Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Public Trust Board Meeting: Wednesday 13 January 2021**

**TB2021.09**

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| **Title:** | **Learning from deaths report quarter 2 of 2020/21** |

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| **Status:** | **For Information** |
| **History:** | **This is a quarterly paper to the Trust Board** |

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| **Board Lead:** | **Chief Medical Officer** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Assurance** |

## Executive Summary

1. During quarter 2 of 2020/21 there were 601 inpatient deaths reported at OUH. There were 534 (89%) of cases reviewed within 8 weeks. Of these reviews, there were 260 (43%) comprehensive Level 2 reviews and 11 (2%) structured mortality reviews which include 3 structured reviews for patients with learning disabilities. There were no deaths judged more likely than not to have been due to problems in the care provided.
2. The Summary Hospital-level Mortality Indicator (SHMI) for the data period August 2019 to July 2020 is 0.91 and remains rated 'as expected.' The Hospital Standardised Mortality Ratio (HSMR) is 87 for the data period September 2019 to August 2020 and remains rated 'lower than expected.
3. The OUH Lead Medical Examiner has submitted the first quarterly report to the National Medical Examiner.
4. Key actions and learning points identified in mortality reviews are presented for the Board. Work on providing a thematic analysis of mortality is ongoing and will be included in the next paper.

## Recommendations

5. The Public Trust Board is asked to receive and discuss the learning identified from mortality reviews.

## Contents

# Learning from deaths report quarter 2 of 2020/21

## 1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for quarter 2 of 2020/21.

## 2. Background

2.1. The Trust Mortality Review policy requires that all inpatient deaths be reviewed within 8 weeks of the death occurring. All deaths have a Level 1 review. The Level 1 review is a peer review by a consultant not directly involved in the patient's care.

2.2. If there are any concerns identified, a comprehensive Level 2 review is completed involving one or more consultants not directly involved in the patient's care. A structured review, completed by a trained reviewer who was not directly involved in the patient's care, is required if the case complies with one of the mandated criteria.

## 3. Mortality reviews quarter 2 of 2020/21

3.1. During quarter 2 of 2020/21 there were 601 inpatient deaths reported at OUH. The number of mortality reviews completed is presented in Table 1. There were 534 (89%) of cases reviewed within 8 weeks. Of these reviews, there were 260 (43%) comprehensive Level 2 reviews and 11 (2%) structured mortality reviews.

**Table 1: Number of mortality reviews quarter 2 of 2020/21**

| Total deaths | Level 1 reviews | Level 2 reviews | Structured reviews | Deaths not reviewed within 8 weeks |
|---|---|---|---|---|
| 601 | 263 (44%) | 260 (43%) | 11 (2%) | 67 (11%) |

3.2. To address the cases awaiting review, the newly appointed Clinical Governance Lead for the Acute Medicine and Rehabilitation Directorate has made the completion of the outstanding Level 1 mortality reviews their first priority. The Neurosurgery Unit have identified a clinician to lead on the completion of the outstanding reviews. The Respiratory Medicine Unit have since completed the remaining mortality reviews and will present the findings at the Mortality Review Group meeting in January 2021.

3.3. The triggers for the structured reviews are listed in Table 2. There were 3 structured reviews for patients with learning disabilities.

**Table 2: Criteria for structured mortality reviews for quarter 2 of 2020/21**

| Criteria for structured review | Number of reviews |
|---|---|
| Learning disabilities | 3 |
| Concern from staff | 5 |
| Concern from staff and Inquest | 2 |
| Concern from family and staff | 1 |

3.4. The clinical units are responsible for disseminating the learning and implementing the actions identified in mortality reviews. Each Division maintains a log of actions from mortality reviews and monitors progress by their clinical units. The Divisions provide updates on actions in the monthly quality reports to the Clinical Governance Committee. The Divisions also provide updates to the Mortality Review Group (MRG) on the previous quarter's actions as part of the next quarter's mortality report.

3.5. During quarter 2 of 2020/21, there were no patient deaths judged more likely than not to have been due to problems in the care provided.

## 4. Medical Examiner System

4.1. The first quarterly report has been submitted by the OUH Lead Medical Examiner to the National Medical Examiner. The activity highlighted in the report included the successful recruitment and induction of additional external Medical Examiners and the scrutiny of NHS staff deaths with COVID-19 by the Medical Examiners.

## 5. Learning and actions from mortality reviews quarter 2 of 2020/21

5.1. Following the investigation of a patient admitted with a haemothorax, the Emergency Department team will share the OUH 'Adult Blunt Chest Wall Injury Pathway' with the patient's GP and the Oxfordshire Clinical Commissioning Group (OCCG). The OCCG will include a summary of the guidance in the GP Bulletin. The OUH working group on blunt chest trauma are to review the current pathway and consider if the Computerised Tomography (CT) protocol needs to include contrast scans when a vascular injury is identified on non-contrast scans.

5.2. Following the investigation of an intrauterine death, the Maternity Directorate have updated the OUH 'Hypertension in Pregnancy Guideline' to ensure alignment with the National Institute for Health and Care Excellence (NICE) guideline for hypertension in pregnancy. Guidance on blood pressure thresholds and monitoring in pregnant women are to be included in the OCCG weekly GP Bulletin with a reminder that the OUH guidelines can be accessed in the Maternity pages on the OCCG website.

5.3. The Surgery team are completing an audit of patients having a laparoscopic cholecystectomy at the various Trust sites, including other sites used by the Trust during COVID-19, to assess the criteria for assigning patients to each site and the post-operative outcomes.

5.4. The Gastroenterology team are arranging a presentation by the Palliative Medicine team on end of life care at one of the Gastroenterology 'Thursday lunchtime session.'

5.5. The Maternity Assessment Unit (MAU) are trialling a 'triage pathway' to address delays in transfers of patients from MAU to the Delivery Suite.

5.6. The Horton General Hospital Emergency Assessment Unit (HGH-EAU) Senior Nursing team have implemented a system of reviewing all discharges from the previous day to ensure that the TTO's (to take out) have been completed and that the patients have the medication.

5.7. The Infectious Diseases team have designated a consultant to provide specialist infection input for patients under the care of the Outpatient Parenteral Antimicrobial Therapy (OPAT) service.

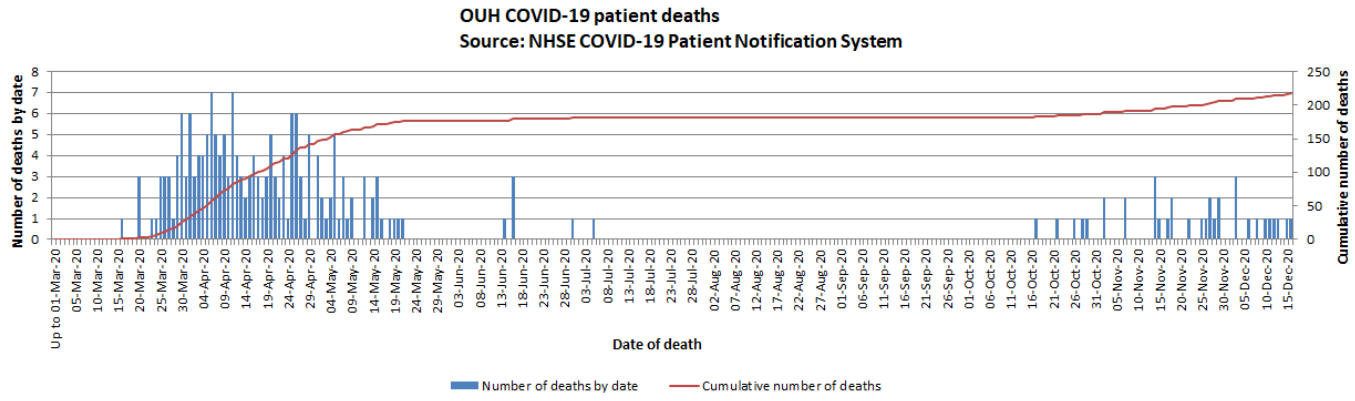
5.8. The Paediatric Critical Care team are developing guidelines for the transfer of patients to Helen and Douglas House Hospice for compassionate extubation.

## 6. COVID-19 deaths

6.1. The OUH COVID-19 crude mortality rate for April to August 2020 was 20.4% compared to the national crude mortality rate of 25.9% (Source: Dr Foster Intelligence).

6.2. There were 35 COVID-19 deaths reported at OUH between 17 October and 16 December 2020. The number of deaths by date of death is depicted in Chart 1.

**Chart 1: OUH COVID-19 patient deaths by date of death**

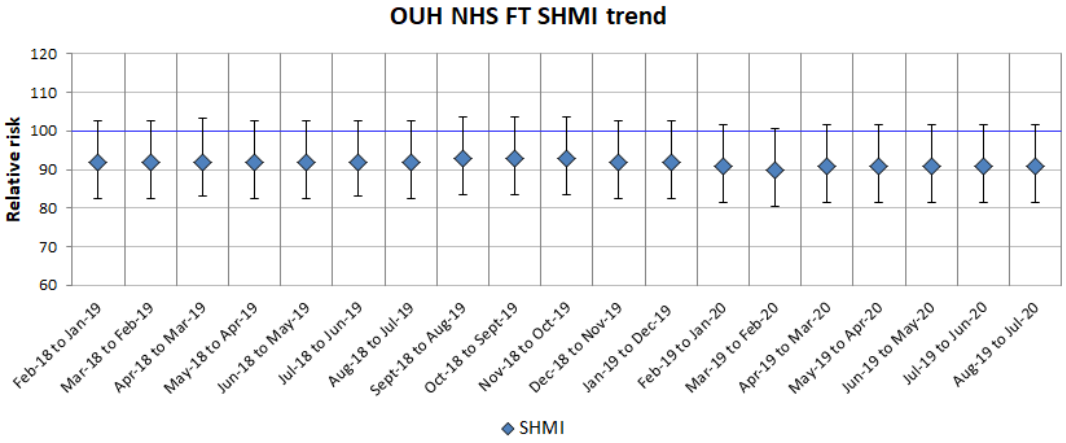


## 7. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

7.1. There has been no mortality outliers reported for OUH from the CQC or the Dr Foster Unit at Imperial College.

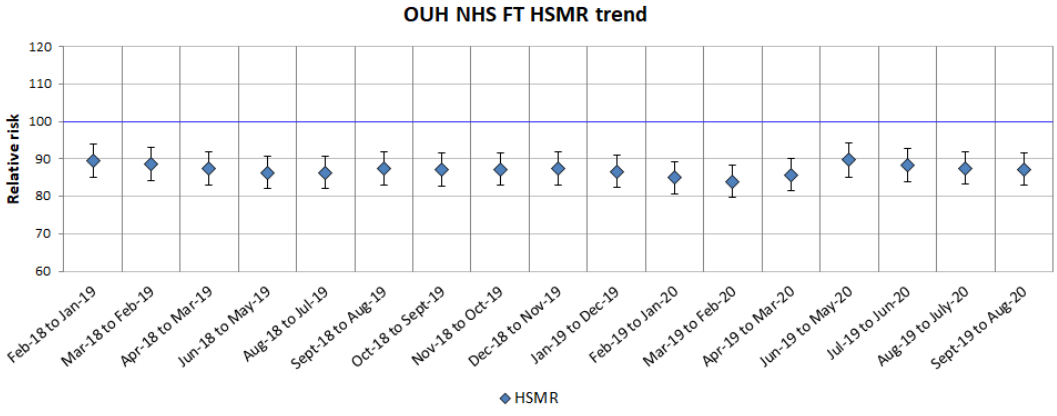
7.2. The SHMI for the data period August 2019 to July 2020 is 0.91. This is rated 'as expected.' Chart 1 depicts the SHMI trend. The SHMI has remained rated 'as expected.'

**Chart 2: SHMI trend** (Presented with a baseline of 100 to enable comparison to the HSMR)




7.3. The HSMR is 87 for the data period September 2019 to August 2020. Chart 3 depicts the HSMR trend. The HSMR has remained rated 'lower than expected.'

**Chart 3: HSMR trend**




## 8. Crude Mortality

8.1. Crude mortality gives a contemporaneous but not risk-adjusted view of mortality across OUH. There was an increase in mortality in March and April 2020. There was a decrease in finished consultant episodes (FCEs) during

this period relating to the preparation for the COVID-19 response. These factors have contributed to the increase in the crude mortality rate by FCEs between March and May 2020. Chart 4 presents the crude mortality for OUH and Chart 5 depicts the crude mortality rate by FCEs.

**Chart 4: Crude Mortality**

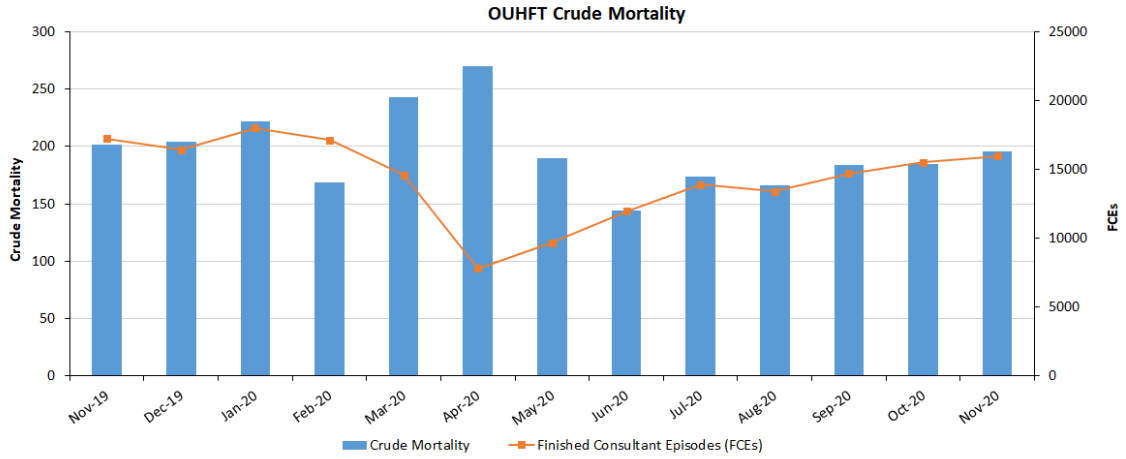
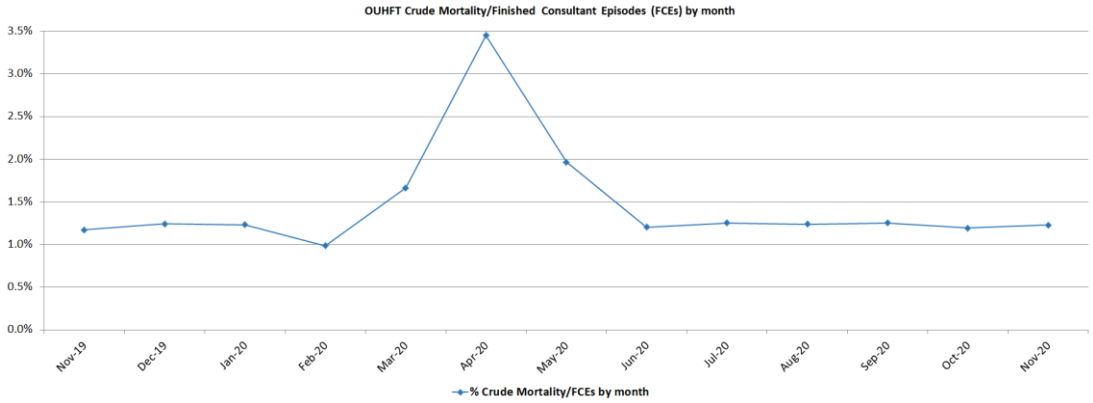



**Chart 5: Crude mortality rate by Finished Consultant Episodes (FCEs)**




8.2. During quarter 2 of 2020/21:

8.2.1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's and Neonatology Division reported that 71 patients died from a total of 12, 436 discharges.

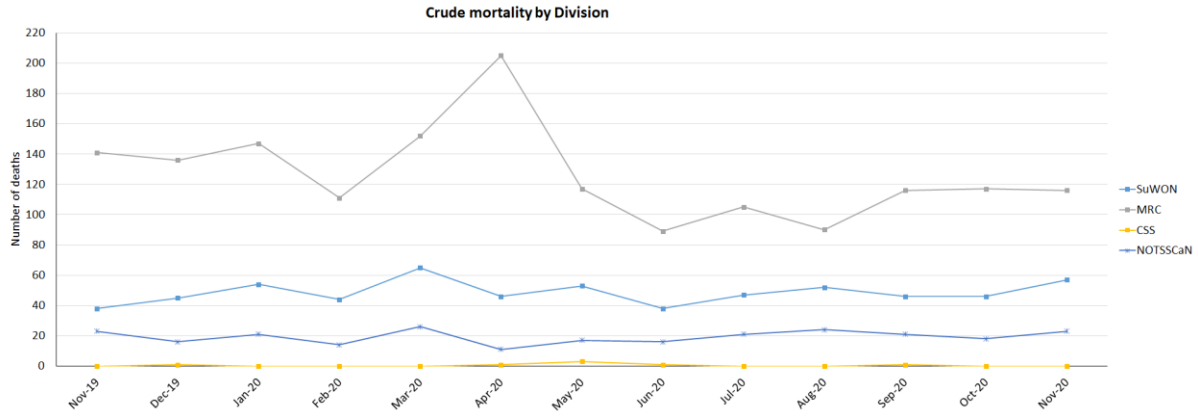
8.2.2. Medical Rehabilitation and Cardiac Division reported that 353 patients died from a total of 14, 209 discharges.

8.2.3. Surgery, Women's and Oncology Division reported that 145 patients died from a total of 15, 374 discharges.

8.2.4. Clinical Support Services Division reported 32 deaths in the Critical Care Units from a total of 326 discharges.

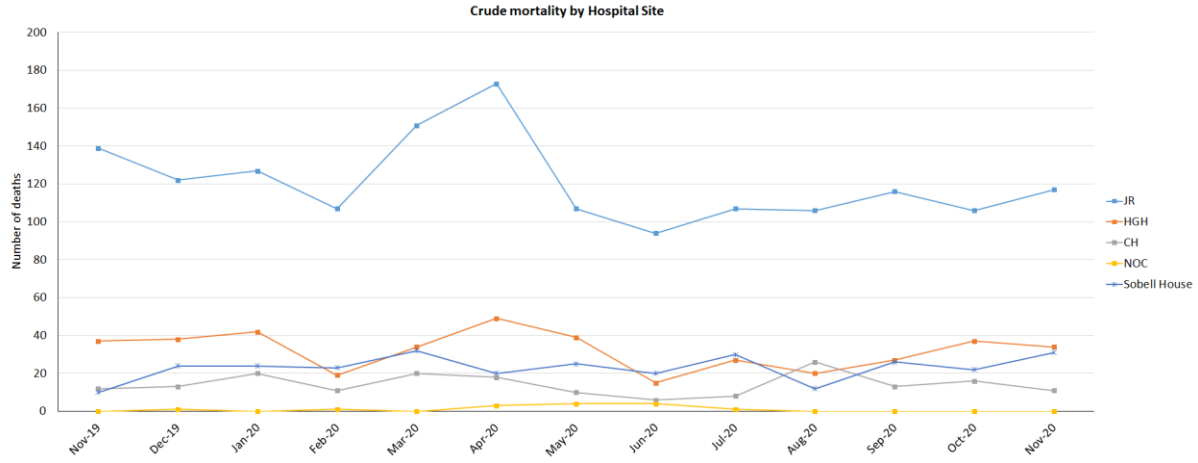
8.2.5. Chart 6 presents the crude mortality by Division.

**Chart 6: Crude mortality by Division**




8.3. Chart 7 depicts the crude mortality by hospital site. Most deaths occur at the John Radcliffe Hospital which has the highest activity.

**Chart 7: Crude mortality by Site**




## 9. Conclusion

9.1. In accordance with national mortality guidance, the Trust has implemented a revised mortality review policy and structured mortality reviews since quarter three of 2017/18. This paper summarises the learning identified in the mortality reviews completed during quarter 2 of 2020/21.

## 10. Recommendations

10.1. The Public Trust Board is asked to receive and discuss the learning identified in mortality reviews.

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