QUALITY CONFERENCE: OUR COLLECTIVE MINDSET FOR HIGH VALUE CARE

LEARNING CULTURE: LEARNING FROM DEATHS IN MENTAL HEALTH, LEARNING DISABILITIES AND COMMUNITY SERVICES

Speakers: Dr Jonathan Bindman, Medical Director, Barnet Enfield and Haringey Mental Health NHS Trust and Paul Farrimond, Non Executive Director, Barnet Enfield and Haringey Mental Health NHS Trust

In this session Dr Jonathan Bindman outlined the approach that his trust is taking to investigating deaths, and invited members of the audience for their views and approaches in this area as well (this session was held under Chatham House rules so details of these discussions have not been noted).

He outlined that at his trust there were approximately 180 unexpected deaths per annum. Within this there are nearly 60 serious incidents (SIs), with approximately 30 of these being suicide.

The trust uses the RCA' methodology - which has known limitations - to perform these SI investigations. It also seeks to not only ensure full duty of duty of candour, but to try and perform duty of candour "plus". This means very extensive involvement with patients' families by senior clinicians and board directors. This can often last years and moves far beyond the normal formal mechanisms for communicating with the families of patients.

Jonathan outlined some of his reflections as an MD in a mental health provider dealing with deaths, and invited a general discussion. Summarising some of the points made in discussion:

- Many trusts struggle with segmentation of deaths. Many deaths are categorised as unexpected when in reality they are not, but the death occurred outside of normal palliative care.
- The level of information given regarding the deaths of children with severe complex disabilities, known to community services, is often very limited due to the data system which presents the results. As there is a separate process of child death reviews for these children, reporting via the Trust is duplication.
- Mental health Trusts have developed mortality review groups in line with current guidance, but these do not serve the same purpose as in acute Trusts and may not be the right way to assess deaths in mental health trusts. Due to volume of deaths and the time constraints the group has to make rapid decisions as to whether a death needs to be investigated or not. Decisions have to be made on a "common sense" basis. It as suggested by discussants that the use of a trigger tool is preferable.
- When investigating a serious incident, how do you what do you define what is "avoidable"?
- How can you ensure when you are investigating a serious incident that you begin from the right starting point – not being defensive and getting the right level on input from the family of the patient?
- What is the right level of resources to allocate to investigating serious incidents when finances are tight across the health service, and to ensure the administrative burden is not disproportionate?