Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 March 2023

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 1 October to 31 December 2022.

Executive Summary

- All deaths directly relating to Covid-19 are reviewed through the Learning from Deaths procedure unless they meet an additional Incident red flag in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. From 1 October to 31 December 2022 there has been zero deaths reported where the patient tested positive for Covid-19.
- The Trust received 643 death notifications of patients who had been in contact with our service within the 6 months prior to their death. There is little variation between male and female deaths; 309 male deaths were reported compared to 334 females.
- No Inpatient deaths were recorded.
- The Mortality Review Group reviewed 12 deaths through a Stage 2 Royal College of Psychiatrists Care Review Tool. These reviews were undertaken by a multi-disciplinary team, of the 12 deaths reviewed none were due to problems in care. There has been a total of 24 meetings scheduled for the period, 12 of these were attended, 12 sessions were not able to proceed due issues affecting attendance.
- The Trust has reported 5 Learning Disability deaths in the reporting timeframe and no patients with a diagnosis of Autism Spectrum Disorder (ASD).
- Discussions with the Regional Medical Examiners have taken place to discuss the successful implementation of the Medical Examiner process within our Trust. It was hoped this process would commence on 1 February 2023 however technical delays within the Acute service have resulted in a delay till 1 March 2023.
- Good practice identified through case record reviews is fed back to clinicians involved as part of our appreciative learning.
- The Patient Safety Team are currently reviewing themes and recommendations from investigations to support better dissemination of 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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	

Assurances

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

- The Quality and Safeguarding Committee received significant assurance from the report on 14 February 2023.

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 October to 31 December 2022. There is very little variation between male and female deaths; 309 male deaths were reported compared to 334 females.
- 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 considered by the Trust Board of Directors and then 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 Technicians

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 the required guidelines. This report presents the data for 1 October to 31 December 2022.

2. Current Position and Progress (including Covid-19 related reviews)

- Meetings with the Chesterfield Royal Hospital and University Hospital of Derby and Burton Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. The standard operating procedure is under review for agreement. It was hoped a go live date of 1 February would be achievable however due to delays in the development of systems for accessing patient records for the Acute this has been extended to 1 March 2023. Medical Examiners will then be able to commence reviewing the Trusts non-coronial deaths.

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. Whilst access to this information is expected to improve through engagement of the Medical Examiners on non-coronial deaths cause of death will remain an issue for those deaths reported through DATIX.

- During 1 October to 31 December 2022 12 Case Record Review sessions have been undertaken in relation to deaths which meet the incident criteria. Unfortunately, 12 sessions did not take place due to lack of medic availability.

- The mortality team have now received a new schedule outlining the medics who will be attending Case Record Review sessions in 2023 for both North and South consultants. Meeting invites for 2023 have now been set up and sent to all consultants involved.

- 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 December 2022.

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

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 August to 31 December 2022.

	October	November	December
Total Deaths Per Month	228	176	239
LD Referral Deaths	3	1	1
Inpatient Deaths	0	0	0

Correct as of 16 January 2023

309 patients were male, 334 were female, of these 477 were white British, 103 were any other ethnic group and 27 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 104. From 1 October to 31 December 2022, the Trust received 643 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Only deaths which meet Trust Red Flags are reported through the Trust incident reporting system (Datix) and are reviewed through the Untoward Incident Reporting and Investigation Process. These Red Flags apply to any patient open to services within the last six months prior to their death.

- COVID – 19 suspected or confirmed death of an open patient (6 month rule not applicable)
- Homicide – perpetrator or victim. (This criterion only relates to patients open to services within the last 6 months)
- Domestic homicide - perpetrator or victim (This criterion relates to patients open to services within the last 6 months)
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatients 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 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/ombudsman, or staff have raised a significant concern about the quality of care provision
- Death of a child (and will likely 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 patient 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
- Psychosis within the last episode of care
- Autism

Total number of Deaths from 1 October to 31 December 2022 reported on Datix	64 "Unexpected deaths" 0 Covid-19 deaths 4 "Suspected deaths" 8 "Expected - end of life pathway" NB some expected deaths have been rejected so these incidents are not included in the above figure 0 Inpatients deaths
Incidents assigned for a review	58 incidents assigned to the operational incident group 0 did not meet the requirement 0 incident is to be confirmed

5. Learning from Deaths Procedure

The mortality team review all applicable non DATIX reported deaths against the Trust red flags and those outlined in the Royal College of Psychiatrists Care Review Tool. All non DATIX deaths including community deaths are reviewed to ascertain if they meet the Trust red flags. Those patient deaths which meet these 'red flag' criteria are DATIX reported and subject to the Trust internal incident review 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'. Previously under mortality the Trust was reviewing community deaths against locally defined flags in addition to what is required but had over committed its resources in this area and a redesign of the process was undertaken as learning was limited from these reviews.

The form based on section one of the Royal College of Psychiatrists Care Review Tool for mortality reviews has now been prepared for utilisation within the EPR. The go live date for this was expected 1 February 2023 however has been delayed till 1 March 2023 to allow for greater communication with Operational colleagues. 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.

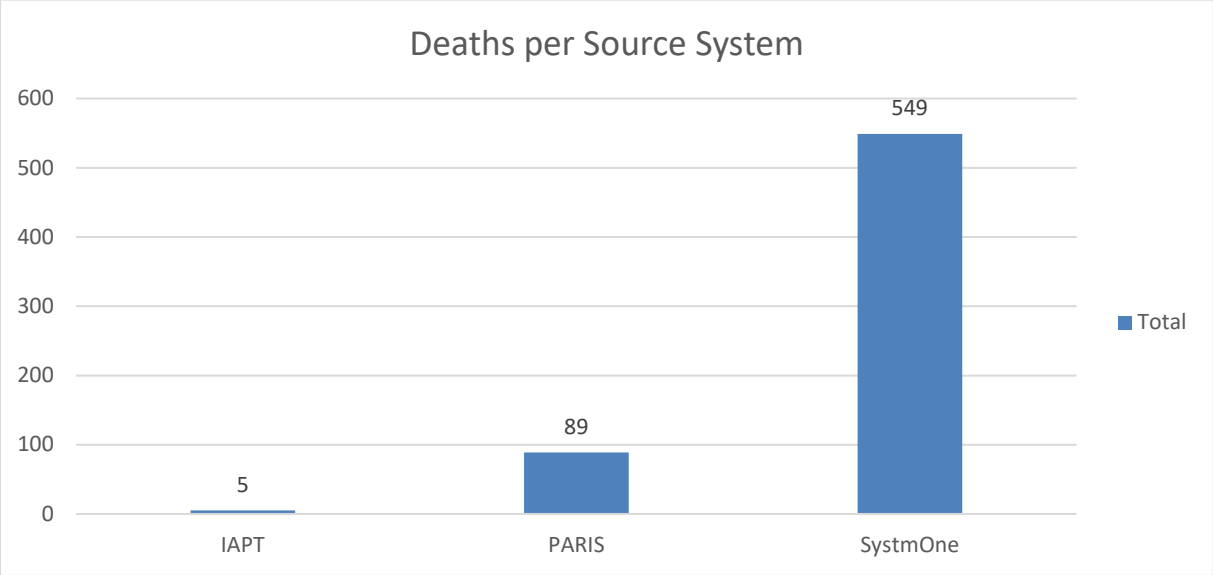
For the period 1 October to 31 December 2022, the Mortality Review Group reviewed 12 deaths through a Stage 2 Case Record Review. These reviews were undertaken by a multi-disciplinary team, and it was established that of the 12 deaths reviewed, none were due to problems in care.

From the 1 October to 31 December 2022 there has been no deaths reported where the patient tested positive for Covid-19.

Head of Clinical Quality from NHS Derby and Derbyshire Integrated Care Board / Joined Up Care Derbyshire was invited by the Lead Professional for Patient Safety/Experience to undertake an independent review of the Trust Incident Process to ascertain if any improvements could be made. No actions were required and there was satisfaction that the Trust had robust systems in place for monitoring incidents.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 October to 31 December 2022

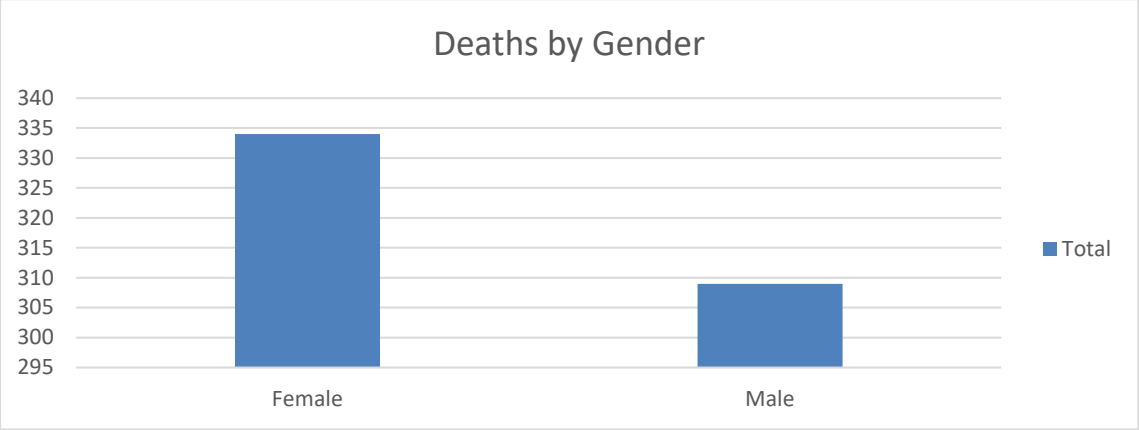


System	Number of Deaths
IAPT	5
PARIS	89
SystmOne	549
Grand Total	**643**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were pulled from SystmOne. 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. The Trust has now moved to one EPR and future reports will no longer provide this information.

6.2 Deaths by Gender

The data below shows the total number of deaths by gender for 1 October to 31 December 2022

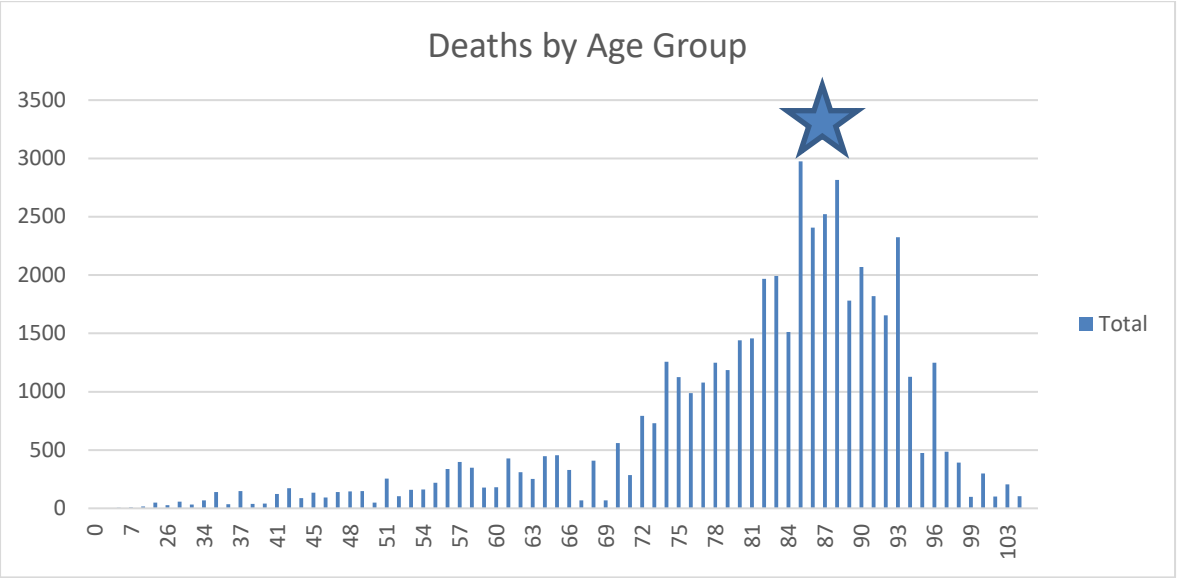


Gender	Number of Deaths
Female	334
Male	309
Grand Total	**643**

There is very little variation between male and female deaths; 309 male deaths were reported compared to 334 females.

6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 104 years. Most deaths occurred within the 85-88 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	August	September	December
LD Deaths	3	1	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.

During 1 October to 31 December 2022, the Trust has recorded five 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.

The Trust also is required from 1 January 2022 to report deaths of patients who have a diagnosis of Autism Spectrum Disorder (ASD) for this reporting period the Trust has reported no deaths.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 477 recorded deaths, 27 deaths had no recorded ethnicity assigned, and 12 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count of Ethnicity
Black or Black British - Caribbean	1
Black or Black British - African	1
Asian or Asian British - Indian	1
Asian or Asian British - Any other Asian background	1
Black or Black British - Any other Black background	2
White - Irish	3
Asian or Asian British - Pakistani	5
White - Any other White background	10
Not stated	12
Not Known	27
Other Ethnic Groups - Any other ethnic group	103
White - British	477
Grand Total	**643**

6.6 Death by Religion

Christianity is the highest recorded religion group with 308 recorded deaths, 248 deaths were (blank) with no recorded religion assigned. The table below outlines all religious groups.

Religion	Count of Religion
Sikh	1
Anglican	1
Pentecostalist	1
Catholic religion	1
Catholic: Not Roman Catholic	2
Atheist	2
Not Given Patient Refused	2
Christian religion	2
Patient Religion Unknown	2
Religion NOS	2
Jehovah's Witness	3
Agnostic	3
Muslim	4
Not Religious	6
Methodist	7
Roman Catholic	8
Church of England, follower of	41
Unknown	248
Christian	308
Grand Total	**643**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 331 recorded deaths. 293 had no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Count of Sexual Orientation
Male homosexual	1
Not Appropriate To Ask	1
Bisexual	1
Female homosexual	1
Homosexuality NOS	1
Sexual orientation not given - patient refused	14
Unknown	293
Heterosexual Or Straight	331
Grand Total	**643**

6.8 Death by Disability

The table below details the top five categories by disability. Gross motor disability was the highest recorded disability group with 103 recorded deaths.

Disability	Count of Disability
Walking disability	2
Physical disability	2
Learning Disability	2
Emotional behaviour disability	13
Hearing disability	17
Intellectual functioning disability	34
Gross motor disability	103
Grand Total	**173**

There was a total of 186 deaths with a disability assigned and the remainder 457 were blank (had no assigned disability).

7. Medical Examiners

Medical Examiner officers have been established at all Acute Trusts in England. The role of these officers is now being extended to also cover deaths occurring in the community, including at NHS Mental Health and Community Trusts. Medical Examiners are to provide independent scrutiny of deaths not taken at the outset for Coroner investigation. They will carry out a proportionate review of medical records and give families and next of kin an opportunity to ask questions and raise concerns. This process will inform learning to improve care for future patients, or, in a smaller number of cases, may be referred to others for further review. Their involvement will also provide reassurance to the bereaved.

Overall Medical Examiners will seek to answer the following three questions:

- What caused the death of the deceased?
- Does the coroner need to be notified of the death?
- Was the care before death appropriate?

Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure is currently under review for agreement and plans were in place for a go live date of 1 February 2023. Due to difficulties for the Acute in accessing multiple system types and records the implementation date has been moved back to 1 March 2023. By 1 March 2023 the Acute will have been able to finalise a system which supports Medical Examiner direct EPR access and reviews into the Trust non-coronial deaths will commence.

8. Recommendations and Learning

The Trust senior Mortality review group is currently undergoing a revision and will become more focussed on the process of embedding learning from all incidents and supporting operational teams around the review process for non-red flag deaths. The Patient Safety Team is currently mapping out how this group will work with others under development.

Improvement issue	Actions required update
Transfer of the deteriorating patient	Internal investigations have highlighted themes regarding the transfer and return of patients between inpatient services for the Trust and Acute providers such as Chesterfield Royal Hospital. This includes handover of information, and the way patients are conveyed. A quality improvement project is underway between Derby Hospital and DCHFT
Self-harm of patients whilst on leave from inpatient services	Investigations have highlighted issues in relation to adult inpatient leave arrangements including section 17 leave arrangements. A further thematic review has been completed on conclusion of current inpatient suspected suicide incidents active at present. An action plan has been developed. The Patient safety Team is leading on the coordination of the review of the current processes and quality improvement actions
MDT process improvements within CMHTs	Investigations have highlighted themes in relation to MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Falls prevention	Pockets of increased falls have been noted and currently there are pilots underway within Older Adult in patient service for the use of bed and chair sensors. A Trust Falls Group meets regularly to discuss improvements and themes
Family liaison and engagement	The package of support available to families involved in an internal investigation/ review has been identified as an area for improvement. This includes consistency of support, timeframes and establishing a pathway for escalation. Work is underway to develop an agreed package which will be offered and how this will be supported by the Trust.
Multi-agency engagement following incidents	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Relapse prevention and MDT resource management within Amber Valley Adult Community Mental Health Services	As a result of an internal investigation and concerns raised by staff a piece of work is being commissioned to consider themes in relation to the resource and function of the MDT process within the Amber Valley CMHT.
Integrated care services	Investigations have highlighted the need for improvements in the care pathway of patients open to more than one service. A conference will be held which will include representation from all service lines, Clinical Directors, Medical Director and Deputy Director of Nursing and Quality as well as incident investigation leads to review themes and devise a plan of action to enhance internal integrated care. This conference will also include external integrated care with providers such as Social Care.
Inappropriate admission to inpatient adult ward	Investigations into high profile incidents of inappropriate admissions to Adult Mental Health inpatient services brought to attention an on-going issue in this area. Review of lower grade incidents and discussions with the service line have confirmed a long-standing theme in this area. A review of inappropriate admissions is currently underway