Board of Directors

Subject:	Learning from Deaths – Annual Summary Report	**Date:** 06/0619	
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 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 2019/20		**Approval**	
		Assurance	x
		Update	x
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x			x	x

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
	x	x		

Risks/Issues	
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

Executive Summary

As early implementers of the National Learning from Deaths Guidance (2017), 2018/19 has seen the Trust continue the progress already made in the review of the care provided to patients whilst an inpatient in one of the Trust's hospitals prior to their death.

In particular 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).

Through the Mortality Surveillance Group (MSG) the Trust will continue to develop the mortality agenda to enable us to get a clear understanding of the care delivered to patients, their families and loved ones at what is a very emotional and difficult time.

We will strengthen the knowledge for specialty teams in understanding where they perform in terms of mortality, supporting them to identify areas of excellent practice but also areas of improvement and required changes to practice.

The Annual Summary Report seeks to bring together the progress to date and work undertaken through 21018/19, to highlight the key learning themes and outline the plans to further enhance the agenda through 2019/20.

The Board of Directors is asked to:

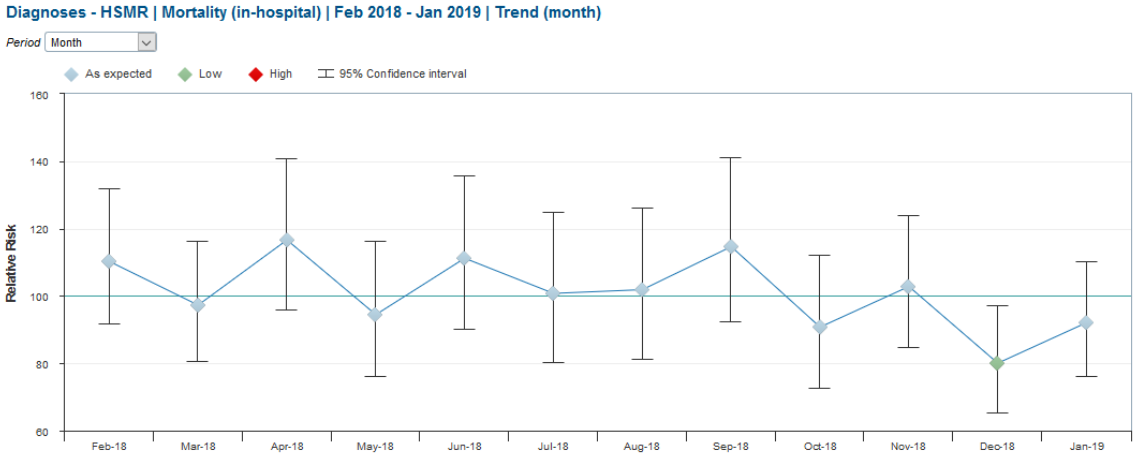
- Note the content of the Report
- Note the performance of against the requirement to review 90% of all deaths
- Note the preparatory work undertaken through 2018/19 to ensure the successful implementation of the ReSPECT Tool in April 2019.

1. Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) Mortality

1.1 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).

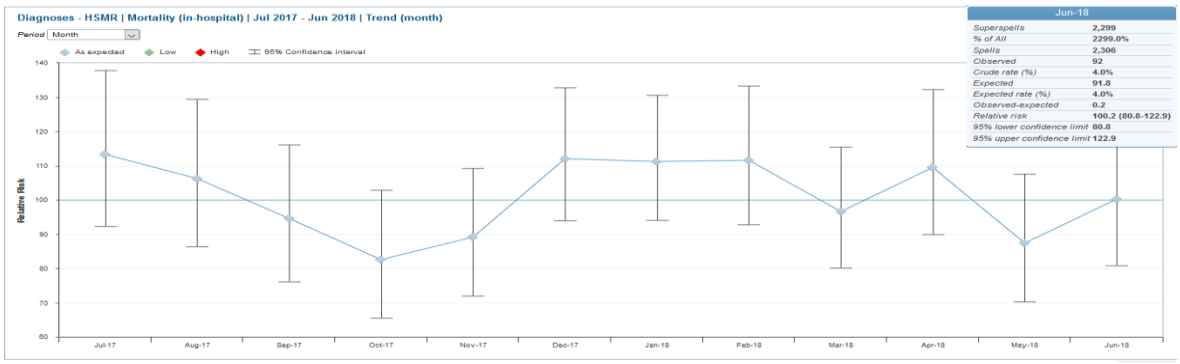
1.2 The Trust has consistently performed within the expected HSMR range since April 2016 despite increased crude mortality in the winters of 2017 and 2018. Winter 2019 data is not yet available.

1.3 Graph 1 illustrates the monthly mortality trend between February 2018 and January 2019 demonstrating a consistent performance.



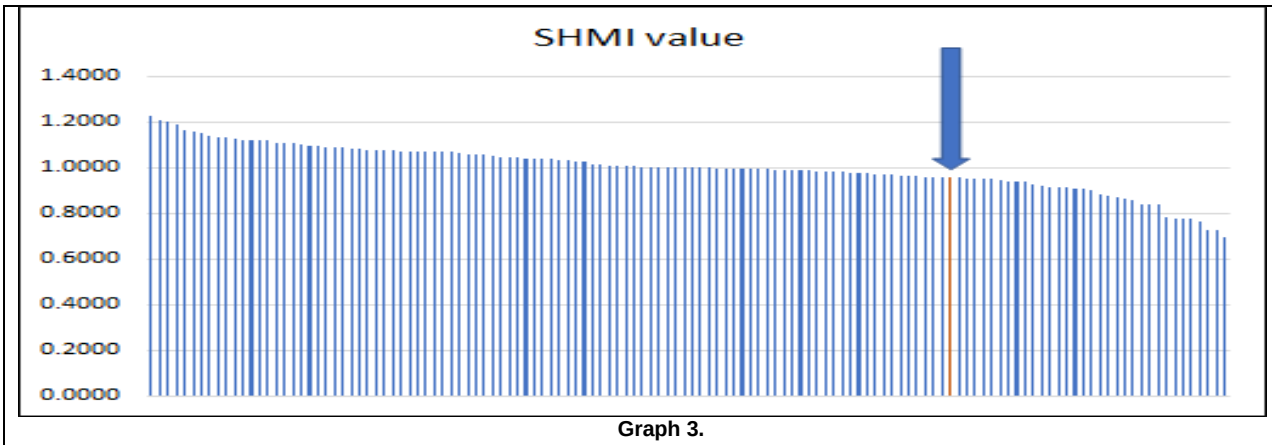
Graph 1.

1.4 Graph 2 demonstrates the same performance over the 12 month rolling period



Graph 2.

1.5 Graph 3 demonstrates the most recent data covering the 2018 calendar year showing SFHFT with an improved SHMI – 95.64. This current publication is the first time SFHFT has shown below expected since 2010 when the SHMI was first published

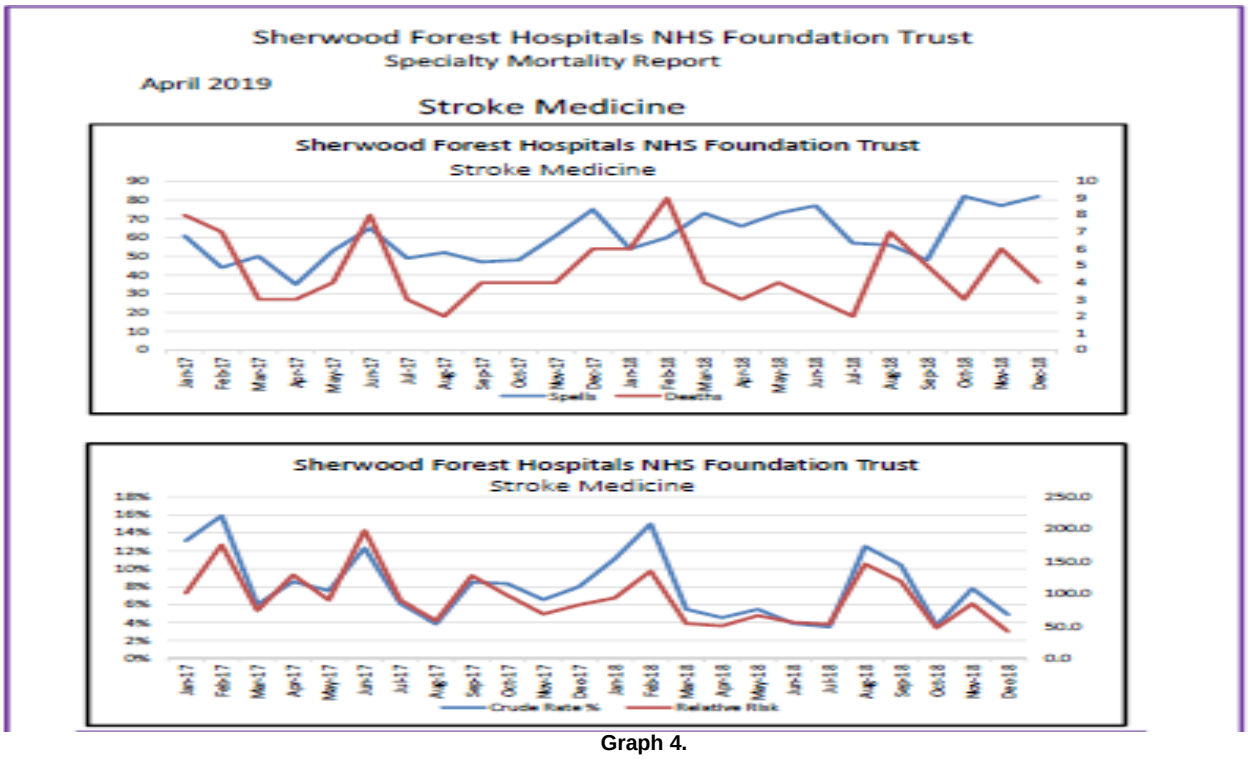


Graph 3.

1.6 The aim for services through 2019/20 is to understand their own mortality position, particularly those factors driving either a good or poor performance. To facilitate this Dr Foster are working closely with mortality leads to design bespoke mortality reports that specialties will be able to access to support local mortality and morbidity meetings.

1.7 Graph 4 provides an example of such a report that was presented to MSG in March illustrating the current mortality position for Cerebrovascular Disease (Stroke Medicine).

1.8 Comparison of the data shows the Trust performs in the top 5 of similar-sized Trusts nationally for stroke mortality with a relative risk of 69.2. It is important for the Trust to understand the drivers behind such excellent performance in order to see if they can be replicated across other diagnosis.



Graph 4.

2. Dr Foster Mortality Outlier Alert 2018/19

2.1 As the management of mortality improved the Trust were confident that they would be in a good position to identify any mortality concerns in a specific service early and respond accordingly – be that commissioning an internal review or providing information to external bodies.

2.2 The Trust responded to a Mortality Outlier Alert from the Dr Foster Intelligence Unit, Imperial College, London in October 2018 relating to Biliary Tract Disease. This unit is a separate entity to the Dr Foster Hospital section the Trust regularly works with. Mortality alerts from this unit are based on very sensitive parameters and as such alert at a much lower threshold than the regular monthly report received at MSG.
2.3 MSG had already recognised a need to look closely at this particular diagnosis group and as such had undertaken a further review at all deaths within the alert timeframe.
2.4 The response submitted by the Trust was not accepted by the Mortality Outlier team of the Care Quality Commission (CQC). This was further discussed at the regular CQC Engagement meeting in February 2019 with a recommendation to submit a revised response.
2.5 At the time of writing this report, although no formal letter of acceptance has been received a checklist from the outlier team recommending the alert was closed was circulated as part of the meeting papers.

3. Structured Judgement Review (SJR)

3.1 As reported throughout 2018/19 it has been challenging to collate the themes and outcomes from mortality meeting discussions. This has been a key driver of the way in which MSG will develop in 2019/20. Further explanation of the plan for mortality going forward is described in section 8.
3.2 As reported in the quarter three report MSG are not assured all cases that meet the criteria for presentation to MSG are being scheduled. These criteria have been reiterated to all clinical teams.
3.3 To widen the discussion and provide further opportunities for learning and sharing practice the criteria for presentation to MSG has been extended to include cases of particular interest. Cases that do not necessarily meet the specification for statutory inclusion but are felt to be of particular interest – i.e. complex cases with multi-specialty or organisational involvement will be encouraged.
3.4 The Deputy Director of Governance and Quality Improvement has met on a 121 basis with each mortality lead and was assured that robust mortality discussions are taking place and improvements are being made as a consequence. 2019/20 will see better capture and dissemination of this information.

4. Maternity, Neonatal and Paediatric Mortality Review

4.1 The Clinical Governance Lead for the Women and Children's Division is a core member of MSG and as such provides a monthly report for obstetric, neonatal, paediatric and gynaecology deaths.
4.2 It is recognised however, deaths within these services, with the exception of gynaecology are subject to robust external scrutiny and review processes. The purpose of including them within this report is for the Board of Directors to recognise the improvement and learning undertaken by the Division.
4.3 A Quality Summit for Maternity Services had been called in January 2017 where concern re the Trust stillbirth rate had been raised. MSG has received significant assurance since this time that the stillbirth rate continues to be reported externally appropriately and is well within the expected range.
4.4 All child deaths are reported to the Child Death Overview Panel (CDOP) and referred to the Coroner as a matter of routine.
4.5 Neonatal deaths are reported through the MMBRACE reporting tool.
4.6 The Learning from Deaths Guidance requires only adult mortality reviews to be reported to the Board of Directors but this annual summary has taken the opportunity to report deaths for other groups. The table below indicates deaths for maternity (still-births), neonates and children.

Patient Group	No. Deaths	Learning
Maternity – Total still born	7	Asthma child – Local Learning. Consideration for use of Epi-pens with some brittle asthma cases. Updating action plans to include post 999 call advice. 10 month infant – Cause of Death Sudden Infant Death Syndrome. Now closed to Coroner's. Local Learning: Well-run arrest scenario with clear leadership, reminder re use of drug prescription chart circulated 14 year old hanging victim. M&M noted exceptional ED led resus and care acknowledged. Concern continues regarding GP to CAMHS referral. Issues raised in respect to out of area children who die in Nottinghamshire and differences in cross border policies and processes. Good Practice: Action taken from CDRT to address this with out of area colleagues. A communication newsletter to be circulated to support the involved clinicians and reiterate Nottinghamshire processes. Network meeting established.
Neonatal	4	
Paediatric	8	

Table 1.

5. Medical Examiner (ME) Role

5.1 As previously reported to the Board of Directors the Trust must comply with the legal requirements of having a Medical Examiner Service when the Coroners and Justice Act 2009 is enforced from April 2019.
5.2 The requirements have been set out in parliamentary statements in 2018. These statements have committed the government to act on the many years of development in response to numerous national inquiries and system failures, such as Mid Staffordshire, Morecombe Bay and Gosport Memorial Hospital.
5.3 The Department of Health and Social Care issues instructions through NHS Improvement to oversee the first phased implementation in Acute Hospital Trusts.
This requirement builds on the existing systems already in place in the Trust.
5.4 The Trust has supported a business case to build on a pilot Medical Examiner Service that ran through Quarters one and two of 2018/19. It is intended to build on the current Bereavement Service.
5.5 The ME has an independent role in the Trust but will remain professionally accountable to the executive Medical Director and is in the employment of the Trust. The independent nature of the role is of the upmost importance.
5.6 Each local ME will become accountable to the regional and national Medical Examiners. The National ME is now in post with recruitment to the regional post due to take pace in June 2019.
5.7 The recruitment process to appoint a substantive ME to SFHFT has commenced with an interview date set for 14 June.

6. Engagement with families and Carers

6.1 The Learning from Deaths Guidance set clear expectations for how NHS Trusts should engage meaningfully and compassionately with bereaved families and carers prior to and following a death.
6.2 In July 2018 additional guidance to support the work with bereaved families was published by the National Quality Board. The guidance was developed by NHS England in collaboration with families who have experienced the death of someone in NHS care and have been involved in investigations, as well as with voluntary sector organisations.
6.3 There are eight principles that set out what bereaved families and carers can expect. These are:

- Being treated as equal partners.
- Receiving clear, honest, compassionate and sensitive response in a sympathetic environment.
- Being informed of their rights to raise a concern.
- Receiving help to inform decisions about whether a review or investigation is needed.
- Receiving timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.
- Being partners in an investigation as they offer a unique and equally valid source of information and evidence.
- Being supported to work in partnership with trusts in delivering training for staff in supporting family and carer involvement where they want to.

6.4 The Trust Bereavement Service has made great progress toward meeting all these expectations and the full implementation of the ME service will enhance this further.

7. Learning Disability

7.1 As indicated in section 3, it would appear that not all patients who met the criteria for formal assessment were known to MSG. One such cohort of patients are those with a know diagnosis of Learning/intellectual Disability.
7.2 It should be noted that the Trust can only review those patients who have been flagged to the learning disability specialist staff and will not include a number of patients who may only be known to primary or social care.
7.3 In 2017 the Trust conducted a review into 14 patients with a known learning disability who had died within one of the Trust's hospitals. This review was conducted alongside the new Learning Disabilities Mortality Review (LeDeR) process.
7.4 The outcome of this review was reported to the Board in the quarter two Learning from Deaths report 2017/18. It concluded that the Structured Judgement Review process adopted by the Trust provided a much more comprehensive view of the care and treatment options offered to patients, their families and carers in the last days of life, in addition to highlighting the learning and improvement opportunities.
7.5 It has become clear through 2018/19 that although the Trust reports every death of a patient with a learning disability to LeDeR they have struggled to conduct their own reviews in a timely manner.
7.6 The Trust is working closely with LeDeR to share the outcome of all relevant SJRs to support this external process.
7.7 In order to capture all deaths of patients with a learning disability the Trust has carried out a retrospective review through quarter four of 2018/19.
7.8 The retrospective review is attached at Appendix One.

8. Plans for 2019/20

8.1 As reported to the Board in January 2019 the proposal to enhance the way in which MSG operates going forward was described.
8.2 Specialties will be required to attend MSG at agreed intervals throughout the year to provide assurance about the effectiveness of local mortality meetings. A schedule of attendance has been drawn up.
8.3 Bespoke mortality reports are being agreed with individual services to support improved understanding and engagement of clinical teams in the factors driving their own mortality.
8.4 Particular focus will be given to three specific cohorts of patients (as defined in the April report to Board), not necessarily to reduce the overall mortality position but to provide an opportunity to improve pathways and treatment decision-making for vulnerable groups. These include:

- Learning Disability
- Schizophrenia
- Acute Psychosis
- Bi-polar Disorder
- Fractured Neck of Femur

9. Learning from Deaths Dashboard 2018/19

9.1 In line with the requirements of NHS Improvement and the CQC the Trust has presented the Learning from Deaths Report to the Board of Directors for all four quarters of 2018/19. Due to the availability of data and the continuing challenges faced by clinical teams facing significant operational pressures the trust has not met the >90% standard for reviewing all deaths.
9.2 The Dashboard shows a final year performance of 86.65% for 2018/19 against a position of 83.87% for 2017/18.
9.3 The Trust has consistently achieved >80% in all four quarters, which is an improvement on the quarter performance of 2017/18. Performance in February 2019 was the only month where performance fell below 80%.
9.4 The dashboard also indicates the number of deaths, that triggered an Avoidability Assessment was 11. This is a decrease from 2017/18 but may be explained by the perceived lack of clarity for deaths that trigger this stage of review.

10. Summary:

10.1 Learning from the care provided to patients who die is integral to the Trust's governance and improvement frameworks, ensuring that any learning derived from mortality reviews is adopted quickly and effectively.
10.2 The Trust now has well-established, sustainable mortality processes in place at both executive and local level. The quarterly 'Learning from Deaths' reports to the Board of Directors provides an opportunity for executive and non-executive directors to appropriately challenge.
10.3 The Trust has continued to make good progress throughout the year and has robust plans in place to improve further. The learning themes from reviews will drive improvement work through the Trust Quality Strategy.
10.4 The robustness of the Trust Mortality Review process was favourably reflected in the 2018 visit by the CQC as further validation of the mortality journey. 360 Assurance will undertake an internal audit of the Learning from Deaths agenda in quarter three 2019.
10.5 CQC has published their *'Learning from Deaths – a review of the first year of NHS Trusts implementing the national guidance'* document in July 2018 concluding trusts are at varied stages in success of implementation.
10.6 SFHFT performs well against the findings of this publication, having demonstrated the Trust has the right leadership, approach, governance and culture in place to build on the work already underway.