Cambridgeshire Community Services NHS Trust

TRUST BOARD

Title:	**Learning from Deaths Q3 (2021/22)**
Action:	**For Discussion**
Meeting:	**18 May 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 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 Committee 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).
- Risk 3260- Risk around impact of Covid-19 on community service delivery of care

Legal and Regulatory requirements: As above

Previous Papers:

Title:	Date Presented:
Learning from Deaths Board Report	15 July 2020
Learning from Deaths Board Report	3 September 2021
Learning From Deaths QISCom Report	December 2021
Learning From Deaths QISCom Report	23 March 2022

Equality and Diversity implications:

Objective	How the report supports achievement of objectives:
To support the development of a Trust wide Anti-Racism Strategy and Organisational Development Plan.	
To finalise the roll out of reverse mentoring as part of all in house development programmes.	
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 Covid-19 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 is from the diverse communities they serve.	

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 ☐

1.0 Introduction/background/context

1.1 A 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. 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.

2.0 Luton Adults

2.1 No report presented at the Quarter 3 Learning from Deaths Meeting. The usual author and service were experiencing significant clinical pressure due to the November/December 2021 Covid wave. A Quarter 3 and 4 report will be provided.

3.0 Safeguarding

3.1 **Child Mortality Review**
The national child mortality (NMCD) rates for the first year of the pandemic using unique data was published on 7 December 2021. The mortality rate was likely to be the lowest on record. The most significant reduction in deaths was seen in children under 10 years old from underlying health conditions.

3.2 A study using NCMD data identified 61 children who died after testing positive for Covid-19; 40% of these children had existing co-morbidities.

3.3 A case study was presented which related to a baby who died at four weeks old from suspected overlay. The child and siblings (all with different Fathers) were subject to a child in need plan. There was a history of domestic abuse and maternal mental health issues and all the father's had extensive criminal histories involving violence and drug misuse. Further action is underway about the inclusion of male carers in assessments and the need to check other parents' record.

4.0 Children's Community Nursing

4.1 **Cambridgeshire Children's Community Nursing Team**
There have been three deaths in the last three months and all the children were known to the service; but two were sudden deaths. The learning identified from these was linked to having de-brief sessions following the death, this has proven especially important for the staff members, who have long term input into these children's lives.

4.2 **Bedfordshire Children's Community Nursing Team**
There were three end of life care deaths within Bedfordshire in the last quarter.

4.3 **Luton Children's Services**
There were 13 deaths recorded in this period:

- A 17-year-old not known to the CCN Team died from sudden cardiac arrest.
- An 11-year with complex needs known to the service transferred home for end of life care. Issue for learning was in relation to a PICC line, which are not removed at home, and this caused distress to the family. This has been flagged to the Keech Hospice for planning in future

- A 16-year-old known to the Team died from a sudden cardiac arrest. This is being reviewed by the CDOP and internal Trust review.
- There were also eight neonatal / still birth deaths in Quarters 3-4 under the Luton Health Visiting Team.

5.0 iCaSH

5.1 There have been four deaths reported in Quarter 3. All deaths are HIV patients, but the death was unrelated to their current care and treatment.

5.2 There have been no Covid-19 related deaths in Quarter 3 and the service have not seen an increase in HIV patients dying due to Covid-19.

5.3 The Safeguarding Forum put in place after a serious incident review is improving knowledge and understanding around safeguarding for all iCaSH patients.

5.4 Service Manager noted that being part of this Learning from Deaths group has assisted iCaSH with their learning from deaths and expanding their peer reviews of cases. There remain challenges with the local MDT in HIV services that we do not provide, but with the widening of the Medical Examiner role this should improve.

5.5 Service Manager explained that they were unable to give a year on year comparator of deaths but confirmed that the service does not consider there to be an increase in deaths, rather that reporting has improved.

6.0 Quality Improvement

6.1 **Luton Adults Complaint (September 2021)**
The actions for this case described in the last report regarding end of life care continues. The full review of the service is underway, and actions are being completed.

6.2 **Child Oliwer actions Child Safeguarding Practice Review publication (CSPR)**
Child Oliwer passed away from an abnormal metabolic disorder, aged 6 years old in December 2020. He was looked after by several services within Luton Children's Services.

As result of the CSPR actions and the Trust's own investigations at the time, a review of the actions took place at an additional panel meeting.

Internal actions:

- The importance of recognising when children with special educational needs achieve their developmental milestones.
- Review and communicate to all staff of the policy on seeing children (Was Not Brought).
- Work on a model of holistic oversight by one professional is required.
- Sharing of records across health professionals within the Trust.

6.3 **Learning Disability**
Discussion took place about overcoming obstacles and recognising learning disabilities in Parents / Carers. A task & finish group is to be set up to review how / where this information is recorded on patients' records.

The Trust attend the BLMK LeDeR panels now with feedback to the Safeguarding Operational Meetings and the Learning from Deaths group.

7.0 Conclusion

- Feedback from the iCaSH case, with a view to making this a staff story for the Trust Board.
- Learning from Child Oliwer – work in progress.
- Examples of excellent end of life care given to patients by the Services.
- New steps will be taken in relation to (LeDeR) and ongoing work on this topic.

Report Ends