Cambridgeshire Community Services NHS Trust

Norfolk Community Health and Care NHS Trust

Agenda item:	8.
Date of meeting:	18 March 2026
Report to the:	Group Trust Board
Title of report:	Learning from Deaths Q2 and Q3 (2025/26)
Report author:	Liz Webb, Deputy Chief Nurse (CCS) Corwen Hull, Clinical Director (NCHC)
Executive sponsor:	Dr Caroline Kavanagh, Chief Medical Officer
Recommendation:	Discuss

Assurance level:	**Substantial** ✓ **Reasonable** ☐ **Partial** ☐ **Minimal** ☐
Rationale:	This report of quarter 2 and 3 was presented and discussed at the Quality Committee 5 February 2026 and provides substantial assurance that both organisations are seeking to learn from deaths. (National Quality Board (NQB) guidance (2017)) which underpins how NHS providers should learn from the deaths of people in their care.

1.0 Executive Summary

1.1 This report was presented to the Quality Committee 5 February 2026. The board are asked to accept the report as substantial assurance that the review of deaths across both trusts seeks to learn and improve care.

1.2 This Quarter 2 and 3 report outlines the requirement for the two Trusts, Norfolk Community Health and Care (NCHC) and Cambridgeshire Community Services NHS Trust working as a Group Board to review the deaths of people who we care for. This is as per the National Quality Board (NQB) guidance (2017) which underpins how NHS providers should learn from the deaths of people in their care. This provides substantial assurance that both organisations are seeking to learn from deaths. We have considered both expected and unexpected deaths and seek to learn from care that could have been better and good care.

2.0 How the report supports tackling Health Inequalities

2.1 The various reports and discussions that took 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.

3.0 Links to Board Assurance Framework / Trust(s) Risk and Issue Registers

3.1 Risk 3653 (Risk Rating 12): With competing clinical priorities and internal/ external pressures, there is a risk that quality and patient safety could be compromised.

4.0 Legal and Regulatory requirements

4.1 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.

5.0 Previous consideration by Committee or Executive

5.1 Joint Groupwide Report from Quarter 1 2025 to Quality Committee on 2 October 2025

6.0 Introduction

6.1 Since the first groupwide learning from deaths group in July 2025, the Learning from deaths group continue to meet and had a second development workshop in November 2025. The meeting frequency was originally set at bi-monthly, but this has adjusted to quarterly for Quarter 3 and 4, in line with Quality Committee cycle of business.

6.2 Work has started to produce a single Learning from Deaths policy that 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 is met. With the addition of meaningful measures of quality of care and experience for both patients, their families and staff.

6.3 The following report provides substantial assurance that both trusts are reviewing and seeking to learn from deaths under our care. The variation in type of data and presentation is reflective of the different portfolios we have; over time this will be refined to underpin learning and opportunities to improve.

6.4 This report covers the six months period July 2025- December 2025 (Quarter 2 and Quarter 3). This is due to postponement of the November 2025 Quality Committee.

Learning from Deaths workshop and next steps

6.5 The meeting membership met for the second workshop in November 2025; the focus was on how we capture and understand the quality of end-of-life care; patient and families experience and feedback; the impact our services have on people at this time. This is in addition to the statutory requirement to undertake mortality reviews of unexpected deaths under our care. Further work is underway with the development of a new trust policy and agreed set of data and other information to inform.

7.0 CCS Unexpected deaths

7.1 Both trusts review unexpected deaths at their respective Safety/Learning Huddles.

7.2 CCS reported a total of twenty-three unexpected deaths in quarter 2 and quarter 3.

7.3 There were eight adult deaths reported on DATIX and reviewed at the weekly safety huddle. Six of the adult deaths relate to people supported with HIV treatment by the integrated contraception and sexual health service (8.0 see below).

7.4 One hot debrief was completed for a case in Bedfordshire Neuro Rehab Service. This highlighted good practice by staff who attended and found a patient had died and additional support was provided.

7.5 The remaining case was in Luton Rapid response who attended to complete a welfare check and found the person had died. Hot debrief concluded that good practice had been followed and additional staff support was offered.

7.6 The eighteen unexpected neonatal and child deaths were noted not to be under the trusts care and correctly referred into the Child Death Overview Process (CDOP).

8.0 CCS Integrated contraception and sexual health service- HIV deaths

8.1 Deaths of people with HIV are reported nationally via the National HIV Mortality Review (NHMR). To support this these deaths are reviewed by the service through a Structured Judgment Review and discussed at the HIV multidisciplinary team reviews.

8.2 There were six deaths in this 6-month period (Quarter 2 and 3) One of these related to HIV care and treatment provided by the Trust and is being reviewed internally and is subject coronial review and we have referred it be considered for a Safeguarding Adult Review (SAR.) The patient had complex health and social care needs in addition to the HIV diagnosis.

Year to date figures:

9 deaths reported since April 2025.
28 deaths in the 2024 – 2025 period
29 deaths in the 2023 – 2024 period.
20 deaths in the 2022 - 2023 period.

9.0 NCHC Inpatients data (Unexpected and expected deaths)

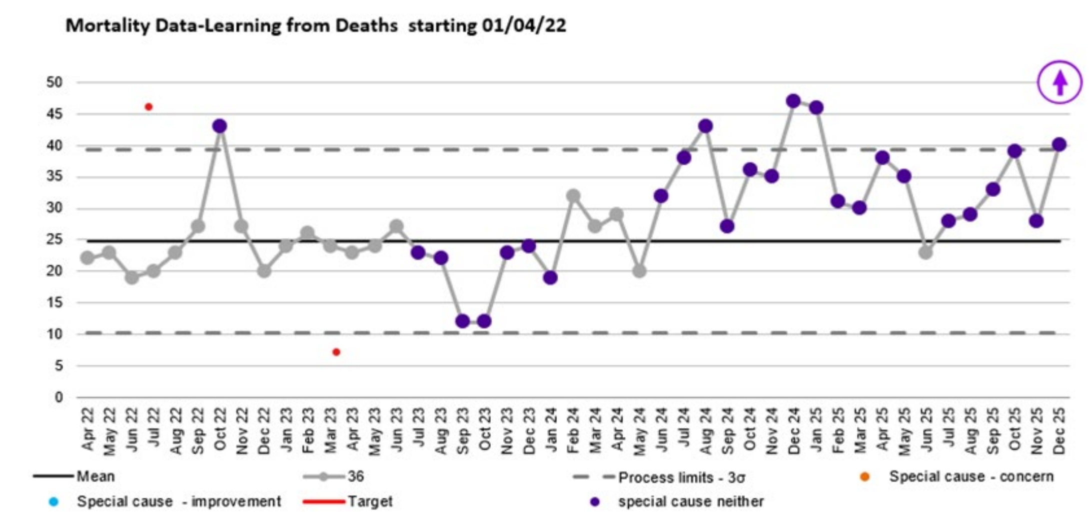
9.1 In Quarters 2 and 3 a total of 197 deaths were recorded across the inpatient areas of NCHC.

- Little statistical variance across the 6-month reporting period
- No complaints received relating to end-of-life care on generalist in patient areas.
- There are currently 5 Coroners cases involving patients who have been cared for while on generalist in patient areas (4 deaths occurred while patients were at NNUH, and one after discharge home following a fall)
- No Coroners cases have been closed during this reporting period
- All patient deaths have been subject to a mortality review with no requests for escalation to level 2 review.

- As expected, the hospice, Patricia Bacon Hospice (PBH) had the highest number of deaths 139 of the 197 reported.

Statistical process chart NCHC All (expected and unexpected) In patient deaths data (April 2022- December 2025). Table 1.

Table 1



Breakdown of in-patient unit deaths

Ward		Q4-24/25	Q1 25/26	Q2 25/26	Q3 25/26
Specialist Palliative Care					
Patricia Bacon Hospice		60	52	59	80
Specialist units					
Caroline House		1	1	0	0
Beech Ward		1	0	0	0
Pine Cottage		0	1	0	0
General Rehabilitation					
North Walsham		15	8	7	9
Alder Ward		4	7	4	3
Swaffham		4	0	0	0
Ogden Court		4	4	3	4
Foxley Unit		6	5	6	2
Willow Unit		0	3	1	3
Pine Heath		12	12	8	6
Quarter Total		**107**	**95**	**82**	**101**

Cause	Patient numbers
Metastatic cancer	143
Pneumonia	8
Frailty	8
Heart failure	5
Stroke	1
Dementia	8
Alcoholic liver disease	2
Small bowel obstruction	1
End stage liver failure	2
COPD	5

10.0 NCHC Learning from Deaths Incidents reviewed at the Learning huddle

Twenty-seven deaths were reviewed in Q2 and Q3.

Key themes identified include:

- Two related to Prescribing and medication administration delays
- The importance of additional support to staff after finding a patient deceased.
- Communication of a person's death between acute hospitals and community resulting in distressing calls to families or unnecessary visits being made.
- Late referral for end of care support and limited opportunity to make plans for care at home

11.0 Expected deaths reports

11.1 CCS Luton Community adults

11.1.1 The number of expected deaths in the Luton Adults Service remains stable.

- Quarter 2 -74
- Quarter 3 -68

11.1.2 Data that is captured from the Electronic Palliative Care Coordinating Systems (EPaCCS) system continues to show a discrepancy between people dying in their preferred place of care compared with their full clinical records. A previous review of these records across two quarters found that where this was discussed and recorded most patients had died in their preferred place of care or one suitable for their care needs at the time.

11.1.3 Work continues to support staff through training and case reflections at handover huddles to have conversation about wishes and place of care. This includes how to record this.

11.1.4 The new PowerBi dashboard for monitoring deaths will be used for future data reports, and this will be able to categorise what care was being provided by Luton Adults Services prior to the individual dying.

11.1.5 Age and ethnicity is reviewed in the data analysis. While most people cared for are in the later age groups predominantly over 70, there are number of younger people that presents different challenges for staff and additional support needed for both the patient family. Ensuring that there is a consideration of children's needs in these cases is vital.

11.1.6 A coproduction project that is working with Asian Pakistani communities about their awareness of support and care at home has almost finished. This work will link with the new Bedfordshire and Luton Palliative Co-ordination service, which provides a single point of access for all end-of-life care needs.

11.1.7 The 10% of the records sampled of those who died in the six months reported highlighted:

- Good collaborative working across community services, GPs, Ambulance service to support people at home.
- The challenges of conflicting individual patient preference about place of care and death and those of the family.
- Good practice with use of translation services to underpin care and planning.
- On going challenge of keeping records up to date about people's care wishes and suitable reporting.
- Specialist services require further education about recording of advance care plans and starting these.

11.2 Children's Community Nursing

Cambridgeshire Children's Community Nursing

11.2.1 In quarter 2 and 3 there were 6 expected deaths. The use of the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). advance care planning document had supported end of life care planning in most cases. Where this was not present, this was linked to the place of care (hospital) or the family's readiness to make these plans. One case sadly was complex with family and young person's choices to seek treatment abroad adding some challenges, but the multi-disciplinary team across acute and community supported end of life care on the return to the UK.

Bedfordshire Children's Community Nursing

11.2.2 There were 6 expected deaths within quarter 2 and 3 within this service. All had advance care plans in place and integrated working with the hospice and acute trusts was evident. There was one unexpected death in hospital of a young person with complex health needs known to the community team. A learning from deaths review is underway and will be reported at the next meeting.

11.3 NCHC Children's

11.3.1 There was one expected death in quarters 2 and 3 with good evidence of advance care planning and working with East Anglia Children's Hospice.

11.3.2 There were two unexpected deaths in this quarter. One was child with known underlying disease; this case is being reviewed by the coroner. The second is a case of a young person dying through suicide. The case is with the coroner and an internal learning from deaths review is underway.

12.0 Safeguarding reviews

Safeguarding children case reviews

12.1 There were 56 deaths in this 6-month period (30 children and 26 neonates). Neonatal deaths are reported to the child death overview panels and national child mortality data base by the relevant maternity units. As applicable the trusts contribute to these reviews if required (e.g if known safeguarding concerns).

12.2 All child deaths have been reviewed on SystmOne (S1). There continues to be evidence of the trusts CDOP S1 template not being used, only 22% of child death cases had a completed CDOP S1 template. A new CDOP draft Group Model S1 template has been developed with a plan to launch this early 2026.

12.3 All cases had evidence of the correct child death processes followed including completion of information for the CDOP review panels being in place and this was recorded clearly on the S1 record. All cases will be reviewed from a multi-agency perspective at CDOP and any learning shared with CCS.

12.4 There have been 4 Sudden Unexpected Deaths in Infancy with 2 of these cases having evidence of co-sleeping due to the baby being unsettled and being away from home. Co sleeping advice is routinely given to parents.

12.5 Our internal Protecting Babies communication campaign continues, where we have developed key messages for parents/carers around preventable accidents and how to keep your baby safe.

12.6 There have sadly been two young person suicides. An internal review is underway of these cases to understand any service involvement and learning.

CCS LeDER reviews

12.7 Since April 2025 there have been 6 deaths of people with Learning Disability recorded in their records. In four cases, additional information has been provided to the LeDER review process. Two cases are currently being reviewed as part of the Learning from Deaths process.

12.8 The CCS Safeguarding team have been actively engaging with the local LeDER review panels and ensuring the members are aware of the services that the trust provides. This has identified some cases where previously the panel may not have requested information. This is particularly related to the dietetics service who care for people over many years with complex feeding needs.

13.0 Coroner cases

NCHC Coroner cases

13.1 There have been nine coroner inquests in quarter two and three relating to patients that NCHC cared for. NCHC provided information as requested supported as required by the legal team. In two cases the trust was listed as an interested party.

CCS Coroner cases

13.2 There was a request for information in one case in the two quarters, which was provided.

14.0 Complaints

14.1 There was one informal complaint in quarter 2 and 3 within CCS regarding end-of-life care. This related to explanation about the use of syringe drivers.

14.2 There were 7 informal complaints and 4 formal complaints in quarter 2 and 3 with NCHC services.

Themes:

- Access to end-of-life care medication and ability to collect it by the family
- Communication with patient and family by the plethora of professionals involved lacking coordination and therefore multi conversations relaying the same information.
- Clarification and guidance needed with regard fast track funding for care and requesting additional private care.
- Delay in attending to give end of care medication due to handover timing.
- Communication across nursing teams e.g. UCR, Community Nursing, Care agencies and GPs needing improvement
- Standard operating procedure needed across the system for deactivating in internal defibrillator (ICD)

15.0 Group wide Discussion points from the meeting:

- Building relationships with the regions medical examiners to support learning from cases, ongoing a medical examiner will be invited to attend each Learning from Deaths meeting.
- What is the data and narrative telling us about the quality of care and experience of our patients?
- The cross over with the Resuscitation guidance; ReSPECT and end of life care and how we ensure that is integrated.
- NCHC Audit of in-patient unit ReSPECT documentation highlighted a good level of practice and completion.
- Expected and unexpected deaths and the need for guidance on where starting a resuscitation is not appropriate.
- How do we support staff who care for patients and families?
- Working with partners e.g. training with EEAST paramedics caring for children who are palliative
- The meeting agenda and reports needs to reflect good practice and be shared as widely as possible.

16.0 Key themes and Learning points

16.1 Across both trusts the need to capture positive feedback and outcomes in the review process.

NCHC

- The number of deaths across the in-patient units remains stable.
- Medication supply and coordination in the community remains challenging but one that is now being addressed by the Palliative and End of Life Care Program Board
- Complaint's themes and incidents directly correlate
- Revision of the deactivation of internal pacemakers standard operating procedure is required to include community patients

CCS

- Evidence of good integrated working and planning is seen across adult and children's services
- On going challenge of capturing peoples wishes in advance care planning enabling accurate reporting.

17.0 Key matters and escalations to the Group Trust Board

There are no escalations for the Group Trust board from the Learning from deaths report.

ENDS