Cambridgeshire Community Services NHS Trust

TRUST BOARD

Title:	**Learning from Deaths Report**
Action:	**For noting**
Meeting:	**January 20 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:	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	15 July 2020
Learning from Deaths Board Report	3 September 2020

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

1.1 In line with the Board's current cycle of business, a Quarter 2 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).

1.2 Due to the cancellation of the Quality and Safety Committee (December 2020), due to the Covid19 Pandemic response this paper has not been reviewed at that committee. It is produced by specialist from each of the trusts directorates and compiled by the Deputy Chief Nurse.

1.3 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.

2. LEARNING FROM DEATHS QUARTER 2

2.1 Luton Adult Services Quarter 2 Report

2.1.1 The review of deaths has been carried out according to the general principles laid out in the Trust's Learning from Deaths Policy.

2.1.2 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.

2.1.3 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

2.1.4 This quarter includes the on-going coronavirus pandemic and the report includes an overview of the system wide work that was undertaken to support the care of patients at home during the pandemic

2.2 Overview

2.2.1 Total of 74 patients died under the care of a clinical team during the quarter:

- 47 patients had evidence of an advance care planning conversation with a PPD recorded
- 45 patients achieved their PPD

2.2.2 For the community services this quarter **96%** of patients who had expressed a preferred place of death achieved it:

- 2 patients declined the opportunity to discuss their wishes around their PPD
- 25 patients had no recorded evidence of advance care planning conversations or were unable to express a preference

Of these

- 12 died in their usual place of residence
- 13 died in hospital

2.3 Coronavirus Pandemic

2.3.1 This quarter continues to cover the ongoing months of the coronavirus pandemic which saw changes across the whole health and social care system working more collaboratively to ensure patients and families continued to be supported. During this period the community teams were beginning to plan to recommence some of the services that had changed their working pattern when the national directive to move to delivery of essential services was initiated at the start of the pandemic.

2.3.2 CCS adult teams continued to be key contributors to the system wide work that was undertaken during this quarter. One key piece of system wide work that the Macmillan Palliative Care Lead Nurse has been involved in is the further development of a template for use on all clinical systems in Luton, across all health providers that will enable any health care professional to record and view information regarding advance care planning that has been undertaken with a patient by anyone involved in their care. Key parts of this information will be able to be uploaded to 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.

2.3.3 During this quarter there has been national work around supporting patients who live in residential homes and nursing homes. This includes a weekly ‘check in’ to the homes by GPs and a monthly MDT meeting. This work has been supported by a wide range of CCS staff and by the end of this quarter was almost fully embedded.

2.3.4 It is encouraging to note that despite the challenges the community teams were working under, where advance planning conversations had taken place with patients 96% of patients died in the place they wished

2.3.5 At the end of this quarter the Trust received a complaint relating to a patient who died in March 2020. The complaint is wide ranging and includes not just care provided by CCS but care provided by partner organisations in Luton. An initial panel meeting has not found any urgent areas of concern around staff practice and the outcome and learning from the complaint will be included in the next quarters report.

2.4 Castletroy Care Home Rapid Review

2.4.1 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. The Service's internal review noted that there were a lot of positive comments from the care home about daily contact by the Service, direct access and the use of iPads, all of which were not included in the final report.

2.5 Luton and Bedfordshire System Covid19 Response

2.5.1 The Deputy Chief Nurse as Co- Chair of the Luton and Bedfordshire System Palliative and End of life Care group (for Covid19 Response) presented a report to the BLMK Health and Social Care cell, which was well received and highlighted the excellent collaboration across the system.

3. HIV Deaths

3.1 There have been 3 deaths reported during Q2 all related to patient living with HIV and unrelated to incidents within the service. This report also includes 2 deaths that occurred externally during Q1 that were not reported to the Trust in quarter 1. Of the 5 deaths, one patient was severely immunocompromised at the time of diagnosis and diet in hospital due to PCP, within two weeks of diagnosis and 2 cases were Covid19 associated.

3.2 Whilst there is no direct clinical learning following review the deaths in quarters the report has identified some reporting gaps within between the clinical system and incident reporting. Of the 5 deaths, 2 had been correctly coded within the clinical record system as patient deceased (recorded in HARS but not demographics). This was identified following cross referencing of reporting between Datix and clinical system reports which removes risk of un-reported cases, however, further communication with teams planned to impress the important of correct recording within the system.

3.3 The service has had a considerably high rate of mortality across the last 2 quarters compared to previous years, however nil trend or causation noted.

4. Children

4.1 The Learning from Deaths Committee received a report from the Heads of Safeguarding which provided an update on the changes to the child death reporting process which had taken place between 2008 and 2018. These changes have meant that since April 2018, although local CDOP processes have remained, the LSCBs notify the National Child Mortality Database (NCMD) of every death. This has meant that the NCMD has become the best place to access information about learning from death (both nationally and locally) including thematic reviews.

4.2 The report also included an overview of a real-time surveillance study on suicide as well as reference to a National Child Death Database Briefing Paper on 'Child Suicide Rates during the Covid19 Pandemic in England: Real-time Surveillance' which used findings from the initial study to review child death by suicide in England during lockdown.

4.3 In addition, the NCMD and CDOP were also undertaking a thematic review on extreme prematurity and were planning to do a similar review on deprivation and its impact on child death.

4.4 **Next steps Learning from Child Deaths.**
Work has now commenced with all services about the importance of linking into these processes and determining how best to use the available data and information as well as other resources such as alerts, webinars and briefing papers. There is a specific action to decide how this information be cascaded to clinical teams. In addition Learning from Child Death Report will be developed in the same style as the Adult one, enabling local and trust wide learning before the broader reviews are concluded. This will support reflective learning, changing practices quickly and ensuring consistency across the trust.

5. Learning Disability Mortality Review (LeDER)

5.1 A report on the Learning Disability Mortality Review (LeDeR) programme was received. The purpose of the LeDeR Is about identifying any avoidable factors that contributed to a person's death and how these could be modified.

5.2 The report provided a summary of the BLMK LeDeR annual report 2019-20 and its findings. One of the key findings was that the average age of death of those with a learning disability in the BLMK region was 56 years which was 24 years younger than the mean age of the general population and three years younger than the national LeDeR data. The report also focussed on the learning from the national report and key recommendations.

5.3 **Next steps Learning from LeDeR**
Steps include communicating this learning to Adults and Children's Services to identify people with learning disabilities and improve the way we could support them by, for example, prompting them to go for regular health checks, diagnostic screening, fluid intake, diet, etc. Also to actively progress the LeDeR agenda as a partner with local hospices and through the Adult Services Management Team.

6. Learning from Coroners Reports

6.1 Coroners reports where we have been involved in the care of the person are now received at the Learning From Deaths Committee to ensure a joined up approach and that learning from these cases is shared. Coroner's cases can take months / years to report and being sighted on these is important.

7. Escalation

- Good practice around PPD
- 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
- Note LeDeR report
- Note CDOP report and how to improve recording of child deaths
- Positive learning from the Castletroy report

End of report