NHS
Cambridgeshire
Community Services
NHS Trust

TRUST BOARD

Title:	**Learning from Deaths Report**
Action:	**For noting**
Meeting:	**15th September 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. This content of this paper and learning is overseen and discussed 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
Author:	Liz Webb	Deputy Chief Nurse
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	15th July 2020
Learning from Deaths Board Report	3 September 2020
Learning from Deaths Board Report	21ST May 2021

Diversity and Inclusion implications:

Objective	How the report supports achievement of objectives:
To support the development of a Trust wide Anti-Racism Strategy and Organisational Development Plan.	N/A
To finalise the roll out of reverse mentoring as part of all in house development programmes.	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

1.1 A Quarter 1 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. This report also describes the ongoing work done with partners in the wider system to respond to the covid19 pandemic and planning and response around end of life care.

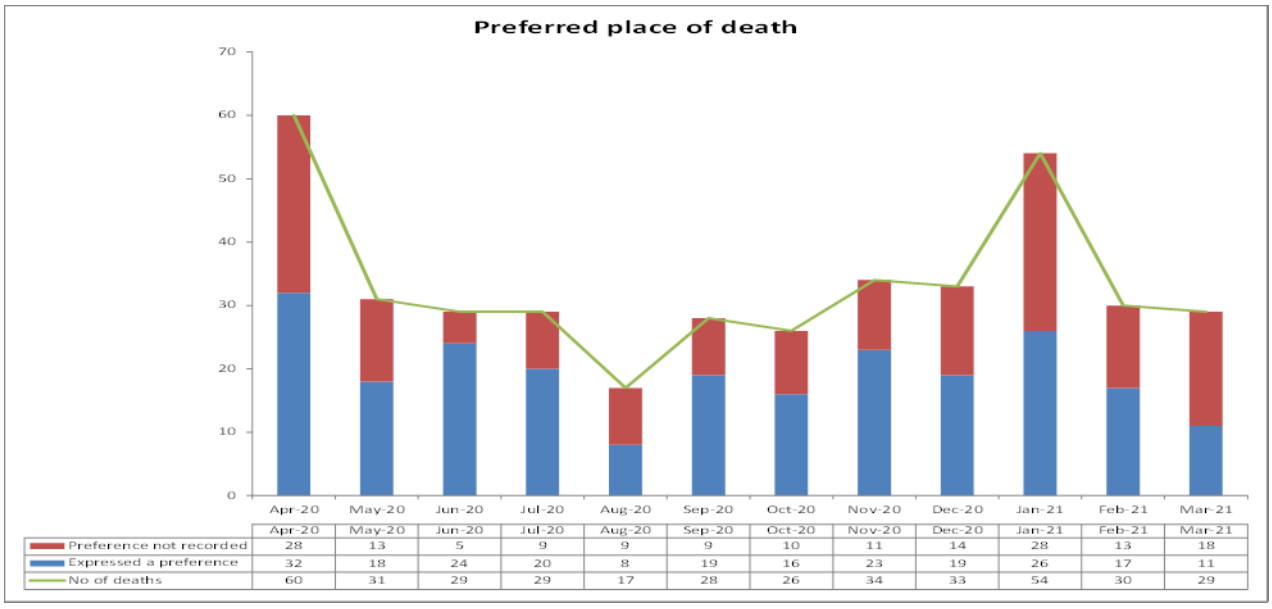
2. LEARNING FROM DEATHS QUARTER 1

2.1 Luton Adult Services Quarter 1 (April May June)

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.

Twelve month analysis of preferred place of care (Table 1)

The chart show spikes in number of deaths of those known to Luton Adults in April 2020 and January 2021 which may reflect the status of the pandemic at that time, although these were expected deaths and the patients did not die from Covid.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Preference not recorded	28	13	5	9	9	9	10	11	14	28	13	18
Expressed a preference	32	18	24	20	8	19	16	23	19	26	17	11
No of deaths	60	31	29	29	17	28	26	34	33	54	30	29

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 1

The review has been broken down by month looking specifically if patients died in their preferred place of death (PPD) and reasons why that did not happen A total of 85 patients died in Luton were under the care of a clinical team at the time of their death.

Results By Month

April 2021

- 24 patients died under the care of CCS in April 2021 .
- 18 patients had their preferred place of death (PPD) recorded
- 16 patients who expressed a preference for their preferred place of death achieved it

The two patients who did not achieve their PPD died in hospital. For one of these patients their family were not accepting of their deterioration and called paramedics when they deteriorated. For the second patient there had been recognition they were nearing the end of their life as recorded in personalised care plan but this does not appear to have been shared with other CCS services. This patient died within 48hrs of admission

89% of patients who had expressed a preferred place of death achieved their wish

75 % patients had an opportunity for advance care planning conversations

For the remaining six patients where there was no record of PPD

One was unable to express their preference due to dementia and died at home. Their family confirmed the patients wish would have been to die at home

Patients died in hospital – one admitted following a fall before seen by CCS team, four were known clinical teams and there was no evidence of any end of life planning conversations being offered

May 2021

- 29 patients died under the care of CCS in May2021
- 15 patients had their preferred place of death (PPD) recorded
- 13 patients who expressed a preference for their preferred place of death achieved it

The two patients who did not achieve their PPD died in hospital. For one of these patients admission was due to an acute event .For the second patient the family called paramedics due to worsening shortness of breath

For both of these patients there may have been an opportunity for early discharge to enable the patient to die in their preferred place of death if pathways within the hospital were more open to earlier input from the hospital palliative care team.

87% of patients who had expressed a preferred place of death achieved their wish

52% patients had an opportunity for advance care planning conversations although an additional 7 patients under CCS care had a diagnosis of dementia so were not able to take part in advance care planning conversations.

For the remaining fourteen patients where there was no record of PPD.

- Seven were unable to express their preference due to dementia and died in their usual place of residence.
- Four patients died in hospital – two were admitted on day of referral to CCS team, one admitted on advice of tertiary centre, one known to a clinical team and there was no evidence of any end of life planning conversations being offered
- Two patients place of death has not been able to be established from record
- One patient died at home following rapid deterioration

June 2021

- 32 patients died under the care of CCS in March 2021
- 25 patients had their preferred place of death (PPD) recorded
- 23 patients who expressed a preference for their preferred place of death achieved it

For two patients who did not achieve their PPD

- One died at home as the rate of deterioration was such that a referral to the hospice could not be made. The patients' family were very happy with care at home
- One died in hospital having been admitted with worsening shortness of breath.
- For this patient there may have been an opportunity for early discharge to enable the patient to die in their preferred place of death if pathways within the hospital were more open to earlier input from the hospital palliative care team.

92% of patients who had expressed a preferred place of death achieved their wish

78% patients had an opportunity for advance care planning conversations although an additional 3 patients under CCS care had a diagnosis of dementia or were too unwell and were not able to take part in advance care planning conversations

For the remaining seven patients where there was no record of PPD

- Three were unable to express their preference due to dementia or being too unwell died in their usual place of residence.
- One patient died at home – there had been some recognition of deterioration while in hospital but this information was not passed on the community teams
- Three patients died in hospital; one admitted before seen by CCS team; one admitted on advice of oncologist; one known to a clinical team and there was no evidence of any end of life planning conversations being offered

2.3 Summary

Total of 85 patients died under the care of the Luton Adults clinical team during the quarter.

58 patients had evidence of an advance care planning conversation and had a PPD recorded.

52 patients achieved their PPD.

For the community services this quarter 90% patients who had expressed a preferred place of death achieved it.

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

Of these:

- 13 died in their usual place of residence
- 12 died in hospital of these 4 had been admitted to hospital before they had been seen by a CCS clinical team

Despite this being another challenging quarter across all services the Luton adults community services were able to continue to support patients to die in their preferred place of death.

There is some evidence that the advance care planning conversations had not been offered to patients who have a palliative diagnosis on a routine basis so patient's wishes around their care including their preferred place of death had not been explored with them.

For those patients who did not have a preference recorded 48% died in their usual place of residence. For most of these patients their dementia diagnosis limited any discussions.

For 4 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.

For some patients there may have been an opportunity for early discharge to enable the patient to die in their preferred place of death if pathways within the hospital were more open to earlier input from the hospital palliative care team.

This report is not able to reflect the complexity of the patients being supported to die at home or the support given to their families.

2.4 Actions from the quarter one review

The matron with a special interest in dementia is looking to ensure advance care planning conversations are offered soon after the CCS service becomes involved in the patients care. Links are also being made with local mental health teams and the memory services encourage other staff involved in supporting this cohort of patients particularly at time of diagnosis to initiate these conversations.

The Specialist Palliative Care team has provided some initial sessions on the practical use of the EPaCCS clinical template (Electronic Palliative Care Co-ordination System) for CCS teams but this has not been progressed as planned due to the ongoing increasing workload the team has seen.

Late referrals to the community teams reflect the national issue of the recognition of people who are nearing the end of their lives.

All staff continues to undertake "mandatory" end of life training which should help to improve staff confidence in ensuring advance care planning conversations are offered to all patients.

The issue of hospital pathways relating to early involvement of the hospital palliative care team to enable patients to die in their preferred place of death will be kept under review by the lead nurse

Within BLMK the lead palliative and end of life commissioner has initiated a system wide review of the EPaCCS clinical template which will ensure a consistent approach for recording

patient's wishes that will be visible for all involved in the patients care. The Lead Nurse in part of this piece of work.

May 2021 saw the national re launch of The Ambitions for Palliative and End of Life Care: A National Framework for local action. This was following a review of the document launched in 2015. The lead nurse will be sharing this document with the SMT for the Luton adult's team over the next months and it will be used as the basis for service development. This will also be used to identify areas of work across the ICS

3.0 Integrated contraception and sexual health service (iCaSH) HIV Deaths

The service reports 6 deaths in Q1 relating to long term care patients, those living with HIV, but the deaths were unrelated to HIV care and treatment. However 4 of these patient deaths were young, with some common themes: alcohol and liver co-morbidities.1 cause of death yet to be confirmed, awaiting post-mortem results. No covid-19 related deaths.

3.1 Of the 6 deaths, 5 patients had good adherence to medication. 1 patient was challenging to engage, (declined to work with all aspects of healthcare, not just iCaSH). Psychology and mental health teams involved, assessed as having mental capacity.

All 6 deaths reported are unrelated to/not directly attributed to HIV care/treatment or a patient safety incident and therefore the duty of candour threshold has not been met.

3.2 Learning from the deaths

This ongoing review previously identified some reporting gaps between the clinical system and incident reporting. Further communication with teams has been shared as well as crib instructions for how to report patient deaths on clinical and DATIX systems. Reminder to be sent to all iCaSH staff on importance of timely reporting of deaths.

Every HIV patient death is discussed and reviewed at the quarterly iCaSH Clinical Advisory Group (iCAG) with the iCaSH consultant body.

4. Children's Services

4.1 Cambridgeshire and Peterborough Children's Community Specialist Nursing Service

Cambridgeshire – none
Peterborough – 2 children
Child A – 3 year old. Metabolic condition
Child B – 3 months old. ARC syndrome

Learning:
Child A died in Peterborough Hospital. This was the choice of the parents.
Child B died at home. The CCN team supported the family but local on-call was not required in this case as the death was very quick following discharge from hospital.
Service manager has recently completed an end of life survey to assess the team's competency in providing end of life care. The survey identified areas in which staff needed more training to feel competent.

Many of the staff identified that all the areas above would be helpful as refresher sessions. Discussions are taking place with EACH to consider training and other helpful resources.

4.2 Luton and Bedfordshire Child Deaths

April	3
May	2
June	3
Total	8

3 unexpected deaths. (Two of them in April and one in May)
5 children were known to palliative team.

5. Learning from Coroners Reports

There were no coroner's case reports reviewed at the meeting.

6. Learning from LeDER

The group didn't receive any specific reviews that fall under the LeDER. However the 2021 Policy, Learning from lives and deaths; People with a learning disability and autistic people (LeDeR) policy was circulated to members for review and discussion within services. We are linked in with this as well via local safeguarding boards and the ICS LeDER leads. Further discussion and action planned at the next meeting.

The new policy has amended the language as described below:
'The Learning from lives and deaths – People with a learning disability and autistic people, or LeDeR (formerly known as the Learning from Deaths Review Programme) started in April 2017. It grew out of the Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD) 1 and was piloted in parts of the country in 2016. A commitment to continuing the LeDeR programme was made in the NHS Long Term Plan 2019:'

https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf

7.0 National Reports

7.1 https://www.england.nhs.uk/blog/renewing-our-ambitions-for-palliative-and-end-of-life-care/

7.2 Medical Examiner Role and CCS responsibility

Learning from mortality reviews and deaths nationally has resulted in the Government introducing the role of the Medical Examiner who is responsible for reviewing all deaths which are not coroner-related; each acute trust should have a Medical Examiner (who is a doctor) from April 2022 and all community trusts should have access to a Medical Examiner.

CCS does not certify a death and would therefore not require a Medical Examiner; however Dr David Vickers is our Executive Lead for Learning from Deaths and is responsible for ensuring that all the right networks are in place and that we link with the appropriate area Medical Examiner when a death occurs. The Medical Examiners are in addition to coroners with a responsibility to look at themes and trends from deaths.

End of report