Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 November 2023

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 June to 31 August 2023.

Executive Summary

- All deaths directly relating to Covid-19 are reviewed through the Learning from Deaths procedure unless they meet an additional Incident Red Flag in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. From 1 June to 31 August 2023 there has been no deaths reported where the patient tested positive for Covid-19.
- The Trust received 490 death notifications of patients who had been in contact with our service within the 6 months prior to their death. There is little variation between male and female deaths; 249 male deaths were reported compared to 241 females.
- No Inpatient deaths were recorded.
- The Mortality Review Group have temporarily changed the objective of the Case Record Review Thursday meetings with medics. The Patient Safety Team Investigation Facilitators are utilising the meetings for advice and medical support for their ongoing investigations.
- The Trust has reported five Learning Disability deaths in the reporting timeframe and two patients with a diagnosis of Autism Spectrum Disorder (ASD).
- Medical Examiner officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community Trusts. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.
- 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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	

Assurances

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

Consultation

The Quality and Safeguarding Committee received assurance from the Trust's approach and agree for the report to be considered by the Trust Board of Directors and then published on the Trust's website as per national guidance

Governance or Legal Issues

- There are no legal issues arising from this report.
- 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 and 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:

- 1 June to 31 August 2023. There is very little variation between male and female deaths; 249 male deaths were reported compared to 241 females.

- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this Mortality Report on assurance from the Quality and Safeguarding Committee as assurance of the Trust's approach and agree for the report to be considered by the Trust Board of Directors and then published on the Trust's website as per national guidance.

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Medical Director

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

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Safer Care Coordinator

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 the required guidelines. The report presents the data for 1 June to 31 August 2023.

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

- Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. It is hoped that this will improve once Medical Examiners commence the process of reviewing the Trusts non-coronial deaths.

- The mortality team have now received a new schedule outlining the medics who will be attending Case Record Review sessions in 2023 for both North and South consultants. Meeting invites for 2023 have now been set up and sent to all consultants involved.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed on 1 October 2023.

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information for 1 June to 31 August 2023.

	June	July	August
Total Deaths Per Month	158	182	150
LD Referral Deaths	4	1	0
Inpatient Deaths	0	0	0

Correct as of 28/09/2023

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

249 patients were male, 241 were female, of these 367 were white British, 91 were any other ethnic group and 32 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 101.

From 1 June to 31 August 2023, the Trust received 490 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 1 June to 31 August 2023 reported on Datix	56 “Unexpected deaths” 0 Covid-19 deaths 10 “Suspected deaths” 1 “Expected - end of life pathway”. NB some expected deaths have been rejected so these incidents are not included in the above figure. 0 Inpatients deaths
Incidents assigned for a review	53 incidents assigned to the operational incident group. 13 incidents assigned to the executive incident group. 0 did not meet the requirement. 1 incident is to be confirmed

Only deaths which meet Trust Red Flags are reported through the Trust incident reporting system (Datix) and are reviewed through the Untoward Incident Reporting and Investigation Process. These Red Flags apply to any patient open to services within the last six months prior to their death:

- 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.
- *Death of a patient with Autism*
- *Death of a patients who had a diagnosis of psychosis within the last episode of care*

The last two red flags have been added this year to ensure that the Trust meets the Learning from Deaths guidance and recent changes to the LEDER reporting requiement of patients who have a diagnosis of autism.

5. Learning from Deaths Procedure

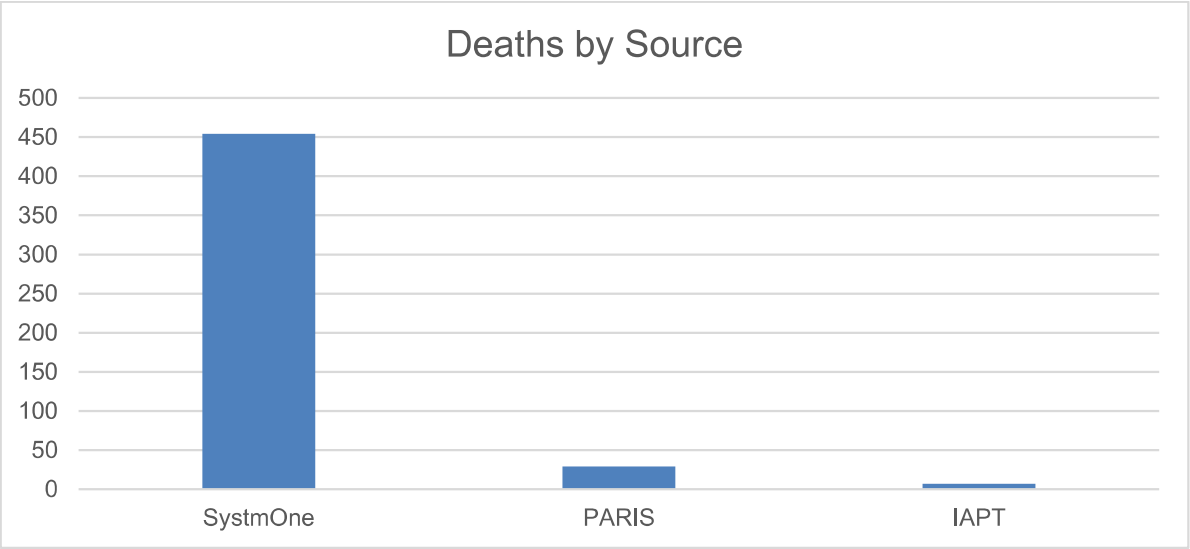
The Trust has now completed the move of its mortality process which has been implemented within the patient Electronic Record, this aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services.

The Mortality team are conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

From the 1 June to 31 August 2023 there has been no deaths reported where the patient tested positive for Covid-19.

6. Analysis of Data

6.1 Analysis of deaths per notification system 1 June to 31 August 2023

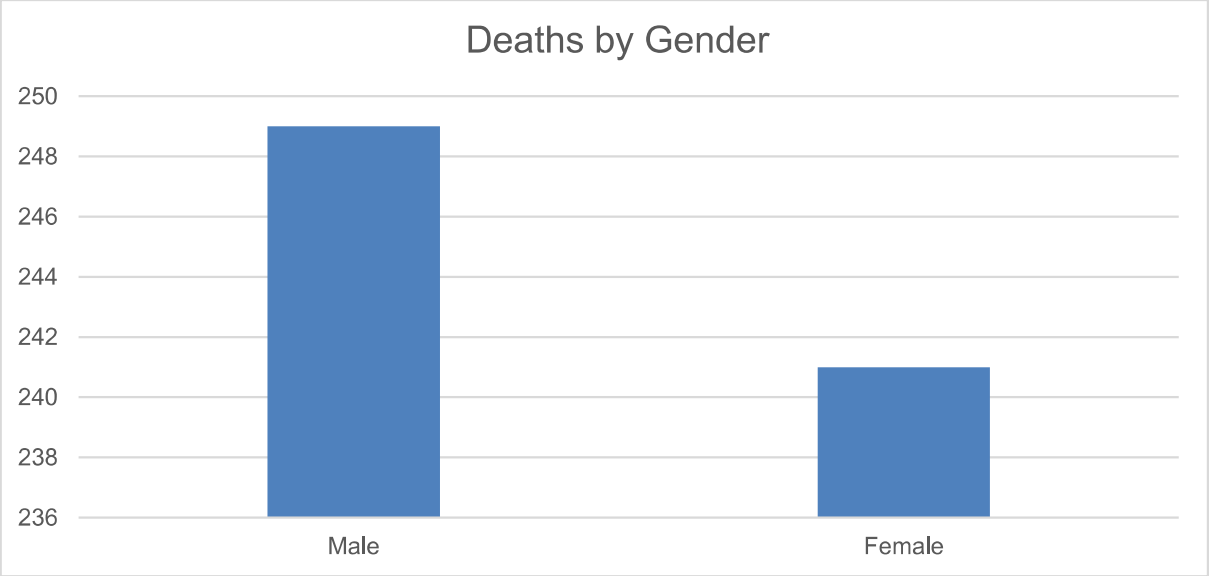


System	Number of Deaths
IAPT	7
PARIS	29
SystmOne	454
Grand Total	**490**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne which is not unexpected given the Trust's move the One EPR.

6.2 Deaths by Gender

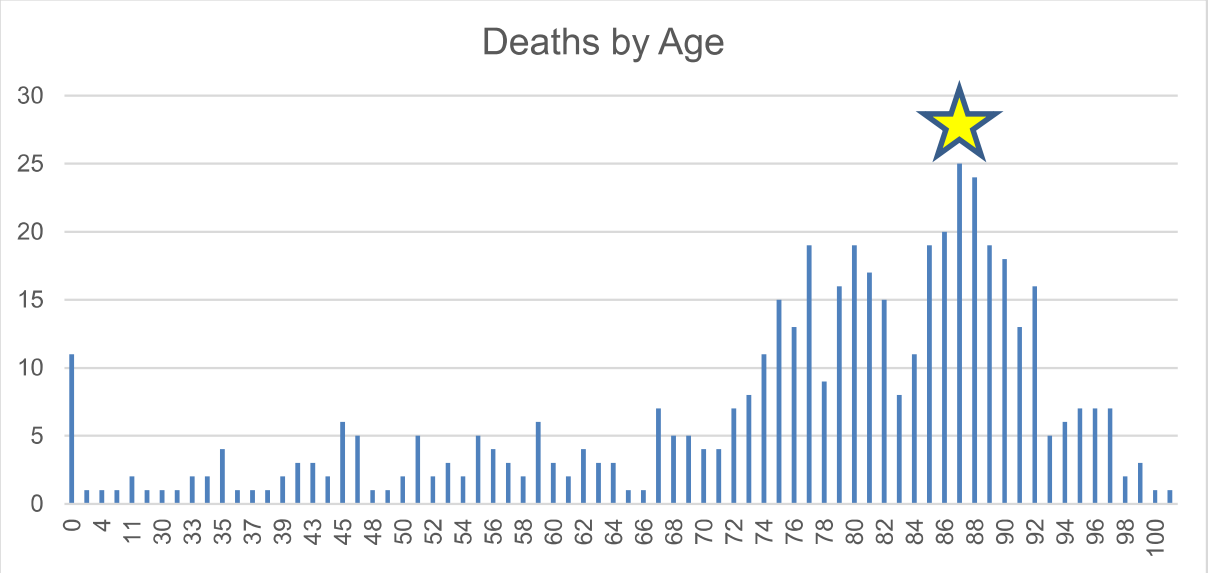
The data below shows the total number of deaths by gender for 1 June to 31 August 2023. There is very little variation between male and female deaths; 249 male deaths were reported compared to 241 females.



Gender	Number of Deaths
Male	249
Female	241
Grand Total	**490**

6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 101 years. Most deaths occurred within the 85-90 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	June	July	August
LD Deaths	4	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.

During 1 June to 31 August 2023, the Trust has recorded five Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

The Trust also is required from 1 January 2022 to report deaths of patients who have a diagnosis of Autism Spectrum Disorder (ASD) for this reporting period the Trust has reported two deaths.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 367 recorded deaths, 22 deaths had no recorded ethnicity assigned, and 10 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
White - British	367
Other Ethnic Groups - Any other ethnic group	73
Not Known	22
Not stated	10
White - Any other White background	5
White - Irish	5
Black or Black British - Any other Black background	2
Mixed - Any other mixed background	2
Asian or Asian British - Indian	2
Asian or Asian British - Any other Asian background	1
Mixed - White and Black African	1
Grand Total	**490**

6.6 Death by Religion

Christianity is the highest recorded religion group with 219 recorded deaths, 187 deaths were (blank) with no recorded religion assigned. The table below outlines all religious groups.

Religion	Number of Deaths
Christian	219
(blank)	187
Church of England, follower of	26
Church of England	22
Unknown	5
Religion NOS	4
Not Religious	4
Methodist	4
Christian religion	3
Roman Catholic	2
Catholic: non Roman Catholic	2
Catholic religion	1
Patient Religion Unknown	1
Atheist	1
Nonconformist	1
Protestant	1
None	1
Atheist movement	1
Sikh	1
Jehovah's Witness	1
Hindu	1
Pagan	1
Muslim	1
Grand Total	**490**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 274 recorded deaths. 187 had no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number of Deaths
Heterosexual	274
(blank)	185
Sexual orientation not given - patient refused	18
Heterosexual or Straight	5
Sexual orientation unknown	2
Unknown	2
Bisexual	2
Homosexuality NOS	1
Not appropriate to ask	1
Grand Total	**490**

6.8 Death by Disability

The table below details the top five categories by disability. Gross motor disability was the highest recorded disability group with 90 recorded deaths.

Disability	Number of Deaths
(Blank)	323
Gross Motor Disability	90
Intellectual Functioning Disability	37
Emotional Behaviour Disability	16
Hearing Disability	9
Physical Disability	6
Walking Disability	2
Registered Disabled	1
Sight	1
Mobility and Gross Motor	1
Other	1
Learning Disability	1
Behaviour And Emotional	1
Learning Disability (Dementia)	1
Grand Total	**490**

There was a total of 167 deaths with a disability assigned and the remainder 323 were blank (had no assigned disability).

7. Medical Examiners

Medical Examiner officers have been established at all Acute Trusts in England. The role of these offices is now being extended to also cover deaths occurring in the community, including at NHS Mental Health and Community Trusts. Medical Examiners are to provide independent scrutiny of deaths not taken at the outset for

coroner investigation. They will carry out a proportionate review of medical records and give families and next of kin an opportunity to ask questions and raise concerns. This process will inform learning to improve care for future patients, or, in a smaller number of cases, may be referred to others for further review. Their involvement will also provide reassurance to the bereaved.

Overall Medical Examiners will seek to answer the following three questions:

- What caused the death of the deceased?
- Does the coroner need to be notified of the death?
- Was the care before death appropriate?

Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

8. Recommendations and Learning

Changes will be implemented within the DATIX system to support early identification of themes and learning from incidents which are not taken to further Patient Safety learning review, this information will be fed into Learning the Lessons Subgroups alongside themes and recommendations from Learning Reviews to support the development of Quality Improvement programmes. Current themes are detailed below:

Improvement issue	Actions required update
Transfer of the deteriorating patient	Internal investigations have highlighted themes regarding the transfer and return of patients between inpatient services for the Trust and Acute providers such as Chesterfield Royal Hospital. This includes handover of information, and the way patients are conveyed. A quality improvement project is underway between Derby Hospital and DCHFT
Self-harm of patients whilst on leave from inpatient services	Investigations have highlighted issues in relation to adult inpatient leave arrangements including section 17 leave arrangements. A further thematic review has been completed on conclusion of current inpatient suspected suicide incidents active at present. An action plan has been developed. The Patient safety Team are leading on the coordination of the review of the current processes and quality improvement actions
MDT process improvements within CMHTs	Investigations have highlighted themes in relation to MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Falls prevention	Pockets of increased falls have been noted and currently there are pilots underway within Older Adult in patient service for the use of bed and chair sensors. A Trust Falls Group meets regularly to discuss improvements and themes
Family liaison and engagement	The package of support available to families involved in an internal investigation/ review has been identified as an area for improvement. This includes consistency of support, timeframes and establishing a pathway for escalation. Work is underway to develop an agreed package which will be offered and how this will be supported by the Trust.
Multi-agency engagement following incidents	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Relapse prevention and MDT resource management within Amber Valley Adult Community Mental Health Services	As a result of an internal investigation and concerns raised by staff a piece of work is being commissioned to consider themes in relation to the resource and function of the MDT process within the Amber Valley CMHT.
Integrated care services	Investigations have highlighted the need for improvements in the care pathway of patients open to more than one service. A conference will be held which will include representation from all service lines, Clinical Directors, Medical Director and Deputy Director of Nursing and Quality as well as incident investigation leads to review themes and devise a plan of action to enhance internal integrated care. This conference will also include external integrated care with providers such as Social Care.
Inappropriate admission to inpatient adult ward	Investigations into high profile incidents of inappropriate admissions to Adult Mental Health inpatient services brought to attention an on-going issue in this area. Review of lower grade incidents and discussions with the service line have confirmed a long-standing theme in this area. A review of inappropriate admissions is currently underway