Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 13 January 2021

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 August to 19 October 2020.

Executive Summary

During the COVID-19 pandemic, the learning from deaths process continued to be undertaken but slight changes to the process were initially made to allow for colleagues to undertake other duties. Activity has now resumed back to normal with weekly case note reviews and the daily reviewing and grading of all new deaths taking place.

All deaths directly relating to COVID-19 are reviewed through the Learning from deaths procedure unless they also meet a datix red flag, in which case they will be reviewed under the Untoward Incident Report Reporting Policy and Procedure.

- From 1 August to 19 October 2020 there has been 0 deaths reported where the patient tested positive for COVID-19.
- From 1 August to 19 October 2020, the Trust received 368 death notifications of patients who had been in contact with our service in the last six months. This is a decrease for the same period the previous year which was 385.
- Two Inpatient deaths were recorded. One patient died whilst on home leave from an adult inpatient ward and one patient died following transfer to A&E from an adult inpatient ward.
- The Mortality Review Group reviewed 29 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 29 deaths reviewed, 26 were not due to problems in care. One death was referred to Serious Incident Group for further review and a further two deaths were pending further information.
- The Trust has reported four Learning Disability deaths from 1 August to 19 October 2020
- There is very little variation between male and female deaths; 194 male deaths were reported compared to 174 female.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.
- The monthly mortality review group will be recommencing in November 2020, this group was put on hold during the COVID pandemic.

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 attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

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

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

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.

- From the 1 August to 19 October 2020 there is very little variation between male and female deaths; 194 male deaths were reported compared to 174 female.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

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

Report presented by: **Dr Mark Broadhurst**
Deputy Medical Director

Learning from Deaths - Mortality Report

1. Background

In line with the Care Quality Commission's (CQC) 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 of the required guidelines.

The report presents the data for 1 August to 19 October 2020

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

- The Trust is still waiting to ascertain if cause of death (COD) will be available through NHS digital. Currently COD is been ascertained through the coroner officers in Chesterfield and Derby but only a very small number of COD have been made available.

- Medic rotas are in place, we are awaiting a new rota for the north and south which is currently in process. We undertook six Case Note Review sessions , but unfortunately 13 sessions did not take place due to lack of medic availability

- 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 Trust has also made a decision to return to grading all new deaths identified through the NHS Spine daily and conducting Case note review meetings twice weekly. All deaths directly relating to COVID-19 will be reviewed initially through the Learning from Deaths procedure unless they also meet a datix red flag (see page 5 of this report for definitions of these), in which case they will be reviewed under the Untoward Incident Reporting Policy and Procedure. The mortality reviewer will also produce a weekly COVID-19 death report to be shared with the incident management team. This report will include but is not limited to patient demographics, patient conditions, diagnosis and vulnerabilities, allowing the team to draw comparisons to identify themes and trends.

- The monthly Mortality review group meetings will resume in November 2020. These were put on hold during the COVID pandemic.

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

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.

	Aug	Sept	Oct (up to 19 October 2020)
Total Deaths Per Month	156	126	86
LD Referral Deaths	2	1	1

The table above shows information for 1 August to 19 October 2020. *Correct as of 19 August 2020*

From 1 August to 19 October 2020, the Trust received 368 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 1 August to 14 October 2020. reported on Datix	50 (of which 39 are reported as "Unexpected deaths"; 6 as "Suspected deaths"; 5 as "Expected - end of life pathway")
Number reviewed through the Serious Incident Group	45 (5 pending for a review).
Number investigated by the Serious Incident Group	0 (16 did not require an investigation; 9 underway and 25 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	16 (29 currently opened to SI group and 5 pending for a review, as of 14/10/2020)

Since 1 August to 19 October 2020 the Trust has recorded two Inpatient deaths at the Hartington Unit. One patient died whilst on home leave from an inpatient ward and one patient died following transfer to A&E from an inpatient ward. These deaths 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 six 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

From 1 August to 19 October 2020, The Mortality Review Group reviewed 29 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 29 deaths reviewed, 26 were not due to problems in care. Two deaths are pending further information and one death was referred to the Serious Incident Group for further review under the Untoward Incident and Reporting Policy and Procedure.

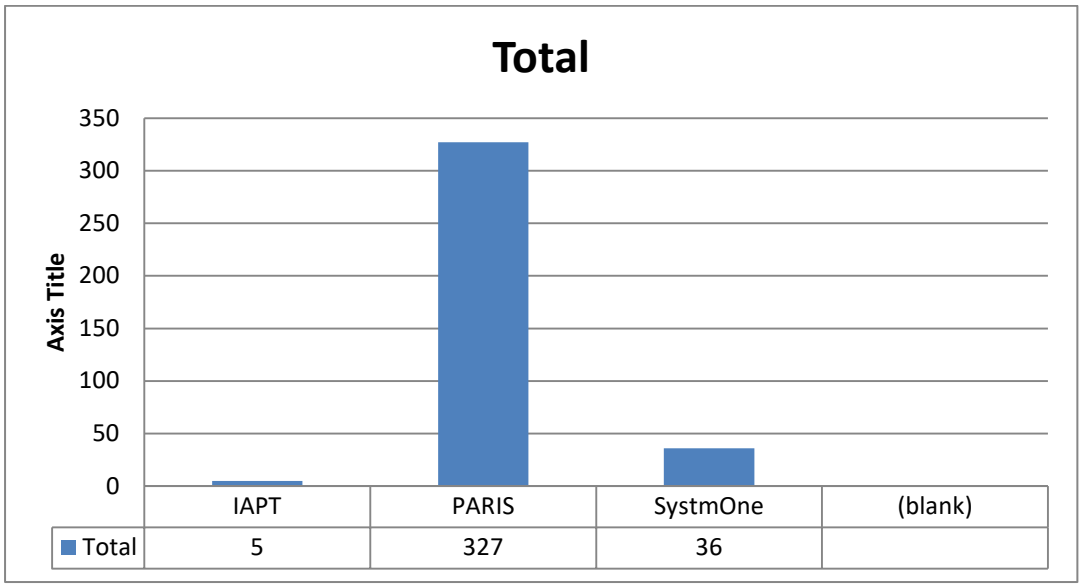
The Mortality Group reviews the deaths of patients who fall under the following ‘red flags’ as from 24 June 2020 these are as follows:

- Patient taking an anti-psychotic medication
- Death of a patient with a learning disability
- Patients with chronic pain
- Patients only open to outpatient services
- Patients with COVID19 (this is a temporary flag)

From 1 August to 19 October 2020 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 since 1 August to 19 October 2020



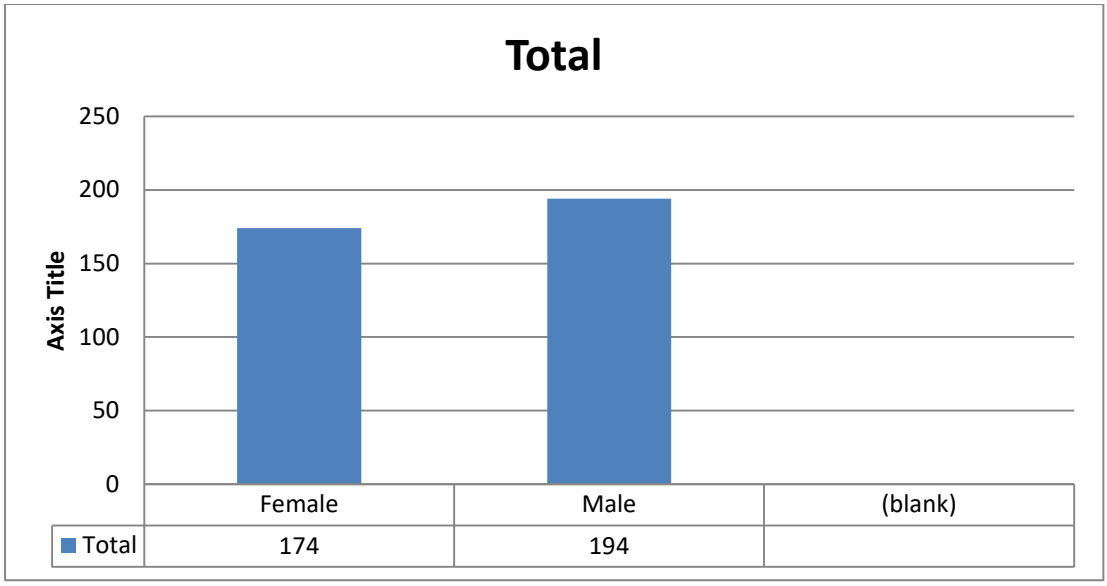
System	Count of Source System
IAPT	5
PARIS	327
SystmOne	36
Grand Total	**368**

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.

6.2 Deaths by Gender since 1 August to 19 October 2020

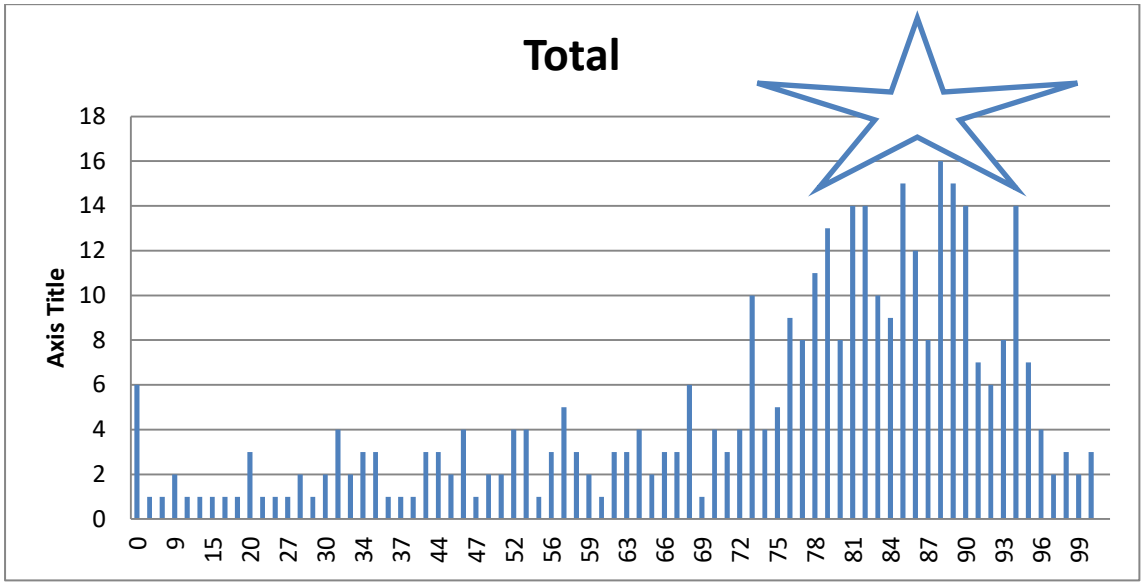
The data below shows the total number of deaths by gender 1 August to 19 October 2020. There is very little variation between male and female deaths; 194 male deaths were reported compared to 174 female.

Gender	Count of Gender
Female	174
Male	194
Grand Total	**368**



6.3 Death by Age Group since 1 August to 19 October 2020

The youngest age was classed as 0, and the oldest age was 100 years. Most deaths occur within the 80-95 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 August to 19 October 2020

	Aug 2020	Sept 2020	Oct 2020
LD Deaths	2	1	1

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. Due to challenges in reporting out from the LeDeR programme, we are unable to ascertain how many of our Trust's deaths have been reviewed through the LeDeR process. The Trust continues to share relevant information with LeDeR when requested which is used to inform their reviews.

Since 1 August to 19 October 2020, the Trust has recorded four 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.

6.5 Death by Ethnicity since 1 August to 19 October 2020

White British is the highest recorded ethnicity group with 294 recorded deaths, 51 deaths had no recorded ethnicity assigned, and 5 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count of Ethnicity
Caribbean	1
Asian or Asian British - Pakistani	1
Pakistani	1
African	1
White - Irish	2
White - Any other White background	3
Indian	4
Not stated	5
Other Ethnic Groups - Any other ethnic group	5
Not Known	51
White - British	294
Grand Total	**368**

6.6 Death by religion since 1 August to 19 October 2020

Christianity is the highest recorded religion group with 56 recorded deaths, 172 deaths had no recorded religion assigned and 11 people refused to state their religion. The chart below outlines all religion groups.

Religion	Count of Religion
Islam	1
Christian religion	1
Church of England, follower of	1
Pentecostalist	1
None	1
Agnostic	2
Catholic: Not Roman Catholic	2
Muslim	2
Atheist movement	2
Sikh	4
Roman Catholic	5
Methodist	7
Not Given Patient Refused	11
Unknown	26
Not Religious	27
Church Of England	47
Christian	56
Blank	172
Grand Total	**368**

6.7 Death by sexual orientation since 1 August to 19 October 2020

Heterosexual or straight is the highest recorded sexual orientation group with 126 recorded deaths. 231 have no recorded information available. The chart below outlines all sexual orientation groups.

Sexual orientation	Count of Sexual Orientation
Homosexual	1
Bi-Sexual	2
Not Stated (declined)	2
Unknown	3
Not Appropriate To Ask	3
Heterosexual Or Straight	126
Blank	231
Grand Total	**368**

6.8 Death by disability since 1 August to 19 October 2020

Behavioural and emotional problems were the highest recorded disability group with 16 recorded deaths.

Top categories by disability	Count of Disability
Sight	4
Physical disability	5
Learning Disability	8
Other	8
Learning Disability (DEMENTIA)	10
Hearing	11
Behaviour and Emotional	16
Grand Total	**62**

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths. 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.

- To further explore the role of families/carers in developing risk assessments, risk management plans and care plans
- Develop, clarify and/or ratify policies in relation to:
    - Section 17 leave
    - The involvement of police on wards (e.g. liaison, individual roles and responsibilities
    - when to escalate and involve the police on the ward, and, how this should be managed, minimised and situations de-escalated)
- The role of the responsible clinician in patient transfers between Trusts/provider services.
- To ensure that key times are accurately recorded in the clinical record if records are made retrospectively
- When staff open and complete a risk assessment it should be authorised in order for it to be clear who the author was.
- To raise with the Suicide Awareness Group the fact that there are a number of locations close to the hospital grounds and acute psychiatric units; where it is possible to make multiple purchases of paracetamol. For the group to consider undertaking a piece of work with shops in order to raise awareness of some of the issues that may be pertinent to patients who use our services.

8. Moving forward and aligning mortality reviews with the planned Patient Safety Incident Review Framework (PSIRF)

Work is currently underway to align the information set out in the National Guidance, Learning from deaths with the new planned Patient Safety Incident Response Framework to ensure that the national guidance in both documents is been adhered to, ensuring there is no duplication and an effective management of resources.