Oxford University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting in Public : Wednesday 8 May 2019

TB2019.50

Title	**Learning from Deaths**

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, 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.'* This was embedded in a new mortality review policy ratified by the Board in September 2017.
2.	In quarter three of 2018/19 there were 18 structured mortality reviews completed which included 5 reviews for patients with learning disabilities. There were no deaths judged more likely than not to be preventable in the completed reviews for quarter three of 2018/19. Two patient deaths reviewed from quarter four of 2017/18 were judged to be more likely than not to have been due to problems in the care provided to the patient.
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, and must be in place by April 2020. Medical Examiners will be independent of the clinical team who cared for a deceased patient and will be accountable to the Regional Lead Medical Examiner. Plans are in development at OUH. 20 Trusts nationally already have a system in place for Medical Examiners and others are working towards this. Training requirements are described.
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 October 2017 to September 2018 is 0.92. This is rated 'as expected' and has remained the same. The Hospital Standardised Mortality Ratio (HSMR) has reduced to 89 for February 2018 to January 2019. This remains rated as 'lower than expected.'
5.	Key actions and learning points identified in mortality reviews completed during quarter three 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 three of 2018/19. The OUH crude mortality and mortality indicators are presented.

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 3 of 2018/19 there were 691 inpatient deaths reported at OUH. The number of mortality reviews completed is presented in Table 1.

Table1: Number of mortality reviews Quarter 3 2018/19

	Level 1	Level 2	Structured reviews
Number of cases reviewed	652 (94%)	355 (51%)	18 (3%)

2.2. Structured reviews have been in place since quarter three of 2017/18. Table 2 provides the number of inpatient deaths and structured reviews for quarter three of 2018/19.

Table 2: Structured mortality reviews

	Oct-2018	Nov-2018	Dec- 2018
Total number of deaths	187	206	207
Total number of structured reviews	6	6	6
Number of deaths judged more likely than not to be preventable in completed [1]	0	0	0

2.3. The triggers for the structured reviews are listed in Table 3:

[1] 7 Structured reviews are still underway

Table 3: Criteria for structured mortality reviews

	Oct-2018	Nov-2018	Dec-2018
Concern from staff	1	1	
Concern from family			
SIRI		1	
SIRI and Inquest			1
Learning disabilities	3	1	1
Coroner's Inquest and concern from staff			2
Coroner's Inquest and concern from family			
Severe mental illness			1
Coroner's Inquest	2	3	1

2.4. Two patient deaths reviewed from quarter four of 2017/18 were judged to be more likely than not to have been due to problems in the care provided to the patient. Both of the cases had structured reviews where it was concluded that it was more likely than not that the death was preventable.

2.4.1. Endocrine Surgery structured mortality review
The level of preparation for a rare but well recognised and potentially life-threatening complication of thyroid surgery was inadequate, both in relation to the location where the patient was nursed after the operation and to the emergency equipment which should have been available.
Following this incident any patient requiring thyroid surgery must be admitted to the Head and Neck ward only. The 'S.C.O.O.P: Acute Management of Post Op Haemorrhage in Thyroid and Parathyroid Surgery' teaching video has been produced by the clinical team and made available. The protocol has been presented at national forums and disseminated at other hospitals. The Coroner delivered a narrative conclusion following the Inquest.

2.4.2. Cardiology structured mortality review
If identification of the need for urgent surgery had occurred soon after the patient was reviewed by the Infectious Diseases team, it is likely that surgery would have been feasible and have taken place in the week prior to the patient's death. Subsequent to this case, stronger links between the Cardiology and Infectious Diseases teams have been instigated, so that all patients with potential infective endocarditis are discussed, and weekly joint multi-disciplinary team meetings are held where difficult or borderline cases are reviewed.

3. Development of the Medical Examiner role

3.1. Dr Alan Fletcher from Sheffield has been appointed as National Medical Examiner. There will be Regional Lead Medical Examiners and Regional Medical Examiner Officers appointed to support Lead Medical Examiners.

3.2. Medical examiners will scrutinise the circumstances and causes of deaths in acute Trusts where these are not already under investigation by the coroner. They will also be a point of contact and source of advice for relatives of deceased patients, healthcare professionals and coroner and registration services. Medical examiners will be employed in the NHS system, with a separate professional line of accountability, allowing for access to information in the sensitive and urgent timescales surrounding death registration – but with independence necessary for the credibility of the scrutiny process. This independence will be overseen by a National Medical Examiner, providing leadership to the system.

3.3. The non-statutory roll-out of the Medical Examiner system will be from April 2019. During the non-statutory phase of implementation, the Department of Health and Social Care (DHSC), NHS Improvement (NHSI) and NHS England (NHSE) will collectively support acute trusts to manage the financial impact of establishing and running local medical examiner offices. There will be written communication about the funding model to Trusts in the coming weeks. Costs will be met by the fee generated from Part 5 of the Cremation form and cost over and above will be reimbursed at the end of the financial year. There will be reimbursement for recruitment costs during the financial year which will be paid quarterly in arrears.

3.4. There are 20 Trusts reported to have implemented the Medical Examiner system thus far.

3.5. The Medical Examiner system model promoted by the Royal College of Pathologists is for there to be a Medical Examiner role supported by Medical Examiner Officers. An example was provided of a Medical Examiner Office with one whole time equivalent (from a rota) Medical Examiner and three whole time equivalent Medical Examiner Officers per approximately 3000 deaths per year. There were 2686 inpatient deaths reported at OUH during the financial year 2017/2018. At Bucks 10 x 0.1 WTE medical examiners are in place.

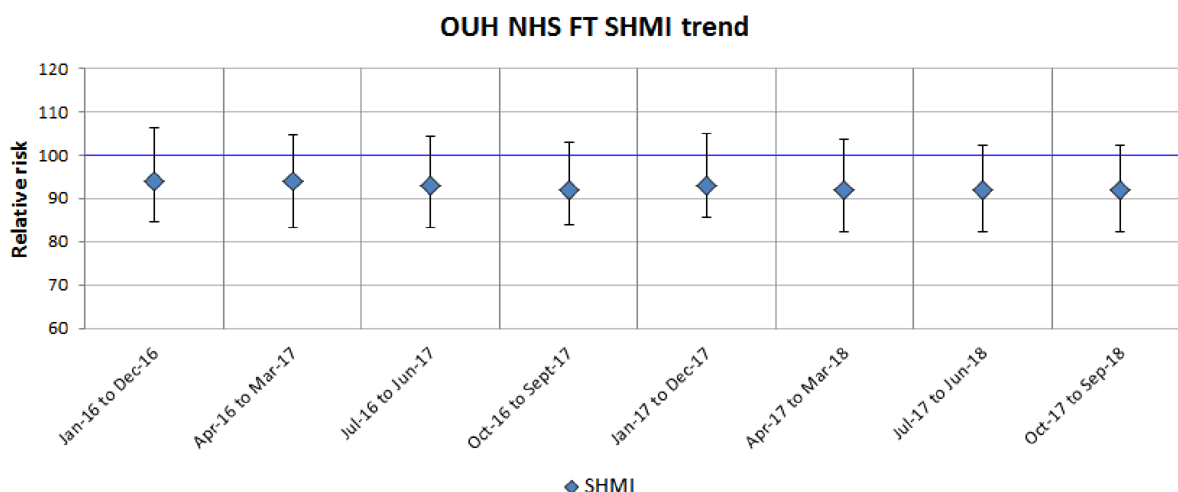
3.6. The Royal College of Pathologists provides medical examiner training. Before taking up post, medical examiners are expected to complete 26 core e-learning modules (estimated at 9-10 hours of work). In addition, all medical examiners are expected to attend a one day face to face training session within six months of taking up post.

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.

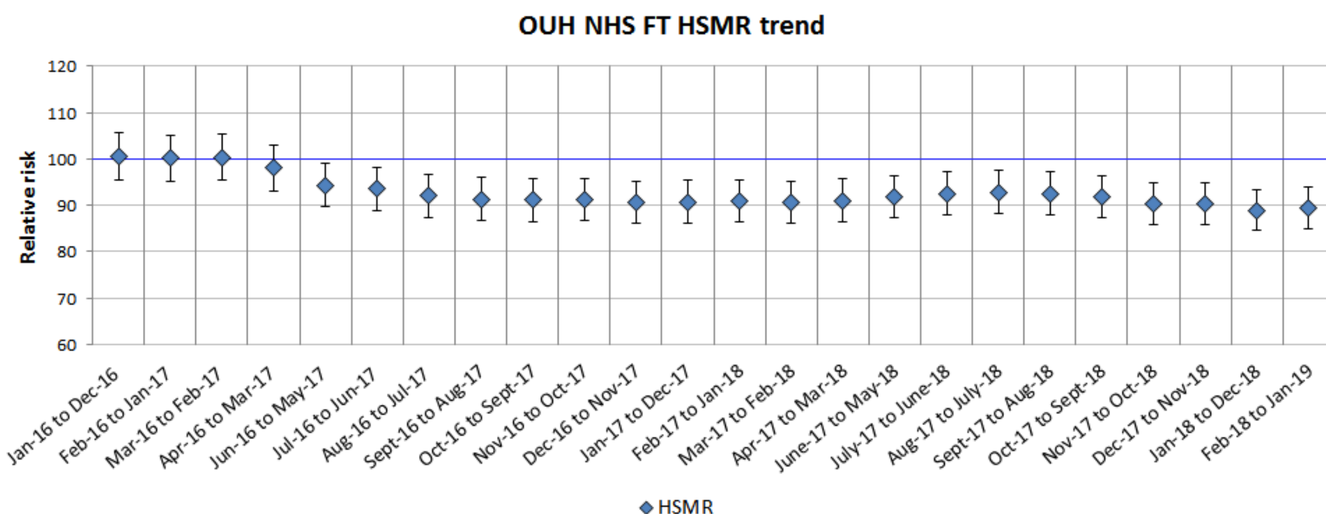
4.2. The SHMI for the data period October 2017 to September 2018 is 0.92. This is rated ‘as expected’ and has remained the same.

Chart 1: SHMI trend analysis



4.3. The HSMR is 89 for February 2018 to January 2019. This remains rated as 'lower than expected' (95% CL 85.5 – 93.6).

Chart 2: HSMR trend analysis



5. Key points of learning and actions from mortality reviews

Review of protocols and pathways

5.1. The Stroke Medicine team are arranging a meeting with the Neurosurgery team to reinvigorate the hemicraniectomy pathway, discuss a plan for managing posterior fossa decompressions and the options for regional referrals of patients with haemorrhagic stroke.

5.2. The Palliative Care team are:

5.2.1. Developing a protocol to enhance the critique of the end of life phase of care within the structured mortality review.

5.2.2. Updating the protocol and checklist for methadone use to reflect current literature.

5.2.3. Have added escalation plans to the medical ward round and clerking templates on Sobell Ward.

5.3. A Critical Care Consultant is working jointly with the Interventional Radiology team to establish a clear pathway for the management of massive and submassive pulmonary emboli. The Critical Care Mortality Lead is reviewing all cases of pulmonary emboli in the Intensive Care Unit over the last year.

5.4. The Surgery, Women's and Oncology Division advise that there are recurrent issues in managing unambiguous and timely end of life discussions to ensure that the patients' wishes are identified and respected. The initiatives to address this include the update of the SAGE and THYME training sessions run by Sobell House Hospice and the development of an Ethics group in the Oncology and Haematology Directorate which enables the discussion and peer review of specific cases.

5.5. The Perinatal Mortality Review Group highlighted that bereavement and hospital information leaflets in other languages should be available and identified a priority group of leaflets. The process for arranging translators and the availability of telephones to facilitate effective communications were also discussed at the Group meeting.

Working with other organisations

5.6. The Neonatal Unit have disseminated information to the Thames Valley Neonatal Network to raise awareness of patients with duct-dependent congenital anomalies and the need to be referred to the Newborn Care Unit with communication between Local, Cardiology and Neonatal teams.

Support for staff

5.7. The Critical Care team have appointed a nurse lead for wellbeing to provide staff with support. The Critical Care team will be holding their first reflective round in May 2019 as part of a suite of interventions to enhance the wellbeing of staff.

6. Sharing learning from structured reviews

6.1. All SIRI related deaths are presented to MRG by the Lead Investigator. There was 1 SIRI report from quarter two of 2018/19 presented at MRG between January and March 2019. Key learning points arising from this investigation include:

6.1.1. Documentation has to be clear regarding the perioperative management of anticoagulation particularly as patients are often cared for by multiple individuals over the course of an emergency admission.

6.1.2. The recommendation to avoid dalteparin prescription errors was for doctors to use the Electronic Prescribing and Medicines Administration (ePMA) PowerPlan and its pre-populated script options rather than manually prescribing using the 'Medication' tab.

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 three of 2018/19:

8.2.1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's and Neonatology Division reported that 77 patients died from a total of 15430 discharges.

8.2.2. Medical Rehabilitation and Cardiac Division reported that 416 patients died from a total of 15761 discharges.

8.2.3. Surgery, Women's and Oncology Division reported that 164 patients died from a total of 20668 discharges.

8.2.4. Clinical Support Services Division reported 34 deaths from a total of 391 patients.

Chart 3: Crude Mortality

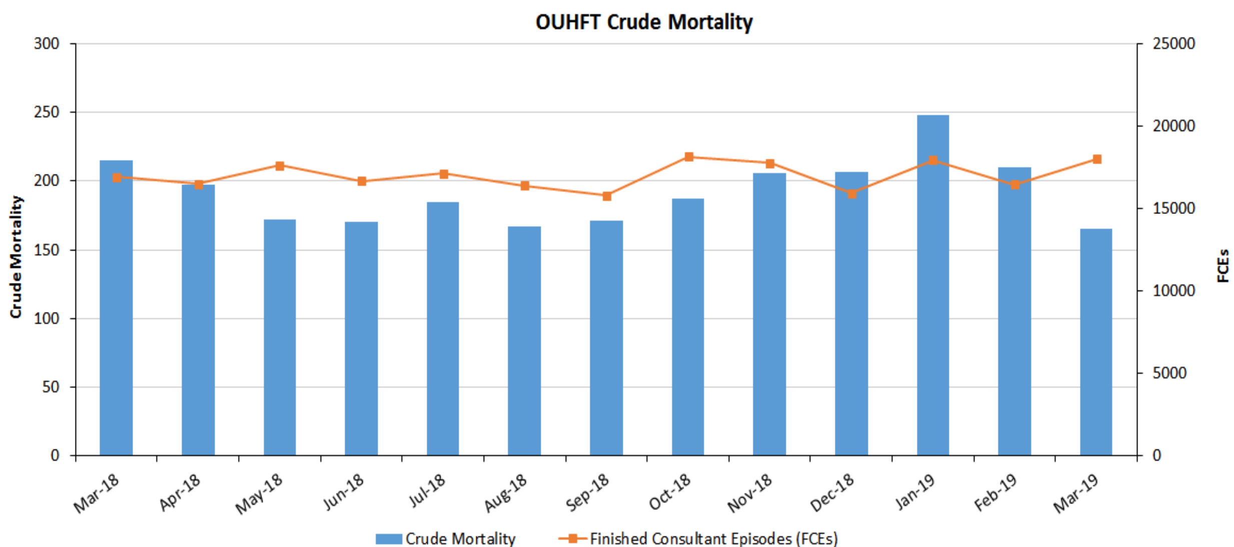


Chart 4: Crude Mortality rate by Finished Consultant Episodes (FCEs)

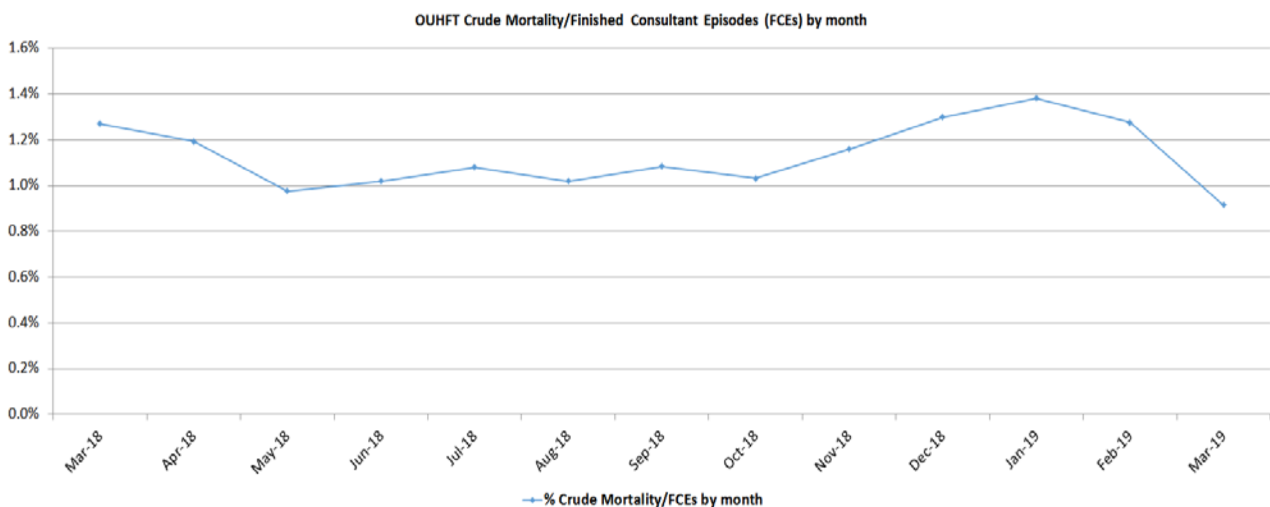


Chart 5: Crude Mortality by Division

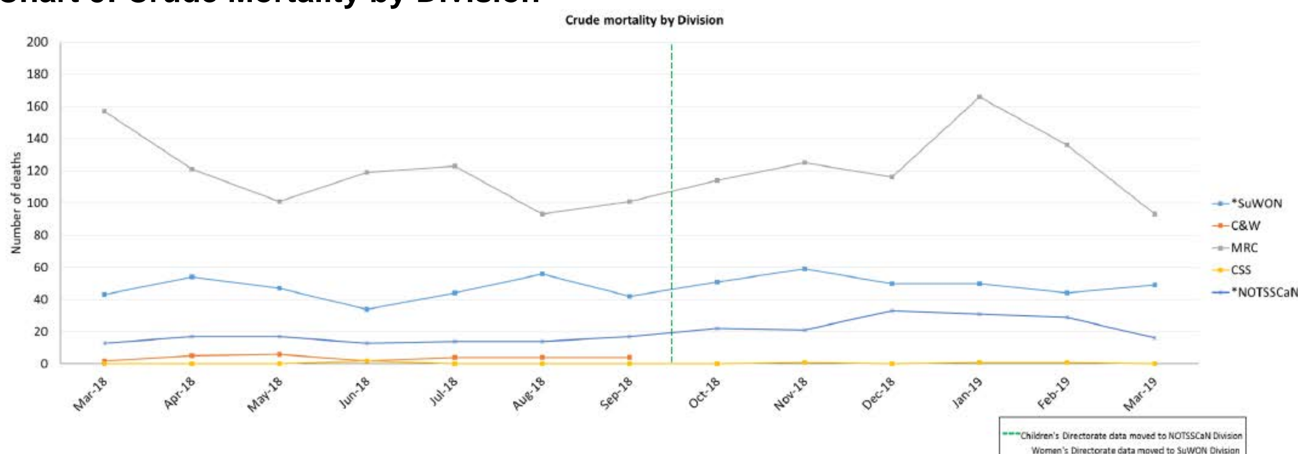
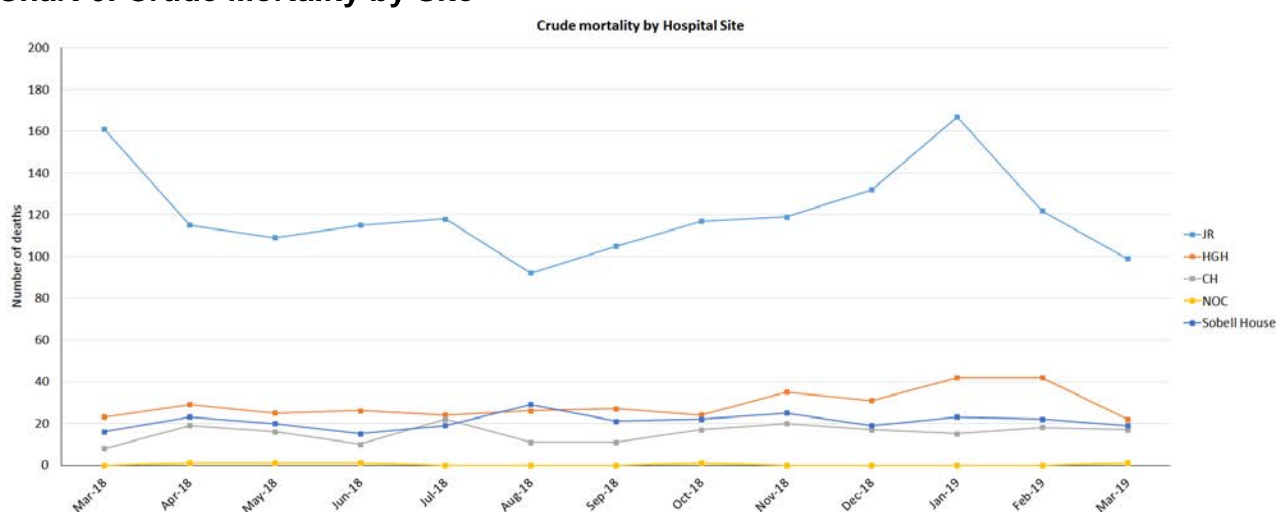


Chart 6: Crude Mortality by Site



9. Conclusion

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 three 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 October 2017 to September 2018 is 0.92. This is rated ‘as expected’ and has remained the same. The HSMR is 89 for February 2018 to January 2019. This remains rated as ‘lower than expected.’

10. Recommendation

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

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May 2019
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