

Learning from Deaths update 2 December 2019

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Agenda Item No: 8.1

Trust Board Report

Meeting Date:	December 2 nd 2019
Title:	Learning from Deaths
Executive Summary:	<p>The paper presents the Trust's most recent mortality data and the work being undertaken to scrutinise and act upon the potential causes for the outlier status of the SHMI indicator.</p> <p>The Trust crude mortality shows a decreasing trend.</p> <p>The national SHMI dataset shows the most recent score for RWT of 1.14, July 2018 to June 2019. This is a further improvement in score although the Trust remains an outlier.</p> <p>Clinical teams have presented reviews of clinical care, both that provided in individual cases and compliance against pathways of care. The renal directorate reviewed chronic kidney disease (CKD) following an alert from the Doctor Foster team. The review showed good care in all but 1 case. The team is satisfied that the requirement for improvement in this case is being addressed through the Trust's sepsis programme.</p> <p>Reports relating to Neonatal deaths, sepsis and Learning Disabilities have also been presented to MRG.</p> <p>The rate of SJR completion is showing an improvement, with the backlog previously reported having reduced. A thematic review of SJR 2 cases has been shared with clinical colleagues. Improvement projects are underway in the areas where learning has been identified including out of hospital care, sepsis recognition and treatment and palliative care provision</p> <p>A proposal to change the SJR process is currently under discussion. The change will reduce duplication, quicken the process including dissemination of learning and provide capacity to introduce other developments including expansion of reviews to out of hospital deaths and quality assurance. The final agreed process will be reflected in an updated Trust Policy OP87.</p>
Action Requested:	Receive and note
For the attention of the Board	To note the SHMI which is showing an improved position of 1.14 this month
Assure	<p>The Board has previously been reassured through data analysis that the increased SHMI is not an indicator of avoidable mortality or quality of care. However, work continues to review and, where possible, enhance quality of care provision across admission pathways with elevated SMR's. Work also continues to address coding & data capture with respect to accuracy and completeness prior to submission of data.</p>
Advise	<p>Raised SMR's can impact on a Trust's reputation. RWT's elevated SHMI is a focus of external scrutiny with assurance being requested and provided regarding the work undertaken, as described above and in this report.</p>

<p style="text-align: center;">Alert</p>	<p>Diagnostic groups with elevated SMRs remain :</p> <p>Chronic renal failure Coma, stupor and brain damage Chronic obstructive pulmonary disease and bronchiectasis</p> <p>Other groups with high excess deaths:</p> <p>Senility and organic mental disorders Respiratory Distress Syndrome Acute cerebrovascular disease Pneumonia Septicaemia Acute Myocardial Infarction</p> <p>Reviews have been conducted, reported internally and where requested to CQC</p>
<p>Author + Contact Details:</p>	<p>Jane McKiernan janemckiernan@nhs.net on behalf of Dr Jonathan Odum – Medical Director 01902 695958 E-mail: jonathan.odum@nhs.net</p>
<p>Links to Trust Strategic Objectives</p>	<ol style="list-style-type: none"> 1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 6. Be in the top 25% of all key performance indicators
<p>Resource Implications:</p>	<p>Revenue: Capital: Workforce: Funding Source: N/A</p>
<p>CQC Domains</p>	<p>Safe: patients, staff and the public are protected from abuse and avoidable harm. Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. Caring: staff involve and treat everyone with compassion, kindness, dignity and respect. Responsive: services are organised so that they meet people's needs. Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.</p>
<p>Equality and Diversity Impact</p>	<p>N/A</p>
<p>Risks: BAF/ TRR</p>	<p>BAF SR 12</p>
<p>Risk: Appetite</p>	
<p>Public or Private:</p>	<p>Public</p>
<p>Other formal bodies involved:</p>	<p>Mortality Review Group/Compliance Oversight Group/Quality Standards Improvement Group/Quality Governance Assurance Committee/Trust Management Committee</p>
<p>References</p>	
<p>NHS Constitution:</p>	<p>In determining this matter, the Board should have regard to the Core principles contained in the Constitution of:</p> <ul style="list-style-type: none"> • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Royal Wolverhampton NHS Trust:

Learning from Deaths Update of monthly activity November 2019

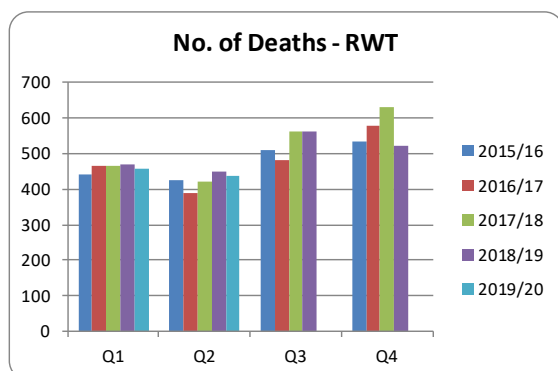
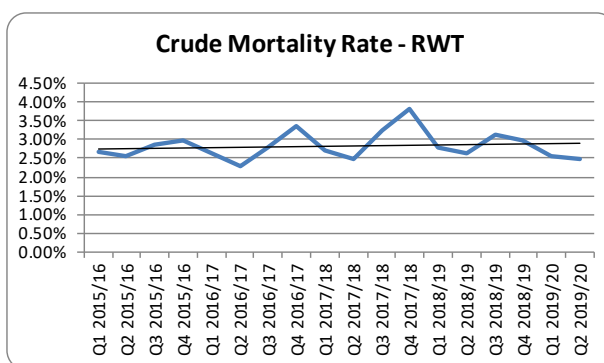
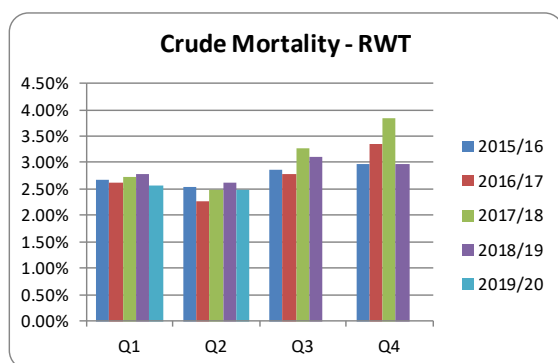
This paper has been updated since November Mortality Review Group to reflect the most up-to-date national SHMI data

1. Update on Standardised Mortality Rates (SMRs) and inpatient data relevant to these calculations

1.1 Crude mortality*

The number of deaths in Q1 and Q2 2019/20 is reduced in comparison to same time 2018/19.

Year to date (April to September 2019) the crude mortality is 2.52%



Period	No. of Ordinary Discharges	No. of Inpatient Deaths	Crude Mortality
2015/16	68888	1908	2.77%
2016/17	69538	1914	2.75%
2017/18	67758	2078	3.07%
2018/19	69558	2004	2.88%
2019/20	35388	893	2.52%

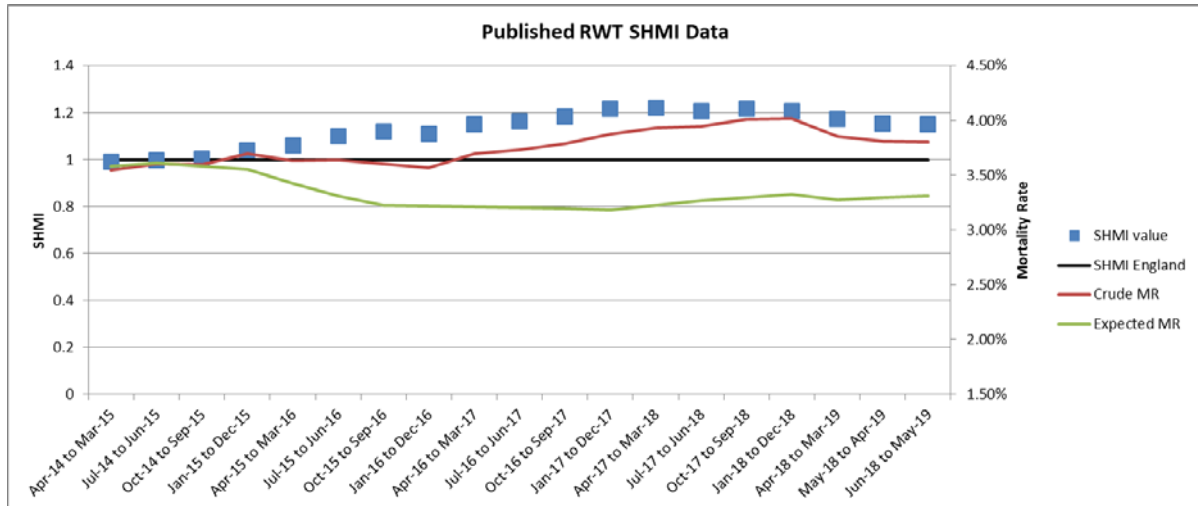
*The number of deaths and crude mortality represent inpatient mortality only (ordinary admissions including still births) extracted from internal data.

1.2 SHMI (Inpatient deaths plus 30 days post discharge)

The most recent published SHMI value, Nov 14th 2019 for the period July 2018 – June 2019 is 1.14.

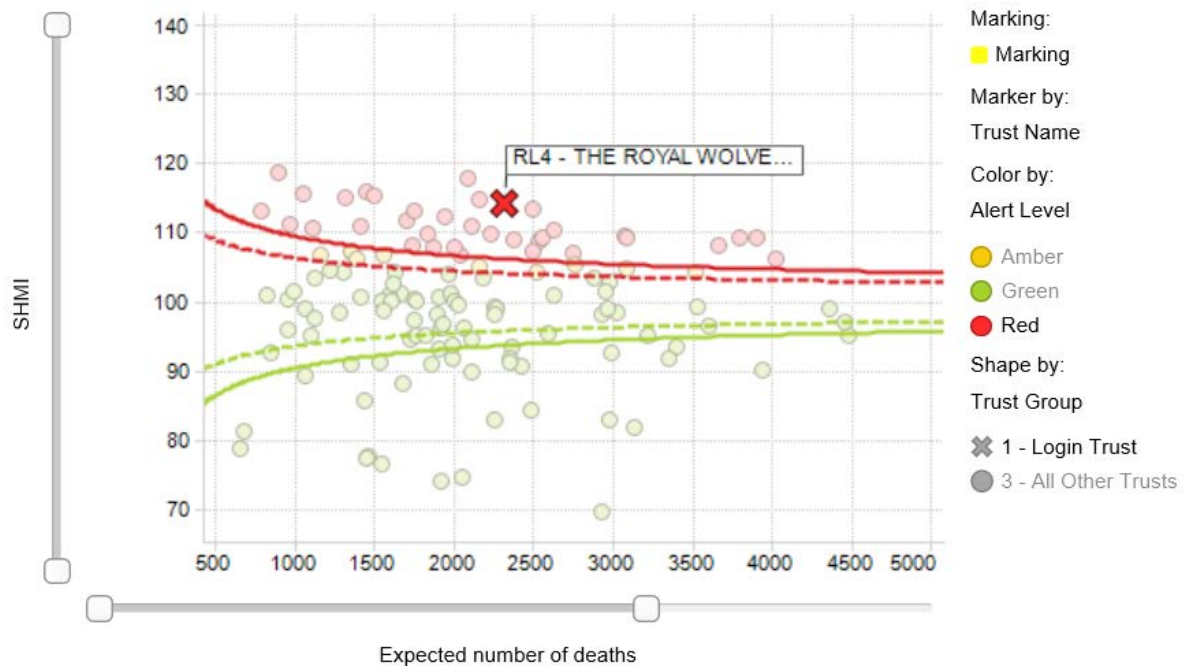
Time period	SHMI Value *	SHMI Crude Mortality %
Jan 2018-Dec 2018	1.21	4.02
Feb 2018 –Jan 2019	1.21	3.99
March 2018 –Feb 2019	1.19	3.94
April 2018 –March 2019	1.17	3.85
May 2018- April 2019	1.15	3.81
June 2018 – May 2019	1.15	3.80
July 2018- June 2019	1.14	3.78

*NHS DIGITAL Nov 14th 2019



This report has previously demonstrated that the change in SHMI is as a result of both an increase in expected deaths and a decrease in the observed.

The Trust is ranked 122 of 130 Trusts across the country and remains an outlier.



1.3 Diagnostic Groups with higher than expected SHMI*

In the table below, those in red are outliers; those in amber are not outlying but lie just below. A review of chronic renal failure was presented at Mortality Review Group in November, see further details below. Reviews of all other conditions have been undertaken within the last 12 months.

Diagnostic Group (CCS)	SHMI	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	Number of mortalities occurring in the hospital	Number of total discharges	Percentage of mortalities occurring in hospital
158 - Chronic renal failure	400.25	6	23	16	96	70%
85 - Coma; stupor; and brain damage	236.6	9	21	20	35	95%
127 - Chronic obstructive pulmonary disease and bronchiectasis	151.83	44	67	49	736	73%
68 - Senility and organic mental disorders	141.01	57	81	53	509	65%
221 - Respiratory distress syndrome	1028.8	0	4	3	68	75%
109 - Acute cerebrovascular disease	118.17	179	212	184	1099	87%
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	111.22	323	359	286	1850	80%
2 - Septicemia (except in labor)	115.85	202	234	194	1107	83%
100 - Acute myocardial infarction	128.09	79	101	87	1442	86%

*June 2018 to May 2019

2. Alerting Diagnostic Groups –Review of Clinical Care

2.1 Renal Disease

The Renal directorate are focused on improving service provision for both patients grouped under the Primary Diagnosis code of Chronic Kidney Disease (CKD) and also Acute Kidney Injury (AKI).

2.1.1 Diagnostic Group Chronic Kidney Disease (CKD, chronic renal failure)

The data below provides an insight into the variability of published mortality figures for this group over recent months.



The Trust received notification from the Dr Foster unit at Imperial Hospital London alerting the Trust to a higher than expected mortality rate for patients with CKD from March 2018 to April 2019. The Chair of the Mortality Review Group requested a review of clinical case notes. This has been reported at MRG in November.

The reviewing team (4 renal Consultants supported by the coding team) reviewed 31 deaths coded in CKD SHMI diagnostic group (code 100) which includes clinical classification software (CCS) codes 158 and 156, for the time period March 2018 – April 2019. All aspects of clinical care, documentation in case notes and coding accuracy have been reviewed in detail.

Mean age of the cohort was 76 yrs. (range 35-96), and mean Charlson score was 15, however 12/31 had a score of less than 6 and 4 patients had a score of 0.

Charlson score band	No.of cases	%
0-5	12	39 %
6-14	8	26 %
15-20	6	19 %
>21	5	16%

Coding of Primary Diagnosis: 24 patients had CKD, (CCS code 158). 7 patients did not fit the globally recognised definition of CKD although they were correctly coded to CCS code 156, which does map to Diagnostic Group CKD.

A descriptor of other comorbidities is listed below. The team found that a primary diagnosis of CKD was chosen for some haemodialysis patients even though the reason for admission included acute MI, acute stroke, hospital acquired pneumonia, GI bleeding and sepsis.

End stage renal failure/CKD 5 patient groups Code 158	Number of patients 24
Patients on palliative care management for advanced CKD	7
Primary diagnosis unrelated to CKD + patients withdrawn from haemodialysis	11
Unsuccessful cardiac arrests (unavoidable)	2
Out of hospital deaths	2
Escalation of care to ITU and died in ITU	2
CCS code 156 Nephritis;nephrosis:renal sclerosis	Cause of death No of patients 7
Pyelonephritis	3 patients – Metastatic malignancy
	2 patients- Pyelonephritis and septic shock
AKI secondary to tubulo-interstitial nephritis	Aspiration pneumonia
Nephrotic syndrome	Metastatic pancreatic cancer

Admission: All patients attended ED as an emergency. One patient was fast tracked and discharged from ED in an efficient manner with appropriate care package and palliative care support in place. There were instances of patients who were admitted on a palliative care

pathway commenced in the community but who were admitted to hospital due to lack of social support and unable to cope at home.

Assessment of Care provision: Care provided to patients has been graded as good to excellent with the exception of one patient who had sepsis secondary to pyelonephritis. Antibiotic administration was delayed by 15 mins and there was a delay of 4 hrs in transfer of this patient to ITU from AMU. This patient's care and death was in April 2018.

NCEPOD score (Measure of Care)	Frequency
1 -Good practice	30
2 – Room for improvement (Aspects of clinical care)	1
3– Room for improvement (Aspects of organisation care)	0
4– Room for improvement (Aspects of clinical and organisational care)	0
5 Less than satisfactory	0
Total	31

Resuscitation and End of life care: 24 out of 31 patients had DNACPR decision either during admission process or prior to admission. The majority of these patients were on palliative pathway for management of advanced CKD or were withdrawn from haemodialysis due to their co-morbidities and difficulties in continuing with long term dialysis due to other clinical reasons. All these patients had evidence of clear discussions with patients/families and ceilings of care documented in clinical records. There was good evidence of recognition and management of patients approaching end of life even though only 6 out of 31 patients had input from palliative team and were given a palliative care diagnostic code.

Conclusion: None of the deaths were avoidable in this cohort of patients given the case-mix of predominantly elderly frail patient with multiple co-morbidities. Except for one case the care received by all patients has been good to excellent. .

Areas of improvement: As the sepsis management in the Trust is continuing to improve with a revised sepsis policy, this review did not identify any new changes to be implemented for sepsis management. One particular area specifically for CKD patients that needs to be addressed is to improve provision for additional palliative/social support for patients on palliative pathway and avoid unnecessary hospital admissions for this cohort of patients.

There is also a need to explore how patients with urinary tract infections particularly with pyelonephritis are being coded in other trusts and to further consider how the primary diagnosis of CKD is arrived at in patients with significant presenting comorbidities.

2.1.2 In a separate exercise the renal team have recently audited Trust performance against the AKI clinical pathway. Good practice was observed in recognition, documentation, referrals seen within 24 hrs, compliance with medication reviews and kidney function monitoring. However gaps in service were found in relation to delay in performing ultrasound and follow up of AKI.

The following actions have been taken:

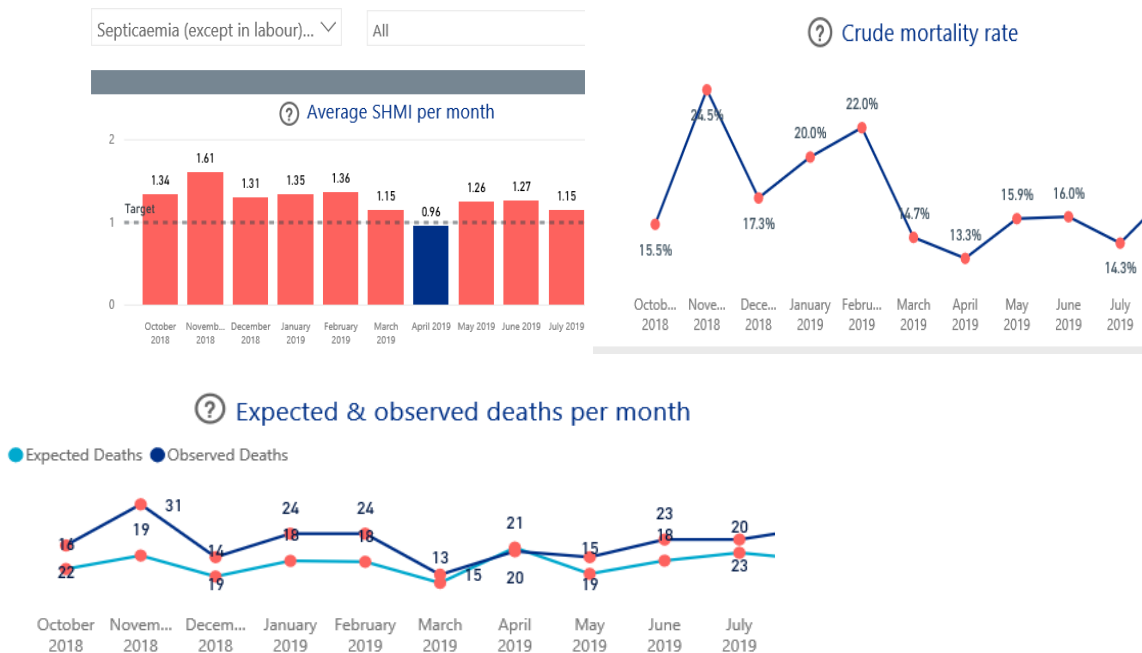
- Change in rota so that a dedicated AKI registrar and cons are on call.
- Utilisation of hot clinics for follow up
- CQI project which will expect to facilitate

- dedicated imaging slots for AKI Stage 3
- medication review
- pre op risk assessment
- improved in-reach service

A business case development to employ specialist nurses is currently at Divisional level

2.2 Sepsis

The data below provides an insight into the published mortality figures for this group over recent months.



Compliance against Process (Compliance is reported monthly to Deteriorating Patient Group)

- ED has demonstrated 100% administration of antibiotics within an hour in October.
- Oncology/Haematology 75% administration within hour
- VOR reports show that in-patient areas using Vital Pac / electronic observations average 50% abx within an hour

Other work

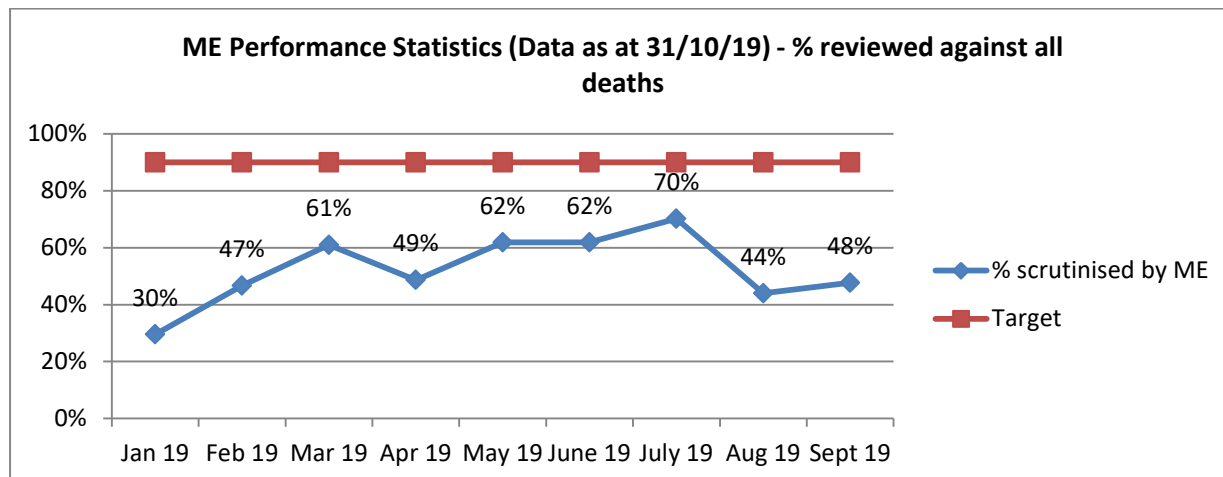
- Continue QIP with inpatient areas. Following 1st PDSA cycle in surgery, antibiotic delivery within an hour increased by 10%
- Continue to work with Informatics department in order to be able to drill down to individual patient information (vital pac model does not provide this option)
- Sepsis Team will pro-actively approach patients who trigger "at risk" of sepsis on daily ward rounds
- PGD training- ongoing in Haem/Onc. Due completion by the end of November
- Vital Pac are currently updating sepsis model.
- Annual sepsis mortality audit to be presented to DPG

2.3 Other Diagnostic Groups

6 weekly progress meetings have been convened to hear progress against identifying gaps in other clinical pathways, Heart Failure, COPD, CVD and Pneumonia. Next meeting is 21st November and an update will be reported to MRG and Trust Board subsequently.

3. Review of Deaths:

3.1 Medical Examiner Process



The number of cases reviewed by Medical Examiners (ME) reduced in August and September 2019. This is due to a combination of short term vacancies and annual leave which means that the office was not covered at all times. Covering of ME leave remains a challenge; however additional ME support will be in place from January 2020 which will help to improve the situation.

The Trust ME and Registrar on site process was presented to the Health Scrutiny Committee at City of Wolverhampton Council (7th November). The paper was received favourably. Team members also attended a national conference in October. It is clear from the presentations and networking discussions that The Royal Wolverhampton Trust is ahead in terms of the resources and progress towards comprehensive ME cover.

3.2 Learning Disabilities Mortality Review (LeDeR)

A report was presented at MRG on behalf of Annette Lawrence, Wolverhampton's Adult Safeguarding Lead and LeDeR Local area contact and Sally Roberts Chief Nurse WCCG.

There have been 26 cases of patient who have died in Wolverhampton with Learning Disabilities between November 1st 2017 and October 31st 2019. Cases are reviewed at a local area level. The report presented the findings of 14 cases, a further 12 cases are still under review.

- 11 died in hospital, 3 in their usual residence
- 4 reviews graded as good, 9 graded as satisfactory, 1 graded as fell short of current practice but not considered to have potential for adverse impact
- Aspiration Pneumonia was the main cause of death, alongside epilepsy, sepsis, ischaemic heart disease, organ failure, respiratory failure, metastatic cancer, subarachnoid haemorrhage

Themes within local learning are consistent with the findings nationally:

There was a wide variety of recommendations made and actions taken, but most commonly, they were in relation to:

- System-level issues (including LD health checks and allocation of key workers in Primary Care)
- Training for staff about supporting people with learning disabilities (including mental capacity and best interests)
- Care coordination and better communication between agencies
- DNACPR orders and end-of-life care (communication and involvement of families and care workers)
- Recognising signs of deteriorating health in a person with learning disabilities

3.3 Neonatal Deaths

The neonatal team have presented the outcome of the review of the baby deaths during quarter 1 2019 (n=7). The results are

- 4 of the 7, no suboptimal care.
- 2 cases provisional report, no suboptimal care but confirmation required after post mortem report
- 1 case (23 weeks plus 6 days), sub optimal care: different management might have made a difference to the outcome. Full report awaited

3.4 Structure Judgment Review

3.4.1 The following data on SJR completion was reported to MRG, 7th November.

- SJR1 backlog (Oct 18 to Jul 19) reduced to 84, as at 30/09/19
- SJR1's identified in August is 24 (6 have been reviewed) and September is 23.
- SJR2 backlog, reduced to 16 as at the 30/09/2019
- SJR2's identified for review in September is 4
- SJR2 outcomes – 24 reported to MRG as 'poor care', 4 recommended as potential SUIs and/or requiring RCA. Of those 4, 2 have already undergone an RCA and 2 are in the process of undergoing non-SUI RCAs.

3.4.2 Thematic Learning from SJR 2s. A report describing the outcome and learning themes from 41 cases undertaken by Mortality Reviewers since July 2019 has been presented at MRG. The cases were chosen because they had an outcome of very poor at initial review. The cases were from patients who died in 2017-2019, a reflection of the backlog of cases that the Mortality Reviewers have been working through and have now completed.

A review of the summary of issues identified by the mortality reviewer for those deaths reviewed identified the following themes:

- Problems in recognition of deteriorating patient (11 cases)
- Compliance with guidelines/pathways (5 cases) - End of Life Care, Clinical assessment, Sepsis care and DOLS with patients with learning disabilities, Medication, Recognition of deteriorating patient and non-specific.
- End of Life Care (6 cases)
- Medication (3 cases)
- Delay in investigations (7 cases)
- Other (8 cases) a) Staff skills/knowledge, b) Communication with relatives when patient lacks capacity, c) Delay in NIV (6hrs), d) Improvement of advanced care planning, e) Communication with family poor & delay in SALT referral & no clear nutrition plan patient remained nil by mouth until death, f) System arrangements for bed management & investigation and treatment of sepsis, g) Poor documentation & delay with investigations, h) Patient managed in an inappropriate clinical area.

- Mental capacity (1 case).

The themes highlighted in this report are similar to those identified in other reports. The Mortality Review Group have previously acknowledged these and made recommendations which have resulted in a number of improvement actions being initiated and monitored across the Trust including sepsis nurse recruitment, deteriorating patient outreach team, palliative care team expansion, implementation of care pathway audits against best practice (QI projects ongoing in sepsis, pneumonia and heart failure).

Recommendations made are:

- The Mortality Review Group should consider the introduction of further reporting categories to identify and record why for example guidelines were not followed and what stage(s) in the identification of a deteriorating patient is failing.
- Share the findings of this report with the Mortality Reviewers in order to embed a consistent approach to completion of 'Problems in Care' sections of the form.
- All Directorates to provide feedback on outcome of SJR2s completed to capture local learning/actions, in particular of those cases where an RCA (local or SUI) has been completed.
- On development of the Quality Assurance process, use the details of the report to set standard for review.

3.4.2 Proposal for revised SJR 1 and 2 Process

A proposal is made to change the process for SJR review

Cases for SJR1 review are currently identified by Medical Examiners (potential concern), mandatory criteria (e.g. Learning Disabilities) as well as a random sample of 10% of cases. When stage-1 SJR identifies 'poor care' our current process dictates that this triggers a second review (SJR2) to be undertaken by medical/nursing colleagues outside of the specialty concerned.

This process has been superseded by the appointment of Mortality Reviewers who now provide independent review at stage 1 level.

The proposal is that where poor care is identified this will not now demand a second 'independent' review. Instead the results will be shared immediately with Directorates and where there is dispute the case will be taken to MRG for clinical discussion.

The change in process will mean that the time between death, review completion and learning is shortened and it will provide further capacity to address other key developments. These include the introduction of an SJR quality assurance process, the desire to review out of hospital deaths and to review those cases where retrospectively the coding data suggests that deceased patients had a low risk of death.

The proposal has been discussed with Mortality Reviewers and was presented to MRG, members were in agreement. The Learning from Deaths Policy (OP87) will be revised and the changes taken through Trust Governance processes.