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Improving Quality and Learning from Investigation of Deaths in Mental Health & Learning Disability Services

Learning from the Mazars Review into Southern Health

Wednesday 22 June 2016 Hallam Conference Centre, London

Chair & Speakers include

Sean Duggan
Chief Executive
The Centre for Mental Health

Mary-Ann Bruce
Director - Health Advisory
Mazars LLP

Supporting Organisations:

Good Governance Institute

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The 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 was published by Mazars and released by NHS England in December 2015. The report highlights failings in the investigation and learning from deaths of people who receive care in mental health and learning disability services and has wide reaching implications for all organisations providing mental health and learning disability services.

"People die for a variety of reasons – both expectedly and unexpectedly. Not all deaths require an investigation and just because someone dies does not mean that the quality of services is poor. What is important though is that when someone does die unexpectedly this is identified so that the correct processes and appropriate levels of enquiry are made with a view to learning and taking preventative action in future…. It is important that the right level of review or investigation is undertaken to improve services, identify any service failure, learn from any mistakes and to provide families and stakeholders with relevant information."

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, Mazars Published December 2015

Speaking on the publication of this report, Dr Paul Lelliott, Deputy Chief Inspector of Hospitals (and lead for mental health) at the Care Quality Commission stated that "We welcome this report, which highlights the failure of Southern Health NHS Foundation Trust to investigate and learn from the deaths of people who received care from their Learning Disability and Mental Health services. ..We will also be undertaking a wider review into the investigation of deaths of people with Learning Disabilities in Mental Health and Acute trusts in different parts of the country. As part of this review, we will assess whether opportunities for prevention of death have been missed, for example by late diagnosis of physical health problems."

Jane Cummings, Chief Executive of NHS England stated that "findings should be shared across England to ensure that deaths are investigated properly. We have jointly committed to ensure that this and the other actions it sets out are taken."

"Reports such as this challenge not only Southern Health, but the wider health and social care system, and society as a whole, to reflect on the way we support, include, and value people with learning disabilities and mental health needs… All providers and commissioners of care can learn from this report. National data on mortality rates confirms that the Trust is not an outlier. We believe that Southern Health's rate of investigations into deaths is in line with that of similar NHS organisations."

Katrina Percy, Chief Executive Southern Health NHS Foundation Trust

T*his conference will focus on improving the Quality of investigations of deaths in mental health and learning disability services, and learning from the December 2015 Mazars Report. Through national updates, practical case studies and extended masterclasses, the conference will provide a step by step guide to high quality investigation and learning from deaths of people who received care from their learning disability or mental health service.*

10.00 **Chairman's Introduction**

Sean Duggan *Chief Executive* The Centre for Mental Health

10.10 **Opening Address: Improving the quality of investigations of deaths in mental health and learning disability services Learning from the Mazars Report**

Mary-Ann Bruce
Director - Health Advisory
Mazars LLP

- key learning from the MAZARS report into Southern Health
- how can services secure the right level of review, enquiry or investigation following a death
- common themes from the review

10.40 **Looking at deaths & serious incidents from a user perspective**

Paul Scates
Peer Specialist, Campaigner and Ambassador

- how do we ensure investigations lead to learning and change?
- moving from reactive to proactive services
- working with peer specialists and service users to ensure we learn from any care and delivery problems or system failures that need to be addressed to prevent future deaths and improve services and identifying if there is any untoward concern in the circumstances leading up to death

11.10 *Question and answers, followed by coffee*

11.45 **EXTENDED MASTERCLASS**
Effective investigation: tools, principles and practice

Sue Bos
PSST Trainer
Patient Safety Science

This extended session will include:
- Which deaths to report and investigate
- A step by step guide to undertaking an effective investigation of a death in a mental health or learning disabilities setting
- Systems for information gathering
- Interviewing staff involved in serious incidents - techniques and tips
- Writing the investigation report - techniques and tips

13.15 *Question and answers, followed by lunch*

14.00 **Changing culture and practice in the investigation of deaths**

Representative
Southern Health NHS Foundation Trust
(Invited)

- improving oversight of the quality of investigations and ensuring appropriate measures are in place to address any issues identified, and that all learning is shared and implemented across the Trust
- our new system for reporting and investigating deaths in consultation with our commissioners to increase monitoring, scrutiny and learning
- providing every family with the opportunity to be involved in investigations relating to a death of a loved one
- what can other organisations learn from our experience?

14.30 **Involving families in investigations**

Jan Bartlett *Serious Incident Investigator and*
Lesley Munshi *Serious Incident Investigator*
Esk and Wear Valleys NHS Foundation Trust

- how can we engage, support and involve families following a death?
- ensuring adherence to the Duty of Candour
- how should we involve families in the investigation process?
- working with families to understand the full circumstances and answer questions

15.00 **Undertaking a self assessment, and continuous review of deaths and investigation practice in your organisation**

External Reference Group Member
External Reference Group Member, 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

- how do you assess whether a death is clinically unavoidable?
- assessing the appropriateness of investigations
- ensuring continuous review, leadership and board oversight of deaths
- identifying themes, patterns or issues that may need further investigation
- undertaking a self assessment of practice in your service
- our experience

15.30 *Question and answers, followed by tea*

16.00 **Zero Suicide: reducing suicide through a zero suicide collaborative: What can we learn from avoidable deaths**

Dr Caroline Dollery
Clinical Director
East of England Strategic Clinical Network

- reduce the risk of suicide in high risk groups and tailoring approaches to improve mental health specific groups;
- reduce access to means of suicide
- providing better information and support to those bereaved or affected by suicide
- supporting research, data collection and monitoring
- our experience as a zero suicide collaborative: what can we learn from avoidable deaths?

16.30 **Looking forward to the National Learning Disability Mortality Review Programme**

Speaker to be announced

- he causes of premature mortality for people with a learning disability
- reducing inequality
- ensuring changes are made as a result of local reviews of deaths

17.00 *Question and answers, followed by close*

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Investigation of Deaths in Mental Health and Learning Disabilities

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