NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
19 OCTOBER 2017

Title	Mortality Review 2016/17
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Purpose of the Report:

To provide an analysis of deaths of service users during the last financial year, their investigation, and future plans for monitoring and investigating patient deaths, that includes external drivers, in line with the new 'Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'.

The Trust Board is asked to:

a) **RECEIVE** and **NOTE** the report;
b) **NOTE** the progress made to date to comply with the new framework for NHS Trusts on identifying, reporting, investigating and learning from deaths in care;
c) **APPROVE** the recommended approach for ELFT;
d) **ENDORSE** the appointment of the Chief Medical Officer as the Patient Safety Director; and
e) **NOMINATE** a Non-Executive Director to oversee the process.

Summary of Key Issues:

The report presents ELFT's current position in relation to the investigation process of Serious Incidents and sets out five recommendations for action based on the new framework.

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

Improving service user satisfaction	☒	The focus of this paper is to provide data by which learning and improvement can be based.
Improving staff satisfaction	☐	
Maintaining financial viability	☐	

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
	This report has not been considered by any other Trust Committees

Implications:

Equality Analysis	The report does not include equalities analysis.
Risk and Assurance	Monitoring and understanding the occurrence of serious incidents, and learning from them is a central governance and quality improvement function. The report provides assurance that this is being effectively carried out.
Service User/Carer/Staff	The focus of the process for managing serious incidents is learning and improvement, which will positively impact the service user, carer and staff experiences.
Financial	There are no financial implications directly associated with the report.

Quality	The themes arising from serious incidents and the work being done to address these themes, set out in the report, have clear quality implications. Serious incidents are drivers for quality improvement work.

Supporting Documents and Research material

None

Glossary

Abbreviation	In full
None	

1.0 Background

1.1 As a result of a number of concerns about the lack of consistent investigation of deaths of patients under NHS care there is a change to the framework that all NHS Trusts will be using. The substance of the changes is laid out in: *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*, produced by the National Quality Board in 2017. All Trusts are required to comply with the new framework though the majority of the document focuses upon Acute Trusts.

1.2 The main focus of the *changes* are on: governance and capability, skills and training, involvement of families in the investigation, improved data collection and reporting,

2.0 Current Position

2.1 There are three levels of scrutiny that a provider can apply to the care provided to someone who dies; (i) death certification; (ii) case record review; and (iii) investigation.

2.2 In Acute Trusts i) and ii) are the most common methods used. Relatively few result in a Serious Untoward Incident (SUI) using root cause analysis (RCA) methodology.

2.3 In Mental Health and Community Trusts deaths are investigated using RCA more than case record review. Mental Health Trusts investigate a much larger proportion of deaths than Acute Trusts using an RCA methodology; partly because of the nature of deaths in mental health settings e.g. by suicide or because the patient is detained and the death has to be reported and investigated. Case record review has not been utilised in mental health settings because the usual tools for the review e.g. a trigger tool has not been developed for mental health settings.

Table 1: Number of all deaths (expected and unexpected) investigated by the Trust in last year:

Investigation level	**Deaths**
Comprehensive panel led (Level 1a) (SI)	9
Comprehensive corporate led (Level 1b) (SI)	84
Concise (Level 2)	47
Local resolution	470
TOTAL	610

Table 2: Number of unexpected deaths (excluding those in receipt of palliative/end of life care) investigated by the Trust last year

Investigation level	**Deaths**
Comprehensive panel led (Level 1a) (SI)	8
Comprehensive corporate led (Level 1b) (SI)	82
Concise Level 2	42
Local resolution	163
TOTAL	295

2.4 The Current Process for Investigation can be summarised as:

- Datix notification of death

- Screened by Chief Medical Officer or Chief Nursing Officer or deputy on a daily basis
- 48 hour report
- Decision at grading meeting as to whether to close or start local or comprehensive or independent investigation using RCA methodology.

2.5 In addition, for the last year the Trust has used a Mortality Review Committee to ensure that those deaths which have not been captured by the Datix reporting system are followed up within the same incident investigation system where required. These are patients who may have had contact with the services e.g. podiatry four years ago whose deaths are found by the NHS spine updating our electronic patient records.

3.0 New system

3.1 There is no change to the current system of incident investigation. Serious Untoward Incidents will continue to be investigated using the RCA methodology. However for all Trusts, including Mental Health Trusts, there will be a system of case reviews for those deaths that do not meet the threshold for an SUI.

3.2 Case Record Review: Some deaths should be subject to further review by the provider, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. At a minimum, providers should require reviews of:

- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
- All in-patient, out-patient and community patient deaths of those with learning disabilities and severe mental illness.
- All deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);
- All deaths in areas where people are not expected to die, for example in relevant elective procedures;
- Deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;
- A further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

3.3 Information on deaths should be published in the quarter after that in which the death occurred. Publication is designed to:

- Support Trusts to learn from each other
- Ensure transparency and openness
- Highlight good and innovative practice
- Encourage action in relation to identified problems in care

4.0 Involvement of Families

4.1 The framework contains the following points relating to involving bereaved families and carers:

- Bereaved families and carers should be treated as equal partners following a bereavement;
- Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment
- Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
- Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one;
- Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed;
- Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;
- Bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;
- Bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in delivering training for staff in supporting family and carer involvement where they want to.

4.2 The Trust currently does involve family and carers in comprehensive reviews but not in the current mortality review meetings which function as an administrative review.

5.0 Board Leadership

5.1 In relation to board leadership the framework requires:

The board should ensure that their organisation:

- Has an existing Board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing Non-Executive Director to take oversight of progress;
- Pays particular attention to the care of patients with a learning disability or mental health needs;
- Has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
- Adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- Ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the Board in order that the Executives remain aware and Non-Executives can provide appropriate challenge. The reporting should be discussed at the public section of the Board level with data suitably anonymised;
- Ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts;
- Shares relevant learning across the organisation and with other services where the insight gained could be useful;

- Ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- Offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;
- Acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved;
- Works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services.

6.0 Issues for ELFT

6.1 There are some significant issues for the Trust that arise from the framework.

- There has been no methodology devised for Mental Health and Community Trusts to undertake the reviews. Significant resources have been used to develop materials for the acute sector but no guidance on how this might be adapted for our Trust. The methodology for Acute Trusts has been developed by the Royal College of Physicians and is called 'Structured Judgement Review'. It is a two part process involving trained reviewers using a structured process to form a view about the care provided which is scored using a 5 point scale. Further review is undertaken if there are problems which have caused harm and an availability scale is used.
- The framework is clear about the scope for the investigations for Acute Trusts i.e. all inpatient deaths and deaths within 30 days of discharge. The framework specifically states that is up to Mental Health Trusts to decide what the scope should be and they have to defend whatever decision they make.
- Case reviews while less time consuming than SUIs, they do require significant resource from trained staff. It is very unlikely that any current investigations will be diverted into the case review pathway therefore additional resource will be required.

7.0 Recommendations for ELFT

7.1 In order for ELFT to comply with the framework, the following actions are recommended. An action plan presenting progress to date, action leads and the timescale for completion of the recommendations is presented at Appendix 1.

a) By the end of Q2 have a policy and approach on review of deaths produced and discussed at the Trust Board in the public part of the meeting. (The requirements of the policy are set out in Appendix C of the framework).
b) By the end of Q3 have published data and learning points from reviews. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, it will include an estimate of how many deaths were judged more likely than not to have been due to problems in care.
c) Nominate an Executive as a Patient Safety Director and a Non-Executive to oversee the process.
d) Adopt the 'Structured Judgment Review' for case note review of deaths which do not meet the threshold for an incident investigation. The scope of the reviews will be all inpatient deaths and outpatient deaths within 3 months of discharge. All community deaths of patient with severe mental illness and each year have a review of specific themes e.g. death below age 50.

e) Deaths of patients with learning disability will be investigated by a separate LeDeR process.

8.0 Action being requested

8.1 The Trust Board is asked to:

f) **RECEIVE** and **NOTE** the report;
g) **NOTE** the progress made to date to comply with the new framework for NHS Trusts on identifying, reporting, investigating and learning from deaths in care;
h) **APPROVE** the recommended approach for ELFT;
i) **ENDORSE** the appointment of the Chief Medical Officer as the Patient Safety Director; and
j) **NOMINATE** a Non-Executive Director to oversee the process.

Appendix 1: Action plan

	Action	Progress update	Responsibility	Date for completion
1	By the end of Q2 have a Policy and Approach on review of deaths produced and discussed at the Trust Board in the public part of the meeting. (The requirements of the policy are set out in Appendix C of the framework).	Policy approved at Quality Committee (Action complete)	Associate Director of Governance & Risk Management	30.09.2017
2	By the end of Q3 have published data and learning points from reviews. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, it will include an estimate of how many deaths were judged more likely than not to have been due to problems in care.	Dashboard in draft format pending refinement of Datix reporting arrangements to capture case note reviews	Associate Director of Governance & Risk Management	31.12.2017
3	Nominate an Executive as a Patient Safety Director and a Non-Executive to oversee the process	To be confirmed at October Board meeting	Chief Medical Officer	31.10.2017
4	Adopt the Structured Judgment Review for case note review of deaths which do not meet the threshold for an incident investigation. The scope of the reviews will be all inpatient deaths and outpatient deaths within 3 months of discharge. All community deaths of patient with severe mental illness and each year have a review of specific themes e.g. death below age 50.	Evaluation of other Trusts' pilot mental health SJR processes prior to implementation.	Chief Medical Officer	31.12.2017
5	Deaths of patients with Learning Disability will be investigated by a separate LeDeR process.	Process linked to SI review management implemented (Action complete)	Associate Director of Governance & Risk Management	31.08.2017