Board of Directors - Public

SUMMARY REPORT	Meeting Date:	25 September 2024
	Agenda Item:	11

Report Title:	**Mortality – Quarterly Report: Quarter 1 2024/25**	
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Accountable Director:	Dr Helen Crimlisk, Executive Medical Director (interim)	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee (QAC) Executive Management Team (EMT)
	Date:	11 September 2024- QAC 19 September 2024- EMT
Key points/ recommendations from those meetings	The committee requested that the summary report provides additional evaluation.	

Summary of key points in report

A range of learning points in relation to mortality linked investigations were identified during Quarter 1 (Q1) 2024/25 including:

- All of the deaths reported by SHSC staff in Quarter 1 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.
- Mortality Group pays particular attention to factors known to contribute to early mortality such as the inappropriate use of antipsychotics and these are looked at more closely through a Structured Judgement Review process for learning.
- Mortality Group is currently identifying a cohort of service users receiving end of life care to review through a Structured Judgement Review process which will be shared through learning events. This has been chosen because of Healthwatch raising this as an area of focus.
- A further group who are being flagged are those who have a diagnosis of eating disorder, chosen because of the concerns about mortality and urgent care in this group of service users.
- There are delays in getting back the learning from deaths involving people with Learning Disability because of backlogs at the Local Authority and the need to wait for other processes to be undertaken.

SHSC reviewed 100% of all reported deaths during Q1 of 2024/25 and a sample of deaths for people who had died within 6 months of a closed episode of care.

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

Appendix attached:

Appendix 1: 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 Q1

Section 1: Analysis and supporting detail

Background

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

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

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

National Quality Board (NQB)

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

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

Better Tomorrow

1.4 Understanding mortality in mental health settings can be complex and extracting learning may mean that exploration of co-morbidities is necessary. SHSC has a robust mortality review system in place but recognises that this is often extremely process focused. A priority for the Mortality Review Group (MRG) 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 in 2023.

Triangulation

3.3 The outcomes from the learning from deaths processes can be triangulated against the learning extracted from Patient Safety Incident Response processes 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:

- Deliver outstanding care
- Create a great place to work
- Effective use of resources
- Ensure 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
- Learning Disabilities Mortality Review (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 standardised 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 Board with an overview of SHSC's mortality processes and any learning from mortality discussed in the Mortality Review Group (MRG) during Q1 2024/25.

During Q1 SHSC was fully compliant with 2017 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 Q1 2024/25, the MRG reviewed a combined total of 87 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?
- Whether the person had a diagnosis of Learning Disability or Autism (referred for LeDeR)
- the setting the person was in in at the time of death, e.g., inpatient, residential or home?
- In addition there is a current focus on issue we know to be important in early mortality:
- whether the person eating disorder during their last episode of care?
- whether the person was on a prescribed antipsychotic and a had a diagnosis of dementia at the time of their death?
- Whether the person was undergoing end of life care

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

Reporting Period	**Source**	**Number**
Quarter 1 2024/25	NHS Spine (national death reporting processes)	7
	Incident report (not LD Deaths)	76
	Learning Disability Deaths	4
Total		**87**

Analysis of All Death Incidents Reported

Deaths reported as incidents during Q1 2024/25 are classified as below:

Death Classification	**No. of Deaths Q1**
Expected Death (Information Only)	22
Expected Death (Reportable to HM Coroner)	2
Suspected Suicide – Community	5
Unexpected Death - SHSC Community	20
Unexpected Death - SHSC Inpatient/Residential	3
Unexpected Death (Suspected Natural Causes)	28
Suspected Homicide	0
TOTAL	**80**

LD Death Classification	No. of Deaths Q1
Expected Death (Information Only)	0
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)	2
Suspected Homicide – Substance Misuse	0
TOTAL	**4**

Out of the 80 (including of LD) deaths that were incident reported in Q1, 70%were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). There are no unexpected deaths awaiting further investigation/inquest through HM Coroner.

There were 5 suspected suicides in the community. 1 incident required no further review via mortality as the patient had not had contact with SHSC for over 12 months. 4 of the incidents were subject to 48hr reports and contact with the family was undertaken.

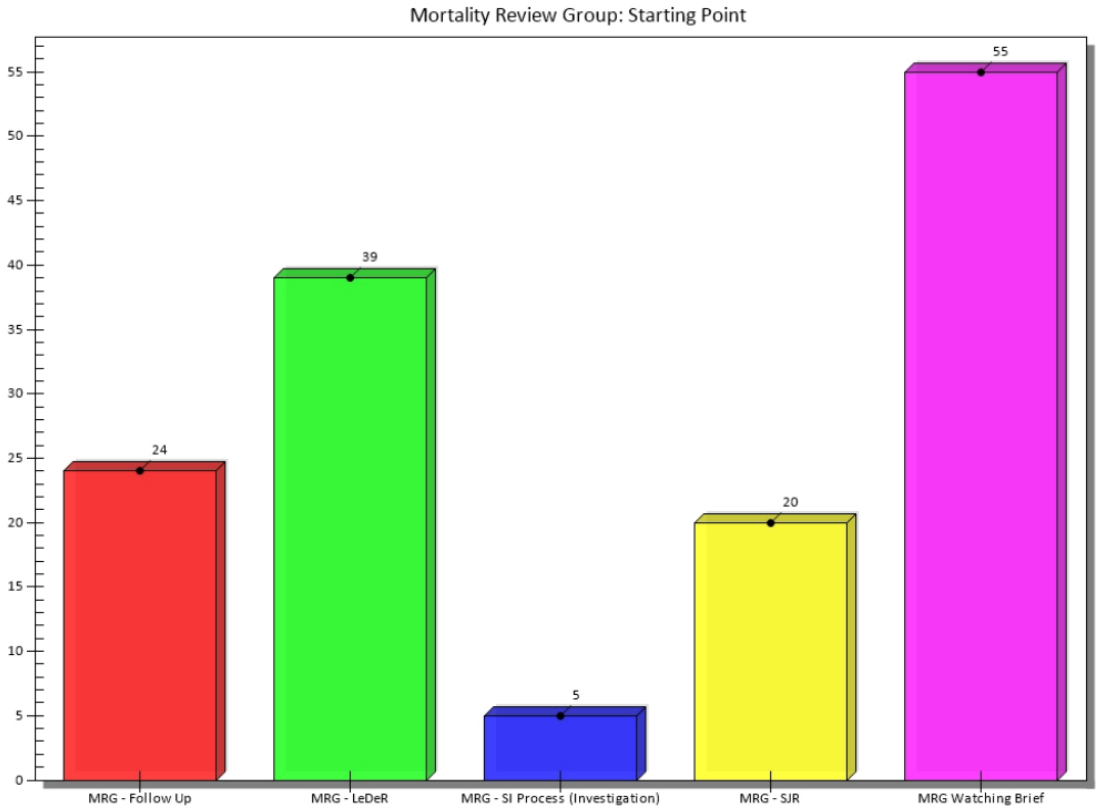
Examples of the natural cause deaths recorded during Q1 include:

- Pneumonia, Covid 19 infection, Motor Neurone Disease, Progressive Supra Nuclear Palsy, Multiple Sclerosis, Staphylococcus Aureus Sepsis, Chronic Myeloid Leukaemia, Heart failure, Septic Cardiomyopathy, Myocardial Infarction, Ischemic Heart Disease, Spontaneous Bowel Obstruction, Lower respiratory failure, Infective Exacerbation of COPD, Metastatic Cancers, Alzheimer's Dementia, Frailty of old age, Frailty due to generalised chorea.

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 143 deaths that are being processed through the internal mortality and patient safety incident systems, 39 that are being managed externally through the ICB LeDeR process and 55 that are subject to an external investigation such as coroner’s inquest.

Overview of current number of mortality cases being processed as of: 3 Sep 2024



Current and Future Learning from Death Outcomes

All incidents reported as having a catastrophic impact were in relation to death and 70% 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 initial 48hr reports completed in Q1.

Learning from 48 hour reports.

Regarding initial learning from 48 hour reports we found the following, themes were derived and feedback given to teams

Theme 1: Suspected Suicide in the community: Limited contact with SHSC via a Section 12 approved doctor in A&E.

Theme 2: Suspected Suicide in the community: A structured Judgement Review (SJR) has been completed and is due to be shared with the family on 29 August 2024.

Theme 3: Suspected Suicide in the community: This incident is being addressed as a Patient Safety Incident Investigation (PSII)

Theme 4: Suspected Suicide in the community: The patient safety team and the clinical team met with the family in order to support them and answer any questions they may have. The learning actions identified included actions around face to face contact with initial assessments and ensuring opening of an episode of care by the community team within 72 hours of admission to an acute mental health unit.

Family members and significant others are contacted via a letter, sent directly from the Director of Nursing, Professions and Quality, 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 MRG 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.

On notification of a learning disability death, SHSC (and/or other organisations) report the death via the online LeDeR platform. Once reported, each person will have a unique reference number that is logged on SHSC reporting system Ulysses (within the incident report of the death). Each review is then managed by the Local Area Integrated Commissioning Board (ICB). For SHSC this is Sheffield ICB, who we liaise with on a regular basis. During these meetings cases are discussed and updates provided about stage of completion. The completion timescale for each review is measured case by case. Completion of LeDeR is dependant on access to records from a number of agencies. Also in some limited cases, a person may be under coronial review, police review or additional safeguarding and all must be completed prior to any LeDeR review taking place. Some people have opted out of sharing data and in those cases no reviews can be completed.

Once a LeDeR review has been completed it is shared with SHSC Risk Department. Any identified learning for SHSC is then reviewed via the weekly Mortality Review Group before being shared with the Community Learning Disability Mortality Lead. The Lead will then either action as required and share the document for any wider learning.

Since January 2022 it is now a requirement to refer anyone to the LeDeR process who has a diagnosis of Autism. This is done in much the same way as with a learning disability death, however SHSC have checks in place to ensure that each new death goes through a checking process where any diagnosis can be identified at this point.

During Q1 SHSC received 4 completed LeDeR reviews and 2 LeDeR family led rejections relating to data share. The 4 reviews received back had no action points for SHSC but included learning points for other organisations. All 4 reviews were discussed at mortality and shared with the Community Learning Disability Team in order to promote wider learning. Positive practice was evident on 2 reviews. LeDeR Review Learning points and positive practice highlighted the following:

- Evidence of good multidisciplinary team working
- Compassionate support during End Of Life Care

Learning from Structured Judgement Reviews (SJR)

SJRs are intended to identify any areas of learning and good practice (or areas for improvement) from the care and treatment provided to patients before their death (while under the care of SHSC). There are specific categories to consider when selecting a death incident to be reviewed under the SJR process.

In 2021 SHSC was part of a pilot scheme to develop SJRs and an SJR platform specific to mental health environments (rather than the generic acute hospital SJRs that were already available). Unfortunately after full development and consultation of both the new SJR and

SJR platform (working with Better Tomorrow) SHSC was unable to successfully implement the online platform. This was due to a number of data and software issues. This has meant that SHSC are still not able to upload data on to a national platform. Staff at the time were trained on how to complete reviews using this new system but this became obsolete after the system failure. Completion of the old style reviews was maintained solely by SHSC's Mortality Reviewer and Patient Safety Specialist.

PSIRF pathway also identifies its own SJR reviews to be completed. The ones identified through the mortality meeting are a sample of the deaths known to the trust at that particular time. Any SJR completed is shared with the involved teams and any learning that comes with each review

SJRs are currently being undertaken for 3 specific groups.

1 Inappropriate use of antipsychotics in patients with dementia (national focus)
2 Current episode of Eating Disorders (national focus)
3 End Of Life Care (local initiative in 2024)

SJRs are themed and will be shared back with teams for learning

Due to a period of staff absence within the Mortality Review Group the content of mortality meetings during Q1 have been business as usual only and resulted in a delay with sharing the themes from the recent SJR's.

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 Q1 (2024/25), deaths were recorded primarily as:

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