East London
NHS Foundation Trust

**REPORT TO THE TRUST BOARD: PUBLIC**
**12 SEPTEMBER 2018**

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| **Title** | Mortality Review Quarter 1 April 1st to June 30th 2018 |
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**Purpose of the report**

To provide an analysis of deaths of service users during the first three 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.

Main actions that have taken place since the last report to the Board include:

- Structured Judgement Review tool has been trialled and tailored to meet the needs of our service users.
- Two full time mortality reviewers have been appointed and trained in using the tool.
- In Q1 a total of **229 deaths** of our service users was reported.
- During Q1 **43 (19%)** Structured Judgement Reviews have taken place.

Initial reviews were mainly of elderly service users who were known to the community health services. Most had chronic and complex physical health illness. They were admitted to acute hospital due to physical deterioration and passed away. Some of those known to community health services were on an end of life pathway and evidence of good quality of care was noted.

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

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| Improved experience of care | ☒ | The focus of this paper is to provide data by which learning and improvement can be based. |
| Improved population health outcomes | ☐ | |
| Improved staff experienced | ☐ | |
| Improved value | ☐ | |

**Committees/meetings where this item has been considered**

| Date | Committee/Meeting |
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| | None |

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| **Implications**<br>E**q**uality 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**

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**Glossary**

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## 1.0 Background/Introduction

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 review and to publish data relating to deaths. The approach to mortality review was reported to the Board in October 2017.

1.2 The main focus of the changes are 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.

1.6 This report sets out Quarter 1 data 2018-19 and reporting will be quarterly.

## 2.0 Mortality Review

2.1 There is no change to the current system of incident investigation. However there are a number of deaths that are not captured on Datix (risk management system) 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.

## 3.0 Case Note Review

3.1 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 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.

3.3 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.

## 4.0 Methodology

4.1 The Royal College of Physicians drafted a case note review template for acute hospitals there is currently no national mental / community health case note review template. During Q2 (17/18) the Trust assessed a number of case note review templates including two from mental health organisations. These were trialled in Q3 (17/18) and have been further revised to be meaningful for our service user group.

## 5.0 Resource

5.1 The NHS 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.

5.2 The Trust has appointed two fixed term reviewers with clinical backgrounds to undertake case note reviews together with relevant serious incident investigations. The role sits within the Governance and Risk department working closely with incident review colleagues.

## 6.0 Presentation and Analysis of Mortality Data for Q1 2018-2019

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

6.1 It is important to recognise that the data reported onto the datix system cannot always be reconciled with the National Spine data because there are variations in reporting timeframes.

- Two hundred and twenty-nine (229) deaths were reported on the Spine and screened for mortality review between April 1st and June 30th.

- Of the reported 229 deaths 43 (19%) have processed through a Structured Judgement Reviews.
- One death is currently the subject of a serious incident review in Q1 (this was identified by the Trust but is not included in the June spine data that we received).
- The death of a service user with a Learning Disability has met the threshold for a Serious Incident review in Q1. LeDeR reviews are commissioned nationally and therefore outside Trust decision making processes. Local commissioners are currently responsible for allocating reviewers. Changes are being made to datix to capture external learning disability reviews.

## 7.0 Learning

- So far a total of 43 cases have undergone Structured Judgement Review. These have been randomly selected. The majority of cases are elderly service users known to community health services who have chronic and complex physical health problems. Some have been admitted to acute hospital due to physical deterioration and passed away. We have no access to this data on their quality of the deaths in these cases.
- A few of these cases have been on an end of life pathway and there is evidence of a good quality of care through the process.
- One case raised concerns regarding the quality of care provided and was escalated to a serious untoward incident.
- We are still at the early stages of collecting data from these reviews. By then end of Q2 we hope to be in a better position to give a review of themes from cases reviewed.

## 8.0 Action being requested

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