Title:	Learning From Deaths Quarter 1 Report
Report to the:	Trust Board
Meeting date:	25 September 2024
Agenda item:	7.7
Report author:	Liz Webb, Deputy Chief Nurse
Executive sponsor:	Dr David Vickers, Medical Director

Assurance level:	Substantial ✓ Reasonable ☐ Partial ☐ Minimal ☐
Rationale:	This Quarter 1 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. The Quality Improvement and Safety Committee have reviewed and agreed the level of assurance through discussion and review of the report.

1.0 Executive Summary

1.1 This Quarter 1 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. As per our governance this report has been reviewed at the Quality Improvement and Safety Committee.

2.0 Recommendation

2.1 The members are asked to:

- Receive this report for n**oting.**
- **Agree** the assurance level.

3.0 How the report supports achievement of the Strategic Objectives:

Provide outstanding care:	The 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 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 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 12).

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 Learning from Deaths Quarter 4 (2023-24), 17 July 2024

8.0 Introduction

8.1 This 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).

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:

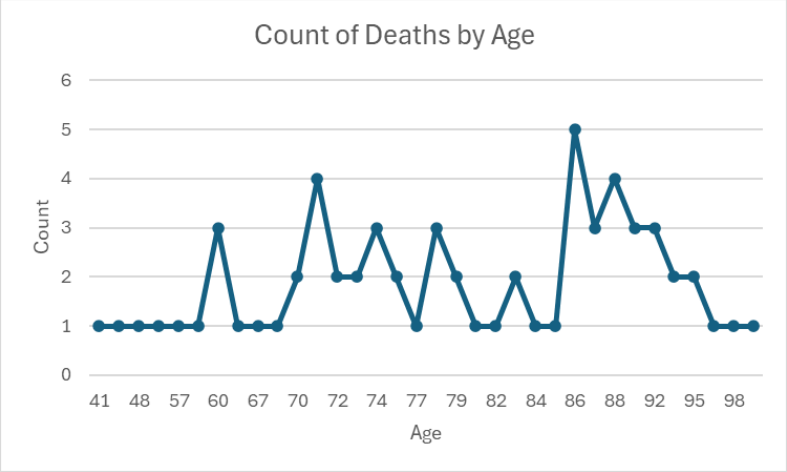
- Died under the care of CCS Luton Adult Unit (Y/ N).
- Age.
- Gender.
- Ethnicity.
- Electronic Palliative Care Coordinating Systems (EPaCCS) template.

9.3 This EPaCCS template gives a single place for staff to record conversations around Advanced Care Planning (ACP) that can include:

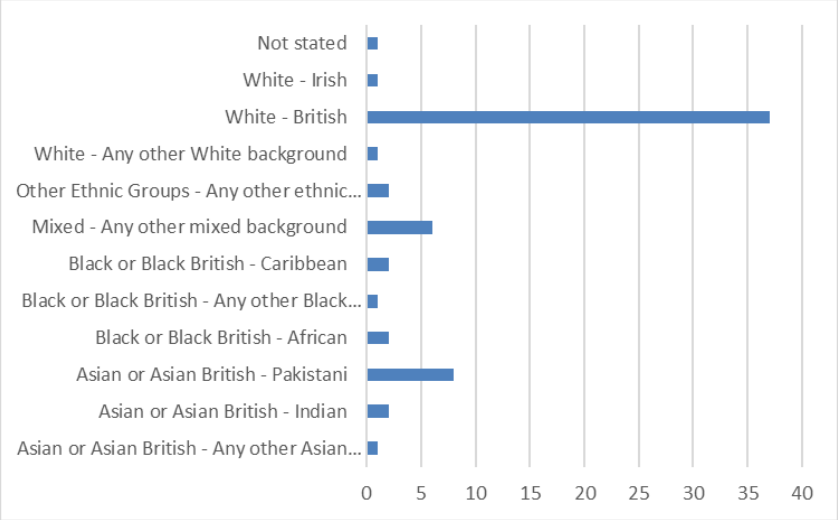
- Preferred place of death (PPD).
- Any end-of-life planning that is in place.
- Actual place of death.
- Reason PPD not met.

9.4 Only the first two months of Quarter one reported due to the timing of the meeting. In April and May of Quarter 1 Luton Adults had 64 expected patient deaths whilst under the care of the nursing services.

9.5 Graph by age distribution

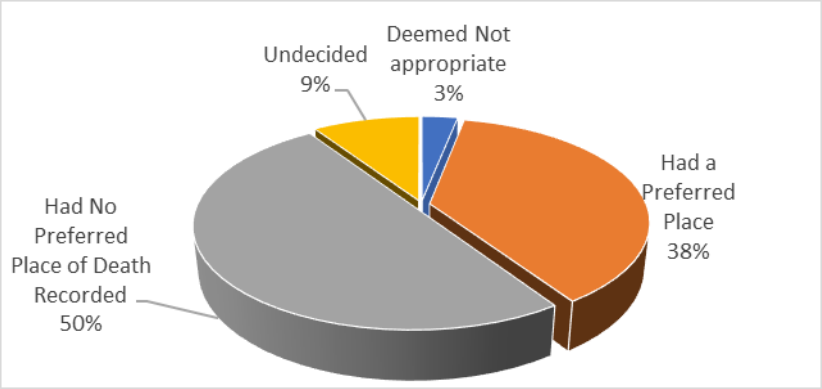


9.6 Graph by ethnicity



9.7 Of the 64 patients that died under the care of Luton Adults in April and May of Quarter 1, 24 had a Preferred Place of Care (PPC) documented, 32 had no PPC documented, 6 were undecided and 2 was deemed not appropriate. It is assumed that those patients that have had a discussion regarding their PPD have had this as part of an ACP conversation. However, we continue to review how we capture this with the current EPACS template. There are currently changes being made to the SystmOne template that may support with this.

9.8 Graph Preferred Place of Care recorded



9.9 Of the 64 patients, 15 died in their PPD, 13 did not die in their PPD and 36 did not have a PPD documented. There is sometimes a delay in the recording of this data in SystmOne and therefore there may be an improvement in this when a report is run early in July for Quarter 1.

Case reviews

9.10 As per the policy, a sample of 10% of the patients who died case notes were reviewed totally six cases. These cases highlighted many examples of excellent care and advanced care planning.

9.10.1 **Example 1**

An 87-year-old lady with Lewy body dementia cared for at home by her daughter was supported by an Admiral Nurse; District Nursing (DN) service and the General Practitioner (GP)led Multi-Disciplinary Team (MDT). With a suitable care plan in place, she died at home peacefully. All the related care planning had been completed.

9.10.2 **Example 2**

78-year-old gentleman with a long-term history of prostate cancer. Throughout his illness he was supported at different points by the Palliative Care team, GP and Oncology. As his disease progressed conversations took place about where he would like to be care for and he asked for Hospice care. As this isn't always available, the community team prepared for care at home as well by applying for fast-track continuing care funding. In the event he was admitted to the Hospice and died peacefully.

9.10.3 **Example 3**

Gentlemen with end stage heart failure and other co-morbidities supported by community services over several years. However, he was admitted to hospital with pleural effusions and died on that admission. This may have been unavoidable but there was limited planning about care at the end of life and no documented plans for what he would have preferred,

9.11 **Luton Adults On going work**

- The Specialist Palliative care team have a rolling training programme. These sessions include EPACS/ ACP training and the deteriorating patient. The sessions that have been delivered so far have received great feedback from the attendees.
- Competencies in caring for a Palliative Patient have been discussed with the Education lead for the DN team, this will enable the Community Nurses to enhance their knowledge and practice in this area.
- A member of the Specialist Palliative Care team attends the DN Huddle meetings to discuss any complex patients and if required will do a reflection session with the team. The aim is for the Community Nurses to feel more confident in caring for these patients and have difficult conversations.
- Support and training are still required for the other specialist teams to have early advanced/ future planning conversations, completion of the EPACS template and encourage service leads to get staff members to attend training sessions. The specialist Palliative Care team have been attending team meetings to advise on the team's service provision and expectations from other specialist services caring for palliative patients.

10.0 Childrens Community Nursing

Cambridgeshire and Peterborough CCN

10.1 One expected death in the service this quarter. The review noted excellent MDT working across Community Children's Nursing and the Each Anglia Children's Hospice (EACH). The family were fully involved and supported to honour their cultural wishes. The key challenge was sourcing suitable medications from a GP or local hospital pharmacy.

Bedfordshire and Luton CCN

10.2 There were 3 expected deaths:

- Two in Luton and 1 in Bedfordshire.
- One was a 1 year-old and 2 were 16 years old (2 males and 1 female).

10.3 Ethnicity data showed one was black African, one British mixed and one white British. The data is similar to our adult counterparts.

10.4 Two out of the three cases had their ACPs documented and met their PPD.

10.5 The patient review for the 16 year-old, who was under the care of the Bedford team but had a GP in Hertfordshire, showed our Children's Nursing team facilitated and supported the care including the order of specialist equipment. He was eventually transferred to Keech Hospice, and he died there. Learning showed good shared care and communication between all the services.

10.6 Some of the actions from this quarter include thinking about engagement in the new Children's Palliative Care Forums. This is a system wide forum with our partners in Bedford Luton and Milton Keynes (BLMK) including Commissioners. There is no direct link to the Bedfordshire Care Alliance work on adult end of life care but the Macmillan End Of Life Care Lead will sit on the children's forum.

11.0 Safeguarding Report

11.1 In the meeting there was a discussion about how we triangulate Child Death Overview Panels (CDOP) data and Datix data. It is noted that there is a variation in reporting on Datix depending on locality and local practice. The Head of Safeguarding and Deputy

Chief Nurse will review this and report back to the next meeting.

- Total unexpected deaths 27 (6 reported on Datix and 19 locality data on CDOP). Neonatal/Stillbirths =15.
- Unexpected death of a child =10.
- Unexpected adult/ young person death =2.

11.2 One of the adult deaths was being assessed by our Integrated Front Door (IFD) at the time of his death. This case is currently being reviewed by the Coroner, we are awaiting a cause of death. This case is being reviewed as a Patient Safety Incident Investigation (PSII) jointly with Norfolk and Suffolk Foundation Trust.

National and regional learning:

11.3 The Daniel and Sophie Child Safeguarding Practice Review (CSPR) has been published this quarter. This involves a baby that sadly died because of abuse and neglect. The main identified learning is below:

- Traumatic childhoods can impact adult functioning which is important to consider when assessing parenting capacity and potential safeguarding risks.
- Pre-birth assessments need to be completed as a multi-agency assessment.
- The importance of supervision when working with complexity.
- Importance of being professionally curious where there is evidence of domestic abuse.
- The use of tools can be very effective in supporting the understanding of the child's lived experience.

National thematic report:

11.4 The thematic report analyses child deaths in England between April 2019 to March 2022, was published earlier this year. Main recommendations include:

- Listening to parents' concerns - ensure escalation for timely senior review.
- Increase public awareness of symptoms and signs of infection particularly in infants promote use of Baby Check App.

https://householdsintemporaryaccommodation.co.uk/wp-content/uploads/2023/01/APPG-Call-For-Evidence-Findings-Report.pdf

11.5 It has been identified by the NCMD for Households in Temporary Accommodation, in the period between 1 April 2019 and 31 March 2022, at least 34 homeless children have died in Temporary Accommodation.

- It is important that professionals enquire about housing status and recognise the affect on a child's health and vulnerabilities of living in Temporary Accommodation.

https://sharedhealthfoundation.org.uk/news/campaign-win-a-cot-for-every-night-for-every-child/

11.6 A national campaign for a cot for ever night for every child has been launched.

Coroners' cases:

11.7 CCS have been named as an interested party for a Norfolk child death case due to be heard in Coroner's Court August 2024. Legal advice sought and plan in place to support the practitioners involved.

11.8 We are awaiting confirmation if there will be a request to Coroner's Court for the Mental Health Access team case, which we are completing a PSII.

11.9 No external statutory reviews have been commissioned this quarter.

11.10 National Prevention of Future deaths Regulation 28 Notice – Epilepsy services and care was reviewed and discussed with regard our services.

12.0 Update from LeDeR (Trust wide).

12.1 The following themes were identified from the Learning Disabilities Mortality Review (LeDeR) in Quarter 4 (not inclusive of June meetings for BLMK and Norfolk):

- Epilepsy and obesity remain a concern in reviews.
- Inadequate or no Mental Capacity Act (MCA)assessment being completed.
- Inappropriate Learning Disabilities (LD) Support during admission.
- Increase in known/ historic Safeguarding concerns.
- No or inadequate Annual Health Checks.
- Known Mental Health Concerns.
- No Advanced Care Planning.

12.2 There was no LeDeR Quality Assurance Panel in Cambridgeshire and Peterborough for the months of April and June – LeDeR lead due into post in August.

13.0 Integrated Contraception and Sexual Health (ICaSH) HIV deaths

13.1 There were 4 deaths of Human Immunodeficiency Virus (HIV) in positive patients reported in Quarter 1. Initial review of each death was completed using Structured Judgement Reviews (SJR'S) these have not identified any concerns around Integrated Contraception and Sexual Health (iCaSH) care with regards HIV treatment, all died of other causes.

13.2 **Data trend is stable:**

- 4 deaths reported since April 2024.
- 29 deaths in the 2023/ 2024 period.
- 20 deaths in the 2022/ 2023 period.

14.0 Summary and escalation points to the Quality Improvement and Safety Committee and Board

14.1 Summary and escalation points to Quality Improvement and Safety Committee (QISCom) and Board included:

- The meeting noted the positive work underway by all the clinical leaders and teams to understand quality of care given when someone is receiving end of life care.
- Planned review of reporting of data relating to child deaths.
- Ongoing work to include and understand ethnicity data.
- Noted changes to death certification process and the role of the Medical Examiner.
- Regulation 28 Notice – Epilepsy (Coroner's Report).

END OF REPORT