East London NHS Foundation Trust

REPORT TO THE TRUST BOARD - PART 1
22 July 2021

Title	Learning from Deaths Review January 2021- March 2021
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Purpose of the Report:

This report covers the period from 01/01/2021 to 31/03/2021 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:

(It should be noted that this reporting period coincided with the second wave of the COVID 19 pandemic. At the September 2021 Trust Board meeting we will present a more in-depth review of the Excess Death During the COVID 19 pandemic.)

The Trust reported a total of 864 deaths between Quarter 4 (Q4): 01/01/2021 to 31/03/2021– The Reporting Period.
A total of 836 Expected deaths were reported in the reporting period and a total of 28 Unexpected deaths. Of the total 28 Unexpected deaths 9 were subject to Patient Safety Serious Incident Reviews (SI)

In Q4 28 inquests were concluded within the time period. There were 10 Coroners verdicts of suicide; 10 drug related; 2 Alcohol related; 3 natural caused and 2 accidental causes of death. There was one narrative conclusion.

During the reporting period there were 214 expected deaths subject to a Structured Judgement Review (SJR). All the 214 cases reviewed were community deaths. Expected deaths in care homes, hospices and hospitals were not reviewed between January 2021 and March 2021 due to the extremely high numbers of deaths occurring during the second peak of the pandemic. The SJR's reviewed related mainly to patients in the 76-100 years age group. Overall, mortality among males across the Trust was higher than for females during this reporting period.

Cancer was the most common cause of death in both males and females across the Trust. There were 106 reported COVID 19 related deaths.

The review identified that all community patients on a Gold Standard Framework (GSF) End of Life Pathway were cared for and died in their preferred place of care (PPC) and death (PPD).

During the reporting period a total of 9 Learning Disability deaths were reported. All of which were submitted to LeDeR for review.

The main areas identified for learning from completed SIs into unexpected deaths during Q4 include;

- Linked records not being identified for service users accessing more than one service
- Telephone follow up when face to face doorstep call would have been more appropriate

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

- Increased compliance with follow up protocols;
- Improved communications within 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
GAD	Generalised Anxiety Disorder
GSF	Gold Standard Framework (End of Life Pathway)
CCP	Co-ordinated Care Plan (Advanced Directive)

Appendices

Appendix 1	Page 16 - Learning from Deaths Report Flow Chart Diagram Deaths

1.0 Background/Introduction

1.1 The report provides an analysis of service user deaths over the period 01/01/2021 and 31/03/2021

2.0 Reporting Deaths Process

2.1 Reported deaths are divided into expected and unexpected deaths.

2.2 Expected deaths are reviewed through the mortality review process. Usually 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. Due to the high rate of death during this period only 50% of these deaths were reviewed using SJR. Deaths that took place in hospital or in care/nursing homes were not reviewed during this period. This was due to the high numbers of deaths occurring within the reporting period which was within the second peak of the COVID 19 pandemic.

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

2.4 Later in this report, there is a summary of the Coroner's findings related to service user deaths that took place in this quarter together with a review of the themes of the outcomes of these findings.

3.0 Presentation and Analysis of Mortality Data for 01/01/2021- 31/03/2021

3.1 The total number of patients who died Trust-wide between January 2021 and March 2021 was 864, of which 836 were expected deaths and 28 were unexpected deaths.

4.0 Summary of deaths and scope of review: 01/01/2021- 31/03/2021

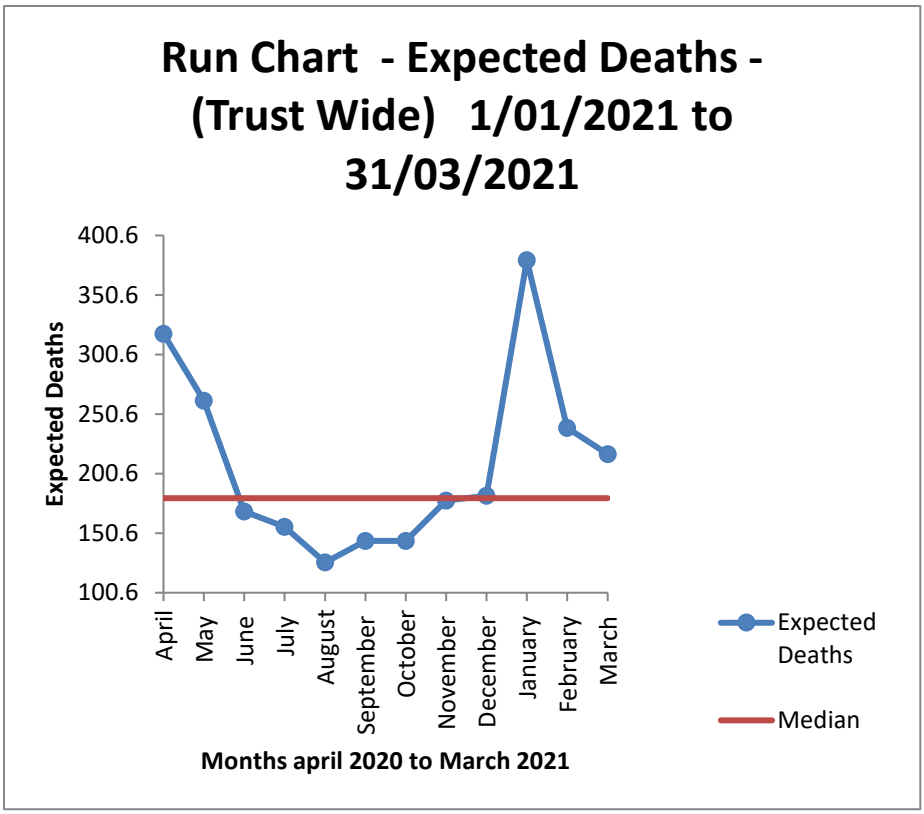
4.1 50% of the reported expected deaths where ELFT was managing care were reviewed under the SJR process.

4.2 SJRs were conducted using patient information (recording) systems: EMIS; RiO; SystmOne and the Incident Reporting System DATIX. The SJRs look at the three months of case notes prior to the patient's death. All expected deaths do not necessarily have sufficient information to be fully reviewed. Reasons for this can include the patient being recently referred to ELFT and not being seen before they died; being seen and then admitted to hospital where they died, or being seen by a service bi-annually or annually for a review.

4.3 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)

5.0 Expected Deaths

Run Chart - Expected Deaths - (Trust Wide) 1/01/2021 to 31/03/2021



2020/2021	Expected Deaths
April	318
May	262
June	169
July	156
August	126
September	144
October	144
November	178
December	182
January	380
February	239
March	217

5.1 The baseline for the report is from 01/04/2020 (Q1) to 31/03/2021 (Q4). The median is 180.

5.2 A total of 836 expected deaths were reported from 01/01/2021 to 31/03/2021.

5.3 We can see a marked increase in the number of expected deaths in January 2021. This marked increase continues through February and March. This peak reflects the time of the second wave of COVID 19.

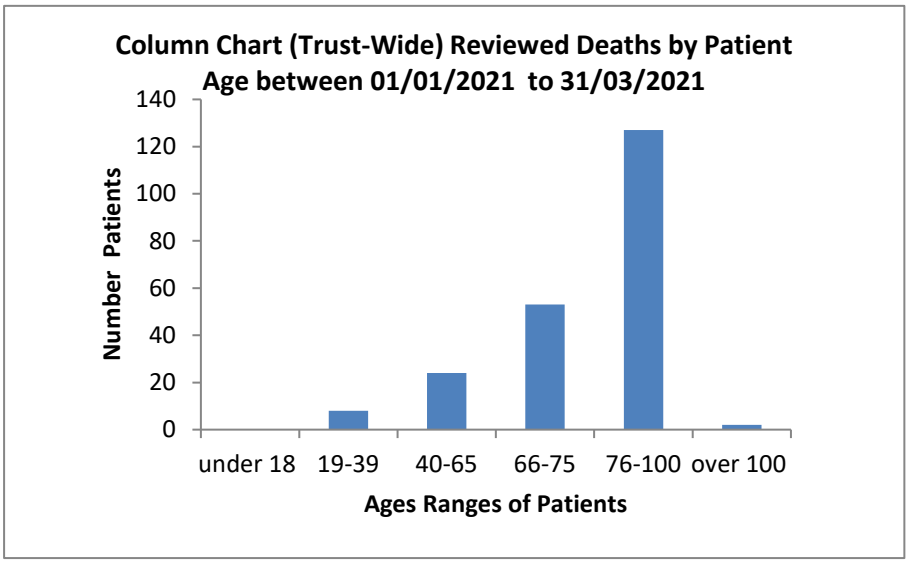
6.0 Structured Judgement Reviews

6.1 Of the 836 total expected deaths reported, 214 were reviewed in the period between 01/01/2021 to 31/03/2021. All 214 patients reviewed were under the care of the Community Health Services at the time of death. This is 50% of the total cases in contact with ELFT at the time of their death. This is usually 100% but due to high number of deaths this had to be reduced.

Deaths that occurred in hospital; hospice or in a care home were not reviewed during the period 01/01/2021 to 31/03/2021. This was due to the high numbers of deaths occurring in these settings during the second peak of the pandemic.

6.2 **Age Ranges between 01/01/2021 and 31/03/2021**

Chart 2 - Column Chart (Trust Wide) Reviewed Deaths by Patients Age



Column Chart

6.3 The chart accounts for the ages of the deaths subject to the SJR process.

6.4 59.24% (127) of the total 214 deaths reviewed occurred in the 76-100 years age group. There were 2 patients over the age of 100. There were no under 18's in this reporting period.

6.5 The highest number of expected deaths were in males while 98 females died expectedly.

6.6 Causes of Death

Cancer was the highest cause of expected death across the Trust in Q4 in both males and females and accounts for 137 of the deaths out of the 214 reviewed cases. This figure also applies to those who tested positive for COVID 19 in the 28 days before they died.

7 COVID 19 Deaths

COVID19 Deaths related data was reported daily to the East London Foundation Trust (ELFT) Infection Control Team; The Trust's Gold Command and to the COVID-19 Patient Notification System (CPNS).

Data was collected on Patient demographics which included; age, gender, ethnicity; place of death, last seen by ELFT, dates of COVID-19 testing swabs and results, relatives awareness, pre-conditions, mental health diagnosis, travel history and date of death.

There were 106 deaths Trust Wide where the patient had a positive COVID 19 test in the 28 days before they died between 01/01/2021 to 31/03/2021.

COVID 19 was the primary cause of death (CoD) for 6 of the patients, the remaining 100 patients had pre-conditions and had tested positive COVID 19 within 28 days of dying.

There were 5 COVID 19 related inpatient deaths between January 2021 and March 2021.

Trust Wide Inpatient deaths between 01/01/2021 and 31/03/2021	
Fothergill Ward	3 males aged 74 years – 87 years on palliative care 1 female aged 56 on palliative care
Bow ward	1 female age 46 years with end stage COPD

8 Findings from Expected Deaths

8.1 All cases reviewed between 01/01/2021 and 31/03/2021 showed good standards of care delivery.

8.2 The Trust aims to ensure that all patients who are on Gold Standards Framework (GSF) and End of Life Pathways (EoLP's) or Co-Ordinated Care Plans (CCP's) have their preferred place of care (PPC) and death (PPD) recorded.

During the period J01/01/2021 and 31/03/, of the 214 deaths reviewed, 94.85% (203) patients had a GSF; EoLP or a CCP. Of the patients receiving a GSF; EoLP or a CCP 100% (214) had recorded their PPC and PPD. The 11 deaths that did not have a GSF; EoLP or a CCP were cases where the patients were receiving palliative care but where the end of life stage had not yet been identified, or they had been referred and died before care started at ELFT Community Services.

All patients on an EoLP; GSF or CCP had an agreed; authorised and signed Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. There was evidence in all case notes and care plans that discussions had been held between GP's and families where the patient lacked capacity.

9.0 Learning Disability Deaths

9.1 There were 9 deaths of service users with a learning disability between 01/01/2021 and 31/03/2021, all of which were reported to LeDeR for review, 7 were COVID related.

10.0 Unexpected Deaths between 01/01/2021 to 31/03/2021

10.1 A total of 28 unexpected deaths were reported Trust-wide on DATIX between January 2021 and March 2021, 9 were patient safety related.

10.2 The remaining 19 reported unexpected deaths were not patient safety related. They related to patients who were expected to die but died before the expected timeframe. These deaths were either closed after completion of a 48 hour or de-escalated and reviewed as an SJR

10.3 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 incident. 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.

10.4 Thematic Review of Unexpected Deaths

10.5 Of the unexpected deaths which occurred during the reporting period, Inquest Conclusions show 6 of these deaths were as a result of suicide.

10.6 The completed SI Reviews into unexpected deaths, which have occurred during this reporting period, have not all yet been reviewed at Inquest. The Inquest findings will support the identification of correlated themes for these incidents.

10.7 Notably all completed Serious Incident Reviews include recommendations and associated Action Plans which have been introduced to address all the care and service delivery issues identified in these Reviews.

11 Inquests

11.1 Coroner's conclusions

11.2 There were a total of 28 inquests concluded within the reporting period.

* Please note that these concluded inquests include inquests into incidents which occurred outside of the January reporting period.

11.3 Please note there were 27 Short Form Conclusions and one Coroners Narrative.

Table 2 - The table below provides details of the Conclusions returned by the Coroner between 01/01/2021 and 31/03/2021.

Short Form Conclusions:	
Suicide	**10**
Drug Related	**10**
Alcohol	**2**
Natural Causes	**3**
Accidental	**2**
Narrative Conclusion	**1**
Service user was open to the non CPA CMHT and was last reviewed in 2019. The plan was to follow up in 6 months, however they failed to do so. Service user was also seen by a keyworker in P2R. COD 1a) Cardiopulmonary Arrest 1b) Cor pulmonale and amphetamine use	

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

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

12 Recommendations and actions

12.1 The Board is asked to **RECEIVE** and **NOTE** this report**.**