

# **Learning from Healthcare Deaths Report**

**Annual Cumulative Report 2020/21**

**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.

All deaths that are in scope are reported to Trust Board each quarter. The latest reports are published on the [Trust website](https://www.southwestyorkshire.nhs.uk/about-us/performance/learning-from-deaths/).

**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 introduced our Learning from healthcare deaths policy in 2017. Staff report deaths where there are concerns from family, clinical staff or through governance processes and where the Trust is the main provider of care. This is what we refer to as ‘in scope deaths’ (further details are available in the Learning from Healthcare deaths policy. The policy has continued to be reviewed and updated to reflect national guidance.

During the first Covid 19 period in March/April 2020, the Learning from deaths policy was considered to see if reporting guidance needed to change. It was felt that the existing reporting requirements were sufficient. There was a national requirement to report externally any inpatient death related to Covid 19, which is covered in our existing reporting criteria.

**Learning from Healthcare Deaths reporting**

During 2020/21, 4085 deaths (row one in Figure 1) were recorded on our clinical systems (figure correct at 5/5/21). This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. 6 months) prior to death, identified from our clinical systems through Business Intelligence software. This includes services such as end of life, district nursing and care home liaison services. Of note is that for a large number of cases, the Trust was not the main provider of care at the time of death.

Figure 1 Summary of 2020/21 Annual Death reporting by financial quarter\*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **2019/20 Total** | **Quarter 12020/21** | **Quarter 2 2020/21** | **Quarter 3 2020/21** | **Quarter 4 2020/21** | **2020/21 total** |
| 1. Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death
 | 3394 | 1190 | 784 | 1174 | 937 | 4085 |
| 1. Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed
 | 355 | 132 | 76 | 115 | 102 | 411 |
| 1. Total Number of deaths which were in scope
 | 286 | 93 | 71 | 85 | 86 | 335 |
| 1. Total Number of deaths reported on Datix that were not in the Trust's scope
 | 51 | 25 | 5 | 30 | 16 | 76 |

\*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

Not all these deaths were reportable as incidents on Datix. Row 2 in Figure 1 shows that 411 deaths were reported on Datix in the year, with the quarterly breakdown. The yearly total is an increase on 2019/20 (355).

All deaths reported on Datix are reviewed by the patient safety support team to ensure they meet the scope criteria. For 2020/21, 335 deaths were in scope and subject to one of the 3 levels of scrutiny the Trust has adopted in line with the National Quality Board guidance (figure 2):

Figure 2 National Quality Board Levels of mortality scrutiny

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

Each quarter, there are a number of reported deaths that do not meet the Learning from Healthcare Deaths reporting criteria which receive no further review. These are not in scope and are not included in data report, although the record remains on Datix.

For the purpose of this report, the date of reporting on Datix is used rather than the date of death. This is to ensure all deaths are systematically reviewed. The figures may differ from other sections of the report. Figure 3 shows the 335 in scope deaths reported by Business Delivery Unit (BDU).

Figure 3 In scope deaths reported by financial quarter and BDU

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Barnsley General Community Services | Barnsley Community Mental Health Services | Calderdale Community Mental Health Services | Kirklees Community Mental Health Services | Wakefield Community Mental Health Services | Mental Health Inpatient Services | Forensic Service | Learning Disability services | CAMHS Specialist Services | Trust wide (Corporate support services) | Total |
| 20/21 Q1 | 2 | 8 | 11 | 27 | 27 | 5 | 0 | 13 | 0 | 0 | 93 |
| 20/21 Q2 | 3 | 5 | 11 | 17 | 19 | 4 | 0 | 12 | 0 | 0 | 71 |
| 20/21 Q3 | 4 | 10 | 19 | 16 | 22 | 2 | 0 | 10 | 1 | 1 | 85 |
| 20/21 Q4 | 2 | 11 | 9 | 25 | 24 | 4 | 1 | 9 | 1 | 0 | 86 |
| Total | 11 | 34 | 50 | 85 | 92 | 15 | 1 | 44 | 2 | 1 | 335 |

The 335 in scope deaths were reviewed in line with the National Quality Board levels of scrutiny as outlined in Figure 2. Figure 4 shows the in-scope deaths by financial quarter they were reported in, against the review level and process.

Figure 4 Learning from Healthcare Deaths during 2020/21 by financial quarter and mortality review process

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Financial quarter | Level 1 | Level 2 | Level 3 | Total |
| Death certified | Manager's 48-hour review  | Structured Judgement Review (SJR) | Service Level Investigation/Significant Event Analysis | Serious Incident Investigation | Learning Disability Mortality Review (LeDeR) | Safeguard review | Specialist IPC Root Cause Analysis |  |
| Quarter 1 | 43 | 19 | 7 | 6 | 4 | 14 | 0 | 0 | 93 |
| Quarter 2 | 33 | 12 | 8 | 0 | 6 | 13 | 0 | 0 | 72\* |
| Quarter 3 | 37 | 15 | 5 | 6 | 8 | 10 | 4 | 0 | 85 |
| Quarter 4 | 39 | 23 | 6 | 2 | 4 | 11 | 0 | 2 | 87\*\* |
| **2020/21 total** | 152 | 69 | 26 | 14 | 22 | 48 | 4 | 2 | 337 |

\*One LD death reported to LeDeR is also undergoing an internal SJR to consider any local learning.

\*\* One LD Death reported to LeDeR is also a Serious Incident Investigation

Figure 5 shows the deaths by BDU and category.

Figure 5 Reported deaths by category and BDU reported during 2020/21

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Barnsley General Community Services | Barnsley Community Mental Health Services | Calderdale Community Mental Health Services | Kirklees Community Mental Health Services | Wakefield Community Mental Health Services | Mental Health Inpatient Services | Forensic Service | Learning Disability services | CAMHS Specialist Services | Trust wide (Corporate support services) | Total |
| Death - confirmed from physical/natural causes | 7 | 13 | 31 | 41 | 66 | 8 | 0 | 20 | 0 | 0 | 186 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 3 | 11 | 10 | 24 | 12 | 3 | 1 | 14 | 1 | 1 | 80 |
| Death - confirmed from infection | 0 | 1 | 2 | 8 | 7 | 0 | 0 | 10 | 0 | 0 | 28 |
| Suicide (apparent) - community team care - current episode | 1 | 10 | 2 | 8 | 5 | 0 | 0 | 0 | 0 | 0 | 26 |
| Suicide (apparent) - community team care - discharged | 0 | 0 | 4 | 3 | 2 | 0 | 0 | 0 | 1 | 0 | 10 |
| Suicide (apparent) - inpatient care - current episode | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 2 |
| Slip, trip or fall - patient | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Death - confirmed related to substance misuse (drug and/or alcohol) | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Death of service user by homicide (alleged or actual) | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Total** | **11** | **35** | **50** | **85** | **92** | **14** | **1** | **44** | **2** | **1** | **335** |

**Deaths reported as Serious Incidents**

Of the 335 in scope deaths reported on Datix between 1 April 2020 and 31 March 2021, 22 were reported as serious incidents.

Please note this figure will not necessarily match those reported in the annual incident report due to the use of different dates for different processes (Serious incident reporting uses date reported on STEIS; mortality uses date reported on Datix).

**Apparent suicides**

The apparent suicides will be reported on further in the Apparent Suicide annual report which will be available later in the year. The figures will be based on the live data, so may not match figures in this report.

**Learning from Deaths findings**

A Learning from deaths report is prepared quarterly and included in the Quarterly Incident reports.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths.  Further work analysis work continues.

**Next Steps**

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

* Continued 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 and support for completing Structured Judgement Reviewers