SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

How Sherwood Forest Hospitals used Dr Foster data to tackle high mortality and become an exemplar of improvement

By Dr Foster
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In 2013, Sherwood Forest Hospitals had one of the highest hospital standardised mortality ratio (HSMR) in the country and was included in the Keogh Review. Then, in 2015, consistently high mortality saw the Trust placed in special measures. Together with Dr Foster, Sherwood Forest Hospitals worked to identify, understand and tackle areas of high mortality and, as a result, its mortality rates have improved significantly. The Trust is now used as an exemplar when it comes to reducing mortality.

Challenge – understanding the reason for high mortality rates

The Keogh Review was a catalyst for change at Sherwood Forest Hospitals. The Trust recognised that it had to urgently reduce mortality, and that it had to understand why high mortality was occurring. Sherwood partnered with Dr Foster and used its Healthcare Intelligence Portal to create a robust mortality review process, enabling the Trust to drill down into the data and identify areas of clinical practice where improvements could be made.

A contributing factor to the Trust's high HSMR was sepsis deaths. As a result, it received a Section 31 notice, which meant mandatory weekly reporting of sepsis mortality for 45 weeks.

Solution – improving staff awareness of mortality is crucial

Elaine Jeffers, deputy director of governance and quality improvement, explains the next steps the Trust took to tackle the issue. "We started looking in detail at the data by diagnosis group so we could make comparisons, understand why mortality was high for patients with sepsis and then implement changes."

In 2016, Dr Foster undertook a review of sepsis deaths, which provided external validation that the Trust was improving. Elaine says: "We were able to demonstrate the improvement we were making was sustainable and the

weekly reporting sanction was lifted in May 2016. We now routinely screen at over 90 per cent for sepsis, we are complying with the sepsis bundle, and there is much greater awareness amongst staff."

At the end of 2015, Sherwood Forest Hospitals set up a mortality surveillance group led by Dr Andy Haynes, medical director, to review HSMR data and began working closely with Dr Foster to develop a trust-wide awareness of mortality. Dr Foster collaborated with the Trust's coding teams to improve information recording processes.

Elaine says increasing staff engagement with the data has made a big difference. "It's about having conversations with individual teams and getting them to produce their own reports. They better understand the impact of recording and measurement."

All specialties have a monthly mortality meeting where cases are discussed to determine quality and safety of care delivered and whether any avoidable or contributory factors to the death of a patient have been identified. Surgery has a divisional learning event every month where the teams discuss issues and improvement opportunities that have resulted from their specialty mortality meetings. In addition, the medicine and urgent and emergency care divisions hold a monthly grand round where any learning can be shared.

Benefits – learning is replicated across the Trust

The Trust has seen a significant reduction in its mortality rates, with deaths below the expected level since April 2016. The summary hospital-level mortality indicator (SHMI) is lower than expected for the first time since 2010.

Sherwood Forest Hospitals was an early adopter of the national guidance for learning from deaths, which was published in 2017 and aimed to standardise the death review process.

The Trust adopted the Royal College of Physician Structured Judgement Review Methodology, training in excess of 80 consultants in the first year. It has also appointed a medical examiner in response to the statutory requirement to provide an independent overview of the mortality review process, which has had the added benefit of supporting junior medical staff with the accurate completion of the Medical Certificate of Death and acting as the point of contact for the coroner.

All divisions are fully engaged with the mortality review process. However, a significant change has been implemented by the critical care department. Elaine says: "Previously, when a patient died in the critical care unit, they would look at all the interventions in that department alone, but now they do a joint mortality review with other teams involved in the pathway to find out if anyone could have done anything differently and whether they collectively provided the best care possible."

The Trust is planning to invite every specialty to the mortality surveillance group to present their mortality stories and agree the specific areas they believe will instigate the greatest improvement to the care they deliver to patients.

Dr Foster is continuing to analyse data by diagnosis group and is now working with the stroke and cardiology teams to understand performance and where improvements can be made. Elaine says: “We have been supported throughout the process by our board and by Dr Foster. Working with them has helped spark a significant turnaround.”

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