East London NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
3 OCTOBER 2019

Title	Learning From Deaths Annual Report
Reporting period	1 April 2018 -31 March 2019
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 2019/20

Summary of Key Issues

- Over the last year the Trust has implemented the Learning from Death guidance. We have tested the system and processes for reviewing expected deaths and looking at themes.
- 1474 deaths (1,217 expected and 257 unexpected) were reported by the Trust between 1 April 2018 and 31 March 2019.
- 637 expected deaths had Structured Judgement Reviews(SJR)
- 101 unexpected deaths were subjected to the SI process in the reporting period
- There were 9 deaths of patients with Learning Disabilities, all of which were subject to a Learning Disability Mortality Review (LeDeR)
- A total of 152 Deaths were subject to a Coroner's Inquests during the reporting period
- 36 deaths were classified as being caused as a result of suicide
- The highest number of deaths occurred to patients within Community Health Services

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
September 2019	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
SI	Serious Incident
SJR	Structured Judgement Review

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 is chaired by the Trust's Chief Medical Officer and has senior representation from across ELFT services.

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 and service users who have been 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 expected deaths that take place in 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 is suspected to 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 (SI) team and are subject to either a panel led or corporate led investigation.

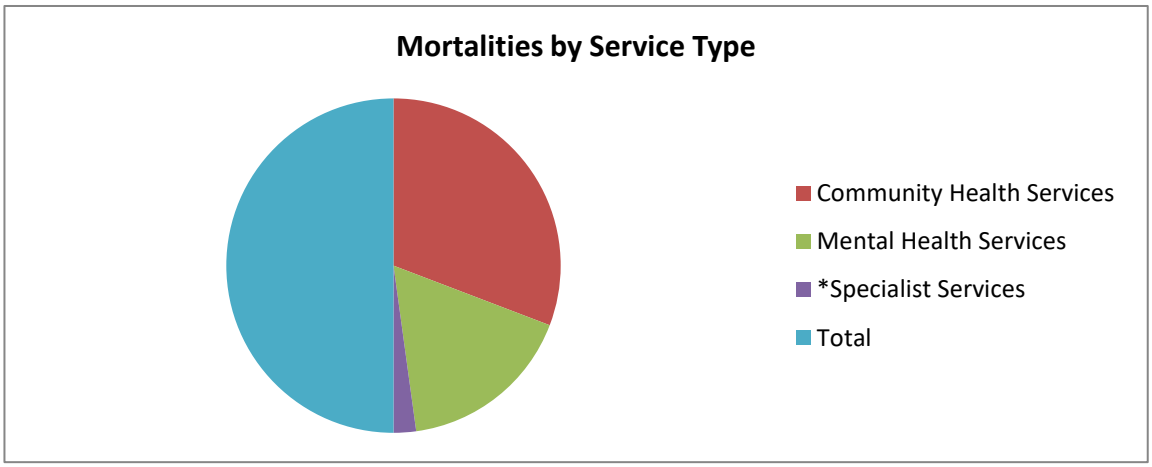
3.4 All Learning Disability Deaths (LeDeR) in ELFT are allocated to the mortality reviewer who is also trained in root cause analysis. These findings are reported to NHS England and Bristol University.

4.0 Learning from Deaths Review Statistics

4.1 Total deaths

There were a total of 1474 deaths (1,217 expected and 257 unexpected) reported by the Trust between 1 April 2018 and 31 March 2019.

Chart 1-Total Deaths Reported (Mental Health; Community Health and Specialist Services)



*Specialist Services include Children's Community Services and Psychological Therapies that are commissioned by NHS England.

A total of 1474 deaths across all Trust services were reported; 908 for Community Services; 502 for Mental Health Services and Specialist services reported 64.

In all quarters, Community Health Service deaths were higher than in Mental Health Services; this was as expected due to more cases of people receiving Palliative or End of Life Care in community services and also due to the size of the areas covered.

5.0 Expected Deaths

5.1 Structured Judgement Review

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 Investigation of concerns identified from a SJR of a death

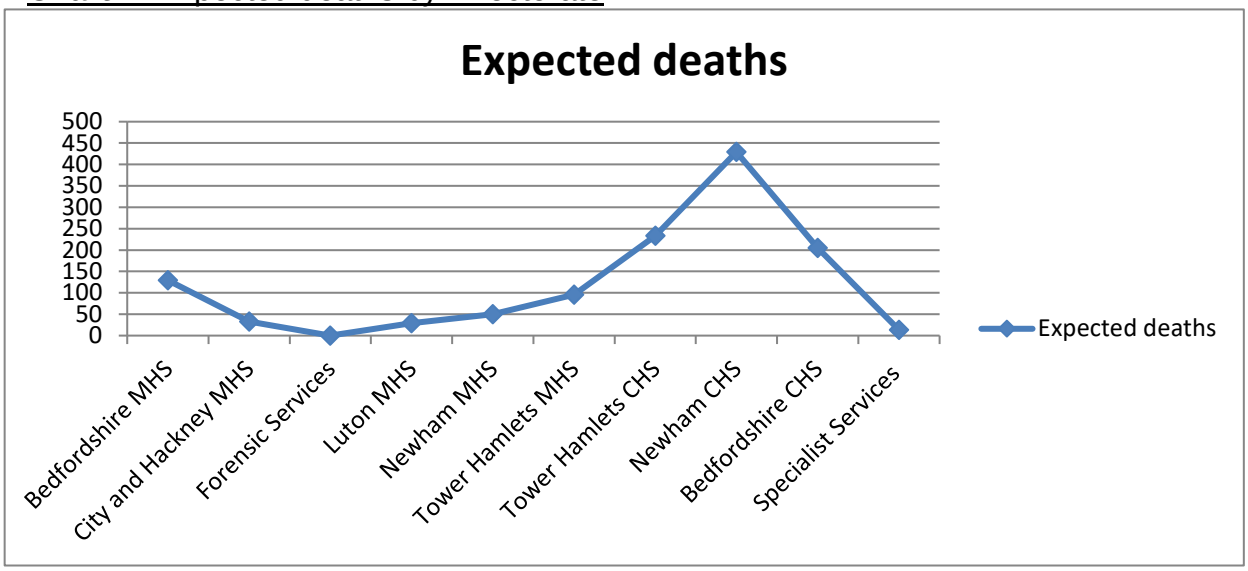
Where there are any concerns identified as a result of a SJR review into a death the panel will request a 48 hour report from the directorate/service to provide additional background information into the care and treatment of a patient /service user whilst under ELFT services.

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

Table 1- Expected deaths by Directorate

Breakdown of expected deaths by Directorate	Total
Mental Health Services	
Bedfordshire Mental Health Services	129
City and Hackney Mental Health Services	33
Forensic Services	0
Luton Mental Health Services	29
Newham Mental Health Services	50
Tower Hamlets Mental Health Services	96
Community Health Services	
Tower Hamlets Community Health Services	233
Newham Community Health Services	429
Bedfordshire Community Health Services	205
Specialist Services	
Specialist Services and CHN Children's Services	13
Total :	**1217**

Chart 2- Expected deaths by Directorate



.A total of 1217 expected deaths were reported in the Trust between 1 April 2018 and 31 March 2019. Mental Health Services reported 337 expected deaths, 27.69% of the total 1217. Bedfordshire had the highest number of expected deaths across Mental Health Services with 129 reported (25% of the total 337). .

There were 13 expected deaths in Specialist Service notably this number did not include any Children's Services related deaths.

Forensic Services did not report any expected deaths in the reporting period.

Community Health Services across the Trust reported a total of 867 expected deaths with Newham Community Services reporting the highest number at 429.

Please note that; Expected deaths in Bedfordshire Community Health Services were not included in the first 2 quarters but appear in Q3 and Q4.

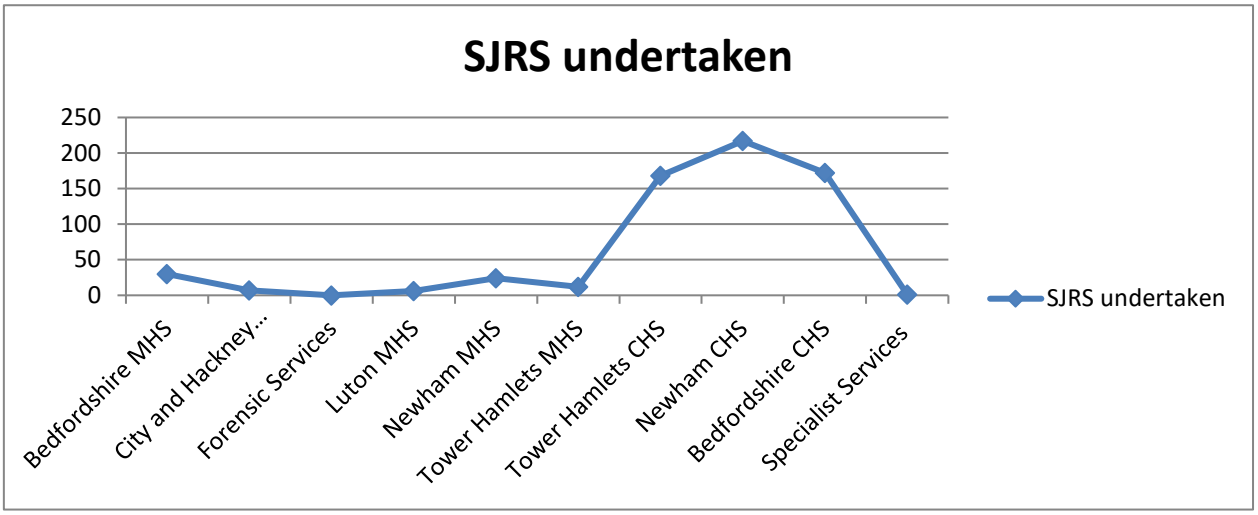
5.3 Deaths reviewed under the SJR Process

A total of 637 SJR's were carried out between 01 April 2018 and 31 March 2019. Bedfordshire expected deaths were reported but not subject to an SJR in Q1; Q2; or Q3 due to restricted access to the clinical records system (SystmOne) in use by Bedfordshire Community Services (access was established from Q4 onwards).

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	30
City and Hackney Mental Health Services	7
Forensic Services	0
Luton Mental Health Services	6
Newham Mental Health Services	24
Tower Hamlets Mental Health Services	12
Community Health Services	
Tower Hamlets Community Health Services	168
Newham Community Health Services	217
Bedfordshire Community Health Services	172
Specialist Services	
Specialist Services and CHN Children's Services	1
Total	**637**

Chart 4- Structure judgement reviews by directorate



637 deaths were reviewed in the reporting period, 79 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 tended to be older and accessing Mental Health Services such as the Memory Service and therapies. Many of the older Mental Health Service users were also under continence; podiatry and diabetic services.

Expected deaths were higher in Community Health Services as there were more over 65's older and terminally ill patients. Patients were also receiving palliative or end of life care. The highest number of deaths arose from cancer and organ failure. Cancers were higher in all age ranges as was organ failure.

Patient Story- John (*pseudonym*)

John was a 76 year old man who was under ELFT Community Health and Community Mental Health Services. He was diagnosed with Schizophrenia in 1993. He was diagnosed with Asperger's Syndrome and metastatic lung cancer in 2018.

John was a hoarder who lived alone in supported accommodation. His living conditions had been described as squalid. He agreed to an inpatient admission on an older persons mental health ward to manage the negative symptoms of his mental illness. He did well and was able to go home with support. He was being seen 4 weekly by the CMHT for his Flupenthixol 100mg. He had been on CPA from May 2017 until March 2018 and his consultant had suggested changing from depot to oral medication. He continued to smoke and was receiving cessation support.

John's health deteriorated and he was admitted to a general hospital due to breathing difficulties. His prognosis was short and he was discharged home, at his request, with support from community health nurses who providing palliative care and the administration of morphine. End of Life was discussed and although a care plan had not been created by the time John died he had expressed his wishes. DNAR was agreed and in place. He was in his preferred place of care and choice to die. His brother and sister were involved but only at the end of life. His mental health remained at the forefront of his care and treatment

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

6.1 One City and Hackney LeDeR review from Q3 was undertaken and completed in Q4 by ELFT LeDeR/Mortality Reviewer.

6.2 A total of nine service users with a learning disability died. All were reported to LeDeR and subjected to a review. Bedfordshire Mental Health services reported three deaths; two were Specialist Services and CHN Children's Services; one was under Tower Hamlets Mental Health and two were under the Community Health Services Newham.

6.3 There was one reported LeDeR death in February 2019 which was subject to an ELFT and Bart's Health joint SI Review which is now completed. In March 2019 there was one LeDeR death reported, this was recorded by ELFT although the patient no longer had contact with ELFT. The reporter was requested by LeDeR to complete a Datix. The Learning from Deaths Review Team will continue to liaise with the Learning Disability Lead for the Trust in order to collate data.

6.4 City & Hackney LeDeR deaths were recorded but not fully captured in Q1, Q2 or Q3 due to reporting issues. The Directorate did not have systems in place and all LeDeR deaths in City & Hackney were reported by another Directorate. This is now rectified and all LeDeR deaths in City& Hackney are reported by the Directorate.

Patient Story- Elsie (*pseudonym*)

Elsie was a 60 year old lady with a diagnosed moderate learning disability and was under the local Cardiology Team. Care was managed by her GP and she was supported by the Learning Disability Team. In August 2018 Elsie was admitted to hospital and diagnosed with a blocked bile duct and infection of the bladder tube.

On 9 September 2019 a best interest meeting was held to establish the most appropriate treatment. Elsie was treated with anti-biotics and a discussion had taken place around discharge planning. Elsie's bilirubin levels were improving and her cardiologist also suggested that a pacemaker would be appropriate option for enhancing her quality of life. The procedure was to be carried out prior to discharge. She was transferred to the cardiac care unit.

On the 12 September 2019 the Learning Disability Team received a call from the hospital to inform them that Elsie had died with her family and carer around her. Elsie's Learning Disability Nurse visited the ward and spoke with a Cardiac Consultant.

As Elsie had a moderate learning disability and died in hospital a full ELFT review was not carried out. Her death will be reviewed by the LeDeR Review team and findings will be released on conclusion of the review.

7.0 Unexpected Deaths

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

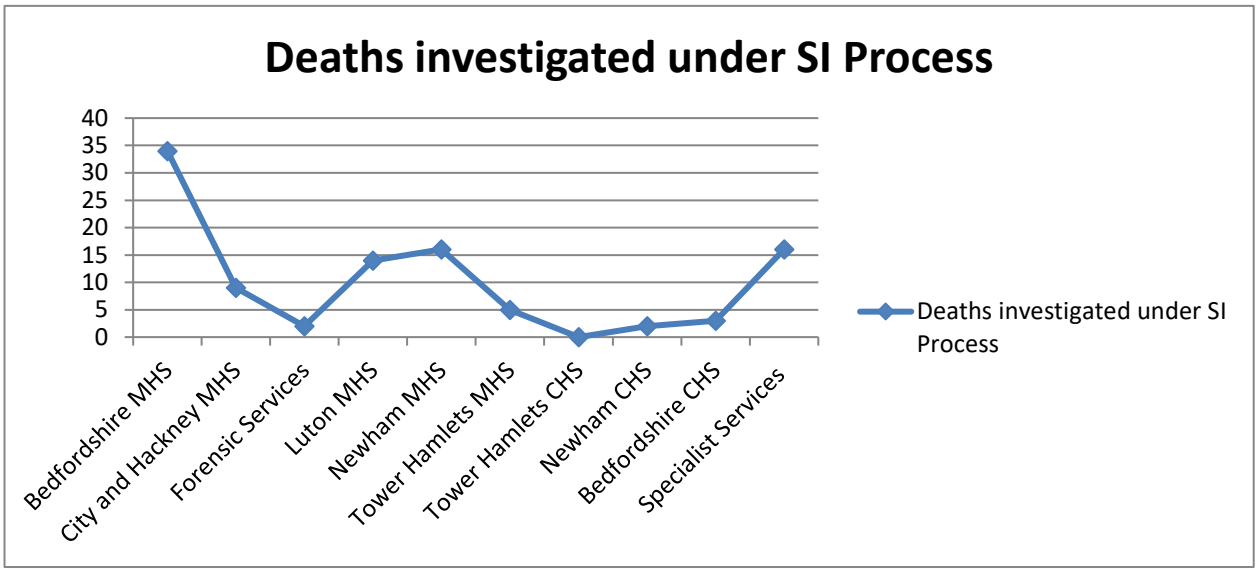
A total of 101 unexpected deaths were subjected to the SI process between 1 April 2018 and 31 March 2019. The five following cases were de-escalated from an SI review:

- A 61 year old lady with multiple physical health problems died in hospital from a cardiac arrest.
- A 49 year old male under the Pathway to Recovery Service (P2R) died from decompensated alcoholic liver disease and previous intravenous drug use.
- A 14 year old girl with cerebral palsy;
- A 52 year old man was found deceased at home. He had been referred to the Memory Clinic. However, he died before being seen by ELFT.
- 62 year old lady under the CMHT who failed to attend her first appointment as she had died 2 weeks previous.

Table 3- Number of deaths investigated under the SI Process

Deaths investigated under SI Process	SI
Mental Health Services	
Bedfordshire Mental Health Services	34
City and Hackney Mental Health Services	9
Forensic Services	2
Luton Mental Health Services	14
Newham Mental Health Services	16
Tower Hamlets Mental Health Services	5
Community Health Services	
Tower Hamlets Community Health Services	0
Newham Community Health Services	2
Bedfordshire Community Health Services	3
Specialist Services	
Specialist Services and CHN Children's Services	16
Total :	**101**

Chart 5- Deaths subject to 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 32 cases subject to an SI. There were 4 suicides in Specialist Services and none from Community Health Services. The suicides in Specialist Services were patients that had been accessing drug and alcohol services or another of the psychological therapies. The highest numbers of suicide was found in males over the age of 40 years. Bedfordshire Mental Health Services had a total of 13 suicides that were investigated by the Trust and subsequently reviewed at a Coroner's inquest.

8.0 Themes & Trends

The review looked at themes and trends from both expected and unexpected deaths across the Trust. The highest number of mortalities was in 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.

8.1 Themes for Unexpected Deaths

8.2 Suicides and Homicide

Figures show suicide as being the highest cause of death with 13 cases in Bedford Mental Health Service's. Males over the age of 40 years had the highest number of suicides across the Trust. Hanging or asphyxiation and hypoxic cardiac arrest caused by hanging were the highest causes of death. There were no cases where a patient was the victim of a homicide.

8.3 Last contact with ELFT Services

Of the deaths appearing at Coroner's Inquest, 74 patients died within 6 months of last contact with ELFT services. 20 of those were within one month and 40 patients died within a week of last being seen. 10 patients were seen outside of the 6 month period after which they died unexpectedly. These were cases appearing at the Coroners Court and had not all been subjected to a full SI.

8.4 Age

There were 3 child deaths from the CCNS and were all children suffering from a life limiting disroder. All 3 cases were under the CCNS for PEG feed, management. In all cases care was being managed by the child's GP, a specialist consultant and a local authority. One cause of death was pneumonia and the other 2 cases were sepsis. The families in all 3 cases would call their GP or consultant if there were every any physical health concerns.

34 cases were between the ages of 18 and 40 years. There were also 34 cases where the patient was over the age of 40

8.5 Gender

The highest number of unexpected deaths was among males over the age of 40; this group had the highest numbers of suicide from across the Mental Health Services. There were more males that died from suicide by hanging in Bedfordshire mental health services than any other directorate.

8.6 Under CMHT or Inpatient facilities

There were 3 deaths on inpatient wards. One patient absconded from the ward and jumped or fell from a height. Another patient was found unresponsive in the toilet cubicle in his room; the Coroner's Inquest is due to take place in November 2019. The third inpatient was found unresponsive on the ward, an SI has been completed and ELFT are now awaiting its Executive Panel approval by SLAM. The remaining cases were all under Community Mental Health Services.

8.7 Demographics

The geographical population of 437,509 in Bedfordshire means that Community Health and Mental Health Services combined are the largest in the Trust. The highest number of unexpected deaths occurred in Bedford Mental Health Services where 36 (.008% of the population) deaths went to Coroner's Inquest.

The Combined Community Health and Mental Health Services in Newham had the second highest rate of unexpected deaths; this was the second highest populated geographical area. Newham Mental Health services had the second highest rate of unexpected deaths with 15 (.00364% of the 411,056 population) cases being subject to an SI. There were 17 cases that went to Coroner's Inquest, 2 of those cases were subject to a 48 hour report and a concise review and were not escalated to an SI.

8.8 Themes for Expected Deaths

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

Data on ELP and PPC was not gathered in Q1, Q2, Q3, or in January and February of Q4. This information was not being reported consistently therefore data was not meaningful. ELP's and PPC's are now reported by staff and are included in March of Q4 and will be reported going forward. There were a total to 50 cases reviewed during the period of March 2019. 14 of the patients where care was being managed by the Trust did have an ELP or PPC that was available for review. Out of the cases that were not being managed by ELFT, there were two ELP's available for review.

ELP's and PPC's where patient s died in a care home or hospitals were not reviewed. This was due to care plans being kept solely in the place of care and not on the systems available for reviewing.

Age

Q1, Q2, Q3 do not capture patients ages. Data was not gathered due to the information having to be gained through manual calculation for each individual case. This was due to the data systems not being specific enough in recording exact ages. Age was captured and reported in Q4. Patients who died expectedly receiving and were receiving palliative care or had life limiting illnesses appeared to be higher in the over 65's.

Gender

Gender was not reported in Q1, Q2, Q3 or January and February of Q4. Data for March of Q4 shows that out of the 50 cases reviewed as an SJR, 28 were male and 22 were female. The Mortality Team are looking at different ways to correlate data for the next reporting period.

There were a small number of cases where missing data prevented a review being undertaken. This is raised with localities and services when missing data is noticed by the ***** Datix Daily Notification Graders and during Serious Incident Review Staff Feedback Meetings.

Overall cases with missing patient details have reduced over Q3 and Q4 during the 2018-2019 reporting period. This is as a result of the advice given to services when they are reporting a death.

Standard of care

Overall the care provided by the Trust has been to a good standard. Mental healthcare; physical healthcare; support and advice; use of medication; shared decision making; the phases of end of life care and family involvement were all reviewed.

The review looked at ELP's; PPC's and DNARS being in place and the maintenance of patient dignity during the dying phases

One case reviewed under the SJR process was raised and investigated as an SI. The patient had chosen to die in her own home with family around. There was a delay and then an error in the prescribing of end of life medication. An OOH GP refused to prescribe due to being unaware of the original intended dose. As a result the patient was taken to a hospice where she died the same day.

Datix - Daily Notification Graders

Incidents are graded daily by the Incident Team. The incidents that have been reported over the previous working day are graded according to the patient or person harm. These cases are presented at the Grading meeting where a panel will discuss the severity of the incident and if it requires further investigation, if so what level is appropriate.

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.

Diagnosis and Cause of Death

This domain was not reported in the first 3 quarters. However, it was recorded in Q4 and reported to the Learning from Deaths Panel. The highest numbers of confirmed cause of death was cancers and organ failure. Themes will be shared with the clinical services.

9.0 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 seeking to 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.

Bedfordshire and Newham have similar population sizes at 43,7509 and 41,1056 respectively. The number of deaths in these populations, are in the main, directly correlated with the population sizes. However, the expected death rates of Newham patients in receipt of community health services at 429 deaths is higher than the corresponding death rates of Bedfordshire patients in receipt of community health services at 205. The total number of expected community health deaths at 35% is almost double the percentage rate for Bedfordshire patients (@17%), despite the fact that Bedfordshire has a slightly larger population. Possible factors which have led to the higher Newham death rate may be related to population factors and higher physical morbidity rates of the general population. However, this will require more in depth analysis to accurately assess those factors which have directly contributed to these poor outcomes and a longitudinal analysis to determine whether this is a usual occurrence in Newham or an anomaly for this reporting period.

With respect to deaths from patients in receipt of mental health services this is completely inverse to the expected death rate of patients in receipt of community health services in Bedfordshire at 129 deaths compared to 24 for Newham patients/services users in receipt of mental health services. The higher rate of expected deaths of Bedfordshire patients in receipt of mental health services in

Bedfordshire at 18.6% is much higher than all other Trust mental health services expected deaths. Again, the factors which have led to this outcome requires more in depth analysis and a longitudinal study to assess the correlated factors behind these figures.

All incidents of death by suicide are assessed as unexpected deaths. Sadly, of a total of 36 deaths, given an inquest verdict of Suicide, 13 involved Bedford mental health services patients/service users. The high incidence of males over the age of 40 in this group has been identified as a theme for these deaths. At a total percentage of 36.11% for Bedford mental health services this issue is one of huge concern to the Trust. The Trust is resolved to work toward preventing and reducing all incidents of suicide and is actively using the National Confidential Enquiry into Deaths Toolkit as one of several mechanisms to support initiatives in this area.

As this is the first concerted attempt that the Trust has made to review and thematically analyse deaths, there is a still a long way to go to accurately determine how best to prevent suicides and other unexpected deaths. The population contributory factors which give rise to the numbers of expected deaths also require more in depth analysis to identify those mechanisms which can be adopted across health and social care to reduce morbidity rates and enhance and increase the overall health of the populations ELFT serves.

Against this background, The Learning from Deaths Group 2019/2020 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.

10.0 Recommendations

10.1 That the Board note this report