

Cover Sheet

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Title: Learning from deaths report – Quarter 2 2023/24

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Executive Summary

1. This paper summarises key learning identified in mortality reviews completed for Quarter 2 of 2023/24; 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 2023/24 there were 652 inpatient deaths reported at OUH. 644 (99%) deaths were reviewed within 8 weeks, including 305 (47%) level 2 and structured mortality reviews.
3. No deaths in this quarter were deemed to be 'avoidable'.
4. No prevention of future deaths (PFD) notices were received by the Trust in Quarter 2 of 2023/24. The Trust responded to one PFD from Quarter 4 of 2022/23.
5. The SHMI for July 2022 to June 2023 was 0.93 (0.89 - 1.12). This is banded 'as expected'.
6. The Trust's HSMR was 88.8 (85.1 - 92.6) for September 2022 to August 2023. The HSMR has decreased and remains banded as 'lower than expected'. The HSMR excluding both Hospices was 80 (71.5-97.6).

Recommendations

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

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Learning from deaths report – Quarter 2 2023/24

1. Purpose

- 1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 2 of 2023/24: July 2023 to September 2023.
- 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 domains¹ 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 mortality review. This review is allocated to the responsible Consultant via the electronic prescribing system (EPR). A minimum of 25% of Level 1 reviews are selected at random for a more detailed 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 2023/24

- 3.1 During Quarter 2 of 2023/24 there were 652 inpatient deaths of which 644 (99%) were reviewed within 8 weeks, including 295 (45%) level 2 and structured mortality reviews (table 1). This was despite the additional pressures of industrial action.
- 3.2 10 Structured Judgement Reviews (SJRs) were completed. The reasons for completing an SJR 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	2625	1349	2625	2692
2023/24 (Q1)	634	628 (99%)	291 (46%)	628 (99%)	634
2023/24 (Q2)	652	644 (99%)	295 (45%)	644 (99%)	644

*including reviews completed after 8 weeks

- 3.4 No prevention of future deaths (PFD) notices were received in Quarter 2 2023/24.
- 3.5 The Trust responded to one PFD from Quarter 4 2022/23. Concerns raised involved multi-agency working between Oxford Health and OUH, sharing of

information, care co-ordination and liaison with Oxford Health. All actions identified in the response have been completed: Oxfordshire CAMHS Service Manager for Getting Help and Getting More Help has presented the outcome of the Inquest to the working group for improving the care of young people who are neuro diverse in Getting Help and Getting More Help; as well as to the Oxfordshire Partnership Improvement group with the Head of Service for Getting Help and Getting More Help.

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 progress:

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

4.3. As of Q2 2023/24, 100% of all adult Hospice deaths are also now reviewed by the Medical Examiners.

4.4. All child deaths within the Trust (excluding Stillbirths which are not scrutinised by the ME Service) are now being scrutinised by the ME Service, which has revealed a need to widen the availability of clinical information in the perinatal period for a few deaths within the Neonatal Intensive Care Unit, but these are being addressed in partnership with the ME Service and clinical units.

4.5. Supported by recruitment of a further 0.4 WTE ME during 2023, the OUH ME Service is working closely with BOB ICB and neighbouring ME Offices to support extension of the ME service to Primary Care, which remains a challenge nationally.

4.6. The Oxfordshire ME Office was visited by the Regional Medical Examiner and Medical Examiner Officer 16 October 2023. A formal report is awaited.

4.7. There are still improvements that can be made within OUH to speed up the process and to increase the early availability of the Death Notification Summary with actions listed below.

- 4.8. The ME team has delivered teaching on “Death, the Coroner and the Medical Examiner” on the Foundation Year Doctors programme (September) and the final year medical students’ Laboratory Medicine course (October).
- 4.9. The Lead Medical Examiner is working with Neurosurgery to improve death documentation (death notification summaries and level 1 electronic mortality reviews) following review at the December Mortality Review Group 2023 meeting.

5. Child death overview process

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, 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 Oxfordshire 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 progress:

- 5.4. There were 12 child deaths in the OUH this quarter. All cases (100%) underwent a multidisciplinary review. No care quality concerns were identified in any of the cases reviewed.
- 5.5. Unplanned extubation was an arising theme in previous quarters on the Newborn Care unit. The neonatal team are participating in a national audit and a Quality Improvement (QI) project to minimize the risk of unplanned extubation. This has seen a reduction in incidents of unplanned extubation reported on the Trusts incident management system.
- 5.6. Following a QI project to increase opportunities for professionals exposed to a child death, a new process of fortnightly psychology-led MDT meetings was launched in June 2023.
- 5.7. Routine Medical Examiner review of all child deaths (except still births) has identified a lack of communication with families at end of life in some

previous cases. This feedback has been shared with the teams and these issues have significantly reduced this quarter, suggesting a positive impact of the ME review process on learning and improvement.

- 5.8. There continue to be missed opportunities for organ and tissue donation following neonatal deaths. Improving the rates of Tissue Donation is a Trust Quality Priority this year and the service are engaged in this ongoing project. A standard operating procedure (SOP) for tissue donation has been created and awareness has improved.
- 5.9. A gap in consistency and knowledge around verification of death in babies and children had been identified. Work to raise awareness of this is ongoing, supported by the Medical Examiners. A new SOP and algorithm for all liveborn babies and children up to 18 years of age has been ratified by the Children's quality and governance committee. The system is based on the existing trust verification SOP.

6. Learning and actions from mortality reviews

- 6.1. *Coordinated communication in SEU*: Family feedback to Surgical Emergency Unit highlighted the issues one family encountered arising from multiple admissions of their relative who received care from 3 specialist teams, had 2 potential diagnoses under review, and had multiple co-morbidities which led to unclear communication. This case was discussed at the Surgical Directorate Governance Meeting. Cases of this nature are increasingly common. The consensus of the discussion was that these cases required a strategic lead to maintain a clear focus throughout the journey which would underpin communication. SEU have now introduced a weekly meeting involving the peri-operative team and associated specialties and a further team meeting later in the week to support clearer communication for staff, patients and relatives.
- 6.2. *Anticoagulants*: One case in Oncology (SUWON Division) highlighted issues around appropriate dosing of subcutaneous anticoagulants. A learning MDT review will be arranged to discuss and look for learning and improvement safety actions.
- 6.3. *Death notification*: Work continues across the Trust to further improve timely completion of death notification summaries level 1 mortality reviews. The Lead Medical Examiner is working with Neurosurgery to support improvements in this area.
- 6.4. *Patient transfers*: A theme has been identified where transfer to OUH was delayed or not appropriate, most notably in the vascular and neurosurgery services. Informative feedback has been provided to referring hospitals.

- 6.5. *Review of observations in the JR trauma service*: Cases have been identified in which the most recent observations were not reviewed/documentated at ward rounds with potential lost opportunities to recognise deterioration. Standards for review and documentation of observations on ward rounds have since been agreed.
- 6.6. *Managing bereavement in Children's and Neonates*: Due to challenges conducting 'hot debriefs' of fatal cases during a busy shift and a need for more opportunities for discussion and reflection later, a working group is developing a formal half day of training for Paediatric, Paediatric Critical Care and ED staff. This training package will be rolled out in 2024 and cover understanding grief and supporting bereavement in families and staff following child death.
- 6.7. *Recognition and response to deterioration*: In the light of out of hours admissions to ICU of patients who would have benefitted from senior MDT discussion in hours to establish clear ceilings of care, work is ongoing to improve early recognition of deteriorating patients and timely referral to ITU. This includes a proposal to establish an ICU outreach service.
- 6.8. A review is underway of all patients who died during periods of industrial action to identify any issues or themes related to industrial action. Feedback will be provided to MRG, with any relevant learning included in the quarter 3 LFD report.
- 6.9. *The Mortality Review Policy* was updated in line with the three-year review. Updates based on learning from previous deaths include addition of the process OUH must follow when a patient dies externally to the trust with OUH involvement during the treatment pathway; and clearer guidance on Mortality and Morbidity (M&M) meetings.

7. Review of potential excess deaths related to long ED waits

- 7.1. On 7 November 2023, an article was published in the Health Services Journal (HSJ) which explored the risk of mortality from excess waits in Emergency Department. Data for all acute trusts was included. The *HSJ* analysis of official data estimated 29,145 'excess deaths' occurred nationally because of long ED waits in 2022-23, up from 22,175 in 2021-22, and 9,783 in 2020-21.
- 7.2. The analysis followed a methodology used in a peer-reviewed [study published in the *Emergency Medicine Journal*](#), which found delays to hospital admission for patients of more than five hours from time of arrival at A&E were associated with an increase in all-cause mortality within 30 days.

7.3. According to the HSJ article, in the OUH 42% of 25,015 admissions waited 6 hours or more. The authors estimated 140 excess deaths had occurred at the OUH due to long ED waits.

7.4. A review is currently underway in collaboration with BOB ICB to identify and review all deaths since April 2020 for which a long wait in ED has been identified as a contributory factor. This review will also explore any potential impact of ethnicity, health inequalities and long-term conditions. The findings of this review will be reported in the quarter 3 LFD report.

8. SIRI and PSII investigations of incidents resulting in death during Quarter 2

8.1. Four incidents with an impact of death were declared as a Serious Incident Requiring Investigation (SIRI) during Quarter 2 2023/24.

8.1.1. Two cases involving intra-uterine deaths were reported. Both cases are being investigated by HSIB.

8.1.2. A maternal death occurred at 26 weeks in a woman with terminal liver metastases.

8.1.3. A patient had an unwitnessed fall and later died.

8.2. The findings of all SIRIs (and Patient Safety Incident Investigations (PSIIs) under the new PSIRF framework) 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.

9. National mortality benchmark data

9.1. There have been no mortality outliers reported for OUH from the Care Quality Commission (CQC) or NHS Digital during Quarter 2 2023/24.

9.2. The Summary Hospital-level Mortality Indicator (SHMI) for July 2022 to June 2023 is 0.93. This is banded 'as expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion (0.89 – 1.12).

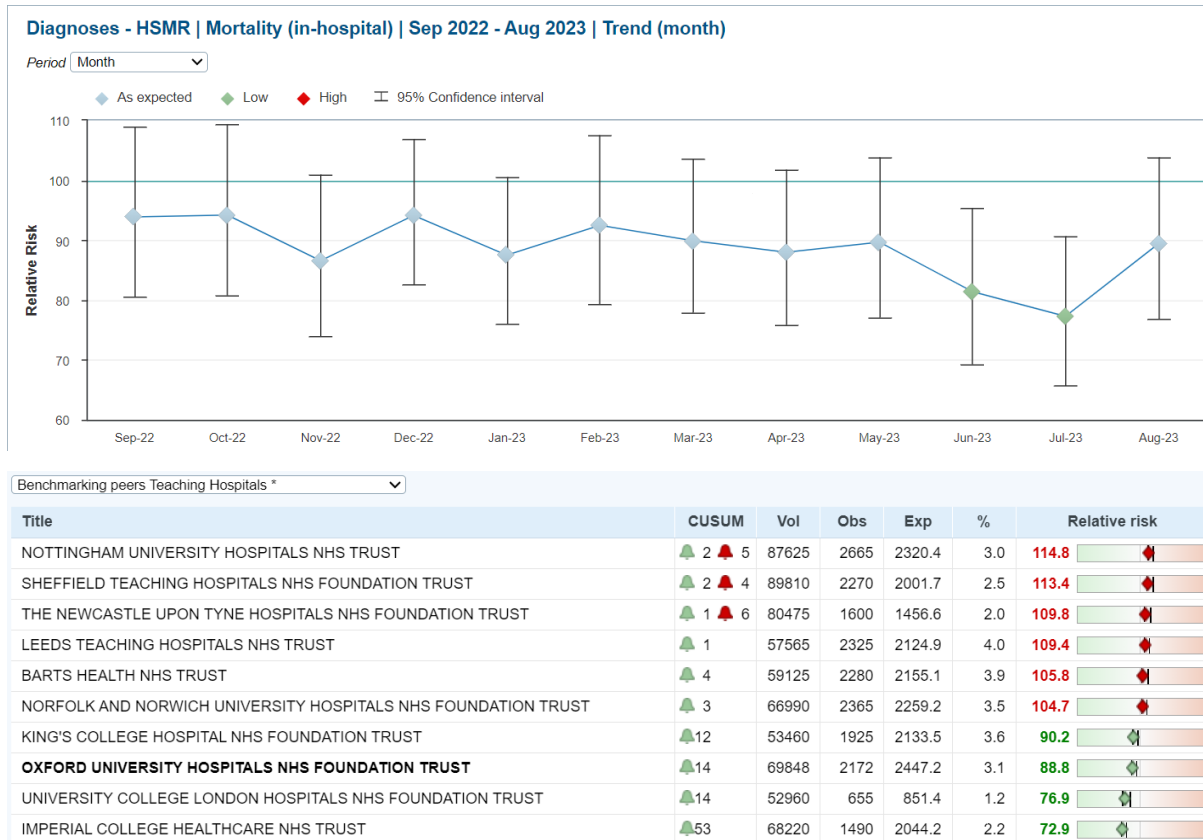
9.3. The Trust's Hospital Standardised Mortality Ratio (HSMR) is 88.8 (95% CL 85.1 – 92.6) for September 2022 to August 2023. The monthly HSMR trend is shown in chart 2. The HSMR has decreased and remains banded as 'lower than expected'. The HSMR excluding both Hospices is 80 (71.5-97.6).

9.4. NHS Digital and Telstra (Dr Foster data) have recommended the Trust level SHMI also exclude deaths that occur in the two Trust hospices (Katherine House Hospice and Sobell House Hospice) in line with benchmarked Trusts. Work is underway at NHS Digital to incorporate this for the SHMI and will be

reflected in future learning from death reports for OUH. The HSMR can be presented with and without Hospice data, as per this report.

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

Chart 2: HSMR trend & comparison with Teaching Hospitals:



10. Detailed analysis of deaths during reporting period

10.1. *Crude mortality:* Chart 3 below shows the crude mortality trend. Crude mortality gives a contemporaneous, but not risk-adjusted, view of mortality across OUH. Chart 4 depicts the crude mortality by hospital site. Most deaths occur at the John Radcliffe Hospital which has the highest activity.

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

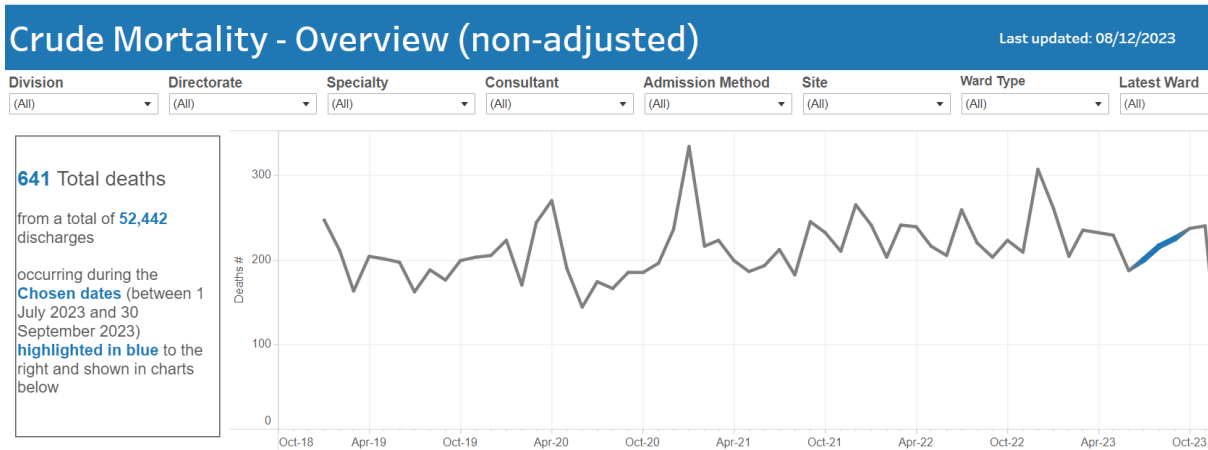
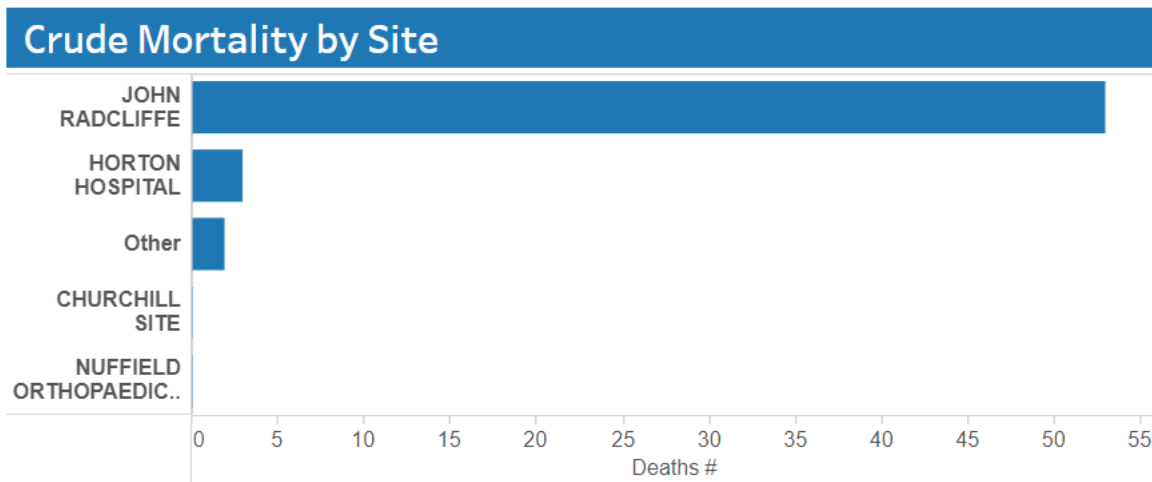


Chart 4: Crude mortality by Site

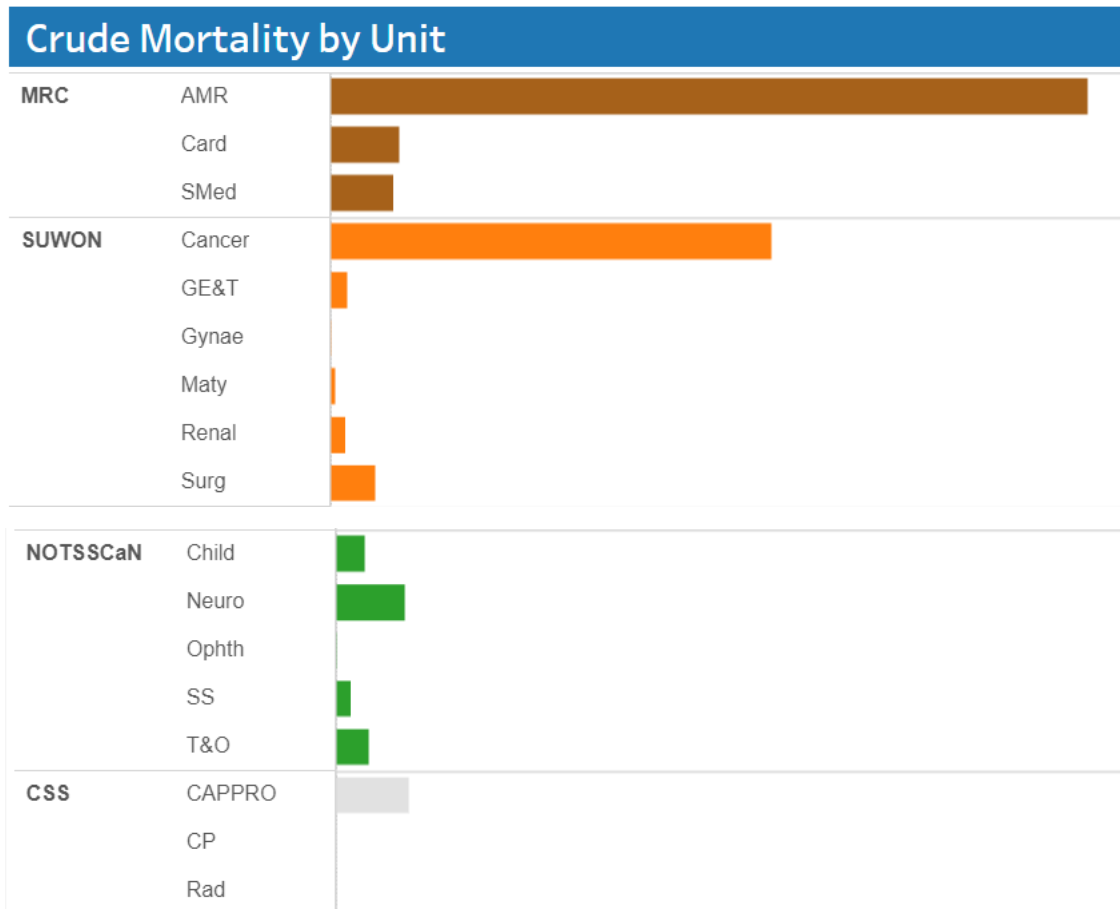


10.2. As usual the highest number of deaths occurred in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (Table 2, Chart 5).

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

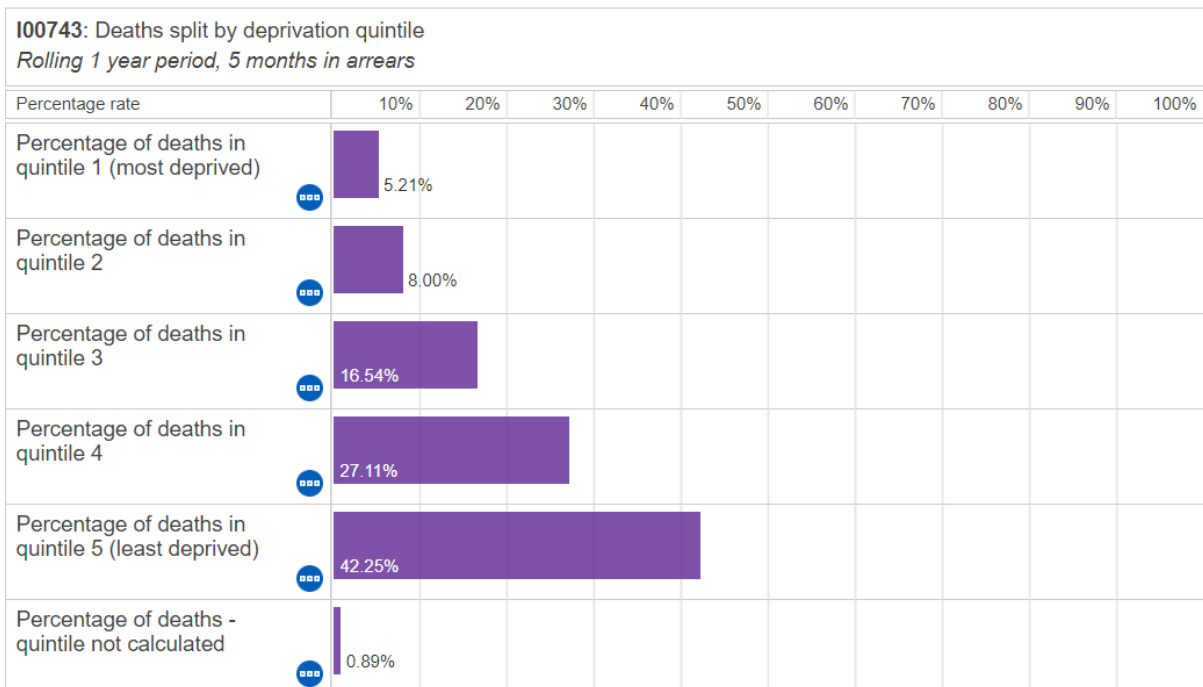
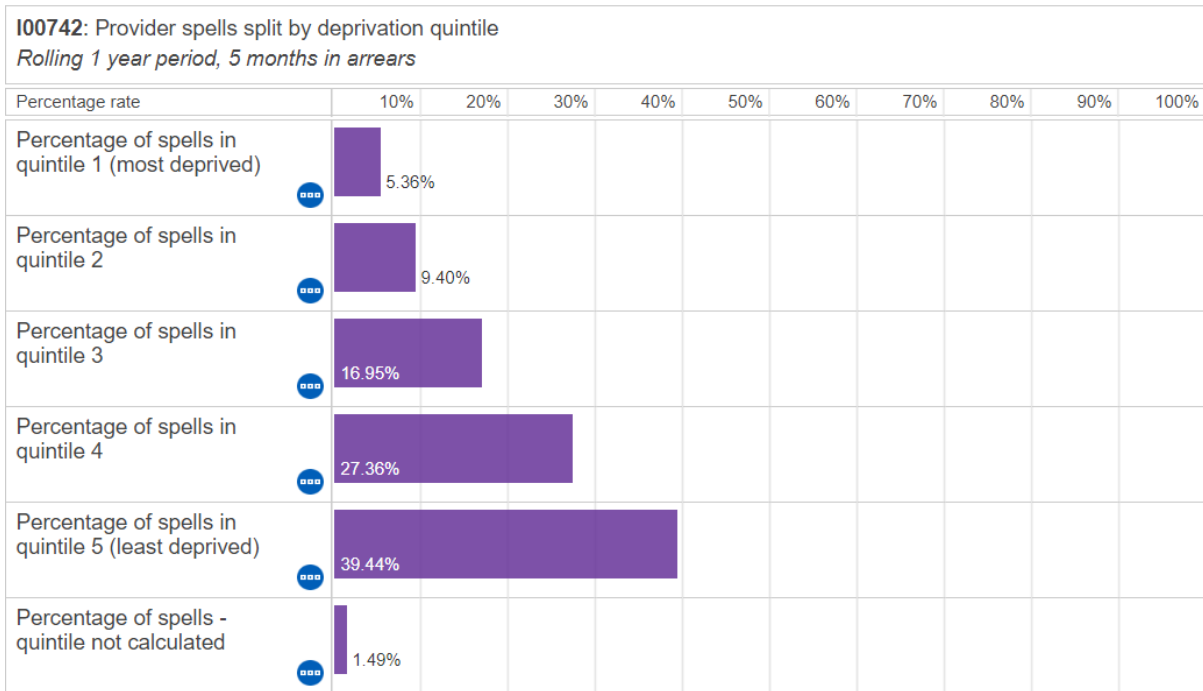
Division	Total Discharges	No of deaths
NOTSSCAN	15,383	58
MRC	17,209	348
SUWON	19,166	206
CSS	668	29

Chart 5: Deaths by Directorate



10.3. *Mortality by Index of Multiple Deprivation:* Chart 6 displays the percentage breakdown of spells and 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 by deprivation quintile



10.4. Ethnicity data is not currently included in this report due to limitations of the data available. Improving ethnicity data is part of a Quality Priority this year.

11. Mortality-related risks in 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 two different systems (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 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.