BOARD OF DIRECTORS MEETING (Open)

Date: 12 December 2018 **Item Ref:** 13

TITLE OF PAPER	Mortality – Quarterly Review Q2 2018/19
TO BE PRESENTED BY	Mike Hunter, Executive Medical Director
ACTION REQUIRED	Receive this report
OUTCOME	To reduce preventable mortality within the Trust.
TIMETABLE FOR DECISION	Discussed at the Quality Assurance Committee in November 2018 and Board of Directors in December 2018.
LINKS TO OTHER KEY REPORTS / DECISIONS	Incident Management Quarterly Reports to the Quality Assurance Committee 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	27 November 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: 12 December 2018

Subject: Mortality – Quarterly Review Q2 2018/19

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 (MRG).

Since the last quarterly report was presented to the Board of Directors in October 2018, the MRG identified a further 2 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 results 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 been developed and is in operation.

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, 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. During Q2 19 deaths from the spine have been examined, with 2 of these identified as benefitting from a SJR being undertaken. A further 48 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 32 to 100 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)
The Trust has used the SJR template developed through the Yorkshire and the Humber NHS Improvement Academy since August 2018. 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 September 2018, 6 SJRs have been undertaken and reviewed by both the MRG and Service User Safety Group. The summaries of the findings have been discussed at the Quality Assurance Committee at November's meeting.

At the Trust's recent Safer Care Event, a stall featuring SJRs was on display, where delegates could view previous SJRs undertaken and discuss the learning that had been discovered as a result of doing these, as well as acknowledging the varying practices that these showed.

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.

8 deaths have been reported to LeDeR, from the Trust, during quarter 2. The findings/ outcomes/lessons learned from any LeDeR review, covering the 2017/18 financial year, have yet to be received by the Trust.

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 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.

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

- 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 this report.

5 Monitoring Arrangements

Mortality discussions occur weekly, the results from which are reported to the Service User Safety Group monthly. 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,
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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)

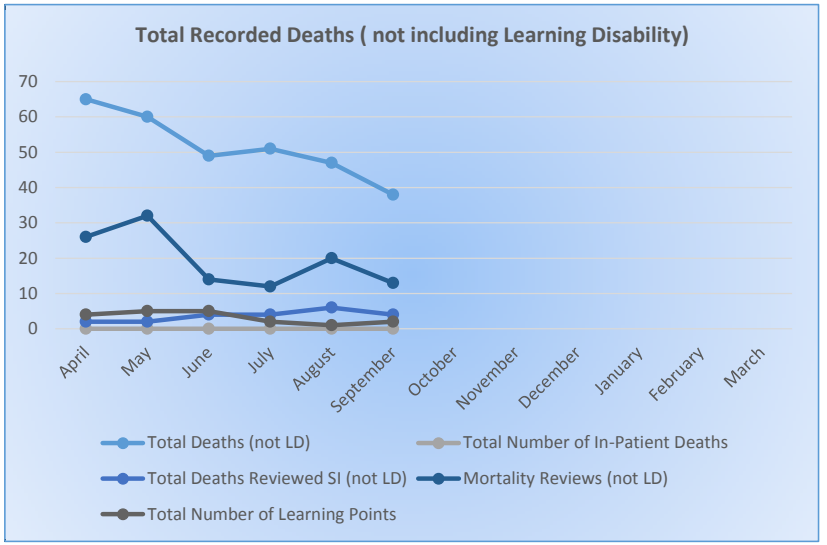
Reporting Period - Quarter 1 and 2 - April 2018 - September 2018

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
174	**0**	**8**	**72**	**14**
Q2	Q2	Q2	Q2	Q2
136	**0**	**14**	**45**	**5**
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
310	**0**	**22**	**117**	**19**



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
3	**0**	**3**	**3**	**4**
Q2	Q2	Q2	Q2	Q2
8	**0**	**8**	**8**	**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
11	**0**	**11**	**11**	**4**