Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 March 2022

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 23 July 2021 to 20 January 2022.

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.

Due to recent sickness within the mortality team, there is a backlog of non Datix reportable deaths that require reviewing against the red flags outlined in the Royal College of Psychiatrists Care Review Tool and the internal Trust red flags. All deaths reported through the Incident Reporting and Investigation Policy and Procedure (Datix) continue to be reviewed.

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 Incident Reporting and Investigation Policy and Procedure.

- From 23 July 2021 to 20 January 2022 there have been 3 deaths reported where the patient tested positive for Covid-19.
- The Trust received 986 death notifications of patients who had been in contact with our service in the last six months There is very little variation between male and female deaths; 507 male deaths were reported compared to 479 females.
- Zero inpatient deaths were recorded.
- The Mortality Review Group reviewed 38 deaths through a Stage 2 Royal College of Psychiatrists Care Review Tool These reviews were undertaken by a multi-disciplinary team and it was established that of the 38 deaths reviewed, none were due to problems in care.
- The Trust has reported 16 Learning Disability deaths in the reporting timeframe.
- 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 23 July 2021 to 20 January 2022 there is very little variation between male and female deaths; 507 male deaths were reported compared to 479 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 Experience

Louise Hamilton
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 23 July 2021 to 20 January 2022.

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. 30 Case Note Review sessions were undertaken, where 38 incidents were reviewed. Unfortunately 17 sessions did not take place due to lack of medic availability and 3 sessions did not take place due to 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 7 January 2022.

- 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. The table below outlines information for 23 July 2021 to 20 January 2022.

2021/22	23 to 31 Jul	Aug	Sept	Oct	Nov	Dec	1 to 20 Jan
Total Deaths Per Month	39	167	174	144	175	189	98
LD Referral Deaths	0	3	4	1	2	3	3

Correct as of 20 January 2022

507 patients were male, 479 female, 742 were white British and 15 Asian/Asian British Pakistani. The youngest age was 0 years, the eldest age was 102.

From 23 July 2021 to 20 January 2022, the Trust received 986 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 23 July 2021 to 20 January 2022 reported on Datix	74 “Unexpected deaths” 3 Covid deaths 16 “Suspected deaths” 11 “Expected - end of life pathway” 0 Inpatient deaths
Incidents assigned for a review	85 incidents assigned to the Operational Incident Group 16 did not meet the requirement 22 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

The mortality team, as well as reviewing identified deaths against the 'red flags' outlined in the Royal College of Psychiatrists Care Review Tool also review deaths against locally defined red flags**.**

From 5 August 2021 these locally defined red flags were:

- Patient diagnosed with a severe mental illness
- Patient only seen as outpatient
- Patient with long term physical condition
- Patient with long term chronic pain

Over the last 12 months the Patient Safety Team with support from NHSE Patient Safety team have been considering current Trust identified Mortality red flags against the red flags identified in the Royal College of Psychiatrists Care Review Tool for mortality reviews. This tool was developed following the publication of the Learning from Deaths Guidance for Mental Health Trusts to use when undertaking mortality reviews. It has become clear that the Trust has overcommitted its resources in this area and a redesign of the Mortality (learning from deaths) process is required.

The red flags identified within the care review tool are met under the Trust Incident review process with the exception of psychosis within the last episode of care.

The mandatory Red Flags for review under this guidance are:

- All patients where family, carers or staff have raised concerns about the care provided.

- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death or have been discharged within 6 months prior to their death.

- All patients who were an inpatient in a mental health unit at the time of death or who had been discharged from in-patient care within the last month.

- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.

- Those patient deaths which meet these 'red flag' criteria above should be subject to a review process if they are not already under the Incident process

At the stage of determining if a death meets the criteria for reporting as an incident, teams are required to review all deaths against the Trust Incident 'Red Flags'. An amendment will be made to the incident reporting system to include Psychosis in the last episode care as a 'Red Flag' for DATIX, this will not however trigger review through the incident process, this will safeguard the Trust during a period of change around the incident and mortality process.

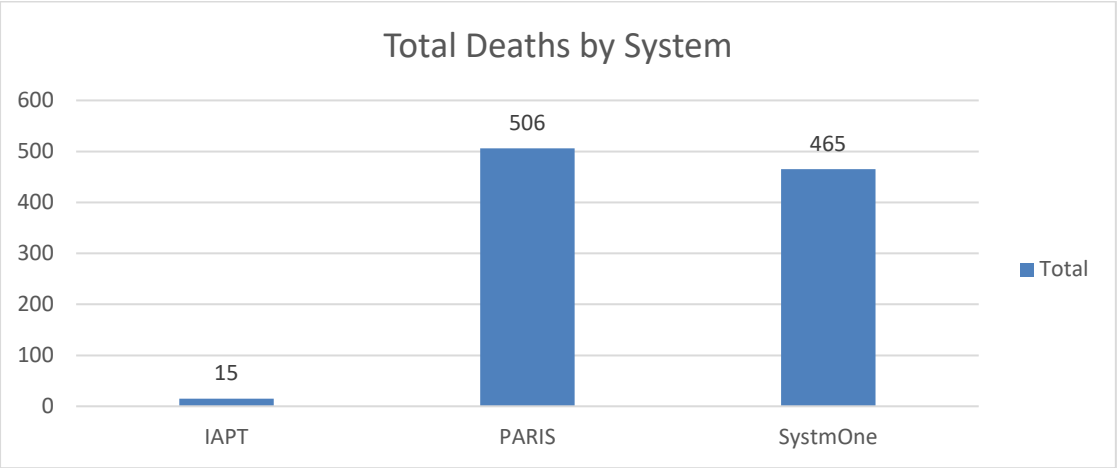
A form is currently under development based on the section 1 of the Royal College of Psychiatrists care review tool for mortality reviews which will sit within the patient electronic record which confirms the consideration against the identified mandatory red flags. It is important to note that clinical teams already assess each death when determining if a DATIX incident is required. This will release capacity within the Patient Safety team and allow for greater return on the Case Record Review process.

For the period 23 July 2021 to 20 January 2022, the Mortality Review Group reviewed 38 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 38 deaths reviewed, 0 were not due to problems in care.

From the 23 July 2021 to 20 January 2022 there have been 3 deaths reported where the patient tested positive for Covid-19. Of these deaths all patients were male and were from a white British background.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 23 July 2021 to 20 January 2022

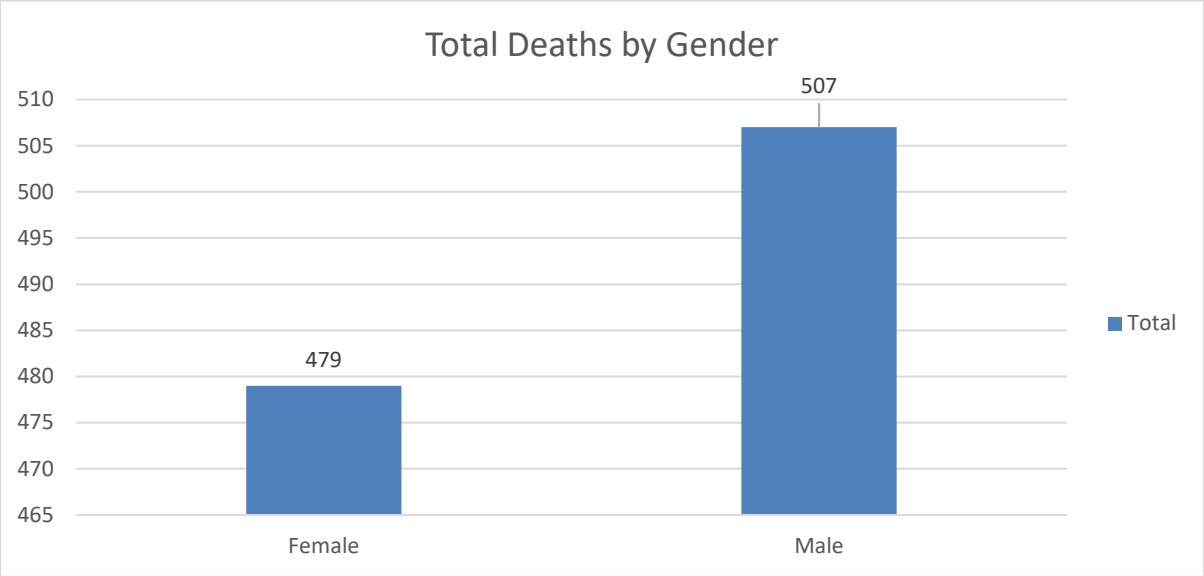


System	Number of Deaths
IAPT	15
SystmOne	465
PARIS	506
Grand Total	**986**

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

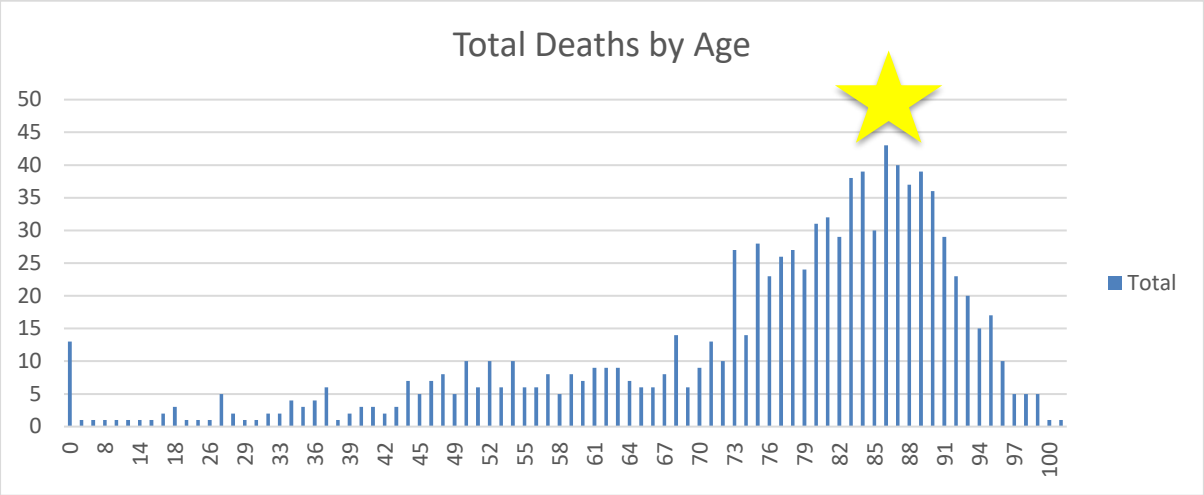
The data below shows the total number of deaths by gender 23 July 2021 to 20 January 2022. There is very little variation between male and female deaths; 507 male deaths were reported compared to 479 females.



Gender	Number of Deaths
Female	479
Male	507
Grand Total	**986**

6.3 Death by Age Group

The youngest age was classed as 0, and the oldest age was 102 years. Most deaths occurred within the 83 to 90 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	23 to 31 Jul	Aug	Sept	Oct	Nov	Dec	1 to 20 Jan
LD Deaths	0	3	4	1	2	3	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.

23 July 2021 to 20 January 2022, the Trust has recorded 16 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

White British is the highest recorded ethnicity group with 742 recorded deaths, 128 deaths had no recorded ethnicity assigned, and 7 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
Asian or Asian British - Bangladeshi	1
Black or Black British - Any other Black background	1
Mixed - White and Black Caribbean	1
Asian or Asian British - Any other Asian background	1
Mixed - White and Asian	2
Black or Black British - Caribbean	2
Mixed - Any other mixed background	3
Asian or Asian British - Pakistani	5
White - Irish	5
Asian or Asian British - Indian	6
Not stated	7
White - Any other White background	21
Other Ethnic Groups - Any other ethnic group	61
Not Known	128
White - British	742
Grand Total	**986**

6.6 Death by Religion

Christianity is the highest recorded religion group with 216 recorded deaths, 562 deaths had no recorded religion assigned and 5 people refused to state their religion. The chart below outlines all religion groups.

Religion	Number of Deaths
(blank)	484
Mixed religion	1
Anglican	1
Catholic religion	1
Congregationalist religion	1
Spiritualist	1
Orthodox Christian religion	1
Islam	1
Pagan	1
Greek Orthodox	1
Protestant	1
Catholic: Not Roman Catholic	1
Quaker religion	1
Not stated	2
Religion NOS	2
Buddhist	2
Jehovah's Witness	2
Nonconformist	3
Muslim	3
Religion (other Not Listed)	3
Atheist	3
Sikh	3
Patient Religion Unknown	4
Not Given Patient Refused	5
None	5
Roman Catholic	11
Methodist	16
Church of England, follower of	41
Not Religious	48
Church Of England	54
Unknown	67
Christian	216
Grand Total	**986**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 166 recorded deaths. 685 have no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number of Deaths
(blank)	676
Gay Or Lesbian	1
Bi-Sexual	1
Homosexual	2
Not Stated (declined)	3
Not Appropriate To Ask	5
Sexual orientation not given - patient refused	8
Unknown	9
Heterosexual Or Straight	115
Heterosexual	166
Grand Total	**986**

6.8 Death by Disability

The table below details the top 5 categories by disability. Gross motor disability was the highest recorded disability group with 37 recorded deaths.

Disability	Number of Deaths
Physical disability	8
Mobility and gross motor	8
Behaviour and emotional	14
Intellectual functioning disability	26
Gross motor disability	37

There were a total of 170 deaths with a disability assigned and the remainder 816 were blank (had no assigned disability).

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.

- Community team Managers to review the current documentation processes for unforeseen absences and agree a standardisation method of documenting contact for all teams.

- 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.

- The Trust should ensure that robust processes are in place to ensure effective and appropriate transfer of patients from medical wards to mental health settings, this must include: Local agreement with neighbouring providers in relation to sharing clinical information Medical review and handover. Documentation within the electronic patient record, including assessment and acceptance of transfers as being medically fit. Mental Health Act assessment completion and documentation pre and post transfer.

- Systems to be in place to ensure there is continuity of care on transfer from services including a pathway which ensures safety reviews prior to discharge and input from all services involved in line with Trust Transfer and Discharge Policy and Procedure.

- Pathway to be developed for MASH Advisory Team in relation to sharing information with services.

- Development of suitable alternative community providers or emergency accommodation for service users with a learning disability leading to reduce admissions to acute psychiatric units.

- Bespoke resuscitation and medical emergency training to be delivered to staff in their clinical environment in order to ensure familiarity with local procedures and equipment through a model of simulation.

- Review the current psychological capacity and offer within acute mental health services.