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<th>Sponsoring Director:</th>
<th>Director of Nursing and Patient Safety.</th>
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<td>Author:</td>
<td>Director of Nursing and Patient Safety.</td>
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<td>Purpose of the report:</td>
<td>To update the Board on progress with reviewing the SIRI management process and to advise the Board of the impact of the CQC report <em>Learning, Candour and Accountability</em> 2016</td>
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| Key Issues and Recommendations: | The Trust is in the process of further strengthening governance processes, part of which includes centralising the clinical governance support function within the Nursing and Patient Safety Directorate.  

The clinical governance function has been devolved to each operational division to manage through their own clinical governance units. Five Clinical Directors have been appointed to work with the Head of Division and nursing/AHP professional leads to further strengthen divisional governance arrangements.  

The CQC report identified significant gaps in the process for the identification, management and monitoring of serious incidents within all Trusts. Five areas have been identified for Trusts to review and improve:  

- involvement of families and carers;  
- identification and reporting;  
- decision to review or investigated;  
- reviews and investigations;  
- governance and learning.  

NHS England has accepted the recommendations in full and will require trusts to improve the management and reporting of incidents. |
All trusts are required to appoint an Executive Director for Patient Safety and a Non-Executive Director to oversee patient safety.

The Trust has incorporated the findings of the CQC report into a Trust SIRI improvement plan which will be monitored through the Quality and Performance sub-committee of the Trust Board.

| Actions required by the Board: | The Board is requested to discuss and note the report. |
1. PURPOSE

1.1 The purpose of this report is to review the findings of the CQC report *Learning, Candour and Accountability* and to update the Trust board on proposed actions to improve the quality of serious investigations and learning outcomes.

2. BACKGROUND

2.1 In 2016, NHS England asked the CQC to conduct an investigation into lessons that needed to be learned following the tragic death of Connor Sparrowhawk in 2013 whilst in the care of Southern Health NHS Foundation Trust. The CQC were also asked to assess more broadly what lessons there are for the broader NHS.

2.2 In order to understand what problems exist and what improvements are needed, CQC looked at five different aspects of the processes and systems that NHS trusts need to have in place in order to learn from the death of a patient.

a) **Involvement of families and carers**: How are families and carers treated? Are they meaningfully involved and how do organisations learn from their experiences?

b) **Identification and reporting**: How are the deaths of people who use services identified and reported, including to other organisations involved in a patient’s care, by NHS clinicians and staff, particularly when people die but are not an inpatient at the time of death?

c) **Decision to review or investigate**: Are there clear responsibilities and expectations to support the decision to review or investigate?

d) **Reviews and investigations**: Is there evidence that investigations are carried out properly and in a way that is likely to identify missed opportunities for preventing death and improving services?
e) **Governance and learning:** Do NHS trust boards have effective governance arrangements to drive quality and learning from the deaths of patients?

3. **INDEPENDENT REVIEW OF SOUTHERN HEALTH NHSFT**

3.1 NHS England commissioned an independent review of Southern Health following the death of Connor Sparrowhawk who died whilst in their care. The team reviewed all deaths of people with a mental health or learning disabilities in the Trust between April 2011 and March 2015. This included 1454 incidents and 195 SIRI’s.

3.2 The subsequent report was damming and identified a lack of leadership, focus and time spent on reporting and the investigation of unexpected deaths. There was a lack of system wide investigation with poor quality investigations and reports and no systematic approach to learning, and in many cases no action plan. Of significance was the lack of engagement with families.

3.3 Specific recommendations highlighted the importance of board leadership and oversight, the importance of involving families and the need for rigorous and consistent approaches to the identification, reporting and investigation of all deaths. As a result of this review, NHS England commissioned the CQC to undertake investigation with the resulting national report “Learning, Candour and Accountability” which was published in December 2016.

4. **CQC REPORT FINDINGS**

4.1 In December 2016 CQC issued their findings in the report “*Learning, candour and accountability*”. Key findings include the following:

- families and carers often have a poor experience of mortality investigations; are sometimes not treated with kindness, respect and sensitivity; can feel their involvement is tokenistic; and often question the independence of the reports;

- the NHS does not prioritise learning from deaths and misses countless opportunities to learn and improve as a result;

- there is no single framework which sets out how local NHS organisations should identify, analyse and learn from deaths of patients in their care;

- as a result there is inconsistency. Some NHS Trusts get some elements of mortality reporting right, but not one gets all elements right;

A Review of the Trust’s Management of Serious Incidents and the Implications of the Care Quality Commission Report – “Learning, Candour and Accountability”
in particular, the leaders of NHS organisations, their doctors, nurses and other staff simply do not have access to the full picture of how many patients die in their care, which deaths were preventable and what needs to be learned.

4.2 NHS England has accepted all of the report’s recommendations and advised that from March 31 next year the Boards of all NHS Trusts and Foundation Trusts will be required to:

• collect a range of specified information on deaths that were potentially avoidable, and serious incidents, and consider what lessons need to be learned on a regular basis. This will include estimates of how many deaths could have been prevented in their own organisation and an assessment of why this might vary positively or negatively from the national average. Trusts to publish that information quarterly;

• alongside that data, Trusts will publish evidence of learning and action that is happening as a consequence of that information. They will feed the information back to NHS Improvement at a national level;

• all trusts will be asked to identify a board-level leader as patient safety director to take responsibility for this agenda and ensure it is prioritised and resourced within their organisation. They will be asked to appoint a non-executive director to take oversight of progress;

• ensure that investigations of any deaths that may be the result of problems in care are more thorough and genuinely involve families and carers;

• all trusts will be asked to follow a standardised national framework for identifying potentially avoidable deaths, reviewing the care provided, and learning from mistakes;

• the NHS National Quality Board, have been asked to draw up guidance on reviewing and learning from the care provided to people who die, in consultation with Keith Conradi, the new Chief Investigator of Healthcare Safety. These guidelines will be published before the end of March next year, for implementation by all trusts in the year starting next April;

• Health Education England will be asked to review the training for all doctors and nurses with respect both to engaging with patients and families after a tragedy and – equally importantly - maintaining their own mental health and resilience in extremely challenging situations.
• because the report identified particular concerns about the treatment of people with learning disabilities, there are two further actions: a) Acute trusts will be asked for particular priority to be given to identifying patients with a mental health problem or a learning disability to make sure their care responds to their particular needs; and that particular trouble is taken over any mortality investigations to ensure wrong assumptions are not made about the inevitability of death. b) NHS England will ensure that the NHS reviews and learns from all deaths of people with learning disabilities, in all settings;

• the Learning Disabilities Mortality Review Programme will provide support to both families and local NHS areas to enable reporting and independent, standardised review of all learning disability deaths between the ages of 4 to 74. NHS England will ensure that there is coverage in all regions by the end of next year and full national roll out by 2019.

4.3 Importantly NHS England will not be setting any target for reducing reported avoidable deaths. Neither will they compare numbers between hospitals because “the data depends on clinical views which may change or vary”.

4.4 They have confirmed that they expect to see an increase in the number of reported avoidable deaths. This is likely to be hospitals get better at spotting and reporting them than because care is deteriorating. Furthermore they have reminded the public that when there is a tragedy in the NHS, there is always a second victim, namely the doctor or nurse involved who invariably suffers huge anguish.

4.5 Following publication of the CQC report NHS England commended the progress made by NHS providers to date and noted the following improvements in care provision -:

• the number of people experiencing the four main hospital harms down by a third since November 2012;

• MRSA and C.Diff rates have halved since 2010;

• there are 10,000 more hospital nurses on wards since the Francis report;

• there is a new Healthcare Safety Investigations Branch to perform speedy, no-blame enquiries into avoidable harm and death modelled on the successful system that has operated in the airline industry for many years;
a consultation has recently concluded on legislation to create a ‘safe space’ for NHS staff to talk openly about how to improve the safety of care for patients without having to worry about litigation or professional consequences.

**Process for investigating deaths**

4.6 Last year 495,309 deaths were registered in England. Of these, 232,442 (47%) people died in hospital with even more dying while receiving services provided by NHS trusts as an outpatient or from community services provided by the trust.

4.7 When a person dies, there is an action and decision that is then taken by someone working in the NHS, whether a doctor, nurse or paramedic. Actions are often routine, for example a doctor confirming the death of a patient.

4.8 A much smaller number of cases are reported by NHS trusts as needing a review of the care provided. From the information NHS England received from trusts, in 2015/16 around 5,500 investigations into the deaths of patients receiving care were completed, with the intention of supporting learning and improvements through changes being made to the services provided for future patients.

4.9 CQC have identified three, sometimes conflicting, reasons for NHS trusts to investigate a patient’s death – identifying what care had been provided to offer learning to improve and change the way care is provided to others in future, supporting candour to share information with others including families, and making sure accountability is identified if failures are found.

4.10 The purpose of an investigation is to understand the care that was provided to the patient before they died and highlight any potential problems. The trust will carry out this investigation to make sure that both it and the patient’s family understand what happened, and that staff can learn and changes can be made.

**Learning Disabilities Mortality Reviews**

4.11 The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. In the South West it is being delivered by a team based at the University of Bristol. Many of the delivery team were involved with the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) which took place between 2010 and 2013.

4.12 CIPOLD reported that for every one person in the general population who dies from a cause of death amenable to good quality care, three people with learning disabilities will do so. One of the key
recommendations of CIPOLD was for the greater scrutiny of deaths of people with learning disabilities. In this way, potentially modifiable circumstances leading to a death could be identified and avoided in the future through improvements to health and care services.

4.13 The LeDeR Programme supports local reviews of deaths of people with learning disabilities aged 4-74 years of age across England. A confidential telephone number and website enables families and other key people to notify the LeDeR team of the death of someone with learning disabilities. An initial review of the death will then take place. The purpose of this is to provide sufficient information to be able to determine if there are any areas of concern in relation to the care of the person who has died, and if any further learning could be gained from a multiagency review of the death that would contribute to improving practice. If indicated, a more in-depth, multiagency review will be conducted.

4.14 The LeDeR programme will be supporting local reviews of deaths of people with learning disabilities from January 2016 and the Clinical Risk team and the Trusts learning disabilities services are actively engaged with the programme.

5. ACTIONS FOR THE TRUST

5.1 Following the Trusts own comprehensive inspection of its services by the CQC in October 2015, the Trust has reviewed its internal governance processes. As a result a number of actions have been completed:

- the strategic leadership of the Clinical Governance function continues to sit with the Director of Nursing, AHP’s and Patient Safety however the delivery of clinical governance has now been delegated through the operational divisions to front line teams;

- in October 2016, the Trusts risk team moved to the Nursing and Patient Safety Directorate to become part of a dedicated Clinical Governance team;

- a revised clinical risk process has been adopted with a stronger focus on managing operational risk within clinical teams;

- in autumn 2016 the Trust appointed its first SIRI investigation lead whose role is to link with SIRI investigators to support the investigation process, to ensure that there is a consistent approach and that a rigorous approach is taken with a focus on improvement and learning;
• a new weekly SIRI monitoring process has been implemented;
• the SIRI policy is currently under review;
• Root Cause Analysis training is being sourced;
• in January 2017 the Trust is hosting a “Making Families Count” workshop on behalf of NHS England.

5.2 Both the CQC and Southern Health report have been scrutinised by the Trusts clinical governance team and a gap analysis completed. Key additional actions have been identified.

**Involvement of families and carers:**

5.3 The Trust is in the process of changing the way that investigations are undertaken with an immediate focus on engaging with families and carers to involve them in the process far earlier. All SIRI investigations already involve the requirement for Duty of Candour standards to be met.

5.4 On 11 January 2017 the Trust hosted a NHS England workshop “Making Families Count”. This event brought together six families whose relative had been subject to a serious incident which included homicide, unexpected death and suicide. The families shared their experience of being involved in NHS reviews much of which was negative – and worked with staff and our clinical governance team as well as staff from the CCG and other Trusts, to identify ways of improving the process.

5.5 As a result the Trust is actively exploring opportunities to use the carer’s service to support families and to proactively include answering the families’ specific questions in the terms of reference and outputs of the report.

**Identification and reporting:**

5.6 The Trust continues to promote the use of Datix to report all unexpected deaths whilst in receipt of our care.

5.7 All will now proceed to a 72 hour report to include immediate actions and learning. Each operational division will be required to monitor reporting rates (including timeliness) through their divisional clinical governance processes.

5.8 Reporting nationally via the National Reporting and Learning System (NRLS) has been increased to fortnightly and close working with the CQC will continue for high risk cases.
Decision to review or investigate:
5.9 A new virtual SIRI panel has been constituted to formalise the initial decision making process regarding the appropriateness to proceed to full investigation. The CCG are actively engaged in this process.

Reviews and investigations
5.10 The Clinical Governance team has introduced a new weekly SIRI monitoring process to ensure that all SIRI’s are investigated in a timely manner. This is shared with Heads of Divisions who will monitor progress through their divisional clinical governance meetings.

5.11 The new SIRI investigation lead now links with front line teams and the investigator to ensure that all investigations are thorough, independent and involve the family.

5.12 Root Cause Analysis training is currently being secured with two cohorts of 25 staff planned to complete training during 2017/18.

5.13 Local debriefs and the development of local action plans now start earlier in the process. In early 2017 the Trusts SIRI groups function will change to focus more on organisational learning.

Governance and learning:
5.14 Each division is now required to monitor their actions plans through the devolved Clinical Governance arrangements. The newly appointed Clinical Directors will work closely with Heads of Division and Professional Leads to oversee this process and to ensure that the learning is embedded in practice.

5.15 The Trust Board is currently participating in an external “Well Led” review.

5.16 The Director of Nursing and Patient Safety has been appointed as the Board level leader for patient safety. A non-Executive Director will need to be appointed to take oversight of the process.

5.17 An internal audit of the SIRI process has been commissioned and completed in December 2016.

6. INTERNAL AUDIT FINDINGS

6.1 The formal internal audit report is yet to be shared with the Trust but preliminary findings have identified a number of areas of good practice as well as areas for improvement.

6.2 The auditors noted that there was a positive culture of incident reporting and that the importance if incident reporting was evident across the Trust. The audit acknowledged that the Trust was currently undertaking
a significant review of the SIRI process and noted that the new draft policy was well written and easy to understand.

6.3 There were no areas identified for improvement which the Trust was not already aware of but it was acknowledged that the audit would provide a focus for implementing the required changes at a local level. Key areas to address from the internal audit include the following:

- a need to improve the timely reporting of incidents;
- a need to ensure that 72 hour reports and staff debriefs are completed on time at a local level;
- a more robust approach to StEIs reporting and monitoring of timescales;
- an improved process for following up action plans within divisions;
- a need for training in incident reporting and Root Cause Analysis.

7. SUMMARY AND NEXT STEPS

7.1 A significant amount of work has been completed to improve the process and outputs following serious incidents. The newly devolved clinical governance functions to operational divisions will help to embed this in practice.

7.2 A SIRI improvement plan has been developed to reflect the current work programme. This has been further amended to reflect the additional actions identified through the CQC report and the internal audit. It is proposed that this will be monitored through the Trusts Quality and Performance Committee.

7.3 The Trust should consider appointing a Non-Executive Director to oversee Patient Safety.

DIRECTOR OF NURSING AND PATIENT SAFETY
## Links to Strategic Themes:
Identify to which of the Somerset Partnership NHS Foundation Trust strategic themes this report relates by including a cross behind the relevant theme(s)

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<thead>
<tr>
<th>Quality and Safety</th>
<th>Sustainability and Transformation</th>
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<tr>
<td>Service Delivery</td>
<td>Culture and People</td>
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## Links to the Assurance Framework:
Identify to which risks of the Assurance Framework this report relates
- not related to any specific risks on the Assurance Framework.

## Links to the NHS Constitution and Trust Values:
Identify the Values to which the issues raised in this report relate by including a cross behind the relevant value(s)

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<th>Working together for patients</th>
<th>Compassion</th>
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<td>Respect and dignity</td>
<td>Improving lives</td>
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<td>Commitment to quality of care</td>
<td>Everyone counts</td>
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## Links to CQC Domains:
Identify which of the CQC domains are covered by this report by including a cross behind the relevant domain(s)

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<th>Is it safe?</th>
<th>Is it caring?</th>
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<td>Is it well-led?</td>
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<td>Is it responsive to people’s needs?</td>
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## Equality:
Identify whether the report has an impact on the protected characteristics set out below, including risks, and if so, say how these risks are to be managed. Only tick the relevant box for which there is an impact.

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<tr>
<th>Age</th>
<th>Disability</th>
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<td>Gender re-assignment</td>
<td>Marriage and Civil Partnership</td>
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<td>Pregnancy and maternity</td>
<td>Race</td>
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<tr>
<td>Sexual Orientation</td>
<td>Learning Disabilities</td>
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**Legal or statutory implications/requirements:**
Awaiting formal reporting requirements from NHS England

**Public/Staff Involvement History:**
The report sets out information relating to patient experience of the quality of services and feedback from patients, carers and the public of NHS services nationally, including feedback from a Making Patients Count workshop

**Previous Consideration:**
This was discussed at the Clinical Governance Group in December 2016.