Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 March 2024

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 September 2023 to 31 December 2023.

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 September to 31 December 2023 there has been one death reported where the patient tested positive for COVID-19.
- The Trust received 722 death notifications of patients who had been in contact with our services within the six months prior to their death. There is little variation between male and female deaths; 358 male deaths were reported compared to 364 females.
- Two inpatient deaths were recorded.
- The weekly Mortality Review Group meetings have been redesigned from direct case review to one of assurance and audit with plans in place to utilise this forum more effectively to review deaths closed at Incident Review Tool level and monitor compliance to Trust Red Flags.
- Learning the Lessons committee and service line subgroups are under development, the committee replaces the Trust Mortality Committee however was struggling to gain momentum therefore this has been re-designed to form an off shoot of the Trust Executive Incident review group on a monthly basis thus allowing for appropriate senior leadership and ownership.
- The Trust has reported eight Learning Disability deaths in the reporting timeframe and two patients with a diagnosis of Autism Spectrum Disorder (ASD).
- Medical Examiner officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community Trusts. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.
- 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 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.

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 September to 31 December 2023. There is very little variation between male and female deaths; 358 male deaths were reported compared to 364 females.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

This report was reviewed by the Quality and Safeguarding Committee, which met on 13 February 2024 and received significant assurance from this report.

We request the Board to note the contents and to approve the publication of the mortality statistics.

Report presented by: **Arun Chidambaram**
Medical Director

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

Louise Hamilton
Safer Care Coordinator

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. The report presents the data for 1 September to 31 December 2023.

2. Current Position and Progress (including COVID-19 Related Reviews)

- 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 will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by
  April 2023. However, due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

- Cause of death information is currently being sought through the Coroner's offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. It is hoped that this will improve once Medical Examiners commence the process of reviewing the Trust's non-coronial deaths.

- 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 22 January 2024.

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 September to 31 December 2023.

	September	October	November	December
Total Deaths Per Month	162	169	183	208
LD Referral Deaths	2	1	2	3
Inpatient Deaths	2	0	0	0

Correct as of 19 January 2024

358 patients were male, 364 were female, of these 542 were white British, 135 were any other ethnic group and 45 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 101.

From 1 September to 31 December 2023, the Trust received 722 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 1 September to 31 December 2023 reported on Datix	62 “Unexpected deaths” (includes 2 inpatient deaths) One COVID-19 deaths 19 “Suspected deaths” Nine “Expected - end of life pathway”. NB some expected deaths have been rejected so these incidents are not included in the above figure. Two Inpatients deaths
Incidents assigned for a review	73 incidents assigned to the operational incident group. 16 incidents assigned to the executive incident group. 0 did not meet the requirement. Two incidents to be confirmed

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:

- 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 patient who had a diagnosis of psychosis within the last episode of care.*

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

5. Learning from Deaths Procedure

The Trust has now completed the move of its mortality process which has been implemented within the patient Electronic Record, this aids staff in identifying deaths which meet the threshold for DATIX reporting.

This process fulfils stage one of the Learning from Deaths, in that all deaths are considered for Red Flags, as identified under the national Learning from Deaths procedure.

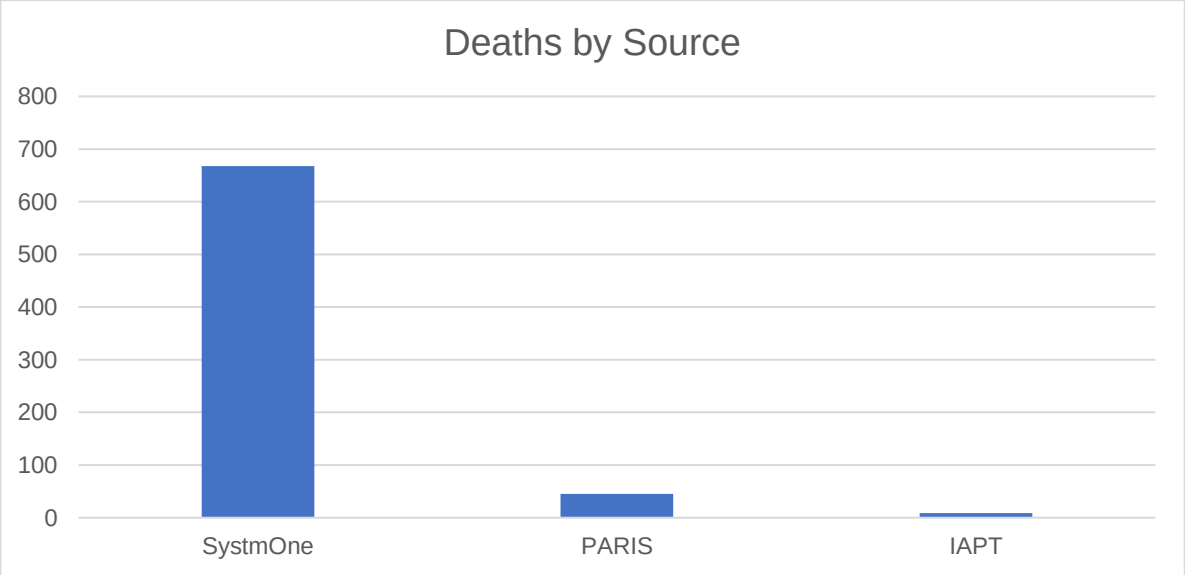
This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services.

The Mortality team is conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

From 1 September to 31 December 2023, there has been one death reported where the patient tested positive for COVID-19.

6. Analysis of Data

6.1 Analysis of Deaths per Notification System 1 September to 31 December 2023

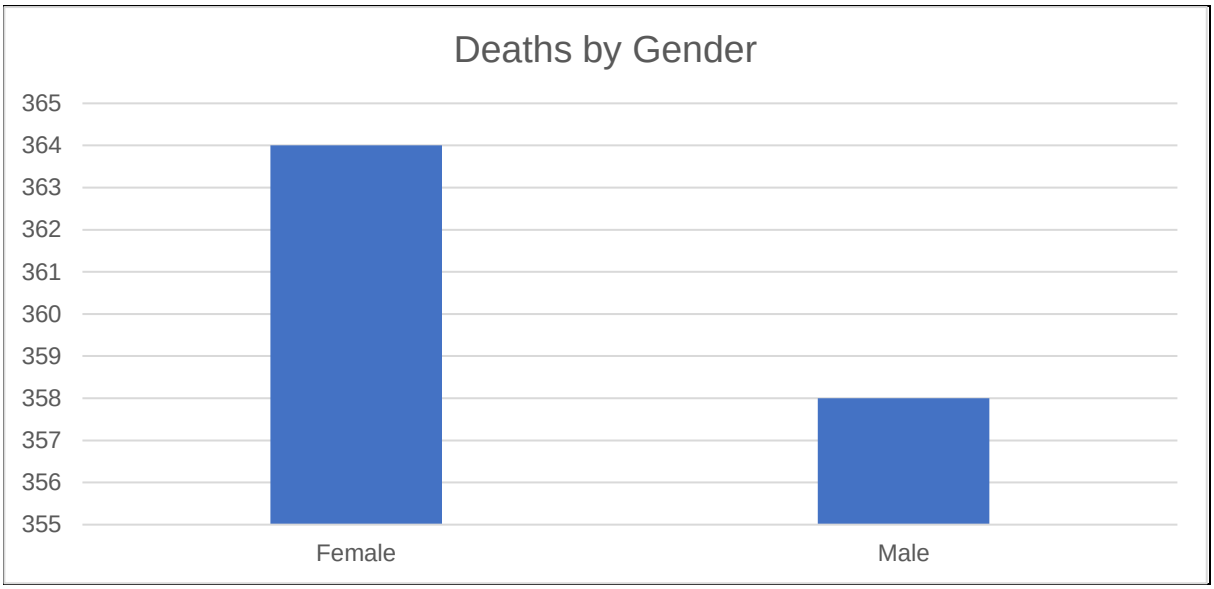


System	Number of Deaths
SystmOne	668
PARIS	45
IAPT	9
Grand Total	**722**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne which is not unexpected, given the Trust's move to one EPR.

6.2 Deaths by Gender

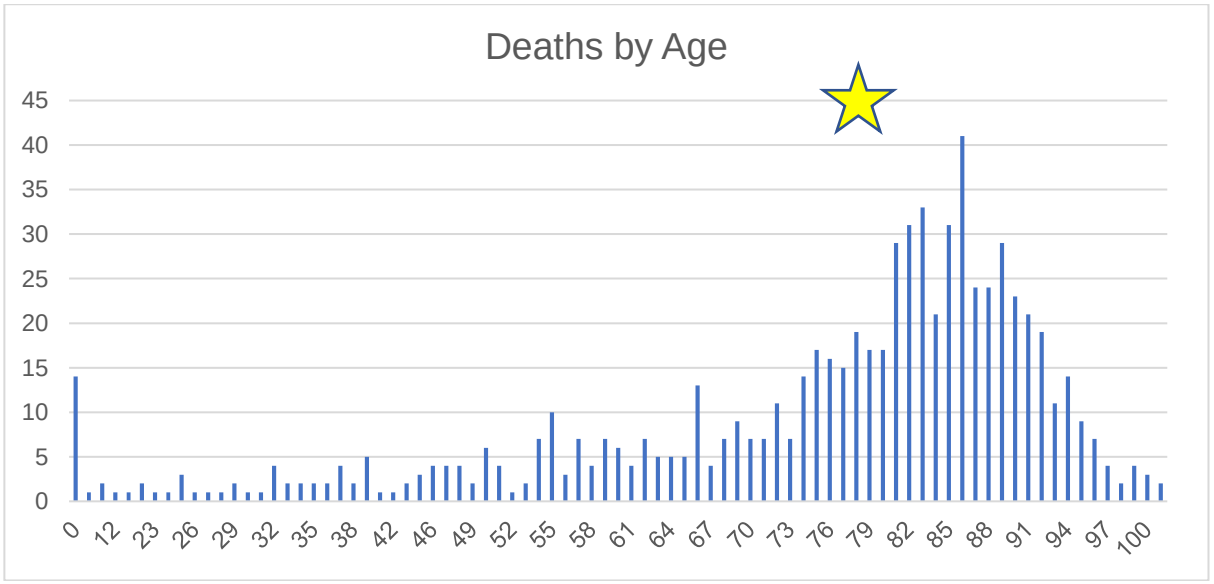
The data below shows the total number of deaths by gender for 1 September to 31 December 2023. There is very little variation between male and female deaths; 364 female deaths were reported compared to 358 males.



Gender	Number of Deaths
Male	358
Female	364
Grand Total	**722**

6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 101 years. Most deaths occurred within the 81-86 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	September	October	November	December
LD Deaths	2	1	2	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.

During 1 September to 31 December 2023, the Trust has recorded eight 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 Trust Executive Incident Review group. Plans are now in place to re-assign one meeting per month within this forum to be a dedicated Learning the Lessons Committee which will have oversight of the operational Learning the Lessons subgroups.

From 1 January 2022, the Trust is also required to report deaths of patients who have a diagnosis of Autism Spectrum Disorder (ASD). For this reporting period the Trust has reported two deaths.

Health Inequalities within the Adult Neurodevelopmental Division (ND)

As part of the neurodevelopmental transformation programme, there is a whole system approach to addressing health inequalities via the health inequality workstream, set up to identify key areas of improvement and work together to make whole system changes.

One of the key areas of improvement over the last year has been implementing actions taken from national reviews, primarily, The Oliver McGowan review and the Clive Treacey report, as well as the Stopping The Over-Medication of children and young People with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) work. This work has been highlighting the inequalities that people with learning disabilities and autistic people face in accessing health and social care, their experiences, and the outcomes. Through the workstream, we have developed action plans to ensure we are addressing these inequalities. Some of these actions include supporting the rollout of the mandatory Oliver McGowan training, improving reasonable adjustments, and implementing the STOMP/STAMP framework.

The ND health inequality workstream has developed a reasonable adjustments steering group. This group has been involved in initiatives such as the new NHS reasonable adjustment flag work. Alongside this, within DHcFT and DCHS ND, the new reasonable adjustment lead, Trainee ACP, has developed an 'easy read' champion programme. ND colleagues have been trained and equipped with skills and resources to improve written information across the division. This work directly supports health inequalities.

Another area of improvement has been around improving annual health checks (AHC) for people with a learning disability. This has included new data reporting on population statistics in relation to AHC within DHcFT, a codesigned quality improvement project looking at why people are not accessing annual health checks as well as scoping out existing programmes such as social prescribing as potential support mechanisms for improving AHCs.

Within DHcFT we have also been working on gathering baseline data intelligence through our own data hub and using NHS Model Hospital to establish better information on who is accessing our services which is informing action plans.

Recognising that people with LD/A often experience health inequalities within health inequalities and underpinned by the 'We Deserve Better' report, the health inequality workstream has begun to map out the different strands of work happening across the system, specifically around health inequalities for ethnic minority groups.

The health facilitation team have been building links with the BAME networks within Derbyshire and Derby Health Inequality Partnership (DHIP), a co-led and a joint initiative between Derby City Council (Public Health) and Community Action Derby with a view to working alongside these groups to understand our population better and develop strong links to improve our services.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 542 recorded deaths, 39 deaths had no recorded ethnicity assigned, and 6 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
White - British	542
Other Ethnic Groups - Any other ethnic group	110

Not Known	39
White - Any other White background	8
Not stated	6
Asian or Asian British - Indian	4
White - Irish	4
Black or Black British - Caribbean	2
Asian or Asian British - Pakistani	2
Black or Black British - Any other Black background	1
Mixed - White and Black Caribbean	1
Mixed - White and Asian	1
Asian or Asian British - Bangladeshi	1
Mixed - White and Black African	1
Grand Total	**722**

6.6 Death by Religion

Christianity is the highest recorded religion group with 324 recorded deaths, 280 deaths were (blank) with no recorded religion assigned. The table below outlines all religious groups.

Religion	**Number of Deaths**
Christian	324
(blank)	280
Church of England, follower of	33
Church of England	15
Roman Catholic	8
Not Religious	6
Christian religion	6
Atheist movement	5
Methodist	5
Christian, follower of religion	4
Agnostic	4
Religion NOS	4
Sikh	3
Catholic religion	3
Jehovah's Witness	3
Unknown	3
Buddhist	2
Patient religion unknown	2
Muslim	2
Not Given Patient Refused	2
Pentecostalist	1
Sikh religion	1
Nonconformist religion	1
Protestant	1
None	1
Jewish	1
Baptist	1
Atheist	1
Grand Total	**722**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 458 (444+14) recorded deaths. 246 (245+1) had no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	444
(blank)	245
Heterosexual Or Straight	14
Sexual orientation not given - patient refused	12
Sexual orientation unknown	3
Bisexual	3
Unknown	1
Grand Total	**722**

6.8 Death by Disability

The table below details the categories by disability. Gross motor disability was the highest recorded disability group with 136 recorded deaths.

Disability	Number of Deaths
(Blank)	437
Gross Motor Disability	136
Intellectual Functioning Disability	50
Patient Reports No Current Disability	43
Hearing Disability	21
Emotional Behaviour Disability	17
Physical Disability	5
Learning Disability	2
Registered Disabled	1
Dementia; Other	1
Walking Disability	1
Behaviour And Emotional; Learning Disability (Dementia); Learning Disability (Dementia); Other; Self Care and Continence	1
Progressive (Lt) Conditions; Other; Mobility and Gross Motor; Other; Other	1
Mobility And Gross Motor	1
Sight	1
Other; Other	1
Fine Motor Disability	1
Hearing; Sight	1
Learning Disability (Dementia); Learning Disability (Dementia)	1
Grand Total	**722**

There was a total of 285 deaths with a disability assigned and the remainder 437 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 offices 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 will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by April 2023. However, due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

8. Recommendations and Learning

Changes have been implemented within the DATIX system to support early identification of themes and learning from incidents which are not taken to further Patient Safety learning review, this information will be fed into Learning the Lessons subgroups alongside themes and recommendations from Learning Reviews to support the development of Quality Improvement programmes.

A review of the Trust Mortality Committee showed that it was no longer performing as intended, following enhancements to the mortality and incident process to better align the two, that the meeting was surplus. Therefore, it has been dissolved and has been replaced with a monthly Learning the Lessons Committee, to oversee the works of the operational service line Learning the Lessons subgroups, which will be the working forums for sharing learning, quality improvement plans and actioning the implementation of actions following Learning Reviews. This work is currently in its infancy and Patient Safety will be working with service lines for a period of six months to support establishment. Current themes within the system remain unchanged however we expect this information will evolve over the coming 18 months.

Improvement Issue	Update on Actions Required
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 printable handover document is now available in SystmOne, changes to the ward handover document has been completed.
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 reviewed and changes made. This includes consistency of support, timeframes and establishing a pathway for escalation.
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, the 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.