Date:	28th March 2024	K
Item:	24.20	

Norfolk and Suffolk
NHS Foundation Trust

Report to:	Trust Board of Directors
Meeting date:	28 March 2024
Title of report:	Learning from Deaths Quarterly Report
Purpose of paper:	For information and Decision
Author:	Gary O'Hare – Governance and Safety Advisor
Director:	Dr Sarah Maxwell – Chief Medical Officer (interim)
Regulation/ Compliance	Regulatory requirement
Link to Trust Strategy	• Improving Health • Improving Care

Executive summary

One of our core transformation and improvement programmes is focussed on learning from deaths, which is split into three clear areas of focus:

- **Collecting, analysing and reporting on deaths**; involving the creation of a new electronic system for mortality information collection, analysis and reporting.
- **Ensure learning through improvements to clinical practice**; reviewing all Prevention of Future Deaths reports from 2013 to identify themes and ensure learning and improvement, including themes from the Forever Gone Report, Domestic Homicide Reviews and Serious Case Reviews.
- **Work with service users, carers and bereaved families**; detailed work with service users, families, carers and bereaved relatives who sit on our Learning from Deaths Action Plan Management Group

This is the first Board of Directors report using the revised Learning from Deaths quarterly report template. Attached as an appendix to this report is a co-designed summary document which has been produced with the support of bereaved families and carers. This includes definitions and a summary of key data included in this report.

The Report begins to highlight how the Trust will:

- Use our data
- Identify, share, and spread our learning
- Measure the impact and change in our practice

It is also the first board report which utilises the data from the new mostly automated mortality recording and management system.

The report covers the period 1 November 2023 to 31 January 2024. Future reports will be aligned to normal reporting cycles.

During the reporting period there were a total of 437 deaths notified to NSFT that met our criteria for reporting. The breakdown of these death is:

- Unexpected Natural 209 = 48% of all deaths
- Expected Natural 147 = 34% of all deaths
- Awaiting cause of death/unable to obtain cause of death 66 = 15% of all deaths
- Unexpected Unnatural 15 = 3% of all deaths

Whilst most of the report focuses on the new mortality data it also provides updates on:

- The work with service Users, carers, and bereaved families.
- The Medical Examiner process
- External support, scrutiny and assurance on our mortality data systems
- Highlights Learning from incidents and reviews
- Coroners Hearings

Recommendations

The Board of Directors are asked to consider the information and updates provided in this report.

The Board of Directors are asked to consider and comment on the structure and presentation of the revised report.

The Board of Directors are asked to consider the future publication of our mortality data on our Trust's website.

The Board of Directors are asked to confirm that the board approve the composite Learning from Deaths action plan at appendix C of this report to be shared with both Norfolk and Suffolk Health Overview and Scrutiny Committees.

1. Background and Introduction

In 2022, Norfolk and Suffolk NHS Foundation Trust (NSFT) asked NHS Norfolk and Waveney and NHS Suffolk and North East Essex Integrated Care Boards (ICB's) to commission an independent review to assess mortality reporting at our Trust between April 2019 and October 2022.

In September 2022, Grant Thornton UK LLP were commissioned to undertake the review, following a procurement process. The review was commissioned for a specific purpose – to provide an independent audit of the processes used by our Trust to collect and report data relating to mortality.

It was not designed to investigate the circumstances of individual deaths or to compare the levels of mortality reported by or related to NSFT with other NHS trusts in the UK.

The Grant Thornton report was published on 28 June 2023. A copy of the report can be read here:

https://improvinglivesnw.org.uk/independent-review-published-on-mortality-reporting-and-recording-at-the-norfolk-and-suffolk-nhs-foundation-trust/.

The expectations in relation to reporting, monitoring and Board oversight of mortality incidents are set out in NHS England's National Quality Board's 'Learning from Deaths' guidance (March 2017), and builds on the recommendations made by the Mazars investigation into Southern Health (Dec 2015), the CQC report 'Learning, Candour and Accountability publication' (Dec 2016) and the Learning Disabilities Mortality Review (LeDeR) which is managed by NHS England.

The Learning from Deaths framework (LfD) places particular responsibility on Trust Boards to ensure their Trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate. The LfD states 'the aim of this process is to ensure that all deaths of people under the Trusts' care are reviewed at the appropriate level and organisational learning occurs'.

This is in addition to the detailed reporting and investigation of deaths meeting the national criteria and local priorities under the Patient Safety Incident Response Framework (PSIRF). To note, PSIRF has replaced the Serious Incident Framework (2015) as of 2023.

Since 2023, our Trust, as with most other NHS mental health trusts follow the Mazars Framework which was written to assist trusts in developing a case selection process for Structured Judgement Reviews.

The three main categories are:

- Expected Natural – e.g., person on end-of-life care
- Unexpected Natural – e.g., cardiac arrest, stroke, diabetes
- Unexpected Unnatural – deaths that potentially meet the Patient Safety Incident Response Framework Priorities e.g., all unexpected inpatient deaths, which is nationally mandated.

Our Trust would like to thank the bereaved families and carers who have supported us to inform how the data is represented in this report, as well as their continued and invaluable support to help us as a Trust, learn from the deaths of their loved ones. We recognise that this report is data focused, however this has been a crucial step in our learning, as this intelligence will allow us to make more informed and focused decisions moving forward.

2. Mortality Incident Recording and Reporting

In response to recommendations from the Grant Thornton review and to improve our Trust's management and reporting of mortality data, we have developed a new largely automated system. This comprises two key components:

- A Microsoft SharePoint list, which holds data on all patient deaths that have occurred during care at NSFT or within 6 months of discharge from NSFT services,
- A Microsoft PowerBI dashboard which displays the patient data and allows users to view the information according to a range of different perspectives, such as age, gender and ethnicity.

Work started on this new process in April 2023, the system was put live on the 6 November 2023 (covering deaths notified after the 1 November), addressing many of the recommendations found in the Grant Thornton report.

Following go-live, the system has been working effectively and further developments and enhancements have been added, through appropriate change control and based on the requirements of the patient safety and mortality teams.

The SharePoint list is updated daily with notifications of deaths from our Electronic Patient Record (EPR) systems and from the Service User Death Report (SUDR), which is a daily Spine notification of any deaths associated with NSFT patients.

In order to provide a secondary check that there are no deaths which the SUDR has failed to notify us of, we also run a monthly Demographic Batch Service trace, which takes our entire patient database and completes a check on what their current death status is on the Spine.

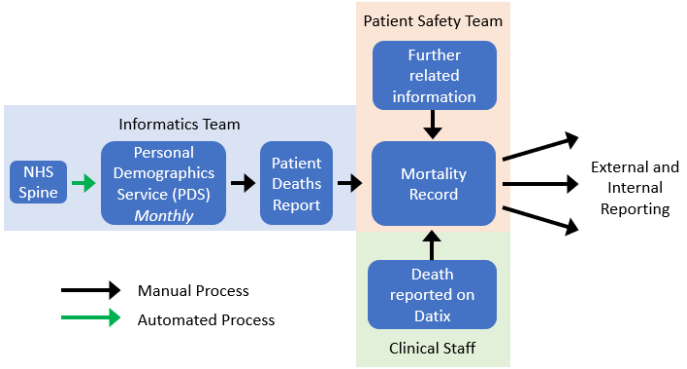
We have now run this monthly process 4 times and (on the third occasion) identified 2 deaths that were not notified to us by the daily SUDR. The 2 cases were subsequently updated in our EPR, which ensures that they are pulled through onto the SharePoint list.

This provides a good degree of assurance that we are being notified of all relevant deaths daily, as well as a means of identifying and including any additional patient deaths that we do find, through a monthly validation process.

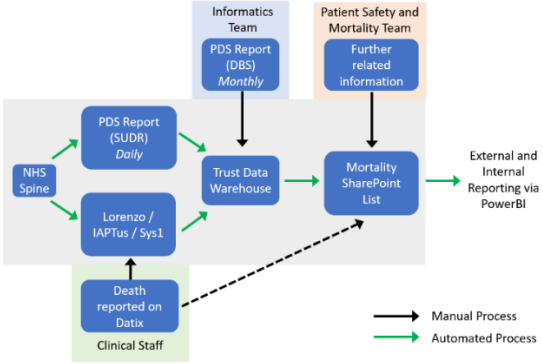
A before and after comparison is shown below, highlighting the benefits of the new approach.

Image 1 – 'Old' vs 'New' mortality recording and reporting processes and associated benefits

Old mortality recording and reporting process



New mortality recording and reporting process



Old	New	Benefit of process change
Mainly manual process	Largely automated process	• Reduced risk of transcription error • Time saving for staff in collating information • Deaths entered manually will be visible in our PowerBI dashboard the next day
Two sources of data	Multiple sources of data	• A more complete and accurate set of mortality data
Run monthly	Run daily	• More regular and up-to-date reporting • Missing information can be quickly identified, and clinical systems updated overnight
Data in different places	Data within a single place	• Easier to manage • Mortality data can be combined with other sources for greater insight
Manual reporting	Automated reporting	• A single consistent reporting source (Power BI) • Time saving for staff to create reports • Greater accuracy of reporting

		• Potential for more interactive and insightful reports
Limited process documentation	Standard Operating Procedures	• Agreed approach and accountability • Enables complete overview of Trust's end to end Mortality process
Limited audit control	Audit control	• Good governance and visibility of all changes that are made

Key to the clarity of reporting are the specific definitions we use:

- **Deceased whilst patient** – The patient has an open referral or hospital stay (a referral without a discharge/end date) within one of our Electronic Patient Record systems.
- **Within 6 months of discharge** –
    - The patient had a recorded contact (regardless of attendance or cancellation) where the date of the contact took place within the 6 months prior to their death.

      OR

    - The patient had a referral or hospital stay where the referral was ended/discharged within the 6 months prior to their death

      OR

    - The patient had a continuation note added to their record within the 6 months prior to their death.

Each case is then screened by a clinician in the Mortality team to check the individual was under the care of NSFT, either receiving treatment or awaiting treatment within a 6-month timeframe.

Once the Mortality team confirm the case needs further investigation, they seek to clarify the cause of death. To do this they make contact with the individual's GP and / or the Medical Examiner service to get cause of death.

The total number of deaths reported for the period from 1 November 2023 (the launch of our new reporting system) until 31 January 2024 is reflected in the tables below.

This data is correct as of 15 March 2024 when the reports were collated. The information reported may change in future reports, based on when additional information comes to light. For example, as cause of death information becomes available those cases which are 'Awaiting cause of death' will be re-categorised accordingly.

Table 1 – Cause of death overview

Cause of Death	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting cause	Total of deaths
Number of deaths	209	147	15	4	62	437
Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team						

Chart 1 – Cause of death overview

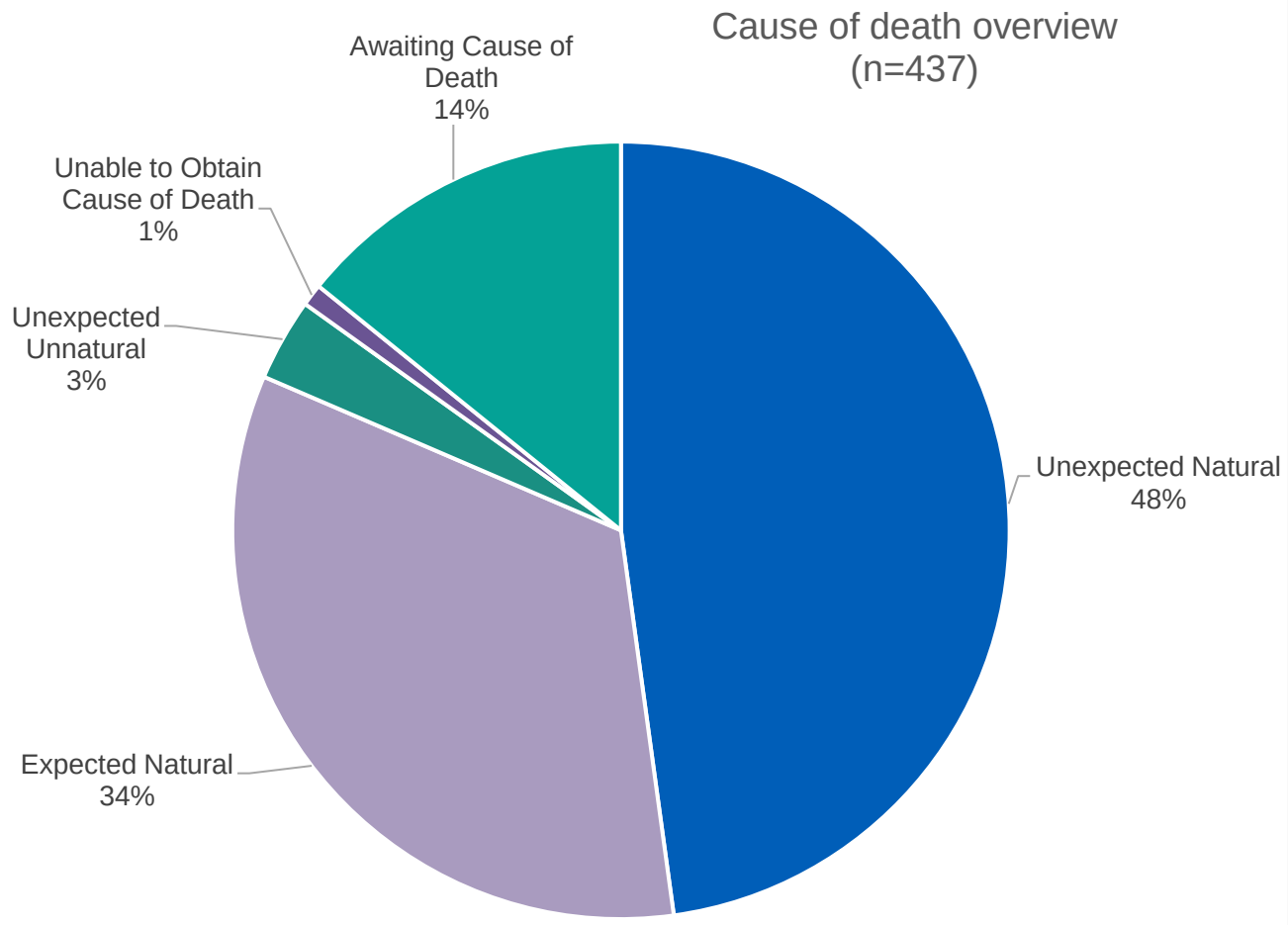


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Table 2 – Cause of death by category

Cause of Death	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting Cause	Total
Respiratory, pneumonia and TB (infectious) Covid-19	64	19			1	84
Neurological disease includes dementia, Parkinson's and epilepsy	20	42				62
Frailty/Old Age	21	36				57
Heart Disease inc. heart attack, CVA and cardio-vascular diseases	40	11	1			52
Cancer	13	21				34
Infectious diseases including Sepsis	19	4				23
Digestive diseases include Gastric, Bowel	14	2	1			17
Organ failure	6	5	1			12
Renal disease including cirrhosis	4	4				8
Hanging			5			5
Respiratory diseases - Chronic includes COPD and asthma	4					4
Unable to obtain cause of death				4		4
Fall		2	1			3
Drug toxicity			2			2
Unspecified effects of external causes	1		1			2
Auto-immune including MS, Chron's Disease, HIV	1					1
Choking	1					1
Drowning			1			1
Herniation of brain	1					1
Hypoxic brain injury		1				1
Injuries from external cause			1			1
Awaiting Cause of Death			1		61	62
Total	**209**	**147**	**15**	**4**	**62**	**437**

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Chart 2 - Cause of death – Expected Natural

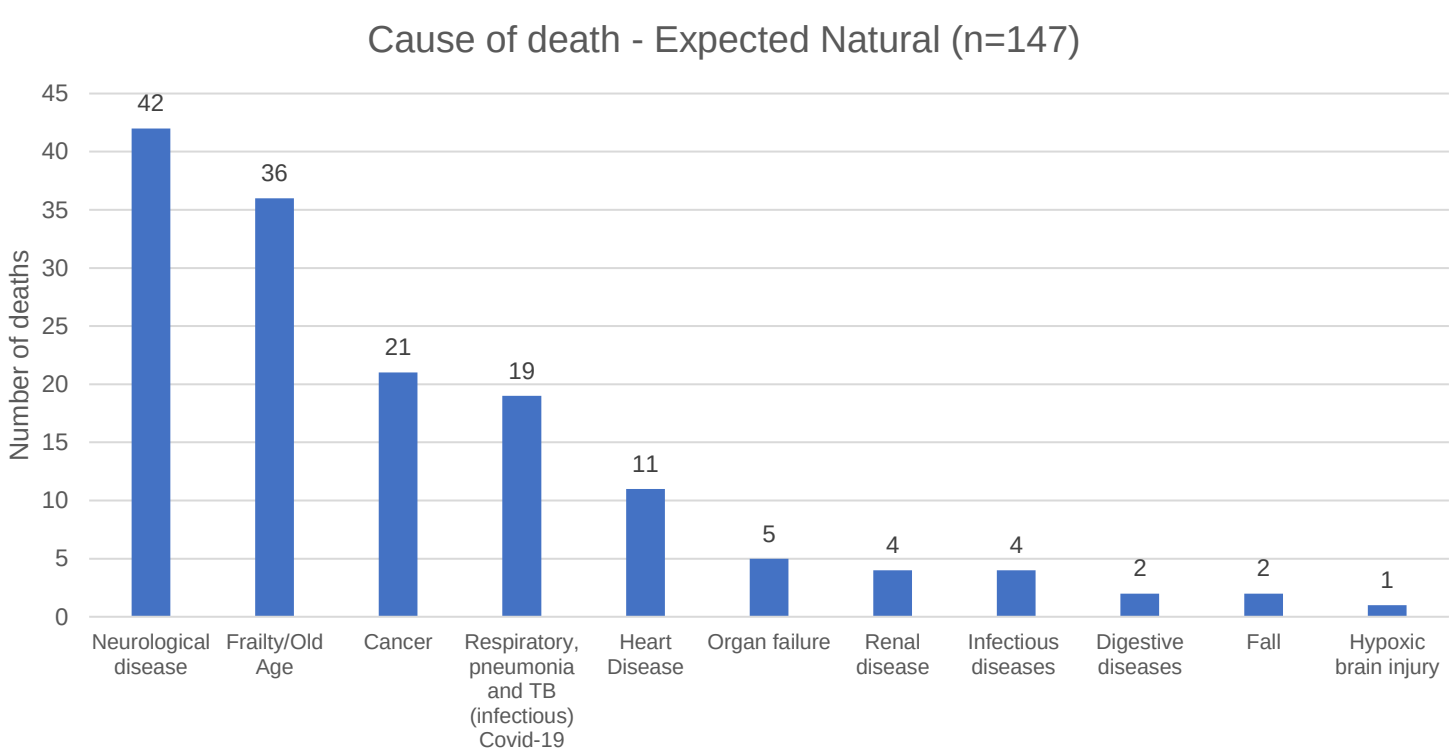

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Chart 3 - Cause of death – Unexpected Natural

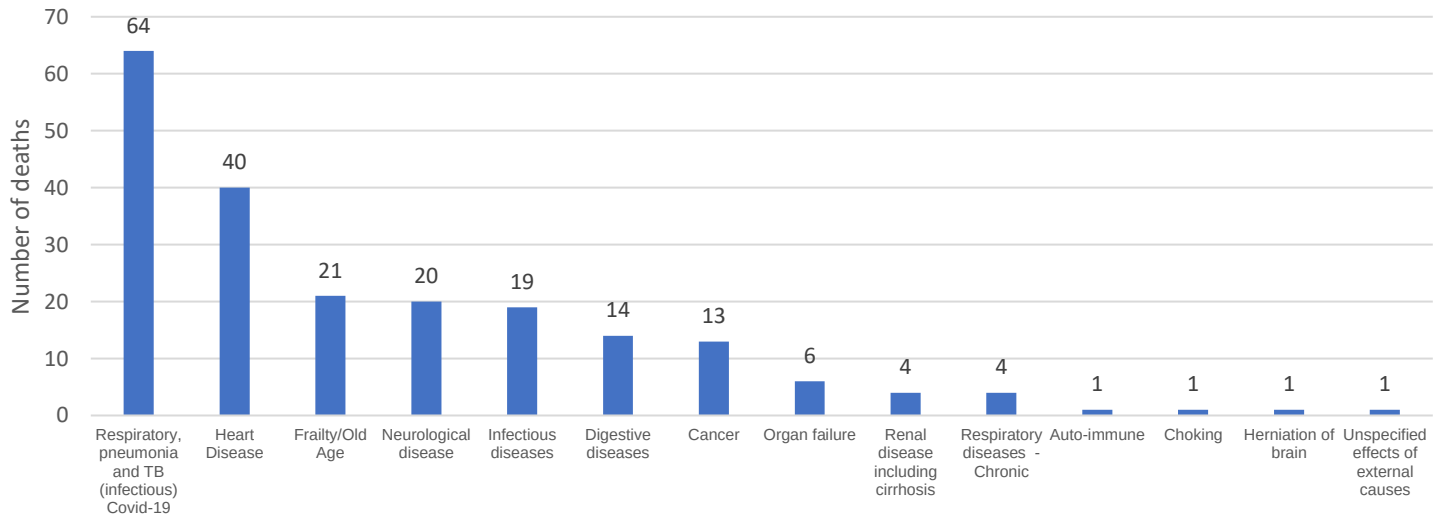

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Chart 4 - Cause of death – Unexpected Unnatural

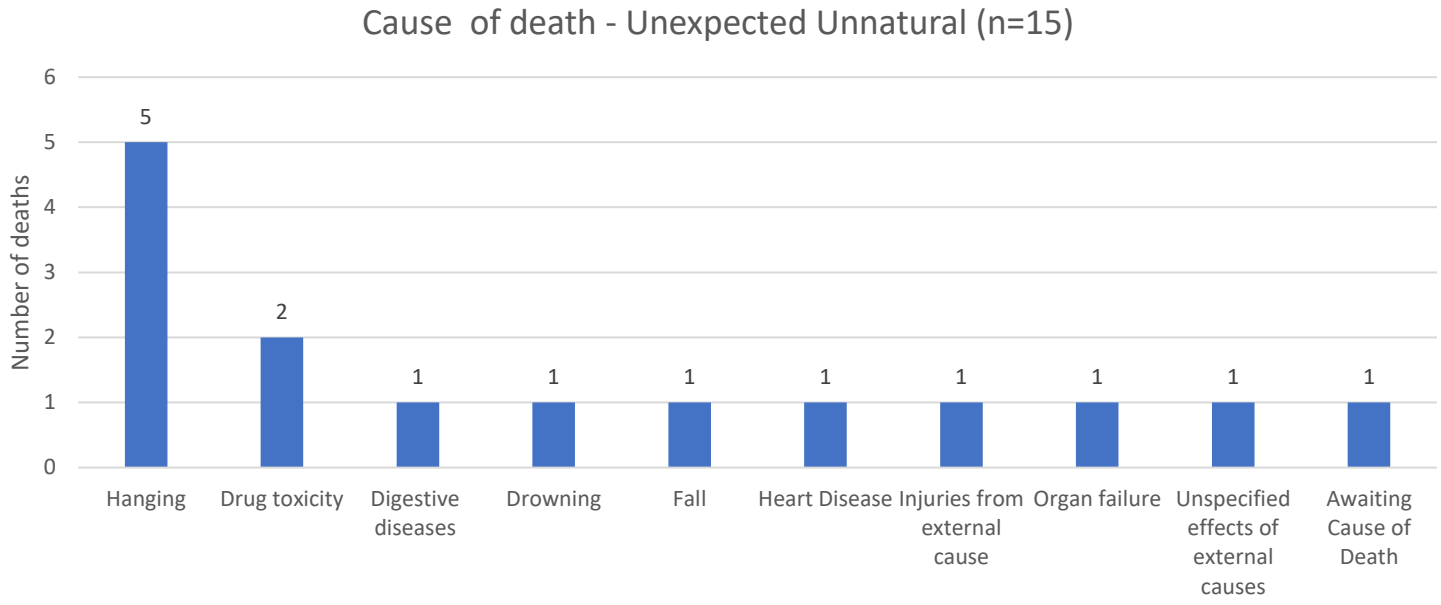

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Table 3 – Age overview

Age Group	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting Cause	Total
0 to 25					3	3
26 to 40			5		5	10
41 to 60	13	6	4		12	35
61 to 75	36	18	3	2	19	78
75+	160	123	3	2	23	311
Total	**209**	**147**	**15**	**4**	**62**	**437**

Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team

Table 4 - Ethnicity Overview

Ethnicity	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting Cause	Total
Black African					1	1
Black Caribbean		1				1
Indian	1					1
Not stated / Unknown	63	43	4	2	17	129
Other Black					1	1
Other ethnic category	2	5	1		1	9
Other mixed	2	1				3
White - British	134	95	10	2	37	278
White - Irish	2					2
White - other white	1	1			3	5
To be completed	4	1			2	7
Total	**209**	**147**	**15**	**4**	**62**	**437**

Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team

Table 5 - Gender Overview

Gender*	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting Cause	Total
Female	89	73	2	3	28	195
Male	120	74	13	1	34	242
Total	**209**	**147**	**15**	**4**	**62**	**437**

Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team
*The Trust recognises that not all people identify as male or female and will look to reflect this in future reports

3. Coroners Updates

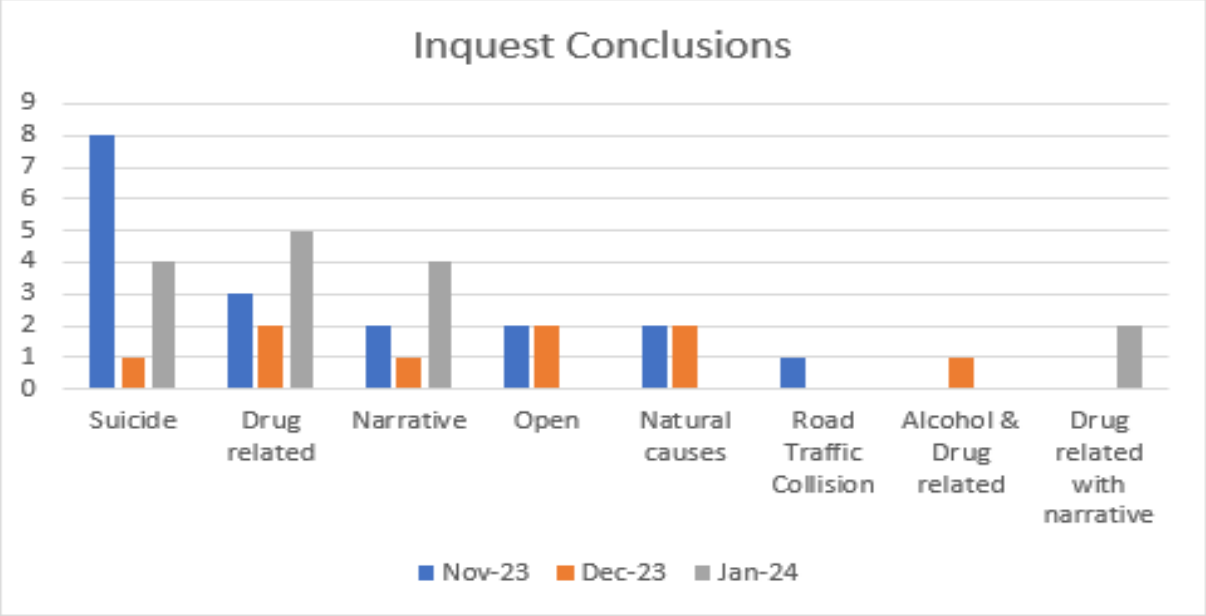
Forty-two inquests were concluded during the reporting period. Of the inquest conclusions reported in the period, none of the deaths occurred within the reporting period (Nov 2023 – Jan 2024).

Inquests are an independent statutory enquiry into who the deceased was, when, where and how they came by their death. This can include the coroner requesting evidence of involvement with the deceased many months prior to their death where no patient safety screening would be triggered.

Coroners are under a duty to complete an inquest within 6 months of opening the inquest, where possible, and must report all inquests over 12 months to the Chief Coroner.

The conclusions for the 42 inquests which reported during this reporting period are described below:

Chart 5 – Inquest conclusions during the reporting period



Open conclusions are returned when there is insufficient evidence to determine how the deceased came by their death.

Narrative conclusions are returned when the Coroner/Jury is not satisfied that a short form conclusion will adequately describe how the deceased came by their death.

During the reporting period, the Trust did not receive any Prevention of Future Death notifications.

4. Working With Service Users, Carers and Bereaved Families

We have met with representatives of bereaved families, and we are also working with local user and carer forums. We have sought their views about the most appropriate way to present data on mortality as we start to publish it. This can be found in appendix A attached to this report.

We will continue to work with families as we develop how best to share and report this data and to be completely transparent with the information we share.

Development of new roles in our Trust

The trust has recently launched new, specialised roles aimed at providing comprehensive support to bereaved families. Our dedicated Family Liaison Officers (FLOs) serve a multifaceted purpose. Not only do they offer impartial support to families throughout the investigative process, but they also play a pivotal role in facilitating avenues for families to openly share their experiences. Furthermore, these officers actively engage families in initiatives geared towards supporting ongoing improvements through a process of collective learning and reflection.

Crucially, the Family Liaison Officers are committed to ensuring that families are informed about the impact of the outcomes of any learning. By fostering transparent communication and providing insight into the tangible outcomes of lessons learned, they aim to empower

families and strengthen trust within our organisation. Their efforts ensure our commitment to not only supporting families during times of loss but also to fostering a culture of continuous improvement and meaningful engagement.

The Family Liaison Officers are actively undertaking programmes of work aimed at enhancing the support provided to families affected by mental health-related deaths. These initiatives include:

- Engaging closely with bereaved families to co-produce a comprehensive standard operating procedure. This procedure will establish a framework for safe and meaningful involvement of families with the organisation, acknowledging the distress and trauma they may be experiencing. It emphasises that involvement remains relevant regardless of the time that has passed since the loss, as every experience holds significance and value.
- Networking and establishing connections with Voluntary, Community, Social, Faith, and Enterprise (VCSFE) partners and other system stakeholders. This proactive engagement ensures that we have access to a comprehensive list of support services readily available for staff and easily accessible to bereaved families. By expanding our network of resources, we strive to address the diverse needs of families in a holistic manner.
- Collaborating with bereaved families to develop Trust resources tailored specifically for FLOs. This collaborative effort involves creating informative leaflets, information packs, and other materials designed to provide practical guidance and support to both FLOs and bereaved families. By listening to the insights and experiences of those directly affected, these resources aim to offer meaningful support and facilitate effective communication and engagement.

Through these ongoing initiatives, our FLOs demonstrate our commitment as a Trust to continuously improve our support services for families affected by mental health-related deaths. By actively involving bereaved families in the development and implementation of these programs, we strive to ensure that our efforts are informed, responsive, and ultimately, beneficial to our communities.

Duty of candour Lead

Our Trust appointed a Duty of Candour officer in October 2023. This is an important new role in our Trust. The Duty of Candour Officer works with the People Participation Team and our Family Liaison Officers to support improvements in the way in which our Trust communicates with families, carers and patients following incidents where duty of candour applies. This role supports the development of processes, polices and facilities to support our staff to discharge duty of candour requirements, providing targeted support to specific teams where necessary and promoting best practice.

Patient Safety Partners

A Patient Safety partner is a member of the patient safety team who is actively involved in the design of safer care in our organisation. This includes sitting on relevant committees to support compliance monitoring and how safety issues should be addressed to ensure learning and change in the organisation. Our patient safety partners consider and prioritise the service user, carer and family perspective and champions a diversity of views. We have

also developed the Trust website page resources to support bereaved people - Young People Who are Experiencing Grief and Loss | Norfolk and Suffolk NHS (nsft.nhs.uk).

In accordance with findings from Public Health and the LeDeR programme, service users with Serious Mental Health Illness are at greater risk of experiencing health inequalities, poorer physical health, and have a reduced life expectancy when compared to the general population. As an organisation, we are committed to bridging this gap and will use local and national learning to be proactive in ensuring learning into action.

5. Update on Medical Examiner Process

The Medical Examiner (ME) process is due to become statutory for mental health trusts in April 2024. In readiness for this the Trust implemented the Medical Examiner process for reporting of non-coronial inpatient deaths on 4 March to provide the Mortality team time to embed the new process and address any issues that arise.

The Information Sharing Agreement has been amended and agreed. We have met with acute hospital MEs to agree the process for sharing documents and we have set up a system so we can securely share patient records with the ME offices. The Mortality team can track the progress of the certification process of each death using another SharePoint platform.

ME colleagues at Norfolk and Norwich University Hospitals NHS Foundation Trust have provided training to medical colleagues which has been recorded so this can be shared with all inpatient teams alongside the process flow and referral documentation. Our Mortality team have a secure email address so they can share sensitive documents with the wards. There is a new mortality tab on Lorenzo where the team can upload medical certificates of cause of death (MCCDs) and associated documents once completed by the MEs onto each EPR.

The coroner has requested that Medical Examiners are copied into any inpatient coronial death notifications.

6. External Support, Scrutiny and Assurance

Our Trust has been working with the Royal Collage of Psychiatrists to engage external, independent senior clinicians to undertake:

- Structured Clinical Judgement Reviews
- Some deep dives to add quality assurance to the Learning from Deaths process
- Some checking of the screening that is currently being undertaken
- Some system testing for the Learning from Deaths process
- Help with identifying learning

There has been significant interest from consultant psychiatrists and senior nurses from several organisations to engage in this work which is scheduled to commence in April/May 2024.

In addition, work is scheduled to commence in April to develop the scope for an audit of the new mortality system by Internal Audit.

7. Themes from reviews, investigations and learning identified

For the reporting period, 34 Structured Judgement Review (SJRs) have been identified as requiring completion. 10 SJR’s have been completed, 1 SJR is awaiting sign off from panel and a further 8 SJR’s are underway.

21 reviews were undertaken into deaths during this period using PSIRF methodology.

During April through to July 2024 we will be reviewing and improving the ways we identify, share, and spread learning across the organisation. This work will involve a range of trust staff, as well as service users, carers, and bereaved families. We will also review national best practice in this area.

Moving forward the Trust holds a firm commitment to fostering a culture of learning and improvement, especially in the aftermath of mental health related deaths. We acknowledge the critical significance of thoroughly analysing each incident, not only to grasp its underlying causes, but also to enact efficient measures to prevent its repetition or minimise related risks.

Central to our commitment is ensuring that families affected by these incidents are kept well-informed about the outcomes of our learning processes. We believe in transparency and accountability, and by openly communicating the insights gained and the actions taken, we aim to empower families with knowledge and understanding. This transparent approach not only builds trust within our organisation but also fosters stronger connections with the communities we serve.

We strive to embed learning outcomes within the organisation, to share learning with our system partners and to provide families with meaningful insights into the impact of our continuous improvement efforts. Additionally, we view this as an opportunity to collaboratively reinforce a culture of continuous improvement, where every stakeholder, including families, plays an integral role in shaping safer and more effective services within our organisation.

A focus on learning into action will be featured within future reporting cycles.

8. Additional activity

Learning from Deaths Action Plan Management Group,

Our Trust has now had two meetings of the Learning from Deaths Action Plan Management Group, with an extended and more inclusive membership to take forward:

- The Grant Thornton report action plan
- Any outstanding actions from the Verita report action plan
- Forever Gone: Losing Count of Patients Deaths and draft action plan from the Mortality Review Collaborative Working Group
- Any outstanding actions from regulation 28 reports to prevent future deaths
- Any outstanding actions from historical thematic reviews
- Domestic Homicide Reviews and Serious Case Reviews.

As part of this work our Trust has developed a composite Learning from Deaths Action Plan which will hold all current and emerging actions in one place in the trust. The composite action plan attached at appendix B reflects the Grant Thornton review and the work undertaken by the Collaborative Working Group, which the trust has agreed to share with both Norfolk and Suffolk Health Overview and Scrutiny Committees (HOSC's)

Work is already underway to develop an electronic version of the Learning from Deaths dynamic action plan.

On the 19 March 2024 the working group, which includes, service users, carers and bereaved relatives received a demonstration of the new mortality dashboard and a presentation of the data reporting period of 1 November 2023 to the 31 January 2024 (as of 12 March 2024). The same data was also presented to the trust Quality Committee.

9. Review of Legacy Cases

Our Trust has commenced a significant piece of work to screen all deaths between April 2019 and October 2023. The time frame is wider than the Grant Thornton review and is using the same definitions – Expected Natural, Expected Unnatural and Unexpected Unnatural - as the new mostly automated system, which will give our Trust five years of data to inform learning and service improvement.

The Board of Directors will receive a comprehensive report once this work is concluded.

Appendix A – Co-designed summary of mortality data

Example of how we process data

Norfolk and Suffolk
NHS Foundation Trust

1. **How NSFT is notified of a death -** NSFT has a new, automated database which came into use on 1 November 2023. A list of individuals who have passed away is updated daily with notifications of deaths from our Electronic Patient Record (EPR) systems and from a Service User Death Report (SUDR). The SUDR is a daily notification from a national NHS source of any deaths associated with the NHS patients. A patient's GP is responsible for updating this national source of data. This information is shared safely and securely with us.

2. **Someone passes away -** It is always devastating when a loved one, family or friend passes away. This could be for a number of different reasons. NSFT's new robust screening process receives notifications of every death for patients who died whilst open to NSFT services or within 6 months of their discharge. Every one of these is then manually screened to assess whether they meet the criteria for reporting as 'Under NSFT care'. The system also identifies which care group the individual was receiving care from or which care group they were discharged from.

3. **What we do and who we work with to assign information -** When we receive these daily updates, a dedicated team of NSFT staff analyse the details of those who have sadly passed away. This team includes clinicians and experts who have vast experience of analysing complex information. Using our new system, we identify people that have passed away whilst open to NSFT services, or within six months of discharge from our services. For those records that are confirmed as being under NSFT care we then establish cause of death and categorise these into one of five categories.

4. **How is the information assigned and why -** Our five categories identify the cause of death of loved ones who have passed away. These categories are: expected natural, unexpected natural, unexpected unnatural, awaiting cause of death, unable to obtain cause of death. By using these categories, we are able to analyse the data and in particular, identify loved ones who passed away which could be related to the quality of care they received from our services.

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NSFT Mortality data

What the data means

Expected natural cause of death

This is a death which has a clear natural cause. Examples may include a death linked to a neurological disease, such as Parkinson's or dementia, frailty or old age, cancer and organ failure.

Unexpected natural cause of death

Deaths in this category are when a loved one passes away unexpectedly but from natural causes. This could be as a result of contracting an infection or respiratory illness or infectious diseases. It can also include illness such as cancer.

Unexpected unnatural cause of death

If the death of a loved one is placed into this category, the cause is linked to reasons where the individual may have decided to take their own life and their death was intentional. Examples include hanging, drug toxicity, drowning, a fall and injuries from an external cause.

Unable to obtain cause

In an unfortunate number or small cases, it is very difficult from the information available or shared with us to determine the actual cause of death, even after in depth screening is done. We will always try to identify a cause of death to categorise the deaths so we can learn from any deaths to help improve the outcomes and experiences for our service users, families and carers.

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NSFT Mortality data

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Information from 1 Nov 2023 to 31 Jan 2024 of people under the care of NSFT

The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive.

The data is reflective of the position as at 15/03/24.

Total patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services, or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team.

Total - 437

Expected natural cause of death
147
34% of total deaths during this period

Unexpected natural cause of death
209
48% of total deaths during this period

Unexpected unnatural cause of death
15
3% of total deaths during this period

Unable to obtain cause of death
4
1% of total deaths during this period

Awaiting cause
62
14% of total deaths during this period

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What is an 'unnatural death'

Losing a loved one is very difficult and as a Trust, we will always do our best to learn from the causes of an unnatural death.

- If the death of a loved one is identified as being unnatural, the cause is linked to reasons where the individual may have decided to take their own life and their death was unfortunately intentional.
- Examples may include hanging, drug toxicity, drowning, a fall and injuries from an external cause.

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What is a 'natural death?'

- In most cases, the death of a service user, whilst they are receiving care or after they have been discharged from our services in the last six months is usually linked to a natural cause.
- The natural death of a loved one is a death which has a clear natural cause.
- Examples may include a death linked to a neurological disease, such as Parkinson's or dementia, frailty or old age, cancer and organ failure. This is a cause which families, friends and carers will know about an illness or condition which would unfortunately lead to them passing in the future.

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What does 'Awaiting Cause' mean?

- When we routinely review the deaths of our service users as part of our screening process, there are some deaths which we cannot categorise at each given moment in time.
- This could be due to the absence of a coroner's report and the absence of a complete report from a medical examiner.
- Deaths which have been placed in this category will be updated as soon as we have a confirmed cause of death shared with us.

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NSFT
Learning From Deaths
This post includes information about mental health and mortality

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Appendix B – Learning from Deaths action plan

Ref	Recommendation	Source		Theme	Responsibility	Expected Timescale	Actions	Updates	Status
		GT	CWG						Green Completed Yellow On Track Amber Timescale slipped but on track for completion Red Outside of timescale
1	Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and	✓		Data	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	3 months – August 2023	1. Seagry consultancy and NSFT to review the technology, solutions and processes used to capture, collate and report mortality data. Interoperability, system upgrade requirement as and when required should be included as part of this review.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24

	transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and the process for validating these outputs.						2. Seagry Consultancy will produce a list of actions with assigned owners to support improvement, processes and tools to assist NSFT in mortality reporting.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							3. A single overarching Standard Operating Procedure (SOP) will be implemented following this work. This will include the formal change management process required when reporting requirements change. The SOP will include inputting of data, extracting of data, validating of data and reporting of data within a given timeframe.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							4. An audit trail will be incorporated into the process as described in action 1.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24

2	Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date	✓		Data	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	6 months- November 2023	1. An overarching SOP will be developed which will detail each stage of the mortality data pathway.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							2. The SOP will include roles and responsibilities within the process.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							3. The SOP will describe the formal change management process when mortality reporting requirements change.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							4. The Learning from Deaths policy will incorporate the requirements of the SOPs.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24

3	Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.	✓		Data	**Executive Lead** Chief Finance Officer	6 months- November 2023	1. Reporting tool to be developed to measure the data fields missing on clinical record system, such as demographics. All Data fields must be made as mandatory as much as technically possible to eliminate missing data and avoid human errors.		Completed for specific action. New action fed into other business as usual work.
					Lead for Delivery Chief Digital Officer	6 months- November 2023	2. To be reported and included in the Care Group Quality and Performance metrics and scrutinised in the Trust's Quality and Performance Meeting		Completed for specific action. New action fed into other business as usual work.
4	Use the Spine as the definitive reference source of identifying deaths, and update this information on a weekly basis.	✓		Data	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding.	3 months – August 2023	1. Develop a system that utilises NHS Spine's automatic update to Lorenzo to reduce the need for manual downloads.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							2. A weekly report will be generated to validate any reporting of Death to Trust against the Spine. This assurance check will be included as part of SOP.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24

5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within Board reports . Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	✓		Reporting	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	3 months – August 2023	1. The proposed standardised reporting structure for mortality will be presented through the Committee structure and agreed by the Board.		Completed
							2. The Learning from Deaths quarterly Board report will include thematic analysis of key metrics such as age, diagnosis, cause of death and deprivation indices.		Completed
6	Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within Board reports.	✓		Reporting	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief DigitalOfficer, Director of Nursing, Patient Safety and	3 months – August 2023	1. The Trust are working with Seagry Consultancy to agree the Mortality data pathway. Part of this work will include further development of Mortality Dashboard.		Completed
							2. This will be underpinned by the work completed as part of recommendations 1 and 5.		Completed

					Safeguarding andMedical Director for Quality		3. The ability for Care Groups to drill down within the dashboard will be enhanced so they are able to interrogate their and other Care Groups data.	The Mortality team plan to roll out the dashboard to Care Groups through a series of sessions with relevant Care Group leadership. The publication of the internal dashboard will be aligned to the overall programme and therefore after the publication of inital data to the Board and HOSC	
							4. The improved dashboard will be supported by the Patient Safety Team and Mortality Team attending Care Group Governance meetings.	As per update 6.3	
							5. The newly developed dashboard will be available on the Trust's intranet.	As per update 6.3	
7	Work with public health and, when in post, medical examiner to identify key themes in the data and identify and implement timely targeted interventions	✓		Reporti ng	**Executive Lead** Chief Medical Officer **Lead for Delivery** Director of Operations (Medical Directorate) and Medical Director of Quality	6 months-November 2023	1. The Norfolk and Waveney ICB have implemented a bi-monthly Learning from Deaths forum. This includes Public Health and Medical Examiners. NSFT are a member of this forum with data shared as part of this meeting		Completed
							2. Learning and themes from NSFT Mortality reviews will be shared with the ICB so wider system learning can be considered.		Completed
							3. Development of Care Group reports and attendance of Mortality Team and Patient Safety Team to local governance meetings to share learning and implement targeted interventions.	The Mortality team plan to roll out the dashboard to Care Groups through a series of sessions with relevant Care Group leadership. The publication of the internal dashboard will be aligned to the overall programme and therefore after the publication of inital data to the Board and HOSC	
							4. Within the Learning from Deaths committee, the Mortality team will share local, regional and national data and learning to guide where improvements need to focus.		Completed

							5. Ensure that NSFT are part of the membership of the Learning from Deaths forum in Suffolk and North East Essex (SNEE) ICB when commenced.		Completed
							6. NSFT will continue to attend regional and national forums		Completed
							7. NSFT to be members of the Norfolk and Waveney ICB LeDeR forum.		Completed
8	Use clinical input to update the cause of death groupings which are presented as part of the dashboard, and used in Board reports, so that it is clear where the Trust is awaiting data (pending), or the Trust feels this data will not be accessible, or will remain unknown	✓		Reporting	**Executive Lead** Chief Finance Officer (SIRO) and Chief Medical Officer **Leads for Delivery** Chief Digital Officer Director of Nursing, Patient Safety and Safeguarding	3 months – August 2023	1. Review the data collected in the Trust Mortality dashboard to include all patient demographics, cause of death, diagnosis, medication etc.. to enable the drilling down both locally and strategically of key metrics. This will include 2 'unknown' cause of death categorisations 'awaiting cause of death' and cause of death not available'.		Completed
							2. The Mortality process, criteria and screening will describe this requirement as part of the overarching SOP (Recommendation 2).		Completed
9	Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting	✓		Clinical Engagement	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief Digital Officer and Director of Nursing, Patient	3 months – August 2023	1. New Mortality Data Pathway as outlined in Recommendations 1, 3, 5 and 6 will detail the process for capturing, collating, validating and reporting mortality data		Completed

					Safety and Safeguarding and Medical Director of Quality		2. Care Groups and Trust committees will be able to utilise the revised Mortality dashboard to drill down into individual Care Groups as well as maintain oversight from a Trust perspective.	The Mortality team plan to roll out the dashboard to Care Groups through a series of sessions with relevant Care Group leadership. The publication of the internal dashboard will be aligned to the overall programme and therefore after the publication of inital data to the Board and HOSC	
							3. The mortality data will be centrally produced, therefore the data will be consistent from 'Ward to Board'.		Completed
							4. The dashboard will be available without patient details on the Trust intranet for all staff to review.	As for update 9.2	
10	Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services	✓		Clinical Engagement	**Executive Lead** Chief Finance Officer and Chief Operating Officer **Lead for Delivery** Chief Digital Officer and Deputy Chief Operating Officer	9 months-February 2024	1. The guidance which details the process for administration staff to follow describing the steps to be taken when discharging a patient from the service will be shared with all Business Managers to action.	There is guidance in place for staff to assist in discharging patients from electronic systems. This guidance is to be reviewed in line with this recommendation through workstreams relating to Standard Operating Procedures for core business	
							2. Further guidance will be developed for administration staff as to the process to follow when a person on the team's caseload is found to be deceased.	There is guidance in place for staff to assist in discharging patients from electronic systems. This guidance is to be reviewed in line with this recommendation through workstreams relating to Standard Operating Procedures for core business	
							3. Caseload Reviews should be carried at a minimum 6 monthly with the involvement of Medical, Nursing, Therapies and Local Manager input and should be embedded in local teams standard practice.	A discharge policy in place and is clear on expectations, further work to ensure that this is being followed will be audited within 6 months	

11	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.			Clinical Engagement	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief Digital Officer, Deputy Chief Operating Officer, Medical Director of Quality	6 months- November 2023	1. Implement training programmes focusing on the importance of mortality reporting dependent on the role the member of staff fulfils.		Completed
							2. To be supported by learning bulletins which highlight the importance of accurate mortality data reporting and how this can assist in improving clinical care.	The 'Learning from Deaths Matters' newsletter has been produced in draft and will be made available by 28/03/2024.	
12	Establish links with primary care networks to explore opportunities to improve the completes of the Trust's mortality data (including cause	✓		Partnership Working	**Executive Lead** Director of Strategy and Partnerships **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Medical Director of Quality and Director of Operations- (Medical Directorate)	6 months- November 2023	1. In order to inform the ICB where their assistance can be best be focused, the Trust will complete an audit of the available cause of death data.		Completed

							2. NSFT will develop a standardised process led by the Mortality Team for contacting GPs, Coroners, Medical Examiners and clinical data systems to obtain the cause of death wherever possible.		Completed
							3. This recommendation will be shared with the ICBs through the dissemination of this report and to be added as an agenda items on ICB Learning from Deaths Forums where/when in place.		Completed
13	Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region	✓		Partnership Working	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	6 months- November 2023	1. Establish formal data sharing agreements between the Trust, Primary and Secondary care within the region.		Completed
14	Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly reference community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and	✓		Governance	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Medical Director for Quality and Director of Operations – (Medical Directorate).	3 months – August 2023	1. Following confirmation of the revised mortality data pathway, the Learning from Deaths policy will be reviewed and updated to include the SOP referenced in Recommendation 2. This will include the nationally defined focus of mortality being both community and inpatient deaths.		Completed
							2. The Learning from Deaths policy will be supported by a 'policy on a page' which will be available to all staff.		Completed
							3. The circulation of information and learning bulletins 'Learning from Deaths Matters' will be published and disseminated throughout the Trust	**19th March 2024 -** The 'Learning from Deaths Matters' newsletter has been produced in draft and will be made available by 28/03/2024.	

	reporting of mortality information.						4. This will be supported by learning events.	The Mortality team plan to roll out the dashboard to Care Groups through a series of sessions with relevant Care Group leadership. The publication of the internal dashboard will be aligned to the overall programme and therefore after the publication of inital data to the Board and HOSC	
15	Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee	✓		Govern ance	**Executive Lead** Chief Nursing Officer and Chief Medical Officer. **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Director of Operations- (Medical Directorate) and Medical Director of Quality	3 months – August 2023	1. The improvement plan will be monitored through the Learning from Deaths and Incidents committee and reported quarterly to the Quality Committee		Completed
16	Introduce a process of assurance over mortality reporting: Introduce a clear audit trail and series of checks to ensure adherence with SOPs, and report outcomes to executive leads on	✓		Govern ance	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	3 months – August 2023	1. An audit process will be developed and implemented every 6 months. The audit will test the comprehensiveness of the mortality data pathway with the findings reported to the Learning from Deaths and Incidents Committee.	SharePoint list has a built-in audit trail of who accessed the record and ability to edit data field and data populated. Now that the pathway is complete, an approach to auditing the SOPs and reporting will be developed. Discussions have been held with N&W ICB's Associate Director of Insight & Analytics and SNEE's Deputy Director for Strategic Analytics.	

	a regular basis. Introduce or commission patient level data reviews to provide assurance over the accuracy of data recording. Link to the clinical validation process established under recommendation 9						2. External verification will be sought by an external consultancy team who are experienced in data within the NHS	Trust is currently considering whether this should be incorporated within the 24/25 Internal Audit plan or whether an external auditor should be retained for this purpose.	
17	Involvement of bereaved relatives as 'critical friends' in the implementation Grant Thornton NSFT elements of the action plan NSFT's new system will go live on 6.11.23 and they have committed to sharing information about changes with bereaved people once any snagging is completed.	✓	✓	Data	Executive Lead Chief Nursing Officer and Chief Medical Officer Lead for Delivery Chief Digital Officer and Governance and Safety Adviser	Mar-24	1. In January 2024 the new Learning from Deaths Action Plan Management Group was established. This group has service user, carer and bereaved family members on the group.		Completed

18	Establish a project plan to explore and develop co-production with bereaved people on the gathering and reporting of NSFT's mortality data, scrutiny of mortality data quality, using the data for learning within NSFT and externally.	✓	✓	Governance	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Chief Digital Officer and Governance and Safety Adviser	June-24	Mortality data from the new system was presented to the Learning from Deaths Action Plan Management Group on the 19th of March 2024.	Mortality data will be scrutinised by the Learning From Deaths Action Plan Management Group, the Trust Quality Committee, and the Board of Directors. Our Trust has been working with the Royal Collage of Psychiatrists to engage external, independent senior clinicians to undertake: • Structured Clinical Judgement Reviews • Some deep dives to add quality assurance to the Learning from Deaths process • Some checking of the screening that is currently being undertaken • Some system testing for the Learning from Deaths process • Help with identifying learning There has been significant interest from consultant psychiatrists and senior nurses from several organisations to engage in this work which is scheduled to commence in April/May 2024. In addition, work is scheduled to commence in April to develop the scope for an audit of the new mortality system by Internal Audit.	On Track

19	Creation of mortality data that is clear, unambiguous, consistent, reliable and verifiable, which is collected and published in ways that all stakeholders can understand and use.	✓	✓	Data	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Chief Digital Officer and Governance and Safety Adviser	June-24	Referenced to action 6 above in line with Grant Thornton recommendation new mortality Power BI dashboard in place.	Mortality data will be scrutinised by the Learning From Deaths Action Plan Management Group, the Trrut Quality Committee, and the Board of Directors. Our Trust has been working with the Royal Collage of Psychiatrists to engage external, independent senior clinicians to undertake: • Structured Clinical Judgement Reviews • Some deep dives to add quality assurance to the Learning from Deaths process • Some checking of the screening that is currently being undertaken • Some system testing for the Learning from Deaths process • Help with identifying learning There has been significant interest from consultant psychiatrists and senior nurses from several organisations to engage in this work which is scheduled to commence in April/May 2024. In addition, work is scheduled to commence in April to develop the scope for an audit of the new mortality system by Internal Audit.	On Track

20	Mortality data needs to be fully utilised to increase learning from deaths	✓	✓	Data	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Chief Digital Officer and Governance and Safety Adviser	June-24	Referenced to action 6 above in line with Grant Thornton recommendation new mortality power BI dashboard in place.	Mortality data will be scrutinised by the Learning From Deaths Action Plan Management Group, the Trrut Quality Committee, and the Board of Directors. Our Trust has been working with the Royal Collage of Psychiatrists to engage external, independent senior clinicians to undertake: • Structured Clinical Judgement Reviews • Some deep dives to add quality assurance to the Learning from Deaths process • Some checking of the screening that is currently being undertaken • Some system testing for the Learning from Deaths process • Help with identifying learning There has been significant interest from consultant psychiatrists and senior nurses from several organisations to engage in this work which is scheduled to commence in April/May 2024. In addition, work is scheduled to commence in April to develop the scope for an audit of the new mortality system by Internal Audit. Learning from Deaths Action Plan Management Group Our Trust has now had two meetings of the Learning from Deaths Action Plan Management Group, with an extended and more inclusive membership to take forward: • The Grant Thornton report action plan• Any outstanding actions from the Verita report action plan• Forever Gone: Losing Count of Patients Deaths and draft action plan from the Mortality Review Collaborative Working Group• Any outstanding actions from regulation 28 reports to prevent future deaths• Any outstanding actions from historical thematic reviews• Domestic Homicide Reviews and Serious Case Reviews	On Track

21	Reparation of relationships with bereaved people and building public trust through restorative approaches. Demonstrate through changed behaviours, in mortality data gathering and reporting, that the concerns of bereaved families have been heard and listened to.	✓	✓	Partnership Working	**Executive Lead** Chief Nursing Officer **Delivery Lead** Patient Participation Lead	June-24	Trust work on service user, carer and bereaved families will be picking up these recommendations as part of the overall co-production workstream	• Duty of candour Lead - Our Trust appointed a Duty of Candour officer in October 2023. This is an important new role in our Trust. The Duty of Candour Officer works with the People Participation Team and our Family Liaison Officers to support improvements in the way in which our Trust communicates with families, carers and patients following incidents where duty of candour is applies. This role supports the development of processes, polices and facilities to support our staff to discharge duty of candour requirements, providing targeted support to specific teams where necessary and promoting best practice. • Patient Safety Partners - A Patient Safety partner is a member of the patient safety team who is actively involved in the design of safer care in our organisation. This includes sitting on relevant committees to support compliance monitoring and how safety issues should be addressed to ensure learning and change in the organisation. Our patient safety partners consider and prioritise the service user, carer and family perspective and champions a diversity of views. • We have also developed the Trust website page resources to support bereaved people - Young People Who are Experiencing Grief and Loss | Norfolk and Suffolk NHS (nsft.nhs.uk) In accordance with findings from Public Health and the LeDeR programme, service users with Serious Mental Health Illness are at greater risk of experiencing health inequalities, poorer physical health, and have a reduced life expectancy when compared to the general population. As an organisation, we are committed to bridging this gap and will use local and national learning to be proactive in ensuring learning into action • Family Liaison officers (FLOs) have been engaging closely with bereaved families to co-produce a comprehensive standard operating procedure. This procedure will establish a framework for safe and meaningful involvement of families with the organisation, acknowledging the distress and trauma they may be experiencing. It emphasises that involvement remains relevant regardless of the time that has passed since the loss, as every experience holds significance and value. There continues to be collaboration with beraved families	On Track
22	Follow up on the practice issues that Grant Thornton identified in their mortality review and co-produce the plans to address these.	✓	✓	Governance	**Executive Lead** Chief Nursing Officer **Delivery Lead** Patient Participation Lead	June-24	Trust work on service user, carer and bereaved families will be picking up these recommendations as part of the overall co-production workstream		On Track
23	Undertake a co-produced equality and quality impact assessment	✓	✓	Partnership Working	**Executive Lead** Chief Nursing Officer **Delivery Lead** Patient Participation Lead	June-24	Trust work on service user, carer and bereaved families will be picking up these recommendations as part of the overall co-production workstream		On Track

								to develop Trust resources tailored specifically for FLOs. This collaborative effort involves creating informative leaflets, information packs, and other materials designed to provide practical guidance and support to both FLOs and bereaved families. By listening to the insights and experiences of those directly affected, these resources aim to offer meaningful support and facilitate effective communication and engagement. • We have met with representatives of bereaved families, and we are also working with local user and carer forums. We have sought their views about the most appropriate way to present data on mortality as we start to publish it. This involvement of all relevant stakeholders will be ongoing as data is published	

Appendix C - Learning from deaths and mortality reporting glossary

This glossary provides information and clarity about some of the terms used in our learning from deaths mortality reporting.

This list is not exhaustive and will be updated as our improvement and transformation work continues.

Term(s)	What this means
Co-design	Different groups of people working together to design a document, programme or piece of work – where everyone's views count, are considered, understood and given equal consideration.
Demographic Batch Service trace	This is a national system which allows us to confidentially submit a file of patient information to the national NHS Spine for tracing against the Personal Demographics Service (PDS) for direct care purposes.
Duty of Candour legislation	This national legislation ensure that NHS providers are open and transparent with people who use services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Electronic Patient Record (EPR)	An EPR system is a digital platform that brings all your patient information, from medical history to results of investigations and medications prescribed, together in one place. Having access to all your information in one place will help improve the quality of care we provide. For example, clinicians will have a full picture of your medical history and

Term(s)	What this means
	treatment in our Trust at their fingertips, which will help inform and speed up decision-making.
Family Liaison Officers (FLOs)	Our Family Liaison Officers (FLOs) offer impartial support to families throughout the investigative process, and play a pivotal role in facilitating avenues for families to openly share their experiences.
Learning from Deaths framework	This national framework places responsibility on Trust Boards to ensure their Trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate.
Medical Examiner Process	This process is due to become statutory for mental health trusts in April 2024 and focuses on interaction with the doctor completing the Medical Certificate of Cause of Death, to agree the causes of death. In readiness for this, our Trust has implemented the Medical Examiner process for reporting of non-coronial inpatient deaths to provide the Mortality team time to embed the new process and address any issues that arise.
Microsoft PowerBI	A software tool that allows information to be analysed and visualised. It can create charts, graphs and dashboards and apply a range of filters to a set of data, allowing users to gain better insight from the information they have.
Microsoft SharePoint	A software platform that allows data and documentation to be stored and shared securely. It is like a central hub where you can store, share, and access information from any device and any location, according to permissions assigned.

Term(s)	What this means
Mortality	This is another term for a death, a loved one who has passed away.
National Learning from deaths guidance	A framework to help standardise and improve how NHS providers identify, report, investigate and learn from deaths.
Patient Safety Incident Response Framework	This is a national framework that all Trusts must use and sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
ReSPECT process	The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.
Service User Death Report (SUDR)	A daily report which provides our Trust with notification of any deaths associated with NSFT patients
Structured Judgement Review (SJR)	Trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.