Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 10 July 2019

TB2019.66

Title	**Mortality Report**

Status	For information
History	This is a regular paper to the Trust Board. The first paper was in January 2018.

Board Lead	**Professor Meghana Pandit, Chief Medical Officer**			
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.'* This was embedded in a revised OUH mortality review policy ratified by the Board in September 2017.
2.	In quarter four of 2018/19 there were 22 structured mortality reviews which includes 9 reviews for patients with learning disabilities. There was one death judged more likely than not to have been due to problems in the care provided. One patient death reviewed from quarter four of 2017/18 was judged to be more likely than not to have been due to problems in the care provided.
3.	OUH are implementing the Medical Examiner system. Medical examiners must be in place by April 2020. Medical Examiners will scrutinise the circumstances and causes of deaths in acute Trusts. They will also be a point of contact and source of advice for relatives of deceased patients, healthcare professionals and coroner and registration services.
4.	Key actions and learning points identified in mortality reviews completed during quarter four of 2018/19 are presented for the Board.
5.	**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 four of 2018/19.

2. Mortality reviews

2.1. The Trust Standardised Mortality Review policy requires that all inpatient deaths need to be reviewed within 8 weeks of the death occurring. All deaths have a Level 1 review by the responsible consultant. 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. During quarter four of 2018/19 there were 741 inpatient deaths reported at OUH. The number of mortality reviews completed is presented in Table 1.

Table 1: Number of mortality reviews for quarter four of 2018/19

Total number of deaths	Number of deaths with Level 1 reviews	Number of deaths with Level 2 reviews	Number of deaths with Structured reviews	Number of deaths not reviewed within 8 weeks of death
741	323 (44%)	327 (44%)	22 (3%)	69 (9%)

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

Table 2: Criteria for structured mortality reviews for quarter four of 2018/19

Criteria for structured review	Number of reviews
Learning disabilities	9
Concern from staff	6
Concern from family and from staff	1
Serious Incident Requiring Investigation (SIRI)	1
SIRI and Coroner's Inquest	1
Concern from staff and Coroner's Inquest	2
Severe mental illness	1
Coroner's Inquest	1

2.3. 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.

2.4. There was one patient death from quarter four of 2018/19 that was judged to be more likely than not to have been due to problems in the care provided. This case related to a patient with learning disabilities. The review found that the delay in recognising the complication following the insertion of a nasogastric (NG) tube is likely to have directly contributed to death. The case is being investigated as a Serious Incident Requiring Investigation (SIRI). The immediate learning points and actions from the structured mortality review were as follows:

2.4.1. Improve staff awareness of the Deprivation of Liberty Safeguards (DoLS) process by presentation of the case at the Clinical Governance meetings and Sisters' meetings.

2.4.2. Improve staff understanding of complications of NG tube insertion by presentation of the case at Clinical Governance meetings and Sisters meetings).

2.4.3. Need for improved documentation on ward rounds and during discussions with the patient's family.

2.4.4. Need for improved communication between Radiology and General Medicine teams.

2.5. One patient death reviewed from quarter four of 2017/18 was judged to be more likely than not to have been due to problems in the care provided. The learning points and actions identified in the review were as follows:

2.5.1. Patients presenting with red flag indicators and syncope should be referred for further assessment and investigation directly by the hospital assessing team(s). This task should not to be delegated for the GP to complete.

2.5.2. The regional training for all specialist registrars will now include a session on syncope specifically addressing the management of red flag cases. This will be part of a wider programme to address common clinical presentations in Cardiology.

2.5.3. The learning points will be shared with both the Emergency Department (ED) and Cardiology units so that any member of the team who sees such a patient recognises the need for further assessment.

2.5.4. This case is currently being investigated as a SIRI.

3. Development of the Medical Examiner role

3.1. OUH are implementing the Medical Examiner system. The business case is under review and the business plan is being completed.

3.2. Medical examiners must be in place by April 2020.

3.3. Medical examiners will scrutinise the circumstances and causes of deaths in acute Trusts. They will also be a point of contact and source of advice for relatives of deceased patients, healthcare professionals and coroner and registration services.

3.4. At OUH it is envisaged that there will be one whole time equivalent (from a rota) Medical Examiner supported by Medical Examiner Officers.

3.5. The Royal College of Pathologists has published dates for the face-to-face training sessions for Medical Examiners. Medical Examiners are required to

complete core e-learning modules before starting work in the role and then attend the training session within six months of taking up the post.

4. Learning and actions from mortality reviews

Review of practice and pathways

4.1. The Cardiology Unit have implemented a change in the timing and positioning of defibrillator pads during insertion of cardiac stimulation procedures to shorten the time to defibrillation should this be required.

4.2. The Neonatal Intensive Care Unit is updating the Patent Ductus Arteriosus (PDA) guideline and ibuprofen drug monograph to include the requirement for a daily renal function test while the patient is on ibuprofen.

4.3. The Neonatal team are to be included in the completion of the WHO Surgical Safety Checklist with the Obstetric team for caesarean sections.

4.4. The Palliative Medicine Unit is completing a Quality Improvement Project for the management of spinal cord compression in the palliative setting.

4.5. The Oncology team have introduced a protocol for all capecitabine prescribed patients to have mandatory testing for DPD[1] (dihydropyrimidine dehydrogenase) enzyme variants and for the capecitabine doses to be adjusted accordingly.

4.6. The Perinatal Mortality Review Group have identified the following actions to ensure that domestic abuse is discussed with mothers:

4.6.1. The Community Midwife Matron will discuss the case at the Band 7 Midwives meeting.

4.6.2. The Community Midwife Matron will remind staff to find an appropriate time to discuss domestic abuse with mothers and document this discussion in the notes.

4.6.3. The guideline for domestic abuse discussions will be reviewed and relaunched by the Maternity unit.

Training

4.7. The Practice Education team have worked with staff on the Haematology and Transplant wards to improve the completion of falls risk assessments.

4.8. The Perinatal Mortality Review Group has recommended increased education for junior doctors for the signs and symptoms of TTTS (Twin-Twin Transfusion Syndrome).

4.9. The Maternity unit are providing further training sessions for bereavement midwives relating to care during labour.

Engagement with bereaved families

4.10. The Perinatal Mortality Review Group have updated bereavement letters with information about the mortality review process and inviting parents to inform the

[1] DPD is an enzyme made by the liver that helps the body break down the chemotherapy drug capecitabine.

team of any concerns or feedback. The bereavement checklists have been updated to prompt midwives to discuss the mortality review process with parents.

4.11. The Maternity Unit are reviewing the bereavement care guidelines. A bereavement partogram is being developed.

4.12. Additional midwives are to be trained in how to counsel and obtain consent for post mortems for perinatal deaths to ensure that parents are aware of the benefits in determining the cause of death and of the option of a limited post mortem if they decline a full post-mortem.

Documentation

4.13. The review of a patient with learning disabilities highlighted the difficulties presented by Echocardiograms (Echos) not being accessible in the Electronic Patient Record (EPR). The Cardiac Unit's Clinical Director and Operational Services Manager were informed of this case to support plans for the integration of Xcelera (cardiology image management system) into EPR.

Equipment

4.14. The Neonatal Intensive Care Unit has introduced new, softer nasogastric tubes following a case of oesophageal perforation.

4.15. The Maternity Unit is currently in the process of obtaining funding for the provision of carbon monoxide monitors for every community midwife. The availability of the monitors will facilitate compliance with the National Institute for Health and Care Excellence (NICE) guidance recommendation that all mothers have a carbon monoxide test.

4.16. Thrombolysis kits are now available in the Adult Intensive Care Units to provide rapid access to treatment when required.

5. Areas of good practice identified in mortality reviews

5.1. The Paediatric Intensive Care and Organ Donation teams arranged for the heart of a teenage patient, who complied with adult criteria, to be accepted for an adult recipient. The organ donation took approximately 18 hours to organise. The patient's heart was donated to a 30 year old recipient. This case has prompted a change in processes which it is envisaged would provide comfort to future donor families and save the lives of more patients waiting for a heart transplant.

5.2. The Neonatal Intensive Care Unit described good consultant involvement throughout the care of a patient including during the out-of-hours period.

5.3. The Surgery team reported good multi-disciplinary team involvement with the Oncology and Community Learning Disability teams. Capacity assessments were completed and an Independent Mental Capacity Advocate (IMCA) was appointed on behalf of the patient.

6. Sharing learning from SIRIs

6.1. All SIRI related deaths are presented to the MRG by the Lead Investigator. The key learning points from reports presented to MRG during April to June 2019 were as follows:

6.1.1. The Radiology unit is considering the development of a standardised list of risks and benefits for procedures where death is a potential complication as part of ongoing work to develop local safety standards (LocSSIPs) for interventional neuroradiology procedures.

6.1.2. The Neurosurgery team are drafting guidance for the timing of anticoagulation prophylaxis when surgery is postponed at short notice.

6.1.3. Existing templates for daily rounds in EPR are being modified to improve the recording of handover decisions between the Neurosciences Intensive Care Unit and Neurosurgery ward.

6.1.4. The Neurosurgery, Microbiology and Infection Control teams are completing a retrospective audit of the rate of infection following the insertion of External Ventricular Drains.

6.1.5. The Neurosurgery Unit are reviewing the feasibility and indications for bed-side ultrasound diagnosis of deep vein thrombosis.

6.1.6. The Urology service is to commence stent change procedures at the Horton General Hospital to increase capacity.

6.1.7. Patients who have not been provided with a theatre date before their due date for a stent change will be discussed by the Urology team at a designated weekly meeting for clinical prioritisation.

6.1.8. Joint weekly multidisciplinary team (MDT) meetings have been initiated by the Cardiac, Acute General Medicine and Infectious Diseases teams.

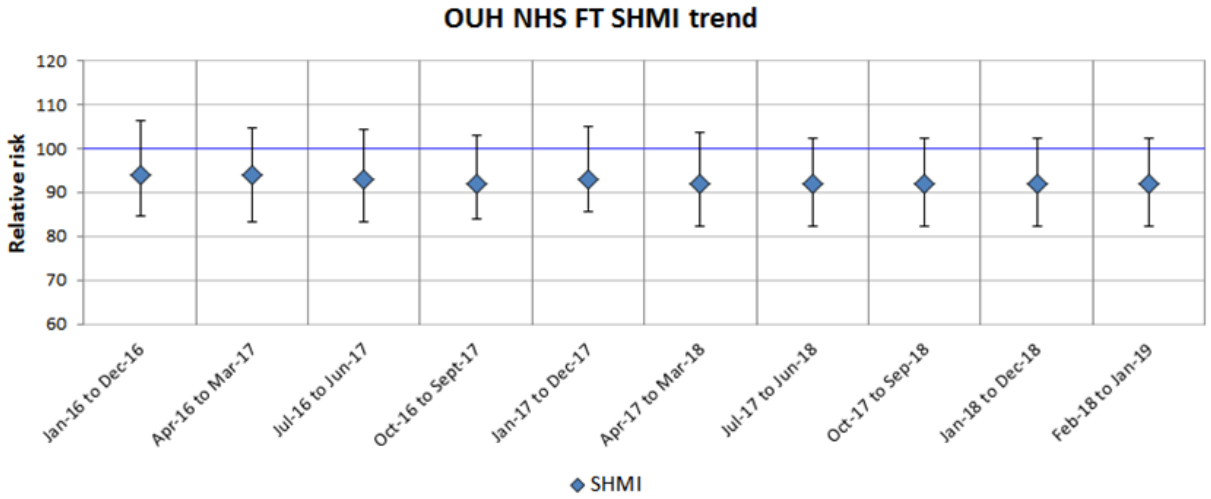
6.1.9. The importance of weekend consultant review of new/transferred patients with a diagnosis of prosthetic valve endocarditis was highlighted to the team at the Cardiac Directorate Clinical Governance meeting.

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

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

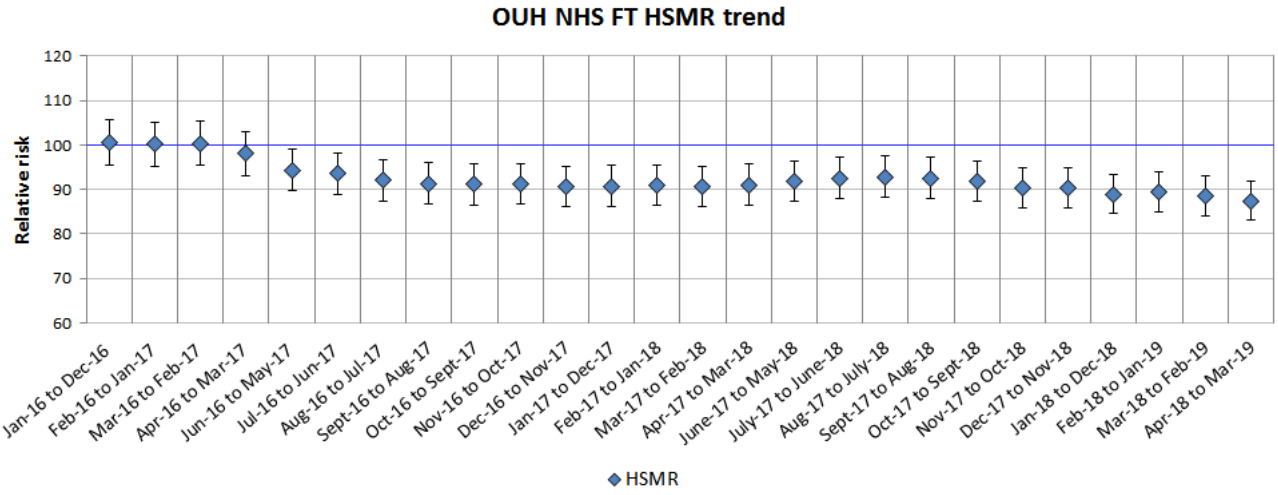
7.2. The SHMI for the data period February 2018 to January 2019 is 0.92. This is rated ‘as expected’ and has remained the same.

Chart 1: SHMI trend analysis



7.3. The HSMR is 87 for April 2018 to March 2019. This remains rated as 'lower than expected' (95% CL 83.4 – 91.4).

Chart 2: HSMR trend analysis



8. Crude Mortality

8.1. Crude mortality gives a contemporaneous but not risk-adjusted view of mortality across OUH.

8.2. During quarter four of 2018/19:

8.2.1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's and Neonatology Division reported that 75 patients died from a total of 15580 discharges.

8.2.2. Medical Rehabilitation and Cardiac Division reported that 470 patients died from a total of 16168 discharges.

8.2.3. Surgery, Women's and Oncology Division reported that 149 patients died from a total of 20733 discharges.

8.2.4. Clinical Support Services Division reported 47 deaths from a total of 584 patients.

Chart 3: Crude Mortality

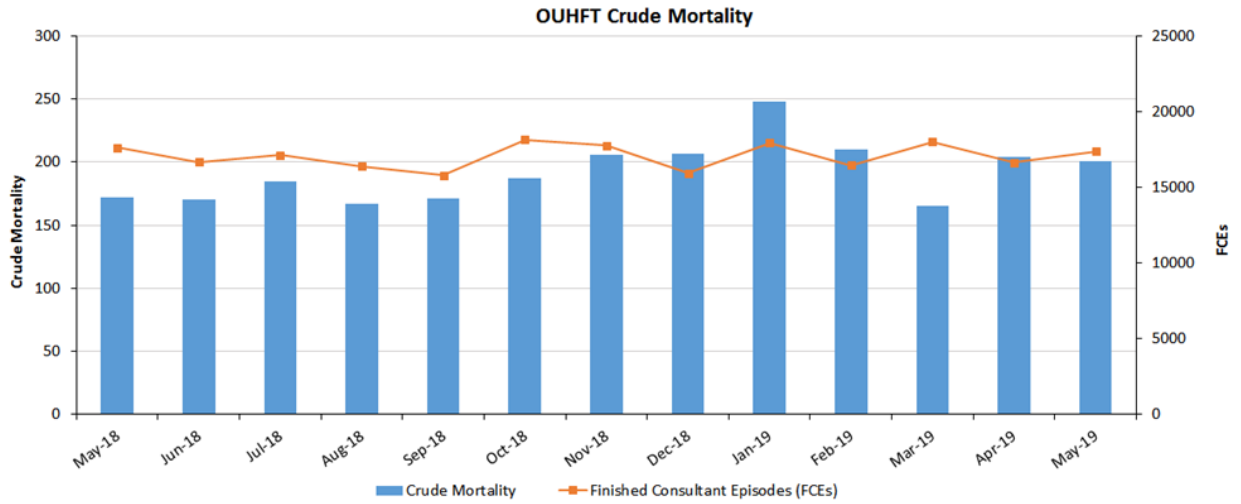


Chart 4: Crude Mortality rate by Finished Consultant Episodes (FCEs)

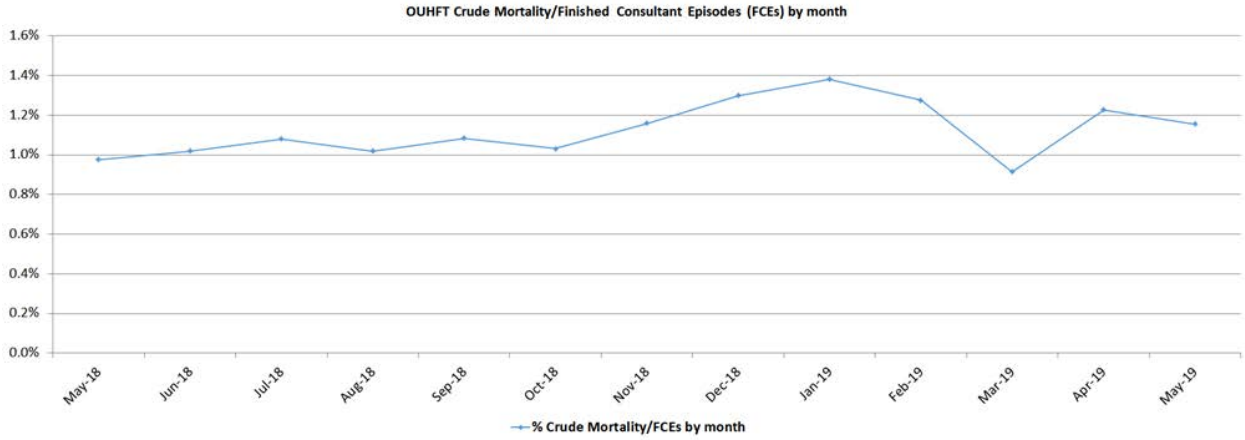


Chart 5: Crude Mortality by Division

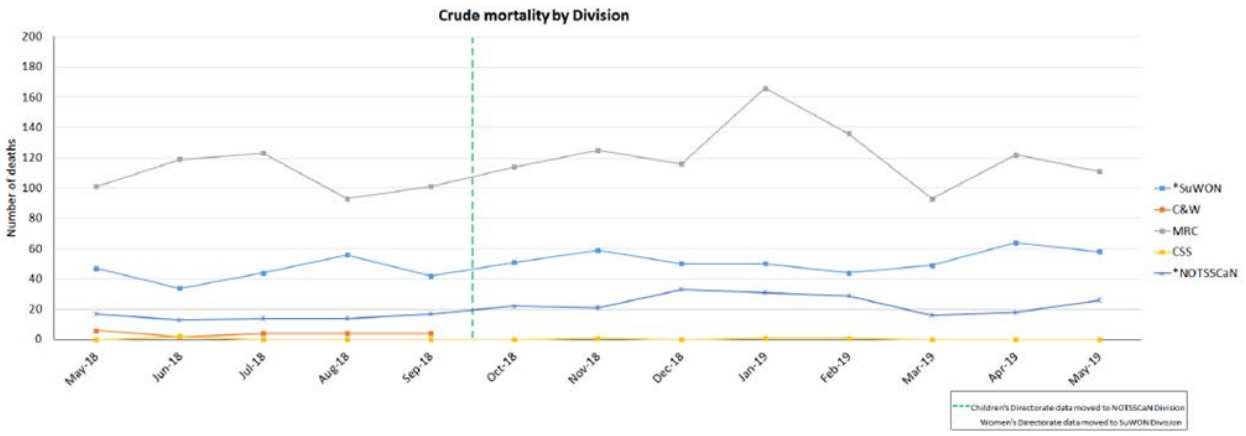
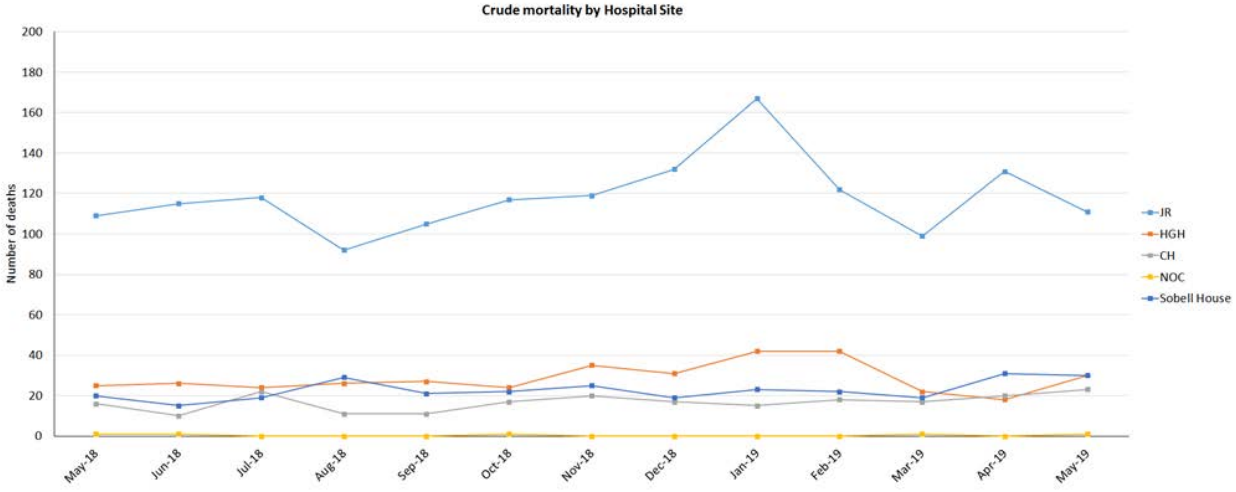


Chart 6: Crude Mortality by Site



9. Conclusion

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 four of 2018/19.

10. Recommendation

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

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