Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 May 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 December 2019 to 25 February 2020.

Executive Summary

- From 1 December 2019 to 25 February 2020, the Trust received 497 death notifications of patients who have been in contact with our service in the last six months.
- There has been one inpatient death following transfer to the acute hospital for further medical treatment. (Incident did not occur following a ward/ward transfer - patient was AWOL at time of incident.)
- The Mortality Review Group reviewed 33 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 33 deaths reviewed, none were classed as due to problems in care.
- The Trust has reported 0 Learning Disability deaths from 1 December 2019 from 25 February 2020.
- There is very little variation between male and female deaths; 238 male deaths were reported compared to 259 female.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

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.

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.

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:

From the 1 December to 25 February 2020 there is very little variation between male and female deaths; 238 male deaths were reported compared to 259 female. No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to 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.

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Medical Director

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Medical Director

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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 December to 25 February 2020

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. The patient safety Lead and Medical Director will be meeting the regional medical examiner to discuss the role of a local medical examiner working with the Trust and whether this could facilitate access to Cause of Death data.

- A northern consultant mortality meeting rota has been in place since November 2018, organised by Dr Sugato Sarkar. . A southern consultant mortality meeting rota has been in place since December 2019, organised by Dr Rais Ahmed.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary changes made. This has included auditing complaint data against names of deceased patients to ensure this meets the National guidance.

- All deaths that are received through the NHS spine have been reviewed to date. The mortality technicians review the case notes to identify patients who meet *the learning from deaths* or *Datix* red flags and raise any concerns if identified. This process ensures that the Trust is complaint with the National Guidance so that all deaths are scrutinised for learning opportunities.

[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.

Month	2019-12-01	2020-01-01	2020-02-01
1. Total Deaths Per Month	191	182	124
5. LD Referral Deaths	0	0	0

The table above shows information for 1 December to 25 February 2020

Correct as at 25 February 2020

From 1 December to 25 February 2020, the Trust received 497 death notifications of patients who have been in contact with our service. There has been 1 inpatient death, the patient died following transfer to the acute hospital after requiring urgent medical attention. (Incident occurred after ward/ward transfer- patient was AWOL at time of incident.)

4. Review of Deaths

1 December to 25 February 2020

Total number of Deaths from 1 December to 25 February 2020 reported on Datix	Total 42 34 Unexpected 6 suspected 2 as “Expected - end of life pathway”
Of above, number reviewed through the Serious Incident Group	39 (3 to be reviewed at the next meeting)
Of above, number investigated by the Serious Incident Group	25 did not require an investigation; 3 underway and 14 pending a review)
Of above, number of Serious Incidents closed by the Serious Incident Group?	25 (As of 25/02/2020, 14 currently opened to SI group and 3 pending for a review)

From 1 December 2019 to 25 February 2020, the Trust has received 497 death notifications of patients who have been with our service within the previous 6 months. 42 deaths were reported through our DATIX system of which 34 were recorded as unexpected deaths, 6 suspected deaths and 2 expected deaths (end of life).

Since 1 December to 25 February 2020 the Trust has recorded 1 inpatient death, the patient died following transfer to the acute hospital for further medical treatment (patient was AWOL at time of incident), which is 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

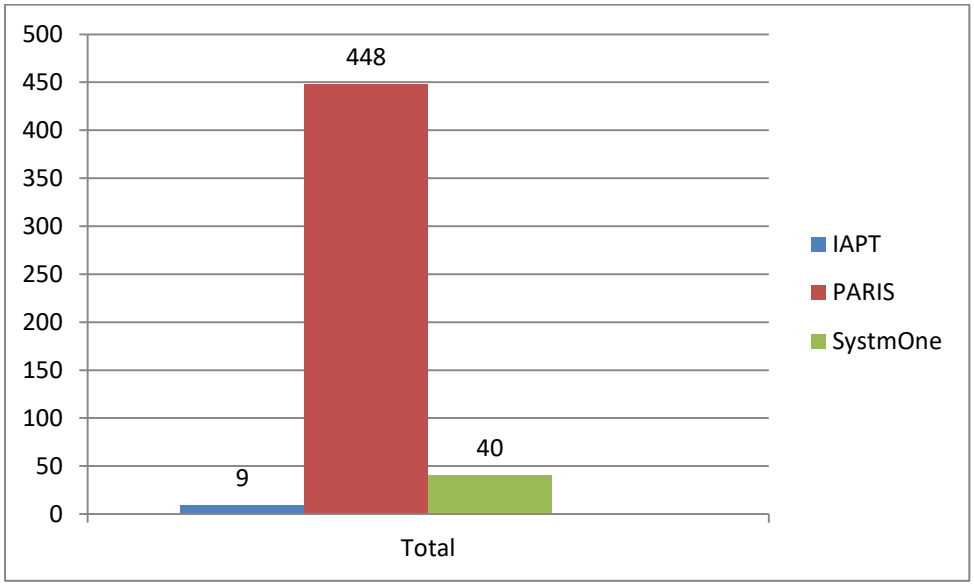
1 December to 25 February 2020, the Mortality Review Group reviewed 33 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 33 deaths reviewed, 33 have been classed as not due to problems in care.

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 December to 25 February 2020

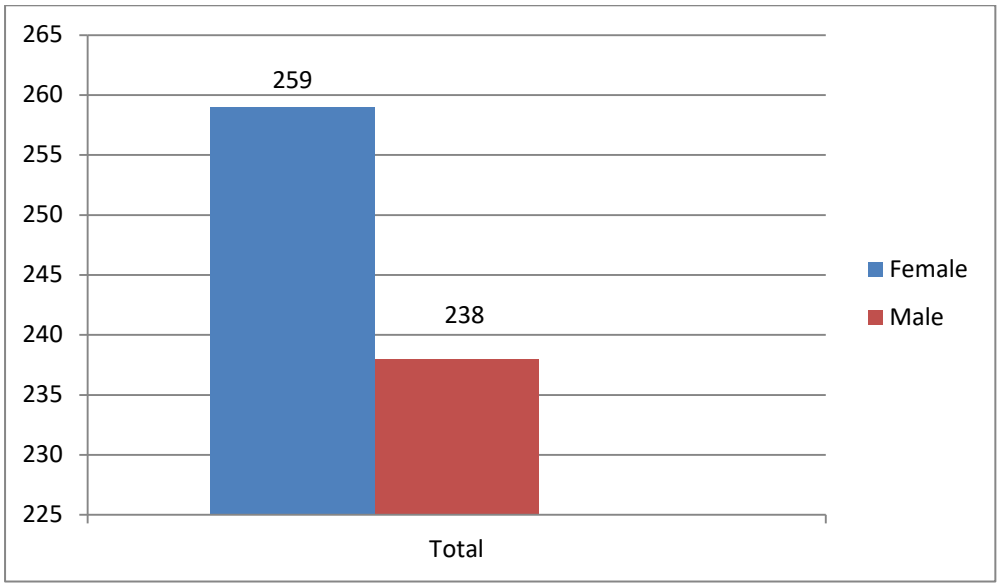


	IAPT	PARIS	SystmOne	Grand Total
Count	**9**	**448**	**40**	**497**

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. 40 death notifications were extracted from SystmOne and 9 death notifications were extracted from IAPT.

6.2 Deaths by Gender since 1 December to 25 February 2020

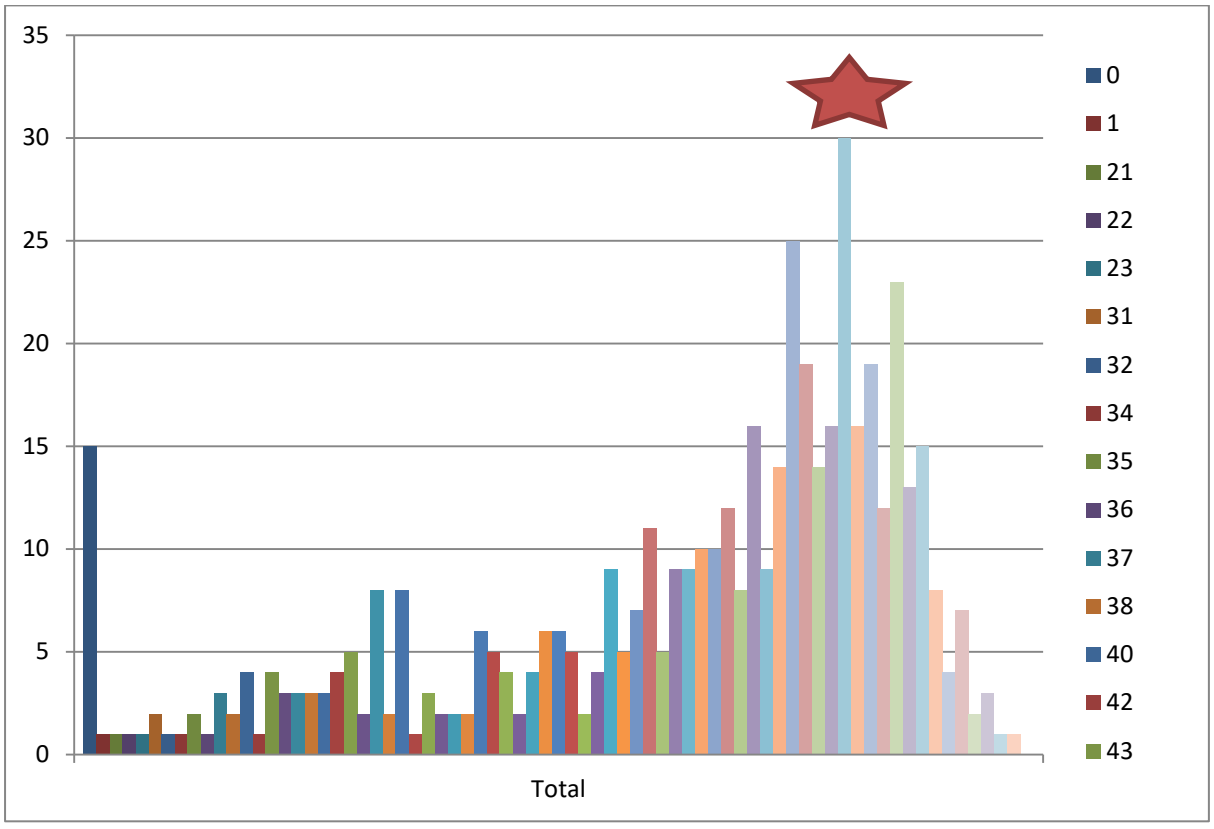
The data below shows the total number of deaths by gender 1 December to 25 February 2020. There is very little variation between male and female deaths; 238 male deaths were reported compared to 259 female.



	Female	Male	Grand Total
Count	259	238	497

6.3 Death by Age Group since 1 December to 25 February 2020

The youngest age was classed as 0, and the oldest age was 103 years. Most deaths occur within the 85-90 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 December to 25 February 2020

	December 2020	January 2020	February 2020
LD Deaths	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 an undisclosed 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. The Trust is continuing to share relevant information with LeDeR which is used in their reviews. Since 1 December to 25 February 2020, the Trust has recorded 0 Learning Disability deaths.

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

6.5 Death by Ethnicity since 1 December to 25 February 2020

White British is the highest recorded ethnicity group with 386 recorded deaths, 65 deaths had no recorded ethnicity assigned, and 5 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	Count of Ethnicity
White - British	386
Not Known	65
White - Any other White background	11
Other Ethnic Groups - Any other ethnic group	10
White - Irish	4
Not stated	5
Asian or Asian British - Pakistani	1
Caribbean	2
Indian	4
Mixed - White and Asian	1
Asian or Asian British - Any other Asian background	2
Mixed - Any other mixed background	1
Mixed - White and Black Caribbean	2
Other Ethnic Groups - Chinese	3
Grand Total	**497**

6.6 Death by religion since 1 December to 25 February 2020

Christianity is the highest recorded religion group with 100 recorded deaths, 52 deaths had no recorded religion assigned and 3 people refused to state their religion. The chart below outlines all religion groups.

Row	Count of Religion
Christian	100
Church Of England	59
Unknown	52
Not Religious	27
Roman Catholic	10
Catholic: Not Roman Catholic	4
Sikh	3
Methodist	3
None	3
Not Given Patient Refused	3
Hindu	2
Muslim	2
Advaitin Hindu	1
Agnostic movement	1
Anglican	1
Atheist	1
Christian religion	1
Jehovah's Witness	1
Lutheran	1
Nonconformist	1
Not stated	1
Pentecostalist	1
Protestant	1
Spiritualist	1
Zoroastrian	1
Grand Total	**281**

6.7 Death by sexual orientation since 1 December to 25 February 2020

Heterosexual or straight is the highest recorded sexual orientation group with 164 recorded deaths. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Heterosexual Or Straight	164
Heterosexual	27
Not Stated (declined)	4
Gay Or Lesbian	2
Not Appropriate To Ask	2
Person Asked And Does Not Know	2
Patient unsure	1
Unknown	1

Grand Total	**203**

6.8 Death by disability since 1 December to 25 February 2020

Behavioural and emotional problems were the highest recorded disability group with 41 recorded deaths.

Row Labels	Count of Disability
Behaviour and emotional	41
Other	33
Dementia	26
Mobility and gross motor	9
Hearing	16
Progressive (LT) Conditions	7
Sight	5
Walking Disability	1
Grand Total	**138**

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths. 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.

- Review of the neighbourhood operating policy in regard to how caseloads are considered for reallocation when staff are absent in terms of their presentation of risk.
- To expand the substance misuse engagement team to focus on GP and hospital appointments.
- Review of access and availability of ligature hooks in inpatient areas
- Develop a clinical competency framework for inpatient senior nurses, lead nurses registered nurses and preceptorship nurses, commensurate with their roles and responsibilities
- Review of the Trust guidelines for the management and treatment of opiate use with consideration to the inclusion of a withdrawal scale assessment tool (I.E. COWS)
- Communication process on admission between primary and secondary care to be reviewed.
- Trust wide assessment of bed stock and market analysis of new equipment to further improve our resources
- To Audit the application of Section 17 leave
- 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.
- Standard Operating Procedure for Dysphagia Screening and Initial Management for Older Peoples Services
- Development of a criteria and referral process for ECW to support decision making in relation to admissions authorisation in these situations
- For an audit of safety plans on the ward to be completed and the results discussed with the qualified nursing team.