring of the percentage improvements in the ability to complete quality investigations within 60 days.	1.5 30.03.16	1.5 On track
			1.6 All incident trackers to form part of the Ulysses Safeguard system rather than stand-alone spreadsheets.	1.6 All investigations to be input on to the Ulysses system as of the 1st January 2016, a dual process will be in place until 1st April 2016 when the trackers will be closed down. This will be monitored by the Ulysses System Analyst.	1.6 31.03.16	1.6 On track
			1.7 Implement the new death reporting process.	1.7 Death / mortality reporting process implemented and compliance to use in practice. These will audited against the Tableau mortality reports.	1.7 31.01.16	1.7 Risk of Slippage Combined Tableau reports with Spine and Ulysses data not available until 03.16
			1.8 Increase compliance to 48hr panel process.	1.8 Monitor compliance to 48 hr panels on a monthly basis aiming to achieve set improvement criteria of 75% by January 2016 and to 95% by February 2016.	1.8 30.06.16	1.8 Compliance being monitored - current trajectory shows risk of slippage
			1.9 All deaths of patients detained under the Mental Health Act to be reported via the Death reporting process and have system 'flag' to ensure that all are investigated as Serious Incidents.	1.9 System generated mortality report and Serious Incident tracking report.	1.9 31.01.16	1.9 Combined Tableau reports with Spine and Ulysses data not available until 03.16
2	Ensure that Serious Incident investigation reports are of the required quality and always identify a clear root cause.	high	2.1 All corporate panels to be chaired by an Executive director.	2.1 There is an Executive chair to each serious incident panel to provide scrutiny and oversight evidenced by minutes.	2.1 Completed	2.1 Completed
			2.2 Recruit and train Serious Incident Investigator team.	2.2 Recruitment process / assessment centre notes for Lead Investigation team and training course documentation.	2.2 Completed	2.2 Completed
			2.3 Include NPSA guidance tools on report writing in training.	2.3 Included in the investigators training packs and training course materials.	2.3 Completed	2.3 Completed
			2.4 Create an investigation template for the Ulysses Safeguard system to guide investigators with the process of report writing and ensure that additional tools / supplementary documents can be stored with the investigation.	2.4 Template for electronic RCA developed in the Ulysses system.	2.4 Completed	2.4 Completed
			2.5 Provide investigation training to Divisional staff undertaking Investigating Officer roles.	2.5 Investigator training offered via LEaD bi-annually. Evidence of course content.	2.5 Completed	2.5 Completed
			2.6 Senior clinician in a senior leadership role to lead Divisional Serious Incident report reviews prior to presentation at corporate panel.	2.6 Evidenced through death reporting process and 48hr panel compliance.	2.6 Completed - process in place	2.6 Completed

			2.7 Ensure the Investigation training provides a definition of root causes and the investigative tools approach as to how to extract them as part of an investigation.	2.7 Included within the investigators training.	2.7 Completed	2.7 Completed
3	Ensure that Serious Incident Investigators are adequately trained.	medium	3.1 Create and deliver a 2 day investigators course to all staff undertaking an Investigating Officer role. Ensure the course encompasses all elements of the historical NPSA course linked to SHFT policies, processes and risk management system.	3.1 Investigators course programme.	3.1 Completed	3.1 Completed
			3.2 Create Lead Investigators roles in all Divisions to provide ongoing expert and competency assessment.	3.2 Central Lead Investigators recruitment (register of names / divisions to be supplied) objectives for the role will be assessed during appraisal.	3.2 Completed	3.2 Completed
			3.3 Develop an investigator supervision session to be held quarterly for case study learning and updates to National guidance.	3.3 Central investigation team clinical supervision session in place but a quarterly wider meeting is still to be developed. Agendas provide evidence.	3.3 31.03.16	3.3 On Track
4	Ensure that Corporate review panels are effective in the sign off of high quality investigation reports and that they are used to capture organisational learning.	high	4.1 Corporate panels to be held every other week with Executive Director Chair and all Serious Incident Investigation Reports to be presented and signed off through this panel (excluding pressure ulcers).	4.1. The corporate panels schedule and the minutes of the panels.	4.1. Completed	4.1. Completed
			4.2 Minor amendment review panels to be held every other week with Associate Director Chair to ensure timely final version reports uploaded onto STEIS.	4.2 The review panel schedule and the minutes of the panels.	4.2 Completed	4.2 Completed
			4.3 Serious Incident panel process to be clearly and simply described in the SHFT policy.	4.3 Up to date policy.	4.3 31.01.16	4.3 On Track
			4.4 Minutes of corporate panels to be recorded and held by the Serious Incident and Incident Team.	4.4 Process in place for the taking of, storage and Chair sign off of serious incident panel minutes. This can be evidenced by SOP.	4.4 Completed	4.4 Completed
			4.5 The learning from Serious Incident investigations to be extracted and shared within 'Hot-Spots'.	4.5 'Hot-Spots' organisational learning tools to be shared.	4.5 Completed	4.5 Completed
			4.6 A scoring mechanism to be added to the corporate panel minutes, scoring the quality of the reports submitted to track improvement.	4.6 Evidence of the scoring mechanism and ability to track improvement	4.6 31.01.16	4.6 On Track
5	Ensure that Duty of Candour requirements are always met.	medium	5.1 Duty of Candour training to be delivered as part of the investigators course.	5.1 Investigators course programme.	5.1 Completed	5.1 Completed
			5.2 Leaflet to be created which explains the Duty of Candour requirements to service users / patients / staff / next of kin.	5.2 Leaflet created approved by the Patient Engagement workstream prior to launch, evidence provided in minutes.	5.2 31.03.16	5.2 On Track

			5.3 Ulysses Safeguard screens to be further developed to map the Duty of Candour requirement and to record full compliance with each stage.	5.3 Ulysses capture screens - screen shots.	5.3 Completed	5.3 Completed
			5.4 Data from Ulysses Safeguard to be used to report the Duty of Candour compliance to Commissioners via CQRM process.	5.4 Informatics report and validation process. Serious Incident panel minutes will capture that the Duty of Candour has been met for all Serious Incidents.	5.4 Completed	5.4 Completed
			5.5 Role description for the Lead Investigator (centralised team) to include the specific role of oversight of communication and involvement of families.	5.5 Role description.	5.5 Completed	5.5 Completed
			5.6 Duty of Candour policy to be reviewed and rewritten to be specific about the involvement of families in investigations.	5.6 Up to date policy.	5.6 31.03.16	5.6 On Track
			5.7 Process to be developed (and included in first revision of new Death reporting procedure) which formally invites any concerns from families to be raised following a death that meets the criteria set out in the new procedure and advises families as to whether an investigation will take place. (this will be over and above the actions already required by Trust policy when it is clear from the outset that the death constitutes a SIRI and Duty of Candour is engaged as well as the requirement to invite families to participate in the investigation)	5.7 Process to be defined and guidance letter templates developed. Reference to these to be included in first review of new Procedure for Reporting and Investigating Deaths.	5.7 31.01.16	5.7 On track
			5.8 Root Cause Analysis investigation template to be amended in order that the section which outlines what involvement/contact there has been with the families is more structured and requires specific details (currently a free text box).	5.8 Corporate panel meetings to review on ongoing basis	5.8 31.03.16	5.8 on track
6	Ensure that there is evidence of the rationale of the decision making process of whether to conduct an investigation into a death and that it is clearly recorded.	high	6.1 Provide a clear definition of the decision making process surrounding what constitutes a serious incident. Incorporate this process in Serious Incident training and document it within the new Procedure for the Reporting and Investigation of Deaths.	6.1 Copy of the Procedure for the Reporting and Investigation of Deaths and evidence of sign off by the Mortality Working Group.	6.1 Completed	6.1 Completed
			6.2 Develop and launch a Ulysses death reporting form. This will commence a process with a senior clinical sign off as to whether a death should be investigated and what level of investigation would be required. This will all be tracked and monitored within the system.	6.2 Screen shot of death reporting form.	6.2 Completed	6.2 Completed
			6.3 Provide Trust wide communication of the new process ahead of 'go live' using bulletin and intranet communications.	6.3 Evidence of Trust communication team circulating the new process ahead of the 'go-live' date.	6.3 Completed	6.3 Completed

			6.4 Monitoring of compliance with this process to be undertaken by the Mortality Working Group under Executive leadership.	6.4 Minutes of the Mortality Working Group and Ulysses extraction to provide assurance of reporting.	6.4 31.01.16	6.4 On Track
7	Ensure a systematic approach to cross organisational learning from deaths through formal Mortality review processes at Divisional and Trust level through Mortality Meetings and themes and trends are clearly identified and acted on.	high	7.1 Divisions to introduce regular Mortality Meetings (minimum of once a quarter).	7.1 Schedule of Mortality Meetings.	7.1 31.03.16	7.1 On Track
			7.2 Terms of Reference and standardised agenda inclusive of case study review to be drawn up by the Governance Workstream of the Quality Programme and implemented within each group.	7.2 Terms of Reference and standardised agenda documents.	7.2 Completed	7.2 For final approval at Mortality Working Group - 12.01.16
			7.3 Divisional Mortality Meetings to report into the Trust Mortality Review Group under Executive leadership (quarterly).	7.3 Minutes of the Mortality Review Group.	7.3 31.03.16	7.3 On Track
			7.4 Divisional Mortality Meetings to be chaired by the senior clinician in a senior leadership role and the data presented by the Lead Investigator for the Division.	7.4 Minutes of the Mortality Meetings.	7.4 31.03.16	7.4 On Track
			7.5 All Divisions to use 'Hot Spots' and 'Could it happen here?' templates to share thematic review findings and enhance organisational, divisional and team learning. This should include learning from family involvement.	7.5 Evidence of the use of 'Hot-Spots' in the Division which contain Serious Incident learning.	7.5 31.03.16	7.5 On Track
			7.6 Data for Mortality Meetings to be produced by the Ulysses systems analyst (monthly).	7.6 Examples of the standardised reports provided.	7.6 Completed only for Spine reports in Tableau	7.6 Risk of Slippage. Combined Tableau reports with Spine and Ulysses data not available until 03.16
			7.7 Organise and deliver bi-annual Serious Incident workshop / conference to discuss improvement progress and changes to national frameworks.	7.7 Programmes for the workshops.	7.7 Completed	7.7 Completed
			7.8 Provide improvement report to the SOG on a quarterly basis.	7.8 Report to be provided.	7.8 Completed	7.8 Completed - 1st report submitted Nov 2015
8	Ensure robust systematic Mortality Reporting to Trust Board and Board Sub-Committees which review mortality.	med	8.1 Develop standardised Board report templates through Mortality Task and Finish Group to include numbers, national benchmarks, case studies, themes and organisational learning.	8.1 Standardised Board and sub-committee reporting of mortality and the associated themes. Evidence will be the papers.	8.1 31.03.16	8.1 On Track
			8.2 The Mortality Review Groups and Mortality Meetings must identify any Mortality themes and link themes to clear risks on the risk register.	8.2 Mortality Review Group and Mortality Meeting minutes.	8.2 31.03.16	8.2 On Track

			8.3 2015/16 Annual Report to include detail of new mortality reporting process and any early identification of themes from specialities. This will not be a complete data set which will be in place for the 2016/17 Annual Report. First draft to be shared in February 2016.	8.3 Content of the Annual Report.	8.3 31.03.16	8.3 On Track
9	Improve thematic review across the Trust and share this process externally with the stakeholders (CCGs) for assurance.	low	9.1 Produce a thematic review template in line with best practice guidance to include lessons learnt.	9.1 Standardised template	9.1 31.01.16	9.1 On Track
			9.2 Share thematic review approach, template and schedule with CCGs.	9.2 Minutes of SOG.	9.2 31.03.16	9.2 On Track
			9.3 Review the themes which the Mortality Report suggests require further investigation such as, the role of the care coordinator. Undertake review and report to Quality and Safety Committee.	9.3 Evidence of thematic reviews.	9.3 30.06.16	9.3 On Track
			9.4 Provide evidence of thematic review to the CCG commissioners through CQRM's and SOG.	9.4 Supply thematic review papers to discussion.	9.4 30.06.16	9.4 On Track
10	Ensure that SHFT incident reporting and management policy is aligned to the national framework and submission of data to the National Reporting and Learning Service is evidenced as correct to guidance.	med	10.1 Re-write SHFT incident policy to ensure alignment to the national framework to acknowledge process developments made during the last year.	10.1 Up to date policy.	10.1 31.01.16	10.1 On Track
			10.2 Governance team to meet with the NRLS centralised team to ensure that the Southern Health impact grading and uplift processes are occurring within the required criteria.	10.2 Minutes of a meeting.	10.2 31.03.16	10.2 On Track
11	Ensure that the requirement for multi-agency retrospective and forward planned thematic reviews and Serious Incident investigations are discussed with partner organisations, CCG's and the Local Authorities to agree process.	med	11.1 Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review.	11.1 Programme for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	11.1 01.02.16	11.1 On Track
			11.2 Engage all stakeholders in a workshop to discuss the process of commissioning and managing multi-agency Serious Incident investigations.	11.2 Content of the agenda for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	11.2 01.02.16	11.2 On Track
			11.3 As part of a wider stakeholder group create a process framework for undertaking multi-agency Serious Incident investigations.	11.3 Process framework for undertaking multi-agency investigations agreed by all stakeholders.	11.3 31.03.16	11.3 On Track

12	Ensure that the physical health needs of patients in mental health and learning disability services are met.	med	12.1 Review the content of the five day physical health course which LEaD provide and ensure that there is the correct percentages of staff attending from each service.	12.1 Course content and learning outcomes which will be reviewed. Attendance data per service.	12.1 31.03.16	12.1 On Track
			12.1 As part of service redesign, ensure that integrated teams contain physical expertise as part of the staffing component.	12.2 Staffing models following service redesign.	12.2 31.03.16	12.2 On Track
			12.3 A clinical audit to be undertaken within Q1 of 2016/17 to evidence that physical health needs of mental health and learning disability patients are being met.	12.3 Clinical audit results achieve above 90% compliance to physical health care plans being in place and up to date.	12.3 30.06.16	12.3 On Track

Appendix III

Southern Health NHS
NHS Foundation Trust

GAP Analysis - Mortality Review

Version No: 6 **Date:** 14.01.16 **Produced by: (Name & Job Title)** Helen Ludford Associate Director of Quality Governance

Mazars Recommendation Theme	Mazars Recommendations	Current Compliance	Current Gap	Barriers to implementation of recommendation	Will the Trust implement the recommendation as suggested or is an alternative approach suggested?	Linked to action plan number
	Number					
Board Leadership and Oversight	The Board needs to address the culture of lack of review and reporting of unexpected deaths, ensure staff at all levels recognise the need for timely, high quality investigation, how to include families and to ensure learning is demonstrated. a. The Board needs to ensure the processes of reporting and investigating unexpected deaths are consistent and robust throughout the organisation and to improve the quality of investigations and the involvement of families in those investigations. The Trust needs to prioritise the review of deaths as part of a wider mortality review process making better use of data available. b. The Board needs to understand and make full use of the data available and the underlying information required for assurance that unexpected deaths are being properly identified and investigated.	a. The Board receives information about deaths - weekly Flash report and CQC serious incident submission b. The Board via Quality Safety Committee receives quarterly serious incident reports which include information regarding process and deaths c. Corporate panels with Executive chair ensure that the duty of candour has been performed correctly for every incident d. Incident investigator training includes a session on the duty of candour and involving families in investigations e. There is a centralised investigation team in post to provide expert help and support to investigators to fulfil the duty of candour and involve families	a. The Board or the sub-committee do not receive a specific mortality report which captures the review of death alone.	Nil	Yes - This will be implemented for the entire Trust across all service areas not just those pertaining to this mortality review.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 2.1, 2.2, 2.4, 2.5, 2.6, 2.7, 3.1, 3.2, 4.1, 4.2, 4.3, 4.5, 4.6, 5.6, 6.4, 7.3, 7.4, 7.5, 7.8, 8.1, 8.2, 8.3, 9.3, 10.1

Board Leadership and Oversight	The Board or its sub-committees should receive regular reports of all incidents of deaths. The report should: a. provide data on all deaths of people using a Mental Health or Learning Disability service including service users of the social care service - TQ21. b. outline how many unexpected deaths there have been and in which areas. c. outline how many IMAs have been written as a result and how many have progressed to CIR and then onto SIRI. d. include a summary of how many deaths are 'pending' for the purposes of investigation with a reason why. This would make the decision-making more transparent as regards to delays in reporting to StEIS. e. provide information to enable trends to be identified and for Board members to become familiar with the information f. provide information which includes the categorisation of all deaths reported to Ulysses g. provide data at least twice a year on all deaths. Themes should be reported on which covers at least the previous 6 quarters (or a sufficient number to provide a reasonable sample from which to identify themes). This is particularly important for the Learning Disability arena where numbers of deaths in each quarter will be low and in areas that may not meet SIRI criteria e.g. non-suicide Mental Health deaths.	a. The Board receives information about deaths - weekly Flash report and CQC serious incident submission b. The Board via Quality Safety Committee receives quarterly serious incident reports which include information regarding process and deaths c. Corporate panels with Executive chair ensure that the duty of candour has taken place correctly for every incident d. Incident investigator training includes a session on the duty of candour and involving families in investigations e. There is a centralised investigation team in post to provide expert help and support to investigators to fulfil the duty of candour and involve families	a. Statistical analysis of serious incident data is undertaken, but due to the manual nature of the process amendment is required. An automated process linked to Ulysses will be live from January 2016 b. Mortality reporting to the Board and sub committees has previously been included within the Incident Report and not as a separate paper. Stand alone reporting will be implemented into the programme of board and sub-committee schedules and will specifically incorporate the 6 quarter review periods.	Ulysses system developments delayed the process of electronic investigation.	Yes - This will be implemented for the entire Trust across all service areas not just those pertaining to this mortality review. The only exception is in respect of recommendation b. The Trust's new procedure for reporting and investigating deaths has moved away from classifying deaths as 'expected' or 'unexpected'. Instead, the report to the Board will outline how many deaths there have been which have warranted further investigation.	8.1, 8.2, 8.3, 9.1, 9.2, 9.3, 10.2, 11.1, 11.2, 11.3
Board Leadership and Oversight	The 2015/16 Annual Report should provide a more transparent breakdown of deaths including a analysis of the themes that occur for people with Mental Health and Learning Disability challenges.	The Trust's Annual Report already contains high level data which has met the national reporting requirements and the NHS guidance document.	The annual report will be developed to include a detailed breakdown of deaths and analysis of the mortality thematic reviews that have been undertaken.	Nil	Yes	8.3, 11.1, 11.2, 11.3

Board Leadership and Oversight	There is clear national and Trust policy guidance on reporting and investigating deaths. Trust policy includes a full set of templates and processes - the Board should ensure these policies are being followed and templates being used.	Policy and procedure documents are in place and specifically relate to reporting and investigating of incidents and deaths. An investigation toolkit, supported by the former NPSA and other organisations is available on the Trust intranet. Process standardisation will be achieve through the implementation of the electronic system. The Trust is compliant with the nationally mandated Serious Incident reporting framework.	Compliance against the reporting process will be shared. This will be provided in the quarterly incident report in line with the current timetables.	Nil locally however a national framework for the reporting of deaths does not exist and the only guidance is that for serious incident reporting.	Yes the Trust will ensure that local templates and processes are followed. Whilst national guidance on reporting and investigating deaths does not currently exist (aside from serious incident guidance), the Trust will comply with any new national guidance as and when it becomes available.	2.3, 2.7, 4.3, 4.6, 5.3, 6.1, 6.2, 6.3, 6.4, 7.1, 7.2, 7.3, 10.1
Monitoring mortality and unexpected deaths / attrition	Unexpected deaths should be defined more clearly. We suggest the Trust uses, as a starting point, the classification outlined in this report to identify the potential need for review or investigation in each case. In particular, the definition of an 'unexpected death' needs to be refined to be more applicable to the circumstances of people with a Learning Disability regardless of setting.	The Trust, has in partnership with Commissioners, developed a process for the reporting of deaths and evidencing what level of investigation is required. This is has been built into the Ulysses Safeguard system. The Trust will not be implementing the system developed by the authors of the report.	Programme of rollout of the new process across the clinical divisions.	There was a delay in the implementation of this recommendation due to system design - Ulysses Safeguard but this has now been resolved. The widely used terminology of expected/unexpected deaths has been unhelpful as it is too subjective. SHFT has defined its own criteria for the reporting and investigating of deaths in conjunction with local commissioners.	No - alternative action proposed. The Trust has developed a new Procedure for Reporting and Investigating Deaths which will provide an evidence trail as to the level of investigation that is required. This is built into the Ulysses Safeguard system. The Trust will not be implementing the system developed by the authors of the report as the classification outlined relies on subjective judgements by frontline staff which has not previously been helpful.	6.1, 6.2, 6.3, 6.4

Monitoring mortality and unexpected deaths / attrition	The Trust should develop a Mental Health and Learning Disability Mortality Review Group which includes reviewing unexpected deaths which do not constitute a serious incident. Clear terms of reference should be developed. This group should serve a number of purposes: a. to provide oversight of all deaths occurring amongst the Trusts Mental Health and Learning Disability service users b. develop a mortality dashboard which is provided to stakeholders and reported in the annual report that provides a full picture of all deaths, themes, CIRs and serious incidents c. monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10 chapters show any trend d. provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues e. to ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings f. should include a GP as part of its membership g. the formation and progress of this new group should be monitored at Board level h. the group must aim to improve the transparency of reporting levels of unexpected deaths.	Not presently compliant although Term of Reference and Standardised Agenda frameworks have been produced to support the implementation.	The need for mortality review groups has been recognised by the Trust but are not yet in place.	Nil	In part. The Trust will hold mortality meetings in each Division to review deaths however it cannot be responsible for monitoring improvements within other providers as this is the role of the commissioners. The Trust cannot mandate the attendance of a GP at these meetings .Concerns about GPs or other providers will be raised through the commissioners to other organisations. The quality manager from the commissioners will be invited to attend the mortality meetings. Recommendation c. cannot be fully implemented as ICD 10 chapters are not used consistently across non- inpatient services and it would not be appropriate to do so. Alternative categorisation of cause of death will be applied.	7.1, 7.2, 7.3, 7.4, 7.5, 7.6, 7.7, 7.8, 8.1,8.3, 11.1, 11.2, 11.3

Thematic reviews	A template for a thematic review should be produced. All thematic reviews should be undertaken in an agreed format which meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change.		The requirement for regular rather than ad hoc thematic reviews has only recently been established within SHFT and there is not yet a standardised template to support them.	Nil	Yes	9.1, 9.2, 9.3
Thematic reviews	There should be further work undertaken to establish whether all deaths of people over the age of 65 are being appropriately reported and investigated - in particular amongst inpatients.	Reporting of deaths now takes place in accordance with the Trust's new Procedure for Reporting and Investigating deaths.	Previously there has been inconsistent practice which has been eliminated with the launch of the electronic reporting tool and new Procedure.	Nil	Yes	6.1, 6.2, 6.3, 6.4

Thematic reviews	The Trust, CCG and local authority should undertake a retrospective review of all Learning Disability unexpected deaths regardless of place of residence with particular reference to: a. the quality, timing and follow up of dysphagia assessments b. the level of support provided by hospital liaison services and the challenges faced in acute liaison c. the decision-making process for PEG insertion d. the hydration and nourishment of service users refusing to eat e. delays in decision-making for treatment - including primary care, decisions by care staff and responses in A&E and on wards f. the inclusion of carers and families in investigations g. waiting times for therapy services and community nursing h. identification of early warning signs of deterioration through behavioural change i. arrangements for attending appointments and seeing healthcare professionals j. reporting and acting on safeguarding concerns.	SHFT has evidence of undertaking some thematic reviews which have been presented to Board sub-committees.	Not applicable - this recommendation is a defined piece of work for further discussion with stakeholders. It is recognised that there could barriers in relation to capacity for this large retrospective review across multiple organisations.	This is a large piece of retrospective work involving external partners which requires coordination and a lead organisation. Capacity to facilitate could feature as a barrier.	To be decided - further discussion is needed with external partners, particularly commissioner colleagues who will need to agree and facilitate this piece of work. SHFT cannot make the decision to undertake this review in isolation as in most instances its records will only provide a limited part of the multi-agency information required. With reference to j. there are no outstanding safeguarding concerns that have not been reported.	11.1, 11.2, 11.3
Thematic reviews	The Trust and CCG should undertake thematic reviews in Mental Health on a number of the issues raised in this review, including: a. A joint review of the circumstances of death of people with serious mental illness on long term antipsychotic drugs encompassing a review of safeguarding alerts, self-neglect and physical health management. b. A joint review of all deaths relating to people with a drug related death in conjunction with local providers encompassing a review of referral processes between agencies. c. A joint review with the CCG of recent cases of death relating to serious eating disorders to understand how services need to improve by bringing both physical and psychological management together. d. A joint review of alcohol related deaths in conjunction with local providers encompassing a review of self-referral processes.	SHFT has evidence of undertaking some thematic reviews which have been presented to Board sub-committees.	Not applicable - this recommendation is a defined piece of work for further discussion with stakeholders. It is recognised that there could barriers in relation to capacity for this large retrospective review across multiple organisations.	This is a large piece of retrospective work involving external partners which requires coordination and a lead organisation. Capacity to facilitate could feature as a barrier. There are also concerns related to c., SHFT are not a specialist service therefore would not see sufficient patient activity in relation to eating disorders to undertake a thematic analysis.	To be decided - further discussion is required with external partners who will need to provide input into this piece of work. SHFT cannot make the decision to undertake this review in isolation as it cannot mandate involvement of other providers or the sharing of information by other providers.	11.1, 11.2, 11.3

Thematic reviews	The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	SHFT already has in place a physical health training course for both nurses and doctors working in the mental health field. This course was strengthened in 2015 and now covers 5 days in total.	Nil	Nil	Yes and this is to be considered as a core competency in relation to job roles	12.1, 12.2, 12.3
Thematic reviews	The Trust should undertake thematic reviews of the issues raised in the review, including: a. Medical input and senior medical oversight b. The role of the care co-ordinator c. The need for pharmacy colleagues to be more explicitly involved in cases involving drug toxicity and polypharmacy.	Although a retrospective review into these areas has not been undertaken reviews have taken place as part of service and process redesign work.	Whilst these issues have been reviewed in relation to service and process redesign, this has not been formally documented as a thematic review.	Nil	In part. A) and b) are particularly broad and rather than carry out a thematic review, the Trust will present its current position in relation to these two areas as papers to Board sub-committees. C. will be implemented in full and pharmacy colleagues will be involved in either the investigation itself or the corporate panel in cases involving drug toxicity or polypharmacy.	9.3
Thematic reviews	A regular review of all sudden deaths of OPMH inpatients should be carried out. This should include a review of whether care treatment decisions are taken quickly enough, whether cooperation and liaison with acute medical staff is adequate and whether staff feel confident in managing and identifying sudden physical deterioration including CPR.	All deaths within OPMH inpatient settings are now reported on the Ulysses system and are managed in line with the new death reporting procedure.	SHFT will need to implement a 6 monthly thematic review of all OPMH inpatient deaths.	Nil	Yes	91, 9.2

Reporting and Identifying Deaths	The Trust should review the way that deaths are categorised under the incident reporting policy so that: a. All relevant deaths are re-graded accurately before and after investigations have taken place. b. All relevant deaths are reported on regardless of impact grading to ensure that deaths have greater prominence in the Trust's reporting systems. c. Accurate information is provided for future Trust Mortality Reviews. d. That immediate work with the NRLS team is undertaken to ensure the changes to the local risk management system map as expected to NRLS and on to CQC.	The Trust policy includes guidance on categorisation of incidents; a. Deaths are graded by the reporter and quality assured by the manager, overseen and sign off by the senior clinician for the Division b. Impact grading is checked at the corporate panel before upload to the NRLS d. NRLS reporting takes place as per NHS requirement as interpreted by the Trust. CQC reporting of deaths is in place as a requirement of registration for deaths which meet the criteria e.g. those patients detained under a section of the Mental Health Act.	Written confirmation from NRLS as to the Trust's interpretation of its guidance	There is a lack of consistent national application of the NRLS guidance. As a Trust we have been assured that we are following the correct procedure.	Yes	4.1, 4.2, 4.5 7.6 10.1, 10.2, 4.5,
Quality of Investigation Reporting	The Serious Incident investigation process needs a major overhaul in the Trust. Improvements are needed in: a. Separation of people responsible for quality assurance and those undertaking investigations. This would enable training in review processes and quality assurance to be targeted at senior staff and in investigation techniques at a dedicated group of investigators. b. Quality assurance processes including independent review and sign off c. Achieving high professional standards in written presentation	Central investigation team, divisional and corporate panels are now all in place to ensure quality assurance and scrutiny. Independent review is achieved through CCG closure panels scrutiny. Investigator training has been undertaken which covers aspects of report writing and an electronic incident report template has been designed and is embedded in the Ulysses Safeguard system.	Development of ongoing assurance programme	Nil	Yes	1.3, 2.1, 2.3, 2.4, 2.5, 2.7, 3.3, 4.3, 5.1, 5.6, 10.1
Timeliness of Investigations	Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	The Trust is presently 47% compliant to this requirement. There is ongoing monitoring of this key performance indicator supported by the central investigation team.	Ensuring that 48 hr death and serious incident review panels occur with senior clinician attendance to make the decision that StEIS reporting is required.	Nil	Yes	1.1, 1.2, 1.7, 1.8
Timeliness of Investigations	There should be more explicit action to commence investigations promptly even when a coroner conclusion is not immediately available unless there is a specific reason to delay; any delay should have senior sign off.	The death reporting and incident procedure is specific that delays do not occur in reporting or commencing an investigation unless there is a specific and recorded reason for doing so.	Documentation of rationale for delaying commencement of a detailed investigation is not kept on Ulysses in a standardised format.	Nil	Yes	1.1, 1.2, 1.3, 1.7

Involvement of Families	The involvement of families in investigations requires improvement. In particular, improvements are needed in: a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams c. the Trust should ensure that investigators talk to families as early as possible in the process to identify any concerns and take these into account in the ensuing investigation d. provide reports to coroners in time for inquests e. explicitly demonstrating why families are not involved f. identifying next of kin details for all service users as part of a core assessment including where consent to share has not been provided to enable investigators to find relatives more easily. g. working with primary care to identify family members h. where the Trust delays the commencement of an investigation due to inquests or other investigations this should be made explicit to families and the reasons explained. i. the performance of divisions in involving families and securing feedback	The Trust is now 100% compliant in relation to this recommendation with the exception of f. and g. Corporate panels with Executive chair ensure that the duty of candour has taken place correctly for every incident. Incident investigator training includes a session on the duty of candour and involving families in investigations There is a centralised investigation team in post to provide expert help and support to investigators to fulfil the duty of candour and involve families.	recommendations f. and g.	f. cannot be implemented as it the patients choice as to whether next of kin details are provided at initial contact. g. next of kin details cannot is be sourced from primary care without the patients consent, this approach will only be taken in event of their death when details will be obtained either from primary care or the coroner.	Yes apart from f. g. will be dependent on information available to primary care partners and the coroner and is therefore not entirely within the Trust's control	5.1, 5.2, 5.3, 5.4, 5.5, 5.6 , 5.7, 5.8
Multi-agency working	The Trust Board should seek co-operation with other providers and commissioners to agree a framework for investigations in preparation for future incidents regarding escalation. Divisions should then apply this framework where the incident report suggests another organisation should review or investigate the circumstances of a death.		Consistent framework not in place for multi-agency investigations. A framework must be agreed with commissioners	Nil	Local commissioners have agreed that it is their responsibility to lead on multi-agency reviews and to share concerns with third party organisations. The Trust will work with commissioners to agree a framework for escalation of concerns about third parties.	11.1, 11.2, 11.3
Deaths in detention and inpatient deaths	The Trust should retain a contemporaneous list of all inpatient deaths mapped to Mental Health Act status to enable Trust-wide oversight of all inpatient deaths and deaths in detention	All inpatient deaths of individuals subject to detention under the Mental Health Act are reported and also reported to the CQC.	A 'flag' will be applied to the Ulysses System to ensure that this is recorded as part of the death reporting process.	Nil	Yes	1.9

Deaths in detention and inpatient deaths	All deaths of service users in detention should be investigated, whether expected or not. These investigations should occur regardless of inquest conclusions. This will give assurance that the 24/7 nature of the care required has been of the highest standard. Specific issues addressed in the Terms of Reference for these investigations should include: a. to ensure that physical health care symptoms are not dismissed where challenging behaviour presents; b. that delays in seeking physical health care are not apparent; c. that service users are fully aware of decisions regarding whether to treat or investigate chronic or acute symptoms and that these are made in an informed manner; d. that access to full care and treatment is not restricted in any way; e. that staff are adequately supported to provide physical health care and trained to do so.	It is SHFT policy to investigate all inpatient deaths of individuals subject to Mental Health Act detention.	Where patients under detention have died in expected circumstances or through natural causes, these have not been automatically investigated as a SIRI.	Nil	Yes	1.1, 1.2, 1.3, 1.4, 1.5
Information management	The Trust should develop an agreed RiO extract and Ulysses reporting protocol to capture all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users including community and inpatient locations to form the basis of future mortality review.	Mortality reports have been developed and are accessed through the Trust business intelligence system Tableau.	Report content/ design of data presentation will be reviewed by the mortality review group. Whilst the new process includes the requirement to report all deaths of LD patients within 12 months of contact and all deaths of MH service users who are inpatients or within 12 months of contact for suicides, it is not practicable to capture the thousands of community OPMH deaths on Ulysses unless a number of specific criterial are met as defined in the Trust's new Procedure for Reporting and Investigating deaths.	Nil	In part - OPMH community deaths are captured only in specific numbers due to the impracticability of recording the high numbers of OPMH community deaths in circumstances which are not untoward.	7.6, 8.1
Information management	The spreadsheet arrangement currently in place in TQ21 is insufficient to monitor deaths at corporate level as part of the whole Learning Disability service provision. TQ21 service users should be incorporated into Trust administration systems in a way which ensures their deaths are captured for reporting and investigation purposes.	The new death reporting process has been implemented within TQ21. The same system is in place across the Trust.	Nil	Nil	Yes	1.6, 2.4