Cambridgeshire Community Services NHS Trust

Norfolk Community Health and Care NHS Trust

Agenda item:	8
Date of meeting:	24 September 2025
Report to the:	Group Trust Board
Title of report:	Learning from Deaths Q1 (2025/26)
Report author:	Liz Webb, Deputy Chief Nurse (CCS) Corwen Hull, Clinical Director (NCHC)
Executive sponsor:	Dr Caroline Kavanagh, Chief Medical Officer
Recommendation:	Note

Assurance level:	**Substantial** ✓ **Reasonable** ☐ **Partial** ☐ **Minimal** ☐
Rationale:	This report was tabled at the Quality Committee 7 August 2025 and details the subjects included in the first Group wide Learning from Deaths took place on 17th July 2025, with a new terms of reference and integrated agenda. The Quality Committee approved this as providing substantial assurance that both organisations are seeking to learn from deaths. The board is asked to note this as per the National Quality Board (NQB) guidance (2017) which underpins how NHS providers should learn from the deaths of people in their care.

1.0 Executive Summary

1.1 This Quarter 1 report was reviewed at the Quality Committee on 7 August 2025 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.

1.2 The first Group wide Learning from Deaths took place on 17th July 2025, with a new terms of reference and integrated agenda. This provides substantial assurance that both organisations are seeking to learn from deaths.

1.3 We 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

- CCS NHST Report from Quarter 4 2025 to Quality Improvement and Safety Committee, 5 June 2025
- NCHCT Chairs Assurance Report to the Quality Committee, 10th March 2025

6.0 Introduction

6.1 The first joint Learning from Deaths group took place between NCHC and CCS on July 17th, 2025. The group had previously agreed a revised terms of reference and agenda with the aim of reviewing both unexpected and expected deaths, quality of care and learning together. This ensures that as a Group Board 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.

6.2 During the coming months the group will review both organisations respective Learning from Deaths Policies with the intention of having a single policy.

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.

7.0 CCS Unexpected deaths

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

7.2 CCS reported 25 unexpected deaths in quarter 1. These were reviewed at the weekly safety huddle and no additional reviews were required. The child deaths were noted not to be under the trusts care and correctly referred into the CDOP process. The 3 adult deaths relate to people supported with HIV treatment by the integrated contraception and sexual health service (see below).

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 three deaths in this quarter none of these related to HIV care and treatment provided by the Trust. This is a reduction in numbers compared to an annual average figure of 25 deaths.

9.0 NCHC Inpatients data (Unexpected and expected deaths)

Ward	Q1-2024	Q2:2024	Q3:2024	Q4:2025	Q1:2025
PBL	44	73	76	60	52
Caroline House	0	0	0	1	1
Swaffham	6	6	6	4	3
Pineheath Ward	11	9	11	12	12
North Walsham	5	6	6	15	8
Alder Ward	2	1	2	4	7
Beech Ward	0	1	1	1	0
Ogden Court	3	5	7	4	4
Foxley Unit	10	5	7	6	5
Birch/Willow Unit	0	2	3	0	3
Quarter Total	**81**	**108**	**119**	**107**	**95**

9.1 It is noted there has been a decrease in the number of deaths reported across the quarter. This is largely accounted for by decrease in numbers reported at PBL and North Walsham.

9.2 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 Pine Cottage and Caroline House.

9.3 As demonstrated in the table below, metastatic cancer remains the main cause of death for patients on the inpatient areas. Average age of death was 82.3, with the youngest patient being 45 years old and the oldest 96.

Cause	Patient numbers
Metastatic cancer	63
Pneumonia	2
Frailty	2
Heart failure	1
Asbestosis	1
Stroke	1
Dementia	3
Alcoholic liver disease	1
Motor Neurone Disease	1
Small bowel obstruction	1
ESR disease	1
End stage liver failure	1
COPD	1
Not yet documented	17

10.0 NCHC Learning from Deaths Incidents reviewed at the Learning huddle

April Incidents

10.1 Six incident reports were received in this month. Three related to the instigation of resuscitation. Of note was a case on an inpatient unit where the ambulance in attendance requested coroners/police input even though a doctor was on site. This was distressing for the family and has been fed back to the EEAST. One related to a delay in verification of expected death by our staff as no request was made. One related to clinical deterioration at home and patients' death in hospital after correct escalation. One good practice report of care of person with a learning disability who died at PBL.

May Incidents

10.2 Four incident reports were reviewed in May.

10.3 There was one Learning disability notifiable death – no concerns or learning identified for NCHC.

10.4 There was one report of the deterioration of a patient receiving neuro rehabilitation, following review and discussion with family, patient supported with end-of-life care. The review indicated excellent practice and team working.

10.5 There was one report of a complex situation for a community team with the rapid deterioration of the partner of a patient. Our community team stepped in to review and support all involved. SWARM review completed and 'Think family' approach highlighted with team and GP surgery as there may have been opportunity earlier to identify situation and offer support.

10.6 There was one report regarding a patient due to be admitted to a community bed due to their deteriorating condition who died in the ambulance before arriving on the ward. Staff managed the situation with care and compassion providing the patient with dignity in death and supporting the family through a difficult time.

June Incidents

10.7 Three incidents were reviewed in June.

10.8 One related to the expected death of a patient at home, but the mother rang for an ambulance to verify the death. The crew escalated to the coroner/police unnecessarily, this is being followed up with EEAST by the hospice.

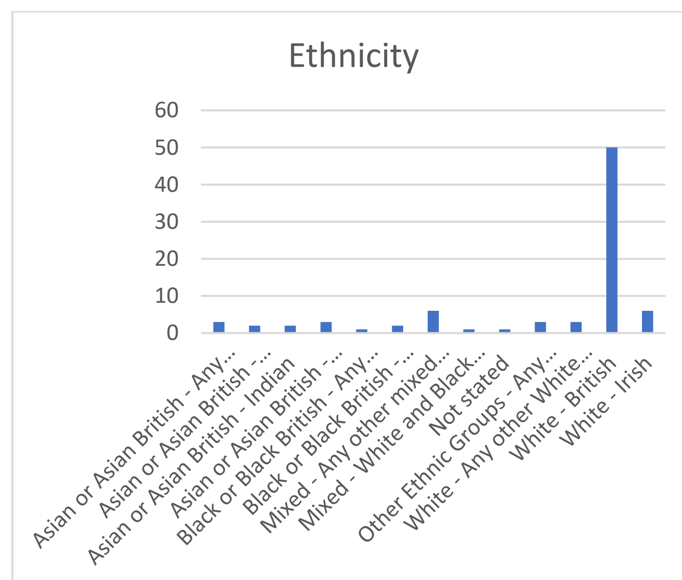
10.9 One raised community safeguarding concern, lack of support and MDT working with GP.

10.10 There were two linked incidents where a palliative patient was discharged home to a very complex environment and safeguarding concerns which impacted on care delivery (hoarding, dirty environment). Team worked hard as an MDT, however identified that silo working may have impacted on ability to respond as quickly as desired. An MDT / round table is planned to include all care providers. Report to be reviewed via Learning from Deaths group in due course.

11.0 Expected deaths reports:

11.1 CCS Luton Community adults

11.1.1 Overview provided of expected deaths within with Luton Adult Community Service. The service provided end of life care to eighty-three people who died within the quarter. Of the 83 patients that died under the care of Luton Adults in Quarter 1, 37 had a preferred place of care documented, 32 had no preferred place of care documented, 10 were undecided and 4 were deemed not appropriate to have this discussion. It is assumed that those patients that have had a discussion regarding their preferred place of death have had this as part of an advanced care planning conversation. 23 of those with a preferred place of care recorded in the Electronic Palliative Care Coordinating Systems (EPaCCS) were documented to have died in this place. However, we are aware from previous detailed analysis that this data is inaccurate and many more die in their preferred place, but this is not recorded in EPACCs.



11.1.2 Work is underway to support more of the diverse population of Luton. The graph above shows that we are capturing this in their data collection. Service lead for Palliative Care is working in collaboration with Co-production on a project to maximise End of Life Care access for Asian Pakistani and Bangladeshi families in Luton.

11.1.3 There is one formal complaint in this quarter. The review of this case is underway and will be fed back to the group in due course.

11.2 CCS Children's Community Nursing

11.2.1 There were five expected deaths within the CCS Children's Community Nursing teams. These cases had advance care plans in place and evidence of collaborative working with the local children's hospices.

11.2.2 There was one unexpected death of a child, this is subject to a coronial review but is unrelated to trust care at the time. Learning will be bought back to the Learning from Deaths group.

11.3 NCHC Children's

11.3.1 There were two expected and planned deaths from the oncology caseload. One death occurred at The Nook children's hospice and one at home. A debrief for both took place including the CCNT. Good practices and learning include working together with The Nook to ensure the child is enabled to stay at home if they choose. A review is underway of the request for frequent line flushes of dying children and how this is not always appropriate. CCS and NCHC teams will look at this together.

12.0 CCS Safeguarding case review

12.1 Safeguarding Team / LeDeR analysis

12.1.1 The Adult Safeguarding Team are currently providing information for 2 LeDeR reviews from the Bedfordshire Luton Milton Keynes (BLMK) area.

12.1.2 There were 27 child deaths this quarter and all correct processes were followed and joint agency responses attended.

12.1.3 Three confirmed teenage suicides plus one suspected. Three of the children were known to mental health services.

12.1.4 Correct recording on Datix is improving. However, only 5% were recorded on the CCS CDOP SystemOne template, so there will be additional work to make this easier to complete.

12.2 NCHC Coroner

12.2.1 There have been some issues with last minute calling of staff to attend inquest and last-minute cancellations in this quarter. A regulation 28 Prevention of Future deaths was sent to the Department of Health relating to an NCHC patient. This raised concerns about unallocated visits and staffing levels.

12.2.2 Previous Themes of learning and actions being taken:

- Mental Capacity Assessments. A MCA audit in progress with results and action plan expected in Quarter two. This has been linked to similar work CCS are doing and being done together.
- Physiological Observations when patient is reporting to be well and may not be symptomatic.
- Regulation 28 PSII in progress with completion projected by the end of August 2025. Learning and actions will be shared at future meetings.
- Support for staff from point of statement request. Policy and staff pack under review, with contribution from frontline staff included.

13.0 Group wide Discussion points

13.1 The integrated group discussed several points which will start to inform further work and discussion as we go forward:

- Subjects for thematic reviews- e.g. themes from complaints like communication
- Could Coroners be attending these meetings regularly.

- Teenage suicides are becoming more prominent, how do we learn from these and support staff in this complex area.
- Further thematic reviews on Ethnicity and health inequalities.
- Discussions took place around adult deaths and meaningful data.
- Invite both Virtual Ward Teams to come to this meeting and think about how this data can be captured better.
- Survey undertaken at Priscilla Bacon Lodge will be shared with all for shared learning.
- Post death, family feedback. PBL participating in an Association with Palliative Medicines Scheme. This will be presented once completed.
- We are keen to seek Medical Examiner's office feedback and build links with these.
- Looking at similar reporting across the whole organisation (Group).
- Looking at a Young People's Group pilot.
- Our participation in a review of patients being admitted to A&E and dying within 24 hours that could have been managed in the community.

14.0 ICB and national themes

14.1 2nd National Analysis SARs by Michael Preston-Shoot

14.1.1 A summary was given. The first analysis took place in 2020 and there are similar themes for the second analysis. The plan is to turn the presentation into a video and upload to the intranet that Teams can share.

14.1.2 Themes from this national review included:

- Practice has improved around record keeping and communication.
- Significance of a Trauma-informed approach
- Impact of Homelessness
- Impact Alcohol and drug use
- No access policy-what is done?
- Escalation and professional challenge
- Gaps in training.

14.1.3 Discussion took place on what next and what can this group do for these 6 points? It was confirmed that the Safeguarding Team review the SARs that come in across the Trust and look at what recommendations and learning have been identified. This will be added onto the agenda of the next Safeguarding Team meeting.

15.0 Key matters and escalations to the Group Trust Board

The first groupwide Learning from deaths started to draw together themes and learning.

15.1 Themes from the meeting:

- Patient feedback.
- Medical Examiner feedback.
- Areas of improvement from the recent SARs analysis.
- Discussions about learning with nutritional equipment and holistic care expectations.
- Advance care planning