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Leicestershire Partnership NHS Trust

Public Trust Board – 29th June 2021

Safety and Quality in Learning from Deaths Assurance (Quarter 4)

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 January to March 2021 inclusive (Quarter 4: Q4), as well as data reviewed and learning from Quarter 3 (Q3: October-December 2020) at Leicestershire Partnership Trust (LPT).

2. Analysis of the issue

- The information presented in this report is collated by the patient safety team and allocated to each Directorate; LfD meetings are carried out within each Directorate, with the presence of the Trust Learning from Deaths Lead.
- As a means of improving from Q3, we have confirmed with the information team that demographic data is to be provided from a service level and are taking actions to ensure we have increased demographic data completion.
- Timely LfD meetings continue within Families Young People and Children/Learning Disabilities on a monthly basis, learning themes are extracted prior to monthly meetings and resulting actions discussed in finer detail during monthly LfD meetings.
- There is also greater communication between the mortality team at University Hospitals of Leicester (UHL), coroners, and the LfD team resulting from the set-up of the LfD inbox.
- The LfD lead will also be meeting with the LPT Legal team on a quarterly basis to discuss inquests and learning that could be extracted from such incidents.
- There has been LPT presence at a Draper and Dash workshop which consisted of a presentation by the regional Medical Examiner (ME) about the ME process; which provided insight into how the presence of an ME will strengthen the LfD process in Community and Mental Health Trusts.

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

We are working on strengthening our links with information teams to provide protected characteristics. Demographic information is provided in Tables 1-5 (p.2).

Table 1: Q4 Gender & Age

Gender	Age Bands									
	1-28 (D)	Up to 12 (M)	1-10 (Y)	11-18	19-24	25-44	45-64	65-79	80+	Total
Female	0	0	1	3	2	4	12	19	21	62
Male	0	1	3	0	0	7	15	15	19	60
Total	**0**	**1**	**4**	**3**	**2**	**11**	**27**	**34**	**40**	**122**

Table 2: Q4 Ethnicity

Ethnicity	
English/Welsh/Scottish/Northern Irish /British/Irish	58%
White & Black African	1%
White & Black Carribean	1%
White & Asian	1%
Multiple Ethnic Background	2%
Indian	9%
Pakistani	2%
Any other Asian Background	2%
African	2%
Not Recorded	23%

Table 3: Q4 Religion

Religion	
Christian	16%
Hindu	7%
Jewish	1%
Muslim	4%
Sikh	1%
No Religion	2%
Not recorded	71%

Table 4: Q4 Disability

Disability	
Disability	24%
No Disability	9%
Not recorded	67%

Table 5: Q4 Sexual Orientation

Sexual Orientation	
Heterosexual	7%
Not Applicable	4%
Not Disclosed	5%
Not Recorded	84%

5. Number of Deaths reported and reviewed in Q3

In adherence with NHS/I (2017) recommendations, the number and percentages of deaths reviewed through mSJR case record review and the Serious Incident (SI) process across LPT in Q3 are shown in Table 6:

Table 6: Time lag in reviewing of deaths by Directorate

Q3	Total number of deaths	Review		% of deaths subject to mSJR* Case record review	% of deaths subject to an SI investigation
		mSJR	SI		
	115	106	9	92%	8%
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	23	mSJR	SI		
		23		22	1
		22	1	100%	100%
DMH/MHSOP	84	84		42	6
		77	7	55%	86%
FYPC/LD	8	8		7	1
		7	1	100%	100%

KEY

CHS: Community Health Services; **DMH/MHSOP:** Directorate of Mental Health/Mental Health Services for Older people; **FYPC/LD:** Families Young Persons and Children/Learning Disabilities

6. Learning themes and good practice

6.1 Learning themes identified

Learning and discussions from Q3 within CHS focused on Covid-19 and surveillance swabbing for end of life patients diagnosed with Covid-19. Discussions focused on balancing the need to continue practice as a means of infection prevention versus patient comfort. CHS are continuing surveillance swabbing and are producing a flowchart for guidance and rationale for ward staff (themed into C616: Clinical Care, investigations. E38: End of life, Compassion and attitude).

In Q3 Learning and actions identified within the DMH/MHSOP directorate are associated with clinical recognition (C926) by which the impact of physical health on patients under the care of mental health services need to be given greater consideration. Actions identified to enact this are as follows:

- Transfer to physical health services earlier.
- Provide input to patients with Serious Mental Illness on managing chronic physical health and lifestyle to help reduce risks to them.

In FYPC/LD it was identified that there was a greater need to identify deteriorating patients in a timely manner (C926, Clinical Care recognition of care) and this would be achieved by carrying out in-team reflections. Additional learning from all directorates is provided in Appendix 1 (p.7).

6.2 Examples of good practice

Directorates demonstrated good practice in Q3 for example:

- **CHS:** As evidence of overcoming Covid-19 pressures, CHS have reviewed all their Q3 deaths and extracted learning and actions.
- **DMH/MHSOP:** Patients are regularly seen by the team, and communication with GP's is getting better as patients are also being seen by District Nurses. An emerging priority is considering the wishes of the patient which is an outcome of excellent and trusting relationships with team members.
- **FYPC/LD:** The need for detailed risk assessments for safe sleep was identified from a 72 hour report.

Examples of good practice in the current Quarter (Q4) consisted of:

- **CHS:** Discussions between Consultant Advanced Nurse Practitioner and the Head of Patient Safety have taken place, which focused on understanding the Duty of Candour in relation to Learning from Deaths and Serious Incidents.
- **DMH/MHSOP:** Patients are provided with **r**egular appointments and are aimed to be seen in between if they request medication.
- **FYPC/LD:** It is noticeable that staff are more proactive in recognising deteriorating patients which was evidenced by a physiotherapist in a particular case. An additional learning point was to start discussions about teaching young mothers how to recognise their child's deteriorating presentations.

7. Number of deaths reported during Q4

Table 7 shows the number of deaths reported by each Directorate for Q4. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR) case record reviews:

- There were 122 deaths in Q4.
- There were 8 CDOP deaths which were reviewed using the mSJR case record review within FYPC.
- There were 3 adult deaths of individuals with Learning Disabilities which are undergoing LeDer review, and were reviewed using the mSJR case record review within FYPC.
- There was one child death which will undergo CDOP review. This death was discussed using the mSJR case record review within FYPC to extract timely learning:

Table 7: Number of deaths

Q4 Mortality Data 2020										
Q4	**Jan**			**Feb**			**Mar**			**Total**
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**122**
Number of Deaths	9	24	5	14	30	4	10	24	2	
Consideration for formal investigation										
	C	**D**	**F†**	**C**	**D**	**F†**	**C**	**D**	**F†**	
Serious Incident	1	2	1	0	1	0	0	4	0	**9**
mSJR* Case record review	8	22	4	14	29	4	10	20	*2*	***113***
Number completed	*0*	*7*	*3*	*0*	*5*	*4*	*0*	*0*	*2*	*21*
Learning Disabilities deaths	0	0	3	0	0	1	0	0	0	4
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	-

KEY

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

8. 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.

9. Governance table

For Board and Board Committees:	Trust Board 29.6.21	
Paper presented by:	Dr Avinash Hiremath	
Paper sponsored by:	Professor Al-Uzri	
Paper authored by:	Saydia Razak & Tracy Ward	
Date submitted:		
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 (27th April 2021)	
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	
	Trust wide 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:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	Yes - Demographic data included	

Appendix 1. Examples of Learning

Learning Code/Theme	Learning Impact	Learning Action
CHS Q3		
E24: communication with family, End of life, management.	Discussion with head of patient safety team regarding utilisation of letter inviting feedback from relatives – this is important to support and give the bereaved a voice.	Utilisation to be discussed by (New Lead for CHS mortality) at next forum meeting.
C513: Clinical care, documentation correspondence with patients and family	Clarity on duty of candour requirements achieved following discussions with Head of Patient Safety, in terms of Deaths on community hospital wards.	Discussed with Head of Patient safety – only required if harm was caused.
E515: End of life, completion of clinical forms (Respect).	Identification of Poor completion of RESPECT forms and poor advanced care planning	National end of life audit to commence in April 2021.
DMH/MHSOP: Q3		
C26: Clinical Care, communication with patients, and reasonable adjustments in response to the Pandemic.	COVID-19 and impact of loneliness, lack of social outings and courses not running identified.	Learning to be shared at DMH Quality and Safety to be disseminated to local Quality and Safety Meetings to consider this when interacting with patients.
DMH/MHSOP: Q4 Learning was possible as discussed in most recent LfD meetings		
C718: Clinical Care, multi-disciplinary, and inter-speciality liaison.	The importance of checking the support to access services, which include the GP, whom if the patients are unwell contact, or they can access themselves.	Actions by individual teams escalated to them by representatives of mortality surveillance group.
FYPC/LD: Q3		
C616: Clinical Care and investigations	All infant and child deaths need to be reported through eIRF to enable services to review care provision and identify gaps/good practice.	Deaths are presented at Weekly Incident Review meetings as well as rapidly reviewed within FYPC/LD.
Q4 Learning was possible as discussed in most recent LfD meetings		
C718 Multidisciplinary team working, Inter-speciality liaison/continuity of care/ownership	Incidental findings in a review by Diana services identified a void in evidence of liaison with the GP after the child did not attend for their two year review.	Initiate discussions on reflecting from incidental findings and how we can better communicate with GPs.

Abbreviations

eIRF: electronic Incident Report Form