Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 13 November 2024

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Title:	**Learning from deaths report – Quarter 1 2024/25**

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

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper summarises key learning identified in mortality reviews completed for Quarter 1 of 2024/25; the latest available Dr Foster Intelligence mortality data; and provides assurance on the actions taken in relation to any highlighted concerns.
2. During Quarter 1 of 2024/25 there were 640 inpatient deaths of which 632 (99%) were reviewed within 8 weeks, including 317 (50%) level 2 and structured mortality reviews. The remaining 8 cases will be reviewed, with compliance monitored via the mortality review group. Therefore 100% of deaths have been reviewed for Quarter 1.
3. No deaths in this quarter were deemed to be 'avoidable'.
4. The Summary Hospital-level Mortality Indicator (SHMI) for April 2023 to March 2024 is 0.86. This has remained the same from the last quarter. This is 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 93.8 (95% CL 89.9 – 97.8) for July 2023 to June 2024. The monthly HSMR trend is shown in chart 2. The HSMR has increased slightly but remains banded as 'lower than expected'. The HSMR excluding both Hospices is 82 (71.5-97.6).

Recommendations

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

Contents

Learning from deaths report – Quarter 1 2024/25

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2024/25: April 2024 to June 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 level 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 1 of 2024/25

3.1. During Quarter 1 of 2024/25 there were 640 inpatient deaths of which 632 (99%) were reviewed within 8 weeks, including 317 (50%) level 2 and structured mortality reviews (table 1).

3.2. 10 SJRs were completed during the quarter. 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	2,625 (97%)	1,349 (50%)	2,625 (97%)	2,692 (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%)
2023/24 (Q4)	725	720 (99%)	351 (48%)	725 (100%)	725 (100%)

Reporting period	Total deaths	Reviews completed within 8 weeks			Total reviews completed*
		Level 1	Level 2 & SJR	Total	
2024/25 (Q1)	640	632 (99%)	317 (50%)	632 (99%)	640 (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 1 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 are now being scrutinised by the ME Service (excluding Stillbirths).

4.5. The OUH ME Service has worked closely with Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board (BOB ICB) and neighbouring ME Offices to support an extension of the ME service to Primary Care.

4.6. Statutory scrutiny of all deaths started on 9 September 2024.

4.7. Changes relating to death certification have been shared to all medical teams across the OUH.

4.8. 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.

4.9. 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 who either undertake a review of the death or contact the relatives if additional information is required.

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 1 update

5.4. There were 13 child/neonatal deaths in the OUH in Quarter 1. 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 issue and ongoing review of units is underway to optimise available space with regular updates provided to MRG.

5.7. The lead for child death is to submit a charitable bid to the Oxford Charities for a key worker specifically designated to liaise between families and professionals in the child death process.

5.8. Training for mortuary processes and interaction has now been conducted with paediatric and neonatal staff to improve care after death.

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

Division	***Service***	***Learning***	***Action***
MRC	Acute General Medicine	Improve transfer of patients out of hours.	A new Standard Operating Procedure (SOP) has been developed and agreed at governance meetings for ward transfers out of hours from the complex medical units, SOP - The Transfer of Patients into and out of the Complex Medicine Units A-D. This was highlighted following an unavoidable death where concerns regarding multiple transfers and lack of discussion of transfers/escalation plans with the NOK were raised.
SUWON	All	Improved DNACPR compliance and effective communication.	Divisional themes highlighted this quarter include timely do not attempt cardiopulmonary resuscitation (DNACPR) decision making and the importance of effective communication between teams, patients and families to ensure all are aware of the decision. Themes to be presented at Divisional and Directorate level meetings with support and training provided where necessary.
NOTSSCaN	Trauma	Negative mortality outlier status: National Hip Fracture	The Division is currently undertaking structured reviews for all hip fracture patients who

		Database (NHFD).	died in Quarters 4 2023/24 and Quarter 1 2024/25 following a negative alert from the National Hip Fracture Database (NHFD). Upon completion, findings will be presented to MRG and learning points will be included in a future LFD report.
CSS	Anaesthetics	Recent completion of a structured review in the Division has highlighted the importance of further review before MRG presentation when poor care is highlighted. Individuals and teams involved in the patients' care at the time should be contacted and care issues discussed prior to MRG presentation.	The Trust mortality review policy and structured review training materials have been updated to reflect this. These updates were presented and approved at the MRG meeting in October 2024.

7. Patient Safety Incident Investigation (PSII)[2] of incidents resulting in death during Quarter 1

7.1. There were no new incidents with an impact of death declared as a PSII during Quarter 1 2024/25.

7.2. 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.

[2] PSII_ patient safety incident investigation

8. National mortality benchmark data

8.1. There have been no mortality outliers reported for OUH from the Care Quality Commission (CQC) or NHS Digital during Quarter 1 2024/25.

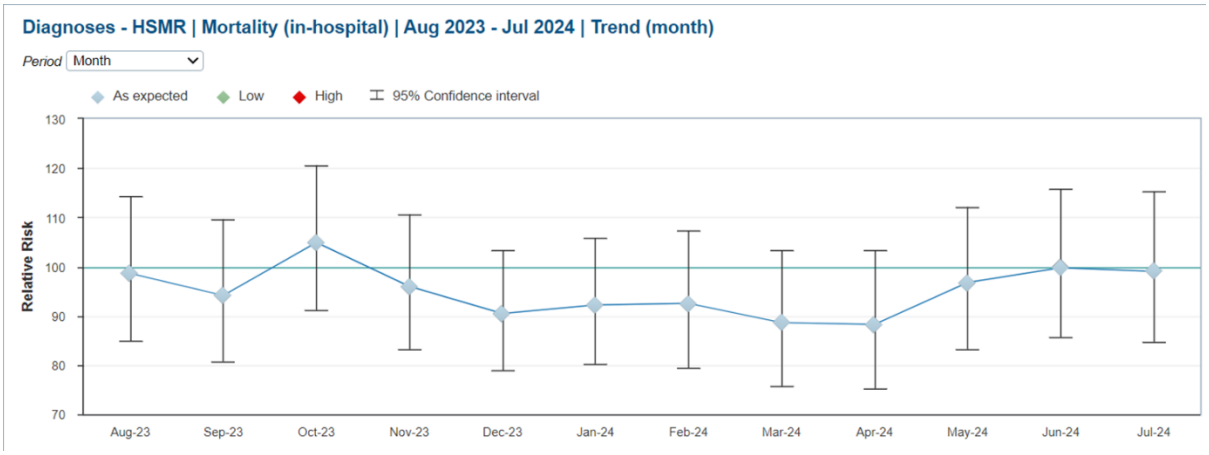
8.2. The SHMI for April 2023 to March 2024 is 0.86. This is banded as 'lower than expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion.

8.3. The Trust's HSMR is 93.8 (95% CL 89.9-97.8) for July 2023 to June 2024. The monthly HSMR trend is shown in chart 2. The HSMR has increased and remains banded as 'lower than expected'. The HSMR excluding both Hospices is 82 (71.5-97.6). The recent rise in HSMR is being investigated by Dr Foster and updates will be provided to MRG when available.

8.4. The Trust level SHMI now excludes deaths that occur in the two Trust hospices (Katherine House Hospice and Sobell House Hospice) in line with benchmarked Trusts.

8.5. 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	2 2	89675	2455	2151.7	2.7	114.1	
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	1	97245	2090	1861.5	2.1	112.3	
LEEDS TEACHING HOSPITALS NHS TRUST	3	57680	2270	2045.8	3.9	111.0	
BARTS HEALTH NHS TRUST	7	63325	2125	2086.8	3.4	101.8	
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	69470	2005	1990.6	2.9	100.7	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	9	48865	1725	1820.8	3.5	94.7	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	7	73037	2180	2323.6	3.0	93.8	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	6	83625	1640	1774.5	2.0	92.4	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	10	54235	695	837.0	1.3	83.0	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	47	73510	1410	1912.4	1.9	73.7	

The Shelford Group *

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	1	97245	2090	1861.5	2.1	112.3	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	9	48865	1725	1820.8	3.5	94.7	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	7	73037	2180	2323.6	3.0	93.8	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	6	83625	1640	1774.5	2.0	92.4	
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	34	139695	3970	4301.5	2.8	92.3	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	14	86515	2450	2714.7	2.8	90.3	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	10	54235	695	837.0	1.3	83.0	
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	37	61925	1280	1672.0	2.1	76.5	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	47	73510	1410	1912.4	1.9	73.7	
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	19	36945	500	681.6	1.4	73.4	

9. Detailed analysis of deaths during reporting period

9.1. *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)

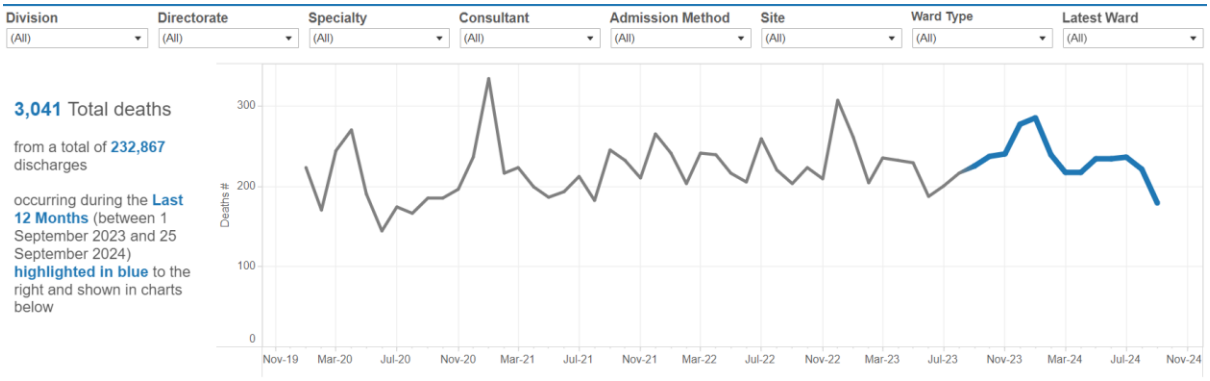
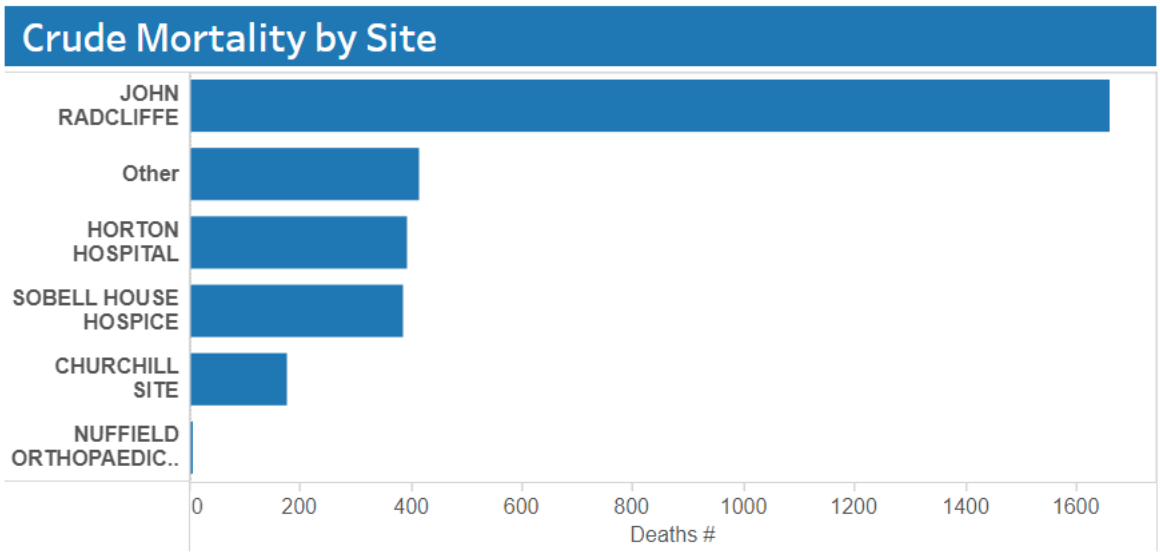


Chart 4: Crude mortality by Site

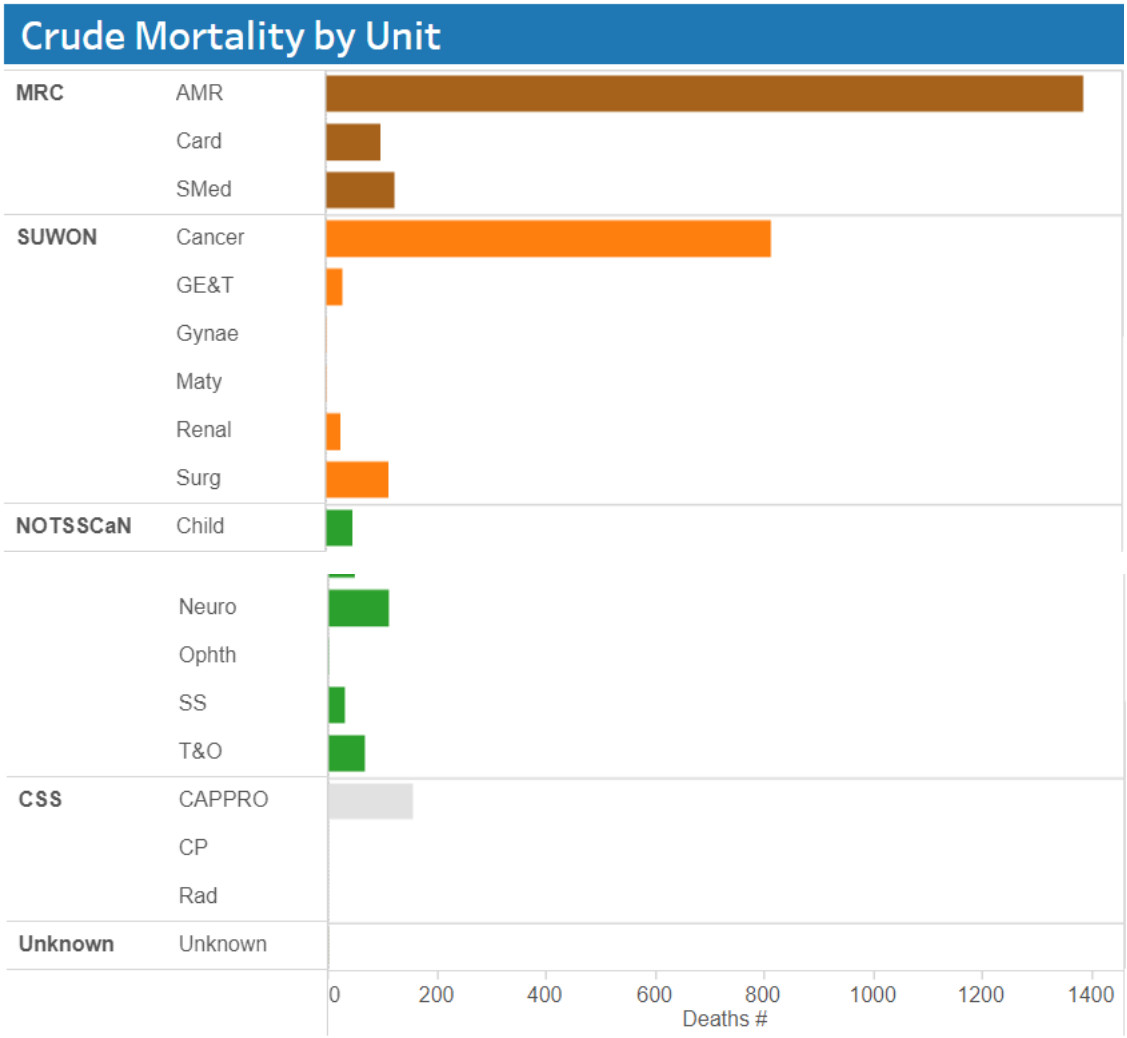


9.2. As usual, the highest number of deaths occurred in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (table 2, chart 5).

Table 2: Crude mortality by Clinical Division, Quarter 1 of 2023/24

Division	Total Discharges	Number of deaths
NOTSSCAN	15,384	61
MRC	19,375	356
SUWON	19,239	237
CSS	728	31

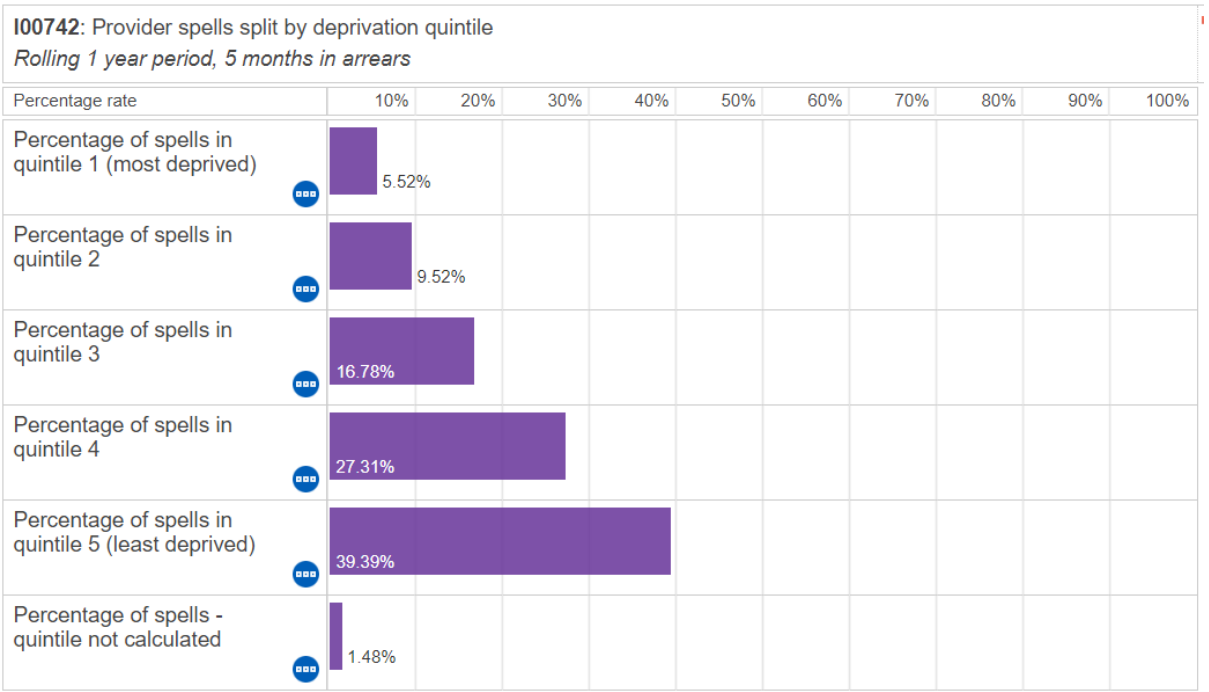
Chart 5: Deaths by Directorate

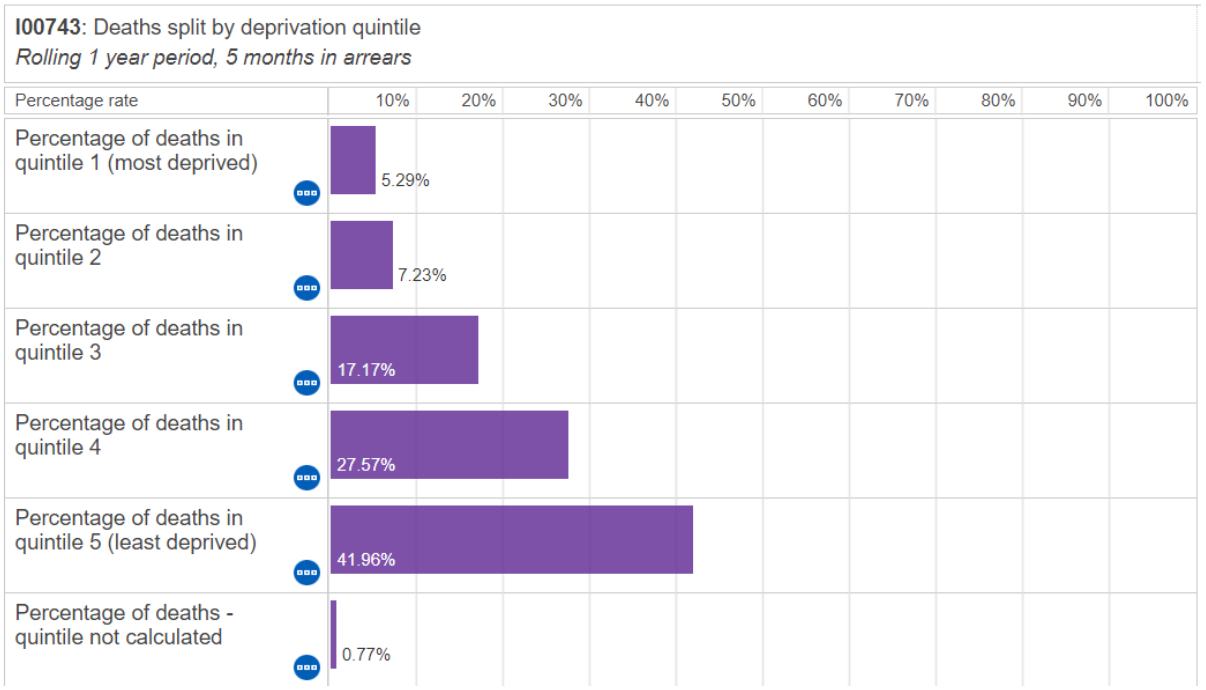


9.3. *Mortality by Index of Multiple Deprivation*: Chart 6 displays the percentage breakdown of deaths by Index of Multiple Deprivation quintile. This pattern is

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 in each deprivation quintile





10. Mortality-related risks on the Corporate Risk Register

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

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

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

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

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

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

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

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

11. Recommendations

11.1. 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.