Meeting of the Board of Directors - Public

08 July 2021

Paper title:	2021 Quality Account Learning from deaths 2020 - 21	**Agenda item** **17**
Presented by:	David Sims Medical Director	
Prepared by:	Beverley Fearnley, Deputy Director of Patient Safety, Compliance and Risk	

Purpose of the report		
The purpose of this report it to provide Board with an overview of the learning the Trust has taken from the deaths of patients within its care during 2020/21.	For approval	
	For discussion	
	For information	X

Executive summary

Learning from deaths is supported by two key policies in BDCT, the Serious Incident policy and the Learning from Deaths policy. These policies guide and inform the organisation about reporting, investigating and learning from deaths. Between April 2020 and the end of March 2021 a total of 323 of Bradford District Care NHS Foundation Trust's patients died.

Between April 2020 and the end of March 2021, 27 Structured Judgement Reviews and 22 Serious Incident investigations were carried out in relation to the care provided to patients who had died. One SJR was later subject to a further level one investigation. As a result of these investigations, no deaths were judged to be 'more likely than not to have been due to problems in the care provided to the patient'.

Learning from excellent and learning for improvement was identified in all cases and shared with teams and across the organisation.

The learning from death approach has taken particular account of COVID-19. We have collected the reports of both inpatient and community deaths relating to the trust. in our learning from death review we have 2 conclusions

1. In reviewing deaths from COVID we have seen that both inpatient and community staff have used appropriate procedures to limit spread and that especially in inpatients we have seen few deaths from spread within our estate.

2. The impact of COVID has not reduced the capacity of the trust to review and to learn from deaths of individuals in our care not just from serious incidents but learning from the experiences of many individuals.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

Recommendation
The Trust Board is asked to • Note the content of the report and take assurance that our processes for reviewing and learning from deaths is robust and appropriate

Strategic vision Please mark those that apply with an **X**				
Providing excellent quality services and seamless access	**Creating the best place to work**	**Supporting people to live to their fullest potential**	**Financial sustainability growth and innovation**	**Governance and well-led**
X				X

Care Quality Commission domains Please mark those that apply with an **X**				
Safe	**Effective**	**Responsive**	**Caring**	**Well Led**
X				**X**

Relationship to the Board Assurance Framework (BAF)	The work contained with this report links to the following strategic risk(s) as identified in the BAF: • N/A
Links to the Supporting Operational Risk Register	The work contained with this report links to the following corporate risk(s) as identified in the Supporting Operational Risk Register: • N/A
Compliance and regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • N/A

Learning from Deaths

Learning from deaths is supported by two key policies in BDCT, the Serious Incident policy and the Learning from Deaths policy. These policies guide and inform the organisation about reporting, investigating and learning from deaths.

Between April 2020 and the end of March 2021 a total of 323 of Bradford District Care NHS Foundation Trust's patients died.

Table 1: Number of reported patient deaths per quarter

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of patients who have died	91	57	100	75

All deaths, whether expected due to a clinical condition, or unexpected are reviewed weekly in the Mortality and Duty of Candour Group. This group commissions reviews of case notes from a sample of deaths using the Structured Judgment Review (SJR) tool. This is a national tool developed by the Royal College of Psychiatrists to allow clinicians to take an expert view of the care offered. The Group may also commission initial reviews which do not consider the full range of factors within the SJR review in order to understand if an SJR is appropriate, or where an SJR is not required but where there may be learning. The Mortality and Duty of Candour Group considers the outcomes of the reviews and asks the relevant Quality and Operational (QuOPs) meeting to develop an action plan in regard to any areas where it has been suggested that care should be improved. Issues that are of general relevance will be added to the trust learning hub to enable broader sharing across the organisation. For all deaths of patients who have a Learning Disability, the initial review is shared in the Mortality and Duty of Candour Group and they are referred to the national Learning Disabilities Mortality Review (LeDeR) programme.

Between April 2020 and the end of March 2021, 27 SJRs and 22 Serious Incident (SI) investigations were carried out in relation to the care provided to patients who had died. One SJR was later subject to a further level one investigation.

The number of deaths in each quarter for which an SJR or SI investigation was carried out are shown in the following table:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of deaths for which a Structured Judgement was carried out	6	5	11	5
Number of deaths for which an SI Investigation was completed	5	5	6	6

The outcome of the SJRs and SI investigations was that there were no deaths judged to be 'more likely than not to have been due to problems in the care provided to the patient'.

There were 5 cases where patients had died in the previous reporting period (2019/2020) but the structured judgement reviews were completed in this reporting period (2020/21).

There were 10 serious incident investigations where deaths had occurred in the previous reporting period (2019/2020) and the investigation was completed in this reported period (2020/21).

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of deaths for which an SI Investigation was completed where the death occurred in 2019/20	8	1	1	0

None of the reviews or investigations into deaths which had occurred in 2019/20 which were completed in 2020/21 concluded that the deaths 'were more likely than not to have been due to problems in the care provided'.

Learning and improvement

BDCT takes a proactive approach to learning from deaths and the following summary highlights where good practice and areas identified for improvement have been highlighted during 2020/21. This learning is used to shape future quality and safety improvements.

Learning from excellence:

A number of reviews were conducted that concluded good and excellent care had been provided by various inpatient and community teams. The aspects of care identified as demonstrating this were:

- Signposting to other services for support
- Communication with families
- Multi agency and collaborative working across teams
- Appropriate and timely medical and nursing reviews
- Consistent and effective working relationships that enhanced engagement and well being of service users
- Respect for individual preferences and plans to enhance care
- Effective care co-ordination

The Trust has commissioned a Patient Safety Lead to support the clinical teams to share and embed learning from excellence across the Trust via case studies of these examples.

Learning for improvement:

Some learning was identified from a number of reviews where care had not gone so well and improvements could be made. An action plan is developed for all events where learning is identified and is monitored through the mortality and quality improvement processes in the Trust. Examples of the learning identified relate to:

- Maintaining consistency in the Care Co-ordinator (CC) role to ensure that when concerns are raised , they are escalated and addressed correctly
- Better management of service user's needs for at the end of life in order to ensure service users and their families and carers are fully supported. Actions have been implemented to enable better monitoring and management of service users whose health is deteriorating.
- Clinical inputs were not always well coordinated and connected, particularly around assessment of capacity, how information was stored and how clinicians communicated with service users. Actions were taken to ensure capacity assessments were appropriately maintained and communication needs are appropriately assessed. The use of hospital passports and written information regarding specific communication needs was identified as learning to embed into standard practice.
- Issues with follow up appointments not being actioned for a number of reasons ((for example clinician sickness or administrative errors). A potential new solution has been piloted within two Community Mental Health Teams via re-structuring some of the functionality in the clinical recording system to identify cases where follow up has not been activated.

The Trust continues to take every available opportunity to improve how we learn from deaths: we remain an active participant in the 'Northern Alliance' of mental health trusts which focusses on mortality review processes; we are considering how best to take forward the recommendations of the learning disabilities mortality review (LeDeR) programme annual report.

COVID-19

The learning from death approach has taken particular account of COVID-19. We have collected the reports of both inpatient and community deaths relating to the trust.

2020-21 Covid Deaths for Community and Inpatients

Between 01 April 20 and 31 March 21 there have been 77 service user deaths relating to Covid. 75 of these being community patients and 2 in-patient deaths. A breakdown of these by month is in the table below:

Community			**Inpatient**	
Apr-20	17.0		Apr-20	2.0
May-20	9.0		May-20	0.0
Jun-20	1.0		Jun-20	0.0
Jul-20	1.0		Jul-20	0.0
Aug-20	1.0		Aug-20	0.0
Sep-20	1.0		Sep-20	0.0
Oct-20	5.0		Oct-20	0.0
Nov-20	12.0		Nov-20	0.0
Dec-20	9.0		Dec-20	0.0
Jan-21	10.0		Jan-21	0.0
Feb-21	6.0		Feb-21	0.0
Mar-21	3.0		Mar-21	0.0
	75.0			2.0

COVID reflections

The COVID deaths linked with the trust have been in line with local prevalence of the pandemic. In patient deaths have been low in the trust and have occurred only in older people. In addition to the 2 deaths recorded there were 3 further death related to stays in our inpatient wards, one of which occurred in March 2020. We are also aware of a number of deaths of individuals from COVID within 28 days of being in our wards. One of these was within an acute provider and will form part of their review of COVID. We have reviewed several individuals who moved into residential care. Of these only one instance could be attributed to possibly having COVID in BDCFT care. As this occurred before PCR testing was available, we were unable to examine this.

Conclusions

In this year we have been affected by the COVID pandemic which has made comparisons with previous information invalid.

However in our learning from death review we have 2 conclusions

1. In reviewing deaths from COVID we have seen that both inpatient and community staff have used appropriate procedures to limit spread and that especially in inpatients we have seen few deaths from spread within our estate.
2. The impact of COVID has not reduced the capacity of the trust to review and to learn from deaths of individuals in our care not just from serious incidents but learning from the experiences of many individuals

Our services have worked hard to keep in mind those who have died through the COVID pandemic in our services. Our tribute to these loved individuals is the Rainbow garden in our Dementia Assessment Unit. It is appropriate to conclude our learning report with a picture of this garden with thanks to the staff and patients and families.