Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 July 2024

Learning from Deaths - Mortality Annual Report 2023/24

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 2023 to 31 March 2024.

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 2023/24 there has been one death reported where the patient tested positive for COVID-19. This death was in the community.
- The Trust received 2,444 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; 1,216 male deaths were reported compared to 1,228 females.
- One inpatient death (expected – end of life), one inpatient death (suspected suicide) and three patients died following transfer to the acute hospital for further treatment (two unexpected and one suspected suicide).
- The Trust has reported 26 Learning Disability deaths in the reporting timeframe and deaths of five 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 comes into force on 9 September 2024. 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.	

Risks and Assurances

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

Consultation

- This report has been reviewed by the Medical Director
- Quality and Safeguarding Committee 14 May 2024.

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 2023/24, there was very little variation between male and female deaths; 1,216 male deaths were reported compared to 1,228 female deaths
- 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: **Louise Hamilton**
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 2023 to 31 March 2024.

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 Trust's non-coronial deaths in September 2024. The Trust continues to meet with the Medical Examiners on a regular basis.

- 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 2 May 2024.

- 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 Case Record review panel process has been evaluated and plans are in place to re-design this to act as an assurance and audit panel over incidents closed through the Operational Incident Review group.

- The Trust Mortality Committee has been evaluated and developed into a Learning the Lessons Oversight Committee which will improve governance around learning and drive quality improvement.

[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 2023 to 31 March 2024.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	164	188	161	187	158	162	190	212	269	261	239	253
LD Referral Deaths	3	2	4	1	0	2	1	2	3	2	4	2

Correct as of 29 April 2024

From 1 April 2023 to 31 March 2024, the Trust received 2,444 death notifications of patients who have been in contact with our services.

Of these deaths 1,216 patients were male, 1,228 female, 1,847 were white British and 26 Asian British. The youngest age was 0 years, the oldest age recorded was 103.

The Trust has reported 26 Learning Disability deaths in the reporting timeframe and death of five patients with a diagnosis of autism.

4. Review of Deaths

Total number of Deaths from 1 April 2023 to 31 March 2024 reported on Datix	222 “Unexpected deaths” 1 COVID death 39 “Suspected deaths” 9 “Expected - end of life pathway” NB some expected deaths have been rejected so these incidents are not included in the above figure. One inpatient death (expected – end of life), one inpatient death (suspected suicide) and three patients died following transfer to the acute hospital for further treatment (two unexpected and one suspected suicide).
Incidents assigned for a review	270 incidents assigned to the operational incident group 1 incident are 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.

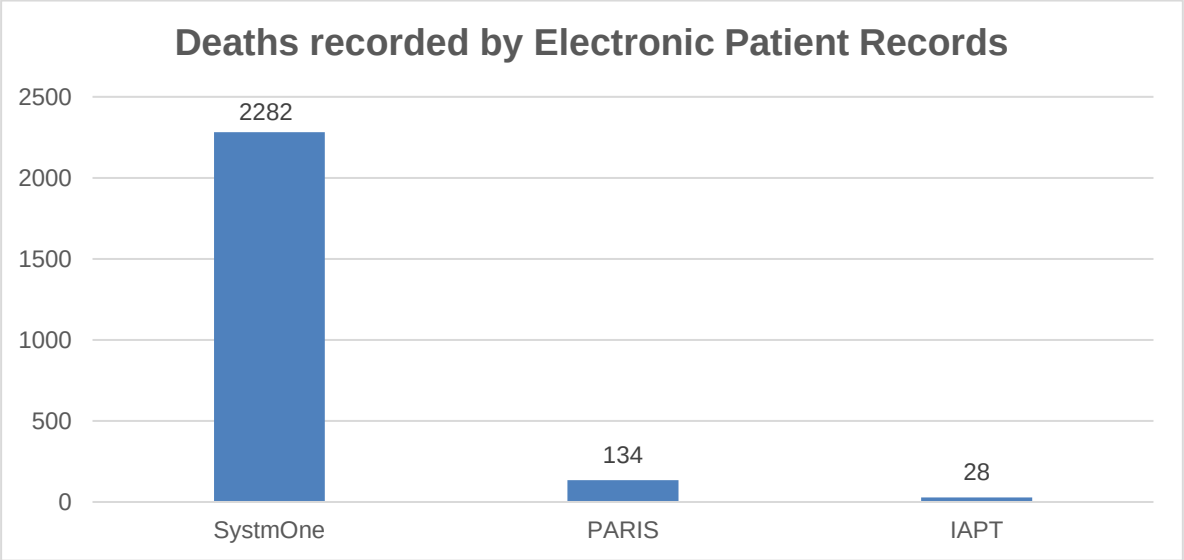
5. Learning from Deaths Procedure

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.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2023 to 31 March 2024



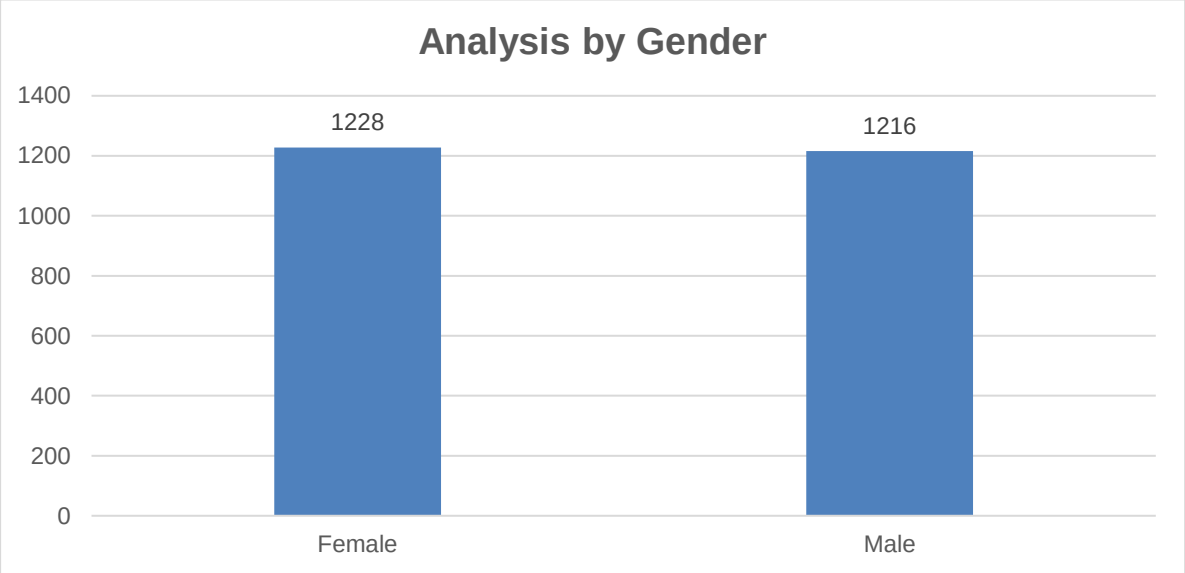
System	Number of Deaths
IAPT	28
PARIS	134
SystmOne	2282
Grand Total	**2444**

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 2023 to 31 March 2024, there has been one death reported where the patient tested positive for COVID-19. The patient was female and from a White British background and was within the community.

6.2 Analysis by gender

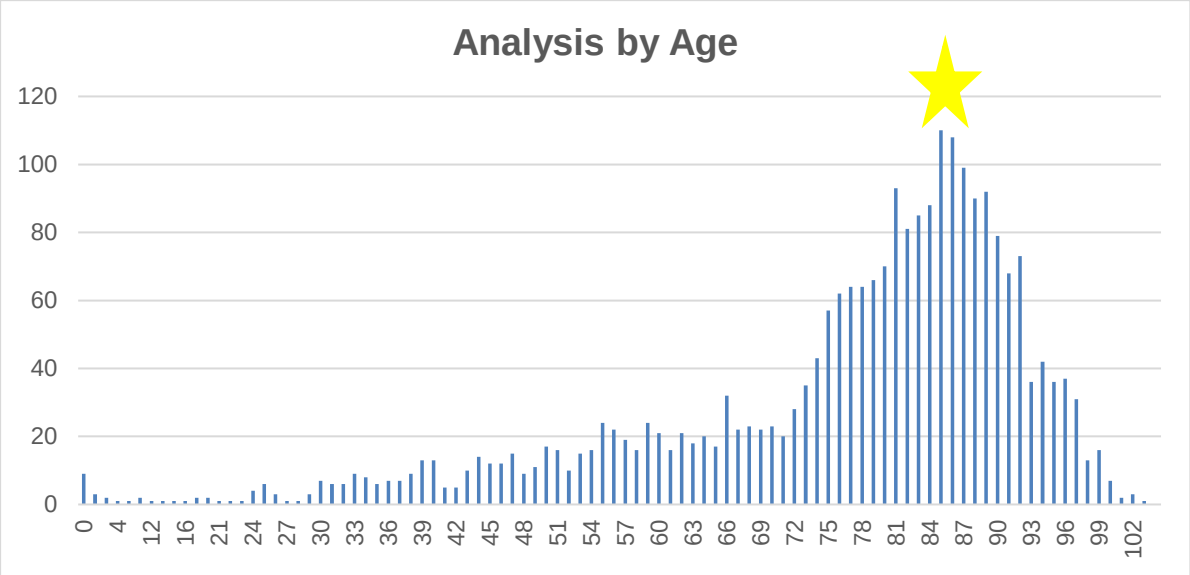
The data below shows the total number of deaths by gender 1 April 2023 to 31 March 2024. There is very little variation between male and female deaths; 1,228 female deaths were reported compared to 1,216 males.



Gender	Number of Deaths
Female	1228
Male	1216
Grand Total	**2444**

6.3 Analysis by Age Group

The youngest age was classed as 0, and the oldest age was 103 years. Most deaths occurred within the 83 to 89 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	3	2	4	1	0	2	1	2	3	2	4	2
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. Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

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

During 1 April 2023 to 31 March 2024, the Trust has recorded 26 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 is currently awaiting the annual LeDeR report.

6.5 Analsysis by Ethnicity

White British is the highest recorded ethnicity group with 1,847 recorded deaths, 108 deaths had no recorded ethnicity assigned, and 32 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
White - British	1847
Other Ethnic Groups - Any other ethnic group	369
Not Known	108
Not stated	32
White - Any other White background	24
White - Irish	16
Asian or Asian British - Indian	15
Asian or Asian British - Pakistani	6
Black or Black British - Any other Black background	6
Mixed - Any other mixed background	4
Asian or Asian British - Any other Asian background	3
Mixed - White and Black Caribbean	3
Black or Black British - African	3
Asian or Asian British - Bangladeshi	2
Black or Black British - Caribbean	2
Mixed - White and Asian	2
Mixed - White and Black African	1
Other Ethnic Groups - Chinese	1
Grand Total	**2444**

6.6 Analysis by Religion

Christianity is the highest recorded religion group with 1002 recorded deaths, 768 deaths had no recorded religion assigned and two people refused to state their religion. The chart below outlines all religion groups.

Religion	Number of Deaths
Christian	1002
Not religious	362
Church of England, follower of	97
Church of England	66
Methodist	17
Roman Catholic	16
Unknown	16
Religion NOS	12
Muslim	11
Christian religion	11
Christian, follower of religion	10
Sikh	9
Atheist movement	7
Catholic religion	7
Catholic: non Roman Catholic	4
Patient religion unknown	4
Atheist	4
Jehovah's Witness	4
Agnostic	3
Buddhist	2
Pagan	2
Protestant	2
Not Given Patient Refused	2
Jewish	2
Spiritualist	1
Catholic: Not Roman Catholic	1
Hindu	1
Islam	1
Sikh religion	1
Nonconformist	1
Anglican	1
Nonconformist religion	1
None	1
(blank)	763
Grand Total	**2444**

6.7 Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 1,453 recorded deaths. 980 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	1419
Sexual orientation not given - patient refused	57
Heterosexual Or Straight	34
Sexual orientation unknown	12
Bisexual	9
Unknown	4
Female homosexual	1
Not Appropriate To Ask	1
Homosexuality NOS	1
(blank)	906
Grand Total	**2444**

6.8 Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 445 recorded deaths.

Disability	Number of Deaths
Gross motor disability	445
Intellectual functioning disability	159
Patient reports no current disability	113
Hearing disability	61
Emotional behaviour disability	58
Physical disability	17
Walking disability	6
Behaviour and emotional	4

There were a total of 889 deaths with a disability assigned and the remainder 1,555 were blank (had no assigned disability).

7. Recommendations and Learning

The table below outlines the current themes arising from incidents.

Improvement issue	Improvement plan
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 has been undertaken between Derby Hospital and DHcFT to develop a transfer and handover proforma. 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 will support 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 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
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.

Physical Health management within inpatient environments	Quality improvement work in relation to improving physical healthcare management, observation and care planning within Older People's 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. 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 MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Self-harm within inpatient environments including management of contraband	Improvement works in relation to Ligature risk assessment and care planning within inpatient services. Quality Improvement programme in relation to self-harm via sharps of females within inpatient services (local priority). Improvement to environment. Improvement to therapeutic engagements. Improvement to risk assessment and management including 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 including assurance and governance	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. Develop pathway to offer clear governance processes. Develop service line learning briefings specific to service learning. Trust-wide learning the lessons to share high level responses and learning. Develop better ways for monitoring and reporting emerging themes. Joined up working between services. Improved monitoring of high-profile cases and joined up working between services involved. Development of more collaborative learning responses.
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.

Application of red flags and flow of incidents resulting in death	Improvement in the application and identification of red flags for reporting death. Revision of current red flags for relevance given changes both nationally and locally. Redesign the function of the 'Mortality' process within structures through the Learning the Lessons subgroups. Review the purpose and function of the Mortality Case Record Review panel and redesign this to one of audit and assurance.
Interface between Mental Health and Substance Misuse service	Suspected suicide of a patient who has a dual diagnosis of substance misuse and mental health but has been rejected by Community Mental Health services is an area which has been noted through Case Record Review. This has been selected as a new local priority for the trust. Themes will be fed into Learning the Lessons subgroups for both services to jointly develop and improvement plan.
Substance Misuse services and Adult Acute Inpatient environments	Learning Responses for unexpected deaths post discharge/ whilst on leave have highlighted gaps around knowledge, support and process for the management and support of risk in relation to addiction and substance misuse. Currently several actions in place. Improvement plan to be developed and managed through the services Learning the Lessons subgroup.