City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report from the, Chief Officer of NHS Airedale, Wharfedale and Craven CCG, NHS Bradford Districts CCG and NHS Bradford City CCG to the meeting of the Health and Wellbeing Board to be held on 13th February 2018

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Subject:

A whole system approach to learning from deaths

Summary statement:

This report provides an update on local progress in implementing the recommendations of the 'Mazars Report', which examined the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust, but which has relevance for every part of the English Health and Social Care system.

The report also considers the next steps to be taken in responding to the Mazars Report, together with the challenges that this presents.

In so doing, the report aims to assist the Bradford and Airedale Health and Wellbeing Board in achieving its long-term vision 'to learn together from deaths openly, involve families, and share and celebrate success across the system'.

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Portfolio:
Health and Wellbeing

Overview & Scrutiny Area:
Health & Social Care

1. SUMMARY

This paper supported by a presentation provides the Health and Wellbeing Board with the local picture of how we currently learn from deaths across the health and social care system, the challenges ahead and how the system plans to work together to utilise learning from deaths. It was prepared at the request of the Health and Wellbeing Board, which, early in 2017, asked for an overview of how learning from deaths takes place in the Bradford and Airedale system. The presentation, will do the following:

- Enable key healthcare providers to summarise their own work on developing systems and processes to learn from deaths.
- Summarise how providers and commissioners have collaborated to learn from deaths of people with a learning disability

Death is of course inevitable and universal, the large majority of deaths do not require any form of formal review. Many people receive excellent care, whether from family and friends or from formal health and social care services. However, as with any other human system there are times when things go wrong and parts of the system do not always work together well. In Bradford and Airedale, local commissioners and providers have agreed that the deaths of people with learning disabilities will be prioritised as the starting point for the development of a comprehensive approach to learning from deaths by the health and social care system.

Deaths of vulnerable groups such as people with learning disabilities or mental health problems provide a greater opportunity for learning as they often receive care across the health and social care system.

Understanding and sharing learning from deaths across the system is a challenge. Our NHS providers are taking steps in the right direction, but the whole system and all its components needs to be taking the same steps to share information and learning.

Locally NHS Trusts' progress against the *National Guidance on Learning from Deaths* (see below) is on track. The learning disabilities mortality review (LeDeR) programme, which was commissioned by NHS England, has posed a significant challenge to both resource and capacity across the system and requires commitment from every organisation to deliver its aims.

This report will also provide an update on:
- 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 (i.e.the Mazars Report, 2015)
- Local roll-out of the learning disabilities mortality review programme (LeDeR).
- Progress against key guidance; Learning, Candour and Accountability (2016 Care Quality Commission, CQC) and National Guidance on Learning from Deaths (2017, National Quality Board, NQB)
- Child Death Overview Panel work which is statutory and has been in place since 2008

2. BACKGROUND

In May 2017, an update was provided to the Health & Wellbeing Board on LeDeR and the Mazars Report. A further update was planned in November 2017; this was deferred until February 2018.

Following events at the former Mid Staffordshire NHS Foundation Trust, close scrutiny was given to every hospital's mortality records and statistics. After some time, however, it became apparent that over-emphasis on what appeared to be statistical evidence of high mortality in individual hospitals was distracting Trust boards from taking practical steps to improve care and service delivery. Nationally, it is now recognised that there are major limitations to mortality statistics and how they can be interpreted.

Instead, a series of guidance documents and standardised processes have been published and introduced to help provide a stronger basis for learning from hospital-related deaths. The standardised processes include the Structured Judgement Review (SJR) for acute trusts and the NHS Serious Incident Process, the Child Death Overview Panel (CDOP) and Domestic Homicide Review.

Important guidance includes *Learning, Candour and Accountability* (2016 Care Quality Commission, CQC) which was published in response to the Mazars Report, which itself highlighted the very low numbers of investigations or reviews into deaths at Southern Health NHS Foundation Trust. The guidance provides a basis for better engagement with families and carers following a death, as their insights are vital sources of learning.

The National Guidance on Learning from Deaths (2017, National Quality Board, NQB) was published last year and sets out a framework for all NHS Trusts to identify, report, investigate and learn from deaths in care. Since the publication of the guidance, there has been a significant shift in expectation about how NHS Trusts should respond to hospital-related deaths.

In Bradford and Airedale, local NHS Trusts have made good progress on implementing the relevant guidance summarised above. Trusts have/will

- Published a 'learning from deaths' policy
- Publish from quarter 3 (2018/19) information on deaths, reviews, investigations and reviews of care provided to people with a learning disability or severe mental health problems
- From June 2018, to publish a yearly overview of the quarterly information in their formal quality accounts
- Pledged to review and investigate deaths where care and service delivery problems have occurred so that everyone can learn and prevent recurrence

The Child Death Overview Panel (CDOP) is statutory and has been in place since 2008 and currently works to the principles outlined in 'Working Together' published in 2015. CDOP is a multiagency group chaired by Public Health which reviews all deaths of children under 18 years of age who are resident in Bradford district. CDOP seeks to identify potentially modifiable causes of child deaths and to ensure the relevant organisations and partners have completed all recommended actions to reduce the risk of

similar deaths in the future. CDOP produces an annual report; CDOP members share the findings of this report at training events and during safeguarding week as well as within a regular Newsletter. Since April 2017, it has also begun to identify all child deaths aged 4 - 17 years that have been reviewed where the child has an identified Learning Disability; this is in order to commence notifications as required as part of the national approach to LeDeR. New guidance on the CDOP process is due to be published in April 2018 as the responsibility for CDOP moves to the Department of Health and will be jointly owned by the CCGs and Local Authority.

In addition, there is key work as part of the district wide Suicide Prevention partnership group which informs the delivery of the Suicide Prevention Action Plan. The learning from the NHS Serious Incident process for deaths where people have had contact with Mental Health services is shared with partners and also the findings from the analysis of Learning Disability deaths are shared with the Transforming Care Programme Board.

In relation to the Learning Disabilities Mortality Review Programme (LeDeR) it is clear that the capability and capacity of staff to complete reviews remains a national challenge. In Airedale and Bradford, the recent allocation of new resources will improve the picture and help us all understand (in line with Mazars' recommendations) how people with learning disabilities move though our health and social care system.

A key next step is to champion and raise awareness in primary care and within local authorities, as approximately 90% of deaths of people with a learning disability are in the community, and of course many people with a learning disability live in residential settings commissioned by the local authority.

Next steps in the implementation of the LeDeR programme include:

- A cross-system collaborative learning from deaths session planned for autumn 2018, with a focus on LeDeR and revisiting the gaps and challenges
- Exploration of how NHS Trusts engage with primary care and local authorities at critical points in the learning from deaths process
- Involving families and carers in the review process, beginning with LeDeR
- Championing the engagement of primary care and local authority in the LeDeR process
- Exploring what vehicles are in place or can be created to improve the sharing of learning across the system

3. OTHER CONSIDERATIONS

There are no known other considerations at this point

4. FINANCIAL & RESOURCE APPRAISAL

There are no financial issues arising

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

There are no known significant risks arising out of the implementation of the proposed recommendations

6. LEGAL APPRAISAL

Not applicable

7. OTHER IMPLICATIONS

Not applicable

7.1 EQUALITY & DIVERSITY

Not applicable

7.2 SUSTAINABILITY IMPLICATIONS

Not applicable

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

Not applicable

7.4 COMMUNITY SAFETY IMPLICATIONS

Not applicable

7.5 HUMAN RIGHTS ACT

Not applicable

7.6 TRADE UNION

Not applicable

7.7 WARD IMPLICATIONS

Not applicable

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

Not applicable

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

None

10. RECOMMENDATIONS

- That the progress already made in response to guidance and commitment to further explore solutions to the challenges be noted.

- That the contribution and commitment which needs to be made by the whole system to learn openly from deaths, to translate learning into improving how we deliver care be considered.

11. APPENDICES

None

12. BACKGROUND DOCUMENTS

None