NHS
East of England
Community Health and Care
NHS Trust

Agenda item:	9
Date of meeting:	22 July 2026
Report to the:	Trust Board
Title of report:	Learning from Deaths Q4 (2025/26)
Report author:	Liz Webb, Deputy Chief Nurse Corwen Hull, Clinical Director
Executive sponsor:	Chief Nursing and Allied Health Professional Officer
Recommendation:	Note

Assurance level:	**Substantial** ☐ **Reasonable** ✓ **Partial** ☐ **Minimal** ☐
Rationale:	This report of quarter 4 provides assurance that the Trust is seeking to learn from deaths. (National Quality Board (NQB) guidance (2017)) underpins how NHS providers should learn from the deaths of people in their care.

1.0 Executive Summary

This Quarter 4 report has been discussed previously at the Quality Committee (May 2026) and is presented to the board to demonstrate the requirement for the two legacy Trusts; Norfolk Community Health and Care NHS Trust and Cambridgeshire Community Services NHS Trust, to work together to review the deaths of people who we care for. 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

The various reports and discussions that took place at the Learning from Deaths meeting include understanding the impact of health inequalities, and this is an evolving area with work still required to fully understand.

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

No current open risks are related.

4.0 Legal and Regulatory requirements

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

Joint Groupwide Report for Quarters 2 and 3 (2025-26) to Quality Committee (5 February 2026) and Trust Board (18 March 2026).

6.0 Introduction

This is the final quarterly report of the 2025-26 period, which has covered the two Trusts CCS and NCHC working as group. The joint approach to learning from deaths of our patients and the experience of them and their families continues to develop. The focus is shifting to real experience and what qualitative information can tell us. 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 in their lives. 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.
The variation in type and presentation of data is reflective of the different portfolios we have across both organisations. With our merger over time this will be refined to underpin learning and opportunities to improve.

7.0 Group wide Discussion points from the meeting:

7.1 Plan for Learning from Deaths analysis

As part of the development of how the Trust understands the data and experience of those we care for at the end of their lives it was agreed the following approach will be adopted for quarter1 2026. The intention is to balance the data and trends with informative information from other qualitative sources,

a) Continue to Collect and report incidents and trends of deaths to monitor for unexpected changes or anomalies that may highlight a problem in care.
b) Conduct several random clinical case reviews each month of expected deaths (% to be agreed subject to numbers)
c) Maintain unexpected death reviews that meet the national NQB Guidance
d) Streamline the two existing approaches to reviews in previous CCS / NCHC or agree a version for in patient deaths and version for community deaths. Include thematic review quarterly and annually.
e) Proposed Qualitative reviews of the following:

- All compliments- via FFT/IQIVA/DATIX- Norfolk compliment cards
- All complaints- formal and informal related to care at the end-of-life
- Capturing staff reflections
- Medical examiner feedback from families
- Medication errors and delays in administration
- Use of ReSPECT documentation – audit data
- Not recognising end of life care phase so planning is delayed
- Late referrals from primary care or discharge home to die by hospital- what do these cases highlight?
- Our patients admitted to hospital who die within 24 hours

f) Explore how we can talk to people as they are cared for at this stage in life and their families to understand what is positive/good care and what is not? This requires a discussion with patient experience / co-production / research. Questions in the National Audit of care at end of life could help us

7.2 **Project of community outreach with residents of Asian Pakistani origin in Luton**

The population of Luton is known for its cultural diversity. The data we were capturing suggested that not all parts of the community were accessing palliative and end of life care. A co-production led study explored this with the Asian Pakistani community. The findings highlighted that while there was some knowledge of services available, this could be better communicated through groups and publications.

7.3 **Actions and improvements from Regulation 28- Prevention of future deaths**

There were two inquests in Norfolk for which regulation 28 notices were issued to NCHC. The Learning from Deaths group and the Norfolk Service Assurance Group have reviewed these and an action plan is in place. This is wide ranging is incorporated within the community nursing and therapies transformation program.

The Norfolk Adults Safety Action Plan sets out 42 actions across the following key areas:

Areas for improvement:

- Community nursing and therapy model
- Wound care and skin integrity pathways
- Neurological conditions pathways
- Bladder and bowel pathways
- Equipment management and provision
- Consent, capacity and safeguarding
- Documentation and record keeping

Areas for evaluation and review:

- Monitoring and recognising the deteriorating patient in the community
- Quality assurance in community services
- Clinical skills and competencies

The Norfolk Adults Safety Action Plan is held and co-ordinated by the Patient Safety Team and monitored through the Norfolk Adult Assurance and Improvement Group (NAIG) and the Norfolk Adults Service Assurance Committee.

8.0 CCS Unexpected deaths

8.1 Both Trusts review unexpected deaths at their respective Safety/Learning Huddles.

8.2 CCS reported a total of twenty-six unexpected deaths in quarter 4. There were 6 adult deaths reported on DATIX and reviewed at the weekly safety huddle. Four of the adult deaths relate to people supported with HIV treatment by the integrated contraception and sexual health service (8.0 see below).

8.3 There were twenty unexpected neonatal and child deaths were nineteen were noted not to be under the Trust's care and correctly referred into the Child Death Overview Process (CDOP). One case is subject to a patient safety incident investigation (PSII) reviewing a young person's unexpected death and subject to coronial review.

CCS Integrated contraception and sexual health service- HIV deaths

8.4 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.

8.5 There were four deaths in this quarter 4.

8.6 There is an ongoing internal review from quarter 3 of an unexpected death of a patient with HIV. The patient had complex health and social care needs in addition to the HIV diagnosis. There is an inquest pending.

Year to date figures:
13 deaths in the 25 - 26 period.
28 deaths in the 24 – 25 period
29 deaths in the 23 – 24 period.
20 deaths in the 22 - 23 period.

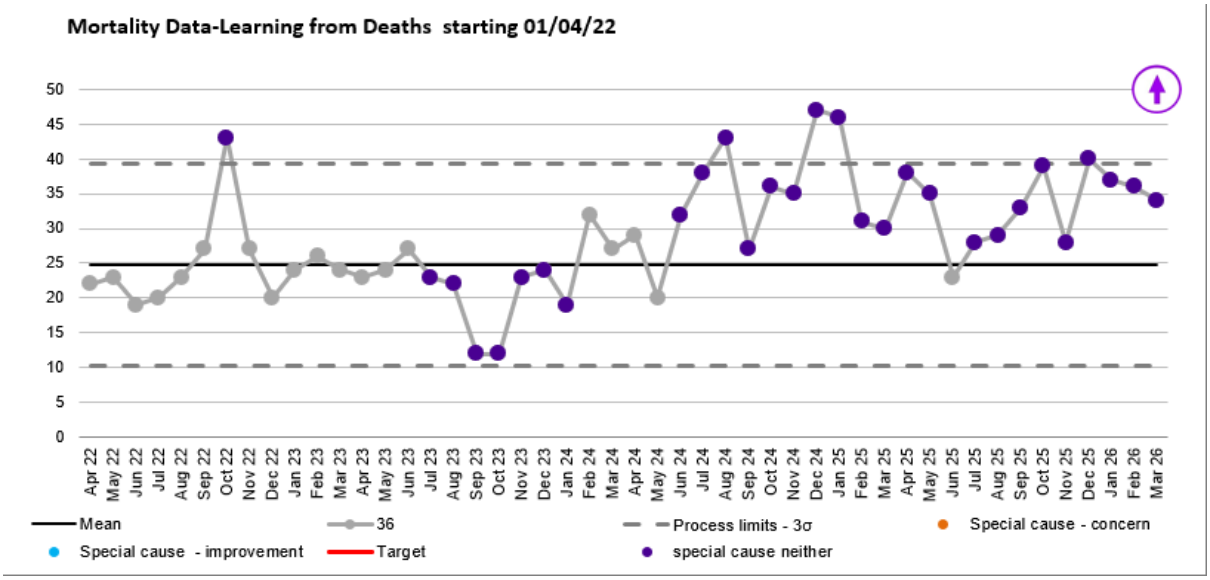
9.0 NCHC Inpatients data (Unexpected and expected deaths)

In Quarter 4 a total of 102 deaths were recorded across the inpatient areas of NCHC.

- Although there has been a small month on month reduction in reported deaths, there is little statistical variation across the reporting period
- As expected, Priscilla Bacon Hospice (PBH) had the highest number of deaths (58 out of the 102 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- March 2026). Table 1.

Table 1



Breakdown of in-patient unit deaths

Ward	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
Specialist Palliative Care				
Patricia Bacon Hospice	52	59	80	58
Specialist units				
Caroline House	1	0	0	0
Beech Ward	0	0	0	1
Pine Cottage	1	0	0	0
General Rehabilitation				
North Walsham	8	7	9	9
Alder Ward	7	4	3	0
Swaffham	0	0	0	8
Ogden Court	4	3	4	7
Foxley Unit	5	6	2	8
Willow Unit	3	1	3	4
Pine Heath	12	8	6	7
Quarter Total	**95**	**82**	**101**	**102**

10.0 NCHC Learning from Deaths Incidents reviewed at the Learning huddle

10.1 Learning huddles reviewed three unexpected in-patient deaths.
These indicated good areas of practice with the management by staff of the deaths at the time and the sensitive way communication with families was managed. The families involved gave positive feedback and thanks to the ward staff for the care and sensitivity shown.

10.2 In the cases where advance care planning and ReSPECT documents were in place the care provided to both the patient and to the family was good. In one case a sudden deterioration and subsequent death required referral to the coroner, in this case the opportunity to contact the next of kin was missed by the ward who had assumed that the paramedics had done it. Follow up learning has been shared.

10.3 In one expected death, the patient had been admitted for rehabilitation following multifactorial falls and admission at NNUH. Patient had extensive medical history with several comorbidities Patient deteriorated and following ACP review, a decision made for escalation to the acute hospital. However, when paramedics arrived and following discussion with relatives' decision made that patient was actively dying, and it would not be in their best interest for escalation. The patient was moved to a side room and anticipatory medication prescribed. The patient passed away peacefully later that evening.

- Due to it being at the weekend ACP review was completed by phone, this can be difficult for ACP to complete and relies upon good documentation and clear communication.
- The role of the MDT including the paramedic team was vital and supported discussions with patients' family and decision making. This is always easier when all present are face to face
- The patient received a peaceful and dignified death with all parties fully involved in the process

11.0 Expected deaths reports

CCS Luton Community adults

11.1 The number of expected deaths in the Luton Adults Service remains stable. There was one unexpected death.

- Quarter 2 -74
- Quarter 3 -68
- Quarter 4- 69

11.2 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.

11.3 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.

11.4 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.

11.5 To aid further learning across Luton adults an analysis of patient's records was selected using the BI dashboard to look at what services were caring for those patients prior to their death. This included those patients who had future planning conversations and those who preferences were not met or discussed. This aims for us to reflect on the "story" behind the patients' journey and aims to identify any learning for Luton Adult services. As previously stated, we always must remember that a patient not dying in their preferred place of care will not always result in a bad experience.

Themes identified

- Good practice and collaborative care were delivered by the Community Nursing Services and Acute Trust.
- 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.
- Good practice and collaborative care were delivered by the Community Nursing Services, Paramedics and BPCS so the patient's preferences were met to be cared for at home.
- A lack of confidence of health professionals recognising the deteriorating / dying patient.
- Challenge of spotting non reversable deterioration in younger people leading to hospital; admission.
- How difficult it can be to identify when a person with advanced dementia and frailty is entering the final phase of life.
- 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.
- Clinical supervision training for selected Band 7's to support clinical supervision sessions for Community Nursing Teams**.**

Children's Community Nursing

Cambridgeshire Children's Community Nursing

11.6 In quarter 4 there were 2 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 both cases

Bedfordshire Children's Community Nursing

11.7 There were 3 expected deaths within quarter 4 within this service. All had advance care plans in place and integrated working with the hospice and acute trusts was evident.

NCHC Children's

11.8 There was one expected death in quarters 4 with several complexities due to the young person's condition. But evidence of good support to family and cross community and hospital working.

11.9 There was one unexpected death in this quarter. One was child with known underlying disease, and complications of an acute infection. Good communication with hospital and community teams.

12.0 Safeguarding children case reviews

12.1 There were 37 deaths in this 6-month period (22 children and 15 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). The new child death S1 template has now been launched within CCS, and this has seen an increase in the use of this template. This quarter there has been 40% of child deaths where this template has been completed correctly.

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:

- Thirty-seven child deaths this quarter (22 children and 15 neonates). Increase for Cambridgeshire and Peterborough.
- Four sudden unexpected deaths, all fit and well - joint agency attended.
- Still waiting to attend Coroner's Court in Norfolk (from 2019 death).
- This quarter submitted an IMR for historic domestic homicide – legal services are supporting.
- A lot of complex child deaths this quarter and staff are being supported.

13.0 CCS LeDeR reviews

The safeguarding team attended 6 LeDeR meetings across the Trust within Q4 and the following themes were identified as concerns:

- Epilepsy
- Known safeguarding concerns
- Obesity
- Aspiration pneumonia

14.0 Coroner cases

NCHC

14.1 There have been eight coroner inquests in Q4 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.

- Actions identified for review of the VTE Policy.
- Clearer processes and shared understanding regarding responsibility for referrals to specialist hospitals.
- There was a missed opportunity to escalate a deteriorating wound sooner.
- Challenges in SPOC / triage where multiple calls had come in for the same patient within a short time – this delayed a medication STAT dose.

CCS

14.2 There were no requests for information in Q4.

15.0 Key themes and Learning points

The Q4 meeting included discussion and planning on how to capture positive feedback and patient outcomes in the review process. As outlined in section 7.1, the members of the group will commence using the criteria described to add further depth to the learning from deaths review process.

16.0 Key matters and escalations to the Trust Board

- Finalising the Learning from Deaths Policy, due end quarter 1.
- Kay Adjei, Co-Production Lead attended the meeting and gave a presentation on the End-of-Life Engagement Project. This was a good piece of work and will inform what we need to do going forward about engagement with our service users.
- Learning from Coroner's inquests and how we take this forward.