Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 12 July 2023

TB2023.70

Title:	**Learning from deaths report – Quarter 4 2022/23**

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

Board Lead:	**Chief Medical Officer**
Author:	**Jonathan Carruthers - Clinical Outcomes Manager, Helen Cobb – Head of Clinical Governance, Dr Rustam Rea – Interim Deputy Chief Medical Officer**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 4 of 2022/23, performance for the latest available Dr Foster Intelligence data and provides assurance that any highlighted concerns are investigated thoroughly, and appropriate action is taken.

2. During Quarter 4 of 2022/23 there were 619 inpatient deaths reported at OUH. Compliance with mortality reviews as per the agreed policy is presented in Table 1. There were 597 (96%) cases reviewed within 8 weeks. Of these reviews, there were 322 (52%) level 2 and structured mortality reviews completed. The remaining 22 cases have been escalated for review by the relevant Divisions.

3. There was one death occurring during Quarter 4 deemed to be potentially 'avoidable'. This case was investigated as a serious incident (SIRI) and details are included in this report.

4. A detailed analysis of completed structured reviews during the quarter is included in this report.

5. The SHMI for the data period January 2022 to December 2022 is 0.96. This is banded 'as expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion (0.89 – 1.12).

6. The Trust's HSMR is 92.4 for April 2022 to March 2023. The HSMR has decreased and remains banded as 'lower than expected' (95% CL 90.9 – 99). The HSMR excluding both Hospices is 85.4 (95% CL 80.7 – 88.4).

Recommendations

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

Contents

Learning from deaths report – Quarter 4 2022/23

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 4 of 2022/23.

1.2. This report provides a quarterly overview of Trust-level mortality data for the period of Quarter 4: January 2023 to March 2023, performance for the latest available Dr Foster Intelligence data and assurance that any highlighted concerns are investigated thoroughly, and appropriate action is taken.

2. Background and Policy

2.1. OUH is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains 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 mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation.

2.3. The Trust Mortality Review policy requires that all inpatient deaths be reviewed within 8 weeks of the death occurring. All deaths need a mortality review.

2.4. The aim is for all Level 1 mortality reviews to be completed by a Consultant independent of the case however with the current capacity constraints this is not possible in all cases. To mitigate this 25% of Level 1 reviews are selected at random for a Level 2 review and all (100%) of deaths undergo scrutiny from the Medical Examiner's office.

2.5. If there are any concerns identified, a comprehensive Level 2 review is completed involving one or more consultants not directly involved in the patient's care. A structured review, completed by a trained reviewer who was not directly involved in the patient's care, is required if the case complies with one of the mandated national criteria - NHS England » Learning from deaths in the NHS.

2.6. Each Division maintains a log of actions from mortality reviews and monitors progress by their clinical units. The clinical units are responsible for disseminating learning and implementing the actions identified.

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

2.8. The Divisions provide updates on actions in the monthly quality reports to the Clinical Governance Committee (CGC). The Divisions also provide updates to the Mortality Review Group (MRG) on the previous quarter's actions as part of the next quarter's mortality report. The Mortality Review Group reports to the Clinical Improvement Committee.

3. Mortality reviews during Quarter 4 of 2022/23

Table 1: Number of mortality reviews completed during Quarter 4 of 2022/23:

Total deaths	Total reviews (L1, L2 or SJR)	Deaths not reviewed within 8 weeks
619	597	22

3.1 During Quarter 4 of 2022/23 there were 619 inpatient deaths reported at OUH. Compliance with mortality reviews as per the agreed policy is presented in Table 1. There were 597 (96%) cases reviewed within 8 weeks. Of these reviews, there were 322 (52%) level 2 and structured mortality reviews completed.

3.2 Trust wide, there were 14 structured reviews completed during Quarter 4 of 2022/23. The reasons for completing the structured review include individuals with a learning disability, concerns raised by staff of families and concerns raised during the Medical Examiner scrutiny. Learning and recommendations from the completed structured reviews are included in this report.

3.3 During Quarter 4 of 2022/23, there was one patient death at the OUH judged potentially 'avoidable'. Details of this case are outlined in the section 4 of the report.

4. Potentially 'avoidable' death SIRI findings

4.1. A patient who underwent a knee replacement procedure at a private provider deteriorated and died shortly after transfer to the OUH. Concerns with the care provided were identified following completion of a structured mortality review.

4.2. Themes from the investigation concluded there were issues with communication, diagnostic tests, and escalation of care.

4.3. A Serious Incident Requiring Investigation (SIRI) report was completed jointly between OUH and the private provider. This was later escalated to a systems wide serious incident which is now being managed by the Integrated Care Board (ICB). The OUH SIRI final report was discussed at the May Mortality Review Group meeting.

4.4. **Recommendations:**

4.5. To consider if acutely unwell patients should be transferred directly to Horton ED for assessment due to the lack of clinical experience of staff at the private provider in diagnosing acute problems and making referrals – action due for completion 31/10/2023.

4.6. Ensure on call junior doctors have access to the Horton Emergency Assessment Unit standard operating procedure – action completed.

4.7. Ensure key medical and nursing staff are aware of the blood gas analyser status when processing samples and know the location of nearby machines on site – action completed.

4.8. Ensure key medical and nursing staff are aware of the Recognising the Acutely Ill and Deteriorating (RAID) policy which contains information regarding Track & Trigger monitoring – action due for completion 31/07/2023.

5. The Medical Examiner system

5.1. 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, ensure appropriate direction of deaths to a Coroner, provide a better service for the bereaved, provide an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data.

5.2. The MEs have been scrutinising deaths within the Acute Trust since June 2020.

5.3. This additional scrutiny has revealed the high quality of clinical notes on EPR. Feedback from the bereaved during telephone discussions reflect a generally high degree of satisfaction for the care provided in the Trust. Any concerns or compliments raised by MEs or the bereaved are fed back through the central Learning from Deaths email and then shared appropriately with clinical teams. Many of these incidents had already been recognised and referred to the Trust's Patient Safety processes or to PALS.

5.4. Medical Examiners (ME) and Medical Examiner Officers (MEO) are working closely with the Regional ME, the National ME and the Coroner's Office to extend the service to scrutinise deaths within the local hospices and in the community setting during 2023-24. Any issues identified with this extension into the community have been raised to the National Medical Examiner. There will be progress reports to the National ME office every quarter.

5.5. The Medical Examiners have monthly meetings to review progress and discuss cases. The feedback received by the MEs from bereaved families as to how they are informed of the deaths of their relatives has led to discussion and review of processes clinically. Examples include escalation of reviews to trust level structured review/SIRIs and changes to death documentation processes.

5.6. The feedback received by the MEs has been shared promptly with the ward teams. This has raised the profile of the ME system within the Trust and clinical teams are recognising and appreciating the ME role as an independent part of the existing Bereavement system.

5.7. The opportunity for families to discuss the care their relative received with an ME has been positively received.

5.8. The Lead Medical Examiner is meeting with external stakeholders ahead of the community roll out. Scrutiny of hospice deaths is established. Meetings with the local ICS and two neighbouring ME Offices are underway to allow introduction of the ME service to the Community. There is capacity among the MEs to start this with further recruitment of MEs and MEOs already under way.

5.9. Data on the activity of the Trust's ME service are submitted every quarter to the National Medical Examiner. The data for 2022-23 provide evidence of the successful roll-out of the ME service for scrutiny of acute deaths, with a progressive increase in the proportion of deaths having been scrutinised each successive quarter:

Chart Title

Legend: ■ Acute deaths ■ Non-acute deaths
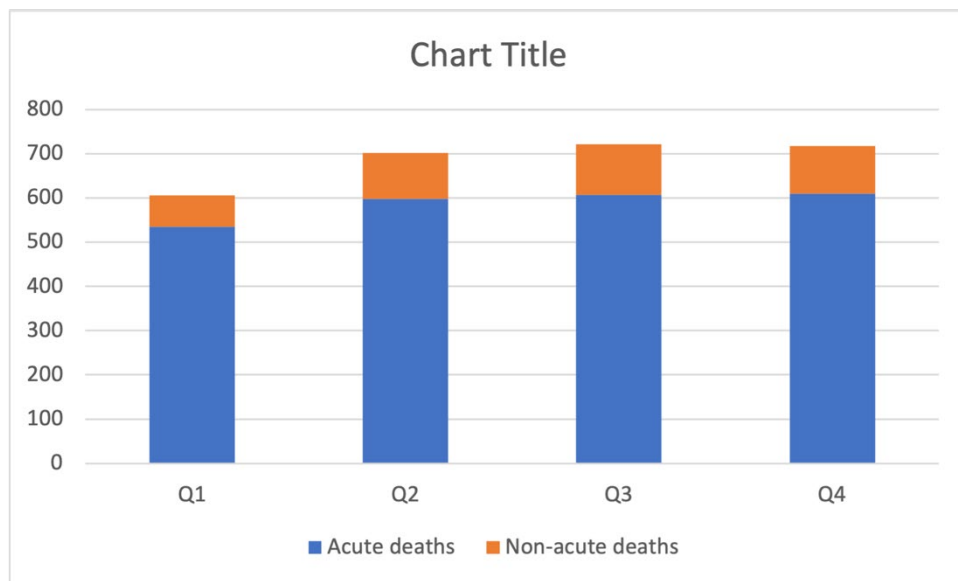
5.10.   By Q4, the total number of acute deaths scrutinised (excluding stillbirths which are not scrutinised by MEs) was 601, of which 10 were deaths of children.

5.11.   72 deaths were accepted by the coroner for investigation. 81 deaths had an Medical Certified Cause of Death (MCCD) issued after referral to the coroner (Part A), of which 64 were scrutinised.

5.12.   The number of MCCDs not completed within 3 calendar days in Q4 was 68, which was by far the lowest of any quarter that year.

5.13.   The number of deaths in Q4 for which a concern was raised through Learning from Deaths was 14.

5.14.   During 2022-23, there were 31 deaths where a rapid release for faith reasons was requested and only one was not achieved.

5.15.   The scrutiny of non-acute deaths was limited to deaths in the adult hospices which increased during the year. In Q4, 109 non-acute (Hospice) deaths were reported through the Trust, of which 7 were referred to the coroner. No ME scrutiny occurred in 18 cases, giving a total scrutiny proportion of 82%.

5.16.   Plans for 2023/24:

5.16.1.   The ME service for the scrutiny of acute deaths is well established. There are still improvements that can be made to speed up the process and to increase the early availability of the Death Notification Summary. The scrutiny of child deaths has started.

5.16.2.   The non-acute deaths which are currently scrutinised are those occurring on the hospices, but there remains some work to do to ensure that all cases are covered.

5.16.3.   The expansion of the ME service to primary care will be the principal challenge of the coming year. National initiatives are under way, including a recent message to all doctors from the National Medical Director.

5.16.4.   The National ME and Undersecretary of State have outlined new guidance to be available on autumn 2023.

5.16.5.   Two new "community" MEOs started in June. The ME Office will be contacting all GP surgeries in the county to reintroduce the ME system, which will be followed up by webinars during the summer.

5.16.6.   There is IT support within the Trust and within the BOB ICB to support the introduction of a means of communication with the GP practices for referral of deaths.

5.16.7.   Further recruitment of 0.4 WTE ME during 2023 will enable the ME Office to deliver the service for all deaths in Oxfordshire.

5.17.   As host Trust, the OUHFT has provided the support necessary to develop the ME Service in Oxfordshire.

6. Child death overview process

6.1. The statutory requirement to establish a panel that would review every child death in their local area has been in place since 2006 (section 14 of the Children Act 2004). These regulations were further developed in Working Together to Safeguard Children (2018).

6.2. The specific functions as laid down in the statutory guidance require the panel to review the available information of deaths of all children up to the age of 18 years. This includes the deaths of infants less than 28 days, including those born before viability, but not those who are stillborn or are terminated pregnancies within the law.

6.3. The Oxfordshire child death overview process (CDOP) is committed to the process of systematically reviewing all children's deaths, ensuring the child death review process is grounded in respect for the rights of children and their families and focuses, where possible, on preventing future child deaths.

6.4. The administration of the Oxfordshire CDOP is hosted by Oxfordshire Integrated Care Board (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.

6.5. All cases were reviewed in a multidisciplinary forum. Compliance with National Guidance for child death reporting and review continues at 100%. There were no concerns in care noted following the reviews in Q4 2023.

6.6. There were 12 child deaths in the OUH this quarter, with an additional planned birth and death at home for a baby with an antenatally diagnosed life-limiting condition.

6.7. Of these there were five child deaths in the Newborn Care unit, three in Paediatric Critical Care (PCC), two on the Delivery Suite. There was one child death in the ED and one child death on the ward.

6.8. The Neonatal deaths were predominantly related to complications of prematurity; in later gestation the cause of death was due to congenital anomalies. One term baby died unexpectedly of necrotizing enterocolitis. This latter case was subjected appropriately to statutory multiagency responses for unexpected death.

6.9. Good practice was highlighted wherever noted and included many examples of coordinated palliative care and end of life planning. The South-Central Ambulance Service (SCAS) team were commended for their pre-hospital care in managing a deteriorating child in the field and in a second case for conveying a child where life was ruled extinct, to hospital. Where congenital anomalies or extreme prematurity had been identified antenatally, good plans were put in place to manage neonates in the delivery suite and in the newborn care unit.

6.10. The CHOX ward team were commended for managing a complex patient with a life limiting mitochondrial illness who was transferred back from the quaternary liver centre and died within 12 hours on the paediatric ward.

6.11. The Child Mortality Team attended a GP practice to support the GP's there and coordinated additional psychological support for their trainee.

6.12. An excellent example of coordinated care following an antenatal diagnosis enabled a term baby to be born at home with a robust palliative care plan supported by Helen and Douglas House.

6.13.   Unplanned extubation remains a significant issue on the Newborn Care unit and are all added to the OUH incident system. Efforts are ongoing to contribute to national audit work and a Quality Improvement (QI) project to minimize this risky complication. Details of the QI work (collaboration with the Karolinska Institute, Sweden) are presented to MRG on a monthly basis. A further QI project examining existing access to reflective opportunities for professionals exposed to child death has now been completed and is being analysed. The newly embedded process of fortnightly multidisciplinary psychology-led meetings is due to launch in June 2023.

6.14.   The Neonatal team contributed effectively to the statutory joint agency response required for the unexpected death of a term baby. There is improved liaison following neonatal deaths with the Child Mortality team for advice and support.

6.15.   The imminent involvement of the Medical Examiner (from April 2023) is seen to be an excellent opportunity to build on robust discussions that already occur with families to enhance considered and transparent death certification. It is hoped that feedback from ME contact can be incorporated into learning how to better support bereaved families going forward.

6.16.   Reviews ongoing for issues identified in child death review include antibiotic and diuretic prescribing, hypernatremia guidance, SCAS systems for harnesses and securing infants and children for transfer.

6.17.   There continue to be missed opportunities for Organ Donation following Neonatal death despite some babies dying at or near term. Tissue Donation, mainly feasible in deaths in the paediatric critical care (PCC) and the ED, remains an area for further improvement with no successful episodes of donation in the past quarter. Improving the rates of Tissue Donation is a Trust Quality Priority this year and the service are keen to engage in this work. Actions to improve education and formalize SOP's is ongoing and expected to come to the Organ Donation committee in the next quarter.

6.18.   A gap in consistency and knowledge around verification of death in babies and children has been identified. Work on an SOP is ongoing with formal education to follow.

7. Learning and actions from mortality reviews during Quarter 4 of 2022/23

7.1. The key learning points to emerge from mortality reviews undertaken during Quarter 4 were:

7.1.1.   Early communication to the families when a patient is at the end of life remains a recurring theme. 5th OUH End of Life Care Symposium was delivered 11th of May 2023. Several talks took place on a variety of subjects around Palliative and End of Life Care (EOLC). This was part of the scheduled events for the annual 'Dying Matters Week' held by Hospice UK for which the aim is to create an open culture in which we're comfortable talking about death, dying and grief as well as equipping professionals with the knowledge and skills to improve the quality of all palliative and end of life care.

7.1.2.   A poster has been created informing patients and carers of their right to an interpreter. A Trust Quality Priority regarding 'empowering patients' is also underway, building partnerships and inclusion.

7.1.3.   The need for accurate EPR notes – the importance of not just 'cutting and pasting' and ensuring that the correct senior clinician's name is entered at the top of ward round record remains a theme within MRC. A Trust Safety Message (weekly safety message 194) has been circulated to staff highlighting this.

7.1.4.   Highlighting that child death reporting systems applies to all children from birth to 18 years of age including any adolescent on an adult ward (AICU, Neuro ICU, Maternity).

7.1.5.   Lessons learned following a SIRI led by SUWON Division were shared trust wide to increase awareness of importance of acting on radiology alerts.

7.1.6.   The Transplant team are striving to improve compliance with the Trust standard to endorse 90% of test results within 7 days following the completion of a SIRI. Overall, Trust endorsement rate is 82.2% and digital solutions are being explored to support improvement, with involvement from the Quality Improvement Team.

7.1.7.   In complex and challenging cases, the vascular department recommends that two consultant vascular surgeons should be required.

7.1.8.   Patients who require AAA repair need to be seen in person in clinic at least once prior to undergoing surgery. All CT angiograms performed to assess AAA are required to have a comment in the report regarding the venous anatomy.

7.1.9.   Induction documents must be made available for locum juniors in specialties they are not familiar with explaining how to contact team members for support.

7.1.10.   Development of guidance for ward staff for stepdown care of patients recently discharged from ITU to the neuroscience ward, to include guidance on nature and minimum frequency of observations in this group.

7.1.11.   Any patient who has demonstrated sensitivity to opioids and required naloxone should have a review of their analgesia prescription as a matter of urgency, and a review by pain team (or on-call anaesthetist if out of hours) for advice.

7.1.12.   Education package/guidance for all OUH staff concerning transition of care of young adults with learning disabilities, including pain assessments in non-verbal patients.

7.1.13.   A Safety message has been circulated to all staff regarding opioid prescribing. Further local teaching has also been delivered within the Pharmacy department.

7.1.14.   Strong opioids must not be administered to any patient if the appropriate observations have not happened and if equipment to perform these observations is missing or broken then this must be escalated as far as required until this is resolved.

7.1.15.   Teaching for existing neurosciences ward staff, and new ward staff on induction, regarding the requirements for observations including oxygen saturation monitoring in all patients on morphine, including the need for escalation if appropriate equipment cannot be found. Explore ward champion role for staff support.

7.1.16.   Explore analgesia options for adult patients with learning disability or those who cannot use patient-controlled analgesia (PCA).

7.1.17.   Increased use of hospital passports[1] and the benefits were highlighted as part of a SIRI and several structured mortality reviews.

8. Patient safety incidents with an impact of death and subsequent SIRI investigations declared during Quarter 4

7.1 Three incidents with an impact of death were declared as a Trust Level Serious Incident Requiring Investigation (SIRI) during Quarter 4 2022/23.

7.2 These concerned:

7.2.1   A patient developed a hospital-associated methicillin-resistant Staphylococcus aureus infection that may have been preventable.

7.2.2   A haematology patient developed unrecognised tumour lysis syndrome leading to cardiac arrest.

7.2.3   A patient discharged from the emergency department with a diagnosis of angina was later found deceased in the community.

7.3 Any SIRI with an impact of death must be presented to MRG upon closure.

7.4 These investigations are currently in progress and any relevant learning will be included in section 6 of future learning from deaths reports.

9. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

9.1. There have been no mortality outliers reported for OUH from the CQC or NHS Digital during Quarter 4.

9.2. The SHMI for the data period January 2022 to December 2022 is 0.96. This is banded 'as expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion (0.89 – 1.12).

---

[1] A hospital passport is a document about a patient and their health needs. It also has other useful information, such as interests, likes, dislikes, how to communicate and any reasonable adjustments that a patient might need.

Chart 1: SHMI trend (Presented with a baseline of 100 to enable comparison to the HSMR)

OUH NHS FT SHMI trend
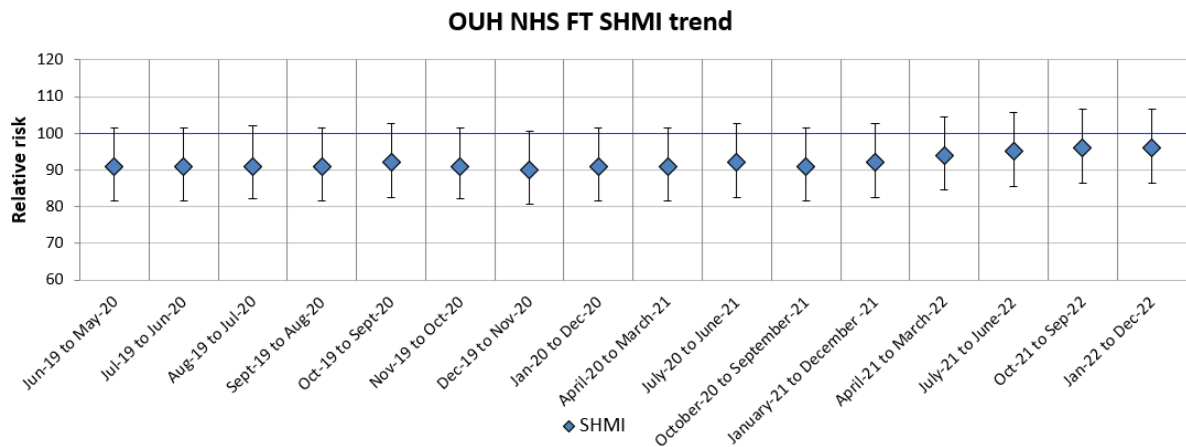
9.3. This chart shows the SHMI trend at various reporting points over between June 2019 and December 2022. The SHMI figure has consistently been between 0.9 and 0.96 which is within the 'as expected' band. As expected, means that the OUH is not an outlier.

9.4. The Trust's HSMR is 92.4 for April 2022 to March 2023. The HSMR has decreased and remains banded as 'lower than expected' (95% CL 90.9 – 99). The HSMR excluding both Hospices is 85.4 (95% CL 80.7 – 88.4).

9.5. Chart 2 depicts the HSMR trend. This chart demonstrates the trust has been classified 'as expected' or 'lower than expected' across the reporting period. This again demonstrates the trust is not an outlier.

9.6. NHS Digital and Telstra have recommended the Trust level SHMI and HSMR data excludes both Katherine House Hospice and Sobell House Hospice due to issues with data adjustment. This has been approved and will be reflected in future learning from death reports for OUH.

Chart 2: HSMR trend & comparison with Teaching Hospitals:

OUH NHS FT HSMR trend

| Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	🔔1 🔺4	87635	2715	2275.3	3.1	119.3	
LEEDS TEACHING HOSPITALS NHS TRUST	🔔2	57515	2430	2171.6	4.2	111.9	
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	🔺2	89580	2300	2065.0	2.6	111.4	
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	🔔6 🔺1	66185	2405	2197.0	3.6	109.5	
BARTS HEALTH NHS TRUST	🔔5 🔺1	58785	2320	2190.0	3.9	105.9	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	🔔6	53330	2010	2091.2	3.8	96.1	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	🔔1	78015	1645	1732.2	2.1	95.0	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	🔔6	67614	2204	2384.6	3.3	92.4	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	🔔18	54190	665	890.7	1.2	74.7	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	🔔51	68500	1530	2064.0	2.2	74.1	

10. Analysis of mortality during Quarter 4:

10.1.   The highest number of deaths were admitted to the Acute Medicine and Rehabilitation (AMR) Directorate under the MRC Division (Chart 4). For comparison, section 10.2 includes information relating to total discharges vs mortality by Division.

10.2.   There is no ethnicity data included in this report as it is in the process of being improved. This is part of a Quality Priority this year and once the data collection has improved, from containing a lot of 'unknown' this will be included and analysed. Ethnicity data for 2022/23 will be included in the annual Learning from Death reports.

Chart 4: Deaths by Directorate

Crude Mortality by Unit
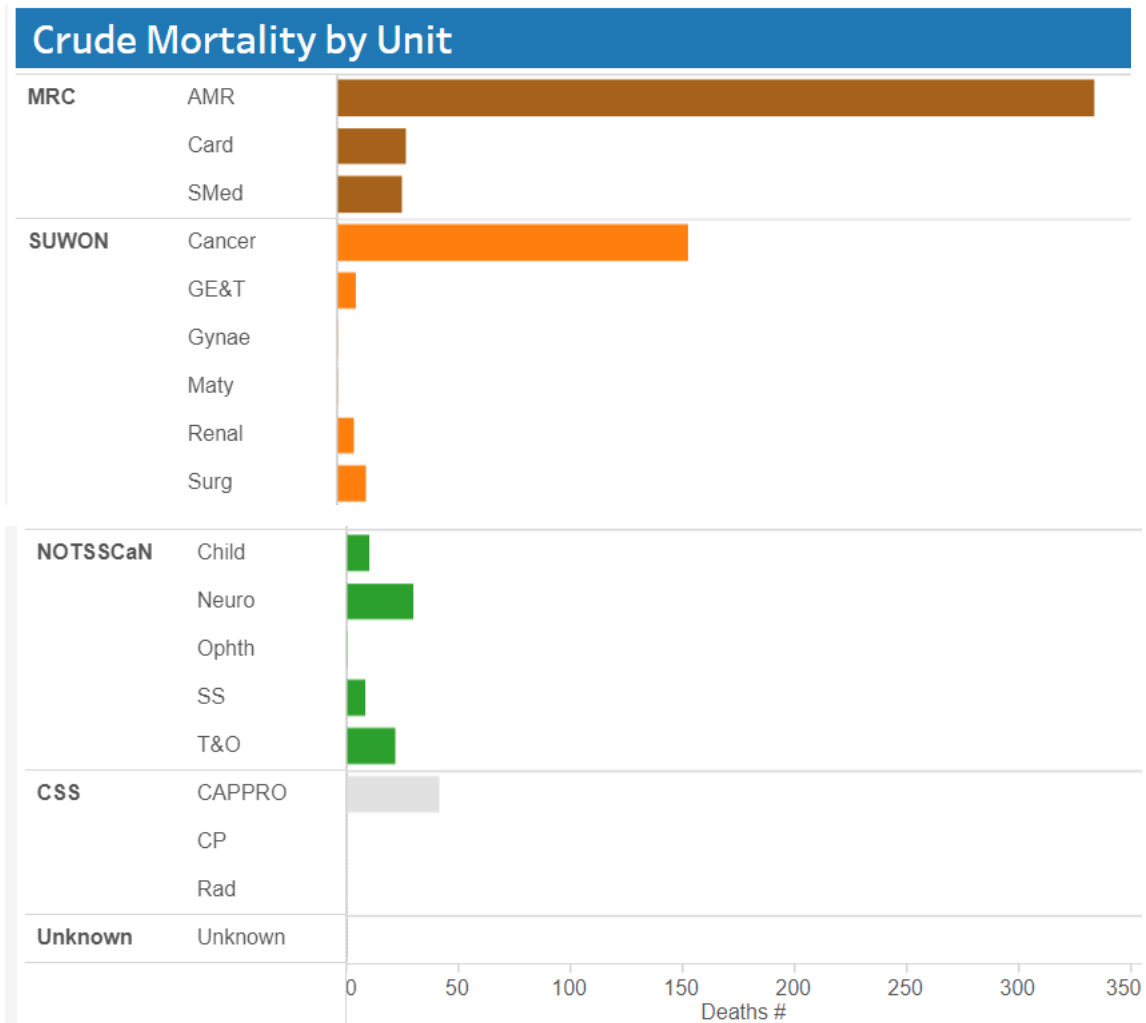
10.3.   NHS Digital reference the same spell level information which was used to calculate the SHMI to report the percentage rates of deaths under each social deprivation quintile.

10.4.   Deprivation quintiles are calculated using the Index of Multiple Deprivation (IMD) Overall Rank field in the Hospital Episodes Statistics (HES) dataset which is based on a weighted combination of factors such as income; employment; health deprivation and disability; education, skills, and training; barriers to housing and services; crime and living environment.

10.5.   Chart 5 displays the percentage breakdown of spells and deaths by deprivation quintile. There is a marginally higher percentage of deaths in

quintiles 4 and 5 relative to the percentage of spells attributed to those
quintiles. This pattern is in line with previous LFD reports.

Chart 5: % SHMI spells and deaths by deprivation quintile

**I00742**: Provider spells split by deprivation quintile
Rolling 1 year period, 5 months in arrears

Percentage rate	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Percentage of spells in quintile 1 (most deprived)	5.24%									
Percentage of spells in quintile 2	9.38%									
Percentage of spells in quintile 3	16.91%									
Percentage of spells in quintile 4	27.49%									
Percentage of spells in quintile 5 (least deprived)	39.52%									
Percentage of spells - quintile not calculated	1.45%									

I00743: Deaths split by deprivation quintile
Rolling 1 year period, 5 months in arrears

Percentage rate	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Percentage of deaths in quintile 1 (most deprived)	4.78%									
Percentage of deaths in quintile 2	6.91%									
Percentage of deaths in quintile 3	16.63%									
Percentage of deaths in quintile 4	27.57%									
Percentage of deaths in quintile 5 (least deprived)	43.26%									
Percentage of deaths - quintile not calculated	0.84%									

11.   Crude Mortality

11.1.   Crude mortality gives a contemporaneous, but not risk-adjusted, view of mortality across OUH.

Chart 6: Crude mortality rate by Finished Consultant Episodes (FCEs)
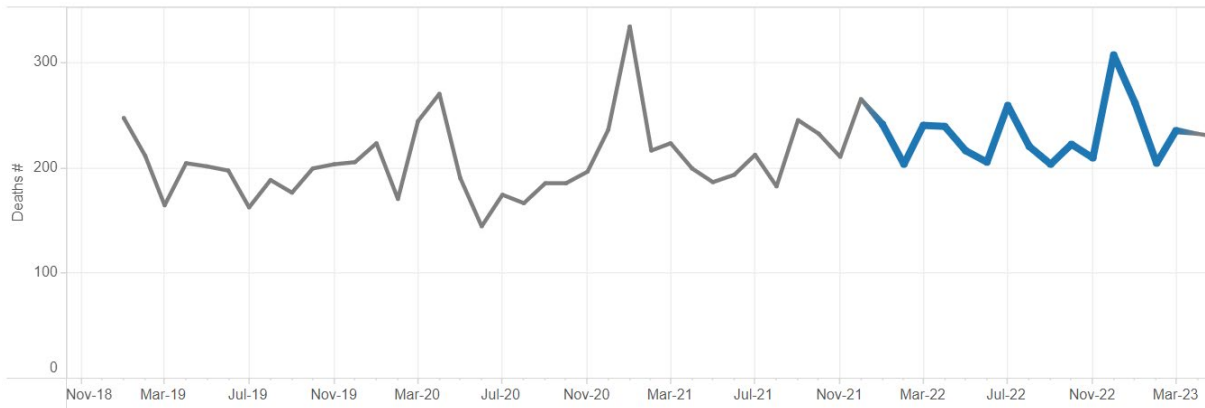

11.2.   During Quarter 4 of 2022/23:

Division	No of deaths in Q4 22/23	Total Discharges
Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's, and Neonatology Division	72	15,421
Medical Rehabilitation and Cardiac Division	398	16,543
Surgery, Women's, and Oncology Division	187	19,065
Clinical Support Services Division in the Critical Care Units	43	706

11.2.1.   These figures are in line with previous reporting quarters.

11.2.2.   Chart 7 depicts the crude mortality by hospital site. Most deaths occur at the John Radcliffe Hospital which has the highest activity.

Chart 7: Crude mortality by Site

Crude mortality by Hospital Site
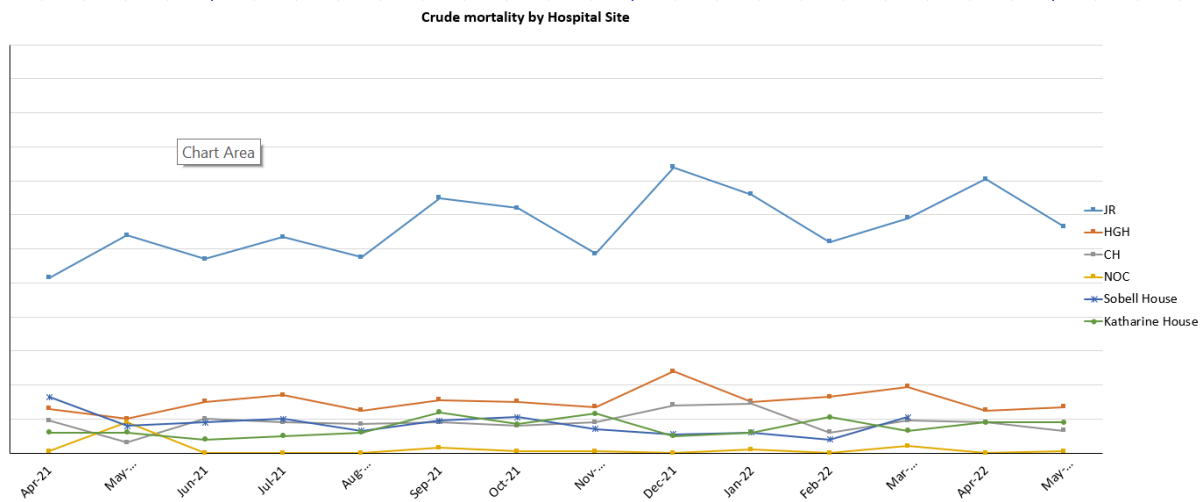
12.   Corporate Risk Register and related Mortality risks

12.1.   Relevant mortality risks from the Corporate Risk Register can be seen below:

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

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

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

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

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

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

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

13.   Mortality Review Governance

13.1.   A quarterly summary of Directorate and Divisional mortality reports from their respective mortality and morbidity reviews are presented to the monthly Mortality Review Group (MRG) Chaired by the Deputy Chief Medical Officer.

13.2.   Monthly MRG summary reports are then presented to the Clinical Improvement Committee (CIC) which is Co-Chaired by the Director of Clinical Improvement and a Divisional Nurse.

13.3.   CIC reports to Clinical Governance Committee (CGC), Chaired by the Chief Medical Officer or the Chief Nursing Officer.

13.4.   CGC reports via Trust Management Executive to the Integrated Assurance Committee (subcommittee of the Trust Board).

14.   Recommendations

14.1.   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'.

Table 5: 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.