Board of Directors (Public Meeting)

SUMMARY REPORT	Meeting Date:	23rd November 2022
	Agenda Item:	15

Report Title:	**Mortality – Q1 & Q2 Report 2022/23**	
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:	13th July 2022 & 9th October 2022
Key points/ recommendations from those meetings	Learning from Mortality workshops highlight useful learning points. Consideration to be given as to whether learning from deaths should also be integrated within the broader lessons learned report provided to Quality Assurance Committee.	

Summary of key points in report

- SHSC has a family liaison role in relation to deaths and the family liaison officer contacts bereaved families to offer support and explore any issues related to care received prior to death. Specific family learning points in Q1 and Q2 include the importance of recording up-to-date family details on the patient record and ensuring externally facing family information (e.g., on the website) is accessible and helpful.
- Other learning included the importance of proactive waiting time management, specifically the importance of clear communication about expected waits and reviewing those waiting in a targeted manner.
- Substance misuse workshops were held to understand in more detail the impact of covid-19 in 2020 on mortality in those services. Key themes included the contribution of other physical health problems and increased alcohol consumption amongst opiate users.
- Work is underway to increase the number of Structured Judgement Reviews completed by SHSC.
- A new digital mortality dashboard has been developed with the national Better Tomorrows team and is being piloted.
- In terms of process, all the deaths reported internally during Q1 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 and/or diagnosis of autism were reviewed and reported through the LeDeR process. Learning from the LeDeR reviews is being managed collaboratively with the ICB.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval		Assurance	X	Information	

The Board is asked to receive the report and consider the learning and assurance contained within.

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.
Environmental Sustainability	*Yes*		*No*	***X***	No identifiable impact

Name of Report: Mortality Quarterly Report Q1

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 process focused. A priority for the mortality review group is to continue to engage with the national Better Tomorrow project in order to develop better learning from deaths.

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 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 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 Q1
Appendix 2: Mortality Dashboard Q2

Q1 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).

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 1 2022/23, the Mortality Review Group reviewed a combined total of 110 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
Quarter 1 2022/23	NHS Spine (national death reporting processes)	16
	Incident report	92
	Learning Disability Deaths*	2
Total		**110**

*Both Learning Disability deaths reviewed were reported to LeDeR.

Analysis of Death Incidents Reported

Deaths reported as incidents during quarter 1, are classified as below:

Death Classification	No. of Deaths Q1
Expected Death (Information Only)	26
Expected Death (Reportable to HM Coroner)	2
Suspected Suicide – Community	5*
Unexpected Death - SHSC Community	22
Unexpected Death - SHSC Inpatient/Residential	5
Unexpected Death (Suspected Natural Causes)	27
Suspected Homicide	5**
TOTAL	**92**

*1 suspected suicide occurred in Wainwright Crescent
** 1 suspected homicide was reported as a suspected domestic homicide

LD Death Classification	No. of Deaths Q1
Expected Death (Information Only)	1

Expected Death (Reportable to HM Coroner)	0
Suspected Suicide – Community	0
Unexpected Death - SHSC Community	0
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	1
Suspected Homicide – Substance Misuse	0
TOTAL	**2**

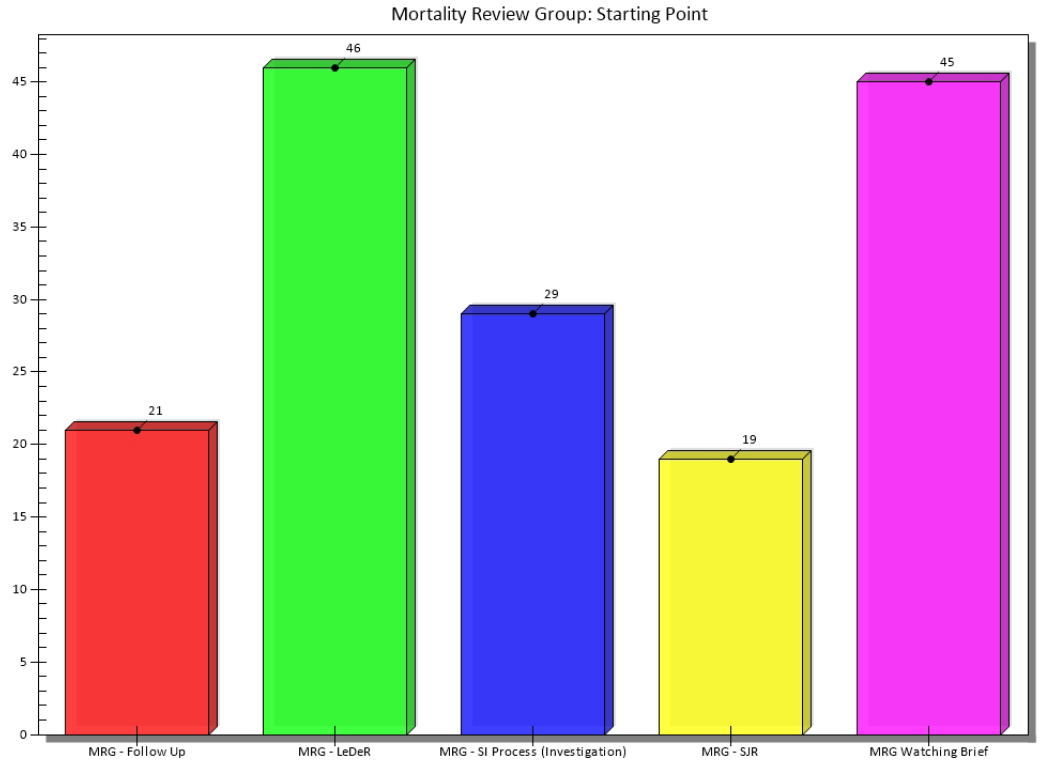
Out of the 110 (including of LD) deaths that were incident reported in Q1, 55 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 4 of the 'natural cause' community deaths were officially classified as Covid-19 deaths. 2 are still awaiting further investigation/inquest through H M Coroner.

There were 4 suspected suicides in the community and 1 suspected suicide at Wainwright Crescent. All 5 incidents are subject to serious incident investigation.

There were 5 suspected homicides during this period. 1 suspected homicide and 1 suspected domestic homicide are subject to Serious Incident investigation. However, these incidents are still under police investigation.

There are currently 160 deaths that are being processed through the internal mortality and serious incident systems, 46 that are being managed externally through the CCG LeDeR process and 45 that are subject to an external investigation such as coroner's inquest.

Overview of current number of mortality cases being processed as of: 30 June 2022



Overall Learning Outcomes

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 monthly 'learning lessons' bulletin and presented to the Quality Assurance Committee. From the Q1 identified learning points that led to changes in practice or highlighted best practice there were 3 broad themes related to serious incident investigation learning including:

Theme 1: Family focused examples included:

- SHSC took action to review information available on the external website to ensure it is clear where to go for support in an emergency situation.

Theme 2: Patient focused examples included:

- Teams took action to ensure services are transparent with service users and carers in relation to communicating the length of waiting times for services they have been referred to. Set standards are to be coproduced and agreed with service users/representatives which set out what is communicated and how, for service users on waiting lists.
- All SPA/EWS waiting lists were moved onto the electronic care record (Insight), to enable regular reporting and a standard approach to monitoring.
- A process was established to ensure contact is made with all service users remaining on waiting list for SPA every 3-4 months and advice on `waiting well` is reissued.

Theme 3: Physical health focused examples included:

- It was identified that multiple physical and psychological co-morbidities can impact on the ability of service users to make sustained changes to their mental well-being, behaviours and rituals despite multiple interventions including specialist in-patient admissions.

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

- Older adult conditions: frailty of old age, respiratory issues, poor physical health, cognitive impairment conditions: dementia (Alzheimer's type), vascular dementia and mixed dementia types

- Physical health conditions: pneumonia, cancer, decompensated alcohol related liver disease, cerebral palsy and motor neurone disease

Where deaths were referred to HM 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, in order to facilitate timely reviews of deaths referred to the coroner's office for inquest.

START Opiates workshops

Detailed Learning from deaths in 2022/23 Q1 Workshops

Substance Misuse

National and local reports of increased mortality in substance misuse service users in 2021 prompted a review of substance misuse mortality data related to deaths of patients cared for by SHSC.

In fact, the data told us that 2021 was relatively stable but that there was an excess number of deaths specifically within our opiate services in 2020. As a result of this, the mortality team worked collaboratively with the Substance Misuse Service during 2021/22 to develop specific all service workshops in order to share and understand the learning from the 20 excess deaths in 2020. There is a final workshop event scheduled for Q2. So far, the learning extracted indicate that:

- There was only 1 covid-19 death in the whole cohort
- There was very little noted in relation to covid-19 in any of the 20 records reviewed. In some cases (5), a change to non-face to face approaches was noted in the records. In 1 case a decision was made to continue with face to face due to individual vulnerability
- The majority of cases were primarily male (18) with an average age of 39
- Comorbid mental health issues featured in 18 of the cases
- Physical health issues played a part in all 20 cases: including hepatitis, respiratory disease, diabetes, weight related issues and liver cirrhosis
- Social deprivation was highlighted in 17 of the 20 cases including poor housing and access to a mobile telephone to maintain contact with others
- Early life trauma and was a feature in almost all case (17), with reference to past abuse both physical and mental
- In 3 cases the client told the key worker that their drinking had increased due to social isolation in particular isolation from family members

Learning from LeDeR Deaths

LeDeR reviews are now managed via the ICB at Sheffield Place 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 Q1 there were no actions identified for SHSC from the 3 LeDeR reviews that were completed by the ICB. All 3 LeDeR reviews were shared with the Learning Disability team in order to promote wider learning.

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 Q1 the learning themes extracted for the 3 completed SJRs included:

- There are excellent examples of the collaborative care planning with service users and their family in regard to their end of life wishes in the older adult care homes
- Fear of contracting covid-19 can have a negative impact on individuals agreeing to hospital admission for physical health care
- There can be difficulty in engagement due to patient being in full employment
- During one episode explored there was a change in care coordinator (CC) and this was managed effectively - contact and introductions were made and there seemed to be a smooth transition from one CC to another. The recovery worker was introduced in an appropriate way and they very quickly engaged with the patient to offer in roads into community support
- There were some initial teething issues with an individual patient's support from services related to the fact that he was new to Sheffield. However, this was resolved and services were engaging well at the time of death from natural causes.

Analysis of National Spine-System Recorded Deaths

From the sample of 16 cases reviewed from the spine (for 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 1 (2022/23), 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.

At the end of Q1 all deaths of people who died while actively under our care were reported as incidents, in line with our policy.

Better Tomorrow Project

SHSC continues to strive to learn from the deaths in our community. During Q2 2022/23 the new mental health dashboard will be launched and this will enable us to broaden our understanding of the way we can contribute to reducing early mortality, particularly for our most vulnerable, marginalised patients.

The process for extracting learning from the electronic SJR+ process is a key focus for ongoing development during 2022/23 in partnership with the National Better Tomorrow team.

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 the SHSC's risk management system (Ulysses) as well as information from our patient administration system (Insight). The dashboard will be replaced with the Better Tomorrow version during Q2 2022/23.

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.

Q2 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) during quarter 2 2022/23.

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

Within quarter 2 2022/23, the Mortality Review Group reviewed a combined total of 139 deaths individually.

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
Quarter 2 2022/23	NHS Spine (national death reporting processes)	19
	Incident report	117
	Learning Disability Deaths*	3*
Total		**139**

* All 3 Learning Disability deaths reviewed were reported to LeDeR.

Analysis of Death Incidents Reported

Deaths reported as incidents during quarter 2, are classified as below:

Death Classification	No. of Deaths Q2
Expected Death (Information Only)	30
Expected Death (Reportable to HM Coroner)	2
Suspected Suicide – Community	12
Unexpected Death - SHSC Community	27
Unexpected Death - SHSC Inpatient/Residential	1*
Unexpected Death (Suspected Natural Causes)	44
Suspected Homicide	1
TOTAL	**117**

*1 Death of a patient in an out of city placement

LD Death Classification	No. of Deaths Q2
Expected Death (Information Only)	2

Expected Death (Reportable to HM Coroner)	0
Suspected Suicide – Community	0
Unexpected Death - SHSC Community	1
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	0
Suspected Homicide – Substance Misuse	0
TOTAL	**3**

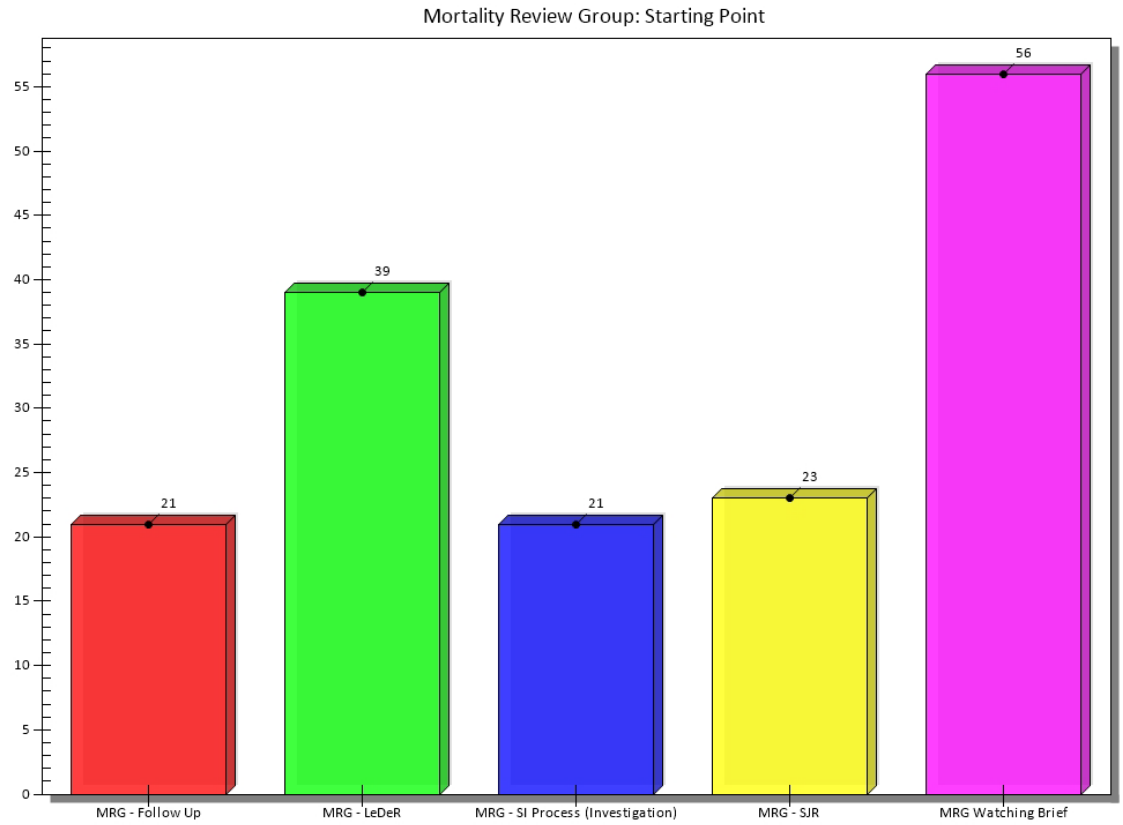
Out of the 139 (including of LD) deaths that were incident reported in Q2, 74 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 1 death of a patient being treated in STH was officially classified as a Covid-19 death. 2 are still awaiting further investigation/inquest through H M Coroner.

There were 12 suspected suicides in the community. All 12 incidents were subject 48hr reporting and 5 incidents went on to further serious incident investigation.

There was 1 suspected homicide during this period. This incident is currently being investigated under the serious incident processes.

As can be seen in the table below there are currently 67 deaths that are being processed through the internal mortality and serious incident systems, 39 that are being managed externally through the ICB LeDeR process and 56 that are subject to an external investigation such as coroner's inquest.

Overview of current number of mortality cases being processed as of: 30 September 2022



Overall Learning Outcomes

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 monthly 'learning lessons' bulletin and presented to the Quality Assurance Committee.

Family and significant others are contacted by SHSC in all cases where Serious Incident investigations are being undertaken. From quarter 4 of 2021/22 SHSC developed a family liaison role. This role is intended as a single point of contact primarily for those bereaved by suicide and offers short-term support and signposting to bereavement support.

Examples of this type of support provided include:

- A family member wanted an explanation of what the care records reported regarding her daughter's behaviour just prior to her death. This information was provided sensitively in a way that suited her.
- A family member wanted the process of investigation explaining before meeting with investigators to contribute to the terms of reference.
- A family member wanted an explanation of staff roles within the team that the patient was supported by.
- A family member wanted to understand how the undertaker would arrange to bring the body of their loved one back to Sheffield.

In deaths that were not been reviewed by either the medical examiner or the coroner, SHSC will contact family as a part of the standard mortality review to offer them the opportunity to ask questions or comment on the care and treatment provided to their loved one.

Examples of the type of comments and questions asked include:

- The family felt well supported by the older adult team and wanted to thank them for their support.

- The family felt it would benefit other families if there was a mobile telephone in the unit for them to be able to speak to their loved one on.
- The family member wanted to understand how the coronial process works.
- A family member wanted to talk about their dissatisfaction with the care their relative received in a non-SHSC nursing home.
- A family member wanted to pass on funeral arrangements in order for the team to attend the funeral for their loved one.

In Q2 identified learning points that led to changes in practice or highlighted best practice there were 3 broad themes related to serious incident investigation learning including:

Theme 1: Family focused examples included:

- A clinician visited the accommodation of patient as a cold call, having been unable to contact her by telephone. On arrival the clinician knocked on the door but got no answer. Outside of the front door she observed 2 bunches of flowers with a card which was visible suggesting that the service user had passed away. The investigation found that there were no Next Of Kin (NOK) details in demographics, and that these are key when trying to find pertinent information and offer support when someone has died. Improvements were required to the collaborative care planning process and communication between teams.

Theme 2: Patient focused examples included:

- In an incident involving the unexpected death of a community patient, it was established that the Dual Diagnosis policy had not been appropriately embedded in services. There is a cross directorate review of the Dual Diagnosis policy being undertaken. Full trust wide implementation is to be agreed once the review is completed.
- While OAHTT Service provision is focused on delivering the safest possible options, this does not always translate to a positive experience for our service users and all their individual needs.

Theme 3: Physical health focused examples included:

- A patient was taken by ambulance from Forest Close Ward 2 to A&E due to low O2 saturation and breathing difficulties. The patient was placed on a ventilator but did not respond to treatment and subsequently died following the medical decision to withdraw treatment. In respect of notable practice, it was noted by the investigation that throughout their involvement within services all practicable attempts were made to offer choice and collaboration in care. The patient had periods of deterioration in her mental/physical health stability, and it was clear that these were responded to in the least restrictive manner wherever possible. It was also clear that a comprehensive review of historical information was used to inform care options and treatment. The care and treatment provided was found to be of a good standard

Examples of the natural cause deaths recorded during quarter 2 include:

- Older adult conditions: frailty of old age, respiratory issues, poor physical health, cognitive impairment conditions: dementia (Alzheimer's type), vascular dementia and mixed dementia types
- Physical health conditions: pneumonia, cancer, decompensated alcohol related liver disease, cerebral palsy and motor neurone disease

Where deaths were referred to HM 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, in order to facilitate timely reviews of deaths referred to the coroner's office for inquest.

Learning from LeDeR Deaths

LeDeR reviews are now managed via the Integrated Commissioning Board (ICB) 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 Mortality Lead.

During Q2 there was 1 action identified for SHSC from the 8 LeDeR reviews that were completed by the ICB. All 8 LeDeR reviews were shared with the Learning Disability team in order to promote wider learning.

SHSC LeDeR action:

Issue: The Community Learning Disability Team were unaware of the patient's death even though he was on an active caseload. The patient passed away in November 2021 and CLDT were informed of his death in March 2022.

Learning and Action: There were missed opportunities for clinicians to follow up and assess the impact of interventions. CLDT Management team will review the meaning and management of 'active caseload' with the team as part of team development. Being unaware of the persons death is a gap in information sharing to be addressed in team governance.

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 Q2 no service-related contributory factors were identified in the cases reviewed. The learning themes extracted for the 2 completed SJRs included:

- An excellent best practice example of collaborative care planning with service users and their family in regard to the use of anti-psychotic medication
- Co-morbidities of alcohol abuse can also be prevalent in patients with a diagnosis of dementia and substance misuse assessment may be required in order to fully understand the impact on the individual
- There can be difficulty in understanding why specific clinical investigations such as ECGs and scans are not carried out when the documentation related to this is limited on the care record system
- Demographics details related to family need to be frequently reviewed and updated to ensure they are correct

Analysis of National Spine-System Recorded Deaths

From the sample of 19 cases reviewed from the spine (for 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 2 (2022/23), deaths were recorded primarily as being due to physical health issues, 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.

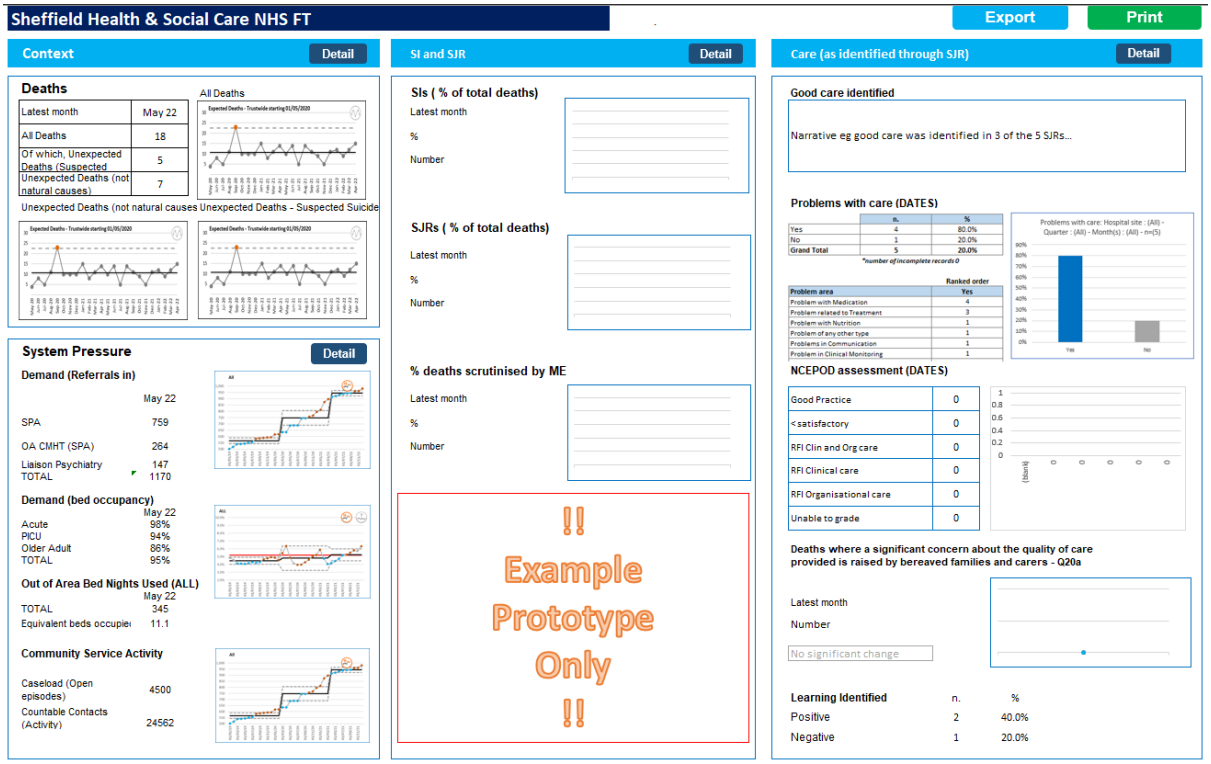
At the end of Q2 all deaths of people who died while actively under our care were reported as incidents, in line with our policy.

Better Tomorrow Project

During Q2 2022/23 the new mental health dashboard was finalised, and this will enable us to broaden our understanding of the way we can contribute to reducing early mortality, particularly for our most vulnerable, marginalised patients.

The new dashboard uses data which is relevant to mental health systems and will provide key indicators of SHSC's mortality profile.

<u>The new mental health dashboard</u>



The process for extracting data into the new dashboard is currently being tested and evaluated and will require technical support from the Ulysses team to enable full functionality.

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 2 was developed by the Northern Alliance for this purpose and contains information from the SHSC's risk management system (Ulysses) as well as information from our patient administration system (Insight). The dashboard will be replaced with the Better Tomorrow version during Q3 2022/23.

The learning points recorded in the dashboard are actions arising from serious incident investigations, SJRs, or LeDeR reviews, that 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.

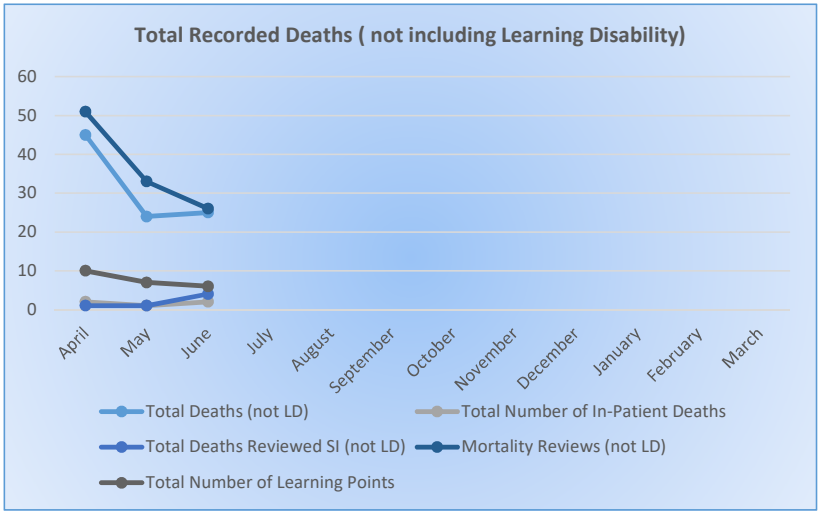
Appendix 1 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 1(April to June 2022)

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)

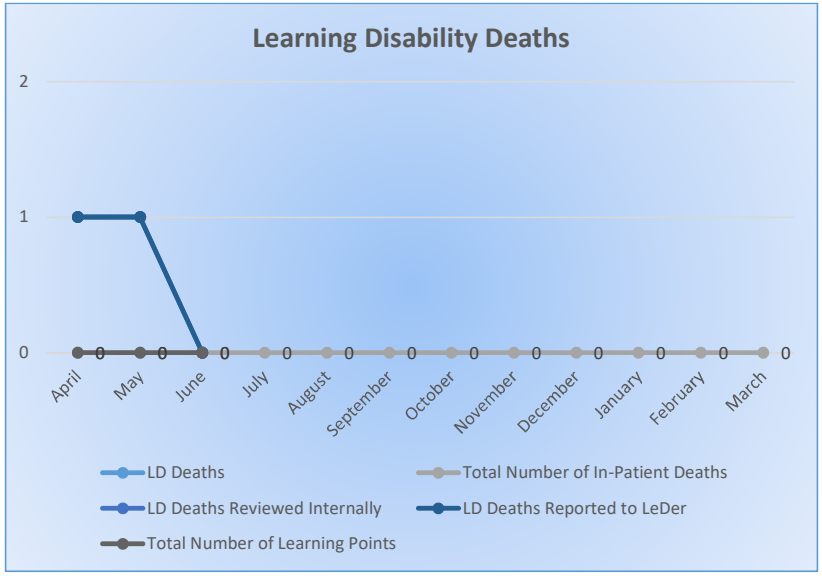
Total Number of Incident Reported Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework	Total number of deaths subject to Mortality Review (incident reported and a sample of SPINE deaths)	Total number of actions resulting in change in practice
Q1	Q1	Q1	Q1	Q1
94	**5**	**6**	**110**	**23**
Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**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
94	**5**	**6**	**110**	**23**



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
2	**0**	**2**	**2**	**0**
Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**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
2	**0**	**2**	**2**	**0**



Appendix 2

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.

	Total Deaths (not LD)	Total Number of In-Patient Deaths	Total Deaths Reviewed SI (not LD)	Mortality Reviews (not LD)	Total Number of Learning Points		LD Deaths	Total Number of In-Patient Deaths	LD Deaths Reviewed Internally	LD Deaths Reported to LeDer	Total Number of Learning Points
April	45	2	1	51	10	April	1	0	1	1	0
May	24	1	1	33	7	May	1	0	1	1	0
June	25	2	4	26	6	June	0	0	0	0	0
Q1	**94**	**5**	**6**	**110**	**23**	Q1	**2**	**0**	**2**	**2**	**0**
July	43	0	4	52	11	July	2	0	2	2	0
August	48	1	3	54	9	August	1	0	1	1	0
September	26	0	1	30	12	September	0	0	0	0	1
Q2	**117**	**1**	**8**	**136**	**32**	Q2	**3**	**0**	**3**	**3**	**1**
October						October		0			
November						November		0			
December						December		0			
Q3	**0**	**0**	**0**	**0**	**0**	Q3	**0**	**0**	**0**	**0**	**0**
January						January		0			
February						February		0			
March						March		0			
Q4	**0**	**0**	**0**	**0**	**0**	Q4	**0**	**0**	**0**	**0**	**0**
YTD	**211**	**6**	**14**	**246**	**55**	YTD	**5**	**0**	**5**	**5**	**1**

april	51	31	5
may	53	20	2
june	53	29	4
	157		
	91		
	58%		

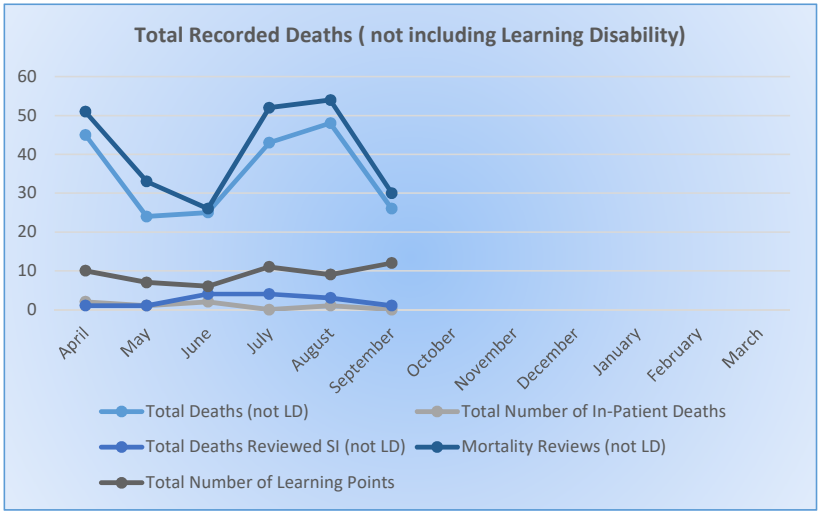
Appendix 1 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 2(July to September 2022)

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 (incident reported and a sample of SPINE deaths)	Total number of actions resulting in change in practice
Q1	Q1	Q1	Q1	Q1
94	**5**	**6**	**110**	**23**
Q2	Q2	Q2	Q2	Q2
117	**1**	**8**	**136**	**32**
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
211	**6**	**14**	**246**	**55**



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
2	**0**	**2**	**2**	**0**
Q2	Q2	Q2	Q2	Q2
3	**0**	**3**	**3**	**1**
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
5	**0**	**5**	**5**	**1**