

## Cover Sheet

Public Trust Board Meeting: Wednesday 10 November 2021

TB2021.95

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**Title:** Learning from deaths report – Quarter Q1 2021-22

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**Status:** For Information

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

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**Confidential:** No

**Key Purpose:** Assurance

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## Executive Summary

1. During quarter 1 of 2021/22 there were 627 inpatient deaths reported at OUH. 601 (96%) cases were reviewed within 8 weeks. Of these reviews, there were 392 (63%) comprehensive Level 2 reviews and 12 (2%) structured mortality reviews.
2. 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.
3. All COVID-19 related deaths are subjected to a Level 1 screening mortality review. There have been no COVID-19 related deaths judged more likely than not to have been due to problems in the care provided.
4. In accordance with national guidance, all probable or definite hospital onset healthcare associated COVID-19 infection deaths are reported and investigated as patient safety incidents.
5. There is one overarching SIRS investigation in progress for all nosocomial COVID-19 probable or definite deaths. Upon completion the report will be presented at a mortality review group meeting.
6. No deaths occurring during Quarter 1 were deemed to be 'avoidable'.
7. The Summary Hospital-level Mortality Indicator (SHMI) for the data period April 2020 to March 2021 is 0.91 and remains rated 'as expected.' The Hospital Standardised Mortality Ratio (HSMR) is 91.2 for the data period April 2020 to March 2021 and remains rated 'lower than expected.'

## Recommendations

8. The Public Trust Board is asked to receive this paper for information and discuss the learning identified from mortality reviews.

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## Learning from deaths report – Quarter Q1 2021-22

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### 1. Purpose

- 1.1. This paper summarises the key learning identified in the mortality reviews completed for quarter 1 of 2021/22.
- 1.2. The approach to reviewing deaths involving COVID-19 is presented with analysis of the cases.

### 2. Background

- 2.1. The Trust Mortality Review policy requires that all inpatient deaths be reviewed within 8 weeks of the death occurring. All deaths have a Level 1 review.
- 2.2. 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.
- 2.3. 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 criteria.
- 2.4. 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.
- 2.5. 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.

### 3. Mortality reviews quarter 1 of 2021/22

- 3.1 During quarter 1 of 2021/22 there were 627 inpatient deaths reported at OUH. The number of mortality reviews completed is presented in Table 1. There were 601 (96%) cases reviewed within 8 weeks. Of these reviews, there were 392 (63%) comprehensive Level 2 reviews and 12 (2%) structured mortality reviews.

**Table 1: Number of mortality reviews completed during quarter 1 of 2020/21:**

Total deaths	Level 1 reviews	Level 2 reviews	Structured reviews	Deaths not reviewed within 8 weeks
627	601	392	12	26

- 3.1 The MRC Medical Director has identified completion of level 1 reviews as a key priority. The Acute Medicine and Rehabilitation Directorate have continued to focus on ensuring level 1 and level 2 mortality reviews are completed. The AMR Directorate generally has the highest number of deaths within the Division of MRC.
- 3.2 Five (1.69%) of the deaths within the Acute Medicine and Rehabilitation Directorate have not had any mortality review (L1, L2 or SJR). These have been flagged to the relevant governance leads to review as a priority. Two reviews have subsequently been completed; the remaining three cases will be discussed at the November mortality meeting. There has been a significant reduction in Q1 of the number of deaths that have not been reviewed. 29 (8.7%) deaths in the previous quarter (Q4 2020/21) did not have any mortality review and these have now been completed.
- 3.1. The Acute General Medicine Clinical Governance lead has worked with the administration team to help support the completion of death notifications. This has helped increase the number reviewed to just under 80% which is the highest level for 18 months.
- 3.2. In Quarter 1, 169 patients died on SUWON inpatient wards, of which 166 (98%) have had a mortality review at level 1, or level 2 as required. The three outstanding cases are awaiting a coroner's report or a post-mortem report to progress the mortality review.
- 3.3. The inadequate number of Level 1 reviews completed in the Neurosurgical and Trauma Services has been the subject of Divisional investigation and action. As a result, the number of Level 1 reviews in each specialty is improving; further improvement is anticipated. A high proportion of these deaths are Coroner referrals, and the clinical areas are awaiting the agreed cause of death.
- 3.4. Trust wide there were 12 structured reviews completed during quarter 1 of 2021/22. The reasons for completing the structured review include learning disability, concerns raised by staff of families and concerns raised during the Medical Examiner scrutiny. Learning and recommendations from the completed structured reviews is included in this report.
- 3.5. During quarter 1 of 2021/22, there were no patient deaths at the OUH judged more likely than not to have been due to problems in the care provided.

#### 4. Approach to COVID-19 deaths

4.1. NHS England and NHS Improvement guidance defines a probable or definite hospital-onset healthcare associated COVID-19 infection death as:

- a) the death of a patient who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e., the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death).
- b) and the COVID-19 infection linked to the death meets the definition of ‘probable’ or ‘definite’ hospital-onset healthcare associated infection;
  - Hospital-Onset Probable Healthcare-Associated - a positive specimen date 8-14 days after hospital admission.
  - Hospital-Onset Definite Healthcare-Associated – a positive specimen date 15 or more days after hospital admission

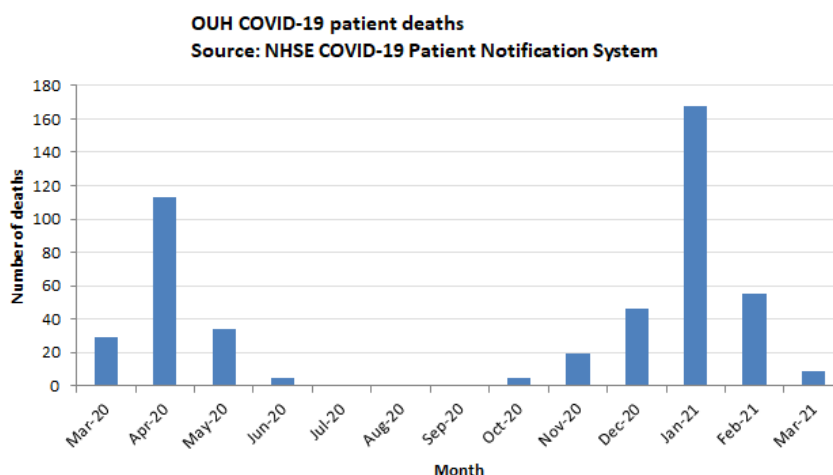
4.2. All probable or definite hospital-onset healthcare associated COVID-19 infection deaths are reported and investigated as patient safety incidents.

#### 5. Analysis of COVID-19 deaths

5.1. All COVID-19 related deaths are subjected to a Level 1 mortality review. There have been no COVID-19 related deaths judged more likely than not to have been due to problems in the care provided.

5.2. The majority of COVID-19 deaths occurred in April 2020 and January 2021.

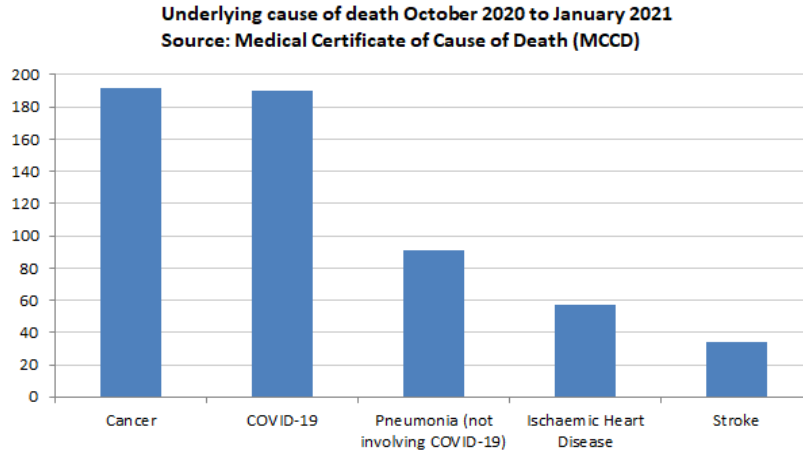
**Chart 1: OUH COVID-19 patient deaths by month of death**



5.3. The OUH COVID-19 crude mortality rate for April to December 2020 was 14.8% compared to the national crude mortality rate of 23.2% (Source: Dr Foster Intelligence).

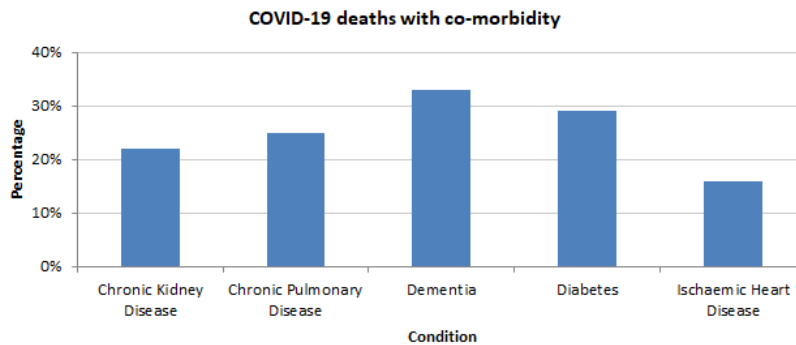
5.4. Between October 2020 and January 2021, the most frequently recorded underlying cause of death was cancer or COVID-19 (Chart 2).

**Chart 2: Underlying cause of death on Medical Certificate of Cause of Death (MCCD)**



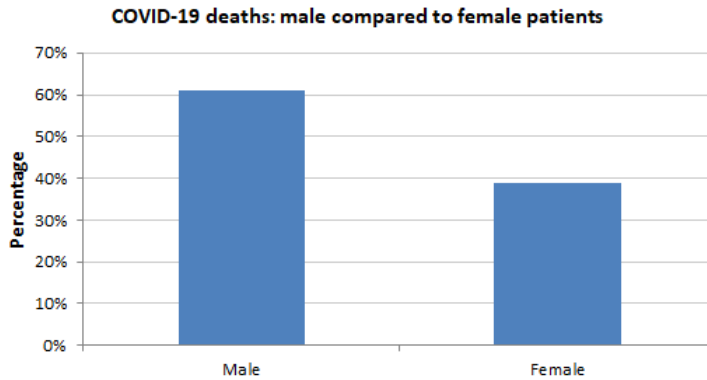
5.5. Of the deaths involving COVID-19; there was at least one co-morbidity in every reported case. Dementia and diabetes were the most common co-morbidity found in deaths involving COVID-19 (Chart 3)

**Chart 3: COVID-19 deaths with co-morbidity**



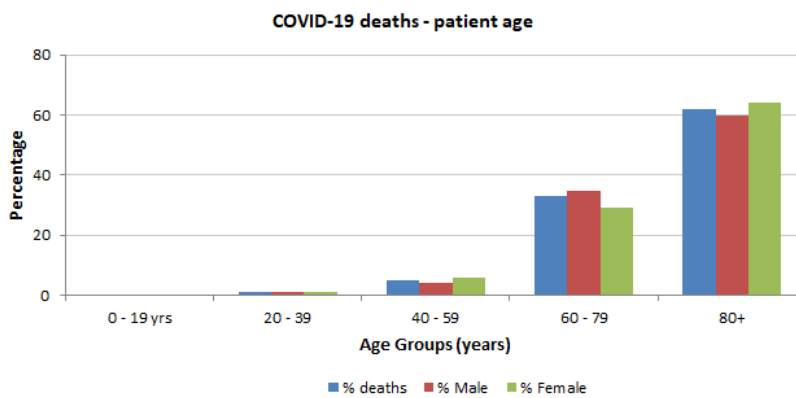
5.6. Male patients had a higher mortality due to COVID-19 when compared to female patients (Chart 4)

**Chart 4: COVID-19 deaths – male compared to female patients**



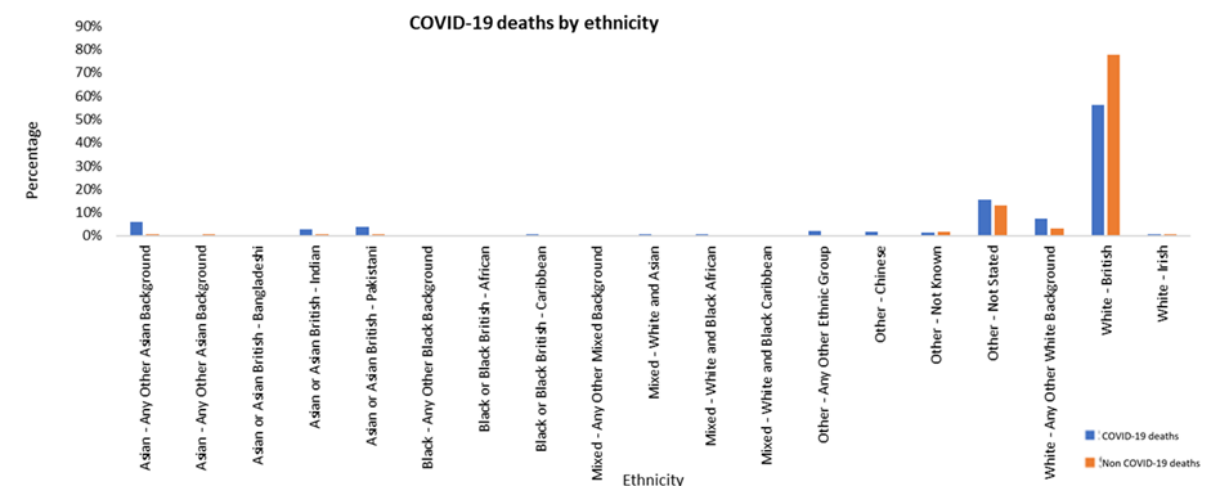
5.7. The majority of COVID-19 deaths were reported in patients over 80 years of age (Chart 5).

**Chart 5: COVID-19 deaths – patient age**



5.8. The following chart displays deaths by ethnicity for COVID-19 and non-COVID-19 deaths.

**Chart 6: Deaths by ethnic background:**





5.9. In line with national guidance, all patients who died with a probable or definite diagnosis of nosocomial COVID-19 (see 4b, above, for definitions), are being investigated at SIRI level. This is the case if COVID-19 is listed anywhere in cause 1 or 2 of the MCCD.

Originally each case was called as a separate SIRI, but following discussion with NHS England, and in agreement with commissioners, a single SIRI is now being used to manage all cases. The local reference for this SIRI is 2021-071.

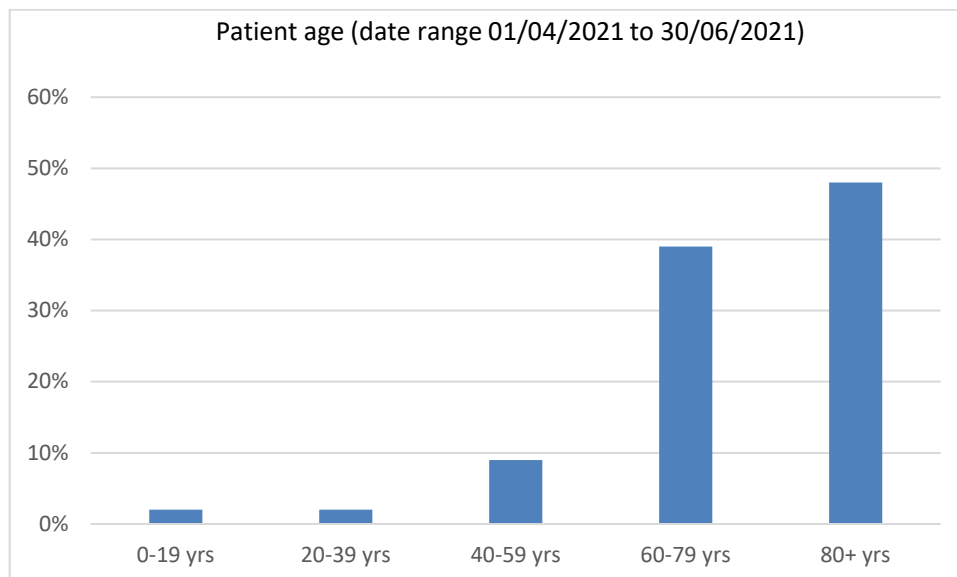
5.10. Once all individual investigations have been completed, a final report against 2021-071 will be created by Patient Safety to summarise all causative issues and learning. Upon completion the lead investigator will be invited to attend the mortality review group meeting to discuss the findings of the investigation. Brief individual summaries for each of these cases will be offered to the patients' relatives.

5.11. In quarter 4 the Deputy Chief Medical Officer instigated regular meetings to manage this process, as a subgroup of the weekly Serious Incident Group meetings.

## 6. Analysis of non-COVID-19 deaths

6.1. Of the non-COVID-19 deaths reported; 39% of deaths occurred in patients aged 60 to 79 years and 48% in patients over 80 years of age (Chart 7).

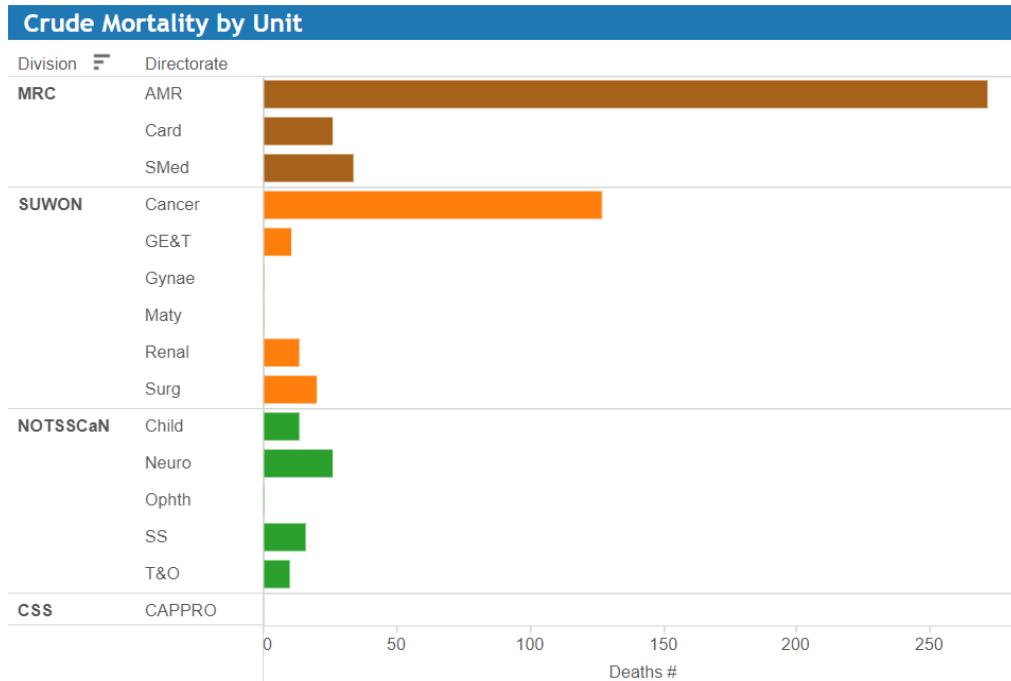
**Chart 7: Non COVID-19 deaths – patient age**



6.2. Of the non-COVID-19 deaths; there was at least one co-morbidity in all cases. Chronic kidney disease, dementia and ischaemic heart disease were the most common co-morbidity found among non-COVID-19 deaths.

6.3. The highest number of deaths were admitted to the Acute Medicine and Rehabilitation (AMR) Directorate under the MRC Division (Chart 8).

**Chart 8: Deaths by Directorate**

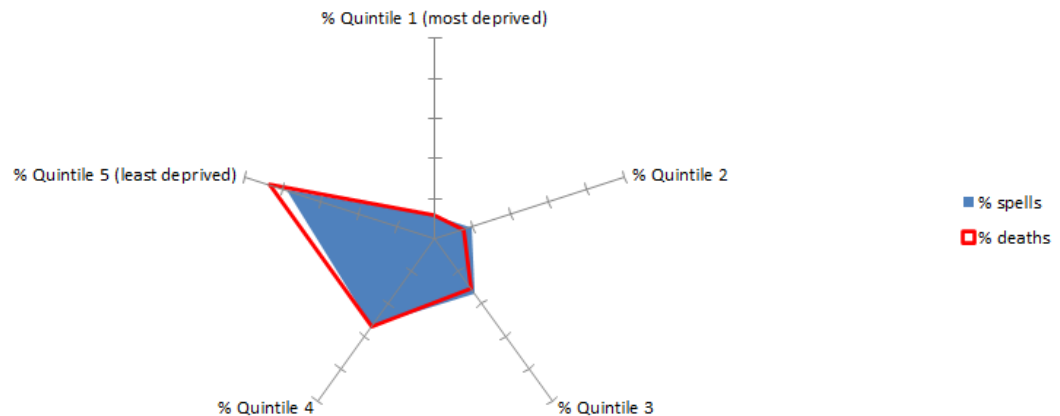


6.4. Of the 280 deaths for the period of quarter 1 occurring under the AMR directorate, 184 (66%) of deaths occurred under the speciality of acute general medicine. The average age at time of death under this speciality was 88 years old which is in line with previous years.

6.5. 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.

6.6. 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.

6.7. Chart 9 displays the percentage breakdown of spells and deaths by deprivation quintile. There remains a higher percentage of deaths in the least deprived group (quintile 5) relative to the percentage of spells attributed to those quintiles; conversely there were fewer deaths observed in quintile 2 relative to the number of spells linked to that group.

**Chart 9: % SHMI spells and deaths by deprivation quintile**

## 7. Patient safety incidents with an impact of death

7.1. The majority of incidents with an impact of death are the subject of a Trust Level Serious Incident Requiring Investigation (SIRI).

7.2. During quarter 1 the Trust confirmed and declared 3 SIRIs relating to incidents graded with an impact of death (excluding investigations subsequently downgraded from SIRI status). These concerned:

7.2.1. A woman with endometrial cancer had a delay to diagnosis and was later found to have advanced disease.

7.2.2. A patient with a type B aortic dissection requiring critical care did not receive a bed. They later deteriorated and died.

7.2.3. A patient admitted to the emergency department with sepsis was incorrectly diagnosed with a different condition and did not receive timely antibiotics; they further deteriorated and died.

7.3. These investigations are currently in progress and any relevant learning will be included in future learning from deaths reports.

## 8. Learning and actions from mortality reviews quarter 1 of 2021/22

### Nosocomial COVID-19 cases

8.1. COVID-19 Safety Audit are being completed at least once a month by all inpatient areas. This audit includes Personal Protective Equipment (PPE), patient screening and adherence with social distancing and staff testing. The audit results are reviewed by Ward Managers and the findings and areas for improvement are shared with staff. The audit results are included in the monthly Divisional Quality Reports submitted to the Clinical Governance Committee (CGC).

- 8.2. COVID-19 swabs for inpatients to be done on the day of admission, day 3 and then weekly. Safety messages to reiterate will be circulated.
- 8.3. Ventilation risk assessments will be completed for all areas with risks added to the Divisional Risk Registers and ventilation programmes adhered to.
- 8.4. Safety Huddles have been held to inform ward staff in 'real time' of changes that may affect their clinical practice in relation to COVID-19.

### **Non COVID-19 cases**

- 8.5. Work continues to improve compliance regarding oxygen prescribing.
- 8.6. MRC are to remind all staff about ceilings of care, treatment escalation plans.
- 8.7. The importance of accurate recording keeping using ePR has been highlighted and not 'copy and pasting' from previous entries.
- 8.8. Work continues to improve timely VTE assessments and prompt reviews during admission.
- 8.9. The importance of accurate DNACPR endorsement on EPR particularly when a patient is readmitted.
- 8.10 Reminder to all, including AGM, to calculate CURB scores for community acquired pneumonia and use micro guide to guide treatment.
- 8.11 The importance of updating family members if a patient has deteriorated and is likely to die, no matter what time it is.
- 8.12 Improved documentation of discussions with patients about wishes regarding care and risk of operations has been highlighted in SUWON Division.
- 8.13 Risks vs benefits of performing surgery on patients who are deemed to be high risk (e.g. significant co-morbidities or are in end of life care – vascular service). A focus on Montgomery consent involving the patient and family in decision making is key.

## **9. The Medical Examiner system**

- 9.1. The purpose of the Medical Examiner 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 and 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.
- 9.2. The Medical Examiners (MEs) have started regular 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 in wards.

9.3. 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 part of the existing Bereavement system.

9.4. The opportunity for families to discuss the care their relative received with an ME has been positively received. To quote one relative, the ME communication was an 'excellent adjunct' to the care provided.

9.5. In line with the Department of Health and Social Care directive; the Lead Medical Examiner is reviewing the deaths of members of staff involving COVID-19.

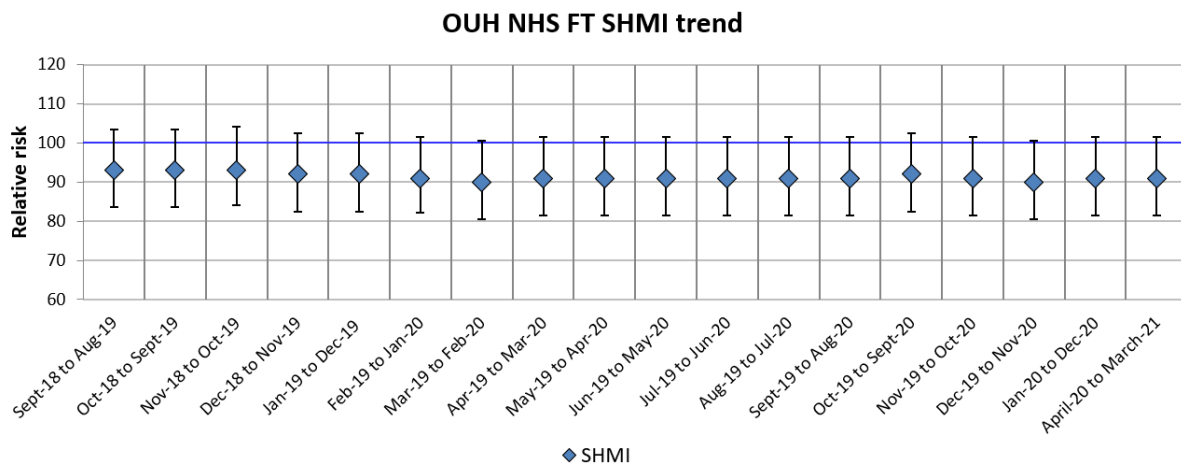
9.6. Planning is now underway to confirm a process for the scrutiny of deaths by the ME in the community.

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

10.1. There have been no mortality outliers reported for OUH from the CQC or the Dr Foster Unit at Imperial College.

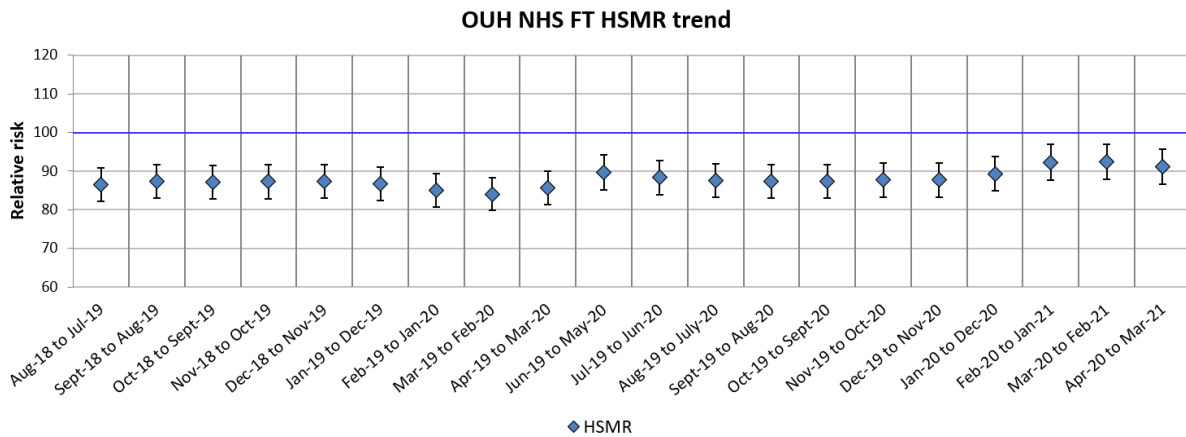
10.2. The SHMI for the data period April 2020 to March 2021 is 0.91. This is rated 'as expected.' Chart 11 depicts the SHMI trend. The SHMI has remained rated 'as expected.'

**Chart 10: SHMI trend** (Presented with a baseline of 100 to enable comparison to the HSMR)



10.3. The HSMR is 91.2 for the data period April 2020 to March 2021. Chart 12 depicts the HSMR trend. The HSMR has remained rated 'lower than expected.'

**Chart 11: HSMR trend**



## 11. Further analysis of deaths involving pneumonia

### Background:

11.1. Deaths involving pneumonia often flag in the top three diagnosis groups for mortality at the trust (source: Dr Foster intelligence). For further assurance, this section of the report will focus on a deeper analysis of pneumonia related mortality.

### Issues identified:

11.1. In 2013, it was felt improvements could be made when treating patients with a diagnosis of pneumonia. Therefore, a Trust level risk summit meeting focusing on pneumonia was held in 2013. The risk summit included presentations in the following areas: Pneumonia care bundle, clinical coding, antimicrobial guidelines, radiology, triage, specialist respiratory input, physiotherapy, HDU, quality metrics, EPR, patient safety incidents, audit, complaints, and patient information.

11.2. 'Risk summits' held during this time were a forum to bring together a wide group of interested parties to review data pertaining to an area of the Trust's work and to agree improvement actions. A total of fifteen actions were developed and shared following the risk summit and these were followed up at a second risk summit meeting. The risk summit at that time identified poor documentation of CURB scores, poor adherence to antibiotic guidelines, long mean length of stay, underuse of urinary tests, rate of early review by senior clinical decision maker falling (and below average) at the Churchill site and higher mortality rate at the John Radcliffe (27%) versus nationally (18%).

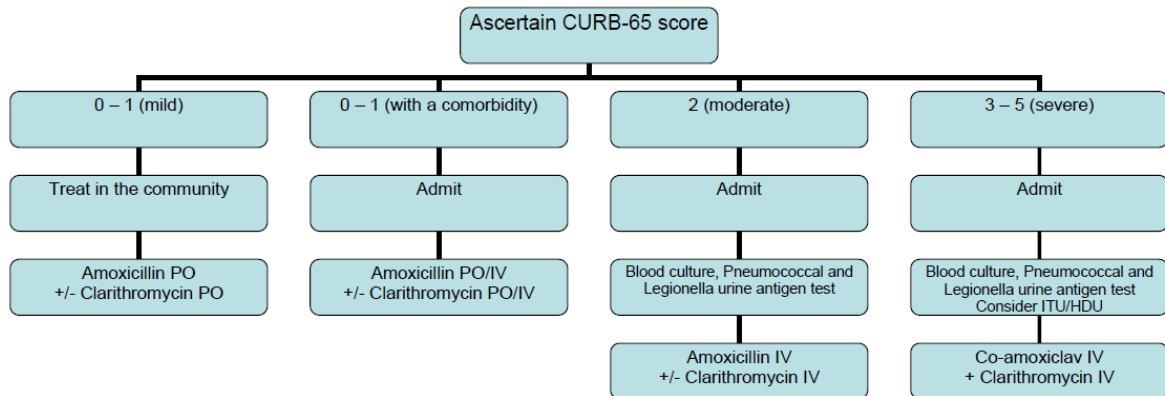
11.3. One of the key actions identified related to the development of a pneumonia care bundle to prompt best practice management and incorporate clear standards. A ‘follow up’ risk summit was held, and the care bundle was presented:

**Definition:** Apply the Care Bundle to new cases of CAP, those cases showing symptoms and signs of lower respiratory tract infection and confirmed by new shadowing on chest x-ray.

(1) **RECORD SEVERITY** - Derive CURB65 - Score 1 each for:

**C**onfusion ▶ **U**rea > 7mmol/l ▶ **R**espiratory Rate > 30/min ▶ **B**lood Pressure – low systolic <90mmHg ▶ **65** years + or diastolic <60mmHg

(2) **APPROPRIATE TRIAGE-**



(3) **ANTIBIOTICS** – Administer 1<sup>st</sup> dose within 4hrs of triage (Refer to hospital guideline)

(4) **ONGOING MANAGEMENT** – Regular review and IV to oral switch

**British Thoracic Society audit 2018/19:**

11.4. The 2018/19 British Thoracic Society (BTS) audit in adult community acquired pneumonia (CAP) was conducted from 1 December 2018 to 31 January 2019. Data capture was closed in May 2019. The aim of the 2018/19 audit was to examine the quality of care and outcomes in a nationally representative cohort of patients admitted to hospital with a diagnosis of CAP and compare it to the national standards. The key objectives were: To examine baseline demographics of patients hospitalised with a primary diagnosis of CAP, to examine processes of care and outcome measures associated with the management of CAP. To identify key areas for improvement in the management of CAP and to assess the magnitude of regional variation in mortality for patients hospitalised with CAP.

The key findings were - Mortality has decreased further; now at the lowest level (10.4%) for the last 10 years. Delivery of BTS CAP care bundle elements is improving, especially time to first antibiotics.

**Findings and analysis of OUH data - rolling 12 months and Q1 2021/22:**

11.5. For the data period July 2020 to June 2021 the overall HSMR for the diagnosis group pneumonia was 73.9 (as expected).

- 11.6. Data points are compared to the standardised rate of admission/attendance nationally.
- 11.7. 95% Confidence intervals are calculated through Byar's approximation.
- 11.8. Data points falling above the upper 95% Byar confidence interval are said to be significantly "higher than expected".

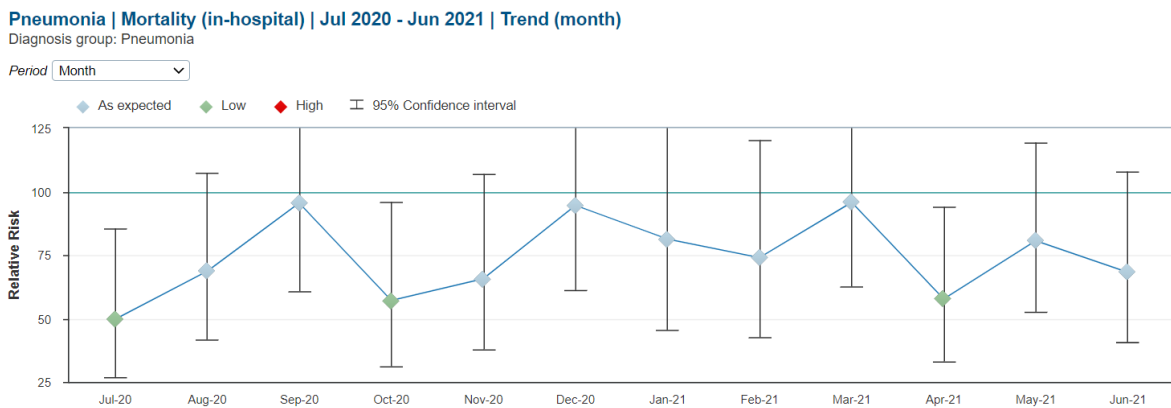
$$\text{Upper 95\% limit} = \left( \frac{\text{observed} + 1}{\text{expected}} \right) * 100 * \left( 1 - \frac{1}{(9 * (\text{observed} + 1))} + \left( \frac{1.96}{(3 * \sqrt{\text{observed} + 1})} \right) \right)^3$$

- 11.9. Data points falling below the lower 95% Byar confidence interval are said to be significantly "lower than expected".

$$\text{Lower 95\% limit} = \left( \frac{\text{observed}}{\text{expected}} \right) * 100 * \left( 1 - \frac{1}{(9 * \text{observed})} - \left( \frac{1.96}{(3 * \sqrt{\text{observed}})} \right) \right)^3$$

- 11.10. Data points falling between the lower 95% Byar confidence interval and the upper 95% Byar confidence interval are said to be within expected range.
- 11.11. The following SPC graph demonstrates the trend of pneumonia deaths over this time period and the relative risk:

**Chart 12: Pneumonia monthly trend (mortality)**



- 11.12. HSMR comparison within the Shelford group can be seen below:

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	▲ 2 ▲ 1	3990	585	569.2	14.7	102.8	
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	▲ 2 ▲ 1	1660	245	252.0	14.8	97.2	
<b>OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST</b>	▲ 6	1989	226	305.6	11.4	<b>73.9</b>	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	▲ 5	1795	215	284.7	12.0	<b>75.5</b>	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	▲ 4	1455	175	219.5	12.0	<b>79.7</b>	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	▲ 1	1020	130	135.1	12.7	96.2	
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	▲ 2	995	130	148.9	13.1	87.3	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	▲ 13	1085	100	188.8	9.2	<b>53.0</b>	
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	▲ 4	775	65	99.0	8.4	<b>65.7</b>	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	▲ 3	445	35	67.5	7.9	<b>51.8</b>	

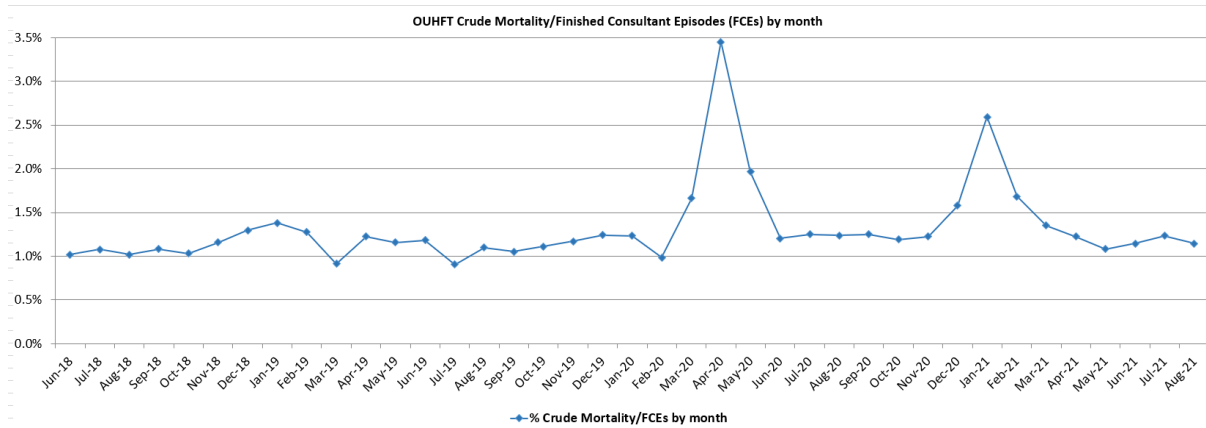


- 11.13. Over the period July 2020 to June 2021 the trust observed 226 deaths relating to pneumonia compared to 305.6 expected deaths (observed – expected = -79.6). As can be seen in the chart above there is variability in the risk of dying of pneumonia over the year however in the time period displayed there are no negative mortality alerts. 73% of deaths occurred at the John Radcliffe, 14% at the Horton and 3% at the Churchill hospital.
- 11.14. Over the period July 2020 to June 2021 the Trust received 6 positive alerts relating to pneumonia mortality and 17 positive alerts relating to length of stay.
- 11.15. 6% of deaths occurring at OUH during quarter 1 had a primary diagnosis of pneumonia. Of the 32 patients who died with a primary diagnosis of pneumonia; 26 were coded as white British, one as Pakistani, one as any other white background and ethnicity was not stated for four patients.
- 11.16. CQUINs concordant with The National Institute for Health and Care Excellence (NICE) guidelines were also implemented in 2019 for same day emergency care (SDEC). Each of the Same Day Emergency Care (SDEC) Commissioning for Quality and Innovations (CQUIN) are intended to promote and support the delivery and expansion of SDEC and include community acquired pneumonia. During quarter 1, a total of 598 inpatient spells were coded as pneumonia with only 98 stays exceeding the 75<sup>th</sup> centile. 72% of these patients were admitted to the John Radcliffe hospital.

## 12. Crude Mortality

- 12.1. Crude mortality gives a contemporaneous but not risk-adjusted view of mortality across OUH. There was a sharp increase in the mortality rate in April 2020 due to the increased number of deaths and decrease in activity related to the COVID-19 pandemic. There is a rise in the mortality rate in January 2021 resulting from the increase in the number of deaths related to the further wave of the COVID-19 pandemic. Chart 13 depicts the crude mortality rate by Finished Consultant Episodes (FCEs).

**Chart 13: Crude mortality rate by Finished Consultant Episodes (FCEs)**



12.2. During quarter 1 of 2021/22:

12.2.1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children’s and Neonatology Division reported that 66 patients died from a total of 15,735 discharges.

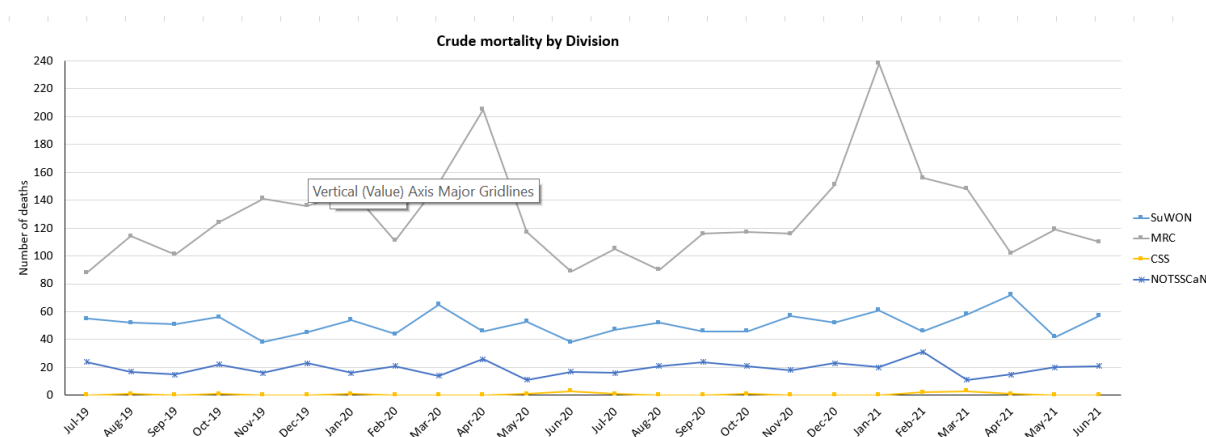
12.2.2. Medical Rehabilitation and Cardiac Division reported that 340 patients died from a total of 16,348 discharges.

12.2.3. Surgery, Women’s and Oncology Division reported that 172 patients died from a total of 18,687 discharges.

12.2.4. Clinical Support Services Division reported 0 deaths in the Critical Care Units from a total of 610 discharges.

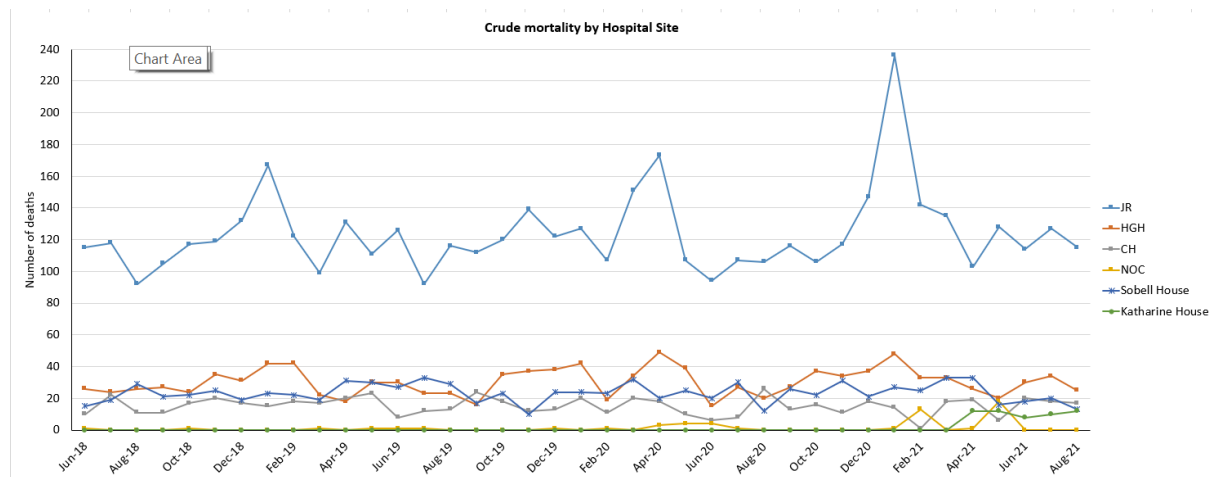
12.2.5. Chart 14 presents the crude mortality by Division.

**Chart 14: Crude mortality by Division**



12.3. Chart 15 depicts the crude mortality by hospital site. Most deaths occur at the John Radcliffe Hospital which has the highest activity.

**Chart 15: Crude mortality by Site**



**13. Recommendations**

13.1. The Public Trust Board is asked to receive this paper for information and discuss the learning identified in mortality reviews.