

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 standardized 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:

- From 1 April 2017 to 29 May 2018, 248 deaths were reported through the Trust incident reporting system (Datix). Of these, 242 were reviewed through the process of the Untoward Incident Reporting and Investigation Policy and Procedure of which 80 warranted a further investigation. 46 reported incidents were closed by the Serious Incident Group
- 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 has amended the current form used in case note reviews in line with a pilot currently being undertaken by the Royal College of Psychiatrists. This form is very similar to the Trust's and will be adopted if required once the final version of the form has been approved by the Royal College of Psychiatrists although delays in establishing cause of death would currently be a problem
- We have audited to ensure compliance with policy and process in that we are conducting cases note reviews. Two have been referred for further investigation.

Challenges include:

- Undertaking a case note review of all deaths as outlined in the national guidance, within available time. This is impossible without substantial additional resources
- Delay in obtaining cause of death. If we can obtain a complete data set from

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

NHS Digital we will identify “hotspots” against the background population and target case reviews against these

- Medical colleague availability to undertake case note reviews at a time when we have a significant number of vacancies
- The sensitivity of our incident recording system means that the total numbers of deaths are potentially higher than comparable trusts.

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*.

Since this report has been prepared further work has been ongoing regarding an analysis of deaths of patient on waiting lists which will feature in the next report.

Consultation

Deputy Director of Nursing and Quality Governance and Medical Director.

Review at Quality Committee in June 2018. Benchmarking of approach against other trusts requested plus ethnicity breakdown for city/county deaths to both be included in next report.

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

We are 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 is requested to accept this Mortality Report as assurance of our approach, and note that the report is required to be published on the Trust website prior to end of June 2018, as per national guidance.

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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 every 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 March, April and May 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 has amended the current form used for case note reviews in line with the pilot undertaken by the Royal College of Psychiatrists. This form was very similar to the Trusts and will be amended if required once the final version of the form has been approved by the Royal College of Psychiatrists.

We have audited 25 records and plan to audit 25 more, and this will be ongoing to ensure compliance with policy and process.

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

3 Data Summary of all deaths

Month	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	Total
Total Deaths Per Month	196	212	230	177	204	194	183	169	226	260	203	219	174	140	2787
Total Deaths On Waiting List	1	0	0	0	1	1	0	0	3	7	2	13	48	29	105
Inpatient Deaths	0	2	0	4	0	1	0	1	1	1	3	1	1	0	15
LD Referral Deaths	2	1	1	2	4	4	0	5	4	4	3	3	2	0	35

Correct as at 29.05.2018

Since April 2017 the Trust has received 2787 death notifications of patients who have been in contact with our service. The figure elsewhere in this paper (3,551) 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 6 months. This took effect from 20 October 2017.

4. Review of Deaths

Total number of Deaths from 1 April 2017 – 29 May 2018 reported on Datix?	248 Incidents were reported as DEATH
Number reviewed through the Serious Incident Group	242
Number investigated by the Serious Incident Group	80
Number of Serious Incidents closed by the Serious Incident Group?	46

The Trust has recorded 15 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 6 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 absconion 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

As of 29.05.18, the Trust has 121 deaths to review under the mortality process that meet the criteria defined below. The Mortality Review Group has currently case reviewed 41 deaths. This was undertaken by a multi-disciplinary team and it established that of the 41 deaths reviewed, 34 have been classed as unavoidable, 7 are on hold pending cause of death and 2 of these 7 have been sent for further investigation under the Untoward Incident Reporting and Investigation Policy and Procedure. The Mortality Review Group is currently reviewing deaths of patients who fall under the following 'red flags':

- 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

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

- Alzheimer's / Dementia
- Old Age
- Pneumonia

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

Guidance

The Royal College of Psychiatrists is currently piloting a Case Record Review Tool which has been adapted from the Structured Judgement Review tool developed by the Royal College of Physicians, to make it suitable for supporting mortality reviews in patients in receipt of mental health services.

The Case Record Review Tool has been designed to support Trusts to respond to concerns from carers and families about any aspect of their care. In addition, the process has the potential to identify cases where, although a Serious Incident Investigation was not initially deemed necessary, concerns when completing the care note review suggests that a Serious Incident investigation might be appropriate.

The tool has two sections:

- ❖ The screen (section 1) **should be completed within three days** of the patient's death.
- ❖ For deaths 'red flagged' as needing further review, section 2 **should be completed within 60 days** of the death being reported.

The Case Record Review Tool has been developed to look at care at different phases of a patient's contact with mental health services, and good care should be recognised, judged and recorded in the same detail as problematic care.

Piloting of the tool has been arranged via members of the Expert Reference Group and is scheduled for April – June 2018. The final version of the tool and care review process will be launched in September 2018.

There is a concern if this is adopted by the Trust that it will be very difficult to complete the relevant sections within 3 days and 60 days respectively due to the current delay in notification of deaths.

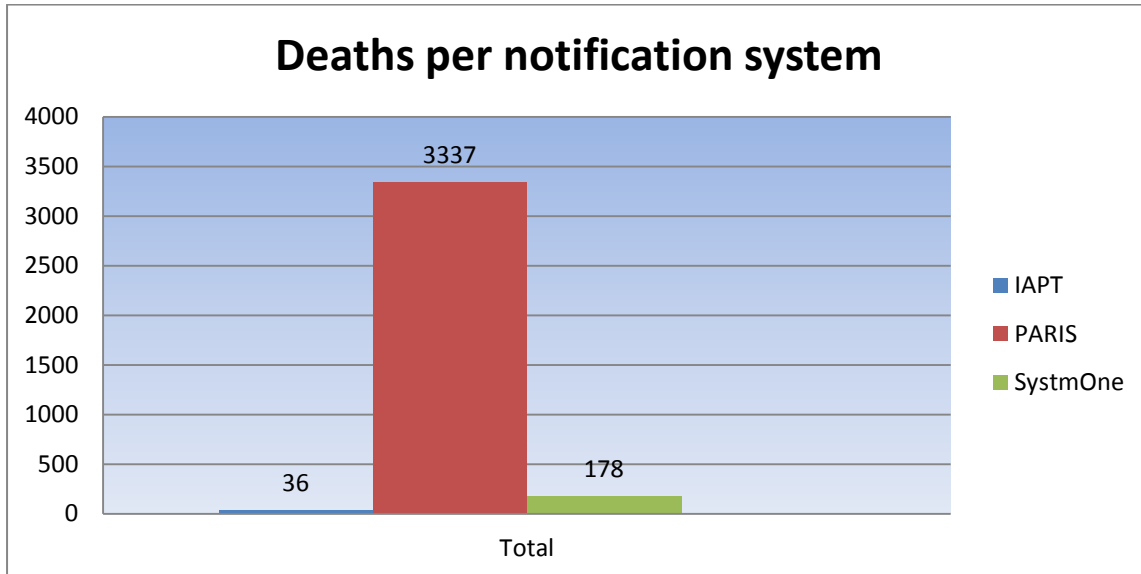
As well as the above pilot, NHS Improvement (NHSI) has published draft guidance: 'Learning from Deaths Workstream 3 – Working with Families'

The purpose of this guidance is to provide information and direction for NHS trusts regarding best practice on how to engage and work effectively with families following the death of a family member. The guidance has been informed by the work of the Workstream 3 steering group, alongside the families, carers, stakeholder organisations and NHS trusts that participated in events to help develop this guidance.

At the current time, the members of the Trust's Mortality Review Group have made the decision that following a case note review if concerns are raised, then the incident will be reviewed through the Serious Incident Process. At this point the family will be contacted to advise that an investigation is being undertaken. Once the NHSI guidance has been finalised, it will be reviewed by the Trust and an update will be provided in the next Mortality Report.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 Jan 2017

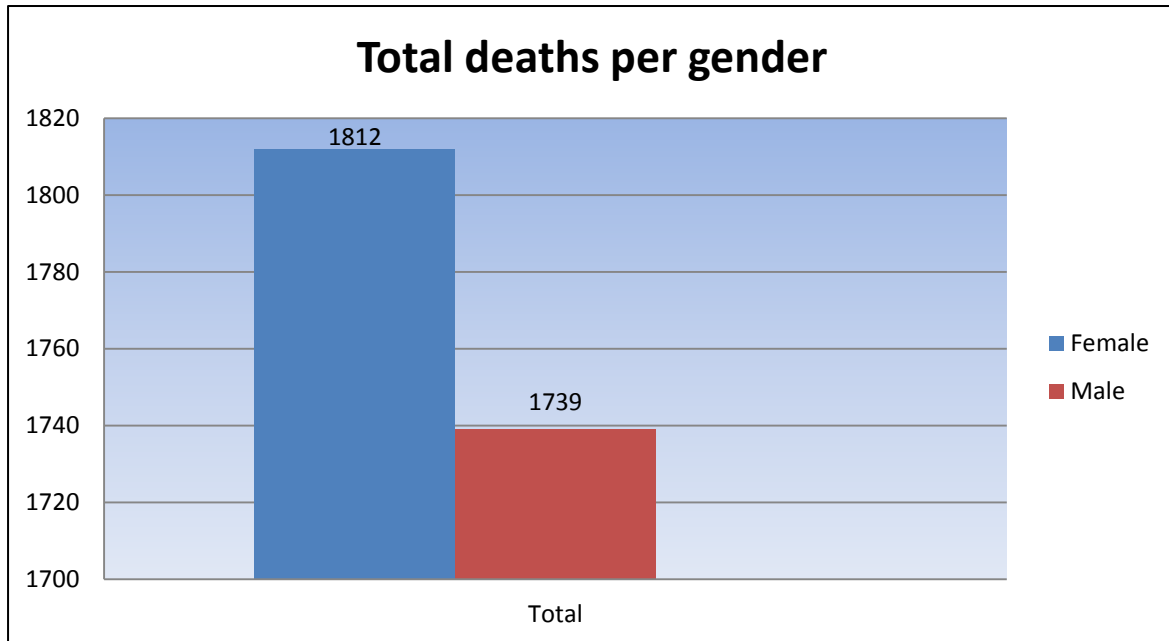


	IAPT	PARIS	SystemOne	Grand Total
Count of Source System	36	3337	178	3551

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. 178 death notifications were pulled from SystemOne and 36 from IAPT.

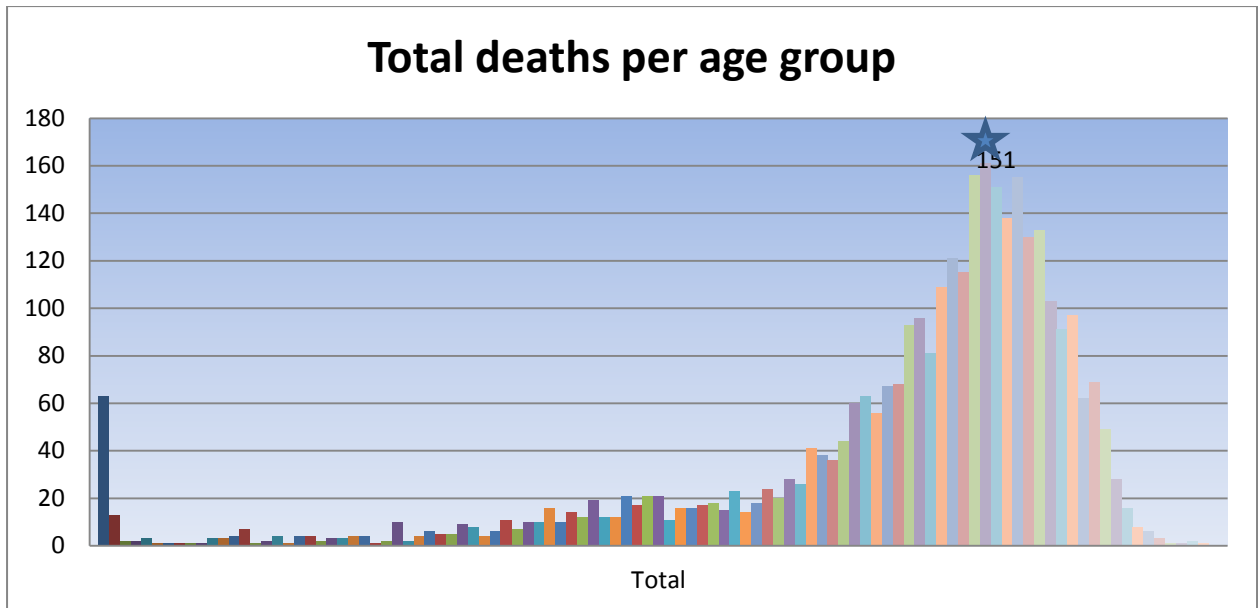
6.2 Deaths by gender since 1 Jan 2017

The data below shows the total number of deaths by gender since 01 Jan 2017. There is very little variation between male and female deaths; 1739 male deaths were reported compared to 1812 female.



	Female	Male	Grand Total
Count of Gender	1812	1739	3551

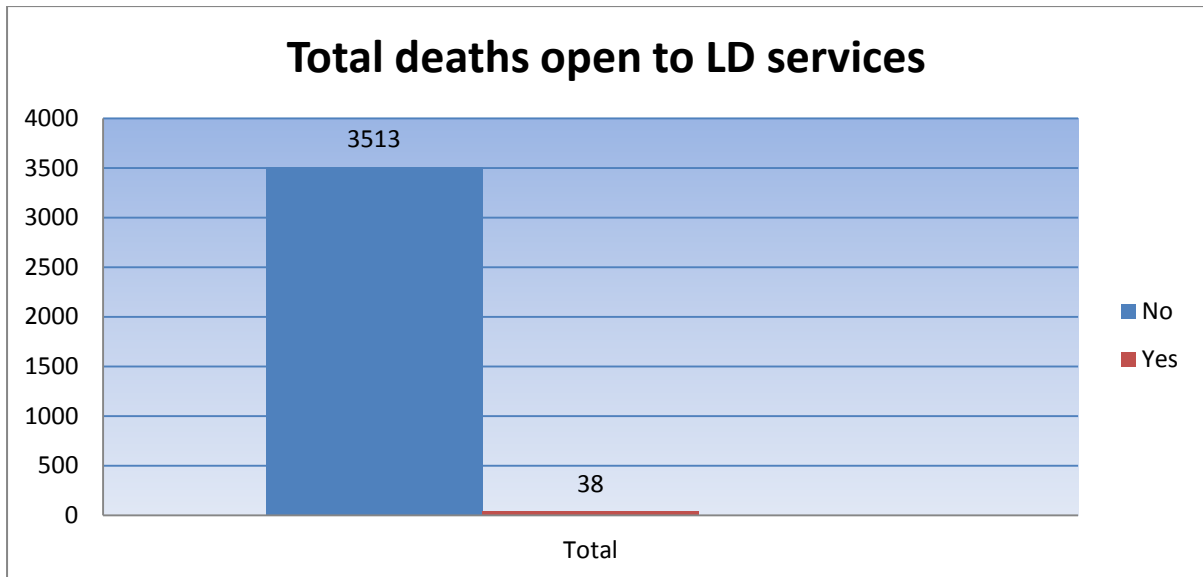
6.3 Death by age group since 1 Jan 2017



The youngest age was classed as 0 and the oldest age was 107 years. Most deaths occur within the 82-87 age groups (indicated by the star); in the last report most deaths occurred between 85-90 age group.

Since April 2018 there were 25 deaths discussed and closed in the period and 2 of these had been referred for Serious Case Review or Learning Review.

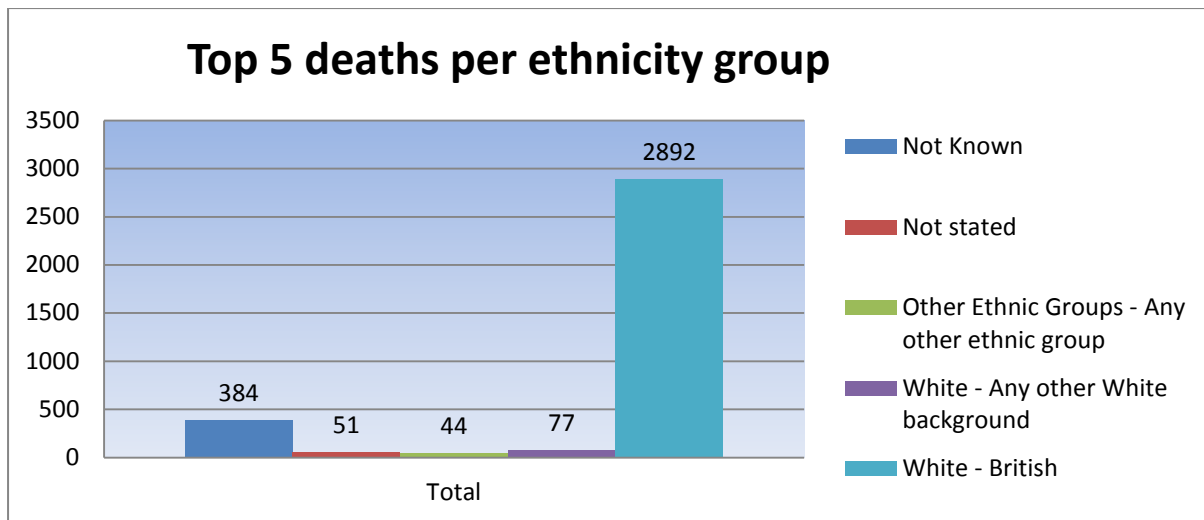
6.4 Learning Disability Deaths since 1 Jan 2017



	No	Yes	Grand Total
Count of Known To LD	3513	38	3551

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, and are unable to tell us if our patients have been part of that sample.

6.5 Death by Ethnicity since 1 Jan 2017



The top 5 recorded deaths per ethnicity group are highlighted above. White British is the highest recorded group with 2892 recorded deaths, 384 deaths had no recorded ethnicity assigned and 51 people did not state what their ethnicity was. The chart below outlines all ethnicity groups.

Ethnicity	Death Count
Asian or Asian British - Any other Asian background	7
Asian or Asian British - Bangladeshi	2
Asian or Asian British - Pakistani	7
Caribbean	20
Indian	19
Mixed - Any other mixed background	7
Mixed - White and Black Caribbean	6
Not Known	384
Not stated	51
Other Ethnic Groups - Any other ethnic group	44
Other Ethnic Groups - Chinese	2
Pakistani	9
White - Any other White background	77
White - British	2892
White - Irish	24
Total	3551

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.

Learning / action log

- Consideration of formal management training for development, support use of IT systems to inform operational decision-making
- Review of blood-borne virus policy
- Review and audit of Safety Box use on the Paris electronic patient record system.
- Review of communication practices between inpatient areas and community teams
- Review standards, training and audit relapse prevention plans with community mental health teams
- Explore with commissioners, the commissioning of a community forensic team and the potential risks and benefits of this model of practice
- Advice to be provided for nursing and medical staff in relation to patients suffering from health anxiety and referral for CBT
- Discussion with commissioners regarding specific services / pathways for individuals with a diagnosis of personality disorder
- Review the number of funded care programme approach co-ordinators in community teams benchmarked against comparable trusts per hundred thousand population
- Review expected standards of practice for patients on a Community Treatment Order. Complete a Trust-wide audit of these revised standards and then monitor via a six monthly audit cycle
- Education/information on the referral process to IAPT for inpatient areas
- All services contracted to provide IAPT services should be given training and read only access to PARIS
- For interagency communication to be improved so information can be shared in a timely manner
- Review of home leave care-plan to include explicit completion of parent/carer contact or to actively state why not required

8. Mortality prevention work undertaken by the Trust;

Summary of Acute Liaison work – Dental day case only – The Royal Derby Hospital

NHS Choices outlines the importance of good oral health and the implications to health

The state of someone's teeth affects their overall health, with gum disease linked to lots of serious health problems in other parts of the body and increasing risk to other health complications, including stroke, diabetes and heart disease. Gum disease has even been linked with problems in pregnancy and dementia.

The dental day cases are held every other Wednesday for essential assessment and treatment if necessary, for individuals where it is apparent that primary health care services would not be able to meet the needs of this group of people. These sessions offer:

- Case by case situations. Organised visits to the dental day case clinic if required as part of any **desensitisation programme**
- Many service users require accessible **information** around coming into hospital which is issued prior to admission.
- Service users are **met upon arrival** at hospital, and are provided with an offer of **support during any outlined procedure**, including administration of anaesthetic / treatment. This support is available throughout the whole process, not just 'booking in'.
- Support is provided in a variety of ways and is tailored to the needs of the individual.

Supporting post-operatively and the discharge process is also invaluable within the dental day case. Whilst it is essential that observations are monitored post-operatively, these can be extremely distressing to some individuals. Being able to support adjustments within this can be of extreme benefit in the recovery process / procedure. Use of an iPad has at times, provided distraction and focus during periods of high anxiety.

Offering this type of **bespoke** service in hospital enhances the positive outcomes for many, as essential treatment is unlikely to be achieved through primary health care services alone.

Working with Chesterfield FC: a short history of 'Active Spireites'

Summary

In 2013, in a chance meeting, the chair of the Chesterfield FC Community Trust (John Croot) was at a networking meeting which included clinicians from the Trust. The two organisations decided to meet to explore opportunities to develop a joint Mental Health Strategy. The Trust was already working on a Healthy Body Healthy Mind programme that ran with Public Health, looking at how people with severe mental health problems improved their physical health. As part of our recovery approach, the Trust wanted to collaborate with the football club to run sessions targeting improving fitness and mental wellbeing using the motivation of football as that therapeutic tool.

In the five years since the initial meeting, several programmes have developed and the Core Active Spireites programme continues on a rolling basis.

Associated projects have included:

- Healthy lifestyle course at the stadium co-facilitated by mental health Occupational Therapists, football coaches and volunteer Peer Supporters (The Core Active Spireites Programme)
- A similar programme targeted particularly at people with substance misuse problems
- Football coaching sessions and competitive football matches facilitated by Chesterfield FC community Trust and Peer Supporters
- Walking for health project
- In-reach work to acute mental health unit from Chesterfield FC Community Trust
- 'Time to change' match events at Chesterfield FC stadium (Twice a year)
- Establishing links with national projects promoting football and mental health projects and presenting details of the programme at national meetings