Oxford University Hospitals
NHS Foundation Trust

Public Trust Board Meeting: Wednesday 10 September 2025

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Title:	**Learning from deaths annual report 2024/25**

Status:	**For Information**
History:	**Annual report**

Board Lead:	**Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. During 2024/25 there were 2761 inpatient deaths reported at Oxford University Hospitals NHS Foundation Trust (OUH) with 2727 (99%) of cases reviewed within 8 weeks (as per policy). 100% of all deaths have now been reviewed.
2. The background, process and governance process for mortality reviews is detailed in this report.
3. Trust HSMR is 94.6 for April 2024 to March 2025. The HSMR is banded as 'lower than expected' (95% CL 90.2-99.1).
4. The Summary Hospital-level Mortality Indicator (SHMI) for the data period January 2024 to December 2024 is 0.91 which is banded as 'as expected.'
5. There were no diagnoses with a higher-than-expected SHMI.
6. There were no reported 'avoidable' deaths during 2024/25.
7. The current corporate risks relating to mortality are listed in the report.
8. Key actions and learning points identified in mortality reviews completed during 2024/25 are presented in this paper.
9. Quarterly reviews of Learning from Deaths were presented in November 2024, January 2025, May 2025, and July 2025. This annual report is a combination of these quarterly reports - Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk).

Recommendations

10. The Trust Board is asked to note the contents of this report for information.

Contents

Learning from deaths annual report 2024/25

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for 2024/25.

1.2. Perinatal mortality reviews are reported separately in the Perinatal Mortality quarterly reports.

2. Background

2.1. OUH is committed to accurately monitoring and understanding its mortality outcomes; and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains[1] set out in the NHS Outcomes Framework:

- Preventing people from dying prematurely.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

2.2. 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. Trust HSMR is 94.6 for April 2024 to March 2025. The HSMR is banded as 'lower than expected' (95% CL 90.2-99.1).

2.4. The Summary Hospital-level Mortality Indicator (SHMI) for the data period January 2024 to December 2024 is 0.91 (95% CL 0.87-1.15) which is banded as 'as expected.'

2.5. There were no diagnoses depicted with a higher-than-expected SHMI.

2.6. The Trust Mortality Review policy requires that all inpatient deaths are reviewed within 8 weeks of the death occurring.

2.7. All patients undergo a level 1 or level 2 mortality review. The level 1 review is allocated to the responsible Consultant via the electronic patient record (EPR). In most departments all deaths also undergo a more comprehensive level 2 review. In a few departments with high number of deaths, a minimum of 25% of Level 1 reviews are selected at random for a Level 2 review.

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

2.8. A Level 2 review is also completed for all cases in which concerns are identified at the Level 1 review. The level 2 review is carried out by one or more consultants not directly involved in the patient's care.

2.9. A structured judgement review (SJR) is required if the case complies with one of the mandated national criteria - NHS England » Learning from deaths in the NHS. All Inquests where there are concerns about the quality of care will have a mortality review and all SJRs that will be presented to Inquest are reviewed and discussed at MRG.

2.10. The SJR's are completed by a trained reviewer not directly involved in the patient's care.

2.11. Each Division maintains a log of actions from mortality reviews (of any type) and monitors progress against these action plans. Actions are recorded using the Ulysses system. The clinical units are responsible for disseminating learning and implementing the actions identified.

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

2.13. 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).

2.14. All deaths also undergo independent scrutiny from the Medical Examiner's office.

3. Mortality reviews completed during 2024/25

3.1. During 2024/25 there were 2761 inpatient deaths reported at OUH with 2727 (99%) of cases reviewed within 8 weeks.

Table 1: Number of mortality reviews 2024/25

Reporting period	Total deaths	Reviews completed within 8 weeks			Total reviews completed*
		Level 1	Level 2 & SJR	Total	
2023/24 (Q1-4)	2762	2731 (99%)	1294 (47%)	2741 (99%)	2762 (100%)
2024/25 (Q1-4)	2761	2727 (99%)	1199 (43%)	2727 (99%)	2761 (100%)

*Including reviews completed after 8 weeks

3.2. Divisions with deaths which were not reviewed within 8 weeks (as per policy) were requested to complete a Level 1 screening review; compliance was monitored via MRG. All deaths during 2024/25 have now been reviewed.

3.3. No structured review completed in 2024/25 deemed any death to be 'avoidable'.

4. Examples of key learning & actions from mortality reviews by quarter

4.1. **In quarter one:** Mortality reviews completed during quarter one identified issues with care during transfers across the Complex Medical Unit (CMU) wards during the night. A risk was identified with out of hours transfers and increases in patient deterioration/death. Therefore, a new Standard Operating Procedure (SOP) was developed in MRC and agreed at Directorate and Divisional governance for transfers out of hours from the CMU wards. This has ensured more appropriate and safer transfer of vulnerable patients.

4.2. **In quarter two:** Different clinical opinions in relation to one SJR highlighted the importance of involving all who were involved in the care of the patient to gain their perspective. This is particularly important if there are concerns about the care of the patient. The Trust mortality review policy and structured review training materials were updated to reflect this. These updates were presented and approved at the MRG meeting in October 2024. Any SJR to be submitted to the coroner in relation to an Inquest is also now reviewed at MRG prior to the inquest to ensure actions resulting from the learning are expedited.

4.3. **In quarter three:** In Neurosciences it was identified during one review that a patient missed a dose of Dalteparin because it was not available to administer to the patient. Although this omission was not thought to have contributed to the death of the patient, key actions were taken to avoid this happening again These included reviewing the Neurosciences stock of Dalteparin and providing training to nursing staff regarding the process for ordering urgent medications via pharmacy. These actions have been effective, with no further missed doses of Dalteparin reported.

4.4. **In quarter four:** A learning response and mortality review were conducted for a patient who deteriorated and died. It was identified that earlier recognition of the deterioration could have provided an opportunity to consider a trial of non-invasive ventilation (NIV) and facilitate referral to the respiratory team. It was agreed that this would not have affected the outcome for the patient. System for Electronic Notification and Documentation (SEND) observations will be reviewed during the ward board round to identify patients who may be deteriorating, so they can be escalated to the appropriate team. The local governance team will monitor this change in practice to ensure consistent implementation.

4.5. Quarterly Learning from Deaths reports containing more detailed summaries of the learning arising in each quarter can be found here - Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk).

5. Examples of learning and actions from incidents and investigations with an impact of death

5.1. Review of the patient streaming area and processes in Emergency Department at the Horton General Hospital. It was identified that the nurse responsible for streaming could be easily interrupted leading to a break in their workflow with potential impact on their assessment. A screen has been installed to reduce distractions. In addition, only band 6 and 7 nursing staff are now allocated to streaming.

5.2. An amylase level is now routinely performed for all patients who present with significant abdominal pain to the Emergency Department as part of the non-specific abdominal pain Powerplan for patients who present to the ED. This will be monitored through audit and feedback at ED Clinical Governance monthly meetings.

5.3. A Quality Improvement project on the short stay wards has been commenced on managing patients who are at the end of their life. This includes looking at effective communication, symptom management, and breaking bad news to patients and families. Staff have attended teaching sessions led by the palliative care team. Simulation training has been undertaken by staff to help them to practice breaking bad news.

5.4. The Nutrition Support Nurses Team has provided education and training sessions to the Blenheim Ward nursing team focusing on post percutaneous endoscopic gastrostomy (PEG) insertion care and ongoing PEG care management. This is now part of the induction for all new nursing and resident doctors. An intranet resource page has been developed as an ongoing reference guide and was launched in June 2024.

6. Corporate Risk Register and related Mortality risks

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

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

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

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

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

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

6.7. Lack of ability to achieve the 85% of patients treated within 62 days of cancer diagnose across all tumour sites.

7. Mortality Review Governance

5.1 A quarterly summary of Directorate and Divisional mortality reports from their respective mortality and morbidity reviews are presented to the monthly MRG Chaired by the Director of Patient Safety and Effectiveness.

7.1. 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.

5.2 CIC reports to CGC, Chaired by the Chief Medical Officer or the Chief Nursing Officer.

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

8. Conclusion

8.1. The Trust can report good compliance with local and national mortality review policy and guidance.

8.2.

8.3. This paper summarises some of the learning identified in the mortality reviews completed during 2024/25.

9. Recommendations

9.1. The Trust Board is asked to note the contents of this report for information.