Board of Directors

Subject:	Learning from Deaths – Quarter One Report	Date: 25/10/18	
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			
The purpose of this paper is to provide the Board of Directors with the Quarter One 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 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
Deteriorating Patient Group 18/10/18

1. Executive Summary

The Trust Mortality Surveillance Group (MSG) continues to oversee the wider mortality agenda, optimising the learning and improvement opportunities as the starting point for quality improvement work.

The MSG work programme focuses on the following key areas:
- Mortality Intelligence
- Mortality Review
- Implementation of the ReSPECT Tool
- National Initiatives/Guidance – Medical Examiner Role

The Board of Directors is asked to note:
- The developing nature of the Mortality Work Programme for 2018/19
- The performance against the Learning from Deaths Guidance (Appendix One)

1. Mortality Intelligence

1.1 The monthly report received from Dr Foster provides an overview of the Hospital Standardised Mortality Ratio (HSMR) performance demonstrating that the Trust remains within the expected range and has done so since April 2016. Figure 1 indicates the position of Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) by the blue dotted line.
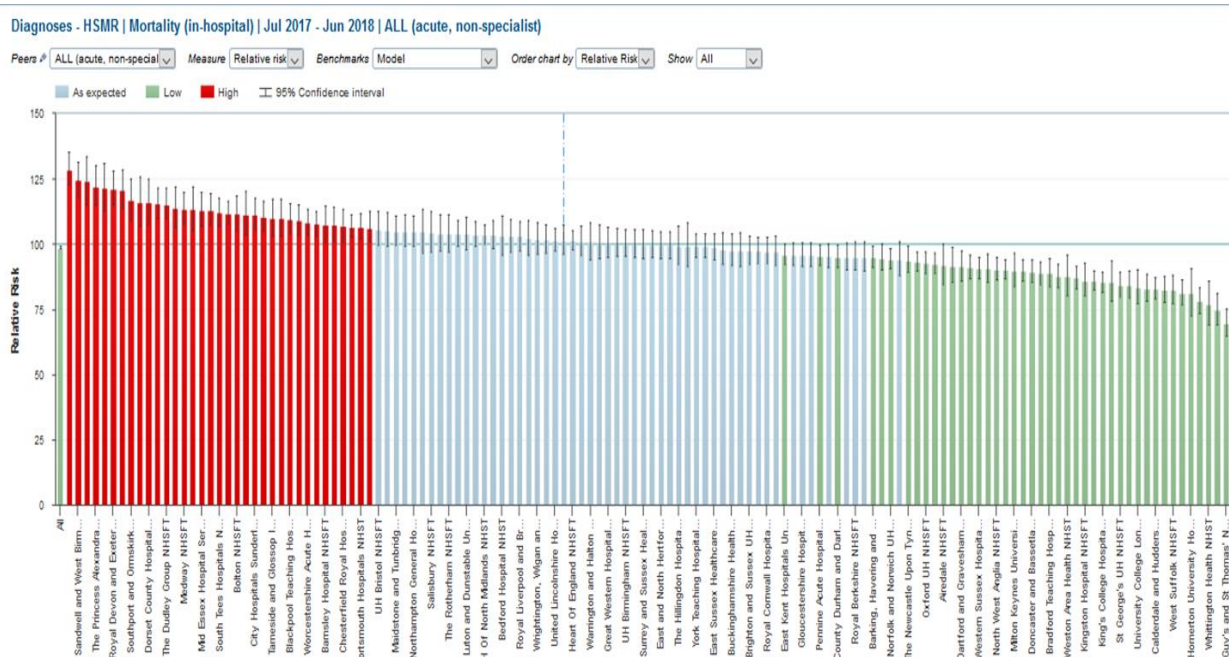

Figure 1.

1.2 The Mortality Surveillance Group (MSG) meeting of Tuesday 16 October 2018 agreed that as part of the Trust *Journey to Outstanding* we needed to further interrogate the data provided by Dr Foster to drive real improvement either in key diagnosis groups or specific clinical pathways.

1.3 MSG was challenged to think differently about which areas in particular should be the initial focus of attention, being mindful that choices need to be intelligence driven and have an overall impact on improving mortality performance as a whole.

1.4 Data highlighting a sample of clinical pathways illustrating comparative data with all non-specialist acute providers indicated the SFHFT current performance against the national average, bottom 25% percentile and top 25% percentile. MSG agreed that this was a good starting point for further discussion.

1.5 MSG recognises there are many intelligence sources available across the organisation to support improvements, with mortality intelligence being one of the key drivers.

1.6 MSG also recognises the importance for clinical teams in having proactive, meaningful data to support decision-making and as such having a greater understanding of, and access to timely intelligence will be of great value.

1.7 In addition to the external data clinical teams need to use internal information sources to support their decision-making. For example the outcomes from incident investigations, complaints and feedback from patients and families can be used to triangulate intelligence, focussing on specific areas for change.

1.8 A small task and finish group will be convened in October to propose the diagnosis group/pathways for improvement to be agreed by MSG at the November meeting.

2. Mortality Outlier Alert – Biliary Tract Disease

2.1 The Trust received a Mortality Outlier Alert from the Dr Foster Unit, Imperial College, London on 23 February 2018 indicating that on at least one occasion, in the three months leading up to November 2017, risk adjusted mortality of double the expected rate was recorded for Biliary Tract Disease.

2.2 Biliary Tract Disease, as one of the basket of 56 diagnosis groups regularly reviewed by MSG, had already been identified as an outlier in summer 2017.

2.3 A deep dive into a cohort of patients who had Biliary Tract Disease as their primary diagnosis at the point of death in 2017 had been undertaken prior to the alert being received by the Trust.

2.4 The deep dive presented to MSG concluded that there were no systemic failures that had triggered the alert. A clear theme indicating all patients within the cohort were frail and unable to undergo any form of aggressive intervention, such as, ERCP and were infact at the end of their life.

2.5 The deep dive did identify that although SFHFT remained within the expected control limits for this cohort of patients, we have a higher proportion of patients in the low risk sub groups compared to the national average.

2.6 Figure 2 demonstrates that although there are higher than average numbers of patients in the lower risk sub group there is a corresponding reduction in the number of patients within the higher risk sub groups. This impacts negatively on the relative risk v expected ratio.
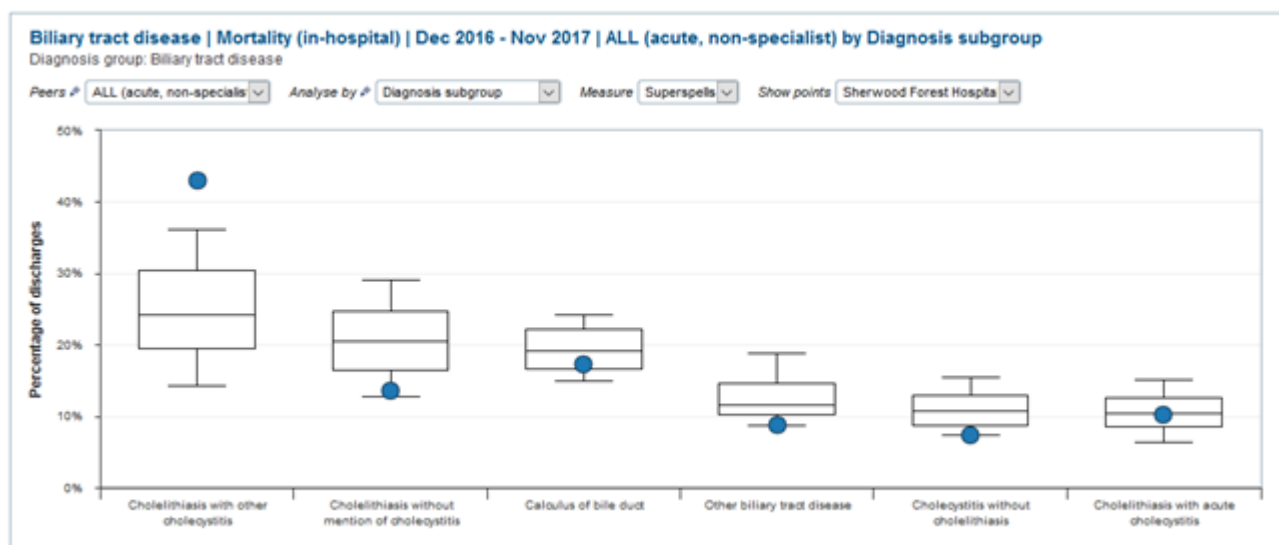

Biliary tract disease | Mortality (in-hospital) | Dec 2016 - Nov 2017 | ALL (acute, non-specialist) by Diagnosis subgroup
Diagnosis group: Biliary tract disease

Figure 2.

2.7 The Trust provided a response to the Mortality Outlier Alert to the CQC in October. Mortality Outlier Alerts are monitored by CQC via the regular engagement meetings with the Trust.

2.8 The data presented to the October MSG meeting confirmed that the relative risk for this diagnosis group remains within the expected control limits.

2.9 Following the recent Acute and Unspecified Renal Failure (AKI) and Biliary Tract Disease Mortality Outlier Alerts the deep dive model has proved effective in truly understanding what the data is telling us and how we can use it to review the care given to a patient prior to death, identifying where we can do better in the future.

2.10 Both the AKI and Biliary Tract Outlier responses demonstrate the further work MSG plans to undertake with regards to identifying and improving those specific pathways where we are above the expected relative risk score.

3. Mortality Review

3.1 Support and guidance continues to be offered to clinical teams in relation to the appropriate use of the Trust Mortality Data Collection Tool (MRT), the Structured Judgement Review Tool (SJR) and the completion of an Avoidability Assessment where necessary.

3.2 A question was raised at the October MSG meeting as to the apparent reduction of mortality reviews where avoidable factors have been identified. Further investigation is underway to understand whether this is real or whether there is a time lag on reporting through to MSG.

3.3 MSG agreed to include any death that occurs within Theatre – either 'on the table' or within recovery on the mandatory list for presentation to MSG. This will be updated for the Quarter Three Report.

3.4 The Trust has been approached to participate in a pilot project being managed through the National Mortality Case Record Review process (NMCRR) looking at the benefits and development of joint mortality reviews with primary care colleagues. Further information will follow once the plans are clear.

3.5 The inaugural meeting between SFHFT, Nottingham University Hospitals NHS Trust (NUH) and Nottingham Healthcare Foundation Trust (Notts Health), led by the Medical Directors of each organisation has taken place, with a plan to hold quarterly meetings to share mortality information for those patients who have accessed care across the providers. In addition each provider will host a multi-provider Learning Event each year where clinical teams from all three organisations can come together to share experiences and learning.

4. ReSPECT Tool

4.1 The Trust has formally agreed to implement the ReSPECT Tool in conjunction with the wider health community as part of the Better Together programme. The implementation is being overseen by the Deteriorating Patient Group (DPG) and is a key component of the DPG Work Programme 2018/19.

4.2 ReSPECT is a joint conversation between the patient and their clinician, setting out recommendations for clinical care in the event of a future emergency in which the patient is unable to make or express their preferred choices.

4.3 The single most evident theme emanating from mortality reviews and the implementation of Learning from Deaths Guidance in 2017/18 was the ability and anxiety of clinical staff to engage with patients and families early in their journey to discuss their wishes when approaching the last weeks and days of life. The application of the ReSPECT Tool will support clinicians in getting this right.

4.4 The Trust ReSPECT Implementation group is now in place and has met in September and October. The group is chaired by the Trust Lead for End of Life, with the Chief Nurse as an integral member. Progress on implementation is through the Deteriorating Patient Group, reporting directly into Patient Safety Quality Group.

4.5 The initial focus of the group is to ensure adequate staff are trained and able to apply the principles of the ReSPECT Tool at the point of 'Go Live' scheduled for April 2019.

4.6 Derbyshire Teaching Hospitals NHS Foundation Trust and Chesterfield Royal NHS Foundation Trust implemented the ReSPECT Tool in summer 2018 and we are working closely with colleagues at both Trusts to understand what works well and how best to prepare.

5. National Guidance - Medical Examiner Role

5.1 A pilot has commenced to test the concept of the Medical Examiner Role within the Trust. Dr Ben Lobo, Trust Lead for End of Life and Mortality is fulfilling this role.

5.2 A random selection of deaths, identified by the Bereavement Centre are selected for scrutiny with immediate feedback and advice offered to the relevant clinical staff.

5.3 Initial feedback from those involved has been positive, particularly from those junior doctors completing the Medical Certificate on Cause of Death (MCCD) in better understanding and accurately recording the cause of death of their patient.

6. Mortality Dashboard Quarter Two 2018/19

6.1 The Mortality Dashboard (Appendix One) indicates that the overall quarter two performance against the 90% review of all deaths standard is 75.5% at the time of writing this report. The year to date performance is 80.12%, which is a significant improvement on the position at the end of quarter two in 2017/18.

6.2 The caveat of the performance is that specialties are completing reviews within two months of a death and as such there will always be a lag time between death and the completion of a review.

7. Summary

7.1 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.

7.2 Mortality remains a key action within the 2018/21 Quality Strategy.

7.3 Evidence was presented to the Quality Committee in September 2018 demonstrating that the mortality actions within the Advancing Quality Programme (AQP) were completed and embedded sustainably across the Trust. Quality Committee approved the completion of the actions at the September meeting.

7.4 The further work proposed through our mortality intelligence as described is section 1 will determine a new set of actions for inclusion within the AQP for 2018/19.