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Public Trust Board of Directors

Leicestershire Partnership NHS Trust

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 2022 (Quarter 1: Q1) as well as learning from Q1 and previous quarters not already reported, at Leicestershire Partnership Trust (LPT).

2. Analysis of the issue

- The information presented in this report is based on reports submitted from the directorates and collated by the Learning from Deaths Governance and Quality Assurance Coordinator within the patient safety team. LfD meetings are carried out monthly 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). Ongoing work with directorates to emphasise the importance of this data as a means of better understanding and overcoming potential health inequalities.
- Community Hospitals deaths are recorded via an eIRF to identify and facilitate learning and improve practice and patient care. Following the ME process, where areas of potential learning or good practice have been identified, these will be discussed at a LfD forum meetings. 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.
- LfD forms have basic demographics added from Ulysses and include notes from the weekly Incident Review Meeting (IRM) if discussed as well as a copy of the ISMR.
- CHS and DMH have recovery plans in place with good progress for the backlog from previous quarters reported in Q4 report.
- FYPC/LD continue to report the lack of senior clinical leadership role (Associate Medical Director) which is affecting its ability to deliver against LfD requirements. FYPC/LD are currently reviewing the format of their LfD meetings for better use of limited resources.

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. The Corporate Patient Safety Team are awaiting further guidance from the directorates and are liaising with the Contract Team to understand what work is in progress.

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	2	2	0	0	7	10	10	22	53
Male	0	2	2	1	0	*7	11	20	29	72
Total	**0**	**4**	**4**	**1**	**0**	**14**	**21**	**30**	**51**	**125**

Key: D: Day; **M:** Months; **Y:** Years *Includes 1 transgender male

Table 2: Q1 Disability

Disability	
Disability not recorded / not known	125
Total	**125**

Table 3: Q1 Religion

Religion	
Christian	1
Not recorded / not known	124
Total	**125**

Table 4: Q1 Sexual Orientation

Sexual orientation	
Not recorded / not known	125
Total	**125**

Table 2: Q1 Ethnicity

Ethnicity	
White	
English/Welsh/Scottish/Northern Irish/British/Irish	93
Any other White background	1
Mixed / Multiple ethnic groups	
White and Black Caribbean	1
Any other Mixed / Multiple ethnic background	3
Asian / Asian British	
Indian	5
Chinese	1
Black / African / Caribbean / Black British	
Caribbean	1
Other ethnic group	
Not recorded / Not known	20
Total	**125**

5. Backlog of reviews of deaths

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 are shown in Table 6:

Table 3: Annual backlog of deaths

Breakdown by Directorate						
	CHS		**DMH/MHSOP**		**FYPC/LD**	
	Q1-Q4 (1st April 21 to 31st March 22)	**Q1 (April 22 to June 22)**	**Q1-Q4 (1st April 21 to 31st March 22)**	**Q1 (April 22 to June 22)**	**Q1-Q4 (1st April 21 to 31st March 22)**	**Q1 (April 22 to June 22)**
Number of deaths reviewed	156	41	279	38	*91	13
Percentage of deaths reviewed	96%	100%	90%	58%	92%	68%
Number of deaths outstanding for Directorate review	6	0	31	27	8	6
Percentage outstanding for directorate review	4%	0%	10%	42%	8%	32%

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

* FYPC this figure includes 13 Neonatal Out of Scope deaths which do not require discussion at LfD meetings

The focus for Q1 for all directorates has been to put recovery plans into place and catch up with the back log of reviews.

CHS

- Additional hours were secured, and all backlog cases were allocated to a team of ANPs. Following this initial review and screening process, the cases that have no action or learning were signed off. The cases that needed further review/discussion were discussed at LFD Forum meetings to identify any learning and actions.
- Where patient feedback from the medical examiner had been received, this was included in the LfD form.

DMH/MHSOP

- Additional hours were secured for DMH to allow dedicated time for clinicians to complete reviews which is ongoing.
- DMH have reviewed and confirmed membership of the group.
- DMH have also re-arranged their meeting to take place on the 3rd Tuesday of the month from August onwards to avoid clashing with SI sign off meetings.
- MHSOP have 1 review outstanding from last financial year and 6 outstanding from Q1 this financial year.

FYPC/LD

- The Adult Learning Disability Death's process is embedded and allows for the LD Governance Team to raise queries and resolve issues prior to submitting the Adult Disability Deaths Review Form to the LFD meeting.
- FYPC/LD are currently reviewing the format of their LfD meetings for better use of limited resources.

In adherence with NHS/I (2017) recommendations Table 7 also 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 125 deaths considered in Q1.
- There was a total of 1 death for Serious Incident Investigation.
- There were 10 adult deaths of individuals with Learning Disabilities which are undergoing LeDer review within FYPC.

Table 7: Number of deaths (Q1)

Q1 Mortality Data										
	Apr			May			Jun			Total
	C	D	F	C	D	F	C	D	F	
Number of Deaths	13	22	5	16	24	8	12	19	6	125
Consideration for formal investigation										
	C	D	F	C	D	F	C	D	F	Total
Serious Incident	0	1	0	0	0	0	0	0	0	1
mSJR* Case record review	13	22	5	16	24	8	12	19	6	125
Learning Disabilities deaths			2			3			5	10
Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	0	1	0	0	0	0	0	0	0	1

KEY

6. Learning themes identified

CHS

Learning and discussions associated with deaths within the CHS directorate in the last financial year, 1st April 21 to 31st March 22 identified the importance of ensuring that End-of-Life documentation is scanned onto SystmOne. Discussions have taken place at Ward Clerk meetings to reiterate the importance of doing so (E5.14 Documentation and Clinical Documentation within Clinical Record). In addition, it was highlighted that Ward Nursing staff/ ANP should check the completeness of ReSPECT forms and highlight any issues to ANP/ Out of hours/ Consultant if necessary (3.8 Dignity & Compassion and compassion and attitude). In Q1 of this financial year, UHL's ME's office confirmed that there were no deaths in quarter 1 for Community Hospital Deaths where the ME's office felt that there was any potential learning to be fed back to LPT.

There are three themes that be the focus for Quarter 2;

- RESPECT forms - There is always room for improvement, these are often revisited on admission and re written.
- Patient care management plans - Nurses rely on management plans to use in SBAR to OOH Dr's etc.
- Lack of access to SystmOne – It is concerning that agency nurses did not have access as it is essential to have access to SystmOne as a basic standard. Access to SystmOne is necessary to provide safe patient care. This results in substantive staff having to document for the whole ward.

Leon Ratcliffe, Advanced Nurse Practitioner and LfD lead will develop action plans.

DMH/MHSOP

Within DMH/MHSOP, a theme was identified around the lack of documented contact with families to offer condolences and support when patient's known to LPT had passed away. The chair wrote an email to all services remaining them to the importance of contacting families/relatives to highlight this issue with their staff (3.8 Dignity & Compassion and compassion and attitude). In addition, there was a case where it appeared that no action had been taken to address the patient's physical health when they were found in distress. This has been raised as a concern with the Corporate Patient Safety Team and an ISMR requested for discussion at IRM (C9.26 Monitoring, Recognition & Escalation/Ceiling of Care and Recognition).

There are three themes from LfD reviews that be the focus for Quarter 2;

- **Family contact –** There is a lack of documented contact with Nok/Family to offer condolences and support.
- **Post DNA contact –** Consideration to contact Nok/Family member post DNA.
- **Notification of death –** In some instances services are finding out about a death rather than being told. This may be as a result of a backlog in dealing with Tasks on SystmOne and may link in with Family Contact.

Sam Hamer, Associate Medical Director and LfD Lead for DMH and Dr Charlotte Messer, Associate Clinical Director and LfD Lead for MHSOP will develop action plans.

FYPC/LD

In FYPC/LD waiting lists are now being monitoring routinely due having long wating lists and 6-week checks are being completed which are being completed by the Access Team (C5.15 Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments). A repeating theme identified by the Diana Service is around Rainbows Out of Hours support which they are currently unable to offer with patients sometimes having to go into intensive care at UHL before being transferred to Rainbows when opened. It is a recognised gap that has been fed back to commissioners.

The main learning theme that be the focus for Quarter 2 will be around how the Diana Service can work with Rainbows to support young people. Carmela Senogles, Deputy Head of Nursing and Julie Potts, Diana Palliative Care Lead Nurse, Diana Community Children's Service will lead on this.

Additional learning from all directorates is provided in **Appendix 1**

7. Examples of good practice

Examples of good practice in the current Quarter Q1 and previous quarters not already reported consisted of:

- **CHS:** There are several examples of good clear management plans which are regularly reviewed as well as examples of good communication with families and compassionate care being provided. There was an excellent example of compassionate care provided by a Health Care Assistant who upon realising that the patient was in their last few moments, stayed with the patient holding their hand.
- **DMH/MHSOP:** There were examples of good quality care being provided as well as good clear management plans, regularly reviewed. There was also good End-of-life documentation ensuring a patient's wishes were fulfilled and passed away at home with husband present.
- **FYPC/LD:** There were good examples of multi-disciplinary working with clear actions and planning which for one case ensured a smooth transition from Children's to Adult's services. There was also excellent care provided by the Diana Service.

Additional good practice from all directorates is provided in Appendix 1

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 Girish Kunigiri	
Paper sponsored by:	Prof Mohammed Al-Uzri	
Paper authored by:	Tracy Ward/Evelyn Finnigan	
Date submitted:	23/08/2022	
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	
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

CHS	
Learning	
E2.5 Communication and Imminence of Death/DNACPR/Prognosis.	Completeness of ReSPECT form – whole of page two not completed.
5.14 Documentation and Clinical Documentation within Clinical Record.	EOL paperwork was documented in S1 as being completed but could not be seen scanned into S1 on comms and letters, so could not comment on the quality of it.
7.20 Multi-disciplinary working and Inter-team Issues (within same speciality).	Two agency nurses on night shift. No access to S1 records, dialled 999 for patient who had a clear plan for end-of-life care if deteriorated, with anticipatory medications prescribed. Appropriately called OOH GP for advice so did as they were advised and called ambulance. Unsure if staff realised the plan for the patient from their verbal handover, but the nurse clearly documented on paper records their rationale for 999.
9.27 Ceiling of Care and Escalation/Ceiling of Care.	OOH advised to dial 999 for a patient who had a clear management plan and escalation plan documented in the electronic records. They patient was deemed nearing the end of life therefore transfer to the acute hospital was not appropriate.
Good practice	
1 Assessment, Diagnosis & Plan	
1.1 Assessment	Short admission. Planned interventions and timely assessments
1.3 Management plan.	Regular reviews of patient, clear management plans.
1.3 Management plan.	Good clinical management plans throughout the record for team to follow. Appropriate discussions with family
1.3 Management plan.	Admitted as EOL clear & concise management plan and good communication with NOK. Very good EOL care given
1.3 Management plan.	Excellent care throughout. Patient reviewed on a regular and timely basis. NOK also kept up to date. Fed back to ANP.
1.3 Management plan.	ANP demonstrated clear documentation of conversations with patient and wife. Very well done. Good care from ANP and MDT.
1.3 Management plan.	Very good clear management plan & communication with family.
2 Communication-Patient & Relatives	
2.4 Results/Management / Discharge Plan.	Good communication with family and clear update
2.4 Results/Management / Discharge Plan.	Good communication with family by all staff
2.4 Results/Management /	Overall, this is an example of managing complex symptoms and having full and honest conversations with family members.

Discharge Plan.	
2.4 Results/Management / Discharge Plan.	Good communication with family.
2.4 Results/Management / Discharge Plan.	Excellent communication with family from ANP's and ward nursing team. Clear plans of care and acted on accordingly.
2.4 Results/Management / Discharge Plan.	Family informed with regards progress and care.
2.4 Results/Management / Discharge Plan.	Well planned care and involved patient and family
2.4 Results/Management / Discharge Plan.	Involved NOK and patient
2.4 Results/Management / Discharge Plan.	Family involved in care.
2.4 Results/Management / Discharge Plan.	NOK involved in care throughout and patient reviewed on a regular basis. Fed back to ANP.
E2.5 Imminence of death, DNACPR	Prognosis Only three-day admission but good EOL care and communication demonstrated.
E2.5 Imminence of death, DNACPR	Admitted as EOL – all EOL care given and family regularly updated
E2.5 Imminence of death, DNACPR	Excellent paperwork.
3 Dignity & Compassion	
3.8 and Compassion / Attitude.	Demonstrated throughout patients journey with LPT. ANP team, GP and MDT demonstrated very good care.
3.8 and Compassion / Attitude.	Good end of life care.
E3.8 and Compassion / Attitude.	Patient approaching EOL, good communication and management plans in place. Appropriate paperwork adhered to and the comfort and dignity of patient was ensured
E3.8 and Compassion / Attitude.	Good EOL care.
E3.8 and Compassion / Attitude.	Good EOL care, decision making and communication.
3.8 and Compassion / Attitude.	Ward nursing staff used initiative and clinical judgement in delivering timely and compassionate care.
3.8 and Compassion / Attitude.	Good end of life care – patient was clear about her wishes and these were accommodated by all staff involved in her care – from the GP and community nurses through to ward staff and out of hours.
3.8 and Compassion / Attitude.	Very good communication skills and documentation from ANP RV's. Good end of life documentation and plans
3.8 and Compassion / Attitude.	Excellent communication by OOH team – contacted relatives who live abroad – explained condition and management plan
3.8 and Compassion / Attitude.	Good practice demonstrated by the team (Demonstrated by the ANP and nursing staff towards patient and NOK).

3.8 and Compassion / Attitude.	Patient was able to die with dignity and comfort Very good practice demonstrated by the ANP, Consultant and MDT
3.8 and Compassion / Attitude.	Good care demonstrated by consultant, ANP and MDT. Demonstrated throughout stay on ward.
3.8 and Compassion / Attitude.	Good documentation by all staff on how patient and family were able to discuss their individual needs and how these could be met. Excellent communication and documentation
3.8 and Compassion / Attitude.	Dignity and comfort prioritised Very good care from ANP / Consultant and nursing staff.
3.8 and Compassion / Attitude.	Care demonstrated dignity for patient in the last days of their life. Clear evidence of good practice from the team.
3.8 and Compassion / Attitude.	Clear documentation of patient care, EOL paperwork utilised and clear management plans for team to follow. Family informed and given emotional support
3.8 and Compassion / Attitude.	Clear identification and rationale for palliative care identified. Good communication and protocols followed to ensure a dignified death
4 Communication – Patients & Relatives	
2.4 Results/Management / Discharge Plan.	Evidence of communication with the patient and family.
5 Documentation-Paper & Electronic	
5.14 Clinician documentation within the clinical record.	Clear documentation – both ANP and nursing team. Respect form completed with clear plan
5.14 Clinician documentation within the clinical record.	Documentation was excellent and plans for care by all members of MDT were clear and easy to follow. Ward staff should be commended on excellent documentation of care of patient symptom management and care and compassion shown to family members who were clearly in distress.
5.14 Clinician documentation within the clinical record.	Clear documentation of diagnosis and prognosis; clear plans for care.
5.14 Clinician documentation within the clinical record.	Excellent documentation.
5.14 Clinician documentation within the clinical record.	Good documentation fed back to team
5.14 Clinician documentation within the clinical record.	Excellent last days of life paperwork completion and management of symptoms.
5.14 Clinician documentation within the clinical record.	Excellent documentation and family involved within the process
5.14 Clinician documentation within the clinical record.	Thorough documentation
5.14 Clinician documentation within the clinical record.	Excellent care and thorough documentation. Fed back to the ward.
5.14 Clinician	Excellent care throughout.

documentation within the clinical record.	
5.14 Clinician documentation within the clinical record.	Good documentation and MDT approach.
5.15 Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	Good overall care – clear documentation. ReSPECT form in place but could not be found on SystmOne.
7 Multi-disciplinary working	
7.18 Inter-speciality liaison / Continuity of care / ownership	Reviewed by MDT
7.19 Inter-speciality referrals/review.	Feedback to out of hours for good care planning, reviews and managing care over bank holiday period in community hospital.
9 Ceiling of Care	
9.26 Recognition.	Symptoms recognised and managed. Attempts made to establish preferred place of care.
9.27 Escalation / Ceiling of Care.	Recognition of deteriorating condition and addressing those issues on the ward and family discussions.
9.27 Escalation / Ceiling of Care.	Clear actions when patient deteriorated, clear management plans. Appropriate palliative decision when required and pathways activated and adhered to.
9.27 Escalation / Ceiling of Care.	Appropriate responses to decline in condition and regular reassessments. Clear management plans. Staff utilised SBAR which aided the communication.
9.27 Escalation / Ceiling of Care.	Regular review which reacted to change in conditions. Clear management plans, escalations and ceiling of care.
9.27 Escalation / Ceiling of Care.	Excellent responses to deterioration, clear management plans and palliative EOL protocols followed
9.27 Escalation / Ceiling of Care.	Good plan from ANP and consultant – nursing staff was aware of deterioration. Good care. Reviewed by ANP / consultant regularly, good treatment , good management plan , patient's daughter was updated throughout his stay on the ward. Family was updated in regards to poor prognosis
Actions taken in response to identified themes/issues, actions planned and an assessment of impact of actions	
5.14 Documentation and Clinical Documentation within Clinical Record. • Ensure EOL documentation is scanned on to SystmOne. This has been discussion at Ward Clerk meetings.	
7.20 - Poor communication • Agency Nurses had lack of access to up to date electronic clinical records	
9.27 Ceiling of Care and Escalation/Ceiling of Care • Ward Nursing staff/ ANP to check completeness of ReSPECT forms and highlight any issues to ANP/ Out of hours/ Consultant if necessary. • Management plans in clinical records not followed	

DMH & MHSOP	
Learning	
1. Assessment, Diagnosis & Plan	
1.1 Assessment	No contact was made with NOK
1.3. Management plan	The information gathered at 1st call could have been discussed in more detail. There are no entries to discuss about rational for a triage call rather than call to 999 given discussed risks. Given the information passed on to CAP to the triage assessment it was less than 2 hours was given priority
C1.3 Management plan.	When Patient was triaged over the telephone by CAP on 28/05/2021, he was given appropriate advice and support but what could have been included is advising him of debt support services or Citizen's advice for support for subjective debts/financial struggles and legal aid for mounting court costs/fees. Learning shared with CAP.
1.3. Management plan	CPN liaised with nursing home and GP around physical health and CPN gave support to nursing home re physical health and managed concerns regarding tissue viability and hep c status appropriately. Under the care of GP and seeing GP. Unknown regarding the care from nursing home and timeliness of interventions.
1.3. Management plan	Many discussions over the month in regards to secondary services referral. Advised in entries consider CMHT or forensics service. Could have been discussed with secondary care team if appropriate and following recommendations a plan be suggested. This was then made on 14th July.
2 Communication – Patients & Relatives.	
2.4 Results / Management / Discharge Plan.	Potentially could have contacted Friend although for patients who are high risk CAP do contact CRSIS Team to contact Team Leader to cold call & send DNA letter to GP.
2.4 Results / Management / Discharge Plan	Potentially could have contacted Friend although for patients who are high risk CAP do contact CRSIS Team to contact Team Leader to cold call & send DNA letter to GP.
2.4 Results / Management / Discharge plan.	Communication between ptn and CAP team. Followed up 02.10 and 06.10 four day gap between follow up given documented risks from GP. No contact was made with Primary care in regards to DNA from 02.10 – 06.10 could GP offered support. Referral information details query directly send to CMHT team. "
2.6 Reasonable adjustments.	When Patient did not answer call on 16th August. A call could have been made to NOK to alert that he had not attended review call at surgery to make family aware given recent hx of medication concerns. There was a discussion at the LfD meeting and it was noted that this is for Primacy Care.
2.6 Reasonable adjustments.	When sending out 14 day CMHT letter following DNA of assessment, address could have been double checked with NOK/GP. NOK could have been contacted to advise of missed assessment.
2.6 Reasonable adjustments.	Another example of staff finding out about a death rather than being told. This has been identified in an SI about another patient and an alerting system is being looked at.
3 Dignity & Compassion	

3.8. Compassion / Attitude	Evidence of translator being used and although the care plan would have been read out and signed, the hard copy left with the patient was not in a language they could understand.
3.8. Compassion / Attitude	Not calling family after death due to physical health related death.
4 Discharge	
4.10. Follow up Management Plan	Lack of follow up by CPN, no consideration for face-to-face appointment-However CPN has moved on.
4.10. Follow up Management Plan	Delay in OP appointment. Heavy OP caseloads causing delay in appointments.
5 Documentation - Paper & Electronic	
5.13 Correspondence with Patients/Other Clinical Teams	No discharge paperwork sent to GP and information re last contact where patient said she was taking 20 laxatives a day.
C5.14 Clinician documentation within the clinical record.	Document if there's no family to provide condolences and support to. If a patient is open to the pool, clinical or any service to look at asking them for contact details of family or close family friend.
5.14 Clinician documentation within the clinical record.	On 14/08/2021, some post death paperwork was documented by one of the Mill Lodge nurses to have been misplaced. Nil further documentation or updates whether the notes were located in the end. Better record keeping needs to be adhered to prevent misplaced notes. Regular Record-Keeping training is essential for data protection and data storage.
5.14 Clinical Documentation within Clinical Record	Excellent reviews with good and timely communication / good quality letters. Good management Plans.
5.14 Clinical Documentation within Clinical Record	8th July discussed if ptn was not at home as per cold call discharge. Plan was to be seen at neutral venue this account differs from MDT discussions. Was not present at sister address on 07th July so not seen.
7 Multi-disciplinary Team Working	
C7.18 Inter-speciality liaison / Continuity of care / ownership	Could have been more joined up working with turning point when there was non-engagement.
C7.19 Inter-speciality referrals/review.	Needed more timely assessment by ADHD
7.19 Inter-speciality referrals/review.	Team Leader for CAP & Hub to look at referral criteria. Also advise HUB and CAMHS that when patients present with unstable personality Disorder they can refer to CMHT for a full assessment.
7.19 Inter-speciality referrals/review.	Patient eligible for 117 but not requested until in the community.
7.19 Inter-speciality referrals/review.	Crisis Team could have referred to Turning Point but patient had self-referred.
7.19 Inter-speciality referrals/review.	Appropriate care and referral to CMHT by CRT and CAP after discussion with GP. Waiting time - Waiting list for outpatients in some CMHT are few months long. There are services that patients can access in the meanwhile like CAP however they may not feel these are helpful.
9 Monitoring, Recognition & Escalation / Ceiling of Care	
9.25 Monitoring.	CPN had facilitated referrals for home adaptations to reduce carer strain. CPN had f/u efficacy of prescribed medication for sleep. CPN had

	planned low key monitoring to support family however there was then a gap of non contact or f/u – to discuss with Team lead.
11. Appointments	
11.32 Did not attend	Patient on outpatients only. Was offered face to face but DNA'd. Patients was expressing suicidal ideas and was experiencing stressful lifestyle. Could there have been any input around stress management and coping over and above medication.
11.33 Arrangements – e.g. chaperone, miscommunication	Delay in seeing patient by Crisis Team due to high volume meant that patient visited A&E instead. Diagnosed with delirium by A&E. Earlier intervention from Crisis may have impacted on the outcome. It is difficult however to prioritise when case loads are unmanageable.
11.33 Arrangements – e.g. chaperone, miscommunication	Despite several contacts with police, PAVE and CAP, no contact from care team and OP appointment delayed, was due for 3 month follow up which was due in October 2021, still no appointment offered at time of death.
11. Appointments	Lost to follow up, no appointment offered as per plan.
14. Chronic Physical and Mental Health Problems	
14.40 Mismanagement of both PH and MH including deterioration	Intervention not requested when nurse visited, patient found to be in distress under duvet, hadn't eaten or drank for several days and a complete change in character, allowing people to carry out physical tests.
Good practice	
1 Assessment, Diagnosis & Plan	
1.1 Assessment	Screening carried out as per guidance, addressed any immediate concerns of which there were none.
1.1 Assessment	Good care provided by LPT, quite assessment with a plan the pt agreed to.
1.3 Management Plan.	Assessment and The F2F MH assessment in ED in November 2019 seemed detailed and extensive. Good level of support and advice was offered to Patient by CAP on 28/05/2021.
1.3 Management Plan.	Good care provided. CAP followed process and sent DNA letter to GP.
C1.3 Management Plan.	Good care provided. CAP followed process and sent DNA letter to GP.
1.3 Management Plan.	Good liaising.
C1.3 Plan and Management Plan.	Regular input, face to face visits during covid. Evidence CPN took time to talk with patient about a range of things to maintain rapport and support.
1.3 Plan and Management Plan.	Good management plan regarding care of ptn. Physical health supported at joint OPA in Feb. Monitoring of health due to medication Risk assessments completed and care plan is person centred. Partner was involved in care. Often assessed in regards to MSE."
1.3 Plan and Management Plan.	Good level of care from the CMHT.
2 Communication – Patients & Relatives	
C2.6 Reasonable adjustments.	Patient had a trial of antidepressants with no efficacy from them so it was suggested patient may benefit from exploring psychological input and although not keen, was given some time to think about it. Outpatient consultant did refer but sadly patient didn't get opportunity

	to explore.
3 Dignity & Compassion	
3.8 Compassion / Attitude	Good care when known to homeless team.
3.8 Compassion / Attitude	CPN appeared to display good communication with the deceased family/father and showed sympathy by expressing their condolences when father informed CPN of discovery of body by the police. 1.3 Assessment and Management Plan. Assessment and management planning all appeared extensive and holistic.
3.8 Compassion / Attitude	Good evidence of family involvements.
3.8 Compassion & attitude.	Good quality and consistent care given by CPN.
3.8 Compassion & attitude.	Good evidence of husband involvement with triage call.
3.8 Compassion & attitude.	The staff member completing triage assessment at the earliest stage alerted emergency services when signs were noted of concern. It appeared to be well assessed and was timely in regard to the conversation as it was unfolding. When the patient wouldn't/couldn't give their address, the call handler managed to get the patient to go downstairs and get the information from an envelope.
3.8 Compassion & attitude.	Good support offered during difficult and sad situation.
E3.8 Compassion & attitude.	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.
4 Discharge	
4.12 Discharge planning.	Good discharge planning by memory services.
5 Documentation - Paper & Electronic	
5.13 Correspondence with Patients/Other Clinical Teams.	Good level of communication between services in regards to seeking support for MH symptoms and opinion for physical health care for operation. Good level of communication between services in regards to seeking support for MH symptoms and opinion for physical health care for operation. Primary care services received feedback in regards to advice on medication and marked as urgent. Consultant booked in an appointment to review mental health as an assessment to send good practice.
7 Multi-disciplinary Team Working	
7.18 Inter-speciality liaison / Continuity of care/ownership	All services worked well regarding support Patient to receive support with assessment of medication, mental health, asked about IAPT referral. Reviewed for thoughts of DSH and advised to contact crisis details. Information in regards to assessment about mental health and risks completed in timely manner and sent to appropriate services allowing reviews to occur of medication. Weekly reviews by GP services were completed which allowed to monitor more closely any adverse side effects of medication. Timely review of mental health from contact with 111 and EMAS. Supported to EDU. Good communication between primary care and Liaison service in regard to suggested review with GP

	and information sharing. At all stages was regularly asked about thoughts, intent or plans of harm towards self and information was shared with all services. Risk assessment completed. Information was provided at all stages of crisis support services.
7.18 Inter-speciality liaison / continuity of care/ownership.	Good evidence of discussion with GP.
7.18 Inter-speciality liaison / continuity of care/ownership.	Lots of discussions in regard to medication and risks at all stages of support provided.
9 Monitoring, Recognition & Escalation / Ceiling of Care	
E9.27 Escalation / Ceiling of Care	Good quality care provided.
11 Appointments	
11.33 Arrangements – e.g. chaperone, miscommunication	Patient accessed service through duty system and was offered same day face-to-face appointment.
Actions taken in response to identified themes and issues, actions planned and an assessment of the impact of actions	
Dr Fabida Aria, DMH Chair wrote an email to all services to highlight the need to reminder to contact families following death to offer condolences.	
Physical health intervention, no action taken when patient found in distress. ISMR requested to investigate further.	

FYPC / LD	
Learning	
5 Documentation - Paper & Electronic	
C5.14 Clinical Documentation within Clinical Record	Access practitioner looked under mental health tab in tab journal on SystmOne but not looked elsewhere, if they had, they would have seen that the death was recorded and therefore could have avoided the 6 week call being made. This has been fedback with practitioner.
C5.15 Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	Some staffing issues over the summer months due to the pandemic. Waiting lists are now being monitoring routinely due to such long wating lists and 6-week checks are being completed. This wasn't in place at the time. There were some gaps in 6-week checks. These are now being completed by the Access Team.
C5.15 Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	No clinical risk assessment by Access Team

C5.15 Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	Patient's weight not being recorded. A set of scales is already on order which has been chased and the delay escalated.
7 Multi-disciplinary Team Working	
C7.18	Interagency working from Social Services could have been improved as LPT not invited to initial conference or core group and not providing up to date/accurate information which they had a duty of care to do so. Discussed further with appropriate person outside of LfD meeting.
C7.19 Inter-speciality referrals/review.	Lack of documented communication on EPR between GP/pharmacy/family regarding alternative thickener being prescribed but not being available.
9 Monitoring, Recognition & Escalation / Ceiling of Care	
9.25 Monitoring.	No falls care plan which should have been completed at the 1st assessment but wouldn't have had any impact. The 1st assessment was by telephone and no concerns had been raised.
9.25 Monitoring.	For existing referrals on the old system, these are done manually. Team Leader does 6-week calls and sends weekly emails if any need updating.
E9.27 Escalation / Ceiling of Care.	Rainbows unable to offer Out of Hours support. It is a recognised gap that has been fedback to commissioners.
E9.27 Escalation / Ceiling of Care.	There is a gap in service in out of hours provision at Rainbows. It is noted that the on-call policy is being reviewed.
E9.27 Escalation / Ceiling of Care.	Rainbows unable to offer Out of Hours support. Patient had to go to intensive care and then be transferred to Rainbows when opened. It is a recognised gap that has been fedback to commissioners.
Good practice	
1 Assessment, Diagnosis & Plan	
E1.3 Management plan.	Went above and beyond in terms of responsiveness.
E1.3 Management plan.	All appointments offered as expected.
E1.3 Management plan.	EoL in place and communicated.
E1.3 Management plan.	Good risk assessment and care plan.
E1.3 Management plan.	Good clear management plan.
2 Communication – Patients & Relatives	
E2.7 Results / Management / Discharge Plan.	Good communication with parents.
3 Dignity & Compassion	
E3.7 ADL Assistance/ Reasonable	The input the team provided ensured a more dignified death.

Adjustments	
E3.8 Compassion / Attitude.	Diana Service provided end of life 24/7 on-call as patient deteriorated.
E3.8 Compassion / Attitude.	Mother offered home visit for son's next universal contact 20/07/2022.
5 Documentation - Paper & Electronic	
C5.13. Correspondence with Patients/Other Clinical Teams	Care Navigator sent text reminders to patient re appointment re-minders.
C5.14 Clinician documentation within the clinical record.	Good holistic approach looking at annual health check.
C5.14 Clinician documentation within the clinical record.	Assessments of growth have been completed however practitioner did not record percentage weight loss on the clinical questionnaire and no evidence of feed volumes being calculated or discussed. Clear analysis and plan on the records however incorrect systm1 questionnaire was used for follow up contacts. Learning opportunities for the practitioner to revisit healthy growth guidelines and review clinical questionnaires used on records.
7 Multi-disciplinary Team Working	
C7.18 Inter-speciality liaison / Continuity of care / ownership	Smooth transition from children's to adult's services.
E7.18 Inter-speciality liaison / Continuity of care / ownership	Family well supported by bereavement nurse and good liaison between bereavement nurse and health visiting.
C7.18 Inter-speciality liaison / Continuity of care / ownership	Good consistency same Health Visitor from previous baby.
C7.18 Inter-speciality liaison/Continuity of care/ownership.	Great example of MDT working to get patient's needs met. Also, great MDT working on completing LfD review with a holistic approach.
C7.19 Inter-speciality referrals/review.	Prompt communications, clear actions, planning, and MDT working evident.
C7.20 Inter team issues (within same specialty)	Good inter team working.
9 Monitoring, Recognition & Escalation / Ceiling of Care	
C9.25 Monitoring.	Health visitor followed up on A&E attendance. Although normal practice, given heavy caseloads this good practice meant it wasn't missed.
E9.27 Escalation /Ceiling of care.	Good practice re escalation when patient deteriorated and good support provided afterwards.
C9.27 Escalation /Ceiling of care.	Recognition of a deteriorating patient, timely referral to palliative care team.
12 Transfer & Handover	
C12.35 Omissions/Errors in Handover communication.	Social care communicated information to HV regarding concerns raised re safety relating to sibling not travelling in a car seat. HV was requested to discuss this information with the family at a follow up contact. There is no evidence in the record that this happened.

Actions taken in response to identified themes and issues, actions planned and an assessment of the impact of actions
Team Leader to discuss thickener with GP Practice & take back to SALT Team re 6 week contact & discussion at Team meeting.