Q

Leicestershire Partnership NHS Trust

Public Trust Board 31.8.21

Safety and Quality in Learning from Deaths Assurance (Quarter 1)

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 April to June 2021 inclusive (Quarter 1: Q1), as well as data reviewed and learning from Quarter 4 (Q4: January-March 2021) 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 Q4, it is clear that demographic information is not being completed at a service level. We are now emphasising the importance of this data as a means of better understanding and overcoming potential health inequalities.
- We have welcomed 2 LeDer Practitioner nurses who attend the FYPC/LD LfD meetings as a means of timely insight into Learning Disabilities deaths.
- The Band 5 Governance and Quality Assurance co-ordinator (LfD) deaths is now advertised as a means of assisting with LfD process at LPT.
- Work is underway to standardise family feedback through bereavement letters or personalised phone calls.
- DMH/MHSOP has identified a number of themes which contribute to the deaths of patients which include: (1) Social Circumstance, (2) Chronic physical and mental health problems, and (3) Self-harm. These have been recommended to be added as categorised themes.

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

Demographic information is provided in Tables 1-5 (p.2). After working with our Information Team it is clear that demographic information is not being captured at a service level. In order to overcome gaps in demographic information, an in-depth discussion took place during the Trust wide LfD meeting, where it was agreed that we needed Directorate and Board Level Support to mandate the completion of demographic information at the service leevl, potentially as soon as a referral to LPT was initiated.

Table 1: Q1 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	1	0	0	1	6	11	16	21	56
Male	0	2	1	0	0	10	11	24	17	65
Total	**0**	**3**	**1**	**0**	**1**	**16**	**22**	**40**	**38**	**121**

Table 2: Q1 Ethnicity

Ethnicity	
English/Welsh/Scottish/Northern Irish /British/Irish	65%
White & Black Carribean	2%
Indian	12%
Bangladeshi	1%
Pakistani	4%
Any other Asian Background	1%
African	2%
Not Recorded	14%
Total	100%

Table 3: Q1 Religion

Religion	
Christian	15%
Hindu	7%
Muslim	4%
Sikh	1%
Not recorded	74%
Total	**100%**

Table 4: Q1 Disability

Disability	
Disability	33%
No Disability	6%
Not recorded	61%
Total	**100%**

Table 5: Q1 Sexual Orientation

Sexual Orientation	
Heterosexual	21%
Not Applicable	3%
Not Disclosed	2%
Not Recorded	74%
Total	**100%**

5. Number of Deaths reported and reviewed in Q4

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 Q4 are shown in Table 6:

Table 6: Time lag in reviewing of deaths by Directorate

Q4	Total number of deaths	Review		% of deaths subject to mSJR* Case record review	% of deaths subject to an SI investigation
		mSJR	SI		
	127	113	14		
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		mSJR	SI		
		33		31	2
		31	2	100%	100%
DMH/MHSOP		83		61	7
		72	11	85%	64%
FYPC/LD		11		9	1
		10	1	90%	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 associated with deaths in Q4 within the CHS directorate identified the importance of timely reviews as learning can be less effective if too much time has elapsed (themed as: C616: Clinical Care, Investigations). A resulting learning action was to take the learning from the reviews back into Directorate more frequently. Within DMH/MHSOP, Learning from Death discussions focused on the need for increased support for patients to access services outside of DMH/MHSOP, which include the GP, whom if the patients are unwell contact (C718: Clinical Care, multi-disciplinary, and inter-speciality liaison) – which will be fed back into services, as a means of increasing support. In FYPC/LD it was emphasised that there was a need for timely and robust information sharing across multiple agencies (C718: Clinical Care, multi-disciplinary team working continuity of care). A quality review has been organised with AHP/Nursing/safeguarding and Patient safety to develop actions based on the learning. Additional learning from all directorates is provided in Appendix 1 (p.6).

6.2 Examples of good practice

Examples of good practice in the current Quarter (Q1) consisted of:

- **CHS:** Derbyshire Health United (DHU) had thoroughly reviewed and communicated the care provided to CHS EOL patients, as a means of enhancing the use of ReSPECT documentation and to have better informed decision making.
- **DMH/MHSOP:** Actions from CPN in which discussions regarding the end of life and advance care planning were initiated with GP, encouraging connected working to benefit our patients.
- **FYPC/LD:** Diana Team and Physiotherapists went over and beyond to support mother following a patient's death.

7. Number of deaths reported during Q1

Table 7 shows the number of deaths reported by each Directorate for Q1. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR) case record reviews:

- There were 121 deaths in Q1.
- There were a total of 16 deaths which are for Serious Incident Investigation.
- There were 12 adult deaths of individuals with Learning Disabilities which are undergoing LeDer review, and are to be reviewed using the mSJR case record review within FYPC.

Table 7: Number of deaths (Q1)

Q1 Mortality Data 2021										
Q1	**Apr**			**May**			**Jun**			**Total**
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**121**
Number of Deaths	18	23	7	9	19	2	9	26	8	
Consideration for formal investigation										
	C	**D**	**F†**	**C**	**D**	**F†**	**C**	**D**	**F†**	
Serious Incident	1	4	0	1	2	0	1	6	1	**16**
mSJR* Case record review	17	19	7	8	17	2	8	20	*7*	***105***
Number completed	*1*	*2*	*6*	*0*	*0*	*0*	*0*	*0*	*0*	*9*
Learning Disabilities deaths	-	-	5	-	-	2	-		5	*12*
Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	0	0	0	NK	NK	NK	NK	NK	NK	-

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	
Paper presented by:	Dr Avinash Hiremath	
Paper sponsored by:	Professor Al-Uzri	
Paper authored by:	Saydia Razak & Tracy Ward	
Date submitted:	24.8.21	
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 (27th July 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:	na	
False and misleading information (FOMI) considerations:	na	
Positive confirmation that the content does not risk the safety of patients or the public	yes	
Equality considerations:	considered	

Appendix 1. Examples of Learning

Learning Code/Theme	Learning Impact	Learning Action
CHS Q4		
C514: Clinical Care, Clinical documentation within the clinical record	Lack of documentation impacted on case review does not promote good practice. This is an ongoing theme.	Discussed with individual staff member to promote learning.
C24: Clinical Care, Communication, Management	Medical plans are not always followed particularly during the OOH period. Discussion regarding advocacy of nursing staff for patients.	Nurse consultant to monitor via monthly readmission report and learning from death reviews.
DMH/MHSOP: Q4		
C718: Clinical Care, multi-disciplinary, and inter-speciality liaison	Learning from Death discussions focused on the need for increased support for patients to access services outside of DMH/MHSOP, which include the GP, whom if the patients are unwell contact.	Learning to be fedback into services.
DMH/MHSOP: Q1 Learning was possible as discussed in most recent LfD meetings		
C927: Clinical Care, Monitoring, Recognition & Escalation/Ceiling of Care, escalation / Ceiling of Care	Discussed the succinct follow up of patients who do not engage with CAP, and the importance of knowing when to escalate or follow up those patients who exhibit a lack of engagement.	Actions by individual teams escalated to them by representatives of mortality surveillance group.
FYPC/LD: Q4		
C718: Clinical Care, multi-disciplinary team working continuity of care	The need for information sharing across multiple agencies.	A quality review has been organised with AHP/Nursing/safeguarding and Patient safety to develop actions based on the learning.
FYPC/LD: Q1: Learning was possible as discussed in most recent LfD meetings		
C1030: Clinical Care, Known to safeguarding	Discussions surrounded a patient's last contact with LPT and how the patient was on a child protection plan.	Themes and Findings are now shared at Clinical Leadership Forum and DMT Quality and Safety meeting.

Abbreviations

AHP: Allied Health Professional; **CAP:** Central Access Point, **OOH:** Out Of Hospital