Cambridgeshire Community Services NHS Trust

Board Report

Title:	**Learning from Deaths Report**
Action:	**For noting**
Meeting:	**26th January 2022**

Purpose:

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 information and learning is overseen by our Learning From Deaths Group. **This report has been received and discussed at the Quality and Safety Committee December 2021, as per the governance process.**

This National Guidance required Trusts to:

- ✓ Have 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.

Level of assurance gained from this report - substantial

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.

	Name	Title
Author:	Liz Webb	Deputy Chief Nurse
Executive sponsor:	Dr David Vickers	Medical Director

Trust Objectives

Objective	How the report supports achievement of the Trust objectives:
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.

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 8).

Legal and Regulatory requirements:
As above

Previous Papers:

Title:	Date Presented:
Learning from Deaths Board Report	15th July 2020
Learning from Deaths Board Report	3 September 2021

Diversity and Inclusion implications:

Objective	How the report supports achievement of objectives:
To support the development of a Trust wide Anti-Racism Strategy and Organisational Development Plan.	N/A
To finalise the roll out of reverse mentoring as part of all in house development programmes.	N/A
We will measure the impact of our virtual clinical platforms, ensuring that they are fully accessible to the diverse communities we serve.	This is applicable in the context of covid19 and care at the EOL. The report highlights good practice. But also highlights our role as experts within iCaSH to ensure all individuals have the same access to care and work with our partners to understand the needs of individuals with protected characteristics.
We will ensure that the recruitment of our volunteers are from the diverse communities they serve.	N/A

Are any of the following protected characteristics impacted by items covered in the paper

Age	Disability	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
☐	☐	☐	☐	☐	☐	☐	☐	X

1. INTRODUCTION

A Quarter 2 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. This report also describes the ongoing work done with partners in the wider system to respond to the covid19 pandemic and planning and response around end of life care.

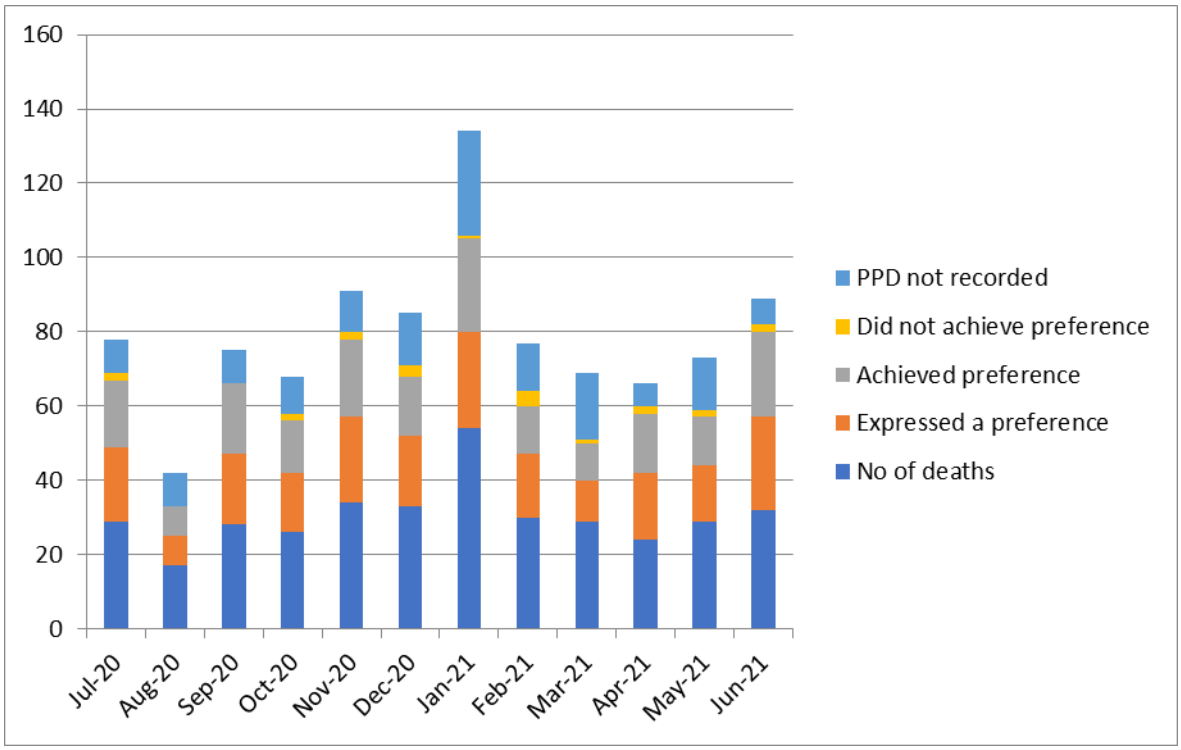
LEARNING FROM DEATHS QUARTER 2

2.1 Luton Adult Services Quarter 2 (July August September)

The review of deaths was carried out according to the general principles laid out in the Trust's Learning from Deaths Policy. Data was obtained by the Trust Informatics Team which was generated from SystmOne of patient deaths that occurred in the review period for those patients who had open episodes of care with CCS Luton Adult Unit at the time of their death. The NHS numbers in the sample list were used to access SystmOne records.

Twelve month analysis of preferred place of care (Table 1)

The chart show spikes in number of deaths of those known to Luton Adults in April 2020 and January 2021 which may reflect the status of the pandemic at that time, although these were expected deaths and the patients did not die from Covid.



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 (Y/N)
- End of life planning in place
- Preferred place of death (PPD)
- Actual place of death
- Reason PPD not met

2.2 Quarter 2 Data

The review has been broken down by month looking specifically if patients were offered an opportunity to have advance planning conversations and if these were ongoing. A review of place of death was undertaken to see if patients died in their preferred place of death (PPD) and reasons why that did not happen

Total of 84 patients died under the care of a clinical team during the quarter

- 61 patients had evidence of an advance care planning conversation
- 2 declined to discuss their wishes and had no recorded PPD
- 59 had a PPD recorded
- 54 patients achieved their PPD

For the community services this quarter
73% patients who had capacity had evidence of some advance care planning conversations.
92% patients who had expressed a preferred place of death achieved it .
23 patients had no recorded evidence of advance care planning conversations or were unable to express a preference.
Of these;

- 6 died in their usual place of residence
- 17 died in hospital

2.3 Themes arising from the review

Despite this being another challenging quarter across the Luton Adults community services they were able to continue to support patients to die in their preferred place of death. There is some evidence that the advance care planning conversations had not been offered to all patients who have a palliative diagnosis on a routine basis so patient's wishes around their care including their preferred place of death had not been explored with them. Had there been some advance care planning conversations they may have helped facilitate early discharges for some patients if there end of life wishes were known. This report is not able to reflect the complexity of the patients being supported to die at home or the support given to their families.

2.4 BLMK Context

The matron with a special interest in dementia is looking to ensure advance care planning conversations are offered soon after the CCS service becomes involved in the care of patients with a dementia diagnosis. Links are also being made with local mental health teams and the memory services to encourage other staff involved in supporting this cohort of patients particularly at time of diagnosis to initiate these conversations.
The Specialist Palliative Care (SPC) team has provided some initial sessions on the practical use of the EPaCCS (Electronic Palliative Care Co-ordination Systems) clinical template for CCS teams.

Annual "mandatory" end of life care training provided by Keech Hospice has been introduced to improve staff confidence in ensuring advance care planning conversations

are offered to all patients and recognising when patients are deteriorating and nearing the end of their life.

Within BLMK the lead palliative and end of life commissioner has planned an initial scoping meeting to review all palliative and end of life care (PEoLC) against the new national service specification for (PEoLC) and Specialist Palliative Care will also be undertaken In addition a system wide review of the EPaCCS clinical template which will ensure a consistent approach for recording patient's wishes that will be visible for all involved in the patients care. The Lead Nurse in part of this piece of work.

2.5 Complaint

A complaint was received about the care of a lady who died in December 2020. The investigation has identified wide ranging actions and learning for the Luton Adults Service which are detailed below:

- A full review of our Palliative Care Service has been initiated by the Chief Nurse, Kate Howard and the Service Director, Pete Reeve.
- Palliative Care Specialist Nurses are to administer pain relief as required
- Palliative Care Staff have been trained to order equipment directly
- Administrators are to ensure that any palliative patient's matters are immediately brought to the attention of a nurse.

3.0 Integrated contraception and sexual health service (iCaSH) HIV Deaths

There have been 4 deaths reported during Q2, and 1 retrospective death in Q1 reported in Q2. All reported deaths related to patients living with HIV, unrelated to current HIV care and treatment.

	Q1			**Q2**		
	April 21	**May 21**	**June 21**	**July 21**	**Aug 21**	**Sept 21**
Total Deaths	**2 + 1 (1 retrospectively reported in Q2)**	**1**	**3**	**1**	**0**	**3**
Local Reviews	**2 x reviewed at June 2021 iCAG** **1 x reviewed at Sept 2021 iCAG**	**1 x reviewed at June 2021 iCAG**	**0***	**Reviewed at Sept 2021 iCAG**		**3 x to be reviewed at iCAG in Dec 2021**
Deaths requiring RCA	**0**	**0**	**0****	**0**	**0**	**0**

The service reported 5 deaths in Q2 relating to long term care patients (HIV), and 1 death in Q1 retrospectively reported in Q2. Deaths unrelated to current HIV care and treatment. However, 3 of these patient deaths were unexpected and referred to the coroner. iCaSH services report challenges in receiving death notifications or details from GPs.

Of the 3 deaths, 2 patients had difficulties in engaging with iCaSH and other healthcare services, and 1 patient history showed previous poor engagement with services during initial diagnosis (not iCaSH) resulting in poor health outcomes. 3 deaths have been discussed/reviewed at iCAG and nil recommendations identified so far. This paper will be submitted to the iCaSH Operational & Performance Board in October 2021.

All deaths reported are unrelated to/not directly attributed to current HIV care/treatment or a patient safety incident and therefore the duty of candour threshold has not been met.

3.1 Learning

This ongoing review previously identified some reporting gaps between the clinical system and incident reporting. Further communication with teams has been shared as well as crib instructions for how to report patient deaths on clinical and datix systems. Improved reporting is evidenced this quarter.

HIV patient deaths are discussed and reviewed at the quarterly iCaSH Clinical Advisory Group (iCAG) with the iCaSH consultant body. Due to the timings and frequency of these meetings, any deaths reported near to or after the quarterly iCaG, will be reviewed in the following Q unless urgent or a patient safety incident is identified. There is therefore an occasional lag in local review reported dates.

4. Children's Services

4.1 Cambridgeshire and Peterborough Children's Community Specialist Nursing Service

There was one palliative care death in Cambridgeshire and Peterborough that the service supported.

4.2 Luton and Bedfordshire Child Deaths

12 deaths recorded in this quarter from CCN, School Nursing and HV teams Luton

1 child was known to Children's community Nursing team

This child died supported on an end-of-life care pathway. There was symptom management plan and DNAR in place. Memory making and supportive care was in place at time of death and was under shared care with Addenbrookes, L&D hospital, CCN team and Keech Hospice Care.
Learning noted was around readiness of the just in case box as some medications were in the home but had not been checked by either team (CCN/Keech). This caused issues when patient suddenly deteriorated as some of the medications were not available and on call had to contact OOH doctors for a prescription. Local teams have reflected on the case and put steps in place to improve planning around JIC medications.

There were 10 neonatal/ still birth deaths in this quarter

5.0 Safeguarding- Learning from child death report and Suicide in Children and People Review.

The group discussed the Child Death Report and the Suicide in Children and Young People Thematic Review Report and noted that sadly the themes have not changed over the years. The case study was reviewed and learning identified.

The Suicide in Children and Young People report was reviewed. This highlighted that 16%

of young people had a neurodevelopmental disorder at the time of their death. Recommendations and training solutions were discussed, and it was agreed that a holistic approach across the Trust would be beneficial. This will be discussed further at the newly formed Children's Trust wide Learning Forum.

6.0 Learning from Coroners Reports

The group received the CSPR for Oliwer which at the time of the meeting was embargoed This was the death of an eight year boy in December 2019 .Several of our children's services cared for this child. At the time an internal RCA was completed and learning, and actions have been taken forward. A review of the CSPR against the RCA will be completed and additional actions and learning taken forward as needed.

7.0 Learning from LeDER

The BLMK CCG Transforming Care Partnership (Learning Disability and/or Autism) LeDer Annual Report 2020/2021 was received and will be discussed at the next meeting but key actions include annual health checks and robust mental capacity assessment.

https://www.blmkccg.nhs.uk/documents/blmk-leder-annual-report-2020-2021/

8.0 National Reports

Nationally there have been several documents relating to palliative and end of life care issued these include:

- End of Life Care Learning Outcomes: for all staff undertaking end of life care from Heath Education England
- New National service specification for palliative and end of life care (PEoLC)
- New National service specification for Specialist Palliative Care
- NICE Quality Standard for End of Life Care for Adults updated

End of report