Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Learning from Deaths - Mortality Annual Report 2022/23

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 2022 to 31 March 2023.

Executive Summary

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.

- During 2022/23 there have been two deaths reported where the patient tested positive for COVID-19. These deaths were in the community.
- The Trust received 2302 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; 1124 male deaths were reported compared to 1176 females (2 not specified).
- Three inpatient deaths (expected), two patients died following transfer to the acute hospital for further treatment and three patients died whilst on leave from the ward (unexpected).
- The Mortality Review Group reviewed 46 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 46 deaths reviewed, none were due to problems in care.
- The Trust has reported 23 Learning Disability deaths in the reporting timeframe and death of three patients with a diagnosis of autism.
- Medical Examiner Officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community Trusts. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.
- A process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure.

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.

Consultation

Quality and Safeguarding Committee 11 April 2023.

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:

- During 2022/23 there was very little variation between male and female deaths; 1,124 male deaths were reported compared to 1,176 female (two not specified).
- 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 Arun Chidambaram**
Medical Director

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

Louise Hamilton & Nicola Burton
Safer Care Co-ordinator

Learning from Deaths - Mortality Report

1. Background

In line with the Care Quality Commission's (CQC) 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 April 2022 to 31 March 2023.

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

- 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. This will improve once Medical Examiners commence the process of reviewing the Trusts non-coronial deaths which has currently been put on hold nationally however the rust continues to meet with the Medical Examiners on a regular basis.

- Medic rotas for the north and south have been updated and a rota is in place until December 2023. 46 Case Note Review sessions were undertaken, where 46 incidents were reviewed. Unfortunately, 16 sessions did not take place due to lack of medic availability, 1 meeting was cancelled due to computer accessibility issues, 2 meetings were cancelled due to strike action and 5 sessions did not take place due to nurse availability.

- 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 16 January 2023.

- A process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services.

[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 from 1 April 2022 to 31 March 2023.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	181	189	174	210	168	147	229	178	242	223	176	185
LD Referral Deaths	4	2	2	1	1	3	3	1	1	1	1	3

Correct as of 5/4/2023

From 1 April 2022 to 31 March 2023, the Trust received 2302 death notifications of patients who have been in contact with our services.

Of these deaths 1,124 patients were male, 1,176 female, 1,714 were white British and 14 Asian/Asian British Pakistani. The youngest age was 0 years, the oldest age recorded was 105.

The Trust has reported 23 Learning Disability deaths in the reporting timeframe and death of three patients with a diagnosis of autism.

4. Review of Deaths

Total number of Deaths from 1 April 2022 to 31 March 2023 reported on Datix	219 “Unexpected deaths”; 2 COVID deaths 32 “Suspected deaths” 25 “Expected - end of life pathway”) NB some expected deaths have been rejected so these incidents are not included in the above figure Three inpatient deaths (expected), two patients died following transfer to the acute hospital for further treatment (unexpected) and three patients died whilst on leave from the ward (unexpected).
Incidents assigned for a review	271 incidents assigned to the operational incident group 6 did not meet the requirement 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.
- *Death of a patient with Autism*
- *Death of a patients who had a diagnosis of psychosis within the last episode of care*

The last two red flags have been added this year to ensure that the Trust meets the Learning from Deaths guidance and recent changes to the Learning Disability Mortality Review (LeDeR) reporting requiement of patients who have a diagnosis of autism.

5. Learning from Deaths Procedure

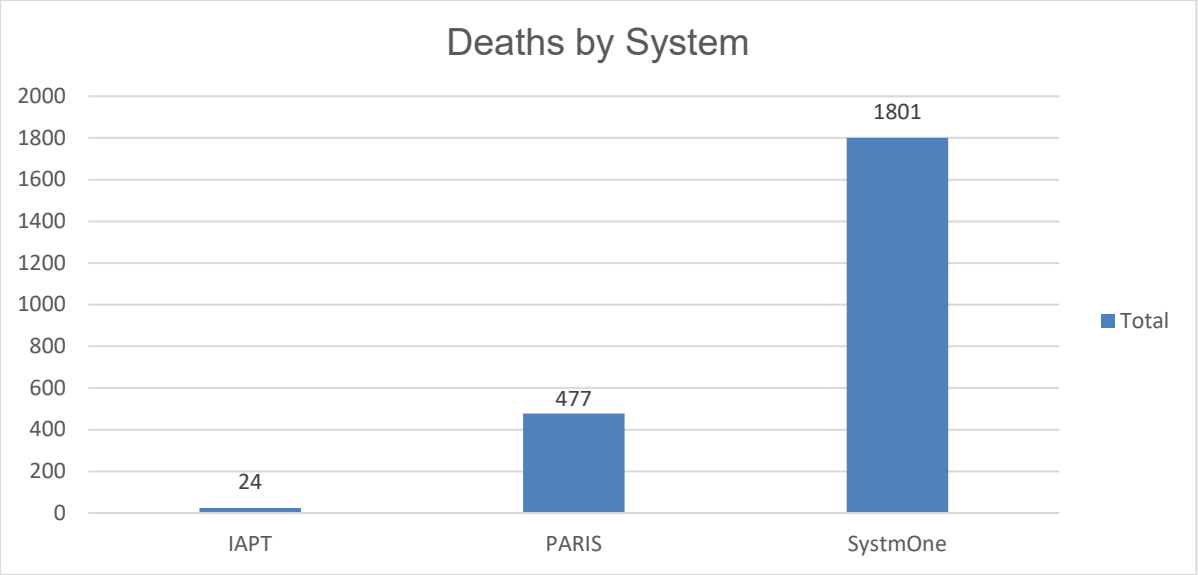
The Trust has now completed a move in terms of its mortality process, a process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services.

Th Mortality team are conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

During 2022/23 the Mortality Review Group reviewed 46 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team, and it was established that of the 46 deaths reviewed, 0 were not due to problems in care. Unfortunately, 16 sessions did not take place due to lack of medic availability, 1 meeting cancelled due to connection issues, 2 meetings cancelled due to strike action, and 5 sessions did not take place due to nurse availability. Unavailability of medics to attend these meetings remains a recurring problem.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2022 to 31 March 2023



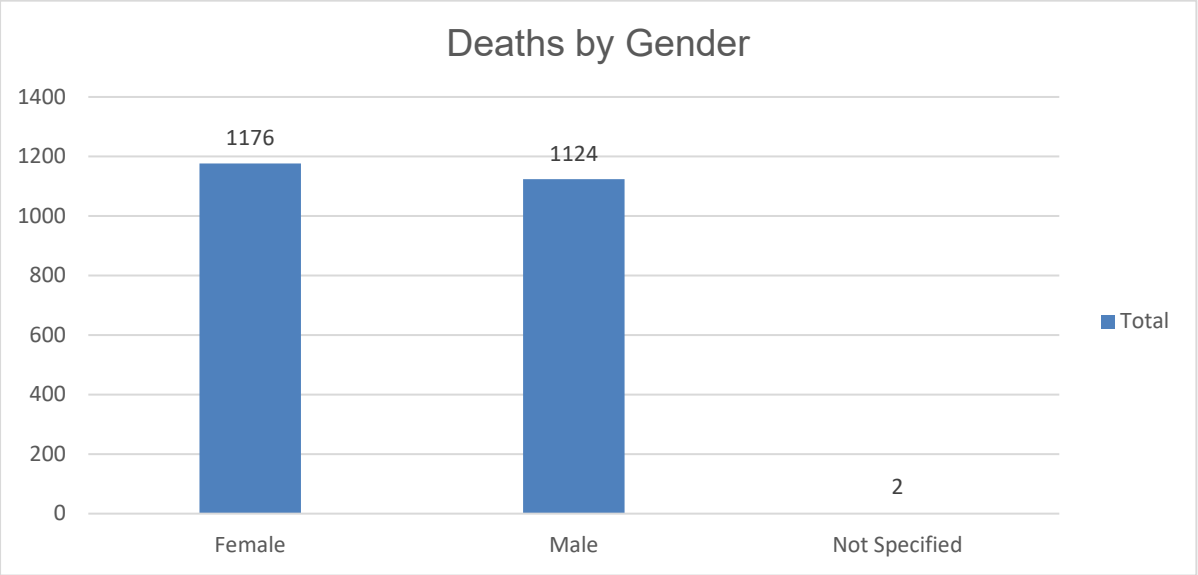
System	Number of Deaths
IAPT	24
PARIS	477
SystmOne	1801
Grand Total	**2302**

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.

From the 1 April 2022 to 31 March 2023 there have been 2 deaths reported where the patient tested positive for COVID-19. Of these deaths 2 patients both were female and from a White British background. And were within the community

6.2 Deaths by Gender

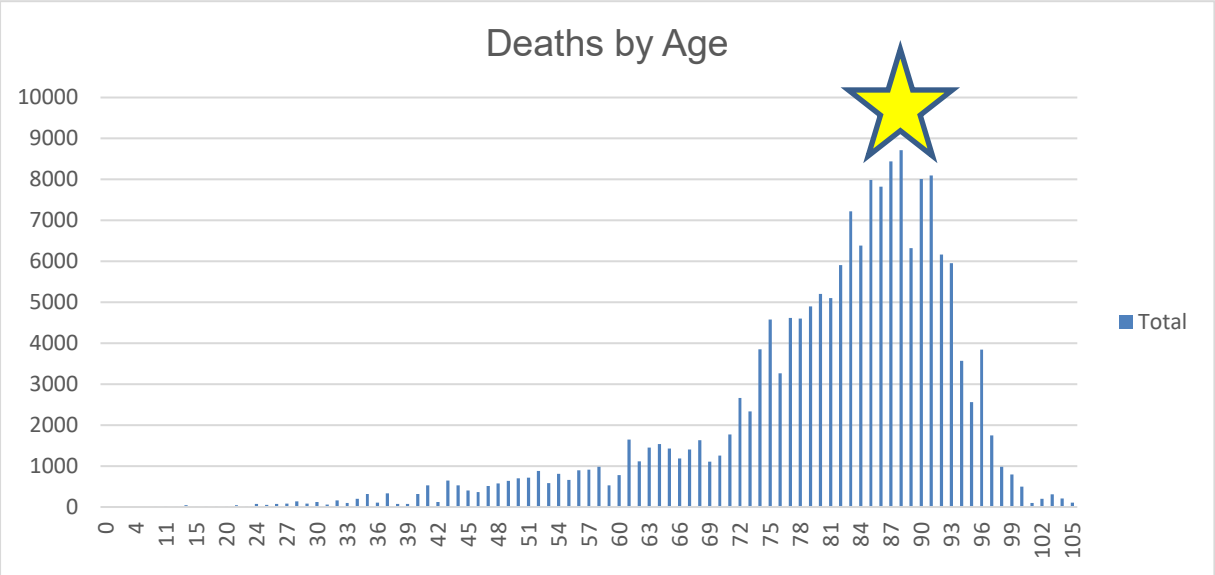
The data below shows the total number of deaths by gender 1 April 2022 to 31 March 2023. There is very little variation between male and female deaths;1176 female deaths were reported compared to 1124 males.



Gender	Number of Deaths
Female	1176
Male	1124
Not Specified	2
Grand Total	**2302**

6.3 Death by Age Group

The youngest age was classed as 0, and the oldest age was 105 years. Most deaths occurred within the 85 to 88 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LD Deaths	4	2	2	1	1	3	3	1	1	1	1	3
Autism	1	0	2	0	0	0	0	0	0	0	0	0

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 LeDeR programme. The Trust is currently awaiting the annual LeDeR report.

From 1 January 2022 the Trust has been required to report any death of a patient with autism to date three patients has been referred.

During 1 April 2022 to 31 March 2023, the Trust has recorded 23 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.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 1,714 recorded deaths, 130 deaths had no recorded ethnicity assigned, and 43 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
Asian or Asian British – Any other Asian Background	1
Asian or Asian British – Indian	10
Asian or Asian British – Pakistani	14
Black or Black British – African	2
Black or Black British – Any other Black background	9
Black or Black British – Caribbean	4
Mixed – Any other mixed background	3
Mixed – White and Asian	2
Mixed - White and Black Caribbean	3
Not known	130
Not stated	43
Other Ethnic Groups - any other ethnic group	320
Other Ethnic Groups – Chinese	1
White – Any other White background	33
White – British	1714
White – Irish	13
Grand Total	**2302**

6.6 Death by Religion

Christianity is the highest recorded religion group with 958 recorded deaths, 915 deaths had no recorded religion assigned and 6 people refused to state their religion. The chart below outlines all religion groups.

Religion	Number of Deaths
Agnostic	5
Agnostic movement	2
Anglican	2
Atheist	4
Atheist movement	6
Baptist	2
Buddhist	2
Catholic religion	4
Catholic: non Roman Catholic	1
Catholic: Not Roman Catholic	1
Christian	958
Christian religion	14
Church Of England	79
Church of England, follower of	79
Church of Scotland	1
Church of Scotland, follower of	1
Congregationalist religion	1
Hindu	1
Islam	1
Jehovah's Witness	7
Methodist	17
Mormon	1
Muslim	10
Nonconformist	2
None	8
Not Given Patient Refused	6
Not Religious	36
Not stated	3
Pagan	1
Patient Religion Unknown	5
Pentecostalist	1
Quaker religion	1
Religion (other Not Listed)	1
Religion NOS	7
Roman Catholic	24
Sikh	8
Spiritualist	1
United Reform Church	1
Unknown	82
(blank)	915
Grand Total	**2302**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 887 recorded deaths. 1,345 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Bisexual	1
Female homosexual	1
Gay or lesbian	2
Heterosexual	798
Heterosexual or straight	89
Homosexuality NOS	1
Lesbian or gay	1
Not appropriate to ask	3
Not stated (declined)	2
Patient unsure	1
Person declined to disclose	2
Sexual orientation not given - patient refused	45
Sexual orientation unknown	1
Unknown	10
(blank)	1345
Grand Total	**2302**

6.8 Death by Disability

The table below details the top 8 categories by disability. Gross motor disability was the highest recorded disability group with 235 recorded deaths.

Disability	Number of Deaths
Learning Disability	6
Behaviour And Emotional	7
Physical	7
Other	7
Emotional Behaviour Disability	38
Hearing Disability	43
Intellectual Functioning Disability	107
Gross Motor Disability	235

There were a total of 511 deaths with a disability assigned and the remainder 1,791 were blank (had no assigned disability).

7. Recommendations and Learning

The table below outlines the current themes from incidents

Improvement issue	Actions required update
Transfer, Leave and Discharge	**Transfer of the deteriorating patient.** Internal investigations highlighted themes around the transfer and return of patients between inpatient services for the Trust and Acute providers. This includes handover of information, and the way patients are conveyed. A quality improvement project is underway between Derby Hospital and DCHFT. **Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements.** A number of investigations have highlighted issues in relation to leave arrangements for inpatient services including follow up. A further thematic review was completed on conclusion of a cluster of inpatient suspected suicide incidents. An action plan has been developed. The Patient Safety Team are leading on the coordination of the review of the current processes and quality improvement actions. The works will include review of the pathway of communication and documentation (including risk assessments and care plan) between Crisis Resolution and Home Treatment/ Community teams and Inpatient Services when a patient is due to be on s17 leave/ discharged.
Suicide Prevention	The trust has identified the need to re-establish Suicide Prevention training across services, this is being led by the Trust Medical Director.
Training and awareness of Emotionally Unstable Personality Disorder	The trust will develop a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
Family liaison and engagement	A considerable amount of work has been undertaken to ensure that the Trust is complaint with regulation 20. Operating procedures are now in place, template letters for family engagement, set timescales for family contacts, signposting to relevant support services, and helping family members identify coping mechanisms. Benchmarking against key guidance has been undertaken, Duty of Candour training has been developed including a bereavement leaflet and guidelines for operational staff Roll out of patient safety partners.
Falls prevention	A Trust Falls Group meets regularly to discuss improvements and themes arising from falls within inpatient services, a quality improvement plan is required to assure improvements.
Multi-agency engagement following incidents	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Improving Physical Healthcare monitoring	Quality improvement work in relation to improving physical healthcare management, observation, and care planning within Older Peoples services. Enhancement of wound care management and infection prevention and control investigation and follow up within inpatient services. Introduction of RESTORE2 into ILS training framework including review of current ILS provision.

Improvement issue	Actions required update
	Establish a physical health reporting working group to establish the new system one reporting frameworks to improve reports for assurance. Introduction of RESTORE2 into ILS training framework including review of current ILS provision. Notification of increased NEWS score via system one to senior colleagues to be reviewed.
MDT process improvements within CMHTs	Investigations have highlighted themes in relation to Multi-Disciplinary Team processes within Community Mental Health Trusts and works are currently underway to review the Electronic Patient Record and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Observation levels	To continue commissioned working group to review handheld clinical devices and compliance with observations including physical health observations.
Dissemination of learning and service improvements following incidents	Work is underway to improve the way in which the trust learning and improves from incidents, this will include a revision to the processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process.
Inappropriate admission to inpatient adult ward	Investigations into high profile incidents of inappropriate admissions to Adult Mental Health inpatient services brought to attention an on-going issue in this area. Review of lower grade incidents and discussions with the service line have confirmed a long-standing theme in this area. A review of inappropriate admissions is currently underway.