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Trust Board 29th November 2022

Leicestershire Partnership NHS Trust

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

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 July to September 2022 (Quarter 2: Q2) as well as learning from Q2 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 although there has been an improvement in the recording of ethnicity). Ongoing work with directorates to emphasise the importance of this data as a means of better understanding and overcoming potential health inequalities.
- LfD forms have basic demographics and incident details added from Ulysses and include notes from the weekly Incident Review Meeting (IRM) if discussed as well as a copy of the ISMR.
- CHS no longer have a backlog now the ME process is fully embedded. The Medical Examiner (ME) review process reviews all CHS Community Hospital Deaths. The ME's office agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it. The ME will discuss the cause of death with the next of kin/informant and establish if they have questions or any concerns with care before death. Any learning or good practice identified is shared through the LPT's Learning from Deaths email lpt.learningfromdeaths@nhs.net .
- MHSOP have no reviews outstanding from the previous year, 1st April 21 to 31st March 22.
- DMH planned to complete outstanding reviews by the end of quarter 2. The amount outstanding has decreased from 10% to 6% and additional overtime has been agreed to complete reviews.
- FYPC/LD no longer have a backlog withing the directorate. The directorate continues to report the lack of senior clinical leadership role (Associate Medical Director) which is affecting its ability to deliver against LfD requirements. FYPC/LD

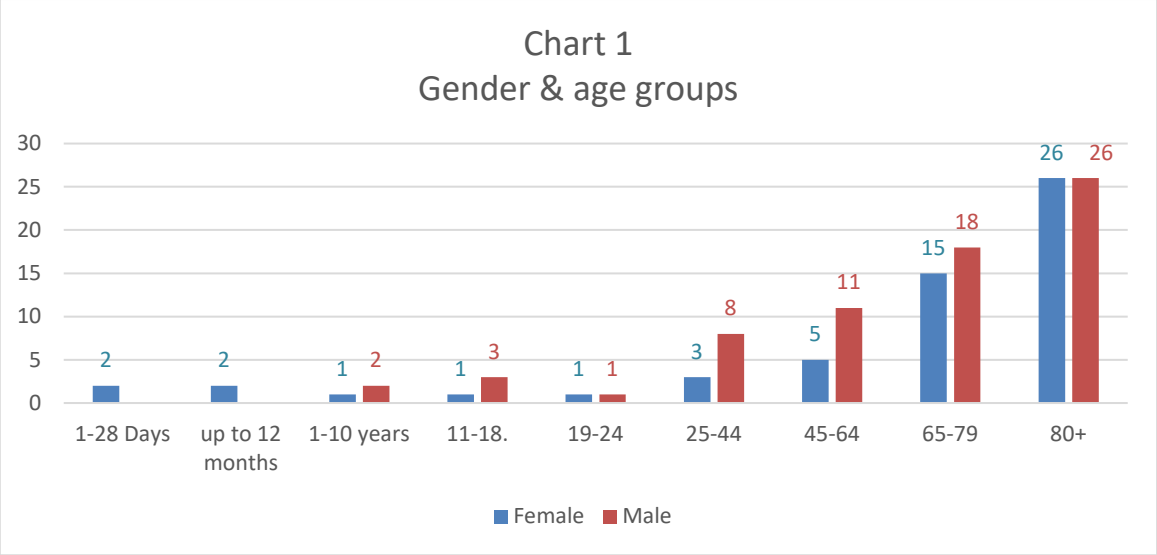
have met twice to review the format of their LfD meetings for better use of limited resources and a further meeting is to be arranged.

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 continued progress being made in the LfD process at LPT.

4. Demographics

Demographic information is provided in Charts 1-6. It remains clear that demographic information is not being captured at a service level. The CPST are working with the Information Team to progress this. Tom Gregory, Clinical Safety Office/IM&T Clinical Lead has clarified the actions from the DQ committee meeting for this and will be arranging to meet up with Kim Dawson and Colin Purves to look at the dashboard that they can create for protected characteristics. This will then be taken back to DQC for the next meeting. It can then be added to the DQ Plan which is owned by Sarah Ratcliffe.



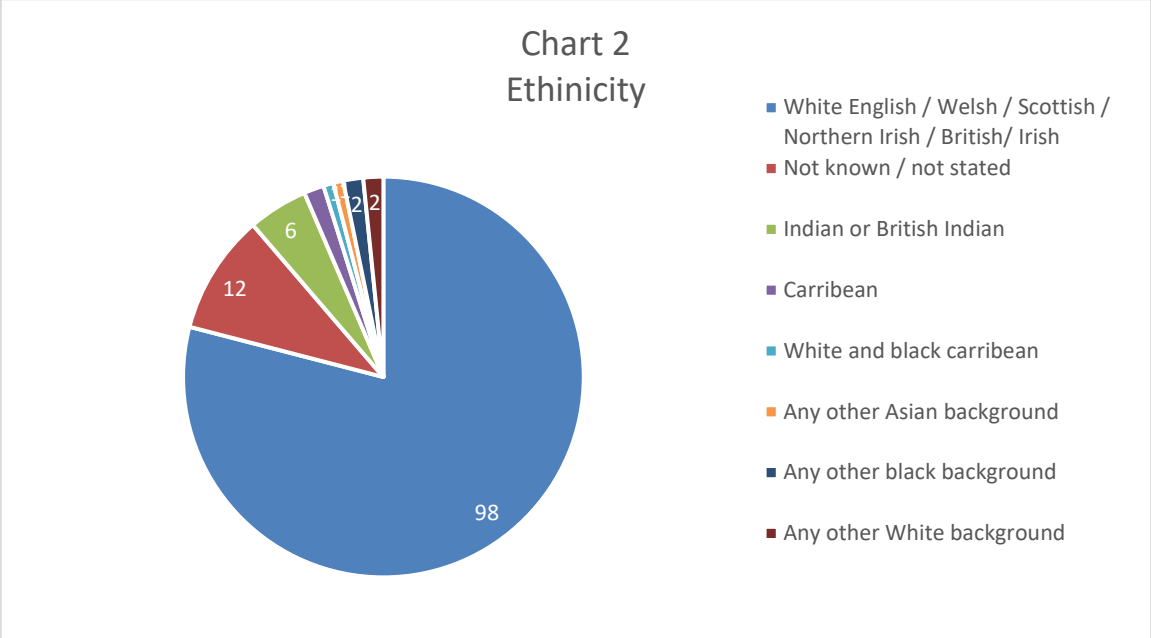
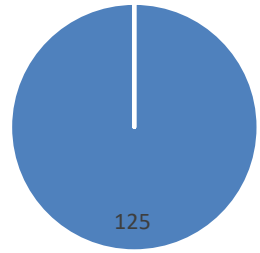
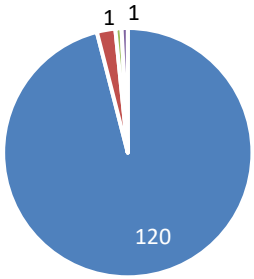


Chart 3
Disability



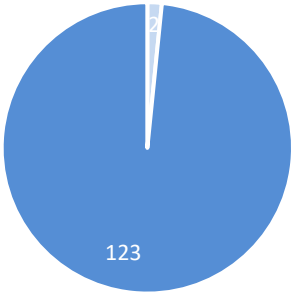
Not known / not recorded

Chart 4
Religious orientation



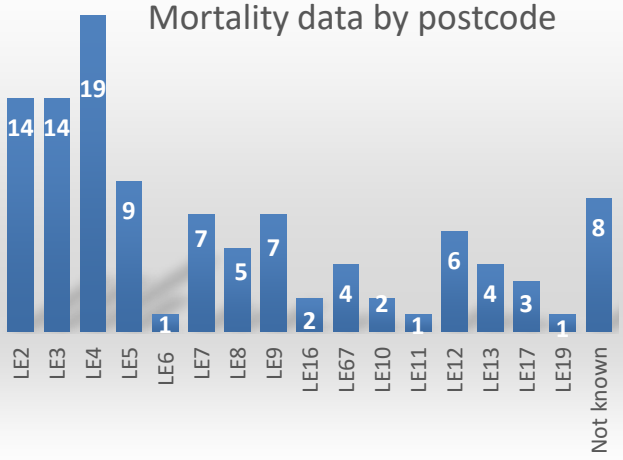
Not known / not recorded Christian Hinduism Sikh

Chart 5
Sexual orientation



Hetrosexual Not known / not recorded

Chart 6
Mortality data by postcode



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 2:

Table 1: Annual backlog of deaths (Q2)

Breakdown by Directorate									
	CHS			**DMH/MHSOP**			**FYPC/LD**		
	Q1-Q4 (1st April 21 to 31st March 22)	Q1 (April 22 to June 22)**	Q2 (July 22 to Septem ber 22)	**Q1-Q4 (1st April 21 to 31st March 22)***	Q1 (April 22 to June 22)	Q2 (July 22 to Septem ber 22)	**Q1-Q4 (1st April 21 to 31st March 22)**	Q1 (April 22 to June 22)	Q2 (July 22 to Septem ber 22)
Number of deaths reviewed	**162**	40	42	**290**	56	39	**99**	16	16
Percentage of deaths reviewed	**100%**	100%	100%	**94%**	85%	58%	**99%**	84%	89%
Number of deaths outstanding for Directorate review	**0**	0	0	**20**	10	26	**1**	3	2
Percentage outstanding for directorate review	**0%**	0%	0%	**6%**	15%	42%	**1%**	16%	11%

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's Q1's total is 1 less than previously reported due to a May death being recorded twice on Ulysses.
** DMH/MHSOP's Q1's total is 1 more than previously reported due to a death that occurred in June being reported late.

CHS

CHS no longer have a backlog now the ME process is fully embedded and are due to complete their action plan form Quarter 1 (below) within stated timeframes.

Quarter 1 Action Plan

Recommendation	Agreed Action	Lead	Completion Date	Outcome
• RESPECT forms - There is always room for improvement, these are often revisited on admission and re written.	ANP update/refresher training	LR	October 2022	October's ANP educational session will be focused on Version 3 of the ReSPECT form. Erin Ford, ANP, will approach appropriate Consultant Geriatrician or practitioner to deliver this session.
• Management plans - Nurses rely on management plans to use in SBAR to OOH Dr's etc.	To have a clearer structure within SystmOne in relation to management plans	LR and JD	Jan 2023	Leon Ratcliffe and Jonathan Dexter working with SystmOne to implement a clear and robust visual prompt for staff in relation to OOH management plans
• 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.	There is an agreed SOP for obtaining SystmOne access for all CHS agency nurses.	Matron (SS)	Completed	Flow Chart - For obtaining SystmOne C Appendix 4 Non Substantive staff SystmOne access Fina Appendix 5

DMH/MHSOP
The focus for Q2 for DMH has been to continue with their recovery plans to catch up with the backlog of reviews.

FYPC/LD
The focus for Q2 for FYPC/LD has been to continue with their recovery plans and catch up with the back log of reviews.

In adherence with NHS/I (2017) recommendations Table 2 also 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) case record reviews:

- There were 125 deaths considered in Q2.
- There was a total of 9 deaths for Serious Incident Investigation.
- There were 7 adult deaths of individuals with Learning Disabilities which are undergoing LeDer review within FYPC.

Table 2: Number of deaths (Q2)

Q2 Mortality Data										
	Jul			Aug			Sep			Total
	C	D	F	C	D	F	C	D	F	
Number of Deaths	19	26	9	13	27	7	10	12	2	125
	Consideration for formal investigation									
	C	D	F	C	D	F	C	D	F	Total
Serious Incident	2	1	0	0	5	0	0	1	0	9
mSJR* Case record review	19	26	9	13	27	7	10	12	2	125
Learning Disabilities deaths			5			2			0	7
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
	Learning									
	C	D	F	C	D	F	C	D	F	Total
Number of family contacted for feedback	19	2	2	13	0	3	10	0	1	50
Number of family feeding back	4	1	1	8	0	3	4	0	1	22
Number of awaiting feedback from family	0	0	0	0	0	0	0	0	0	0

KEY

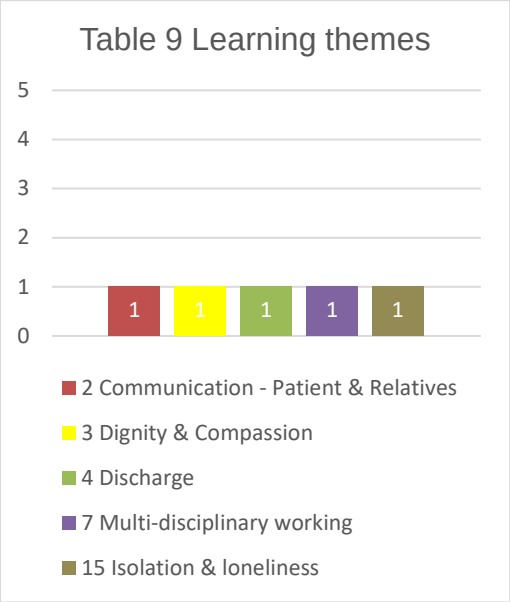
C: Community Health Services; **D:** Directorate of Mental Health/MHSOP; **F:** Families Young Persons and Children/LD

The Diana team complete the learning from deaths form within 48 hours of the child's death. All families where there is involvement from the Diana service at the time of the child's death will be contacted for feedback. All child deaths will be reviewed through the Child Death Overview Panel which will provide families a further platform to prove feedback.

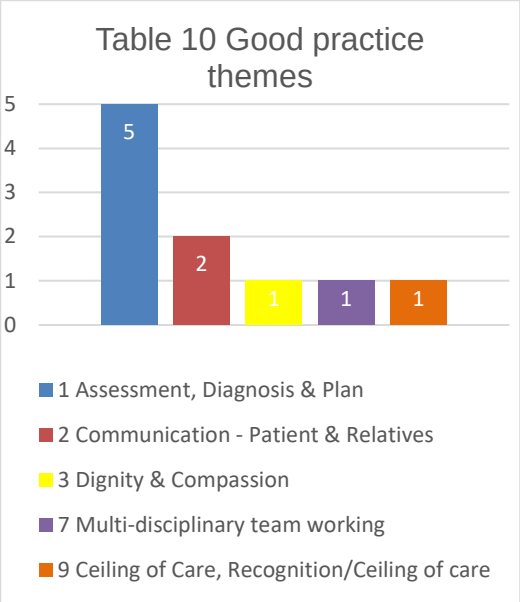
5. Learning themes and good practice identified

CHS

Learning themes (Q2)



Good practice themes (Q2)



Full details of learning themes and good practice can be found in **Appendix 1.**

There was 1 death that occurred in July of quarter 2 where the ME's office felt that there was potential learning for LPT and this is being investigated through the SI process and has been reported to the Coroner. Learning and action plans will be presented once those investigations are completed and SI Final report signed off.

Actions taken in response to identified themes/issues, actions planned and an assessment of impact of actions

- Ward round SOP (9.26. Ceiling of care and Recognition)

Patient admitted as palliation – had PEG feed in place – numerous times asking for oral fluids and diet – feed at risk but still PEG feed continued for 3 weeks after this decision despite family asking if this could be stopped as not benefiting patient. A Ward

round SOP is currently being discussed so the reviewer of the learning from deaths form will highlight the need for MDT attendance at ward rounds.

Full details of learning themes and good practice can be found in **Appendix 1.**

DMH/MHSOP

The three theming themes identified in Quarter 1 (below) were shared at the MHSOP Clinical Network meeting and reminders were given to the teams about following the DNA Policy. These themes will be monitored for reoccurrence.

- Family contact – There is a lack of documented contact with Nok/Family to offer condolences and support.

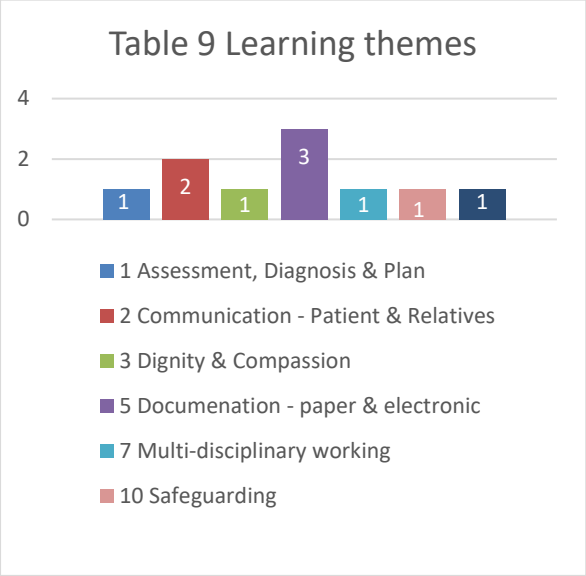
Where a patient is known to the service it would be appropriate to either call to offer condolences or if unable to contact, write a letter.

- Post DNA contact – Consideration to contact Nok/Family member post DNA.

Staff reminded to follow the Trust's DNA Policy.

- 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. Directorates are receiving reports regarding the amount of tasks outstanding.

Learning themes (Q2)



Good practice themes (Q2)

Full details of learning themes and good practice can be found in **Appendix 1.**

Actions taken in response to identified themes/issues, actions planned and an assessment of impact of actions

- Waiting list management process and delay in offering assessment (C1.1 Assessment and assessment)

There was a delay in assessment which was only partially completed and the record is very unclear why it took so long to complete. The nurse is not with team anymore to follow it up. This had not impacted on the death. This case was discussed at the Team Leader meeting held on 28th July 22.

- Communication between patient and CAP team (2.4 Communication and Results/Management/Discharge plan)

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.

- Interpreting Service (C2.6 Communication and Reasonable Adjustments).

An interpreter was organised for the outpatient appointment but could have been arranged for a telephone call too. This has been fedback to the Memory Service and a reminder will be sent to staff about the use of independent interpreters.

- Breach calls (C5.13 Documentation and Correspondence with Patients/Other Clinical Teams)

There was a small gap in follow up of breach calls but all others were made appropriately. Reviewer to send reminder email.

- Discussion with Social Services (C7.19 Multi-disciplinary working and Inter-speciality referrals/review)

CPN advised patient he would discuss his case with the social services team to look at support- does not appear to be any evidence this happened. No evidence electricity was topped up for at least 12 days. Further enquires being made.

- Prescribing (C8.21 Medication and Prescribing)

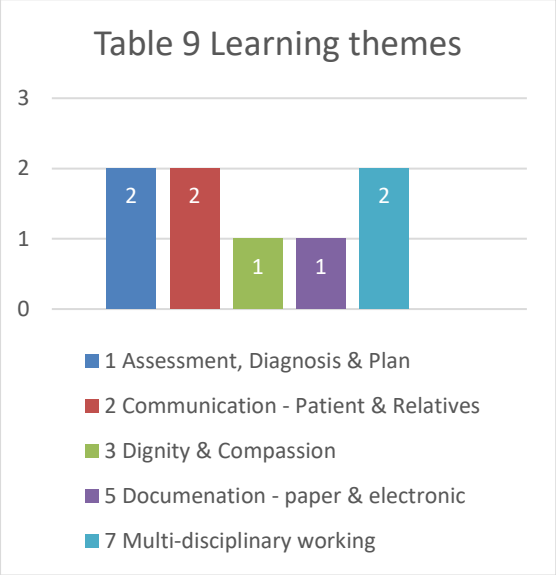
Service were looking patient's sleep and they were on a trail (Melatonina – Black drug) but this was not followed up. The next OPD was arranged but patient went into respite care, then admitted to acute and discharged home with 24-hour package of care. Reviewer discussed with LfD Chair and Consultant.

- Safeguarding C10.31. Safeguarding and Safeguarding concerns and voids.

Family member threatened to punch patient if they didn't go back into hospital. Discussed with CPN.

FYPC/LD

Learning themes (Q2)



Good practice themes (Q2)

Full details of learning themes and good practice can be found in **Appendix 1.**

Actions taken in response to identified themes/issues, actions planned and an assessment of impact of actions

- Equipment ordering process (C9.26 Ceiling of Care and Recognition)

If slings are either too big or too small, a question needs to be flagged up to ask if it is because of any significant weight loss\gain? There is a meeting to look at guidelines around equipment for the Access Team so this will be included.

- Out of Hours medical support for Rainbows (E9.25 Ceiling of Care and Monitoring / E9.26 Recognition / E9.27 Escalation / Ceiling of care).

The Diana team were previously able to access specialist advise from Rainbows Medical team with a specialty in palliative care, this was a 'good will gesture' but this support is no longer available. The Diana team are able to access 1PA community paediatrician, who acts as lead for palliative care for FYPC. There is currently no Consultant or Medic with an expertise in Palliative Care within LLR to gain advice and support. The Diana Team will always link with the child's Lead Consultant to plan for End-of-Life Care as part of their clear process for setting up and delivering on-call.

It is of note that the Diana team work their contracted hours and in addition will provide on call care for children requiring end of life care. this may have an impact on the services delivered by the team in hours. Rainbows have changed to not accept young people out of hours, this may have an impact for the Diana team and hospital admissions.

- Communication

Learning from deaths Quality & Safety Review form was reviewed at the team meeting to reflect and con-sider if we could we have had a conversation with Community Nurse if around patient's overall health needs or could we have gotten some dementia services involvement.

- Incident reporting of deaths

A reminder was sent to staff that an EIRF needs to be completed following a patient death.

6. 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.

7. Governance table

For Board and Board Committees:	Trust Board	
Paper presented by:	Dr Avinash Hiremath	
Paper sponsored by:	Prof Mohammed 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	
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. Examples of Learning identified, both good practice and areas for improvement

CHS	
Learning	
2 Communication-Patient & Relatives	
E2.4 Communication and Results/Management/Discharge plan.	Highlight importance of communicating key events to NOK e.g., syringe driver
3 Dignity & Compassion	
3.8. Compassion/Attitude	No paperwork and no documentation if contacted NoK/Friend.
4 Discharge	
4.10. Follow up Management Plan	Very poor medical management plan on 2nd transfer – stated ward based ceiling of care but for ACB if needs high flow oxygen – it was clear this gentleman was dying yet OOH wanted to send back in to acute. There is an issue with working across Trusts and two clinical systems as LPT don't share visual clinical patient record. LPT are looking at how to give access in a short capacity to DHU to see part of our electronic patient record.
7 Multi-disciplinary working	
E7.19. Multi-disciplinary working and Inter-speciality referrals/review	Out of Hours couldn't see notes, they could only access GP notes. This issue has already been identified and is being addressed Jonathan Dexter is the link with SystmOne. This case has already been highlighted/discussed with him.
15 Isolation & loneliness	
15.43. Lack of support	Patient had expectations of family being able to visit. Acute hospital had different visiting policy – family and patient had expected something similar. The response from ward staff regarding visiting and COVID appeared quite harsh in written form. Ward having to borrow iPad from another ward so relatives could facetime as only two family members could visit – do not all wards have their own devices for communication with family members?
Negative feedback from families regarding LPT care provided. • Felt communications over the last few weeks was not as good as it could have been.	

Good practice	
1 Assessment	
1.1 Assessment and assessment.	Prompt treatment and assessments
E1.3 Assessment and management plan.	Symptoms well managed.
C1.3 Assessment and management plan.	Excellent example of care which has been fedback to Stroke Ward.
C1.3 Assessment and management plan.	Excellent example of care from the wall areas. Lots of conversation and clear documentation on decision making.
E1.3 Assessment and management plan.	Overall good care as complexity of patient, as per ME feedback very difficult, patient very uncooperative, was seen by psychiatry.
2 Communication	
2.4 Communication and Results/Management/Discharge plan.	Good communication and updates to NOK.
2.4 Communication and Results/Management/Discharge plan.	Regular medical reviews – good communication with family re prognosis and when discharge planning.
3 Dignity & Compassion	
E3.8 Dignity & Compassion and Compassion & Attitude	Good standard of Eol care. Physical and psychological needs addressed
7 Multi-disciplinary working	
7.18 Multi-disciplinary working and Inter-speciality liaison / Continuity of care / ownership.	Nursing staff worked well with patients' support workers, recognising that continuity of care was a priority and that people that knew the patient the best was around to support his hospital stay.
9 Ceiling of Care	
9.27 Ceiling of Care and Escalation/Ceiling of Care.	ANP Review stopped a further admission to the LRI as agreed not in patient's best interest
Positive ME feedback from families regarding LPT care provided.	
• Husband was happy with care. • Care at Melton Mowbray Hospital was fine - no concerns. • No issues with care. • All care was marvellous. • Staff at Rutland Memorial Hospital were very good, kept in touch daily. • Care marvellous • Son happy with care.	

- Hinckley & Bosworth Community Hospital were very good.
- Care at St Luke's' Hospital - acceptable and happy.
- Loughborough Hospital Care was wonderful.
- Care was excellent at Loughborough Hospital.
- Great Care at Melton Mowbray Hospital.
- Patient was happy at Coalville and got on with all staff.
- Happy with care - wonderful. St Luke's Hospital.
- Good care.

DMH & MHSOP	
Learning	
1. Assessment, Diagnosis & Plan	
1.1 Assessment and assessment	No contact was made with NOK. Was there permission to engage with NOK to offer collateral information on presentation. GP was contacted to inform of DNA attempt in gaps between contacts with CAP. Assessment detailed process of sending to CMHT directly for review.
2 Communication – Patients & Relatives.	
C2.6 Communication And Reasonable Adjustments	No documented evidence of offering patient an interpreter when completing sessions.
C2.6 Communication And Reasonable Adjustments	An interpreter was organised for the outpatient appointment but could have been arranged for a telephone call too.
3 Dignity & Compassion	
E3.8 Dignity & compassion and Compassion / Attitude	Does not appear to be any contact with the family following his death. However, was not under care of the ward and was in supported accommodation, family were aware of the deterioration as were LPT.
5 Documentation - Paper & Electronic	
E5.13. Documentation and Correspondence with Patients/Other Clinical Teams	Email was sent from Triage making teams aware of Patient sadly passing away. Correspondence was sent to address and Out patient appointment was arranged for after passing. Mum was contacted. Appears communications were not reviewed appropriately after November. Covid restrictions meant patient was not seen in person, telephone contact unable to see presentation which forms part of picture of presentation. Followed guidance in regards to COVID 19.

E5.13. Documentation and Correspondence with Patients/Other Clinical Teams	Small gap in follow up of breach calls but all others were made appropriately.
C5.15. Completion of clinical forms i.e DNACPR, Consent, Nursing Assessments.	Core and risk assessments not updated with physical health problems diagnosed in September 2021 and no physical health care plan in place.
7 Multi-disciplinary Team Working	
C7.19 Multi-disciplinary working and Inter-speciality referrals/review	Delay in referral or discussion with forensic social workers regarding support- patient described not being able to get electricity and food, electricity was needed to work his oxygen machine, when found deceased there was no electricity in the flat.
10. Safeguarding	
C10.31 Safeguarding and Safeguarding concerns and voids	When documented patient made comments about being punched on arm no follow up to gather any information in regards to any concerns with these statements with family or patient."
11. Appointments	
C11.32. Appointments & Did Not Attend	Possibly letting GP know that patient not contactable for many months and contacted nominated person or Next of Kin if noted on referral form?

Good practice	
1 Assessment, Diagnosis & Plan	
1.1 Assessment and Assessment.	Coordinator involved at CAP team to risk assess. Was Followed up twice.
1.1 Assessment and Assessment.	Coordinator involved at CAP team to risk assess. Was Followed up twice. Prism assessment very detailed provided CAP with substantial information.
C1.1 Assessment and assessment.	Reviewed by medic team which reviewed risks appropriate
C1.1 Assessment and assessment.	It had been identified that he would benefit from psychological input once he had moved to Oxford.
1.1 Assessment and assessment.	Referral was processed promptly.
C1.1 Assessment and assessment.	Assessed by crisis team and recommended Cruise and Lets talk wellbeing, Partner was involved in assessment. Risks assessed with patient and explored alcohol use.
C1.1 Assessment and Assessment.	View past outpatient clinic , record it showed that patient was attending his appointment well and his medication was also being monitored accordingly
C1.3 Assessment and Management plan.	Care plan had been completed and patient had agreed to this and had a copy.

C1.1 Assessment and assessment.	Very thorough remote assessment due to Covid outbreak in Home (unable to start as died 3 days later)
C1.1 Assessment and assessment.	Clear timely assessment and holistic look at situation.
C1.1 Assessment and assessment.	CRT completed comprehensive assessment with team members.
C1.1 Assessment and Assessment.	Full, thorough assessment done and risk assessment. Appropriate treatment plan and discharge.
C1.1 Assessment and assessment.	Professional and triage well inline of presentation if attendance was required.
C1.1 Assessment and assessment.	CRT completed comprehensive assessment with team members.
C1.3 Assessment and Management plan.	Offered turning point and appropriate referral to Psychology.
C1.3 Assessment and Management plan.	Care planning in the CMHT was of a good standard when assessed in 2020.
1.3 Assessment and Management plan.	In-reach team responded quickly to referral and reviewed the patient regularly. In-reach nurse identified some discrepancy between medication prescribed vs what the patient was receiving. This was explored with the in-reach medic and a new prescription issued. This appeared to improve the patient's presentation
1.3 Assessment and Management plan.	CRT had offered a good level of support for patient when he was referred following his arrest for drink driving, with thoughts of self-harm, but with no intents or plans to act on thoughts. Following his engagement from CRT, there was a good and safe discharge planning with the support of his family and other services to support him with his alcohol addiction
1.3 Assessment and Management plan.	1.3 Assessment and Management plan. Assessment and care planning took place by MHF and was collaborative approach supported by Care home and looked at both physical and mental health.
2 Communication – Patients & Relatives	
C2.4 Communication and Results/Management/ Discharge plan.	Family were involved in the care process
C2.4 Communication and Results/Management/ Discharge plan.	Good use of sign posting to contact TP services when struggling with alcohol use. Mum contacted CMHT and was offered support in timely manner. Sleeping medication appeared to be prescribed by consultant good way to closely monitor the use of this.
C2.4. Communication and Results/Management/ Discharge plan.	Good communication when having medical intervention sought up dates of presentation.

C2.4. Communication and Results/Management/ Discharge plan.	Involved family were possible to find out information. Was sign posted to services that could offer support, talking therapies. Highlighted illicit substance misuse cause of mental health issues, Turning point offered.
C2.4. Communication and Results/Management/ Discharge plan.	Good communication between all MDT members in regards to care and treatment and plans discussed with family well throughout. Communication in regards to CPN and family and support team supported a robust care plan to monitoring both physical and mental health which supported the appropriate use of medication when required.
E2.5 Communication and Imminence of Death / DNACPR / Prognosis	Good contact with family and CPN followed up while patient was in hospital and when being sent for palliative care
3 Dignity & Compassion	
C3.7 Dignity & Compassion and ADL Assistance/Reasonable Adjustments.	Depot was administered with patient's preference at home
E3.7 Dignity & Compassion and ADL Assistance/Reasonable Adjustments.	Team was respectful to religious practices and contacted and supported with home visit thereafter which was very respectful and offered ongoing support. Offered support with language barrier and social needs considered noise and parking in area above and beyond job.
E3.8 Dignity & Compassion and Compassion/Attitude.	It is very clear that the team genuinely showed high levels of dignity and respect to both Nok and patient. Listened to the wishes of patient well during end of life. In final hours patient was supported well with her wishes to feel nature and supported as per car plan by staff who she had a good rapport with and NOK was well supported when missed last breath of Patient. Support was provided to staff members in the form of a debrief.
3.8 Dignity & Compassion and Compassion & attitude.	Good evidence of husband involvement with triage call.
5 Documentation - Paper & Electronic	
C5.13 Documentation and Correspondence with Patients/Other Clinical Teams.	In letters to patients, transparency with waiting times in Memory Service being longer than normal. In apology letter, there are useful contact numbers eg Alzheimer's Society, CAP, Social Services and Age UK
C5.13 Documentation and Correspondence with Patients / Other Clinical Teams.	Memory services made several attempts to contact patient to establish contact- including writing letters

C5.15 Documentation and Completion of clinical forms i.e DNACPR, Consent, Nursing Assessments.	Impressive level of detail in the documentation by the CMHT. It seemed like they really did spend a huge amount of time trying to pick up the pieces after this discharge. CMHT remained involved when patient was at UHL and identified that he had been discharged without POC in place. They ensured ASC were aware, safeguarding informed and performed urgent home visit. Fedback to Team Manager, City East CMHT.
C5.15 Documentation and Completion of clinical forms i.e DNACPR, Consent, Nursing Assessments.	FCMT and CPN initially responded quickly when patient reported difficulty in getting supplies.
7 Multi-disciplinary Team Working	
C7.18 Multi-disciplinary working and Inter-speciality liaison/Continuity of care/ownership.	Reviewed often by social services and CPN with team meetings often discussed risks. Completed home visits listened to patient and looked at packages of care several times to offer support. Discussed turning point many times
7.18 Multi-disciplinary working and Inter-speciality liaison/Continuity of care/ownership.	Both psychically and mental health were well supported and documented with lots of MDT and CPA's.
7.18 Multi-disciplinary working and Inter-speciality liaison/Continuity of care/ownership.	Excellent communication from CMHT
7.18 Multi-disciplinary working and Inter-speciality liaison/Continuity of care/ownership.	Good liaison with oncology and acute care to support
C7.19 Multi-disciplinary working and Inter-speciality referrals/review.	Both CRT team and CMHT communicated well together through referral process. Care plans and had introductions with CPNs
C7.19 Multi-disciplinary working and Inter-speciality referrals/review.	Social services involved in double assessments
8 Medication	
C8.24 Medication and Review.	Medication was reviewed in timely manner and discussed a detailed plan of support. Team made several attempts to contact and wrote to GP to inform them of medication changes good practice.

11 Appointments	
C11.32 Appointments and Did Not Attend.	DNA attempts made by the team to contact the patient. Staff knew patient well and actually cold called at home address. Unfortunately patient seen in chair deceased through window. Staff member being supported.
C11.32 Appointments and Did Not Attend.	When DNA's with outpatients appointments still made to offer reviews.
C11.32 Appointments and Did Not Attend.	In May 2021 appeared patient was well supported despite did not attends of appointments
C11.32 Appointments and Did Not Attend.	Even though there were times could have been discharged due to non-engagement was provided with time to engage and encouraged this and met halfway with patient so he could attend appointments. When missed OPA on 2021, was called and left a message. Due to present risks met in two person visits with CRT in neutral environment
C11.32 Appointments and Did Not Attend	Seen promptly when DNA'd. Discussed in MDT and referrals made.

FYPC/LD	
Learning	
1 Assessment, Diagnosis & Plan	
C1.1, C1.2 & C1.3 Assessment / Diagnosis / Management Plan.	Regarding SKID.
C1.3 Management plan	? SALT referral when patient was EOL. History of LRTI and no SLT referral before this. I don't think a SALT referral would have made a difference but this was identified as a possible need when she was already EOL.
2 Communication – Patients & Relatives	
C2.4 Results / Management / Discharge plan.	Communication with family.
E2.4 Results / Management / Discharge Plan.	Potentially learning for noting in case of further instances but also Good practice: There was a communication barrier and despite using a translator, not sure if they fully understood the role of LPT's role.
3 Dignity & Compassion	
C3.8 Compassion / Attitude.	Could have been better with compassionate care with family and listening to their anxiety around previous sibling death.
5 Documentation – Paper & Electronic	

5.14 Clinical Documentation within Clinical Record	FRAT should have triggered; however, this should have been picked up when screener assessment was reviewed by CNLD and during discussion in locality meeting. This discussion did not take place as patient had sadly passed away prior to the assessment being completed. Learning taken back and cross checked against the improvement plan around clinical pathways in LD and FRAT and risk assessments with the Screener role to ensure learning is embedded and report back in 3 months. A meeting has already been organised on 9th August to review the pathway.
7 Multi-disciplinary Team Working	
C7.19 Inter-speciality referrals/review.	As patient was in a private home rather than a home we'd have known better, we've lost a little of the multi-disciplinary working in the locality.
E7.18 Inter-speciality liaison/continuity of care/ownership.	It can be challenging to identify the lead consultant because it's not normally LPT, it's a UHL consultant. Also there a gap in confidence of being comfortable with children's palliative care within the Derbyshire Out of Hours GP Team.

Good practice	
1 Assessment, Diagnosis & Plan	
C1.1 Assessment.	Really well supported to successfully have their COVID-19 vaccinations
C1.1, C1.2 & C1.3 Assessment / Diagnosis / Management Plan.	Good assessment, monitoring and management plan.
C1.1 & C1.3 Assessment / Management Plan.	Responded promptly and identified home wasn't following plan so were able to advise them to follow the plan.
C1.1 & C1.3 Assessment / Management Plan.	LPT triaged and responded promptly and put a management plan in place.
C1.1 & C1.3 Assessment / Management Plan.	Key documents were all completed with the people that potentially knew the patient the best.
C1.3 Management Plan.	It's not clear if staff within the LD service know what their role is around end of life and vice versa, what is the role of the learning Disability Service when GP and district nurses etc are involved? This is already being followed up in general with Service Manager Learning Disabilities, AHP Lead & Deputy Head of Nursing
E1.3 Management Plan.	High level of compassion care provided working all services involved.
2 Communication – Patients & Relatives	

E2.5 Imminence of death, DNACPR, Prognosis	Good clear plans with Pharmacy and Consultant.
3 Dignity & Compassion	
E3.8. Compassion / Attitude	Services were able to ensure the family got their wish regarding end of life care.
E3.8 & E3.9 Compassion/Attitude / Environment.	Diana Service plan for young people to deteriorate and how they will implement an end of life on call service. This prompts advance care planning and anticipatory planning. The Diana team currently activate on call within hours; They are unable to activate the end of life on call service out of hours as this this need to be a multidisciplinary approach. The Diana Service endeavour to offer choice of care location to all families expected to die where time allows. When the Diana Service have been involved in caring for a child/YP at home feedback from the LfD group has highlighted the exceptional care and support delivered. When the Diana Service have been involved in caring for a child/YP at home feedback from the LfD group has highlighted the exceptional care and support delivered.
7 Multi-disciplinary Team Working	
E7.18 Inter-speciality liaison/continuity of care/ownership.	High level of compassion care provided working all services involved.
E7.18 Inter-speciality liaison/continuity of care/ownership.	All services worked together including sharing drug charts and care plans.
9 Ceiling of Care	
E9.25, E9.26 & E9.27 Monitoring / Recognition / Escalation / Ceiling of care.	The Diana team were previously able to access specialist advise from Rainbows Medical team with a specialty in palliative care, this was a 'good will gesture' but this support is no longer available. The Diana team are able to access 1PA community paediatrician, who acts as lead for palliative care for FYPC. There is currently Consultant or Medic with an expertise in Palliative Care within LLR to gain advice and support. The Diana Team will always link with the child's Lead Consultant to plan for End of Life Care as part of their clear process for setting up and delivering on-call. When the Diana Service have been involved in caring for a child/YP at home feedback from the LfD group has highlighted the exceptional care and support delivered.
C9.26 Recognition.	Good physio and OT input with prompt escalation of environment and wider holistic health care needs as well as close working with Social Care.

Appendix 2: Learning and Good practice

Learning from Deaths Learning & Good Practice Themes Guidance

Cat	Theme & Sub theme code	Theme & Sub Themes	Theming Code Combos
	1	**Assessment, Diagnosis & Plan**	
C or E	1.1	Assessment	C11 C12 C13 E11 E12 E13
C	1.2	Diagnosis	
C or E	1.3	Management plan	
	2	**Communication – Patients & Relatives**	
C or E	2.4	Results/Management / Discharge Plan	C24 C25 C26 E24 E25 E26
E	2.5	Imminence of death, DNACPR, Prognosis	
C or E	2.6	Reasonable adjustments	
	3	**Dignity & Compassion**	
C or E	3.7	ADL Assistance/ Reasonable Adjustments	C37 C38 C39 E37 E38 E39
C or E	3.8	Compassion / Attitude	
C or E	3.9	Environment	
	4	**Discharge**	
C	4.10	F/up management plan	C410 C411 C412 E410 E411 E412
C or E	4.11	Equipment/POC	
C or E	4.12	Discharge Planning	
	5	**Documentation - Paper & Electronic**	
C or E	5.13	Correspondence – with patients, other clinical teams	C513 C514 C515 E513 E514 E515
C or E	5.14	Clinician documentation within the clinical record	
C or E	5.15	Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	
	6	**Investigations / Results**	
C	6.16	Investigations	C616 C617 E616 E617
C	6.17	Results	
	7	**Multi-Disciplinary Working**	
C or E	7.18	Inter-speciality liaison/continuity of care/ownership	C718 C719 C720 E718 E719 E720
C or E	7.19	Inter-speciality referrals/review	
C or E	7.20	Inter team issues (within same specialty)	
	8	**Medication**	
C or E	8.21	Prescribing	C821 C822 C823 C824 E821 E822 E823 E824
C or E	8.22	Supply	
C or E	8.23	Administration	
C or E	8.24	Review	
	9	**Ceiling of Care**	
C or E	9.25	Monitoring	C925 C926 C927 E925 E926 E927
C or E	9.26	Recognition	
C or E	9.27	Escalation / Ceiling of Care	
	10	**Safeguarding**	
C or E	**10.28**	**Risk to themselves**	C1028 C1029 C1030 E1028 E1029 E1030
C or E	**10.29**	**Risk to others**	
C or E	**10.30**	**Known to safeguarding**	
C or E	**10.31**	**Safeguarding concerns and voids**	
	11	**Appointments**	
C or E	**11.32**	**Did not attend**	C1131 C1132
C or E	**11.33**	**Arrangements – e.g. chaperone, miscommunication**	

Cat	Theme & Sub theme code	Theme & Sub Themes	Theming Code Combos
	12	**Transfer & Handover**	
C or E	12.34	Delays to correct speciality/setting	C1233 C1234 E1233 E1234 C1235 E1235
C or E	12.35	Inappropriate Outlying / Transfer arrangements incl where pt not clinically fit for transfer, or inappropriate transfer arrangements to take into account level of acuity	
C or E	12.36	Omissions/Errors in Handover communication	
	13	**Self-harm**	
C or E	13.37	Drug and alcohol misuse	C1337, C1338 E1337, E1338
C or E	13.38	Physical self-harm: e.g. cutting, ligaturing, head banging	
	14	**Chronic physical and mental health problems**	
C or E	14.39	Unknown impact of PH on MH or vice versa	C1439, C1440, C1441 E1439, E1440, E1441
C or E	14.40	Mismanagement of both PH and MH including deterioration	
C or E	14.41	Medications related to PH and/or MH	
	15	**Isolation & loneliness**	
C or E	14.42	Recognition of the impact of isolation and loneliness	C1442, C1443, C1444 E1442, E1443, E1444
C or E	14.43	Lack of support	
C or E	14.44	Multi-agency support	

Abbreviations: C: Clinical care; **E:** End of Life; **ADL:** Activities of Daily Living; **POC:** Point of Care; **DNACPR:** Do Not Attempt Cardio Pulmonary Resuscitation

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Appendix 3 Theming guidance

1. Glossary

Category: Point of discussion is based on the clinical care (C) or end of life care of the patient (E).

Theme: The overarching general construct or feature associated with the care of the patient.

Sub-theme: Specific construct or feature associated with the care of the patient; stems from the theme.

Sub-theme codes: Number allocated to the sub-theme.

Theme code: Number allocated to the theme.

Theming code combos: Combination of the category (C or E) + Theme code (1-12) + Subtheme code (1-35).

2. The coding process

Information from each directorate is to be coded so that we can see which themes are prominent throughout the trust, highlight gaps in knowledge or practice, and have a streamlined way of learning, sharing, and acting on our Learning from Death process:

Coded learning impact and actions

Learning Code/Theme	Learning Impact	Learning Action
DMH		
C927: Clinical care, Monitoring, recognition & 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.