Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 10 May 2022

Learning from Deaths - Mortality Annual 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 April 2021 to 25 March 2022.

Executive Summary

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 Datix 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 1 April 2021 to 25 March 2022 there have been seven deaths reported where the patient tested positive for COVID-19.
- The Trust received 1,981 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; 980 male deaths were reported compared to 1,001 females.
- Two inpatient deaths were recorded, three patients died whilst on leave from an inpatient ward
- The Mortality Review Group reviewed 77 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 77 deaths reviewed, none were due to problems in care.
- The Trust has reported 26 Learning Disability deaths in the reporting timeframe and death of one patient with a diagnosis of autism
- 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

Quality and Safeguarding Committee 12 April 2022.

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:

- 1 April 2021 to 25 March 2022 there is very little variation between male and female deaths; 980 male deaths were reported compared to 1,001 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

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Lead Professional for Patient Safety and Experience

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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 1 April 2021 to 25 March 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. 61 Case Note Review sessions were undertaken, where 77 incidents were reviewed. Unfortunately 34 sessions did not take place due to lack of medic availability and 7 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 18 March 2022.

- The monthly mortality review group meetings have resumed

- Due to 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 Datix red flags. All deaths reported through the Incident Reporting and Investigation Policy and Procedure (Datix) continue to be reviewed.

[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 1 April 2021 to 25 March 2022.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	144	144	154	174	168	174	145	175	191	214	153	145
LD Referral Deaths	3	2	1	0	3	4	1	2	3	4	3	0

Correct as of 30 March 2022

From 1 April 2021 to 25 March 2022, the Trust received 1981 death notifications of patients who have been in contact with our services.

Of these deaths 980 patients were male, 1001 female, 1494 were white British and 26 Asian/Asian British Pakistani. The youngest age was 0 years, the oldest age recorded was 102.

The Trust has reported 26 Learning Disability deaths in the reporting timeframe and death of one patient with a diagnosis of autism

4. Review of Deaths

Total number of Deaths from 1 April 2021 to 25 March 2022 reported on Datix	167 “Unexpected deaths”; 7 COVID deaths 38 “Suspected deaths” 14 “Expected - end of life pathway”) NB some expected deaths have been rejected so these incidents are not included in the above figure 2 inpatient deaths 3 patients died whilst on leave from an acute inpatient ward
Incidents assigned for a review	176 incidents assigned to the operational incident group 5 did not meet the requirement 9 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.
- *Death of a patient with Autism*
- *Death of a patients who had a diagnosis of psychosis within the last episode of care*

The last two red flags have been added to ensure that the Trust meets the Learning from Deaths guidance and recent changes to the LEDER reporting requiement of patients who have a diagnosis of autism.

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 24 June 2020 these locally defined red flags were:

- 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 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 the 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 was required.

The red flags identified within the Care Review Tool were already met under the Trust Incident review process with the exception of psychosis within the last episode of care which has now been added as a Datix red flag.

The mandatory Flags for review under the Royal College of Psychiatrists Care Review Tool for mortality reviews 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 in-patient 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.

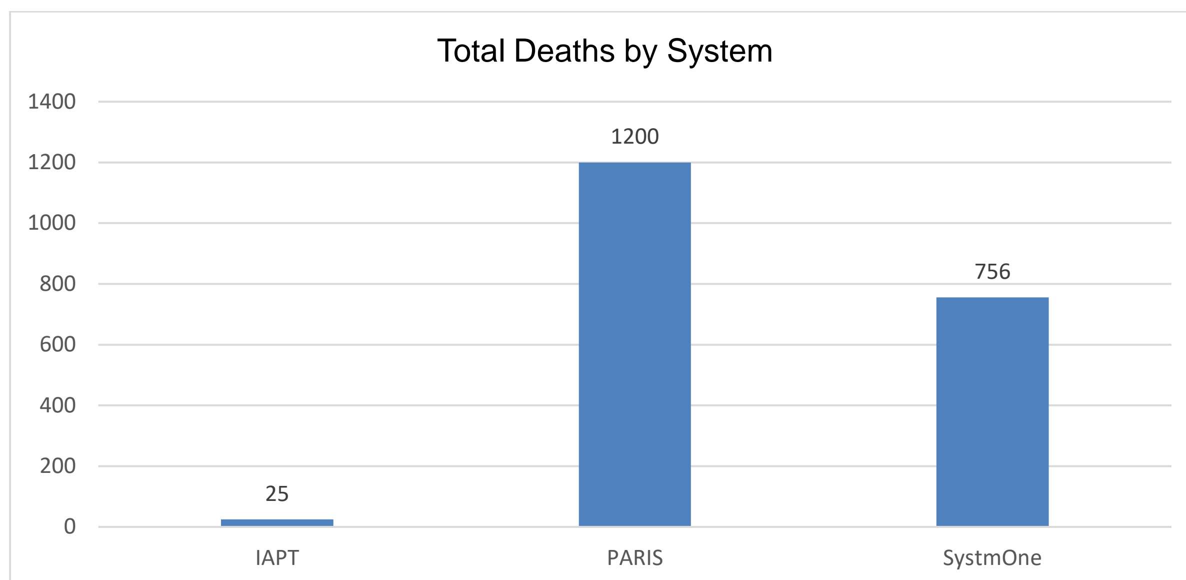
Those patient deaths which meet these ‘red flag’ criteria above should be subject to a review process if they are not already under the Incident process. At the stage of determining if a death meets the criteria for reporting as an incident, teams are required to review all deaths against the Trust Incident ‘Red Flags’.

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 Electronic Patient 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 1 April 2021 to 25 March 2022, the Mortality Review Group reviewed 77 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 77 deaths reviewed, 0 were not due to problems in care. Unfortunately, 34 sessions did not take place due to lack of medic availability and 7 sessions did not take place due to nurse availability. Unavailability of medics to attend these meetings remains a recurring problem.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2021 to 25 March 2022



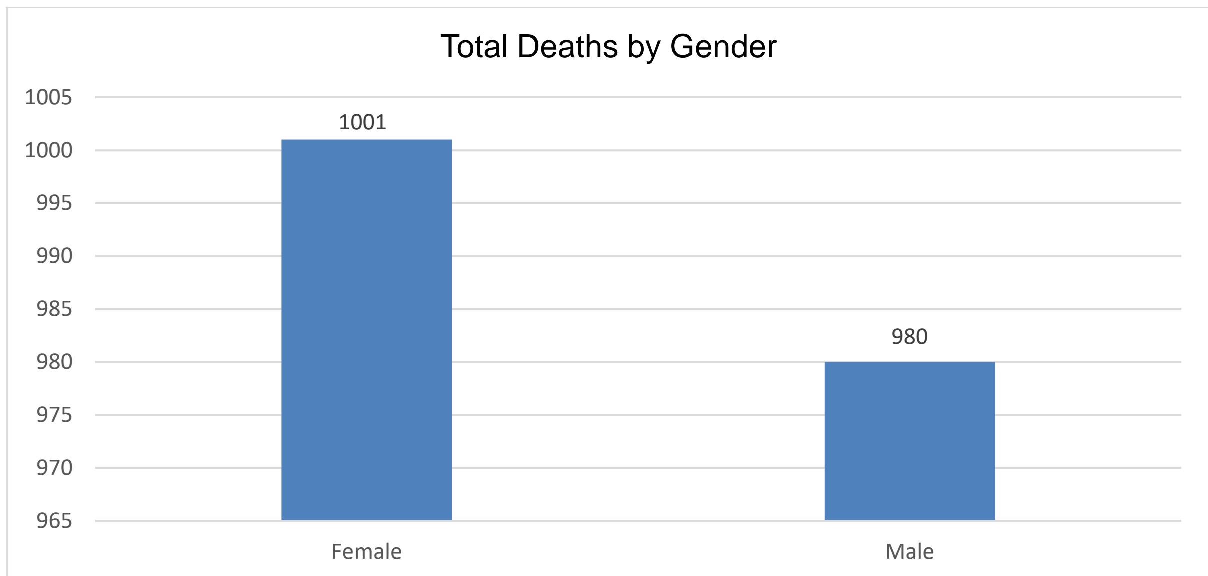
System	Number of Deaths
IAPT	25
SystmOne	756
PARIS	1200
Grand Total	**1981**

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.

From the 1 April 2021 to 25 March 2022 there have been 7 deaths reported where the patient tested positive for COVID-19. Of these deaths 6 patients were male and 1 female. 5 males and 1 female were from a White British background and 1 male was from a British Pakistani background.

6.2 Deaths by Gender

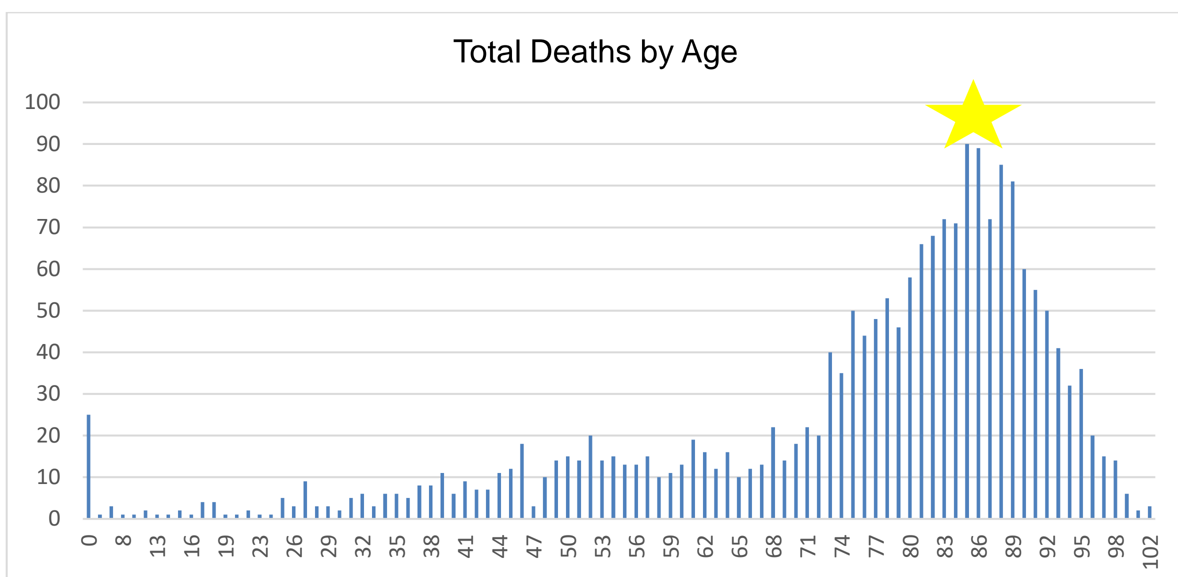
The data below shows the total number of deaths by gender 1 April 2021 to 25 March 2022. There is very little variation between male and female deaths; 1001 female deaths were reported compared to 980 males.



Gender	Number of Deaths
Male	980
Female	1001
Grand Total	**1981**

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 85 to 89 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LD Deaths	3	2	1	0	3	4	1	2	3	4	3	0
Autism	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	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. Following a meeting with the Commissioning Manager for Learning Disabilities and Autism, further information has been made available, 13 patients who were referred for LeDer have had reviews and feedback has been made available. This will be shared with the teams and in the Mortality Review Group.

From 1 January 2022 the Trust has been required to report any death of a patient with autism to date one patient has been referred.

During 1 April 2021 to 25 March 2022, the Trust has recorded 26 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 1,494 recorded deaths, 255 deaths had no recorded ethnicity assigned, and 15 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
Asian or Asian British - any other Asian background	1
British	1
Mixed - White and Black African	1
Any other Black background	1
Indian	2
Mixed - White and Asian	2
Mixed - White and Black Caribbean	3
Black or Black British - African	4
Black or Black British - Caribbean	6
Mixed - any other mixed background	8
Asian or Asian British - Pakistani	11
Asian or Asian British - Indian	11
Not stated	15
White - Irish	15
White - any other White background	45
Other Ethnic Groups - any other ethnic group	104
Not known	255
White - British	1494
Grand Total	**1981**

6.6 Death by Religion

Christianity is the highest recorded religion group with 414 recorded deaths, 1097 deaths had no recorded religion assigned and 12 people refused to state their religion. The chart below outlines all religion groups.

Religion	Number of Deaths
Jewish	1
Anglican	1
Mixed religion	1
Humanist	1
Quaker religion	1
Islam	1
Christian Scientist religious	1
Not religious - old code	1
Spiritualist	1
Orthodox Christian religion	1
Congregationalist religion	1
Pagan	1
Catholic religion	1
Protestant	1
Hindu	2
Greek Orthodox	2
Atheist movement	2
Christian religion	2
Church of Scotland	2
Baptist	3
Not stated	3
Religion NOS	3
Buddhist	3
Atheist	4
Jehovah's Witness	4
Nonconformist	5
Catholic: not Roman Catholic	5
Sikh	5
Patient religion unknown	6
Religion (other Not Listed)	6
None	7
Muslim	8
Not given patient refused	12
Methodist	21
Roman Catholic	29
Church of England, follower of	59
Not religious	112
Unknown	141
Church of England	151
Christian	414
Blank	956
Grand Total	**1981**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 586 recorded deaths. 1,334 have no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number of Deaths
Person asked and does not know	1
Sexual orientation unknown	1
Person declined to disclose	1
Bi-sexual	2
Homosexual	2
Gay or lesbian	4
Not appropriate to ask	10
Sexual orientation not given - patient refused	10
Not stated (declined)	14
Unknown	16
Heterosexual	279
Heterosexual or straight	307
(blank)	1334
Grand Total	**1981**

6.8 Death by Disability

The table below details the top 6 categories by disability. Gross motor disability was the highest recorded disability group with 63 recorded deaths.

Disability	Number of Deaths
Learning Disability	16
Other	18
Physical Disability	19
Behaviour and Emotional	35
Intellectual Functioning Disability	43
Gross Motor Disability	63

There were a total of 377 deaths with a disability assigned and the remainder 1604 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.

- Pathway development in relation to the Crisis team and Hope and Resilience hub to improve discharge, information sharing and communication.

- The transition of the electronic patient record system from PARIS to SystmOne should be supported by: Clinical standards for risk assessment, formulation and mitigation. A Standard Operating Procedure to demonstrate how these standards should be applied and recorded in practice. A training package to inform and support staff in the application of these standards in practice. A single, accessible place on the EPR in which the assessment, formulation and mitigation of risk is recorded. A corresponding governance process.

- To develop guidance and procedure for managing the transfer of patients from Acute hospitals to Mental Health hospitals who are physically unwell through the review of the Trust Discharge Transitions Transfers and Leave Policy.

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

- A learning event to be undertaken to support and enhance medic knowledge and learning in relation to hyponatraemia. This event should be undertaken jointly with an Endocrinologist and be presented through the current Doctors training programme.

- The Trust to develop a process with partner agency (Social Care) for multi-disciplinary meetings to be held more frequently between services when patients have moved to new residential placement to ensure the care provider and patient has effective support during this transition.