Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 08 November 2023

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Title:	**Learning from deaths report – Quarter 1 2023/24**

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

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2023/24, 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 1 of 2023/24 there were 634 inpatient deaths reported at OUH. Compliance with mortality reviews as per the agreed policy is presented in Table 1. There were 628 (99%) cases reviewed within 8 weeks. Of these reviews, there were 291 (46%) level 2 and structured mortality reviews completed.
3. There was one death occurring during Quarter 1 deemed to be potentially 'avoidable'. This case was discussed at the mortality review group and details of the case are included in this report (section 4).
4. The SHMI for the data period April 2022 to March 2023 is 0.95. This is banded 'as expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion (0.89 – 1.12).
5. The Trust's HSMR is 91.6 for July 2022 to June 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 1 2023/24

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2023/24.

1.2. This report provides a quarterly overview of Trust-level mortality data for the period of Quarter 1: April 2023 to June 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. Oxford University Hospitals NHS Foundation Trust (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[1] 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

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

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 at the Level 1 review, a comprehensive Level 2 review is completed involving one or more consultants not directly involved in the patient's care. A structured judgement review (SJR), 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 (of any type) 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 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 1 of 2023/24

Table 1: Number of mortality reviews completed during Quarter 1 of 2023/24:

Total deaths	Total reviews (L1, L2 or SJR)	Deaths not reviewed within 8 weeks
634	628	6

3.1 During Quarter 1 of 2023/24 there were 634 inpatient deaths reported at OUH. Compliance with mortality reviews as per the agreed policy is presented in Table 1. There were 628 (99%) cases reviewed within 8 weeks. Of these reviews, there were 291 (46%) level 2 and structured mortality reviews completed.

3.2 Trust wide, there were 6 structured reviews completed during Quarter 1 of 2023/24. The reasons for completing the structured review include individuals with a learning disability, concerns raised by staff or families and concerns raised during the Medical Examiner scrutiny.

3.3 During Quarter 1 of 2023/24, there was one patient death at the OUH judged potentially 'avoidable'. Details and learning from this case are outlined in this report (section 4).

4. Potentially avoidable death in Q2

Background:

4.1. A structured mortality review was undertaken on the case of a 90-year-old previously fit patient who had a fall a month prior to admission and later died. The patient later fell again so an ambulance was called.

4.2. An x-ray in the Emergency Department confirmed a hip fracture and the patient was reviewed promptly by the Trauma team with surgery planned. The patient was also reviewed by the Orthogeriatric team and optimised for theatre including a plan to increase steroid dose peri-operatively with regular nutritional drinks prescribed.

4.3. The patient was given a clinical frailty score of 4, and a Nottingham Hip Fracture score of 6 giving 15% predicted 30-day mortality. A VTE assessment was completed, and anticoagulant was given at 18:00 every day. It is documented on admission that his calves were soft and nontender.

4.4. The patient was reviewed daily by the Trauma team whilst awaiting surgery with no concerns regarding VTE raised. All observations were normal including those done just prior to surgery.

4.5. The patient went to theatre at 08:30 on 21 June 2023 to undergo a hemiarthroplasty under general anaesthetic. The operative note states the Anaesthetist alerted the team to deterioration as "femoral shaft prepared with rasp and broach". CPR was commenced without success, and the patient died at 11:02.

4.6. The cause of death following a Postmortem was confirmed as 1a) Pulmonary embolism 1b) Left fractured neck of femur (operated) 2) Polymyalgia rheumatica, previous sacral fractures. VTE prophylaxis was confirmed exemplary.

Issues identified:

4.7. Best practice guidelines state that patients with a fractured hip should be operated on within 36 hours of admission. Prolonged immobility would increase the risk of venous thromboembolism.

4.8. Unfortunately, the patient waited 101 hours for surgery. All appropriate investigations were done with a clear management plan, including a hip block for pain.

4.9. The death was felt to have been potentially avoidable and following presentation of the mortality review to the mortality review group, it was

agreed to write a letter to the Coroner explaining the steps being taken to improve time to theatre.

Key findings and recommendations:

4.10. Delays with getting emergency patients into theatre is an issue known to the Trust and there has been considerable work done trying to improve this.

4.11. This issue is not only local to OUHFT but across the Thames Valley region and increase in waiting times usually coincides with summer weather as per this case.

4.12. Examples of efforts to decompress waiting times include:

- Relocating elective surgeries such as metalwork removal to alternative sites.
- Some ambulatory trauma is being relocated to the Horton.
- Theatre summits where surgery allocation is discussed.
- Longer term a new theatre build will address some of the issues highlighted from the mortality review.

4.13. A key issue relates to the nature of trauma – for example, two pelvis surgeries can occupy an emergency operating list, resulting in other surgeries on the day needing to be postponed to the following day.

4.14. Capacity, prioritisation, and the uniqueness of the trust being a major trauma centre for both adults/paediatrics and not being co-located with elective orthopaedic practises were also identified as contributing factors. This issue is also impacting staff.

4.15. The number of trauma patients has been increasing for several years; therefore, the trust will need to expand capacity to deal with the expansion. Business cases to address this remain in progress.

4.16. Further ideas for improvement include expansion of non-medical, administrative, and clinical coordinating staff.

4.17. The structured mortality review which focused on the case and identifies that there was a delayed time to theatre will be shared with Coroner as well as a separate letter which explains the Trusts current position and improvement plan moving forward to address the issue.

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. In Quarter one 2023/24 100% of Trust deaths were reviewed by the Medical Examiner's office.

5.4. This additional scrutiny has revealed the high quality of clinical notes on the electronic patient record (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 through the Trust's Patient Safety processes or to PALS.

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. ME's 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.

5.9. The Lead Medical Examiner is meeting with external stakeholders ahead of the community roll out. Scrutiny of hospice deaths is now established.

5.10. Meetings with the local Berkshire, Oxford, Buckinghamshire (BOB) Integrated Care Board (ICB) and two neighbouring ME Offices are underway to allow introduction of the ME service to the Community.

5.11. There is capacity among the MEs to start this with further recruitment of MEs and MEOs already under way.

5.12. 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.

5.13. Plans for 2023/24 include:

5.13.1. There are still improvements that can be made to speed up the process and to increase the early availability of the Death Notification Summary. An EPR change request form has been submitted and trust wide messages disseminated.

5.13.2. 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.

5.13.3. In Q2 the cumulative proportion of Hospice deaths scrutinised by the ME Service was 90%, but full coverage had been achieved by the end of the quarter: 100% of all adult Hospice deaths are currently being scrutinised by the ME Service.

5.13.4. The ME Service is working closely with the BOB ICB and neighbouring ME Offices to try and overcome the concerns which are preventing engagement of Primary Care with the ME Service. This is not a situation limited to Oxfordshire. National guidance (due, according to the Undersecretary of State and the National ME, in Autumn 2023 – not available as of 25th October 2023) is awaited and it is hoped that this will address the concerns which have prevented roll-

out of the ME Service into Primary Care. The ME Service has kept the Oxfordshire Registrar Service and HM Coroner informed of the situation.

5.13.5. Two new “community” MEOs started in June 2023. The ME Office will be contacting all GP surgeries in the county to reintroduce the ME system.

5.13.6. 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.

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

5.14. As host Trust, the OUH 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 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 Quarter 1. There were 13 child deaths in the OUH this quarter.

6.6. Unplanned extubation remains a significant issue on the Newborn Care unit and are all added to the OUH incident management 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 monthly. 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 was launched in June 2023.

6.7. The involvement of the Medical Examiner 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. In previous quarters, clear themes around a lack of communication with families at end of life were identified (via the learning from deaths corporate level email inbox). These issues have significantly reduced this quarter, demonstrating learning and improvement across the OUHFT.

6.8. 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. Improving the rates of Tissue Donation is a Trust Quality Priority this year and the service are keen to engage in this work.

6.9. 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 1 of 2023/24

7.1. 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 11 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.

7.2. 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.

7.3. The need for accurate EPR notes has been reiterated – 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 and can be found on the intranet.

7.4. The importance of documentation of time, date and consultant undertaking medical reviews on admission has been highlighted in MRC. The importance of ensuring that the next of kin details are correct on admission and available on EPR was also highlighted.

7.5. It has been highlighted 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).

7.6. 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%. A working group (established through the patient safety incident response framework (PSIRF) patient safety profile analysis) has been convened where digital solutions are being explored to support improvement, with involvement from the Quality Improvement Team.

7.7. Patients who require an abdominal aortic aneurysm (AAA) repair are now 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.

7.8. The importance of induction documents being created and available was identified in (MRC) and this will be rolled out across the trust.

7.9. 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.

7.10. A Safety message has been circulated to all staff regarding opioid prescribing (weekly safety message 218). Further local teaching has also

been delivered within the Pharmacy department and this is a Trust quality priority.

7.11. Some deaths have highlighted the need to provide pertinent information relevant to decision making around pursuing active treatment to avoid unnecessary transfer to the JR and ongoing unnecessary treatment.

7.12. Reminder to nursing colleagues of blood pressure targets post t-PA[2] and empower nursing staff to contact duty stroke consultant if they feel their concerns have not been adequately addressed by junior doctors.

7.13. 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.

8. Patient safety incidents with an impact of death and subsequent SIRI investigations declared during Quarter 1

7.1 One incident with an impact of death was declared as a Trust Level SIRI during Quarter 1 2023/24.

7.1.1 An intra-uterine death was diagnosed on admission to Maternity Assessment Unit. This case is being investigated by HSIB.

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

7.3 Any relevant learning from this investigation will be included in section 6 of a future learning from deaths report.

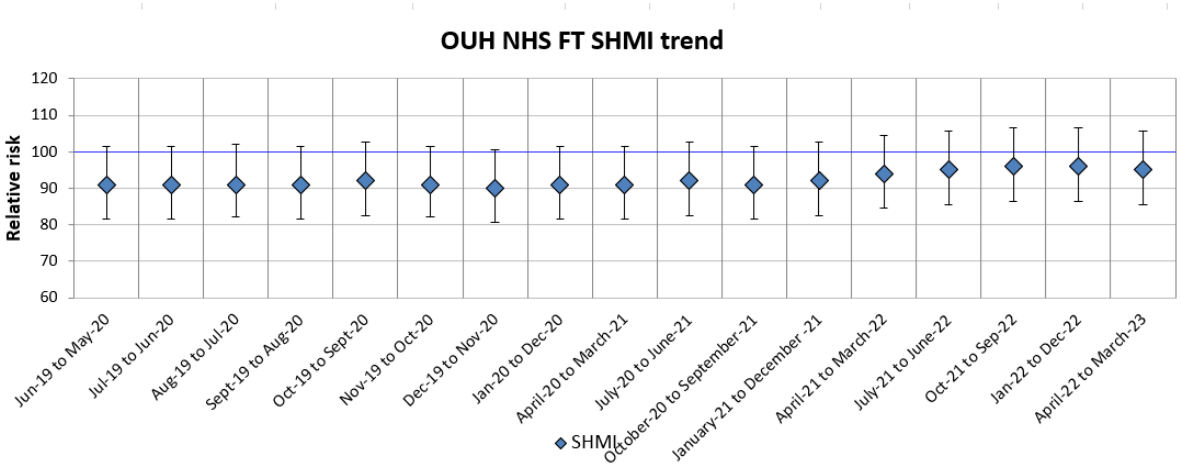
9. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

9.1. There have been no mortality outliers reported for OUH from the Care Quality Commission (CQC) or NHS Digital during Quarter 1 2023/24.

9.2. The SHMI for the data period April 2022 to March 2023 is 0.95. This is banded ‘as expected’ based on NHS Digital’s 95% control limits, adjusted for over-dispersion (0.89 – 1.12).

[2] Tissue plasminogen activator (tPA) is classified as a serine protease (enzymes that cleave peptide bonds in proteins). It is thus one of the essential components of the dissolution of blood clots.

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



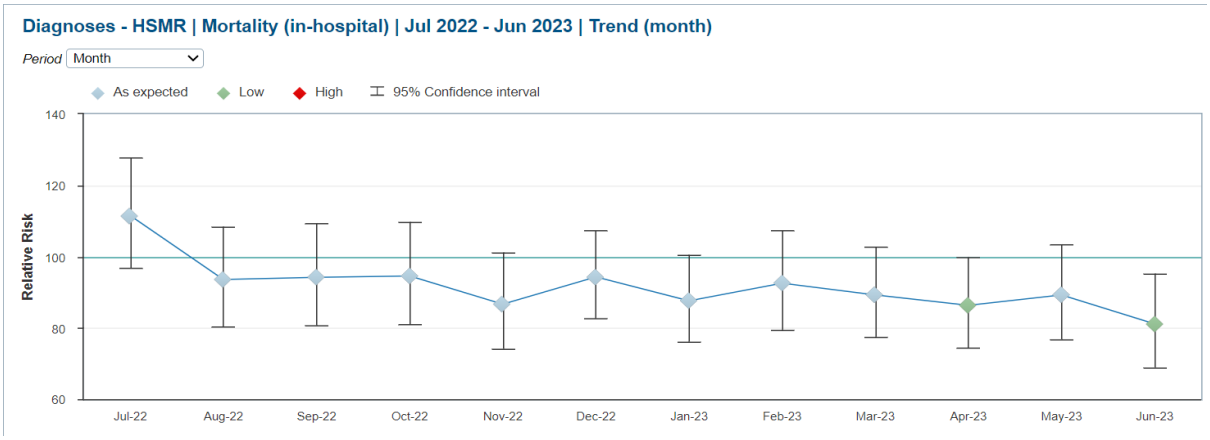
9.3. This chart shows the SHMI trend at various reporting points between June 2019 and March 2023. The SHMI figure has consistently been between 0.9 and 0.96 which is within the ‘as expected’ band. As expected, means that the OUH is not an outlier.

9.4. The Trust’s HSMR is 91.6 for July 2022 to June 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 (Dr Foster data) 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:



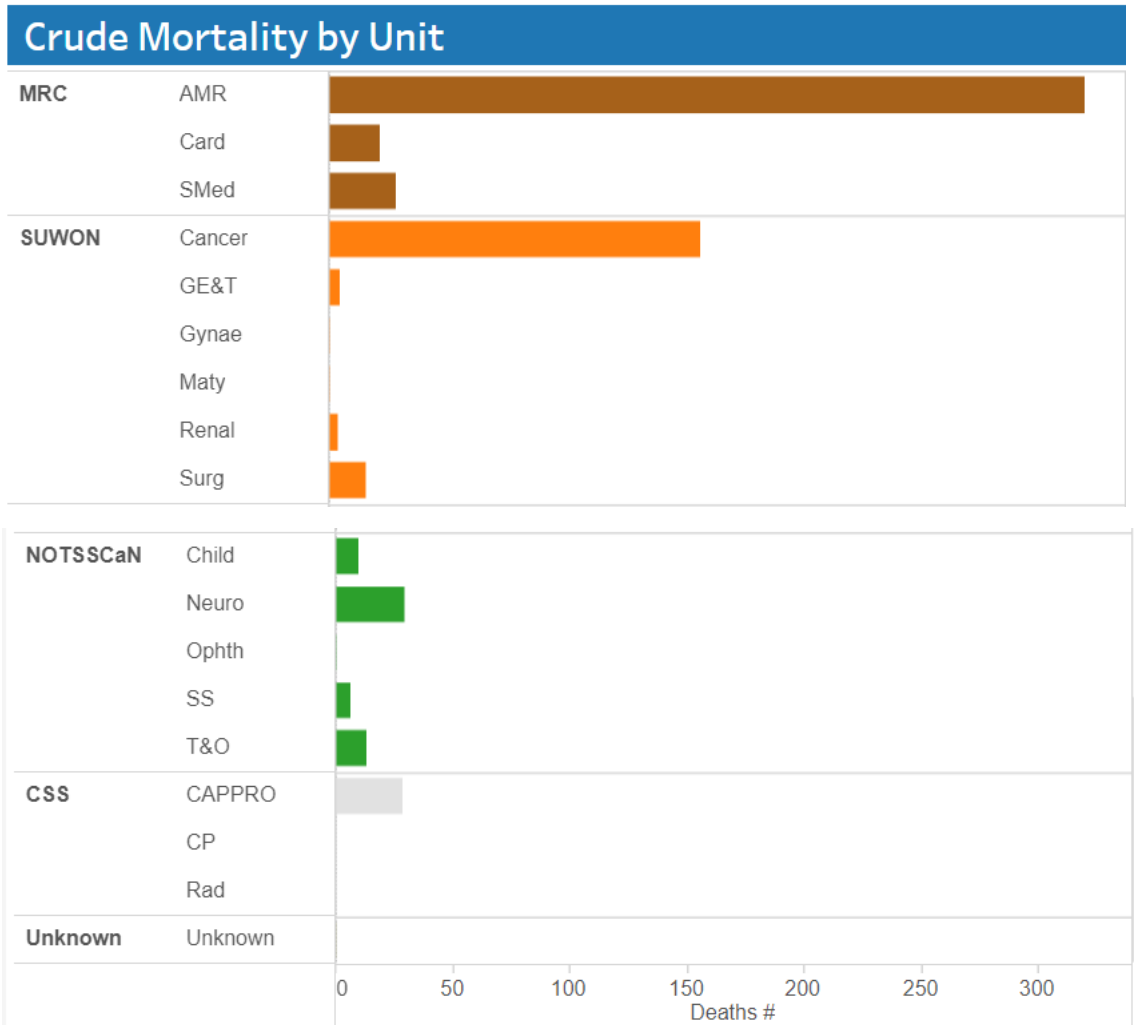
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	3 6	88015	2765	2352.7	3.1	117.5	
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	2 2	88645	2280	2004.5	2.6	113.7	
LEEDS TEACHING HOSPITALS NHS TRUST	2	57600	2395	2132.1	4.2	112.3	
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3 1	67535	2430	2219.7	3.6	109.5	
BARTS HEALTH NHS TRUST	4	56195	2215	2087.7	3.9	106.1	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	12	53420	1960	2113.1	3.7	92.8	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	4	79170	1620	1760.2	2.0	92.0	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	11	69221	2223	2427.5	3.2	91.6	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	18	54120	680	890.0	1.3	76.4	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	53	68570	1510	2058.1	2.2	73.4	

10. Analysis of mortality during Quarter 1:

10.1. The highest number of deaths were admitted to the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (Chart 4). For comparison, section 11.2 includes information relating to mortality compared to total discharges by Division.

10.2. There is no ethnicity data included in this report as it is in the process of being reviewed (it contains a lot of 'unknown'). This is part of a Quality Priority this year and once the data collection has improved this will be included and analysed.

Chart 4: Deaths by Directorate



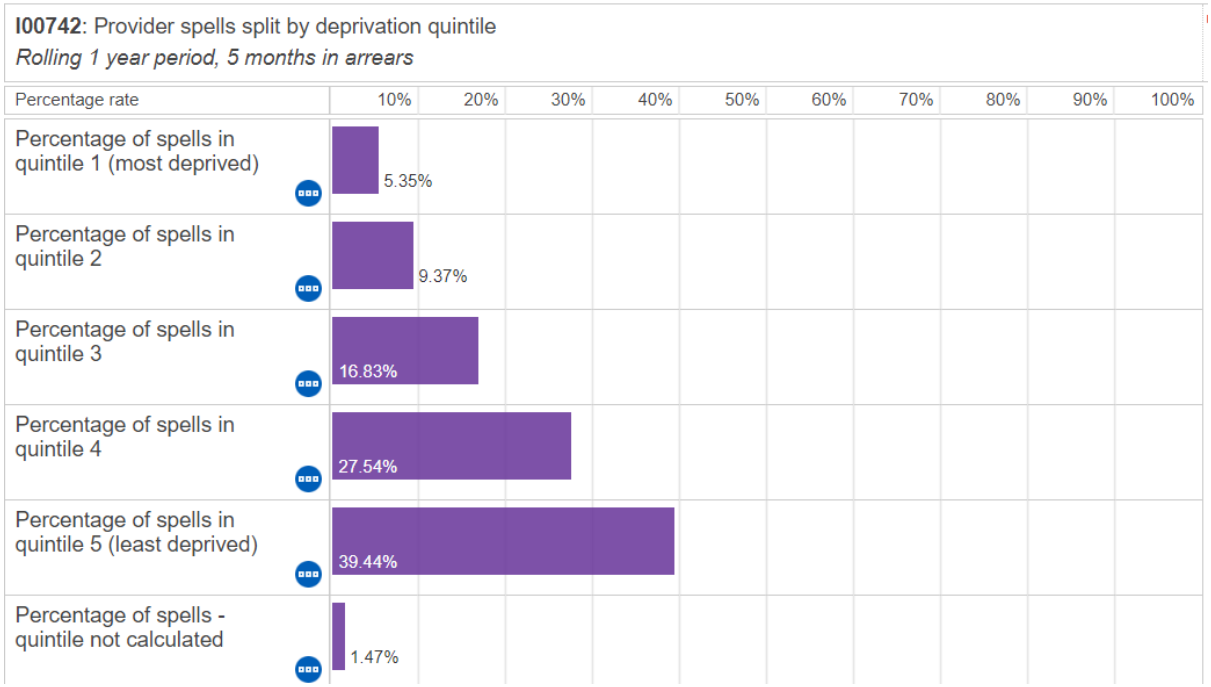
10.3. NHS Digital reference the same spell[3] level information which was used to calculate the SHMI to report the percentage rates of deaths under each social deprivation quintile.

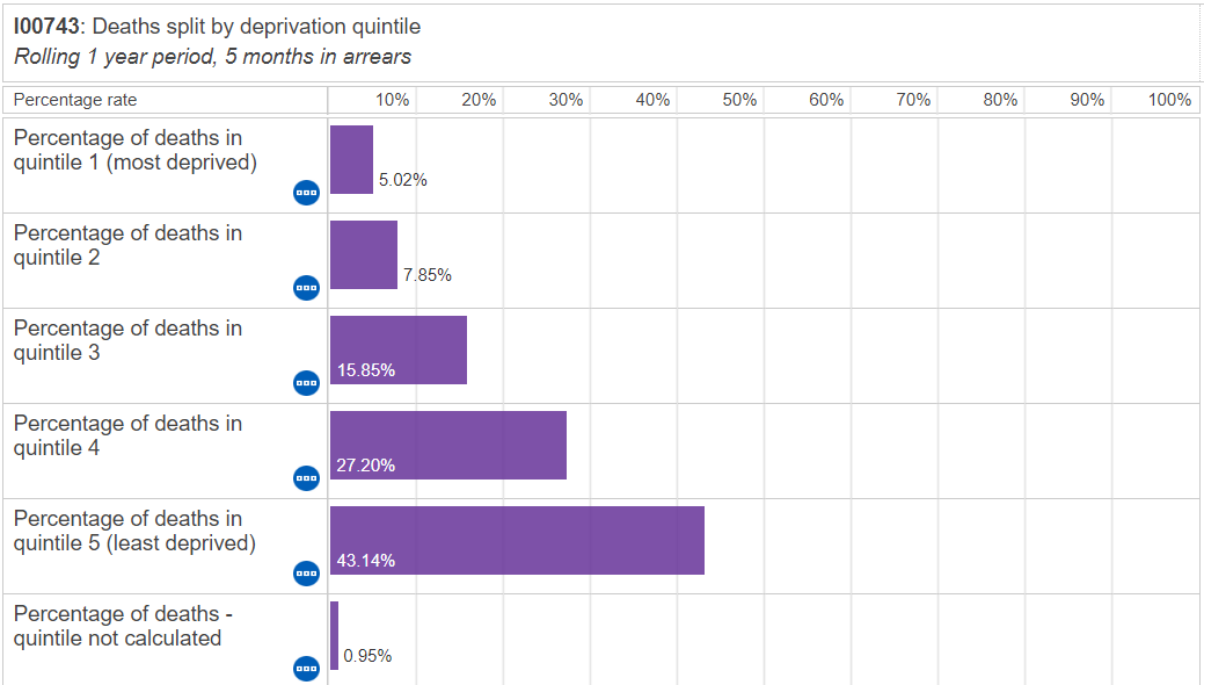
10.4. Deprivation quintiles are calculated using the Index of Multiple Deprivation (IMD) Overall Rank field in the Hospital Episodes Statistics (HES) dataset which is based on a weighted combination of factors such as income; employment; health deprivation and disability; education, skills, and training;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

[3] A Hospital Provider Spell is the total continuous stay of a patient using a Hospital Bed on premises controlled by a Health Care Provider during which medical care is the responsibility of one or more Consultants, or the Patient is receiving care under one or more Nursing Episodes or Midwife Episodes in a ward.

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 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

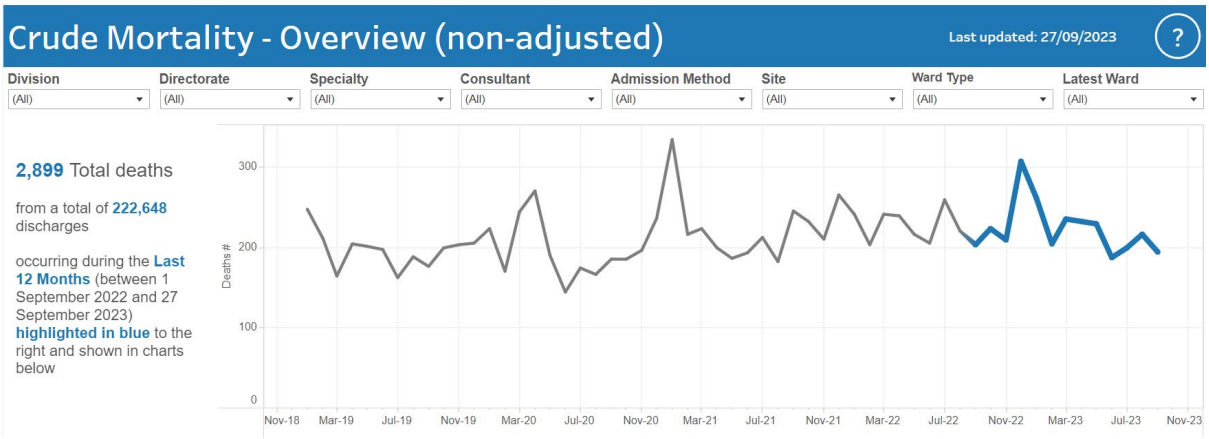




11. Crude Mortality

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)



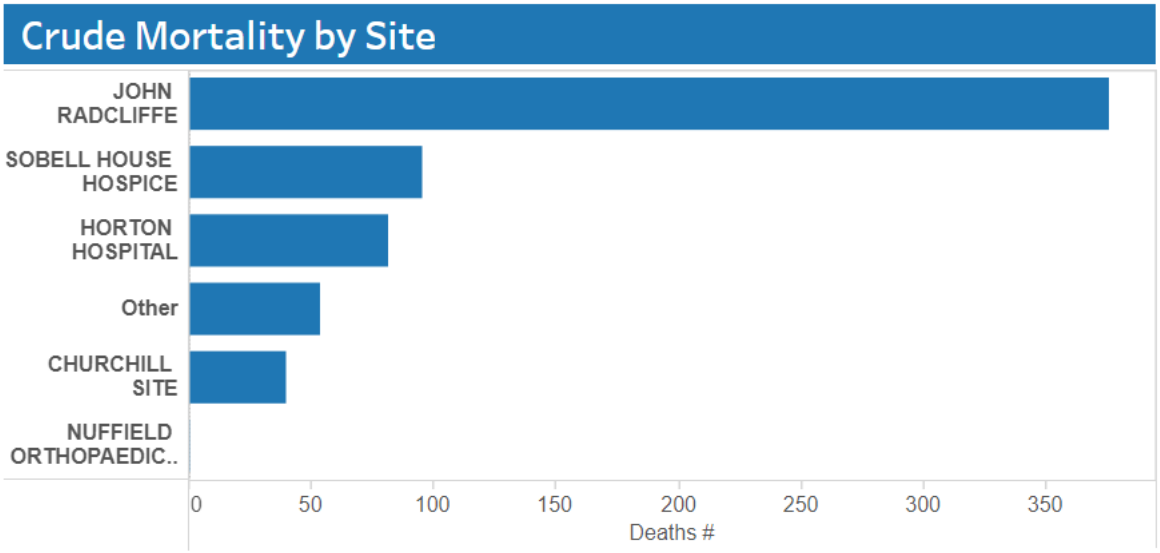
11.2. During Quarter 1 of 2023/24:

Division:	No of deaths:	Total Discharges:
Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's, and Neonatology Division	61	15,658
Medical Rehabilitation and Cardiac Division	374	17.049
Surgery, Women's, and Oncology Division	184	18,813
Clinical Support Services Division in the Critical Care Units	29	727

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



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 diagnosis 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 MRG Chaired by the Deputy Chief Medical Officer.

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

13.3. CIC reports to 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.