BOARD OF DIRECTORS MEETING (Open)

Date: 10ᵗʰ October 2018   **Item Ref:** | 11

TITLE OF PAPER	Mortality – Quarterly Review Q1 2018/19
TO BE PRESENTED BY	Mike Hunter, Executive Medical Director
ACTION REQUIRED	For the Board of Directors to receive this report and the assurance it provides.

OUTCOME	To reduce preventable mortality within the Trust.
TIMETABLE FOR DECISION	Discussed at September's Quality Assurance Committee meeting and October's Board of Directors meeting.
LINKS TO OTHER KEY REPORTS/ DECISIONS	Incident Management Quarterly Reports LeDeR Annual Report 2016/17
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	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
LINKS TO THE NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	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 & 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 September 2018

SUMMARY REPORT

Report to: **Board of Directors**

Subject: **Mortality – Quarterly Review Q1 2018/19**

From: **Mike Hunter, Executive Medical Director**

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 (MRG).

Since the last quarterly report was presented to the Quality Assurance Committee in May, the MRG identified a further 7 cases suitable for a Structured Judgement Review (SJR) to be undertaken, using the template devised through the Yorkshire and the Humber NHS Improvement Academy. The findings from all SJRs are taken through the Trust's Service User Safety Group, then into the Patient Safety and Experience Team, for onward dissemination and feedback to the teams involved in care provision. A flowchart setting out this process has also been developed and approved during quarter 1.

Mike Hunter, Executive Medical Director, is the nominated Executive Director with the lead for mortality within the Trust and Sandie Keene is the nominated Non-Executive Director overseeing the learning from deaths processes and progress in this area.

SHSC's Mortality Review Group (MRG) (the Group)
The Group, chaired by the Executive Medical Director, continues to meet 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. During quarter 1 18 deaths from the spine have been examined, with 7 of these identified as benefitting from a SJR being undertaken. A further 53 deaths were reviewed by the Group following the death being reported via the Trust's Ulysses system. The age range of the deaths reviewed was from 25 to 96 years of age.

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. Factors such as the cause of death, concerns regarding the care provision (raised by family or staff), medication concerns, etc are taken into account when deciding whether the Group is assured and adequately understand the circumstances leading to the death. Where all these factors are not known, further investigatory work is undertaken and brought back to the Group.

Structured Judgement Reviews (SJRs)

Following the training run by the Yorkshire and the Humber NHS Improvement Academy on 26 April 2018, the Trust has been using the revised SJR template. Unlike the previous 2-staged approach, the SJRs undertaken now are a single stage, with a judgement provided at each stage of care, together with an overall judgement of care.

Since the last quarterly report in May 2018, all SJRs undertaken have been reviewed by both the MRG and Service User Safety Group. The summaries of the findings from these were presented and discussed at the Quality Assurance Committee in September 2018.

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 'adequately understood'. Findings from each review including lessons learnt and recommendations are fed into the LeDeR Steering Group which are taken forward for action/implementation.

Four deaths have been reported to LeDer, from the Trust, during quarter 1. The findings/outcomes/lessons learned from any LeDeR review, covering the 2018/19 financial year, have yet to be received by the Trust.

The findings from the first annual report, covering the period July 2016 to November 2017, published by LeDeR was reported to the Committee in May 2018 and identified learning and recommendations in relation to:
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. 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 or SJRs, where these actions would potentially result in changes in practice. The dashboard currently shows only four '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). The learning points identified are from a SJR that was undertaken. These figures are refreshed on a quarterly basis to capture investigations (including LeDeR reviews) that are still ongoing at report publication, due to the 12 week investigation timescale.

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 six 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 recorded as an incident (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

- 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   Required Actions

The Board of Directors is asked to:

Receive and discuss the assurance this report provides.

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 has been 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
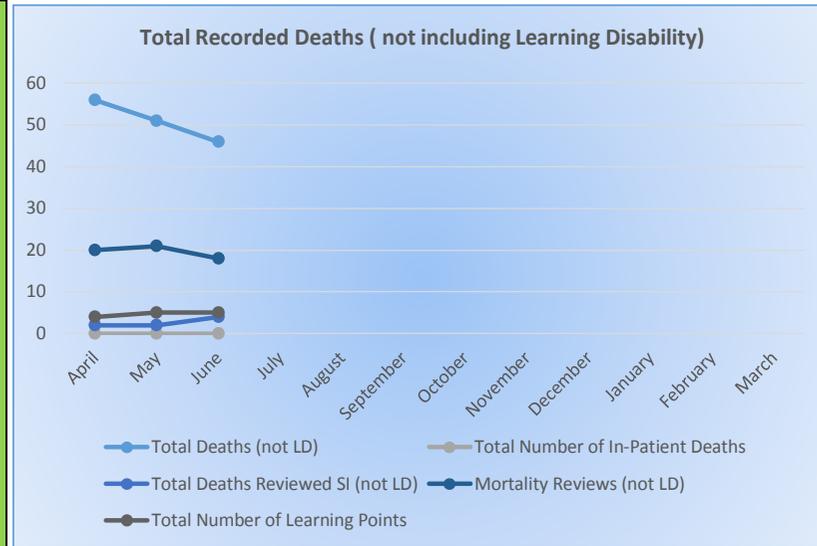
Learning From All Deaths Within Mental Health And Learning Disability Services

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.

Learning from Deaths Dashboard - Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 1 April 2018 - March 2019

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
153	**0**	**8**	**59**	**14**
Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**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
153	**0**	**8**	**59**	**14**

Total Recorded Deaths (not including Learning Disability)

Legend: Total Deaths (not LD); Total Number of In-Patient Deaths; Total Deaths Reviewed SI (not LD); Mortality Reviews (not LD); Total Number of Learning Points

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
4	**0**	**4**	**4**	**4**
Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**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
4	**0**	**4**	**4**	**4**

Learning Disability Deaths

Legend: LD Deaths; Total Number of In-Patient Deaths; LD Deaths Reviewed Internally; LD Deaths Reported to LeDer; Total Number of Learning Points