Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 14 May 2025

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Title:	**Learning From Deaths Report – Quarter 3 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 3 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 3 of 2024/25 there were 736 inpatient deaths of which 720 (98%) were reviewed within 8 weeks, including 294 (40%) level 2 and ten structured mortality reviews (table 1). The remaining 16 cases have now also been reviewed. Therefore 100% of deaths have been reviewed for Quarter 3.
3. No deaths in this quarter were deemed to be 'avoidable'.
4. The Summary Hospital-level Mortality Indicator (SHMI) for October 2023 to September 2024 is 0.90 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.
5. The Trust's HSMR is 99.3 (95% CL 93.4-102) for January 2024 to December 2024. The monthly HSMR trend is shown in chart 2. The HSMR remains banded 'as expected'. The HSMR excluding both hospices is 92.5 (87.3-95.9) and 'lower than expected'. To avoid confusion and facilitate appropriate comparison with other Trusts following changes to the way palliative care is accounted for, Telstra recommends routine presentation of HSMR data without hospice data. This recommendation is in line with NHS Digital's approach in removing hospice data from the Standardised Hospital Mortality Indicator (SHMI) and is supported by the Mortality Review Group.

Recommendations

6. The Trust Board is asked to:
    - Note the Learning from Deaths update for Quarter 3 (2024-2025).
    - Approve the recommendation by Telstra and the Mortality Review Group for routine presentation of HSMR data excluding hospices in line with NHS Digital's approach to the SHMI, to facilitate appropriate comparison with other Trusts.

Contents

Learning From Deaths Report – Quarter 3 2024/25

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 3 of 2024/25: October 2024 to December 2024.

1.2. This report provides a quarterly overview of Trust-level mortality data; the latest available Dr Foster Intelligence (Telstra) mortality data; and 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]

3. Mortality reviews during Quarter 3 of 2024/25

3.1. A summary of the Trust's learning from deaths policy and processes, including mortality reviews, is provided in the Appendix 2.

3.2. During Quarter 3 of 2024/25 there were 736 inpatient deaths of which 720 (98%) were reviewed within 8 weeks, including 284 (40%) level 2 and ten structured mortality reviews (table 1). The 16 remaining cases will be monitored locally to ensure a mortality review is conducted.

3.3. Ten 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.

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

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

Table 1: Mortality reviews completed

Reporting period	Total deaths	Reviews completed within 8 weeks			Total reviews completed*
		Level 1	Level 2 & SJR	Total	
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%)
2024/25 (Q3)	736	720 (98%)	294 (40%)	720 (98%)	736 (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 3 update and progress

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

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

4.6. The process for raising concerns and positive feedback from the ME to the OUH has now been strengthened as per previous reports and the process is working well.

4.7. All ME feedback forms are collated and presented to MRG each month. A thematic analysis will be conducted each quarter with the first being presented in April 2025 (quarter 4 data).

4.8. Learning themes during Quarter 3 were:

4.8.1. Clear and effective communication with relatives

4.8.2. Effective pain relief at end-of-life.

4.9. Both themes will be discussed at the next MRG meeting.

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 3 update

5.4. There were 18 child/neonatal deaths in the OUH in Quarter 3. All cases (100%) underwent a multidisciplinary review. Learning included-

5.4.1. In one case no bereavement key worker in OUH was available to support a family following a child death. A new post has been created using charitable funds which will now go through the vacancy control process.

5.4.2. An Emergency Department (ED) process and guideline is being developed for urgent transfers from ED to Theatres.

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

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

Division (Service)	***Learning***	***Action***
MRC (Oak High Care Unit)	To be confirmed upon completion of investigation and MRG discussion. Key learning points at this early stage are ensuring treatment plans are appropriate and ceilings of care are established with effective communication to both the patient and families.	There has been a rise in the number of cardiac arrests in the Oak High Care Unit, with a total of seven incidents reported since April 2024. An initial review by the resuscitation team has not indicated any concerns regarding the quality of care; however, a more comprehensive investigation will be conducted. This report will be presented to MRG upon completion.
SUWON (Divisional)	Learning includes ensuring patient suitability for the procedure and the development of a protocol for informing the Surgeon during the procedure if fluid deficit is identified.	There were two patients who underwent Holmium Laser Enucleation of the Prostate (HoLEP) procedure and died soon after (one end December 2024 and one end of January 2025). As a result, these procedures were paused while an internal investigation was underway.
NOTSSCaN (Neurosciences)	It was identified during one review that a patient missed a dose of Dalteparin as it was not available to administer to the patient, but this was not thought to have contributed to	Actions included reviewing the Neurosciences stock of Dalteparin and providing training to nursing staff regarding the process for ordering urgent medications via pharmacy.

	the death of the patient.	
CSS (Critical Care)	One review highlighted the importance of early discussion and treatment escalation plans (i.e. on post-take ward round) to reduce likelihood of inappropriate ICU admissions.	This will be discussed at the Acute General Medicine mortality meeting.

7. Patient Safety Incident Investigation (PSII) of incidents resulting in death during Quarter 3

7.1. There were two new incidents with an impact of death declared as a PSII during Quarter 3 2024/25:

- A baby was readmitted to hospital one day following discharge and had a cardiac arrest and died. This investigation is still in progress.
- A patient attended the Maternity Assessment Unit, and an intrapartum intrauterine death was diagnosed. This investigation is still in progress.

7.2. The findings of all PSIIs with an impact of death are presented to MRG (as well as the usual patient safety governance routes). Any relevant learning from these investigations will be included in 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 3 2024/25.

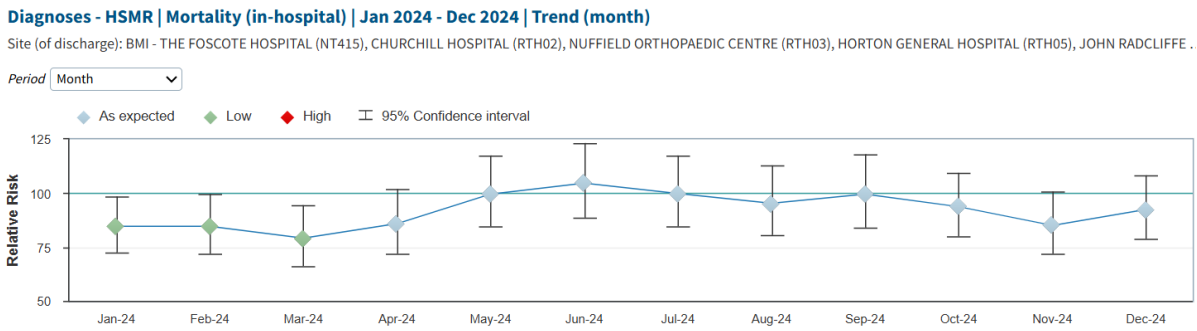
8.2. The SHMI for October 2023 to September 2024 is 0.90 which remains consistent with previous quarters. This is banded as ‘lower than expected’ based on NHS Digital’s 95% control limits, adjusted for over-dispersion. The Trust level SHMI now excludes deaths that occur in the two Trust hospices (Katherine House Hospice and Sobell House Hospice) in line with benchmarked Trusts.

8.3. The Trust’s HSMR (including hospices) is 99.3 (95% CL 93.4-102) for January 2024 to December 2024. The monthly HSMR trend is shown in chart 2. The HSMR remains banded ‘as expected’. The HSMR excluding

both hospices is 92.5 (87.3-95.9; 'lower than expected'). Telstra has recommended removing the two Hospices (Sobell House and Katherine House Hospice) when calculating the HSMR due to changes in methodology including less adjustment for palliative care coding. This would also align the HSMR to the SHMI data which already excludes Hospice data on the advice of NHS Digital.

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

HSMR Excluding Hospice data:



Shelford Group HSMR comparison:

Trust	HSMR
Sheffield Teaching NHS Trust	107.5
Newcastle Upon Tyne NHS Trust	99.7
Oxford University Hospitals NHS Trust	92.5
Kings College	90
Cambridge University NHS Trust	88.8
University Hospitals Birmingham	87.3
University College London Hospitals Trust	86.9
Guys and St Thomas NHS Trust	86
Manchester University NHS Trust	82.5
Imperial College NHS Trust	77.7

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)

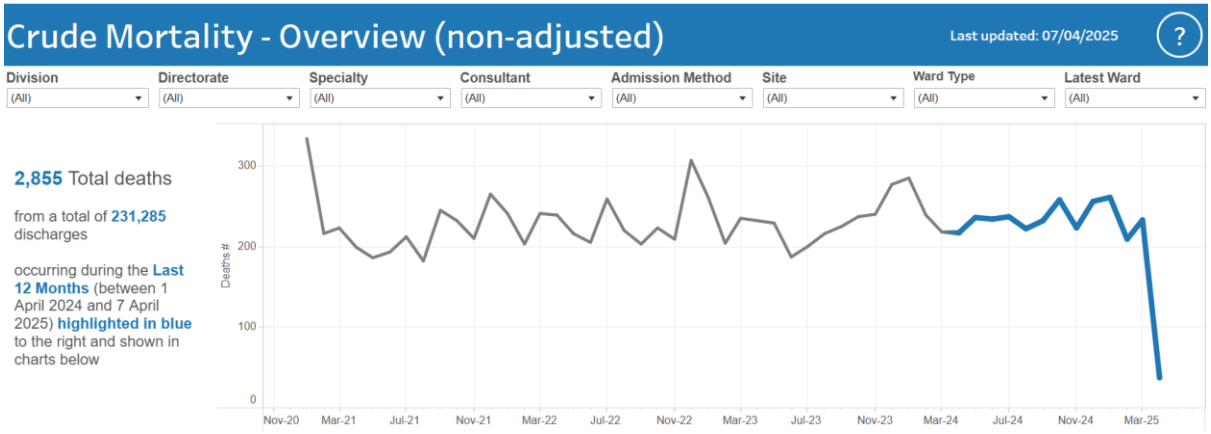
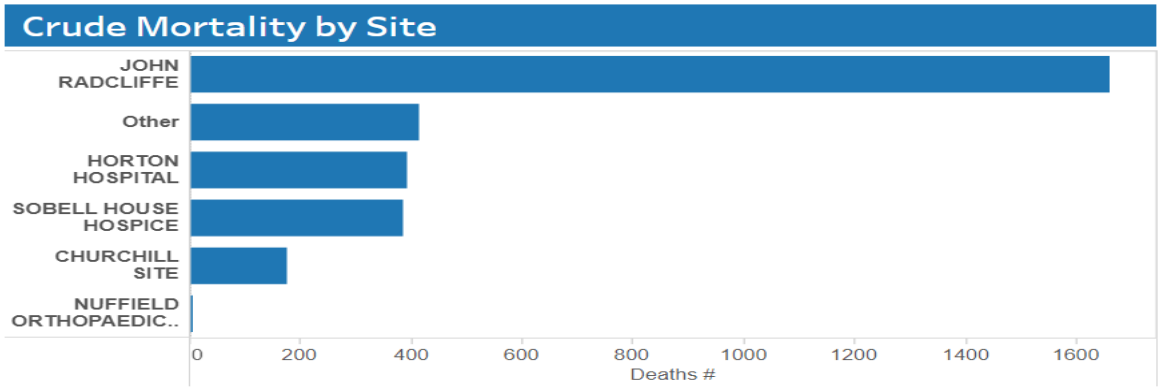


Chart 4: Crude mortality by Site

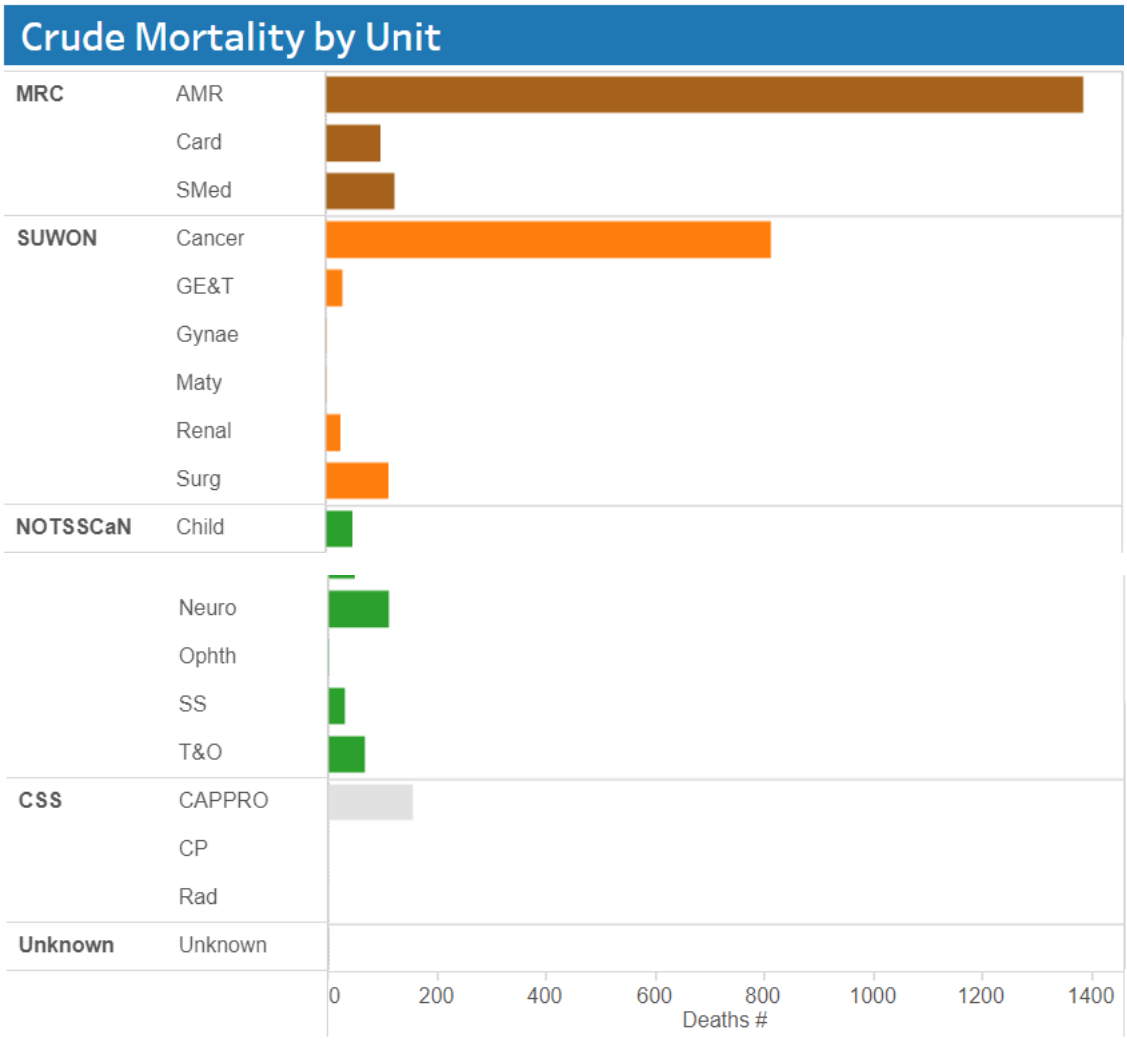


The highest number of deaths occurred in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (table 2, chart 5).

Table 2: Crude mortality by Clinical Division, Quarter 3 of 2024/25

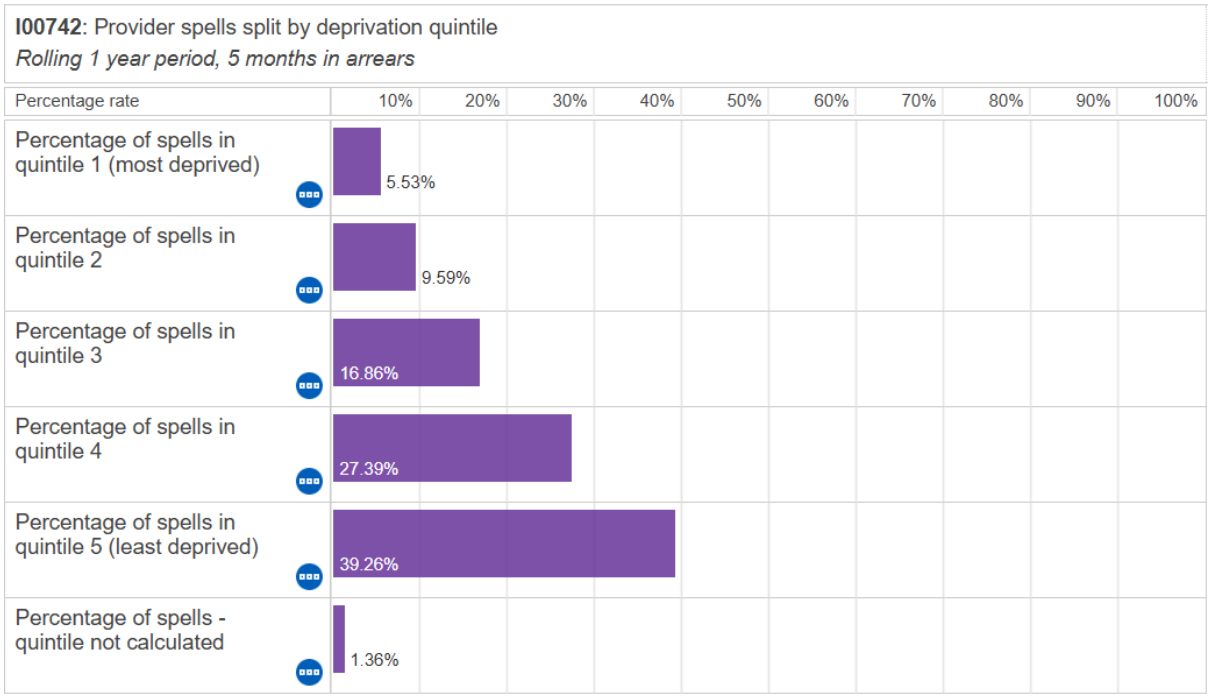
Division	Total Discharges	Number of deaths
NOTSSCAN	16,302	27
MRC	19,744	397
SUWON	19,459	243
CSS	729	26

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.

10.2. Patients harmed because of difficulty finding information across multiple systems (including paper and digital).

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

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

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

11. Recommendations

11.1. The Trust Board is asked to:

- Note the Learning from Deaths update for Quarter 3 (2024-2025).
- Approve the recommendation by Telstra and the Mortality Review Group for routine presentation of HSMR data excluding hospices in line with NHS Digital's approach to the SHMI, to facilitate appropriate comparison with other Trusts.

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: Background and Policy

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[2] set out in the NHS Outcomes Framework:
    - Preventing people from dying prematurely.
    - Treating and caring for people in a safe environment and protecting them from avoidable harm.
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.
3. The Trust Mortality Review policy requires that all inpatient deaths are reviewed within 8 weeks of the death occurring.
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.
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 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. More recently an SJR is requested if there is a Coroner's Inquest.
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.
7. Mortality related actions are reported quarterly to the Mortality Review Group (MRG) and via the Divisional Quality Reports presented to the Clinical Governance Committee (CGC).
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).

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