NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	13 September 2018
Paper number	F1

Learning from Deaths report

For approval:		For assurance:	√	To note:	

Accountable Director	Dr Suneil Kapadia CMO		
Presented by	Dr Suneil Kapadia CMO	**Author /s**	SA Kapadia, S Graystone and J Reading

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√	Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients		Continuously improve our services to secure our reputation as the local provider of choice			

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability		Operational Performance		Quality of Care	√
Finance and use of resources		Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
QGC (extended version)	August 2018	Discussed. Limited assurance

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	N	BAF number(s)	

Assurance in respect of: process/outcome/other (*please detail*) Learning from deaths process.

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☒ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	Trust Board to • note the level of scrutiny of the care provided to patients dying whilst in our care. • note the learning and improvements in care resulting from this review programme.

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Executive Summary

The Trust mortality review process ensures the care of over 80% of patients who die on our care is reviewed. Apparent serious lapses in care are further investigated using the Serious Incident investigation process.

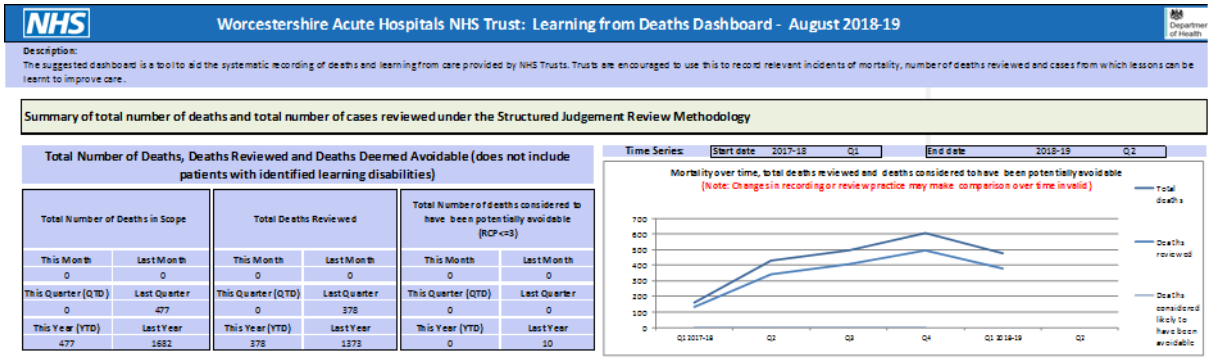
Nine deaths have been deemed more likely than not to be avoidable and changes in practice have occurred to prevent recurrence. Broader themes are being addressed

Background

A mortality review programme was established in May 2017 to identify opportunities for improving the care provided to our patients. The trust uses the process set out by the National Quality Board.

Issues and options

Mortality Review - Results



NHS Worcestershire Acute Hospitals NHS Trust: Learning from Deaths Dashboard - August 2018-19

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement 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 (RCP<=3)	
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	477	0	378	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
477	1682	378	1373	0	10

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable
(Note: Changes in recording or review practice may make comparison over time invalid)

Of the deaths occurring, 81.1% (1751) have been reviewed. Of these, 51 cases (2.9%) raised significant concerns and were investigated as Serious Incidents. Of those, nine deaths were deemed, on a 50:50 probability rating as being avoidable.

The concern raised and learning are contained in the table below

	Issue identified	**Learning/Changes in practice**
Case 1	Discharged from ED following trauma without senior review	Mechanism of injury and injury to others to be factored into assessment. Senior review of Trauma cases before discharge
Case 2	Failure in clarity of 'ownership' of patient in ED with delayed admission	Improvement in referral processes to specialty teams Improvement in escalation processes should a patient deteriorate Focus on reducing time patients spend in the ED
Case 3	Delayed review of deteriorating patient resulting in cardiac arrest	New clinical areas opened have clear escalation protocols and clarity of clinical ownership of patients
Case 4	Failure to recognises and respond to metastatic spinal cord compression	Changes in alerting system for oncology patients Improved pathway and training regarding

		potential spinal cord compression
Case 5	Failure to review investigation results resulting in failure to treat	System for alerting abnormal results were test done by external laboratory to be implemented Identification and management of vasculitis included in local junior doctor training
Case 6	Failure to monitor resulting in failure to escalate and respond to deterioration in ED	Improved handover processes Focussed training on recognition of deterioration and sepsis and appropriate escalation protocols
Case 7	Misplaced NG tube not recognised	Complete overhaul of NG tube management protocol and implementation of training programme
Case 8	Delay in involving Intensive Care Team in ED	Improved pathway for MDT management of overdose patients presenting to ED
Case 9	Inconsistent approach to VTE prophylaxis in ambulatory trauma patients	Consistent approach implemented so patients receive consistent advice & management

The data collected using the Trust's Mortality Review database, which includes Structured Judgement Reviews and those completed by specialty clinicians, has been reviewed by the information department for Q4 2017/18 and Q1 2018/19.

The key findings are:

Question	Q4 2017/18 (total responses)	Q1 2018/19 (total responses)
Clear initial documentation of likely diagnosis, investigation and management plan?	94.77% (287)	98.31% (236)
Consultant review and clear plan documented within 14 hours of admission?	80.84% (287)	77.54% (236)
Daily review (including weekends) by Consultant with clear documentation in the notes.	43.55% (287)	43.16% (234)
Evidence of poor response to deterioration	5.23% (287)	5.98% (234)
If DNACPR* decision made, was the DNACPR form completed correctly (including mental capacity assessment and discussion with the patient and / or relative) and signed by the consultant at the earliest opportunity (no longer than 24 hours after initiation?)	80.66% (305)	79.52% (249)
If the patient needed to be on the End of Life Care Pathway did this occur?	75.08% (305)	72.69% (249)
Was the patient subject to a 2222 call?	10.80% (287)	12.39% (234)
Was this a death following sepsis	19.16% (287)	21.37% (234)
Was this a readmission within 30 days of discharge	16.03% (287)	20.34% (236)
Were there any operational / system-wide issues identified?	16.78% (286)	17.52% (234)

Where specialist reviews completed within 24 hours of request with a clear management plan documented in the notes?	92.33% (287)	94.02% (234)

* Do not attempt CPR

Deaths in patients with registered Learning Disabilities

12 patients have been identified as having a registered learning disability. The Trust has reviewed these deaths and fed the outcome into the wider learning disability review programme. At the time of writing none of these wider reviews have been completed.

Next actions

- DNACPR policy to be reviewed and ensure inclusion in training programmes such as Induction.
- Extract the patient details for the cohort readmitted within 30 days of discharge for a further review.

Recommendations

Trust Board to

- note the level of scrutiny of the care provided to patients dying whilst in our care.
- note the learning and improvements in care resulting from this review programme.