1. **Learning from Healthcare Deaths Report**

**Annual Cumulative Report 2022/23 (covering the period 1/4/2022 – 31/12/2022)**

* 1. **Background context**

**1.1.1 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 2022/2023, 2812 deaths (row one in figure 1) were recorded on our clinical systems (figure correct at 12/4/2023). 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. The Trust was not the main provider of care at the time of death for a large number of cases.

**Figure 1 Summary of 2022/2023 Annual Death reporting by financial quarter\***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **2021/2022 total** | **2022/2023 Q1** | **2022/2023 Q2** | **2022/2023 Q3** | **2022/2023 Q4** | **2022/2023 Total** |
| 1. Total number of deaths reported on the Trust clinical systems where there has been system activity within 180 days of date of death | 3609 | 812 | 710 | 754 | 536 | 2812 |
| 1. Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed | 404 | 95 | 87 | 97 | 100 | 379 |
| 1. Total Number of deaths which were in scope | 307 | 68 | 55 | 62 | 68 | 253 |
| 1. Total Number of deaths reported on Datix that were not in the Trust's scope | 97 | 27 | 32 | 35 | 32 | 126 |

\*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 1shows that 379 deaths were reported on Datix in the year, with the quarterly breakdown. Row 4 shows those deaths that were not felt to meet the Learning from Deaths criteria. The second column of the table shows the comparative figures from 2021/2022. The total number of deaths reported has reduced this year, along with those in scope. The number of deaths reported that were not in scope has increased, however they have been reviewed to ensure this is accurate. No particular patterns or reasons have been identified.

All deaths reported on Datix are reviewed by the patient safety support team to ensure they meet the scope criteria. For 2022/2023, 253 deaths (a reduction on 2021/2022) 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 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 3 below shows a Statistical Process Control chart of all reported deaths (by reported date) between 1/4/2021-31/3/2023.

Chart, line chart

Description automatically generated**Figure 3 Statistical Process Control Report of all deaths reported 1/4/2021 – 31/3/2023 by date reported**

Figure 4 show the 253 in scope deaths reported by Care Group, and figure 5 by the review process followed in line with the National Quality Board levels of scrutiny, described earlier. These are reported against the financial quarter in which the death was reported.

**Figure 4 In scope deaths reported by financial quarter and Care Group**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Financial quarter - date reported | Barnsley Integrated Care Group | Adult and Older People Mental Health Care group | Learning Disability & ADHD / ASD Care Group | CAMHS and Childrens Care Group | Forensic Care Group | Total |
| Quarter 1 | 11 | 49 | 8 | 0 | 0 | 68 |
| Quarter 2 | 11 | 40 | 3 | 1 | 0 | 55 |
| Quarter 3 | 10 | 41 | 11 | 0 | 0 | 62 |
| Quarter 4 | 13 | 45 | 9 | 1 | 0 | 68 |
| **Total** | **45** | **175** | **31** | **2** | **0** | **253** |

**Figure 5 Learning from Healthcare Deaths during 2022/2023 by financial quarter and mortality review process**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Financial quarter – date reported | Level 1 | Level 2 | | Level 3 | | | | Total |
| Death certified | Manager's 48-hour review | Structured Judgement Review (SJR) | Service Level Investigation | Serious Incident Investigation | Learning Disability Review (LeDeR) | Safeguarding review |
| Quarter 1 | 34 | 15 | 6 | 1 | 4 | 8 | 0 | 68 |
| Quarter 2 | 23 | 13 | 5 | 4 | 4 | 6 | 0 | 55 |
| Quarter 3 | 27 | 15 | 6 | 1 | 0 | 12 | 1 | 62 |
| Quarter 4 | 24 | 24 | 4 | 4 | 2 | 10 | 0 | 68 |
| **Total** | **108** | **67** | **21** | **10** | **10** | **36\*** | **1** | **253** |

\*One learning disability death reported to LEDER was also subject to a Structured Judgement Review

Of the 143 deaths that were subject to a level 2 case note review (92) or level 3 investigation (51) [NB these also included an initial case note review] 108 have been completed (at the time of reporting 11/4/2022) and no problem in care was identified which directly resulted in those deaths. 35 cases remain under review at the time of reporting.

Deaths that were reported between 1/4/2021 and 31/3/2023 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 six months prior to death occurring.
* Teams report deaths of discharged patients, when they are informed/identified if they have provided care in the last six months prior to death, e.g., request for coroner’s report for a discharged patient.

**Learning disability deaths**

Figure 4 above shows 31 deaths were 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 other than Learning Disability Services; in this period this includes Paediatric Therapy, Epilepsy, Children’s Speech and Language Therapy, Mental Health Liaison Team (figure 5 shows there were 36 deaths for review via Learning Disability Review Programme [LeDeR]. One further learning disability death was not reported because the age was below the threshold for LeDeR reporting (four years). When Learning Disability deaths are reviewed using SPC, reporting has remained within the normal range.

Over the period 1 April 2022 to 31 March 2023, of the 37 deaths of people with a Learning Disability, 31 deaths were under the care of Learning Disability services. Fourteen died in an acute hospital, 12 died at home, nine in residential care/nursing home and two in a hospice. Thirty-three deaths were confirmed to have been from physical health/natural cause (11 expected). Of the remaining deaths, cause of death has not been received, although one of these was on end-of-life care.

**Category of death**

Figure 6 shows the reported deaths by Care Group and category.

**Figure 6 Reported deaths by category and BDU reported during 2022/2023**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Category** | **Barnsley Integrated Care Group** | **CAMHS and Children Care Group** | **Adult and Older People Mental Health Care group** | **Learning Disability & ADHD / ASD Care Group** | **Total** |
| Death - confirmed from physical/natural causes | 23 | 0 | 115 | 26 | 164 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 16 | 1 | 22 | 4 | 43 |
| Suicide (incl apparent) - community team care - current episode | 4 | 0 | 17 | 0 | 21 |
| Death - confirmed from infection | 0 | 0 | 10 | 1 | 11 |
| Suicide (incl apparent) - community team care - discharged | 0 | 1 | 4 | 0 | 5 |
| Death - confirmed related to substance misuse (drug and/or alcohol) | 2 | 0 | 2 | 0 | 4 |
| Death - confirmed as accidental | 0 | 0 | 3 | 0 | 3 |
| Apparent suicide - not Trust incident (for use by Patient Safety only) see notes | 0 | 0 | 2 | 0 | 2 |
| **Total** | **45** | **2** | **175** | **31** | **253** |

**Inpatient deaths**

Figure 7 below shows that over the year 2022/2023, there were 21 inpatient deaths reported. There were no inpatient deaths relating to Learning Disability Services. It should be noted that inpatient deaths can include where a death has occurred within 30 days of discharge from the unit.

**Figure 7 Trust wide Inpatient deaths in 2022/2023 by date reported**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Care Group** | **Ward** | **Financial quarter - date reported** | | | | **Total** |
| **Q1 2022/2023** | **Q2 2022/2023** | **Q3 2022/2023** | **Q4 2022/2023** |
| Adult and Older People Mental Health Care group | Poplars Unit, Wakefield | 1 | 0 | 1 | 1 | 3 |
| Beechdale Ward, The Dales Unit | 2 | 1 | 0 | 0 | 3 |
| Crofton Ward (OPS), Wakefield | 2 | 2 | 0 | 0 | 4 |
| Willow Ward - Barnsley | 1 | 0 | 0 | 0 | 1 |
| Ward 19 (OPS) | 1 | 1 | 0 | 2 | 4 |
| Ashdale Ward | 0 | 0 | 1 | 0 | 1 |
| Stanley Ward, Wakefield | 0 | 0 | 0 | 1 | 1 |
| **Barnsley Integrated Care Group** | Neuro Rehab Unit - Barnsley | 0 | 0 | 3 | 0 | 3 |
| Stroke Unit, Barnsley | 0 | 0 | 1 | 0 | 1 |
| **Total** | | **7** | **4** | **6** | **4** | **21** |

Of the 21 deaths that occurred related to the Trust inpatient settings:

* Ten deaths occurred at the Trust inpatient wards, nine deaths occurred in an acute hospital setting and two deaths were in the patient's home (one person had been discharged from the ward, the other was on leave from the ward. Both died unexpectedly).
* None of the deaths were related to apparent suicide.
* Nine of the 21 deaths were expected. 12 were unexpected deaths from physical causes (some are awaiting confirmation).
* One death related to choking event occurred in care home setting but had recently been discharged from Trust inpatient care.
* Three deaths were related to covid infection.
* One of the deaths was reported as Serious Incident.

**Location of deaths**

Figure 8 below shows that the top three locations for where patients died were acute /general hospital setting (40%), patients own home (28%) and care/residential home (17%).

**Figure 8 Location of deaths that were reported during 2022/2023**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Location of death** | **Q1**  **2022-2023** | **Q2 2022-2023** | **Q3 2022-2023** | **Q4 2022-2023** | **Total** |
| Acute Trust / General Hospital | 27 | 22 | 23 | 30 | 102 |
| Patient's home | 18 | 20 | 21 | 14 | 73 |
| Care/Residential Home | 13 | 9 | 10 | 15 | 47 |
| Inpatient facility (the Trust) | 3 | 1 | 5 | 1 | 10 |
| Unknown | 1 | 0 | 2 | 4 | 7 |
| Hospice | 3 | 1 | 0 | 2 | 6 |
| Public place | 2 | 1 | 0 | 1 | 4 |
| Other person's home | 1 | 1 | 0 | 0 | 2 |
| Other country | 0 | 0 | 1 | 0 | 1 |
| Other mental health provider (not the Trust) | 0 | 0 | 0 | 1 | 1 |
| **Total** | **68** | **55** | **62** | **68** | **253** |

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 253 patients who died. The highest type of cause of death recorded was from a physical cause, including expected and unexpected deaths.

**Figure 9 Causes of death for in scope deaths recorded during 2022/2023 by geographical area (note this is not BDU)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Barnsley Integrated Care Group** | **Adult and Older People Mental Health Care group** | **Learning Disability & ADHD / ASD Care Group** | **CAMHS and Children Care Group** | **Total** |
| Physical health related | 16 | 94 | 19 | 0 | 129 |
| Physical health related (end of life) | 13 | 31 | 9 | 0 | 53 |
| Unknown at time of reporting | 9 | 22 | 2 | 0 | 33 |
| Apparent suicide | 4 | 22 | 0 | 1 | 27 |
| Suspected overdose | 2 | 1 | 0 | 0 | 3 |
| unknown at time of reporting (end of life) | 0 | 1 | 1 | 0 | 2 |
| Accidental suspected | 0 | 1 | 0 | 1 | 2 |
| Choking (community setting) | 0 | 1 | 0 | 0 | 1 |
| Choking (acute hospital) | 1 | 0 | 0 | 0 | 1 |
| Choking (care home - recent discharge from the Trust inpatient ward) | 0 | 1 | 0 | 0 | 1 |
| Substance misuse | 0 | 1 | 0 | 0 | 1 |
| **Total** | **45** | **175** | **31** | **2** | **253** |

**Deaths reported as Serious Incidents**

Of the 253 in scope deaths reported on Datix between 1 April 2022 and 31 March 2023, 9 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 separately. 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:

* At the time of writing, the Family Liaison Professional post has been advertised. The post will provide support to newly bereaved individuals, supporting the Care Groups 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.
* Aligning our Learning from Deaths processes with the Patient Safety Incident Response Framework response methods and updating our policy accordingly.
* Development of Dashboards for data quality reviews throughout the year.
* Continued networking via Regional Mortality Meetings to share best practice and learning in relation to the scrutiny, review and output from Learning from Deaths processes.