Derbyshire Healthcare NHS Foundation Trust
Report to the Quality Committee - 8 March 2018

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 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

Progress to date includes:

- Production of a *Learning from Deaths Procedure*
- Development of a Mortality Review Group which has been focusing on developing the systems and processes to support review and learning from deaths
- Appointment of a Mortality Technician to support processes for learning from deaths
- Self-assessment against requirement for family and carer involvement in deaths
- Implementation of new database which now captures:
  - Improving access to psychological therapies (IAPT)
  - Deaths of patients who had died on a waiting list
  - Ability to capture all patient deaths
- Provision of data to date to enable analysis and review
- Application to NHS Digital

Challenges include:

- Reviewing of all deaths as outlined in the national guidance
- Time constraints
- Delay in obtaining cause of death

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

Strategic Considerations (All applicable strategic considerations to be marked with X in end column)	
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

- Supports Board Assurance Risks re failure to achieve clinical quality standards required by our regulators which may lead to harm to service users
- 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*

Consultation

Deputy Director of Nursing and Quality Governance , Medical Director and Executive Director of Nursing and Patient Experience

Governance or Legal Issues

- There are no legal issues arising from this Board report
- Care Quality Commission Regulations - this report provides assurance to:
  - 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 ensure a quorum. This is been monitored through the Mortality Review Group and Executive Serious Incident Group

Recommendations

The Quality Committee is requested to accept this Mortality Report and agree for it to be published on to the Trust website prior to end of March 2018, as per national guidance.

Report prepared and presented by:

Rachel Williams
Lead Professional for Patient Safety and Patient Experience
Aneesa Alam
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 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 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 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.

This report outlines the information required to be reported by the end of Quarter 4.

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 this allows the Trust to gather cause of death from a national database.
- The Mortality Review Group has chosen to use an amended form based on a national review tool called PRISM, as the alternative Structured Judgement Review tool did not meet the requirements for Mental Health case note reviews.
- Since the publication on the last Mortality Report, the Trust has implemented a new database which now captures:
    - People receiving a service from Improving Access to Psychological Therapies (IAPT)
    - Deaths of patients who had died whilst on a waiting list
    - All children deaths

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

3. Data Summary

Month	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Total
Total Deaths Per Month	195	212	229	178	204	194	184	169	224	260	145	2194
Deaths of patients on a Waiting List	49	45	36	41	48	51	30	38	48	62	32	480
Inpatient Deaths	0	2	0	4	0	1	0	1	1	1	0	10
Learning Disability Deaths	2	1	1	2	4	4	0	5	4	4	2	29

Correct as at 27.02.2018
Since April 2017 the Trust has received 2194 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 contact within the last 6 months. This took effect from 20th October 2017.

4. Review of Deaths

From 1 April to 27 February 2018, 183 deaths were reported through the Trust incident reporting system (Datix). Of these, 177 have been reviewed through the process of the Untoward Incident Reporting and Investigation Policy and Procedure, and 6 (new) incidents were awaiting review. 22 incidents warranted a further investigation (extended Initial Service Management Review (ISMR) / Peer Review / two person investigation) and 72 incidents had been closed to the Serious Incident Group. 83 incidents remain open to the Serious Incident group.

The Trust has recorded ten 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. (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 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 (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 13 deaths. This was undertaken by a multi-disciplinary team and it established that of the 13 deaths reviewed, 11 have been classed as unavoidable and 2 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’:

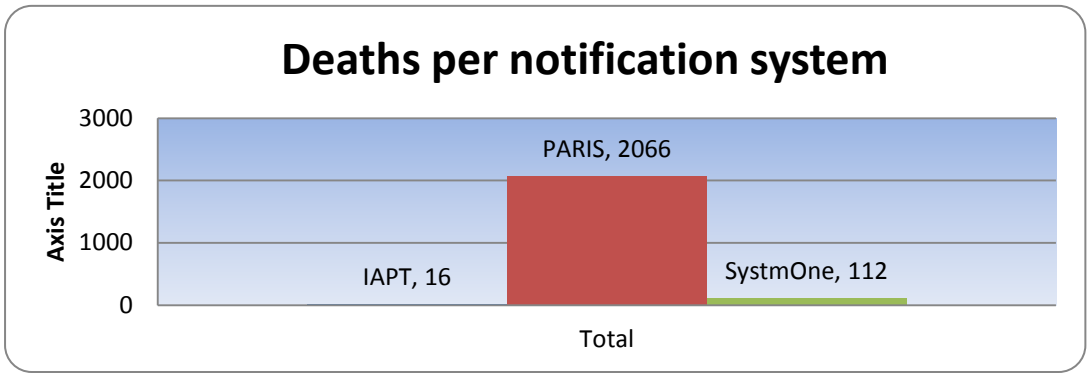
- Patient on end of life pathway, subject to palliative care
- Anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

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

- Alzheimer’s Dementia
- Old Age
- Pneumonia

6. Analysis of Data

6.1 Analysis of deaths per notification system

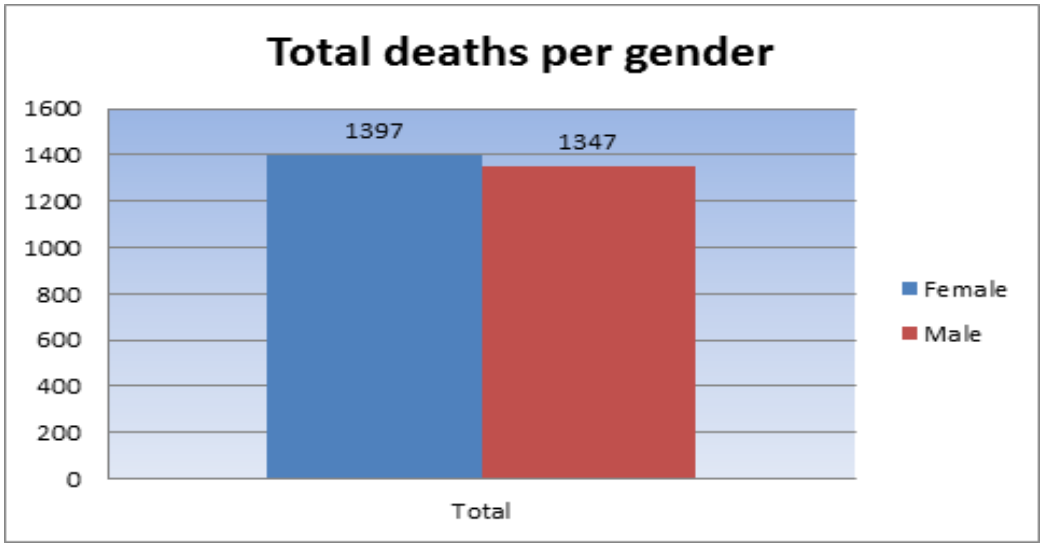


	IAPT	PARIS	SystmOne	Total
System	**16**	**2066**	**112**	**2194**

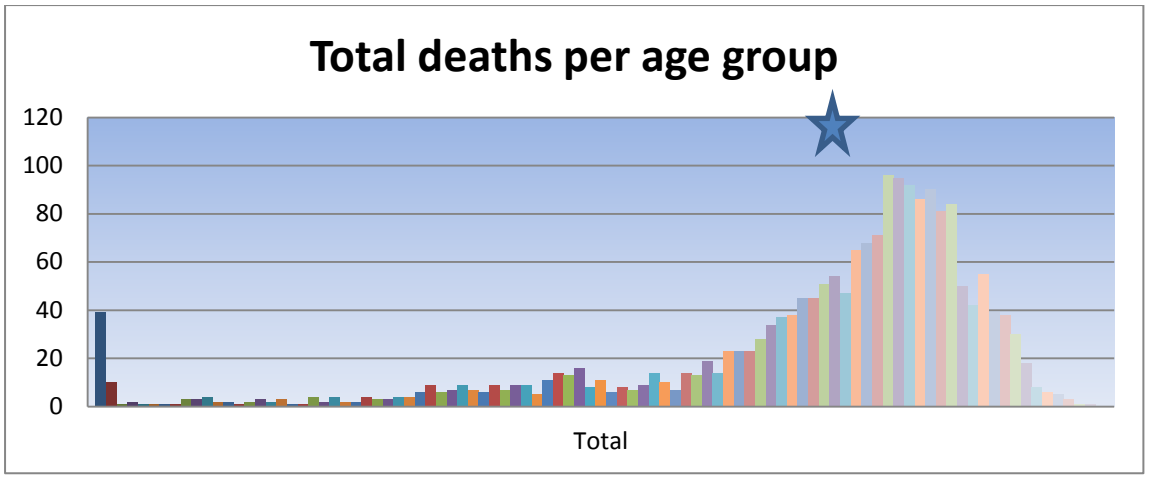
The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS, as we would expect as this clinical record system is aligned to our largest population of patients and a population at greatest risk of death. 112 death notifications were pulled from SystmOne and 16 from IAPT.

6.2 Deaths by gender

The data below shows the total number of deaths by gender. There is very little variation between male and female deaths; 1101 male deaths were reported compared to 1093 female



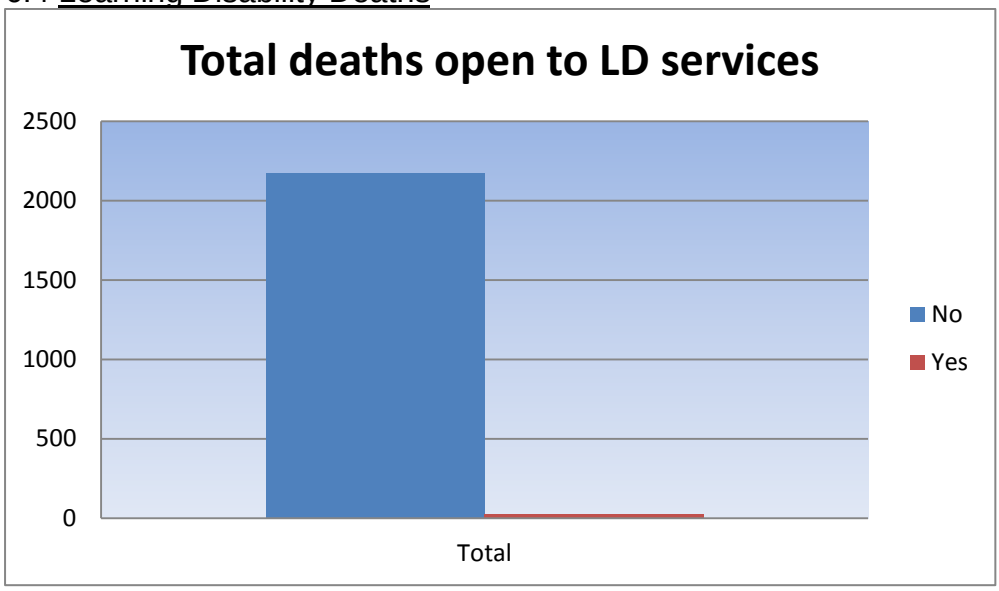
6.3 Death by age group



The youngest age was classed as 0 and the oldest age was 107 years, an increase from the previous report of 105 years. Most deaths occur within the 85-90 age groups(indicated by the star).

15 children's deaths had been investigated by the Child Death Overview Panel (CDOP) and have been closed.

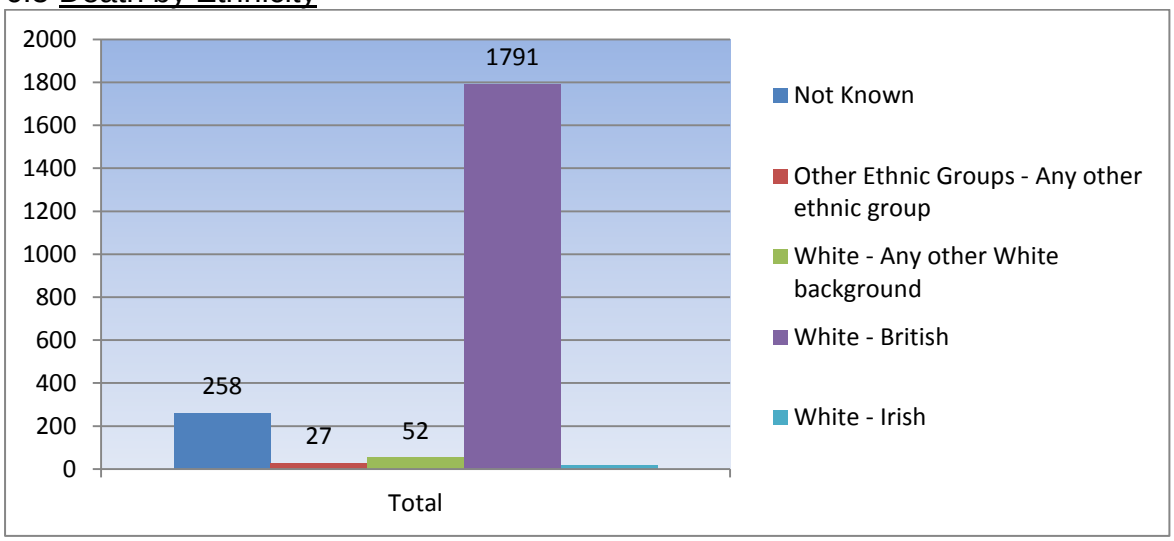
6.4 Learning Disability Deaths



Known to LD	Count of deaths
No	2172
yes	22
Total	**2194**

The Trust currently sends all Learning Disability deaths that have been reported through the DATIX system to the Learning Disabilities Mortality Review (LeDeR) Programme. Currently the Trust are unable to ascertain how many of these deaths have been reviewed through the LeDeR process. LeDeR only look at a sample of overall deaths, and are unable to tell us if our patients have been part of that sample. The Trust however reviews all Learning Disability deaths.

6.5 Death by Ethnicity



The top 5 recorded deaths per ethnicity group are highlighted above. White British is the highest recorded group with 1791 recorded deaths, 258 deaths had no recorded ethnicity assigned. 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	3
Pakistani	**1**
Indian	14
Caribbean	12
Mixed - White and Black Caribbean	5
Mixed - Any other mixed background	5
Other Ethnic Groups - Any other ethnic group	27
Other Ethnic Groups - Chinese	1
White - British	1791
White - Irish	16
White - Any other White background	52
Not Known	230
Not stated	28
Grand Total	**2194**

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 and are allocated to specific team and individual's to be completed. This is not an exhaustive list.

1. Briefing to be circulated regarding `Duty of Candour` and the MHA 1983: Code of Practice (Department of Health, 2015), patients should be fully

involved in decisions about care, support and treatment`, and that the `views of families, carers and others should be fully considered when taking decisions.

2. Inpatient teams to be re-briefed on the principles of Clinical risk management and relapse planning, specifically in relation to inpatient care planning and discharge planning.
3. Inpatient team to be briefed on record keeping standards, specific involvement of patient and views of carers.
4. The Clinical Operational Assurance Team (COAT) to consider/review the communication problems identified in the report between the Inpatient and Outpatient team and advice as to systems that need to be in place to overcome/address potential communication barriers
5. The Clinical Operational Assurance Team (COAT) to consider the need for identifying patients who due to their complexity require a comprehensive case summary to inform clinicians in situations (frequent occurrence) when it would not be possible to review all records in the time span available, for example, admitting Doctors/Nurses.
6. Confirmation required in relation to requirements for the trust when a patient has a diagnosis of Hepatitis C positive and our responsibilities to notify statutory bodies
7. To review the arrangements within the team where the Care Co-ordinator is a part-time worker.
8. Access across both Paris and SystmOne for all children's services staff to be considered.
9. A communication system in the team to be considered which is consistent and includes a back up to ensure the team know messages have been received such as a 'read message' response set up as a default on the email system for all clinicians.
10. Consideration needs to be given to maximum caseloads and workload in general and the impact of this
11. Liaison Team Wi-Fi and accessibility to main computer to be reviewed.
12. It is recommended that CRHT develop how they offer support and make contact with families and carers at assessment, including an information leaflet.
13. The depth and assessment of suicidal thoughts need exploration alongside consideration of protective factors when assessing suicidal ideation
14. Exploration of consent regarding families and carer with the service receiver, especially when a person has not given consent to contact.
15. To approve an Operational Policy for Liaison South.
16. To scope the possibility of being able to share information between Paris and SystmOne for community patients
17. The lead for Positive and Proactive Support Training to review the training requirements for all Rehabilitation services
18. Service planning for people with highly complex non-psychosis mental illness to be included in the responsive communities sustainability and transformation plan
19. The purpose and quality of inpatient admissions to be addressed collectively through the Bed Optimisation Project and the CRHT [Crisis Resolution Home Treatment Team] review

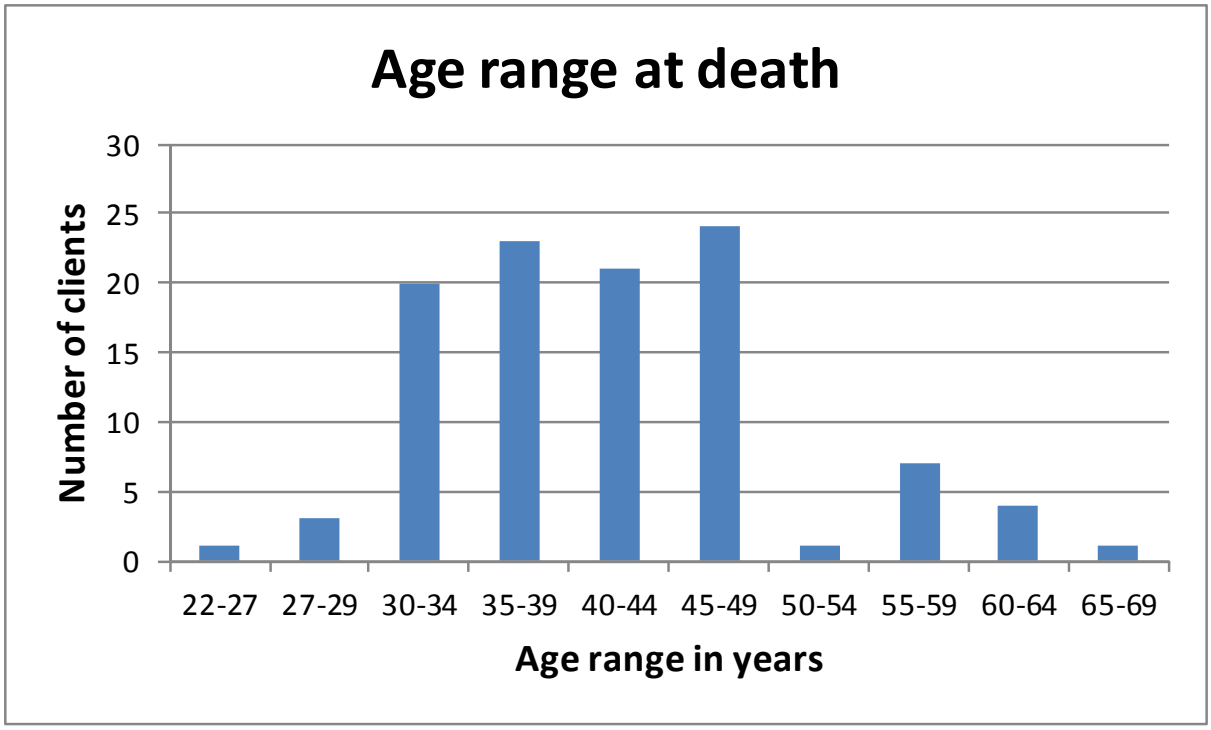
20. To review policy in relation to relapse signature and guidance on relapse reduction, care planning and reviewing clinical history
21. Possibility of an information sharing agreement to be pursued with Pennine Care Trust. This would include reciprocal system access.
22. Learning review to discuss importance of exploring family/ carer concerns regarding relapse indicators, when it is advisable to access previous paper records and reciprocal communication with other organisations that work with service users on clinician caseloads.
23. Scope an improvement project with 3 outcomes:
    a. Staff support in waiting list management
    b. Improvement on patient flow and discharge
    c. Improvement work on support worker role including scope of practice on what work cannot be undertaken
24. Information sharing from Derbyshire Constabulary in relation to the Peer Review has been identified as an issue and will need to be addressed within the multi-agency partnership
25. For Substance Misuse services to undertake an audit to establish if physical health monitoring is undertaken on assessment and at least annually, which would include staff ensuring annual reviews have been completed via the GP.
26. It is recommended that there is greater exploration around family involvement when a person is open to CRHT. There needs to be a change with regards to viewing family involvement on a continuum rather than a ‘yes or no’ answer.
27. Scope the possibility of a message system built into Paris which is easily accessible and which flags up urgent messages.
28. Liaison Team South to utilise a standard assessment proforma.
29. Consider the notification system for MHA expiry of detention as well as the regularity of reviews of the Safety Assessment for inpatients
30. Revisit policies in relation to transfer, both operationally and clinically, to ensure that they include systems – particularly in relation to communication that would mitigate against such gaps in care occurring in the future.
31. Paris to develop a way of tracking actions related to admission or care stays.
32. Re-iteration of standards for assessment of Waterlow Score as an assessment for Tissue Viability as per Trust policy
33. Body Map to be completed within 4 hours of admission

Drug Related Deaths

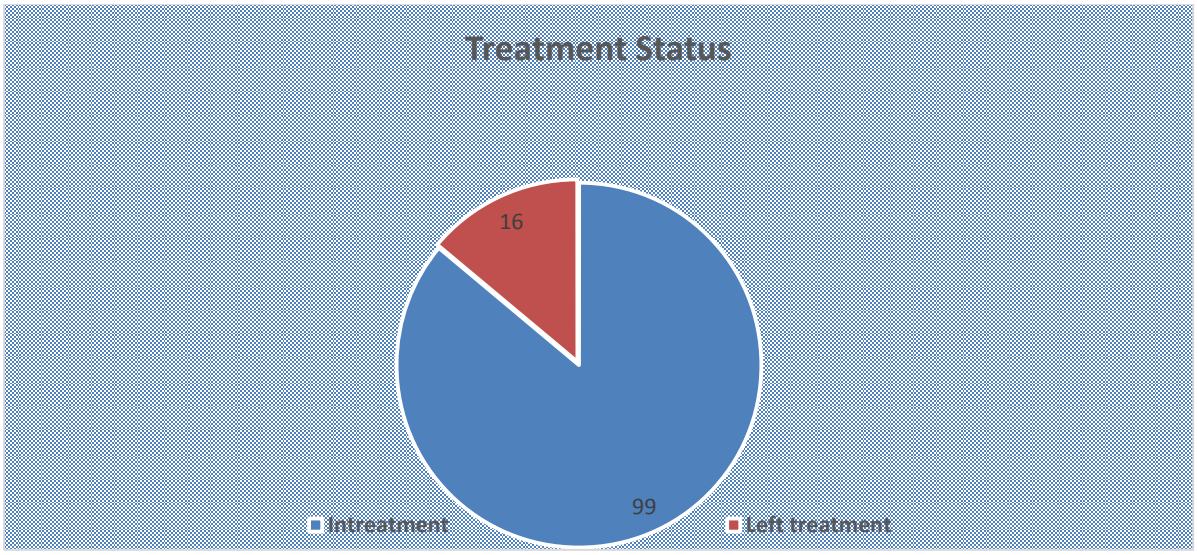
The Trust has undertaken a six year review of drug related deaths (DRD). The Trust receives notifications of deaths from the police, hospital, family, General Practitioner and through SystmOne and the DRD alert.

All DRD are reviewed through the DRD steering group. The Trust has a compressive strategy which is evidence based, has recovery focussed interventions and aims to:

- Reduce illicit and other harmful drug use
- Increase the rates of people recovering from their dependence
- Integrating prison and community
- Recruitment of National Recovery Champion answerable to the Home Secretary and a new Home office board.



The graph above outlines the number of DRD by age group from 2012-2017
The below graph shows the deaths of those who were engaged in treatment at the time and those who had left treatment in both planned and unplanned ways



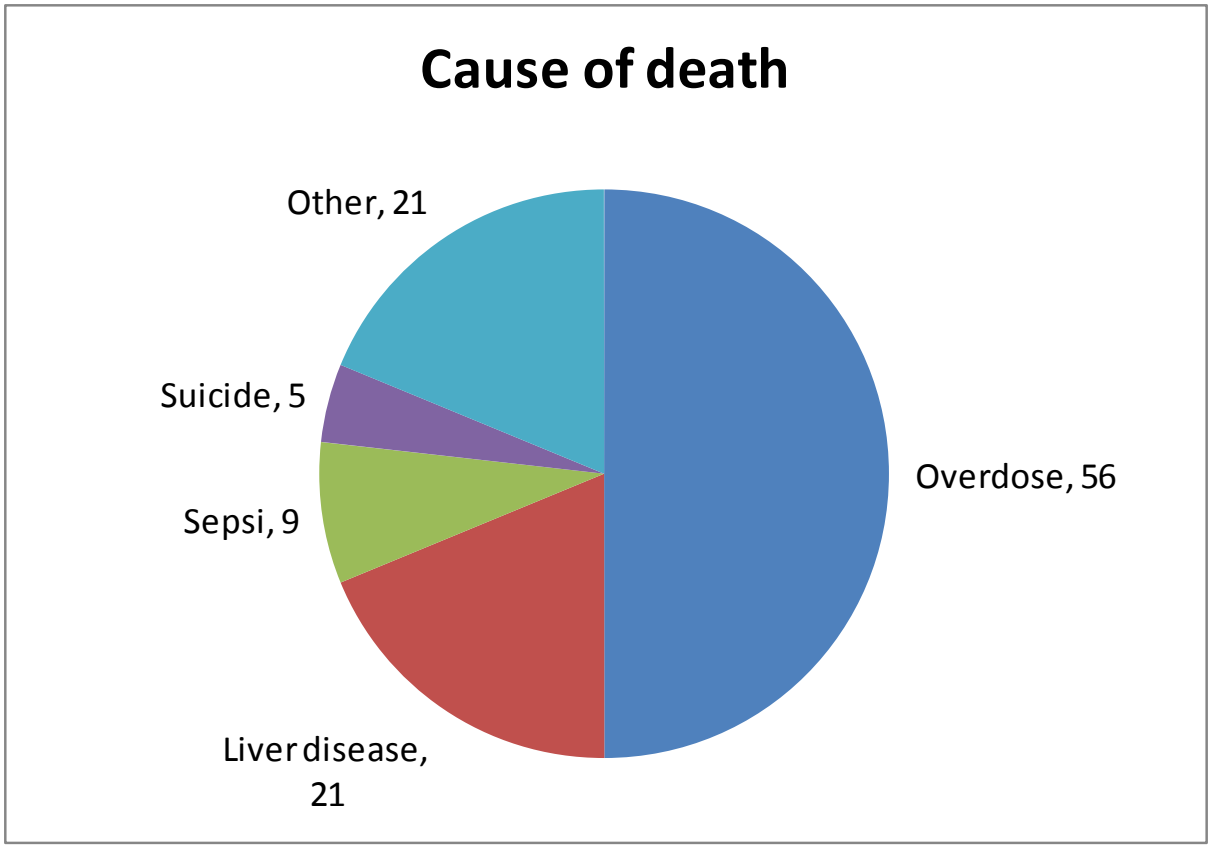
In total 86% (99) died whilst in treatment and 14% (16) died within the first 12 months after exiting treatment.

In Derby City 46% (53) of patients died whilst engaging in services and 7% (8) died after leaving treatment.

Derbyshire county recorded that 42% (48) of patients died during treatment and 5% (6) died after leaving treatment. A total of 15% (17) service users died whilst not in receipt of opiate substitution therapy (OST), the reasons for this varied but included incidence of nonattendance and failure to pick up medication from the chemist.

To further understand the circumstances surrounding these deaths, a review of patient's treatment progress was undertaken for those in treatment and a review into the present circumstances for those discharged from treatment.

From the 99 in-treatment deaths reviewed, (62) 53% were having their medication reduced. Within the group who were reducing their medication, (32) 62% of them were regularly testing positive to opiates and other drugs. Information was not available for everyone due to a lack of data.



Further Analysis of the 115 deceased patients:

- 20 people died of liver disease. Of these 16 were known to have a diagnosis of Hepatitis C.
- 64 were parents (at the time of triage)
- 108 were recorded as unemployed / on benefits (at the time of triage)
- 61 were recorded as drinking alcohol daily (at time of triage or evidenced in recent key work sessions)
- 109 were recorded as being smokers (in ISMRs or key work sessions). Eight had no data.
- 79 were recorded as living in isolation (at the time of triage) – such as living in hostels, B&Bs, and sofa surfing or on their own
- The total number of people diagnosed with Hepatitis C was 37.

Key recommendations following review of Drug Related Deaths

<u>Treatment System</u>

- To segment the treatment population to gain a better understanding of the recovery potential of different groups and target interventions more appropriately. (Medications in Recovery 2010).
- To consider implementing prior to discharge a check list that ensures each service user has sufficient recovery capital. An individual's recovery capital is one of the best predictors of sustained recovery. (Medication reductions alone will nearly always result in relapse).

- Treatment should be more attentive to the comorbid health conditions faced by older adults, unique prescribing / health clinics need to be considered for this group.
- Recognition needs to be given to liver disease and Hepatitis C. This group require more joined up working and a different approach needs to be applied.
- Review current practice to identify gaps and where appropriate provide training
- All clients with an unknown Hepatitis C status should be tested
- Clients with an existing active Hepatitis C positive status to be referred for treatment
- For clients who refuse to be tested, the reason should be recorded and counter signed by the service user, and re-testing should also be reoffered every 6 months.
- Clients who continue to be involved in high risk behaviour should be routinely retested
- Review existing Hepatitis C treatment pathways
- Set up an Hepatitis C prescribing clinic where appropriate in order to maximise health gains and to embed expertise within this clinic from external sources.
- To influence local authorities to take this public health issue more seriously.
- To ensure Hepatitis C literature is available on assessment and where possible we need to develop intervention materials for all.
- Roll out of dry blood spot testing that includes rapid blood testing for positive reactions to the blood spot testing.
- Always check the Hepatitis status of females requesting pregnancy tests.
- Develop a vision and framework for recovery that is visible to people in treatment, owned by all staff and maintained by strong clinical leadership.
- Create space for staff to discuss and share concerns / good practice within a backdrop of targets that can challenge safe practice.
- Optimisation of opiate substitution therapy should be standard for all those that require it
- Treatment providers to be more community facing, in line with the Trust's vision, and work more effectively with community based organisations.
- There are weekly Multidisciplinary meetings (where staff from several different professional backgrounds come together to share information). In practice, these are limited to only Trust staff coming together. Once per month the multidisciplinary meetings need to be dedicated to social care cases where Health Visitors and Social Workers are invited as routine. This approach needs to be normalised and embedded into practice.

<u>Prescribing</u>

- There was little evidence of rationales around prescribing decision making. When making a medication choice with an opioid dependent patient the NICE TA114 recommends that prescribers consider three factors.
  - Risk and Benefits of each treatment, (Safeguarding children)
  - Diversion and Misuse (Risk of death to others if medication is passed on)
  - Mental and Physical Health (Comorbidities, Cognitive and Emotional Effects, Mortality Risks)

- Drug Interactions (Interactions with other medications including alcohol, benzodiazepines and other prescribed medication). Both consultants to ensure all prescribers justify their prescribing decisions by taking into account the above as in line with NICE guidance.
- This report has highlighted a growing theme of medication reductions regardless if the patient is still using drugs. A reduction in medication has the potential to cause more harm to the patient and to the community. A review of all reductions would be clinically prudent to ensure this is being managed in a safe and effective way.
- Derby City to review the use of Daily Supervised Consumption and to ensure it is in line with NICE guidance and is being used as a supportive measure.