Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

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 June to 24 August 2020.

Executive Summary

During the COVID-19 pandemic, the learning from deaths process continued to be undertaken but slight changes to the process were initially made to allow for colleagues to undertake other duties. Activity has now resumed back to normal with weekly case note reviews and the daily reviewing and grading of all new deaths taking place.

Since the last report the Mortality Group has reviewed and agreed a two stage process for screening new deaths. New deaths have always been reviewed by the mortality technician but this process has been further formalised and strengthened. If a patient does not meet a Datix or mortality red flag after the mortality technician has reviewed the patients Electronic Patient Record the death is now closed at stage 1 and this review is documented within the case note review form. If the death meets any of the mortality flags then a case note review is conducted (also referred to as stage 2 review). If any death meets the Datix red flag then this is investigated under the Untoward Incident and Reporting Policy and Procedure. An audit of the deaths closed at stage 1 will be undertaken by members of the patient safety team to ensure compliance with the policy.

All deaths directly relating to COVID-19 are reviewed through the Learning from deaths procedure unless they also meet a Datix red flag, in which case they will be reviewed under the Untoward Incident Report Reporting Policy and Procedure. The mortality reviewer produces a weekly COVID-19 death report which is shared with the incident management team. This report includes but is not limited to patient demographics, patient conditions, diagnosis and vulnerabilities, allowing the team to draw comparisons to identify themes and trends.

- From 1 June to 24 August 2020 there has been one death reported where the patient tested positive for COVID-19. This patient was a White, British 88 year old female with a diagnosis of Alzheimer's dementia.
- From 1 June to 24 August, the Trust received 370 death notifications of patients who had been in contact with our service in the last six months
- Two Inpatient deaths were recorded. One patient died whilst on home leave from an inpatient ward and one patient died on the Cubley Male ward- this was an expected end of life death.
- The Mortality Review Group reviewed 41 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 41 deaths reviewed, 40 were not due to problems in care. One death was referred to the Serious Incident Group for further review.

- The Trust has reported three Learning Disability deaths from 1 June to 24 August 2020
- There is very little variation between male and female deaths; 185 male deaths were reported compared to 184 female. One death had no gender specified or recorded; this was the death of a baby.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

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

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 and there will now be a focus on selecting cases where physical health care was a prominent feature of care.

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.

- From 1 June to 24 August 2020 there is very little variation between male and female deaths; 185 male deaths were reported compared to 184 female. One death had no gender specified or recorded, this was the death of a baby.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

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Medical Director

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Lead Professional for Patient Safety and Patient Experience

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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.

To date the Trust has met all of the required guidelines.

The report presents the data for 1 June to 24 August 2020.

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

- The Trust is still waiting to ascertain if Cause of death (COD) will be available through NHS digital. Currently COD is been ascertained through the coroner officers in Chesterfield and Derby but only a very small number of COD have been made available.

- Medic rotas have been made available for the north and south of the county and this did initially improve the number of case note reviews completed. Since the pandemic and the reduction to monthly case note reviews from weekly, the number of case note reviews has decreased. During this period only eight case note reviews have taken place this has been mainly due to the unavailability of medics.

- 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.

- Due to the current circumstances surrounding COVID-19, the Mortality Review Group along with other departments has followed government guidance to allow staff to work remotely. As of 24 June 2020 the Mortality group has agreed to a new formalised process strengthening the work already being undertaken. A 2 stage process involving an initial screening of the patient's Electronic Patient Record is undertaken to determine if the death meets any red flags, if no flags are met, the death is closed at a stage 1 review. If the death meets any of the mortality flags then a case note review is conducted (also referred to as a stage 2). If the death meets a datix red flag then this is investigated under the Untoward Incident Reporting Policy and Procedure. This process will be audited by members of the patient safety team to ensure compliance with policy.

- The Trust has also made a decision to return to grading all new deaths identified through the NHS Spine daily and conducting Case note review meetings twice weekly. All deaths directly relating to COVID-19 will be

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

reviewed initially through the Learning from Deaths procedure unless they also meet a Datix red flag , in which case they will be reviewed under the Untoward Incident Reporting Policy and Procedure. The mortality reviewer will also produce a weekly COVID-19 death report to be shared with the incident management team. This report will include but is not limited to patient demographics, patient conditions, diagnosis and vulnerabilities, allowing the team to draw comparisons to identify themes and trends. From 1 June to 24 August 2020 there has been 1 death reported where the patient tested positive for COVID-19.

3. Data Summary of all Deaths

Note that inpatients with learning disabilities (LD) are based upon whether the patient has an open inpatient or LD referral at time of death.

	June	July	August
1. Total Deaths Per Month	150	129	91
5. LD Referral Deaths	1	1	1

The table above shows information for 1 June to 24 August 2020. *Correct as at 24 August 2020 2020*

From 1 June to 24 August 2020, the Trust received 370 death notifications of patients who have been in contact with our services.

4. Review of Deaths - 1 June to 24 August 2020

Total number of Deaths from 11 June to 24 August 2020., reported on Datix	29 (of which 12 are reported as “Unexpected deaths”; 11 as “Suspected deaths”; 6 as “Expected - end of life pathway” NB some expected deaths have been rejected so these incidents are not included in the above figure.
Number reviewed through the Serious Incident Group	22 (7 pending for a review).
Number investigated by the Serious Incident Group	9 did not require an investigation; 6 underway and 14 pending for a review
Number of Serious Incidents closed by the Serious Incident Group?	9 (13 currently opened to SI group and 7 pending for a review, as of 24/08/2020)

There are currently 7 incidents that have not yet been reviewed by the SI Group*

Since 1 June to 24 August 2020 the Trust has recorded 2 inpatient deaths. One patient died whilst on home leave from an inpatient ward and the second patient died on the Cubley male ward, this death was an expected end of life death. These

deaths 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

From 1 June to 24 August 2020, the Mortality Review Group reviewed 41 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 41 deaths reviewed, 40 have been classed as not due to problems in care. One death was referred to Serious Incident Group for further review under the Untoward Incident and Reporting Policy and Procedure.

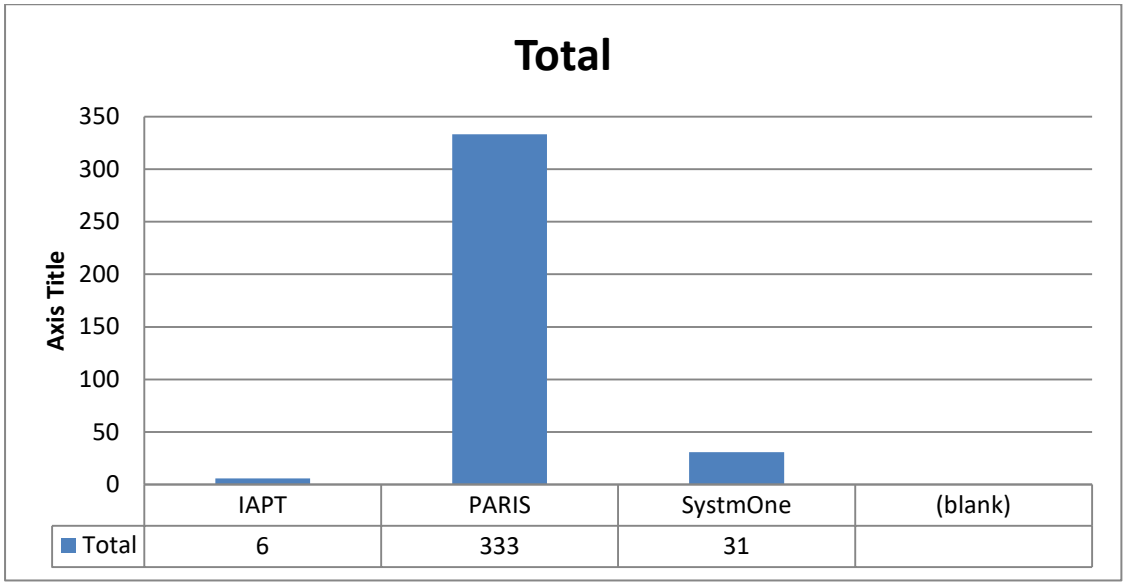
The Mortality Group review the deaths of patients who fall under the following 'red flags' as from 24 June 2020 these are as follows:

- Patient taking an anti-psychotic medication
- Death of a patient with a learning disability
- Patients with chronic pain
- Patients only open to outpatient services
- Patients with COVID19 (this is a temporary flag)

From 1 June to 24 August 2020 there has been one death reported where the patient tested positive for COVID-19. This patient was a White, British 88 year old female with a diagnosis of Alzheimer's dementia.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 June to 24 August 2020



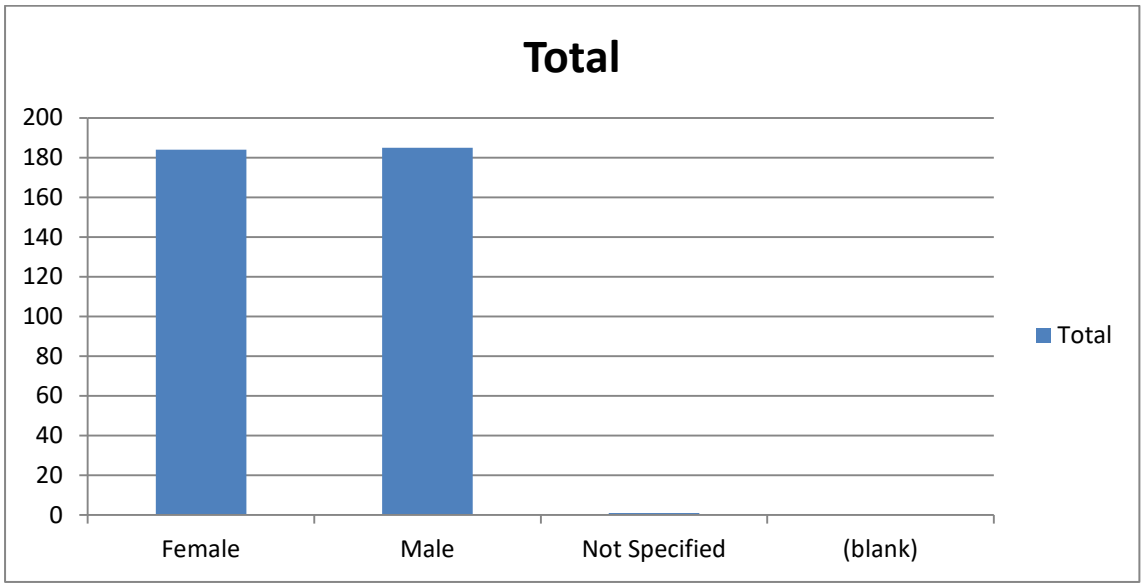
Row Labels	Count of Source System
IAPT	6
PARIS	333
SystmOne	31
Grand Total	**370**

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. 31 death notifications were extracted from SystemOne and 6 death notifications were extracted from Improving Access to Psychological Therapies (IAPT).

6.2 Deaths by Gender since 1 June to 24 August 2020

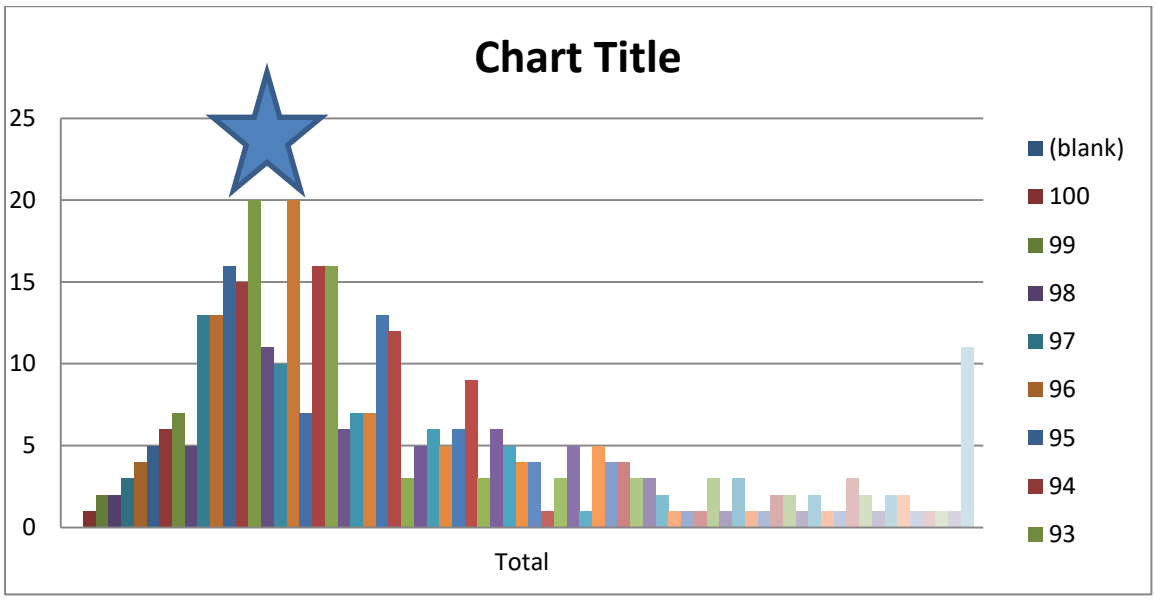
The data below shows the total number of deaths by gender 1 June to 24 August 2020. There is very little variation between male and female deaths; 185 male deaths were reported compared to 184 female. One death had no gender specified / recorded; this was the death of a baby.

Row Labels	Count of Gender
Female	184
Male	185
Not Specified	1
Grand Total	**370**



6.3 Death by Age Group since 1 June to 24 August 2020

The youngest age was classed as 0, and the oldest age was 100 years. Most deaths occur within the 84-87 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 June to 24 August 2020

	June 2020	July 2020	August 2020
LD Deaths	1	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. We are unable to ascertain how many of these deaths have been reviewed through the LeDeR process. The Trust continues to share relevant information with LeDeR when requested which is used to inform their reviews. Since 1 June to 24 August 2020, the Trust has recorded 3 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning.

6.5 Death by Ethnicity since 1 June to 24 August 2020

White British is the highest recorded ethnicity group with 278 recorded deaths, 63 deaths had no recorded ethnicity assigned, and 4 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	Count of Ethnicity
Indian	1
Asian or Asian British - Pakistani	1
Asian or Asian British - Indian	1
Any other black background	2
Pakistani	2
Other ethnic groups - any other ethnic group	3
Not stated	4
White - Irish	4
Caribbean	5
White - any other white background	6
Not known	63
White - British	278
Grand Total	**370**

6.6 Death by religion since 1 June to 24 August 2020

Christianity is the highest recorded religion group with 61 recorded deaths, 177 deaths had no recorded religion assigned and 8 people refused to state their religion. The chart below outlines all religion groups.

Row Labels	Count of Religion
Muslim	1
Pentocostal Christian	1
Christian religion	1
Sikh	1
Catholic: Not Roman Catholic	1
Sikh religion	1
None	2
Pentecostalist	2
Baptist	2
Atheist movement	3
Agnostic	3
Methodist	4
Roman Catholic	5
Not given patient refused	8
Not Religious	25
Unknown	26
Church Of England	46
Christian	61
(blank)	177
Grand Total	**370**

6.7 Death by sexual orientation since 1 June to 24 August 2020

Heterosexual or straight is the highest recorded sexual orientation group with 138 recorded deaths. 224 have no recorded information available. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Homosexual	1
Unknown	1
Bi-Sexual	1
Not appropriate to ask	2
Not Stated (declined)	3
Heterosexual or straight	138
Blank	224
Grand Total	**370**

6.8 **Death by disability since 1 June to 24 August 2020**

Behavioural and emotional problems were the highest recorded disability group with 16 recorded deaths.

Top 6 recorded deaths by disability groups	Count of Disability
Sight	2
Self-care and continence	2
Mobility and gross motor	4
Hearing	6
Dementia	8
Behaviour and emotional; learning disability (dementia)	16
Grand Total	**38**

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths. These recommendations are monitored by the Patient Safety Team and are allocated to a specific team, and individuals to be completed. This is not an exhaustive list.

- To clarify in the appropriate policy, Section 17 leave and the involvement of police on wards (e.g. liaison, individual roles and responsibilities, when to escalate and involve the police on the ward, and, how this should be managed, minimised and situations de-escalated)

- To provide clarification of the role of the responsible clinician in patient transfers between Trusts and other provider services.

- For bank staff to routinely work alongside a substantive member of the team when carrying out assessments. In the rare event that this is not possible, assessment outcomes and significant changes to care plans should be discussed within the team daily

- Procedure to identify a defined response and actions for administrators if an urgent call is received for patients who are open to outpatient clinics only. This should include triage by a clinician.

- Local protocol for staff in the event a patient reports a sexual assault

- Education and training on the complexity and dilemmas faced when confidentiality, capacity and family/carer involvement collide is needed.

- Assurances are required that there is parity of services and consistency in how services run in terms of Crisis team north and south.

- Community Mental Health Teams (CMHTs) referrals process to be mapped to achieve consistency amongst all teams.

- Consideration for virtual attendance at ward rounds from CMHTs.