

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

**Annual Cumulative Report 2019/20 (covering the period 1/4/2019 – 31/03/2020)**

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.

**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 InvestigationSerious 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 – 31/3/2020**

**Table 1 Summary of 2019/20 Annual Death reporting by financial quarter to 31/03/2020\***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **2018/19 total** | **Quarter 12019/20** | **Quarter 2 2019/20** | **Quarter 3 2019/20** | **Quarter 4 2019/20** | **2019/20 total** |
| Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death\* | 2583\*\* | 778 | 700 | 902 | 882 | 3262 |
| Total number of deaths reported on Datix by staff (by reported date, not date of death)  | 344 | 74 | 78 | 95 | 108 | 355 |
| Total number of deaths reviewed  | 344 | 74 | 78 | 95 | 108 | 355 |
| Total Number of deaths which were in scope  | 274 | 63 | 61 | 80 | 82 | 286 |
| Total Number of deaths reported on Datix that were not in the Trust's scope  | 37 | 4 | 15 | 12 | 21 | 52 |
| Total Number of reported deaths which were rejected following review, as not reportable or duplicated.  | 33 | 7 | 2 | 3 | 5 | 17 |

\*Data extracted from Business Intelligence Dashboards 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 the 2018/19 figure was run, the data source is now solely from SystmOne, therefore figures have increased due to improved flow of data from the Spine. 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 in 2019/20 by service area by financial quarter**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Total Number of Deaths reviewed | Mental Health Community | Mental Health Inpatient | General Community | General Community Inpatient | Learning Disability | CAMHS and ADHD | Forensic Services |
| **Quarter 1** | **63** | **45** | **3** | **3** | **0** | **12** | **0** | **0** |
| **Quarter 2** | **61** | **40** | **4** | **3** | **0** | **14** | **0** | **0** |
| **Quarter 3** | **80** | **65** | **5** | **0** | **0** | **9** | **0** | **1** |
| **Quarter 4** | **82** | **61** | **5** | **3** | **1** | **11** | **0** | **1** |
| **Year total** | **286** | **211** | **17** | **9** | **1** | **46** | **0** | **2** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Financial quarter | Level 1 | Level 2 | Level 3 | Total |
| Death certified | Manager's 48 hour review  | Structured Judgment Review (SJR) | Service Level Investigation | Serious Incident Investigation | LeDeR3 | Other investigation |  |
| Quarter 1 | 23 | 8 | 8 | 0 | 9 | 14 | 1 | 63 |
| Quarter 2 | 13 | 15 | 8 | 1 | 10 | 14 | 0 | 61 |
| Quarter 3 | 35 | 16 | 9 | 2 | 8 | 8 | 2 | 80 |
| Quarter 4 | 34 | 16 | 6 | 1 | 10 | 13 | 2 | 82 |
| **2019/20 total** | 105 | 55 | 31 | 4 | 37 | 49 | 5 | 286 |

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Total Number of Deaths in scope | In-Patient Deaths | Deaths Reviewed in line with SI Framework | Deaths reviewed through other investigation processes | Deaths subject to Structured Judgement Review | Deaths where 48 hour review accepted (1st stage case note review) | Deaths Certified |
| **Quarter 1** | **49** | **3** | **9** | **1** | **8** | **8** | **23** |
| **Quarter 2** | **47** | **4** | **10** | **1** | **8** | **15** | **13** |
| **Quarter 3** | **72** | **5** | **8** | **4** | **9** | **16** | **35** |
| **Quarter 4** | **69** | **5** | **10** | **3** | **6** | **16** | **34** |
| **Year total** | **237** | **17** | **37** | **9** | **31** | **55** | **106** |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Total Number of Learning Disability Deaths in scope | In-Patient Deaths | Deaths Reviewed internally | Deaths reported through LeDer (By SWYPFT) | Deaths reported through LeDer (By other organisation) |
| **Quarter 1** | **14** | **0** | **14** | **14** | **0** |
| **Quarter 2** | **14** | **0** | **14** | **14** | **0** |
| **Quarter 3** | **8** | **0** | **8** | **8** | **0** |
| **Quarter 4** | **13** | **0** | **13** | **12** | **1** |
| **Year total** | **49** | **0** | **49** | **48** | **1** |

In line with national reporting of deaths, we are required to separate our reporting of in scope deaths into learning disability deaths and all other deaths. All Learning disbaility dealths have to be reported on LeDeR[[1]](#footnote-1).

1. Learning Disability Mortality Review programme (LeDeR) [↑](#footnote-ref-1)