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NHS
Sheffield Health and Social Care
NHS Foundation Trust

Board of Directors – Public

SUMMARY REPORT	Meeting Date:	27 September 2023
	Agenda Item:	14.2

Report Title:	Mortality Annual Report 2022/23	
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:	13 September 2023
Key points/ recommendations from those meetings	The Quality Assurance Committee were assured that SHSC were compliant with national and local policy standards for Learning from Deaths. It was agreed that the quarter 2 mortality report would explore the National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH) Safety Scorecard 2017, 2018 and 2019 in order to establish the validity of this data. It is suggested that this data included deaths of people solely accessing substance and alcohol misuse services, hence why SHSC is above the national average for mental health trusts.	

Summary of key points in report							
This annual mortality report seeks to give assurance that during 2022/23 SHSC was compliant with the NQB standards for learning from deaths. The final section of the report provides assurance that we fully embrace an open learning culture via a summary of our work to learn from deaths, with some narrative examples, during 2022/23.							
Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	**X**	**Information**	
It is recommended that the Board of Directors is assured that SHC is compliant with national standards and local policy for learning from deaths.							

Please identify which strategic priorities will be impacted by this report:				
Recover services and improve efficiency	Yes	x	No	
Continuous quality improvement	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, Engagement 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.
Sustainability	Yes				No identifiable impact.

Mortality Annual Report 2022/23

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 National Health NHS Service (NHS Trust) and later failures to learn from the deaths of patients such as Conner 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 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 to make the required improvements. Finally, the report provides the assurance that we fully embrace an open learning culture via a summary of our work to learn from deaths during 2022/23.

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 2022/23. Amendments made to the policy were in line with the improvements we made in collaboration with the Better Tomorrow team during 2021/22. A shorter date for the next policy review has been agreed for 12 months' time. This will allow for further significant policy updates, expected during 2023/24, to be added before the usual 3-year review cycle. The changes expected relate to the final version of the MH dashboard and the roll out of community based Medical Examiners.

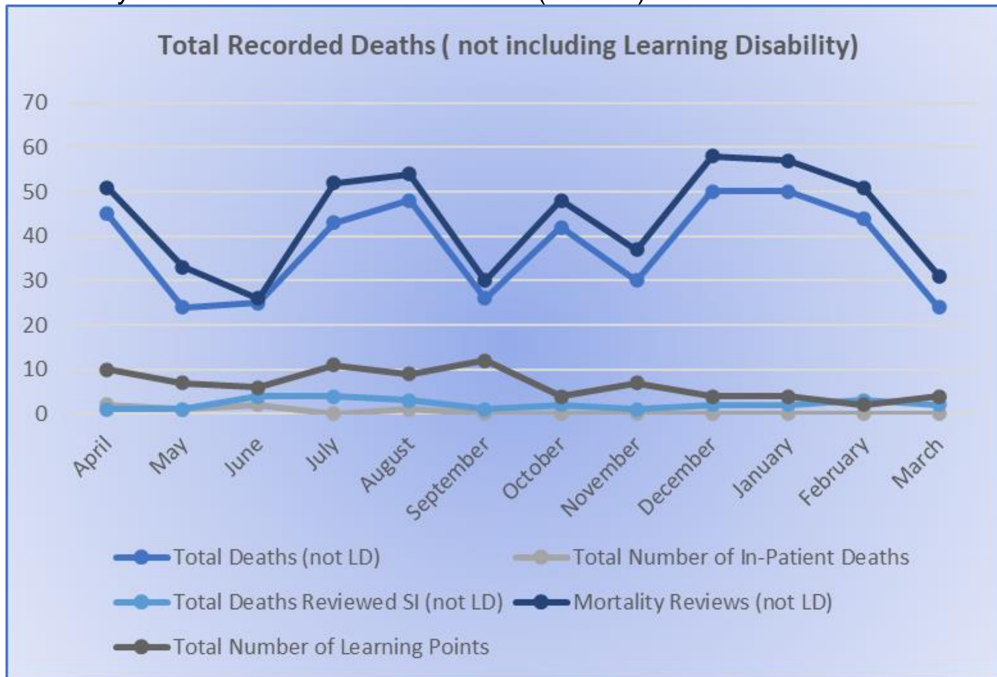
1.3 **Mortality Dashboard**

All organisations are expected to have a mortality dashboard. During 2021/22 the mortality team worked 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 was expected to supersede the current mortality dashboard during 2022/23. However, due to a number of unforeseen technical issues related the SHSC's IT interface the new dashboard is not yet in a usable format and SHSC continues with the use of the older dashboard developed in

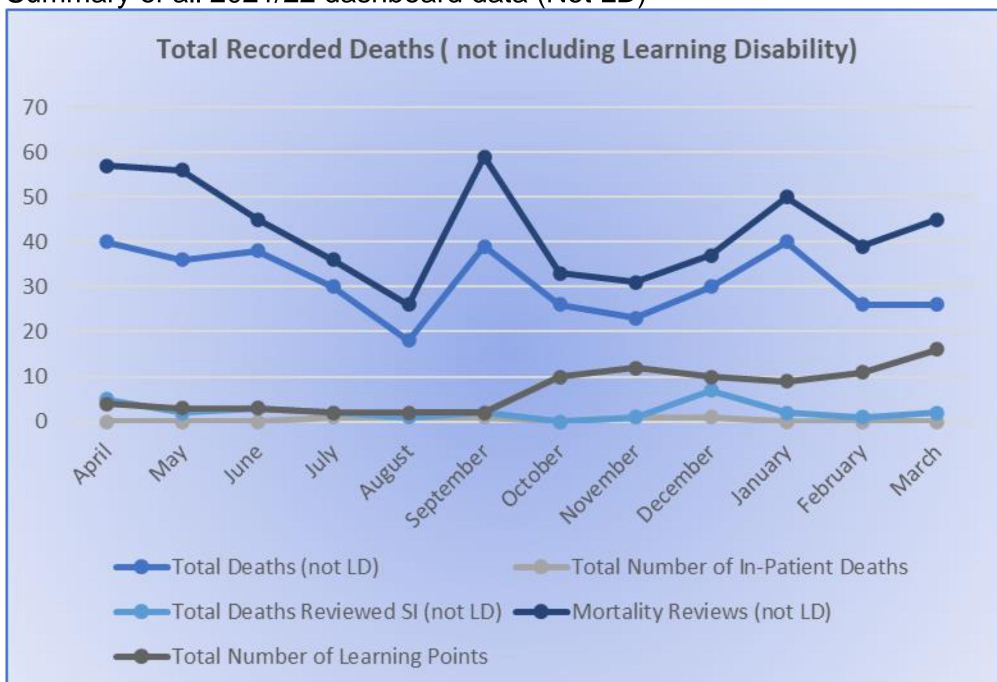
collaboration with the learning from death Northern Alliance. It is anticipated the the new dashboard will be available for use in quarter 2 of 2023/24

Below is a summary of the 2022/23 dashboard data compared against the dashboard from 2021/22.

Summary of all 2022/23 dashboard data (Not LD)

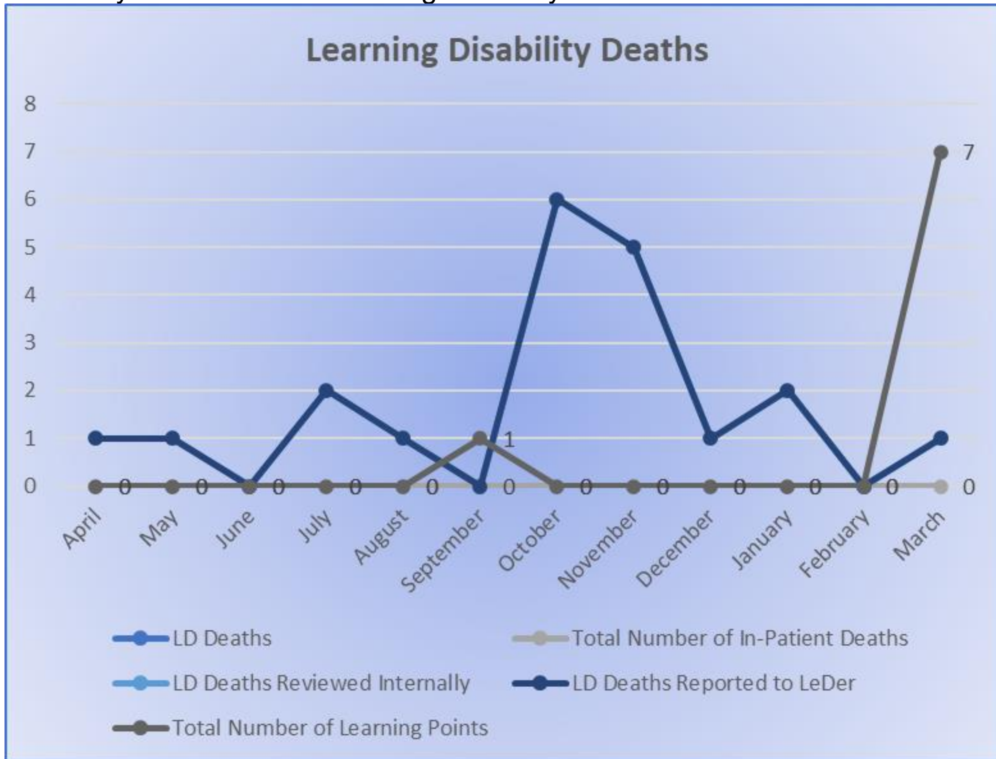


Summary of all 2021/22 dashboard data (Not LD)



The dashboard for 2022/23 continues to show that SHSC regularly extracted learning points which were then disseminated throughout SHSC. 2022/23 data 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 2022/23 Learning Disability dashboard data



Summary of all 2021/22 Learning Disability dashboard data

All Learning disability deaths are reported to LeDeR. SHSC has a robust system in place for the management and dissemination of learning identified from these deaths. From January 2021 all deaths of those with a known diagnosis of autism were

externally reported for a LeDeR type review. Learning points extracted from the LeDeR review process are shared via the mortality review team with the Community Learning Disability Team (CLDT) for either implementation of actions or dissemination of general learning.

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 2022/23 learning from deaths policy clearly outlines which patients are under our care and has clear guidance on those specifically excluded from care reviews. 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. The SHSC mortality team work on the principle of professional curiosity when any death is reported that meets the criteria for review.

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

During 2022/23 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 ICB and the CQC. During 2022/23 all open episode deaths were reported on the Ulysses incident reporting system and were subject to systematic review in the weekly mortality review meeting. During 2022/23 12 deaths were discovered to have been unreported by services, however further due diligence established that these deaths were related to people held as open episodes on the dementia register. These deaths were subsequently reported and subject to mortality review processes.

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 2022/23 SHSC reviewed a total of 72 deaths of people who had been discharged from services within 6 months of their death and were therefore not considered to under our care at the time of their death. A random sample of the 72 deaths (8) 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 2022/23 all expected deaths were reviewed against the required criteria set out in the learning from deaths policy. 7 detailed Structured Judgement Reviews (SJR's) completed were related to learning from expected natural cause deaths with a specific focus on end-of-life care.

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 2022/23 were subject to review using the learning from deaths and serious incident management policy criteria. 19 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 elicit 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. During 2022/23 the mortality team enrolled in specific Making Families Count training in order to continue to expand, enhance and improve the overall family liaison skills within the team. Engaging with family and carers will be embedded further into our processes as we move to the new Patient Safety Incident Response Framework (PSIRF) in October 2023.

1.9.1 **Developments in embracing an open learning culture in mortality during 2022/23.**

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. The Better Tomorrow project was ceased during 2023, however, SHSC retains membership of the nation group focused on learning from deaths.

1.9.2 **Detailed Learning from deaths in 2022/23**

- Substance Misuse

In December 2021 Sheffield Star reported that 'new figures' showed an increase in the number of deaths of people in Sheffield undergoing drug treatment. This prompted an immediate review of substance misuse mortality data related to deaths of patients cared for by SHSC.

A number of workshop events were held during 2022. The learning extracted and shared indicated 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 20 records reviewed. In some cases (5), a change to non-face to face approaches was noted in the records. In 1 case a decision was made to continue with face to face due to individual vulnerability.
- The majority of cases were primarily male (18) with an average age of 39
- Comorbid mental health issues featured in 18 of the cases.
- Physical health issues played a part in all 20 cases: including hepatitis, respiratory disease, diabetes, weight related issues and liver cirrhosis.
- Social depravation was highlighted in 17 of the 20 cases including poor housing and access to a mobile telephone to maintain contact with others.
- Early life trauma and was a feature in almost all case (17), with reference to past abuse both physical and mental.
- In 3 cases the client told the key worker that their drinking had increased due to social isolation in particular isolation from family members.

A detailed report on this work was provided in the 2022/23 Q1 Mortality report including an outline of the action learning points.

Other 2022/23 Examples of Mortality Learning

- Long-Term Neurological Conditions deaths (LTNC)

During 2022/23 it was recognised via the Daily Incident Safety Huddle that there appeared to be an increase in the number of deaths being reported by LTNC, particularly in December 2022. Initial comparison data revealed that in Q3 of 2021/22 LTNC reported 8 deaths, however, during Q3 of 2022/23 LTNC reported 18 deaths. The mortality team and the LTNC management team carried out in-depth work to understand the causes of this potential increase and held 2

workshops with all LTNC staff in March 2023. The results of this work was included in the Q4 2022/23 mortality report.

- Reported Deaths on the Insight System

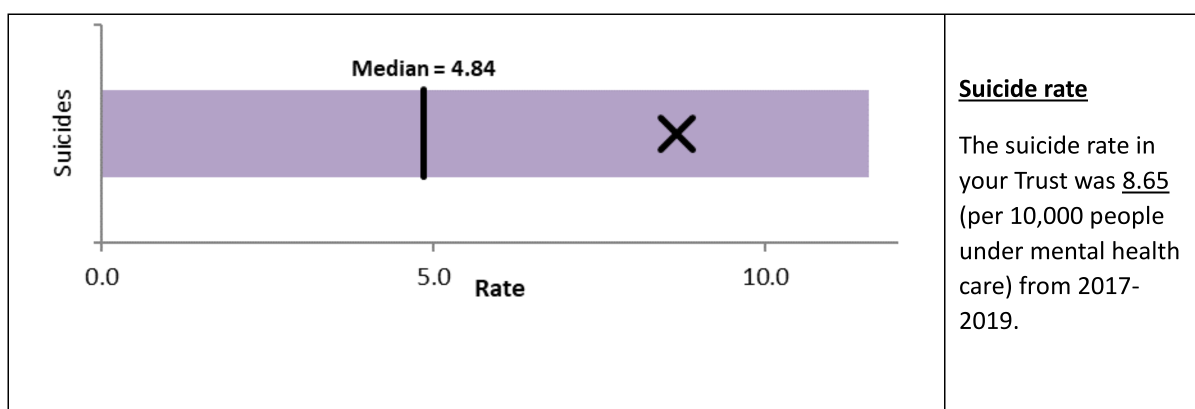
It was assumed that all deaths of people who died whilst actively under our care had been reported as incidents, in line with our policy. However, in November 2022 the mortality team were informed, by information governance, that there were 922 deaths that remained open on the electronic patient record system for patients that were known to have died. The cause of this issue was found to be linked to a clerical/administrative oversight. The mortality team reviewed all of this data and took the required action. Information governance have since taken steps to prevent this error reoccurring.

- National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH) Safety Scorecard 2017, 2018 and 2019

The NCISH Safety Scorecard was developed in response to a request from commissioners and the Healthcare Quality Improvement Partnership (HQIP), for benchmarking data to support quality improvement. It was shared with SHSC in 2022/23 and led to further detailed work.

- The information in the scorecard is based on data provided by SHSC. The scorecard consists of 2 indicators that relate to the mortality work of SHSC: suicide rate and homicide rate.

- The figures show the range of results across trusts in England in addition to our own position that is represented by an 'X'.



Suicide rate

The suicide rate in your Trust was 8.65 (per 10,000 people under mental health care) from 2017-2019.

During 2022/23 SHSC continued to play a key part the local and regional suicide awareness and prevention groups and played a part in the development of Real Time Surveillance, which aims to afford organisations timely data on the circumstances of each individual suicide, with a view to reducing the number of suicides overall. SHSC thematically reviewed the suicides of its service users in 2019 and again in 2022.

Learning shared with the teams during 2022/23:

- 6 patients reviewed using the structured judgement tool had long-term mental health issues (15yrs+) and were receiving long-term anti-psychotic medication. All 6 patients had physical health issues which could have been monitored in a more structured way.
- In each of the 6 cases communication with external partners could have been more robust in relation to their ongoing physical health issues.

- The Recovery teams identified a gap in communication between GP, STH and the Trust and action was taken to address this by the clinical leads for the services involved.
- 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 number of patients to live longer in the community with robust family support and frequent MDT monitoring.
- There was evidence of good medication and diagnosis guidance for patients and their loved ones.
- In 4 case reviews the care coordinators supported the patient to attend important meeting to review their physical health.
- In number of SJR's highlighted the good practice of developing safety plans with individuals at risk of suicide.
- The 2 nursing homes were identified as sensitively planning end of life care via collaboratively developed care plans.
- A patient had a long and complex physical health history and her relationship with alcohol was often difficult to manage. She drank consistently high quantities of alcohol as a way to self-medicate or cope with her many life stressors. The home environment didn't support alcohol reduction as other family members also drank. Although they did want to reduce and then stop alcohol this was only done in short time periods then they would suffer relapse. Staff offered appropriate treatment plans and options for support throughout the time when she was on active caseload including helping them recognise why they were self-medicating, and then trying to help them deal with both the underlying condition and the problems created by their drinking.

Learning from mortality in 2023/24

SHSC will continue to strive to learn from the deaths in our community. During 2023/24 the new mental health 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 2023/24.

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 2023/24.

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

Compliance - Legal/Regulatory

4.6 As previously described.