

Learning from Deaths - Mortality Report

NHS Improvement and the National Quality Board have requested all NHS Trusts to publish a review of mortality by 31 December 2017. This is our Trust 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'¹. 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 specified information on deaths quarterly. This should be through a paper and Board item to a public board meeting in each quarter to set out the Trusts policy and approach (by end of Q2) and publication of the data and learning points by Quarter 3. 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, how many of these deaths were judged more likely than not to have been due to problems in care. This report outlines the information required to be reported by the end of Quarter 3.

2. Current position and progress

- Learning from Deaths Procedure approved through Public board papers
- Application for NHS digital continues and the Trust is currently awaiting an outcome.
- Two staff, Professional Lead for Patient Safety and Experience and Investigation Facilitator have attended the national training on Structured Judgement Reviews (SJR) by the Royal College of Physicians
- The Mortality Review Group continue to trial two methods to case review records, these are PRISM and Structured Judgement Review

3. Data Summary

Total number of deaths recorded since 1 April 2017								Total
April	May	June	July	August	September	October	November	
148	145	151	141	142	128	93	82	1030

Correct as at 30.11.2017

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

Since April 2017 the Trust has received 1030 death notifications of patients who have been in contact with our service. 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 6 months contact, this took effect from 20 October 2017. A decrease can therefore be seen in the number of deaths recorded for the months of October and November.

4. Review of Deaths

Untoward Incident and Investigation policy and procedure

From 1 April to 30 November 2017, 129 deaths reported through the Trust incident reporting system (Datix). Of these 48 have been reviewed and closed through the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*.

An Initial Service Management Review (ISMR) was completed for all 11 inpatient deaths; these were discussed at the Serious Incident Group where 6 deaths were then commissioned for further investigation, one of which was an expected death.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are 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. (This criteria only relates to patients open to services within the last 6 months)
- Domestic homicide - perpetrator or victim (This criteria relates to patients open to services within the last 6 months)
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatients 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 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/ombudsman, or staff have raised a significant concern about the quality of care provision
- Death of a child (and will likely 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

The Mortality Review Group has currently case reviewed four deaths using the PRISM method. This was undertaken by a multi-disciplinary team and it was established that no deaths were due to problems in care. The Mortality Group are currently reviewing the following red flags:

- Patient on end of life pathway, subject to palliative care
- Anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

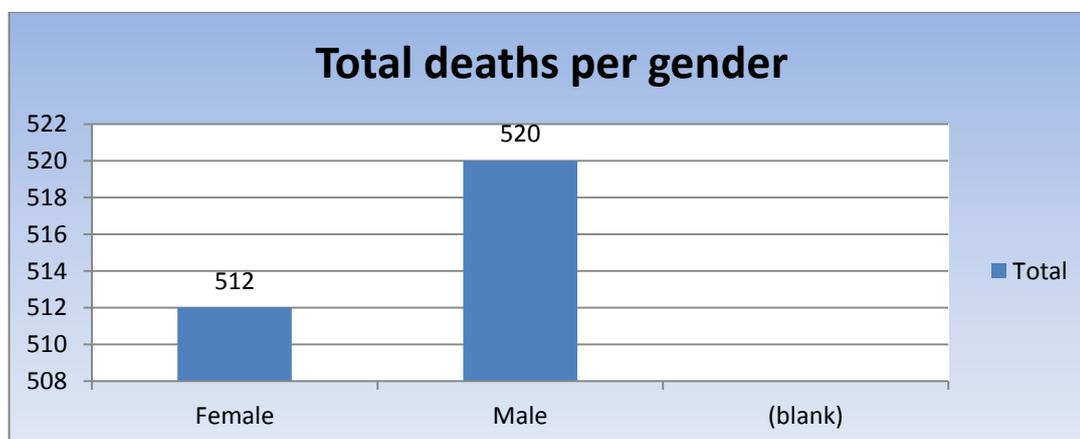
Initial analysis of death notification information shows the most prevalent causes of death are:

- Alzheimers Dementia
- Old Age
- Pneumonia

6. Analysis of Data

6.1 Deaths by gender

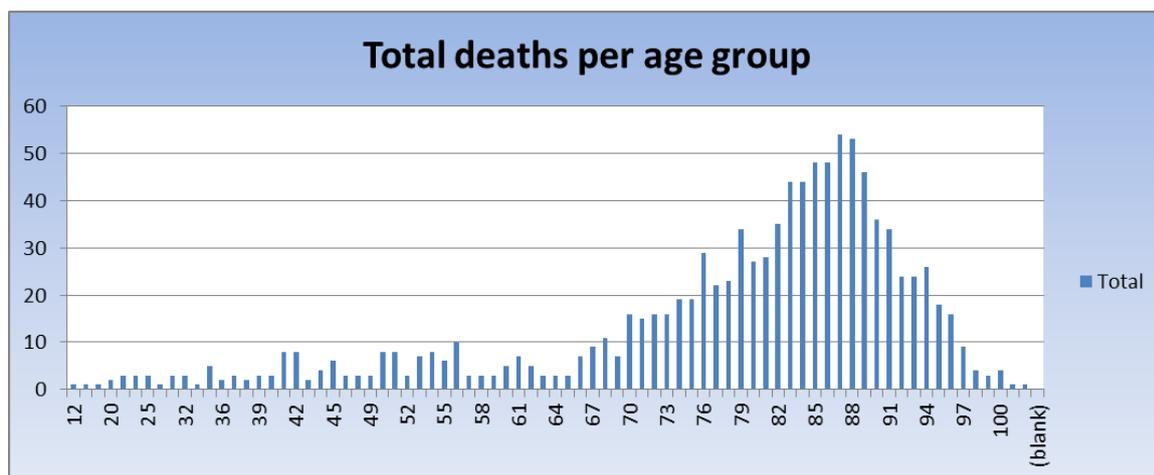
The data below shows the total number of deaths by gender. There is very little variation between male and female deaths, 520 male deaths were reported compared to 512 female



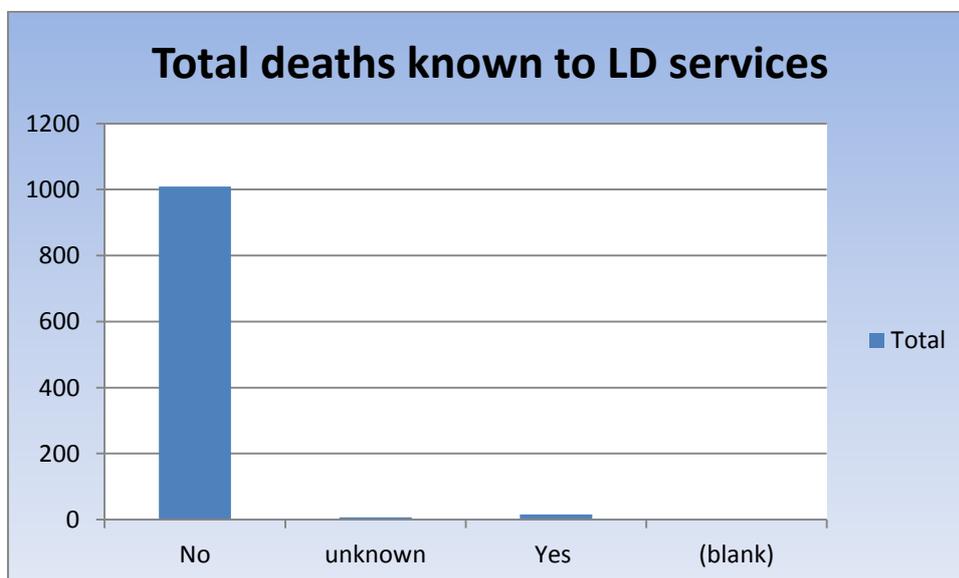
6.2 Death by age group

The youngest age was 12 and the oldest age was 104 years. Most deaths occur within the 80-90 age group.

Three child deaths are currently being investigated by the Child Death Overview Panel (CDOP).



6.3 Learning Disability Deaths

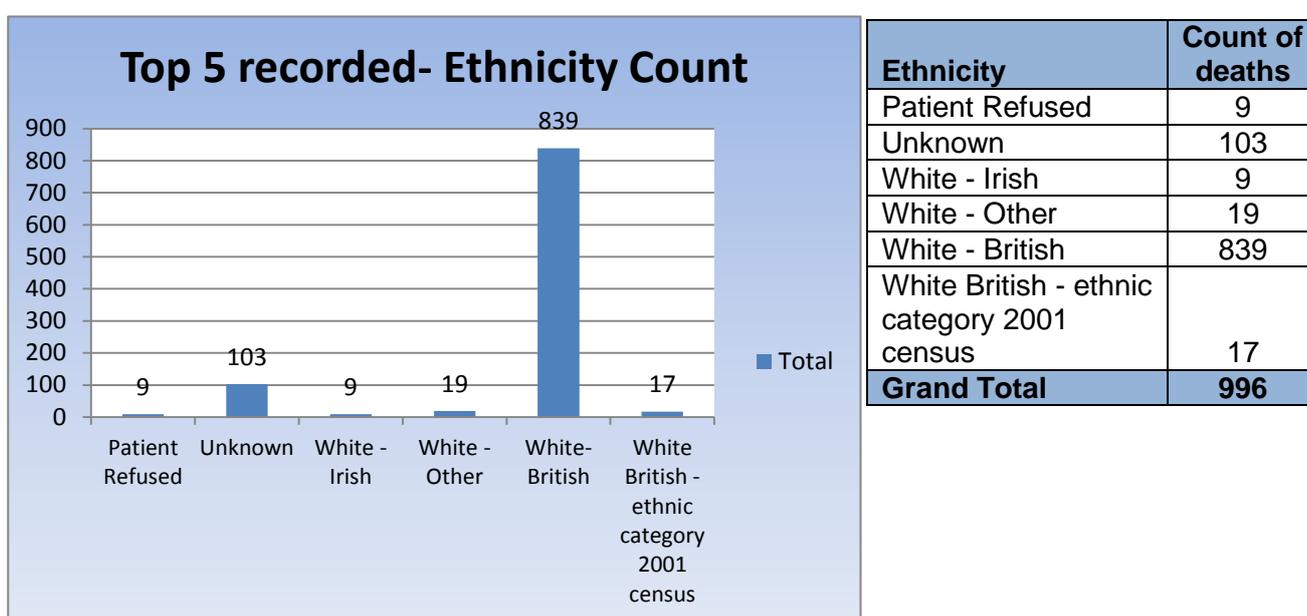


Known to LD	Count of deaths
No	1007
yes	16
Unknown	6
Total	1030

18 deaths have been sent to LeDER for review as per procedure. The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period.

A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The Programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements

6.3 Death by Ethnicity



White British is the highest recorded ethnic group, 9 patients refused to give their ethnic origin and ethnicity of 103 were unknown.

7. Recommendations and learning

Below are examples of the recommendations that has 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. This is not an exhaustive list

1. Liaison with alcohol services should be made prior to decisions being made on whether to assess or not.
2. Scanning of patient records on to the Trust electronic patient record (PARIS) for patients under the care of the HUB
3. There appears to be an overreliance on assurance based on a patients presentation at a particular time as opposed to risk assessment based on an understanding of a patient's life story, family and social circumstance

4. Improvement of physical healthcare and associated risk assessments and care-plans, fluid and nutrition monitoring.
5. The Process for managing Front Door Presentations to Psychiatric Units needs to be reviewed and clarified.
6. Review the process for discharge when concerns have been raised by the patient or family.
7. Reinforcement of use of the safety box to medical staff
8. An offer of psychiatric advice around complex medication issues should form part of the discharge information sent to primary care for patient who have Severe Mental illness
9. Staff learning events using case studies highlighting the importance of updating risk assessments, robust care planning in relation to suicide/self-harm and the Think Family principles and involving universal services when children are present.
10. Any clinical discussion with 3rd party sector including Primary Care during an in-patient admission or post-discharge from services should be documented in the patient's electronic patient records system.
11. As per recommendation within the DHCFT Substance Misuse Operational Policy Guidelines, service users who have a history of and/or significant ongoing mental health issues should be discussed in Multi-Disciplinary Meeting allocated to be under the care of the Consultant Psychiatrist.
12. Clear and comprehensive documentation of all clinical contact with patient.
13. Clinical/caseload supervision to include risk data audit
14. Closer collaboration and joint working with the General Practitioner
15. Collateral information should be sought from families wherever possible to add to the clinical assessment and understanding of the presentation.
16. Review of Adult safeguarding training to ensure consideration of families with multiple and complex needs with chronic issues, including limited engagement with key family members and the impact of individual's behaviour on others within the family.
17. Community Psychiatric Nurses and the Consultant to be briefed about the need for taking in to account the prescribed medications as part of suicide prevention strategy and also to link with primary care to enable regular review of medications like Morphine and pain killers.
18. Development of a Safeguarding Protocol which would include details regarding how to access safeguarding advice and support which would complement information already available via the Safeguarding Connect web page.
19. Development of clinical standards for 2 day and 7 day follow ups with expectations of practice in the Trust Discharge and Transition policy
20. Review of NICE guidance on Acute Kidney Injury (2013) if not already undertaken to assess implications for service. Consideration of development of teaching packages / information (not polices) for the clinical ward staff to access on adequate fluid intake and signs of dehydration

8. Update on action plan

Action	Handler	Timescale
'Learning from Deaths' process to be written, agreed and implemented as a process within the Trust	<ul style="list-style-type: none"> Lead for Patient Safety 	30 September 2017
Await confirmation from NHS Digital on success of application	<ul style="list-style-type: none"> Lead for Patient Safety 	31 December 2017
Pilot two methods of reviewing case records within the mortality process – Prism and Structured Judgement Review – in progress	<ul style="list-style-type: none"> Mortality Review Group 	31 December 2017
Attendance of selected members of the Mortality Group to attend national training on a method to undertake reviews (Structured Judgement Review) and cascade this training to the review group – training dates November and December 2017 Update 2 staff have attended the training	<ul style="list-style-type: none"> Investigation Facilitators Interim Assistant Director of Clinical Professional Practice Medical Director Lead for Patient Safety 	31 December 2017
Complete areas for improvement actions for family and carer involvement during investigations.	<ul style="list-style-type: none"> Lead for Patient Safety Family Liaison Facilitator 	31 December 2017