The Royal Wolverhampton NHS Trust

Learning from Deaths Update Report
4 June 2019

Agenda Item No: 7.1

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS
NHS Trust

Trust Board Report

Meeting Date:	4th June 2019
Title:	Learning from Deaths
Executive Summary:	The paper presents the Trust's most recent mortality data and a summary of the underlying causes for the outlier status of the SHMI indicator. The SHMI remains at 121. However the most recent quarter Q4 2018/19 shows a reduction in crude mortality as does the crude mortality for the year 2018/19. The number of case notes scrutinised by the Medical Examiners continues to increase as the process is embedded. The timeliness of case note reviews via SJR is not at expected levels. The Trust is currently recruiting to mortality reviewers who will have dedicated time to complete SJRs. The Trust continues to work with external agencies (PWC) to identify improvement both in data submission and to support improvement in clinical pathway compliance. This month the Trust welcomed Dr Ron Daniels CEO of Sepsis Trust who raised awareness of sepsis treatment with clinicians from across disciplines and met with the sepsis team importantly to discuss future action planning. This month the Trust Clinical Lead for End of Life care presented the Trust results of the National Audit of Care at the End of Life (NACEL). This information is important to the Trust as there is evidence that more patients die in hospital rather than other locations in Wolverhampton compared to the national average. A key strand of the Trust work alongside the CCG is to ensure that there is recognition that when the patient is at the end of life, the appropriate pathway of care is provided. This will include recognising a pre agreed plan of care which could include death in a location other than hospital where appropriate. The majority of summary scores for RWT were above the national summary scores however there is a requirement to consider improvement in a number of areas including the development of the bereavement service and the requirement to document preferred location of death.
Action Requested:	Receive and approve
For the attention of the Board	To note the SHMI which remains on a plateauing trend.
Assure	The Board has previously been reassured through data analysis that the increased SHMI is not an indicator of avoidable mortality or quality of care. However, work continues to review and, where possible, enhance quality of care provision across admission pathways with elevated SMR's. Work also continues to address coding & data capture with respect to accuracy and completeness prior to submission of data.

Advise	Raised SMR's can impact on a Trust's reputation. RWT's elevated SHMI is a focus of external scrutiny with assurance being requested and provided regarding the work undertaken, as described above and in this report.

Alert	Diagnostic groups with elevated SMRs are as follows: Influenza, Chronic renal failure Chronic ulcer of the skin Pneumonia Senility Reviews have been conducted and reported internally and to CQC. More recently the following diagnosis groups have alerted: Respiratory Distress Syndrome COPD Reviews for these are under way
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Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 6. Be in the top 25% of all key performance indicators
Resource Implications:	Revenue: Capital: Workforce: Funding Source: N/A
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	N/A
Risks: BAF/ TRR	BAF SR 12
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	Mortality Review Group/Compliance Oversight Group/Quality Standards Improvement Group/Quality Governance Assurance Committee/Trust Management Committee
References	
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

LEARNING FROM DEATH REPORT May 2019

This report describes the most recent Trust mortality data and a summary of the possible drivers for the outlier status of the SHMI indicator. It also provides detail on how areas for review and potential action are being identified, the work that has been undertaken in the last month and that planned.

SHMI and ALERTING DIAGNOSIS

The latest SHMI is 121 and continues as a plateauing trend, (January 2018 to December 2018). The crude mortality for the SHMI basket (including out of hospital deaths) and for the same period, was 4.04%. However the number of hospital deaths for the period 2018/19 is less than the previous year 2017/18 and the crude mortality for the year was 2.88%, compared to 3.07%.

The diagnosis groups that are currently showing a higher than expected SHMI remain Influenza, Chronic Renal Failure, Chronic Ulcer of the Skin, Senility, Chronic Obstructive Pulmonary disease (COPD) and Respiratory Distress syndrome. Improvements are noted for Pneumonia, now with a SHMI within expected limits. A clinical review of case notes for COPD has been requested. Case note reviews have been presented at Mortality Review Group (MRG) for all other diagnosis within the last 6 months.

In addition MRG continues to monitor the SHMI trend for diagnosis groups that have previously alerted or are higher than benchmark without reaching statistical significance. These remain Acute Cerebral Vascular Disease, Short Gestation low birth rate and Malignant neoplasm without specification of site. Peripheral and Visceral Atherosclerosis and Acute Myocardial Infarction were showing an increasing trend but these now show a SHMI within expected limits.

Expansion of all of this information is attached as Appendix 1.

MORTALITY (CASE NOTE) REVIEW OF CLINICAL CARE

There are no new case note reviews of alerting diagnostic groups to report this month. A review of Malignant Neoplasm without specification of site and COPD has been requested.

Case Note Review of Deaths

The Trust continues to review the case notes of patients following death against a set criteria and methodology as outlined in OP87 Learning from Death Policy, (e.g. LEDeR, children, elective patients). This criteria leads to the selection of the case notes required for review as a minimum. In addition the Trust chooses to scrutinise cases in excess of this minimum requirement.

Cases allocated and reviewed

Scrutiny of Deaths – Data:	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19	Mar-19
Total Number of Deaths (taken from PAS)					208	161	158
No. of Deaths scrutinised via ME				8	75	85	103
No. of Deaths identified for SJR1 Review – that meet the mandatory criteria	27	28	35	36	36	26	21
No. of Deaths identified for SJR1 Review - via ME Assessment					4	5	1
No. of SJR1s Reviewed (mandatory criteria)	18	11	25	17	17	8	0
No. of SJR1s Reviewed (identified by ME)					0	0	0
No. of Additional SJR1s Reviewed (Agreed locally)	65	59	34	20	10	2	0

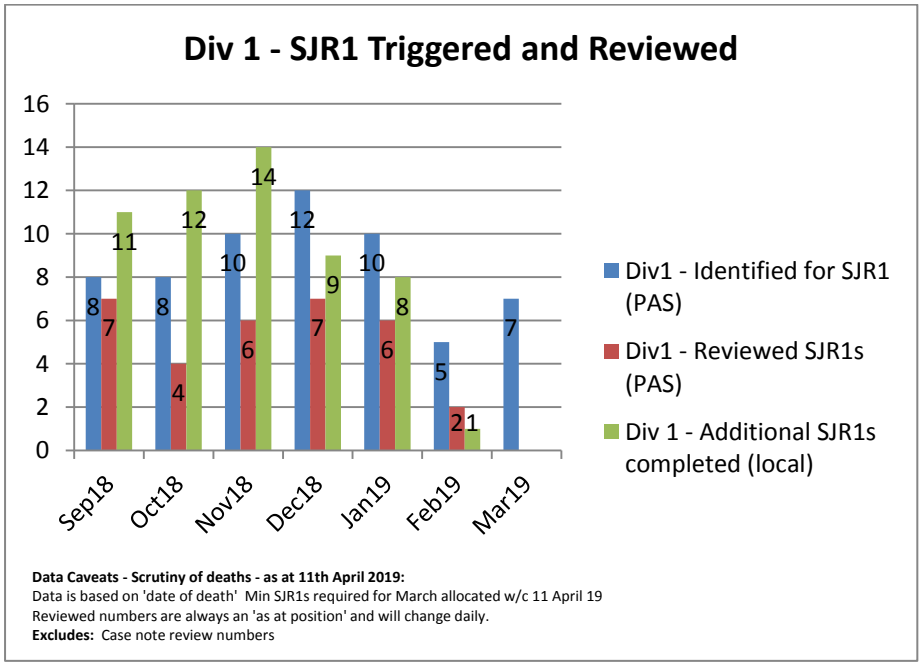
Data Caveats - Scrutiny of deaths - as at 11th April 2019:

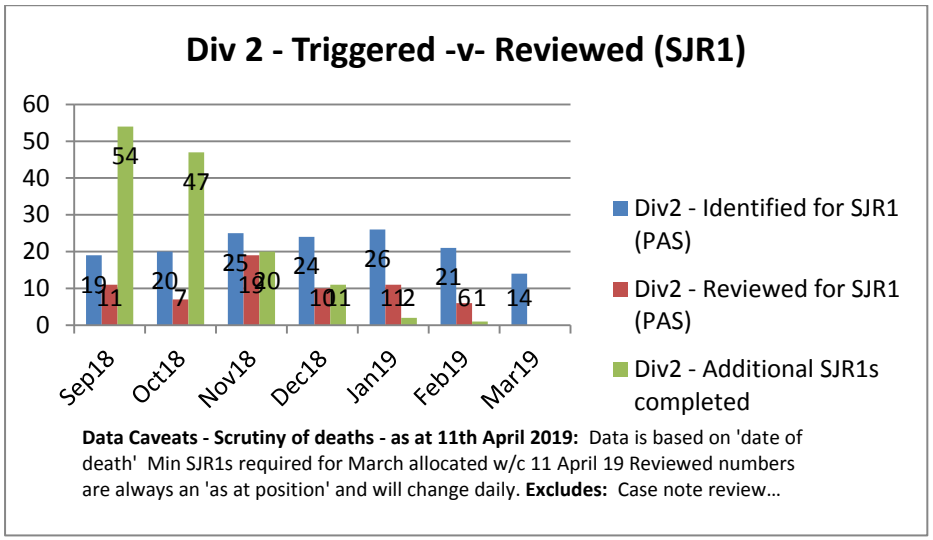
Data is based on 'date of death'

Reviewed numbers are always an 'as at position' and will change daily.

Excludes: Case note review numbers (undertaken separately for Alerting Diagnosis Groups)

The completion of mortality reviews is lagging behind that required. The actions taken to prompt SJR review include reporting position monthly to the Directorate Mortality lead and inclusion of data in the Divisional Performance report. However the Trust is in the process of recruiting to the posts of Mortality Reviewers from a cohort of consultants currently employed in the Trust. A key role of these Reviewers will be to complete the SJR reviews and therefore the timeliness of completion will improve. We expect these Mortality Reviewers to take position within the next 3 months.

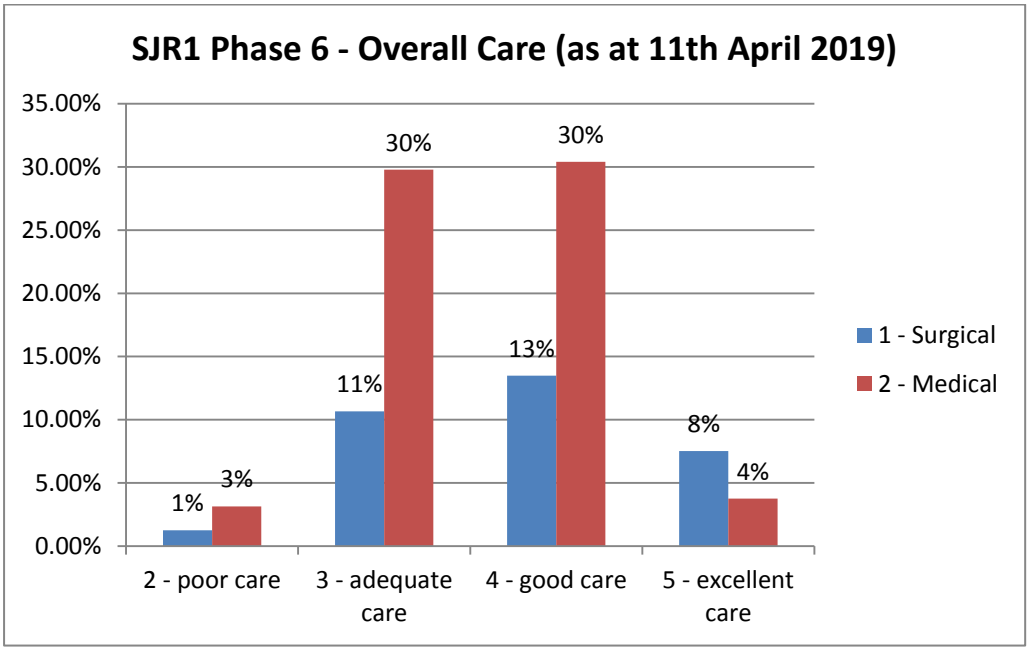




There have been 0 hospital deaths in Division 3 in this period. Deaths that occur in Maternity, Neonatal and Children's Services are reviewed via a Wolverhampton system wide process, 3 monthly reports are brought to MRG.

Outcomes of SJR 1

The following table describes the outcome of the SJR1 reviews, Sept 018 to March 2019, using the 6 Phase criteria.



Where care is identified as being potentially poor or very poor, a further review is conducted (SJR2). This review is undertaken by 2 independant clinicians.

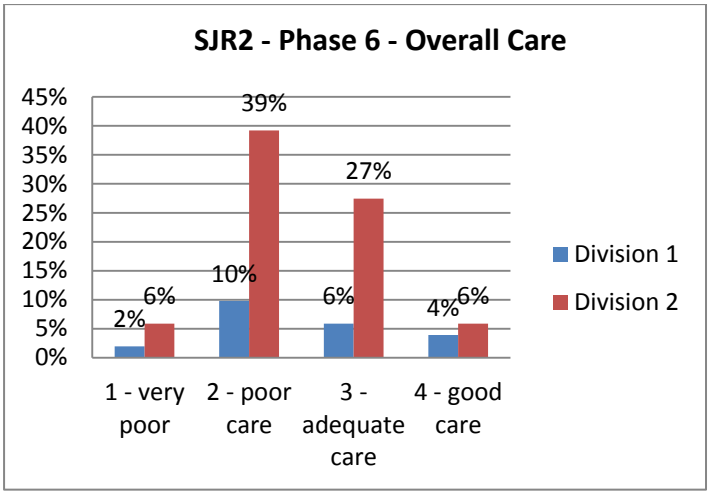
SJR2 reviews

Scrutiny of Deaths – Data:	Pre Sep18	Oct18	Nov18	Dec18	Jan19	Feb19	Mar-19
No. of Deaths identified for SJR2 Review – (following SJR1)	82	6	1		2		1
No. of SJR2s Reviewed	51						
No. of SJR2s Outstanding (All allocated)	31	6	1		2		1
No. of Deaths identified for RCA (following SJR2)	2						

Data Caveats - Scrutiny of deaths - as at 11th April 2019:

Data is based on 'date of death'
Min SJR1s required for March allocated w/c 11 April 19
Reviewed numbers are always an 'as at position' and will change daily.
Excludes: Case note review numbers (undertaken separately for Alerting Diagnosis Groups)

SJR 2 outcomes



QUALITY IMPROVEMENT: CLINICAL PATHWAY REVIEW

The CEO of the Sepsis Trust, Dr Ron Daniels visited the Trust on April 24th 2019. He met with the sepsis team to review progress against clinical standards and provide advice on reporting mechanisms. As part of the strategy to continue to raise awareness, he gave a talk to a full lecture theatre with delegates from a cross section of directorates and disciplines.

The Sepsis team have also presented this month to the Clinical Executive team as well as representatives from the Quality Improvement Team. They presented the data previously reported in this report showing improvement in compliance against key indicators (screening and time to antibiotics). Future work (3rd year of the 3 year plan) will include a focus on awareness and culture shift and consideration of improvements required to improve the other indicators in the Sepsis 6 Bundle. They will be given support from the QI team to further improve Trust performance.

ACCURACY OF CODING

An initial audit of the primary diagnosis recorded for all deaths from December 2017 to November 2018 for the peripheral and visceral atherosclerosis group has suggested that accuracy of recording from the documentation provided is good. Further work to be undertaken by clinicians to review the clinical data provided to the coders for this group of patients.

A pilot programme has started on AMU whereby coders will meet with clinicians to review the accuracy of coding from recently discharged patients. Early data suggests that there are amendments to be made which will improve coding accuracy.

The Trust continues to work with Price Waterhouse Cooper who have provided external scrutiny and are now supporting the team to further identify where the coding of clinical notes could be improved.

END OF LIFE CARE

This month the Trust Clinical Lead for End of Life care presented the results of the National Audit of Care at the End of Life (NACEL). This audit was commissioned in Oct 2017 on behalf of NHSE. The local results for organisations were published in April 2019. The national report and NACEL recommendations are awaited. This information is important to the Trust as there is evidence that more patients die in hospital rather than other locations in Wolverhampton compared to the national average. A key strand of the Trust work alongside the CCG is to ensure that there is recognition that when the patient is at the end of life, the appropriate pathway of care is provided. This will include recognising a pre agreed plan of care which could include death in a location other than hospital.

The majority of summary scores for RWT were above the national summary scores and the audit showed the following **good practice**:

- Documented evidence that that patient may die imminently.
- Communication with the patient and their families
- Involvement in decision making (e.g. DNACPR discussion)
- Recognition of the needs of the family
- Overall individual plan of care
- Governance arrangements for end of life care in place

However there were some areas of omission and areas that **require work:**

- Requirement to document evidence of the side effects of medication
- No guidelines available for engagement with families and carers
- Little evidence/documentation of spiritual and cultural needs of the families
- Little evidence/documentation of the preferred place of death
- No way of understanding family experience
- No mechanism for flagging complaints relating to end of life care
- 7 day service not available

- End of life care training is not mandatory

An **action plan** will be developed and will include

- Promotion of the SWAN Care in the last days of Life Document
- Need for and role of Bereavement service/team
- Scoping the potential for volunteers to support patient and family at end of life
- Scoping access to counselling and psychology services
- Establish a mechanism to identify, report and learn from complaints
- Implement a 7 day service
- Consider how to deliver training for end of life care.

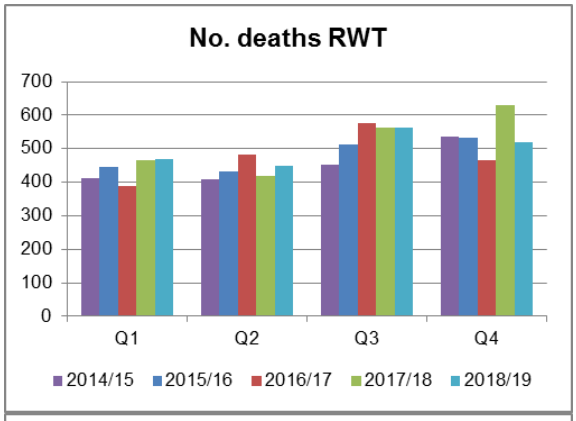
The results of this audit and consequent work identified will be complimented by the appointment of the Bereavement Nurse (start date 15th July) and by the joint work being undertaken to identify the reasons for transfers from nursing homes.

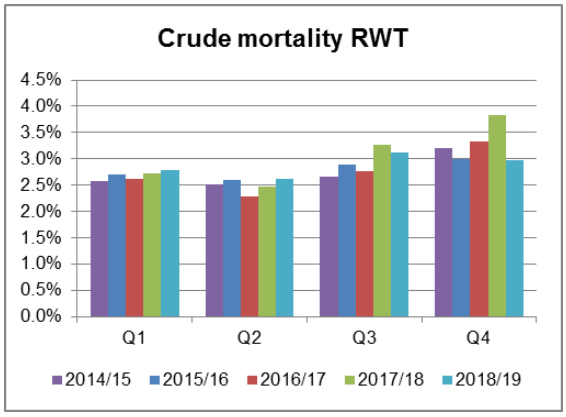
Update on Standardised Mortality Rates (SMRs) and Inpatient data relevant to these calculations

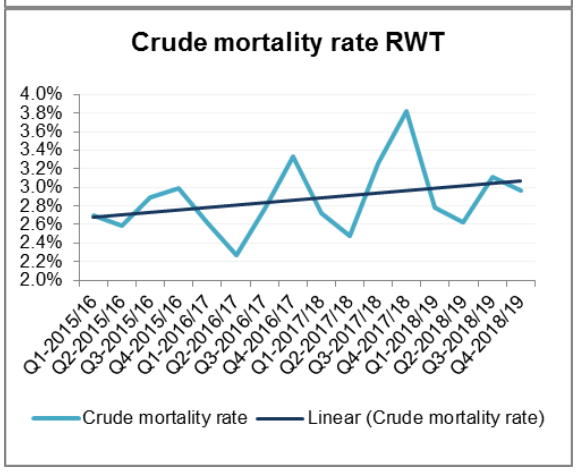
May 2019

1. Crude mortality

The number of deaths and crude mortality represent inpatients mortality only (ordinary admissions including still births) extracted from internal data. The inpatient crude mortality for 2018-19 was lower at 2.88% compared to 3.07% for 2017-18 but still higher than the 3 years prior to 2017/18. Fewer deaths were observed in hospital in 2018-19 compared to 2017-18 (-75). More ordinary admissions were recorded in 2018-19 (+1821) compared to 2017-18.





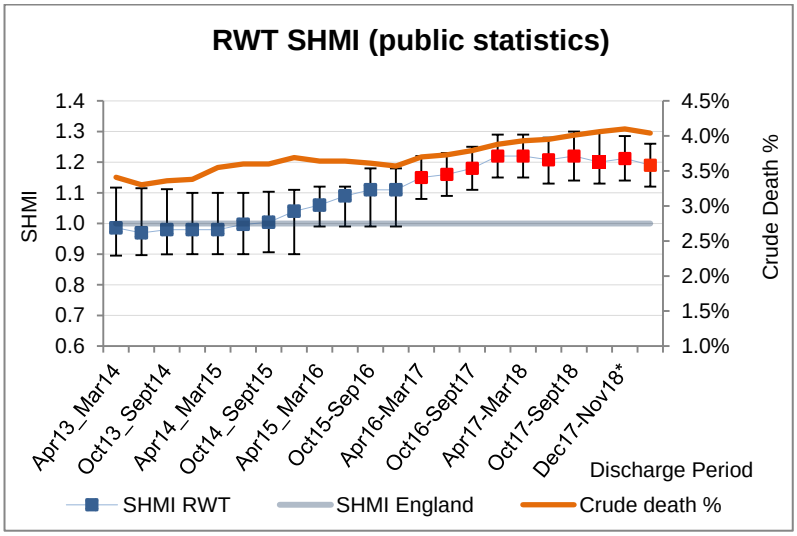


	No. ordinary discharges	No. inpatient deaths	Crude mortality
2014/15	66072	1812	2.74%
2015/16	68677	1922	2.80%
2016/17	69520	1913	2.75%
2017/18	67728	2076	3.07%
2018/19	69549	2001	2.88%

2. SHMI

2.1. Current position

The SHMI estimate for January – December 2018 was 119 (higher than expected). The figure is provisional and likely to increase to 121 for this period. The crude mortality for the SHMI basket** for this period was 4.04% for this period, one of the highest recorded since 2013.



**Dec17-Nov 18 and Jan-Dec 2018 are estimates and will be replaced with published data in May 2019*

***SHMI basket includes deaths occurring in hospital and within 30 days post discharge.*

2.2. Diagnosis groups with higher than expected SHMI

The following diagnoses groups have a higher than expected estimated SHMI (red) for January - December 2018 or are close to being classed as higher than expected (amber) (using the 99.8% confidence intervals).

Diagnosis Group (CCS)	SHMI	Number of total discharges	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	Number of deaths in hospital	% of deaths in hospital
221 - Respiratory distress syndrome	1162	64	0	4	3	75%
158 - Chronic renal failure	442	83	5	20	15	75%
123 - Influenza	436	278	9	39	32	82%
199 - Chronic ulcer of skin	287	76	5	14	10	71%
219 - Short gestation; low birth weight; and fetal growth retardation	239	366	6	15	14	93%
43 - Malignant neoplasm without specification of site	185	67	17	31	23	74%
68 - Senility and organic mental disorders	164	456	54	89	64	72%
127 - Chronic obstructive pulmonary disease and bronchiectasis	151	817	50	76	57	75%
109 - Acute cerebrovascular disease	121	992	164	199	180	90%
122 - Pneumonia	108	1756	320	347	285	82%

Improvements are noted for Pneumonia, longstanding outlier, now with a SHMI within expected limits. All the other red diagnosis groups were in the same position last month.

The SHMI for congestive heart failure and acute myocardial infarction is within expected limits for this period.

A review of changes in data for the short gestation diagnosis group is included in appendix 1. The information is presented subject to review and discussion with the neonatology lead.

2.3. CUSUM alerts

(data provided by HED, based on the HSMR dataset and using the CQC methodology for establishing outliers, which is different to the methodology used by the Imperial College); the score for alerting is 5.

There are no new CUSUM alerts for this period.

After a previously reported increase in CUSUM trend, the COPD diagnosis group triggered a CUSUM alert in December 2018. The Trust has also received an external alert letter from Dr Foster Unit regarding the higher than expected mortality for COPD. This is likely to be followed by a CQC alert.

2.3.1. The **Malignant neoplasm without specification of site** diagnosis group continues to show an increasing CUSUM trend; current value 4.74 from 4.17 last month (based on the HSMR dataset). Further work is needed to understand the position for this diagnosis group considering the following factors:

- Discrepancies in SMRs data:
- HSMR, Jan to Dec 18, 244 spells with 23 deaths and 9.7 expected. Of these, 205 spells (84%) and 3 deaths were elective admissions with an expected number of deaths of 0.6 (0.3%). The expected mortality expressed as a percentage is 23.2% for non-emergency admissions. The HSMR value would be more than 20 points lower if the palliative care adjustment was taken out. We expect that the recent expansion of the palliative care team will improve the palliative care coding.
- SHMI, Jan to Dec 18, 67 spells, 31 deaths of which 23 in hospital with 16.8 expected. Of these, 28 spells and 4 deaths (3 in hospital) were elective admissions.
- The average comorbidity score in the HSMI dataset is 17.3 for these admissions whilst the HSMR dataset shows an average score of 12.97 for elective admissions and 19.2 for emergencies.
- RWT has the 3rd highest number of deaths for this diagnosis group in England in the HSMR dataset, whilst showing a relatively small number of spells.
- NEXT steps: the two datasets (HSMR and SHMI) will be compared to identify discrepant records. A review of data quality looking at accuracy of admission method will be investigated in first instance (for instance it is possible that the elective admissions may be more accurately described as non elective). A further review will be undertaken to check accuracy of coding for primary diagnosis and comorbidities. A cross check with internal inpatient data is recommended to identify the pathways for these patients.

3. COPD data review

(Unless indicated otherwise, analysis is based on Hospital Episode Statistics (HES) data accessed through the Healthcare Evaluation Data (HED) modules).

The Standardised Mortality Rates (SMRs) for the COPD diagnosis group show higher than expected mortality for RWT; the trust is one of two trusts in England with higher than expected mortality for SHMI and one of four in the outlying position for HSMR. An alert was also received by the trust from the Dr Foster Unit at Imperial College; a run of negative events was

observed from October to December 2018 with a signal in December. The alert refers to 825 super spells, 55 deaths and 32.1 expected deaths for the period January – December 2018 (based on date of discharge).

The SHMI data show 817 discharges (of which 11 elective admissions) for this diagnosis group from January to December 2018, with 76 deaths observed, of which 57 in hospital (1 elective admission), and 50 expected deaths. For this period the SHMI was 151, higher than expected.

Figure 1: SHMI - COPD, acute trusts in England January – December 2018.

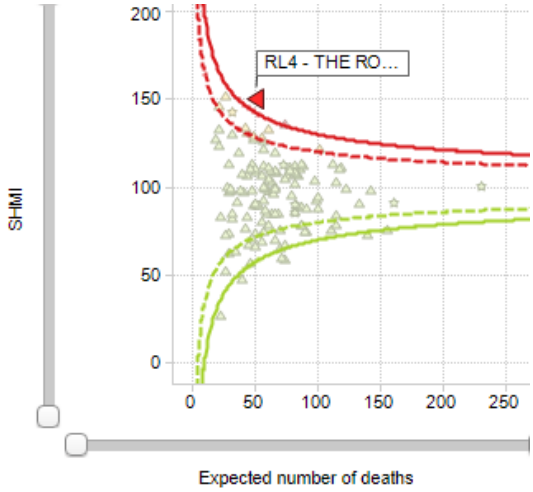


Figure 2: SHMI - COPD, acute trusts in England 2017/18

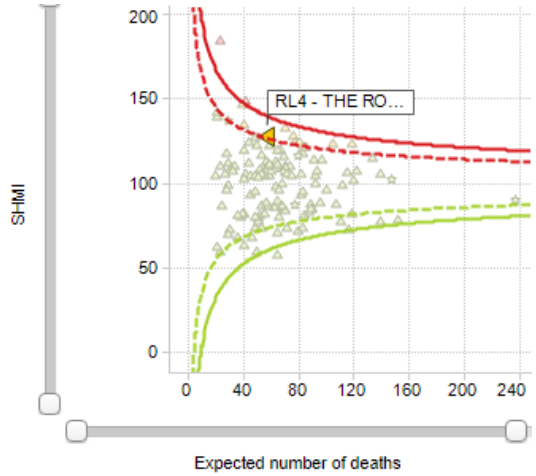
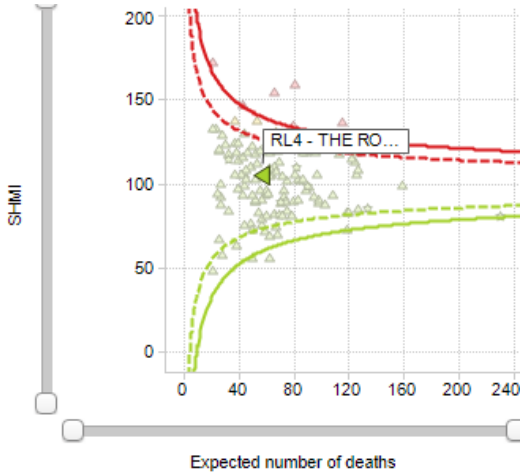


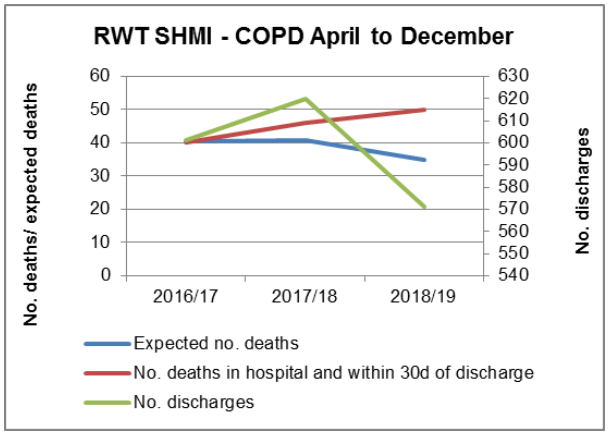
Figure 3: SHMI - COPD, acute trusts in England 2016/17

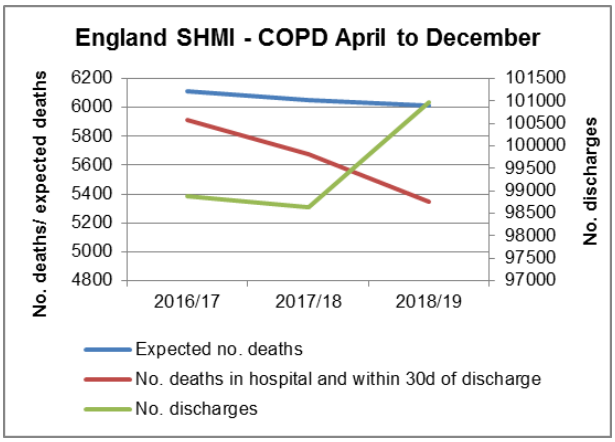


The COPD diagnosis group was within expected limits in 2016/17 and borderline within expected in 2017/18.

There were 42 more COPD spells in the SHMI dataset in 2017-18 when compared to the previous year and 7 more deaths; the expected number of deaths stayed exactly the same. In 2018-19 Q1-Q3, there were fewer admissions, more deaths and fewer expected deaths when compared to the previous two years, which led to the higher than expected SHMI (figure 4a). This is in contrast with the picture in England where the number of discharges had increased from 2017-18 and fewer deaths were observed, which means that the expected mortality has reduced nationally. In other words, with more admissions nationally and fewer deaths, the survival expectancy has increased, which is in contrast with the picture seen for RWT.

Figure 4a and 4 b: RWT & England SHMI – COPD; spells, deaths and expected deaths comparison





In addition, the most obvious discrepancy is shown at acute trust level. Most trusts in England with a similar number of deaths in this diagnosis group have more admissions with COPD, including regional trusts. Trusts with similar number of admissions with COPD have fewer deaths observed in this diagnosis group.

The age profile of patients admitted at RWT with a diagnosis from the COPD group is similar to that of patients admitted across England (table 1). Some variation is observed in the under 64 and over 75 patients groups. In England a smaller proportion of deaths are observed in the under 64 age group when compared with RWT and 2% more of the admissions with COPD are in this group. Nationally 63% of the deaths are aged 75+ whilst at RWT 59% of the deaths are in this age group. The proportion of spells for the 75+ group is similar with 44% for RWT and 43% for England.

Table 1: SHMI discharges with an admission diagnosis from the COPD group, January – December 2018.

Jan-Dec 2018	**RWT**								**England**		
Age Group	Number of spells	Number of deaths in hospital or within 30 days	Expected number of deaths	Expected deaths %	Crude death %	Number of deaths in hospital	% Spells	% Deaths	% Spells	% Deaths	Crude death %
0-64	182	10	5	2.6%	5.5%	8	22%	13%	24%	10%	2.4%
65-69	121	6	6	4.7%	5.0%	4	15%	8%	14%	10%	4.3%
70-74	145	13	9	5.9%	9.0%	9	18%	17%	18%	17%	5.4%
75-89	326	42	26	8.1%	12.9%	31	40%	55%	39%	54%	7.9%
90+	32	3	5	14.4%	9.4%	3	4%	4%	4%	9%	12.7%
Unknown	11	2	0	4.5%	18.2%	2	1%	3%	1%	1%	3.4%
Grand total	817	76	50	6.2%	9.3%	57					5.8%

Whilst the expected mortality, expressed as a percentage is very slightly higher for RWT than for England, the crude mortality rate for RWT is almost double that of England for COPD. The COPD diagnosis group represents 1.6% of SHMI discharges and 2.9% of SHMI deaths nationally for January to December 2018. For RWT 1.2% of SHMI discharges and 2.8% of SHMI deaths are in this diagnosis group for the same period.

There was no significant difference between admissions during the week and at weekend; 26% of admissions and 30% of the deaths in this cohort were admitted at the weekend.

The comorbidity score (based on the Charlson index) is slightly higher on average for RWT (7.95) when compared with England's (7.6). The proportional distribution of spells and deaths by the three Charlson score bands is very similar for RWT and England (table 2).

Table 2: SHMI discharges with an admission diagnosis from the COPD group, January – December 2018 by Charlson comorbidity score band, RWT and England

	RWT				England			
Charlson Comorbidity (3 bands)	Number of spells	% spells	Number of deaths in hospital & 30d post discharge	% deaths	Number of spells	% spells	Number of deaths in hospital & 30d post discharge	% deaths
0	282	35%	18	24%	52747	37%	1980	24%
1-5	181	22%	13	17%	31131	22%	1257	15%
6+	354	43%	45	59%	60114	42%	5092	61%
Grand tota	817		76		143992		8329	

In conclusion, it is likely that the higher than expected SHMI for the COPD diagnosis group is due to the fact that RWT's trends for admissions and deaths diverge from the national trends (the benchmark). It is possible that the COPD clinic (patients treated via an ambulatory route rather than being admitted) accounts for these differences.

There will be a validation exercise to ensure that all deaths with a primary diagnosis on admission from this group have been assigned the correct primary diagnosis. Following the coding review for April to October 2018, we will extend the review to include discharges (deceased) between October and December 2018 as a minimum.

Assuming the coding is an accurate reflection of the primary diagnosis on admission for these cases it is reasonable to conclude that the cause of the higher than expected SHMI and the CUSUM alert is the denominator effect; too few admissions for this diagnosis group when compared to the benchmark.

It is important to note that this analysis refers strictly to data and the standardised mortality rates and it is not meant to evaluate clinical care. A clinical case note review is in progress to provide assurance on the quality of care provided to the deceased patients.

Quality Improvement Plan 1 (Mortality)

Version 19
Updated 29th April 2019

	Objective	Activity	Expected Output/Outcome	Benefit	Milestone (Y/N)	Start Date	End Date	Owner	Exec Director Sponsor (TBC)	Status Date of Update 07/11/18	Status Date of Update 10/12/18	Status Date of Update 07/01/19	Status Date of Update 25/02/19	Status Date of Update 20/03/19	Status Date of Update 29/04/19
A1	**Programme Management (PM) and Governance**														
	1	Develop a Trust Mortality Strategy	Strategy developed via consultation			01/09/2018	30/11/2018	D Hickman	J Odum/ AM Cannaby						
	2	Agree TOR of MIG to include scope and development/review	MIG terms of reference			01/06/2018	30/07/2018	S Roberts	J Odum/ AM Cannaby						
	3	Terms of Reference for Mortality Review Group following merger of MoRAG	MRG TOR developed			01/06/2018	30/07/2018	A Viswanath	J Odum						
	4	Programme Board and Action Plan to be developed	Programme Board established. Action plan formulated			01/08/2018	15/10/2018	J Odum/AM Cannaby	J Odum						
	5	Dashboard to be developed for monitoring of impact of actions	Dashboard presented to MRG			01/07/2018	15/10/2018	S Hickman	J Odum						
	6	Board Assurance Framework submission	Risk added to BAF			01/08/2018	30/08/2018	J McKiernan	J Odum						
	7	Appoint external analytic expertise	Contract commenced			04/10/2018	ongoing	S Mahmud	S Mahmud						
	8	Appoint external medical expert	Contract commenced			17/09/2018	12 months	J Odum	J Odum						
	9	Review mortality quality improvement plan monthly at programme board	Trust Board monthly update against action plan			05/11/2018	monthly	AM Cannaby	AM Cannaby						
	10	Review Divisional participation and involvement in Mortality Governance	DMD influence at MRG, outputs of audits reported at QSI.			01/03/2019	31/07/2019	DMD's	J Odum						
	11	Review Directorate participation and involvement in Mortality Governance	MDT involvement in M&M/Governance meets, CQI outputs			01/03/2019	01/06/2019	DMD's	J Odum						
	12	Work with other organisations across the Black Country	Adopt best practice from other organisations			01/04/2019	01/09/2019	J McKiernan	J Odum						
A2	**City wide programme**														
	1	Draw together current interested groups to work to one strategy (Acute, Comm, PH, Compton)	MIG meeting established, with action plan			01/07/2018	ongoing	S Roberts	J Odum/ AM Cannaby						
	2	Pathways of EoL Care in and out of hospital reviewed	Redesign/agreement of pathways. Number of patients who die outside hospital			01/07/2018	28/02/2019	AM Cannaby/S Roberts	AM Cannaby						
	3	In reach to care/nursing homes by C/E team / Scope Nursing Home admissions	Review data and consider new care pathways for planned reduction in admissions from Nursing Homes. Data sent to CCG.			01/09/2018	31/12/2018	N Ballard/K Shaw/ S Hutchinson / S Roberts	J Odum/ AM Cannaby						
	4	City wide EoL Strategy developed with milestones. Monitor GSF roll out for inpatient and community populations. Scope EoL activity.	City wide strategy. Quarterly review of rollout plan to COG.			30/10/2018	ongoing	Chair EoL Group / Palliative Care Lead/ K Warren	AM Cannaby						
A3	**Policy/Processes**														
	1	Establish a pathway for death certification linked to mortality reviews	Implement Medical Examiner model to integrate with SJR process			01/08/2018	30/11/2018	A Viswanath	J Odum						
	2	Monitor compliance with OP87 (Learning from Deaths) SJR 1 & 2	Completion of SJR 1& 2reviews as per agreed standard			01/08/2018	30/11/2018	A Viswanath	J Odum/ AM Cannaby						
	3	Establish primary care mortality reviews for deaths within 30 days after hospital discharge	RWT, primary care and CCG to establish process and secure funding to undertake reviews			01/08/2018	31/12/2018	J McKiernan/S Roberts	J Odum/ AM Cannaby						
	4	Re-establish RWT End of Life Group, ToR and Action Plan	Action Plan agreed			31/08/2018	30/11/2018	AM Cannaby	AM Cannaby						
	5	To establish the process for including families/relatives in the mortality reviews	Bereavement Nurse in post			01/04/2019		Martina Morris	AM Cannaby						
	6	Monitor results of mortality reviews and compile learning outcomes. Triangulate outcomes of SJR's with lessons learned from clinical audits, mortality reviews and coroners' reports.	Directorates present learning outcomes after SJR reviews at the Mortality Review Group. Clinical audit programme reflects learning outcomes.			01/10/2018	ongoing	A Viswanath	J Odum/ AM Cannaby						
	7	Expansion of the numbers of trained nurses/AHPs to support completion of SJR 1 and 2	Recruitment of nurses to undertake SJRs			01/10/2018	15/12/2018	Martina Morris	AM Cannaby						
	8	Learning from SJR 2s to be shared with Divisions, Trust Board and CCG	Lessons shared			01/10/2018	ongoing	Divisional leads/Execs	J Odum/ AM Cannaby						
	9	Coding reflects full diagnosis of population of admitted patients to include definitive co-morbidities. Primary and secondary diagnoses.	Feedback on additional software; revised Coding Policy.			01/10/2018	30/11/2018	J Cotterell	J Odum/ K Stringer						
	10	Review analytical data provided by external experts to inform Directorates/Division/Coding and Executive teams. Data submitted to PWC.	Feedback of coding and HED data monthly			01/11/2018	ongoing	N Coates / Sultan Mahmud	S Mahmud						
	11	Implementation of NEWS2 track and trigger system and protocol for sepsis identified.	Identify and management of sepsis/deteriorating patient in line with national guidance.						J Odum						
	13	Review Governance feedback mechanisms across the Trust	Individuals and Directorates are aware of the results and actions from investigations/incidents			01/03/2019	31/07/2019	M Arthur	AM Cannaby						
	14	Develop IT platform (worksheets, data collection, directorate feedback)	Trends of Mortality reviews			01/01/2019		S Parton	K Stringer						
A4	**Quality/Safety of Care Mortality Reviews**														
	1	Reduce number of short term FCEs at 'front door'	Appropriate reduction of FCEs			01/01/2018	31/05/2018	J Cotterell	J Odum/ K Stringer						
	2	Alerting diagnosis baskets receive case note reviews via specialists within two months	Alerts returned within two months Report presented and discussed at MRG within agreed timescales			01/01/2018	ongoing	A Viswanath	J Odum						
	3	Implement care pathway audit against best practice standards as CQI in all directorates. Utilise reviews of alerting diagnosis outcomes to decide on "prospective" audits. MRG to liaise with Clinical Audit.	Directorates to agree and complete CQI audits			01/07/2018	01/06/2019	Medical Divisional leads / A Viswanath / S Cherukuri	J Odum						

	Objective		Activity	Expected Output/Outcome	Benefit	Milestone (Y/N)	Start Date	End Date	Owner	Exec Director Sponsor (TBC)	Status Date of Update 07/11/18	Status Date of Update 10/12/18	Status Date of Update 07/01/19	Status Date of Update 25/02/19	Status Date of Update 20/03/19	Status Date of Update 29/04/19
		4	PDSA community in reach	PDSA cycles to be tested			01/09/2018	01/03/2019	AM Cannaby	AM Cannaby						
		5	Monitor complaints, incident trends at Directorate, Divisional and Trust level via IQPR and TMC / Trust Board	Evidenced in meeting minutes			01/01/2018	ongoing	J Odum	J Odum						
		6	Develop a process of undertaking harm reviews 104 day+ Cancer waits	Harm reviews discussed with CCG and RWT			01/09/2018	31/10/2018	Cancer lead	AM Cannaby/ G Nuttall						
		7	Monitor compliance of VTE, sepsis, IP incidents, falls, pressure injuries via Directorate/ Division/Trust	To all Governance meetings			01/06/2018	ongoing	Divisional leads/Execs	J Odum/ AM Cannaby						
		8	Nursing mortality audits commencing with sepsis and pneumonia pathways	Completion and dissemination of audit results			10/09/2018	30/11/2018	Martina Morris	AM Cannaby						
		9	Quality Improvement strategy and agenda rolled out across the Trust with emphasis on embedding concept into daily activity	QI inititatives reported at QSI			01/04/2019		Simon Evans	M Sharon						
		10	Work with CEO of Sepsis Trust				01/03/2019			AM Cannaby						
		11	Use best practice pathway as standard to monitor SJR 2 against				01/03/2019		A Viswanath	J Odum						
A5	**Education**															
		1	Educational Package for coding to be developed for Medical teams	Educational Package developed and delivered Reduction in number of patients 'R' coded at 1st/2nd FCE (need to			01/01/2018	30/04/2018	J Cotterell	J Odum/ K Stringer						
		2	Educational Package for SJRs to be developed for Medical and Nursing teams	Educational Package developed and delivered			01/01/2018	01/12/2018	S Hutchinson	J Odum						
		3	Monitor and disseminate learning of SUIs through Governance structure	Evidence of improvements in care across pathways at quarterly Directorate/Divisional reviews			01/01/2018	ongoing	Divisional leads/Execs	J Odum/ AM Cannaby						
		4	Review content of and attendance at leadership training for staff including medical staff	Programme of leadership training, completion expectations			01/03/2019	ongoing	B McKaig	J Odum						
A6	**Workforce**															
		1	Implement Medical Examiner model	ME recruitment and training 5 day ME rota (recruit and commence)			01/07/2018	01/12/2018	A Viswanath	J Odum						
		2	Safe nurse staffing levels at ward and team level	Staffing reviews bi-annually by Board providing transparent reporting			01/01/2018	ongoing	AM Cannaby	AM Cannaby						
		3	Monitor vacancy rates and implement Trust recruitment strategy	Report progress on monthly basis to Governance structure as per the NSF plan			01/06/2018	01/03/2019	AM Cannaby	AM Cannaby						
		4	Ensure safe medical staffing levels and adherence to 7 day standards. Reduce Agency usage.	All patients seen daily by a consultant within 14 hours of admission and daily as standard			01/01/2018	ongoing	J Odum / Dev Singh	J Odum						
		5	Further expand deteriorating patient 'out reach team'	Business case 10th October recruitment Nov - Jan expansion of service Feb 2019			10/10/2018	31/03/20198	Divisional leads	J Odum/ AM Cannaby						
		6	Recruit senior nurses to sepsis programme	Nurses commence Jan 2019 and improvement programme devised with measurable actions December 2018			01/09/2018	31/01/2019	Sepsis lead/V Whatley	J Odum/ AM Cannaby						
		7	Palliative Care team business case and implementation plan	Business case 20th October recruitment Nov - Jan expansion of service Feb 2019			10/10/2018	31/03/20198	Divisional leads	AM Cannaby						
A7	**Communication Plan**															
		1	Trust Board mortality briefings monthly to include status of top 5 diagnostic groups	Minutes of Trust Board			01/07/2018	monthly	J Odum	J Odum						
		2	Senior Managers' Briefing	Update of actions monthly			01/09/2018	monthly	J Odum	J Odum						
		3	Trust Newsletter	Quarterly Newsletter update			30/11/2018	quarterly	S Evans	A Duffell						