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Public Trust Board of Directors

Leicestershire Partnership NHS Trust

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 2021 inclusive (Quarter 3: Q3) as well as data reviewed and learning from Q3 and previous quarters not already reported, 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.
- There remains a theme around the full and accurate gathering of demographic information. This is not being consistently completed at a service level (particularly Disability, sexual orientation and Religion). We are however emphasising the importance of this data as a means of better understanding and overcoming potential health inequalities.
- The Band 5 Governance and Quality Assurance co-ordinator LfD commenced in post on 25th October 2021 and has been assisting Directorates with LfD process.
- CHS Community Hospitals review deaths recorded via eIRF to identify and facilitate learning and improve practice and patient care. This is achieved in two ways. Documentation is reviewed by members of a clinical team on a monthly basis via a pro forma to identify good practice and to identify areas where improvement or actions may be required. There is then a recommendation for a proportion of these to be discussed at a quarterly forum. These presentations allow discussion in greater detail and reflection with actions from the learning being implemented. Individuals that were caring for the patient are also involved allowing for real time learning and reflection.
- CHS's greatest reflection and learning is from the forum meeting however there is discussion and actions from the screening meetings. From December 2021, the screening meetings have a formal agenda and minutes taken as well as any actions arising from screening meeting being added to the action log.
- CHS There will be a mandated requirement to report all deaths to the medical examiner from April 2022. A process for this has commenced in CHS. All patients' relatives will be contacted via this process with the opportunity to give feedback positive or for improvement to CHS.
- DMH have been challenged in being able to convene meetings and have a recovery plan in place.
- FYPC/LD have worked to refresh their 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

Demographic information is provided in Tables 1-5. 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 level, potentially as soon as a referral to LPT was initiated. An initial meeting has been held and further investigation is required. A further meeting will take place in a months time.

Table 1: Q3 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	5	2	0	3	0	4	9	15	25	63
Male	2	5	3	2	3	9	24	16	26	90
Total	**7**	**7**	**3**	**5**	**3**	**13**	**33**	**31**	**51**	**153**

Key: D: Day; **M:** Months; **Y:** Years

Table 2: Q3 Disability

Disability	
Disability	0
No Disability	0
Disability not recorded / not known	153
Total	**153**

Table 3: Q3 Religion

Religion	
Buddhist	0
Christian	2
Hindu	0
Jewish	0
Muslim	0
Sikh	0
Other	0
Not recorded / not known	151
No religion	0
Total	**153**

Table 4: Q3 Sexual Orientation

Sexual orientation	
Bisexual	0
Heterosexual	0
Homosexual	0
None recorded	153
Not Disclosed	0
Not applicable	0
Total	**153**

Table 2: Q3 Ethnicity

Ethnicity	
White	
English / Welsh / Scottish / Northern Irish / British / Irish	110
Any other White background	1
Mixed / Multiple ethnic groups	
White and Black African	1
White and Asian	1
Asian / Asian British	
Indian	8
Pakistani	1
Any other Asian background	6
Black / African / Caribbean / Black British	
African	4
Any other Black / African / Caribbean background	1
Other ethnic group	
Not recorded / Not known	20
Total	153

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 3: Annual backlog of deaths

Breakdown by Directorate									
	CHS			**DMH/MHSOP**			**FYPC/LD**		
	Q1 (Apr-Jun)	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q1 (Apr-Jun)**	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q1 (Apr-Jun)**	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**
Number of deaths reviewed	39	34	45	57	39	32	6	30	16***
Percentage of deaths reviewed	90%	65%	16%	80%	52%	42%	43%	83%	58%
Number of deaths outstanding for Directorate review	4	12	38*	14	36**	45**	8	6	15
Percentage outstanding for directorate review	10%	35%	84%	20%	48%	58%	57%	17%	52%

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

*CHS Allocation of December's reviews deferred to February 22.
**DMH September, October, November and December reviews for DMH are awaiting allocation.
*** FYPC this figure includes 13 Neonatal Out of Scope deaths which do not require discussion at LfD meetings

CHS

- The LFD forum meeting due to be held on 21st January 2022 was postponed due to the step down of Level 2 meetings and clinical commitments of staff engaged with Surge which has resulted in a backlog of reviews.
- The plan to recover the backlog of reviews of deaths;
    - Deaths that occurred in December 2021 were circulated for review w/c 31st January 2021 and discussed at the Screening meeting held on 22nd February 2022.

DMH(MHSOP)

- The DMH meeting due to be held on 21st December 2021 was postponed due to the step down of Level 2 meetings which has resulted in an increased backlog of reviews.
- DMH meetings were restarted in March 2022 and dates have been agreed for the next financial year 1st April 2022 to 31st March 2023. DMH will meet monthly on 1st Tuesday of the month.
- The plan to recover DMH's backlog of reviews of deaths is to meet twice monthly in March, April and May on the 2nd Tuesday of the month until caught up. This will be reviewed again in May's meeting and further additional meetings arranged if necessary.
- MHSOP have 4 outstanding reviews, 2 from Quarter 2 and 2 from Quarter 3.

FYPC/LD

- Report disseminated through the FYPC LD Clinical Leadership Forum.
- There is a new process for learning and reviewing deaths for people with a learning disability. The clinician who reported the death with complete an Adult Learning Disability Deaths Review form which is based on the IRM but also includes the learning elements from the Learning form Deaths Quality & Safety Review form.
- Not all adult deaths in December have been added to Ulysses (this is being addressed)

5.1 Learning themes identified

Learning and discussions associated with deaths in Q3 within the CHS directorate identified the importance of timely reviews as learning can be less effective if too much time has elapsed. A resulting learning action was to take the learning from the reviews back into Directorate more frequently. The use of NEWS2 and it's associated escalation remains a theme and there is a programme of work to support this. There has been an additional risk associated with the switch to BRIGID which is also being addressed. 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 and the wider voluntary sector, acknowledging patients may be too unwell to initiate this 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) and a need to develop a process to identify complex patients needing care coordination. Additional learning from all directorates is provided in **Appendix 1.**

5.2 Examples of good practice

Examples of good practice in the current Quarter Q3 and previous quarters not already reported consisted of:

- **CHS:** Some examples of good communication with families

- **DMH/MHSOP:** Evidence of CPN's building really good supportive relationships for patient and families
- **FYPC/LD:** have developed a process for weighing of patients in the community to support their care

6. Number of deaths reported during Q3

In adherence with NHS/I (2017) recommendations Table 7 also 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) case record reviews:

- There were 153 deaths considered in Q3.
- There were a total of 11 deaths which are for Serious Incident Investigation.
- There were 11 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 (Q3)

Q3 Mortality Data 2021										
Q3	**Oct**			**Nov**			**Dec**			**Total**
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**153**
Number of Deaths	11	21	10	17	30	10	17	26	11	
Consideration for formal investigation										
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**Total**
Serious Incident	0	6	0	0	4	0	0	1	0	**11**
mSJR* Case record review	11	21	10	17	30	10	17	26	11	**153**
Learning Disabilities deaths			2			2		7		**11**
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	0	0	0	0	**0**

KEY

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

7. 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.

8. Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper presented by:	Dr Avinash Hiremath	
Paper sponsored by:	Professor Al-Uzri	
Paper authored by:	Tracy Ward/Evelyn Finnigan	
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):	N/A due to no meeting	
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	
	Reaching Out	
	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. Examples of Learning identified, both good practice and areas for improvement

Learning Code	Theme	Learning impact & Action
CHS		
E5 Documentation - Paper & Electronic	15 Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	Nursing and ANP documentation clear and easy to follow. Due to rapid deterioration – End-of-life paperwork not completed. Outpatient needs to communicate with the ward if possible. Observation and escalation of screening for Sepsis. Trust wide programme in training and escalation in NEWS2 and Sepsis screening.
8 Medication	23 Administration (meds)	Staff to escalate refusal of medication to allow remedial action to be taken.
1 Assessment, Diagnosis & Plan	3 Management plan	Ensure all plans are scanned and kept in a consistent location for ease of staff reference and to be available and seen by staff.
E5 Documentation - Paper & Electronic	13 Correspondence – with patients, other clinical teams	Good communication with family & patient's partner.
DMH/MHSOP		
2 Communication	5 Imminence of Death/DNACPR/Prognosis	Patient had RESPECT form completed at UHL, not LPT. He reported that this had not been discussed with him first. A reminder to discuss RESPECT forms with NOK in advance when possible.
9 Ceiling of care	27 Escalation / Ceiling of care	Physical health deterioration since the admission leading to dehydration and electrolyte imbalance should have been escalated sooner. Patient was admitted to UHL and died of cardiac arrest. Signs of dehydration to be monitored and recognised and escalated promptly. Trust Task & Finish Group (Sub group of deteriorating patient and resus group) to develop and produce guidance and training.
2 Communications	4 Results/Management / Discharge Plan	Daughter was very thankful to the CPN for the support she provided from a mental health perspective and liaising with social care.
1 Assessment	1.1 Assessment	Good core assessment. Clinician had clearly identified risk and protective factors.
2 Communications	2.5 Imminence of Death/DNACPR/Prognosis	The CMHT- CPN and HCSW- kept in contact with the patient's husband when she was admitted to UHL. They made a plan to discharge her when it was clear that she was receiving end of life care.
2 Communications	4 Results/Management / Discharge Plan	Patient and care home supported by Care Home In reach team.

7 Multi-disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership	Good working between the CMHT and Unscheduled care Service. Breach process in place and working appropriately.
7 Multi-disciplinary Team Working	19 Inter-speciality referrals/review	Standard MDT practice including joint working with Safeguarding.
1 Assessment, Diagnosis & Plan	3 Management Plan	Remained under care of DMH services.
2 Communications	4 Results/Management / Discharge Plan	CMHT were very supportive and responsive.
2 Communications	4 Results/Management / Discharge Plan	Good communication with MDT and with the family.
7 Multi-disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership	Thorough assessment of need. Multi-disciplinary working.
2 Communications	4 Results/Management / Discharge Plan	CPN updated the notes regularly and liaised with others- including family and Admiral nurse.
5 Documentation – Paper & Electronic	14 Clinician documentation within the clinical record	
2 Communications	4 Results/Management / Discharge Plan	Good communication between LPT, family and GP.
7 Multi-disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership	
FYPC/LD		
C10 Transfer & Handover	30 Omissions/Errors in Handover communication.	Service to ensure Safeguarding referral had been done. Investigation identified that the Ambulance Service had completed the Safeguarding referral.
7 Multi-Disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership	Need to identify a Lead Practitioner to co-ordinate care across LD community services where multi services involved
3 Dignity & Compassion	7 ADL Assistance/Reasonable Adjustments	Weighing patients with learning disabilities, especially weighing patients in wheelchairs.
9 Monitoring, Recognition & Escalation/Ceiling of Care	25 Monitoring	Continuation of care for patients with complex needs and nurse oversight (i.e., patients under diffident specialities for example physio and speech and language who become unwell but haven't had any nurse oversight).
C&E7 Multi-Disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership 19 Inter-speciality referrals/review	Placed on end of life. Happened over weekend so acute liaison nurses did not have input. Sister said main issue is did they know brother had an LD and was in pain. Was his pain relief handled properly? She has raised this with LRI issues related to people with LD. If a weekday may have been better liaison/care. staff at hospital needed training to communicate better with patients with Learning disability