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Leicestershire Partnership NHS Trust

Public Trust Board of Directors

Safety and Quality in Learning from Deaths Assurance (Quarter 1)

1. Purpose of the report

This report is presented to the Trust Board as assurance of the efficacy of the Learning from Deaths (LfD), Child Death Overview Panel (CDOP), Learning Disabilities Mortality Review (LeDeR), and Serious Incident (SI) processes in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017). This Report presents data from April to June 2023 (Quarter 1: Q1) as well as learning from Q1 and previous quarters not already reported, at Leicestershire Partnership Trust (LPT).

The deaths within scope for mortality review are those where, at the time of death the patient was subject to

- Any inpatient setting – including community hospitals.
- Community Health Services (CHS): anyone discharged from a community hospital within 30 days where known. It does not include any deaths where LPT is not classed as the main provider.
- Adult Mental Health Services (DMH) & Mental Health Services for Older People & MHSOP) patients on active caseloads or were discharged from the service in the last 6 months.
- If the family or coroner raise concerns about the death.

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 Families, Young people and children's services / Learning disabilities & Autism (FYPC/LDA). LfD forum meetings in CHS are carried out on an ad-hoc basis to discuss Unexpected deaths and should further discussion be identified through the ME process or as identified by LPT Staff.

- **Demographics** – Protected characteristic information is now gathered from Systmone and is included in this report. There remains an issue around sexual orientation which is captured on Systmone, but this information is not currently being processed in LPT's data warehouse however there is ongoing work with the Health Informatics Service (HIS) to set this up. There is also ongoing work with directorates to emphasise the importance of this data as a means of better understanding and overcoming potential health inequalities. Where there are gaps in recording, this is due to there being nothing captured in SystmOne.

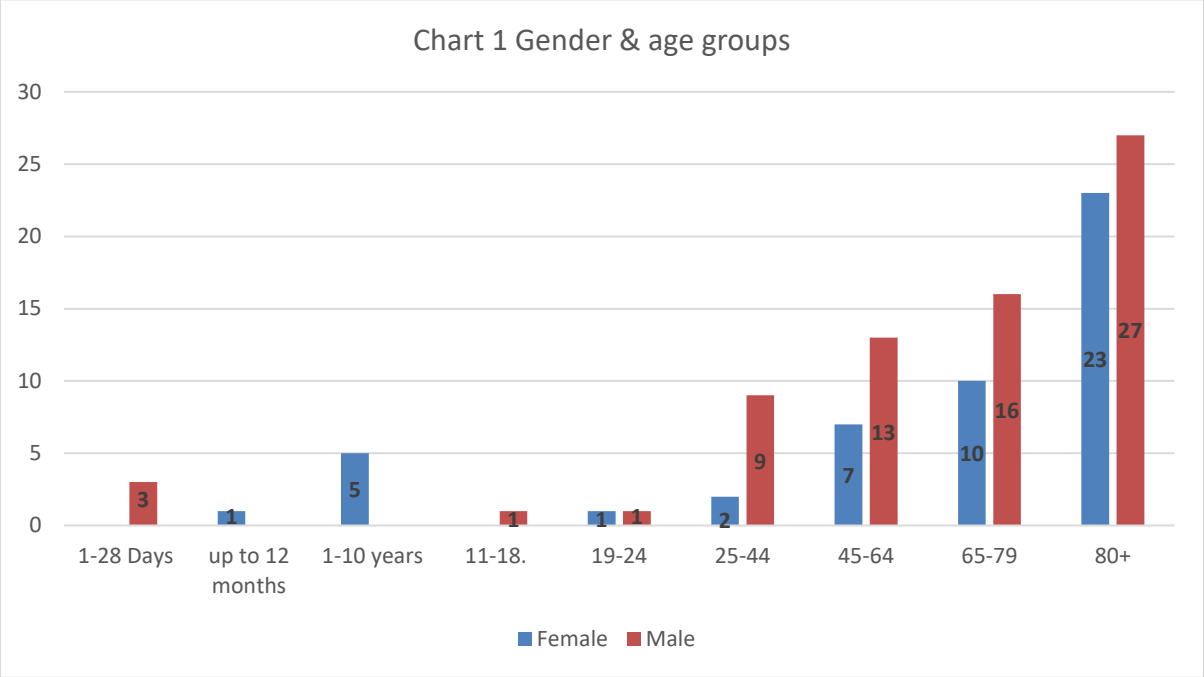
- **Medical Examiner (ME) process** - The ME process is fully embedded in CHS and work is ongoing to embed in DMH/MHSOP & FYPC/LDA.
- **CHS** are in the process of reviewing the format of the LfD Forum meeting with a view to expanding the meeting to include mortality & morbidity style reviews.
- **DMH / MHSOP Backlog** prioritised completing the oldest outstanding reviews, reallocating reviews within the LfD group of reviewers to ensure they were completed and have held extended LfD meetings. In addition, the LfD Coordinator has sent reminders to reviewers of their outstanding forms prior to meetings. The backlog of reviews for the financial year 2022/2023 has reduced from 70 outstanding at the end of Quarter 4 to 13 outstanding at the end of Quarter 1. The LfD Coordinator is working closely with the Clinical and Quality Lead for DMH regarding reducing the backlog further.

3. Proposal

The Board is asked to consider the content of this paper in alignment with Learning from Deaths policy. 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 and it has been identified that it is also not being captured in SystmOne. The Corporate Patient Safety Team are working with the Information Team to progress this.



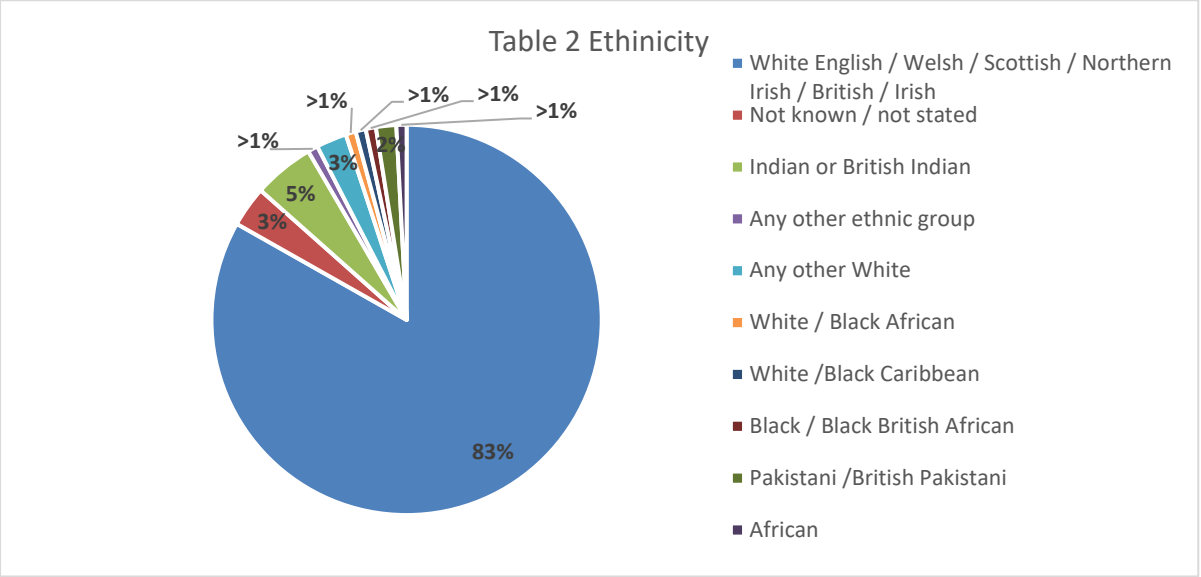


Table 2 Ethinicity
>1%
>1%
>1%
>1%
>1%
3%
2%
5%
3%
83%
White English / Welsh / Scottish / Northern Irish / British / Irish
Not known / not stated
Indian or British Indian
Any other ethnic group
Any other White
White / Black African
White /Black Caribbean
Black / Black British African
Pakistani /British Pakistani
African

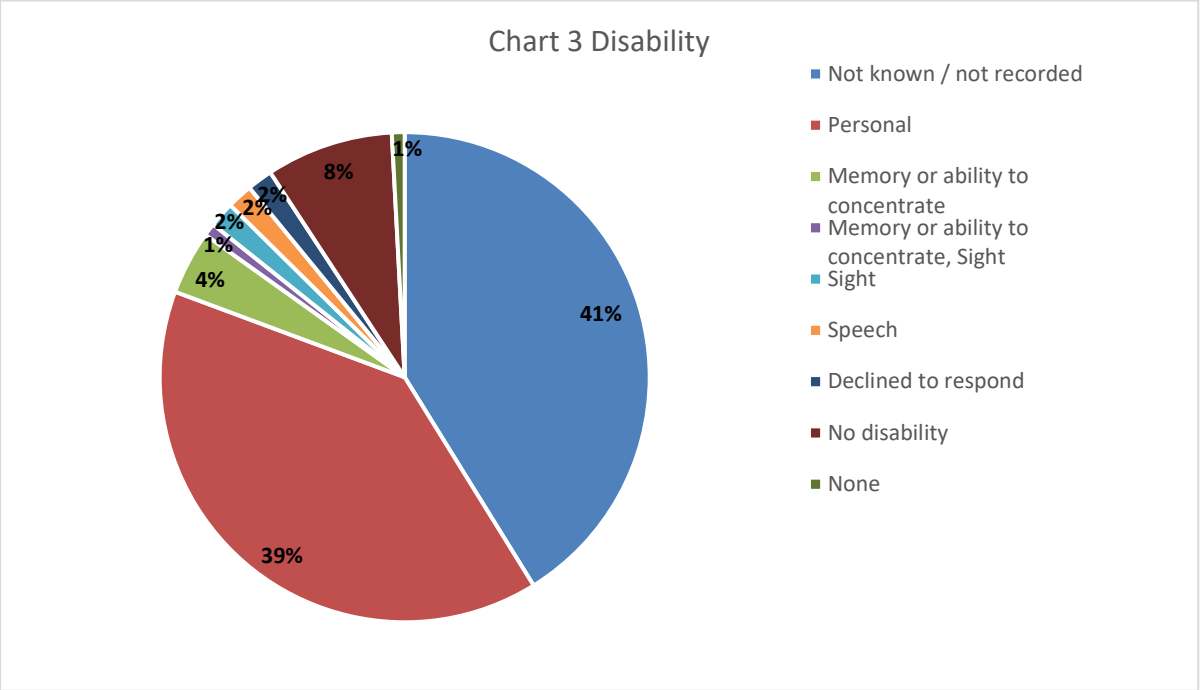


Chart 3 Disability
1%
8%
2%
2%
2%
1%
4%
41%
39%
Not known / not recorded
Personal
Memory or ability to concentrate
Memory or ability to concentrate, Sight
Sight
Speech
Declined to respond
No disability
None

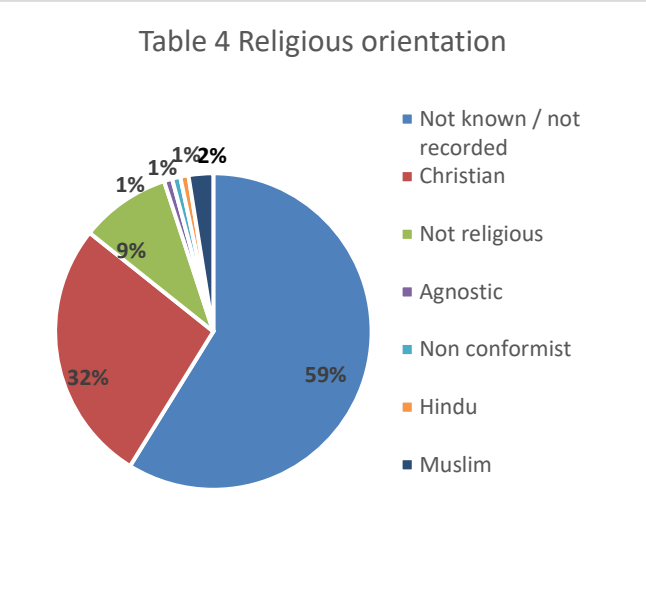


Table 4 Religious orientation
1%
1%
1%
2%
1%
9%
32%
59%
Not known / not recorded
Christian
Not religious
Agnostic
Non conformist
Hindu
Muslim

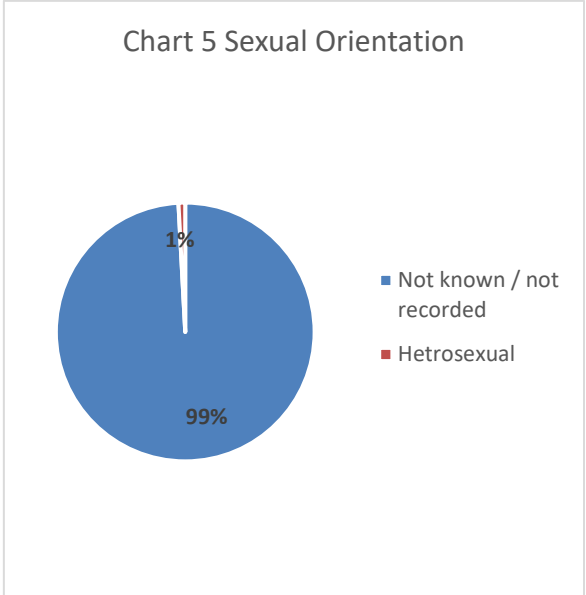


Chart 5 Sexual Orientation
1%
99%
Not known / not recorded
Hetrosexual

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.

Ethnicity data has been compared with the Leicester, Leicestershire and Rutland population based on the latest 2021 Census and is comparable.

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-Q4 (1st April 22 to 31st March 23)	**Q1 (April 23 to June 23)**	**Q1-Q4 (1st April 22 to 31st March 23)**	**Q1 (April 23 to June 23)**	**Q1-Q4 (1st April 22 to 31st March 23)**	**Q1 (April 23 to June 23)**
Number of deaths reviewed	149	39	314	34	78	7
Percentage of deaths reviewed	100%	100%	96%	52%	90%	50%
Number of deaths outstanding for Directorate review	0	0	13	32	9	7
Percentage outstanding for directorate review	0%	0%	4%	48%	10%	50%

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

In adherence with NHS/I (2017) recommendations Table 2 also shows the number of deaths reported by each Directorate for Q1. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR) case record reviews:

- There were 119 deaths considered in Q1.
- There was a total of 5 deaths for Serious Incident Investigation.
- There were 4 adult deaths of individuals with Learning Disabilities which are undergoing LeDeR review within FYPC/LDA.
- There were 0 unexpected deaths within CHS.

Table 2: Number of deaths (Q1)

Q1 Mortality Data										
	Apr			May			Jun			Total
	C	D	F	C	D	F	C	D	F	119
Number of Deaths	15	19	3	10	32	3	14	15	8	
	Consideration for formal investigation									
	C	D	F	C	D	F	C	D	F	Total
Serious Incident	0	1	0	0	2	0	0	2	0	5
mSJR* Case record review	15	19	3	10	32	3	14	15	8	119
Learning Disabilities deaths			0			0			4	4
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	15	5	0	10	5	0	14	0	3	52
Number of family feeding back	7	1	0	3	1	0	6	0	1	19
Number of awaiting feedback from family	2	0	0	1	0	0	3	0	0	6

KEY

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

We are currently reporting on the number of families contacted in the same quarter in which the death occurred. As reviews may not have been completed within the same quarter that the death occurred, these figures are likely to be highly once all completed reviews have been received.

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

Learning is based on using standardised themes adapted from the University Hospital Leicester (Learning from Deaths Learning & Good Practice Themes Appendix 4 & Theming guidance Appendix 5).

6.1 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 ME 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 Nurse 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

- Management plans

Nurses rely on clinical and medical management plans; they use the nationally recognised communication tool called SBAR (situation, background, assessment and recommendation) to inform the out of hour's service. CHS have utilised the functionality on the electronic patient record, Systmone, to ensure there is a clear and robust visual prompt for staff in relation to out of hours clinical / medical management plans.

Feedback from the ME process

All feedback received from families has been shared with the Hospitals and any actions arisen as a result of feedback are monitored through CHS Governance Team.

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 End of Life (EoL) report will also provide family feedback theming and identified Learning outcomes to the EoL Steering group.

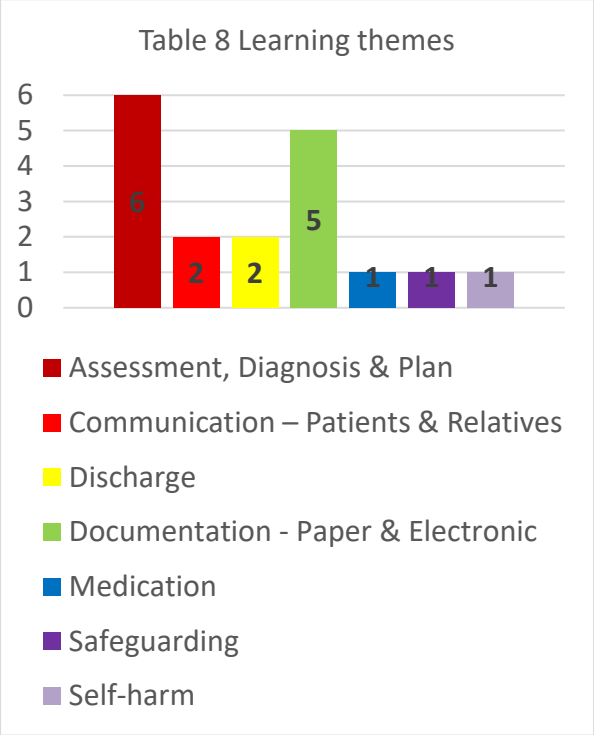
In quarter 1, families felt that the care provided in our community hospitals was good to excellent. Families also felt that their loved ones had good pain relief for palliative care as well as stating that their loved one had the best treatment they had ever had.

Where families mentioned communication was an issue with the Occupational Health Team in Hinckley and receiving mixed messages from the St Luke's Hospital Team since the patient's death, 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.

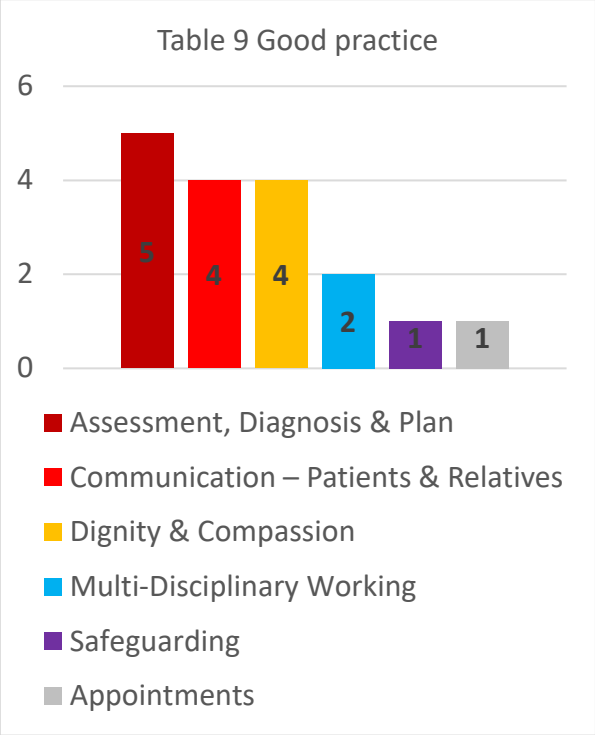
Full details of feedback from families can be found in CHS's LfD Q1 report in Appendix 1.

6.2 DMH/MHSOP

Learning themes (Q1)



Good practice themes (Q1)



Full details of learning themes and good practice can be found in DMH/MHSOP's Q1 LfD report in Appendix 1.

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

- Assessment, Diagnosis & Plans - Waiting lists / delays in being seen

There were a couple of reviews that identified long waits for memory services. There is currently a service wide improvement plan for memory service in terms of early access to assessments and treatment and a trajectory to reduce the waiting list.

- Self-harm – Drug and alcohol misuse

The Community Mental Health Team made numerous efforts to encourage Patient to engage with turning point regarding their alcohol consumption. There was however no reference to discussion with dual diagnosis team who may have been able to offer support to the team to assertively engage Patient. The substance misuse pathway will be reviewed to ensure that even if patients decline Turning point, there is a way of supporting staff to support the patient. Dual Diagnosis work is currently being undertaken by trust and the Dual Diagnosis team are happy to deliver training about substance misuse pathway to all teams.

- Documentation – Paper & electronic - Clinical documentation with clinical record

A review of a Mill Lodge patient identified that there was no in-date care plan in place. This did not impact on the death of the patient. The Matron will introduce a clinical audit process and ensure that all patients have an in-date care plan and an up-to-date risk assessment in place.

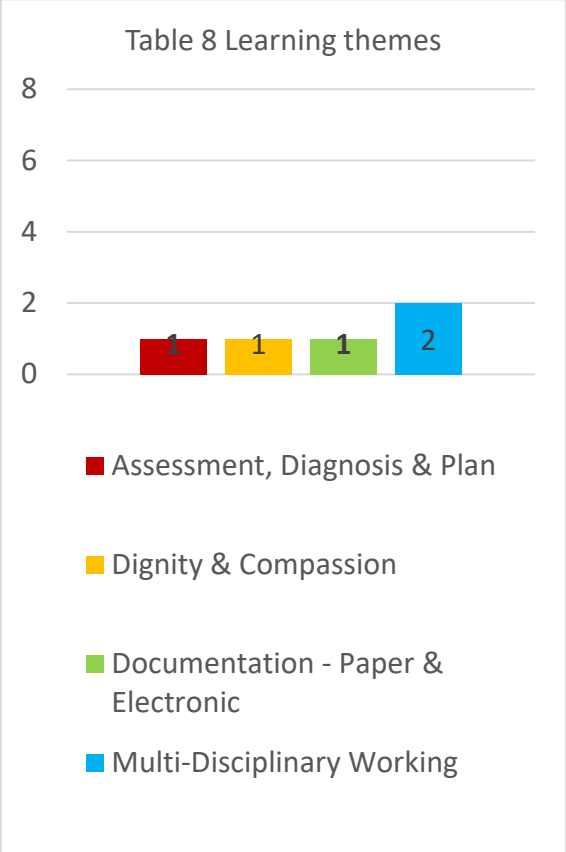
Family Feedback

Positive feedback was received from five families who;

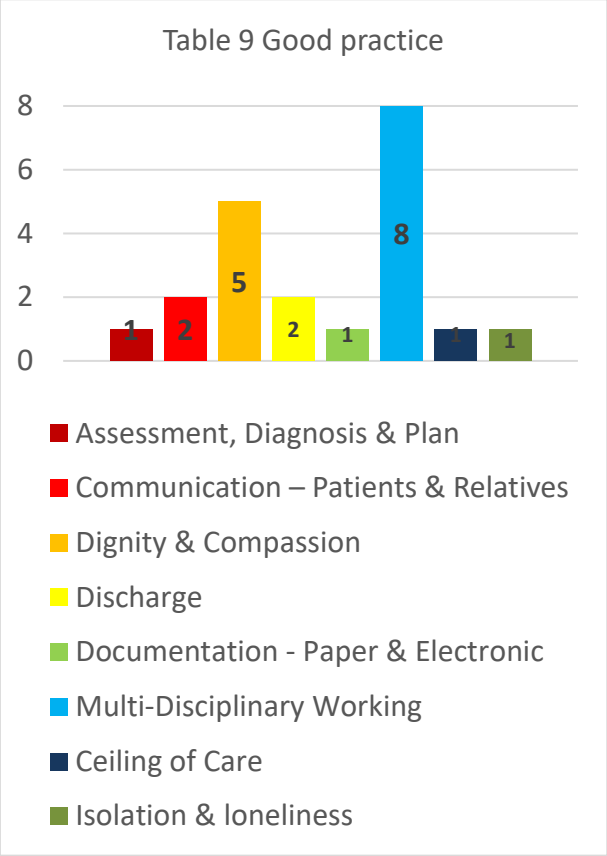
- Felt well supported and thanked the team for all they had done for daughter.
- Grateful for a contact from a medic to express condolences.
- Were kept informed and were thankful to both CMHT and inpatient teams for the care given.
- Thanked the CMHT for their support.
- Thanked the team.

6.3 FYPC/LD

Learning themes (Q1)



Good practice themes (Q1)



Full details of learning themes and good practice can be found in FYPC/LDA's Qtr1 LfD report in Appendix 1.

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

Respect forms

- The Respect form was completed by GP with care home however it was without involvement of an IMCA. The Patient had no record of a next-of-kin other than the care home and this was their preferred place of care. The hospital had referred to IMCA and were awaiting a reply which caused a delay in discharge.

- Clarity is required around Next of Kin and completion of ReSPECT form where there is no Next of Kin other than the Care Home. This discussion needs to be Trust Wide and escalated through LfD Corporate Group and EoL Steering Group. Furthermore, the LD Services does not have access to the palliative

view on their unit and this will be taken as an action in their Systmone optimisation.

Although not learning for LPT, it was felt important to note that one review identified that a Respect Form, written by the patient's GP, had learning disability stated instead of end stage dementia. LfD Chair & LfD reviewer will be writing to the practice regarding this.

Documentation

There was one review that identified that the patient's Care plan had been commenced but not completed. The Therapist had intended on completing the risk assessment and Occupational Therapy Care plan on the next arranged visit however the second visit didn't get attended and was continually rearranged, so the risk assessment and care plan didn't get completed and wasn't in place at the time of death. This did not impact on the death.

This was discussed with leadership and fedback and as a result, administration staff now make the first initial appointments and staff block out enough time in their diaries to complete necessary paperwork.

LeDeR feedback

LeDeR's Learning into actions is available in their annual report and they are working on producing quarterly learning into action reports. It is not possible to identify individual cases as the Learning is around service improvement. The information regarding any themes is then put into subcategories by LPT to review learnings and recommendations and what LPT's response is to them. This information is then fed into the Health inequalities group, Deteriorating patient group and further disseminated.

There have been positive improvements for LPT over the last year in the following areas; reasonable adjustments, cancer screening, care coordination, communication, deteriorating patient diagnostic overshadowing, end of life feeding, Mental Capacity Act, Prisma (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) adjustments and record keeping.

CDOP

An intial CDP meeting is held within 48 hours of the child's death to identify any immediate learning and actions. Should any concerns be identified, an ISMR would be requested and discussed at the weekly Incident Review meeting for agreement on next steps. It is recognised that CDOP, as part of their review, contact families.

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. Directorate Qtr 1 LfD Reports


CHS LfD Quarter 1 Report.docx


DMH & MHSOP Quarter 1 report.doc


FYPC&LD Quarter 1 report.docx