Bradford District Care
NHS Foundation Trust

Board of Directors - Public

8 September 2022

Paper title:	Learning from deaths and Serious Incident Investigations	**Agenda item** **16.0**
Presented by:	Dr David Sims, Medical Director	
Prepared by:	Rachel Howitt, Head of Patient Safety, Compliance and Risk	

Purpose of the report		
The purpose of this report it to provide Trust Board with an overview of the learning the Trust has taken from the deaths of patients within its care during Q1, 2022.	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 01 April and 30 June 2022 there have been **63** deaths reported. This is a decrease of 24% to the same period in the previous year.

Structured judgement reviews and serious investigation reports have been completed for 6 deaths.

Learning from excellence and learning for improvement was identified in all cases and continues to be shared with teams and across the organisation.

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 Board of Directors is asked to:

- Note the content and take assurance from the report and the scrutiny at Quality and Safety Committee.
- Agree to receive further reports through the QSC AAA report.

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**		**X**

Care Quality Commission domains Please mark those that apply with an **X**				
Safe	**Effective**	**Responsive**	**Caring**	**Well Led**
X	**X**	**X**	**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: • SO3 (3.2, 3.3) Organisational learning, Learning from best practice • SO4 (4.2, 4.3) Embedding culture of Quality Improvement, reducing health inequalities
Links to the Supporting Organisational Risk Register (SORR)	The work contained with this report links to the following organisational risk(s) as identified in the SORR: • Not applicable
Compliance and regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Not applicable

Meeting of the Board of Directors - Public
8 September 2022

Learning from Deaths 2022/2023 Q1

1 Introduction and background

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.

2 Current status

Between 01 April and 30 June 2022, a total of 63 of Bradford District Care NHS Foundation Trust's patients died. There were 83 in Q1 last year.

Table 1: Number of reported patient deaths per quarter (rolling 12 months)

	Quarter 2 20/21	Quarter 3 20/21	Quarter 4 20/21	**Quarter 1** **22/23**
Number of patients who have died 2022/23	July – 16 Aug – 23 Sept - 26	Oct – 25 Nov – 36 Dec – 23	Jan – 40 Feb – 27 Mar - 15	**Apr – 25** **May – 25** **Jun – 13**
Total per quarter	65	84	82	**63**
Total number of patients who have died in the last 4 quarters	294			

This quarter 2 deaths had COVID as a contributory factor, which is the same number (2) as Q1 of 2020/21.

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 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.

In April 2022, a paper proposing some improvements to the process and language of SJR reviews was approved at the Mortality and Duty of Candour Group and has been implemented during Q1.

Progress against these changes has been made as follows:

- New SJR template in place, some minor amendments made following feedback from reviewers completing the tool
- Mortality screening tool embedded on Safeguard enabling reporters to provide more complete information regarding deaths at an earlier point. This is helping facilitate the decisions at MDCRG regarding level of review/investigation required. Some amendments have also been, made to this process following feedback from users which has been complete and reduced duplication within the system
- Work has commenced to ensure processes align to the new Leder programme national policy which now includes to requirement to refer all deaths of people with a diagnosis of Autism as well as a Learning Disability, and this will be progressed over Q2.

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

	Quarter 2 20/21	Quarter 3 20/21	Quarter 4 20/21	**Quarter 1 22/23**
Number of deaths for which a Structured Judgement was completed	2	1	2	**1**
Number of deaths for which an SI Investigation was completed	7	6	5	**5**

These figures include

- **1** case where a patient had died in the previous reporting period, but the SJR was completed in this reporting period (Q1 2022).
- **5** SI investigations where deaths had occurred in previous reporting periods and the investigations were completed in this reporting period (Q1 2022).

This SJR concluded that the death was not judged to be 'more likely than not to have been due to problems in the care provided to the patient'.

The SI investigations' remit is to identify system learning for improvement.

3 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 Q1, 2022/23. This learning is used to shape future quality and safety improvements.

Learning from good and 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:

- Evidence of excellent supportive relationships sustained by Care Coordinators;
  - ~ supporting SU's with attending appointments health and social
  - ~ shopping, ensuring food parcels accessible
  - ~ housing/benefit advice, facilitating resolution of property issues with landlords
  - ~ ensuring continuum of care and support still available whilst formal transfer of care processes undertaken
- Good escalation and communication of safeguarding concerns by staff to the Police and BDCFT Safeguarding team
- Positive feedback – SU highlighted gratitude for good care received as an inpatient at both ACMH and LMH
- Patient centred care maintained despite challenges of the chaotic nature of SU engagement
- Compassion and understanding demonstrated 'above and beyond'
  - ~ Pharmacy demonstrating extra help
  - ~ Genuine concern and offers of help around funeral arrangements shown by management and staff following SU death
- Excellent assessment in all areas - thorough, considered, timely and appropriate and good one to one care.

Learning for improvement:

Some learning was identified from a number of reviews where care had not gone so well, and improvements could be made. A management response or action plan is developed for all events where learning is identified from investigations or reviews. These are reported through the mortality and quality improvement processes and monitored through the relevant Quality and Operational governance arrangements in the Trust. Examples of the learning identified relate to:

- Risk Assessment and Care Plans
  - ~ not updated appropriately or in timely way
  - ~ partial completion risk assessment, risk formulation and safety plan
  - ~ risk assessment not to the required BDCFT quality standard

- Record keeping
  - ~ retrospective entries on SystmOne
  - ~ Next of Kin information out of date
  - ~ records not updated and maintained in line with quality expectations
  - ~ Family contact details and address were not documented
  - ~ standard of documentation was not in line with BDCFT quality standards or professional standards
  - ~ weekly management audits not providing the required level of assurance about compliance with standards

- Medication management
  - ~ Non-compliance despite SU assurances
  - ~ Medicines Policy requires an update to provide clearer guidance to Designated Community Prescribers about recording medication on S1 and notifying GP's when a prescription is provided
  - ~ process for prescribing medication in the community is not in line with the BDCFT Medicines Policy

- Communication / professional curiosity
  - ~ communication between services not effective
  - ~ response to service user's concerns not effective
  - ~ Handover of Care Policy does not provide sufficient guidance about good practice/communication requirements when a service user is unable to confirm permanency of a move, impacting on delays in assessment
  - ~ alleged abusive incident was not sufficiently explored
  - ~ lack of face to face contact which would be beneficial in a difficult case in terms of communication and transfer of care
  - ~ risk details were sufficient to escalate to management for further consideration of risk mitigation actions/ referral but was not progressed

- Discharge
  - ~ discharge was undertaken at an appropriate time
  - ~ formal referral for discharge follow-up home visit not made, in line with BDCFT policy

Management response action plans are developed for all areas of improvement learning identified. These are developed and monitored through the relevant Trust Governance processes.

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.

4 COVID-19

The learning from deaths approach has taken particular account of Covid-19. We continue to collect the reports of both inpatient and community deaths relating to the trust.

There were 2 deaths where covid was a contributing factor reported in the community (1 April, 1 May, 0 June) and 0 deaths from covid occurring in inpatients between 01 April and 30 June 2022.

5 Conclusion

For Q1, 2022/23 there was a 24% decrease in the number of deaths reported compared to the same period last year. There has been an 23% decrease in the number of deaths reported in Q1 of 2022/23 compared to Q4 of 2021/22. Deaths under the care of the NHS is an inevitable outcome for some patients and patients may experience good and excellent care in the months or years leading up to their death. The reporting of deaths and governance arrangements have supported BDCFT to identify learning where care could be improved and where the good practice can be shared. The reports indicate that the learning required arises from multiple contributory factors, which are system-wide issues and has arrangements in place to act upon this learning to prevent reoccurrence of similar incidents.

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7 July 2022