Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 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 30 April to 22 July 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 30 April to 22 July 2021 there have been zero deaths reported where the patient tested positive for COVID-19
- During this period the Trust received 385 death notifications of patients who had been in contact with our service in the last six months
- One inpatient death was recorded.
- The Mortality Review Group reviewed 28 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 28 deaths reviewed, 28 were not due to problems in care.
- During this period the Trust has reported 6 Learning Disability. There is very little variation between male and female deaths; 187 male deaths were reported compared to 207 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.

Consultation

This report was previously considered by the Quality and Safeguarding Committee and the Serious Incident Group.

Governance or Legal Issues

There are no legal issues arising from this 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 30 April to 22 July 2021 There is very little variation between male and female deaths; 187 male deaths were reported compared to 207 females.
- No unexpected trends were identified according to ethnic origin or religion.
- Further analysis is underway to examine if any trends can be detected by considering a larger data sample over an extended time frame.

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 published on the Trust's website as per national guidance.

Report presented by: **Dr John R Sykes**
Medical Director

Report prepared by: **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 the required guidelines.

The report presents the data for 30 April to 22 July 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 and the national Medical Examiner System. 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. 28 Case Note Review sessions were undertaken, where 28 incidents were reviewed. Unfortunately, 3 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 on 9 April 2021.

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

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 30 April to 22 July 2021.

Month	2021-04-01	2021-05-01	2021-06-01	2021-07-01
1. Total Deaths Per Month	1	143	153	89
5. LD Referral Deaths	3	2	1	0

Correct as of 22 July 2021

178 patients were male, 207 females,297 were white British and 1 Asian/Asian British Pakistani. The youngest age was 0 years, the eldest age was 102 years old.

From 30 April to 22 July 2021, the Trust received 385 death notifications of patients who have been in contact with our services.

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

4. Review of Deaths

Total number of Deaths from 30 April to 22 July 2021 reported on Datix	38 unexpected deaths 0 COVID deaths 12 suspected deaths 3 expected (end of life pathway) 1 Inpatient death
Incidents assigned for a review	38 incidents assigned to the operational incident group 0 did not meet the requirement 6 incidents are to be confirmed

During 30 April to 22 July 2021 the Trust has recorded 1 Inpatient death.

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 30 April to 22 July 2021, The Mortality Review Group reviewed 28 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 28 deaths reviewed, 28 were not due to problems in care.

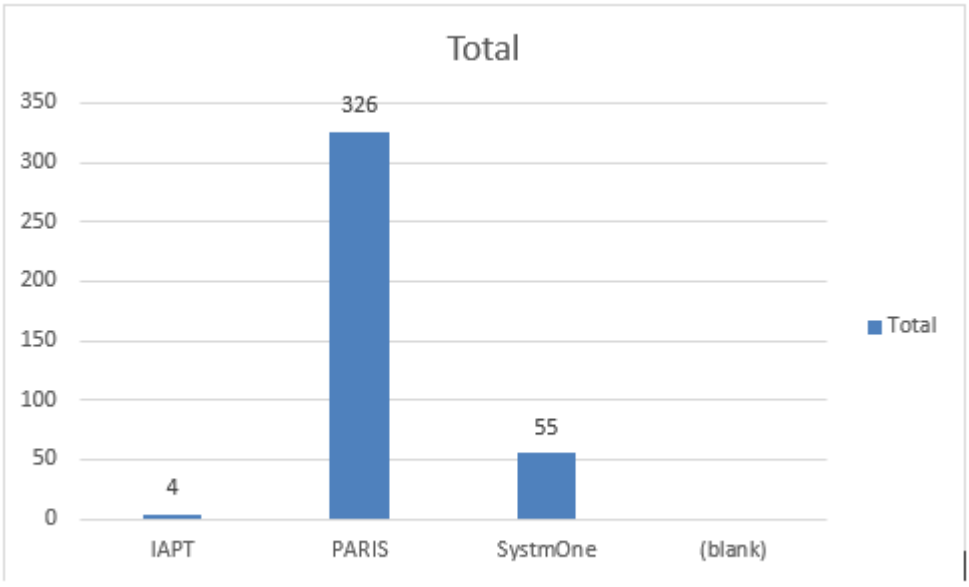
The Mortality Group review the deaths of patients who fall under the following 'red flags' as from 24 June 2020 these are as follows:

- 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 30 April to 22 July 2021 there has been 0 deaths reported where the patient tested positive for COVID-19.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 30 April to 22 July 2021

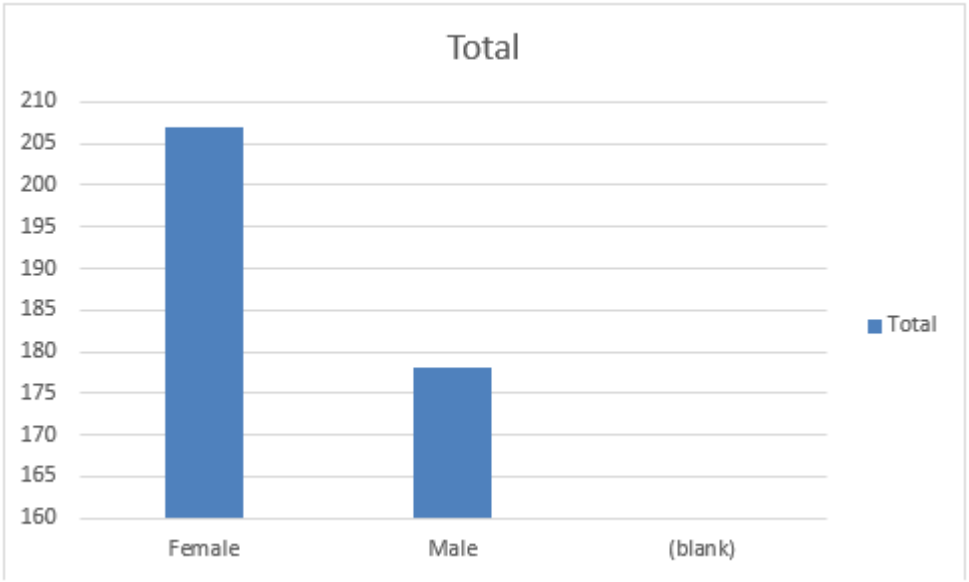


Row Labels	Count of Source System
IAPT	4
SystmOne	55
PARIS	326
Grand Total	385

The data above shows the total number of deaths reported by each notification system. Most 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 30 April to 22 July 2021

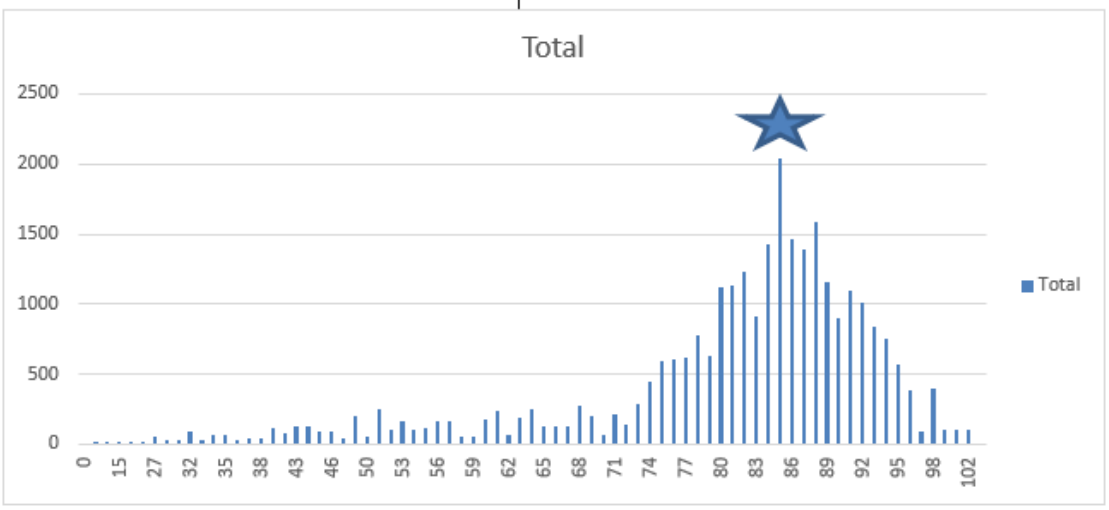
The data below shows the total number of deaths by gender. There is very little variation between male and female deaths; 178 male deaths were reported compared to 207 females.



Row Labels	Count of Gender
Female	207
Male	178
Grand Total	385

6.3 Death by Age Group since 30 April to 22 July 2021

The youngest age was classed as 0, and the oldest age was 102 years. Most deaths occurred within between the 85 years old age group (indicated by the star).



6.4 Learning Disability Deaths (LD) since 30 April to 22 July 2021

	April 2021	May 2021	June 2021	July 2021
LD Deaths	3	2	1	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 30 April to 22 July 2021, the Trust has recorded 6 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 30 April to 22 July 2021

White British is the highest recorded ethnicity group with 297 recorded deaths, 59 deaths had no recorded ethnicity assigned, and 1 person 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
Black or Black British - African	1
Mixed - White and Black African	1
Not stated	1
Asian or Asian British - Pakistani	1
Indian	2
White - Irish	3
Mixed - Any other mixed background	3
Other Ethnic Groups - Any other ethnic group	6
White - Any other White background	9
Not Known	59
White - British	297
Grand Total	**385**

6.6 Death by religion 30 April to 22 July 2021

Christianity is the highest recorded religion group with 58 recorded deaths, 209 deaths had no recorded religion assigned and 5 people refused to state their religion. The chart below outlines all religion groups.

Row Labels	Count of Religion
Jewish	1
Atheist movement	1
Catholic: not Roman Catholic	1
Muslim	1
Greek Orthodox	1
Patient religion unknown	1
Christian religion	1
Religion (other not listed)	1
Sikh	1
Religion NOS	1
Church of England, follower of	2
None	2
Baptist	2
Jehovah's Witness	2
Methodist	4
Roman Catholic	5
Not given patient refused	5
Not religious	37
Church Of England	49
Christian	58
(blank)	209
Grand Total	**385**

6.7 Death by sexual orientation since 30 April to 22 July 2021

Heterosexual or straight is the highest recorded sexual orientation group with 114 recorded deaths. 262 deaths have no recorded information available. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Bi-sexual	1
Not appropriate to ask	1
Gay or lesbian	1
Not Stated (declined)	6
Heterosexual or straight	114
Unknown	262
Grand Total	**385**

6.8 Death by disability since 30 April to 22 July 2021

The table below details the top 10 categories by disability. Behavioural and emotional problems were the highest recorded disability group with 11 recorded deaths.

Row Labels	Count of Disability
Hearing; other	2
Learning Disability (Dementia)	2
Behaviour and emotional; sight	2
Learning disability	3
Mobility and gross motor	3
Progressive (Lt) conditions	3
Hearing	3
Other	5
Physical disability	5
Behaviour and emotional	11
Grand Total	**39**

There was a total of 88 deaths with a disability assigned and the remainder 297 were blank (had no assigned disability).

Row Labels	Count of Disability
Hearing; learning disability (dementia); progressive (lt) conditions	1
Hearing; manual dexterity; learning disability (dementia); learning disability (dementia); mobility and gross motor	1
Hearing; mobility and gross motor	1
Behaviour and emotional; hearing; learning disability (dementia)	1
Hearing; progressive (lt) conditions	1
Behaviour and emotional; hearing; mobility and gross motor; sight	1
Hearing; speech	1
Behaviour and emotional; learning disability (dementia); learning disability (dementia)	1
Learning disability; manual dexterity	1
Behaviour and emotional; mobility and gross motor; sight; other	1
Learning disability (dementia); learning disability (dementia)	1
Behaviour and emotional; other; mobility and gross motor	1
Learning disability (dementia); mobility and gross motor	1
Behaviour and emotional; progressive (lt) conditions; other; mobility and gross motor; other	1
Manual dexterity	1
Disability - slight	1
Manual dexterity; learning disability	1
Gross motor disability	1
Manual dexterity; self care and continence; mobility and gross motor	1
Hearing; learning disability; mobility and gross motor; speech	1
Mobility and gross motor; behaviour and emotional	1

Row Labels	Count of Disability
Hearing; learning disability (dementia); learning disability (dementia); other; self-care and continence	1
Mobility and gross motor; hearing	1
Behaviour and emotional; dementia	1
Mobility and gross motor; other	1
Behaviour and emotional; learning disability (dementia)	1
Mobility and gross motor; self-care and continence	1
Behaviour and emotional; other	1
Mobility and gross motor; sight	1
Behaviour and emotional; self-care and continence	1
Mobility and gross motor; speech	1
Hearing; learning disability	1
Other; self-care and continence	1
Behaviour and emotional; behaviour and emotional; manual dexterity; learning disability	1
Progressive (lt) conditions; other; mobility and gross motor; other	1
Behaviour and emotional; manual dexterity; mobility and gross motor; perception of physical danger; other	1
Self-care and continence; learning disability	1
Emotional behaviour disability	1
Self-care and continence; mobility and gross motor; other	1
Behaviour and emotional; hearing; learning disability (dementia); perception of physical danger; self-care and continence	1
Self-care and continence; progressive (lt) conditions	1
Hearing; learning disability (dementia)	1
Sight	1
Behaviour and emotional; progressive (lt) conditions	1
Sight; sight	1
Hearing; other	2
Behaviour and emotional; sight	2
Hearing disability	2
Hearing; sight	2
Learning disability (dementia)	2
Learning disability	3
Hearing	3
Mobility and gross motor	3
Progressive (lt) conditions	3
Other	5
Physical disability	5
Behaviour and emotional	11
Unknown (blank)	297
Grand Total	**385**