East London NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
13 MARCH 2019

Title	Learning from Deaths Q3, 1 October 2018 to 31 December 2018
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Purpose of the Report

All deaths of service users are reported on Datix, the Trust incident reporting system. All deaths that are unexpected will have a 48 hour report completed. Most will then have at least a concise report with an action plan or proceed to a full Serious Incident investigation. All unexpected deaths are fully investigated and the learning from them is shared through the Trust's monthly Serious Incident Committee and regular Trust wide Learning Lesson events.

The deaths that are expected we review 50% of these cases using a Structured Judgement Review (SJR). The following reports gives details of these reviews, emerging themes and learning gained.

This report provides an analysis of service user expected deaths over the three month period 1 October 2018 to 31 December 2018.

Summary of Key Issues

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

Of the total of 268 expected deaths, the majority (73%) were known to Community Health Services. Similar themes were noted to those reviewed in Q2; elderly; chronic complex illness; died in acute hospital.

One of our concerns is the lack of end of life care plans in a total of 6 cases over the quarter. We are addressing this through local meetings with other stakeholders to improve end of life care pathways.

The majority of expected deaths occur after our service users are admitted to acute hospital, where we do not have routine access to the records. We are exploring ways of joint learning with acute hospitals, primary care, and other stakeholders through quarterly meetings where shared cases are discussed.

We are also exploring with acute hospitals for them to share their findings when they review the death of one of our patients in their care.

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 the progress on learning from deaths.
Improved health of the communities we serve	☒	To improve the quality of death for those in contact with our services.

Improved staff experience	☒	To learn from Structure Judgement Reviews on how we can improve the quality of death for service users.
Improved value for money	☐	N/A

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
Mortality Review meeting 23.10.18	
Mortality Review meeting 20.11.18	

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
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
System 1	Patient information recording system, Bedfordshire Community
ELFT	East London NHS Foundation Trust
HSMR	Hospital Standardized Mortality Ratio
LeDeR	Learning Disabilities Mortality Review
SJR	Structured Judgement Reviews

1.0 Background

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 first reported to the Board in October 2017.

1.2 All deaths of service users are now reported on Datix, our Trust incident reporting system. All deaths that are unexpected will have a 48 hour report completed. Most will then have at least a concise report or proceed to a full Serious Incident investigation. All unexpected deaths are fully investigated and the learning from them is shared through the Trust's monthly Serious Incident Committee and regular Trust wide Learning Lesson events.

1.3 Of those deaths that are expected we are presently review 50% of these cases using a Structured Judgement Review. The following reports gives details of these reviews, emerging themes and learning gained.

1.4 This report sets out Quarter 3 data 2018-19 and reporting will continue to be quarterly.

2.0 Presentation and Analysis of Mortality Data for Q3 2018-2019

Summary of deaths and scope of review: 1 October 2018 – 31 December 2018

2.1 268 (100%) expected deaths were reported between 1 October 2018 and 31 December 2018, Q3. 134 (50%) were reviewed under the Structured Judgement Review (SJR) Process. Expected deaths occurring in Bedfordshire and Luton are included in the fifty percent not reviewed as there was no access to System One.

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

2.3 As in Q2 the majority of cases were elderly services users in contact with Community Health Services (74%). They tended to have complex and chronic physical health problems. Majority died in acute hospital and we have no access to their notes to review their death.

2.4 There is one current LeDeR review being undertaken by one a Trust LeDeR/Mortality Reviewer, this was allocated in Q3 by City and Hackney. LeDeR is a national system for investigating the deaths of those with a learning disability. This runs parallel to the Trust investigation system.

2.5 3 Learning Disability (LD) deaths were reported to LeDeR for review. One case was subject to a Trust 48 hour report. Of the three, one patient died of sepsis; one died symptomatic of congenial heart disease and one suffered from a right sided Cerebrovascular Accident (CVA).

2.6 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.

2.7 Details of expected deaths reported in Q1, Q2 and Q3 are listed in Tables 1, 2 and 3.

Table 1: Expected deaths reported in Q3

Directorate	Oct 18	Nov 18	Dec 18	Total
Bedford Mental Health Services	5	11	8	**24**
Bedford Community Health Services	22	15	25	**62**
City and Hackney Mental Health Services	3	1	2	**6**
Luton Mental Health Services	1	3	2	**6**
Newham (Mental Health)	4	3	5	**12**
Newham Community Health Services	37	36	27	**100**
Tower Hamlets Mental Health Services	7	3	8	**18**
Tower Hamlets Community Health Services	11	15	8	**34**
Specialist Services and CHN Children's Services	0	4	2	**6**
Forensic Services	0	0	0	**0**
Total	**90**	**91**	**87**	**268**

Table 2: Structured Judgement Reviews undertaken in Q3

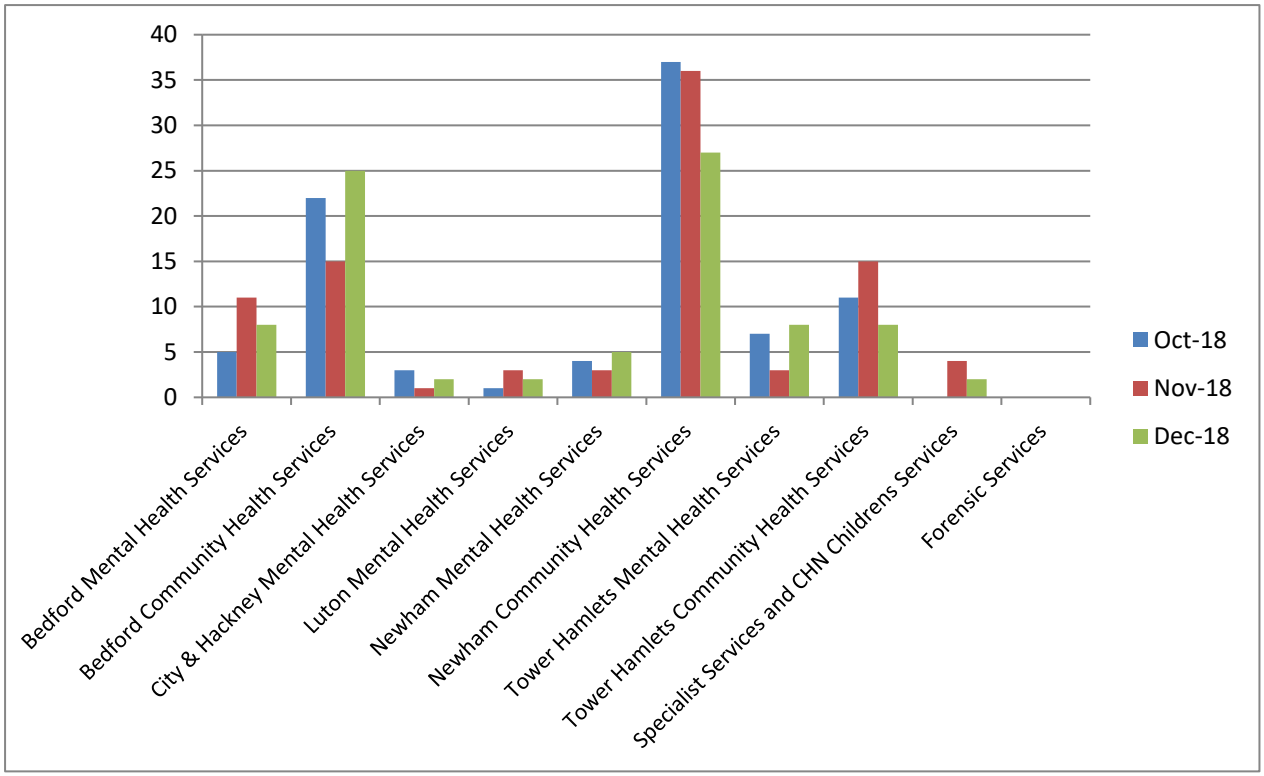
Directorate	Oct 18	Nov 18	Dec 18	Total
Bedford Mental Health Services	4	0	0	**0**
Bedford Community Health Services	0	0	0	**0**
City and Hackney Mental Health Services	0	1	1	**2**
Luton Mental Health Services	0	0	0	**0**
Newham (Mental Health)	2	3	1	**6**
Newham Community Health Services	25	29	28	**82**
Tower Hamlets Mental Health Services	2	4	1	**7**
Tower Hamlets Community Health Services	17	8	18	**43**
Specialist Services and CHN Children's	0	0	0	**0**
Forensic Services	0	0	0	**0**
Total	**50**	**45**	**49**	**134**

Table 3: Expected deaths in Q2

Directorate	Jul 2018	Aug 2018	Sep 2018	Total
Bedford Mental Health Services	7	19	15	**41**
City and Hackney	4	2	1	**7**
Community Health Services	91	72	67	**230**
Luton Mental Health Services	1	1	1	**3**
Newham Mental Health	3	4	10	**17**
Specialist Services and CHN Children's Services	1	0	0	**1**
Tower Hamlets	19	6	13	**38**
Total	**126**	**104**	**107**	**337**

Table 4: Structured Judgement reviews undertaken in Q2

Directorate	July 18	Aug 18	Sept 18	Total
Bedford Mental Health Services	7	8	7	**22**
Bedford Community Health Service	61	47	29	**137**
City and Hackney Mental Health Service	2	1	0	**3**
City and Hackney Community Health Services	26	27	18	**71**
Forensic Services	0	0	0	**0**
Luton Mental Health Services	2	1	0	**3**
Newham (Mental Health)	2	7	7	**16**
Newham Community Health Services	21	25	26	**72**
Specialist Services and CHN Children's Services	0	0	0	**0**
Tower Hamlets Community Health Services	51	19	30	**100**
Total	**172**	**136**	**117**	**424**



3.0 Learning and Themes

3.1 The majority of expected deaths reported occurred in hospital or in a nursing home where ELFT was notified but did not manage care at time of death.

3.2 A total of six cases, three in November 2018 and three in December 2018 did not have End of Life Care Plans available for review as per Dignity in Care at the End Of Life Practice Guidance.

3.3 There were 10 recorded cases with missing patient details or where staff had recorded their own personal details.

3.4 I terminally ill patient had travelled to India to die with his wider family.

3.5 In Q2 and Q3 the Trust Mortality Reviewers did not have access to the patient information recording system (System1) used by Bedfordshire and Luton Community Services. System 1 is now accessible to the Mortality Reviewers, therefore Bedfordshire and Luton expected deaths will be reflected in the Q4 report.

What are we doing to further improve our learning from expected deaths?

3.6 We want to have a better understanding of the deaths that were expected that we managed in the community. We understand why a death occurred but we want to learn more about how the death occurred and how we can further improve our care for service users at the end of life. To improve our learning we will use a Structured Judgement Review in all cases (100%) where we managed the death.

3.7 Further work needs to be done within our Community Health Services working on the End of Life pathway with other stakeholders in the local area.

3.8 Dr Gilluley, Chief Medical Officer has written to the Medical Directors in all acute hospitals covering the area to ask for joint meeting in how we can learn from deaths in acute hospital of our service users. The aim would be to have a quarterly meeting with acute hospital, primary care, community health and mental health services in the area so we can have some shared learning.

3.9 A request has also been made for acute hospitals to share any information they have relating to the deaths of our services users in their care so we can learn from this.

3.10 We will continue to review cases where we were not involved in managing the death but will reduce this to 25% of the cases.

4.0 Recommendations and actions

4.1 The Board is recommended to receive and note this report**.**