Board of Directors – Public

SUMMARY REPORT	Meeting Date:	27 July 2022
	Agenda Item:	14

Report Title:	**Mortality Annual Report 2021/22**	
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:	13th July 2022
Key points/ recommendations from those meetings	To continue to draw out learning from a more systematic approach to mortality workshops with teams.	

Summary of key points in report

This annual mortality report seeks to give assurance that during 2021/22 SHSC was compliant with the National Quality Board standards for learning from deaths.

The report also gives assurance that we are an organisation working at pace to improve learning.

The final section of the report provides assurance that we are developing an open learning culture via a summary of our work to learn from deaths, with some narrative examples, during 2021/22.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**		**Assurance**	**X**	**Information**	

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

Is this report relevant to compliance with any key standards ?					State specific standard
Care Quality Commission Fundamental Standards	*Yes*				Person Centred Care and Dignity and Respect
Data Security and Protection Toolkit			*No*		This is not applicable to mortality processes
Any other specific standard?	*Yes*				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*				Involving carers and families to ensure their rights and wishes are respected.
Financial (revenue &capital)	*Yes*				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 identifiable impact.
Equality, Diversity & Inclusion	*Yes*				The mortality processes are inclusive of all ages, genders and cultural and ethnic backgrounds.
Legal	*Yes*				No identifiable impact.

Name of Report: Mortality Annual Report 2021/22

Section 1: Analysis and supporting detail

1.1 **Introduction**

Learning from the deaths of people in our care can help us improve the quality of the care we provide to patients and their families, and identify where we could do more. The Learning from Deaths national policy and processes were implemented in response to multiple failures to learn from deaths first identified at the Southern Health NHS Trust and later failures to learn from the deaths of patients such as Connor Sparrowhawk.

SHSC have robust systems in place in order to learn from and have insight into all patient deaths, including a weekly mortality review meeting chaired by the Executive Medical Director.

The National Quality Board (NQB) and the Care Quality Commission

The NQB guidance outlines how our organisation should respond to deaths within our community. In 2020 the Care Quality Commission (CQC) inspections had shown good progress was being made by some NHS hospital trusts to implement national guidance on learning from deaths. However, failure to fully embrace an open, learning culture may be holding some organisations back from making the required changes at the pace needed.

Assurance

This annual mortality report first sets out assurance in relation to our compliance with the NQB standards for learning from deaths. The report then offers assurance that we are an organisation working at pace to make the required improvements. Finally, the report provides the assurance that we are developing an open learning culture via a summary of our work to learn from deaths during 2021/22.

1.2 **Policy**

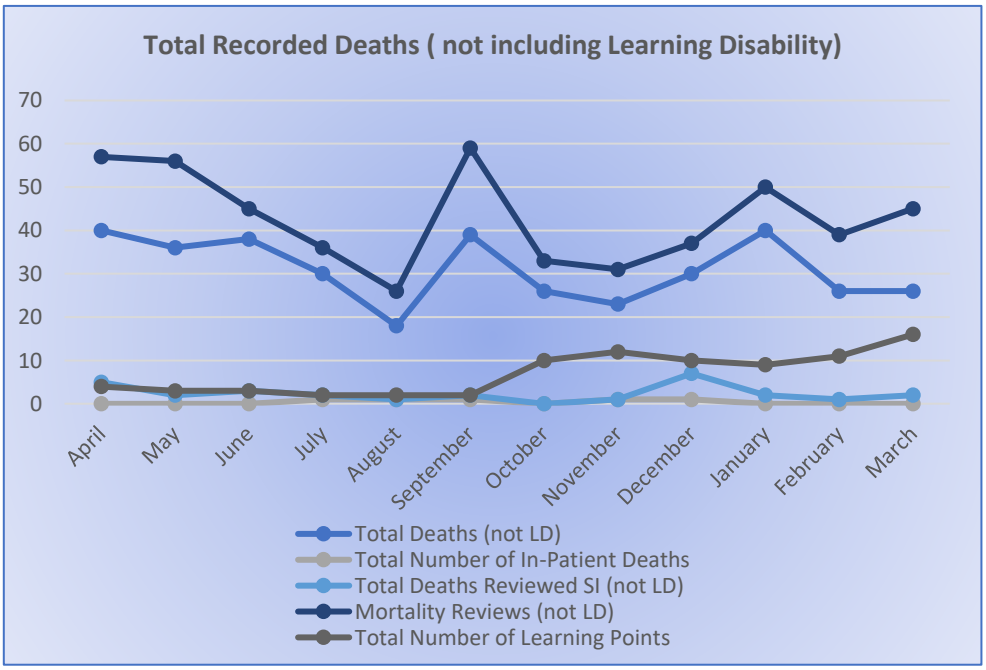
The NQB standard dictates that we should have a learning from deaths policy in place. The SHSC learning from deaths policy was fully reviewed during 2021/22. Amendments made to the policy were in line with the improvements we have made in collaboration with the national Better Tomorrow learning from deaths team during 2021/22. A shorter date for the next review has been agreed for 12 months' time. This will allow for further significant policy updates, expected during 2022/23, to be added before the usual 3-year review cycle. The changes expected relate to the final version of the mental health learning from deaths dashboard and the roll out of community based Medical Examiners.

1.3 **A tool records relevant incidents of mortality**

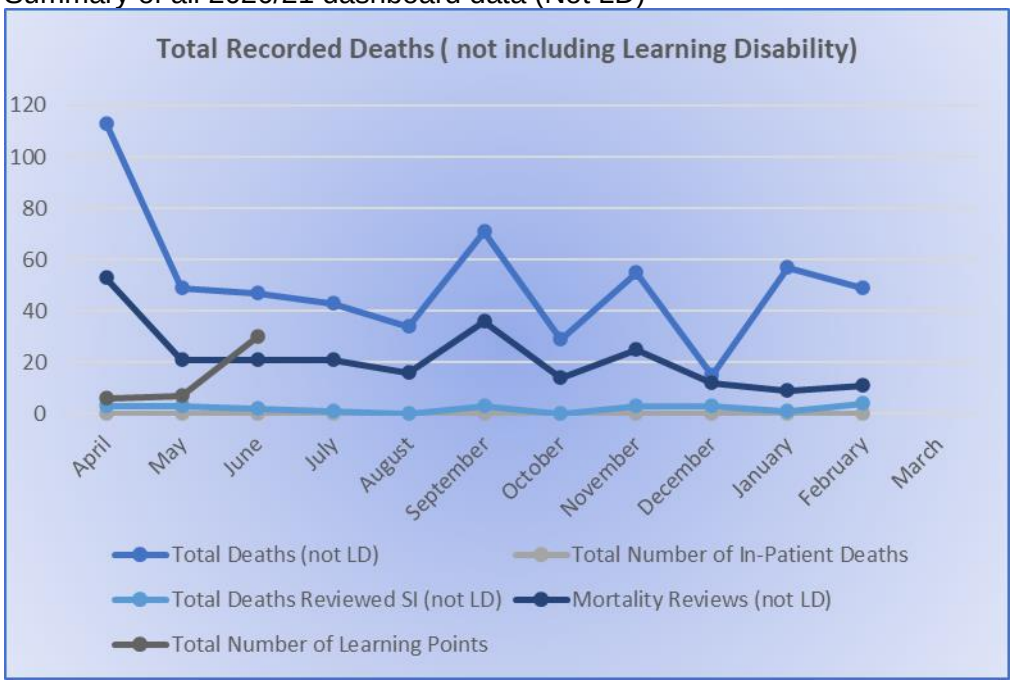
All organisations are expected to have a mortality dashboard. During 2021/22 the mortality team have been working closely with the Better Tomorrow team to develop a specific mental health mortality dashboard that includes metrics that are relevant to our organisational need. The new dashboard will supersede the current mortality dashboard during 2022/23. The 1st iteration of the new MH dashboard is expected at the end of July 2022.

Below is a summary of the current 2021/22 dashboard data compared against the dashboard from 2020/21.

Summary of all 2021/22 dashboard data (Not LD)

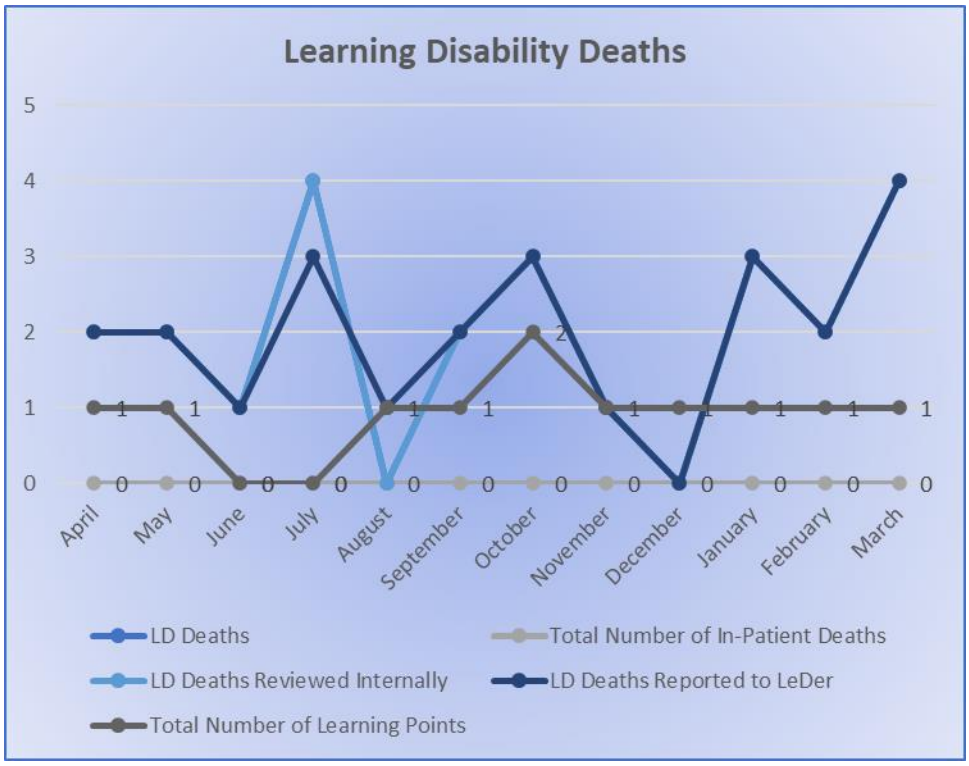


Summary of all 2020/21 dashboard data (Not LD)



By comparison the dashboard for 2021/22 shows an increase in the number of extracted learning points disseminated throughout SHSC. 2021/22 also clearly shows that the number of mortality reviews is higher than the total number of deaths reported via the incident reporting system. This offers assurance that SHSC are reviewing a sample of deaths related to people who died within 6 months of discharge from services as well as all of those with an open episode of care.

Summary of all 2021/22 Learning Disability dashboard data



Summary of all 2020/21 Learning Disability dashboard data

By comparison the Learning Disability dashboard for 2021/22 shows an increase in the number of learning points derived from these types of deaths. There was also an increase in the number of internally reviewed Learning Disability deaths. All Learning disability deaths for 2021/22 were reported to LeDeR. SHSC has a robust system in place for the management and dissemination of learning identified from these deaths.

1.4 **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)**

The 2021/22 learning from deaths policy clearly outlines which patients are under our care and has clear guidance on those specifically excluded from care reviews.
In addition to people with an open episode of care, anyone who has had contact with SHSC services within 6 months of their discharge can be subject to a care review either due to the circumstances of their death or as a part of SHSC's random sampling process.

1.5 **All open episode deaths will be reported within our organisation and to other organisations who may have an interest**

During 2021/22 the mortality review group cross checked all open episodes of care reported via the National SPINE monthly to ensure every death was internally reported. Where required SHSC linked to the GP and other services including the coroner, the CCG and the CQC. During 2021/22 all open episode deaths were reported on the Ulysses incident reporting system and were subject to systematic review in the weekly mortality review meeting.

1.6 **We will review the care provided to patients who we do not consider to have been under our care at the time of death**

During 2021/22 SHSC reviewed a total of 90 deaths of people who did not have an open episode of care at the time of their death. A sample of the 90 deaths (5) were taken forward for a Structured Judgement Review (SJR) and the learning was disseminated directly into teams.

1.7 **We will review the care provided to patients whose death may have been expected, for example those receiving end of life care**

During 2021/22 all expected deaths were reviewed against the required criteria set out in the learning from deaths policy. Eight detailed Structured Judgement Reviews (SJRs) completed were related to learning from expected natural cause deaths with a specific focus on end-of-life care. Learning from one expected death of a patient with an eating disorder was extracted using Serious Incident Investigation processes.

1.8 **We will record the outcome of our decision whether or not to review or investigate the death, informed by the views of bereaved families and carers**

All decisions pertaining to the review and potential investigation of a deaths were recorded on the Ulysses incident management system. All deaths in 2021/22 were subject to review using the learning from deaths and serious incident management policy criteria. 16 were subject to SJR processes and 26 were formally investigated using Serious Incident Investigation processes.
Where deaths were not reviewed by the medical examiner or coroner, bereaved families and carers were contacted directly by SHSC to understand their experience of the care and treatment provided to their loved one. Where deaths were subject to Serious Incident Investigation the families and carers were contacted in order to involve them fully in the investigation.

1.9 **We will engage meaningfully and compassionately with bereaved families and carers**

During 2021/22 a family liaison officer role was developed in order to ensure that all bereaved families and carers are afforded the opportunity to engage meaningfully with SHSC. Whilst this is currently a limited resource a 12-month impact assessment is underway. During 2021/22 the mortality team enrolled in specific Making Families Count training in order to expand, enhance and improve the overall family liaison skills within the team.

1.9.1 **Developments in embracing an open learning culture in mortality during 2021/22**

In April 2021, Sheffield Health and Social Care NHS Foundation Trust (SHSC) carried out the Better Tomorrow desktop review of its systems and processes for learning from deaths. This included a review of key documents such as the Trust's learning from deaths policy and strategy and end-of-life care plans.

Since then, the Trust's mortality leads have met regularly with the Better Tomorrow team to discuss the context for the desktop review, identify gaps and agree the final improvement project plan for 2021/22. An identified key risk to the delivery of these improvements was the need for project management support. An improvement investment was made in April 2021 by NHS England Improvement and a 2 day per week project support officer was recruited.

The agreed 2021/22 Project Plan:

Task	Timescale	Task outcome
Update the learning from deaths policy to include horizon scanning and clear lines of reporting	October 2021 to January 2022	Policy accepted- shorter review time given to allow for horizon scan change's including the MH dashboard and community medical examiners.
Redesign the learning from deaths process, setting out the steps to link to other safety processes through to monitoring.	October 2021 to April 2022	Spine to dashboard reporting redesigned and ongoing monitoring in line with policy update
Influence organisational culture promoting learning from deaths through development sessions, workshops and existing meetings	October 2021 to March 2022 (starting with Dying for Change trilogy 12th October)	Staff engagement completed. 100% attendance at multidisciplinary workshops. Presentations at CQSG, QIF, QAC and Nursing and allied professionals' meetings.
Design an electronic SJR – using the RC-Psych tool and SJR+ elements	Initially use Microsoft Forms then ORIS November 2021 to pilot in April 2022	Online system available to use from June 2022 following pilot phase and data extraction
Support development of cohort of multi-disciplinary reviewers through online training and masterclass delivery	October 2021 – December 2021	Cohort of registered clinicians trained across the organisation.
Develop stakeholder communication plan and information sharing including mortality dashboard	December to July 2022	Evidence of sharing output from mortality reviews and trends for different staff groups currently underway

SHSC Key Improvement Successes during 2021/22:

1) **Structured Judgement Reviews:** The process in place at the time of the desk top review relied heavily on the mortality team completing the SJR's, disseminating the learning to teams and the SJR template was not fit for purpose within mental health settings. During 2021/22 the mortality team digitised and re-structured the SJR template. The Better Tomorrow team and the mortality team collaboratively delivered SJR+ training to multidisciplinary clinicians across the Trust. This improvement now allows local teams to have responsibility for their own SJR+ reviews and subsequent learning in a format that is relevant to their client group.
2) **Ensuring that SHSC has key membership in the national lead's mortality learning group:** SHSC has had representation at each monthly meeting and has played a key part in developing the emerging national practice in learning from death included being at the forefront of the development of a mental health mortality dashboard which will eventually be rolled out nationally.
3) **Developing mental health metrics and the national mortality dashboard:** During 2021/22 the mortality team, in collaboration with the Better Tomorrow team, have been developing and refining the metrics that will be used in the final mortality dashboard due to be launched at the end of July 2022.

1.9.2 **Detailed Learning from deaths in 2021/22**

- Substance Misuse

We reviewed the deaths of people within our substance misuse services following local and national reports of potential excess deaths since the pandemic. The data told us that 2021 was relatively stable but that there was an excess number of deaths specifically within our opiate services in 2020. As a result of this the mortality team worked collaboratively with the Substance Misuse Service during 2021/22 to develop specific all service workshops in order to share and understand the learning from the estimated 20 excess deaths in 2020. There is a final workshop event scheduled for July 2022. So far, the learning extracted indicate that:

- There was only 1 covid-19 death in the whole cohort
- There was very little noted in relation to covid-19 in any of the records reviewed. In some cases (5), a change to non-face to face approaches was noted in the records. In one case a decision was made to continue with face to face due to individual vulnerability
- The majority of cases were male with an average age of 39
- Comorbid mental health issues featured in most cases
- Physical health issues played a part in all cases reviewed: including hepatitis, respiratory disease, diabetes, weight related issues and liver cirrhosis
- Social depravation was highlighted in most cases including poor housing and access to a mobile telephone to maintain contact with others
- Early life trauma was a feature in almost all cases, with reference to past abuse both physical and mental
- In three cases the client told the key worker that their drinking had increased due to social isolation in particular isolation from family members

Once this work is completed a more detailed report will be provided in the Q1 Mortality report including an outline of the action learning points.

- Homeless Assessment and Support Team (HAST)

During a covid related mortality review HAST identified 10 client deaths over a 13-month period between 2020 and 2021. This was a large number of deaths for this service. Therefore, the service wanted to understand and explore whether

there were any issues to be aware of or themes with regards to the deaths. Initial learning extraction highlighted:

- Care of clients - was found to be good overall
- Complexity – All clients had a high level of complexity of need and life experience, meaning that they often had multiple service contact, or could be reluctant to engage or untrusting of services.
- Risk – Majority of clients were in high-risk category due to co-morbidity and vulnerabilities. Age range at time of death was not untypical of client group.

The mortality team in collaboration with HAST are developing a number of focused learning workshops which will be reported in Q2 2022/23.

- Other 2021/22 Examples of Mortality Learning

Learning shared with the teams during 2021/22:

- 4 patients reviewed using the structured judgement tool had long-term mental health issues (15yrs+) and were receiving long-term anti-psychotic medication. All 4 patients had physical health issues which could have been monitored in a more structured way.
- In each of the 4 cases communication with the patients GP could have been more robust in relation to their ongoing physical health issues.
- The Older Adult Home Treatment Team (OAHTT) identified a gap in communication between GP, acute hospital and SHSC, and action was taken to address this by the clinical leads for the services involved.
- Covid-19 constraints left some patients feeling more isolated when face to face visits were reduced in number.
- Patients experienced challenges in navigating contact with different teams. In 4 case reviews the patients were being seen by different teams without one clear single point of care coordination.

Examples of good practice:

- The Older Adult Community Team enabled a patient to live longer in the community with robust family support and frequent MDT monitoring.
- There was evidence of good medication guidance for patients and their family
- In 4 case reviews the care coordinators supported the patient to attend regular hospital appointments.
- In 4 cases reviewed the collaborative care plans and risk assessments were updated and reflective of the care and treatment being provided by the team.
- Nursing homes were identified as sensitively planning end of life care plans
- Investigators found good evidence of inter-agency working between the Recovery team, acute hospital and the council's housing team

Covid- 19 deaths in 2021/22
All covid-19 deaths were reviewed and recorded by the mortality review group. During 2021/22 there were 14 covid-19 deaths reported. These deaths were primarily patients cared for by older adult community teams.

Learning from mortality in 2022/23
SHSC will continue to develop processes and learning in 22/23. During 2022/23 the new mental health mortality dashboard will enable us to broaden our understanding of the way we can contribute to reducing early mortality, particularly for our most vulnerable, marginalised patients.

The process for extracting learning from the electronic SJR+ process will be a key focus for development during 2022/23. We will audit this new process in the first 12 months.

The mortality quarterly reporting template, currently being reviewed nationally, will be re-structured to align with the new national template during 2022/23.

The mortality team will continue to work with individual teams and services to ensure that we continue to collaboratively understand mortality themes and trends during 2022/23.

Section 2: Risks

2.1 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 internal 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

4.3 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 N/A

Compliance - Legal/Regulatory

4.7 As previously described