NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
23 July 2020

Title	Learning from Deaths Review Q4 January 2020 – March 2020
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Purpose of the Report:

This report covers the three month period from 1st January 2020 until 31st March 2020 (Q4) and provides:

- An analysis of service user deaths including expected and unexpected deaths, and coroner's inquests;
- Overview of the findings;
- Key themes from learning including triangulation of learning;
- Actions being taken to address the learning.

Summary of Key Issues:

The Trust reported a total of 561 deaths between 1st January 2020 and 31st March 2020. Until October 2019 the Trust wide Podiatry/ Foot Health services were included in the total number of deaths reported. In Q4 deaths reported by the Podiatry/Foot Health Services were not included in the total reported deaths as patients only tended to be seen for Bi-annual or annual foot health checks.

A total of 432 expected deaths were reported in Q4, there were a total of 129 unexpected deaths.

31 inquests were concluded within the period 1st January 2020 and 31st March 2020.

The 242 expected deaths subject to a Structured Judgement Review (SJR) in Q4 relate mainly to patients in the 66-100 years age group. Overall, mortalities among males across the Trust was higher than for females as of 31st March 2020.

Cancer was the most common cause of death in both males and females across the Trust.

Data which looked at patients on Gold Standard Framework (GSF) Pathway's is reported in Q4. All the patients on a GSF End of Life Pathway were cared for and died in their preferred place of care (PPC) and death (PPD).

During Q4 there were a total of 11 LeDeR reportable deaths across ELFT. Of these:

- 2 deaths in Community Health Services
- 2 deaths in Mental Health Services
- 7 deaths where the patient was under a Learning Disability Service

There were no completed LeDeR investigation reports received during this period. All of the reported deaths are presently under investigation by LeDeR.

There were 129 unexpected deaths for the reporting period, 17 of which were investigated across the Trust as SIs.

There were a total of 6 suspected suicides (this will be confirmed following the completion of a Coroner's inquest into these deaths). Three main areas of completed SI in unexpected deaths for learning are:

- Sub optimal identification of deteriorating patients and failure to escalate physical health check findings;
- Poor communications;
- Poor compliance with policy requirements.
- Poor resuscitation process

The main lessons learnt from these verdicts were:

- Prescribing guidelines were not followed appropriately.
- Poor oversight of the service users care management plan.
- There were systemic shortcomings in ensuring the patients care plan was followed or that needs identified were followed up.
- Inadequate resuscitation process
- The ward did not inform the service user's family that she had passed away on the ward.
- Lack of consistency in understanding and applying the Trust observation policy. The service user's physical health was not monitored consistently

Triangulating these themes will be conducted within the Trust's Risk and Governance Networks to ensure learning is shared across the Trust:

Increase compliance with follow up protocols;
Improve communications within in and out with the organisation.

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 patient deaths and lessons learnt to improve the patients' safety.
Improved health of the communities we serve	☒	Summarises the investigations where the aim is to learn lessons to improve the health of the communities we serve.
Improved staff experience	☒	The purpose of this report is to update the Board on patients' death and lessons learnt by staff to improve their working experience.

Improved value for money	☒	Through full investigation of these incidents we aim to improve the quality of care we provide including improving efficiencies and providing value for money.

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
25/02/2020	Learning from Deaths Panel Meeting

Implications

Equality Analysis	The report does not include an equality analysis.
Risk and Assurance	Monitoring and understanding mortality and learning from deaths provides assurance that there is a robust approach to mortality.
Service User/Carer/Staff	The process for analysing and investigating deaths ensures that learning and improvement takes place, positively impacting on service users, carers and families.
Financial	There are financial implications associated with mortality reviews. NHS Quality Board national guidance requires case note review of mortality to be routinely undertaken.
Quality	The themes arising from serious incidents and the work being done to address them have clear quality implications and act as drivers for improvement.

Supporting Documents and Research material

1. Mortality Dashboard
2. The NHS Quality Board framework

Glossary

Abbreviation	In full
Datix	Trust incidents and complaints reporting and management system
RiO	Patient information recording system, ELFT Mental Health
EMIS	Patient information recording system, ELFT Community Health
SystmOne	Patient information recording system, Bedfordshire Community Health
ELFT	East London NHS Foundation Trust
HSMR	Hospital Standardized Mortality Ratio
LeDeR	Learning Disabilities Mortality Review
SJR	Structured Judgement Reviews
EoL	End of Life pathway
PPC	Preferred Place of Care
DNAR	Do not attempt resuscitation
StEIS	Strategic Executive Information System
CVA	Cerebrovascular Accident
CNS	Central Nervous System
BNF	British National Formulary

1.0 Background/Introduction

1.0 The report will provide an analysis of service user deaths over the three month period 1st January 2020 till 31st March 2020 (Q4).

1.1 Reported deaths are divided into expected and unexpected deaths.

1.2 Expected deaths are dealt with through the mortality review process. 100% of those deaths where the service user is being managed by ELFT services at the time of their death are reviewed using a Structured Judgement Review (SJR) tool. 25% of expected deaths which take place in hospital or in care/nursing home are also reviewed using SJR tool.

1.3 Unexpected deaths, where appropriate, will usually be dealt with through formal investigation processes and Serious Incident Reviews. The outcomes and recommendations of these reports are then reviewed as themes from which the organisation can learn from.

1.4 There is a summary of the Coroner's hearings of service users that took place in this quarter and a review of the themes of the outcomes of these.

2.0 Presentation and Analysis of Mortality Data for Q4

2.1 The total number of patients who died Trust-wide in Q4 was 561. 432 were expected deaths and 129 were unexpected deaths.

3.0 Summary of deaths and scope of review: Q4

3.1 100% of reported expected deaths where ELFT was managing care were reviewed under the SJR process. 25% of the deaths where care was not being managed by ELFT, or where the patient died in hospital or in a care home were also reviewed.

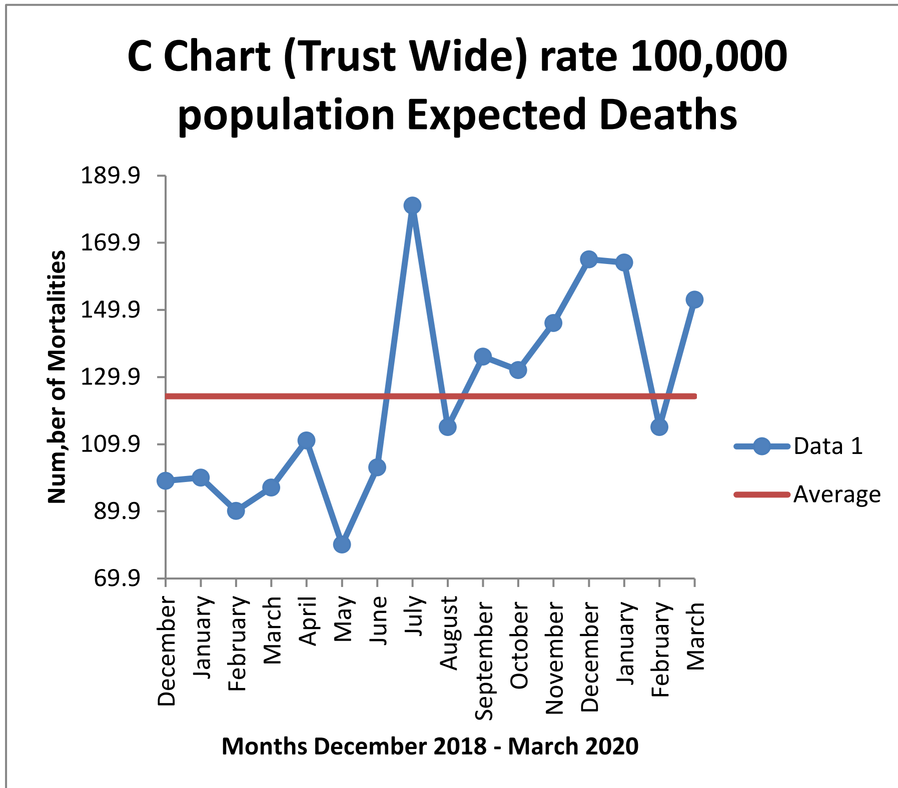
3.2 SJRs have been conducted using patient information (recording) systems: EMIS; RiO; SystmOne and the Incident Reporting System DATIX. The SJRs look at the six months of case notes prior to the patient's death.

3.3 All unexpected deaths are not necessarily reviewed via the Serious Incident Review process as they may not meet the threshold for an SI investigation. *An SI Review is required when the cause of death is related to severe harm, is unknown and / or the potential for learning is so great or the consequences to patients, families and carers or staff or organisations that these incidents require a formal investigation.* (NHSE SI Framework 2015)

3.4 The overall data reported runs from January 1st 2020 until March 31st 2020. The presentation of data during this period has been with the use of Control Charts. Mortality data collection has been continuous over 2018 and 2020.

4.0 Expected Deaths between 1st January and 31st March 2020 against population.

C Chart (Trust Wide) rate 100,000 population Expected Deaths



2018 -2020	Expected deaths	population
December	99	1,659,900
January	100	1,659,900
February	90	1,659,900
March	97	1,659,900
April	111	1,659,900
May	80	1,659,900
June	103	1,659,900
July	181	1,659,900
August	115	1,659,900
September	136	1,659,900
October	132	1,659,900
November	146	1,659,900
December	165	1,659,900
January	164	1,659,900
February	115	1,659,900
March	153	1,659,900

4.1 The baseline for the report is from December 2018 until 30 September 2019. The mean for this period is 6.4 deaths per 100,000 populations.

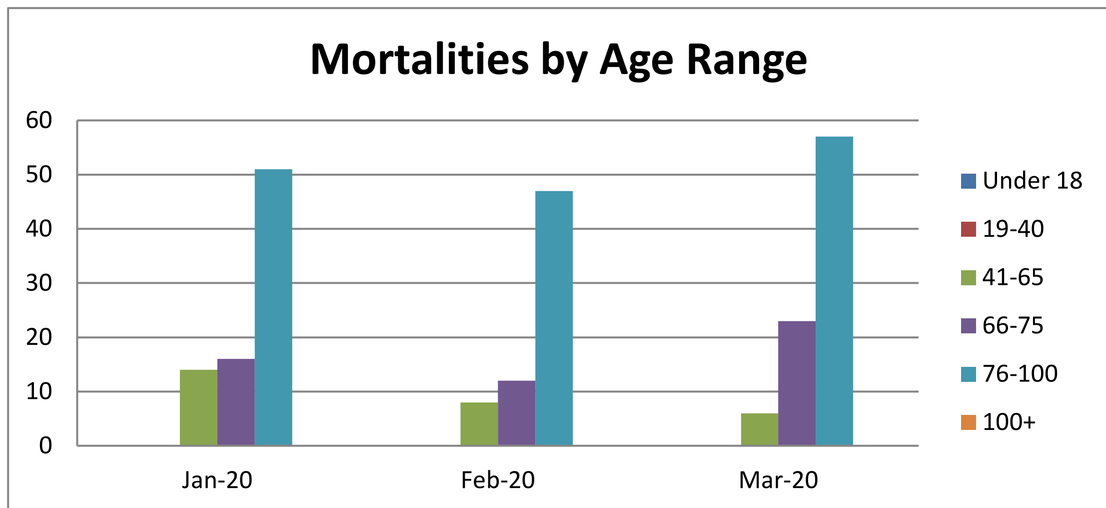
4.2 The expected deaths over all three months in 2020 are significantly above the rates reported for the same three months in 2019. Comparing the three months in 2020 against each other there is a drop in February but both January and March are comparable.

5.0 Structured Judgement Reviews

5.1 Of 242 expected deaths which occurred in Q4, 186 deaths of patients who were under the care of the Community Health Services at the time of their deaths were reviewed under the SJR process. There were 56 patients who died expectedly in a hospital/care home and whose care was not being managed by ELFT but who were also reviewed via the SJR process. A total of 242 SJR's of expected deaths were completed.

5.2 **Age Ranges between 1st January 2020 and 31st March 2020**

Column Chart (Trust Wide) rate 100,000 population



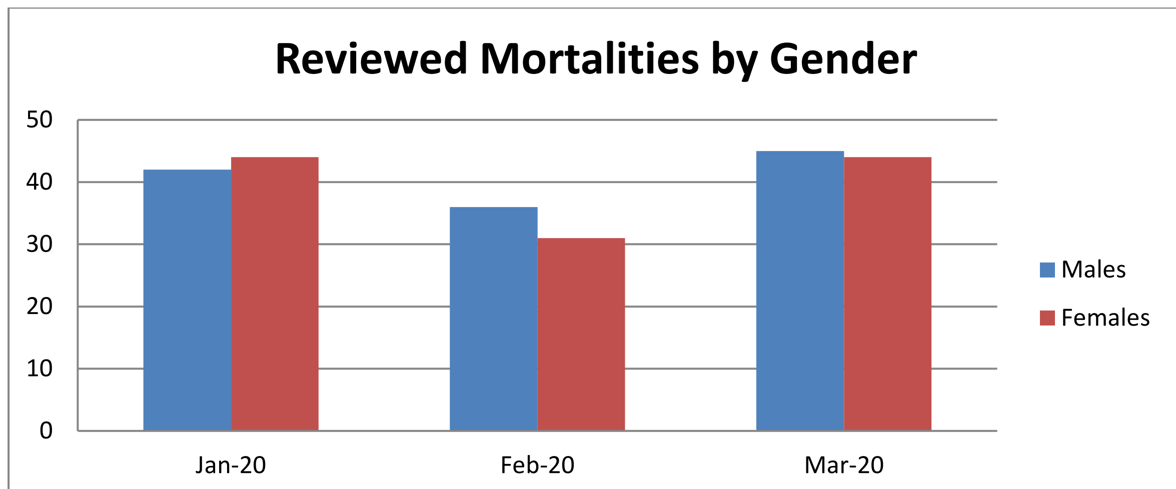
5.3 The chart accounts for the ages of the 242 deaths reviewed via the SJR process.

5.4 64% (155) of the deaths reviewed occurred in the 76 - 100 years age group. 21.07 % (51) of the deaths reviewed were in the age 66 -75 years range. There were no deaths of patients under the age of 18.

5.5 One 23 year old Bangladeshi male died from organ failure in an acute hospital.

5.7 Reviewed Mortalities by Gender between 1st January 2020 and 31st March 2020

Column Chart (Trust Wide) **rate 100,000 population**



5.8 A total of 123 female deaths and 119 male deaths were reviewed in Q4.

5.9 Causes of Death

5.9.1 Cancer was the highest cause of death (CoD) throughout January, February and March 2020. Cancer was the highest CoD in all age groups and in both males and females, accounting for 37.6% (91) of the total reviewed mortalities.

5.10 Findings from Expected Deaths

5.10.1 All cases reviewed in Q4 showed good standards of care delivery.

5.10.2 The Trust aims to ensure that all patients who are on Gold Standards Framework (GSF) and End of Life Pathways (EoLP's) have their preferred place of care (PPC) and death (PPD) recorded.

During Q4, of the 242 deaths reviewed 80.57% (195) patients had a Gold Standard Framework End of Life care plan. All (100%) of the patients receiving a Gold Standard Framework had recorded their PPC and PPD. 20 of those patients did not die in their PPD due to being admitted to an acute hospital where they died.

The remaining 47 (19.42%) patients were either on palliative care, death was premature and an End of Life care plan had not yet been created; the patient died after being been admitted to a care home or hospital; or had been referred to the Trust but died before being discharged from hospital.

5.10.3 Do Not Attempt Resuscitation (DNAR) was in place for all the patients that were on an End of Life Pathway.

5.10.4 170 (87.17%) patients from the total 195 with a GSF were cared for and died with family or carer involvement.

6.0 Learning Disability Deaths

6.1 During this period, there were 11 LeDeR reportable deaths across ELFT in Q4. Of these:

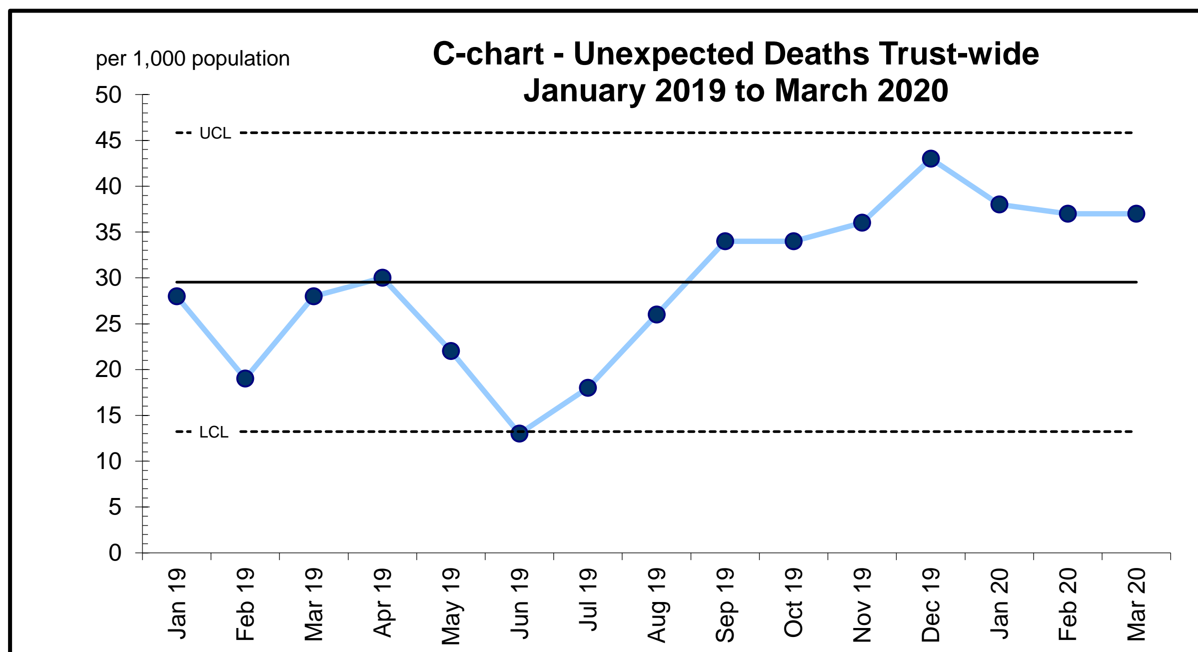
- 2 Bedfordshire Community Health deaths
- 1 Bedfordshire Mental Health inpatient death
- 2 Bedfordshire Learning Disability Services deaths
- 2 Newham Learning Disability Services deaths
- 2 Tower Hamlets Learning Disability Services deaths
- 1 City & Hackney Mental Health Services death
- 1 Luton Learning Disability services death

6.2 There was no completed LeDeR investigation reports received during this period. All of the reported deaths are presently under investigation. There was one unexpected death under City& Hackney.

7.0 Unexpected Deaths between 1st January 2020 and 31st March 2020

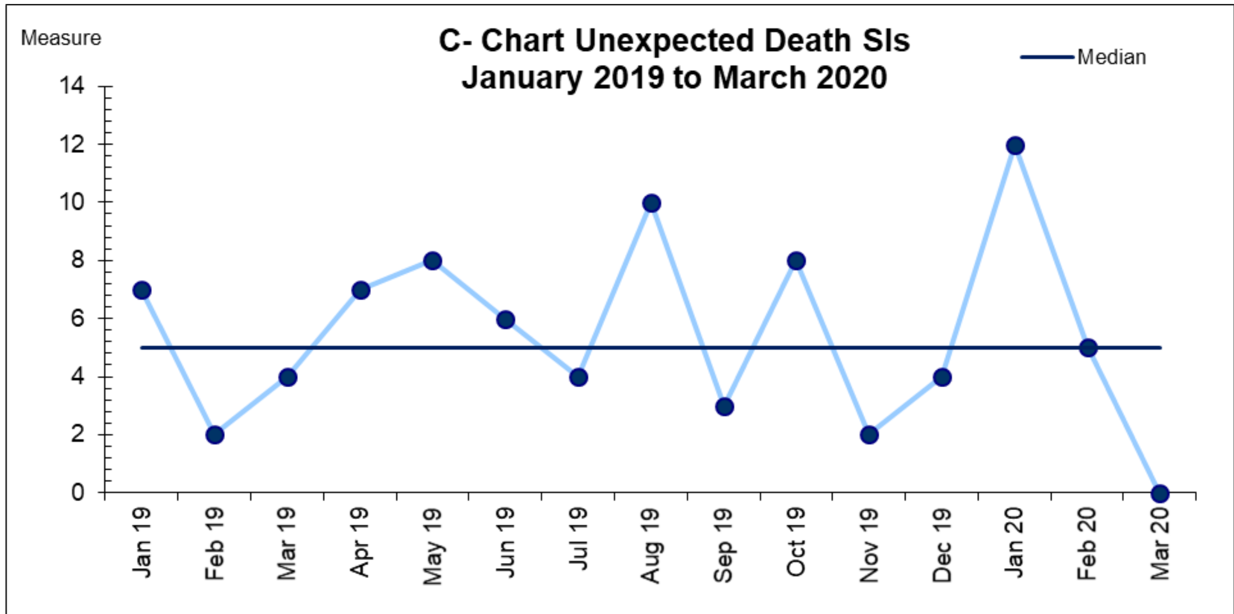
7.1 The baseline for reporting is from January 2018 until January 2019. The mean for this period is 19.9. Q4 data runs from January 2020 until March 2020.

C- Chart Unexpected Deaths Trust-wide between 1st January 2019 and 31st March 2020



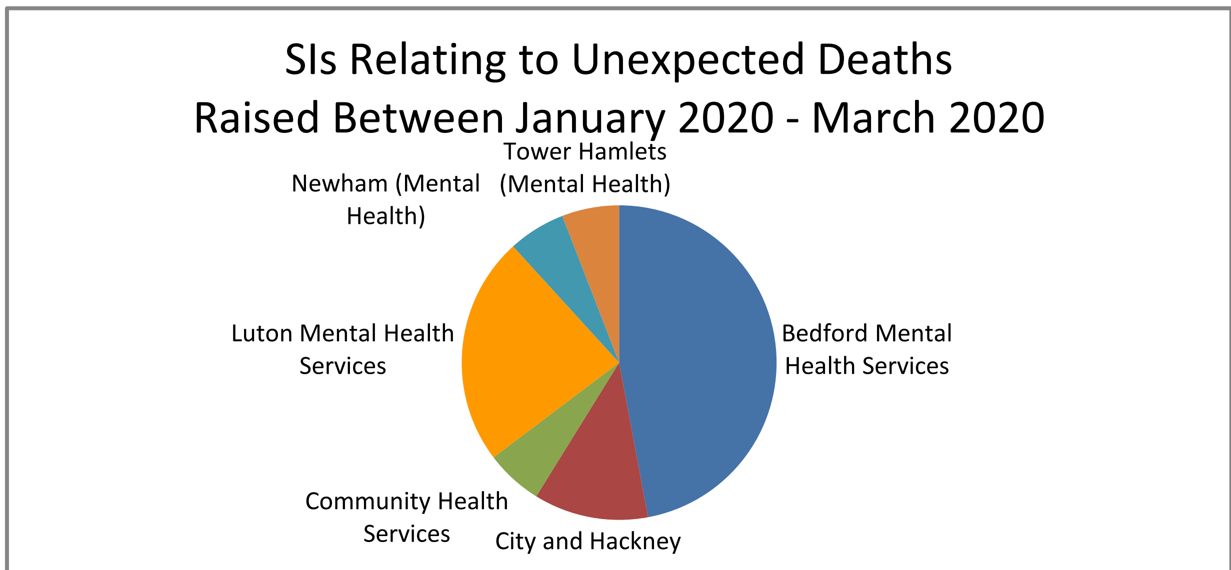
7.2 SIs relating to Unexpected Deaths Trust-wide

C Chart - SIs relating to Unexpected Deaths Trust-wide from January 2019 – March 2020



7.3 **SIs relating to unexpected deaths Trust wide by Directorate between January 2020 and March 2020**

Chart showing- Q4 Unexpected Deaths Trust wide by directorate subject to an SI



During Q4, 112 Unexpected Deaths were reported across the Trust, 17 of which were raised to a Serious Incident Review (SIR), 4 of which were panel-led reviews. Recommendations and their associated Action Plans have been introduced to address all the care and service delivery issues identified in these Panel Reviews The remaining 95 unexpected deaths were either reviewed as a 48 hour report and did not require further investigation or they were de-escalated.

Initial preliminary findings indicate that at least 6 out of 17 of these deaths are likely to be as a result of suicides (subject to inquest conclusions). 5 of the 6 suspected suicides (subject to inquest conclusions) occurred at home. The sixth suspected suicide occurred at a public woodlands area.

Whilst we recognise that a larger proportion of the unexpected deaths occurred in Bedfordshire, it should be noted that Bedfordshire has an estimated population that is much greater (at approx. 463,000) than that of other areas (Tower Hamlets approx. 322,000, Newham approx. 359,800), and subsequently has a higher number of its population in contact with ELFT services

7.4 Notably, not all deaths which are reported on the Trust's Incident Reporting system, Datix, have occurred as a result of Trust-related patient safety incidents. However, for completeness, particularly in the case of Community Health Services - all deaths are reported on Datix by Community Staff, to ensure the closing down of patient records and for learning purposes.

7.5 **Q4 Thematic Review of Unexpected Deaths**

7.6 Of the unexpected deaths for the reporting period, there were a total of seven suspected suicides (this will be confirmed following the completion of a Coroner's inquest into these deaths).

7.7 The completed SI Reviews into unexpected deaths, which have occurred during this reporting period, have indicated the following themes:

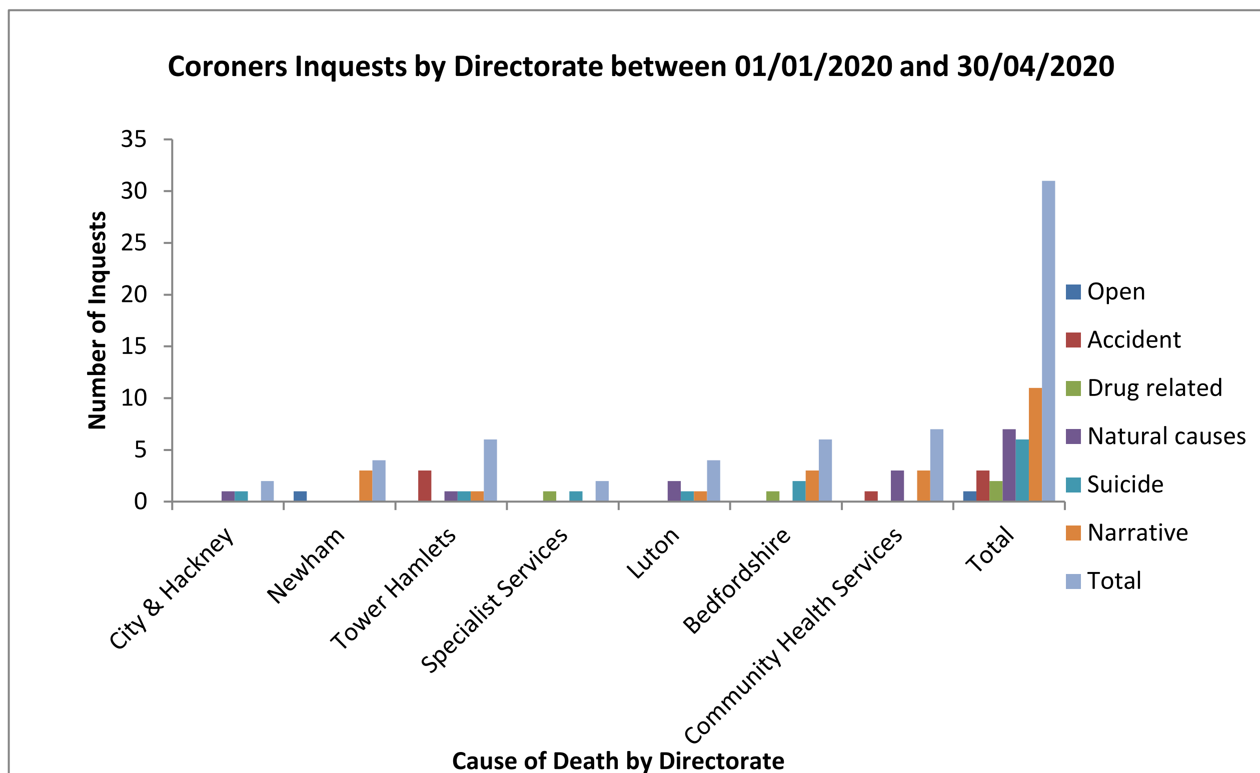
- Ward staff did not follow ELFT's opiate substitute prescribing guidelines for the initiation, prescribing and monitoring of Methadone.
- There was, at times, a lack of oversight regarding the service user's care management, including reviews of NEWS scores and UDS results
- There were systemic shortcomings in ensuring that tasks identified in Care Plans during the service user's inpatient admission, were consistently allocated and followed up.
- Inadequate resuscitation process
- The ward did not inform the service user's family that she had passed away on the ward.
- Lack of consistency in understanding and application of the Trust observation policy.
- The service user's physical health was not monitored consistently.
- Inpatient Care Plan and Risk Assessment not updated following an assault on the service user

The recommendations and their associated Action Plans have been introduced to address all the care and service delivery issues identified in these Panel Reviews.

8.0 Quarter 4 Inquests

8.1 There were a total of 31 inquests concluded within Q4. There were 12 verdicts of suicide and 11 narrative verdicts. The chart below shows the number of Inquests by Directorate:

Chart Showing Coroners Inquests by Directorate between 01/01/2020 and 30/04/2020



8.2 Coroner's conclusions

8.2.1 The table below provides details of the Conclusions returned by the Coroner in the period 01/01/2020 until 30/04/2020

Short Form Conclusions:	
Accident	4
Drug Related	2
Natural Causes	7
Open	1
Suicide	6
Narrative Conclusions:	11

Coroners Narrative Conclusions	
The death was concluded as suicide under the influence of alcohol	
The deceased died from acute respiratory failure directly caused by an exacerbation of COPD but the pressure ulcers she developed during a recent hospital admission were a contributory factor in her death.	
Deceased died from a combination of natural causes and accident.	
On 4th May 2019 the patient fell to the ground outside his home, his head hitting the ground. He was intoxicated at the time and despite assistance from his neighbour, he declined medical intervention. On 9th May 2019 he was found lifeless at home, having died as a consequence of injuries sustained during the fall	
The Deceased died from acute respiratory failure due to the ingestion of heroin and cocaine. She was under the care of mental health services at the time and was known to be at risk of drug and alcohol overdose. The fact that she had not been provided with the appropriate treatment in the Community (in the form of DBT and 24 hour residential care services) both prior to and following discharge from her recent in-patient admission contributed to her death.	
The medical cause of death could not be determined due to advanced decomposition but there were no suspicious circumstances.	
The Deceased died after placing himself into the path of a high speed train but his intentions in doing so remained unclear.	
The patient took the action that led to her death but the evidence during the course of the Inquest does not reveal her intention.	
The deceased died of self-inflicted injuries. Her intent at the time inflicted remains unclear.	
The patient died on 12/08/2019 at Royal London Hospital as a result of a severe bladder infection and small bowel obstruction from which he was unable to survive	
An 85 year old lady was admitted to Newham University Hospital on 5/09/2019 with an infected, category 4 sacral pressure ulcer. The ulcer had been reviewed at the patient's home by the district nurse service since the 21/06/2019, during that period the wound had deteriorated and become deeper. Her condition deteriorated as an inpatient and she died from complications of her ulcer on 1/09/2019	

8.3 Themes

8.3.1 A review of all Inquests concluded in the quarter has been undertaken and the following themes identified:

- Opiate substitute prescribing guidelines for the initiation, prescribing and monitoring of Methadone were not followed appropriately.
- Poor oversight of the service users care management plan. Poor management of NEWS scores and UDS results
- There were systemic shortcomings in ensuring the patients care plan was followed or that needs identified were followed up.
- Inadequate resuscitation process
- The ward did not inform the service user's family that she had passed away on the ward.
- Lack of consistency in understanding and applying the Trust observation policy.
- The service user's physical health was not monitored consistently.

8.3.2 All of the issues detailed above were identified during Serious Incident Reviews with associated recommendations/actions.

8.4 **Prevention of Future Deaths (PFD)**

8.4.1 The Trust did not receive any PFDs during the period:

8.5 **Non-Trust PFD**

8.51 There were no Non PDF concerns raised by the coroner during this period.

9.0 Recommendations and actions

9.1 The Board is recommended to **RECEIVE** and **NOTE** this report**.**