The Royal Wolverhampton NHS Trust

Learning from Deaths Update Report
1 July 2019

Agenda Item No:10.1

The Royal Wolverhampton NHS
NHS Trust

Trust Board Report

Meeting Date:	1st July 2019
Title:	Learning from Deaths
Executive Summary:	The paper presents the Trust's most recent mortality data and the work being undertaken to scrutinise and act upon the potential causes for the outlier status of the SHMI indicator. The Trust SHMI remains at 121 (Feb 2018-Jan 2019). The Mortality Review Group has taken presentations from Learning Disabilities and Neonatal services this month. In both cases deaths are reviewed at a system wide level (e.g. Wolverhampton agencies and referring hospital). There are no concerns about the care of individual cases but particularly in the case of learning disabilities further work is required to improve the adherence to national guidance on communication, family engagement and recognition and completion of documentation. The Learning Disability team have been tasked with expanding on their current action plan. Further understanding of performance against clinical pathways (particularly in ED) is presented. ED is working alongside the CQI team to identify the reasons for variability with the intention to trial change via PDSA methodology. A dashboard of metrics has been developed which will be used to monitor progress. In response to the many review of case notes where discrepancies in actual diagnosis compared to that coded have been evident the Trust has set up a series of education opportunities with coders and clinicians with the aim of improving the coding accuracy. This month 2 sessions have been held between the coding department and external support from PWC. Three times weekly meetings between AMU clinicians and coders have commenced to review specific case notes. Trust wide education sessions have been advertised for clinicians, specialist nurses and AHPs. Mortality Reviewers have started in post and we therefore expect all outstanding SJR2 reviews to be completed in the coming month.
Action Requested:	Receive and note
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 June 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 SHMI data was published on 20th June 2019. The SHMI remains at 121 (period of reporting Feb 2018-Jan 2019).

MORTALITY (CASE NOTE) REVIEW OF CLINICAL CARE

The Trust has currently no outstanding requests for review from CQC. However MRG has requested the appropriate services to review Malignant Neoplasm without specification of site and COPD. The outcomes of these reviews are awaited.

Both neonatal deaths and deaths of patients with learning disabilities are investigated through a wider network outside of the internal Trust's system. Results from both of these services were brought to the Mortality Review Group in June 2019.

Learning Disabilities Mortalities Review (LeDeR)

The lead nurse for Learning Disabilities has this month presented a report on the key messages from the LeDeR 3rd National Annual Review. The report covers the period of 1st July to 31st December 2018.

The LeDeR report identified the disparity in the age of death for people with Learning Disabilities (LD) compared to the general population, average age of death is 59 years. 62% of people with LD died in hospital compared to 46% for the general population.

The national report identified that the main cause of death for people with LD was from respiratory disease and that in some instances DNACPR's where being completed inappropriately using 'learning disability' or 'Downs Syndrome' as rationale not to attempt resuscitation.

The full report can be found at http://www.bristol.ac.uk/sps/leder/resources/annual-reports/

The meeting was informed that from the list of recommendations, 12 were relevant to this Trust including:

- NHSI are investing, with the CCG's into improving the timeliness of reviews. Wolverhampton CCG have confirmed that there are currently no outstanding reviews. .
- Standardising the terminology between health, education and social care – so that the term "learning disabilities" is commonly used.
- Promote the "Ask, Do, Listen" – one in ten families stated that they were never asked or felt they were not listened to in relation to their relatives care.
- The report highlighted a short fall in the adherence to the Statutory Guidance Needs and Disability Code of Practice and this needs to be addressed. Work is on-going within the Trust to address this.
- CQC have been asked to identify issues in regards to DNACPR and raise this with the providers from their recommendations.

The recommendations from the report will be managed through the National Guidance Process and incorporated into a local plan.

Local cases

Since July 2018, 9 LeDeR case note reviews have been completed in Wolverhampton and 6 are currently in progress.

The main themes that have come from the reviews undertaken are:

- Mental Capacity Assessments not being completed consistently.
- Best interest and decision making guidance not always being followed
- Deprivation of Liberty Safeguards (DoLS) not always being identified or applied for
- Annual health checks not being completed consistently
- Failure to discuss DNACPR's with relatives, often because of difficulty of contacting the next of kin when the patient is resident in a care setting.

Of note the number of deaths of patients with learning disabilities, reported in Wolverhampton is approximately 40% less than the national average and has been for some years. The main causes of death in Wolverhampton has been identified as aspiration pneumonia, epilepsy and sepsis.

In light of the themes that have arisen from the case note reviews the lead nurse for Learning Disability will draw together an action plan for presentation and reporting to the Mortality Review Group.

Neonatal Mortality Q3/4 2018-19

Local Process

Neonatal mortality is reviewed internally by the Neonatal team at monthly review meeting which has external and public health input and also with Obstetrics in the monthly perinatal mortality meeting. Together the teams complete the national online Perinatal Mortality Review Tool (PMRT) at a separate meeting with extra input from obstetrics and neonatal services referring units where the mother or baby was transferred from. The review results and action plans are shared with the Staffordshire, Shropshire and Black Country Newborn Network for dissemination to other units in an anonymised fashion.

Local Cases

There were eleven neonatal deaths in Q3 and 4 2018/19. Five of these babies were less than 24 weeks and four had congenital anomalies including one on a palliative care pathway and would therefore be excluded from the national MBRRACE report. The other deaths were one baby born at 25 weeks and one at 27 weeks. Eight were early neonatal deaths (within 1st 28 days of life), and three late neonatal deaths including one at Acorns Hospice.

The primary causes of death were recorded as pulmonary hypoplasia (renal dysgenesis) (2), pulmonary immaturity (3), necrotising enterocolitis (1), pulmonary interstitial emphysema (2), cardiomyopathy (1) , acute renal failure (1) and lissencephaly (1).

One baby was referred to the coroner and a contributory factor to death of aspergillus infection found (of note baby was already on antifungal treatment).Six of the babies were booked and born at New Cross, one was an in-utero transfer and four were ex-utero transfers.

Lessons learnt:

9 of the babies received National Patient Safety Agency (NPSA) code 0, 2 received NPSA code 1.

The 2 NPSA 1's related to poor documentation. This reduction in quality of documentation coincided with the Trusts move to the use of Badger EPR. Further teaching sessions on its use and internal checking of data quality has been started

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:	Jan19	Feb19	Mar 19	Apr 19	May 19
Total Number of Deaths (taken from PAS)	208	161	158	158	149
No. of Deaths scrutinised via ME	75	85	103	98	97
No. of Deaths identified for SJR1 Review – that meet the mandatory criteria	36	26	22	22	Data not yet known
No. of Deaths identified for SJR1 Review - via ME Assessment	4	5	1	10	15
No. of SJR1s Reviewed	23	17	9	3	0
No. of Additional SJR1s Reviewed (Directorate choice)	27	14	7	1	Data not yet known
No of Deaths identified for SJR2 review	3	1	2	1	Data not yet known
No of SJR2 reviewed		0	0	0	0

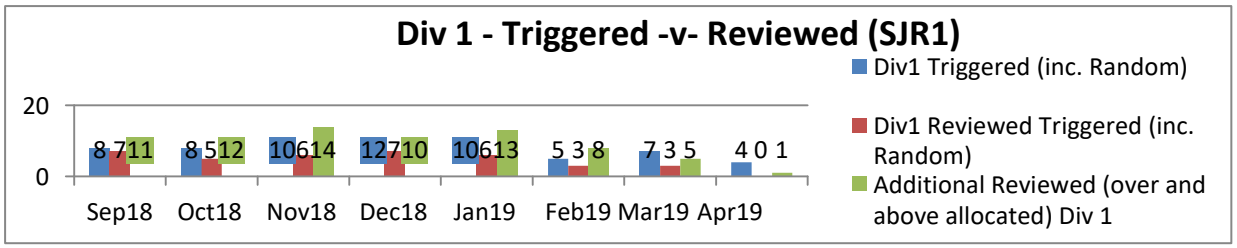
Data Caveats - Scrutiny of deaths - as at 3rd June 2019:

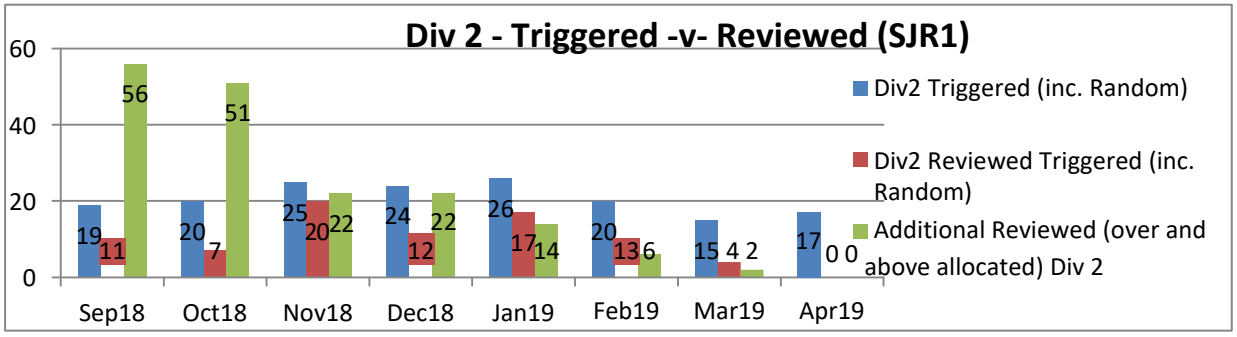
Data is based on 'date of death'

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. The Trust has recruited 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. The Mortality Reviewers took up post on June 17th 2019.

The Divisional position follows;



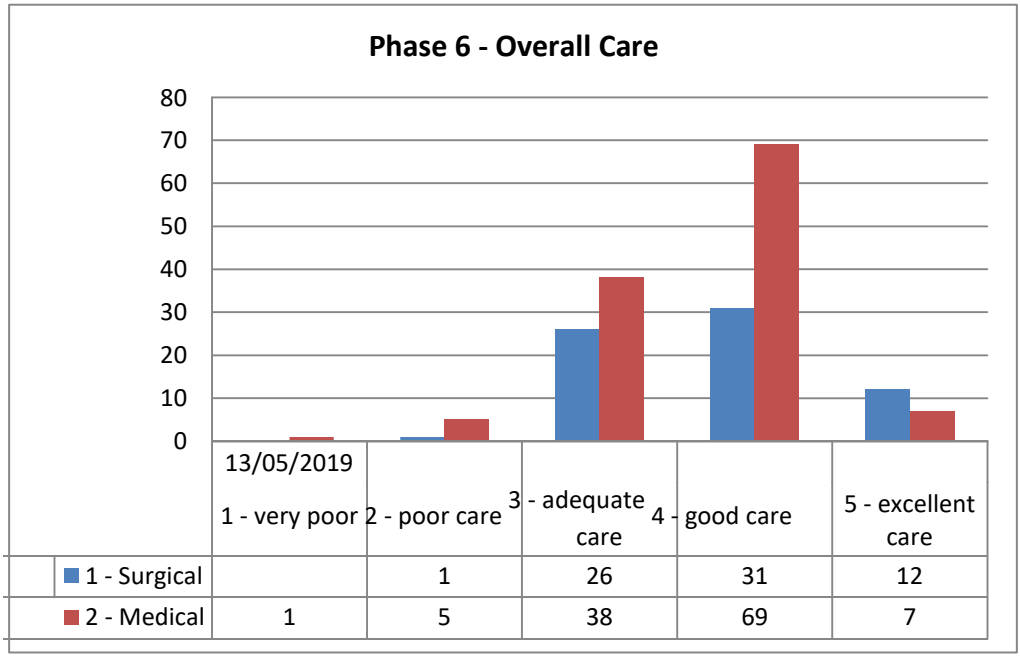


*Note that 10% of cases are also selected for review in addition to those that trigger according to Trust policy.

There have been 0 hospital deaths in Division 3 in this period that are not part of the Wolverhampton wide scrutiny process i.e. 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, 1st March 2019 to 30th April 2019 using the 6 Phase criteria.



13/05/2019	1 - very poor	2 - poor care	3 - adequate care	4 - good care	5 - excellent care
1 - Surgical		1	26	31	12
2 - Medical	1	5	38	69	7

Data at 5th June 2019

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.

7 patient notes have been escalated to SJR2 for the period Jan to April 2019.

All of these cases for SJR2 review are outstanding. Mortality Reviewers are now in post and are tasked with review of these cases as a matter of expediency.

QUALITY IMPROVEMENT: CLINICAL PATHWAY REVIEW

There are a number of high volume diagnostic groups where the Trust has seen SHMI alert within the last 2 years. The Trust is therefore concentrating its efforts on reviewing compliance against best practice and focusing quality improvement initiatives where a requirement for change is identifies.

SEPSIS

The performance of the Trust, including ED, against the sepsis pathway has previously been reported and is subject to continued review. ED have now begun a programme of work alongside the Continuous Quality Improvement team. The teams are concentrating on understanding the reasons for variability (in the first instance on antibiotic delivery), including formal process mapping to facilitate an understanding of the areas required for sustained change. These changes will then be trialled by a PDSA approach.. A dashboard of metrics has been developed to monitor impact. Additionally learning from other

organisations is being explored including meeting with the Addenbrookes Quality team who are working on sepsis, and with The Black Country Alliance.

PNEUMONIA

An audit in ED has been concluded and presented. From the audit, ED had good compliance against care delivery where patients also triggered sepsis. However work is required to improve care for those who do not. Highlights from the audit include

- Total 93% (27/29) had CXR taken (52% of CXR were taken within 2 hours – RWT guidelines, 89% of CXR within 4 hours of attendance – NICE & British Thoracic Society guidelines)
- 100% of patients had saturation levels assessed as part of nursing triage/observations, and treated accordingly.
    - 0% had oxygen therapy prescribed on a treatment chart
    - 10.5% of patients had target saturations documented in their medical record
- CURB65 score was documented in 3.5% of notes, however these instances were incomplete/incorrect
- 100% of IV antibiotics were given within 4hrs of attendance (55% of IV antibiotics were given in the first hour of attendance)
- Only 20% of patients had ABG or VBG followed by ABG investigations
- 57% of patients were given intravenous fluids
- 93% of patients presenting with raised temperature (>38.3ºC) had blood cultures taken

Recommendations

- Consideration of developing a specific Pneumonia pathway/bundle for ED, building on the care bundle already in use by Respiratory nurses and linked with the development of ED pneumonia pathway documentation. .

- Exploration of the introduction of a change to the requesting pathway for x-rays to enable fast track within the pneumonia pathway.

- Consideration of the introduction of an ED suite of tests to incorporate the top 80% of presentations due to potential infection, based around pathology and radiological investigations.

- Consideration of diagnostic bias factors which could influence treatment alignment to known pre-existing respiratory conditions irrespective of any other infective processes at presentation.

- Review of current pathway documents in use to assess if 'fit for purpose'

As with the Sepsis work the methodology used to implement change will be linked with a CQI programme of work.

ACCURACY OF CODING

Clinical Coding Update

Three times weekly meetings between coders and AMU clinicians commenced 8th May 2019. This piece of work is for patients who have been admitted and discharged from AMU and who do not go onto a base ward, and concentrate on targeting five diagnostic groups which have historically been SHMI alerting. To date there has been 58 reviews with more being undertaken. Of the 58 reviews there have been 17 where the primary diagnosis has been amended. At least 50% of the queries are around the LRTI diagnostic group. The work will continue to be monitored and in particular to understand how changes can be made to improve prospective coding behaviour.

Four SHMI/Coding education sessions have been arranged for July for all medical staff, specialist nurses and AHPs.

END OF LIFE CARE

The number of patients who die in hospital (rather than in their usual place of residency) in Wolverhampton is higher than the national average. A number of initiatives are underway to ensure that end of life care is appropriate and sensitive to patient and family needs.

Key areas of work include:

- A quality improvement project (QIP) is in the planning stage with the Renal Directorate, Palliate Care Team and CQI leads, to develop excellence in an inpatient environment. A toolkit will be developed to roll out to other areas based on the learning from this.
- An analysis of complaints summaries relating to the end of life has been undertaking showing that communication is the key areas for complaints but a deeper dive is planned.
- An education session for nurse leaders to launch actions and call to action will be held on 24th July.
- Additional nurse training is being sought to maximise the impact of Fast Track (discharge to die).
- The Community End of Life model has been developed in collaboration with various agencies.
- End of Life has been the focus of this year's dignity day event.
- Several research topics are in discussion/development around how we survey bereavement and analyse complaints thematically.
- In conjunction with CCG, a review of attendances and admission at RWT from nursing homes is underway in an effort to contribute to the understanding of the drivers for request to transfer.

Quality Improvement Plan 1 (Mortality)

Version 20
Updated 31st May 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 of Update 07/01/19	Date	Status Date of Update 25/02/19	Status Date of Update 20/03/19	Status Date of Update 29/04/19	Status Date of Update 31/05/19
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								
	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								

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		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	Mortality Reviewers will have access to standards for key diagnostic pathways			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 stipulate a %)			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								