The Royal Wolverhampton NHS Trust

Learning from Deaths update
7 April 2020

Agenda Item No:10.1

The Royal Wolverhampton NHS
NHS Trust

Trust Board Report

Meeting Date:	7 April 2020
Title:	Learning from Deaths
Executive Summary:	The paper presents the Trust's most recent mortality data and the work being undertaken to scrutinise and continually improve. The national SHMI dataset shows the most recent score for RWT of 1.087, November 2018 – October 2019. The Trust is now ranked 98 out of 129 Trusts across the country and is within the expected range for the fourth consecutive month. The trust currently has a higher than expected value for HSMR at 114.61. However, the HSMR has steadily decreased over the last 12 periods. An 'Engagement with families' action plan has been developed and will be monitored via the End of Life (EOL) steering group. Work continues on a new learning from deaths IT dashboard and the go live date will now be 1st June 2020. The percentage of deaths reviewed by the Medical Examiner (ME) in Jan 2020 was 49% of total inpatient and ED deaths. The Medical Examiner team has recruited to vacancies and the benefit will be seen from March 2020 with increased numbers of deaths receiving ME scrutiny.
Action Requested:	Receive and note
For the attention of the Board	To note the SHMI of 1.087. This is within the expected range for the fourth consecutive month.
Assure	The Board has previously been reassured through data analysis that the previously 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 previously elevated SHMI remains 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 remain : Chronic renal failure Other groups with high excess deaths: Septicaemia Acute cerebrovascular disease Peripheral and visceral atherosclerosis Pneumonia Reviews have previously been conducted, reported internally and where requested to CQC. Coma; stupor and brain damage has dropped out of the

	outlying list this month, following a review of coding quality in 2019 and reported in February 2020 report. Clinical teams leading the diagnostic groups Chronic Renal failure, Septicaemia, Acute Cerebrovascular disease, and Pneumonia are all involved in quality improvement projects and monitoring of progress continues by the Mortality team. Peripheral and Visceral atherosclerosis has not been previously alerting and the status will be monitored.
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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
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
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

Royal Wolverhampton NHS Trust:

Learning from Deaths Update of monthly activity March 2020

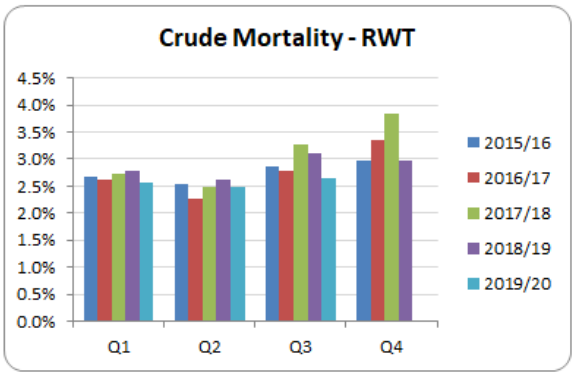
1. Update on Standardised Mortality Rates (SMRs) and inpatient data relevant to these calculations

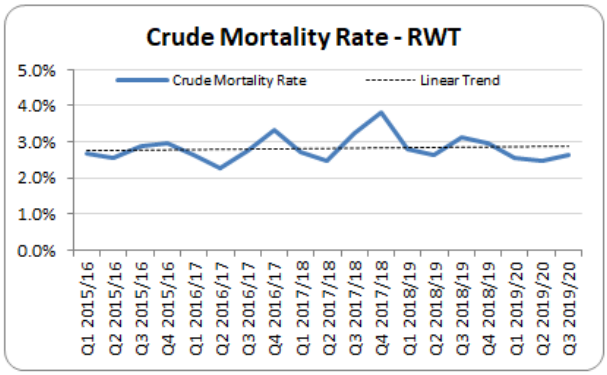
1.1 Crude mortality*

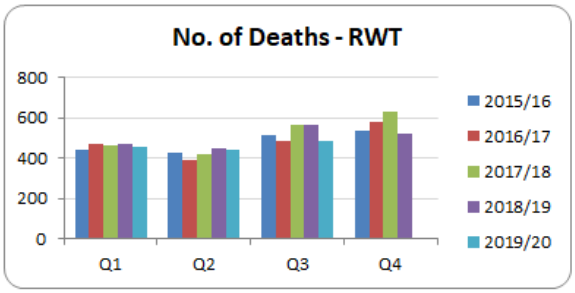
The number of deaths in each quarter in 2019/20 is reduced in comparison to same time 2018/19.

The crude mortality rate was 2.65% in Q3; The year to date crude mortality rate (April to Feb 2020) is 2.63%.

The crude mortality rate for January and February 2020 is 2.93%.







Period	No. of Ordinary Discharges	No. of Inpatient Deaths	Crude Mortality
2015/16	68888	1908	2.77%
2016/17	69538	1914	2.75%
2017/18	67758	2078	3.07%
2018/19	69558	2004	2.88%
2019/20	59910	1564	2.61%

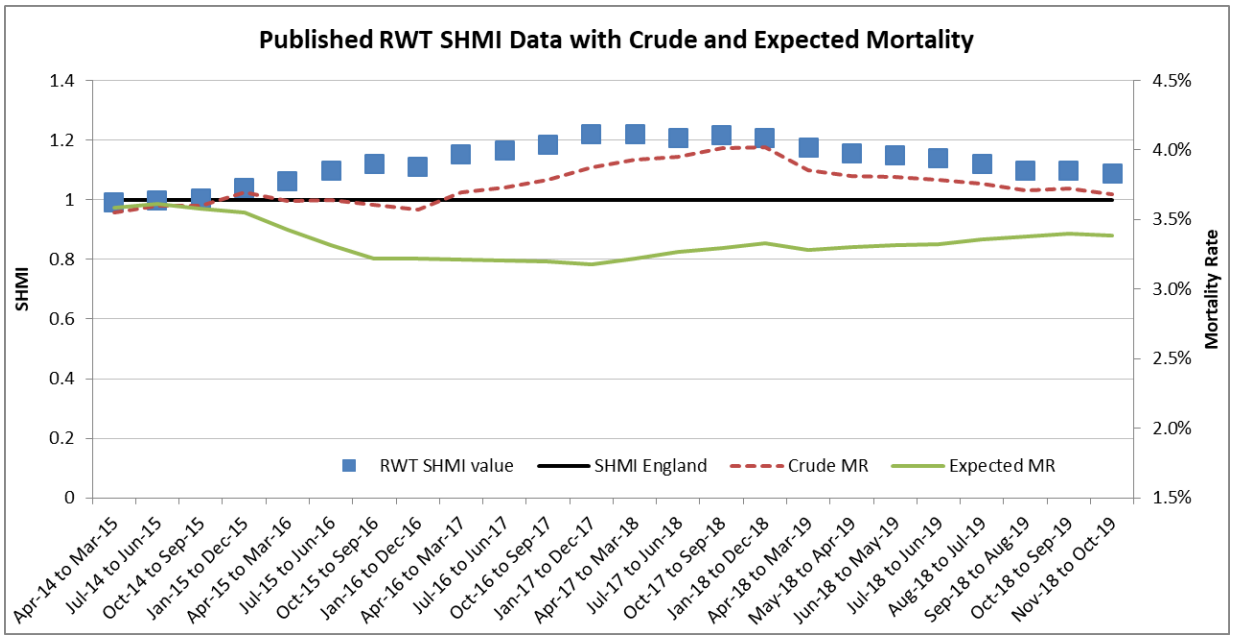
*The number of deaths and crude mortality represent inpatient mortality only (ordinary admissions including still births) extracted from internal data.

1.2 SHMI (Inpatient deaths plus 30 days post discharge)

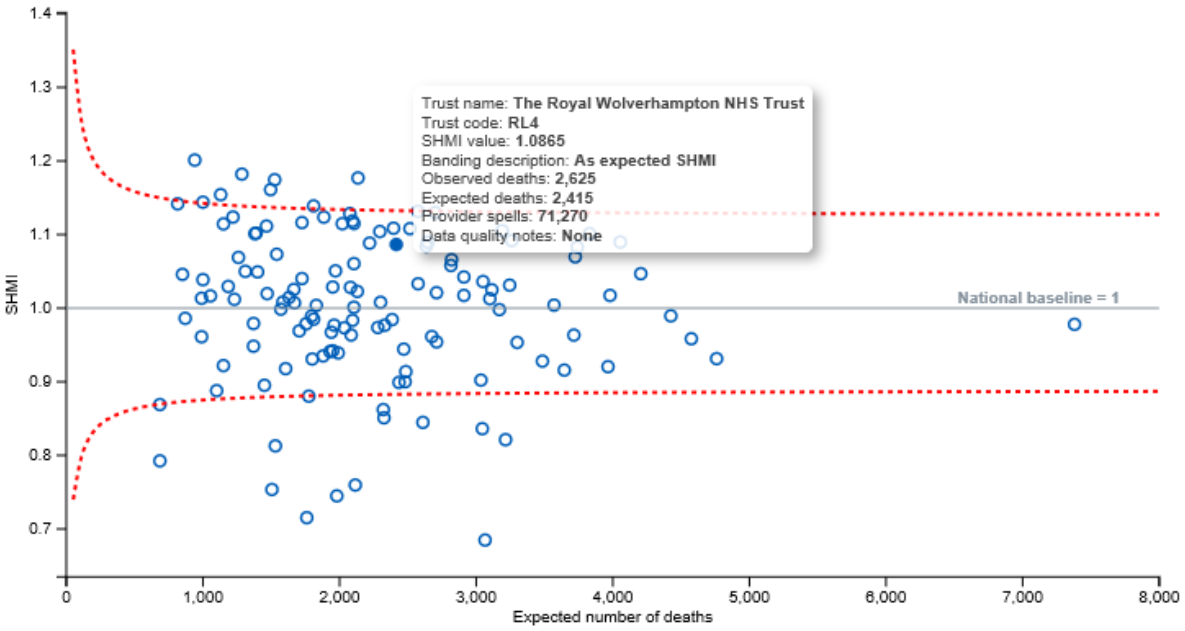
The most recent published SHMI value, (NHS DIGITAL March 12th 2020) for the period November 2018 – October 2019 is 1.087.

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
July 2018- June 2019	1.14	3.78
Aug 2018- July 2019	1.12*	3.76
Sept 2018- Aug 2019	1.097*	3.71
Oct 2018 – Sept 2019	1.097*	3.72
Nov 2018 – Oct 2019	1.087*	3.68

*within expected range



The Trust is now ranked 98 out of 129 Trusts across the country and is within the expected range for the fourth consecutive month.



1.3 SHMI in comparison with neighbouring Trusts

Trust	Nov 2018 – Oct 2019 (published March 12th 2020)
The Royal Wolverhampton NHS Trust	1.087
The Dudley Group NHS Foundation Trust	1.118
Walsall Healthcare NHS Trust	1.101
Shrewsbury and Telford Hospitals NHS Trust	1.021
University Hospitals North Midlands	0.990
Sandwell and West Birmingham NHS Trust	1.051

1.4 RWT Diagnostic Groups with higher than expected SHMI*

In the table below, those in red are outliers; those in amber are not outlying but lie just below.

Diagnostic Group (CCS)	SHMI	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	Number of mortalities occurring in the hospital	Number of total discharges	Percentage of mortalities occurring in hospital
158 - Chronic renal failure	299.2	6	19	14	99	74%
2 - Septicemia (except in labor)	119.7	213	255	205	1155	80%
109 - Acute cerebrovascular disease	120.6	176	212	186	1078	88%
114 - Peripheral and visceral atherosclerosis	210.8	10	21	20	52	95%
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	112.3	328	368	284	1892	77%

* Nov 2018 – Oct 2019

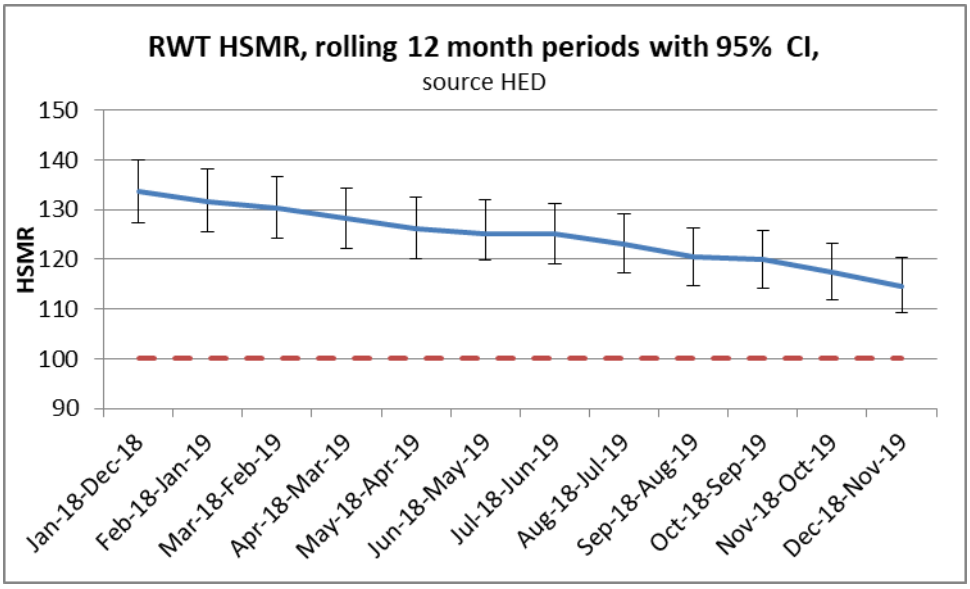
Coma; stupor and brain damage has dropped out of the outlying list this month, following a review of coding quality in 2019. This review was reported in the February 2020 report.

Clinical teams leading the diagnostic groups Chronic Renal failure, Septicaemia, Acute Cerebrovascular disease, and Pneumonia are all involved in quality improvement projects and monitoring of progress continues by the Mortality team.

Peripheral and Visceral atherosclerosis has not been previously alerting and the status will be monitored.

1.5 HSMR (Hospital Standardised Mortality Rates, does not include patients 30 days after discharge)

The trust currently has a higher than expected value for HSMR at 114.61 (95% limits 109.15, 120.27). However, the HSMR has steadily decreased over the last 12 periods.



When broken down to the 56 CCS diagnosis groups that make up the HSMR, the trust is an outlier in the groups in the table below for the period Dec 2018 – Nov 2019.

Diagnostic Group (CCS)	Number of discharges	Expected number of deaths	Number of deaths	Percentage of deaths attributed through transfer	HSMR	HSMR 95% Lower CI	HSMR 95% Upper CI
133 - Other lower respiratory disease	505	7.17	15	0%	209.19	117	345.06
108 - Congestive heart failure; nonhypertensive	760	77.62	101	1%	130.13	105.99	158.12
127 - Chronic obstructive pulmonary disease and bronchiectasis	771	28.04	41	0%	146.21	104.91	198.36
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	1913	240.6	282	0.4%	117.21	103.93	131.72
2 - Septicemia (except in labor)	1135	158	187	0%	118.35	102	136.59
224 - Other perinatal conditions	1033	18.29	28	14.3%	153.06	101.68	221.22

The groups that are outlying largely reflect the same conditions as those identified by the SHMI methodology.

In addition for the CCS group 'Other perinatal conditions', 14% of deaths are spells where there is a transfers into or out of RWT. There are 4 deaths at Birmingham Children's Hospital that are also counted against RWT. These deaths are subject to external review via the regional Child Death Review Group.

2. Diagnostic Groups –Review of Clinical Care

2.1 Liver disease due to alcohol

Deaths in this diagnostic group have shown a steady increase over a 6 month period. Whilst this is not a SHMI outlier, the clinical team have reviewed a set of case notes for assurance. A case note review of 39 patients who were coded as having liver disease due to alcohol has been presented at the Mortality Review Group. Dates of death for patients reviewed were from July 2018 to June 2019.

From the case note reviews;

- 23/39 (62%) were seen by the GI team within 24 hours of referral
- 19/39 (49%) died on C41
- 6/39 (15%) the team felt were unexpected deaths
- 30/39 (77%) were felt to have died due to liver disease

Of the 6 deaths that were unexpected, 3 were liver deaths and 3 were due to causes not related to liver disease (sub arachnoid haemorrhage, respiratory failure and a cardiac arrest with cancer diagnosis).

The case note review illustrated that the vast majority of patients were seen by the GI team, promptness of this could be better in some cases (i.e. within 24 hours). Patients reviewed were a sick cohort indicated by high average UKELD score (United Kingdom Model for End-

Stage Liver Disease) with high mortality expected. The palliative care team attendance at MDTs was welcomed as good practice.

The Liver team are working with the CQI team and AMU to improve the liver care pathway at admission. The CQI project will also help to identify potential areas for improvement such as junior doctor training, development of liver champions and an audit of antibiotic delivery. The team will present at the next clinical pathway meeting on April 2nd 2020.

2.2 Care of the Elderly

8 deaths were presented to the Mortality Review Group whereby previous SJRs indicated poor or adequate care (6 and 2 cases respectively). The 8 deaths reviewed occurred from 2017-2019 (2017; 2 deaths, 2018; 4 deaths and 2019; 2 deaths).

Themes identified from reviewed cases were:

- **Feed at risk/ NG feeding.**
  A number of the cases reviewed had various issues surrounding swallowing assessments, feed at risk decisions and variability of oral intake relating to cognition (delirium/dementia). These cases are historical and practice has improved supported by recent trust policy.

- **Ceilings of Care / End Of Life Care / Symptom Control**
  A number of cases reviewed had issues around timely ceiling of care decisions, the transition to end of life care and investigation and management of symptoms at the end of life. Some of this reflected variations in individual practice due to the lack of availability of supporting evidence and some due to omissions that were indeed poor.

  Recent use of huddle tools, the Clinical Frailty Scale (CFS) score and Gold Standards surprise question to support consideration of transition to end of life care are being rolled out and developed.

- **Adherence to Antibiotic Protocols**
  One case where antibiotic protocol had not been adhered to was noted. Recognition of the challenge of clinical vs biochemical improvement in older frail patients is appreciated.

Feedback has been given to the directorate through Mortality and Morbidity meetings and email correspondence.

2.3 Learning from Deaths – engagement with families

The engagement with families' action plan is monitored via the End of Life (EOL) steering group.

Key actions include:

- Update 'Practical help following the death of a relative or friend' booklet to include more information with regards to how to raise concerns, provide feedback and how to access medical records.
- Ongoing work surrounding the possibility to send letters to the deceased's next of kin (if consent given at registration of death) 6-8 weeks after death to include condolences to the families, signpost to support and welcome families to share feedback via the bereavement care questionnaire.
- Offering training in advanced communication skills to non-cancer health care professionals and EOL study days, coordinated by specialist palliative care. The trusts

bereavement nurse along with palliative care team is working together to produce staff training and education for EOL communication.

From March 2020, there will be a monthly bereavement hub within the hospital, available for both staff and the public. This is a joint partnership with Compton Care which uses the established Compassionate Communities model. Trained volunteers will facilitate the hub which is offered as a means of support to anyone affected by loss or grief, offer a friendly place to meet and talk to others who share similar experiences.

3. Learning from Deaths IT Platform:

IT testing of the new Learning from Deaths Platform is taking longer than originally planned; as a result the go live date will be postponed until 1st June 2020. This does not impact on the current delivery or monitoring capability. A transition plan is currently being developed to ensure that all staff are trained and processes are in place to support implementation.

4. Review of Deaths:

The following tables provides information on the number of deaths reviewed (by Medical Examiner) and those scrutinised via the SJR process.

Scrutiny of Deaths – Data:	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Total Number of Deaths	**181**	**181**	**160**	**161**	**157**	**172**	**169**	**193**	**211**	**222**
Total ME Reviewed	100	107	103	98	79	85	101	108	101	109
Total SJR 1 Identified	35	37	36	33	24	24	27	35	36	30
Total SJR1 Reviewed	35	38	35	30	22	22	27	34	28	2
Mandatory SJR1s o/s	0	0	1	3	2	2	0	2	8	28

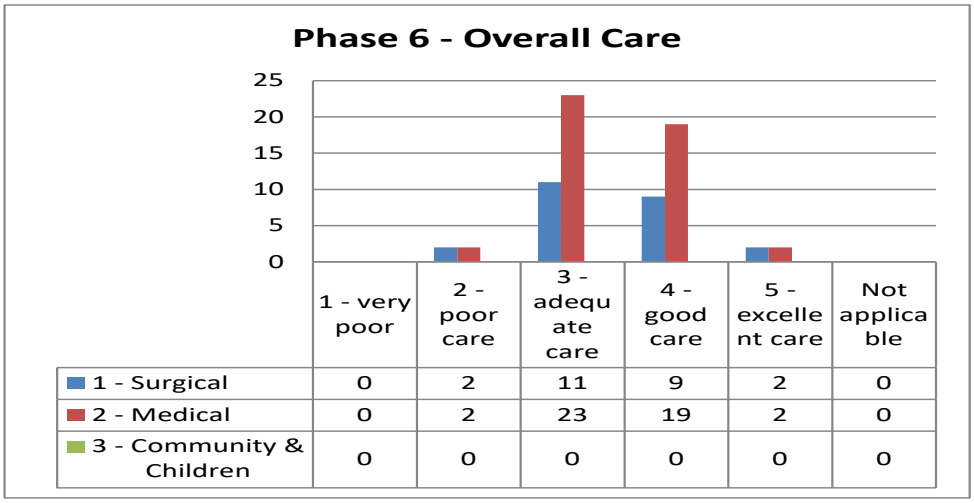
Data at 12th Feb 2020

The percentage of deaths reviewed by the Medical Examiner (ME) in Jan 2020 was 49% of total inpatient and ED deaths. This has reduced from previous months of 55-60%. A combination of increased deaths in January along with continued vacancies in the ME rota has contributed to this. The medical examiner team has recruited to vacancies and the benefit should be seen from March 2020 with increased numbers of deaths receiving ME scrutiny.

The previous SJR backlog outstanding for the period of October 2018 to July 2019 has reduced to 24. As of August 2019, the most recent SJRs are now being conducted in a timely fashion.

SJRs conducted in January 2020 show 4 cases where poor care was identified, these relate to deaths from September 2019 – December 2020. Directorates have been made aware of the outcome. After directorate review of the 4 cases, 1 resulted in no incident to report, 1 has been allocated to a local RCA, 1 has an external review currently being organised and the fourth case is a potential SUI where an SJR2 for a second opinion has been requested.

In addition, there was one SJR2 reviewed by Mortality Reviewers over the period 1st January 2020 to 31st January 2020 for a death occurring in September 2019. This was identified as poor care with Mortality lead reviewing and a potential SUI.



	1 - very poor	2 - poor care	3 - adequate care	4 - good care	5 - excellent care	Not applicable
1 - Surgical	0	2	11	9	2	0
2 - Medical	0	2	23	19	2	0
3 - Community & Children	0	0	0	0	0	0

LEARNING FROM DEATH PROGRAMME PLAN

VERSION 28 13/03/2020

Grant Thornton recommendation

Stan Silverman recommendation

BENEFITS

1. The Trust is assured that the programmes of care are driving up quality of care provision

2. The programme is supporting the Trust to deliver it mission statement and objectives

	Objective		Activity	Output	Outcome	Updates 10/02/2020	Start Date	End Date	Owner	Exec Director Sponsor	Status Date of Update 11/02/2020
A1		**Programme Management (PM) including Governance**									
	1		Develop a Trust Mortality Strategy	A programme of work including an action plan	We have a methodology for assuring the Trust that resources and systems are in place to deliver and monitor the Mortality agenda Trust staff understand the Mortality programme and are able to influence the agenda We triangulate learning from a variety of sources		01/09/2018	03/11/2018	A Viswanath	J Odum	
	2		Set up a Governance system for reporting, advising on and monitoring the Mortality agenda	Monthly review of Action Plan			01/06/2018	30/07/2018	A Viswanath	J Odum	
		2a	Revise TOR for Mortality Review Group	Monthly quorate meetings			01/06/2018	30/07/2018	A Viswanath	J Odum	
		2b	Quality Improvement Board -Mortality to be developed	Monthly quorate meetings			01/10/2018	15/10/2018	J Odum	J Odum	
		2c	Develop a directorate and divisional system for participation and involvement that links mortality to other aspects of the Div Governance agenda	Governance Structure which includes links with the Mortality Review Group		Mortality is a standing item on Directorate Governance agendas to allow reporting from Mortality leads on reviews undertaken, outcomes and themes. The responsibilities of Mortality leads and expectations on reporting (at M&M meetings, Directorate Governance and MRG) will be identified within the Mortality policy (refer activity 2e). Divisions report Mortality review performance to QSIG monthly, Directorate reporting needs to include more on themes, learning and actions from reviews. This should be picked up in the Mortality leads responsibilities in 2e.	01/04/2019	30/03/2020	M Arthur	J Odum	
		2d	Develop a dashboard for Directorate use	Monthly report of metrics		Dashboard developed and available for use. Updated version released w/c 20/01/20.	01/07/2018	15/10/2018	S Rowles	J Odum	
		2e	Directorate Mortality and Morbidity meetings have a defined membership and agenda which is consistent across the Trust	Evidence of discussion/reports on reporting diagnostic groups and learning shared at directorate governance meetings.		TOR previously issued but Directorates requested fexibility. The Mortality lead responsibilities are to be defined and updated in the Mortality Policy.	01/04/2019	30/04/2020	S Hickman	J Odum	
	3		City wide programme developed to work to one strategy (Acute, Comm, PH, Compton)	City wide meeting with TOR	Cross city work is coherent and cogent		01/06/2018	30/07/2018	S Roberts	CCG Chair	
	4		Assurance		We have a methodology for assuring the Trust that resources and systems are in place to deliver and monitor the Mortality agenda						
		4a	Report Progress to Trust Board and Quality Committees ensuring that papers meet the mandated national guidance	Monthly paper that is signed off at MRG		Trust papers are now routinely shared at the public Board session. Problems in Care likely to have contributed to death 06/02/2020.	01/07/2019	31/10/2019	J McKiernan	J Odum	
		4b	Provide Trust Board mortality briefings monthly to include status of top 5 diagnostic groups	Monthly paper that is signed off at MRG			01/07/2018	30/06/2019	J McKiernan	J Odum	
		4c	Board Assurance Framework Risk submission	4 monthly review of risk			01/08/2018	01/12/2018	K Wilshere	J Odum	
		4d	Appoint and receive advice from external analytic expertise	Report following system review			04/10/2018	01/02/2019	S Mahmud	J Odum	
		4e	Appoint and receive advise on external medical expert	Report following system review			17/09/2018	16/09/2019	J Odum	J Odum	

	5		Review Governance feedback mechanisms across the Trust, including simplification of messages and dissemination	Learning Platform which records Divisional governance data	Themes from results of mortality reviews are compiled and triangulated with lessons learned from clinical audits, mortality reviews and coroners' reports. Trust staff understand the Mortality programme and are able to influence the agenda	Directorate Packs: Are circulated monthly to all specialties, the Directorates are asked to complete/return learning for all SJRs where poor/very poor care have been identified so that 'local' actions are identified. These are discussed at MRG (agenda planned). Divisional Reports: Are circulated monthly provide detail of deaths/reviews undertaken and where cases are poor/very poor for them to utilise through their quality and performance meetings. Divisions also report to QSIG in terms of oversight. Mortality leads and the Mortality review group feeds learning/themes into the LfD log which is reported to MRG. This informs the Trust learning framework and is reviewed along with themes from complaints, claims, SUI and other sources of learning. A report is then made to the appropriate Trust Committee on themes (with sources of evidence) and proposed action/work requirements.	01/04/2019	31/03/2020	M Arthur	J Odum	
		5a	Ensure staff receive feedback after incidents are reported			Process available that outlines how this should happen. Incident feedback process in place. Further cultural changes required	01/04/2019	30/03/2020	M Arthur	J Odum	
		5b	Develop a centralised learning log and develop processes to monitor and review progress of the implemented actions against the identified learning. Individuals to be assigned actions	Learning Log		Learning log and process developed, implementation will be ongoing and will involve Mortality leads reporting themes, the review of LfD log at MRG, MRG members reviewing themes and deciding on areas for action/improvement and liaising with appropriate group, CQI or establishing a task and finish group to address an issue/theme identified. Mortality learning will contribute to the wider learning framework established for the Trust.	01/08/2019	31/03/2020	M Arthur	J Odum	
A2		**City wide programme for End of Life Care**									
	1		City wide programme developed to work to EOL strategy through the ICA (Acute, Comm, PH, Compton)	City wide strategy	Cross city work is coherent and cogent	City wide EOL group set up and meet. Timelines etc will need to reflect ICA wide action plan	30/10/2018		ICA Project	S Roberts	
	2		Re-establish RWT End of Life Group, ToR and Action Plan	Trust Strategy reviewed and monitored			31/08/2018	30/11/2018	V Whatley	AM Cannaby	
	3		EOL identification and care provision		We have the capability to support patients to die in place of choice						
		3a	Review data and consider new care pathways for planned reduction in admissions from Nursing Homes	Reduction in NH admissions		This is part of a city wide project and timelines etc will need to reflect ICA wide action plan.			ICA project	S Roberts	
		3b	Pathways of EoL Care in hospital reviewed and revised	Pathways agreed and redesigned		CQI project launched and PDSA cycles underway Staff reintroduced to GSF training and ACP documents. Project now on hold.	01/06/2019	30/03/2020	J Shears	AM Cannaby	
		3c	Inreach to care/nursing homes by C/E and RITS teams	Appropriate service model		Service available. Will be reviewed in line with business case and ICA .	01/09/2018	31/12/2018	Head of Nursing Div 3	AM Cannaby	
	4		City wide Business case aimed at enabling more people to die in their preferred place of death	EOL Care Coordination Centre Rapid Response Team Compassionate communities , EOL website		This is part of a city wide project and timelines etc will need to reflect ICA wide action plan. ICA group under review. Review of service delivery and workforce requirements on hold			V Whatley	J Odum	
A3	**Policy and Process**										
		Mortality Reviews that are timely and identify learning from deaths									
	1		Improve quality of death certificate completion	> 90% MCCD completed with ME	We have the capability to scrutinise all deaths We have the capability to identify and review those deaths where there is potential concern	Education for junior docs provided, system to monitor change now required. Discussions with specialities to increase ME scrunity e.g. ED, TNO. Recruitment for additional ME resource with expected start dates March-April 20.	01/08/2018	30/06/2020	M Norell	J Odum	
	2		Revise process for identifying those deaths requiring review	Policy Revision		Policy available on line for staff	01/08/2018	30/11/2018	A Viswanath	J Odum	

	3		Implement standardised methodolgy for reviewing deaths	Trust Policy		Policy completed and implemented March 2019, however version 2 now required in order to meet new developments (MR/PC)	01/09/2019	31/03/2020	A Viswanath	J Odum	
		3a	Implement Medical Examiner Model that covers 5 days	> 90% cases scrutinised by MEs		MEs recruited and model in place. Vacancies mean that 5 days not consistently covered. Increase in capacity from Jan 2020 and recruitment process in place to recruit additional ME resource - expected start dates March-April 20	01/07/2018	30/05/2020	M Norell	J Odum	
		3b	Implement Mortality Reviewer Model	Trained MR in post			01/08/2018	30/11/2018	A Viswanath	J Odum	
		3c	Include trained nurses/AHPs to support completion of SJR 1 and 2	Nursing colleagues conducting SJR's			01/10/2018	15/12/2018	M Morris	AM Cannaby	
		3d	Develop standardised best practice pathways for major diagnosis for use by MRs	Standards available for Mortality Reviewers		Stroke, palliative care, COPD, pneumonia and sepsis pathways available	01/01/2019	01/12/2019	A Viswanath	J Odum	
		3e	Develop Mortality Reviewer assurance model	Regular report of SJR completeness and timeliness		System agreed and outputs awaited	01/08/2019	31/03/2020	A Viswanath	J Odum	
	4		RWT/Primary Care/CCG to establish process for reviewing deaths within 30 days after hospital discharge								
		4a	Conduct audit to understand resource required	Number of PC deaths requiring review			01/08/2018	31/12/2018	A Viswanath	J Odum	
		4b	Develop process of joint PC and RWT review of OOH deaths including reporting mechanisms	Process agreed by GPs and RWT		Process for PC colleagues under discussion. RWT will pilot system with VI practices. Dr Mona Sidhu involved in piloting within VI and next meeting planned March 20.	01/01/2019	30/09/2020	S Roberts	J Odum	
	5		Processes for including families/relatives in the mortality reviews		We have the capability to listen to relatives and carers following death						
		5a	Appoint a Bereavement Nurse	BN in post			01/12/2018	30/07/2019	M Morris	AM Cannaby	
		5b	Action Plan designed to meet National LFD Working with Bereaved families developed	Action plan monitored		Action Plan agreed	01/04/2019	30/12/2019	J Shears/J Jones	AM Cannaby	
		5c	Evidence of learning from families	ME/BN contact with families, feedback from concerns/complaints collated		Some learning available and ongoing work to embed	01/04/2019	30/12/2019	J Jones	AM Cannaby	
	6		Results of SJRs are reviewed and acted upon by Divisions and Directortaes		Themes from results of mortality reviews are complied and triangulated with lessons learned from clinical audits, mortality reviews and coroners' reports.						
		6a	Thematic review of SJR results presented to include clinical involvement in process	6 monthly thematic reviews presented at MRG		Governance dept uses nurse to support thematic development. MR identified to become involved	01/07/2019	31/10/2019	S Hickman	J Odum	
		6b	Share SJR results with Directorates	Monthly email with SJR results			01/04/2019	31/07/2019	S Hickman	J Odum	
	7		Provide an IT platform that describes required inputs, data capture and feedback on themes of Mortality reviews	Project Plan	Repository of results from scrutiny, review, and investigation that provides a mechanism for sharing learning from deaths	Weekly meetings	01/10/2018	31/03/2020	S Parton	K Stringer	
		7a	Develop the software	Functioning IT platform		Phase 1 due Dec 2019, delayed by Trust Network upgrade. IT Platform plan due to Go Live 31st March. IT testing of the new Learning from Deaths Platform is taking longer than originally anticipated; as a result the go live date is being postponed until 1st June 2020. Both IT and Business Transition Plan being developed.	01/01/2019	31/03/2020	S Parton	K Stringer	
		7b	Implement the programme	Functioning IT platform		IT testing of the new Learning from Deaths Platform is taking longer than originally anticipated; as a result the go live date is being postponed until 1st June 2020.	01/10/2019	31/03/2020	S Parton	K Stringer	
		Coding Data is Accurate									
	8		Reduce the number of short term FCEs at 'front door'	Increase in average hours for FCE	Coding reflects full diagnosis of population of admitted patients including definitive co-morbidities, primary and secondary diagnoses.		01/01/2018	31/05/2018	J Cotterell	K Stringer	
	9		Educational package for coding to be delivered to Medical teams	Increase in average CCI Reduced anamolies in PD seen at case note reviews			01/01/2018	01/12/2018	J Cotterell	J Odum	
	10		Documentation at portals of entry reflects diagnosis and CCs by improvement in proforma and CQI project			Proforma introduced 2018. Improvement in CCI. Further work required to improve PD	01/01/2018	30/04/2020	H Ward	J Odum	
	11		Coding policy developed which allows for retrospective review of case notes				01/10/2018	31/12/2018	J Cotterell	K Stringer	
		11a	Retrospective ongoing review of clinical documentation accuracy				01/04/2019	30/03/2020	J Cotterell	K Stringer	

		11b	Coders and AMU Consultants to meet to review documentation and impact on coding				30/03/2020	30/03/2020	J Cotterell	K Stringer	
A4		**Clinical Pathways deliver high quality care**									
	1		A Quality Improvement strategy and agenda is rolled out across the Trust with emphasis on embedding concept into daily activity	Directorates report QI inititatives			01/04/2019	31/03/2020	Si Evans	M Sharon	
	2		Implement care pathway audit against best practice standards to inform CQI programmes. Concentrate on clinical groups were SHMI is high	CQI programmes produced by leads for high excess deaths groups	We have evidence of the standard of care provided for our patients	All high SHMI diagnostic groups have been reviewed, improvement plans have been developed and CQI commenced in majority of areas	01/07/2018	01/06/2019	Mortality Leads	J Odum	
		2a	Develop rolling reviews of audits across directorates led by Divisions	Evidence of action following audits		Rolling review of change impact is part of the CQI process	01/07/2018	01/03/2020	DMDs	J Odum	
		2b	Undertake nursing care audits	Realtime audits of sepsis and pneumonia,			10/09/2018	30/11/2018	M Morris /V Whatley	AM Cannaby	
	3		Community in reach project to be audited via a PDSA methodolgy				01/09/2018	01/03/2019	AM Cannaby	AM Cannaby	
	4		Best practice sepsis care, including working with CEO UK Sepsis Trust, Action plan inc CQI programme of work	Sepsis six monitored across organisation		CEO has visited and part of edcation week. CQI programme of work commenced. Action plan developed inc CQI prog of work	01/03/2019	01/09/2019	Dr Gulati/Saibal Ganguly	J Odum	
		4a	Implement NEWS2 track and trigger system and protocol for sepsis .				01/01/2018		Dr Gulati/Saibal	J Odum	
	5		Develop a process of undertaking harm reviews 104 day+ Cancer waits	Harm reviews reported monthly			01/09/2018	31/10/2018	Cancer lead	G Nuttall	
	6		Adhere to national 7 day service agenda	90% compliance against Standards 2,5,6,8			01/04/2018	31/03/2020	J McKiernan	J Odum	
A5		**Education**									
	1		Develop a Programme of leadership training for medical staff including MDT, HF, unwarranted variation, chairing of meetings, inflencing and negotiation	Medical staff completing the course	Trust staff understand the Mortality programme and are able to influence the agenda	Leadership programme launched including induction sessons for new Consultants. Then modules available for Cons and other medical staff inc internal and external courses.	01/03/2019	30/03/2020	L Nickell	J Odum	
	2	2a	Leadership training for doctors should be included in PDPs			Deptuty Medical Director and Lead Medical Appraiser to use consultant development programme to link leadership development into PDPs	01/07/2019	30/06/2020	B McKaig	J Odum	
		2b	Assurance of impact of leadership training				01/07/2019	31/12/2020	B McKaig	J Odum	
	3		Training for junior doctors on completion of Medical Certificate	Training at induction			01/01/2019	01/08/2019	M Norell	J Odum	
	4		Provide oportunities for Medical Examiners to meet and share experience	Bi monthly meetings			01/01/2019	01/08/2019	M Norell	J Odum	
A6		**Workforce**									
	1		Implement Trust recruitment strategy for nursing	Vacancy rate/clinical output	We have safe nursing levels		01/01/2018	01/12/2018	R Baker	AM Cannaby	
	2		Further expand deteriorating patient 'out reach team'	Nurses in post/clinical output	We have the capability to support the deteriorating patient 24/7		10/10/2018	31/03/2019	Head of Nursing Div 1	AM Cannaby	
	3		Recruit senior nurses to sepsis programme	Additional nurses in post/clinical output	We have the capability of identifying and treating patients at risk of sepsis		01/09/2018	31/01/2019	V Whatley	AM Cannaby	
	4		Expand Palliative care team	Additional nursing and Consultants in post	We have the capability to support patients to die in place of choice		10/10/2018	31/03/20198	D Black	AM Cannaby	
A7		**Communication Plan**									
		1	Senior Managers' Briefing	Presentation at SMB and ongoing	Trust staff understand the Mortality programme and are able to influence the agenda		01/09/2018	01/04/2019	J Odum	J Odum	
		2	Trust Communication	Updates in Trust newsletters		Communication via TB/TMC reports and directorate meetings	30/11/2018	01/12/2019	J McKiernan	J Odum	
		3	Directorate Engagement	Meetings with Directorates		Restart meetings from 1/04/2020	01/06/2019	30/07/2020	A Viswanath	J Odum	