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Leicestershire Partnership NHS Trust

Public Trust Board of Directors

Safety and Quality in Learning from Deaths Assurance (Quarter 4)

1. Purpose of the report

This report is presented to the Trust Board as assurance of the efficacy of the Learning from Deaths (LfD), Child Death Overview Panel (CDOP), Learning Disabilities Mortality Review (LeDeR), and Serious Incident (SI) processes in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017). This Report presents data from January to March 2023 (Quarter 4: Q4) as well as learning from Q4 and previous quarters not already reported, at Leicestershire Partnership Trust (LPT).

2. Analysis of the issue

The information presented in this report is 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). There is ongoing work with directorates to emphasise the importance of this data as a means of better understanding and overcoming potential health inequalities.
- **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.
- **CHS** - 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.

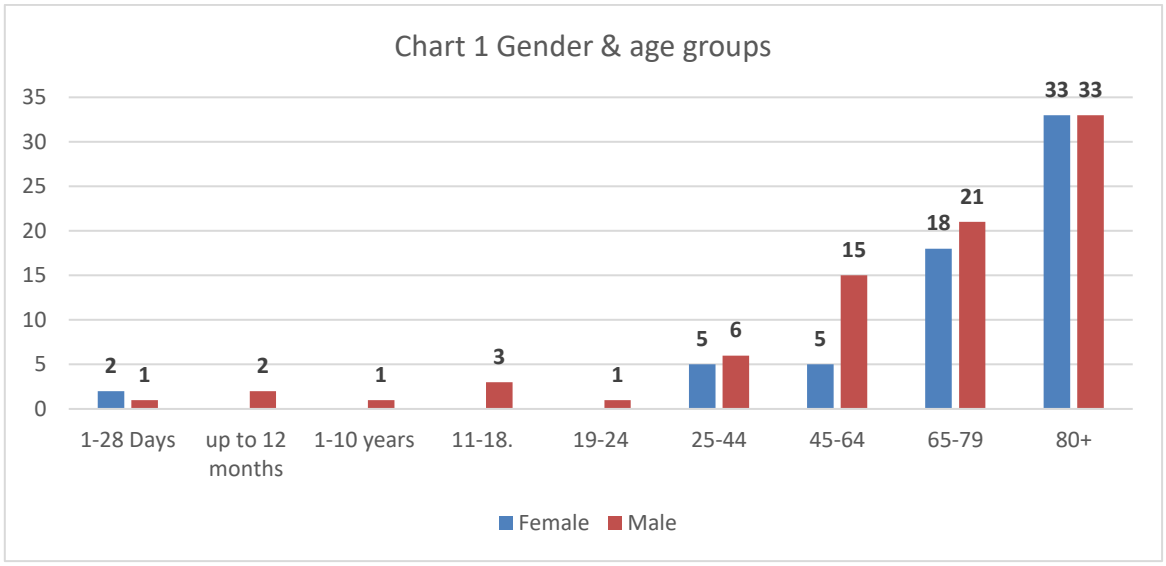
- **DMH** have completed work on their backlog and have no reviews outstanding from the previous financial year, 1st April 21 to 31st March 22.
- **FYPC/LD** - Dr Rohit Gumber has been appointed as Associate Medical Director and has taken over the responsibility of Chair for LfD meetings.

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 1-5. 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 and there are there are ongoing discussions regarding obtaining demographic data directly from SystmOne. The CHS Business & Transformation Team are in the process of writing a report to this effect for CHS with the intention of reports being available for deaths occurring from April 23 onwards.



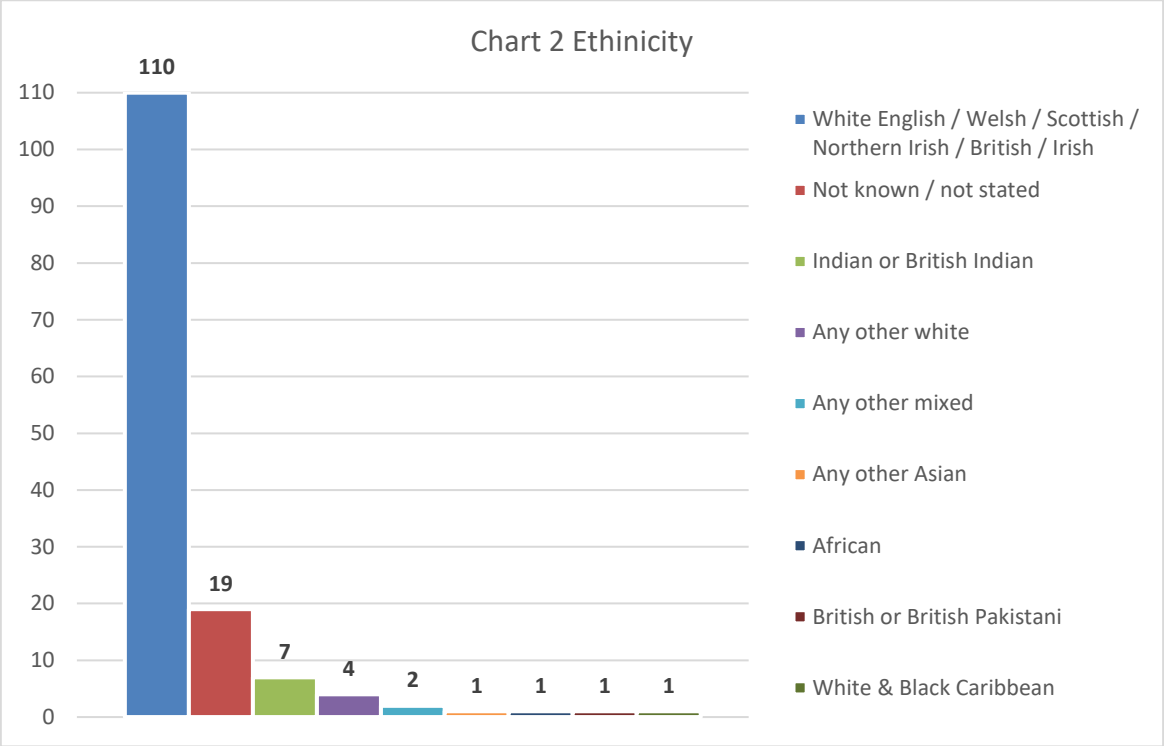


Chart 2 Ethinicity
110
19
7
4
2
1
1
1
1
0
10
20
30
40
50
60
70
80
90
100
110
White English / Welsh / Scottish / Northern Irish / British / Irish
Not known / not stated
Indian or British Indian
Any other white
Any other mixed
Any other Asian
African
British or British Pakistani
White & Black Caribbean

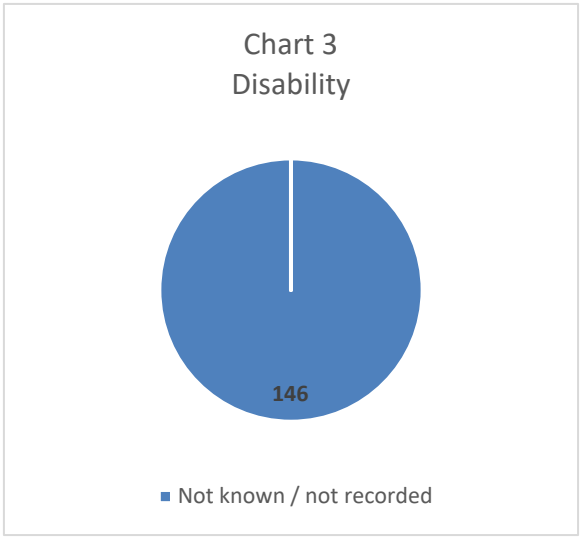


Chart 3
Disability
146
Not known / not recorded

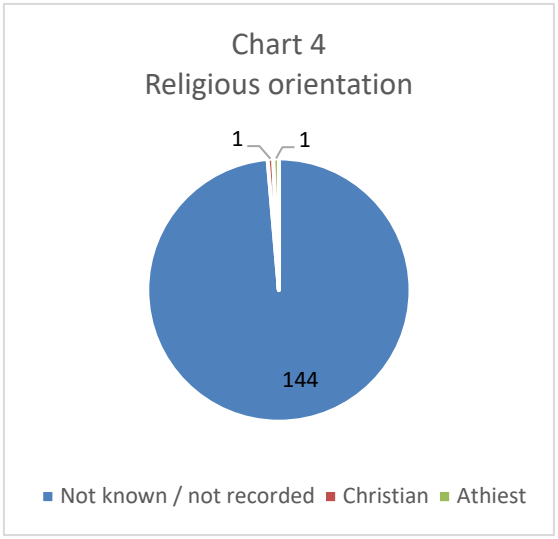


Chart 4
Religious orientation
1
1
144
Not known / not recorded
Christian
Athiest

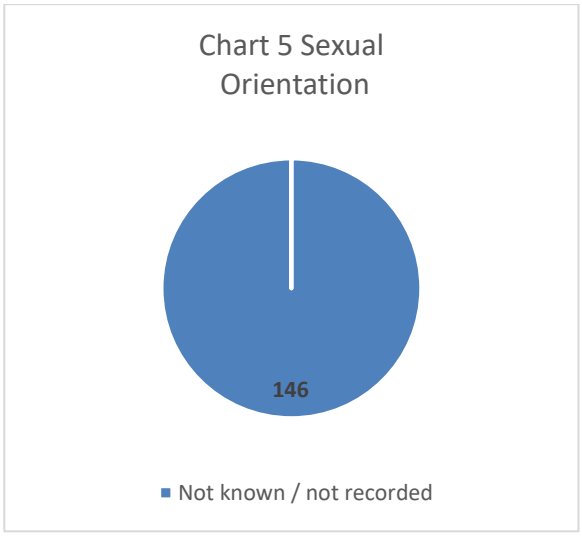


Chart 5 Sexual Orientation
146
Not known / not recorded

The Corporate Patient Safety Team are in discussions with the Information Team to ascertain a meaningful way to analyse health inequalities and mortality data by geographically area.

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 2:

Table 1: Annual backlog of deaths

Breakdown by Directorate												
	CHS				**DMH/MHSOP**				**FYPC/LD**			
	Q1 (Apr-Jun)	**Q2 (Jul-Sep) ***	**Q3 (Oct-Nov)**	**Q4 (Jan-Mar)**	**Q1 (Apr-Jun)**	**Q2 (Jul-Sep) ****	**Q3 (Oct-Nov) ****	**Q4 (Jan-Mar)**	**Q1 (Apr-Jun) *****	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov) *****	**Q4 (Jan-Mar)**
Number of deaths reviewed	40	44	25	40	65	73	79	38	20	19	24	10
Percentage of deaths reviewed	100%	100%	100%	100%	99%	96%	85%	42%	100%	100%	96%	63%
Number of deaths outstanding for Directorate review	0	0	0	0	1	3	14	52	0	0	1	6
Percentage outstanding for directorate review	0%	0%	0%	0%	1%	4%	15%	58%	0%	0%	4%	37%

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

*Q2's total is 1 less than previously reported due to 1 July death that was Out of Scope being inadvertently included in the figures.

** DMH/MHSOP Qtr 2 is 1 less that previously recorded as 1 August death reported in December was a November death and shouldn't have been included in Qtr 2's figures. Qtr 3 is 20 more than previously reported as 1 October death, 2 November deaths and 15 December deaths were reported in January; 1 December death reported in February; 2 November SI's inadvertently not counted and 1 December death that should not have been included as it was out of scope.

*** FYPC/LD Qtr 1's figures is 1 more than previously reported as 1 June death was reported in February and Qtr 3's figure is 1 less than previously reported due to one death being out of scope.

In adherence with NHS/I (2017) recommendations Table 2 also shows the number of deaths reported by each Directorate for Q4. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR) case record reviews:

- There were 146 deaths considered in Q4.
- There was a total of 4 deaths for Serious Incident Investigation.
- There were 7 adult deaths of individuals with Learning Disabilities which are undergoing LeDeR review within FYPC.
- There were 1 unexpected death within CHS which had an ISMR completed and was discussed at IRM. The learning identified is captured under 6 Learning themes and good practice identified. 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 (Q4)

Q4 Mortality Data										
	Jan			Feb			Mar			Total
	C	D	F	C	D	F	C	D	F	146
Number of Deaths	9	43	4	11	15	5	20	32	7	
Consideration for formal investigation										
	C	D	F	C	D	F	C	D	F	Total
Serious Incident	0	2	0	0	1	0	0	1	0	**4**
mSJR* Case record review	9	43	4	11	15	5	20	32	7	**146**
Learning Disabilities deaths			2			3			2	**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	**0**
Learning										
	C	D	F	C	D	F	C	D	F	Total
Number of family contacted for feedback	9	3	1	11	1	0	20	0	0	**45**
Number of family feeding back	4	1	0	5	1	0	8	0	0	**19**
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.

6. Learning themes and good practice identified

CHS

All deaths are being reviewed by the ME which has meant that CHS is not as close to the process as previously. The ME will share any areas of good practice and concern. This quarter there were no concerns identified by the ME's office and no learning actions in response to the themes identified.

Routine 6-8 week Bereavement Support Service (BSS Nurse) contact is offered to all CHS bereaved families by the Medical Examiner during their conversation around the certification of death process however if questions or concerns are raised about the care received during this conversation, the BSS will make contact the family at around 2-3 weeks.

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

- MDT Working

A common learning theme from across the whole directorate from Internal Investigations and SIs is MDT working and Lead professional role which is also a Trust wide theme.

- Referrals between services

There is a piece of work from an SI currently being undertaken for Therapies both in CHS and Adult Learning Disabilities in streamlining referrals between services which is being led by AHP Lead for FYPC & LD.

- Transitioning from Children's to Adult's Services

The Diana Service Lead will link with Deputy Head of Nursing and Clinical Director for Community Paediatrics Discussion to gain a better understanding of the potential services available for patients who are transitioning from Children's to Adult's Services and how to better work together when dealing with young people with complex needs. The Diana Service Lead will also attend the Community MDT meeting.

Learning from Unexpected death identified in ISMR

- Review of NEWS2 learning on Ulearn has identified that the escalation pathway does not reflect the current escalation pathway being used on the community hospital wards/Brigid.
- Use of SBAR – supervision taking place across the ward with all RNs

- Review of the Deteriorating Patient Policy – the Trust does not have an up-to-date policy – to raise through DPRG for update
- ANP have reflected and there is no clear Trust guidance to support the decision – not to support CPR if a similar event were to take place with a patient who is imminently dying who have not the DNACPR in place. Further scoping required.
- Review of the resuscitation policy – and the best practice guidance relating to continuing any CPR for up to 20 mins.
- Resuscitation Officer visited the ward and has reviewed the case notes, identifying learning around documentation. Reflective discussion in relation to this particular visit and importance of supportive language impacting on the team.
- Feedback to UHL and ward team at LGH via TCS and to query in relation to DNAR/Respect discussions prior to transfer.

Feedback from the National Medical Examiner (ME) process

Opportunities for potential learning may arise from family feedback, which will be taken forward by the BSS Nurse, and may be addressed in the form of feedback to the ward, requesting and coordinating a review of care to identify learning and opportunity for process or system updates, or for further escalation as appropriate.

Any identified learning outcomes are shared with the family (where requested) and within LPT via appropriate clinical team's or directorate wide communication channels. A BSS quarterly EoL report will also provide family feedback theming and identified Learning outcomes to the EoL Steering group.

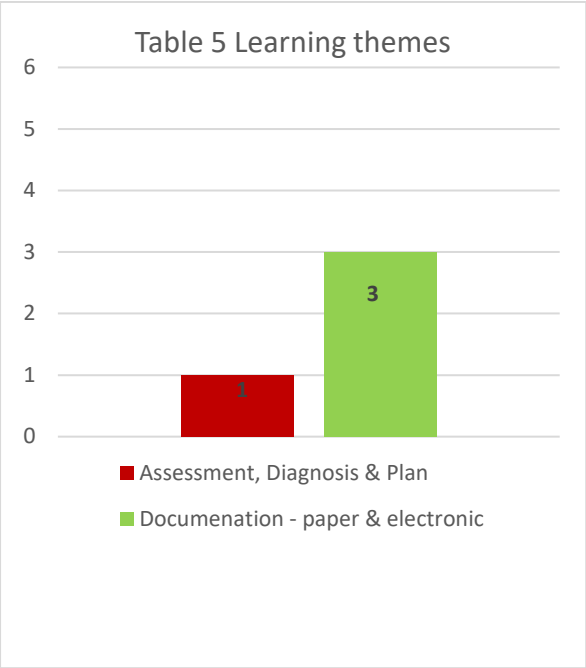
In quarter 4, families advised that they were happy with care provided in our community hospitals and in some cases, felt that that care was excellent. Families also felt their loved ones had good palliative care and symptom control as well as feeling that staff couldn't have done enough for their loved one.

Where families felt that they had issue with end-of life-care, missed diagnosis and were unhappy with their loved one being moved in the middle of the night, the BSS Nurse will ensure these are addressed in the form of feedback to the ward, requesting and coordinating a review of care to identify learning and opportunity for process or system updates, or for further escalation as appropriate. Any actions arisen as a result of feedback are monitored through CHS Governance Team.

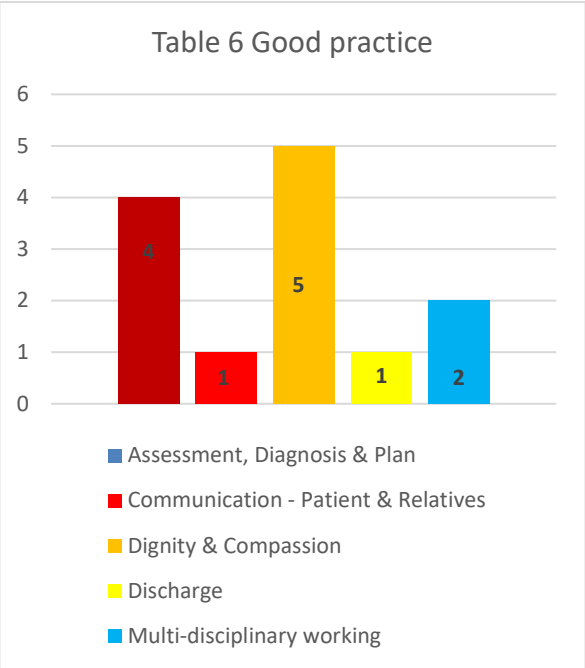
Full details of feedback from families praising care provided by LPT can be found in Appendix 1.

DMH/MHSOP

Learning themes (Q4)



Good practice themes (Q4)



Full details of learning themes and good practice can be found in Appendix 2.

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

- Documentation (5.14 Documentation – Paper & Electronic and Clinical Documentation within Clinical Record)

Staff did not document details of fall in a timely manner and not until after speaking with the son the following day. Staff not having the information to answer any queries regarding the time of the fall resulted in the family raised concerns about the accuracy of the information shared. Fall was on CCTV and no concerns identified. This case was discussed at Team Meeting to reiterate importance of completing documentation and sharing accurate information with family.

Risk assessment should have been updated more regularly, the patient had been struggling with suicidal ideations whenever they felt overwhelmed and distressed, due to their OCD traits, which were their trigger factors. Care plans not being updated by CPNs due to capacity within teams is on the Trust's Rick Register. The risk will continue to be reviewed whilst it remains on the Trust's Risk Register.

Immediate learning identified in Rapid Reviews

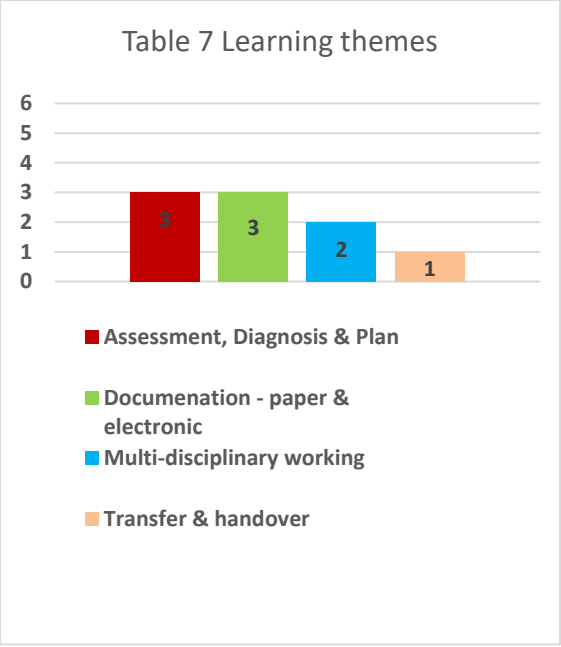
- Potential learning for CAP Team. There were missed some opportunities especially for an urgent triage rather than safe & well check at end of shift.
- Missed Safety Plan for CRHT.

- From a substance misuse perspective, the assist lite should have been completed and further exploration of substance use, as alcohol was a factor in the notes and involved in previous overdose attempts.
- Shared information around local hospitals and how we follow up patients who have been seen in out of area hospitals.
- There were a number of professionals external to LPT that were involved with the patient's care and a hospital admission outside Leicester that LPT were not aware of at the time. How these types of information could be shared needs exploring.
- The issue around follow up post DNA to the Hub and potential review of Hub DNA process to be further explored in Internal Investigation.
- The issue around how the Pathfinder appointment was cancelled and rescheduled to be ascertained as part of SI investigation.

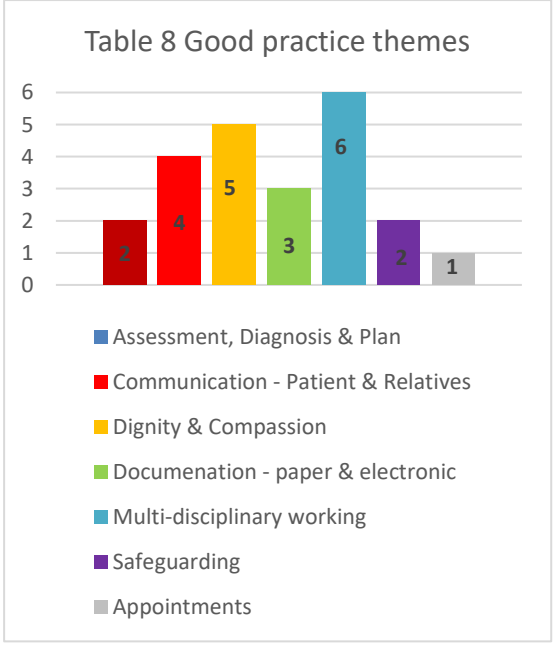
The DMH Learning from deaths group has been asked to consider a theme identified from investigation of Serious & Internal Investigations of male patients in their 50/60's who have been found deceased at home who have not been identified as having taken their own life. There is evidence of self-neglect or substance misuse. Although these deaths are considered as 'natural causes' it is important for us to understand if there was other action or learning we could take to better support these patients to access help and support.

FYPC/LD

Learning themes (Q4)



Good practice themes (Q4)



Full details of learning themes and good practice can be found in Appendix 2.

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- Transitioning from Children's to Adult's Services

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Immediate learning identified in ISMRs

- Visits cancelled by the team, CDOP aware and strategy call took place. Baby's notes have been ended and documented on mother and siblings of baby's death documented. CTL in the allocated team is aware to support staff if required with visits to the sibling, FSM was made aware.
- Review of notes on patient record taken place. Support provided to staff who supported the patient and family contacted to offer condolences and support.

7. Decision required

The Trust Board is required to confirm assurance on the implementation of the National Quality Boards Learning from Deaths guidance within the Trust.

8. Governance table

For Board and Board Committees:	Trust Board	
Paper presented by:	Dr Saquib Muhammed	
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. Feedback from families praising care provided by LPT

CHS

Coalville Community Hospital

- Happy with care, Coalville hospital. Palliative care good and symptoms control good.
- Very well look after at Coalville
- Husband very impressed with care at Coalville.
- Daughter very pleased with the care her mum received

Loughborough Hospital

- End of Life Care at Loughborough excellent
- Very good care at Loughborough
- Very happy with care at both UHL and Loughborough
- Happy with care
- Care provided was excellent
- All care 150%
- Very happy with care

Hinckley & Bosworth Community Hospital

- Amazing care at Hinckley Hospital
- Hinckley Care excellent
- Absolutely happy with care. Unbelievable care. Both at LRI and community

St Luke's Hospital, Market Harborough

- Very happy with care at both LRI and St Luke's – very complementary.
- Care "was brilliant., couldn't have done enough for her"

Feedback from families where they were unhappy with the care provided.

Loughborough Community Hospital

- Slight resentment at repeated calls asking if he could be moved out of the Evington Centre, when it was obvious he had not long to live – one call even on the day before his death!
- Partner is of the view that diagnosis was missed both on ultrasound in Dec 2021 and check cystoscopy.

Hinckley & Bosworth Community Hospital

- Issue with EOLC
- Very unhappy with care. Not fed as had Parkinson's. Also moved to the Leicester Royal Infirmary in middle of night.

Appendix 2. Examples of Learning identified, both good practice and areas for improvement

DHM/MHSOP

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

1. Assessment, Diagnosis & Plan	
1.1 Assessment and Assessment	Assessment not offered in a timely way. Inability to offer timely assessment and interventions is already captured as a risk for the directorate and has mitigation plans in place and work via transformation. Continue transformation work and case load reviews for outpatients.
5 Documentation - Paper & Electronic	
5.14. Clinical Documentation within Clinical Record	Staff did not document details of fall in a timely manner and not until after speaking with the son the following day. Staff not having the information to answer any queries regarding the time of the fall resulted in the family raised concerns about the accuracy of the information shared. Fall was on CCTV and no concerns identified. Action: Case to be discussed at Team Meeting to reiterate importance of completing documentation and sharing accurate information with family.
	Risk assessment should have been updated more regularly, the patient had been struggling with suicidal ideations whenever they felt overwhelmed and distressed, due to their OCD traits, which were their trigger factors. Care plans not being updated by CPNs due to capacity within teams is on the Trust's Rick Register. The risk will continue to be reviewed whilst it remains on the Trust's Risk Register.
5.15 Documentation and Completion of clinical forms i.e., DNACPR, Consent, Nursing Assessments.	Most recent Core mental health assessment missing. Most recent core mental health assessment not recorded or updated, although discharge plan was discussed and agreed by patient and care, there was a long delay in posting letter to patient and her carer.

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

1 Assessment, Diagnosis & Plan	
1.1 Assessment and assessment	Holistic assessment from CMHT with consideration to psychosocial needs and the needs of patient in relation to being a member of the armed forces community Throughout care with Urgent Care/ CMHT consideration for

	meeting needs with multi agency support evidenced "
	Patient was attended immediately post fall. Reviewed by medics and ambulance arranged to transfer to ED for further assessment and treatment.
	Clear documentation of well-established annual mental health reviews
1.3 Assessment and Management plan.	MHP gave the correct advice to the ward UHL to contact the police.
2 Communication – Patients & Relatives	
C2.4 Communication and Results/Management/Discharge plan.	Staff member maintained good communication with patient and family including signposting. There is also good evidence of physical health referrals and referral to ascertain support with patients physical health needs / social care needs
3 Dignity & Compassion	
E3.8 Dignity & Compassion and Compassion/Attitude.	Patient and family were well supported by CPN.
	Excellent compassionate care provided by LPT staff, regular reviews of both physical and mental health. Regular contact with family. Care was responsive to changing needs.
	Since patient was referred and seen in the community, there are full evidence through documentation that patient and her NOK were treated with dignity and respect. There is also good evidence of constant flow in communication with NOK in regards to care being provided as well as Medical decisions up until patient reached to end of life before she passed away. This will be fedback to team.
	It is very clear that the team showed good levels of dignity and respect to patient following her referral to LPT.
	Well documented that patient`s mental, social and physical health care needs were closely monitored, there are evidence of good rapport which was established with patient during his involvement with community team
4 Discharge	
4.10 Follow up Management Plan.	Patient`s care was discussed and reviewed in MDTs, medication was regularly reviewed, patient was supported by home visit and telephone call support as well
7 Multi-disciplinary Team Working	
C7.18 Multi-disciplinary working and Inter-speciality liaison/Continuity of care/ownership.	Both psychically and mental health were well supported and documented with lots of correspondence letters as supporting evidence."
7.20 Multi-disciplinary working and Inter-team Issues (within same speciality)	Well documented good communication and liaison among other medical and non-medical team well documented.

FYPC/LD

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

1 Assessment, Diagnosis & Plan	
1.1 Assessment and Assessment	Missed 6 week contact at the very beginning. A central list has been developed to keep track of all the six-week contacts that are being done. The Access Team now monitor these and SystmOne flags a due date.
	Slight delay between allocation and initial visit which has been fedback to everyone in the team to ensure all calls and attempts to make appointments are logged in notes.
1.1 Assessment and Assessment 1.2 Assessment and Diagnosis	LPT's learning was around communication with the GP concerning the working diagnosis of dementia and advising them of when it was no longer a working diagnosis."
1.3 Assessment and Management plan	Baby should have had a Universal Partnership Plus referral allocation due to the complex family background and other services and Social Care involvement with Mother and wider family. Action: Reflection and discussion with CTL if unsure of referral allocation.
5 Documentation – Paper & Electronic	
5.13. Correspondence with Patients/Other Clinical Teams	LPT's learning was around communication with the GP concerning the working diagnosis of dementia and advising them of when it was no longer a working diagnosis."
	Potentially it may have been thought that we had more information than we did, but unfortunately, that wasn't the case. (also 7.18) There is a piece of work from an SI currently being undertaken for Therapies both in CHS and Adult Learning Disabilities in streamlining referrals between services which is being led by AHP Lead for FYPC & LD.
5.14. Documentation and Clinical Documentation within Clinical Record	To ensure all phone calls and emails are recorded onto the electronic record contemporaneously. Action: Reflection and discussion with CTL if unsure of referral allocation.
7 Multi-disciplinary Team Working	
7.18 Multi-disciplinary working and Inter-speciality liasion/Contunuity of care/ownership.	Potentially it may have been thought that we had more information than we did but unfortunately, that wasn't the case. (also 5.13) There is a piece of work from an SI currently being undertaken for Therapies both in CHS and Adult Learning Disabilities in streamlining referrals between services which is being led by AHP Lead for FYPC & LD.
7.19 Multi-disciplinary working and Inter-speciality referrals	Discussion to take place to gain a better understanding of the potential services available for patients who are transitioning from Children's to Adult's Services. Role of Diana Service and

/review.	how to better work together when dealing with young people with complex needs. Action: Diana Service Lead to link with Deputy Head of Nursing and attend Community MDT meeting. Also, link with Clinical Director for Community Paediatrics.
12 Transfer & Handover	
12.34 Transfer & Handover and Delays to correct speciality/setting.	No communication form local midwifery team to update that baby was home and had been seen. No communication from hospital to update Healthy Together that child had been discharged home. To be highlighted to LfD Trust Board and included on Highlight Report: Midwifery team use a different electronic patient record to Healthy Together which has been a theme is some SI Action plans and has been escalated to the Safeguarding Board as a Risk and is on the Trusts Risk Register.

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

1 Assessment, Diagnosis & Plan	
1.3. Assessment and Management plan.	Identified levels of vulnerability and undertook targeted antenatal even though family known not to engage well. Door stop visit took place and followed up on Was not brought policy. It was noted that the practitioner is known to have a good rapport with teenager mothers. (also 3.7, 3.8 & 11.32)
1.1 Assessment and Assessment; 1.2 Assessment and Diagnosis; 1.3 Assessment and Management Plan	PHN - HV delivered a very good practice of care at Universal, it was and delivered with accordance of the SOG, appropriate questionnaires and assessments used and plan of care recorded within required timeframes. (also 7.19)
2 Communication – Patients & Relatives	
2.4 Communication and Results/Management/ Discharge plan.	Communication was good.
	Good communication with mum.
	Good communication and support. (also 7.18)
2.4 Communication – Patients & Relatives and Results / Management / Discharge Plan; 2.5 Communication – Patients & Relatives and Imminence of death, DNACPR, Prognosis & 2.6 Communication – Patients & Relatives	Responsive care was provided working with Safeguarding to escalate concerns around diagnosis of end-of-life and arranging same day hospital readmittance. (also 10.31)

and Reasonable adjustments.	
3 Dignity & Compassion	
3.7 ADL Assistance/ Reasonable Adjustments	Identified levels of vulnerability and undertook targeted antenatal even though family known not to engage well. Door stop visit took place and followed up on Was not brought policy. It was noted that the practitioner is known to have a good rapport with teenager mothers. (also 3.7, 3.8 & 11.32)
3.8. Compassion / Attitude	Mother offered universal contacts as per health visiting guidance even though baby was on the neonatal unit. The Health Visitor kept in regular contact with mother for an update on baby's progress and to offer additional support to mother if she required.
	Team communicated very well with lots of communication with family and impatient teams and were compassionate throughout. (also 7.18)
	PHN aware of baby's hospitalisation contacted mother to offer support and when informed of baby's death offered condolences. PHN continued to offer Universal Plus service to the family. (also 5.14)
	Identified levels of vulnerability and undertook targeted antenatal even though family known not to engage well. Door stop visit took place and followed up on Was not brought policy. It was noted that the practitioner is known to have a good rapport with teenager mothers. (also 3.7, 3.8 & 11.32)
5 Documentation	
5.14 Documentation and Clinical Documentation within Clinical Record.	PHN documentation was thorough with clear analysis and rationale. Appropriate referral allocation added to records. At New Birth Visit on 6.1.23, PHN HV discussed Safe Sleeping Guidance as per Healthy Together Standard Operating Guidance. PHN HV discussed risks of smoking. Safe smoking guidance and safety at home. (also 3.8)
	Contemporaneous Record keeping
	SystmOne record updated.
7 Multi-disciplinary Team Working	
7.18 Multi-disciplinary working and Inter-speciality liaison/Continuity of care/ownership.	Team communicated very well with lots of communication with family and impatient teams and were compassionate throughout. (also 3.8)
	Patient had access to a lot of generic services.
	Good examples of multi-disciplinary working.
	Good communication and support. (also 2.4)
	Good multidisciplinary working with LPT.
7.19 Multi-disciplinary working and Inter-speciality referrals/review.	PHN - HV delivered a very good practice of care at Universal, it was and delivered with accordance of the SOG, appropriate questionnaires and assessments used and plan of care recorded within required timeframes. (also 1.1, 1.2 & 1.3)

10 Safeguarding	
10.30 Safeguarding and Known to Safeguarding.	Historical safeguarding concerns shared – ensuring that Health could provide appropriate support to the family.
10.31 Safeguarding and Safeguarding concerns and voids	Responsive care was provided working with Safeguarding to escalate concerns around diagnosis of end-of-life and arranging same day hospital readmittance. (also 2.4, 2.5 & 2.6)
11 Appointments	
11.32 Appointments and Did not attend	Identified levels of vulnerability and undertook targeted antenatal even though family known not to engage well. Door stop visit took place and followed up on Was not brought policy. It was noted that the practitioner is known to have a good rapport with teenager mothers. (also 3.7, 3.8 & 11.32)

Appendix 3: Learning and Good practice

Learning from Deaths Learning & Good Practice Themes

1	**Assessment, Diagnosis & Plan**
1.1	Assessment
1.2	Diagnosis
1.3	Management plan
2	**Communication – Patients & Relatives**
2.4	Results/Management / Discharge Plan
2.5	Imminence of death, DNACPR, Prognosis
2.6	Reasonable adjustments
3	**Dignity & Compassion**
3.7	ADL Assistance/ Reasonable Adjustments
3.8	Compassion / Attitude
3.9	Environment
4	**Discharge**
4.1	F/up management plan
4.11	Equipment/POC
4.12	Discharge Planning
5	**Documentation - Paper & Electronic**
5.13	Correspondence – with patients, other clinical teams
5.14	Clinician documentation within the clinical record
5.15	Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments
6	**Investigations / Results**
6.16	Investigations
6.17	Results
7	**Multi-Disciplinary Working**
7.18	Inter-speciality liaison/continuity of care/ownership
7.19	Inter-speciality referrals/review
7.2	Inter team issues (within same specialty)
8	**Medication**
8.21	Prescribing
8.22	Supply
8.23	Administration
8.24	Review
9	**Ceiling of Care**
9.25	Monitoring
9.26	Recognition
9.27	Escalation / Ceiling of Care
10	**Safeguarding**
10.28	**Risk to themselves**
10.29	**Risk to others**

10.3	**Known to safeguarding**
10.31	**Safeguarding concerns and voids**
11	**Appointments**
11.32	**Did not attend**
11.33	**Arrangements – e.g. chaperone, miscommunication**
12	**Transfer & Handover**
12.34	Delays to correct speciality/setting
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
12.36	Omissions/Errors in Handover communication
13	**Self-harm**
13.37	Drug and alcohol misuse
13.38	Physical self-harm: e.g. cutting, ligaturing, head banging
14	**Chronic physical and mental health problems**
14.39	Unknown impact of PH on MH or vice versa
14.4	Mismanagement of both PH and MH including deterioration
14.41	Medications related to PH and/or MH
15	**Isolation & loneliness**
14.42	Recognition of the impact of isolation and loneliness
14.43	Lack of support
14.44	Multi-agency support

Abbreviations: ADL: Activities of Daily Living; **POC:** Point of Care; **DNACPR:** Do Not Attempt Cardio Pulmonary Resuscitation

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Appendix 4 Theming guidance

1. Glossary

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.

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
9.27: 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.

Illustration of the process of coding derived from Learning and Good Practices themes.