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Public Trust Board 31st May 2022

Leicestershire Partnership NHS Trust

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 2022 inclusive (Quarter 4: Q4) as well as data reviewed and learning from Q4 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.
- Learning from deaths review meetings were Level 2 meetings and as such stepped down. Each directorate has a recovery plan in place to catch up with the back log of reviews.
- 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.
- FYPC/LD have worked to refresh their process in respect of Adult deaths.

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. We await further guidance from the directorates on how this is progressing.

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	1	4	0	0	6	10	11	34	68
Male	1	0	0	3	1	7	14	14	37	77
Unknown	1	0	0	0	0	0	0	0	0	1
Total	**2**	**1**	**4**	**3**	**1**	**13**	**24**	**25**	**71**	**144**

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

Table 2: Q4 Disability

Disability	
Disability	0
No Disability	0
Disability not recorded / not known	144
Total	**144**

Table 3: Q4 Religion

Religion	
Buddhist	0
Christian	1
Hindu	1
Jewish	0
Muslim	0
Sikh	0
Other	0
Not recorded / not known	142
No religion	0
Total	**144**

Table 4: Q3 Sexual Orientation

Sexual orientation	
Bisexual	0
Heterosexual	0
Homosexual	0
Not recorded / not known	144
Not Disclosed	0
Not applicable	0
Total	**144**

Table 2: Q4 Ethnicity

Ethnicity	
White	
English / Welsh / Scottish / Northern Irish / British / Irish	105
Any other White background	2
Mixed / Multiple ethnic groups	
White and Black African	1
White and Black Caribbean	1
Any other Mixed / Multiple ethnic background	2
Asian / Asian British	
Indian	3
Any other Asian background	3
Black / African / Caribbean / Black British	
African	1
Caribbean	1
Other ethnic group	
Not recorded / Not known	25
Total	**144**

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 3: Annual backlog of deaths

Breakdown by Directorate												
	CHS				**DMH/MHSOP**				**FYPC/LD**			
	Q1 (Apr-Jun)	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q4 (Jan-Mar)**	**Q1 (Apr-Jun)**	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q4 (Jan-Mar)**	**Q1 (Apr-Jun)**	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q4 (Jan-Mar)**
Number of deaths reviewed	34*	22*	21*	3	57	43	45	53	6	30	16 ***	7
Percentage of deaths reviewed	92%	65%	47%	7%	80%	57%	58%	65%	43%	83%	52%	39%
Number of deaths outstanding for Directorate review	3	12	24	41	14	32	32**	29**	8	6	15	11
Percentage outstanding for directorate review	8%	35%	53%	93%	20%	43%	42%	35%	57%	17%	48%	61%

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

* Data validation exercise for CHS identified 6 less cases in Q1 and 12 less in Q2 than previously reported. Furthermore the number of deaths reviewed for Q3 was 7, not 45.
** December, January & March's 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

- Where patient feedback from the medical examiner is received, this is included in the learning from death reviews.

DMH/MHSOP

- DMH Meetings were arranged for 1st Tuesday of the month however this clashed with the SI sign off meetings so has been re-arranged to the 2nd Tuesday of the month.
- MHSOP have no reviews outstanding from previous quarters and 10 reviews outstanding from Quarter 4.

FYPC/LD

- 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.

5.1 Learning themes identified

Learning and discussions associated with deaths in Q4 within the DMH identified that there were some examples of cases where it was not documented that families had been contacted following the death of a patient known to LPT therefore Dr Fabida Aria, Chair to write to all services re reminder to contact family following death to offer condolences. And in MHSOP, it was identified that some RESPECT forms completed by other organisations weren't as good as they could be, so a general discussion around this and what to do in these cases took place at their MCM meeting on 21st March 22. Within FYPC/LD, Learning from Death discussions identified that not all deaths were being routinely recorded on Ulysses so an email was circulated to staff to remind them to do so. Additional learning from all directorates is provided in Appendix 1.

5.2 Examples of good practice

Examples of good practice in the current Quarter Q4 and previous quarters not already reported consisted of:

- **CHS:** There were some examples of good communication with families. There was also an excellent example of meeting a patient's family's spiritual needs by arranging a Chaplin to visit prior to the patient passing away.
- **DMH/MHSOP:** There were multiple examples of Good Multiple disciplinary working and good communication with patients and their families during their care.
- **FYPC/LD:** Good practice and good management plans were noted .

6. Number of deaths reported during Q4

In adherence with NHS/I (2017) recommendations Table 7 also 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 144 deaths considered in Q4.
- There were a total of 4 deaths which are for Serious Incident Investigation.
- There were 9 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 (Q4)

Q4 Mortality Data 2021										
Q4	**Jan**			**Feb**			**Mar**			**Total**
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**144**
Number of Deaths	16	24	1	15	28	12	13	30	5	
Consideration for formal investigation										
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**Total**
Serious Incident	0	3	0	0	1	0	0	0	0	**4**
mSJR* Case record review	16	24	1	15	28	12	13	30	5	**144**
Learning Disabilities deaths			1			5			3	**9**
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 31.5.22	
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		
Good practice		
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	Good communication with family
2 Communication – Patients & Relatives	5 Imminence of death, DNACPR, Prognosis	Good clear documentation about deterioration both from the nursing staff and ANP. OOH review – as per notes – palliative / eol care started – d/w family – good approach from ooh clinician. AR to feedback to clinician / ward re good practice.
9 Monitoring, Recognition & Escalation/Ceiling of Care	27 Escalation / Ceiling of Care	Excellent escalation process.
3 Dignity & Compassion	8 Compassion / Attitude	Family visited and Chaplin arranged really quickly to meet spiritual needs.
DMH/MHSOP		
Learning		
5 Documentation – Paper & Electronic	14 Clinician documentation within the clinical record	Whilst this would have not impacted on the patient's death it would be beneficial to follow up on agreed actions. The patient did not receive any further face to face visits from the CPN following the initial assessment in July 2021. A documented rationale for this would have been beneficial.
2 Communication – Patients & Relatives	6 Reasonable adjustments	Some impact on change of professional seeing patient and to be minimised as much as possible. Patient had not asked for eligible benefits for many years and was living off an inheritance. It may help to explore finances and support needed
3 Dignity & Compassion	8 Compassion / Attitude	No evidence of call to family after death due to physical health related death. Dr Fabida Aria, Chair to write to all services re reminder to contact family following death to offer condolences.
Good practice		
7 Multi-Disciplinary Team Working	20 Inter team issues (within same specialty)	Good MDT working , awaiting commencement of treatment for Alzheimer's disease
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	Good responsive care – good liaison with family. Referral to CMHT as high priority and allocated CPN the next day who made contact and arranged visit for 2 days later.

2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	Maintained regular contact with the son.
7 Multi-Disciplinary Team Working	20 Inter team issues (within same specialty)	Evidence of good MDT working.
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	CPN reviewed the patient regularly and maintained contact with her daughter.
9 Monitoring, Recognition & Escalation/Ceiling of Care	25 Monitoring	Good level of care from the CMHT
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	Good care provided by LPT, quite assessment with a plan the patient agreed to.
7 Multi-Disciplinary Team Working	19 Inter-speciality referrals/review	Effective triage from CAP in that information gathered lead to correct decision to refer on to Crisis
1 Assessment, Diagnosis & Plan	1 Assessment	Patient accessed service through duty system and was offered same day face-to-face appointment.
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	End-of-Life documentation (died at home with husband as wished), good collaborative working, had very clear plan for both admission with regular community reviews.
Actions taken in response to identified themes and issues		
5 Documentation – Paper & Electronic	15 Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	MHSOP had a general discussion around Respect forms received from other organisations at their MCM meeting on 21st March 22.
FYPC/LD		
Good practice		
C1 Assessment, Diagnosis & Plan	3 Management plan	Good day to day care & good practice.
C1 Assessment, Diagnosis & Plan	3 Management plan.	Good practice.
C1 Assessment, Diagnosis & Plan	3 Management plan	Good practice with well management plans.
7 Multi-Disciplinary Team Working	20 Inter team issues (within same specialty)	Peer working ensures all aspects of care covered when dealing with complex patients.
Actions taken in response to identified themes and issues		
Reminder to staff that an EIRF needs to be completed following a patient death.		