Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 9 July 2025

TB2025.60

Title:	**Learning From Deaths Report – Quarter 4 2024/25**

Status:	**For Information**
History:	**Quarterly reporting**

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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 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 4 of 2024/25 there were 724 inpatient deaths of which 720 (99%) were reviewed within 8 weeks. This included 280 (39%) level 2 reviews and 7 structured mortality reviews (table 1). The 4 remaining cases have been monitored locally and mortality review conducted (outside of the 8-week policy).
3. No deaths in this quarter were deemed to be 'avoidable'.
4. The latest Summary Hospital-level Mortality Indicator (SHMI) data for January 2024 to December 2024 is 0.91 which remains consistent with previous quarters. This is banded 'as expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion.
5. The Trust's Hospital standardised mortality ratio (HSMR) is 94.6 (95% CL 90.2 - 99.1) for April 2024 to March 2025. The HSMR is banded as 'lower than expected'. The HSMR has seen a gradual increase, the reasons for which have been explored with Telstra and are included in the report along with further actions.

Recommendations

6. The Trust Board is asked to:
    - Note the Learning from Deaths update for Quarter 4 (2024/25)
    - Note the findings from Telstra in relation to the increase in HSMR

Contents

Learning From Deaths Report – Quarter 4 2024/25

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 4 of 2024/25: January 2025 to March 2025.

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]

2.2. Mortality reviews during Quarter 4 of 2024/25.

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

2.4. During Quarter 4 of 2024/25 there were 724 inpatient deaths of which 720 (99%) were reviewed within 8 weeks, including 280 (39%) level 2 and 7 structured mortality reviews (table 1). The 4 remaining mortality reviews have since been completed outside the expected 8-week window.

2.5. Seven structured judgement mortality review (SJR) were completed during Quarter 4. The reasons for completing an SJRs included:

- Death of individuals with a learning disability
- Concerns raised by staff or families
- Concerns raised during the Medical Examiner scrutiny
- An inquest

2.6. 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

		Reviews completed within 8 weeks			
Reporting period	Total deaths	Level 1	Level 2 & SJRs	Total	Total reviews completed*
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%)
2024/25 (Q4)	724	720 (99%)	287 (40%)	720 (99%)	724 (100%)

*Including reviews completed after 8 weeks

3. The Medical Examiner (ME) system

Background

3.1. At OUH MEs have been scrutinising deaths since June 2020. The purpose of the ME system is to provide greater safeguards for the public by:

- Ensuring proper scrutiny of all non-Coronial deaths.
- Ensuring appropriate referral 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.
- Improved quality of death certification and mortality data.

Quarter 4 update and progress

3.2. 100% of Trust deaths were reviewed by the ME.

3.3. 100% of adult Hospice deaths were also reviewed by the ME.

3.4. All child/neonatal deaths within the Trust are also scrutinised by the ME Service (excluding Stillbirths and termination of pregnancies).

3.5. Statutory scrutiny of all deaths including those in Primary Care started on 9 September 2024.

3.6. The process for raising concerns and positive feedback from the ME to the OUH has been strengthened as per previous reports and the process is working well. All ME feedback forms are collated and presented to MRG each month. 21 feedback forms were received during quarter 4.

3.7. Feedback forms are summarised by category below.

Table 2: Medical Examiner feedback by month and category

Category	**Jan**	**Feb**	**Mar**
A – significant concern about the quality of care provided is raised by the bereaved family and carers	4	5	1
B – significant concern about the quality of care provided is raised by the Medical Examiner or Staff.	2	3	3
C – Learning Disability death	0	0	0
D – Feedback related to a provider 'alarm'	0	0	0
E – Death in elective care setting	0	0	0
F – Death in an area where planned improvement is already underway	0	0	1
G – Excellent care identified	2	0	0

3.8. When received, forms are shared with the relevant Divisions to investigate and feedback to families where requested. Divisions review cases highlighted during the quarter. Divisions have been requested to include a section in future quarterly mortality reports to MRG reporting any significant learning identified from ME feedback. Work is on-going to further strengthen this process.

3.9. Learning from the ME feedback during Quarter 4 included the following themes:

3.9.1. The importance of clear and effective communication with relatives. The Palliative care team are providing sessions on this as part of their annual plan.

3.9.2. Insulin management during inpatient admissions was highlighted in two feedback forms.

- Case 1 – An incident report was submitted, and learning includes a meeting with ward staff and the diabetes specialist nurse reiterating the importance of not omitting insulin for patients with type I diabetes. (insulin management was not the cause of this patients' death).

- Case 2 – The monitoring of blood glucose levels was raised by a family member. The Division are currently reviewing this case to identify any learning.

3.9.3. Pain management at end of life. To support this the following actions have been completed:

- Intranet site updates
- EPR prompts
- Use of Eolas[2] to provide essential guidance for symptom management
- Guidance documents for staff and families
- Dying matters symposium (completed 7 May 2025).

4. Child death overview process (CDOP) Quarter 4 update

4.1. There were 16 child/neonatal deaths in the OUH in Quarter 4. All cases (100%) underwent a multidisciplinary review. Learning included:

4.1.1. Babies born before 25 weeks are considered extremely premature. National guidance recommends a Neonatal Consultant presence for births at this gestation.

4.1.2. Following a review, South Central Ambulance Service (SCAS) will aim to allocate one member of their team to communicate with families on the scene for child collapses at home. This will ensure families are kept updated of clinical events in a timely manner.

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

5.1. Examples of learning during this quarter are summarised in the table below.

[2] An AI knowledge management platform for healthcare professionals

Table 3: Learning and Actions from mortality reviews

Division (Service)	Learning	Action
Medicine, Rehabilitation and Cardiac (MRC) Directorate (Acute General Medicine) A learning response and mortality review was conducted for a patient who deteriorated and died.	It was identified that earlier recognition of the deterioration could have provided an opportunity to consider or trial non-invasive ventilation (NIV) and facilitate referral to the respiratory team. It was felt this would not have affected the outcome for the patient.	System for Electronic Notification and Documentation (SEND) observations will be reviewed during the ward board round to identify patients who may be deteriorating, so they can be escalated to the appropriate team.
Surgery, Women's and Oncology (SUWON) (Urology) 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.	No common themes were identified between the two cases, and there is no evidence from the reviews including postmortem results to suggest that either death was avoidable. Wider learning includes ensuring patient suitability for the procedure and the development of a protocol for informing the Surgeon during the procedure if a fluid deficit is identified.	Q4 update – two actions have now been completed: The patients are reviewed for suitability (frailty etc) – to ensure confidence that the right people are receiving the operation. There is clarity of responsibility for informing the surgeon early in the operation if there is fluid deficit. Protocol agreed of how to manage this during the operation with the theatre teams.
Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Ophthalmology, Children and Neonates (NOTSSCAN) Directorate (Neonatal)	A mortality review found that, moving a very unstable neonate to paediatric theatre for urgent surgery is occasionally not possible due to theatre location. For this reason, a patient will have their surgery on the neonatal unit. This does/can create additional challenges for the anaesthetic and surgical teams.	The service will explore the possible use of a theatre located nearer the ward. The service will also ensure this issue is listed on the risk register. An analysis of incidents relating to this issue has confirmed no harm has been caused to date.
Clinical Support Services (CSS) Directorate (Critical Care)	Four mortality reviews completed in the quarter highlighted admission to the Critical Care unit of patients for whom escalation to critical care may not have been appropriate.	Discussion with referring units to ensure shared learning. Discussions to include the importance of early identification of ceilings of care and treatment escalation plans.

6. Patient Safety Incident Investigation (PSII) of incidents resulting in death during Quarter 4

6.1. There was one new incident with an impact of death declared as a PSII during Quarter 4 2024/25:

6.1.1. An intrauterine death occurred at 39 weeks' gestation. This is being investigated by Maternity and Newborn Safety Investigations (MNSI).

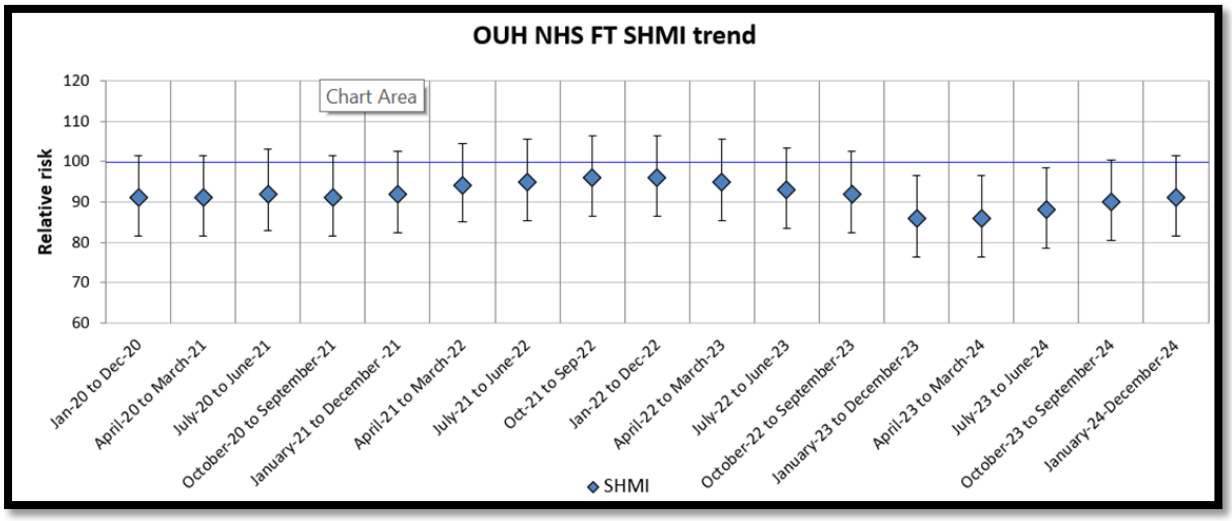
6.2. The findings of all PSIIs with an impact of death are presented to MRG (as well as patient safety governance routes). Any relevant learning from these investigations will be included in a future learning from deaths report.

7. National mortality benchmark data

7.1. There have been no mortality outliers reported for OUH from the Care Quality Commission (CQC) or NHS Digital during Quarter 4 2024/25.

7.2. The Summary Hospital-level Mortality Indicator (SHMI) for January 2024 to December 2024 is 0.91 which remains consistent with previous quarters. This is banded 'as expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion.

Chart 1: OUH SHMI trend (12-month rolling)



7.3. 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 and as agreed at Trust Board May 2025.

7.4. The Trust's HSMR is 94.6 (95% CL 90.2 - 99.1) for April 2024 to March 2025. The monthly HSMR trend is shown in chart 2. The HSMR is banded as 'lower than expected'.

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

Chart 2: HSMR + rolling data over 12 months, excluding Hospice data

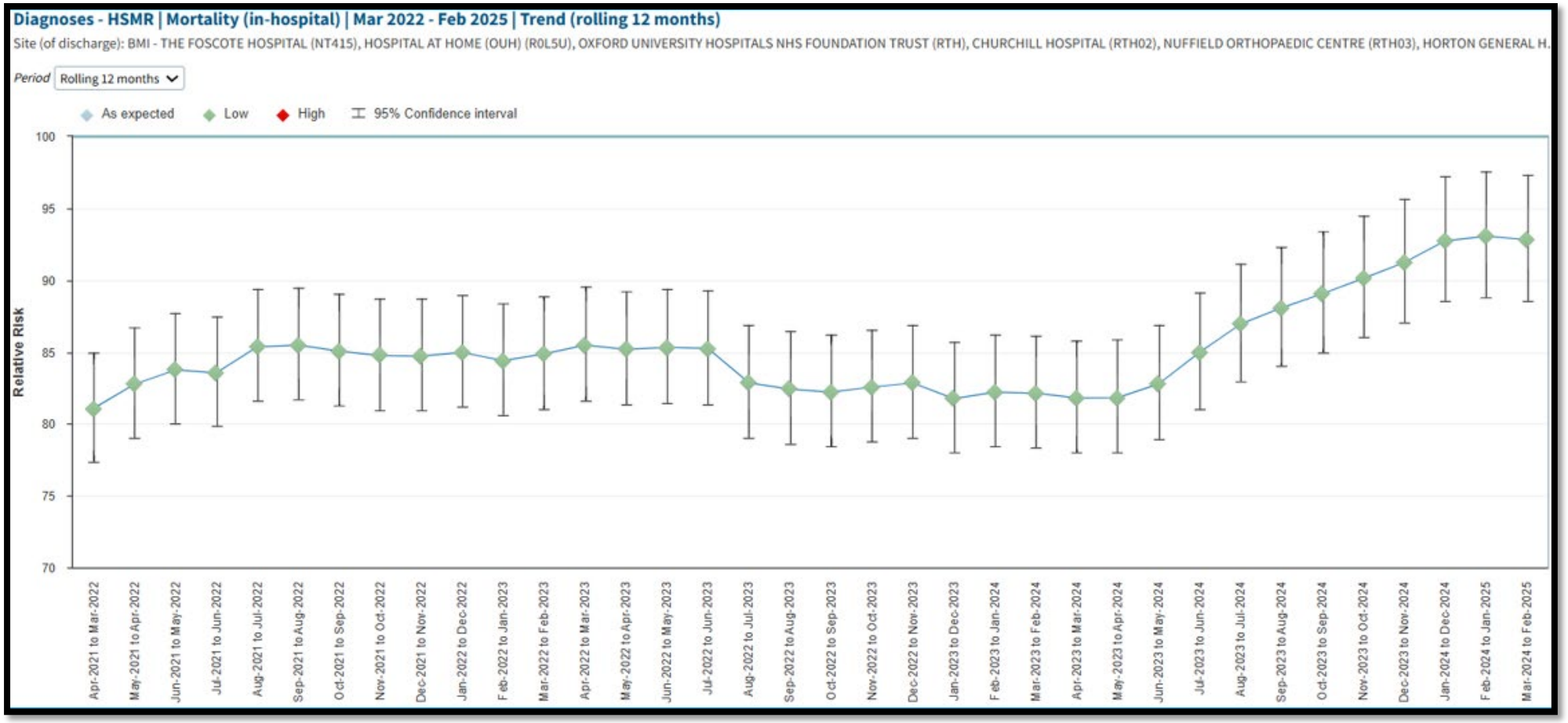
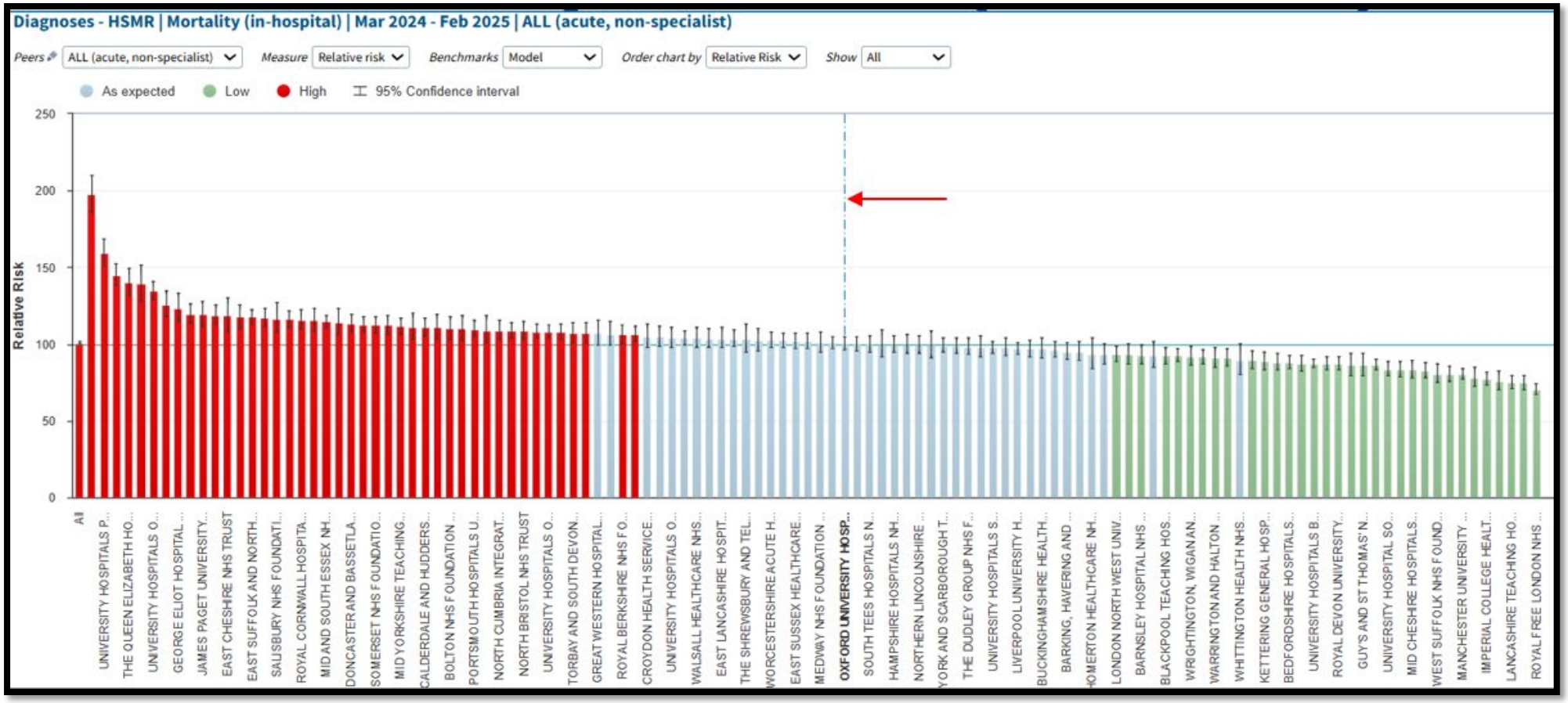


Chart 3: HSMR+ peer comparison (including all OUH sites)



9. Rising HSMR

9.1. The rising HSMR+ has been identified at MRG and therefore a bespoke report exploring this was requested from Telstra.

9.2. Both the rolling 12-month HSMR+ and standardised mortality ratio (SMR) show an increasing trend, with a sharp increase beginning around the June 23 to May 24 data point.

9.3. This trend remains with and without inclusion of the hospice sites.

9.4. The rise in HSMR+ is driven by the John Radcliffe Hospital site and differs from Shelford Group peers.

9.5. The rise is underpinned by a consistent decline in expected deaths and a recent slight increase in observed deaths.

9.6. The most notable factors contributing to the trend are around reduced depth of coding and reduced documentation of comorbidity and frailty.

9.7. The proportion of both spells and deaths with either no recorded comorbidity or a comorbidity score of ‘0 or less than 0’ has increased whilst the proportion of activity with the highest comorbidity scores has declined.

9.8. Of those patients ‘eligible’ for a frailty score calculation (aged 75 and over), there has been a decrease in the proportions of both super spells and deaths with a recorded frailty condition and a decline in overall frailty scores.

9.9. Together, both ‘depth of coding’ indicators suggest a decline in the capture of acuity of patients being admitted to John Radcliffe Hospital which will likely be adversely impacting the expected rate of mortality and contributing to the observed increase in HSMR+ trend at a Trust level.

9.10. There are also some changes in case-mix observed with John Radcliffe hospital reporting an increasingly younger case-mix for admissions. A similar increase in HSMR+ is observed in the youngest age cohorts (0-24).

9.11. There are 3 outlying diagnosis groups at John Radcliffe Hospital which require further review:

- Senility and organic mental disorders (delirium)
- Acute cerebrovascular disease
- Septicaemia (except in labour)

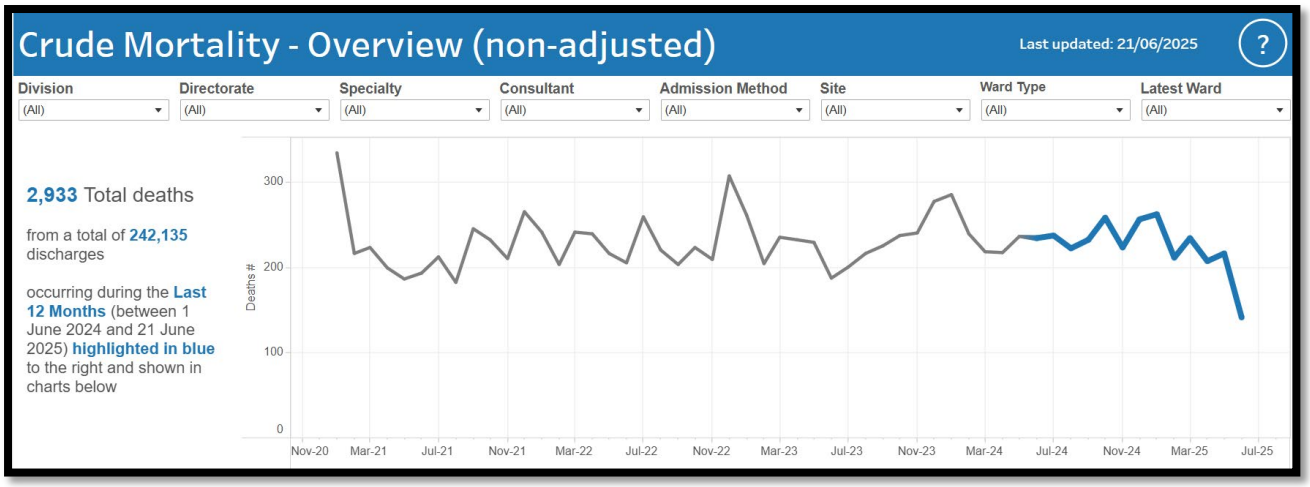
9.12. Additionally, there are some discharge specialties that observe a greater decline in expected rate and subsequent increase in relative risk - in particular, Stroke Medicine and Geriatric medicine.

9.13. Further analysis is underway to understand better these observed trends. A working group has been established including the chair of MRG, coding, clinicians and digital representatives. They are exploring depth of coding across the 3 diagnosis groups listed above. The findings of this review will be shared at MRG and in the next Learning from Deaths report.

10. Detailed analysis of deaths during reporting period

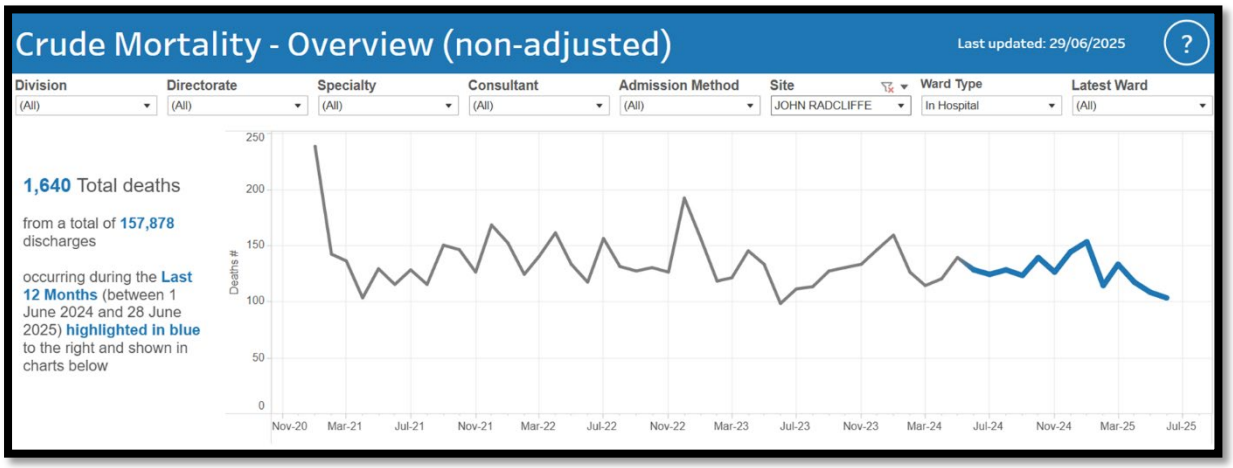
10.1. *Crude mortality*: Chart 4 below shows the latest crude mortality rate for a rolling 12-month period (in blue). Crude mortality gives a contemporaneous, but not risk-adjusted, view of mortality across OUH.

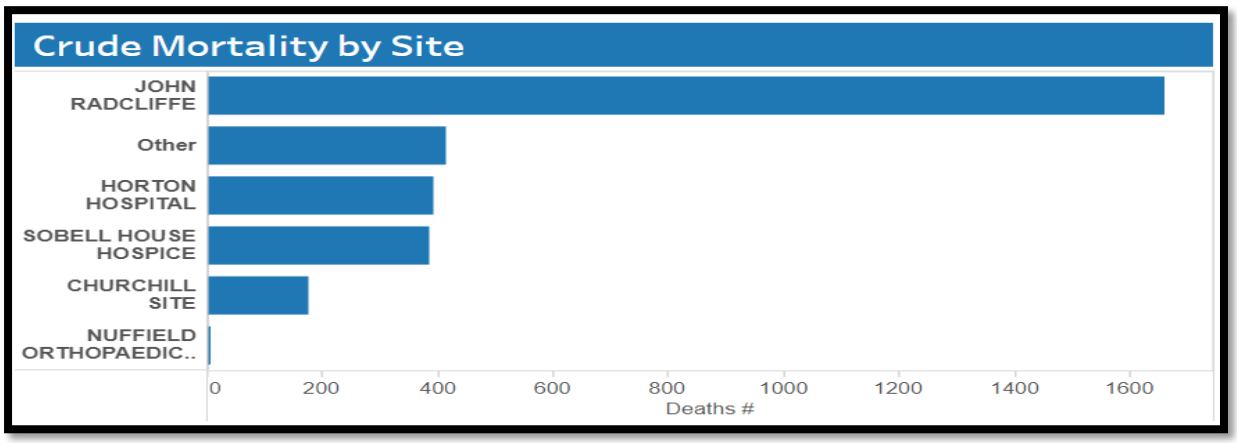
Chart 4: Crude mortality rate by Finished Consultant Episodes (FCEs)



10.2. Chart 5 depicts the crude mortality rate at the John Radcliffe site and crude annual 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 5: Crude mortality rate by Finished Consultant Episodes (FCEs) John Radcliffe site and Crude mortality by site (annual data)



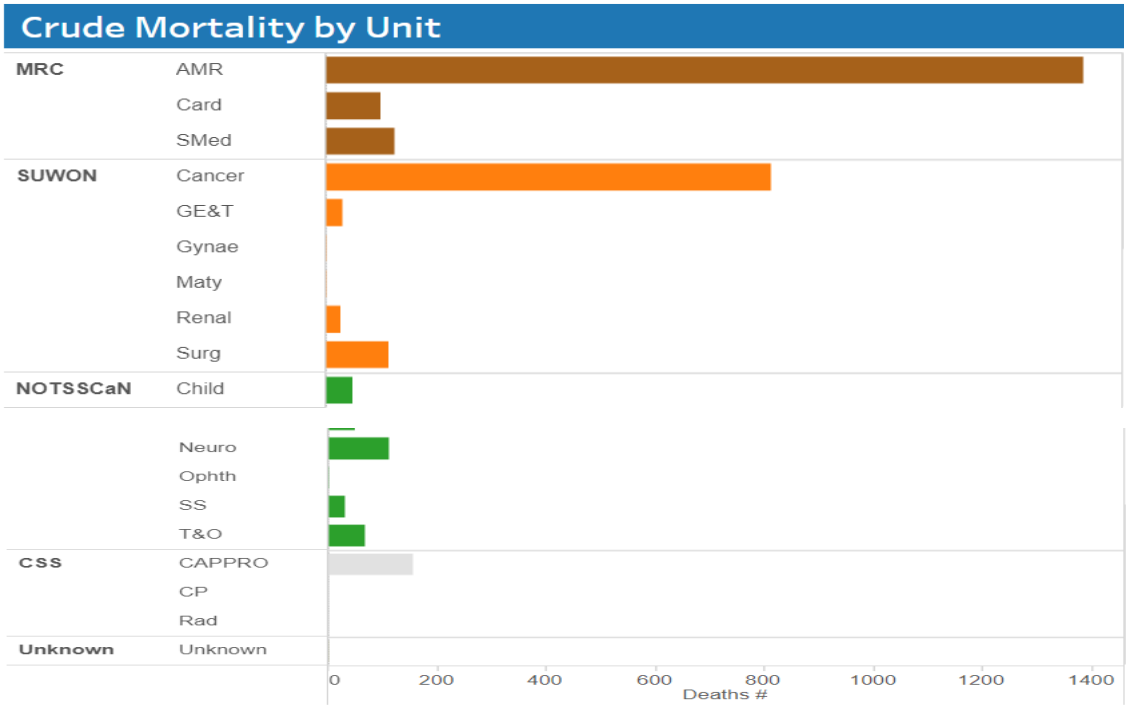


10.3. The highest number of deaths occur in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (table 4, chart 6. This is consistent with previous reports.

10.4. Table 4: Crude mortality by Clinical Division, Quarter 4 of 2024/25

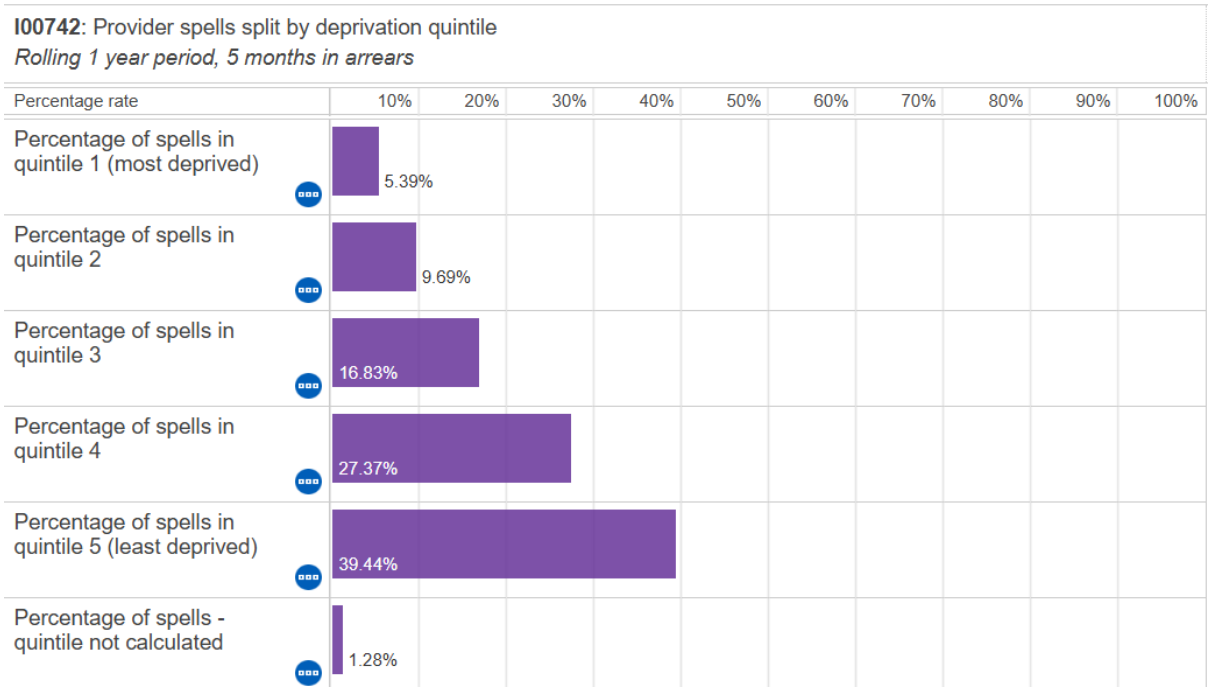
Division	Total Discharges	Number of deaths
NOTSSCAN	16,520	71
MRC	19,722	385
SUWON	19,752	220
CSS	806	31

Chart 6: Deaths by Directorate (annual data)



10.5. *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. This chart demonstrates that the majority of patients admitted to OUH are in the least deprived areas of the region. Detailed interpretation of this data is difficult without adjusting for confounders such as age which may explain much of the observed variation.

Chart 7: % SHMI spells in each deprivation quintile



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 multiple systems (including 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 Trust Board is asked to:

- Note the Learning from Deaths update for Quarter 4 (2024/25).
- Note the findings from Telstra in relation to the increase in HSMR

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 41 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.	Not 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).	Admission type, age, year of discharge, deprivation, diagnosis subgroup, sex, Elix Hauser comorbidity score, emergency admissions in last comorbidity score, emergency admissions in last 12 months, month of admission, source of admission, interaction between age on admission group and comorbidity admission group.

Appendix 2: Background, Policy and monitoring of mortality related actions

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[3] 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. Actions are recording using the trust incident reporting system (Ulysses).
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).

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

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).

CDOP background

9. 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*).
10. Panels are required to review deaths of all children up to the age of 18 years and neonates less than 28 days old. (including babies born before viability, but not those who are stillborn or are terminated pregnancies within the law).
11. 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.