Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 15 January 2025

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Title:	**Learning from deaths report – Quarter 2 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 2 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 2 of 2024/25 there were 661 inpatient deaths of which 647 (98%) were reviewed within 8 weeks, including 301 (46%) level 2 and structured mortality reviews (table 1). The remaining 14 cases have now also been reviewed. Therefore 100% of deaths have been reviewed for Quarter 2.
3. No deaths in this quarter were deemed to be 'avoidable'.
4. The Summary Hospital-level Mortality Indicator (SHMI) for July 2023 to June 2024 is 0.88. 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 97.6 (95% CL 93.4-102) for October 2023 to September 2024. The monthly HSMR trend is shown in chart 2. The HSMR has increased and remains banded 'as expected'. The HSMR excluding both Hospices is 88.1 (94-92.4).

Recommendations

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

Contents

Learning from deaths report – Quarter 2 2024/25

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 2 of 2024/25: July 2024 to September 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 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 then 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 2 of 2024/25

3.1. During Quarter 2 of 2024/25 there were 661 inpatient deaths of which 647 (98%) were reviewed within 8 weeks, including 301 (46%) level 2 and structured mortality reviews (table 1).

3.2. 13 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 (Q1-4)	2762	2731 (99%)	1294 (47%)	2731 (99%)	2762 (100%)
2024/25 (Q1)	640	632 (99%)	317 (50%)	632 (99%)	640 (100%)
2024/25 (Q2)	661	647 (98%)	301 (46%)	647 (98%)	661 (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 2 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 2 update

5.4. There were 14 child/neonatal deaths in the OUH in Quarter 2. All cases (100%) underwent a multidisciplinary review.

5.5. The Neonatal and Neurosurgical teams are reviewing processes to optimise outcomes in post haemorrhagic ventricular dilatation following a case review during the quarter.

5.6. Family liaison nurse appointed to enable communication with all teams for children with complex needs.

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

6.1. Examples of learning from deaths in each of the clinical divisions are summarised in the table below.

Division (Service)	***Learning***	***Action***
MRC (Respiratory)	Recruitment to strengthen the respiratory service at the Horton Hospital.	Recruitment of a substantive Respiratory Consultant at the Horton Hospital is underway. This will improve patient care and reduce the need of transfer patients between hospital sites.

SUWON (Gastro-enterology)	Anticoagulation audit	Audit of Dalteparin use in cases of COVID was completed in Gastroenterology following a structured review of a patient. This case was the subject of an inquest. An SJR was undertaken which highlighted a concern regarding Dalteparin dose. A subsequent audit reviewed the dose for three patients with suspected Covid. The dose of Dalteparin was appropriate for each case reviewed.
NOTSSCaN	Some cases have highlighted that community teams were unaware of end-of-life discussions and death of the patient until after the event.	Division to review community process
CSS (Anaesthetics)	Different clinical opinions in relation to one SJR highlighted the importance of involving all who were involved in the care of the patient to gain their perspective. This is particularly important if there are concerns about the care of the patient.	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. Further policy updates now stipulate that any SJR to be submitted to the Coroner in relation to an Inquest be reviewed at MRG to identify and expedite an action plan in relation to any learning before sharing with the Coroner's office.

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

7.1. There were two new incidents with an impact of death declared as a PSII during Quarter 2 2024/25:

- A patient had a cardiac arrest in the Emergency Department and died.
- A baby was found unresponsive requiring resuscitation, they later passed away. This incident is being investigated by MNSI.

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.

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 2 2024/25.

8.2. The Trust was reported as an outlier on the National Hip Fracture Database (NHFD) during quarter 4 2023/24 and quarter 1 2024/25. A detailed action plan to address the mortality outlier status was developed and the service is currently reviewing all the deaths from the two affected quarters. A final summary will be presented to MRG once completed. As of quarter 2 2024/25, mortality for the NHFD is now within expected ranges.

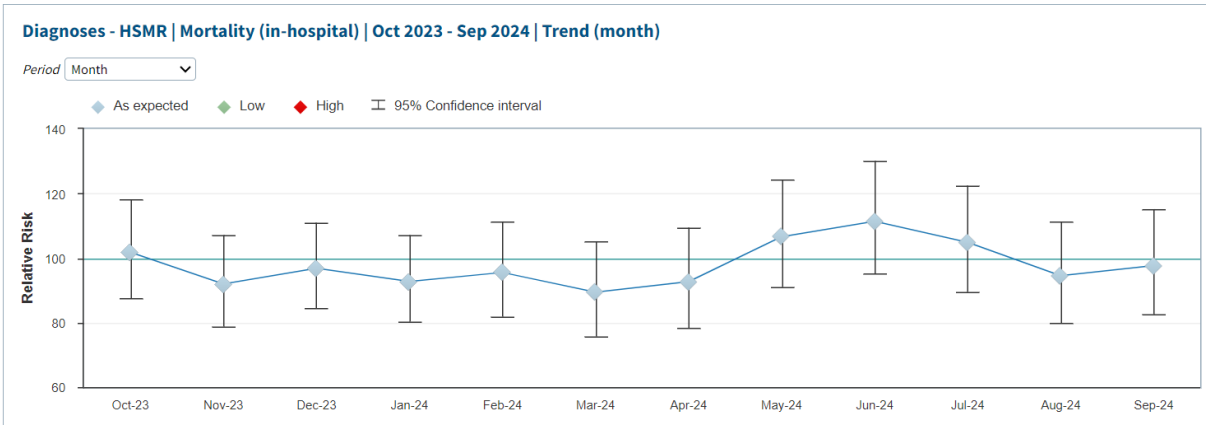
8.3. The SHMI for July 2023 to June 2024 is 0.88 which remains consistent with previous quarters. This is banded as ‘lower than expected’ based on NHS Digital’s 95% control limits, adjusted for over-dispersion. The Trust level SHMI now excludes deaths that occur in the two Trust hospices (Katherine House Hospice and Sobell House Hospice) in line with benchmarked Trusts.

8.4. The Trust’s HSMR is 97.6 (95% CL 93.4-102) for October 2023 to September 2024. The monthly HSMR trend is shown in chart 2. The HSMR remains banded ‘as expected’. The HSMR excluding both Hospices is 88.1 (94-92.4) and ‘lower than expected’.

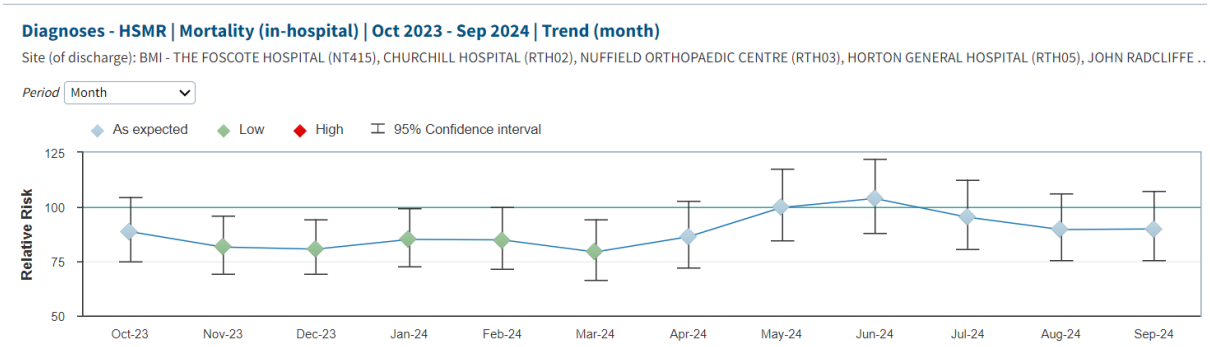
8.5. A summary and comparison of the methods used to calculate the SHMI and HSMR is included in Appendix 1.

[2] PSII_ patient safety incident investigation

Chart 2: HSMR trend (including hospice data), HSMR trend (excluding hospice data) comparison with Teaching Hospitals and Shelford Group



HSMR Excluding Hospice data:



Benchmarking peers Teaching Hospitals *

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		48955	1925	1584.4	3.9	121.5	
LEEDS TEACHING HOSPITALS NHS TRUST	3	46645	2245	2132.0	4.8	105.3	
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	3	64305	1985	1888.5	3.1	105.1	
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	8	62100	2060	2039.3	3.3	101.0	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3	57880	1984	2032.3	3.4	97.6	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	6	60000	1570	1672.4	2.6	93.9	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	9	38325	1675	1829.1	4.4	91.6	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	5	33240	640	716.3	1.9	89.3	
BARTS HEALTH NHS TRUST	20	52745	1960	2252.7	3.7	87.0	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	35	49045	1270	1684.2	2.6	75.4	

The Shelford Group *

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	3	64305	1985	1888.5	3.1	105.1	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3	57880	1984	2032.3	3.4	97.6	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	6	60000	1570	1672.4	2.6	93.9	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	9	38325	1675	1829.1	4.4	91.6	
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	44	111590	3825	4271.7	3.4	89.5	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	5	33240	640	716.3	1.9	89.3	
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6	43735	1235	1398.3	2.8	88.3	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	37	63930	2225	2704.1	3.5	82.3	
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	12	25625	495	620.8	1.9	79.7	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	35	49045	1270	1684.2	2.6	75.4	

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. Deaths recorded as 'other' will be monitored and mostly occur under Katherine House Hospice or ambulatory pathways.

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

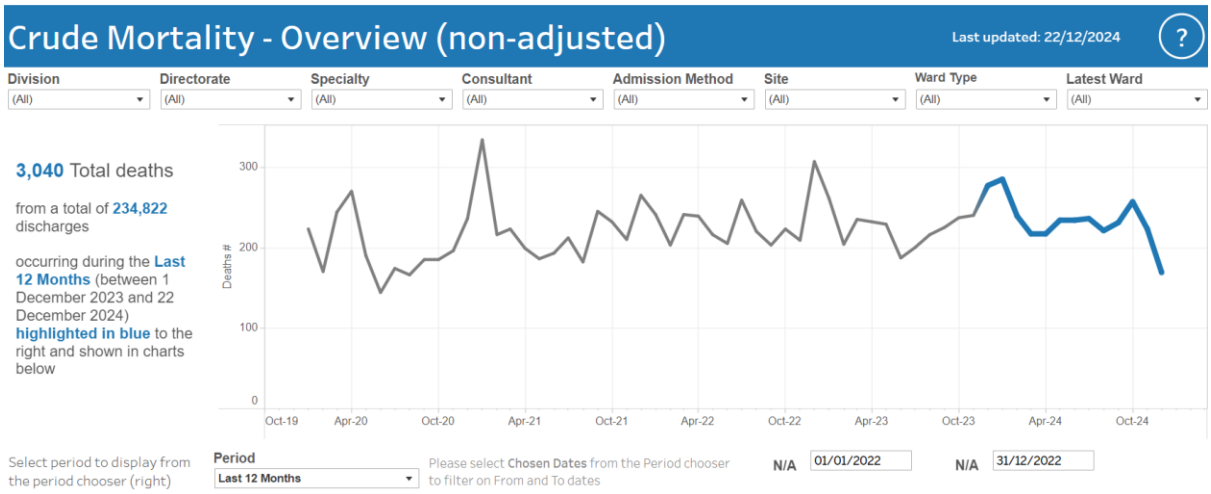
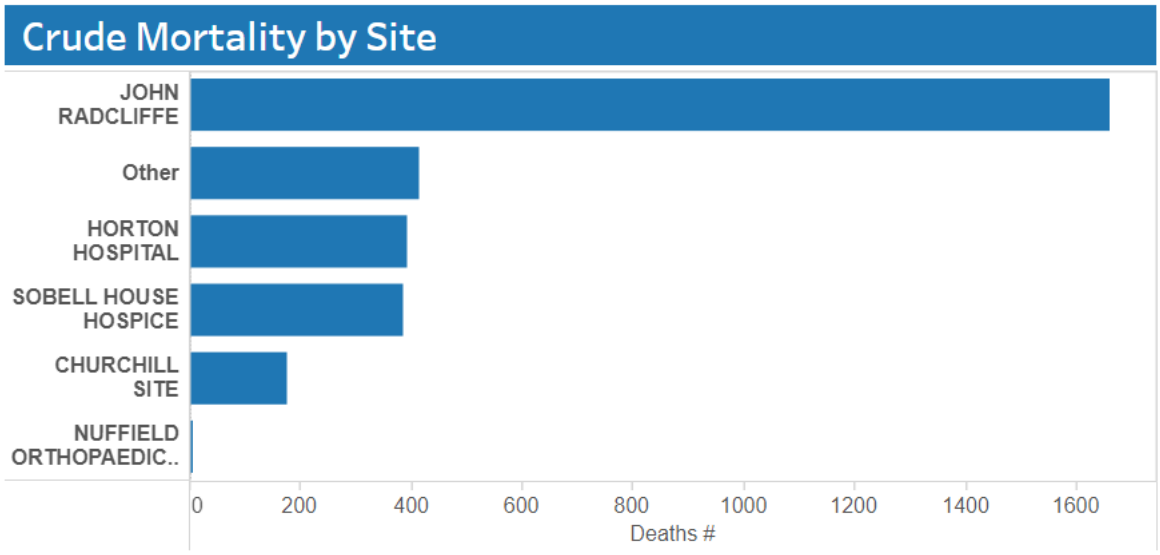


Chart 4: Crude mortality by Site

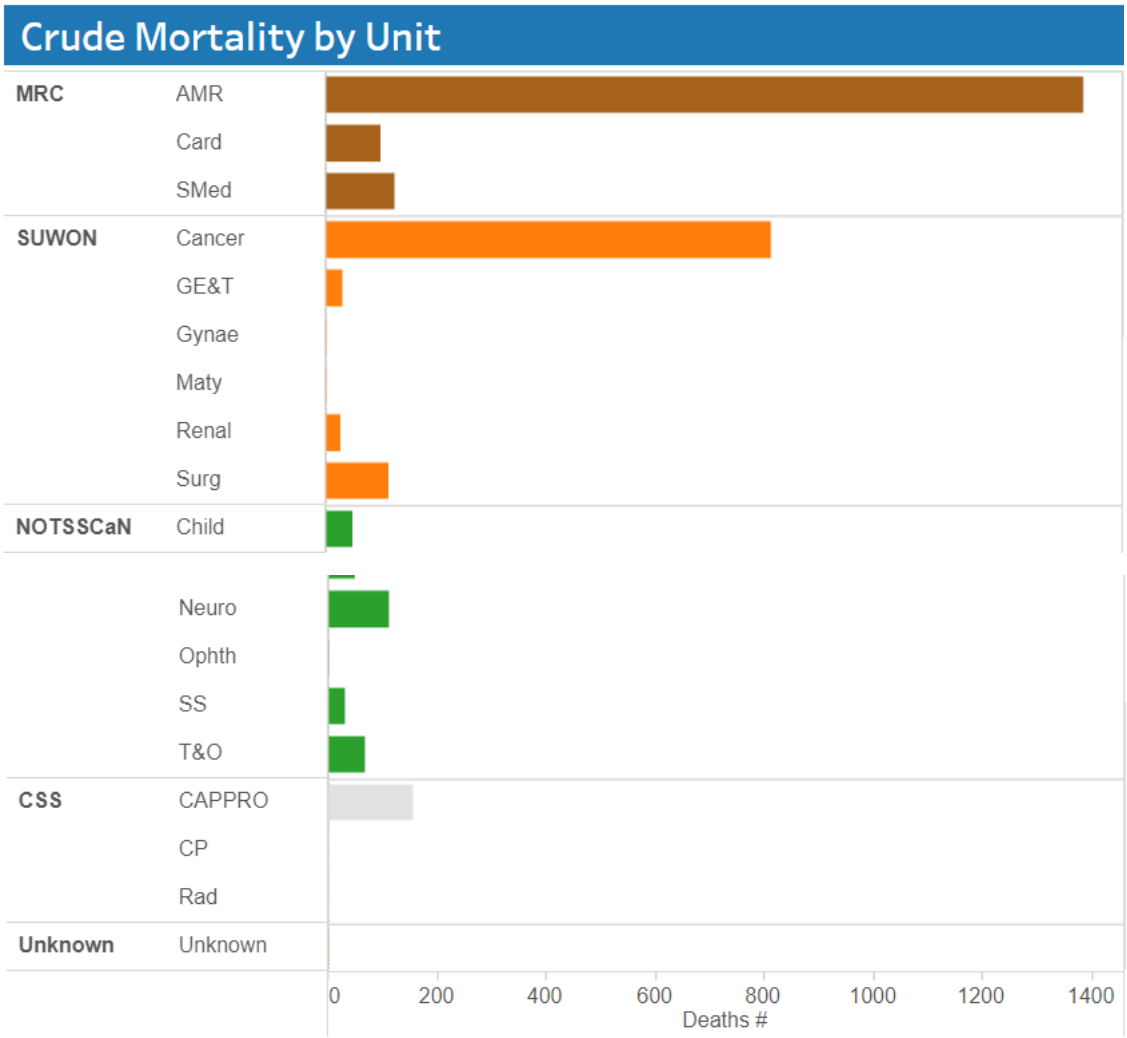


As usual, the highest number of deaths occurred in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (table 2, chart 5).

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

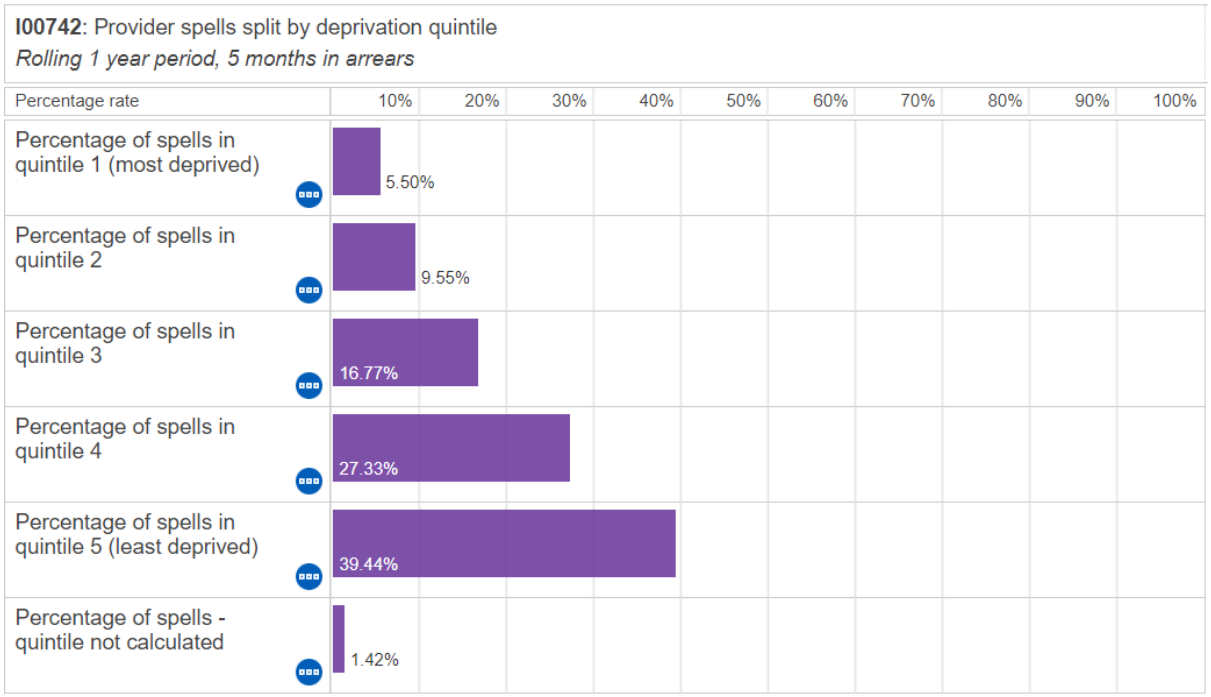
Division	Total Discharges	Number of deaths
NOTSSCAN	15,362	62
MRC	19,742	349
SUWON	19,562	238
CSS	805	38

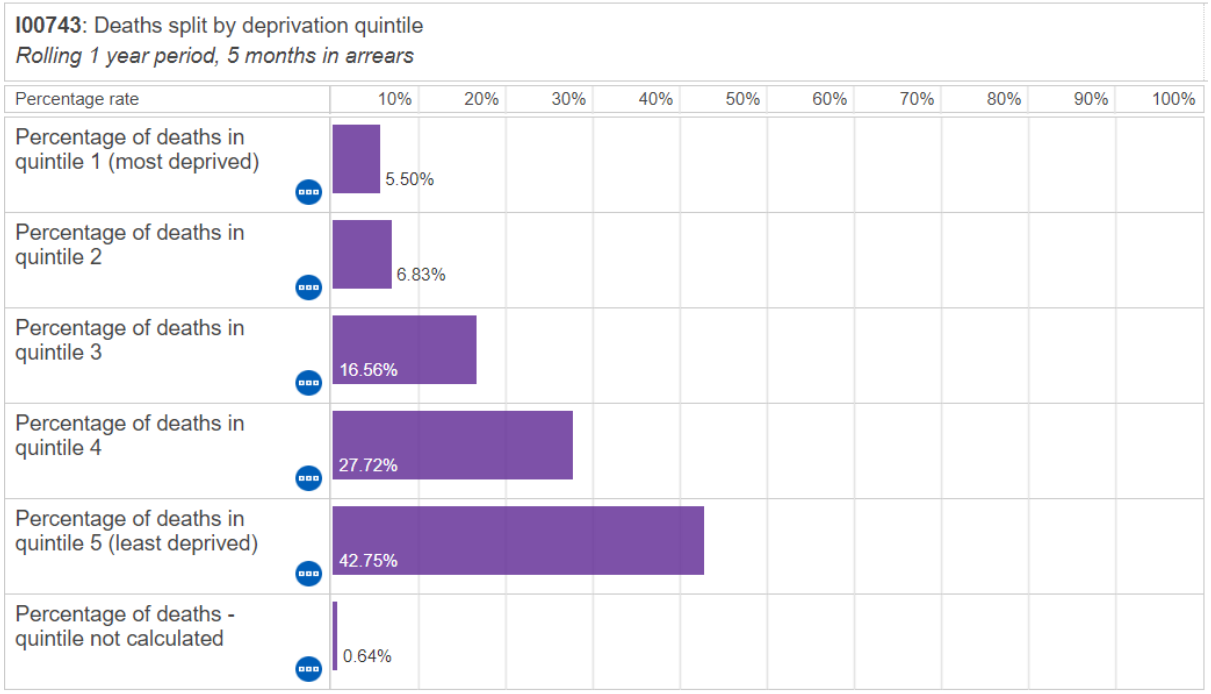
Chart 5: Deaths by Directorate



9.2. *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.