

Agenda item:	9
Date of meeting:	30 September 2026
Report to the:	Trust Board
Title of report:	Learning from Deaths, Quarter 1 (2026-27)
Report author:	Liz Webb, Deputy Chief Nurse
Executive sponsor:	Kate Howard, Chief Nursing and Allied Health Professional Officer
Recommendation:	Discuss

Assurance level:	Substantial ✓ Reasonable ☐ Partial ☐ Minimal ☐
Rationale:	This report for quarter 1 provides substantial assurance the trust is 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 Quarter 1 report summarises activities that meet the requirement for the trust 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.
- 1.2 The contents of this report were discussed at the Quality Committee on 13 August 2026 and are presented to the board for assurance.
- 1.3 This provides substantial assurance the organisations are seeking to learn from deaths. Learning from 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 No current open risks are related.

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 Learning from Deaths Report for Quarter 4 (2025-26), 28 May 2026.

6.0 Introduction

- 6.1 The approach to learning from deaths of our patients and the experience of them and their families continues to develop. This is in addition to the statutory requirement to undertake mortality reviews of unexpected deaths under our care. Work is continuing with the development of a new trust policy and agreed set of data and other information to inform. The following report provides substantial assurance that we are reviewing and seeking to learn from deaths under our care.

7.0 Discussion points from the meeting:

7.1 Presentation of a thematic review of incidents

Presentation of a thematic review of incidents within the Norfolk adults Palliative Care Services June 2025 - January 2026. A Norfolk wide End of Life Care Program Board and project are underway which aims to address these.

End of life and palliative care services across Norfolk are delivered by several services including GPs, Community services, Hospice Services.

Themes identified

- Medication and syringe pump issues
- Delays in referral to community services
- Communication gaps and care coordination
- Equipment access and set up
- Who was responsible of end-of-life decision making.

7.2 Presentation and discussion on a complex case

Presentation and discussion on a complex case cared for by the virtual ward. This case was about a patient who chose to stay at home for end-of-life care. There were complex factors that required careful planning and risk assessment, specifically an unstable spinal fracture and the person's weight. But with coordinated work across the multi-disciplinary team and communication the patient and family were cared for well and the patient died at home.

Themes identified:

- Supporting patients' autonomy
- Early coordination with MDT including acute and community
- Shared risk and specialist care plans enabled care at home
- Improved access to bariatric equipment rapidly in the community
- Training for staff on care of unstable spinal fractures.

8.0 Inquests

- 8.1 A central trust wide inquest management process is now in place. This is ensuring oversight of cases and ensuring triangulation with incidents or complaints. In addition, ensuring sufficient support to families and staff including legal expertise as required.
- 8.2 There were 4 inquests in quarter 1 where the trust was an interested party. These were related to Norfolk Adults patients, reflective of the portfolio this directorate. Learning was shared that included:
- How we communicate and support patients and families who have a learning disability when they are dying. This will be linked to work on the LD Strategy.
 - Prescribing and risk assessment for venous thromboembolism risk.
 - Tissue Viability expertise for wound care

9.0 Unexpected deaths

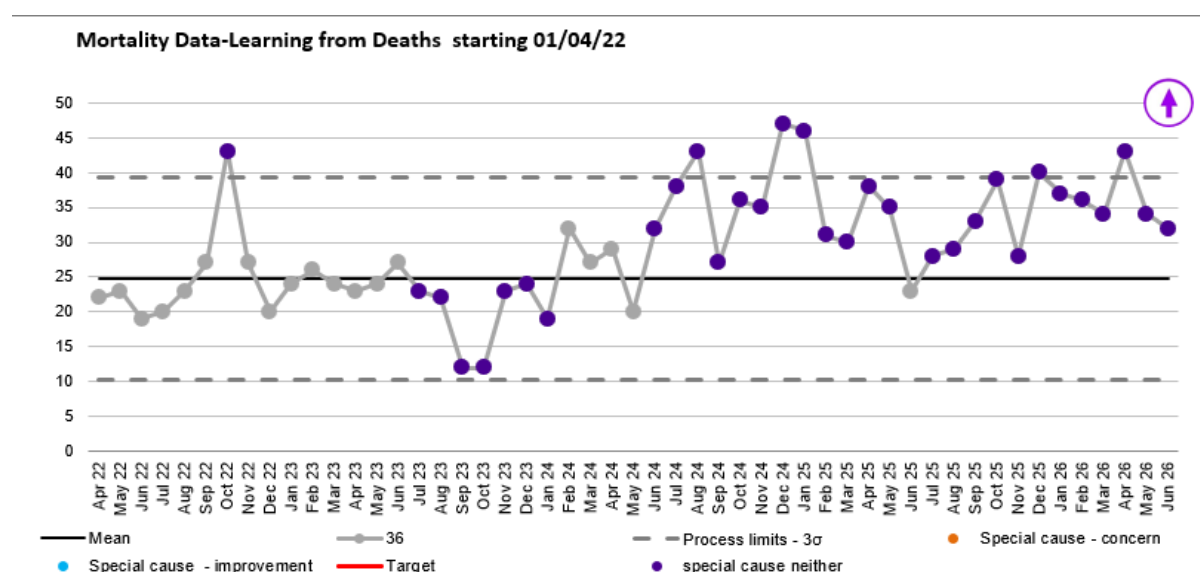
- 9.1 Norfolk Adults see section 10 below.
- 9.2 **Luton Adults**
Reported one unexpected death of a patient at home, actions of the staff were as expected and staff debrief provided.
- 9.3 **Children**
There were twenty-four unexpected neonatal and child deaths where all were noted not to be under the trusts care and correctly referred into the Child Death Overview Process (CDOP).
- 9.4 **Integrated contraception and sexual health service- HIV deaths**
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.
- There were four deaths in this quarter 1, there were no concerns with HIV care and treatment.
- The internal review from quarter 3 of an unexpected death of a patient with HIV has been concluded. The patient had complex health and social care needs in addition to the HIV diagnosis. There is an inquest pending where the trust is an interested party.

10.0 NCHC Inpatients data (Unexpected and expected deaths)

- 10.1 In Quarter 1 a total of 109 deaths were recorded across the inpatient areas of Norfolk Adults.
- 10.2 As expected, the hospice (Patricia Bacon Hospice) has the highest number of deaths (67 out of the 109 reported) however this represents a much lower percentage than seen across previous quarters. This will continue to be reviewed and monitored over the coming months

Statistical process chart NCHC All (expected and unexpected) In patient deaths data (April 2022- June 2026). Table 1.

Table 1



10.3 Breakdown of in-patient unit deaths

Ward	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27
Specialist Palliative Care				
Patricia Bacon Hospice	59	80	58	67
Specialist units				
Caroline House	0	0	0	0
Beech Ward	0	0	1	0
Pine Cottage	0	0	0	0
General Rehabilitation				
North Walsham	7	9	9	6
Alder Ward	4	3	0	9
Swaffham	0	0	8	2
Ogden Court	3	4	7	5
Foxley Unit	6	2	8	5
Willow Unit	1	3	4	3
Pine Heath	8	6	7	12
Quarter Total	82	101	102	109

10.4 Norfolk Adults Learning from Deaths Incidents reviewed at the Safety Learning huddle

(Unexpected and Expected)

- 10.4.1 Learning huddle reviewed three unexpected in-patient deaths. Learning identified focused on how advance care planning and completion of Respect documents can support care delivery. These elements are being supported through training and a documentation review. The verification of death process for registered nurses was identified as requiring update. This will be

reviewed in line with the new Norfolk Community Death Pathway which has been shared by the Coroner's Office

10.4.2 Four unexpected community deaths were reviewed at the Learning huddle. Further review via Patient Safety Incident Investigations is underway for two cases where gaps in care were highlighted.

10.4.3 A formal complaint on an inpatient area is being reviewed. This related to missed opportunity to contact relatives when a patient who was receiving end of life care condition deteriorated, and the family were not informed.

11.0 Expected deaths reports

11.1 Luton Community adults

The number of expected deaths in the Luton Adults Service remains stable at sixty-four. There was one unexpected death.

11.2 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.

Themes identified

- Good practice and collaborative care were delivered by the Community Nursing Services, Paramedics and Bedfordshire Palliative Care Services so the patient's preferences were met to be cared for at home.
- On going education and support for non-cancer specialist teams (Parkinson, Heart Failure, respiratory) to recognise end of life care needs and support planning at an early stage with their patients.
- Electronic Palliative Care Coordinating Systems (EPACCS) template and assessments was completed, and patient's preferences were met which led to good end-of-life care.
- Occasional lack of confidence of health professionals recognising the deteriorating / dying patient.
- Highlights the emotional impact that unexpected deaths can have on lone-working community nurses. It reinforces the importance of regular Basic Life Support (BLS) training to ensure staff feel confident and prepared when responding to emergencies, particularly when working alone.

Learning actions

- Ensure attendance by all Luton teams at the rolling education programme provided by the specialist palliative care team on the deteriorating patient training.
- Support all staff to attend their annual basic life support training.

11.3 Children's Community Nursing

11.3.1 Cambridgeshire Children's Community Nursing

In quarter 1 there was one expected death where care was supported by the service and East Anglia Children's Hospice.

11.3.2 **Bedfordshire Children's Community Nursing**

There were 4 expected deaths within quarter 1 within this service. All had advance care plans in place and integrated working with the hospice and acute trusts was evident.

11.3.3 **NCHC Children's**

There was one expected death in quarter 1 with several complexities due to the young person's condition. But evidence of good support to family and cross community and hospital working.

12.0 **Safeguarding children case reviews**

12.1 There were 24 deaths in quarter 1 across the trust's geography. Neonatal deaths are reported to the child death overview panels and national child mortality data base by the relevant maternity units. As applicable the trust contributes to these reviews if required (e.g if known safeguarding concerns).

12.2 All child deaths have been reviewed on SystemOne (S1).

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.

13.0 **Learning from the lives and deaths of people with a learning disability and autism (LeDER) reviews update**

13.1 The national and ICB (Integrated Care Board) led LeDER review process is currently paused while arrangements are reviewed, and a new approach is established to ensure sustainable and effective delivery of the programme. The aim is to strengthen regional processes, clarify responsibilities, and ensure future LeDER reviews are undertaken in a consistent and meaningful way, with a continued focus on improving the quality of care and reducing health inequalities for people have a learning disability or autism.

13.2 During this period, organisations are asked to continue to maintain oversight of relevant deaths and capture learning through existing governance, mortality review and safeguarding processes where appropriate. The trust will do this as part its learning from deaths process ensuring these cases are flagged at safety huddles and reviewed as required.

14.0 **Key matters and Learning points**

- Working through capturing expected death data for Norfolk Community Adults.
- Good evidence of conversations happening together around cases.
- Discussion about learning disability and autism cases and how we need to make sure that we pay our own internal attention to learning from the deaths in these situations, coming together of our strategy and communication with patients within this category.
- The Group received Coroner's inquest updates.
- Discussion around topics to be discussed at the face-to-face Workshop in September 2026.
- A new report template is being tested by Authors.

- The Learning from Deaths Policy is a work in progress
- Terms of Reference are being reviewed for annual approval.
- HIV deaths are being reviewed and are in a stable position.
- Conversations took place around children's services and interventions / MDT working in palliative spaces.

ENDS