Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 2 April 2019

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 April 2018 to March 2019.

Executive Summary

The Care Quality Commission (CQC) has recently published a review of the first year of NHS Trusts' implementation of the national guidance.

The Medical Director attended a conference in March in which Professor Ted Baker, Chief Inspector of Hospitals talked to this and other relevant CQC publications relating to safety. These notes are a reflection on this material.

For decades, the NHS has sought to reassure the public that services are 'safe'. Research however showed that 3.6% of hospital deaths had a 50% chance of being avoided (Hogan et al 2015) and later the NHS England report into how deaths were investigated by Southern Health FT found that learning opportunities were missed and noted the poor experience of bereaved families hence the emphasis on 'learning from deaths'. Many elderly people, however, are in hospital services during the last twelve months of their life and many are frail and suffering from dementia. The concept of 'avoidable' deaths therefore has given way to deaths associated with 'problems in care'. Mortality 'case reviews' are now seen as a hallmark of an open inquisitive culture thought to be essential to ground up quality (or continuous) improvement. Likewise support and encouragement with bereaved families are a hallmark of openness and compassion.

The concept of a safety culture is being developed. There is a danger of an inappropriate tolerance of impaired safety paradoxically taking root in services that are under intense operational pressure dealing with patients with potentially high clinical risk. There can be a general acceptance that in these situations we should run services as safely as possible but that this may fall short of being as safe as they can be. No trust in England has 'outstanding' for safety and 37% of mental health trusts (including our own) have 'require improvement' for this domain (40% of acutes). An airline would never habitually fly overloaded or crew with staff who are not compliant with mandatory (simulation) training and/or who are temporary / not employed directly, yet the equivalent is common place in the NHS.

The State of Mental Health Services 2014/2017 highlights the following as safety concerns:

- Poor environment particularly inpatient wards
- Use of restrictive practices including seclusion
- Sexual safety concerns

- Medication management being suboptimal
- Low staffing levels (and failure to vary according to demand).

Sir Simon Wessely's Review of the Mental Health Act reached much the same conclusions.

Themes identified in other high pressure clinical services are also likely to be relevant:

- Leadership / culture
- Patient flow
- Triage and early identification of a deteriorating clinical state

Issues that impair a safety culture are likely to be:

- Culture and leadership barriers -
  - A top down approach
  - Professional rivalries
  - Externalisation of problems
  - Never ending mergers, eg North versus South, etc

- Strategic barriers -
  - Financial problems
  - Estate legacy
  - Failure to reconfigure

- System barriers -
  - Lack of integration

These therefore, are the factors to consider alongside the reported mortality information when considering whether the Trust has a 'safety culture'. We need to learn all we can from deaths but this is only part of the picture. We must avoid significant incident investigations and mortality reviews becoming a source of excessive anxiety for staff as this can lead to risk avoidance behaviour and decision making that can inadvertently increase clinical risk. This is particularly relevant to patients detained under the Mental Health Act. We need to learn from critical but appreciate analysis of practice and above all foster a culture of curiosity and continuous improvement.

A network of 'medical examiners' is to be established over the next twelve months overseeing mortality / safety in acute hospitals but later covering community and mental health 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.	X
4) We will **transform** services to achieve long-term financial sustainability.	

Assurances

This report provides assurance that the Trust is following recommendations outlined in the National Guidance but that there is a bigger picture to consider related to developing a Safety Culture.

Since April 2018, the Trust has received 1,861 death notifications of patients who have been with our service within the previous six months. 197 (10.5%) were reported through our DATIX system of which 41 (2%) warranted further investigation.

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.

Consultation

This report has been received by the Trust's Quality Committee. The Committee asked for an Executive Summary to give the report 'context'.

We are engaged positively with the CQC who gave the following citation in their annual review:

> **Derbyshire Healthcare NHS Foundation Trust**
> Although Derbyshire Healthcare NHS Foundation Trust was rated as requires improvement overall in September 2018, it had strong processes in place for engaging with bereaved families and carers. Feedback from families about support received from the family liaison team was overwhelmingly positive.
>
> The family liaison role has evolved in line with learning from the national learning from deaths guidance. The family liaison team works with families where there has been a serious incident or unexpected death as reported through the trust's reporting system. They also work with families on referral through the process for learning from deaths, serious incident process and the complaints process where concerns have been highlighted about care.
>
> The team start engaging with families after the death of their loved one has been identified. A single point of contact is established, initial condolences

are given and the duty of candour, where applicable, is applied at the first point of contact, which can include providing the clinical team with advice.

Engagement with families is individualised and person-centred, and families are invited to contribute to the investigation's terms of reference and outline any specific questions they want answered about their relative's care and treatment. Monitoring of these actions is done through the Serious Incident Group (SIG) and the family liaison team who can review and see if the report answers the family's questions.

Families are invited to feedback on the care and treatment of their family member, and the family liaison worker meets with the family at the end of the investigation process to explain the outcome of the investigation. The family liaison team will support the family for as long as they need them up until the inquest, then work towards closure. Any additional needs are met through arranging activities such as referral to independent advocacy or psychological services.

There is also a range of information shared with families including details about the Samaritans, Public Health England's 'Help is at Hand' booklet, WAY (Widowed and Young) (if under 50), details of local support groups, and The Compassionate Friends leaflet. The information that is sent to families depends on the circumstances around the death of their loved one.

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

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).	
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.	X

Actions to Mitigate/Minimise Identified Risks
There is recognition that nationally mental health services have been under-resourced for decades and that this is now being addressed through commissioning and contract arrangements. The 'bigger picture' of safety culture requires a strategic approach which is being addressed by the Board.

Recommendations
The Board of Directors is requested to accept this Mortality Report as assurance of our approach and note its publication on the Trust's website as per national guidance.

Report presented by:	**Dr John R Sykes** **Medical Director**
Report prepared by:	**Dr John R Sykes** **Medical Director** **Rachel Williams** **Lead Professional for Patient Safety and Patient Experience** **Tracy Bates and Louise Hamilton** **Mortality Technicians**

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[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 each 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 this financial year from April 2018, incorporating new data for the periods December 2018, January and February 2019.

2. Current Position and Progress

- As a way of accessing 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 continues to undertake regular case note reviews and there have been improvements in medic availability since the implementation of a rota for attendance from the North consultants. A rota incorporating medics from the South of the County is currently been discussed.
- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary changes made.

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

3. Data Summary of all Deaths

Month	2018-04-01	2018-05-01	2018-06-01	2018-07-01	2018-08-01	2018-09-01	2018-10-01	2018-11-01	2018-12-01	2019-01-01	2019-02-01
Total Deaths Per Month	164	186	145	183	135	140	200	174	184	224	126
Inpatient Deaths	1	0	2	1	0	0	1	0	1	1	0
LD Referral Deaths	2	5	0	5	4	1	5	0	2	1	0

Note that inpatients and LD are based upon whether the patient has an open inpatient or LD referral at time of death.

Correct as at 01.03.2019

The table above now only shows information for this current financial year, whereas previous reports have outlined number of deaths since January 2017.

Since April 2018, the Trust has received 1,861 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 20 October 2017.

4. Review of Deaths

Total number of Deaths from 1 April 2018 – 1 March 2019 reported on Datix	197 (of which 152 are reported as “Unexpected deaths”; 33 as “Suspected deaths”; and 12 as “Expected - end of life pathway”)
Number reviewed through the Serious Incident Group	195 (1 was not required to be reviewed by SI group and 1 pending for a review).
Number investigated by the Serious Incident Group	41 (155 did not require an investigation and 1 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	138 (58 currently opened to SI group and 1 pending for a review, as at 01/03/2019)

The Trust has recorded 7 inpatient deaths since April 2018, of all which have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*. None of these deaths have been due to problems in care.

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 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

Since April 2018, the Mortality Review Group has reviewed 76 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 76 deaths reviewed, 74 have been classed as not due to problems in care.4 were referred to the Serious Incident Group where 2 required no further action, and a further 2 are currently under further investigation.

The Mortality Group reviewed the deaths of patients who fall under the following 'red flags' from 1 November 2018:

- Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team)
- Patient diagnosed with a severe mental illness
- Patient only seen as an Outpatient
- Patient taking an Anti-psychotic medication

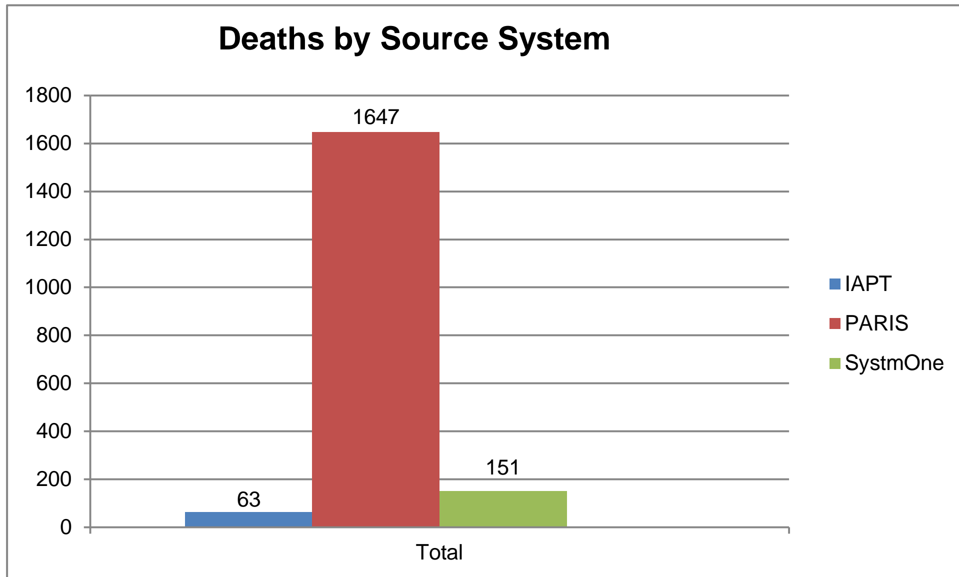
We have received 9 cause of deaths since April 2018, of these, initial analysis of death notification information shows the most prevalent causes of death are:

- Bronchopneumonia
- Heart disease
- Dementia

Undertaking Case Note Reviews of deaths has improved from the previous quarter due to the North Consultant rota which has meant that only 3 reviews have had to be cancelled due to lack of medic availability. We will be scoping the implementation of a South Consultant rota to further improve the availability of the medics.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2018

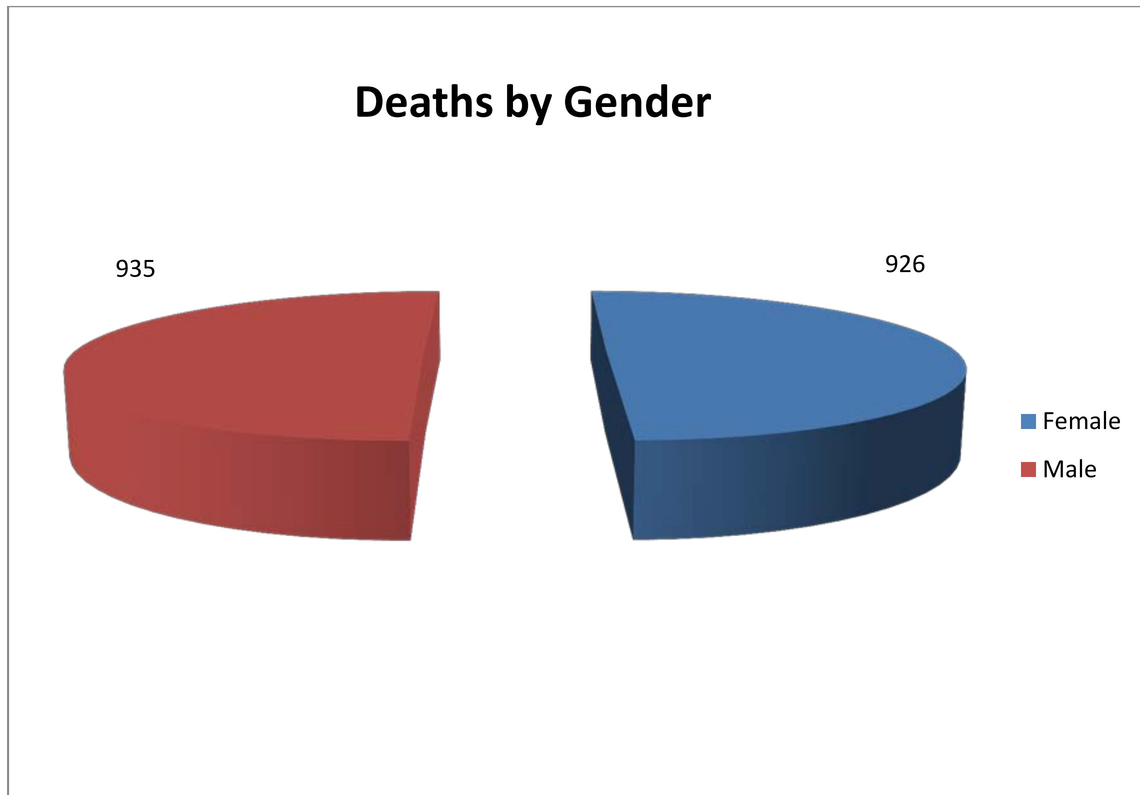


	IAPT	PARIS	SystmOne	Grand Total
Count	63	1647	151	1861

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. 151 death notifications were extracted from SystmOne and 63 death notifications were extracted from IAPT.

6.2 Deaths by Gender since 1 April 2018

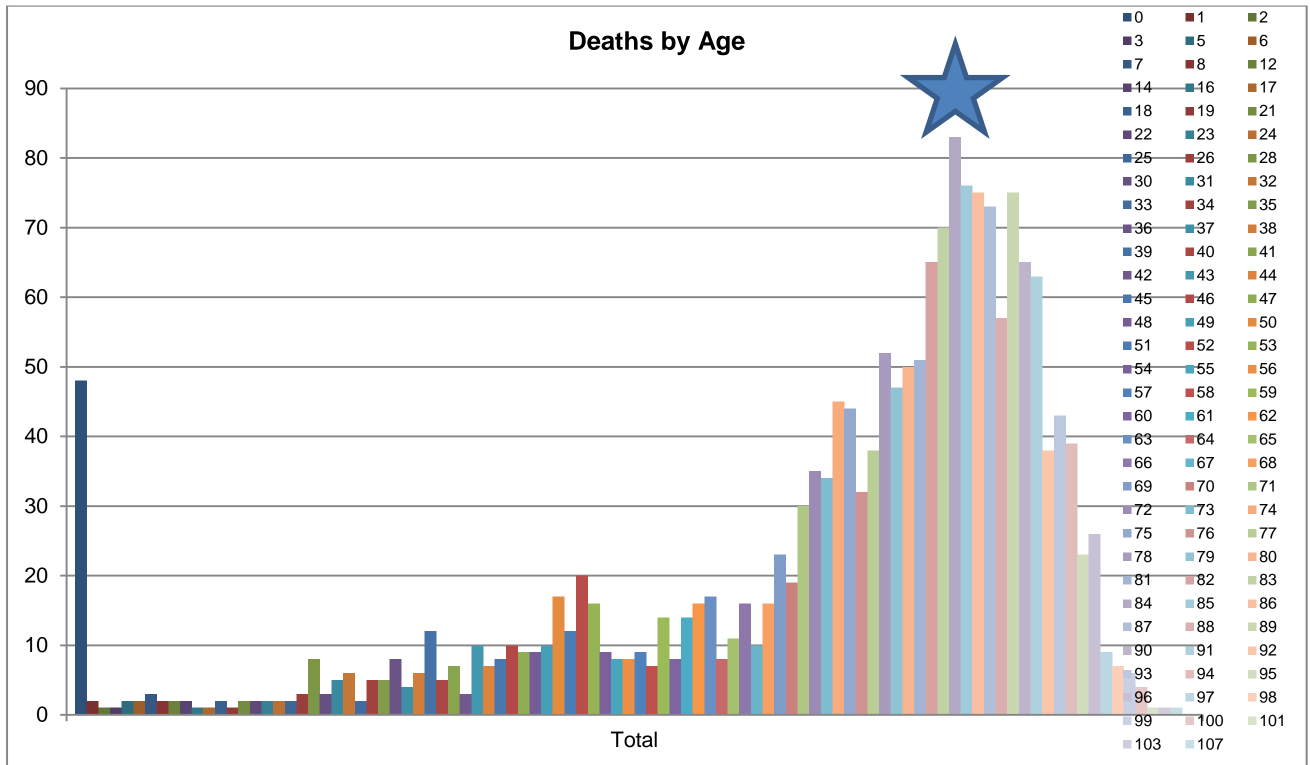
The data below shows the total number of deaths by gender since 1 April 2018. There is very little variation between male and female deaths; 935 male deaths were reported compared to 926 female.



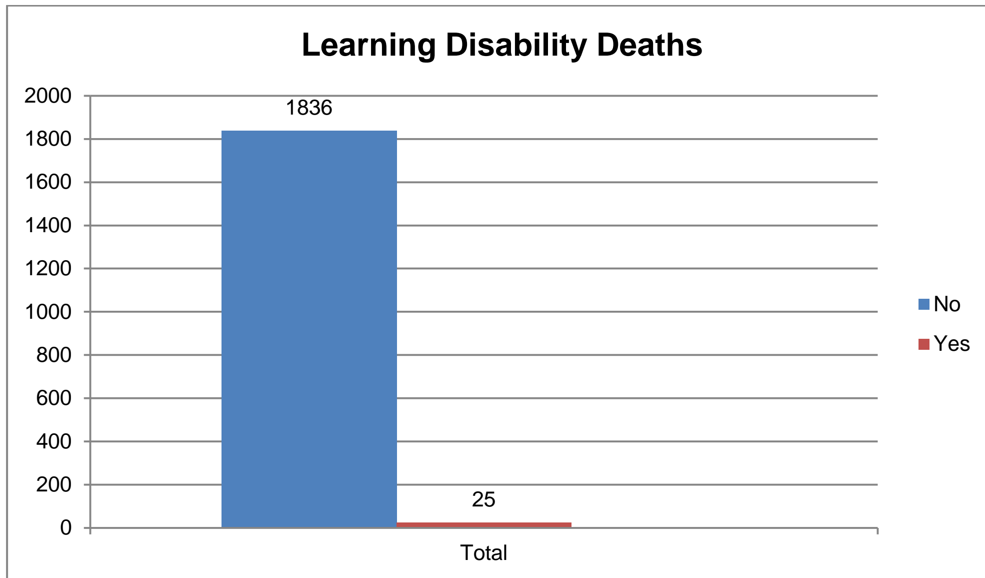
	Female	Male	Grand Total
Count	926	935	1861

6.3 Death by Age Group since 1 April 2018

The youngest age was classed as 0, and the oldest age was 107 years. Most deaths occur within the 83-87 age groups (indicated by the star). In the last report, most deaths occurred between 85-89 age groups.



6.4 Learning Disability Deaths since 1 April 2018



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 a 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. Since the last report, the Trust is now sharing relevant information with LeDeR which is used in their reviews. Since April 2018, the Trust has recorded 25 Learning Disability deaths.

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

6.5 Death by Ethnicity since 1 April 2018

White British is the highest recorded ethnicity group with 1,389 recorded deaths, 323 deaths had no recorded ethnicity assigned, and 19 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count
White - British	1389
Not Known	323
White - Any other White background	41
Other Ethnic Groups - Any other ethnic group	37
Not stated	19
Caribbean	13
Indian	11
White - Irish	9
Asian or Asian British - Pakistani	6
Pakistani	3
Mixed - Any other mixed background	3
Asian or Asian British - Indian	2
Mixed - White and Asian	2
Mixed - White and Black Caribbean	2
Asian or Asian British - Any other Asian background	1
Grand Total	**1861**

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 a specific team, and individuals to be completed. This is not an exhaustive list.

7.1 Action Log

- Observation Policy and Procedure to be reviewed.
- Medication changes which are likely to impact upon the risk of falls should be recorded in the Multi-Disciplinary Team process and care plans updated accordingly.
- New Crisis Assessment and Home Treatment Operational Policy to be updated.
- To develop standard operating policy/procedures for Hepatitis A, B and C, HIV testing and vaccinating against Hepatitis A and B.
- The consideration of relapse reduction model including relapse signature to be a continuous quality improvement priority for mental health service in 2018.
- Clarify protocols with NHS England surrounding gatekeeping assessments for low secure services.
- Collateral information should be sought from families wherever possible to add to the clinical assessment and understanding of the presentation.
- A clinical supervision framework that ensures clinicians have routine access to professionals with clinical expertise in forensic care.
- Review of Liaison Team South's documentation / risk assessment against expected standards.
- Site visits to be organised for junior doctors during induction.
- Community Team Learning Disability Teams to review Triangle of Care action plans with Multi-Disciplinary Team members & carers champions.
- Non-recent sexual abuse reporting process to be discussed with ward staff and all staff to be forwarded link to the Trust procedures.
- To explore the development of Eating Disorder awareness training package to the relevant Trust teams
- Development of a new standard operating procedure in the acute care pathways in the North and South for all complex case clinical reviews.
- To consider the Clinical Safety Plan becoming part of the main PARIS tree index so that it is more easily accessible to all agencies involved.