Board of Directors - Public

SUMMARY REPORT	Meeting Date:	27 March 2024
	Agenda Item:	21

Report Title:	**Mortality – Quarterly Report: Quarter 3 2023/24**	
Author(s):	Vin Lewin, Patient Safety Specialist	
Accountable Director:	Dr Helen Crimlisk, 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:	7 February 2024
Key points/ recommendations from those meetings	The QAC were assured by the report. Going forward the committee would like to see the report focus more clearly on learning from the deaths of service users.	

Summary of key points in report

A range of learning points in relation to mortality linked investigations were identified during quarter 3 2023/24 including:

- The majority of deaths reported by SHSC staff are in relation to older people living in community settings with a diagnosis of dementia and conditions related to older age. The most common cause of death is natural causes. In Q3 there were no SHSC acute inpatient deaths reported.
- There continue to be learning opportunities in relation to suspected suicides in the community linked to ongoing improvement actions for communication, documentation.
- Learning from Structured Judgement Reviews (SJR's) highlights that there is good monitoring of older adults with dementia who are prescribed anti-psychotic medication. There is also a continued theme of complex comorbid physical health issues and mental health issues that require expert support across a range of professionals.
- All of the learning and action points shared by the Integrated Care Board (ICB) are managed directly by the Community Learning Disability Team.

During quarter 3 SHSC completed Parts 1,2 and 3 of the Learning from Deaths clinical audit (full reports are provided in appendix 1 & 2). Whilst the majority of findings from the audits give assurance that robust mortality review systems are in place a number of recommendations have been made to strengthen the process.

SHSC reviewed 100% of all reported deaths during quarter 3 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.

Appendices:
Appendix 1: Learning from Deaths audits Part 1 & Part 2
Appendix 2: Learning from Deaths audit part 3: Case-note audit
Appendix 3: Mortality Dashboard

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	**X**	**Information**	
It is recommended that the Board is assured that SHSC has a robust mortality and learning from deaths review process in place.							

Please identify which strategic priorities will be impacted by this report:				
Effective Use of Resources	*Yes*	***X***	*No*	
Deliver Outstanding Care	*Yes*	***X***	*No*	
Great Place to Work	*Yes*		*No*	***X***
Ensuring our services are inclusive	*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, 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 Q2

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:

- Effective Use of Resources
- Deliver Outstanding Care
- Great Place to Work
- Ensuring our services are inclusive

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:

- 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 in section 4.1

Section 5: List of Appendices

Appendix 1: Learning from Deaths audits Part 1 & Part 2
Appendix 2: Learning from Deaths audit part 3: Case-note audit
Appendix 3: Mortality Dashboard

Summary Report

This report provides the Quality Assurance Committee with an overview of SHSC's mortality processes and any learning from mortality discussed in the Mortality Review Group (MRG) during quarter 3 2023/24.

During quarter 3 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 3 2023/24, the Mortality Review Group reviewed a combined total of 113 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 3 2023/24	NHS Spine (national death reporting processes)	25
	Incident report	79
	Learning Disability Deaths	9
Total		**113***

*1 reported death was in regard to a Child Serious Case Review therefore actual number reported: 114

Analysis of Death Incidents Reported

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

Death Classification	No. of Deaths Q3
Expected Death (Information Only)	22
Expected Death (Reportable to HM Coroner)	3
Suspected Suicide – Community	4
Unexpected Death - SHSC Community	24
Unexpected Death - SHSC Inpatient/Residential	1
Unexpected Death (Suspected Natural Causes)	25
Suspected Homicide	0
TOTAL	**79**

Learning Disability (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	6
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	0
Suspected Homicide – Substance Misuse	0
TOTAL	**9**

Out of the 88 (including of LD) deaths that were incident reported in Q3, 68 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 20 unexpected deaths are still awaiting further investigation/inquest through HM Coroner.

There were 5 suspected suicides in the community. 2 incidents were adequately understood via mortality review as the patients had not had contact with SHSC for over 12 months. 3 of the incidents were subject to 48hr reports and contact with the family was undertaken.

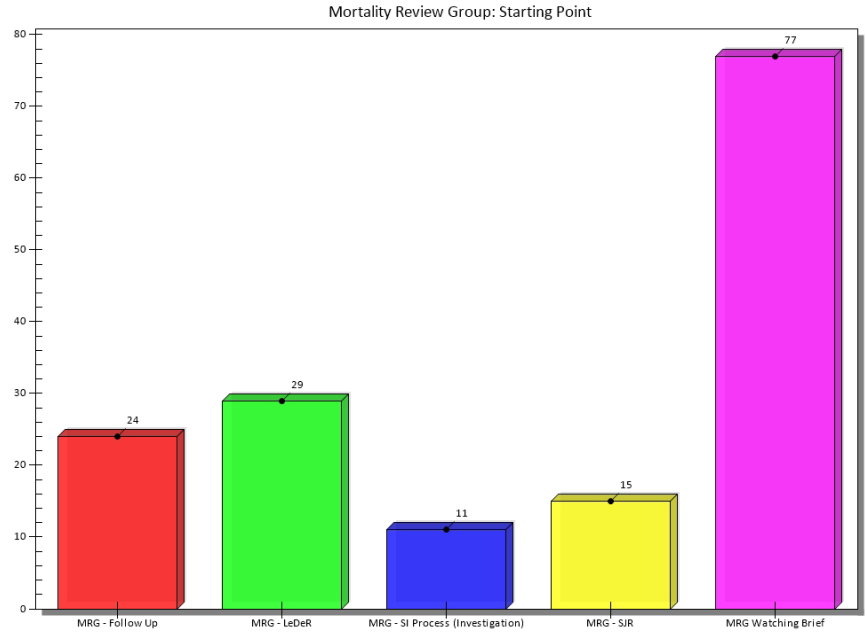
Examples of the natural cause deaths recorded during quarter 3 include:

- Bronchopneumonia, Enterobacter Cloacae Sepsis, Gallbladder carcinoma, Ischemic Heart Disease, Type 2 Diabetes Mellitus, Pulmonary Fibrosis, Hypotension Syndrome, Sepsis, Multiple Sclerosis, Metastatic Cancer's and Alzheimer's Dementia, Non-Hodgkin's Lymphoma and Acute Myocardial Infarction.

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 156 deaths that are being processed through the internal mortality and patient safety incident systems, 29 that are being managed externally through the ICB LeDeR process and 77 that are subject to an external investigation such as coroner's inquest.

Overview of current number of mortality cases being processed as of: 28 December 2023



Current and Future Learning from Death Outcomes

All incidents reported as having a catastrophic impact were in relation to death and 77% of these were either suspected or known to be due to natural causes.

During Q3 there continued to be a downward trend in the number of deaths reported. In quarter 1 there were 150 deaths reported and in quarter 2 there were 130. This continued reduction is due to the cessation of reporting by the START teams which are no longer commissioned with SHSC.

All deaths from suspected suicide were subject to individual due diligence and where required a 48hr report was completed.

It should be noted that this report considers deaths but not those that are categorised as patient safety incidents (except for capturing the statistical data within the figures). Detailed learning outcomes following patient safety incident investigations (PSII's) 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 Q2 and potential learning identified in Q3.

Learning identified from completed investigations in Q2:

Learning from investigations

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

- Theme 1

Following the investigation into the suspected suicide of a patient with the Recovery team learning was actioned to ensure the recently ratified Standard Operating Procedure for clinical record keeping, currently being rolled, out is embedded within the Recovery Team. The expectation that safety planning documentation is of a high standard is also being reinforced with the team.

- Theme 2

Whilst the investigation into the suspected suicide of a patient with the Crisis Resolution and Home Treatment Team found no specific learning for SHSC it was identified that there was a missed opportunity for there to have been more robust communication around discharge planning by Sheffield Teaching Hospitals in order for the team to have identified the patient's intention not to comply with physical health treatments sooner.

In Q3 of the 2 Serious incidents related to mortality, where potential learning was identified:

- 2 were suspected suicides in the community.

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 Q3 there were 6 learning points and 5 positive practice point identified for SHSC from the 12 LeDeR reviews that were completed and returned by the ICB. All 12 LeDeR reviews were shared with the Community Learning Disability Team in order to promote wider learning.

LeDeR Review Learning points and positive practice:

Learning points:

- An autism review highlighted that the individual's decision making was affected by alcohol consumption. The review action identified that all agencies must: **a)** ensure staff fully understand the Mental Capacity Act and their responsibilities in its application, **b)** must enable people to access appropriate health appointments or reasonable adjustment alternatives are made and **c)** provide Best Interests decision-making evidence as to why the person has not had that opportunity.

- There did not appear to have been any planning once the person reached the age of 18 years and moved from a residential placement to no support being in place. SHSC were actioned to ensure assessment of need under adult legislation takes place as part of the transition through to adult services.

- Safeguarding alerts where he is vulnerable to youths in the community. SHSC were actioned to be aware that Vulnerable Adults processes be implemented in a timely way.

- Two referrals made to LD Psychiatry were signposted on to older people's service even though the person was being supported by other members of the Community Learning Disability Team and no rationale was evidenced in 2011 and 2013. Despite the fact that this action references issues identified from 2011 and 2013 the ICB reviewer actioned SHSC to review this case alongside their referral pathway to determine if/where improvement can be made.

- Older persons psychiatry gave a diagnosis of dementia. The Community Learning Disability Team later reassessed and confirmed that he did not have dementia. This was confirmed by the Memory service. The review suggested that it would have been more beneficial for an annual review of medication to take place in cases where a probable diagnosis is given.

- The individual was unhappy in their residential accommodation and a multi-disciplinary meeting agreed that alternative accommodation be sourced that could provide meaningful activity, have more personal money to enable him to visit friends which would all support a reduction in challenging behaviours. The reviewer suggested that all professional involved in providing care be mindful of people with learning disabilities willingness to say what someone wants to hear. When asking people for their opinion professionals must ensure that they explore this fully in a meaningful way that enables their true wishes to be identified.

Positive Practice

- The review identified that there was a positive transitional plan from children to adult services.

- There was positive multi-disciplinary working from children's service, through to transitions and adult care, which ensured the individuals care was managed well.

- Good communication by all professionals involved and good co-ordination of care.

- Excellent record keeping by CLDT and St Luke's palliative care team.

- The individual was supported to remain in her own home surrounded by people who loved and cared about her until her death.

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 the learning themes extracted for the 5 completed SJRs included:

Communication

- The Recovery team highlighted concerns about the patient's physical health including weight loss. However, the patient expressly withdrew their consent for the team to discuss this with the GP. The team attempted to circumnavigate this by asking a Recovery team medic to review the patient, but the patient refused this course of action. There was no record of an attempt to assess capacity to make this decision, but this may not have been relevant as the patient clearly told the team they would speak directly to their GP. The team did encourage the patient to re-consider their decision at several subsequent face to face meetings.

Use of Anti-psychotic medication in older adults with dementia

- 2 SJR's were completed as it was identified that anti-psychotic medication had been prescribed despite there being a diagnosis a cognitive impairment. In both cases the older adult team reviewed the use of the medication and gave clear advice to the patients GP and the nursing home specifically. In one case the medication was reduced and a plan for monitoring put in place and in the other the medication was changed. In both cases it was evident that the CPN had explained the pros and cons of the medication to the family and professionals (in the nursing home) involved.

Capacity

- The SJR noted that for one service user memory deficits were leading to missed appointments and failure to take prescribed medication, which was impacting on their health and wellbeing. There were no identified family involved and the team attended several Best Interest meetings in order to share their understanding of the service users need for increased care support. The service user eventually became housebound due to frailty and the CMHT supported a capacity assessment to decide on a move to supported accommodation prior to successful discharge.

Waiting times

- The patient was triaged to the memory service from the CMHT but during the period that she was on the waiting list she deteriorated physically and required admission the STH. The patient was admitted to a nursing home and subsequently discharged from the memory service waiting list, however her transfer to a nursing home precipitated further referral to the CMHT due to agitation and anxiety. The patient was assessed and supported by the CMHT before being successfully discharged.

Family support

- The patient's daughter was assessed as experiencing carer stress due to the ongoing nature of the nature of care required over a 24hr period. The team supported the family in making the decision to move the patient into 24hr residential home care. There was clear documentary evidence of the team offering advice and support to the patients' daughter, including advice about their own health and wellbeing and signposting for respite care.

Analysis of National Spine-System Recorded Deaths

From the sample of 25 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 (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 was minimal input by SHSC.

Learning from Death Clinical Audit Parts 1,2 and 3 (Appendix 1 & 2)

Learning from deaths is an important element of quality assurance and improvement. As such, an audit of the Trust's policies and processes for learning from service user deaths was commissioned as part of the 2022-23 Clinical Audit Programme.

The audit was undertaken in three parts:

- Part 1: A desktop review of the 'Leadership and culture' standards in the National Quality Board Guidance on Learning from Deaths
- Part 2: A desktop review of the 'Policy' standards in the National Quality Board Guidance on Learning from Deaths
- Part 3: Audit of deaths recorded on Ulysses

Part 1 and Part 2 Desk Top Reviews

Based on the results of this desktop audit, SHSC currently fully meets 11 out of 19 standards (58%) that are relevant. SHSC partially meets a further 8 standards (42%). Tables 1 and 2 of the attached report summarise which standards are met.

Actions and reauditing

SHSC will:

- Continue to progress work on the National Mortality agenda, in order to improve reporting about Learning from Deaths (standard 1.6)
- Consider including information on learning and actions arising from Serious Incidents in the Quality Accounts (standard 1.7)
- Implement the Patient Safety Incident Response Framework (PSIRF) and the National Learning from Deaths processes, in order to ensure relevant learning is shared across services (standard 1.8)
- Consider including the following information in the next version of the *Patient Safety Incident Response Framework Policy and procedure*:
    - The circumstances in which an independent investigation may be commissioned (Standard 1.11)
    - How the Trust responds to maternal and child deaths (Standard 2.3)
    - The Trust's approach to reviewing the care of patients who were not under the care of SHSC at the time of their death.
    - How decisions regarding investigations should be recorded on the Trust's systems

Re-audit

The Trust will repeat this audit in 12-18 months following review of the findings and implementation of the Patient Safety Incident Response Framework (PSIRF).

Part 3 Case Note Audit

Summary of results

	Audit standard	Relevance (denominator)	Percentage of relevant cases meeting standing
1	When a service becomes aware that a patient has died, staff contact the family/carer and offer condolences and contact details. Details of this contact are recorded on Insight.	Service users with at least one open SHSC episode, where the death is reported on Ulysses within one month. n = 72	32%
2	All deaths reported on Ulysses are discussed at the Mortality Review Group (MRG) and this is documented on Ulysses.	All n = 100	100%
3	The outcome of the decision to review or not to review the death is recorded on Ulysses.	All n = 100	100%
4	The MRG review process is only concluded without follow-up or further investigation if the death is adequately understood and there are no concerns. This is documented on Ulysses.	All deaths concluded at the first MRG, without any further follow-up or investigation. n = 13	92%
5	All deaths of service users with a learning disability and/or autism are reviewed through the LeDeR process. This is recorded on Ulysses.	All deaths where the service user had a learning disability and/or autism n = 10	100%

Summary of recommendations

- **Standard 1:** The importance of documenting contact with families following a death (or the reason that families were not contacted) could be emphasised in staff training.
- The MRG may wish to consider routinely adding a comment regarding family/carer contact on Ulysses, following the first discussion at MRG.
- **Standards 2 and 3:** The MRG may wish to standardise how the rationale for closing cases is recorded on Ulysses (e.g., consistently using a formula such as "*Cause of death […]. [Rationale for closure], therefore no investigation required. LD/autism pathway checked, nothing to suggest a diagnosis*.")
- **Standard 4:** When cases are closed at the first MRG meeting, there should be a clear rationale documented on Ulysses.
- **Standard 5:** The MRG could consider standardising documentation of how learning from LeDeR reviews is shared with the LD team (and other relevant teams).

Four of the five above recommendations relate to standardising how MRG discussions and decisions are recorded on Ulysses. Considering this, it may be useful to develop a short guide/template/SOP to support MRG documentation, which could be used by the MRG and the administrative staff who support the group's work.

In addition, the auditor made three further recommendations:

- The Risk Team and Patient Safety Specialist could consider working with the Clinical Effectiveness Team to develop an audit process which could be run annually, using this audit as a starting point.
- The MRG could consider additional quality assurance processes in addition to audit, such as including an observer in the meetings on a quarterly basis, to provide additional scrutiny and feedback.
- Cases recorded on Ulysses without Insight numbers could not be included in this audit. The MRG may wish to undertake a separate review of mortality processes for SHSC services which do not use Insight or Rio.

Re-audit

The Trust will repeat this audit in 12-18 months following review of the findings and implementation of the Patient Safety Incident Response Framework (PSIRF).

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 3** 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 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 audits Part 1 & Part 2

Prepared for the Research, Innovation, Effectiveness & Improvement Group – March 2023

Audit lead: Vin Lewin, Patient Safety Specialist, vin.lewin@shsc.nhs.uk
Report author: Rosina Muir, Clinical Audit Facilitator, rosina.muir@shsc.nhs.uk
Report date: 8 March 2023

Background

Learning from deaths is an important element of quality assurance and improvement. As such, an audit of the Trust's policies and processes for learning from service user deaths was commissions as part of the 2022-23 Clinical Audit Programme.

The audit is being undertaken in three parts:

- Part 1: A desktop review of the 'Leadership and culture' standards in the National Quality Board Guidance on Learning from Deaths
- Part 2: A desktop review of the 'Policy' standards in the National Quality Board Guidance on Learning from Deaths
- Part 3: Audit of deaths recorded on Ulysses

This work will span 2022-23 and 2023-24.

In addition, the Clinical Effectiveness Team is working with the Patient Safety Specialist and other stakeholders to develop an assessment tool to measure the Trust's safety and learning culture. This will include measures of whether learning from deaths (and other incidents) is reaching front-line staff and resulting in changes to practice. It may be possible to use or adapt a validated tool that has been used in other Trusts.

This report concerns Part 1 and Part 2 of the audit, which were desktop audits against National Quality Board standards.

Standards

The National Quality Board's *Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care* outlines how NHS trusts are expected to respond to the deaths of service users. Fully implementing the Framework is an important step towards embracing a learning culture that is open, caring, and focused on system issues rather than individual responsibility. The Framework sets out the standards expected of Trusts in relation to learning from deaths.

Methodology

The Clinical Effectiveness Team developed a desktop audit tool to facilitate a self-assessment against key NQB standards. These are split into two sections: standards relating to Board-level responsibility (taken from Annex A of the NQB Framework) and those standards relating to Trust policies (taken from Annex C of the NQB Framework).

The desktop audit tool was completed by the Trust's Patient Safety Specialist (who leads on the mortality workstream within the Trust) with assistance from the Clinical Effectiveness team. The completed audit tool is included on pages 3 – 22.

Results

Based on the results of this desktop audit, the Trust currently fully meets 11 out of 19 standards (58%) that are relevant to the Trust. The Trust partially meets a further 8 standards (42%). Tables 1 and 2 on the following pages summarise which standards are met.

One standard (Standard 2.8), was not deemed not relevant to SHSC.

Actions and reauditing

Actions agreed with the Trust's Patient Safety Specialist

The Trust will:

- Continue to progress work on the National Mortality agenda, in order to improve reporting about Learning from Deaths (standard 1.6)
- Consider including information on learning and actions arising from Serious Incidents in the Quality Accounts (standard 1.7)
- Implement the PSIRF and the National Learning from Deaths processes, in order to ensure relevant learning is shared across services. (standard 1.8)
- Consider including the following information in the next version of the *Incident Management (Including Serious Incidents) Policy and procedure*:
    - The circumstances in which an independent investigation may be commissioned (Standard 1.11)
    - How the Trust responds to maternal and child deaths (Standard 2.3)
    - The Trust's approach to reviewing the care of patients who were not under the care of SHSC at the time of their death.
    - How decisions regarding investigations should be recorded on the Trust's systems

Re-audit

The Trust will repeat this audit in 12-18 months following review of the findings and implementation of the Patient Safety Incident Response Framework (PSIRF).

Case-note audit

A case-note audit is currently underway, to provide additional assurance and Insight regarding the Trust's LFD process.

Summary of results
Please see pages 3-21 for details and evidence.

Desktop self-assessment Part 1 – Leadership and culture	Standard met	Partially met	Comments
1.1 has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress;	✓		
1.2 pays particular attention to the care of patients with a learning disability or mental health needs	✓		
1.3 has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review	✓		
1.4 adopts a robust and effective methodology for case record reviews of all selected deaths […] with the outcome documented	✓		
1.5 ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors […]	✓		
1.6 ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board […]		×	
1.7 ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts		×	
1.8 shares relevant learning across the organisation and with other services where the insight gained could be useful		×	
1.9 ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths		×	
1.10 offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death		×	
1.11 acknowledges that an independent investigation […] may in some circumstances be warranted […]	✓		
1.12 works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services […]	✓		

Desktop self-assessment Part 2 – Policy	Standard met	Partially met	Comments
2.1 determine which patients are considered to be under their care and included for case record review if they die […]	✓		
2.2 report the death within the organisation and to other organisations who may have an interest […]	✓		
2.3 respond to the death of an individual with a learning disability or mental health needs, an infant or child death and a stillbirth or maternal death […]		×	
2.4 review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided […]		×	
2.5 review the care provided to patients whose death may have been expected, for example those receiving end of life care	✓		
2.6 record the outcome of their decision whether or not to review or investigate the death		×	
2.7 engage meaningfully and compassionately with bereaved families and carers […]	✓		
2.8 offer guidance, where appropriate, on obtaining legal advice for families, carers or staff.	Not relevant to SHSC.		

Desktop self-assessment Part 1 – Leadership and culture

This organisational questionnaire is primarily based on the standards in Annex A of the National Guidance on Learning from Deaths, which specifies board-level responsibilities for learning from deaths. Please see the Guidance/rationale column for the exact source.

Part 1: Leadership and culture		GUIDANCE / RATIONALE
The board should ensure that their organisation:		
1.1 has an existing board-level leader acting as **patient safety director** to take responsibility for the learning from deaths agenda and an existing **non-executive director** to take oversight of progress;		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 1*
	Comments: • Dr Mike Hunter (Executive Medical Director) is the board-level leader acting as patient safety director, who has responsibility for the Trust's learning from deaths agenda. • Heather Smith is the non-Executive Director with responsibility for the Trust's learning from deaths agenda. **Evidence:** • SHSC (2022) *Policy – Learning from Deaths: The right thing to do (ratified 13 April 2022)*	

1.2 pays particular attention to the care of patients with a **learning disability or mental health needs**;		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 2*
	Comments: **The Trust pays particular attention to the care of patients with a learning disability and autism:** • All deaths of service users with a learning disability or a formal diagnosis of autism are reviewed individually in the Trust's weekly Mortality Review Group (MRG) meeting and referred to the Sheffield LeDeR process. Once the LeDeR review is completed, the findings are discussed at the weekly MRG meeting, including any areas of good practice, areas of concern, or wider learning points. The report is also sent to the relevant clinical team(s) for their consideration in team governance meetings and implementation of recommendations. • Data on the number of deaths of service users with learning disabilities is included in a quarterly report to the Quality Assurance Committee, the quarterly and annual Board Mortality Reports. Quarterly and annual reports highlight any trends or learning points from the relevant period. **The Trust pays particular attention to the care of patients with mental health needs:** • The majority of the Trust's service users have mental health needs, which are routinely considered as part of the Trust's mortality review processes. **Evidence:** • SHSC (2022) *Policy – Learning from Deaths: The right thing to do (ratified 13 April 2022)* • SHSC (2022) Board of Directors Public Meeting Papers, Nov. 2022: *LeDeR Learning from lives and deaths – People with a learning disability and autistic people – Annual report 2021, and the context for Sheffield* • SHSC (2022) Board of Directors Public Meeting Papers, Nov. 2022: *Mortality Q1 & Q2 Report 2022/23*	

1.3 has a systematic approach to **identifying those deaths requiring review** and selecting other patients whose care they will review		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 3*
	Comments: **Identifying "must-do mortality reviews"** The Trust has a well-established and systematic approach to identifying deaths requiring review. The Trust's *Learning from Deaths* policy requires staff members to report any deaths they are made aware of on Ulysses (the Trust's incident management system) within 24 hours. All deaths recorded on Ulysses are reviewed at the Trust's Daily Safety Incident huddle, which identifies unnatural unexpected deaths that require a Serious Incident investigation. The weekly Mortality Review Meeting reviews all deaths recorded on Ulysses, as well as a sample of deaths reported on the NHS central Spine via the national death reporting process (this provides a check to ensure that all deaths have been reported appropriately). As an additional safeguard, the Mortality Review Group receives a monthly report of all deaths reported on Insight, the Trust's clinical record system. A sample of these deaths is cross-referenced with the data from Ulysses, to ensure deaths are being reported appropriately. In order to ensure that all relevant deaths are subject to appropriate investigation, the Mortality Review Group follows up each death until the group is satisfied that the following information has been established: ○ Cause of death ○ What services were involved with the individual at the time of death ○ Whether the death was expected or unexpected ○ Where the individual died ○ Who verified the death ○ Whether contact needs to be made with the family, to offer them an opportunity to ask any questions or raise concerns.	

	If the Mortality Review Group has concerns about the care provided, a 48-hour report may be requested from the relevant service, or the case may be submitted for a structured judgement review (SJR). Following completion of the 48-hour report or SJR, the death will either be signed off as warranting no further investigation, or it may be investigated further via the Trust's mortality review and/or incident management processes. The Mortality Review Group follows the NQB guidance on identifying "must do" mortality investigations (e.g., any death of a person with a learning disability, any death where a significant concern about the quality of care has been raised – please see NQB guidance for the full list, or the Trust's *Learning from Deaths* policy). **Identifying other patients whose care will be reviewed** Each month, the Mortality Review Group identifies a sample of deaths reported on Insight which do not meet any of the criteria for investigation. This sample of deaths is subject to an SJR, in order to identify learning for the Trust from deaths that would not otherwise meet the threshold for an in-depth review. **Evidence:** • SHSC (2022) *Policy – Learning from Deaths: The right thing to do (ratified 13 April 2022)* • SHSC (2022) Board of Directors Public Meeting Papers, Nov. 2022: *Mortality Q1 & Q2 Report 2022/23* • SHSC (2022) Board of Directors Public Meeting Papers, Jul. 2022: *Mortality Annual Report 2021/22*	
1.4 adopts a robust and **effective methodology for case record reviews** of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 4*

Comments:

The Trust utilises effective methodologies for case reviews of all selected deaths, all of which ensure that areas of concerns or lapses are identified. In all cases, the outcome of the review or investigation is documented.

Serious Incidents

The Trust follows the NHS England's Serious Incident Framework (March 2015). A Patient Safety Investigator is assigned to each Serious Incident to facilitate and support the investigation. The Trust's *Incident Management (Including Serious Incident)* policy describes the local Serious Incident investigation process, including how carers and family members are involved in investigations. The process is overseen by the weekly Investigations Panel and the final report is signed off by the relevant triumvirate, the Director of Quality, and the Executive Director of Nursing, Professions and Operations.

LeDeR

All deaths of people with a Learning Disability are referred to the LeDeR programme. LeDeR reviews are managed by the South Yorkshire Integrated Care Board and undertaken in line with national guidance.

Structured Judgement Reviews

The SHSC Structured Judgement Review template is based on the Better Tomorrow Structured Judgement Review methodology. Structured Judgement Reviews provide a structure which enables reviewers to make judgements about each aspect of care, in the form of written comments and a score for each element. Structured Judgement Reviews are used to identify learning points from individual cases. When the information is aggregated, they can also be used to identify themes and trends.

Other types of investigation

SHSC is in the process of implementing the Patient Safety Incident Response Framework (PSIRF), which will replace the National Serious Incident Framework. PSIRF encourages Trusts to use a range of methodologies to respond to patient safety incidents, including after action reviews, multidisciplinary team reviews, and patient safety incident investigations. In future, some deaths may be investigated under these methodologies.

	Evidence: • SHSC (2022) *Policy – Learning from Deaths: The right thing to do (ratified 13 April 2022)*	
1.5 ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 5*
	Comments: **Focus on system factors** Case record reviews are undertaken using Structured Judgement Review methodology using a standardised template. The Structured Judgement Review process focuses on the strengths and weaknesses of clinical processes, rather than individuals. The Trust's *Incident Management (Including Serious Incident)* Policy references the Just Culture methodology, which emphasises that problems with care or service delivery are most often the result of systems issues, rather than individual factors. In addition, the Trust has recently re-launched human factors/systems thinking training for investigators, which is accompanied by a training handbook. **Quality assurance process** The Trust has a robust system of quality assurance for all investigations. • LeDeR reports are overseen by the Integrated Care Board, which is responsible for quality assurance. • Structured Judgement Reviews are presented at the Mortality Review Group's weekly meeting, which is chaired by the Medical Director, for review and approval. • Serious Incident investigations are overseen by the weekly Investigation Panel. Completed investigation reports are approved by the Investigation Panel, the Trust's Director of Quality, and the Executive	

	Director of Nursing, Professions and Operations. Reports are also reviewed by the Trust's commissioners (the Integrated Care Board) prior to being closed on StEIS (the current national system for reporting and monitoring serious incident investigations). **Evidence:** • SHSC (2022) *Policy – Learning from Deaths: The right thing to do (ratified 13 April 2022)* • SHSC (2022) *Policy – Incident Management (Including Serious Incidents) Policy and Procedure (Issued January 2022)*	
1.6 ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised		
	☐ Standard met ☒ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 6*
	Comments: The Board receives quarterly and annual Mortality Review reports, as well as an annual LeDeR report. These reports include data on the number of deaths reported each quarter or year, with high-level analysis and summaries or examples of learning points. The reports periodically provide a breakdown of the number of mortality cases being managed through the Trust's mortality review and serious incident processes. The learning points from thematic reviews of deaths are also reported to the Board (e.g., a 2022 thematic review of deaths of service users accessing substance misuse services during the Covid-19 pandemic). The Board also receives the Integrated Performance and Quality Report (IPQR) on a bi-monthly basis, which includes data on open Serious Incidents (a proportion of which are deaths) and outstanding actions (which may relate to service user deaths). However, the Board is not routinely sighted on the detail of investigations or key issues arising from Serious Incidents and Structured Judgement Reviews, and there is only high-level reporting to the Quality Assurance	

	Committee. As a result, the Board has a limited ability to provide challenge. This was noted as an area of limited assurance in a recent self-assessment completed by SHSC leaders in response to the Ockenden Report.[1] As part of the Better Tomorrow agenda, the Trust is working towards putting in place systems to provide more detailed, data-driven reporting to the Board. The SJR process will be fully digitalised, which will allow learning to be fed directly into a dashboard. The learning from each SJR will be extracted and categorised thematically. **Evidence:** • SHSC (2022) Board of Directors Public Meeting Papers, Jul. 2022: *Ockenden Report and Paterson Review: SHSC Self-Assessment* • SHSC (2022) Board of Directors Public Meeting Papers, Sept. 2022: *Integrated Performance and Quality Report (IPQR) July 2022* • SHSC (2022) Board of Directors Public Meeting Papers, Jul. 2022: *Mortality Annual report 2021/22*[2]	
1.7 ensures that learning from reviews and investigations is **acted on** to sustainably change clinical and organisational practice and improve care, and **reported in annual Quality Accounts**		
	☐ Standard met ☒ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 7*
	Comments: **Actions arising from Structured Judgement Reviews** The Mortality Review Group is responsible for reviewing and approving and monitoring any required actions identified by a Structured Judgement Review. These are cascaded through the appropriate clinical or corporate management structures as appropriate.	

[1] The self-assessment noted: "*The Board are not fully sighted on the timeliness and key issues of serious [incident] investigations, the reporting to Quality [Assurance] Committee is high level*."

[2] See section 1.9.2 for details of the learning from deaths in the substance misuse services during the pandemic.

	Actions arising from Serious Incident Following the completion of a Serious Incident report, the investigation findings are reviewed by the relevant triumvirate, who are responsible for creating an action plan to address the root causes of the issues identified by the investigation. The action plan is reviewed and approved by the Director of Quality and the Executive Director of Nursing, Professions and Operations. Once the action plan is approved, actions are logged on Ulysses for monitoring until completion. The number and completion of Serious Incident actions is reported in the monthly IPQR report, along with how long they have been open for. **Creating sustainable change in response to lessons learned** Learning from mortality investigations is not always well-embedded across the Trust and within clinical teams. As noted above, action plans arising from Structured Judgement Reviews and Serious Incidents are identified, approved and monitored at senior team level, rather than by the teams who worked directly with the service user who died. However, there is no system in place to audit the embeddedness of actions following the closure of a serious incident action plan (as noted in the recent self-assessment completed by SHSC in response to the Ockenden Report). The implementation of PSIRF in 2023 will provide greater scope for clinical teams to engage in the investigation and action planning process. Learning and actions from Serious Incidents are not currently reported in the Trust's Quality Account, however the Trust will consider adding this to future Quality Accounts. **Evidence:** • SHSC (2022) *Policy – Learning from Deaths: The right thing to do* (ratified 13 April 2022) • SHSC (2022) *Quality Account 2021/22*	
1.8 shares relevant learning across the organisation and with other services where the insight gained could be useful		
	☐ Standard met ☒ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 8*

	Comments: The Trust has forums for sharing learning, including network (directorate) governance meetings, team meetings, the Learning Hub on Jarvis and Blue Light alerts (patient safety newsletters), however these do not reach reliably all members of staff. In 2023, the Trust will implement PSIRF, which will be an opportunity to review how the Trust shares learning from deaths and incidents. In addition, the Trust is reviewing and developing the process of sharing learning from Structured Judgement Reviews, by building the capacity to share completed reviews with clinical teams through the electronic system. **Evidence:** • SHSC (2022) Board of Directors Public Meeting Papers, Jul. 2022: Mortality Annual report 2021/22	
1.9 ensures sufficient numbers of **nominated staff have appropriate skills** through specialist training and protected time as part of their contracted hours to review and investigate deaths		
	☐ Standard met ☒ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 9*
	Comments: **Serious Incident investigations** The Trust has trained a number of patient safety investigators to facilitate and support Serious Incident investigators using the Root Cause Analysis (RCA) methodology, however there are insufficient numbers of trained investigators. Training for investigators has recently been re-launched and this is expected to improve over time. **Structured Judgement Reviews** In 2021/22, the SHSC Mortality team and the national Better Tomorrow team provided training for reviewers through an online masterclass. This allowed local teams to take on responsibility for their own SJR reviews and subsequent learning in a format that is relevant to them. Further training sessions have been delivered in early 2023.	

	Human Factors training / other training From late 2021, the Trust has provided Human Factors training to several cohorts of staff members. **Limitations** Although the Trust does have a training offer, there are currently insufficient numbers of trained investigators and structured judgement reviewers. In addition, the Trust does not offer protected time for staff to complete reviews and investigations (staff are expected to complete these within their contracted hours). **Evidence:** • SHSC (2022) Policy – *Incident Management (Including Serious Incidents) Policy and Procedure (Issued January 2022)*	
1.10 offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 10*
	Comments: When a service becomes aware that a service user has died, service staff will contact the family or carer and offer condolences. Details of this contact should be recorded on Insight, as well as on the Ulysses incident report that is generated for each death. All deaths reported on Ulysses are reviewed at the weekly Mortality Review Meeting. As part of this review, the group seeks to confirm that contact has been made with the family or carer. If this cannot be confirmed based on Insight and/or the Ulysses incident report, it will be followed up by the Patient Safety Specialist, to ensure an	

	appropriate person has contacted the family (in some cases, this could include a GP or the Coroner). In 2021/22 the Mortality team undertook 'Making Families Count' training to expand and enhance family liaison skills within the team. A Family Liaison Officer is also now in post. If a Serious Incident investigation is commissioned to review the death of a service user, the risk team will make a referral to the Trust's Family Liaison Officer, who will contact the family or carers to offer them an opportunity to ask any questions and inform them about the investigation process. As part of this initial contact, the Family Liaison Officer will inform the family/carers that the risk team will also be in contact with them. The nature and frequency of subsequent communications during the investigation will take into account the family or carer's needs and preferences. When the investigation has been finalised, the family or carer will be offered a meeting to discuss the report. **Evidence:** • SHSC (2022) *Policy – Learning from Deaths: The right thing to do* (ratified 13 April 2022) • SHSC (2022) Board of Directors Public Meeting Papers, Jul. 2022: *Mortality Annual report 2021/22*	
1.11 acknowledges that an **independent investigation** (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved		
	☐ Standard met ☒ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 11*
	Comments: The Trust's *Incident Management (Including Serious Incident)* Policy does not specifically outline the circumstances which would trigger an external investigation. However, the Trust has robust processes of review which would be able to identify when an independent investigation was needed. The Trust will consider adding more detail regarding this process to the next version of the policy.	

	Evidence: • SHSC (2022) Policy – *Learning from Deaths: The right thing to do* (ratified 13 April 2022) • SHSC (2022) Policy – *Incident Management (Including Serious Incidents) Policy and Procedure (Issued January 2022)*	
1.12 works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex A, point 12*
	Comments: Individual Serious Incident reports are submitted to the Trust's Commissioners for review prior to closure on StEIS and a Trust representative attends the ICB's Serious Incident closure panel. Trust representatives attend regular meetings with the commissioners to discuss any queries or concerns relating to investigations and present evidence following the completion of action plans. The Trust also works with Commissioners to review learning from deaths identified through the LeDeR process. In addition, the Trust's quarterly and annual mortality review papers are discussed with the Trust's Commissioners at the regular local quality interface meeting. **Evidence:** • SHSC (2022) *Policy – Incident Management (Including Serious Incidents) Policy and Procedure (Issued January 2022)*	

Organisational Questionnaire Part 2 – Policy

This organisational questionnaire is primarily based on the standards in Annex C of the National Guidance on Learning from Deaths, which specifies that Trusts should have a policy that sets out how they respond to deaths, and provides guidance on what the policy should include. Please see the Guidance/rationale column for the exact source.

Part 2: Policy		GUIDANCE / RATIONALE
The policy should include how providers:		
2.1 determine which patients are considered to be under their care and included for case record review if they die (it should also state which patients are specifically excluded)		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex C, point 1*
	Comments: The Trust's *Learning from Deaths* policy outlines which service users are considered to be under the Trust's care for the purpose of mortality reviews. Deceased service users are considered to have been under the Trust's care and potentially subject to a mortality case record review if they have an open episode of care or an open episode within the last 6 months, with the following exceptions. • For service users in the Memory Service, the death must have occurred within 6 months of contact with the service. • For drug and alcohol, acute hospital liaison, and care home liaison services, the lead provider is the GP. Deaths of service users in these groups are not subject to a mortality review. In addition to the above, if the Trust becomes aware that an act or omission on the part of SHSC may have contributed in any way to a service user's death, a mortality case record review may be undertaken.	

	Evidence: • SHSC (2022) *Policy – Learning from Deaths: The right thing to do (ratified 13 April 2022)*	
2.2 report the death within the organisation and to other organisations who may have an interest (including the deceased person's GP), including how they determine which other organisations should be informed		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex C, point 2*
	Comments: The Trust's Learning from Deaths policy provides clear guidance to staff on reporting deaths on Ulysses (the Trust's incident management system) within 24 hours of being informed. The Trust's Mortality Review Group cross-checks deaths reported on the National SPINE where the service user has an open episode of care against the Trust's internal records to ensure that all deaths are appropriately reported. When required, the Trust liaises with the GP, the Coroner, the medical examiner, the local commissioning group and the CQC to ensure deaths are reported appropriately to external organisations. The *Learning from Deaths* policy includes guidance regarding when deaths need to be communicated to the service user's GP, and which deaths require a report to the CQC. In addition, the *Incident Management (Including Serious Incidents) Policy* includes a table outlining when incidents (e.g., suicides) need to be reported externally and to which organisations. **Evidence:** • *SHSC (2022) Policy – Learning from Deaths: The right thing to do (ratified 13 April 2022)* • *SHSC (2022) Policy – Incident Management (Including Serious Incidents) Policy and Procedure (Issued January 2022)*	

2.3 respond to the death of an individual with a learning disability or mental health needs, an infant or child death and a stillbirth or maternal death and the provider's processes to support such deaths		
	☐ Standard met ☒ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex C, point 3*
	Comments: **Responding to the deaths of individuals with a learning disability** The Trust's Learning from Deaths policy outlines how the Trust engages with the LeDeR programme to review the deaths of all people with a learning disability (or autism), in order to identify learning and contribute to national work to identify common themes. **Responding to the deaths of individuals with mental health needs** The majority of the Trust's service users have mental health needs, which are routinely considered as part of the Trust's mortality review processes. **Responding to the death of an infant or child, a stillbirth, or a maternal death** The Trust would not be the lead provider for infants, children or women giving birth, however if any act or omission by a trust staff member was believed to have contributed to such a death, the Trust would undertake, or participate in, an appropriate review. The deaths of pregnant women would be reviewed through the Trust's normal processes (including the Daily Incident Safety Huddle and the Mortality Review Group meeting. The Trust responds to each death on a case-by-case basis, and any particular risk factors (e.g., pregnancy/recent birth) would be taken into account. The Trust's policies do not explicitly outline how it would respond to these categories of deaths. The Trust will consider including more detail about responding to these categories of deaths in the next version of the policy.	

	Evidence: • *SHSC (2022) Policy – Learning from Deaths: The right thing to do (ratified 13 April 2022)* • *SHSC (2022) Policy – Incident Management (Including Serious Incidents) Policy and Procedure (Issued January 2022)*	
2.4 review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past		
	☐ Standard met ☒ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex C, point 4*
	Evidence/comments: **Comments:** The Trust's *Learning from Deaths* policy specifies that the Trust will review the deaths of all patients where family members, carers, or staff have raised a concern, as well as any death in an area where people are not expected to die (as per the NQB guidance). In line with this guidance, the Trust would review the care provided to patient who was not under their care, but where an external provider suggests that the Trust should review past care (e.g., if an acute Trust highlighted a death where there were concerns about past care under SHSC). In addition, the Mortality Review Group deliberately reviews a sample of deaths of people who do not have an open episode of care at the time of their death. A small number of these are subject to a Structured Judgement Review, to identify learning. Although the Trust has appropriate processes in place, they are not explicitly outlined in the *Learning from Deaths* policy. The Trust will consider adding this into the next version of the policy. **Evidence:** • SHSC (2022) Policy – *Learning from Deaths: The right thing to do (ratified 13 April 2022)* • SHSC (2022) Board of Directors Public Meeting Papers, Jul. 2022: *Mortality Annual Report 2021/22* •	

2.5 review the care provided to patients whose death may have been expected, for example those receiving end of life care		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex C, point 5*
	Comments: The Trust's Learning from Deaths policy specifies that all deaths of service users with an open episode of care and those who had an open episode within the previous 6 months must be reported on Ulysses. All deaths reported on Ulysses are reviewed at the weekly Mortality Group Meeting and may be selected for case review, whether they were expected or unexpected. Deaths are selected for case review if the Mortality Review Group has a query about the service user's care or death (this may include queries about the quality of end-of-life care, for example). Reviews of expected deaths would usually take the form of Structured Judgment Reviews. **Evidence:** • SHSC (2022) Policy – *Learning from Deaths: The right thing to do (ratified 13 April 2022)* • SHSC (2022) Board of Directors Public Meeting Papers, Jul. 2022: *Mortality Annual Report 2021/22*	
2.6 record the outcome of their decision whether or not to review or investigate the death, which should have been informed by the views of bereaved families and carers		
	☐ Standard met ☒ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex C, point 6*
	Comments: The Trust's *Learning from Deaths* policy does not specify where or how the Trust should record the outcome of decisions regarding whether or not to investigate a death. In practice, the Daily Incident Safety Huddle and the Mortality Review Group meeting each keep their own records of decisions. If the Trust makes the decision to	

	investigate a death under the Serious Incident framework or conduct a case review (e.g., an SJR), this may be recorded on Ulysses, however the decision ***not*** to investigate is not recorded systematically. The Trust will consider adding more detail about how the outcome of decision-making is recorded on Trust systems to the next version of the policy. In addition, the Trust is currently undertaken an audit of the documentation of the LFD process which will provide additional assurance. **Evidence:** • SHSC (2022) Policy – *Learning from Deaths: The right thing to do (ratified 13 April 2022)*	
2.7 engage meaningfully and compassionately with bereaved families and carers - this should include informing the family/carers if the provider intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved. Initial contact with families/carers are often managed by the clinicians responsible for the care of the patient. Given that providers must offer families/carers the opportunity to express concerns about the care given to patients who have died, then the involvement of clinicians who cared for the patient may be considered a barrier to raising concerns. Providers should therefore offer other routes for doing this		
	☒ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☐ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex C, point 7*
	Comments: The Trust's *Learning from Deaths* policy outlines how staff should engage with family members following the death of a service user, to offer condolences, support and give appropriate information about being involved in any reviews of care (if relevant). Additionally, the *Incident Management (Including Serious Incident)* policy specifies that if a Serious Incident investigation is commissioned to review the death of a service user, the investigation team will contact the family or carer and provide initial support. The nature and frequency of communications during the investigation will take into account the family or carer's needs and preferences. When the investigation has been finalised, the family or carer will be offered a meeting to discuss the report.	

	The Trust has developed a local Duty of Candour training package which is mandatory for all staff members and provides guidance on engaging with families and carers following incidents that meet the threshold for Duty of Candour (including death incidents). The Trust does not routinely involve families in Structured Judgement Reviews, in line with national practice. **Evidence:** • SHSC (2022) *Policy – Learning from Deaths: The right thing to do* (ratified 13 April 2022) • SHSC (2022) Policy – *Incident Management (Including Serious Incidents) Policy and Procedure (Issued January 2022)*	
2.8 offer guidance, where appropriate, on obtaining legal advice for families, carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by providers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates.		
	☐ Standard met ☐ Standard partially met (please explain in comments) ☐ Evaluation needed to determine if standard is being met ☐ Standard not met ☒ Standard not relevant to SHSC	*National Guidance on Learning from Deaths – Annex C, point 8*
	Comments: The Trust's *Incident Management (Including Serious Incident)* Policy specifies that as part of the response to incidents (including deaths), managers consider the actions that may be required to protect the wellbeing of staff involved. This may involve legal advice, as well as other sources of support (e.g., human resources, occupational health, or the workplace wellbeing service). In addition, many staff have access to legal support through their union. The Trust does not routinely signpost families and carers to legal advice. If the family or carer was not satisfied with the trust's response to a service user's death, this would initially be dealt with via the complaints route. If the family remained unsatisfied after the second complaint response, the Trust would signpost them to the Parliamentary and Health Service Ombudsman.	

Appendix 2

Learning from Deaths audit part 3: Case-note audit

Version 2 – 29/01/2024

Prepared by the SHSC Clinical Effectiveness Team in November 2023 and updated in January 2024 following discussion at the *Research, Innovation, Effectiveness, and Improvement Group* (RIEIG) in November 2023

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Introduction

Background

The national Learning from Deaths (LFD) programme is a key element of the Trust's patient safety agenda and can be an important source of learning and improvement.

In the 2022-23 financial year, an audit of the Trust's LFD process was commissioned as part of the annual Clinical Audit Programme. The audit has been undertaken in three parts:

> **Part 1:** A desktop review of the 'Leadership and culture' standards in the National Quality Board Guidance on Learning from Deaths (reported in March 2023)
>
> **Part 2:** A desktop review of the 'Policy' standards in the National Quality Board Guidance on Learning from Deaths (reported in March 2023)
>
> **Part 3:** Case-note audit of deaths recorded on Ulysses (reported here)

Part 3 of the audit (reported here) involved reviewing information about individual deaths recorded on Ulysses, the Trust's incident reporting and learning system, to determine if the documentation on Ulysses could provide assurance that death incidents are being managed according to the SHSC Learning from Deaths policy and the National Quality Board (NQB) Guidance.

About the Trust's Mortality Review Process at the time of the audit[1]

All deaths reported on Ulysses, the Trust's incident management system, are discussed at the weekly Mortality Review Group (MRG).

The MRG review process may be concluded following the first discussion at the MRG if the death is adequately understood and there are no concerns that require further investigation. 'Adequately understood' means that key information has been established, including the cause of death, which services were involved with the service user, where the individual died, and whether contact was made with the family and/or carer.

If it is clear at the time of the first discussion at MRG that a death requires a full investigation, the Chair may commission a Serious Incident report, which is conducted in line with NHS England's *Serious Incident Framework*.
If more information is needed before a case can be concluded at MRG (e.g., if cause of death is not yet confirmed), it is marked for 'Follow up', which may involve discussion at future MRG meetings, or being placed on a 'Watching brief' list pending the outcome of a coronial or police investigation. All such cases must be discussed again at MRG in order to agree that the relevant information has been obtained and the review process can be concluded.

At any point in this information gathering process, a decision may be made that a Serious Incident or Structured Judgement Review needs to be commissioned. Cases are concluded when they are adequately understood, or when the investigation has been completed and a

[1] Note: This audit was undertaken prior to the national implementation of the *Patient Safety Incident Response Framework (PSIRF)* in September 2023. The PSIRF replaces the Serious Incident Framework, which was issued by NHS England in 2015.

plan for disseminating any learning points has been agreed. Decisions of the MRG are recorded on Ulysses.

All deaths of people with a learning disability and/or autism are reviewed via the Learning Disabilities Mortality Review programme (LeDeR), which is managed by the South Yorkshire & Bassetlaw Integrated Care System. The outcomes of LeDeR reviews are fed back to the MRG, which in turn communicates any learning points to the SHSC Learning Disabilities team for dissemination within the service.

Contact with families and bereavement support

When a service user dies, staff from the relevant service are responsible for contacting the family/carer to offer condolences and provide contact details for the Trust. Details of the contact should be recorded on Insight and where possible on the Ulysses incident form. The Trust's family liaison officer may also make contact with families to offer support, make further enquiries, or explain Trust processes. However, in some circumstances, it may not be necessary for anyone from the Trust to contact the family/carer, for example if the coroner has already contacted the family/carer and additional contact from SHSC would not be expected or required. In all cases, who contacted the family/carer should be documented on Ulysses.

Audit aims

The audit had two aims:

1. To supplement the desktop audits undertaken in March 2023, which focused on SHSC policies and practices (rather than individual records). In particular, the audit aimed to provide additional assurance with regards to National Quality Board standard 2.6: *"The [Trust's LFD] policy should include how providers record the outcome of their decision whether or not to review or investigate the death, which should have been informed by the views of bereaved families and carers*".

2. To explore the usefulness and feasibility of a case-note audit of Learning from Deaths records.

Audit standards

As no existing audit tool was available, practical audit standards had to be developed, based on local and national guidance, and what was feasible using the available data. This work was undertaken by a Clinical Effectiveness Facilitator. As such, this audit should be considered an exploratory investigation, which could be refined and built on in future years in collaboration with the Mortality Review Group and the Risk Team.

The following standards were used for the audit:

Audit standard	Reference / source of standard
When a service becomes aware that a patient has died, staff contact the family/carer and offer condolences and contact details. Details of this contact are recorded on Insight.	SHSC Learning from Deaths policy (V4 March 2022), p. 1, p. 8 & p. 17
All deaths reported on Ulysses are discussed at the Mortality Review Group (MRG) and this is documented on Ulysses.	SHSC Learning from Deaths policy (V4 March 2022), p. 1, p. 9, and p. 11
The outcome of the decision to review or not to review the death is recorded on Ulysses.	National Quality Board LFD standard 2.6
The MRG review process is only concluded without follow-up or further investigation if the death is adequately understood and there are no concerns. This is documented on Ulysses.	SHSC Learning from Deaths policy (V4 March 2022), p. 12 National Quality Board LFD standard 2.6
All deaths of service users with a learning disability and/or autism are reviewed through the LeDeR process and followed up as appropriate. This is recorded on Ulysses.	SHSC Learning from Deaths policy (V4 March 2022), p. 12 National Quality Board LFD standard 2.6

Methodology

The SHSC Risk team provided a spreadsheet listing all service user deaths between March and August 2022. The first 100 deaths reported on Ulysses during this period were included in the audit, excluding any cases which did not have Insight numbers (these were generally service users who had been under the care of the long-term neurological conditions service).

The information on the spreadsheet provided by the Risk team included:

- Incident number
- Insight number
- Date reported on Ulysses
- Details of Ulysses incident
- Cause of death (without information about when this information was entered on Ulysses)
- Details of the first MRG review, including date discussed, information acquired, and outcome
- Details of follow-up at MRG, including the date it was decided follow-up was required ('date placed in follow-up'), the reason for follow-up, the outcome of this follow-up, and the date the case was concluded at MRG
- Details of cases placed on the MRG watching brief (used for cases that could not be concluded, pending the outcome of an inquest)
- Details of cases investigated through the Serious Incident, Structured Judgement Review, and LeDeR processes, including date the investigation/review was commissioned, the outcome/status of the investigation, and the date the case was concluded at MRG

The dataset was supplemented by additional information from Insight, particularly regarding family contact.

Data analysis was undertaken in Microsoft Excel.

Audit sample characteristics

Please see p. 18 for information about the demographics of the audit sample (and other statistical information not directly relevant to the audit standards).

Summary of results

	Audit standard	Relevance (denominator)	Percentage of relevant cases meeting standing
1	When a service becomes aware that a patient has died, staff contact the family/carer and offer condolences and contact details. Details of this contact are recorded on Insight.	Service users with at least one open SHSC episode, where the death is reported on Ulysses within one month. n = 72	32%
2	All deaths reported on Ulysses are discussed at the Mortality Review Group (MRG) and this is documented on Ulysses.	All n = 100	100%
3	The outcome of the decision to review or not to review the death is recorded on Ulysses.	All n = 100	100%
4	The MRG review process is only concluded without follow-up or further investigation if the death is adequately understood and there are no concerns. This is documented on Ulysses.	All deaths concluded at the first MRG, without any further follow-up or investigation. n = 13	92%
5	All deaths of service users with a learning disability and/or autism are reviewed through the LeDeR process. This is recorded on Ulysses.	All deaths where the service user had a learning disability and/or autism n = 10	100%

Limitations and caveats

- The audit was developed and undertaken by a Clinical Effectiveness Facilitator, based on Ulysses data provided by the Risk team and information recorded on Insight. The Clinical Effectiveness Facilitator had access to data downloaded from Ulysses, but not to the Ulysses system itself. One advantage of this approach is that it provides an outsider's perspective on the LFD process and associated record keeping. However, it also means there is a risk of information being misinterpreted or read without the benefit of additional sources of information available to the Risk team (e.g., knowledge of custom and practice within the team, or records held outside of Ulysses and Insight).

- Some data used in the audit was collected manually from Insight by the Clinical Effectiveness Facilitator, who is a non-clinical member of staff (e.g., documentation of family contact following a death, autism/learning disability diagnosis). As a result, there is a risk that relevant information may have been missed.

- The data provided by the Risk team was a snapshot of Ulysses at a particular point in time. Ulysses is a live system which is updated as incidents move through the incident management process and new information is obtained. As such, it was not always possible to know if certain information was available at the time a case was discussed at MRG. In light of this, information has been interpreted cautiously and sometimes cross-checked against Insight, however it would be useful to work with the Risk team to improve the audit methodology.

- As noted above, the audit standards are based on what was feasible given the available data and the knowledge of the person undertaking the audit. The audit cannot provide full assurance that the Trust is meeting the relevant national and local standards. For example:
    - The audit does not provide assurance that the Trust is undertaken all 'must do' investigations specified by the National Quality Board (e.g., deaths in a service where an alarm has been raised – this information was not available as part of the audit).
    - The audit provides limited assurance about the quality of the follow-up and reviews of service user deaths, as it is focused on the process. This audit cannot provide assurance that the decisions made by MRG were correct.
    - Due to the volume of cases reviewed by the MRG, documentation on Ulysses is sometimes brief and does not capture the full discussion of each case. As a result, an audit of documentation using data from Ulysses and Insight was not able to assess every aspect of the MRG process outlined in the Trust's policy. Additional quality assurance mechanisms could be useful, such as occasionally including an observer in MRG meetings to provide feedback.

Summary of recommendations

- **Standard 1:** The importance of documenting contact with families following a death (or the reason that families were not contacted) could be emphasised in staff training.

- The MRG may wish to consider routinely adding a comment regarding family/carer contact on Ulysses, following the first discussion at MRG.

- **Standards 2 and 3:** The MRG may wish to standardise how the rationale for closing cases is recorded on Ulysses (e.g., consistently using a formula such as "*Cause of death […]. [Rationale for closure], therefore no investigation required. LD/autism pathway checked, nothing to suggest a diagnosis*.")

- **Standard 4:** When cases are closed at the first MRG meeting, there should be a clear rationale documented on Ulysses.

- **Standard 5:** The MRG could consider standardising documentation of how learning from LeDeR reviews is shared with the LD team (and other relevant teams).

Four of the five above recommendations relate to standardising how MRG discussions and decisions are recorded on Ulysses. Considering this, it may be useful to develop a short guide/template/SOP to support MRG documentation, which could be used by the MRG and the administrative staff who support the group's work.

In addition, the auditor makes three further recommendations:

- The Risk Team and Patient Safety Specialist could consider working with the Clinical Effectiveness Team to develop an audit process which could be run annually, using this audit as a starting point.
- The MRG could consider additional quality assurance processes in addition to audit, such as including an observer in the meetings on a quarterly basis, to provide additional scrutiny and feedback.
- Cases recorded on Ulysses without Insight numbers could not be included in this audit. The MRG may wish to undertake a separate review of mortality processes for SHSC services which do not use Insight or Rio.

Results

Standard 1: When a service becomes aware that a patient has died, staff contact the family/carer and offer condolences and contact details. Details of this contact are recorded on Insight.

For the purpose of the audit, this standard was considered to apply to all service users who had at least one open episode with SHSC at the time of death, and where the death was reported on Ulysses within one month of the date of death.

There were 72 deaths in the audit sample which met those criteria. Of these, 23 (or 32%) had documented contact with the family/carer on Insight, and were considered to have met the standard.

	Contact with family documented on Insight (n)	Contact with family documented on Insight (%)
Yes	23	32%
No	49	68%
Total	72	100%

Possible explanations for the lack of documented contact with families/carers

Of the 49 deaths where this standard was relevant and there was no documented contact with the family on Insight:

- 14 out of 49 were open only to the Liaison Psychology team, who may have had minimal contact with the service user and their family/carer (e.g., assessing an end-of-life patient for delirium).
- 25 out of 49 died in an acute hospital or non-SHSC care home (in many cases it may be appropriate for these organisations to take the lead in liaising with the family/carer and providing bereavement support).

Staff sometimes documented a reason why the family/carer could not be contacted, for example:

- The service user had no known next of kin
- A phone call was attempted but was not answered
- An episode of care had been opened following a referral, but the service user had not yet been seen

In other cases, there was no reason noted for the lack of documented contact with the family/carer. The audit did not attempt to determine if not contacting the family/carer was appropriate, as it would depend on the specific circumstances and the nature of the service's relationship with the service user.

Standard 1: Conclusion and recommendation

The standard was met for 32% of cases where it was relevant. However, in a number of cases where the standard was not met, there was a reason why the family was not contacted (although this was only rarely documented on Insight).

Contacting families and carers (when appropriate) is important, both because it is the right thing to do and because it provides an opportunity for families to ask questions or raise

concerns regarding care, which is in line with the NQB's standards and the new Patient Safety Incident Framework (PSIRF).

Recommendations for consideration:

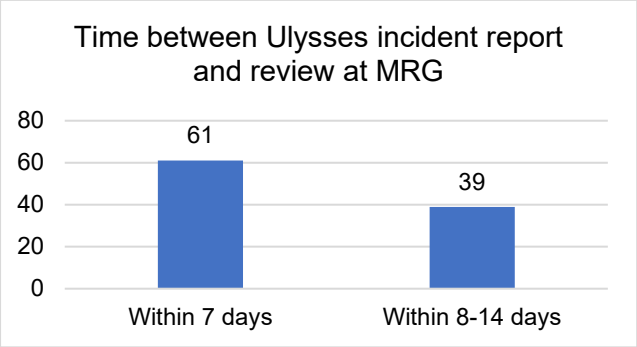
- The importance of documenting contact with families following a death (or the reason that families were not contacted) could be emphasised in staff training.
- The MRG may wish to consider routinely adding a comment regarding family/carer contact on Ulysses, following the first discussion at MRG.

Standard 2: All deaths reported on Ulysses are discussed at the Mortality Review Group (MRG) and this is documented on Ulysses, *and*

Standard 3: The outcome of the decision to review or not to review the death is recorded on Ulysses.

Standards 2 and 3 were relevant to all 100 deaths included in the audit sample.

In all 100 cases, the death was discussed at the Mortality Review Group within 14 days, with the majority of cases (61 out of 100) being discussed within 7 days. As the MRG meets weekly, this means that no case discussion was delayed by more than one meeting.



Time between Ulysses incident report and review at MRG	Number
Within 7 days	61
Within 8-14 days	39
Total	100

In all 100 cases, the decision whether or not to commission a case review was recorded on Ulysses in the 'Outcome' field, where the potential options are "No further action", "Follow Up/Further Info Require[d]", or one of the specific types of investigations (e.g., Serious Incident, Structure Judgement Review).

The diagram on p. 12 shows the final outcome of the MRG review process for each case. It is important to note that case reviews may be commissioned the first time a case is discussed at the MRG or following a period of information gathering during which cases are placed on the 'watching brief' list. Cases may also move between these categories.

There was significant variation in how the free-text rationale for MRG decisions regarding concluding a case at the various stages in the review process were documented on Ulysses in the 'Info acquired' field.

For example, in some cases an explicit reason was given, e.g., "*This is a natural causes death so no investigation required. Cause of death noted as 1a) Dementia*". In some cases (but not all), there was also an additional note such as "*LD/Autism pathway checked. Nothing noted that would suggest a diagnosis*" (indicating a LeDeR review was not required). In contrast, the documentation in other cases was minimal, e.g., "*Alcohol, hepatitis & liver disease*" with no further explanation.

Standards 2 and 3: Conclusions and recommendations

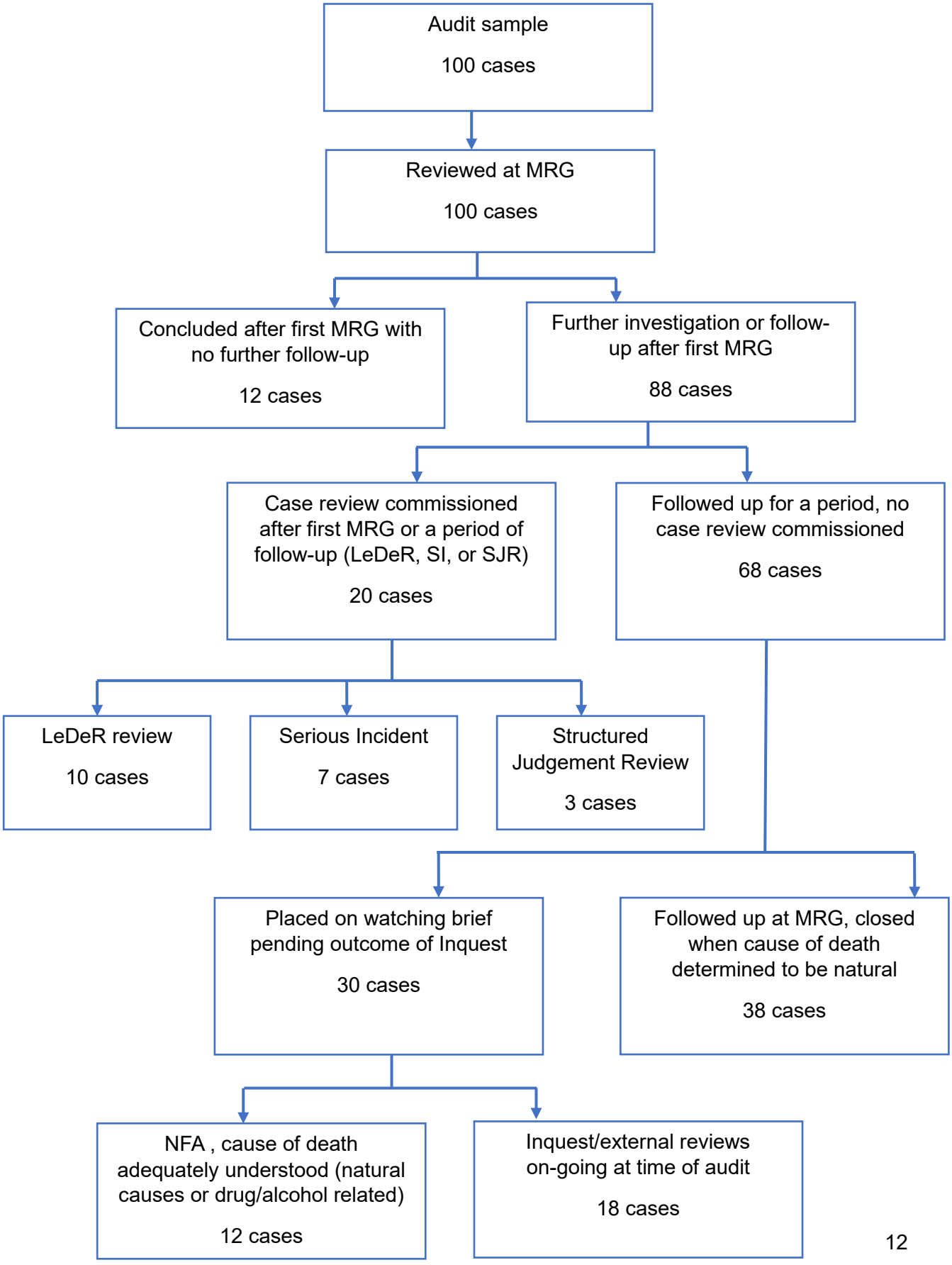
All cases included in the audit sample (100%) met standards 2 and 3. However, there is potential to improve how the rationale for decisions is recorded on Ulysses.

Recommendations for consideration:

- The MRG may wish to standardise how the rationale for closing cases is recorded on Ulysses (e.g., consistently using a formula such as "*Cause of death […]. [Rationale for closure], therefore no investigation required. LD/autism pathway checked, nothing to suggest a diagnosis*.")

MRG decision outcomes as recorded on Ulysses

This diagram shows the final outcome of the MRG process for all cases in the audit. The exact pathway through the MRG process can be variable (e.g., one case was initially concluded at the first MRG meeting, but was later re-opened for a LeDeR review).



Standard 4: Reviews of deaths are only concluded without follow-up or further investigation if the death is adequately understood and there are no concerns. This is documented on Ulysses.

Standard 4 was assessed by reviewing those deaths which were concluded following the first MRG meeting, with no further follow-up or case review (12 cases). All other cases in the audit sample went through a process of gathering further information and/or investigation before being concluded.

Standard 4 has been assessed in two ways:

a) Was the rationale for concluding the case documented in Ulysses following the first MRG meeting?

b) Regardless of whether the rationale for concluding the case was documented, is it clear from the documentation on Insight and Ulysses that no further follow-up was required?

a) Was the rationale for concluding the case documented in Ulysses following the MRG meeting?

Out of the 100 cases included in the audit sample, there were 13 cases where the outcome of the first MRG was 'No further action' or 'Completed'. In one case, this was either documented in error or the decision was reversed, as a LeDeR review was later commissioned. As it was not possible to tell which from the audit data, this case has been excluded from the analysis, however it highlights the benefits of systematically checking whether service users were on an autism or learning disability pathway and documenting this on Ulysses.

Of the 12 cases which were concluded at the first MRG meeting and not subject to any further review, 6 had a clear rationale for concluding the case documented in the 'Info acquired' field on Ulysses, including the service user's cause of death and a note confirming the death was 'adequately understood'. For the remaining 6 cases (including the case which later became a LeDeR review), the field was blank and there was no further information on Ulysses.

Using this criterion, the standard was met for 6 out of 12 cases (50%).

b) Regardless of whether the rationale for concluding the case was documented, is it clear from the totality of the documentation on Insight and Ulysses that no further follow-up was required?

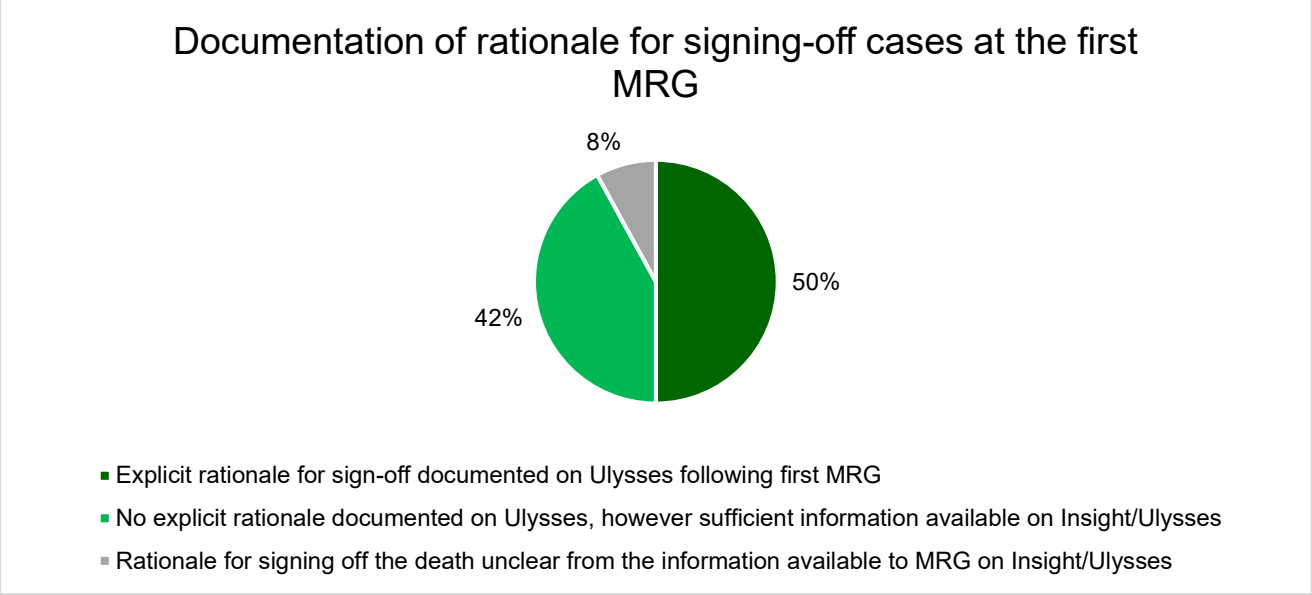
Although the explicit rationale for concluding the case at the first MRG meeting was only documented in around half of the cases, it appears that there was sufficient information documented on Insight and/or Ulysses to justify concluding the case in at least five of the six cases.

- 3 service users were open to only Liaison Psychiatry at the time of death and died of a physical illness while in hospital or under the care of an acute Trust. In all 3 cases, the cause of death was documented on Insight prior to the MRG meeting.

- In two cases, SHSC became aware of the deaths following police enquiries regarding individuals found dead outside of care settings (i.e., at home or in public spaces). In both cases, they had not been open to any SHSC service in several years.

- In one case, there was minimal information recorded on the initial Ulysses incident report or Insight (no cause of death or place of death). However, the individual appears to have been under the care of the Long Term Neurological Conditions service, so it is likely that information was available on SystmOne and/or ICE. [2] A (natural) cause of death is recorded on Ulysses, however it is not clear what the source of this information is, or when it became known (please see footnote for further information which became available following the audit).

Using both criteria together, the standard was met for 11 out of 12 cases (92%).



Standard 4: Conclusions and recommendations

Of the 12 cases which were concluded at the first MRG meeting without any further follow-up or review, 6 had a clear rationale for concluding the case documented on Ulysses. However, looking at the totality of the available information, it is clear that there was sufficient information on Insight and/or Ulysses to justify concluding the case in at least 11 cases.

Recommendations for consideration:

- When cases are closed at the first MRG meeting, there should be a clear rationale documented on Ulysses.

Standard 5: All deaths of service users with a learning disability and/or autism are reviewed through the LeDeR process and followed up as appropriate. This is recorded on Ulysses.

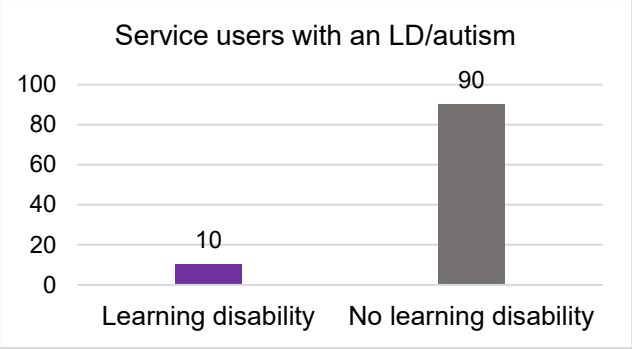
[2] Following discussion of this report at the *Research, Innovation, Effectiveness and Improvement Group* (RIEIG) in November 2023, the Trust's Patient Safety Specialist made enquiries regarding this death with the Long Term Neurological Conditions (LTNC) Service. The service user was admitted to hospital and died shortly after a referral was made to LTNC, which explains why the case was concluded without further review. Although there are no concerns about this death requiring further review, this case highlights the importance of recording relevant information on Ulysses so that there is clear documentation to explain why a mortality case has been concluded.

Learning disability/autism cases in the sample

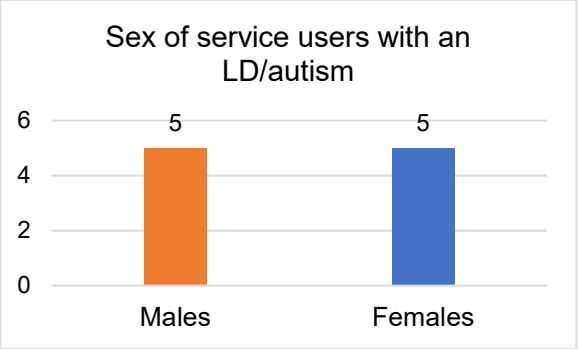
Out of the 100 cases included in the audit, 10 service users were noted to have a learning disability and/or autism. Service users with a learning/disability or autism were identified by the fact that they had an open or recent episode with the learning disability service at the time of death, or there was mention of a learning disability or autism on Insight and/or Ulysses. It is possible that some people's diagnoses were missed in the audit.

Of the 10 service users with a learning disability and/or autism in the audit sample, 50% were male and 50% were female. One had their ethnicity recorded as 'Asian other', the other nine were 'White British'.

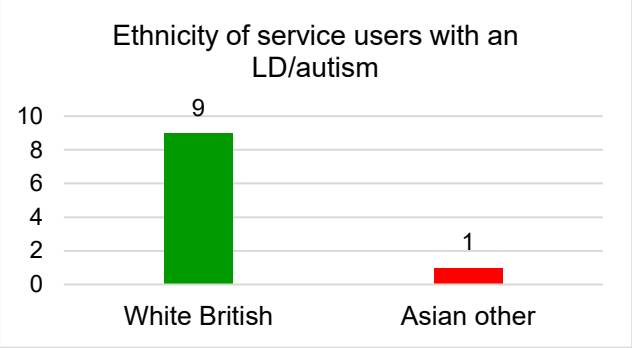
Seven were reported on Ulysses as expected deaths, and three were reported as unexpected deaths (including one inpatient/residential).



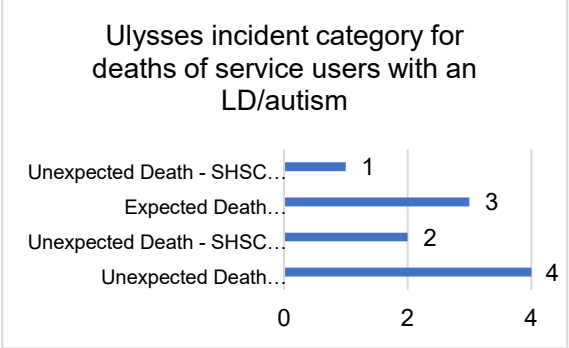
	Number
LD and/or autism	10
No LD and/or autism	90
Total	100



	Number
Males	5
Females	5
Total	10



	Number
White British	9
Asian other	1
Total	10



	Number
Unexpected Death (Suspected Natural Causes)	4
Unexpected Death - SHSC Community	2
Expected Death (Information Only)	3
Unexpected Death - SHSC Inpatient/Residential	1
Total	10

Review of learning disability and/or autism cases in the sample under the LeDeR process

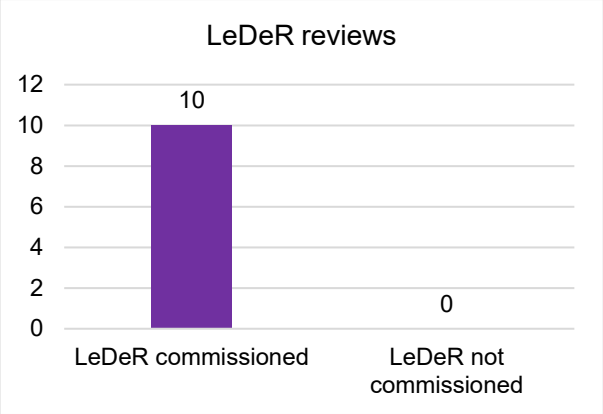
All 10 deaths of service users with a learning disability and/or autism were investigated through the LeDeR process.

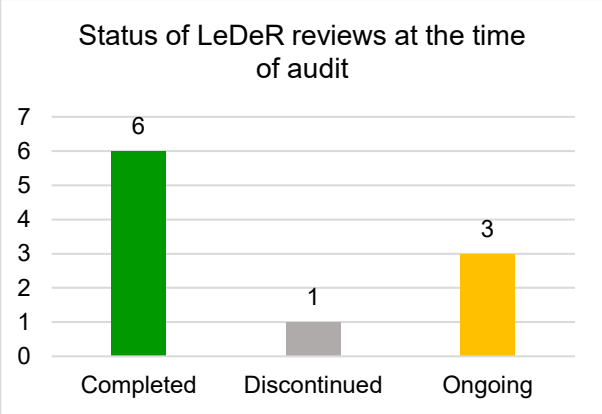
At the time of the audit, six of the LeDeR reviews had been completed and concluded at MRG. One was discontinued because the family opted out of the record sharing required to enable the review. Three remained on-going.

In two of the six cases where the LeDeR review was completed, at least one learning point was identified for SHSC.

In five out of the six cases where the LeDeR review was completed, there was documentation on Ulysses that the review had been shared (or would be shared) with relevant people in the learning disabilities team. In the single case where this was missing, there were no follow-up actions identified for SHSC. It is likely that the review was shared, but that this was not documented.

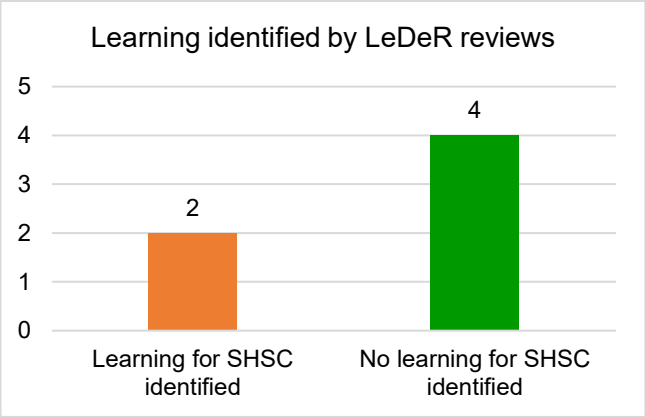
Standard 5 was met for all deaths involving service users with a learning disability and/or autism.

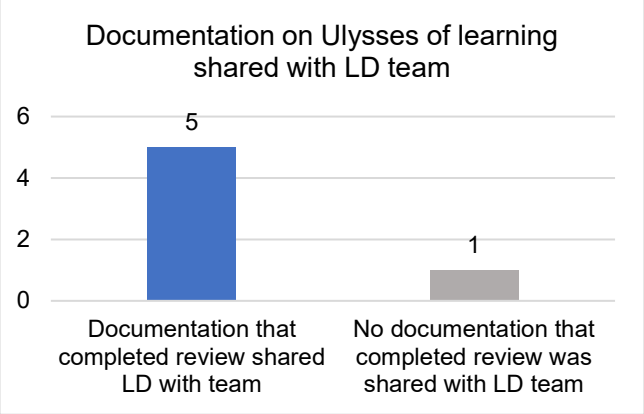




	LeDeR review
LeDeR commissioned	10
LeDeR not commissioned	0
Total	10

	LeDeR review
Completed	6
Discontinued	1
Ongoing	3
Total	10





	LeDeR review
Learning for SHSC identified	2
No learning for SHSC identified	4
Total	10

	LeDeR review
Documentation that completed review shared with LD team	5
No documentation that completed review was shared with LD team	6
Total	6

Standard 5: Conclusions and recommendations

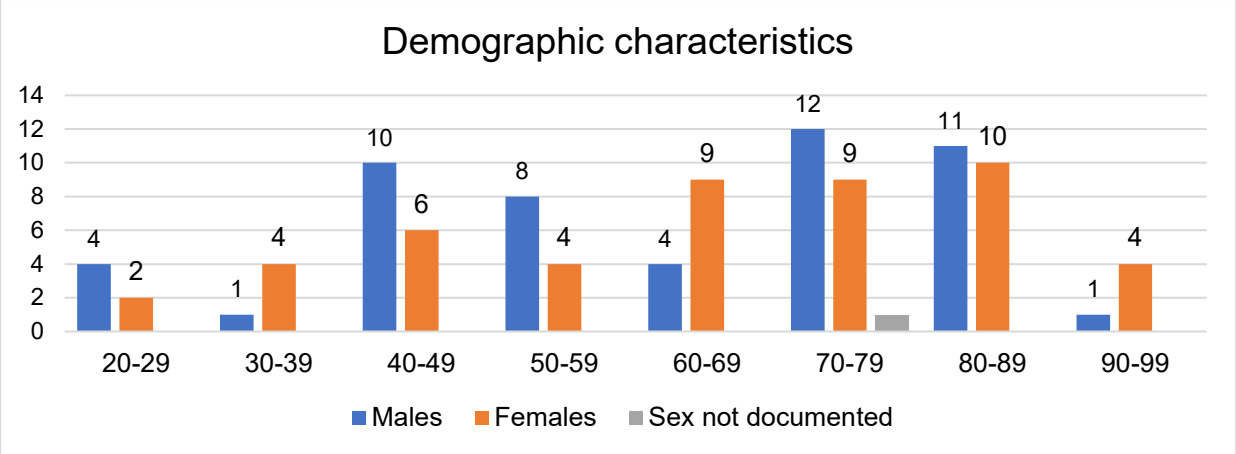
All 10 deaths of service users with a learning disability and/or autism were investigated through the LeDeR process. However, there was not always consistent documentation of how the learning was shared with the LD team.

Recommendations for consideration:

- The MRG could consider standardising documentation of how learning from LeDeR reviews is shared with the LD team (and other relevant teams).

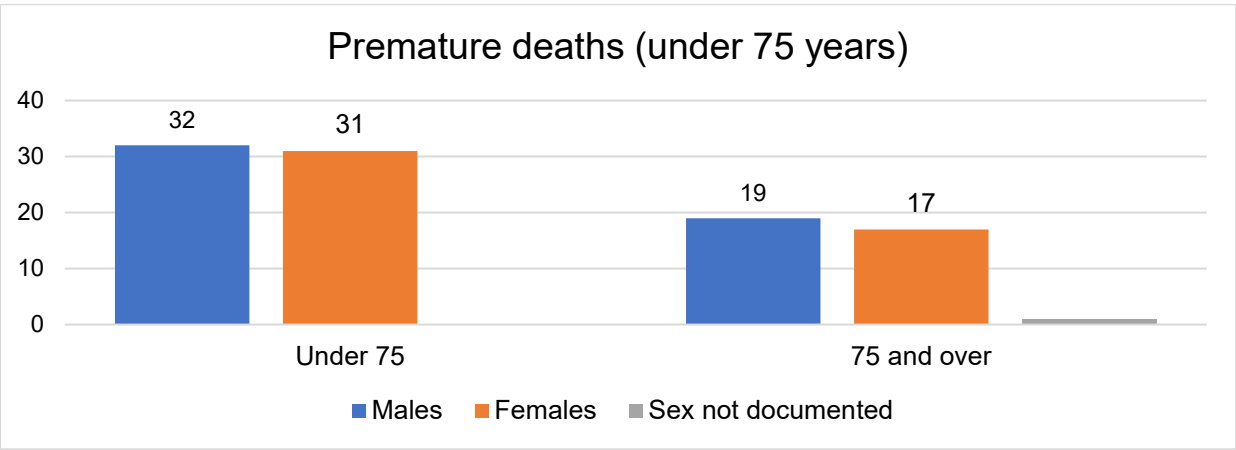
Appendix: Audit sample demographics and key information

Demographic characteristics



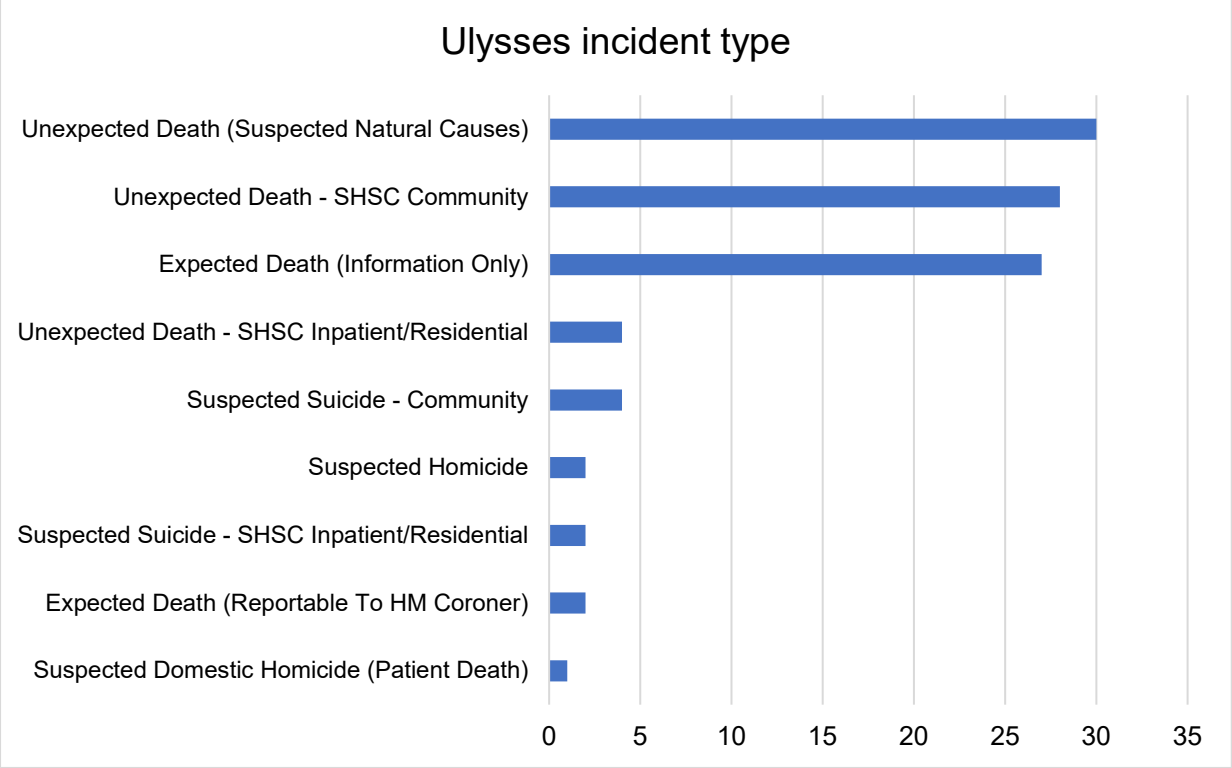
Age range	Males	Females	Sex not documented	Total
20-29	4	2	0	6
30-39	1	4	0	5
40-49	10	6	0	16
50-59	8	4	0	12
60-69	4	9	0	13
70-79	12	9	1	22
80-89	11	10	0	21
90-99	1	4	0	5
Total	51	48	1	100

Premature deaths



Age range	Males	Females	Sex not documented	Total
Under 75	32	31	0	63
75 and over	19	17	1	37
Total	51	48	1	100

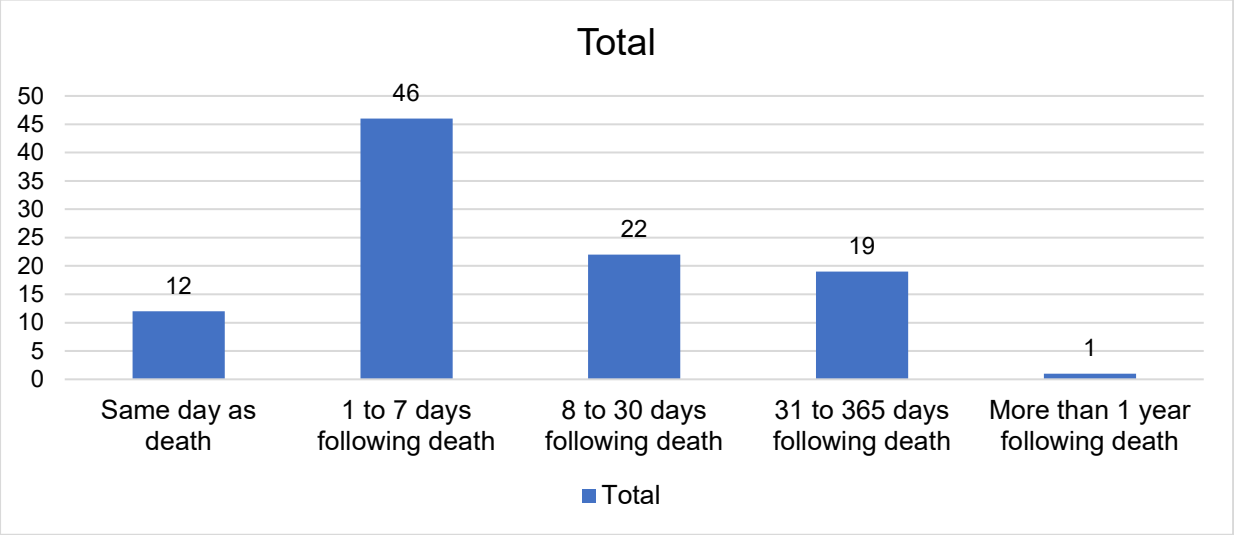
Ulysses incident type



Incident type	Number
Unexpected Death (Suspected Natural Causes)	30
Unexpected Death - SHSC Community	28
Expected Death (Information Only)	27
Suspected Suicide - Community	4
Unexpected Death - SHSC Inpatient/Residential	4
Expected Death (Reportable To HM Coroner)	2
Suspected Suicide - SHSC Inpatient/Residential	2
Suspected Homicide	2
Suspected Domestic Homicide (Patient Death)	1
Total	100

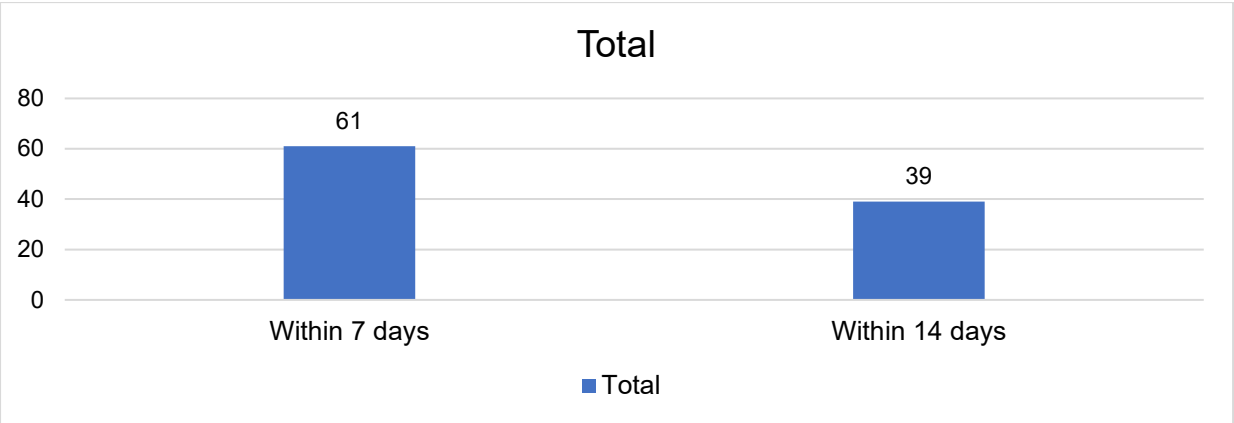
Process timeframes

Time between death and Ulysses incident report



Time between death an Ulysses report	Number
Same day as death	12
1 to 7 days following death	46
8 to 30 days following death	22
31 to 365 days following death	19
More than 1 year following death	1
Total	100

Time between Ulysses incident report and first review at the Mortality Review Group



Incident type	Number
Within 7 days	61
Within 14 days	39
Total	100

References

- National Quality Board, *Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (1st edition, March 2017)* (https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf)
- SHSC, *Policy MD002: Learning from deaths – the right thing to do, V4 March 2022* (https://jarvis.shsc.nhs.uk/documents/learning-deaths-policy-md-002-v4-march-2022-extension-review-date-april-2024)
- NHS England, *Serious Incident Framework: Supporting learning to prevent recurrence* (2015) (https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf)
- NHS England, *Patient Safety Incident Response Framework* (Version 1, August 2022) (https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-1.-PSIRF-v1-FINAL.pdf)

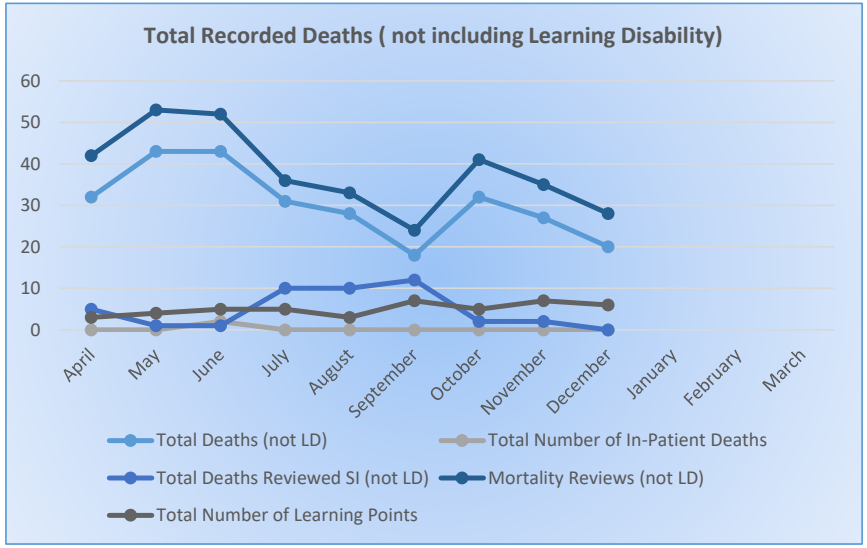
Appendix 3- Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 2(July to September 2022)

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
118	**2**	**7**	**147**	**12**
Q2	Q2	Q2	Q2	Q2
77	**0**	**32**	**93**	**15**
Q3	Q3	Q3	Q3	Q3
79	**0**	**4**	**104**	**18**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
274	**2**	**43**	**344**	**45**



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**	**4**
Q2	Q2	Q2	Q2	Q2
3	**0**	**3**	**3**	**9**
Q3	Q3	Q3	Q3	Q3
9	**0**	**9**	**9**	**11**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
24	**0**	**24**	**24**	**24**