Trust Board

Title:	**LEARNING FROM DEATHS Q4 2018-19 REPORT**
Action:	**FOR DISCUSSION AND AGREEMENT**
Meeting:	**10th July 2019**

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 which reports into our Quality Improvement and Safety Committee.

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.

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Executive sponsor:	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 within the subject area.
Collaborate with other organisations	Individual component topics identify when collaboration has been undertaken.
Be an excellent employer	Learning from the subject area supports staff safety and overall level of practice.
Be a sustainable organisation	On-going learning and compliance with standards.

Trust risk register
BAF risk 2967– *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 4)

Legal and Regulatory requirements:
As above

Previous Papers:

Title:	Date Presented:
Quality Report – February 2019	27 February 2019

Equality and Diversity implications:
Nil 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	Not referenced in this report
To introduce people participation in our diversity and inclusion initiatives to capture the experience of hard to reach/seldom heard/varied community groups.	The Learning from Deaths approach taken by the trust includes families and carers in any investigation and related learning
To introduce wider diversity on recruitment selection panels.	Not referenced in this report
To deliver customised training and development for staff to further improve awareness of diversity and inclusion.	Not referenced in this report

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. INTRODUCTION

The National Quality Board (NQB) Guidance published in March 2017 includes a recommendation that a Quarterly report on deaths, reviews and investigations should be discussed at public Board meetings. This report provides an update on Quarter 4 Learning from Deaths across the Trust.

2. LEARNING FROM DEATHS QUARTER 4

2.1 As described in previous reports to the Quality Improvement and Safety Committee, discussion and learning from deaths has matured during 2018-19 along with some agreed changes to the scope of the policy and refinement to the reviewing of deaths which will be introduced in 2019-20. The policy has been approved by the Board and staff have been informed of the changes with some training to follow. The focus will move towards looking in detail for rich learning from particular cases going forward.

2.2 **Luton Adult Services Report**

The service provided a detailed report to the Learning from Deaths Group which was discussed; a summary is described below.

During the period January to March 2019, there were 193 deaths of patients known to the Trust which included the complex cohort of frail patients receiving care under the Specialist Nursing Team in the community: the enhanced models of care pilot. The total number of deaths was higher than in previous quarters and directly related to the project.

Quarter	No. of Deaths	No. of cases reviewed
1	127	60
2	130	82
3	50	50 The Palliative Care Specialist Nurse who carried out the review believed this figure was accurate and only included patients receiving care at the time of death.
4	193	115

It was noted that 35 patients had a recorded preferred place of care to be at home and 25 of these patients passed away in the community cared for by community nursing staff, with evidence of good collaborative working between the District Nursing and Out of Hour's Services. Overall 65% of patients, known to the Trust died in the community (home, nursing home, hospice, residential home). However, only 24% of the 193 had stated a preference of where they would like to be cared for.

2.3 **Themes in the report identified**

- Patients and patients' families were consistently supported during the process of care. Continuity of care was established through the provision of 24 hours services where patients and families had access to the nurses through the Out Of Hours Nursing Team.
- Anticipatory drugs were prescribed and available for palliative symptom control which was effective and administered as prescribed. Medication administered during end of life nursing care was recorded in the controlled drug charts in patients' pink folders at home.
- There were on-going issues with inconsistencies with nurses not completing the end of life care template within SystmOne. Plans are in place for the Palliative Care Team to

educate colleagues on how best the template can be used across SystmOne in Luton and part of the plan will be to support staff in the recognition of deteriorating patients.

- Review of patients' records following death also highlighted that nurses were not always ending the care plan when patients have died.
- The care needs and learning from deaths were incorporated in discussion at daily handover meetings and highlighted as the themes of the week.
- The service was reviewing bereavement information and support available in line with National Quality Board (2018) guidance.
- There were no complaints received which related to end of life care in Quarter 4 at the time of the report but two complaints were received in May 2019 relating to this period. These will be discussed when concluded at the next Learning from Deaths Group.
- There was one incident reported in this quarter with regards to a rapidly deteriorating patient not being assessed for risk of pressure ulcers and developing an unstageable pressure ulcer. The learning from this incident has included additional training by the Tissue Viability Team for the Palliative Care Team and reminders about risk assessing for pressure ulcers being the responsibility of all clinical staff along with the subsequent provision of equipment.

2.4 **iCaSH**

- There were no new notifiable HIV deaths in Quarter 4.

2.5 **Children**

- There were 35 child deaths in the populations covered by Trust between 01/02/2019 – 30/04/2019: 12 of those deaths were unexpected, 13 deaths were expected and 10 deaths where 'no outcome' was recorded. Children are not always known to our services and future reports will focus on those where our services are involved.
- The Trust's Emotional Health and Wellbeing Service is working with wider health partners to develop a 'Supporting Schools and Colleges in responding to suicides in teenagers: A multi-agency guide for practitioners'.
- 0-19 Service provides health advice about the importance of sleeping babies on their backs and the dangers of co-sleeping.

End of report