Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 10 July 2024

TB2024.60

Title:	**Learning from deaths report – Quarter 4 2023/24**

Status:	**For Information**
History:	**This is a quarterly paper to the Trust Board**

Board Lead:	**Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper summarises key learning identified in mortality reviews completed for Quarter 4 of 2023/24; the latest available Dr Foster Intelligence mortality data; and provides assurance on the actions taken in relation to any highlighted concerns.
2. During Quarter 4 of 2023/24 there were 725 inpatient deaths of which 720 (99%) were reviewed within 8 weeks, including 351 (48%) level 2 and structured mortality reviews. The remaining 5 cases have now been reviewed, therefore 100% of deaths have been reviewed for Quarter 4.
3. No deaths in this quarter were deemed to be 'avoidable'.
4. The Summary Hospital-level Mortality Indicator (SHMI) for January 2023 to December 2023 is 0.86. This has decreased from 0.92 for Oct 2022 – Sept 2023 ('as expected') and is now banded as 'lower than expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion.
5. The Trust's Hospital Standardised Mortality Ratio (HSMR) is 90.3 (95% CL 85.1 – 92.6) for January 2023 to December 2023. The HSMR has decreased and remains banded as 'lower than expected'. The HSMR excluding both Hospices is 80 (71.5-97.6).

Recommendations

The Public Trust Board is asked to receive this paper for information.

Contents

Learning from deaths report – Quarter 4 2023/24

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 4 of 2023/24: January 2024 to March 2024.

1.2. This report provides a quarterly overview of Trust-level mortality data; performance for the latest available Dr Foster Intelligence mortality data; and provides assurance on the actions taken in relation to any highlighted concerns.

2. Background and Policy

2.1. Oxford University Hospitals NHS Foundation Trust (OUH) is committed to accurately monitoring and understanding its mortality outcomes; and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains[1] set out in the NHS Outcomes Framework:

2.1.1. Preventing people from dying prematurely.

2.1.2. Treating and caring for people in a safe environment and protecting them from avoidable harm.

2.2. OUH uses the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. Although these are not direct measures of the quality of care, benchmark outcome data help identify areas for investigation and potential improvement.

2.3. The Trust Mortality Review policy requires that all inpatient deaths are reviewed within 8 weeks of the death occurring.

2.4. All patients undergo a level 1 or level 2 mortality review. The leve 1 review is allocated to the responsible Consultant via the electronic patient record (EPR). A minimum of 25% of Level 1 reviews are selected at random for a more comprehensive Level 2 review (in many departments all deaths undergo a level 2 review) and all (100%) of deaths undergo independent scrutiny from the Medical Examiner's office.

2.5. A comprehensive Level 2 review is also completed for all cases in which concerns are identified at the Level 1 review. The level 2 review involves one or more consultants not directly involved in the patient's care. A structured judgement review (SJR) is required if the case complies with one of the

[1] About the NHS Outcomes Framework (NHS OF) - NHS Digital

mandated national criteria - NHS England » Learning from deaths in the NHS. This is completed by a trained reviewer not directly involved in the patient's care,

2.6. Each Division maintains a log of actions from mortality reviews (of any type) and monitors progress against these action plans. The clinical units are responsible for disseminating learning and implementing the actions identified.

2.7. Mortality related actions are reported quarterly to the Mortality Review Group (MRG) and included in Divisional quality reports presented to the Clinical Governance Committee (CGC).

2.8. The Divisions also provide updates to MRG on the previous quarter's actions as part of the next quarter's mortality report. MRG reports to the Clinical Improvement Committee (CIC).

3. Mortality reviews during Quarter 4 of 2023/24

3.1 During quarter 4 of 2023/24 there were 725 inpatient deaths of which 720 (99%) were reviewed within 8 weeks, including 351 (48%) level 2 and structured mortality reviews (table 1).

3.2 Twenty SJRs were completed. The reasons for completing these SJRs include death of individuals with a learning disability, concerns raised by staff or families, and concerns raised during the Medical Examiner scrutiny.

3.3 No death was deemed to be 'avoidable' during the reporting period.

Table 1: Mortality reviews completed

Reporting period	Total deaths	Reviews completed within 8 weeks			Total reviews completed*
		Level 1	Level 2 & SJR	Total	
2022/23 (Q1-4)	2719	2625 (97%)	1349 (50%)	2625 (97%)	2692 (99%)
2023/24 (Q1)	634	628 (99%)	291 (46%)	628 (99%)	634 (100%)
2023/24 (Q2)	652	644 (99%)	295 (45%)	644 (99%)	652 (100%)
2023/24 (Q3)	751	739 (98%)	357 (48%)	744 (99%)	751 (100%)
2023/23 (Q4)	725	720 (99%)	351 (48%)	725 (100%)	725 (100%)

*including reviews completed after 8 weeks

4. The Medical Examiner system

Background

4.1. The purpose of the Medical Examiner (ME) system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-Coronial deaths; appropriate direction of deaths to a Coroner; a better service for the bereaved including an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased; and improved quality of death certification and mortality data. At OUH MEs have been scrutinising deaths since June 2020.

Quarter 4 update and progress

4.2. 100% of Trust deaths were reviewed by the Medical Examiners.

4.3. 100% of all adult Hospice deaths were also reviewed by the Medical Examiners.

4.4. All child deaths within the Trust (excluding Stillbirths which are not scrutinised by the ME Service) are now being scrutinised by the ME Service.

4.5. The OUH ME Service is working closely with Berkshire, Oxfordshire, Buckinghamshire Integrated Care Board (BOB ICB) and neighbouring ME Offices to support an extension of the ME service to Primary Care; this remains a challenge nationally. Statutory scrutiny of all deaths will be from 9 September 2024.

4.6. The process for raising concerns and positive feedback from the ME to the OUH has now been strengthened. There is now a formal referral form for recording concerns which is submitted by the ME to the Learning from Deaths email account managed by the Clinical Outcomes Manager. This form provides a clearer summary of the domains of concern highlighted to the trust. It also provides an opportunity for MEs to highlight excellent care. These categories of feedback are shown below.

4.7. Data on the number of forms completed will be presented at MRG monthly and a thematic review will be presented quarterly. All forms are passed to the relevant Division to raise with the clinical team and either undertake a review of the death or contact the relatives if additional information is required.

Oxfordshire Medical Examiners' Office NHS

Learning From Deaths Feedback Form

Name of Deceased:
NHS/MRN Number:
Date of Birth:
Date of Death:
Agreed cause of death following review by ME: 1a. 1b. 1c. 1d. 2.
Case Reviewed on:
ME:
Feedback:
NOK details:
NOK Contacted on:
NOK would like feedback: YES/NO
NOK intend / are likely to approach PALS ☐

Category of feedback* (ME to complete and please copy form to medical.examiners@ouh.nhs.uk)	
a. Death where a significant concern about the quality of care provided is raised by the bereaved family and carers	☐
b. Death where a significant concern about the quality of care is raised by the medical examiner or staff	☐
c. Deaths of those with learning disabilities and with severe mental illness	☐
d. Deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider by any means	☐
e. Deaths in areas where people are not expected to die, for example in relevant elective procedure	☐
f. Deaths where learning will inform the provider's existing or planned improvement work, e.g. improving sepsis or end of life care	☐
g. Deaths where excellent care has been identified by the ME or bereaved	☐

*see National Guidance on Learning from Deaths, NHS 2017

5. Child death overview process (CDOP)

Background

5.1. There is a statutory requirement for local panels to review every child death (section 14 of the *Children Act 2004* and *Working Together to Safeguard Children 2018*).

5.2. Panels are required to review deaths of all children up to the age of 18 years. This includes the deaths of infants less than 28 days old, including

those born before viability, but not those who are stillborn or are terminated pregnancies within the law.

5.3. The administration of the Oxfordshire CDOP is hosted by the BOB ICB and is chaired by the Director of Quality and Lead Nurse from the ICB. The Designated Doctor for Child Death is a Consultant Paediatrician at OUH and is commissioned by the ICB to undertake this role. The CDOP is committed to ensuring the review process is grounded in respect for the rights of children and their families and focuses, where possible, on preventing future child deaths.

Quarter 4 update

5.4. There were 18 child/neonatal deaths in the OUH this quarter. All cases (100%) underwent a multidisciplinary review.

5.5. The Neonatal unit is to create a guideline for the certification of death of the extremely premature infant to improve the efficiency of the process.

5.6. Suboptimal space for end-of-life care remains a problem. This is a known risk, and ongoing review of units is underway to optimise available space.

5.7. Training for mortuary processes and interaction is now being conducted with paediatric and neonatal staff to improve care after death.

5.8. Pathways for improved communication regarding clinical care when families and professionals disagree is to be explored. Depending on the context, this may include external mediation, professional second opinions, spiritual leaders, and referrals to the legal team.

6. Learning and actions from mortality reviews (adults and children)

6.1. *Patient transfers*: A theme has been identified where transfer to OUH was delayed or not appropriate in some cases, most notably in the vascular service. Informative feedback has been provided to referring hospitals and this theme has been flagged to the BOB ICB. This issue was also identified last quarter. A hospital transfer Standard Operating Procedure and associated proforma which captures the essential information required to transfer a patient safely is being developed and co-designed with partner organisations to improve this process.

6.2. *Recognition and response to deterioration*: A review is being undertaken of out of hours admissions to the intensive care unit (ICU) of patients who would have benefitted from senior multidisciplinary team (MDT) discussion in hours to establish clear ceilings of care.

6.3. Work is also ongoing to improve early recognition of deteriorating patients and timely referral to ICU.

6.4. *In Acute General Medicine (AGM)*, a patient began to deteriorate overnight but was not reviewed by a clinician from the evening to the next morning. There was a lack of escalation of care, but this did not impact on the outcome for the patient. The Matron for the area has been working with the Practice Development team to ensure all staff in AGM have received RAID[2] training (as of May 2024, 90% of staff have attended training).

6.5. *Prescribing awareness* of opioids in patients with impaired renal function was highlighted in SuWOn. The importance of a multidisciplinary team approach to ensure appropriate opioid prescribing was noted. EPR workflows are being explored and a Trust wide Safety Message relating to this learning has been disseminated. EPR system changes will be reported in the next report.

6.6. *Crude mortality:* There was an increase in mortality and unexpected deteriorations in SUWON; early indication is that this is related to an increase in the number and severity of illness of patients admitted. A review of the cases has identified a significant number of patients who were frail on admission with the decision taken to take a conservative approach after diagnostic assessment. All cases have been reviewed at L1/ L2 and SJR but no concerns regarding the quality of care for each patient were identified. This was discussed at MRG where it was requested that a review of parameters including NEWS2 scores, admission to ICU, complexity of patients and number of co-morbidities was included in the analysis. The Division will continue to review the data and an updated report will be presented to MRG upon completion.

6.7. A thematic case review has recently been undertaken following the deaths of three patients who were referred to the Community Cardiology Service but died prior to being seen in the service. This has now led to improved processes within the service. Details of this can be found in Appendix 2.

6.8. There was significant positive feedback across NOTSSCaN Division, one case relating to a patient who had a prolonged inpatient admission. Other cases highlighted advance care planning and family support at end of life. Positive feedback has been shared with the clinical teams involved.

7. Review of potential excess deaths related to long ED waits

7.1. As per the quarter 2 report – On 7 November 2023, an article was published in the Health Services Journal (HSJ) which explored the risk of mortality from excess waits in the Emergency Department. Data for all acute trusts was included. The *HSJ* analysis of official data estimated 29,145 ‘excess deaths’

[2] RAID- Recognising the acutely ill and deteriorating patient

occurred nationally because of long ED waits in 2022-23, up from 22,175 in 2021-22, and 9,783 in 2020-21.

7.2. The Clinical Outcomes Manager has explored data for potential impact of ethnicity, health inequalities and long-term conditions with no evidence these markers have impacted outcomes in the Emergency Departments. This data has now been shared locally with the Emergency Department Clinical Governance Lead and Consultant Nurse and will be explored further (ongoing). Outcomes from this local review will be shared at ED Clinical Governance meetings and included in the annual learning from deaths (LFD) Trust Board report. Details of this review has also been shared at MRG. No concerns or actions have been identified during the review to this date.

8. Patient Safety Incident Investigation (PSII)[3] of incidents resulting in death during Quarter 4

8.1. One incident with an impact of death was declared as a PSII during Quarter 4 2023/24:

8.1.1. A patient had an unexpected cardiac arrest and died. This case has been escalated to the Safeguarding team and a rapid review has been conducted. This PSII is ongoing, an action plan is in progress and learning points will be included in the quarter 1 report.

8.2. The findings of all PSIIs with an impact of death are presented to MRG. Any relevant learning from these investigations will be included in section 6 of a future learning from deaths report.

9. National mortality benchmark data

9.1. There have been no mortality outliers reported for OUH from the Care Quality Commission (CQC) or NHS Digital during Quarter 4 2023/24.

9.2. The SHMI for January 2023 to December 2023 is 0.86. This is banded as ‘lower than expected’ based on NHS Digital’s 95% control limits, adjusted for over-dispersion.

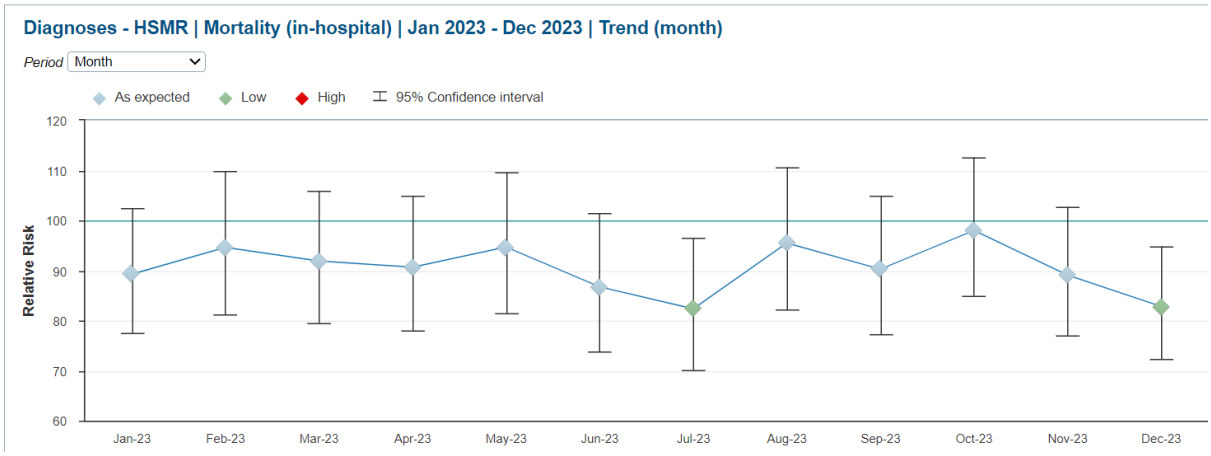
9.3. The Trust’s HSMR is 90.3 (95% CL 85.1 – 92.6) for January 2023 to December 2023. The monthly HSMR trend is shown in chart 2. The HSMR has decreased and remains banded as ‘lower than expected’. The HSMR excluding both Hospices is 80 (71.5-97.6).

[3] PSII_ patient safety incident investigation

9.4. From May 2024, the Trust level SHMI will exclude deaths that occur in the two Trust hospices (Katherine House Hospice and Sobell House Hospice) in line with benchmarked Trusts.

9.5. A summary and comparison of the methods used to calculate the SHMI and HSMR is included in Appendix 1.

Chart 2: HSMR trend, comparison with Teaching Hospitals and Shelford Group



Benchmarking peers Teaching Hospitals *

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	1 1	85830	2355	2080.9	2.7	113.2	
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	1	94325	2165	1924.0	2.3	112.5	
LEEDS TEACHING HOSPITALS NHS TRUST	3 1	56480	2215	2040.8	3.9	108.5	
BARTS HEALTH NHS TRUST	2	59245	2170	2027.3	3.7	107.0	
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	67525	2140	2104.7	3.2	101.7	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	4	40225	1405	1522.9	3.5	92.3	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	6	82465	1655	1808.1	2.0	91.5	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	13	71860	2208	2445.2	3.1	90.3	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	13	52830	660	832.7	1.2	79.3	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	49	69220	1460	1969.4	2.1	74.1	

The Shelford Group *

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	1	94325	2165	1924.0	2.3	112.5	
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	35	134395	4175	4491.9	3.1	93.0	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	4	40225	1405	1522.9	3.5	92.3	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	6	82465	1655	1808.1	2.0	91.5	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	13	71860	2208	2445.2	3.1	90.3	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	28	81060	2240	2602.5	2.8	86.1	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	13	52830	660	832.7	1.2	79.3	
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	16	43765	700	922.9	1.6	75.8	
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	39	60730	1285	1708.7	2.1	75.2	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	49	69220	1460	1969.4	2.1	74.1	

10. Detailed analysis of deaths during reporting period

10.1. *Crude mortality*: Chart 3 below shows the crude mortality rate for a rolling 12-month period. Crude mortality gives a contemporaneous, but not risk-adjusted, view of mortality across OUH. Chart 4 depicts the crude mortality by hospital site. Most deaths occur at the John Radcliffe Hospital which has the highest activity.

Chart 3: Crude mortality rate by Finished Consultant Episodes (FCEs)

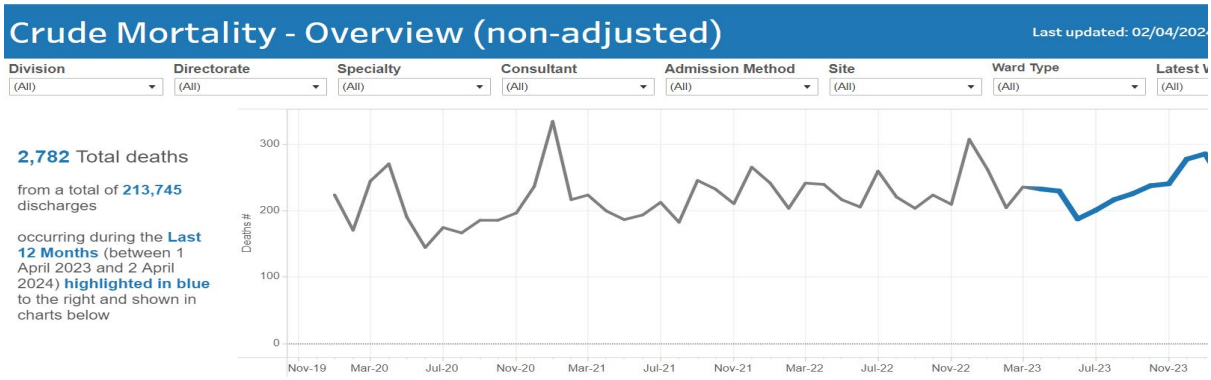
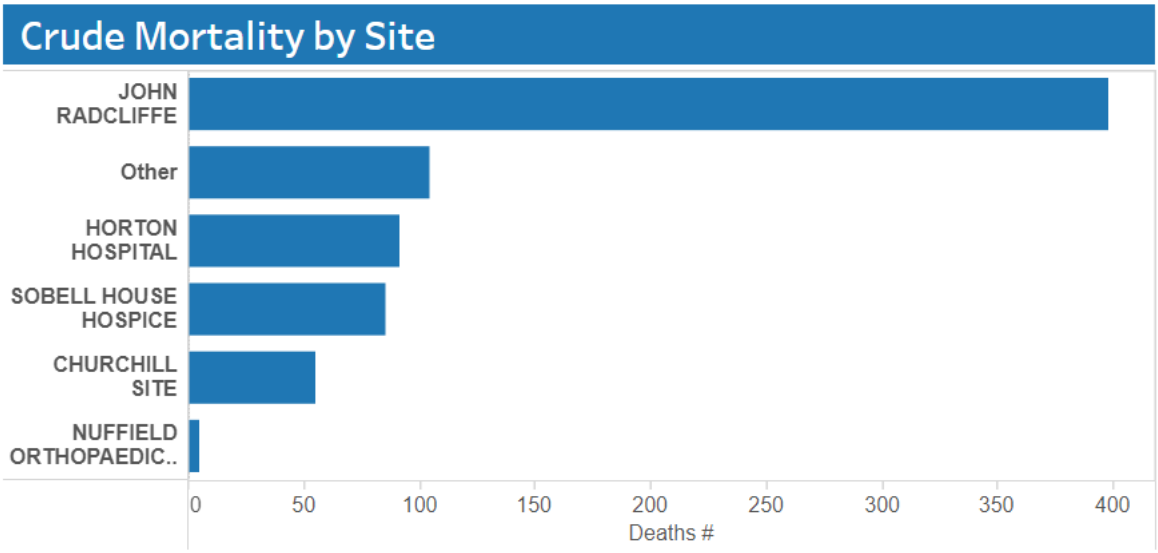


Chart 4: Crude mortality by Site



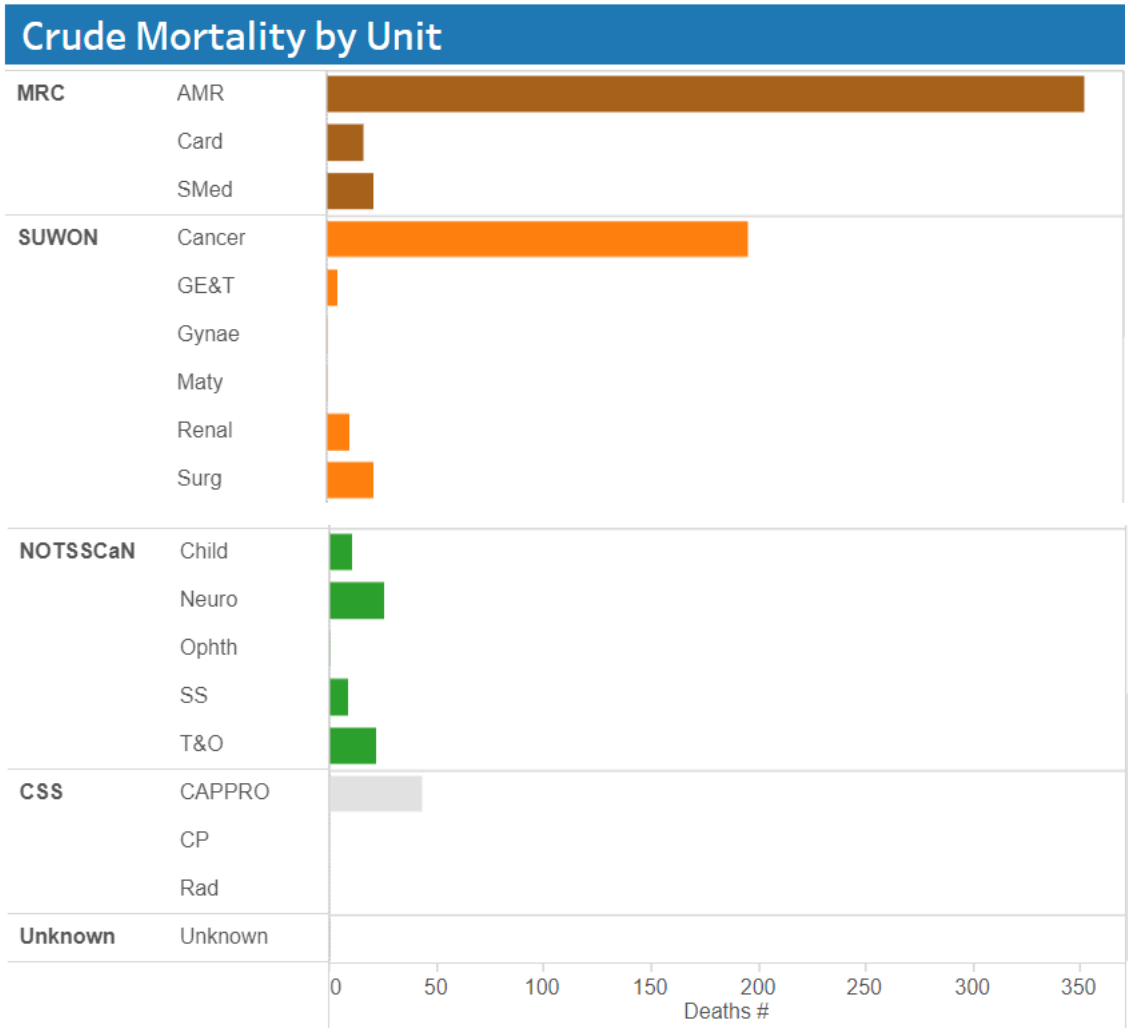
10.2. As usual the highest number of deaths occurred in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (Table 2, Chart 5).

10.3. Deaths coded under 'other' have been explored further and these include deaths in the Emergency Department and deaths at home whilst under the Oncology services. The volume of deaths coded as other will be monitored in the next quarter.

Table 2: Crude mortality by Clinical Division, Quarter 4 of 2023/24

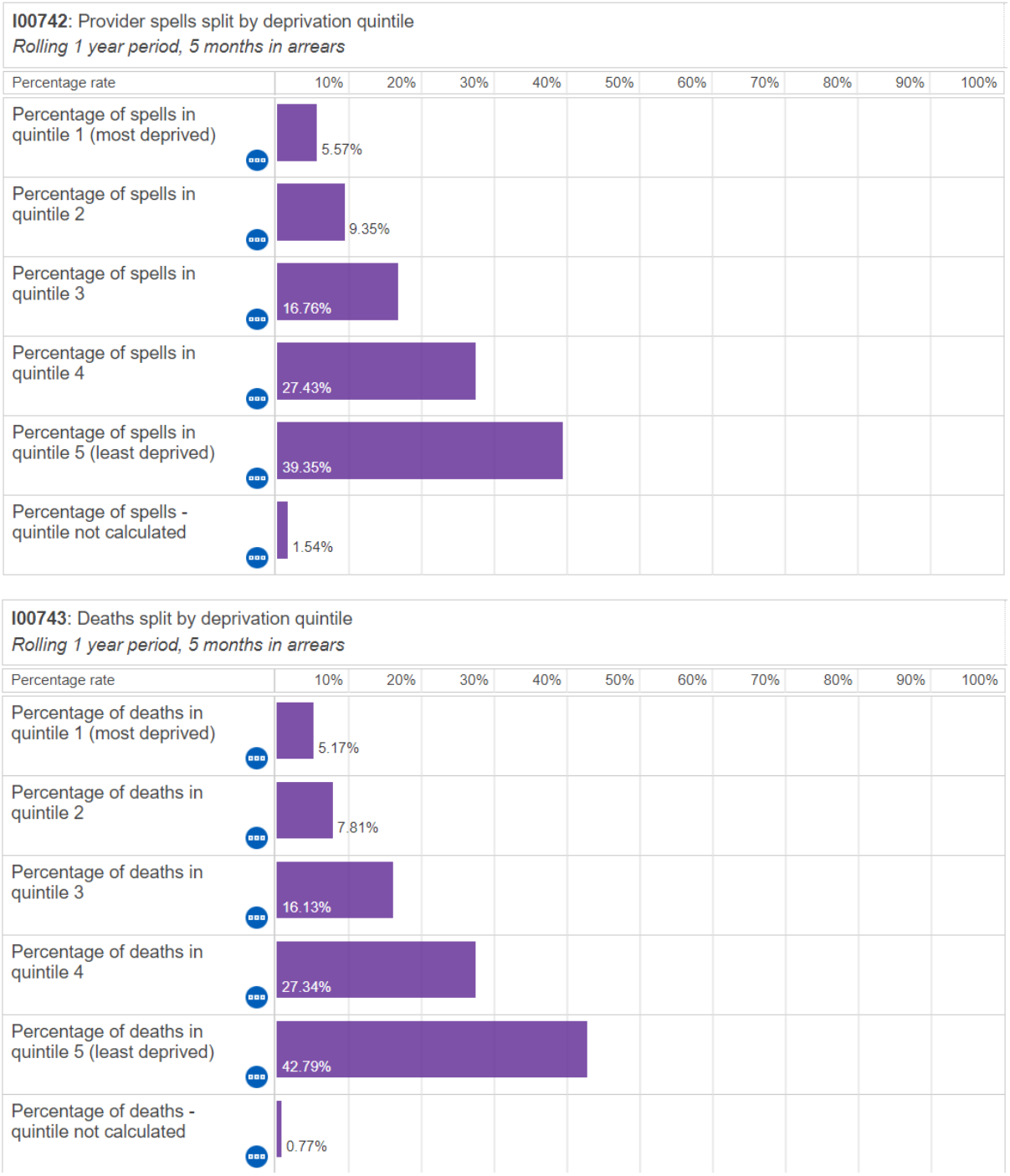
Division	Total Discharges	Number of deaths
NOTSSCAN	15,900	68
MRC	19,168	393
SUWON	19,206	236
CSS	756	44

Chart 5: Deaths by Directorate

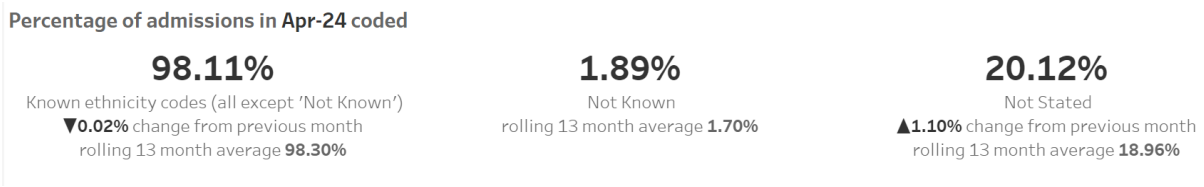


10.4. *Mortality by Index of Multiple Deprivation*: Chart 6 displays the percentage breakdown of deaths by Index of Multiple Deprivation quintile. This pattern is in line with previous LFD reports. Detailed interpretation of this data is difficult without adjusting for confounders such as age which may explain much of the observed variation.

Chart 6: % SHMI spells and deaths by deprivation quintile



10.5. Ethnicity data for all admissions can be seen below. Mortality rate by ethnicity can also be seen below using mortality data for the past three years. Detailed interpretation of this data is difficult without adjusting for confounders such as age which may explain much of the observed variation. The annual LFD report will report mortality by ethnicity for the 2023/24 period.



Mortality rate by ethnicity

- African = 0.26%
- Asian Background = 0.34%
- Black background = 0.12%
- Other ethnic group = 0.49%
- Other mixed background = 0.08%
- Other white background = 3%
- Bangladeshi = 0.1%
- Caribbean = 0.21%
- Chinese = 0.1%
- Indian = 0.23%
- Pakistani = 0.47%
- White and Asian = 0.04%
- White and black African = 0.03%
- White and black Caribbean = 0.12%
- White British = 9.36%
- White Irish = 0.1%
- Unknown = 0.0004%
- Not stated = 1.5%

11. Mortality-related risks on the Corporate Risk Register

11.1. Relevant mortality-related risks from the Corporate Risk Register are listed below:

11.1.1. Failure to care for patients correctly across providers at the right place at the right time.

11.1.2. Trust-wide loss of IT infrastructure and systems (e.g., from Cyber-attack, loss of services etc).

11.1.3. Failing to respond to the results of diagnostic tests.

11.1.4. Patients harmed because of difficulty finding information across two different systems (Paper and digital).

11.1.5. Potential harm to patients, staff, and the public from nosocomial COVID-19 exposure.

11.1.6. Lack of capacity to meet the demand for patients waiting 52 weeks or longer.

11.1.7. Ability to achieve the 85% of patients treated within 62 days of cancer diagnosis across all tumour sites.

12. Recommendations

12.1. The Public Trust Board is asked to receive this paper for information.

Appendix 1: Key differences between the SHMI and HSMR

The Trust references two mortality indicators: the SHMI, which is produced by NHS Digital, and the HSMR produced by Dr Foster Intelligence.

Both are standardised mortality indicators, expressed as a ratio of the observed number of deaths compared to the expected number of deaths adjusted for the characteristics of patients treated at a Trust.

While both mortality indicators use slightly different methodology to arrive at the indicator value; both aim to provide a risk adjusted comparison to a national benchmark (1 for SHMI or 100 for HSMR) to ascertain whether a trust's mortality is 'as expected', 'lower than expected' or 'higher than expected'.

Key differences between the SHMI and HSMR

Indicator	**Summary Hospital-level Mortality Indicator (SHMI)**	**Hospital Standardised Mortality Ratio (HSMR)**
Published by	NHS Digital	Dr Foster Intelligence
Publication frequency	Monthly	Monthly
Data period to calculate indicator value	Rolling 12-month period for each release, approximately five months in arrears.	Provider-selected period, up to three months in arrears
Coverage	Deaths occurring in hospital or within 30 days of discharge. All diagnosis groups excluding stillbirths. Day cases and regular attenders are excluded.	In-hospital deaths for 56 selected diagnosis groups that accounts for 80% of in-hospital mortality. Regular attenders are excluded.
Assignment of deaths	Deaths that happen post transfer count against the transfer hospital (acute non-specialist trusts only).	Includes deaths that occur post transfer to another hospital (superspell effect).
Palliative Care	Not adjusted for in the model.	Adjusted for in the model.
Casemix adjustment	8 factors: diagnosis, age, sex, method of admission, Charlson comorbidity score, month of admission, year, birth weight (for individuals aged <1 year in perinatal diagnosis group).	12 factors: admission type, age, year of discharge, deprivation, diagnosis subgroup, sex, Charlson comorbidity score, emergency admissions in last comorbidity score, emergency admissions in last 12 months, palliative care, month of admission, source of admission, interaction between age on admission group and comorbidity admission group.

Appendix 2: Community Cardiology Service review

What happened

Three patients are known to have died between referral by the GP, and their first appointment in the Community Cardiology Service.

The Community Cardiology Service is part of OUH Cardiology services. It is an innovative service in which the triage and service delivery for most patients is delivered by a group of 8-12 GPs who have had additional training in Cardiology and who work as an integrated part of OUH Cardiology and are employed by the trust. The service won the HSJ Value Awards for Cardiovascular Care in 2021.

The clinical governance arrangements are identical to those for other parts of the Cardiac service. The Community Cardiology Service has been running for 7 years, and in that time has seen over 10,000 patients.

Findings

All three cases were discussed at the Mortality Review Group in May 2024.

In the first case, the patient died of unrelated natural causes, and in discussion with the directorate management team, governance team, the CSU M&M, and the Patient Safety team, no further inquiry was considered necessary, and this case was not considered further.

In the other two cases, the patients died of known or suspected cardiac causes. In the second case, the patient died of heart failure within a few days of referral for the same problem and may have been better served by referral to an inpatient pathway. Feedback will be provided to the primary care centre.

In the final case, the patient died just two days before a scheduled appointment – which was scheduled for 6 weeks and one day after referral due to a lack of available appointments. It is not clear if there would have been sufficient time for a full range of investigations to have been completed prior to the death. An earlier appointment and timely intervention might possibly have improved the prognosis and prevented the death. This latter case provided several learning opportunities for OUH and resulting actions are recommended below.

Actions

Action	Progress
Updated triage model and guidance. Revised escalation process for admin staff, where the triage decision cannot immediately be delivered.	Complete (see below)
More capacity for Urgent/Priority patients.	In progress
Messaging to referring GPs in Oxfordshire regarding the updates and updated triage models.	In progress
Feedback to specific GP involved in one of the case reviews.	Complete

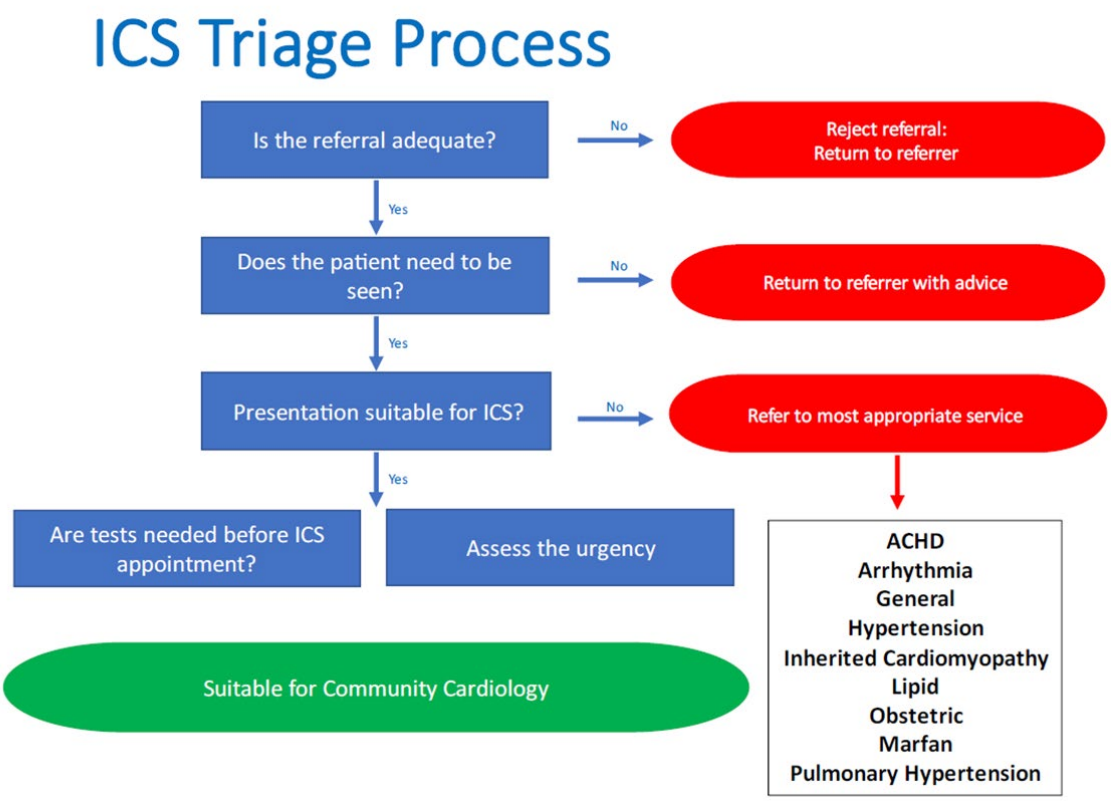
Conclusion

As per the table above, several actions have now been closed. The original and improved triage models can be seen below.

Any delays in reporting deaths of patients who are on the waiting list to the Community Cardiology service will be addressed through a complete review of all processes. This includes the processes for referral and triage of patients, the review of urgent and priority patients, and a review of the triage failure escalation procedure over the last 3 months. This topic will be added as a standing item to Quarterly CSU meetings and CSU 6-weekly admin catch-ups (with directorate management team involvement).

The Service will monitor, in real-time, any deaths that occur in patients on the waiting list, and will discuss any that are, or could be, of cardiovascular cause, in the local mortality meeting, and bring to MRG if there are any concerns about the processes.

Original triage model



Updated triage model