Sheffield Health and Social Care NHS Foundation Trust

Board of Directors - Public

Date:	26 May 2021	Item Ref:	10a

TITLE OF PAPER	**Mortality – Quarterly Review Q4 2020/21**
TO BE PRESENTED BY	Dr Mike Hunter, Medical Director
ACTION REQUIRED	The Board of Directors is asked to: • Receive this report and note the assurance it provides

OUTCOME	To reduce preventable mortality within the Trust and learn lessons from reviewing care provision in SHSC.
TIMETABLE FOR DECISION	To be discussed at May 2021 Board of Directors meeting.
LINKS TO OTHER KEY REPORTS / DECISIONS	Monthly Integrated Performance and Quality Reports LeDeR Annual Reports
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	Strategic Aims: Deliver outstanding care Create a great place to work Strategic Priorities: Getting back to good Covid – getting through safely 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 reduced confidence, 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	May 2021

Proud to care in Sheffield

Sheffield Health and Social Care NHS Foundation Trust

Mortality – Quarterly Review Q4 2020/21

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
	X			X		

2. Summary

The content of this report was presented to the Quality Assurance Committee in May 2021 and provides assurance to the Board of Directors on the Trust's mortality processes and the learning from mortality that has been obtained via the Trust's Mortality Review Group (MRG) during quarter 4 (1 January 2021 – 31 March 2021).

In April 2021, the SHSC Mortality Review Group commenced work with the national Better Tomorrows programme, which is focussed on improving learning from deaths in organisations. We have identified key areas for development in the programme of work, including an integrated quality improvement approach to learning from deaths, improved communications and shared learning, and more effective Committee and Board reporting.

Within quarter 4 2020/21, the MRG reviewed deaths to establish:

- cause of death
- who certified the death
- whether family/carers or staff had any concerns in connection with the death
- the setting the person was in in at the time of death, e.g., inpatient, residential or home
- whether the person had a diagnosis of psychosis or eating disorder during their last episode of care

The table below shows the breakdown of source of deaths information during the quarter.

Reporting Period	Source	Number
Quarter 4 2020/21	NHS Spine (national death reporting processes)*	20
	Incident report	116
	Learning Disability Reviews (LeDeR)	4
	Structured Judgement Reviews	4
	Total	**144**

*A weighted two-month sample from the national system to check consistency with local reporting

The overarching learning themes from deaths in the quarter included the importance of communication and coordination between teams and organisations, and the development of systematic clinical approaches to engaging complex service users in physical health promotion.

The remaining information and appendix provide a more detailed overview as presented to the Quality Assurance Committee in May 2021.

Analysis of Death Incidents Reported

Deaths reported as incidents during quarter 4, are classified as below:

Death Classification	No. of Deaths
Expected Death (Information Only)	27
Expected Death (Reportable to HM Coroner)	2
Suspected Suicide – Community	9
Unexpected Death - SHSC Community	37
Unexpected Death - SHSC Inpatient/Residential	1
Unexpected Death (Suspected Natural Causes)	40
TOTAL	**116**

Out of the 116 deaths that were incident reported (1st January 2021 – 31 March 2021), 72 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 15 of the 'natural cause' deaths were officially classified as Covid-19 deaths. 44 are still awaiting further investigation/inquest through H M Coroner.

Learning Outcomes

Key learning themes from deaths in the quarter included the importance of communication and coordination between teams and organisations, and the development of systematic clinical approaches to engaging complex service users in physical health promotion.

Examples of learning identified through four Structured Judgement Reviews (SJRs) this quarter include a service user who died of a cardiac arrest whilst on the SPA waiting list, who had no contact from being put on the waiting list up to the point of death (circa 5 months). A review was also undertaken regarding the death of a person with multiple health conditions and limited medication compliance. In this case there was evidence of sustained attempts by the individual's team to engage with them in complex circumstances. Another review showed positive work by the Community Enhancing Recovery Team, working with a vulnerable person with sporadic use of street drugs. Finally, a review showed careful consideration of the risks and benefits of psychotropic medication in an elderly and frail individual.

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

A representative from the team(s) involved in care provision are present when SJRs are presented through the MRG. This enables learning to be taken directly back into the respective teams, through the representative present.

Examples of the natural cause deaths recorded during the quarter include frailty syndrome and old age, aspiration pneumonia, dementia (Alzheimer's type), pneumonia, decompensated alcohol related liver disease, cerebral palsy and motor neurone disease.

Where deaths were referred to H M Coroner, follow up has been/is being undertaken to establish any additional potential learning for the Trust from these cases.

It should be noted that this report considers deaths but not those not arising from serious incidents (except for capturing the statistical side within the figures). Learning outcomes following serious incident investigations are reported within the quarterly 'learning lessons' report, presented to the Quality Assurance Committee from May 2021 onwards. Thematic learning from deaths will also be fed into the 'learning lessons' report to support triangulation of intelligence and lessons learned.

Learning from LeDeR Deaths

Four LeDeR reviews were received through the MRG during the quarter. Learning from these reviews included:

1. Gaps in GPs completing annual health checks for people with learning disabilities living in the community.
2. Social care providers showed good use of the Mental Capacity Act to assist in accommodation changes.
3. Leaning disability is often mis-recorded as learning difficulty on death certification forms.
4. Medical appointments may be missed when service users are in residential settings.

One learning point arose from the four reviews that was specifically for SHSC to follow up. This was related to hospital passports and health action plans not being completed. This is being followed by the Community Learning Disability Team and reported into the LeDeR Multi-Agency Group.

Analysis of Spine Deaths

From the 20 cases reviewed from the spine (for people who died within 6 months of contact with SHSC services) during quarter 4 (2021/21) deaths were recorded as being due to cancers of various organs (e.g., breast, lung), renal failure, stroke during surgery, pneumonia, Covid-19 and frailty syndrome and old age. The ages of those who died and were reviewed within the quarter varied from 38 to 102 (with the majority being over 75). Cases reviewed from the spine are generally of people living in the community, either in their own homes or residential/supported living settings. Some deaths occur in general (acute) hospital settings with many of these individuals having been seen by the Trust's Liaison Psychiatry Service for advice/assessment.

Death Statistics

National Quality Board (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 Mortality Review for this purpose and contains information from the Trust's risk management system (Ulysses) as well as information from the Trust's patient administration system (Insight).

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 as and when processes are completed and learning is identified.

Better Tomorrows

In April 2021, the SHSC Mortality Review Group commenced work with the national Better Tomorrows programme, which is focussed on improving learning from deaths in organisations. We have identified key areas for development including an integrated quality improvement approach to learning from deaths, improved communications and shared learning, and more effective Committee and Board reporting.

3. Next Steps

- Work with the Better Tomorrows programme will continue in order to improve our learning outcomes and strengthen reporting;
- Annual mortality data will be reported in the Trust's Annual Quality Report 2020/21;
- Quarterly reporting to the Quality Assurance Committee and Board of Directors will continue;
- Thematic learning from deaths will be included within the organisational learning report from quarter 1 2021/22.

4. Required Actions

The Board of Directors is asked to receive this report and note the assurance it provides.

5. Monitoring Arrangements

Deaths are reported monthly within the Integrated Performance and Quality Report, which is presented to clinical directorates, the Clinical Quality and Safety Group, the Quality Assurance Committee and the Board of Directors.

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

Annual mortality reporting is incorporated into the Trust's annual Quality Report.

6. Contact Details

For further information, please contact: Tania Baxter, Head of Clinical Governance, Tel: 0114 226 3279, tania.baxter@shsc.nhs.uk

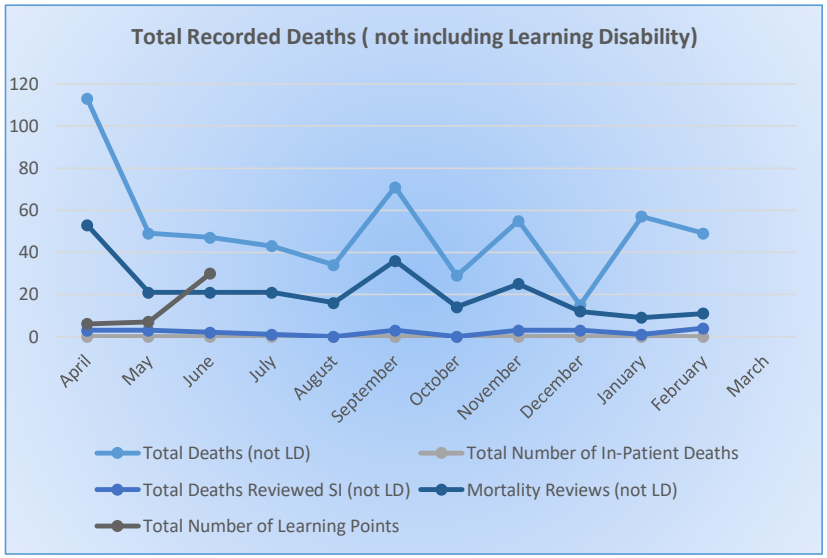
Appendix 2 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 1, Quarter 2, Quarter 3 and Quarter 4 (January - February 2021)

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
148	**0**	**4**	**73**	**0**
Q3	Q3	Q3	Q3	Q3
99	**0**	**6**	**51**	**0**
Q4	Q4	Q4	Q4	Q4
106	**0**	**5**	**20**	**0**
YTD	YTD	YTD	YTD	YTD
562	**0**	**23**	**239**	**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
11	**0**	**11**	**11**	**0**
Q3	Q3	Q3	Q3	Q3
8	**0**	**8**	**8**	**0**
Q4	Q4	Q4	Q4	Q4
3	**1**	**3**	**3**	**0**
YTD	YTD	YTD	YTD	YTD
32	**1**	**32**	**32**	**2**