Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors

Subject:	Learning from Deaths – Quarter Four Report	**Date:** 01/08/19	
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 One (2019/20) 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

N/A

1. Executive Summary

The Trust Mortality Surveillance Group continues to meet on the third Tuesday of each month. A key focus of the group is to progress the next phase of mortality development through 2019/20.

The Board of Directors is asked to note:

- The content of the report
- The performance with the Mortality Review process (Appendix One)

1. Work Programme for 2019/20

1.1 Dr Foster has commenced speciality level training to enable individual services create and understand their own mortality information. Cardiology are the first service to undertake the training and will present their mortality story at the August Mortality Surveillance Group (MSG).

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 The Trust continues to work closely with the Learning Disabilities Mortality Review (LeDeR) process are the accountable body for reviewing all deaths for patients aged between 4-75 years of age who have a learning disability.

2.3 The Structured Judgement Reviews completed by clinical teams provide a high level of detail and information to LeDeR, not only on the circumstances surrounding the death of each patient but crucially relating to the care provided prior to death.

2.4 LeDeR has found our submission very useful to support their process, specifically in providing assurances to families in the days and weeks following their relative's death.

2.5 Patients with a specified mental health condition are also likely to have a reduced life expectancy than other adults. Our 2019/20 Work Programme is also focussing on patients with a clinical code of Schizophrenia, Acute Psychosis and Bi-polar Disorder.

2.6 The Advancing Quality Programme Mortality measures are being updated for year two to include the structured judgement review process for both patients with a learning disability and those with the identified mental health conditions.

3. Dr Foster Monthly Report

3.1 Chart 1 demonstrates the Trust Hospital Standardised Mortality Ratio (HSMR) position remains well within the expected range. The February position has been reported as 93.4 with March reported as 94.2. This is a very positive position given the pressures of the winter months.

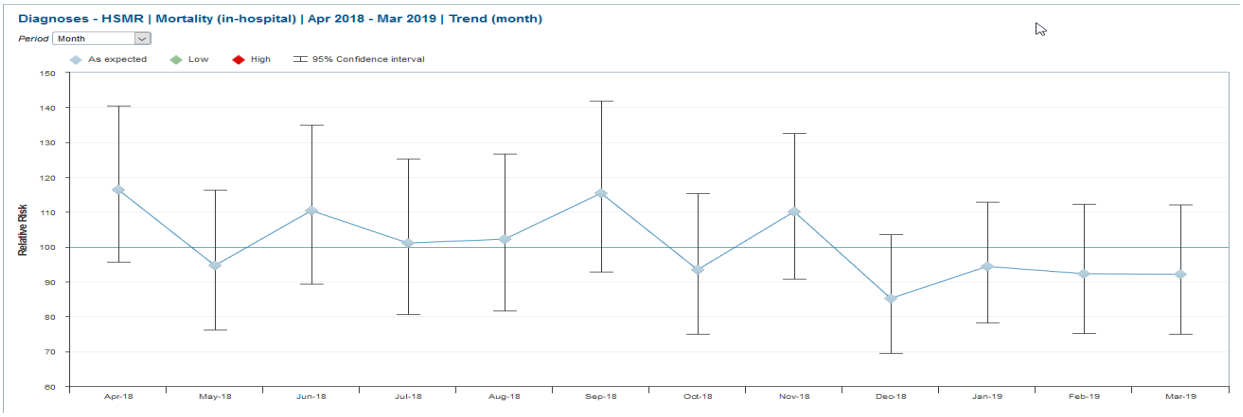

Chart 1.

3.2 Chart 2 indicates the rolling 12 month performance as 99.3

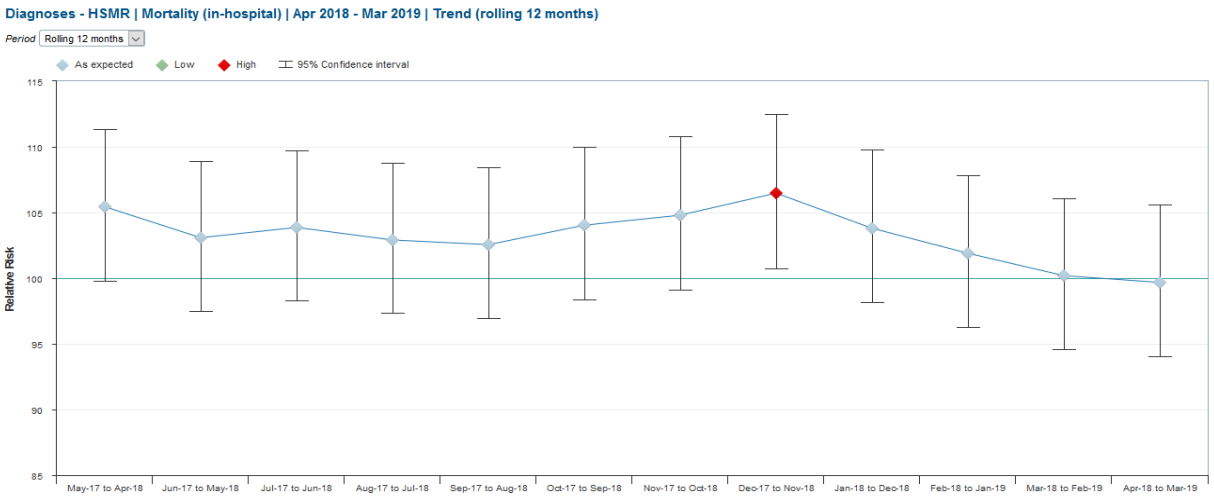

Chart 2.

3.3 Weekend V Weekday (admission) mortality shows similar values for both groups of patients as indicated in chart 3 triangulating the work the Trust continues to undertake to ensure patients receive the same senior level of input regardless of day of the week.

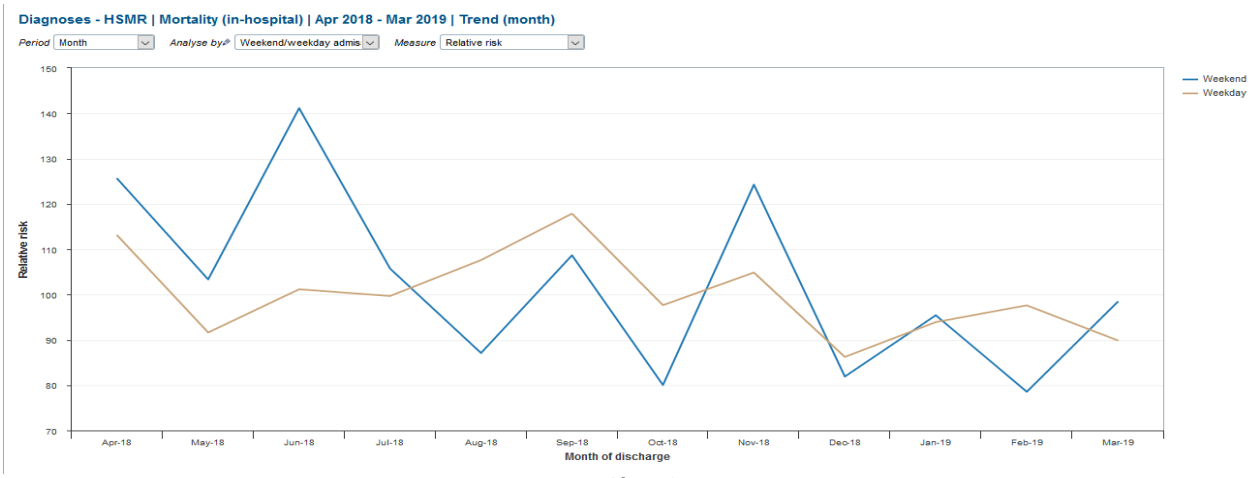

Chart 3.

3.4 Chart 4 highlighting the Elective V Emergency activity shows consistent values for emergency activity between week days and the weekend. The elective performance is erratic due to small numbers with the rolling 12 month shows below expected mortality.

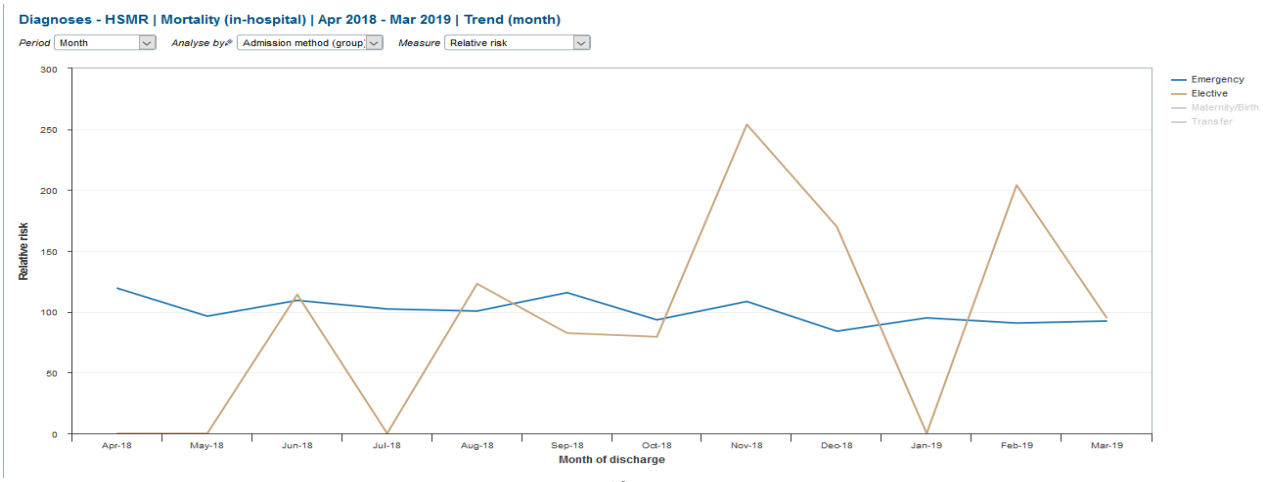

Chart 4.

4. Dr Foster Mortality Outlier Alert – Biliary Tract Disease

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 Unfortunately the second response submitted to the CQC Mortality outlier team in March 2019 has not been accepted with a further response due on 26 July
4.3 The Dr Foster performance provided for the July MSG meeting indicates that mortality for this diagnosis group has been well within the expected since February 2018 as demonstrated in chart 5.

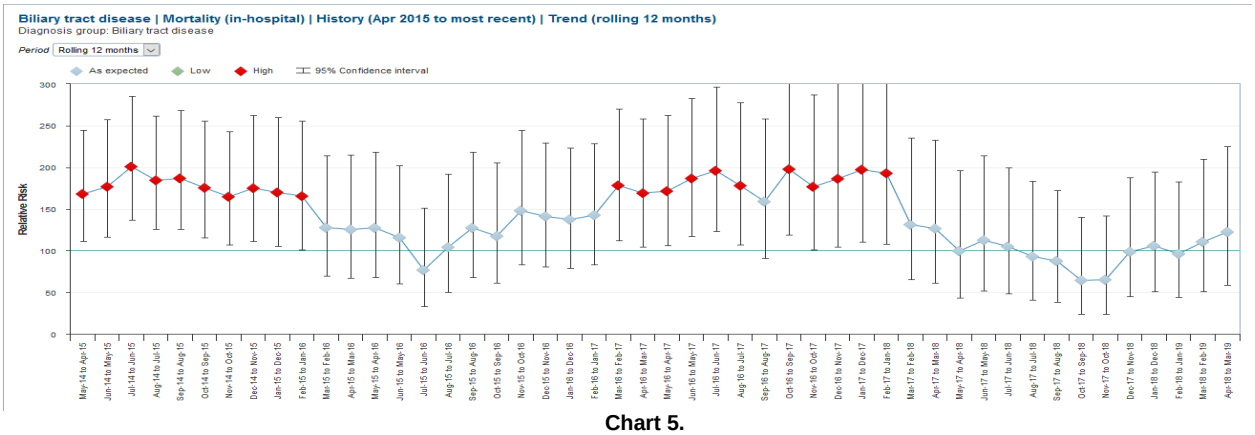

Chart 5.

5. Medical Examiner Role

5.1 There remains a requirement for all acute trusts to implement a Medical Examiner role by April 2019 with the statutory requirement due to go live in 2020.
5.2 Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) met this requirement with an interim solution, which allowed a thorough testing of the service to support a business case for the additional resource required.
5.3 The National Medical Examiner – Dr Alan Fletcher has been appointed and will provide advice, support and guidance over the coming months.
5.4 We are pleased to announce the Regional Medical Examiner – Dr Ben Lobo (SFHFT) has been appointed and will take up his post in early autumn. Dr Lobo has been instrumental in developing the Medical Examiner role across the Trust, building effective relationships with internal and external colleagues, in particular the Coroner.
5.5 The Trust appointed Dr Remy Bahl as the SFHFT Medical Examiner on Thursday 11 July. Dr Bahl is able to bring significant experience to the Trust and the required element of independence needed to provide the impartiality the role necessitates. Dr Bahl is looking forward to taking up his post at some point mid-August.

6. Mortality Dashboard Quarter One 2019/20

6.1 The Mortality Dashboard (Appendix One) indicates that the overall performance for the quarter against the 90% review of all deaths standard is 82.10% at the time of writing this report.
6.2 The current year to date performance is 82.10% compared to the total performance rate of 87.02%% for 2018/19.
6.3 The standard for completing a review within six weeks of a death remains a significant challenge for some specialties, particularly those where high numbers of deaths occur.
6.4 It is worth noting that reviews continue to be undertaken following this period and thus quarter performance numbers are adjusted throughout the year.