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Leicestershire Partnership NHS Trust

Public Trust Board of Directors

Safety and Quality in Learning from Deaths Assurance (Quarter 2)

1. Introduction

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) and NHS Improvement (NHS/I) Framework (2017). The NQB mandates NHS Trusts to collect and publish specified information on deaths on a quarterly basis. This report presents the data from July to September 2021 inclusive, as well as data reviewed from Q1 to represent the expected time lag. This report is additionally presented as evidence that the Leicestershire Partnership Trust (LPT) is continuing to improve and streamline its LfD process (Appendix 1, p. 6).

2. Aims

- To provide the Trust Board confirmation with assurance that there is thorough implementation of NQB Learning from Deaths guidance within the Trust.

3. Demographics

Knowing the demographics of our patients allows the identification of concerns and pre-disposing factors which affect specific populations, resulting in better informed interventions. Currently, demographic information is obtained manually by Directorates (Table 1). The collection of this information in a more robust way is being undertaken by the Quality Group.

Table 1: Q2 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	2	1	5	1	5	10	9	29	62
Male	4	2	2	2	2	12	15	11	23	73
Total	**4**	**4**	**3**	**7**	**3**	**17**	**25**	**20**	**52**	**135**

Future reports will include Disability, Religious orientation, Sexual orientation, and Ethnicity.

4. Mortality Data

In adherence with NHS/I (2017) recommendations, the percentage of deaths reviewed and completed for Q1 are shown in Table 2 (NB: these figures are deaths that have been reviewed in quarter, not the total number of deaths in quarter).

Table2: Time lag in reviewing of deaths by Directorate

Q1	Total number of deaths reviewed	Reviews		% of deaths subject to mSJR* Case record review	% of deaths subject to an SI investigation
		mSJR	SI		
	119	104	15	87%	13%
Breakdown by Directorate				Number and % of deaths subject to mSJR* case record review completed	Number and % of deaths subject to an SI investigation completed
		mSJR	SI		
CHS	34	34	0	100%	0%
DMH/MHSOP	73	69	4	95%	5%
FYPC/LD	12	11	1	92%	8%

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

5. Examples of good practice and What working well in Q2

Learning that has been identified from the review or investigation of deaths concluded in Q2 2021 and can be seen in Appendix 2 (p. 7). A coding and theming method has been implemented to categorise learning in Appendix 3 (p.9) Examples of good practice as a result of learning include:

- **CHS:** Identification of good practice in relation to completion of ReSPECT forms to be shared with primary care colleagues through representation at network group to encourage wider learning.
- **DMH:** Adequate care provided when received. Good assessment and discharge plan. Team offered several face-to-face appointments, support with social aspects – benefits etc, referral to services done.

- **FYPC:** Clear management plan if someone is going in and out of hospital on an ongoing basis with coordinator. To discuss with UHL communication around this issue. Identified themes – multi disciplinary working, communication with other agencies.
  Good end of life care by the Diane Team.

6. Number of deaths reported during Q2

Table 3 shows the number of deaths reported by each Directorate for Q2. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR). The number of reviews completed is also presented.

- There were of 116 In-scope deaths for the Q2.
- There were 9 CDOP deaths which are distributed under "F", and are included in the total number of deaths in Table 3.
- There was 1 death in Q2 which was more likely than not to have been due to problems in the care provided.

Table 2: Number of deaths (Q2)

Q2 Mortality Data 2021										
Q2	**July**			**August**			**September**			**Total**
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	
Number of Deaths	9	23	4	10	19	18	15	24	4	**126**
Consideration for formal investigation										
	C	**D**	**F†**	**C**	**D**	**F†**	**C**	**D**	**F†**	
Serious Incident	0	2	0	0	1	1	0	1	0	**3**
mSJR* Case record review	9	15	3	10	4	3	15		*17*	***53***
Number completed	9	21		0	6		0	0		**36**
Learning Disabilities deaths			1			1			2	***4***
Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	0	0	0	0	0	1	0	0	0	**0**

KEY

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

***LPT implements a modified mSJR to review all deaths In-scope. In-scope and Out of scope deaths are defined in Section 4.0 of the Learning from Deaths Policy.

† FYPC case review all deaths and are included in the mSJR case record review total count.

7. Recommendations

We recommend that the Trust Board is assured that the LPT LfD Process is in line with NQB guidance and note steps have been taken:

- To ensure the sustainability of robust data comparable across all Directorates.
- To provide clear understanding of our current situation.
- To establish systems for gathering active learning.

8. Discussion

The LfD process is undergoing review. The LfD group is prioritising the following key areas:

- Improved reporting of mortality data.
- Transparency in report and review time lag.
- Establish a robust LfD process, which considers variation in practice amongst Directorates.

Collaborative working between the Patient Safety Team, Directorates, and their administration teams has introduced opportunities to embed the LPT *"Step up to Great"* ethos.

9. Conclusion

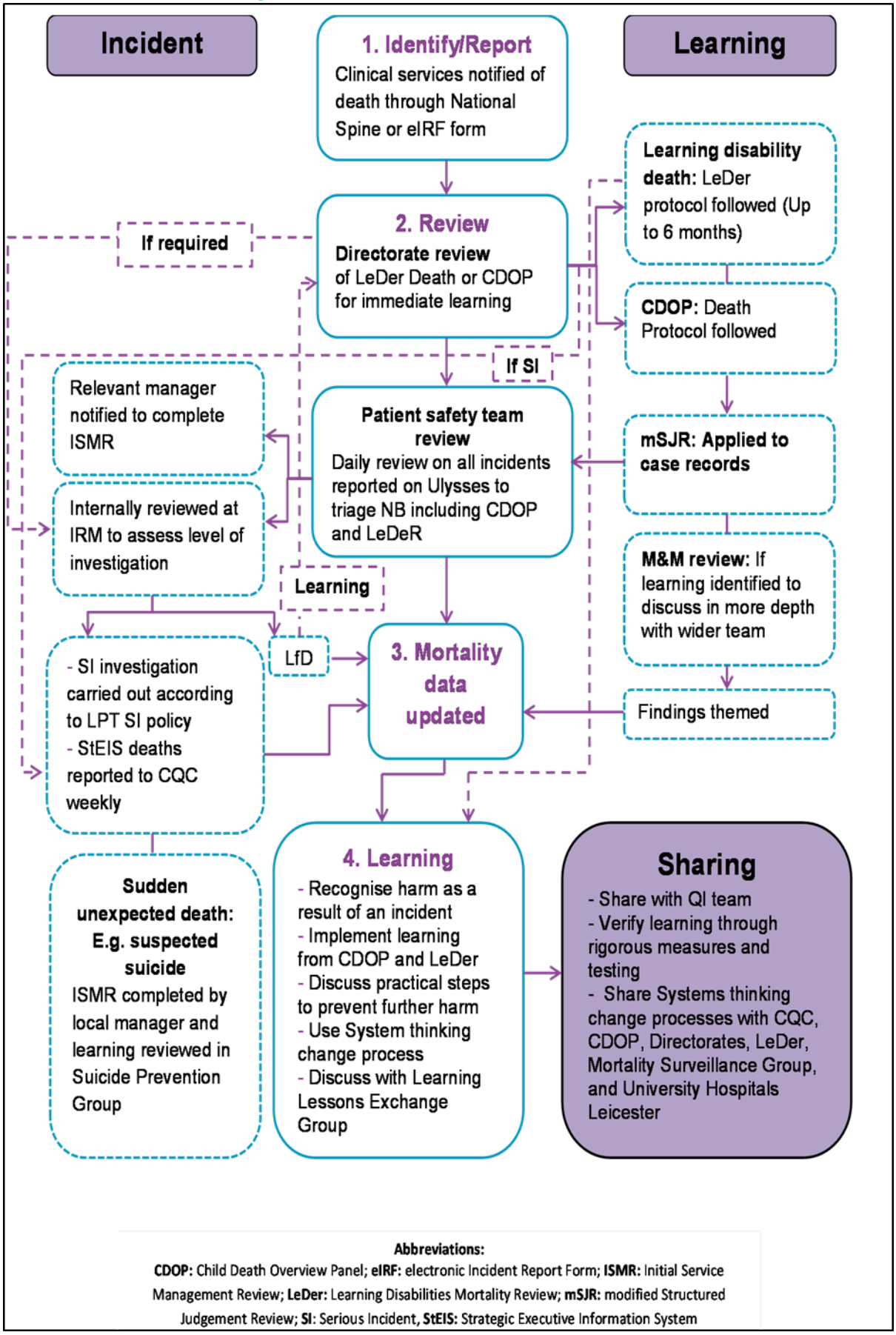
This quarter has presented the continuation of a transitionary period for the LfD process at LPT. The transition is a result of a review of the LfD process and a change in personnel. The recognition of variation and challenges associated with collecting and reviewing data have been a positive outcome. The need to place more focus on learning impact and implementing learning actions are our next priority.

10. Governance table

For Board and Board Committees:	Trust Board
Paper presented by:	Dr Avinash Hiremath
Paper sponsored by:	Professor Al-Uzri
Paper authored by:	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 (26th October 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:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

Appendix 1. **Learning from Deaths Process**



Appendix 2. Examples of learning

Learning Code/Theme	Learning Impact	Learning Action
CHS Q1		
E514**: End of life care, documentation, clinical documentation within the clinical record**	Last days of life paperwork not currently completed on electronic record – scanned onto system one. On structured review paperwork often missing or difficult to locate. Assurance required that it is being completed – assured that care carried out and paperwork completed as this is reflected in the patient notes.	A communication has gone out to ward clerks to ensure paperwork is scanned onto system one. Work being undertaken with IT to develop electronic version for completion in system one.
DMH/MHSOP: Q1		
C412: **Clinical care, discharge, discharge planning**	-Void in communication in physical care follow up. -Patients with substance misuse problem DNA. -Cancelled appointments can result in negative coping mechanisms.	-GP will receive a copy of the correspondence to patients to ensure GP checks on the patient's physical wellbeing. -Create an appointments code/theme to address DNA complications. -Outpatient booking systems needs review - Space needed for urgent reviews
C927: **Clinical care, Monitoring, recognition & Escalation/Ceiling of Care, escalation/ceiling of care.**	-Void amongst support workers in escalating health concerns when patients not compliant with medications (physical and mental health).	-Educating support workers in escalating to medics/senior clinicians when abnormal physical health parameters
C718: **Clinical care, multi-disciplinary team working, inter-speciality liaison/continuity of care/ownership**	- Supporting patients who have substance misuse and mental health problems.	-Share learning across primary and secondary care.
FYPC/LD: Q1		
E24**: End of Life, communication, patients & relatives, results/management/discharge plan**	Supporting families with bereavement.	-Reports to be shared with families when signed off by the CCG.
C720: **Clinical care, multidisciplinary team working**	Supporting staff to learn from deaths.	**-**Reports to be shared with staff when signed off by the CCG.

C1020: **Clinical care, transfer & handover**	- Resulting from an incident based on stepping down of care from CAMHS Crisis team to CAMHS outpatients team.	- Following stepping down care form a crisis, a follow up appointment should be negotiated and appointed as a safeguard. -Require an appointments theme to ensure a review of practice within CAMHS for patients who are not brought to appointments to ensure that practice is in line with policy.

Abbreviations

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

Appendix 3. Themes Guidance

Cat	Th	Th Code	Theme & Sub Themes	Sub Theme Codes	Theming Code Combos
	Ass	**1**	**Assessment, Diagnosis & Plan**		
C or E	Ass		Assessment	1	C11 C12 C13 E11 E12 E13
C	Ass		Diagnosis	2	
C or E	Ass		Management plan	3	
	Com	**2**	**Communication – Patients & Relatives**		
C or E	Com		Results/Management / Discharge Plan	4	C24 C25 C26 E24 E25 E26
E	Com		Imminence of death, DNACPR, Prognosis	5	
C or E	Com		Reasonable adjustments	6	
	D&C	**3**	**Dignity & Compassion**		
C or E	D&C		ADL Assistance/ Reasonable Adjustments	7	C37 C38 C39 E37 E38 E39
C or E	D&C		Compassion / Attitude	8	
C or E	D&C		Environment	9	
	Dis	**4**	**Discharge**		
C	Dis		F/up management plan	10	C410 C411 C412 E410 E411 E412
C or E	Dis		Equipment/POC	11	
C or E	Dis		Discharge Planning	12	
	Doc	**5**	**Documentation - Paper & Electronic**		
C or E	Doc		Correspondence – with patients, other clinical teams	13	C513 C514 C515 E513 E514 E515
C or E	Doc		Clinician documentation within the clinical record	14	
C or E	Doc		Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	15	
	Inv	**6**	**Investigations & Acting on Results**		
C	Inv		Investigations	16	C616 C617 E616 E617
C	Inv		Results	17	
	MDT	**7**	**Multi-Disciplinary Team Working**		
C or E	Mdt		Inter-speciality liaison/continuity of care/ownership	18	C718 C719 C720 E718 E719 E720
C or E	Mdt		Inter-speciality referrals/review	19	
C or E	Mdt		Inter team issues (within same specialty)	20	
	Med	**8**	**Medication**		
C or E	Med		Prescribing	21	C821 C822 C823 C824 E821 E822 E823 E824
C or E	Med		Supply	22	
C or E	Med		Administration	23	
C or E	Med		Review	24	
	Mon	**9**	**Monitoring, Recognition & Escalation/Ceiling of Care**		
C or E	Mon		Monitoring	25	C925 C926 C927 E925 E926 E927
C or E	Mon		Recognition	26	
C or E	Mon		Escalation / Ceiling of Care	27	
	Tr	**10**	**Transfer & Handover**		
C or E	T&H		Delays to correct speciality/setting	28	C1028 C1029 C1030 E1028 E1029 E1030
C or E	T&H		Inappropriate Outlying / Transfer arrangements incl where pt not clinically fit for transfer, or inappropriate transfer arrangements to take into account level of acuity	29	
C or E	T&H		Omissions/Errors in Handover communication	30	

Abbreviations: ADL: Activities of Daily Living; **POC:** Point of Care; **DNACPR:** Do Not Attempt Cardio Pulmonary Resuscitation