Report to:	Trust Board	Agenda item:	SFT 4054
Date of Meeting:	7 June 2018	Report title:	

	Learning from deaths Q1 – Q4 2017 - 2018			
Status:	Information	Discussion	Assurance	Approval
			X	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting) :	Dr Christine Blanshard, Medical Director			
Appendices (list if applicable):	Appendix 1 – Mortality dashboard 2017/18 Appendix 2 - Learning from death themes and improvement actions. Appendix 3 – Mortality dashboard explanation of terms			

Recommendation:
Recommendation – assurance that the Trust is learning from deaths and making improvements. Assurance – a mortality dashboard 17/18 shows the number of reviews, learning themes and improvement actions. Most importantly, the support of bereaved families will be strengthened by additional end of life care nurses listening to experiences and driving improvements. HSMR is within the expected range but SHMI is increasing. The relative risk of deaths in high risk groups shows a declining trend in 5 groups and remains within the expected range in 2 groups. Improvement actions in the biggest causes of death are ongoing.

Executive Summary:

number of new requirements on Trusts. These are to collect and publish information on learning from deaths and resulting quality improvements, publish a mortality policy on how the Trust responds to and learns from the deaths and publish an annual overview in the Quality Account.

- The report includes our dashboard with the number of reviews and learning themes published for the full year 2017/18.
- Most importantly, the support for bereaved families and carers will be strengthened with additional end of life care specialist nurses to drive improvements.

Board Assurance Framework – Strategic Priorities	
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	

- ¾ Introduction of the ReSPECT form (treatment escalation plan and DNAR form) led by the Resuscitation Committee by March 2019.
- ¾ Ongoing education programme on end of life care to include ReSPECT and resuscitation training.
- ¾ Development of a frailty unit for acutely unwell elderly patients.

ward moves in high risk patients 2) early involvement of the mental health team 3) MDT decision making about assisted feeding 4) Improve documentation of mental capacity when a patient refuses care.

11.0 HSMR and SHMI - February 2017 to January 2018

HSMR is 102.3 and within the expected range and shows a linear decrease over the last 12 months. Emergency weekend HSMR is 100.9 and is within the expected range as is weekday HSMR at 103.8.

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14. Child death – the death of a child up to the age of 18. All unexpected child deaths are reviewed by the Wiltshire and Swindon Child Death Overview Panel.

15. Learning disability deaths – all patients with learning disabilities aged 4 to 74 years. The Trust reports all these deaths to the LeDeR programme.

16. LeDeR programme – Learning Disabilities Mortality review programme hosted by the University of Bristol aims to guide improvements in the quality of health and social care services for people with learning disabilities across England. The programme reviews the deaths of people with learning disabilities.

17. Serious mental illness – all patients who die with a serious mental illness.

18. Maternal deaths – is the death of a woman while pregnant or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management. Maternal deaths are rare events.

Reference