Lincolnshire Partnership NHS
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	25 February 2016
Section:	Risk
Report title:	Lessons Learnt from the Southern Health NHS Foundation Trust Report
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Lead officer:	Anne-Maria Olphert, Director of Nursing & Quality
Board Action Required:	For information
For Assurance (Yes or No)**:**	Yes

Purpose of the Report

In 2013 at an Assessment and Treatment Unit in Oxford (Southern Health Foundation Trust) a patient drowned unsupervised in a bath, probably due to an epileptic seizure. The Trust initially identified the death as 'natural causes' but an independent investigation identified the death as 'preventable'. The Coroner's Inquest returned a narrative verdict which concluded 'neglect ' had contributed to death. NHS England (NHSE) commissioned a review of deaths at Southern Health Foundation Trust (SHFT) which occurred between April 2011 and March 2015.

In light of the findings of the NHSE commissioned review, the Executive Team of Lincolnshire Partnership NHS Foundation Trust (LPFT) commissioned a small scale review of deaths within LPFT to gain assurance that reporting and investigation processes are robust. The findings and recommendations of the review are presented within this report.

Key Issues, Options and Risks

The findings of the review of SHFT deaths were:

- No comprehensive, systematic approach to learning from deaths as evidenced by action plans, board review and follow-up;
- No effective systematic management and oversight of the reporting of deaths and the investigations that followed;
- Lack of Board oversight and lack of Board challenge to the systems, including how decisions were made on whether to investigate deaths;
- Ad-hoc and inadequate approach to involving families and carers in investigations, with only 35% of investigations engaging families.
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National Findings:

- National guidance for reporting and investigating is not statutory and therefore relies upon the implementation of good local quality governance and assurance frameworks from commissioners and providers.
- The definition of an 'unexpected death' needs to be refined when applied to people with a Learning Disability.

To support LPFT's review, a request was made to the Lincolnshire Coroner's Office to provide causes of death for all service users where none was recorded on the Trust's clinical

systems. The Superintendent Registrar declined the request to provide this information prior to 2014. This request does not meet the requirements of a Freedom of Information (FOI) request, so it was not possible to pursue this course of enquiry.

The Quality and Safety Team therefore reviewed a random sample of 55 cases of patients who died between 1st April 2011 and 31st March 2015 drawn from CAMHS, Adult, Learning Disability and Older Adult Services. Findings evidenced a varying quality of recording at the point of death across the cases. The cases reviewed that met criteria for Serious Incident (SI) investigation were cross checked and all were found to have been escalated for SI investigation. From the sample, and based upon the evidence within the records, no cases from the random sample were identified as having been missed as requiring SI investigation.

The use of the Trust's incident reporting system DATIX enables the accurate capturing of all deaths, whether or not they are unexpected. This is a robust system for the initial reporting of a death (or incident) as soon as possible after it has occurred. A senior manager is required to review the DATIX incident report within a closely monitored timeframe, which provides assurance that all deaths are reviewed in a timely manner. A challenge is that the cause of death is often not known at the time of initial reporting, and this information may not be available for a number of months. Therefore, a vulnerability of DATIX is that it relies on a staff member to retrospectively record the cause of death when this is known. This information recording can, therefore, be inconsistent. Despite the limitations, this process does enable the option to spot audit future deaths to provide assurance that correct investigation processes have been followed where required across Trust services.

The Trust received a FOI request from the BBC following the publication of the review of deaths by NHSE at SFHT. In complying with the FOI request, the Trust identified the following information:

- Between 1st April 2011 and 31st March 2015, 1104 service users died and who were registered as 'open' to Trust services at the time of their death.
- Of the 1104 deaths, 173 were recorded as 'unexpected deaths'.
- All unexpected deaths are reviewed through a preliminary investigation process. Depending on the outcome of the preliminary investigation, a further enhanced level of investigation, serious incident investigation (SI), may be required. During this period all 173 'unexpected deaths' were investigated and 61 of 173 where investigated SIs.
- 2 deaths were investigated as SIs involving service users who were registered with the Trust's Learning Disability Services.
- 11 deaths were investigated as SIs involving service users who were in receipt of the Trust's Older Adult Services.

To support scrutiny of Trust performance in respect of investigation of deaths, Trust practice is mapped against the findings by NHSE following review of the SHFT deaths as follows:

Within SHFT NHSE found no comprehensive, systematic approach to learning from deaths as evidenced by action plans, board review and follow-up

- LPFT has a comprehensive and systematic approach to learning from deaths. Assurance in respect of this was obtained through the retrospective sample testing of deceased patients (55), which evidenced that where these cases met SI criteria, they had been investigated as such. The Board receives a monthly review of all SIs and Serious Case Reviews (SCRs) within its private section. The Trust has a Serious Incident Review Group (SIRG), with representation from all clinical divisions, the Quality and Safety Team and key others including a medical representative, a clinical systems representative, and a legal team representative. There is work underway to strenthen the embedding of SI investigation practice and related action plan implementation and monitoring within clinical divisions. There is also work underway to increase the training and support available to SI investigators to ensure a consistently high standard of investigations is achieved. The Trust has a Learning Lessons Bulletin, and there has been considerable work undertaken to embed learning lessons within clinical teams. The Trust launched its Suicide Prevention

Strategy (September 2015) and is working closely with partners across Lincolnshire to ensure learning from deaths is embedded across services.

- *Within SHFT NHSE found no effective systematic management and oversight of the reporting of deaths and the investigations that followed*
  LPFT has an effective system for the management and oversight of the reporting of deaths via Datix reports, which are scrutinised daily by the Quality and Safety Team. Where SI criteria are met, there is an effective system for reporting on STEIS (or via Public Health where appropriate) and CQC (where appropriate). There is close monitoring of SI investigation progress by the Quality and Safety Team in partnership with clinical divisions and our commissioners. There is work underway, led by the divisional Quality Assurance and Improvement Leads (QAILs), to support and hold to account investigators to complete investigations to required timelines and to ensure subsequent action plans are monitored through to completion within clinical divisions. There is close working by the Trust's Quality and Safety Team with commissioners to strenthen communication and understanding of requirements to ensure these are met within required timelines. There have been breaches in timely completion of SI investigations at times over the past year, and the clinical divisions are working closely with the Quality and Safety Team to implement strategies to implement a zero tolerance to breaches going forwards. A priority for the Trust is the establishment of a Mortality Review Group, which is closely aligned to the Trust's existing SIRG and Suicide Review Group.

- *Within SHFT NHSE found a lack of Board oversight and lack of Board challenge to the systems, including how decisions were made on whether to investigate deaths*
  LPFT has Board oversight of serious incidents, receiving a monthly related Board paper. All SI investigations level 1 are reviewed and approved by an Executive Director (the Director of Nursing and Quality, the Director of Operations or the Medical Director). Non-Executive Directors (NEDs) are involved in level 2 SI investigations, providing support as well as an objective critical review function to the related panels. Work continues to strengthen SI themes and trends, including triangulating these with other available performance intelligence, an example of which is through the Trust's Integrated Performance Report and Heat Map. An example of the Board's challenge to ensure robust related systems are in place was in its commissioning of a two part internal audit *Assuring our Assurance* which reported in October 2015 (part 1) and December 2015 (part 2). Part 2 focussed on a retrospective review of SI investigations to establish whether actions and lessons learned had been embedded into practice. There was assurance that the majority of related actions were embedded, though not all. Strengthening national benchmarking, skills of staff in SI report writing, and being able to evidence consistent embedding of lessons learned are priorities.

- *Within SHFT NHSE found an ad-hoc and inadequate approach to involving families and carers in investigations, with only 35% of investigations engaging families*
  Duty of Candour is evidenced in all Trust SI investigations, with compliance reported quarterly to commissioners within the Trust's Quality Schedule. SI investigators are encouraged to ascertain as early in their investigations as possible how much involvement families and carers wish to have in SI investigations, including what questions they would like an investigation to answer and whether they wish to have a copy of the final investigation report. This is an area the Trust is working to strengthen further to ensure robust and consistent levels of engagement with families and carers in achieved.

Executive Analysis

- There is a high level of assurance that the concerns identified by NHSE in its investigation of deaths within SHFT are not replicated within LPFT. However, there are areas required for strengthening in LPFT's related systems, processes, staff skills and embedding of learning lessons across clinical services. This work is already

underway and will continue in 2016/17.

- There is evidence of Board scrutiny, involvement and challenge in SI monitoring, processes and trends.
- The process for recording deaths on the Trust's incident system DATIX enables close monitoring of all deaths and the ability to scrutinise decisions made regarding SI criteria for investigation. There are limitations of the DATIX system, including the reliance on clinicians to update records when cause of death is confirmed, which may be many months later. This limitation risks this important detail being ommitted in some cases. However, on balance, the recording of all deaths on DATIX does provide assurance that all are promptly reviewed by both clinical leaders and the Quality and Safety Team.
- LPFT has liaised with other providers across the Midlands and East and identified the majority are currently experiencing similar challenges with identifying the best model to implement for mortality reviews.
- A gap identified is the lack of a Trust Mortality Review Group, aligned closely with the Trust's SIRG and Suicide Review Group.

Recommendation (action required, by whom, by when)

- The establishment of a Mortality Review Group, aligned closely with the Trust's Suicide Review Group and SIRG.
- The continued reporting of all deaths on the Trust's incident system DATIX. It is recognised that all deaths are not unexpected, however, recording all enables better monitoring of trends and enables the option to spot audit the review of deaths to provide assurance that correct investiation processes have been followed where required.
- A continued focus on learning lessons and preventing future deaths, underpinned by the Trust's Suicide Prevention Strategy.
- Aligned to the recommendation that unexpected death requires refining when applied to people with a Learning Disability, it is recommended that the Trust approves the folowing definition for use across its services: *'an unexpected death is a death which occurs where natural causes are not suspected (i.e. not caused by the natural course of the patient's illness or underlying medical condition when managed in accordance with best practice).'*

CQC Regulations Impacted:	All with regulatory standards measured against the five domains of safe, caring, well-led, effective and responsive.
Financial Implications:	None specific
Equality Analysis:	N/A
Compliance Impact:	NHSLA, Monitor and CQC