Title:	**Learning from Deaths Group – Quarter 4, 2022-23 Report**		
Report to:	**Board**		
Meeting:	**19th July 2023**	**Agenda item:**	**11**
Purpose of the report:	**For Noting:** ☐	**For Decision:** ☐	**For Assurance:** ☒

Executive Summary:

This report meets the requirements of the National Quality Board (NQB) guidance (2017) for NHS providers on how they should learn from the deaths of people in their care. This report has been presented and discussed at the Quality Improvement and Safety Committee on 28 June 2023

The National Guidance required Trusts to:

- Have a Learning from Deaths Policy approved and published by the end of September 2017 which reflects the guidance and sets out how the Trust responds to, and learns from, deaths of patients who die under its management and care. The policy should also include deaths of individuals with a learning disability and children.
- Publish information on deaths, reviews and investigations via an agenda item and paper to public Board meetings.
- Have a considered approach to the engagement of families and carers in the mortality review process.
- Publish evidence of learning and actions taken as a result of the mortality review and Learning from Deaths process in the Trust's Quality Account from June 2018.

Recommendation:

The Board is asked to note the contents of the report and agree the level of assurance that can be taken from the detailed analysis of activity and learning in the report.
Level of assurance recommended from this report: **Substantial**.

	Name		Title	
Report author:	Liz Webb		Deputy Chief Nurse	
Executive sponsor:	Dr David Vickers			
Assurance level:	**Substantial** x☐	**Reasonable** ☐	**Partial** ☐	**No assurance** ☐
Rationale for Assurance rating:	- Evidence of reports across clinical services where people die under our care - Evidence of discussion and analysis			
Assurance action:	-			

How the report supports achievement of the Trust objectives

Trust Objective	
Provide outstanding care	Report details learning and required activity relating to people who die under our care.
Collaborate with others	Identifies when collaboration has been undertaken.
Be an excellent employer	Learning from the Learning from deaths supports staff safety and overall level of practice.
Be a sustainable organisation	On-going learning and compliance with standards.
Equality and Diversity Objective - Describe how this report / papers addresses Health Inequalities:	
Within the Learning from Deaths Group memberships and any discussion around care at the end of life, consideration of anti-racist practice is considered. The collection of demographic data for people who give feedback will be explored via the Patient experience and Safety team including the use of DATIX to capture this information.	

Links to BAF risks / Trust risk register

- Risk 3166– There is a risk that patients and service users do not receive outstanding care if services fail to remain compliant with CQC Fundamentals of Care Standards (Risk rating 12).

Legal and Regulatory requirements:

Previous Papers (last meeting only):

Title:	**Date Presented:**
Learning from Deaths Group Quarter 3 Report	March 2023

1. Introduction

1.1 This Quarter 4 report on Learning from Deaths across the Trust is detailed below as per the Trust's Learning from Deaths Policy, in line with National Quality Board (NQB) guidance (2017). This gives substantial assurance that the Trust is proactively seeking to improve care provided at the end of life and seeking to learn from cases when things go wrong. The Learning from Deaths Group meets quarterly, and service leads provide individual reports and analysis which makes up the content of this report.

2. Luton Adults

2.1 The review of deaths has been conducted according to the general principles laid out in the Trust's Learning from Deaths Policy 2.0.

2.2 Data, generated from SystmOne, was obtained by the Trust's Informatics Team and included patient deaths that occurred in the review period for those patients who had open episodes of care with CCS Luton Adults Unit at the time of their death. Patients who were not under the care of a CCS clinical team at the time of their death were excluded from the review.

Of note the author of the report has changed. This highlighted a difference in application of the data analysis described above (reported in quarter 3). This relates to which patients within the Luton Adults SystmOne Unit are included. For this paper the data used is the same as quarter 1 and 2 & 3, which are those people who died within District Nursing and Palliative Care. We have agreed that for the new financial year all services covered by the Luton Adults Unit will be covered and will include ethnicity data to allow further analysis.

2.3 The NHS numbers in the list were used to access SystmOne records. For each patient record, the following information was reviewed:

- Died under the care of CCS Luton Adult Unit (Y/N)
- Age
- Gender
- Use of End-of-life care (EoLC) SystmOne template

2.4 This template gives a single place for staff to record conversations around advance care planning that can include:

- Preferred place of death (PPD)
- Any end-of-life planning that is in place
- Actual place of death
- Reason PPD not met.

2.5 **Overview**

A total of 90 patients died in Q4 under the care of the district nursing/palliative care team

Of these, 50 patients had an advance care planning discussion recorded within the EPaCCS template. The Electronic Palliative Care Coordination Systems, or EPaCCS, is a means to capture and share information from people's discussions about their care with any professional. The aim of this is to ensure that any professional involved in that person's care has access to the most up to date information, including any changes to their preferences and wishes and personalised care plans.

45 of these Patients had a preferred place of death documented.

Of the 45 Patients, 37 Patients/died in their PPD (82%)

2.6 Themes arising from the Luton adult review.

Incidents
There have been 7 incidents reported on Datix in Q4, 6 were categorised as low/no harm.

These included:

- number of medication vials dispensed being different to the number prescribed leaving a shortfall in what was available to administer.
- Grade 2 pressure sore developed as patient not using the appropriate equipment that had been supplied.
- Missing medications in the property
- Medications not being stored correctly.

Learning and outcomes included:

- Discussions with external colleagues
- Development of the end-of-life template, electronic recording of controlled drugs and the need for a risk assessment prior to putting controlled drugs in a patient's property.
- Amendment of policies.
- Review of the safe storage of controlled drugs in the patient's home? a universal bag to easily identify.

There was one moderate harm incident that when reviewed highlighted the excellent combined working between the teams and the palliative care documentation was excellent and addressed all the concerns raised.

End of Life Care template
Work has been ongoing to develop a template that will be used by District nurses, rapid response, and palliative care to record specific elements of care such as drug doses, care provided, and plans made with the patient and family. It will be where everyone can see advice and recommendations which should increase continuity of care for patients.

Education Plan
The Specialist Palliative Care team are planning to deliver mandatory training to CCS teams. Including advance care planning, deteriorating patient and end of life care. This training will be monitored via ESR.

Friends and Family Survey
The finalised survey started being used in the month of March with 12 being handed out to new patients, however there were no returns. This has been reviewed, and the team have been supported to develop their awareness and confidence in handing these out and it has been agreed that the team will undertake a follow up call a week later to encourage completion of the survey.

Service metrics
As a service we aim to contact all new referrals within 48hrs of referrals so far we have had 100% compliance with this.

Audits completed

EPACS audit completed, a retrospective audit of 20 patients' records looking at EPACS and whether preferred place of care and death was documented, whether patients and carers were involved in decision making, DNAR documented, and medications reviewed. Overall compliance was high there was only two areas which scored 90% which is accounted when first assessments and therefore potentially discussions are not appropriate. This needs to be reflected in documentation.

- Record Keeping
  The record keeping audit in which there was overall high compliance. The areas that did not score highly was a falls assessment was not carried out at first assessment and there was mixed compliance with PURPOSE T/HNA's..

3.0 Safeguarding Q4 Report

We received a summary of the 'Sudden unexpected death in infancy' (SUDI) for children under 12 months or 'sudden expected death in childhood' (SUDC) for children aged over 12 report. What we heard is that some of the deaths of children are explained following a post-mortem examination and or other investigations (48%). However, the majority remain unexplained (52%). Deaths of children under one year of age are often described as sudden infant death syndrome.

Summary of what we do know about demographic characteristics of families in which SIDS occurs is:

- More deaths occur in males (57%)
- Greater risk is identified among infants with lower birthweight.
- Prematurity (shorter gestation period)
- Neonatal complications
- Young maternal age is a correlating factor
- Having more children
- Multiple births
- Single mother
- Complicated obstetric history
- Socio-economically deprived families – 42% (although also known to occur across the social strata – 8%)
- Smoking

Risk reducing factors:

- Sleeping babies on their backs on a flat, firm surface.

The report makes 10 recommendations, and the following are significant for CCS services and are included in relevant staff competence and training:

Recommendation 3

Ensure safer sleeping advice is personalised to the individual circumstances of each family, and that support addresses both the environmental and psychological barriers to following advice, to reduce the risks of sudden, unexpected, unexplained death in infancy. Professionals discussing safer sleep advice should be aware of the high number of deaths in which unplanned co-sleeping took place in a hazardous environment so they can ensure that every family gets advice for such situations.

Recommendation 4

Consider use of validated Safer Sleep Assessment Tools to identify families with infants at higher risk of SIDS. This will support Health Visitors, Social Workers, GPS and Adult Mental Health Services to identify vulnerable families and provide enhanced support. This should include seeing where the infant sleeps during home visits and providing person-centred advice for families depending on their individual circumstances.

Recommendation 5

Ensure that health visitors and midwives in the CORE20PLUS5 areas have enhanced staff numbers to allow for support and training to deliver individualised safe sleeping advice. This will utilise the NHS England CORE20PLUS5 approach to reducing health inequalities and current multi-disciplinary training.
https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

4.0 HIV Deaths – Integrated Contraceptive and Sexual Health Service (iCaSH)

The service reported three deaths in the quarter, two unrelated to HIV care and treatment following peer review. One review to be undertaken. The Duty of candour threshold has not been met in any of the reported deaths. HIV patient deaths are discussed and reviewed at the local MDT HIV Network meetings and overviewed by the quarterly iCaSH Clinical Advisory Group (iCAG) with the iCaSH consultant body and any shared learning identified.
National reporting of HIV Mortality is mandated via UKHSA.

5. Child Deaths - Children's Community Nursing only

5.1 Bedfordshire and Luton CCN

Bedfordshire children's community nursing reported no deaths in quarter 4.

5.2 Luton children community nursing

We received this report from the CCN who leads the Palliative care for the Luton team, it was a busy quarter with seven deaths. Most children cared for had complex genetic health needs.

Learning

- There was an unexpected, expected death which has prompted ongoing work with Safeguarding Team and local Coroner about procedures when this occurs as it created delay and unnecessary distress for the family.

- A child who moved into Luton area was missing paperwork of Advance Care Plan/Respect that had been put in place in London. Although the child died peacefully on ward with family present and symptoms well managed, they could have been managed at home with Palliative team / hospice support.

- Each case demonstrated the complexity of physical and emotional support provided to the child and the families that facilitated the care at the end of life to be in the place preferred.

5.3 Cambridgeshire and Peterborough CCN

- There was one child death in the quarter. This was a nearly eighteen-year-old. The case highlighted excellent joint working between our team; EACH and the adult hospice Arthur Rank and Addenbrookes.

6.0 Medical Examiner rollout to Community Services update

The roll out of medical examiners has been slower than anticipated in community settings, the original requirement was for 1 April 2023 but now likely to be by the end of December 2023.The first route of information request for our services from the Medical Examiner Office would be via GP Records as we don't have in patient beds. Dr David Vickers has meet with Cambridgeshire and Peterborough medical examiner and highlighted our role with HIV care and consequently may be asked for information in these cases. There is an Information Governance Sharing Agreement in place, so this gives approval to release information including iCaSH records.

7.0 Summary

- There is work being undertaken in the Adult Service around review of data and roll out of templates, this will lead to a more detailed understanding of PPD and also those service users not achieving this and reasons.
- Noting the number of child deaths in Luton in terms of population and the impact on staff.
- Noting the work being undertaken in iCaSH Service on HIV and the robust processes in place to review HIV deaths.
- Roll out of the Statutory Medical Examiner System.
- Inclusion of ethnicity and demographic information going forward for Luton Adults data on improving health and inequality. This will also need to be considered for iCaSH and Children's Services.

ENDS