

**BOD 67/2016**

(agenda item: 11)

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**25 May 2016**

**Trust Mortality Review**

**For: Approval**

**Executive Summary**

In December 2015, NHS England published an independent report by the Mazars Group into the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust, and highlighted a system-wide response. Following this, all NHS providers were asked by the Director of Patient Safety and Medical Director at NHS England to compile and submit figures in January 2016 (we used 2014/15 data) around the number of deaths in a year, of those deaths how many were locally reviewed and how many were potentially preventable.

In addition the CQC in May 2016 have asked mental health and learning disability providers for data on deaths from 1st April 2015 which will inform a thematic review on mortality. The themed review will focus on the quality of practice in relation to identifying, reporting, investigating and learning from deaths of people with a learning disability or mental health problem. After analysing the responses, the CQC will conduct phone interviews with thirty acute, mental health and community trusts to get more information and then visit twelve to get a real in-depth understanding of their practices and processes. The outcome of the themed review is planned to be shared in December 2016.

The trust has carried out a self-assessment against the recommendations in the above independent report as well as other national guidance i.e. Monitor’s mortality governance guide, to test our current processes and systems and to identify any improvements to be made. A project team was formed covering a range of professions and representatives from each of the clinical directorates, the risk team and safer care team, which has been chaired by the Director of Nursing and Clinical Standards or the Medical Director. The project team has met monthly between January-May 2016. A range of individuals have been asked to assess and rate the trust against these standards/ recommendations and indicate the evidence we have to support this.

The outcome of the self-assessment has indicated subsequent work which is needed to ensure our processes are robust and we are doing everything we can to identify and learn from avoidable deaths. Enclosed is a list of the key work streams identified; the timescales and leads for each action still need to be finalised. Additional resource is needed to support the work and ensure this is completed in the next few months.

One key recommendation in the Mazar’s report was the formation of a trust wide mortality review group which would spend regular time reviewing patient deaths and the care provided, to be able to provide assurance of the robustness of processes to learn and reduce avoidable deaths. Initially the group will focus on implementing the key work streams identified from the self-assessment. This group will report to the safety quality sub-committee and is due to first meet in June 2016. We have developed a draft terms of reference based on a suggested national template, which is enclosed.

To ensure we have appropriate assurance of mortality process the key questions we need to ask are:

1. Do we identify and report deaths correctly?
2. Do we review and investigate unexpected deaths properly and without delay?
3. Do we meet our obligations to others?
4. Do we learn from deaths?
5. Are we being transparent and open in our reporting and investigating of deaths?

*(source: Mazars)*

Enclosed are the documents mentioned above;

* Terms of reference for mortality review group
* Self-assessment
* Key work streams

The self-assessment, proposed work streams and draft Terms of Reference for the Mortality Review Group were discussed at a Board Seminar on 13th April and circulated to the Extended Executive on 17th May for comments.

**Recommendation**

The Board is asked to:

Note the report. Updates will be provided through the Safety Quality Report.

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