NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Date: **3 February 2021**

Part: **Public**

Agenda item: **07/22iii**

Title	Learning from Death Q1 & Q2 Report 2021/22 V1.1
Sponsoring Director	Dr Ted Adams – Medical Director
Authors	Victoria Heilbron – Assistant Director Professional Regulation & Clinical Assurance Dr Ted Adams – Medical Director
Presented by	Dr Ted Adams – Medical Director
Exec Summary/Purpose	This paper gives an overview on the deaths that have occurred to patients who were receiving services from the Trust at the time of their death. The trust will use this information to develop further learning. Patients included within this report were either: • Patients who were being cared for in an inpatient bedded unit by staff who were employed by the Trust at the time. • Patients/Care givers who had received consultation either directly face to face or via telephone communication, from staff that were contracted/employed by the Trust, within the last 30 days prior to their death. • It should be noted that reporting and investigation of unexpected deaths over the year has improved and the teams and committees who support this process should be commended. • No harm was found to have been caused by Bridgewater services in Q1 and Q2. • Only minimal gaps were found in care and none of these were deemed attributable to the cause of death.
Previously considered at	SIRP
Related Trust Objective/ Intentions	**Quality** – to deliver high quality, safe and effective care which meets both individual and community needs **Equality, Diversity, and Inclusion** – to actively promote equality, diversity, and inclusion by creating the conditions that enable compassion and inclusivity to thrive.
Which CQC domains are	***Safe*** ***Effective***

supported by this report?	***Caring*** ***Responsive*** ***Well-led***
Which BAF risks are addressed in this report?	BAF 1 - Failure to implement and maintain sound systems of Corporate Governance BAF 2 - Failure to deliver safe and effective patient care BAF 9 - Risk to Trust's objectives due to COVID-19 pandemic
Other risks highlighted/addressed in this paper? (e.g. financial, quality, regulatory, other)	National Quality Board's "Guidance on Learning from Deaths" (published in March 2017) Guidance for NHS Trust on working with bereaved families and carers (published July 2018) Care Quality Commissions (CQC's) review "Learning, Candour and Accountability: a review of the way Trusts review and investigate the deaths of patients in England". Although the NHSE LeDeR policy now includes autism they have not yet made changes to the national reporting form to capture reporting. This change, according to the LeDeR website, will take place during 2021. Guidance awaited from the support team to see if they can be any more specific.
Equality Impact assessment	
Action Plan in place?	No overall action plan is required at present, however, should themes or recurrent issues be identified during ongoing reporting then this will be considered
Explanation of any acronyms in the report	SIRP – Serious Incident Review Panel CCG – Clinical Commissioning Group Q&S – Quality & Safety Committee BAF – Board Assurance Framework NHSE – National Health Service England LeDeR – Learning from deaths of people with a learning disability SJR – Structured Judgement Review RCA – Root Cause Analysis Ulysses – Trust risk management system PSG – Patient Safety Group NEWS2 – National Early Warning Score to identify acutely ill patients CPR – Cardiopulmonary resuscitation DNACPR – Do not attempt cardiopulmonary resuscitation GPs – general practitioners DNs – district nurses HVs – health visitors SOP – standard operating procedure

Next steps	• Individual colleagues identified to assist with consistency in data collection. • Thematic review and analysis of learning from deaths findings e.g. are there themes around clinical monitoring that need further analysis and actions. • Reports to Q&S on a 6 monthly rolling basis i.e. November for Q1and Q2, and June for full year. • Future reports will compare previous years figures to the current year.
Recommendations	The Board is asked to note the contents for information.

Title	Learning from Death Q1&Q2 Report 2021/22 v1.1
Author	Victoria Heilbron – Assistant Director Professional Regulation & Clinical Assurance Dr Ted Adams Medical Director
Date of report	26/01/2022
Purpose	This paper gives an overview on the deaths that have occurred to patients who were receiving services from the Trust within 30 days of the time of their death. The trust will use this information to develop further learning.
Audience	SIRP, Quality Council, Board, Warrington CCG
Meeting Date	January 2022

1. Introduction:

The scrutiny of patients' deaths has been high on the Government agenda since the publication of National Quality Board report – published in 2017. Bridgewater Community Healthcare NHS Foundation Trust (Trust) has had a learning from death policy since November 2017, which sets out how we identify, investigate, and report our learning. Our Trust has also published the learning from death figures in the Trust's Quality Report since 2018/19.

The trust has recently reviewed the Learning from Deaths policy to take into account not only the National Quality Board's "Guidance on Learning from Deaths" (published in March 2017) but also Guidance for NHS Trust on working with bereaved families and carers (published July 2018), as part of a national drive to implement the recommendations of the Care Quality Commissions (CQC's) review "Learning, Candour and Accountability: a review of the way Trusts review and investigate the deaths of patients in England".

Most people will be in receipt of care at the time of their death and experience excellent care leading up to their death. However, for some people, their experience is different, and they may have received poor quality care for several reasons, including system failure.

2. Scope of this report:

Baseline Measure:

The baseline figures used to monitor learning from deaths data is taken from the Trust patient management system. This is defined as all deaths reported through the national spine, who died in each quarter and had an open referral with the Trust and been seen within 30 days of passing away, whether their referral was ended on the same day they died or not.

This measure is then used as a baseline figure, set against the Trust Risk Management Reporting system.

Criteria for Reporting a Death on the Risk Management Reporting System for investigation:

- The bereaved family have expressed a concern about the care their relative received from the Trust or other partner services
- Staff employed by the Trust have expressed a concern about the quality of care received by the deceased e.g. did not die in their preferred place of care

- The death occurred whilst the patient was under the care of a service where concerns have previous been raised (e.g. through audit or CQC inspection)
- The deceased patient had a learning disability
- The death was a maternal death, neonatal death or still birth
- The deceased patient was a child aged <18 years
- The death was unexpected and the last service intervention was less than 30 days ago.

If any of the above criteria apply, the death must be reported as an incident, in accordance with the Incident Reporting Policy, using the online Risk Management Reporting System, within 48 hours of the death being notified.

A serious incident 72 hours report must be completed, along with Learning from Deaths Case Note/Assessment Tool), within 72 hours of the death being notified and uploaded onto Risk Management Reporting System.

Method used to undertake a case review or investigation of death reported on Risk Management System:

The method adopted by the Trust in undertaking initial investigation of deaths is based on the Structured Judgement Reviews (SJRs) for improvement by Royal College of Physicians V1.3 June 2018.

The benefit of utilising this type of methodology is that it provides a structured and replicable process to reviewing deaths across the Trust. This method examines not only intervention but also looks at the holistic care, giving a rich data set of information.

Using the SJR method, the Trust has established a community-based Learning from Death Case Review process (see appendix 1, Operational Process for Learning from Death Case Review). This method allows for the identification and feedback of both good and 'problematic' care, as there is much to be learned from both.

As part of this process, a Case Review Assessment Tool (see appendix 2) - Learning from Deaths Case Note/Assessment Tool) is completed by the lead clinician within a service, once it has been identified the patient death has triggered one or more of the reporting criteria outlined above. This assessment tool forms part of the overall serious incident 72 hour update report undertaken.

3. Summary of Findings

Table 1: All Deaths (expected and unexpected) reported from 1st April 2021 to 31st March 2022 through the national spine, who died in each quarter and had an open referral and been seen within 30 days of passing away, whether their referral was ended on the same day they died or not with comparison to previous years				
	2020 - 2021	2021-2022	2022-2023	2023-2024
Quarter 1	500	308		
Quarter 2	266	347		
Quarter 3	398			
Quarter 4	405			
Total	1569			

Table 2: All deaths reported by Gender (same parameters as Table 1)								
	2020 - 2021		2021-2022		2022-2023		2023-2024	
Gender	Male	Female	Male	Female	Male	Female	Male	Female
Quarter 1	*	*	170	138				
Quarter 2	131	135	156	191				
Quarter 3	203	195						
Quarter 4	188	222						
Total	*	*						

* Information not available

Table 3a: All deaths reported by Halton borough (same parameters as Table 1)				
	2020 - 2021	2021-2022	2022-2023	2023-2024
Borough	Halton			
Quarter 1	*	67		
Quarter 2	*	112		
Quarter 3	110			
Quarter 4	141			
Total	*			

* Information not available

Table 3b: All deaths reported by Warrington borough (same parameters as Table 1)				
	2020 - 2021	2021-2022	2022-2023	2023-2024
Borough	Warrington			
Quarter 1	*	234		
Quarter 2	*	224		
Quarter 3	292			
Quarter 4	279			
Total	*			

* Information not available

Table 3c: All deaths reported by Oldham borough (same parameters as Table 1)				
	2020 – 2021	2021-2022	2022-2023	2023-2024
Borough	Oldham			
Quarter 1	*	*		
Quarter 2	*	1		
Quarter 3	*			
Quarter 4	*			
Total	*			

* Information not available

Table 3d: All deaths reported by St Helens borough (same parameters as Table 1)				
	2020 – 2021	2021-2022	2022-2023	2023-2024
Borough	St Helens			
Quarter 1	*	11		
Quarter 2	*	16		
Quarter 3	12			
Quarter 4	19			
Total	*			

* Information not available

Table 4: Number of Deaths Reported for Patients Diagnosed with a Learning Disability				
	2020 - 2021	2021-2022	2022-2023	2023-2024
Quarter 1	*	1		
Quarter 2	*	5		
Quarter 3	*			
Quarter 4	*			
Total	6			

* Information not available due to collation of data not broken down to this level of detail until April 2021

Table 5: Number of Deaths Reported for Patients with a Diagnosis of Autism				
	2020 - 2021	2021-2022	2022-2023	2023-2024
Quarter 1	*	*		
Quarter 2	*	*		
Quarter 3	*			
Quarter 4	*			
Total	*			

* Information not available due to reporting of this parameter not required until NHSE LeDeR policy is reviewed. Trust systems will be altered to allow reporting when date is known.

Table 6: Total Number of Unexpected Deaths Reported by Ethnicity					
	Ethnicity	**2020 – 2021**	**2021-2022**	**2022-2023**	**2023-2024**
Quarter 1	White British	*	12		
	White European	*	1		
	Not Stated	*	6		
	Pakistani	*	2		
	British	*	1		
	Asian Pakistani	*	2		
	Bangladeshi	*	1		
Quarter 2	White British	*	22		
	Asian	*	1		
	British	*	2		
	Asian/Indian	*	1		
	Mixed British	*	2		
	Romanian	*	1		
	Pakistani	*	1		
	Bangladeshi	*	1		
	Not Stated		12		
Quarter 3		*			
Quarter 4		*			
Total		*			

***** **Information not available due to collation of data not broken down to this level of detail until April 2021. Information as reported on Ulysses.**

Table 7: Cases reviewed and/or investigated as a percentage of total deaths (as recorded in Table 1)												
	2020 - 2021			**2021-2022**			**2022-2023**			**2023-2024**		
	Tot	**M**	**F**	**Tot**	**M**	**F**	**Tot**	**M**	**F**	**Tot**	**M**	**F**
Quarter 1	16	9	7	25	9	15						
Quarter 2	25	6	14	43	21	20						
Quarter 3	22	8	1									
Quarter 4	24	13	11									
% (Num) against total deaths	5.5% (77) annually			10.4% (68) Q1&Q2								

(Some incidents did not have gender recorded. This accounts for any discrepancy in numbers between gender and total deaths reviewed/investigated). Information taken from Ulysses

Table 8: Harm Caused as a percentage of overall deaths (as recorded in table 1)				
	2020 - 2021	2021-2022	2022-2023	2023-2024
Quarter 1	0% (0)	0% (0)		
Quarter 2	0.4% (1)	0% (0)		
Quarter 3	0% (0)			
Quarter 4	0% (0)			
% (Num) against total deaths	0.06% (1)			

Table 9: Gaps in care as a percentage of overall deaths (as recorded in table 1)				
	2020 - 2021	2021-2022	2022-2023	2023-2024
Quarter 1	0.4% (2)	0% (0)		
Quarter 2	3% (8)	0.6% (2)		
Quarter 3	1.8% (7)			
Quarter 4	1.2% (5)			
% (Num) against total deaths	1.4% (22) annually	0.3% (2) Q1&Q2		

- The gaps for Q2 (2021-22) relate to:
  - Problem in assessment
  - Problem related to treatment or care plans
  - Problem in clinical monitoring
  - Problems identified in communication between partners services
  - Problem identified with regards to record keeping

4. Learning from Death Reviews and investigation: :

This section of the report contains an overview of themes identified from reviews and investigations that have been completed for deaths reported between 1st April 2021 and 30th September 2021. The information is taken from Qlik Sense, 72 hour reports, RCAs, Learning from Deaths tool and SIRP minutes as recorded on Ulysses.

Quarter 1 data
Ulysses shows that a Learning from Deaths Tool was completed in 17 cases.
Patient safety groups reviewed 21 of the unexpected deaths.
SIRP reviewed 13 of these cases
The 1 Learning Disability death was reviewed and referred for a LeDeR.

Quarter 2 data
Ulysses shows that a Learning from Deaths Tool was completed in 30 cases.
Patient safety groups reviewed 33 of the unexpected deaths.
SIRP reviewed 31 of these cases
The 1 unexpected Learning Disability death was reviewed and referred for a LeDeR.
The 4 expected Learning Disability cases were internally reviewed.

Further learning may need to be added where investigations are still ongoing or learning action is being monitored.

The author of this report is following up outstanding 72 hour reviews, learning from death tools, PSG and SIRP reviews with the individual managers responsible for managing the incident. Therefore, some results currently reported for Q1 & Q2 may be altered in the next report.

Whilst none of the investigations have identified harm caused by Bridgewater, the Trust has identified some common themes and lessons learned from the Learning from Deaths Process and these are noted below. They are separated into each quarter to identify ongoing trends or areas to be addressed.

Table 10i: A summary of themes that have been identified in Q1 as lessons learned for the Trust, in relation to the deaths**.**

Quarter 1

A	Problem in assessment, investigation, or diagnosis?	1
B	Problem with medication	0
C	Problem with IV/oxygen	0
D	Problem related to treatment or care plans?	1
E	Problem accessing other services?	1
F	Problems with infection management	0
G	Problem in clinical monitoring?	1
H	Problems in resuscitation following cardiac or respiratory arrest	0
I	Concerns from Family or Carers reported?	0
J	Mental Health concerns raised?	1
K	Problems identified in communication between partners services.	2
L	Problem identified with regards to record keeping.	1
M	Problems which do not fit into any other category above	0

Q1 Themes

A relates to mum not being aware of pregnancy
D relates to frustration voiced by parent of lack of feeding plan by other provider
E relates to a safeguarding referral made by partner agency due to patient requiring 24hr care, but local authority had been unable to access this.
G relates to NEWS2 being used to monitor sepsis only and not the deteriorating patient.
J relates to mental health concerns for Mum following special circumstances divulged at pre-birth assessment
K relates to 0-19 service being alerted to death of an 18 year old via an automated systmone message, and a lack of notification of still birth from hospital to 0-19 service.
L relates to NEWS2 not being completed and recorded.

Q1 Actions taken in relation to lessons learned from above

- Full action plan drawn up in relation to the use of NEWS2 tool. Action plan being cascaded by team leaders throughout Halton & Warrington district nursing teams and being monitored via SIRP
- Trust Safeguarding liaised with hospital; hospital was unaware that service went up to 19 years of age.

Table 10ii: A summary of themes that have been identified in Q2 as lessons learned for the Trust, in relation to the deaths**.**

Quarter 2

A	Problem in assessment, investigation, or diagnosis?	3
B	Problem with medication	0
C	Problem with IV/oxygen	0
D	Problem related to treatment or care plans?	3
E	Problem accessing other services?	2
F	Problems with infection management	0
G	Problem in clinical monitoring?	2
H	Problems in resuscitation following cardiac or respiratory arrest	1
I	Concerns from Family or Carers reported?	0
J	Mental Health concerns raised?	1
K	Problems identified in communication between partners services.	4
L	Problem identified with regards to record keeping.	3
M	Problems which do not fit into any other category above	2

Q2 Themes

A escalation of deteriorating patient for new starters, NEWS2 and mental capacity assessment not completed
D problem related to care plan/treatment; problems related to patient care (commencing CPR)
E access to other services – GP's, social care
G problems with clinical monitoring,
H CM to discuss with agencies timely DNACPRs.
J mental health concerns raised; assessment not carried out
K relating to delays in setting up care package with Warrington Borough Council, communicating with GPs
L missing entries, assessments, contemporaneous record keeping
M Patient may possibly have been treated at home, missed Vulnerable Persons Assessment

Q2 Actions taken in relation to lessons learned from above

- Community Matron to discuss with agencies timely DNACPRs
- Bridgewater services to ensure any DNACPR paperwork is readily available and visible within the patient record
- Reminder issued to all clinical personnel that they can use clinical judgement to commence CPR, in line with updated Trust policy
- Team leaders to ensure new starters are trained in actions required should they come across a deteriorating patient
- Contemporaneous record keeping discussed with team & reflective piece from staff member

- DNs had discussion re what to do when a patient passes in their care,
- SOPs required for effective caseload management & handling of Vulnerable person assessments within Health Visiting
- Bereavement training for all HVs, SOP to be devised (inc post bereavement contact) birth pack not to be sent out pre-birth visit.

Learning Disability

1 unexpected death was recorded in Q1 for 2021/2022 in a person recorded as having a learning disability. The death recorded does not show evidence of harm or gaps in care and was referred for a LeDeR review.

4 expected and 1 unexpected death was recorded in Q2. The 1 unexpected Learning Disability death was reviewed and referred for a LeDeR whilst the 4 expected Learning Disability cases were internally reviewed. No gaps or harm was found by Bridgewater services.

This is compared to 6 reported in for the full year of 2020/21

5. Next Steps:

The Trust has used national spine data to ensure that the deaths of all patients under our care are potentially included in the review. This is a very innovative practice that utilises national data and translates it into a local setting to provide assurance that we are looking at all parts of our services.

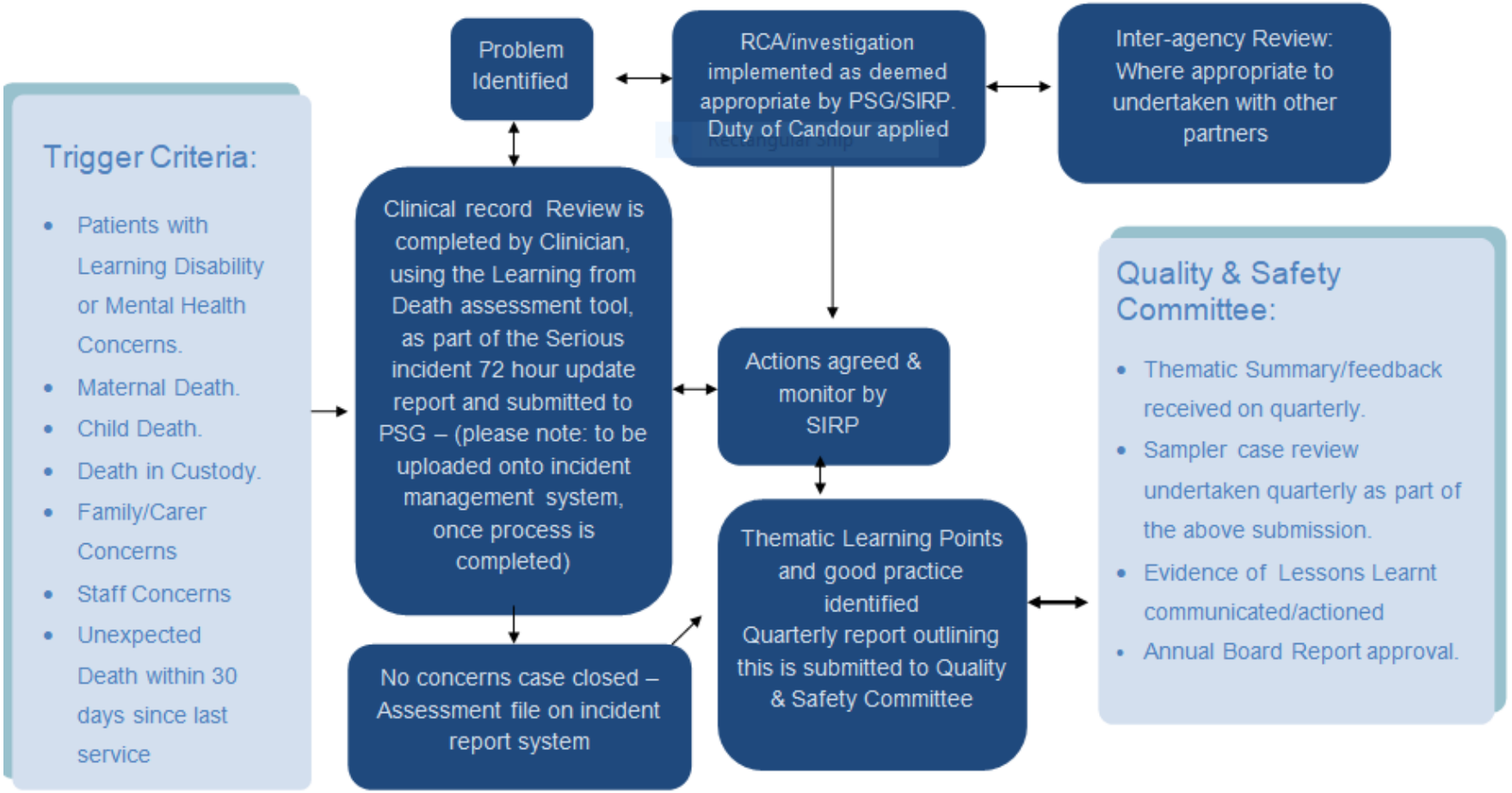
Our work to support learning from deaths continues, and will include:

- Weekly review of unexpected deaths
- Six monthly thematic review and analysis of learning from deaths findings e.g., are there themes around clinical monitoring that need further analysis and actions.
- Annual reports going forward will look back to previous years to establish if ongoing themes are occurring.
- Six monthly reports to SIRP, Quality Council, Q&S and Board going forward.
- Analysis (where recorded), of demographics such as age, ethnicity, borough, and last service to be involved with patient.
- It is noted that the Learning from Deaths template was reviewed and updated in October 2020. This has led to some confusion as to which template should be used and difficulty in identifying some themes. It is recommended that this template is reviewed in quarter 3 of each year in order that consistent collation of information can be undertaken each year.

6. Recommendation:

The Board is asked to note the contents for information.

Appendix 1 - Operational Process for Learning from Death Case Reviews (SJR)



Appendix 2: Learning from Deaths Case Note/Assessment Tool

LEARNING FROM DEATH CASE NOTE REVIEW/ASSESSMENT TOOL Reviewers are asked to comment on whether one or more specific types of problems have occurred. Where a problem has been identified, then a full 72hr review must also be submitted to Patient Safety Group.					
Incident No	**Criteria for reporting a death :**		Please tick	**Clinician completing the case review :**	
	Learning Disability			**Borough:**	
	Maternal Death			**Date completed :**	
	Child Death			**Date Submitted to Patient Safety Group :**	
	Death in Custody				Comments /Action taken:
	Family/Carers/staff concerns raised				
	Unexpected Death				
	Problem Type	**Yes**	**No**		
	Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism VTE or history of falls) ?				
	Problem with medication?				
	Problems with IV fluids/Oxygen ?				
	Problem related to treatment or care plans (e.g. plans not followed or communicated) ?				
	Problem accessing other services ?				
	Problems with Infection Management ?				
	Problems with transferring of care ?				
	Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to change)?				
	Problem in resuscitation following a cardiac or respiratory arrest ?				
	Concerns from Family or Carers reported ?				
	Mental Health concerns raised ?				
	Problems identified in communication between partners services ?				
	Problem identified with regards to recordkeeping ?				
	Problem of any other type not fitting the categories above ?				
		No	**Uncertain**	**Yes**	
	Did the problem lead to harm ?				
		to have gaps	**to be appropriate**		
	Care was considered				
		open	**complete**	Date closed	
	72hrs Review				

Appendix 3 –Summary of Finding for Warrington & Halton CCG -2021-2022 ***(to be completed and submitted after Q2 and Q4)***

Table 1: **All Deaths (expected and unexpected) reported from 1st April 2021 to 31st March 2022** through the national spine, who died in each quarter and had an open referral and been seen within 30 days of passing away, whether their referral was ended on the same day they died or not.					
DEATHS	Q1	Q2	Q3	Q4	TOTAL
	308	347			

Table 2: Reviewed/Investigated as a % of overall deaths (table 1)	Q1	Q2	Q3	Q4	TOTAL
Number	25	43			
% review against total deaths	8.1%	12.4%			

Table 3: Harm caused as a % of overall deaths (table 1)	Q1	Q2	Q3	Q4	TOTAL
	0%	0%			

Table 4: Gaps in care identified as a % of overall deaths (table 1)	Q1	Q2	Q3	Q4	TOTAL
	0%	0.6%			

Table 5: A summary of themes that have been identified as gaps in care by the Trust, in relation to the deaths identified in **table 2.**

A	Problem in assessment, investigation, or diagnosis?	4
B	Problem with medication	0
C	Problem with IV/oxygen	0
D	Problem related to treatment or care plans?	4
E	Problem accessing other services?	3
F	Problems with infection management	0
G	Problem in clinical monitoring?	3
H	Problems in resuscitation following cardiac or respiratory arrest	1
I	Concerns from Family or Carers reported?	0
J	Mental Health concerns raised?	2
K	Problems identified in communication between partners services.	6
L	Problem identified with regards to recordkeeping.	4
M	Problems which do not fit into any other category above	2

Q1 Themes

A relates to mum not being aware of pregnancy
D relates to frustration voiced by parent of lack of feeding plan by other provider
E relates to a safeguarding referral made by partner agency due to patient requiring 24hr care, but local authority had been unable to access this.
G relates to NEWS2 being used to monitor sepsis only and not the deteriorating patient.
J relates to mental health concerns for Mum following special circumstances divulged at pre-birth assessment
K relates to 0-19 service being alerted to death of an 18 year old via an automated systmone message, and a lack of notification of still birth from hospital to 0-19 service.
L relates to NEWS2 not being completed and recorded.

Q1 Actions taken in relation to lessons learned from above

- Full action plan drawn up in relation to the use of NEWS2 tool. Action plan being cascaded by team leaders throughout Halton & Warrington district nursing teams and being monitored via SIRP
- Trust Safeguarding liaised with hospital; hospital was unaware that service went up to 19 years of age.

Q2 Themes

A escalation of deteriorating patient for new starters, NEWS2 and mental capacity assessment not completed
D problem related to care plan/treatment; problems related to patient care (commencing CPR)
E access to other services – GP's, social care
G problems with clinical monitoring,
H CM to discuss with agencies timely DNACPRs.
J mental health concerns raised; assessment not carried out
K relating to delays in setting up care package with Warrington Borough Council, communicating with GPs
L missing entries, assessments, contemporaneous record keeping
M Patient may possibly have been treated at home, missed Vulnerable Persons Assessment

Q2 Actions taken in relation to lessons learned from above

- Community Matron to discuss with agencies timely DNACPRs
- Bridgewater services to ensure any DNACPR paperwork is readily available and visible within the patient record

- Reminder issued to all clinical personnel that they can use clinical judgement to commence CPR, in line with updated Trust policy
- Team leaders to ensure new starters are trained in actions required should they come across a deteriorating patient
- Contemporaneous record keeping discussed with team & reflective piece from staff member
- DNs had discussion re what to do when a patient passes in their care,
- SOPs required for effective caseload management & handling of Vulnerable person assessments within Health Visiting
- Bereavement training for all HVs, SOP to be devised (inc post bereavement contact) birth pack not to be sent out pre-birth visit.