Board of Directors (Public Meeting)

SUMMARY REPORT	Meeting Date:	22 March 2023
	Agenda Item:	14

Report Title:	**Q3 Mortality 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:	8 February 2023
Key points/ recommendations from those meetings	The committee suggested that the learning contained with the report be brought forward into the key points section.	

Summary of key points in report

Learning from mortality: Themes for quarter 3

- Most deaths reported into SHSC are of those people that die of natural causes related to older age and frailty.
- Administrative issues related to record keeping, risk assessment and waiting times featured as learning themes in Q3 and individual team actions were undertaken to make system improvements as a result.
- A good example of learning into action that will improve patient care is highlighted by Sheffield Adult Autism and Neurodevelopmental Service (SAANS) who changed their practice in order to ensure people on waiting lists were waiting well and being given appropriate signposting when additional help and support was needed.
- During Q3, seven LeDeR reviews were received from the ICB and whilst there was no direct learning identified for SHSC the reviews were shared with the Community Learning Disabilities Team (CLDT) for their awareness.
- Learning from Structured Judgement Reviews (SJRs) highlighted a range of good practice that included collaborative family support, communication with significant others including GPs, and emotional support for family members having to make difficult decisions.
- Learning from the 21 National Spine cases reviewed highlighted physical health issues related to old age, cognitive impairment and frailty were the key causes of death for those that had had contact with SHSC in the 6 months prior to their death.
- Information governance data, revealing deaths that remained open on Insight, has been fully reviewed by the mortality team to ensure the correct review process is followed.
- The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Safety Scorecard for 2017, 2018 and 2019 was received in November 2022 and has been reviewed against the deaths reported into SHSC during this period. The scorecard benchmarks SHSC as being amongst the Mental Health Trusts with higher suicide rates during this period. We are undertaking work to analyse more up-to-date data to understand interpretation and potential learning.
- The new mental health deaths dashboard will replace the current dashboard in Q1 2023/24

Mortality Standards Compliance

- SHSC is compliant with National Quality Board standards management of processes following the death of a person using our services.
- All the deaths reported internally during Q3 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 deaths reported for people with a learning disability and/or diagnosis of autism were reviewed via internal processes and also 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**	

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*	***X***	*No*	
Partnerships – Working together to make a bigger impact	*Yes*	***X***	*No*	

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.
Sustainability	***Yes***	***X***	***No***		The mortality review process has a low impact on resource usage and offers the opportunity to learn and improve in a sustainable way.

Name of Report: Mortality Quarterly Report Q3

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 during 2022/23

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; Reduce inequalities
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
- SYICB in Place at Sheffield 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

Sustainable development and climate change adaptation

4.6 Improving care by learning from deaths is likely to lead to the development of more person-centred and evidence-led care that by its nature is more sustainable.

Compliance - Legal/Regulatory

4.7 As previously described

Section 5: List of Appendices

Appendix 1: Mortality Dashboard

Summary Report

This report provides the Board with an overview of SHSC's mortality processes and any learning from mortality discussed in the Mortality Review Group (MRG) during quarter 3 2022/23.

100% of 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 3 2022/23, the Mortality Review Group reviewed a combined total of 155 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.

Table 1

Reporting Period	**Source**	**Number**
Quarter 2 2022/23	NHS Spine (national death reporting processes)	21
	Incident report	122
	Learning Disability Deaths*	12
Total		**155**

Analysis of Death Incidents Reported

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

Table 2

Death Classification	**No. of Deaths Q3**
Expected Death (Information Only)	21
Expected Death (Reportable to HM Coroner)	2
Suspected Suicide – Community	6
Unexpected Death - SHSC Community	46
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	46
Suspected Homicide	1
TOTAL	**122**

Table 3

LD Death Classification	**No. of Deaths Q3**
Expected Death (Information Only)	3

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)	4
Suspected Homicide – Substance Misuse	0
TOTAL	**12**

Out of the 134 (including of LD) deaths that were incident reported in Q3, 74 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 3 deaths of SHSC community patients were officially classified as a Covid-19 related. 2 unexpected deaths are still awaiting further investigation/inquest through H M Coroner.

There were 6 suspected suicides in the community. 5 incidents were subject to 48hr reporting and 2 incidents went on to further serious incident investigation.

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

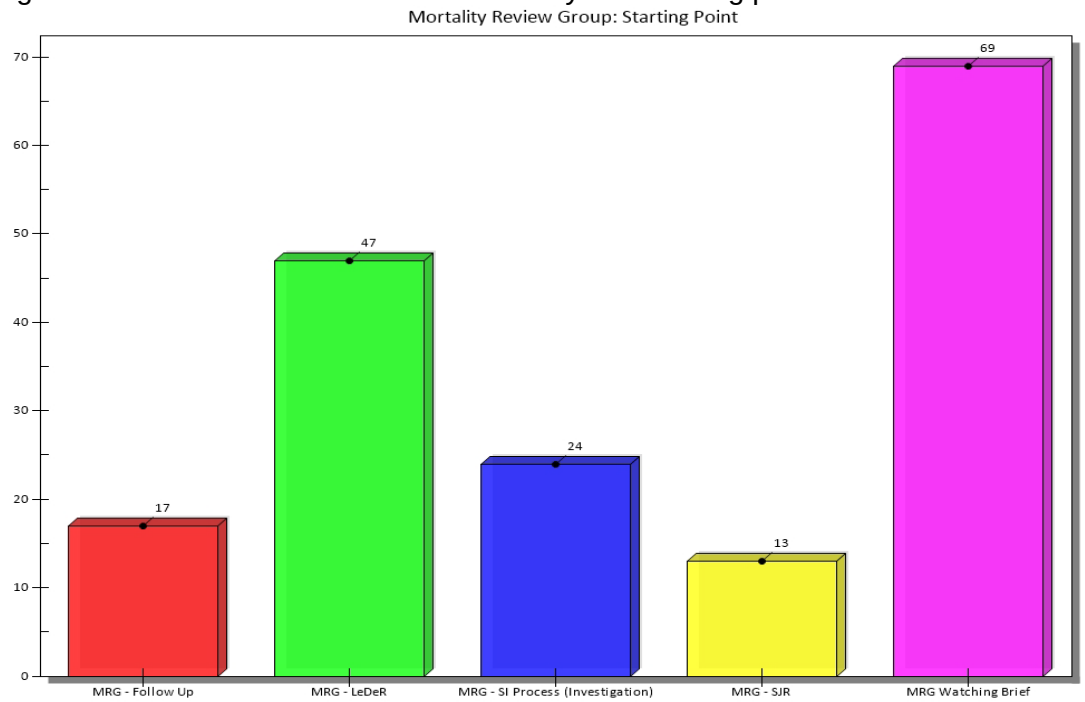
Examples of the natural cause deaths recorded during quarter 3 include:

- 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.

As can be seen in the table below there are currently 54 deaths that are being considered through the internal mortality and serious incident systems, 47 that are being managed externally through the ICB LeDeR process and 69 that are subject to an external investigation such as coroner's inquest.

Fig1: Overview of current number of mortality cases being processed as of: 22 Dec 2022



Current and Future Learning from Death 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). Detailed learning outcomes following serious incident investigations are reported within the monthly 'learning lessons' bulletin and presented to the Quality Assurance Committee in the quarterly learning report. Below is a brief summary of the identified learning taken from investigations completed in Q2 and potential learning identified in Q3.

Learning and notable practice from completed investigations:

In Q2 three learning themes emerged from the completed serious incident investigations into unexpected patient deaths including:

Theme 1: The patient was discharged and sent a discharge letter. However they were not formally discharged on the electronic records system and appeared to have an open episode at the time of their death. The action required as a result of this learning is being addressed by the team.

Theme 2: The patients risk assessment was not updated at any point during two periods of engagement with substance misuse services. The action required as a result of this learning is being addressed by the team.

Theme 3: At the time of the patient's referral for an ADHD assessment the waiting list letter that was provided did not stipulate how long they would wait. The action required as a result of this learning was recognised, and the service now advises on expected waiting times and offers 'waiting well signposting' for additional help and/or support.

Two areas of notable practice were highlighted including:

1. The team attempting to engage the patient demonstrated tenacity in their approach which consisted of telephone calls, letters and frequently rearranged appointments to meet the patient's needs.
2. The speed at which professionals contacted the patient following referrals was exceptionally quick and often on the same day.

Learning investigations being undertaken:

In Q3 the 2 incidents of community suicide identified for further investigation included:

Incident 1

Following a telephone call made to the patients relative, to ascertain patient safety, the relative informed SHSC that Service User had died. Confirmation was received subsequently via the coroner's office that Service User had been found dead at home.

The learning investigation that is underway will focus on the system for allocation of a care coordinator when the patient requests a different care coordinator and the communication and escalation of patient risk between relevant teams.

Incident 2

Service User 1 contacted the service to inform staff that a close relative, Service User 2, who was also under services had died from suicide the previous day.

The learning investigation that is underway will focus on the impact of experience on a waiting list and the type of care that was offered when the patient was identified as having suicidal thoughts.

In Q3 the incident of suspected domestic homicide was detailed as:

Police contacted Out of Hours (OOH) team requesting information re: whether a person was known to mental health services. Police were unable to share further details.

Long-Term Neurological Conditions Deaths (LTNC)

During Q3 it was recognised via the Daily Incident Safety Huddle that there appeared to be an increase in the number of deaths being reported by LTNC, particularly in December 2022. Initial comparison data revealed that in Q3 of 2021/22 LTNC reported 8 deaths, however, during Q3 of 2022/23 LTNC reported 18 deaths. The mortality team and the LTNC management team met during Q3 to plan further in-depth work to understand the causes of this potential increase and will hold a workshop with all LTNC staff in March 2023. The results of this work will be included in the Q4 mortality report.

Learning from LeDeR Deaths

LeDeR reviews are managed via the Integrated Care Board (ICB) and any identified learning for SHSC is initially reviewed via the weekly mortality review group before being actioned and reported on by the Community Learning Disability Mortality Lead. LeDeR referrals are also made for any patients with a formal diagnosis of autism, including in the absence of learning disability.

During Q3 there were no actions identified for SHSC from the 7 LeDeR reviews that were completed by the ICB. All 7 LeDeR reviews were shared with the SHSC 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 Q3 no system-related contributory factors were identified in the cases reviewed. The learning themes extracted for the 3 completed SJRs included:

- A best practice example of collaborative family support when the service user received a diagnosis of a terminal illness.
- An example of how physical health comorbidities can result in a need for complex case management. From the records it could be seen that the Recovery team were offering regular appointments both with the care co-ordinator and the medic. Appropriate onward referrals were made to Home Treatment, crisis house and for psychology sessions. There were also good links and communication with the GP in evidence.
- An example of good documentation of the emotional support provided to the patient's family when it was no longer possible for them to be cared for at home. It was deemed appropriate to look for more suitable accommodation as the patient's needs could no longer be met in the family home environment. The patient was discharged from NGH to a nursing home for a short period, but placement wasn't suitable. He was admitted back to hospital and then discharged to a nursing home, where he remained for 3 years until he died. He was visited regularly by his wife and his son.

Analysis of National Spine-System Recorded Deaths

From the sample of 21 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 3 (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 24 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.

Audit of Deaths Missing from Insight

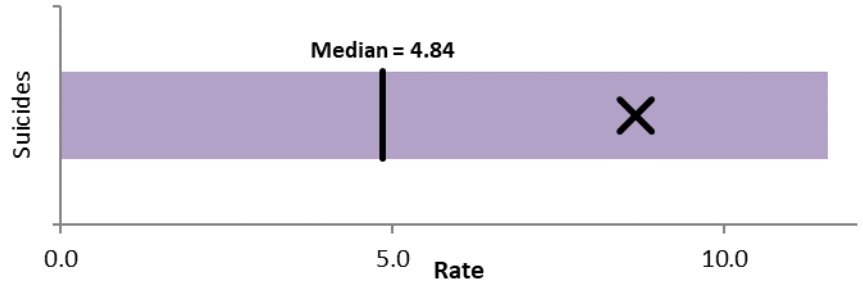
In November 2022, an administrative error in the IT pathway was discovered, which had led to the deaths of service users not being recorded on the Insight system, particularly in the latter half of 2022. The majority of these were cases where the individual had either no recorded activity with SHSC or no open episode of care at the time of their death and no activity in the six months prior to their death. However, an audit of all cases revealed a number that required incident reporting according to the SHSC Learning from Deaths Policy:

- 31 were open on the memory service active caseload. The team have been made aware of these deaths and they will be reported on to the Ulysses incident management system.
- 11 patients were in active care with other SHSC services. The teams have been made aware of these deaths and they will be reported on to the Ulysses incident management system.
- 1 death was notifiable to the LeDeR process, which has been actioned

National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH) Safety Scorecard 2017, 2018 and 2019

The NCISH Safety Scorecard was developed in response to a request from commissioners and the Healthcare Quality Improvement Partnership (HQIP), for benchmarking data to support quality improvement. The SHSC Safety Scorecard for the calendar years 2017-2019 was provided in November 2022.

Fig 2: show the range of suicided rates across trusts in England in addition to our own position that is represented by an 'X'.



Suicide rate

The suicide rate in your Trust was 8.65 (per 10,000 people under mental health care) from 2017-2019.

The NCISH report also provides additional benchmarking for suicide that shows that SHSC was amongst the 10 Mental Health Trusts with the higher suicide rates during this period. By way of context, the national 2019 suicide rate was the highest since 2000. Yorkshire and the Humber had the highest rate of the regions.

In SHSC services, there were 71 recorded deaths by suicide in the period 2017-2019. Using an estimate of the total number of people under SHSC's care during the period, our own data suggest a similar figure to the NCISH scorecard. A working hypothesis is that the SHSC rate is above the median because we were a provider of substance misuse services during the period concerned. As the NCISH data lags by some years, this gives SHSC the opportunity to calculate our own figures for 2020, 2021 and 2022, which will be incorporated in the Q4 report to give a better impression of the current picture and potential for learning and suicide prevention.

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 Q1 2023/24.

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.

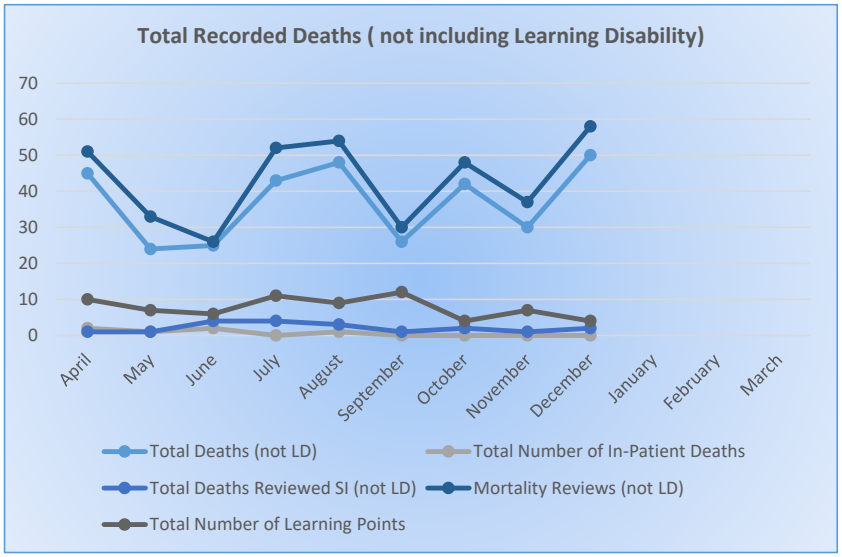
Appendix 1 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 3(October to December 2022)

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)

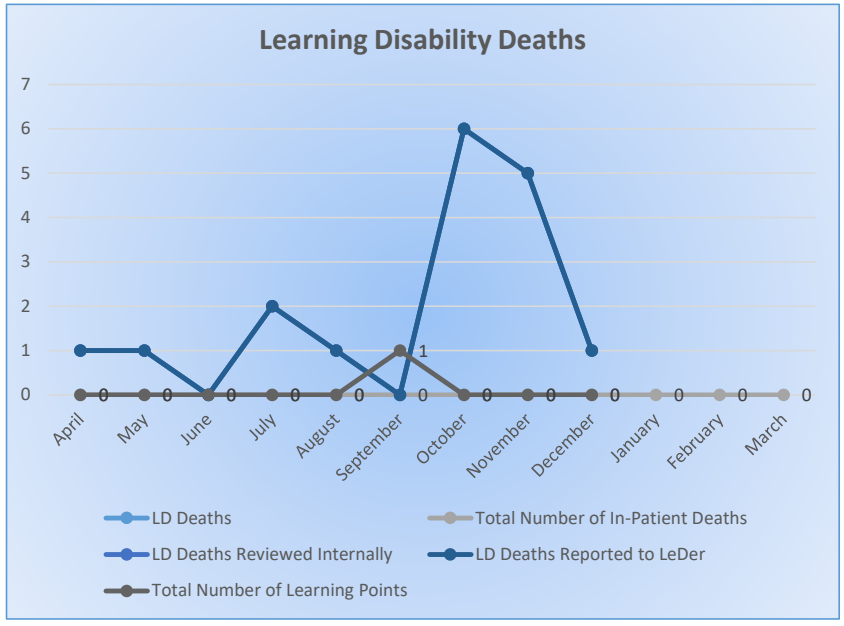
Total Number of Incident Reported Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework	Total number of deaths subject to Mortality Review (incident reported and a sample of SPINE deaths)	Total number of actions resulting in change in practice
Q1	Q1	Q1	Q1	Q1
94	**5**	**6**	**110**	**23**
Q2	Q2	Q2	Q2	Q2
117	**1**	**8**	**136**	**32**
Q3	Q3	Q3	Q3	Q3
122	**0**	**5**	**143**	**15**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
333	**6**	**19**	**389**	**70**



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
12	**0**	**12**	**12**	**0**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
17	**0**	**17**	**17**	**1**



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.