QUALITY IMPROVEMENT AND SAFETY COMMITTEE

Title:	**Report from Learning from Deaths**
Action:	**FOR NOTING**
Meeting:	**12 December 2018**

Purpose:

The committee are asked to note this paper from the Learning from Deaths Group. The purpose of the group is to provide assurance to the Trust Board that any avoidable deaths identified where CCS was in a position to influence the outcome brings about change in practice. This paper summarises learning from deaths in quarter 2 (July/Aug/Sept) and outlines next steps with this quality requirement.

Recommendation:

For noting and approval to review current policy to better reflect the nature of the trusts approach to learning from deaths.

	Name	Title
Author:	Liz Webb	Deputy Chief Nurse
Executive sponsor:	Dr David Vickers Julia Curtis	Medical Director Chief Nurse

Trust Objectives

Objective	How the report supports achievement of the Trust objectives:
Provide outstanding care	Learning from deaths, whether expected or unexpected gives the opportunity to improve and therefore provide excellent care.
Collaborate with other organisations	When an individual dies under the trusts care there are usually other organisations involved. As relevant working together to learn and improve is core to this aspect of care
Be an excellent employer	Supporting staff is an outcome of the Learning from deaths work
Be a sustainable organisation	NA

Trust risk register
The key strategic risk for this committee is 1320 relating to compliance with CQC standards which includes how we learn from deaths.

Legal and Regulatory requirements:
This responds to National Quality Board: Learning from Deaths 2017 and July 2018 that requires trust to review and learn from unexpected deaths that occur in their care.

Previous Papers:
List related papers previously presented to this Board/committee including title and date when presented.

Title:	Date Presented:
Learning from Deaths quarter 1	August 29th 2018

Equality and Diversity implications:
Indicate here how equality and diversity objectives are met or state if not relevant. Is a QIA or EQIA applicable to the proposals in this paper? If so, have they been completed? What are the key risks and mitigations identified?

Objective	How the report supports achievement of objectives:
Achieve an improvement in the percentage of service users who report that they are able to access the Trust services that they require	Access to high quality End of Life Care
To introduce people participation in our diversity and inclusion initiatives to capture the experience of hard to reach/seldom heard/varied community groups.	Working with bereaved families to learn where we can improve care.
To introduce wider diversity on recruitment selection panels.	NA
To deliver customised training and development for staff to further improve awareness of diversity and inclusion.	NA

Are any of the following protected characteristics impacted by items covered in the paper NO

Age	Disability	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
☐	☐	☐	☐	☐	☐	☐	☐	☐

1.0 Introduction and Background

The Trust introduced a Learning from Deaths policy and committee in September 2017, in response to the National Quality Boards Guidance that outlines the requirement to learn from unexpected deaths and work directly with bereaved families. This guidance was written for the acute sector with community trusts required to consider how they learn from deaths in their in-patient facilities. We are an outlier with regards this as we do not have adult inpatient units and many of our patients are children or healthy adults.

2.0 Quarter Two Summary (July- September 2018)

2.1 Luton Adults.

See also attached Luton Adults Report.

- Retrospective reviewing of just over 50% of records was carried out and noted that that all deaths were expected. Evidence of good quality care and collaborative working are noted.
- There was one case where a patient died in hospital with sepsis that was missed by community staff. An RCA was completed and identified that sepsis awareness training is required for all community staff. This training is available but is being reviewed for its applicability and the level of detail.
- The new end of life care template in S1 (replaced GSF framework) was noted as not being well used and further work was required.
- One complaint was received relating to discharge planning. This was related to miscommunication between the hospital team and discharge planning team that the patient actually wished to die in hospital; but a conversation took place about going home from the discharge planning team nurse.

2.2 Children's Mortality Data :

- 9 deaths in Luton; 19 in Cambridgeshire 15 in Norfolk.
- One incident during the quarter related Holly Ward; a child was discharged from the ward but died a few days later in a different hospital. This is being investigated by the trust involved and the report and learning will be shared when available.

3.0 Update on actions from the previous reports

- The learning from deaths screening tool which was to introduce in Luton adult services has been challenging to implement ; resulting in time consuming retrospective audits of records at the end of each quarter. Action agreed going forward is a fortnightly review of deaths by district nursing cluster. This will be led by the clinical lead and reported into the quarterly reporting.

- The Learning from Deaths group have agreed to review the policy and process for reviewing deaths within the trust. The focus being to look in detail for rich learning from particular cases. A full review of the policy and related process will be carried out with a revised approach from April 2019. The introduction of the Medical examiner role described in section 4 will also enhance the learning we can participate in going forward

4.0 Additional information National Changes

4.1 Medical examiner Role

The introduction of the Medical Examiner role in health systems will enable us as a trust to participate in specific reviews of deaths, where we were involved. These will be introduced through a phased roll-out from April 2019; medical examiners will be introduced to the death certification process to confirm the cause of all deaths that do not need to be investigated by a coroner. The new system will also ensure that the bereaved will be involved in the process of death certification and offer them an opportunity to raise any concerns. Due to the geographical spread of the trust we will be working with a number of medical examiners across the patch.

4.2 Gosport Hospital Report: Government Response.

The government recently published its response to this independent investigation. The recommendations recognize that while much has changed in the health system that would pick up a similar situation today, there is much work to do. Whilst this about patients who died, the key points are applicable to all health care delivery.

Key points:

- Listening to staff patients, families and staff. Ensuring that candor and consent is core to care.
- The importance of supporting whistleblowers and the role of the Freedom to Speak up process.
- Ensuring the quality of all investigations is robust and that a culture of continuous improvement and learning is the norm.
- Safe care as a priority, with specific emphasis on controlled drugs and the way these are managed throughout the system.
- When there are problems in care identified, these are dealt with robustly through the regulatory processes be that the CQC at a care delivery level or GMC/NMC when there are individual cases to answer.
- Joined up approach to investigations when a variety of routes are identifying problems with an organization.

5.0 Next Steps

- Review policy and processes for Learning From Deaths, so that this is a true learning opportunity rather than a lengthy audit process. Taking account of the evolving guidance being shared from NHSi and other routes.

- Review Gosport Hospital Report.

- Plan and imbed in all services bereavement information that is given to relatives routinely, regardless of which services patients may be cared for.

- Explore how we can link into the learning from child deaths investigated via CDOP with meaningful information routinely.

Luton Adults Services
Learning from deaths report for the period July to September 2018

1. This report provides an analysis of selected deaths during the above period in line with the Trust's Learning From Deaths Policy. The report also provides a way forward to reviews the deaths on an ongoing basis rather than at the end of each quarter.

2. During the period July to september 2018, there were 130 deaths of patients known to Cambridgeshire Community Services NHS Trust. 82 deaths have been reviewed by senior nurses and it accounts for 63%. All the deaths reviewed were expected and there were no deaths that occurred (whilst the patients were under CCS care) where a root cause analysis was required. However, one patient whose care was investigated by CCS died in hospital and it was agreed with the hospital that they would include the patient in their mortality review. CCS agreed to contribute to the review if required.

3. It is noted that many patients passed away in hospital or care homes. . For those patients who died at home there was evidence of good collaborative working between the district nursing team – including the out of hours team – and the Specialist Palliative Care team. Some of the patients were under the care of 5 different teams and the co-ordination of care was very good. We also noted that some relatives contacted the service after the deaths of their families to express their gratitude for the care and compassion of CCS staff.

4. The review also highlighted that the relatives were offered bereavement support and in some cases completed. Some families had good family structure to support themselves. The Do Not Attempt Resuscitation and anticipatory drugs paperwork were available in the homes of the patients. The communication between GPs and community staff to ensure optimum care for the patients was also noted as good practice

5. The review highlighted inconsistencies in completion of the new End of Life Care template on SystmOne by the teams. This template replaces the previous Gold Standard Template and was introduced across the community nursing teams at the end of the previous quarter.Future reviews will continue to monitor the use of this template.

6. For the quarter 3 report, it was agreed that fortnightly review of the deaths will be undertaken by a team not invloved in the care and the themes will be analysed by a Cluster Lead and the Cancer & Palliative Care Lead; actions will be taken as and when required folowing the fortnightly reviews. This will ensure not only ongoing learning and actions but the gathering of cummulative evidence for the quarterly report. The Q3 report will therefore contain more information and analysis as the fortnightly reviews will be recorded on a template in adition to the screening tool. For example, the age range, gender, place of deaths and ethnicity will be analysed.

7. The main action arising from this report is the need to consistently use the end of ife template on SystmOne. This will be discussed with staff at team meetings.

8. The Learning From Deaths meeting is asked to note this report and the planned way forward for improved reporting from quarter 3 onwards.

HMKhatib

Head of Quality 01 November 2018