

1. **Learning from Healthcare Deaths Report**

**Annual Cumulative Report 2023/2024 (covering the period 1/4/2023 – 30/9/2023)**

* 1. **Background context**
		1. **Introduction**

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.

Nationally, most people will be in receipt of care from the NHS in the weeks, months or years leading up to their death. However, for some people, their experience is of 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.

* + 1. **Scope**

The Trust has systems that identify and capture the known deaths of its service users on its electronic clinical information system and on its Datix system where the death requires reporting.

The Trust Learning from Deaths policy sets out how deaths should be responded to, which deaths are reportable, how we should engage families and how reportable deaths will be reviewed. 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. **Annual Cumulative Dashboard[[1]](#footnote-1) Report 2023/2024 covering the period 1/4/2023 – 30/9/2023**

Figure 1 Summary of 2023/2024 Annual Death reporting by financial quarter to 30/9/2023

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Reporting criteria | 2022/ 2023 total | 23/24 Q1 | 23/24 Q2 | 23/24 Q3 | 23/24 Q4 | 2023/ 2024 Total (to date) |
| 1 | Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death[[2]](#footnote-2) | 2918 | 539 | 471 |  |  | 1010 |
| 2 | Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed | 379 | 94 | 98 |  |  | 192 |
| 3 | Total Number of deaths which were in scope  | 253 | 71 | 75 |  |  | 146 |
| 4 | Total Number of deaths reported on Datix that were not in the Trust's scope  | 126 | 23 | 23 |  |  | 46 |

As shown in Figure 1, row 2 shows that 98 deaths were reported on Datix during Q2 2023/2024. Deaths reported are mainly deaths of those who have died in the community. All reported deaths are reviewed to understand if the death meets the critieria for being in scope for mortality review using the 3 levels as described earlier.

Figure 2 below shows a Statistical Process Control chart of all reported deaths (by reported date) between 1/4/2021-30/9/2023. Reporting rates have been checked and remain within the normal variation, within an SPC chart. This demonstrates there has been no increase outside of the anticipated parameters. There are no areas of special cause variation that require further exploration at this time.

Figure 2 Statistical Process Control Report of all deaths reported 1/4/2021 – 30/9/2023 by date reported.



Figure 3 Breakdown of the total number of in scope deaths reviewed in 2023/2024 by Care Group by financial quarter

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Financial quarter - date reported | Barnsley Integrated Care Group | Adults and Older People Mental Health Care Group (community) | Adults and Older People Mental Health Care Group (inpatients) | Learning Disability and ASD/ADHD Care Group | Forensic Services Care Group | CAMHS and Children services | Total |  |
| 2023/2024 Q1 | 19 | 40 | 3 | 8 | 1 | 0 | **71** |  |
| 2023/2024 Q2 | 9 | 53 | 2 | 10 | 0 | 1 | **75** |  |
| 2023/2024 Q3 |  |  |  |  |  |  |  |  |
| 2023/2024 Q4 |  |  |  |  |  |  |  |  |
| Total | **28** | **93** | **5** | **18** | **1** | **1** | **146** |  |

Figure 4 Summary of total number of all in scope deaths in 2023/2024 to the end of Quarter 2 by the respective mortality review process

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Financial quarter reported | Level 1:Certified | Level 2:Case note review | Level 3:Investigation | Total |
| Death certified | Manager's 48-hour review  | Structured Judgment Review  | Case Note review (PSST) | Serious Incident Investigation  | Learning Disability Death process (LeDeR3) |
| 2023/2024 Q1 | 25 | 27 | 8 | 0 | 3 | 8 | 71 |
| 2023/2024 Q2 | 24 | 34 | 4 | 2 | 1 | 10 | 75 |
| 2023/2024 Q3 |  |  |  |  |  |  |  |
| 2023/2024 Q4 |  |  |  |  |  |  |  |
| Total | **49** | **61** | **12\*** | **2** | **4** | **18\*** | **146** |

\*One Structured judgement review (SJR) was also reported to LeDeR[[3]](#footnote-3) but is counted under SJR figures.

Figure 4 above shows the total number of all in scope deaths in 2023/2024 to date. The number of deaths in scope for Q2 (n=75).

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.

**Learning Disability deaths**

As of 2021 LeDeR stands for Learning from Life and Death Reviews. The programme was previously known as the Learning Disabilities Mortality Review. The LeDeR work originated from the Confidential Inquiry into the Premature deaths of people with Learning Disabilities (CIPOLD). Information available here: <https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf>

The death of any patient with a Learning Disability has to be reported to LeDeR. It should be noted that the figures may not tally with the figures above by care group. This is because we identify Learning Disability not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability irrespective of where they were cared for.

Figure 5 below shows number of learning disability deaths and their status of being reported to the Learning Disability Review Programme (LeDeR).

Figure 5 Summary of total number of in scope deaths in 2023/2024 by the Review process (excluding Learning Disability deaths)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Learning Disability Death process (LeDeR) | Reported on LEDER by another organisation | Total |
| 2023/2024 Q1 | 9 | 0 | 9 |
| 2023/2024 Q2 | 9 | 1 | 10 |
| 2023/2024 Q3 |  |  |  |
| 2023/2024 Q4 |  |  |  |
| Total | **18** | **1** | **19** |

Of the 10 Learning Disability deaths which were reported to LeDeR during Quarter 2, all had the Manager’s 48 hour review completed.

**Other deaths**

Figure 6 below shows all deaths where the patient is recorded as not have a learning disability and what level of review was completed. All deaths reported have the Manager’s 48 hour review completed to ensure we have considered the care and treatment we have provided leading up to a death, although if there is another review process followed or the death was certified, this will be what is reported on.

Figure 6 Summary of total number of in scope deaths in 2023/2024 to the end of Quarter 2 by the Review process (excluding Learning Disability deaths)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Financial quarter - date reported | Level 1:Certified | Level 2:Case note review | Level 3:Investigation |  |
| Death certified | Manager's 48-hour review  | Structured Judgment Review  | Case Note Review | Serious Incident Investigation  | Total |
| 2023/2024 Q1 | 25 | 27 | 7 | 0 | 3 | **62** |
| 2023/2024 Q2 | 24 | 34 | 4 | 2 | 1 | **65** |
| 2023/2024 Q3 |  |  |  |  |  |  |
| 2023/2024 Q4 |  |  |  |  |  |  |
| Total | **48** | **61** | **11** | **2** | **4** | **127** |

**Inpatient deaths**

Figure 7 below shows that over the year 2023/2024 to the end of Quarter 2, there were seven inpatient deaths reported. There were no inpatient deaths relating to Learning Disability Services.

Figure 7 Trust wide Inpatient deaths in 2023/2024 by date reported.

|  |  |  |  |
| --- | --- | --- | --- |
| Care Group | Ward | Financial quarter - date reported | Total |
| 2023/2024 Q1 | 2023/2024 Q2 | 2023/2024 Q3 | 2023/2024 Q4 |
| **Adults and Older People Mental Health Care Group (Inpatient)** | Beechdale Ward, The Dales Unit | 1 | 1 |  |  | **2** |
| Ward 19 (OPS) | 1 | 0 |  |  | **1** |
| Ashdale Ward | 1 | 0 |  |  | **1** |
| Poplars Unit | 0 | 1 |  |  | **1** |
| **Forensic Services Care Group** | Johnson Ward | 1 | 0 |  |  | **1** |
| **Barnsley Integrated Care Services Group** | Stroke Unit | 1 | 0 |  |  | **1** |
| Total | **5** | **2** |  |  | **7** |

* 1. **Next Steps**

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

* The recently appointed Family Liaison Professional commenced in post in August 2023. This role will focus on engaging, involving and supporting bereaved families through the incident learning response and investigation process and ensuring families are linked into the support of the coroner’s court.
* We are attending Regional Mortality Meetings hosted by the Improvement Academy and Northern alliance of mental health Trusts to share best practice in relation to the scrutiny/review/learning from deaths.
* We are reviewing our Learning from Deaths policy to reflect the upcoming implementation of the Patient Safety Incident Response Framework.
* We have re-established the Mortality Review Group from 23 October 2023, which will meet quarterly.
1. Dashboard format and content as agreed by Northern Alliance group. [↑](#footnote-ref-1)
2. Data extracted from Business Intelligence Dashboards. 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 [↑](#footnote-ref-2)
3. Learning Disability deaths reportable to Learning from Life and Death Reviews (LeDeR) [↑](#footnote-ref-3)