NHS
Cambridgeshire
Community Services
NHS Trust

TRUST BOARD

Title:	**Learning from Deaths Report**
Action:	**For noting**
Meeting:	**16th September 2020**

Purpose:

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. The information and learning is overseen by our Learning From Deaths Group.

This National Guidance required Trusts to:

- ✓ Have Learning from Deaths Policy approved and published by the end of September 2017 which reflects the guidance and sets out how the Trust responds to, and learns from, deaths of patients who die under its management and care. The policy should also include deaths of individuals with a learning disability and children.

- ✓ Publish information on deaths, reviews and investigations via an agenda item and paper to public Board meetings.

- ✓ Have a considered approach to the engagement of families and carers in the mortality review process.

- ✓ Publish evidence of learning and actions taken as a result of the mortality review and Learning from Deaths process in the Trust's Quality Account from June 2018.

Level of assurance gained from this report - substantial

Recommendation:
The Committee is asked to note the contents of the report and agree the level of assurance that can be taken from the detailed analysis of activity and learning in the report.

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Executive sponsor:	David Vickers	Medical Director

Trust Objectives

Objective	How the report supports achievement of the Trust objectives:
Provide outstanding care	Report details learning and required activity relating to people who die under our care.
Collaborate with others	Identifies when collaboration has been undertaken.
Be an excellent employer	Learning from the Learning from deaths supports staff safety and overall level of practice.
Be a sustainable organisation	On-going learning and compliance with standards.

Trust risk register
BAF risk 3166– There is a risk that patients and service users do not receive outstanding care if services fail to remain compliant with CQC Fundamentals of Care Standards (Risk rating 8).

Legal and Regulatory requirements:
As above

Previous Papers:

Title:	Date Presented:
Learning from Deaths Board Report	15th July 2020

Diversity and Inclusion implications:

Objective	How the report supports achievement of objectives:
To re-launch the Trust Staff Diversity Network and, where staff indicate a desire, to establish protected characteristics specific sub networks. The Networks to be a forum for staff to share experiences, review the Trust Diversity and Inclusion Policy and practices and to give feedback and suggestions on how the Trust can support its diverse workforce and seek to eliminate any bias.	N/A
To introduce reverse mentoring into all our in house management and leadership development programmes, to promote diverse leadership through lived experiences.	N/A
We will measure the impact of our virtual clinical platforms, ensuring that they are fully accessible to the diverse communities we serve.	This is applicable in the context of covid19 and care at the EOL. The report highlights good practice. But also highlights our role as experts within iCaSH to ensure all individuals have the same access to care and work with our partners to understand the needs of individuals with protected characteristics.
We will ensure that the recruitment of our volunteers are from the diverse communities they serve.	N/A

Are any of the following protected characteristics impacted by items covered in the paper

Section 6.0 HIV deaths; suggests that late diagnosis of HIV by partner services remains an on-going issue, which the iCaSH services are working with commissioners and primary colleagues.

Age	Disability	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
☐	☐	☐	☐	☐	☐	☐	☐	X

1. INTRODUCTION

1.1 In line with the Board's current cycle of business, a Quarter 1 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).

1.2 This report was presented and reviewed by the Quality and Safety Committee (September 3 2020). It is produced by specialist from each of the trusts directorates and compiled by the Deputy Chief Nurse.

1.3 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. This report also describes the work done with partners in the wider system to respond to the covid19 pandemic and planning and response around end of life care.

LEARNING FROM DEATHS QUARTER 1

2. Luton Adult Services Quarter 1 Report

2.1 The review of deaths has been carried out according to the general principles laid out in the Trust's Learning from Deaths Policy.

2.2 Data was obtained by the Trust Informatics Team which was generated from SystmOne of patient deaths that occurred in the review period for those patients who had open episodes of care with CCS Luton Adult Unit at the time of their death. The NHS numbers in the sample list were used to access SystmOne records.

2.3 For each patient record, the following information was reviewed

- Died under the care of CCS Luton Adult Unit (Y/N)
- Age
- Gender
- Use of End of life care (EoLC) SystmOne template (Y/N)
- End of life planning in place
- Preferred place of death (PPD)
- Actual place of death
- Reason PPD not met

2.4 The review has been broken down by month looking specifically if patients died in their preferred place of death (PPD) and if their usual place of residence was either a nursing home or residential care home

2.5 This quarter included the initial months of the coronavirus pandemic and the report includes an overview of the system wide work that was undertaken to support the care of patients at home during the pandemic

2.6 The following were not reviewed this quarter
- Anticipatory medications given
- Continuous subcutaneous infusion (syringe driver) needed

2.7 The number of patients who were recorded as having died under the care of a CCS Luton Adult Unit between April-June 2020 was 165 but 45 were not known to a clinical team so have been removed from this review.

2.8 Therefore a total of 120 patients died in Luton recorded as being under the care of a clinical team at the time of their death. These records were reviewed

3. Results By Month

April 2020

3.1 81 patients died under the care of CCS in April 2020. Of these 21 patients were not under the care of a clinical team at the time of their death. For this report the records of these patients have not been reviewed.

3.2 Of the 60 remaining patients their preferred place of death (PPD) was reviewed

- 32 patients expressed a preference for their preferred place of death
- 30 who patients expressed a preference for their preferred place of death and achieved it
- For the 2 patients who did not die in their preferred place of death the reasons are detailed below:
- 1 patient whose preference was to die in the hospice died at home as they were too unwell to transfer to the hospice and family were happy to support them to die at home
- 1 patient whose preference was to die in their nursing home died in hospital as nursing home staff were concerned and they were admitted to hospital

3.3 In total 94% patients who had expressed a preferred place of death achieved their wish

3.4 Of the remaining 28 patients

- 12 patients were unable to express a preference or their preference was not known or they declined to express a preference died in their usual place of residence
- 16 patients did not have a preference recorded and died in hospital
- Usual place of residence
- 8 patients lived in nursing home
- 19 patients lived in residential care home

May 2020

3.5 46 patients died under the care of CCS in May 2020. Of these 15 patients were not under the care of a clinical team at the time of their death For this report the records of these patients have not been reviewed.

3.6 Of the 31 remaining patients
- 18 patients expressed a preference for their preferred place of death
- 16 patients who expressed a preference for their preferred place of death and achieved it

- For the 2 patients who did not die in their preferred place of death the reasons are detailed below
- 1 was too unwell to be transferred from hospital to home
- 1 had been admitted to hospital by GP with shortness of breath and died during that admission

3.7 In total 89% patients who had expressed a preferred place of death achieved their wish

3.8 Of the remaining 13 patients

- 4 patients were unable to express a preference or their preference was not known or they declined to express a preference died in their usual place of residence
- 9 patients did not have a preference recorded or declined to express a preference died in hospital
- Usual place of residence
- 1 patient lived in nursing
- 8 patients lived in residential care home

June 2020

3.9 38 patients died under the care of CCS in June 2020. Of these 9 patients were not under the care of a clinical team at the time of their death. For this report the records of these patients have not been reviewed.

3.10 Of the 29 remaining patients

- 24 patients expressed a preference for their preferred place of death
- 21 patients who expressed a preference for their preferred place of death and achieved it
- For the 3 patients who did not die in their preferred place of death the reasons are detailed below
- 1 patient whose preference was to die in the hospice died at home as they were too unwell to transfer to the hospice and family were happy to support them to die at home
- 1 patient whose preference was to die at home died in hospital while safe discharge was being planned
- 1 patient died in hospital following an admission for an acute event
- In total 88% patients who had expressed a preferred place of death achieved their wish
- Of the remaining 5 patients
- 2 patients were unable to express a preference or their preference was not known and they died in their usual place of residence
- 3 patients did not have a preference recorded and died in hospital
- Usual place of residence
- 4 patients lived in nursing home
- 4 patients lived in residential care home

Overview

3.11 Total of 120 patients died under the care of a clinical team during the quarter

Advance care planning

- 74 patients had evidence of an advance care planning conversation
- For 71 of those their preferred place of death was known and recorded
- 67 patients achieved their PPD

3.12 For the community services this quarter 91% of patients who had expressed a preferred place of death achieved it

3.13 46 patients had no recorded evidence of advance care planning conversations or were unable to express a preference .Of these 18 died in their usual place of residence 28 died in hospital

4. Coronavirus Pandemic

4.1 This quarter covers the initial months of the coronavirus pandemic which saw changes across the whole health and social care system working more collaboratively to ensure patients and families continued to be supported.

4.2 The Trust's adult teams were key contributors to the systemwide work that was undertaken during this quarter.

4.3 This work led to the development of the following:

- Specific guidance for management of coronavirus symptoms
- Review of current practice around anticipatory medication which led to an increase in medication stocked within community pharmacies and access to a dispensing pharmacist across 24 hour period if needed
- Development of 'grab bags' of drugs held in GP out of hours services
- Additional training for both CCS staff and care home staff to enable the verification of an expected death to be undertaken by community staff
- Provision of information for GPs to support advance care planning conversation
- Development of guidance for family members caring for loved ones at home which included advice on use of PPE and the provision of PPE for family members as needed.

5. Themes arising from the review

5.1 Despite this being a challenging quarter for across all services the community services were able to continue to support patients to die in their preferred place of death. Where advance care planning conversations are not offered to patients the majority of patients will die in hospital and this is evidenced by this report. As services stabilise the Macmillan Palliative Care lead nurse is reviewing ways of increasing the confidence of CCS staff to initiate advance care planning conversations and ensuring these are recorded. During the quarter there had been no incidents or complaints linked to end of life care received by the Trust

Castletroy care home

5.2 Luton SAB is conducting a SAR In-Rapid-Time to learn from the response of all partners to the outbreak of Covid-10 in Castletroy care home. Sadly there were 15 residents deaths between 28/03/20-12/04/20 this was at the peak of the Covid pandemic and frequent guideline refinement of discharge to care homes and PPE. There is no suggestion of abuse or neglect within Castletroy.
A summary report & learning will be provided to the next meeting.

6. HIV Deaths

6.1 In the period January-July 2020 there were 4 HIV deaths reported via iCaSH. This is the first period in the history of the Learning from Deaths review process that any HIV deaths have been reported.

Patient 1 Late diagnosis – July 2020

The patient was a 70 year old man who was referred to iCaSH early May 2020 following a positive HIV test which was done by the hospital Respiratory Team. The patient had been referred to the Respiratory Team by the GP with weight loss, loss of appetite, dysphagia, general deterioration, multiple skin infections and had been unwell for over 12 months. His partner was tested for HIV and is also positive. By the time the HIV diagnosis was made the patient had late HIV, with a very low CD4 count. He was started on HIV medication in iCaSH Mid-May. He was then transferred for specialist HIV care in the regional centre at Addenbrookes. Unfortunately the patient passed away in 22nd July.

6.2 A review of this case did not identify any omissions in the care delivered by iCaSH, however this is considered a late diagnosis and has been shared with the local commissioning authority to feed into the system review of late diagnosis and support the further learning around primary care screening for HIV earlier in the assessment of patients. This is an ongoing area of learning and stream of work that iCaSH experts are supporting.

Patient 2 – May 2020 Covid19

iCaSH informed that a patient had been admitted to ICU with a COVID 19 diagnosis. This gentleman had a number of other co-morbidities including renal failure. Patient was still taking his HIV medication with good CD4 count and Viral Load. Death certificate issued as COVID 19 related death.

6.3 A review of this case did not identify any omissions in the care delivered by iCaSH, liaised closely with the hospital to support HIV management whilst they remained an inpatient. It is unclear if people living with HIV who have well managed CD4 count and viral load are at any more risk of serious consequences when contracting covid19

Patient 3 –April 2020 Covid19

This was a lady had positive HIV test in early 2018. From April 2020 she was an inpatient in an acute hospital and close liaison between iCaSH regarding best options for HIV management plan. It was noted that this patient has multiple comorbidities, including Diabetes, Sleep apnoea, previous DVT and very high BMI. Patient died from COVID 19 pneumonia

6.4 A review of this case did not identify any omissions in the care delivered by iCaSH, liaised closely with the hospital to support HIV management whilst they remained an inpatient

Patient 4 January 2020

This 65 year old patient has been HIV positive since 1998 and was stable from the HIV point of view with a negative HIV viral load. However had other comorbidities including, chronic pancreatitis, squamous cell carcinoma of lung with right middle lobe collapse and coronary artery disease with stents. Died of cancer January 2020.

6.5 A review of this case did not identify any omissions in the care delivered by iCaSH, liaised closely with the hospital to support HIV management whilst they remained an inpatient.

PHE has partnered with British HIV Association (BHIVA) to roll out an annual National HIV Mortality Review. They are asking clinicians to submit enhanced data on HIV patients attending for care at their service who died, or HIV patients attending elsewhere who died at their hospital using this form: https://snapsurvey.phe.org.uk/nationalHIVmortalityreview

7. Children

7.1 Child death data was not reviewed at this meeting as agreed previously. Recorded data of child deaths is currently being reviewed to incorporate both expected and unexpected child deaths. A full report will be provided for the next meeting.

End of report