ENC No 14A

Walsall Healthcare NHS
NHS Trust

Meeting	Trust Board
Date	27th November 2014
Title of Paper	Mortality Action Plan
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PURPOSE OF THE PAPER

The paper provides an update to the Trust Board on the organisations mortality action plan which addresses the areas identified for improvement during recent reviews and to set out the plans for the focus of work in the mortality agenda in the coming year.

SUMMARY OF THE KEY POINTS

- Improving hospital mortality is one of the Trust's key priorities as set out in the Quality & Safety Strategy.
- The Hospital Standardised Mortality Rate (HSMR) has remained consistently low throughout the past year, showing the positive results of the work undertaken.
- Following the completion of a in depth review of the Trusts mortality processes by Mott MacDonald, A phase 2 mortality reduction action plan was put into operation.
- This action plan included surveillance, early warning in respect to mortality and overall quality alongside a programme of further improvement. Regular monitoring and reporting of progress against this action plan has been received by Quality and Safety Committee.
- This new action plan addresses remaining issues which had not been fully implemented in previous iterations of this action plan and looks to address newly identified issues and set out further areas for examination, review and improvement over the coming year.

RECOMMENDATIONS

1. NOTE the Trust's current hospital mortality rate & associated commentary

LINKS	
• Strategic Objectives	Safe, High Quality Care *(Patient Promise: In Safe Hands)*
• Annual objectives	To reduce hospital mortality rates
• Monitor / CQC / Regulatory Requirements	Mortality rates are reviewed by both CQC and Monitor
IMPACT	
• Patient Experience	
• Quality & Safety	Hospital mortality rate is a key measure of quality and safety of care
• Financial	Resources have been invested in additional consultant and palliative care support
• Workforce	A medical workforce review has been undertaken as part of this plan
• Equality & Diversity	
• Estates	
• IM&T	
• Communications / Engagement	Effective communication will be key to the success of the plan
RISKS • Failure to deliver continued improvements in hospital mortality risks damaging the reputation of the Trust with its stakeholders • Failure to deliver improvements may present a risk to the continued progress of the Trust's Foundation Trust application	
PREVIOUS CONSIDERATION Quality & Safety Committee, 20th November 2014	

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PROGRAMME TITLE	**Mortality Action Plan**
LEAD	Medical Director, Associate Medical Directors (supported by Head of Patient Relations & Patient Safety Project Manager)
PROGRAMME SPONSOR	Amir Khan Medical Director
AIM OF PROGRAMME	This is the third phase of the mortality reduction programme begun in early 2012. This seeks to sustain the improvements delivered *(continued reduction in SHMI & HSMR level)* and deliver further improvements which are identified via a robust monitoring process. The Programme is based around four key activities **1. Maintaining and developing the strength of governance process around mortality review, feedback and action** **2. Continuation of action commenced in 2012/13 which requires support to sustain & drive further improvements** **3. Improvement activity based on intelligence from clinical reviews and available data** **4. Addressing organisation wide and health economy wide issues that will improve the outcomes & experience of patients in cross covering issues such as Palliative Care, Referral process & Fluid Administration.**
MEASURE(S) OF SUCCESS	1. Standardised Hospital Mortality Index (SHMI) & Specific diagnostic group analysis 2. Hospital Standardised Mortality Rate (HMSR) & Specific diagnostic group analysis 3. Crude Hospital Mortality Rate Compared to regional & National 4. Number of Hospital Deaths 5. Mortality reviews demonstrating improvement in target areas
PERFORMANCE MANAGEMENT	Mortality & Quality of Care Group with Trust Board reporting via Quality & Safety Committee

Action	Lead	Source of Assurance for completion	Current progress towards completion	Agreed date for completion	R / A / G	Escalation for amber / red
Objective 1 – To improve the quality of Documentation and the use of Care Plans and Care Bundles						
Eliminate reports of Illegibility of health records by improving both documentation and individual practice	MD, AMD, DoN, HoNs	Positive reports from reviews, Patient Records Audits	Formal letter returned to all Consultants from medical Director, dated 13th June 2014 stressing the importance of good documentation quality. Item identified in actions for improvement following elderly care group mortality reviews. Actions continuing	Ongoing		Issues relating to poor documentation quality continue to be identified.
Reiterate importance of legible signatures, date, time and print to aid in identification of individual clinicians to improve documentation quality.	CDs	Positive reports from reviews, Minutes of Care Groups, Patient Records Audits	As above – Item also discussed s part of Jr Dr Induction programmes and name stamp available to all Doctors.	Aug 2014		
Facilitate better Improve the filing & condition of health records by targeting information & training towards ward clerks.	Head of Health Records	Positive reports from reviews, Patient Records Audits	Trust wide process for management of clinical records is contained within Health Records Policy, to be recirculated.	~~Sept 2014~~ Feb 2015		
Ensure the ease of availability of NOF, Sepsis, UTI, CA pneumonia, COPD, Heart Failure and Stroke to ensure all patients who require the use of these bundles have them in place.	AMU Consultants	Improved clinical outcomes	Stress tests by Patient Safety team and case reviews by AMU Consultants show improving use of care plans and good availability. Working group on Sepsis attempting to roll out principles of sepsis care bundle to other inpatient areas.	April 2014		Documents easily available in relevant areas (A&E, AMU, MSK wards for NOF); working to ensure understanding and availability in all ward areas.

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Establish ongoing process for the monitoring and reporting of the use of care bundles into Quality Teams and Care Groups of the number of patients who had the bundle used and the full implementation of all actions.	PSPM	Population of data reporting in monthly mortality reports to Care Groups & Quality Teams	Exploration of process using Dr Foster model performed, does not meet Trusts requirements. Discussion held at MRG Oct 2014 about how to monitor use within the Trust, process to undergo further exploration.	~~Oct 2014~~ Feb 2015		
Familiarity with care bundles and their importance to the quality of outcomes for patients to be addressed to new start Doctors and at each rotation.	MD	Induction programme	Care bundles included on Junior Doctor Induction programme	August 2014		
Review process for Consultant to Consultant referrals and between specialities.	MD	Process flow chart, Positive reports from reviews	Process for Consultant to Consultant referrals discussed at MAC.	Oct 2014		
Objective 2 – To assure the Trust of robust and independent procedures for the coding of mortality cases						
Continue to investigate and participate in National discussion on the inclusion protocol for the use of Z51.5 Palliative care code including for telephone advice and consultation.	MD, Head of Coding	Minutes of Mortality Review Group, HES Data	Agreed protocol amongst coding regional network on the process for use of palliative codes. WHNT protocol remains robust with agreement from Palliative Consultant and cross check with Somerset database required for use of Z51.5 codes.	Ongoing		

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Instigate procedures for robust assurance and ongoing audit of mortality coding including Consultant sign off.	MD, Head of Coding	Agreement of process for mortality coding sign off.	Lorenzo system now able to provide print outs of coding. Consultant coding reviews commencing for mortalities from November 2014 onwards.	June 2014		
Audit of process for palliative care coding procedures to assure consistency and accuracy of process.	Head of Coding	Audit report and action plan	Not yet commenced	Dec 2014		
Objective 3 – To ensure that Clinical Guidelines are available and robust to support care decisions and consistency of approach.						
Develop database of all clinical guidelines to ensure version control and archiving arrangements.	Audit and Effectiveness Manager	Database in place	Complete - managed by Audit and Effectiveness manager.	April 2014		
Develop and agree standardised format for the use of clinical guidelines.	Audit and Effectiveness Manager	SOP	Complete - SOP agreed for standard guideline formatting at MAC November 2014.	July 2014		
Develop Standard Operating Procedure for the review, preparation, ratification and audit of clinical guidelines.	Audit and Effectiveness Manager	SOP published on intranet	Complete - SOP agreed for standard guideline formatting at MAC November 2014.	Sept 2014		

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Objective 4 – To ensure Clinicians have been suitably equipped with the knowledge received through mortality reviews						
Review the programme for update training for Consultants to ensure it includes all trends and themes identified through Mortality reviews.	MD, AMDs, Head of Learning Centre	Programme of clinical update sessions, training records	Review undertaken of clinical mandatory training to include fluid balance. A monthly newsletter is circulated to all clinicians. Mortality reviews are included in the specialty team meetings.	July 2014		
Objective 5 – To perform in depth reviews of mortalities on an ongoing basis to identify trends and trigger service improvements						
Continue to develop processes and procedures for Consultant review of all hospital mortalities.	MD, CN, PSPM	Completed review proforma documents	Process in place for individual care groups to review maximum of 10 mortality cases each month with Consultants assigned to a rota system and feedback to the monthly care group with identified actions.	May 2014		
Perform comparative review of returned mortality review documents in order to identify where individual Consultants require additional support to identify the required depth of data quality.	CN, PSPM	Use of review data to trigger feedback	Review initially convened but abandoned in depth. Anecdotal compassions show some	~~June 2014~~ March 15		
Provide formalised training back to individuals identified as requiring additional support to assure accurate data quality from mortality reviews.	CN	Minutes and schedules of training	Action deferred – cannot be commenced until above action is completed.	~~July 2014~~ March 15		

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Develop feedback loop from mortality reviews to advise clinicians of issues and concerns with quality of care delivered for learning and service improvement.	CN, PSPM	Letters, presentations, minutes & meeting schedules, changes in HSMR	Formal letter from medical director to all consultants following MRG with actions and trends. Care Groups take responsibility for their own mortality reviews and feedback. Presentation to joint audit group by CN in 10/14. Patient Safety team investigating launch of monthly newsletter “learning lessons”.	Aug 2014		
Liaise with CCG to aid in facilitating reviews by GPs of patient deaths within 30 days of discharge.	MD, PSPM	Presentation of results and action plan	Review agreed, scope and process for identifying and performing review to be agreed. Participation in group agreed and patient sample identified for review	June 2014		
Liaise with Social Care and Public Health at council to facilitate reviews of patients admitted to hospital with LOS 0-3 days from Care homes and Residential homes	MD, PSPM	Presentation of results and action plan	Cases identified and fed back to group, identified no significant trend for patients either from specific GP practices or from nursing or residential homes.	June 2014		
Objective 6 – To address specific identified areas for improvement in care quality						
Convene task and finish group with multidisciplinary membership with mandate to tackle recurring fluid balance concerns.	PSPM	Minutes of meeting, Terms of Reference, Project Initiation Plan	Group convened, chaired by Dr Epstein. Revised fluid balance documentation and monitoring chart drafted and trialled in several areas. Following	April 14		

Action	Lead	Source of Assurance for completion	Current progress towards completion	Agreed date for completion	R / A / G	Escalation for amber / red
			feedback, chart to be forwarded for approval, printing and deployment.			
Undertake review and improvement activity in respect to mortality data which highlights Urinary Tract Infection	AMD Medicine	Presentation of results and action plan	Not yet commenced, dates to be agreed	TBC		
Undertake review and improvement activity in respect to mortality data which highlights Fractured Neck of Femur	AMD Surgery	Presentation of results and action plan	Trauma meeting group convened in November 2014, meeting to be held to review all NOF cases April – July 14 on December 4th.	December 2014		
Undertake review and improvement activity in respect to mortality data which highlights Respiratory Failure	AMD Medicine	Presentation of results and action plan	Not yet commenced, dates to be agreed	TBC		