East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD: PART 1
25 July 2019

Title	**Learning From Deaths Annual Report**
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:

- 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 reportted deaths within this period.
- To update the Board on the Learning from Deaths group's planned focus for 2019/20

Summary of Key Issues:

- This report covers the time period from April 2018 to 31 March 2019.
- There were 1217 expected deaths of service users in contact with the service during the time period.
- There were 257 unexpected deaths all of which were subject to review.
- There were 9 deaths of patients with Learning Disabilities (LeDeR) which were all reviewed.
- A total of 152 deaths were subject to a Coroner's Inquest Verdict during the reporting period *(some deaths may have occurred prior to 1 April 2018 but the inquest was held 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

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
	Learning from Deaths Group

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.

Glossary

Abbreviation	In full
SI	Serious Incident investigations led by a corporate SI reviewer together with a co-reviewer from the locality.
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.
LeDeR	Review of deaths into Learning Disabled Patients
ELP	End of Life Pathway
PPC	Preferred Plan of Care
CHN	Community Health Newham
SJR	Structured Judgement Review

Annual Learning from Deaths Report

April 2018 – March 2019

We Care We Respect We are inclusive

Contents

Introduction

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. The Trust has one Mortality Reviewers and a Mortality Administrator. 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. The Learning from Deaths Review Panel consists of the following:

Dr Paul Gilluley (Chief Medical Officer)

Lorraine Sunduza (Chief Nurse)

Abiola Ajayi-Obe (Associate Director of Governance & Risk)

Dr David Bridle (Consultant Psychiatrist and Medical Director)

Dr Ben Braithwaite (Clinical Director)

Ruth Bradley (Director of Nursing- Integrated Care)

Kim MacGillivray (Mortality Reviewer)

Rashed Ahmed (Mortality Administrator)

Background

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.

The 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.

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, it is very clear that Trusts are able to determine their own local approaches to undertaking mortality reviews including definition of those deaths in scope for review.

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 on deaths meeting the national criteria for serious incident review.

Mortality Review Process

ELFT reviews 100% of all expected deaths of Community Health and Mental Health patients. 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 hospital or care home deaths are also reviewed. All trends and themes are reported to the Learning from Deaths Panel. A 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 subject to either a corporate led or a panel led investigation.

Unexpected deaths in ELFT are directed to the Serious Incident (SI) Team and are subject to either a panel led or corporate led investigation.

All Learning Disability Deaths (LeDeR) in ELFT are allocated to the mortality reviewers who are appointed trained reviewers who report their findings to NHS England and Bristol University.

Structured Judgement Review

The application of a Structured Judgement Review (SJR) is to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. At ELFT, SJRs are carried out by Mortality Reviewers (MR) who examine the last 6 months of care provision provided to patients/Service Users (SU) prior to their death.

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.

Identified concerns from SJR of a death due to a problem in care

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.

SI Review

An SI review is a systematic analysis of an incident, including an unexpected death, 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 reduce the risk of future occurrence of similar events.

Learning from Deaths Panel

The Learning from Deaths Panel meet on a monthly basis.

Mortality Review Results

Statistics for 1 April 2018 to 31 March 2019

Category 1: Total reported deaths

Table 1. Total of all reported deaths in reporting period for all Directorates.

No. of total mortalities	Total
Expected deaths	1,217
Unexpected deaths	257
Total:	**1,474**

Table 1.

All unexpected deaths are investigated further by one of the following processes - 48hr report; concise report or an SI investigation. Please see table 6.

Breakdown of quarterly reporting

In Q1, 229 total expected deaths of which 43 (19%) were subject to the SJR process. These figures included both community and mental health services.

There was a total of 337 expected deaths in Q2. 424 deaths were subject to the SJR process in Q2, this was due to the Mortality Review being a newly formed process in Q2 and includes reported deaths from Q1.

Q3 recorded 268 expected deaths of which 134 were subject to the SJR process, this was 100% of community health and mental health cases where ELFT managed care and 50% of all care home or hospital deaths, where care was not managed by ELFT were reviewed.

Q4 - 307 total expected deaths of which 145 were subject to the SJR process, this was 100% of community health and mental health cases where ELFT managed care and 25% of all care home or hospital deaths, where care was not managed by ELFT were reviewed.

Category 2: Breakdown of total reported deaths in Mental Health ; Community Health and Specialist Services in the reporting period.

Table 2. Total reported deaths Mental Health ; Community Health and Specialist Services in the reporting period.

No. of total community health; mental health and specialist services mortalities	Total
Community Health Services	**908**
Mental Health Services	502
*Specialist Services	64
Total	**1474**

Community health services show higher numbers of deaths.

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

Q1, Q2, Q3 did not report Specialist Services separately.

Category 3 - Total deaths by Directorates in reporting period

Table 3. Total expected deaths by Directorate in reporting period

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

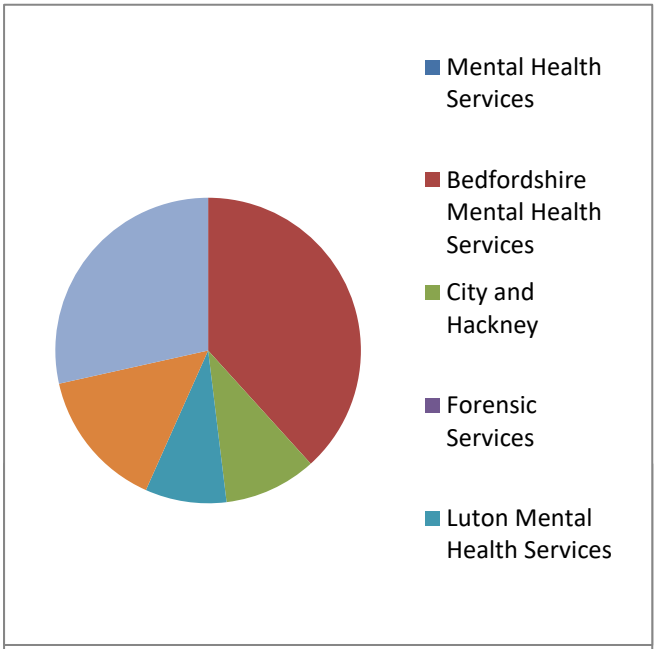
In Q3 expected deaths occurring in Bedfordshire and Luton were not included in the 100% reviewed; this was due to Mortality Reviewers not having access to System 1.

In Q3 report all expected deaths occurring in Bedfordshire and Luton are included and have been reviewed for Q4.

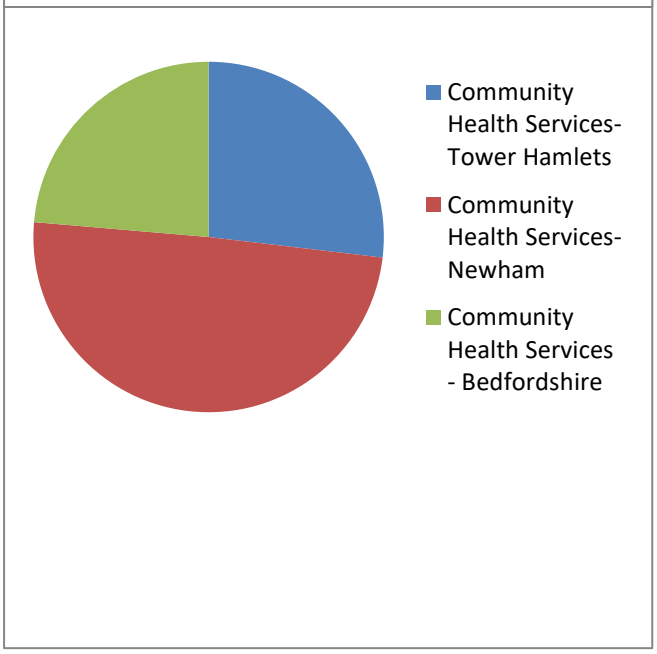
Numbers of expected deaths reported in Q3 shows a slight decrease. This could be explained by the SJR process having been newly introduced in Q2, which included a small number of expected deaths that occurred before July 2018, the start of the quarterly reporting period Q1.

Community health services show higher numbers than mental health services, this is as expected due to the patient population having more cases of patients receiving palliative care.

Graph 1 and graph 2 relating to table 3- total expected deaths by Directorate in reporting period



Graph 1. Mental Health Services



Graph 2. Community Health Services

Category 4: Number of deaths separated into Mental Health and Community Health subject to an SJR by Directorate

Table 4: Number of deaths separated into Mental Health and Community Health subject to an SJR by Directorate

Community health & mental health by Directorate subject to a structured judgment review	Total
Mental Health Services	
Bedfordshire Mental Health Services	30
City and Hackney	7
Forensic Services	0
Luton Mental Health Services	6
Newham Mental Health	24
Tower Hamlets Mental Health	12
Community Health Services	
Community Health Services- Tower Hamlets	168
Community Health Services-Newham	217
Community Health Services - Bedfordshire	172
Specialist Services and CHN Children's Services	**1**
Total :	**637**

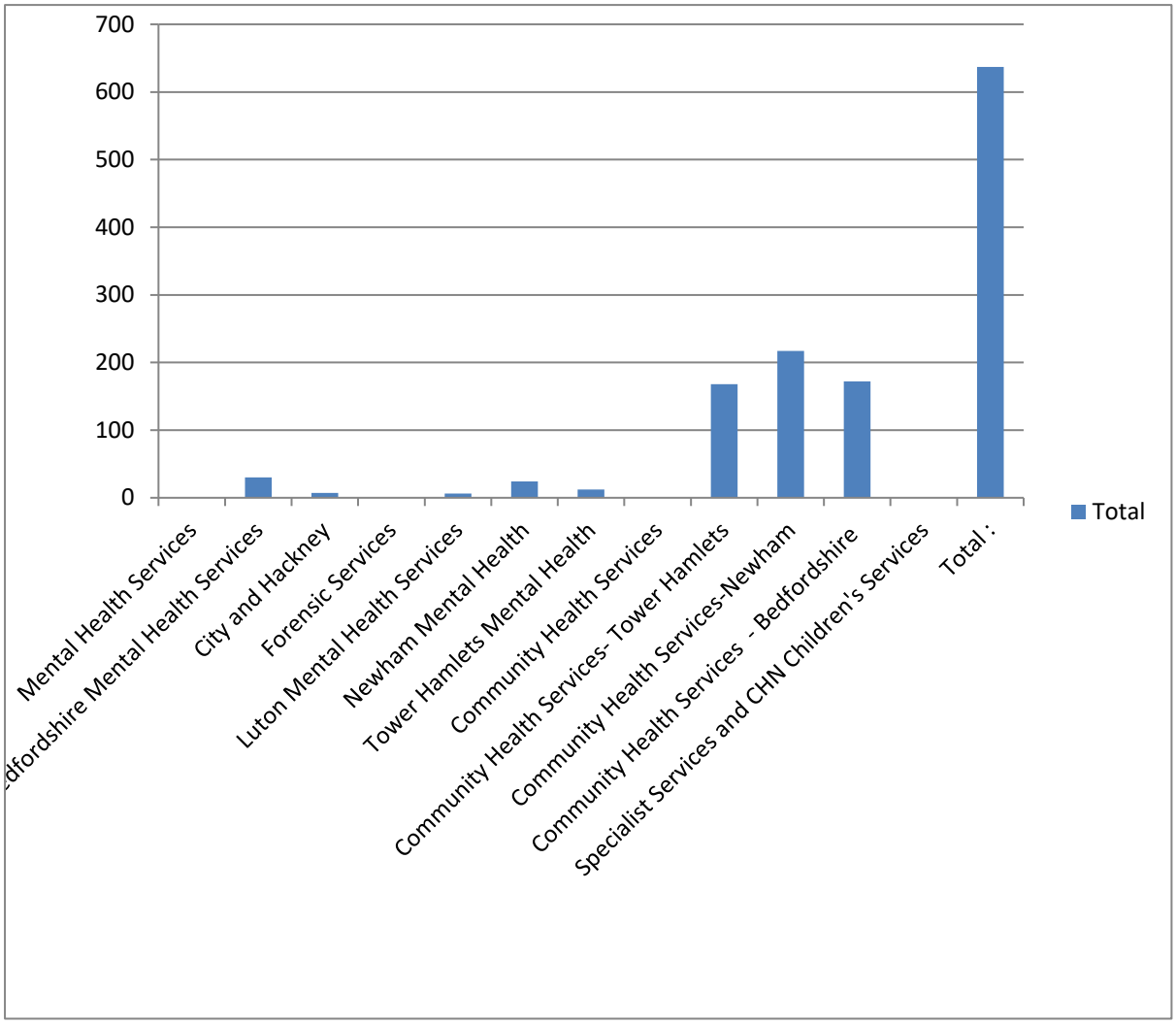
Of the reported 229 deaths in Q1, 43 (19%) were processed through a Subject Judgement Review.

In Q2, 424 expected deaths were reviewed under the SJR Process. In Q2 the mortalities that were reviewed were slightly higher than expected due to incorporating reviews of deaths which occurred prior to July 2018 for completeness.

The Trust reported 268 expected deaths between 1 October 2018 and 31 December 2018. Of the 268, 134 (50%) were reviewed using the SJR Process.

Of the 307 expected deaths, 100% percent of those being managed by ELFT services were reviewed under the SJR Process. 1 in 4 (25%) of expected deaths where care was provided but not managed by ELFT was reviewed under the SJR process. In Q3 expected deaths occurring in Bedfordshire and Luton were not included in the 100% reviewed; this was due to Mortality Reviewers not having access to System 1. However, all expected deaths occurring in Bedfordshire and Luton were reviewed for Q4.

Graph 4. Relating to table 4. - Community Health & Mental Health by Directorate subject to an SJ



Category 5: Number of deaths subject to a LeDeR review process

Table 5. Number of deaths subject to a LeDeR review process

Breakdown of all LeDeR mortalities by Directorates	Total
Mental Health Services	
Bedfordshire Mental Health Services	3
City and Hackney	1
Forensic Services	0
Luton Mental Health Services	0
Newham Mental Health	0
Tower Hamlets Mental Health	1
Community Health Services	0
Specialist Services and CHN Children's Services	2
Community Health Services- Tower Hamlets	0
Community Health Services-Newham	3
Community Health Services - Bedfordshire	0
Total :	**9**

LeDeR

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

In the reporting period there was a total of nine reported LeDeR deaths, three were under Bedfordshire Mental Health services; 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.

There was one reported LeDeR death in February 2019 which was subject to an ELFT and Bart's Health joint 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 Mortality Reviewing team will continue to liaise with the Learning Disability Lead for the Trust in order to collate data.

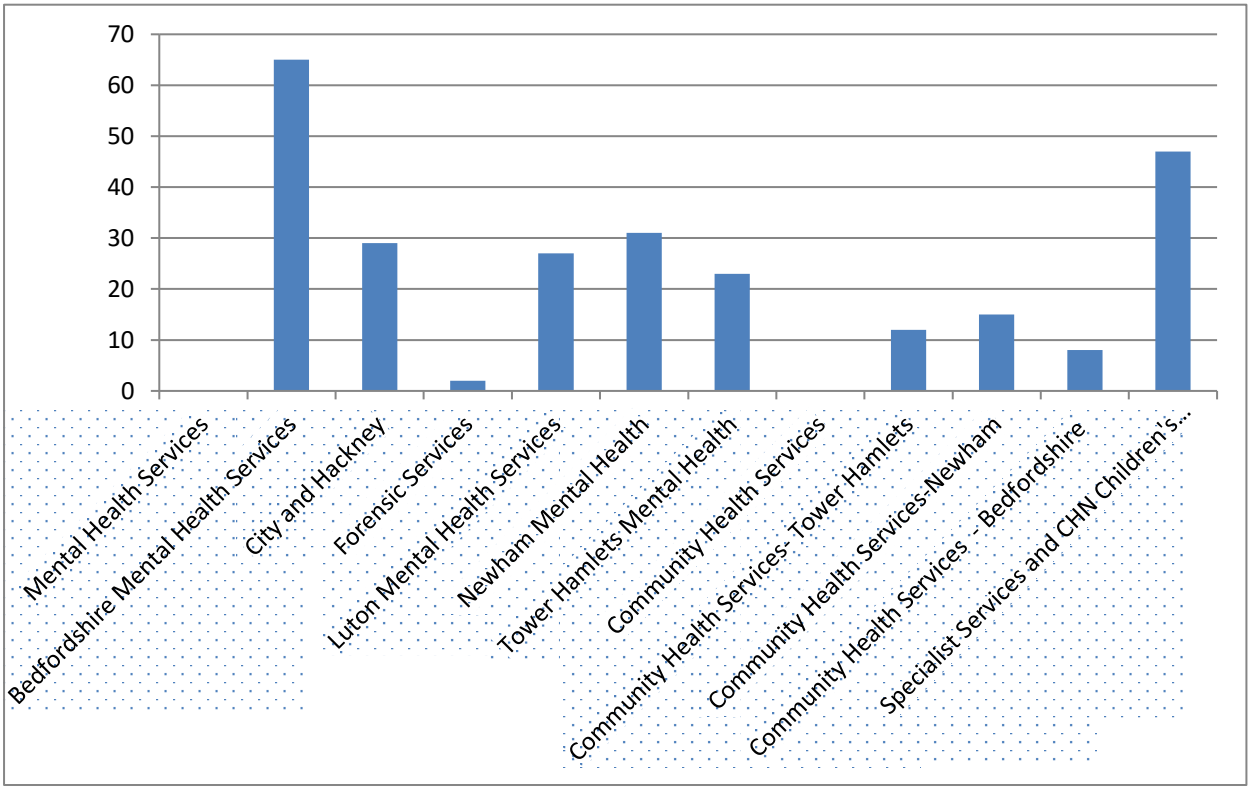
Deaths subject to investigation

Category 6: Number of deaths investigated by 48 hour report and SI investigations separated into Mental Health and Community Health

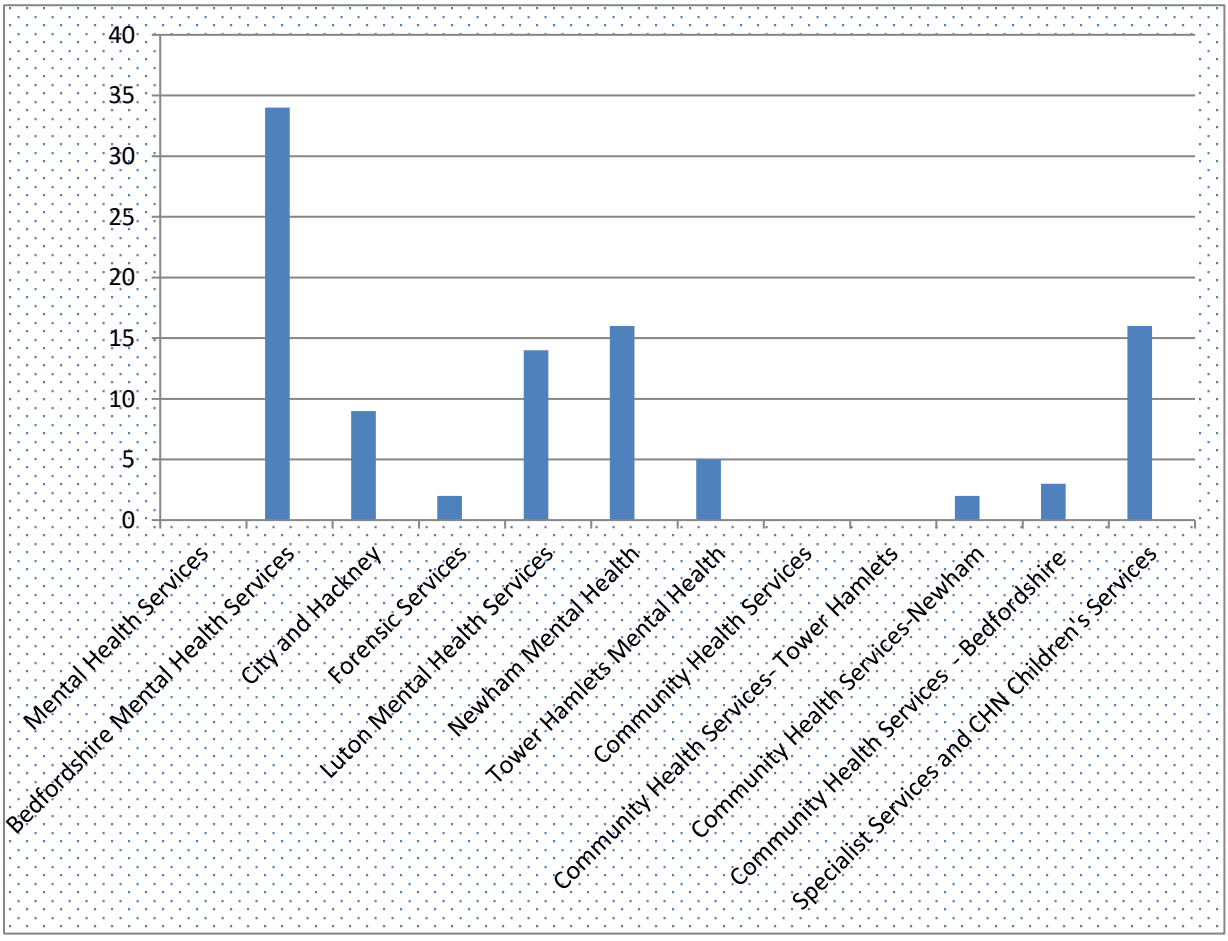
Table 6. Number of deaths investigated by 48 hour report and SI investigations separated into Mental Health and Community Health

Deaths investigated by 48 hour report and SI investigations	48 hr	SI
Mental Health Services		
Bedfordshire Mental Health Services	65	34
City and Hackney	29	9
Forensic Services	2	2
Luton Mental Health Services	27	14
Newham Mental Health	31	16
Tower Hamlets Mental Health	23	5
Community Health Services		
Community Health Services- Tower Hamlets	12	0
Community Health Services-Newham	15	2
Community Health Services - Bedfordshire	8	3
Specialist Services and CHN Children's Services	47	16
Total :	**259**	**101**

Graph 5 . Cases subject to a 48hr report



Graph 6. Cases subjected to Serious Incident Review



Category 7: Number of deaths subject to Coroner's Inquest and Verdicts

	Accident	Alcohol Related	Drug Related	Alcohol/ Drug Related	Misadventure	Narrative	Natural Causes	Open	Suicide	Total
Bedford Mental Health Services	3	0	4	1	0	12	2	1	13	36
City and Hackney	3	0	1	0	1	5	2	4	6	22
Luton Mental Health Services	1	0	1	0	2	2	1	1	5	13
Newham (Mental Health)	0	0	3	0	1	5	2	2	4	17
Specialist Services and CHN Children's Services	4	2	7	2	1	2	2	3	4	27
Tower Hamlets (Mental Health)	2	0	3	2	1	5	3	5	4	25
Totals:	13	2	19	5	6	31	12	16	36	140

	Accident	Drug Related	Alcohol/Drug Related	Narrative	Natural Causes	Open	Total
Community Health Services - Bedfordshire	1	0	0	3	1	0	5
Community Health Services - Newham	0	1	1	1	1	1	5
Community Health Services - Tower Hamlets	1	1	0	0	0	0	2
Totals:	2	2	1	4	2	1	12

Table 7: Inquests concluded in 2018-2019 (*some may relate to deaths/incidents occurring prior to 1 April 2018)*

Category 7: Number of deaths subject to Coroner's inquest & verdicts

The highest number of deaths which result in a Coroner's Inquest relate to death by suicide. Deaths as a result of suicide are, sadly, one of the most frequent causes of death to people who have accessed mental health services. The Trust together with NHS England are actively working to reduce the number of death by suicide with a number of initiatives including; adopting the 10 Key Elements of the National Confidential Inquiry into Suicide and Safety.

Themes & Trends

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. There were a total to 50 cases reviewed during the period of March 2019. 14 of the patients where care was being managed for ELFT 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.

EoL plans and PPC's where patient s died in a care home or hospital 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 patient age. Age was captured in Q4. In Q4 there was one case of a six year old male child which was subjected to a LeDeR and joint ELFT/ Bart's Health review but not an SJR. This has now concluded.

A higher number of patients who died were receiving palliative care or had life limiting illnesses and were the age of 65 and over.

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 28 were male and 22 were female. The Mortality Team are looking at different ways to correlate data for the next reporting period.

Missing details

There were a small number of cases where missing data prevented a review being undertaken. This is being 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 in the reporting period 2018-2019. This can be related to 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. One case that was reviewed under the SJR process was raised and investigated as a serious incident.

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. Cases show high numbers of deaths from; deaths, sepsis and heart failure. Themes will be shared with the clinical services.

Conclusion

As is expected 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. Additionally, the sad incidents of death by suicide is a matter that the Trust is resolved to prevent and reduce. The use of the National Confidential Enquiry into Deaths toolkit is one of several mechanisms the Trust has adopted to support initiatives in this area.

The Learning from Deaths process for the Trust has evolved during the course of 2018/19. The meeting tasked with overseeing the Structured Judgement Review process was initially called the Mortality Review Group with a focus on;

I. Reviewing - issues that arose during the process of care ensuring that any adverse trends are discussed and, where appropriate, following a review of individual cases, acted upon.
II. Monitoring - deaths reported on the National Personal Demographics Spine against deaths reported on the Trust's Incident management database – Datix - to identify themes and trends.
III. Ensuring – that learning and all associated actions identified as a result of learning from deaths are acted upon.

During the course of the year the group identified repetitions in themes arising following mortality reviews and moved to focus in more depth on learning and driving improvements to end of life care planning and the revision of services where necessary.

Going forward , 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.