ITEM 15.2

Report to: Joint Trust Board, 6 June 2019
Author: Dr Amjad Uppal, Medical Director and Paul Ryder, Patient Safety Manager
Presented by: Dr Amjad Uppal / Paul Ryder

SUBJECT: **Learning from Deaths Report**

Can this report be discussed at a public Board meeting?	**Yes**
If not, explain why	

This Report is provided for:			
Decision	Endorsement	**Assurance**	**Information**

EXECUTIVE SUMMARY

The data presented represents those available for the period October to December 2018 (Q3 2018/19).

Changes to the selection criteria and the Mortality Review function – RCPsych SJR adopted in November 2018, applied to open deaths and incorporated into the Learning from Deaths process.

111 deaths have been closed without further review due to being open to solely ACI-Monitoring caseloads (58) or excluded due to a primary diagnosis of dementia and over 70 years of age (53).

1 deaths raised a cause for concern within a partner organisations during Q3 2018/19. That death was raised with the organisation's Mortality Lead. There were no concerns about care provision within 2gether.

There has been a key post vacant since August 2018 that has been covered by temporary staffing. The Patient Safety Manager is now recruiting a substantive PST Administrator.

The Board is asked to note the contents for information and to recognise that remedial work continues to improve the unsatisfactory position currently observed.

RECOMMENDATIONS

The Board is asked to note the contents of this Mortality Review Report which covers Quarter 3 of 2018/19.

Corporate Considerations	
Quality implications	Required by National Guidance to support system learning
Resource implications:	Significant time commitment from clinical and administrative staff
Equalities implications:	None
Risk implications:	None

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	Yes
Increasing Engagement	No
Ensuring Sustainability	No

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			Yes
Excelling and improving	Yes	Inclusive open and honest	Yes
Responsive	Yes	Can do	
Valuing and respectful	Yes	Efficient	

Reviewed by:		
Amjad Uppal	Date	21 March 2019

Where in the Trust has this been discussed before?		
Mortality Review Committee (MoReC) Trust Board Executive Team	Date	15 March 2019 27 March 2019 15 April 2019

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. INTRODUCTION

1.1 In accordance with national guidance and legislation, the Trust currently reports all incidents and near misses, irrespective of the outcome, which affect one or more persons, related to service users, staff, students, contractors or visitors to Trust premises; or involve equipment, buildings or property. This arrangement is set out in the Trust policy on reporting and managing incidents.

1.2 In March 2017, the National Quality Board published its *National Guidance on Learning from Deaths: a Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*. This guidance sets out mandatory standards for organisations in the collecting of data, review and investigation, and publication of information relating to the deaths of patients under their care.

1.3 Since Quarter 3 2017/18, the Trust Board has received a quarterly (or as prescribed nationally) dashboard report to a public meeting, following the format of Appendix D, including:

- number of deaths
- number of deaths subject to case record review (now SJR Part 2+)
- number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- themes and issues identified from review and investigation (including examples of good practice)
- actions taken in response, actions planned and an assessment of the impact of actions taken.

1.4 From June 2018, the Trust will publish an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

1.5 This paper offers the subsequent iteration of data for the period October to December 2018.

2. PROCESS

2.1 All 2gether Trust staff are required to notify, using the Datix system, the deaths of all Trust patients. This comprises anyone open to a Trust caseload at the time of their death and who dies within 30 days of receiving care from 2gether. Following discussion at Mortality Review Committee (MoReC) in and at countywide Mortality Steering Groups in both Gloucestershire and Herefordshire, it was agreed to exclude from active review those open for ACI Monitoring only and those with a primary diagnosis of dementia who are over 70 years old. MoReC had become very aware that older people with dementia die whilst this had resulted in very little learning from this cohort of patients. There will be a continued focus on those 70 years and under.

2.2 Mandatory mortality reviews are required for:

- All patients where family, carers, or staff have raised concerns about the care provided.
- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death.

- All patients who were an inpatient in a mental health unit at the time of death or who had been discharged from inpatient care within the last month.
- All patients who were under a Crisis Resolution & Home Treatment Team (or equivalent) at the time of death (noting that these deaths will likely be categorised as Serious Incidents).

2.3 The format of a Mortality Review was modified following the publication of the Royal College of Psychiatrists Structured Judgement Review in January 2019. With regard to process detail, “Table Top Reviews” are now referred to as SJR Part 1, and “Care Record Reviews” are SJR Part 2+ (including parts 2-7). The RCPsych SJR is attached for reference. The parts of the review consider:

- Part 1 The allocation and initial review or assessment of the patient (this is usually completed within Datix only) resulting in a Mazars categorisation
- Part 2 The ongoing care of the patient, including both physical health and mental health
- Part 3 Care during admission
- Part 4 Care at the end of life
- Part 5 Discharge planning
- Part 6 An option for organisations to rate particular aspects of care the reviewers feel is necessary for that individual
- Part 7 Overall care

2.4 Based upon the information provided, patient deaths are assigned to one of the six categories developed by the Mazars report into Southern Health NHS Foundation Trust (2015).

2.5 Expected Natural deaths (EN1 & EN2) are sorted into those where there may be concerns and those where no possible concerns are identified. Unexpected Natural deaths (UN1 & UN2) are subjected to a case record review and sorted into those where there may be concerns and those where no possible concerns are identified.

Type	Description
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and in some cases would benefit from further investigation
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.
Unexpected Natural (UN1	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke These deaths should be reviewed and some may need an investigation.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect These deaths are likely to need investigating

2.6 All Unnatural deaths (EU & UU) are discussed, individually with the Patient Safety manager to identify those that fall into the category of serious incidents requiring investigation, within statute, and according to the relevant Trust policy. Where there appears to be further information required or learning to be derived, incidents that do not require a serious incident review are notified to the relevant team manager for a clinical incident review. The remaining incidents are sorted into those where there may be concerns and those where no possible concerns are identified.

2.7 Where no concerns are identified, the Datix incident is closed without further action.

2.8 Where concerns are raised, the case is be elevated to the clinical leads for review and, depending upon the outcome, can be treated as a serious incident, referred for multiagency review or notified to the relevant team manager for a clinical incident review.

2.9 The data obtained will be subjected to a modified version of the structured judgement review methodology defined by the Royal College of Physicians and assigned to one of three categories:

Category 1: "not due to problems in care"

Category 2: "possibly due to problems in care within ^{2}gether"

Category 3: "possibly due to problems in care within an external organisation"

2.10 For those deaths that fall into Category 2, learning is collated and an action plan developed to be progressed through operational and clinical leads and reported to Governance Committee. For Category 3, the issues identified are escalated to local partner organisations through the relevant Clinical Commissioning Group lead for mortality review. For distant organisations, issues will be shared with the local lead for learning from deaths within the organisation.

2.11 All deaths of patients with a learning disability will be also reported through the appropriate Learning Disabilities Mortality Review Program (LeDeR) process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

2.12 During the first year of implementation, the MR process has proven to have a demonstrably high administrative burden. The quality of the output from a large proportion of Mortality Reviews indicated that, within that large proportion, the care afforded to the patient during their End of Life Care was not provided by 2gether teams, but often from 3rd sector providers (i.e. care homes) and GP practices. There has been limited learning produced from reviewing these cases.

3. DATA

3.1 The data presented below represents those available for the period October to December 2018.

3.2 111 deaths have been closed without further review due to being open to solely ACI-Monitoring caseloads and/or with a primary diagnosis of dementia and over 70 years of age. 20 death incident reports were rejected due to not being on an open caseload at the point of their death (or within 1 month of discharge).

3.3 No deaths have raised a cause for concern within 2gether and one concern was raised with a partner organisation during Q3 2018/19.

4. CONCLUSION

4.1 This, the Q3 report for 2018/19 of mortality review data under the Learning from Deaths policy focusses on the progress made during Q3.

4.2 The new bank Patient Safety Team Administrator joined the team on 29 October 2018, after the post had remained vacant since August 2018. She has made a significant impact on the outstanding and overdue Mortality Reviews as is demonstrated by the current quarterly "Open Mortality Reviews" data shown. At the end of Q2 there were 184 open cases (96 for Q2 alone) and as of end Q3 there remain 29 open cases. Substantive recruitment has begun following Director of Quality agreement.

4.3 By Q3 2018/19, it was projected that significant progress would be made regarding the number of Q1-Q2 2018/19 death incidents being reviewed. There is good assurance that this is the case. Furthermore, the PST Administrator has requested access to the SystmOne records database in order to further enhance her ability to collect relevant data following patient deaths. This should further improve the time taken to completed Part 1 reviews.

4.4 Mortality Review Committees have convened regularly since November 2018. However, whilst learning from these reviews is limited, the active review of patient deaths does provide assurance that End of Life Care and the care provided to our patients is of an excellent quality which seldom results in unexpected deaths, natural or otherwise.

4.5 The Lessons Learned documents produced following completion of Serious Incident Final Reports are attached for

- SI-13-19
- SI-14-19
- SI-15-19
- SI-16-19

This learning is published to the 2getherNet intranet and the documents have been distributed through locality governance committees for cascade to wards, teams and bases.

Financial Year 2018-2019

Q3 MoReC Figures - correct up to 30 December 2018

Closed Mortality Reviews

Month	Closed ACI Caseload Deaths	Deaths excluded from full Table Top Review	Closed Following RCPsych SJR Section 1			Closed Following RCPsych SJR Part 2+			Closed Following Serious Incident Review			Total
			Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	
Oct-18	27	14	2	0	0	3	0	1	4	0	0	51
Nov-18	17	18	0	0	0	1	0	0	3	0	0	39
Dec-18	14	21	0	0	0	0	0	0	2	0	0	37
	58	53	2	0	0	4	0	1	9	0	0	127

Open Mortality Reviews

Month	Awaiting Information to Complete Part 1	Awaiting Part 1 Review	Awaiting Part 2+ (MoReC)	Awaiting Clinical Review (SI's)	Total	Quarterly Total
Oct-18	6	0	1	0	7	29
Nov-18	6	0	2	2	10	
Dec-18	6	0	6	0	12	
	18	0	9	2	29	