Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 13 November 2019

TB2019.106

Title	**Mortality Report: Learning from Deaths 2019-20 Quarter 1**

Status	For information
History	This is a regular paper.

Board Lead	**Professor Meghana Pandit, Chief Medical Officer**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. This paper presents the findings from reviews completed for inpatient deaths during 2019-20 Quarter 1 (April – June).

2. In 2019-20 Quarter 1, there were 18 structured mortality reviews which includes 8 reviews for patients with learning disabilities. There was 1 case judged more likely than not to have been due to problems in the care provided.

3. The Medical Examiner Business Case and Implementation Plan were approved by the Trust Management Executive on 26 September 2019. Medical examiners are expected to be in place by April 2020.

4. Key learning points and actions identified in mortality reviews completed during 2019-20 Quarter 1are presented for the Board.

5. **Recommendation**
   The Board is asked to receive this report for information and discuss the learning identified from mortality reviews.

Mortality Report: Learning from deaths 2019-20 Q1

1. Purpose

1.1. This paper summarises the key learning points and actions identified in the mortality reviews completed for quarter one of 2019/20.

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 one of 2019/20 there were 666 inpatient deaths reported at OUH. The number of mortality reviews completed is presented in Table 1.

Table 1: Number of mortality reviews for quarter one of 2019/20

Total number of deaths	Number of Level 1 reviews	Number of Level 2 reviews	Number of Structured reviews	Number of deaths not reviewed within 8 weeks
666	304 (45%)	286 (43%)	18 (3%)	58 (9%)

2.2. The deaths which were not reviewed within 8 weeks are to have a Level 1 screening review.

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

Table 2: Criteria for structured mortality reviews for quarter one of 2019/20

Criteria for structured review	Number of reviews
Learning disabilities	8
Concern from staff	3
Concern from family	1
Maternal death	1
Serious Incident Requiring Investigation (SIRI)	1
Concern from staff and Coroner's Inquest	1
Severe mental illness	3

2.4. 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 (CGC) and quarterly mortality reports to the Mortality Review Group (MRG).

2.5. There was 1 patient death from quarter one of 2019/20 judged more likely than not to have been due to problems in the care provided. The case related to a patient who had a ruptured aortic aneurysm. The following actions from the structured mortality review are being led by the Clinical Lead for Cardiac Surgery and will be discussed at the Complex Aortic Surgery Multi-disciplinary Team (MDT) meeting in November:

2.5.1. The complex aortic surgery pathway should be reviewed to ensure that all steps in the process are rationalised and that the timescales agreed are feasible.

2.5.2. The Trust should consider appointing a patient pathway co-ordinator for complex aortic surgery to monitor and support the patient pathway, to facilitate more electronic requesting of investigations, and to identify patients at risk of breaching the required standards which would facilitate such patients to either be fast-tracked through subsequent steps or to be referred elsewhere.

3. Development of the Medical Examiner role

3.1. OUH are implementing the Medical Examiner system. The Business Case and Implementation Plan have been approved by the Trust Management Executive (TME) on 26th September 2019.

3.2. Medical examiners are expected to 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 a 1 whole time equivalent Medical Examiner from a rota of 10 consultants contributing approximately 1 session per week and including 1 consultant contributing an additional 0.5 session to provide the Lead Medical Examiner service. The Medical Examiners will cover all 4 hospital sites and will be supported by the Bereavement team.

4. Learning and actions from mortality reviews

Review of practice and pathways

4.1. The John Radcliffe Hospital (JR) is a national outlier for 30 day mortality in hip fracture patients. ‘Time to ward’ and ‘time to theatre’ have been highlighted as areas of concern. The following actions have been implemented to address these concerns:

4.1.1. The JR Emergency Department (ED) pathway for patients with hip fractures has been modified and simplified. This includes criteria to identify the ‘Fast Track’ patient who is likely to be suitable for direct transfer to the operating theatre for early surgery.

4.1.2. The JR-ED pathway has also simplified the guidance concerning early analgesia including local anaesthetic nerve block.

4.1.3. The JR-ED is reviewing and re-considering the introduction of a Nurse-led referral pathway from ED replicating that in place at the Horton General Hospital (HGH).

4.1.4. A Patient Group Direction (PGD) for the use of intravenous paracetamol in ED is being discussed with the Pharmacy team.

4.1.5. There are discussions underway with South Central Ambulance Service (SCAS) about supporting the pre-hospital use of intravenous paracetamol in patients with suspected hip fractures.

4.1.6. The provision of ring-fenced beds in JR Trauma wards for hip fracture admissions to be fast-tracked to the ward and prioritised for surgery.

4.1.7. The 'time to theatre' and outcomes of surgery are reported on a monthly dashboard to enable continuous monitoring by the Trauma team.

4.1.8. A Standard Operating Procedure (SOP) has been agreed SCAS for hip fracture patients to be transported directly to HGH if they are from the north of the county, and for the transfer of patients from the JR-ED to HGH for surgery if there is no immediate capacity at the JR.

4.1.9. There are quality improvement projects underway in the Trauma wards relating to pain management, delirium and nutrition of frail older peri-operative patients.

4.2. The neurosurgical team have implemented a practice of administering a dose of low molecular weight heparin (LMWH) in the morning to patients who have had their planned surgery cancelled thereby ensuring that patients receive chemical venous thromboembolism (VTE) prophylaxis on every calendar day. An alert will be created on the Electronic Patient Record (EPR) as a reminder for this requirement and to facilitate compliance.

4.3. The Neonatal Unit have updated antibiotic guidelines following a case of Klebsiella septicaemia. In cases where babies are severely unwell, there is a high suspicion of Extended Spectrum Beta Lactamase (ESBL)/multi-drug resistant organism or the antibiotic regime is escalated to Ciprofloxacin and Vancomycin; then one single dose of Amikacin should be given and a fresh blood culture taken.

4.4. The Horton Medicine team are drafting a SOP for medical patients on outlier wards to be repatriated to the medical wards within 5 days.

Documentation

4.5. The Palliative Care team have implemented the following actions to improve the patient record:

4.5.1. Bespoke escalation plans are being implemented for the Inpatient Unit (IPU) patients.

4.5.2. The Chaplaincy team are recording details related to the patient's spiritual care on EPR and have introduced a section to complete at the MDT meeting.

4.5.3. The IPU ward clerk is to ensure that the discharge documentation indicate that the patient is still under the Community Palliative Care team.

4.5.4. 'Knowing Me' documents for IPU patients with a learning disability are being scanned and uploaded to EPR.

4.5.5. The 'Outcomes Measures Project' has commenced to document patient recorded outcomes.

Equipment and facilities

4.6. The Respiratory Medicine team have identified that there are insufficient High Level Care/High Dependency Unit beds to accommodate the requirements for non-invasive ventilation (NIV) patients. This issue has been added to the Unit's Risk Register for review.

4.7. The Horton Medicine team have agreed that there be a centrally located spirometry machine. A Respiratory Medicine consultant is to provide training to junior clinical staff on how to use the machine.

4.8. New NIV machines are in use at the HGH-ED and Emergency Assessment Unit (EAU).

Quality Improvement projects

4.9. The Critical Care Unit have initiated a quality improvement programme with active participation of trainees and fellows. The projects include a review of readmissions to intensive care within 48 hours over the last 12 months with the aim of identifying commonalities and possible avenues of preventability. The Unit will also review delayed admissions to intensive care.

Supporting patients

4.10. The Renal service have identified a trend in complaints related to end of life care. This has led to the team securing funding to commission a review of these cases by a Palliative Care consultant using the structured review framework to identify learning points and themes.

4.11. The Oncology and Haematology Directorate have acquired funding from the 'Enhanced Supportive Care' project to offer a more holistic package of care to patients through collaboration between the Oncology and Palliative Care teams. This initiative stemmed from a recognition of the benefits of removing barriers to the involvement of palliative care expertise earlier in the cancer pathway. The benefits include access to a range of expertise: pain management, interventional radiology, complementary therapy, psycho-oncology and spiritual care, physiotherapy, dietetics and occupational therapy. This approach enables increased patient involvement in decision making about treatment and quality of life.

5. Sharing learning from Serious Incidents Requiring Investigation (SIRI)

5.1. All SIRI related deaths are presented to MRG by the Lead Investigator. The key learning points and actions from reports presented to MRG during July to October 2019 were as follows:

5.1.1. A teaching session is to be arranged for all Gynae-Oncology trainees at the Unit's next quarterly Mortality and Morbidity meeting to highlight the importance of performing clinical examinations and documenting appropriately.

5.1.2. The Gynae-Oncology Clinical Lead is to meet with all consultants at the MDT meeting to highlight that they must be aware of their challenging cases, provide appropriate input and document that they have done so and that key findings for any patient should be presented at the MDT meeting for discussion with senior staff.

5.1.3. The SOP for the care of postoperative patients in the Cardiothoracic Critical Care Unit is being updated to include guidance on the management of postoperative changes in ventricular function.

5.1.4. A SOP for the care of patients in the Cardiac Unit is to be developed to include a requirement for the formal and documented handover of care of patients to cover consultant absences.

5.1.5. The protocol for the use of anti-platelet medication post coronary artery bypass grafts will be updated.

5.1.6. VEST (external stent for coronary artery bypass grafts) devices will be removed from the operating areas and consultants informed that they are not to be used.

5.1.7. The need to pay attention to hypernatraemia when the patient is hyperglycaemic has been highlighted to the Acute Medicine and Rehabilitation Directorate clinical teams.

5.1.8. Advice on fluid management is to be included in the Medicines Information Leaflet (MIL) for glycaemic management during enteral feeding for inpatients with diabetes.

5.1.9. The Horton Medicine Unit are offering medical and nursing staff additional training and support in the completion of electronic documentation. A spot audit of documentation standards within the Unit is to be completed to monitor compliance.

5.1.10. The Horton Medicine Unit are developing an electronic on call patient handover list on EPR which all doctors will have access to and will review at handover meetings.

5.1.11. The Cardiology Unit have included a session on syncope in the regional training for specialist registrars specifically addressing the management of red flag cases. This will be part of a wider program to address common clinical presentations in Cardiology.

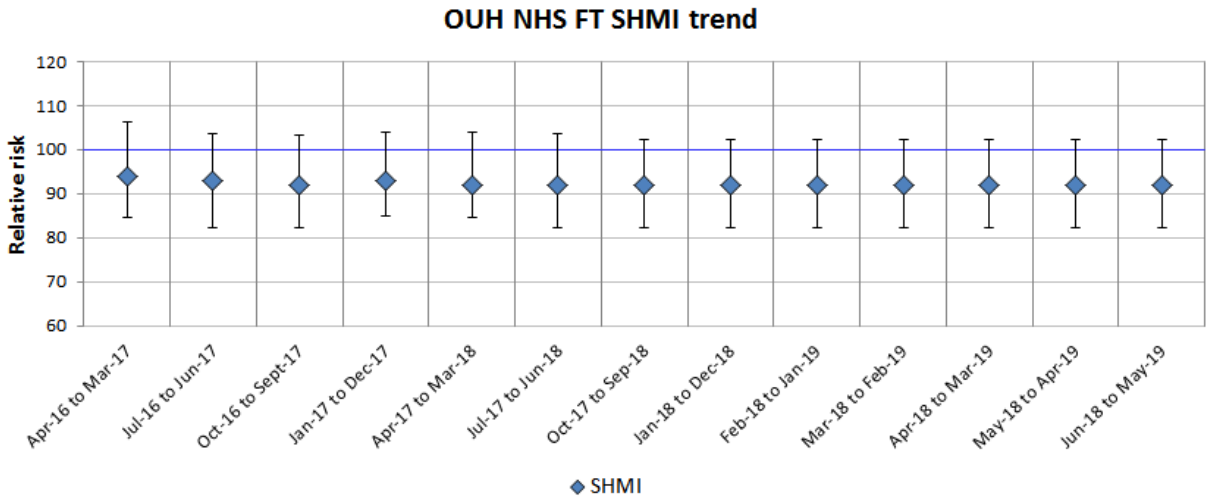
5.1.12. The Gynaecology team are developing, with Clinical Support Services Division (CSS), a SOP for patients who are high risk and need outpatient procedures. This will include the steps to follow if the patient is unable to have a computerised tomography (CT) scan due to habitus.

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

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

6.2. The SHMI for the data period June 2018 to May 2019 is 0.92. This remains rated ‘as expected.’

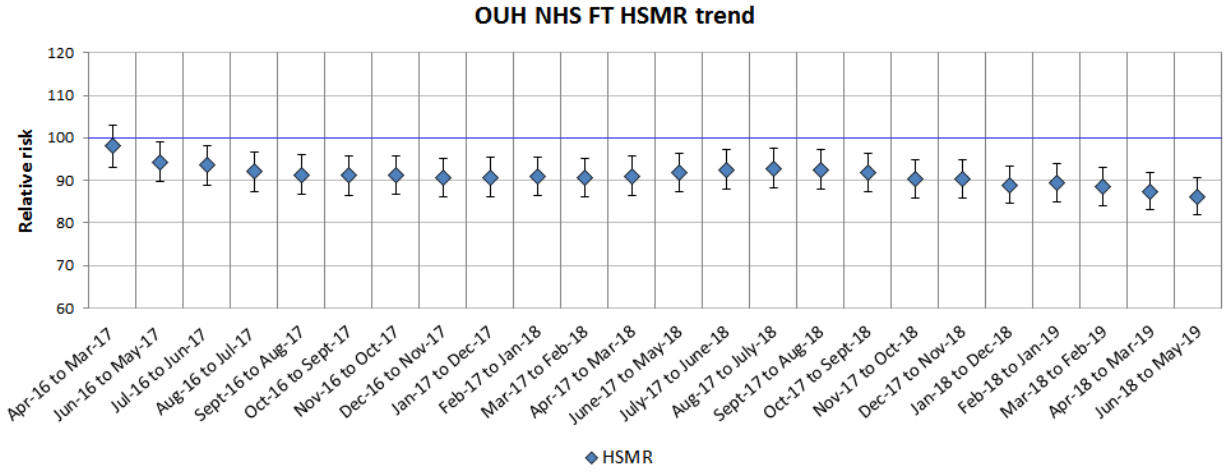
Chart 1: SHMI trend analysis*



**Represented with a baseline of 100 to enable comparison to the HSMR*

6.3. The HSMR is 86 for June 2018 to May 2019. This remains rated as 'lower than expected' (95% CL 82.4 – 90.3).

Chart 2: HSMR trend analysis



7. Crude Mortality

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

7.2. During quarter one of 2019/20:

7.2.1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's and Neonatology Division reported that 71 patients died from a total of 14, 596 discharges.

7.2.2. Medical Rehabilitation and Cardiac Division reported that 374 patients died from a total of 15, 682 discharges.

7.2.3. Surgery, Women's and Oncology Division reported that 178 patients died from a total of 20, 511 discharges.

7.2.4. Clinical Support Services Division reported 43 deaths from a total of 602 patients.

Chart 3: Crude Mortality

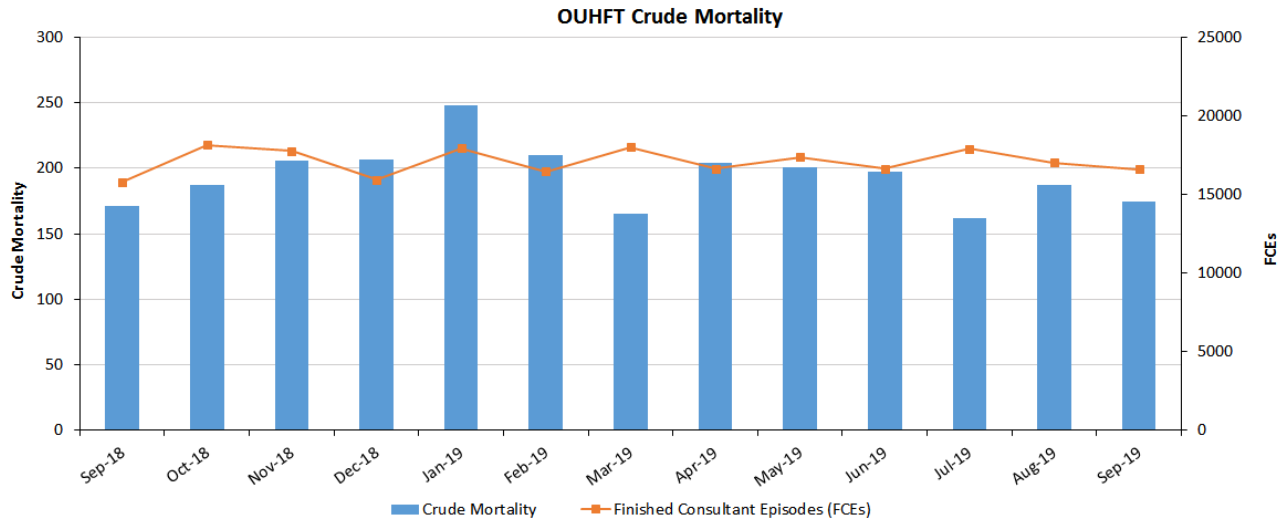


Chart 4: Crude Mortality rate by Finished Consultant Episodes (FCEs)

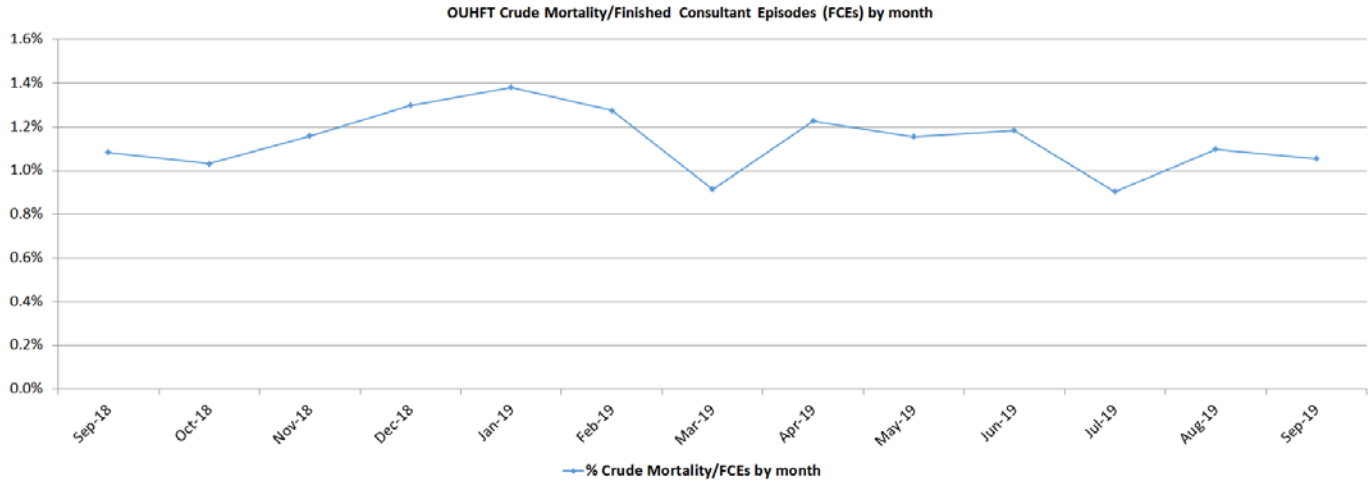


Chart 5: Crude Mortality by Division

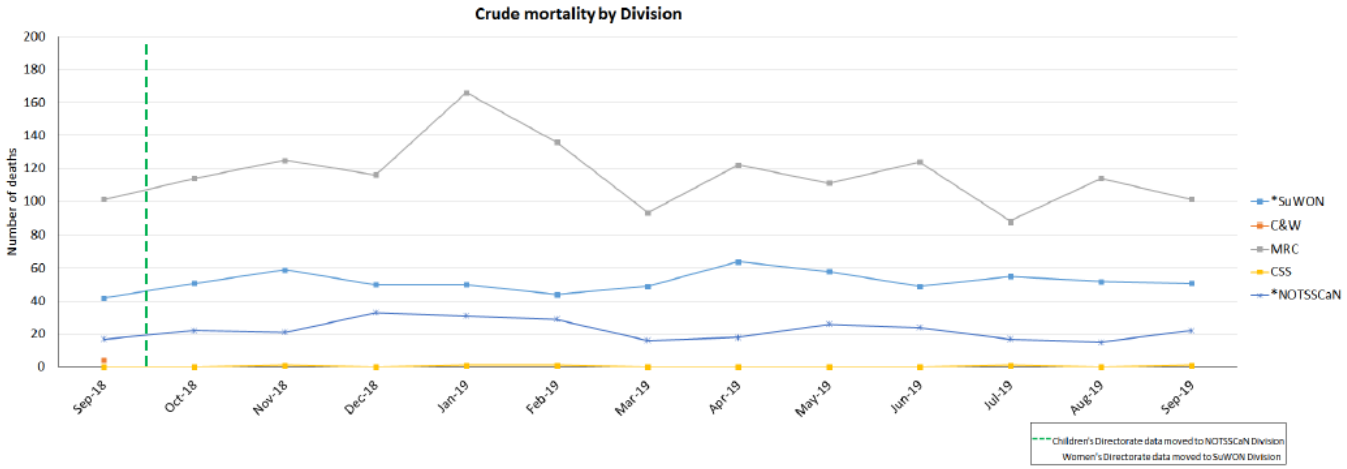
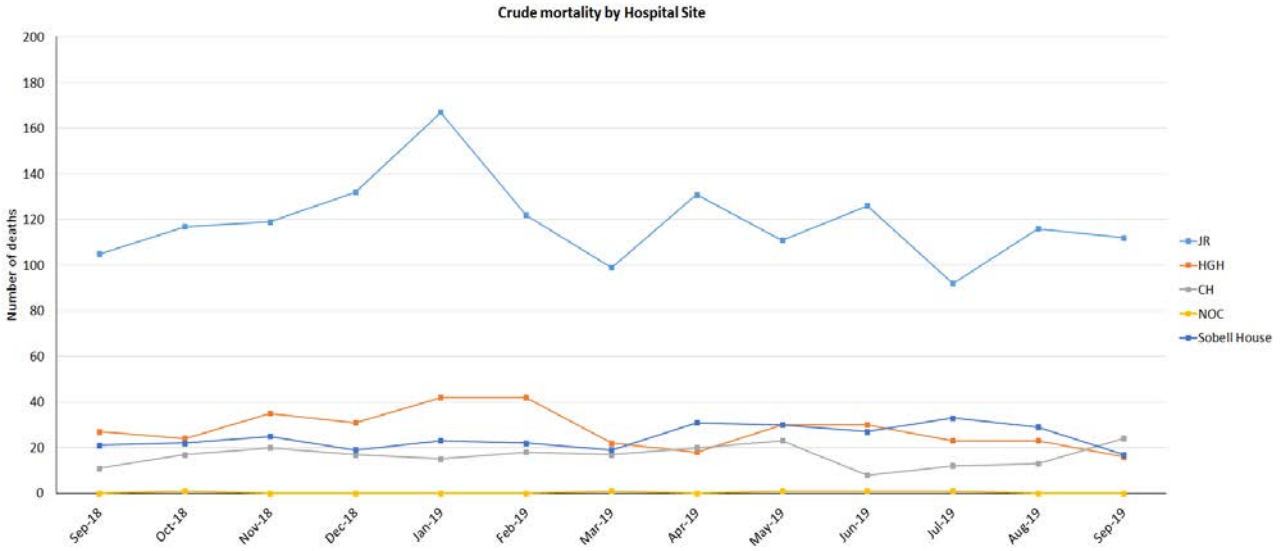


Chart 6: Crude Mortality by Site



8. 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 and actions identified in the mortality reviews completed during quarter one of 2019/20.

9. Recommendation

The Board is asked to receive this report for information and discuss the learning identified from mortality reviews.

Professor Meghana Pandit
Chief Medical Officer

Paper prepared by:
Sandhya Chundhur - Clinical Outcomes Manager
Dr Peyton Davis - Director of Safety and Clinical Effectiveness

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