Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

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 April 2019 to 30 June 2019. This report was due to be considered by the Quality Committee in September 2019, but was deferred to the October meeting.

Executive Summary

- From 1 April 2019 to 30 June 2019, the Trust received 460 death notifications of patients who have been in contact with our service.
- There have been two inpatient deaths since 1 April 2019, these have been expected deaths.
- 1 April 2019 to 30 June 2019, the Mortality Review Group reviewed 27 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 27 deaths reviewed, 26 have been classed as not due to problems in care. One was referred to the Serious Incident Group and is currently under further investigation.
- The Trust has reported four Learning Disability deaths.
- There is very little variation between male and female deaths; 248 male deaths were reported compared to 212 female.
- During collection of the disability data it became apparent that when clinicians were choosing 'memory or ability to concentrate learn or understand, as a disability this was being categorised by the system as a 'learning disability'. Therefore the PARIS team to ensure that it is clearer for clinicians and to improve accuracy of data, the current option of "Learning Disability" will be changed to reflect the fact that it has historically included dementia. This will then be end dated and a new option of "Learning Disability" has now been added. A new code has been added specifically to allow clinicians to pick dementia. This change will allow the two disabilities to be independently analysed moving forward.
- Good practice identified through case note reviews is fed back to clinicians involved.
- The case note rota for medics was reviewed by the Executive Serious Investigation Group on 26 September 2019 and recommended further consideration of the extension of an organised rota for the north and commencement of a rota for the south, to the Trust Management Team (TMT) to establish an agreed process for consultant cover north and south.

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 but that there is a bigger picture to consider related to developing a Safety Culture.
- From April 2019 to 30 June 2019, the Trust has received 460 death notifications of patients who have been with our service within the previous six months. 38 (8.26%) were reported through our DATIX system of which 9 (1.95%) warranted further investigation.
- All inpatient deaths are reviewed and quarterly reports received by the Executive Leadership Team (ELT) in addition to coroner's inquest updates. Medical availability for mortality reviews has improved.
- This report was reviewed by the Quality Committee in October.

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 & 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:

There is recognition that nationally mental health services have been under-resourced for decades and that this is now being addressed through commissioning and contract arrangements. The 'bigger picture' of safety culture requires a strategic approach which is being addressed by the Board.

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of our approach and note that it is required to be published on the Trust's website in line with national guidance.

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

Report prepared by: **Dr John R Sykes**
Medical Director

Rachel Williams
Lead Professional for Patient Safety and Patient Experience

Nosheen Asim
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.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish each 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 for the 1st Quarter of year 2019 - 20 from 1 April 2019 to 30 June 2019.

2. Current Position and Progress

- As a way of accessing 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.

- A northern consultant mortality meeting rota has been in place since November 2018, organised by Dr Sugato Sarkar. The rota for November 2018 to the end of October 2019 was distributed to the consultants in October 2018. On the whole the rota has worked well and the majority of the meetings have taken place, but unfortunately several meetings have been cancelled either the day before or on the actual meeting date. When the next rota is available for distribution to the consultants it will also be distributed to their medical secretaries to ensure that we have consultant cover for the meetings. Despite several attempts to put a rota in place for the southern consultants we have not managed to facilitate this to date. The case note rota was reviewed by the Executive Serious Investigation Group on 26th September 2019 recommended further consideration of this issue through TMT to establish an agreed process for consultant cover north and south.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary changes made.

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

3. Data Summary of all Deaths

Note that inpatients and LD are based upon whether the patient has an open inpatient or LD referral at time of death.

	April 2019	May 2019	June 2019
Total number of deaths per month	178	168	116
Inpatient deaths	1	1	0
Learning Disability Referral Deaths	0	4	4

The table above shows information for 1 April 2019 to 30 June 2019.

Correct as at 30 June 2019

From 1 April 2019 to 30 June 2019, the Trust received 460 death notifications of patients who have been in contact with our service.

There have been two inpatient deaths since 1 April 2019, these have been expected deaths.

4. Review of Deaths

1 April 2019 to 30 June 2019:

Total number of Deaths from 1 April 2019 – 30 June 2019 reported on Datix	38 (of which 19 are reported as "Unexpected deaths"; 13 as "Suspected deaths"; and 6 as "Expected - end of life pathway")
Number reviewed through the Serious Incident Group	36 (0 was not required to be reviewed by SI group and 2 pending for a review).
Number investigated by the Serious Incident Group	9 (0 did not require an investigation and 27 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	9 (27 currently opened to SI group and 2 pending for a review, as at 26 June 2019)

The Trust has recorded two inpatient deaths April 2019 to 30 June 2019, of all which have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*. None of these deaths have been due to problems in care.
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

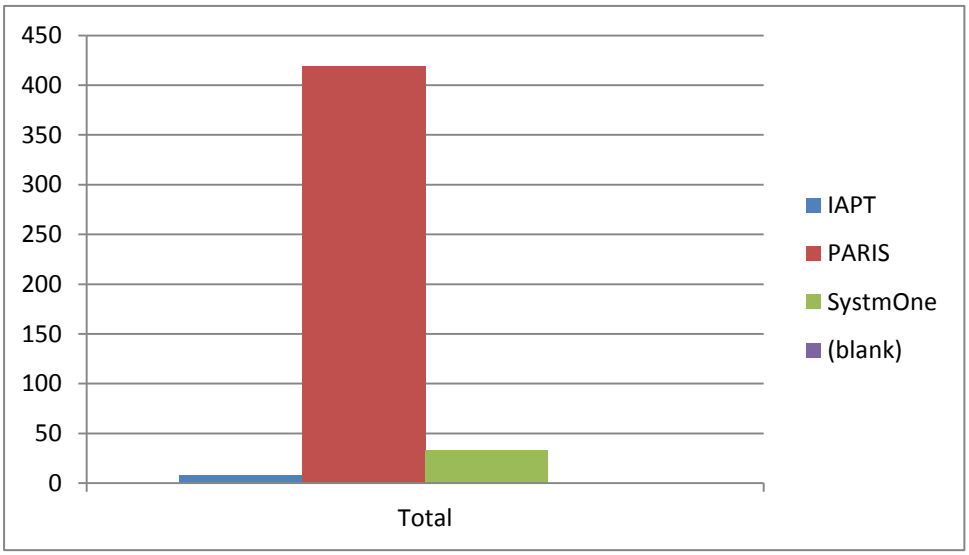
1 April 2019 to 30 June 2019, the Mortality Review Group reviewed 27 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 27 deaths reviewed, 26 have been classed as not due to problems in care. 1 was referred to the Serious Incident Group and is currently under further investigation.

The Mortality Group review the deaths of patients who fall under the following 'red flags' from 28 March 2019:

- Patient taking an Anti-psychotic medication
- Patients whose care plan was not reviewed in the 6 months prior to their death
- Patient whose risk plan and or safety plan was not in place or updated as per policy, prior to death
- Death of a patient with a learning disability

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2019 to 30 June 2019

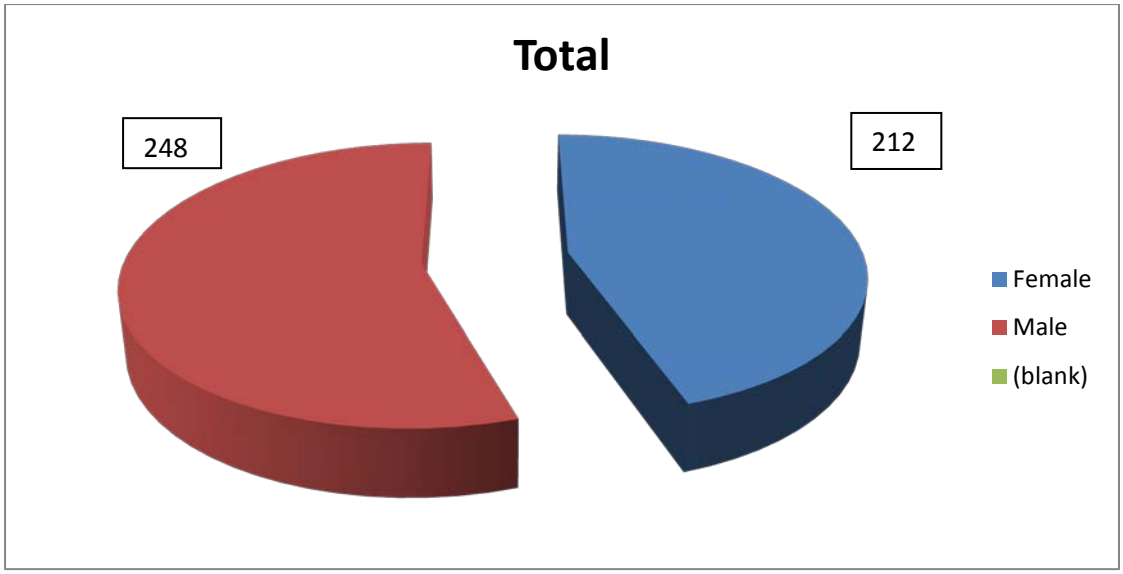


	IAPT	PARIS	SystmOne	Grand Total
Count	8	419	33	460

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. 33 death notifications were extracted from SystmOne and 8 death notifications were extracted from IAPT.

6.2 Deaths by Gender since 1 April 2019 to 30 June 2019

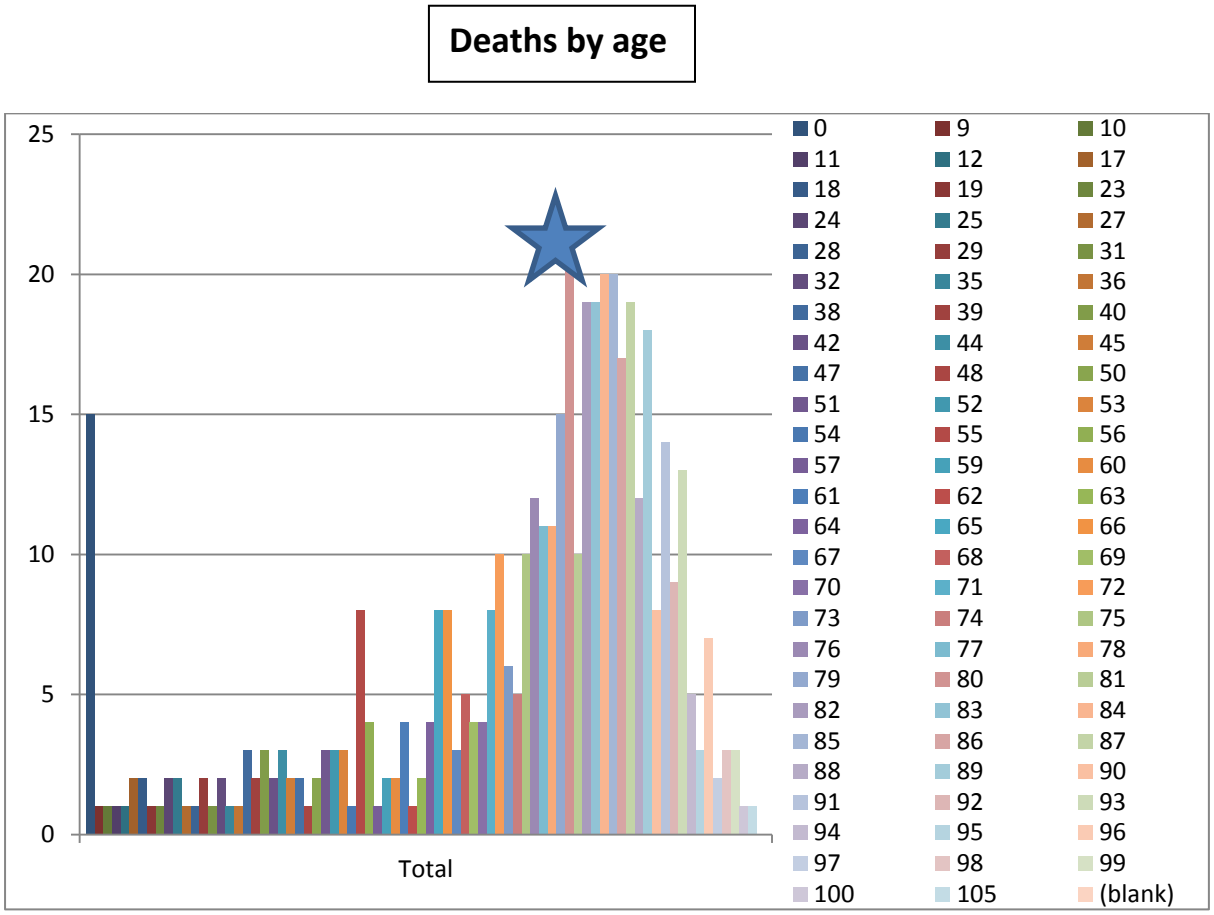
The data below shows the total number of deaths by gender 1 April 2019 to 30 June 2019. There is very little variation between male and female deaths; 248 male deaths were reported compared to 212 female.



	Male	Female	Grand Total
Count	248	212	460

6.3 Death by Age Group since 1 April 2019 to 30 June 2019

The youngest age was classed as 0, and the oldest age was 105 years. Most deaths occur within the 80 - 85 age groups (indicated by the star). In the last report, most deaths occurred between 86 - 91 age groups.



6.4 Learning Disability Deaths since 1 April 2019 to 30 June 2019

	April 2019	May 2019	June 2019
LD Deaths	0	4	4

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. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process, as LeDeR only looks 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 involved moving forward in the review process. Since the last report, the Trust is now sharing relevant information with LeDeR which is used in their reviews. Since 1 April 2019 to 30 June 2019, the Trust has recorded 8 Learning Disability deaths.

The Trust now receives a quarterly update from LeDeR which highlights good practice and identified learning.

6.5 Death by Ethnicity 1 April 2019 to 30 June 2019

White British is the highest recorded ethnicity group with 369 recorded deaths, 61 deaths had no recorded ethnicity assigned, and two people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count
White – British	369
Not Known	61
White - Any other White background	12
Other Ethnic Groups - Any other ethnic group	5
Not stated	2
Caribbean	1
White – Irish	4
Asian or Asian British – Pakistani	2
Pakistani	1
Asian or Asian British – Indian	2
Mixed - White and Black Caribbean	1
Grand Total	**460**

6.6 Death by religion 1 April 2019 to 30 June 2019

Christianity is the highest recorded religion group with 85 recorded deaths, 44 deaths had no recorded religion assigned, 10 people refused to state their religion and 212 left this information blank. The chart below outlines all religion groups.

Row Labels	Count of Religion
Christian	85
Church Of England	55
Unknown	44
Not Religious	29
Not Given Patient Refused	10
Roman Catholic	8
Methodist	5
None	2
Muslim	1
Not Religious - Old Code	1
Jehovah's Witness	1
Catholic: Not Roman Catholic	1
Sikh	1
Patient Religion Unknown	1
Atheist movement	1
Pentecostal Christian	1
Spiritualist	1
United Reform	1
(blank)	212
Grand Total	**460**

6.7 Death by sexual orientation 1 April 2019 to 30 June 2019

Heterosexual or straight is the highest recorded sexual orientation group with 133 recorded deaths, 314 people left this information black. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Heterosexual Or Straight	120
Heterosexual	13
Bi-Sexual	1
Gay Or Lesbian	1
Not Appropriate To Ask	2
Not Stated (declined)	5
Person Asked And Does Not Know	2
Unknown	2
(blank)	314
Grand Total	**460**

6.8 Death by disability 1 April 2019 to 30 June 2019

Other is the highest recorded disability group with 15 recorded deaths, 13 deaths had a learning disability (dementia) assigned, and 12 people had behaviour and emotional disability assigned. From the 460 deaths only 110 patients' electronic records had a disability assigned. The chart below outlines all disability groups however changes have been made to how the below data will be collated moving forward. During collection of the data it was apparent that if clinicians were choosing 'memory or ability to concentrate learn or understand; this was being categorised as learning disability. Therefore the PARIS team to ensure that it is clearer for clinicians and to improve accuracy of data, the current option of "Learning Disability" will be changed to reflect the fact that it has historically included dementia. This will then be end dated and a new option of "Learning Disability" will be added. A new code has been added specifically to allow clinicians to pick dementia. This change will allow the two disabilities to be independently analysed moving forward.

Row Labels	Count of Disability
Other	15
Learning Disability (Dementia)	13
Behaviour and Emotional	12
Hearing	5
Mobility and Gross Motor	4
Progressive (LT) Conditions	4
Learning Disability (Dementia)	3
Learning Disability (Dementia); Mobility And Gross Motor	3
Behaviour and Emotional; Learning Disability (Dementia); Learning Disability (Dementia); Other; Self Care and Continence	2
Behaviour and Emotional; Mobility and Gross Motor	2
Self-Care and Continence	2
Behaviour and Emotional; Behaviour and Emotional	1
Behaviour and Emotional; Learning Disability (Dementia)	1
Behaviour and Emotional; Learning Disability (Dementia)	1
Behaviour and Emotional; Learning Disability (Dementia); Learning Disability (Dementia); Perception of Physical Danger; Other	1

Row Labels	Count of Disability
Behaviour and Emotional; Learning Disability (Dementia); Mobility and Gross Motor; Self Care and Continence	1
Behaviour and Emotional; Learning Disability (Dementia); Perception of Physical Danger; Self Care And Continence	1
Behaviour and Emotional; Manual Dexterity; Learning Disability (Dementia)	1
Behaviour and Emotional; Manual Dexterity; Mobility and Gross Motor; Speech; Self Care and Continence	1
Behaviour and Emotional; Other; Self Care and Continence	1
Behaviour and Emotional; Other; Self Care And Continence; Sight	1
Behaviour and Emotional; Progressive (LT) Conditions; Other; Mobility and Gross Motor; Other	1
Behaviour and Emotional; Self Care and Continence; Sight; Other	1
Hearing; Learning Disability (Dementia)	1
Hearing; Learning Disability (Dementia); Learning Disability (Dementia)	1
Hearing; Learning Disability (Dementia); Mobility and Gross Motor; Learning Disability (Dementia)	1
Hearing; Learning Disability (Dementia); Mobility And Gross Motor; Self Care And Continence; Sight	1
Hearing; Mobility and Gross Motor	1
Hearing; Mobility and Gross Motor; Other; Self Care and Continence; Other	1
Hearing; Mobility and Gross Motor; Sight; Self Care and Continence	1
Hearing; Other	1
Hearing; Self Care and Continence; Sight; Mobility and Gross Motor	1
Hearing; Self Care And Continence; Speech; Progressive (Lt) Conditions	1
Learning Disability (Dementia); Hearing; Self Care And Continence; Speech	1
Learning Disability (Dementia); Learning Disability (Dementia); Perception of Physical Danger; Progressive (LT) Conditions; Other	1
Learning Disability (Dementia); Mobility and Gross Motor	1
Learning Disability (Dementia); Perception of Physical Danger; Self Care and Continence	1
Learning Disability (Dementia); Self Care and Continence	1
Learning Disability (Dementia); Sight	1
Manual Dexterity	1
Manual Dexterity; Learning Disability (Dementia); Learning Disability (Dementia); Mobility and Gross Motor; Other	1
Manual Dexterity; Mobility and Gross Motor; Self Care and Continence	1
Manual Dexterity; Progressive (LT) Conditions	1
Mobility and Gross Motor; Behaviour and Emotional; Self Care and Continence	1
Mobility and Gross Motor; Behaviour and Emotional; Sight	1
Mobility and Gross Motor; Manual Dexterity; Self Care and Continence	1
Mobility and Gross Motor; Mobility and Gross Motor	1
Mobility and Gross Motor; Speech; Other; Behaviour and Emotional	1
Other; Behaviour and Emotional; Hearing	1
Other; Self Care and Continence; Other	1
Physical Disability	1
Progressive (LT) Conditions; Other; Mobility and Gross Motor; Other	1
Self-Care and Continence; Mobility and Gross Motor	1
Self-Care and Continence; Perception of Physical Danger	1
Self-Care and Continence; Speech; Progressive (LT) Conditions	1
Speech; Learning Disability (Dementia); Other	1
Grand Total	**110**

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 a specific team, and individuals to be completed. This is not an exhaustive list.

7.1 Action Log

Areas of good practice have been identified whilst undertaking the Case Record Reviews, these have included;

- Good regular contact, patient well supported
- Strong link between Community Psychiatric Nurse, General Practitioner and Adult Social Care.
- Recorded Mental Capacity Assessments
- Detailed entries made by the doctor and clinicians
- Well-co-ordinated care and liaison between services
- Safety box contained relevant and helpful detail

Actions recorded from completed Serious Incidents;

- To feedback the requirements for the completion/ updating of Safety Assessments when risks are increasing. Case notes to reflect that any risks have been considered/ reviewed and note any immediate concerns.
- Manager to scope out the teams knowledge and understanding around substance misuse services, assessing and understanding of substance and alcohol misuse, the interventions and support available in the local area.
- Audit required in relation to initial assessments, a sample from all team members.
- Recruitment, sickness and leave to be reviewed and actioned
- To develop a team protocol upon transferring patients to other wards.
- EPR PARIS team clarification needed around current process in relation to death notification
- To improve services for forensic patients with a community setting.
- To improve: Communication regarding serious incidents relating to mental health patients via community forensic services. Information sharing from non-trust forensic providers.
- To scope to possibility of increasing the provision of ED training to adult psychiatric teams
- Scope possibility of enhanced physical health recording on Paris IT system
- Neighbourhood CMHT to review current practice in relation to message taking
- The Service Manager to audit the current processes for the Service against the Operational policy being used.
- Review of the Trust guidelines for the management and treatment of opiate use with consideration to the inclusion of a withdrawal scale assessment tool (i.e. COWS)
- Internal transfer policy and procedure to be reviewed.
- To review current criteria for in-patient admissions for the Hartington Unit.