**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 6 July 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 January to 29 April 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 are reviewed under the Untoward Incident Report Reporting Policy and Procedure.

- From 20 January to 29 April there have been 19 deaths reported where the patient tested positive for Covid-19
- From 20 January to 29 April the Trust received 558 death notifications of patients who had been in contact with our service in the last six months
- No Inpatient deaths were recorded
- 17 Case Note Review sessions were undertaken, where 22 incidents were reviewed. Unfortunately, 13 sessions did not take place due to either lack of medic or nurse availability
- Mortality reviews now include scrutiny between primary care and secondary care and include the reviewing of physical healthcare monitoring
- The Trust has reported 8 Learning Disability deaths from 20 January to 29 April
- There is very little variation between male and female deaths; 278 male deaths were reported compared to 280 females
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

| 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 and 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 January 2021 to 29 April 2021 There is very little variation between male and female deaths; 278 male deaths were reported compared to 280 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.

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**Medical Director**

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

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**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 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 January to 29 April 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. 17 Case Note Review sessions were undertaken, where twenty-two incidents were reviewed. Unfortunately 13 sessions did not take place due to either lack of medic or nurse 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 in April.

- The monthly mortality review group meetings continue.

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

## 2. 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. The table below outlines information for 20 January to 29 April.

| | January | February | March | April |
|---|---|---|---|---|
| Total Deaths Per Month | 112 | 201 | 136 | 109 |
| LD Referral Deaths | 0 | 4 | 1 | 3 |

Correct as of 29 April 2021

There have been no inpatient deaths reported during this period.

From 20 January to 29 April 2021, the Trust received 558 death notifications of patients who have been in contact with our services.

## 3. Review of Deaths

| | |
|---|---|
| Total number of Deaths from 20 January to 29 April 2021reported on Datix | 81 (of which 49 are reported as unexpected deaths<br>19 Covid deaths<br>9 as suspected deaths<br>4 as expected - end of life pathway<br>NB some expected deaths have been rejected so these incidents are not included in the above figure.<br>Inpatient deaths = 0 |
| Incidents assigned for a review | 66 incidents assigned to the operational incident group<br>1 did not meet the requirement<br>14 incidents are to be confirmed |

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 January to 29 April 2021, The Mortality Review Group reviewed 22 deaths through a Stage 2 Case Note Review.  These reviews were undertaken by a multi-disciplinary team and it was established that of the 22 deaths reviewed, none were 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)

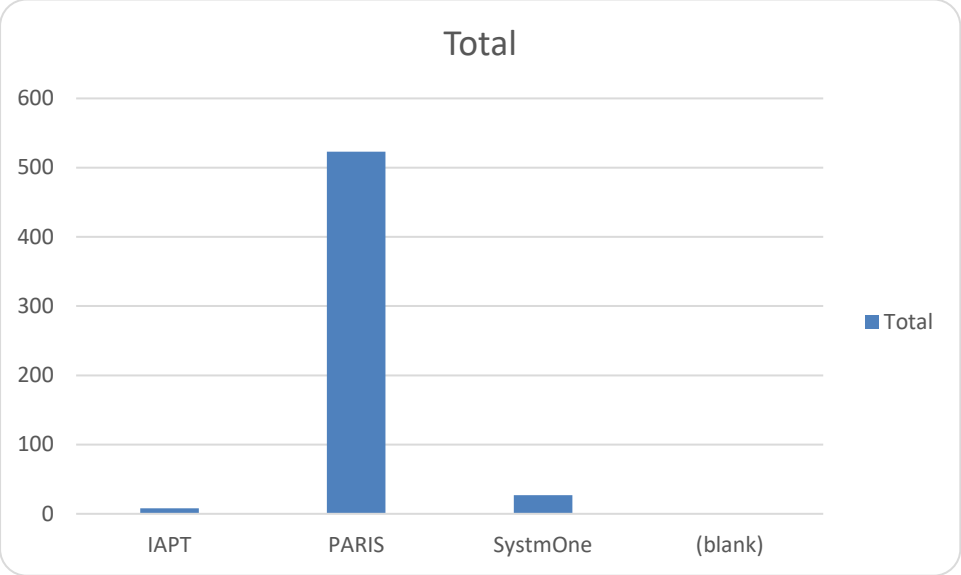
From 20 January to 29 April 2021 there has been 19 deaths reported where the patient tested positive for Covid-19. Of these deaths 9 were female and 10 were male. 17 patients were from a White British background, 1 ‘other ethnic group’ and 1 ‘not stated’.

### Physical Health care monitoring

The mortality reviews will now include scrutiny of the interface between primary and secondary, in particular the Trust’s physical health monitoring. The reviews will ascertain whether if appropriate a physical healthcare monitoring questionnaire or Lester tool was completed and overall determine if the physical healthcare monitoring provided was correct.

## 6. Analysis of Data

### 6.1 Analysis of deaths per notification system 20 January to 29 April 2021

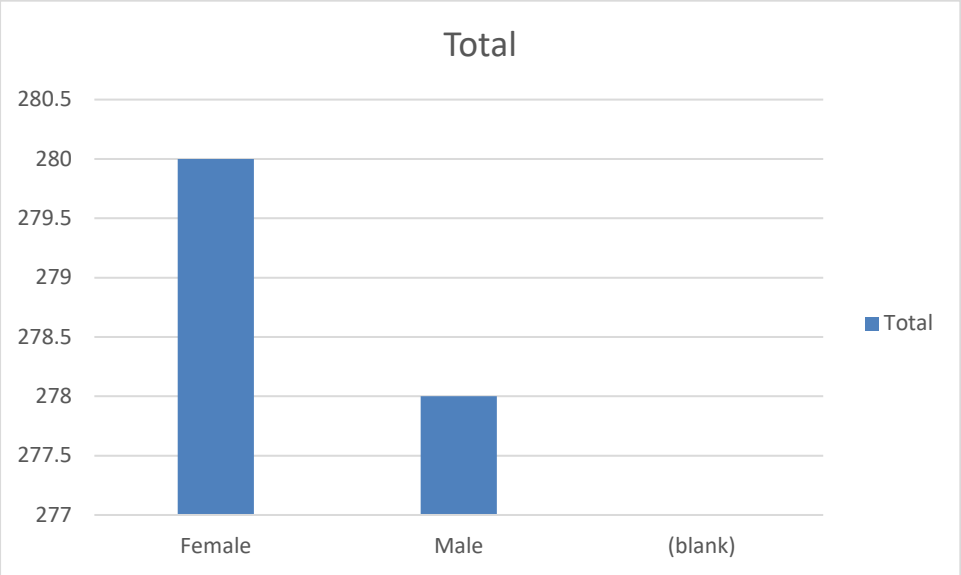



| Row Labels | Count of Source System |
|---|---|
| IAPT | 8 |
| SystmOne | 27 |
| PARIS | 523 |
| **Grand Total** | **558** |

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 20 January to 29 April 2021

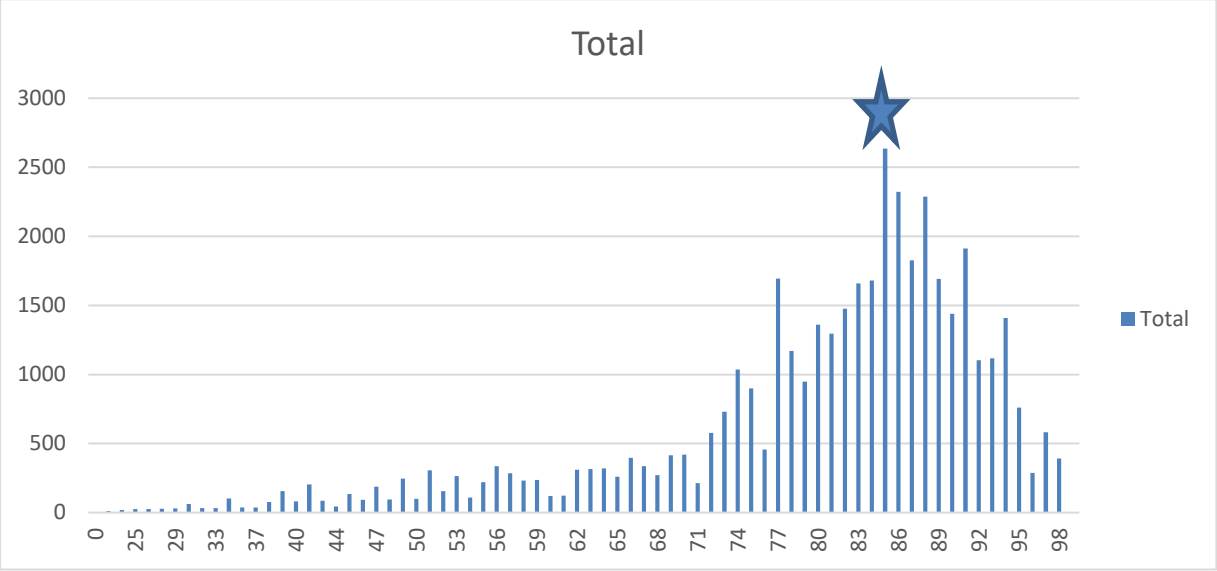
The data below shows the total number of deaths by gender from 20 January to 29 April. There is very little variation between male and female deaths; 280 male deaths were reported compared to 278 females.




| Row Labels | Count of Gender |
|---|---|
| Female | 280 |
| Male | 278 |
| **Grand Total** | **558** |

## 6.3 Death by Age Group 20 January to 29 April 2021

The youngest age was classed as 0, and the oldest age was 98 years. Most deaths occurred within the 85-90 age groups (indicated by the star).



### 6.4 Learning Disability Deaths (LD) 20 January to 29 April 2021

| | January 2021 | February | March | April |
|---|---|---|---|---|
| **LD Deaths** | 0 | 4 | 1 | 3 |

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. 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.

Since 20 January 2021 to 29 April 2021, the Trust has recorded eight deaths of patients who were open to Learning Disability at time of death. Four patients were male, four female, seven were white British and one Asian/Asian British Pakistani. The youngest age was 31 years, the eldest age, 82 years.

### 6.5 Death by ethnicity 20 January to 29 April 2021

White British is the highest recorded ethnicity group with 464 recorded deaths, 58 deaths had no recorded ethnicity assigned, and 6 people did not state their ethnicity. The chart below outlines all ethnicity groups.

| Row Labels | Count of Ethnicity |
|---|---|
| Asian or Asian British - any other Asian background | 1 |
| Asian or Asian British - Pakistani | 1 |
| British | 1 |
| Asian or Asian British - Indian | 2 |
| African | 2 |
| Indian | 3 |
| Pakistani | 3 |
| Other Ethnic Groups - any other ethnic group | 4 |
| White - Irish | 5 |
| Not stated | 6 |
| White - any other White background | 8 |
| Not Known | 58 |
| White - British | 464 |
| **Grand Total** | **558** |

### 6.6 Death by religion 20 January to 29 April 2021

Christianity is the highest recorded religion group with 100 recorded deaths, 248 deaths had no recorded religion assigned and 3 people refused to state their religion. The chart below outlines all religion groups.

| Row Labels | Count of Religion |
|---|---|
| Evangelical Christian | 1 |
| Baptist | 1 |
| Presbyterian | 1 |
| Not Religious - Old Code | 1 |
| Agnostic | 2 |
| Pentecostalist | 2 |
| Church of England, follower of | 2 |
| Nonconformist | 2 |
| Patient Religion Unknown | 2 |
| Salvation Army Member | 2 |
| Atheist | 2 |
| Sikh | 2 |
| Not given patient refused | 3 |
| Methodist | 3 |
| Muslim | 4 |
| Roman Catholic | 13 |
| Unknown | 38 |
| Not Religious | 39 |
| Church of England | 90 |
| Christian | 100 |
| (blank) | 248 |
| **Grand Total** | **558** |

## 6.7 Death by sexual orientation 20 January to 29 April 2021

Heterosexual or straight is the highest recorded sexual orientation group with 162 recorded deaths. 381 have no recorded information available. The chart below outlines all sexual orientation groups.

| Row Labels | Count of Sexual Orientation |
|---|---|
| Bi-sexual | 1 |
| Person asked and does not know | 1 |
| Gay or lesbian | 2 |
| Not stated (declined) | 5 |
| Not appropriate to ask | 6 |
| Heterosexual or straight | 162 |
| (blank) | 381 |
| **Grand Total** | **558** |

## 6.8 Death by disability 20 January to 29 April 2021

The table below details the top five categories by disability. Behavioural and emotional problems were the highest recorded disability group with 15 recorded deaths.

| Row Labels | Count of Disability |
|---|---|
| SIGHT | 6 |
| OTHER | 6 |
| LEARNING DISABILITY | 8 |
| LEARNING DISABILITY (DEMENTIA) | 10 |
| BEHAVIOUR AND EMOTIONAL | 15 |
| **Grand Total** | **45** |

There was a total of 119 deaths with a disability assigned and the remainder 439 were blank (had no assigned disability).

| Row Labels | Count of Disability |
|---|---|
| LEARNING DISABILITY; PROGRESSIVE (LT) CONDITIONS | 1 |
| LEARNING DISABILITY; MOBILITY AND GROSS MOTOR | 1 |
| SPEECH; SIGHT; LEARNING DISABILITY (DEMENTIA); OTHER | 1 |
| BEHAVIOUR AND EMOTIONAL; BEHAVIOUR AND EMOTIONAL | 1 |
| BEHAVIOUR AND EMOTIONAL; HEARING; LEARNING DISABILITY (DEMENTIA); PERCEPTION OF PHYSICAL DANGER; SIGHT | 1 |
| BEHAVIOUR AND EMOTIONAL; DEMENTIA; PERCEPTION OF PHYSICAL DANGER; SPEECH | 1 |
| BEHAVIOUR AND EMOTIONAL; LEARNING DISABILITY (DEMENTIA); SELF CARE AND CONTINENCE; OTHER | 1 |

| Row Labels | Count of Disability |
|---|---|
| LEARNING DISABILITY (DEMENTIA); LEARNING DISABILITY (DEMENTIA); BEHAVIOUR AND EMOTIONAL | 1 |
| BEHAVIOUR AND EMOTIONAL; MOBILITY AND GROSS MOTOR; SIGHT | 1 |
| LEARNING DISABILITY (DEMENTIA); LEARNING DISABILITY (DEMENTIA); PERCEPTION OF PHYSICAL DANGER; OTHER; SELF CARE AND CONTINENCE | 1 |
| BEHAVIOUR AND EMOTIONAL; SIGHT; BEHAVIOUR AND EMOTIONAL | 1 |
| LEARNING DISABILITY (DEMENTIA); LEARNING DISABILITY (DEMENTIA); PROGRESSIVE (LT) CONDITIONS | 1 |
| DEMENTIA; BEHAVIOUR AND EMOTIONAL | 1 |
| LEARNING DISABILITY (DEMENTIA); LEARNING DISABILITY (DEMENTIA); PROGRESSIVE (LT) CONDITIONS; OTHER; MOBILITY AND GROSS MOTOR | 1 |
| DEMENTIA; MOBILITY AND GROSS MOTOR; SELF CARE AND CONTINENCE; PROGRESSIVE (LT) CONDITIONS | 1 |
| MANUAL DEXTERITY | 1 |
| HEARING; BEHAVIOUR AND EMOTIONAL | 1 |
| HEARING; LEARNING DISABILITY (DEMENTIA); MOBILITY AND GROSS MOTOR; SELF CARE AND CONTINENCE; SPEECH | 1 |
| SPEECH | 1 |
| MOBILITY AND GROSS MOTOR; HEARING; SELF CARE AND CONTINENCE | 1 |
| HEARING; SELF CARE AND CONTINENCE; SIGHT; LEARNING DISABILITY (DEMENTIA); PERCEPTION OF PHYSICAL DANGER | 1 |
| MOBILITY AND GROSS MOTOR; PROGRESSIVE (LT) CONDITIONS | 1 |
| LEARNING DISABILITY; DEMENTIA | 1 |
| OTHER; HEARING | 1 |
| BEHAVIOUR AND EMOTIONAL; HEARING; MOBILITY AND GROSS MOTOR; PERCEPTION OF PHYSICAL DANGER; SELF CARE AND CONTINENCE | 1 |
| OTHER; LEARNING DISABILITY | 1 |
| BEHAVIOUR AND EMOTIONAL; SELF CARE AND CONTINENCE; MOBILITY AND GROSS MOTOR; LEARNING DISABILITY; OTHER | 1 |
| OTHER; MOBILITY AND GROSS MOTOR | 1 |
| HEARING; LEARNING DISABILITY; SIGHT | 1 |
| PERCEPTION OF PHYSICAL DANGER | 1 |
| HEARING; SIGHT; SELF CARE AND CONTINENCE | 1 |
| PERCEPTION OF PHYSICAL DANGER; OTHER; SELF CARE AND CONTINENCE; SPEECH; BEHAVIOUR AND EMOTIONAL | 1 |
| BEHAVIOUR AND EMOTIONAL; MOBILITY AND GROSS MOTOR | 1 |
| PROGRESSIVE (LT) CONDITIONS; MOBILITY AND GROSS MOTOR | 1 |
| HEARING; MANUAL DEXTERITY; MANUAL DEXTERITY; MOBILITY AND GROSS MOTOR; PROGRESSIVE (LT) CONDITIONS | 1 |
| SELF CARE AND CONTINENCE; BEHAVIOUR AND EMOTIONAL; PROGRESSIVE (LT) CONDITIONS; SIGHT | 1 |
| DEMENTIA; MOBILITY AND GROSS MOTOR; BEHAVIOUR AND EMOTIONAL; SELF CARE AND CONTINENCE | 1 |
| SELF CARE AND CONTINENCE; MOBILITY AND GROSS MOTOR | 1 |

| Row Labels | Count of Disability |
|---|---|
| BEHAVIOUR AND EMOTIONAL; HEARING; BEHAVIOUR AND EMOTIONAL | 1 |
| SIGHT; DEMENTIA | 1 |
| MOBILITY AND GROSS MOTOR; HEARING | 2 |
| OTHER; BEHAVIOUR AND EMOTIONAL | 2 |
| DEMENTIA; SELF CARE AND CONTINENCE | 2 |
| DEMENTIA | 2 |
| LEARNING DISABILITY (DEMENTIA); LEARNING DISABILITY (DEMENTIA) | 3 |
| MOBILITY AND GROSS MOTOR | 3 |
| SELF CARE AND CONTINENCE | 3 |
| HEARING | 4 |
| PHYSICAL DISABILITY | 4 |
| HEARING; SIGHT | 4 |
| PROGRESSIVE (LT) CONDITIONS | 5 |
| SIGHT | 6 |
| OTHER | 6 |
| LEARNING DISABILITY | 8 |
| LEARNING DISABILITY (DEMENTIA) | 10 |
| BEHAVIOUR AND EMOTIONAL | 15 |
| BLANK | 439 |
| **Grand Total** | **558** |

## 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 discuss with clinical commissioners the possibility of jointly developing an action plan in relation to Autism pathways including repeated placement failures to reduce risks in patients with complex needs and issues in relation to area definition.

- To review and consider the current practice for the involvement of Substance Misuse services support/ workers within in inpatient mental health services to ensure so far as is possible effective continuity of care.

- Current policy to be reviewed to ensure it is consistent with NICE guidelines for self-harm for children and young people taking in to account the learning.

- Ensure compliance with E-learning for Autism Spectrum Disorder (ASD) across children's services following development and implementation of ASD practice guidance.

- Learning to be undertaken on the early detection of patients who require support from a dietician regarding refusal of food and fluids this is to include referral to Speech and Language Therapy where there are concerns of choking.

- Further work to develop and embed the involvement of Substance Misuse services in the inpatient care and treatment of patients where need is identified.

- Development of process and protocols for the management of patients who are out of area including Psychiatric Intensive Care (PICU) and Gynaecology Assessment Unit (GAU). Key dates need to inform Multidisciplinary Team Meeting (MDT) review and collaborative care planning.

- A shared protocol to be designed for young people, with minimum standards of practice, to be linked to the Child and Adolescent Mental Health Services (CAMHS) operational policy.

- To implement effective multi-agency management of patients that may present long-term risks. The panel recommend an inter-agency collaboration facilitated by NHS Derby and Derbyshire Clinical Commissioning Group (CCG), with representation by a senior clinician and senior manager from the Trust and a senior case worker and senior manager from Derventio Housing Trust.

- To consider the need for development of a dedicated community forensic team and high support hostel for the population of Derbyshire. This would be informed by a needs analysis of the current Derbyshire patient population in secure mental health services commissioned by NHS England and a projection of those held in the criminal justice system considered to have a profound mental health need.

- All agencies to provide assurance and evidence to the Domestic Abuse, Sexual Violence (DA/SV) Governance Board that routine enquiry is embedded in practice and that processes are in place to follow up where enquiries could not be completed.