Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Director – 2 March 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 20 October 2020 to 19 January 2021.

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 20 October to 19 January 2021 there have been 25 deaths reported where the patient tested positive for Covid-19
- From 20 October to 19 January 2021 the Trust received 567 death notifications of patients who had been in contact with our service in the last six months
- 0 Inpatient deaths were recorded. However one patient died following discharge from an acute inpatient ward and one patient died following transfer to the acute hospital.
- The Mortality Review Group reviewed 11 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 11 deaths reviewed, none were due to problems in care.
- The Trust has reported one Learning Disability deaths from 20 October to 19 January 2021
- There is very little variation between male and female deaths; 309 male deaths were reported compared to 258 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 recommenced 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.

Below is a summary of the equality-related impacts of the report:

- From 20 October to 19 January 2021. There is very little variation between male and female deaths; 309 male deaths were reported compared to 258 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 John R Sykes**
Medical Director

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

Aneesa Akhtar-Alam
Mortality Technician

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 20 October to 19 January 2021.

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 for the north and south have been updated. Nine Case Note Review sessions were undertaken, where eleven incidents were reviewed. Unfortunately eleven 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 last audit was completed October 2020.

- The monthly Mortality review group meetings resumed 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.

	October	November	December	January
Total Deaths Per Month	66 (this is from 20/10/2020	203	174	124
LD Referral Deaths	0	1	0	0

The table above shows information for 20 October to 19 January 2021. Correct as of 19 January 2021.

From 20 October to 19 January 2021, the Trust received 567 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 20 October to 19 January 2021 reported on Datix	76 (of which 41 are reported as "Unexpected deaths" 5 as death categorised as "suspected" 25 Covid deaths 5 as "Expected - end of life pathway" NB some expected deaths have been rejected so these incidents are not included in the above figure.
Number reviewed through the Serious Incident Group	64 (9 pending for a review).
Number investigated by the Serious Incident Group	3 did not require an investigation; 13 underway and 59 pending for a review
Number of Serious Incidents closed by the Serious Incident Group	26 (47 currently opened to SI group as of 19/01/2021)

Since 20 October to 19 January 202 the Trust has recorded 0 Inpatient deaths. However one patient died following discharge from an acute inpatient ward and one patient died following transfer to the acute hospital.

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 20 October to 19 January 2021, The Mortality Review Group reviewed 11 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 11 deaths reviewed, 11 were not due to problems in care.

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

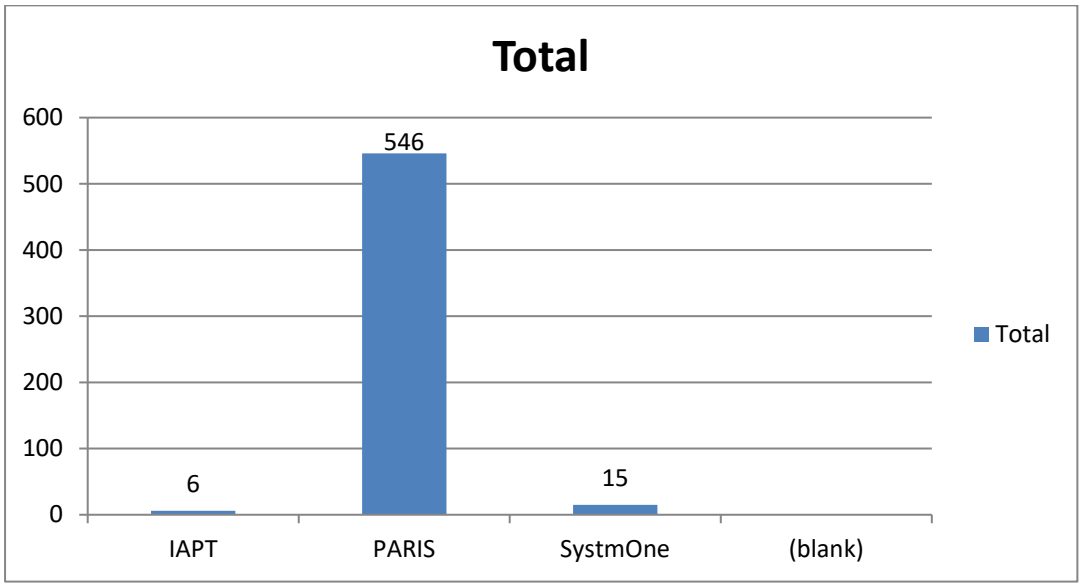
- Patient taking an anti-psychotic medication
- Death of a patient with a learning disability
- Patients with chronic pain
- Patients only open to outpatient services
- Patients with covid19 (this is a temporary flag)

From 20 October 2020 to 19 January 2021 there has been 25 deaths reported where the patient tested positive for covid-19. Of these deaths 13 were female and 12 male. Of the 25 deaths ethnicity was recorded as white (British) or White (other) , a total of 24 , with only one death recorded as black Caribbean. Age range varied with the significant number been over the age of 71 years.

Age	total
26-50	1
51-65	3
66-70	2
Over 71	19

6. Analysis of Data

6.1 Analysis of deaths per notification system since 20th October to 19th January 2021.



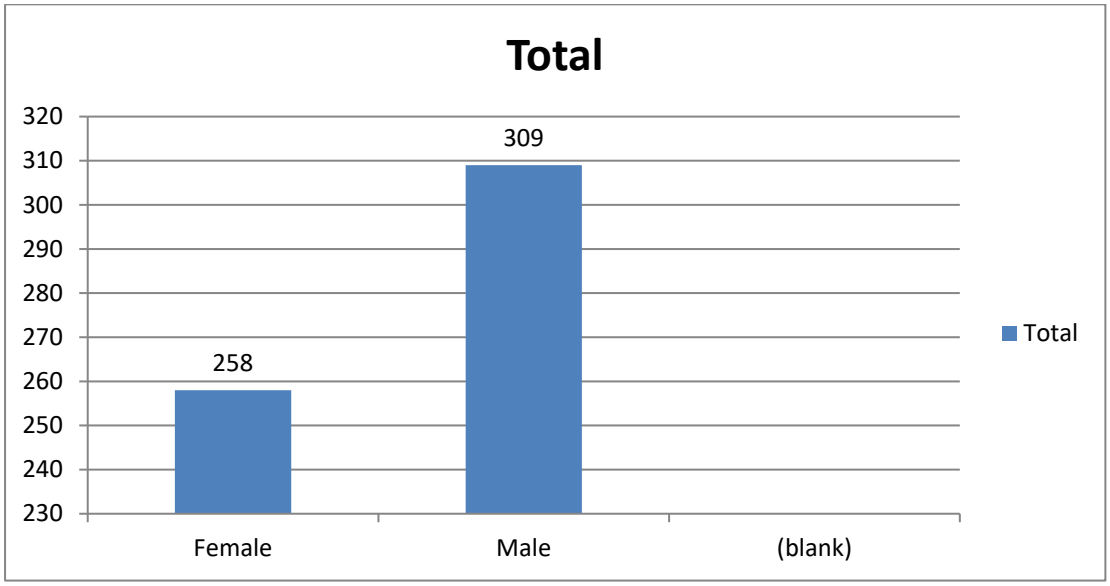
Row Labels	Count of Source System
IAPT	6
SystmOne	15
PARIS	546
Grand Total	**567**

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 20 October to 19 January 2021.

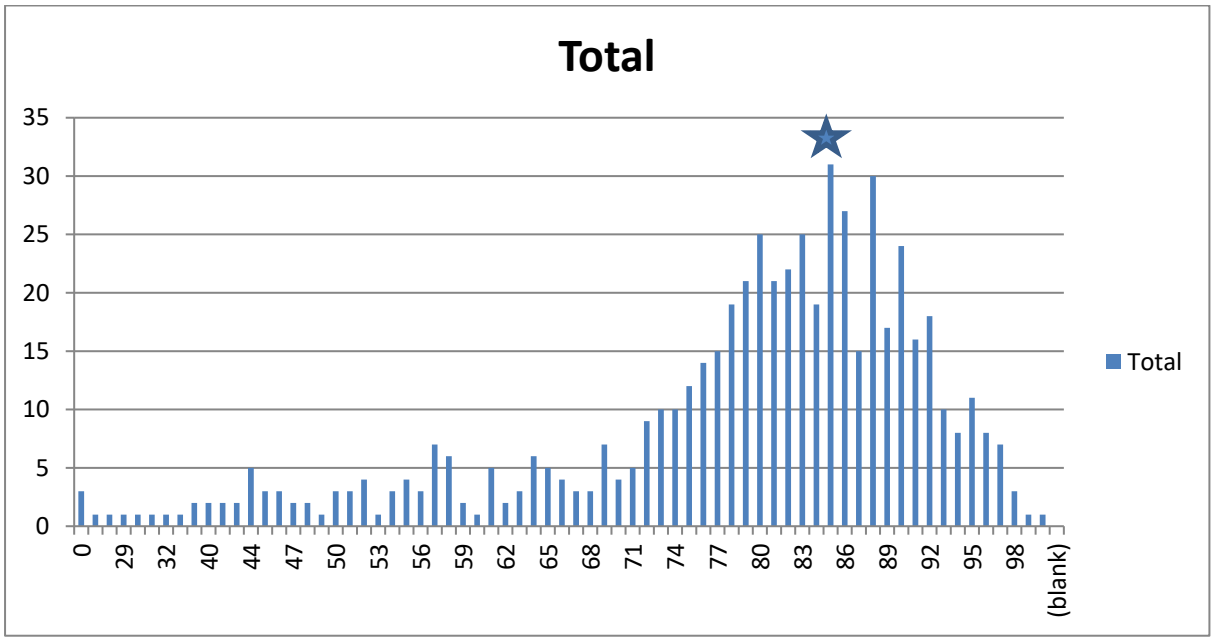
The data below shows the total number of deaths by gender 20 October to 19 January 2021.There is very little variation between male and female deaths; 309 male deaths were reported compared to 258 female.

Row Labels	Count of Gender
Female	258
Male	309
Grand Total	**567**



6.3 Death by Age Group since 20th October to 19th January 2021.

The youngest age was classed as 0, and the oldest age was 85 years (indicated by the star). Most deaths occurred within the 80-90 age groups.



6.4 Learning Disability Deaths (LD) since 20 October to 19 January 2021

	Oct 2020	Nov 2020	Dec 2020	Jan 2021
LD Deaths	0	1	0	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. 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 20 October to 19 January 2021, the Trust has recorded one 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 20 October to 19 January 2021.

White British is the highest recorded ethnicity group with 440 recorded deaths, 73 deaths had no recorded ethnicity assigned, and 10 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	Count of Ethnicity
Mixed - White and Black Caribbean	1
Any other Black background	1
Asian or Asian British - Any other Asian background	1
Other Ethnic Groups - Chinese	1
Mixed - White and Asian	2
Caribbean	3
Pakistani	4
Indian	6
Other Ethnic Groups - any other ethnic group	6
White - Irish	6
Not stated	10
White - any other White background	13
Not known	73
White - British	440
Grand Total	**567**

6.6 Death by religion since 20 October to 19 January 2021.

Christianity is the highest recorded religion group with 95 recorded deaths, 248 deaths had no recorded religion assigned and 10 people refused to state their religion. The chart below outlines all religion groups.

Row Labels	Count of Religion
Nonconformist	1
None	1
Calvinist	1
Christian religion	1
Spiritualist	1
Not Religious - Old Code	1
Hindu	1
Mormon	1
Religion NOS	1
Pentecostalist	1
Church of England, follower of	1
Protestant	1
Atheist	1
Religion (other Not Listed)	1
Patient Religion Unknown	2
Anglican	2
Catholic: Not Roman Catholic	3
Muslim	3
Methodist	3
Sikh	4
Jehovah's Witness	5
Roman Catholic	7
Not Given Patient Refused	10
Not Religious	44
Unknown	44
Church Of England	83
Christian	95
Blank	248
Grand Total	**567**

6.7 Death by sexual orientation since 20 October to 19 January 2021.

Heterosexual or straight is the highest recorded sexual orientation group with 180 recorded deaths. 369 have no recorded information available. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Person asked and does not know	1
Not appropriate to ask	3
Not stated (declined)	7
Unknown	7
Heterosexual or straight	180
(Blank)	369
Grand Total	**567**

6.8 Death by disability since 20 October 2020 to 19 January 2021

The table below details the top 5 categories by disability. Behavioural and emotional problems were the highest recorded disability group with 18 recorded deaths.

Top 5 recorded categories by disability	Count of Disability
Progressive (LT) Conditions	5
Learning Disability	6
Learning Disability (Dementia)	9
Other	11
Behaviour And Emotional	18

There were a total of 139 deaths with a disability assigned and the remainder 428 were blank (had no assigned disability).

Row Labels	Count of Disability
Hearing; mobility and gross motor	1
Hearing; progressive (LT) conditions	1
Behaviour and emotional; behaviour and emotional; other	1
Hearing; speech	1
Behaviour and emotional; hearing; learning disability (dementia); perception of physical danger; self-care and continence	1
Learning disability; hearing; mobility and gross motor	1
Behaviour and emotional; hearing; manual dexterity; learning disability (dementia); mobility and gross motor	1
Learning disability; mobility and gross motor; behaviour and emotional; manual dexterity; self-care and continence	1
Behaviour and emotional; hearing; self-care and continence; learning disability; mobility and gross motor	1
Learning disability; mobility and gross motor; self-care and continence	1

Row Labels	Count of Disability
Behaviour and emotional; learning disability (dementia); learning disability (dementia)	1
Learning disability; self-care and continence	1
Behaviour and emotional; learning disability (dementia); learning disability (dementia); perception of physical danger; other	1
Learning disability (dementia); learning disability (dementia); mobility and gross motor; perception of physical danger; other	1
Behaviour and emotional; manual dexterity; learning disability (dementia); learning disability (dementia); mobility and gross motor	1
Learning disability (dementia); learning disability (dementia); other; self-care and continence; sight	1
Behaviour and emotional; mobility and gross motor; progressive (LT) Conditions	1
Learning disability (dementia); learning disability (dementia); self-care and continence; behaviour and emotional	1
Behaviour and emotional; progressive (LT) conditions	1
Learning disability (dementia); mobility and gross motor; self-care and continence; sight; speech	1
Behaviour and emotional; self-care and continence; mobility and gross motor; hearing	1
Learning disability (dementia); sight	1
Dementia; behaviour and emotional	1
Learning disability (dementia); sight; other	1
Dementia; self-care and continence; behaviour and emotional; mobility and gross motor	1
Manual Dexterity; Learning Disability; Self Care And Continence; Progressive (LT) Conditions	1
Hearing; learning disability (dementia); mobility and gross motor	1
Manual Dexterity; learning disability (dementia); learning disability (dementia); mobility and gross motor; sight	1
Hearing; manual dexterity; learning disability (dementia); sight	1
Manual dexterity; sight; mobility and gross motor	1
Behaviour and emotional; dementia	1
Manual dexterity; speech; self-care and continence; hearing; sight	1
Behaviour and emotional; hearing; mobility and gross motor; self-care and continence; sight	1
Mobility and gross motor; behaviour and emotional	1
Behaviour and emotional; learning disability (dementia); learning disability (dementia); other	1
Mobility and gross motor; behaviour and emotional; self-care and continence	1

Row Labels	Count of Disability
Behaviour and emotional; mobility and gross motor; other; self-care and continence	1
Mobility and gross motor; mobility and gross motor	1
Behaviour and emotional; self-care and continence; manual dexterity	1
Mobility and gross motor; other; learning disability (dementia)	1
Dementia; mobility and gross motor; behaviour and emotional; self-care and continence; hearing	1
Other; behaviour and emotional; learning disability (dementia)	1
Hearing; manual dexterity; learning disability	1
Other; dementia	1
Behaviour and emotional; hearing; manual dexterity; learning disability (dementia); learning disability (dementia)	1
Other; other	1
Behaviour and emotional; learning disability (dementia); self-care and continence	1
Perception of physical danger; behaviour and emotional; self-care and continence; sight	1
Behaviour and emotional; sight	1
Progressive (LT) conditions; other; mobility and gross motor; other; other	1
behaviour and emotional; behaviour and emotional	1
Self-care and continence; mobility and gross motor; behaviour and emotional	1
Behaviour and emotional; mobility and gross motor; self-care and continence; sight; speech	1
Self-care and continence; mobility and gross motor; progressive (LT) conditions	1
Behaviour and emotional; learning disability	1
Self-care and continence; other	1
Dementia; self-care and continence; hearing; mobility and gross motor	1
Sight; hearing	1
Hearing; sight	2
Hearing; learning disability; sight	2
Behaviour and emotional; self-care and continence	2
Self-care and continence	2
Hearing; learning disability	2
Hearing	3
Dementia	3
Learning disability (dementia); learning disability (dementia); mobility and gross motor	3
Mobility and gross motor	3
Behaviour and emotional; learning disability (dementia)	3

Row Labels	Count of Disability
Sight	3
Learning disability (dementia); learning disability (dementia)	4
Progressive (LT) conditions	5
Learning disability	6
Learning disability (dementia)	9
Other	11
Behaviour and emotional	18
Blank	428
Grand Total	**567**

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.

- Electronic systems to be reviewed and processes implemented where possible to provide systems that will alert clinical staff when referrals are due or assessments are delayed.

- Review standards of Neurological Assessment and completion including Fundoscopy. Review availability of equipment to complete Neurological assessments. Admission clerking to include Neurological observations including Fundoscopy, to be reviewed and updated.

- Design a bitesize training video on neurological observations and escalation of physical health concerns.

- A review to be completed to assess the quality of information being recorded and therefore available on admission, transfer and discharge between wards and teams.

- A review is to be completed into the standards of ward rounds across acute wards and the quality of documentation being completed before, during and after.

- Organisation to disseminate the best practice use of side effect rating scales such as Glasgow Antipsychotic Side-effect Scale (GASS).