

## Cover Sheet

Public Trust Board Meeting: Wednesday 08 May 2024

TB2024.42

---

**Title:** Learning from deaths report – Quarter 3 2023/24

---

---

**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 – Deputy Chief Medical Officer

**Confidential:** No

**Key Purpose:** Assurance

---

## **Executive Summary**

1. This paper summarises key learning identified in mortality reviews completed for Quarter 3 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 3 of 2023/24 there were 751 inpatient deaths of which 744 (99%) were reviewed within 8 weeks, including 357 (48%) level 2 and structured mortality reviews. This was despite the additional pressures of industrial action during this quarter.
3. No deaths in this quarter were deemed to be 'avoidable'.
4. The SHMI for October 2022 to September 2023 was 0.92 (0.89 - 1.12). This is banded 'as expected'.
5. The Trust's HSMR was 90.3 (85.1 - 92.6) for January 2023 to December 2023. The HSMR 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.

## Contents

Cover Sheet.....	1
Executive Summary.....	2
Learning from deaths report – Quarter 3 2023/24 .....	4
1. Purpose.....	4
2. Background and Policy .....	4
3. Mortality reviews during Quarter 3 of 2023/24.....	5
4. The Medical Examiner system.....	6
5. Child death overview process.....	7
6. Learning and actions from mortality reviews.....	7
7. Review of potential excess deaths related to long ED waits.....	8
8. SIRI and PSII investigations of incidents resulting in death during Quarter 3	9
9. National mortality benchmark data.....	9
10. Detailed analysis of deaths during reporting period .....	10
11. Mortality-related risks in the Corporate Risk Register .....	14
12. Recommendations .....	15
Appendix 1: Key differences between the SHMI and HSMR.....	16

## Learning from deaths report – Quarter 3 2023/24

---

### 1. Purpose

- 1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 3 of 2023/24: October 2023 to December 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 domains<sup>1</sup> 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

---

<sup>1</sup> [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 3 of 2023/24

- 3.1 During Quarter 3 of 2023/24 there were 751 inpatient deaths of which 744 (99%) were reviewed within 8 weeks, including 357 (48%) level 2 and structured mortality reviews (table 1). This was despite the additional pressures of industrial action.
- 3.2 Eleven 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 (97%)	1349 (50%)	2625 (97%)	2692 (99%)
2023/24 (Q1)	634	628 (99%)	291 (46%)	628 (99%)	634 (100%)
2023/24 (Q2)	652	644 (99%)	295 (45%)	644 (99%)	652 (100%)
2023/24 (Q3)	751	739 (98%)	357 (48%)	744 (99%)	751 (100%)

\*including reviews completed after 8 weeks

## 4. The Medical Examiner system

### Background:

4.1. The purpose of the Medical Examiner (ME) system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-Coronial deaths; appropriate direction of deaths to a Coroner; a better service for the bereaved including an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased; and improved quality of death certification and mortality data. At OUH MEs have been scrutinising deaths since June 2020.

### Quarter 3 progress:

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

4.3. 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. This has highlighted a need to widen the availability of clinical information in the perinatal period for a few deaths within the Neonatal Intensive Care Unit. Plans are underway to address this issue in partnership with the ME Service and clinical units.

4.5. 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. Statutory scrutiny of all deaths will be from 9<sup>th</sup> September 2024.

4.6. 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. Improvement areas have been discussed at the monthly mortality review group with support from the clinical coding team.

4.7. The ME team 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).

4.8. The ME Office is checking that all concerns are recorded by the MEs and that the threshold for raising concerns is appropriate. The process for raising concerns to the OUH is currently under review – agreed changes to process and reporting concerns by MEs will be included in the quarter 4 LFD report.

## 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 3 update:

- 5.4. There were 17 child deaths in the OUH this quarter. All cases (100%) underwent a multidisciplinary review. The Neonatal unit is to create a guideline for the certification of death of the extremely premature infant.
- 5.5. Routine Medical Examiner review of all child deaths (except still births) had identified a lack of communication with families at end of life in some previous cases in quarter 2. This feedback has been shared with the teams and these issues have significantly reduced this quarter (no cases raised to learning from deaths in Q3), suggesting a positive impact of the ME review process on learning and improvement.
- 5.6. In one review the 'Crash Bleeps' that alert the Neonatal team did not work as anticipated: this has been reported as a 'Ulysses' incident and is being investigated by Neonatal governance lead. Findings and recommendations following this will be included in the quarter 4 LFD report.
- 5.7. Thames Valley Police and South-Central Ambulance Service will review statutory processes and update policies in managing a child who has died at home, i.e. The need to transport to hospital without delay, regardless of time of death. This will be followed up at the next CDOP panel meeting.

## 6. Learning and actions from mortality reviews

- 6.1. *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 and this theme has been flagged to the ICB. This issue was identified last quarter but remains a theme in quarter 3.

- 6.2. *Recognition and response to deterioration*: In 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 with work now underway.
- 6.3. *Mortality review*: A review is underway of all patients who died during periods of industrial action in MRC to identify any issues or themes related to industrial action. Feedback will be provided to MRG, with any relevant learning included in the *quarter 4 LFD report*.
- 6.4. *Pain management*: Acute General Medicine are planning to introduce the Abby Pain Score to enable patients with cognitive impairment who cannot verbalise communicate their level of pain. The Abbey Pain Scale will be used as part of an overall pain management plan.
- 6.5. *Crude mortality*: There was an increase in mortality in the Surgery Directorate from 18 patients in Q2 to 34 patients in Quarter 3; early indication is that this is related to an increase in the number and severity of illness of patients admitted to SEU. A review of the cases has identified a significant number of patients who were frail on admission with the decision taken to take a conservative approach after diagnostic assessment. All cases have been reviewed at L1/ L2 or structured judgement review but no concerns regarding the quality of care were identified.

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

- 7.1. As per the quarter 2 report - On 7 November 2023, an article was published in the Health Services Journal (HSJ) which explored the risk of mortality from excess waits in the 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 Clinical Outcomes Manager has explored data for potential impact of ethnicity, health inequalities and long-term conditions. This information has been noted at MRG and a fuller report with findings is expected in quarter 4.



## 8. SIRI and PSII investigations of incidents resulting in death during Quarter 3

8.1. Three incidents with an impact of death were declared as Patient Safety Incident Investigations during Quarter 3 2023/24:

8.1.1. A child diagnosed with an ear infection re-attended the Horton Emergency Department and was found to have a necrotic mass in the temporal lobe; the patient was transferred to the John Radcliffe for emergency surgery. They were cardiovascularly unstable on arrival and died in the operating theatre before the surgery.

8.1.2. A patient was found unresponsive in their home, 5 days after PEG insertion. Concerns have been raised regarding the post-operative care and discharge of the patient, which are being investigated through this learning response.

8.1.3. An intrauterine death is being investigated by the Maternity and Newborn Safety Investigation Programme (formerly HSIB) as a Patient Safety Incident Investigation (PSII).

8.2. The findings of all SIRIs and PSIIs 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 3 2023/24.

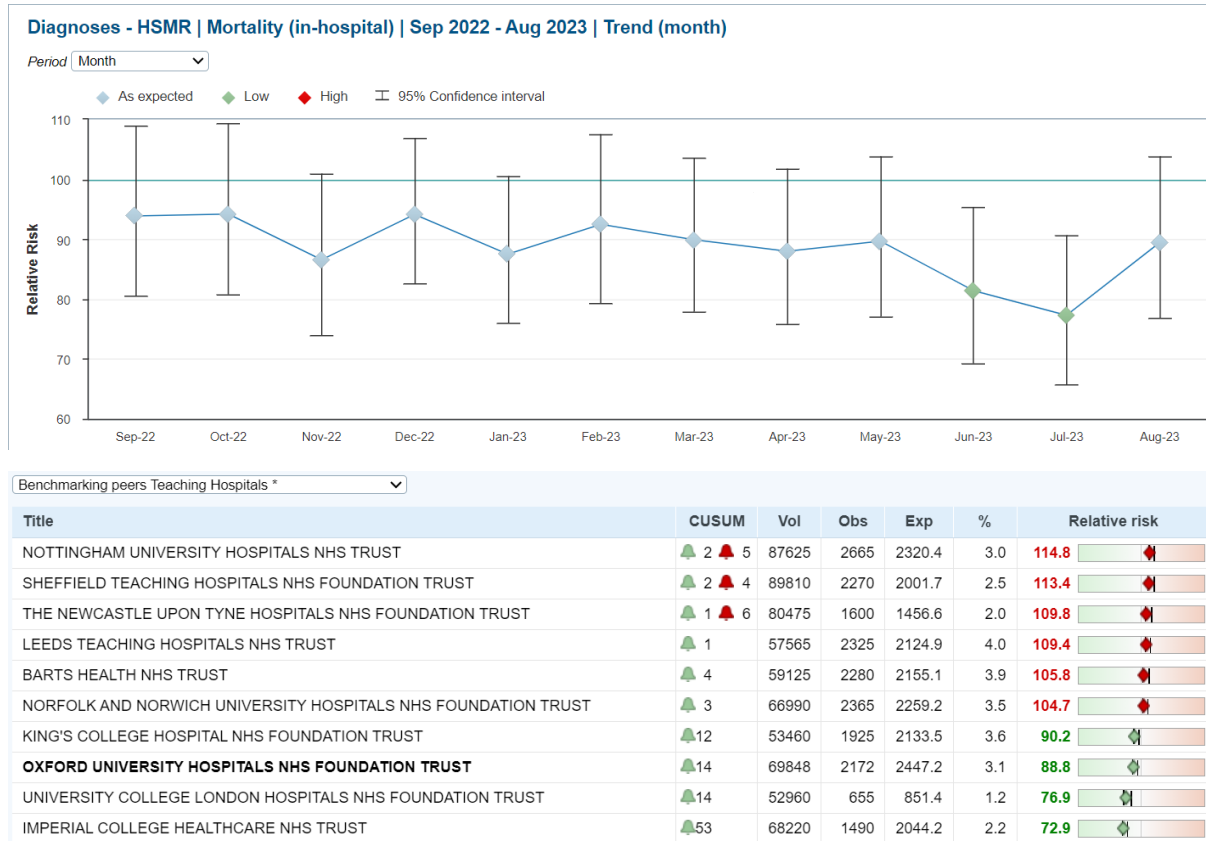
9.2. The Summary Hospital-level Mortality Indicator (SHMI) for October 2022 to September 2023 is 0.92. This is banded 'as expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion (0.89 – 1.12).

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. From May 2024, the Trust level SHMI will exclude deaths that occur in the two Trust hospices (Katherine House Hospice and Sobell House Hospice) in line with benchmarked Trusts. Provisional NHSE data shared with the Trust shows a SHMI excluding the hospices of 0.86 for January to December 2023, which is banded as 'lower than expected'.

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

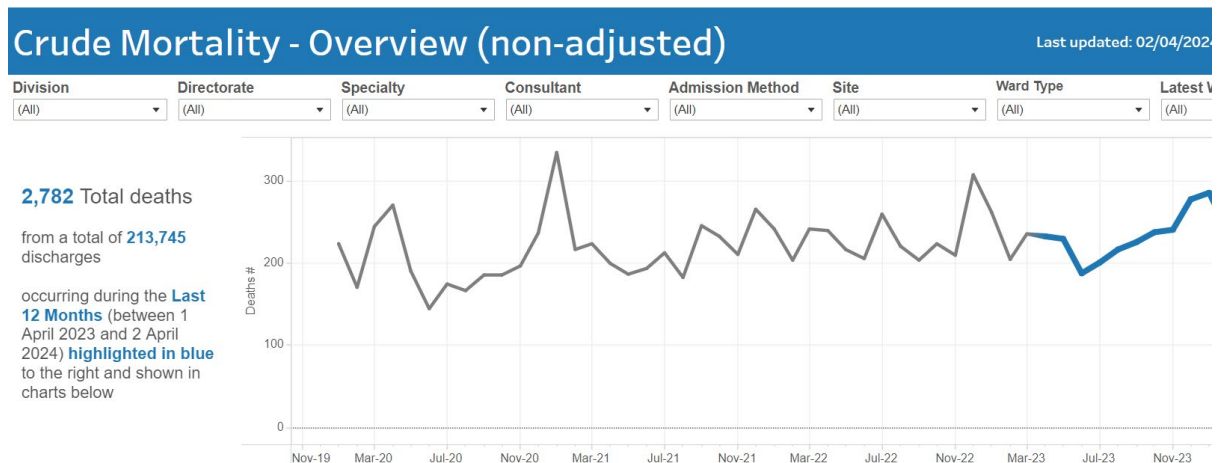
**Chart 2: HSMR trend & comparison with Teaching Hospitals**



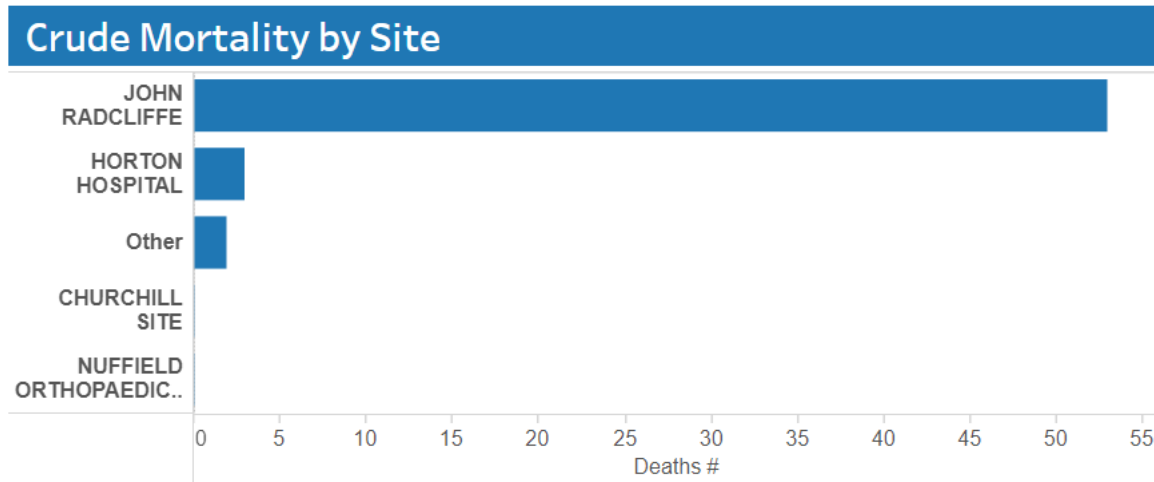
**10. Detailed analysis of deaths during reporting period**

10.1. *Crude mortality:* Chart 3 below shows the crude mortality rate for a rolling 12 month period. Crude mortality gives a contemporaneous, but not risk-adjusted, view of mortality across OUH. Chart 4 depicts the crude mortality by hospital site. Most deaths occur at the John Radcliffe Hospital which has the highest activity.

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



**Chart 4: Crude mortality by Site**

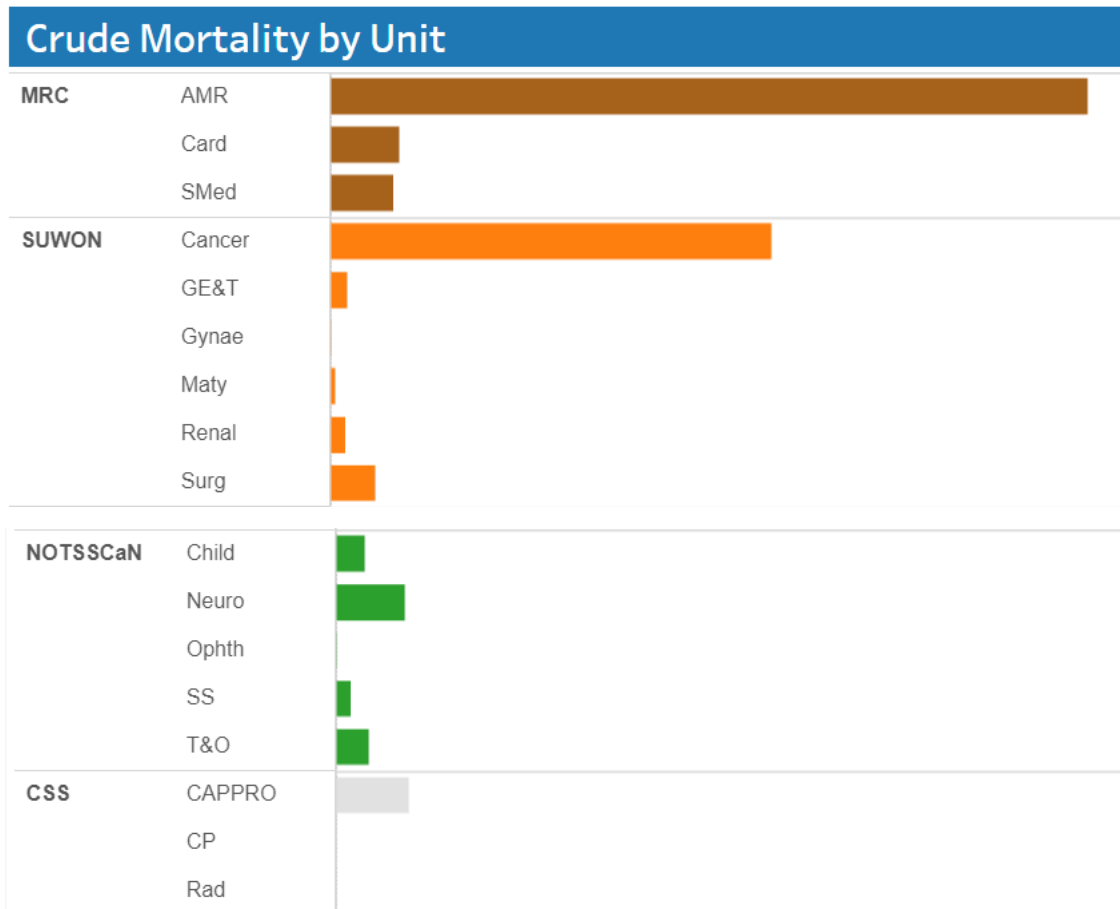


10.2. As usual the highest number of deaths occurred in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (Table 2, Chart 5).

**Table 2: Crude mortality by Clinical Division, Quarter 3 of 2023/24**

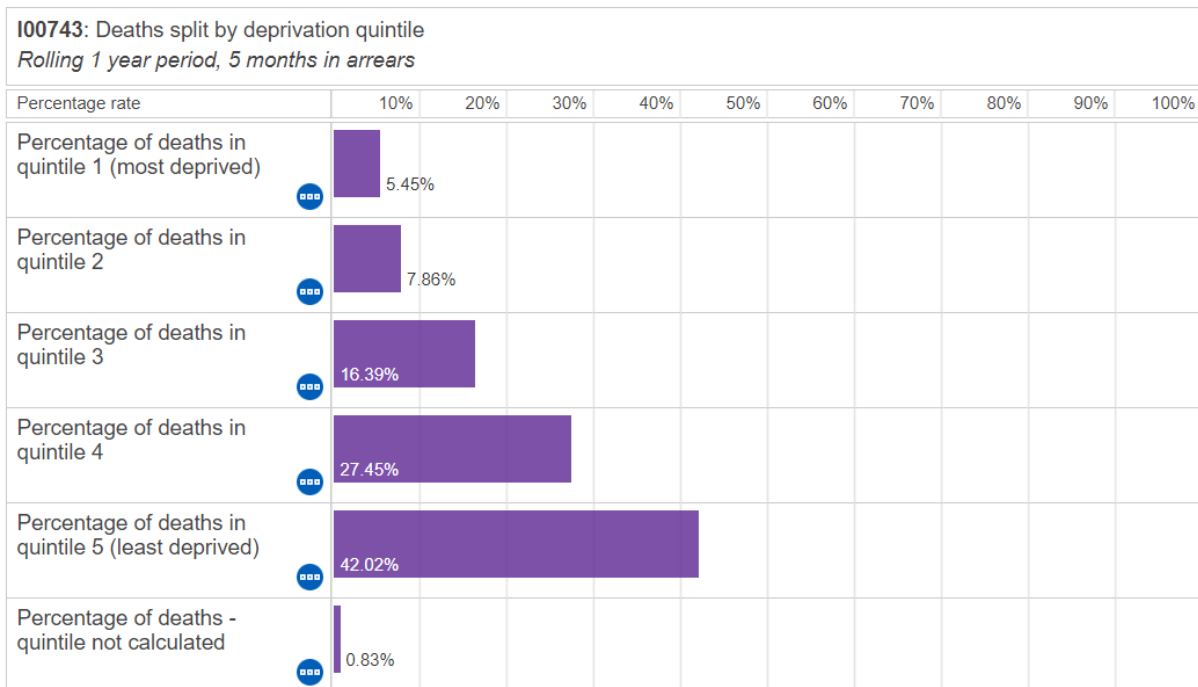
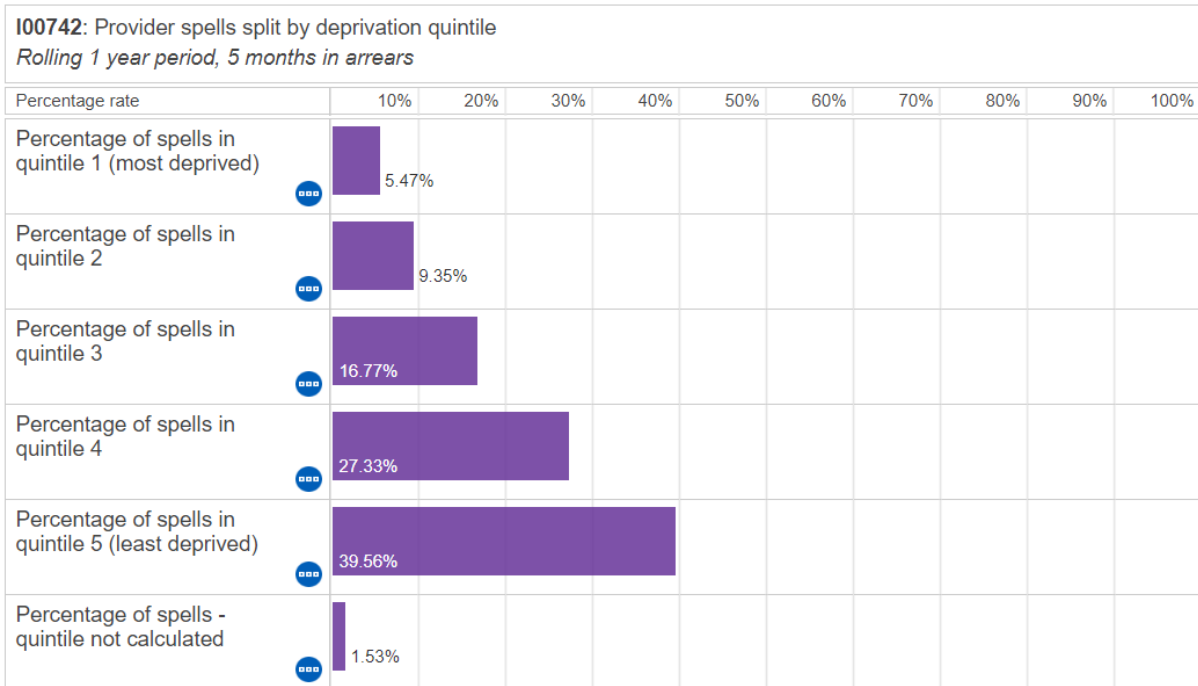
Division	Total Discharges	No of deaths
NOTSSCAN	16,324	67
MRC	17,770	412
SUWON	18,934	242
CSS	714	33

**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 for all admissions can be seen below. Mortality rate by ethnicity can also be seen below using mortality data for the past three years. The annual LFD report will report ethnicity data for the 2023/24 period.

## Percentage of admissions in Apr-24 coded

**98.11%**

Known ethnicity codes (all except 'Not Known')  
 ▼0.02% change from previous month  
 rolling 13 month average 98.30%

**1.89%**

Not Known  
 rolling 13 month average 1.70%

**20.12%**

Not Stated  
 ▲1.10% change from previous month  
 rolling 13 month average 18.96%

**Mortality rate by ethnicity:**

- African = 0.26%
- Asian Background = 0.34%
- Black background = 0.12%
- Other ethnic group = 0.49%
- Other mixed background = 0.08%
- Other white background = 3%
- Bangladeshi = 0.1%
- Caribbean = 0.21%
- Chinese = 0.1%
- Indian = 0.23%
- Pakistani = 0.47%
- White and Asian = 0.04%
- White and black African = 0.03%
- White and black Caribbean = 0.12%
- White British = 9.36%
- White Irish = 0.1%
- Unknown = 0.0004%
- Not stated = 1.5%

**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.