

Trust Board Meeting in Public: Wednesday 11<sup>th</sup> July 2018

TB2018.59

<b>Title</b>	<b>Learning from deaths</b>
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<b>Status</b>	For information
<b>History</b>	This is a regular paper to the Trust Board. The first paper was in January 2018.

<b>Board Lead</b>	<b>Dr Tony Berendt, Medical Director</b>			
<b>Key purpose</b>	Strategy	<b>Assurance</b>	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 national guidance, the revised OUH Standardised Mortality Review Policy was published on 30<sup>th</sup> September 2017 and structured mortality review was implemented from quarter three of 2017/18.
3. The Mortality review group meets monthly and considers the findings from SIRI reports with a death involved, Divisional quarterly mortality reports, structured mortality reviews with poor Phase of Care scores and all learning disability mortality reviews. The summary from the learning disability mortality reviews are submitted to the Oxfordshire Vulnerable Adults Mortality Subgroup and the national LeDer programme.
4. Key learning points identified in the structured mortality reviews and investigations completed during quarter four of 2017/18 are summarised as follows:
  - The requirement for a local protocol that lowers the threshold for the surgical treatment of a ruptured abdominal aortic aneurysm in female patients.
  - The need to define the level of care and frequency of observations following the discharge of patients from Neurosciences Intensive Care Unit to the ward.
  - The use of high-flow oxygen in patients with a wheeze should prompt an arterial blood gas check.
  - The consent process for Ventricular Tachycardia ablation now includes discussion with patients of an appropriate and individualised mortality risk.
  - The benefit of appointing an Independent Mental Capacity Advocate for some patients where mental capacity was being assessed.
  - The importance of liaising with community services to establish more advanced care planning to include Do Not Attempt Cardiopulmonary Resuscitation discussions, discontinuation of drugs, appropriate treatment interventions and the prevention of admission.
  - The processes for communication of potential urgent deliveries and for midwifery requests for an obstetric review of cardiotocograms have been reviewed.
  - A 'Local Safety Standard for Invasive Procedures' is being developed for patients requiring a colonic stent.
  - There was good communication with parents during the transition to end of life care for their child with the provision of post-bereavement support.
  - The Electronic Foetal Monitoring Antenatal Guideline has been updated.
  - The Medicines Information Leaflet on warfarin reversal has been updated.
  - The Electronic Patient Record discharge summaries are to include information on incidental findings on discharge.
  - The Surgical Emergency Unit handbook and discharge checklist have been amended to prompt the noting of incidental findings during admission.

**5. Mortality indicators**

No new mortality outliers from the CQC have been received by the Trust in this reporting schedule.

The SHMI for the data period October 2016 to September 2017 is 0.92. This is rated 'as expected' and has decreased from 0.93.

The HSMR is 91 for March 2017 to February 2018. This is 'lower than expected' and has remained the same.

**6. Recommendation**

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

## Learning from deaths

### 1. Purpose

- 1.1. This paper summarises the key learning identified in the structured mortality reviews completed for quarter four of 2017/18 thus far. 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 30<sup>th</sup> September 2017 and structured mortality review was introduced from quarter three of 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 is 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. Deaths of people with learning disabilities
  - 2.3.4. Deaths of people with severe mental illness
  - 2.3.5. Maternal deaths
  - 2.3.6. Serious Incidents 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 College, 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. The national mortality review process for children is due to be published at a later date. Currently deaths of a child have a Level 2 review completed by the responsible OUH team where and the review is completed in accordance with the Child Death Overview Panel (CDOP) process.

### 3. Progress with implementation of the revised OUH Standardised Mortality Review policy:

#### Training

- 3.1. There have been 3 in house training sessions held in 2018 to date and 7 sessions in total since August 2017. Thus far 56 clinicians (including 49 consultants) and governance staff have been trained in the structured review methodology. 7 further training sessions are scheduled between July 2018 and March 2019. The training sessions are available to book on the Trust Intranet via E-LMS (Electronic Learning Management System).
- 3.2. The Deputy Medical Director chairs the Oxford Academic Health Science Network (AHSN) mortality group to further develop good practice by learning from other Trusts.

#### Engagement with bereaved families

- 3.3. The Bereavement Booklet has been revised to include information on the Trust's mortality review process.
- 3.4. An Appendix has been included in the OUH Standardised Mortality Review policy advising staff on the process for the involvement of bereaved families and carers in mortality reviews.

### 4. Structured mortality reviews

- 4.1. Structured reviews have been in place since quarter three of 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 quarter four of 2017/18.

**Table 1: Structured mortality reviews**

	January 2018	February 2018	March 2018
Total number of deaths	270	210	215
Deaths of people with learning disabilities	4	3	4
Total number of structured reviews	14 (5%)	4 (2%)	7 (3%)
Number of deaths judged more likely than not to be preventable in completed reviews <sup>1</sup>	0	0	0

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

<sup>1</sup> 8 Structured reviews are still underway

**Table 2: Criteria for structured mortality reviews**

	January 2018	February 2018	March 2018
Concern from staff	8	1	1
Concern from family	0	0	2
SIRI	1	0	0
Learning disabilities	4	3	4
Coroner's Inquest and concern from family	1	0	0

#### 4.3. Key areas for potential learning and action

##### 4.3.1. Neurosciences, Orthopaedics, Trauma and Specialist Surgery

4.3.1.1. The Neurosciences Intensive Care Unit highlighted the need to define the level of care and frequency of observations required following the discharge of patients to the ward.

4.3.1.2. The Vascular Surgery Unit is developing a local protocol that lowers the threshold for the surgical treatment of an abdominal aortic aneurysm in female patients on the basis that aortas are smaller in women.

4.3.1.3. The Nuffield Orthopaedic Centre (NOC) highlighted that patients admitted to the site are increasingly complex; older with multiple co-morbidities. Addition of an Orthogeriatrician available at the NOC site was reported to be of potential value but is difficult to recruit to area.

##### 4.3.2. Medical Rehabilitation and Cardiac

4.3.2.1. The review of a patient with a learning disability highlighted the need for more detail on Post Take Ward Round notes in general and in particular, for younger patients with definite pneumonia.

4.3.2.2. It was underlined that the use of high-flow oxygen in patients with a wheeze should prompt an arterial blood gas check.

4.3.2.3. A learning disability mortality review highlighted that there was a possibility that the patient had deteriorated in their care home for several days prior to it being recognised, leading to a possible delay in access to treatment. A recommendation for review by the care home has been made to the Oxfordshire Vulnerable Adults Mortality Subgroup (VAM).

4.3.2.4. The consent process for Ventricular Tachycardia ablation<sup>2</sup> now includes discussion with patients of an appropriate and individualised mortality risk.

##### 4.3.3. Surgery and Oncology

4.3.3.1. A learning disability mortality review noted the benefit of appointing an IMCA (Independent Mental Capacity Advocate) for some patients where their mental capacity was being assessed.

<sup>2</sup> Ventricular tachycardia occurs when electrical signals within the lower chambers of the heart (ventricles) cause the heart to beat too quickly. Ventricular tachycardia ablation is a procedure to eliminate the areas of the heart where erratic electrical signals arise that can cause the heart to beat ineffectively.

4.3.3.2. The Division are liaising with community services to establish more advanced care planning to include DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) discussions, discontinuation of drugs, appropriate treatment interventions and the prevention of admission.

#### 4.3.4. **Clinical Support Services**

4.3.4.1. A learning disability case is the subject of the national LeDeR (Learning Disability Mortality Review) programme multi-agency Priority Theme review. The multi-agency review meeting took place on the 20<sup>th</sup> June 2018 with the OUH Intensive Care Consultant, the Learning Disability Lead Nurse and Clinical Outcomes Manager attending. The final LeDeR report will be presented to the Trust Mortality Review Group (MRG).

4.3.4.2. The need for consultant to consultant referral of complex haematology patients was reiterated.

4.3.4.3. A standard operating procedure for time critical implementation of renal replacement therapy is in progress.

4.3.4.4. Communication from theatres to ICU about difficult airway patients is to be supported by a departmental airway proforma.

#### 4.3.5. **Children's and Women's**

4.3.5.1. The Children's Directorate highlighted cases of good communication with parents during the transition to end of life care for their child with the provision of post-bereavement support.

4.3.5.2. Guidance is to be updated to provide antenatal steroids at 22+5 weeks rather than 23+0 weeks for pregnancies at risk for extreme prematurity.

4.3.5.3. Haemophilia was highlighted as a possible cause of haemorrhage in male infants.

4.3.5.4. There had been no maternal deaths in the reporting period.

## 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 MRG for review. MRG has cross divisional clinical representation who are tasked to 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 4 completed thus far there was one case with a phase of care score <3. The case highlighted the difficulty in accessing Non Invasive Ventilation beds, though this was not considered have impacted on the outcome in this case. MRG have requested this to be raised with the MRC management team for options appraisal.

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 VAM and populated on the LeDeR system.

5.5. All SIRS related deaths are presented to MRG by the Lead Investigator.

- 5.5.1. There were 7 SIRS reports from quarter two and three of 2017/18 which were presented at MRG between January and May 2018. One has been downgraded by OCCG and is no longer a SIRS. Key actions arising from these investigations include:
- 5.5.1.1. The Electronic Foetal Monitoring Antenatal Guideline has been updated with improved clarity on the interpretation of cardiocograms (CTG)<sup>3</sup> and the actions for the team to take. This includes the urgency with which midwives should request obstetric reviews and obstetricians should advise delivery.
  - 5.5.1.2. A Local Safety Standards for Invasive Procedures (LocSSIP) is being developed for patients requiring a colonic stent.
  - 5.5.1.3. The OUH MIL (Medicines Information Leaflet) on warfarin reversal has been updated to include an isolated Haemoglobin drop < 20g/L in the definition of a major bleed.
  - 5.5.1.4. The Electronic Patient Record (EPR) discharge summaries are to include information on incidental findings on discharge. The Surgical Emergency Unit (SEU) handbook and discharge checklist are to be amended to prompt the noting of incidental findings during admission.

5.6. The numbers of structured reviews and key learning identified has been reported in the 2017/18 Quality Account in accordance with the revised regulations.

## 6. Challenges to completing structured reviews

6.1. With increasing clinical demands, lead reviewers have encountered difficulties in securing sufficient time to complete reviews. 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. The completion of reviews within 8 weeks of the patient's death has not been attained in some cases in high activity clinical areas. This is being monitored and meetings of the Medical Director's Team with the division which has the largest number of deaths are in place to support the process.

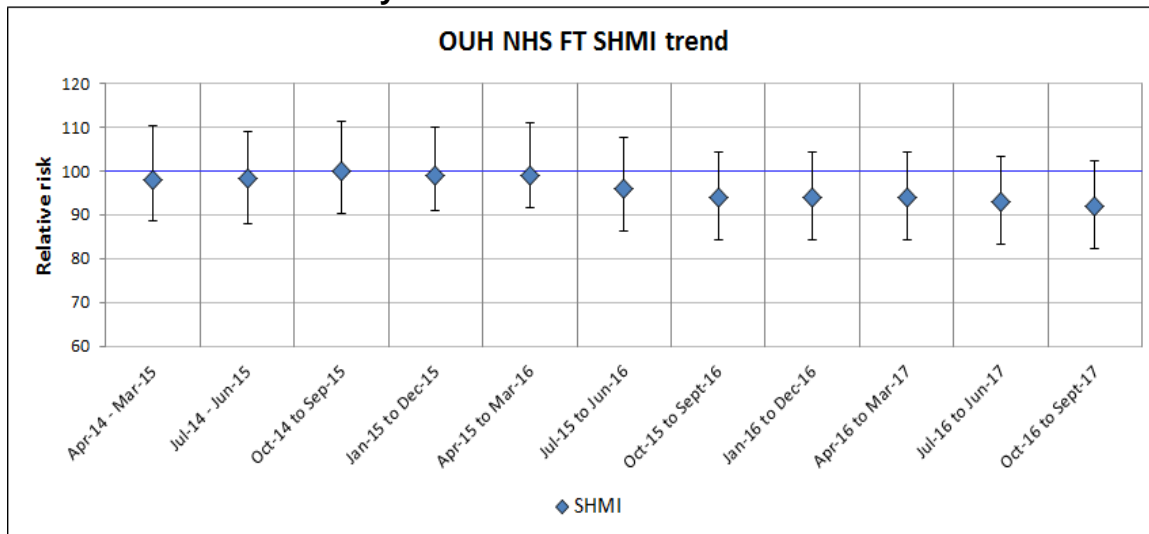
## 7. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

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 October 2016 to September 2017 is 0.92. This is rated 'as expected.'

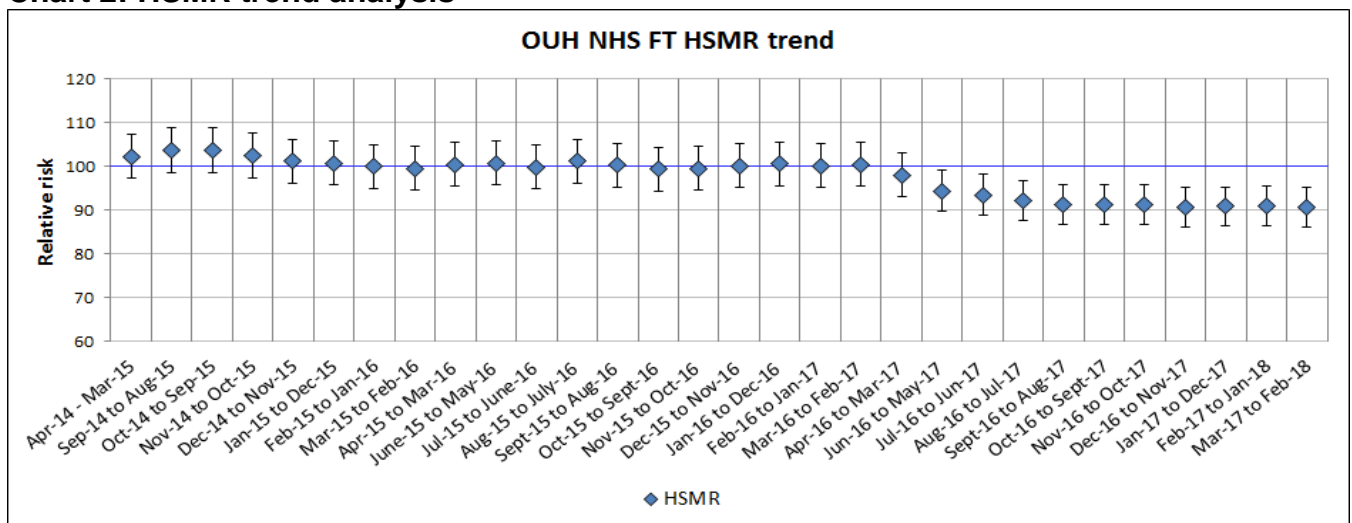


**Chart 1: SHMI trend analysis**



7.3. The HSMR is 91 for March 2017 to February 2018. This is ‘lower than expected’ (95% CI 86.8 – 94.9).

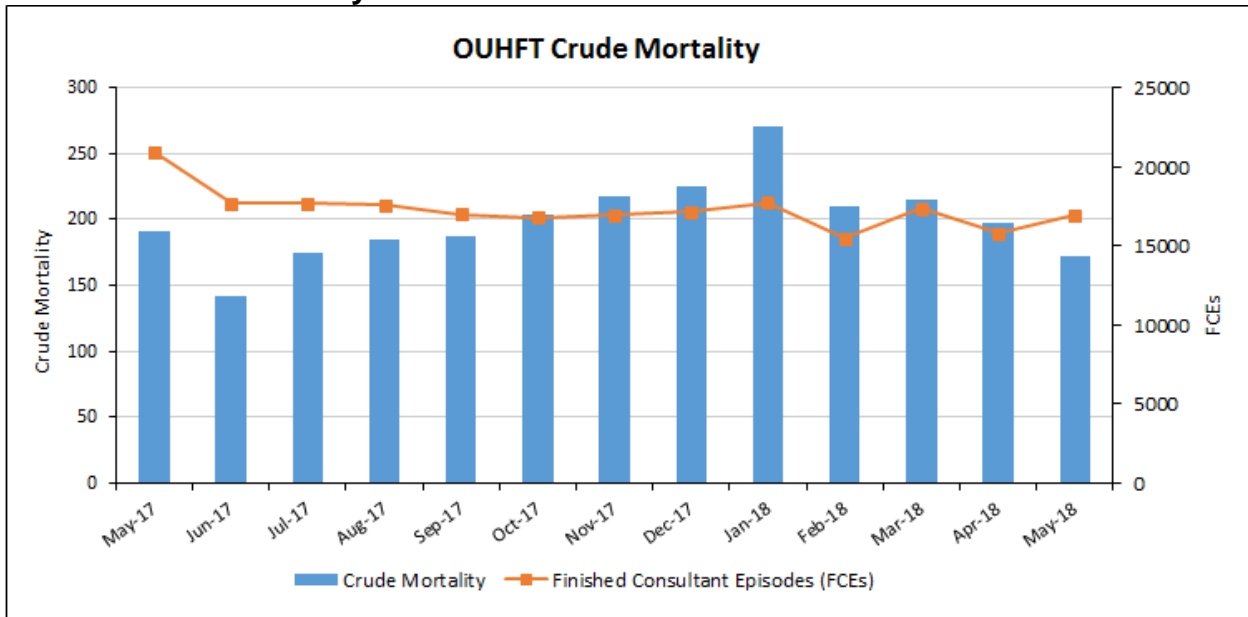
**Chart 2: HSMR trend analysis**



**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)**

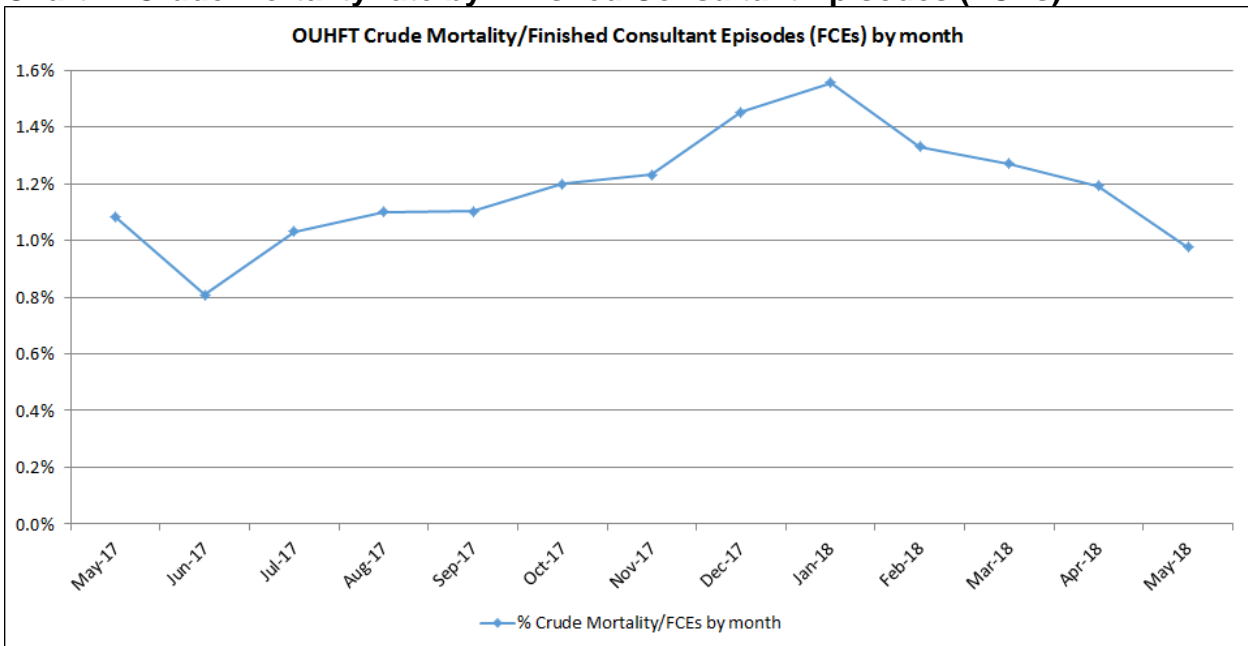


Chart 5: Crude Mortality by Division

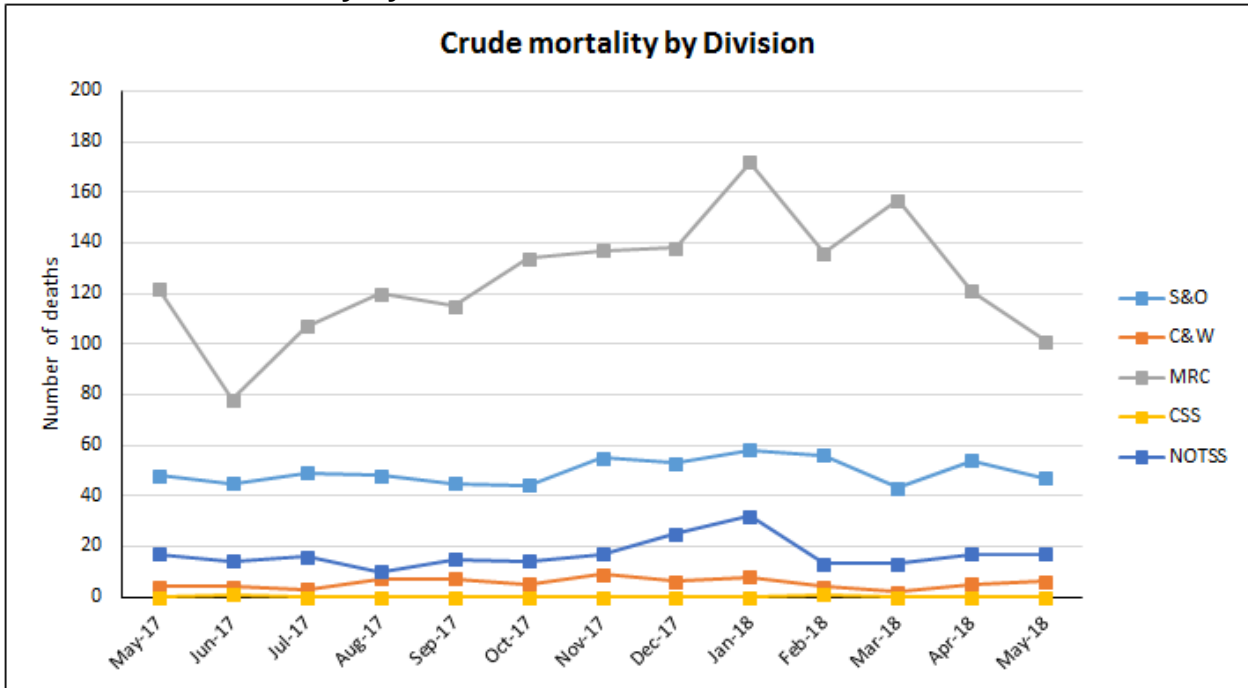
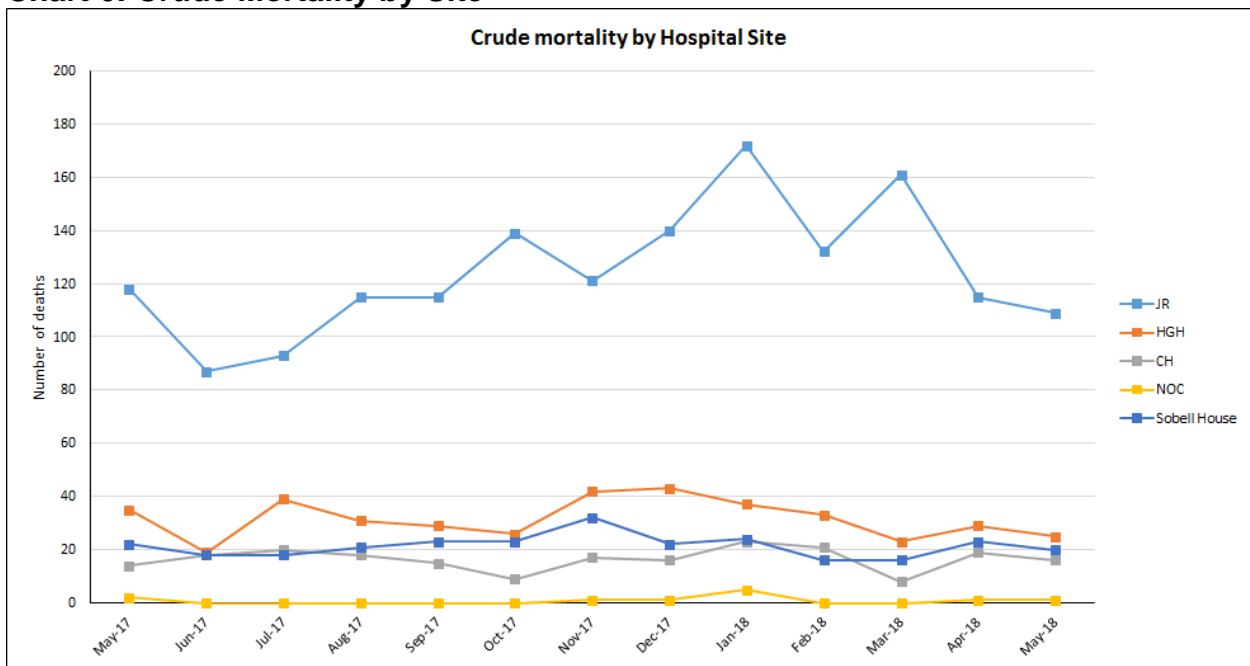


Chart 6: Crude Mortality by Site



**9. Conclusion**

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

9.2. No new CQC mortality outliers have been received by the Trust in this reporting schedule. The SHMI for the data period October 2016 to September 2017 is 0.92. This is rated 'as expected' and has decreased from 0.93. The HSMR is 91 for March 2017 to February 2018. This is 'lower than expected' and has remained the same.

**10. Recommendation**

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

Report compiled by:

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Date: 3<sup>rd</sup> July 2018