Board of Directors

Subject:	'Learning from Deaths' – Mortality Report	**Date:** 25/01/18
Prepared By:	Elaine Jeffers – Deputy Director of Governance & Quality Improvement	
Approved By:	Dr Andy Haynes, Medical Director	
Presented By:	Dr Andy Haynes, Medical Director	

Purpose		
The purpose of this paper is to provide the Board of Directors with an overview of the current compliance with the 90% standard of reviewing all deaths as required through the National Learning from Deaths Guidance and to highlight the learning identified from Mortality Reviews for Quarter 3.	**Decision**	
	Approval	
	Assurance	X

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	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

This Report was presented to the Deteriorating Patient Group on 18/01/18

1. Executive Summary:

The Trust is fully engaged with the requirement of the 'Learning from Deaths' Guidance (2017) and remains on track to deliver the >90% review of ***all*** deaths by 31/03/18.

It is essential that, in order to ***'make mortality more meaningful'*** and maximise the learning opportunities as set out by the National Quality Board and the Care Quality Commission (CQC) our developing systems are supported by strong quality governance, including confidence in our performance, data quality and information management.

In addition to the robust reporting systems required by the Trust Mortality Surveillance Group (MSG) there has been an intense focus on our information services and data quality through Quarter 3 (Q3).

As a consequence of this work we have implemented a programme of targeted audits of compliance with both the completion of the Mortality Review Tool (MRT) and the Structured Judgement Review Methodology (SJR), in addition to further supporting the training of individual mortality leads and clinical teams.

This report describes the activities that have taken place over Q3, the current performance to date, including the themes and learning from specialty mortality reviews.

1.1 The Board of Directors is asked:

- To note the content of this report
- To note the current Q3 compliance rate of ** in relation to the requirement to achieve the standard of reviewing 90% of all deaths by 31st March 2018
- To note the excellent performance in October 2017
- To note the learning from Mortality Reviews for Q3

2. Mortality Review

2.1 Q3 has been particularly challenging with regards to the overall compliance at specialty level with the MRT, particularly for December. The Board of Directors should note that a final compliance figure for November and December 2017 has yet to be confirmed and will be included within the Q4 section of the Annual Learning from Deaths Report due to be presented to Board in May 2018. The Board of Directors should also note the excellent performance across the Trust in achieving the >90% standard for the month of October.

2.2 December has experienced a higher than monthly average of reported deaths and due to the significant operational pressures that have continued into January mortality meetings have not been held in all specialties over this period, thus there is currently a backlog in completing the initial reviews and MRT.

2.3 The Bereavement Centre has been extremely supportive in assisting doctors to commence the MRT whilst completing the Death Certificate. This enables clinical teams to have early sight where it is felt there may be cause for concern or an interest taken by the Coroner in a specific case.

2.4 The Trust Lead for Mortality – Dr Ben Lobo continues to provide team and 121 advice, support and guidance to ensure the local review processes are as effective as possible and that the discussions focus on the learning and any required changes in practice.

3. Serious Incident Mortality Review

3.1 The number of Serious Incidents involving the death of a patient in Q3 – both internal investigations and those that meet the criteria for reporting on STEIS are included within the Mortality Dashboard. (Appendix 1)

3.2 The themes from the Incident Investigations and subsequent action plans are correlated with themes that are derived from the mortality reviews so that the scale of the issue can be quantified and prioritised.

4. Mortality Dashboard

4.1 The Trust is required to collect specific data to be included within the quarterly report to the Board of Directors. The data includes:

- Total number of deaths – to include the number receiving the initial review via the MRT
- Number of deaths scoring <3 on the Avoidability Assessment following a Structured Judgement Review
- Number of Deaths investigated under the Trust Serious Incident Framework
- Themes and issues identified through review and investigation
- Changes that have been made as a consequence of this process

4.2 As reported to the Board of Directors in October there is a robust monitoring framework in place to ensure we remain on track to deliver the compliance standard within the required timeframe.

5. Learning from other organisations

5.1 Through Q3 Dr Andy Haynes, Executive Medical Director and Elaine Jeffers, Deputy Director of Governance & Quality Improvement were invited to tell the **'*Sherwood Story of Mortality Improvement*'** to a number of different fora. The Presentation used to support our story is attached at Appendix 3:

- **NHSI** invitation to speak at a West Midlands Learning Event (Birmingham) – October 2017
- **Dr Foster** invitation to speak at a Dr Foster Learning Event (London) – October 2017
- **NHSI** invitation to provide a case study for inclusion in the NHSI *'Learning from Deaths: Case Studies from Trusts*' Publication – December 2017
- **NHSI** invitation to attend a 'Learning from Deaths, one year on' Event (London – December 2017

5.2 It was clear when speaking with colleagues across the country at the above events that the Trust is one of a small number of acute healthcare providers who have fully adopted the Learning from Deaths Guidance, in its entirety. Many other Trusts have opted to introduce a variation on the review process.

5.3 The challenge to review all deaths and conduct multidisciplinary, multispecialty reviews on the care delivered to patients in the days leading up to their death should not be underestimated. It is a resource-intense operation. However we still firmly believe that it affords us the best possible opportunity to understand when we provide excellent care and when we must make improvements or changes to practice. Alternative options include:

5.4 The 'Medical Examiner Role' - whereby one individual or a very small team take sole responsibility for conducting the mortality reviews. This approach has been debated nationally, without reaching overall consensus as to whether this is a model that should be more widely adopted. Some Trusts have adopted this model and whilst it achieves a high level of consistency and expertise, it limits the opportunities for the wider clinical team to contribute to the discussion and decision-making.

5.5 Selecting a small, defined cohort of patients – i.e. patients with a specific cause of death as the criteria for a full Structured Judgement Mortality Review. Selecting only a small sample of patients again limits the involvement of wider clinical teams and opportunities for learning.

5.6 The Trust has agreed specific cases where a Structured Judgement Review is mandated over and above those where an avoidability score of <3 has been determined. All these cases are required to present to the Mortality Surveillance Group.

These cases include:

- All cases accepted by the Coroner
- All cases that will proceed to an Inquest
- Cases that are subject to a Serious Incident Investigation that meets the criteria for reporting to STEIS
- All complex cases that are subject to an Internal Investigation with multispecialty involvement
- All cases involving a patient with a Learning Disability

6. Bereaved families

6.1 The Learning from Deaths, one year on Event in London in December 2017 focussed on how organisations would start to work more closely with bereaved families, not just to address concerns they may have raised following the death of their loved one but to really involve them in the improvements to care and the re-design of care pathways and service delivery where necessary.

6.2 Guidance on how to engage and involve bereaved families is to be circulated by NHSI sometime early in 2018.

7. Learning, themes and improvements

7.1 Learning from deaths should not be seen in isolation of other learning opportunities but should be an integral part of service and the wider Trust Governance Framework. Key issues identified as part of the Mortality Review process are considered alongside those themes and trends from other intelligence sources to aid the prioritisation of immediate and future improvement requirements.

7.2 The Trust continues to promote the organisational benefits of as broad a learning experience as possible. This can only be achieved by ensuring that clinical teams implement a robust specialty-level Governance Framework with Mortality Review firmly embedded at its core.

7.3 Themes identified from the mortality review process to date are being considered for inclusion within the Advancing Quality Programme (AQP) for 2018/19.

7.4 The themes identified through Q3 are indicated at Appendix 2.

8. Mortality Surveillance Group Q3 Actions

8.1 **Performance** - A paper was highlighted to the January Mortality Surveillance Group (MSG) indicating which clinical teams were most challenged with regards to mortality review compliance. An audit was undertaken on a specialty that has a very high number of deaths with a view to understanding their current position and agree remedial actions to address the backlog of reviews. Recovery will be monitored through MSG.

8.2 **Data quality, information management and clinical coding improvement in relation to mortality reviews** -the Bereavement Centre, Clinical Coding and the Trust Informatics team are now working very closely to ensure that the correct Consultant is notified in as real time as possible about the death of a patient under their care, that the cause of death is accurately captured by the coding team and that the informatics team record the most up to date compliance data to populate the Mortality Dashboard.

8.3 **Quality Improvement and Mortality systems: Sepsis and Serious Infection** – A new clinical audit was introduced looking at the clinical engagement, reporting compliance and learning from deaths where sepsis and serious infections were considered causal factors. The aim of the audit is to drive improvements in sepsis and infection related outcomes by ensuring there is proactive learning and improvements in overall clinical team practice. The objectives of the audit are:

- To correlate internal independent data with data provided by the Trust Informatics team to determine the accuracy of the current sepsis self-reporting system
- To understand the level of assurance the MRT provides as evidence that teams have reviewed, reported and are learning from patients who have died where sepsis and serious infection were a cause (1) on the Medical Certificate.
- To identify what interventions might be needed to improve clinical team review, reporting and learning.

9. Conclusion

9.1 The Trust continues to make good progress; however the significant operational pressures experienced through December and January have reduced the ability of clinical teams to hold meaningful, well-attended local governance meetings, including Mortality. This has had a negative impact on our performance compliance against the requirement to review >90% of deaths but it is expected that our recovery plans will still deliver the standard by the end of March 2018.

Appendix 1

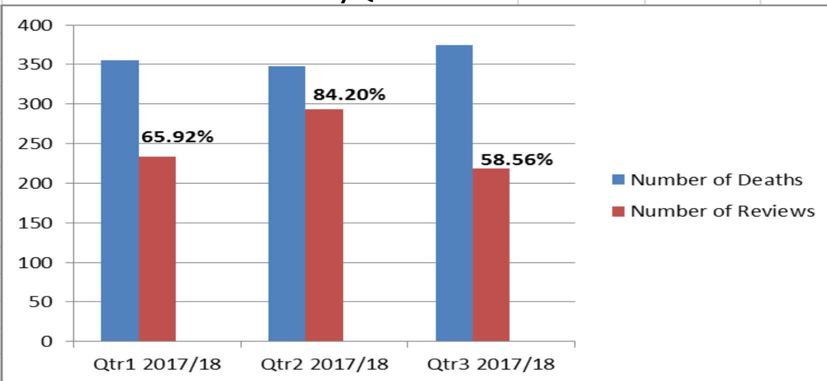
Reporting Learning from Deaths to Board

Sherwood Forest Hospitals NHS Foundation Trust

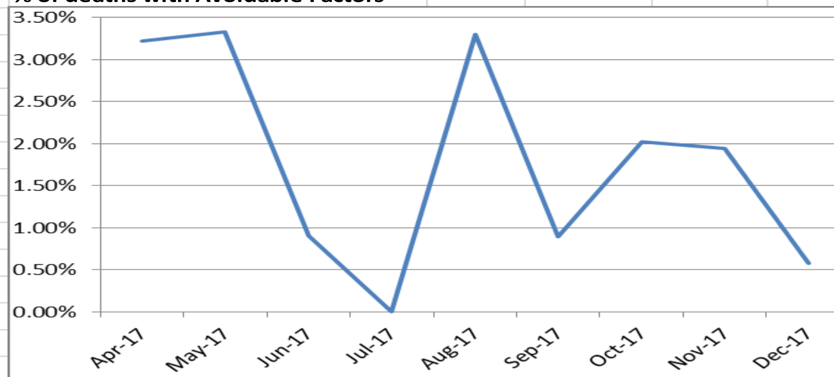
Learning from Deaths Dashboard Quarter 3 2017/18

Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Qtr 1	355	234	65.92%	9
Qtr 2	348	293	84.20%	5
Oct-17	99	92	92.93%	2
Nov-17	103	69	66.99%	2
Dec-17	173	58	33.53%	1
Year to Date	1078	746	69.20%	19

Number of Deaths & Reviews by Quarter



% of deaths with Avoidable Factors



Deaths in groups under special focus Qtr3

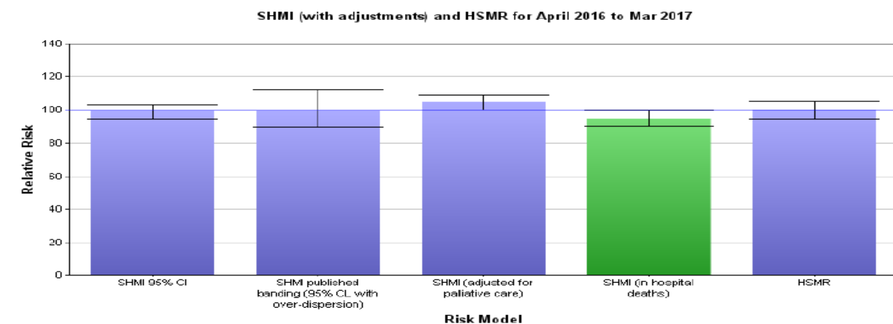
Group	Total
Learning Disability / Mental Health Patients	1
Deaths accepted by the coroner	59
Coroner's Inquest	2
STEIS SI	2
Internal Investigations	3

General Learning/Themes identified

Ceilings of Care	Ceilings of Care and early discussions with the patient and family about what to expect and how best to manage the last few weeks and/or days of life – this issue will be addressed through the implementation of the ResPECT Tool.
Responding to the Deteriorating Patient	There appears to be some disparity in understanding of appropriate escalation when a patient deteriorates. This has been compounded following the implementation of NerveCentre. A review of the Observation and Escalation Policy has been undertaken and additional training put in place. Monitored through the Deteeriorating Patient Group

Summary Hospital Mortality Index (SHMI)

SHMI (with adjustments) and HSMR for April 2016 to Mar 2017



Appendix 2

Learning themes identified from Trust Mortality Review – Quarter 2 2017/18

<table>
<tr><th>Specialty</th><th>Issue</th><th>Learning identified</th></tr>
<tr><td>Orthopaedics</td><td>Complex Orthopaedic Case</td><td>Very complex case involving a number of other specialties. There were potentially missed opportunities for putting appropriate ceilings of care in place earlier. Also the responsive setting of parameters to ensure appropriate and timely escalation of deterioration was a key feature of the learning</td></tr>
<tr><td>Orthopaedics/Critical Care</td><td>Complex Orthopaedic Case – Learning Disability</td><td>Complex patient with Down's Syndrome from a Care Home setting. Underwent complex and prolonged surgery for long bone fractures. Learning in relation to complexity of major trauma and complications of Long Bone Fracture surgery and associated blood loss. Additional learning points relating to application of the Sepsis Six Bundle and the Observation and Escalation Policy. Documentation to be improved.</td></tr>
<tr><td>Medicine</td><td>Sepsis</td><td>Patient admitted with Left Leg Cellulitis ?Sepsis. Unlikely to have responded to antibiotics and aggressive circulatory support. Acute septic episode was likely to have recurred and prolonged patient suffering. Good instigation of End of Life Care.</td></tr>
<tr><td>Acute Medicine</td><td>Recognise and Rescue – responding to the Deteriorating Patient</td><td>Prompt and appropriate investigations to be actioned at all times
Should not rely solely on Early Warning Scores (EWS) but use clinical judgement and assessment
Early discussions with the patient and family about prognosis, specifically in sick and deteriorating patients</td></tr>
<tr><td colspan="3">Q3 continues to report the 2 key areas where there remain considerable learning opportunities:

• Ceilings of Care and early discussions with the patient and family about what to expect and how best to manage the last few weeks and/or days of life – this issue will be addressed through the implementation of the ResPECT Tool. The End of Life Medical Lead and the Lead Nurse for EoL are currently undertaking a raising awareness campaign across the Trust to improve the knowledge and understanding for staff when looking after patients in their last few days.
• Early and responsive recognition of deterioration – there appears to be some disparity in understanding of appropriate escalation when a patient deteriorates. This has been compounded following the implementation of NerveCentre. A review of the Observation and Escalation Policy has been undertaken. The Trust Deteriorating Patient Group are accountable for ensuring all elements that support the sickest patients are effective and as such monitoring the response when a patient deteriorates is identified within the Terms of Reference.</td></tr>
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