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

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|---|---|-------------------|------------------|-----------------|
| Report Title: | Learning from deaths Q2 2018 - 2019 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | | | |
| Executive Sponsor (presenting): | Dr Christine Blanshard, Medical Director | | | |
| Appendices (list if applicable): | Appendix 1 – Mortality dashboard Q2 2018/19 Appendix 2 - Learning from death themes and improvement actions. Appendix 3 | | | |

1.

Escalation of deteriorating patients.

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

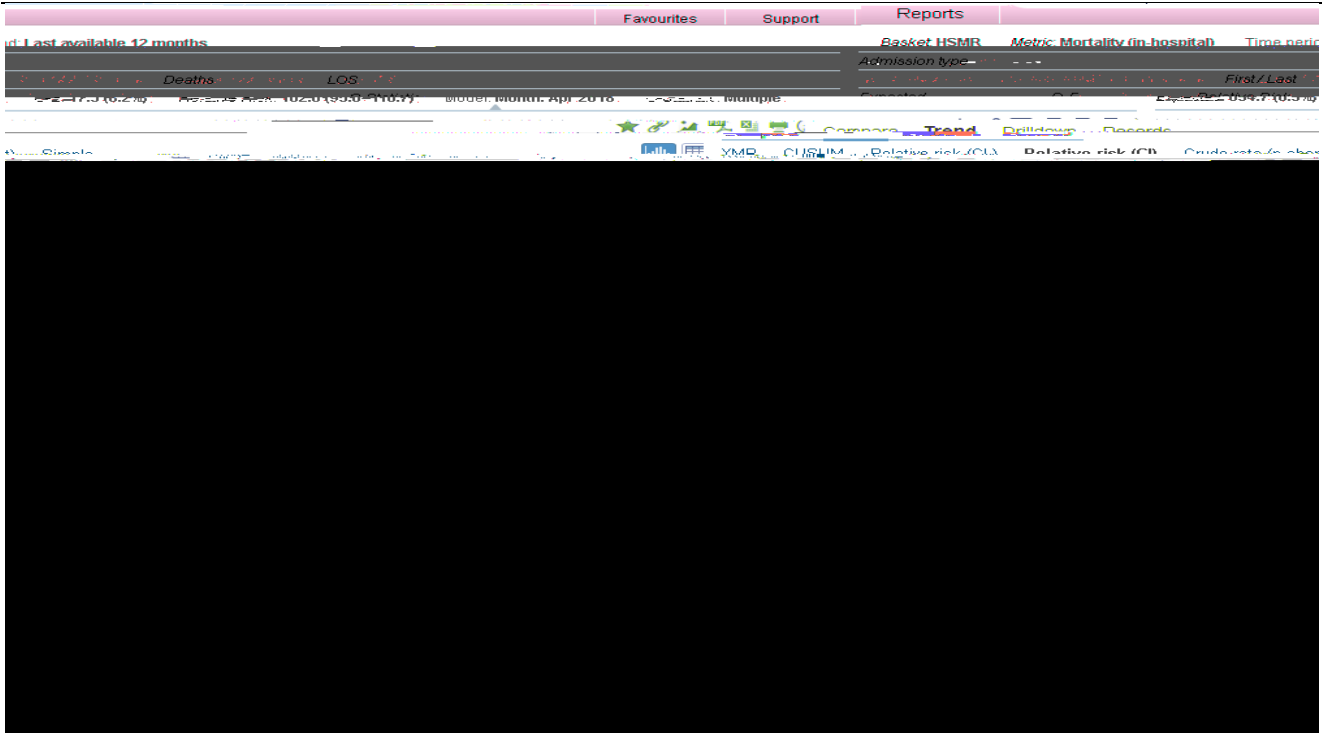
Redesign the PICC line service with 2 nurses identified to undertake training

Introduction of the ReSPECT form led by the Resuscitation Committee

Continue end of life care education programme

Development of a frailty unit for acutely unwell elderly patients

Introduction of LocSIPPs (standard operating procedures) for Io2 Tc 8nTd [(f)-17(o)118662(e)]w912561701



14.0 SHMI April 2017 – March 2018

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

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

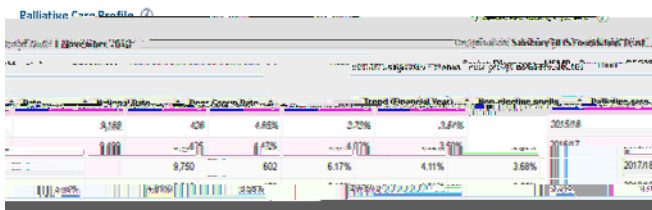
15.0 Comorbidity and palliative care coding 18/19

Organisation: Salisbury NHS Foundation Trust

Report Date: 1 November 2018

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

Upper-quartile comorbidity as index of national (100)



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

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

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

17.0 Highest causes of death (August 17 – July 18) and improvement cases – Pneumonia care bundle and

Septicaemia (77 cases) – monthly sepsis audit

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MORTALITY DASHBOARD 2018/2019**

| | Apr 18 | May 18 | Jun 18 | Q1 | Jul 18 | Aug 18 | Sep 18 | Q2 | Oct 18 | Nov 18 | Dec 18 | Q3 | Jan 19 | Feb 19 | Mar 19 | Q4 | Total |
|--------------------------|--------|--------|--------|-----|--------|--------|--------|-----|--------|--------|--------|----|--------|--------|--------|----|-------|
| Deaths | 69 | 61 | 55 | 185 | 53 | 67 | 55 | 175 | | | | | | | | | 360 |
| 1 st screen | 69 | 59 | 55 | 183 | 50 | 67 | 52 | 169 | | | | | | | | | 352 |
| % 1 st screen | 100% | 97% | 100% | | | | | | | | | | | | | | |

Note: Appendix 3 - explanatory notes

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

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MORTALITY DASHBOARD – EXPLANATION OF TERMS**

1. Deaths – the number of adult, child and young people deaths in the hospital and the Hospice.
2. 1st screen - the number of deaths screened by medical staff to decide whether they need a full case review.
3. Case review - the number of deaths subject to a full case review using a structured method. Case record reviews involve finely balanced judgements. Different reviewers may have different opinions about whether problems in care caused a death. This is why the data is not comparable.
4. Deaths with a Hogan score of 1 – 3. The scores are defined as: 1) Definitely avoidable 2) Strong evidence for avoidability 3) Probably avoidable, more than 50/50 but close call . NHSI guidance ‘Any publication that seeks to compare organisations on the basis of the number of deaths thought likely to be due to problems in care is actively and recklessly misleading the reader’.
5. Deaths with a Hogan score of 4 – 6. The scores are defined as 4) Possible avoidable but not very likely, less than 50/50 but close call. 5) Slight evidence of avoidability 6) Definitely not avoidable.
6. Learning points – the number of issues identified from reviews and investigation (including)

13. Neonatal death – is the death of a live born baby during the first 28 days after birth.
14. Child death – the death of a child up to the age of 18. All unexpected child deaths are reviewed by the Wiltshire and Swindon Child Death Overview Panel.
15. Learning disability deaths – all patients with learning disabilities aged 4 to 74 years. The Trust reports all these deaths to the LeDeR programme.
16. LeDeR programme – Learning Disabilities Mortality review programme hosted by the University of Bristol aims to guide improvements in the quality of health and social care services for people with learning disabilities across England. The programme reviews the deaths of people with learning disabilities.
17. Serious mental illness – all patients who die with a serious mental illness.
18. Maternal deaths – is the death of a woman while pregnant or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management. Maternal deaths are rare events.

Reference

NHS Improvement, July 2017. Implementing the learning from deaths framework: key requirements for Trust Boards. NHS Improvement, London.

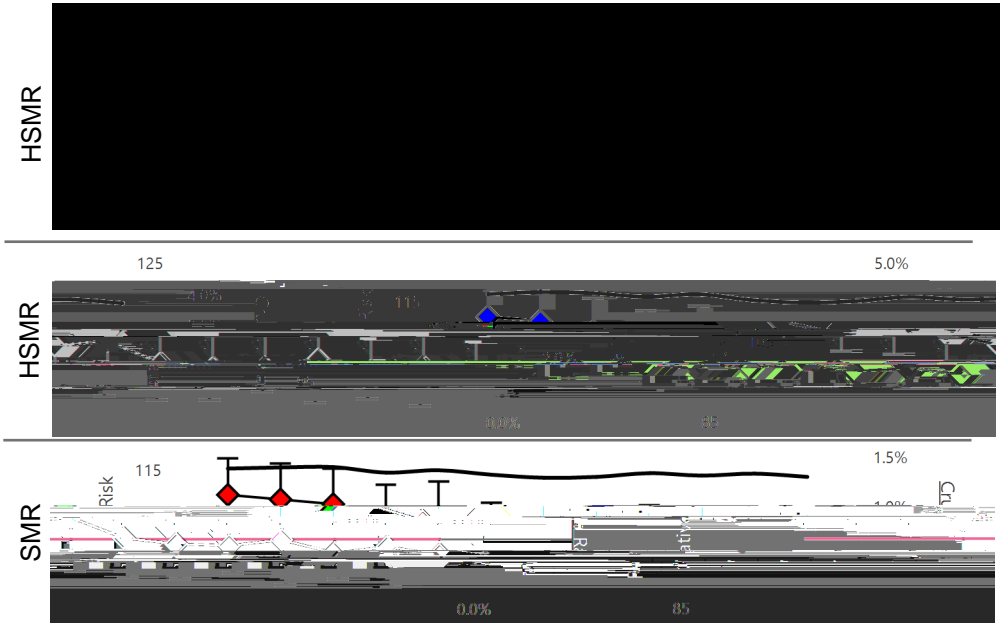
Diagnosis Groups

| Relative Risk Alerts (Top 8) | CUSUM | Obs | Exp | RR | LCI | Trend |
|------------------------------|-------|-----|-----|----|-----|-------|
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| CUSUM-only Alerts (Top 6) | CUSUM | Obs | Exp | RR | LCI | Trend |
|---|-------|-----|-----|-------|------|-------|
| Intestinal infection | 1 | 12 | 7.1 | 168.2 | 86.8 | |
| Other connective tissue disease | 1 | 11 | 7.1 | 154.1 | 76.8 | |
| Malaise and fatigue | 1 | 2 | 0.6 | 335.4 | 37.7 | |
| Other nutritional, endocrine, and metabolic disorders | 1 | 2 | 1.2 | 164.0 | 18.4 | |
| Other bone disease and musculoskeletal deformities | 1 | 1 | 0.1 | 862.8 | 11.3 | |

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

Rolling 12-Month Trends



HSMR Peer Comparison



HSMR and Influencers

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

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