Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 8 July 2020

TB2020.58

Title	**Learning from deaths Quarter 4**

Status	For information
History	Trust Management Executive – 25 June 2020

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

Executive Summary

1. This paper is a quarter report to the Trust Board and presents the findings from reviews completed for inpatient deaths during quarter four of 2019/20.
2. In quarter four of 2019/20, there were 11 structured mortality reviews which includes 5 reviews for patients with learning disabilities.
3. The implementation of the Medical Examiner system has resumed following suspension to support the COVID-19 response.
4. There were 197 inpatient deaths reported at OUH involving COVID-19 up to 12 June 2020.
5. Key learning points and actions identified in mortality reviews completed during quarter four of 2019/20 are presented for the Board.
6. **Recommendation** The Trust Board is asked to receive the paper and discuss the learning points identified in mortality reviews.

Learning from deaths

1. Purpose

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

2. Mortality reviews

2.1. The Trust Standardised Mortality Review policy requires that all inpatient deaths be reviewed within 8 weeks of the death occurring. All deaths have a Level 1 review. The Level 1 review is a peer review by a consultant not directly involved in the patient's care.

2.2. 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 2019/20 there were 779 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 2019/20

Total deaths	Level 1 reviews	Level 2 reviews	Structured reviews	Deaths not reviewed within 8 weeks
779	385 (49.4%)	302 (38.8%)	11 (1.4%)	81 (10.4%)

2.3. The deaths which were not reviewed within 8 weeks are to have a Level 1 screening review. The Acute General Medicine, Respiratory Medicine and Infectious Diseases Units are re-establishing processes for mortality reviews as the COVID-19 activity subsides.

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

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

Criteria for structured review	Number of reviews
Learning disabilities	5
Concern from staff	5
Concern from staff and Inquest	1

2.5. 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).

3. Medical Examiner system

3.1. The implementation of the Medical Examiner system has resumed following suspension to support the COVID-19 response. The four appointed Medical Examiners are to start reviewing cases. Recruitment is underway for additional Medical Examiners.

4. Learning and actions from mortality reviews

Pathways

4.1. The Urology Clinical Governance Lead presented the 'Malignant Upper Urinary Tract Obstruction Pathway' to the Oncology Department at the annual 'Acute Oncology Update and Audit' meeting. The presentation was prompted by a review which highlighted that the use of the pathway may have led to an earlier resolution of the patient's management plan.

4.2. The Discharge Liaison Hub team is to remind staff of the importance of an up to date handover when patients are discharged to Hub beds. This action is in response to a case where the Community Hospital team was not up to date with the patient's needs and rehabilitation goals.

Facilities

4.3. The Respiratory Medicine Unit have reported that the Osler Chest Ward 7E at the John Radcliffe Hospital (Respiratory Inpatient Ward) did not have sufficient higher level care beds to accommodate all patients admitted to the Trust needing non-invasive ventilation support prior to the COVID-19 pandemic. This will remain extant over the foreseeable future as the Unit is accommodating all patients requiring this level of support on a Respiratory High Dependency Unit (HDU) in a different location and which will include both COVID-19 and non COVID-19 patients. The future plans for Respiratory HDU provision is currently under discussion at the Trust.

Medication

4.4. The Palliative Medicine team have re-familiarised the ward nursing staff with the use of diamorphine (preferred to morphine at high dose because of high solubility and hence smaller injection volumes). The use of diamorphine was discussed at the Palliative Medicine Mortality and Morbidity meeting and the meeting minutes have been disseminated within the Palliative Medicine team.

4.5. The Palliative Medicine team reminded staff that patients may need a Home Office licence to travel with high doses of opioids. A checklist relating the requirements has been circulated to Sobell House staff to assist with advising patients.

4.6. The Acute General Medicine Unit are to present and discuss the Anticoagulation Medicine Information Leaflets (MILs) at Divisional Governance and Junior Doctor meetings. The discussions were prompted by a review which highlighted that there was a need for increased awareness amongst the team about the protocol for stopping anti-coagulation before a procedure. This protocol will also be added to the Doctors' Induction Handbook.

Documentation

4.7. The Medicine, Rehabilitation and Cardiac (MRC) Divisional Digital Lead Nurse is to review with medical staff the information required in a discharge summary. A flow sheet is being considered to assist doctors to produce good quality discharge summaries.

Reporting Excellence

4.8. The review of a learning disability patient identified notable professional practice. The Learning Disability Nursing team provided support and guidance for the patient's carers and family, helped with the transfer of the patient to the ward and ensured that all requests were fully documented and in place. The Epilepsy Specialist Nurse stayed after their shift had ended to ensure that the patient was not alone whilst waiting for their next of kin and a new carer to arrive. This feedback will be shared with the members of the team via the Trust's 'Reporting Excellence' programme.

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 the investigation of a patient who had a post endoscopic retrograde cholangio-pancreatography sphincterotomy (ERCP) bleed were as follows:

5.1.1. The investigation identified no specific root causes. The ERCP was appropriate to perform at that time as there was an expectation that it would lead to an improvement in the patient's clinical condition and open up opportunities for further management.

5.1.2. There were three opportunities to escalate to more senior members of the medical team which were missed. It was not possible to determine whether escalation would have changed the outcome.

5.1.3. There were aspects of this case identified which were used as the basis for education of medical and nursing teams in the identification of the sick/deteriorating patient and in the management of gastrointestinal bleeding, particularly in the post-procedure setting, including a lunchtime Acute General Medicine teaching class, a presentation to the Gastroenterology departmental meeting on the "pitfalls and practicalities" of direct oral anti-coagulants, and the inclusion of gastro-intestinal bleed management in the foundation year, core medical trainee and registrar training programs.

5.1.4. The local medical handover standard operating procedure has also been revised accordingly and recirculated.

5.1.5. A Trustwide safety message to reiterate that all observations must be recorded solely on the SEND system is planned.

5.1.6. The structured mortality review concluded that the death was possibly avoidable but not very likely (less than 50:50).

6. Deaths involving COVID-19

6.1. There were 197 inpatient deaths reported at OUH involving COVID-19[1] up to 12th June 2020.

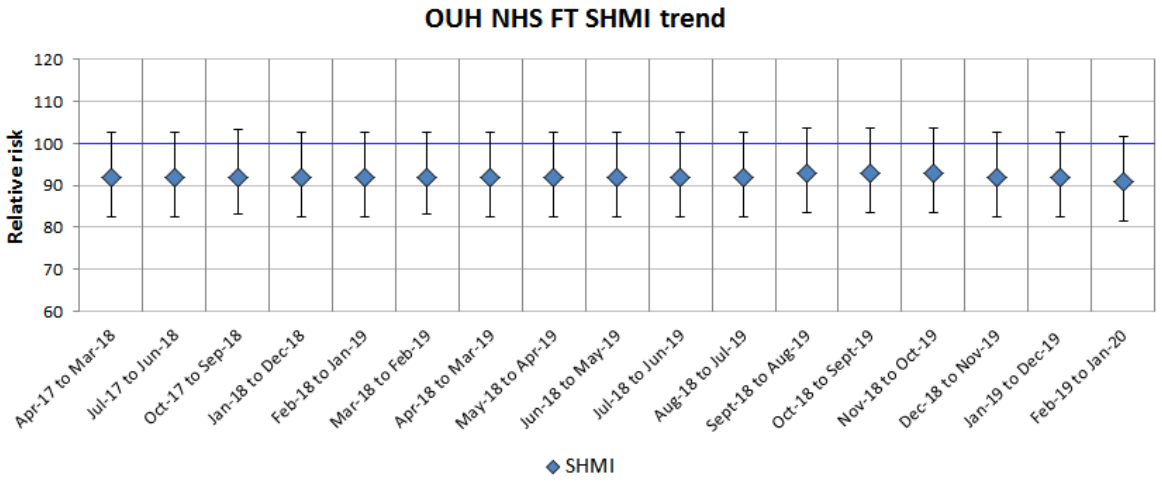
6.2. The COVID-19 survival rate was 72% and the COVID-19 mortality rate was 28%.

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 2019 to January 2020 is 0.91. The SHMI remains rated 'as expected'.

Chart 1: SHMI trend analysis*

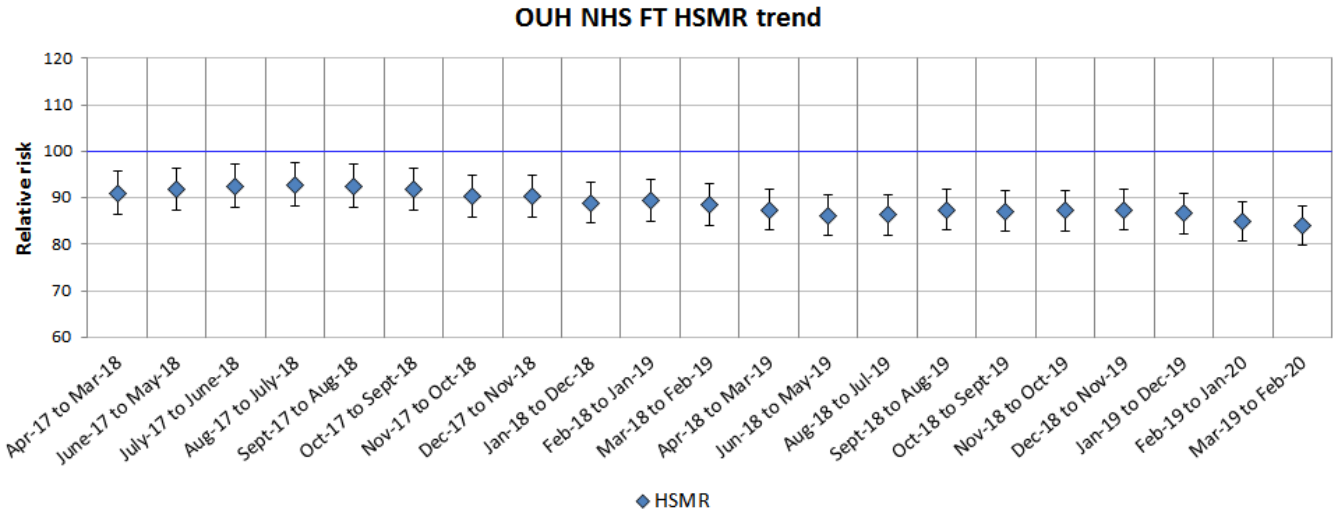


**Represented with a baseline of 100 to enable comparison to the HSMR*

7.3. The HSMR is 84 for March 2019 to February 2020. The HSMR remains rated as 'lower than expected' (95% CL 80.3 – 88).

[1] The term 'involving COVID-19' refers to deaths that had COVID-19 mentioned anywhere on the death certificate, whether as an underlying cause or not.

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 2019/20:

8.2.1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's and Neonatology Division reported that 61 patients died from a total of 14, 441 discharges.

8.2.2. Medical Rehabilitation and Cardiac Division reported that 513 patients died from a total of 15, 310 discharges.

8.2.3. Surgery, Women's and Oncology Division reported that 163 patients died from a total of 19, 623 discharges.

8.2.4. Clinical Support Services Division reported 42 deaths from a total of 386 Adult Intensive Care Unit and Churchill Intensive Care Unit discharges.

Chart 3: Crude Mortality

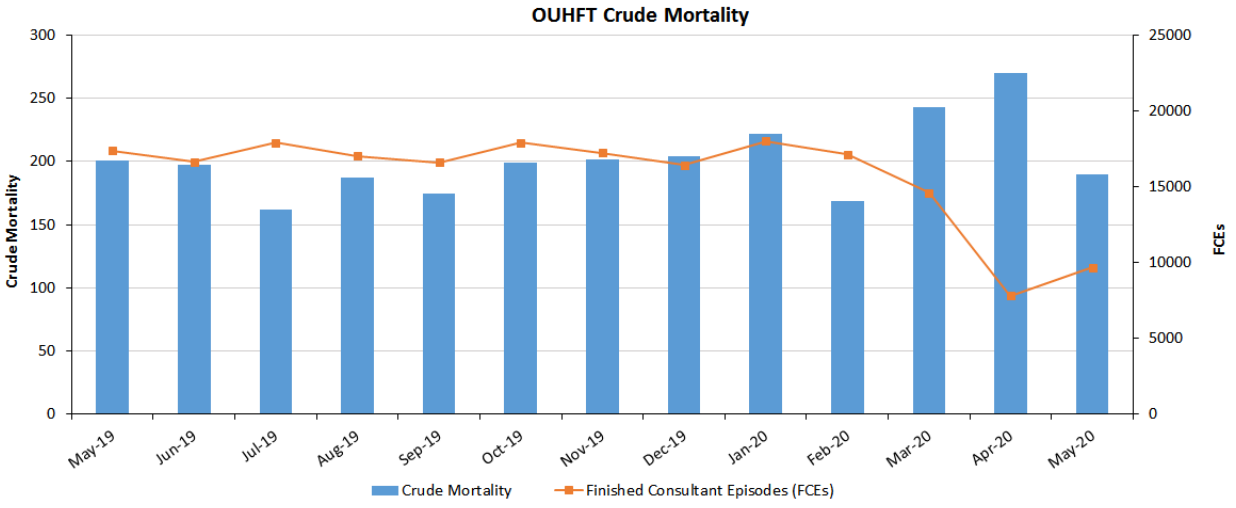


Chart 4: Crude Mortality rate by Finished Consultant Episodes (FCEs)

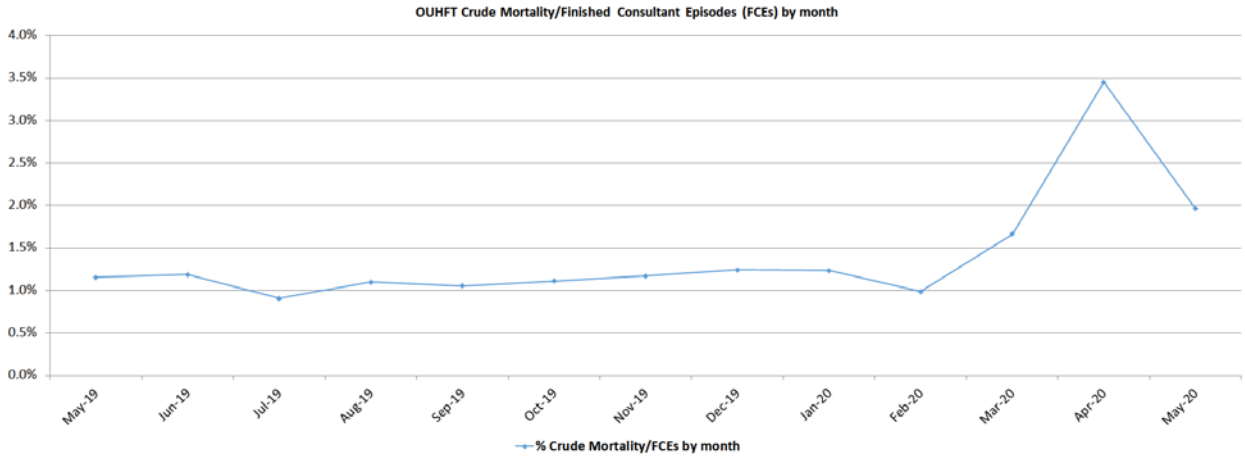


Chart 5: Crude Mortality by Division

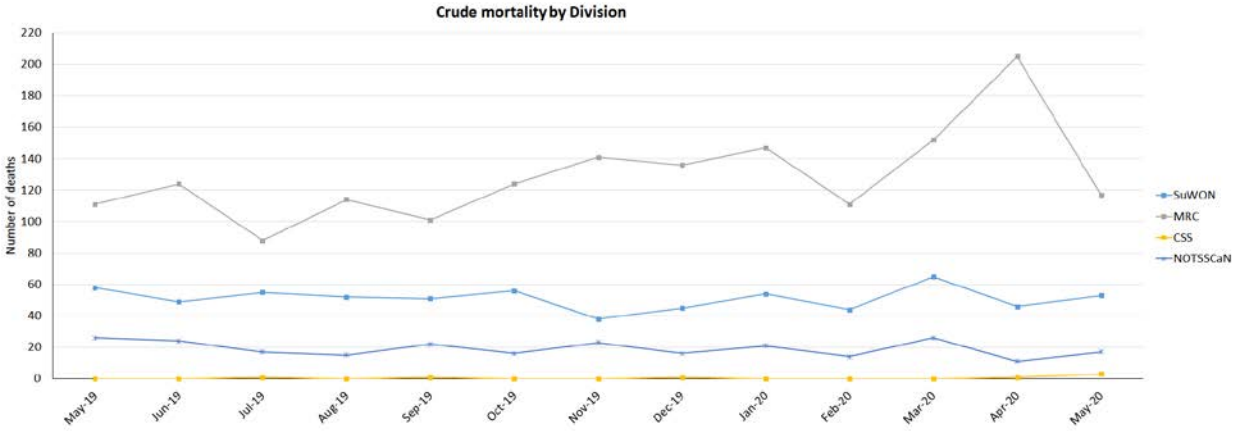
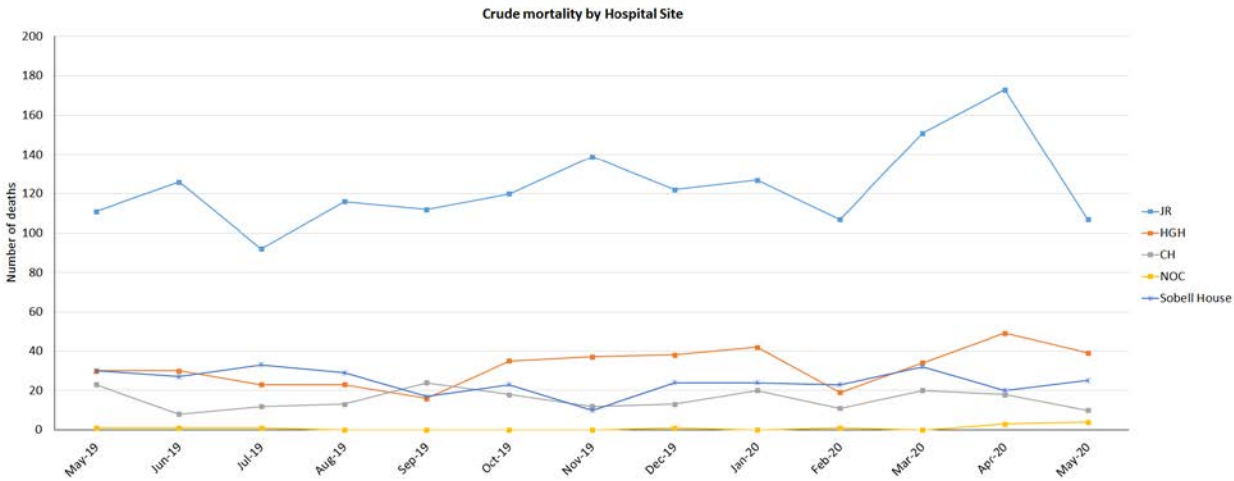


Chart 6: Crude Mortality by Site



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

10. Recommendation

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

Professor Meghana Pandit
Chief Medical Officer

Dr Peyton Davis
Director of Safety and Clinical Effectiveness
Deputy Chief Medical Officer

Paper prepared by:
Sandhya Chundhur
Clinical Outcomes Manager
19 June 2020