Southern Health NHS
NHS Foundation Trust

Death / Mortality and Serious Incident Reporting, Management and Assurance

1. Purpose and Background

1.1. On the 11 January 2016 NHS Improvement (formally Monitor) confirmed that members of their Provider Regulation Executive had approved the undertakings submitted by the Trust. These undertakings are in addition to those accepted by NHS Improvement in April 2014. The Trust is expected to take action to comply with these Enforcement Undertakings. On 19 January 2016 NHS Improvement published the undertakings that have been agreed with the Trust in response to the Mazars report.

1.2. This paper provides evidence and assurance that the undertakings the Trust has agreed with NHS Improvement are delivered.

1.3. Oversight of the delivery of the improvement action plan is being undertaken by the Serious Incident Oversight and Assurance Committee (SIOAC) which meets on a fortnightly basis and reports to the Board.

1.4. As of 1 April 2016 the NHS Improvement Director, Alan Yates, has commenced in post and is working with the Executive Team to apply scrutiny, challenge and seek assurance as to the delivery of the improvement plan.

1.5. An expert reviewer, Niche Consultancy and Grant Thornton, have assessed the action plan and have provided feedback to the Trust on 17 May 2016. A rewrite of the action plan is now taking place.

1.6. Mortality and serious incident management are key indicators of the Trusts safety and effectiveness. This paper provides an update for the Trust Board on serious incident management and mortality reporting since 1 December 2015 when a new process was commenced as a result of the review into deaths.

1.7. The Trust is committed to identifying, reporting and investigating deaths and serious incidents, ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence. The Trust seeks, where at all possible, to prevent the occurrence of serious incidents by taking a proactive approach to the reporting and management of risk, to ensure safe care is provided to patients, through the promotion of a positive reporting and investigation culture.

2. Death / Mortality

2.1. Death / mortality reporting has been in place as from the 1 December 2015 following the guidance of the Trust-wide document *Procedure for the reporting and investigating of deaths* SH NCP75 issued December 2015. Data collection is via the Ulysses Safeguard risk management system on an electronic platform.

2.2. Deaths are reported under categories stipulated within the procedure, reviewed by a senior manager (initial management assessment) and decision made at a 48 hour panel as to whether an investigation is required and at what level; no investigation, local investigation (internal reporting) or serious incident investigation (external reporting[1]).

2.3. Compliance with the new procedure has been monitored using an auditable extraction from the Ulysses database. Compliance to the dataset has been available to all of the divisions on a daily basis and has featured as an element of the Quality Governance Flash report which is produced for the organisation every Monday.

2.4. The data extraction produced on the 8 June 2016 showed an overall Trust-wide compliance of 100% to the process. This meets the improvement target on the action plan. Performance is being monitored and discussed at the Mortality Working Group (MGW).

2.5. The compliance results as of 8 June 2016 are;

Mortality data														Number of deaths	459
Division	No of deaths reported from 1st Dec 15	IMA completed?	48 hour panels completed	% 48 hour panels completed	Trend for the last 4 weeks : % Panels completed in 48 hours and (no of reported deaths)										
					09/05/2016		16/05/2016		23/05/2016		30/05/2016		Trend		
Childrens	20	20	20	100%		(0)		(0)	100%	(2)		(0)	▲		
East ISD	139	139	139	100%	100%	(7)	100%	(2)	100%	(3)	75%	(4)	▼		
Learning Disabilities	40	40	40	100%	100%	(1)		(0)	100%	(2)		(0)	▲		
Mental Health	79	77	78	99%	100%	(3)	100%	(2)	100%	(2)	33%	(3)	▼		
North East ICS	10	10	10	100%		(0)	100%	(1)		(0)		(0)	▶		
Southampton & West ISD	163	163	161	99%	67%	(9)	83%	(6)	75%	(4)	25%	(4)	▼		
TQ Twentyone	3	3	3	100%		(0)		(0)		(0)		(0)	▶		
Trust Wide	459	457	456	99.3%	85%	(20)	91%	(11)	92%	(13)	45%	(11)	▼		

2.6. Analysis and quality assurance of the data provides to following information.

2.6.1. Compliance detail;

- 456 out of the 459 reported deaths have been reviewed as of 8 June 2015; 99.3% compliance
- Compliance to the review taking place within 48 hrs dropped in May to 84% therefore the Trust has not met the target of 95%. This will be discussed at the June Mortality Working Group (MWG) directly with the panel Chairs.
- In May 12 (22%) of the 55 deaths reviewed in May were reported as Serious Incidents.

Compliance to the 48 hour panels on a monthly basis							
Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
12%	54%	68%	93%	88% (53/60)	84% (59/70)		

2.6.2. Quality Assurance;

2.6.2.1. An audit of a random 20% sample of the Ulysses held records of the mortality panels and decision making occurs every month.

2.6.2.2. The overarching audit question for the establishment of the results was: Ensure there is evidence of the rationale of the decision making process of whether to conduct an investigation into a death and this is clearly recorded.

[1] Serious Incidents are those which meet the requirement of reporting to the Strategic Executive Information System (StEIS) as guided by the national Serious Incident Framework 2015.

2.6.2.3. The audit tool was changed in April following review of the first four months audit. It is now more specific regarding the review of the IMA and the 48 hour panel decision. An additional question about the Duty of Candour evidence has also been added.

2.6.2.4. The target set for the monitoring of the mortality process was that 60% of death reports would be correct without central moderation and there would be a robust audit trail of the decisions to investigate a death.

2.6.2.5. The overall results were:

December	January	February	March	April
94%	100%	100%	75%	83%

2.7. The results have been shared with the Mortality Working Group (MWG) at the May meeting and moving forwards a wider group of senior clinicians will be undertaking the audit.

2.8. A further deep dive audit of 10 cases specific to a location noted as having poor compliance was undertaken by the Associate Medical Director – Patient Safety. The results have been discussed with the Senior Management Team which shows marked variety between the information provided by the locality teams. This will repeated in three months' time. The Learning Disability division has been found to produce robust IMAs and 48 hour panel records.

2.9. Following review of the first four months audit data the audit tool has been adjusted to be more specific regarding the review of the IMA and the 48 hour panel decision. An additional question about the Duty of Candour evidence has also been added. A further review of the tool will take place at the end of the next quarter.

2.10. All activity is being reported to Quality Improvement and Development Forum and the Serious Incident Oversight and Assurance Committee.

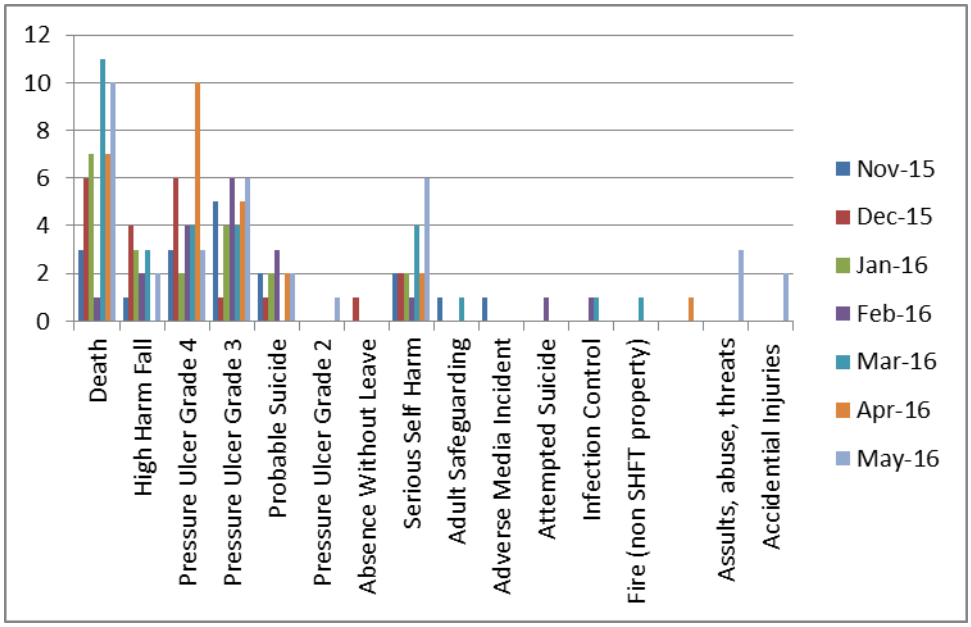
3. Serious Incidents

3.1. There were 27 Serious Incidents reported during March. This is a slight decrease on the previous month but remains within normal statistical control (SPC).

Division	No. of SI's reported in May 2016 (April 2016 in brackets)	Type of Incident
ICS North East	0 (4)	
East ISD	3 (9)	1 death 1 high harm fall 1 grade 4 pressure ulcer
West ISD	12 (4)	2 deaths 1 high harm fall 1 grade 2 pressure ulcer 6 grade 3 pressure ulcers 2 grade 4 pressure ulcers
Mental Health (includes Specialised	19 (9)	2 probable suicides 6 deaths

Services)		6 serious self-harm 3 assaults (to staff/patients/ visitor/public) 2 accident or injury
Learning Disabilities	1(1)	1 death
TQtwentyone	0(0)	
Children and Families Division	0(0)	
Corporate	0(0)	
Total	35(27)	

3.2. The 35 Serious Incidents can be broken down into the following categories;



3.3. All serious incidents must be reported, investigated, approved by corporate panel and submitted through the StEIS system within 60 working days as stipulated in the national framework document.

3.4. The position 8 June 2016 showed 66 open Serious Incident investigations underway in the Trust, 5 have been officially paused due to Safeguarding Serious Case Reviews (SCR) or police investigations taking place.

3.5. From a position of the Trust having a backlog of investigation reports past the required submission deadline. All current reports remain within 60 working days.

Number of reports overdue for submission:

February 2016	March 2016	April 2016	May 2016	June 2016
39	39	35	24	0

4. Present Status – 08.06.16

4.1. There are no investigation reports overdue on the 60 day submission to StEIS criteria.

4.2. The June trajectory report is predicting:

4.2.1. 94% compliance to the 60 day uplift to StEIS requirement for June supported by 21 out of the 24 expected reports booked to panel dates

4.2.2. 42% has already been achieved through early submission to StEIS

4.2.3. 6% / 3 reports (North) East ISD do not have confirmed panel dates

StEIS number	Incident number	Division	Due date	Dates in Red are panel dates booked but not yet concluded Dates in Black are concluded panel dates		
2016/6705	93876	East ISD	03/06/2016	01/06/2016	Yes	
2016/6699	93754/93780	North East ISD	03/06/2016	27/05/2016	Yes	
2016/7630	92642	Mental Health	13/06/2016	27/05/2016	Yes	
2016/7768	93177	Southampton & West ISD (PU)	14/06/2016	08/06/2016	Yes	Downgrade requested on 19/05/16 further request made to commissioners 1/6/2016, and 8/6
2016/7766	92296	North East ISD (PU)	14/06/2016	DATES AWAITED	Yes	Booked on Divisional Panel on 11/03/2016 to be reviewed by new Matron
2016/7765	93575	Southampton & West ISD (PU)	14/06/2016	07/06/2016	Yes	Approved on 7/6/2016 Awaiting Action Plan
2016/7769	94095	North East ISD	14/06/2016	08/06/2016	Yes	Virtual panel 08/06/2016
2016/7770	93443	Mental Health	14/06/2016	20/05/2016	Yes	
2016/7763	94298	Mental Health	14/06/2016	10/06/2016	Yes	Booked on Corporate 10/06/2016
2016/7749	93269	Specialised Services	14/06/2016	10/06/2016	Yes	Booked on Corporate 10/06/2016
2016/7826	94167	Childrens	15/06/2016	24/05/2016	Yes	
2016/7963	94601	Childrens	16/06/2016	24/05/2016	Yes	
2016/8084	94154	OPMH	16/06/2016	08/06/2016	Yes	Virtual panel 08/06/2016
2016/8090	93836	Mental Health	16/06/2016	23/05/2016	Yes	
2016/8094	91188	Mental Health	16/06/2016	10/06/2016	Yes	Booked on Corporate 10/06/2016
2016/8158	94349	North East ISD (PU)	17/06/2016	DATES AWAITED	Yes	
2016/8613	93327	Mental Health	22/06/2016	07/06/2016	Yes	
2016/8623	93404	Mental Health	22/06/2016	07/06/2016	Yes	
2016/5511	92333	East ISD	22/06/2016	17/06/2016	Yes	4 week extn (from 25/5/16) agreed by Julia Barton. Booked to corp panel 17/06/16
2016/8949	85568	Mental Health	24/06/2016	22/04/2016	Yes	
2016/8941	94855	Mental Health	24/06/2016	10/06/2016	Yes	Booked on Corporate 10/06/2016
2016/9152	94472	North East ISD (PU)	28/06/2016	DATES AWAITED	Yes	
2016/9159	94615	Southampton & West ISD (PU)	28/06/2016	13/06/2016	Yes	Booked on Divisional MAP panel on 13/06/2016
2016/9165	94815	Southampton & West ISD (PU)	28/06/2016	23/06/2016	Yes	Divisional Panel 23/06/2016

4.3. Moving forwards:

4.3.1. 21 reports are due in July, 20 have panel dates

4.3.2. 40 reports are due in August, all have panel dates

5. Lessons Learned

5.1. Common themes resulting from the serious incident panels in May:

5.1.1. The Did Not Attend / Did Not Engage policy used in Mental Health and Older Persons Mental Health to be reviewed as could be viewed as inflexible and not meeting the needs of our service users. Task and finish group established to review the policy especially considering escalation of concerns following sudden and unexpected disengaging.

5.1.2. Lack of up-to-date risk assessments, care plans or risk factors which is captured solely in the RiO progress note is a contributory factor in a very high percentage of investigation reports. Thematic review has now been commissioned.

5.1.3. Lack of accurate next of kin information being kept within the clinical record. This makes contact difficult for the investigating officers and hampers the timely involvement of families in investigations.

5.1.4. Several cases where the investigation is completed but lacks information related to physical health provided by primary care. Engagement within the investigation process across service providers is not consistent. These have been reported to CCG Quality Managers for follow up within primary care.

5.2. One Trust-wide alert was published warning all staff of the dangers related to oxygen cylinders being managed in an upright position in people's homes. The correct position is side lying. A serious incident resulting in illness leading to death had occurred due to

a cylinder falling on an elderly patients foot which lead to the development of gangrene.

5.3. Improvement action plans resulting from major and catastrophic SI's are being scheduled to an Improvement Monitoring Panel where completion will be checked by the Executive Director level Chair. The first panel is scheduled to take place on 20th June 2016 and five improvement action plans are due to be heard.

6. Risks

6.1. There was a high level of activity of divisional and corporate panels during May to clear the backlog of serious incident investigation reports and there is a risk of slippage if the activity is not sustained during June. Twice weekly trajectory monitoring calls are in place as an early warning system to prevent this.