Trust Board

Title:	**LEARNING FROM DEATHS Q1 2019-19 REPORT**
Action:	**FOR DISCUSSION AND AGREEMENT**
Meeting:	**18th September 2019**

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 which reports into our Quality Improvement and Safety Committee.

This National Guidance required Trusts to:

- ✓ Have a 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.

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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 within the subject area.
Collaborate with other organisations	Individual component topics identify when collaboration has been undertaken.
Be an excellent employer	Learning from the subject area supports staff safety and overall level of practice.
Be a sustainable organisation	On-going learning and compliance with standards.

Trust risk register
BAF risk 2967– *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 4)

Legal and Regulatory requirements:
As above

Previous Papers:

Title:	Date Presented:
Quality Report – February 2019	27 February 2019
Learning from Deaths Report	10th July 2019

Equality and Diversity implications:
Nil identified

Objective	How the report supports achievement of objectives:
Achieve an improvement in the percentage of service users who report that they are able to access the Trust services that they require	Not referenced in this report
To introduce people participation in our diversity and inclusion initiatives to capture the experience of hard to reach/seldom heard/varied community groups.	The Learning from Deaths approach taken by the trust includes families and carers in any investigation and related learning
Introduce Disability Passport Scheme to record agreed reasonable adjustments.	Not referenced in this report
To utilise the diverse experience and backgrounds of our Trust Board members in promoting an inclusive culture.	Not referenced in this report

Are any of the following protected characteristics impacted by items covered in the paper No								
Age	Disability	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation

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1. INTRODUCTION

The National Quality Board (NQB) Guidance published in March 2017 includes a recommendation that a Quarterly report on deaths, reviews and investigations should be discussed at public Board meetings. This report provides an update on Quarter 1 Learning from Deaths across the Trust. This summary has been scrutinised by both the learning From Deaths Group and the Quality Improvement and Safety Committee prior to presentation to the Board.

2. LEARNING FROM DEATHS QUARTER 1 2019/20

2.1 2.1 The revised policy has been introduced.

2.2 **Luton Adult Services Report**

The service provided a detailed report to the Learning from Deaths Group which was discussed.

- During the period April-June 2019 there were 158 deaths of patients known to CCS.
- 58 of these patients were cared for under the Enhanced Collaborative Models of Care (ECMoC) programme.
- There were two complaints relating to care leading up to the death of two individuals reported in April. While these both relate to the previous quarter (Quarter 4) the investigation and learning is in progress and will be shared at the next Learning From Deaths Group. One of these was reported as a Serious Incident.
- Discussion is underway with Luton & Dunstable Hospital to enable collaborative working focusing on reviewing the patients cared for under the Enhanced Collaborative Models of Care and frailty.

Summary :

- Data shows that there is a clear correlation of patients dying in their Preferred Place of Death (PPD) when their wishes are known – 87% of patients who expressed a preference have died in their PPD this quarter.
- 70% died in hospital where a preference has not been documented this quarter
- The Lead Nurse for Cancer and Palliative Care has reviewed 16 records in detail. Findings from this reflected general findings as above as where there had been recognition patients were nearing the end of their lives and discussions had taken place, patients died in their preferred place of death.
- The end of life template is not consistently used by the community nursing teams and staff are not always confident in recognising when patients deterioration is due to them nearing the end of their lives. This can mean that practical issues such as anticipatory medication and DNACPR may not be in place in a timely way. Additional training is included in the competency framework that is being implemented.
- Care in the last days of life for patients within the community is of a high standard with good collaboration particularly between the district nursing and palliative care teams.
- Where possible the palliative care team are attending the district nursing daily handover to provide additional support for the district nursing team particularly around the recognition of deterioration that indicates a patient may be nearing the end of their life.
- Where appropriate the use of the end of life template is highlighted as a way of ensuring all teams involved in the patients care are aware of discussions that have taken place, planning that is in place and patient's wishes around their preferred place of death.

- The data relating to those patients supported by ECMoC will be discussed with the implementation team, particularly as a significant number of those patients who died in hospital were not under the care of a community clinical team but are registered as being under CCS care.
- The Lead Nurse for Cancer and Palliative Care plans to link with the practice development team to look for opportunities to improve staff confidence in recognising deterioration that indicates a patient may be nearing the end of their life.

HIV Deaths

- There were no HIV deaths reported in Quarter 1.
- Head of Service to do a review to see if there were any deaths not reported to this group and also to ask whether or not HIV related deaths are recorded anywhere else at the next Consultant Review Group.

Children

- There were 29 child deaths across the trust in the period April- June 2019.
- Trust staff were involved in 24 of these cases.
- All of these cases were recorded and followed up as part of the Local Child Death Overview Panels (CDOP) process. CCS professionals provide information and participate in their local CDOP processes in cases of unexpected deaths where the child had been known to CCS.
- Learning Disability Mortality Reviews (LeDer) in Bedfordshire are taking place via the Adult Safeguarding Board CCS are undertaking a small number of the Luton LeDer reviews. The trust Named Nurse for Safeguarding Adults is undertaking the training .

End of report