NHS
Cambridgeshire
Community Services
NHS Trust

Title:	Learning From Deaths Quarter 4 (2023-24) Report
Report to the:	Trust Board
Meeting date:	17 July 2024
Agenda item:	6
Report author:	Liz Webb (Deputy Chief Nurse)
Executive sponsor:	Dr David Vickers (Medical Director)

Assurance level:	Substantial ✓ Reasonable ☐ Partial ☐ Minimal ☐
Rationale:	This quarter 4 report outlines the requirement for Trusts to review the deaths of people who we care for as per the National Quality Board (NQB) guidance (2017) for NHS providers on how they should learn from the deaths of people in their care. We consider both expected and unexpected deaths and seek to learn from care that could have been better and good care.
Assurance action:	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.

1.0 Executive Summary

1.1 This quarter 4 report outlines the requirement for trusts to review the deaths of people who we care for as per the National Quality Board (NQB) guidance (2017) for NHS providers on how they should learn from the deaths of people in their care. We consider both expected and unexpected deaths and seek to learn from care that could have been better and good care. This report was reviewed and discussed at the Quality Improvement and Safety Committee on 27 June 2024 as per governance process.

2.0 Recommendation

2.1 The members are asked to:

- **discuss** the report.

3.0 How the report supports achievement of the Strategic Objectives:

Provide outstanding care:	Report details learning and required activity relating to people who die under our care.
Be collaborative:	Identifies when collaboration has been undertaken.
Be an excellent employer:	Learning from deaths supports staff safety and overall level of practice.
Be sustainable:	Ongoing learning and compliance with standards.

4.0 How the report supports tackling Health Inequalities

4.1 The various reports and discussions that take place at the Learning From Deaths meeting include understanding the impact of health inequalities, however this is an evolving area with work still required to fully understand.

5.0 Links to Board Assurance Framework / Trust Risk Register

5.1 **Risk 3530**: There is a risk that if the Trust cannot meet the requirements of the CQC's fundamental standards of care, patients may not receive high quality care and the impact of this would be a poorer experience for the patient and the potential that the Trust would not maintain it's outstanding rating (Risk rating 4).

6.0 Legal and Regulatory requirements

6.1 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.

7.0 Previous report

7.1 22 May 2024, Learning From Deaths Quarter 3 (2023-24) Report.

8.0 Introduction

8.1 This Quarter 4 report on Learning from Deaths across the Trust is detailed below in line with the Trust's Learning from Deaths Policy and National Quality Board (NQB) guidance (2017). This report was reviewed and discussed at the Quality Improvement and Safety Committee in June 2024 as per governance process.

8.2 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.

9.0 Luton Adults

9.1 The review of deaths has been conducted according to the general principles laid out in the Trust's Learning from Deaths Policy 4.0. Data, generated from SystmOne, was obtained by the Trust's Informatics Team and included patient deaths that occurred in the review period for those patients who had open episodes of care with CCS Luton Adults Unit at the time of their death. Patients who were not under the care of a CCS clinical team at the time of their death were excluded from the review.

9.2 The NHS numbers in the 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.
- Ethnicity.
- Electronic Palliative Care Coordinating Systems (EPaCCS) template.

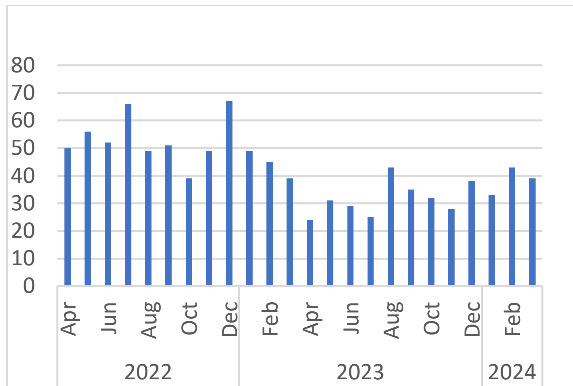
9.3 This Electronic Palliative Care Coordinating Systems (EPaCCS) template gives a single place for staff to record conversations around advance care planning that can include:

- Preferred place of death (PPD).
- Any end-of-life planning that is in place.
- Actual place of death.
- Reason PPD not met.

Overview

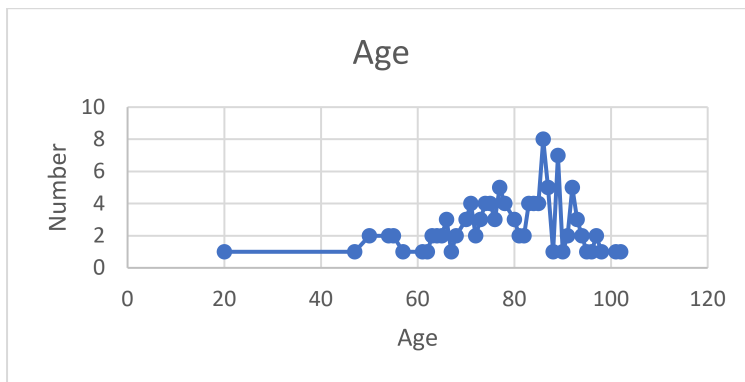
9.4 In Quarter 4 Luton Adults had 115 patients die whilst under the care of their nursing services. The graph below shows the trend of expected deaths on the service over the last three years.

Graph 1



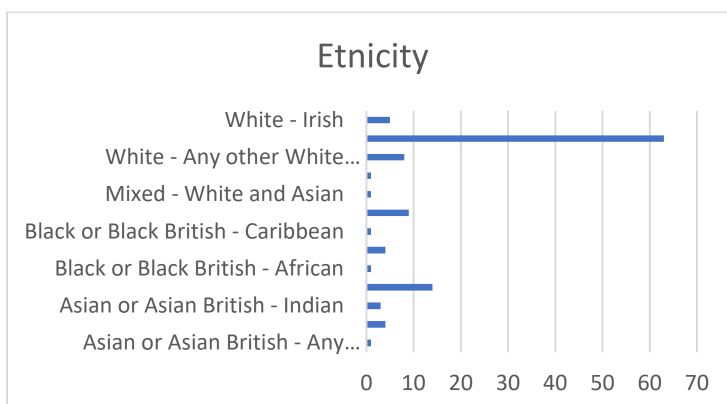
9.5 The Age split for this quarter shown below (Graph 2) with most patients dying between the ages of 70-90 years of age, however this does demonstrate that they are also supporting some patients at end of life across the age ranges.

Graph 2



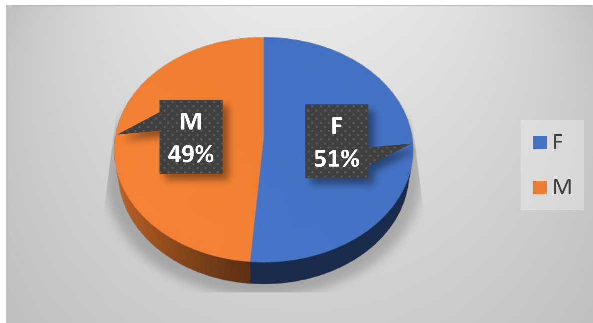
9.6 Graph 3 below demonstrates that most patients that die whilst on the caseload are White British, whilst this does not match with the overall demographics within Luton, the service has work underway about how we can further engage with our diverse population; work has already started with in the Diabetes and Respiratory team. In addition, the Bedfordshire Care Alliance has a Palliative and End of Life program that seeks to address this.

Graph 3



9.7 The gender split for this quarter shows as below:

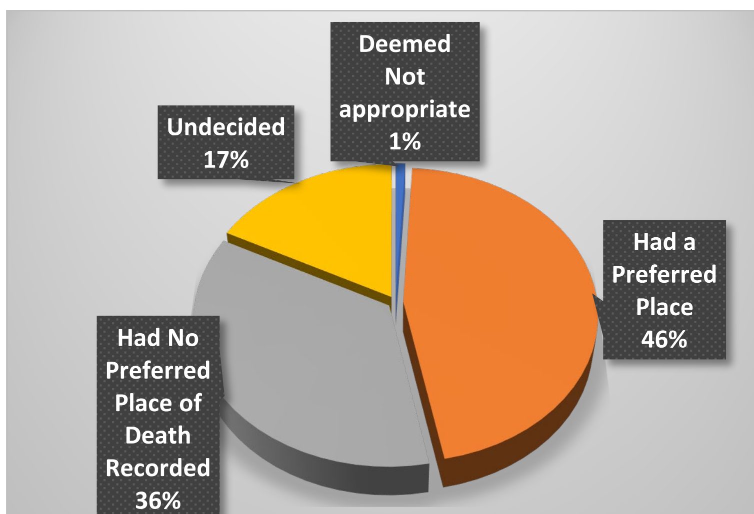
Graph 4



9.8 **Preferred Place of Care document:**
Of the 115 patients that died under the care of Luton Adults in Quarter 4; 53 had a preferred place of care documented, 41 had no preferred place of care documented, 20 were undecided and 1 was deemed not appropriate. This demonstrates an increase from Quarter 3 where 36% of patients had their preferred place of death documented. The service has established that previous data reports were not pulling through conversations other organisations such as Primary Care were having which may contribute to this increase.

9.9 Of the 53 patients that had a preferred place of death recorded; 57% died in their preferred place of death, this is an increase from Quarter 3 when 44% of patients died in their preferred place of care.

Graph 5



9.10 Eight patient records were reviewed in detail and noted the following learning:

- The patient reviews demonstrated good collaborative working across the teams that provided good end of life care.
- There is a need for earlier conversations for patients who have a non-curable disease.
- Increase the use of the EPaCCS template across Luton Adults.
- SystmOne and EPaCCS training for the Integrated Discharge Team so conversations are held in secondary care.

9.11 Palliative and End of Life Skills training is now a routine part of all regular training for Luton staff. This is received positively. A member of the Specialist Palliative Care Team and an Education Practitioner of the District Nursing team are developing a competency booklet for the District Nurses (DN) in caring for a Palliative Patient. The Specialist Palliative Care Nurses attend joint visits with the Community Nurse to enable them to enhance their knowledge and practice in this area and attend DN Huddle meetings to do reflection sessions and discuss any complex patients, the aim is for the Community Nurses to feel more confident in caring for these patients and having difficult conversations.

9.12 EPaCCS is routinely used by the specialist team in Luton, however issues remain with access to this by the acute hospitals.

10.0 Childrens Community Nursing

Cambridgeshire and Peterborough CCN

10.1 Three expected deaths occurred, work continues to have consistency with Advanced Care Planning (ACP) and difficult conversations.

10.2 Of these cases, two had no ACP discussed and one had an Oncology ACP in place, with preferred place of death (PPD) documented and facilitated within the community team. A seventeen-year-old was supported by our services, and adult hospice to die at her mother's home.

Bedfordshire and Luton CCN

10.3 There were no unexpected deaths. There were eleven expected deaths in Luton.

10.4 For a one-year-old there were lots of issues involved including safeguarding concerns. There was an ACP conversation but as this was an unexpected, expected death this was not achieved.

10.5 The was one expected death in Bedford. In this case the CCN supported end of life alongside Keech Hospice and the Regional Advice and Facilitation (RAaTF) Team. Good, shared communications across the Teams was noted but it appears that the pain management was provided by adult unit at Keech. An ACP was in place, and this was achieved.

11.0 Integrated Contraception and Sexual Health (ICaSH)

11.1 There were eight HIV deaths in Quarter 4. None of these were related to HIV care and treatment. All are reviewed using a Structured Judgement Review process and discussed at the HIV Multi-Disciplinary Team meeting . In the year 2023-2024 there have been 29 deaths; compared to 20 deaths in 2022-2023.

12.0 Coroners Cases

W73640- Death of seventeen-year-old within Bedfordshire services.

12.1 The Coroner gave a narrative verdict at the inquest in February 2024, with an expectation that all services review how staff understand the diagnosis and treatment of constipation. This work continues as part of a Trust wide Quality Improvement plan. CCS have been named as an interested party for a Norfolk child death case due to be heard in Coroner's Court in August 2024.

12.2 We are awaiting the outcome of 3 Coroners cases that we provided witness reports to from the iCaSH service. These are not related to service care delivery, but the Trust were involved in the care of the patient.

13.0 Learning from Unexpected Deaths Cases

13.1 There were no unexpected death cases discussed at this Quarter 4 meeting.

14.0 Learning Disabilities Mortality Review.(LeDeR) update

14.1 Bedfordshire, Luton and Milton Keynes and Cambridgeshire & Peterborough LeDeR have been cancelled in Quarter 4, so themes are not consistent. There remains a lower number of reviews that contain a person with a sole diagnosis of autism (no learning difficulties). All the areas are working on the backlog, currently up to August 2023, so this may show an improvement at the next meeting.

14.2 Themes identified to date were epilepsy and obesity, inadequate or no mental capacity recorded, inappropriate learning disability support during admission and transfer of care from children to adults when someone is admitted to hospital.

14.3 There has been an increase in known and historic safeguarding concerns and no or inadequate annual health checks.

14.4 Ongoing work by Integrated Care Boards (ICBs) and GP Surgeries to record learning disabilities.

15.0 Summary and escalation points to Quality Improvement and Safety Committee and Board

15.1 Summary and escalation points to Quality Improvement and Safety Committee (QISCom) and Board include:

- No issues requiring escalation.
- Reviewing all the quarterly data and what are the numbers telling us. Review of Datix reporting process for consistency.
- There was a detailed discussion held around the Luton Adult Report and the preferred place of death data, as it is really important to see the context of what this means for patients; in that not dying in a preferred place of care is not necessarily the wrong outcome.
- The majority of cases discussed were positive stories on the support and good partnership working within Bedfordshire and Luton Children and Adult's Services and Acute/ Community Services.