Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 17th January 2018

TB2018.07

Title	**Learning from deaths**

Status	For information
History	The 'OUH Mortality Review Strategy and Standardised Mortality Review policy following new guidance from NHS England' was presented at the Trust Board on 13th September 2017.

Board Lead	**Dr Tony Berendt, Medical Director**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1.	In March 2017 the National Quality Board published guidance based on the recommendations from the Care Quality Commission (CQC) report *'Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England.'*
2.	In accordance with the new national guidance the revised OUH Standardised Mortality Review Policy was published on 30th September 2017 and structured mortality reviews were implemented from Quarter 3 of 2017/18.
3.	This paper describes the implementation of the revised mortality policy and summarises the learning identified in the structured mortality reviews.
4.	OUH mortality indicators No new mortality outliers have been received by the Trust in this reporting schedule. The SHMI for the data period July 2016 to June 2017 is 0.93. This is rated 'as expected' and has decreased from 0.94. The HSMR is 91 for September 2016 to August 2017. This is 'lower than expected' and has decreased from 94.
5.	**Recommendation** The Board is asked to receive and discuss the implementation of the policy and the learning identified from structured mortality reviews.

Learning from deaths

1. Purpose

1.1. This paper summarises the implementation of the revised OUH Standardised Mortality Review Policy. The key learning identified in the structured mortality reviews completed for quarter three 2017/18 thus far is highlighted. The OUH crude mortality and mortality indicators are presented.

2. Background

2.1. In March 2017 the National Quality Board published guidance based on the recommendations from the Care Quality Commission (CQC) report *'Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England'*.

2.2. In accordance with the new national guidance the revised OUH Standardised Mortality Review Policy was published on 30th September 2017 and structured mortality review was introduced from quarter three 2017/18.

2.3. **Criteria for Structured Review:** The mortality review process includes a programme of structured review based on the Royal College of Physicians (RCP) methodology. Structured review instead of a Level 2 review will be mandated in the following cases:

2.3.1. Bereaved families and carers have raised a significant concern about the quality of care provision

2.3.2. Staff have raised a significant concern about the quality of care provision

2.3.3. Learning disabilities

2.3.4. Severe mental illness

2.3.5. Maternal deaths

2.3.6. Serious Incident Requiring Investigation (SIRI) involving a patient death

2.3.7. Mortality alerts from alerts for Summary Hospital-level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR), Dr Foster Unit at Imperial, Care Quality Commission (CQC) or other external regulator

2.3.8. Inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths"

2.4. NHS Improvement has informed the Trust that the structured review methodology will not apply to child deaths. The national mortality review process for children is due to be published at a later date. Currently child deaths have a Level 2 review completed by the responsible OUH team or where applicable the review is completed in accordance with the Child Death Overview Panel (CDOP) process.

2.5. The national guidance requires publication to the Trust Board of the data and learning points from Q3 2017/18 onwards. These data will include:

2.5.1. the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts)

2.5.2. those deaths that the Trust has subjected to structured review

2.5.3. of those deaths subjected to structured review; the total number of deaths considered to have more than a 50% chance of having been avoidable

2.5.4. the total number of inpatient deaths for patients with identified learning disabilities

2.5.5. the total number of deaths of patients with identified learning disabilities considered to have been potentially avoidable

3. Implementation of the revised OUH Standardised Mortality Review policy:

Trust Board:

3.1. The Medical Director is the Board level lead with responsibility delegated to the Deputy Medical Director. The Deputy Medical Director is the Trust Management Executive (TME) level lead acting as Patient Safety Director with accountability for the learning from deaths agenda.

3.2. The Trust Vice Chair is the designated Non-Executive Director responsible for oversight of progress with the mortality guidance.

3.3. The Quality Committee was provided with an update on the progress with structured mortality reviews on 13th December 2017.

Training

3.4. The Deputy Medical Director, a Consultant Intensivist and Mortality Lead for ITU and a Consultant Physician have attended training by RCP on the structured judgement review methodology and are now accredited cascade trainers.

3.5. In 4 in house training sessions held between August and November 2017, 37 clinicians (including 21 mortality leads) and governance staff have been trained in the structured review methodology. Further training is scheduled for 2018s.

3.6. The Deputy Medical Director chairs the Oxford Academic Health Science Network (AHSN) mortality group to further develop good practice.

Engagement with bereaved families

3.7. The bereavement team advise families when they meet with them that the Trust reviews all patient deaths to find out if there is anything we can learn from the care provided. At this face to face meeting the families are asked by the bereavement team if there are any concerns that they have in relation to the quality of care received by their relative.

3.8. The families are also provided with a leaflet, in the information pack provided to all bereaved families, advising of the Trust's mortality review process and contact details should they have any concerns.

3.9. The Bereavement Booklet is currently being revised and the new version will include information on mortality reviews for bereaved families.

4. Structured mortality reviews

4.1. Structured reviews have been in place since quarter three 2017/18. Clinical teams are required to complete reviews within 8 weeks of the patient's death.

Table 1 provides the number of inpatient deaths and structured reviews for October and November 2017.

Table 1: Structured mortality reviews

	October 2017	November 2017	December 2017
Total number of deaths	204	218	225
Learning disabilities deaths	1	1	0
Total number of structured reviews	7 (3%)	10 (5%)	1 (0.4%) (Reviews in progress)
Number of deaths judged more likely than not to be preventable	0	0	Reviews in progress

4.2. The triggers for the structured reviews are listed in Table 2:

Table 2: Criteria for structured mortality reviews

	October 2017	November 2017	December 2017
Concern from family	3	2	1
Concern from staff	2	3	0
Concern from family and staff	0	1	0
SIRI	1	2	0
Learning disabilities	1	1	0
Coroner's Inquest	0	1	0

4.3. **Key areas for potential learning and action** (October - November 2017)

4.3.1. **Clinical Support Services**

4.3.1.1. A potential missed opportunity to recognise a patient's developing illness at a previous attendance.

4.3.1.2. The risks of, and difficulty in responding to, equipment failure in a physically constrained environment

4.3.2. **Medical Rehabilitation and Cardiac**

4.3.2.1. Communication on patient discharge

4.3.2.2. Communication with a patient and their family on the medical ward.

4.3.2.3. The frequency of the recording of a patient's observations on SEND (system for electronic notification and documentation) and the prescribing of oxygen.

4.3.2.4. Prevention and management of a fall in a patient on anticoagulation

4.3.3. **Children's and Women's**

4.3.3.1. Prevention and management of a post-operative cardiac arrest

5. Sharing learning from structured reviews

5.1. Structured reviews are submitted to the clinical unit's mortality and morbidity meeting for the learning to be discussed and actions completed.

5.2. All completed structured review forms are submitted to the Mortality Review Group (MRG) for review. MRG has cross divisional clinical representation who share relevant learning with their specific clinical areas.

5.3. The reviews where any phase of care score is <3 are independently reviewed by MRG. Of the structured reviews during quarter 3 completed thus far; there were 2 cases independently reviewed by MRG. For one case MRG advised that the team complete a further review of the patient's care during their procedure. MRG concluded that a higher level investigation was not required in either of the cases.

5.4. The reviews for the deaths of patients with learning disabilities are presented by the Lead Reviewer to MRG. A summary is provided to the OCCG and Vulnerable Adults Mortality Subgroup and populated on the LeDeR (the national Learning Disabilities Mortality Review) system.

5.5. All SIRI related deaths are presented to MRG by the Lead Investigator. There was 1 SIRI declared in October 2017 and 2 SIRIs declared in November 2017. The investigations are being completed and they are scheduled for presentation at MRG in January and February 2018.

5.6. The numbers of structured reviews and key learning identified will be reported in the annual Quality Account in accordance with the revised regulations.

6. Challenges to completing structured reviews

6.1. Lead reviewers have advised that they have encountered difficulties in securing sufficient time to complete reviews with increasing clinical demands. A single case has been found to take on average 1 hour to review if all required patient records are available and the required members of the clinical team are present. The required time is increased if different specialties have to provide input and increased further still if the specialties are located on different hospital sites.

6.2. The availability and quality of the medical record has impacted on the completeness and the time taken to complete reviews.

6.3. The assessment of the Phase of Care scores has presented difficulties with some teams in reaching consensus.

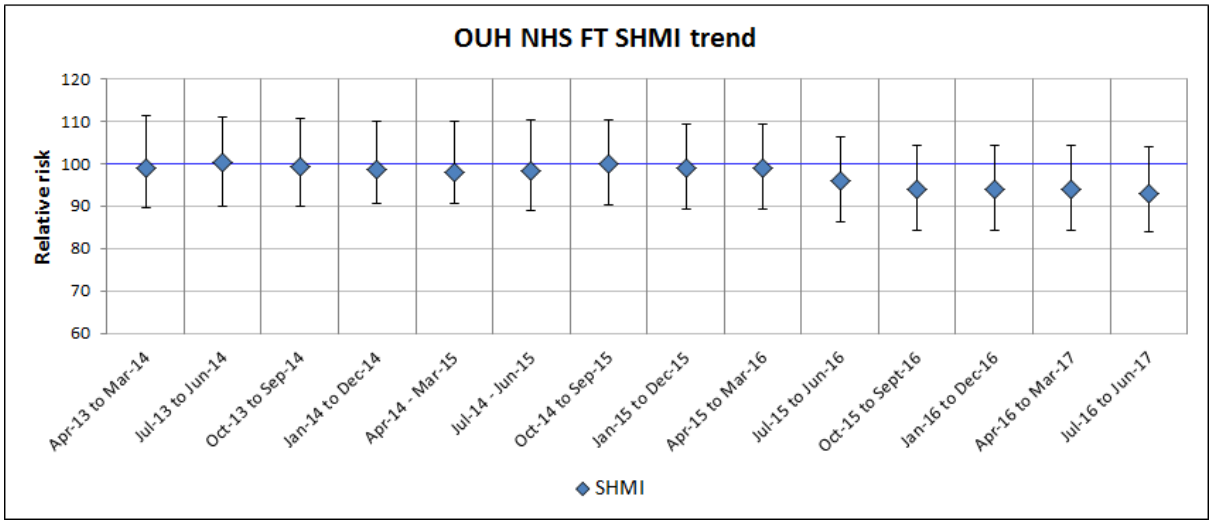
6.4. In cases where a concurrent SIRI, complaint and coroner's inquest is underway there have been difficulties in co-ordinating responses and an increased administrative burden has been experienced by clinical teams.

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

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

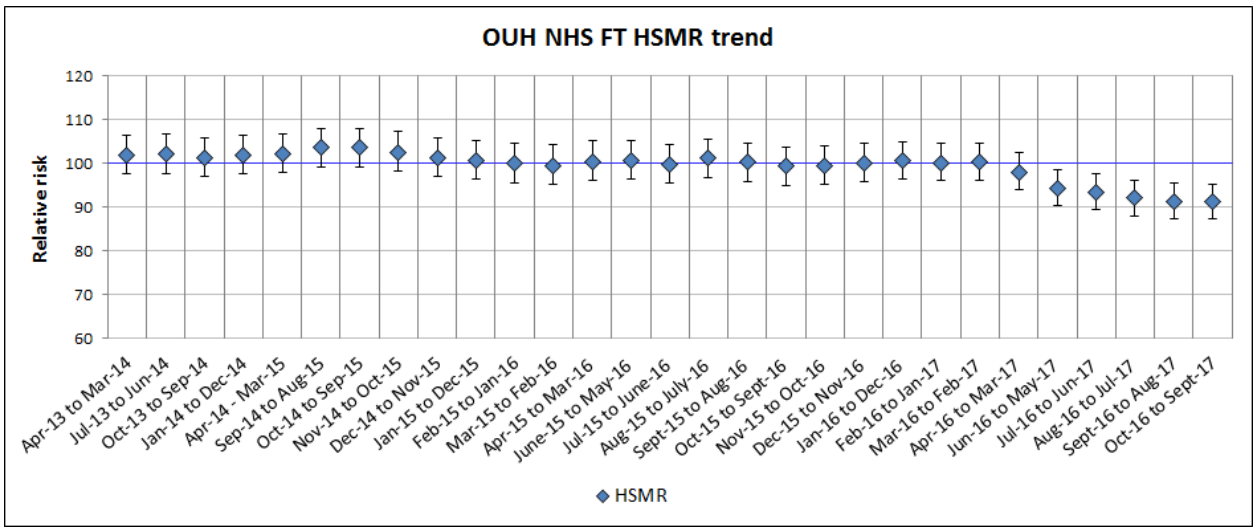
7.2. The SHMI for the data period July 2016 to June 2017 is 0.93. This is rated 'as expected.'

Chart 1: SHMI trend analysis



7.3. The HSMR is 91 for October 2016 to September 2017. This is 'lower than expected' (95% CI 87.2 – 95.3).

Chart 2: HSMR trend analysis



8. Crude Mortality

Crude mortality gives a contemporaneous but not risk adjusted view of mortality across OUHFT.

Chart 3: Crude Mortality

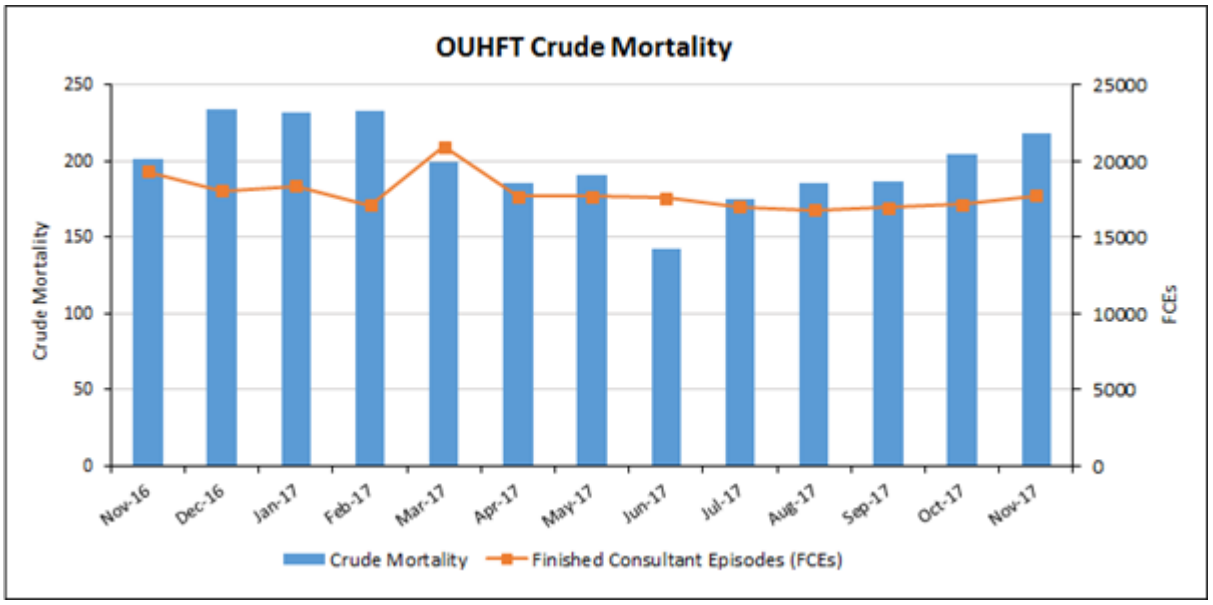


Chart 4: Crude Mortality rate by Finished Consultant Episodes (FCEs)

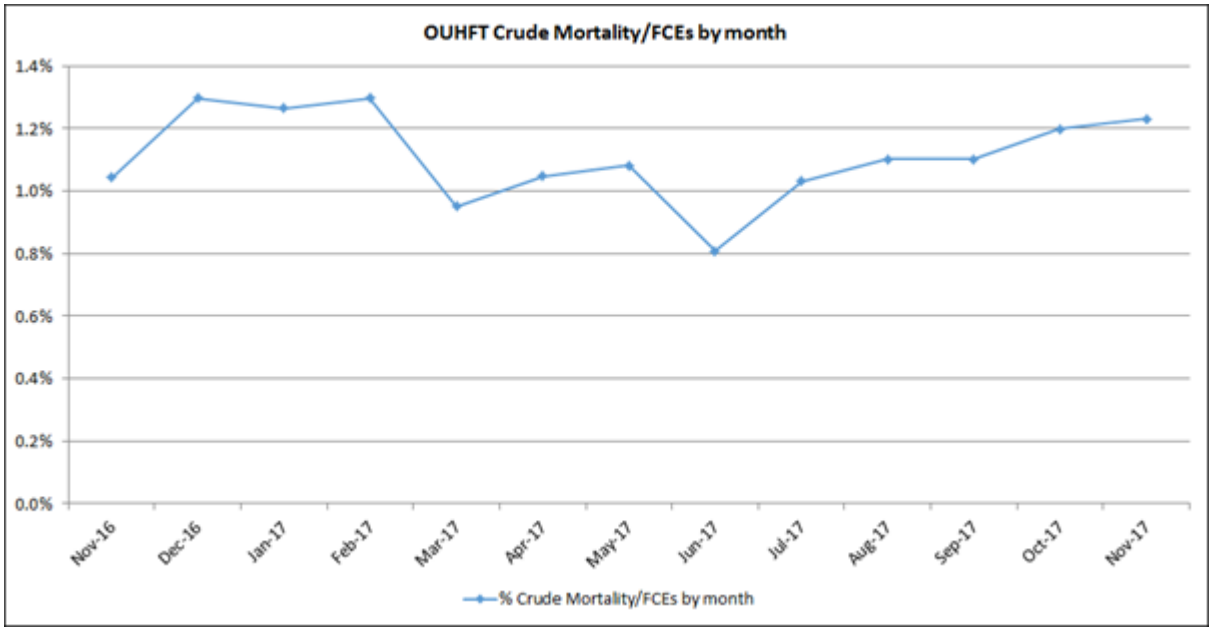


Chart 5: Crude Mortality by Division

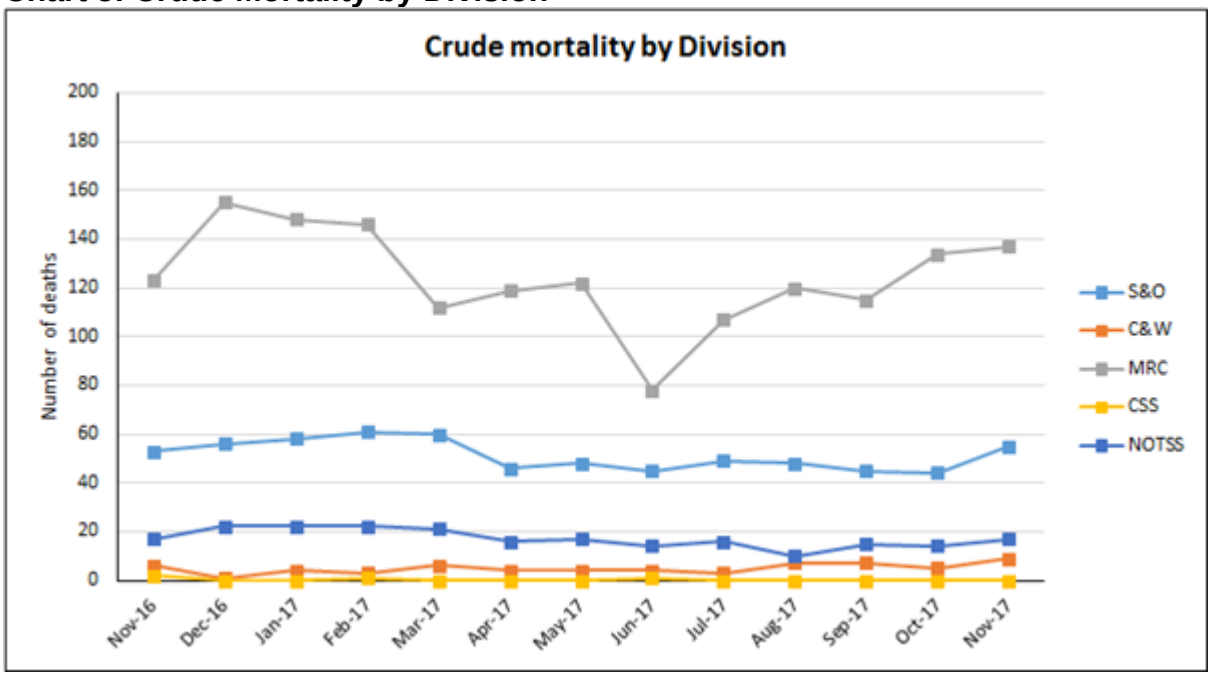
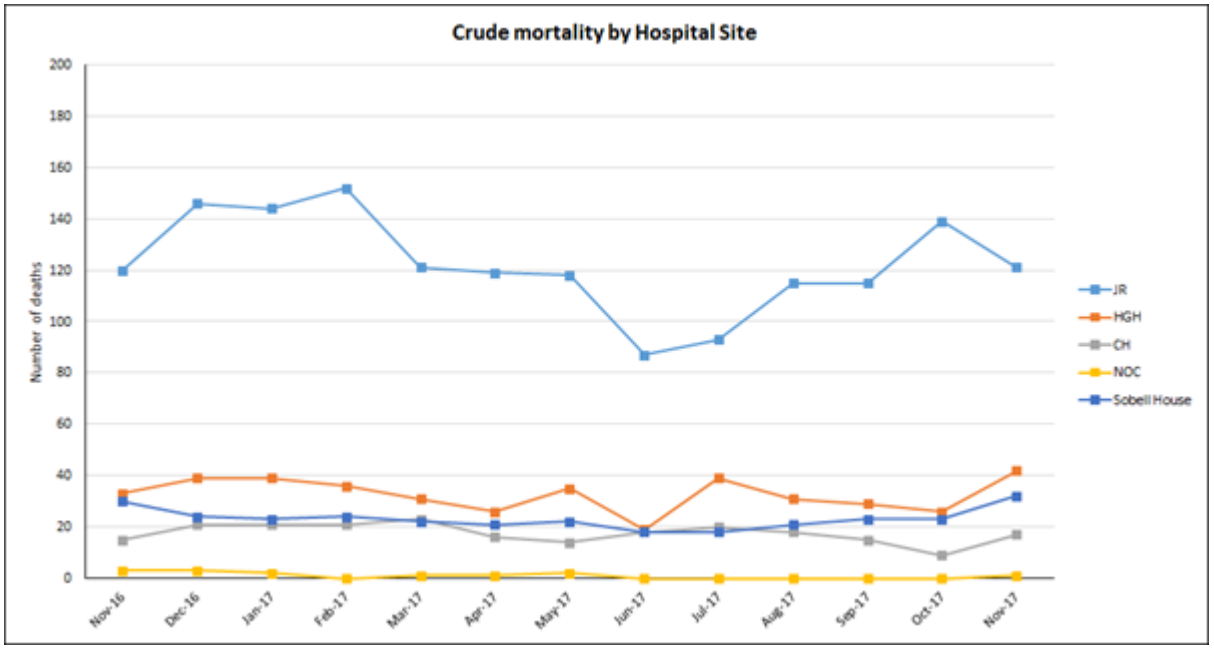


Chart 6: Crude Mortality by Site



9. Conclusion

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

9.2. No new mortality outliers have been received by the Trust in this reporting schedule. The SHMI for the data period July 2016 to June 2017 is 0.93. This is

rated ‘as expected’ and has decreased from 0.94. The HSMR is 91 for October 2016 to September 2017. This value is ‘lower than expected’ and has remained the same.

10. Recommendation

10.1. The Board is asked to receive and discuss the implementation of the policy and the learning identified from structured mortality reviews.

Report compiled by:

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January 2018