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Leicestershire Partnership NHS Trust

Public Trust Board – 2nd March 2021

Safety and Quality in Learning from Deaths Assurance (Quarter 3)

1. Purpose of the report

This report is presented to the Trust Board as assurance of the efficacy of the Learning from Deaths (LfD), Child Death Overview Panel (CDOP), Learning Disabilities Mortality Review (LeDeR), and Serious Incident (SI) processes in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017). This Report presents data from October to December 2020 inclusive (Quarter 3: Q3), as well as data reviewed and learning from Quarter 2 (Q2: July-September 2020).

2. Analysis of the issue

- The data presented in this report is collated by the patient safety team and allocated to each Directorate; LfD meetings are carried out within each Directorate.
- In order to provide timely information, automatic alerts have been set by the patient safety team to provide monthly as well as quarterly information.
- As a means of improving from Q2, meetings were held with members of the LPT performance team to obtain demographic data.
- Progress has been made to provide greater learning from deaths of individuals with Learning Disabilities. A learning lessons exchange group has been initiated to create a more robust process of LD reviews within the Families, Young Persons, and Children/ Learning Disabilities (FYPC/LD) Directorate through implementing Plan, Do, Study, Act which is a model for improvement and it provides a framework for developing, testing, and implementing changes leading to improvement (NHS/I, 2017a) (Appendix 1, p. 6)
- To further assure the Board that quality improvement is an integral part of our work, progress resulting from LfD scoping exercise is already evident. A recommendation of the exercise was to standardise the clinical expertise and support during monthly Directorate LfD meetings across LPT. As a result there are more in-depth discussions about the quality and safety of care provided to our patients, and learning can be categorised in a timelier manner.
- A further local improvement is that we have an immediate review of children deaths and Learning Disabilities deaths using the mSJR in FYPC/LD as well as the full CDOP and LeDeR process.

3. Proposal

The Board is asked to consider the content of this paper in alignment with Learning from Deaths guidance. The board is also asked to recognise the action and progress being in the LfD process at LPT.

4. Demographics

Patient information (demographics and protected characteristics) are extracted from two patient information systems (Rio and System1). It has become clear that Directorates have knowledge of demographics such as age and gender; however some characteristics are not recorded on either system. As assurance and in line with Step Up to Great Ambition, LPT is gradually moving towards adopting a single patient record, it is envisaged that obtaining demographics in particular protected characteristic data will be more attainable as a result of this transition. Demographic information is provided below:

Table 1: Q3 Gender & Age

	1-28 (D)	Up to 12 (M)	1-10 (Y)	11-18	19-24	25-44	45-64	65-79	80+	Total
Female	1	1	0	3	0	3	15	15	16	54
Male	0	0	0	1	1	7	18	18	16	61
Total	1	1	0	4	1	10	33	33	32	115

Table 2: Q3 Ethnicity

English/Welsh/Scottish/ Northern Irish/British/Irish	39.10%
Indian	12.20%
Pakistani	3.50%
Black/African/Caribbean	0.90%
Not recorded	43.50%

Table 3: Q3 Religion

Christian	35.50%
Hindu	16.10%
Jewish	6.50%
Muslim	6.50%
Sikh	3.20%
Other	3.20%
No religion	3.20%
Not recorded	25.80%

Table 4: Q3 Disability

Disability	51.60%
No Disability	16.10%
Not recorded	32.30%

Table 5: Q3 Sexual Orientation

Heterosexual	6.50%
Not recorded	93.50%

6. Deaths in Q2

In adherence with NHS/I (2017) recommendations, the percentages of deaths reviewed and completed for Q2 are shown in Table 6:

Table 6: Time lag in reviewing of deaths by Directorate

Q2	Total number of deaths	Review		% of deaths subject to mSJR* Case record review	% of deaths subject to an SI investigation
		mSJR	SI		
	90	84	6	93%	7%
Breakdown by Directorate				Number and % of deaths subject to mSJR* case record review completed	Number and % of deaths subject to an SI investigation completed
CHS	28	mSJR	SI		
		28		19	0
		28	0	68%	0%
DMH/MHSOP	55	55		45	3

KEY

CHS: Community Health Services; **DMH/MHSOP:** Directorate of Mental

		50	5	82%	5%
FYPC/LD	7	7		6	1
		6	1	86%	14%

7. Learning themes and good practice

7.1 Learning themes identified

Learning and discussions from Q2 consisted of DMH/MHSOP identifying the need to focus on the impact of physical health of patients and the importance of clinical recognition (C926). Improvements consisted of providing input to patients with Serious Medical Illnesses on managing chronic physical health and their lifestyle to help reduce risks. This learning was shared with DMH/MHSOP local Quality and Safety Meetings. Within CHS, individuals that were caring for the patient actively contribute to LfD meetings; this allows real time learning and encourages wider reflection. Learning was identified within the clinical care medication, administration theme (C823) in which an opiate medication patch was duplicated as new one commenced; a learning action was to add an automatic reminder to Electronic Prescribing and Medicines Administration system to remove the previous patch. FYPC/LD identified learning within C719 with reference to clinical care and speciality referrals, in which improving contact with social services was a priority. A learning action was to review the escalation policy.

A new development to enhance the LfD process at LPT is the provision of greater support for Directorates DMH/MHSOP and FYPC/LD) in monthly LfD meetings; as a result, learning themes and actions from the current quarter (Q3) can be extracted and immediately applied. An example of a DMH/MHSOP learning theme was in the clinical phase of the patients care journey, for example C617 highlighted the importance and challenges associated with metabolic monitoring in providing high-quality care for patient. An action to overcome this was that Matrons would escalate to team manager meetings to further unpack how managing metabolic monitoring was being achieved. Further learning that has been identified from mSJR case record reviews can be seen in Appendix 2 (p. 7).

7.2 Examples of good practice

Directorates demonstrated good practice in Q2:

- **CHS:** EOL paperwork has improved in this quarter-over 98% of the relevant documentation appeared to be completed.
- **DMH/MHSOP:** Lot of thought gone into considering the wishes of the patient. Excellent relationship with team members and a good trusting relationship.
- **FYPC/LD:** In order to strengthen communication between FYPC and safeguarding, the quality of safeguarding supervision and communication is being implemented in Quality Improvement work as a part of the Patient Safety Support Group.

Examples of good practice in Q3 consisted of:

- **CHS:** Unable to identify good practice in Q3 due to COVID-19 priorities/pressures.
- **DMH/MHSOP:** Shared good practice within the Mental Health Urgent Care Hub, in which succinct escalation in adherence to NEWS2 guidance was implemented to respond to physical health observations.

- **FYPC/LD:** In order to strengthen communication between FYPC and safeguarding, the quality of safeguarding supervision and communication is being implemented in Quality Improvement work as a part of the Patient Safety Support Group.

8. Number of deaths reported during Q3

Table 7 shows the number of deaths reported by each Directorate for Q3. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR). The number of reviews completed is also presented.

- There were 115 deaths for Q3.
- There were 2 deaths of individuals with Learning Disabilities which are undergoing LeDer review, and were reviewed using the mSJR case record review within FYPC.
- There were 8 CDOP deaths which were reviewed using the mSJR case record review within FYPC:

Table 7: Number of deaths

Q3 Mortality Data 2020										
	Oct			Nov			Dec			Total
	C	D	F	C	D	F	C	D	F	
Number of Deaths	8	23	3	8	24	1	7	37	4	115
Consideration for formal investigation										
	C	D	F†	C	D	F†	C	D	F†	
Serious Incident	1	5	0	0	4	0	0	0	1	**11**
Number completed	*1*	*3*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*5*
mSJR* Case record review	7	18	3	8	20	1	7	37	3	**104**
Learning Disabilities deaths	0	0	1	0	0	0	0	1	0	2
Number completed	*0*	*14*	*2*	*0*	*0*	*1*	*0*	*0*	*2*	*19*
Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	NK	0	0	NK	0	0	NK	0	0	0

KEY

C: Community Health Services; **D:** Directorate of Mental Health/MHSOP; **F:** Families Young Persons and Children/LD

9. Decision required

The Trust Board is required to confirm assurance on the implementation of the National Quality Boards Learning from Deaths guidance within the Trust.

10. Governance table

For Board and Board Committees:	Public Trust Board	
Paper sponsored by:	Professor Al-Uzri	
Paper authored by:	Saydia Razak & Tracy Ward	
Date submitted:	18.02.21	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Learning from Deaths Meeting (26th January 2021) & Quality Forum	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Report provided to the Trust Board quarterly	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Report provided to the Trust Board quarterly	
STEP up to GREAT strategic alignment*:	High **S**tandards	✓
	Transformation	
	Environments	
	Patient Involvement	✓
	Well **G**overned	
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	✓
Organisational Risk Register considerations:	List risk number and title of risk	1, 3
Is the decision required consistent with LPT's risk appetite:	NA	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	NA	
Equality considerations:	NA	

Appendix 1. Cycle 1 PDSA LD implementation of Learning Lessons Exchange Group

Authored by Bernadette Cawley-Nash (LD Matron)

PDSA (part 1)	
Plan	
What are we trying to accomplish?	A robust governance structure and learning lessons exchange forum to improve the LD service's ability to learn lessons.
How do we know if the change is an improvement?	A greater engagement from the service in terms of learning lessons and an improvement in the learning lessons culture in learning disability services. Improvement in service user experience and reduction in avoidable harm incidents.
What measures of success will we use?	Overall improved health outcomes and engagement from service users Reduction in avoidable harm incidents.
What changes can we make that will result in improvement?	Improve interface with LeDer programme led by the CCG to ensure lessons are learned from their reviews locally and support the learning into action plan from LeDeR. Create a local learning lessons forum that engages grass root level staff to ensure learning is shared across all levels of the learning disability service. Create a robust governance structure. Create a terms of reference for the learning lessons forum. Engagement with the directorate learning from deaths forum. Robust process for allocating Serious Incident reviews, mortality reviews and holding the actions plans and the accountability of those action plans.
Do	
Where are we now?	There is attendance to the LLR LeDeR steering group however the sharing of information and governance locally could be improved. There have been delays in the LeDeR reports being produced and subsequently lessons learned from deaths have not been shared in a timely manner. Through the changes in directorates there is a need to review the process for LD to establish a robust governance process to embed learning from all elements of incidents. It is on the LD senior Leadership Agenda to discuss however there is very limited time to share the level of information in this forum. There is limited engagement with all levels of the workforce and limited assurance that a learning lessons culture is embedded. LD have adopted the FYPC process for mortality reviews and want to ensure there is a process to share these lessons learning throughout the workforce. We have action plans that are generated from ISMR's, Serious Incident reviews and LeDeR reviews but do not hold this in one place to ensure there is accountability and monitoring of actions being completed. It has been identified in previous action plans that we do not have a clear channel of escalation processes when concerns arise in partner agency establishments, for example access to primary care, delayed health interventions in UHL, poor quality of care provided by supported living placements.

PDSA (part 2)

Do (cont.)	
What we do well?	LD services are well known to be at the forefront of reducing health inequalities and improving patient outcomes, LPT LD services have adopted the national agendas to support this and it is believed that our workforce underpin their practice with these national drivers e.g. Transforming Care Programme, NICE Guidelines. We have skills staff members who are trained to complete LeDeR reviews; we have growing and developing relationships with our partner agencies and a shared ambition to improve our culture around learning lessons.
What could we do better?	We have identified time of agenda's to discuss learning lessons but the governance structure needs to be improved to support the efficacy of this. Have a shared space to review incidents and create a forum for learning lessons. Stronger relationships with UHL. Escalating and raising concerns in a timely manner.
How are we going to overcome the problems?	Identify lead professionals to engage in a patient safety focus Agree governance arrangements Strengthen the engagement with LeDeR and ensure information is shared through agreed governance arrangements Improve relationships with UHL and review the roles and functions of the acute liaison nurses in UHL. Better connection with Primary Care Liaison Nurses throughout the LD teams Create a learning lessons exchange forum that will take place at least quarterly with attendance from grass roots level staff and ensuring that there is representation from all disciplines and that the forum's learning is shared locally in their teams. Create a terms of reference for the learning lessons exchange group, initial ideas: • Share themes and action plans from SI's, ISMR's, LeDeR, safeguarding, CQC, mortality reviews • Hold the accountability of actions plans from reviews • Safe space to reflect and review practice and learn lessons • Data is provided on matters arising and escalating concerns from reporting of incidents • Robust rota on the allocation of SI's
Study	
Produce surveys and collect the data **Cultural engagement and improvement in learning lessons** **Complete a thematic review of the data collected to help identify real life problems captured from service users/family/carers and LPT staff**	
Act	
Enter cycle 2 of PDSA or implement based on study phase	

Abbreviations

CQC: Care Quality commission; **ISMR:** Initial Service Manager Review; **UHL:** University Hospitals of Leicester; **LD:** Learning Disabilities **LRI:** Leicester Royal Infirmary **SI:** Serious Incident

Appendix 2. Examples of Learning

Learning Code/Theme	Learning Impact	Learning Action

CHS Q2		
C823: Clinical, medication administration	Opiate medication patch duplicated as new one commenced, current patch not removed.	Automatic reminder to be added to EPMA when administering patch to remove old one.
C514: Clinical, documentation within clinical record	Missing documentation on system one – isolated incident on ward as ward clerk on annual leave.	Ward to nominate a replacement to cover annual leave to mitigate this.
E412: End of life, discharge, discharge planning	Delay in death verification due to low numbers of staff trained to carry out verification.	ANP's to re instigate training and training package in ward areas.
DMH/MHSOP: Q2		
C926: Clinical, recognition	The impact of physical health on patients under the care of mental health services not being considered.	Need to transfer to physical health services earlier Missed opportunities to treat Providing input to patients with SMI on managing chronic physical health and lifestyle to help reduce risks to them.
DMH/MHSOP: Q3 Learning was possible as discussed in most recent LfD meetings		
C24: Clinical, communication, management	The need for teams to be informed by primary care or Mental Health Facilitator about patient not attending annual physical health checks.	The need to consider when other services should be involved such as Safeguarding, MECC, and or the homeless team.
FYPC/LD: Q2		
C718: Clinical care, multidisciplinary working, Inter-speciality liaison/continuity of care/ownership	Required enhanced processes for health visitors to contact the safeguarding advice line.	Included as part of the Quality Improvement work. Quality of safeguarding supervision work and communication.
Learning is from Q3 because this was discussed in most LfD meetings		
C1235: Clinical, omissions in handover communication	Omissions identified in communication between FYPC/LD midwifery	Escalation to Serious Incident to extract impactful actions.
C411: Clinical care discharge equipment	Although safe sleeping advice is provided to mothers, death of this nature still occurs.	A safe sleep risk assessment tool would be beneficial for all multi agency services to use in order to identify sleep positioning and risk factors. This is being escalated with Public Health commissioners and Midwifery.
E718: End of life, Multidisciplinary team working, continuity of care	Consider rapid deterioration of end of life patients and the support provided from FYPC/Diana services.	Reflections within team about activating on call. Alternative method of support (ambulance/GP) is effective however, difficulties associated with setting up on-call as dependency on other Trust medical teams who lead on child's clinical care; resulting in delays in advance care planning and anticipatory planning.

Abbreviations

ANP: Advanced Nurse Practitioner; **EPMA:** Electronic Prescribing and Medication Administration **MECC:** Making Every Contact Count