Cambridgeshire Community Services NHS Trust

QUALITY IMPROVEMENT AND SAFETY COMMITTEE / TRUST BOARD

Title:	**Learning from Deaths Q4 (2021/22)**
Action:	**For Discussion**
Meeting:	**18.05.2022**

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.

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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 16).
- 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 paper highlights some issues with interpreters providing support for clinical staff with sensitive conversations.
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 4 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.

2.0 Luton Adults

2.1 No report presented at the Quarter 4 Learning from Deaths Meeting. The usual author and service were experiencing significant clinical pressure at the time of the meeting, with palliative caseloads increasing from approx. 80 per month to over 100 (in the past quarter). A verbal update was however provided which highlighted the increase of casework, and the level of complexity being seen, it was also noted that the service was providing care to a younger cohort of patients. A complaint linked to CCS's palliative care service is being investigated and a root cause analysis is also being undertaken, learning from this will be actioned by the service but also overseen by the Palliative and End of Life Governance Group which is chaired by the Chief Nurse.

2.2 Discussion was had in relation to supporting patients (whose first language is not English) with difficult conversations, often linked to end of life or the imminent death of a loved one – challenges with the interpreter services were highlighted e.g. the interpreters themselves are often unprepared for the emotional impact of delivering bad news and that sometimes it is better to have an interpreter in the room (face to face) rather than on the phone or on a devise.

3.0 Safeguarding

3.1 **Child Mortality Review**

In April 2022, the NCMD (National Child Mortality Review) made several updates to the format of three forms used in the child death review process: the notification form, the reporting form, and the care pathways form. The changes streamline the forms, making them easier for professionals to complete, and also add new prompts to collect more detailed information.

<u>Updates to the Notification Form</u>

1. The wording of the alert question has changed slightly. Information related to deaths due to Covid19 is now collected elsewhere.
2. An additional option has been added for instances where the child does not have an NHS number. You can now select either "Child non-resident in England" or "NHS number not currently available".
3. A validation rule on the NHS number field to prompt you if you enter an invalid NHS number has been added.

<u>Updates to Reporting Forms</u>

1. Maternal BMI has been moved from the supplementary reporting form on chromosomal, genetic and congenital anomalies to the core reporting form. It now appears in the Child's section underneath the question on gravidity and parity.
2. Fields to record the child's height and weight have been added.
3. Two new questions have been added to the service provision section as follows: "Was bereavement support offered to the family?" Yes/No

If yes is selected to the question above, the following question is triggered:
"If yes, what support was offered?" Free text field

4. For deaths on a delivery suite / labour ward or neonatal unit. If the baby dies due to infection, neonatal herpes has been added to the list of options to select.

Updates to Care Pathway Form

- The care pathway form has been moved to the supplementary reporting form section of the system.
- You can now select the separate stages of the care pathway form and send them to individuals to complete.
- If the child has experienced any of the stages in relation to their final illness or event then the relevant section(s) should be completed.
- Not all stages will be relevant for every case.

4.0 Children's Community Nursing

Cambridgeshire and Peterborough

4.1 In Cambridgeshire there has been 2 children's deaths**,** a baby who died at the Hospice and was not actively cared for by the team and a 14 month old who was end of life.

4.2 In Peterborough there has been 3 children's deaths, a 4 year old with complex needs who died unexpectedly (Police and Social Care are involved). A baby with a cardiac condition who was discharged home from hospital to die as planned at home, and a seven month old with complex needs who died in hospital following sepsis. Learning has been identified in the case of the 7 month old, in relation to how services engage and support families from the travelling community.

Luton Children's Services

4.3 There were 13 deaths recorded in this period:

- 7 neonatal deaths
- 2 infant deaths on NICU
- 3 unexpected deaths not known to CCN team/school nursing teams
- 1 child infant death under CCN care

An area of learning has been identified from one of the neonatal deaths; following the parents of an unborn child being provided with the devastating news that their baby had severe disabilities and would not survive the birth. The baby did survive and lived for a short period of time. A discussion was held around supporting parents who have had this diagnosis to understand that in some circumstances the baby could survive. Our Children's Community Teams will be looking to see how this can be achieved in a sensitive and timely way. A point was raised in relation to psychological support for staff not just when supporting someone who is dying, but during the palliative stage and also during any traumatic event.

Bedfordshire Children's Services

4.3 A report was not provided at this meeting.

5.0 iCaSH

5.1 There have been seven deaths reported in Quarter 4. Five of the deaths are HIV patients but the deaths were unrelated to their current care and treatment. One patient we are still awaiting the cause of death, and in one case the Trust has declared a serious incident (this is a non-HIV death).

5.2 There have been no Covid-19 related deaths in Quarter 4 and the Service have not seen an increase in HIV patients dying due to Covid-19.

5.3 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 identified.

5.4 National reporting of HIV Mortality is now mandated via the UKSHA.

6.0 Learning from Deaths Policy

6.1 The policy has been circulated for review and comment, feedback has been provided to the Deputy Chief Nurse.

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. The internal actions are now underway.

7.0 Conclusion

- Feedback on issues pertaining to interpretation will be fed back to the Trust lead
- Lessons learned in relation to supporting/ guiding parents from within the traveller community
- Feedback to be provided to the group in relation to psychological support
- Child Oliwer internal action plan underway

Report Ends