Title:	**Learning from Deaths Group – Quarter 1, 2022-23 Report**		
Report to:	**Trust Board**		
Meeting:	**28 September 2022**	**Agenda item:**	
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 7 September 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 4 Report	June 2022

1. Introduction/background/context

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.

1.2 This report also includes the reviewed Learning from Deaths Policy, which has been updated to reflect recent developments related to LeDER process. The Committee is asked to approve the policy.

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 A total of 71 patients died under the care of a clinical team during the quarter:

- 39 patients (55%) had evidence of an advance care planning conversation
- 37 patients (52%) had a PPD recorded
- 32 patients (87%) achieved their PPD

2.6 For the community services this quarter 87% of patients who had expressed a preferred place of death achieved it.

2.7 32 patients (45%) had no recorded evidence of advance care planning conversations or were unable to express a preference. Of these:

- 16 died in their usual place of residence
- 15 died in hospital
- 1 place of death not known

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

2.8.1 The majority of advance care planning conversations are being offered and undertaken by the Specialist Palliative Care team. Advance care planning conversations had not been offered to patients who have a palliative diagnosis on a routine basis by other community nursing teams, so patients' wishes around their care, including their preferred place of death, had not been explored with them. In some cases, advance care planning conversations had been initiated some time before death but had not been followed up as patients deteriorated. 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.

2.9 **Developments Luton Adults**

2.9.1 The end-of-life service review project initiated after two complaints regarding end-of-life care continues. The progress on this is taking time, requiring staff training, and understanding clearly what is in each team members role and required competence.

2.9.2 In addition, 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 patient's care. Links are also being made with local mental health teams and the memory services encourage other staff involved in supporting this cohort of patients, particularly at time of diagnosis, to initiate these conversations.

2.9.3 Within BLMK the lead palliative and end of life commissioner has initiated a system wide review of the EPaCCS clinical template which will ensure a consistent approach for recording patients' wishes that will be visible for all involved in the patient's care. The Lead Nurse is part of this piece of work.

3. Safeguarding Review of Child Death Overview panel findings

3.1 The group reviewed the themes from each of the county's CDOP reports for 2020/21. Common themes from Trust wide include safer sleeping, including smoking cessation, alcohol / drug misuse and healthy weights in mothers.

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

4.1 The service reported five HIV patients (two in Q4 and three in Q1). Four were unrelated to HIV care and treatment, one awaits full structured judgement review, but initial review indicated that it was unrelated to HIV care and treatment.

4.2 All deaths reported were not directly attributed to current HIV care/treatment or a patient safety incident, and therefore the duty of candour threshold had not been met.

4.3 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 is identified.

4.4 Ongoing serious incident reported due to neonatal death (Q4 2021/22). RCA completed and final report to be shared with service user.

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

5. Child Deaths

5.1 Cambridgeshire (Children's Community Nursing only)

5.1.1 The team cared for four children who were expected to die. They all died in their place of choice.

5.2 Bedfordshire and Luton

- 15 deaths were recorded in this period from CCN, School Nursing and HV teams Luton.
- Five children were on the Luton CCN caseload and three on the Bedfordshire CCN Caseload.

5.3 Learning identified

- It is difficult for our small teams to manage when a child and family is known personally.
- GP prescribing medications in a timely way can be difficult.
- Supporting transient families who move between counties during a child's illness presents specific issues when trying to plan care and support a child and family.
- The benefits of advance care plans to ensure choice of place of care.
- Support given post death through both parents being able to have their deceased child at home with them in a 'cuddle cot' or cold bed.

6. End of Life Care and equality and diversity

6.1 The group was asked to discuss how we know that the care and data that we review reflects the diversity of our population. This links to wider work around the recording of individuals' demographic information to enable proper review and analysis. This is an area we will keep sighted on and, as data becomes available, include in our reviews.

ENDS