# SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

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<th>Meeting</th>
<th>Board of Directors</th>
<th>Date</th>
<th>6 December 2017</th>
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<td><strong>Subject</strong></td>
<td>Mortality Update (including 6 Monthly Update on the Trust’s Performance against National Guidance on Learning from Deaths)</td>
<td>Enclosure</td>
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<td><strong>Nature of item</strong></td>
<td>For information ✓</td>
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<td><strong>Decision required (if any)</strong></td>
<td>The Board is asked to receive and note this report.</td>
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**General Information**

- **Report Author**: Fraser Millard, Associate Medical Director Governance
- **Lead Director**: Charles Ashton, Medical Director

**Received or approved by**

- **Meeting**
- **Date**

**Resource Implications**

- Revenue
- Capital
- Workforce
- Use of Estate
- Funding Source

**Applicable Quality Improvement Priorities**

- Integrated Care
- Patient Experience – End of Life
- Patient Experience – Dementia
- Patient Experience – Booking
- Delayed Transfers of Care
- Normal Birth Rates
- Leg Ulcer Healing Rates
- Electronic Observations
- Medicines Management

**Freedom of Information**

- Confidential (Y/N) (if yes, give reasons): No
- Final/draft format: Draft
- Ownership: Trust
- Intended for release to the public: Yes
South Warwickshire NHS Foundation Trust

Report to Board of Directors – 6 December 2017

Mortality Update – including 6 Monthly Update on the Trust's Performance against National Guidance on Learning from Deaths

Executive Opinion

This is an assuring paper that provides a Mortality Update to include the Trust’s performance against the National Guidance on Learning from Deaths and demonstrates no cause for concern.

Dr Fraser Millard
Associate Medical Director (AMD) – Governance
On behalf of Dr Charles Ashton, Medical Director

Executive Summary

Over the last quarter, the Mortality Surveillance Committee (MSC) has met in July, August and October 2017. The report provides assurance that:

- mortality rates for all deaths remain in the “As Expected” range;
- the MSC continues to monitor risk adjusted mortality at speciality and diagnosis level, and commissions further detailed work when appropriate;
- resulting learning is shared, and
- the Trust complies with the National Guidance on Learning from Deaths, and is working to further improve the mortality review process. The updated action plan, with acknowledgement to Andy Butters, Head of Governance, is included.
Mortality Update – including 6 Monthly Update on the Trust’s Performance against National Guidance on Learning from Deaths

Mortality Rates

1) Summary Hospital-level Mortality Indicator (SHMI):
The latest values for SHMI from the HSCIC Clinical Indicator Previewer:
- April 2016 to March 2017 1.06 (lower 0.89, Upper 1.13)
- January 2016 to December 2016 1.07 (Lower 0.89, Upper 1.12)
- October 2015 to September 2016 1.06 (Lower 0.89, Upper 1.13)
- July 2015 to June 2016 1.06 (Lower 0.89, Upper 1.13)

These figures are banded, “As Expected.”

2) Risk Adjusted Mortality Index (RAMI) 2016:
Trust RAMI (August 2016 to July 2017) 82
Peer RAMI (August 2016 to July 2017) 92
Trust RAMI (August 2015 to July 2016) 93

Current year = 670 Observed and 814 Expected, previous year 651 Observed and 698 Expected.

These figures are banded as, “Green” on the latest mortality scorecard.
3) Hospital Standardised Mortality Ratio (HSMR):

**KEY**
- **Blue**: SWFT
- **Green**: Peer

**KEY**
- **Dark Red**: Upper Control limit (3 sigma)
- **Pale Red**: Upper Control limit (2 sigma)
- **Dark Green**: Lower Control limit (3 sigma)
- **Pale Green**: Lower Control limit (2 sigma)
- **Blue**: SWFT
4) RAMI at Speciality and Diagnosis Level:

The MSC continues to monitor risk adjusted mortality at speciality and diagnosis level and commissions further detailed work when appropriate:

Indicators rated red on the latest Mortality Scorecard when compared to peer:

- Deaths with Zero Length of Stay - a sample of deaths has been reviewed and assurance provided to the MSC at the June 2017 Meeting;
- Acute MI – currently monitored by the MSC in view of low numbers and resulting statistical variation with:
  Current Year = 11 Observed and 11 Expected
  Previous Year = 9 Observed and 12 Expected
  RAMI (August 2016 to July 2017) Trust 104 vs Peer 87;
- COPD – response from Respiratory Medicine reviewed by the MSC at the May 2017 meeting; Respiratory Medicine attended November 2017 meeting of the MSC with:
  Current Year = 22 Observed and 20 Expected
  Previous Year = 15 Observed and 16 Expected
  RAMI (August 2016 to July 2017) Trust 112 vs Peer 102;
- Heart Failure - a sample of deaths is being reviewed and a report is being prepared for the MSC with:
  Current Year = 37 Observed and 35 Expected
  Previous Year = 28 Observed and 28 Expected
  RAMI (August 2016 to July 2017) Trust 107 vs Peer 93;
- Fractured Neck of Femur (#NOF) - a review of the #NOF deaths provided assurance at the MSC April 2016 meeting.
Deaths and Mortality Reviews

In the Trust, for the period September 2016 to August 2017, there were:

- 824 deaths and 446 reviews completed;
- 2 deaths which were deemed avoidable:
  - Treated as Serious Incidents and reported to the Clinical Governance Committee as well as South Warwickshire Clinical Commissioning Group (CCG);
- 0 deaths of patients with identified learning disabilities.

Mortality reviews are performed in accordance with the National Guidance on Learning from Deaths with the numbers of deaths and number of mortality reviews:

The MSC also has the following standard agenda items enabling discussion and triangulation of any lessons learnt:

- the Mortality scorecard;
- the Mortality page from the Patient Safety Monthly Report;
- Junior Doctor feedback;
- Reports from the Elective and Emergency Divisions Audit and Operational Governance Groups;
- Serious Incidents (SIs) Root Cause Analyses (RCAs) with reference to avoidable deaths, and
- Initial Management Review (IMR) Minutes for Unexpected Deaths (non-Serious Incidents).
The Trust has met with the NHS South Warwickshire CCG’s Head of Nursing and Quality, and Mortality Lead who attends the MSC, to develop links to facilitate the reviews of patients who have died within 30 days of leaving hospital.

Recent Learning from Mortality Reviews

- Hospital admission is potentially preventable with advanced care planning or end of life care planning in place in the community;
- Full and clear completion of the ReSPECT documentation – please ensure patient/carer discussions and wishes with regards to the ceiling of care and DNAR decision are clearly documented;
- Early diagnosis of the dying patient may prevent inappropriate observations, investigations and treatment;
- Please assess patients on the history and examination, taking care to avoid assumptions based on the patient’s age and miscommunication, to ensure recognition of the deteriorating patient with appropriate escalation;
- Delayed transfer of care may contribute to multiple falls and hospital acquired pneumonia;
- Advanced care planning prior to discharge may have prevented readmission and allowed a patient to die at home;
- Lessons from Coding:
  - Case notes and discharge summaries must clearly state the patient’s primary diagnosis or describe the treatment plan in terms of ‘treat as….’ Or ‘probable….’ The use of terms such as ‘likely’ ‘possible’ or ‘?’ or using the heading ‘impression’ cannot be used to code patients and therefore should be avoided;
  - Mortality indicators such as SHMI, HSMR are compiled using the coding of the primary diagnosis for the First Consultant Episode and therefore may not reflect the final diagnosis of the cause of death as recorded on the death certificate for example.

The learning from mortality reviews is shared within the Trust through for example the Audit and Operational Governance Groups (AOGGs), Grand Rounds, Multidisciplinary Mortality Meetings, Speciality Department Governance Meetings, Patient Safety Monthly Reports, Patient Safety Newsletters, ePulse, screensavers, Safety Practice Alerts, and Investigation Reports.

Action plans from IMRs and SI RCAs are monitored by the Patient Safety Team and reported to the relevant AOGG.

Learning from mortality reviews is to be shared more widely across the West Midlands through the West Midlands Mortality Leads Meetings, to be feedback through the MSC.

National Guidance on Learning from Deaths

The National Guidance on Learning from Deaths provides a Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. The background to the Guidance lies in the Francis Report, and the Care Quality Commission (CQC) Report Learning, Candour and Accountability, and emphasises learning from deaths, and engaging with families and carers.
The National Guidance on Learning from Deaths was reviewed at the MSC in April 2017.

A briefing paper for information and including an action plan to address the Guidance with recommendations was presented to and accepted by the Board of Directors Meeting in May 2017.


The Trust complies with the Guidance.

Following the Guidance, there have been many events over the last quarter at which the Trust has been represented which have included:

- NHS Improvement Mortality Learning Events;
- The Royal College of Physicians National Mortality Review Structured Judgement Review Training sessions;
- West Midlands Mortality Leads Meeting;
- Browne Jacobson Information Sharing and Networking Forum.

The feedback from these events has stimulated ongoing discussions in the Trust to develop a vision for learning from deaths for the future which will further improve the current processes in place, under the leadership of Dr Pablo Garcia de Paso, Deputy AMD for Governance, and the auspices of the MSC.
### Board Leadership

Mortality Governance should be a key priority for Trust Boards. Executives and Non-Executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge. A lead Executive Director and Non-Executive Director should be identified to lead and provide scrutiny and oversight.

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<tr>
<th>Recommendation</th>
<th>Trust Position</th>
<th>Development Required</th>
<th>Lead</th>
<th>Completion Date</th>
<th>RAG Rating</th>
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<tr>
<td><strong>1.</strong> Lead Director</td>
<td>Trust Medical Director</td>
<td>1. Briefing paper to the Board outlining Trust position and the new recommendation to include on a quarterly basis a paper and supporting data to the public Board meeting</td>
<td>1. AMD for Governance</td>
<td>1. 24 May 2017 Board of Directors meeting</td>
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<td><strong>2.</strong> Lead Non-Executive Director</td>
<td>Chair of the Trust Clinical Governance Committee</td>
<td>2. Trusts should publish by September 2017 on the Trust public website an updated policy on how it responds to and learns from, deaths of patients who die under its management and care</td>
<td>2. Head of Governance</td>
<td>2. August 2017</td>
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<td><strong>3.</strong> Mortality Surveillance Committee Chaired by the Trust Medical Director with GP Executive representation from South Warwickshire CCG reports quarterly to the Clinical Governance Committee (CGC) and to the Board via Chair of the CGC</td>
<td>3. Changes to Quality Accounts regulations will require that the data providers publish be summarised in Quality in Quality Accounts from June 2018</td>
<td>3. Trust Assurance Manager</td>
<td>3. June 2018</td>
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<td><strong>Data Collection and Reporting</strong>&lt;br&gt;From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths (Policy and approach by end of Q2 and publication of the data and learning points from Q3 onwards. The data should include the total number of the trusts inpatients deaths (including emergency department deaths) and those deaths that the trust has subjected to a case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged to have been due to problems in care.</td>
<td>1. Head of information provides on a monthly basis to AMD for Governance and Patient Safety team and distributed to clinical specialities&lt;br&gt;2. Mortality reviews completed by divisions using standardised mortality proforma and returned to patient safety team to collate numbers and learning points.&lt;br&gt;3. Data and learning published within monthly patient safety report that is reviewed at both the patient safety surveillance committee and the Trust Mortality Surveillance Committee.&lt;br&gt;4. The Board receive Quality and performance Dashboard monthly&lt;br&gt;5. The Trust responds to and reviews any alerts raised by Imperial College Dr Foster&lt;br&gt;6. The Trust CHKS system provides a mortality score card that includes SHMI,</td>
<td>1. Emergency Department deaths will need including&lt;br&gt;2. Mortality proforma will require review and amendment to capture structured judgement review methodology developed by the Royal College of Physicians. Dashboard requirements will need to be developed to support external reporting, to include total number of inpatients deaths, the subset of these that have been subjected to case review including those that are assessed as more likely than not to be due to problems in care. Evidence of learning and actions taken will also need to be included</td>
<td>1. Clinical Director for the Emergency Department&lt;br&gt;AMD for Governance&lt;br&gt;Head of Information&lt;br&gt;2. AMD for Governance&lt;br&gt;Head of Information&lt;br&gt;Head of Governance</td>
<td>1. June 2017</td>
<td>June 2017</td>
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<td><strong>Responding to Deaths Incident Reporting and Investigation</strong></td>
<td>HSMR, RAMI, Clinical Indicators requiring close scrutiny this is reviewed on a monthly basis at the Trust Mortality Surveillance Committee 7. Completed Initial Management Reviews of unexpected deaths are peer reviewed at the MSC and a decision is taken on whether the death was preventable or not</td>
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<td>1. The Trust has in place a Risk Management Incident Reporting System (DATIX) Incidents are reviewed daily by the Director of Nursing. Staff report unexpected deaths via DATIX and are investigated using Root Cause Analysis methodology. 2. The Trust has in place a Management of Incidents and Serious Incident Policy 3. All incidents following</td>
<td>1. Responding to deaths. The trust will need to enhance its current procedures and develop a policy to ensure it meets all the key principles contained within the national guidance. The new policy will need to be published on the Trust public viewing website by September 2017</td>
<td>1. Head of Governance</td>
<td>1. August 2017</td>
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<td><strong>Skills and Training</strong>&lt;br&gt;Providers should review skills and training to support the National Guidance with specialist training and protected time under their contract hours to review and investigate deaths to a high standard</td>
<td>investigation and closure are uploaded to the National Reporting Learning Service on a weekly basis&lt;br&gt;4. The Trust has in place a Duty of Candour and Being Open Policy</td>
<td>1. Acute Trusts will receive training to use the Royal College of Physicians Structured Judgement Review Case Note Methodology. Health Education England and the Healthcare Safety Investigation Branch will engage with system partners, families and carers and staff to understand broader training needs and to develop approaches so that NHS staff can undertake good quality investigations of deaths</td>
<td>1. Head of Learning and Development to ensure access to training available to trust</td>
<td>1. No timescale has been advised</td>
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<td><strong>Engagement with bereaved families and carers</strong>&lt;br&gt;Providers should have a clear policy for engagement with bereaved families and</td>
<td>1. The Trust has a bereavement service, specialist bereavement Midwife, a Learning disability Nurse ,</td>
<td>1-3. The services and policies will be reviewed and enhanced with the key principles recommended and provided within the</td>
<td>1-3. The Director of Nursing and the Head of Governance</td>
<td>1-2. July 2017</td>
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carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

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<td>1. Establish independent investigations where the integrity of the investigation is likely to be challenged 2. Review Childrens Policies and Procedures and align to best guidance</td>
<td>1. Executive representation at Safeguarding Childrens Board 2. Statutory Policies and Procedures are in place. 3. Lead Paediatricians in place 4. MASH arrangements in place 5. OFSTED and CQC reviews 2016 completed</td>
<td>National Guidance.</td>
<td>1-2. General Manager Women’s and Children’s Division Dr Peter Sidebotham and Dr Vinodhini Clarke Consultant Paediatricians David Widdas</td>
<td>Bereavement policy currently under review for completion by Jan 2018</td>
<td>On-going Jan 2018</td>
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### Children and Young People

NHS England is currently undertaking a review of child mortality review process both in hospital and Community. A National Mortality Database is currently being commissioned. Further guidance is expected in late 2017.
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<td>Maternity Services</td>
<td>Maternal deaths and stillbirths occurring in acute and community trusts should be included by trusts in quarterly reporting from April 2017. This will also include deaths that occur in local midwifery units, or during home births. The definition also covers up to 42 days after the end of pregnancy</td>
<td>Women’s and Children’s AOGG in place. With Clinical Director and Governance leads Policies and Procedures relating to neonatal and maternal deaths are in place. Any unexpected death is investigated using Root Cause Analysis methodology.</td>
<td>Data reporting requirements to The Board</td>
<td>Head of Midwifery Services and Governance Midwife</td>
<td>May 2017</td>
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<td>Mental Health</td>
<td>Regulations require registered providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the CQC without delay.</td>
<td>1. The Trust is registered with the CQC to provide care to patients detained under the Mental Health Act and is fully compliant with notification and investigation requirements. 2. The Trust has in place a Mental Health Partnership arrangement with the local MH provider. 3. Any unexpected death will be subject to Root Cause Analysis Investigation and reported to the CCG.</td>
<td>1. Policy Review</td>
<td>1. Head of Governance</td>
<td>1. June 2017</td>
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| **Learning Disabilities**                           | 1. Lead Director  
2. Director of Nursing who sits on both Safeguarding Adult Board and Safeguarding Childrens Board  
3. Learning Disabilities Nurse in place  
4. Safeguarding Childrens teams in place  
5. Safeguarding Adult lead in place  
6. All unexpected deaths are subject to a Root Cause Analysis Investigation and reported to the CCG | Further guidance to be provided by NHS England                                       | Director of Nursing       | December 2017         | Green       |
| Cross System Reviews and Investigations             | 1. Concordat arrangement with CCG  
2. Informal arrangements in place with all local providers                      | 2 Concordat arrangement acknowledged in public Board Papers                            | Medical Director          | On-going              | Yellow      |

- Learning Disabilities: There is unequivocal evidence that demands additional scrutiny be placed on deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review Programme. Once fully rolled out by NHS England (NHSE), the programme will receive notification of all deaths of people with Learning Disabilities. This will support a standardised approach and the reviews will be conducted by trained staff.

- Cross System Reviews and Investigations: Mortality Review Concordat (NHSE) Sharing of Information October 2017