MEETING OF THE BOARD OF DIRECTORS – 21th February 2024			
Report Title: Mortality and Learning from Deaths			**Agenda No.: 11**
Report Author and Job Title:	Dr C McKenna Deputy CMO	**Lead Executive Director:**	Dr Chris Abbott, CMO
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☐		
Situation:	The Trust is committed to reporting, reviewing, and where appropriate investigating deaths. The processes and mechanisms for ensuring this occurs are undergoing significant change across the NHS through the introduction of the Patient Safety Incident Response Framework (PSIRF, NHS England » Patient Safety Incident Response Framework and also see Trust intranet) . The emphasis in this new framework is on learning and improving patient safety. There are additional internal changes supporting mortality reporting and learning from deaths which are discussed below.		
Background:	The Trust has an established though recently re-constituted monthly Clinical Incident and Safety Group chaired by the Associate Director of Quality. A Mortality and Learning from Deaths subgroup chaired by the Deputy CMO will report alongside the Clinical Incident and Safety Group. All deaths will be reviewed, and decisions taken about how to proceed within the new framework (PSIRF). This subgroup will proactively monitor and review deaths, review reports e.g. After Action Review, SJRs and consider the findings of mortality audits. A 3-day intensive PSIRF training for a group of senior clinical and administrative staff took place recently. The development of PSIRF in the Trust is in keeping with several other NHS Organisations (information recently shared at the Quality and Safety Committee). The Mortality and Learning from Deaths subgroup will seek to provide assurance to the Trust Board that through PSIRF all deaths are reported and responded to appropriately to ensure learning is shared, improvements are implemented, monitored, and maintained and that the organisation evidences how it enacts a just culture. Specific mortality audits have previously been presented to the Quality and Safety Committee (Nov 2023) and to the Trust Board (April 2023). The findings have been escalated to NHS England where appropriate, particularly in relation to long waiting lists for specialist services. An audit of deaths occurring within 6 months of case closure in Adult GIC is currently being undertaken. The next significant Trust wide mortality audit to be completed will be an audit of patient deaths (open cases and waiting list) 1 April 2023-31 March 2024. The key questions are– what are the number of unexpected		

	deaths and how many are classified as unexpected unnatural deaths? How can patient safety and patient care be improved, including for those on waiting lists? The Trust Risk Management and Compliance System is being replaced by Radar (www.radarhealthcare.com).The implementation project is underway but will take several months. There has been an initial scoping of the mortality module by key people in the Trust who will be using this module. H.M Coroners in England and Wales have a duty to write a Regulation 28 report when they identify causes for concern that, if addressed, could prevent future deaths. The Trust received two Regulation 28 rulings (Prevention of Future Deaths) during 2023 (April and December) and in both cases this related to death of patients on Adult GIC waiting list. See links - Prevention of future deaths report - 2023-0503 (judiciary.uk) Prevention of future deaths report - Courts and Tribunals Judiciary In relation to the GIC, the Trust is working with NHS England and other providers to develop innovative ways of reducing the waiting list and providing support to patients while on the waiting list; this includes the development of new roles including nurse led triage and peer support workers. A timetable of learning lessons events for the calendar year is in draft and includes presentations on the National Child Mortality Database NCMD | The National Child Mortality Database, Annual Report from The National Confidential Inquiry into Suicide and Safety in Mental Health NCISH | The University of Manchester and Suicide Prevention. The Trust has established a working group to consider how best to support Trust staff following the death of a patient by suicide.
Assessment:	New processes are being established to ensure that the Trust continues to support mortality reporting, learning from deaths and safety incidences. The planned mortality audit (April 2023-March 2024) will be reported in Q1 2024/25 and there will be an associated learning event.
Key recommendation(s):	The Board of Directors is asked to note the work that is currently being undertaken to ensure that new structures, processes, and mechanisms will be in place to support reporting and learning from deaths.

Implications:				
Strategic Objectives:				
☒ Improve delivery of high-quality clinical services which make a significant	☐ Be a great & safe place to work, train & learn for everyone. A place where we can all	☐ Develop & deliver a strategy & financial plan that supports medium & long-term	☐ Be an effective, integrated partner within the ICS & nationally, supporting	☐ Ensure we are well-led & effectively governed.

difference to the lives of the people & communities we serve.	thrive and feel proud in a culture of inclusivity, compassion & collaboration.	organisational sustainability & aligns with the ICS.	improvements in population health & care & reducing health inequalities.	

Relevant CQC Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		
	Risk Ref and Title:				
Legal and Regulatory Implications:	Yes ☐	No x☐			
	However, there may be legal and regulatory implications related to deaths (PFD, Regulation 28)				
Resource Implications:	Yes ☒	No ☐			
	There are resources implications arising from this report in terms of continuing to support 1. audits, 2 supporting inquests, 3 legal advice via NHS R				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☒	No ☐			
	Very long waiting lists preclude easy access to the service.				
Freedom of Information (FOI) status:	x☐ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:					
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	