Agenda item:	8.2
Date of meeting:	16 July 2025
Report to the:	Group Trust Board
Title of report:	NCHC Learning From Deaths (Quarter 4)
Report author:	Corwen Hull, Clinical Director Intermediate Care and Urgent Community Response
Executive sponsor:	Dr Caroline Kavanagh, Chief Medical Officer
Recommendation:	Note

Assurance level:	**Substantial** ✓ **Reasonable** ☐ **Partial** ☐ **Minimal** ☐
Rationale:	This annual report outlines how we 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.

1.0 Executive Summary

1.1 This Quarter 4 report outlines the requirement for the Trust 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. This paper is based on the Chairs Assurance Report which has been reviewed and discussed at the Quality and Safety Committee.

2.0 How the report supports tackling Health Inequalities

2.1 The various reports and discussions 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.

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

3.1 Risk 5200 (Risk Rating 20): With competing clinical priorities and internal/ external pressures, there is a risk that quality and patient safety could be compromised.
Risk 5223 (Risk Rating 12): Staffing level on PBH.

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 Chairs Assurance Reports have previously been submitted to NCHC Quality Committee

6.0 Report

6.1 Introduction

This Quarterly 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). The Learning from Deaths Group meets quarterly to review in patient data, mortality reviews and receive case reviews

6.1.2 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.

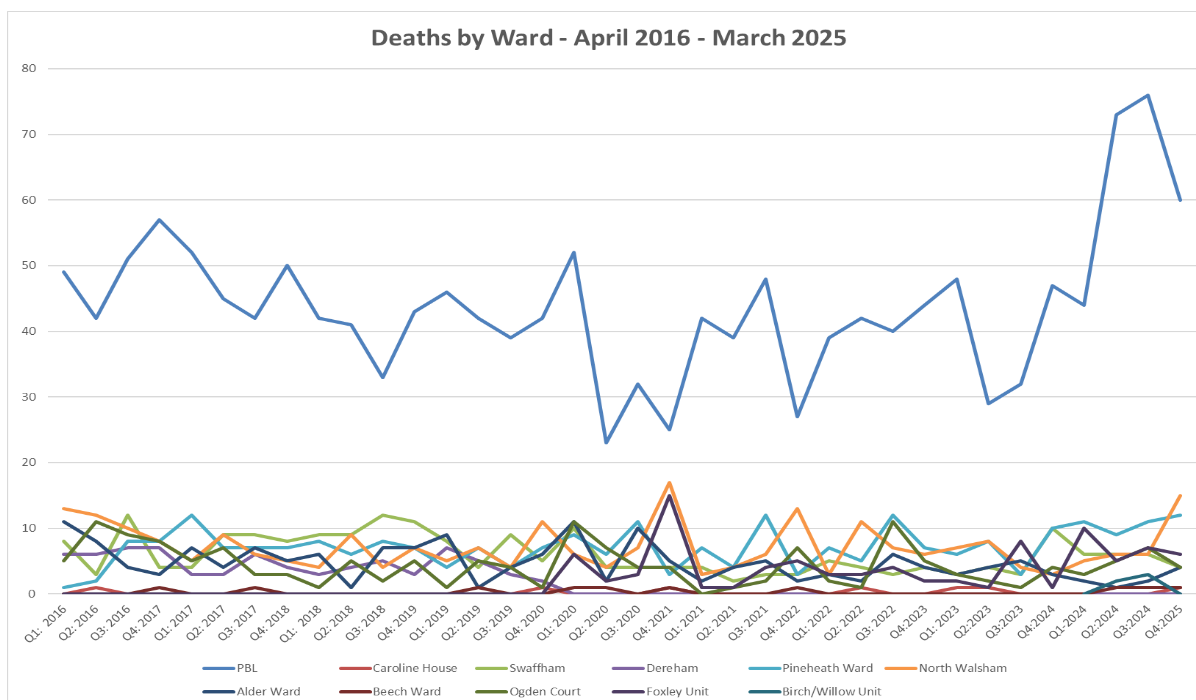
6.2 In patient data review

6.2.1 The table below identifies the deaths reported in the generalist and specialist rehabilitation units at NCHC

Ward	Q1: 2023	Q2:2023	Q3:2023	Q4:2024	Q1-2024	Q2:2024	Q3:2024	Q4:2025
PBL	48	29	32	47	44	73	76	60
Caroline House	1	1	0	0	0	0	0	1
Swaffham	3	4	3	10	6	6	6	4
Dereham	0	0	0	0	0	0	0	0
Pineheath Ward	6	8	3	10	11	9	11	12
North Walsham	7	8	4	3	5	6	6	15
Alder Ward	3	4	5	3	2	1	2	4
Beech Ward	0	0	0	0	0	1	1	1
Ogden Court	3	2	1	4	3	5	7	4
Foxley Unit	2	1	8	1	10	5	7	6
Birch/Willow Unit					0	2	3	0
Quarter Total	73	55	56	78	81	108	119	107

6.2.2 There has been a decrease in the number of deaths reported across the quarter. This is accounted for by decrease in numbers reported at PBL. There have been slight variations in deaths reported on in patient units, but this is within normal statistical variance. There have been two deaths reported on the inpatient specialist units this quarter, this was on Beech ward and Caroline House.

6.2.3 The table below provides a year-on-year oversight of the deaths reported on the in-patient areas from April 2016.



6.2.4 A review of the causes of death is detailed in the table below

Cause	Patient numbers
Metastatic cancer	73
Aspiration pneumonia	1
Frailty/old age	10
Heart failure	2
Pneumonia	3
Stroke	1
Dementia	2
FLU	1
Motor Neurone Disease	1
Small bowel obstruction	1
Renal disease	1
Upper GI bleed	1
Hypoxic brain injury	1
Not yet documented	10

6.2.5 The average age of death in this quarter was 82.3 years with the youngest patient being 37 years old and the oldest 99 years.

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

- Review of the mortality data has identified an increase in the cohort of younger patients (under 50 years) being cared for within PBL. This is significant as there is the potential for staff to experience trauma due to dealing with younger patients and younger families. It was also raised that there is a gap for support for Community Nurses dealing with complex situations in relation to younger patients in the community setting
- PBL staff have access to support from the clinical psychology team and Chaplaincy team. Team debriefs are also available and supported by the ward clinical team
- Debrief support for community staff is offered on an ad hoc perspective. Place teams have been asked to review what support is available and what is required in each of their areas and feedback at the next meeting
- Concerns continue about the responsiveness of the Fastrack process for patients and families at end of life. Cases were presented, that due to the protracted pathway and delays in the CHC and fast track process, patients died without additional care and support being approved and implemented. This has been raised with the ICB and additional training has been delivered to support community staff to complete the assessment and referral process.
- ICB led training already in place – this is being highlighted
- Nurse led education sessions to help identify rapid deterioration and utilise prognostic indicator tools under development
- Improvement of SystmOne templates, integrating evidence based prognostic tools and standardising information submitted to each Fastrack checklist. Currently being reviewed by working group within the ICB.
- Work to improve symptom control via appropriate prescribing and medication availability continues via the NWICS Palliative and End of Life care medication workstream. Our CMO is involved in this workstream and has expressed her concerns about the longevity of this unresolved issue. Quality improvement initiatives including end of life prescribing and medication availability are being reviewed. These are two areas of concern that have been highlighted in previous NCHC Learning from Deaths meetings. It is positive that a system approach is being taken to these important aspects of patient care, although this is not a new issue.
- The joint collaborative workshop between CCS and NCHC received very positive feedback from both attendees and presenters. The next workshop is booked for 14th November with confirmation of attendance by Norfolk and Cambridge Coroners.
- Joint bi- monthly NCHC and CCS Learning from Death meetings now arranged from July 2025. Joint TOR has been developed
- Invitation to Norfolk Coroner Court Open Day on 26th August shared and circulated to staff. This is a great opportunity for staff to attend and understand the workings of the Coroners court both in the court room and behind the scenes