# BOARD OF DIRECTORS MEETING (Open)

**Date:** 13th December 2017 **Item Ref:** 14

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| **TITLE OF PAPER** | **Learning from Deaths – Mortality Dashboard** |
| **TO BE PRESENTED BY** | Mike Hunter, Executive Medical Director |
| **ACTION REQUIRED** | For the Board of Directors to receive this report. |
| **OUTCOME** | To reduce preventable mortality within the Trust. |
| **TIMETABLE FOR DECISION** | This was discussed at October's Quality Assurance Committee meeting and reported to November's Board of Directors meeting through the Significant Issues Report. For presenting to December's Board of Directors meeting. |
| **LINKS TO OTHER KEY REPORTS / DECISIONS** | Incident Management Quarterly Reports<br>Mortality Review Quarterly Reports<br>Learning from Deaths Policy |
| **LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES** | Strategic Objective: A101 and A303<br>BAF Risk: A101 and A303<br>CQC Regulation 18: Notification of other incidents<br>CQC Review of Learning from Deaths<br>LeDeR Project<br>NHS Sheffield CCG Quality Schedule<br>NHS England Serious Incident Framework<br>SHSC Incident Management Policy and Procedures<br>SHSC Duty of Candour Policy<br>National Quality Board Guidance on Learning from Deaths<br><br>HSE ❑ MH Act ☐ Equality ❑<br>NHS Constitution: Patients ☐ Public ❑ Staff ❑ |
| **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. |

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| **Author of Report** | Tania Baxter |
| **Designation** | Head of Clinical Governance |
| **Date of Report** | 29 November 2017 |

# SUMMARY REPORT

**Report to:** **BOARD OF DIRECTORS MEETING**

**Date:** **13th December 2017**

**Subject:** **Learning from Deaths – Mortality Dashboard**

**Presented by:** **Dr 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 update on the mortality work that is being undertaken within the Trust, in line with the National Quality Board's (NQB) Guidance on Learning from Deaths. It also reports the quarterly mortality dashboard, which is being presented to the Board of Directors for the first time and covers the first two quarters of 2017-2018.

Quarterly mortality reports are presented to the Quality Assurance Committee, with the latest one presented in October 2017. These are reported to the Board of Directors through the significant issues reports from the Committee.

In line with the NQB Guidance, the Trust has developed a Learning from Deaths Policy, which was published on 29 September 2017.

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

The Trust has continued to work with the Northern Alliance, (a group of nine mental health Trusts in the North of England) in this area and whilst the formal engagement sessions have ended, Trusts have committed to continue the excellent collaborative approach and sharing of ideas/lessons learned as we go forwards.

## 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). The Group has recently gained additional members, with a Senior Operational Manager from the Specialist Directorate and a higher trainee with a particular interest in physical health who is undertaking their Health Education England Leadership Fellow year.

Following this process, 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. This is currently a manual process and further work is required to automate this as much as possible. 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. A number of Trusts have begun to pilot various mental health adaptations of the SJR. SHSC has recently been notified of training opportunities in this area, in order to gain a more consistent approach of reviewing expected/natural cause deaths.

## 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) has been established to drive improvement in the quality of health and social care service delivery for people with earning disabilities and to help reduce premature mortality and health inequalities in this population. SHSC has reported all deaths of individuals with a learning disability to the LeDeR project using an on-line reporting tool since 1 November 2016. To date 24 deaths have been reported from SHSC and a total of 51 have been reported in Sheffield. 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 provide 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 collect and 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 reports to the Quality Assurance Committee 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 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.

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.

The 'green' column in the dashboard is currently under development. The Northern Alliance have agreed that, in the absence of an agreed, consistent basis for calculating 'preventability of death', this column currently only shows the number of actions highlighted through the Trust's serious incident processes that have led to changes in practice.

## 3. Next Steps

- The Trust will continue to work with other Trusts in relation to developing SJR for use within SHSC;
- Quarterly reporting to the Board of Directors via a dashboard will commence from November 2017.

## 4. Required Actions

The Board of Directors is asked to:

- Receive and discuss this report;
- Agree quarterly reporting to the Board of Directors via a mortality dashboard;
- Provide appropriate assurances to the Board of Directors.

## 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 will commence, utilising the agreed dashboard, in line with the guidance from the NQB.

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)

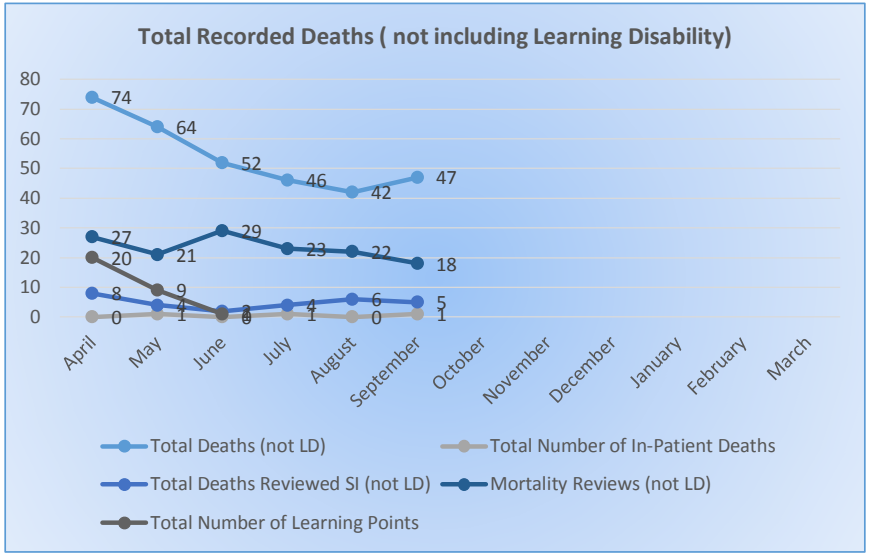
## Reporting Period - Quarter 1 & 2 - April - September 2017

NHS 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** | **0** |
| Q3 | Q3 | Q3 | Q3 | Q3 |
| **0** | **0** | **0** | **0** | **0** |
| Q4 | Q4 | Q4 | Q4 | Q4 |
| **0** | **0** | **0** | **0** | **0** |
| YTD | YTD | YTD | YTD | YTD |
| **325** | **3** | **29** | **140** | **30** |




***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 |
| **0** | **0** | **0** | **0** | **0** |
| Q4 | Q4 | Q4 | Q4 | Q4 |
| **0** | **0** | **0** | **0** | **0** |
| YTD | YTD | YTD | YTD | YTD |
| **8** | **0** | **8** | **8** | **0** |