Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors

Subject:	Learning from Deaths – Quarter Four Report	**Date:** 02/05/19	
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 Four 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 promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
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

1. Executive Summary

The Trust Mortality Surveillance Group has met on the third Tuesday of each month through quarter four. A key focus of the group has been to agree the next phase of mortality development through 2019/20.

The Board of Directors is asked to note:

- The content of the report
- The developing nature of the Mortality Work Programme for 2019/20
- The specific focus on patients with a known learning disability or identified mental health condition
- The successful implementation of the national ReSPECT Tool on 1 April 2019
- The performance with the Mortality Review process (Appendix One)

1. Work Programme for 2019/20

1.1 As described in the quarter three report to the Board of Directors the plans to further enhance the function of the Trust Mortality Surveillance Group (MSG) are in progress.
1.2 A schedule of attendance by specialty mortality leads has been agreed whereby individual services will be given the opportunity to present their mortality journey.
1.3 As part of the ongoing preparations for a visit from the Care Quality Commission services are being asked, in particular, to focus on their learning from mortality review and to be able to describe what changes and improvements they have made to the care of a patient as a consequence.

2. Learning Disability and Mental Health

2.1 The way in which we care for patients with a known learning disability is a key indicator within the 2018/21 Quality Strategy. The timely and compassionate review of the death of a person with a learning disability is also one of the mandatory criteria for the completion of a Structured Judgement Review and presentation of findings to MSG.
2.2 It became apparent at the February MSG meeting that services had not been aware of the requirement for this group of patients and as a consequence had not been reporting as necessary.
2.3 There is an external mechanism – the Learning Disabilities Mortality Review process (LeDer) who are accountable for reviewing all deaths for patients aged between 4-75 years of age who have a learning disability. Following an internal review carried out in 2017 we have been able to demonstrate that our internal process gathers much richer intelligence on the care delivered and improvements required. We will provide our internal review to support the LeDer process going forward.
2.4 MSG is working closely with the Trust Lead Nurse for Learning Disabilities to ensure we maximise the learning and improvement opportunities and have a comprehensive list of patients.
2.5 A further internal exercise has been undertaken through March 2019 to ensure all deaths of patients with a learning disability have undergone a thorough mortality review with outcomes presented appropriately. Further detail will be provided to the Board of Directors in the Learning from Deaths Annual Summary report in June 2019.
2.6 Building on the work underway around specific cohorts of patients we recognise that patients with a mental health condition are likely to have a reduced life expectancy than other adults. Our 2019/20 Work Programme will also focus on patients with a clinical code of Schizophrenia, Acute Psychosis and Bi-polar Disorder.

3. Dr Foster Monthly Report

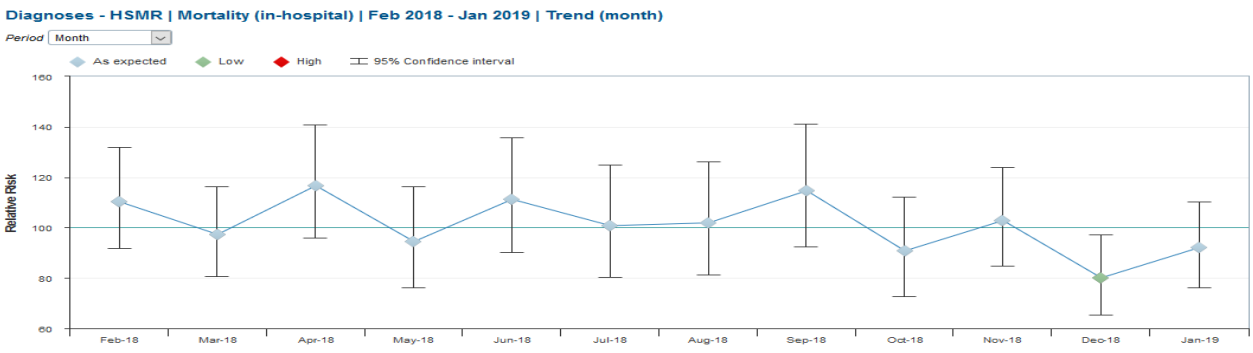

Chart 1.

3.1 As indicated in chart 1 the Trust has maintained the position of being well within the expected range for mortality relative risk. It is recognised that we will remain within expected due to the current provision of Specialist Palliative Care.
3.2 The Trust has made significant progress along the mortality journey and it would not be unreasonable to accept the current 'within expected range' position without further question. As a Trust aspiring to be outstanding we recognise that we should continue to strive for improvement and as such our 2019/20 work programme includes a detailed look behind the Trust level numbers to determine which diagnosis groups require additional focus.
3.3 The Dr Foster Report (February 2019) highlighted the top 15 conditions where 75% of our deaths occur using December 2017-November 2018 data. The data showed the national standard (median) v the Trust position for crude, expected and relative risk mortality.
3.4 Using the same data set we also looked at the difference between the Trust performance and the top 25% performing trusts (the data had been adjusted to remove teaching hospitals and specialist acute hospitals).
3.5 Interrogating the data in this way stimulated a different discussion indicating a suite of conditions to be considered for further work.
3.6 Three areas have been selected in the first instance:

- Acute Cerebrovascular Disease (Stroke)
- Congestive Heart Failure (Cardiology)
- Fractured Neck of Femur (Trauma and Orthopaedics)

3.7 The aim is for the services to understand their data in more detail, particularly why it is driving the current performance and whether there is any wider learning opportunities or improvements to be made
3.8 The Dr Foster Report (April 2019) has taken this initial work further providing a specialty-specific report for Stroke Services that indicated we are performing in the top 5 of similar sized District General Hospital nationally.

4. Dr Foster Mortality Outlier Alert

4.1 As reported previously the Trust received a Mortality Outlier Alert from the Dr Foster Unit, Imperial College, London and responded accordingly.
4.2 Following the CQC Engagement meeting in February 2019, although we appealed the decision, we were requested to resubmit our response with further information.
4.3 We await a final decision as to whether our response has satisfied the CQC Outlier Alert team.

5. ReSPECT Tool

5.1 Under the accountability of the Deteriorating Patient Group (DPG) the Trust successfully launched the national ReSPECT Tool on 01 April 2019 as planned.
5.2 A significant number of clinical staff have now been trained in using the tool and we are seeing evidence of the effective application.
5.3 This has been quite challenging for a number of colleagues, particularly those who see patients at the very beginning of their inpatient journey, however there has been good engagement with the process.
5.4 DPG will continue to have oversight of the use reporting to Patient safety Quality Group through the DPG Dashboard.

6. Medical Examiner Role

6.1 The Trust approved the Business Case to develop the Medical Examiner Service within the organisation in line with the national requirement to develop a service from April 2019.
6.2 It is recognised that this is a significant change to current practice with a full service not expected to be in place until 2021.
6.3 The National Medical Examiner has been appointed and will provide advice, support and guidance over the coming months.
6.4 To support the independent nature of the role it is likely a Regional Medical Examiner will be appointed but this is not imminent.
6.5 The Trust has concluded the pilot phase of preparing for this role and on the whole it has evaluated well. Of particular benefit has been the enhanced discussions with bereaved families who are given the opportunity to have a full explanation of the cause of death and to have any questions and queries answered by a subjective senior doctor not directly involved in the care of their loved one.
6.6 Junior doctors who are often unclear as to what to record on the Medical Cause of Death Certificate have also benefited from the additional support and teaching this service offers.
6.7 We plan to roll out formal implementation and appointment of the inaugural Medical Examiner for the Trust through quarter one.

7. Mortality Dashboard Quarter Four 2018/19

7.1 The Mortality Dashboard (Appendix One) indicates that the overall performance for the quarter against the 90% review of all deaths standard is 70.84% at the time of writing this report.
7.2 The current year to date performance is 83.06% compared to the total performance rate of 83.87% for 2017/18. It is expected that this will increase prior to the final year end position presented in the Annual Summary Report in June 2019.
7.3 MSG continues to promote the standard for completing a review within six weeks, unless there are legitimate reasons for a delay. This ensures we understand the care given at this vulnerable time and adopt any learning in a timely way.

8. Summary

8.1 The 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.