NHS
Bradford District Care
NHS Foundation Trust

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

20 February 2025

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/Patient Safety Specialist	
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 Q3, 2024/25.

Executive Summary	
Learning from deaths is supported by two key policies in Bradford District Care 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 October 2024 and 31 December 2024 there have been 89 deaths reported. This is consistent with the same period the previous year. **6** Patient Safety Incident Investigation reports have been completed for 6 deaths. **1 LLR** monitored via the patient safety process have been completed this quarter, along with **1** completed Structured Judgement Review (SJR) 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: • n/a
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

20 February 2025

Learning from Deaths 2024/2025 Q3

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 October 2024 and 31 December 2024, a total of 89 of Bradford District Care NHS Foundation Trust's patients died. There were 98 in Q3 last year.

During Q3 there were 9 reported deaths of a Service User with a registered Learning Disability and/or a clinical diagnosis of Autism. These have undergone Learning for Lives and Deaths (LeDeR) service improvement reviews.

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

	Quarter 4 23/24	Quarter 1 24/25	Quarter 2 24/25	Quarter 3 24/25
Number of patients who have died during previous 12 months	Jan – 21 Feb – 26 Mar - 27	April – 21 May – 24 June - 25	Jul – 20 Aug – 21 Sept – 22	Oct - 21 Nov - 31 Dec - 37
Total per quarter	74	78	63	89
Total number of patients who have died in the last 4 quarters	304			

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 Patient Safety and Learning page 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 for Lives and Deaths (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 a Review, Thematic Analysis or Patient Safety Incident Investigation (PSII) was carried out are shown in the following table:

<table>
<tr><th></th><th>Quarter 4 23/24</th><th>Quarter 1 24/25</th><th>Quarter 2 24/25</th><th>Quarter 3 24/25</th></tr>
<tr><td>Number of deaths for which a Structured Judgement Review was completed</td><td>6*</td><td>5*</td><td>5</td><td>1</td></tr>
<tr><td>Number of deaths for which a Local Learning Review was completed</td><td colspan="2" rowspan="3">*Not previously broken down by type, figures included in the above*</td><td>3</td><td>2</td></tr>
<tr><td>Number of deaths for which an After Action Review was completed</td><td>0</td><td>0</td></tr>
<tr><td>Number of deaths which were included in a completed Thematic Analysis</td><td></td><td>10</td></tr>
<tr><td>Number of deaths for which a PSII was completed</td><td>4</td><td>3</td><td>5</td><td>6</td></tr>
</table>

Please note:

1 LLR and **1 SJR** monitored via the patient safety process are for deaths that both occurred in Q2 and the reviews were completed in Q3.

2 SJRs monitored via PSEP were commissioned in previous reporting periods and are now overdue.

All 6 PSII investigations were for deaths that occurred in previous reporting periods and the investigations were completed in this reporting period (Q3 24/25).

The 10 deaths covered under thematic analysis were from previous reporting periods and were completed under 2 TA's:

- TA (3 deaths) - Service users with Gender dysphoria who died by suicide/suspected suicide whilst under the care of CAMHS.
- TA (7 deaths) - Suspected suicide where Service user had contact/assessment with crisis Services (First Response, Acute Liaison Psychiatry) within 1 month of death but was not under secondary MH care.

All types of incident response (PSII, SJR, TA, 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 Q3, 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:

- Risk assessment and discussion about **crisis plan reviewed at every contact**.
- **Concerns acknowledged and acted upon** by bringing the Community Mental Health Team (CMHT) assessment appointment forward.
- Initial **assessment changed from phone assessment to face-to-face** when concerns were noted about deterioration of mental health.
- Physical health was **adequately monitored**.
- Project 6 **appropriately involved** to address co-morbid alcohol and cannabis use.
- **Self-help literature** on coping with hearing voices sent to Service User.
- Communication between teams was effective in **providing seamless, coordinated care**.
- **Risk assessment and care planning was sufficient** to mitigate the perceived risks at the time.
- Risk management was **proactive and responsive** to changing needs.
- There is good evidence of **clear communication**.
- The care received was delivered in line with local and national guidelines, was **individualised and delivered with compassion**.
- Communication with patient (and family when appropriate) around discharge planning was **robust** and the team made every effort to **manage any anxieties** about the pending transfer of care.
- There were different professional views about the place of safety for the patient and her children following the Mental Health Act assessment. Although communication with the patientand some key professionals could be improved, the evidence supports the fact that there was **compliance with the Mental Health Act** 1983 procedures.
- The SystmOne **notes are clear**, documenting interventions, outlining review of risks and interventions made and actions to be taken if needed (contingency planning).
- The review found **several areas of good practice**.
- Overall, the care given was **caring, service user centred and responsive** to their changing needs.

- The Community Mental Health Assessment Team (CMH AT) were **issuing an Opt-In letter to service users** that had not been outlined or agreed in their standard operating procedure or mental health governance forum.
- Overall, **good practice with continuity and proactive care** evident.
- **Joint working and decision-making** between the Integrated Outreach Team (IOT) and Physical Health (PH) were **appropriate and followed the correct process.**

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 via QuOps structures and in the Patient Safety and Learning Group (PSLG). Examples of the learning identified relate to:

- SystmOne **tasking was delayed** following receipt of referral from the General Practitioner (GP).
- Referral not appropriate but **no clear communication in place** to re-direct service user.
- **Unclear if referral was considered** to Intensive Home Treatment Team (IHTT), especially in light of several concerns raised about worsening psychotic symptoms.
- **Delay in communicating appointment dates** between CMH AT and Service User.
- Where long waiting lists exist, a system should be considered to help **prioritise service uses with greatest risk** or have a clear need of psychotropic medications.
- **Limited evidence of sharing information** relating to risk found despite consent to share.
- Potential psychiatric reactions were **not identified or discussed** during care.
- The Trust's Safeguarding Team were **not utilised appropriately**.
- Team **did not take advantage of opportunities** to escalate issues up to management.
- The role and scope of the Advanced Mental Health Practitioner (AMHP) was **not always well understood or clarified**.
- Some clinical staff felt their professional opinions, concerns or specialist knowledge/experience were **not given due consideration.**
- **Not all teams used appropriate methods** to ensure relevant and proportionate information was shared in a timely manner.
- Assessing staff **did not always challenge information,** leading to potentially false assurance reflected in subsequent decision making.
- There was **no clear risk assessment and care plan** in place to address non-compliance with medicines and the potential impact.
- Staff are **not routinely asking about preference for an interpreter.**
- Information from interpreter services highlights only the top ten languages which **does not provide clarity of issues** when trying to procure a rare language.
- Text messages and other communication were not always documented on SystmOne which potentially could lead to **gaps in information**.
- **Prolonged time period** between initial referral and first face-to-face contact longer than indicated by standard operating procedure.
- The Trust is **not fulfilling its commitment** to carers in relation to known carer stress.
- The "Passive Watch and Wait" **process was not implemented in line with policy**.
- Several factors led to **skin checks being omitted** between discharge from hospital and discovery of an advanced pressure ulcer.

- There is **no formal trust wide process** for substance misuse assessment and treatment
- The manner in which some Trust staff were made aware of the death **caused distress**.
- **Not completing an appointment outcome and discharge letter** is a contributory factor in patient being "lost to follow up".
- Safeguarding documentation **not being routinely used** in line with training and policy.
- There were several areas where **recording in SystmOne can be improved.**
- **Trust protocol needed for contacting external providers** active in providing support to a service user when an unexpected death is known.
- **Process of providing access rights may impact** on all appropriate individuals/services having access to safeguarding information.

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) continues to provide the governance structure for the learning from deaths work and the Patient Safety Incident Response Framework (PSIRF) requirements. The annual review and refresh of the Trusts Patient Safety Incident Response Plan (PSIRP) will be undertaken in April 2025

Following the Trusts Mortality Data Audit, completed in Q2 by Audit Yorkshire, the 5 recommendations (3 minor, 2 moderate) noted within the findings have been completed in line with the end of 2024 deadline.

Under the LfD Framework with the National Quality Board (NQB) we are required to further review a sample of deaths, that do not fit within the main identified categories, so we can take a broader overview of where learning and improvement is needed. We have compiled our first sample pool of mortalities, and SJR's are currently being undertaken for these 15 deaths from the Q3 period, the learning from these will be included in the next report.

BDCFT's participation in the 'Northern Alliance' of mental health trusts is continuing well. Progress has begun with some focussed discussions around developing an online SJR training package and reviewing LfD reporting metrics for better aligning these across the Bradford and Craven 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.

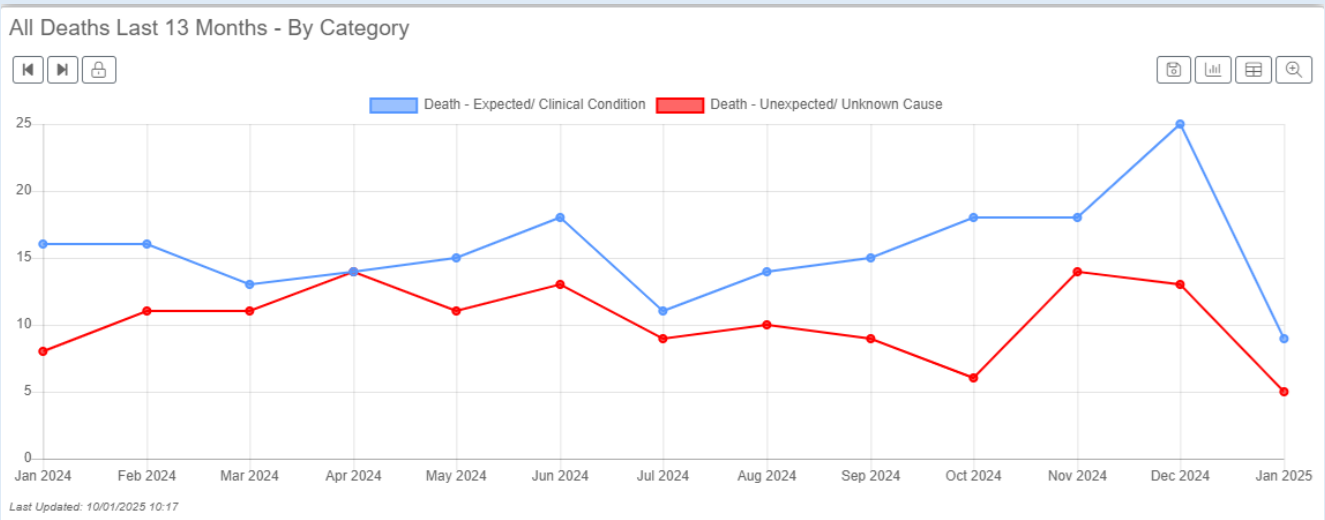
In addition, other ongoing developments include:

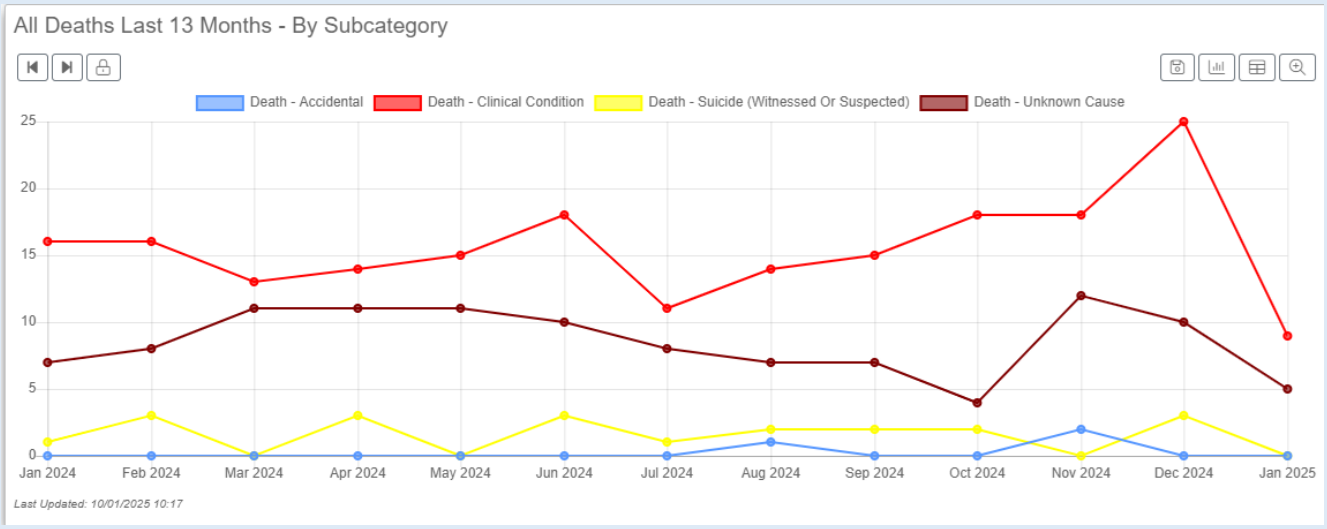
- Evaluating how assurance is received that appropriate learning has been identified and actions taken as a result in order to minimise the risk of future harm
- Next quarter will mark 12 months of working under the Patient Safety Incident Response Framework and a review will be undertaken to ensure ongoing 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

- Expanding the use and development of systems-based PSIRF approaches to incident response, including rolling out training for LLR methods into clinical services.
- Further refinement to published learning from deaths data in line with the regional and local mortality groups.

Conclusion

For Q3, 2024/25 there has been a 9% decrease on the number of deaths reported compared to the same period last year. There has been a 49% increase in the number of deaths reported in Q3 of 2024/25 compared to Q2 of 2024/25. This increase is commonly seen between quarters moving into the winter period, with last year showing a 78% increase. The increases are predominantly due to clinical conditions and expected deaths, with unexpected deaths and suicide related deaths remaining low, as shown below:





Death under the care of the National Health Service (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 support 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.

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