NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
14 NOVEMBER 2018

Title	Mortality review. Q 2 July 1st to September 30th 2018
Author	Duncan Hall, Incidents & Complaints Manager and Tracey Keyes, Mortality Reviewer
Accountable Executive Director	Dr Paul Gilluley, Chief Medical Officer

Purpose of the Report:

To provide an analysis of deaths of service users during the last 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 this reporting period, the Trust reported three hundred and thirty seven expected deaths and undertook four hundred and twenty four Structured Judgement Reviews (SJR); this included SJR of a sample of reported expected deaths from Q1 and Q2.

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
2. The NHS Quality Board framework

Glossary

Abbreviation	In full
Datix	Trust incidents and complaints reporting and management system
ELFT	East London NHS Foundation Trust
HSMR	Hospital Standardized Mortality Ratio
LeDeR	Learning Disabilities Mortality Review
SJR	Structured Judgement Reviews

1.0 Background/Introduction

1.0 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.

1.1 The main focuses of the changes are on governance and capability, skills and training, family involvement in reviews, improved data collection and recording.

1.2 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.

1.3 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.

1.4 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.

1.5 This report sets out Quarter 2 data 2018-19 and reporting will be quarterly.

2.0 Mortality Review Process

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.

2.2 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

2.3 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.

2.4 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 process.

3.0 Resources

3.1 The NHS Quality Board framework specifies that case note review should be undertaken by clinicians to enable the application of an avoid ability score after scrutiny, ranging from definitely avoidable to definitely not avoidable.

3.2 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.

4.0 Presentation and Analysis of Mortality Data for Q2 2018-2019

Summary of deaths and scope of review: 01/07/18 to the 30/09/18

In Q2, four hundred and twenty four deaths (424) were reviewed under the Structured Judgement Review (SJR) Process. As this is a newly formed process in Q2 the mortalities that were reviewed is slightly higher than expected due to incorporating reviews of deaths which occurred prior to July 2018. Details of the actual expected deaths reported in Q1 and Q2 are listed in Table 2 and 3.

The mortalities which were reviewed in Q2 have been broken down by the following;

Age Range of Mortalities

Of the 424 reported expected deaths this quarter

- 5 people were over the age of one hundred
- 380 people were over the age of seventy five
- 36 people were between the age of sixty five and seventy five
- 2 people were between the ages of fifty five to sixty five
- 1 person was under the age of fifty five

Table 1: 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

Table 2 – Expected Deaths Reported in Q1

	Apr 2018	May 2018	Jun 2018	Total
Bedford Mental Health Services	34	3	7	44
City and Hackney	6	6	0	12
Community Health Services	44	54	63	161
Luton Mental Health Services	8	3	8	19
Newham (Mental Health)	5	5	2	12
Specialist Services and CHN Children's Services	5	1	0	6
Tower Hamlets	15	10	7	32
Total	117	82	87	286

Table 3 – Expected Deaths Reported in Q2

	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 – Graph of Expected Deaths in 2017/18

5.0 Learning and Themes

- There was one death of a service user with a Learning Disability for Q2; this case will follow the LeDeR investigation process. No other local reviews have been commissioned for investigation
- One Structured Judgement Review has resulted in a Serious Incident Investigation
- Of note, the predominant causality of deaths reported in this quarter is largely attributed to different types of cancers and heart conditions. Two have died due to pneumonia
- The majority of expected deaths reported in this quarter, 90% (382), occurred whist in hospital or whilst in nursing homes; with the remaining 42 (10%) deaths occurred in the patient's home with family members present
- With all reported (to date) mortalities occurring in Bedfordshire and Luton, the patients records are recorded on System One (electronic patient recording system). Currently, the Trust and mortality reviewers do not have access to System One which limits the extent of the SJRs. Access to System One is currently in the process of being arranged

6.0 Recommendations and actions

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