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# Learning from Healthcare Deaths Report

* **Annual Cumulative Report 2021/22 (covering the period 1/4/2021 – 31/3/2022)**

***(Please note this report is extracted from the Incident Management Annual Report 2021/22, numbering aligns with that report)***

**Background context**

**Introduction**

Scrutiny of healthcare deaths remains high on the Government’s agenda. In line with the National Quality Board report published in 2017, the Trust has a Learning from Healthcare Deaths policy which 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 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.

The Trust has a representative from the Patient Safety Support Team who attends the Regional Mortality Meeting which are held quarterly. This meeting facilitates the dissemination of good practice around learning from deaths with sharing of processes that other trusts have in place to review deaths and improve care.

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/) when approved.

**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](http://nww.swyt.nhs.uk/docs/Documents/1180.docx)). The policy has continued to be reviewed and updated to reflect national guidance.

**Learning from Healthcare Deaths reporting**

During 2021/22, 3473 deaths (row one in Figure 26) were recorded on our clinical systems (figure correct at 11/4/2022). 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 , the Trust was not the main provider of care at the time of death for a large number of cases,.

**Figure 26 Summary of 2021/22 Annual Death reporting by financial quarter\***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **2020/21 total** | **21/22 Q1** | **21/22 Q2** | **21/22 Q3** | **21/22 Q4** | **2021/22 Total** |
| 1. Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death | 4217 | 800 | 921 | 943 | 809 | **3473** |
| 1. Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed | 411 | 91 | 99 | 99 | 115 | **405** |
| 1. Total Number of deaths which were in scope | 335 | 77 | 74 | 67 | 89 | **308** |
| 1. Total Number of deaths reported on Datix that were not in the Trust's scope | 76 | 14 | 25 | 32 | 26 | **97** |

\*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 26 shows that 405 deaths were reported on Datix in the year, with the quarterly breakdown. The yearly total is a small reduction of 2020/21 (411).

All deaths reported on Datix are reviewed by the patient safety support team to ensure they meet the scope criteria. For 2021/22, 308 deaths (a reduction on 2020/21) 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 27):

**Figure 27 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 Investigation  Serious 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 the data report, although the record remains on Datix.

For the purpose of this section, 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 28 below shows a Statistical Process Control chart of all reported deaths (by reported date) between 1/1/2020-31/3/2022. The peak in April 2020 is at the upper confidence limit and moving into special cause variation, this coincides with the peak of the first wave of the pandemic, and more deaths were reported at this time. Throughout the rest of the period, numbers have varied over time with some higher numbers around the times of other pandemic peaks.

**Figure 28 Statistical Process Control Report of all deaths reported 1/1/2020 – 31/3/2022 by date reported**

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Figure 29 show the 308 in scope deaths reported by BDU, and figure 30 by the review process followed in line with the National Quality Board levels of scrutinty, described earlier. These are reported against the financial quarter in which the death was reported.

**Figure 29 In scope deaths reported by financial quarter and BDU**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Financial quarter - date reported | 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 Services | Learning Disability services | ADHD and Autism services | Total | Total |
| 21/22 Q1 | 3 | 11 | 15 | 19 | 20 | 5 | 1 | 3 | 0 | 77 |  |
| 21/22 Q2 | 0 | 6 | 19 | 12 | 23 | 8 | 0 | 5 | 1 | 74 |  |
| 21/22 Q3 | 2 | 11 | 11 | 8 | 17 | 6 | 0 | 13 | 0 | 68 |  |
| 21/22 Q4 | 0 | 9 | 18 | 24 | 25 | 5 | 1 | 7 | 0 | 89 |  |
| Total | **6** | **37** | **63** | **63** | **85** | **24** | **2** | **28** | **1** | **308** |  |

**Figure** **30 Learning from Healthcare Deaths during 2021/22 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) | Specialist Root Cause Analysis |  |
| Quarter 1 | 35 | 13 | 13 | 4 | 7 | 5 | 0 | 77 |
| Quarter 2 | 21 | 26 | 11 | 2 | 7 | 5 | 2 | 74 |
| Quarter 3 | 21 | 22 | 4 | 5 | 3 | 13 | 0 | 68 |
| Quarter 4 | 27 | 44 | 9 | 1 | 0 | 8 | 0 | 89 |
| **2021/22 total** | **104** | **105** | **37** | **12** | **17** | **31** | **2** | **308** |

Of the deaths 204 deaths that were subject to a level 2 case note review (173) or investigation (31 [these also included a case note review]) 165 have been completed (at the time of reporting 6/4/22) and no problem in care was identified which directly resulted in death. 39 cases remain under review at the time of reporting.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths.  Working with eight other mental health trusts in the North of England Alliance, we jointly developed a policy and use a common reporting dashboard that brings together important information. The Alliance are unable to report on what are described in general hospital services as “avoidable deaths” in inpatient services.  This is because there is currently no research base on this for mental health services, no satisfactory definition of ‘avoidable’ and no consistent accepted basis for calculating this data.  We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused.

Our Structured Judgement Reviews are conducted by trained reviewers from a clinical background (e.g., medicine, nursing, physio) who work outside the clinical area. The reviewer scrutinises the clinical records to review the care and treatment the individual received leading up to their death. They record their findings in a template under specific phases of care. Each phase of care is rated with supporting narrative. The reviewer also makes a judgement about whether the death was due to problems in care that resulted in harm. All completed reviews are discussed at Business Delivery Unit governance groups to agree next steps, which may include areas for improvement or further investigation.

Our investigations range from local level investigations to serious incident investigations. Investigators will review the care and treatment of the individual who died to identify any care and service delivery issues in the care received over a period of time. The focus is on human factors, systems, and processes. They will also examine if any issue led to the death occurring. Most care and service delivery issues identified are not contributory to the death occurring.

Deaths that were reported between 1/1/2020 and 31/3/2022 have been analysed using Statistical Process Control [SPC] to identify any areas of special cause variation. Data has also been interrogated to understand further details.

There are a number of factors that can affect death reporting figures when viewed over time. These include:

* The mortality data in this report is based on when deaths were reported, not when they occurred.
* The use of the date reported on Datix for reporting ensures no deaths that are retrospectively reported are missed, in line with other mental health trusts.
* Incidents reported may have occurred at an earlier date, but the report reflects when they were reported on Datix as teams became aware.
* Teams report deaths in line with the Learning from deaths policy; reporting deaths irrespective of the cause of death where there is/has been a package of care given in the previous 6 months prior to death occurring.
* Teams report deaths of discharged patients, when they are informed/identified if they have provided care in the last 6 months prior to death, e.g., request for coroner’s report for a discharged patient.

**Kirklees Mental Health community services**

Deaths reported in Kirklees Mental Health community services have remained within normal variation between 1/1/2020 and 31/3/2022, although the reporting rate has been variable over the months. In 2021/22, there were two particular peaks, in June 2021 and February 2022, with 11 deaths reported in each month. Further examination has shown these were within the normal range. In both June 21 (11) and February 22 (11), 16 of the 22 deaths were from physical causes.

**Wakefield Community Mental Health Services**

Wakefield Community Mental Health BDU had the highest reporting rate of deaths in fig 29 (85). Reporting has remained consistent, with no outlying areas over time. Work has been done with the service to clarify reporting guidance, as they have historically over reported deaths. Older Peoples services CMHTs report the most deaths; this has been the same over a number of years. These teams tend to report all deaths they are aware of, including those who are under consultant only care. Patient Safety Team have done work with them to ensure the right deaths are recorded. For all deaths, the Managers 48-hour review is completed which helps determine if the death is in scope or not. Where this is unclear, the death us usually included in the figures so this may increase the figures in this area. Most deaths in these teams are certified as from a physical cause.

**Learning disability deaths**

Fig 29 above shows 28 deaths reported by Learning Disability Services. However, any deaths of a person who has a Learning disability is reportable on Datix, irrespective of the service they are under, in line with the Learning from Healthcare Deaths policy and national guidance.

This can be people who are under the care of teams outside of Learning Disability Services, such as Epilepsy, Dietetics, mental health services (figure 30 shows there were 31 deaths for review via Learning Disability Review Programme [LeDeR], this includes all the above). When Learning disability deaths are reviewed using SPC, reporting has remained within the normal range. As can be seen in fig 29 and 30, there were more Learning Disability deaths reported in Quarter 3.

Further exploration of these revealed that there were above average deaths reported in October 2021, but this was still within the normal variation. Over the period 1 April 2020 to 31 March 2022, by financial quarter, the number of deaths reported of people with a learning disability has ranged from 5 to 14, with the average being 10 per quarter). The factors described above affect reporting rates. In figure 29, of the 31 people who died who were recorded to have a learning disability, 17 died in acute hospital, 7 died at home, 6 in residential care home and one in a hospice. 28 deaths were confirmed to have been from physical health/natural cause. 3 cases are awaiting cause of death, but also appear to be related to physical health deterioration.

Figure 31 below shows that there are a number of learning disability deaths are pending reported to LeDeR. The system has change to an an online form rather than telephone reporting, which has made this process more difficult. Reporting gaps have been raised with the service and support offered.

**Figure 31 Summary of total number of Learning Disability deaths in 2021/22 which were in scope**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Financial quarter - date reported | Reported to LeDeR | Reported to LeDeR by another organisation | Pending reporting to LeDeR | Total |
| 21/22 Q1 | 5 | 0 | 0 | 5 |
| 21/22 Q2 | 3 | 2 | 0 | 5 |
| 21/22 Q3 | 11 | 2 | 0 | 13 |
| 21/22 Q4 | 0 | 2 | 6 | 8 |
| Total | **19** | **6** | **6** | **31** |

**Category of death**

Figure 32 shows the reported deaths by BDU and category.

**Figure 32 Reported deaths by category and BDU reported during 2021/22**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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 | ADHD and Autism Services | Total |
| Death - confirmed from physical/natural causes | 4 | 18 | 39 | 41 | 52 | 15 | 0 | 20 | 0 | 189 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 0 | 4 | 9 | 5 | 10 | 3 | 1 | 3 | 0 | 35 |
| Suicide (incl apparent) - community team care - current episode | 0 | 4 | 4 | 10 | 9 | 0 | 0 | 0 | 1 | 28 |
| Death - confirmed from infection | 1 | 1 | 2 | 2 | 5 | 2 | 0 | 5 | 0 | 18 |
| Death - confirmed related to substance misuse (drug and/or alcohol) | 0 | 5 | 4 | 0 | 6 | 0 | 1 | 0 | 0 | 16 |
| Suicide (incl apparent) - community team care - discharged | 0 | 4 | 4 | 5 | 2 | 0 | 0 | 0 | 0 | 15 |
| Suicide (incl apparent) - inpatient care - current episode | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 3 |
| Death - confirmed as accidental | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
| Death of service user by homicide (alleged or actual) | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Patient choking resulting in death | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| **Grand Total** | **5** | **37** | **63** | **63** | **85** | **24** | **2** | **28** | **1** | **308** |

**Inpatient deaths**

Figure 33 below shows that over the year 2021/22, there were 27 inpatient deaths reported. There were no inpatient deaths relating to Learning Disability Services.

**Figure 33 Trust wide Inpatient deaths in 2021/22 by date reported**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BDU | Ward | Financial quarter - date reported | | | | Total |
| Q1 21/22 | Q2 21/22 | Q3 21/22 | Q4 21/22 |
| **Mental Health Inpatient Services** | Poplars Unit, Wakefield | 0 | 1 | 1 | 1 | 3 |
| Beechdale Ward, The Dales Unit | 1 | 1 | 2 | 1 | 5 |
| Crofton Ward (OPS), Wakefield | 1 | 2 | 0 | 0 | 3 |
| Willow Ward - Barnsley | 1 | 2 | 0 | 1 | 4 |
| Ward 19 (OPS) | 0 | 0 | 1 | 2 | 3 |
| Ward 18, Priestley Unit | 1 | 0 | 0 | 0 | 1 |
| Stanley Ward, Wakefield | 0 | 0 | 1 | 0 | 1 |
| Walton PICU | 0 | 0 | 1 | 0 | 1 |
| Ashdale Ward | 1 | 1 | 0 | 0 | 2 |
| Elmdale Ward | 0 | 1 | 0 | 0 | 1 |
| **Forensic Service** | Priestley Ward, Newton Lodge | 1 | 0 | 0 | 0 | 1 |
| **Barnsley General Community Services** | Neuro Rehab Unit - Barnsley | 0 | 0 | 1 | 0 | 1 |
| Stroke Unit, Barnsley | 0 | 0 | 1 | 0 | 1 |
| Total | | **6** | **8** | **8** | **5** | **27** |

Of the 27 deaths that occurred related to SWYPFT inpatient settings:

* 12 deaths occurred at SWYPFT inpatient wards, 11 deaths occurred in an acute hospital setting and the 4 other deaths occurred at various locations (patient's home, residential care setting, hospice and at a hotel type accommodation).
* 3 deaths were related to apparent suicide. 2 of these occurred in an inpatient setting, and one at a patient's home whilst on leave from the ward. 1 further death was related to a choking incident on a ward.
* 19 of the 27 deaths were from a physical cause, with a further 3 not yet confirmed but expected to be related to a physical cause.
* 1 death was confirmed as being related to illegal substance overdose whilst absent from a ward.
* 3 deaths were related to covid infection.
* 7 of the deaths were reported as Serious Incidents.

**Location of deaths**

Figure 34 below shows that the top 3 locations for where patients died were acute /general hospital setting (34%), patients own home (31%) and care/residential home (52).

**Figure 34 Location of deaths that were reported during 2021/21**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Q1**  **2021-22** | **Q2 2021-22** | **Q3 2021-22** | **Q4 2021-22** | **Total** |
| Acute Trust / General Hospital | 32 | 21 | 20 | 33 | 106 |
| Patient's home | 27 | 22 | 19 | 28 | 96 |
| Care/Residential Home | 6 | 19 | 11 | 16 | 52 |
| Public place | 3 | 2 | 6 | 3 | 14 |
| Unknown | 4 | 7 | 2 | 1 | 14 |
| Inpatient facility (SWYPFT) | 1 | 1 | 7 | 3 | 12 |
| Hospice | 1 | 2 | 2 | 3 | 8 |
| Hotel/B&B | 1 | 0 | 1 | 1 | 3 |
| Other mental health provider (not SWYPFT) | 1 | 0 | 0 | 1 | 2 |
| Patient’s workplace | 1 | 0 | 0 | 0 | 1 |
| **Total** | **77** | **74** | **68** | **89** | **308** |

Where the location of death is unknown, this is often because we identify a patient has died from a third-party update on the clinical record.

**Causes of death**

In terms of causes of death, the table below shows the broad cause of death for the 308 patients who died. The highest type of cause of death recorded was from a physical cause, including expected and unexpected deaths.

**Figure 35 Causes of death for in scope deaths recorded during 2021/22 by geographical area (note this is not BDU)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Barnsley | Calderdale | Kirklees | Wakefield | not recorded | Total |
| Physical cause | 33 | 51 | 50 | 68 | 0 | 202 |
| Apparent suicide | 7 | 8 | 14 | 12 | 1 | 42 |
| Covid related | 3 | 5 | 1 | 4 | 0 | 28 |
| Substance misuse | 2 | 1 | 2 | 5 | 0 | 13 |
| Overdose | 2 | 0 | 1 | 2 | 0 | 10 |
| Toxicity | 0 | 1 | 0 | 2 | 0 | 5 |
| Accidental | 1 | 0 | 0 | 2 | 0 | 3 |
| Choking | 0 | 0 | 1 | 0 | 0 | 3 |
| not known | 4 | 8 | 9 | 6 | 1 | 1 |
| Homicide | 0 | 1 | 0 | 0 | 0 | 1 |
| Total | 52 | 75 | 78 | 101 | 2 | 308 |

**Deaths reported as SIs**

Of the 308 in scope deaths reported on Datix between 1 April 2021 and 31 March 2022, 17 were reported as serious incidents.

Please note this figure will not necessarily match those reported in the Serious Incident section of this 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.

**Next Steps**

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

* As part of the continued development of processes to support bereaved families and carers we have been successful in a new post of Family Liaison Professional. The post will provide support to newly bereaved individuals, supporting the Business Delivery Units and staff who have bereavement link roles in ensuring that bereaved families and carers are engaged and supported, by giving them the opportunity to raise questions and share any concerns they may have in relation to the quality of care received by their family member. The job description and person specification are currently be developed.
* Thematic review and analysis of learning from deaths findings.
* Further development of internal processes and consistency in data collection.
* Networking continues via the Regional Mortality Meeting which is led by the Improvement Academy to share best practice in relation to the scrutiny/review/learning from deaths.
* Embedding best practice and national guidance into the Trust Learning from Deaths policy and being open policy in conjunction with national developments around the Patient Safety Incident Response Framework.