N

Leicestershire Partnership
NHS Trust

Public Trust Board – 22nd December 2020

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) and NHS Improvement (NHS/I) Framework (2017). This Report presents data from July to September 2020 inclusive (Quarter 2: Q2), as well as data reviewed and learning from Quarter 1 (Q1: April-June 2020). An update of efforts made to improve the LfD process at LPT is also presented.

2 Analysis of the issue

- Q1 introduced how LPT was streamlining its LfD process to optimise learning and the quality and safety of the care that we provide to our patients. Trust-wide standardisation is being implemented to address the complex variability associated with the LfD process which reflects the wider NHS LfD organisational goal of improvement through standardisation (National Quality Board, 2017). The data presented in this report is provided by each Directorate to the Trust Learning from Death Lead who then synthesises this information.
- LPT is aware that the National Patient Safety Incident Response Framework (PSIRF) is to be effected by 2021. Being an organisation which strives for excellence through systematic preparation, we have improved the way we investigate Serious Incidents (SI) by adopting Just Culture thinking to redesign processes of care.
- In line with LPT's Step Up To Great (SUTG) agenda, improving quality is about continuously evaluating and iteratively improving to ensure sustainable high standards are achieved on a trust-wide level. A bottom up collaborative approach has been taken to ensure best practice; an example of this is reviewing, updating, and implementing qualitative learning themes recommended by the Royal College of Physicians (2016).
- Learning for improvement is being implemented by networking closely with Northamptonshire Healthcare and University Hospitals Leicester.
- To further assure the Board that quality improvement is integral part of our work, the patient safety team carried out an LfD scoping exercise. Soft intelligence, Human Factors and Ergonomics theoretical principles such as *Safety-II*, (to identify and share areas of effective practice), and discussions with clinicians involved in the LfD process were conducted. An update will be presented once recommendations have been implemented.

3 Proposal

The Board is asked to consider the content of this paper and alignment with the Learning from Deaths guidance. The board is also asked to recognise the challenges and actions being taken to enhance the LfD process at LPT.

4 Demographics

Currently, demographic information is obtained manually by Directorates. Efforts have been made by individual directorates to obtain this information (e.g. ethnicity). This is not reported due to the variation across directorates. The Information Team and Patient Safety Team are working on a spreadsheet and discussions about receiving the demographic information of people who have died are taking place.

5 Mortality Data

In adherence with NHS/I (2017) recommendations, the percentages of deaths reviewed and completed for Q1 are shown in Table 2:

Table 1: Time lag in reviewing of deaths by Directorate

Directorate	Total number of deaths	In-scope		% of deaths subject mSJR* Case record review	% of deaths subject to an SI investigation
		mSJR	SI	% completed	% completed
CHS	42	42		**100**	**0**
		42	0	100%	0
DMH	70	70		**90%**	**10%**
		63	7	100%	100%
FYPC/LD	9	9		**89%**	**11%**
		8	1	100%	100%
Total	**121**	**121**		**93%**	**7%**
		113	**8**	101%*	100%

*DMH had an increase of 3 deaths reported for Q1 which were reviewed in Q2

5.1 Learning themes identified in Q4

The CHS learning theme was in the End of Life (EOL) phase of the patients care journey, learning was based on the falling quality of end of life documentation, which has improved in Q2. DMH learning themes were in the clinical care phase of the patient's journey. FYPC/LD had a mixture of clinical care and end of life learning themes; for example, theme E24 was based on supporting families with bereavement and the learning action was to share reports with families.

5.2 Examples of good practice in Q1

Learning that has been identified from the review or investigation of deaths concluded in Q4 2020 can be seen in Appendix 2 (p. 5). Examples of good practice include:

- **DMH:** Shared good practice from the Assertive Outreach in which the patients' needs are made central to all actions of staff. For example a patient was involved in all of his decisions,

autonomously discussed organ donation, and was supported to make contact with loved ones.

- **CHS:** Good practice was evidenced by staff in Community Hospitals prioritising video calls at End of Life during the COVID-19 pandemic. A particular example of meeting the patients' spiritual and religious needs was a member of staff driving to Loughborough to purchase Rosemary beads as per the patient's request.
- **FYPC:** Planned and had their first Learning from Deaths forum on the 22nd September 2020.

5.3 Number of deaths reported during Q2

Table 3 shows the number of deaths reported by each Directorate for Q2. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR). The number of reviews completed is also presented.

- There were 90 deaths for Q2.
- 9 deaths were considered as Serious Incidents.
- There were 7 CDOP deaths which are distributed under "F", and are included in the total number of deaths in Table 3:

Table 2: Number of deaths

Q2 Mortality Data 2020										
	Jul			Aug			Sep			Total
	C	D	F	C	D	F	C	D	F	
In-scope deaths	12	21	3	7	11	2	9	23	2	**90**
Consideration for formal investigation										
	C	D	F†	C	D	F†	C	D	F†	
Serious Incident	1	3	0	0	2	0	0	3	0	**9**
mSJR* Case record review	11	18	3	7	9	2	9	20	2	**81**
Number completed	*8*	*16*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*24*
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

KEY

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

*LPT implements a modified mSJR to review all deaths In-scope. In-scope and Out of scope deaths are defined in Section 4.0 of the Learning from Deaths Policy.

† FYPC have allocated reviews to monthly meetings for timely learning.

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 sponsored by:	Avinash Hiremath – Medical Director	
Paper authored by:	Saydia Razak & Tracy Ward	
Date submitted:	4th December 2020	
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):	Learning from Deaths Meeting (27th October 2020) & Quality Forum	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
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	
	Trustwide 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:	NA	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	Y	
Equality considerations:	NA	

Appendix 1. Examples of Learning

Learning Code/Theme	Learning Impact	Learning Action
CHS: Learning is from Q2 because this was discussed in most recent meetings		
E13: End of Life, assessment, diagnosis, and plan	Ensuring that the patient needs are met in terms of "Preferred Place of Death" (PPOD).	Directorate invited LfD lead to CHS unit to show current system and potential change in documentation identified by front line staff (ANP involved in directorate LfD meetings).
C13: Clinical assessment, diagnosis management plan	Being transparent in care plans and involving carers in the potential deterioration of their relatives/friend's needs.	Extended PPOD initiative on a trust-wide level by reviewing "Caring Confidentiality" leaflet to address the needs of CHS patients on admittance to service.
E514: End of life care, documentation, clinical documentation within the clinical record	Enhanced documentation for reviews: EOL paperwork improved in Q2 -over 98% of the relevant documentation be completed.	Improvement from last quarter, disseminate this across directorate to encourage continuity.
DMH		
C1235: Clinical care, communication, transfer and handover omissions in handover communication	Missed opportunity to treat: Patient was treated in LRI for physical health needs. Needs ISMR and further investigation. Updated by GP of death due to Ischemic Colitis and Frailty.	Learning to be obtained through SI report.
C24: Clinical care, management, and discharge plan	Potential void in continuity of care: Limited discussion with MDT and approximately a 2 week gap before further attempted contacted.	Arrange follow up by CPN and follow up arrangement when patient is not available.
C718: Clinical care, Multi-disciplinary working, Inter-speciality liaison/continuity of care/ownership	Establish a greater recognition of the physical and mental health care need dynamic: Long history of cardiac problems, was compliant, depot anti-psychotic given after discussing with pharmacist.	Establish how to provide effective input into the care of our patients who have SMI, chronic physical health, and risk orientated lifestyle.
FYPC/LD		
C718: Clinical care, multidisciplinary working, Inter-speciality liaison/continuity of care/ownership	Streamline contact processes because there is ambiguity in how health visitors contact safe guarding line.	Recommend better processes for health visitors to contact the safeguarding advice line.
C719: Clinical care, inter-speciality referrals/review	Improve contact with social care, as currently a void in succinct contact.	Review escalation policy.
C13: Clinical care, assessment, diagnosis and management plan	Transparency and understanding of multi-disciplinary efforts.	Pathways to be updated in relation to children that have been referred to social care.

Abbreviations

ANP: Advanced Nurse Practitioner; **CPN:** Community Psychiatry Nurse **EOL:** End of Life; **ISMR:** Initial Service Management Review **LRI**: Leicester Royal Infirmary; **MDT:** Multi-Disciplinary Team **PPOD:** Preferred Place of