South West Yorkshire Partnership NHS Foundation Trust

Learning from healthcare deaths

1/4/2017-31/3/2018

Report prepared by Patient Safety Support Team

South West Yorkshire Partnership NHS Foundation Trust

Learning from healthcare deaths Report: The right thing to do
Annual Cumulative Report 2017/18 covering the period 1/4/2017 – 31/3/18

1. Background context

1.1 Introduction

Scrutiny of healthcare deaths has been high on the government's agenda for some time. Reports such as Francis report and Southern Healthcare has intensified this.

All Healthcare providers were asked to develop a healthcare deaths policy by September 2017 that sets out how it identifies, reports, investigates and learns from a patient's death. Trusts must also report and publish data from April 2017 (from quarter 3 2017/18 onwards).

The Trust fully supports this approach and has developed this with other providers in the North of England as part of our collaborative approach to learning from deaths a review of the policy and learning is in the process of being planned.

Most people will be in receipt of care from the NHS at the time of their death and experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, their experience is different and they receive poor quality care for a number of reasons including system failure.

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Therefore, it is important that organisations widen the scope of deaths which are reviewed in order to maximise learning.

The Confidential Inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

The Trust will review/investigate deaths we have agreed are in scope through the policy. We aim to work with families/carers of patients who have died as they offer an invaluable source of insight to learn lessons and improve services.

1.2 Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (PAS) and on its Datix system where the death requires reporting.

The Trust's Performance and Information team is also working with local registration of deaths services to ensure data on deaths is accurate and timely, and this will develop over time.

Whilst this work was being developed, and to introduce the process in a manageable way, from April 2017 to September 2017 the Trust started reviewing all deaths reported on Datix, using an incremental approach and to date has subjected the following to further review:

- All inpatient deaths or where they had been discharged in last 30 days
- Learning Disability Mortality Review (LeDeR) deaths in scope. All deaths were reviewed but then excluded deaths that took place in acute trusts as they would be undertaking the review and linking with SWYPFT if required. We still ensured all deaths had been reported to the LeDeR programme.
- Existing Serious Incident Framework – deaths requiring reporting through this system on STEIS
- Deaths subjected to service level investigation
- Any death where there were family, clinical or governance concerns that did not meet any of the above
- A case where we were not the main provider at the time of death but worked with the acute Trust
- Other processes such as serious case review

From 1 October 2017, Trust staff must report deaths where there are concerns from family, clinical staff or through governance processes and where the Trust is the main provider of care, reporting these deaths on Datix within 24 hours of being informed and providing the cause of death where known.

This scope is further developed in the policy Learning from healthcare deaths – the right thing to do.

Following the publication of the Trust policy it was expected that the total number of deaths not in scope would reduce, staff are still gaining confidence in this so we saw deaths that were not in scope being reported, but this has reduced in quarter 4. This was due to staff understanding what can be recorded on the clinical system and what needs reporting on Datixweb. The numbers of deaths in scope have risen as expected through the expansion of what is included.

Each reported death is reviewed in line with the three levels of scrutiny the Trust has adopted. These are as suggested in the National Quality Board guidance:

1. Death Certification
2. Case record review, through Structured Judgment Record Review (SJRR) or Managers 48 hour review acceptance by risk panel. This latter option was introduced in early 2018.
3. Investigation – that could be service level, serious incident reported on STEIS or other review e.g. LeDeR, safeguarding.

1.3 Next Steps

- A review of learning from healthcare deaths has been completed by internal audit providing significant assurance. The report stated “A significant amount of work has taken place at the Trust in developing, implementing and establishing arrangements for learning from deaths in compliance with the NQB requirements (issued in March 2017). Whilst there are still some requirements which need to be fulfilled, the Trust is acutely aware of these and work is continuing to achieve these.” The Mortality review group held a workshop in June 2018 where implementation of the audit findings was agreed. The report has identified 4 risks (1 medium and 3 low) and proposed/agreed 10 actions (6 medium and 4 low)
- This will include:
  - A review of the Learning from Healthcare Deaths policy will take place to include feedback from the audit findings and learning from the first six months of policy implementation in consultation with Northern Alliance colleagues.
  - To agree the function, accountability and purpose of the mortality review group, including a review of mortality groups terms of reference
  - Develop an annual work plan to support work stream priorities
  - Further develop processes and consistency in sharing learning
  - Strengthen our approach to identification and recording of main providers other than SWYPFT and processes to support sharing of information is strengthened.
  - We will continue to be part of the group working with Improvement academy with service users and carers about communication and approach following mortality. This work is nearing completion and has been shortlisted for national awards.
- The resource and capacity to undertake and develop this work is significant and a business case to support this will be submitted to enable this work to take place.
- The Trust will provide training to increase the number of Structured Judgment Record Reviewers.

2. Annual Cumulative Dashboard Report 2017/2018 covering the period 1/4/2017 – 31/3/18

Table 1 Summary of 2017/18 Annual Death reporting by financial quarter to 31/3/2018

	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	2017/18 total
Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death	745	675	725	739	2884
Total number of deaths reported on Datix by staff (by reported date, not date of death)	158	168	146	96	568
Total number of deaths reviewed	158	168	146	96	568
Total Number of deaths reported on Datix that were in scope	27	23	62	55	167
Total Number of reported deaths not in the Trust scope (where the Trust was not the lead provider of care; and there were no concerns raised about care provided) NB includes rejected incidents and those not in scope for mortality	135	155	84	41	415

[1]Data extracted from Business Intelligence and Datix risk management systems. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems. Dashboard format and content as agreed by Northern Alliance group

Table 2 Breakdown of the total number of deaths reviewed by service area by financial quarter up to 31/3/2018

Total Number of Deaths reviewed	Mental Health Community	Mental Health Inpatient	General Community	General Community Inpatient	Specialist Services Learning Disability	Specialist Services CAMHS	Specialist Services ADHD	Forensic
Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1
158	**143**	**3**	**0**	**7**	**4**	**0**	**1**	**0**
Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2
168	**157**	**3**	**0**	**0**	**8**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3
146	**126**	**5**	**0**	**5**	**8**	**2**	**0**	**0**
Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4
96	**79**	**4**	**1**	**0**	**11**	**1**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD
568	**505**	**15**	**1**	**12**	**31**	**3**	**1**	**0**

Table 3 Summary of total number of deaths in scope and resulting review process by financial quarter up to 31/3/2018 (excluding learning disability deaths)

Total Number of Deaths in scope	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework***	Total Number of Deaths (other investigation)***	Total number of deaths subject to Structured Judgement Record Review**	Case Note Review (48 hour review)	Total number of deaths that were certified*
Q1	Q1	Q1	Q1	Q1	Q1	Q1
26	**10**	**10**	**1**	**4**	**0**	**11**
Q2	Q2	Q2	Q2	Q2	Q2	Q2
21	**3**	**11**	**3**	**6**	**0**	**1**
Q3	Q3	Q3	Q3	Q3	Q3	Q3
57	**10**	**16**	**6**	**14**	**3**	**18**
Q4	Q4	Q4	Q4	Q4	Q4	Q4
46	**4**	**7**	**3**	**9**	**19**	**8**
YTD	YTD	YTD	YTD	YTD	YTD	YTD
150	**27**	**44**	**13**	**33**	**22**	**38**

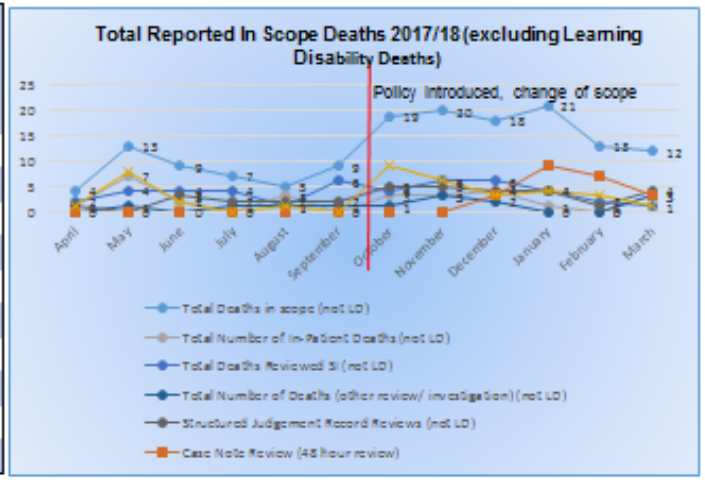
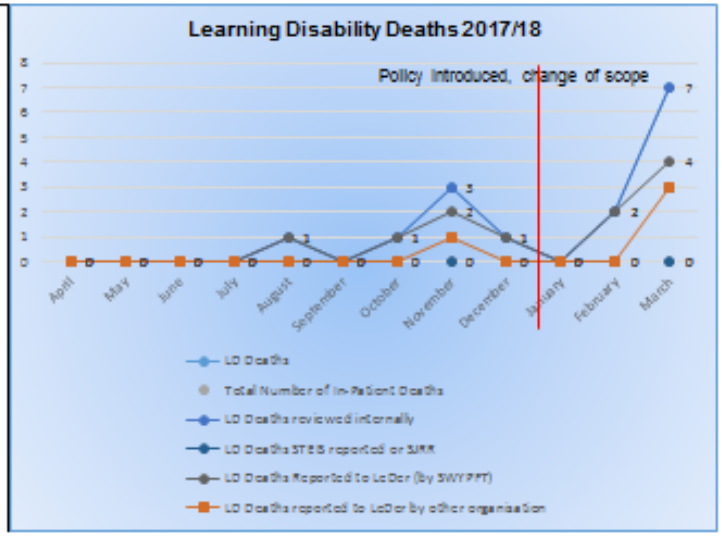


Table 4 Summary of total number of Learning Disability deaths which where in scope by financial quarter up to 31/3/2018

Total Number of Learning Disability Deaths in scope	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed internally	Total Number of Deaths Reviewed in Line with SI Framework* or Structured Judgement Record Review**	Total number of deaths reported through LeDer (By SWYPFT)**	Total number of deaths reported through LeDer (By other organisation)**
Q1	Q1	Q1	Q1	Q1	Q1
0	**0**	**0**	**0**	**0**	**0**
Q2	Q2	Q2	Q2	Q2	Q2
1	**0**	**1**	**0**	**1**	**0**
Q3	Q3	Q3	Q3	Q3	Q3
5	**0**	**5**	**0**	**4**	**1**
Q4	Q4	Q4	Q4	Q4	Q4
9	**0**	**9**	**0**	**6**	**3**
YTD	YTD	YTD	YTD	YTD	YTD
15	**0**	**15**	**0**	**11**	**4**



3. Learning from Healthcare Death reviews and investigations

This section of the report contains a summary of learning identified from reviews and investigations that have been completed so far for deaths reported between 1/4/17 – 31/3/18. Further learning will be added as these are completed.

3.1 Learning from healthcare deaths reported as Serious Incidents

This section provides information on deaths reported as Serious Incidents on Datix between 1 April 2017 and 31 March 2018.

Number of deaths that were reported as serious incidents and investigations commenced	47
Number of investigations that have been completed (at 5/4/18)	38
Number of investigations completed where there were no recommendations for improvement	4
Number of investigations completed to date resulting in recommendations	34
Number of investigations underway (learning identified through these investigations will be added at the conclusion of the investigation process).	9

3.1.1 Themes from completed Serious Incident investigations

From the Serious Incidents that were reported between on Datix between 1 April 2017 and 31 March 2018, 34 resulted in recommendations for improvement. The table below sets out the main themes from the resulting actions:

Action theme	Number of times theme identified	Number of SI reports where theme appears
A5 Record keeping	20	11
A4 Risk assessment	9	6
F1 Staff education, training and supervision	8	5
F2.1 Policy and procedure - in place but not adhered to	7	6
B1 Communication	6	6
G1 Organisational systems, management issues	5	4
B3 Carers/family	4	3
F2.2 Policy and procedures, not in place	3	3
F4 Team service systems, roles and management	3	3
A1 Care pathway	2	2
A2 Care delivery	2	2
A3 Care coordination	2	2
C1 Medicine management	2	2
F3 Staff attitude, conduct, professional practice	1	1
J1 Other	1	1

The top theme, record keeping, is consistent with that identified in recent annual reports, available here. Further analysis of the themes emerging from Serious Incident investigations completed during 2017/18 has been prepared and included in the 2017/18 annual report, available shortly.

3.2 Learning from Structured Judgment Record Reviews

This section provides information on deaths reported on Datix between 1 April 2017 and 31 March 2018 which resulted in a Structured Judgment Record Review. All Structure Judgment Record Reviews that are complete are now approved by a clinical member of the Mortality Review Group before themes are entered into Datix.

Number of Structure Judgment Record Reviews that were commissioned for deaths reported between 1/4/17 – 31/3/18	32
Number of Structure Judgment Record Reviews that have been completed and approved (at 3/7/18).	20
Number of Structure Judgment Record Reviews that are underway	3
Number of Structure Judgment Record Reviews that are in the approval process	8
Number of Structure Judgment Record Reviews that have been referred for further investigation	1

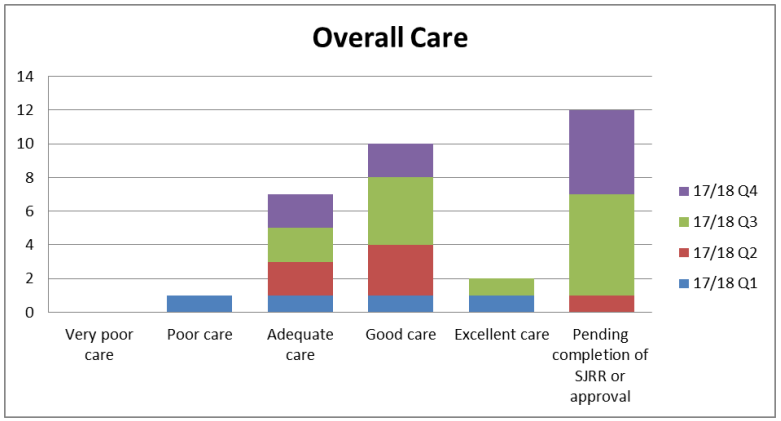
During a Structure Judgment Record Review, the reviewer assesses each phase of care and records their findings on a template under those headings. They also give a view on the care overall. Below is a summary of the rating for overall care, and examples of areas for improvement and positive practice.

Assessment of Care Overall

60% of reviews completed to date rated overall care as good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	1	1	1	0	4
17/18 Q2	0	0	2	3	0	1	6
17/18 Q3	0	0	2	4	1	6	13
17/18 Q4	0	0	2	2	0	5	9
Total	0	1	7	10	2	12*	32

*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group



3.2.1 Areas to consider for improving practice

Due to the small number of completed structured judgement record reviews, it is difficult to identify any themes. However below are some examples of areas for improving practice identified in reviews completed and approved between 1 April 2017 and 31 March 2018. Examples will be added as more reviews are completed:

- The person was at risk of falls and died as a result of a fall at home. There was no evidence of using the skills of the whole team in mitigating risk e.g. Occupational Therapy assessment.
- Convening best interest case conference or strategy meeting to discuss service user's capacity would be valuable. Robust plan to further review their capacity in the community would also be useful.
- The severity of a service user's condition by different practitioners and services was underestimated. There appeared to be a relative lack of knowledge across different services that a man presenting in his mid 50's with severe treatment-resistant anxiety symptoms is likely to have a depressive illness of moderate to severe intensity. When reviewed by a senior practitioner, the severity was immediately noted who did a robust and well-recorded assessment. A senior review (or by someone having a higher level of training and awareness) earlier on in the episode of illness is likely to have identified the severity and risks at an earlier stage.
- Ensuring that when specific treatments cannot be provided, that this is documented clearly and explained. In this example, it appeared to lead to the service user being pre-occupied with a pathway that was not available until the point of death.
- Risk assessments need to be comprehensively documented.
- It was not clear in the documentation that any action had been taken following 7 day discharge follow up.
- Ensuring review of both physical and mental health and ensuring this is documented
- Ensuring the Trust Covert medication policy is being followed. In one case, there was no evidence of a best interest meeting, nor any documentation to support this.

- Risks were identified and detailed in the progress notes as were the care plans associated with same. However the organisation of this information could have been more clearly documented within the assessments and care plans on RIO.
- Ensuring clearly defined contingency plans are available on the clinical system to ensure colleagues are directed to the risk assessments and offered guidance to support informed decision making at times of contact with services.

3.2.2 Positive practice examples

It is difficult to draw themes from a small number structured judgement record reviews, however there was much more evidence of positive practice identified through the process. Below are some examples from reviews completed and approved between 1 April 2017 and 31 March 2018:

- "Overall the care was excellent. Input from a wide variety of disciplines, with regular review and regular consideration of which pharmacological options would suit him and his circumstances best. High-quality physical health care. Measures taken to increase observation/avoid falls to keep him safe. Family indicated that they were happy with his care."
- "Advocacy contacted on his behalf."
- "Overall the patient was cared for and time being taken to engage with her….There was a multidisciplinary approach throughout involving specialist advisors for assessment and advice."
- "When a fall occurred they were being observed constantly. Changes to presentation were discussed with the multidisciplinary team and the family."
- "The family were involved in the resuscitation decision. A palliative approach was taken following difficulty swallowing and deterioration in physical health."
- "From the care record there is evidence of structured risk assessments appertaining to the community aspect of care prior to admission. These were carried out by staff who had a good therapeutic working knowledge and relationship with the patient…close working relationships and coordination between the community and inpatient teams was evident."
- The risk triggers were identified and the plan was adhered to resulting in an informal admission to the ward. This was in a timely manner and did not escalate to a formal admission under the mental health act.
- "Discharge was being planned from an early stage in the admission with the patient being actively involved in her care arrangements…The ward team were able to facilitate escorted home leave then worked with the community teams to increase the time spent at home. Good feedback from each visit is documented and provided a basis to inform the MDT of each stage to discharge."
- "Well documented evidence of good and collaborative joint working evident which was person-centred and responsive to the needs."
- "Family/carer views were taken on board throughout. The team listened and acted on family concerns"
- "Individual assessments at the outset of various trust services all complied with good practice guidelines and all risk assessments were completed."
- "The in-patient stay was excellent, detailed investigations and plans made. Collaboration with spouse and evidence of plenty of MDT working. Good planned discharge and follow up all provided in a timely fashion."
- "During an inpatient stay in hospital...evidence of prompt and thorough assessments following falls with clear action points"
- "Consultant Physician attended for physical health review- good MDT working"

- “There is evidence that staff encouraged and involved patient in variety of OT activities. In the nursing daily reviews, the staff start off RIO entries by highlighting the MHA detention status and Nursing Level of Observations- Good practice”
- “Covert medication plan was initiated during admission due to risks of non-concordance, family were informed.”
- "Attempts were made to be collaborative in devising and agreeing a care plan that met the service user needs. There was evidence of multi-agency working and sign posting to relevant agencies to support care and treatment."
- “The Care-coordinator had supported the patient to attend out-patient appointments, manage medication, gain new accommodation on three occasions, manage finances and had provided support on seven admissions and provided comprehensive follow up on discharge from the wards. The service user was often difficult to engage and frequently missed appointments which were always followed up by the Community Team. They had issues with alcohol and substance misuse and support was given to address. There was a pattern of relapse following increase in consumption of alcohol and/or illicit substances; when this did happen the Community Team dealt with this in a professional and non-judgemental manner. The Care-coordinator involved family members appropriately and demonstrated flexibility in order to ensure the service user received the care they needed. Every effort was made throughout the episode of care to make sure the service user was involved in decision making and their wishes around medication were taken into account and often a compromise was reached when the service user’s wishes were different to the medical recommendation.”
- “The service user’s care and treatment whilst an inpatient seemed to be compassionate and attentive. Staff responded to fluctuating needs promptly and they had good input from the MDT, including therapy staff. When the patient began complaining of transient pain in the leg with no apparent onset this was monitored for three days at which point the pain was more consistent and impacting on mobility. The patient was provided with an x-ray that showed an historic fracture that has reopened. From this point on care was delivered by general hospital staff which was appropriate”

3.2.3 Additional data

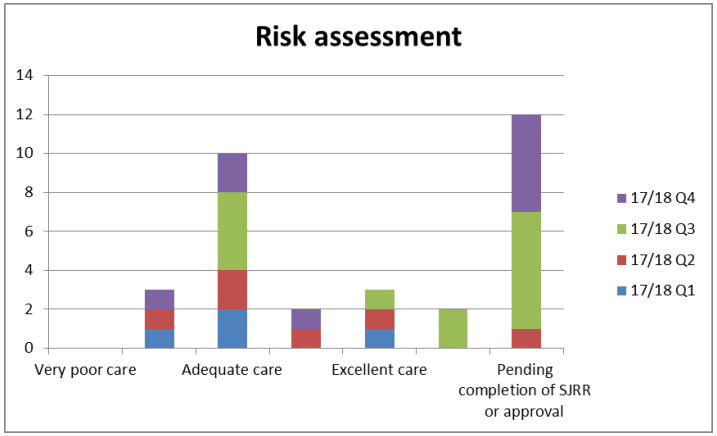
Below is a summary of the ratings given for each phase of care:-

Risk assessment:

25% were rated good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Not applicable	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	2	0	1	0	0	4
17/18 Q2	0	1	2	1	1	0	1	6
17/18 Q3	0	0	4	0	1	2	6	13
17/18 Q4	0	1	2	1	0	0	5	9
Total	0	3	10	2	3	2	12*	32

*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group

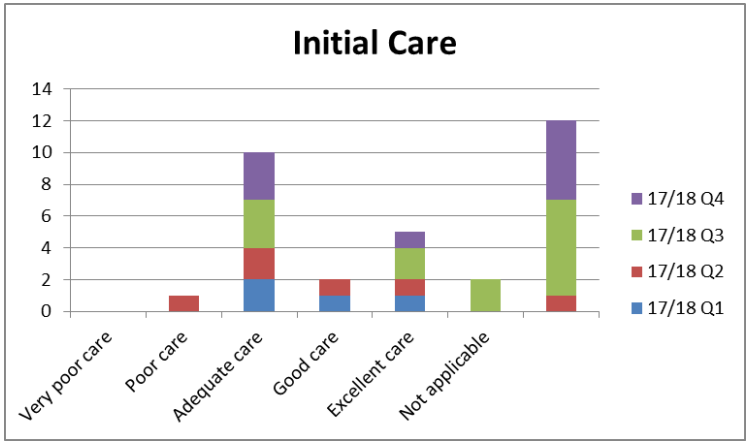


Allocation/ Initial Review:

35% were rated good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Not applicable	Pending completion of SJRR or approval	Total
17/18 Q1	0	0	2	1	1	0	0	4
17/18 Q2	0	1	2	1	1	0	1	6
17/18 Q3	0	0	3	0	2	2	6	13
17/18 Q4	0	0	3	0	1	0	5	9
Total	0	1	10	2	5	2	12*	32

*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group

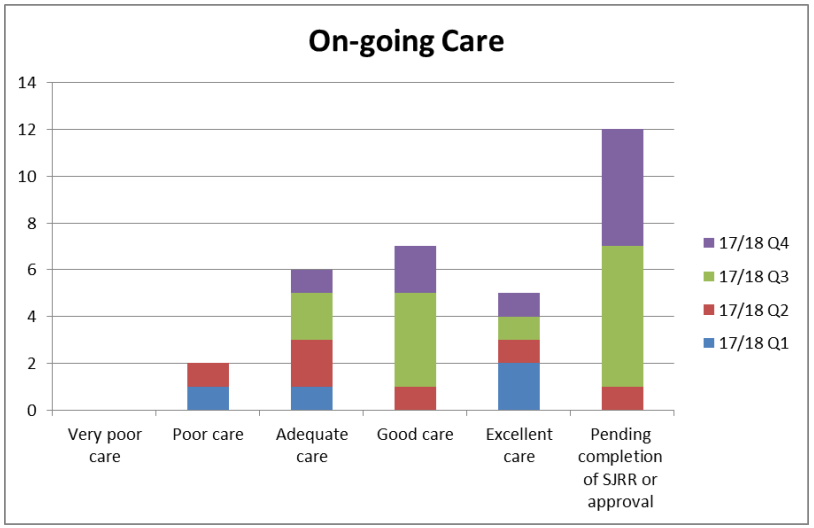


On-going Care:

60% were rated good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	1	0	2	0	4
17/18 Q2	0	1	2	1	1	1	6
17/18 Q3	0	0	2	4	1	6	13
17/18 Q4	0	0	1	2	1	5	9
Total	0	2	6	7	5	12*	32

*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group

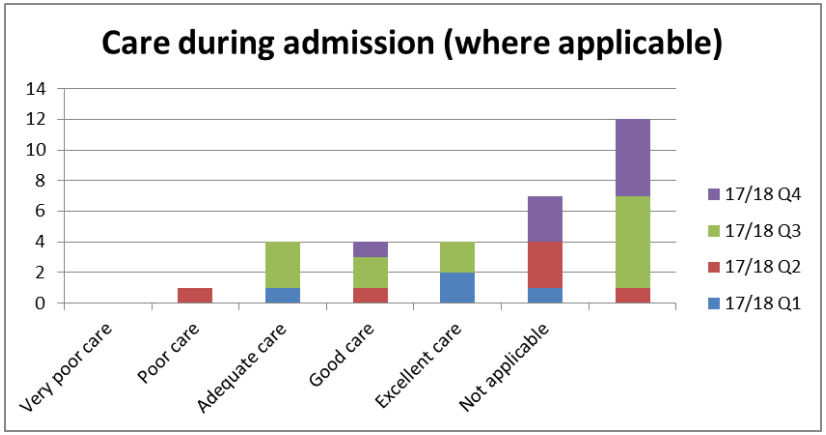


Care During Admissions (where applicable):

62% were rated good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Not applicable	Pending completion of SJRR or approval	Total
17/18 Q1	0	0	1	0	2	1	0	4
17/18 Q2	0	1	0	1	0	3	1	6
17/18 Q3	0	0	3	2	2	0	6	13
17/18 Q4	0	0	0	1	0	3	5	9
Total	0	1	4	4	4	7	12*	32

*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group

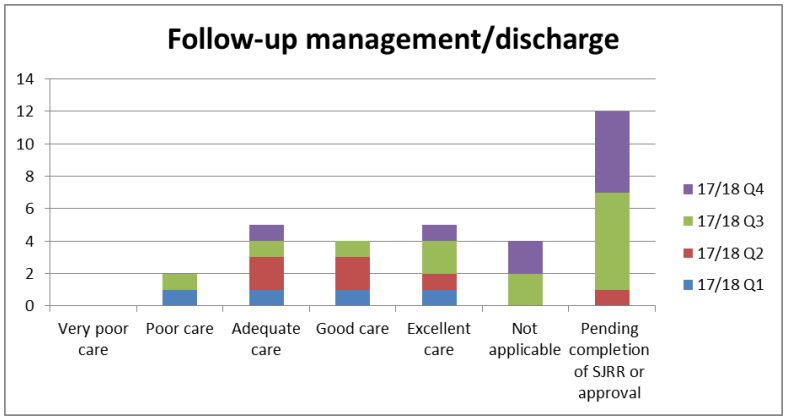


Follow-up Management / Discharge:

62% were rated good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Not applicable	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	1	1	1	0	0	4
17/18 Q2	0	0	2	2	1	0	1	6
17/18 Q3	0	1	1	1	2	2	6	13
17/18 Q4	0	0	1	0	1	2	5	9
Total	0	2	5	4	5	4	12*	32

*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group

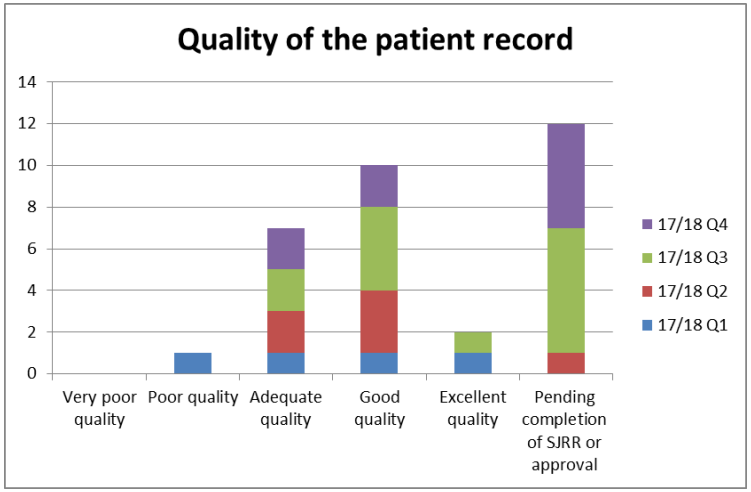


Quality of the patient record in enabling good quality of care to be provided:

50% were rated good or excellent

	Very poor quality	Poor quality	Adequate quality	Good quality	Excellent quality	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	1	1	1	0	4
17/18 Q2	0	0	2	3	0	1	6
17/18 Q3	0	0	2	4	1	6	13
17/18 Q4	0	0	2	2	0	5	9
Total	0	1	7	10	2	12*	32

*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group



3.3 Learning from other Investigations

a) Service level investigations

Of the 10 service level investigations for deaths reported between 1 April 2017 and 31 March 2018, 5 investigations have been completed (at 3/7/18).

The areas identified for improvement are summarised and themed below:

Care delivery

- Although teams have systems and processes there are times when an individual staff member has not taken responsibility for tasks allocated to them and care delivered was not provided as planned.

Risk assessment

- Ensuring Sainsbury's level 1 risk assessment is completed at the appropriate time.
- Completion of a Level 1 risk assessment at a medical review does not always happen however the formulation relating to risk is documented in the Medical Care Plan. This will be reviewed as part of the trust wide review of risk assessment documentation, in the transition to a new electronic records system. This review is underway and will give consideration to developing a more formative approach to risk assessment.
- When no face to face contact has been possible and service user contacts the team; to ensure that a qualified member of staff speaks with the service user in order to carry out a risk assessment in relation to urgency of assessment required.

Record keeping

- Need to check details on system at the time of taking a verbal referral e.g. GP details and address of patient.

Communication

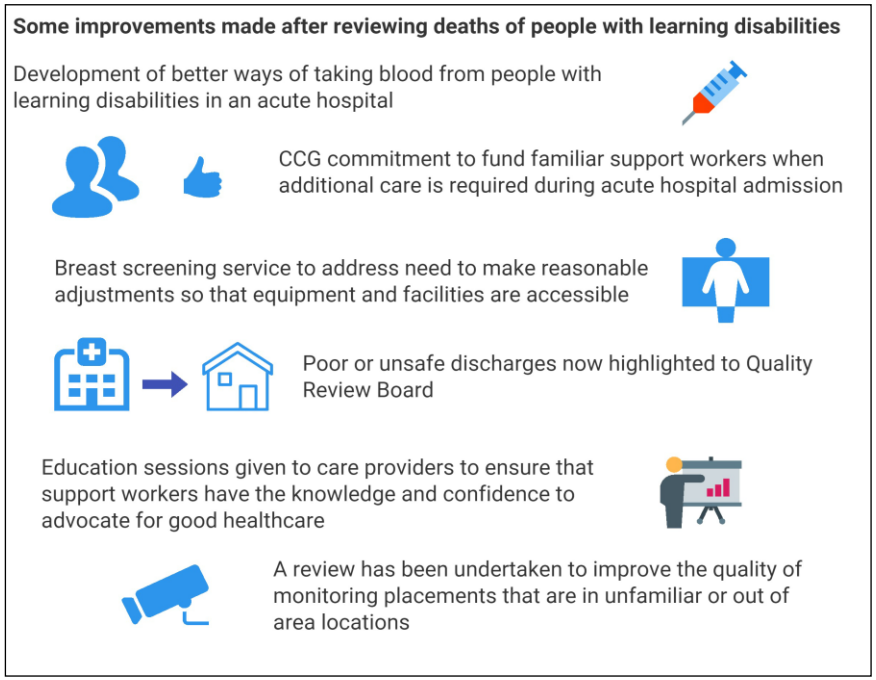
- There were some communication issues between teams regarding attendance at A&E.
- Ensuring that when a patient does not attend for an outpatient appointment, that this is referred to the duty worker to follow up as per procedure.

b) Safeguarding reviews

During 2017/18 there have been 3 cases that were originally identified for safeguarding reviews, one has since had an Individual Management Review (IMR) completed and a Service Level Investigation has now been commissioned to explore some issues further. The two remaining safeguarding cases are currently being reviewed. Learning will be updated when this is available.

c) Learning disability reviews

Feedback from the Learning Disability Mortality Review programme (LeDeR) has been limited to date. The interim national report for 2016/7 tells us that 521 deaths that are eligible for review have been notified to the LeDeR programme from 1st January 2016- 30th May 2017. Priority is being given to themed reviews of death of young people aged 18-24 years and people from black and minority ethnic background.



They have identified key challenges to be:-

- 45% have not yet been allocated to a reviewer.
- A small proportion of trained reviewers are 'active' in reviewing deaths 27%.
- A majority of reviewers are from nursing and care backgrounds, and better representation of medical professions is required.

The Trust reviewers tell us that in Yorkshire and Humber there have been over 200 notifications since the programme started and there is a backlog in reviews being undertaken.

Main findings:

- 50% of deaths are due to aspiration pneumonia
- Contributing factors are:-
  Behavioural risk factors, Medication and Seizures, poor oral health, post sedation and post dentistry aspiration

Learning is not yet available at Trust or locality level to date.