The Royal Wolverhampton NHS Trust

# Learning from Deaths
# 6 November 2019

Agenda Item No: 9.3

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS
NHS Trust

# Trust Board Report

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| **Meeting Date:** | November 6th 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.<br><br>The Trust crude mortality shows a decreasing trend.<br><br>The national SHMI dataset shows the most recent score for RWT of 1.15, June 2018 to May 2019. This is a maintained position following 3 months of an improved SHMI score.<br><br>The Trust continues to work with colleagues to identify cases where documentation does not fully represent the Charlson comorbidity scores or the risk of death and this work has had an impact on the expected deaths reported.<br><br>Mortality reviewers have now been in post for 2 months and the rate of SJR completion is showing an improvement.<br><br>Clinical groups reported their gap analysis and improvement plans to CQC on 19th September. These action plans will continue to be reviewed through the Mortality Governance processes |
| **Action Requested:** | Receive and note |
| **For the attention of the Board** | To note the SHMI which has maintained its position of 1.15 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.<br>Work also continues to address coding & data capture with respect to accuracy and completeness prior to submission of data. |

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| **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 or high excess deaths remain :<br><br>Influenza<br>Chronic renal failure<br>Respiratory Distress Syndrome<br>Malignant neoplasm without specification of site<br>Acute cerebrovascular disease<br>Pneumonia<br>Chronic obstructive pulmonary disease and bronchiectasis<br>Septicaemia |

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|---|---|
| | Reviews have been conducted, reported internally and where requested to CQC |
| **Author + Contact Details:** | Jane McKiernan janemckiernan@nhs.net<br>on behalf of Dr Jonathan Odum – Medical Director<br>01902 695958 E-mail: jonathan.odum@nhs.net |
| **Links to Trust Strategic Objectives** | 1. Create a culture of compassion, safety and quality<br>2. Proactively seek opportunities to develop our services<br>3. To have an effective and well integrated local health and care system that operates efficiently<br>6. Be in the top 25% of all key performance indicators |
| **Resource Implications:** | Revenue:<br>Capital:<br>Workforce:<br>Funding Source: N/A |
| **CQC Domains** | **Safe:** patients, staff and the public are protected from abuse and avoidable harm.<br>**Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence.<br>**Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect.<br>**Responsive:** services are organised so that they meet people's needs.<br>**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:<br>• Equality of treatment and access to services<br>• High standards of excellence and professionalism<br>• Service user preferences<br>• Cross community working<br>• Best Value<br>• Accountability through local influence and scrutiny |

**Learning from Deaths: Update of monthly activity October 2019**

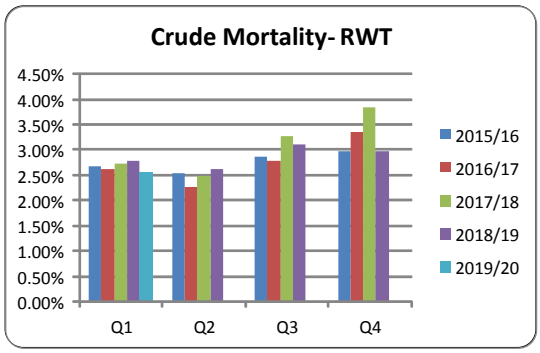
**Update on Standardised Mortality Rates (SMRs) and Inpatient data relevant to these calculations**

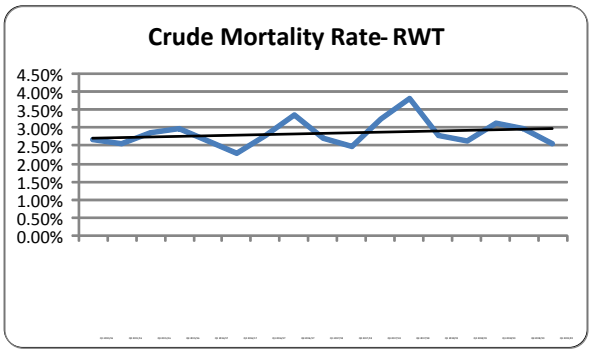
1. **Crude mortality**

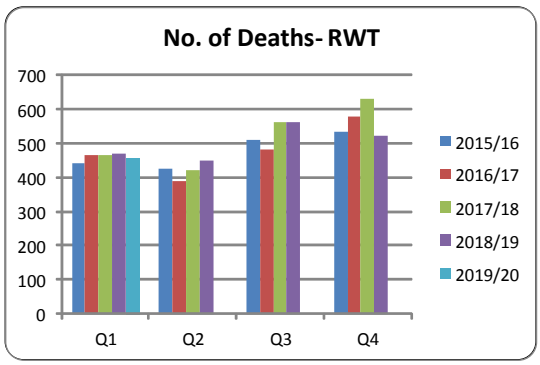
The number of deaths and crude mortality represent inpatient mortality only (ordinary admissions including still births) extracted from internal data.

For the period Q1 2019/20, the inpatient crude mortality rate was 2.57%. Year to date (April to August 2019) the crude mortality is 2.49%.

These figures continue to represent a reduction in comparison to similar time periods in 2017/18 and 2018/19.



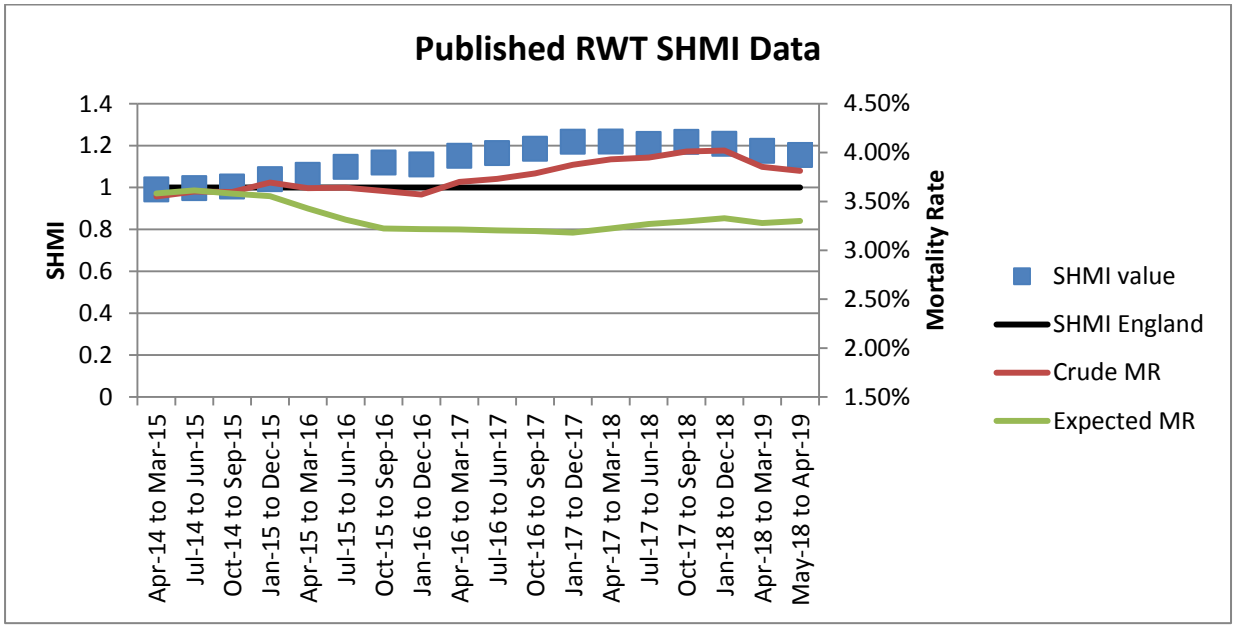

| Period | No. of Ordinary Discharges | No. of Inpatient Deaths | Crude Mortality |
|---|---|---|---|
| 2015/16 | 68888 | 1886 | 2.74% |
| 2016/17 | 69538 | 1898 | 2.73% |
| 2017/18 | 67758 | 2036 | 3.00% |
| 2018/19 | 69558 | 1986 | 2.86% |
| 2019/20 | 29575 | 737 | 2.49% |

2. **Standardised Hospital Mortality Index: SHMI (inpatient deaths plus deaths 30 days after discharge)**

The most recent published SHMI value, Oct 10th 2019 for the period June 2018 – May 2019 was 1.15.

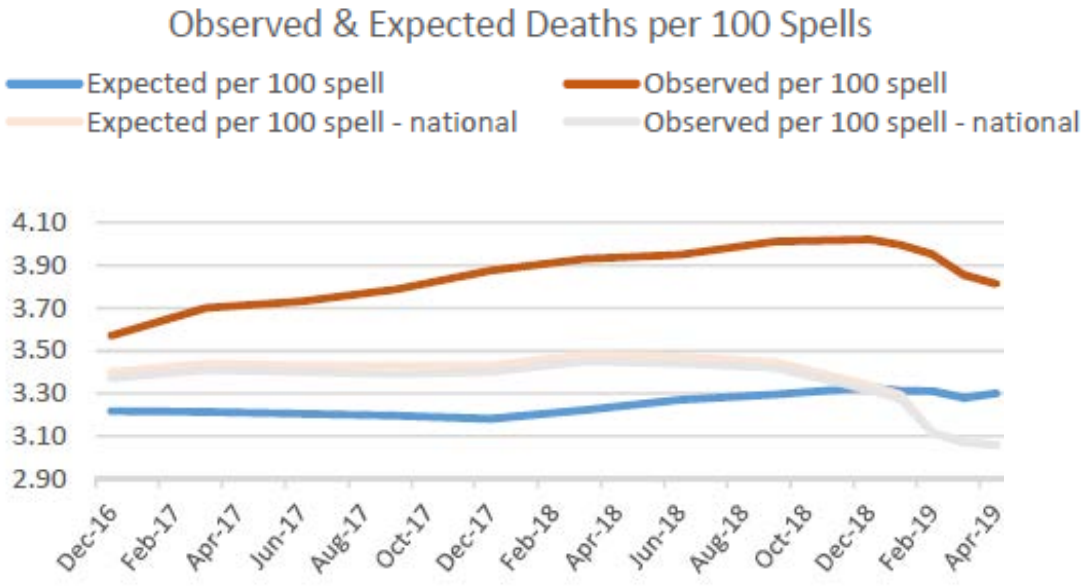
| Time period | SHMI Value * | SHMI Crude Mortality % |
|---|---|---|
| Jan 2018-Dec 2018 | 1.21 | 4.02 |
| Feb 2018 –Jan 2019 | 1.21 | 3.99 |
| March 2018 –Feb 2019 | 1.19 | 3.94 |
| April 2018 –March 2019 | 1.17 | 3.85 |
| May 2018- April 2019 | 1.15 | 3.81 |
| June 2018- May 2019 | 1.15 | 3.80 |

*NHS DIGITAL Oct 10th 2019




SHMI is derived from the ratio between observed and expected deaths. Changes in either or both of these 2 values will result in a change in the SHMI.

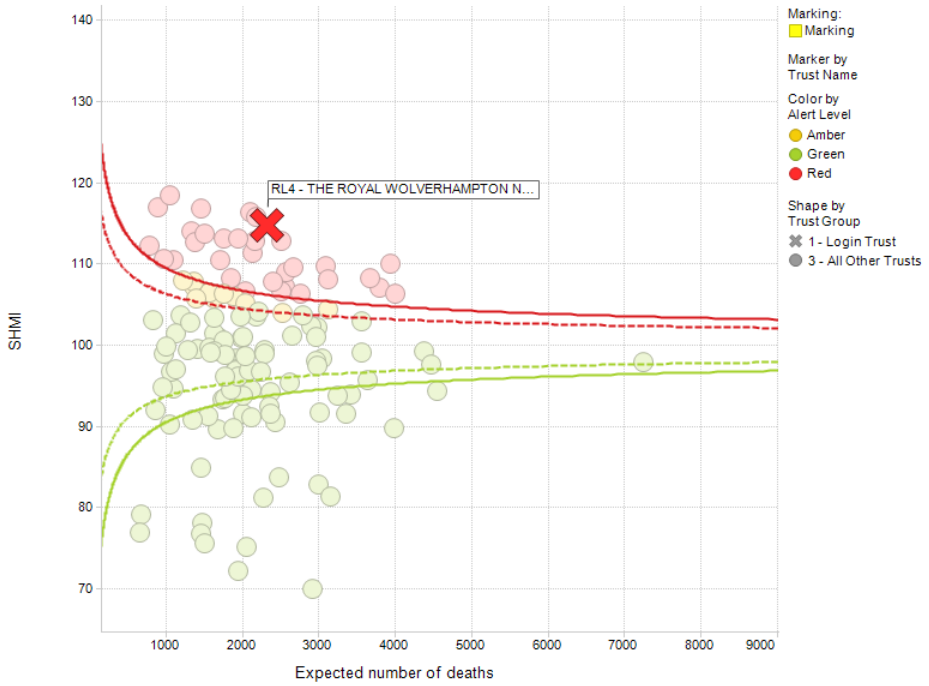
The figure below shows that the Trust's expected deaths has increased, against the national trend. The Trust's observed deaths have decreased as has the national trend.




The Trust continues to work with PWC to identify those cases where documentation may not represent fully the Charlson comorbidity scores or the risk of death. This together with changes in processes relating to documentation and coding will have contributed to the increase in expected deaths reported.

The Trust is ranked 125 of 130 Trusts across the country and remains an outlier.

**Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.**

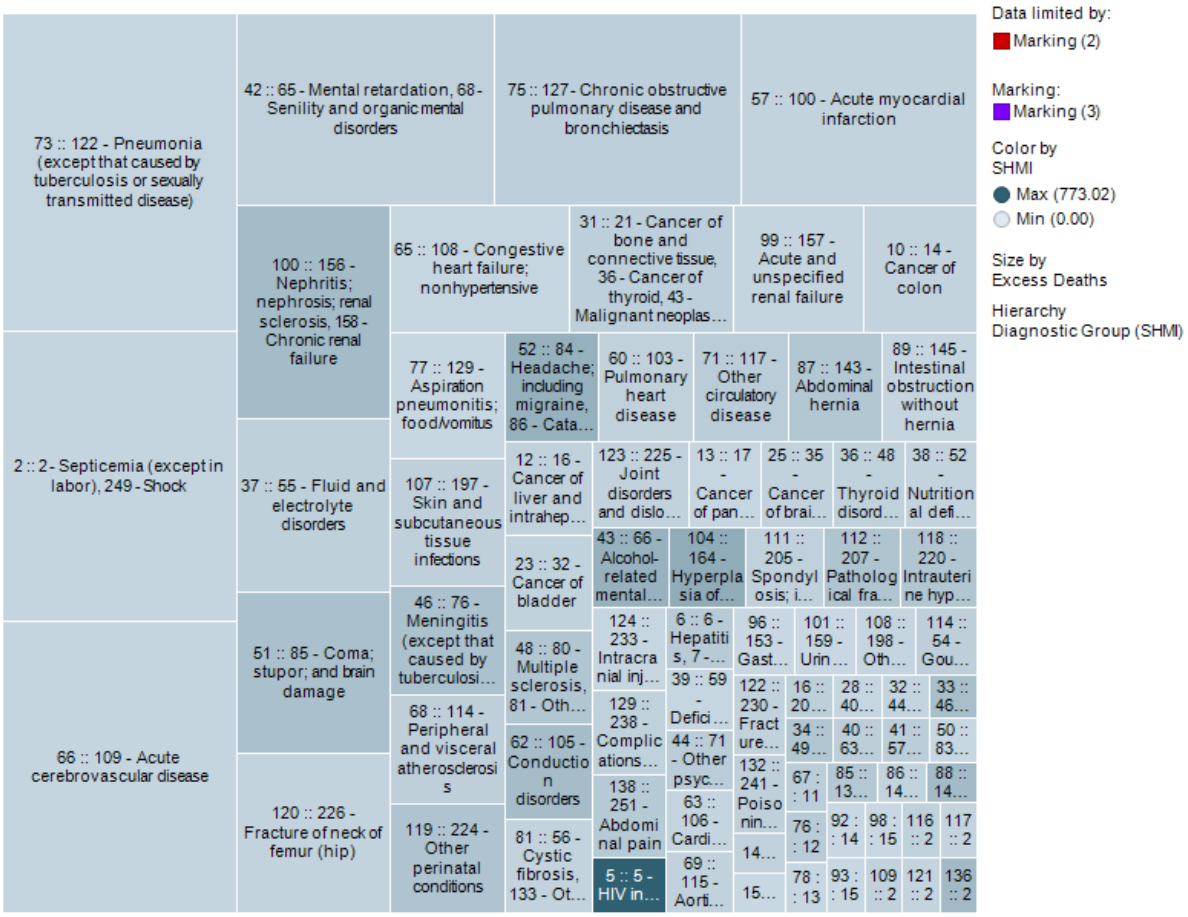



## 3. Diagnostic groups with high SHMI

Table 1 overleaf, demonstrates the diagnosis groups with the highest excess deaths, the larger the size of box, the higher the number of excess deaths. The highest SHMIs are represented by the deepest shading.

The leads for the diagnostic pathways, pneumonia, stroke, septicaemia, heart failure, COPD and renal failure have all identified areas for improvement (from case note scrutiny and benchmark data) and continue to develop and implement action plans.

Table 1 Diagnostic Groups (RWT) with highest excess deaths and highest SHMI




4. **CUSM alert**

| Alert Trigger | CCS Diagnostic Group | Expected Deaths | Observed Deaths | Number of Discharges |
|---|---|---|---|---|
| May 19 | Chronic Renal Failure | 7.2 | 15 | 195 |

After a previously reported increase in CUSUM trend, the Chronic Renal Failure diagnosis group triggered a CUSUM alert in May 2019. The Trust has also received an external alert letter from Dr Foster Unit regarding the higher than expected mortality for CKI. This is likely to be followed by a CQC alert.

Mortality Review Group has instigated a clinical review of deaths for this time period and this will be reported at MRG in Dec 2019.

A review of the coding of Primary Diagnosis has already been undertaken. 27 cases were reviewed and amendments made in 1 case. The audit highlighted the relative underreporting of definite diagnosis in these cases and confirmed the requirement to continue the ongoing work with education and process changes.

5. **Learning from Deaths- Scrutiny of Case Notes**

The summary table below, provides a position for Q2 for the period of 1st July to 31st August 2019, reported at 12th September

The transition plan for transfer of completion of all SJRs by the Mortality Reviewers has now been implemented and the SJR1 reviews that remains outstanding for the period of October 2018 to 31st July is 107. In August a further 25 SJR1s have been identified for review.

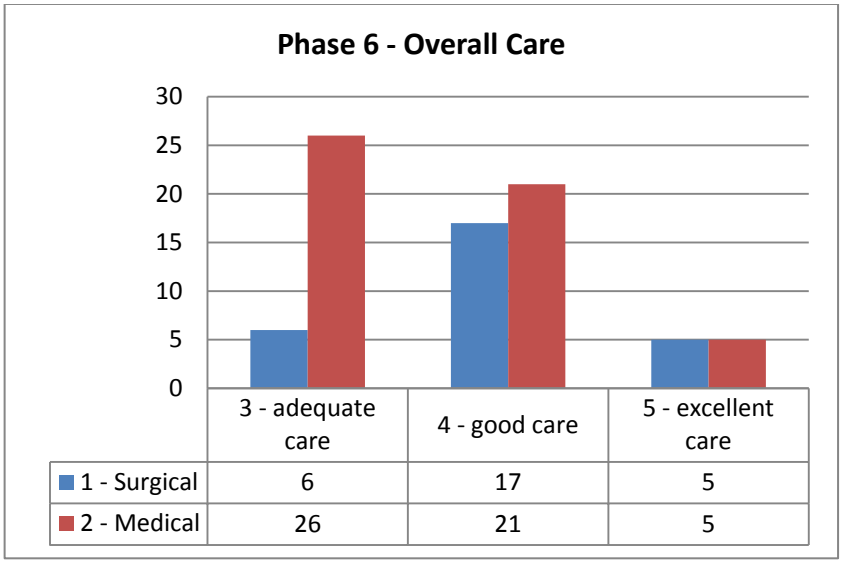
The outstanding SJR2s (48) have all been allocated to Mortality Reviewers. At 27th September, 32 have been completed leaving 16 SJR2s outstanding. These reviews relate to deaths that occurred in early 2018.

A role of the Medical Examiner and Bereavement nurse is to contact and discuss the case with families. 67% of assessments have resulted in discussion with families. The comments are largely positive. The Bereavement team is currently working through a plan to take the themes of the learning and share in a meaningful way with directorates.

Table 2 Summary Position Scrutiny of Deaths (data correct at 12th September 2019)

| | **Scrutiny of Deaths – Data:** | **Oct-18** | **Nov-18** | **Dec-18** | **Jan-19** | **Feb-19** | **Mar-19** | **Apr-19** | **May-19** | **Jun-19** | **Jul-19** | **Aug-19** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Total Number of Deaths (admissions) | 180 | 200 | 178 | 208 | 163 | 150 | 160 | 151 | 143 | 146 | 136 |
| 2 | Total Number of Deaths (ED attendance) | 7 | 25 | 26 | 27 | 16 | 16 | 18 | 26 | 14 | 17 | 16 |
| | **Total Number of Deaths** | **187** | **225** | **204** | **235** | **179** | **166** | **178** | **177** | **157** | **163** | **152** |
| | Total No. of Deaths referred to Coroner (Gen Office/ME) | | | | | 72 | 61 | 85 | 83 | 82 | 85 | 81 |
| 5 | ME assessments completed | | | 10 | 69 | 84 | 103 | 88 | 112 | 99 | 113 | 89 |
| **10** | **Total SJR1s Identified (Mandated/ME)** | **27** | **36** | **37** | **39** | **31** | **24** | **36** | **39** | **36** | **34** | **25** |
| 11 | No. of SJR1s completed (mandated/ME) | 18 | 32 | 28 | 28 | 23 | 16 | 19 | 18 | 15 | 2 | 0 |
| **12** | **No of SJR1s outstanding (Mandated/ME)** | ***9*** | ***4*** | ***9*** | ***8*** | ***6*** | ***7*** | ***12*** | ***12*** | ***18*** | ***30*** | ***24*** |
| 13 | No. of SJR1s completed in addition to mandated | 68 | 38 | 40 | 27 | 14 | 10 | 7 | 1 | 1 | 0 | 0 |
| | | | | | | | | | | | | |
| 15 | **Total SJR2s Identified (cumulative)** | 6 | 1 | 1 | 3 | 1 | 2 | 1 | 0 | 2 | 0 | 0 |
| 16 | No. of SJR2s completed | | | | 51 | | | | | | 15 | 9 |
| **17** | **No. of SJR2s Outstanding (cumulative)** | | | | **42** | **43** | **45** | **46** | **46** | **48** | **33** | **24** |
| 18 | No. of Deaths identified for RCA (following SJR2) | | | | 2 | | | | | | | |

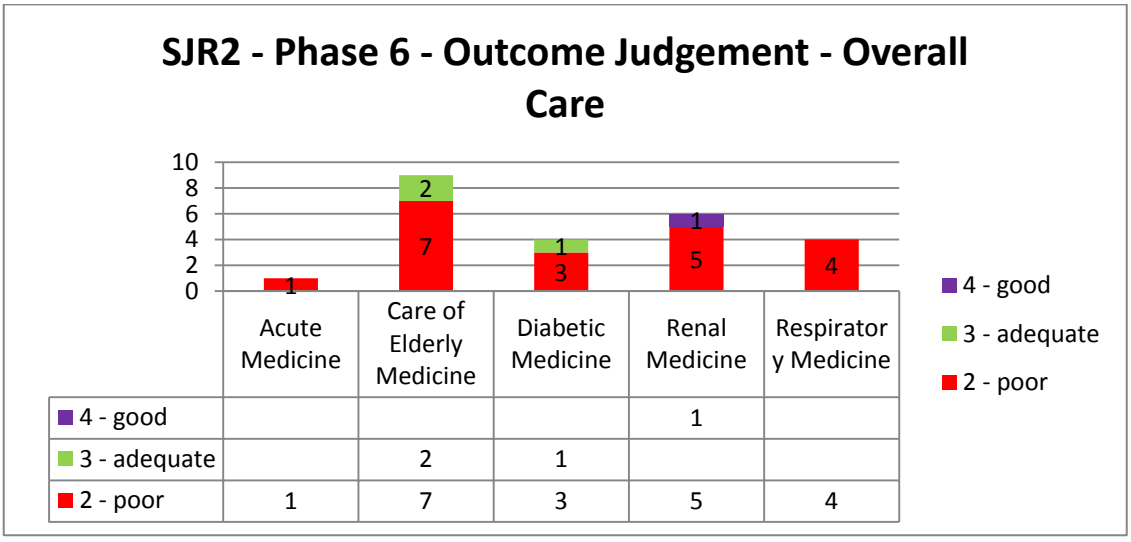
**SJR1 Outcomes –** The completed SJR2s as at 12th September were reported to MRG for the period 1st July to 31st August.




Poor and very poor care was not identified in any case during these 2 months.

SJR 2 Outcomes

The outcomes of reviews undertaken during the period of 1st July to 31st August are reported. Where the overall outcome has been deemed 'poor care' (20 in total), these are communicated to each of the relevant Mortality Leads for them to review and consider whether they are SI reportable. Of the 13 SJR2's previously reported to MRG, each Directorate has confirmed that none meet the criteria for an SUI.



**Quality Improvement Plan 1 (Mortality)**

Version 23
17/09/2019

| | Objective | Activity | Expected Output/Outcome | Progress at 10/09/19 (exceptions only) | Start Date | End Date | Owner | Exec Director Sponsor | Status Date of Update 29/04/19 | Status Date of Update 31/05/19 | Status Date of Update 26/07/19 | Status Date of Update 10/9/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A1 | **Programme Management (PM) and Governance** | | | | | | | | | | | |
| | **1** | Develop a Trust Mortality Strategy | Strategy developed via consultation | | 01/09/18 | 30/11/18 | D Hickman | J Odum/ AM Cannaby | | | | |
| | 2 | Agree TOR of MIG to include scope and development/review | MIG terms of reference | | 01/06/18 | 30/07/18 | S Roberts | J Odum/ AM Cannaby | | | | |
| | 3 | Terms of Reference for Mortality Review Group following merger of MoRAG | MRG TOR developed | | 01/06/18 | 30/07/18 | A Viswanath | J Odum | | | | |
| | 4 | Programme Board and Action Plan to be developed | Programme Board established. Action plan formulated | | 01/08/18 | 15/10/18 | J Odum/AM Cannaby | J Odum | | | | |
| | 5 | Dashboard to be developed for monitoring of impact of actions | Dashboard presented to MRG | | 01/07/18 | 15/10/18 | S Hickman | J Odum | | | | |
| | 6 | Board Assurance Framework submission | Risk added to BAF | | 01/08/18 | 30/08/18 | J McKiernan | J Odum | | | | |
| | 7 | Appoint external analytic expertise | Contract commenced | | 04/10/18 | ongoing | S Mahmud | S Mahmud | | | | |
| | 8 | Appoint external medical expert | Contract commenced | | 17/09/18 | 12 months | J Odum | J Odum | | | | |
| | 9 | Review mortality quality improvement plan monthly at programme board | Trust Board monthly update against action plan | | 05/11/18 | monthly | AM Cannaby | AM Cannaby | | | | |
| | 10 | Review Divisional participation and involvement in Mortality Governance | DMD influence at MRG, outputs of audits reported at QSI. | | 01/03/19 | 31/07/19 | DMD's | J Odum | | | | |
| | 11 | Review Directorate participation and involvement in Mortality Governance | MDT involvement in M&M/Governance meets, CQI outputs | | 01/03/19 | 01/06/19 | 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 | Quarterly Mortality Leads meeting. No progress yet on case note peer review | 01/04/19 | ongoing | 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 | | 01/07/18 | 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 understood | Baseline understood. Ongoing CQI project | 01/07/18 | ongoing | Head of Nursing Div 3, Palliative Care Lead | 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. | Baseline understood, review of NH cases admitted to RWT presented to MIG Oct 2019. Presentation to ICA November 2019 | 01/09/18 | 31/12/18 | Lead C/E Cons/Head of Nursing Div 3 | Chief Nurse CCG/ AM Cannaby | | | | |
| | 4 | City-wide Business case aimed at enabling more people to die in their preferred palace of death. To develop: The establishment of a Wolverhampton End of Life Care Co-ordination Centre<br>• Rapid Response Service to support End of Life patients at home and prevent hospital admissions<br>• Compassionate Communities<br>• Wolverhampton End of Life website | The ratio of the number of people dying in the communtity refelects the national picture | Business case in draft. | 30/10/18 | ongoing | Chair ICA | 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 | Established Jan 2019, continuous review of process to improve ME coverage | 01/08/18 | 30/11/18 | A Viswanath | J Odum | | | | |
| | 2 | Monitor compliance with OP87 (Learning from Deaths) SJR 1 & 2 | Completion of SJR 1& 2reviews as per agreed standard | Overall good practice identified against the policy (Grant Thornton). But delays in process recognised(also by at MRG). Active changes made by appointment of Mortality Reviewers | 01/08/18 | 30/11/18 | 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 | CCG working with Primary c care to establish proces | 01/08/18 | 31/12/18 | S Roberts | J Odum/ AM Cannaby | | | | |
| | 4 | Re-establish RWT End of Life Group, ToR and Action Plan | Action Plan agreed | | 31/08/18 | 30/11/18 | AM Cannaby | AM Cannaby | | | | |
| | 5 | To establish the process for including families/relatives in the mortality reviews | Bereavement Nurse in post | B Nurse in post since July. Monitor contact with family and learning from feedback. Early data showing positive feedback from families. Strategy to be developed to pass on learning to directorates. | 01/04/19 | 30/12/19 | 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. | Themes from SJRs discussed at MRG. Learning log to be developed | 01/10/18 | 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 | New process of SJR (via Mortality Reviewers, 2 nurses appointed as part of this, review reqt for more in time ) | 01/10/18 | 15/12/18 | Martina Morris | AM Cannaby | | | | |
| | 8 | Learning from SJR 2s to be shared with Divisions, Trust Board and CCG | Lessons shared | | 01/10/18 | ongoing | Divisional leads/Execs | J Odum/ AM Cannaby | | | | |

| | Objective | Activity | Expected Output/Outcome | Progress at 10/09/19 (exceptions only) | Start Date | End Date | Owner | Exec Director Sponsor | Status Date of Update 29/04/19 | Status Date of Update 31/05/19 | Status Date of Update 26/07/19 | Status Date of Update 10/9/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 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. | Change in practices appears to have influenced the ouputs e.g. improvements in depth of CCI seen, increase in length of FCE . Ongoing monitoring required | 01/10/18 | 30/11/18 | 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 | Monthly reports from PWC, shared with Diagnosis leads, predictor model in place | 01/11/18 | 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 | Review of process will be developed in line with Grant Thornton recommendations | 01/03/19 | 31/07/19 | M Arthur | AM Cannaby | | | | |
| | 14 | Develop IT platform (worksheets, data collection, directorate feedback) | Trends of Mortality reviews | Programme of work underway, bi weekly meetings to progress project | 01/01/19 | 31/03/20 | 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 | | 01/01/18 | 31/05/18 | J Cotterell | J Odum/ K Stringer | | | | |
| | 2 | Cases in 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 | Alerts now reviwed (8 to CQC within last 48 months). Other alerts presented to MRG | 01/01/18 | ongoing | A Viswanath | J Odum | | | | |
| | 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 | QI projects ongoing in sepsis, pneumonia. Heart Failure and AKI in development. Regular feedback meetings have been set up to monitor progress. | 01/07/18 | 01/06/19 | Medical Divisional leads / A Viswanath / S Cherukuri | J Odum | | | | |
| | 4 | PDSA community in reach | PDSA cycles to be tested | | 01/09/18 | 01/03/19 | 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 | | 01/01/18 | ongoing | J Odum | J Odum | | | | |
| | 6 | Develop a process of undertaking harm reviews 104 day+ Cancer waits | Harm reviews discussed with CCG and RWT | | 01/09/18 | 31/10/18 | 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 | | 01/06/18 | ongoing | Divisional leads/Execs | J Odum/ AM Cannaby | | | | |
| | 8 | Nursing mortality audits commencing with sepsis and pneumonia pathways | Completion and dissemination of audit results | | 10/09/18 | 30/11/18 | 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 | Team in place since April 2091, Quarterly reports at TMC/TB | 01/04/19 | | Simon Evans | M Sharon | | | | |
| | 10 | Work with CEO of Sepsis Trust | | | 01/03/19 | | | 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 | Stroke have produced, Further to be develope | 01/03/19 | | 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 | | 01/01/18 | 30/04/18 | J Cotterell | J Odum/ K Stringer | | | | |
| | 2 | Educational Package for SJRs to be developed for Medical and Nursing teams | Educational Package developed and delivered | | 01/01/18 | 01/12/18 | 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 | | 01/01/18 | 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 | Leadership training package has been launched by education department, (particularly for all Cons). Included in Cons induction package | 01/03/19 | ongoing | B McKaig | J Odum | | | | |
| A6 | **Workforce** | | | | | | | | | | | |
| | 1 | Implement Medical Examiner model | ME recruitment and training 5 day ME rota (recruit and commence) | | 01/07/18 | 01/12/18 | A Viswanath | J Odum | | | | |
| | 2 | Safe nurse staffing levels at ward and team level | Staffing reviews bi-annually by Board providing transparent reporting | | 01/01/18 | 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 | | 01/06/18 | 01/03/19 | 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 | 14hrs standard is compliant. Daily review is at 86%. Audit October 2019 will be presented NOV | 01/01/18 | 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 | | 10/10/18 | 31/03/2019 | 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 | | 01/09/18 | 31/01/19 | 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 | | 10/10/18 | 31/03/2019 | Divisional leads | AM Cannaby | | | | |

| | Objective | Activity | Expected Output/Outcome | Progress at 10/09/19 (exceptions only) | Start Date | End Date | Owner | Exec Director Sponsor | Status Date of Update 29/04/19 | Status Date of Update 31/05/19 | Status Date of Update 26/07/19 | Status Date of Update 10/9/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A7 | **Communication Plan** | | | | | | | | | | | |
| | 1 | Trust Board mortality briefings monthly to include status of top 5 diagnostic groups | Minutes of Trust Board | | 01/07/18 | monthly | J Odum | J Odum | | | | |
| | 2 | Senior Managers' Briefing | Update of actions monthly | Review of comms plan, website available, Video in development | 01/09/18 | monthly | J Odum | J Odum | | | | |
| | 3 | Trust Newsletter | Quarterly Newsletter update | Review of comms plan, Website available, Video in development | 30/11/18 | quarterly | S Evans | A Duffell | | | | |