NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
Thursday 30 January 2020

Title	Learning from Deaths Review Q2 July 2019 - September 2019
Author	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:

This report covers the three month period from 1 July 2019 to 30 September 2019 (Q2) 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 523 deaths between 1st July 2019 and 30th September 2019.

A total of 432 expected deaths were reported in Q2. There were a total of 91 unexpected deaths in the same time period. Of the 91 unexpected deaths 48 cases were noted to involve ELFT patient safety incidents.

28 inquests were concluded within the period 1st July 2019 – 30th September 2019.

Our 212 SJR of expected deaths in Q2 show that deaths relate mainly to service users over 65 years, with a higher number of female than males. The most common cause of death was cancer. Work is being developed on looking at those on the End of Life pathway who are under the care of ELFT. We are aiming to identify if a preferred place of death and involvement of family are documented. This is showing no trends at present.

Of the 91 identified unexpected deaths for this 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) and two suicides. Suicide/suspected suicide at approximately 10% of all the unexpected deaths is the highest cause of death category in these unexpected deaths. Three main areas of completed SI in unexpected deaths for learning are:

- Failure of follow up
- Failure to engage family
- Difficult to engage patients

There were a total of 28 inquests concluded within Q2. There were 8 verdicts of suicide and 7 narrative verdicts. The main lessons learnt from these verdicts were:

- 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.

Triangulating these themes there is work to be carried out 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
26/11/2019	Learning from Deaths Panel Meeting
13/12/2019	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 July 2019 till 30th September 2019 (Q2).

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 will usually be dealt with through formal investigation processes and Serious Incident investigations. The outcomes and recommendations of these reports are then reviewed and themes from which the organisation can learn from are noted.

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

2.0 Presentation and Analysis of Mortality Data for Q2

2.1 The total number of service users who died Trust-wide in Q2 was 523 of which 432 were expected deaths and 91 were unexpected deaths.

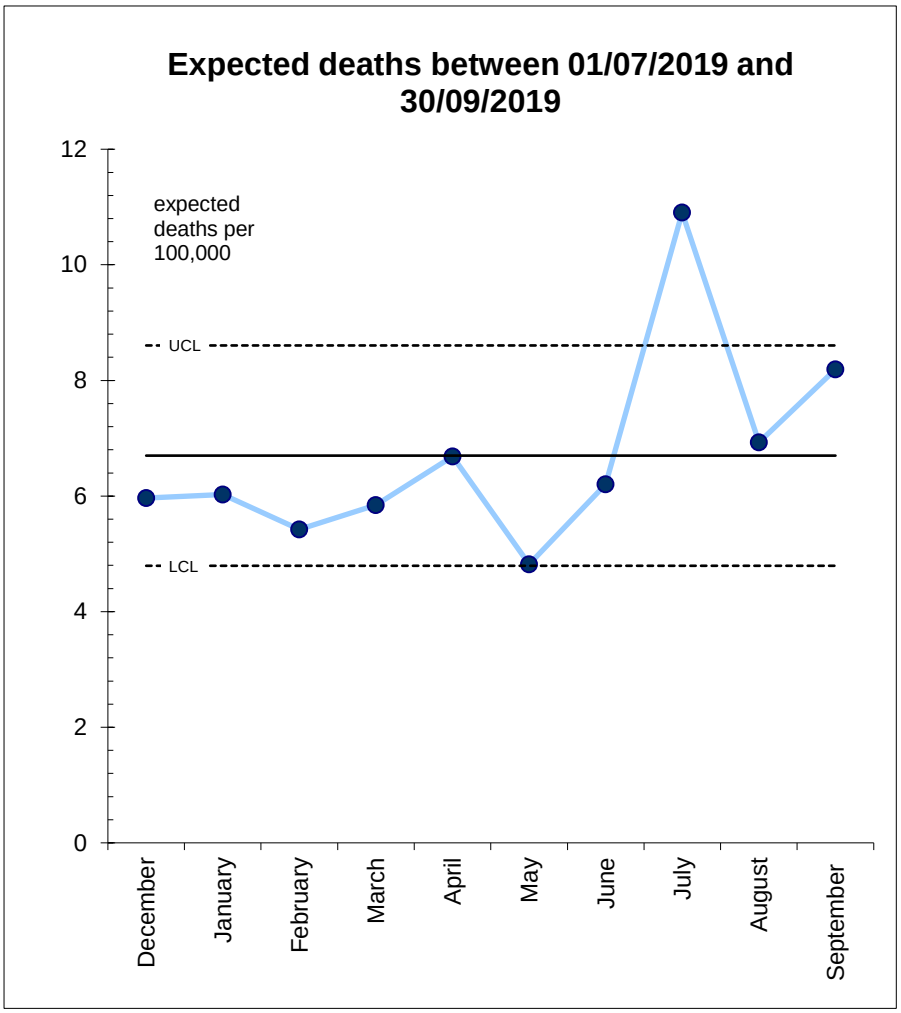
2.2 SJRs have been conducted using patient information (recording) systems: EMIS; RiO; SystmOne and the Incident Reporting System DATIX. The SJRs look at the six months of case notes prior to the patient's death.

2.3 Of the 91 unexpected deaths 48 were noted to involve ELFT Patient Safety incidents. 48 cases were reviewed via the Serious Incident Review process.

2.4 The overall data reported runs from December 2018 until September 2019. The presentation of data during this period has been with the use of Control Charts. Mortality data collection has been continuous over 2018 and 2019.

3.0 Expected Deaths between 01/07/2019 and 30/09/2019 against population

U Chart (Trust-wide) rate 100,000



2018 -2019	Expected Deaths	Pop
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

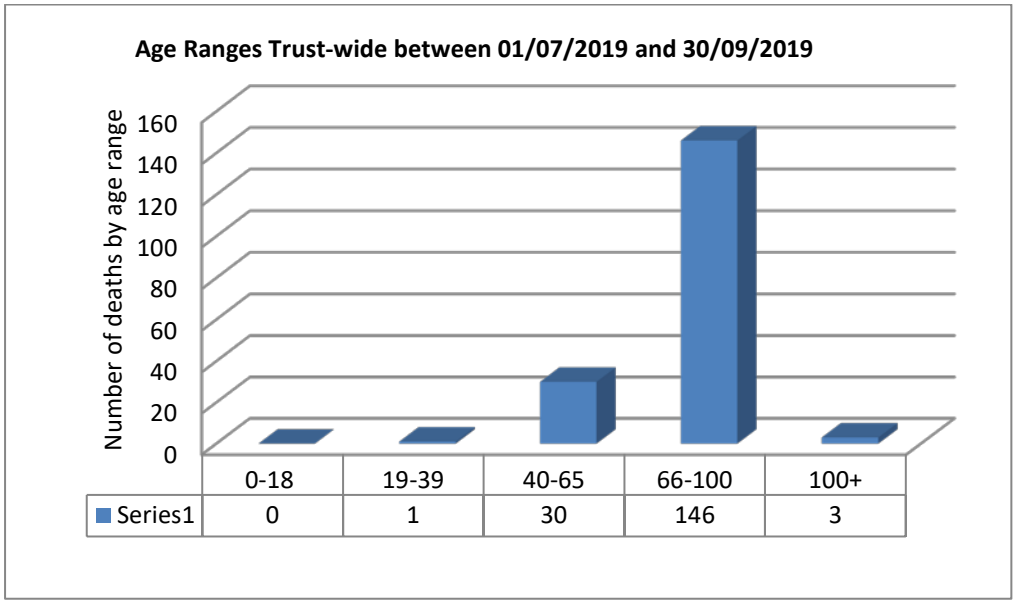
3.1 The baseline for the report is from December 2019 until 30 September 2019. The mean for this period is 6.4 deaths per 100,000 populations.

3.2 Expected deaths were higher in July 2019. This is likely to be explained by hot weather over that period.

4.0 Structured Judgement Reviews

4.1 Of the 432 expected deaths which occurred in Q2, all 148 expected 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. Additionally, 64 patients who were also expected to die, but who died in a hospital/care home and whose care was not being managed by ELFT were also reviewed via the SJR process. A total of 212 SJR of expected deaths was carried out for this time period.

Age Ranges - Column Chart

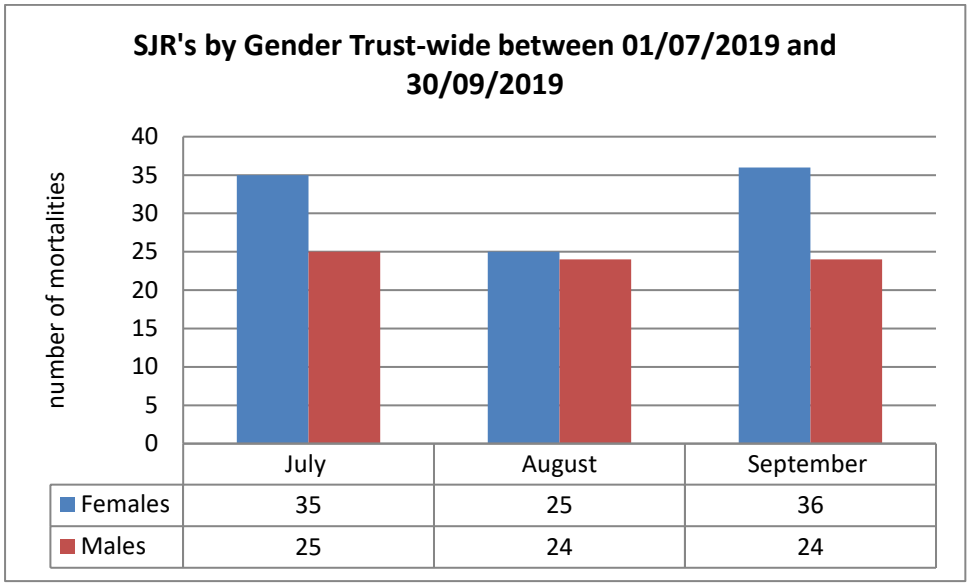


4.2 The chart accounts for the ages of 180 of the 212 reviewed deaths. Of the remaining 32 cases age was either not recorded on Datix correctly. The highest number of deaths occurred in the age group 66 - 100 years. There were three patients over the age of 100 years, two males and one female.

4.3 One male patient of 102 years was not reviewed as he had been a new referral and died in hospital before he could be seen. Another patient of 101 years died after a Cerebrovascular Accident (CVA). She was on an End of Life (EoL) Care Package at home which was provided by social services. Care was provided by Newham Community Health Services. The third patient was a 103 year old female who died in hospital from respiratory failure from a deteriorating chest infection.

4.4 The youngest patient death was that of a four month old female infant who was being cared for in St Mary's Hospital and was known to the Diana Team. This child died from a diagnosed life limiting illness (Jeune's Asphyxiating Thoracic Dystrophy).

Gender - Column Chart



4.5 The table shows 169 of the 212 cases reviewed. Missing patient details on Datix at the time of the reporting account for the 43 cases not reported on the table. Requests for Datix to be updated with this information is part of the SJR process and will not show in the above table. Females had the highest mortality rate in Q2 with a total of 96. 73 male mortalities were reviewed in Q2. There was no specific trend identified for male mortalities.

4.6 **Causes of Death**

4.6.1 Cancer was the highest cause of death throughout the months of Q2 in all services for expected deaths.

4.6.2 There was one case of sepsis in July with none being reported in August or September.

4.7 **Findings from Expected Deaths**

4.7.1 Of the expected deaths reviewed in Q2, all cases demonstrated a good standard of care. There were three cases without patient details reported on Datix. This is a significant improvement over the year 2018 -2019 and is mainly attributable to the training provided by the Datix Team.

4.7.2 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.

4.7.3 EoL pathways were in place for 116 out of a total of 432 patients over the period of Q2.

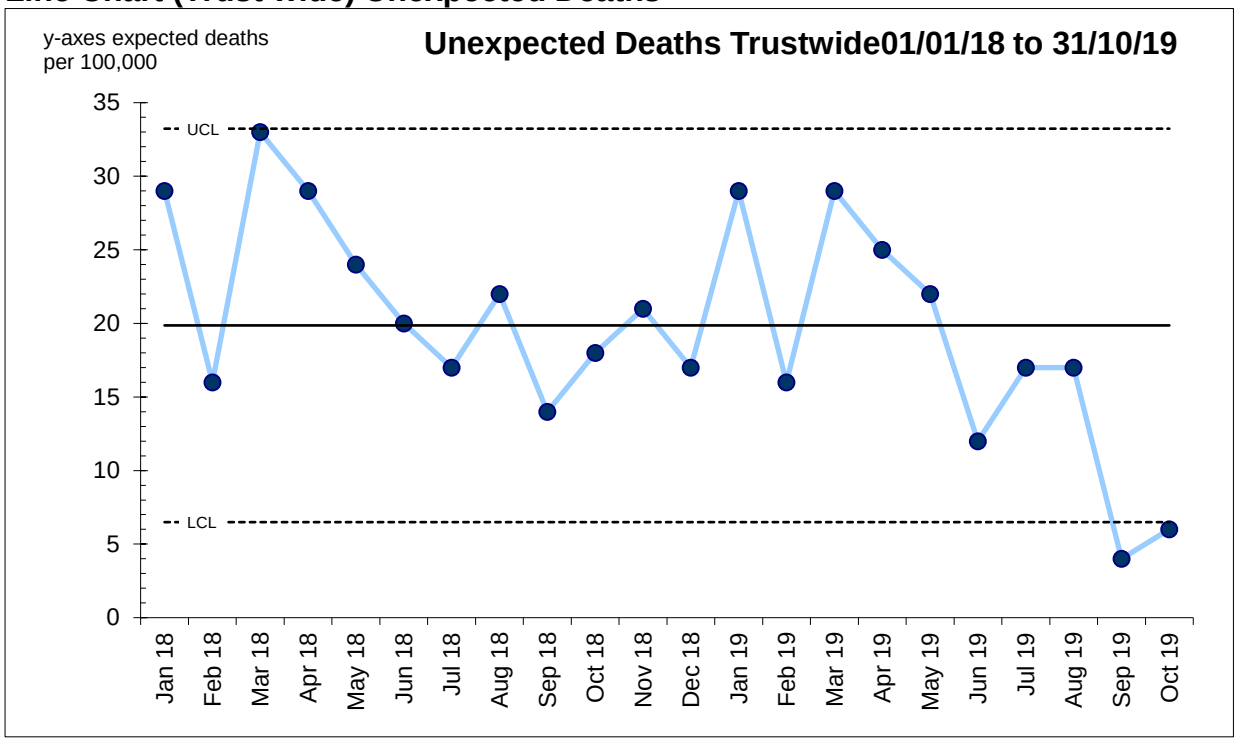
4.7.4 Family involvement and support was recorded in 90 of the cases that were reviewed over Q2. Data on this domain was not available if the patient died in hospital or in a care home.

4.7.5 Moving forward, we are aiming at improving our identification of the preferred place of death and the documentation of this.

5.0 Unexpected deaths

5.1 The chart for Unexpected Deaths shows data from 1st January 2018 until 31st October 2019; this timescale is longer than Run Charts shown for Expected Deaths which show from 1st December 2018 until 30th September 2019. The difference is due to expected deaths being subjected to the SJR process two calendar months after the death has been reported.

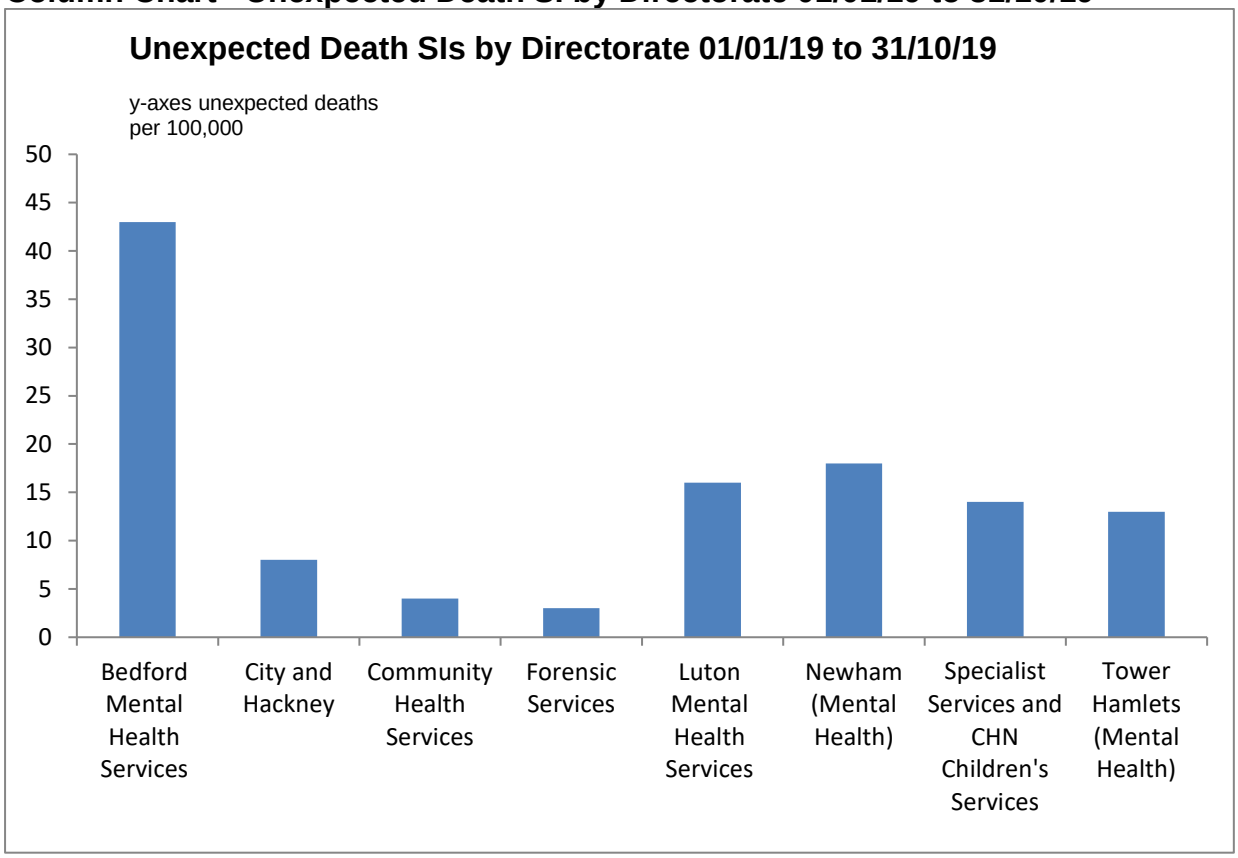
Line Chart (Trust-wide) Unexpected Deaths



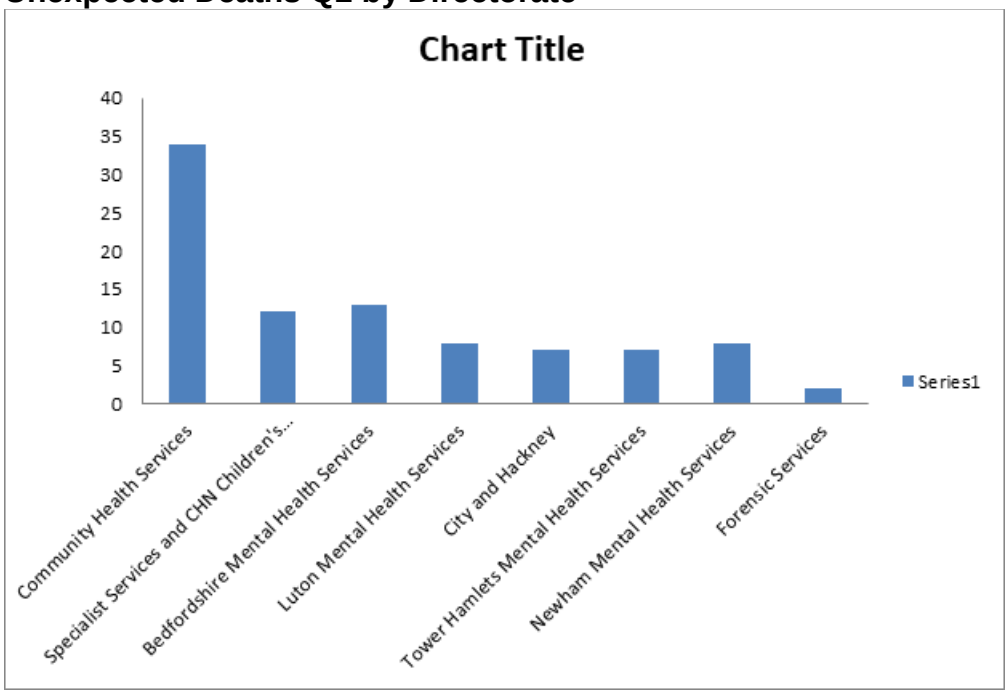
5.2 The baseline for reporting is from January 2018 until January 2019. The mean for this period is 19.9.

5.3 During Q2 there was a decrease in the number of unexpected deaths which were reported on Datix. This is explained by the new categorisation of deaths introduced in September 2019 providing for reporters to record deaths with more accuracy. Previous to September 2019, some cases were recorded as unexpected but with the cause known, where the patient may have been on palliative care and died outside the expected timeframe.

Column Chart - Unexpected Death SI by Directorate 01/01/19 to 31/10/19



Unexpected Deaths Q2 by Directorate



5.4 There were a total of 91 unexpected deaths which occurred during the Q2 reporting period, of which 48 were ELFT patient safety related unexpected deaths.

5.5 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, particularly in the case of Community Health Services, all deaths are reported on Datix by Community Staff for completeness, with respect to closing down patient records and for learning purposes.

5.6 **Q2 Thematic Review of Unexpected Deaths**

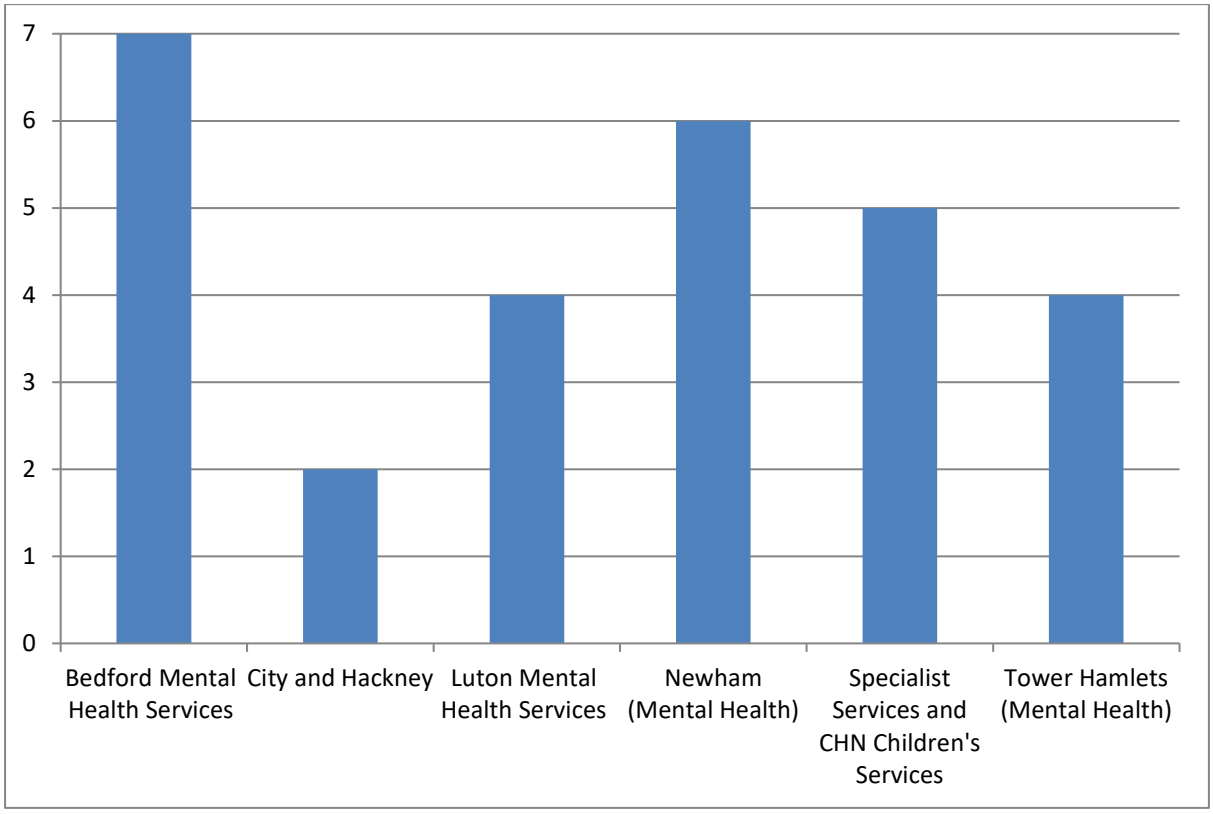
5.6.1 Of the 91 unexpected deaths for the reporting period, there were a total of seven suspected suicides (this will be confirmed following the completion of a Coroner's inquest into these deaths) and two suicides. Suicide/suspected suicide at approximately 10% of all the unexpected deaths is the highest cause of death category.

5.6.2 The completed SI Reviews into a sample of the unexpected deaths which have occurred during this reporting period have indicated that where service users are not followed up in line with agreed protocols/referral criteria, that there is an increased likelihood that they may come to risk of harm. Many of the failures to follow up or incidences of gaps in care is often due to human error or a lack of awareness of the need to follow protocols to the letter. Incidences of failures to proactively engage with families were also identified as negatively impacting on clinical teams' understanding of the collateral history of patients. Sadly, in cases where patient factors prevented their engagement with services this resulted in higher risk of patient unexpected death. However, due to the dynamic nature of many mental health conditions despite services being robustly provided patients could also still succumb to poor outcomes resulting in death.

All these findings have been identified together with mechanisms, where applicable, for them to be addressed in completed SI Reviews. These will be followed up via monitored Action Plans and also at Risk and Governance Directorate reviews via rolling SI Review implementation programmes to be agreed with the Risk and Governance department commencing from March 2020.

6.0 Quarter 2 Inquests

6.1 28 inquests were concluded within Q2. The graph below shows the number of inquests by Directorate:



6.2 Coroner's Conclusions

6.2.1 The table below provides details of the conclusions returned by the Coroner:

Short Form Conclusions:	
Accident	1
Alcohol/Drug Related	1
Drug Related	7
Misadventure	1
Natural Causes	1
Open	2
Suicide	8
Narrative Conclusions:	7
"Following an abrupt decline in his mental health and whilst receiving treatment for injuries sustained in an earlier suicide attempt, the deceased absconded from his hospital bed and ended his life intentionally by jumping out of an 8th floor window of a neighbouring building."	

"[The deceased] who suffered from chronic psychotic illness died from burns sustained during a fire at his home address. This was no evidence of suicide or third party involvement."	
"The Deceased took his own life but his intention in doing so remained unclear."	
"[The deceased] fell from a multi-storey car park sustaining multiple traumatic fatal injuries, but the evidence does not fully explain whether or not he intended to fall, or that he intended to take his own life by doing so."	
"The deceased died as a result of taking a combination of oxycodone and amitriptyline prescribed to him by health professionals. The combination of drugs is known to carry a risk of sedation. Despite exhibiting signs of sedation particularly following the doubling of his amitriptyline dose on 23 May 2018 his prescription remained unaltered."	
"[The deceased] died from an overdose of multiple prescribed drugs which he had been taking for over a year for a mental health condition. He took these drugs himself but the circumstances do not allow for a positive finding that he intended to end his life."	
"The Deceased suffered from dysphagia and, having already suffered from a number of episodes of aspiration, was being appropriately 'fed at risk' when he developed a further episode of aspiration pneumonia from which he did not recover."	

6.3 **Themes**

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

- 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.

6.3.2 All of the issues detailed above had been previously identified during Serious Incident Reviews with associated recommendations/actions.

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

The Trust received one PFD during the period:

Coroner's concerns	**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	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 HTT will be providing additional training

floor window intending to jump. The Crisis Line call taker read his medical notes and so knew this history, but nevertheless did not ask him if he was now feeling suicidal. If she had asked him 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.	during its away days scheduled for 4th and 5th December 2019. This will include: • 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.

6.4 **Non-Trust PFD**

The Coroner issued a PFD to another organisation as set out below:

Coroner's concerns	**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

7.0 Recommendations and actions

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