Title:	**Learning from Deaths Group – Quarter 3, 2022-23 Report**		
Report to:	**Board**		
Meeting:	**17th May 2023**	**Agenda item:**	**6**
Purpose of the report:	**For Noting:** ☐	**For Decision:** ☐	**For Assurance:** ☒

Executive Summary:

This report was originally presented and discussed at Quality Improvement and Safety Committee on 30 March 2023. It is bought to board as part of the national 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 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 gained from this report: Substantial.

	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 12).

Legal and Regulatory requirements:

Previous Papers (last meeting only):

Title:	**Date Presented:**
Learning from Deaths Group Quarter 2 Report	December 2022

1. Introduction/background/context

1.1 This Quarter 3 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.

The author of the report for quarter 3 has changed. This has highlighted a difference in application of the data analysis described above. This relates to which patients within the Luton Adults SystemOne Unit are included. For this paper the data used is the same as quarter 1 and 2; which are those people who died within District Nursing and Palliative Care. We are reviewing this anomaly and will report in due course any revision of the data set and analysis required.

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 105 patients died in Q3 under the care of the district nursing/palliative care team.

56 patients/53.3% had a preferred place of death documented.
1 patient/1% were unable to express their PPD.
5 patients/8.9% it was not appropriate to have the conversation.
3 patients/2.9% were undecided.

Of the 56 Patients
31 Patients/55.4% died in their PPD.

29 (93.5%) of the 31 died in their usual place of resident and 2 (6.5%) dies in the hospice.

2.6 Themes arising from the Luton adult review.

Going forward a more detailed analysis of the data will be completed to explore:

- The variation in data noted with change of report author.
- Health inequalities- using demographic data as available to highlight particular concerns.
- Why was no preferred place of death documented?
- What contributed to someone not dying in their preferred place of death?
- Why was no actual place of death documented?
- Establish what the benchmark should be for having documented preferred place of death for our population.

2.7 Palliative and End of Life transformation plan

For the last year Luton Adults have had a Palliative and End of Life transformation plan which focuses on addressing learning identified through a combination of factors including serious incidents, complaints, and a change in national guidance. Work on the plan continues with input from teams/services across Luton Adults and the trusts Quality team. Progress is discussed and monitored through the Palliative and End of Life Governance group meeting.

Completed action includes:

- Introduction of a weekly Internal Palliative Care MDT
- Electronic Palliative Care Coordinating System (EPaCCS) training underway for all staff.
- An audit to assess the quality of individualised care planning and discussion in line with national standards has been written. This remains pending a start date and will be completed quarterly with learning shared across the team.
- Friends and Family test data collection (FFT) has been introduced.
  Historically the specialist palliative care team have had a yearly patient feedback programme and actions following this, opting out of the FFT. However, the team have now moved to monthly FFT feedback approach in line with the other teams across Luton Adults, after additional support from the co-production lead.
  .
- There have been no complaints in Q3.

3. Safeguarding Q3 Report

3.1 National Report update

The National child Mortality Database (NCMD) received 3,470 notifications of child deaths from Child death overview panels (CDOPs) in England where the child died between 1 April 2021 and 31 March 2022. This is 396 greater number of deaths than the previous year. This is a return to the pre-pandemic levels of winter 2020 which showed a reduction in notifications.

The child death rate of children resident in the most deprived neighbourhoods in England (40.1 deaths per 100,000 children) was more than twice that of children resident in the least deprived neighbourhoods (18.9 deaths per 100,000 children).

East of England death rate is lower than the average for England.

Almost half of (41%) where a child was known to social care at the time of their death had modifiable factors indicated in comparison to 33% of reviews where the child was never known to social care. However, when a Child Safeguarding Practice Review (CSPR) was carried out (n=96), 77% had identified modifiable factors compared to 35% where a CSPR did not take place.

3.2 Child Safeguarding Practice Reviews:

The group heard about learning from Child Safeguarding Practice Reviews Published October / November 2022 specifically related to Child AL and Child AK

The importance of understanding a child's lived experience by describing what is being observed was emphasised – doing so provides an opportunity to get beneath the surface to the heart of a child's world - this correlates with the findings from national reviews. Understanding a child's world - paying attention to the language we use.

3.3 Safeguarding Adult Reviews -Max:

18-year-old young man who had been adopted in infancy and had high functioning autism and anxiety. He died of an accidental overdose alone in his flat in 2022. Max's life had become increasingly chaotic in the covid 19 lockdowns, with repeated admissions to mental health wards in periods of crisis. He was living alone but was unprepared to live alone, with no self-care skills and no ability to weigh risk. He had no care plan or safeguarding plan in pace from adult mental health or social care support.

3.4 CCS Action Plans for published SAR and CSPRs:

A combined action plan has been developed to consider learning across CCS for all published safeguarding adult reviews and child safeguarding practice reviews this quarter.

3.5 CDOP reporting template:

A new reporting template for child death reviews (CDOP) has been developed by S1 team and will be going live once further amendments and activity reporting is agreed, to support documentation and record keeping in such cases.

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

The service reported seven deaths, three were pending cause of death, and two cases awaiting peer review. The Duty of candour threshold has not been met in any of the reported deaths.

4.1 Learning from these deaths

HIV patient deaths continue to be 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.)

4.2 Serious incident report update due to neonatal death
(Datix W68167 Q4 2021/22)
Shared learning:

- 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 catches 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.

5. Child Deaths - Children's Community Nursing only

5.1 Bedfordshire and Luton

Bedford

The learning is this in the quarter related to the sad case of a 17-year-old wishing to die at home. The case evidenced excellent system working to support this young person to remain at home with cross working from district nurses, Children's community nursing and hospice. It did highlight issues with age of young people's access to services but the team worked around this.

5.2 Luton

Four children died under the care of the CCN team.
While all four died in hospital families continued to be supported by the CCN team throughout the children's lives and with bereavement.

One case had specific learning with regard medical teams to referring to palliative teams at 20/40-week scans when a baby is not expected to survive so families can be engaged with parallel plans by both hospital and community teams. This would ensue parents have all the information they need about possible outcomes of such difficult cases.

5.3 Cambridgeshire and Peterborough

No deaths in this period

ENDS