Sheffield Health and Social Care NHS Foundation Trust

Board of Directors' (Open)

Date:	11 November 2020	Item Ref:	12a

TITLE OF PAPER	Mortality – Quarterly Review Q1/Q2 2020/21
TO BE PRESENTED BY	Dr Mike Hunter, Executive Medical Director
ACTION REQUIRED	The Board of Directors' is asked to: • Receive this report in line with national requirements

OUTCOME	To reduce preventable mortality within the Trust.
TIMETABLE FOR DECISION	Discussed at October's Quality Assurance Committee meeting and presented to November's Board of Directors meeting.
LINKS TO OTHER KEY REPORTS / DECISIONS	Incident Management Quarterly Reports Monthly Quality and Performance Reports LeDeR Annual Reports
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	Strategic Aim: Deliver Outstanding Care Strategic Priority: Covid – Getting through safely Strategic Aim: Create a great place to work Strategic Priority: CQC: Getting back to good BAF.0003: There is a risk that the Trust is unable to improve patient safety resulting in a failure to comply with CQC requirements and achieve necessary improvements.
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	October 2020

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Sheffield Health and Social Care NHS Foundation Trust

Summary Report

1. Purpose

For Approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
	✓			✓		

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 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 and fed back to the teams involved.

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.

Within quarter 1 and quarter 2 2020/21, the Mortality Review Group reviewed 173 deaths. For the deaths that have completed the review process, 33 had Covid-19 recorded on the death certificate (24 of which occurred in April 2020). It should be noted, however, that many deaths have still to complete the certification processes and are awaiting a confirmed cause of death.

Two Structured Judgement Reviews (SJRs) reviewed during the two quarters were from Birch Avenue and Woodland View. Both of these showed extremely good practice with person-centred care, including thinking about the patients' spiritual needs, involvement with family and showed real understanding of the individual patients.

Two main issues highlighted within other SJRs were the number of different assessments documented in care records, where details were not always transferred consistently from one to another, and the monitoring of physical health checks being much more inbuilt within inpatient services, more than the community, where this tended not be as systematic.

Both of these areas are workstreams within our Back to Good programme and the findings from these reviews have been fed into the workstreams.

None of the deaths reviewed within the SJRs undertaken were considered more likely than not to have resulted from problems in care delivery or service provision.

19 LeDeR reviews were received through the MRG during the two quarters. Two of these had learning for our organisation. These involved an individual's health needs not being identified, and no reasonable adjustments made in connection with a needle phobia. The Community

Learning Disability Team has implemented a needle phobia pathway in response to this.

Appendix 1 shows the number of deaths recorded of SHSC patients (where contact occurred within 6 months of their death) since April 2017. This clearly indicates an increase in the number of deaths in April 2020, the peak of the initial pandemic.

3. Next Steps

- Additional feedback from LeDeR reviews will be incorporated into these reports as and when available;
- Annual mortality data will be reported in the Trust's Annual Quality Report 2019/20;
- Quarterly reporting to the Quality Assurance Committee and Board of Directors will continue.

4. Required Actions

The Board of Directors' is asked to:

- Receive this report in line with national requirements.

5. Monitoring Arrangements

The Mortality Review Group occurs 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 performance and quality reports provided 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 is incorporated into the Trust's annual Quality Reports.

6. Contact Details

For further information, please contact: Tania Baxter, Head of Clinical Governance,
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SHSC's Mortality Review Group (MRG) (the Group)
The Group, chaired by the Executive Medical Director, meets weekly and considers all deaths recorded as an incident and those sampled through the deaths recorded via national death reporting processes. During the reporting period, the following numbers of deaths have been examined.

Reporting Period	Source	Number
Quarter 1 2020/21	Spine (national death reporting processes)	25
	Incident report	88
	LeDeR	7
Quarter 2 2020/21	Spine	11*
	Incident report	30
	LeDeR	12

*Only 2 months spine data has been reviewed at the time of report production

For all deaths reviewed, the Group considers whether sufficient information is known about the individual and 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 care provision (raised by family/carers or staff), medication concerns, etc are taken into account by the Group when deciding whether it 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 uses the SJR template published by the Royal College of Psychiatrists (RCP) in November 2018. All Trusts in the Northern Alliance (nine mental health trusts in the north of England) have committed to using this Tool.

Four SJRs have been completed during the two quarters and reviewed through the MRG and the Service User Safety Group and fed back to the teams involved. From September 2020, a representative from the team/service where the death(s) occurred has been invited to hear the discussion on the completed SJRs within the weekly MRG meeting. The feedback received from this has been extremely positive and has enabled the learning/feedback to be given to the team/service in a much more timely way. It also helps to broaden the understanding of the Trust's mortality review processes within clinical services. It is hoped that this will help engage practitioners to volunteer to undertake SJRs in their own services, thus increasing the Trust's capacity to complete these.

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. SHSC reports all deaths of individuals with a learning disability to the LeDeR project, in line with requirements. 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. LeDeR provides independent quality assurance on the reviews. SHSC's MRG receives the LeDeR findings of cases submitted from the Trust and lessons learnt and recommendations are also fed into the LeDeR Steering Group for action/implementation.

10 deaths have been reported to LeDer, from the Trust, during quarters 1 and 2 2020/21. There have been 19 completed LeDeR reviews discussed through the MRG during this same period.

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.

The learning points recorded in the dashboard are actions arising from serious incident investigations, SJRs, or LeDeR reviews, that will potentially result in changes in practice. The dashboard is updated throughout the year to incorporate any learning points following the receipt of LeDeR reviews.

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 during quarter 1, 219 deaths of SHSC service users occurred, with 120 (55%) of these receiving a review through the MRG. During quarter 2*, 82 deaths occurred, with 53 (65%) receiving a review.
* Only two months spine data has been included within the reporting period as spine reviews are undertaken at the end of the following month.

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).

From deaths that have been reviewed during quarters 1 and 2, the causes of death have been due to old age and frailty, pneumonia, aspiration pneumonia, stroke, cancers, alcohol toxicity, chest infection, sepsis and Covid-19.

Learning from SJRs

From the SJRs completed during this reporting period, a number of learning points have been identified, including positive practice in the thoroughness of Mental Health Act assessments undertaken. The 'this is me' assessment tool used in dementia services was deemed to be useful in enabling thorough understanding of a person and the SJR author questioned whether this could be used to shape personalised care across all teams, irrespective of the focus on diagnosis. Medicines and physical health management, risk assessment and collaborative care planning were detailed and helpful with evidence of respectful and considerate care. Good communication between services and with family members was evidenced. Family support was also offered and provided throughout. Good liaison was evidenced between teams and with GPs and appropriate referrals were made into supportive services.

Two main issues arose from the completed SJRs. One of these was around the number of different assessments documented in care records, where details were not always transferred consistently from one to another, which could potentially lead to a patient safety risk and at least lack of consistency for the patient. Secondly, the documented monitoring of physical health checks was much more inbuilt within inpatient services, more than the community, where these tended not be as systematic.

None of the SJRs reviewed were considered more likely than not to have resulted from problems in care delivery or service provision.

As reported earlier, the learning from individual SJRs is shared through the MRG and the Service User Safety Group, into the Clinical Operations patient safety groups, back into the teams.

Learning from LeDeR - Nationally
The 2019 LeDeR annual report was published on 16 July 2020. This presents findings from 3,195 reviews of deaths of people with learning disabilities and identifies that treatable causes of death accounted for 403 per 100,000 deaths in people with learning disabilities, compared to just 83 per 100,000 deaths in the general population.

The Learning Disabilities Mortality Review (LeDeR) Programme Annual Report, published on 16 July 2020, indicates that the majority of people with learning disabilities continue to die before reaching the age of 65. In the general population, 85 per cent of deaths happen at or after the age of 65, but in sharp contrast this is the case for just 37 per cent of people with learning disabilities. Of the deaths notified to the LeDeR programme in 2019, two-fifths of adults and almost a quarter of children died from pneumonia, an illness which is normally treatable in this country. These figures are very similar to the figures for deaths caused by pneumonia published in the two previous annual reports.

Easy read information about the programme and its publications can be found at:
http://www.bristol.ac.uk/sps/leder/easy-read-information/

Learning from LeDeR - Locally
During the reporting period, 19 completed LeDeR reviews were received and discussed at the Mortality Review Group meetings. 16 actions were noted from these reviews, relevant to a number of health and social care agencies across the city. Two actions were noted to relate to the Trust's Community Learning Disability Team (CLDT).

SHSC learning from all reviews is themed as follows:

- Individuals' health needs were identified as not optimised, with non-concordance believed to be a significant factors. There were missed opportunities to involve the CLDT and the GP was not fully aware of the issues. CLDT have a direct role in engaging with individuals and families to optimise access to health care. However, following the Decision Support Tool assessment, the expected pathway for the identified action was not followed.
- Care records indicated needle phobia with no action or reasonable adjustments being taken to respond to this need. The CLDT have implemented a needle phobia pathway in response to this.

Other providers/social care learning identified:

- Continuing healthcare checklists were screened and returned for further information to the Local Authority. The updated information was not actioned and resubmitted by the referrer.
- Delay in review appointment for Cardiology resulted in the pathway for review appointments being revisited.
- The impact on couples and of their respective roles as 'carer' and 'cared for' was not explored. While people have the right to decline a formal Carer's Assessment, the needs of carers with a learning disability and those they care for may not be fully recognised or addressed. Learning Disability Providers must ensure they work collaboratively with the person and other relevant parties to identify and address issues around caring roles.
- Social Care assessments were not reviewed on an annual basis.
- The Mental Capacity Act was not applied consistently around key hospital decisions.
- Key information about the past history of a person did not follow them through services. Staff do not routinely keep 'My History' information of a person who has moved through services.
- Throughout care records across a number of agencies, there is reference to the person having a Mild or Moderate Learning Disability or Difficulties. Documentation from the GP should show the correct diagnosis, and this should be followed throughout all notes

about the person.

- The ability of individuals to retain information when attending their GP appointments alone resulted in a recommendation for GPs to provide a copy of consultation printouts to individuals who attend appointments alone.

All completed LeDeR reviews are discussed through the MR. Where LeDeR reviews affect numerous organisations, a joint LeDeR review panel is held to share the learning across the range of organisations involved and to monitor any resulting actions required.

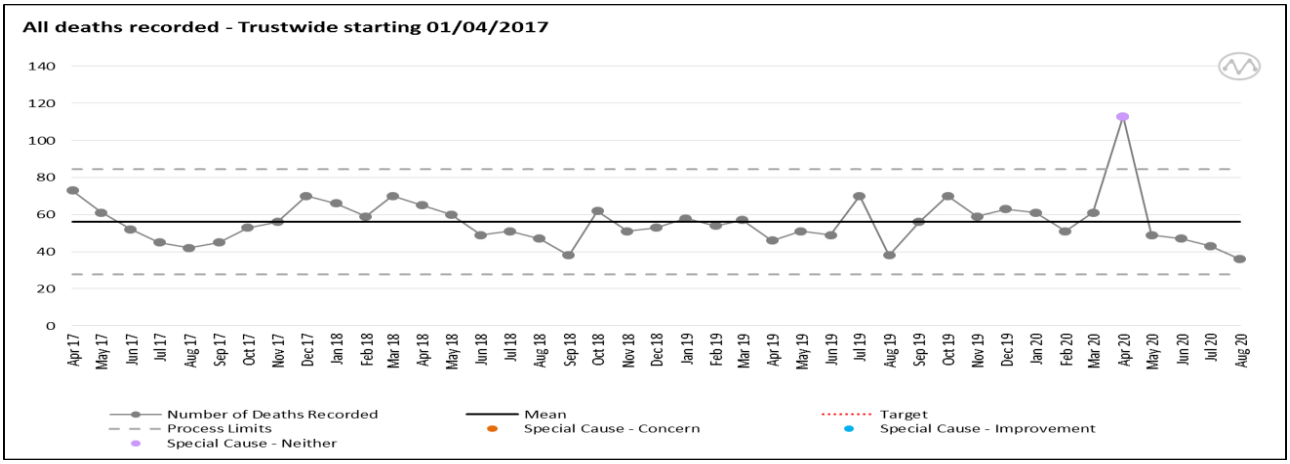
Due to the delay in receiving LeDeR reviews back from the LeDeR programme, the learning points that arise are for deaths often outside the current reporting period, therefore may not show as learning points on the mortality dashboard at Appendix 2.

Statistical Process Control Charts

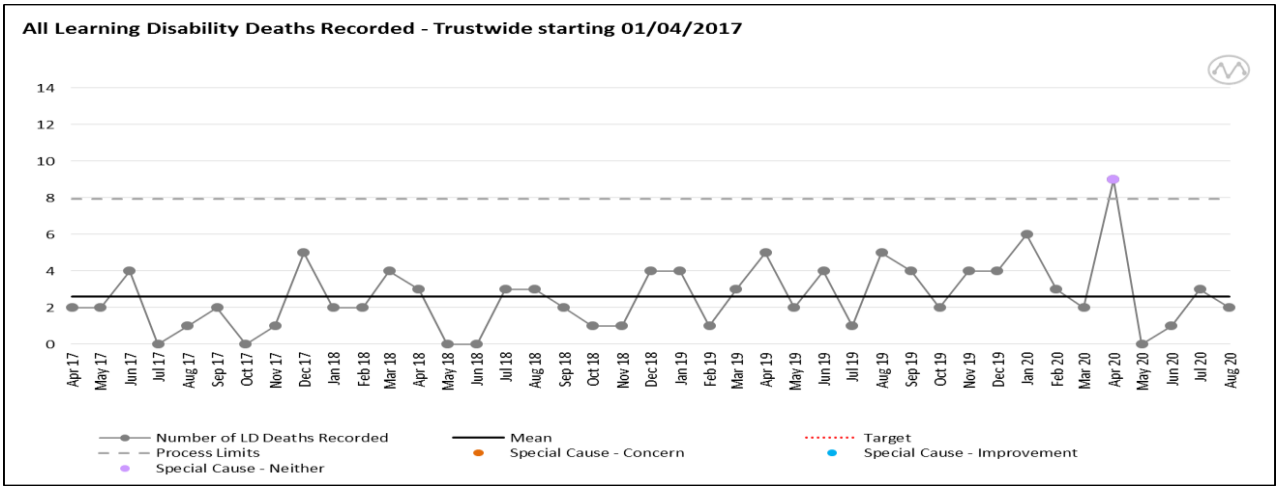
To complement the quarterly mortality figures, a number of statistical process control charts have been produced (see Appendix 1) in order to show whether normal variance or special cause variation is experienced in these areas.

Appendix 1

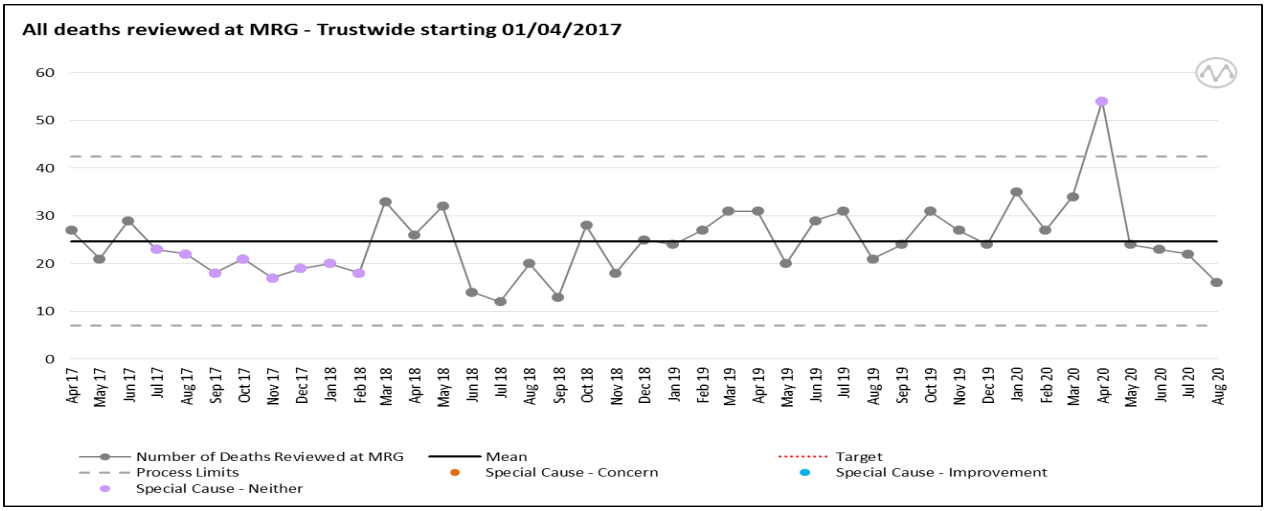
All deaths recorded via the national spine 1 April 2017 – 31 August 2020



All Learning Disability deaths 1 April 2017 – 31 August 2020



Deaths Reviewed at MRG 1 April 2017 – 31 August 2020



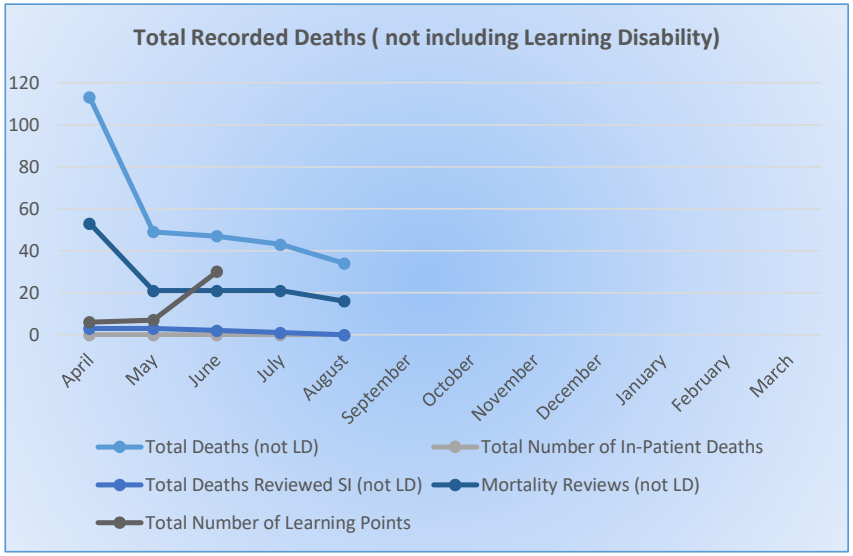
Appendix 2 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 1 and 2 (April 2020 - August 2020)

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
209	**0**	**8**	**95**	**43**
Q2	Q2	Q2	Q2	Q2
77	**0**	**1**	**37**	**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
286	**0**	**9**	**132**	**43**



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
10	**0**	**10**	**10**	**2**
Q2	Q2	Q2	Q2	Q2
5	**5**	**5**	**5**	**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
15	**5**	**15**	**15**	**2**