Mazars 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

Clinical Commissioning Group Recommendation Action Plan

	Recommendation or Issue	Currently in Place	Actions	Impact	Lead	Timescales	Update
Commissioners Recommendations							
1	**Recommendation One** The CCG should take action to ensure: 1. incidents are reported to StEIS within 2 working days as required 2. that reports are provided to closure panels within 60 days as required 3. that the quality of IMAs, Critical Incident Reviews and Serious Incident investigations improves radically 4. that Serious Incident investigations are completed within an agreed timeframe 5. that the data provided to them relating to deaths is accurate. **Commissioners recognise that this recommendation is applicable to all its providers.** **COMPLETED**	National Policy and Guidance Contractual Schedule Local CCG Policies SHFT Policy for reporting and investigation deaths SHFT Policy for Managing Incidents and Serious Incidents MH/LD CQRM ICS CQRM Joint SIRI panels	1.1 Commissioners to undertake a baseline review of SIRI reporting at SHFT, analysing current response and closure times. **COMPLETED** 1.2 Commissioners to include number of SIRIs on the provider quality scorecard. **COMPLETED** 1.3 Commissioners to include the number of SIRI's reported within 2 working days on the provider quality scorecard. **COMPLETED** 1.4 Commissioners to include overdue SIRI's on the scorecard. **COMPLETED** 1.5 MH/LD CQRM will receive a monthly report on SIRIs at each meeting, SHFT will provide report. **COMPLETED** 1.6 Commissioners to identify appropriate contractual levers to assist in quality improvement. **COMPLETED** 1.7 Commissioners to review current SIRI process for SHFT at Strategic Oversight Group and identify improvements including medical, nursing, patient, carer oversight by CCGs and MH/LD commissioner involvement. **COMPLETED** 1.8 Commissioners to develop an audit tool for quality checking IMA's - to be completed by SHFT. **COMPLETED** 1.9 SIRI Panel to receive SHFTs completed SIRI report even if the Coroner has not reported. Coroners verdicts on SIRIs will be reviewed at the panels once it has been finalised. **COMPLETED** 1.10 Thematic review of all MH/LD SIRI's to be undertaken twice yearly by SHFT to identify themes and trends.	Improvement in reporting and closure rates of SIRI's Improvement in the quality of the SIRI report and robustness of actions Consistent approach to SIRIs across all SHFT Commissioners Information used from thematic review to inform future commissioning intentions Consistent approach across providers Improved timeliness of learning	Edmund Cartwright/ Carole Berryman	May 2016	Dashboard has been updated for the 2016/17 contract and includes SIs that have been reported in the month, total open SI's and numbers breaching the 60 working day deadline. SI's are a standing item on the monthly Clinical Quality Review Meetings (CQRM). Quarterly SI reports now include progress on thematic reviews. Contractual levers have been explored with the contracts team and the national contractual levers will be applied as necessary i.e. GC9 and SC28 (information breach). Joint CCG and provider SI panels terms of reference have been revised to include the use of the new quality checklist and the reporting of deaths without waiting for the outcome from the Coroners Court. The ToR also include a requirement for an in-depth assurance meetings 2-3 times a year to provide assurance to commissioners that actions have been taken and are embedded in front-line operational practice across the trust. The trust mortality meetings now include a monthly audit of IMA's. Commissioners are invited to these meetings and receive the audit information quarterly at CQRM.

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			COMPLETED				
2	**Recommendation Two** All Commissioners of services from the Trust should ensure that all unexpected deaths of people with: 1) a Learning Disability, 2) inpatients on Older Peoples Mental Health wards and 3) in cases of suicides of people in the period between referral and treatment are properly considered before a decision is taken not to report as a Serious Incident or report under CQC Regulation 16.	There has been more proactive work in the last few years to understand the scale of unexpected deaths which has included a Hampshire County Council joint response to the Mencap 6 lives report (2009) and a local assurance report around "74 lives and counting" (deaths in hospital (2013) Learning from previous investigations is demonstrated by: - Prevention of suicide by assessment and reporting of ligature risks. A report was provided to the CCG by the trust - Review of environmental safety and the safe disposal of medicines reports provided by the trusts A Hampshire wide choking strategy for LD and older people has gone to every provider in Hampshire and is in the quality schedule of the contract. Individual risk assessments are mandated in the specification.	1) Learning Disability (LD): Commissioners in Hampshire to ensure that there is a clear incident management protocol for investigation of all LD deaths whether they are in primary, community, acute or specialist care – this forms part of the learning disability national mortality review that all CCGs will participate in from April 2016. **IN PROGRESS** Commissioners to fully participate in Learning Disability Mortality Review (LeDeR programme) and ensure there are mechanisms in place to sustain the investigation of all LD deaths in future. . **IN PROGRESS** Commissioners to review current SIRI process for SHFT at Strategic Oversight Group and identify improvements including medical and nursing oversight by CCGs and how learning can be cascaded wider. **COMPLETED** Public Health has offered support to SHFT to improve reporting of suicides / mortality to CQRM. **COMPLETED** Work to develop a joint transition protocol between CAMHS (SPFT) and SHFT is underway; this needs to include deaths following transition - WHCCG to contact SPFT to ensure this is picked up in discussions. **COMPLETED** 2) Suicides between referral and treatment: Commissioners actively promote joint working with the Health & Wellbeing Boards (supported by Public Health) on suicide prevention **COMPLETED** 2.2.2 Commissioners to continue their	Reduction in LD deaths Development of appropriate pathways to support long term health and wellbeing of individuals with a learning disability Reduction in mortality rate across Hampshire	Beverley Meeson Edmund Cartwright/ Carole Berryman	Dec 16	The trusts new Procedure for Reporting and Investigating Deaths has been seen at CQRM. Commissioners have been in attendance at 3 of the AMH and LD divisional mortality review meetings and note that there are still improvements to be made in the governance of these meetings by the trust. Commissioners will continue to attend these meetings until assured by the processes. Recent CCG attendance at the OPMH mortality meetings has provided better assurance that processes are in place for learning. Public Health and CCGs are working together with local authority, police and fire services to ensure any learning from suicides, including primary care is taken forward which will include suicides of patients referred for treatment. Commissioners are fully participating in the LeDeR programme although there has been a delay in the start due to technical issues in the Bristol office. September 2016 – these issues are now resolved and the programme has begun. This will remain as "in progress" until it is more firmly established. The incident management protocol is being raised in the Wessex LD forum and the Regional Board in October. WHCCG and SCCCG have staff trained in this programme to undertake the deaths reviews. Thematic reviews of deaths within the LD, AMH and OPMH services have been requested at CQRM. Specific OPMH mortality meeting feeds into Trust-wide Mortality meeting. Outputs are included in the quality

			development of a multiagency SIRI / incident review process and ensure successful implementation. **IN PROGRESS** WHCCG to request stronger participation from SHFT on the Hampshire suicide prevention strategy work with HCC Public Health department including the development of a mental health suicide prevention strategy. **COMPLETED**				indicators for the MHLD services across Hampshire for 2016/17 contracts. Multi-agency workshop held to discuss and develop joint investigation protocol now in development by WHCCG. SHFT are holding a second multi-agency workshop on 20 September. WHCCG and HCC Adult Services have identified a list of LD patients that died from 2011 to 2015; this is currently with SHFT reviewing whether these deaths have been investigated by SHFT. A case note audit of these patients will then be undertaken individually to identify learning. 2) Suicide: Commissioners are involved with Public Health on the implementation of the Hampshire Strategy for suicide prevention and with Southampton City Council. Public Health now attend the Clinical Quality Review Meetings when the suicide and mortality reports are presented by SHFT and are working together to ensure a more joined up approach. Awaiting further information from Coroner's Office within the next couple of weeks which will inform the Southampton picture for years 2013-2015. Public Health and CCGs are working together to ensure any learning from suicides in primary care is taken forward which will include suicides of patients referred for treatment. SHFT will raise a file as soon as a person is referred to them. HCC Public Health and SHFT are working together with other partners to develop a Suicide Prevention Plan. A response from the Coroner regarding people who die before being seen by mental health teams is that he would follow this through to ascertain why the person had not been seen. The transition protocol is in the final

							stages of development and commissioners will now seek clinical approvals in CCGs and provider organisations.
3	**Recommendation Three** The CCGs with CQC should ensure that the Trust reports and investigates all deaths in detention to ensure that full learning is derived from this group of deaths.		3.1 CCGs to work with SHFT to ensure that all deaths of patients detained are recorded as a serious incident requiring investigation. **COMPLETED** 3.2 SHFT quality scorecard to include deaths of patients detained. **COMPLETED** 3.3. Commissioners to review current SIRI process for SHFT at Strategic Oversight Group and identify improvements including medical and nursing oversight by CCGs and MH/LD commissioner involvement. **COMPLETED**	Provider can clearly articulate all deaths of detained patients Learning from the SIRIs informs future commissioning decisions	Edmund Cartwright/ Carole Berryman	May 2016	All deaths of people who are detained under the MHA are investigated as part of the Mortality reviews and are reported as a SIRI and investigated accordingly. This is also specifically included with the Quality indicators for 2016/17 and on the SHFT scorecard and therefore the timescale has been amended to the start of the contract. SCCCG reviews all incidents in SHFT at a local level, future reporting will include the requirement to include detention status to allow oversight that these are being investigated appropriately. The quality scorecard specifies number of MH deaths and number of SI reportable MH deaths. Commissioners have been in attendance at 3 of the AMH and LD divisional mortality review meetings and note that there are still improvements to be made in the governance of these meetings by the trust. Commissioners will continue to attend these meetings until assured by the processes.
4	**Recommendation Four** The CCGs, with NHS England, should review whether GPs should be involved in initial management assessments of people with a Learning Disability and the extent to which GPs are sufficiently informed to talk with the Coroner if needed. As registered Drs, GPs are empowered to sign a death certificate in circumstances where the death is deemed to be of natural causes, if a GP is uncertain or there are specific circumstances ie DOLs the certification is deferred to the coroner.	Work to date has been to improve the identification of learning disability patients within the community and primary care and has focussed on improvements in the Quality and Outcomes Framework register and the need to undertake annual reviews on individuals with a learning disability. CCGs report the take up of the Directly Enhanced Service for those aged 14 above. West Hampshire CCG has additionally supported this work with CQUIN monies.	4.1 CCGs in Hampshire to ensure that there is a clear incident management protocol for investigation of all LD deaths whether they are in primary, community, acute or specialist care – this forms part of the learning disability national mortality review that all CCGs will participate in from April 2016 (see Rec. 2) **IN PROGRESS** 4.2 Commissioners to participate in Learning Disability Mortality Review and ensure there are mechanisms in place to sustain the investigation of all LD deaths in future (see Rec. 2) **IN PROGRESS** 4.3 CCGs to develop early intervention		Bev Meeson/ Ciara Rogers	Jan 2017	See updates in Recommendation 2. NHSE has involved the LMC in the National Learning Disabilities Mortality Review Programme pilot, where a number of issues with general practice will be resolved this includes competencies for signing off death certificates and access to GP records for mortality reviews. The National Learning Disabilities Mortality Review Programme (LeDeR) pilot in Wessex have established a steering group. A training day organised by NHSE held in February and March 2016 for clinicians who will become the key reviewers for the LeDer programme.

		In West Hampshire we now have 46 practices signed up.	and prevention interface with primary care to review the QOF and Commissioning of the Learning Disability Directly Enhanced Service. A discussion with the Local Medical Council is required to discuss how the CCG could engage about the level of empowerment of GPs for certification of death. **IN PROGRESS**				This was attended by approximately 20 clinicians from providers including SHFT, social care and WHCCG Learning Disability nurse The Vulnerable Adults Team and CHC team are looking at how GPs will be notified of DoLS. A CCG DoLS training session has been undertaken. Contact has been made contact with the Chair of the LMC and discussions are underway with the CCG regarding the level of empowerment of GPs for death certification. CCG clinical lead for MH/LD services has been asked how this can be progressed.
5	**Recommendation Five** Commissioners should provide support to the mortality reviews in the Trust including agreeing appropriate independent representation and if possible a GP member.	Work within Hampshire to date has been more proactive and joint working with the local authority is around people who are at risk. Any learning from serious case reviews, in taken up in partnership with local authorities Projects on adult mental health crisis support, e.g. the serenity project are an example of the work that has come out of those serious case reviews Hampshire CCGs have reviewed and updated the multiagency safeguarding policy and this was re-issued in October.	5.1 Commissioners to work together to identify how they can support SHFTs new mortality review process. . **COMPLETED** 5.2 Reports of the mortality reviews, including the number of cases reviewed, any learning identified and actions to be taken to be provided to the CCGs. CCGs to monitor all actions. **COMPLETED** 5.3 Benchmarking has been considered but is not possible as no benchmarking data exists that will accurately reflect the Trust, however this will be included in the annual mortality report. **COMPLETED**	This provides greater scrutiny to the process and informs the system, including primary care of any issues/gaps in care pathways that can be modified	Edmund Cartwright/ Carole Berryman	May 2016	Trusts new mortality process has been seen at CQRM. Commissioners have commented on this and are awaiting formal sign-off. Commissioners have also been invited to be involved in the process. The trusts new Procedure for Reporting and Investigating Deaths has been seen at CQRM. Commissioners have been in attendance at 3 of the AMH and LD divisional mortality review meetings and note that there are still improvements to be made in the governance of these meetings by the trust. Commissioners will continue to attend these meetings until assured by the processes. Mortality data is included on the scorecard.
6	**Recommendation Six** All commissioners should monitor the progress of the Trust in its improved use of mortality data and contract negotiations should reflect the changes required from this review.	An indication of the scale of prevention of mortality by use of data might be found in benchmarking data. NHS Right care suggests that Hampshire CCGs are in the 4th Quintile (.ie lower rates than average for the Standardised mortality ratio	6.1 Commissioners to incorporate mortality quality indicators within the 2016/17 contract. **COMPLETED** 6.2 Commissioners to ensure that at the MH/LD CQRM there is a six monthly in-depth review of mortality. This review needs to include Public Health and clinicians. **COMPLETED**	CCGs will have greater oversight of all mortality Reduction in mortality Improved system wide learning from deaths	Edmund Cartwright/ Carole Berryman	May 2016	Mortality indicators are included within the 2016/17 contract quality schedule. Six-monthly in-depth report of mortality occurs as part of the QI reporting. CCG to invite Public Health are invited /involved in biannual mortality meetings. Public Health attended the April 2016 CQRM and received the mortality report. Public Health is

		(SMR) in people aged 18–74 years in contact with mental health services by upper-tier local authority The Hampshire CCGs have signed up to the national Review of Learning Disability Deaths.	6.3 CCGs to review nationally available benchmarking data on mortality and suicides to ensure that the trust is not an outlier **COMPLETED**				supporting SHFT to improve reporting of suicides / mortality to CQRM. Nationally available data is reviewed monthly. The trusts new Procedure for Reporting and Investigating Deaths has been seen at CQRM. Commissioners have been in attendance at 3 of the AMH and LD divisional mortality review meetings and note that there are still improvements to be made in the governance of these meetings by the trust. Commissioners will continue to attend these meetings until assured by the processes.
7	**Recommendation Seven** The CCGs should discuss the implications of this review with acute care providers in the area and agree a protocol for ensuring joint investigation between NHS providers, in particular, for people with a Learning Disability.	There is been recent investment by the Hampshire CCGs for psychiatric liaison within acute providers this will increase the quantity and coverage of support over a 24 hour period. CCGs are also key partners of the Crisis Care Concordat Group (including police and ambulance) and Systems Resilience Groups which both provide potential vehicles for discussion of the outcome of this report.	7.1 Commissioners to participate in Learning Disability Mortality Review and ensure there are mechanisms in place to sustain the investigation of all LD deaths in future. **IN PROGRESS** 7.2 Commissioners to continue its development of a multiagency SIRI review process and ensure successful implementation. **IN PROGRESS** 7.3 Commissioners and providers to jointly review current liaison and arrangements in place for learning disability patients accessing different healthcare environments. **COMPLETED** 7.4 Commissioners to ensure that there is alignment of their local process with the multi-agency safeguarding process. **COMPLETED**	Improved care pathways Improved specialist support to acute providers Improved patient experience Improved patient outcomes Reduced admissions into acute environments	Bev Meeson/ Ciara Rogers	January 2017	Multi-agency workshop held to discuss and develop joint investigation protocol now in development by WHCCG. Workshop being held by SHFT in September 2016 with multi-agency attendance. WHCCG and SEH/FGCCG local safeguarding processes are in line with the Hampshire multi-agency safeguarding policy. WHCCG are currently reviewing internal process to ensure safeguarding team are alerted to appropriate SIRI raised by SHFT. Current LD liaison arrangements in place for learning disability patients have been reviewed by Commissioners. Hospital liaison for Learning Disability patients will be provided in acute hospitals as part of the Transforming Care Partnerships work.
8	**Recommendation Eight** The CCGs with local authorities should develop a detailed needs assessment of people with a Mental Health or Learning Disability in their area.	The current Hampshire Adult Mental Health Strategy runs from 2012 - 2017 and was based on the Joint Strategic Needs Assessment at the time and as well as a specific needs assessment of mental	8.1 CCG will review locally commissioned services for people with a learning disability and reconfigure as appropriate between April 2016 and April 2017 to ensure their health needs are met in primary, acute and specialist services. **COMPLETED**	Early intervention and prevention will enable people to be supported at home and manage their health needs. There will be an	Bev Meeson/ Michelle Stickland/ Paul Turner / Simon Bryant	April 2017	Transforming Care Partnerships (TCP) plan submitted to NHSE includes a detailed needs assessment. Age stratified profile for Learning Disability has been completed by Public Health Work on demographics has now started by Public Health (HCC) and will feed

		health, wellbeing and Learning disabilities. In Hampshire there is an updated JSNA for 2015, which was signed off by the Health and Wellbeing Board in November 2015. The specific Mental Health and Learning Disability needs assessment is also currently being updated for completion in 2016. This will inform the Mental Health Strategy refresh required for 2017. In Hampshire there is an Older Persons Mental Health Strategy that was refreshed in 2014. In Hampshire there is a Learning Disability Strategy for 2012 to 2015 which has also been refreshed and has an annual plan. In Hampshire there is a Joint Health and Social Care Assessment Framework which is completed on an annual basis and informs the annual plan Hampshire has a Learning Disability Partnership Board, who through co-production developed and launched the Hampshire Learning Disability Plan in July 2014 in response to the needs of people with a learning disability, their families/carers and third sector organisations. In addition the Partnership Board In Hampshire works with the 5 CCGs and Hampshire County Council to undertake the annual Joint Health and Social Care Needs Assessment. This gathers feedback on		upskilled workforce and a joint housing strategy which will give people the option of where they live and people will have more control over how and when their support is delivered.			into appropriate strategies. This data can now include health related data from the TCP. TCP plan was approved April 2016. All PID's were approved by the TCP Board. Five year TCP programme is well underway.

		current service provision and is jointly reported to the Hampshire Health and Wellbeing Board. Hampshire is also part of the Individual Personalised Commissioning 'My Life, My Way' pilot Programme, which sees joint working across Adults and Children's Health, Social Care, SEN, third sector and parent/carer networks in Hampshire.					
9	**Recommendation Nine** Commissioners should use the intelligence provided in this review to secure access to data on Mental Health and Learning Disability services to: 1. Develop investigation protocols that look across pathways more systematically 2. inform service developments.	Utilisation of the Best Interests and Consent processes to secure access to data.	9.1 The Hampshire CCGs should undertake a review of all current MH/LD services and highlight where current service specifications do not meet best practice guidance. A plan should then be developed to ensure that services for MH/LD patients are developed to ensure high quality services that meet future need, and are value for money. **COMPLETED** 9.2 Develop action plan to obtain independent intelligence from service users and families. **COMPLETED** The actions for this recommendation link in with actions detailed in recommendation 1, 2 and 7	Improved patient outcomes Improved patient experience Reduction in MH/LD mortality	Bev Meeson/ Michelle Stickland/ Paul Turner	August 2016	Review of the specifications and crisis review as part of the annual contract round has been completed. The quality schedule for SHFT has an enhanced indicator on mortality and physical health assessments and will include participation in the MH Safety Thermometer. WHCCG. On behalf of Hampshire CCGs, is investigating methods of benchmarking sources e.g. Right Care, NHS England MH Dashboard and Benchmarking networks The Vulnerable Adults team will request SHFT to join the NHS Benchmarking network as part of the strategic plan refresh to reflect the MH 5 year forward view. WHCCG undertaking a project on the crisis pathway in the acute psychiatric liaison services. Report will be ready in October 2016. Public Health are mapping the self-harm hotspots to help Commissioners target informal crisis support. A self-harm pathway for children is being reviewed by HCC (PH) and Hampshire Children's Safeguarding leads. Action plan for getting independent intelligence from service users and families presented to WHCCG Clinical Governance Committee May 2016