Appendix 4 Quarterly report on Learning from Deaths

1. This report forms part of the requirement to report on the review of deaths. The analysis refers to Q1 (April 2018 to June 2018). Deaths in adult services in Luton Community Services were reviewed.

2. 127 deaths were reported on SystmOne in Luton during Q1. 68 of the patients who died were females and 79 were males. There were no deaths reported on DATIX for Q1.

3. The age breakdown is as follows:

Age band	40 & under	41-50	51-60	61-70	71-80	81-90	91-100	100 & over	Total
Females	1	1	2	5	14	22	10	1	68
Males	0	1	3	12	19	22	2	0	59

The screening tool of the Learning from Deaths Policy was used to analyse SystmOne. Sixty clinical records were reviewed from the 127 deaths.

4. The key findings from the review are:

4.1 All the deaths were expected as per the definition in section 4.1 of the policy. None of the deaths reviewed met the criteria in section 5.3 of the policy. However, it was difficult to see if any of the patients had a learning disability as this status is not recorded on SystmOne. This is noted in the learning section of this report.

4.2 There was evidence of good collaboration between acute services notably Clinical Navigator Team (CNT) in A&E, as well as with patients's GPs.

4.3 Good coordination between the District Nursing and Hospice services enabled a patient to be transferred timely into an inpatient bed.

4.4 The assessment and care delivered were well documented for each patient. There were numerous instances where it was noted that the family members or relatives were involved in communication and their wishes met. For example, the staff responded generally well to family requests for visits and for pain management.

4.5 There was evidence of very good communication between the community teams and the GPs.

4.6 Where the patients were eligible for the Gold Standard Framework, this was well documented. The GSF is a process for supporting the patients and their families through physical symptoms control e.g. anticipatory drugs for pain and sickness; patient choice for place of care; support and information and the community & primary care team working well together for the patient.

4.7 Of the 60 deaths reviewed, 40 were on GSF; 31 died in their preferred place of deaths; in 7 cases, it was noted that relatives / patients refused to discuss the matter. All cases reviewed had the place of death recorded.

4.8 Of the 20 non-GSF patients who died, 8 died at home, 7 in hospital, 1 in a hospice, 2 in a residential home and 2 in a nursing home. Those who attended hospital were because they became acutely unwell and were admitted for symptoms management.

4.9 The 2 cases where it was documented that they had declined to discuss preferred place of care, both died in hospital.

4.10 One patient was discharged from the district nursing service 1 month prior to a sudden collapse at home. The case was referred to the coroner for clarification of cause of death. It is recorded that there were no clinical concerns raised when the patient was last visited by the CCS service.

4.11 The good practice noted included:

- The ability to communicate with the patient / relatives or when an interpreter is required.
- Psychological issues were recognised and appropriate interventions provided
- Evidence of planning noted with the provision of anticipatory medications
- Heart failure specialist team involved on 2 occasions
- Staff offered advice on bereavement and made calls following the deaths to enquire of the families
- A care home patient experienced difficulty in registering with a local GP, CCG were made aware by senior CCS management who supported the care home staff and patient.
- One occasion a paramedic called to a patient at home contacted the service and concerns discussed. Patient remained at home supported by community services.
- In one case Pharmacy Technicians were involved and supported District Nursing in medicine management in the patient's home.
- Evidence of the Welfare Benefits service being used on several occasions
- Dept. of Health Fast Track funding ("evidence of rapidly deteriorating condition entering a terminal phase") used appropriately to support patients in their care at home.

4.12 The learning points from the review included:

- GSF should be considered for all eligible patients
- Preferred Place of Care discussion should be offered to all patients and recorded
- Improved knowledge of care of leaking nephrostomy tube in an End of Life patient required and this guidance is being prepared.
- There were no notifications about Learning Disability on the records reviewed. A discussion with the staff including the SystmOne technical staff on how to know and record the LD status of patients
- Evidence that staff did prioritise end of life care visits with one patient receiving timely symptom management in the out of hour's period.

5. An update on the actions from the previous two reports.

- The Learning From Deaths screening tool has been shared with the staff. There are ongoing discussions about the timing of the review to ensure that there is no backlog reviews.
- The Standard Operating Procedure for prioritising urgent clinical needs include the needs of patients who are nearing end of life will be discussed with staff.
- This report (and future reports) will be discussed at meetings with staff. A review of meeting governance is underway and this item will be part of the agenda for future staff meetings.
- The End of Life policy has been updated.

6. The next steps are:

6.1 to share the findings from this quarterly review with all clinical staff in the adult services in Luton

6.2 to ensure that the review is ongoing at the end of each month, involving staff who provide End of Life care

6.3 to review Learning From Deaths in all services in the Trust.

Author
Hussein Khatib
June 2018.