NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	**SFT4148**
Date of Meeting:	6 December 2018		

Report Title:	Learning from deaths Q2 2018 - 2019			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Prepared by:	Dr Belinda Cornforth, Consultant Anaesthetist Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director			
Appendices (list if applicable):	Appendix 1 – Mortality dashboard Q2 2018/19 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.

Executive Summary:
➢ In June 2018, the government announced the introduction of a system of medical examiners (MEs) in England by 31/3/19. The aim is to improve engagement with the bereaved in the process of death certification and offer them an opportunity to raise any concerns, improve the accuracy of medical certificates of cause of death, and improve detection of malpractice. Our proposal for the introduction of MEs is set out in the report. ➢ In July 18, the National Quality Board published guidance for NHS Trusts on working with bereaved families and carers on how Trusts should support and engage with families after a loved one has died in our care. A workshop was held in October to ascertain compliance with the 8 guiding principles and an action plan will be drawn up. ➢ A mortality dashboard Q2 18/19 shows the number of reviews, learning themes and improvement actions. Most importantly, the support of bereaved families will be strengthened by the plans for the introduction of the Medical Examiner and the support of the bereavement and end of life care team. HSMR has sustained the decrease over the last 2 years and is within the expected range and SHMI has decreased. The relative risk of deaths in high risk groups are within expected range. Improvement actions in the biggest causes of death are ongoing.

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	☐

1. 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.

2. Background

2.1 The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

3.0 Medical Examiners

3.1 In June 2018, the government announced the introduction of a system of non-statutory Medical Examiners (MEs) in England by 31/3/19 with a view to statutory implementation shortly afterwards at a date to be decided by the Secretary of State for Health and Social Care. The aim is to improve engagement with the bereaved in the process of death certification and offer them an opportunity to raise any concerns; improve the accuracy of medical certificates of cause of death; and improve detection of malpractice. Medical examiners will report into local clinical governance systems to support local learning and changes to practice and procedures. Our proposal for implementation is set out in 3.2 and 3.3.

3.2 At SFT, the new ME service will provide:

- A 5 day Medical Examiner roster covering all adult and paediatric deaths, including cover for all leave.
- A facility for Qualified Attending Physicians (QAP's) to discuss each death and death certification in a meaningful way with the ME.
- A facility for each ME to have a meaningful discussion with the next of kin regarding the end of life care of a loved one within the Trust, and an explanation of the death certification and discuss and feedback on any concerns.
- A framework for ensuring that deaths highlighted by the ME as requiring further review are forwarded to the Trust Mortality Surveillance Group.
- The facility for accurate recording of ME datasets and for our data to be benchmarked nationally.

3.3 In order to ensure the ME process does not delay death certification, it will require a roster of senior doctors to be available 5 days a week (80 consultant hours per week), from the existing consultant body. It could form part of a persons' SPA activity. Administrative support and office space would be required.

Training for the ME role will be in place nationally from early 2019. A national IT system is planned but is unlikely to be ready for the introduction of the system in April 2019.

4.0 Working with bereavement families

In July 18, the National Quality Board published guidance for NHS Trusts on working with bereaved families and carers on how Trusts should support and engage with families after a loved one has died in our care.

In October 18, the End of Life care team hosted a workshop to ascertain our compliance with the 8 guiding principles and plan further actions as needed. The work will link with existing processes and the new Medical Examiner system.

5.0 Mortality dashboard, learning, themes and actions

In Q2 18/19, 175 deaths occurred in the Trust. Of these 169 (96%) were screened to ascertain whether the death needed a full case review. In Q2, 61 (35%) of deaths had a full case review. Three deaths (all serious incident inquiries) had a greater than 50% chance of death being due to problems in care and 10 deaths had slight evidence of avoidability. Themes arising from the 16 learning points were:

- End of life care – recognition of situation, communication with patients and families and speeding up fast track discharge home.
- DNACPR decisions, documentation and communication with families.
- Treatment escalation plan/advance directive and wish to stop active treatment not followed.

- Escalation of deteriorating patients.

Improvement actions (to be completed by March 19) include:

- Redesign the PICC line service with 2 nurses identified to undertake training
- Introduction of the ReSPECT form led by the Resuscitation Committee
- Continue end of life care education programme
- Development of a frailty unit for acutely unwell elderly patients
- Introduction of LocSIPPs (standard operating procedures) for local procedures.
- Timely escalation of deteriorating patients – introduction of NEWS2 & escalation process. Agree a HANT escalation protocol when workload exceeds the ability to respond promptly (Jan 19).

Learning was shared at a Learning from Deaths Clinical Governance session on 13 July and via quarterly mortality bulletins available on the intranet.

6.0 Bereavement support

In Q2 18/19 there were no concerns raised by families. However, of the 3 deaths investigated as a serious incident inquiry, families were able to pose questions and offered a face to face meeting to receive an explanation of the report.

7.0 CUSUM alerts

Two new CUSUM alerts arose in Q2 and both will be investigated.

8.0 Death following a planned admission to hospital

Three patients died following planned surgery:

1) Open repair of very large hernia of a patient with multiple co-morbidities and obesity. Progressed back to baseline on ITU and transferred to ward. Mobilised and was well but very suddenly developed agonal breathing and died.
2) Laparoscopic cholecystectomy with 5% risk of major complications. Uneventful surgery but developed sepsis on day 2 and despite a laparotomy, bowel resection and optimal treatment on ITU the patient deteriorated and active treatment was withdrawn in discussion with the family. Good recognition of deteriorating patient and appropriate senior action throughout.
3) 90 year old patient had an elective hip replacement – uneventful surgery and immediate post-operative recovery. Hypotensive episode day 2 treated with IV fluids. Later a CT showed likely ischaemic bowel. Surgical review unlikely to survive laparotomy. Active treatment on ITU but deteriorated and died. Learning:

- Elderly patients should automatically be seen by a consultant anaesthetist in the pre-assessment clinic.
- Consider planned HDU admission post-operatively for elderly patients – discussed at Anaesthetic CG meeting.

1 patient admitted for colonoscopy was acutely septic on admission was treated appropriately but deteriorated despite optimal treatment and died.

9.0 Unexpected deaths

In Q2, there were 3 unexpected deaths all investigated as serious incident inquiries.

- 2 unexpected deaths after patients left the Emergency Department – inquiry reports due in December 18.
- 1 related to the failure to recognise and respond to the severity of the clinical situation although the outlook for the patient was poor.

Action:

- Agree a HANT escalation protocol when workload exceeds the ability to respond promptly (Jan 19).

10.0 Stillbirths and neonatal deaths

Two stillbirths (both were normally grown babies). 1 neonatal death (due to extreme prematurity).

11.0 Patients with a learning disability

In 17/18, at year end, Information Services ran a report which indicated there were 12 deaths of patients with a learning disability. All the cases were reviewed:

- 4 cases were patients with a confirmed learning disability and reported to the LeDeR programme.
- 2 patients who died within 30 days of discharge were reviewed and included in the report.
- 6 patients – all died out of hospital and most had not been admitted since 2015. The patient's results and X-rays were reviewed and a discussion held with the GP to ascertain further information and any concerns.

Learning points:

- Use of Diclofenac with a heparin infusion – analgesia suggested by specialist nurse but not picked up as a potential interaction.
- Admission could have been avoided from the nursing home as an advanced care plan stated not for intravenous fluids or antibiotics. The patient was admitted for end of life care.
- 'About me' documentation to better understand the level of learning disability would have been helpful. Resuscitation status was prompted in hospital rather than prior to admission.

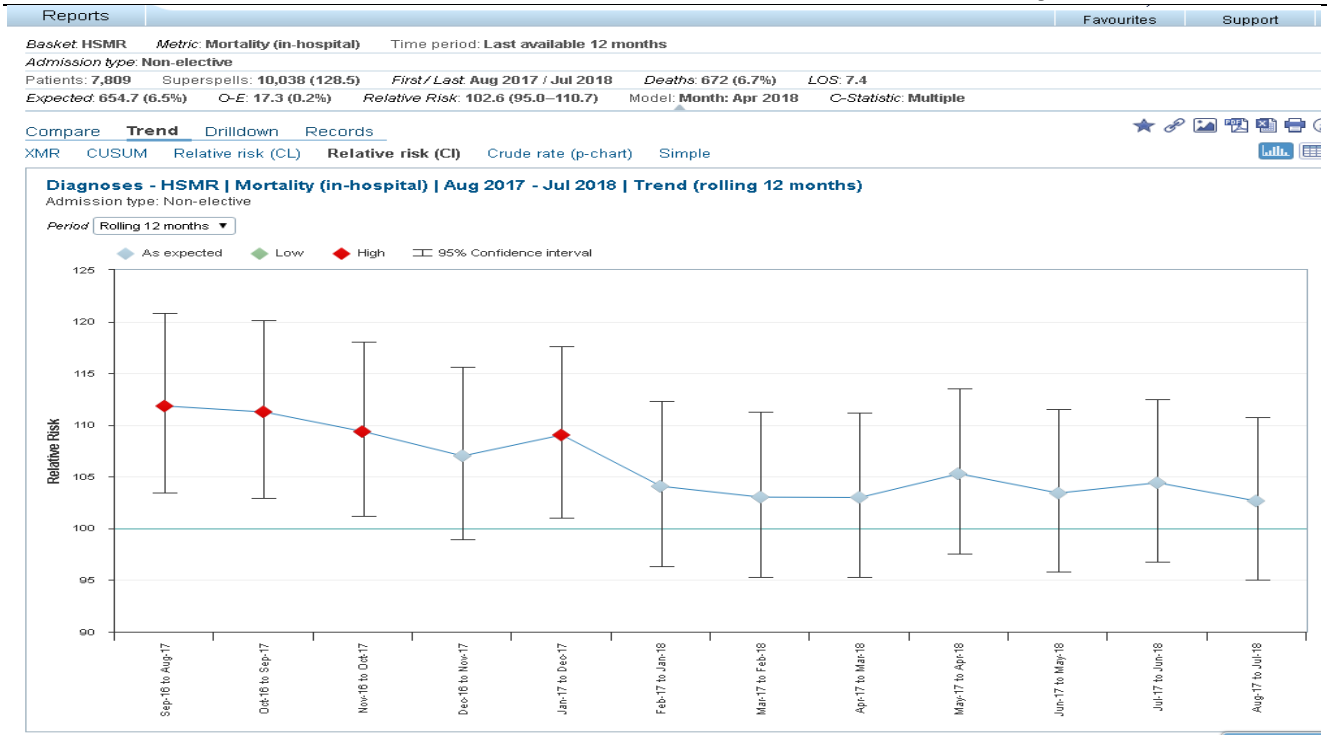
In Q1 18/19, four patients with learning disabilities died out of hospital but were not reviewed as most had not been admitted since 2016. In Q2 18/19, two patients with learning disabilities died in hospital and these will be reported in Q3.

12.0 Patient with a serious mental illness

One patient with a serious mental illness died in Q2. The case is subject to a full case review by a Consultant Psychiatrist and will be reported in Q3.

13.0 HSMR trend to July 2018

Table1: HSMR relative risk of all non-elective diagnoses September 2016 – July 2018

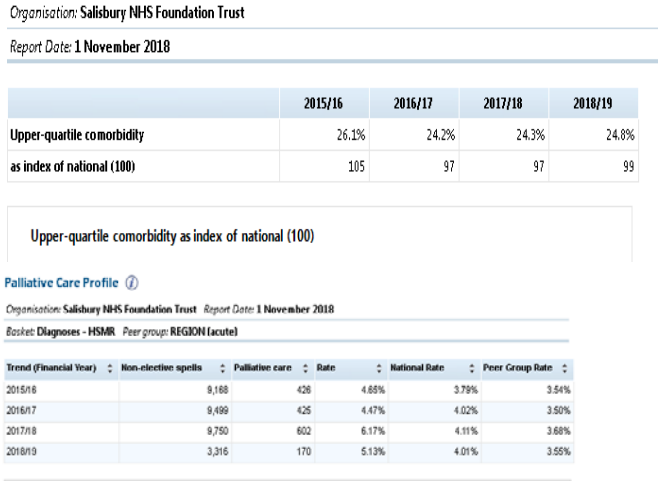


14.0 SHMI April 2017 – March 2018

SHMI reduced from 108 to December 17 to 106 to March 18.

SHMI adjusted for palliative care reduced from 102 to December 17 to 98 to March 18.

15.0 Comorbidity and palliative care coding 18/19



Organisation: Salisbury NHS Foundation Trust

Report Date: 1 November 2018

	2015/16	2016/17	2017/18	2018/19
Upper-quartile comorbidity	26.1%	24.2%	24.3%	24.8%
as index of national (100)	105	97	97	99

Upper-quartile comorbidity as index of national (100)

Palliative Care Profile

Organisation: Salisbury NHS Foundation Trust *Report Date:* 1 November 2018

Basket: Diagnoses - HSMR *Peer group:* REGION (acute)

Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2015/16	9,168	426	4.65%	3.79%	3.54%
2016/17	9,499	425	4.47%	4.02%	3.50%
2017/18	9,750	602	6.17%	4.11%	3.68%
2018/19	3,316	170	5.13%	4.01%	3.55%

16.0 Deaths in high risk diagnosis groups (16/17, 17/18, Q1 & Q2 18/19)

Diagnosis group	Relative risk 16/17	Relative risk 17/18	Q1 18/19	Q2 18/19
Acute and unspecified renal failure	94	87	87	94
Acute cerebrovascular disease	116	84	91	67
Acute myocardial infarction	89	59	118	94
Congestive heart failure	85	96	108	110

Fractured neck of femur	103	69	80	119
Pneumonia	130	93	109	124
Septicaemia (except in labour)	123	108	105	124

17.0 Highest causes of death (August 17 – July 18) and improvement actions

- Pneumonia (97 cases) – test pneumonia care bundle and report to the Safety Steering Group.
- Septicaemia (77 cases) – monthly sepsis audit, feedback and education continues; reported to the Safety Steering Group. Introduction of NEWS2 in January/February 19.
- Acute cerebrovascular disease (60 cases) – patient level data submitted to the Sentinel Stroke National Audit Programme score B to March 18. SFT are part of an STP stroke improvement collaborative.

18.0 Summary

A mortality dashboard Q2 18/19 shows the number of reviews, learning themes and improvement actions. Most importantly, the support of bereaved families will be strengthened by the plans for the introduction of the Medical Examiner and the support of the bereavement and end of life care teams. HSMR has sustained the decrease over the last 2 years and is within the expected range and SHMI has decreased. The relative risk of deaths in high risk groups are within expected range. Improvement actions in the biggest causes of death are ongoing.

19.0 Recommendation

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

Dr Belinda Cornforth
Consultant Anaesthetist
Chair of the Mortality Surveillance Group

Claire Gorzanski
Head of Clinical Effectiveness
5 November 2018

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD 2018/2019

	Apr 18	May 18	Jun 18	Q1	Jul 18	Aug 18	Sep 18	Q2	Oct 18	Nov 18	Dec 18	Q3	Jan 19	Feb 19	Mar 19	Q4	Total
Deaths	69	61	55	**185**	53	67	55	**175**									**360**
1st screen	69	59	55	**183**	50	67	52	**169**									**352**
% 1st screen	100%	97%	100%	**99%**	94%	100%	94%	**96%**									**98%**
Case reviews	29	19	24	**72**	9	26	26	**61**									**133**
% case reviews	42%	31%	42%	**39%**	17%	39%	47%	**35%**									**37%**
Deaths with Hogan score 1-3	0	0	0	**0**	1	2	0	**3**									**3**
Deaths with Hogan score 4-6	1	3	3	**7**	3	5	2	**10**									**17**
Learning points	5	8	5	**18**	8	5	3	**16**									**34**
Family/carer concerns	1	1	0	**2**	0	0	0	**0**									**2**
CUSUM alerts	1	2	3	**6**	0	0	2	**2**									**8**
CUSUM investigated	0	1	2	**3**	0	0	0	**0**									**3**
Deaths investigated as an SII	1	1	1	**3**	0	2	1	**3**									**6**
Death following an elective admission	0	1	0	**1**	2	0	2	**4**									**5**
Unexpected	2	1	1	**4**	1	2	0	**3**									**7**
Stillbirths/ neonatal/child death	2	3	1	**6**	1	2	0	**3**									**9**
Learning disability deaths*	0	0	0	**0**	2*	0	0	**2**									**2**
Reported to LeDeR programme LeDeR	0	0	0	**0**	0	0	0	**0**									**0**
Serious mental illness	1	0	0	**1**	0	0	1	**1**									**2**
Maternal deaths	0	0	0	**0**	0	0	0	**0**									**0**

Note: Appendix 3 - explanatory notes

*Cases to be reviewed and reported to LeDeR if the patient had a learning disability

Appendix 2

SALISBURY NHS FOUNDATION TRUST

MORTALITY DASHBOARD THEMES AND ACTIONS 2018/2019

No	Learning points	Action point	By whom	By when	Status
1	Delay in IV access. PICC line service – Monday to Friday service and single handed practitioner	Redesign PICC line service with 2 nurses identified to undertake training	S Williams, Surgical DMT	31/03/19	
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	Timely and regular reviews of the ceiling of care as the condition changes.	Continue to provide end of life care training	Specialist Palliative Care team End of Life Care team	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	B Cornforth Risk Team	31/03/19	
6	Timely escalation of deteriorating patients	1) Introduction of NEWS2 & escalation process. Education programme. 2) Agree a HANT escalation protocol when workload exceeds the ability to respond promptly (Jan 19).	1) M Ford 2) HANT Board	1) 31/03/2019 2) 31/1/19	

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 by medical staff 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.

Mortality Summary for 12 months to Jul-2018 as at 06/11/2018

Salisbury NHS Foundation Trust - Salisbury District Hospital (RNZ02)

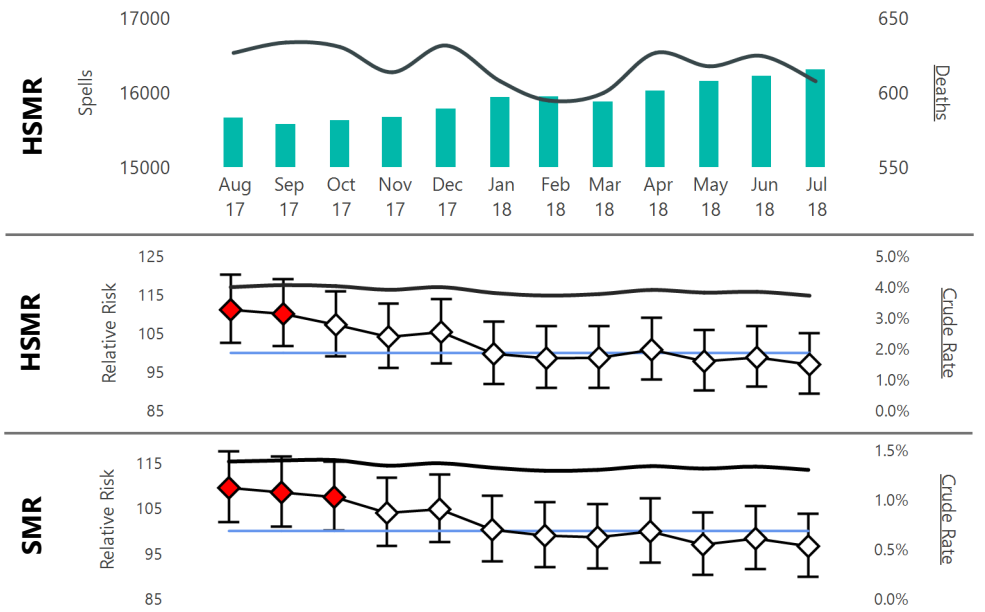
Diagnosis Groups

Relative Risk Alerts (Top 8)	CUSUM	Obs	Exp	RR	LCI	Trend

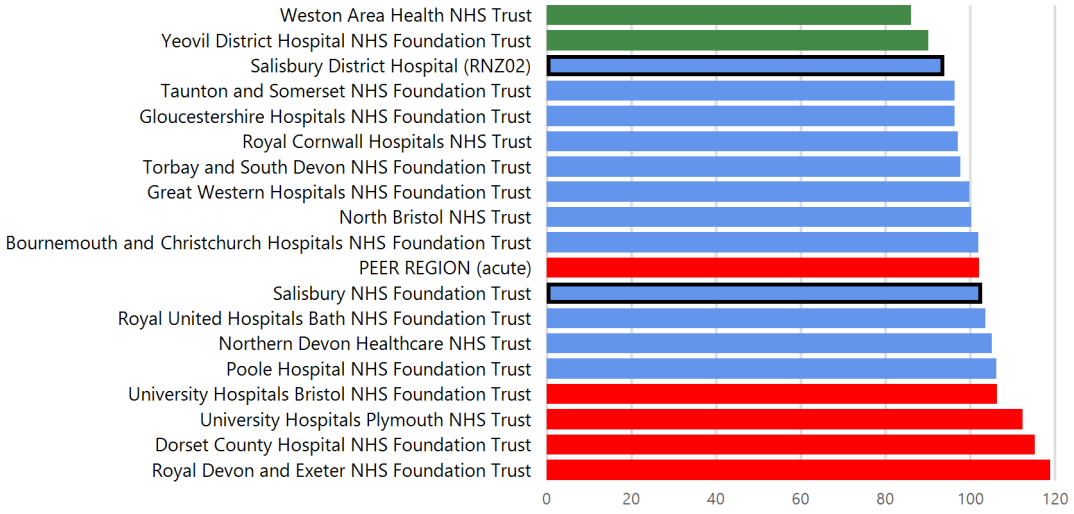
CUSUM-only Alerts (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Intestinal infection	1	12	7.1	168.2	86.8	
Other connective tissue disease	1	11	7.1	154.1	76.8	
Malaise and fatigue	1	2	0.6	335.4	37.7	
Other nutritional, endocrine, and metabolic disorders	1	2	1.2	164.0	18.4	
Other bone disease and musculoskeletal deformities	1	1	0.1	862.8	11.3	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend
Deaths after surgery	17	22.0	77.2	44.9	
Deaths in low-risk diagnosis groups	11	12.2	90.1	44.9	

Rolling 12-Month Trends



HSMR Peer Comparison



HSMR and Influencers

Performance	Site	Trust	Peer	National
HSMR	97.0	102.7	102.2	98.8
SMR	96.6	101.9	101.6	99.1
Elective (HSMR)	74.6	102.8	113.1	105.3
Non-elective (HSMR)	97.3	102.7	101.9	98.7
Weekday, non-elective (HSMR)	94.4	100.6	100.3	97.3
Weekend, non-elective (HSMR)	105.5	108.8	106.8	103.0

Coding / Casemix	Site	Trust	Peer	National
% Deaths in HSMR basket (elective)	63.6%	71.4%	74.2%	65.7%
% Deaths in HSMR basket (non-elective)	80.7%	80.6%	83.3%	84.0%
% Non-elective deaths with palliative care	46.1%	51.6%	28.4%	30.4%
% Non-elective spells with palliative care	4.9%	6.0%	3.6%	4.1%
% Spells in Symptoms & Signs chapter	5.8%	5.8%	6.9%	6.5%
% Spells with Charlson comorbidity score = 0	51.8%	51.5%	46.7%	48.7%
% Spells with Charlson comorbidity score = 20+	8.4%	8.4%	9.2%	8.6%