East London NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
23 May 2019

Title	Learning from Deaths. Q 4: 1 January 2019 to 31 March 2019
Author	Kim MacGillivray, Mortality Reviewer
Accountable Executive Director	Dr Paul Gilluley, Chief Medical Officer

Purpose of the Report

To provide an analysis of service user expected deaths over the three month period 1 January 2019 to 31 March 2019.

Summary of Key Issues

The Trust reported 307 expected deaths between 1 January 2019 and 31 March 2019.

Of the 307 reported expected deaths, 100 percent of the expected deaths managed by ELFT community and mental health services were reviewed under the Structured Judgement Review (SJR) Process. Of the expected deaths where care was provided but not managed by ELFT services; where death occurred in a hospital, hospice or care home, one in four cases was reviewed under the SJR process.

Committees/Meetings where this item has been considered

Date	Committee/Meeting
None	

	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/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 first reported to the Board in October 2017.

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

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 4 data 2018-19 and reporting will continue to be quarterly.

2.0 Mortality Review Process

2.1 There were a number of deaths not captured on Datix (risk management system) as individuals were not being managed by the service reporting the death. 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.

2.2 Bedfordshire Services were not recorded in Q3. The Mortality Review Team did not have access to the patient recording system that the Bedfordshire and Luton Community Services use, System 1. This is now accessible to the Mortality Reviewers and Bedfordshire and Luton are reflected in this quarter. To ensure all deaths are effectively reviewed and managed, a monthly Mortality Review Panel has been set up. The panel looks at trends across services and localities and may ask for a thematic review 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.

2.3 Under the new framework organisations are required to undertake Structured Judgement Reviews (SJR) 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

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

2.5 A further sample is required where deaths do not fit the above categories but learning and improvement could be gained from review. Until Q3 the Trust undertook 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 reviews should be undertaken by clinicians to enable the application of an avoidable score after scrutiny, ranging from definitely avoidable to definitely not avoidable.

3.2 The Trust has appointed two fixed term Mortality Reviewers (MR) and a Bank Mortality Administrator (MA).

Since January of Q4 MR's have undertaken case note reviews for 100% of ELFT managed expected deaths with relevant serious incident investigations.

The role sits within the Governance and Risk Department working closely with incident review colleagues. The Trust MA is responsible for the collection, analysis and reporting of data.

4.0 Presentation and Analysis of Mortality Data for Q4 2018-2019

4.1 Summary of deaths and scope of review: 1 January 2019 – 31 March 2019

307 expected deaths were reported in Q4 between 1 January 2019 and 31 March 2019.

Of the 307 expected deaths 100 percent of those being managed by ELFT services were reviewed under the SJR Process. 1 in 4 of expected deaths where care was provided but not managed by ELFT was reviewed under the SJR process.

Numbers of expected deaths reported in Q4 shows a slight increase from those reported in Q3. This could be explained by the reviewing process which has been enhanced to capture data on cases where care was being provided and managed by ELFT. One in four cases of patients who died in either a hospital; hospice or care home, where care was not being managed by ELFT were reviewed and are included in the figures below.

Graph 1 Showing total of expected deaths reported in Q4

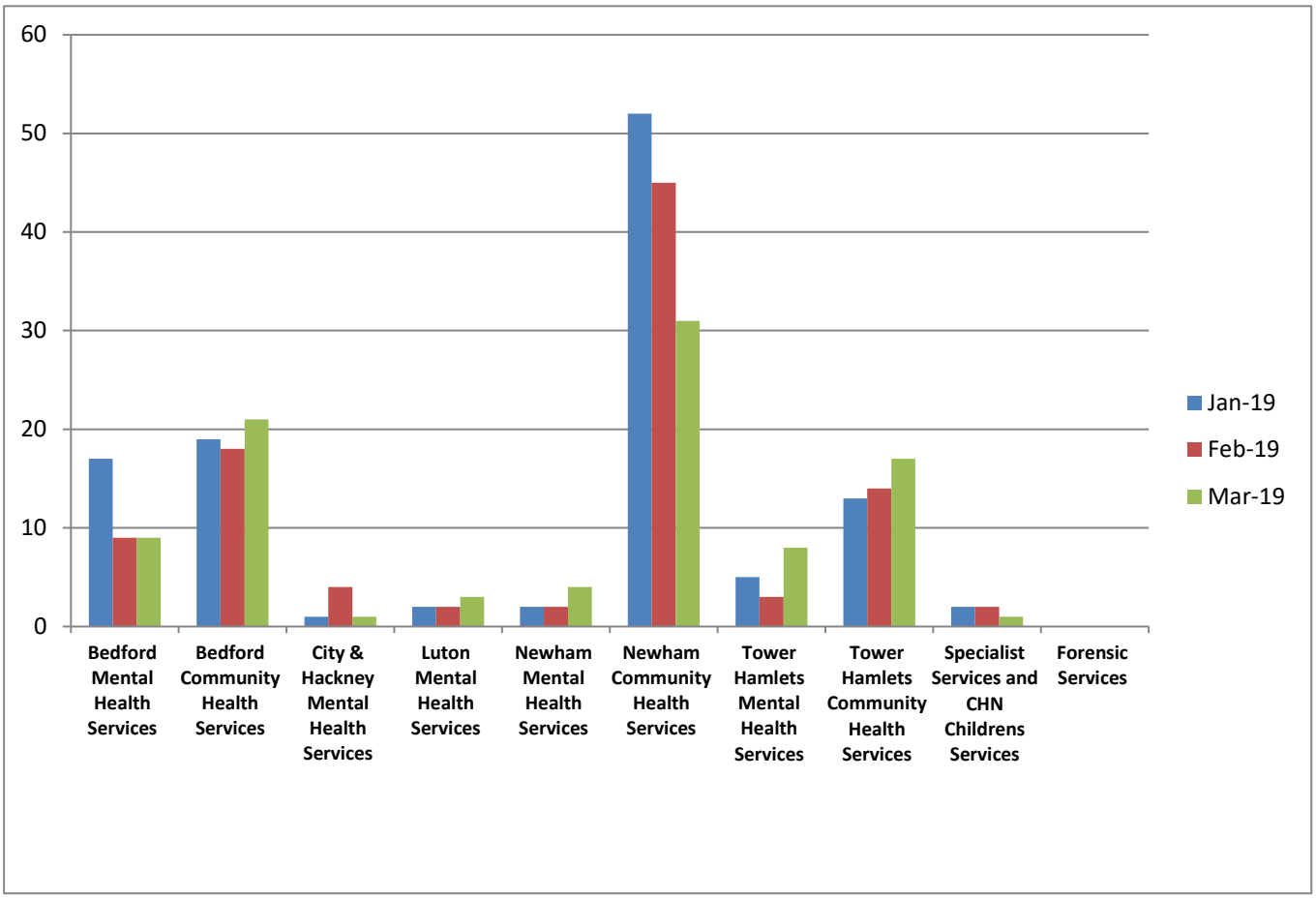

Table 1: Shows all expected deaths by directorate in Q4

Directorate	Jan19	Feb 19	March 19	Total
Bedford Mental Health Services	17	9	9	**35**
Bedford Community Health Services	19	18	21	**58**
City and Hackney Mental Health Services	1	4	1	**6**
Luton Mental Health Services	2	2	3	**7**
Newham (Mental Health)	2	2	4	**8**
Newham Community Health Services	52	45	31	**128**
Tower Hamlets Mental Health Services	5	3	8	**16**
Tower Hamlets Community Health Services	13	14	17	**44**
Specialist Services and CHN Children's Services	2	2	1	**5**
Forensic Services	0	0	0	**0**
Total	**113**	**99**	**95**	**307**

Table 1a: Shows all expected deaths by directorate that were subject to an SJR in Q4

Directorate	Jan19	Feb 19	March 19	Total
Bedford Mental Health Services	5	1	2	**8**
Bedford Community Health Services	9	15	11	**35**
City and Hackney Mental Health Services	1	1	1	**3**
Luton Mental Health Services	1	0	2	**3**
Newham (Mental Health)	0	0	2	**2**
Newham Community Health Services	21	25	17	**63**
Tower Hamlets Mental Health Services	2	1	2	**5**
Tower Hamlets Community Health Services	7	6	12	**25**
Specialist Services and CHN Children's Services	0	0	1	**1**
Forensic Services	0	0	0	**0**
Total	**46**	**49**	**50**	**145**

Details of expected deaths reported in Q1, Q2 and Q3 are listed in Tables 2, 3 and 4

Table 2: Shows all expected deaths by directorate 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 2a: Shows all expected deaths by directorate that were subject to an SJR 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 Services	0	0	0	**0**
Forensic Services	0	0	0	**0**
Total	**50**	**45**	**49**	**134**

Table 3: Shows all expected deaths by directorate 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 3a: Shows all expected deaths by directorate that were subject to an SJR in Q2. Data includes SJR's from Q1

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 4: Shows all expected deaths by directorate 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 4 - No SJR's were completed in Q1. Mortalities that were reported in Q1 were subject to an SJR during the Q2 period. Completed SJR's for Q1 are included in Table 3a. Learning and Themes

4.2 LeDeR

One City and Hackney LeDeR review from Q3 was undertaken and completed in Q4 by ELFT LeDeR/Mortality Reviewer (MR).

In January 2019 there were a total of eight reported LeDeR deaths, three were under Bedfordshire Mental Health services; two were Specialist Services and CHN Children's Services; one was under Tower Hamlets Mental Health and two were under the Community Health Services Newham.

There was one reported LeDeR death in February 2019; this was subject to an ELFT and Bart's Health joint review which is still ongoing. In March 2019 there was one LeDeR death reported, this was recorded by ELFT although the patient no longer had contact with ELFT. The reporter was requested by LeDeR to complete a Datix.

4.3 End of Life Pathway (ELP) and Preferred Plan of Care (PPC)

One hundred and sixty two patients' who accessed ELFT care but either died in a hospital, hospice or care home. Forty of these cases were reviewed under the SJR process. End of Life Pathway (ELP) and Preferred Plan of Care (PPC) were not available to review as care was not being managed by ELFT services or had not accessed services for a prolonged period of time.

Data on ELP and PPC was not gathered in Q1, Q2, Q3, or in January and February of Q4.There were a total to 50 cases reviewed during the period 1-31 March 2019. Fourteen of the patients where care was being managed for ELFT had either an ELP or PPC that was available for review. Out of the cases that were not being managed by ELFT, there were two ELP's available for review.

4.4 **Age**

January data does not capture patient age or gender. This has been included in the February and March figures and will show in future board reports.

Of the forty nine cases reviewed in February there was one case of a male child under the age of eighteen which was subjected to a LeDeR and joint ELFT/ Barts Health review but not an SJR. There were six deaths of patients' between the age of nineteen and sixty and forty- three deaths for those of the age of sixty, with one ninety nine year old and one hundred year old.

In March, there were no cases reviewed with patients under the age of eighteen. Of the fifty cases reviewed, two patients were under the age of sixty. All other reviewed cases were over the age of sixty.

4.5 **Gender**

Gender was not reported in Q1, Q2, Q3 or January and February of Q4. Data for March of Q4 shows that out of the 50 cases reviewed 28 were male and 22 were female.

4.6 **Missing details**

There were three cases in January where the reporters did not record patient details. Two of these cases were raised with the locality and one was an overseas visitor with no further action. There were no cases in February or March that had missing details.

Overall cases with missing patient details have reduced over the reporting period 2018-2019.

4.7 **Escalated to 48hr Report; Concise Report or Serious Incident Review (SIR)**

There were no escalations in January. One case was escalated to a 48 hour report in February, with no escalations in March.

5.0 Recommendations and actions

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