NHS
Bradford District Care
NHS Foundation Trust

Quality and Safety Committee

16 November 2023

Paper title:	Learning from deaths and Patient Safety Incident Investigations	Agenda Item 17.0
Presented by:	Dr David Sims, Medical Director	
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Committees where content has been discussed previously	n/a
Purpose of the paper Please check **ONE** box only:	☐ For approval ☒ For information ☐ For discussion

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF.		
Being the Best Place to Work	Looking after our people	
	Belonging to our organisation	
	New ways of working and delivering care	
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	√
	Improving the experience of people who use our services	√
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	√

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 Q2, 2023.

Executive Summary

Learning from deaths (LfD) is supported by two key policies in Bradford District Care 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 July and 30 September 2023 there have been 55 deaths reported. This is a significant decrease of 34% to the same period in the previous year. Whilst there is no specific reason identified from the analysis of the data, a development priority will be set to interrogate patterns and trends to monitor this going forward.

4 Structured judgement reviews, Local Learning Reviews (1 managed via the Patient Safety process) and serious investigation reports (7) have been completed for 11 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 & 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

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: • •
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☐ Effective ☒ Responsive ☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • n/a

Quality & Safety Committee

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Learning from Deaths 2023/2024 Q2

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 July and 30 September 2023, a total of 55 of Bradford District Care NHS Foundation Trust's patients died. There were 84 in Q2 last year.

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

	Quarter 3 22/23	Quarter 4 22/23	Quarter 1 23/24	Quarter 2 23/24
Number of patients who have died during previous 12 months	Oct – 23 Nov – 40 Dec - 33	Jan – 32 Feb – 24 Mar - 23	April – 25 May – 26 June - 24	Jul – 17 Aug – 19 Sept – 19
Total per quarter	96	79	75	55
Total number of patients who have died in the last 4 quarters	305			

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 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 Patient Safety Incident Investigation (PSII) was carried out are shown in the following table:

	Quarter 3 22/23	Quarter 4 22/23	Quarter 1 23/24	Quarter 2 23/24
Number of deaths for which a Structured Judgement or Local Learning Review was completed	1	3	2	4
Number of deaths for which a PSII was completed	5	4	4	7

Please note:

- **1** Learning Review and **1** SJR monitored via the patient safety process were commissioned in the Q2 period, but the completed review will be included in the next quarters figures.

- **1** completed SJR monitored via the patient safety process, was a death that occurred in previous reporting periods and the investigation was completed in this reporting period (Q2 2023).

- **4** SJR monitored via MDCRG were commissioned in the Q2 period, but the completed review will be included in the next quarters figures.

- **3** completed SJR monitored via MDCRG, were deaths that occurred in previous reporting periods and the reviews were completed in this reporting period (Q2 2023).

- **All 7** PSII investigations were for deaths that occurred in previous reporting periods and the investigations were completed in this reporting period (Q2 2023).

The PSII 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 Q2, 2023/24. 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:

- Community Mental Health Team (CMHT) Consultant Psychiatrists continued to **seek updates on care coordination**.
- CMHT Consultant Psychiatrist **offered advice and guidance** in relation to the home environment to the GP, to speed up a potential 3rd party referral.
- CMHT Consultant Psychiatrists had **regularly reviewed medication, offered advice** on several occasions and was alert to the patient's alcohol and drug abuse history.
- District Nurse team ensured they **kept in touch** with the patient throughout her cancer care treatment; challenges of frequent hospital visits, cancellations, postponements were overcome and a **good working relationship** with the patient was maintained.
- Good practice of a keyworker **raising concerns** via her line manager in relation to her confidence and skill set in working with a service user's **level of risk** and plan for co-working with assistant psychologist made, along with onward referral.
- Staff recognising the **impact of carer stress** and taking steps to mitigate against this.
- A patient's **historical risks were explored**, formulation developed and regularly revisited, and knowledge used to frame the patient's **care plan and risk assessment.**
- Clinical teams hearing and **rapidly responding to concerns** raised by a patient's mother.
- Working effectively across teams to enable shared, mutual understanding of the patient's presentation, enabling a **consistent approach to risk management.**
- Face-to-face assessment highlighted a **thorough consideration of risk** to others.
- The First Response Service (FRS) also evidenced **good patient focused activity** in getting the patient to attend Lynfield Mount Hospital (LMH) for a further face to face assessment, rather than over the phone.
- Intensive Home Treatment Team (IHTT) **sought advice** from the Safeguarding Team following request for patient information from someone reporting to be a social worker to ensure the request was genuine and relevant action was taken. This was **good information governance**.
- Care Coordinator proactive work with Consultant Psychiatrist to **bring forward an outpatient appointment** due to unease at a patient's presentation.
- **Good liaison between IHTT and CMHT** to ensure a patient received a speedy review of medication by the Consultant Psychiatrist.
- IHTT worked hard to secure a local inpatient bed and showed **compassion and understanding** of the difficulties a patient had when in an out of area bed.
- **A thorough mental health assessment** was undertaken by the Mental Health Liaison Nurse which highlighted key risk which resulted in an assessment under the MHA and subsequent inpatient admission.
- Inpatient Occupational Therapy (OT) team rang a patient's partner to **explore if the patient could return home** on discharge and whether decision basis was temporary or permanent at that stage. OT team **continued to support** with housing options.

- Throughout the care of a patient, the service **requested carers support** for the partner and family and made enquiries with the Safeguarding Team. The Care Coordinator also **utilised collateral information** received from a family friend and ensured follow up requests for medication, electrocardiogram (ECG) and outpatient appointments.
- IHTT, Improving Access to Psychological Therapy (IAPT) and CMHT delivered **timely and appropriate referrals** to the support network within the service.
- FRS, IHTT and the IHTT Consultant Psychiatrist **did not rely only on the initial answers** provided by a patient. They continued to support the patient because there was a belief that he was underplaying his attempts at self-harm.
- Whenever there were concerns for a patient's safety because he had not been in contact with the service or his family, appropriate actions were taken in **informing the emergency services to undertake a welfare check**. There was also **good contact** made with the family to obtain collateral information about the patient.
- **Good liaison** between the Yorkshire Ambulance Service and FRS when the ambulance service had concerns about leaving a patient alone in the house following self-harm, as well as other instances of **good liaison** between FRS and IHTT.
- Consultant Psychiatrist sent an **update to the GP** following failed attempt at assessment under the MHA, despite not seeing the patient, to advise on **changes in anti-depressant medication** due to possible side effects impacts.
- **Regular communication** with the acute Trust whilst the patient was admitted in hospital.
- The General Practitioner (GP) did not mention that the patient symptoms could be related to a specific medication. **Teaching sessions were carried out by BDCFT Pharmacists** within primary care to increase knowledge of potential side effects of clozapine.
- Clozapine added to repeat templates within GP surgeries as "other medication" so it is reviewed when new medications are prescribed in case of drug interactions.

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:

- District Nursing (DN) Team **did not take action** when issues of **domestic violence / safeguarding** issues were brought to their attention
- The impact of a **sharing restriction on a SystmOne (S1)** record is not fully understood.
- The **S1 Adult Safeguarding mode** is not always used to record safeguarding concerns, in line with the **Safeguarding Policy**
- There is a tendency to **review only inexperienced District Nurses** for accuracy and completion of templates etc.
- A user can override a key control on the **S1 District Nurse record** in relation to completion of all templates
- The District Nurse Team displayed a **lack of professional curiosity** in several key areas when caring for the patient
- There were two occasions when the District Nurse Team **did not complete an Electronic Incident Report (IRE)** form in line with the Trust's **Incident Reporting Policy.**

- **Concerns for the service user's wellbeing**, expressed by family via voicemail message were **not responded to**. Failure to attend appointment **did not result in a re-assessment of risk** or an escalation in the service user's care.
- Opportunities for improvement relating to aspects of the Child & Adolescent Mental Health Service (**CAMHS) teams' safety culture**, including the use of **standardised crisis and contingency plans**, and the **absence of robust systems to escalate** the care of a service user experiencing a mental health crisis or increased risks, including in response to family's earlier concerns.
- An absence of **CAMHS specific staff training**, or an enhanced support offer for those staff transitioning from the provision of adult mental health care into the CAMHS service, including the **absence of caseload supervision**.
- A significant disparity between the **concerns being expressed by the patient's mother** and the settled and credible presentation with which they were presented during each assessment and contact.
- Efficient and effective controls may not be in place to mitigate the risk that a service user is lost to community mental health services **outpatient appointment process.**
- Physical health issues highlighted during inpatient stay were not sufficiently highlighted on a **Risk Assessment** at discharge or detailed in the corresponding **letter to the GP.**
- The record of the temporary address was **not recorded appropriately on S1**.
- There were several areas where the **communication with the Care Coordinator** should have been better managed.
- A letter was typed and saved system but **patient and GP did not receive a copy.**
- Documentation evidenced multiple occasions when **patient's wife was scared** and at times patient disclosed risk in behaviour. Although family impact was commented on, there was **no evidence of the recognition of risk by IHTT, Acute Liaison Psychiatry Service** (**ALPS) or CMHT.**

4. Next steps

A number of developments are ongoing to enable the workstreams in relation to mortality to improve and mature.

The areas to develop over 2023/24:

- A new Patient Safety Executive Panel (PSEP) commenced in October 2023. This replaces the Mortality and Duty of Candour Group and the Executive Patient Safety Approval Panel. The group has been formed to align with good governance processes for the Patient Safety Incident Response Framework (PSIRF) requirements.
  The purpose of PSEP is to ensure that the trust is identifying and appropriately responding to patient safety incidents, including deaths, in a way that is in line with legislation, best practice and guidance and actively promotes and supports a just learning and generative safety culture across the organisation.
  The group has delegated authority from the Board of Directors to oversee the development of the trust's Patient Safety Incident Response Plan (PSIRP), the quality and appropriateness of the trust's response to patient safety incidents and to seek assurance that appropriate learning has been identified and actions taken as a result in order to minimise the risk of future harm.

- Review of how SJR processes align with the BDCFT 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
- Review of how data on deaths is analysed to refine how patterns, trends and themes are identified

Response from the NHS Improvement Academy for Yorkshire and the Humber regarding further SJR reviewer training has been slow, however this is now progressing and training is planned to be in place before the end of 2023, along with a wider learning and development offer linking LfD, PSIRF and Patient Safety together within the medical training programme.

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 now in place and being used. The ME's now attend the Patient Safety Group (subgroup of the System Quality Committee) on a quarterly basis with Bradford provider and Integrated Care Board (ICB) Patient Safety Specialists. The ME process becomes statutory in April 2024 and BDCFT have built good foundations with the process in preparation. In Q3 the Patient Safety Group will be working to review how learning from deaths can be better aligned across place.

The MDCR group now receives a Coroners Learning from Deaths Summary Report on a monthly basis. This provides a summary of national Prevention of Future Death Reports and will be used to proactively identify if any learning from other areas is relevant to BDCFT, to inform further triangulation and any safety action required.

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. We are also members of the YHIA Regional Mortality Steering Group which follows a similar theme on a quarterly basis.

5. Conclusion

For Q2, 2023/24 there was a significant 34% decrease in the number of deaths reported compared to the same period last year. There has been an 26% decrease in the number of deaths reported in Q2 of 2023/24 compared to Q1 of 2022/23.

Whilst the 34% decrease is in comparison to the same quarter for last year, the actual decrease has been gradual over the past year with an extra decrease since last quarter. This is more prominent across unexpected deaths, than expected deaths. Further analysis will allow better understanding of the data to identify potential reasons behind the changes identified. This is a development priority across the next quarter.

When comparing deaths reported by individual teams in Q2 this year and Q2 last year, there has been a reduction across all areas of the trust in line with a Trust-wide trend of reduced reporting generally around Q2 this year. This will be monitored and inform further analysis.

Death 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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