BOARD OF DIRECTORS MEETING (Open)

Date: 11 July 2018 **Item Ref:** 18

TITLE OF PAPER	**Mortality – Quarterly Review**
TO BE PRESENTED BY	Mike Hunter, Executive Medical Director
ACTION REQUIRED	For the Board of Directors to be assured of the Trust's mortality processes.
OUTCOME	To reduce preventable mortality within the Trust.
TIMETABLE FOR DECISION	Discussed at May's Quality Assurance Committee meeting and July's Board of Directors meeting.
LINKS TO OTHER KEY REPORTS / DECISIONS	Incident Management Quarterly Reports LeDeR Annual Report 2016/17
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 CQC Regulation 18: Notification of other incidents CQC's Review of Learning from Deaths LeDeR Project NHS Sheffield CCG's Quality Schedule NHS England's Serious Incident Framework SHSC's Incident Management Policy and Procedures SHSC's Duty of Candour Policy SHSC's Learning from Deaths 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	14 May 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: 11 July 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 in March, the Trust has carried out a number of Structured Judgement Reviews (SJRs) and hosted a training session on this run by the Yorkshire and the Humber NHS Improvement Academy.

Mike Hunter, Executive Medical Director, is the nominated Executive Director with the lead for mortality within the Trust and Sandie Keene is the newly nominated Non-Executive Director overseeing the learning from deaths processes and progress in this area, following the departure of Mervyn Thomas at the end of March 2018.

SHSC's Mortality Review Group (MRG) (the Group)

The Group, chaired by the Executive 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), together with sampling a number of deaths not recorded as an incident, but whose death has been recorded through national death reporting processes.

Each death is considered to ascertain if sufficient information is known about the care provided, leading up to the person's death, to enable the Group to be satisfied and assured. The following factors are considered, in accordance with the Trust's Learning from Deaths Policy:

Has the cause of death been established?
Who certified the death?
Where did the person die?
Are there any concerns raised by family/carers relating to the care/death?
Are there any concerns relating to medication surrounding the death?
Are there any concerns raised by staff members relating to the care/death?

Following the review, each death is classified as being:
Adequately understood,
Requiring Further Information,
Watching brief (usually used when coronial processes regarding cause of death are taking place),
Within Serious Incident processes, or
Within LeDer processes

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

Structured Judgement Reviews (SJRs)
SHSC hosted a training event run by the Yorkshire and the Humber NHS Improvement Academy on 26 April 2018, with over 20 delegates from a number of mental health trusts. The aims of the training session were to enable mental health organisations to collect mortality information on the safety and quality of care in sufficient and comparable detail to support both quality improvement and clinical governance needs and to provide reviewers with the knowledge and expertise required to perform explicit structured judgement reviews within their organisations.

SHSC had previously utilised a SJR template adapted by Humber NHS Foundation Trust for mental health, however, the template utilised as part of the training has now been licenced for use and will now be adopted.

Since the last quarterly report in March 2018, a further 7 SJRs have been undertaken and reviewed by both the MRG and Service User Safety Group. One of the reviews highlighted in February, warranting further review, has also been undertaken. The findings from this have been discussed at the Quality Assurance Committee.

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. 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.

8 deaths have been reported to LeDer, from the Trust, during quarter 4. The findings/outcomes/lessons learned from any LeDeR review, covering the 2017/18 financial year, have yet to be received by the Trust.

The annual report covering the period July 2016 to November 2017 has recently been published by LeDeR. In total 1,311 deaths were reported to LeDeR during this period, with 103 of these reviewed thus far.

The most commonly reported learning and recommendations identified in the report, were made in relation to the need for:
a) Inter-agency collaboration and communication;
b) Awareness of the needs of people with learning disabilities;
c) The understanding and application of the Mental Capacity Act (MCA).

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. 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 on these cases (as reported above). These figures are refreshed on a quarterly basis to capture investigations (including LeDeR reviews) that are still ongoing at report publication. There are currently no learning points highlighted from quarter 4 serious incidents currently shown on the dashboard. This is because, due to investigations taking up to 12 weeks, the learning from quarter 4 will be concluded during quarter 1 of the following year. The dashboard will therefore be retrospectively updated in this regard.

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 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).

3. Next Steps

- The Trust will adopt the revised SJR template, as presented by the Yorkshire and the Humber NHS Improvement Academy training session;

- Feedback from LeDeR reviews will be incorporated into these reports as and when available;
- Quarterly reporting to the Executive Directors Group, Quality Assurance Committee and Board of Directors will continue.

4. Actions

The Board of Directors is asked to:

- Receive and discuss this report;
- Receive assurances regarding the Trust's mortality processes.

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 (Ulysses) and Patient Information System (Insight)+A1

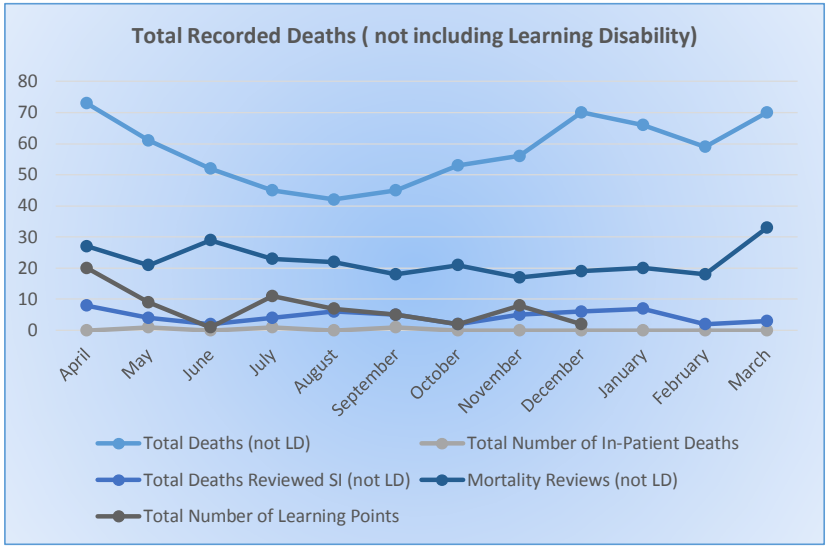
Reporting Period - Quarter 1, 2, 3 and 4 - April 2017 - March 2018

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
182	**1**	**14**	**77**	**30**
Q2	Q2	Q2	Q2	Q2
132	**2**	**15**	**63**	**23**
Q3	Q3	Q3	Q3	Q3
179	**0**	**13**	**57**	**12**
Q4	Q4	Q4	Q4	Q4
195	**0**	**12**	**71**	**0**
YTD	YTD	YTD	YTD	YTD
688	**3**	**54**	**268**	**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
8	**0**	**8**	**8**	**0**
Q2	Q2	Q2	Q2	Q2
3	**0**	**3**	**3**	**0**
Q3	Q3	Q3	Q3	Q3
6	**0**	**6**	**6**	**0**
Q4	Q4	Q4	Q4	Q4
8	**0**	**8**	**8**	**0**
YTD	YTD	YTD	YTD	YTD
25	**0**	**25**	**25**	**0**