Title:	Learning From Deaths [Quarter 3] Report
Report to the:	Trust Board
Meeting date:	22 May 2024
Agenda item:	8.6
Report author:	Liz Webb (Deputy Chief Nurse)
Executive sponsor:	Dr David Vickers (Medical Director)

Assurance level:	Substantial ✓ Reasonable ☐ Partial ☐ Minimal ☐
Rationale:	This quarter 3 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

This quarter 3 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.

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 the Learning from deaths supports staff safety and overall level of practice.
Be sustainable:	On-going learning and compliance with standards.

4.0 How the report supports tackling Health Inequalities

4.1 The various reports and discussion 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 6 December 2023

8.0 Report

8.1 Introduction

This Quarter 3 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). As per usual process this has been reviewed and discussed at the Quality Improvement and Safety Committee.

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

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.

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.

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

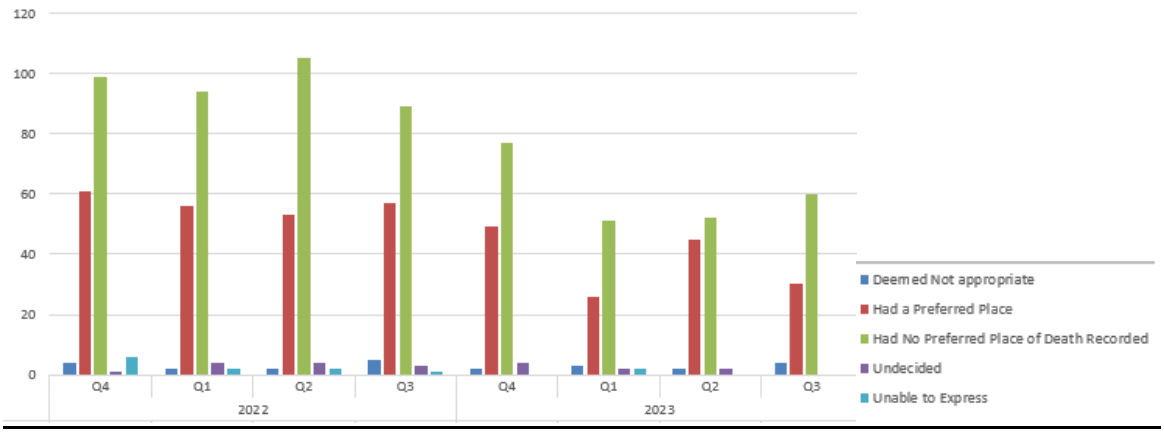
- Preferred place of death (PPD).
- Any end-of-life planning that is in place.
- Actual place of death.
- Reason PPD not met.

9.1 Overview

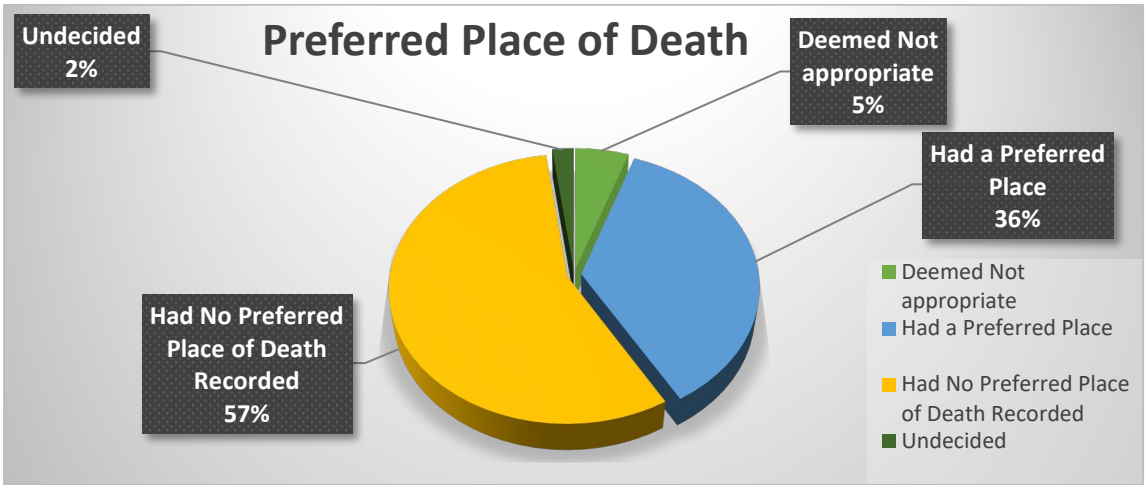
The below graph shows the rolling data for the last 24 months split into the years quarters; from the data we can see that the number of patients that die under the care of Luton Adults varies per quarter, but we can see quite a significant difference in Q1-3 of 2023. We are unsure why this is but the data collection and analysis process was amended around this time to capture all patients in the Luton Adult services, rather than only district nursing and palliative care.

The percentage of patients that have a preferred place of death documented is between 51.5% to 63.8%.

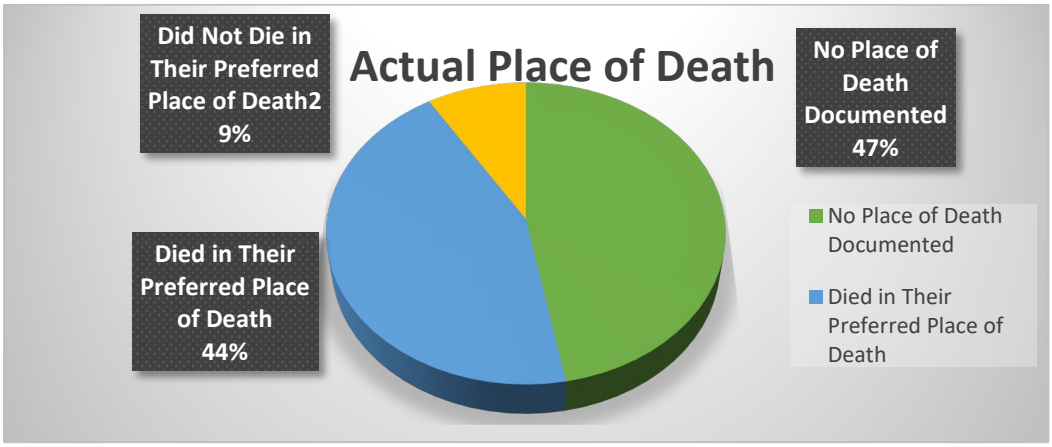
The percentage of patients that have not had a preferred place of death documented is between 21% - 44.6%.



In Q3 there were a total of 94 deaths within Luton Adults. Thirty four patients had a preferred place of death recorded, 53 had not preferred place of death recorded. It is reported that 5 patients the conversation was not appropriate and 2 were undecided.



Of the 34 that had a preferred place of death recorded 15 died in their preferred place of death and 3 did not die in their preferred place of death. The other 16 did not have a place of death documented.



The above data shows evidence that there is a continued need to support staff to have conversations about preferred place of death and to also ensure that clinicians record when the patients decline to have this conversation.

9.2 Preferred Place of Death- Ethnicity
Of the 94 patients that died whilst under the care of Luton Adults 53 were of White British origin and 41 were from various ethnic minority groups which doesn;t demonstrtae our local population demographics. We are aware of work that needs to be done both localy and nationally to target these ethnic groups to support them at the end of life.

9.3 Detailed Review of cases.
To aid further learning across Luton adults, an analysis of 10% of patient's records was selected at random with those patients who died in their preferred place of death. These included those patients who had future planning conversations and those who's preferences were not met or discussed. This aims for being to reflect on the "story" behind the patients journey and aims to identify any learning for Luton Adult services.

10.Safeguarding Q3 Report

There were 24 unexpected deaths in Q3. There were a higher number of Neonatal deaths within BLMK, and we were also advised that the ICB in Norfolk is looking at their high numbers and potentially linking factors – one theme is poverty.

10.1 Annual Child Death Overview Report (CDOP)
The Norfolk and Suffolk CDOP 2022-23 Annual Report was shared at the meeting.
Key themes taken directly from the report:

> ***Information sharing****:*
> *It is a common theme in all areas of care and challenges arise due to lack of shared records, and anxieties and unwillingness to share important information.*
>
> ***Record Keeping****:*
> *This is vital as it is the way that information is shared between clinicians. If information is not recorded; it cannot be evidenced to have happened.*

***Assessments**:*
It is important that assessments are thoroughly completed, whether this is a clinical or social assessment. Professional curiosity and talking to others are vital to ensure we are as rigorous as possible.

***Parental factors**:*
There are several cases in which parental behaviours affecting health such as smoking, recreational drug and alcohol use, obesity and neglect of their children's care affect a child's well-being. Services can only try to encourage adults to change their behaviours and ensure that where they exist suitable interventions are persistently offered even after any initial refusal to accept. It is important that professionals consider the potential impact of parental behaviours on their children's health and wellbeing.

Safe sleeping environment:
This is a recurrent theme in cases of unexpected infant and early childhood deaths. A safe sleep area can reduce the risk for sudden infant death syndrome (SIDs) and other sleep related deaths. The importance of repeating the message about safe sleeping environments cannot be overemphasised.

***Training**:*
All organisations must encourage training and identify deficiencies where additional input could improve the situation. This can be a challenge as there are increasing amounts of required training mandated, and staff may become overloaded with 'opportunities to learn and improve'. Consideration should be given to which opportunities are key and would make the most difference for staff in their area of work.

***Listening to parents**:*
Parents feeling that they have not been fully listened to or understood is a common theme.
Of course, it is very hard to make comparisons with all cases where children survivor however, we need to be very cautious that we do not dismiss a parent's concerns without full consideration and a thorough assessment.

These themes are included across training and supervision for all our staff even though sadly the themes are noted in incidents reported when a child dies.

10. 2 Coroners Cases
It was noted that we have been named as an interested party for a Norfolk child death case due to be heard in Coroner's court August 2024. We have also been requested to provide further information and be available for Coroner's court for a Norfolk young person suicide case, court date at the end of January. For both cases, legal advice has been sought and the outcome will be shared at the Learning from Deaths Group in due course.

11.0 HIV Deaths – Integrated Contraceptive and Sexual Health Service (iCaSH)

11.1 Summary of HIV patient deaths reported in quarter (financial years)

7 deaths reported in Quarter 3
21 deaths since April 2023
(compared to 20 deaths in the 2022/2023 period)

Full reviews of each death using a structured judgment review were completed and did not identify any failure in care from the service perspective. Two local rapid reviews were undertaken in addition as part of the patient safety incident response process. Both these cases are pending coroner's inquest and witness statements have been provided.

Case One
The unexpected death of a 38-year-old man with known HIV infection who had been lost to follow up was admitted in A&E and sadly died. This patient had not engaged with services since 2016 even though contact had been attempted via various communication methods.

Case Two
The unexpected death of patient during caesarean section. This was unrelated to HIV care. However, the patient had been known to service and seen within 4 weeks prior to death and treated for a sexually transmitted disease. The postmortem outcome is unknown to date, but the local review found that the treatment plan was in line with clinical guidelines.

12.0 Childrens Community Nursing (CCN)

12.1 Bedfordshire

There were no unexpected deaths in quarter 3.

4 in Luton 2 Bedfordshire

There were 6 expected deaths within Q3 – 4 in Luton and 2 in Bedfordshire. Learning has been identified for one of the deaths, mainly around issues getting equipment for the child and long waiting lists.

12.2 Cambridgeshire & Peterborough

There were two expected deaths in the quarter and no unexpected deaths.

Child A: died at Milton Hospice with EACH, as per parental wishes.

Child B: died at Great Ormond Street Hospital, parents' wishes and conversations around end of life had not been discussed. This may be because end of life was not thought to be imminent.

13.0 Learning from Unexpected Deaths Cases

Learning from Serious Incident W73640
A summary of the learning from the serious incident report relating to the care of a 17-year-old young man with complex needs. He sadly died as a result of chronic constipation and was cared for over a number of years by our services. There is an inquest in February and work is ongoing to ensure that changes are made in care pathways for treatment of constipation.

- Ensure all members of staff understand the challenges around constipation and how to care for young people with the condition. Additional education and training is underway.
- Which Service is the overarching Lead Professional when the patients see several clinical staff?

- Being professional curious particularly around what parents are telling us. Especially there understanding and knowledge of what is meant.
- Ensure Mental Capacity Act Assessments are up to date and completed for all young people.
- Further work trust wide in terms of supporting families when transitioning to adult services.
- Review of caseloads has been completed to check for other children and young people with chronic constipation.
- A text message was circulated to all children's carers across Bedfordshire Childrens Services with a link to the updated webpage detailing what constipation is and how to seek help and advice. The same message will be circulated to Cambridgeshire and Peterborough/Norfolk services.
- The Was Not Brought Policy has been reviewed to include what to do when assessment tools are not returned or completed.

14.0 Learning Disabilities Mortality Review.(LeDeR) update

Cambridgeshire and Peterborough system LeDeR meeting was delayed but there is full day workshop at the end of January reviewing all their outstanding cases.

No information requested by Norfolk and BLMK systems in relation to learning disabilities in the last quarter but themes that were identified were:

- Mental Capacity Act (MCA) assessments not completed
- No or insufficient annual health checks
- Poor quality of care
- Lack of professional support
- Hospital passport not used
- Covid19
- Lack of professional support
- Delay in appropriate referrals and assessments

Across the trust mental capacity act assessment workshops have taken place and a new template has been developed.

A review of Annual Health Checks is underway Annual Health checks are from the age of 14 and over. This includes identification in the clinical record of who has a learning disability.

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

- Two ongoing cases within iCaSH Services being monitored / reviewed.
- The meeting noted the higher number of Safeguarding neonatal deaths.
- A new standardised template has been created for quarterly reports – this is a work in progress.
- The Terms of Reference were reviewed.
- Currently working on data within Luton Adults on preferred place of death (PPD). It is appearing that PPD data is decreasing but the information may not be available. This is ongoing.
- A flowchart is being created to assist staff when dealing with Coroner's Cases. -**END**-