

## Learning from Deaths Report Q4 2022/23

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	31 <sup>st</sup> May 2023		
Document Title:	Learning from Deaths Q4 2022/23		
Responsible Director:	Prof Alastair Hutchison	Date of Executive Approval	
Author:	Prof Alastair Hutchison		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No. However formatted in line with SW Regional guidance. Breadth of data presented is recognised as an exemplar within SW Region.		

2. Prior Discussion		
Job Title or Meeting Title	Date	Recommendations/Comments
Hospital Mortality Group	17 <sup>th</sup> May 2023	Accepted
Quality Committee	23 <sup>rd</sup> May 2023	Accepted

3. Purpose of the Paper	To inform the Quality Committee of the learning occurring from deaths being reported, investigated and appropriate findings disseminated throughout the Trust. To also outline additional measures put in place to assure the Trust that unnecessary deaths are not occurring at DCH despite the elevated SHMI. Presentation of the Learning from Deaths report at Quality Committee and Trust Board is a mandatory obligation for all Trusts.						
	Note (✓)		Discuss (✓)		Recommend		Approve (✓)
4. Key Issues	<p>The latest published SHMI data (5 months in arrears) for DCH was above the 'Expected Range' for the rolling 12 months to October, November and December 2022 (page 7) but on a downward trend. No other local or national indicators suggest excess unexpected deaths are occurring at DCH, but SW Region acting through Dorset ICS, are seeking additional assurance from an external audit of Structured Judgment Reviews (SJRs). SJRs are used to examine the care of a significant sample of people who died whilst in-patients (around 20% vs national standard of 10%), and to learn from any good practice or lapses in care identified. The independent DCH Medical Examiners review every death, speak to immediate relatives and highlight any obvious causes for concern.</p> <p>Prof Hutchison will commence an internal SJR audit during w/b 29<sup>th</sup> May, of 50 consecutive deaths occurring in September 2022 to look for unexpected events, and report to the quality Committee separately as soon as this is complete.</p>						
5. Action recommended	<p>The Quality Committee is recommended to:</p> <ol style="list-style-type: none"> <li>1. <b>DISCUSS</b> and <b>NOTE</b> the findings of the report</li> <li>2. <b>DISCUSS</b> the additional scrutiny occurring</li> <li>3. <b>APPROVE</b> the report and escalate to Trust Board</li> </ol>						

6. Governance and Compliance Obligations			
Legal / Regulatory Link	Yes		Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Impact on CQC Standards	Yes		An elevated SHMI will raise concerns with NHS E&I and the CQC. The previous reduction in SHMI and improvements in coding are acknowledged, but Covid-19 and elective tariff incentivisation targets adversely influenced coding and therefore recent SHMI figures are inaccurate
Risk Link	Yes		<ul style="list-style-type: none"> <li>• Reputational risk due to higher than expected SHMI</li> </ul>

			<ul style="list-style-type: none"> <li>Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement</li> <li>Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care</li> <li>Clinical safety issues may be under-reported or unnoticed if data quality is poor</li> </ul> <p>Other mortality data sources (primarily from national audits) are regularly checked for any evidence of unexpected deaths.</p>
<b>Impact on Social Value</b>		<b>No</b>	If yes, please summarise how your report contributes to the Trust's Social Value Pledge
<b>Trust Strategy Link</b>	<b>How does this report link to the Trust's Strategic Objectives?</b>		
<b>Strategic Objectives</b>	People	N/A	
	Place	Health inequalities related to 'Place' are well known to impact life expectancy and will be referenced in future reports.	
	Partnership	N/A	
<b>Dorset Integrated Care System (ICS) goals</b>	<b>Which Dorset ICS goal does this report link to / support?</b>		
Improving population health and healthcare		<b>No</b>	
Tackling unequal outcomes and access	<b>Yes</b>		Health inequalities related to 'Place' are well known to impact life expectancy and will be referenced in future reports.
Enhancing productivity and value for money		<b>No</b>	
Helping the NHS to support broader social and economic development		<b>No</b>	
<b>Assessments</b>	<b>Have these assessments been completed?</b> <i>If yes, please include the assessment in the appendix to the report.. If no, please state the reason in the comment box below. (Please delete as appropriate)</i>		
Equality Impact Assessment (EIA)		<b>No</b>	Not applicable
Quality Impact Assessment (QIA)		<b>No</b>	Not applicable

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## 1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a quarterly report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning.

### 1.1 Family Services and Surgical Division Report - Quarter 4 Report

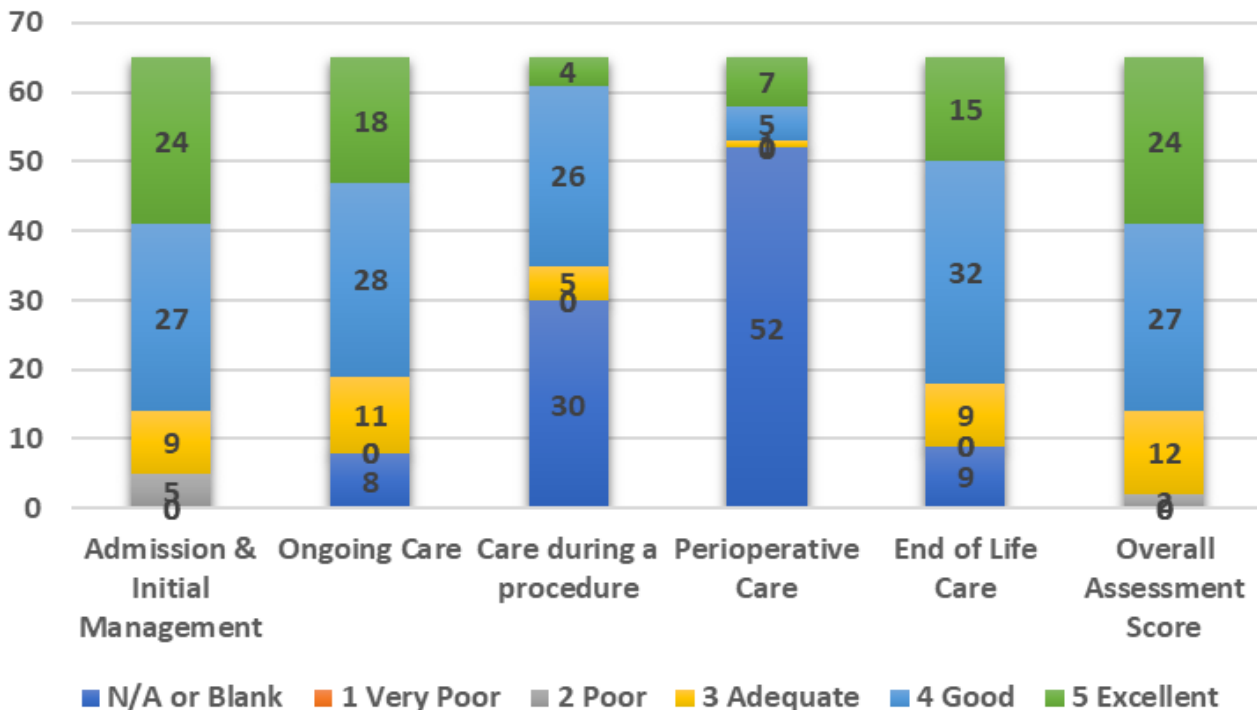
**Structured Judgement Review Results:** The Family Services & Division had 46 deaths in quarter 4, of which 41 that require SJR's to be completed. Of these 19 have had a SJR completed. Within quarter 4 an additional 46 SJR's have also been completed from previous months.

**Outstanding SJR's:** The Division have completed a large number of SJR's from previous quarters, reducing the overall backlog significantly. The backlog of outstanding SJR's (> 2 months) for the Division as at 30/04/2023 is 13:

October	November	December	January 23	February
2	3	3	1	4

Feedback from SJR's Completed in Quarter 4:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
<b>N/A or Blank</b>	0	8	30	52	9	0
<b>1 Very Poor</b>	0	0	0	0	0	0
<b>2 Poor</b>	5	0	0	0	0	2
<b>3 Adequate</b>	9	11	5	1	9	12
<b>4 Good</b>	27	28	26	5	32	27
<b>5 Excellent</b>	24	18	4	7	15	24



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	4	14	27	20

Comments:

- Clear and comprehensive documentation from admission through to patients death from the medical/surgical and anaesthetic teams, nurses and the MDT (dietician, physio etc).
- Consultant review not documented if it happened. Therefore over 48 hours from arrival.
- Difficult to follow Agyle notes and give impression of care.
- Unsure whether there are notes missing. Nothing available for review pre-ICU referral. Very poor surgical clerking.
- Notes loose and out of order but documentation, especially from medical reviews was clear.
- Some difficult handwriting.
- Whilst detailed contemporaneous documentation is difficult in hyper acute clinical scenarios such as this the scribe has missed key information from the trauma booklet which makes it difficult retrospectively to identify all present and have the full clinical picture from the time. Perhaps more experienced nurses/clinicians should fulfil this role.

Ongoing issue with patients' medical records being scanned to DPR before the SJR has been completed. There is a process in place for any records with Medical Examiners notifications to have a sticker on the front not to be scanned before SJR completed, however this does not capture the records of those that do not have a ME notification but still require a SJR (Family & Surgery Division review all deaths). Quality Manager continues to monitor when the Mortuary have released the records to obtain them before they go to the scanning team to try and mitigate this.

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	4	12	49

**Report completed by: Richard Jee – Divisional Mortality Lead  
Laura Symes – Quality Manager**

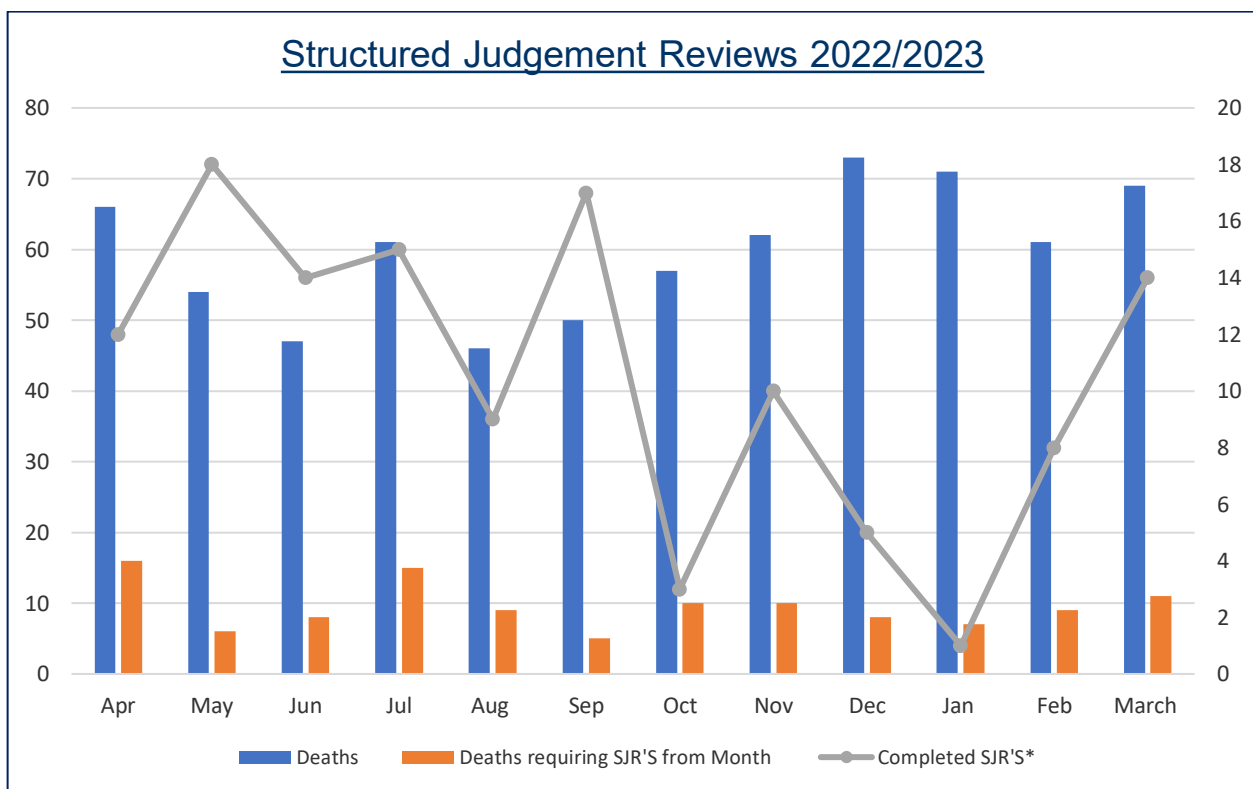
## 1.2 Division of Urgent & Integrated Care – Quarter 4 Report

Structured Judgement Reviews: In quarter 4 there were 201 deaths, 27 SJR's requested from these deaths and 23 SJR's were completed in total (completed SJR's not necessarily from this quarter).

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD
<b>Deaths</b>	<b>66</b>	<b>54</b>	<b>47</b>	<b>61</b>	<b>46</b>	<b>50</b>	<b>57</b>	<b>62</b>	<b>73</b>	<b>71</b>	<b>61</b>	<b>69</b>	<b>717</b>
<b>Deaths requiring SJR'S from Month</b>	<b>16</b>	<b>6</b>	<b>8</b>	<b>15</b>	<b>9</b>	<b>5</b>	<b>10</b>	<b>10</b>	<b>8</b>	<b>7</b>	<b>9</b>	<b>11</b>	<b>114</b>
<b>Completed SJR'S*</b>	<b>12</b>	<b>18</b>	<b>14</b>	<b>15</b>	<b>9</b>	<b>17</b>	<b>3</b>	<b>10</b>	<b>5</b>	<b>1</b>	<b>8</b>	<b>14</b>	<b>126</b>

Total outstanding SJR's (not including nosocomial) = **38 (29)**

Outstanding SJR's >2 months (prior to 30/11/2022) = **18 (20)**

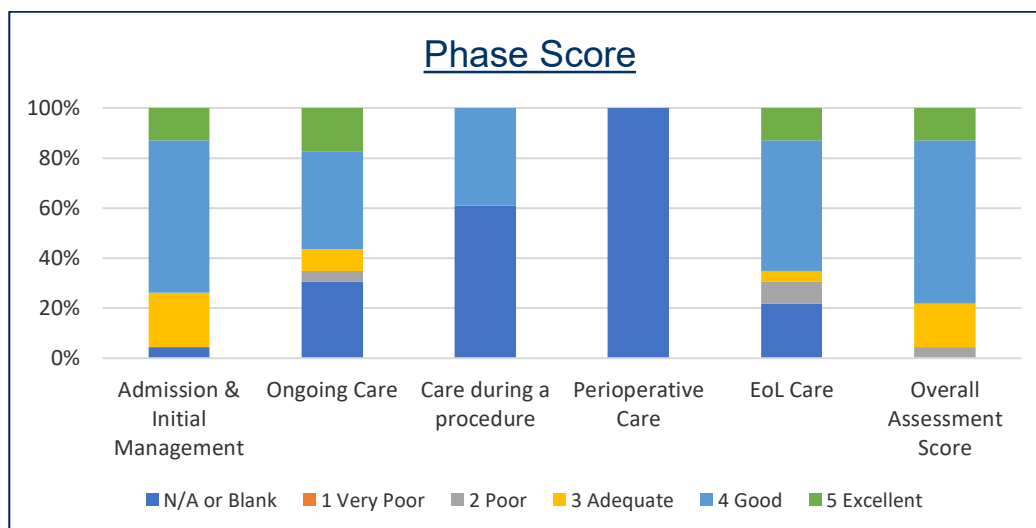


Nosocomial SJR Requests: 20 Nosocomial deaths that were to be reviewed by James Metcalfe (not included in above figures) (9 reviewed so far but Datix not updated as part of report rather than individual SJR's, 12 remaining from original list). 3 further Nosocomial SJR Trigger SJR's received (1 x Feb, 1 x March and 1 x April).

Phase score from 24 completed SJR's in Quarter 4:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	EoL Care	Overall Assessment Score
<b>N/A or Blank</b>	1	7	14	23	5	0
<b>1 Very Poor</b>	0	0	0	0	0	0
<b>2 Poor</b>	0	1	0	0	2	1
<b>3 Adequate</b>	5	2	0	0	1	4
<b>4 Good</b>	14	9	9	0	12	15
<b>5 Excellent</b>	3	4	0	0	3	3

\*Returned to clinician who completed for score to be added – 30/01/23



#### Overall quality of patient record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	1	3	14	5

Quality of patient record improved on last quarter with 19 of the 23 records reviewed scoring good or excellent.

#### Avoidability of Death Judgement Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (> 50:50)	Score 4 Possibly avoidable but not very likely (<50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	1	2	20

SJR

with judgement score of 4, sent to Acute Medicine team beginning of February for sharing and discussing at their next M+M. I am pending minutes of this meeting for learning. Once minutes received, to be shared in divisional newsletter.

**Jemma Newman, Quality Manager,**  
**Sonia Gamblen, Divisional Head of Nursing & Quality**  
**James Metcalfe, Divisional Director**

## 2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

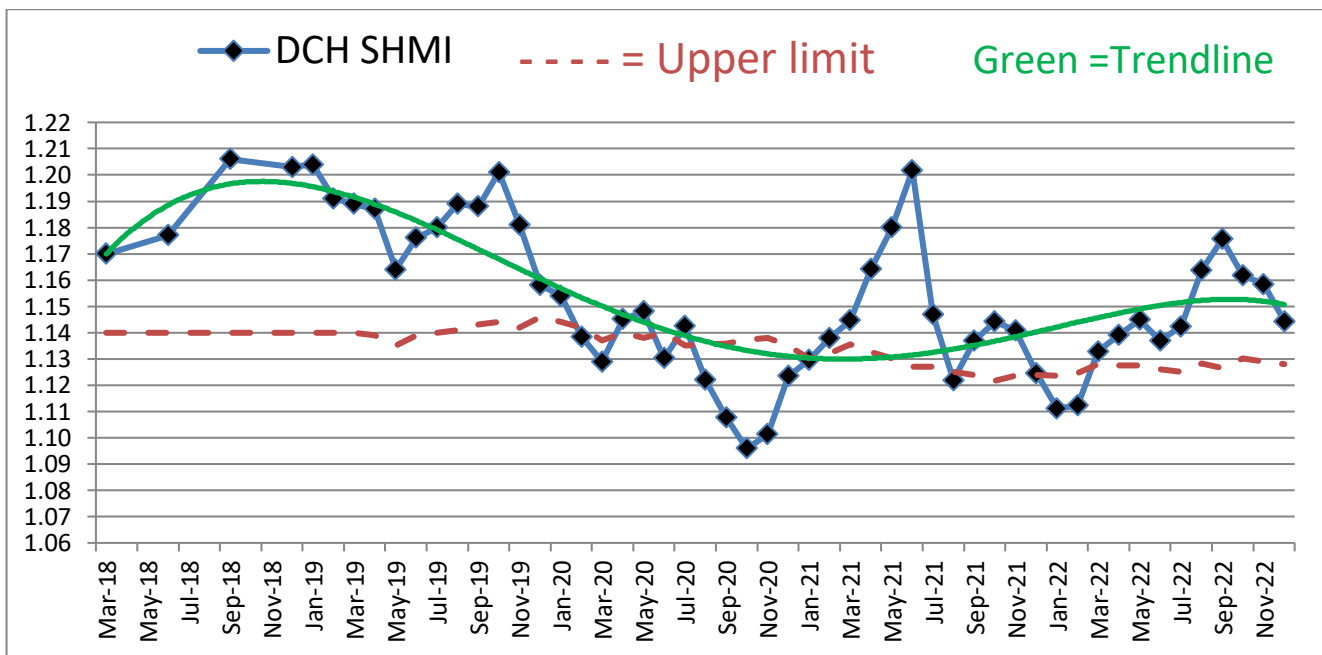
### 2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge.

The most recently published data for the rolling 12 months to October, November and December 2022 is reducing but remains outside the 'Expected Range' and we know that our data continues to be adversely influenced by short staffing in the Coding Department, and a possible under-reporting of 'sepsis' in the written medical record. NHS Digital continues to exclude all deaths related to covid from the reported data.

Victoria Stevens reports that the Clinical Coding Department has a coding backlog of more than 4,000 SPELLS with 2 vacancies for qualified coders, which may prevent us from reporting all SPELLS for this financial year. This is likely to continue to adversely influence the accuracy of DCH's SHMI data. Once the qualified and trainee coders are integrated and fully contributing to the work of the Clinical Coding team, DCH will have a robust team that provides a timely service of high quality.

The latest published SHMI (rolling year to December 2022) is shown below:

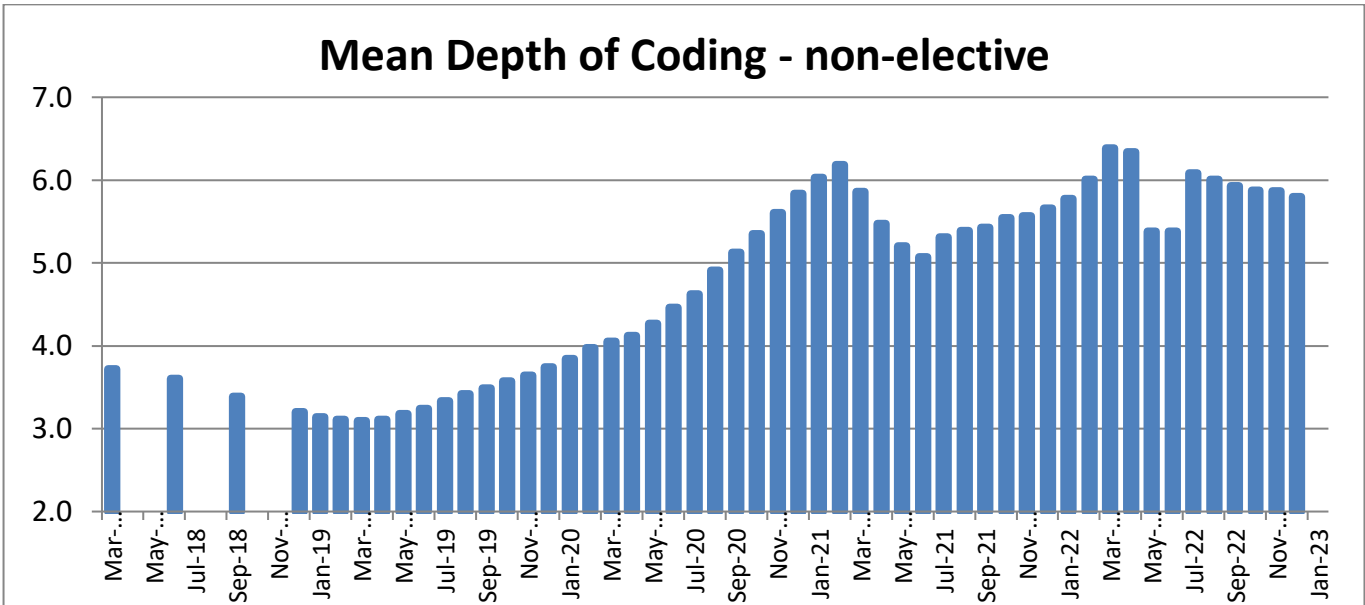


SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding of all admissions). From October 2019 onwards there had been a steady trend of improvement in DCH's SHMI as a result of focus on SJRs, M&M meetings and a full Medical Examiner service, plus investment in the coding department which resulted in more accurate coding returns to NHS Digital.

**2.3 Depth of coding:** NHS Digital states "As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected number of deaths. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities but may also be due to differences in coding practices between trusts."

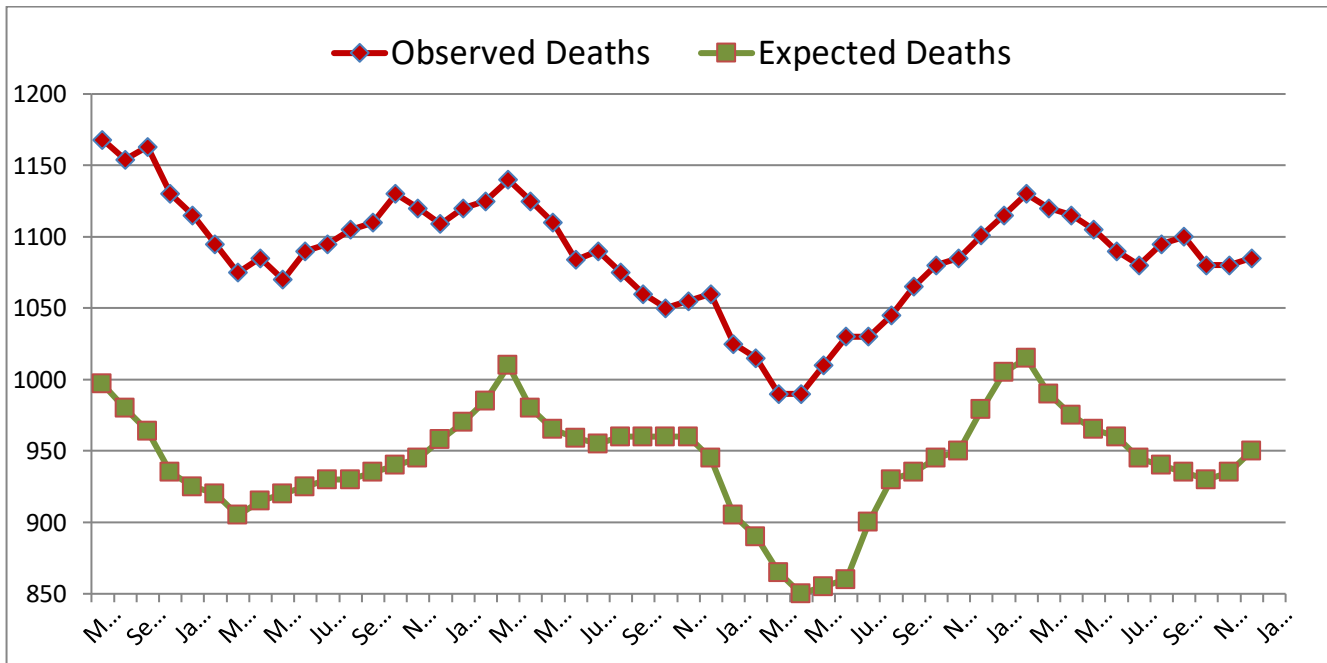
DCH's depth of coding had been improving steadily up to March 2022 (see graph below), but the most recently reported months which include the corrected M14 data show a significant decrease. This may partially explain the recent reduction in 'Expected Deaths' and consequent rise in SHMI.

## Mean Depth of Coding - non-elective



### 2.4 Expected Deaths (based on diagnoses across all admissions (except covid) per rolling 12 months):

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths over the past 4+ years (rolling years from March 18 to Dec 23), the numbers of which are directly influenced by the number of in-patients particularly during and immediately after the covid-19 pandemic. Whilst both observed and expected deaths tended to decrease over the 7 months to October 23 (as the total number of in-patients has tended to decrease), the expected deaths have recently increased back to their average of around 950 per 12 months.



### 3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group continues to meet on a monthly basis to examine any other data which might indicate changes in standards of care. The following sections report data available from various national bodies which report on Trusts' individual performance. However much of this data has also been interrupted by covid-19 and is only gradually catching up again.

For other metrics of care including complaints responses, sepsis data, AKI, patient deterioration and DNACPR data and VTE assessment data please see the Quality Report presented on a monthly basis to Quality Committee by the Chief Nursing Officer.



In light of various issues related to maternity units and excess deaths of both children and mothers, NHS Digital has now published the first iterations of a “[National Maternity Dashboard](#)”. This data is also contained within the monthly Quality report.

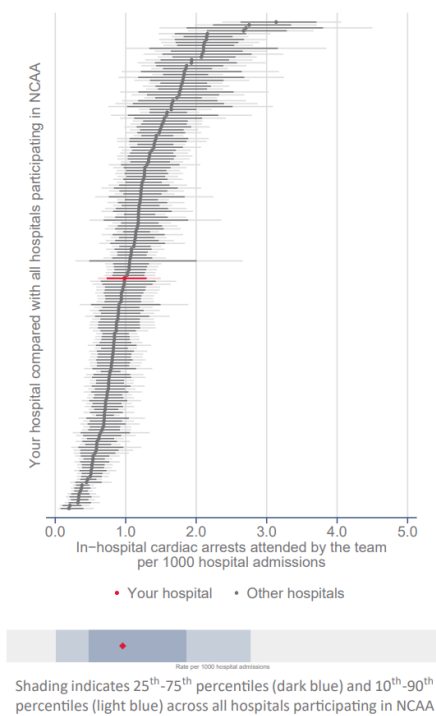
### 3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2022 to December 2022 (quarters 1, 2 and 3) was published on 23/03/2023. Frequent cardiac arrest calls suggest unanticipated deterioration in a patient’s condition, whereas fewer calls suggest higher standards of ward care, although this is unproven. A total of 50 cardiac arrest calls were recorded for this 9 month period, but not all were definite cardiac events since the cardiac arrest call is also used for any serious or unexpected patient event.

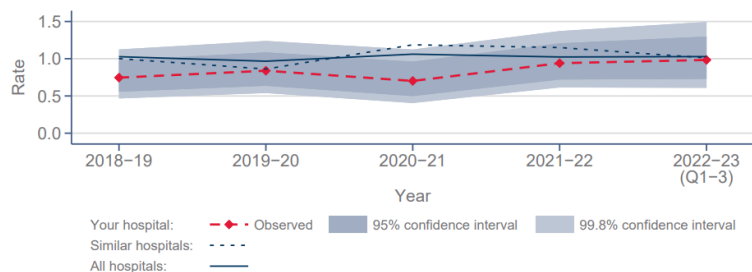
The graph below represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCAA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the graph below the table summarises the past 5 years.



#### Rate of cardiac arrests per 1000 hospital admissions



	Hospital admissions	Eligible team visits	Rate per 1000 hospital admissions	95% confidence interval	99.8% confidence interval
Quarter 1	16802	19	1.13	(0.68, 1.77)	(0.49, 2.18)
Quarter 2	16587	16	0.96	(0.55, 1.57)	(0.39, 1.97)
Quarter 3	17446	15	0.86	(0.48, 1.42)	(0.33, 1.79)
Quarter 4					
Year to date	50835	50	0.98	(0.73, 1.30)	(0.61, 1.49)



- Definition**
- Hospital admissions: Total includes elective, non-elective, day cases, babies born in your hospital and neonates
  - Eligible team visits: All reported in-hospital cardiac arrests attended by the team
  - Observed rate: The total number of cardiac arrests attended by the team divided by the total number of admissions to your hospital multiplied by 1000 to give a rate per 1000 hospital admissions
  - Confidence interval: Reflects the degree of uncertainty surrounding your observed rate, given the total number of admissions to your hospital

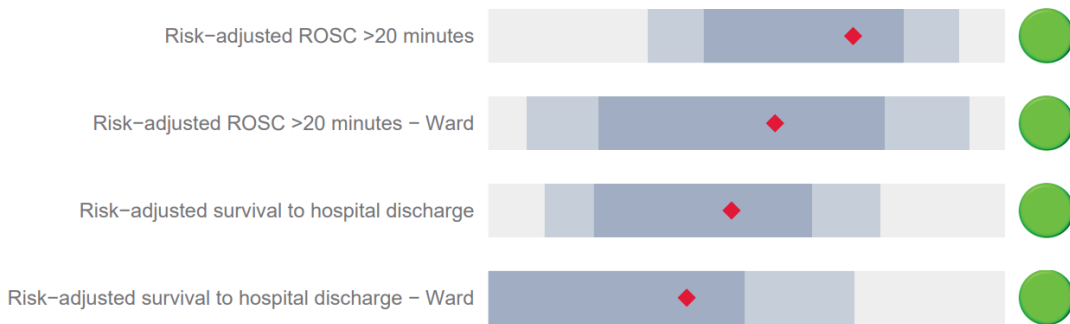
The dashboard below shows two important risk-adjusted outcome measures arising from a cardiac arrest:

- Time to ‘Return of Spontaneous Circulation’ (a measure of resuscitation effectiveness) and
- Survival to Discharge.

These and all other measures in the report get a ‘green’ indicator for the most recently reported Quarters 1, 2 and 3 (2022/23).



## Risk-adjusted outcomes: Dashboard



**3.2 National Adult Community Acquired Pneumonia Audit** latest data – last published Nov 2019 (see below), and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 for publication in Summer this year.

**3.3 ICNARC Intensive Care survival latest data** for April to December 2022; published 21/02/2023; n = 491 patients.

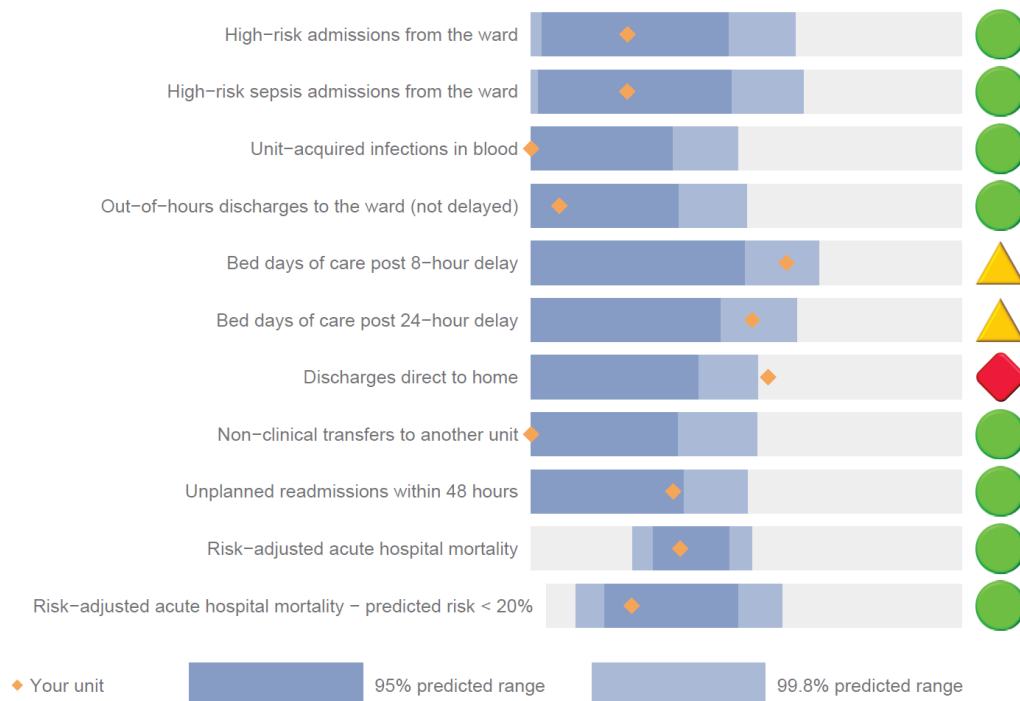
The amber indicators in the chart below indicate delays in being able to discharge patients from ICU, with some delays being long enough that the patient was discharged direct to home (red indicator). This is an indication of DCH bed pressures.

Unplanned readmissions were higher than expected in Q1 (4% versus expected 1%) but normalised during Q2 (1.0% versus expected 0.9%). The combined result for Q1 + Q2 + Q3 is within the expected range.

Dorset County Hospital, Intensive Care/High Dependency Unit  
Quarterly Quality Report: 1 April 2022 to 31 December 2022



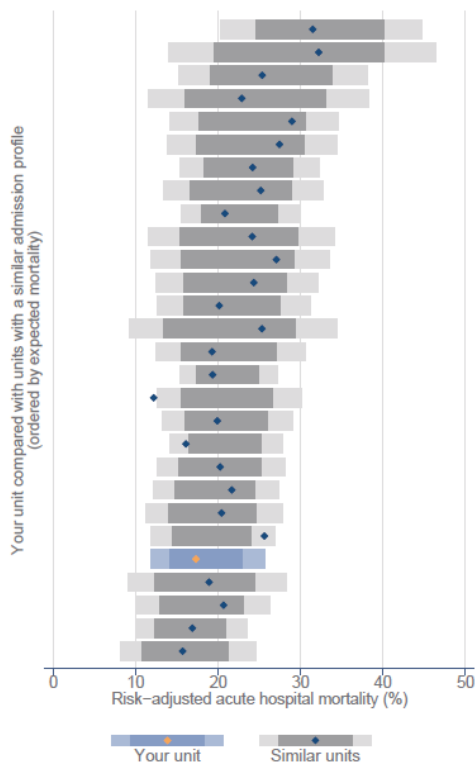
## Quality indicator dashboard



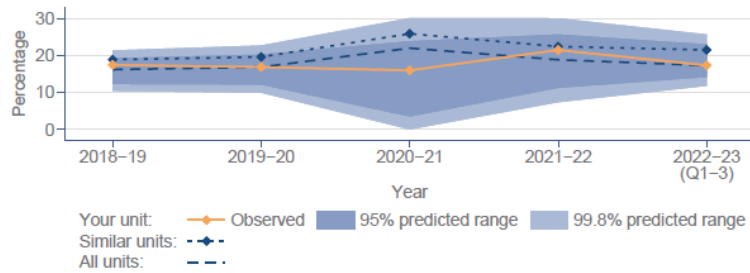
The charts below show the “risk-adjusted acute hospital mortality” following admission to the DCH Critical Care Unit in Q1, 2 and 3 2022/23. They compare observed and expected death rates in a similar fashion to SHMI. Lower is better.



### Risk-adjusted acute hospital mortality



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	146	134	14.2	18.1	(11.4, 24.5)	(8.2, 28.7)	●
Quarter 2	166	158	16.5	18.9	(12.7, 24.9)	(9.6, 28.8)	●
Quarter 3	179	170	20.6	18.7	(12.7, 24.5)	(9.7, 28.1)	●
Quarter 4							
Year to date	491	462	17.3	18.6	(14.1, 23.0)	(11.8, 25.7)	●



**Definition**

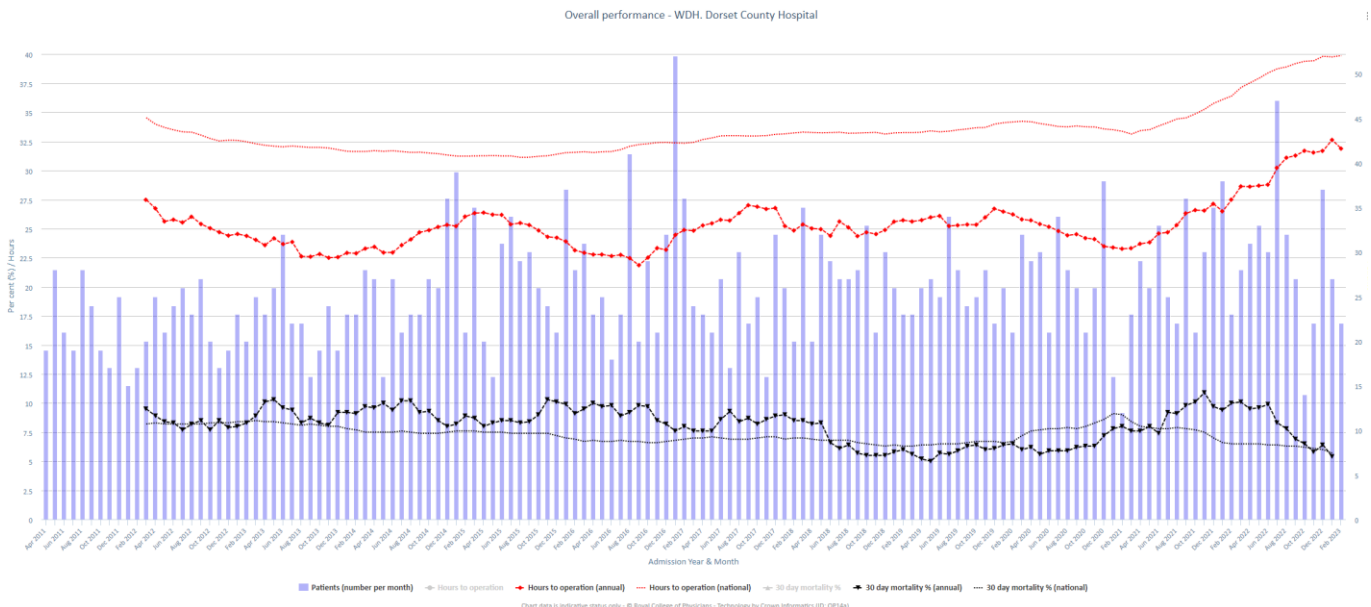
- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Observed percentage: The percentage of eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths among eligible admissions, calculated as the mean predicted risk of death from the ICNARC<sub>FF-2018</sub> model for eligible admissions to your unit
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

Date of report: 21/02/2023

These results are well within the expected range.

### 3.5 National Hip Fracture database to April 2021

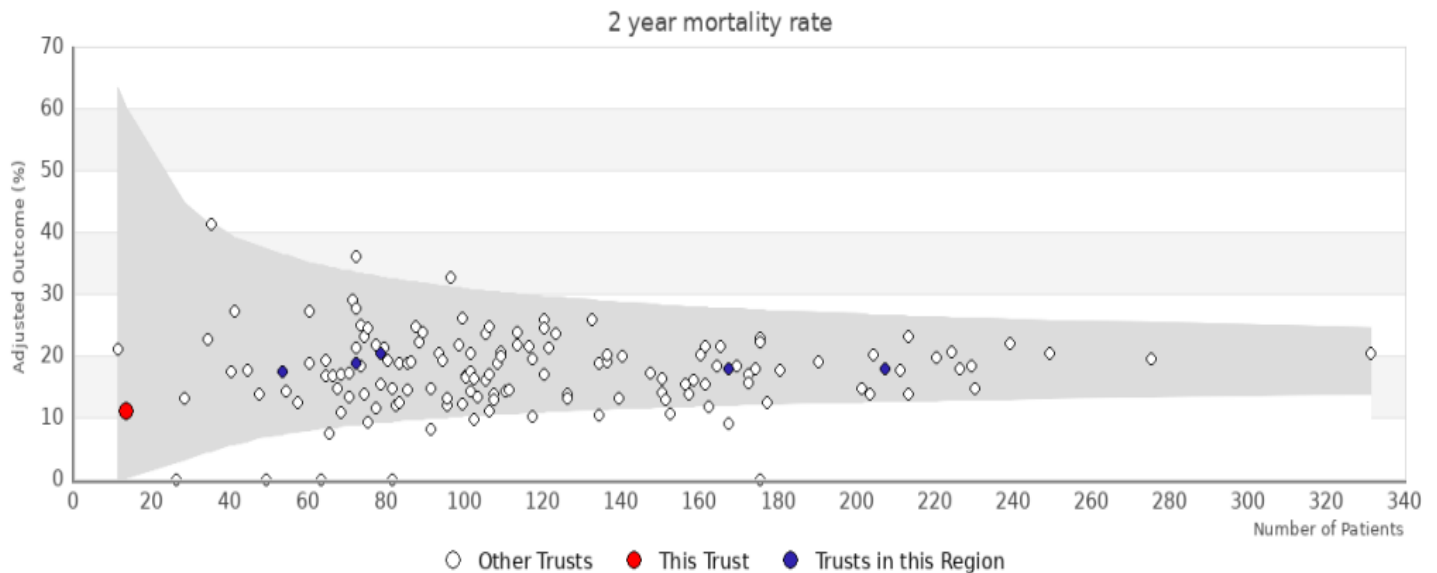
30 day mortality rose in 2021/22 but has now fallen below the national average once again (5.4 vs 5.7%).



'Hours to operation' remains significantly better than the national average for Q3 (31.9 vs 39.9 hours) but there has been a steady rise across the country post-covid.

### 3.6 National Bowel Cancer Annual audit

Data for 2 year survival after bowel cancer surgery for patients in England and Wales diagnosed with bowel cancer 1 April 2020 – 31 March 2021 was published earlier this year. The graph below shows the latest available 2 year survival data for these patients compared to all other NHS Trusts, with other Wessex Trusts in dark blue. The numbers are very small reflecting the effect of the covid pandemic on admissions, however 2-year survival data for DCH is good with an expected death rate of 10.9% versus an actual rate of 7.8%. This percentage difference probably reflects a difference of a single patient's survival.



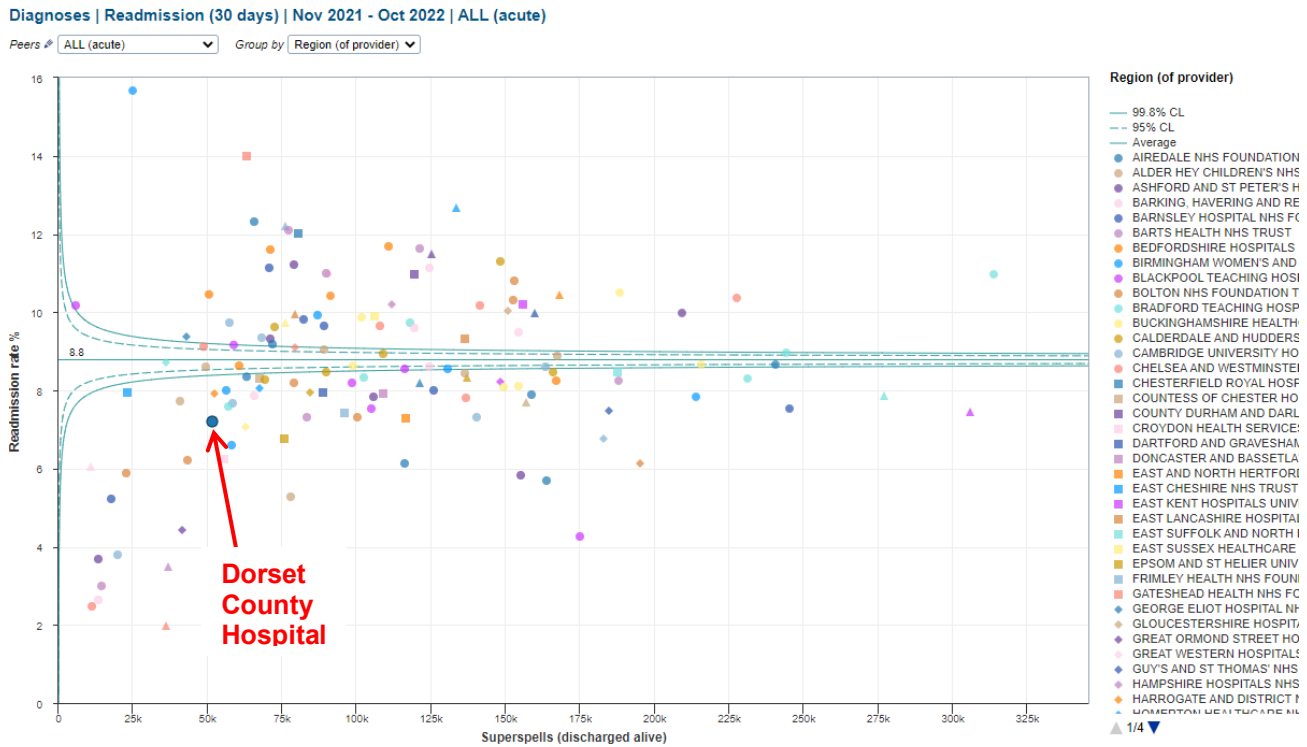
### 3.7 Getting it Right First Time; reviews in Qtr 4

GIRFT are now responsible for, and primarily focusing on, recovery of waiting lists in 6 High Volume, Low Complexity (HVLC) specialties – ophthalmology, ENT, gynaecology, general surgery, urology and orthopaedics. However, this has no direct bearing on Learning from Deaths. None of these services have been reviewed during Q4.

### 3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. No new data has been published since that reported in the previous Q2 Learning from Deaths report. The data is therefore unchanged and reports up to December 2021 only. The TARN website states that a data update will be available by 31<sup>st</sup> May 2023.

### 3.9 Readmission to hospital within 30 days, latest available data (Dr Foster); lower is better



A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process. However, DCH's readmission rate continues to be significantly lower than the average of other acute Trusts.

### 3.10 Dr Foster Safety Dashboard

This dashboard has been temporarily withdrawn by Dr. Foster but will apparently be reinstated later this year.

## 4.0 QUALITY IMPROVEMENT ARISING FROM SJRS

The following themes have been previously identified from SJRs and are being translated into quality improvement projects:

a) Poor quality of some admission clerking notes, particularly in surgery - the hospital clerking proforma has been revised, and the continuation note paper has had reminder watermarks added to remind staff to date, time, print name/GMC no. The introduction of the 'AGYLE' electronic patient record software occurred in the Emergency Dept. at the end of Q4 last year and, as this is rolled out across the Trust, it will be fully auditable and replace written records. This will solve many of the legibility and quality issues that exist with written records. UHD are now adopting AGYLE for their A&E department, creating a single software system across the Dorset Acute Trusts but based at DCH.

b) Morbidity and Mortality meetings - standardization and governance (see next item).

c) With an elevated SHMI and in the absence of any obvious flags from SJRs, an audit of 50 consecutive deaths is being undertaken in June 2023 (strikes permitting) to re-examine the accuracy and quality of the SJR scrutiny, in association with the Dorset ICS Learning from Deaths committee.

## 5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers. Dates of these meetings are reported in sections 1.1 and 1.2 above.

## 6.0 LEARNING FROM CORONER'S INQUESTS Q3

DCH has been notified of 17 new Coroner's inquests being opened in the period October 2022 – December 2022.

11 inquests were held during Quarter 4. 4 inquests were heard as Documentary hearings, not requiring DCH attendance. 2 required the clinician to attend Court in person. 3 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams. 2 inquests were held hybrid – attending in person and some clinicians joining remotely.

We currently have 57 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 0 pre-inquest reviews were listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings. The coroner requested that from May 2022 witnesses should attend the court room at the Town Hall, Bournemouth in person. Authority is now required if we wish the clinician to attend remotely. The number of inquests being listed appear to be increasing which logistically causes challenges. We have a date in February, where 3 inquests are scheduled on one day.

## 7.0 LEARNING FROM CLAIMS Q3

Legal claims are facilitated by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs. GIRFT is also requesting us to examine our pattern of claims for the past 5 years to see what learning can be gleaned – this is currently in process with a deadline of the Spring.

Claims pattern this Quarter:

New potential claims	10
Disclosed patient records	22 (including disclosure to the Coroner as well as claims)
Formal claims	3 clinical negligence, 0 employee claim
Settled claims	3 clinical negligence, 1 employee claim
Closed - no damages	0 clinical negligence, 0 employee claim

## 8.0 SUMMARY

SHMI has not improved as expected following the updated HES data for 2021/22, submitted to NHS Digital by the deadline of 19<sup>th</sup> May 2022. A stable coding backlog exists of around 4,000 cases and the coding department continues to attempt to recruit to vacancies to solve this problem. All mortality data requires on-going scrutiny and an audit of approximately 50 deaths is about to commence to look for any evidence of 'avoidability' or poor care, as well as closer examination of diagnostic groups that are indicating higher observed than expected deaths.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH and much of the national data suggests better than average mortality, although National Hip Fracture mortality was less good during covid-19 but is currently better than the national average again. Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.