Drug Related Death Monitoring Terms of Reference

Name of the system:

Drug & Alcohol Related Deaths (DARD) Monitoring Group

Purpose of group:

The purpose of this group is to examine drug or alcohol related deaths which occur through either deaths in treatment or deaths identified as DRDs by the local coroner, and to look at learning opportunities from examination of the cases and the exploration of common themes and issues.

The Drug Related Deaths Monitoring Group does not replace existing SAR panel responsibilities or any current live review of cases but will when identified share information through the safeguarding lead into those panels.

Deaths when they occur are entered by named individuals within the treatment system into the IMS Online Drug Related Deaths (DRD) module, with any supporting documentation including NDTMS details and internal review details.

Once a quarter Public Health Institute (PHI)'s Intelligence and Surveillance Team will receive details from the coroner's office of any deaths originally reported by the treatment services, and any deaths notified by the coroner as drug related, regardless of whether the individual was in treatment or not.

Once a case has been entered onto the system using either route, each member of the local Drug Related Deaths Monitoring Group will receive a notification along with a log-in for the IMS Online portal where they can check whether the individual was known to their organisation. If they were known to them, they are then able to append any relevant additional information to that record.

The group was established by Liverpool John Moores University's Public Health Institute in conjunction with the Local Authority with the aim of bringing personnel together from the treatment agencies and other services in order to provide a broad range of knowledge and expertise.

Scope of Group

The group will review deaths in treatment with our current treatment provider or DRD identified through the local coroner. The following definition covers the scope of the panel:

1. A death where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved.
2. All drug poisoning deaths from controlled medication and from alcohol.
3. All deaths of individuals in treatment at the time of their death or up to six months before the date of death, which include deaths from natural causes/physical health – includes alcohol deaths in treatment.

Membership of the group:

The panel group membership should consist of at least:

- A representative from the treatment provider(s)

- The prescriber from the treatment provider(s)
- A representative from the Local Authority's Public Health department
- A representative from the local safeguarding partnership boards
- A chairperson from LJMU's PHI

The group should also include representatives from key sectors such as housing, mental health, adult social care, probation and pharmacy, who should provide context to cases from an organisational perspective both prior to the panel (using the IMS Online portal) and during the panel using any case notes they hold for the deceased individual. Their expertise more generally can contribute to cases for which they have had no direct involvement.

The group should further attempt to include any other relevant personnel involved in an individual's care on an ad hoc basis – where the same individual is recurrently involved in an individual's care, a more permanent invitation to sit on the panels may be extended. The period of membership will last for as long as the panel meets.

Accountability:

The Chair of the panel, a representative from PHI, will feed back notes taken from the panel to the group and will also circulate a quarterly action log which will devolve responsibility for certain areas to individuals to report back on in future months.

Review:

An annual report will be produced giving an overview of the work of the panel over the previous 12 months, alongside an annual event which brings together the work of all participating LAs in this area and ensures that the system is still functioning well and relevant. Suggestions for improvement from both the report and the event will be implemented for the following year.

Working methods:

A shared learning approach will be used to facilitate any panel discussions with an emphasis on no or fair blame. The panels will not be formally minuted, in order to encourage open and honest participation from all partners, but notes of key points discussed and recommendation made will be circulated following the panel.

Meetings:

The panels will be held quarterly at a suitable venue or via Microsoft Teams and be chaired by a representative from PHI with a grounded knowledge in this area. The panels will examine cases in the previous quarter's DRD report which will be distributed to panel members at least one week in advance of the panel taking place. Notes and an action log will be circulated as soon as possible after the panel has taken place. These will be produced by the PHI chair. The Chair will also invite individuals from other

organisations to the panels based on information provided by the DRD template or recommendations from panel members.

Commitment and involvement of panel membership:

In order to ensure the information recorded in the reports by treatment providers is of sufficiently high quality to enable useful discussion, a data quality / operational meeting will take place between treatment provider and LJMU immediately prior to the quarterly data entry deadline which will be an opportunity for providers and LJMU to liaise on any missing data, queries around completion and highlighting where improvements can be made.

While treatment providers have a key role in providing all relevant information to the panels, there should be a commitment alongside this from the wider panel membership from different sectors to share information about cases. To facilitate valuable discussion about the cases and make the best use of panel time, members are expected to look at the cases report prior to the meeting and come prepared with any additional information. Where a member of the group is not able to attend a panel for its duration, they should attempt to deputise this role to a suitable colleague.

Sharing of information and resources:

The IMS Online DRD tool is available for the entering of all data including the facility to attach NDTMS details in CSV format. Quarterly DRD reports will be circulated via the secure IMS Online file sharing portal. Notes and minutes without reference to any personally identifiable information will be shared by email. Because individuals are deceased, GDPR and the DPA 2018 do not apply although there is a duty of care with all information and access to this will only be granted to members of each specific area's Drug & Alcohol Related Deaths Monitoring Group.

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