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Leicestershire Partnership NHS Trust

Public Trust Board of Directors

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

1. Purpose of the report

This report is presented to the Trust Board as assurance of the efficacy of the Learning from Deaths (LfD), Child Death Overview Panel (CDOP), Learning Disabilities Mortality Review (LeDeR), and Serious Incident (SI) processes in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017). This Report presents data from April to June 2023 (Quarter 2: Q2) as well as learning from Q2 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.

- **Deaths Data Validation**
  DMH/MSHOP & FYPC/LDA It has been established that there is an underreporting of deaths on Ulysses. In Quarter 1 the LfD Coordinator provided the Information Team with the Ulysses reports for DHM/MHSOP and FYPC/LDA, who in turn, provided the Systmone protected characteristics data to match the Ulysses data provided. For Quarter 2, the aim was to set up a report on the Click Sense reporting dashboard so that all 3 directorate systmone reports could be accessed in the same manner. When the report from the Information Team was received it became apparent that there were significantly more deaths than that recorded on Ulysses.

CHS The LfD Coordinator receives deaths data from Ulysses and the ME's office as well as accessing Systmone from Click Sense reporting dashboard to triangulate the deaths for CHS.

- **Demographics** – Protected characteristic information from Systmone is included in this report. Where there are gaps in recording, this is due to there being nothing captured in SystmOne. 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 HIS to finalise an automated report from Systmone.
- **Medical Examiner (ME) process** - The ME process is fully embedded in CHS and work is ongoing to embed in DMH/MHSOP & FYPC/LDA.
- **Deaths reviewed where Cause of death has been requested** Upon receipt of the cause of death (COD) from the Coroner's Office, the LfD Coordinator forwards the COD with the completed LfD Quality & Safety Review form to the Reviewer for consideration and if further discussion is required, it will be added to the agenda of the next LfD meeting.
- **CHS** Meetings were held in June 23 and September 23 and the next meeting planned for December 23.
- **DMH / MHSOP Backlog** All reviews for the financial year 2022/2023 have been completed. The LfD Coordinator is working closely with the Clinical and Quality Lead for DMH to monitor backlog and outstanding reviews.
- **FYPC/LDA** There is 1 backlog case which will be discussed at the next LfD meeting.

3. Actions

Corporate Investigators within the Corporate Patient Safety Team will undertake a sample review of the additional deaths identified for DMH/MHSOP & FYPC/LDA and undertake a thematic analysis of the completed reviews.

The Corporate Patient Safety Team will work with HIS and Data Teams to understand discrepancies within the data.

Actions arising from Learning identified will be taken forward by Directorates and monitored through the Learning from Deaths meetings and Directorate governance meetings.

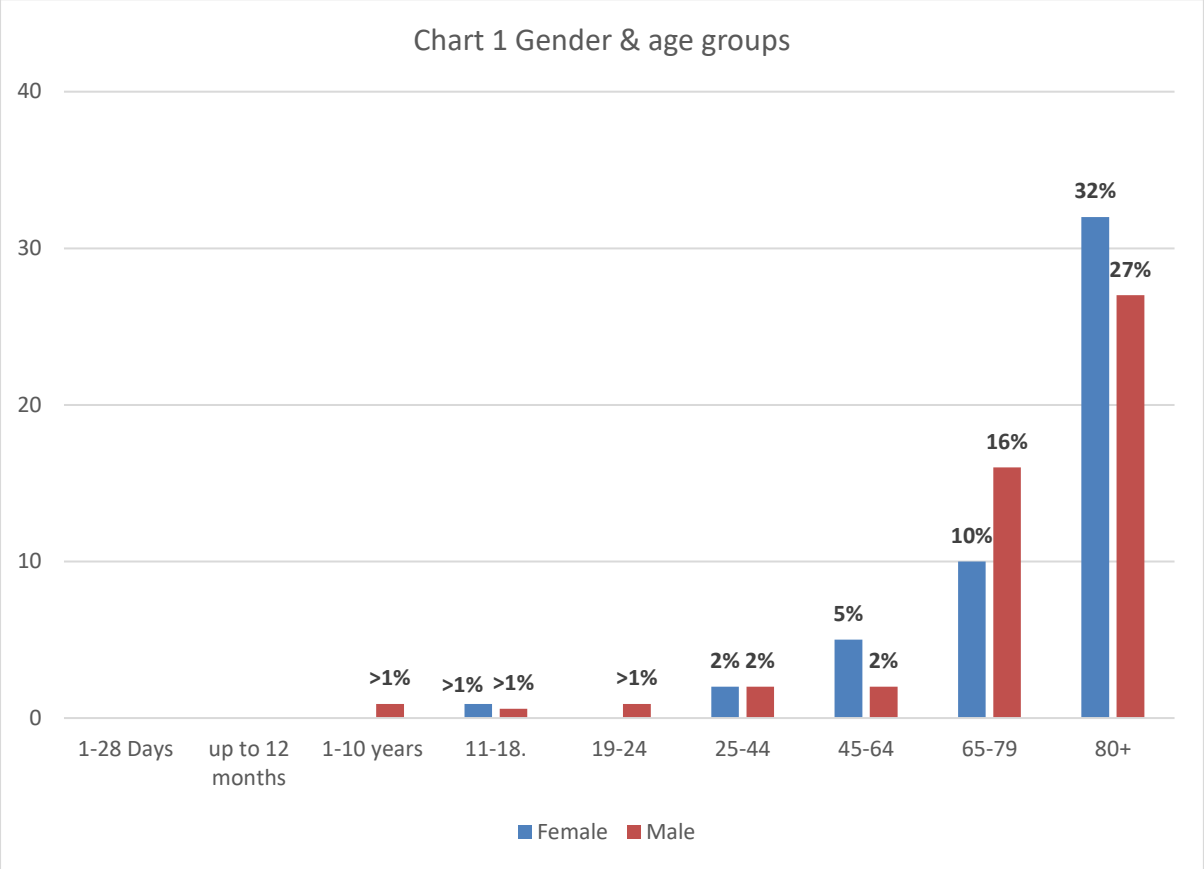
4. Proposal

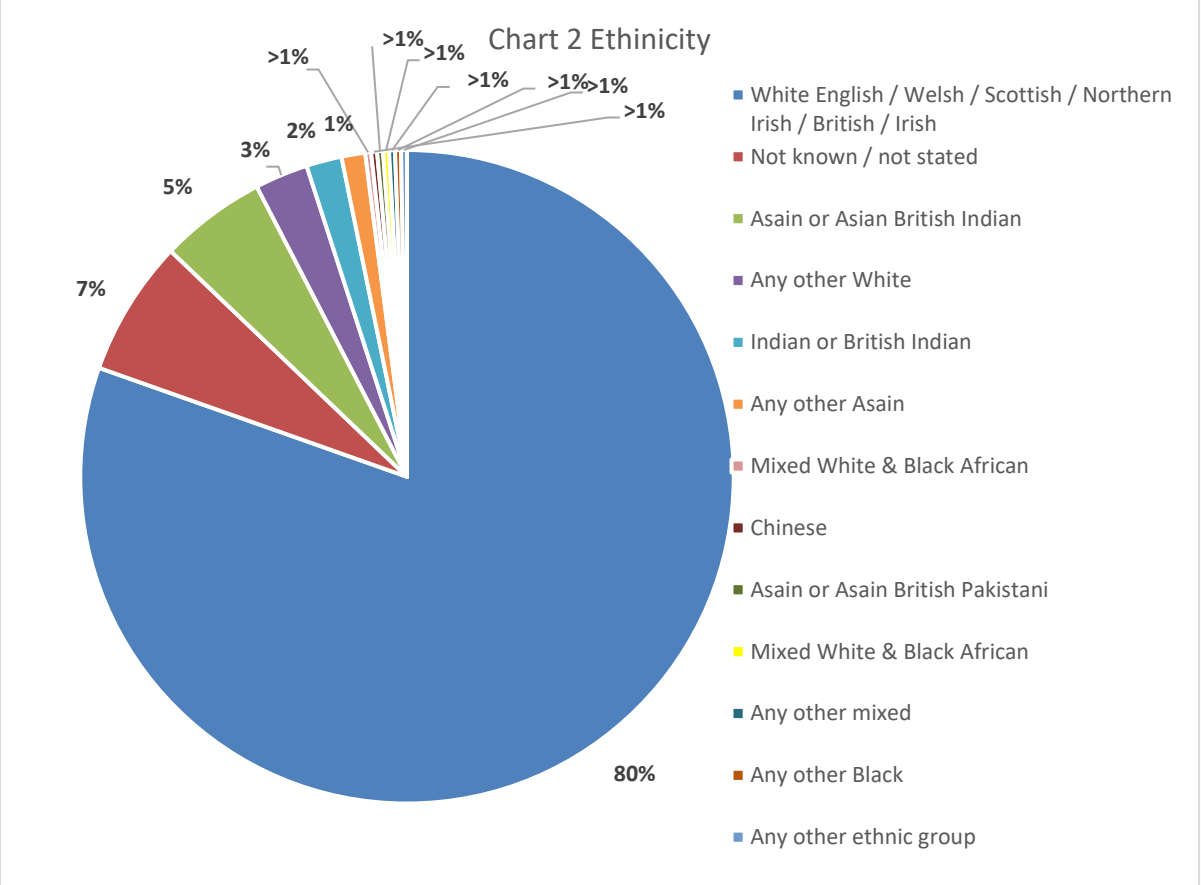
The Board is asked to consider the content of this paper in alignment with Learning from Deaths policy. The board is also asked to recognise the action and continued progress being made in the LfD process at LPT.

5. 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.





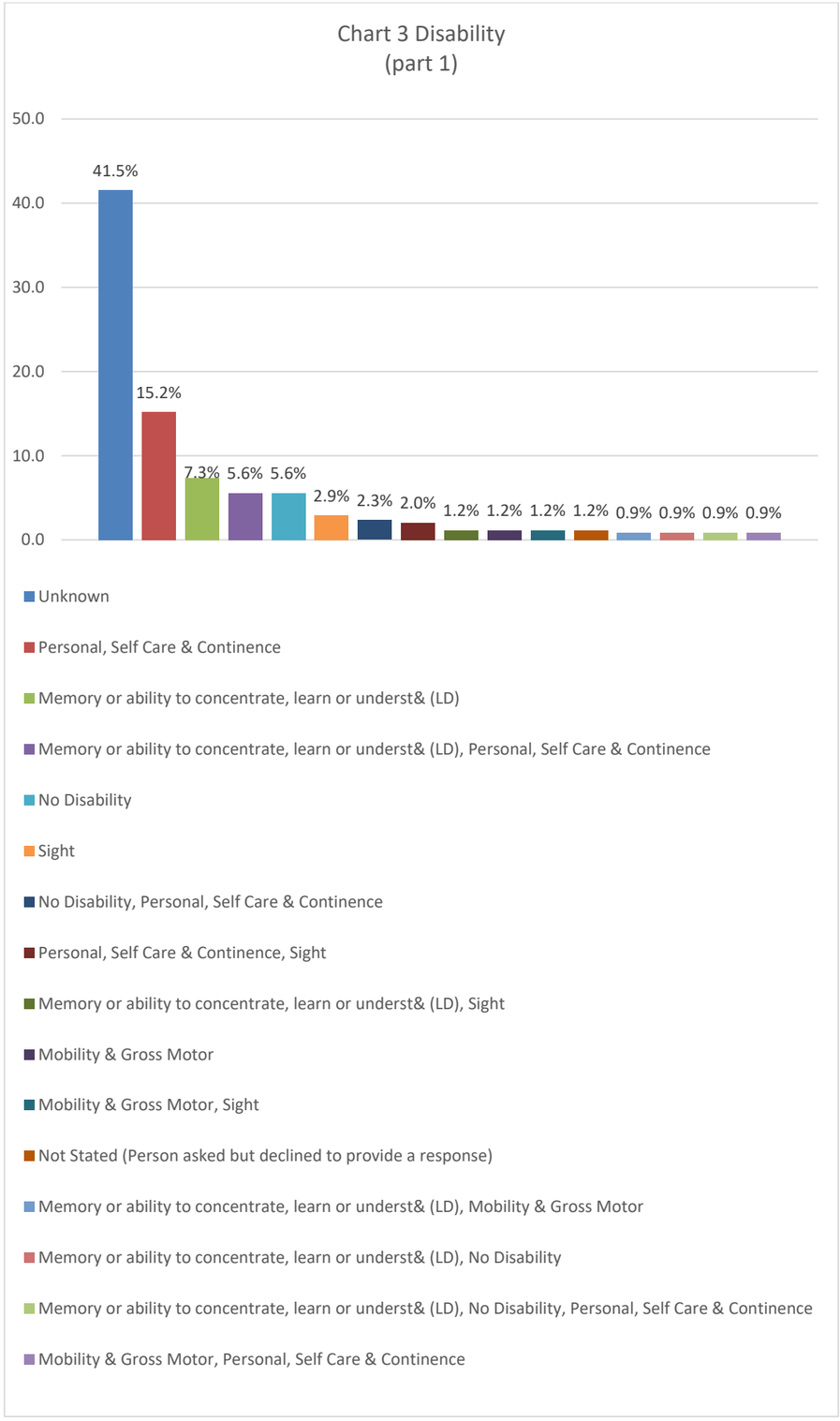


Chart 3 Disability
(part 1)
50.0
40.0
30.0
20.0
10.0
0.0
41.5%
15.2%
7.3%
5.6%
5.6%
2.9%
2.3%
2.0%
1.2%
1.2%
1.2%
1.2%
0.9%
0.9%
0.9%
0.9%
Unknown
Personal, Self Care & Continence
Memory or ability to concentrate, learn or underst& (LD)
Memory or ability to concentrate, learn or underst& (LD), Personal, Self Care & Continence
No Disability
Sight
No Disability, Personal, Self Care & Continence
Personal, Self Care & Continence, Sight
Memory or ability to concentrate, learn or underst& (LD), Sight
Mobility & Gross Motor
Mobility & Gross Motor, Sight
Not Stated (Person asked but declined to provide a response)
Memory or ability to concentrate, learn or underst& (LD), Mobility & Gross Motor
Memory or ability to concentrate, learn or underst& (LD), No Disability
Memory or ability to concentrate, learn or underst& (LD), No Disability, Personal, Self Care & Continence
Mobility & Gross Motor, Personal, Self Care & Continence

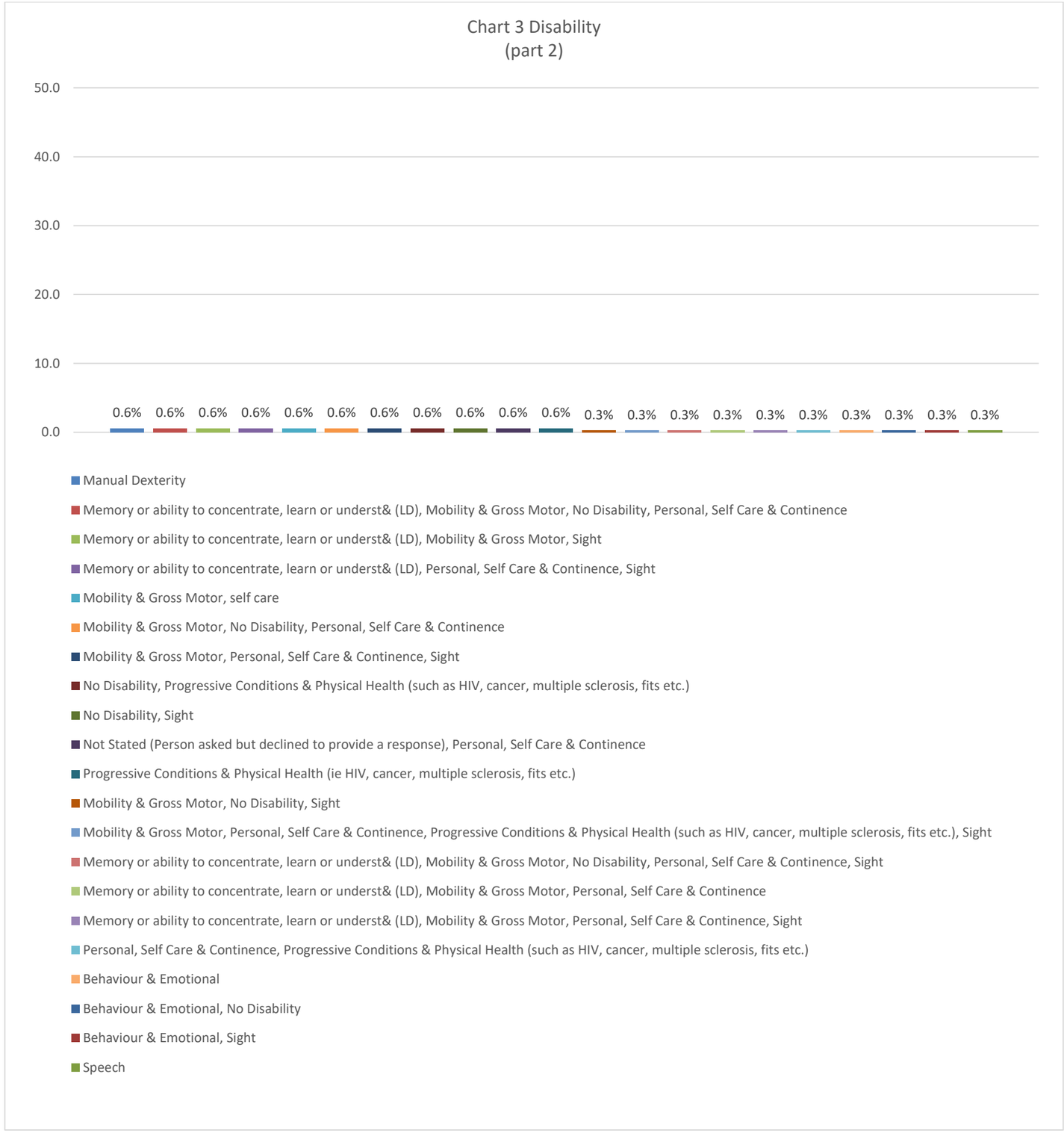


Chart 3 Disability
(part 2)
50.0
40.0
30.0
20.0
10.0
0.0
0.6%
0.6%
0.6%
0.6%
0.6%
0.6%
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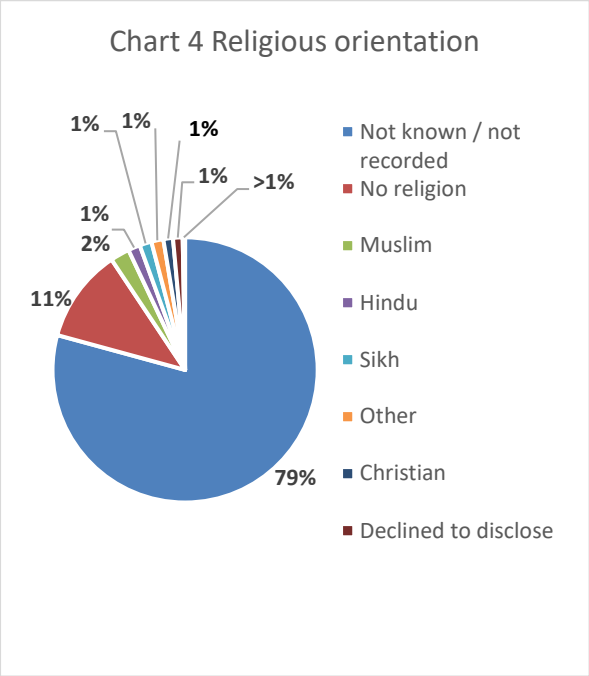
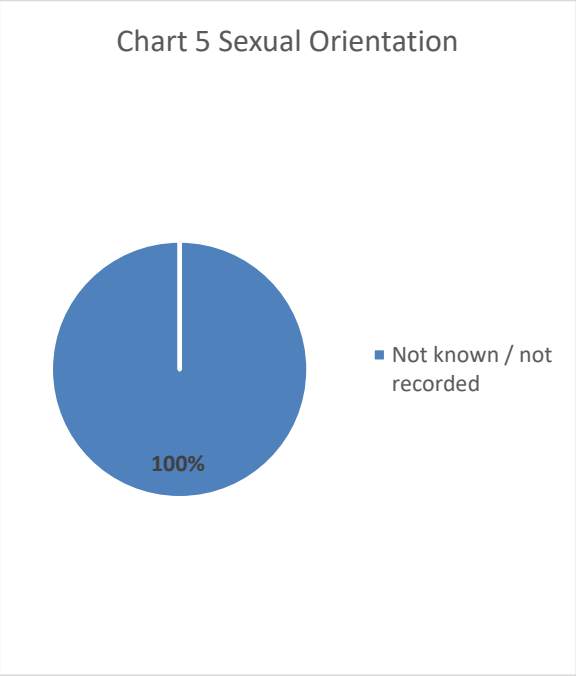
Manual Dexterity
Memory or ability to concentrate, learn or underst& (LD), Mobility & Gross Motor, No Disability, Personal, Self Care & Continence
Memory or ability to concentrate, learn or underst& (LD), Mobility & Gross Motor, Sight
Memory or ability to concentrate, learn or underst& (LD), Personal, Self Care & Continence, Sight
Mobility & Gross Motor, self care
Mobility & Gross Motor, No Disability, Personal, Self Care & Continence
Mobility & Gross Motor, Personal, Self Care & Continence, Sight
No Disability, Progressive Conditions & Physical Health (such as HIV, cancer, multiple sclerosis, fits etc.)
No Disability, Sight
Not Stated (Person asked but declined to provide a response), Personal, Self Care & Continence
Progressive Conditions & Physical Health (ie HIV, cancer, multiple sclerosis, fits etc.)
Mobility & Gross Motor, No Disability, Sight
Mobility & Gross Motor, Personal, Self Care & Continence, Progressive Conditions & Physical Health (such as HIV, cancer, multiple sclerosis, fits etc.), Sight
Memory or ability to concentrate, learn or underst& (LD), Mobility & Gross Motor, No Disability, Personal, Self Care & Continence, Sight
Memory or ability to concentrate, learn or underst& (LD), Mobility & Gross Motor, Personal, Self Care & Continence
Memory or ability to concentrate, learn or underst& (LD), Mobility & Gross Motor, Personal, Self Care & Continence, Sight
Personal, Self Care & Continence, Progressive Conditions & Physical Health (such as HIV, cancer, multiple sclerosis, fits etc.)
Behaviour & Emotional
Behaviour & Emotional, No Disability
Behaviour & Emotional, Sight
Speech





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.

6. 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 23 to Jun 23)**	**Q2 (Jul 23 to Sep 23)**	**Q1 (Apr 23 to Jun 23)****	**Q2 (Jul 23 to Sep 23)***	**Q1 (Apr 23 to Jun 23)****	**Q2 (Jul 23 to Sep 23)***
Number of deaths reviewed	41	45	54	22	14	12
Percentage of deaths reviewed	100%	100%	79%	8%	93%	60%

Number of deaths outstanding for Directorate review	0	0	14	255	1	8
Percentage outstanding for directorate review	0%	0%	21%	92%	7%	40%

* Data for Qtr 2 is based on SystmOne deaths data

** CHS: Qtr 1 figures is 2 more than previously reported due to 1 May death being reported in September and 1 June death being reported in August.

DMH/MHSOP: Qtr 1 is 2 more than previously recorded as 3 June deaths were reported in August and 1 April death was Out of Scope and should not have been included in the figures.

FYPC/LDA: Qtr 1 figure is 1 more than previously reported due to 1 July death being reported in August.

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 342 deaths considered in Q2.
- There was 1 death for Serious Incident Investigation.
- There were 12 adult deaths of individuals with Learning Disabilities which are undergoing LeDeR review within FYPC/LDA.
- There were 1 unexpected death within CHS.

Table 2: Number of deaths (Q2)

Q2 Mortality Data										
	Jul			Aug			Sep			Total
	C	D	F	C	D	F	C	D	F	342
Number of Deaths	13	88	8	14	96	9	18	93	3	
Consideration for formal investigation										
	C	D	F	C	D	F	C	D	F	Total
Serious Incident	0	0	0	0	1	0	0	0	0	**1**
mSJR* Case record review	13	88	8	13	96	9	18	93	3	**342**
Learning Disabilities deaths			6			4			2	**12**
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	13	2	5	14	1	3	18	0	2	**58**
Number of family feeding back	12	1	0	10	1	0	11	0	0	**35**
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*

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.

7. 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).

7.1 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.

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.

ME Comments and questions

- Why was pain relief delayed at Hinckley & Bosworth Community Hospital?

After the incident an email was circulated to all staff to advise them to chase any medication delivery delays by phoning pharmacy and writing this in the patient record when they have no stock of a medication. In this instance, the pharmacy had to order the medication from their suppliers it was a dose that was not kept in LPT pharmacy but it took 4 days to arrive. Other PRN medication was prescribed.

- Resuscitation commenced despite RESPECT from being in place. CPR stopped after form reviewed.

This death was reviewed at IRM on 18th August 23 and the decision was to undertake an Internal Investigation. An initial review through LfD was discussed at September's LfD meeting and it was felt that there were communication issues around the Respect form and it was agreed to have a Task & Finish Group to look at pulling together an educational video around best practice for ward rounds.

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.

Family feedback

In quarter 2, families felt that the care provided in our community hospitals was good to exemplary and that patients were treated with dignity and respect. Families were also complementary regarding our staff who were kind, caring and good communicators. One family felt that there loved one was in the best place they could be.

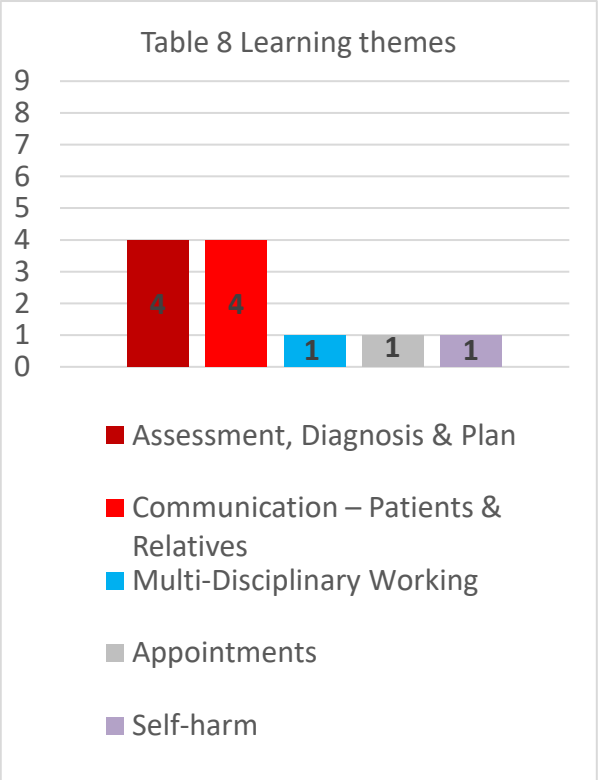
Where families mentioned that there was an issue with delayed transfer, pain relief communication and missing possessions, the BSS Nurse will ensure these are addressed in the form of feedback to the ward, requesting and coordinating a review of care to identify learning and opportunity for process or system updates, or for

further escalation as appropriate. Any actions arisen as a result of feedback are monitored through CHS Governance Team.

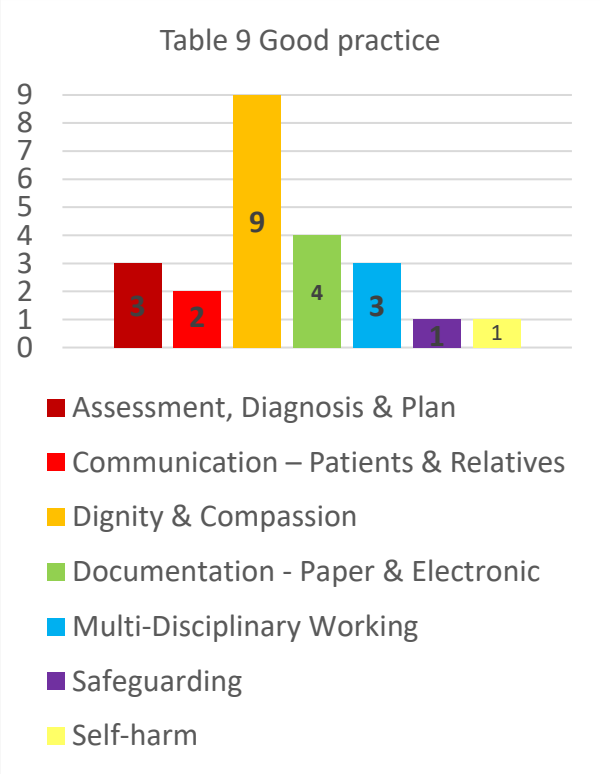
Full details of feedback from families can be found in CHS's LfD Q2 report in Appendix 1.

7.2 DMH/MHSOP

Learning themes (Q2)



Good practice themes (Q2)



Full details of learning themes and good practice can be found in DMH/MHSOP's Q2 LfD report in Appendix 1.

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

- Documentation

There were a couple of reviews that identified that documentation could have been more thorough, minimal collaborative care-plan is with little information provided and no evidence that it has been evaluated. Over the next 12 months, this will look at barriers to documenting, systems and processes and identify any learning. In addition, the DNA policy will be circulated to all staff as a reminder.

- Waiting List breaches

There were a couple of reviews where there were waiting list breaches. No additional action was required as this is a known risk which is being addressed within the service.

Family Feedback

Positive feedback was received from three families which includes deaths that occurred prior to Quarter 2;

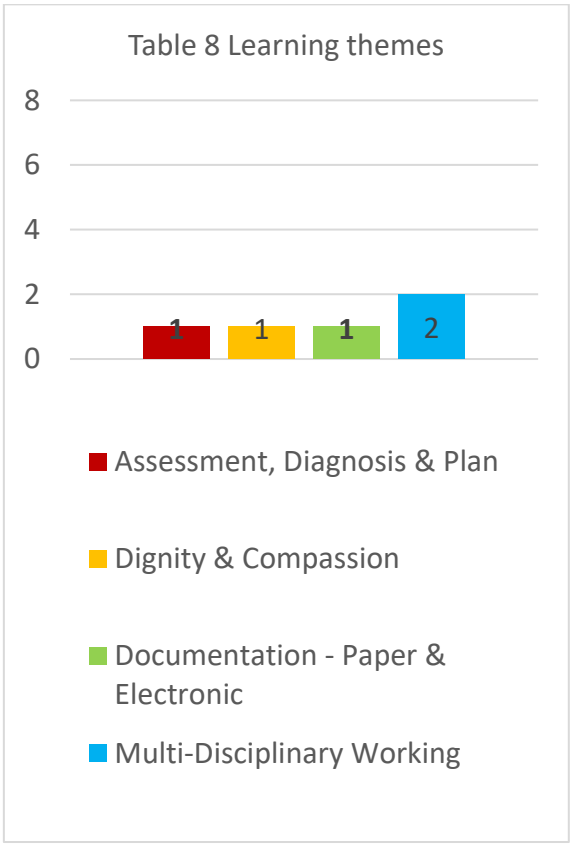
- Husband was thankful for CPN for support.
- Daughter expressed thanks for condolences phone call and the opportunity to talk about her dad.
- Parents were grateful for CPNs call to offer condolences.

The Learning from deaths Quality & Safety Review form was updated on 7th September to include rationale for non-contact when making contact to offer condolences. These reasons for non-contact were;

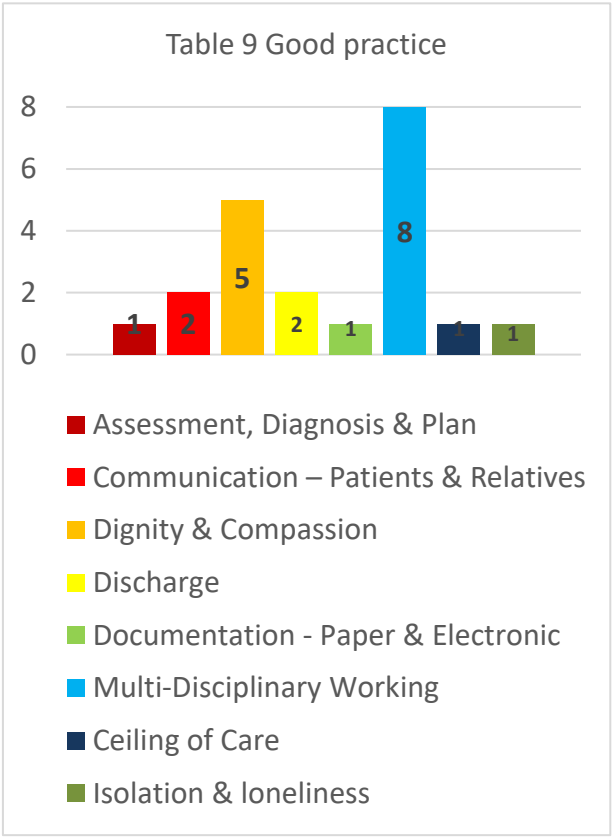
- Hospital advised family of death.
- Patient on waiting list to be assessed. X2
- Son contacted LPT.
- CPN attempted to contact the daughter multiple times prior to patient dying - no response.

7.3 FYPC/LD

Learning themes (Q2)



Good practice themes (Q2)



Full details of learning themes and good practice can be found in FYPC/LDA's Qtr2 LfD report in Appendix 1.

Family feedback

- Both parents expressed gratitude for the care given over the years and that they really appreciated all of the support.
- Mum grateful of support offered and also for staff attending the funeral.
- Parents extremely grateful to have the opportunity to be at home with support of Diana on-call service. Gave thanks to the nurses present and particularly to the Diana Macmillan Nurse who had supported them on their journey since the beginning of their child's illness.
- It was not possible to contact one family as they were in India.

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

Catheterisation in children who are end-of-life

The Diana Service is keen to explore how to avoid children attending hospital, especially those at end-of-life The Diana Nurses currently do not have the updated skills and competencies to catheterise in the community as there are only a very small number of children requiring this and it would be difficult for all nurses on-call to maintain their competencies to allow an equitable service for all.

The current process is to call the on-call Registrar or Consultant identified as the medical support for the child on-call who would arrange for the appropriate professionals to go to the Emergency Department (ED) to assist.

The Diana Service undertook a short project to look at options and possible solutions. Evidence was collated from Birmingham Children's Hospital, University Hospitals of Leicester and Northampton alongside a District Nurse Team as a comparison and none of the local surrounding children's nursing teams offered catheterisation for End-of-life care, they all advocated an acute setting, namely ED.

The Diana Service will continue to look at the options to support children safely in the community at all times.

Service internal 6-week reviews

In a LfD review of an August death, the person who undertook the 6-week review was a Therapy Support worker rather than a Therapist. There were some actions identified around safeguarding and following up care plans that weren't necessarily specific to physiotherapy but were appropriate as an LD practitioner. This was escalated to a qualified practitioner at the time. It is a long-standing recognition of the need to have consistent access and is a review of the RFI and access processes

and waiting list management that. This process is currently under review and any changes will follow appropriate governance processes.

CDOP Annual Report 2022/2023

The key themes highlighted in the report were Infant Mortality, Learning disability mortality reviews, Suicide & Self-Harm and Children with life-limiting conditions.

The recommendations for 2023/24 are around looking at Safer Sleeping, Digital solutions to improve communication, Infant Mortality, Suicide & self-harm, Deaths of young people with a learning disability. 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.

LeDer Annual Report 2022/2023

Top areas of learning identified were End-of -life, Care Co-ordination and communication.

The Learning into Action learning and positive practice shared with LPT were;

- Accurate weight checking services for those who require alternative weighing than stand on scales. Accessible portable scales have been purchased, next step of how this will be rolled out across LLR and how wider GP networks can utilise is to be established.
- Venepuncture – seeking to establish a service appropriate for those requiring more restrictive intervention under the MCA in community care.
- Epilepsy pathway joint with UHL changes to the access to service, templates and assessments incorporating a more robust assessment of physical health and encouraging access to AHC's.

8. Decision required

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

9. Governance table

For Board and Board Committees:	Trust Board	
Paper presented by:	Dr 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 2 LfD Reports

All embedded documents contained within this report can be made available on request.

CHS LfD Quarter 2 Report.docx

DMH & MHSOP Quarter 2 report.docx

FYPC&LD Quarter 2 report.docx