Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 February 2019

Learning from Deaths - Mortality Report

Purpose of Report

To meet the requirements set out in the 'National Guidance on Learning from Deaths[1]' which outlines that the Trust is required to collect and publish on a quarterly basis specified information on deaths.

Executive Summary

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - *'National Guidance on Learning from Deaths'.* The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

Progress to date includes:

- Since April 2017 the Trust has received 4256 death notifications of patients who have been in contact with our service.
- From 1 April 2017 to 23 November 2018, 348 deaths were reported through the Trust incident reporting system (Datix). Of these, 342 were reviewed through the process of the Untoward Incident Reporting and Investigation Policy and Procedure of which 111 warranted a further investigation. 273 reported incidents were closed by the Serious Incident Group.
- The Trust has recorded 16 inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.
- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome. This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements. The Trust's Medical Director has escalated this to the Regional Medical Director, Midlands and East.
- 94 deaths have been reviewed through the Learning from Deaths Procedure
- 342 deaths have been reviewed under the Untoward Incident Reporting Policy and Procedure
- No inpatient deaths were found to be avoidable on review by the Medical Director

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

Challenges include:

- Undertaking a case note review of all deaths as outlined in the national guidance, within available time
- Delay in obtaining cause of death
- The sensitivity of our incident recording system means that the total numbers of deaths are potentially higher than comparable Trusts.

Availability of medic staff has improved following the consultants in the north of the county providing medic cover on a rota basis

Strategic Considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	x
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	
4) We will **transform** services to achieve long-term financial sustainability.	

Assurances

Our approach to ensuring that we're meeting the guidance supports Board Assurance risks. Failure to achieve the clinical quality standards required by our regulators with regards to learning from deaths may lead to harm to service users

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on learning from Deaths – *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*

Consultation

Deputy Director of Nursing and Quality Governance and Medical Director.

Governance or Legal Issues

There are no legal issues arising from this Board report.

The Care Quality Commission Regulations this report provides assurance to are as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting Staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Regulation 20 Duty of Candour

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

The Trust is making an assertive effort to ensure that there is attendance from the multi-disciplinary team to attend Case Note Reviews to ensure quoracy. This is being monitored through the Mortality Review Group and Executive Serious Incident Group

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of the Trust's approach and acknowledge that it has been published on the Trust's website together with the papers supporting the 5 February Board meeting agenda.

Report presented by: **John Sykes**
Medical Director

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety and Patient Experience

Louise Hamilton
Mortality Technician

Learning from Deaths - Mortality Report

1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths[2]'. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish each quarter specified information on deaths. This is through a paper and Board item to a public Board meeting in each quarter, to set out the Trust's policy and approach (by end of Q2) 2017-2018 and publication of the data and learning points by Quarter 3 2017/18. The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subject to review, we are asked to consider how many of these deaths were judged more likely than not to have been due to problems in care.

The report presents the data so far from April 2017 incorporating new data for the periods September, October and November 2018.

2. Current Position and Progress

- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome .This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements.

- The Mortality Review Group continues to undertake regular case note reviews and there have been improvements in medic availability since the implementation of a rota for attendance from the North consultants.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure.

[2] National Guidance on Learning from Deaths. National Quality Board. March 2017

3. Data Summary of all deaths

Month	2017-01-01	2017-02-01	2017-03-01	2017-04-01	2017-05-01	2017-06-01	2017-07-01	2017-08-01	2017-09-01	2017-10-01	2017-11-01	2017-12-01	2018-01-01	2018-02-01	2018-03-01	2018-04-01	2018-05-01	2018-06-01	2018-07-01	2018-08-01	2018-09-01	2018-10-01	2018-11-01
Total Deaths Per Month	285	205	215	182	201	213	173	183	182	169	154	205	231	196	203	165	185	139	183	134	135	189	129
Open inpatient referral deaths	0	0	1	0	2	0	4	0	1	0	1	1	1	3	1	1	0	2	1	1	0	1	0
LD Referral Deaths	2	2	2	1	0	1	2	3	2	0	3	5	4	3	3	2	5	0	5	4	1	5	0
Inpatient deaths	0	0	1	0	1	0	3	0	0	0	1	2	0	2	1	1	0	2	1	0	0	1	0

Correct as at 29 November 2018

Since the publication of the previous report clarification of the number of inpatient deaths has been undertaken .In previous notes the inpatient death figures were in relation to patients who at time of death had an open inpatient referral. The figure that has been reported was higher than the actual number of inpatient deaths.

Since April 2017 the Trust has received 4,256 death notifications of patients who have been in contact with our service. The figure elsewhere in this paper (4,560) is for all deaths from 1 January 2017. Initially, the Trust recorded all deaths of patients who had contact within the last 12 months but this was changed after discussion with Commissioners to contact within the last six months. This took effect from 20 October 2017.

4. Review of Deaths

Total number of Deaths from 1 April 2017 – 23 November 2018 reported on Datix?	348 (of which 257 are reported as "Unexpected deaths")
Number reviewed through the Serious Incident Group	342 (1 was not required to be reviewed by SI (Serious Incident) group as patient not open to service and 5 pending a review).
Number investigated by the Serious Incident Group	111 (232 did not require an investigation and 5 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	273 (75 currently opened to SI group, as at 23/11/2018)

The Trust has recorded 16 inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.
Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*;

Any patient open to services within the last six months who has died and meets the following:

- Homicide – perpetrator or victim.
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / The Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death

- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not

5. Learning from Deaths Procedure

The Mortality Review Group has currently case reviewed 94 deaths. These reviews were undertaken by a multi-disciplinary team and it established that of the 94 deaths reviewed, 82 have been classed as unavoidable, 10 are on hold pending cause of death and 2 have been referred to the serious incident group.

The Mortality Review Group reviewed deaths of patients who fall under the following 'red flags', up to 31 October 2018:

- Patient on end of life pathway, subject to palliative care
- Patient prescribed anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

The Mortality Group reviewed the deaths of patients who fall under the following 'red flags' from 1 November 2018:

- Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team)
- Patient diagnosed with a severe mental illness
- Patient only seen as an Outpatient
- Anti-psychotic medication

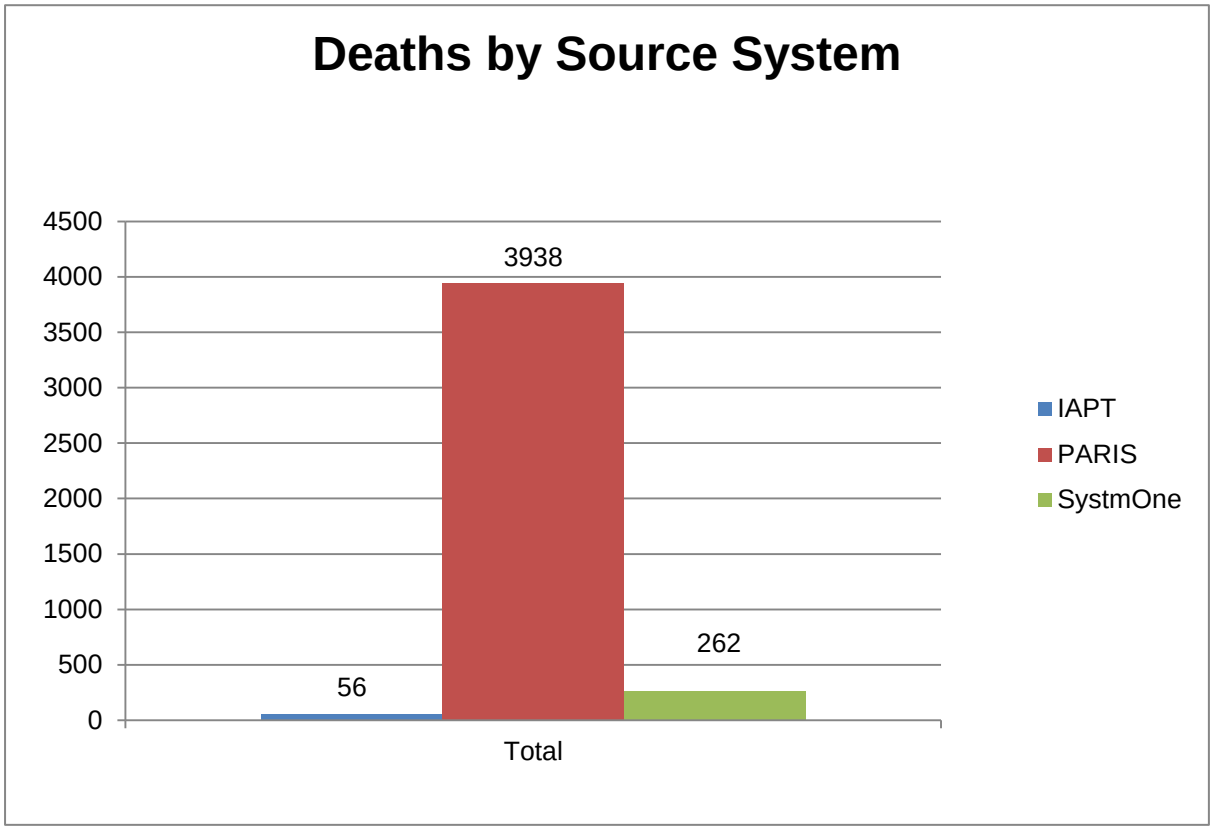
Initial analysis of death notification information shows the most prevalent causes of death are:

- Alzheimer's Dementia/ Vascular Dementia
- Old Age
- Ischaemic Heart Disease

Undertaking Case Note Reviews of deaths remains a challenge due to lack of medical colleague availability. This lack of availability has resulted in a 14 Case Note Review meetings being cancelled.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 January 2017

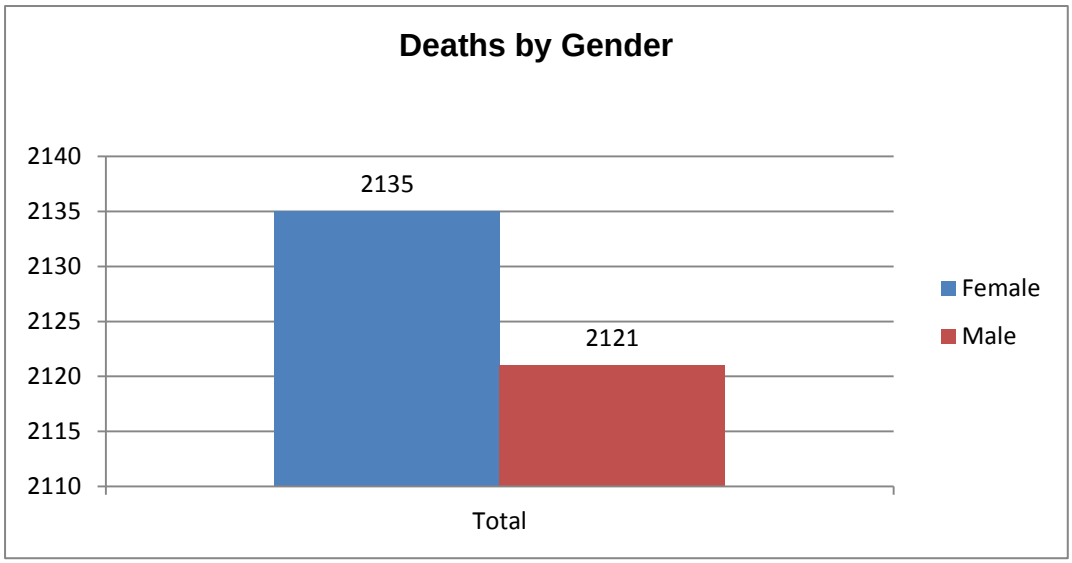


	IAPT	PARIS	SystmOne	Grand Total
Count of Source System	56	3938	262	4256

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS, as we would expect as this clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care. 262 death notifications were pulled from SystmOne and 56 from IAPT.

6.2 Deaths by Gender since 1 January 2017

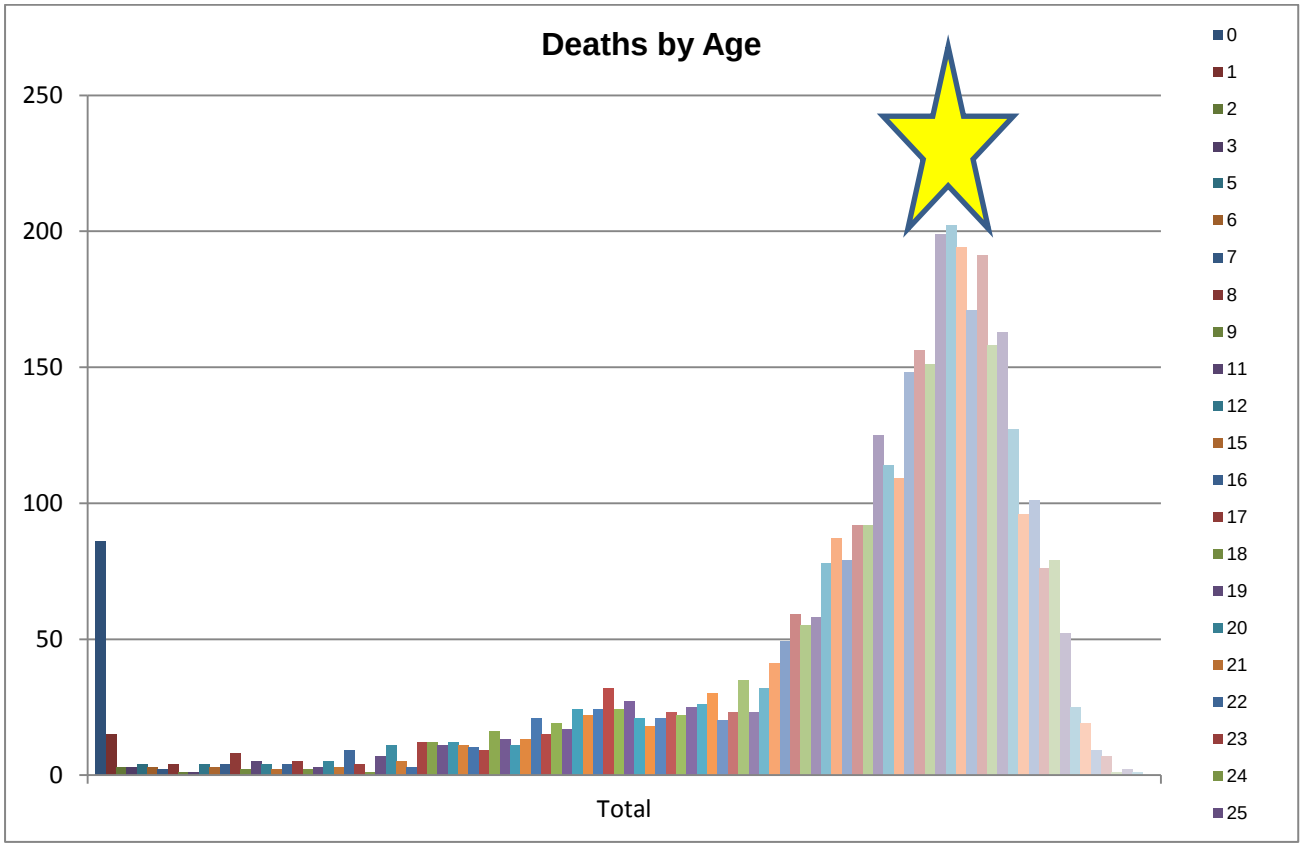
The data below shows the total number of deaths by gender since 1 January 2017. There is very little variation between male and female deaths; 2121 male deaths were reported compared to 2135 female.



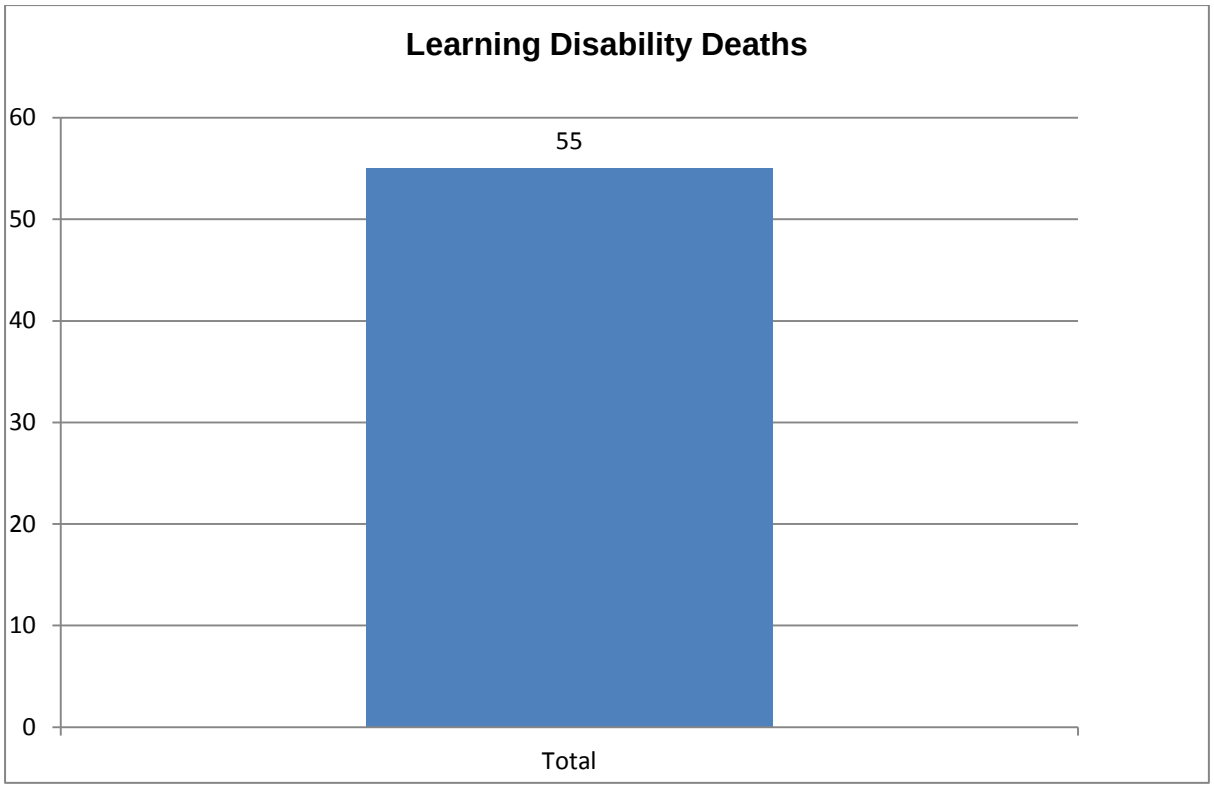
	Female	Male	Grand Total
Gender	2135	2121	4256

6.3 Death by age group since 1 January 2017

The youngest age was classed as 0 and the oldest age was 106 years. Most deaths occur within the 85-89 age groups (indicated by the star), in the last report most deaths occurred between 82-87 age group.



6.4 Learning Disability Deaths since 1 January 2017



The Trust reviews all Learning Disability deaths. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) Programme. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process as LeDeR only look at a sample of overall deaths. Currently the Lead Professional for Patient Safety and Experience is working closely with LeDeR so that the Trust can be involving moving forward in the review process and since the last report the Trust is now sharing relevant information with LeDeR which is used in their reviews.

6.5 Death by Ethnicity since 1 January 2017

White British is the highest recorded group with 3418 recorded deaths, 496 deaths had no recorded ethnicity assigned and 55 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Asian or Asian British - Any other Asian background	8
Asian or Asian British - Bangladeshi	2
Asian or Asian British - Indian	3
Asian or Asian British - Pakistani	10
Caribbean	26
Indian	27
Mixed - Any other mixed background	8
Mixed - White and Asian	2
Mixed - White and Black Caribbean	8
Not Known	496
Not stated	55
Other Ethnic Groups - Any other ethnic group	65
Other Ethnic Groups - Chinese	2
Pakistani	11
White - Any other White background	91
White - British	3418
White - Irish	24
Grand Total	**4256**

7. Recommendations and learning

Below are examples of the recommendations that have been undertaken following the review of deaths either through the *Untoward Incident Reporting and Investigation Policy and Procedure* or *Learning from Deaths Procedure.* These recommendations are monitored by the Patient Safety Team and are allocated to specific team and individuals to be completed. This is not an exhaustive list.

7.1 Learning / Action Log

- Discuss the importance of using the analgesic ladder to manage pain in older people with dementia. Review use of pain management tools.
- The Eating Disorder team to facilitate a reflective session with the Neighbourhood teams in relation to managing Eating Disorder patients and timely referrals.
- To review the monitoring and communication process to patients with suicidal thoughts following the administration of medication where there are known suicidal side effects.
- Develop an operational policy that clarifies the roles and responsibilities of the organisation, teams and individuals in the delivery of care to forensic patients in the community.
- The development of a Trust infrastructure that supports staff in providing safe, effective care to community forensic patients.
- Clinical guidelines that reflect the specific needs of forensic patients in the community, including CPA (Care Plan Approach) and risk management.
- A programme of education and training that reflects the expertise required working with community forensic patients.
- A clinical supervision framework that ensures clinicians have routine access to professionals with clinical expertise in forensic care.
- To explore the development of Eating Disorder awareness training package to the relevant Trust teams.
- Eating Disorder Service to raise with MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) Lead and Derby Hospitals Mental Health Steering Group the need to establish joint protocols for patients to be directed to appropriate support/ services, and joint clinics and / or regular review meetings for high
- Discuss with the multidisciplinary team the importance of adopting a broader approach to advanced decision making which is discussed in conjunction with DNAR (Do Not Attempt Resuscitation decisions.
- Where Social Care are involved with a client, an multi-disciplinary team and multi-agency meeting should be arranged once a year or more frequently if required due to significant change in accordance with CPA guidelines. CPA Review to be multi-disciplinary and multi-agency where relevant.
- The Trust requires an adequately commissioned community forensic team that addresses service the gaps identified within this report, so that community forensic care is safe and effective.
- Consideration should be given to whether S37/s. 41 patients discharged into the community should ever be transferred directly to non-forensic, generic

teams, or whether all such cases should at least initially be under the care of a forensic psychiatrist.

- Develop the role of end of life link workers or champions on the ward, to promote a culture of positive end of life care.
- To request commissioners to review contracts to include direction as to the expected level of discharge information and the timeliness of the communication from private providers.