Cambridgeshire Community Services NHS Trust

TRUST BOARD

Title:	**Learning from Deaths Report**
Action:	**For noting**
Meeting:	**20th May 2021**

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:	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
BAF 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).

Legal and Regulatory requirements:
As above

Previous Papers:

Title:	Date Presented:
Learning from Deaths Board Report	20th January 2021

Diversity and Inclusion implications:

Objective	How the report supports achievement of objectives:
To re-launch the Trust Staff Diversity Network and, where staff indicate a desire, to establish protected characteristics specific sub networks. The Networks to be a forum for staff to share experiences, review the Trust Diversity and Inclusion Policy and practices and to give feedback and suggestions on how the Trust can support its diverse workforce and seek to eliminate any bias.	N/A
To introduce reverse mentoring into all our in house management and leadership development programmes, to promote diverse leadership through lived experiences.	N/A
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 covid19 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 are from the diverse communities they serve.	N/A

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 X

1. INTRODUCTION

A Quarter 3 and 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. This report also describes the work done with partners in the wider system to respond to the covid19 pandemic and planning and response around end of life care.

LEARNING FROM DEATHS QUARTER 3 and 4

2.1 Luton Adult Services Quarter 3 and 4 Report (Oct/Nov/Dec)

The review of deaths was carried out according to the general principles laid out in the Trust's Learning from Deaths Policy. Data was obtained by the Trust Informatics Team which was generated from SystmOne of patient deaths that occurred in the review period for those patients who had open episodes of care with CCS Luton Adult Unit at the time of their death. The NHS numbers in the sample list were used to access SystmOne records.

For each patient record, the following information was reviewed

- Died under the care of CCS Luton Adult Unit (Y/N)
- Age
- Gender
- Use of End of life care (EoLC) SystmOne template (Y/N)
- End of life planning in place
- Preferred place of death (PPD)
- Actual place of death
- Reason PPD not met

2.2 Quarter 3

A total of 93 patients received end of life care from Luton Adult services at the time of their death. These records were reviewed.

60 patients had evidence of an advance care planning conversation and for 58 there was a Preferred Place of Care/death (PPC/PPD) recorded. Two patients declined the opportunity to discuss their wishes.

51 patients were cared for and died in their Preferred Place of Care/death.

For the community services this quarter 88% of patients who had expressed a preferred place of death achieved it.

33 patients had no recorded evidence of advance care planning conversations or were unable to express a preference.

Of these:

- 16 died in their usual place of residence
- 17 died in hospital

Themes from the records of those without advance plans in place included being unable to state a preference due to dementia; sudden deterioration with admission to hospital or death at home. For those patients who did not have a preference recorded 48% died in their usual place of residence

For some patients who died in hospital a referral had only been made to the community services 24-48hrs before the patient was admitted so there had been no opportunity to have discussions with patients.

2.3 Quarter 4 (Jan/Feb/March)

The number of patients who received end of life care from Luton Adult services between January - March 2021 was a total of 113 patients. Of these:

- 56 patients had evidence of an advance care planning conversation for 54 there was a Preferred Place of Care/death (PPC/PPD) recorded
- 48 patients were cared for and died in their preferred place.

For the community services this quarter 86% of patients who had expressed a preferred place of death achieved it

2 patients declined the opportunity to discuss their wishes

In total 56 patients were given the opportunity to discuss their wishes around their end of life care

57 patients had no recorded evidence of advance care planning conversations or were unable to express a preference

Of these:

- 20 died in their usual place of residence
- 4 place of death not clear from record
- 33 died in hospital of these 6 had been admitted to hospital before they had been seen by a CCS clinical team

2.4 Themes arising from the review

Despite this being another challenging six months, the community services were able to continue to support patients to die in their preferred place of care and death when this was known.

There was evidence that the advance care planning process had been offered and started with some patients but these initial conversations had not always been ongoing or revisited so patient's wishes around their preferred place of death had not been explored with them, which identifies a training need or reflects capacity of staff during this period.

For those patients who did not have a preference recorded 48% died in their usual place of residence.

For some patients who died in hospital a referral had only been made to the community services 24-48hrs before the patient was admitted so there had been no opportunity to have discussions with patients.

As services stabilise the Macmillan Palliative Care lead nurse continues to review ways of increasing the confidence of CCS staff to both initiate advance care planning conversations

and continue conversations that have been started. This will include reminding staff of the importance of recording the outcomes of any advance care planning conversations.

With the introduction of the new clinical template across the Luton health system this will give a further opportunity to re enforce the importance of recording patients wishes

2.5 Castletroy Care Home Rapid Review

Eight recommendations were made in this system wide review:

- The need for a proactive, strategic local resilience forum that works for the care sector.
- Business Continuity Plans are needed across the piece.
- Mechanisms to flag and address unintended consequences of system adaptations in an emergency are needed.
- Providing training for care home staff to anticipate restrictions in face to face health care input, in advance of when it is needed.
- Integration of providers in multi-agency planning and commissioning forums.
- Value added of, 'NHS Improvement Framework for enhanced health in care homes' in a pandemic, which linked care homes to GP Primary care networks.
- Resource-demand mismatch in infection prevention and control expertise.
- Maintaining a high index of suspicion with regard outbreaks of covid19.

Family views were also included about the significance of communication; management of the death; standards of care; and use of PPE.

The learning outcomes from the Castletroy report have been received and are part of ongoing work to ensure a single point of access to support nursing/care home staff. There were also many positive learning points from this review including the trusts work with the care home sector and the use of digital media to enable weekly MDTs and sharing PPE when care homes were short.

2.6 Coronavirus Pandemic- themes and projects

- October 2020 to March 2021 was a period that continued to cover the ongoing months of the coronavirus pandemic and includes the period of time covered by a further national lockdown.
- Both of the last 2 quarters have seen an increase in the number of patients supported by the community nursing teams unfortunately previous issues with data means that a direct comparison of end of life care provided with the previous year is not possible. However referrals to Specialist Palliative care team are can be compared and show a 20% increase**. [2019-2020 - 694 2020-2021 - 859.]** The increase seen by the community nursing teams in Luton though the year mirrors experience of community teams nationally. Data available on PHE website confirms the impact of Covid on deaths in community settings and can be found here; https://fingertips.phe.org.uk/static-reports/mortality-surveillance/excess-mortality-in-england-latest.html

- CCS adult teams continued to be key contributors to the system wide work that was undertaken during this quarter which included: The ongoing regular meetings with palliative care teams across BLMK to highlight and support each other with system wide issues co-chaired by our Deputy Chief Nurse and ELFT. This meeting is going to evolve into the End Of Life Clinical Reference Group for BLMK.

- The introduction of a twice weekly capacity review call with the specialist palliative care teams and three hospices to review capacity across BLMK, particularly around hospice bed capacity. This is facilitating transfers to a hospice bed more rapidly.

- Work is underway on a common referral form for specialist palliative care services for use across BLMK

- The weekly, 'check in' to residential care and nursing homes by GPs and a monthly MDT meeting has been ongoing.

- It continues to be encouraging that despite the challenges the community teams continue to work under, where advance planning conversations had taken place with patients 88% of patients died in the place they wished

- The introduction of the updated clinical template for use across all health providers that enables any health care professional to record and view information regarding advance care planning that has been undertaken with patients by anyone involved in their care. When t GPs use this template key parts of this information can be uploaded to a patients summary care record and will therefore be available to any part of the health system that currently has access to the summary care data.

3. Integrated contraception and sexual health service (iCaSH) HIV Deaths

There have been 5 deaths reported during quarters 3 and 4 all related to patient living with HIV and unrelated to incidents within the service. This brings the total of deaths in year to 13 all related to patients living with HIV

Of the 5 deaths, one patient died of an unrelated lung cancer diagnosis; one of renal failure; one patient was severely immunocompromised at the time of admission to hospital potentially due to poor adherence to ART medication and difficulty in engaging with service; one case was COVID-19 associated. The remaining case is unrelated to iCaSH but will be reviewed in due course due to death date being close to report submission.

All deaths reported are deemed unavoidable and unrelated to the patient safety incident and therefore the duty of candour threshold was not met.

3.1 Learning from these deaths

The review has identified some reporting gaps between the clinical system and incident reporting, as well as issues identified with informatics reporting, which has been internally raised and further communication with teams is planned to impress the importance of correct recording within both the clinical record and Trust's Datix incident reporting systems.

Datix W63209 has identified significant shared learning in relation to safeguarding and missed opportunities to escalate appropriately; this has been declared as a serious incident. Shared learning and agreed actions will be shared service wide once the investigation has been concluded. Immediate safeguarding checks have been undertaken to ensure safety.

The service has had a considerably higher rate of mortality across the last year compared to previous years, however nil trend or causation noted as of yet although all relating to long term care patients (HIV), but deaths unrelated to the patient safety incident.

4. Children's Services

4.1 The Learning from Deaths Committee received reports from the Children's Community Nursing services across the trust. As discussed previously, hearing the children's voice through the learning from deaths meeting is important, so at this meeting reports from Cambridgeshire and Peterborough and Luton and Bedfordshire Children's Community nursing teams were presented. In addition throughout the year learning from the CDOP process will also be presented and shared but often this is some time after the child died

4.2 Cambridgeshire and Peterborough Children's Community Specialist Nursing Service

The team have supported end of life care for four children in the past 6 months. In two of the cases the CCSN service had a greater level of involvement, sharing the end of life care with East Anglia Children's hospices (EACH). This worked extremely well but did raise the on-going issue of palliative care competencies in the CCSN staff. As the team do not have a regular amount of children requiring end of life care, a large percentage of full time staff and staff turnover and experience, there have been anxieties about staff confidence and competence, especially in syringe driver and buccal medications. EACH have supported the team in the administration and preparation of these medications.

4.3 Next steps:

- Joint training with CCN/EACH to take place
- Regular learning and update sessions on syringe drivers including practical learning to be held on practice development days
- CCSN palliative care competencies to be developed using the RCN End of life document
- Staff to discuss learning and development needs in 1:1's
- Access to EACH learning sessions throughout the year
- Shadowing posts or work experience at EACH to be considered in learning and development plans
- Shadowing across the service when children are end of life

4.4 Luton and Bedfordshire Child Deaths

During this 6 month period, the two previous Children's Community nursing services merged under one leadership team. This is reflected in the information provided below (Q3 is Luton; Q4 is Luton and Bedfordshire)

There were three deaths recorded in Luton Children's Services in Q3.Two were expected , one was a child at home who was receiving palliative care jointly with the hospice. One child died unexpectedly; currently awaiting post mortem report and result of investigation but death not connected with care provided by the Service. In Q4, eight deaths in Children's Services were recorded. Three children were cared for by the CCNT and the remaining were known to Health Visiting and School Nursing services.

4.5 Learning:

It was noted that the Luton and Bedford service has joined up with the hospital as part of their Child Death Review meetings, meeting every two months to share learning between the community and hospital trust. This opportunity allows the Service to make sure that they are on course with CDOP reporting and to share information from SCRs and RCAs. For example, the hospital trust has shared a review of temperature monitoring of babies under six months where the hospital has changed all its thermometers, to see whether

practice needs to be modified in the community. The importance of this review was stressed particularly in relation to the Rapid Referral Service.

It was also noted that, since the CDOP nurse role ceased, there was a gap in supporting families who have experienced an unexpected child death. Currently this gap has been filled by the Service but the capacity to continue to support the health visiting team consistently going forward has been raised with the CDOP lead.

Additional learning from the BLMK CDOP meeting several 5 cases we heard of from Luton, where there was possible link of high maternal BMI. Learning about signposting weight management during anti-natal period. Health visitors and midwives have a role to play in antenatal contact of subsequent pregnancies.

Both services across the trust identify the challenge of small teams and sustainability of the on call that is required when caring for a child at end of life.

5. Learning from Coroners Reports

There were no coroners case reports reviewed at the meeting.

6. National Reports

The end of the quarter also saw the publication of a number of reports relating to the pandemic and impact of end of life care. These were shared with the Learning from death meeting.

Marie Curie "Better End of Life Care 2021 ;

www.mariecurie.org.uk/policy/better-end-life-report.

Learning from lives and deaths people with a learning disability and autistic people (LeDER) policy. www.england.nhs.uk/publication/learning-from-lives-and-deaths-people-with-a-learning-disability-and-autistic-people-leder-policy-2021/.

CQC DNACPR Report (Protect, respect, connect – decisions about living and dying well during COVID-19, March 2021). This report highlighted poor practice with regard decision making around do not attempt resuscitation decisions. Within the BLMK system we raised back in April 2020 the importance of individualised planning and the service do not experience evidence of this.

8. Escalation

- Good practice around advance care planning.
- Improvement in data quality.
- EoLC template now in place.
- Increase in collaborative work across the system during COVID-19 pandemic to improve the way we work together.
- Local reports on child deaths and related nursing
- Note LeDeR report.

End of report