Board of Directors (Public Meeting)

SUMMARY REPORT	Meeting Date:	23 March 2022
	Agenda Item:	12

Report Title:	**Mortality – Quarterly Review Q3**	
Author(s):	Vin Lewin, Patient Safety Specialist	
Accountable Director:	Dr Mike Hunter, Executive Medical Director	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	9 February 2022
Key points/ recommendations from those meetings	The Mortality Team reviewed data and reported an increase in deaths of Service Users with substance misuse, particularly in the Opiate Services, in 2020, and a reduction in 2021. A workshop has been arranged with Substance Misuse Services to develop learning. Aim for Q4 - develop a Dashboard which automatically extracts key learning information from Structured Judgement Reviews (SJRs). Ensuring this is in place on the Ulysses system and there are enough staff able to conduct SJRs. The Committee received the report and was assured by progress.	

Summary of key points in report

- All the deaths reported internally during Q3 were reviewed in the weekly mortality review group. The mortality review group also sampled and reviewed the deaths of patients who had contact with services 6 months prior to death.
- All the deaths reported for people with a learning disability were reviewed and reported through the LeDeR process. Learning from the LeDeR reviews is being managed collaboratively with the CCG.
- A rapid review of the deaths of those with substance misuse revealed an increase in the number of deaths in this cohort for the 2020 period. Further detailed work is underway to extract learning from this data.
- Learning from the completion of Structured Judgement Reviews has been disseminated into teams.
- The Better Tomorrow project, which seeks to improve the learning from deaths process, is progressing as planned and will complete in Q4 21/22.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval		Assurance	X	Information	X

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*	***X***	*No*	
CQC Getting Back to Good	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*		*No*	***X***
Partnerships – Working together to make a bigger impact	*Yes*		*No*	***X***

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		Person Centred Care and Dignity and Respect
Data Security and Protection Toolkit	*Yes*		*No*	***X***	This is not applicable to mortality processes
Any other specific standard?	*Yes*	***X***			National Guidance on Learning from Deaths (2017)

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety 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.

Name of Report: Mortality – Quarterly Review

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 engage with the national Better Tomorrow project in order to develop better learning from deaths. The quarterly report outlining the learning from deaths within SHSC will be significantly improved as the project progresses.

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 will be developed as a part of the Better Tomorrow project.

3.2 Learning from Deaths will be subject to clinical audit

3.3 Professional advice has been provided by the Better Tomorrow project team

Triangulation

3.4 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

3.5 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.

3.6 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. As the Better Tomorrow project advances, Structured Judgement Reviews will be completed by a growing pool of clinical staff across SHSC.

Section 4: Implications

Strategic Priorities and Board Assurance Framework

4.1 Strategic Aims: Provide outstanding care; Create a great place to work
Strategic Priorities: Covid-19 Recovering effectively; CQC Getting back to good

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

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

Equalities, diversity and inclusion

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

Culture and People

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

Integration and system thinking

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

Financial

4.5 N/A

Compliance - Legal/Regulatory

4.6 As previously described

Section 5: List of Appendices

Appendix 1: Mortality Dashboard

Summary Report

This report provides the Board of Directors with an overview of SHSC's mortality review and the learning from mortality discussed in the Mortality Review Group (MRG).

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

Within quarter 3 2020/21, the Mortality Review Group reviewed a combined total of 104 deaths.

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
Quarters 3 2020/21	NHS Spine (national death reporting processes)	22
	Incident report*	78
	Learning Disability Deaths**	4
Total		**104**

* There was an actual total of 79 reported deaths in Q3 but 1 report was related to a non-SHSC individual and therefore not taken forward for detailed follow up.
**All 4 Learning Disability deaths reviewed were reported to LeDeR.

Analysis of Death Incidents Reported

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

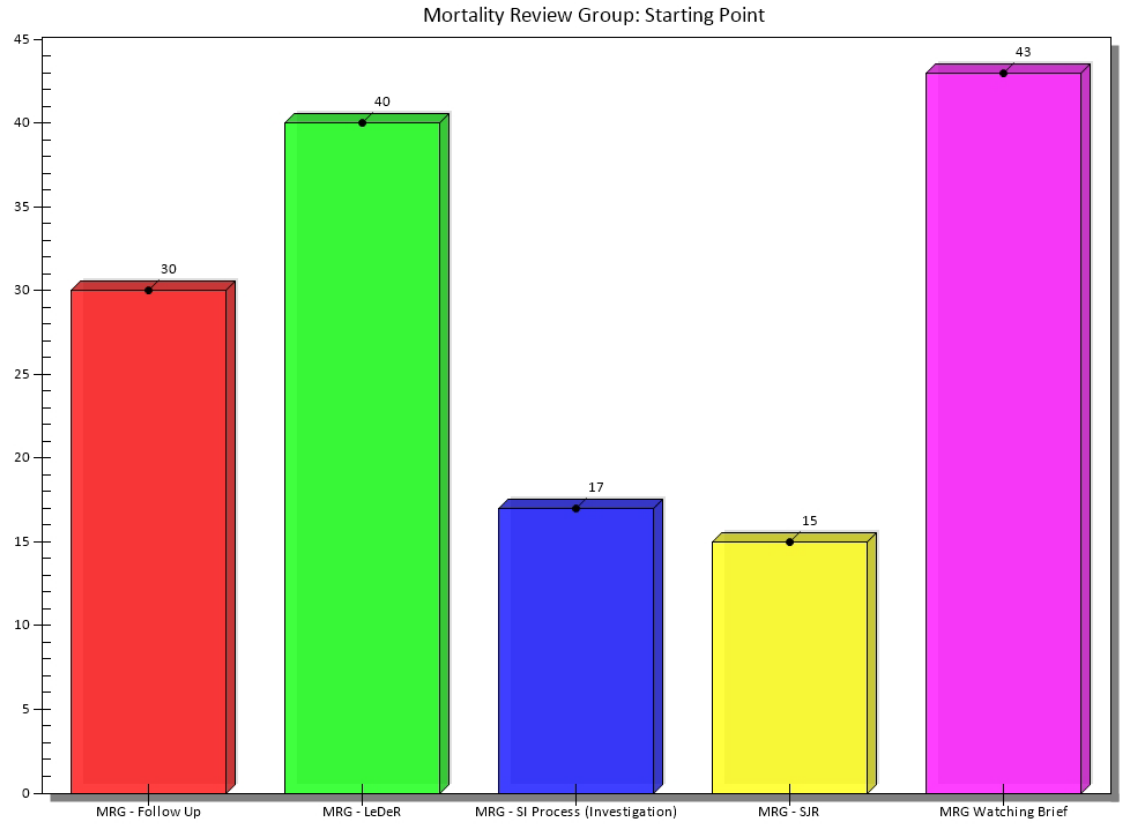
Death Classification	No. of Deaths Q3
Expected Death (Information Only)	20
Expected Death (Reportable to HM Coroner)	2
Suspected Suicide – Community	5
Unexpected Death - SHSC Community	29
Unexpected Death - SHSC Inpatient/Residential	1
Unexpected Death (Suspected Natural Causes)	21
TOTAL	**78**

Out of the 78 deaths that were incident reported in Q3, 66 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 4 of the 'natural cause' deaths were officially classified as Covid-19 deaths. 7 are still awaiting further investigation/inquest through H M Coroner.

There were 5 suspected suicides in the community of which 4 are subject to serious incident investigation and 1 is being investigated by another Trust with our support.

There are currently 62 deaths that are being processed through the internal mortality and serious incident systems, 40 that are being managed externally through the CCG LeDeR process and 43 that are subject to an external investigation such as coroner's inquest.

Overview of current number of mortality cases being processed as of: 30 December 2021



Overall Learning Outcomes and Specific Focus on Substance Misuse

It should be noted that this report considers deaths but not those arising from serious incidents (except for capturing the statistical side within the figures). Learning outcomes following serious incident investigations are reported within the quarterly 'learning lessons' report and presented to the Quality Assurance Committee. From the 24 identified learning points there were 4 broad themes for learning outlined in the lessons learned report related to serious incident investigations including:

- Team focused learning: communication and internal processes
- Patient focused learning: communication with patients related to their care and treatment
- External teams focused learning: collaboration and communication with non-SHSC services
- Physical health focused learning: physical health monitoring and processes

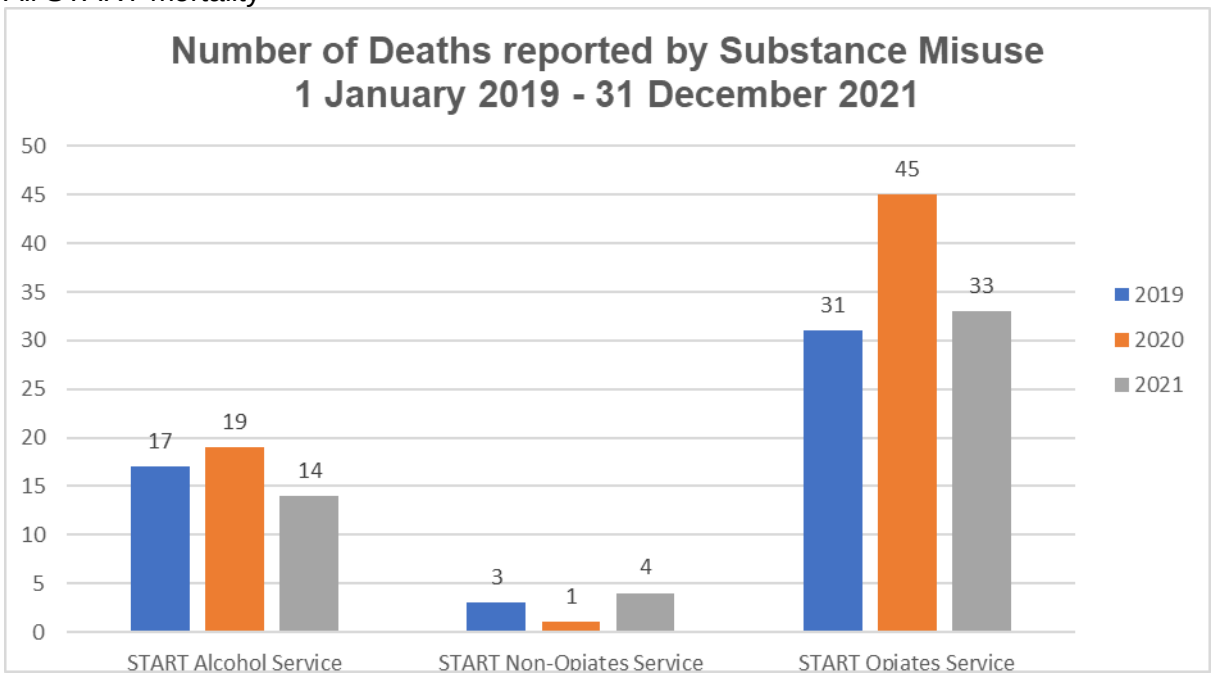
Examples of the natural cause deaths recorded during quarter 3 are older adult conditions including: frailty syndrome and old age, physical health conditions including: heart attack, pneumonia, decompensated alcohol related liver disease, cerebral palsy and motor neurone disease and cognitive impairment conditions including: dementia (Alzheimer's type), vascular dementia and mixed dementia types

Where deaths were referred to H M Coroner, follow up has been/is being undertaken to ensure there is no additional learning for SHSC from these cases. 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.

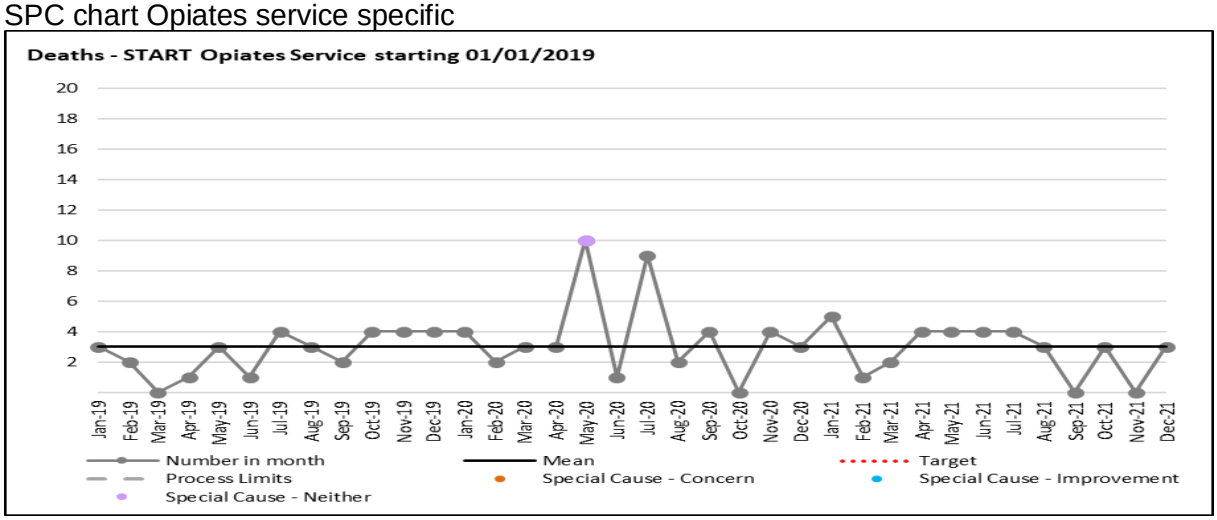
In the light of local and national reporting concerning a possible excess of deaths amongst people with substance misuse problems during the pandemic, we reviewed together the last three years data in these services.

Accepting that this is an early analysis, it appears there was an excess number of deaths specifically within opiate services in 2020, correlated in time with the first wave of the pandemic. Work is underway to disentangle the direct and indirect effects of Covid at this stage. A workshop is being held with SHSC's substance misuse services in Q4 21/22 to further explore specific learning and improvement outside of the usual serious incident investigation learning.

All START mortality



SPC chart Opiates service specific



Learning from LeDeR Deaths

LeDeR reviews are now managed via the Clinical Commissioning Group (CCG) and any identified learning for SHSC is initially fed in via the weekly mortality review group before being actioned and reported on by the Community Learning Disability Lead.
During Q3 there were 4 learning actions identified for SHSC:

1. Lack of records being held for hearing & sight tests: The Community Nurses are evaluating the implications of the contents of the Head-to-Toe Assessment being used as a 'living' document. The outcome will be reported to the CCG.

2. The LeDeR reviewer was unable to identify a formal Asperger's assessment within records: Feedback has been given to senior clinicians and CPA leads that they must

ensure records relating to the diagnosis of a person is accurate and up to date. The outcome will be reported to the CCG.

3. No hospital passport was evident in a patient's records: CLDT have now incorporated hospital passport request in referral forms as part of the proforma. The outcome will be reported to the CCG

4. A patient's missed appointments were not followed up on: CLDT are ensuring that each appointment that is missed is followed up with an individual telephone call on the day and a further appointment offered. Risk assessments will be updated as required with a daily progress note to say appointment was not attended. The outcome will be reported to the CCG

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 3 completed SJRs included:

- Collaborative working between mental health teams and substance misuse teams is essential to ensure that patients with co-morbid conditions receive the correct interventions.

- Physical health monitoring, including support for smoking cessation, continues to be an area that requires ongoing focus ensuring that we are meeting the needs of our patients

- The covid-19 pandemic increased the feelings of social isolation for those that were classed as clinically vulnerable and shielding in the first wave of the pandemic

- Trauma and extremes of stress can increase an individuals' feelings of hopelessness and have complex impacts on their mental well-being.

The completed SJR's revealed several good practice points including:

- Robust support for an individual at a time of crisis

- Good support for an individual's wider family and completion of a carer assessment

- Good transition support as the patient moved between teams

- Excellent collaborative care planning

The specific learning and good practice identified in the completed SJRs has been shared with the teams involved with the patients at the time of their death.

Analysis of National Spine-System Recorded Deaths

From the sample of 22 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 (2021/22), deaths were recorded as being due to cancers of various organs, multiple organ failure, pneumonia, dementia, frailty syndrome and old age. The ages of those who died ranged from 30 to 99 (with the majority being over 75). Cases reviewed from the spine are people living in the community, either in their own homes or residential/supported living settings. Some deaths occur in general (acute) hospital settings, many of these individuals are seen by SHSC's Liaison Psychiatry Service for

advice/assessment. These are logged as SHSC deaths for the purposes of internal recording, even though there has been minimal input.

During quarter 3 the reviewed spine data provided assurance that all of the incidents that required reporting via the Trust's internal system, Ulysses, were correctly reported. That is, all deaths of people who died while actively under our care were reported as incidents, in line with our policy.

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 has been 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). It is anticipated that this dashboard will be replaced with the Better Tomorrow version for the Q4 / Annual report.

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

Better Tomorrow Project update

As part of NHSE/I's support package for SHSC, we are participating in a national project to improve learning from deaths, with external expert support. The aim is to work with Better Tomorrow, utilising our quality improvement approach, to better understand our mortality information and identify the learning opportunities this presents. This will enable us to improve and strengthen our quarterly reporting and focus on learning.

Work to date:

The project has now moved into the final stages of completion. The whole project has included:

- Mortality review staff training
- Clinical staff training for completion of structured Judgement Reviews (SJR's)
- Mortality processes and learning extraction development
- Policy development and review

The mortality staff team training is now completed with the team having attended several national training events led by the Better Tomorrow team.

During quarters 1, 2 and 3 the mortality team have been focused on the development of mortality processes and specifically on how learning from deaths can be systematically captured, extracted and reported. The SJR template has now been refined for use on the Ulysses incident management system to provide a platform for the electronic sharing and storage of the document. This will improve the length of time taken to complete and report on the learning extracted from the SJR process. The Better Tomorrow team will lead on the wider training for Trust staff in February 2022, thereby increasing the capacity of SJR trained staff.

A newly configured learning extraction system and dashboard is anticipated as going live for the quarter 4 / Annual mortality report. This will improve the monitoring, extraction of learning and reporting elements of the mortality processes. It should be noted that this is a complex process that will require adaptations to the Ulysses incident management system.

The final stage of the Better Tomorrow project will see the development of a revised policy that reflects the mortality process changes and improvements ready for the start of Q1 2022/23.

Learning From All Deaths Within Mental Health And Learning Disability Services

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from ALL DEATHS. Working with eight other mental health trusts in the north of England we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur. We have decided not to initially report on what are described in general hospital services as "avoidable deaths" in inpatient services. This is because there has previously been no research base on this for mental health services an+A1d no consistent accepted basis for calculating this data. In November 2018 the Royal College of Psychiatrists developed a Care Review Tool which introduces the 'avoidable mortality' question. We are continuing to work with the other trusts in the North of England to test this approach and will review this dashboard accordingly, following this.

Appendix 1 - Learning from Deaths Dashboard

Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)

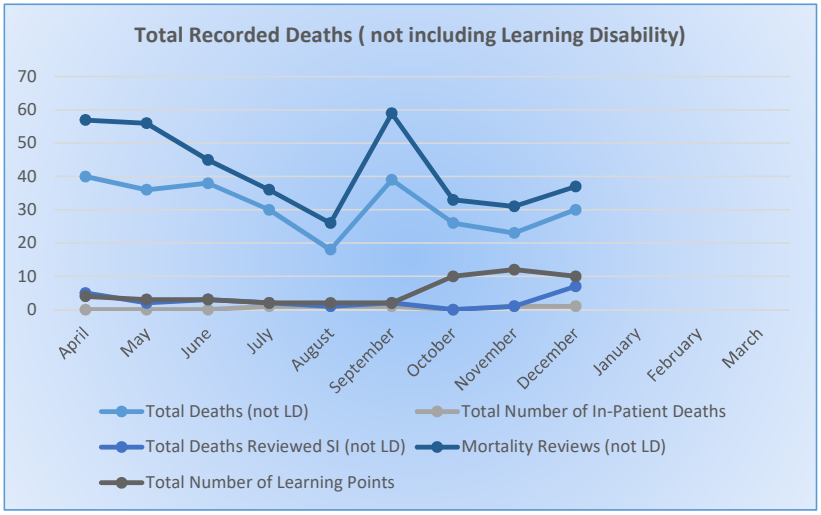
Reporting Period - Quarter 3 (October - December 2021)

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 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	Total number of actions resulting in change in practice
Q1	Q1	Q1	Q1	Q1
114	**0**	**10**	**158**	**10**
Q2	Q2	Q2	Q2	Q2
87	**3**	**5**	**121**	**6**
Q3	Q3	Q3	Q3	Q3
79	**2**	**8**	**100**	**32**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
280	**5**	**23**	**379**	**48**



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
5	**0**	**5**	**5**	**2**
Q2	Q2	Q2	Q2	Q2
6	**0**	**6**	**6**	**2**
Q3	Q3	Q3	Q3	Q3
4	**0**	**4**	**4**	**4**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
15	**0**	**15**	**15**	**8**