Title:	**Learning from Deaths Group – Quarter 2, 2022-23 Report**		
Report to:	**Trust Board**		
Meeting:	**25th January 2023**	**Agenda item:**	**5**
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. The information and learning is overseen by our Learning from Deaths Group; and was reviewed and discussed at the Quality and Safety Committee 6 December 2022

This 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.

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	
Report author:	Liz Webb		Deputy Chief Nurse	
Executive sponsor:	Dr David Vickers		Medical Director	
Assurance level:	**Substantial** ☒	**Reasonable** ☐	**Partial** ☐	**No assurance** ☐

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 are 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 8).
- Risk 3260- Risk around impact of Covid-19 on community service delivery of care

Legal and Regulatory requirements:

Previous Papers (last meeting only):

Title:	**Date Presented:**
Learning from Deaths Group Quarter 1 Report	September 2022

1. Introduction/background/context

1.1 This 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 paper has been presented and discussed at the Quality Improvement and Safety Committee 6 December 2022. 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.

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

Total of 63 patients died under the care of a clinical team during the quarter

- 33 patients (52%) had evidence of an advance care planning conversation
- 32 patients (51%) had a PPD recorded (1 declined to discuss this)
- 30 patients (91%) achieved their PPD

For the community services this quarter 91% patients who had expressed a preferred place of death achieved it
30 patients (48%) had no recorded evidence of advance care planning conversations or were unable to express a preference

Of these

- 13 died in their usual place of residence
- 11 died in hospital
- 2 died in hospice
- 4 place of death not known

2.8 **Themes arising from the Luton adult review**

Advance care planning conversations continue to be mostly led by the specialist palliative care team.
The data around preferred place of care and death remains stable, with those people who have indicated a preference achieving this.
To improve this figure, it is important to ensure these planning conversations happen across the Luton Adults teams. Further support and training is underway. From April 2023 annual mandatory palliative and end of life training will be in place for all adult community nursing staff which will include advance care planning and practical use of the end-of-life care (EPaCCs) template.

Within BLMK the lead palliative and end of life commissioner has initiated a system wide review of the EPaCCS clinical template with the aim of ensuring a consistent approach for recording patient's wishes that will be visible for all involved in the patients care which is ongoing.

3. Safeguarding Review – national report

A report was received regarding, 'The Contribution of New-born Health to Child Mortality across England National Child Mortality Database Programme Thematic Report'

Learning Points

- From a public health perspective, it is possible that neonatal illness contributes to 72% of all deaths under 10 years of age.
- Children who received additional care after birth (neonatal care) made up 83% of children who died before their 1st birthday, 38% of deaths in the next 4 years, and 27% of deaths between the ages of 5 and 9.
- For babies born alive, at or after 22 weeks gestation, who subsequently died before 10 years of age between 1 April 2019 and 31 March 2021, half of the deaths occurred in children over one month old.
- There is a clear association between childhood death following neonatal illness and learning disabilities. Over half of the children who died also had learning disabilities.
- Where deaths were found to be caused by a perinatal event, the majority (78%) were caused by prematurity-related conditions. 13% were caused by perinatal asphyxia, 4% were caused by a perinatally acquired infection, and 4% were due to other causes.
- Modifiable factors were identified in 34% of the deaths reviewed. The most common were smoking in pregnancy, lack of involvement of appropriate services, and maternal obesity.

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

2.1 The service reported eight deaths in this quarter, with seven HIV patient deaths; six deaths of these are unrelated to HIV care and treatment.

A structured judgement review (SJR) of one HIV death identified a missing annual Q risk assessment and subsequent communication with GP. Patient had long history of raised cholesterol, and this had previously been communicated to GP. There is BHIVA guidance to undertake annual Q risk assessment in all patients over 40 years. Guidance was recirculated to staff and feedback as part of learning from the SJR review.

A non-HIV related death (stillbirth to mother with Syphilis) was also investigated. (See 3.2 below)

3.1 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.

3.2 Ongoing serious incident reported due to neonatal death was shared and discussed.

Quality Improvements from this case:

- 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 is being standardised with the aim to move to a single recall system across all iCaSH clinics.
- 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.

4.5 National reporting of HIV Mortality is now mandated via UKHSA.

5. Child Deaths

5.1 Cambridgeshire (Children's Community Nursing only)

The team cared for eight children who were expected to die. All children whose death was expected died in the place of choice, except one, whose choice was Hospice, but was too unstable to move from hospital.

5.2 Bedfordshire and Luton (Children's Community Nursing only)

The team cared for three children in this quarter. There was good evidence of advance care planning and advocacy for a child with the hospital.

6. End of Life Care and equality and diversity

6.1 Where possible with available data, the next set of reports to the group will aim to include relevant information to support analysis of the patients supported to die in our communities- looking at patterns and uptake.

ENDS