Board of Directors - Public

SUMMARY REPORT	Meeting Date:	22 May 2024
	Agenda Item:	18

Report Title:	**Mortality – Quarterly Report: Quarter 4 2023/24**	
Author(s):	Adele Eckhardt	
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**	QAC
	Date:	09/05/2024
Key points/ recommendations from those meetings	No changes require following receipt at Quality Assurance Committee in May 2024.	

Summary of key points in report

A range of learning points in relation to mortality linked investigations were identified during quarter 4 2023/24 including:

- All of the deaths reported by SHSC staff in quarter 4 are in relation to people living in community settings. The majority are older people with a diagnosis of dementia and conditions related to older age. The most common cause of death is natural causes (Frailty of Old Age).
- In Q4 there were no SHSC acute inpatient deaths or residential care deaths reported.
- There continue to be learning opportunities in relation to unexpected deaths in the community linked to ongoing improvement actions for communication, documentation and reducing waiting times.
- Learning from SJR's highlights that waiting times impacted on patients across services that include older adult, gender identity and autism assessment. There is also a continued theme of complex comorbid physical health and mental health issues that require expert support across a range of professionals.
- All of the learning and action points shared by the ICB are managed directly by the Community Learning Disability Team.
- The recently published annual LeDeR report highlights that there is still work to be done to ensure equality and parity of esteem for those with a learning disability and/or autism, although there is evidence of much needed progress in improving cancer awareness, constipation and circulatory conditions.

SHSC reviewed 100% of all reported deaths during quarter 4 of 2023/24 and a sample of deaths for people who had died within 6 months of a closed episode of care.

SHSC is compliant with the 2017 National Quality Board (NQB) standards for learning from deaths.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval		Assurance	X	Information	

It is recommended that the Board of Directors 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 Q4

Section 1: Analysis and supporting detail

Background

1.1 The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people.

1.2 Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities.

1.3 The findings of the Care Quality Commission (CQC) report "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England", found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

National Quality Board (NQB)

The NQB guidance outlines that all providers should have a policy in place setting out how they respond to the deaths of patients who die under their management and care, including how we will:

- Determine which patients are considered to be under our care and included for case record review if they die (also stating which patients are specifically excluded)
- Report the death within our organisation and to other organisations who may have an interest (including the deceased person's GP)
- Respond to the death of an individual with a learning disability or mental health needs
- Review the care provided to patients who we do not consider to have been under our care at the time of death but where another organisation suggests we should review the care SHSC provided to the patient in the past
- Review the care provided to patients whose death may have been expected, for example those receiving end of life care
- Record the outcome of our decision whether or not to review or investigate the death, informed by the views of bereaved families and carers
- Engage meaningfully and compassionately with bereaved families and carers

Better Tomorrow

1.4 Understanding mortality in mental health settings can be complex and extracting learning may mean that exploration of co-morbidities is necessary. SHSC has a robust mortality review system in place but recognises that this is often extremely process focused. A priority for the mortality review group 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:

1. Effective Use of Resources
2. Deliver Outstanding Care
3. Great Place to Work
4. Ensuring our services

BAF.0024: There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care; caused by leadership changes, short staffing, cultural challenges, the lead in time for significant estates and ISMT actions and the impact of the global pandemic; resulting in risk of harm to people in our care and a breach in the Health and Social Care Act.

- CQC Regulation 18: Notification of other incidents
- CQC's Review of Learning from Deaths
- LeDeR Project
- NHS Sheffield CCG's Quality Schedule
- NHS England's Serious Incident Framework
- SHSC's Incident Management Policy and Procedures
- SHSC's Duty of Candour/Being Open Policy
- SHSC's Learning from Deaths Policy
- National Quality Board Guidance on Learning from Deaths

Equalities, diversity and inclusion

4.2 The report has been reviewed for any impact on equality, in relation to groups protected by the Equality Act 2010.

Culture and People

4.3 The implication for the workforce is positive as it empowers staff to take ownership of learning from deaths and deliver improved patient care, and links with the development of a safety led culture.

Integration and system thinking

4.4 Mortality review and the development of the processes for learning from deaths is likely to lead to the development of standardized and systematic approaches that can be used in mental health services across systems.

Financial

4.5 N/A

Sustainable development and climate change adaptation

4.6 The SHSC Green Plan sets out our commitment to:

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

Compliance - Legal/Regulatory

4.7 As previously described above.

Section 5: List of Appendices

Appendix 1: Mortality Dashboard

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 4 2023/24.

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

100% of deaths reported through SHSC's incident management system (Ulysses), together with a sample of deaths recorded through national death reporting processes, were reviewed at the weekly MRG.

Within quarter 4 2023/24, the Mortality Review Group reviewed a combined total of 104 deaths individually.

Following an initial review all deaths are subject to in-depth follow up until the following criteria are satisfied:

- cause of death?
- who certified the death?
- whether family/carers or staff had any questions/concerns in connection with the death?
- the setting the person was in in at the time of death, e.g., inpatient, residential or home?
- whether the person had a diagnosis of psychosis or eating disorder during their last episode of care?
- whether the person was on a prescribed antipsychotic at the time of their death?

The table below shows the number and type of deaths reviewed by MRG during the period.

Reporting Period	Source	Number
Quarter 4 2023/24	NHS Spine (national death reporting processes)	7
	Incident report (not LD Deaths)	89
	Learning Disability Deaths	8
Total		**104**

Analysis of Death Incidents Reported

Deaths reported as incidents during quarter 4, are classified as below:

Death Classification	No. of Deaths Q4
Expected Death (Information Only)	28
Expected Death (Reportable to HM Coroner)	1
Suspected Suicide – Community	8
Unexpected Death - SHSC Community	13
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	39
Suspected Homicide	0
TOTAL	**89**

LD Death Classification	No. of Deaths Q4
Expected Death (Information Only)	3
Expected Death (Reportable to HM Coroner)	0
Suspected Suicide – Community	0
Unexpected Death - SHSC Community	2
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	3
Suspected Homicide – Substance Misuse	0
TOTAL	**8**

Out of the 97 (including of LD) deaths that were incident reported in Q4, 78 (80%) were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 19 unexpected deaths are still awaiting further investigation/inquest through HM Coroner.

There were 8 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. 6 of the incidents were subject to 48hr reports and contact with the family was undertaken.

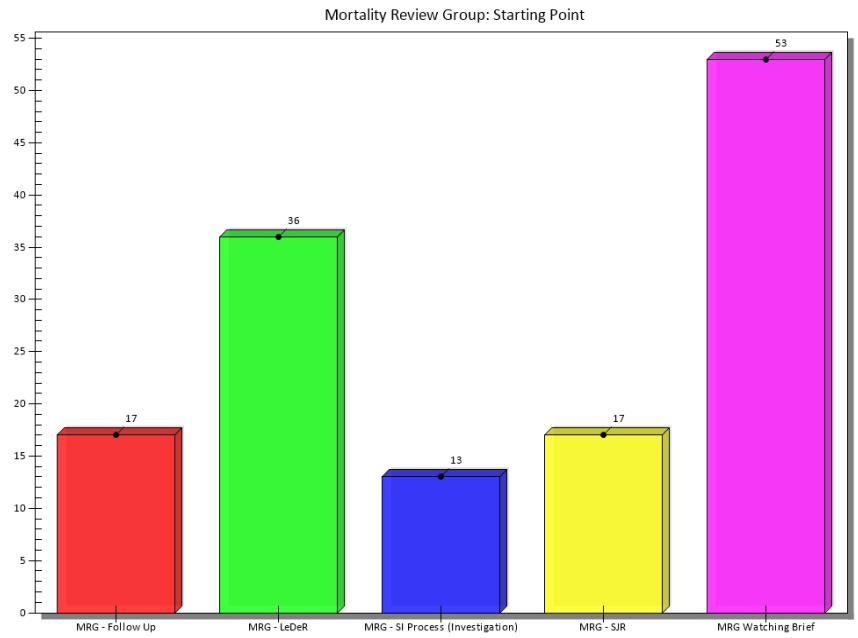
Examples of the natural cause deaths recorded during quarter 4 include:

- 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 136 deaths that are being processed through the internal mortality and patient safety incident systems, 36 that are being managed externally through the ICB LeDeR process and 53 that are subject to an external investigation such as coroner's inquest.

Overview of current number of mortality cases being processed as of: 31 March 2024



Current and Future Learning from Death Outcomes

All incidents reported as having a catastrophic impact were in relation to death and 80% of these were either suspected or known to be due to natural causes.

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 Q3 and 48hr reports completed in Q4.

Learning identified from completed investigations in Q3:

Learning from investigations

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

- Theme 1

Assessments were all carried out appropriately and in a timely manner. The correct staff were involved with care and referrals were all deemed to be appropriate.
Suicide and harm risks were reviewed on a regular basis and were documented within the medical notes. The DRAM (risk assessment document) was updated regularly and when any changes were noted with regards to Service User A.

- Theme 2

Throughout the care under SHSC, all professionals involved had the dedication to do the right thing for Service User. In particular nurse 2 showed dedication supporting the Service User and doing the right thing throughout his care. This was highlighted through wife's gratitude expressed to the service after the Service User died.

- Theme 3

It would be beneficial if professionals and family members could refer people into the Single Point of Access without gaining consent of the person, if there were concerns about a person's imminent risk. This could potentially reduce the time for when contact is made. It should be noted that this would not be indicated in every situation and that there may be times when the police would need to be called. It should be further explored how to balance the factors of consent against high-risk referrals and if the risk presenting at the time of referral is imminent, whether this should override the consent requirement.

SPA is currently going through a transformation programme and will be under the remit of primary care mental health, ensuring a more connected and integrated system going forwards. The transformation aims to dissolve barriers between primary and secondary care and stop individuals falling between gaps in local services.

- Theme 4

Although it is the investigators view that not making a safeguarding referral was correct in this instance, the investigator would have liked to have seen documented evidence of the rationale for not doing this,

SHSC are delivering a service-wide project to address wider issues with record keeping, both in contact notes and risk assessments. In addition, a new electronic patient record system is being rolled out to all teams which will provide practitioners with further tools to maintain a high standard of record keeping and a high standard of risk assessments.

- Theme 5

Although not related to the terms of reference – learning identified around sending letters to patient on the same day, one related to psychology appointment, one related to medic appointment, could have been confusing for the patient.

In Q4 two reported incidents related to suicide were for patients discharged in 2022 so no 48hr report was requested, two requested 48hr reports established that recent contact with the patient's had been limited due to them moving out of city. Four 48hr reports were reviewed in the Patient Safety Oversight Panel (PSOP) and learning included:

1. It would appear from reviewing the records that the team were providing a robust service, she was being seen on a weekly basis in the hearing voices group, led by psychologists, she was also regularly seen by qualified nurses for her depot medication to be administered and additionally she did have a named worker although this had recently changed due to the original worker having a prolonged sickness absence. She would also receive regular calls from our duty team. Staff had identified a persistence to her low mood and highlighted this accordingly in the notes putting in place an appropriate response.

2. The police advised that the concern about a lack of contact with a patient is a Right Care Right Person matter and is a matter for the ambulance service. Staff were advised to contact the ambulance service who would attempt to see the patient, if the patient does not open the door, they will contact the fire brigade/police in order to gain entry into the flat. Safe and Well Checks are no longer carried out by the police and team were updated on the "Right Person Right Care" model. Slides have now been sent out to the Team which ultimately show that police don't carry out Safe and Well Checks as a matter of course. This is now carried out YAS and SY Fire Service.

3. SPA attempted contact several times over 4 separate days, from the 15th -19th Jan. Brief contact was made via phone on 18th whereby the patient reported he was visiting a family member in hospital and couldn't speak, a further time was agreed. Senior Recovery Worker contacted at the agreed time, however, he stated he was unable to speak as he was again on his way to the hospital and agreed a further time. No further contacts were responded to and an opt in letter was sent.

4. As per standard protocol for new service users, the clinician tried to engage the patient in a thorough risk assessment. He indicated that he had taken overdoses in the past therefore the clinician attempted to engage him in making a safety plan to support him keeping himself safe should things deteriorate but he declined. He did assure the clinician that he could keep himself safe on the day of the assessment and that he had no immediate plans to hurt himself or end his life. He cited his children as a protective factor.

   He was discharged and a detailed discharge letter was sent to his GP the same day.

Family members and significant others are contacted via a letter, sent directly from the Patient Safety Specialist, offering them the opportunity to discuss the findings of the 48hr report and the opportunity to ask questions about the care and treatment provided.

Learning from LeDeR Deaths

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

During Q4 there were 1 learning point and 2 positive practice points identified for SHSC from the 2 LeDeR reviews that were completed and returned by the ICB. Both 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:

- Sheffield Health and Social Care NHS Trust to ensure patient information records are kept up to date containing current GP practice details.

Positive Practice

- There was evidence of good multidisciplinary team working.
- The patient's medication was well managed by the team in the community.

During Q4 the National LeDeR annual report for 2022 was published and the findings can be summarised as follows:

- In 2022, 3328 LeDeR's were submitted and 2884 were completed.
- 622 were completed in our region.
- It was identified that of the 622, 25% came from deprived and impoverished areas.
- Some of the most common causes of death for people with LD are Circulatory, Cancer, Respiratory, nervous system, congenital chromosomal abnormalities.
- Down syndrome is still noted as cause of death in either 1a/2 and was identified in 281 causes of death. This means that an accurate cause of death cannot be noted so data is effectively missing for this service user group.
- Ongoing work re: improving inequalities is in place but there is still more to be developed.
- A much lower rate of people with a learning disability are referred to the coroner in comparison to the general population.
- Ethnicity is still not well recorded as it should be, meaning there are gaps in our understanding of individual needs.
- People with a learning disability are still dying from avoidable causes – the main one being epilepsy.
- In July 2022 we had a heatwave and there was a spike in LD deaths – Kings College are currently doing a deep dive in to this, and we will outline their findings.
- Deaths from Covid 19 have declined and the vaccine programme has been greatly appreciated by the learning disability community – there has been a good take up overall of vaccines for this community.
- A very small percentage of autism deaths were recorded only 36, SHSC have reported 100% of these deaths and have a robust checking system. 11 of the reported deaths had a cause of death of suicide.
- Work has been done around cancer awareness, constipation , circulatory conditions.

Learning from Structured Judgement Reviews (SJR)

SJRs are intended to identify any areas of learning and good practice from the care and treatment provided to patients before their death.

The learning drawn from each SJR is shared with the teams involved with the patient at the time of their death and the final approved SJR is uploaded on to the Trust-wide learning hub.

During Q4 the learning themes extracted for the 7 completed SJRs included:

Communication and Waiting Lists

- The Collaborative Care Plan and DRAM did not include some of the more recent concerns that developed as the patient became more physically unwell, however, the family were noted to have commended the team for their support and care.
- Following a request to transition to a male gender the patient was placed on a waiting list and informed they could be waiting 3 years; they were also placed on a waiting

list for an autism assessment. These assessments were not completed before they sadly passed away.

- The patient was referred to the Older Adult Community Mental Health team and waited 8 months before an appointment letter for assessment was sent. By this time, she was in 24hr care and so was discharged without ever being seen.
- During the extended time spent waiting to be seen by the memory service the patient declined physically and was admitted to Sheffield Teaching Hospital. She eventually successfully supported by the Older Adult Community Mental Health team and discharged to 24hr care.

Capacity and Good Practice

- Admitted to NGH with symptoms of refeeding syndrome, particularly afraid of fear of food rather than portioning. Crisis assessment completed but identified that the patient wasn't presenting with anything that could be managed by Liaison Psychiatry. She had insight throughout assessment and full capacity. Liaison Psychiatry referred on to eating disorder service. Eating disorder service responded straight away and reviewed bloods and addressed concerns with the ward staff. Over the next day or so she became increasingly confused and pulled out her nasogastric tube on a number of occasions. A further assessment was completed with plans put in place to manage the changeable situation. However, she died in the early hours of the following morning.
- There were issues with assessing capacity due to ongoing communication needs so the team involved discussions with Speech and Language Therapist. They also held 'team around the person meetings' on multiple occasions. Vulnerable Adults Risk Reduction Model (VARRM) meetings were also completed, and he had appropriate Collaborative Care Plan's and DRAM in place with evidence of regular reviews.
- The Liaison Psychiatry team supported the patient during a time of crisis at Sheffield Teaching Hospital. They were able to offer collaborative support and care for the patient whilst they underwent physical health treatment.

Completed Structured Judgement Review's are uploaded to the learning hub and shared with the clinical team/s involved in order to disseminate learning and good practice.

Analysis of National Spine-System Recorded Deaths

From the sample of 7 cases reviewed from the spine (for people who were not under our care at the time of their death but died within 6 months of contact with SHSC services) during quarter 4 (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 87 (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.

Public Reporting of Death Statistics

National Quality Board (NQB) Guidance states that Trusts must report their mortality figures to a public Board meeting on a quarterly basis. The current dashboard attached at Appendix 1 was developed by the Northern Alliance for this purpose and contains information from the SHSC's risk management system (Ulysses) as well as information from our patient administration system (Insight).

The learning points recorded in the dashboard are actions arising from serious incident investigations, SJRs, or LeDeR reviews, that result in changes in practice. The dashboard will be updated as and when processes are completed, and learning is identified.

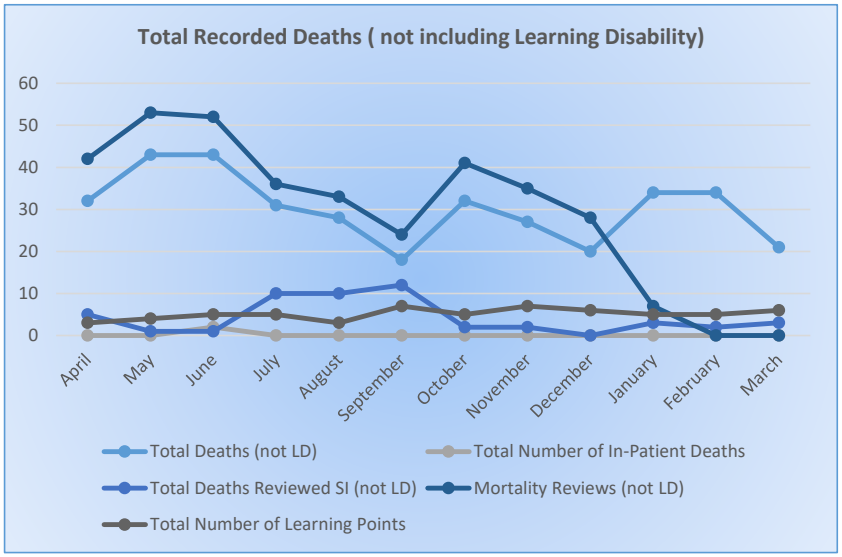
Appendix 1 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 4(January to March 2024)

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
89	**0**	**8**	**7**	**16**
YTD	YTD	YTD	YTD	YTD
363	**2**	**51**	**351**	**61**



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
8	**0**	**8**	**8**	**2**
YTD	YTD	YTD	YTD	YTD
32	**0**	**32**	**32**	**26**