Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	SFT4119
Date of Meeting:	4 October 2018		

Report Title:	Learning from deaths Q1 2018 - 2019			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
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 Q1 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.

Assurance – A mortality dashboard for Q1 18/19 shows the number of reviews, learning themes and improvement actions. Further guidance is awaited about the system of Medical Examiners. HSMR showed a linear decrease over the last 2 years and is within the expected range. SHMI has decreased. The relative risk of deaths in high risk groups shows a reducing trend in 6 groups and 1 group with a small increase within the expected range. Improvement actions in the biggest causes of death are ongoing.

Executive Summary:

- In June 2018, the government announced the introduction of a system of Medical Examiners in all Trusts by 31/3/19. The aims are to improve engagement with the bereaved in the process of death certification and offer them an opportunity to raise any concerns and improve the accuracy of medical certificates of cause of death. Medical examiners will report into local clinical governance systems to support local learning and changes to practice and procedures.
- In July 18, the National Quality Board published guidance for NHS Trust 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 bereavement support service and survey will be introduced soon.
- HSMR showed a linear decrease over the last 2 years and is within the expected range. SHMI has decreased. The relative risk of deaths in 6 high risk groups shows a declining trend and a small increase in 1 group within the 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 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. 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.

2.2 In June 2018, the government announced the introduction of a system of medical examiners (MEs) in England by 31/3/19. The aims are 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:

- Medical examiners will review all non-coronial deaths.
- A two stage funding of the system will apply whilst legislation is in progress. Further guidance is awaited but it is envisaged MEs will be recruited and trained by the NHS and provided with resources but be 'independent'. Initially MEs will be funded through the existing fee for completing medical cremation forms in combination with central government funding for ME work not covered by those fees. Funding will be revisited when the system moves to a statutory footing when parliamentary time allows.
- All child deaths will be exempt from the costs associated with the ME system.
- A national medical examiner will be appointed.

Along with the introduction of MEs, the proposed legislation will bring about changes to the notification of deaths to the coroner and changes in the cremation form system.

2.3 In July 18, the National Quality Board published guidance for NHS Trust 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.

3.0 Mortality dashboard, learning, themes and actions

In Q1 18/19, 185 deaths occurred in the Trust. Of these 183 (99%) were screened to ascertain whether the death needed a full case review. In Q1, 72 (39%) of deaths had a full case review. None of the deaths had a greater than 50% chance of death being due to problems in care but 2 deaths were possibly avoidable and 5 deaths had slight evidence of avoidability. Themes arising from the 18 learning points were:

- Timely DNACPR decisions and documentation.
- Treatment escalation plans and early ceilings of care discussions
- Escalation of deteriorating patients
- Procedural documentation regarding risks, benefits and consent of ward based procedures such as ascitic taps.

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 NatSIPPs (standard operating procedures) for local procedures.
- Timely escalation of deteriorating patients – introduction of NEWS2 & escalation process.

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

4.0 Bereavement support

There were 2 family/carer concerns raised through the screening process in Q1. 1) Multiple teams dealing with a complex patient. A patient/family meeting with the co-ordinating team would have helped their understanding and involvement in the management plan. 2) Concern about poor nutritional intake as part of end of life care. In 17/18, a bereavement survey was introduced but was put on hold due to the unanticipated workload whilst a business case was written to seek additional funding to support this work. The business case was agreed and recruitment is underway. The bereavement survey will restart later in the year. The service is being planned in accordance with the National Quality Board guidance published in July 18.

5.0 CUSUM alerts

6 CUSUM alerts arose in Q1 and one has been investigated. Learning:

1) Patient fell after discharge but did not have a repeat chest X-ray when re-admitted the next day. Later found to have fractured ribs and a pneumothorax. Learning is that after a new fall or presentation of an elderly patient previous X-rays should be checked and if clinically concerned a new X-ray ordered.

Two CUSUM alerts have been recently investigated will be monitored. Three alerts to be investigated.

6.0 Death following a planned admission to hospital

One patient died following a planned admission to hospital for a stent placement as a palliative intervention for known metastatic cancer and died from sepsis which failed to respond to antibiotic treatment.

7.0 Unexpected deaths

There were 4 unexpected deaths which were judged to be unavoidable. Learning:

1) Routine reading of cardiac devices (CRT-D) if the patient dies after an arrest call (found to be fully functioning).

2) An elderly patient weighing less than 50kg prescribed Paracetamol above the recommended dose with the risk of an unintentional overdose. Item in the 'Mortality Matters' bulletin.

Three deaths were investigated as a serious incident inquiry in Q1 (1 neonatal death and 2 stillbirths).

8.0 Stillbirths and neonatal deaths

Four stillbirths (all were normally grown babies). 2 neonatal deaths (1 was due to extreme prematurity unexpectedly born at home).

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. Two patients with learning disabilities who died within 30 days of discharge were also reviewed. None of the deaths were considered avoidable.

Learning points:

- Use of Diclofenac with a heparin infusion – analgesia not obviously picked up as a potential interaction.
- Admission could have been avoided from nursing home as 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.

The end of year check identified 12 patients (4 cases had already been reviewed, 2 cases died out of hospital within 30 days of discharge – both of these cases are included in the report. The other 6 patients all died out of hospital and most had not been admitted since 2015. The reviewer had looked at results and X-rays and contacted the patient's GP practice to confirm this was the case).

In Q1 18/19, there were no patients with learning disabilities who died in hospital.

10.0 Patient with a serious mental illness

One patient with a serious mental illness died in Q1. The case is subject to a full case review by a Consultant Psychiatrist. An elderly patient with an intentional overdose and wish to die. Learning:

1) Early involvement of the mental health team

11.0 HSMR and SHMI trend to March 2018

Table1: HSMR trend in all non-elective diagnoses May 2016 – March 2018

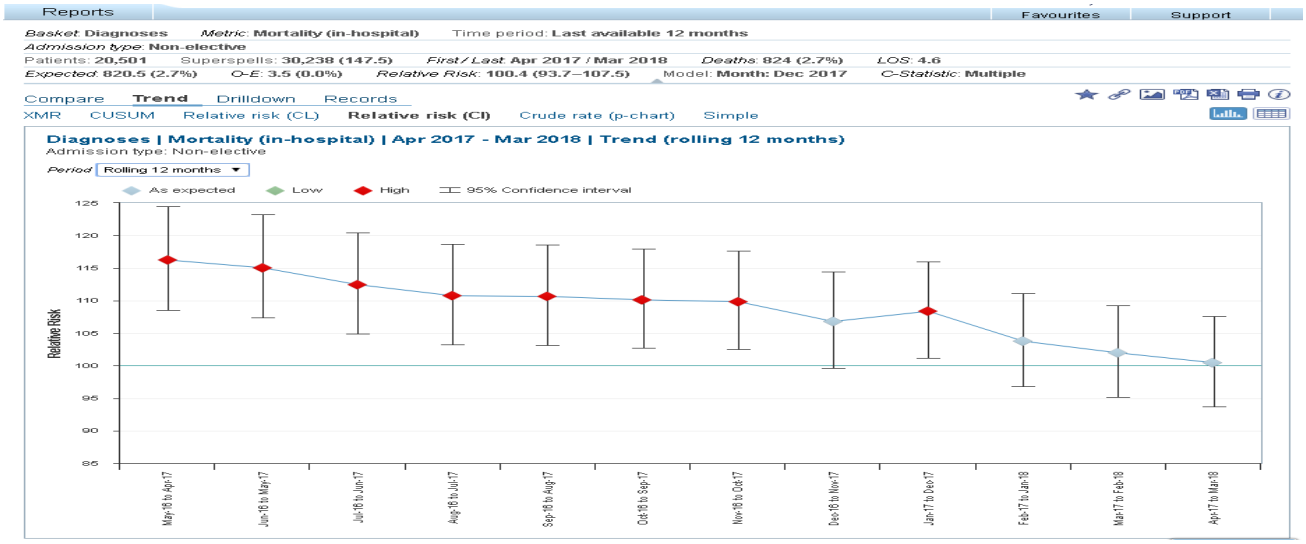
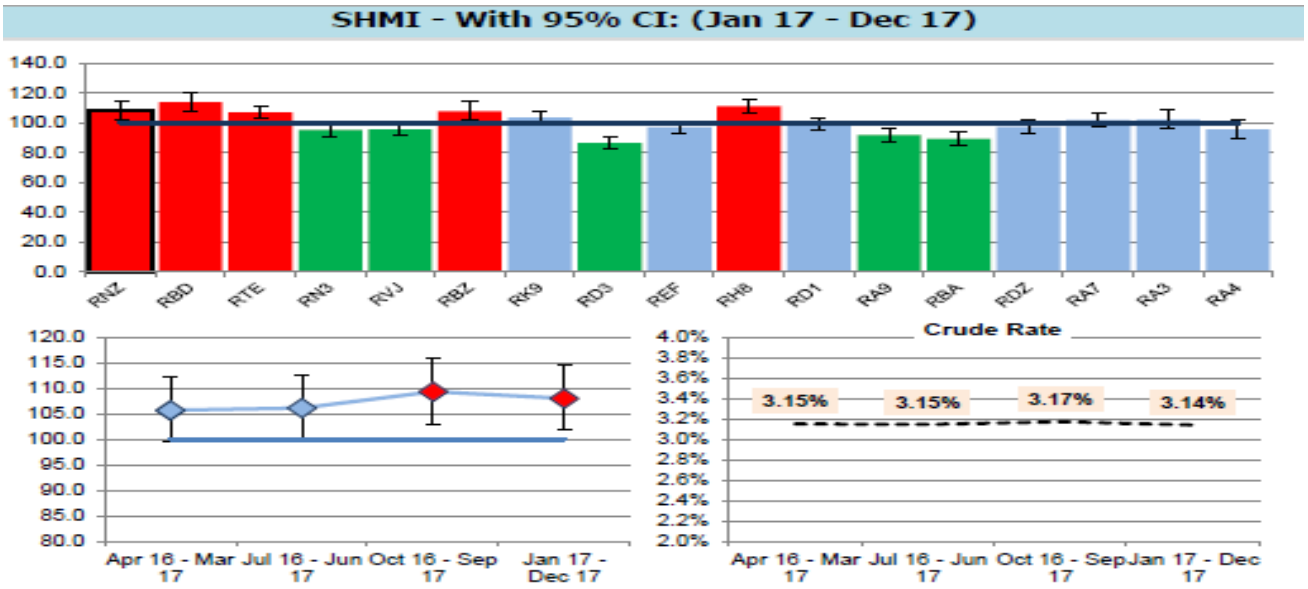


Table 2: SHMI trend April 2016 to December 2017 compared to NHSE South



RNZ = Salisbury NHS Foundation Trust

SHMI adjusted for palliative care reduced from 104.4 in September 17 to 102 to December 17.

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 for all admissions has increased from 4.47% to 6.25% in 17/18 and is higher than the national rate of 4.16%. The palliative care coding rate for the acute Trust only for all admissions has increased from 3.8% in 16/17 to 5.0% in 17/18.

13.0 Deaths in high risk diagnosis groups (16/17 compared 17/18)

Diagnosis group	Relative risk 16/17	Relative risk 17/18	Relative risk 16/17 vs 17/18
Acute and unspecified renal failure	94	87	⇩
Acute cerebrovascular disease	116	84	⇩
Acute myocardial infarction	89	59	⇩
Congestive heart failure	85	96	Within the expected range
Fractured neck of femur	103	69	⇩
Pneumonia	130	93	⇩
Septicaemia (except in labour)	123	108	⇩

14.0 Biggest causes of death 17/18 and improvement actions

- Pneumonia (113 cases) – test pneumonia care bundle and report to the Safety Steering Group.
- Septicaemia (86 cases) – monthly sepsis audit, feedback and education continues reported to the Safety Steering Group. Introduction of NEWS2 by end of Q3.
- Acute cerebrovascular disease (70 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 Q1 18/19 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 showed a linear 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 shows a declining trend in 6 groups and within expected range in 1 group. 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.

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Chair of the Mortality Surveillance Group

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13 September 2018

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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
Deaths	69	61	55	**185**												
1st screen	69	59	55	**183**												
% 1st screen	100%	97%	100%	**99%**												
Case reviews	29	19	24	**72**												
% case reviews	42%	31%	42%	**39%**												
Deaths with Hogan score 1-3	0	0	0	**0**												
Deaths with Hogan score 4-6	1	3	3	**7**												
Learning points	5	8	5	**18**												
Family/carer concerns	1	1	0	**2**												
CUSUM alerts	1	2	3	**6**												
CUSUM investigated	0	1	0	**1**												
Deaths investigated as an SII	1	1	1	**3**												
Death following an elective admission	0	1	0	**1**												
Unexpected	2	1	1	**4**												
Stillbirths/ neonatal/child death	2	3	1	**6**												
Learning disability deaths*	0	0	0	**0**												
Reported to LeDeR programme LeDeR	0	0	0	**0**												
Serious mental illness	1	0	0	**1**												
Maternal deaths	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

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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	Introduction of NEWS2 & escalation process. Education programme	M Ford	31/12/18	

Appendix 3

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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