The Royal Wolverhampton NHS Trust

Learning from Deaths Update Report

5 August 2019

Agenda Item No: 6.1

The Royal Wolverhampton NHS
NHS Trust

Trust Board Report

Meeting Date:	5th August 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 national SHMI dataset shows the most recent score for RWT of 119 (March 2018- Feb 2019) a slight improvement from recent scores of 121. The Trust remains an outlier. The data set will be monitored for a consistent change in trend. An improvement in sepsis performance against clinical pathways 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. The Trust is beginning to see improvement in coding depth in the significant area of Charlson Co morbidity scores. 3 education sessions with senior clinical staff have been delivered with a 4th planned for the end of July. 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 has shown a small improvement this month.
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 Senility Coma, stupor and brain damage Malignant neoplasm without specification of site Reviews have been conducted, reported internally and where requested to CQC

	The CQC has asked for a review to be conducted on COPD. Review is underway and will be submitted Sept 4th 2019
Author + Contact Details:	Dr Jonathan Odum – Medical Director 01902 695958 E-mail: jonathan.odum@nhs.net
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 July 2019

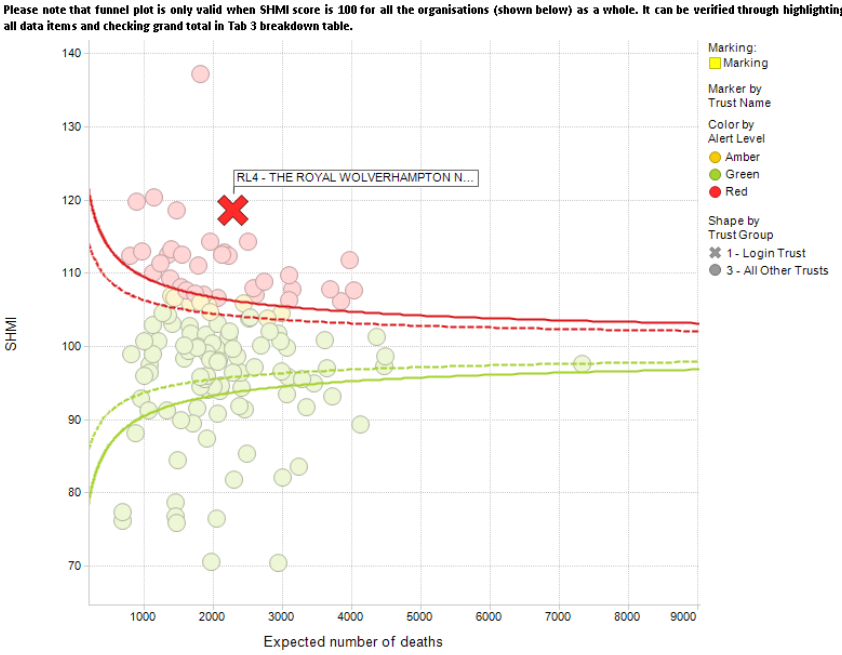
This report describes the most recent Trust mortality data and a summary of the possible drivers for the outlier status of the Summary Hospital-level Mortality Indicator (SHMI). It also provides detail on how areas for review and potential action are being identified, the work that has been undertaken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

SHMI, CRUDE MORTALITY and ALERTING DIAGNOSIS

SHMI

In the latest publication (18th July 2019) from NHS Digital, RWT SHMI (March 2018 to February 2019) was 119 . This is a slight improvement compared to previous published SHMI of 121 (February 2018 to January 2019). RWT is still an outlier in comparison to peers.

Fig 1 SHMI RWT (March 2018 to February 2019)

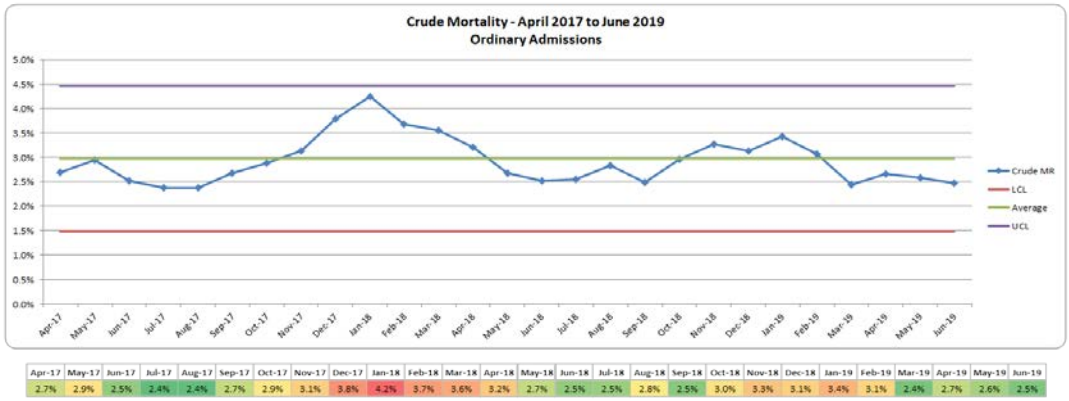


SHMI is a ratio of observed to expected death and it is likely that a change in these factors has contributed to the reduction. We will continue to monitor for a consistent trend.

Crude Mortality

The number of deaths and crude mortality represents inpatient mortality only (ordinary admissions including still births) extracted from internal data, i.e. it does not include the 25% of deaths that occur after discharge and within 30days.

Fig 2 Crude Mortality April 2017 to June 2019



Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
2.7%	2.9%	2.5%	2.4%	2.4%	2.7%	2.9%	3.1%	3.8%	4.2%	3.7%	3.6%	3.2%	2.7%	2.5%	2.5%	2.8%	2.5%	3.0%	3.3%	3.1%	3.4%	3.1%	2.4%	2.7%	2.6%	2.5%

Table 1 Crude Mortality

	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%

For the period Q1, (April - June 2019), there were a total of 454 deaths, and a crude mortality of 2.6%.

Alerting Diagnosis

The following diagnoses groups have a higher than expected estimated SHMI for March 2018 –Feb 2019.

Table 2

Diagnostic Group	SHMI	Expected Deaths	Observed Deaths (in hospital or with 30days of discharge)	Number of Discharges
158- Chronic Renal Failure	385.47	5.45	21	91
123- Influenza	284.82	9.48	27	283
85-Coma;stupor; and brain damage	205.78	9.23	19	36
43-Malignant neoplasm without specification of site	174.39	19.5	34	70
68-Senility and organic mental disorders	146.62	51.15	75	447

Coma; stupor and brain damage has previously alerted but not within the last 18 months. In line with MRG practice this diagnosis will be investigated including coding review, trends analysis and clinical case review.

The other four diagnostic groups have previously been investigated and where requested the results have been forwarded to CQC. The results have previously been shared with the Trust Board.

SHMI Diagnostic baskets, Respiratory Distress syndrome and Chronic Ulcer of skin, are no longer alerting.

Request from CQC

The Trust has received a request from the CQC for investigation of COPD cases (Feb to Dec 2018) in response to a SHMI outlier alert. The Mortality Review Group (MRG) had pre-empted this request and have already begun an internal data quality investigation, trends analysis and case note review. The Trust has also commissioned Price Waterhouse Cooper to undertake an independent trends analysis review. The Trust response will be ready for 4th September and will be reported to Trust Board.

MORTALITY (CASE NOTE) REVIEW OF CLINICAL CARE

Case Note Review of Deaths

The Trust continues to review the case notes of patients following death against a set criteria and methodology (Structured Judgement review: SJR) as outlined in OP87 Learning from Death Policy. 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.

Table 3 Cases allocated and reviewed

	Scrutiny of Deaths – Data:	Data Source/Caveats	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
1	Total Number of Deaths (admissions)	PAS Data	208	163	150	160	151	143
2	Total Number of Deaths (ED attendance)	MSS Data	27	16	16	18	26	14
	Total Number of Deaths (Row 1+2)		**235**	**179**	**166**	**178**	**177**	**157**
3	No. of Deaths referred to Coroner (Total figure)	General Office Data				70	85	
4	No. of Deaths referred to Coroner (by ME)	ME SharePoint			3	29	23	
5	ME assessments completed	ME SharePoint figure may include SJR1 reviews undertaken	69	83	97	98	106	98
7	No. of Child Deaths for Child Death Review		2	2	4	3	4	3
8	No. of Deaths identified for SJR1 Review (incl in row 5 (M	ME SharePoint figure may be in addition to mandatory criteria identified (col 9)	4	4	2	10	14	9
9	Mandatory Criteria identified	Access Query (PAS Risk Flags)	35	27	22	26	26	26
10	**Total SJR1s Identified (rows 8+9)**		**39**	**31**	**24**	**36**	**40**	**35**
11	Directorate completed SJR1s	SJR Repository Figure may include ME review undertaken	24	19	12	11	6	0
12	**Directorate unreviewed SJR1s (row 9-row 11)**		***11***	***8***	***10***	***15***	***19***	***26***
13	Additional SJR1s completed by Directorates (i.e. over and above Mandated and ME Assessment)	Over & above Mandated/ME Assessed Access Query (PAS/ME/SJR Repository)	27	14	10	4	0	0
14	**ases Unreviewed by ME/SJR1 (Data source Month by Specialty Access Queries)**		**122**	**76**	**54**	**66**	**65**	**57**
15	No. of Deaths identified for SJR2 Review –	SJR Repository – i.e. Overall Care = 1-Very Poor/2-Poor Care	3	1	2	1	0	
16	No. of SJR2s Reviewed (as per SharePoint) (cumulative	SJR2 Repository	51	51	51	51	51	
17	No. of SJR2s Outstanding (cumulative)	SJR2 Repository	42	43	45	46	46	
18	No. of Deaths identified for RCA (following SJR2)	SJR2 Repository	2					

MRG has been aware of the poor rate of completion of review of SJRs and has therefore changed the process so that newly appointed Mortality Reviewers (July 2019) will be responsible for completion. Hence there will be an improvement in completion rate from this date.

The Divisional position follows;

Fig 3 Division 1 Identification and completion of SJR1

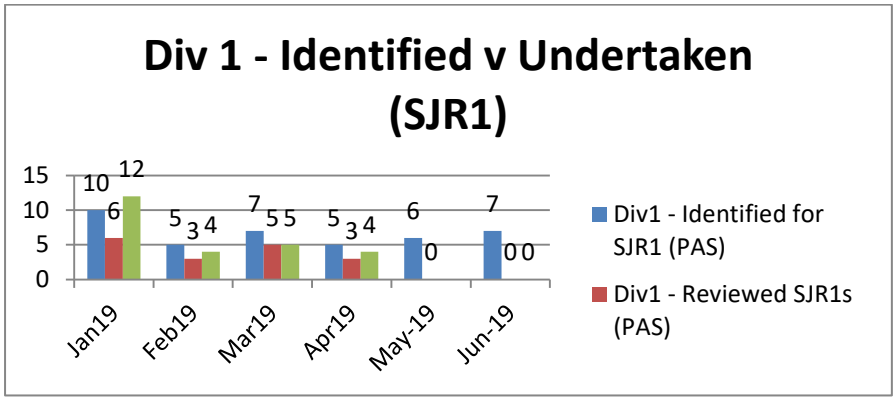
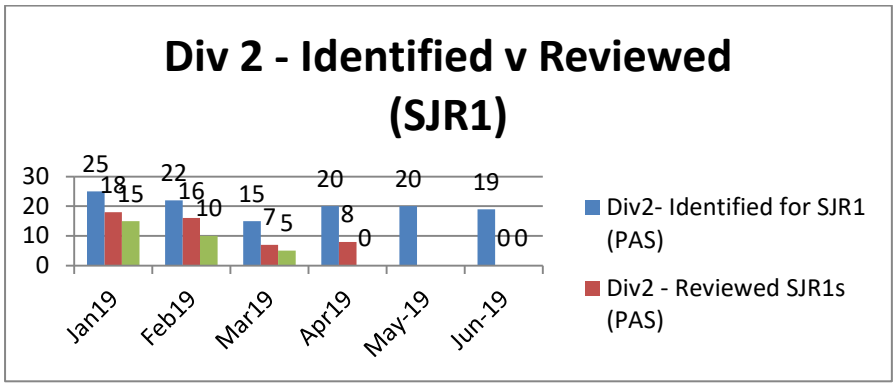


Fig 4 Division 2 Identification and completion of SJR2



Div 3

All Division 3 deaths (Paediatrics and Neonatal) are reviewed via system wide mechanisms i.e. MBRACE and CDOP. The outcomes of these reviews are reported quarterly to MRG, the last report was included in June 2019.

Outcomes of SJR 1

Within the period April to May 30th 2019, an assessment of overall poor care at SJR1 was recorded in one case out of 32 reviews. The case has been referred for further review via SJR2. Excellent overall care was recorded in 2 cases out of 32. Feedback has been provided to the Directorates involved.

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 identified.

SEPSIS

The performance of the Trust, including ED, against the sepsis pathway has previously been reported and is subject to continued review. There is currently a programme of work using CQI methodology being undertaken in ED.

Results for June 2019: see Appendix 1

- % screened has been above the ED average for 7 months – suggestive of a statistically significant improvement aligned to initiatives around education and red phone doctor
- % Antibiotics within 1 hour – last month (June) achieved 90% target for the first time, again performance has been on upward trend with 7 months above average – statistically significant improvement

Additional actions:

- A dashboard has been developed and is shared across the ED team on a monthly basis.
- First process mapping exercise completed, primarily concentrating on patients triaged through RAT or, when through waiting room, directly admitted into RAT or a cubicle.
- A number of problem areas have been identified and potential solutions; Prioritisation of solution implementation under development and will be based on impact on patient care, ease of change and departmental working practice. Implementation will be on a phased basis so as to enable a study impact of each implemented change.
- Antibiotic regime for PGDs agreed with Microbiology and in process of being written – implementation date yet to be set.
- Management/treatment pack for Neutropenic patients under development
- Review of benefits and potential adverse consequences of pre-mixed antibiotics underway in conjunction with pharmacy.

Other CQI projects

The CQI team are also actively involved in improvement strategies related to the pneumonia pathway in ED. Activities with Acute Kidney Injury and End of life care are being explored.

NURSING QUALITY REVIEW

The nursing team are reviewing nursing related practice, designed to add to the knowledge of the care provided to patients who die in the hospital. Their report presented to Mortality Review Group in July followed the fourth audit cycle, where 144 patients who died from pneumonia or sepsis was a primary cause of death. A locally developed audit tool has been created, with nursing students undertaking a case note review, similar to a condensed Structured Judgement Review. The results show that there are positive nursing processes such as tissue viability assessments; however there are themes open to improvement. These themes can be grouped into wider cohorts', nutrition and hydration as a primary focus. The data has been presented to Nutrition Steering group and Deteriorating patient groups who will support the nursing teams to identify and implement clinical practice developments. The fifth audit cycle will be undertaken in July 2019.

ACCURACY OF CODING

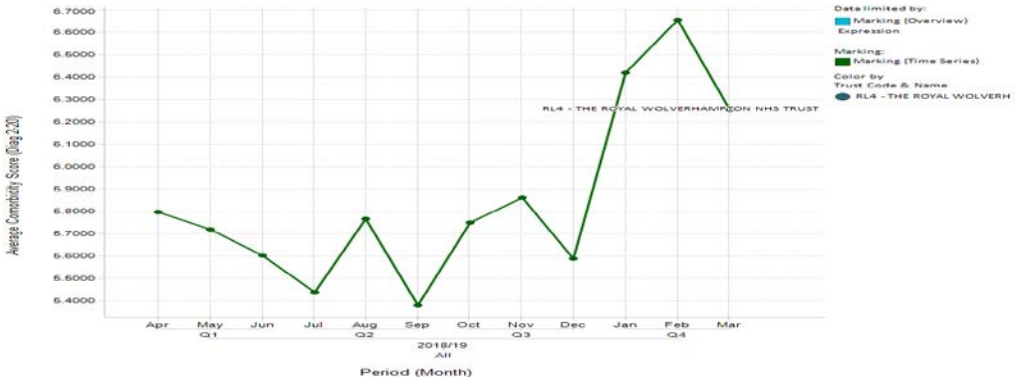
Clinical Coding Update

Accuracy of clinical coding is vital so that the expected number of deaths reported is reflective of the case mix and to ensure that the occurring deaths are allocated to the correct SHMI diagnostic basket.

A number of initiatives have been implemented in an effort to improve clinical documentation and subsequent coding quality. These include the adoption of an amended coding policy in January 2019 and from that time support from Price Waterhouse Cooper by providing the intelligence to identify potential cases for clinical and coding review allowing where appropriate subsequent amendment in documentation of case notes and in coding.

There has been a subsequent increase in the average Comorbidity score and this is demonstrated below.

Fig 5 Average Co Morbidity Score/patient Royal Wolverhampton NHS Trust



Education for clinicians

This change in coding practice has been supplemented with education sessions for Coding and clinical teams. Three SHMI/Coding education sessions have been delivered in July (41 attendees) with a further 2 planned. The coding team continue to meet with the AMU team 3 times each week to review individual cases and provide 1-1 coaching.

An awareness raising meeting is due to be held between all Clinical directors, the chair of the MRG and the medical director

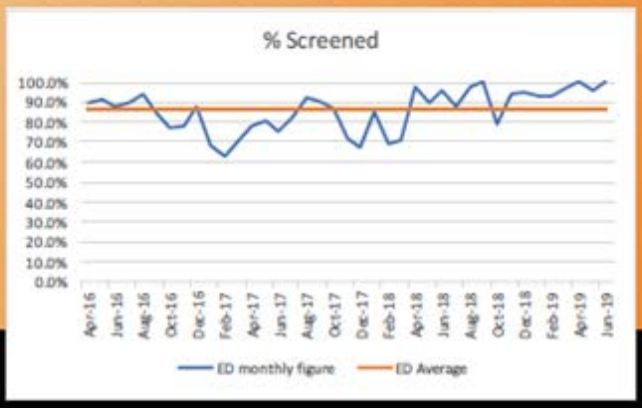
The MRG chair has started a systematic programme of conversation with each of the directorates to understand how mortality learning is taken forward in each area. When completed good practice will be shared and support provided for those directorates who require it.

APPENDIX 1

ED SEPSIS DASHBOARD - July 2019

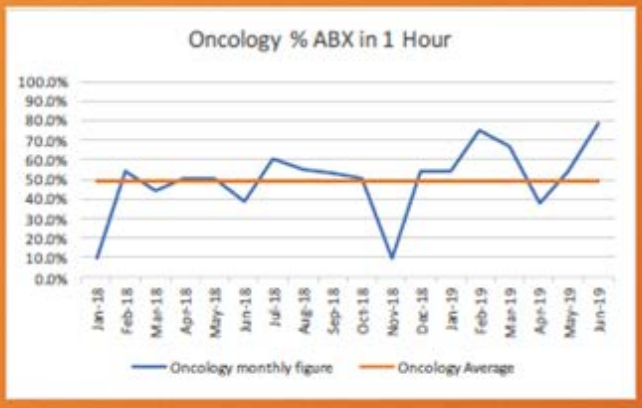
FANTASTIC PERFORMANCE!

Please email emma.jenkinson1@nhs.net with any comments or queries.



These are 'run charts': they show our monthly performance, as well as our average performance overall. 7 points above the average is suggestive of a significant improvement in performance: we have achieved this!

Last month, for the first time, we achieved our 90% target with respect to antibiotic administration within an hour! This is fantastic



We also performed much better last month with the oncology (neutropenic) patients but we still have a lot of work to do with this patient group: the ED sepsis nursing team are working on a new pathway/treatment pack.

What next?

- Process mapping
- Antibiotic PGDs
- Pre-mixed ABx
- Neutropenia pack

Quality Improvement Plan 1 (Mortality)

Version 21
Updated 26.6.19

	Objective	Activity	Expected Output/Outcome	Start Date	End Date	Owner	Exec Director Sponsor (TBC)	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	Status Date of Update 31/05/19	Status Date of Update 26/06/19
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. WM group have agreed in principle to set up a sytem of case note peer review	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. Further email requesting progress sent to Y Higgins 25.06.19	RWT, primary care and CCG to establish process and secure funding to undertake reviews	01/08/2018	31/12/2018	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						

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	3	Implement care pathway audit against best practice standards as CQI in specific directorates. Utilise reviews of alerting diagnosis outcomes to decide on "prospective" CQI programme MRG to liaise with CQI	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						
	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	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	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						