Bradford District Care
NHS Foundation Trust

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

18 September 2024

Paper title:	Learning from deaths and Patient Safety Incident Investigations	**Agenda Item**
Presented by:	Dr David Sims, Medical Director	**XX**
Prepared by:	Sallie Turner, Mortality & Duty of Candour Improvement Facilitator / 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 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 Q1, 2024/25.

Executive Summary	
Learning from deaths is supported by two key policies in Bradford District Care NHS Foundation Trust (BDCFT), the Patient Safety Incident Response Policy (PSIRP) and the Learning from Deaths (LfD) Policy. These policies guide and inform the organisation about reporting, investigating and learning from deaths. Between 01 April 2024 and 30 June 2024 there have been 78 deaths reported. This is almost an identical amount to the same period in the previous year. 3 Patient Safety Incident Investigation reports have been completed for 3 deaths (no After Action Reviews (AAR) or Local Learning Reviews (LLR) managed via the Patient Safety process have been completed this quarter), along with 4 completed Structured Judgement Reviews (SJR) and 1 LLR, commissioned by the Patient Safety Executive Panel (PSEP). 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 SLT - Quality, Safety and Governance group 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

SLT - Quality, Safety and Governance

18 September 2024

Learning from Deaths 2024/2025 Q1

Introduction and background

Learning from deaths is supported by two key policies in BDCFT; the Patient Safety Incident Response Policy (PSIRP) and the Learning from Deaths (LfD) Policy. These policies guide and inform the organisation about reporting, investigating and learning from deaths.

Current Status

Between 01 April 2024 and 30 June 2024, a total of 78 of Bradford District Care NHS Foundation Trust's patients died. There were 75 in Q1 last year.

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

	Quarter 2 23/24	Quarter 3 23/24	Quarter 4 23/24	**Quarter 1 24/25**
Number of patients who have died during previous 12 months	Jul – 17 Aug – 19 Sept – 19	Oct – 36 Nov – 24 Dec - 38	Jan – 21 Feb – 26 Mar - 27	**April – 21** **May – 24** **June - 25**
Total per quarter	55	98	74	**78**
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 Patient Safety Executive Panel (PSEP) which aligns with good governance processes under the Patient Safety Incident Response Framework (PSIRF) requirements which commenced in April 2024.

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, other review methods may be used for example a Local Learning

Review (LLR), After Action Review (AAR) or Thematic Analysis (TA) to identifying learning in order to minimise the risk of future harm.

The Patient Safety Executive Panel 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 Patient Safety Executive Panel and they are referred to the national Learning Disabilities Mortality Review (LeDeR) programme.

The Mortality screening tool, embedded on Safeguard, continues to enable reporters to provide more complete information regarding deaths at an earlier point. This is helping facilitate the decisions at PSEP 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 2 23/24	Quarter 3 23/24	Quarter 4 23/24	Quarter 1 24/25
Number of deaths for which a Structured Judgement, Local Learning or After Action Review was completed	4	9	6	5
Number of deaths for which a PSII was completed	7	5	4	3

Please note:

No AARs or LLRs monitored via the patient safety process were completed in Q1 24/25. There was 1 LLR commissioned in Q1 (death on DAU), however, this remains ongoing.

5 SJRs monitored via PSEP were commissioned in the Q1 period, but the completed reviews will be included in the next quarters figures.

All 4 completed SJR's monitored via PSEP, were deaths that occurred in previous reporting periods and the reviews were completed in this reporting period (Q1*, Q3 and Q4 2023/24)

***** Improvements were made in early 2023 to minimise delays around SJR allocation / completion, however this SJR was requested prior to that change.

All 3 PSII investigations were for deaths that occurred in previous reporting periods and the investigations were completed in this reporting period (Q1 24/25).

All types of incident response (PSII, SJR, LLR or AAR) have the same remit of identifying system learning for improvement.

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 Q1, 2024/25. 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:

- **Consistent General Practitioner (GP) involvement** addressing physical and mental health needs and coordinating care with other services.
- Comprehensive referrals to appropriate services including Early Intervention in Psychosis (EIP) team, counselling, drug and alcohol services, and pain management clinics, indicating a **recognition of complex needs**.
- Encouraging engagement with community support/resources to **improve patient outcomes** and provide a sense of purpose, social connection, and the importance of continuity of care in the community
- **Rapid response** to crisis situations from emergency services and mental health crisis teams, preventing more serious harm.
- Recognition of the need for further assessment following initial assessment, which demonstrated an **understanding that a more comprehensive assessment was necessary** to fully understand the patients' needs.
- Identification of key risk factors was a positive step towards **understanding patient needs** and informing future care planning.
- Documentation of the assessment **appropriately identified risks**, which was a positive practice in terms of ensuring information sharing and continuity of care.
- Attempts were made to **engage the patient** in discussions about treatment and involvement in decision-making processes.
- Positive **assertive approach** to a patient that had a chronic high level of risk, medical and psychiatric complexity and difficulties maintaining engagement.
- **Holistic approach** to the patient recognising the links between mental disorder and physical health.
- Communication with other services was robust and led to **rapid management of deteriorating condition.**
- **Ongoing support** was provided to patient and family even during palliative stage of patient's treatment.
- Care Coordinator and Responsible Clinician **very proactive in their approach** throughout this stage of care.
- Care coordinator had been **proactively liaising** with various agencies including housing, addiction service and crisis service at different times to provide best care to patient.
- Patient was **informed immediately** when care-coordinator was absent and was made aware of the point of contact for crisis. Evidence of regular supportive contacts with patient during care-coordinator's absence.

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 operational quality improvement processes in the Trust, with oversight in the Patient Safety and Learning Group. Examples of the learning identified relate to:

- There was inadequate long-term mental health support due to patient difficulties in engagement and a **lack of assertive outreach**, creating a potential gap for individuals with complex needs who may have a dual diagnosis.
- Co-occurring physical and mental health issues were not co-ordinated to **enhance a robust integrated long-term care pathway** for patients, particularly those with chronic pain and substance misuse.
- Improving **flexible and person-centred approaches** to care around long-term mental health support, such as assertive outreach and community-based support, for individuals with complex needs who may not fit into specific diagnostic categories.
- Lack of a comprehensive, person-centred approach that considered unique needs, preferences, and life circumstances to **better involve the patient** in their care planning and decision-making.
- There were **missed opportunities for addressing substance misuse in the discharge plan**, which were likely significant contributors to overall mental health and well-being, and a lack of clear referrals or recommendations for substance misuse treatment services.
- Limited **involvement and engagement of family** and support network in the discharge planning process or post-discharge care. Engaging these individuals could have helped to create a more supportive environment, providing valuable insights into day-to-day functioning and ensure better monitoring of well-being.
- No **clear crisis plan** that outlined strategies for managing future crises and preventing relapse.

Next steps

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

The Patient Safety Executive Panel (PSEP) is now well established and continues to provide the governance structure for the learning from deaths work and the Patient Safety Incident Response Framework (PSIRF) requirements.

Ongoing developments include:

- Evaluating how assurance is received that appropriate learning has been identified and actions taken as a result in order to minimise the risk of future harm
- Continuing to embed PSIRF by ensuring appropriate response 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
- Supporting the use and development of systems-based PSIRF approaches to incident response

- A review of how SJR score breakdowns and narrative can be developed to triangulate data and enhance learning.
- Further refinement to published learning from deaths data.

Our LfD Policy has been updated and aligned with PSIRF implementation, ensuring an appropriate response to patient deaths in line with legislation, best practice and guidance and actively promotes and supports a just learning and generative safety culture across the organisation.

A Mortality Dashboard has been created, within the Trusts' Incident Report and Risk Register System, to refine data analysis and incorporate patterns, trends and themes as the data builds over the coming quarterly reporting periods.

We have also taken the first few steps to ensure the deaths of people with a diagnosis of Autism are identified on the Mortality Screening Tool and fed into the LeDeR process for review.

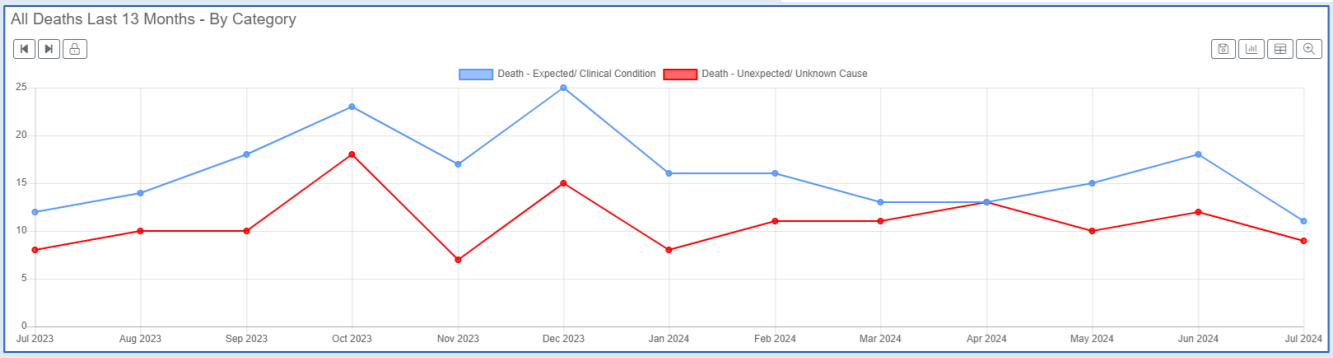
The collaboration with Medical Examiners (ME's) continues to strengthen regionally, sharing intelligence regarding non-coronial deaths with Bradford providers and Integrated Care Board (ICB) Patient Safety Specialists, however the statutory ME process has been delayed until **September 2024**. Despite this, work is continuing to review and improve how learning from deaths can be better aligned across place.

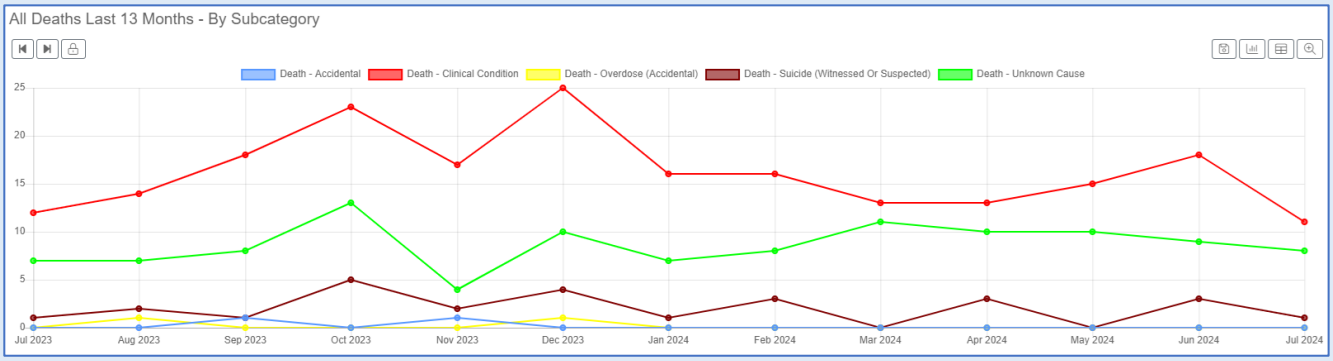
The PSEP group receives a Coroners Learning from Deaths Summary Report on a monthly basis. This provides a summary of national Prevention of Future Death Reports and is also received by the Patient Safety and Learning Group (Insights) to inform triangulation and any safety action required.

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 Yorkshire & Humber Improvement Academy (YHIA) Regional Mortality Steering Group which follows a similar theme on a quarterly basis.

Conclusion

For Q1, 2024/25 there was almost an identical number of deaths reported compared to the same period last year. There has been a 5% increase in the number of deaths reported in Q1 of 2024/25 compared to Q4 of 2023/24.





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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