# Board of Directors

| SUMMARY REPORT | Meeting Date: | 24 November 2021 |
|---|---|---|
| | Agenda Item: | 9a |

| | | |
|---|---|---|
| **Report Title:** | **Mortality – Quarterly Review Q 1 & 2 2021/22 (combined report)** | |
| **Author(s):** | Vin Lewin, Patient Safety Specialist | |
| **Accountable Director:** | Dr Mike Hunter, Executive Medical Director | |
| **Other meetings this paper has been presented to or previously agreed at:** | **Committee/Tier 2 Group/Tier 3 Group** | Quality Assurance Committee |
| | **Date:** | 10th November 2021 |
| **Key points/ recommendations from those meetings** | The Committee asked that further information regarding learning from Structured Judgement Reviews be incorporated into the report. | |

**Summary of key points in report**

The findings of the Care Quality Commission (CQC) report "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England", found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

This report has been combined to represent SHSC data for Q1 and Q2 of 2021/22.

This report looks at deaths of SHSC service users in line with national guidance in order to ensure that we learn from and understand the relevant information associated with these deaths.

The deaths highlighted in this report suggest that there is more to do to learn from service user deaths, to engage families and carers and to recognise their insights as a vital source of learning.

This report provides assurance that all deaths of service users are reviewed in line with national guidance and that steps are being taken to develop robust processes for capturing and utilising valuable learning through the Better Tomorrow project.

Within quarters 1 & 2, 2021/22, the Mortality Review Group reviewed a combined total of 290 deaths.

**Recommendation for the Board/Committee to consider:**

| Consider for Action | | Approval | | Assurance | X | Information | X |
|---|---|---|---|---|---|---|---|

The Board is asked to receive the information in the report and take assurance that the development of the Trust's Learning from Deaths process is being appropriately managed and that there are tangible plans in place that will lead to improvements in extracting learning in order to provide safe and effective patient care.

| **Please identify which strategic priorities will be impacted by this report:** | | | | |
|---|---|---|---|---|
| Covid-19 Recovering effectively | *Yes* | ***X*** | *No* | |
| CQC Getting Back to Good – Continuous improvement | *Yes* | ***X*** | *No* | |
| Transformation – Changing things that will make a difference | *Yes* | | *No* | ***X*** |
| Partnerships – Working together to make a bigger impact | *Yes* | | *No* | ***X*** |

| **Is this report relevant to compliance with any key standards ?** | | | | | **State specific standard** |
|---|---|---|---|---|---|
| **Care Quality Commission Fundamental Standards** | *Yes* | ***X*** | *No* | | Person Centred Care and Dignity and Respect |
| **Data Security and Protection Toolkit** | *Yes* | | *No* | ***X*** | This is not applicable to mortality processes |
| **Any other specific standard?** | *Yes* | ***X*** | | | National Guidance on Learning from Deaths (2017) |

| **Have these areas been considered ? YES/NO** | | | | | If Yes, what are the implications or the impact? If no, please explain why |
|---|---|---|---|---|---|
| Service User and Carer Safety and Experience | *Yes* | ***X*** | *No* | | Involving carers and families to ensure their rights and wishes are respected. |
| Financial (revenue &capital) | *Yes* | | *No* | ***X*** | There are no financial implications in the mortality process. The Better Tomorrow project is funded through the Back to Good improvement funding. |
| Organisational Development /Workforce | *Yes* | | *No* | ***X*** | No identifiable impact. |
| Equality, Diversity & Inclusion | *Yes* | ***X*** | *No* | | The mortality processes are inclusive of all ages, genders and cultural and ethnic backgrounds. |
| Legal | *Yes* | | *No* | ***X*** | No identifiable impact. |

**Name of Report: Mortality – Quarterly Review**

# Section 1: Analysis and supporting detail

### Background

1.1 The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people.

*1.2* Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities.

1.3 The findings of the Care Quality Commission (CQC) report "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England", found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

### National Quality Board (NQB)

The NQB guidance outlines that all providers should have a policy in place setting out how they respond to the deaths of patients who die under their management and care, including how we will:

- Determine which patients are considered to be under our care and included for case record review if they die (also stating which patients are specifically excluded)
- Report the death within our organisation and to other organisations who may have an interest (including the deceased person's GP)
- Respond to the death of an individual with a learning disability or mental health needs
- Review the care provided to patients who we do not consider to have been under our care at the time of death but where another organisation suggests we should review the care SHSC provided to the patient in the past
- Review the care provided to patients whose death may have been expected, for example those receiving end of life care
- Record the outcome of our decision whether or not to review or investigate the death, informed by the views of bereaved families and carers
- Engage meaningfully and compassionately with bereaved families and carers

### Better Tomorrow

1.4 Understanding mortality in mental health settings can be complex and extracting learning may mean that exploration of co-morbidities is necessary. The Trust has a robust mortality review system in place but recognises that this is often extremely process focused. A priority for the mortality review group has been to engage with the national Better Tomorrow project in order to develop better learning from deaths. The quarterly report outlining the learning from deaths within SHSC will be significantly improved as the project progresses.

# Section 2: Risks

2.0 The primary risk is that incomplete learning from deaths is associated with the provision of suboptimal care.

## Section 3: Assurance

### Benchmarking

3.1 Since the Covid-19 outbreak the benchmarking processes, available via the Northern Alliance for mortality review, have been unavailable. Benchmarking will be developed as a part of the Better Tomorrow project.

*3.2* Learning from Deaths will be subject to internal audit

*3.3* Professional advice has been provided by the Better Tomorrow project team

### Triangulation

3.4 The outcomes from the learning from deaths processes can be triangulated against the learning extracted from Serious Incident investigations into the deaths of service users.

### Engagement

3.5 The current process for reviewing deaths reported within SHSC includes contact with bereaved relatives and carers to express the Trust condolences and ask for feedback on the quality of the service provided to their family member.

*3.6* The Structured Judgement Review process requires that all completed reviews and the learning from those reviews is presented to the individual teams provided care to the deceased patient. Structured Judgement Reviews will be completed by clinical staff across the Trust.

## Section 4: Implications

### Strategic Priorities and Board Assurance Framework

4.1 Strategic Aims: Provide outstanding care; Create a great place to work:
Strategic Priorities: Covid-19 Recovering effectively; CQC Getting back to good

BAF.0024: There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care; caused by leadership changes, short staffing, cultural challenges, the lead in time for significant estates and ISMT actions and the impact of the global pandemic; resulting in risk of harm to people in our care and a breach in the Health and Social Care Act.

- 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

### Equalities, diversity and inclusion

4.2 The report has been reviewed for any impact on equality, in relation to groups protected by the Equality Act 2010.

### Culture and People

4.3 The implication for the workforce is positive as it empowers staff to take ownership of learning from deaths and deliver improved patient care, and links with the development of a safety led culture.

### Integration and system thinking

4.4 Mortality review and the development of the processes for learning from deaths is likely to lead to the development of standardized and systematic approaches that can be used in mental health services across systems.

### Financial

4.5 N/A

### Compliance - Legal/Regulatory

4.6 As previously described

## Section 5: List of Appendices

Appendix 1: Mortality Dashboard

# Summary Report

This report provides the Quality Assurance Committee / Board of Directors with an overview of SHSC's mortality and the learning from mortality discussed in the Mortality Review Group (MRG).

All deaths reported through SHSC's incident management system (Ulysses), together with a sample of deaths recorded through national death reporting processes, are reviewed at the weekly MRG.

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, e.g. inpatient, residential or home
- whether the person had a diagnosis of psychosis or eating disorder during their last episode of care
- whether the person was on a prescribed antipsychotic at the time of their death.

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

| **Reporting Period** | **Source** | **Number** |
|---|---|---|
| Quarters 1 & 2 2020/21 | NHS Spine (national death reporting processes) | 78 |
| | Incident report | 201 |
| | LeDeR | 11 |
| **Total** | | **290** |

**Analysis of Death Incidents Reported**

Deaths reported as incidents during quarters 1 & 2, are classified as below:

| **Death Classification** | **No. of Deaths Q1** | **No. of Deaths Q2** |
|---|---|---|
| Expected Death (Information Only) | 33 | 28 |
| Expected Death (Reportable to HM Coroner) | 3 | 0 |
| Suspected Suicide – Community | 10 | 5 |
| Unexpected Death - SHSC Community | 31 | 30 |
| Unexpected Death - SHSC Inpatient/Residential | 1 | 2 |
| Unexpected Death (Suspected Natural Causes) | 36 | 22 |
| **TOTAL** | **114** | **87** |

Out of the 201 deaths that were incident reported (1st April 2021 – 30 September 2021), 107 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 4 of the 'natural cause' deaths were officially classified as Covid-19 deaths. 18 are still awaiting further investigation/inquest through H M Coroner.

## Learning Outcomes

Note that learning outcomes following serious incident investigations (e.g., suspected suicide) are reported within the quarterly 'learning lessons' report presented to the Quality Assurance Committee.

Examples of the natural cause deaths recorded during quarters 1 & 2 are 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 ensure there is no additional learning for SHSC from these cases. In April of quarter 1, a formal coronial link was authorised by the senior coroner in order to facilitate more timely reviews by SHSC of deaths referred to the coroner's office.

## Learning from LeDeR Deaths

Eight LeDeR reviews were received through the MRG during quarters 1 & 2. Learning from these reviews show that there are gaps in the process for effective communication between supported accommodation and hospitals, care providers responded well to families when individuals had died of Covid-19, and learning disability continued to be mis-recorded as learning difficulty on death certification forms.

From quarter 1 2021/22 the LeDer review process became the primary responsibility of the Sheffield Clinical Commissioning Group. SHSC continues to report all Learning Disability deaths into the LeDeR process and work is underway to ensure that any identified learning from relevant LeDeR reviews is fed back into the Trust via the weekly mortality review meeting.

## Analysis of Spine Deaths

From the 78 cases reviewed from the spine (for people who died within 6 months of contact with SHSC services) during quarters 1 & 2 (2021/22) deaths were recorded as being due to cancers of various organs, multiple organ failure, pneumonia, dementia, frailty syndrome and old age. The ages of those deaths reviewed within the 2 quarters varied from 35 to 98 (with the majority being over 75). Cases reviewed from the spine are people living in the community, either in their own homes or residential/supported living settings. Some deaths occur in general (acute) hospital settings, many of these individuals are seen by the Trust's Liaison Psychiatry Service for advice/assessment. These are logged as SHSC deaths for the purposes of internal recording, even though there has been minimal input. During quarters 1 & 2, the reviewed spine data provided assurance that all of the incidents which required reporting via SHSC's internal system, Ulysses, were correctly reported.

## Death Statistics

National Quality Board (NQB) Guidance states that Trusts must report their mortality data to a public Board meeting. 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.

## Learning from Structured Judgement Reviews (SJRs)

Appendix 2 highlights thematic learning from eight SJRs undertaken in quarters 1 & 2. SJRs are clinically driven desktop reviews that are intended to identify areas of learning and good practice from the care and treatment provided to the patient before their death. The learning drawn from each SJR is shared with the team(s) involved with the patient at the time of their death, and the final approved SJR is uploaded on to the SHSC-wide learning hub.

**Better Tomorrow Project update**

As part of NHS England's/NHS Improvement's enhanced support package to SHSC, a project initialisation session with the Better Tomorrow programme lead was held on 29th April 2021. This followed a desktop review SHSC had undertaken. Subsequently, a number of further sessions have been held with the national team to develop SHSC's approach.

The aim is to work with Better Tomorrow, utilising our quality improvement methodology, to better understand our mortality and identify the learning opportunities this presents. This will enable us to improve and strengthen our quarterly reporting and focus on learning.

The mortality team is currently engaged in training clinical staff in the completion of SJRs, to broaden the pool of experts and to extract valuable learning from the deaths of service users. The SJR process will refresh in Q3 2021/22 using a mental health focused electronic review form that has been developed in collaboration with the Better Tomorrow project.

The Learning from Deaths policy will be fully reviewed and ratified for March 2022 and it is expected that this will better reflect the improved learning from deaths processes embedded in SHSC through Better Tomorrow.

# Appendix 1 - Learning from Deaths Dashboard
## Data Taken from SHSC's Risk Management System (Ulysses) and Patient Information System (Insight)
## Reporting Period - Quarter 1, Quarter 2, (April - September 2021)

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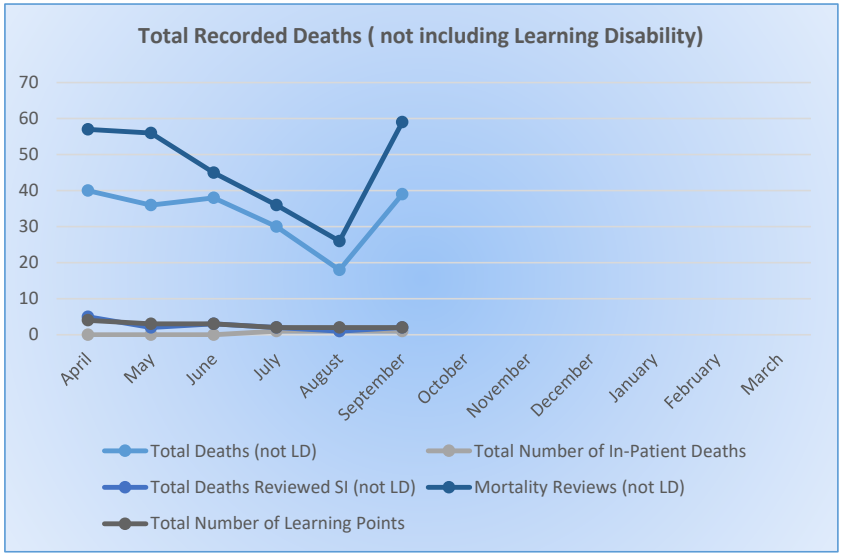
***Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review***

**Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)**

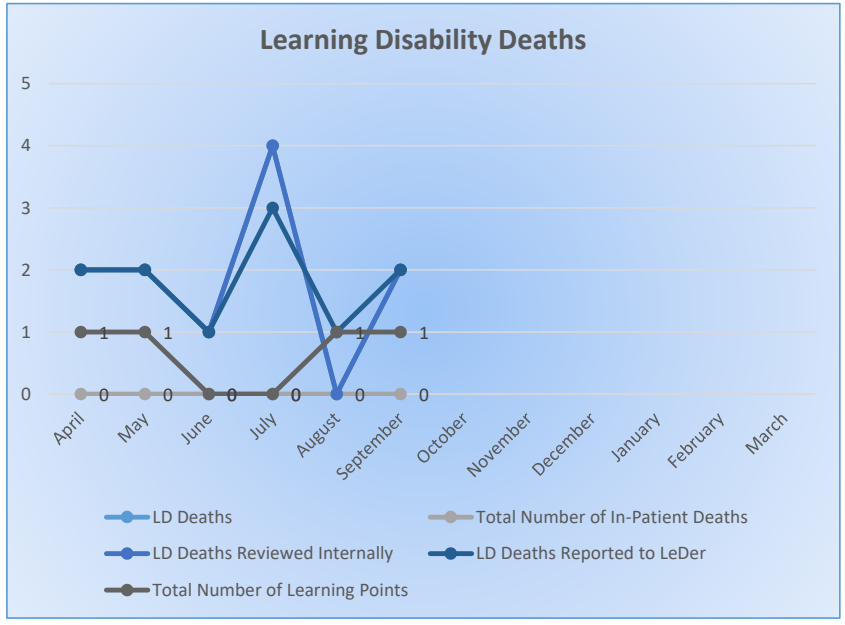
| Total Number of Deaths | Total Number of In-Patient Deaths | Total Number of Deaths Reviewed in Line with SI Framework | Total number of deaths subject to Mortality Review | Total number of actions resulting in change in practice |
|---|---|---|---|---|
| Q1 | Q1 | Q1 | Q1 | Q1 |
| **114** | **0** | **10** | **158** | **10** |
| Q2 | Q2 | Q2 | Q2 | Q2 |
| **87** | **3** | **5** | **121** | **6** |
| 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 |
| **201** | **3** | **15** | **279** | **16** |




***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 |
| **5** | **0** | **5** | **5** | **2** |
| Q2 | Q2 | Q2 | Q2 | Q2 |
| **6** | **0** | **6** | **6** | **2** |
| 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** |



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# Learning from Deaths
# KEY THEMES
# Q1 & Q2
# 1 April to 30 September 2021/22

A structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

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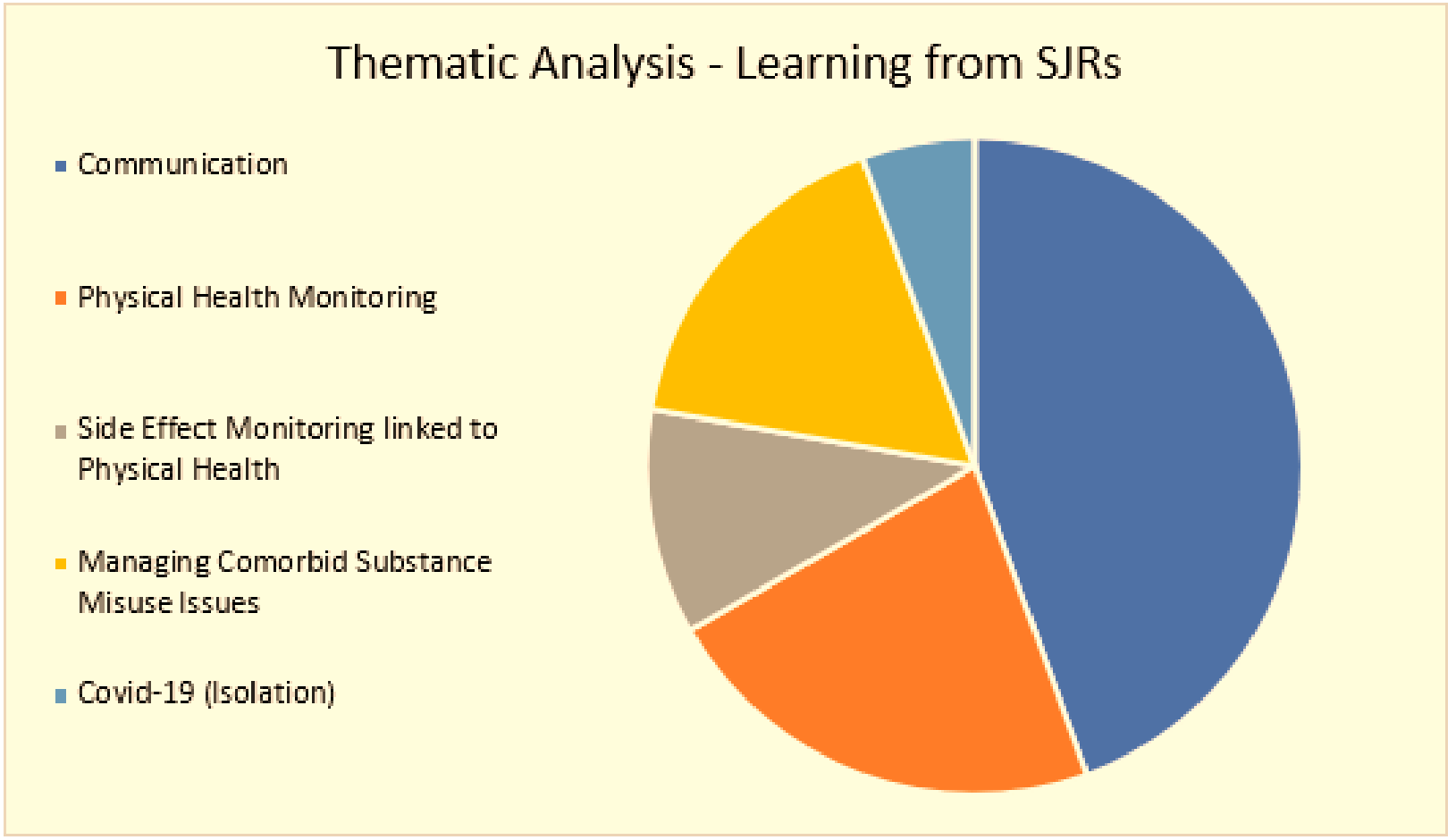
# Structured Judgement Reviews Combined Learning

Sheffield Health and Social Care NHS Foundation Trust

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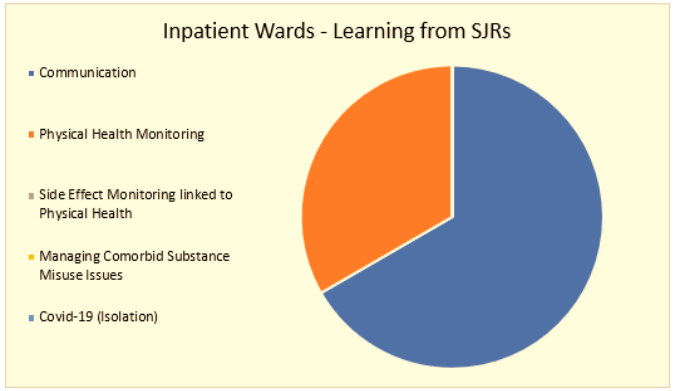
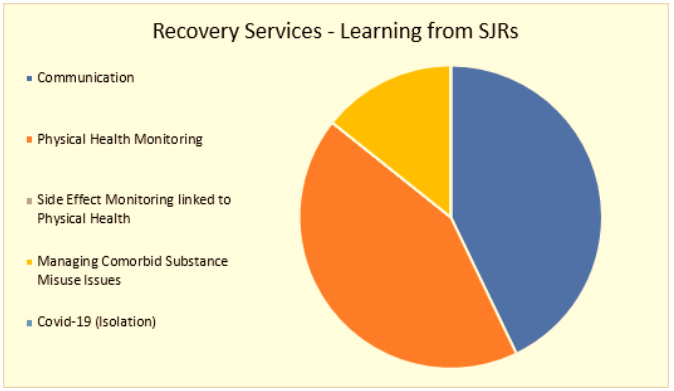
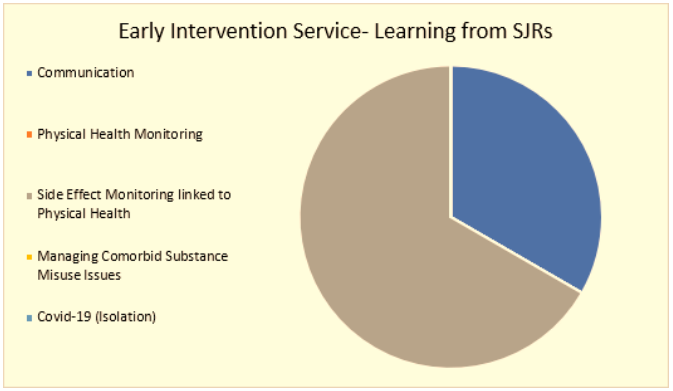
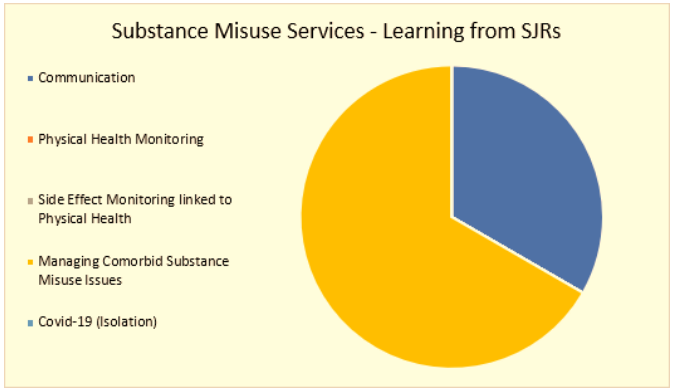
# Structured Judgement Reviews Combined Learning

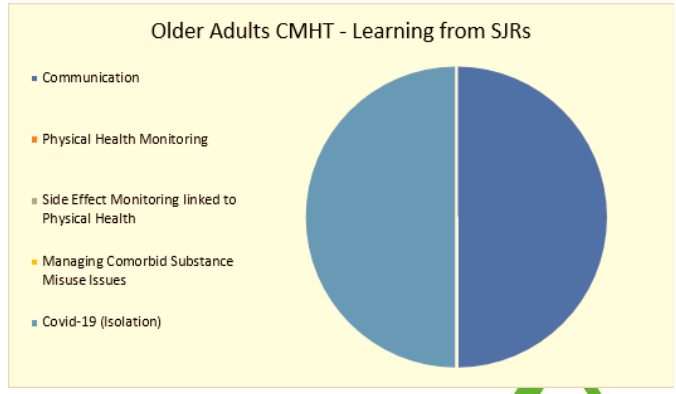
Sheffield Health and Social Care NHS Foundation Trust

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# Structured Judgement Reviews Q1&2: Learning

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- A number of service users whose care was reviewed using the structured judgement tool had long-term mental health issues (15yrs+) and were receiving long-term anti-psychotic medication.  However, side-effect monitoring was inconsistent.
- Monitoring of concurrent physical health issues was also inconsistent and would have benefited from a more structured approach.
- Communication with GPs in relation to concurrent physical and mental health issues showed room for improvement.
- Complex mental health issues and comorbid drug and alcohol misuse require more robust communication and collaborative work between internal services.
- The effect of alterations to practice in the pandemic left some service users feeling more isolated when face-to-face visits were reduced.
- Some service users experienced challenges in navigating contact with different teams. For example, two service users were being seen by different teams and it was difficult to identify a single point of care coordination.

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# Structured Judgement Reviews Q1&2: Good Practice

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- Service users requiring regular general hospital appointments were supported by their care coordinators to attend.
- Collaborative care plans and risk assessments were updated and reflected the care and treatment being provided.
- The Older Adult Community Team enabled a service user to live longer in the community with robust family support and frequent MDT monitoring.
- Medication guidance was provided to service users and their families.

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