NHS
Bradford District Care
NHS Foundation Trust

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

16 May 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 Q4, 2023/24.

Executive Summary	
Learning from deaths (LfD) is supported by two key policies in Bradford District Care Trust (BDCFT), the Serious Incident policy (to be replaced by the Patient Safety Incident Response Policy) and the Learning from Deaths policy. These policies guide and inform the organisation about reporting, investigating and learning from deaths. Between 01 January 2024 and 31 March 2024 there have been 74 deaths reported. This is almost an identical amount to the same period in the previous year. 1 Local Learning Review, 2 After Action Reviews and 4 Patient Safety Incident Investigation reports have been completed for 7 deaths (managed via the Patient Safety process), along with 3 completed SJRs 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

16 May 2024

Learning from Deaths 2023/2024 Q4

Introduction and background

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

Current Status

Between 01 January 2024 and 31 March 2024, a total of 74 of Bradford District Care NHS Foundation Trust's patients died. There were 79 in Q4 last year.

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

	Quarter 1 23/24	Quarter 2 23/24	Quarter 3 23/24	Quarter 4 23/24
Number of patients who have died during previous 12 months	April – 25 May – 26 June - 24	Jul – 17 Aug – 19 Sept – 19	Oct – 36 Nov – 24 Dec - 38	Jan – 21 Feb – 26 Mar - 27
Total per quarter	75	55	98	74
Total number of patients who have died in the last 4 quarters	302			

All deaths, whether expected due to a clinical condition or unexpected, are reviewed bi-weekly in the Patient Safety Executive Panel (PSEP) and 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 1 23/24	Quarter 2 23/24	Quarter 3 23/24	Quarter 4 23/24
Number of deaths for which a Structured Judgement, Local Learning or After Action Review was completed	2	4	9	6
Number of deaths for which a PSII was completed	4	7	5	4

Please note:

The 2 AARs and 1 LLR completed and monitored via the patient safety process, were deaths that occurred in the previous reporting period and the investigations were completed in this reporting period (Q4 23/24).

3 SJRs monitored via PSEP were commissioned in the Q4 period, but the completed reviews will be included in the next quarters figures.

2 completed SJR's monitored via PSEP, were deaths that occurred in previous reporting periods and the reviews were completed in this reporting period (Q4 2022/23* and Q3 2023/24)

***** Improvements were made back in early 2023 to minimise delays around SJR allocation/completion, however this SJR was requested prior to that change and also underwent an additional review in support of the development of Higher Trainee's learning, which incurred a further delay in final completion.

All 4 PSII investigations were for deaths that occurred in previous reporting periods and the investigations were completed in this reporting period (Q4 23/24).

The PSII investigations' remit is to identify 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 Q4, 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:

- Child & Adolescent Mental Health Service (CAMHS) had **attended 7 previous Child Protection meetings** (prior to the one missed).
- Concerns about a Patients physical health whilst he was an inpatient were **swiftly acted on** including facilitating transfer to the acute hospital.
- The patient had **regular ward reviews** by his inpatient consultant and the other members of his inpatient treating team.
- Multiple agencies involved in a CAMHS patient's care **liaised and informed** each of the **patient's care and presenting behaviours** in-between the Child Protection Conferences and Core Group meetings.
- **Good communication** between BDCFT CAMHS, Children and Families Trust social workers and MHES.
- Always the same consistent junior doctor available, ensuring **continuity of care.**
- Clear evidence of **appropriate management including referral for a Mental Health Act assessment** following concerns noted in the community regarding his risks.
- Good practice was followed around a patient's **failure to attend appointments** between his voluntary admission and his death.
- **Significant risks to self and others correctly identified**, hospital admission recommended, and a review of medications done including discontinuing antidepressant due to concerns about manic presentation.

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:

- The most robust **Community Mental Health Team** (CMHT**) meetings**, where the Assessment Team attend to discuss patient referrals, have **administrative/medical secretaries in attendance**. But not all locality CMHT's have this process in place.
- When an email is sent to admin services, this transfers the email into an electronic tasking system called **Hornbill** which is used throughout BDCFT as an **IT tasking solution**. When administrative services check the task requests on Hornbill, they either complete the task themselves or allocate the task to the most appropriate

person to complete. But in a one patient's case, it was found that **not all tasks were completed, and an outpatients' appointment was not made.**

- A patient changed their address and General Practitioner (GP) prior to being discharged from hospital and a **referral was made to the wrong CMHT locality**. The referral was then closed but not re-opened in the correct locality. As such, the patient **did not have an open referral with any CMHT when she was discharged from hospital.**
- There was **no structure to a care and safety plan** and as such, if any CAMHS patient was to present in crisis to BDCFT First Response Service (FRS), the crisis team would not have timely access to a concise and specific plan of care and/or access to instant safety plan or the advice that patients have been given to **maintain their safety**.
- A patient **did not have a planned medication review**. the patient's medication was managed by her father and relied on him ringing for a medication review and/or repeat prescriptions. Medication management was a safeguarding concern.
- Despite indications that a patient's insight into his mental illness was limited and there were indications of his limited engagement with his care coordinator when on leave, **discharge to a Rehabilitation and Recovery Inpatient Centre was not considered** as part of discharge planning, although it had been mentioned in the early part of his hospital admission.
- There was **no robust process for repeat prescriptions** neither with several days' notice, or for urgent requests when the patient ran out of medication.
- **CAMHS were not present at a Child Protection Review** where it was discussed that the patient's sisters were leaving the family home to attend university and that this would be a huge upheaval for the patient as both sisters supported care in the family. A **risk assessment should have been updated** to reflect the future considerations from potential increased risk and change in situation as per BDCFT Clinical Risk Assessment and Management in Mental Health Policy and Procedures. However, the investigation was **not able to find an invite from the Child Protection Review to CAMHS** and neither were any minutes of the meeting shared with CAMHS.
- Both historical and recent examples of opportunities for improvement in the **management of safeguarding concerns**, specifically in relation to the management of **risks posed by the service user to minors.**
- Concerns were expressed by the Patient's care coordinator about his capacity to decline support in the community, but **a Mental Capacity assessment regarding this decision was not conducted**.
- **Absence of a clear information sharing protocol** between the Trust and West Yorkshire Police for situations in which information is requested immediately, but the circumstances fall short of an emergency.
- Following a short voluntary admission to an acute mental health ward, a patient took their own discharge against medical advice. He was **not allocated a care coordinator** at that time and **no care planning** could take place before he left the ward. He remained under standard care.

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.

Further developments will include:

- Evaluating the governance structure to ensure the delegated Board authority to oversee the quality and appropriateness of the trust's response to patient safety incidents and deaths is robust
- 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
- Continue 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
- Support the use and development of systems-based PSIRF approaches to incident response
- Update of the LfD Policy to align it 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 review of how SJR score breakdowns and narrative can be developed to triangulate data and enhance learning.
- A refresh of how data on deaths is analysed incorporating Statistical Process Control (SPC) charts/Dashboards to refine how patterns, trends and themes are identified.
- Develop system to ensure the deaths of people with a diagnosis of Autism are identified and fed into the LeDeR process for review

SJR reviewer training was provided by the Yorkshire & Humber Improvement Academy (YHIA) in February 2024 to further support the organisation in ensuring that meaningful learning is identified from reviews. Plans are being developed to create a succinct internal development offer within the medical training programme during 2024.

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 YHIA Regional Mortality Steering Group which follows a similar theme on a quarterly basis.

Conclusion

For Q4, 2023/24 there was almost an identical number of deaths reported compared to the same period last year. There has been an 24% decrease in the number of deaths reported in Q4 of 2023/24 compared to Q3 of 2023/24.

Further analysis will allow better understanding of the data and a new approach to presenting this will be ready for the next report.

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 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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