Board of Directors

SUMMARY REPORT	Meeting Date:	24th May 2023
	Agenda Item:	14

Report Title:	**Mortality – Quarterly 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:	10 May 2023
Key points/ recommendations from those meetings	The Quality Assurance Committee received the report and discussed the assurance in its content, and approved the report for submission to the Board of Directors.	

Summary of key points in report

In Q4 there was key learning related to the premature deaths of people with severe mental illnesses (SMI). The report of the National Mental Health Intelligence Network into premature deaths of people with SMI was published, showing that this inequality remains and has widened between 2015 and 2020. In our local learning, it is apparent that premature death due to "natural" causes is often associated with the same chronic physical health conditions as in the national sample, including cardiovascular disease and type 2 diabetes.

It was also apparent in SHSC's learning that issues including delays in the allocation of a care coordinator and the usability of the current patient record system contributed to negative experiences of service users prior to death.

All of these areas can be mapped on to improvement work currently underway in SHSC, including the work of the Physical Health Monitoring Group, the QUITT smokefree programme, the Electronic Patient Record programme and the Primary and Community Mental Health transformation programme. This suggests several measures related to deaths, including rates and average age of death, that could be tracked in SHSC to assess the impact of the improvement work.

SHSC benchmarks as amongst NHS Mental Health Trusts with higher standardised rates of death by suicide. A working hypothesis is that this may be connected with SHSC having been a provider of substance misuse services, whilst many Trusts are not. Work is underway to review and standardise (according to total care contacts) the number of deaths by suicide of SHSC service users compared to the Sheffield population for the years 2020, 2021 and 2022. This will report in Q1 2023/24

An external review is currently underway into suspected homicides involving SHSC service users in 2022, which will report via Quality Assurance Committee and to the Board of Directors.

In terms of process, SHSC reviewed 100% of all reported deaths during quarter 4 of 2022/23 and a sample of deaths for people who had died within 6 months of a closed episode of care. SHSC is compliant with the

2017 National Quality Board (NQB) standards for learning from deaths.

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	**X**	**Information**	

The Board is asked to consider the assurance on learning from deaths in the report and how changes from such learning are tracked to assess the impact of improvement programmes.

Please identify which strategic priorities will be impacted by this report:				
Recover services and improve efficiency	*Yes*		*No*	*x*
Continuous quality improvement	*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?		*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, Engagement 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*	*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 Q4

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 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 has been subject to clinical audit in 22/23, which will be reported back via Quality Assurance Committee.

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.

Section 4: Implications

Strategic Priorities and Board Assurance Framework

4.1 Strategic Aims: Provide outstanding care; Create a great place to work
Strategic Priorities: Recover Services and Improve Efficiency, Continuous Quality Improvement

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

Sustainable development and climate change adaptation

4.6 The SHSC Green Plan sets out our commitment to:

- Target the emissions we control directly (our carbon footprint) to be net zero by 2030 and for the emissions we can influence to be net zero by 2045.
- To provide sustainable services through ensuring value for money, reducing wastage and increasing productivity from our resources
- Continuously developing our approach to improving the mental, physical and social wellbeing of the communities we serve through innovation, partnership and sharing
- We will promote a culture of collaboration, supporting our people and suppliers to work together to make a difference
- We will innovate and transform to provide high quality care and support as early as possible in order to improve physical, mental and social wellbeing

Compliance - Legal/Regulatory

4.7 As previously described

Section 5: List of Appendices

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 4 2022/23.

During quarter 4 SHSC was fully compliant with 2017 National Quality Board (NQB) standards for learning from deaths.

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 4 2022/23, the Mortality Review Group reviewed a combined total of 142 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 4 2022/23	NHS Spine (national death reporting processes)	21
	Incident report	118
	Learning Disability Deaths	3
Total		**142**

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)	32
Expected Death (Reportable to HM Coroner)	1
Suspected Suicide – Community	5
Unexpected Death - SHSC Community	43
Unexpected Death - SHSC Inpatient/Residential	1
Unexpected Death (Suspected Natural Causes)	34
Suspected Homicide	2
TOTAL	**118**

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	1
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	0
Suspected Homicide – Substance Misuse	0
TOTAL	**3**

Out of the 121 (including of LD) deaths that were incident reported in Q4, 113 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 1 death of an SHSC community patient was officially classified as a Covid-19 related. 8 unexpected deaths are still awaiting further investigation/inquest through H M Coroner.

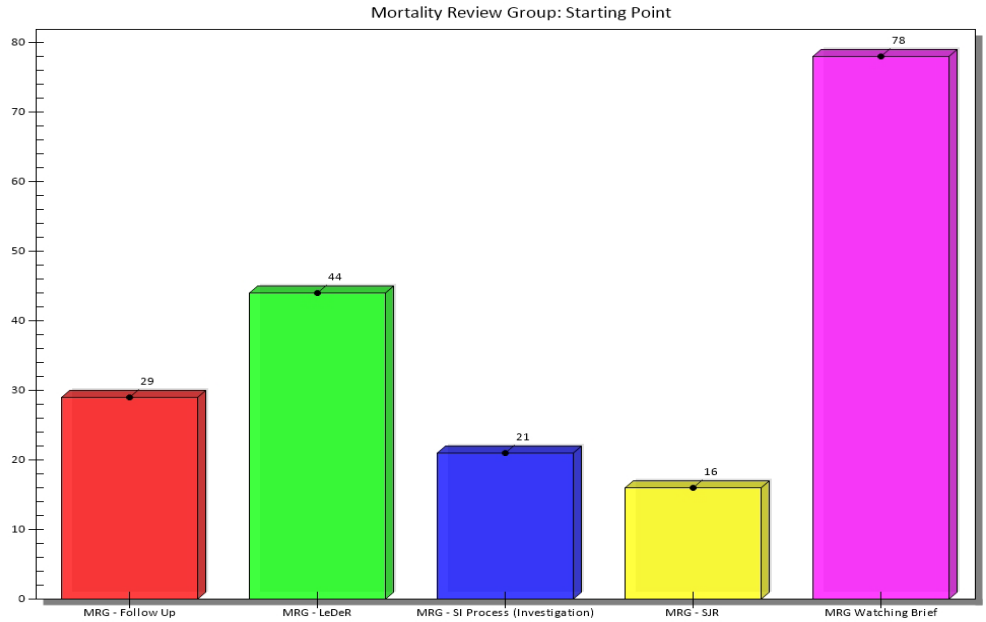
Examples of the natural cause deaths recorded during quarter 4 include:

- Bronchopneumonia, Ischemic Heart Disease, Type 2 Diabetes Mellitus, Obstructive Sleep Apnoea, Sepsis, Huntington's Disease, Multiple Sclerosis, Metastatic Ovarian Cancer and Spontaneous Ruptured Abdominal Aortic Aneurysm

Where deaths were referred to HM Coroner, follow up has been/is being undertaken to ensure that any additional learning for SHSC is identified. 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. However, it should be noted that in quarter 4 SHSC were informed by the coroner's team that they are experiencing ongoing service delivery issues due to unforeseen circumstances. The impact of this for our services is a delay in establishing conclusions as to the cause of death for those cases held in the mortality Watching Brief file.

As can be seen in the table below there are currently 188 deaths that are being processed through the internal mortality and serious incident systems, 44 that are being managed externally through the ICB LeDeR process and 78 that are subject to an external investigation such as coroner's inquest.

Overview of current number of mortality cases being reviewed as of: 31 March 2023



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 Q3 and potential learning identified in Q4.

Learning and notable practice from completed investigations in Q3:

- Theme 1

The delay in allocation of a care coordinator to individual patients was identified in 2 completed Serious Incident investigations. The roles and functions of care coordinators is currently being reviewed as a part of the community transformation project.

- Theme 2

The useability of the patient record system, including how care plans and DRAMs are documented may have contributed to information being missed that could have guided more effective risk assessment/management. The insight system is being replaced with the RIO electronic records system to improve the useability and functionality of record keeping across SHSC.

- Theme 3

The team supporting the patient took a holistic approach to delivering care and acknowledged and validated the impact that poor physical health was having on the patient.

In Q4, after following the SHSC initial review process, one incident of community death by suspected suicide was identified for further investigation in the serious incident framework:

- SHSC were informed of the patient's death by the patient's daughter The patient is suspected to have died following an overdose of co-codamol tablets. Support was provided to the daughter and following the receipt of a 48hr report terms of reference were established.

Terms of reference for the investigation being undertaken in Q4

- The investigation into the Q4 community suicide will seek to understand:
  - Whether the overall care provided was in line with NICE guidelines https://www.nice.org.uk/guidance/cg185
  - If the system in place within the North Recovery team for identifying whether service users are being reviewed in a timely manner is in line with their presenting needs.
  - The system in place within the North Recovery team for monitoring and documentation meets expected standards.

In Q4 the incident/s of suspected homicide are detailed as:

- The police informed SHSC that a service user with the substance misuse team had been arrested for the suspected murder of a member of the public. This incident is currently being investigated as a Serious Incident. The learning from this will be outlined in a subsequent report on completion of the investigation.
- Police contacted SHSC to ascertain the next of kin details for a deceased service user. It was apparent that another service user, open to the substance misuse team, had been arrested on suspicion of murder. The 48hr report for this incident outlined the details of contact and established that a serious incident investigation was unlikely to lead to further relevant information.

An external review of homicides reported by SHSC since 2022 is currently underway. The findings and learning from this review will be outlined in this report on completion.

Long-Term Neurological Conditions deaths (LTNC)

- During Q4 the mortality team worked in collaboration with LTNC to review an identified increase in mortality reporting during Q3 2022/23. Whilst these deaths were identified to be of natural causes, linked to the neurological condition the

service user was experiencing, it was established that the LTNC teams required planned time to consider their team responses to the deaths of their service users. 2 workshops are scheduled for May 2023.

Learning from LeDeR Deaths

LeDeR reviews are managed via the Integrated Commissioning 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.
During Q4 there were 7 actions identified for SHSC from the 4 LeDeR reviews that were completed by the ICB. All 4 LeDeR reviews were shared with the Learning Disability team in order to promote wider learning.
The 7 actions identified by the ICB were all in relation to the care and treatment of a service user using the Assessment and Treatment Unit (ATU) at Firshill Rise. This service user died in 2021 as a result of covid 19. Whilst learning was identified and shared the LeDeR report outlined that there were no unique acts or omissions in relation to care provided that had a direct impact on outcome.

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 4 completed SJRs included:

- Physical health comorbidity can be complex to manage. All 4 service users died as a result of natural causes related to poor physical health.
- Support for physical health in one case was difficult to accomplish due to the low motivation of the service user to engage with regular GP reviews and this may have been as a result of ongoing mental health issues.
- One service user with cognitive impairment had a good standard of end of life support prior to their death and this included a good standard of support for their family.

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 4 (2022/23), deaths were recorded primarily as:

- Old age frailty, cognitive impairment and older age-related conditions.

The ages of those who died ranged from 45 to 93 (with the majority being over 70). 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.

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. This data was provided in the quarter 3 report.
Work is still underway to reflect on the suicides recorded by SHSC during 2020, 2021 and 2022 in comparison to the wider number of Sheffield citizens that took their own life during this period. The findings from this review will be outlined in quarter 1 2023/24.

National Mental Health Intelligence Network report on Premature mortality in adults with severe mental illness (SMI) 2023

People with Severe Mental Illness (SMI) often experience poor physical health as well as poor mental health. They frequently develop chronic physical health conditions at a younger age than people without SMI. These chronic conditions include obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), stroke, heart failure and liver disease. People with SMI are at increased risk of developing more than one of these chronic conditions.

These physical health problems increase the risk of premature death in people with SMI. However, research shows, SMI is rarely recorded as an underlying cause of death, and indeed, is often not recorded on death certificates even as a contributory cause. Although people with SMI die prematurely from physical conditions, their SMI may still have been a significant feature in their lives, influencing their lifestyle, risk of developing chronic health conditions, their access to health services, and their ability to self-manage physical health conditions. It is estimated that for people with SMI, 2 out of 3 deaths are from physical illnesses that can be prevented.

Summary of 2023 report on Premature mortality in adults with severe mental illness (SMI): The report is about premature mortality, under the age of 75 years, in people with severe mental illness (SMI). It presents the latest data for the period 2018 to 2020 and examines trends over time since 2015 to 2017.

- Based on data from 2018 to 2020, in England, people with SMI were around 5 times more likely to die prematurely than those who do not have SMI. This level of inequality is seen for both males and females.
- Excess premature mortality, the difference in premature mortality between people with SMI and those who do not have SMI, in 2018 to 2020 increased compared to 2015 to 2017 for persons, males and females. This suggests adults with SMI are increasingly more likely to die prematurely than people without SMI.

There was wide variation in excess premature mortality in adults with SMI across England. The range of premature mortality showed that:

- Adults with SMI were from 2.5 to 7.2 times more likely to die before the age of 75 than adults without SMI.
- Males with SMI were from 2.7 to 7.4 times more likely to die before the age of 75 than males without SMI.
- Females with SMI were from 2.6 to 6.9 times more likely to die before the age of 75 than females without SMI.

The premature mortality in adults with severe mental illness (SMI) report will be taken forward to the Clinical Quality and Safety Group and the Physical Health Monitoring Group in order to inform planning, management and delivery of preventive and supportive services for people with SMI.

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 will be 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.

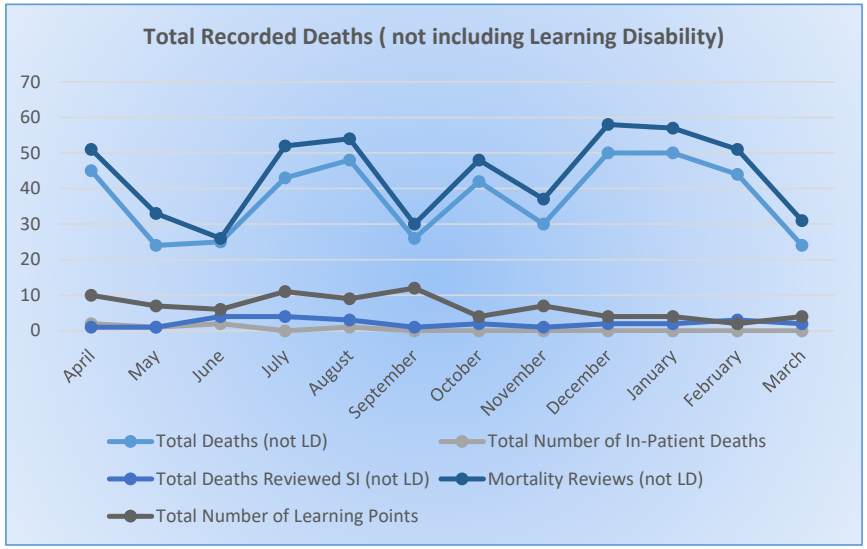
Appendix 1 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 2(July to September 2022)

NHS 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
118	**0**	**7**	**139**	**10**
YTD	YTD	YTD	YTD	YTD
451	**6**	**26**	**528**	**80**



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
3	**0**	**3**	**3**	**7**
YTD	YTD	YTD	YTD	YTD
20	**0**	**20**	**20**	**8**