Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors

Subject:	Learning from Deaths Report Q4	**Date: 26/04/18**	
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			
		Approval	
		Assurance	
		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 service delivery 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

The Trust treats hundreds of patients each year. Most patients receive treatment, get better and are able to return home or go to other care settings. Sadly and inevitably, some patients will die whilst an inpatient in one of our hospitals (approximately 1500 or 3.5% of all admissions). While most deaths are unavoidable and would be considered to be 'expected', there will be cases where sub-optimal care in hospital may have contributed to the death. The Trust continues to take every opportunity to learn lessons to improve the quality of care for other patients and families.

As reported to the Board of Directors previously the Trust Mortality Surveillance Group (MSG) is well embedded within the governance framework. MSG is committed to driving improvements in treatment and care for all patients and to actively look for variations in standards and clinical outcomes.

1.1 The Board of Directors is asked:

- To note the content of the Report
- To note the current Q4 compliance of 67.92% and year end position to date of 77.04% taking account of the time lag in completing mortality reviews due to operational pressures and increased number of deaths in some specialties over the winter period
- To note that the Learning from Deaths Annual Summary Report will be provide to the Board of Directors at the May meeting.

2. Mortality Review

2.1 Achievement of the >90% review of all deaths standard continued to prove challenging through Q4 due to the ongoing operational pressures experienced across the Trust. Some specialties have seen a significant increase in the number of deaths during the winter period – i.e. Geriatrics and Respiratory in particular.

2.2 There is a programme of ongoing education and support provided to clinical teams and individual clinicians to increase awareness and the necessary competency to undertake a meaningful mortality review.

2.3 As part of this education programme an audit of deaths where there was no evidence that a mortality review had taken place (i.e. no record of the death on the electronic mortality tool) has been conducted to identify where there may be missed learning opportunities and ensure those cases that trigger the requirement for a second stage (SJR) review are identified to the relevant clinical team.

2.4 The audit identified a small number of specialties where compliance with the mortality review requirement was less than satisfactory. Teams, both with very small numbers of deaths and very large numbers of deaths were identified with targeted actions taken by the relevant Division to provide the necessary support to improve performance. Examples of good practice has been shared as encouragement and further development.

2.5 The audit also identified deficiencies in some cases in the accurate recording of 'cause of death' in the death certification process and further training and education for junior medical staff in this area will be a focus in 2018/19. This will be specifically around the use of Sepsis or Acute Kidney Injury (AKI) as a causal factor on the death certificate.

3. Learning Disability

3.1 The Trust is committed to pursue and learn from all cases where a patient has died whilst an inpatient in any of our hospitals. In addition, there is a national requirement to conduct thorough mortality reviews through the nationally mandated system – LeDer for patients with a diagnosis of a learning disability or intellectual development disability. LeDer is the national multi agency system of review for learning disability now being used in Nottinghamshire.

3.2 In order to identify good practice or if relevant sub-optimal care for this vulnerable group of patients a full Structured Judgement Review (SJR) will be carried out in addition to the LeDer process. There are immediate benefits to clinical teams of instigating both review processes as the SJR methodology offers early learning opportunities that may be delayed with the LeDer process.

3.3 Further work is underway with clinical staff to ensure adequate, proactive and contemporaneous review processes for learning disability patients have been completed. In particular this is to test the degree of cause or contributory factors relating to epilepsy and aspiration pneumonia and avoidable harm/death.

3.4 The work to date has concluded that better identification of learning disability patients must

be achieved during admission, this is specifically vital for those patients not formally on a Learning Disability Register and therefore not automatically alerted to clinical staff.

3.5 Discussion with the Learning Disability Specialist Nurse, Specialist Epilepsy and Intellectual Disability Service will take place regarding the promotion of and active sharing relating to Advance Care Plans and support treatment and necessary escalation plans.

4. Mortality systems: Performance, Data Quality and Information Management

4.1 To further enhance our mortality review processes it is essential that they are supported by strong quality governance, including confidence in performance, data quality and information management.

4.2 Key changes that have been instigated to date relate to improvements in accurate consultant coding, accurate clinical coding, initiating independent audit and assurance of reviews, provision of information relating to specialist palliative care activity.

4.3 Consultant Coding – attributing the correct consultant code to a patient is vital to ensure accountability of the care a patient receives prior to their death and to provide opportunities for learning and improvement. It is important to know which consultant and clinical team will be responsible for the review of a death in order that good practice and areas for improvement are identified, actioned and shared. There has been a great improvement in the accuracy of consultant coding meaning that reviews can be carried out in a much more time efficient manner. The Bereavement Centre work closely with the Informatics Teams and we have seen a significant reduction in the number of unallocated patients.

4.4 Clinical Coding – clinical coding is a professional service that is subject to specific data quality systems standards. 17 randomly selected patient deaths from October 2017 were audited to specifically look at the quality and accuracy of coding by the Trust Lead for Mortality reporting the findings to the Mortality Surveillance Group. In general high standards of coding were observed as was accurate consultant coding. A key learning point noted from this audit was that in approximately 25% of cases the fact that the patient was nearing the end of their life could have been better recognised, which, whilst not changing the outcome could have better prepared the families. As a consequence of the audit clinical coders will continue to learn from and recognise new systems of documentation that indicate general or specialist palliative care activity, in addition to strengthening their working relationships with the Bereavement Centre to improve coding accuracy.

5. Mortality Review dashboard Q4

5.1 The Trust has provided a ‘Learning from Deaths’ Report to the Board of Directors each quarter through 2017/18. This report meets the criteria as set out by NHS Improvement (NHSI) and the Care Quality Commission (CQC).

5.2 Appendix 1 indicates the performance for Q4 and the annual position to date. The Board of Directors should note that due to the inevitable time lag in completing a thorough mortality review and the increased number of deaths during the winter period the attached dashboard does not give the final year end position.

5.3 A Learning from Death Annual Summary Report will be provided to the Board of Directors at the May meeting where the final position will be provided. The Trust remains on track to deliver the required >90% of all deaths reviewed standard.