Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 February 2020

Learning from Deaths - Mortality Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 July 2019 to 30 November 2019. This report was reviewed at the Quality committee on the 14th January 2020.

Executive Summary

- From 1 July 2019 to 30 November 2019, the Trust received 757 death notifications of patients who have been in contact with our service.
- There have been five inpatients that died following transfer to the acute hospital for further medical treatment.
- One patient died on one of the wards. This was an unexpected death.
- The Mortality Review Group reviewed 36 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 36 deaths reviewed, 36 have been classed as not due to problems in care. One was referred to the Serious Incident Group and also found not to be due to problems in care.
- The Trust has reported six Learning Disability deaths.
- There is very little variation between male and female deaths; 366 male deaths were reported compared to 391 female.
- During collection of the disability data it became apparent that when clinicians were choosing 'memory or ability to concentrate learn or understand, as a disability this was being categorised by the system as a 'learning disability' rather than dementia. A new code has been added specifically to allow clinicians to pick dementia. This change will allow the two disabilities to be independently analysed moving forward.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.
- The case note rota for medics was reviewed by the Executive Serious Investigation Group on 26 September 2019 and recommended further consideration of the extension of an organised rota for the north and commencement of a rota for the south. Both are now rotas in place.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

From 1 July to 30 November 2019, the Trust has received 757 death notifications of patients who have been with our service within the previous six months. 72 deaths were reported through our DATIX system of which 49 unexpected deaths, 19 suspected deaths and 4 expected deaths of people at the end of life.

All inpatient deaths are reviewed and quarterly reports received by the Executive Leadership Team (ELT) in addition to coroner's inquest updates. Medical availability for mortality reviews has improved and there will now be a focus on selecting cases where physical health care was a prominent feature of care.

The Quality Committee has reviewed and scrutinised the data, the progress and the learning. The report was offered with significant assurance and this was accepted. As a clinical quality team, the team will now consider how we are undertaking reviews and what further quality improvements we can accept to add value to our standard operating process and explore opportunity to look at the impact of our mortality analysis.

Governance or Legal Issues

There are no legal issues arising from this Board report.

The Care Quality Commission Regulations - this report provides assurance 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
- Duty of Candour (Regulation 20)

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

There is recognition that nationally mental health services have been under-resourced for decades and that this is now being addressed through commissioning and contract arrangements. The 'bigger picture' of safety culture requires a strategic approach which is being addressed by ELT in December 2019. A report will be submitted to the Quality committee.

From the 1 July 2019 to 30 November 2019, there is very little variation between male and female deaths; 366 male deaths were reported compared to 391 female. No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to:

1) Accept this Mortality Report as assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.
2) Note that the Quality Committee endorsed the Mortality Group recommendation to audit the Trust's approach to mortality reviews. This consistent approach based on selecting cases through a 'red flag' system has provided assurance based on a lack of concern and appreciative learning and has not identified any 'problems in care'. An alternative approach (pending access to NHS Digital data) envisages casting a wider net to see if this generates different results.

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Director of Nursing and Patient Experience

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Medical Director

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Lead Professional for Patient Safety and Patient Experience

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Mortality Technicians

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 framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. 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.

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, and 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 above has been completed as outlined in the national guidance.

The report presents the data for 1 July 2019 to 30 November 2019.

2. Current Position and Progress

- As a way of accessing a national database for cause of death, our application for NHS Digital continues, but has not been given priority at national level the emphasis being on acute Trusts.

- A northern consultant mortality meeting rota has been in place since November 2018, organised by Clinical Directors in the north of the county. The rota for November 2018 to the end of October 2019 was distributed to the consultants in October 2018. On the whole the rota has worked well and the majority of the meetings have taken place, but unfortunately several meetings have been cancelled either the day before or on the actual meeting date.

- A southern consultant mortality meeting rota has been in place since December 2019, organised by Clinical Directors in the south.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary changes made.

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

3. Data Summary of all Deaths

Note that inpatients and LD are based upon whether the patient has an open inpatient or LD referral at time of death.

19-20

Month	2019-07-01	2019-08-01	2019-09-01	2019-10-01	2019-11-01
1. Total Deaths Per Month	160	151	136	160	151
2. LD Referral Deaths	3	3	0	0	0

The table above shows information for 1 July 2019 to 30 November 2019

Correct as at 17 December 2019

- From 1 July 2019 to 30 November 2019, the Trust received 757 death notifications of patients who have been in contact with our service. There have been 5 patients who have died following transfer to the acute hospital after requiring urgent medical attention. One patient died on one of our wards – an unexpected death

4. Review of Deaths

1 July 2019 to 30 November 2019:

72 Total number of Deaths from 1 July 2019 to 30 November 2019 reported on Datix	49 as "Unexpected deaths" 19 as unconfirmed deaths which are awaiting confirmation from coroner or NHS Spine 4 as "Expected - end of life pathway"
Of above, number reviewed through the Serious Incident Group	72
Of above, number investigated by the Serious Incident Group	3 (40 did not require an investigation; 15 underway and 14 pending a review)
Of above, number of Serious Incidents closed by the Serious Incident Group?	43 (As of 18/12/2019, 15 currently opened to SI group and 14 pending for a review)

The Trust has recorded one inpatient death and five inpatients who died following transfer to the acute hospital for further medical treatment since 1 July 2019 to 30 November 2019, of all which have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*. None of these deaths have been due to problems in care.

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

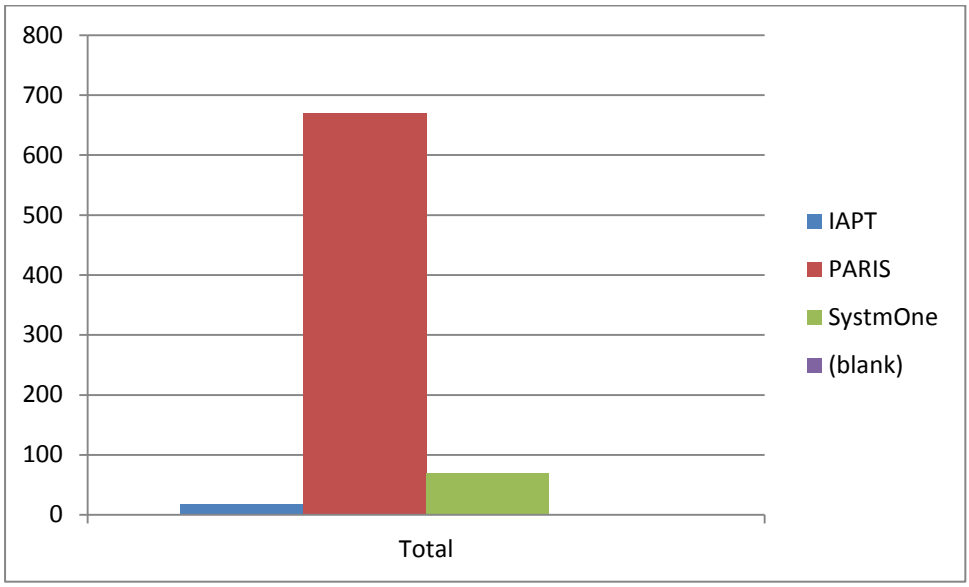
1 July 2019 to 30 November 2019, the Mortality Review Group reviewed 36 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 36 deaths reviewed, 36 have been classed as not due to problems in care. One was referred to the Serious Incident Group and was also found not to be due to problems in care.

The Mortality Group review the deaths of patients who fall under the following 'red flags' from 28 March 2019:

- Patient taking an anti-psychotic medication
- Patients whose care plan was not reviewed in the 6 months prior to their death
- Patient whose risk plan and or safety plan was not in place or updated as per policy, prior to death
- Death of a patient with a learning disability

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 July 2019 to 30 November 2019

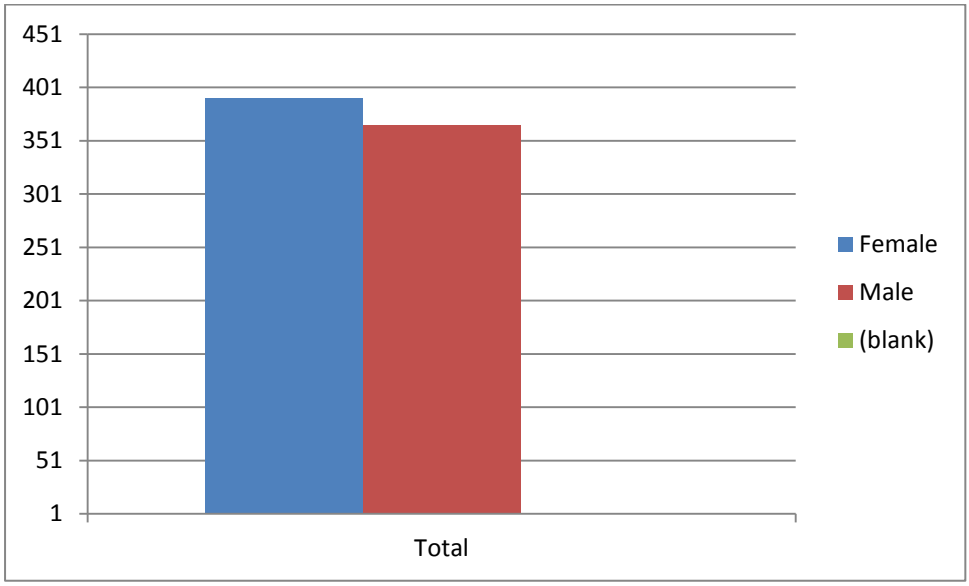


	IAPT	PARIS	SystmOne	Grand Total
Count	18	669	70	757

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS. 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. 70 death notifications were extracted from SystmOne and 18 death notifications were extracted from IAPT.

6.2 Deaths by Gender since 1 July 2019 to 30 November 2019

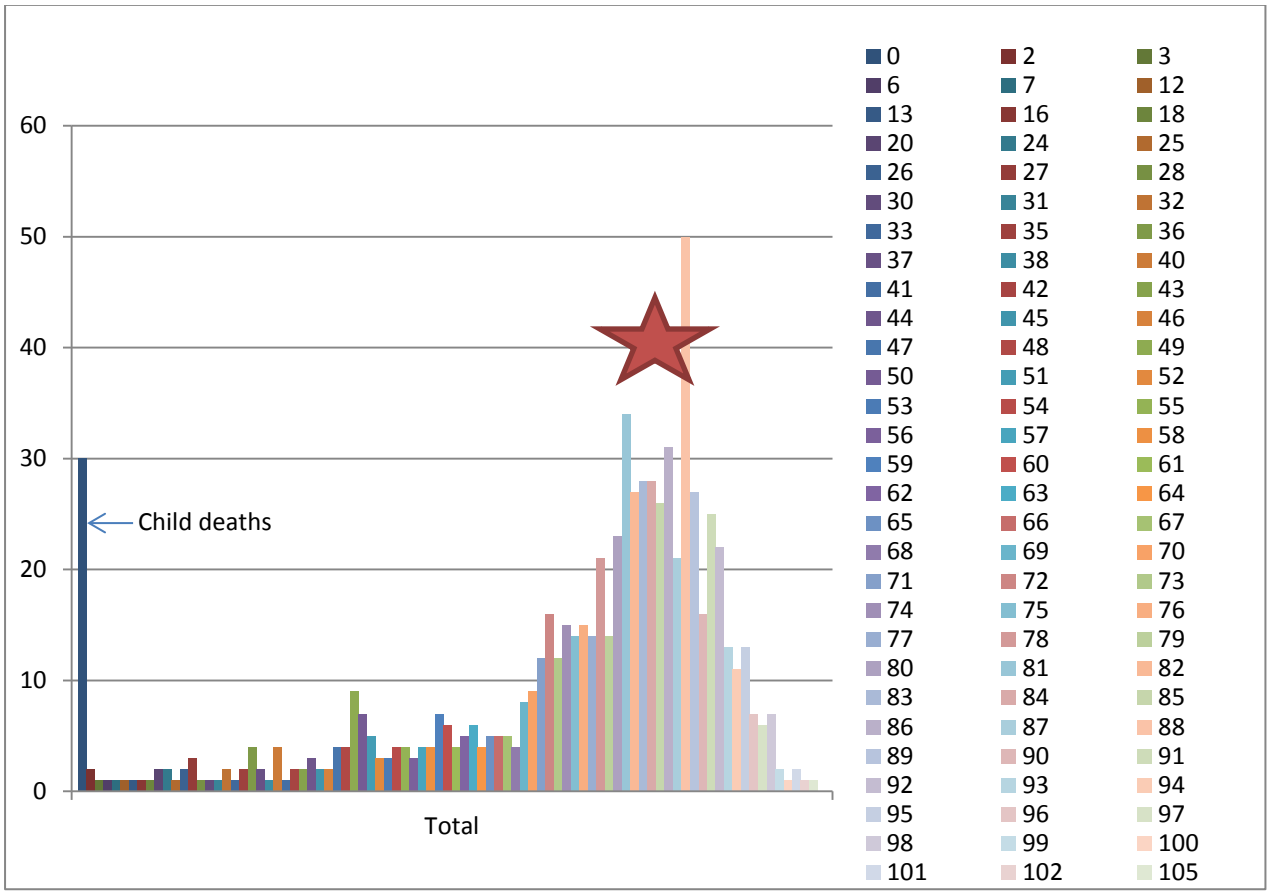
The data below shows the total number of deaths by gender 1 July 2019 to 30 November 2019. There is very little variation between male and female deaths; 366 male deaths were reported compared to 391 female.



	Male	Female	Grand Total
Count	366	391	757

6.3 Death by Age Group since 1 July 2019 to 30 November 2019

The youngest age was classed as 0, and the oldest age was 105 years. Most deaths occur within the 80-85 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 July 2019 to 30 November 2019

	July 2019	August 2019	September 2019	October 2019	November 2019
LD Deaths	3	3	0	0	0

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. 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 looks 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 involved moving forward in the review process. Since the last report, the Trust is now sharing relevant information with LeDeR which is used in their reviews. Since 1 July 2019 to 30 November2019, the Trust has recorded 6 Learning Disability deaths.

The Trust now receives a quarterly update from LeDeR which highlights good practice and identified learning.

6.5 Death by Ethnicity 1 July 2019 to 30 November 2019

White British is the highest recorded ethnicity group with 484 recorded deaths, 77 deaths had no recorded ethnicity assigned, and 3 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	Count of Ethnicity
White - British	609
Not Known	94
White - Any other White background	14
Other Ethnic Groups - Any other ethnic group	14
Pakistani	4
White - Irish	4
Not stated	3
Asian or Asian British - Pakistani	3
Caribbean	2
Indian	2
Mixed - White and Asian	2
Any other Black background	1
Asian or Asian British - Any other Asian background	1
Asian or Asian British - Bangladeshi	1
Mixed - Any other mixed background	1
Mixed - White and Black Caribbean	1
Other Ethnic Groups - Chinese	1
(blank)	
Grand Total	**757**

6.6 Death by religion 1 July 2019 to 30 November 2019

Christianity is the highest recorded religion group with 137 recorded deaths, 65 deaths had no recorded religion assigned, 18 people refused to state their religion and 345 left this information blank. The chart below outlines all religion groups.

Row Labels	Count of Religion
Christian	137
Church Of England	97
Unknown	65
Not Religious	41
Not Given Patient Refused	18
Roman Catholic	15
Methodist	7
None	7
Muslim	4
Jehovah's Witness	4
Spiritualist	3
Salvation Army Member	2
Patient Religion Unknown	2
Jewish	1

Row Labels	Count of Religion
Anglican	1
Religion (other Not Listed)	1
Atheist	1
Hindu	1
Sikh	1
Nonconformist	1
Catholic religion	1
Baha'i	1
Not Religious - Old Code	1
Orthodox Christian	1
(blank)	345
Grand Total	**757**

6.7 Death by sexual orientation 1 July 2019 to 30 November 2019

Heterosexual or straight is the highest recorded sexual orientation group with 226 recorded deaths, 477 people left this information blank. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Heterosexual Or Straight	226
Heterosexual	33
Unknown	7
Not Stated (declined)	5
Person Asked And Does Not Know	2
Gay Or Lesbian	2
Person declined to disclose	1
Not Appropriate To Ask	1
Bisexual	2
Lesbian or gay	1
(blank)	477
Grand Total	**757**

6.8 Death by disability 1 July 2019 to 30 November 2019

Behavioural and emotional problems is the highest recorded disability group with 29 recorded deaths, 571 recorded deaths had no recorded information. The table below only outlines the top ten recorded disability groups. During collection of the data it was apparent that if clinicians were choosing ‘memory or ability to concentrate learn or understand, this was being categorised as learning disability. Therefore the PARIS team to improve accuracy of data have changed, the current option of “Learning Disability” to reflect the fact that it has historically included dementia. This will then be end dated and a new option of “Learning Disability” will be added. A new code has been added specifically to allow clinicians to pick dementia. This change will allow the two disabilities to be independently analysed moving forward.

Row Labels	Count of Disability
Behaviour and emotional	29
Other	20
Learning disability (Dementia)	11
Mobility and gross motor	9
Hearing	8
Progressive (LT)cConditions	6
Sight	6
Learning disability (Dementia)	4
Behaviour and emotional; progressive (LT) conditions	3
Behaviour and emotional; self-care and Continence	3
(blank)	571
Grand Total	**757**

7. Recommendations and Learning

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

- Raising with the Commissioners, as a priority matter, the lack of any CRHT team provision for older adults in the north of the county. It is now planned to introduce this service in 2020.
- To arrange timely multidisciplinary meetings when physical health and self-neglect needs have identified.
- Review of Discharge, transfers and transitions and leave policy and procedures with particular reference to transfer between trust teams, cultural improvement in the safe and efficient hand over of care and communication and information sharing with partner agencies.
- Implement Falls CQUIN (Commissioning for Quality and Innovation) and then review and amend current Falls Policy on learning and national best practice
- Further exploration is required in relation to Red2green, its function and suitability in terms of recording within the clinical record.
- Communication of referrals in emergency situations to be delivered using SBARD Situation, Background, Assessment, Recommendation) methodology with written summary
- To undertake a learning review with commissioners to explore the need to invest in psychological support services, for individuals who are victims of non-recent abuse to increase accessible therapy.