Paper 16

Recommendation ☐ **DECISION** ☑ **NOTE**	**Trust Board** is asked to **Discuss** the current performance in relation to key quality indicators as at the end of October 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	29 November 2018
Paper Title	Quality Governance Report
Brief Description	The purpose of this report is to provide the Committee with assurance relating to our compliance with quality performance measures during October 2018 **Key points to note:** We reported one MRSA contaminant in October relating to a patient in ED in PRH. This is the third such incident this year. Additional training has been provided to the staff in the department and following this incident a one month trial will be carried out of only Trust staff taking blood cultures will take place which will bring them into line with the emergency department at the Royal Shrewsbury Hospital. The patient concerned was known to have MRSA at the time of admission. The Trust is now in the top quartile of incident reporters when benchmarked with similar sized trusts when previously we have been in the lowest quartile as measured by the NRLS. We did not report any avoidable grade three or four pressure ulcers in October but have reported one grade four in November – this has been raised as a safeguarding incident. In October 2018 we reported three serious incidents and overall reporting numbers are slightly lower in 2018/19 when compared to the same reporting period for 2017/18 In October 2018 we recorded that 40 patients were delayed more than 12 hours once they were considered well enough to leave the ITU areas. In October 2018 there were 22 mixed sex breaches due to patients waiting over 12 hours to be transferred out of the ITU and HDU areas into a ward environment. Sixteen of these breaches were at RSH and six at PRH. There were no incidents resulting in a breach of Mixed Sex Accommodation definitions outside of the critical care areas reported in October. In October there were seven referrals made to the local authorities Safeguarding Teams in relation to people with care and support needs. Five were made by the Trust against either other care providers (four) or family members (one). Two related to the care of patients in the Trust and both of these will be investigated under Section 42 of the Care Act.

	Fifty five formal complaints were received October 2018, in line with expected figures. Twenty nine complaints related to the Royal Shrewsbury Hospital, and 27 complaints related to the Princess Royal Hospital. There continue to be a number of complaints about problems relating to appointments, which have been raised with the relevant specialties. The overall percentage of respondents who would recommend the ward they were treated on to friends and family if they needed similar care and treatment was 97.2% which was slight improvement on September's overall figure.
Sponsoring Director	Deirdre Fowler, Director of Nursing, Midwifery and Quality
Author(s)	Dee Radford, Quality Manager Sam Hooper, Medical Performance Manager
Recommended / escalated by (Tier 2 Committee)	Quality & Safety Committee
Previously considered by	**None**
Link to CQC domain	**All CQC Domains** ◉ **Safe** ○ **Effective** ○ **Caring** ○ **Responsive** ○ **Well-led**
Link to strategic objectives	PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care
Link to Board Assurance Framework	RR 1204 If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage
Outline of public/patient involvement	RR 561 If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards RR 668 If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients RR 859 Risk to sustainability of clinical services due to shortages of key clinical staff
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** *** EIA must be attached for Board Approval** ○ 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**

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Quality Governance Report November 2018

INTRODUCTION

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of October 2018. The report will provide assurance to the Quality and Safety Assurance Committee where 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 as a standalone document and will then be presented to Trust Board as part of the integrated reports for consideration and triangulation with performance and workforce indicators.

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

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.

CONTENTS

Section one: Our Key Quality Measures – how are we doing?

Measure	Year end 17/18	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18	Aug 18	Sep 18	Oct 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
CDI due to lapse in care (CCG panel)	13	1	3	1	1	0	1	1	2					4	0	25
Total CDI reported	32	3	6	6	2	2	2	2	2	0	2	2	1	11	None	None
MRSA Bacteraemia Infections *Contaminant	0	0	0	0	0	0	1	1*	0	1*	0	0	1*	4	0	0
MSSA Bacteraemia Infections	26	2	4	2	3	1	1	1	3	2	4	3	1	15	None	None
E. Coli Bacteraemia Infections	29	4	2	6	5	2	4	2	6	6	4	3	7	32	None	None
MRSA Screening (elective) (%)		96.4	96.0	94.0	95.0	95.4	96.5	96.5	95.7	95.6	95.4	97.6	95.4	96.0	95%	95%
MRSA Screening (non elective) (%)		95.3	95.5	94.8	94.0	95.62	96.7	95.9	96.6	96.2	96.8	96.7	96.5	96.5	95%	95%
Grade 2 Avoidable	48	6	4	6	5	4	0	3	2	3	0	2	0	10	0	0
Grade 2 Unavoidable	157	12	12	14	17	9	15	6	9	5	5	3	0	43	None	None
Grade 3 Avoidable	9	2	1	0	0	1	0	0	0	0	0	0	0	0	0	0
Grade 3 Unavoidable	22	0	2	6	1	2	2	1	0	3	0	3	1	10	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	1	0	0	0	0	0	1	None	None
Falls reported as serious incidents	3	0	0	0	1	0	0	0	1	0	1	0	0	2	None	None
Number of Serious Incidents	48	7	3	3	3	2	2	4	9	1	2	2	3	23	None	None
Never Event	2	0	1	0	1	0	0	1	1	1	0	1	0	4	0	0

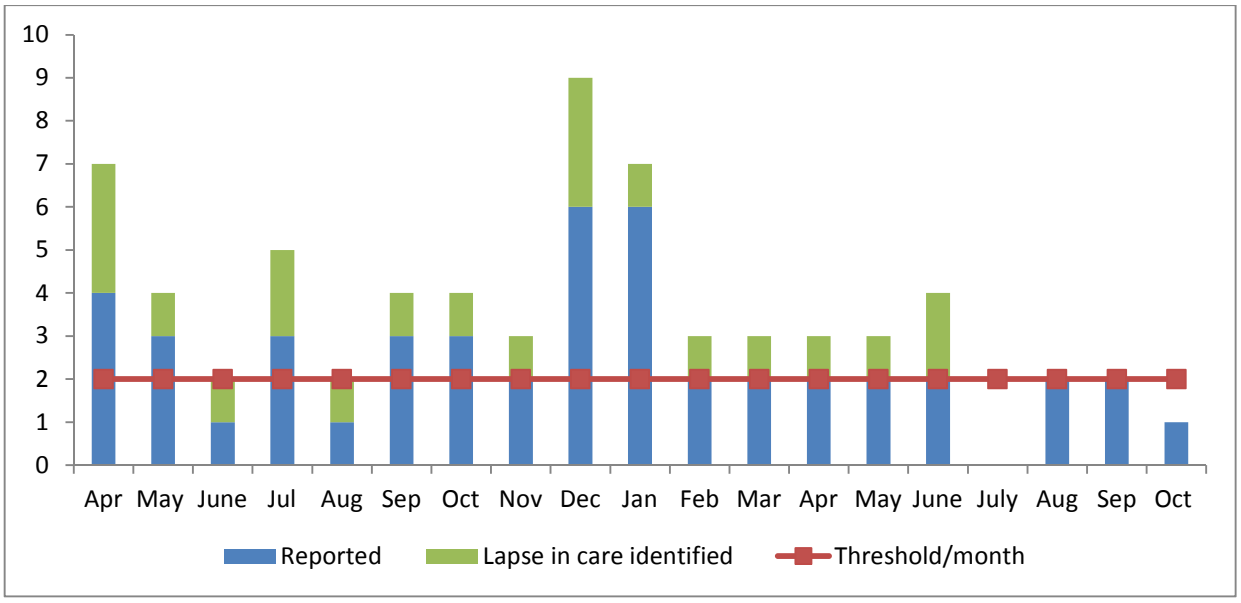
Measure	Year end 17/18	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18	Aug 18	Sep 18	Oct 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
Catheter Associated UTI (number of patients on prevalence audit)		6	6	3	1	6	3	2	10	1	3	3	2	24	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE Assessment		95.9	95.5	95.1	95.68	95.2%	95.1%	95.9%	95.9%	95.9%	95.6%	96.0%			95%	95%
ITU discharge delays>12hrs	380	33	39	17	28	35	41	27	35	36	36	46	40	261	None	None
No of MSA breaches other areas	1	1	0	0	0	0	0	0	0	1	0	0	0	1	None	None
Complaints (No)	600	61	31	49	60	56	54	55	55	60	54	58	55	391	None	None
Friends and Family Response Rate (%)	23.8%	14.3%	12.3%	11.1	13.6%	16.1%	19.9%	17.7%	20.4%	20.8%	20.8%	16.5%	14.6%	18.7%	None	None
Friends and Family Test Score (%)	96.6%	96.8	97.4	96.6	96.2%	96.4%	97.3%	96.6%	96.6%	95.6%	93.3%	97.1%	97.2%	96.2%	95%	95%

Section Two: Key Messages by exception

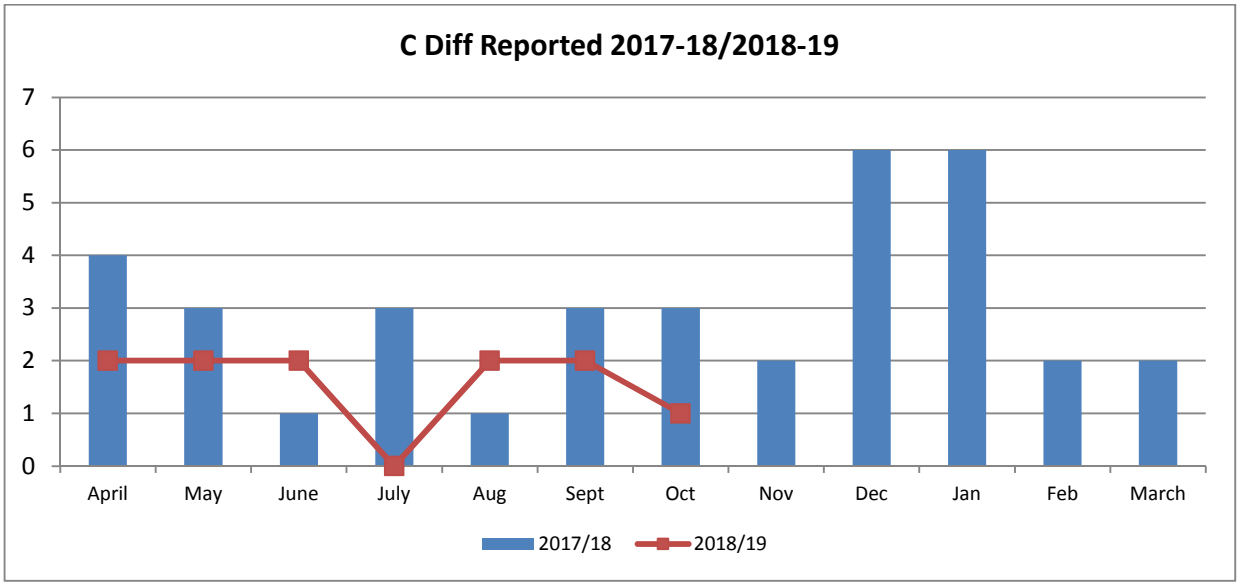
Infection Prevention and Control

Clostridium Difficile (C Diff)

We reported one incident of C Diff during October 2018. The quarterly review panel convened by our commissioners to review the incidents from Quarter two has not met at the time of reporting and therefore the final decision relating to any lapse in care identified will be reported in December.



The number of C Diff incidents has reduced compared to the same period in 2017-2018 as shown below.

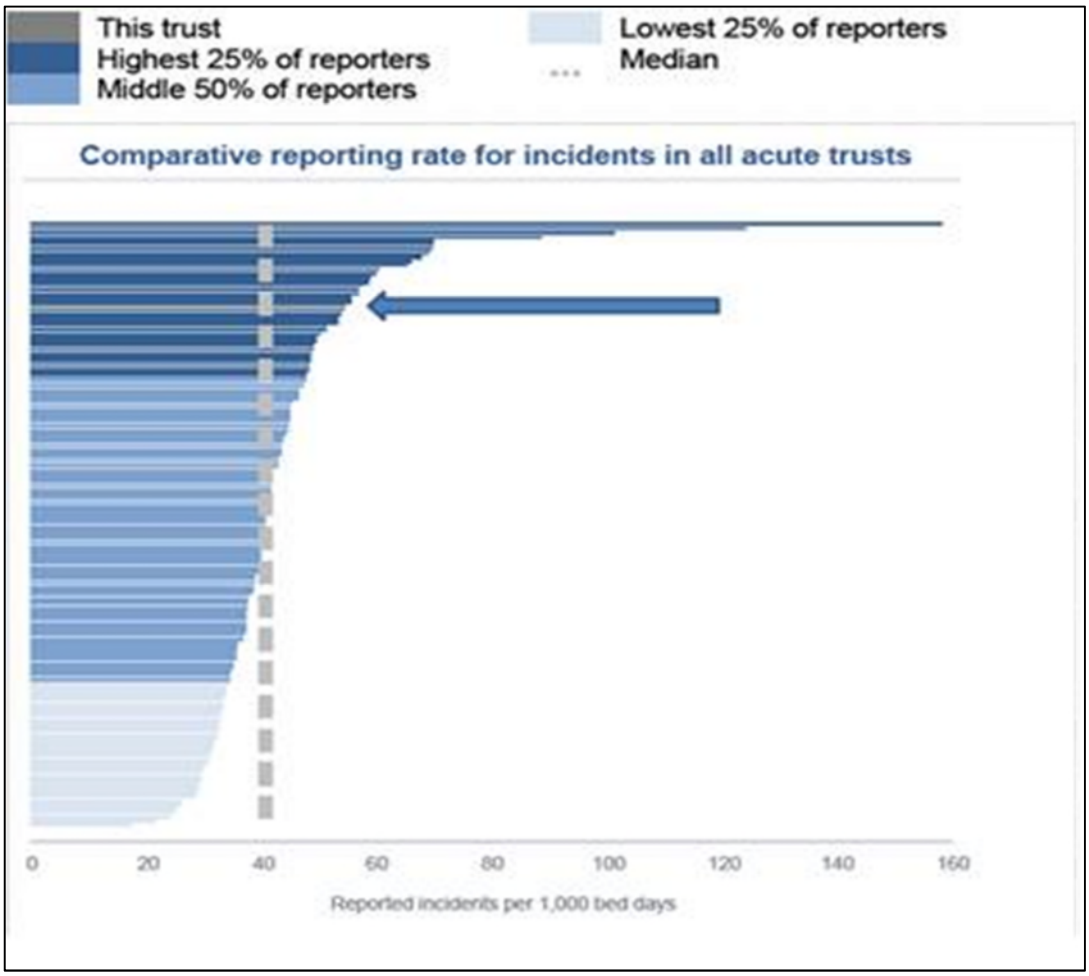


Methicillin-resistant Staphylococcus Aureus (MRSA)

In October we reported one incident of MRSA which was a contaminant not a bacteremia. This is the third such incident this year, all of which have occurred in the emergency department at the Princess Royal Hospital. Additional training has been provided to the staff in the department since the last incident and following this incident a one month trial of only Trust staff taking blood cultures will take place which will bring them into line with the emergency department at the Royal Shrewsbury Hospital. The patient concerned was known to have MRSA at the time of admission.

Learning from Incidents

The graph below indicates that the Trust is now in the top quartile of incident reporters when benchmarked with similar sized Trusts, where previously we have been in the lower quartile. There are two factors affecting this progress; firstly the Trust is reporting more patient safety incidents, proportionally the majority of which result in no harm or low harm. Secondly, there has been a change in practice in relation to uploading incidents to the NRLS. Where previously the Trust has waited until the incidents have been reviewed and given final approval, incidents are now uploaded very promptly (less than three working days) if required the incidents are re-uploaded once final approval has been given. Therefore there is no time lag in uploading and all relevant patient safety incidents are included.



Learning from in service pressure ulcer incidence

In October there was one category 3 pressure ulcer that developed which did not meet the criteria for reporting as a Serious Incident and is in the process of being managed as High Risk Case Review. There were no category 4 pressure ulcers, either avoidable or unavoidable, however a category 4 Trust acquired avoidable pressure ulcer has been reported in November and is being managed as a Serious Incident.

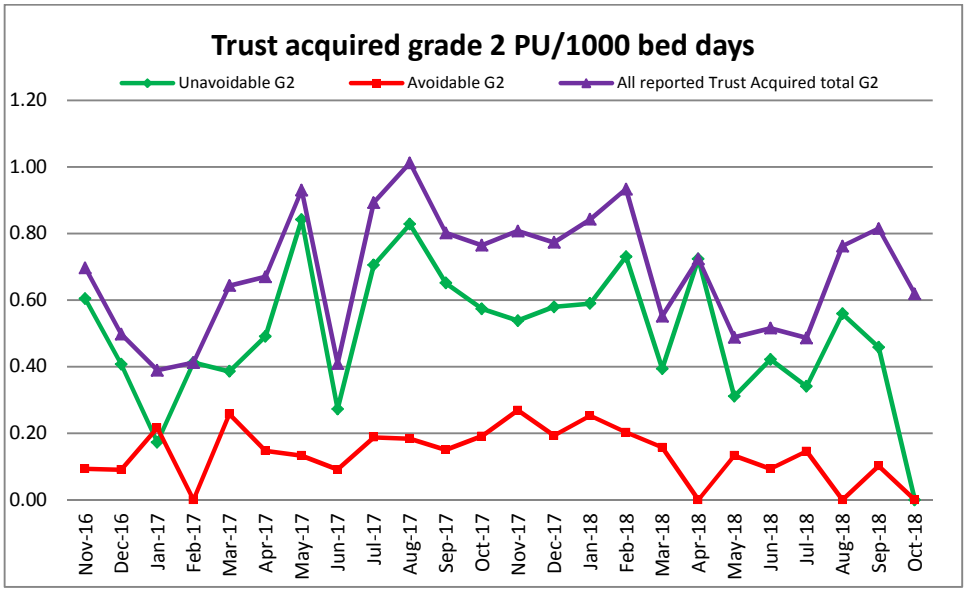
High Risk Case Review (HRCR) Pressure Ulcers October 2018

Category 3 Ear	Ward 15	Small category 3 pressure ulcer to top of left ear caused by elastic from oxygen mask.

No category 2 pressure ulcers have so far been determined to be avoidable for October 2018.

The numbers of Trust acquire category 2 pressure ulcers that we are reporting are shown in the table below. This indicates that overall the total number of category two pressure ulcers reported has

decreased since during April-October 2018 (0.63 per 1000 bed days) when compared to the same reporting period in 2017 (0.77 per 1000 bed days). Of the total number of category 2 pressure ulcers reported, there is also a decreasing trend in the number reported as avoidable.

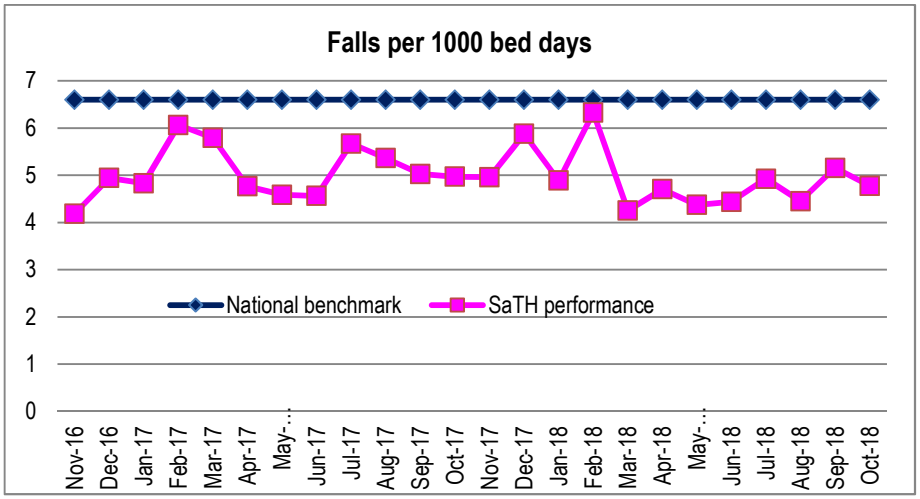


Learning from falls

In October 2018 there were no falls reported which required reporting as Serious Incidents and three falls which resulted in fractures which were determined to be suitable to manage as a HRCRs:

Fall injury	Rationale for not reporting as an SI
Fracture pubic rami	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 ankle	Classed as moderate harm, no surgical intervention required. Review has determined that this was likely to be unpreventable. Indications are that appropriate risk reduction measures were in place
Fractured wrist	Classed as moderate harm, no surgical intervention required. This incident was reported late (occurred in July) the investigation will include a review as to why it was not escalated in accordance with Trust protocol

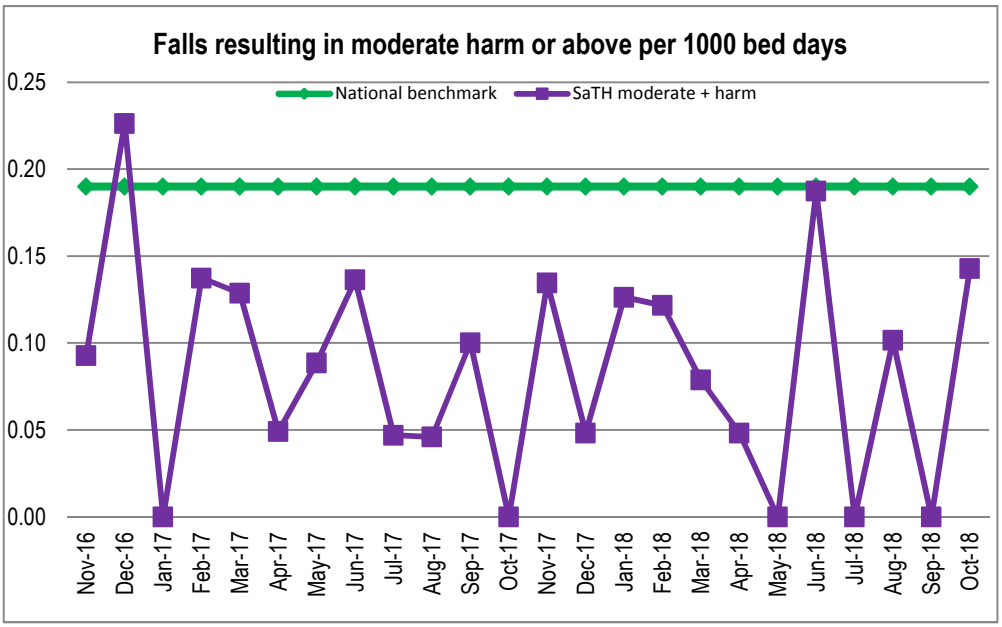
The chart below shows that we remain below the national benchmark for falls per 1000 bed days to October 2018. While there was an increase in the number of falls in February 2018 which was replicated in January and February 2017, overall, since January 2018 there has been a consistent level of reporting well below the national benchmark.



Falls resulting in moderate harm or above

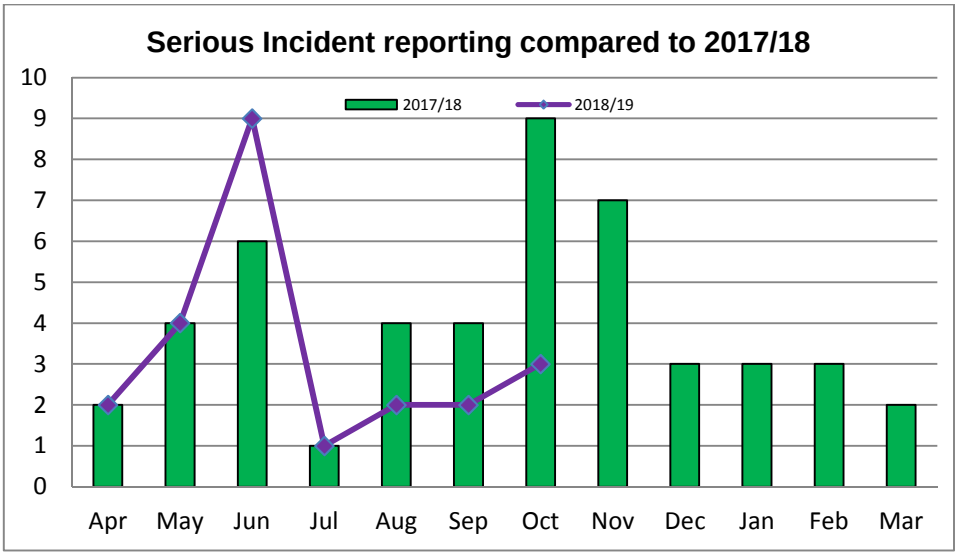
From January 2017 to October 2018 the Trust has sustained a lower than the national benchmark number of falls resulting in moderate harm or above for our patients. There was an unusual number of falls resulting in moderate harm and above during June 2018 which took the Trust to the national benchmark for the first time since December 2016.

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.



Learning from moderate and serious incidents

In October 2018 we reported three serious incidents as shown below and overall reporting numbers are slightly lower in 2018/19 when compared to the same reporting period for 2017/18



The categories of incident are shown in table one below:

Categories of incidents reported in October 2018

Category	Number
Treatment Delay -	1
Diagnostic Delay	1
Vulnerable Adult/potential media	1
Total	**3**

Treatment delay:

Patient attended ED following an injury to his calf. Examined and bloods taken, routine bloods reviewed and no 'red flags'. Patient discharged with advice on monitoring for signs of a DVT. Patient returned 26 hours later following a collapse at home, CPR commenced at home was continued in ED. Review of blood results from the previous admission noted DDimer was not viewed (available after the previous routine bloods). DDimer indicative of possible venous thromboembolism. Patient died in ED. Coroner aware, noted as 'high risk inquest' at Rapid review 09/11/2018

Delayed diagnosis:

Patient identified with a 3cm lung lesion on chest X-Ray in Jan 2012, follow up PET scan confirmed the lung lesion, but also noted a hotspot on her colon. Management of the lung lesion was through the cardiothoracic team at UHNM. For the hotspot on her bowel she was referred to gastroenterology. The appointment with the gastroenterologist conflicted when the patient was undergoing surgery at UHNM. The information was relayed back to the Consultant Gastroenterologist who subsequently left the Trust, no further action appears to have been taken. She was referred back to the Trust for altered bowel habit in July 2018. Investigation has identified that she has a large invasive tumour of the bowel with liver metastases.

Vulnerable Adult/Media:

In February 2018 following complaints and escalations of concerns, disciplinary investigations were commenced in regards to 2 non-permanent members of SaTH staff. The allegations related to; Omissions in care which constitute neglect and psychological ill-treatment of 3 identified patients. The disciplinary process concluded 26/10/2018 when the information was escalated within the organisation. The investigation concluded that there was cause for concern following the outcome of the report. While the level of harm to the patients is considered to be low and there is assurance that such neglect will not be tolerated, this would constitute a near miss organisationally and should be reported in the spirit of openness and transparency.

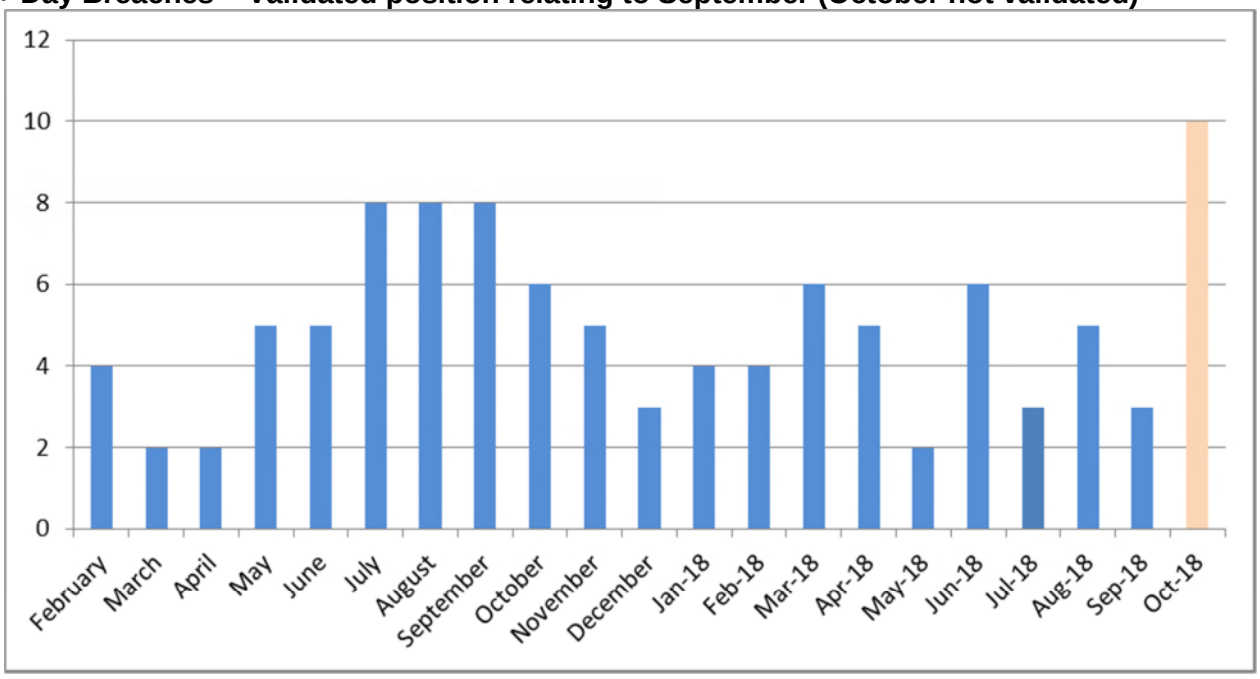
All incidents will be investigated using the Trust processes for serious incident investigations and the reports submitted to the commissioners when complete.

< 12 Hour ED breaches/harm reviews

During October 8 <12 hour ED wait breaches were recorded. All these episodes had a serious harm review undertaken. All 8 reviews concluded that no harm had been caused.

Waiting for cancer treatment for more than 104 days

104+ Day Breaches – Validated position relating to September (October not validated)



There were five patients that did not receive their first definitive treatment within 104 days during August. Review of their pathways showed that none of them were considered to have come to harm as a result of the delays which were for a variety of reasons. Two patients were on the lung pathway, two on upper GI and one on urology pathways. The longest wait time for these patients was 122 days.

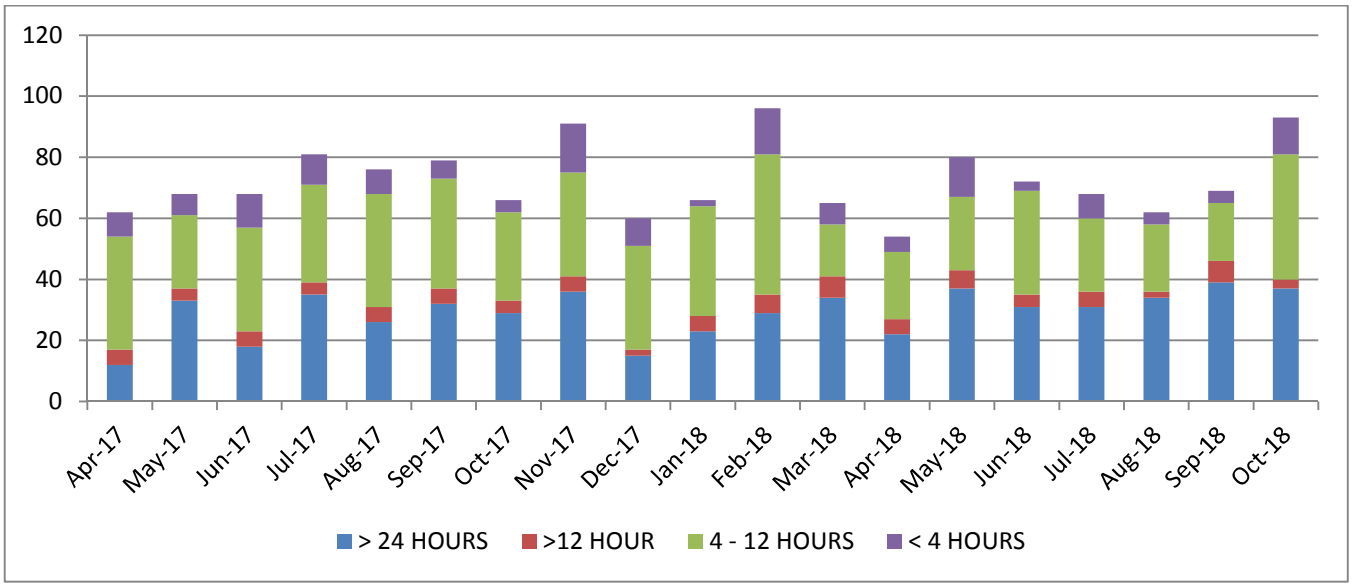
Three patients received their first definitive treatment for cancer after 104 days in September 2018 (the target for referral to treatment being 62 days) as shown in the table above. Two were patients on the lung pathway and one on the upper gastrointestinal (Upper GI) pathway.

In accordance with the Trust's procedure, a harm proforma and an investigation report are requested from the clinician and operational team responsible for each individual patient. On completion, both the harm proforma and report are reviewed and signed off by the Cancer Board prior to sharing with the CCG in line with NHS England Guidelines. From December 2017, under the leadership of the Lead Cancer Nurse, a clinical incident review will also be undertaken for any patient graded as 1B (potential harm) or 1C (harm caused) following completion of the harm proforma.

Escalation highlights for all patients reaching day 83 are flagged to Operational Managers either at weekly meeting or by email from Cancer Performance Manager with request to confirm actions to be taken to avoid day 104+ breaches. These escalations will be in addition to usual escalation procedure.

Delayed Discharges from ITU and Mixed Sex Accommodation Breaches

Delayed Discharges from ITU



In October 2018 we recorded that 40 patients were delayed more than 12 hours once they were considered well enough to leave the ITU areas.

The total number of patients transferred from the units was more in October (93) compared to 69 in September. 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, one patient waited between 12 and 24 hours and ten over 24 hours. Forty patients were transferred in less than 12 hours at the Royal Shrewsbury Hospital and 13 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 October 2018 there were 22 mixed sex breaches due to patients waiting over 12 hours to be transferred out of the ITU and HDU areas into a ward environment. Sixteen of these breaches were at RSH and six at PRH.

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

Safeguarding Adults with Care and Support Needs and Children and Young People

In October there were seven referrals made to the local authorities Safeguarding Teams in relation to people with care and support needs. Three are in Shropshire, three in Telford and Wrekin and one in Powys. Five were made by the Trust against either other care providers (four) or family members (one). Two related to the care of patients in the Trust – one was related to a patient on Ward 10 who developed a category four pressure ulcer whilst in our care and was raised by the Trust Safeguarding Team. This will be investigated under Section 42 of the Care Act 2014. The patient has now been discharged from our care. The other relates to a patient that was on Ward 9 and was raised by their Social Worker (the patient has a Learning Disability). This is also being investigated under Section 42 of the Care Act 2014. The patient remains in our care at the Princess Royal Hospital.

There were three referrals by the Trust to Social Care relating to children and young people in October. None were children in care or on a Child Protection Plan. All were referrals made by the Paediatric Ward.

Patient and Carer Experience

Complaints and PALS

Fifty five formal complaints were received October 2018, in line with expected figures. Twenty nine complaints related to the Royal Shrewsbury Hospital, and 27 complaints related to the Princess Royal Hospital. There continue to be a number of complaints about problems relating to appointments, which have been raised with the relevant specialties.

A total of 125 PALS contacts were received in October 2018. The main themes are appointments and communication.

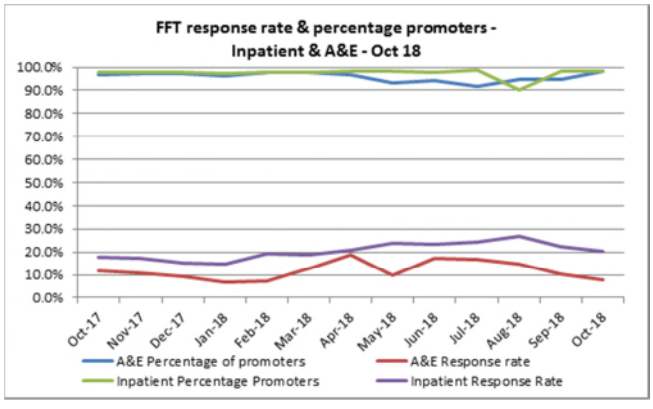
Friends and Family Test

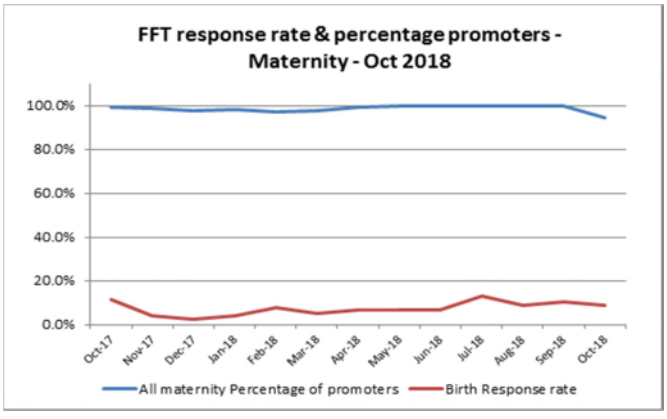
The overall percentage of respondents who would recommend the ward they were treated on to friends and family if they needed similar care and treatment was 97.2% which was slight improvement on September's overall figure.

Individually, A&E saw an increase in the percentage of patients who would recommend compared to September. Maternity, inpatients and outpatients were all however lower than September.

The overall response rate was 14.6% which is a decline compared to the previous month (16.5%). Inpatients, A&E and Maternity Birth all individually saw a decrease in the number of returns compared to September.

	Percentage Promoters	Response Rate
Maternity overall	94.7%	8.9% (Birth only)
A&E	98.1%	7.7%
Inpatient	98.3%	20.5%
Outpatients	96.1%	NA





Section Three: Mortality Review

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 (July 2017 – July 2018)

(SaTH 0.88% v Peer 1.12%)

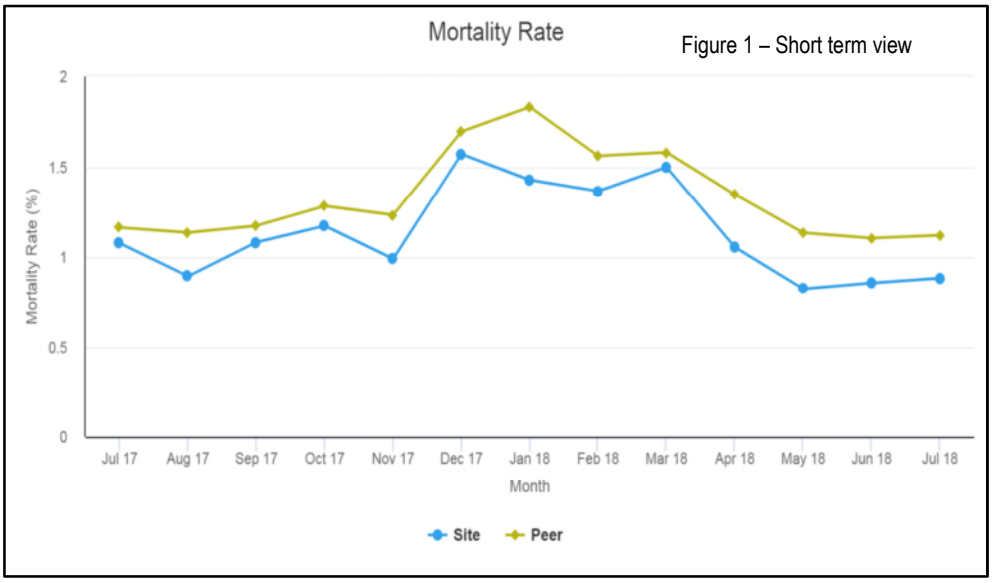


Figure 1 – Short term view

SaTH Mortality Rate (January 2013 – July 2018)

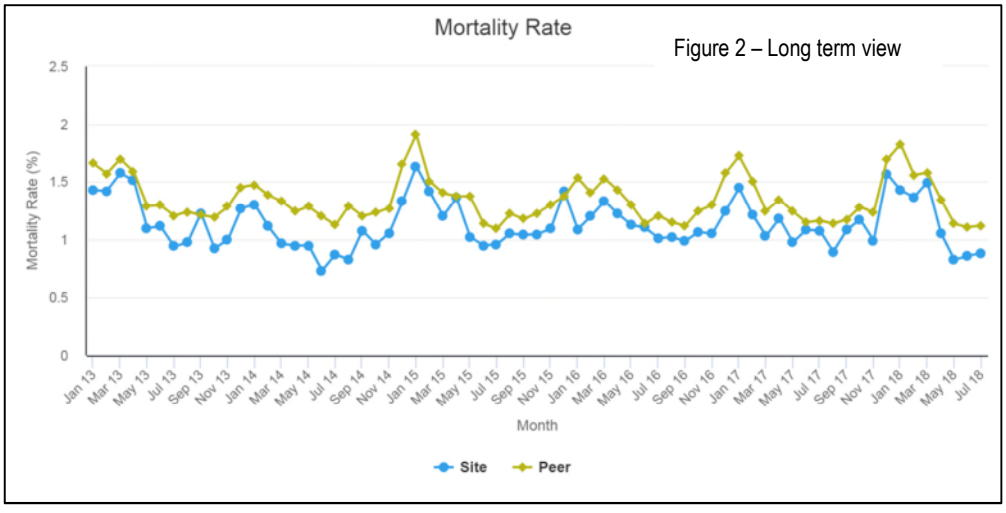
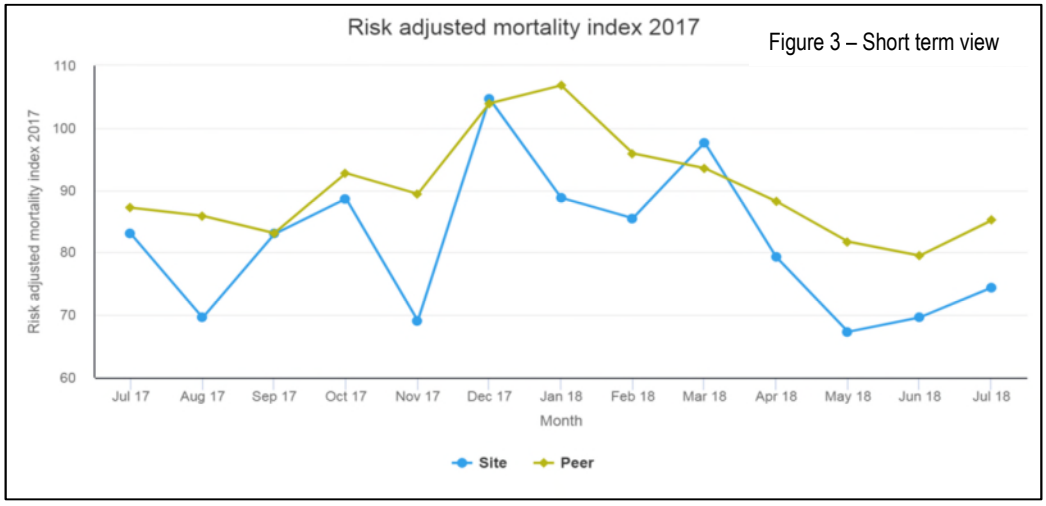


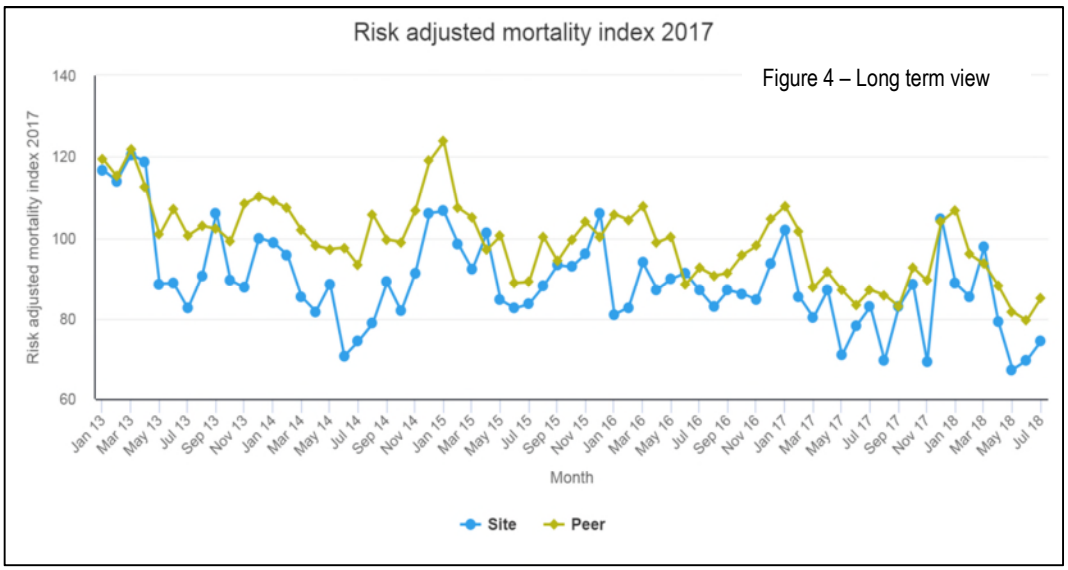
Figure 2 – Long term view

2. Risk Adjusted Mortality Index *

RAMI (July 2017 – July 2018)
(SaTH 74.39 v Peer 85.11)



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



* 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 (July 2017 – July 2018)
(SaTH 76.11 v Peer 90.27)

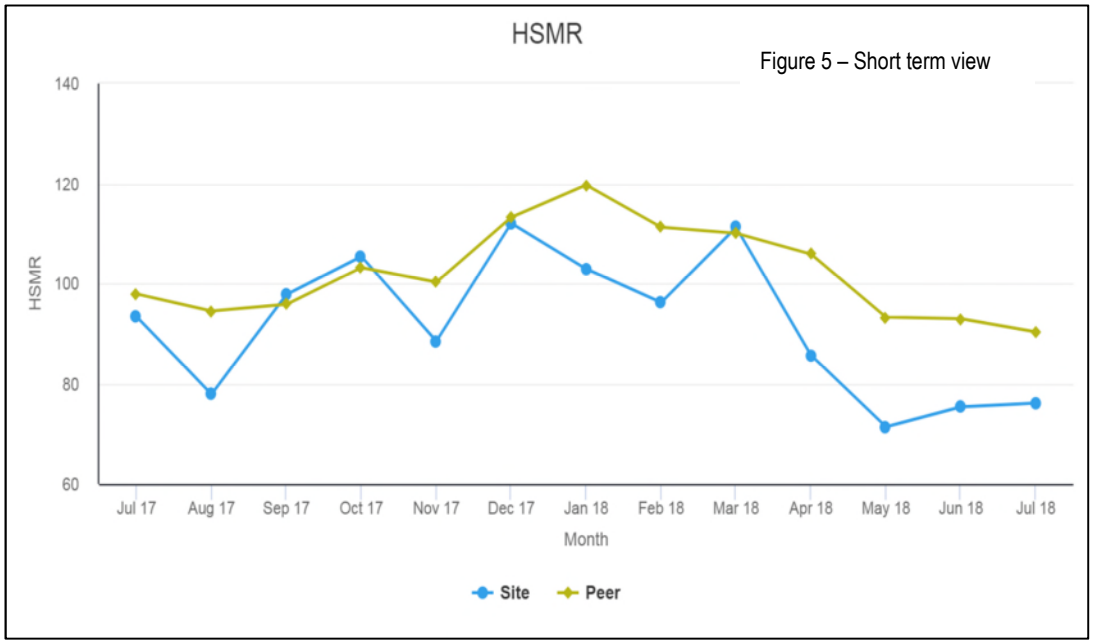


Figure 5 – Short term view

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

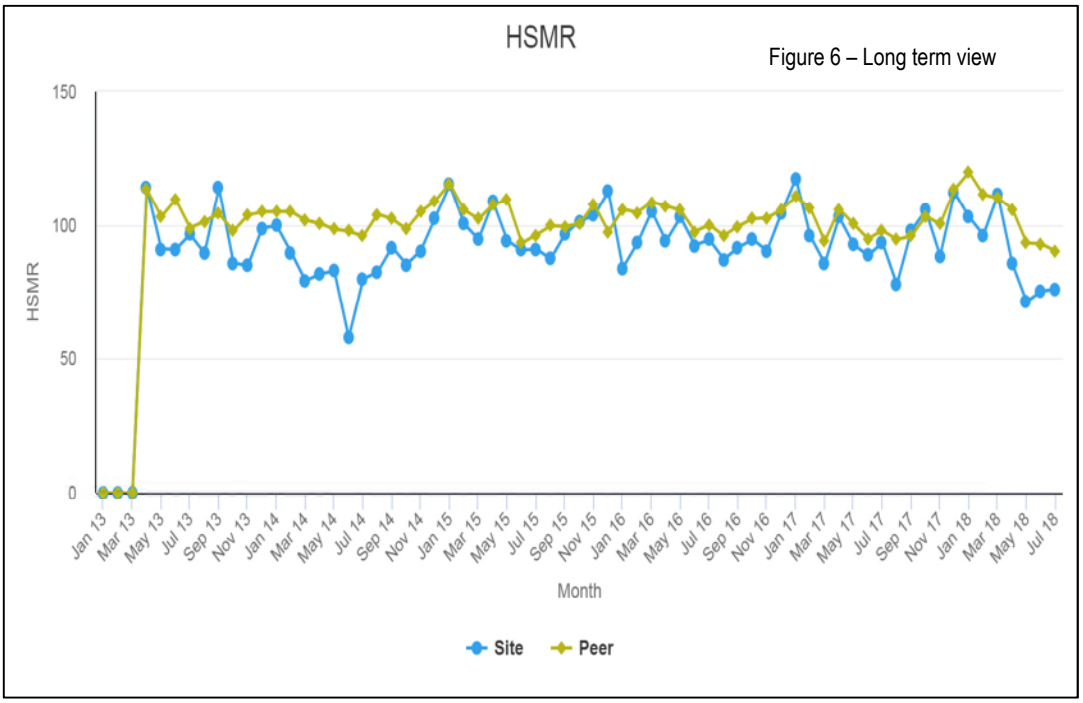


Figure 6 – Long term view

** 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 (July 2017 – July 2018)
(SaTH 50.85 v Peer 59.3)

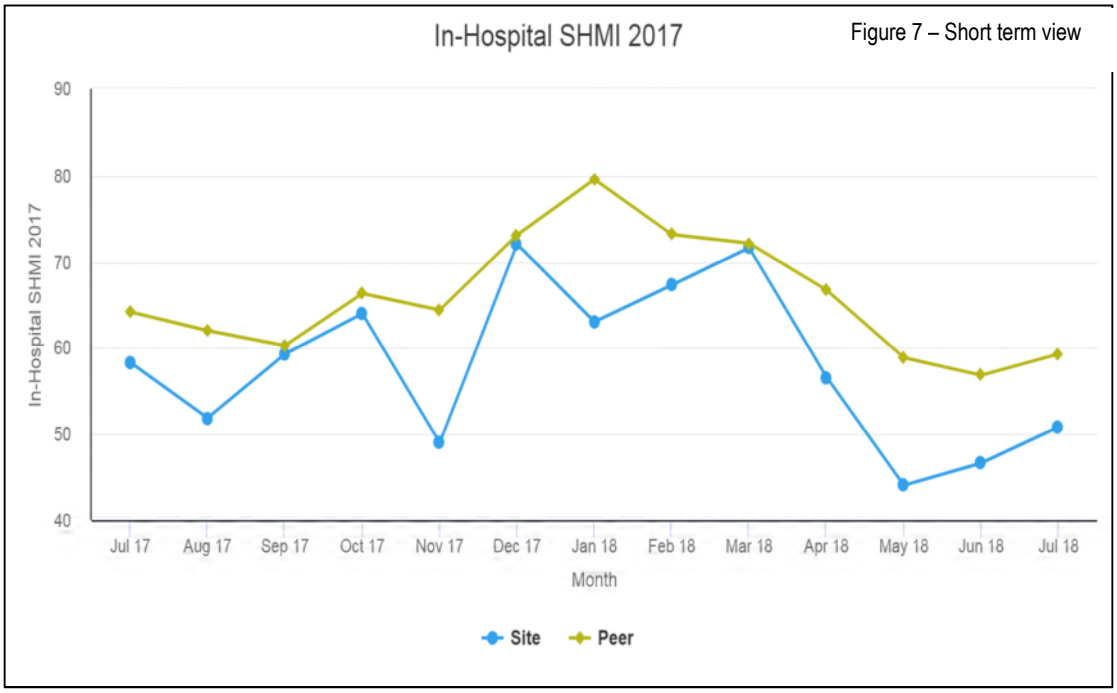


Figure 7 – Short term view

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

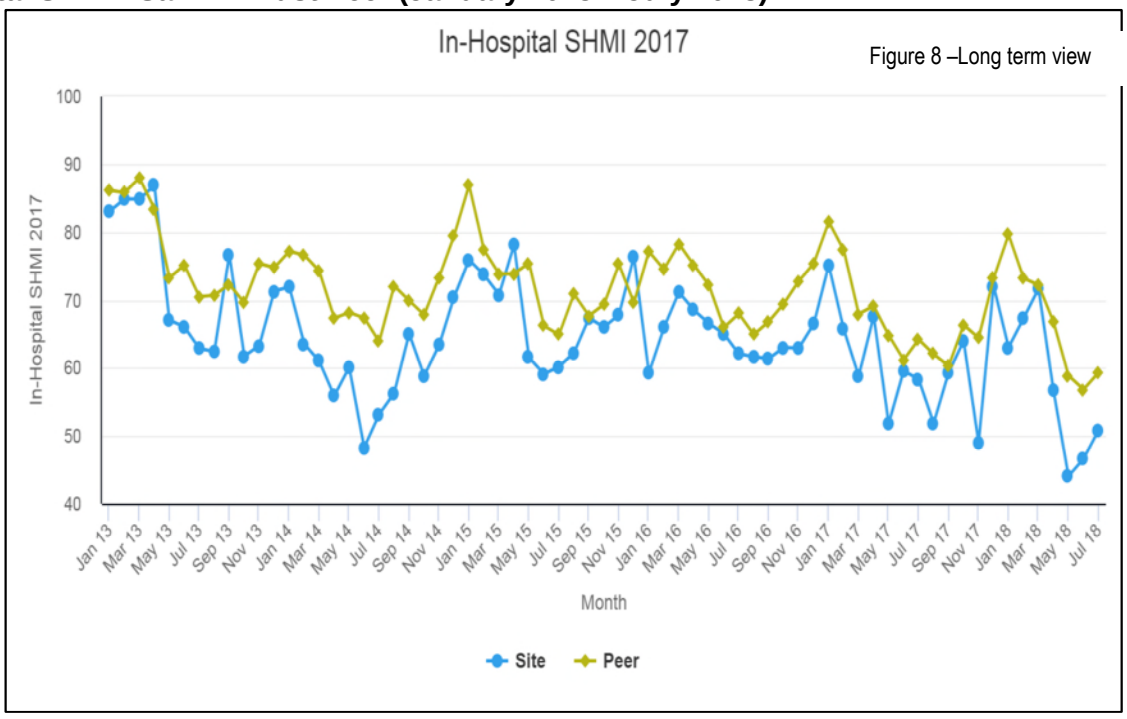


Figure 8 –Long term view

*** 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.

Quarter 1 (2018/2019) – PE 90 day post-discharge

Audit is in progress using the NICE guidelines from March 2018. Reports will be completed to be presented at the Mortality Meeting in November.

Quarter 2 (2018/2019) – Emergency Department Mortality

A report identifying the patients under the new codes was put in place and the number of deaths has been checked back to April 2016. For 2017-18 there were 144 deaths recorded at PRH ED and 124 at RSH ED. There was a change in coding of deaths in the ED at the end of last year, which caused difficulties with identifying the patients for review. This information has been shared as part of a regularly updated Review of Safety Metrics in our EDs. A detailed paper, that will consolidate all work on Mortality in our EDs, is being prepared, in order to provide a baseline assessment prior to the changes in service provision overnight at PRH.

The preliminary findings of a detailed analysis of Emergency Department deaths at SaTH during 2017-18 suggests that the higher number of total deaths at PRH ED is partly attributable to a higher number of patients who suffered out of hospital cardiac arrests being brought to the PRH Emergency department (20-25% more). There is concern on both sites regarding the early recognition and treatment of sepsis and this featured in a small number of Serious Incidents reported by PRH. This is being addressed though the roll-out of the Trust's Sepsis Improvement Plan.

Casenote reviews confirm there is not a large variation in care between the 2 sites for patients who died in the EDs. The reporting of these incidents at PRH can be seen as a measure of robust Governance for which the work of the ED and Medical Clinical Governance Leads should be acknowledged. However, a higher number of attendances and higher number of patients requiring admission via the ED in 2017-18 suggests more acutely unwell patients are currently attending PRH than in previous years, leading to a concurrent rise in death rates. With less permanent medical and nursing staff based in this department, this is of concern.

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	ED Mortality
Quarter 3	Fracture Neck of Femur - PRH

Peer Group

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 Four: 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 October 2018
- Consider the actions being taken where performance requires improvement
- Question the report to ensure appropriate assurance is in place