Title:	Learning from Deaths Group – Quarter 1, 2023-24 Report		
Report to:	Trust Board		
Meeting:	27-09-2023	Agenda item:	11.0
Purpose of the report:	For Noting: x	For Decision:	

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.

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 because 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 gained 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	
To fully implement the actions identified following our review of the No More Tick Boxes review of potential bias in Recruitment practices	Not applicable.
The Trust Board will role model behaviours that support the Trust ambition to be an anti-racist organisation including actively implementing the Trust's and their personal anti racism pledges, to instil a sense of belonging for all our staff.	Within the Learning from Deaths Group memberships and any discussion around care at the end of life, consideration of anti-racist practice is considered.
To commence collection of demographic data for people who give feedback.	This will be explored via the Patient experience and Safety team including the use of DATIX to capture this information.
To work with the data team and clinical services to target the collection of demographic data.	As above.

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 1 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 3.0.

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.

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/ EPaCCS.

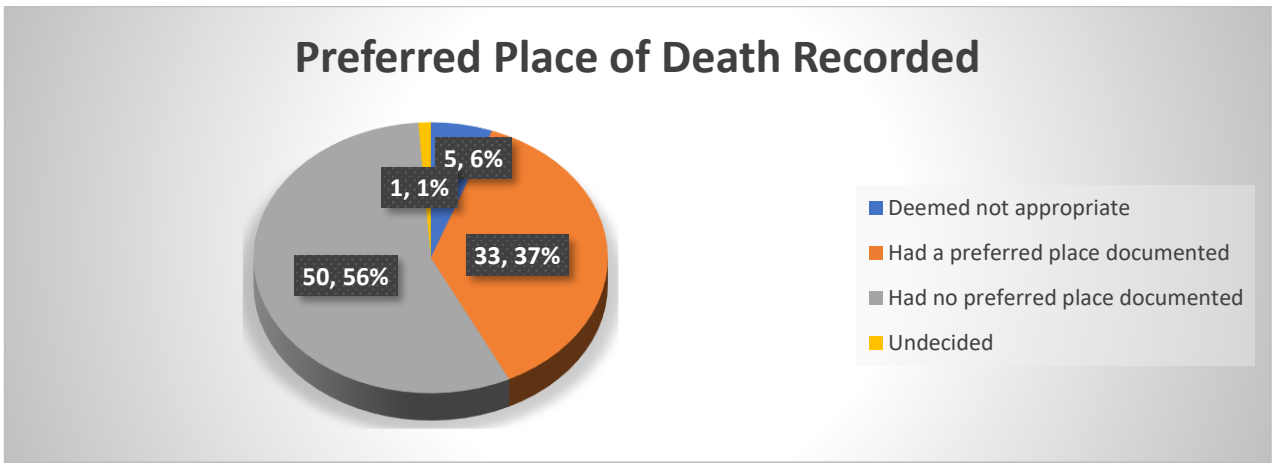
2.4 This template gives a single place for staff to record conversations around advance care planning that can include:

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

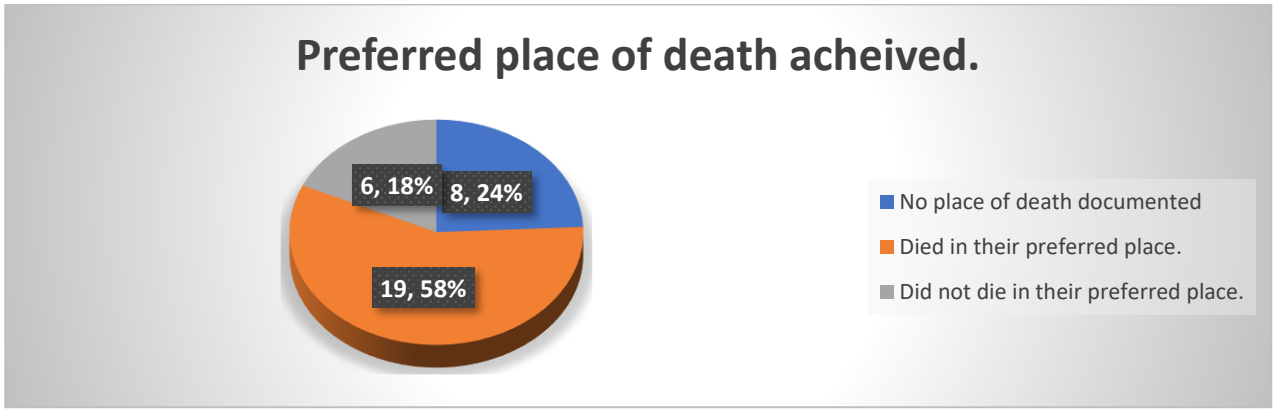
2.5 Overview

2.5.1 The below data shows the number of patients that have died in Q1 and shares the information we have captured through the EPaCCS (Electronic Palliative Care Coordination template). The template supports the adult teams to have a documented advanced planning conversation with their patients, including the patients preferred place of care and death then recording their actual place of death. The report covers all of the nursing teams in Luton Adults apart from Phlebotomy, Falls and At home first. This is change from previous reporting.

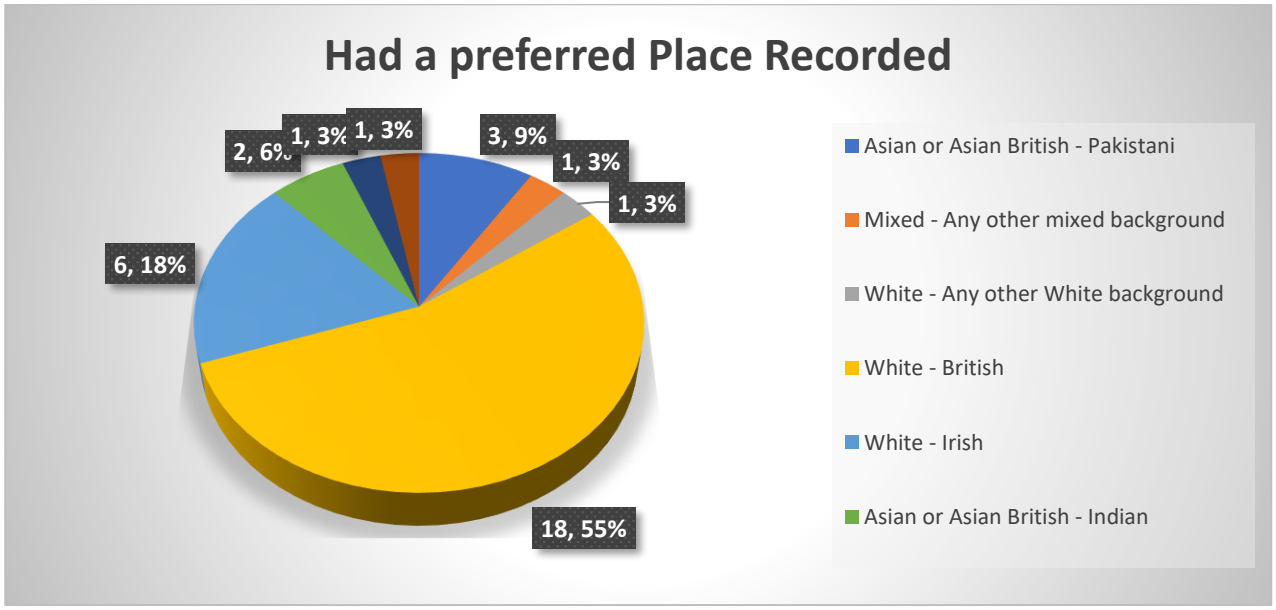
2.5.2 In quarter 1 there were 89 patients who died under the care of teams in Luton Adults teams. Of those, 33 had a preferred place of death recorded.

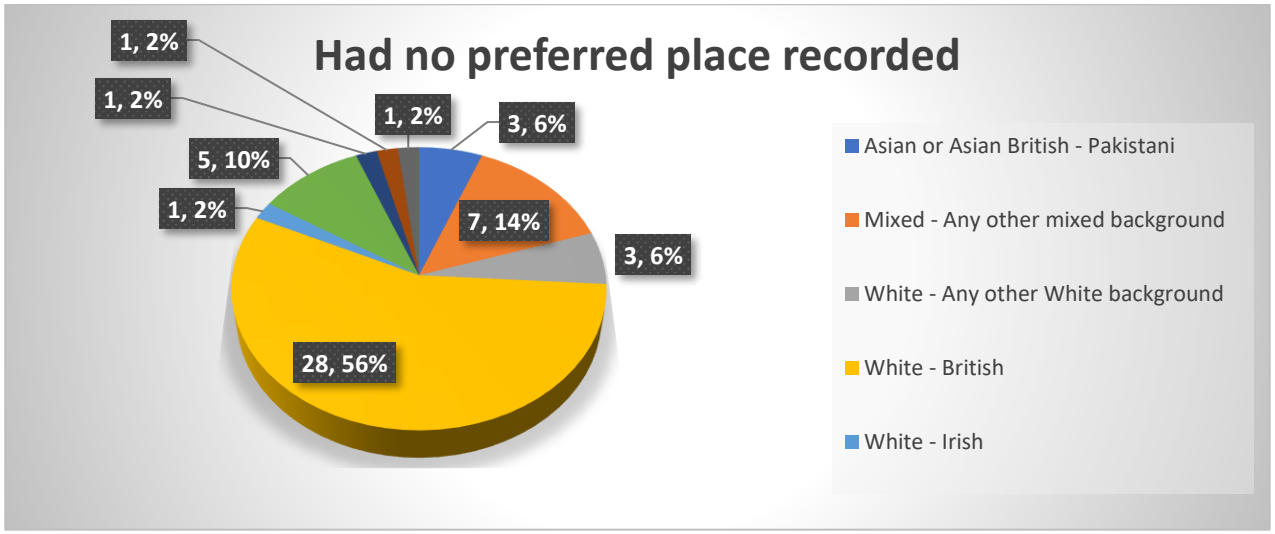


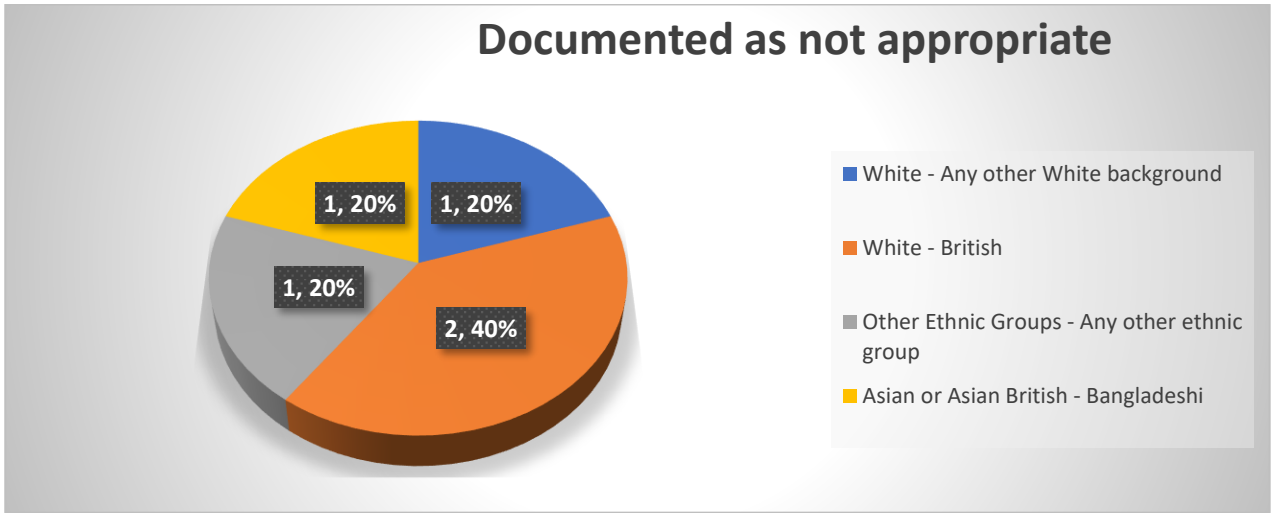
2.5.3 Of the 33 that had a preferred place of death documented, 19 died in their preferred place of death.



2.6 **Ethnicity and preferred place of care:**
The data below looks at those 89 patients who died under the Luton Adult Services and whether there had been a documented conversation about preferred place of death broken down by ethnicity. This is the first time we have analysed this measure. Further analysis is planned to include where people are actually cared for; in comparison of who we support in terms of ethnicity as a reflection of the age demographic in Luton.







2.7 Review of records

To support further learning across Luton Adults a review of the notes of patients selected at random who died in their preferred place of care and those who had not had a conversation about the preferred place of care were be completed. This will support the "story" behind the patients experience and identify any learning, we must remember that a patient dying in their preferred place of care will not always be achieved but this does not always result in a bad experience. These were discussed at the Learning from Deaths meeting-example of two stories are given here:

2.7.1 Mr C

76-year-old man. Had a diagnosis of heart failure, dementia, hypertension, and prostate cancer and had been cared for by our community nursing services, heart failure nurses, community matron, district nurses, since 2016. Despite all of his comorbidities and regular reviews no Advance Care plan or EPACCS completed.

2.7.1.1 The patient had been clinically deteriorating over the last few weeks at home. Mobility had reduced and was now bed bound and Poor nutritional intake. Patient was being seen regularly by the community nurses for wound/ pressure area care to sacrum. Ex-wife who was main carer had discussed general decline with the health professionals visiting and how difficult she was finding this.

The patient did have a DNAR and died Peacefully at home due to rapid decline.

2.7.1.2 **Learning identified** – The gentleman was known to multiple service and although there is evidence of him deteriorating over the last few weeks of his life there was no advanced care planning conversations documented. There was no evidence of a conversation for consideration of a referral to My Care Co-ordination team who could have provided support/advice to both the patient and the carer.

2.7.2 Mr D

86-year-old man who lives in a residential home. Had a diagnosis of end stage Heart failure and Parkinson disease. Documented that patient's general condition had been deteriorating over the last few weeks, reduced mobility carers using hoist to move from bed to chair. Was being seen regularly by District Nursing team with reference to wound dressing / pressure sore to r hip, which was deteriorating rapidly, and Datix/safeguarding referrals completed.

2.7.2.1 DN team transferred patient to hospital as had become acutely unwell and had red flags for Sepsis. Patients condition continued to deteriorate whilst in hospital and patient died.

2.7.2.2 **Learning identified** – there was no documented conversation about advanced care planning in the records, despite regular reviews.

2.7.2.3 **Actions:**

There is ongoing support required for the teams to have early advanced/future planning conversations. A training programme is being developed by the specialist palliative care team to provide learning on End-of-life care, and advanced care planning. Another programme of work is for the Clinical lead to develop a staff survey (based on the National Audit of Care at the End of Life (NACEL) survey) that asks staff their level of confidence in having an advanced care planning conversation which will help to identify any other learning and support that is required.

3.0 Safeguarding Q1 Report

3.1 Two safeguarding adult and child practice reviews have been published over this quarter in our geography.

3.2 Review 1

3.2.1 Anika was a young 17-year-old girl who died from a serious infection caused by her PEG tube receding into her stomach which resulted in peritonitis and a fatal sepsis. This review has been shared with the children's community nursing teams across the Trust to support cascade of learning across the system and localities. The review sets out the need to have clear management oversight of cases of children with complex needs.

3.2.2 **Learning identified:**

- Health professionals must receive mandatory training in the proper functionality of PEG tubes where the person with the tube is vulnerable.
- Parental capacity to manage PEG tube feeding should be reviewed regularly.
- Named lead professional should be identified to co-ordinate, oversee and monitor actions and ensure that children are seen and heard.
- Arrangements for transition of young people into adult services must be reviewed.

3.3 Review 2

3.3.1 Nigel was a man with a learning disability who lived in conditions of self-neglect. Although he lived with his sisters in the family home after the death of their parents, they too appeared to find it hard to do everything around the house which meant that there was

evidence of hoarding in the home. A LeDeR review was undertaken which reported that there was a need to have undertaken a Safeguarding Adult Review 4 months previously. The subsequent SAR is published in easy read format to enable the findings to be more widely appreciated by all in the community including people with learning disability or difficulty.

3.3.2 **Learning identified:**

- Mental capacity act assessments continue to feature in safeguarding adult reviews as a significant aspect of clinical practice which requires ongoing oversight by the Trust.

3.4 Learning Disability Mortality Review (LeDeR) Programme Update and Children and Young People's LeDeR Policy Change Confirmation

3.5 From 1 July 2023, there will no longer be any requirement for deaths of children with a learning disability to also be notified to the LeDer. This change in review raises some questions particularly as the Child Death Overview Panel (CDOP) does not have direct access to medical records but the LeDer review did. There was a discussion within the meeting about whether we could do anything internally as this gives a lot of concern, even from an adult service point of view. For example, LeDer reviews the life and death of the person but through CDOP it mainly focuses on the death, so you don't get the whole holistic view.

3.6 The meeting was reminded that LeDer is not just inclusive of learning disabilities it also includes autism.

3.7 It was highlighted that if a patient has opted out of their health records being reviewed by any other reason than healthcare, prior to their death, then their death will not be reviewed via LeDer when it comes to a SAR. We can override that, but the national stance is they are not attempting to override at this stage.

3.8 The Safeguarding team are attending LeDer in BLMK and Norfolk and plan to attend Cambridgeshire and Peterborough as well.

4.0 HIV Deaths – Integrated Contraceptive and Sexual Health Service (iCaSH)
(National reporting of HIV Mortality is mandated via UKHSA.)

4.1 The following was noted:

- Service reported 4 deaths across the teams in Q1.
- Seven patient deaths (from previous quarters) have now been reported in Q1.
- All deaths have not reached the threshold for Duty of Candour.
- All deaths are reviewed and discussed at the local MDT HIV Network Meeting.
- None of the deaths were related to HIV care or treatment.

4.2 **Update on actions from neonatal death in Q4 21/2022 (W68167)**

- Clinical Assessment process and templates have been reviewed to require a second professional to peer review all cases and management plan where a pregnant woman presents with syphilis; all initial appointments in this case will be face-to-face.
- The recall process across all our clinics has been reviewed and a safety net process implemented in all localities, with weekly recording instigated to demonstrate assurance that the recall catch all is being run in each service.
- In addition to the above, the recall process has been standardised with a reduced list of option types now available (update in Q1).
- All cases of syphilis in pregnant women across the whole of iCaSH in previous 12 months have been audited; all meet the UK national guidelines on the management of syphilis as required, including recall standards. This audit will be repeated annually.

- Identified clinician's cohort: All cases of syphilis in any patient within the in the last 2 year have been audited; all meet the UK national guidelines on the management of syphilis as required, including recall standards. This audit will be repeated annually.

5.0 Child Deaths - Children's Community Nursing only

5.1 Bedfordshire and Luton CCN

5.1.1 Luton

5.1.2 There was 1 child death in this quarter, known to the CCN Team. The child was premature with complex cardiac issues and deteriorated rapidly. A JAR was held in May 2023 led by Luton & Dunstable Hospital.

5.2 Bedfordshire

- There were no deaths this quarter known to the CCN Team.
- Two children have died known to the Special School Nursing Service:
- A16-year-old with an acquired brain injury; sudden and unexpected death due to bowel obstruction and faecal loading. A root causes analysis investigation is underway as the young person was cared for by our bowel care service and community paediatrics. The outcome of the report will be reviewed further at the meeting and the coroner has requested this report.
- A14-year-old with multiple complex needs, died in hospital but advance care planning completed with parents.

5.3 Cambridgeshire and Peterborough CCN

5.3.1 There were no deaths in this quarter.

5.4 Coroner's Case Updates

5.4.1 A Coroner's Case from approx. 4 years ago is being reopened in Norfolk after a judicial review, our healthy child program was involved with the case. All the learning identified from the judicial review is to be brought back, and our health visitor is required to attend again. They are being supported by the legal team and local management team.

5.5 Child Death Overview Panel (CDOP) Notifications and oversight:

5.5.1 A review has commenced of the policy and process of how we work with the CDOP panels. These all work slightly different across our geography. A summary of the process and the differences will be pulled into a single standard operating procedure. This will ensure communication is effective and that staff are kept informed when a review is being conducted.

5.5.2 **Summary**

- Luton Adults making progress in understanding and developing training to support staff in advanced care planning. Starting to explore ethnicity data to improve access to all communities if required.
- iCaSH have completed the syphilis neonatal action plan.
- Change to the LeDer Policy. There will no longer be any requirement for deaths of children with a learning disability to also be notified to LeDer.
- Child Death Overview Panel SOP review underway.