TRUST BOARD

Title:	**LEARNING FROM DEATHS Q3 and Q4 2019-2020 REPORT**
Action:	**FOR DISCUSSION**
Meeting:	**15TH June 2020**

Purpose:

This report was discussed at Quality Improvement and Safety Committee (QISCOM) 29 June 2020 and ensures the trust 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 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 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:
Quality Report	

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
To introduce wider diversity on recruitment selection panels.	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 Reassign-ment ☐	Marriage and Civil Partnership ☐	Pregnancy and Maternity ☐	Race ☐	Religion and Belief ☐	Sex ☐	Sexual Orientation ☐

1. INTRODUCTION

1.1 In line with the Quality Improvement and Safety Committee's current cycle of business, a Quarter 3 and Quarter 4 update 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). The Quarter 3 update is delayed due to the pandemic response required.

1.2 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.

LEARNING FROM DEATHS QUARTER 3 and 4, 2019-20

2. Luton Adult Services Quarter 3 Report (Oct-Dec 2019)

2.1 The service provided a detailed report to the Learning from Deaths Group for Quarter 3 and Quarter 4 which were discussed. There were no unexpected deaths. A 10% random sample of patient deaths were reviewed as per the Trust's policy. 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)
- Advance care planning offered (Y/N)
- Preferred place of death (PPD)
- Actual place of death
- **The following were not reviewed in quarter 3**
- Reason PPD not met
- Anticipatory medications given
- Continuous subcutaneous infusion (syringe driver) needed

2.2 Of those patients who had at least one episode of care recorded at some point in their life with a CCS Luton Adult Unit service, a total of 264 patients died in 2019 Q3 .Through the sampling process described, 27 patient entries were reviewed.

2.3 From the initial list of 264. Of these 9 were found not to be under the care of CCS Luton Adult Unit. Therefore 18 patient records were reviewed.

Themes arising from the quarter 3 review

2.4 The data confirms what is known nationally that patients who are recognised as being in the last year of life and are given the opportunity to discuss their wishes around their care as they deteriorate are more likely to die in the place they have identified as their preferred place of death.

2.5 The use of the EoLC template enables easy identification of any end of life planning in place or needed and a consistent place for patients PPD to be recorded.

2.6 CCS Macmillan Cancer & Palliative Care Lead Nurse was involved in the development of this template that was developed for use across the whole of the Luton system Further

work is currently being undertaken via the Luton End of Life Local implementation group (Luton LIG) to embed the use of this template across the wider system in Luton

2.7 There continues to be ongoing issues with data quality which will be discussed further with Deputy Chief Nurse, Macmillan lead Nurse Cancer & Palliative care & data support staff in the Luton Adult Unit.

2.8 To consider further analysis of the data of patients who are supported by the AHFC team as these patients may be missing out of the opportunity to have conversations about their wishes around their care.

3. Luton Adults Quarter 4 (Jan-March 2020)

3.1 A total of 106 patients died during the quarter under CCS care. This quarter's data reflects that the longstanding issues with data quality have been resolved.

Review of Anticipatory Prescribing

3.2 In light of the review of CCS current policy of anticipatory prescribing a snapshot review of whether anticipatory medication is in place as part of good practice in end of life planning was undertaken for those patients who died in February 2020.

3.3 Of the 30 patients who died in February, 22 had evidence of anticipatory medication being in place. These had been prescribed by:

- hospital team as part of patient medication on discharge
- CCS non-medical prescriber
- GP at request of CCS staff
- GP

3.4 One request for these to be prescribed was declined by GP in some cases it was not clear from the record if medication had been prescribed.

3.5 Most medication had been prescribed 4 - 6weeks prior to the patient's death although for one patient medication had been prescribed by CCS non-medical prescriber in August 2019.

Themes arising from the quarter 4 review

3.6 The review of anticipatory medication indicates that this part of end of life planning for patients, which is national good practice, is embedded within the community teams. It would be useful for this review to be repeated.

3.7 The above data confirms what is known nationally that patients who are recognised as being in the last year of life and are given the opportunity to discuss their wishes around their care as they deteriorate are more likely to die in the place they have identified as their preferred place of death.

3.8 The use of the EoLC template was not included in this report but CCS Macmillan Cancer & Palliative Care Lead Nurse continues to be involved in the ongoing development of this template that is currently being undertaken via the Luton End of Life Local implementation group (Luton LIG) to embed the use of this template across the wider system in Luton.

3.9 To consider further analysis of the data of patients who have not had an opportunity to have conversations about their wishes around their care as they deteriorate.

3.10 During the quarter there had been no incidents or complaints linked to end of life care received by the Trust.

4. HIV Deaths

4.1 There were no HIV related deaths reported in Quarter 3 or 4 via the iCaSH service. The iCaSH service is noting that deaths as a result HIV related illness are rare as this disease is considered a long term condition when appropriate drug regimes are followed.

4.2 This committee asked for clarification about the national picture regards HIV deaths. A quote below clarifies the picture at present. The data used is collected from labs/providers of HIV treatment and support such as iCaSH.

'In 2018, there were 225 people with an AIDS-defining illness reported at HIV diagnosis. Moreover, there were 473 deaths among people living with HIV. Over the past decade there has been a 20% decrease in the number of deaths in people living with HIV (591 in 2009 to 473 in 2018) 8 Given that previous work has shown that 58% of deaths in people with HIV are HIV related [6], the number of deaths due to HIV has decreased slowly over the past decade from an estimated 340 in 2009 to 270 in 2018.'

[Publication: Trends in new HIV diagnoses and in people receiving HIV-related care in the United Kingdom: data to the end of December 2018* Health Protection Report Volume 13 Number 31 page 5 6 September 2019]

5. Children

5.1 Heads of Safeguarding proposed at the Quarter 3 meeting that rather than providing a 'number' based report with minimal opportunity for learning instead they provide report on the emerging themes from the local CCG/Public Health CDOP reports, LeDeR annual national report and Local Child Safeguarding Practice Reviews. This reporting will highlight national and local learning and identify actions that need to be considered to prevent early avoidable deaths.

5.2 Summary of themes from CDOP Report Bedfordshire CPOD Annual Report 1st April 2018 –March 31st 2019

5.3 This is being presented as an example of the information and learning from CDOP process.

5.4 During the period 1st April 2018 to 31st March 2019 the panel met on 7 occasions and completed full reviews on 37 children residing in Bedford Borough, Central Bedfordshire and Luton. These cases included deaths from 2015-2019 as there can be a delay in reviewing cases due to other processes such as coronial inquests, criminal investigations and toxicology reports.

5.5 Of the total reported deaths 53% were female and 46% were male; this is contrary to national and prior local data, whereby there are usually more male than female deaths. During 2018-19 Bedfordshire CDOP reviewed and closed 37 cases at panel meetings. Modifiable factors were identified in 32% of these cases; this is lower than last year where modifiable factors were found in 39% of cases heard at panel. Similarly to previous years, the modifiable factors identified included service provision, consanguinity, maternal BMI; with BMI & service provision featuring as the highest factors.

5.6 A modifiable factor is defined as '*one which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.'* (Working Together to Safeguard Children, DfE 2013).

- Chromosomal, Genetic and Congenital anomalies made up 32% of the reviewed cases. This is an increase on the previous 2 years where 30% of cases in 2017-18 and 24% of cases in 2016-17 closed under this category. This is also higher than the national average of 25%.
- The number of deaths closed under the category of Perinatal/Neonatal events decreased slightly this year to 30%, compared to 32% in 2017-18, although higher than the 2016-17 figure of 26%. The national average is similar at 34%.
- The third highest category for child deaths reviewed in Bedfordshire this year is Acute, Medical or Surgical conditions which accounted for 16% closed under this category. This is significantly higher than the percentage of National Cases which is 6%.
- In Central Bedfordshire there were 20 deaths in 2018-19; this continues the 2-year trend of an increase of 3 deaths each year. There was also significant decrease in unexpected deaths at 10% compared to 18% in 2017-18 and 36% in 2016-17
- In Bedford Borough there were 21 deaths; this is an increase of 6 deaths from 2017-18 and 9 from 2016-17. 43% of these deaths were unexpected - a slight increase from 2017-18 when 40% were unexpected and significant increase from 2016-17 (25%)..
- In Luton there were 30 deaths; this is an increase of 5 deaths on the previous year and 2 from 2016-17. There was nearly twice the proportion of unexpected deaths (23%) compared to 2017-18 (12%), although less than in 2016-17 (32%).

CDOP Training & Development Sessions

5.7 CDOP continues to be part of the Level 3 Safeguarding training for GPs in Bedfordshire and Luton. This has continued to work effectively and has received positive feedback.

5.8 Formal CDOP training sessions have temporarily been put on hold whilst clarity and systems are established in response to the new child death reporting statutory guidelines from September 2019. However, individual and small group sessions have been facilitated in response to identified/requested need. These session have been promoted by the Pan Bedfordshire LSCB Training Unit. Going forward an electronic reporting E-CDOP is to be implemented and training will be offered to CCS professionals.

5.9 A suicide awareness event in Bedfordshire in November featured a session on the new statutory guidelines and processes. Local support guidance to educational establishments has been development and implement. CCS School Nurses have been involved in the development and implementation of these local processes.

5.10 Further joint liaison with Public Health and Midwifery continues, with a focus on increasing awareness of maternal high BMI risk factors.

6. Additional work

- Intranet pages developed to share learning and signpost staff.

- A meeting with the Luton & Dunstable Hospital Mortality lead to be arranged.

- Implementation of the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) document within BLMK STP footprint, specifically the Luton system is not underway at this time. We are attending regular Palliative Care Working Groups where this will be progressed, but at the moment this is not a planned project which requires some significant co-ordination system-wide. ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.

End of report