Bradford District Care
NHS Foundation Trust

Senior Leadership Team (SLT) - Quality, Safety and Governance

21 June 2023

Paper title:	Learning from deaths and Patient Safety Incident Investigations	**Agenda Item**
Presented by:	Dr David Sims, Medical Director	**XX**
Prepared by:	Rachel Howitt, Head of Patient Safety, Compliance and Risk	
Committees where content has been discussed previously	n/a	
Purpose of the paper Please check **ONE** box only:	☐ For approval ☐ For discussion ☒ For information	
Link to Trust Strategic Vision Please check **ALL** that apply	☒ 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	
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☐ Effective ☒ Responsive ☒ Caring ☒ Well-Led	

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 Q4, 2022.

Executive Summary
Learning from deaths is supported by two key policies in Bradford District Care NHS Foundation Trust (BDCFT), 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 January and 31 March 2023 there have been 79 deaths reported. This is a decrease of 3% to the same period in the previous year. Structured judgement reviews (3 all managed via the serious incident (SI) process and serious investigation reports (4) have been completed for 7 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?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)
The Quality and Safety Committee 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

Relationship to the Board Assurance Framework (BAF)	
The work contained with this report links to the following strategic risks as identified in the BAF: ☐ **SO1**: Engaging with our patients, service users and wider community to ensure they are equal partners in care delivery (Quality & Safety Committee (QSC)) ☐ **SO2**: Prioritising our people, ensuring they have the tools, skills and right environment to be effective leaders with a culture that is open, compassionate, improvement-focused and inclusive culture (Workforce & Equality Committee - WEC) ☒ **SO3**: Maximising the potential of services to delivery outstanding care to our communities (QSC) ☐ **SO4**: Collaborating to drive innovation and transformation, enabling us to deliver against local and national ambitions (Board) ☐ **SO5**: To make effective use of our resources to ensure services are environmentally and financially sustainable and resilient (Finance, Business, Investment Committee - FBIC) ☐ **SO6**: To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS (FBIC)	
Links to the Strategic Organisational Risk register (SORR)	The work contained with this report links to the following corporate risks as identified in the SORR: • N/A
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • N/A

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Learning from Deaths 2022/2023 Q4

1. Introduction and background

Learning from deaths is supported by two key policies in BDCFT; 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 January and 31 March 2023, a total of 79 of Bradford District Care NHS Foundation Trust's patients died. There were 82 in Q4 last year.

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

	Quarter 1 22/23	Quarter 2 22/23	Quarter 3 22/23	Quarter 4 22/23
Number of patients who have died 2022/23	Apr – 25 May – 25 Jun – 13	Jul – 22 Aug – 20 Sept – 42	Oct – 23 Nov – 40 Dec - 33	Jan – 32 Feb – 24 Mar - 23
Total per quarter	63	84	96	79
Total number of patients who have died in the last 4 quarters	322			

This quarter, 2 community-based deaths had COVID as a contributory factor, which is a decrease from 10 in Q4 of 2021/22.

All deaths, whether expected due to a clinical condition, or unexpected are reviewed bi-weekly in the Mortality and Duty of Candour Group (MDCRG). 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.

The Mortality screening tool is now embedded on Safeguard and being utilised, 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.

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

These figures include:

- To note: 2 SJR's were commissioned in the Q4 period but the completed reviews will be included in the next quarters figures
- **3** SJR's monitored via the SI process, where deaths had occurred in previous reporting periods and the investigations were completed in this reporting period (Q4 2022).
- **4** SI investigations where deaths had occurred in previous reporting periods and the investigations were completed in this reporting period (Q3 2022).

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

3. Learning and improvement

BDCFT 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 Q4, 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:

- **Care delivered was of a good standard** and in line with the Trust's policies, procedures and guidelines.
- Extensive evidence of **joint working** within BDCFT services including the members of the Multi-Disciplinary Team (MDT), detailed and personalised **risk assessments and care plans** of known needs, signposting the patient to available support, responding to the patient's concerns and First Response Service (FRS) staff member **escalating concerns**.
- Good evidence of **case load management meetings**.
- Noting potential issue of domestic abuse during initial telephone contact.
- Providing **practical advice** regarding accessing financial and emergency support.
- Good **continuity of care**.
- Clinical documentation with **good detail recorded.**

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:

- **Triage assessment** and associated **documentation not completed** after Yorkshire Ambulance Service (YAS) referral.
- **Patient unaware of a referral.**
- **Letter** providing the full details of an assessment **not sent to GP.**
- **Tasking facility on SystmOne (S1)** being yet fully operationalised within the mental health service.
- **No formal process in place** for both Bradford Teaching Hospitals Foundation Trust (BTHFT) and BDCFT to help ensure **joint working** when a patient is under both the Health Psychology Service at BTHFT and the community mental health services in BDCFT.
- **Staff not recording discussions** with other organisations **on SystmOne.**
- **Lack of contact with a patient** (patient may have been deceased for 1-month prior to emergency services attending).
- **Not referring/signposting** to a relevant organisation for support with the misuse of prescribed medication.
- **A referral** being closed **not communicated** to the patient's General Practitioner (GP).
- Key decisions in the initial Intensive Home Treatment Team (IHTT) assessment were **not documented on the S1 record**.

- The **discharge process** was not in the spirit of the **BDCFT discharge policy**.
- Review dates of **BDCFT policy** having passed and **out of date**.
- Challenge about available information or missing details would have better demonstrated **professional curiosity**.
- **Absence of collaborative working**.
- A frequent caller **not escalated** as per **service guide**.
- Information **not recorded** in a patient's **care plan or risk assessment**.
- An identified **plan not in place** around Older People's (OP) Community Mental Health Team (CMHT) scheduled visits by a Care Co-Ordinator (CC) or Health Care Support Worker (HCSW). This was also not identified in his **care plan or risk assessment.**
- Lack of clarity around **CMHT review** timescale and lack of **professional oversight** in between consultant reviews.
- Help not summoned immediately as part of the **resuscitation process and policy.**
- The information/advice in the **Resuscitation policy, Death and Dying policy and Do Not Attempt (DNA) Cardio Pulmonary Resuscitation (CPR) policy** are not providing consistent information and advice and need to reference **ReSPECT policy**.
- Evidence of verbal discussions/documentation not in line with BDCFT **record management policy**.
- The process for communication with the patient's GP not in line with BDCFT **Service level Agreement (SLA).**
- IHTT pathway not adhered to as per BDCFT **policies and procedures**.
- The **implementation of policies, procedures and guidelines** specifically relating to updating of **risk assessment and care plan** in a timely manner to capture a patient's non-concordance with medication and the role of the HCSW with regards to this.
- Evidence of verbal **discussions/documentation** not in line with BDCFT record management policy and procedure.

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 during Quarter 4 and 0 deaths from covid occurring in inpatients.

5. Next steps

A number of developments are underway and although these have been subject to delay, mainly due to capacity issues, since the successful recruitment into a new Mortality and Duty of Candour Facilitator post this will now enable some of the workstreams in relation to mortality to progress at a better pace.

The areas to develop over 2023/24:

- Review of how SJR processes align with the BDCT approach to incident response (including deaths) under the Patient Safety Incident Response Plan, currently in development

- Review how SJR score breakdowns and narrative can be developed and triangulated to enhance learning
- Develop system to ensure the deaths of people with a diagnosis of Autism are identified and fed into the LeDeR process for review

We are continuing to liaise with the NHS Improvement Academy for Yorkshire and the Humber regarding further SJR reviewer training.

The collaboration with Medical Examiners (ME's) has strengthened with a process now in place for sharing intelligence regarding non-coronial deaths. The IT system support for this process is currently being developed. The ME's will be attending the Patient Safety Group (subgroup of the System Quality Committee) on a quarterly basis with Bradford provider and ICB Patient Safety Specialists.

BDCFT participates in the 'Northern Alliance' of mental health trusts, which focusses on mortality review processes, providing a regional network for identifying and sharing opportunities for learning and improvement.

6. Conclusion

For Q4, 2022/23 there was a 3% decrease in the number of deaths reported compared to the same period last year. There has been an 17% decrease in the number of deaths reported in Q4 of 2022/23 compared to Q3 of 2022/23. 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 feed into quality improvement activity to prevent reoccurrence of similar incidents.

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24 May 2023