**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 5 July 2022

# 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 26 March to 30 May 2022.

## Executive Summary

Due to recent sickness within the mortality team, there is a backlog of non Datix reportable deaths that require reviewing against the red flags outlined in the Royal College of Psychiatrists Care Review Tool and the internal Trust red flags. All deaths reported through the Incident Reporting and Investigation Policy and Procedure (Datix) continue to be reviewed.

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 are reviewed under the Incident Reporting and Investigation Policy and Procedure.

- From 26 March to 30 May 2022 there have been 0 deaths reported where the patient tested positive for COVID-19.
- The Trust received 353 death notifications of patients who had been in contact with our service in the last six months There is very little variation between male and female deaths; 169 male deaths were reported compared to 183 females.
- Two Inpatient deaths were recorded.
- The Mortality Review Group reviewed 9 deaths through a Stage 2 Royal College of Psychiatrists Care Review Tool. These reviews were undertaken by a multi-disciplinary team and it was established that of the 9 deaths reviewed, none were due to problems in care.
- The Trust has reported 6 Learning Disability deaths in the reporting timeframe and 1 patient with a diagnosis of Autism Spectrum Disorder (ASD).

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.

**Consultation**

Quality and Safeguarding Committee 14 June 2022.

**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:

- 26 March 2022 to 30 May 2022 There is very little variation between male and female deaths; 169 male deaths were reported compared to 183 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 published on the Trust's website as per national guidance.

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

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

**Louise Hamilton**
**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 26 March to 30 May 2022.

## 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.

- Eight Case Note Review sessions were undertaken, where nine incidents were reviewed. Unfortunately, five sessions did not take place due to lack of medic availability and five sessions did not take place due to the availability of an Investigation Facilitator.

- 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 18 March 2022.

- The monthly mortality review group meetings resumed in November 2020. These were put on hold during the COVID pandemic but have now resumed. During this period one meeting took place and one was cancelled due to the Medical Director been unavailable.

## 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 26 March to 30 May 2022.

| | 26 – 31 March | April | May |
|---|---|---|---|
| Total Deaths Per Month | 22 | 176 | 155 |
| LD Referral Deaths | 0 | 4 | 2 |
| ASD referral to LeDeR | | | 1 |
| Inpatient Deaths | 0 | 1 | 1 |

Correct as of 1 June 2022

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

169 patients were male, 183 were female, 271 were white British and 3 Asian/Asian British Pakistani. The youngest age was 0 years, the eldest age was 99.

From 26 March to 30 May 2022, the Trust received 353 death notifications of patients who have been in contact with our services.

## 4. Review of Deaths

| | |
|---|---|
| Total number of Deaths from 26 March to 30 May 2022 reported on Datix | 29 “Unexpected deaths”<br>0 COVID-19 deaths<br>4 “Suspected deaths”<br>5 “Expected - end of life pathway”<br>NB some expected deaths have been rejected so these incidents are not included in the above figure<br>2 Inpatient deaths |
| Incidents assigned for a review | 37 incidents assigned to the operational incident group<br>0 did not meet the requirement<br>1 incident is to be confirmed |

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

The mortality team, as well as reviewing identified deaths against the 'red flags' outlined in the Royal College of Psychiatrists Care Review Tool also review deaths against locally defined red flags**.**

From 5 August 2021 these locally defined red flags were:

- Patient diagnosed with a severe mental illness
- Patient only seen as outpatient
- Patient with long term physical condition
- Patient with long term chronic pain

Over the last 12 months the Patient Safety Team with support from NHSE Patient Safety team have been considering current Trust identified Mortality red flags against the red flags identified in the Royal College of Psychiatrists Care Review Tool for mortality reviews. This tool was developed following the publication of the Learning from Deaths Guidance for Mental Health Trusts to use when undertaking mortality reviews It has become clear that the Trust has overcommitted its resources in this area and a redesign of the Mortality (learning from deaths) process is required.

The red flags identified within the care review tool are met under the Trust Incident review process with the exception of psychosis within the last episode of care which has now been added as a Datix red flag.

The mandatory Flags for review under the Royal College of Psychiatrists Care Review Tool for mortality reviews are:

- All patients where family, carers or staff have raised concerns about the care provided.

- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death or have been discharged within 6 months prior to their death.

- All patients who were an in-patient in a mental health unit at the time of death or who had been discharged from in-patient care within the last month.

- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.

Those patient deaths which meet these 'red flag' criteria above should be subject to a review process if they are not already under the Incident 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'.

The form based on section 1 of the Royal College of Psychiatrists Care Review Tool for mortality reviews still remains under development, the intention is that this form will be added to the Electronic Patient Record . It is important to note that clinical teams already assess each death when determining if a DATIX incident is required.

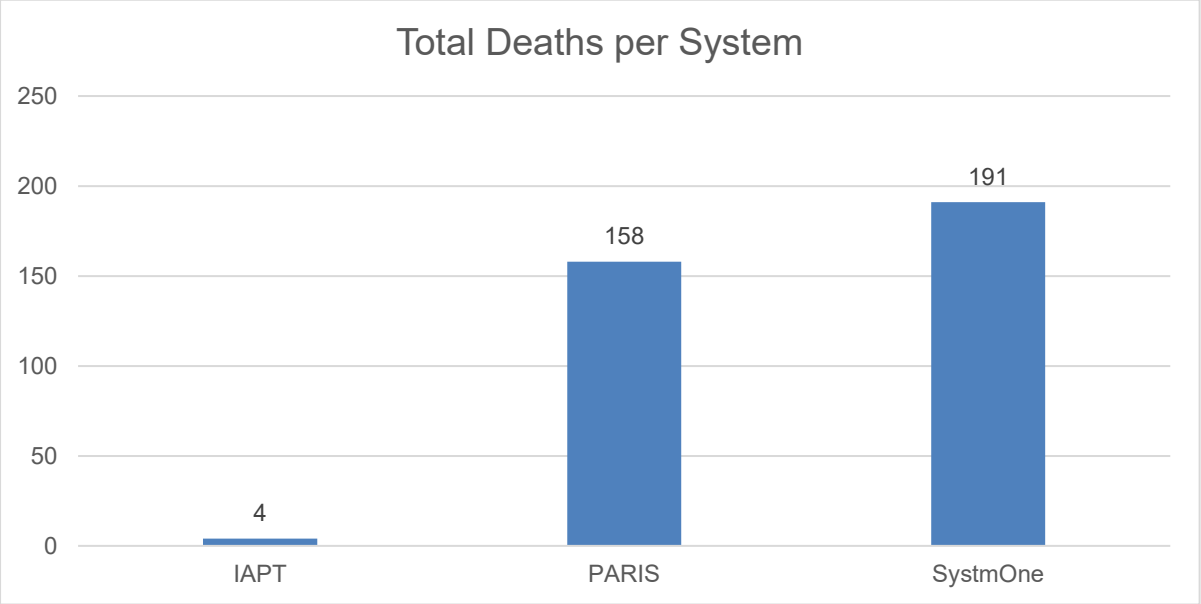
This will release capacity within the Patient Safety team and allow for greater return on the Case Record Review process.

For the period 26 March to 30 May 2022, the Mortality Review Group reviewed 9 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 9 deaths reviewed, none were due to problems in care.

From the 26 March to 30 May 2022 there have been no deaths reported where the patient tested positive for COVID-19. Of these deaths all patients were male and were from a White British background.

## 6. Analysis of Data

### 6.1 Analysis of deaths per notification system since 26 March to 30 May 2022

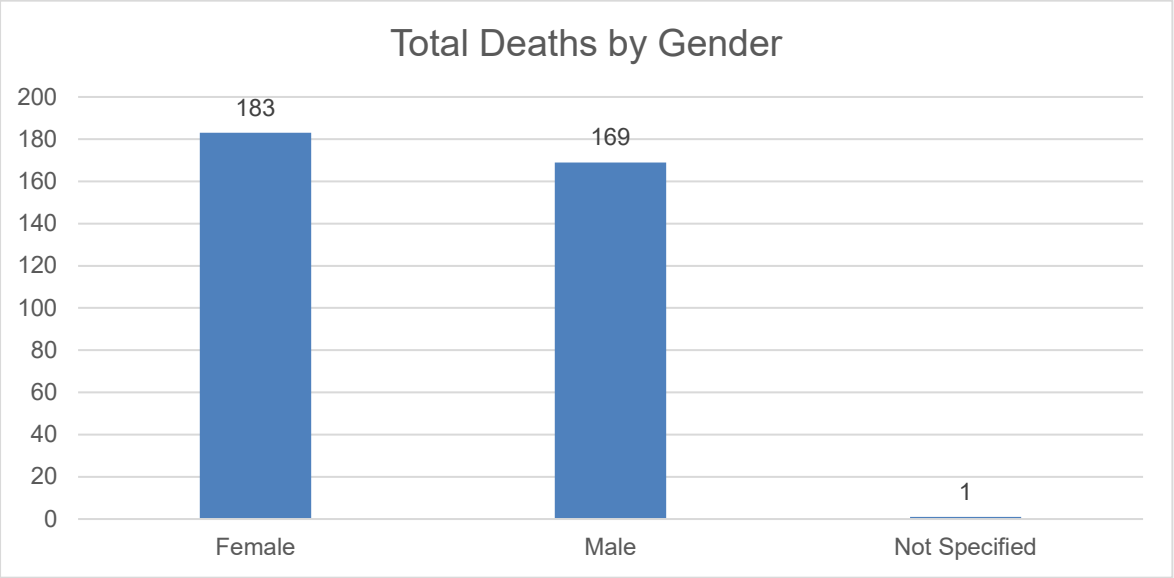



| System | Number of Deaths |
|---|---|
| IAPT | 4 |
| SystmOne | 158 |
| PARIS | 191 |
| **Grand Total** | **353** |

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.

## 6.2 Deaths by Gender

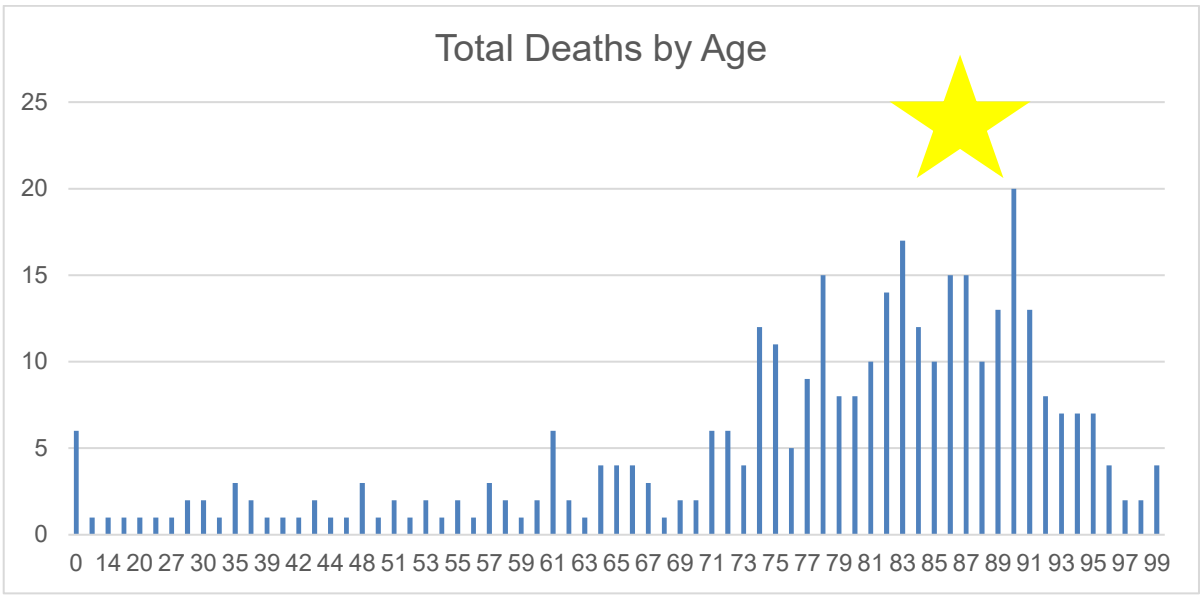
The data below shows the total number of deaths by gender 26 March to 30 May 2022. There is very little variation between male and female deaths; 169 male deaths were reported compared to 183 females and 1 not specified.




| Gender | Number of Deaths |
|---|---|
| Female | 183 |
| Male | 169 |
| Not Specified | 1 |
| **Grand Total** | **353** |

## 6.3 Death by Age Group

The youngest age was classed as 0, and the oldest age was 99 years. Most deaths occurred within the 81 to 91 age groups (indicated by the star).



## 6.4 Learning Disability Deaths (LD)

| | 26 – 31 March | April | May |
|---|---|---|---|
| LD Deaths | 0 | 4 | 2 |
| Autism Spectrum Disorder | 0 | 0 | 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. Due to challenges in reporting out from the LeDeR programme, we are unable to ascertain how many of our Trust's 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.

During 26 March to 30 May 2022, the Trust has recorded 6 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 1 death.

## 6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 271 recorded deaths, 26 deaths had no recorded ethnicity assigned, and 4 people did not state their ethnicity. The chart below outlines all ethnicity groups.

| Ethnicity | Number |
|---|---|
| Mixed - White and Black Caribbean | 1 |
| Black or Black British - Caribbean | 1 |
| Black or Black British - any other Black background | 1 |
| Asian or Asian British - Pakistani | 3 |
| White - Irish | 4 |
| Not stated | 4 |
| White - any other White background | 7 |
| Not known | 26 |
| Other Ethnic Groups - any other ethnic group | 35 |
| White - British | 271 |
| **Total** | **353** |

### 6.6 Death by Religion

Christianity is the highest recorded religion group with 105 recorded deaths, 188 deaths had no recorded religion assigned and one person refused to state their religion. The chart below outlines all religious groups.

| Rellgion | Number |
|---|---|
| (blank) | 162 |
| Jehovah's Witness | 1 |
| Nonconformist | 1 |
| Not Given Patient Refused | 1 |
| None | 2 |
| Christian religion | 2 |
| Muslim | 3 |
| Methodist | 3 |
| Roman Catholic | 5 |
| Not Religious | 10 |
| Church of England, follower of | 11 |
| Church of England | 23 |
| Unknown | 24 |
| Christian | 105 |
| **Total** | **353** |

### 6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 113 recorded deaths. 226 have no recorded information available. The chart below outlines all sexual orientation groups.

| Sexual Orientation | Number |
|---|---|
| (blank) | 223 |
| Patient unsure | 1 |
| Gay Or Lesbian | 1 |
| Sexual orientation unknown | 1 |
| Unknown | 3 |
| Sexual orientation not given - patient refused | 11 |
| Heterosexual Or Straight | 32 |
| Heterosexual | 81 |
| **Total** | **353** |

## 6.8 Death by Disability

The table below details the top 5 categories by disability. Gross motor disability was the highest recorded disability group with 24 recorded deaths.

| Disability | Number |
|---|---|
| Emotional behaviour disability | 5 |
| HEARING | 5 |
| Hearing disability | 7 |
| Intellectual functioning disability | 12 |
| Gross motor disability | 24 |

There was a total of 76 deaths with a disability assigned and the remainder 277 were blank (had no assigned disability).

## 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.

- There have been a number of EPR developments made to enhance the documentation used. The clinicians involved in the Local Implementation Groups (LIG's) designed a new structure for safety planning, completing a Risk screening tool, to identify the need for a formal risk assessment and then to use this information with the people we care for to co-produce the safety plan. The Care plan has also changed, moving to a single care plan that follows the patient on their journey through the Trust. Each professional area will contribute to this single care plan. The care plan has also been developed by the clinicians that volunteered in the LIGs and has been shared with relevant patient and carers forums. All future developments and projects for Digital health care will follow a redesigned governance process, ensuring changes are clinical lead, clinical driven, and for the interest of the people we work for and with.

- The forensic team was launched in 2019, further investment was secured in 2021/22 to continue to grow the team to the NHSE Community Forensic Model. The team works both from a relational security standard and a recovery focus. The team has undertaken advanced risk assessment training and utilise the HCR20. There is an access criteria which follows the 4 stages of the Royal College of Psychiatry Guidance for a Forensic Community Team. The team have enhanced clinical supervision, there are also drop in sessions for staff members within the Trust should they want advice and guidance on a patient they are seeing and there is supervision from the community forensic team for staff who are carrying or may have a forensic patient on their caseload There is an annual 37/41 MHA audit to ensure compliance with record keeping and MOJ standards .

- There is a multi-agency forensic meeting established for networking , building relationships, and identifying best practice and challenges within the forensic cohort. There is a strong relationship with MAPPA with clinical support to level 3 and guidance at level 2.

- Older Adult Services to lead on an educational session with medics in relation to the treatment and management of hyponatraemia, this should include specialist input from an Endocrinologist.

- The Trust's Medical Director to work with neighbouring providers to develop and implement a standard agreement in relation to information sharing, assessment and handover of patients being transferred into mental health settings.

- Review of Crisis House operational policy

- A quality improvement project to be undertaken in relation to record keeping standards and multi-disciplinary team meetings within acute inpatient services

- To advise of the importance of collaborative safety assessment formulation within the electronic patient record to enable risk information, risk management and risk mitigation to be conveyed in an easily accessible way; risk information to include current risk and where available historical risks.

- Further exploration of the need for a Trust wide approach via policy in relation to sickness/emergency and follow up for cancelled appointments. This may provide a 'fail safe' so service users do not "fall through the net" and miss appointments.