Leicestershire Partnership NHS Trust

Public Trust Board of Directors

Safety and Quality in Learning from Deaths Assurance (Quarter 3)

1. Purpose of the report

This report is presented to the Trust Board as assurance of the efficacy of the Learning from Deaths (LfD), Child Death Overview Panel (CDOP), Learning Disabilities Mortality Review (LeDeR), and Serious Incident (SI) processes in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017). This Report presents data from October to December 2022 (Quarter 3: Q3) as well as learning from Q3 and previous quarters not already reported, at Leicestershire Partnership Trust (LPT).

2. Analysis of the issue

The information presented in this report is 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 DMH/MHSOP and FYPC/LD. LfD meetings in CHS are carried out on an ad-hoc basis should further discussion be identified through the ME process or as identified by LPT Staff.

- Demographics - 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 QSR forms – The Learning from Deaths Coordinator adds basic demographics and incident details from Ulysses to the form. Furthermore, if the death is discussed at an Incident Review Meeting (IRM), the notes recorded on Ulysses and a copy of the ISMR are also included.
- The ME process - The ME process is fully embedded in CHS and has been extended to include DMH inpatient deaths from 1st January 2023. The ME's office agrees 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.
- During quarter three we have been working to ensure that we are maximising the learning. The majority of the deaths within CHS are expected i.e. the patient has been identified as end of life and a conversation held in relation to Respect. All CHS inpatient deaths are reviewed by the ME including a conversation with the family and any learning shared with us. In addition, our bereavement support nurse will follow up with the family in 6/8 weeks to offer any support in relation to

their bereavement. This is also an opportunity to proactively ask for feedback in relation to their relatives care for our learning either positive or areas to improve. This learning is shared with the end-of-life steering group. Where there has been an unexpected death these are reviewed usually using an Initial service managers review (ISMR) that is discussed at the weekly incident review meeting (IRM) and from there the decision is made to review as a serious incident/internal investigation or remain as an ISMR, the outcome of all of these reviews will be heard and discussed at CHS's learning from deaths forum meeting.

- Outstanding reviews
    - FYPC/LD and MHSOP have no reviews outstanding from the previous year, 1st April 21 to 31st March 22.
    - DMH have further reduced their backlog of outstanding reviews from the previous year, 1st April 21 to 31st March 22, from 20 (6%) outstanding to 7 (2%) outstanding and these are being completed as a priority.
      Training sessions have been completed within DMH to increase the number of clinicians undertaking reviews which is starting to have an impact in reducing the backlog.

      It should be noted that the average deaths per month for review within DMH has increased by 44% over the last 6 months from an average of 9 deaths per month to 13 deaths per month.

- FYPC/LD meetings are ongoing regarding the review the format of their LfD meetings, Terms of Reference and Group membership.

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. Is there an update?

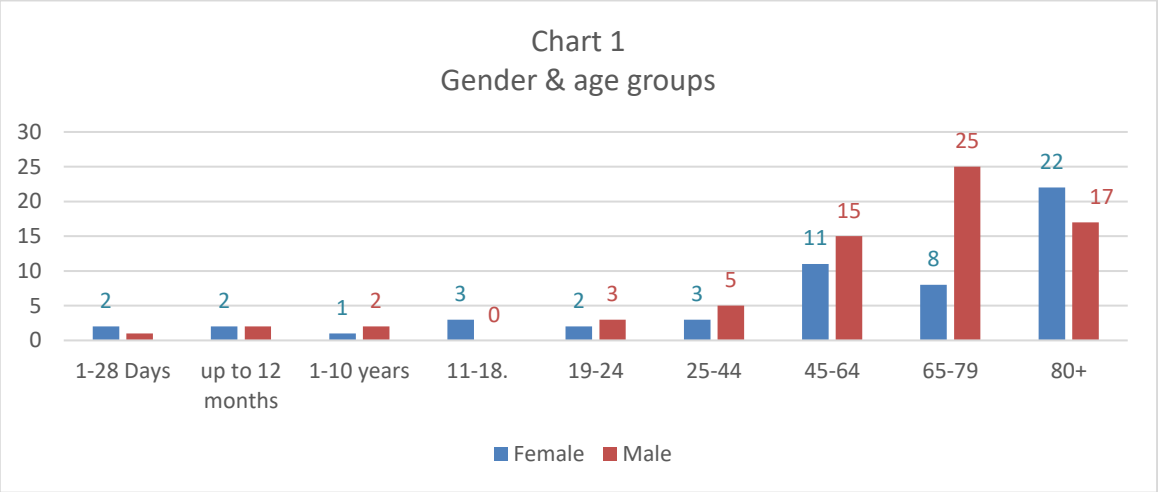


Chart 1
Gender & age groups
30
25
20
15
10
5
0
2
2
1
2
3
0
2
3
3
5
11
15
8
25
22
17
1-28 Days
up to 12 months
1-10 years
11-18.
19-24
25-44
45-64
65-79
80+
Female
Male

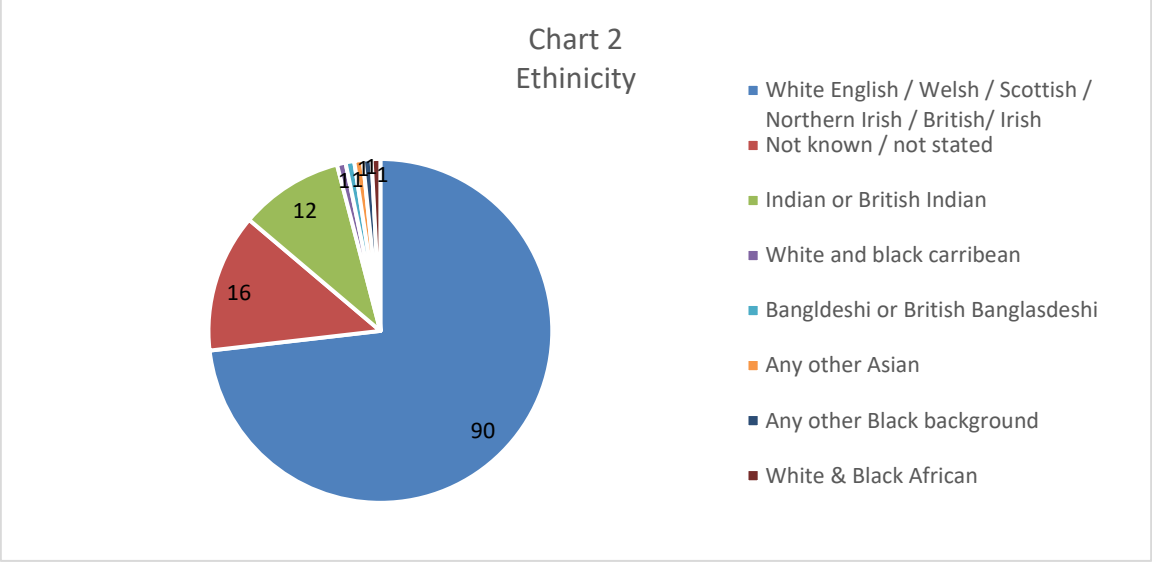


Chart 2
Ethinicity
12
16
90
1
1
1
1
White English / Welsh / Scottish / Northern Irish / British/ Irish
Not known / not stated
Indian or British Indian
White and black carribean
Bangldeshi or British Banglasdeshi
Any other Asian
Any other Black background
White & Black African

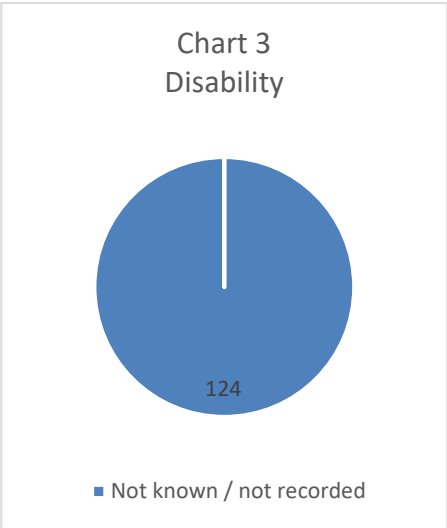


Chart 3
Disability
124
Not known / not recorded

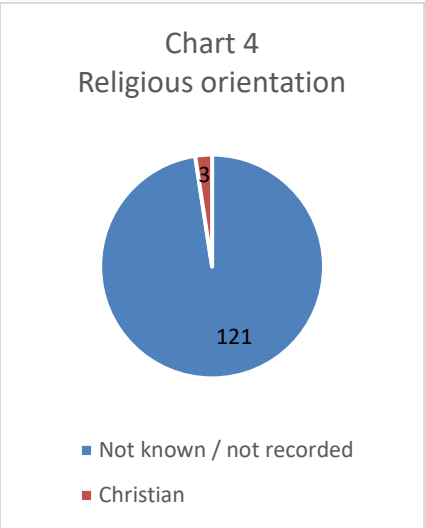


Chart 4
Religious orientation
3
121
Not known / not recorded
Christian

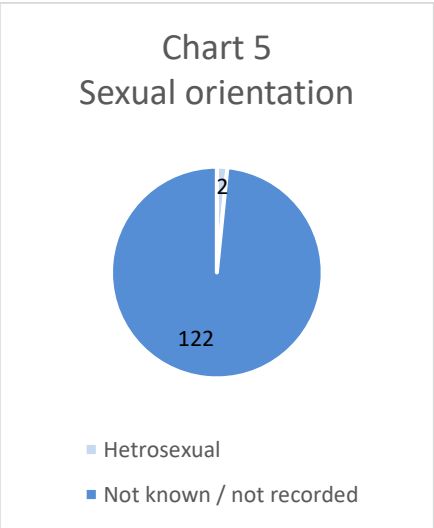
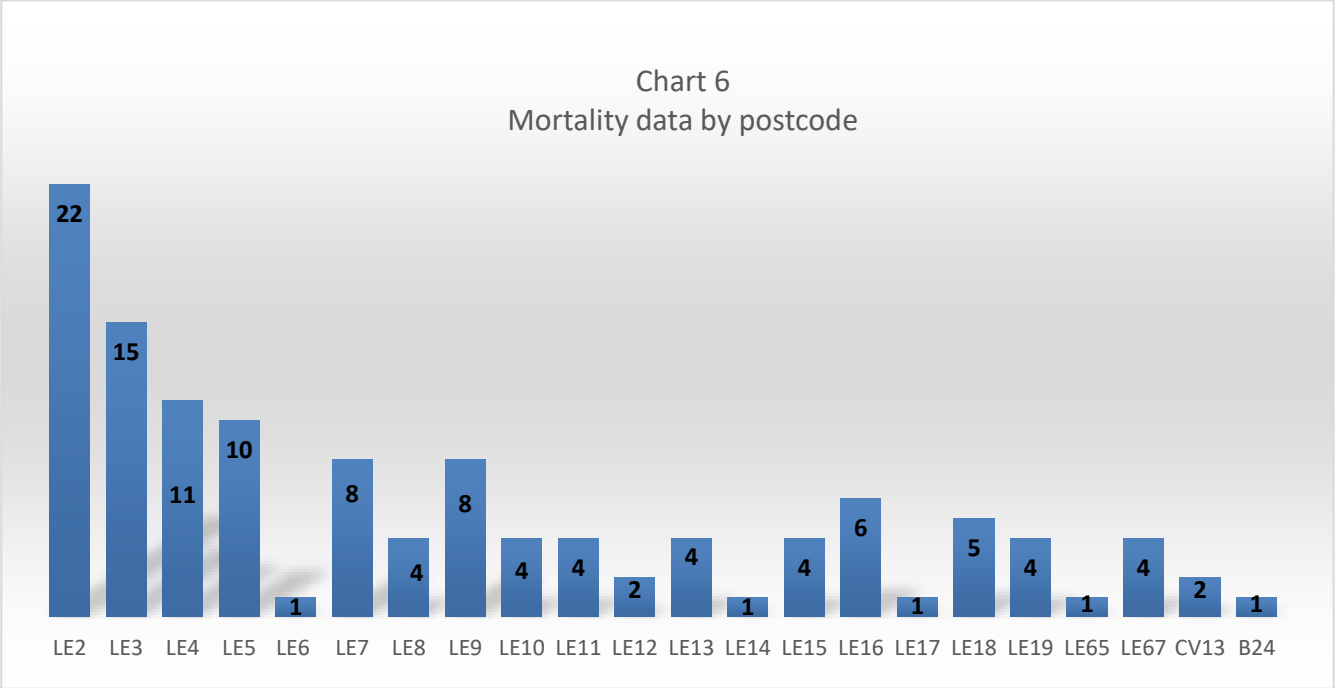


Chart 5
Sexual orientation
2
122
Hetrosexual
Not known / not recorded



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 (Q3)

Breakdown by Directorate										
	CHS			DMH/MHSOP				FYPC/LD		
	Q1 (Apr 22 - Jun 22)	Q2 (Jul 22 - Sep 22)*	Q3 (Oct 22 - Dec 22)	**Q1-Q4 (Apr 21- to Mar 22)**	Q1 (Apr 22 - Jun 22)	Q2 (Jul 22 to Sep 22)**	Q3 (Oct 22 - Dec 22)	Q1 (Apr 22 - Jun 22)	Q2 (Jul 22 - Sep 22)***	Q3 (Oct 22 - Dec 22)
Number of deaths reviewed	40	45	25	**303**	56	67	40	19	19	17
Percentage of deaths reviewed	100%	100%	100%	**98%**	85%	88%	55%	100%	100%	65%
Number of deaths outstanding for Directorate review	0	0	0	**7**	10	9	33	0	0	9

Percentage outstanding for directorate review	0%	0%	0%	**2%**	15%	12%	45%	0%	0%	35%

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 Q2 total is 3 more than previously reported due to 3 September deaths being reported in November 22.

**DMH's Q2 total is 11 more than previously reported due to 8 SI's inadvertently not being included in figures, 1 August death that was reported in December and 2 September deaths that were reported in October.

***FYPC/LD's** Q2 total is 1 more than previously reported due to 1 Internal Investigation inadvertently not being included in figures

CHS

CHS's have one action to be completed from their action plan from Quarter 1 as per below:

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	March 2023 ~~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 Getting the change around IT has been a challenge coupled with winter pressures and the current bed crisis the emphasis has been on service delivery. There is a meeting planned with IM&T to progress.
• 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 Non Substantive staff SystmOne access Fina

In adherence with NHS/I (2017) recommendations Table 2 also shows the number of deaths reported by each Directorate for Q3. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR) case record reviews:

- There were 124 deaths considered in Q3.
- There was a total of 7 deaths for Serious Incident Investigation.
- There were 13 adult deaths of individuals with Learning Disabilities which are undergoing LeDeR review within FYPC.
- There were 2 unexpected deaths within CHS of which 1 is being investigated as an Internal and the other will go through the End-of-Life Steering group. Expected deaths will have a Respect form/ACP in place and unexpected not. Also, an expected death would have a clear EOL/management plan in place.

Table 2: Number of deaths (Q3)

Q3 Mortality Data										
	Oct			Nov			Dec			Total
	C	D	F	C	D	F	C	D	F	
Number of Deaths	10	25	12	7	25	8	8	23	6	**124**
Consideration for formal investigation										
	C	D	F	C	D	F	C	D	F	Total
Serious Incident	0	3	0	0	2	0	1	1	0	**7**
mSJR* Case record review	10	25	12	7	25	8	8	23	6	**124**
Learning Disabilities deaths			5			4			4	**13**
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**
Learning										
	C	D	F	C	D	F	C	D	F	Total
Number of family contacted for feedback	10	10	3	7	0	0	8	0	0	**38**
Number of family feeding back	4	2	1	3	0	0	1	0	0	**11**
Number of awaiting feedback from family	0	0	0	0	0	0	0	0	0	**0**

KEY

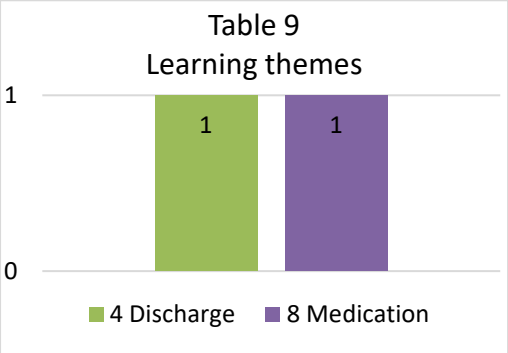
C: *Community Health Services;* ***D:*** *Directorate of Mental Health/Mental Health Service for Older People;* ***F:*** *Families Young Persons and Children/LD*

The Diana team complete the LfD QSR 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.

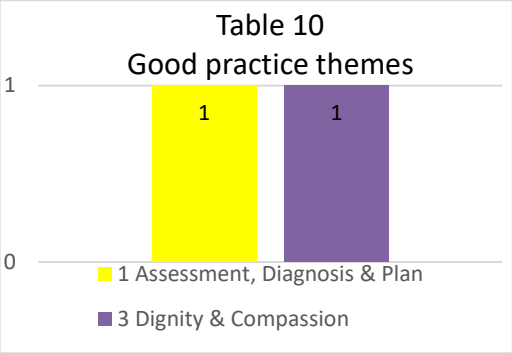
5. Learning themes and good practice identified

CHS

Learning themes (Q3)



Good practice themes (Q3)



There are no actions in response to the themes identified and no concerns identified by the ME's office.

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

Feedback from the National Medical Examiner (ME) process

CHS identified 1 death that wasn't referred to the ME's office. The ME's office advised that as a certificate had already been issued and likely that relatives had already had contact with the registrars/received the certificate, it was felt that there would be no need for ME involvement.

Positive feedback from families regarding LPT care provided.

- Happy with care - excellent at both LRI and St Luke's.
- St Luke's fantastic.
- St Luke's nursing care was excellent.
- Fantastic at St Luke's
- Nurses in both hospitals given fantastic care (North Ward, Hinckley & Bosworth Community Hospital).
- They were brilliant. Looked after mum really well. (Ellistown ward, Coalville Community Hospital)

Negative feedback from families regarding LPT care provided.

- Daughter expressed concern that it took a long time to come to establish a diagnosis despite being in hospital for total of 4 month in 2 admissions; delay

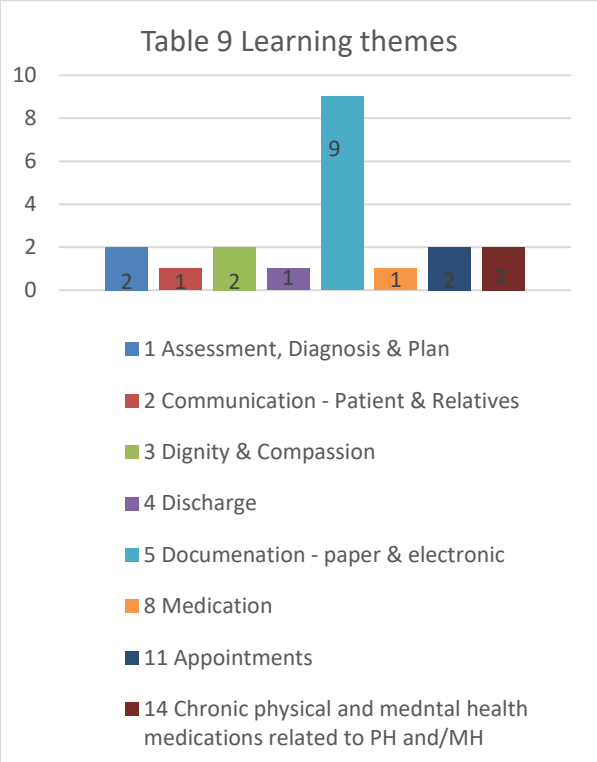
in getting scans or results. Nursing care was good. Would like Bereavement Nurse to follow up. Bereavement Nurse will make contact.

- Many issues. Bereavement Nurse will call to discuss.

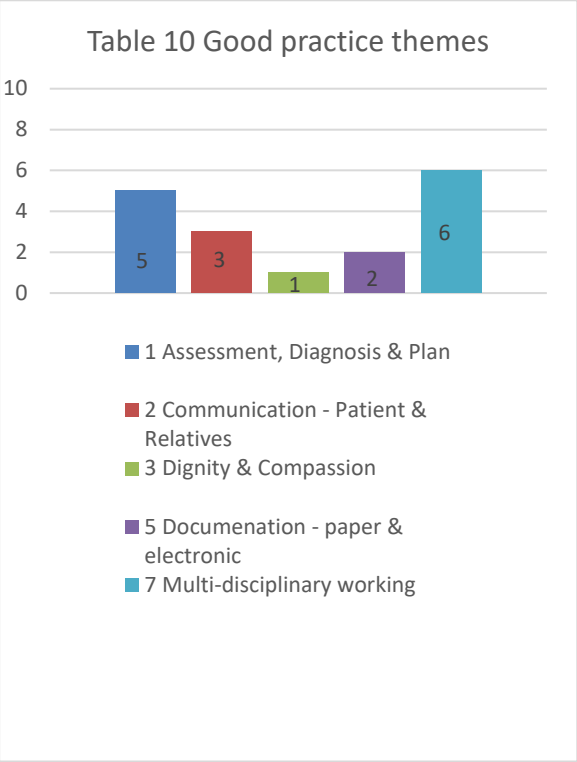
DMH/MHSOP

There were no common themes identified.

Learning themes (Q3)



Good practice themes (Q3)



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

- Staff knowledge (14.41 Chronic Physical and Mental Health Problems and Medications related to physical health and/or mental health)

Guidance notes on SystmOne to be reviewed and discussed with Alison O'Donnell regarding training / possible email to staff.

- Lack of contact (5.13 Documentation and Correspondence with Patients / Other Clinical Teams)

There does not appear to be any communication with elderly father, who lived with patient and administered medication. Previous safeguarding concerns raised that father had lost his access to his motor scooter as patient had crashed it intoxicated. Reflection with CPN will take place.

- CAP Triage process (1.1 Assessment and Assessment)

Declined assessment – 10th May 2021 felt to have capacity – no capacity assessment noted or recorded. Action: Alcohol dependence – referred for CBT, reference to Turning point in the notes in March 2019 and June 2020. The CAP Triage process is being reviewed in line with national guidance. SBAR already completed and there is a paper that will be going to the Quality & Safety Summit in January 23.

- Transformation workstream (2.4. Communications and 2.4. Results / Management / Discharge plan)

Outpatient review in November 2020 identified follow up for 2 months' time, next review was September 2021. Action: Communication from outpatients when reviews are not scheduled as planned could be communicated with the patient. Dr Vesna Acovski & Sam Hamer to take this forward with the transformation workstream. Part of the process will be looking at patient expectation and how we communicate with them if we are unable to meet appointments when advised.

- Discharge (4.12 Discharge and Discharge Planning)

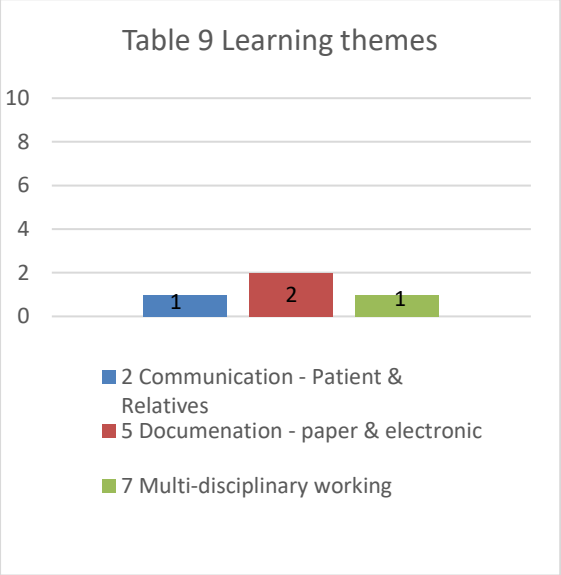
There were no mental health concerns so probably should have considered discharge. Action: JN & SH to liaise with Sanjay Rao, Vesna Acovski and Debbie to review as part of the caseload review and discharge planning and arrange for the Discharge SOP to be included in the Locum Inductions so that they are aware of the thresholds for discharge.

- Did not attend (11.32 Appointments and Did Not Attend)

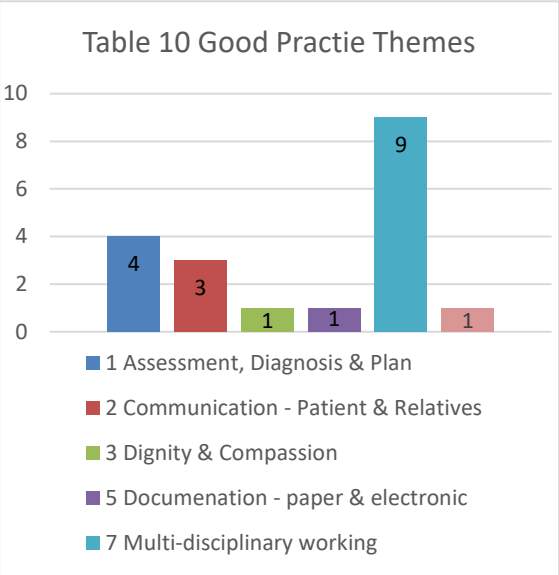
DNA letters / opt in and further appointments. Action: Explore / check DNA process for those that miss appointments. This is covered in the updated DNA Policy which has just been reviewed and is awaiting sign off.

FYPC/LD

Learning themes (Q3)



Good practice themes (Q3)



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

- Diagnostic overshadowing

Although there was some really good practice looking holistically at ruling out all the possible causes of agitation before going down behaviour route the issue of diagnostic overshadowing was discussed in November's Learning from Deaths meeting. Thea discussion was around diagnostic over shadowing and perhaps comorbidity of dementia being a potential theme and although it was not LPT learning, the service is very mindful of that certain cohorts of people might be disadvantaged because of that. The discussion was also around not always been good at having a ceiling of care for patients, especially with dementia and being proactive although it's not necessarily the LD team's responsibility to do that. It's a physical health need and that should of a collaborative and potentially dependent upon how robust the annual health checks are. Dr Shweta, Gangavati to discuss with Dr Rohit Gumber to ascertain if there is a forum to have a more strategic level discussion.

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:		
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 themes and issues identified as part of the review/investigation.

4 Discharge	
4.10. Follow up Management Plan	Discharge not discussed, until sometime into the admission. Discussion reply preferred place of care wasn't documented in notes until 5 weeks after end-of-life paperwork commenced. Unsure whether some decision should have been made a little earlier on. Patient had plateaued. Maybe there was an opportunity to discuss discharge.
8 Medication	
8.34 Administration	Syringe driver prescribed on admission to manage symptoms. Patient did not receive medications in syringe driver. Patient was then agitated later that day and required PRN rescue medication to relieve symptoms. If syringe driver had been administered when prescribed it is likely that the patient would not have become distressed, negating the need for rescue medication to be administered, and for the patient to have a peaceful end of life in comfort. There is an SI with a similar theme so this case will be pulled together with that case.

Good practice themes identified as part of the review/investigation.

1 Assessment	
1.3 Assessment and management plan	Patient admitted from home for symptom management, which was addressed on admission with a clear plan.
3 Dignity & Compassion	
E3.8 Dignity & Compassion and Compassion & Attitude	This was a difficult case. Patient developed delirium post stroke. Must have been hard for team to observe. Particularly as patient was refusing to eat and drink. Very good care, psychological support was sought from In-reach. Family updated regularly.

DHM/MHSOP

Learning themes and issues identified as part of the review/investigation.

1. Assessment, Diagnosis & Plan	
1.1 Assessment and Assessment	Declined assessment – 10th May 2021 felt to have capacity – no capacity assessment noted or recorded. Alcohol dependence – referred for CBT, reference to Turning point in the notes in March 2019 and June 2020. The CAP Triage process is being reviewed in line with national guidance. SBAR already completed and there is a paper that will be going to the Quality & Safety Summit in January 23.
1.3 Assessment and Management Plan	Some gaps in follow up noted, however appears patient was not always welcoming of calls
2. Communication	
2.4 Communication and Results / Management / Discharge	Outpatient review in November 2020 identified follow up for 2 months' time, next review was September 2021. Communication from outpatients when reviews are not scheduled as planned could be communicated with the patient. To be taken forward with the transformation workstream. Part of the process will be looking at patient expectation and how we communicate with them if we are unable to meet appointments when advised.
3. Dignity & Compassion	
3.8 Dignity & compassion and Compassion / attitude	The Outpatient team did not show compassion to the son of the patient in a distressing time.
	No contact with the family however not clear if family were involved in this patient's care.
4. Discharge	
4.12 Discharge and Discharge Planning.	There were no mental health concerns so probably should have considered discharge. To be reviewed as part of the caseload review and discharge planning and arrange for the Discharge SOP to be included in the Locum Inductions so that they are aware of the thresholds for discharge.
5 Documentation - Paper & Electronic	
E5.13. Documentation and Correspondence with Patients/Other Clinical Teams	Lack of contact from MHF and CPN with each other. No care plans since 2020 Does not appear to be any communication with elderly father, who lived with patient and administered medication. Previous safeguarding concerns raised that father had lost his access to his motor scooter as Pt had crashed it intoxicated. Reflection with CPN will take place.
	Referral was seen and triaged on day of referral. Communication with GP advising of referral being placed on waiting list and potential for delay in allocation.

	Both patient and NoK did not receive letters and were not aware of assessments when arranged. No documentation of Follow up call on 17th August to make aware of appointment. Within the Communication template mentions that patient does not answer the phone due to cold calling scams. Advised to call 2-3 times in a row. There is no alert on SystmOne to make aware of this or handover to LPT services in regards to this.
	Correspondence to patient and NOK to ensure this is checked and appropriate. This has been fedback to Team Leader to have conversation and reflection with team.
	There was no regular contact with the patient from LPT and if deemed unnecessary due to patient's mental health being stable should the patient have been discharged from secondary care.
5.14. Clinical Documentation within Clinical Record	No evidence of any care plan or risk assessment being completed during the period of assessment. Whilst the lack of documentation has not directly impacted this death there needs to be a discussion with team lead re clinical documentation and ensuring needs and risk are fully captured.
	Whilst the lack of documentation has not directly impacted this death there needs to be a discussion with team lead re clinical documentation and ensuring needs and risk are fully captured.
	Risk summary and management of risk (risk assessment in ED didn't reflect risks management).
	Numerous physical health concerns, but communication between mental and physical health not robust. Discharge planning was identified on the 14th of October, but no documentation that this had been started or communicated. This has been picked up with CPN through Team Manager for City Central.
8 Medication	
8.21. Medication and Prescribing	A delay in the patient receiving memantine after it had initially been agreed in July. She didn't receive her first dose until October. Action: To consider ways to make the process more efficient e.g., if bloods required, organise for them to be taken when decision made to commence medication. Passed to In-Reach Team to review.
11 Appointments	
11.32 Appointments and Did not attend	DNA letters / opt in and further appointments. Action: Explore / check DNA process for those that miss appointments. This is covered in the updated DNA Policy which has just been reviewed and is awaiting sign off.
11.33 Appointments & Arrangements - e.g.	The patient had not been seen face to face by his CPN since the start of Covid. There is an expectation that once

chaperone, miscommunication	services are functioning as usual the patient would be seen face to face for some of the appointments.
14 Chronic Physical and Mental Health problems	
14.41 Chronic Physical and Mental Health Problems and Medications related to PH and/or MH	May need to improve staff knowledge around this subject through medicine's management training. Guidance notes on SystmOne to be reviewed and regarding training/possible email to staff.
	In 2011 patient was pre diabetic, their anti-psychotic medication was not changed or an alternative considered until November 2018.

FYPC/LD

Learning themes and issues identified as part of the review/investigation.

2 Communication – Patients & Relatives	
2.6. Communication – Patients & Relatives and Reasonable Adjustments	Whilst communication within the MDT was very good, the basic under-standing of what the risks were of not allowing / encouraging the patient to have Bloods, ultimately impacted on the longer-term management.
5 Documentation – Paper & Electronic	
5.13. Correspondence with Patients/Other Clinical Teams	Was on a routine waiting list for physio which, due to staff shortages and capacity. Approximately 10 month wait for mobility and transfers assessment. JBW to flag with Julia re deterioration whilst on waiting list. Action: LfD mtg 22/11/22. JR Diagnostic over shadowing was discussed as a potential theme although not LPT learning, there may have been opportunities missed around changes in mobility being put down to being due to their learning disability rather than physical heath.
	Although good practice has noted good information sharing system in place, it would be easier if acute team could see our records.
5.14. Documentation and Clinical Documentation within Clinical Record	It would have been beneficial to have been able to read UHL's notes to have a better understanding. There is a Trust-wide steering group already looking at better integration.
7 Multi-disciplinary Team Working	
C7.18 Multi-disciplinary working and Inter-speciality liaison/Continuity of care/ownership.	Action: No learning for LPT but agreed action to highlight that this gentleman was vulnerable to regular moves and because of all his health concerns, the real worry is that information is not well transferred from home to home and it happens so frequently. Shared with LeDeR Group via Siouxie Nelson & Rebecca Eccles.

Good practice themes identified as part of the review/investigation.

1 Assessment, Diagnosis & Plan	
1.1 Assessment and Assessment.	Baby received assessment by PHN HV during universal review and was correctly identified as having additional health needs, therefore placed onto UPP pathway and offered additional visits. The primary reason for additional visits was growth reviews. The baby was on a strict feeding plan (given by NNU team, not PHN HV) to ensure maintenance of blood sugars.
1.1 Assessment and Assessment plus 1.3. Assessment and Management plan.	Physical health prioritised. Learning disability team were extremely responsive, providing responsive care.
1.3. Assessment and Management plan.	Very detailed eating & drinking plan, good physiotherapy input and appropriate equipment in place.
	Patient had robust eating & drinking plan.
2 Communication – Patients & Relatives	
2.4 Communication and Results/Management/ Discharge plan.	Health Visitor called mother to arrange the contact within our guidance timeframe.
	Really good practice in terms of communication and assessments and recommendations.
2.5 Communication – Patients & Relatives and Imminence of death, DNACPR, Prognosis.	Excellent communication by Diana Service regrading understanding of end-of-life prognosis.
3 Dignity & Compassion	
3.8. Compassion / Attitude	Services were able to ensure the family got their wish regarding end-of-life care.
	Feedback from mum who felt that it was NHS care at its best that her son's needs were never discounted due to his learning disability, and all options were open to him.
	It is a testament to the team to ensure patient was able to stay out of hospital.
5 Documentation	
5.14 Documentation and Clinical Documentation within Clinical Record.	The PHN HV recorded details of each visit clearly on the S1 electronic health record, she also recorded an ongoing plan. The PHN HV followed the SOG.
	Tasks on SystmOne being used more consistently.
7 Multi-disciplinary Team Working	
7.18 Multi-disciplinary working and Inter-speciality	Learning disability team were aware to be careful about the accuracy of the information being given by the care home who, from experience, had a tendency to elaborate on information."

liaison/Continuity of care/ownership.	Really good collaborative practice around coordination between Physio, speech and language therapy, GP, the home and the community nurses and psychiatry. Holistically looking at ruling out all the possible causes of agitation before going down behaviour route.
	Health Visitor called the hospital to get an update from the nursing staff.
	Good liaison and have a good system in place between the acute team and speech and language therapy. Good information sharing system in place although it would be easier if acute team could see our records.
	Strong links between community and acute hospital team led to joined up care
	Diana Service had great communication with Rainbows and their staff in the hospital.
	Patient and SALT liaised with inpatient setting whilst Patient was in hospital. When patient was discharged under palliative care, Access took a call from the care home manager, contacted the involved PT who completed RFIs to OT and SALT. Each AHP team responded promptly to this referral; PT visited within 24 hours, OT visited the day after allocation, SALT telephoned to give advice the day after call to Access received.
	Really good collaborative practice around coordination between Physio, speech and language therapy, GP, the home and the community nurses and psychiatry. Holistically looking at ruling out all the possible causes of agitation before going down behaviour route.
7.19 Multi-disciplinary working and Inter-speciality referrals/review.	LPT assisted in identifying an alternative placement and engaged well with trying to find out what was going on because patient's health had deteriorated so rapidly. When discharged from hospital for EOL care, the Community LD Team continued to be involved in supporting and advising staff at the home.
9 Ceiling of Care	
9.25 Ceiling of Care and Monitoring.	Good monitoring.

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.