BOARD OF DIRECTORS MEETING (Open)

Date: 14th March 2018 **Item Ref: 06**

TITLE OF PAPER	Mortality – Quarterly Review
TO BE PRESENTED BY	Mike Hunter, Executive Medical Director
ACTION REQUIRED	For the Board of Directors to note this report and receive appropriate assurance.
OUTCOME	To reduce preventable mortality within the Trust.
TIMETABLE FOR DECISION	Discussed at February's Quality Assurance Committee meeting, prior to the Board of Directors in March 2018.
LINKS TO OTHER KEY REPORTS / DECISIONS	Incident Management Quarterly Reports Learning from Deaths Policy
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES	Strategic Aim Quality and Safety Strategic Objective: A101 Effective quality assurance and improvement will underpin all we do BAF Risk: A101ii Inability to provide assurance regarding improvement in the quality of patient care Strategic Aim Future Services Strategic Objective: A303: Provide Effective Community Care And Treatment BAF Risk: A303: Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration CQC Regulation 18: Notification of other incidents CQC Review of Learning from Deaths LeDeR Project NHS Sheffield CCG Quality Schedule NHS England Serious Incident Framework SHSC Incident Management Policy and Procedures SHSC Duty of Candour Policy National Quality Board Guidance on Learning from Deaths
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Poor patient care. Preventable mortality could lead to reputation damage, poor staff morale and ultimately service closure.
CONSIDERATION OF LEGAL ISSUES	Potential breaches of regulatory, contractual and statutory legislation. Increased risk of litigation and coronial rulings.

Author of Report	Tania Baxter
Designation	Head of Clinical Governance
Date of Report	13 February 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: 14th March 2018

Subject: Mortality – Quarterly Review

Presented by: Mike Hunter, Executive Medical Director

Author: Tania Baxter, Head of Clinical Governance

1. Purpose

For approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (Please state below)*
		✓		✓	

2. Summary

This report provides the Board of Directors with an overview of the Trust's mortality and the continued findings from the Trust's Mortality Review Group.

Since the last quarterly report was presented to the Board of Directors in December 2017, the Trust has completed its first Structured Judgement Reviews (SJRs) and 360 Assurance has conducted an audit to assess the Trust's compliance with the requirements set out within the National Quality Board (NQB) guidance. Significant Assurance was given from the internal audit. The findings of which have been reported separately to the Quality Assurance Committee.

Mike Hunter, Medical Director, is the nominated Executive Director with the lead for mortality within the Trust and Mervyn Thomas is the current nominated Non-Executive Director that oversees the learning from deaths processes and oversees progress in this area.

SHSC's Mortality Review Group (MRG) (the Group)
The Group, chaired by the Medical Director, meets weekly and considers and discusses all deaths that have been recorded as an incident on the Trust's risk management system (Ulysses).

Following this process, as previously reported, each death is classified as being:

Signed off,
Requiring Further Information,
Watching brief,
Within Serious Incident processes, or
Within LeDer processes

The Group monitors the progress of each individual death going through these processes, until they are 'signed off'.

Each month service user deaths reported on Ulysses are cross-matched with deaths reported on Insight. The Group takes a sampling approach of the deaths 'not matched' in order to review these and determine potential preventability of death.

The NQB Guidance suggests that all Trusts use an adapted form of the Structured Judgement Review (SJR) to review such deaths. SHSC has recently begun using SJR templates developed by other Trusts, the findings from these are included below.

On 13 February 2018 the NHS Improvement Academy contacted the Trust to inform them that revised SJR tools have been developed by them and a training session for Yorkshire and the Humber is being scheduled for April. SHSC has offered to host this training, along with Bradford and NAVIGO.

SHSC Thematic Breakdown of Mortality

From the deaths reviewed within SHSC's MRG many of them have been expected deaths in older adults with comorbidity, eg dementia, pneumonia; natural cause deaths in middle aged people with comorbidity, eg ischemic heart disease. The Group has reviewed a number of younger to middle aged people mainly within START services (opiates, non-opiates and alcohol) who were 'found deceased'. A small number of younger to middle aged people due to suicide/suspected suicide and a group of people within Neuro Enablement and Long Term Neurological Conditions services with enduring health problems.

LeDeR

The Learning Disabilities Mortality Review Programme (LeDeR) was established to drive improvement in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities in this population. In line with requirements, SHSC has reported all deaths of individuals with a learning disability to the LeDeR project since 1 November 2016. From 1 April 2017 to 31 December 2017 SHSC has reported 12 deaths to LeDeR. Anita Winter is the Local Area Contact for LeDeR and manages the process of allocating cases to local trained reviewers and quality assessing the completed reviews. The completed reviews are submitted to LeDeR, who provides independent quality assurance on the review. SHSC's MRG receive the LeDeR findings of cases submitted from the Trust. This then enables these deaths to be 'signed off'. Findings from each review including lessons learnt and recommendations are fed into the LeDeR Steering Group which are taken forward for action/implementation.

Learning from Deaths – Dashboard

NQB Guidance states that Trusts must report their mortality to a public Board meeting on a quarterly basis from quarter 3 onwards. SHSC has been reporting their mortality data quarterly via these reports and monthly via the Safety Dashboard for some considerable time. The dashboard attached at Appendix 1 has been developed by the Northern Alliance for this purpose. Due to the current inconsistent methodology around SJRs for mental health trusts currently, the Northern Alliance Trusts have agreed that they are not in a position to publish data on 'preventable deaths' and this will be considered as a future development.

What is recorded in the dashboard as 'learning points' are actions arising from serious incident investigations that will potentially result in changes in practice. Following the completion of SJRs, learning resulting in practice changes will also be incorporated into the dashboard. The dashboard currently shows no 'learning points' from the learning disability deaths recorded for the first 3 quarters. This is because none of the incidents were serious incidents requiring an investigation and the findings from the LeDeR reviews have yet to be received. These figures are refreshed on a quarterly basis to capture investigations (including LeDeR reviews) that are still ongoing at report publication.

The dashboard contains information from the Trust's risk management system (Ulysses) as well as information from the Trust's patient administration system (Insight). All deaths recorded on Ulysses have been included, together with all deaths recorded on Insight where an individual has received face to face contact with Trust services within 6 months of the date of death, irrespective of whether the individual had an open episode of care at the time of death. Deaths have only been reported separately for inpatient services and learning disability services, all other deaths, ie community and individuals within residential settings are recorded collectively.

Whilst all deaths (including serious incidents (SIs)) are reviewed within Mortality Review Group meetings, for the purpose of the dashboard, these have only been counted once (ie under those reviewed through SI processes).

Ulysses is continuing to develop a mortality questionnaire, to aide mortality review and SJR processes. Whilst this is still in its infancy, SHSC will continue to be linked into these developments, which may involve dashboard development in the future.

Structured Judgement Review Learning
Within this quarter, the Trust has piloted the use of SJR templates used in other mental health trusts. A two stage approach has been used on a number of deaths highlighted as benefitting from further review.

From the SJR reviews undertaken so far, no death has been found to be 'avoidable'. DRAMs and care plans have been found to be up to date with adequate or good care in most cases. One screening tool identified poor care and this was based on the fact that the service user was referred on numerous occasions to the CMHT but was rejected despite a number of factors that seemed to indicate an assessment should have been allocated. The SJR screening identified that a more in-depth SJR should be undertaken, which is ongoing.

3. Next Steps

- The Trust to attend the NHS Improvement Academy training in April on the developed SJR tools and then adopt these tools for use within SHSC;
- Quarterly reporting to continue to enable annual reporting in the 2017/18 Quality Report.

4. Required Actions

The Board of Directors is asked to:
Receive and discuss this report.

5. Monitoring Arrangements

Mortality discussions occur weekly, the results from which are reported to the Service User Safety Group monthly. Mortality is recorded within quarterly incident management reports presented to the Quality Assurance Committee. Reporting on the categorisation of deaths (eg natural causes, suicide, drug/alcohol related), following coronial procedures is incorporated in the monthly safety dashboard reported to the Board of Directors.

Quarterly reporting to the Board of Directors, utilising the agreed dashboard, in line with the guidance from the NQB, is also established.

Annual mortality reporting will be incorporated into the Quality Report from 2017/18.

6. Contact Details

For further information, please contact: Tania Baxter, Head of Clinical Governance,
Tel: 0114 226 3279, tania.baxter@shsc.nhs.uk

Appendix 1

Learning From All Deaths Within Mental Health And Learning Disability Services

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from ALL DEATHS. Working with eight other mental health trusts in the north of England we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur. We have decided not to initially report on what are described in general hospital services as "avoidable deaths" in inpatient services. This is because there is currently no research base on this for mental health services and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. We will review this decision not later than April 2018 and will continue to support work to develop our data and general understanding of the issues.

Learning from Deaths Dashboard - Data Taken from Trust's Risk Management System (Safeguard) and Patient Information System (Insight)

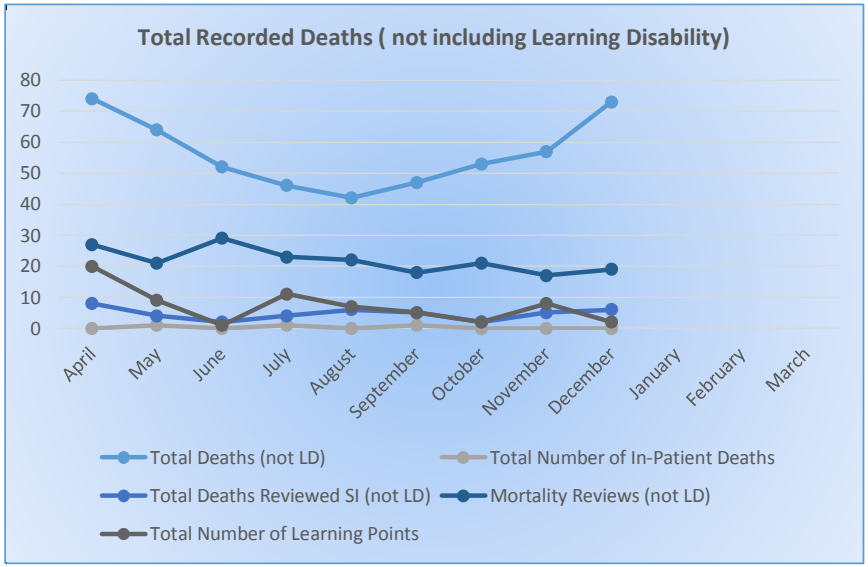
Reporting Period - Quarter 1 & 2 - April - September 2017

Sheffield Health and Social Care NHS Foundation Trust

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

Total Number of Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework	Total number of deaths subject to Mortality Review	Total number of actions resulting in change in practice
Q1	Q1	Q1	Q1	Q1
190	**1**	**14**	**77**	**30**
Q2	Q2	Q2	Q2	Q2
135	**2**	**15**	**63**	**23**
Q3	Q3	Q3	Q3	Q3
183	**0**	**13**	**57**	**12**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
508	**3**	**42**	**197**	**65**



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

Total Number of Learning Disability Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework or Subject to Mortality Review	Total number of deaths reported through LeDer	Total number of actions resulting in change in practice
Q1	Q1	Q1	Q1	Q1
7	**0**	**7**	**7**	**0**
Q2	Q2	Q2	Q2	Q2
1	**0**	**1**	**1**	**0**
Q3	Q3	Q3	Q3	Q3
4	**0**	**4**	**4**	**0**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
12	**0**	**12**	**12**	**0**