Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors – Public Board

Subject:	Learning from Deaths – Annual Summary Report	**Date:** 31/05/18
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Approved By:	Dr Andy Haynes, Executive Medical Director	
Presented By:	Dr Andy Haynes, Executive Medical Director	

Purpose		
The purpose of this paper is to present the Board of Directors with the Annual Summary of the implementation of the Learning from Deaths Guidance, providing an overview on compliance against the 90% standard to review all deaths, the lessons learned and plans for 2018/19	**Approval**	
	Assurance	x
	Update	
	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

None

1. Executive Summary

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) had begun to make considerable improvements in the journey to fully understand and improve the care delivered to patients in their final days as far back as 2014/15. As a consequence we were early implementers of the National Learning from Deaths Guidance that came into effect in April 2017.

Throughout 2017/18 the Trust made considerable progress, particularly in the compliance with the electronic Mortality Review Tool (MRT), the adoption and application of the Royal College of Physician Structured Judgement Review Methodology (SJR) and the overall effectiveness of the Mortality Surveillance Group (MSG).

The Annual Summary Report seeks to bring together the progress to date, to highlight the key learning themes and outline the plans to further enhance the agenda through 2018/19.

1.1 The Board of Directors is asked to:

- Note the content of the Report
- Note the performance of 83.87% against the requirement to review 90% of all deaths
- Note the requirement to consider the role of the Medical Examiner due to be approved nationally in April 2019
- Note the intention to implement the ReSPECT Tool in conjunction with regional partner organisation

2. Sherwood Forest Hospitals NHS Foundation Trust Mortality

2.1 There have been a number of components to the success of the SFHFT Mortality story. The Trust had been working closely with Dr Foster for a number of years, however the real progress became evident in 2014/15 when this collaborative relationship began to fully understand our mortality position by getting underneath the data and responding to what it was telling us.

2.2 The first step was in recognising the actions required to not only improve our Hospital Standardised Mortality Ratio (HSMR) but also the changes needed to ensure the same level of care, access to diagnostics and senior input was available regardless of day of the week.

2.3 It was acknowledged internally and externally that through 2015 the position was likely to deteriorate whilst changes in practice, systems and processes were embedded. This was the case with the first sustainable improvements noted towards the end of 2015.

2.4 We have continued to build on the relationship with Dr Foster with a much more engaged and proactive approach to the monthly report presented through the Mortality Surveillance Group (MSG). An example being the receipt of a Mortality Outlier Alert in October 2017 from the Dr Foster Unit, Imperial College, London for Acute and Unspecified Renal Failure (AKI) where we were immediately able to demonstrate that we had already recognised this issue, reviewed all the patients included within the alert and concluded that these were a group of frail elderly patients who had died with AKI as part of their complex medical condition rather than from it.

2.5 The Trust has consistently performed within the expected HSMR range since April 2016 despite increased crude mortality in the winters of 2017 and 2018.

3. Mortality Surveillance Group

3.1 The Mortality Surveillance Group is a well-established sub-group of the Patient Safety Quality Group (PSQG). Chaired by the Medical Director it has regular attendance from all Divisions, the Trust Clinical Lead for Mortality, and representatives from Governance, Legal Services, Clinical Coding, Informatics, Patient Experience, Safeguarding (including Learning Disabilities where appropriate) and Dr Foster.

3.2 MSG meets monthly receiving Divisional Exception Reports, the Dr Foster HSMR Report and where relevant considers cases where an Avoidability Assessment has been completed as part of the SJR process to identify any probable avoidable factors.

3.3 MSG holds each Division to account for compliance with the MRT and SJR methodology to support compliance with the requirement to review in excess of 90% of all deaths each year. SFHFT have performed well against this standard through 2017/18 acknowledging that to achieve >90% has been quite challenging for those specialties that experience large numbers of deaths

(i.e. Geriatrics and Respiratory). Additional support has been given to ensure these teams are in a position to maximise their reviews and optimise their learning opportunities.

3.4 As reported to the Board in April the achievement of the 90% standard was further challenged through Quarter Four due to the significant operational pressures during that period.

4. Mortality Review

4.1 The Royal College of Physician's Structured Judgement Review Methodology (SJR) is the established review method across the organisation. An action on the 2015 Quality Improvement Programme (QIP) had been to introduce a method of capturing patient level mortality data. This we achieved with the implementation of the MRT, however the adoption of the SJR has taken this action further and we now have a comprehensive, standardised methodology that is well understood across the Trust and facilitates the multidisciplinary and (where necessary) multispecialty review of care delivery and learning.

4.2 Clinical teams continue to be trained and supported with the Trust Mortality Lead providing team and/or 121 tuition where required. We approached the training requirements on a 'train the trainer' basis to spread the knowledge base and will continue to support as wide a knowledge base as possible with a range of clinical staff groups gaining competency.

4.3 As part of the 2018 Care Quality Commission (CQC) Assessment the Mortality Surveillance Group and the Mortality Review Process and subsequent learning themes was reviewed both during the Core Service Assessment and the Well-led element with positive feedback received from the CQC teams in attendance.

5. Medical Examiner Role

5.1 Following the murders of over 200 patients by Dr Harold Shipman provision has been made in the Coroners and Justice Act (2009) for all deaths in England and Wales not investigated by a Coroner to be scrutinised by an independent 'Medical Examiner'.

5.2 These reforms have not yet been fully implemented but pilot sites across the country have now tested and developed the system proposed in the legislation with an expectation that the role of the Medical Examiner will be clarified by April 2019. The pilot has found:

- The accuracy of death certification improves
- Referrals to the Coroner are more consistent and appropriate
- Rejection of the medical certificate of the cause of death (MCCD) by the Registrar is eliminated
- Input from relatives is assured

5.3 The aims of the reforms identified above were met with the cost per death scrutinised thought to be less than the current cremation form fee. It is expected this fee will be abolished once medical examiners are in post.

5.4 Throughout the pilot sites bereaved relatives were particularly pleased to have their opinions requested and to be offered an authoritative and independent explanation of the cause of death. In addition, independent scrutiny of medical records, supplemented by discussions with the bereaved, has proved to be a consistent source of high-quality information about the quality of care, irrespective of the nature of the problem and irrespective of the type of organisation involved.

5.5 Medical Examiners will be senior doctors, specifically trained for this role, who will question the cause of death proposed by the treating doctor on the basis of proportional scrutiny of the medical records, an interview with the next of kin and an external examination of the deceased. The

agreement of the Medical Examiner will be necessary before the death can be registered, unless the case has been accepted by the coroner.

5.6 The implications of the Medical Examiner role at SFHFT has been presented to MSG and PSQG. Dr Ben Lobo will be responsible for providing updates as and when further clarity is available.

6. Structured Judgement Review (SJR)

6.1 In line with national guidance the Trust has agreed those cases where, regardless of cause of death or care delivered, a Structured Judgement Review of the case must be completed. It is recognised that due to the demographics of our patients the Trust refers a higher than average number of cases for consideration by the coroner. For those cases that have been accepted by the coroner during this year the Trust has received positive feedback stating the usefulness of the SJR in supporting the coronial process.

6.2 As the Mortality Review system has matured across specialties, teams are becoming more competent at identifying those cases where a more in-depth review is required. This has led to some complex, but extremely productive multidisciplinary and multispecialty interactions and enhanced the opportunities for teams to learn together.

6.3 Although the numbers are relatively small there has been a focus on those deaths of a patient with a diagnosed Learning Disability. The NHSI *'National Guidance on Learning from Deaths' (2017)* and the review by the CQC – *'Learning, candour and accountability' (2016)* both acknowledge that a person with a known learning disability dies much sooner and as such have introduced a stand alone process for externally reviewing all deaths for this vulnerable group of patients.

6.4 The 'Learning Disabilities Mortality Review' Programme (LeDer), commissioned by the Healthcare Quality Improvement Partnership (HQUIP) receives notification of all deaths of people with a learning disability. The programme supports the independent review of each death for persons aged 4-74 years.

6.5 The Trust carried out a mortality review using the SJR methodology for 14 learning disability cases and concluded that the Trust mechanism was robust and infact elicited more detail and learning opportunities with regards to care delivered than LeDer. We will continue to apply both processes.

7. End of Life

7.1 Throughout 2017/18 the Learning from Deaths quarterly reports to the Board of Directors has outlined the common themes identified as a consequence of a SJR. Most commonly indicated is the confidence, ability and timeliness that clinical staff to have a documented discussion with a patient, their families and carers around care planning, in particular planning when a patient is nearing the end of their life.

7.2 A significant proportion of SJR/Avoidability Assessment presentations to MSG identify a failure to apply appropriate, well-documented, well-explained and timely ceilings of care. This often leads to distress and confusion for the patient and relatives and on occasions inappropriate treatment or intervention. The application of ceilings of care has also been identified in serious incident investigations and complaints and concerns raised by families. Supporting patients and families to best manage the last days of life has been included within the Quality Priorities for 2018/21.

7.3 The Trust is working collaboratively with external partner organisations to implement the ReSPECT Tool. The ReSPECT process creates individualised recommendations for a person's

clinical care in emergency situations, including cardiorespiratory arrest, in which they are not able to decide for themselves or communicate their wishes. The process involves a conversation which:

- Develops a shared understanding of a person's condition, circumstances and future outlook
- Explores that person's preferences for their care and realistic treatment in the event of a future emergency
- Makes and records agreed clinical recommendations for their care and treatment in a future emergency in which they cannot make or express decisions at the time

7.4 ReSPECT aims to encourage patient and family involvement in decision-making, to consider recommendations about CPR in the context of broader plans for emergency care and treatment, and to record the resulting recommendations on a form that would be used and recognised by health professionals across the UK.

7.5 Following presentation of the implications of implementing ReSPECT to the PSQG agreement was reached that the implementation of the tool will be overseen by the Deteriorating Patient Group (DPG) as one of the 3 key work programmes in 2018/19 reporting progress monthly to PSQG.

8. Plans for 2018/19

8.1 As reported through the quarterly Learning from Deaths Board Reports a key focus for the coming year will be the further involvement of bereaved families. The National Learning from Deaths Guidance attempted to set out the expectations, however further specific guidance has been delayed as it is widely recognised that this is an incredibly challenging issue.

8.2 The Trust already has a system in place to provide an opportunity for families to speak to the relevant clinical team or doctor to understand what happened to their loved one and to raise any questions or concerns at the point of death or death registration. In addition, the Bereavement Centre send a questionnaire approximately six weeks post death, again giving a further opportunity for any questions or concerns to be answered.

8.3 The Bereavement Booklet, given to relatives at the point of death certification has been recently amended to include a statement explaining - that in order to learn from and continuously improve the care given to patients we review all deaths and as a consequence may find something we would like to talk to them about.

8.4 In addition to the above – the implementation of the ReSPECT Tool and the introduction of a 'medical examiner' role will further facilitate the way in which we communicate with and support bereaved families at such a difficult time. Campaign One of the Quality Strategy 2018/21 also focuses on how we can involve and co-design our services with patients and the public and this will include families who have experienced the loss of a relative in our hospitals.

8.5 Plans are in place to enhance the mortality review process across our partner organisations. Many of our patients have shared care episodes with Nottingham University Hospitals NHS Trust (NUH) and Nottinghamshire Healthcare NHS Foundation Trust (Notts Health) and in order to share learning and have shared ownership of patients, quarterly joint meetings are being scheduled between the Medical Directors and Mortality Leads of all three organisations.

9. Mortality Dashboard – Annual Summary 2017/18

9.1 In line with the requirements of NHSI and the CQC the Trust has presented a Learning from Deaths Report to the Board of Directors for all four quarters of 2017/18. Due to the availability of data and the challenges faced by clinical teams through the unprecedented pressures in Q4 and their ability to review a significantly higher than average number of deaths within the reporting period the final performance was not reflected in the Q4 Report. Appendix A now summarises the full 2017/18 end of year position.

9.2 The Dashboard indicates that the overall performance against the 90% review of all deaths standard is 83.87%

9.3 The Dashboard also indicates the number of deaths where, through the SJR methodology the death was believed to be avoidable or avoidable factors were identified. This is reported as 21 cases or 1.35% of all deaths and 1.61% of those deaths reviewed.

9.4 The Dashboard also indicates the total number of deaths accepted by the Coroner, the number involving a patient with a known learning disability or mental health need, the number subject to a serious investigation both as reported on STEIS or subject to internal investigation and the number of cases that proceeded to Inquest.

9.5 A summary of the learning themes from the 2017/18 review of deaths is indicated at Appendix 2.

10. Summary

10.1 The Trust recognises that learning from the care given to patients in their final days is about understanding how that care met their needs and those of their relatives and carers. It is about understanding that the right decisions were made in conjunction with them and that they were fully informed at all times.

10.2 We have made good progress throughout the year and have a firm basis on which to improve even further. The learning themes from our mortality reviews have helped shape some of the Quality Strategy and improvement requirements for the coming year and it is hoped that we continue to optimise our learning opportunities, sharing good practice across the organisation and wider health system.