The Shrewsbury and Telford Hospital NHS Trust

Paper 8

Recommendation ☑ **DECISION** ☑ **NOTE**	**The Trust Board is asked to:** **Discuss** the current performance in relation to key quality indicators as at the end of August 2018 **Consider** the actions being taken where performance requires improvement **Question** the report to ensure appropriate assurance is in place
Reporting to:	**Trust Board**
Date	27 September 2018
Paper Title	Quality Governance Report
Brief Description	The purpose of this report is to provide the Trust Board with assurance relating to our compliance with quality performance measures during August 2018 **Key points to note:** The Care Quality Commission visited the Trust in August 2018 and raised concerns relating to care of patients in the Emergency Departments ED) and also regarding the practice of placing additional patients on the wards. Since the visit the Trust has enhanced the processes already in place to identify, escalate and manage patients who may present with sepsis or deteriorating condition. Monitoring has shown that there has been much improved compliance with both observation and escalation. We have had no incidences of additional patients being placed on the wards since 24 August 2018. The Trust has received, and responded to a Regulation 28 Prevention of Future Death Report from the Coroner's Office. The Trust has responded to the concerns raised which related to a delay in the treatment of a patient with sepsis. In August we reported no avoidable pressure ulcers of any grade – it is now five months since we have reported an avoidable grade three or four pressure ulcer and in the year to date we have reported four grade two avoidable pressure ulcers. The monthly audit continues to show 100% compliance with the WHO Safer Surgery checklist. One form was completed per list, and a total of 61 lists were audited across all theatres during August. Work to improve the culture is on-going via Value Stream 8 One fall resulting in a fracture was reported as a serious incident and there was one further serious incident reported in the month relating to an issue with the electronic Patient Administration System bringing the total number of serious incidents reported since April 2018 to 18 compared to 15 for the same period in 2017-2018. Further analysis relating to the themes of these incidents may be found within the paper. The number of patients waiting more than 12 hours for transfer to a ward from the ITU remains the same as the previous month although the total number of patients being transferred has dropped slightly. The greater number of delays is seen at RSH and resulted in 18 mixed sex accommodation breaches occurring within the ITU setting. There were no safeguarding concerns raised by external agencies against Trust services in August either for adults or children and young people. The Trust raised ten adult concerns, one of which was against one of our wards that did

	not ensure a safe transfer home for a patient resulting in readmission. Safeguarding training figures for Level Two training are low at 60% for Adults and 62% for Children as are those for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). A recovery plan is in place and additional training sessions purchased in order to bring the training compliance levels up. We continue to provide Workshop for Raising Awareness of Prevent (WRAP) and at present our compliance is 62% of applicable staff attended. Fifty four complaints were received in August in relation to Trust services and a reduction in complaints was noted within Unscheduled Care. There was an increase in the number of complaints related to appointments.
Sponsoring Director	Deirdre Fowler, Director of Nursing and Quality
Author(s)	Dee Radford, Quality Manager Sam Hooper, Medical Performance Manager
Recommended / escalated by	Quality and Safety Committee
Previously considered by	**Quality and Safety Committee**
Link to strategic objectives	**Patient and Family** – through partnership working we will deliver operational performance objectives **Safest and Kindest –** delivering the safest and highest quality care causing zero harm
Link to Board Assurance Framework	RR561 RR951 RR1185
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	○ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

The Shrewsbury and Telford Hospital NHS Trust

Paper 8

Quality Governance Report

September 2018

Introduction

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of August 2018. The report will provide assurance to the Trust Board that we are compliant with key performance measures and that where we have not met our targets that there are recovery plans in place.

The report will be submitted to the Quality and Safety Committee and will then be presented to Trust Board for consideration and triangulation with performance and workforce indicators.

The report will be submitted to our commissioners to provide assurance to them that we are fulfilling our contractual requirements as required in the Quality Schedule of our 2018-2019 contract.

Every quarter we provide a detailed report to the Committee relating to a number of metrics as reported here but with the additional detailed triangulation with patient experience metrics such as complaints and PALS and further detail relating to incident reporting down to Care Group level.

This report relates to the Care Quality Commission (CQC) domains of quality – that we provide safe, caring, responsive and effective services that are well led, as well as the goals laid out within our organisational strategy and our vision to provide the safest, kindest care in the NHS.

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Section one: Our Key Quality Measures

Measure	Year end 17/18	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18	Aug 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
CDI due to lapse in care (CCG panel)	13	1	1	1	3	1	1	0	1	1	2			4	0	25
Total CDI reported	32	1	1	3	6	6	2	2	2	2	2	0	2	8	None	None
MRSA Bacteraemia Infections	0	0	0	0	0	0	0	0	1	1	1	1	0	3	0	0
MSSA Bacteraemia Infections	26	2	3	2	4	2	3	1	1	1	3	2	4	11	None	None
E. Coli Bacteraemia Infections	29	3	1	4	2	6	5	2	4	2	6	6	4	22	None	None
MRSA Screening (elective) (%)		95.6	95.5	96.4	96.0	94.0	95.0	95.4	96.5	96.5	95.7	95.6	95.4	95.8	95%	95%
MRSA Screening (non elective) (%)		97.0	97.2	95.3	95.5	94.8	94.0	95.62	96.7	95.9	96.6	96.2	96.8	96.5	95%	95%
Grade 2 Avoidable	46	3	4	6	4	6	4	3	0	2	2	0	0	4	0	0
Grade 2 Unavoidable	157	13	12	12	12	14	17	9	15	6	9	5	3	38	None	None
Grade 3 Avoidable	9	1	2	2	1	0	0	1	0	0	0	0	0	0	0	0
Grade 3 Unavoidable	22	0	1	0	2	6	1	2	2	0	0	4	0	6	None	None
Grade 4 Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grade 4 Unavoidable	1	0	0	0	0	0	0	0	0	1	0	0	0	1	None	None
Falls reported as serious incidents	3	0	0	0	0	0	1	0	0	0	1	0	1	2	None	None
Number of Serious Incidents	77	4	9	7	3	8	15	13	2	4	9	1	2	18	None	None

Measure	Year end 17/18	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18	Aug 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
Never Events	2	0	0	1	1	0	1	0	1	1	1	1	0	3	0	0
Catheter Associated UTI (number of patients on prevalence audit)		6	5	6	6	3	1	6	3	2	10	1	3	19	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE Assessment		95.4	96.4	95.9	95.5	95.1	95.68	95.2%	95.1%	95.9%	95.9%	95.9%		95.7%	95%	95%
ITU discharge delays>12hrs	380	31	37	33	39	17	28	35	41	27	35	36	36	175	None	None
No of MSA breaches other areas	1	0	0	1	0	0	0	0	0	0	0	1	0	1	None	None
Complaints (No)	600	45	45	61	31	49	60	56	54	55	55	60	54	224	None	None
Friends and Family Response Rate (%)	23.8%	18.3%	15%	14.3 %	12.3%	11.1%	13.6%	16.1%	19.9%	17.7%	20.4%	20.8%	20.8%	19.92%	None	None
Friends and Family Test Score (%)	96.6%	97.2	96.1	96.8	97.4	96.6	96.2%	96.4%	97.3%	96.6%	96.6%	95.6%	93.3%	96.5%	95%	95%

Section Two: Key Messages by exception

Feedback from the Care Quality Commission (CQC)

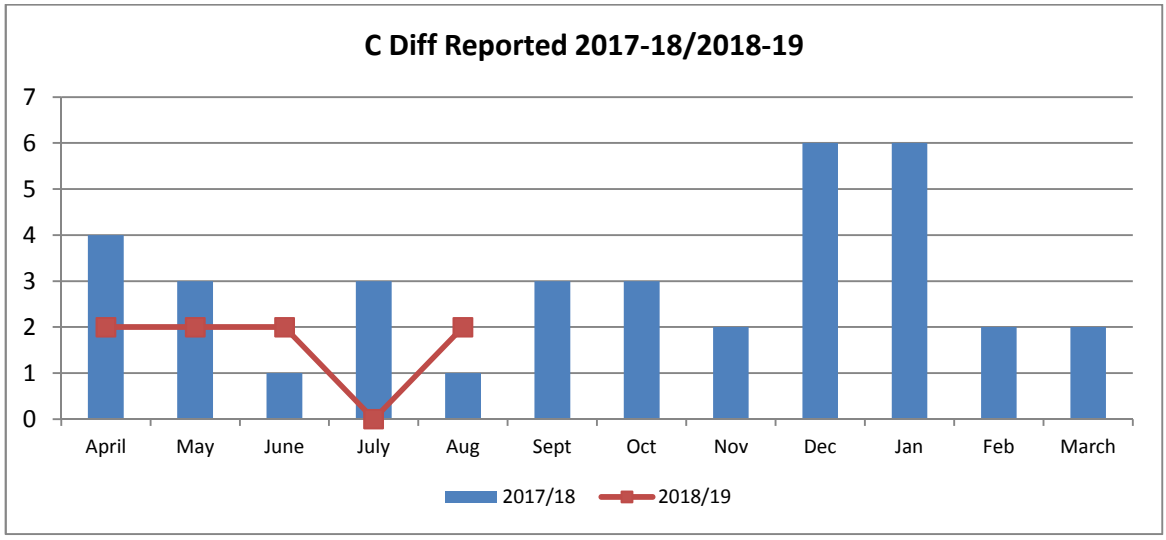
The CQC visited the Trust in August 2018 and raised concerns which relate to the care of patients in our Emergency Departments (ED). The concerns were specifically about the management and escalation of concerns relating to patients with sepsis or a deteriorating medical condition.

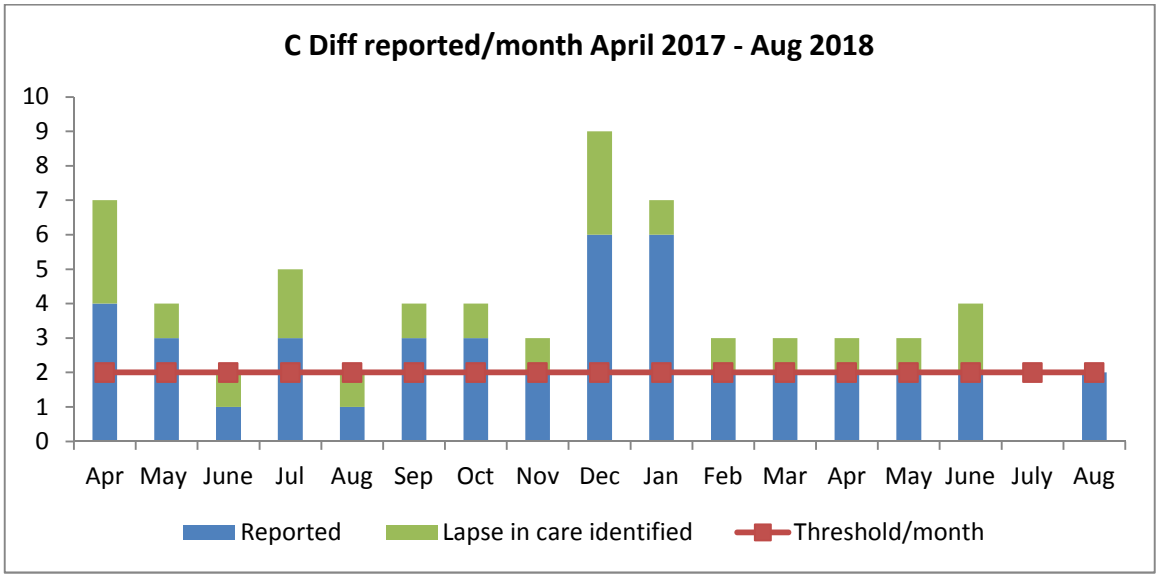
Since the visit the Trust has enhanced the processes already in place to identify, escalate and manage patients who may present with sepsis or deteriorating condition. Monitoring has shown that there has been much improved compliance with both observation and escalation.

Additionally the CQC stated their concerns about the placement of additional patients on the wards at times of escalation. Since 22 August we have not had any such incidences. Escalation areas have been opened in line with Trust escalation plans when required.

Infection Prevention and Control

Clostridium Difficile (C Diff) Reported





Two cases of C Diff were reported in August 2018 taking the total number reported in year to eight compared to 12 at the same point last year.

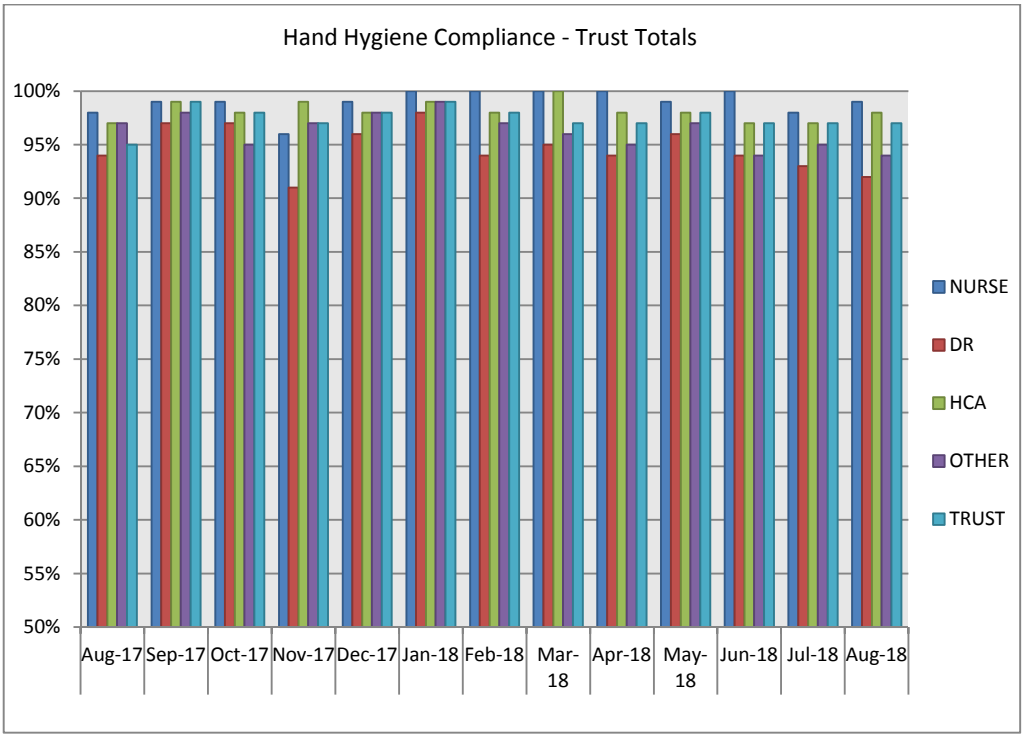
The table below indicates the Trust data in relation to the rate of C Diff reported cases per 100,000 bed days since 2016-2017.

Year	SaTH rate	National rate
	per 100,000 bed days	
2016-2017	8.4	
2017-2018	12.3	13.7
Qtr One 2018-2019	9.0	13.1

We continue to review all cases to assess whether there was a “lapse in care”. Cases where the trust does not feel there was a lapse in care are sent for appeal to be reviewed by an external panel comprising members of the Clinical Commissioning Groups for Shropshire County and Telford and Wrekin, Public Health England, and NHSi.

Overview of Hand Hygiene Observational Audits August 2018

The hand hygiene observational audit results have been analysed against staff groups and show the following level of compliance:



NURSE	DR	HCA	OTHER	TRUST
99%	92%	98%	94%	97%

Learning from Incidents

Regulation 28 Notice Coroners (Investigations) Regulations 2013

The Trust was issued with a Regulation 28 Prevention of Future Death Report on the 19 June 2018. This related to an inquest into the death of a patient who died following a delay in diagnosis of sepsis. The Coroner highlighted three points for the Trust to respond to and explain what actions have been taken to improve this. These are:

- Too few doctors were on duty in general to cover patient needs and there did not seem to be a programme in place for trying to get a third doctor to cover sickness absence.

- Specific medication was not in stock and led to some 2 hours 25 minutes delay in administration. Other suitable drugs were in stock, but not considered.

- Whilst there was a general awareness of the dangers from sepsis from the hospital witness evidence:
    - Red flags of sepsis were missed
    - Leg bandages were not removed to allow for a full top to toe examination
    - Sepsis 6 care bundles were not followed in accordance with guidelines.

The Trust has responded to the notice to the Coroner's Office. The response from the Trust will be published on the Ministry of Justice website in due course.

WHO Safer Site Surgery Checklist

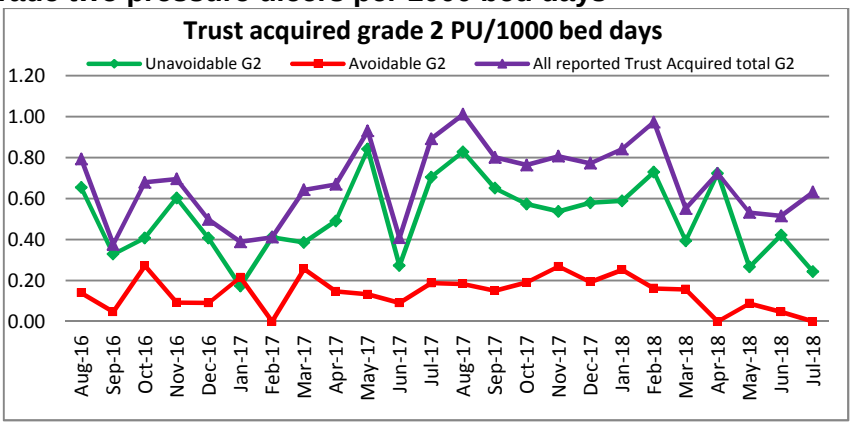
The monthly Safer Site Checklist audit shows 100% compliance with completion of all elements of the checklist during August as in previous months. The audit was carried out by theatre staff during August 2018. Theatre staff completed audit proformas for operating lists across all theatres across both sites. A variety of lists were audited, to ensure inclusion of all speciality areas. One form was completed per list, and a total of 61 lists were audited across all theatres during August. Where possible, all patients on the list were included in the audit, resulting in data being collected for 189 patients. The checklist relies on all information at the time of the completion being correct and so if this is not the case there is a chance that an error may occur.

Learning from in service pressure ulcer incidence

In August there were no category three or category four pressure ulcers reported as Trust acquired meaning that we have reported none in the financial year to date. Additionally, no category two pressure ulcers have so far been determined to be avoidable for August 2018.

The numbers of Trust acquire category two pressure ulcers that we are reporting are shown in the chart below. This indicates that overall the total number of grade two pressure ulcers reported has increased since June 2017, although there is currently a decreasing trend since April 2018. There are still a number that require investigations to be carried out by the ward manager to identify whether these were avoidable.

Trust acquired grade two pressure ulcers per 1000 bed days



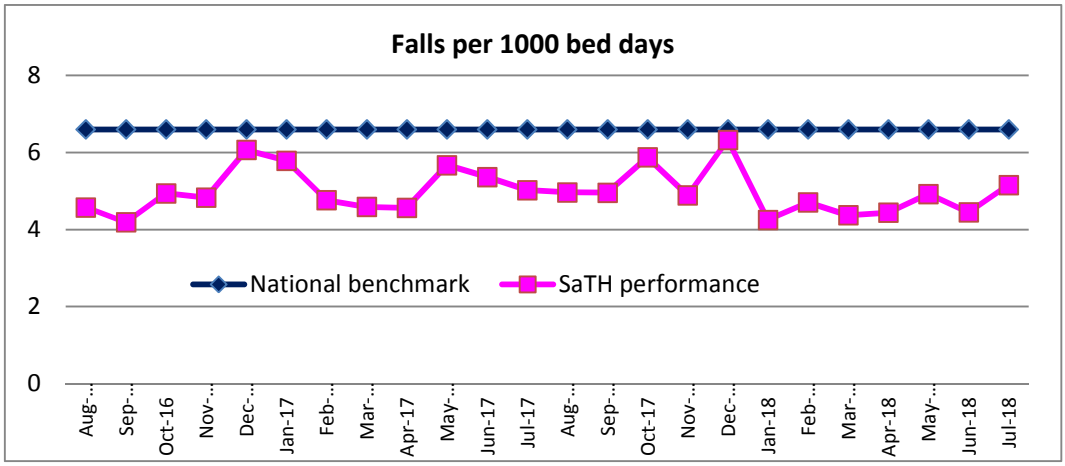
Learning from falls

In August 2018 we reported one fall resulting in a fracture as a Serious Incident and two falls which resulted in fractures which were determined to be suitable to manage as High Risk Case Reviews (HRCR):

Fall injury	Rationale for not reporting as an SI
Fracture head of humerus	Classed as moderate harm, no surgical intervention required, conservative management recommended. HRCR will determine preventability, but initial indications are that appropriate risk reduction measures were in place
Fractured wrist	Classed as moderate harm, no surgical intervention required. HRCR will determine preventability, but initial indications are that appropriate risk reduction measures were in place

The chart below shows that we remain below the national benchmark for falls per 1000 bed days to July 2018. In both December 2016 and December 2017 there were increases in the number of falls in but since January 2018 there has been a consistent level of reporting well below the national benchmark.

Falls per 1000 bed days

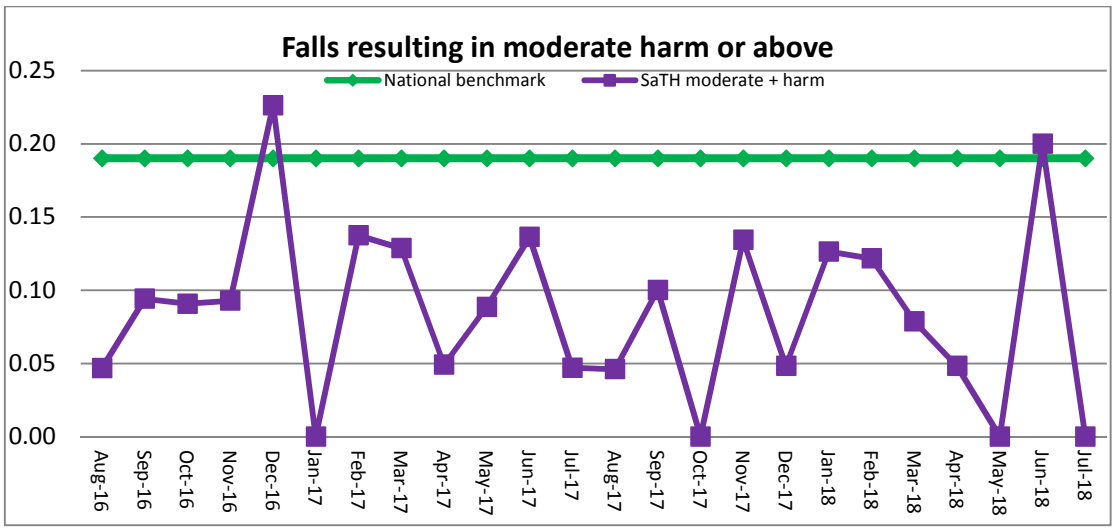


The chart below shows that we also remain below the benchmark for falls resulting in moderate harm or above to May 2018.

From December 2016 to May 2018 the Trust had sustained a lower than the national benchmark number of falls resulting in moderate harm or above for our patients. There was an unusual number of falls resulting in moderate harm and above during June 2018 which took the Trust above the national benchmark for the first time since December 2016. As there have been none during July, this is likely to be an unusual fluctuation, but the outcomes of the investigations (all managed as HRCR) will be reviewed for trends/themes and learning.

Over the past 12 months the average number of moderate harms or above measured per 1000 bed days is sustained at 0.08/1000 bed days which is half the national benchmark.

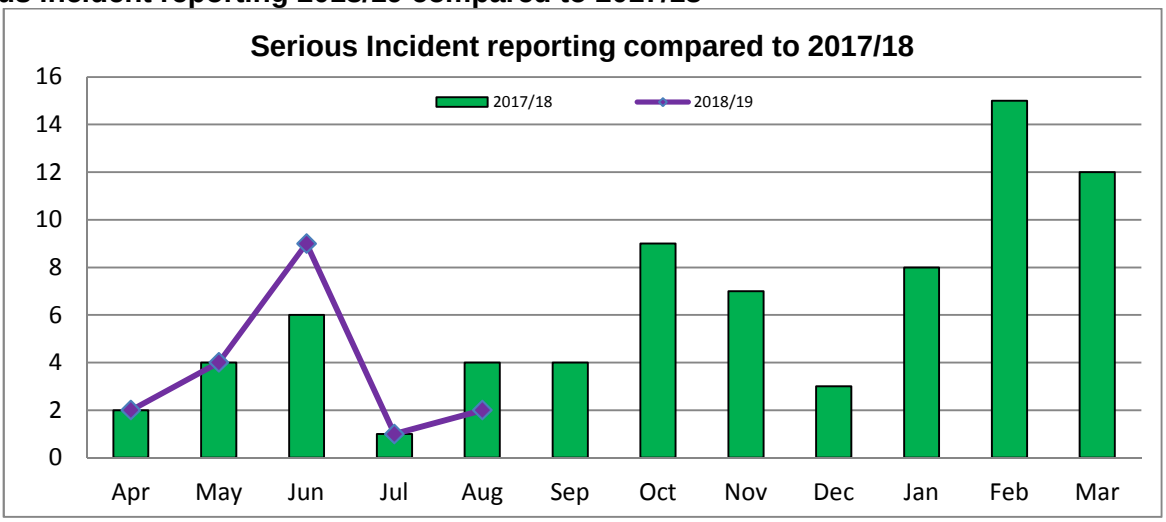
Falls resulting in moderate harm or above



Learning from moderate and serious incidents

In August 2018 we reported two serious incidents as shown in the chart below and are currently following a similar pattern to reporting as the previous financial year.

Serious incident reporting 2018/19 compared to 2017/18



The categories of incident are shown in table one below:

Categories of serious incidents reported in August 2018

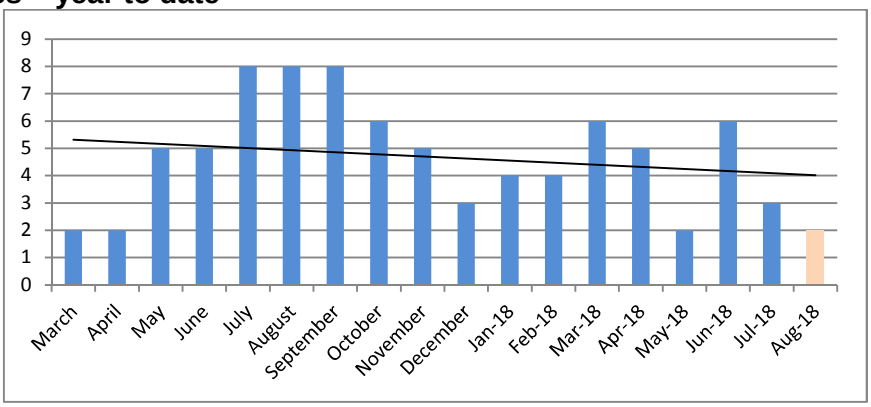
Category	Number
Fall resulting in a fractured femur.	1
Cluster of OPD appointments (related to a previous incident)	1
Total	**2**

All incidents will be investigated using the Trust processes for serious incident investigations and the reports submitted to the commissioners when complete.

Trends for the serious incidents in the year to date show that we have had four Never Events compared to none in the same period last year and three incidents related to a delay in treatment and two to delayed diagnosis which is broadly similar to 2017-2018. In both periods there was one fall that resulted in a serious incident being reported. In 2017-2018 there was one maternity incident reported in the period compared to none in 2018-2019.

Waiting for cancer treatment for more than 104 days

104 day breaches – year to date

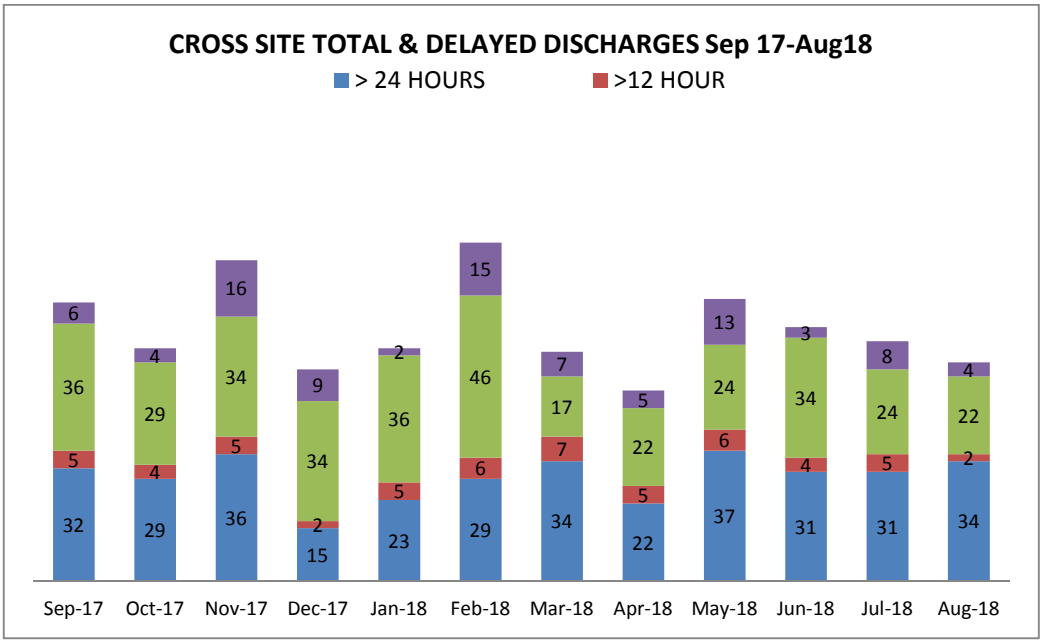


During August there were two reviews of patients that had waited for more than 104 days before receiving the treatment required for their condition. In both instances the patients were found not to have experienced status deterioration or stage progression as a result of the time it took to carry out the requisite tests and gather the opinions required. Both related to patients on the lung cancer pathway.

In accordance with the Trust's procedure, a harm proforma and an investigation report was completed from the clinician / operational team responsible for each individual patient. On completion, both the harm proforma and report were reviewed and signed off by the lead Cancer clinician prior to sharing with the CCG (in line with NHS England Guidelines).

It is our aspiration to eradicate any 104 day breach linked to capacity at SaTH. We will also ensure that any action plans generated as a result of case reviews are reviewed by the Cancer Board and any learning points and actions are followed up to ensure compliance with the action plan in the relevant clinical operational area.

Delayed Discharges from ITU and Mixed Sex Accommodation Breaches



In August the number of patients that were waiting more than 12 hours to be transferred from our high dependency areas to a ward remained the same as in July (36). The total number of patients

transferred from the units was slightly less (62 in July compared to 68 in July). The greatest numbers of patients delayed were at the Royal Shrewsbury Hospital where 29 patients waited more than 12 hours, 27 of whom were delayed more than 24 hours. At the Princess Royal Hospital, no patients waited between 12 and 24 hours and seven over 24 hours. Eleven patients were transferred in less than 12 hours at the Royal Shrewsbury Hospital and 15 at the Princess Royal Hospital.

Whilst waiting for transfer patients are cared for in an area that may have members of the opposite sex also receiving care. Every effort is made to ensure that patients' privacy and dignity is maintained during this time and that when a bed is available on the appropriate ward they are moved as soon as possible. The number of patients waiting for transfer is discussed at the three times a day bed meeting so that a suitable bed is identified for them in a timely way. In August 2018 there were 18 mixed sex breaches due to patients waiting over 12 hours to be transferred out of the ITU and HDU areas into a ward environment. Seventeen of these breaches were at RSH and one at PRH.

There were no incidents resulting in a breach of Mixed Sex Accommodation definitions outside of the critical care areas reported in August.

Safeguarding Adults at Risk and Children and Young People

In August there were ten safeguarding concerns relating to adults raised with the local authorities that involved the Trust. All were raised by Trust services of which six were raised by the emergency department at RSH against either other care providers or individuals. Five concerns related to neglect or omission of care, two to potential physical abuse, one to financial, one to domestic abuse and one to self-neglect. One referral was made by the Trust Safeguarding team against a ward at RSH that had not ensured that care was in place for a patient on discharge resulting in the patient being readmitted the next day.

There were three concerns raised to Social Care relating to Children and Young People in August were made by Trust services (Children's Ward and emergency department). None of these related to children in care or that were subject to a Child Protection Plan.

The percentages of staff that have completed Level Two safeguarding training and training for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) are low and the Trust has put a recovery plan in place to address this and to bring the percentages up to required levels.

We continue to provide Workshop for Raising Awareness of Prevent (WRAP) and at present our compliance is 62% of applicable staff attended over the last three years.

Patient and Carer Experience

Complaints and PALS

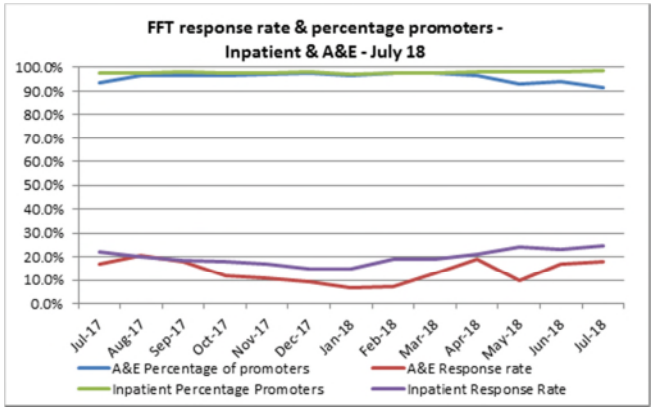
A total of 54 formal complaints were received in August 2018, in line with expected figures. Of these, 29 complaints related to RSH, and 25 complaints related to PRH. There was a significant decrease in complaints relating to Unscheduled Care, but a significant increase in complaints relating to Scheduled Care, particularly in relation to problems with appointments. In addition, there has been an increase in complaints relating to SAU, which has been shared with the ward manager and matron for further review.

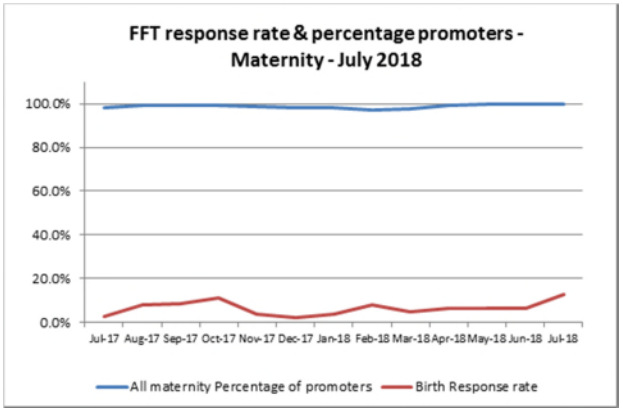
A total of148 PALS contacts were received in August 2018. A lot of the concerns relate to appointments, particularly within ENT and Ophthalmology.

Friends and Family Test

The overall percentage of patients that said they would recommend the ward they were treated on to friends and family, if they needed similar care and treatment, was 93.3% which was lower than in July

2018. The overall response rate was 20.8%. Maternity, Birth and Inpatients all individually saw improved response rates compared to July and A&E was just 0.2% lower than July.





Section Three: Mortality Review

Introduction

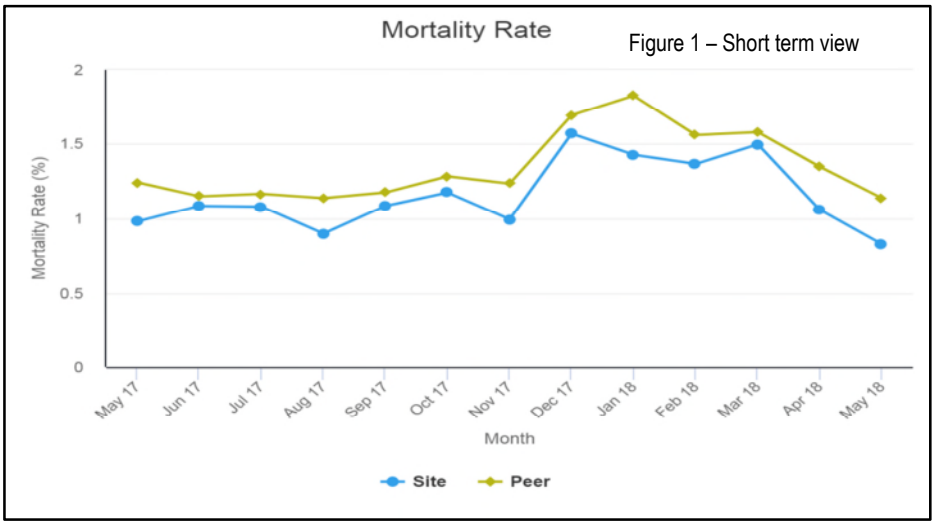
SaTH aspires to be an organisation delivering high quality care which is clinically effective and safe and this partly is achieved by continually monitoring and learning from mortality. These can provide SaTH with valuable insights into areas for improvement. To support that the governance around mortality is well developed, in order to provide continued learning and improvements to the clinical pathways and to reduce unnecessary harm to patients.

We have seen an improvement in our performance regarding mortality over the last four years, and this has been maintained over the last year. This is demonstrated consistently over the four mortality parameters that we use and we now are consistently lower than our peer comparators. The following is an update of progress in this area, based on the most up to date information available.

1. Mortality Rate

This indicator provides a basic view of mortality: the number of deaths divided by the total spells.

SaTH Mortality Rate (May 2017 – May 2018) SaTH 0.82% v Peer 1.13%



SaTH Mortality Rate (January 2013 – May 2018)

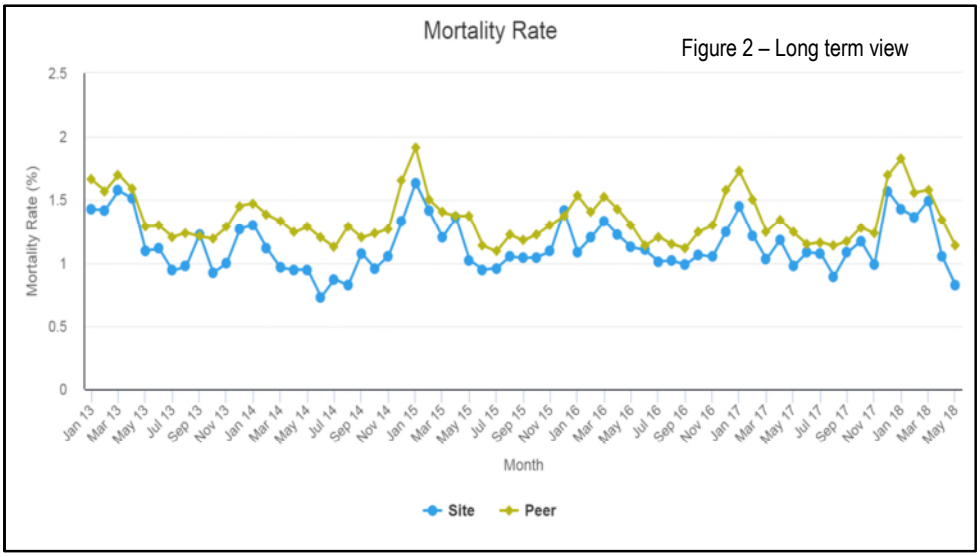


Figure 2 – Long term view

2. RAMI – Risk Adjusted Mortality Index *

RAMI (May 2017 – May 2018) SaTH 67.32 v Peer 81.83

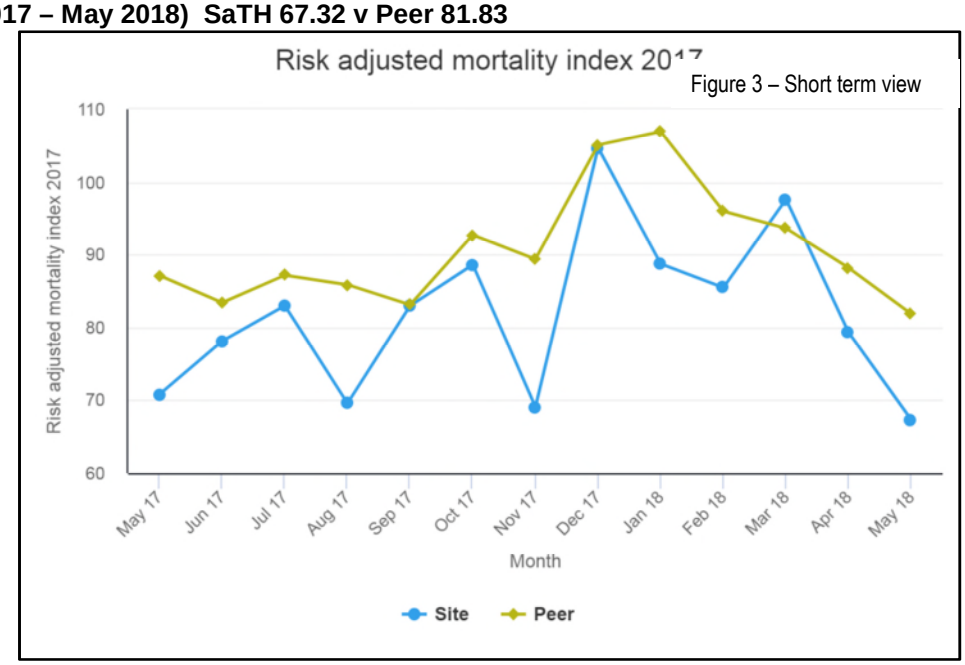


Figure 3 – Short term view

RAMI – SaTH v Trust Peer (January 2013 – May 2018)

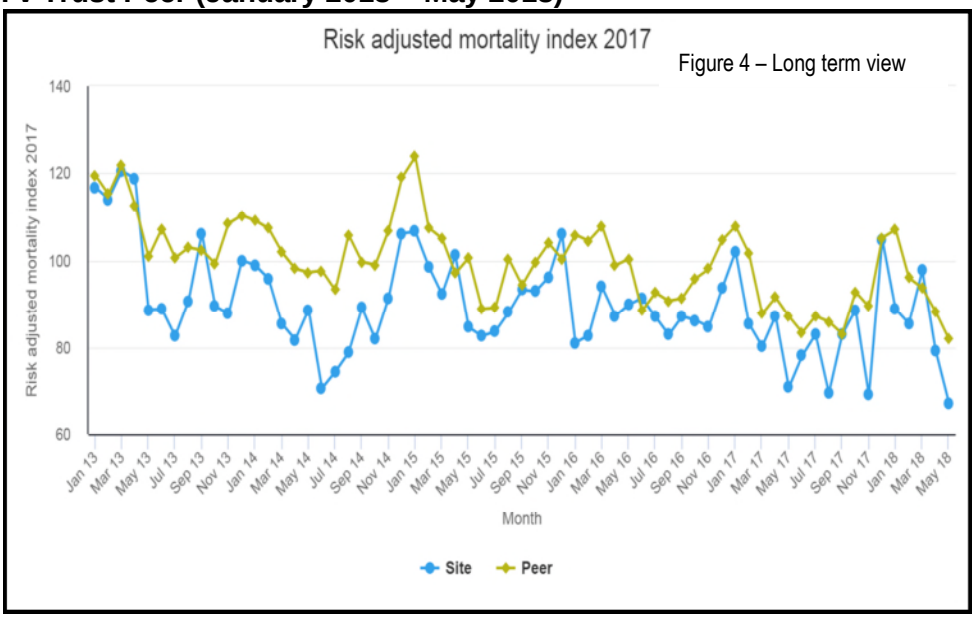


Figure 4 – Long term view

* This mortality ratio is described as the number of observed deaths divided by the number of predicted deaths. RAMI was developed by CHKS (Caspe Healthcare Knowledge System). It includes palliative care but excludes certain specialties, such as Mental Handicap, Mental Illness, Child & Adolescent Psychiatry, Forensic Psychiatry, Psychotherapy, Old Age Psychiatry.

3. HSMR – Hospital Standardised Mortality Ratio **

HSMR (May 2017 – May 2018) SaTH 70.73 v Peer 93.27

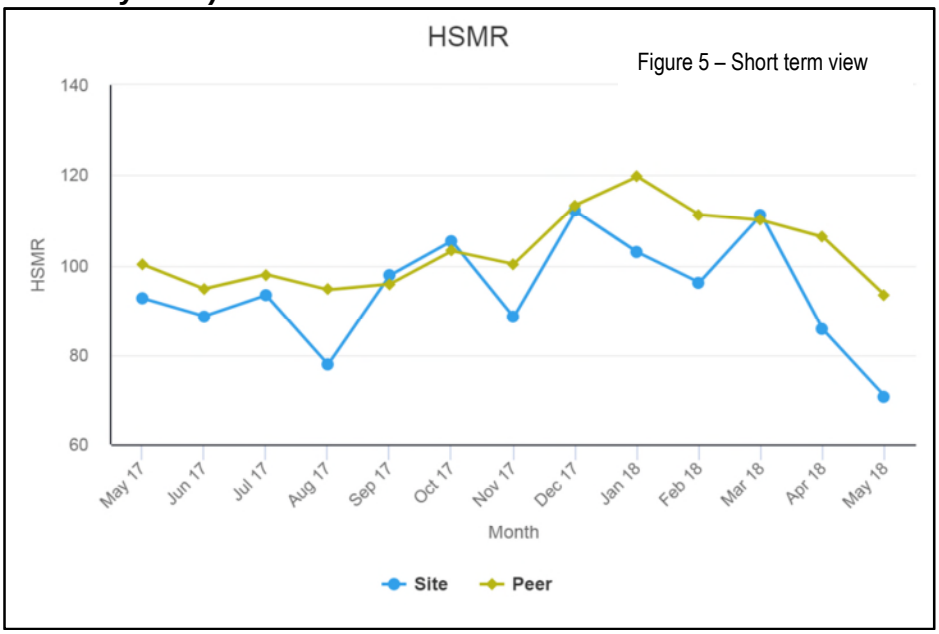


Figure 5 – Short term view

HSMR - SaTH v Trust Peer (January 2013 – May 2018)

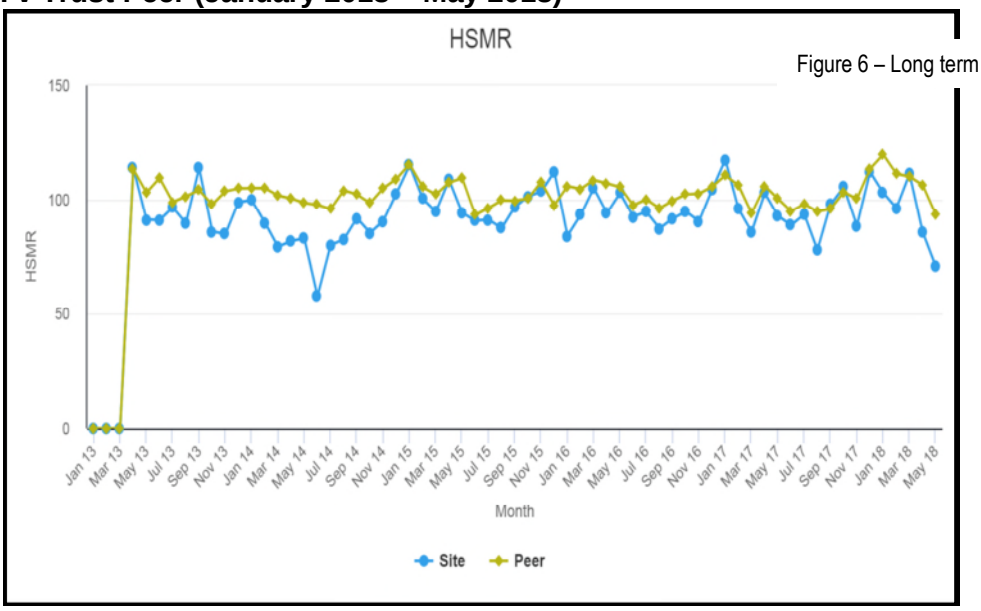


Figure 6 – Long term view

** The HSMR is the ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups. These groups contribute to over 80% of in-hospital deaths in England.

NB A value greater than 100 means that the patient group being studied has a higher mortality level than NHS average performance.

4. SHMI – Summary Hospital-level Mortality Indicator (In-hospital) ***

In-Hospital SHMI (May 2017 – May 2018) SaTH 44.07 v Peer 58.96

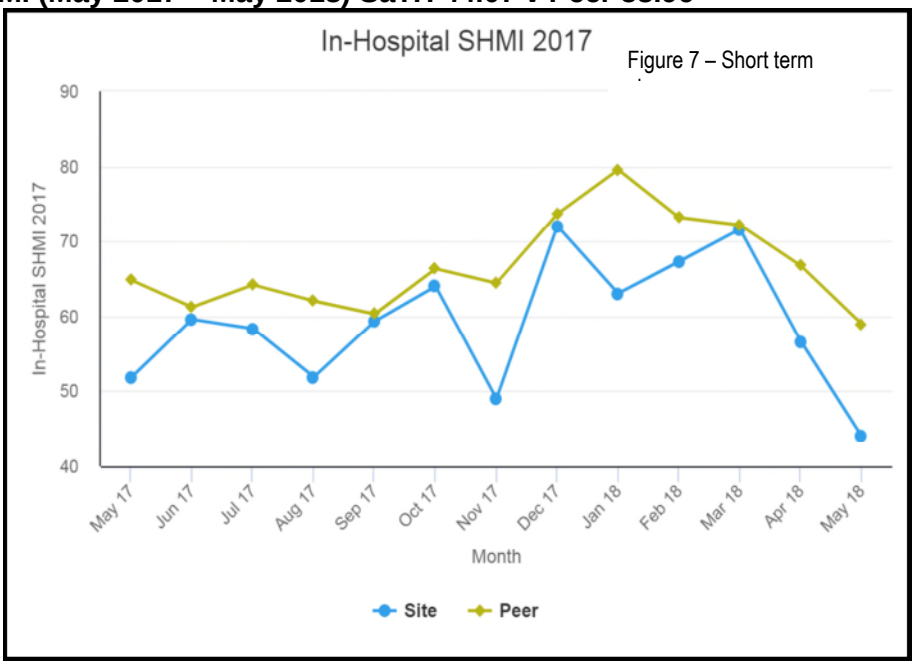
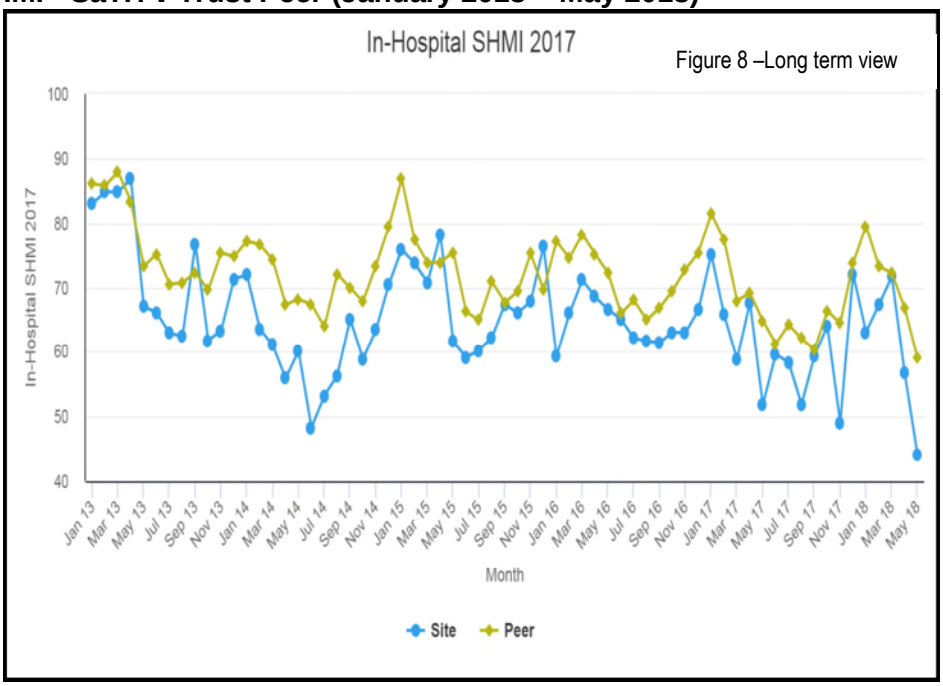


Figure 7 – Short term

In-Hospital SHMI - SaTH v Trust Peer (January 2013 – May 2018)



*** The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die, on the basis of average England figures, given the characteristics of the patients treated there. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital and is counted once against the discharging hospital. This does not exclude palliative care but does exclude day cases. It is based on 259 clinical classification system diagnostic groups.

SHMI-type indicators **cannot** be used to quantify hospital care quality directly due to the limitations of datasets in SUS and HES

Action Schedule Summaries

Quarter 1 (2017/2018) – Fractured Neck of Femur – RSH
An in-depth review of mortality was undertaken. The formal report noted two patients whose deaths have had avoidable factors identified. In the first patient, following an inquest, a narrative verdict found that the patient died from the effects of natural disease shortly after undergoing surgery. The second patient died following an in-patient fall but did not proceed to inquest and cause of death was noted as myocardial ischaemia, coronary artery atheroma, osteoporotic fracture left hip (treated). All patients had characteristics of frailty and significant co-morbidities. All but four patients had acute illness leading up to fracture neck of femur and need for surgery. Recommendations following the review were:

- to introduce a single page guideline for the management of hypotension based on NICE guidelines for junior doctors called to see patients with a fractured neck of femur - completed.
- Extend recovery resource for monitoring post-operatively – completed.
- Additional physiotherapy support during the winter period (November - April) – completed.

Quarter 2 (2017/2018) – Fluids and Electrolytes
An in-depth review was undertaken that demonstrated that 15% of the sample were incorrectly included due to administrative errors on source of admission. This was due to incorrect coding as this not the first consultant episode, or it was readmission from Community Hospitals when end of life care would have been more appropriate. Concern was raised about an increase in December 2015, March and April 2016 which may reflect patients being readmitted with fluid and electrolyte disorders at times of high activity. Most patients were admitted with dehydration secondary to sepsis, UTI or pneumonia. Readmission rate within 28 days overall was below peer average. The figures in

November 2016 showed variation between observed and expected mortality as stable and within expected control limits. Recommendations following the review were:

- Continue to monitor this group for a further 6 months to assess any changes
- Identify administrative personnel to address the administrative errors.
- SaTH Medical Director to speak with Shropshire Community Medical Director to share conclusions and consider how to reduce number of unnecessary transfers – completed.

Further joint review of Fluid and Electrolytes completed with the Community Trust July 2017
This demonstrated a group of frail and complex patients with underlying co-morbidities which had been recognised in the previous review. It was noted that there were a number of differences in the clinical management between Acute Trust and Community Trust which include:

- Intravenous fluid administration protocols
- Use of subcutaneous fluid administration
- Administration of the Sepsis bundle
- The need for greater co-ordination of decision making by and for patients regarding end of life care

This will be part of an ongoing review of continued co-operation between the Trusts.

Quarter 3 (2017/2018) - Work on Learning from Deaths Report
The standards set out within *the National Quality Board Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, investigating and Learning from Deaths in Care* were met within the specified timescales. In November 2017, the Medical Director presented the first Trust Mortality casenote review Dashboard at Trust Board. Findings from the mortality casenote review process and LeDeR review will continue to be published quarterly.

Quarter 4 (2017/2018) - Pneumonia – pleurisy, pneumothorax and pulmonary collapse
This classification group contains small numbers. 19 observed deaths over the year, compared to a sum of 12 expected deaths. Small cumulative variations therefore made a large difference, and in September 2017, 4 consecutive months of 0-2 more observed than expected deaths caused the plot line to cross the 2 SD limit, potentially triggering an alert. The 2 patients in July died at the Community hospitals and are included as superspells. Like the Fluid and Electrolyte group, these patients were elderly, with multiple co-morbidities, and whilst the majority were treated for a pleural effusion in the first consultant episode (FCE), the underlying cause of the effusion was the cause of their death.

Investigation complete and findings presented at Mortality Group. No further action to be taken.

Action Schedule
Mortality review meetings identify areas which need further investigation which are noted on the table below.

2015/2016	**Theme**
Quarter 2	Understand and implement actions to reduce avoidable deaths in nephrological conditions and Acute Kidney Injury
Quarter 3	National Indicator - PE 90 day post discharge mortality per 1,000 spells. 28 cases
Quarter 4	Deaths with bowel pathology - 'Acute abdomens' at PRH
2016/2017	**Theme**
Quarter 1	Infectious Conditions – understand and implement actions to reduce avoidable deaths from infectious conditions and Sepsis

Quarter 2	Acute Myeloid Leukaemia
Quarter 3	Acute Myocardial Infarction
Quarter 4	Other Perinatal Conditions
2017/2018	**Theme**
Quarter 1	Fractured Neck of Femur - RSH
Quarter 2	Fluid and Electrolyte Disorders
Quarter 3	Working on Learning from Deaths Report
Quarter 4	Pneumonia – pleurisy, pneumothorax and pulmonary collapse
2018/2019	**Theme**
Quarter 1	PE 90 day post-discharge
Quarter 2	Fracture Neck of Femur - PRH

The Peer group used for this report comprises of the following Trusts:

- Gloucestershire Hospitals NHS Trust
- Sandwell and West Birmingham NHS Trust
- York Teaching Hospitals NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- The Royal Wolverhampton Hospital NHS Trust
- The Dudley Group NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust
- East and North Hertfordshire NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- Western Sussex Hospitals NHS Foundation Trust

Section five: Recommendations for the Committee

The Quality and Safety Committee is asked to:

- Discuss the current performance in relation to key quality indicators as at the end of August 2018
- Consider the actions being taken where performance requires improvement
- Question the report to ensure appropriate assurance is in place