BOARD OF DIRECTORS MEETING (Open)

Date: 11 December 2019 **Item Ref:** 16

TITLE OF PAPER	Mortality – Quarterly Review Q2 2019/20
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	Discussed at November's Quality Assurance Committee meeting, for discussion at December's Board of Directors meeting.
LINKS TO OTHER KEY REPORTS / DECISIONS	Incident Management Quarterly Reports Monthly Performance Reports (incorporating Safety Dashboards) LeDeR Annual Reports
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Aim: Quality & Safety Strategic Objective: A101 Effective Governance, Quality Assurance and Improvement will Underpin all we do. BAF Risk Number: A101ii Risk Description: Inability to improve the quality of patient care. Strategic Objective: A102 We Will Deliver Safe Care At All Times. BAF Risk No. A102ii - Inability to improve the safety of patient care.
LINKS TO 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/Being Open 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	3 December 2019

SUMMARY REPORT

Report to: **Board of Directors**

Date: **11 December 2019**

Subject: **Mortality – Quarterly Review Q2 2019/20**

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).

The MRG 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. These are considered to establish if they are suitable for a Structured Judgement Review (SJR) to be undertaken. All completed 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 is in operation which sets out this process.

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 recorded as an incident and those sampled through the deaths recorded via national death reporting processes. During Q2 20 deaths from the spine have been examined, with none of these identified as benefitting from a SJR being undertaken. A further 66 deaths were reviewed by the Group following the death being reported via the Trust's Ulysses system.

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, death certification, 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 continued to use the SJR template developed by the Royal College of Psychiatrists (RCP), since the publication of their Care Review Tool in November 2018. This is very similar to the Yorkshire & the Humber Improvement Academy tool used previously, with an avoidability indicator built into the review process. All Trusts in the Northern Alliance (nine mental health trusts in the north of England) have committed to using the RCP tool.

Two SJRs have been completed during this quarter and reviewed through MRG and the Service User Safety Group. These reviews have been fed back to the teams involved via the Clinical Operations' Patient Safety Groups.

The learning coming from the Northern Alliance is that more clinical SJR trained reviewers are required. Ideally, to maximise the learning, reviewers should be practitioners directly involved in care provision within the service where the individual whose care is being reviewed, was linked to. Liz Fletcher is currently working within the Risk Department in order to engage clinicians in this important area of work.

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 receives the LeDeR findings of cases submitted from the Trust to enable the deaths to be 'adequately understood'. Findings from each review including lessons learnt and recommendations are fed into the LeDeR Steering Group which are then taken forward for action/implementation.

Ten deaths have been reported to LeDer, from the Trust, during quarter 2. There have been no additional LeDeR reviews discussed through the MRG, since the last quarterly report was presented to the Quality Assurance Committee In October 2019.

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 2 has been developed by the Northern Alliance for this purpose. Due to the previous inconsistent methodology around SJRs for mental health trusts, the Northern Alliance Trusts agreed not to publish data on 'preventable deaths' within the dashboard. Following the publication and wider use of the RCP Care Review Tool, Trusts should be able to start to quantify the avoidability of deaths in a relatively consistent way.

What is currently recorded in the dashboard as 'learning points' are actions arising from serious incident investigations that will potentially result in changes in practice. As SJRs are completed, any learning resulting in practice changes are also incorporated into the dashboard.

As there are delays in learning arising through the LeDeR project reviews, the dashboard will be updated as and when these are known, which may be after the close of the financial year that the dashboard relates to.

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 from 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.

In total, over the quarter, 174 deaths of SHSC service users occurred, with 86 of these (52%) receiving a review through the MRG.

Deaths are 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 MRG meetings, for the purpose of the dashboard, these have only been counted once (ie under those reviewed through SI processes).

To complement the quarterly mortality figures, a number of basic control charts have been produced (see Appendix 1) in order to show whether normal variance or special cause variation is experienced in these areas. These all show normal variance over the 10 quarters shown. Trusts within the Northern Alliance have been working on developing some common indicators in order to gain some benchmarking intelligence in this area.

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 this report.

5 Monitoring Arrangements

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

Quarterly reporting to the Quality Assurance Committee and Board of Directors, in line with the guidance from the NQB, is established.

Annual mortality reporting has been incorporated into the Trust's Quality Report since 2017/18.

6 Contact Details

For further information, please contact: Tania Baxter, Head of Clinical Governance,
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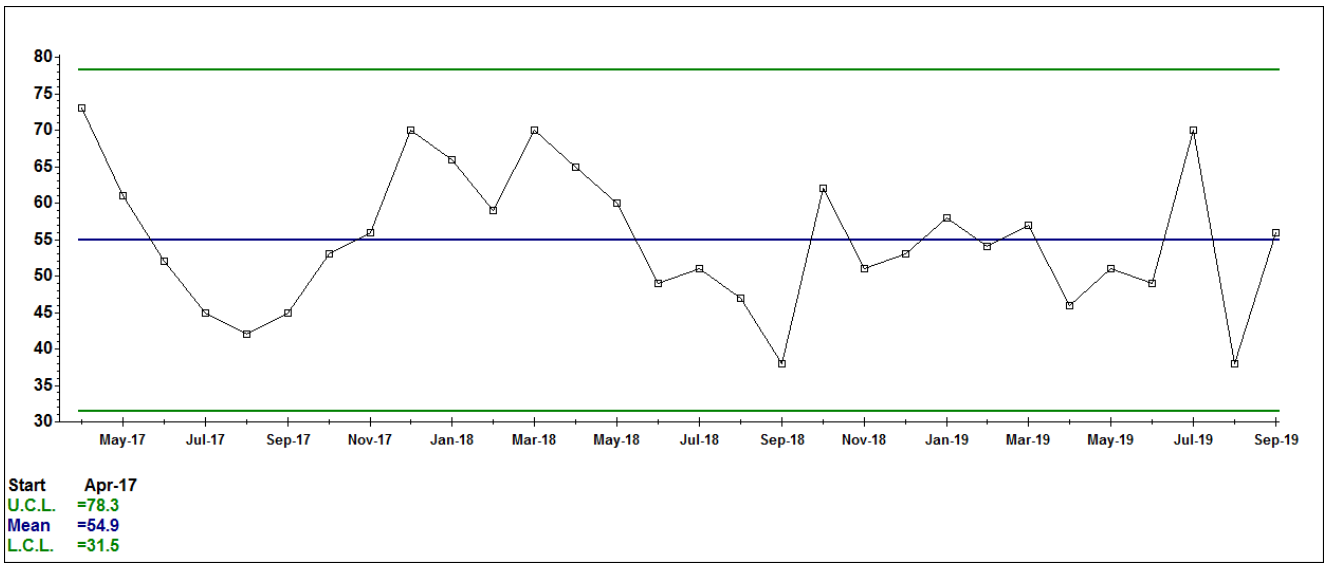
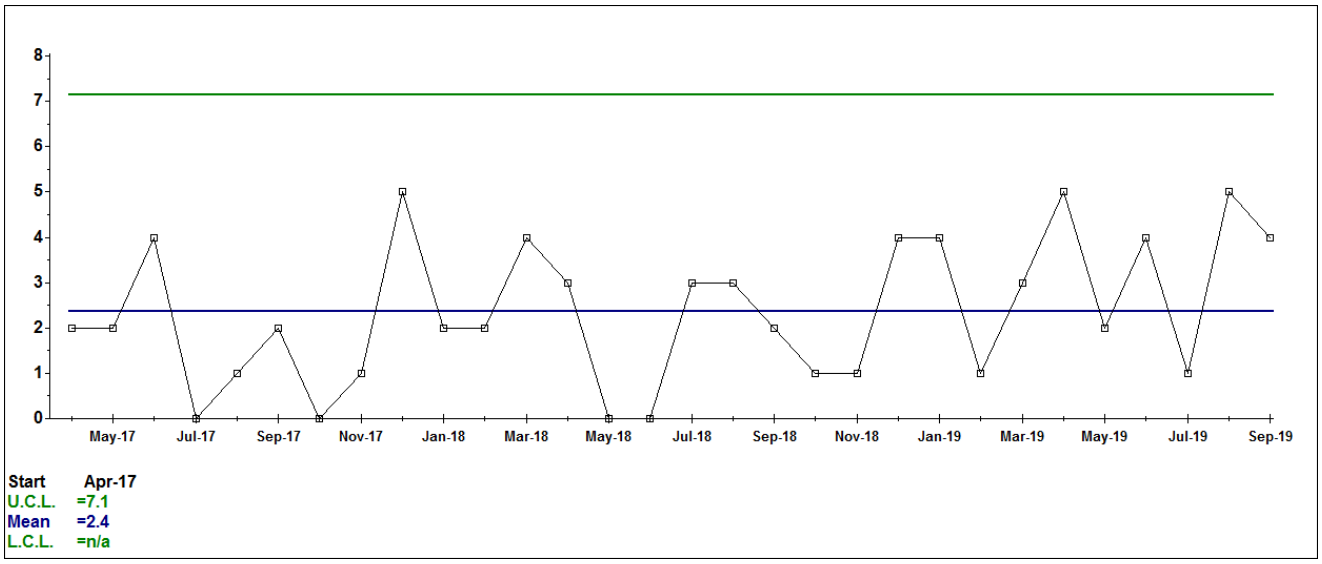
Appendix 1

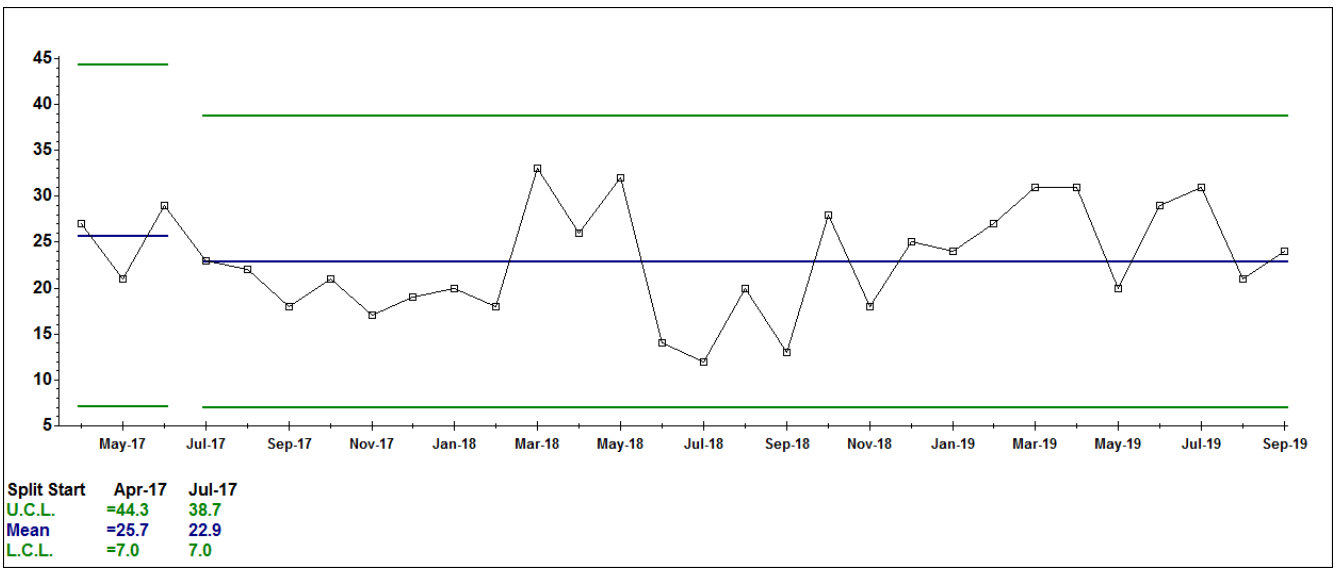
All deaths April 2017 – September 2019



All Learning Disability deaths April 2017 – September 2019



Deaths Reviewed at MRG (not including SIs) April 2017 – September 2019



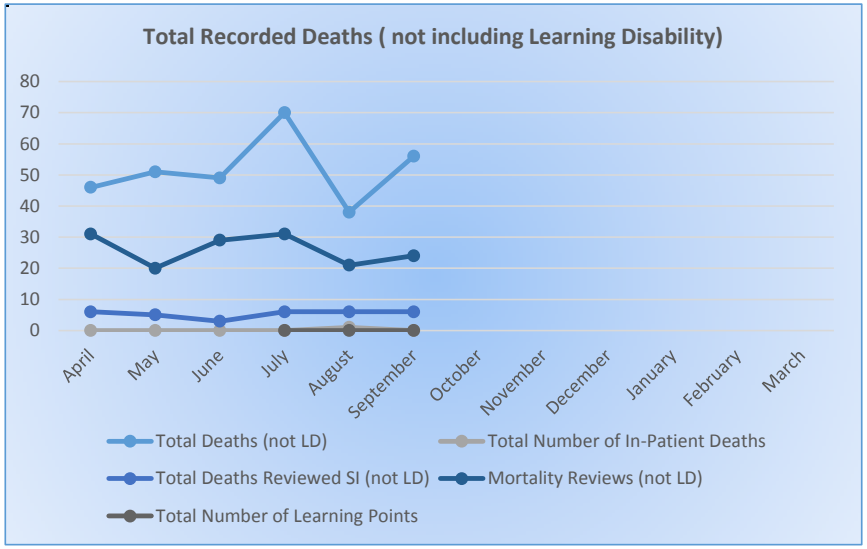
Appendix 2 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 1 & 2 April 2019 - September 2019

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
146	**0**	**14**	**80**	**0**
Q2	Q2	Q2	Q2	Q2
164	**1**	**18**	**76**	**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
310	**1**	**32**	**156**	**0**



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
11	**0**	**11**	**11**	**0**
Q2	Q2	Q2	Q2	Q2
10	**0**	**10**	**10**	**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
21	**0**	**21**	**21**	**0**