Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 July 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 March to 29 May 2020.

The Quality and Safeguarding Committee previously accepted this Mortality Report on 9 June as assurance of the Trust's approach and agreed for the report to be considered by the Trust Board of Directors.

Executive Summary

Since the start of the COVID-19 pandemic, the learning from deaths process has continued but some changes have had to be made. As of 18 March 2020 all new deaths identified through the NHS Spine are reviewed and graded once a week (instead of daily) and Case note review meetings have been reduced to once a month instead of weekly.

In addition to continuing to review deaths which meet the current red flag criteria, all deaths directly relating to COVID-19 are either reviewed through the Learning from deaths procedure or the Untoward Incident reporting policy and procedure. A weekly COVID-19 death report is completed for the incident management team. This report includes but is not limited to patient demographics, patient conditions, diagnosis and vulnerabilities, allowing the team to draw comparisons to identify themes and trends.

- From 1 March to 29 May 2020, the Trust received 679 death notifications of patients who have been in contact with our service in the last six months
- Two patients died whilst an inpatient on our wards and six patients died following transfer to an acute hospital or in the community
- The Mortality Review Group reviewed eight deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the eight deaths reviewed, none were classed as due to problems in care.
- The Trust has reported one Learning Disability deaths from 1 March to 29 May 2020
- There is very little variation between male and female deaths; 349 male deaths were reported compared to 330 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 March to 29 May 2020 there is very little variation between male and female deaths; 349 male deaths were reported compared to 330 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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Deputy Medical Director

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Lead Professional for Patient Safety and Patient Experience

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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 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.

To date the Trust has met all of the required guidelines.

The report presents the data for 1 March to 29 May 2020.

2. Current Position and Progress (including COVID-19 related reviews)

- The Trust is still waiting to ascertain if Cause of death (COD) will be available through NHS digital. Currently COD is been ascertained through the coroner officers in Chesterfield and Derby but only a very small number of COD have been made available.

- There are currently medic rotas for the north and south which did improve the number of case notes reviews completed initially but since the pandemic and the reduction of monthly case note reviews, the number of case note reviews have decreased. During this period only eight case note reviews have taken place this is due to cancellation of medics.

- 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.

- Due to the current circumstances surrounding COVID-19, the Mortality Review Group along with other departments has followed government guidance to allow staff to work remotely. As of 18 March 2020 the Trust's Mortality reviewer will grade all new deaths identified through the NHS Spine once a week (instead of daily) and case note review meetings will be reduced to once a month instead of weekly. In addition to continuing to review deaths which meet the current red flag criteria, all deaths directly relating to COVID-19 will be reviewed either through the Learning from deaths procedure or the Untoward Incident reporting policy and procedure. The mortality reviewer will also produce a weekly COVID-19 death report to be shared with the incident management team. This report will include but is not limited to patient demographics, patient conditions, diagnosis and vulnerabilities, allowing the team to draw comparisons to identify themes and trends.

[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	March	April	May
1. Total Deaths Per Month	210	321	148
5. LD Referral Deaths	0	1	0

The table above shows information for 1 March to 29 May 2020.

Correct as at 29 May 2020

From 1 March to 29 May 2020, the Trust received 679 death notifications of patients who have been in contact with our service. There have been two patients who have died on our wards both of these patients were confirmed as having COVID-19 and four have died following transfer to an acute hospital for further medical treatment and two patients in the community. Of these eight deaths, three patients were confirmed as having COVID-19 and one was suspected. One male patient who had a learning disability died in April 2020.

4. Review of Deaths-

1 March to 29 May 2020

Total number of Deaths from 1 March 2020 to 31 May 2020 reported on Datix	88 (of which 78 are reported as "Unexpected deaths"; 10 as "Suspected deaths"; 0 as "Expected - end of life pathway")
Number reviewed through the Serious Incident Group	84 (4 pending for a review).
Number investigated by the Serious Incident Group	11 (54 did not require an investigation; 19 underway and 4 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	54 (19 currently opened to SI group and 4 pending for a review, as of 01/06/2020)

From 1 March to 29 May 202, the Trust has received 679 death notifications of patients who have been in contact with our service within the previous six months. 88 deaths were reported through our DATIX system of which 78 were recorded as unexpected deaths, 10 suspected deaths and 0 expected deaths (end of life).

Since 1 March to 29 May 2020 the Trust has recorded 2 patients who have died on our wards and 6 who have died either on transfer to an acute hospital for further treatment or in the community. Of these deaths 3 patients were confirmed as having COVID-19 and 1 one was suspected, these deaths have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*.

During this period, a total of 43 deaths were reported through datix, of these deaths 35 patients had died in the community . Of the community patients, 15 patients had been tested positive for COVID-19, the rest of the patients were recorded has having suspected COVID-19. A review will be undertaken to look further into all of the community deaths during this period and this will reported when completed.

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

From 1 March to 29 May 2020, the Mortality Review Group reviewed 8 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 8 deaths reviewed, 0 have been classed as due to problems in care.

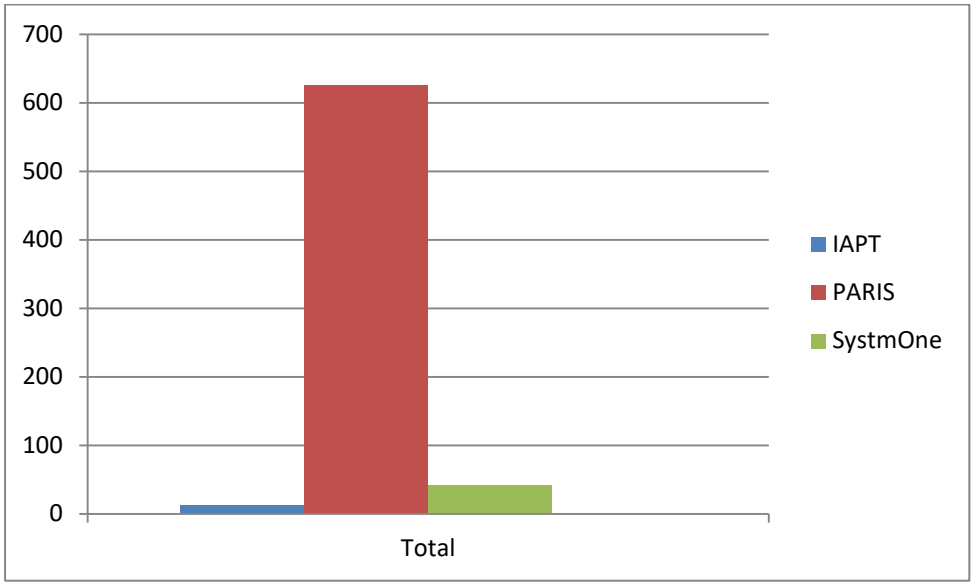
As of Wednesday 18 March 2020 the Trust's Mortality reviewer will grade all new deaths identified through the NHS Spine once a week (instead of daily) and Case note review meetings will be reduced to once a month instead of weekly. This way of working will remain in place until further guidance is issued.

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 March to 29 May 2020



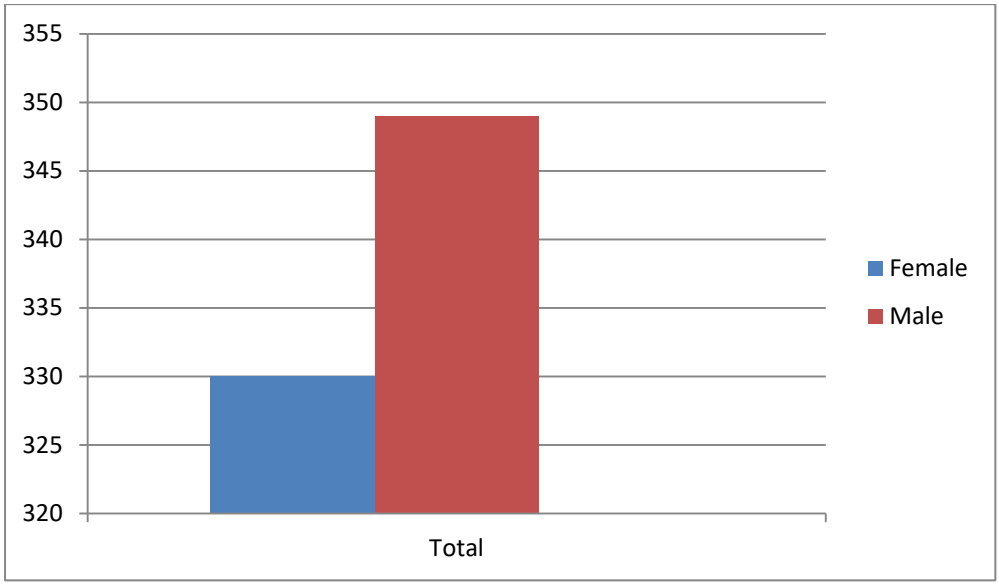
	IAPT	PARIS	SystmOne	Grand Total
Count of Source System	**12**	**626**	**41**	**679**

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. 41 death notifications were extracted from SystmOne and 12 death notifications were extracted from Improving Access to Psychological Therapies (IAPT).

6.2 Deaths by Gender since 1 March to 29 May 2020

The data below shows the total number of deaths by gender 1 March to 29 May 2020. There is very little variation between male and female deaths; 349 male deaths were reported compared to 330 female.

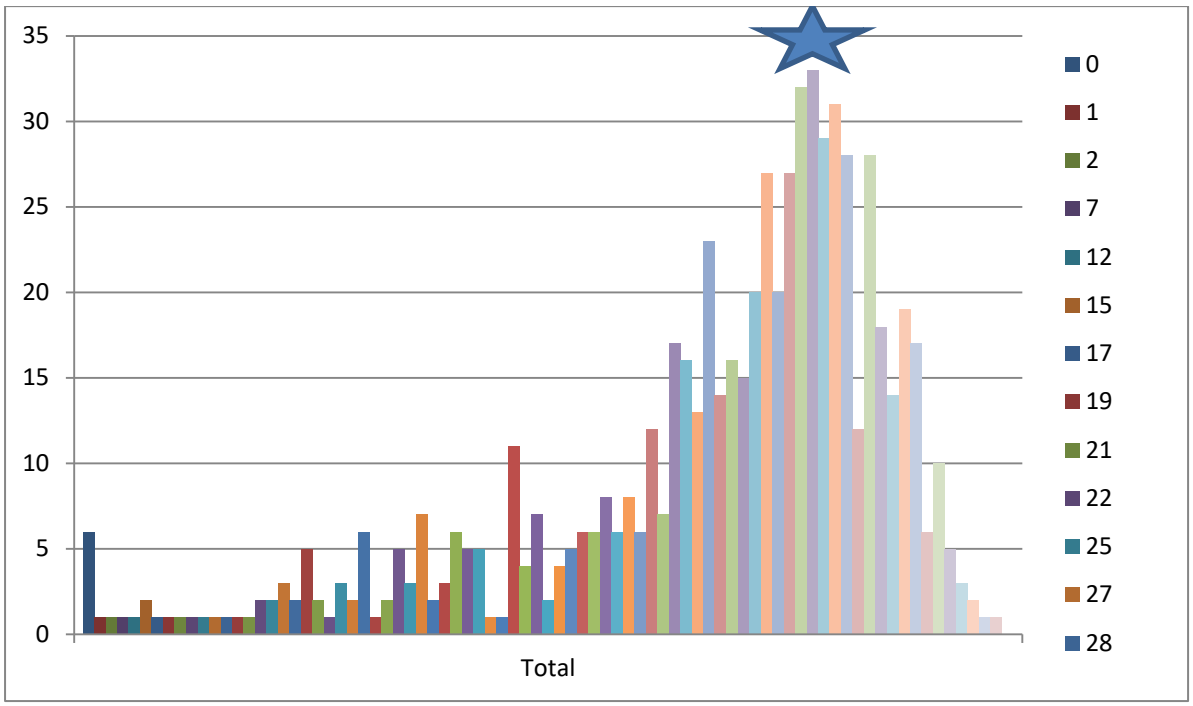
During this period of time 22 females and 21 males have died in our service with either suspected or confirmed COVID-19.



	Female	Male
Count of Gender	**330**	**349**

6.3 Death by Age Group since 1 March to 29 May 2020

The youngest age was classed as 0, and the oldest age was 103 years. Most deaths occur within the 80-90 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 March 2020 to 29 May 2020

	March 2020	April 2020	May 2020
LD Deaths	0	1	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 March 2020 to 29 May 2020, the Trust has recorded 1 Learning Disability death who had suspected/confirmed COVID-19.

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

6.5 Death by Ethnicity since 1 March to 29 May 2020

White British is the highest recorded ethnicity group with 560 recorded deaths, 73 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
Mixed - White and Black Caribbean	1
Mixed - White and Black African	1
Asian or Asian British - Any other Asian background	2
Pakistani	2
Caribbean	4
Indian	4
White - Irish	4
Asian or Asian British - Pakistani	4
Not stated	5
Other Ethnic Groups - Any other ethnic group	7
White - Any other White background	12
Not Known	73
White - British	560
Grand Total	**679**

Of the 43 patients who had suspected /confirmed COVID-19, 38 were from a white British background, 2 were recorded as Asian/Asian British–Pakistani, 3 did not have their ethnicity stated

6.6 Death by religion since 1 March to 29 May 2020

Christianity is the highest recorded religion group with 159 recorded deaths, 325 deaths had no recorded religion assigned and 18 people refused to state their religion. The chart below outlines all religion groups.

Row Labels	Count of Religion
Jehovah's Witness	1
Agnostic	1
Nonconformist	1
Atheist / Agnostic	1
Salvation Army Member	1
Baptist	1
Sikh	1
Muslim	2
Lutheran	2
Anglican	2
Patient Religion Unknown	2
Atheist	2
Religion (other Not Listed)	2
Hindu	2
None	3
Methodist	6
Roman Catholic	10
Not Given Patient Refused	18
Not Religious	51
Church Of England	86
Christian	159
(blank)	325
Grand Total	**697**

6.7 Death by sexual orientation since 1 March 2020 to 29 May 2020

Heterosexual or straight is the highest recorded sexual orientation group with 241 recorded deaths. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Gay Or Lesbian	1
Person Asked And Does Not Know	1
Sexual orientation unknown	1
Not Appropriate To Ask	3
Unknown	6
Not Stated (declined)	7
Heterosexual Or Straight	241
(blank)	437
Grand Total	**697**

6.8 Death by disability since 1 March 2020 to 29 May 2020

Behavioural and emotional problems were the highest recorded disability group with 20 recorded deaths.

Top 6 (highest) recorded disabilities	Count of Disability
Learning Disability (dementia)	6
Mobility and gross motor	9
Progressive (LT) conditions	15
Learning Disability (dementia)	19
Behaviour and emotional	20
other	45
Grand Total	**114**

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.

- Service Manager to revisit with team the standards required when transferring care to another Community Mental Health Team (CMHT) or ward, ensuring clinical risk is managed, and requirements of Care Programme Approach are adhered to.

- Need for clearer guidelines regards the transferring of Care Co-ordinator role between CMHT and Wards during lengthy inpatient admissions.

- The Trust to review the management of patients who are aggressive / are carrying weapons / who pose a more serious threat to others and identify if there would be further discussions to be forged with the Police to support in such incidents as this.

- The Trust to provide bite-sized training and refresher courses regarding Community treatment Orders to ensure that practitioners are fully conversant with the legalities, use and administration requirements of them.

- Requests for inpatient admission should incorporate escalation actions to take place where patients may require detention under the Mental Health Act.

- All relevant providers must ensure that when external referrals for a mental health bed are made by prison healthcare psychiatrists, the process designed to achieve this should be locally agreed between the commissioners and providers.

- Any patient referred to DRP for alcohol misuse should be breathalysed on first meeting, half way through treatment and at the end of treatment. This could be used as a monitoring tool as well as part of self-care and support to the person

- Further investment in educating staff around the presentation and impact of disorders such as Huntington’s Disease.