Board of Directors
Item number: 12
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Confidential / public paper:	Public
Report Title:	Mortality Annual Report 2024/25
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Accountable Director:	Professor Helen Crimlisk, interim executive medical director
Presented by:	Professor Helen Crimlisk, interim executive medical director
Vision and values:	The Mortality Review Team supports the Trust to deliver on the vision **to improve the mental, physical and social wellbeing of the people in our communities** by: • **Working together** with and advocating for the local population • Refocusing our services towards prevention and early intervention • Continuous **improvement** of our services • Developing a confident, skilled, **kind and respectful** workforce • Ensuring excellent and sustainable services
Purpose:	This report provides the Board of Directors with an overview of SHSC's mortality processes and any learning from mortality discussed in the Mortality Review Group (MRG) and Quality Assurance Committee. 100% of 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.
Executive summary:	During 2024/25, SHSC was fully compliant with the 2017 National Quality Board (NQB) standards for learning from deaths. 325 deaths (17 of which were learning disability deaths) were incident reported and reviewed via mortality processes, together with 1 additional death reviewed from the national spine to understand how the person came about their death and to ensure due diligence was followed and a review of care undertaken. This report analyses the deaths that have occurred by service/team, age, ethnicity and gender, in line with the National Quality Board guidance. As we move into 2025/26, mortality will be considered across other protected characteristics, not just ethnicity. The report aligns with the quarterly patient safety and learning report presented to the Quality Assurance Committee. **Appendices:** Appendix 1 - Deaths reported by service area/team, broken down by quarter and ethnicity Appendix 2 - National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) characteristics of SHSC suicides Appendix 3 - 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***	**X**	*No*		
Reduce inequalities	*Yes*		***No***	**X**	

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:

- CQC Regulation 18: Notification of other incidents
- CQC's Review of Learning from Deaths
- Learning Disabilities Mortality Review (LeDeR) Project
- NHS Sheffield Integrated Care Board Quality Schedule (part of NHS Contract)
- NHS England's Patient Safety Incident Response Framework
- SHSC's Patient Safety Incident Response Framework and Patient Safety Incident Response Plan
- SHSC's Duty of Candour/Being Open Policy
- SHSC's Learning from Deaths Policy
- National Quality Board Guidance on Learning from Deaths (2017)

Board assurance framework (BAF) and corporate risk/s:	There is currently 1 risk associated with this item: **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:	The Board of Directors have received reports covering mortality for the first 3 quarters of the year. The Quality Assurance Committee has also received these and this report. This report covers quarter 4 of 2024/25, as well as the annual overview.
Recommendation:	It is recommended that the Board of Directors: • Receives **assurance** that SHSC has robust mortality and learning from deaths review processes in place.

Mortality Annual Report 2024/25

1. Purpose

This report provides the Board of Directors with an overview of SHSC's mortality processes and any learning from mortality discussed in the Mortality Review Group (MRG).
100% of 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.

For each death reviewed, the mortality processes aim to determine and understand:

- 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 setting or own home?
- Whether the patient had a Learning Disability or Autism Spectrum Disorder?
- 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?
- Whether there was any other indicator that they may not have received good care including inequalities markers?

2. Background

2.1 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.

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

2.3. 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, autism or mental health needs
- Review the care provided to patients who we do not consider having 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.

National Mortality and Learning from Deaths

2.4 Understanding mortality in mental health settings can be complex and extracting learning may mean that exploration of co-morbidities is necessary. A priority for the Mortality Review Group (MRG) was to continue to engage with the national Better Tomorrow project in order to improve and strengthen our learning from deaths.

2.5 The Better Tomorrow project came to an end, however, SHSC remains an active member of the National Mortality and Learning from Deaths group, which is a legacy of the Better Tomorrow project. Members of the mortality group have attended the National and Learning from Deaths Group, national LeDeR and national Structured Judgement Review (SJR) meetings as well as local mortality groups. This enables members to remain updated for both national and Integrated Care Board perspectives. This is a valuable learning experience about trends in deaths which informs the focus of the SJRs undertaken. This informs our focus which is currently around end-of-life care in regard for SJRs.

2.6 During June and July 2025, SJR training sessions have been set up within SHSC to train circa 15 medical staff in undertaking SJRs. For the SJRs that are required to be undertaken, a prioritisation process will occur to ensure those where maximum learning is anticipated, will be completed first.

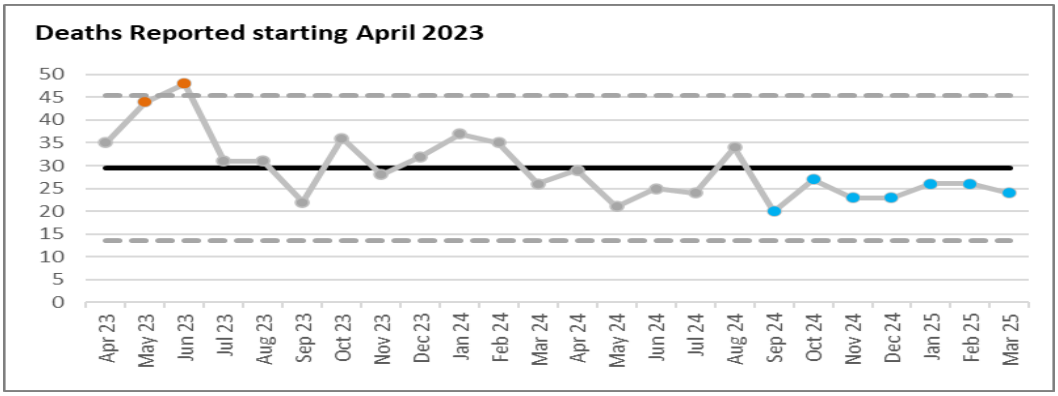
3. Mortality Data

100% of deaths reported through SHSC's incident management system (Ulysses), together with a sample of deaths recorded through national death reporting processes, were reviewed at the weekly MRG. Within 2024/25, the MRG reviewed a combined total of 326 deaths individually.

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

Reporting Period	Source	Number of Deaths
2024/25	NHS Spine (National Death Reporting Process)	1
	Incident Report (excluding LD Deaths)	308
	Learning Disability Deaths	17
	Total	326

The statistical process chart below shows the number of deaths reported as an incident on a monthly basis from April 2023 to March 2025. The chart shows a potential downward trend, which is thought, partially, to be a legacy effect of the loss of substance misuse services. However, this will continue to be monitored going forwards and may result in a reduction in the upper control limits if this reduction is sustained.

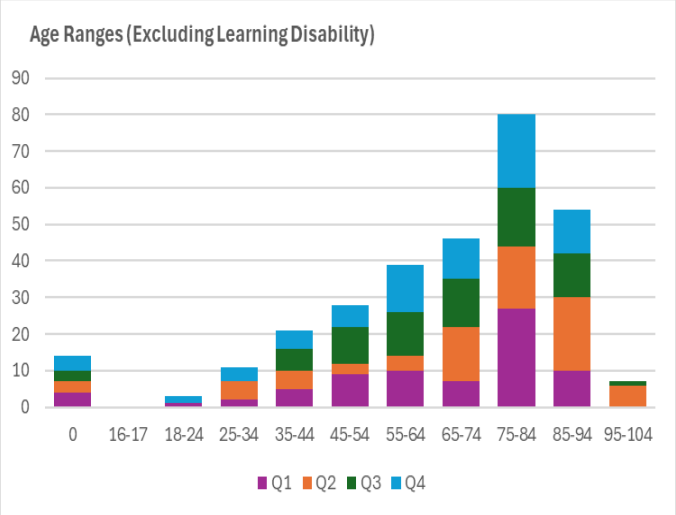


Analysis of All Death Incidents Reported (Excluding Learning Disabilities)

Deaths reported as incidents during 2024/25 are classified in the table overleaf, broken down by reporting quarter:

Death Classification (all deaths except LD)	Q1	Q2	Q3	Q4
Expected Death (Information Only)	32	28	30	27
Expected Death (Reportable to HM Coroner)	2	0	0	0
Suspected Suicide – Community	5	6	6	4
Unexpected Death - SHSC Community	19	13	17	17
Unexpected Death - SHSC Inpatient/Residential	3	1	0	1
Unexpected Death (Suspected Natural Causes)	26	30	18	23
Suspected Homicide	0	0	0	0
Total	87	**78**	**71**	72

The chart/table below show the age breakdown for deaths that were incident reported (excluding Learning Disability deaths):



Age Range	Q1	Q2	Q3	Q4	Total
0*	4	3	3	4	**14***
16-17	0	0	0	0	**0**
18-24	1	0	0	2	**3**
25-34	2	5	0	4	**11**
35-44	5	5	6	5	**21**
45-54	10	3	10	6	**29**
55-64	10	4	12	13	**39**
65-74	7	15	13	11	**46**
75-84	27	17	16	20	**78**
85-94	11	20	14	12	**57**
95-104	0	6	1	0	**7**

** These deaths have no age recorded on Ulysses. This is due to the patient information not being pulled from Insight (or Rio), eg the service user may have been under such teams as LTNC, which use SystmOne instead of Insight/Rio.*

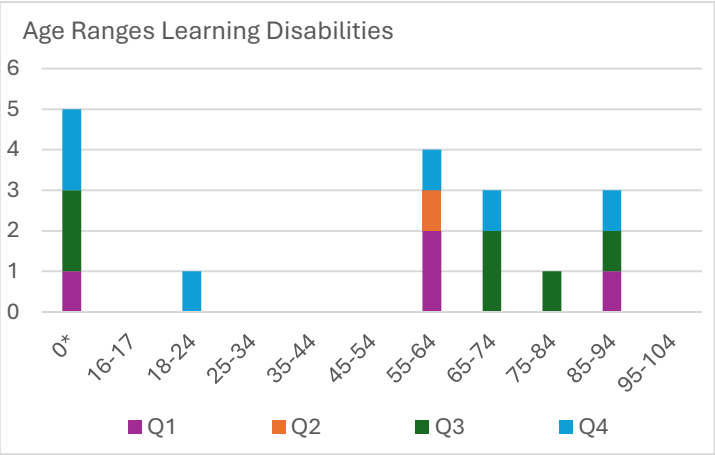
The above shows that the highest number of deaths reported in 2024/25 were service users aged between 75-84 years of age, followed by people in the 85– 94 age range.

Analysis of Learning Disability Deaths Reported

Learning disability Deaths reported as incidents during 2024/25 are classified in the table below, broken down by reporting quarter:

Death Classification (LD only)	Q1	Q2	Q3	Q4
Expected Death (Information Only)	0	0	1	3
Expected Death (Reportable to HM Coroner)	0	0	0	0
Suspected Suicide - Community	0	0	0	0
Unexpected Death - SHSC Community	2	0	1	1
Unexpected Death - SHSC Inpatient/Residential	0	0	0	0
Unexpected Death (Suspected Natural Causes)	2	1	4	2
Suspected Homicide	0	0	0	0
Total	4	1	6	6

The chart/table below shows the age breakdown for learning disability deaths that were incident reported in 2024/25:



Age Range	Q1	Q2	Q3	Q4	Total
0*	1	0	2	2	**5***
16-17	0	0	0	0	**0**
18-24	0	0	0	1	**1**
25-34	0	0	0	0	**0**
35-44	0	0	0	0	**0**
45-54	0	0	0	0	**0**
55-64	2	1	0	1	**4**
65-74	0	0	2	1	**3**
75-84	0	0	1	0	**1**
85-94	1	0	1	1	**3**
95-104	0	0	0	0	**0**

* *These deaths have no age recorded on Ulysses. This is due to the patient information not being pulled from Insight (or Rio), eg the service user may have been under such teams as LTNC, which use SystmOne instead of Insight/Rio.*

The above shows that the highest number of deaths reported in 2024/25 were service users aged between 55-64 years of age, followed by people in the 65-74 age range. This demonstrates what previous studies (including LeDeR reviews) have found that typically, people with a learning disability die approximately 20 years younger than people without a learning disability.

Breakdown by Service Area/Team

A detailed breakdown for deaths reported as incidents during 2024/25 per service area/team is provided in Appendix 1.

The table below provides a summary of which services were providing the care (or the most recent) care episode) at the time of death, as a percentage of the total number of deaths.

Service Area/Team	Percentage of all deaths recorded
Older Adult CMHT	35.17%
LTNC/Neuro Enablement Services	14.37%
CMHT	9.17%
Liaison Psychiatry	8.77%
Learning Disability Services	5.2%
Woodland View	4.89%
SPA/Urgent & Crisis Services	3.98%
Birch Avenue	2.75%
Sheffield Talking Therapies	2.14%
G1	2.14%
Early Intervention Service	1.53%
Crisis Resolution & Home Treatment Team	1.22%
Gender Identity Service	1.22%
Substance Misuse Services	1.22%
Assertive Outreach Team	0.92%
Homeless & Assess Support Team	0.92%
Dovedale	0.61%
Perinatal Mental Health Service	0.61%

Beech Step-down Unit	0.31%
Central AMPH Team	0.31%
CDSS	0.31%
Decisions Unit	0.31%
ECT Suite	0.31%
Flow Coordinators	0.31%
Forest Close	0.31%
Forest Lodge	0.31%
Health Inclusion Team	0.31%
Memory Service	0.31%

This shows that 44% (n143) of all deaths reported were service users who were open to older adult services (including community, residential and memory services). The second highest largest number of deaths were of service users open to our long-term neurological conditions services with 14.4% (n47) deaths reported in the year.

Conclusion

Out of the 325 deaths that were incident reported during 2024/25, 76% (n247) were deemed to have been due to natural causes (this determination may have been following initial Coronial enquiries, such as a postmortem).

Examples of the natural cause deaths recorded during 2024/25 include:

- Dementia (including Alzheimer's Dementia, Lewy Body Dementia etc)
- Motor Neurone Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Huntington's Disease
- Bronchopneumonia / Pneumonia / Aspiration Pneumonia
- Frailty
- Progressive Supranuclear Palsy
- Cancer (some examples are Metastatic Bowel Cancer, Pancreatic Cancer, Metastatic Squamous Cell Lung Cancer, Basal Cell Carcinoma, Chorea/Cell lymphoma)
- Myocardial Infarction
- Sepsis
- Parkinson's Disease

53% (n172) of all deaths reported during 2024/25 were of white British service users. The full ethnicity breakdown can be seen in Appendix 1. 116 service users' ethnicity is 'not stated' or 'blank'. This prohibits more detailed analysis to be effective. Work is ongoing to improve the demographics and protected characteristics reporting across all teams.

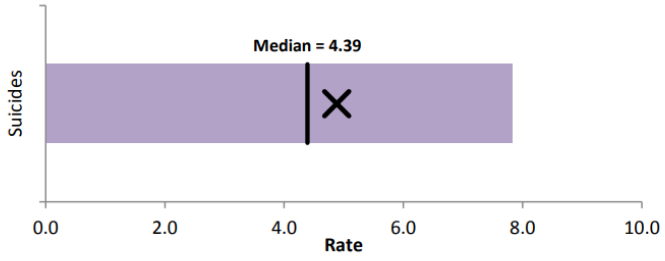
56% (n181) of all deaths reported were male service users. 42% (n136) were female and 8 individuals did not have a gender recorded on the Ulysses system (likely to be caused by a system error).

4. Benchmarking

4.1 Following the Covid-19 outbreak, regional benchmarking processes, available via the Northern Alliance for mortality review were unavailable. In early 2024/25 the Northern Alliance Group was re-formed and the Trust re-engaged with this group.

4.2 Learning from Deaths was subject to wider clinical audit in 2022/2023 and will be subject to repeat audits as per the trust-wide annual audit programme.

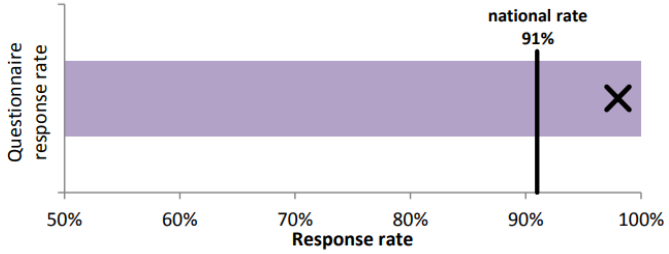
4.3 Our safety scorecard for 2025 (covering a 3-year period from 2020-22) has recently been received from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). This shows that our suicide rate is higher than the median for mental health trusts in the UK. Our internal data does not, however, appear to show the number of deaths recorded as suicide to be outside of 'normal' variation.



Suicide rate

The suicide rate in your Trust was 4.88 (per 10,000 people under mental health care) from 2020-2022.

The Trust has also returned 98% of the NCISH questionnaire's, which is one of the highest rates of questionnaire returns.



NCISH questionnaire response rate

You have returned 98% of NCISH questionnaires between January 2022 and September 2024.

The key characteristics of service users who died by suicide between 2012-2022 has also been provided by NCISH and is attached at Appendix 2. This shows SHSC's results compared with regional and national statistics. SHSC's deaths show that we have more services who live alone, who take their lives by suicide, than both the region and England and less service users who are unemployed, that complete suicide. This information also shows that we have a higher percentage of service users diagnosed with a personality disorder, who take their own lives, than regionally and nationally and a higher proportion of service users with a substance dependence.

5. Triangulation

The outcomes from the learning from deaths processes, is outlined in the separate Patient Safety Learning Report that the Quality Assurance Committee receives on a quarterly basis. This report brings together all the various elements, eg incident reporting, patient safety investigations, learning responses, safeguarding concerns, Freedom to Speak Up concerns, mortality processes and Coronial procedures to establish themes and to outline what work is being undertaken to address these themes. A thematic review of unexpected deaths is also currently underway in line with SHSC's Patient Safety Incident Response Plan.

6. Engagement with Families

6.1 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.

6.2 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. Structured Judgement Reviews will be completed by a growing pool of clinical staff across SHSC and all reviews will be presented to the Patient Safety Oversight Panel, before final review at the Mortality Review Group.

7. Public Reporting of Death Statistics

National Quality Board Guidance states that Trusts must report their mortality figures to a public Board meeting on a quarterly basis. The current dashboard attached at Appendix 3 was developed by the Northern Alliance for this purpose and contains information from the SHSC's risk management system (Ulysses) as well as information from our patient administration system (Insight). The learning points recorded in the dashboard are actions arising from patient safety incident investigations, structured judgement reviews, or LeDeR reviews, that result in changes in practice. The dashboard attached covers information across all four quarters for 2024/25 and will be updated as and when processes are completed and additional learning is identified.

8. Recommendations

It is recommended that the Board of Directors:

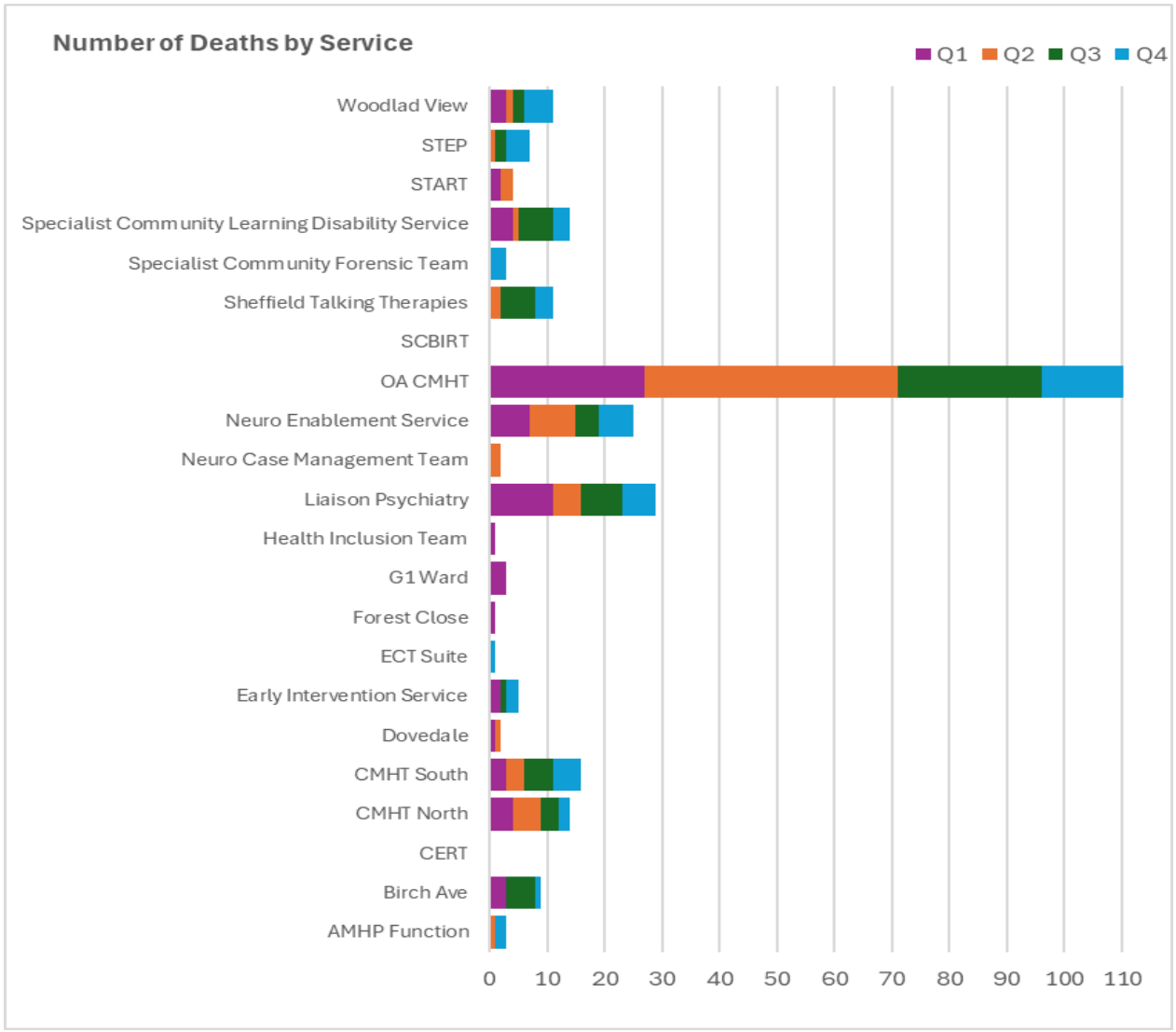
- Receives **assurance** that SHSC has robust mortality and learning from deaths review processes in place.

Appendices:

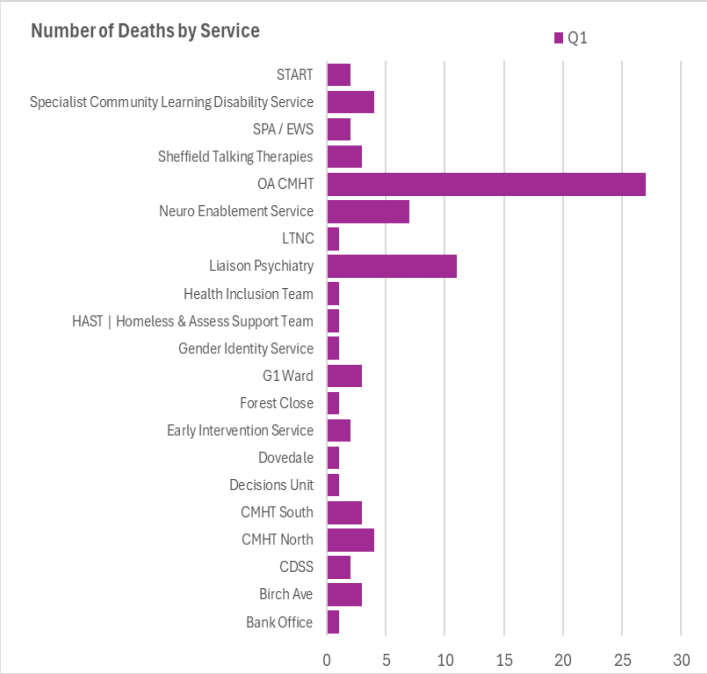
Appendix 1 - Deaths reported by service area/team, broken down by quarter and ethnicity
Appendix 2 - National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) characteristics of SHSC suicides
Appendix 3 - Mortality Dashboard

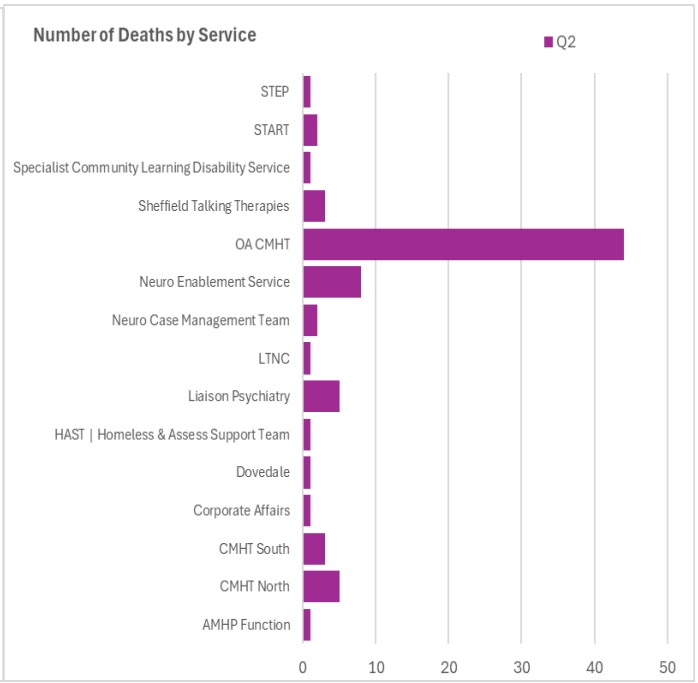
Appendix 1

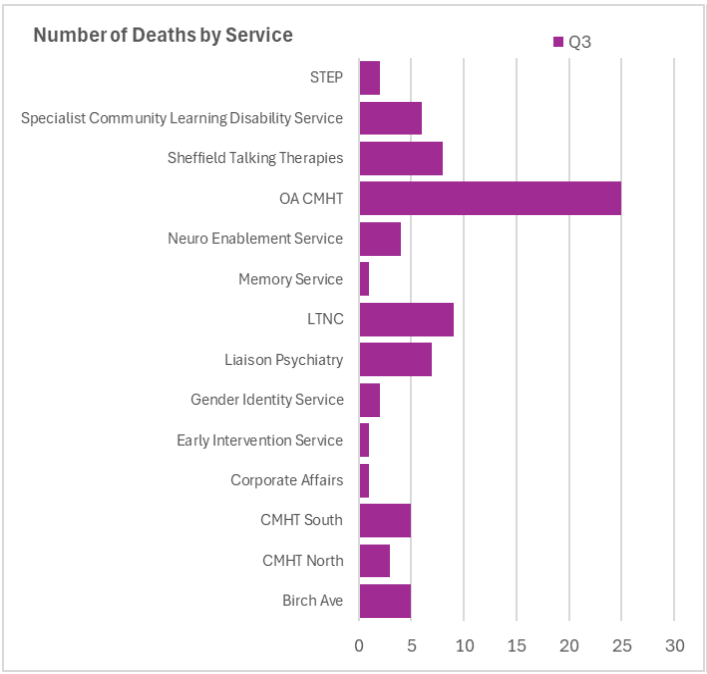
Deaths reported 2024/25 - broken down by Service Area/Team

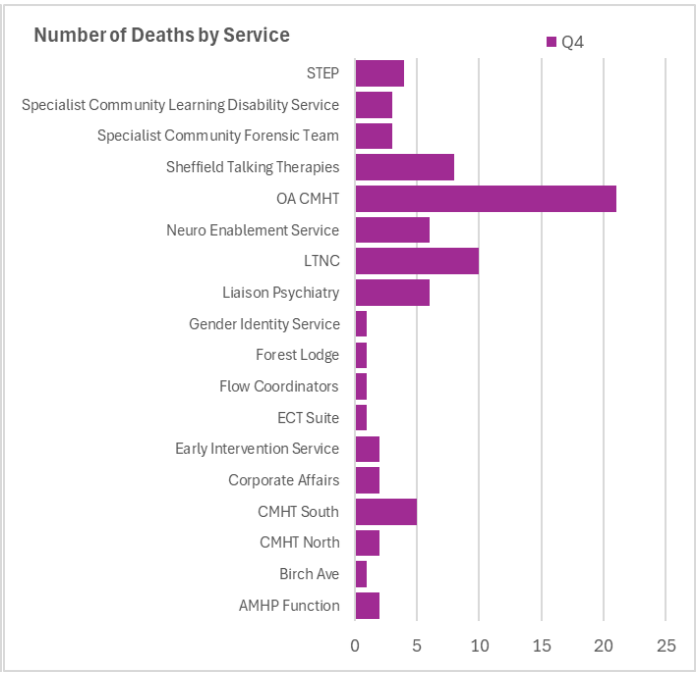


Service Area/Team Breakdown by Quarter:









Deaths reported 2024/25 - broken down by Ethnicity

Ethnicity	Number of deaths recorded
A - White British	172
B - White Irish	2
C - White Other	4
D - Mixed White & Black Caribbean	2
F - Mixed White & Asian	1
G - Mixed Other	3
H - Asian or Asian British Indian	2
J - Asian or Asian British Pakistani	5
L - Asian Other	2
M - Black or Black British Caribbean	7
N - Black or Black British African	5
P - Black Other	1
S - Other	3
Z - Not Stated	63
(blank)	53
Grand Total	**325**

Appendix 2

Characteristics of patients who died by suicide in SHSC compared with regional and national data

Year	2012 - 2022		
	Sheffield Health & Social Care NHS Foundation Trust	Yorkshire and the Humber	ENGLAND
Percentages given are valid percentages	N=173	N=1,310	N=13,893
Sociodemographic:			
Age Median (Min-Max)	44 (16-87)	45 (14-95)	46 (12-100)
Male	117 (67.6%)	886 (67.6%)	9,061 (65.2%)
Female	56 (32.4%)	424 (32.4%)	4,832 (34.8%)
Living alone	83 (54.2%)	577 (47.6%)	6,026 (46.7%)
Unemployed	58 (38.7%)	510 (43.5%)	5,738 (45.6%)
Clinical:			
In-patient at time of suicide	4 (2.3%)	77 (5.9%)	743 (5.4%)
Died within 3 months of discharge from in-patient care	18 (10.7%)	140 (11.5%)	1,667 (12.8%)
Primary diagnosis:			
Schizophrenia & other primary psychotic disorders	26 (15.7%)	183 (14.5%)	2,100 (15.5%)
Affective disorders	63 (38.0%)	512 (40.5%)	5,609 (41.5%)
Alcohol dependence/misuse	5 (3.0%)	69 (5.5%)	737 (5.5%)
Drug dependence/misuse	17 (10.2%)↑	61 (4.8%)	499 (3.7%)
Personality disorder	25 (15.1%)	130 (10.3%)	1,492 (11.0%)
Other diagnosis	27 (16.3%)	247 (19.5%)	2,635 (19.5%)
Any comorbid diagnosis	94 (57.3%)	649 (51.7%)	7,323 (54.6%)
History of self-harm	108 (66.3%)	743 (60.1%)	8,058 (60.8%)
History of alcohol misuse	77 (48.1%)	565 (46.3%)	5,768 (44.0%)
History of drug misuse	61 (37.7%)	438 (35.6%)	4,642 (35.1%)
Risk:			
Short-term risk low or none	90 (73.2%)	914 (83.2%)	9,285 (79.9%)

↑significantly higher compared to national data (England)

Appendix 3 - Mortalty Dashboard (Learning from Deaths Dashboard)

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

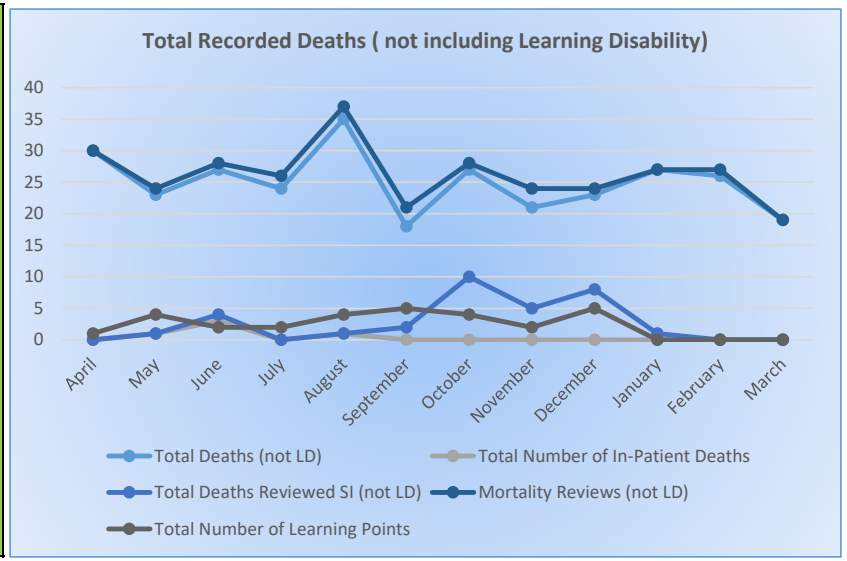
Reporting Period - Quarter 1-4(April 2024 to Mar 2025)

NHS 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 Incident Reported 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 (incident reported and a sample of SPINE deaths)	Total number of actions resulting in change in practice
Q1	Q1	Q1	Q1	Q1
80	**4**	**5**	**82**	**7**
Q2	Q2	Q2	Q2	Q2
77	**1**	**3**	**84**	**11**
Q3	Q3	Q3	Q3	Q3
71	**0**	**23**	**76**	**11**
Q4	Q4	Q4	Q4	Q4
72	**0**	**1**	**73**	**0**
YTD	YTD	YTD	YTD	YTD
300	**5**	**32**	**315**	**29**



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
4	**0**	**4**	**4**	**2**
Q2	Q2	Q2	Q2	Q2
1	**0**	**1**	**2**	**68**
Q3	Q3	Q3	Q3	Q3
6	**0**	**6**	**6**	**26**
Q4	Q4	Q4	Q4	Q4
6	**0**	**6**	**7**	**0**
YTD	YTD	YTD	YTD	YTD
17	**0**	**17**	**19**	**96**