Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 17 January 2023

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 August to 30 September 2022.

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 August to 30 September 2022 there has been zero deaths reported where the patient tested positive for COVID-19.
- The Trust received 317 death notifications of patients who had been in contact with our service within the six months prior to their death. There is little variation between male and female deaths; 146 male deaths were reported compared to 171 females.
- No inpatient deaths were recorded.
- The Mortality Review Group reviewed 10 deaths through a Stage 2 Royal College of Psychiatrists Care Review Tool. These reviews were undertaken by a multi-disciplinary team, of the 10 deaths reviewed none were due to problems in care. Since January 2022 there has been a total of 94 meetings scheduled, 37 of these were attended, 43 sessions were not able to proceed due issues affecting attendance, 8 were cancelled.
- The Trust has reported four Learning Disability (LD) deaths in the reporting timeframe and no patients with a diagnosis of Autism Spectrum Disorder (ASD).
- Discussions with the Regional Medical Examiners have taken place to discuss the successful implementation of the Medical Examiner process within our Trust. It is hoped this process will commence on 1 February 2023.
- 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.

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 August to 30 September 2022. There is very little variation between male and female deaths; 146 male deaths were reported compared to 171 females
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

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

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

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

Louise Hamilton and Aneesa Akhtar-Alam
Mortality Technicians

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 August to 30 September 2022.

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

- Meetings with the Chesterfield Royal Hospital and University Hospital of Derby and Burton Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. It is hoped following development of a standard operating procedure that the Medical Examiners will commence reviewing the Trusts non-coronial deaths and Trust Incident Red Flag deaths from 1 February 2023.

- Cause of death information is currently being sought through the coroner 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 Trusts non-coronial deaths.

- During 1 August to 30 September 2022 10 Case Record Review sessions have been undertaken in relation to deaths which meet the incident criteria. Unfortunately, 6 sessions did not take place due to lack of medic availability and one session did not take place due to a lack of admin.

- Since January there has been a total of 94 meetings scheduled, of these 37 scheduled sessions took place however 43 sessions failed due to issues such as attendance and 8 were cancelled. The mortality team are currently awaiting a new schedule outlining the medics who will be attending Case Record Review sessions in 2023.

- 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 in October 2022.

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

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 August to 30 September 2022.

	August	September
Total Deaths Per Month	169	148
LD Referral Deaths	1	3
ASD referral to LeDeR	0	0
Inpatient Deaths	0	0

Correct as of 20 October 2022

146 patients were male, 171 were female, 224 were white British, 50 were any other ethnic group and 19 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 103.

From 1 August to 30 September 2022, the Trust received 317 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 1 August 2022 to 30 September 2022 reported on Datix	19 “Unexpected deaths” 0 COVID-19 deaths 2 “Suspected deaths” 4 “Expected - end of life pathway” NB some expected deaths have been rejected so these incidents are not included in the above figure 0 Inpatients deaths
Incidents assigned for a review	24 incidents assigned to the operational incident group 0 did not meet the requirement 1 incident is 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.

5. Learning from Deaths Procedure

The mortality team review all applicable non DATIX reported deaths against the Trust Red Flags and those outlined in the Royal College of Psychiatrists Care Review Tool, these 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 six 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.

All deaths including community deaths are reviewed to ascertain if they meet the criteria above. 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’. Previously under mortality the Trust was reviewing community deaths against locally defined flags in addition to what is required but had over committed its resources in this area and a redesign of the process was undertaken as learning was limited from these reviews.

The form based on section one of the Royal College of Psychiatrists Care Review Tool for mortality reviews 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. It is hoped that the form will be available on SystmOne in the new year as it has now been developed.

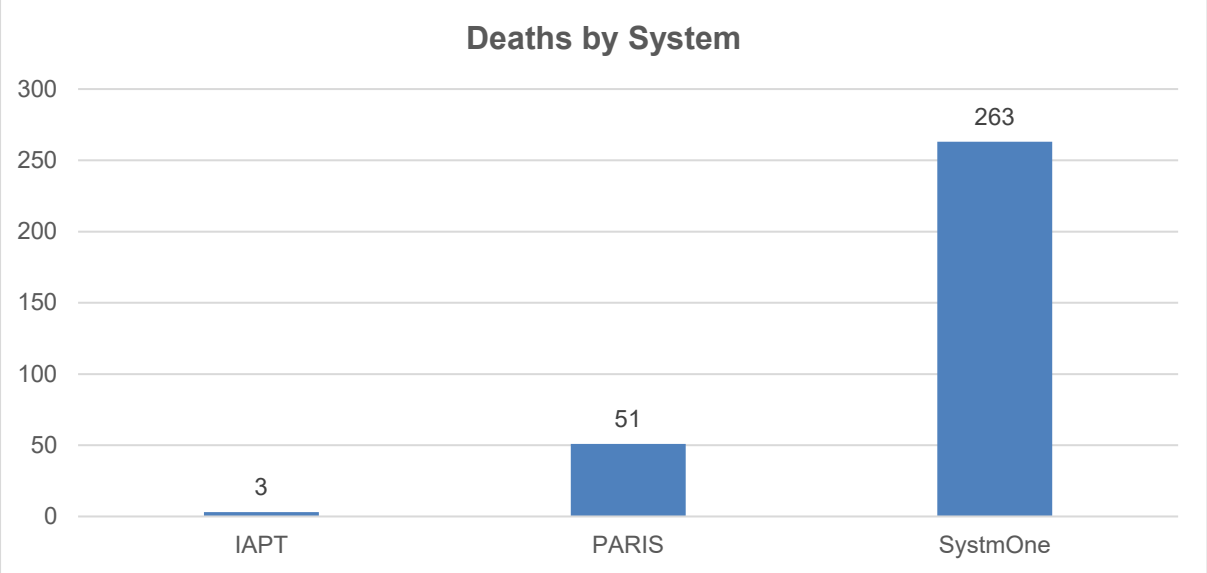
For the period 1 August to 30 September 2022, the Mortality Review Group reviewed 10 deaths through a Stage 2 Case Record Review. These reviews were undertaken by a multi-disciplinary team, and it was established that of the 10 deaths reviewed, none were due to problems in care.

From the 1 August to 30 September 2022 there has been no deaths reported where the patient tested positive for COVID-19.

Head of Clinical Quality from NHS Derby and Derbyshire Integrated Care Board / Joined Up Care Derbyshire was invited by the Lead Professional for Patient Safety/Experience to undertake an independent review of the Trust Incident Process to ascertain if any improvements could be made. No actions were required and there was satisfaction that the Trust had robust systems in place for monitoring incidents.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 August to 30 September 2022

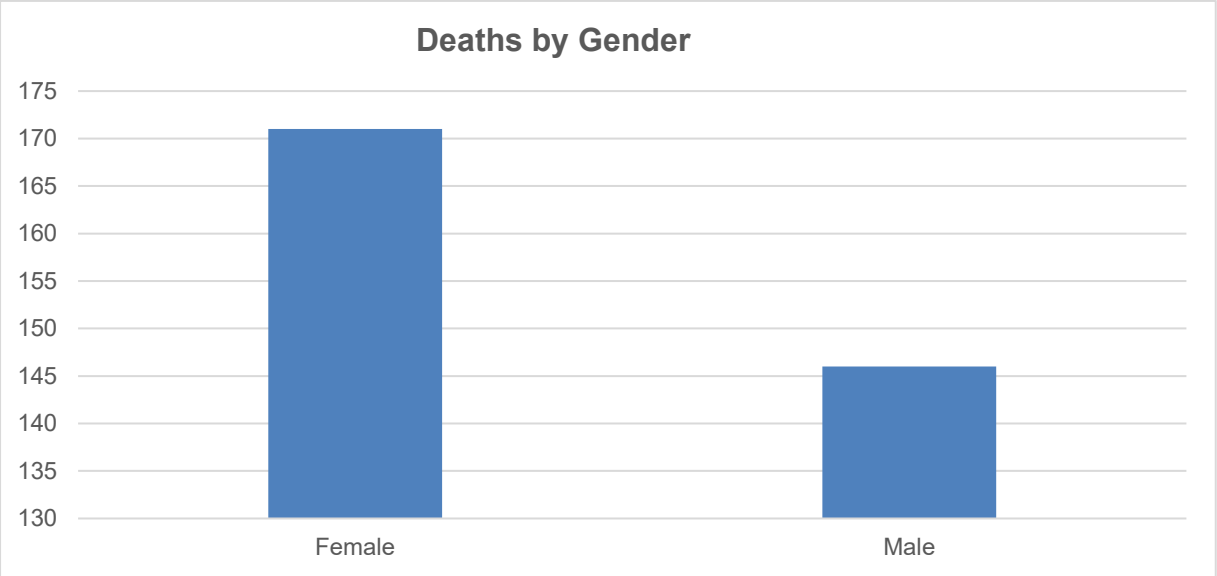


System	Number of Deaths
IAPT	3
PARIS	51
SystmOne	263
Grand Total	**317**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne. 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. This data will no longer be utilised moving forward as all teams have now moved to one EPR with System1 fully rolled out across the Trust.

6.2 Deaths by Gender

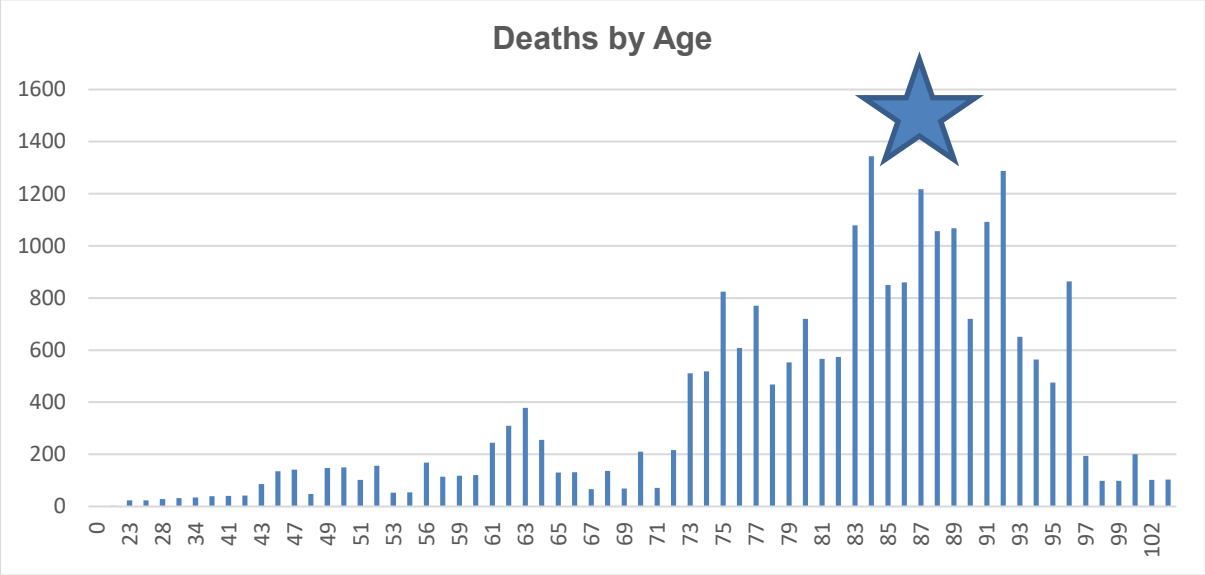
The data below shows the total number of deaths by gender for 1 August to 30 September 2022. There is very little variation between male and female deaths; 146 male deaths were reported compared to 171 females.



Gender	Number of Deaths
Female	171
Male	146
Grand Total	**317**

6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 103 years. Most deaths occurred within the 83 to 92 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	August	September
LD Deaths	1	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. The Trust has received the recent LeDeR themes by provider for reviews completed between the 01 April and 30 September 2022, these will be shared in the Executive Incident group.

During 1 August to 30 September 2022, the Trust has recorded four 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 no deaths.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 224 recorded deaths, 19 deaths had no recorded ethnicity assigned, and seven people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
Mixed - White and Asian	1
Black or Black British - African	1
Black or Black British - Any other Black background	2
Asian or Asian British - Indian	3
Asian or Asian British - Pakistani	3
White - Irish	3
White - Any other White background	4
Not stated	7
Not Known	19
Other Ethnic Groups - Any other ethnic group	50
White - British	224
Grand Total	**317**

6.6 Death by Religion

Christianity is the highest recorded religion group with 128 recorded deaths, 125 deaths were (blank) with no recorded religion assigned. The chart below outlines all religious groups.

Religion	Number of Deaths
Jehovah's Witness	1
Quaker religion	1
Church of Scotland, follower o	1
Religion (other Not Listed)	1
Anglican	1
Spiritualist	1
Muslim	2
Christian religion	2
None	2
Not Given Patient Refused	2
Agnostic	2
Atheist movement	2
Roman Catholic	2
Sikh	3
Methodist	4
Not Religious	4
Unknown	10
Church Of England	11
Church of England, follower of	12
Christian	128
(Blank)	125
Grand Total	**317**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 148 recorded deaths. 156 have no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number of Deaths
Gay Or Lesbian	1
Not Stated (declined)	1
Unknown	1
Not Appropriate To Ask	2
Sexual orientation not given - patient refused	8
Heterosexual	148
(blank)	156
Grand Total	**317**

6.8 Death by Disability

The table below details the top five categories by disability. Gross motor disability was the highest recorded disability group with 34 recorded deaths.

Disability	Number of Deaths
Physical disability	5
Hearing disability	7
Emotional behaviour disability	7
Intellectual functioning disability	18
Gross motor disability	34
Grand Total	**71**

There was a total of 83 deaths with a disability assigned and the remainder 234 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 officers 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?

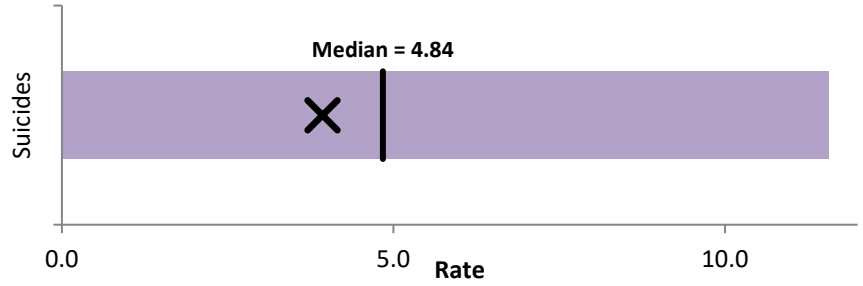
Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. It is hoped that the new process of the medical examiner reviewing all non-coronial deaths will hopefully commence on 1 February 2023.

8. National Confidential Inquiry into Suicide and Safety in Mental Health Safety Score Card

The NCISH safety scorecard was developed as a request of the Healthcare Quality Improvement Partnership (HQIP) as a way to support Trusts to implement quality improvement where appropriate. The data also allows Trusts to compare themselves to other Trusts, allowing some benchmarking.

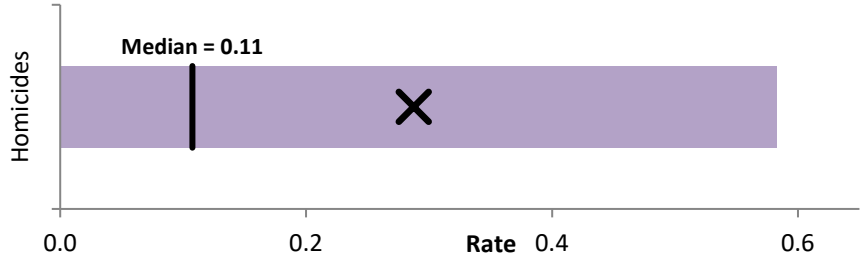
The data within the figures below show information from a range of results for mental health providers across England, based on the most recent available figures: 2017-2019 for suicides and homicides, 31 October 2020 – 31 October 2021 for non-medical staff turnover and January 2018 to February 2022 for trust questionnaire response rates. 'X' marks the position of your trust. Rates have been rounded to the nearest 2 decimal places and percentages to whole percentage numbers. These data sets were chosen has within research they have demonstrated contribution to risk increase.

The NCISH Safety Scorecard consists of 4 indicators that relate to the work of NCISH: suicide rate and homicide rate, non-medical staff turnover, and NCISH suicide questionnaire response rate.



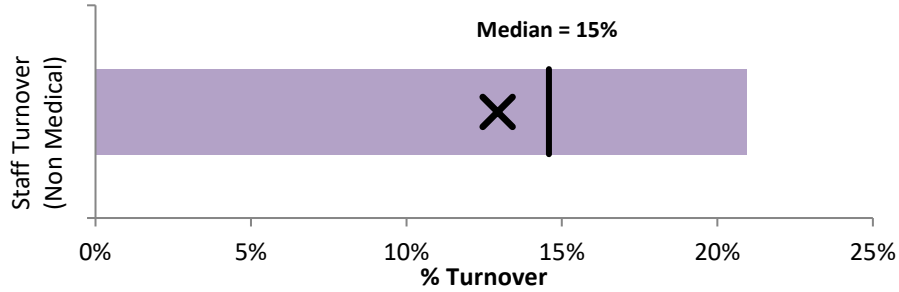
Suicide rate

The suicide rate in your Trust was 3.93 (per 10,000 people under mental health care) from 2017-2019



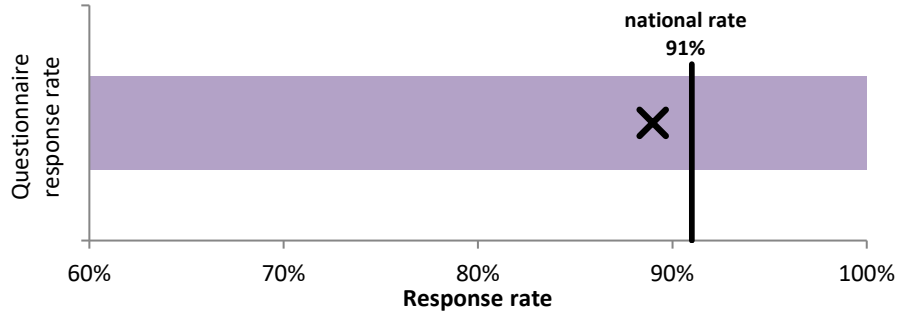
Homicide rate

The homicide rate was 0.29 (per 10,000 people under mental health care) from 2017-2019.



Staff Turnover

Non-medical staff turnover was 13% between October 2020 and October 2021.



NCISH questionnaire response rate

You have returned 89% of NCISH questionnaires between January 2018 and February 2022.

9. Recommendations and Learning

Following the findings of the 'Analysis of Inpatients Deaths 2019-2022' the following recommendations have been made:

- A review of the pathway of communication and documentation (including risk assessments and careplan) between the Crisis Team, ward areas and CMHT when a patient is due to be on section 17 leave / discharged
- To develop training on Emotionally Unstable Personality Disorder for all clinical staff
- To continue to raise the profile of referring patients who are high risk at discharge or complex to the complex risk panel
- An audit of DNA/CPR /respect forms to be undertaken on the older adult acute inpatient wards
- A focus group to be implemented in collaboration with the Acute Trusts to improve the admissions / transfers process when a patient is physically deteriorating (this work is underway, and a focus group is currently being established with the Royal Derby Hospital Medical Directorate to take this work forward)
- Establish a physical health reporting working group to establish the new SystmOne reporting frameworks to improve reports for assurance
- Introduction of RESTORE2 into ILS training framework including review of current ILS provision
- Review the Acute Inpatient Mental Health Services for Adults of Working Age Policy and Procedures and Discharge, Transfer, Transitions and leave policy
- Develop a 'Learning the lessons from Incidents' forum.