East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
9 MAY 2018

Title	Mortality Review: Six-month report October 2017 – March 2018
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Purpose of the Report:

To provide an analysis of deaths of service users during the last six months of the financial year, their investigation, and future plans for monitoring and investigating patient deaths in accordance with national drivers.

Summary of Key Issues:

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. The Trust's Incident Policy was revised to include its approach to mortality and published in September 2017. A report outlining the Trust's approach to implementation of the National guidance was taken to the October Board meeting.

This paper outlines implementation from October 2017 – March 2018 together with a summary of the actions taken and next steps.

Strategic priorities this paper supports (Please check box including brief statement)

Improved patient experience	☒	The purpose of the report is to learn lessons and improve the patient experience of care.
Improved health of the communities we serve	☒	The purpose of the report is to learn lessons and improve the health of the communities we serve
Improved staff experience	☐	
Improved value for money	☐	

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
	None

Implications

Equality Analysis	The report does not include 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 review. 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 are drivers for improvement

Supporting Documents and Research material

1. Mortality dashboard

Glossary

Abbreviation	In full
LeDeR	Learning Disabilities Mortality Review

1.0 Background / Introduction

1.1 In March 2017 the NHS England National 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 approach to mortality review was reported to the Trust Board in October 2017.

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

1.3 This is the second report to the Board in terms of mortality data. 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, it is very clear that Trusts are able to determine their own local approaches to undertaking mortality review including definition of those deaths in scope for review. Mortality data is therefore **not** comparable between Trusts.

1.5 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, tabled routinely under Part 2 Board papers.

1.6 This report sets out 2017–18 data for Q3 and Q4. From 2018-19 reporting will be quarterly.

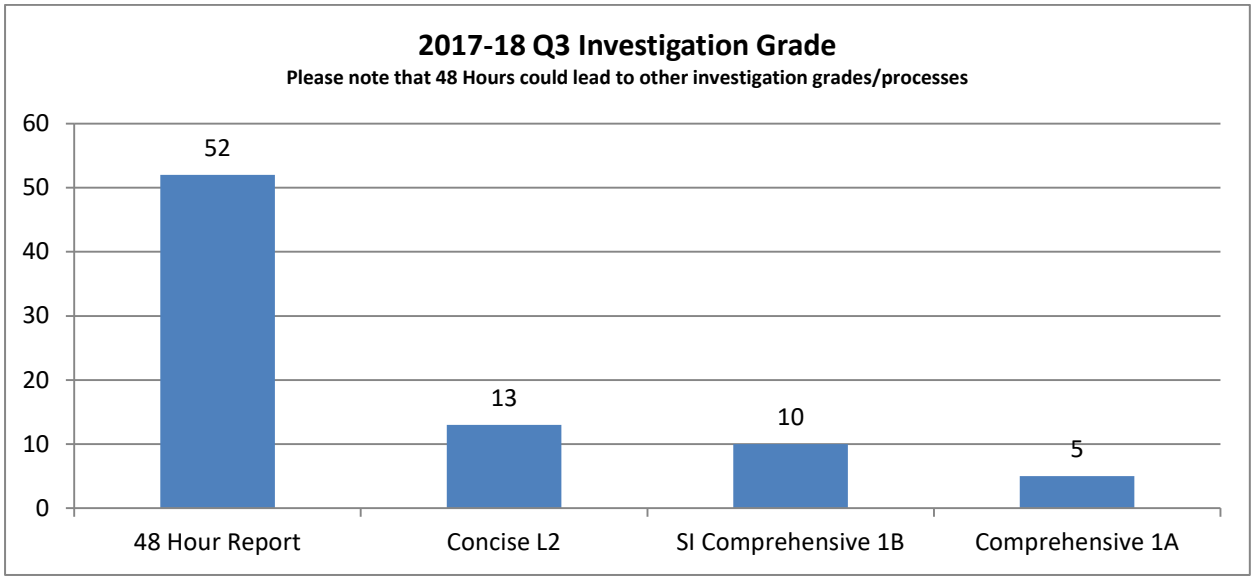
2.0 Current Scrutiny

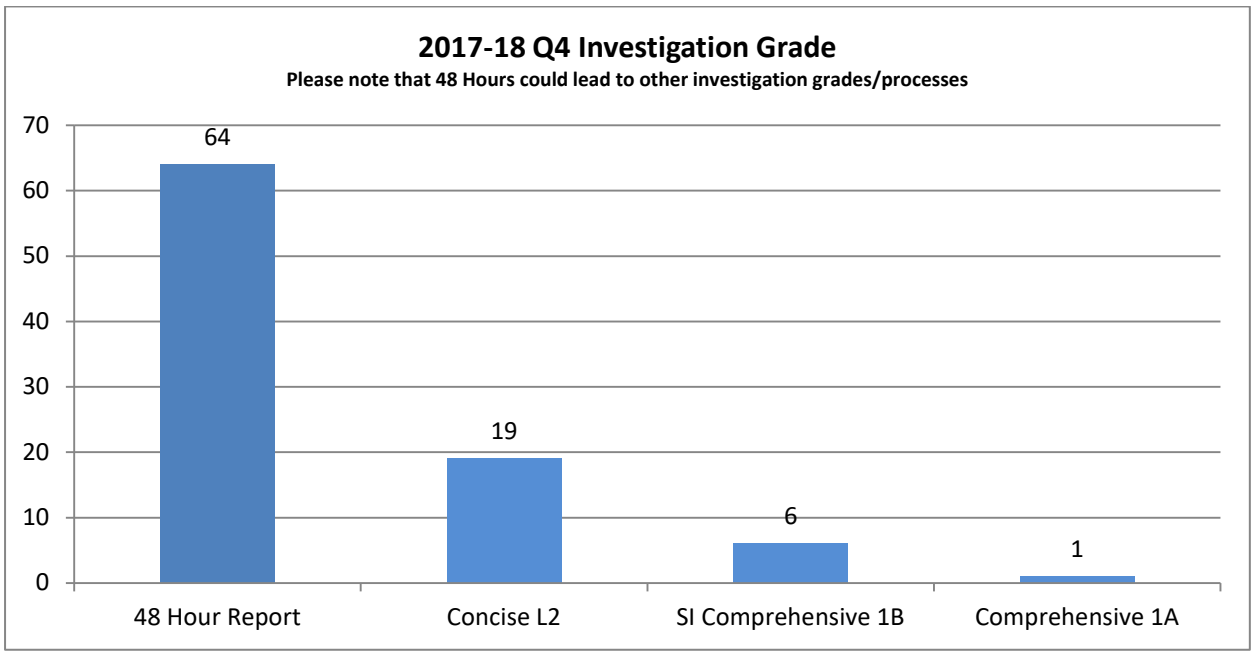
2.1 There are three levels of scrutiny a provider can apply to the care provided to someone who dies: death certification, case note review and investigation (the latter to various depths). In acute settings, the most commonly used methods are death certification and case note review. Mental and community health organisations have not historically utilised case note review methodology as no appropriate trigger tool has been developed therefore tending to focus on root cause analysis investigation (RCA) instead. This is appropriate given the nature of deaths in mental health settings where circumstances are often unclear at the time of the death.

2.2 The current process for investigation is:

- Datix notification of death
- Daily screening by Chief Medical Officer / Chief Nurse
- 48-hour report
- Decision at grading to close or seek further investigation. In future a proportion will be automatically identified for case note review

2.3 Tables 1a/b below sets out the number of deaths reported on Datix (the Trust's incident reporting system) and the actions taken in Q3 and Q4:





3.0 New system

3.1 Mortality Review Panel

3.1.1 There is no change to the current system of incident investigation. However there are a number of deaths that are not captured on Datix as they are unknown to the service where care was received. 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. To ensure that all deaths are effectively scrutinised and managed a monthly mortality review panel has been set up. The panel looks at trends across age ranges, 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

3.2 **Case note review**

3.2.1 Under the new framework organisations are required to undertake Structured Judgement Reviews (case note reviews) 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 LeDeR process)
- Where an alarm / concerns have been raised from another agency
- Where thematic learning could take place.

3.2.2 These categories will normally be reviewed through the routine incident review processes. Apart from deaths investigated through LeDeR which is an externally controlled process the Trust will not normally undertake a case note review for individual deaths in addition to the serious incident review process.

3.2.3 A further sample is required where deaths do not fit the above categories but learning and improvement could be gained from review. The Trust will undertake case note reviews for this sample based on up to 50% of deaths outside of the serious incident process.

3.3 **Methodology**

3.3.1 Although the Royal College of Physicians has drafted a case note review template for acute hospitals, there is currently no national mental / community health case note review template. During Q2 the Trust assessed a number of case note review templates including two from mental health organisations. These were trialled in Q3 and have been further revised to be meaningful.

3.4 **Resource**

3.4.1 The National Quality Board framework specifies that case note review should be undertaken by clinicians to enable the application of an avoidability score after scrutiny, ranging from definitely avoidable to definitely not avoidable. In view of the close links to the serious incident review process it is practical for the corporate serious incident reviewers to undertake case note reviews. Resource implications associated with this have been addressed as in 3.4.2.

3.4.2 The Trust has recently advertised for two fixed-term reviewers with clinical backgrounds to undertake case note reviews together with relevant serious incident investigations. Interviews have taken place. Whilst one candidate is external to the Trust the other is internal. This candidate will be able to start work within the next month.

4.0 Presentation and Analysis of Mortality Data for Q3 and Q4 2017/18

4.1 This section sets out a summary of deaths within scope for mortality review in Q3 and Q4 2017/18 and the level of scrutiny undertaken: this is the first presentation of the data. Both content and presentation will be refined as mortality review evolves both locally and nationally. Mortality data is attached at Appendix 1.

4.2 **Summary of deaths in scope for review:**

- 281 deaths were reported on Datix and scrutinised for mortality review between October and December 2017 and a further 246 between January and March 2018. Of those deaths, nine were deaths of patients with a learning disability in the third quarter and 14 in the last quarter.

- Fifteen were subject to serious incident review in Q3 and seven in Q4.

- No learning disability deaths have met the threshold for serious incident review in either quarter. LeDeR reviews are commissioned nationally and therefore outside Trust decision-making processes. Local commissioners are currently responsible for allocating reviews. Changes are being made to Datix to capture external learning disability reviews.

- 151 deaths were additionally scrutinised by the mortality review panel during Q3 whilst 191 were scrutinised in Q4. Note that these deaths would subsequently have been reported on Datix and are therefore not additional deaths.

- Avoidability scores have not been applied as they are outside the incident review process. They will however be applied in future to Structured Judgement Reviews when the newly appointed case note reviewers commence their roles.

4.3 **Learning**

4.3.1 There are a number of themes emerging from investigations into deaths:

- Record keeping – timeliness and completeness
- Risk assessments – patients who do not present a risk on discharge and subsequently go on to take their own lives
- Patterns of alleged suicides in Tower Hamlets. This is subject to a thematic review.

5.0 Recommendations

5.1 The Board is recommended to receive and note this report

6.0 Action being requested

6.1 The Board is asked to **RECEIVE** and **NOTE** the report for information

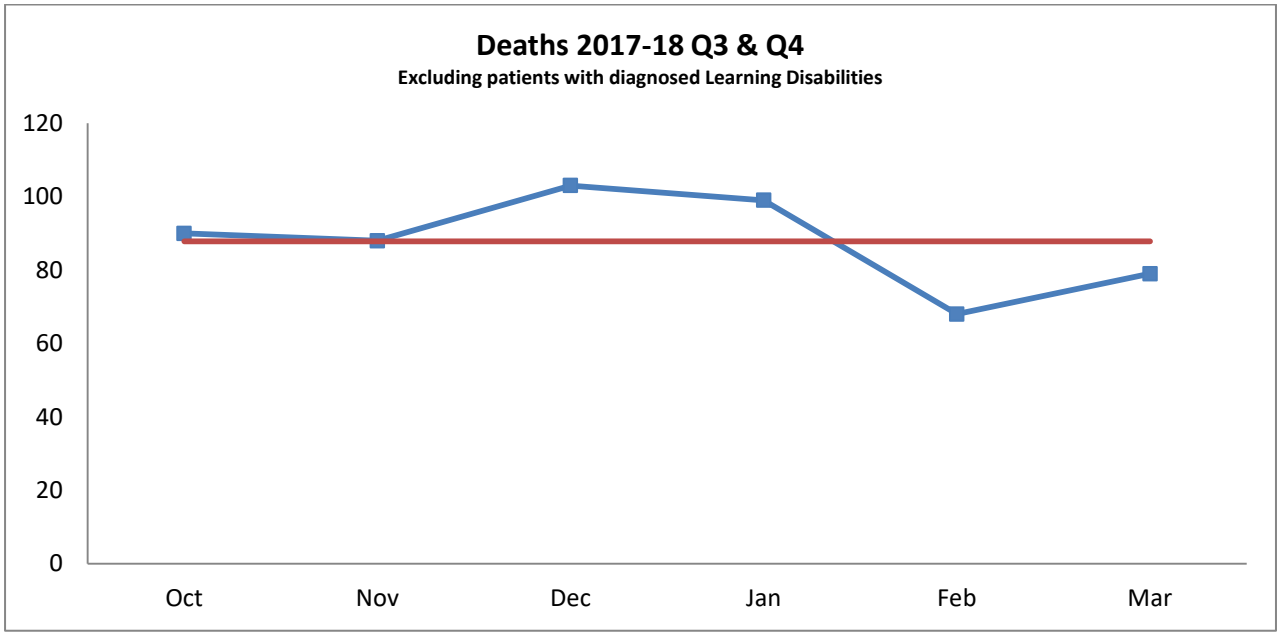
Appendix 1. Mortality Dashboard

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (excluding patients with diagnosed Learning Disabilities)

Total Number of Deaths in Scope	
Quarter 4	**Quarter 3**
246	281
This Year (YTD)	**Last Year**
1055	0

Total Deaths Reviewed By SI Process	
Quarter 4	**Quarter 3**
7	15
This Year (YTD)	**Last Year**
59	0

Total Number of Deaths considered to have been potentially avoidable	
Quarter 4	**Quarter 3**
N/A	N/A
This Year (YTD)	**Last Year**
N/A	N/A

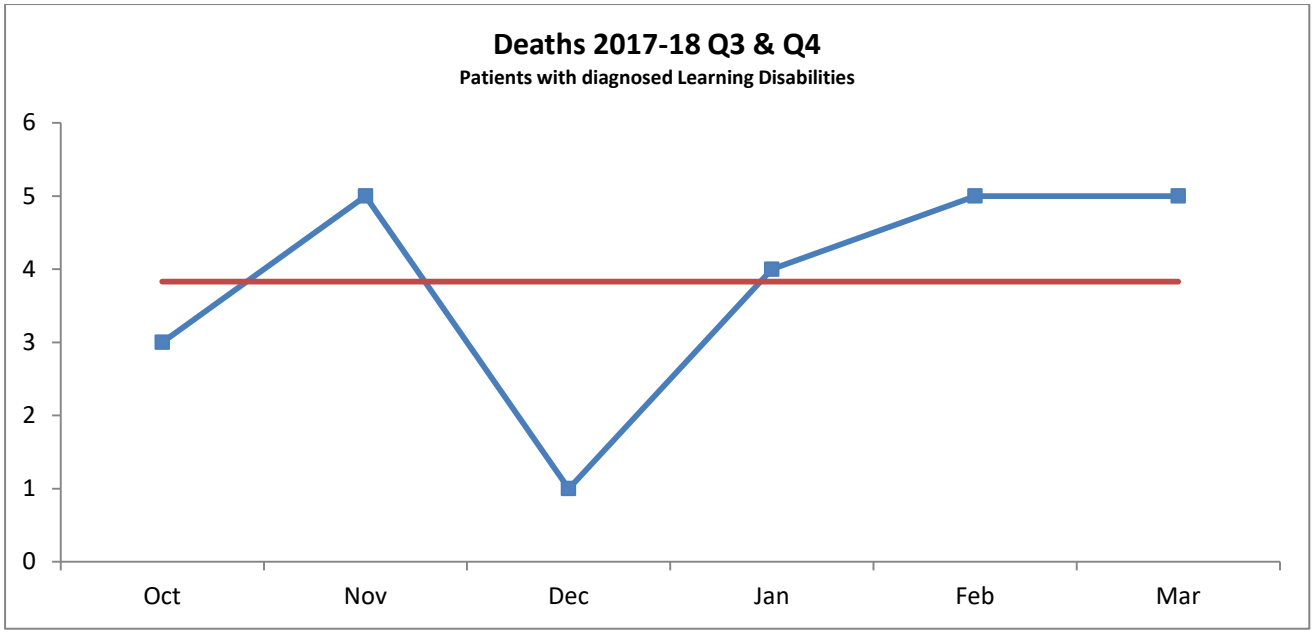


Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with diagnosed Learning Disabilities

Total Number of Deaths in Scope	
Quarter 4	**Quarter 3**
14	9
This Year (YTD)	**Last Year**
43	0

Total Deaths Reviewed By SI Process	
Quarter 4	**Quarter 3**
0	0
This Year (YTD)	**Last Year**
5	0

Total Number of Deaths considered to have been potentially avoidable	
Quarter 4	**Quarter 3**
N/A	N/A
This Year (YTD)	**Last Year**
N/A	N/A


Deaths 2017-18 Q3 & Q4
Patients with diagnosed Learning Disabilities
6
5
4
3
2
1
0
Oct
Nov
Dec
Jan
Feb
Mar