East London NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE
17 September 2019

Title	**Learning From Deaths Annual Report**
Reporting period	**1st April 2019 31st March 2020**
Author(s)	Kim MacGillivray, Mortality Reviewer Abiola Ajayi-Obe, Associate Director Risk and Governance
Accountable Executive Director	Dr Paul Gilluley, Chief Medical Officer

Purpose of the Report:

- To inform the Board of themes and trends from all reported deaths during the reporting period.
- To inform the Board of all LeDeR deaths
- To inform the Board of deaths reviewed at Coroner's inquests
- To inform the Board of any trends or concerns from reported deaths within this period.
- To update the Board on the Learning from Deaths Panel's planned focus for 2020/21

Summary of Key Issues:

- There were 1931 deaths (1601 expected and 330 unexpected) reported by the Trust between 1 April 2019 and 31 March 2020.
- Of the 1601 Expected Deaths reported 814 were subjected to the SJR process
- Of the 330 unexpected deaths, 69 were subject to the SI process.
- There were 12 reported deaths of patients with Learning Disabilities. Of which 8 were subject to a Learning Disability Mortality Review (LeDeR). Two were subject to an ELFT Serious Incident Patient Safety Review (SIR) both concluded that neither death could have been prevented. The remaining two were subject to a 48 hour report.
- The highest number of deaths overall during the reporting period was in Community Health Services with 1328 reported.
- There were 118 Inquests held and concluded during the reporting period.
- 30 deaths were classified by Coroner's conclusion as being caused as a result of suicide
- 1 Prevention of Future Deaths report was issued to the Trust during the reporting period.

Strategic priorities this paper supports (Please check box including brief statement)

Improved patient experience	☒	The purpose of this report is to update the Board on the themes and trends identified as a result of learning from deaths reviews
Improved health of the communities we serve	☒	Summarises themes where the aim is to learn lessons to improve the health of the communities we serve and deliver requested end of life care pathways
Improved staff experience	☒	The purpose of this report is to update the Board on learning from deaths investigations and lessons learnt by staff to improve their working experience.
Improved value for money	☐	There are no financial implications

Committees / Meetings where this item has been considered:

Date	Committee / Meeting
August 2020	Learning from Deaths Committee

Implications:

Equality Analysis	This report will have no impact on equalities
Risk and Assurance	This report outlines actions taken following investigations to improve the safety of patients and quality of care we provide.
Service User / Carer / Staff	This paper has implications for staff service users and carers.
Financial	Any financial implications of recommendations from the investigations are highlighted but discussed in other forums.
Quality	This report outlines actions taken following investigations to improve the safety of patients and quality of care we provide.

Supporting Documents and Research material

a) National Quality Board Guidance on Learning from Deaths 2017
b) Learning Disability Mortality review (LeDeR) 2017
c) ELFT Serious Incidents Policy
d) NHSE SI framework 2015

Glossary

Abbreviation	In Full
CHN	Community Health Newham
Corporate Reviews	Serious Incident investigations led by a corporate SI reviewer together with a co-reviewer from the locality.
ELP	End of Life Pathway
LeDeR	Review of deaths into Learning Disabled Patients
Panel Led investigations	Investigations into the most serious of incidents (e.g. homicide) which are led by an independent reviewer together with an independent clinician and a lead nurse.
PPC	Preferred Plan of Care
SIR	Serious Incident Review
SJR	Structured Judgement Review
HTT	Home Treatment Team
LRTI.	Lower Respiratory Tract Infection

1.0 Introduction

1.1 In March 2017 the NHS Quality Board issued national guidance on Learning from Deaths. This required Trusts to put in place a policy setting out their approach to mortality review and to publish data relating to deaths.

1.2 The Trust has one full time Mortality Reviewer (MR) and a Mortality Administrator Apprentice. The Mortality Reviewer undertakes structured judgment reviews (SJR's) for all East London Foundation Trust (ELFT) managed expected deaths and 25% of hospital and care home deaths. The Trust Mortality Administrator is responsible for the collection, analysis and reporting of data. The roles sit within the Governance & Risk Department working closely with incident review colleagues and are overseen by the Trust's Learning from Deaths Review Panel

1.3 The Learning from Deaths Review Panel consists of the following:

Dr Paul Gilluley (Chief Medical Officer/Chair)
Lorraine Sunduza (Chief Nurse)
Abiola Ajayi-Obe (Associate Director of Governance & Risk)
Duncan Hall (Incidents &
Complaints Manager)
Kim MacGillivray (Mortality Reviewer)
Kanwal Zohra (Mortality Administrator)
Dr David Bridle (Consultant Psychiatrist and Medical Director)
Dr Ben Braithwaite (Clinical Director)
Ruth Bradley (Director of Nursing- Integrated Care)
Ruth Cooper (Strategic Lead for Learning Disability and Autism, and Interim Associate Clinical Director for Services for People who have a Learning Disability)
Sanjay Nelson (Consultant Psychiatrist and Clinical Director for LD)

2.0 Background

2.1 In December 2015, the secretaries of State for Health commissioned the Care Quality Commission (CQC) to carry out a review of how acute, community and mental health Trusts across the country investigate incidents and learn from deaths. This was to find out whether opportunities for preventing deaths have been missed, and identify any improvements needed.

2.2 The NHS Quality Board national guidance was followed in July 2018 with specific guidance for NHS Trusts on working with families and carers. This was co-produced with families and carers to provide Trusts with advice on how they should support, communicate and engage with families following the death of someone in their care.

2.3 Whilst the guidance from the National Quality Board makes it clear that Trusts should report on inpatient deaths and those inpatients that have died within 30 days of leaving hospital. Locally Trusts are able to determine their own individual approaches to undertaking mortality reviews including definitions of deaths in scope for review.

Consequently, Mortality data is therefore not comparable between Trusts. As such the Trust will continue to evolve its processes and refine reporting over time in accordance with local and national learning. This is in addition to the detailed reporting and investigation of deaths meeting the national criteria for serious incident review.

3.0 Learning from Deaths Review Process

3.1 ELFT reviews 100% of all expected deaths of Community Health and Mental Health patients in contact with ELFT services at the time of their death. These are subject to a Structured Judgement Review (SJR), a process to effectively review the care received by patients who have died. It also aims to improve learning and understanding about problems and processes in healthcare that are associated with mortality and share best practice. 1 in 4 hospital or care home deaths are also reviewed via this process.

3.2 Trends and themes are reported to the Learning from Deaths Panel. Any SJR that reveals any concerns around care provision, service provision, or identifies issues which may have contributed to the death of a service user or patient will be presented to the Learning from Deaths Panel and be reviewed via a serious incident Root Cause Analysis investigation.

3.3 Unexpected deaths in ELFT are directed to the Serious Incident Review (SI) team and are subject to either a panel led or corporate led investigation.

3.4 All Learning Disability Deaths (LeDeR) in ELFT are allocated to the mortality reviewer who is also trained in root cause analysis. These findings are reported to NHS England and Bristol University.

4.0 Learning from Deaths Review Statistics

4.1 <u>Total deaths</u>

A total of 1931 deaths were reported by the Trust between 1 April 2019 and 31 March 2020, of which 1601 were expected and 330 were unexpected. 69 unexpected deaths were subject to the SI process.

5.0 Expected Deaths

5.1 Structured Judgement Review Process

The application of a Structured Judgement Review (SJR) is to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. At ELFT, SJRs are carried out by Mortality Reviewers who examine the last 6 months of care provision provided to patients/Service Users (SU) prior to their death.

Any death that has been clinically assessed using a SJR of case records and is more likely than not to have resulted from problems in care provision will be raised and discussed at the monthly Learning from Deaths Panel.

5.2 Identified concerns from SJR of a death due to a problem in care

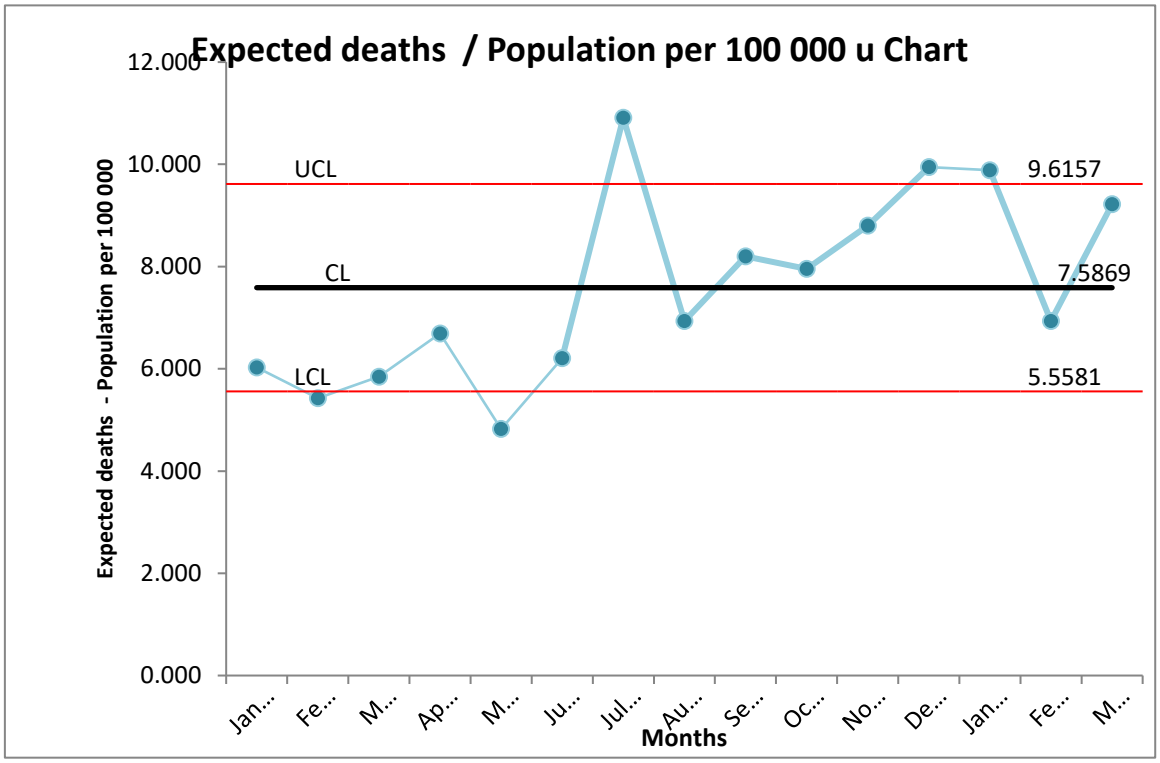
Where there are any concerns identified as a result of a SJR review into a death the panel will request a 48 hour report from the directorate/service to provide additional background information into the care and treatment of a patient /service user whilst under ELFT services.

Any case which requires further investigation will be subject to a Serious Incident (SI) Review and will be investigated by the ELFT SI Team.

A total of 1601 expected deaths were reported Trust-wide between 01 April 2019 and 31 March 2020.

Chart 1 below shows the data on expected deaths Trust-wide since the start of collection in January 2019. A total of 1888 patient had expected deaths during the period. Between April 2019 and March 2020, the reporting period, a total of 1601 patients died expectedly.

Chart 1. Expected deaths Trust-wide January 2019 until March 2020



2019 - 2020	Expected deaths	population per 100,000
Jan-19	100	16.59
Feb-19	90	16.59
Mar-19	97	16.59
Apr-19	111	16.59
May-19	80	16.59
Jun-19	103	16.59
Jul-19	181	16.59
Aug-19	115	16.59
Sep-19	136	16.59
Oct-19	132	16.59
Nov-19	146	16.59
Dec-19	165	16.59
Jan-20	164	16.59
Feb-20	115	16.59
Mar-20	153	16.59

Table 1. Breakdown of expected deaths by Directorate

Breakdown of expected deaths by Directorate	Total
Mental Health Services	
Bedfordshire Mental Health Services	109
City and Hackney Mental Health Services	24
Forensic Services	1
Luton Mental Health Services	31
Newham Mental Health Services	47
Tower Hamlets Mental Health Services	50
Community Health Services	
Tower Hamlets Community Health Services	518
Newham Community Health Services	428
Bedfordshire Community Health Services	382
Specialist Services	
Specialist Services and CHN Children's Services	11
Total :	**1601**

Mental Health Services reported 262 expected deaths, 16.36% of the total 1601 reported between 1 April 2019 and 31 March 2020. Bedfordshire reported the highest number of expected deaths in the Trust's Mental Health Services at 109 in the reporting period, 41.6% of the 262 total reported in Mental Health Services. Higher figures in Bedfordshire can be explained by the larger population size; population age and physical health related deaths

related to people accessing services such as Memory clinics and Older Persons Occupational Therapy.
There were 11 expected deaths in Specialist Services, Children's Services and different therapies. Forensic Services reported one death in the reporting period.

Community Health Services across the Trust reported a total of 1328 expected deaths. Tower Hamlets Community Services reported the highest number with 518 deaths. This could be explained by the Directorate reporting a backlog of deaths at the end of June 2019 and the beginning of July 2019.

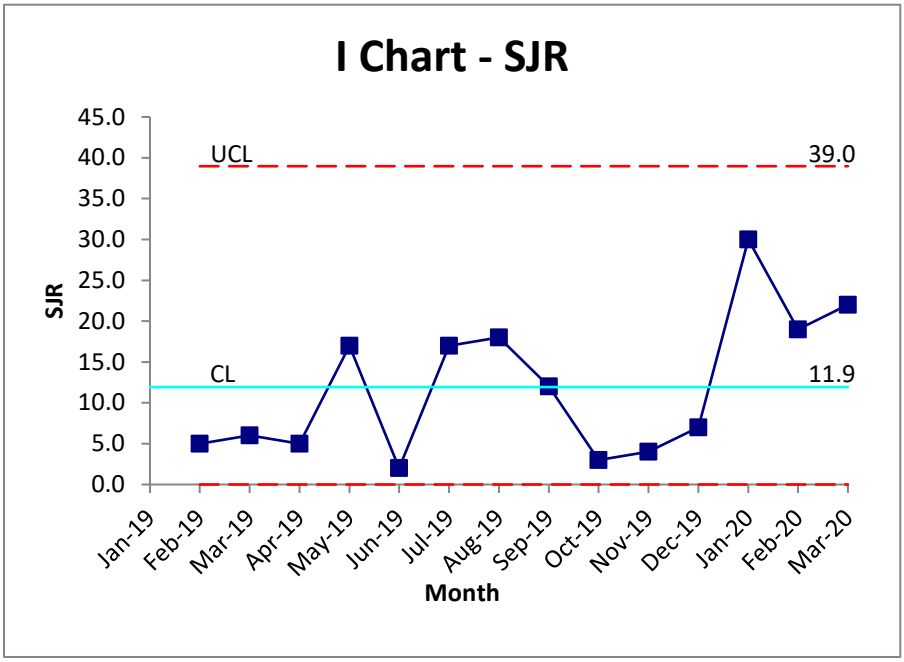
5.3 Deaths reviewed under the SJR Process

A total of 814 SJR's were carried out between 01 April 2019 and 31 March 2020.

Table 2. Number of deaths by Mental Health and Community Health subject to an SJR by Directorate

Community Health & Mental Health deaths subject to an SJR	Total
Mental Health Services	
Bedfordshire Mental Health Services	47
City and Hackney Mental Health Services	18
Forensic Services	0
Luton Mental Health Services	20
Newham Mental Health Services	24
Tower Hamlets Mental Health Services	23
Community Health Services	
Tower Hamlets Community Health Services	237
Newham Community Health Services	198
Bedfordshire Community Health Services	238
Specialist Services	
Specialist Services and CHN Children's Services	9
Total	**814**

Chart 2. Structure Judgement Reviews



2018 - 2020	SJR	Population per 100 000
Jan-19	66	16.59
Feb-19	71	16.59
Mar-19	65	16.59
Apr-19	70	16.59
May-19	53	16.59
Jun-19	51	16.59
Jul-19	68	16.59
Aug-19	50	16.59
Sep-19	62	16.59
Oct-19	59	16.59
Nov-19	63	16.59
Dec-19	56	16.59
Jan-20	86	16.59
Feb-20	67	16.59
Mar-20	89	16.59

814 deaths were reviewed in the reporting period, 132 of which were expected deaths across Mental Health Services. These patients were also receiving physical health care; palliative care or end of life care. Patients whose expected deaths resulted in a structured judgement review tended to be older and accessing Mental Health Services such as the Memory Clinics and therapies. Many of the older Mental Health Service users were also under continence; podiatry and diabetic services.

Overall expected deaths were higher in Community Health Services as they include more over 65's, older and terminally ill patients and patients in receipt of palliative or end of life care. Within this cohort of patients, the highest number of deaths arose in patients with cancer and organ failure. Cancer related deaths were higher in all age ranges as was deaths from organ failure. Older patients also died from causes related to end stage dementia

Patient Story – Ann *(pseudonym)*

Ann was a 56 year old lady who was under the Bedfordshire Community Health Services. She had been diagnosed with a spinal cord tumour and was being seen at home twice daily by the Community Nursing Team for palliative support and syringe driver management; she had a Gold Standard Framework End Of Life Plan in place.

Ann lived at home with her husband and family who were very supportive and involved in her care. There was good communication between the family and the nursing team, referrals were appropriate and the patient was continuously assessed. Nursing support increased to 4 visits per day as the patient neared the end of her life.

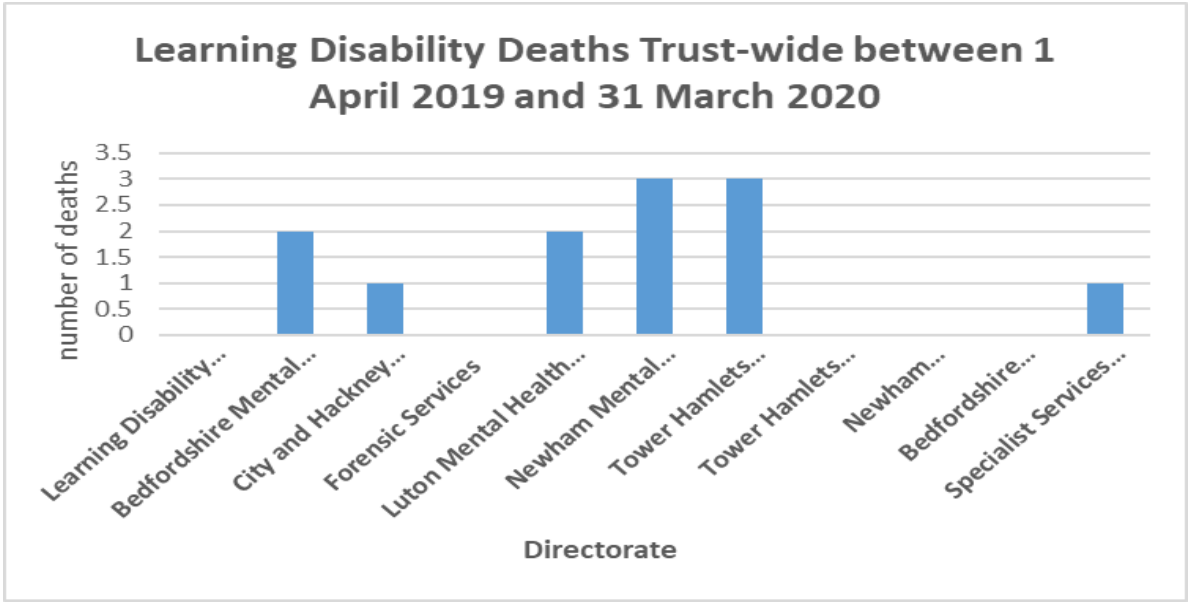
Care plans were in place for SSKIN, GSF and syringe driver management. There was evidence that the patient's skin was monitored very closely. Regular medication was discontinued and end of life pain control was commenced via syringe driver as the patient entered the end of life phase and could no longer swallow oral medication.

Care in the last days of life was appropriate to the Gold Standard Framework criteria and guidelines.

6.0 Deaths reported to the Learning Disability Mortality Review (LeDeR)

6.1 12 deaths were reported where the patient had a learning disability between April 2019 and March 2020, with 8 patients registered under a learning disability service and were reported to LeDeR. There were 4learning disability deaths subject to the SI process, two were reviewed as 48 hour reports and two were escalated to SI and reviewed. Conclusions were that these patient deaths although predicted could not be prevented.

Chart 3. Learning Disability Deaths by Directorate between 1 April 2019 and March 2020



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Patient Story - Jim (*pseudonym*)

Jim was a 41 year old man known to the Learning Disability services and had been under the care of ELFT) for a number of years.

He had a diagnosis of schizophrenia and a Learning Disability. He was seen at home on a fortnightly basis by the nurses to administer his medication. He was last seen in March 2019.

Concerns were raised as he had lost his appetite and he had a poor sleep pattern, the team was planning to assist him to see his GP. Sadly they were informed that he had taken his own life and cause of death was Asphyxia. A Patient Safety Serious Incident review was completed.

The review team were not seeking to identify a root cause of Mr A's tragic death, rather to review the care provided to him in relation to any potential contributory factors. Although the review identified some areas for improvement they were not deemed to have been a contributory factor to Mr A's death.

The review team were asked to comment on predictability and preventability. In relation to the care and services provided by ELFT, the review concluded that the tragic death of Mr A could not have been predicted or prevented.

Patient Story - Ahmed *(pseudonym)*

Ahmed was a 24 year old man with complex health needs and was under the Learning Disability Team. He had a three week hospital admission in February 2020 and was diagnosed with sepsis secondary to Lower Respiratory Tract Infection (LRTI)

He went home after treatment and an ambulance was called again at the beginning of March 2020. Ahmed had deteriorated and was again diagnosed with sepsis.

He was readmitted to hospital where he deteriorated further and was subsequently diagnosed with ischaemic bowel following a CT scan. Ahmed died in hospital the following day with his community health nurse and family around. The death was reported to LeDeR.

7.0 Unexpected Deaths

Chart 4. Unexpected Deaths Trust-wide January 2019 to March 2020

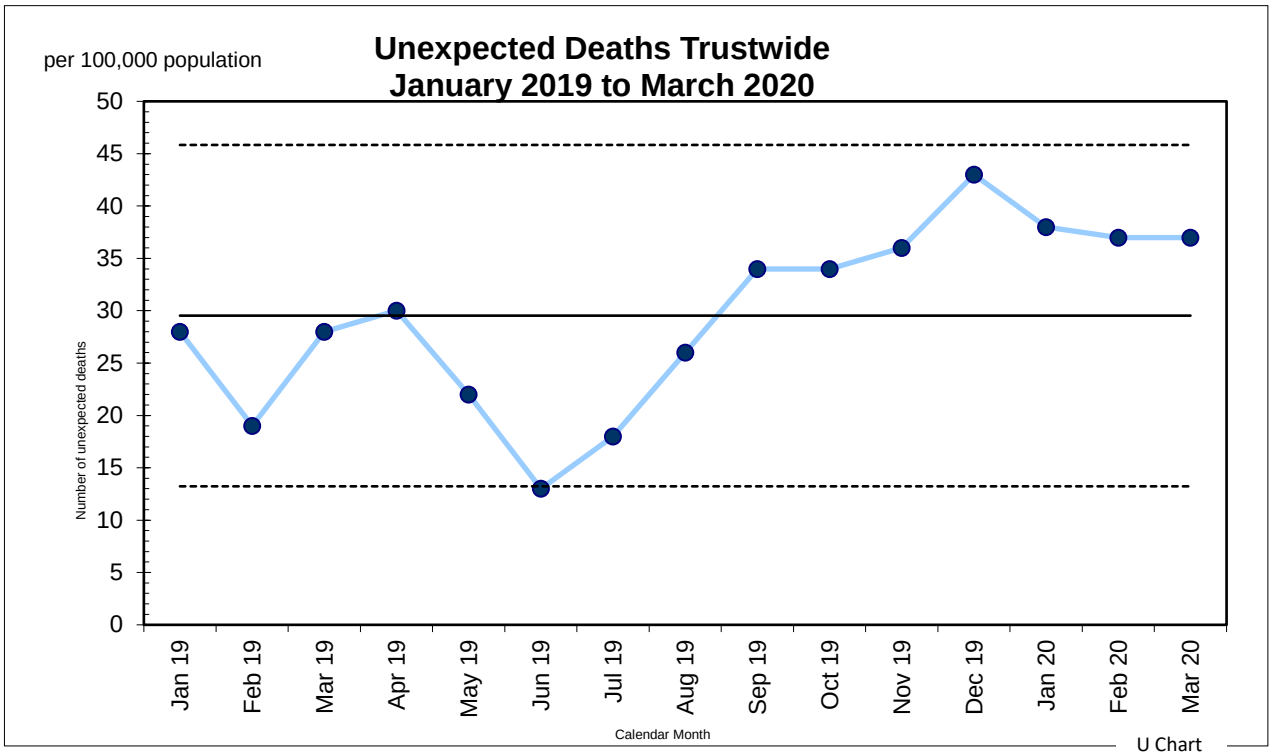
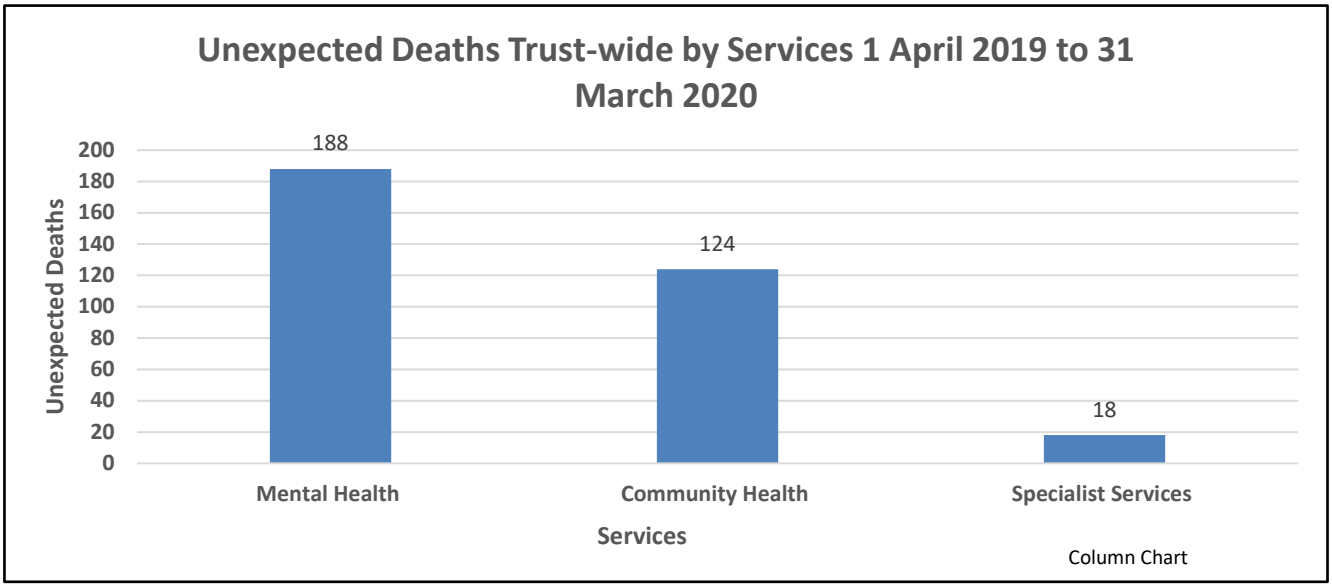


Chart 4 above shows all unexpected deaths Trust wide since the start of data collection in January 2019. During which time the number of unexpected death incidents which have been reported on Datix has been unremarkable compared to previous months. However, there was a spike in unexpected deaths in December this was attributable to the change in criteria for incident reporting on DATIX.

Notably, not all unexpected deaths meet the threshold to be investigated as a Serious Incident Review. During the reporting period of 1 April 2019 and 31 March 2020 the total number of unexpected deaths reported on Datix was 330 as indicated in Chart 5 below.

Chart 5. Unexpected Deaths Trust-wide by Service 1 April 2019 to 31 March 2020



7.1 Serious Incident Review Process (SI)

An SI review is a systematic analysis of an iatrogenic or naturally occurring incident, including unexpected deaths, to identify what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to, where possible, reduce the risk of future occurrence of similar events.

7.2 Unexpected Deaths subject to investigation

A total of 330 unexpected deaths were reported Trust-wide between April 2019 and March 2020, 69 of which were subject to the SI process.

Chart 6 below shows deaths that were subject to an SI from January 2019, when data collection commenced, until March 2020.

Chart 6. Unexpected Deaths subject to the SI process

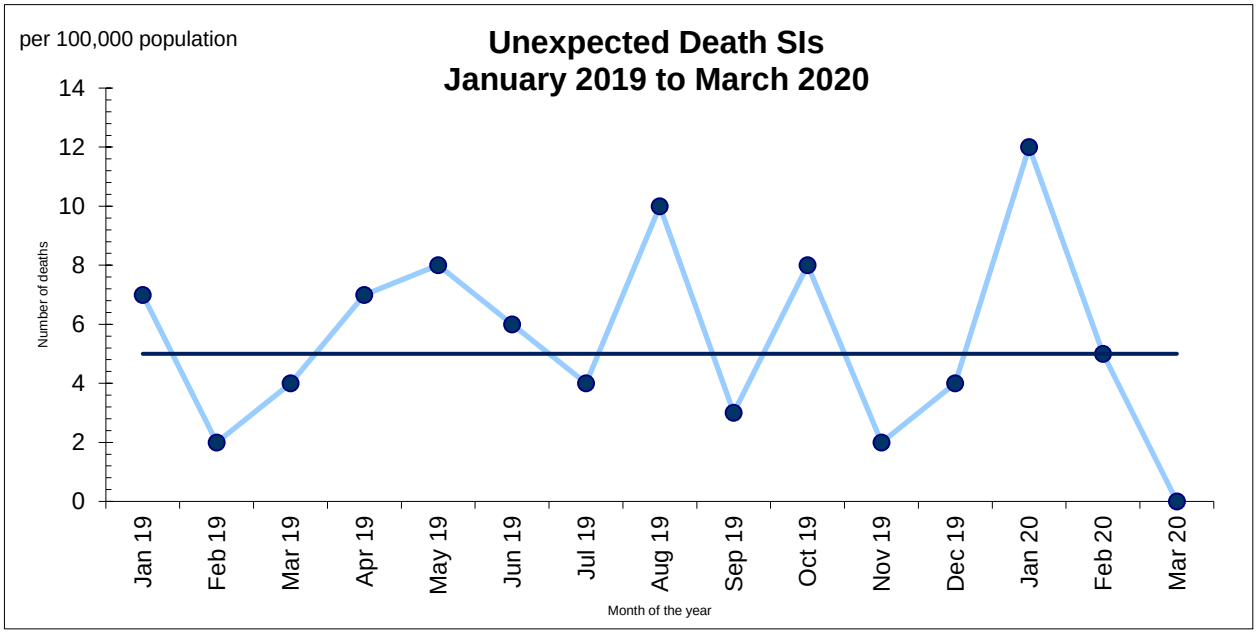


Table 3. Unexpected Death SI's April 2019 and March 2020 by Directorate

Deaths investigated under SI Process	SI
Mental Health Services	
Bedfordshire Mental Health Services	21
City and Hackney Mental Health Services	9
Forensic Services	2
Luton Mental Health Services	13
Newham Mental Health Services	10
Tower Hamlets Mental Health Services	8
Community Health Services	
Tower Hamlets Community Health Services	1
Newham Community Health Services	1
Bedfordshire Community Health Services	0
Specialist Services	
Specialist Services and CHN Children's Services	4
Total :	**69**

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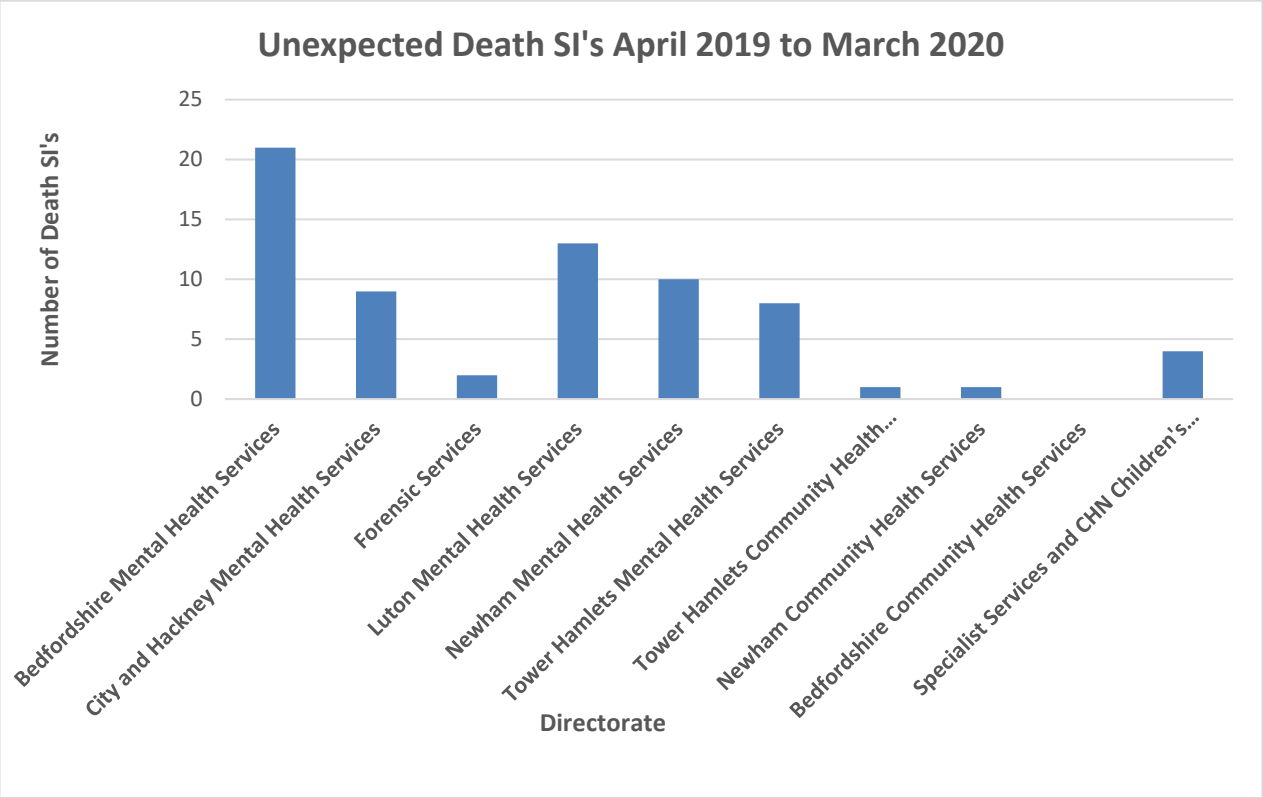
Chart 7. Unexpected Death SI's April 2019 to March 2020

Column Chart



Bedford Mental Health services had the highest number of unexpected deaths that underwent an SI review. Deaths that were investigated under the SI process showed suicide as the highest cause of death in Mental Health Services with a total of 69 cases subject to an SI. There was one suicide in Specialist Services and none from Community Health Services. The suicides in Specialist Services was a patient that had been accessing drug and alcohol services.

8.0 Learning from Inquests

A death is reported to a Coroner in the following situations:

- a doctor did not treat the person during their last illness
- a doctor did not see or treat the person for the condition from which they died within 28 days of death
- the cause of death was sudden, violent or unnatural such as an accident, or suicide
- the cause of death was murder
- the cause of death was an industrial disease of the lungs such as asbestosis
- the death occurred in any other circumstances that may require investigation

A death in hospital should be reported if:

- There is a question of negligence or misadventure about the treatment of the person who died
- they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause
- the patient died as the result of the administration of an anaesthetic

- death should be reported to a Coroner by the police, when a dead body is found death is unexpected or unexplained, or when a death occurs in suspicious circumstances

Chart 8. Inquests by Directorate

Column Chart

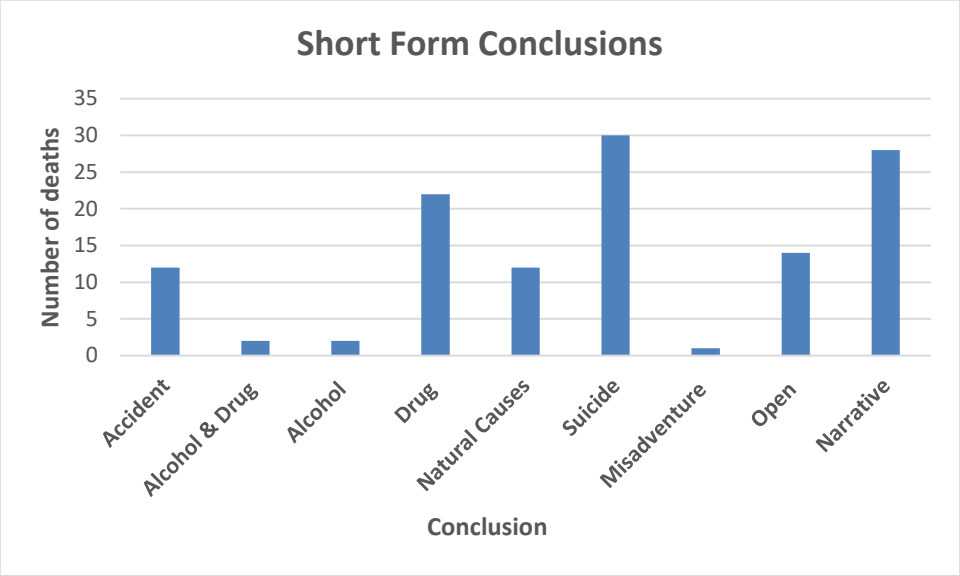
8.1 Number of deaths subject to Coroner's Inquest and Verdicts

A total of 118 deaths were heard at Coroners Court, 9 of those were Community Health Service related deaths. Mental health services across the Trust had the highest number of deaths that were heard at a Coroner's inquest. Bedford Mental Health services had the highest with 33 deaths being heard at Coroner's Court.

The highest number of ELFT deaths which resulted in a Coroner's Inquest relate to death by suicide. Nationally deaths as a result of suicide are, sadly, one of the most frequent causes of death to people who have accessed mental health services. The Trust together with NHS England are actively working to reduce the number of deaths by suicide with a number of initiatives including; adopting the 10 Key Elements of the National Confidential Inquiry into Suicide and Safety.

8.2 Short Form Conclusions

Chart 9. Short Form Conclusions



There was a total of 30 suicides Trust-wide, the second highest cause of death was from drug use. Suicide was the highest unexpected cause of death in Mental Health Services across the Trust.

8.3 Narrative conclusions

There were 28 narrative conclusions between 01 April 2019 and 31 March 2020

8.5 Themes for Unexpected Deaths

Due to challenges with capturing and recording data from Inquests during the Covid-19 lockdown working arrangements. The data captured at the end of Quarter 4 was not as complete as has been the case in Quarters 1-3 of the reporting period.

8.6 Suicides and Homicide

There were a total of 30 suicides determined by concluded Coroner's inquests during the reporting period.

8.7 Themes from Prevention of Future Deaths Reports

The Trust received one PFD during the period:

Coroner's concerns and Trust's response

The deceased rang the crisis line a little over an hour after he had been discharged from the emergency department. He had been seen at the emergency department because he had been found by Police standing by an 8th floor window intending to jump. The Crisis Line call taker read his medical notes and so knew this history, but did not ask him if he was now feeling suicidal. If she had asked and he had said yes, she could have asked him to come in to the hospital again or she could have called an ambulance for him. The importance of good quality, full, complete and appropriate risk assessments is a key skill for all our clinical staff at the Trust. In order to reinforce this, the City and Hackney Home Treatment Team (HTT) will be providing additional training during its away days held on 4 and 5 December 2019. This training included:

- Reviewing the core competencies and standard of risk assessment required by clinicians operating the crisis line in line with the Trust's Competency framework for Mental Health Crisis Lines; and
- Reinforcing the standard of medical record taking expected by the crisis line clinicians in accordance with the Trust's Mental Health Crisis Line Standard Operating Procedure.
- Good quality handover of patient care is also expected of our clinical staff at the Trust included in cases of sudden illness. The HTT will also be providing training in relation to this.

<u>Non-Trust PFD</u>

The Coroner issued a PFD to another organisation, the implications of which ELFT has noted, as set out below:

Coroner's concerns and Trust's response

PFD issued to - NICE

In relation to prescribing/monitoring of patients on oxycodone and other CNS depressant medications, noting that although other pharmacological guidance such as Medscape

Drug Interaction Checker and Stockley's Interaction Checker recommend the need for both caution and monitoring when prescribing amitriptyline and oxycodone simultaneously, such advice does not appear to be provided by the BNF which is regularly consulted and relied upon by GPs. A clinical alert was circulated by the Chief Medical Officer.

8.8 Themes from Inquest Verdicts

Themes

A review of all Inquests has been undertaken and the following themes identified from the 118 concluded inquests conducted into unexpected death inquests held during the reporting period as follows:

- Lack of/failure to update care plans/risk assessments
- Lack of appropriate follow up (following referrals and ward discharge)
- Communication between Trust services (P2R/PLS/CMHT/District Nurses)
- Multi-agency communication (probation/housing)
- Delay in allocation of care co-ordinator
- Poor communication between teams /clinicians
- Actions not being discussed and actions not being carried out following MDT meetings.
- Key individuals not being invited to meetings opiate guidelines not followed correctly
- Poor management of MEWS scores
- Inadequate resuscitation process
- Failure to inform family that patient died on the ward
- Lack of understanding of the observation policy / Physical Health not monitored
- Poor documentation on RiO
- Procedure/ protocol not followed (referrals);
- Poor record keeping;
- Delay/ Lack of communication between CMHT and GP;
- Poor communication between teams/ clinicians;
- Lack of assessment/ assessments not being undertaken in a timely manner;
- Actions not being discussed during/ actions not being carried out following MDT meetings;
- Key individuals not invited to meetings.

All of the above issues were identified during SI reviews which all associated recommendations and actions had created to address these findings.

8.9 Last contact with ELFT Services

During the reporting period a total of 118 Coroner's Inquest were held and concluded. Due to challenges with capturing inquest data during the latter stages of Quarter 4 due to the Covid-19 lockdown, comprehensive data on inquest cases / patients' last contact with

ELFT services and demographic information were not collated. Some of this information will be collected during ongoing SI reviews for later reporting. Notably, not all cases held at inquest during the Covid-19 lockdown period were subject to a full SI review, which did not allow for comprehensive data collection.

9.0 Themes from Expected Deaths

9.1 Themes & Trends

The review looked at themes and trends from both expected and unexpected deaths across the Trust. The highest number of overall mortalities related to patients under Community Health Services. There were more expected deaths than unexpected deaths. Unexpected deaths were higher in the Inpatient and Community Mental Health Services, where suicide was the highest figure.

End of Life Pathway (ELP) and Preferred Plan of Care (PPC)

Over the period 1 April 2019 and 31 March 2020 there has been a steady increase in the number of patients with and End of Life Plans (ELP). Patients that did not have an ELP in place that was available for review had either; deteriorated unexpectedly requiring a hospital or hospice admission and end of life care was not provided by ELFT, or the patient was referred and died before being seen.

Age

The highest mortality rate was observed in the 76 – 100 year old age group. Unsurprisingly, the highest number of deaths occurred with patients under Community Health Services. Deaths that occurred in patients' under the age of 18 were all under Specialist Children's Services and all had life limiting conditions.

Gender

Differences in the numbers of deaths in males and females were noted through each individual month of the reporting year. These differences were small and when observed as a collective showed that overall 34 more females died than males.

Standard of care

Care of the dying person was reviewed using the East London Foundation Trust (ELFT) Dignity in Care at the End of Life Practice Guidance and the Gold Standard Framework (GSF) Guidance.

Dignity in Care at the End of Life Practice Guidelines enables teams to develop a person centred holistic plan of care enabling patients to make their own choices on where they wished to be cared for and their preferred place to die.

Daily Graders also look at the quality of information being reported on the DATIX incident report: missing information, missing patient details and any other required information.

The GSF sets out 7 domains of guidance communication; co-ordination; control of symptoms; continuity of care; continued learning; care support and care in the dying phase. The domains are reviewed under the SJR process.

Between April 2019 and March 2020 the case notes reviewed under the SJR process showed that in general the care delivered across the Trust met the requirements expected when caring for a dying person and that had a GSF in place.

Patients that did not have an end of life plan in place that was available for review had either: deteriorated unexpectedly requiring a hospital or hospice admission and end of life care was not provided by ELFT, or the patient was referred and died before being seen.

Diagnosis and Cause of Death

The highest number of deaths was amongst cancer patients. Deaths from organ and respiratory failure saw an increase in the number of deaths especially between December 2019 and March 2020, this coincides with the Coronavirus pandemic when patients were showing symptoms similar to those of COVID 19 but were never recorded as such as data collection did not commence until 1 April 2020.

10.0 Conclusion

The highest proportion of deaths at ELFT occur within Community Health Services where the morbidity rate of patients is highest and where the number of patients in receipt of palliative care is greatest. This has led to the Trust increasing its focus on reviewing and evaluating end of life care pathways to determine how patients' preferences with respect to their wishes regarding where they wish to die have been met or not.

During the reporting period there sadly have been a total of 30 deaths which were concluded at Inquest as being due to suicide. These incidents of death by suicide are a matter that the Trust is resolved to work toward preventing and reducing. The use of the National Confidential Enquiry into Deaths Toolkit is one of several mechanisms the Trust has adopted to support initiatives in this area.

The focus of the PFD issued to the Trust related to the need for Crisis Line call staff to ensure that all lines of inquiry are pursued when talking to service users in crisis to ensure that, where possible, avoidable patient safety incidents are prevented. Additionally, the Trust is committed to embracing recommendations from PFDs issued to other organisations, which the Trust can utilise to ensure the patient safety of our patients and service users.

The Learning from Deaths Group (formally called The Mortality Review Group) review process for the Trust has evolved during the course of 2019/20. The Learning from Deaths Group is responsible for overseeing the Structured Judgement Review process with a focus on;

I. Reviewing - issues associated with deaths that arose during the process of care ensuring that any adverse trends are discussed and, where appropriate, following a review of individual cases, acted upon.
II. Monitoring - deaths reported on the National Personal Demographics Spine against deaths reported on the Trust's Incident management database – DATIX - to identify themes and trends.
III. Ensuring – that learning and all associated actions identified as a result of learning from deaths are acted upon.

During the course of the year the group identified repetitions in themes arising following mortality reviews and moved to focus in greater depth on learning and driving improvements to end of life care planning and the revision of services where necessary.

Going forward, The Learning from Deaths Group 2020 - 2021 plan is to focus on;

I. Reviewing and evaluating End of Life Pathways to determine whether patients preferences, including their wishes related to where they wish to die, have been met or not.
II. Engaging in Partnership Learning from Deaths together with ELFTs partner healthcare providers including; GPs and Hospices.
III. Reviewing, with the aid of the Structured Review of Deaths Toolkit;
- deaths on the national personal demographics spine against those reported on the Trust's incident reporting database (Datix)
- individual case reviews
- Themes and trends identified from the process of care

IV. Conducting High Level Strategic Reviews of all deaths to inform systems and planning processes.
V. Embracing learning from PFD reports issued to other organisations where the patient safety of ELFT patients can be further enhanced.

11.0 Recommendations

11.1 It is recommended that the Board receive and approve this report.

12.0 Action being requested

12.1 For noting and discussion