East London NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
3 OCTOBER 2019

Title	Learning from Deaths Review
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Purpose of the Report

Death of a service user has a major impact not only on their family but also our staff and the community as a whole. It is important we learn from deaths on how we can prevent a death from occurring or in the case of an expected death make sure we take into account what matters to the service user and their family. Learning what we could have done to prevent a death or make a death better is important for us in improving the service we provide for our community. This process of reviewing and learning from deaths is also important for the family so they understand the circumstances and what we doing to improve our services.

This report provides an analysis of service user deaths over the three month period 1 April – 30 June 2019.

Summary of Key Issues

The Trust reported a total of 368 deaths between 1 April 2019 and 30 June 2019, of those 294 were expected and 74 were unexpected.

All 74 cases of unexpected deaths were subjected to a 48 hour report to determine whether additional investigations were necessary. 19 of those deaths were subject to the SI process, where the RCA investigation is externally reported onto the Strategic Executive Information System (StEIS).

The 13 learning disability deaths reported in Q1 were routinely subjected to the LeDeR process. 8 of the deaths were expected and were not subject to any further Trust review. 3 cases where death was reported as unexpected were investigated further via a SI review by the Trust.

Of the 294 reported expected deaths, 174 were reviewed using Structured Judgement Review (SJR) in Q1. This comprised of 129 cases where ELFT had direct contact with the service user at time of death and 45 cases where death occurred in hospital/care home.

Of the 174 expected deaths reviewed in Q1, all cases were to a good standard of care.

End of Life Pathway was in place for 130 of the cases reviewed; this was 74% of the total 174 cases.

There was good evidence of family involvement in 120 (79%) of the cases reviewed in Q1. Most of the cases had clear documentation of decision making, advice and support being given to the friends and families of the patient.

Committees/Meetings where this item has been considered

09/09/2019	Trust Quality Assurance Committee
17/09/2019	Learning from Deaths Committee

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

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
System 1	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

1.0 Background/Introduction

1.0 Death of a service user has a major impact not only on their family but also our staff and the community as a whole. It is important we learn from deaths on how we can prevent a death from occurring or in the case of an expected death make sure we take into account what matters to the service user and their family. Learning what we could have done to prevent a death or make a death better is important for us in improving the service we provide for our community. This process of reviewing and learning from deaths is also important for the family so they understand the circumstances and what we doing to improve our services.

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 reviews and to publish data relating to deaths. This approach to mortality reviews was first reported to the Board in October 2017.

1.2 The main focus of the changes is on governance and capability, skills and training, patient safety, family involvement in reviews, improved data collection and recording.

1.3 Mortality review processes and associated data / information are in their formative stages both nationally and within the Trust especially for mental and community health mortalities although acute hospitals have routinely reviewed and reported on expected deaths through the mandatory Hospital Standardised Mortality Ratio (HSMR) data.

1.4 Whilst the guidance from the National Quality Board makes it clear that Trusts should report on inpatient deaths and those inpatients who have died within 30 days of leaving hospital, Trusts are able to determine their own local approaches to undertaking mortality review including defining the scope of deaths for review. Mortality data is therefore **not** comparable between Trusts.

1.5 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 on deaths meeting the national criteria for serious incident review.

1.6 This report sets out Quarter 1 data for 2019- 2020.

2.0 Mortality Review Process

2.1 There were a number of deaths not captured on Datix (electronic risk management system) as the individuals concerned were not being managed by the service reporting the death. Typically such deaths are notified through the national Summary Care Record, advised through other agencies / individuals etc. and subsequently matched to information recorded on clinical systems.

2.2 To ensure all deaths are effectively reviewed and managed, deaths are reviewed via a monthly Learning from Deaths Panel, chaired by the Trust's Chief Medical Officer. The Panel looks at trends across services and localities and may ask for a thematic review or for particular cases to be reviewed using structured judgement (case note review) methodology. The membership, terms of reference and requirements of the Panel are continually evolving.

2.3 Under the new framework organisations are required to undertake Structured Judgement Reviews (SJR) of deaths where:

- Bereaved families / carers or staff have raised a significant concern about the quality of care provision

- The patient had a learning disability (through the Learning Disabilities Mortality Review (LeDeR) process)
- Where an alarm / concerns have been raised from another agency
- Where thematic learning could take place.

2.4 These categories will normally be reviewed through the routine Incident Review Process. Apart from deaths investigated through LeDeR which is controlled externally, the Trust will not normally undertake SJRs for individual deaths in addition to the Serious Incident Review process (SIR). All unexpected deaths are reported in this report.

2.5 A sample is also provided of expected deaths that do not fit the already mentioned processes, but where learning and improvement could be gained from review. The Trust undertakes case-note reviews on 100% of all expected deaths where the care was being managed by the Trust. The Trust also reviews 25% of expected deaths where patients were accessing an ELFT service, where the care was not managed by ELFT and they died in a care home or a hospital.

2.6 In the case of unexpected deaths a 48 hour report would be completed and consideration of SI made. A 48 hour report is much more rigorous than a SJR and therefor these are not required in unexpected deaths.

3.0 Resources

3.1 The NHS Quality Board framework specifies that case note review should be undertaken by clinicians/reviewers to enable the application of 'avoidability' score after scrutiny. The "avoidability" scores ranges from definitely avoidable to definitely not avoidable.

3.2 During Q1 the Trust has appointed one substantive Mortality Reviewer and is in the process of appointing a Mortality Apprentice. These roles sit within the Governance and Risk Department working closely with the Incident Review Team. The Mortality Reviewer is responsible for the collection, analysis and reporting of data.

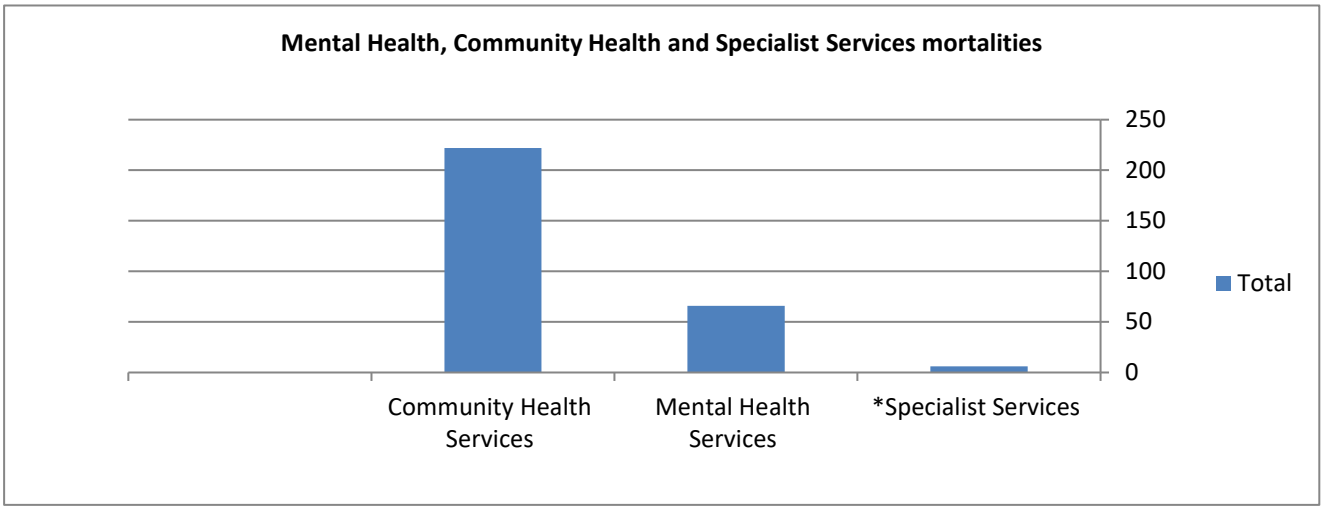
4.0 Presentation and Analysis of Mortality Data for Q1 2019-2020

4.1 Summary of deaths and scope of review: 1 April 2019 - 30 June 2019

- 100% of reported 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
- SJRs have been conducted using patient information (recording) systems EMIS; RiO; SystmOne and the Incident Reporting System DATIX. The SJRs look at the 6 months of case notes prior to the patient's death
- All unexpected deaths are reviewed via the SIR process.

4.2 Number of patients who died in Q1 2019-20120

A total of 368 deaths were reported between 1 April 2019 and 30 June 2019, 294 of were expected deaths and 74 were unexpected. Figures were similar to the number of reported deaths in Q1 in 2018/2019 where a total of 376 deaths were reported.



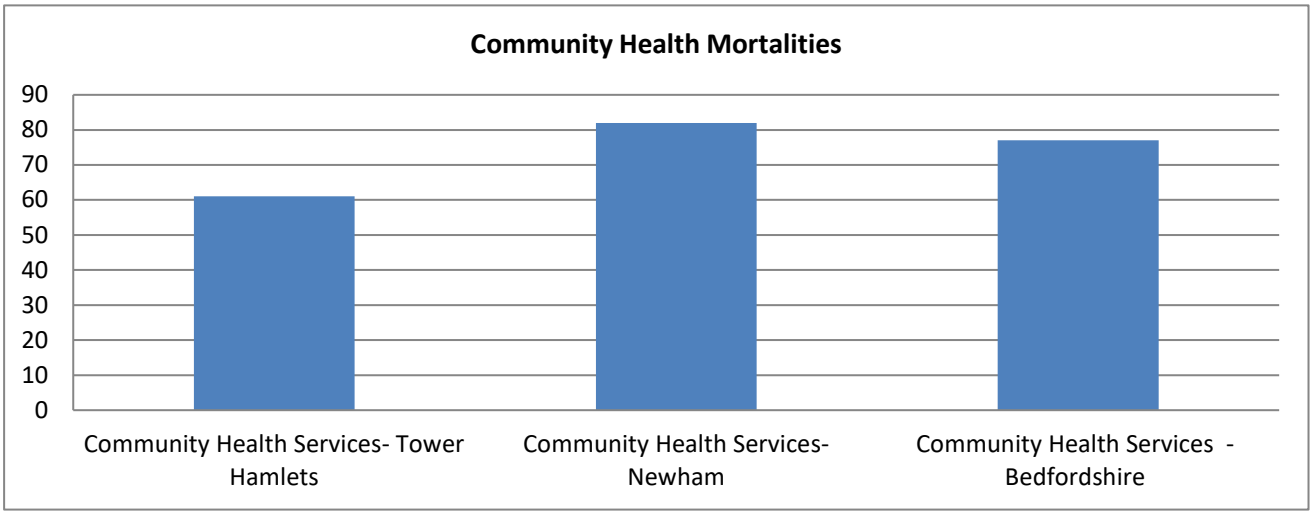
Graph 1. Expected deaths across Mental Health; Community Mental Health and Specialist Services

*Specialist services include Children Community Services and psychological therapies are also commissioned by NHS England.

Community Health Services across the Trust showed higher numbers of expected deaths in the reporting period than those of Mental Health Services. A total of 222 Community Health deaths were reported in Q1. Mental Health Services reported 66 deaths, during this quarter, with Specialist Services reporting 6 during the reporting period.

The high numbers of expected deaths in community services is not unusual due to the prevalence of palliative /care and end of life services provided.

Expected deaths in mental health services mainly arose in older person's services or where the patient also had a physical diagnosis, e.g. terminal illness. Expected deaths in Specialist Services mainly occurred in Children's Community Health Services or where patients were accessing a therapy and also had a physical diagnosis.

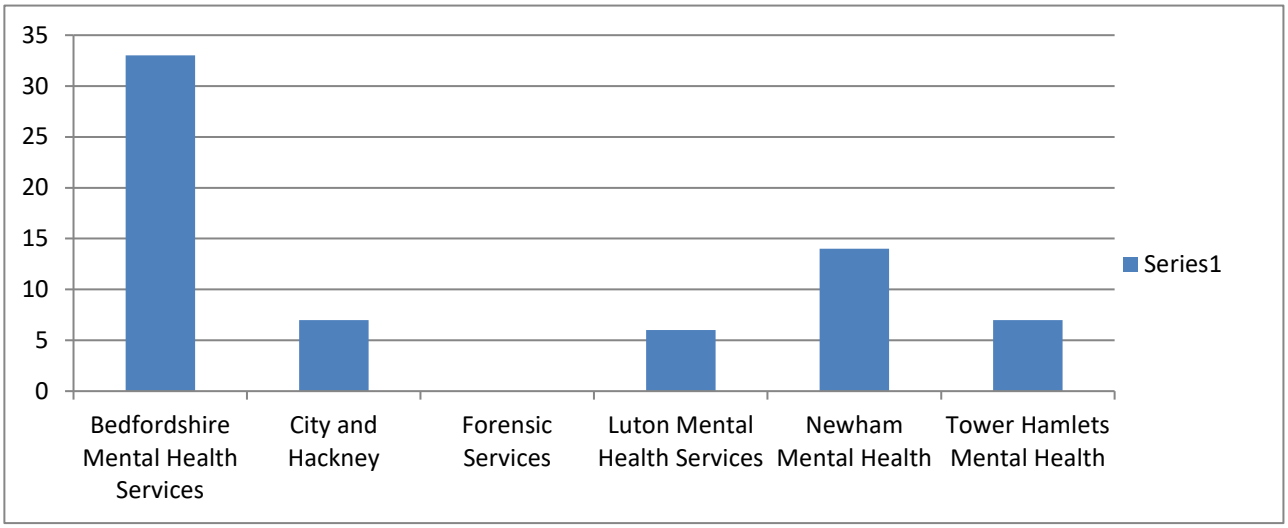


Graph 2. Expected deaths by Community Health Directorates

Over the 3 month period of Q1 Newham Community services had the highest number of deaths at 82. Bedfordshire showed the second highest at 77 and Tower Hamlets at 61.

Community services have the highest overall numbers of elderly patients and see the highest number of patients in receipt of palliative care including: end of life care. Therefore, the high numbers of deaths in community services is not unusual.

Graph 3. Expected deaths by Mental Health Directorates



Bedford Mental Health Services had the highest number of expected deaths over the Q1 with a total of 33, period. Newham Mental Health Services showed the second highest rate with 19 reported expected deaths.

Expected deaths in Bedfordshire Mental Health Services were significantly higher than the other Directorates due to the higher number of elderly patients in receipt of older person's services, e.g. for Memory Clinics.

Factors that had an impact on figures in Bedfordshire Mental Health Services were: patients were between 66-100 years old they were also accessing community health services and died from a terminal illness.

4.3 Structured Judgement Reviews

Of the 294 reported expected deaths, 174 were reviewed in Q1, comprising of 129 (all reported expected community deaths) and 45 expected hospital/care home deaths were reviewed under the SJR process.

Of the 45 SJRs undertaken of the patients who died in hospitals or care homes, 37 were accessing one or more ELFT services prior to their inpatient/care home admission.

Patient story 1: James *(pseudonym)*
James was a 55 year old British man who died in Hospital ITU. He had been under the CMHT and had been known to services since 2003 when he was diagnosed with schizophrenia. He was being seen every 2 weeks for his depot and his mental health was reportedly being managed well.

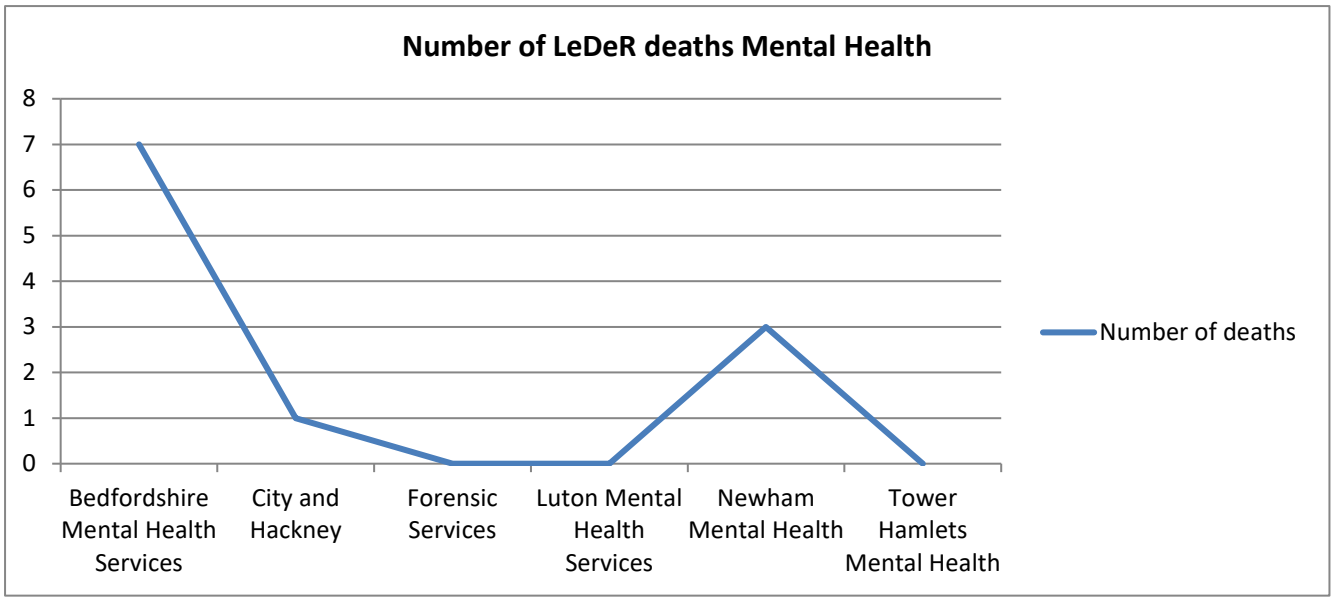
James, however, had no insight into his poor physical health, mainly due to his alcohol problem. The CMHT offered support and encouragement to attend drug and alcohol services which he was reluctant to do.

Sadly James was admitted to hospital where he died two weeks later. His diagnosis and cause of death (CoD) was advanced lung disease, kidney and liver failure due to alcohol use. The prognosis was very poor and he deteriorated rapidly and passed away due to multiple organ failure. James death was predictable due to his poor physical prognosis and his reluctance to address his alcohol problem, which was causing the decline in his physical health.

The care and support provided by the CMHT was to a good standard, communication was open between the GP and the CMHT, and there was evidence of meetings and attempts to encourage James to accept support from drug and alcohol services. James died in hospital with his family around him. James was not under an End of Life (EoL) pathway whilst under ELFT care. EoL pathway was implemented in ITU.

4.4 Learning Disabilities Mortality Review (LeDeR)

Graph 4. LeDer deaths in Mental Health Services



The 13 learning disability deaths reported in Q1 were routinely subjected to the LeDeR process. 8 of the deaths were expected and were not subject to any further Trust review. 2 of the unexpected deaths did not require further review as one patient had accessed an ELFT service for a hearing assessment and had not been seen due to his passing. The second case was not reviewed by the Trust as the patient had not been seen for more than a year but the service took responsibility for reporting the death, the patient died of a brain haemorrhage. The remaining 3 cases where death was reported as unexpected were investigated further via a SI review by the Trust.

Patient story 2- Michael *(pseudonym)*

Michael was a 39 year old man with a diagnosis of Mild Learning Disability, Depressive Episode and Diabetes Mellitus Type-2. Michael had been seen recently in the psychiatric outpatient clinics with the health facilitation staff. Michael's mental state was stable and his compliance with diabetic medication had improved. He was exercising regularly and improved his diet. He had not expressed any suicidal thoughts/plans to harm himself. His next appointment was to be in 4 months and no changes had been made to his treatment plan.

Michael was found unresponsive at his home. A concise review was undertaken and there was no indication that this had any suspicious circumstances. RIO case notes were reviewed. Record of last contact noted and no changes to treatment plan. No concerns were noted from his last contact with ELFT. Condolences were offered to the family

The LeDeR review is not complete and an exact cause of death has not been identified at this time. There were no service delivery or service delivery problems.

4.5 Unexpected deaths

Table 2. Number of deaths investigated by SI Process by Directorate

Directorate	**Unexpected deaths subject to serious incident review**
Bedfordshire MHS	6
City & Hackney MHS	0
Community Health Services Bedfordshire	0
Community Health Services Tower Hamlets	0
Community Health Services Newham	0
Forensic Services	1
Luton MHS	5
Newham MHS	2
Specialist Services & CHN Children's Services	3
Tower Hamlets MHS	2
Total	**19**

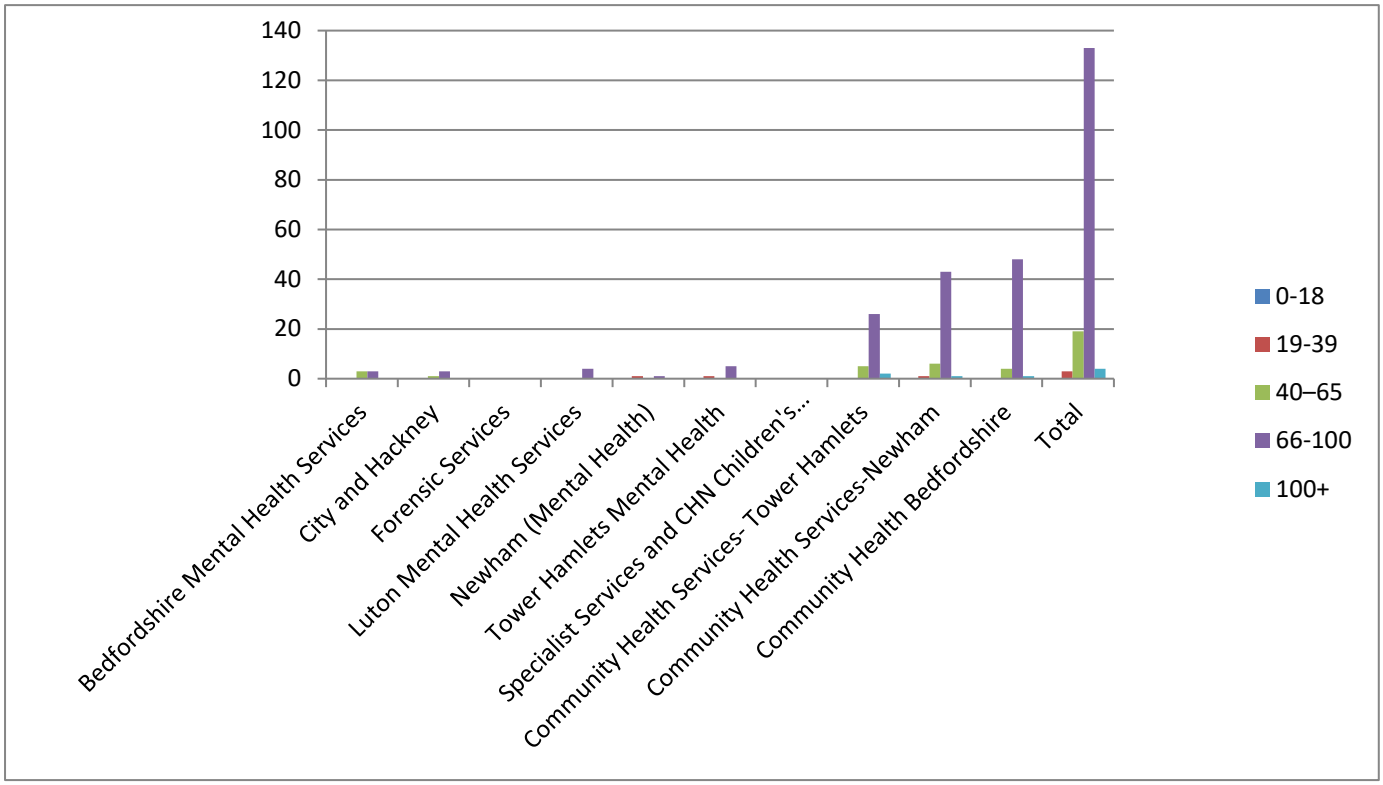
All 74 cases of unexpected deaths were subjected to a 48 hour report to determine whether additional investigations were necessary.

19 of those deaths were subject to the SI process, where the RCA investigation is externally reported onto the Strategic Executive Information System (StEIS).

3 cases were de-escalated to a concise (internal) review
1 case with a patient with a mild learning disability who also had diabetes was subject to a LeDeR review.
7 of the remaining 15 cases were reported as suspected suicide by strangulation or hanging.
1 death was due to self-laceration of the wrists;
4 were reported as falling from heights,
1 from a building
2 from bridges where one person drowned.

4.6 Age ranges

Graph 4. Age range of deaths by Directorate



Community Health Services saw the highest rate of expected deaths in the age 66 - 115 years range with 2 cases at 100 years and 115 years respectively. Community Health Services also saw the highest rates of patients receiving either palliative or end of life care which would explain the figures.

Expected deaths in Mental Health Services ranged mostly between the ages of 40 and 100. The majority of the cases reviewed were from Older Persons Mental Health services and many had died from end stage dementia, or had accessed the memory clinic and died from physical complications either symptomatic with dementia or another diagnosis.

Patient story 3: Mohammad *(pseudonym)*

Mohammad was a 115 years old Bengali man who lived in a supported care accommodation and had a local authority care package. Mohammed was under the ELFT Continuing Care team who were visiting him weekly for palliative support. His family were very involved and supportive and took turns in staying overnight with him.

Mohammad had kept in good health all his life and there were no concerns over his mental health until he was diagnosed with dementia.

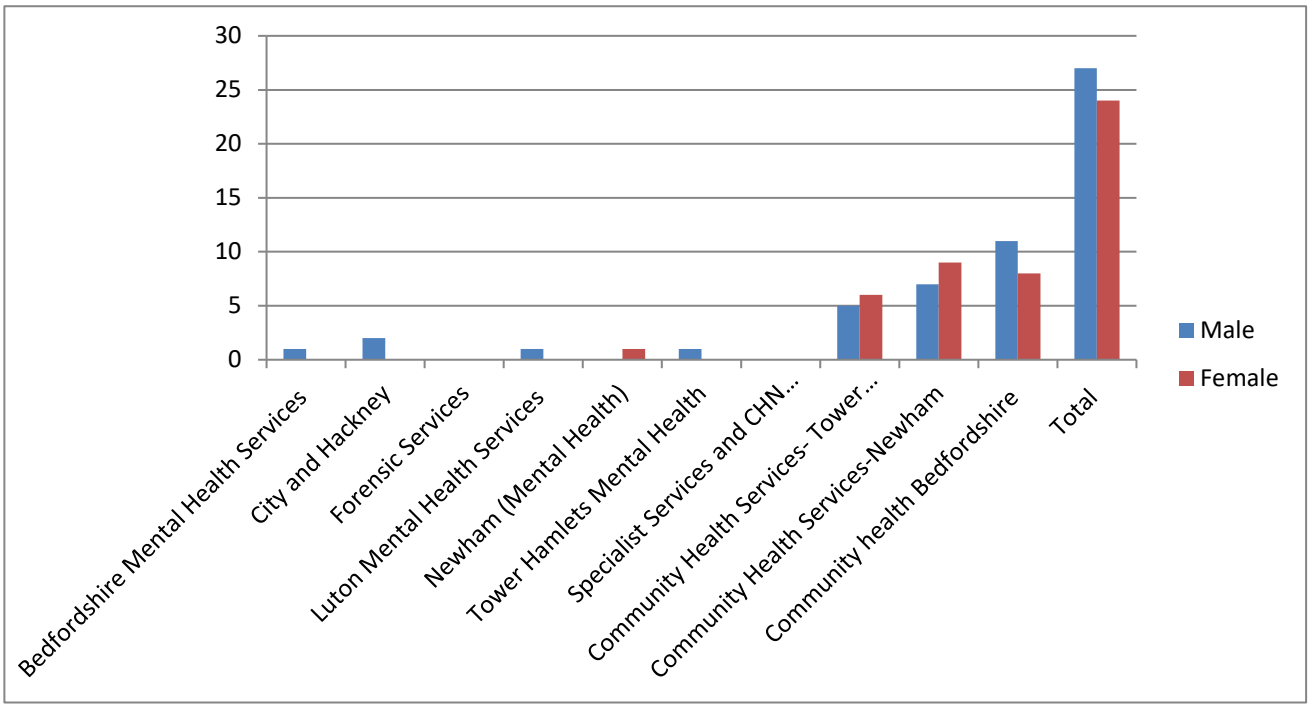
Mohammad's son administered his medication that was prescribed by his GP. Mohammad's carers and nurses were monitoring his skin for signs of pressure damage which had remained intact.

He had a recent admission to hospital with delirium and he had been prone to falls. He was found not to be suitable for a bed rail due to his dementia. Mohammad lacked capacity and a best interest decision was made on his behalf, he received a Floor Bed which was effective and meant he could be cared for at home as per his wishes specified in his Preferred Place of Care Plan (PPC).

Mohammad had an end of life (EoL) pathway; anticipatory medication and DNAR were all in place. He passed away with his family around in his preferred place to die. Mohammad had a poor prognosis and he was frail, his death could not have been prevented. Mohammad was able to die in his preferred place with his family around. He was not suffering pain and his best interests were forefront. This was evident in the case notes that were reviewed.

4.7 Gender

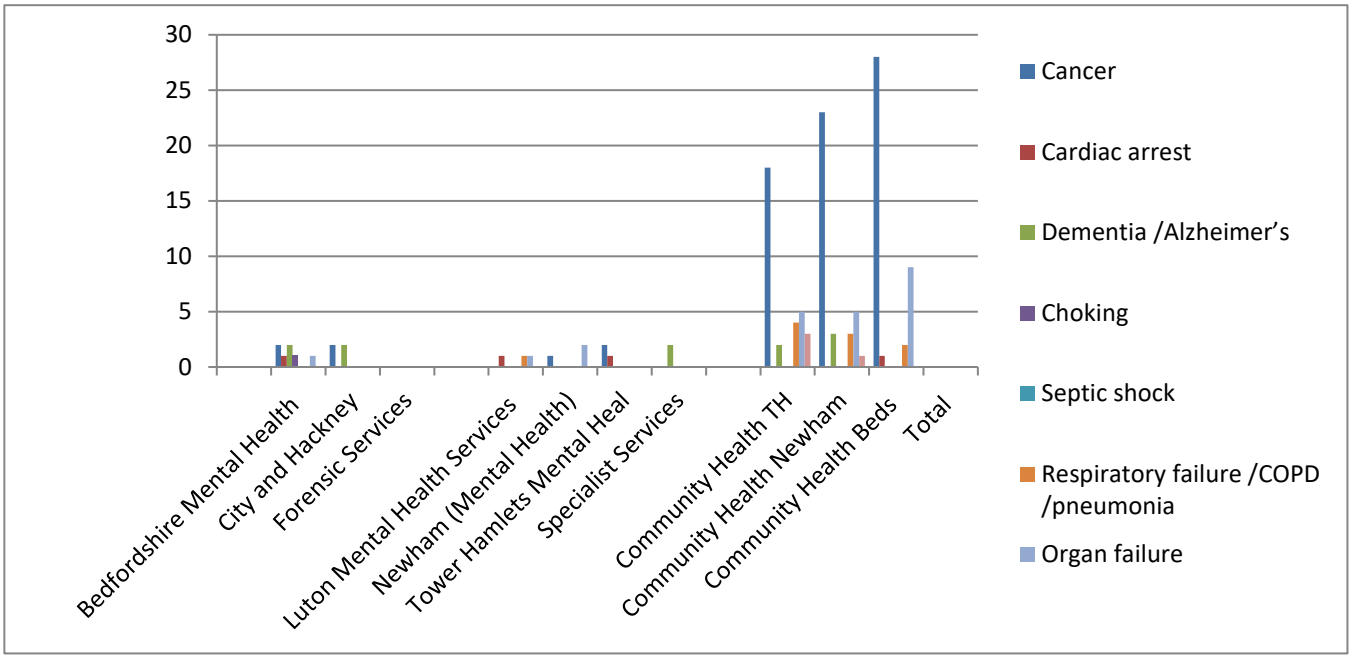
Graph 5. Gender by Directorate



Males overall had the highest rate of expected deaths in the Trust during Q1. Q1 2018-2019 also showed higher numbers of expected mortalities in males and in the Community Health Services.

4.8 Causes of Death

Graph 6. Cause of death by directorate



In all areas cancer was the predominant cause of death in the cases reviewed. A total of 76 patients died across the Trust from various types of cancer. Figures were, as expected, higher in the community health services.

In Q1 there were 4 deaths where the patient had a confirmed cause of death as septic shock. 27 patients died from organ failure and 2 with multiple organ failure in Q1. Organ failure was the second highest cause of death among community mental health patients and community health patients.

Community Health Services patients died in greater numbers than mental health service patients. The majority of CHS patients died in a hospital or at home where they had a terminal illness that they were being treated for, or the terminal illness was also the expected cause of death.

There were no expected deaths in the Forensic directorate in Q1.

5.0 Learning and Themes

5.1 Of the 174 expected deaths reviewed in Q1, all cases were to a good standard of care.

5.2 End of Life Pathway was in place for 130 of the cases reviewed; this was 74% of the total 174 cases. It was not possible to determine in some of the cases if an EoL pathway was in place as the patients died in hospital or in a care home where the care was being managed external to ELFT. DNAR was not reported in Q1 but will be included going forward and will appear in Q2 data for 2019/2020.

5.3 There was good evidence of family involvement in 120 (79%) of the cases reviewed in Q1. Most of the cases had clear documentation of decision making, advice and support being given to the friends and families of the patient.

5.4 It was difficult to determine an accurate figure of the patients' preferred choices of place of care as this was not recorded in the notes of patients' that died in hospital or a care home. In Q1, 69 (32%) patients preferred place of care or where to die was recorded.

5.5 The Trust aims to ensure that all patients who are involved in EoL pathways have their preferred place of care identified as part of this process and that this is acted on where possible.

6.0 Recommendations and actions

6.1 The Board is recommended to receive and note this report**.**