Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 October 2018

Learning from Deaths - Mortality Report

Purpose of Report

To meet the requirements set out in the 'National Guidance on Learning from Deaths[1]' which outlines that the Trust is required to collect and publish on a quarterly basis specified information on deaths.

Executive Summary

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - *'National Guidance on Learning from Deaths'*. The purpose of the framework is to introduce a more standardized approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning

Progress to date includes:

- Since April 2017 the Trust has received 3314 death notifications of patients who have been in contact with our service.
- From 1 April 2017 to 31 August 2018, 297 deaths were reported through the Trust incident reporting system (Datix). Of these, 286 were reviewed through the process of the Untoward Incident Reporting and Investigation Policy and Procedure of which 92 warranted a further investigation. 193 reported incidents were closed by the Serious Incident Group.
- The Trust has recorded 18 inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.
- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome. This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements.
- 75 deaths have been reviewed through the Learning from Deaths Procedure
- 286 deaths have been reviewed under the Untoward Incident Reporting Policy and Procedure
- It is not possible with present resources to investigate or (case note) review all deaths. The “red flag” sampling method for mortality (case note) reviews is providing assurance through a lack of concern – no untoward issues have been identified in the 70+ reviews conducted so far. This has been agreed, by the Board, as a proportionate use of clinical and administrative resources. The lack of progress with NHS Digital to access the Cause of Death in all

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

cases is frustrating and has been raised by the Medical director at national meetings. Apparently the issue is under consideration. Likewise the decision not to involve or inform families of mortality (case note reviews) was endorsed by the Board. Contacting families so long after a death would be likely to cause alarm and distress. If anything untoward was to be found a full SI investigation would be triggered and families informed and involved at that stage.

Challenges include:

- Undertaking a case note review of all deaths as outlined in the national guidance, within available time. The Trust approach and its limitations are described above. We do not appear to be an outlier with this approach but there is great variability across the country
- Delay in obtaining cause of death
- Medical colleague availability to undertake case note reviews- this has been escalated to the Executive Leadership Team
- The sensitivity of our incident recording system means that the total numbers of deaths are potentially higher than comparable trusts.

Strategic Considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	x
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	
4) We will **transform** services to achieve long-term financial sustainability.	

Assurances

- Our approach to ensuring that we're meeting the guidance supports Board Assurance risks. Failure to achieve the clinical quality standards required by our regulators with regards to learning from deaths may lead to harm to service users
- This report provides assurance that the Trust is following recommendations outlined in the National Guidance on learning from Deaths – *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*

Consultation

Deputy Director of Nursing and Quality Governance and Medical Director

Governance or Legal Issues

There are no legal issues arising from this Board report.

The Care Quality Commission Regulations this report provides assurance to are 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
- Regulation 20 Duty of Candour

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

We are making an assertive effort to ensure that there is attendance from the multi-disciplinary team to attend Case Note Reviews to ensure quoracy. This is being monitored through the Mortality Review Group and Executive Serious Incident Group

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of our approach, and agree for it to be published on the Trust website prior to end of October 2018, as per national guidance.

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

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

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Mortality Technician & Legal Services Support

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 new national framework for NHS Trusts - 'National Guidance on Learning from Deaths[2]'. The purpose of the new 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.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish every quarter specified information on deaths. This is through a paper and Board item to a public Board meeting in each quarter, to set out the Trust's policy and approach (by end of Q2) 2017-2018 and publication of the data and learning points by Quarter 3 2017/18. The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subject to review, we are asked to consider how many of these deaths were judged more likely than not to have been due to problems in care.

The report presents the data so far from April 2017 incorporating new data for the periods June, July and August 2018.

2. Current position and progress

- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome .This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements.

- The Mortality Review Group continues to undertake regular case note reviews however medic availability remains a challenge.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure.

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

3. Data Summary of all deaths

Month	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Total Deaths Per Month	198	211	230	182	198	195	182	166	230	260	204	225	175	193	147	194	124
Inpatient Deaths	0	2	0	4	0	1	0	1	1	1	3	1	1	0	2	1	0
LD Referral Deaths	2	1	1	3	3	4	0	5	4	4	3	3	2	4	0	6	4
CDOP ** deaths	4	4	6	9	11	6	5	3	5	9	5	4	7	10	6	1	5

Correct as at 31.08.18

* *Learning Disabilities*

** *Child Death Overview Panel*

Since April 2017 the Trust has received 3314 death notifications of patients who have been in contact with our service. The figure elsewhere in this paper (4,078) is for all deaths from 1 January 2017. Initially, the Trust recorded all deaths of patients who had contact within the last 12 months but this was changed after discussion with Commissioners to contact within the last six months. This took effect from 20 October 2017.

4. Review of Deaths

Total number of Deaths from 1 April 2017 – 31 August 2018 reported on Datix?	297 (of which 20 are reported as "Unexpected deaths")
Number reviewed through the Serious Incident Group	286 (1 was not reviewed by Serious Incident Group and 10 pending for a review).
Number investigated by the Serious Incident Group	92 (205 did not require an investigation)
Number of Serious Incidents closed by the Serious Incident Group	193 (104 currently opened to Serious Incident Group, as at31 August 2018)

The Trust has recorded 18 inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.

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

As of 31 August 2018 the Trust currently had 78 deaths to review under the Learning from Deaths Procedure that meet the criteria defined below. The Mortality Review Group has currently case reviewed 75 deaths. These reviews were undertaken by a multi-disciplinary team and it established that of the 75 deaths reviewed, 68 have been classed as unavoidable and 7 are on hold pending cause of death.

The Mortality Review Group is currently reviewing deaths of patients who fall under the following 'red flags', these categories will change during September 2018:

- Patient on end of life pathway, subject to palliative care
- Patient prescribed anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

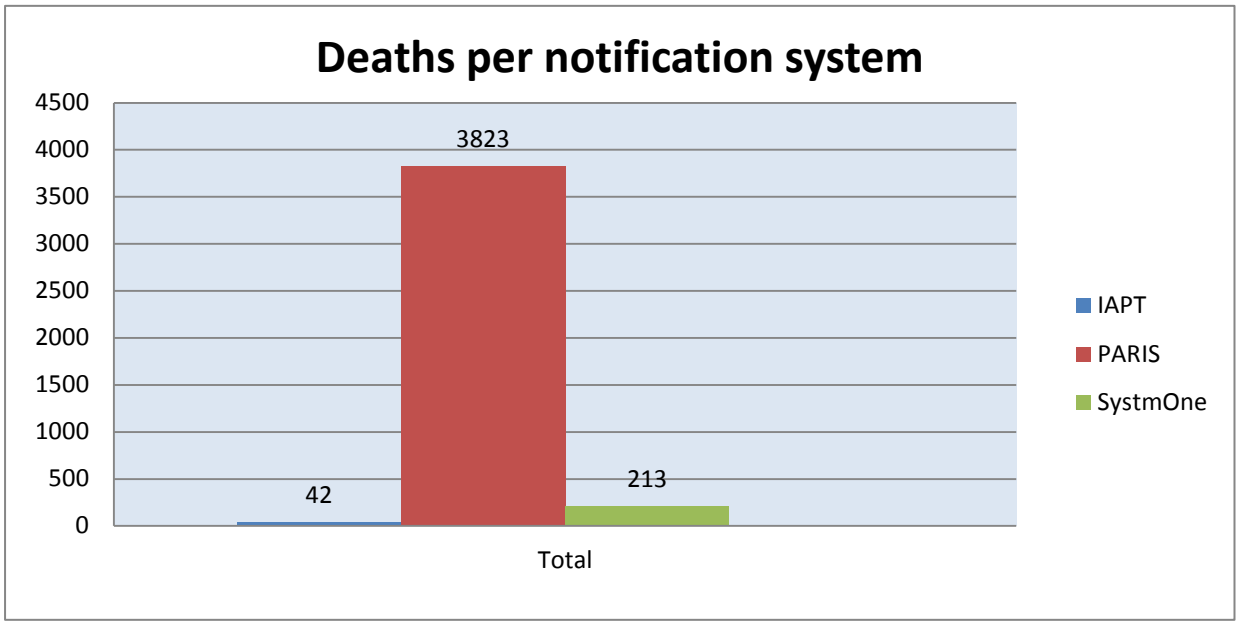
Initial analysis of death notification information shows the most prevalent causes of death are:

- Alzheimer's Dementia / Vascular Dementia
- Old Age
- Ischaemic Heart Disease

Undertaking Case Note Reviews of deaths remains a challenge due to lack of medical colleague availability. This lack of availability has resulted in a 28 Case Note Review meetings being cancelled.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 January 2017

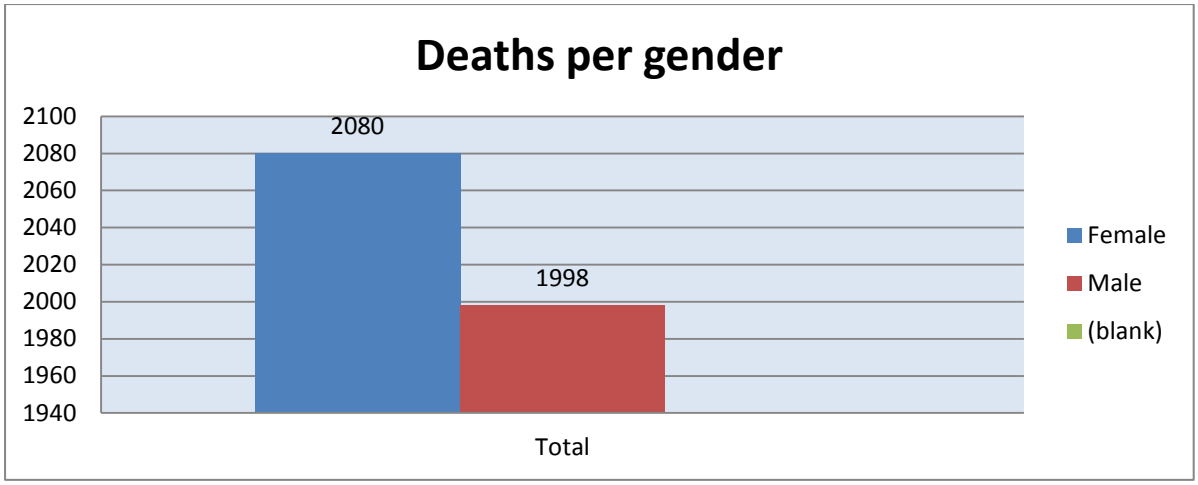


	IAPT	PARIS	SystmOne	Grand Total
Count of Source System	**42**	**3823**	**213**	**4078**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS, as we would expect as 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. 213 death notifications were pulled from SystmOne and 42 from IAPT.

6.2 Deaths by gender since 1 January 2017

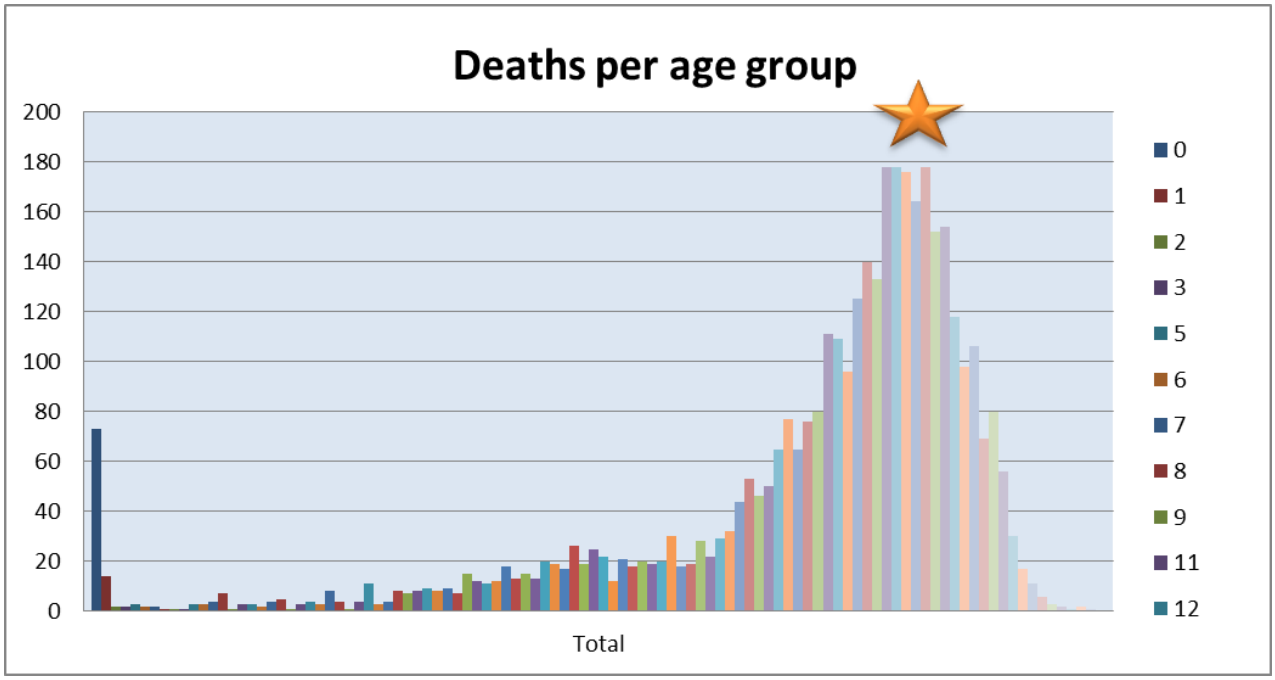
The data below shows the total number of deaths by gender since 1 January 2017. There is very little variation between male and female deaths; 1998 male deaths were reported compared to 2080 female.



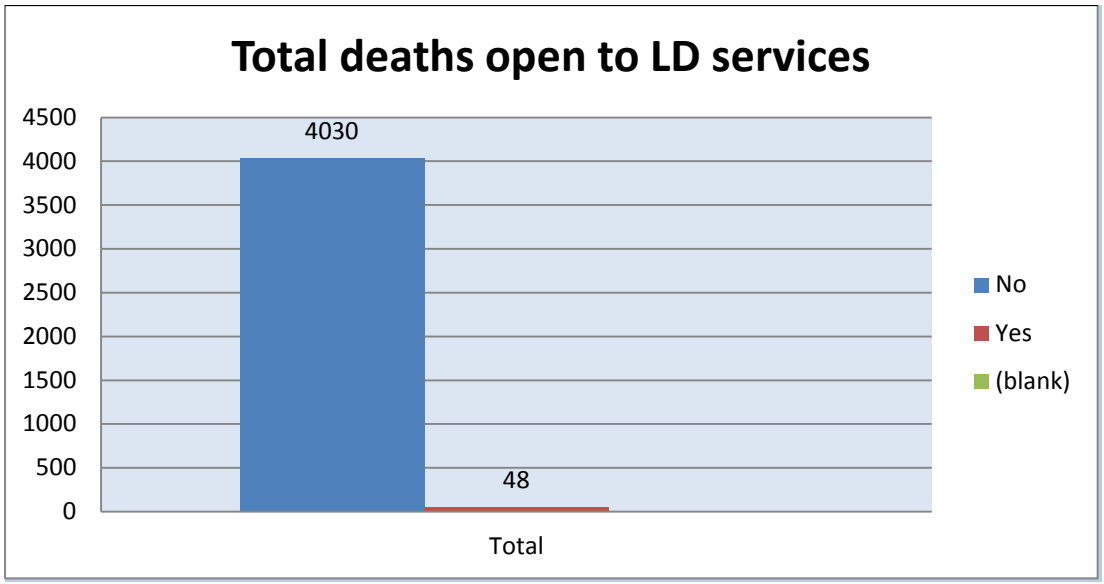
	Female	Male	Grand Total
Count of Gender	**2080**	**1998**	**4078**

6.3 Death by age group since 1 January 2017

The youngest age was classed as 0 and the oldest age was 107 years. Most deaths occur within the 85-89 age groups (indicated by the star), in the last report most deaths occurred between 82-87 age group.



6.4 Learning Disability Deaths since 1 January 2017



	No	Yes	Grand Total
Count of Known To LD	**4030**	**48**	**4078**

The Trust reviews all Learning Disability deaths. 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. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process as LeDeR only look at a sample of overall deaths. Currently the Lead Professional for Patient Safety and Experience is working closely with LeDeR so that the Trust can be involving moving forward in the review process.

6.5 Death by Ethnicity since 1 January 2017

White British is the highest recorded group with 3275 recorded deaths, 483 deaths had no recorded ethnicity assigned and 54 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	Count of Ethnicity
White - British	3275
Not Known	483
White - Any other White background	95
Not stated	54
Other Ethnic Groups - Any other ethnic group	54
Indian	25
White - Irish	25
Caribbean	22
Mixed - Any other mixed background	9
Pakistani	9

Row Labels	Count of Ethnicity
Asian or Asian British - Pakistani	7
Asian or Asian British - Any other Asian background	7
Mixed - White and Black Caribbean	7
Other Ethnic Groups - Chinese	2
Asian or Asian British - Bangladeshi	2
Asian or Asian British - Indian	1
Mixed - White and Asian	1
Grand Total	**4078**

7. Recommendations and learning

Below are examples of the recommendations that have been undertaken following the review of deaths either through the *Untoward Incident Reporting and Investigation Policy and Procedure* or *Learning from Deaths Procedure.* These recommendations are monitored by the Patient Safety Team and are allocated to specific team and individuals to be completed. This is not an exhaustive list.

7.1 Learning / action log

- To clarify in the seclusion policy the reasons why all seclusions are to be detailed as moderate harm

- To consider developing new / incorporating within training already provided a module about the Mental Health Act paperwork linked to seclusion, including seclusion exception reporting and the seclusion policy

- To share with commissioners, the impact and access of community based psychological therapy for interfamilial child trauma

- Where there are co morbid complex physical health issues in someone with a severe mental illness, their care plan safety plan must reflect any concerns or risk related to the management of that physical health need. This includes any concerns around medication.

- To identify the threshold for Forensic Service input and method of referral and dissemination of information

- To gain an understanding of the issues related to being a veteran and our responsibilities with regard to the Armed Forces Covenant.

- Development of a Safeguarding Protocol which would include details regarding how to access safeguarding advice and support which would complement information already available via the Safeguarding Connect web page.

- The process for managing Front Door Presentations to Psychiatric Units needs to be clarified and reviewed.

- An offer of psychiatric advice around complex medication issues should form part of the discharge information sent to primary care for patient who have Severe Mental illness

- There is a waiting list for psychological therapy, for EMDR (Eye movement desensitization and reprocessing (EMDR) is a type of psychotherapy that was developed to help people deal with and heal from experiences that have caused emotional trauma). Review with commissioners solutions to reduce the waiting time

- A team awareness raising session regarding the frequent revisiting of a service user's decision to withhold information from family and carers using the 'Advanced Planning for People with Bipolar Disorder Guide' from the East Midlands Academic Health Science Network and also the 'Sharing information with family and carers' booklet and the 'Advance Statement about information sharing and involvement of family carers'.

- To review the MDT (Multi-Disciplinary team) documentation processes with regard to the decision making actions when there are patient safety concerns. This should take into account the immediate action taken by the medics, care co-ordinators and supervisors.

- For DHCFT staff who work in out of hours services (mental health triage hub, Crisis team) to have access to IAPTUS (patient management system for Improving Access to Psychological Therapy) notes as read only.

- Trust to ensure development of clinical standards for personality disorder and a robust Personality Disorders Pathway and appropriate training for staff and teams

- For the Mental Health Office to develop a system of escalation for confirmation that sections are invalid. With only B5 or B7 (or escalation to RK in their absence) with final authority

- Ensure family are involved in assessments and decision making process wherever possible in line with Think Family and Triangle of Care approach, and also making sure that support is offered to carers and children

- Review of the CPA (Care Programme Approach) policy in terms of transfer between secondary services to provide clarity. Transition policy to be updated in include process in the event of a dispute between services in transition Clarity required for services regarding dispute resolution in transition

- If it is considered that withholding a script is in the interest of safety for a service user, then prior to this decision being made, it is imperative that this is discussed with a consultant, senior practitioner or manager; all options need exploring before coming to this decision.