Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors

Subject:	Learning from Deaths – Quarter One Report	Date: 26/07/18
Prepared By:	Elaine Jeffers, Deputy Director of Governance & Quality Improvement	
Approved By:	Dr Andy Haynes, Executive Medical Director	
Presented By:	Dr Andy Haynes, Executive Medical Director	

Purpose		
The purpose of this paper is to provide the Board of Directors with the Quarter One update on compliance against the Learning from Deaths Guidance and the wider Mortality agenda.	Approval	
	Assurance	
	Update	x
	Consider	

Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
x	x	x	x	x
Indicate which strategic objective(s) the report support				

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
Indicate the overall level of assurance provided by the report -	External Reports/Audits x	Triangulated internal reports x	Reports which refer to only one data source, no triangulation	Negative reports

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	No financial implications are anticipated at this time
Patient Impact	Improvements to services and care will be realised through the timely and comprehensive review of each death to maximise learning opportunities
Staff Impact	Changes to practice and care will be identified through the Mortality Review Process
Services	Changes to practice and care will be identified through the Mortality Review Process
Reputational	Potential reputational damage

Committees/groups where this item has been presented before

Quality Committee – 18/07/18

1. Executive Summary

As outlined in the Learning from Deaths Annual Summary Report to the Board of Directors in May 2018 the Trust Mortality Surveillance Group (MSG) will continue to oversee the plans to further progress the wider mortality agenda.

The Work Programme for 2018/19 will include:

- Enhancing the partnership working with Dr Foster, using the intelligence collated by our clinical teams to drive the areas of focus.
- Working closely with bereaved families to ensure we sensitively and compassionately address their concerns and answer questions in relation to the death of a loved one.
- Implementing the ReSPECT Tool to ensure robust systems, processes and appropriate training are in place to support staff caring for patients in the last days and weeks of life.
- Implementing the Medical Examiner Role

- Building effective and collaborative working relationships with partner organisations to ensure a seamless journey for patients across shared pathways and to maximise the learning opportunities across the wider health community.
- Increasing the learning opportunities afforded by the comprehensive review of care delivered to our patients prior to death and the identification of themes for inclusion within improvement programmes.

The Board of Directors is asked to note:

- The content of the report
- The developing nature of the Mortality Agenda for 2018/19
- The performance against the Learning from Deaths Guidance (Appendix One)

1. Dr Foster

1.1 The Trust has built a very good working relationship with Dr Foster over a number of years. This relationship has been integral to the improved and sustained position the Trust has achieved with regards to the Hospital Standardised Mortality Ratio (HSMR)

1.2 The Board of Directors have received a monthly report indicating that the Trust HSMR has been within the expected range since April 2016. This has been achieved in a number of ways but primarily by an increased understanding and analysis of our data.

1.3 In conjunction with intelligence from Dr Foster we were able to take appropriate action to address those diagnosis groups that were deemed to be outliers. In addition, improvements in the depth and quality of coding practices – both by the coding team but also by clinical teams had a significant impact.

1.4 The contract with Dr Foster has been renewed for a further three years on the basis that the Trust, through the Structured Judgement Review (SJR) process, start to drive the mortality agenda using intelligence collated from mortality reviews and speciality governance. The data provided by Dr Foster will also be used to benchmark against the top performing Trusts for an agreed sub-set of the diagnosis basket. This work will commence from September 2018.

1.5 A key area of the work will be to look at the variance in mortality for elective patients versus non-elective patients. HSMR is designed to focus on non-elective pathways but given the challenges faced around elective procedures, particularly when the organisation is under significant operational pressure, this work will enable us to understand the impact on outcomes and mortality for elective patients and should contribute to future operational decision-making.

2. Bereaved Families

2.1 As reported to the Board in May the National Guidance on Learning from Deaths has attempted to set out expectations for how Trusts work more closely with bereaved families to answer questions and concerns they may have in relation to the care and treatment and cause of death of their relative. This continues to prove challenging as all organisations recognise this must be handled with ultimate care and compassion when families are ready.

2.2 The Trust has good systems in place through an effective Bereavement Service. Families are already given the opportunity to raise concerns and questions with the relevant clinical team at the point of registering a death and this is followed up by the receipt of a booklet containing appropriate information, contact details and next step advice. All families receive a follow up questionnaire six weeks post death allowing further questions to be raised that may not have been immediately present.

2.3 The challenge for the organisation is how best to involve families when lapses in care become apparent through the mortality review. On occasions there can be quite a time difference due to complexities with coronial or internal processes and it may be necessary to raise issues with families some months after the death. It is hoped that the implementation of the ReSPECT Tool may support this somewhat.

3. ReSPECT Tool

3.1 The Trust has formally agreed to implement the ReSPECT Tool in conjunction with the wider health community as part of the Better Together programme. The implementation is being overseen by the Deteriorating Patient Group (DPG) and is a key component of the DPG Work programme 2018/19.

3.2 ReSPECT is a joint conversation between the patient and their clinician setting out recommendations for clinical care in the event of a future emergency in which the patient is unable to make or express their preferred choices.

3.3 The single most evident theme emanating from mortality reviews and the implementation of Learning from Deaths Guidance in 2017/18 was the ability and unwillingness of clinical staff to engage early with patients and families about ceilings of care and plans to support the last weeks and days of life.

3.4 A missed opportunity to have timely discussions was a theme in a number of mortality reviews and has also been a theme across complaints and incident investigations. The effective application of ReSPECT will give clinical staff the confidence, tools and techniques to have a meaningful and supportive conversation, which in turn should help families understand and come to terms with the death of their loved one.

4. Medical Examiner Role

4.1 Guidance has been published on the requirements for trusts or health communities to develop an independent 'Medical Examiner' role to provide an external objective view of care delivered to a patient and the circumstances surrounding their death.

4.2 There is little clarity on how this role should be implemented and the development of a suitable model will be left to the discretion of individual organisations to determine. Furthermore, there is even less clarity on the funding stream for such a role. Those organisations that have been pilot sites have all taken a very different approach and it would seem that there is no agreed 'one size fits all' solution.

4.3 The Trust recognises the value of such a role and the current Trust Mortality Lead has been an early adopter of the principles of the Medical Examiner through the support given to clinical teams in implementing the Learning from Deaths Guidance.

4.4 It is expected that the Medical Examiner role should be in place by the end of March 2019. Although the Trust has made significant progress there is further work to do to understand the wider implications of the role – i.e. the relationship between a Medical Examiner and the Coroner, the impartiality of a local Medical Examiner and clinical teams, the definition and identification of supporting Medical Examiner Officers and the relationship with partner health and social care organisations, specifically when a patient's care spans more than one provider.

4.5 A proposal is currently being worked up and will be presented to MSG in September 2018.

5. Partner Organisations

5.1 To enhance the overall learning opportunities and joint working arrangements quarterly meetings are being scheduled with Nottingham University Hospitals NHS Trust (NUH) and Nottinghamshire Healthcare NHS Foundation Trust (Notts Health). In time this may also include commissioning groups, primary care and social care as our patients often have contact across multiple sectors.

6. Structured Judgement Review

6.1 Clinical teams have made excellent progress in the implementation of the Structured Judgement Review process as our mandated Mortality Review methodology throughout 2017/18. This has been evidenced and commended throughout the 2018 inspection by the Care Quality Commission (CQC) and is being held up as exemplar practice.

6.2 Despite the progress made we continue to improve. We have a standardised electronic mechanism for the initial collection of information following a death (Mortality Review Tool (MRT) phase one SJR) and a clear line of sight into MSG for those reviews where

avoidable or contributory factors are deemed to be present (phase three SJR). There is, however, a recognised gap in potential learning opportunities for sharing across specialties and divisions – (phase two SJR).

6.3 To date it has been difficult to collate the themes and learning that have been identified through the multidisciplinary mortality meetings where the detail of the care delivered to the patient is discussed. It is through this phase that the real richness of information should be forthcoming. It is through this phase where the most valuable learning can be found. It is this phase where MSG will turn its attention throughout this year.

7. Mortality Dashboard Quarter one 2018/19

7.1 The Mortality Dashboard (Appendix One) indicates that the overall performance against the 90% review of all deaths standard is 68.78% at the time of writing this report. The caveat of the performance is that specialties are completing reviews within two months of a death and as such there will always be a lag time between death and the completion of a review. This is a particular issue for specialties that have a high number of deaths per month – i.e. geriatric medicine and respiratory medicine.

7.2 MSG is proposing that the standard for completing a review should be four weeks, unless there are legitimate reasons for a delay – such as a coronial or serious incident investigation. This is to ensure that the learning opportunities and any relevant actions are identified at the earliest possible time.

7.3 Sub-optimal performance in two specialties has been reported through the Medicine Divisional Exception Report to MSG in July 2018. These are Respiratory and Haematology. MSG were satisfied that appropriate remedial action has been taken and expect to see an improvement in performance at the September meeting.

8. Summary

8.1The Report highlights the next steps in our journey to *‘make mortality more meaningful’.* We have a firm foundation on which to build further improvements. The learning themes from our 2017/18 mortality reviews have helped shape elements of our improvement work for 2018/19 with MSG remaining flexible enough to incorporate the requirements of national guidance as and when published.