Cambridgeshire Community Services NHS Trust

TRUST BOARD

Title:	**Learning from Deaths-Quarter 2 Report 2019-2020**
Action:	**For approval**
Meeting:	**January 15th 2020**

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 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
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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 relating to people who die under our care.
Collaborate with other organisations	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
BAF risk ID 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:
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. This is in addition to the CQC Fundamentals of Care Standards.

Previous Papers:

Title:	Date Presented:
Learning from Deaths Quarter 1 Report 2019-2020	18 September 2019

Diversity and Inclusion implications:

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
Introduce Disability Passport Scheme to record agreed reasonable adjustments.	Not referenced in this report
To utilise the diverse experience and backgrounds of our Trust Board members in promoting an inclusive culture.	Not referenced in this report

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. INTRODUCTION

1.1 In line with the Quality Improvement and Safety Committee's current cycle of business, a Quarter 2 update 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.

LEARNING FROM DEATHS QUARTER 2, 2019-20

2. Luton Adult Services Report

2.1 The service provided a detailed report to the Learning from Deaths Group which was discussed. This was the first occasion where the 10% sampling method was used for expected deaths. There were no unexpected deaths.

2.2 The Committee asked for further analysis of themes of why an individual may or may not achieve their preferred place of care/death. This is provided below.

3. Themes arising from the review

3.1 In the CCS Luton Adult services, a total of 198 patients died in 2019 Q2. It could not be determined how many of these patients had an open episode of care with CCS Luton Adult Services at the time of their death due to the way the data was captured.

3.2 Through the sampling process described above, 20 patient entries were extracted from the initial list of 198. Of these, 13 died during an open episode of care under the care of CCS Luton Adult Services. These 13 deaths were reviewed and the following themes were noted:

3.3 **Use of End of Life Care (EoLC) template and advanced care planning**
An EoLC template was used for six patients. Some elements of advance care planning (e.g. DNACPR, anticipatory prescribing) were present for eight patients, of which three were added by the patients' respective GP.

3.4 **Record of Preferred place of death (PPD)**
Recording of PPD was as follows:

- PPD was stated for 6 patients (4 chose home and 2 chose care home)
- 2 patients declined to state their PPD
- 1 patient had their PPD stated based on a best interest decision
- 1 patient had their PPD stated as discussion not appropriate
- 3 patients had no record of PPD

3.5 **People able to achieve their preferred place of care/deaths**
Among the six patients who stated their PPD, three achieved this. Of the three remaining patients who did not achieve this, all stated PPD as home:

- 1 patient had an acute admission to hospital after a fall at home
- 1 patient died in a nursing home where the patient had been transferred to for respite
- 1 patient was admitted to hospital due to acute or chronic renal failure

3.6 **Of the two patients who declined to state a PPD:**

- 1 patient died in a hospice
- 1 patient died in a hospital

3.7 **Of the four patients for whom there was no PPD recorded or for whom PPD discussion was deemed not appropriate:**

- 1 patient died in a nursing home
- 1 patient died in hospital after GP suggestion of admission for a lower respiratory tract infection
- 1 patient died in hospital coronary care unit after multiple hospital admissions
- 1 patient had their last records made private and place of death could not be determined.

4. Deaths that required further investigation

4.1 Of the 13 deaths reviewed, only one triggered at least one of the criteria in Appendix 1 of the policy. The case triggered the following two criteria: deaths where bereaved families have expressed a concern and any death where concern has been expressed about the quality of care delivered by the Trust including adult safeguarding concerns.

4.2 This is the case of a patient with palliative care needs who was transferred on 5 July to a nursing home for respite care, whose PPD was home and who ultimately died on 5 August during the period of respite. After the patient's death, the patient's daughter expressed concerns that her mother died in pain from a foul smelling pressure sore (category 4) and a broken tibia, and that a tissue viability nursing (TVN) visit had been set to a date more than a week from the date of referral from the nursing home. The TVN service received the referral on 30 July and patient died on 5 August, before the arranged TVN service appointment date. On 11 September, Luton Borough Council MASH requested TVN service information on the case. The TVN responded that information could not be provided as the service did not have any contact with the patient. The TVN team was reviewing the length of time from referral to initial assessment which at present is two weeks.

5. Feedback from previous cases

5.1 **Complaint 1**

A complaint received about the care of a frail lady was declared as a serious incident investigation. The investigation related to care between October 2018 and death in March 2019 and has been reviewed by both the service and the Learning from Deaths Group. This was a multi-agency case led by the Trust with the GP and Luton & Dunstable Hospital. The investigation identified that there was significant learning relating to care, however, it was not clear that the sub-optimal care directly led to the patient's death. The learning was as follows:

- GP discussion about the case when referred is vital.
- Process for oversight by qualified staff of complex wounds is vital.
- Staff require additional training and support to be professionally curious and to apply clinical knowledge applied to long term conditions to elicit potential risks in care - part of One Service and a team approach across all specialisms is needed.
- CCS will work with the CCG and GPs with regards sharing records via SystmOne.

5.2 Julia Curtis (Chief Nurse), Lisa Parrish (Service Manager) and Louise Palmer (Head of Clinical Quality) met with the family to discuss the findings and apologised for the care that their mother received.

5.3 **Complaint 2**
A complaint received about the wound care of a frail lady was investigated through an internal root cause analysis. This was a multi-agency case led by the Trust with the GP and Luton & Dunstable Hospital. The investigation identified that all appropriate care plan actions had been taken by the Trust but that communication by one of the staff was not as effective as it could have been. It also identified learning related to the GP prescribing the correct type of medicine (liquid rather than tablets) as well as stock piling of dressings.

5.4 In light of the issues identified in both of these cases regarding wound care and particularly the provision of the right dressings at the right time, the service is reviewing the opportunity to introduce central ordering of dressings to streamline the process and remove significant delays that currently occur.

6. HIV Deaths

6.1 There were no HIV related deaths reported in Quarter 2 via the iCaSH service. The iCaSH service is noting that deaths as a result HIV related illness are rare as this disease is considered a long term condition when appropriate drug regimes are followed.

7. Children

7.1 The total number of child deaths across CCS for this period was 36; CCS professionals were involved in 21 of these cases. Seventeen were expected deaths and19 were unexpected but none was subject to a Serious Case Review or internal investigation. It is noted that two deaths in Luton were sadly from drowning.

7.2 Going forward, the following will be considered and led by the two Heads of Safeguarding:
- Partnership working
- Advanced care planning
- Children's death reported on SystmOne

8. Additional work
- Intranet pages developed to share learning and signpost staff.
- A meeting with the Luton & Dunstable Hospital Mortality lead to be arranged.

End of report