

Medical Directorate
6th Floor, Skipton House
80 London Road
SE1 6LH

TO:
**Medical Directors of Acute, Mental
Health and Community Trusts**

17th December 2015

Dear colleagues,

Re: Self-assessment on Avoidable Mortality

All around the world individuals, institutions and healthcare systems are grappling with the distinction between excess and avoidable mortality. In England this came in to sharp relief during the 2013 review into the 14 hospitals with the highest mortality. The debate continues, but we have started to make some progress.

Following the review into those hospitals Professor Nick Black from the London School of Hygiene and Tropical Medicine and Professor Lord Ara Darzi were asked to examine the relationship between excess and avoidable mortality using established case note review methodology. They determined that about 4% of deaths in our hospitals were potentially avoidable and that there was no obvious relationship with excess deaths over and above the average. Given the experience gleaned through this process we are seeking to establish a standardised methodology for reviewing deaths in our hospitals with the aim of identifying themes for improvement both nationally and within organisations. We are currently procuring a training programme for retrospective case record review and will engage the Academy of Medical Royal Colleges to help guide the process to ensure clinical relevance.

In addition, we are pleased to say that the Government remains committed to reforming the process of death certification, subject to consultation, with the intention of introducing Medical Examiners to improve the accuracy of local reporting and thereby support measures to reduce avoidable deaths. This was an accepted recommendation of the Francis Inquiry. The process has worked particularly well in Sheffield, University Hospital Birmingham and Heart of England amongst others.

Many Trusts already take this very seriously and have sophisticated governance processes in place, but to encourage all Trust boards to focus on this difficult issue, the NHS Mandate includes an intention to publish avoidable mortality by Trust. The exact form this will take has yet to be determined and will be considered carefully.

To start the process we are asking Trusts to conduct a self-assessment of their

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avoidable mortality using a simple tool that we have developed which accompanies this letter. **Please return this self-assessment to england.rcrr@nhs.net by the 31st of January.** Please note that due to the differences in the evidence base between acute and other services, there are different sections of the tool for different service types. Please complete only the relevant section.

At the same time we are sharing a Mortality Governance Guide developed by Monitor and the Trust Development Authority to help support Trust Boards to take a common and systematic approach to the issue of potentially avoidable mortality and to link this to quality improvement work.

Evidence from CQC inspections suggests that useful areas for Trusts to focus on are their early warning and escalation systems for patients who are deteriorating and the application of the sepsis bundle particularly in acute medical settings.

Should you have any queries, please contact the team at england.rcrr@nhs.net.

Yours sincerely,



Dr Mike Durkin
Director of Patient Safety,
NHS England and NHS Improvement



Professor Sir Bruce Keogh
National Medical Director,
NHS England