Board of Directors - Public

SUMMARY REPORT	Meeting Date:	27 September 2023
	Agenda Item:	14.1

Report Title:	**Quarter 1 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:	13 September 2023
Key points/ recommendations from those meetings	The Quality Assurance Committee declared that they were assured and formally approved the quarter 1 report for submission to the Board of Directors.	

Summary of key points in report

A range of learning points in relation to mortality linked investigations were identified during quarter 1 2023/24 including:

- Following the death of a community patient the investigation identified a need for improved communication and information sharing with neighboring mental health service providers and Service Users' GP practice.
- Following the suspected suicide of a liaison psychiatry client an investigation established that a significant factor in the client leaving the emergency department before assessment was a prolonged assessment waiting time. Work is underway to formulate contingency plans and protocols that can be enacted when the standard waiting time cannot be met. This will allow for positive engagement with those facing longer waits prior to assessment taking place and may mitigate the risk of the client leaving the department as a result of frustration.
- Following the suspected suicide of a patient whilst out on unescorted Section 17 leave it was established that the Detailed Risk Assessment and Management plan (DRAM) design and format does not provide the functionality required to support clinicians in building and maintaining a structured clinical risk assessment. Work is underway to replace the DRAM as it is no longer fit for purpose.
- Following the death of a community patient the Single Point of Access (SPA) team have updated their team awareness of NICE guidelines around self-harm. Work is underway to ensure that all staff are aware of which services outside of SHSC can refer to the Liaison Psychiatry team. The interface and clinical pathways between Minor Injuries at Sheffield Teaching Hospitals and SHSC are being reviewed to ensure there is clarity of communication between services.
- Following the death of a community patient the Recovery teams are developing a system that flags a lack of contact with care coordinators in order to prevent excessive gaps between contacts. A clear system is being developed for contacts when allocated care coordinators are away from work.

SHSC reviewed 100% of all reported deaths during quarter 1 of 2023/24 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**	
It is recommended that the Board of Directors take assurance, from this report, that SHSC reviews all deaths reported via the Ulysses Incident Reporting System and reviews a significant proportion of deaths for people discharged from SHSC but who died within 6 months of their last contact. It is also recommended that the Board of Directors are assured that systems are in place to extract and share learning in relation to the deaths of patient.							

Please identify which strategic priorities will be impacted by this report:				
Recover services and improve efficiency	*Yes*	***X***	*No*	
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*		*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, 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.
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.

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 extremely process focused. A priority for the mortality review group has been to continue to engage with the national Better Tomorrow project in order to develop better learning from deaths. The Better Tomorrow project came to an end in quarter 4 of 2023. However, SHSC remains an active member of the national mortality and learning from deaths group which is a legacy of the Better Tomorrow project.

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 has been developed as a part of the Better Tomorrow project.

3.2 Learning from Deaths was subject to clinical audit during 2022/23

Triangulation

3.3 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

3.4 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.

3.5 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: 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

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 above.

Section 5: List of Appendices

Appendix 1: Mortality Dashboard
Appendix 2: 2022/23 Annual Compliance Report

Summary Report

This report provides the Board of Directors with an overview of SHSC's mortality processes and any learning from mortality discussed in the Mortality Review Group (MRG) during quarter 1 2023/24.

During quarter 1 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 1 2023/24, the Mortality Review Group reviewed a combined total of 159 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 1 2023/24	NHS Spine (national death reporting processes)	29
	Incident report	118
	Learning Disability Deaths	12
Total		**159**

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)	36
Expected Death (Reportable to HM Coroner)	4
Suspected Suicide – Community	3
Unexpected Death - SHSC Community	34
Unexpected Death - SHSC Inpatient/Residential	1
Unexpected Death (Suspected Natural Causes)	39
Suspected Homicide	1
TOTAL	**118**

LD Death Classification	No. of Deaths Q1
Expected Death (Information Only)	8
Expected Death (Reportable to HM Coroner)	0
Suspected Suicide – Community	0
Unexpected Death - SHSC Community	4
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	0
Suspected Homicide – Substance Misuse	0
TOTAL	**12**

Out of the 130 (including of LD) deaths that were incident reported in Q1, 84 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 HM Coroner.

There were 3 suspected suicides in the community. All incidents were subject 48hr reporting, however none of the incidents went on to further serious incident investigation.

There was 1 suspected domestic homicide reported during this period. Serious incident investigation processes were not required.

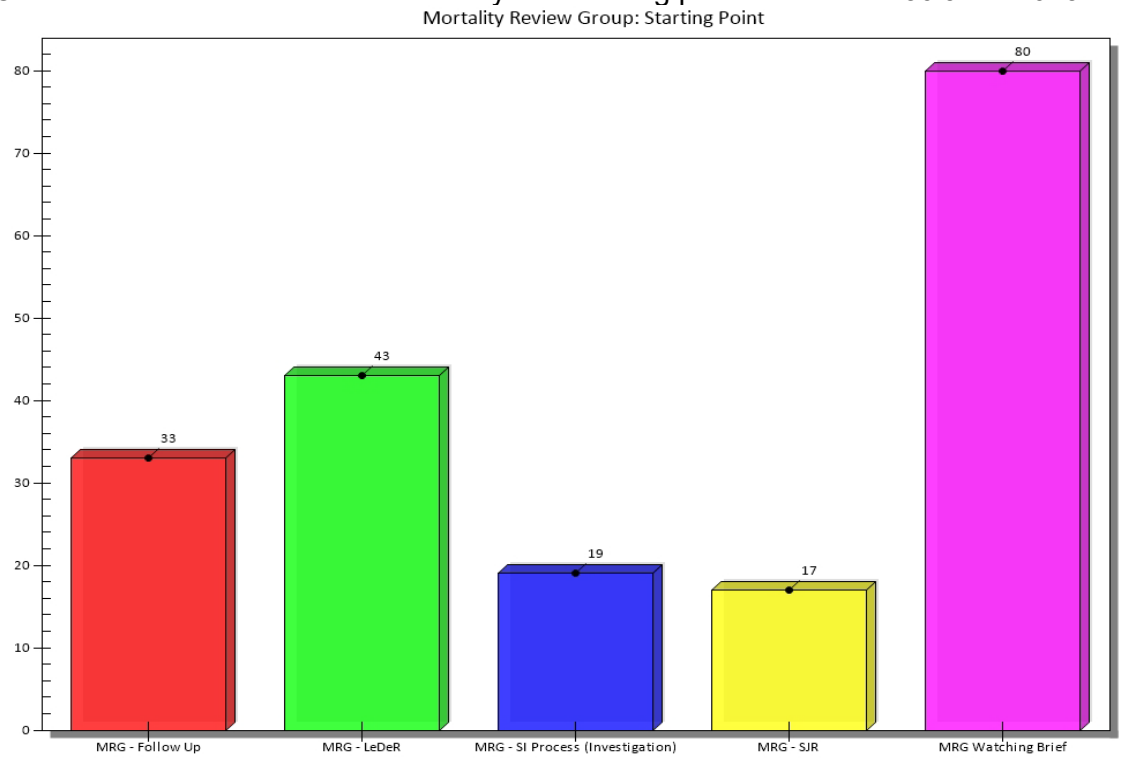
Examples of the natural cause deaths recorded during quarter 1 include:

- Bronchopneumonia, Ischemic Heart Disease, Type 2 Diabetes Mellitus, Obstructive Sleep Apnoea, Hypotension Syndrome, Sepsis, Huntington's Disease, Multiple Sclerosis, Metastatic Cancer's 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.

As can be seen in the table below there are currently 192 deaths that are being processed through the internal mortality and serious incident systems, 43 that are being managed externally through the ICB LeDeR process and 80 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 2023



Current and Future Learning from Death Outcomes

All incidents reported as having a catastrophic impact were in relation to death and 74% of these were either suspected or known to be due to natural causes. 1 expected death was reported by one the two nursing homes, all other reported deaths were reported by community-based services.

All deaths from suspected suicide (2%) were subject to individual due diligence and where required a 48hr report was completed. One homicide was reported in Q1 in relation to the death of a service user. The perpetrator was not known to SHSC and further investigation will be considered by the Local Authority Safeguarding team.

19% of reported deaths originated from substance misuse services. These services are no longer commissioned from SHSC and it is anticipated that this will lead to a reduction in the number of reported deaths overall.

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 and Safety report. Below is a brief summary of the identified learning taken from investigations completed in Q4 and potential learning identified in Q1.

Learning and notable practice from completed investigations in Q4:

Notable Practice

In regard to notable practices that have been identified during an investigation, investigators found the following:

- Good documentation of legitimate reasons for not involving family members in specific decision making was noted.
- The care the patient received from NHS Talking Therapies (Previously known as IAPT) was of a high standard and met all of the relevant guidelines.
- Staff interviewed demonstrated that they were considering the impact of stress associated with recent circumstances, age, redundancy, separation, shame associated with recent criminal charge and a forthcoming court date.

- It is unusual for a medically unfit person to be referred to the SPA team. The medical emergency was identified and properly prioritised with appropriate action taken. The SPA team acted on previous advice to facilitate the patient getting to the Minor Injuries department rather than A&E and provided him with transport.
- It is noted that the Service User had a difficult and traumatic upbringing which affected him throughout his life. However, the care, communication and attempts to engage proactively and sympathetically with the Service User, despite his risk history, was of notable practice, particularly by the Forensic Social Worker involved.

Learning from investigations

Regarding themes, lessons learned and actions, investigations found the following:

- Theme 1

Follow the suspected suicide of a community patient the investigation identified a need for improved communication and information sharing with neighboring mental health service providers and Service Users' GP practice. The following actions were undertaken:

  - A review of procedures relating to the sharing of Mental Health Act assessments with GPs, and the robustness of these procedures.
  - A review of the current Standard Operating Procedure (SOP) to ensure clarity on information sharing with neighbouring providers, in the event of an out of area Health Based Place of Safety (HBPoS) bed being utilised for a Sheffield resident.
  - A review of the training provided to Approved Mental Health Practitioners (AMHPs) and s12 doctors in relation to alcohol misuse and mental health.

- Theme 2

Following the suspected suicide of a liaison psychiatry client an investigation established that a significant factor in the client leaving the emergency department before assessment was a prolonged assessment waiting time. Work is underway to formulate contingency plans and protocols that can be enacted when the standard waiting time cannot be met. This will allow for positive engagement with those facing longer waits prior to assessment taking place and may mitigate the risk of the client leaving the department as a result of frustration.

- Theme 3

Following the suspected suicide of a patient whilst out on unescorted Section 17 leave it was established that the Detailed Risk Assessment and Management plan (DRAM) design and format does not provide the functionality required to support clinicians in building and maintaining a structured clinical risk assessment. There is also a planned review of SHSC's Leave Policy, specifically the arrangements for informal leave processes, to simplify and agree a standard method for recording/monitoring and responding to those who do not return in line with their plan.

In Q1 of the 5 Serious incidents related to mortality, where potential learning was identified:

- 1 was a suspected suicide in the community.
- 2 were unexpected deaths in the community, cause unknown.
- 1 was an expected death as a result of Covid-19.
- 1 was a suspected homicide, however, after due diligence this was requested to be delogged from StEIS as no learning investigation was required by SHSC.

Collaborative Learning sessions

Early Intervention Service (EIS)

- During Q1 the mortality team worked in collaboration with EIS in relation to their team learning from death and their team response to being informed a client had died which included how they should support, communicate and engage with families following a death of someone in their care.

Long-Term Neurological Conditions (LTNC) team and the Sheffield Community Brain Injury Rehabilitation Team (SCBIRT) workshops

- 2 workshops were held with the Long-Term Neurological Conditions (LTNC) team and the Sheffield Community Brain Injury Rehabilitation Team (SCBIRT) in Q1. Whilst the deaths reported by these teams were identified to be of natural causes, linked to the neurological condition the service user was experiencing, it was established that the LTNC and SCBIRT required planned time to consider their team responses to the deaths of their service users.

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 Q1 there were 2 actions and positive practice point identified for SHSC from the 11 LeDeR reviews that were completed and returned by the ICB. All 11 LeDeR reviews were shared with the Community Learning Disability Team in order to promote wider learning.

LeDeR Review Learning points and positive practice:

- The Community Learning Disability Team (CLDT) are required to share information with relevant providers in regard to eating guidelines to ensure guidance informs the development of care plans and risk assessments.
- No use of hospital passport could be evidenced. The CLDT must ensure this is completed whilst undertaking health work around Head-to-Toe Assessment.
- The transition from living with ********** to moving in with friend and neighbour, ******, was quickly and efficiently organised. This meant that ****** could stay in the community she knew with someone she had grown up with which must have been a reassuring and stabilising influence in her time of grief. There was oversight and support by 'Shared Lives' and Sheffield Health and Social Care Trust

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 4 completed SJRs included:

- The Older Adult CMHT were able to support the wife and daughter of a client prior to them being admitted to a long-term care home. The family described this support as invaluable in helping them come to terms with a diagnosis of dementia.
- A patient had a long and complex physical health history and her relationship with alcohol was often difficult to manage. She drank consistently high quantities of alcohol as a way to self-medicate or cope with her many life stressors. The home environment didn't support alcohol reduction as other family members also drank. Although they did want to reduce and then stop alcohol this was only done in short time periods then they would suffer relapse. Staff offered appropriate treatment plans and options for support throughout the time when she was on active caseload including helping them recognise why they were self-medicating, and then trying to help them deal with both the underlying condition and the problems created by their drinking.
- The SJR noted that for one service user with cognitive impairment, renal impairment and a range of physical health conditions that there was no recorded status in regard to Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) whilst it was noted that the client had a good standard of end-of-life support prior to their death best

practice would have been for this to have been collaboratively discussed and then appropriately recorded.

- The Patients collaborative care plan was found to be very brief and did not fully explore all of the care needs of the patient. Whilst this did not have a negative impact when the patients regular care coordinator was visiting it did make fully understanding the care needs of the patient more difficult when the usual care coordinator was absent from work. Collaborative care plans can be a vital source of information when the client is not well known to new staff.

Analysis of National Spine-System Recorded Deaths

From the sample of 29 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 (2023/24), deaths were recorded primarily as:

- Old age frailty, cognitive impairment and older age-related conditions, drug and alcohol related conditions and pre-existing medical conditions.

The ages of those who died ranged from 53 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.

Covid- 19 deaths

Since April 2020 there have been 107 covid-19 deaths with older people's services having the highest cohort of those that died as a result. As of 30 June 2023, we will no longer be expected to automatically investigate a covid-19 death as a Serious Incident Investigation, where an inpatient has died from covid-19. However, the deaths of individuals from covid-19 will remain subject to the same level of mortality review as any other death.

COVID-19 Deaths 1 April 2020 – 31 June 2023	
ATS (Firshill Rise)	1
Birch Ave	5
CISS (LDS)	1
CLDT	6
G1 Ward	6
Liaison Psychiatry	10
LTNC	3
Memory Service	7
Mental Health Recovery Team (South)	2
Neuro Case Management Team	1
Neuro Enablement Service	4
OA CMHT North	22
OA CMHT South East	15
OA CMHT South West	9
OA CMHT West	5
OA Home Treatment	3
SPA / EWS (Netherthorpe)	1
START Alcohol Service	1
START Opiates Service	2
Woodland View | Oak Cottage	2
Grand Total	107

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 was due be replaced with the Mental Health national dashboard version during Q1 2023/24. However there have been a number of significant IT interface issues that are still in the process of being resolved between SHSC and the national team. It is anticipated that the interface issues will be resolved in order for the new dashboard to be used in quarter 2 of 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.

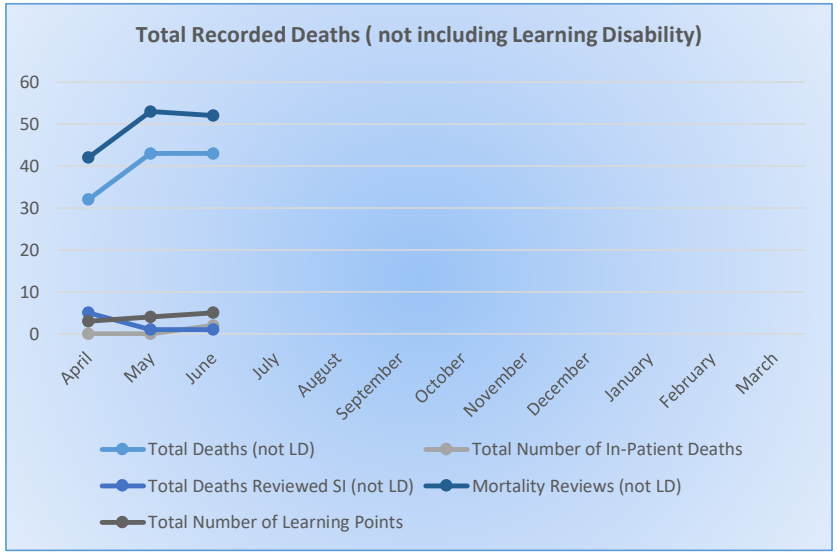
Appendix 1 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 2(July to September 2022)

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
118	**2**	**7**	**147**	**0**
Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3
0	**0**	**5**	**0**	**0**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
118	**2**	**12**	**147**	**0**



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
12	**0**	**12**	**12**	**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
12	**0**	**12**	**12**	**0**