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:

- The National Quality Board published guidance on learning from deaths in March 2017 and placed a 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.
- HSMR is within the expected range but SHMI is increasing. The relative risk in high risk groups is declining or within the expected range. Ongoing improvement actions are described in the biggest causes of death.

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	☐

Purpose

1.1 To comply with the national requirements of the learning from deaths framework, Trust Boards must publish information on deaths, reviews and investigations via a quarterly agenda item and present a paper to a public board meeting.

1. Background

2.1 In December 2016, the Care Quality Commission (CQC) published 'Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England'. The report made recommendations about how the approach to learning from deaths could be standardised across the NHS. In particular, they found that families and carers often had a poor experience of investigations and there was no single framework for NHS Trusts that sets out what needs to be done to maximise the learning from deaths.

2.2 The National Quality Board published guidance on learning from deaths in March 2017 and placed a number of new requirements on Trusts. Hospitals must collect and publish information on learning from deaths and resulting quality improvements, publish a mortality policy on how it responds to and learns from the deaths and an annual overview in the Quality Account.

2.3 The main purpose of this initiative is to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

3.0 Mortality dashboard, learning, themes and actions

In 2017/18, 841 deaths occurred in the Trust. A new screening process was introduced in August and by the end of March, 529 (90%) deaths had been subject to a first screen. Between Q1 and Q4 17/18, 302 (36%) deaths had had a full case review. None of the deaths had a greater than 50% chance of death being due to problems in care but 29 deaths had slight evidence of avoidability. Themes arising from the 56 learning points were:

- Delays in insertion of PICC lines.
- Treatment escalation plans not in place to ensure that patients had their ceiling of care documented in the event of the patient deteriorating.
- The need to regularly review the ceiling of care as the patient's condition changes.
- Timely DNACPR decisions.
- Insufficient senior medical review over a weekend of acutely unwell elderly patients leading to late recognition of deterioration.
- Procedural documentation regarding risks and benefits of ward based procedures such as lumbar puncture.

Improvement actions include:

- Redesign of the PICC line service with 2 nurses identified to undertake training.

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

Learning is shared via favourably evaluated quarterly mortality bulletins available on the intranet and through educational events. An annual overview of learning from deaths is published in our Quality Account 2017/18.

4.0 Bereavement support

There were 11 family/carer concerns raised throughout the year either from the screening process but mostly from the bereavement survey. At the end of Q3 the survey was put on hold due to the unanticipated workload whilst a business case was written to seek additional funding to support this work. There was a noticeable decline in family concerns raised in Q4. The business case was agreed and the bereavement follow up service is to be introduced and the survey will restart in July 18.

5.0 CUSUM alerts

12 CUSUM alerts arose during the year and 8 have been investigated. Learning included: 1) Timely DNAR decisions 2) Repeat X-rays or CT after a new fall or presentation of an elderly patient. Assess the cause of the fall as well as the damage done. 3) Inadequate care over a weekend of an acutely unwell patient. 4) Timely screening and administration of antibiotics of patients with sepsis.

6.0 Death following a planned admission to hospital

There were 20 patients who died during a planned admission to hospital. Reviews indicated that the majority of these patients had metastatic cancer and were admitted to hospital for symptom control or a procedure to relieve their symptoms and died from disease progression.

7.0 Unexpected deaths

There were 5 unexpected deaths all of which were judged to be unavoidable. Learning included: 1) Ensure the initial assessment is completed and documented thoroughly and the patient is reviewed on the post take ward round with all the available results 2) Update the safety brief as soon as the patient moves within and between wards 3) Continue CPR until the status is clear.

No deaths were investigated either as a serious incident inquiry or clinical review in 2017/18.

8.0 Stillbirths and neonatal deaths

7 stillbirths (6 stillbirths were normally grown babies. 1 stillbirth was being monitored by the GROW programme but was not identified as small for gestational age until birth).

7 neonatal deaths (5 due to extreme prematurity). 1 baby was born at home whose mother had not had any antenatal care. 1 baby was born prematurely with a known anomaly and died within a few hours of birth.

9.0 Patients with a learning disability

Four patients with learning disabilities died in 17/18 and all these were reported to the LeDeR programme. None of the deaths were considered avoidable. An end of year check was carried out to ensure all deaths had been captured and a further 12 patients were identified. These cases will receive a full case review and be included in the next quarterly report.

10.0 Patients with a serious mental illness

2 patients with a serious mental illness died in 17/18. The mental illness was not the primary cause of death but contributed to it. These cases were subject to a full case review by a Consultant Psychiatrist. Both were elderly patients transferred from a mental health hospital for medical management of severe malnutrition and pneumonia. Neither death was avoidable but there were learning points 1) Need to reduce

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. When combined, HSMR is 103.1 and is as expected.

SHMI is 109.3 to September 17 and within the expected range using NHS Digital statistical banding but is statistically higher than expected using 95% confidence intervals. Using Dr Foster's statistical banding SHMI is higher than expected and on an upward trend. Although SHMI does not use palliative care codes it can be adjusted to take it into account. SHMI adjusted for palliative care is 104.4.

12.0 Comorbidity and palliative care coding 17/18

Comorbidity coding is 97 as an index of national and is the same as in 16/17.

Palliative care coding rate is 6.17% compared to the national rate of 4.04%.

13.0 Deaths in high risk diagnosis groups (February 2017 to January 18)

Deaths in the following five diagnosis groups show a downward trend in relative risk:

- Septicaemia (except in labour) – 122 decreased to 109
- Pneumonia - 135 decreased to 90
- Acute cerebrovascular disease - 124 decreased to 81
- Acute myocardial infarction - 100 decreased to 64
- Fractured neck of femur - 117 decreased to 81

Deaths in the following two diagnosis groups show an upward trend in relative risk but remains within the expected range:

- Congestive heart failure - 87 increased to 97. Our national heart failure audit results showed improvement.
- Acute and unspecified renal failure – 87 to 96.

14.0 Biggest causes of death 17/18 and improvement actions

- Pneumonia (115 cases) – test pneumonia care bundle and report to the Safety Steering Group.
- Septicaemia (80 cases) – monthly sepsis audit, feedback and education continues reported to the Safety Steering Group.
- Acute cerebrovascular disease (66 cases) – patient level data submitted to the Sentinel Stroke National Audit Programme. SFT are part of an STP stroke improvement collaborative.

15.0 Summary

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 their experiences and using them to drive 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 within expected range in 2 groups. Improvement actions in the biggest causes of death are ongoing.

16.0 Recommendation

The report is provided for assurance that the Trust is learning from deaths and making improvements.

Claire Gorzanski
Head of Clinical Effectiveness
10 May 2018

Appendix 1

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD 2017/2018

	April 17	May 17	Jun17	Jul 17	Aug 17	*Sep17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total
Deaths	62	69	54	70	67	68	66	49	96	87	74	79	841
1st screen					54	63	60	42	92	82	72	64	529/586
% 1st screen					81%	93%	91%	86%	96%	94%	97%	81%	90%
Case reviews	30	21	9	37	31	18	35	21	32	34	16	18	302
% case reviews	48%	30%	17%	53%	46%	26%	53%	43%	33%	39%	22%	23%	36%
Deaths with Hogan score 1 - 3	0	0	0	0	0	0	0	0	0	0	0	0	0
Deaths with Hogan score 4 - 6	0	1	1	3	4	3	4	2	7	3	1	0	29
Learning points	5	4	0	3	7	8	9	3	8	3	4	2	56
Family/carer concerns	0	0	0	1	3	2	3	0	2	0	0	0	11
CUSUM alerts	0	4	0	1	1	0	0	2	2	1	1	1	12
CUSUM investigated	0	3	0	1	1	0	0	1	2	1	0	0	8
Deaths investigated as an SII	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective deaths	3	3	1	3	0	0	2	3	1	1	2	1	20
Unexpected	0	0	0	0	0	0	1	1	1	1	1	0	5
Stillbirths/ neonatal/child death	1	1	3	2	1	2	0	1	3	1	0	0	15
Learning disability deaths	0	1	0	1	1	1	0	0	0	0	0	0	4
Reported to LeDeR	0	1	0	1	1	1	0	0	0	0	0	0	4
Serious mental illness	0	0	0	0	1	0	1	0	0	0	0	0	2
Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0

*1st screen commenced of patients who died in the Hospice

Note: Appendix 3 - explanatory notes

Appendix 2

SALISBURY NHS FOUNDATION TRUST

MORTALITY DASHBOARD THEMES AND ACTIONS 2017/2018

No	Learning points	Action point	By whom	By when	Status
1	PICC line service – Monday to Friday service and single handed practitioner	Redesign service to provide capacity required.	Dr S Williams, Surgical DMT	31/12/18	
2	Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form)	Work programme to be developed in 2018/19	Resuscitation Committee	31/03/19	
3	Insufficient senior medical review over a weekend of acutely unwell elderly patients which has led to late recognition of deterioration	Development of the frailty service	Dr J Drayson, Medicine DMT	31/03/19	
4	Continuing to review the ceiling of care regularly as condition changes.	Part of EOLC ongoing training and introduction of ReSPECT	SPCT & EOLC teams	31/03/19	
5	Improve documentation of consent, risk and benefits of ward based procedures such as chest drains, lumbar punctures and ascitic taps	Ongoing education programme on consent Implementation of LocSIPPs	J Austin Risk Team	31/03/19	

Appendix 3

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD – EXPLANATION OF TERMS

1. Deaths – the number of adult, child and young people deaths in the hospital and the Hospice.

2. 1st screen - the number of deaths screened to decide whether they need a full case review.

3. Case review - the number of deaths subject to a full case review using a structured method. Case record reviews involve finely balanced judgements. Different reviewers may have different opinions about whether problems in care caused a death. This is why the data is not comparable.

4. Deaths with a Hogan score of 1 – 3. The scores are defined as: 1) Definitely avoidable 2) Strong evidence for avoidability 3) Probably avoidable, more than 50/50 but close call . NHSI guidance 'Any publication that seeks to compare organisations on the basis of the number of deaths thought likely to be due to problems in care is actively and recklessly misleading the reader'.

5. Deaths with a Hogan score of 4 – 6. The scores are defined as 4) Possible avoidable but not very likely, less than 50/50 but close call. 5) Slight evidence of avoidability 6) Definitely not avoidable.

6. Learning points – the number of issues identified from reviews and investigation (including examples of good practice). The main purpose of this initiative is to promote learning and improve how Trusts support and engage with families and carers of those who die in our care.

7. Family/carer concerns – the number of concerns raised by families and carers that have been considered when determining whether or not to review or investigate a death. All families are offered support from our bereavement service and involved in investigations where relevant.

8. CUSUM (or cumulative sum) alerts - are statistical quality control measure which alerts the Trust to when the number of deaths observed exceeds the number expected in a diagnostic or procedure group. Each death in a CUSUM alert is subject to a full case review to promote learning and improvement.

9. Deaths investigated as a SII (serious incident inquiry).

10. Elective deaths – are patients who died following a planned admission to hospital. Our reviews indicate that the majority of these patients had metastatic cancer and were admitted to hospital for symptom control or a procedure to relieve their symptoms and died from disease progression.

11. Unexpected deaths – of patients who were not expected to die during their admission to hospital are subject to a full case review.

12. Stillbirth – is a baby that is born dead after 24 completed weeks of pregnancy.

13. Neonatal death – is the death of a live born baby during the first 28 days after birth.

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

NHS Improvement, July 2017. Implementing the learning from deaths framework: key requirements for Trust Boards. NHS Improvement, London