The Shrewsbury and Telford Hospital NHS Trust

Cover page	
Meeting	Trust Board
Paper Title	Learning from Deaths Report QTR1 2019-20
Date of meeting	1st August 2019
Date paper was written	17th July 2019
Responsible Director	Dr Edwin Borman, Director for Clinical Effectiveness
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Executive Summary

The Trust has well developed systems for reviewing mortality and has published corporate mortality data quarterly as a dashboard since 2017. Thematic analysis of deaths, with focused reviews, generating identified areas for improvement, have been undertaken each quarter, with action plans confirming delivery.

For the year 2019/20, the local reporting requirements have changed.

This report for Quarter 1 is based on available reports, prepared by the Care Groups, and has been triangulated by the author. Systems and processes to triangulate learning from the various quality measures will be further strengthened during 2019.

Due to the timing of the report, that must meet national reporting requirements, the number of casenote reviews appears low for Quarter 1.

The Medical Examiner process was introduced at RSH, in April 2019, and systems have been put in place, and roles clarified, for escalating concerns.

Overall, the Trust Mortality metrics are within the expected range. Of the available Clinical Classification System (CCS) groups, only the Acute Cerebrovascular Disease group is showing SaTH as an outlier, in HSMR only. The reasons for this currently are being explored.

Previously considered by	Quality and Safety Committee

The Board is asked to:			
☐ Approve	☐ Receive	☑ Note	☐ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☐ Effective	☐ Caring	☐ Responsive	☐ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☐ 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 ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	RR 423 If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
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
Financial assessment	No

Main Paper

Situation

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For the year 2019/20, the local reporting requirements have changed.

This report for Quarter 1 is based on available reports, prepared by the Care Groups, and has been triangulated by the author. Systems and processes to triangulate learning from the various quality measures will be further strengthened during 2019.

Background

The Learning from Deaths report will be published quarterly and includes:

- emerging trends and themes following mortality reviews.
- evidence of embedded learning, triangulated with other quality measures (Serious Incidents, LeDer reviews, complaints).
- an action plan on identified themes of deaths (including LeDeR findings) based on the findings of the review.
- a copy of the Learning from Deaths dashboard, in line with the date of national reporting submission of the dashboard.

Assessment

- Due to the early submission of this paper after the Quarter 1 end, the number of mortality reviews for this quarter is low.
- With the launch of the ME process at RSH in April, some clinicians assumed that this replaced the structured mortality review process. It has been re-iterated that this is not the case.
- A SOP has been developed to clarify the interaction between the ME, Serious Incident and mortality review processes.
- There have been no avoidable deaths reported in this quarter. There have been 5 Serious incidents reported in which the patient died. The investigation have not yet all been completed, but at the time of this report it is believed they will be graded CESDI 1-2, (sub optimal care which might or might not have affected the outcome).
- Overall the Mortality metrics for the Trust, including HSMR, are within the expected range. However, the Trust is currently reported as an outlier for the CCS group 'Acute cerebrovascular disease', but only in HSMR. The reasons for this likely are multifactorial and are being investigated. This group includes not only Stroke patients admitted to PRH, but also younger patients who suffer spontaneous catastrophic intra-cerebral haemorrhages, who are admitted to RSH.

Recommendation

- The appointment of the Director for Clinical Effectiveness will allow current structures and processes to be reviewed.
- The appointment of an Unscheduled Care Group Governance Practitioner will support the processes needed to implement more effective and timely mortality case note review in this care Group.
- Better co-ordination is required to triangulate Trust-wide learning from Serious Incidents, Mortality and Complaints. A weekly Executive review meeting has been proposed to complement the current Rapid Review meeting and to provide greater oversight.

Learning from Deaths

April – June 2019

1. Avoidable deaths

There have been no avoidable deaths identified via the Mortality casenote review process

There have been 5 Serious Incidents, reported in Quarter 1, in which the patient died. The extent to which the incident affected the outcome is still to be determined by the investigations, but at this stage, it is thought they are likely to be graded as CESDI 1- 2 (sub optimal care which might or might not have affected the outcome).

These are

2019/9288 Possible delay in diagnosis of a leaking abdominal aortic aneurysm RSH ED
2019/10416 A lady with swallowing difficulties who choked on a sandwich she had requested to eat RSH
2019/12134 Possible delay in diagnosis of a myocardial infarction PRH AMU
2019/13418 Unexpected neonatal death
2019/14274 Possible delayed diagnosis of an intra-cerebral haemorrhage RSH ED

The neonatal death is thought likely to have been due to natural causes but confirmation is awaited from post mortem results.

There are no common themes within this group of incidents. 2 occurred at RSH ED, one of which involved a locum doctor. Both concerned the clinical interpretation of atypical symptoms and not the monitoring or escalation of the deteriorating patient.

2. Deaths where family, carers or staff have raised a concern about the quality of care provision.

1. A patient fell whist an inpatient on the ward at RSH, and subsequently passed away whilst an inpatient. The family raised concerns regarding the care provided in preventing his fall. This case was investigated as SI 2019/7987. The Inquest was held on 17th July.

- The learning from this incident was a need to ensure that all agency staff working on wards are familiar with falls risk prevention, and comply with risk assessments undertaken and falls protocols.
- Review if there is any immediately visible means at the bedside to identify what should be in place, i.e. signs at the bedside for bed rails lowered, crash mats in place. This would ensure all other staff in the bay would be able to see what should be in place for each individual patient

The new standardised Patient Information Boards were approved at the Clinical Governance Executive in July 2019 and will be rolled out Trust-wide. This will improve the visibility of safety measures for Nursing care.

2. A 69 year old lady fell at home, was admitted to PRH and discharged home, but fell again and was re-admitted. This time she was discharged to a Community hospital where she received prophylactic anticoagulation. She was readmitted to RSH with headaches and electrolyte imbalance. She was transferred back to the Community hospital then readmitted again to RSH with dehydration and abnormal bloods, and concerns about sepsis.

The family accept the cause of death - 1a) Hypovolaemia, b) Electrolyte Imbalance and Hypovolaemia. c) Extradural Haematoma - but do have some concerns regarding the hospital care. Specifically these relate to a general lack of communication at PRH, RSH & the Community Hospital, and concerns that an earlier diagnosis could have been made. Legal services are contacting the Doctors involved to arrange responses.

There is some concern that the previous investigation into Fluid and Electrolyte HSMR outlier report in 2017 identified patients, with multiple re-admissions to and from Community Hospitals, with hypovolaemia, electrolyte disorders and underlying frailty.

Learning points from Complaints when a patient has died

- The Frailty admission tool is being trialled.
- Communication with family – some areas are introducing family clinics.
- Additional training / support for staff in breaking bad news.
- Need to ensure that DNAR discussions take place early on.
- Additional training from Tissue Viability nurses around mattress selection documentation and the grading of pressure areas.
- Clinical Placement Educational team to be requested to supply additional training to staff members on the importance of fluid balance charts, and to emphasise the importance that they are correctly filled out.
- Ensure all patients drink supplements to minimise muscle loss.
- Complaint used as case study in huddles to highlight importance of having Next of Kin logged.

3. LeDeR reviews

There have been no in-patient deaths of patients with Learning Disabilities this quarter.

Recommendations from previous reviews completed this quarter include:

- Improved advance care planning, stating preferred place of care and treatment requirements if these had been in place to prevent deaths in hospital
- The Community Learning Disability teams screening tool needs a review.
- A high number of the patients suffered,from obesity-related conditions that contributed to their deaths. Better monitoring and practical dietary support, offering resources and sign-posting in the community may help reduce the incidence.
- . The patient was in a stable environment that knew her well and responded effectively to her changing health needs. The GP was proactive and it was stated the family and the care provider felt supported with the health complexities the patient experienced over the years as well as during the last few months. The paramedics and hospital staff treated, referred or signposted and family were happy with the level of communication from the hospital as they do not live close and relied on them to relay information to them.
- When developing a pan-Shropshire end of life strategy, the needs of Learning Disability residential staff should be considered in training, and how to access support.

The results of the National Cardiac Arrest Audit 2018-19 reported a higher than national average number of patients being resuscitated at PRH. There are reports of patients (without LDs), who have written community DNACPR orders still being resuscitated before a Trust DNACPR order can be completed. There also have been incidents of Care Homes using hospital transfer DNACPR forms until community forms can be completed. The RESPECT programme should minimise these incidents, and help with End of Life Care planning, including for patients with Learning Disabilities. Roll-out is planned to start in October 2019.

A change to the Nursing assessment documentation has been piloted in the Trust. This was a recommendation from the death and Inquest of a patient with Learning Disabilities in 2018. Nurses are now directed to ask the patient or carer how the patient normally responds to pain or distress. This will be used for patients with Learning Disabilities, Dementia, or who are non-verbal, and will inform the assessment of Sepsis, deterioration and the Abbey pain score.

4. Themes from Speciality Mortality Reviews and incidents.

Swift diagnosis of an acute abdomen, in most cases, is likely to take precedence over concerns of contrast-associated nephropathy in patients presenting with acute renal failure. The learning for teams is to assess on a case by case basis. Radiology advice regarding the options in cases of reduced eGFR was circulated. (The index case was of a Surgical patient whose CT scan, and diagnosis were delayed until her AKI was corrected and eGFR >30).

When advice is sought from the Medical on-call teams, and a plan is written in the case notes, it is important that both teams understand who is nominated as responsible for undertaking the tasks in the plan. (Joint presentation to T&O and Medical Mortality meeting of a patient who did not have Arterial Blood Gases repeated).

Following a High Risk case Review in ED, it was identified there is an underlying theme around relying on paper request reports, which cannot be tracked. An electronic alert system, for radiology reports which carry the NPSA alert, is to be expedited.

Calcium gluconate for injection is now routinely stocked on all wards following a delay in the treatment of hyperkalaemia. While the patient died from his co-morbidities and the delay did not contribute to his death, this learning point was derived from the review of this case..

A high risk case review (HRCR) identified that it is not easy for Nurses to identify for how long a patient has been dependent on 15ls of oxygen to maintain normal oxygen saturations. The Learning Clinic have been contacted to request an electronic alert to be added to VitalPAC if a patient has required 60% or 15ls of oxygen for more than 4 hours.

The passing of NG tubes has been confirmed as a core nursing competency following concerns that drainage NG tubes may not being passed early enough in patients with suspected bowel obstruction. The surgical team identified that in some of their reviews, clinical staff were waiting for confirmation by CT scan, which may be contributing to the risk of aspiration pneumonia in these patients.

There was one death following an in-patient fall this quarter. The number of in-patient falls is at the Sign up to Safety target of 4.6 per 1000 bed days. This is below the national average of 6.6 per 100 bed days. Work is on-going, with a number of initiatives due for next quarter. In this quarter, the internal and external web page was developed to give patients, family and staff better access to information.

The Women's and Children's team continue to contribute to a number of reviews. The outcome from the Secretary of State's review is expected in the next quarter. HSIB will be visiting the Trust on the 25th of July as part of their investigation into a maternal death where the patient died from respiratory problems on ITU. Maternity reviews form a separate report.

5. Thematic reviews

2017/2018 Quarter 1	Fractured Neck of Femur - RSH
Quarter 2	Fluid and Electrolyte Disorders
Quarter 3	Developing requirements for Learning from Deaths - Dashboard
Quarter 4	Pneumonia – pleurisy, pneumothorax and pulmonary collapse
2018/2019 Quarter 1	PE 90 day post-discharge
Quarter 2	ED Mortality
Quarter 3	Fracture Neck of Femur – PRH
Quarter 4	Acute Cerebrovascular disease – HSMR SaTH
2019/20 Quarter 1	Implementation of the Medical Examiner process at RSH and the interaction with Serious Incident and Mortality review processes

Action Schedule Summaries 2018-19

Quarter 1 (2018/2019) – PE 90 day post-discharge deaths per 1,000 spells

SaTH was recorded as having a higher than peer rate of deaths from Pulmonary embolism within 90 days of discharge from hospital.
The numbers are small, (21 per year) and data are taken from ONS data from Medical Death Certificates. Approximately a quarter of the Causes of Death were made on post-mortem examinations. Most patients have an assessment and the correct form of prophylaxis suited to their risk of bleeding and VTE. *The Baseline Assessment Tool for venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism* (NICE clinical guideline NG89 – updated March 2018) was used to audit the care of 7 patients whose admissions were not day cases and not related to cancer. Although the results cannot be linked to the patients' deaths, from this small sample, the duration of therapy and the advice and education given to the patient, families and carers, particularly on discharge, need to be addressed before the Trust can be confident these factors are not contributing to post-discharge mortality. The findings of this review have been shared with the Trust VTE Group for consideration and further action.
Figures for Dec17 - Nov18 show an improvement nearer to peer.(0.23 to national average 0.17)

Quarter 2 (2018/2019) – Emergency Department Mortality

For 2017 - 18 there were 144 deaths recorded at PRH ED and 124 at RSH ED.
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 fewer and less permanent medical and nursing staff based in this department, this concern was highlighted.
The review informs a larger body of improvement work for the Emergency Departments.

Quarter 3 (2018/2019) – Fracture Neck of Femur – PRH

29 patients were identified from the National Hip Fracture Database (NHFD), who died within 30 days of admission, during the calendar year 2017. A multi-disciplinary group was formed under the chairmanship of the Deputy Medical Director for Quality, and casenote review undertaken. There were no avoidable deaths found as part of this review. There were 3 patients (10% of total) who are unusual for the PRH casemix, and who, because of their age, will have had a significant impact on the risk adjusted mortality. All the patients had characteristics of frailty and significant co-morbidities, and over 50% had an identified acute illness leading up to the fractured neck of femur, and the need for surgery.
An in-depth action plan was developed with recommendations including:

- Continued advertisement of the Orthogeriatrician post at PRH and alternate provision of medical cover while difficulties with recruitment continue..
- Review of the Theatre template to increase trauma list time, and cross-site Consultant Anaesthetist availability.
- Implementation of the 'FAB 4' – fluids, analgesia, blood tests and 4 hour admission to the ward from ED.
- Review of fractured neck of femur Pathway document to improve continuity and communication.

Recent NHFD data show that mortality at PRH is back in line with peer comparators for the last 3 months recorded.

Quarter 4 (2018/19) Acute cerebrovascular disease

Mortality for the CCS Group Acute Cerebrovascular disease is varied across the 4 Mortality measures used by the Trust – Crude Mortality rate, SHMI, RAMI and HSMR - but all show an upward trend. HSMR, in particular, is causing concern as the CUSUM (cumulative sum of the difference between observed and expected deaths) has crossed the 95% Upper Control Limit and, for the 2018-19 year alone, is on, or over the 99% Control limit. The reasons why the HSMR is showing the Trust as a statistically significant outlier, and the other metrics do not, are still being investigated. This cohort of patients is not solely admitted to the Stroke Unit at PRH, and there has been a higher number of younger patients admitted to RSH with catastrophic intra-cerebral haemorrhages. Because of the numbers involved, the review is not yet complete.
A Stroke Improvement Plan already is underway, and was last updated in June 2019. Any additional findings from this review will be fed back to the Stroke Improvement Group.

Quarter 1 2019/20 Implementation of the Medical Examiner process at RSH

The Medical Examiner process was introduced at RSH in April 2019. The purpose of the ME team is to:
1. Agree the proposed cause of death with the clinical team in charge of the patient's care to ensure the death certificate is accurate
2. To discuss the cause of death with the next of kin and establish whether they have any concerns about the care provided
3. Identify any deaths where greater scrutiny is needed, or patient safety issues warrant an organisation-wide or broader response.

An SOP was developed and approved at the Clinical Governance Executive to triangulate escalating concerns, either from the ME or the patient's family, and to define the interaction between the ME, Serious Incident and Mortality review processes. Any concerns raised by the MEs are also reported at the weekly Rapid Review meeting where High Risk incidents, complaints and Inquests are discussed.

Concerns were raised over care at Bridgnorth Hospital in one ME review, and this information has been passed to the Community team via the N2N concern process.

Action plan

The issues described above already have action plans, on which work is well established.
As part of the review of Serious Incident reporting processes, options are being discussed for the Virginia Mason Transforming Care Institute to run Rapid Improvement events on corporate recommendations and actions from investigations and reviews that are outside the control of a single Care Group. This will be developed further in the next report.

SATH Mortality Case-note Review Dashboard Quarter 1 2019-20

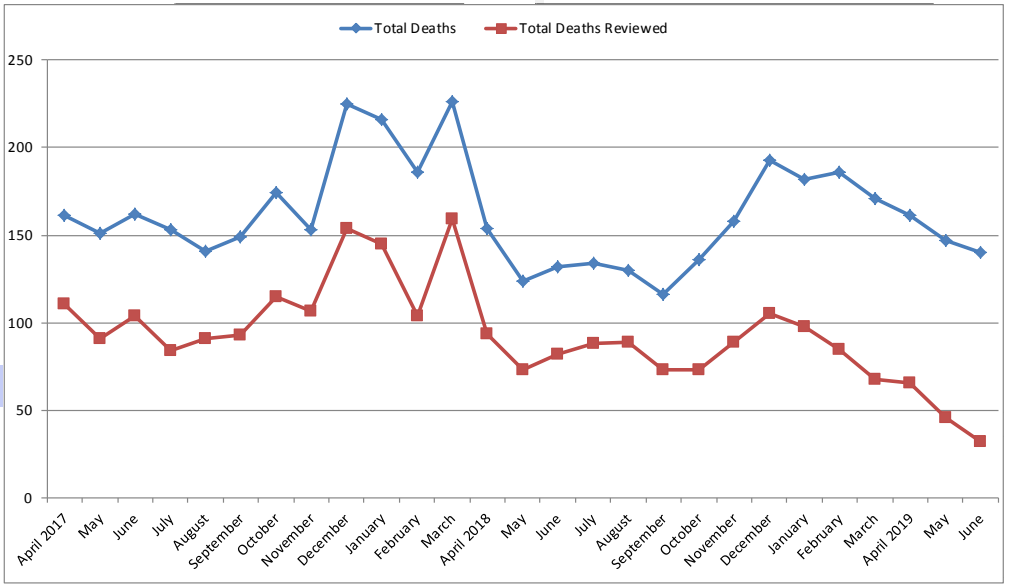
Summary of total number of deaths and total number of cases reviewed under the Trust Casenote Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total number of deaths considered to have been potentially avoidable (CESDI 3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
140	147	32	46	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
448	539	144	251	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
448	1816	144	1017	0	4

Total Deaths Reviewed by Methodology Score

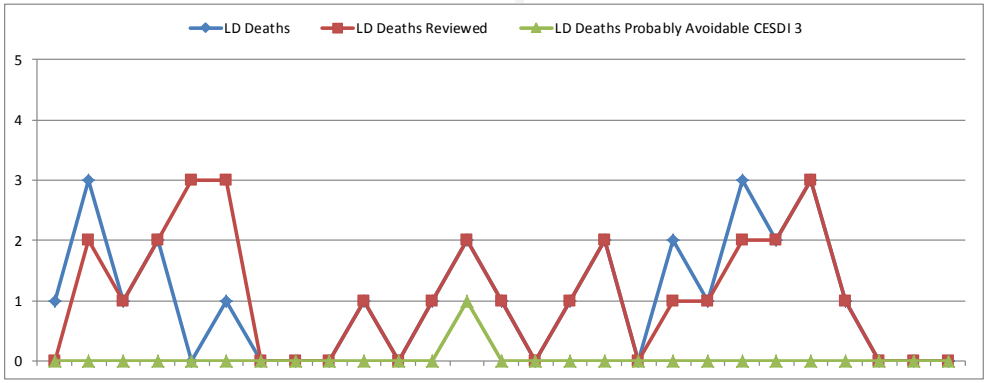
CESDI 0 No sub optimal care		CESDI 1 Some sub optimal care which did not affect the patient's outcome		CESDI 2 Some sub optimal care which might have affected the patient's outcome	
This Month	56	This Month	9	This Month	2
This Quarter (QTD)	109	This Quarter (QTD)	14	This Quarter (QTD)	3
This Year (YTD)	109	This Year (YTD)	14	This Year (YTD)	3



Summary of total number of deaths of patients with a Learning Disability and, the total number reviewed under the LeDeR and Trust methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed by Trust or Reported Through the LeDeR Methodology		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	6	0	6	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	18	0	18	0	0



Mortality metrics CHKS April 2018 – March 2019

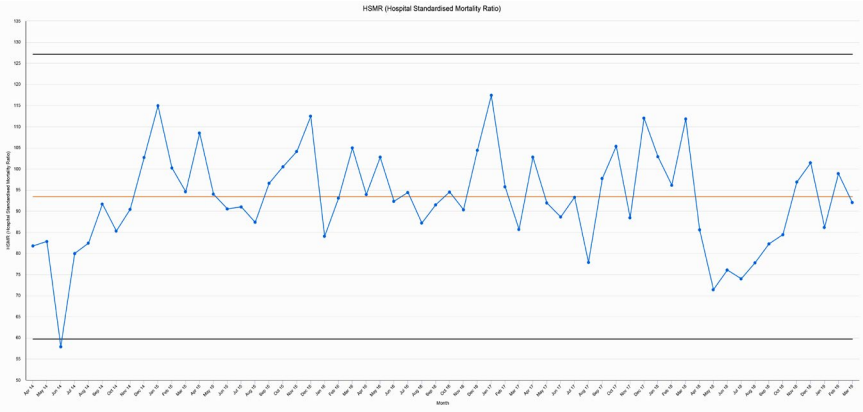
Description	Local Numerator	Local Denominator	Apr 18 - Mar 19	Apr 17 - Mar 18	Change	Peer Value	Performance
Mortality Rate	1600	165855	0.9647%	1.1896%	-18.906%	1.1551%	
Deaths in Low Mortality CCS Groups	15	12580	0.11924%	0.16825%	-29.130%	0.10784%	
Rate of Mortality in hospital within 30 days of elective surgery	1	3252	0.030750%	0.24405%	-87.40%	0.13219%	
Rate of Mortality in hospital within 30 days of Non elective surgery	84	7977	1.0530%	1.2661%	-16.831%	1.3550%	
% Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)	6	240	2.5000%	5.806%	-56.94%	4.689%	
Rates of mortality in hospital within 30 days of emergency admission with a stroke	111	906	12.252%	9.948%	23.161%	11.932%	
% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	2	304	0.6579%	1.2407%	-46.97%	3.170%	
RAMI (Risk adjusted mortality index) 2017	1600	2013	79.50	84.05	-5.413%	83.68	
RAMI (Risk adjusted mortality index) 2018	1600	1869	85.60	90.65	-5.571%	89.87	
In-Hospital SHMI (Summary Hospital-Level Mortality Index) 2017	1600	3014	53.09	61.42	-13.565%	61.91	
In-Hospital SHMI (Summary Hospital-Level Mortality Index) 2018	1600	2778	57.59	65.75	-12.408%	67	
SHMI (Summary Hospital-Level Mortality Index) +	1925	1947	98.89	103.03	-4.015%	99	
HSMR (Hospital Standardised Mortality Ratio)	1475	1717	85.89	97.86	-12.236%	92.57	

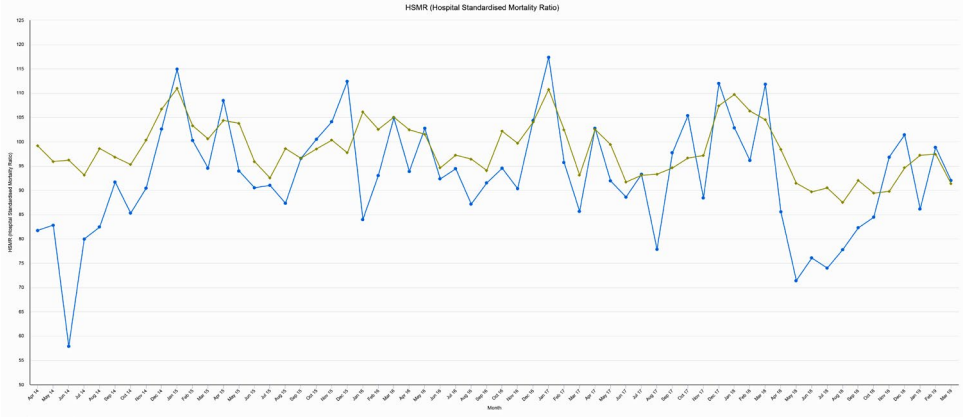
5 year Mortality metrics CHKS April 2014 – March 2019

SPC run chart

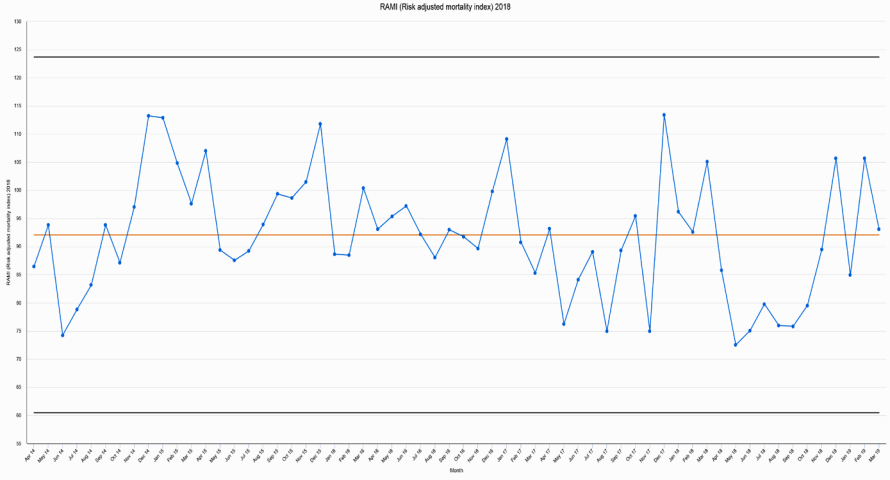
Monthly variation compared to peer average (Trust blue line)

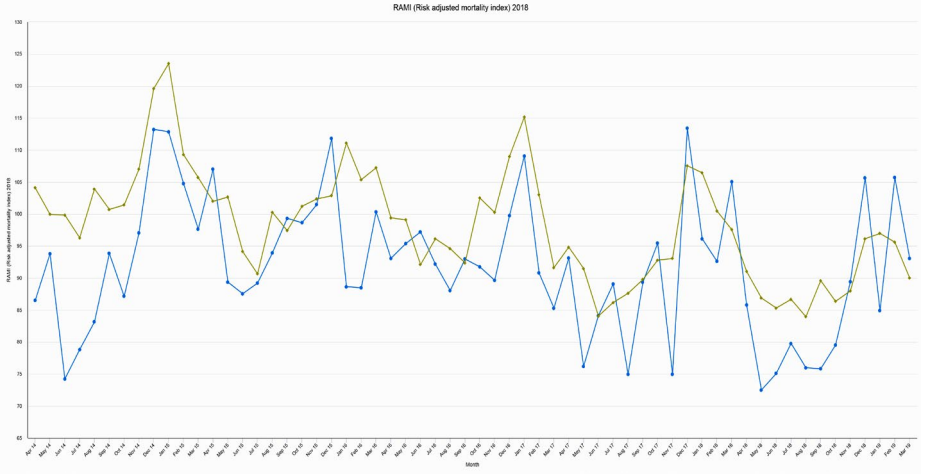
HSMR





RAMI

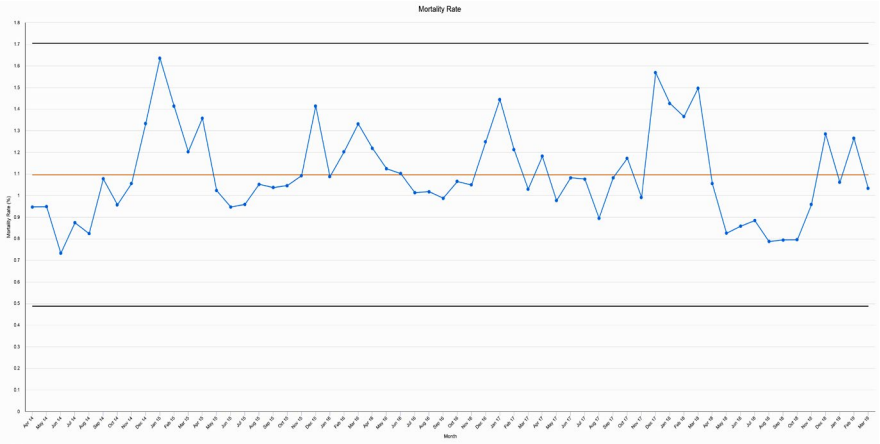


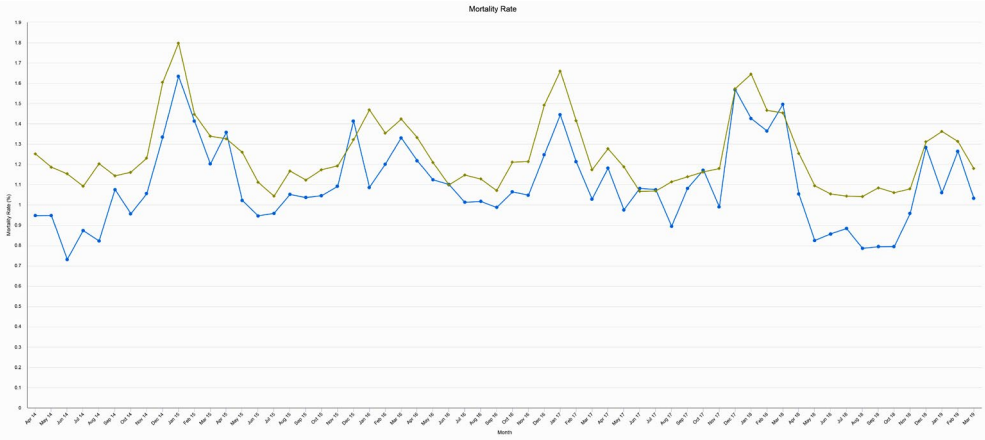


SPC run chart

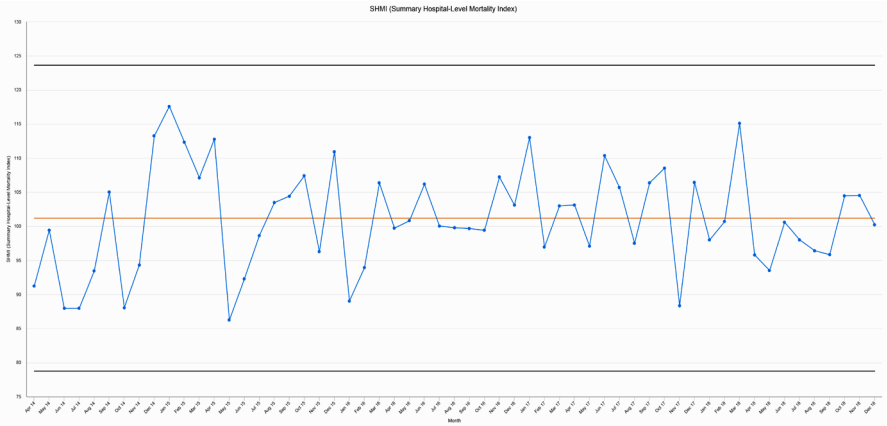
Monthly variation compared to peer average (Trust blue line)

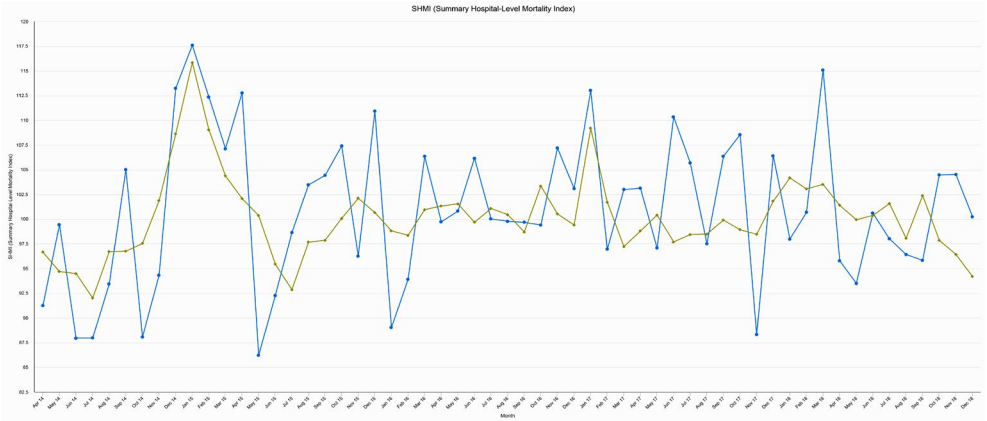
Crude Mortality Rate





SHMI – note data only available up to Dec 18





All the metrics (except SHMI which includes discharges up to 30 days) show a significantly better than peer performance from May to September 2018 with winter months returning to normal seasonal variation.