Trust Board Meeting in Public: Wednesday 16\textsuperscript{th} January 2019

TB2019.07

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<tr>
<th>Title</th>
<th>Learning from deaths</th>
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<th>Status</th>
<th>For information</th>
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<tr>
<th>History</th>
<th>This is a regular paper to the Trust Board. The first paper was in January 2018.</th>
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<tr>
<th>Board Lead</th>
<th>Professor Meghana Pandit, Medical Director</th>
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<tbody>
<tr>
<td>Key purpose</td>
<td>Strategy</td>
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TB2019.07 Learning from Deaths
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. The Mortality Review Group (MRG) meets monthly and considers the findings from Serious Incidents Requiring Investigation (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 is submitted to the Oxfordshire Vulnerable Adults Mortality Subgroup (VAM) and the national Learning Disability Mortality Review (LeDeR) programme.

3. In quarter two of 2018/19 there were 22 structured mortality reviews completed which included 10 reviews for patients with learning disabilities. There were no deaths judged more likely than not to be preventable in the completed reviews.

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

   The Summary Hospital-level Mortality Indicator (SHMI) for the data period July 2017 to June 2018 is 0.92. This is rated ‘as expected’ and has remained the same.

   The Hospital Standardised Mortality Ratio (HSMR) is 92 for October 2017 to September 2018. This remains rated as ‘lower than expected.’

5. Key actions and learning points identified in mortality reviews completed during quarter two of 2018/19 are presented for the Board.

6. Recommendation
   The Board is asked to receive and discuss the learning identified from mortality reviews.
Learning from deaths

1. Purpose
   1.1. This paper summarises the key learning identified in the mortality reviews completed for quarter two of 2018/19. The OUH crude mortality and mortality indicators are presented.

2. Background
   2.1. 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 of 2017/18.
   2.2. **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 mortality review is mandated in the following cases:
      2.2.1. Bereaved families and carers have raised a significant concern about the quality of care provision
      2.2.2. Staff have raised a significant concern about the quality of care provision
      2.2.3. Deaths of people with learning disabilities
      2.2.4. Deaths of people with severe mental illness
      2.2.5. Maternal deaths
      2.2.6. Serious Incidents Requiring Investigation (SIRI) involving a patient death
      2.2.7. Mortality alerts from the 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
      2.2.8. Inquest and issue of a “Regulation 28 Report on Action to Prevent Future Deaths”
   2.3. The national mortality review process for children is due to be implemented. Currently deaths of a child have a Level 2 review completed by the responsible OUH team and a review is completed in accordance with the Child Death Overview Panel (CDOP) process.

3.Structured mortality reviews
   3.1. 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 two of 2018/19.
### Table 1: Structured mortality reviews

<table>
<thead>
<tr>
<th></th>
<th>July 2018</th>
<th>August 2018</th>
<th>September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of deaths</td>
<td>187</td>
<td>168</td>
<td>170</td>
</tr>
<tr>
<td>Deaths of people with learning disabilities</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total number of structured reviews</td>
<td>12(6%)</td>
<td>4(2%)</td>
<td>6 (1%)</td>
</tr>
<tr>
<td>Number of deaths judged more likely than not to be preventable in completed</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</table>

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

### Table 2: Criteria for structured mortality reviews

<table>
<thead>
<tr>
<th></th>
<th>July 2018</th>
<th>August 2018</th>
<th>September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concern from staff</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Concern from family</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>SIRI and Coroner’s Inquest</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Coroner’s Inquest and concern from staff</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Coroner’s Inquest and concern from family</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Coroner’s Inquest</td>
<td>0</td>
<td>0</td>
<td>1</td>
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</tbody>
</table>

3.3. A proportion of cases which do not trigger a structured review have a comprehensive case record review (Level 2 review). During quarter two of 2018/19 339 (55%) of inpatient deaths had a Level 2 review. 60% of deaths have had a level 1 review. The overall level of mortality review within 8 weeks of a death is 83% (514 reviews).

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

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

4.2. The SHMI for the data period July 2017 to June 2018 is 0.92. This is rated ‘as expected’ and has remained the same.

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11 Structured reviews are still underway

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4.3. The HSMR is 92 for October 2017 to September 2018. This remains rated as ‘lower than expected’ (95% CI 87.8 – 96.1).

5. Key points of learning and actions from mortality reviews

5.1. New protocols and pathways

5.1.1. The Vascular Unit have started a supporting process when an amputation is being considered. The treating consultant is to seek a second opinion from a vascular consultant to ensure that there is agreement over the decision to amputate as this is a high risk procedure. The Unit report that this process has been successful thus far in supporting decision making.

5.1.2. Fasciotomies for vascular patients can be performed on the Adult Intensive Care Unit. This will decrease the time to procedure and avoid the need for theatre time and preparation.
5.1.3. The Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM) are writing a protocol for how to manage patients in the outpatients department that need admission but are not critically unwell.

5.1.4. The Palliative Medicine team are developing guidelines, in quarter four of 2018/19, to clarify the process for methadone commencement to ensure consistency of provision and to assist on-call doctors so that they are aware of the rationale and the monitoring required.

5.1.5. The Clinical Haematology Unit highlighted cases of difficult discussions about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and where it would have been more appropriate to have had the discussions earlier in the care pathway. The Unit have introduced regular meetings with patients, who have chronic conditions that are not improving and where there could be a sudden decline (for example, chronic Graft versus Host Disease), and their family to discuss resuscitation decisions.

5.2. Review of guidance and checklists
5.2.1. The Neonatal Unit reviewed guidance for referral of cases for Extracorporeal Membrane Oxygenation (ECMO).

5.3. Clinical audits and service evaluations
5.3.1. The Palliative Medicine team are completing a quality improvement audit of PRNs (as needed) medication given at night and the indication for these.

5.3.2. The Gastroenterology Unit are completing a systematic review of the use of Rocket indwelling drains. The review is to include an assessment of local practice and the current literature. The findings of the review will be presented at the Unit’s weekly teaching session.

5.4. Training and Education
5.4.1. The Children's Directorate highlighted that communication with families in an emergency situation can be challenging when there is a language barrier. This case will be discussed at the Perinatal Mortality and Morbidity Panel meeting for wider dissemination of information about the Interpreting and Translation Services available at OUH and how these services may be accessed.

5.4.2. The Neonatal Unit reminded the team to prescribe probiotics on the admission of preterm babies and that the probiotics should commence when babies start to tolerate minimal enteral feeds.

5.4.3. The Emergency Department Clinical Governance Lead will be including the diagnosis and management of spontaneous haemopneumothorax in teaching sessions at both the JR and HGH Emergency Departments (ED).
5.4.4. The ED team have circulated learning points on the transmission and diagnosis of rabies.

5.4.5. The Falls Prevention Practice Educator has been invited to present the work on Falls prevention to the ED and Acute General Medicine Clinical Governance meetings.

5.4.6. OCDEM are arranging human factors training for the clinical team which will focus on how to manage a deteriorating patient in an outpatient setting.

5.4.7. The Stroke Medicine Unit are to discuss stroke recognition training for nurses with the Acute General Medicine Matron.

5.4.8. The Cardiology Unit reported that a case of a transcatheter aortic valve implantation (TAVI) had led to learning within the clinical team on the management of vascular complications particularly in relation to sizing and deployment of vascular stents.

5.4.9. The Oncology Unit highlighted the need for resuscitation decisions to be made at an appropriate time before a patient’s acute admission. The Unit advised that discussions should occur between the patient and their clinical team during clinic attendances. It was recommended that clinicians attend the Sobell House course, Sage and Thyme, on end of life conversations to assist with discussions about resuscitations decisions.

5.4.10. The Renal Unit highlighted the importance of a Best Interests meeting as part of the preparation for renal replacement therapy for patients who did not have capacity. All consultants and pre-dialysis nurses were made aware of Best Interests meetings and instructed that they should consider them in cases where capacity is uncertain or absent.

5.4.11. The Surgery Unit highlighted to the clinical team, at the Unit’s mortality meeting, the need for early physiotherapy input for elderly patients following a laparotomy.

5.4.12. The Horton Medicine Unit identified that there was an increased number of oncology patients being admitted to the HGH. The Unit will be inviting an Oncology Consultant and Oncology Specialist Nurse to the Horton Medicine Clinical Governance meeting to discuss the provision of care for these patients.

5.5. **Other points highlighted**

5.5.1. The Acute General Medicine Unit highlighted the impact of the sparse provision of adult Intensive Care Unit (ICU) beds and the lack of High Dependency Unit (HDU) beds which results in only those patients most likely to benefit from critical care being selected for admission to adult ICU.
5.5.2. OCDEM highlighted the lack of availability of SEND (System for Electronic Notification and Documentation) equipment in Bagot and Drake Ward at the Churchill Hospital. There were observations on EPR that were manually entered to ensure clear handover to the JR ED team. The order for SEND equipment has been followed up with the Medical Device Strategy and Project Manager.

5.5.3. The Thoracic Surgery Unit highlighted as good practice effective liaison with the palliative care team which allowed patients to be repatriated to a local hospital or to be discharged home when further surgical treatment was deemed to be futile.

5.5.4. The Surgery Unit identified that there were an increase in admissions of patients with newly diagnosed cancers for palliative care to the Surgical Emergency Unit. The Surgical and the Acute General Medicine teams are reviewing where the appropriate place of care for these patients should be.

5.5.5. The Critical Care Unit identified a theme in mortality reviews of delayed and denied admission to ICU especially for high-dependency care.

6. **Sharing learning from structured reviews**

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

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

6.3. The reviews where any phase of care score is <3 are independently reviewed by MRG. Of the structured reviews during quarter 2 completed thus far there was one case with a phase of care score <3. The structured review concluded that this death was possibly avoidable but not very likely (less than 50:50).

6.4. 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 the Oxfordshire Vulnerable Adults Mortality Subgroup (VAM) and populated on the national Learning Disability Mortality Review (LeDeR) system.

6.5. All SIRI related deaths are presented to MRG by the Lead Investigator. There were 3 SIRI reports from quarter one of 2018/19 and 2 SIRI reports from 2018/19 which were presented at MRG between September and December 2018. Key actions arising from these investigations include:

6.5.1. The Maternity Unit have reviewed how Ultrasound Scan (USS) reports are shared. If a copy of an USS report is not present in the patient’s maternity notes for an antenatal appointment, then the community midwife should telephone the OUH Maternity Ultrasound department to request the scan results verbally until a paper copy of the report can be filed in the
6.5.2. The standard practice of using a Robertson drain following burr hole evacuation is being reviewed by the Neurosurgery service with a view to choosing the safest postoperative drain system which is currently available.

6.5.3. A standardised local safety procedure (LocSSIP) for patients with liver cirrhosis undergoing paracentesis is being developed by the Gastroenterology Unit which will include the requirement for the clinical team to provide advice to patients about when to stop their anticoagulation.

6.5.4. The Gastroenterology Unit are to use a Patient Information Leaflet (PIL) to inform the patient that they will be advised on their medication (including anticoagulants) and that if they have any concerns including the risks of stopping they should contact the service using the contact number provided.

6.5.5. Staff members in the Upper Gastrointestinal team have completed Human Factors training focussing on the Track and Trigger Escalation Pathway.

6.5.6. The Standard Operating Procedure (SOP) for Peri-operative Management of Pacemakers and Implantable Cardio-defibrillators will be provided to the Anaesthetics and Surgery teams. The SOP will be enabled under the search function in the guidelines section of the OUH Intranet.

6.5.7. An audit of oxygen prescription will be completed in the Upper Gastrointestinal ward to ensure compliance with the Oxygen Prescription and Administration Policy.

7. Challenges to completing structured reviews
Lead reviewers continue to report difficulties in securing sufficient time to complete reviews due to increasing clinical commitments. 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.

8. Crude Mortality
8.1. Crude mortality gives a contemporaneous but not risk-adjusted view of mortality across OUH.
8.2. During quarter two of 2018/19:

8.2.1. Children’s, Neurosciences, Orthopaedics, Trauma and Specialist Surgery Division reported that 46 patients died from a total of 17897 discharges.

8.2.2. Medical Rehabilitation and Cardiac Division reported that 380 patients died from a total of 15156 discharges.

8.2.3. Surgery, Women’s and Oncology Division reported that 144 patients died from a total of 19408 discharges.

8.2.4. Clinical Support Services Division reported 34 deaths from a total of 240 patients.

**Chart 3: Crude Mortality**

**Chart 4: Crude Mortality rate by Finished Consultant Episodes (FCEs)**
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 2017/18. This paper summarises the learning identified in the structured mortality reviews completed during quarter two of 2018/19.

9.2. No new CQC mortality outliers have been received by the Trust in this reporting schedule. The SHMI for the data period July 2017 to June 2018 is 0.92. This is rated ‘as expected’ and has remained the same. The HSMR is 92 for September 2017 to August 2018. This remains rated as ‘lower than expected.’

10. Recommendation

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

Report compiled by:
Sandhya Chundhur, Clinical Outcomes Manager
On behalf of Dr Clare Dollery, Deputy Medical Director
Date: 07/01/2019