Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors

Subject:	Learning from Deaths – Quarter Three Report	**Date:** 31/01/19
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 Three 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

1. Executive Summary

The Trust Mortality Surveillance Group has now been established for three years in its current configuration. The Group is a key part of the wider Governance Framework reporting both o the Deteriorating Patient Group and Patient Safety Quality Group. This report will focus on work undertaken across the wider mortality agenda through quarter three and set out proposals for next steps through quarter four and 2019/20.

The Board of Directors is asked to note:

- The content of the report
- The developing nature of the Mortality Agenda for 2019/20
- The proposed reconfiguration of the Mortality Surveillance Group (Appendix One)
- The performance with the Mortality Review process (Appendix Two)

1. Work Programme for 2019/20

1.1 As set out in the Q2 Learning from Deaths Report to the October 2018 Board of Directors, enhancing the partnership working with Dr Foster, using the intelligence collated by our clinical teams to drive areas of focus, is a key element of our future plans.
1.2 At the Mortality Surveillance Group (MSG) meeting on 15/01/19 a proposal was presented setting out the way in which MSG will function going forward. A slide describing the new model is attached at Appendix One.
1.3 As reported to the Board of Directors since April 2016 the Trust has maintained its performance with the Hospital Standardised Mortality Ratio (HSMR) as well within the expected range.
1.4 As part of our journey to outstanding we, as a Trust, feel we now need to push the boundaries to further improve this position.
1.5 Board should note the caveat to this is our limited ability to influence Specialist Palliative Care coding, which has an overall impact on our HSMR position.
1.6 To date MSG has been attended by divisional representation, in addition to representatives from the corporate functions of governance, bereavement, coding, informatics and legal services.
1.7 The new model will take the divisional contribution further. Specialty mortality leads will be required to attend MSG meetings at an agreed frequency to discuss their mortality position, areas of concern and importantly what they have learned from their mortality review processes and the improvements and changes they have made as a consequence.
1.8 This model is in the early stages of consultation but is to be implemented from April 2019.

2. Dr Foster Mortality Outlier Alert

2.1 The Trust responded to a Mortality Outlier Alert from the Dr Foster Intelligence Unit (Imperial College, London) relating to Biliary Tract Disease in October 2018. Mortality outlier alerts from this unit are based on very sensitive parameters and as such alert at a lower threshold than the regular monthly report received from the hospital section of Dr Foster.
2.2 As with the Mortality Outlier Alert for Acute Kidney Injury (AKI) received in October 2017 the Trust had already recognised the issue, had reviewed all patients identified and demonstrated that appropriate interventions had reduced the relative risk.
2.3 The Trust response was sent to the Care Quality Commission (CQC) Monitoring Unit who require assurance that all relevant actions have been taken to bring the alert back within the expected range. Any ongoing monitoring required is managed through the regular CQC Engagement meetings.
2.4 Intelligence has been received to say the response submitted re Biliary Tract Disease has not been accepted by CQC; however we are waiting for the formal notification. This will be an agenda item at the CQC Engagement meeting scheduled for 25/02/19. It is likely we will challenge this decision.

3. ReSPECT Tool

3.1 Following the agreement with the wider health community the Trust continues the implementation of the ReSPECT Tool.
3.2 A Trust ReSPECT Steering Group is well established who are working through the elements of the implementation programme.
3.3 A series of training sessions have been delivered with good attendance from a number of clinical staff; however attendance from medical colleagues is below expected. This concern has been raised at both the Deteriorating Patient group (DPG) and Patient Safety Quality Group. Attendance of colleagues from the Urgent and Emergency Care Division has also been raised as a concern. All Clinical Chairs have been asked to support and facilitate

attendance. The implementation team have also agreed to amend their training programme and accommodate clinical teams wherever possible.

3.4 Derby and Chesterfield Hospitals have implemented the Tool with little consultation and we are working closely with colleagues from these organisations to learn lessons.

3.5 Patients are being admitted to the Trust with ReSPECT documentation in place making it more important that we raise the awareness of this change quickly and effectively.

3.6 We remain on target to launch ReSPECT across the Trust from April 2019.

4. Medical Examiner Role

4.1 The Trust must comply with the legal requirement of having a Medical Examiner Service when the Coroners and Justice Act is enforced in April 2019.

4.2 A Business case to support this new role is being developed for presentation in January. It reflects the funding and business administration requirements to deliver a high quality service aiming to:

- Ensure there is accurate medical certification of the cause of death
- Detect significant problems in treatment or care and ensure they are reported and reviewed through the appropriate governance systems
- Increase transparency for the bereaved and listen to their concerns and where necessary explain the cause of death

4.3 The Trust – through the MSG has been proactive to date in their preparations to this requirement since early 2018. We have attended national conferences and looked at the outcomes from the local pilot sites in Leicester and Sheffield.

4.4 The Lead Clinician for Mortality completed the core competencies required in April 2018 and has been undertaking a shadow role within a pilot project through Q2 and Q3 2018/19.

4.5 Feedback from the pilot, particularly from the Bereavement Centre and junior medical staff has been very positive with improved communication with bereaved families and enhanced learning for junior doctors reported.

4.6 This proposed service will build on the existing Bereavement Centre Service and line management arrangements.

4.7 The Medical Examiner (ME) will have an independent role within the organisation but will remain accountable to the Medical Director. There will be an accountability relationship for all Medical Examiners to the regional and national Medical Examiner system once developed.

4.8 The Trust has been liaising with partner organisations to understand where there will be opportunities for economies of scale, joint working and learning.

4.9 It is anticipated at this time that each organisation will develop a Medical Examiner Role but regional and national roles may emerge in time.

5. Structured Judgement Review

5.1 As reported in the Q2 Learning from Deaths Report to Board it continues to be a challenge to collate the themes and learning that have been identified through the multidisciplinary mortality meetings. It is expected the new model of the MSG Meeting format will support the extraction of this rich intelligence source.

5.2 The Medical Director and Deputy Director of Governance & Quality Improvement plan to attend a number of specialty Mortality meetings through Q4 to quality assure their effectiveness but offer support and guidance where necessary. The effectiveness of mortality discussions will also feature within core service self-assessments.

5.3 The criteria for undertaking a Structured Judgement Review and/or an Avoidability Assessment as part of the Trust Mortality review process will be reiterated. MSG is not currently assured that all cases, particularly those mandated for presentation at MSG are being identified.

6. Mortality Dashboard Quarter Three 2018/19

6.1 The Mortality Dashboard (Appendix Two) indicates that the overall performance for the quarter against the 90% review of all deaths standard is 77.11% at the time of writing this report. The low performance is due, in the main, to the Christmas and New Year period and will be rectified through Q4.

6.2 The performance for Q1 and Q2 increased through Q3 from 83.98% to 84.53% and 75.5% to 86.75% respectively.

6.3 The current year to date performance is 82.54% compared to the total performance rate of 83.87% for 2017/18.

6.4 MSG continues to promote the standard for completing a review within four weeks, unless there are legitimate reasons for a delay. This ensures we understand the care given at this vulnerable time and adopt any learning in a timely way.

6.5 The sub optimal performance of two specialties reported in the Q1 Learning from Deaths Board Report has been resolved and as such will have a positive impact on the overall performance by the year end.

6.6 The continued decline of the identification of deaths with avoidable factors has been noted and is being addressed through the reconfiguration of MSG and the further support being given to specialty mortality processes.

6.7 The Dashboard highlights examples of the learning following a series of complex inquests through Q3. Although the Coroner identified significant learning and improvement opportunities for the Trust no inquest resulted in a Regulation 28 – Prevent Future Deaths Report.

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. The learning themes from our 2017/18 mortality reviews have helped shape elements of our improvement work for 2018/19 with MSG remaining flexible enough to incorporate the requirements of national guidance as and when published.