Front sheet: **Public Board of Directors**
Item number: **13**
Date: **26 March 2025**

Private/ public paper:	Public
Report Title:	**Mortality quarterly report: Quarter 3 2024/25**
Author(s) Accountable Director:	Adele Eckhardt, Care Standards Lead Dr Helen Crimlisk, Executive Medical Director (interim)
Presented by:	Adele Eckhardt, Care Standards Lead
Vision and values:	The report is in line with the Trust vision to improve the mental, physical and social wellbeing of the people in our communities by **working together** to **improve quality** through continuous improvement we will continue to improve safety and make a positive difference to the lives of our patients, carers and communities.
Purpose and key actions:	The purpose of this report is to provide the Board with an overview of the Trust's mortality processes and learning from mortality discussed in the Mortality Review Group (MRG) and to provide assurance that robust mortality and learning from deaths review processes are in place.
Executive summary:	SHSC reviewed 100% of all reported deaths during Quarter 3 of 2024/25 and a sample of deaths for people who were not open to our services at the time of death but died within 6 months of a closed episode of care. **Eleven points of actions or themes were identified** through this process which are summarised within the relevant sections of this report as well as the learning points from LeDeR review relevant to SHSC. A range of learning points in relation to mortality linked investigations and reviews are noted below. • All of the deaths reported in Quarter 3 were in relation to people living in community settings. There were no deaths in SHSC inpatient settings. The majority were white British older adults with a diagnosis of dementia and conditions related to older age. • The Mortality Review 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. • The mortality group identified a cohort of service users receiving end of life care to review through a structured judgement review process chosen because of Healthwatch raising this as an area of focus. • A further group which flagged are those with a diagnosis of eating disorder, chosen because of the concerns about mortality and urgent care in this group of service users. • Delays continue in receiving the learning from deaths involving people with Learning Disabilities because of the need to wait for all other processes to be undertaken. SHSC is compliant with the 2017 National Quality Board (NQB) standards for learning from deaths.

	The outcomes from the learning from deaths processes, which is outlined in the separate Patient Safety Learning Report, can be triangulated against the learning extracted from Patient Safety Incident Response processes into the deaths of service users and from coronial inquests. **Appendix attached:** Appendix 1: Mortality Dashboard

Which strategic objective does the item primarily contribute to:					
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*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
This report is relevant to compliance with the following key standards. • Care Quality Commission Fundament Standards: Person centred care and dignity and respect. • National Guidance on Learning from Deaths (2017)	
BAF and corporate risk/s:	**BAF 0024** Risk of failing to meet fundamental standards of care caused by lack of appropriate systems and auditing of compliance with standards, resulting in avoidable harm and negative impact on service user outcomes and experience, staff wellbeing, development of closed cultures, reputation, future sustainability of particular services which could result in potential for regulatory action.
Any background papers/ items previously considered:	This is a quarterly report received at the Quality Assurance Committee and the Board.
Recommendation:	The Board of Directors are asked to: • **Note** for assurance that the Trust has a robust mortality and learning from deaths review in place. • **Note** for assurance that the Trust is compliant with the 2017 National Quality Board (NQB) standards for learning from deaths • **Note** the plan to work more closely in association with the developing PSIRF processes and to how to ensure a more inequalities-based approach going forward

Public Board of Directors
Mortality Report Q3

March 2025

Purpose

This purpose of this report is to provide the Board with an overview of the SHSC mortality processes and any learning from mortality discussed in the Mortality Review Group (MRG) and to provide assurance that robust mortality and learning from deaths reviews are in place.

Background:

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.

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

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.

In early 2024/25 the Northern Alliance Group was re-formed and the Trust re-engaged with this group.

Introduction:

The outcomes from the learning from deaths processes, which is outlined in the separate Patient Safety Learning Report, can be triangulated against the learning extracted from Patient Safety Incident Response processes into the deaths of service users and from coronial inquests.

National Quality Board (NQB)

The NQB guidance (2017) 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

Quarter 3 Review of Deaths

During Q3 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 Mortality Review Group, chaired by the Medical Director.

Within Q3 2024/25, the MRG reviewed a combined total of 82 deaths individually.

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

- What was the 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., an inpatient, residential home or their own home?
- Whether the patient had a learning disability or autism diagnosis?
- Whether the person had a diagnosis of psychosis or eating disorder during their last episode of care?
- Whether the person was prescribed antipsychotic medication 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 2024/25	NHS Spine (national death reporting processes)	5
	Incident report (not LD Deaths)	71
	Learning Disability Deaths	6
Total		**82**

Analysis of All Death Incidents Reported (Excluding LD)

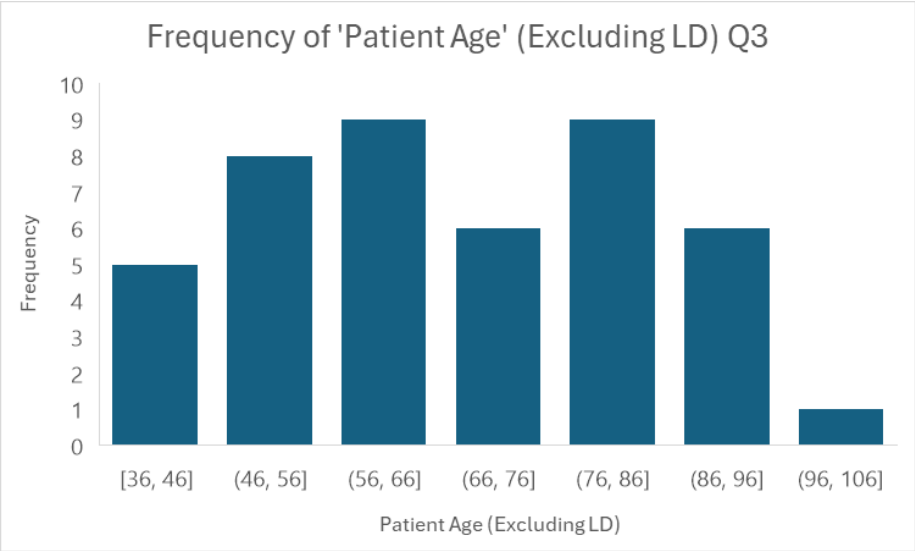
Deaths reported as incidents during Q3 2024/25 are classified in the table below:

Death Classification	No. of Deaths Q3
Expected Death (Information Only)	31
Expected Death (Reportable to HM Coroner)	0
Suspected Suicide – Community	6
Unexpected Death - SHSC Community	17
Unexpected Death - SHSC Inpatient	0
Unexpected Death - SHSC Residential	0
Unexpected Death (Suspected Natural Causes)	17
Suspected Homicide	0
TOTAL	**71**

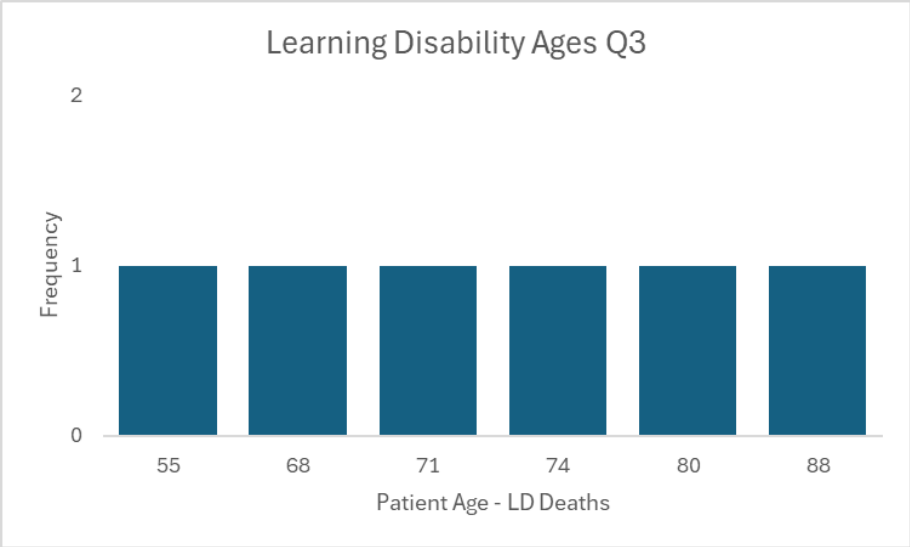
Learning Disability deaths reported during Q3 2024/25:

LD Death Classification	No. of Deaths Q3
Expected Death (Information Only)	1
Expected Death (Reportable to HM Coroner)	0
Suspected Suicide – Community	0
Unexpected Death - SHSC Community	1
Unexpected Death - SHSC Inpatient	0
Unexpected Death - SHSC Residential	0
Unexpected Death (Suspected Natural Causes)	4
Suspected Homicide – Substance Misuse	0
TOTAL	**6**

Age ranges of all deaths (excluding Learning Disability):



Age ranges of Learning Disability Deaths:



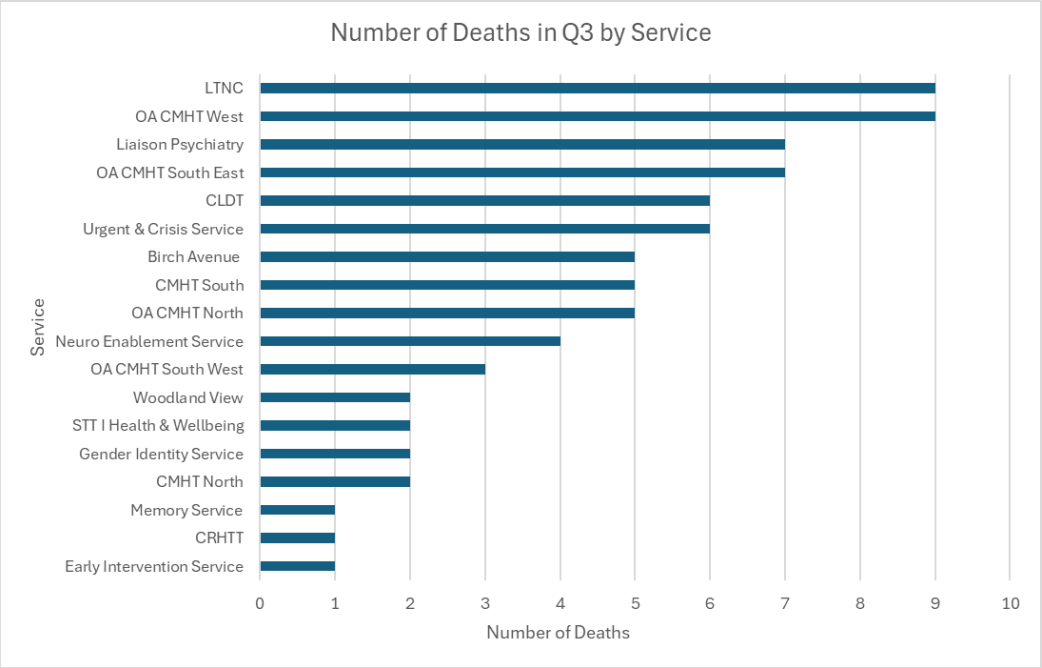
Out of the 77 (including of LD) deaths that were incident reported in Q3, approximately 66% were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries such as a postmortem).

Examples of the natural cause deaths recorded during Q3 include:

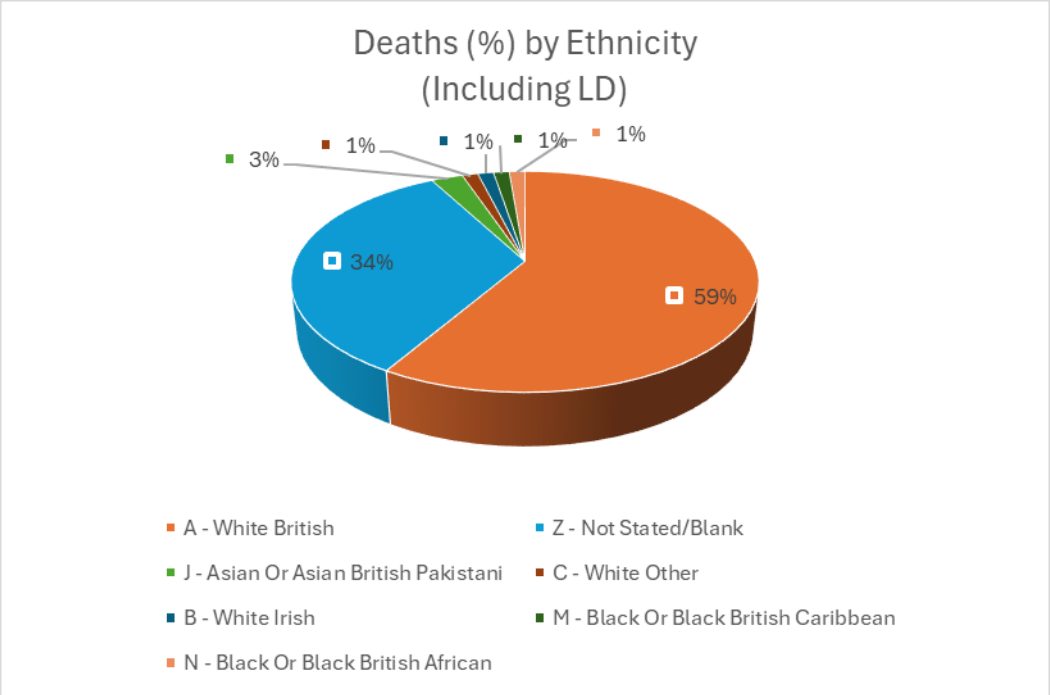
- Dementia, Alzheimer's Dementia, Vascular Dementia, Motor Neurone Disease, Huntington's Disease, Bronchopneumonia, Pneumonia, Metastatic Squamous Cell Lung Cancer, Clostridium Difficile Colitis, Sepsis, Lewy Body Dementia, Cortico-Basal Degeneration, Heart Failure, Aspiration Pneumonia caused by Central Cord Syndrome, Myocardial Infarction, Untreatable Prostate Mass which led to Multiple Organ Deterioration, Ischemic Bowel

As shown in the table below, just under half of all deaths occurred in patients open to our older adult services. The next highest group were adults with Long Term Neurological Conditions whose ages spans from 44 to 81 years.

There were seven deaths of residents within our Care Homes, all were classified as 'Expected Deaths (Information only).

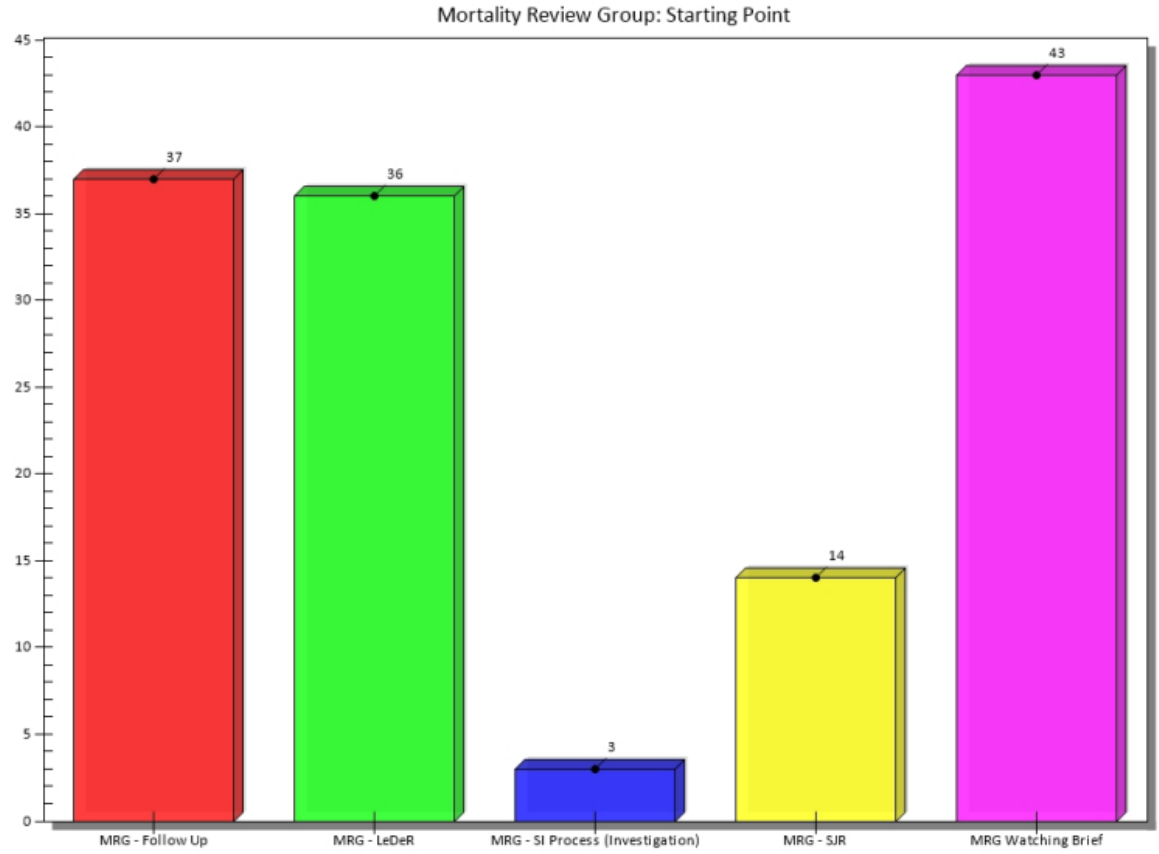


Where patient ethnicity was recorded, the majority of deaths were either White British (45), White Irish (1) or White Other (1) and 4 were from ethnic minority groups. There were 26 deaths where ethnicity was not stated.



As represented in the table below, there are 133 deaths currently still active and under review within our mortality and/or patient safety incident systems. 36 of these are being managed externally through the Integrated Care Board LeDeR process and 43 are subject to an external investigation such as coroner's inquest. Where deaths were referred to HM Coroner, follow up is undertaken to ensure that any additional learning for SHSC is identified, details of this learning would be included in the separate Patient Safety Learning Report.

Overview of current number of mortality cases being processed as of 25 February 2025



Current and Future Learning from Death Outcomes

All incidents reported as having a catastrophic impact were in relation to deaths, the majority of these were either suspected or known to be due to natural causes.

All deaths from suspected suicide are subject to individual due diligence through SHSC Patient Safety processes.

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 and shared within the monthly 'learning lessons' bulletin and presented to the Quality Assurance Committee in the Patient Safety and Learning Report.

Learning Identified from Unexpected Deaths (48 Hour Reports)

Learning identified from unexpected deaths are detailed in the Patient Safety and Learning Report. The following information is a summary of themes taken from the most recent report.

> *Theme 1: Following a suspected suicide, a theme identified in one 48-hour report was ensuring a risk assessment is carried out, when teams are referring into the Urgent and Crisis service for concerns that a patient is expressing suicidal thoughts. Risk assessment is essential to ensure good risk management and a clear understanding of risk from the assessing staff member. This is contained in relevant Standard Operating*

Procedures and the action is to explore with the team any barriers to undertaking risk assessments. It is important to not that risk assessment is a repeat theme across incidents. This is being addressed through two workstreams – Culture of Care in the inpatient wards and currently focussed training in the CMHTs.

Theme 2: waitlists for specialist services was raised in two 48-hour reports related to suspected suicides and unexpected deaths. It was acknowledged that there are long waiting lists in certain specialist services. Improvement work is being undertaken in services to review care pathways and reduce waiting lists and to ensure those on waiting lists are up to date. Some positive improvements are noted in some services through the IPQR. For the 48-hour reports, there was learning identified to ensure that waiting well strategies are communicated, the details we hold for people are up to date, and that people are aware of expectations, including information about how long waiting lists are predicted to be.

Theme 3: One 48-hour report following an unexpected death identified particularly good practice regarding a patient being fully involved in their care and enjoying a good relationship with their named worker.

Theme 4: delays in assessment due to problems with waiting list referrals have been identified through two 48-hour reports for a service who receive referrals via SystmOne. The two 48-hour reports both relate to the same patient and were separately reporting the delay in assessment and the person's unexpected death. While it does not appear that the delay in assessment affected the patient's sad outcome, there was some clear learning regarding SystmOne's referral process. The referral system is built in a way that human error could occur, if not processed correctly by administrators and enquiries have been made about fail safes, but this is not possible to build in. However, regular auditing will take place of referrals which will then identify if referrals have not been processed in the right way and used to inform learning and supervision within the teams

Theme 5: information sharing with relevant carers and professionals was identified and has been an identified theme in the previous quarter's 48-hour reports. In one 48-hour report, following an unexpected death, it was noted that a patient had understood advice that staff gave around their choking risks, declined to follow the risk management plan and had capacity to understand that doing so could put her themself at risk. This was documented clearly; however, care home staff were not informed of the risks so they could support management of the risks where possible. The service is producing a standard operating procedure to assist where patients choose not to follow advice, to include the sharing of information with relevant people (where there is consent). In a second 48-hour report following an unexpected death, information around a patient's risks was posted to their GP when the patient did not attend an assessment session. However, the risks were identified as significant, and the learning was that a conversation with the GP to ensure those risks were understood would have been supportive. This will be conveyed to the staff and adjusted in the team's usual procedures.

Theme 6: follow-up of patients when a staff member is unexpectedly on leave was raised in one 48-hour report, and this links to a noted theme from last quarter of follow up for patients when appointments are cancelled due to annual leave. Learning was identified around ensuring there is oversight for staff members unexpectedly absent long term. Positively, the service manager attended the Patient Safety Oversight Panel to update on the work that the team has done to build these oversight processes into standard practice

Family members and significant others are contacted by letter 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.

LeDeR Death Reviews

Background:

LeDeR reviews are managed by the Integrated Commissioning Board (ICB) and any identified learning for SHSC is shared to all care providers involved. On notification of a learning disability death, SHSC (and/or other organisations) report the death on the online LeDeR platform. All reviews are managed by the Local Integrated Commissioning Board (ICB). For SHSC this is Sheffield ICB, who we liaise with on a regular basis where cases are discussed and any updates provided.

Completion of LeDeR review is dependent on access to records from a number of different agencies. In some limited cases, a person may be under coronial review, police review or additional safeguarding and all other reviews must be completed prior to the LeDeR review taking place. Some people have opted out of sharing their data prior to death and in those cases no review will take place.

There remains a significant delay in getting reports back from the LeDeR process, and these remain in our numbers until this report is shared and the learning from this identified and shared.

On completion of a LeDeR review the report is shared with SHSC and any identified learning is initially reviewed at the weekly mortality meeting before being shared with the Community Learning Disability Mortality Lead. The Lead will then action if required and share the document for wider learning with the Community Learning Disability Team (CLDT).

Since January 2022 it is now a requirement to refer anyone to the LeDeR process who has a diagnosis of autism. Each new death is reviewed to identify if the patient had a diagnosis of autism.

Quarter 3 LeDeR reviews:
During Q3 SHSC received **four** completed LeDeR (Learning Disability) reviews.

The four reviews received had a combined total of twelve positive learning points and fourteen points to consider issues or where improvements needed. Of this total SHSC received two positive points of care:

- Good level of collaborative working noted
- Well documented records

There were no improvements or action requited relating to SHSC in this quarter.

We also received **five** reviews of patients previously known to SHSC but had been discharged some time before their death. These reports were also shared with the CLDT Mortality Lead. For wider learning.

We received notification of **three** patients reported to LeDeR but where a review did not take place due to family not providing consent for data sharing to take place.

There were no LeDeR Autism deaths received for review during this quarter.

Structured Judgement Reviews (SJRs)

Background:
Structured Judgement Reviews are intended to identify any areas of learning and good practice (or areas for improvement) of the care and treatment provided to patients before their death. 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.

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 SHSC was unable to successfully implement the online platform 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. This will be revisited as a priority once Rio has been fully

implemented within the trust. The current reviews continue to be completed using the previous editable document.

The PSIRF pathway also identifies deaths for Structured Judgement Reviews. These reviews are completed by a growing pool of clinical staff across SHSC and all reviews presented to the Patient Safety Oversight Panel before final review at the Mortality Review Group.

Quarter 3 SJR reviews:
In the last quarter there were **four** SJR reviews completed for service users who had been under either Early Intervention Service or the Community Mental Health Team. These reviews showed excellent levels of care was provided for complex service users. Personal feedback was sent to each team with comments from the Medical Director following review in mortality.

In the last quarter we identified some SJR's selected to specifically look at End of Life Care Provision. Four of these have now been reviewed, the remaining three will be included in the next report.
Of the four End of Life SJR's reviewed in Q3, the information concluded that the teams involved (Birch Avenue and Woodland View) provided a 'good' or 'excellent' level of care in all cases. There was evidence of patient centred care and care plans were tailored specifically for each individual.
One example was when a family pet was able to be brought into the care home for the final few days of a resident's life. Records described the comfort the resident and family gained from this support.

In addition, there were five SJR's previously selected but were closed at the mortality review group due to either very little information available in the electronic patient records or where the service user had been referred but had not been seen, ie only open for medication a review or was in the last hours of life.

Analysis of National Spine-System Recorded Deaths

From the sample of five cases reviewed from the National Spine-System (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 Q3 (2024/25), deaths where information was recorded was primarily due to the following:

- Old age frailty, cognitive impairment and pre-existing medical conditions.

The ages of those who died ranged from 21 to 73. Cases reviewed from the spine are people living in the community, either in their own homes or residential/supported living settings or deaths that occurred in another hospital. The majority of other hospital deaths were of patient seen by SHSC's Liaison Psychiatry Service for one off advice/assessment and were end of life. Whilst these are recorded as SHSC deaths for the purposes of internal recording, there was minimal input or intervention by SHSC staff for these patients.

Public Reporting of Death Statistics

National Quality Board Guidance (2017) states that Trusts must report their mortality figures to a public Board meeting on a quarterly basis. The current dashboard (see 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 electronic patient record.

The learning points recorded in the dashboard are actions arising from patient safety related death investigations, SJRs, or LeDeR reviews, that have resulted in changes in practice. The dashboard is updated as and when processes are completed, and learning has been identified.

Summary

National Mortality and Learning from Deaths

Understanding mortality in mental health settings can be complex and extracting learning may mean that exploration of co-morbidities is necessary. Members of the mortality group attend the National and Learning from Deaths Group, National LeDeR and National Structured Judgement Review (SJR) groups on a regular basis as well as local mortality groups. This enables members to remain updated from both National and Integrated Care Board perspectives. These provide valuable learning about trends in deaths which informs things such as where the focus of SJRs is to be undertaken.

SHSC have robust mortality review systems in place which occur on a weekly basis and are working closely with the PSIRF processes. At the mortality group, respect is maintained when reviewing and discussing information and details about all who may be affected by such extremely sad events.

The group is currently working to think about how to better bring in an improved health inequalities angle (which is already present to some degree with the particular focus on people with LD and ASD) and ensure that there is particular curiosity about how inequalities impact on mortality.

Recommendations:

The Trust Board are asked to:

- **Note** for assurance that the Trust has a robust mortality and learning from deaths review and processes in place.
- **Note** for assurance that the Trust is compliant with the 2017 National Quality Board (NQB) standards for learning from deaths.
- **Note** the plan to work more closely in association with the developing PSIRF processes and to how to ensure a more inequalities based approach going forward