Sheffield Health and Social Care NHS Foundation Trust

Board of Directors - Public

Date:	10 March 2021	Item Ref:	10a

TITLE OF PAPER	**Mortality – Quarterly Review Q3 2020/21**
TO BE PRESENTED BY	Dr Mike Hunter, Executive Medical Director
ACTION REQUIRED	The Board of Directors is asked to: • Receive this report

OUTCOME	To reduce preventable mortality within the Trust and learn lessons from reviewing care provision in SHSC.
TIMETABLE FOR DECISION	Discussed at February's Quality Assurance Committee meeting and March's Board of Directors meeting.
LINKS TO OTHER KEY REPORTS / DECISIONS	Incident Management Quarterly Reports Monthly Integrated Performance and Quality Reports LeDeR Annual Reports
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	Strategic Aim: Deliver Outstanding Care 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	February 2021

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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 Quality Assurance Committee/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, then into the Patient Safety and Experience Team, for onward dissemination and feedback to the teams involved in care provision.

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.

It should be noted that this report considers deaths, but not those not arising from serious incidents. Learning for the Trust following serious incident investigations is currently incorporated within quarterly incident management reports presented to the Quality Assurance Committee. The development of a 'learning report' for the Trust is currently underway. Consideration will be given as to whether the thematic learning is also fed into this report to support triangulation of intelligence and lessons learnt. The Mortality Quarterly Report is a statutory requirement for NHS Trusts.

Within quarter 3 2020/21, the Mortality Review Group reviewed 158 deaths. All deaths were reviewed 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, eg inpatient, residential or home
- whether the person had a diagnosis of psychosis or eating disorder during their last episode of care.

Only when the above details are known, will the death be 'adequately understood'. Where concerns have been raised regarding the death, or the patient had a diagnosis as above, this raises a 'flag' within the MRG and suggests that further review, by undertaking a structured judgement review, is required.

The table below shows the number and type of deaths reviewed by MRG during the quarter.

Reporting Period	Source	Number
Quarter 3 2020/21	NHS Spine (national death reporting processes)	18
	Incident report	99
	LeDeR	37
	Structured Judgement Reviews	4
	Total	**158**

Analysis of Death Incidents Reported

Deaths reported as incidents during quarter 3, are classified as below:

Death Classification	No. of Deaths
Expected Death (Information Only)	29
Expected Death (Reportable to HM Coroner)	1
Suspected Suicide - Community	6
Unexpected Death - SHSC Community	37
Unexpected Death - SHSC Inpatient/Residential	1
Unexpected Death (Suspected Natural Causes)	25
TOTAL	**99**

Out of the 99 deaths that were incident reported (1st October 2020 – 31 December 2020), 63 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 16 of the 'natural cause' deaths were officially classified as Covid-19 deaths. 36 are still awaiting further investigation/inquest through H M Coroner.

Examples of the natural cause deaths recorded as being due to Parkinson's Disease, severe stroke, Motor Neurone Disease, severe chest infection and anaemia, pneumonia, aspiration pneumonia and dementia.

Analysis of NHS Spine National System Deaths

From the 18 cases reviewed from the spine (for people who died within 6 months of contact with SHSC services) during quarter 3 (2021/21) deaths were recorded as being due to cancers of various organs (eg breast, lung), Broncho-pneumonia, sepsis (unknown origin), chronic kidney disease, diabetes mellitus and old age and frailty. The ages of those deaths reviewed within the quarter varied from 68 to 102 (with the majority being over 75). All the spine deaths were recorded as natural cause deaths. Where deaths were referred to H M Coroner, follow up has been/is being undertaken to ensure there is no additional learning from these cases. All 18 cases were people living in the community, either in their own homes or residential/supported living settings.

Analysis of Structured Judgement Reviews (SJRs)

Four structured judgement reviews were reviewed through the Service User Safety Group during quarter 3.

1. Death of a person from a cardiac arrest whilst in police custody. The person had been in substance and alcohol misuse services for a number of years, their frequent custodial sentences and street living made it difficult for services to engage. Many positive attempts were made to engage, involving our Single Point of Access and misuse services and staff teamed up with the probation service.

2. Death by suicide of a person at home. The GP asked for advice about medication. A response by a medic was provided to the GP, which advised against prescribing psychotropic medications, including mood stabilisers, as these were not recommended due to the diagnosis. Instead, recommendations were made for an educational programme to better understand their disorder/diagnosis. Although the request in and response provided were timely, thorough and appropriate, this occurred a relatively short time prior to the person's death.

3. Death of a person with Alzheimer's dementia, resident in a nursing home, following an assessment period, died in hospital from a cardiac arrest. Overall the care and treatment provided was deemed to be of a high standard and managed effectively. Cardiac monitoring had been instigated when issues were identified by the consultant and specialist input was provided. All correct and appropriate documentation was completed and in place. Good liaison with family throughout. Of particular note was the support given for the resident to continue family visits.

4. Death of a person, diagnosed with Alzheimer's dementia, residing in a nursing home, who died in hospital from sepsis/heart failure. The person had suffered several chest infections and had been prescribed antibiotics appropriately. Health records were very thorough with no elements of care observed to be lacking. The service was deemed to be responsive to family with good communication with external agencies. There was a rapid deterioration in their health, which resulted in hospital admission, where sadly the person died several days later.

A representative from the team(s) involved in care provision are now present when SJRs are presented through the MRG. This has proved invaluable and enables both positive and negative feedback to be taken directly back into the respective teams, through the representative. Following presentation at MRG, SJRs are taken through the Service User Safety Group and into clinical services to ensure learning and feedback is shared.

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.

Analysis of LeDeR Deaths

When a death of a person with a learning disability is determined to be 'adequately understood' following review at MRG, it then proceeds through a separate LeDeR review. Upon completion of these reviews, the findings are provided back to the provider reporting the death, or where the review suggests, a multi-agency panel is called to undertake the review. SHSC's MRG receives the LeDeR reviews undertaken on SHSC's service users.

37 LeDeR reviews were received through the MRG during the quarter, over four sessions. The volume reviewed was as a result of the national requirement to complete all outstanding LeDeR reviews for any deaths occurring pre-July 2020 by 31 December 2020. Out of the 37 reviews received, none had any direct learning for SHSC as a provider organisation.

The LeDeR report into deaths of people with a learning disability from Covid-19 was published in November 2020. This national report highlighted some good practice in the care of people with a learning disability, but it also highlighted concerns about the care that some people received. Issues such as detection of deterioration in the health of people in community and home settings, learning disability being recorded as the cause of death on death certificates, ill health being attributed to mental health or learning disability and reasonable adjustments were all identified as areas for improvement. The report also highlights the actions that have been undertaken nationally on the back of these findings. Click here to see the full report.

Local reviews of deaths of people with a learning disability from Covid-19 have also been undertaken during quarter 3 2020/21. These found that a number of cases highlighted routine hospital appointments, especially for such things as cancer screening, had not been effectively pursued and the Mental Capacity Act had not been used in cases where individuals had declined such offers of screening. These cases referred to people living in their own homes or within supported living accommodation. None of the learning was specifically associated with SHSC's care provision.

NHS Sheffield Clinical Commissioning Group (NHSSCCG) has also recently published their annual LeDeR report on the learning from deaths of those people with learning disabilities within Sheffield from November 2016 to 30 September 2020. The aim of this report is to bring information together to understand and to reflect on themes that can inform and improve practice across the health and social care community in Sheffield. Click here to see the full report.

Death Statistics

A number of statistical process charts (SPC) are provided at Appendix 1 that show the number of deaths recorded of SHSC patients (where contact occurred within 6 months of their death), the number of learning disability deaths recorded and the number of deaths reviewed at MRG since April 2017. These clearly indicate an increase in the number of deaths in April 2020. Whilst we do not know the individual causes of death for many of these cases, we do know that April 2020 was where our 'surge' of Covid-19 deaths were reported thus far in the pandemic (n25). It is therefore assumed that this is replicated across all SHSC patient deaths.

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 2 has been developed by the Northern Alliance for this purpose.

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.

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 SJRs and LeDeR reviews through the MRG. The learning from quarter 2 serious incidents will be added into this report prior to it being presented to the Board of Directors in March 2021.

3. Next Steps

- Additional feedback from LeDeR reviews will be incorporated into these reports as and when available;
- Following recommendation, this report will be presented to the Board of Directors in March 2021;
- 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 in the organisational learning report.

4. Required Actions

The Quality Assurance Committee is asked to:

- Receive this report
- Recommend it to the Board of Directors, in line with national requirements.

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 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.

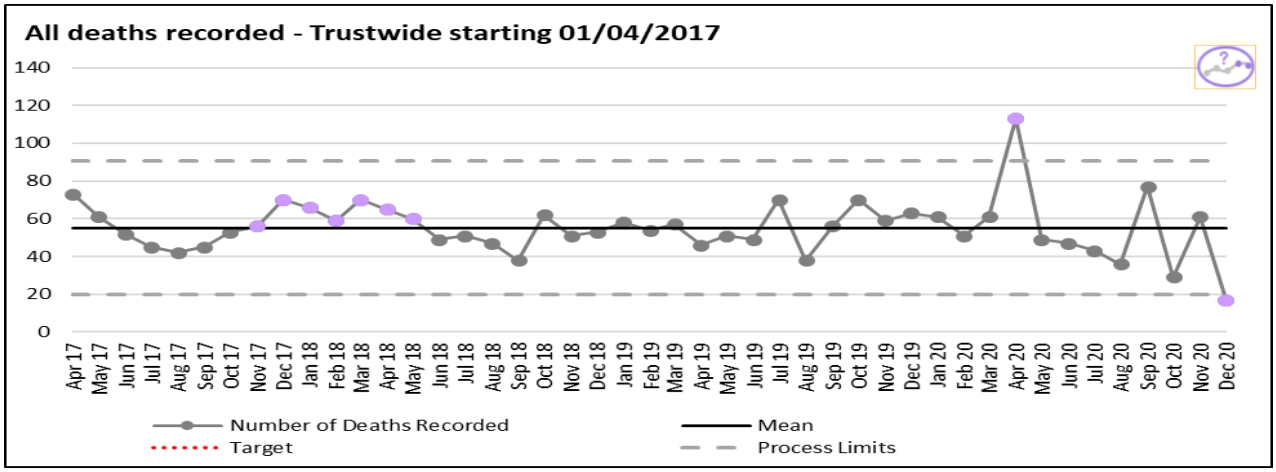
Annual mortality reporting is incorporated into the Trust's annual Quality Reports.

6. Contact Details

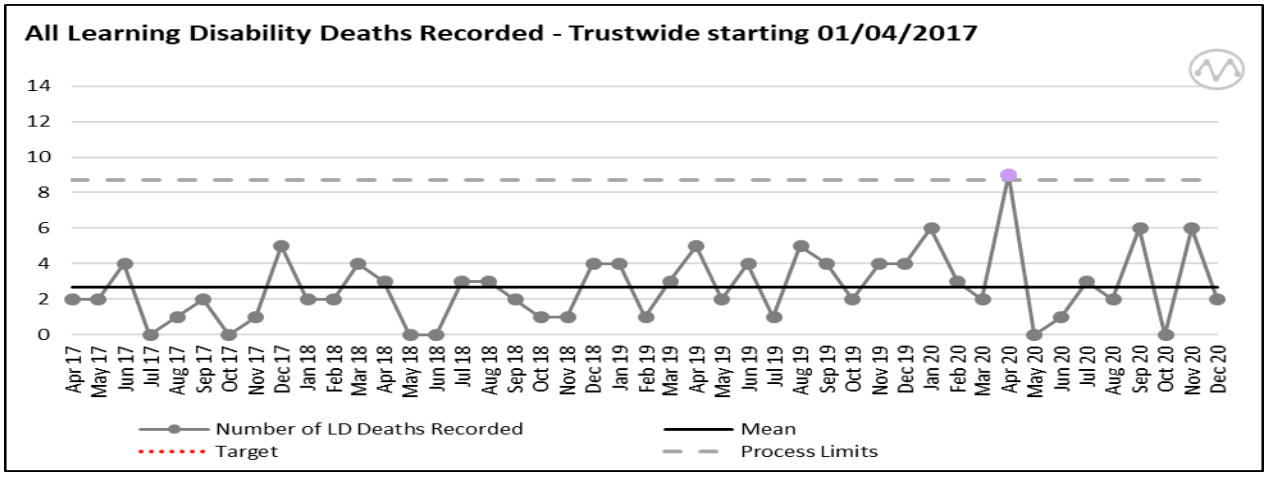
For further information, please contact: Tania Baxter, Head of Clinical Governance,
Tel: 0114 226 3279, tania.baxter@shsc.nhs.uk

Appendix 1

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



All Learning Disability deaths 1 April 2017 – 31 December 2020



Deaths Reviewed at MRG 1 April 2017 – 31 December 2020