Board of Directors (Public Meeting)

SUMMARY REPORT	Meeting Date:	25th May 2022
	Agenda Item:	13

Report Title:	**Mortality – Quarterly Review: Q4**	
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:	11/05/2022
Key points/ recommendations from those meetings	• There should be an annual mortality report provided separately in July 2022. • The rapid review of the deaths of those with an open episode of care with the Homeless Assessment and Support Team should be re-visited in order to extract more detailed learning in relation to specific demographics of the deceased. • A more precise date for the launch of the new mortality dashboard should be agreed with the Better Tomorrow project team.	

Summary of key points in report

- All the deaths reported internally during Q4 were reviewed in the weekly mortality review group. The mortality review group also sampled and reviewed the deaths of patients who had contact with services 6 months prior to death.
- All the deaths reported for people with a learning disability were reviewed and reported through the LeDeR process. Learning from the LeDeR reviews is being managed collaboratively with the CCG.
- A rapid review of the deaths of those with an open episode of care with the Homeless Assessment and Support Team was undertaken due to an identified increase in the number of deaths in this cohort for the 2021 period. Learning was extracted from this review and changes to practice were identified.
- Learning from the completion of Structured Judgement Reviews has been disseminated into teams.
- The Better Tomorrow project, which seeks to improve the learning from deaths process, is progressing but there is a further work required to agree the national dashboard metrics. The completion of the dashboard will be in Q3 2022/23.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval		Assurance	X	Information	X

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*	***X***	*No*	
CQC Getting Back to Good	*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. SHSC 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 regional 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 clinical 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 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 that provided care to the deceased patient. As the Better Tomorrow project advances, Structured Judgement Reviews will be completed by a growing pool of clinical staff across SHSC.

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 Board of Directors with an overview of SHSC's mortality review and the learning from mortality discussed in the Mortality Review Group (MRG).

An annual summary of mortality will be provided in July 2022.

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.

Within quarter 4 2020/21, the Mortality Review Group reviewed a combined total of 143 deaths.

Following an initial review all deaths are subject to in-depth follow up until the following criteria are satisfied:

- cause of death?
- who certified the death?
- whether family/carers or staff had any questions/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 4 2020/21	NHS Spine (national death reporting processes)	42
	Incident report	92
	Learning Disability Deaths*	9
Total		**143**

*All 9 Learning Disability deaths reviewed were reported to LeDeR.

Analysis of Death Incidents Reported

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

Death Classification	**No. of Deaths Q4**
Expected Death (Information Only)	29
Expected Death (Reportable to HM Coroner)	2
Suspected Suicide – Community	7
Unexpected Death - SHSC Community	24
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	28
Suspected Homicide – Substance Misuse	2
TOTAL	**92**

LD Death Classification	No. of Deaths Q4
Expected Death (Information Only)	2
Expected Death (Reportable to HM Coroner)	0
Suspected Suicide – Community	0
Unexpected Death - SHSC Community	5
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	2
Suspected Homicide – Substance Misuse	0
TOTAL	**9**

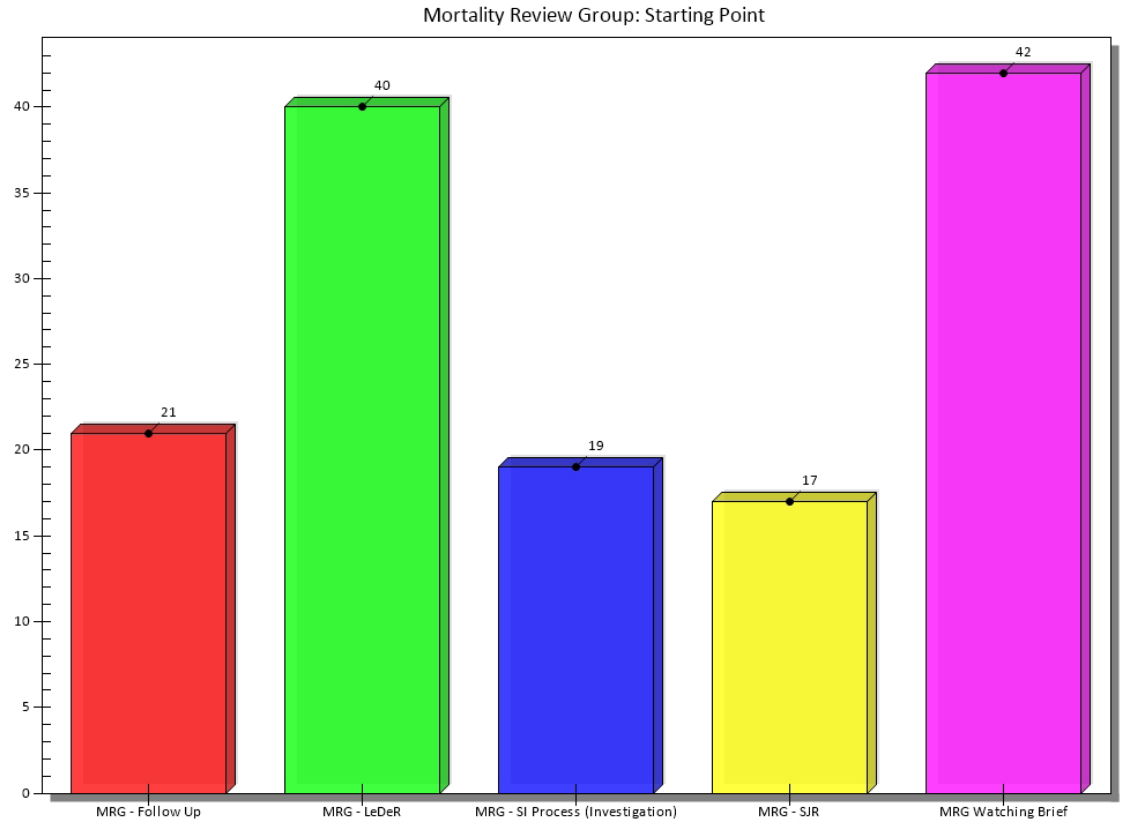
Out of the 101 (including of LD) deaths that were incident reported in Q4, 61 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 6 of the 'natural cause' deaths were officially classified as Covid-19 deaths. 14 are still awaiting further investigation/inquest through H M Coroner.

There were 7 suspected suicides in the community of which 3 are subject to serious incident investigation.

There were 2 suspected homicides during this period. In February we were made aware that a patient that had an open episode of care with START (Alcohol) was being held in connection with a suspected homicide outside of Sheffield. We are providing collaborative support to the local investigation team. In March we were made aware that a patient with START (Alcohol) had died as a result of suspected homicide. This incident is still under police investigation.

There are currently 139 deaths that are being processed through the internal mortality and serious incident systems, 40 that are being managed externally through the CCG LeDeR process and 42 that are subject to an external investigation such as coroner's inquest.

Overview of current number of mortality cases being processed as of: 31 March 2022



Overall Learning Outcomes and reflective learning from Homeless Assessment and Support Team (HAST)

It should be noted that this report considers deaths but not those 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 and presented to the Quality Assurance Committee. From the Q4 identified learning points that led to changes in practice or highlighted best practice there were 4 broad themes related to serious incident investigation learning including:

Theme 1: Team-focused examples included:

- The Older Adult Home Treatment Team OAHTT identified a gap in communication between GP, STH and SHSC. Action was taken to address this by the clinical leads for the services involved.
- Investigators found good evidence of excellent inter-agency working between the Recovery team, STH and SCC housing team.

Theme 2: Patient-focused examples included:

- Investigators identified some specific notable practice at Forest Close in their communication, collaborative support and emergency assistance for a patient that later died of natural causes at STH.
- Investigators highlighted further notable practice in the Recovery team related to the continued maintenance of dignity for a patient prior to their death.

Theme 3: Physical health-focused examples included:

- Lithium blood results communication pathways, procedures, risk communication and shared care agreements were reviewed to assess the current robustness of the system and identify if any failures in the system occurred in a specific case.

Examples of the natural cause deaths recorded during quarter 4 include:

- Older adult conditions: frailty of old age, respiratory issues, poor general physical health, cognitive impairment conditions: dementia (Alzheimer's type), vascular dementia and mixed dementia types
- Other physical health conditions: pneumonia, cancer, 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. SHSC has a formal coronial link, authorised by the senior coroner, to facilitate timely reviews of deaths referred to the coroner's office for inquest.

HAST reflective learning

The Homeless Assessment and Support Team (HAST) provides access to healthcare and support services for homeless people in Sheffield who have mental health problems.

There were 10 client deaths over a 13-month period between 2020 and 2021. This was a larger than would have been expected number of deaths for this service. Therefore, the service wanted to understand and explore whether there were any issues to be aware of or themes with regards to the deaths.

HAST were one of a few teams that continued to offer face to face contact with clients during the early COVID waves. The priority was rough sleepers, as many other services were closed or provided a limited service to this group. The effect was that clients didn't have access to the same level of support as prior to COVID. Contact was complicated as many usual meeting places were closed or restricted.

Contact with clients that may have been reluctant to engage prior to COVID was further complicated as this client group didn't typically have access to alternative communication equipment such as phones and laptops. This meant that, on the whole, platforms such as Attend Anywhere were not viable.

Summary of findings:

- **Care of clients** – This was viewed to be good overall
- **Complexity** – All clients had a high level of complexity of need and life experience, meaning that they often had multiple service contacts, or could be reluctant to engage or untrusting of services.
- **Risk** – Majority of clients were in high-risk category due to co-morbidity and vulnerabilities. Age range at time of death was not untypical of client group.

As reported by Office for National Statistics – *'Among homeless people, the mean age at death was 45.9 years for males and 43.4 years for females in 2019; in the general population of England and Wales, the mean age at death was 76.1 years for men and 80.9 years for women'.*

- **Multiple Service Involvement** – Some clients were involved with services outside of SHSC, so intervention not always acknowledged or recorded on Insight.
- **Other service involvement** – Some services discharged this client group due to non-engagement etc. This may then have affected HAST's involvement and level of need of the client.
- **Care Planning** – Unclear what documentation responsibility relates to HAST or other services. SHSC documents are completed by some of HAST team but not all; some were completed by other services. Collaborative Care Plans are sometimes difficult to decipher when completed by multiple services.
- **Notes** – Care record notes following worker action or contact not always recorded in a timely manner. Also, some notes were recorded after death of client.
- **Caseload** – Number of clients on case load at any one time can vary with each worker. Unclear how many is feasible at any one time, some staff have more than others.

- **Length of time in service –** There was sometimes a lack of clarity regarding the purpose of and potential end-point for involvement with the HAST service.

Further Action:

Following the presentation of an earlier version of this report at the Quality Assurance Committee, it has been agreed that further work will be undertaken to examine the individual details of the deceased individuals in order to better understand the wider learning resulting from these deaths.

Learning from LeDeR Deaths

LeDeR reviews are now managed via the Sheffield Clinical Commissioning Group (CCG) and any identified learning for SHSC is initially fed in via the weekly mortality review group before being actioned and reported on by the Community Learning Disability Lead.

During Q4 there were 3 actions identified for SHSC that were completed:

1. The Community Learning Disability Team are to ensure they follow the protocol in place to review and reallocate priority cases if the clinician is off with long-term sickness
2. Where an individual has multiple professionals involved, identification of who has a lead responsibility will be agreed (All agencies, including SHSC)
3. Consideration of the Mental Capacity Act will be highlighted clearly in the clinical records (All agencies, including SHSC)

Learning from Structured Judgement Reviews (SJR)

SJRs are intended to identify any areas of learning and good practice from the care and treatment provided to patients before their death.

The learning drawn from each SJR is shared with the teams involved with the patient at the time of their death and the final approved SJR is uploaded on to the Trust-wide learning hub.

During Q4, the learning themes extracted for the 3 completed SJRs included:

- Patients often have multiple points of contact with services. Where mental and physical health conditions are long-term and chronic it can lead to them experiencing difficulties in maintaining their health care contacts.
- There will often be a need for increased specialist mental health support when a patient receives a terminal diagnosis such as lung cancer.

The completed SJR's revealed several good practice points including:

- Excellent Insight notes and up to date records for the patient.
- Weekly mini team meetings were helpful in offering a quick summary of care for that week.
- The family of the deceased reported that they felt well supported by the community team and this felt like a positive link to their son after his death.

Analysis of National Spine-System Recorded Deaths

From the sample of 42 cases reviewed from the spine (to identify people who were not under our care at the time of their death but died within 6 months of contact with SHSC services) during quarter 4 (2021/22), deaths were recorded primarily as being due to multiple organ failure, dementia, frailty syndrome and old age.

The ages of those who died ranged from 30 to 96 (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 SHSC'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 quarter 4, 28 of the 42 spine deaths had already been reported internally via the SHSC incident reporting system. The reviewed spine data highlighted 4 deaths that should have been reported via SHSC's internal incident reporting system – these were subsequently correctly reported. At the end of Q4 all deaths of people who died while actively under our care were reported as incidents, in line with our policy.

Better Tomorrow Project Update

As part of NHSE/I's support package for SHSC, we are participating in a national project to improve learning from deaths, with external expert support. The aim is to work with Better Tomorrow, utilising our quality improvement approach, to better understand our mortality information and identify the learning opportunities this presents. This will enable us to improve and strengthen our quarterly reporting and focus on learning.

Update on the project plan:

- The Structured Judgement Review (SJR) is now available via the Ulysses system and training has been undertaken with various teams across SHSC. Further in house training will continue to be offered via the mortality team on an ongoing basis.

- The mortality team staff training is now completed. The team have attended several national training events led by the Better Tomorrow project.

- The learning extraction system and dashboard requires further work. It had been hoped that the dashboard element of this work would be available for this Q4 report, however, there is further work to do in developing the correct metrics for mental health deaths nationally. This work is being led by the national team and SHSC continue to work closely with them on its development, although the final completion date is outside of the control of SHSC. Once the dashboard is developed, there will be a need for this to be adapted onto the Ulysses system, so it is projected that this will be completed during Q3 2022/23.

- The policy on Learning from Deaths has been extended for 12 months as it will require further updates during this period including:

  - An updated section on reviewing death of people with a diagnosis of autism
  - An outline of the role of the community Medical Examiner (ME)
  - An updated section on how learning is extracted

Public Reporting of Death Statistics

National Quality Board (NQB) Guidance states that Trusts must report their mortality figures to a public Board meeting on a quarterly basis. The current dashboard attached at Appendix 1 was developed by the Northern Alliance for this purpose and contains information from SHSC's risk management system (Ulysses) as well as information from our patient administration system (Insight). It is anticipated that this dashboard will be replaced with the Better Tomorrow version by Q3 of this year.

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 All Deaths Within Mental Health And Learning Disability Services

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from ALL DEATHS. Working with eight other mental health trusts in the north of England we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur. We have decided not to initially report on what are described in general hospital services as "avoidable deaths" in inpatient services. This is because there has previously been no research base on this for mental health services an+A1d no consistent accepted basis for calculating this data. In November 2018 the Royal College of Psychiatrists developed a Care Review Tool which introduces the 'avoidable mortality' question. We are continuing to work with the other trusts in the North of England to test this approach and will review this dashboard accordingly, following this.

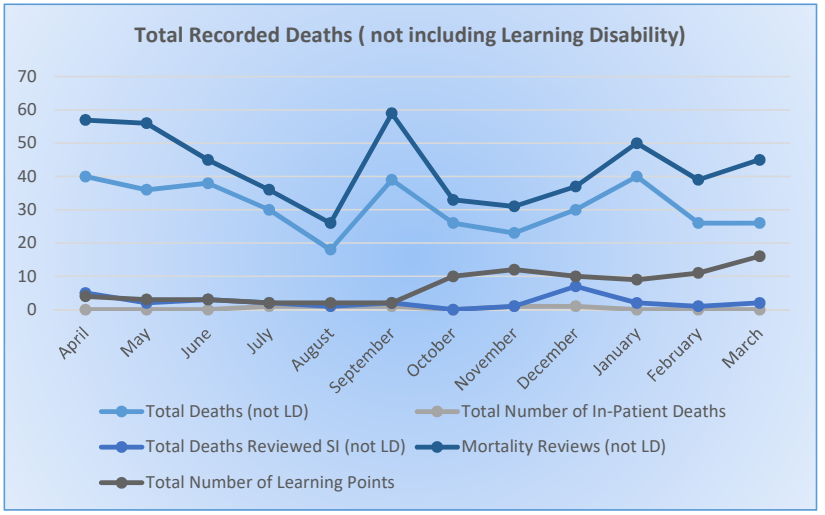
Appendix 1 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 4 (January to March 2022)

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 Incident Reported 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 (all incident reported + SPINE sample)	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
79	**2**	**8**	**101**	**32**
Q4	Q4	Q4	Q4	Q4
92	**0**	**5**	**134**	**36**
YTD	YTD	YTD	YTD	YTD
372	**5**	**28**	**514**	**84**



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
4	**0**	**4**	**4**	**4**
Q4	Q4	Q4	Q4	Q4
9	**0**	**9**	**9**	**3**
YTD	YTD	YTD	YTD	YTD
24	**0**	**24**	**24**	**11**