

# Learning from healthcare deaths Report: The right thing to do

**Annual Cumulative Report 2019/20 (covering the period 1/4/2019 – 31/12/19)**

1. **Background context**

**1.1 Introduction**

Scrutiny of healthcare deaths has been high on the government’s agenda for some time. In line with the National Quality Board report published in 2017, the Trust has had Learning from Healthcare Deaths policy in place since September 2017 that sets out how we identify, report, investigate and learn from a patient’s death. The Trust has been reporting and publishing our data on our website since October 2017.

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 has worked collaboratively with other providers in the North of England to develop our approach. The Trust will review/investigate reportable deaths in line with 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. 3

**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.

From 1 October 2017, the Trust introduced our Learning from healthcare deaths – the right thing to do policy which introduced a revised scope for reporting deaths. 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. The policy was reviewed and updated in January 2020.

Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny the Trust has adopted in line with the National Quality Board guidance:

|  |  |  |
| --- | --- | --- |
| **In scope deaths should be reviewed using one of the 3 levels of scrutiny:** | | |
| 1 | Death Certification | Details of the cause of death as certified by the attending doctor. |
| 2 | Case record review | Includes:  (1) Managers 48 hour review  (2) Structured Judgement Review |
| 3 | Investigation | Includes:  Service Level Investigation  Serious Incident Investigation (reported on STEIS)  Other reviews e.g. LeDeR, safeguarding. |

**1.3 Next Steps**

Our work to support learning from deaths continues, and includes:

* Development of processes to support bereaved families and carers.
* Ongoing development of the Clinical Mortality Review Group
* Thematic review and analysis of learning from deaths findings
* Further development of internal processes and consistency in data collection
* Continued training for Structured Judgement Reviewers.

1. **Annual Cumulative Dashboard Report 2019/2020 covering the period 1/4/2019 – 31/12/19**

**Table 1 Summary of 2019/20 Annual Death reporting by financial quarter to 31/12/2019**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **2018/19 total** | **Quarter 1 2019/20** | **Quarter 2  2019/20** | **Quarter 3  2019/20** | **Quarter 4  2019/20** | **2019/20 total to date** |
| Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death\* | 2583\*\* | 769 | 679 | 823 |  | 2271 |
| Total number of deaths reported on Datix by staff (by reported date, not date of death) | 344 | 74 | 77 | 94 |  | 245 |
| Total number of deaths reviewed | 344 | 74 | 77 | 94 |  | 245 |
| Total Number of deaths which were in scope | 274 | 63 | 60 | 81 |  | 204 |
| Total Number of deaths reported on Datix that were not in the Trust's scope | 37 | 4 | 15 | 10 |  | 29 |
| Total Number of reported deaths which were rejected following review, as not reportable or duplicated. | 33 | 7 | 2 | 3 |  | 12 |

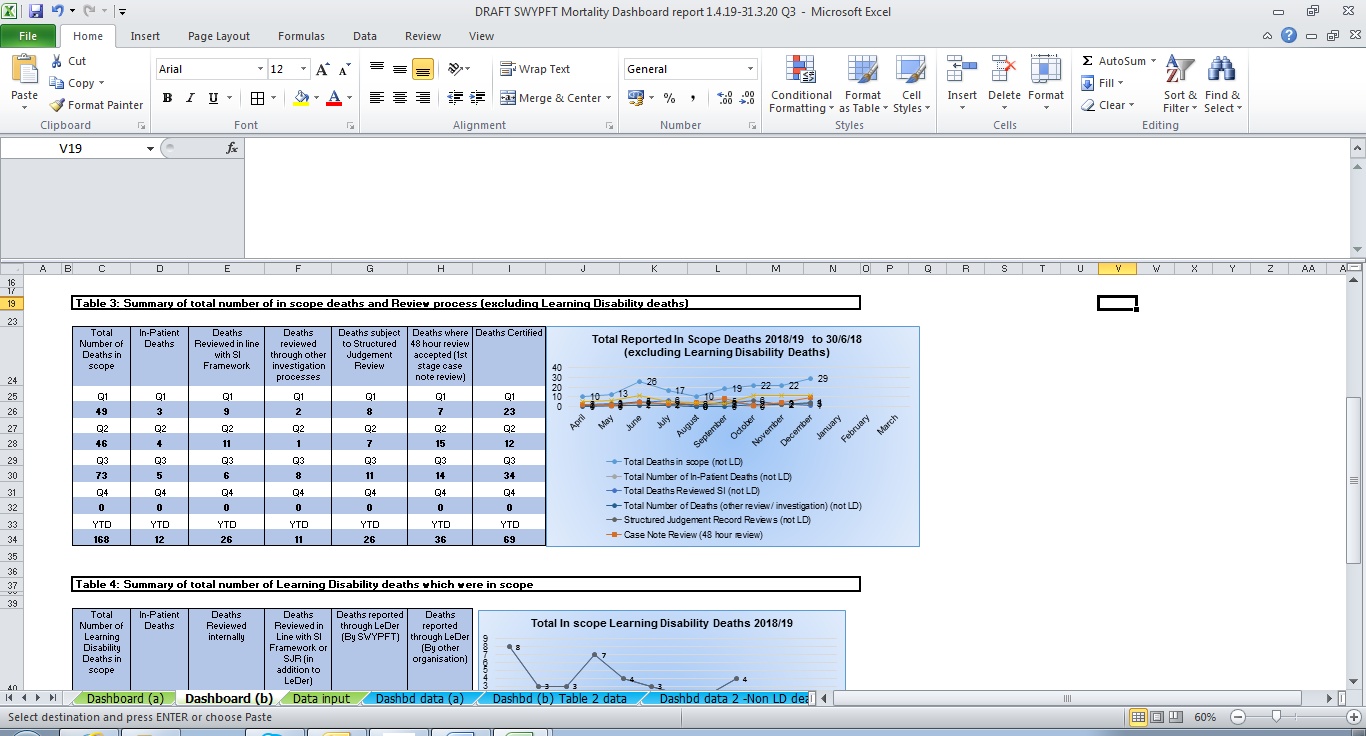
\*\*Data extracted from Business Intelligence and Datix risk management systems. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems. Dashboard format and content as agreed by Northern Alliance group

\* since this figure was run, the data source is now solely from SystmOne, therefore figures will have increased due to improved flow of data. For the purposes of this report and data contained in Quality Accounts, the total for 2018/19 has not been refreshed.

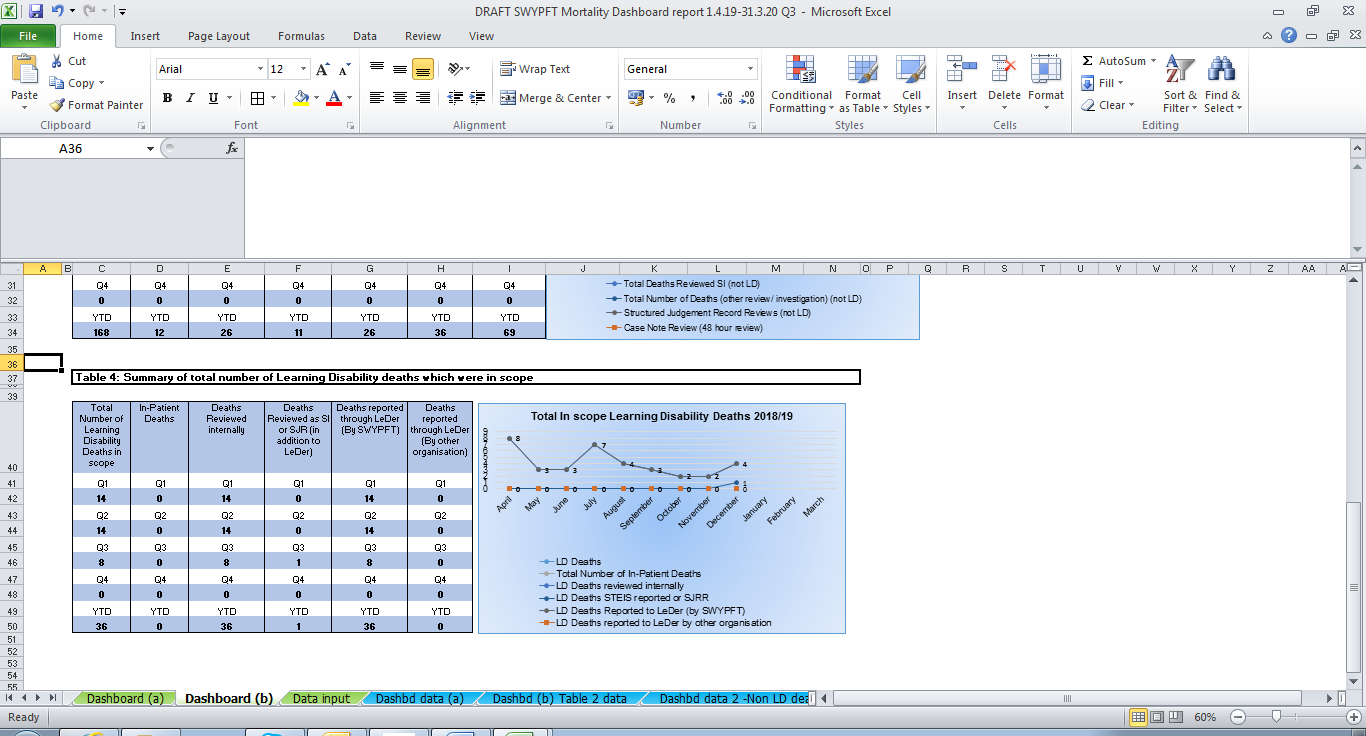
**Table 2 Breakdown of the total number of deaths reviewed by service area by financial quarter up to 30/9/2019**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Total Number of Deaths reviewed | Mental Health Community | Mental Health Inpatient | General Community | General Community Inpatient | Specialist Services Learning Disability | Specialist Services CAMHS | Forensic Services | Specialist Services ADHD |
| Q1 | Q1 | Q1 | Q1 | Q1 | Q1 | Q1 | Q1 | Q1 |
| **63** | **45** | **3** | **3** | **0** | **12** | **0** | **0** | **0** |
| Q2 | Q2 | Q2 | Q2 | Q2 | Q2 | Q2 | Q2 | Q2 |
| **60** | **39** | **4** | **3** | **0** | **14** | **0** | **0** | **0** |
| Q3 | Q3 | Q3 | Q3 | Q3 | Q3 | Q3 | Q3 | Q3 |
| **81** | **66** | **5** | **0** | **0** | **9** | **0** | **1** | **0** |
| Q4 | Q4 | Q4 | Q4 | Q4 | Q4 | Q4 | Q4 | Q4 |
| **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| YTD | YTD | YTD | YTD | YTD | YTD | YTD | YTD | YTD |
| **204** | **150** | **12** | **6** | **0** | **35** | **0** | **1** | **0** |

**Table 3: Summary of total number of in scope deaths and Review process (excluding Learning Disability deaths)**



**Table 4: Summary of total number of Learning Disability deaths which were in scope**



1. **Learning from Healthcare Death reviews and investigations**

This section of the report contains an overview of themes identified from reviews and investigations that have been completed so far (by 13/11/19) for deaths reported between 1/4/17 – 30/9/19. Further learning will be added as these are completed.

The narrative from investigations and reviews that have been completed by 13/11/2019 have been extracted from Datix and grouped by theme for further detailed analysis. Some of this data has been reviewed at the Clinical Mortality Review Group. Learning library summaries are being prepared (as set out in Appendix A) to enable us to share thematic learning and key messages.

**1 Learning from Structured Judgement Reviews**

This section provides information on deaths reported on Datix between 1 April 2017 and 30 September 2019 which resulted in a Structured Judgement Review. The information in the charts is cumulative over time.

During a Structure Judgement Review, the reviewer assesses each phase of care and records their findings on a template under those headings. The sections below show the ratings for each phase of care.

**Assessment of Care Overall**

**55%** of the 77 reviews completed to date rated overall care as good or excellent. This compares with the previous position of 56%.

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

**51%** of the 77 reviews completed were rated the patient record in enabling good quality care as good or excellent. This is the same as reported last year 51%

**Phases of care**

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

**Risk assessment:**

**40%** of the 73 reviews completed rated risk assessment (where this was relevant) as good or excellent. This percentage has increased slightly from the last year (35%)

**Allocation/Initial Review:**

**60%** of the 68 reviews completed rated the initial review/allocation (where this was relevant) asgood or excellent. Improved position on previous year (46%)

**On-going Care:**

**59%** of the 71 reviews completed rated the initial review/allocation (where this was relevant) asgood or excellent. Improved on previous year (56%)

**Care During Admissions (where applicable):**

**63%** of the 30 reviews completed rated the Care during admissions (where this was relevant) asgood or excellent. Improved on previous year (57%)

**Follow-up Management / Discharge:**

**52%** of the 50 reviews completed rated the Follow up management/discharge (where this was relevant) asgood or excellent. This percentage has reduced slightly on the last report (56%)

**End of Life care**

**100%** of the 4 reviews completed rated End of Life care (where this was relevant) asgood or excellent. This has remained consistent.

**2 Learning from Investigations**

**2.1 Themes from completed Serious Incident investigations**

From the Serious Incidents for deaths that were reported on Datix between 1 April 2017 and 30 September 2019 where the investigation has been completed, 56 investigations resulted in recommendations and actions for improvement. The table below sets out the main themes from the resulting actions alongside how many serious incident investigations they related to:

|  |  |  |
| --- | --- | --- |
| **Action theme and descriptor** | **Number of times theme identified** | **Number of SI reports where theme appears** |
| **Record keeping** & documentation | 36 | 23 |
| **Communication** between staff (same service) | 22 | 20 |
| **Risk assessment**, management & contingency | 21 | 16 |
| **Staff education, training & supervision** | 17 | 12 |
| **Policy & procedures** – in place but not adhered to | 16 | 14 |
| **Carers/family** – communication, liaison, assessment | 15 | 13 |
| **Care pathway** – referral, access, discharge, transition between agencies, services & related communications | 13 | 10 |
| **Team/service systems**, roles & management | 11 | 10 |
| **Care delivery** - needs assessment, diagnosis, care planning, CPA, care delivery | 9 | 7 |
| P**olicy and procedures,** not in place | 8 | 7 |
| **Organisational systems,** management issues | 8 | 7 |
| **Care coordination** | 5 | 4 |
| **Other** | 4 | 4 |
| **Medicine management** | 3 | 3 |
| **Environment/equipment** – security and safety, furniture, medical devices, hardware, ligatures, storage, etc | 3 | 1 |
| **Staff attitude**, conduct, professional practice | 1 | 1 |
| **Information governance** - confidentiality breach, information management | 1 | 1 |
| **Total themes** | **193** | **56** |

* 1. **Service level investigations**

Of the 32 service level investigations for deaths reported between 1 April 2017 and 30 September 2019, 25 investigations have been completed (at 13/11/19).

Of the 25 completed investigations, 2 have not yet been updated on Datix. 17 cases had identified care or service delivery issues; some had more than one issue identified. These are themed below:

|  |  |
| --- | --- |
| Record keeping | 7 |
| Risk assessment/management | 6 |
| Carers/ family | 4 |
| Policy and procedure issues | 4 |
| Care delivery | 3 |
| Care pathway | 3 |
| Physical healthcare | 3 |
| Staff education, training and supervision | 3 |
| Communication | 2 |
| Discharge | 2 |
| Team/service issues | 2 |
| Environment | 1 |
| Equipment | 1 |
| Safeguarding | 1 |
| Medicine management | 1 |

* 1. **Safeguarding reviews**

Between 1 April 2017 and 30 September 2019, there are six deaths that have been/are being reviewed through safeguarding processes. Learning will be updated when this is available.

Three of these cases have some initial findings recorded pending further safeguarding review. One is recorded as being concluded. Themes from these are included below; more than one theme can be added to a record:

|  |  |
| --- | --- |
| Record keeping | 1 |
| Environment | 1 |
| Risk assessment | 1 |
| Physical health | 1 |
| Patient Engagement | 1 |

* 1. **Learning disability reviews**

The Mortality Review Group has agreed that for any learning disability deaths, the managers 48 hour review will be completed, and in some cases a Structured Judgement Review will be requested to enable internal learning. This is alongside the LeDeR programme. Learning from any Structured Judgement reviews will be included above. Feedback from the Learning Disability Mortality Review programme (LeDeR) reported to Trust board is available in Appendix B.

**3 Next Steps**

**3.1 Thematic Review**

The Clinical Mortality Review Group has developed the provisional timetable (Appendix A) to facilitate the ongoing review of thematic data related to the top 10 themes. The volume of data available has vastly increased so a staggered approach to reviewing by theme is now necessary to manage content.

Each theme has or will be reviewed by the group through group-work or task and finish group. The aim is to develop prepared [Learning library](http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx) summaries using the SBAR headings (Situation, Background, Analysis, Recommendation) as the vehicle to share key messages and common learning points related to each theme. In some cases, specialist advisors will be asked to support their development.

The completed SBAR learning summaries will be added to the Learning Library K drive folder, and shared on the Learning Library intranet pages, through the ‘Headlines’ communication and reported back through Learning from Healthcare Deaths reports and Clinical Mortality Review group.

As further data becomes available, this will be added to the sources of information being used.

Report prepared by

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December 2019

**Appendix A**

**Provisional timetable for reviewing Learning from Deaths - Thematic data** (this document will be updated separately)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Theme** | **Source of information** | **Review process** | **Financial Quarter** | **Action**  *Hyperlinks will be added as content is available* |
| **Record keeping** & documentation and information governance | SIs, investigations | Information Governance group | Quarter 1  19/20 | [**Bad news**](Learning%20Library%20template%20Ref:%20Bad%20News%20Mitigation)  [**Discharge letters**](Learning%20Library%20Re:%20Discharge%20letters)  [**Consensus status**](Sharing%20of%20information%20to%20prevent%20suicide%20-%20consensus%20statements​) |
| **Care pathway** – referral, access, discharge, transition between agencies, services & related communications | SIs, investigations  SJR phases of care – allocation / initial review & follow up | Clinical Mortality Review Group | Quarter 1 |  |
| **Risk assessment**, management & contingency | SIs, investigations  SJR phase of care | Clinical Mortality Review Group | Quarter 1 |  |
| **Care delivery** - needs assessment, diagnosis, care planning, Care coordination, CPA, ongoing care | SIs, investigations  SJR phases of care – Ongoing Care & Care during admission | Clinical Mortality Review Group | Quarter 2 |  |
| **Policy & procedures**   * in place but not adhered to * not in place | SIs, investigations | Clinical Mortality Review Group | Quarter 2 |  |
| **Staff attitude**, conduct, professional practice | SIs, investigations | Clinical Mortality Review Group | Quarter 2 |  |
| **Carers/family** – communication, liaison, assessment | SJR content,  SIs, investigations | Clinical Mortality Review Group 18/11/19 | Quarter 3 | SBARs being prepared around:  Information will be shared via Headlines |
| **Other** | SIs, investigations | Clinical Mortality Review Group and task and finish group | Quarter 3 | SBAR being prepared around choking |
| **Team/service systems**, roles & management | SIs, investigations | Clinical Mortality Review Group | Quarter 3 |  |
| **Organisational systems,** management issues | SIs, investigations | Clinical Mortality Review Group | Quarter 3 |  |
| **Communication** between staff (same service) | SIs, investigations | Clinical Mortality Review Group | Quarter 4 |  |
| **Staff education, training & supervision** | SIs, investigations | Clinical Mortality Review Group | Quarter 4 |  |
| **Medicine management** | SIs, investigations | Clinical Mortality Review Group | Quarter 4 |  |
| **Environment/equipment** – security and safety, furniture, medical devices, hardware, ligatures, storage, etc. | SIs, investigations | Clinical Mortality Review Group | Quarter 4 |  |

**Appendix B**

**Feedback from the Learning Disability Mortality Review programme (LeDeR):**

|  |  |
| --- | --- |
| **Situation** | * The LeDeR Programme was set up to provide a robust independent review of deaths of people with learning disabilities to support learning and hopefully help people with learning disabilities to live longer * The most significant challenge has been to provide timely reviews largely driven by four key factors: a) large numbers of deaths being notified before full capacity was in place locally to review them b) the low proportion of people trained in LeDeR methodology who have gone on to complete a mortality review c) trained reviewers having sufficient time away from their other duties to be able to complete a mortality review and d) the process not being formally mandated. * All deaths will have an initial review – if further learning felt useful a multi-agency review will be conducted |
| **Background** | * It is well documented that People with Learning Disabilities have poorer health than the general population resulting in earlier death (15-20 years earlier) * From 1st July 2016 to 31st December 2018, 4,302 deaths were notified to the LeDeR programme. This was a massive increased in reporting from the last report. These figures are understood to be approximately 86% of the estimated deaths of people with learning disabilities. * Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes: * Children aged 4-17 (42% of deaths reported were from a BAME group) * Adults aged 18-24 (26% of deaths reported were from a BAME group) * Adults 25+ (7% of deaths reported were from a BAME group) * 25% of people from BAME groups had profound and multiple LD – TWICE the proportion of those from White British (11%) * 93% (590 people from a BAME group) had at least 1 long term condition in addition to the Learning Disability * The most common causes of death across all groups were Pneumonia (25%), Aspiration Pneumonia (16%), Sepsis (7%), Dementia (6&), Ischemic heart disease (6%), Epilepsy (5%). * Where gaps in service were reported those individuals more frequently died from Sepsis * A third of reviews identified good practice in the areas of strong effective multi-agency working, person centred care and end of life care. * The box below demonstrates the difference in age of death for people with Learning Disability as opposed to the general population      * Since reporting via notifications commenced on the 1st November 2016 **SWYPFT have reported 97 Deaths of people with learning disabilities via Datix** (End June 2019) * In SWYPFT we currently have 3 trained reviewers and a further 2 reviewers being trained in the near future. |
| **Actions for the Trust** | * In the forthcoming year the LeDeR programme will focus on actions that are being taken locally and sharing examples of good practice to affect service improvement (SWYPFT now links this work to the Mortality Group) * Health Action plans are formulated with people with learning disabilities where accessible format is required by learning disability service and these are shared accordingly and shared between services * There should be a named person (Care Co-ordinator) to help professionals work together (SWYPFT have either CPA Coordinator or Lead Professional) * Reasonable adjustments should be recorded on individual records * Learning Disability Awareness Training should be provided to all those who support people with learning disabilities – SWYPFT have developed a briefing paper to go to the Education & Training Governance Group that addresses this issue. * People need to understand more about the problems with infections in people with learning disabilities (pneumonia & sepsis in particular and constipation) - SWYPFT have commissioned an Advanced Practitioner in Respiratory Care post which can support the reduction in reported deaths due to respiratory issues * There should be much more of a focus on the use of the Mental Capacity Act * A strategic approach is required to training reviewers – Reviewer training is available via e-learning |
| **Recommendations for the Trust** | * SWYPFT need to continue to support the review process and more reviewers will be required * SWYPFT will consider how reasonable adjustments are evidenced in records * The community learning disability team will continue to support the development of health action plans in an accessible format to support people with learning disabilities to maintain and improve their health through better understanding of conditions * The Trust will develop a system for learning from reviews to enable service improvement to occur and a lead for the Trust should be considered – still required * The Trust need to consider Information Sharing agreements with Partners – Systmone will be helpful in terms of sharing information with GP’s * Action plan to be developed, monitored and delivered by the Local Area Contact which Reviewers feed into and attend support forums. The CCG in each area is responsible for collating the learning. |