Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 September 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 April to 31 May 2023.

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 April to 31 May 2023 there has been zero deaths reported where the patient tested positive for Covid-19.
- The Trust received 343 death notifications of patients who had been in contact with our service within the 6 months prior to their death. There is little variation between male and female deaths; 167 male deaths were reported compared to 175 females.
- No Inpatient deaths were recorded.
- Due to the number of active Case Record Reviews the function of the weekly Mortality Review Group supported by medical staff has been temporarily adapted to allow Investigation Facilitators to take specific active complex cases for medical opinion or input to offer a timelier resolution. This is a temporary arrangement to assist in reducing backlog and the function of the group will return to weekly review of non-complex deaths.
- The Trust has reported five Learning Disability deaths in the reporting timeframe and no patients with a diagnosis of Autism Spectrum Disorder (ASD).
- 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.

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

The Quality and Safeguarding Committee reviewed the report on 11 July 2023 and agreed for it to be considered by the Trust Board of Directors.

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.

- For the period 1 April to 31 May 2023 there was little variation between male and female deaths; 167 male deaths were reported compared to 175 females.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this Mortality Report on the recommendation of the Quality and Safeguarding Committee 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: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Arun Chidambaram
Medical Director

Report prepared by: **Lead Professional for Patient Safety and Experience and Mortality Reviewers**

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 April to 31 May 2023.

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

- 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. 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.

- 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.

- The mortality team have now received a new schedule outlining the medics who will be attending Case Record Review sessions in 2023 for both North and South consultants. Meeting invites for 2023 have now been set up and sent to all consultants involved.

- 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 on 26 June 2023.

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

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 April to 31 May 2023.

	April	May
Total Deaths Per Month	163	180
LD Referral Deaths	3	2
Inpatient Deaths	1	0

Correct as of 22 June 2023

167 patients were male, 175 were female, of these 268 were white British, 46 were any other ethnic group and 17 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 102.

From 1 April to 31 May 2023, the Trust received 343 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 1 April to 31May 2023 reported on Datix	41 “Unexpected deaths” 0 Covid-19 deaths 9 “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	53 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.
- *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 LEDER reporting requirement of patients with a learning disability 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.

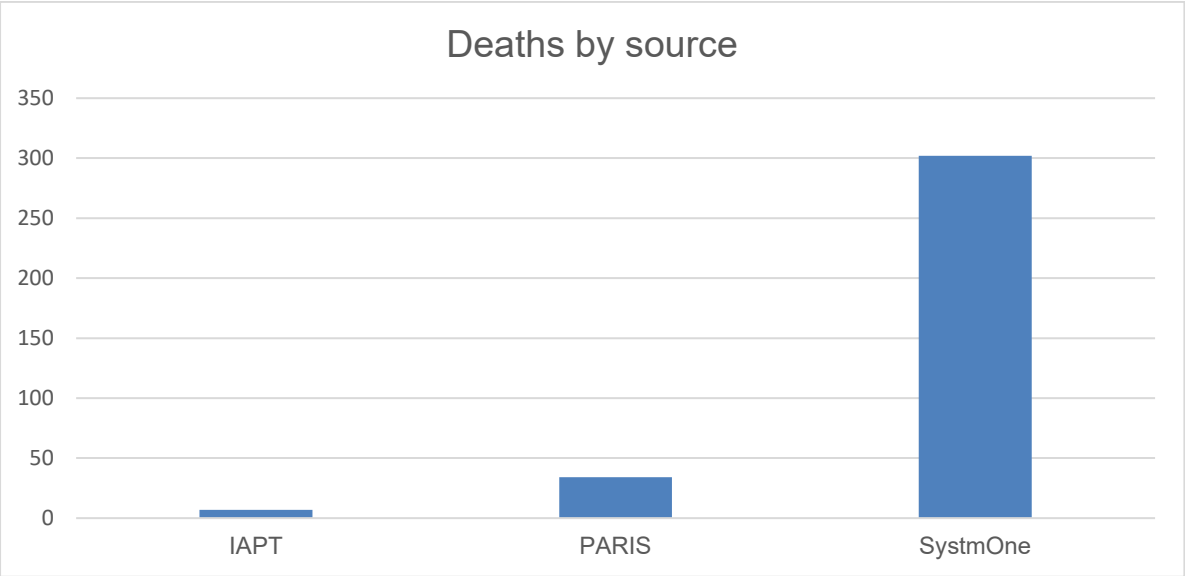
The Mortality team are conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

From the 1 April 2023 to 31 May 2023 there has been no deaths reported where the patient tested positive for Covid-19.

Analysis of Data

The Trust Mortality database is fed directly by the NHS Spine, therefore one point of data only. This data is updated approximately every 8 hours. The Data is in relation to any active patient or patient who has died within 6 months of discharge from services. The Trust continues in efforts to obtain cause of death information for non-coronial deaths, however any death which meets a Trust Red Flag for deaths will be reported to the DATIX system and considered under the incident process, this would include actively seeking cause of death from Coroners. This is problematic and can take considerable time to obtain. Once established the Medical Examiners process will help to establish cause of death for non-coronial deaths.

6.1 Analysis of deaths per notification system since 1 April 2023 – 31 May 2023

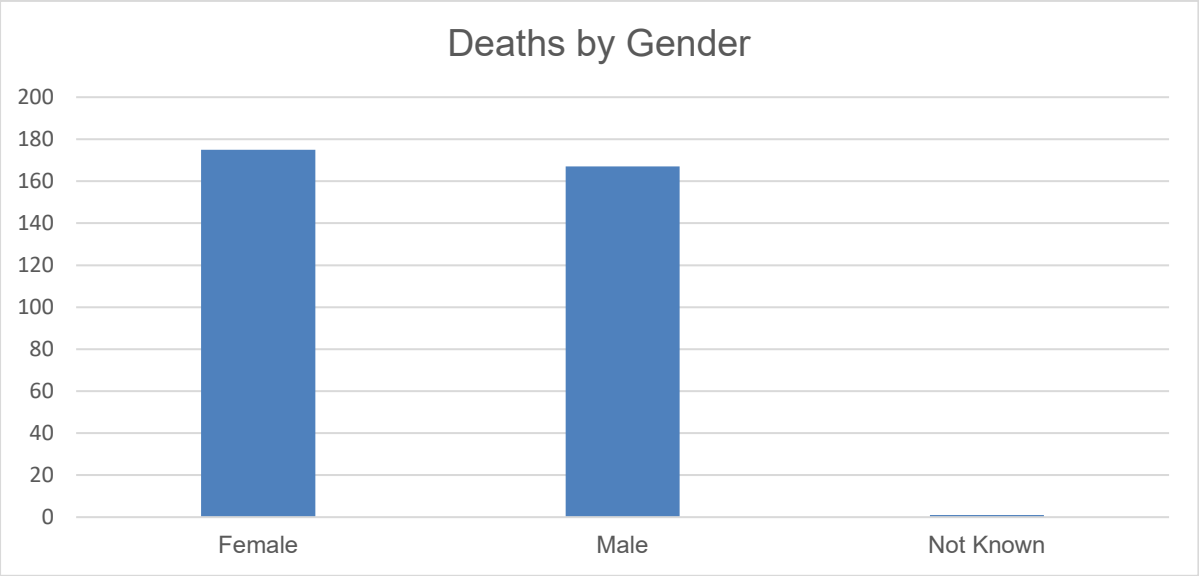


System	Number of Deaths
IAPT	7
PARIS	34
SystmOne	302
Grand Total	**343**

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.

6.2 Deaths by Gender

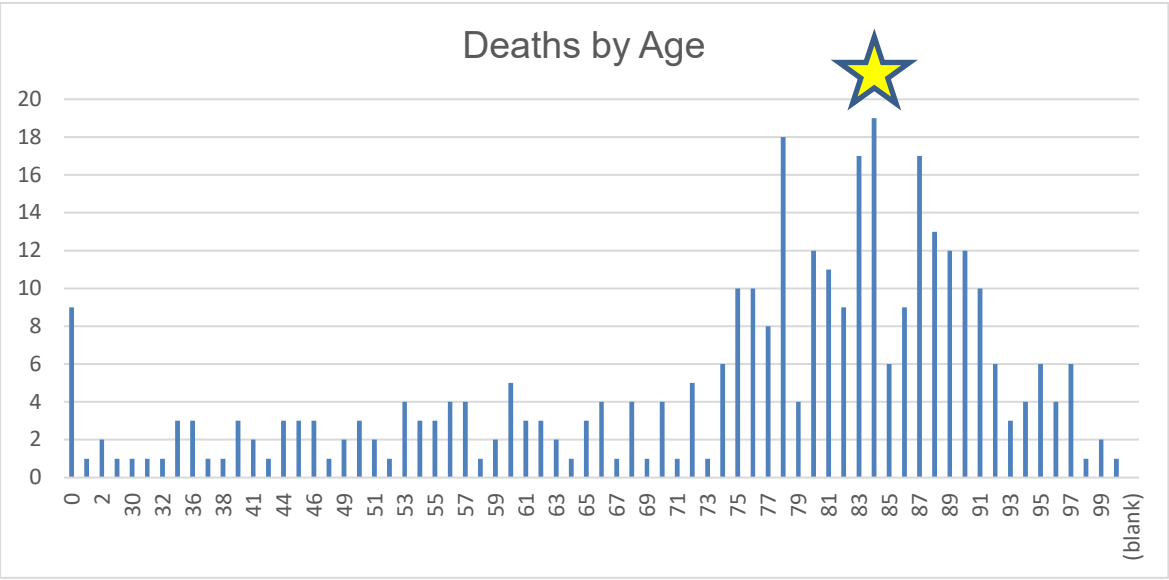
The data below shows the total number of deaths by gender for 1 April 2023 – 31 May 2023. There is very little variation between male and female deaths; 167 male deaths were reported compared to 175 females.



Gender	Number of Deaths
Female	175
Male	167
Not Known	1
Grand Total	**343**

6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 104 years. Most deaths occurred within the 85-88 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	April	May
LD Deaths	3	2

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.

During 1 April 2023 to 31 May 2023, the Trust has recorded five 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 268 recorded deaths, 13 deaths had no recorded ethnicity assigned, and 4 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count of Ethnicity
Asian or Asian British - Bangladeshi	1
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	3
Black or Black British - African	2
Black or Black or Black British - Caribbean Black British - Any other Black background	2
Mixed – Any other mixed background	1
Mixed – White and Black Caribbean	1
Not Known	13
Not stated	4
Other Ethnic Groups - Any other ethnic group	46
White - British	268
White - Irish	1
Grand Total	**343**

6.6 Death by Religion

Christianity is the highest recorded religion group with 152 recorded deaths, 125 deaths were (blank) with no recorded religion assigned. The table below outlines all religious groups.

Religion	Number of Deaths
Agnostic	1
Atheist	1
Atheist movement	2
Catholic religion	1
Catholic: Not Roman Catholic	1
Christian	149
Christian religion	3
Church of England	14
Church of England, follower of	17
Methodist	3
Muslim	5
None	4
Not Religious	2
Pagan	1
Patient Religion Unknown	1
Religion NOS	2
Roman Catholic	4
Unknown	6
Blank	125
Grand Total	**343**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 204 recorded deaths. 126 had no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number of Deaths
Bisexual	1
Heterosexual	194
Heterosexual or Straight	10
Sexual orientation not given - patient refused	7
Unknown	1
Blank	125
Grand Total	**343**

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 60 recorded deaths.

Disability	Number of Deaths
Behaviour and Emotional	2
Behaviour and Emotions: Learning Disability (Dementia); Self-care and Continence	1
Emotional behaviour disability	9
Gross motor disability	60
Hearing disability	6
Intellectual functioning disability	28
Learning Disability	1
Other	1
Blank	262
Grand Total	**343**

There was a total of 81 deaths with a disability assigned and the remainder 262 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 offices 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. 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.

8. Recommendations and Learning

Action
Review the pathway of communication and documentation (including risk assessments and care plan) between crisis team and ward areas when a patient is due to be on s17 leave/discharged
Review the pathway of communication and documentation (including risk assessments and care plan) between CMHT and ward areas when a patient is due to be on s17 leave/discharged
Suicide prevention training to be restarted
To develop training on Emotionally Unstable Personality Disorder
Quality improvement project –ligature risks on inpatient units
To continue to raise the profile of referring patient who are high risk at discharge or complex on to the complex risk panel
Share the inpatient death report with all ward staff
To commence the bed sensor project – Cubley ward
Audit DNA/CPR /respect forms
Focus group to develop admission /transfer between the Trust and Acute when a patient is physically deteriorating
Quality improvement project older adult - Improving physical healthcare observations and care plans
ACP to continue to support transition between Acute and Mental health inpatient services alongside medical colleagues at the unit
Establish a physical health reporting working group to establish the new system one reporting frameworks to improve reports for assurance
Health Protection Unit to support wound care management and infection prevention and control investigation and follow up
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
Review the discharge, transfer transitions, and leave policy
Review the Acute Inpatient Mental Health Services for Adults of Working Age Policy and Procedures
Following NHS training on MHOST in October, plan is to be rolled out incrementally across inpatient areas

To develop a ‘learning the lessons’ from incidents forum
To continue commissioned working group to review handheld clinical devices and compliance with observations including physical health observations
To review the possibility of an expert by experience for patient safety
Roll out of patient safety partners