

Barnet, Enfield and Haringey 

Mental Health NHS Trust

A University Teaching Trust

Title:	The Trust response to the Care Quality Commission Report 'Learning, Candour and Accountability; A review of the way NHS trusts review and investigate the deaths of patients in England'
Report to:	Trust Board
Date:	30 January 2017
Security Classification:	Public Board Meeting
Purpose of Report:	<p>This report describes and summarises the recent Care Quality Commission (CQC) report into the investigation of deaths. It describes the current processes of investigation of deaths within the Trust and considers to what extent gaps in assurance identified in the report are replicated within the Trust. Recommendations for improvement are then made to address those identified gaps.</p>
Recommendations:	<p>The name of Committee is asked to agree:</p> <ol style="list-style-type: none"> 1. That the Trust should audit regularly samples of deaths reported from community services via Datix, to ensure that decisions in respect of the level of investigation required are recorded, robust and consistent. Audits and their learning should be reported via the Quality and Safety Committee and to commissioners. 2. Actions to ensure a more robust system for learning from Serious Incidents investigations and disseminating them should be monitored via the Trust's governance framework. 3. That the Trust supports the approach to be taken by the Care Quality Commission to improving the consistency of investigation of deaths at a national level, and supports the work to provide consistent definitions of natural, expected, and unavoidable death.
Report Sponsor:	Jonathan Bindman, Medical Director
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Report History:	First Report
Budgetary, Financial / Resource Implications:	Training in Root Cause Analysis for investigators should be continued at a cost of x per year.
Equality and Diversity Implications:	None

Links to the Trust's Objectives, Board Assurance Framework and / or Corporate Risk Register	The associated risks are managed through the Risk Register and Board Assurance Framework.
List of Appendices: <ul style="list-style-type: none">• An extract of data concerning deaths, coroners recommendations (regulation 28), and duty of candour reported to the Quality and Safety Committee 7.11.16	

Report

1. Introduction and Background

- 1.1 The Care Quality Commission (CQC) published a report, 'Learning, candour and accountability; A review of the way NHS trusts review and investigate the deaths of patients in England' on 13 December 2016.
- 1.2 The report describes a review of the process of investigating deaths in a sample of NHS acute, mental health and community Trusts in England. This was undertaken in response to a review of mental health and learning disability deaths at Southern Health NHS Foundation Trust between April 2011 and March 2015. That report identified a number of failings in the way the trust recorded and investigated deaths, and highlighted that certain groups of patients including people with a learning disability and older people receiving mental health care were far less likely to have their deaths investigated by the trust than deaths in other groups.
- 1.3 The Secretary of State for Health asked the CQC to look at how acute, community and mental health NHS trusts across the country investigate deaths, and how learning is derived from these investigations, in order to find out whether opportunities for prevention of death have been missed, and identify any improvements that are needed. The CQC visited 12 trusts in England, sent out a national survey and talked with 100 families, NHS staff and charities.
- 1.4 In the interests of brevity the findings of the report are not detailed here; they can be found at <http://www.cqc.org.uk/content/learning-candour-and-accountability>. This report provides an overview of the investigation of deaths in BEH, then presents the CQC's summary of their findings in five key areas (italicised below), and describes the relevant circumstances in BEH MHT in each area. It then makes a brief comment on each of the CQC report's recommendations. It then identifies potential gaps in assurance in BEH, and makes recommendations for improvement.

2. Overview of the Investigation of Deaths at Barnet, Enfield and Haringey Mental Health Trust

- 2.1 The Trust's Serious Incident Policy sets out how all patient safety incidents in the Trust are to be entered on to the Datix system, graded according to severity. The Patient Safety Team (PST) reviews all Datix submissions and their grading, seeks further information via a 24 hour report where indicated, and in discussion with the senior managers of the three borough services and the Specialist Services, agrees the level of investigation required. Cases graded as severe will be reported to the Commissioning Support Unit using the national reporting system ('StEIS'), and may be escalated further if external investigation is warranted.
- 2.2 Investigation reports are all reviewed by service level Serious Incident Review Group (SIRG), and a Trust wide SIRG, chaired by the Medical Director and with Non-Executive Director representation. All reports approved by SIRGs are then reviewed by the Medical Director or the Executive Director of Nursing, Quality and Governance, before being submitted to the Commissioning Support Unit (CSU). The CSU then reviews the reports in committee and may seek further assurance before accepting the report, and also receives assurance of the completion of actions identified in investigation report action plans.
- 2.3 Investigations may be carried out within a service, or across services, and incidents graded as severe will be considered, with the involvement of Executive Directors, for a Board Level Inquiry.
- 2.4 Within this overarching system, all deaths are required to be reported, but no rigid definition is applied concerning whether the deaths are 'expected or unexpected', 'natural or unnatural', or 'avoidable or not avoidable'. This is in recognition of the fact that there are no consistent definitions for these constructs yet agreed within the NHS, and also that care and service

delivery problems (CSDPs) meriting investigation and providing opportunities for learning may arise even in circumstances where a death might be regarded as 'natural', unavoidable' or 'expected'.

- 2.5 Through this process, all deaths are reviewed by the reporting service and the Patient Safety Team. Deaths are reported in Deep Dive reports in each service. There are multiple ways in which learning from deaths can be disseminated within the Trust, including service based learning events, Trust Wide Berwick events, Quality News, and specific quality alerts. Overall data on deaths is reported to the Trust Quality and Safety sub-committee of the Board (see appendix) and to our lead Clinical Commissioning Group (Enfield) via the Joint Performance and Quality meetings. Plans are in place to incorporate mortality data and a supporting narrative into the Trust's 2016/7 Quality Account.

3. CQC Summary Findings and situation at Barnet, Enfield and Haringey Mental Health Trust

3.1. Involvement of families and carers

- 3.1.1 *'The CQC found that families and carers often have a poor experience of reviews and investigations, and are not always treated with kindness, respect and sensitivity. We found that the extent of their involvement in reviews and investigations varies and they are not always listened to.'*
- 3.1.2 The Trust has long experience of conducting investigations into deaths and involving families and carers; the current approach is set out in the investigation policy and was based on the NPSA 'Being Open' Framework issues in 2009 (<http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726>) and has developed subsequently through the 'Duty of Candour'. The appendix to this report shows basic data concerning the duty of candour which is reported to the Quality and Safety Committee and to commissioners via the Joint Performance and Quality Committee. While this data provides assurance that families are informed of incidents affecting their relatives, the assurance that families are fully engaged and properly treated throughout investigation processes is dependent on a culture of respect for families and carers throughout the Trust's investigatory structures.
- 3.1.3 All investigators offer to meet families and carers as a matter of routine during investigations, and Clinical Directors offer to meet them as part of letters of condolence when a death occurs. A positive culture of engaging with families and carers is of great personal importance to the Chief Executive, the Medical Director and the Executive Director of Nursing Quality and Governance. All of these members of the Executive are available to meet with and support families and carers, and have done so whenever concerns have been raised about investigations. Naturally given the sensitivities involved, there have been situations in which families and carers have been dissatisfied with the conduct and findings of investigations and have not felt listened to, but senior members of the Executive are always keen to try to achieve a resolution of such cases.
- 3.1.4 This positive culture of involvement has been well established in mental health services offered by the Trust for several years. While it has been suggested that the approach to involvement of families in community Trusts has been less well developed than in mental health in some areas (such as Southern Health), in this Trust a common approach has developed across our mental health and community services. This is a good example of the benefits of the integration of mental health and community services within the Trust, in that managers from mental health services have, through their role in investigations and in the SIRG, been able to ensure that a common culture has developed.

3.2 Identification and reporting

3.2.1 *'The CQC found inconsistency in the way organisations become aware of the deaths of people in their care, with no clear systems for a provider that identifies a death to tell commissioners or other providers involved in the person's care. Other issues include the lack of a consistent way of recording the deaths of patients that have recently been discharged. They also found that electronic systems do not always support the sharing of information between NHS trusts and other services involved in someone's care.'*

3.2.2 The lack of clear systems for transferring information between organisations is undoubtedly an issue for our Trust. However, a distinction must be made between the investigation of deaths in mental health services and those in community services. In mental health services, we are confident that the great majority of deaths are identified, and all those not identified on the basis of clear evidence as due to natural causes are fully investigated. The National Confidential Inquiry into Suicides and Homicides (NCISH) has ensured for 10 years that there is an effective linkage between coroners offices and Trusts, and that meticulous case finding is carried out to ensure that all deaths which are, or are likely to be, the result of suicide are investigated.

3.2.3 In our community services the challenges are different. Patients referred are often in the last years of life, and the number who die in our care, while waiting for it, or shortly after receiving it, is naturally higher. The recent focus on these deaths as a result of the Southern Health investigation has led to increased reporting of these deaths, but there is still no comprehensive national or local system across Trusts which can ensure we are informed about all deaths occurring outside our services in patients who have left our care.

3.3 Decision to review or investigate

3.3.1 *'Healthcare staff use the Serious Incident Framework to help them decide whether a review or investigation is needed. But this can mean investigations only happen if a serious incident has been reported, and the criteria for deciding to report an incident and the application of the framework both vary. Clinicians are using different methods to record their decisions, definitions used to identify and report deaths are used inconsistently, and sharing information between providers is often difficult'*

3.3.2 The application of the Serious Incident Framework in the Trust in respect of deaths occurring in mental health services is very clear and we can be confident that all such deaths occurring in patients under our care are reported. As stated the work of the NCISH ensures that we are informed in all cases of deaths occurring among people who have been in our care in the 12 months prior to death, even if they have been discharged and services have lost contact with them. While a decision may be made not to undertake a full investigation under certain circumstances, this is made by the PST in consultation with senior clinicians and the CSU, and while a subjective element to the decision cannot be avoided, consistency is sought by careful discussion in each case, and by ensuring that sufficient evidence is available to support the clinical judgment made.

3.3.3 In community services, the decision to report a death may have been made inconsistently in the past. In the last year we have clarified that all deaths must be reported on Datix and can now demonstrate a clear process by which decisions are made by senior clinicians about which deaths require a full SI investigation. These decisions are made on the basis of local clinical judgement with the oversight of the Patient Safety Team (and the Commissioning Support Team, if the deaths are reported on StEIS), which can ensure a degree of consistency. However, there are as yet no clear national guidelines which enable us to classify these deaths as natural, expected, or unavoidable in a way which can be validated externally. We would also acknowledge that, as above, systems do not support the sharing of information between multiple providers, and there may be situations in which we must make a judgement not to investigate based on the best available information. We would benefit from

the further work recommended by the CQC report, and from the joined up local data collection systems they propose.

3.4 **Reviews and investigations**

- 3.4.1 *'The report found that the quality of investigations is often poor and methods set out in the Serious Incident Framework are not applied consistently. Specialised training and support are not given to all staff carrying out investigations. There are problems with the timeliness of investigations and confusion about standards and timelines set out in the guidance. Where a number of agencies are involved, their ability to work together is restricted by a lack of clarity over which agency is responsible for leading the investigation, and they often work in isolation.'*
- 3.4.2 We would acknowledge that the quality of investigations is variable within the Trust. However, the oversight by SIRGs, and the requirement for sign off by senior clinical members of the Executive has demonstrably allowed identification of reports which are below an acceptable standard, and has resulted in investigations being provided with additional support, additional investigations being undertaken, reports being rewritten, and in rare cases even an external review being commissioned. We take careful account of the fact that reports will be shared with families and coroners and may be the last service we can do for someone who has been under our care. We take the quality of our investigations very seriously and respond to external feedback from the CSU and from coroners, and have on some occasions responded via the complaints process to concerns about investigations and investigation reports.
- 3.4.3 We would acknowledge problems with timeliness of investigations but are held to account for this by our commissioners, who apply a 45 day standard for reports and require authorisation to be sought for extensions, and explanations to be provided for delays.
- 3.4.4 We recognise that there may be a tension between the need to deliver a report promptly to a timescale, and the need to obtain all the necessary evidence and engage all the relevant parties, which may take more time than the 45 day timescale allows.
- 3.4.5 Concerning training, staff conducting investigations must undertake investigator training, and the Deputy Director of Quality has commissioned Root Cause Analysis training, which has been well received and is continuing. In addition, SIRGs pay careful attention to the suitability and competence of investigators, and arrange for support and mentoring where necessary. We recognise a tension between the benefits of having experienced practising clinicians undertaking investigations, and the consequence that investigators have demanding day jobs, and undertake relatively few investigations, with an impact on their ability to develop expertise and to deliver timely reports. It has been debated previously whether we should develop and employ a cadre of specialist investigators, as other Trusts have done, but the resources have proved prohibitive and we believe we are offering a good quality service with the resource available.

3.5 **Governance and learning**

- 3.5.1 *The report points out that there are no consistent frameworks or guidance requiring boards to keep all deaths under review, and boards only receive limited information about the deaths of people using their services. The report suggests that when they do receive information, they often do not challenge the data effectively. Where investigations take place, there are no consistent systems to make sure recommendations are acted on or learning is shared. There is a lack of robust mechanisms to disseminate learning from investigations or benchmark beyond a single trust.*
- 3.5.2 We currently report data on deaths regularly to the Quality and Safety Committee of the Board, which has been able to offer appropriate challenge. The requirement that clinical members of the Executive review all SI reports provides an opportunity for every report to be

subjected to challenge. There is a clear system via the CSU for ensuring that recommendations are acted on. We would acknowledge that we face challenges in ensuring that lessons are disseminated within the Trust, and this was identified in our CQC inspection, but we have identified a range of actions to address this, covered and monitored elsewhere. We regularly receive external reports concerning deaths at the Board though would acknowledge that there is no clear national system for ensuring that this takes pace consistently, though current plans for the Healthcare safety Investigation Branch (HSIB) are intended to address this.

4. CQC Report recommendations

4.1 The CQC made a number of recommendations summarized as follows:

1. Learning from deaths needs much greater priority within the NHS to avoid missing opportunities to improve care.

Recommendation above Trust level.

2. Bereaved relatives and carers must receive an honest and caring response from health and social care providers and the NHS should support their right to be meaningfully involved.

We agree and seek to provide this in the Trust through our Being Open approach and culture.

3. Healthcare providers should have a consistent approach to identifying and reporting the deaths of people using their services and share this information with other services involved in a patient's care.

We would welcome defined national guidance on this but in the interim have agreed an approach with our commissioners. National guidance would allow us to benchmark our data and ensure we have validated comparative data for services.

4. There needs to be a clear approach to support healthcare professionals' decisions to review and/or investigate a death, informed by timely access to information.

We agree, and have a reasonably robust system, acknowledging we do not have access to all the information from elsewhere in the system that would assist this.

5. Reviews and investigations need to be high quality and focus on system analysis rather than individual errors. Staff should have specialist training and protected time to undertake investigations.

We support this and are making reasonable efforts to ensure this within the resources available. To be fully addressed the affordability issue would need to be resolved.

6. Greater clarity is needed to support agencies working together to investigate deaths and to identify improvements needed across services and commissioning.

Recommendation above the level of the Trust.

7. Learning from reviews and investigations needs to be better disseminated across trusts and other health and social care agencies, ensuring that appropriate actions are implemented and reviewed.

We accept this and are will continue to develop and extend the plans we already have in place to disseminate learning.

8. More work is needed to ensure the deaths of people with a mental health or learning disability diagnosis receive the attention they need.

We are confident that we pay a high level of attention to the deaths of people with mental health diagnoses, though we might benefit from greater recognition of the issues by acute Trusts. We deliver Learning Disability Services in partnership with Local Authorities and must rely on them for investigatory processes, though we discuss with our own staff the importance of participating in investigations and of incorporating learning into their own professional development and revalidation (for which we are responsible).

5. Gaps in assurance identified

5.1 Quality of Investigation and engagement with relatives and carers

- 5.1.1 The Trust recognises risks to the quality of serious incident investigations and reports and has put in place extensive mitigations over a number of years. The quality of our investigation reports has undoubtedly improved as a consequence, but good reports take considerable resource and can put great demands on services. The risk of an investigation which fails to identify learning effectively, or fails to engage and satisfy families and carers is never entirely mitigated and requires further efforts to ensure families feel involved.

5.2 Identification and reporting

- 5.2.1 As the CQC identified, there is a lack of systems for communication between providers to ensure that deaths identified in one part of the system are flagged to other parts of the system. That is the case locally, and it is possible that a death in an acute hospital or in the community of someone seen by us in the last 6 months might not be known to us. This cannot be fully mitigated by the Trust.
- 5.2.2 However, with the agreement of our commissioners we are currently focusing on the identification of the deaths of people who have been seen by us within 12 weeks of their death. We find that we are being notified of such deaths from a number of sources including carers and the acute hospitals. We believe we are identifying all deaths of people for whom we are providing care, or who are on waiting lists, as we actively follow up failures to attend. It is not possible to pro-actively assure the subsequent identification of deaths of all the people discharged from our care, and we are dependent on others providing us with the information. This will only be fully mitigated by a centralised system for recording deaths linked to all relevant providers.

5.3 Decision to review or investigate

- 5.3.1 Where a death is identified, we require reporting to the Patient Safety Team using a Datix form. Completion of the Datix will in itself require a degree of investigation, involving consideration of the information received about the death, examination of the records to establish what the nature of the contact with services was, and consideration of whether a fuller investigation is indicated or likely to yield useful learning. We have adapted the Datix form to allow senior managers in the service identifying the death to note this information, and to indicate that they have made a decision about whether a fuller investigation is required or appropriate, and if their decision is that it is not, to state why this is the case. The Patient Safety Team then review this decision and seek further information, including a 24 hour report, before deciding whether fuller investigation is warranted.
- 5.3.2 We are identifying through this approach numerous cases (see appendix) in which people in the last months of life have been referred to the community services for treatment in what proves to be a final illness, some of whom are not in fact seen by the service before their

death, and in the majority of such cases a full Serious Incident Investigation does not appear to be either appropriate or feasible. However, we are able to audit samples of cases for which further investigation has been felt to be unnecessary to confirm the validity of these decisions. We are confident that for now this allows a reasonable balance to be struck by experienced clinicians between the need to investigate deaths and identify learning, with the possibility of intrusive and inappropriate contact with families if trying to investigate natural deaths.

- 5.3.3 However, as noted by the CQC, in the absence of clear and widely accepted definitions of the concepts of 'avoidable', 'expected', 'unexpected', 'natural', and 'unnatural' deaths, it is impossible to assure that the decisions our clinicians and our Patient Safety Team make about the level of investigation required would be consistent with those taken by others.

6. Conclusions

- 6.1 The CQC report takes a critical view of the investigation of deaths in the Trusts they reviewed, and identifies a number of concerns about the wider system in which these investigations take place.
- 6.2 We must acknowledge that this Trust is similarly impacted by the deficiencies of the wider system, which make it impossible to be assured that deaths of service users which occur in other parts of the care system will always be identified or be notified to our organisation.
- 6.3 We have extensive experience in investigating deaths in mental health services and in engaging appropriately with families and carers, and good systems both internally and externally which assure the quality of investigations, and that families and carers are engaged with candour. Our investigations of deaths under our care are extensively assured both internally and externally, and we believe our systems are robust.
- 6.4 However, we would acknowledge that the comprehensive reporting of deaths in community services has developed more recently, and the decision about which deaths to investigate, and to what extent, remains a challenging one if we are to avoid the medicalisation of natural death, and the development of a culture which is intrusive to families, and risks the blaming of staff involved with patients in the last years of life.

Implications

4. Budgetary / Financial Implications

- 4.1 None.

5. Risk Management

- 5.1 None.

6. Equality and Diversity Implications

- 6.1 None.

Current Data Reported by BEH (as reported to Quality and Safety Committee 7.11.16) concerning deaths, coroners recommendations to prevent future deaths (regulation 28), and the Duty of Candour

2.1 Investigation of Unexpected Death incidents

- 2.1.1 The Trust continues to review all deaths incidents. The total number of deaths reported in Q1 and 2, 2016/17 was 187.
- 2.1.2 The number of expected deaths reported on Datix continues to rise, as expected, following the Trust decision in January 2016 that all deaths must be reported. The reporting of deaths has been encouraged and aided by the changes made to the Datix system. Teams reporting these deaths must provide assurance that no care or service delivery concerns were identified. To date, all expected deaths were of palliative care patients and no care or service problems have been identified. An audit of expected deaths from Q1 and Q2 of 2016/17 is being undertaken in October 2016 in order to provide assurance that care is optimal in this group of patients and addressed if not.
- 2.1.3 In order to provide the Trust with additional assurance with regards to the management of deaths, on a quarterly basis, the Patient Safety Team compares the number of deaths incidents reported on Datix with Trust mortality data. One would not expect all deaths recorded on RiO to be incidents and hence there will be a variance between the two.

Table 1: The number of deaths recorded on RiO and Datix, April to September 2016

Month	Number of deaths recorded - RiO	Number of deaths reported on Datix
Apr	45	35
May	42	31
Jun	47	30
Jul	41	34
Aug	42	28
Sep	34	29
Total	251	187

- 2.1.4 Table 2 shows the number of death incidents reported in Q1 and 2, 2016/17.

Table 2: Reported death incidents Q1 and 2, 2016/17

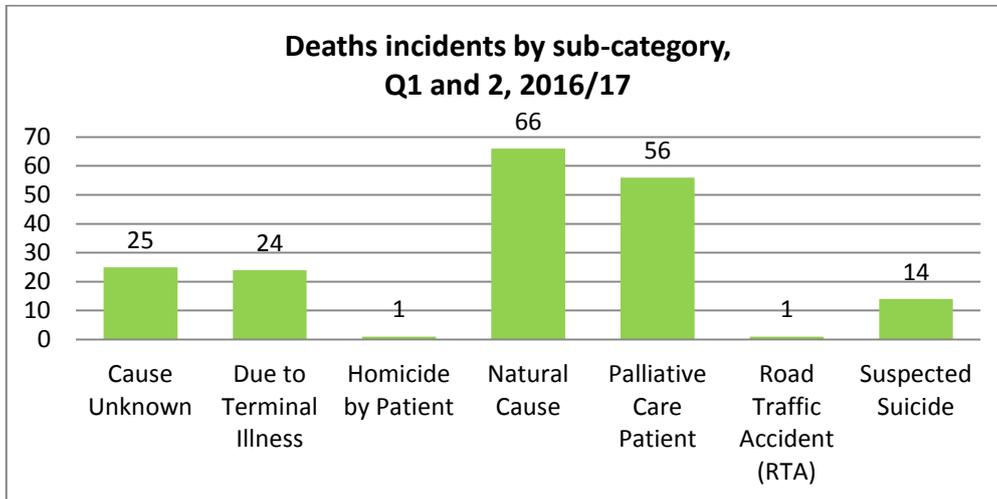
The number of deaths among our service users during 1 April – 30 th September 2016	187
The number of these that were unexpected deaths	47
The number of these that were natural cause deaths	53
The number of these that were expected deaths	87
The number of unexpected deaths that were treated as a Serious Incident Requiring Investigation.	19
For Learning Disability service users, the number of unexpected deaths that were treated as a Serious Incident Requiring Investigation	0 unexpected deaths
For Older People Mental Health Services the number of unexpected deaths that were treated as a Serious Incident Requiring Investigation	2
For service users under section, the number of unexpected deaths treated as a Serious Incident Requiring Investigation	1

2.1.5 All unexpected deaths were reviewed locally:

- 23 unexpected deaths were confirmed by the Coroner as being related to an underlying condition such as idiopathic malignancy epilepsy, renal failure and pneumonia, aspiration pneumonia, and myocardial infarction.
- In Q2, 2016/17, the Trust reported two unexpected deaths of elderly patients to StEIS, the Strategic Executive Incident System.
- Of these, one has since been confirmed by the Coroner to be a natural cause death. The Trust will continue to investigate the incident to establish if there were any gaps in the care and service provided to the patient and to identify lessons to be learned.
- 24 unexpected deaths were not related to physical health or an underlying condition. Fourteen of these incidents were suspected suicide deaths.
- The cause of death for ten incidents is unknown, pending confirmation from the Coroner.

2.1.6 Chart 1 shows the death incidents for Q1 and 2, 2016/17 broken down by subcategory.

Chart 1 – Reported death incidents by sub category, Q1 and 2, 2016/17



2.1.7 All natural cause death incidents are reviewed to establish the exact cause of death (information provided by the Coroner/GP).

4.5 Regulation 28: Report to Prevent Future Deaths

4.5.1 In September 2016, the North London Coroner's Court issued the Trust a Regulation 28 report. Although the inquest into the patient's death found that the patient died of natural causes, based on the evidence, the Coroner felt there was a risk of further deaths occurring unless appropriate action was taken. The Trust must respond by 1st November 2016.

5. Duty of Candour

5.1 During 2015/16, the Trust was robust in its compliance with Duty of Candour regulations and this has been sustained in Q1 and 2 of 2016/17. Compliance with Duty of Candour part 1 for 2015/16 was 96%. In Q1 and 2, 2016/17, compliance with Duty of Candour part 1 was 97%.

5.2 Compliance with Duty of Care part 2 for 2015/16 was 93%. In Q1 and 2 of 2016/17, Compliance with Duty of Care part 2 is 100%.