Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 3 September 2019

Learning from Deaths - Mortality Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This current report covers the financial year from 1 April 2018 to 31 March 2019.

Executive Summary

This end of year report covering the financial year 1 April 2018 to 31 March 2019 outlines the progress to date.

The approach to serious incident investigations and mortality reviews has been developed over the last 12 months.

Emphasis is put on appreciative learning, looking at ways of improving our systems and processes.

Generally the reviews are giving assurance through a lack of concern but are constrained by the lack of a cause of death in many cases. We are not able to obtain the information from NHS Digital. The Medical Director has escalated this to Dr Alan Fletcher, National Medical Examiner.

Although there is an absence of concern in most individual cases there is an assumption based on national data that our patients will be dying at a premature age due to comorbid physical illnesses, particularly related to cardio vascular risk factors. The Trust is introducing the LESTER tool which will enable our clinicians to monitor these risk factors and identify where intervention is required. This will become a focus of mortality reviews from October 2019.

Cigarette smoking carries a particularly high risk of morbidity and mortality and the current policy of inpatient prohibition is not working and a new policy is in place.

Learning from deaths has been triangulated with a gap analysis of our physical healthcare strategy and information supplied to the Mental Health Act Committee.

In inpatient services the EPR system has been developed to aid recording and interpretation of results and we move to the new nationally agreed Early Warning System in the autumn.

In the community physical health clinics have been developed in the north and south and there have been enhancement of community teams, particularly in areas that lie outside of clinic catchment.

LESTER tools have been embedded in the EPR and compliance dashboards will be

available from September 2019. A minimum physical healthcare check has been developed for all patients not just those at enhanced risk.

There are some risks of course that are specific to mental health services:

The Trust has reviewed the clinical pathway for Emotionally Unstable Personality Disorder patients and agreed that this is a top priority for investment and development. Recruitment has started.

Substance misuse services have a notoriously high premature death rate. Analysis of data has indicated that if too much emphasis is directed towards driving recovery there is a high relapse rate and paradoxically increased death rate through accidental overdose, particularly of opiates and alcohol. The thresholds for recovery versus maintenance have therefore been adjusted. A research project is under development to look at big data to further understand the profile of high risk service users and to inform intervention. There is also a very active screening and vaccination campaign focussed on Hepatitis.

The suicide prevention strategy is being taken forward and developed in tandem with safety plan development with an increasing focus on specific safety plan development for individual services which will be linked to the use of suicide prevention assessment tools underpinned with accredited training.

In forensic services there are projects underway to improve closer working with prisons / Ministry of Justice / local authority. Our approach to the management of Section 37/41s has been strengthened.

In learning disability services patients can die prematurely from treatable illnesses. We are connected to the national LeDER system and they regularly share information with the mortality group which to date has included:

- Sepsis information for patients with a learning disability
- An easy guide to bowel cancer screening for people with LD
- Advice regarding treatment of constipation

In eating disorder services a proposal has been made to the CCG's clinical reference group for improved physical health screening in primary care and there have been meetings with acute hospitals to improve liaison with gastroenterology.

In old age services we are developing themes around the best management of frail patients with acute hospitals and regarding the threshold of admission to our challenging behaviour wards. The development of compassion focussed care on the Cubleys has been linked to safety and was presented in a Board Development session.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

- This report provides assurance that the Trust is following recommendations outlined in the National Guidance and the development of a Safety Culture.
- From April 2018 to 31 March 2019, the Trust has received 2,029 death notifications of patients who have been with our service within the previous six months. 218 (10.7%) were reported through our DATIX system of which 51 (2.5%) warranted further investigation.
- All inpatient deaths are reviewed and quarterly reports received by the Executive Leadership Team (ELT) in addition to coroner's inquest updates. Medical availability for mortality reviews has improved.

Consultation

This report was received and discussed at the Quality Committee.

Governance or Legal Issues

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20)

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

People suffering from a mental illness and/or substance misuse problem or who have a mental disorder or leaving difficulty have a reduced life expectancy compared to the general population without these characteristics. Actions to mitigate these risks are described in the executive summary.

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of our approach and note that it is required to be published on the Trust's website in line with national guidance.

Report presented by: **Dr John R Sykes**
Medical Director

Report prepared by: **Dr John R Sykes**
Medical Director

Rachel Williams
Lead Professional for Patient Safety and Patient Experience

Louise Hamilton and Nosheen Asim
Mortality Technicians

Learning from Deaths - Mortality Report

1. Background

It has been over two years since the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the new framework was to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which would lead to better quality investigations and improved embedded learning.

The Guidance outlined specific requirements in relation to reporting requirements. From April 2017, the Trust was required to collect and publish each quarter, specified information on deaths. A paper was produced and was and continues to be a Board item at the Public Board meeting in each quarter. The Trust met the targets to set out the Trust's policy and approach (by end of Q2) 2017-2018 and publication of the data and learning points by Quarter 3 2017/18. The Trust does include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review in each paper. Of these deaths, subject to review, we have considered how many of these deaths were judged more likely than not to have been due to problems in care.

The Trust has met all of the requirements outlined above within the timescales required.

This report outlines data for the previous financial year from April 2018 to March 2019.

2. Current Position and Progress

- Two years on, there has been little progress to accessing a national database for cause of death, our application for NHS Digital continues, and the Trust is currently awaiting an outcome. This continues to be a slow process, to ensure that the Trust meets all of NHS Digital legal requirements.

- The Mortality Review Group continues to undertake regular case note reviews and there have been improvements in medic availability since the implementation of a rota for attendance from the North consultants.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary changes made.

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

3. Data Summary of all Deaths

Note that inpatients and patients with a Learning Disability (LD) are based upon whether the patient has an open inpatient or LD referral at time of death.

Month	2018-04-01	2018-05-01	2018-06-01	2018-07-01	2018-08-01	2018-09-01	2018-10-01	2018-11-01	2018-12-01	2019-01-01	2019-02-01	2019-03-01
Total Deaths Per Month	165	187	141	182	133	138	197	173	192	226	146	149
Inpatient Deaths	1	0	2	1	0	0	1	0	1	1	0	1
LD Referral Deaths	2	5	0	5	4	1	5	0	2	1	0	1

The table above shows information for the last financial year 01/4/2018 – 31/3/2019.

Correct as at 17.5.2019

1 April 2018 to 31 March 2019, the Trust received 2,029 death notifications of patients who have been in contact with our service.

Initially, the Trust recorded all deaths of patients who had contact within the last 12 months, but this was changed after discussion with Commissioners to contact within the last 6 months. This took effect from 20 October 2017.

An inpatient death is recorded as a patient who has died on Trust premises whilst an inpatient on one of the wards. The inpatient death data does not include any patients that may have been transferred to an acute hospital where they then have died.

4. Review of Deaths

1 April 2018 to 31 March 2019:

Total number of Deaths from 1 April 2018 – 1 March 2019 reported on Datix	218 (of which 169 are reported as "Unexpected deaths"; 37 as "Suspected deaths"; and 12 as "Expected - end of life pathway")
Number reviewed through the Serious Incident Group	217 (1 was not required to be reviewed by SI group and 0 pending for a review).
Number investigated by the Serious Incident Group	51 (155 did not require an investigation and 12 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	179 (27 currently opened to SI group and 12 pending for a review, as at 31/3/2019)

The Trust has recorded 8 inpatient deaths April 2018 to 31 March 2019, of all which have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*. None of these deaths have been due to problems in care.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*;

Any patient open to services within the last 6 months who has died, and meets the following:

- Homicide – perpetrator or victim.
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / The Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death

Death of a patient with historical safeguarding concerns, which could be related to the death:

- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not

5. Learning from Deaths Procedure

From the 1 April 2018 to 31 March 2019, the Mortality Review Group case note reviewed 130 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 130 deaths reviewed, 127 have been recorded as not due to problems in care. 3 were referred to the Serious Incident Group where 2 required no further action, and a further 1 is currently under further investigation and is been monitored by the Patient Safety Team.

The Mortality Group reviewed the deaths of patients who fall under the following 'red flags' from April 2018 – November 2018

- Patient on end of life pathway, subject to palliative care
- Anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

From November 2018 to March 2019

- Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team)
- Patient diagnosed with a severe mental illness
- Patient only seen as an Outpatient
- Patient taking an Anti-psychotic medication

We have received 31 causes of death since April 2018, of these, initial analysis of death notification information shows the most prevalent causes of death are:

- Bronchopneumonia
- Heart disease
- Dementia

Undertaking Case Note Reviews was very difficult initially and a number had to be cancelled due to lack of medic availability. However since the implementation of a medic rota, the number of case note reviews has improved and fewer are having to be cancelled.

The Trust as well as taking action when the standard of care could have been improved, it is important that good practice is highlighted and commended.

To date the weekly case note reviews have largely highlighted areas of good practice across the organisation and there has been evidence of person centred care.

During a recent review the CPN involved was noted to have provided exceptional care for the patient and the reviewers identified the CPN demonstrated excellent practice. Throughout the record the clinical care provided by the CPN was of a high standard. There is evidence of regular consultation with the patient's carers and other parties involved. At times when the CPN was advised of concerns by the patient's carer, planned visits were expedited in order that the patient's needs could be assessed sooner. There is detailed documentation clearly demonstrating compassionate, person-centred care and this is noted to be consistent in the 3 years the CPN worked with the patient.

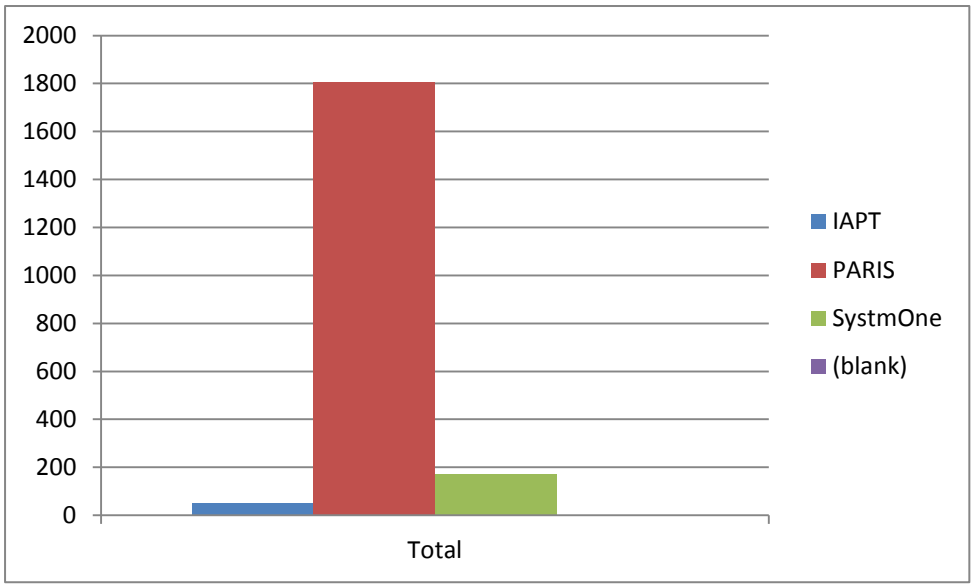
The reviewers felt there is a real sense in the record that the CPN genuinely cared for his patient; "I have also been and sat with him after his lunch, where he was sat in his favourite spot by the fish tank".

When the patients physical health was noted to have deteriorated prior to his death the care home sought advice from the patients CPN concerning where the patient should be cared for as he had no known relatives and the CPN had been involved for some time. This was felt by the reviewers to be testament to the considerate care the patient had received.

The CPN has been provided with feedback following this case note review and nominated for a DEED.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2018 to 31 March 2019

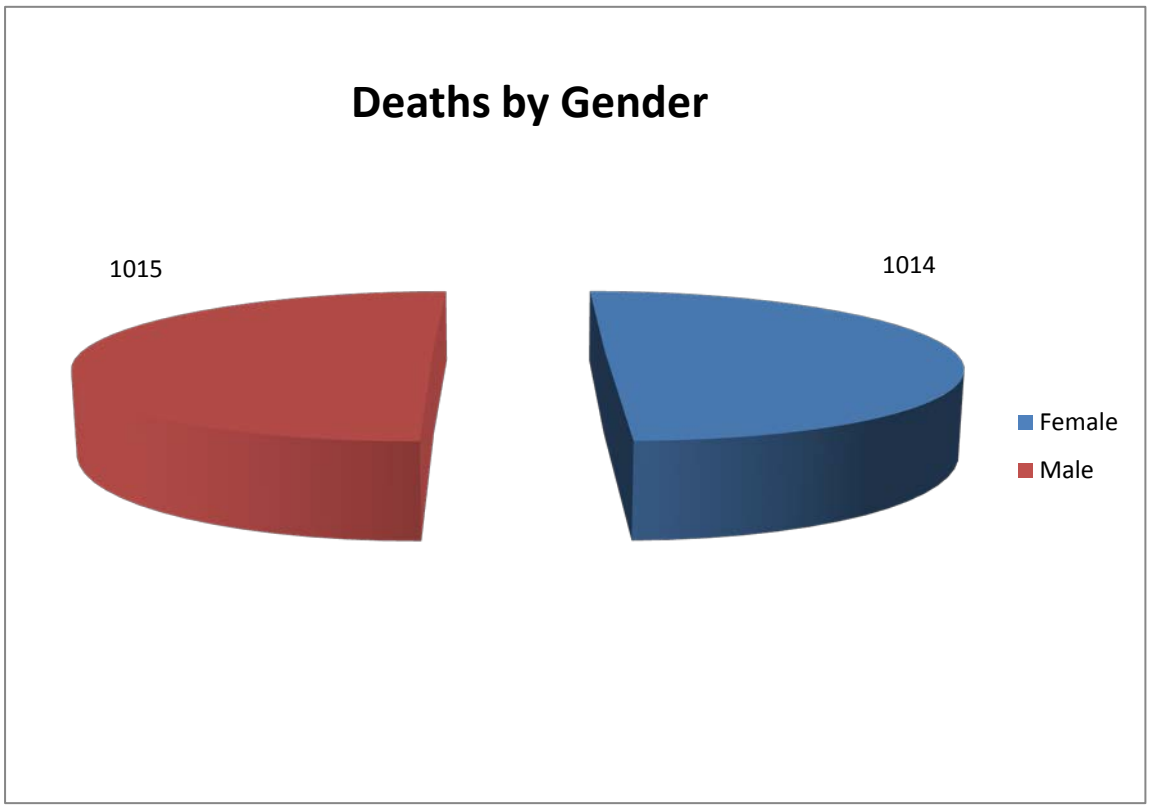


	IAPT	PARIS	SystmOne	Grand Total
Count	51	1806	172	2029

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care. 172 death notifications were extracted from SystmOne and 51 death notifications were extracted from IAPT.

6.2 Deaths by Gender since 1 April 2018 to 31 March 2019

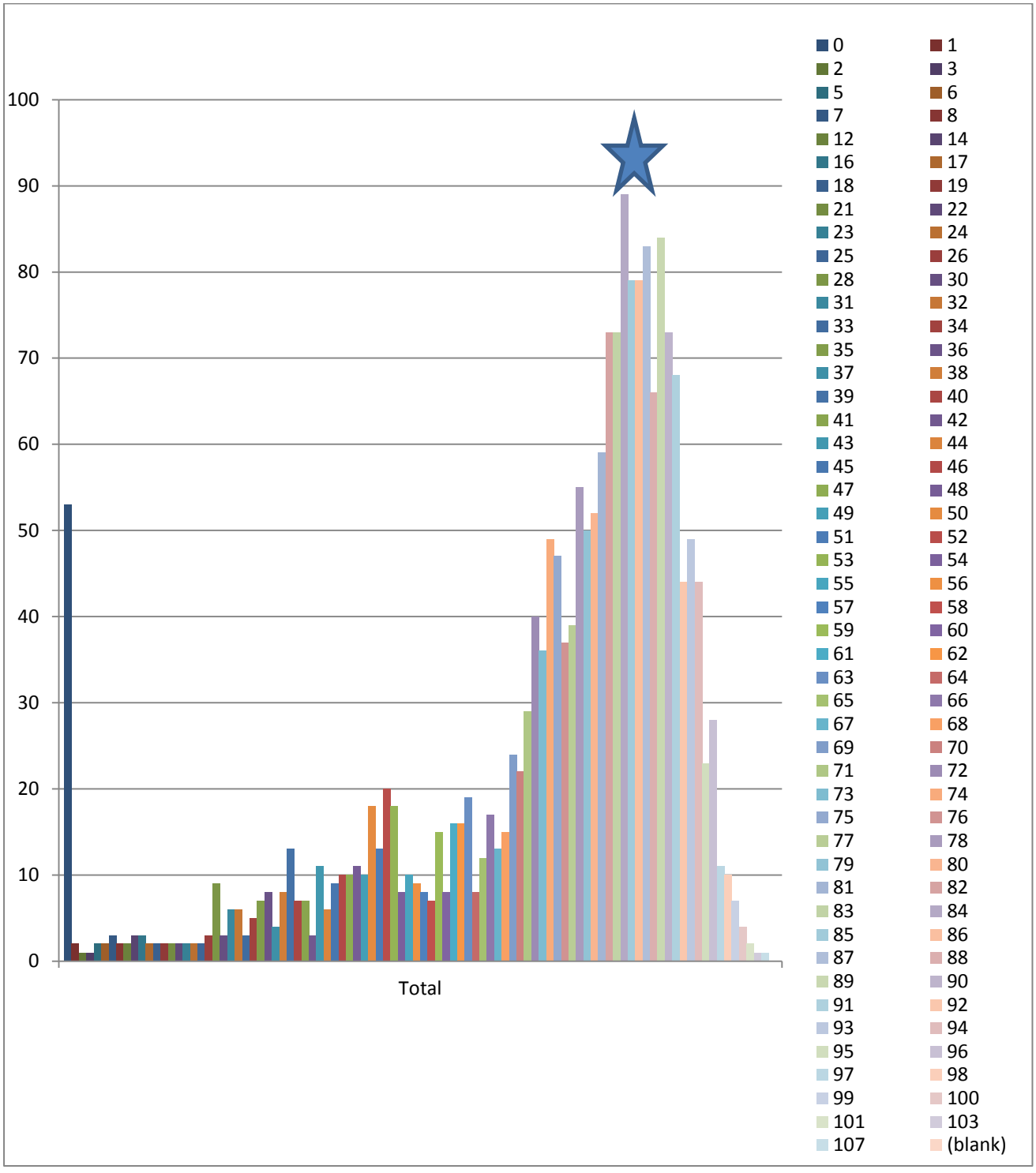
The data below shows the total number of deaths by gender 1 April 2018 to 31 March 2019. There is very little variation between male and female deaths; 1015 male deaths were reported compared to 1014 female.



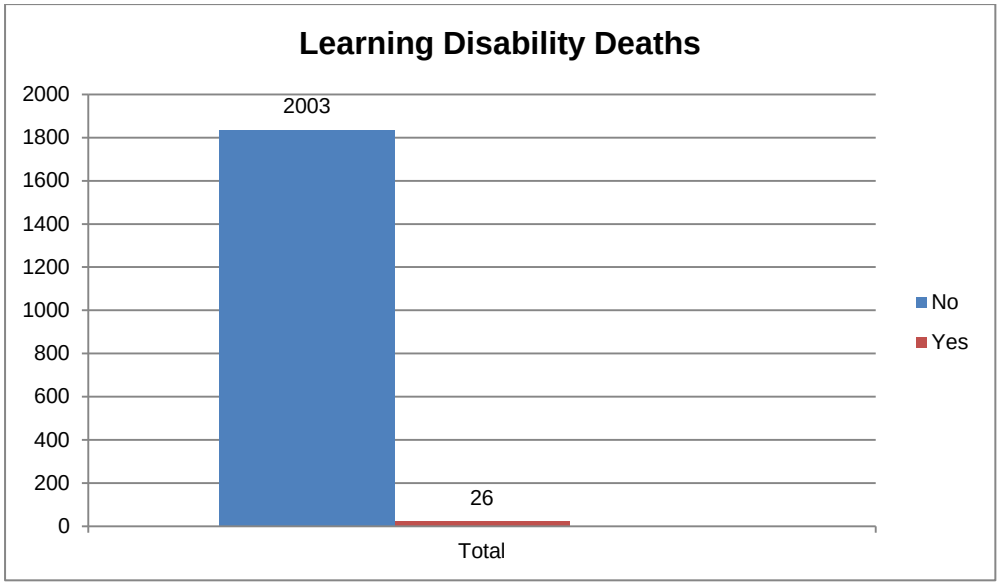
	Female	Male	Grand Total
Count	1014	1015	2029

6.3 Death by Age Group 1 April 2018 – 31 March 2019

The youngest age was classed as 0, and the oldest age was 107 years. Most deaths occur within the 84-87 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 April 2018 to 31 March 2019



The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) Programme. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process, as LeDeR only looks at a sample of overall deaths. Currently the Lead Professional for Patient Safety and Experience is working closely with LeDeR so that the Trust can be involved moving forward in the review process. The Trust is now sharing relevant information with LeDeR. Since April 2018, the Trust has recorded 26 Learning Disability deaths.

The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this report is shared and discussed at the monthly Mortality meeting.

6.5 Death by Ethnicity 1 April 2018 to 31 March 2019

White British is the highest recorded ethnicity group with 1511 recorded deaths, 360 deaths had no recorded ethnicity assigned, and 16 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count
White - British	1511
Not Known	360
White - Any other White background	44
Other Ethnic Groups - Any other ethnic group	42
Not stated	16
Caribbean	13
Indian	12
White - Irish	11
Asian or Asian British - Pakistani	6
Pakistani	3
Mixed - Any other mixed background	3
Asian or Asian British - Indian	2
Mixed - White and Asian	2
Mixed - White and Black Caribbean	3
Asian or Asian British - Any other Asian background	1
Grand Total	**2029**

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths either through the *Untoward Incident Reporting and Investigation Policy and Procedure* or *Learning from Deaths Procedure over the previous financial year.* These recommendations are monitored by the Patient Safety Team and are allocated to a specific team, and individuals to be completed. This is not an exhaustive list

7.1 Action Log

- Options to improve the cohesiveness of working with the Chesterfield Royal Hospital and accessing expert medical opinion for mental health patients whilst they are inpatients on the Hartington Unit.

- Further consideration required by the Trust Medical Director in discussing this case with the GP and his Responsible Officer in the spirit of learning and quality improvement. This is in relation to professional practice and continual learning.

- The Trust to discuss progress with Commissioners the possibility of establishing an older people In-Reach and Home Treatment Team in the North of Derbyshire or an alternative model of home treatment for individuals with PDs care profile.

- Trust Medical Director and Chair of the Physical Health Care Committee to risk assess the benefits of routine Serum C reactive protein levels in inpatient areas.

- The Trust to discuss this case with the Clinical Commissioning Group in the spirit of quality improvement and learning. This is in relation to the Care and Treatment Review referral process and ongoing management in relation to the patients care.

- The Section 136 Joint Policy to be reviewed with relevant external agencies in-line with the outcome of this investigation. This is to ensure effective communication and a consistent approach following the outcome of a Section 136 assessment.

- Further consideration by the Trust in discussing this case with Social Care. This is in relation to the patient's journey from referral to allocation of a Social Worker.

- A Learning Review using this case to be undertaken Trust wide with Social Services to be offered the opportunity to participate. (The CCG have offered support with this in terms of Social Care review)

- Development of a staff resource detailing the Serious Incident process and what to expect following an untoward serious incident.

- Review of the Trust guidelines for the management and treatment of opiate use with consideration to the inclusion of a withdrawal scale assessment tool

- To develop a procedure on options and decision making in Criminal Justice Team which includes advice for out of hours Doctors on what to do out of hours and how to communicate with colleagues.

- Consideration of formal management training for development, support and use of IT systems to inform operational decision-making

- Review of policies-blood-borne virus policy, seclusion policy

- Audits- safety box, relapse prevention plans with community mental health teams, standards of practice for patients on a community treatment order

- Discussion with commissioners regarding specific services / pathways for individuals with a diagnosis of personality disorder

- Review the number of funded care programme approach co-ordinators in community teams benchmarked against comparable trusts per hundred thousand population

- Education/information on the referral process to IAPT for inpatient areas

- To consider developing new / incorporating within training already provided a module about the Mental Health Act paperwork linked to seclusion, including seclusion exception reporting and the seclusion policy

- To share with commissioners, the impact and access of community based psychological therapy for interfamilial child trauma

- Where there are co morbid complex physical health issues in someone with a severe mental illness, their care plan safety plan must reflect any concerns or risk related to the management of that physical health need. This includes any concerns around medication.

- To identify the threshold for Forensic Service input and method of referral and dissemination of information

- Development of a Safeguarding Protocol which would include details regarding how to access safeguarding advice and support which would complement information already available via the Safeguarding Connect web page.

- The Process for managing Front Door Presentations to Psychiatric Units needs to be clarified and reviewed.

- There is a waiting list for psychological therapy, for EMDR. Review with commissioners solutions to reduce the waiting time

- A team awareness raising session regarding the frequent revisiting of a service user's decision to withhold information from family and carers using the 'Advanced Planning for People with Bipolar Disorder Guide' from the East Midlands Academic Health Science Network and also the 'Sharing information with family and carers' booklet and the 'Advance Statement about information sharing and involvement of family carers'.

- To review the MDT documentation processes with regard to the decision making actions when there are patient safety concerns. This should take into account the immediate action taken by the medics, care co-ordinators and supervisors.

- For DHCFT staff who work in out of hours services (mental health triage hub, Crisis team) to have access to IAPTUS notes as read only

- Trust to ensure development of clinical standards for personality disorder and a robust Personality Disorders Pathway and appropriate training for staff and teams

- Review of the CPA policy in terms of transfer between secondary services to provide clarity. Transition policy to be updated in include process in the event of a dispute between services in transition Clarity required for services regarding dispute resolution in transition

- Discuss the importance of using the analgesic ladder to manage pain in older people with dementia. Review use of pain management tools.

- The Eating Disorder team to facilitate a reflective session with the Neighbourhood teams in relation to managing Eating Disorder patients and timely referrals.

- Eating Disorder Service to raise with MARSIPAN Lead and Derby Hospitals Mental Health Steering Group the need to establish joint protocols for patients to be directed to appropriate support/ services, and joint clinics and / or regular review meetings for high

- Discuss with the multidisciplinary team the importance of adopting a broader approach to advanced decision making which is discussed in conjunction with DNAR decisions.

- Where Social Care are involved with a client, an multi-disciplinary team and multi-agency meeting should be arranged once a year or more frequently if required due to significant change in accordance with CPA guidelines. CPA Review to be multi-disciplinary and multi-agency where relevant.

- Develop the role of end of life link workers or champions on the ward, to promote a culture of positive end of life care.

- To request commissioners to review contracts to include direction as to the expected level of discharge information and the timeliness of the communication from private providers.

- Observation Policy and Procedure to be reviewed.

- Medication changes which are likely to impact upon the risk of falls should be recorded in the Multi-Disciplinary Team process and care plans updated accordingly.

- To develop standard operating policy/procedures for Hepatitis A, B and C, HIV testing and vaccinating against Hepatitis A and B.

- The consideration of relapse reduction model including relapse signature to be a continuous quality improvement priority for mental health service in 2018.

- Clarify protocols with NHS England surrounding gatekeeping assessments for low secure services.

- Collateral information should be sought from families wherever possible to add to the clinical assessment and understanding of the presentation.

- A clinical supervision framework that ensures clinicians have routine access to professionals with clinical expertise in forensic care.

- Site visits to be organised for junior doctors during induction.

- Community Team Learning Disability Teams to review Triangle of Care action plans with Multi-Disciplinary Team members & carers champions.

- Non-recent sexual abuse reporting process to be discussed with ward staff and all staff to be forwarded link to the Trust procedures.

- Development of a new standard operating procedure in the acute care pathways in the North and South for all complex case clinical reviews.

- To consider the Clinical Safety Plan becoming part of the main PARIS tree index so that it is more easily accessible to all agencies involved.

8. Mortality prevention work undertaken by the Trust;

8.1 Research Project Title: Investigating all-cause mortality in the substance misuse treatment population

Chief Investigator: Jennifer Ness, Lead Health Services Researcher
Project Team: Martin Smith, Recovery Lead; Laura Dunkley, Research Project Manager

Summary

In England, the number of people dying from drug poisoning or misuse is the highest it has ever been, with rates increasing by a third since 2010 (ONS, 2018). These figures do not include the elevated mortality of drug users from other complex health and social issues, from chronic diseases (Mathers et al, 2013) to homicide (Pierce et al, 2015), and so the actual mortality rate will be much higher. This research will extend the findings of the annual ONS report by looking at epidemiology, clinical outcomes and risk factors for premature mortality (not restricted solely to drug overdose). In this regard, the aim of the project is to gain a better understanding of substance misuse services, in the context of the national drug strategy, and to consider what broader lessons can be learned for prevention.

8.2 Summary of Acute Liaison work – Dental day case only – The Royal Derby Hospital

NHS Choices outlines the importance of good oral health and the implications to health,

The state of someone's teeth affects their overall health, with gum disease linked to lots of serious health problems in other parts of the body and increasing risk to other health complications, including stroke, diabetes and heart disease. Gum disease has even been linked with problems in pregnancy and dementia.

The dental day cases are held every other Wednesday for essential assessment and treatment if necessary, for individuals where it is apparent that primary health care services would not be able to meet the needs of this group of people. These sessions offer:

- Case by case situations. Organised visits to the dental day case clinic if required as part of any **desensitisation programme**
- Many service users require accessible **information** around coming into hospital which is issued prior to admission.
- Service users are **met upon arrival** at hospital, and are provided with an offer of **support during any outlined procedure**, including administration of anaesthetic / treatment. This support is available throughout the whole process, not just 'booking in'.

- Support is provided in a variety of ways and is tailored to the needs of the individual.

Supporting post–operatively and the discharge process is also invaluable within the dental day case. Whilst it is essential that observations are monitored post-operatively, these can be extremely distressing to some individuals. Being able to support adjustments within this can be of extreme benefit in the recovery process / procedure. Use of an iPad has at times, provided distraction and focus during periods of high anxiety.

Offering this type of **bespoke** service in hospital enhances the positive outcomes for many, as essential treatment is unlikely to be achieved through primary health care services alone.

8.3 Working with Chesterfield FC: a short history of 'Active Spireites' Summary

In 2013, in a chance meeting, the chair of the Chesterfield FC Community Trust (John Croot) was at a networking meeting which included clinicians from the Trust. The two organisations decided to meet to explore opportunities to develop a joint Mental Health Strategy. The Trust was already working on a Healthy Body Healthy Mind programme that ran with Public Health, looking at how people with severe mental health problems improved their physical health. As part of our recovery approach, the Trust wanted to collaborate with the football club to run sessions targeting improving fitness and mental wellbeing using the motivation of football as that therapeutic tool.

In the five years since the initial meeting, several programmes have developed and the Core Active Spireites programme continues on a rolling basis.

Associated projects have included:

- Healthy lifestyle course at the stadium co-facilitated by mental health Occupational Therapists, football coaches and volunteer Peer Supporters (The Core Active Spireites Programme)
- A similar programme targeted particularly at people with substance misuse problems
- Football coaching sessions & competitive football matches facilitated by Chesterfield FC community Trust & Peer Supporters
- Walking for health project
- In-reach work to acute mental health unit from Chesterfield FC Community Trust
- 'Time to change' match events at Chesterfield FC stadium (Twice a year)
- Establishing links with national projects promoting football and mental health projects and presenting details of the programme at national meetings

8.4 Community Treatment Order Learning Event

On 17 January 2019 Dr John Sykes, Medical Director, and Bhavnita Bunawah, Investigation Facilitator undertook a Learning event in relation to CTO's (Community Treatment Orders) at the Doctors Academic Meeting in the North. The original recommendation from a serious incident had been specific to the individuals involved in that case however it later transpired there was wider learning around the CTO process which culminated in the learning event.

In addition to the CTO activity from the Mental Health Act office, data was derived from Datix in relation to the incidents that have involved an issue with the CTO process. The attendees were advised of the number of incidents categorised between Insignificant to Catastrophic over past 3 years and the specific themes. This allowed for a discussion of individual experiences but also highlighted where the predominant areas errors in relation to CTO are made thus the greatest learning.

The group were introduced to the Untoward Reporting and Investigation policy and procedure process where the recommendations in relation to CTO from serious incidents were discussed after which they were presented with a serious incident case study on the topic of CTO's. During a breakout session the group were asked to consider the main issues and how lessons are learnt. The attendees were also asked to reflect on what the recommendations would be before the findings of the case and the subsequent action plan were shared.

The feedback received was very positive. The attendees reported the event had provided "clarity on CTOs/ CTO legality", provided a "good opportunity to discuss the challenges of CTO" and learning in relation to the "Investigation process". In addition a number of aspects were identified that attendees reported they would utilise in their own practise including "communication between community and in-patient teams", "importance of filing in current paperwork and "Duty of Candour".

A further CTO Learning Event has been arranged for the South Doctors Academic Meeting in June. It is envisaged moving forward these events will be extended to include other clinical staff who are involved in this process and contributions from AMHP's from Social Care.

9. Achievements

- Following the publication by NHS Resolution in to Learning from suicide-related claims, the Trust was highlighted for its excellent practice. Below is the excerpt from the publication

  Derbyshire NHS Foundation Trust have led the way in developing a family liaison service with which to support bereaved families through an SI investigation and the inquest process if necessary. The model is based on the concept of family inclusive practice and the knowledge gaps in engaging with families in all aspects of mental healthcare. The model was created on behavioural family intervention concepts developed in the Lambeth Early Intervention Services in 2001 by the Trust's director of nursing and influenced

by direct experience of meeting siblings who had not wanted to engage with mental health services due to historical experiences and loss through completed suicide.

Following bereavement, the family is offered the services of a family liaison officer (FLO). The FLO acts as the link between the Trust and the family, keeping them informed as to the progress of the SI investigation and supporting them through the inquest process. The service was designed in 2014 and became operational in 2015. When naming the service, police service terminology was used to retain consistency across organisations.

The Trust does not have a full evaluation of their service – emerging evidence and analysis is required. Early feedback suggests that there has been a substantial reduction in family complaints about not being involved in investigations, reductions in other family complaints, and increase in staff confidence. There is now a formal process and assurance that every family is offered support in all unexpected deaths.

The service offers families full involvement in investigations (including robust governance and compliance around this process), offers of direct referral to psychological services including Improving Access to Psychological Therapy services (IAPT) and family therapy work, including working with bereaved children and siblings. This all occurs within existing trust resources and, it should be noted, contributes to service pressures. The Trust has supported many other organisations, both acute and mental health trusts, with access to their videos, service model, clinical policies and job descriptions. This has resulted in other trusts modelling this practice.

- Following the CQC inspection in July 2018, where the processes and procedures for Learning from deaths were reviewed. There were no recommendation's made, only positive comments by the reviewing inspectors.

- The Care Quality Commission produced a report :Learning from deaths ;a review of the first year of NHS trusts implementing the national guidance. In this guidance the Trust

  Although Derbyshire Healthcare NHS Foundation Trust was rated as requires improvement overall in September 2018, it had strong processes in place for engaging with bereaved families and carers. Feedback from families about support received from the family liaison team was overwhelmingly positive. The family liaison role has evolved in line with learning from the national learning from deaths guidance. The family liaison team works with families where there has been a serious incident or unexpected death as reported through the trust's reporting system. They also work with families on referral through the process for learning from deaths, serious incident process and the complaints process where concerns have been highlighted about care. The team start engaging with families after the death of their loved one has been identified. A single point of contact is established, initial condolences are given and the duty of candour, where applicable, is applied at the first point of contact, which can include providing the clinical team with advice.

Engagement with families is individualised and person-centred, and families are invited to contribute to the investigation's terms of reference and outline any specific questions they want answered about their relative's care and treatment. Monitoring of these actions is done through the Serious Incident Group (SIG) and the family liaison team who can review and see if the report answers the family's questions. Families are invited to feedback on the care and treatment of their family member, and the family liaison worker meets with the family at the end of the investigation process to explain the outcome of the investigation. The family liaison team will support the family for as long as they need them up until the inquest, then work towards closure. Any additional needs are met through arranging activities such as referral to independent advocacy or psychological services. There is also a range of information shared with families including details about the Samaritans, Public Health England's 'Help is at Hand' booklet, WAY Widowed and Young (if under 50), details of local support groups, and The Compassionate Friends leaflet. The information that is sent to families depends on the circumstances around the death of their loved one.