

Learning from Deaths Report Q1 2023/24

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27 September 2023		
Document Title:	Learning from Deaths Q1 2023/24		
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	16 th August 2023	Accepted
Quality Committee	18th August 2023	

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 within the 'Expected Range' for the rolling 12 months to January and February 2023, but fractionally above the range for March 2023 (1.1355 vs 1.1328; page 7). 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. Industrial action has caused delays to these processes. The independent DCH Medical Examiners review every death, speak to immediate relatives and highlight any obvious causes for concern.</p> <p>Prof Hutchison commenced an internal SJR audit during June 2023, 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. This will be independently reviewed by Dr. Sean Weaver under the auspices of SW Region & Dorset ICB.</p>						
5. Action recommended	<p>The Quality Committee is recommended to:</p> <ol style="list-style-type: none"> 1. DISCUSS and NOTE the findings of the report 2. DISCUSS the additional scrutiny occurring 3. APPROVE the report and escalate to Trust Board 						

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, and the overall trend in DCH's SHMI is favourable.
Risk Link	Yes		<ul style="list-style-type: none"> • Reputational risk due to higher than expected SHMI

			<ul style="list-style-type: none"> Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care Clinical safety issues may be under-reported or unnoticed if data quality is poor <p>Other mortality data sources (primarily from national audits) are regularly checked for any evidence of unexpected deaths.</p>
Impact on Social Value		No	If yes, please summarise how your report contributes to the Trust's Social Value Pledge
Trust Strategy Link	How does this report link to the Trust's Strategic Objectives?		
Strategic Objectives	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	
Dorset Integrated Care System (ICS) goals	Which Dorset ICS goal does this report link to / support?		
Improving population health and healthcare		No	
Tackling unequal outcomes and access	Yes		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		No	
Helping the NHS to support broader social and economic development		No	
Assessments	Have these assessments been completed? <i>If yes, please include the assessment in the appendix to the report..</i> <i>If no, please state the reason in the comment box below.</i> <i>(Please delete as appropriate)</i>		
Equality Impact Assessment (EIA)		No	Not applicable
Quality Impact Assessment (QIA)		No	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 1 2022/23 Report

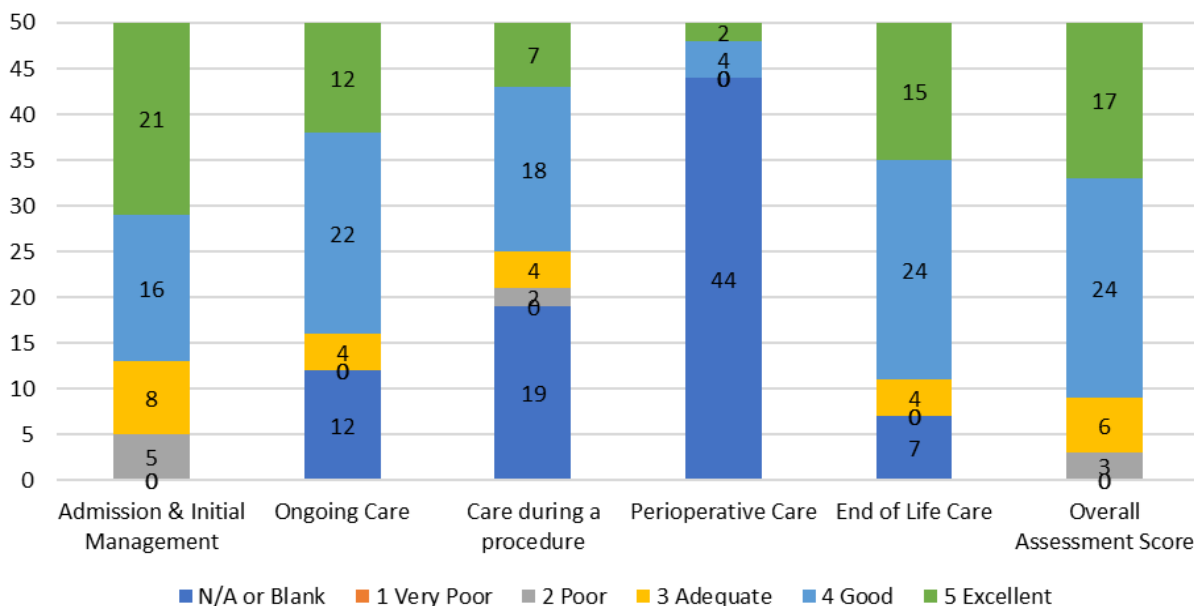
Structured Judgement Review Results: The Family Services & Division had 37 deaths in quarter 1, of which 35 that require SJR's to be completed. Of these 21 have had a SJR completed. Within quarter 1 an additional 29 SJR's have also been completed from previous months.

Outstanding SJR's: The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 25/07/2023 is 15:

October	December	February 23	March	April	May
2	1	1	7	3	1

Feedback from SJR's Completed in Quarter 1:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	12	19	44	7	0
1 Very Poor	0	0	0	0	0	0
2 Poor	5	0	2	0	0	3
3 Adequate	8	4	4	0	4	6
4 Good	16	22	18	4	24	24
5 Excellent	21	12	7	2	15	17



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
2	0	3	5	27	13

- Documentation re: cancer diagnosis not absolutely clear in the notes (although pt was apparently aware.) Otherwise good documentation.
- Missing ED notes.
- ED printed notes very difficult to follow (34 pages).
- Full ERCP report – well written.
- Excellent documentation throughout admission to palliation.
- Unsure whether there are notes missing. Nothing available for review pre-ICU referral.
- No Consultant documentation or written that they were involved in any decision making until next morning – discuss at Clinical Governance Meeting.
- Overall good documentation of daily patient condition/assessment and plan of care. A little difficult to establish exact time line of first and second intubations, ? wrong date written on one piece of documentation making it slightly difficult to follow.
- Record was good but notes loose and in wrong order. Writing sometimes difficult to read.

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	1*	0	2	8	39

*This case resulted from a known complication of a necessary gastroscopy in a frail elderly patient. The case and SJR findings have been referred to the Coroner for an Inquest.

Emerging Themes:

1. Poor surgical clerkings which seem to be deteriorating rather than improving – referred to Mr Ng, General Surgery & Colorectal Clinical Governance & M&M Lead, for surgical review.
2. Delay in decision making on admission to ICU regarding TEP – for discussion at Clinical Governance Meeting (CGM).
3. Delay in obtaining central venous access – for discussion at CGM.
4. Failed attempts for invasive lines and procedures should be documented – for discussion at CGM and Newsletter inclusion.
5. Unclear ICU referrals and timings – for discussion at CGM.

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

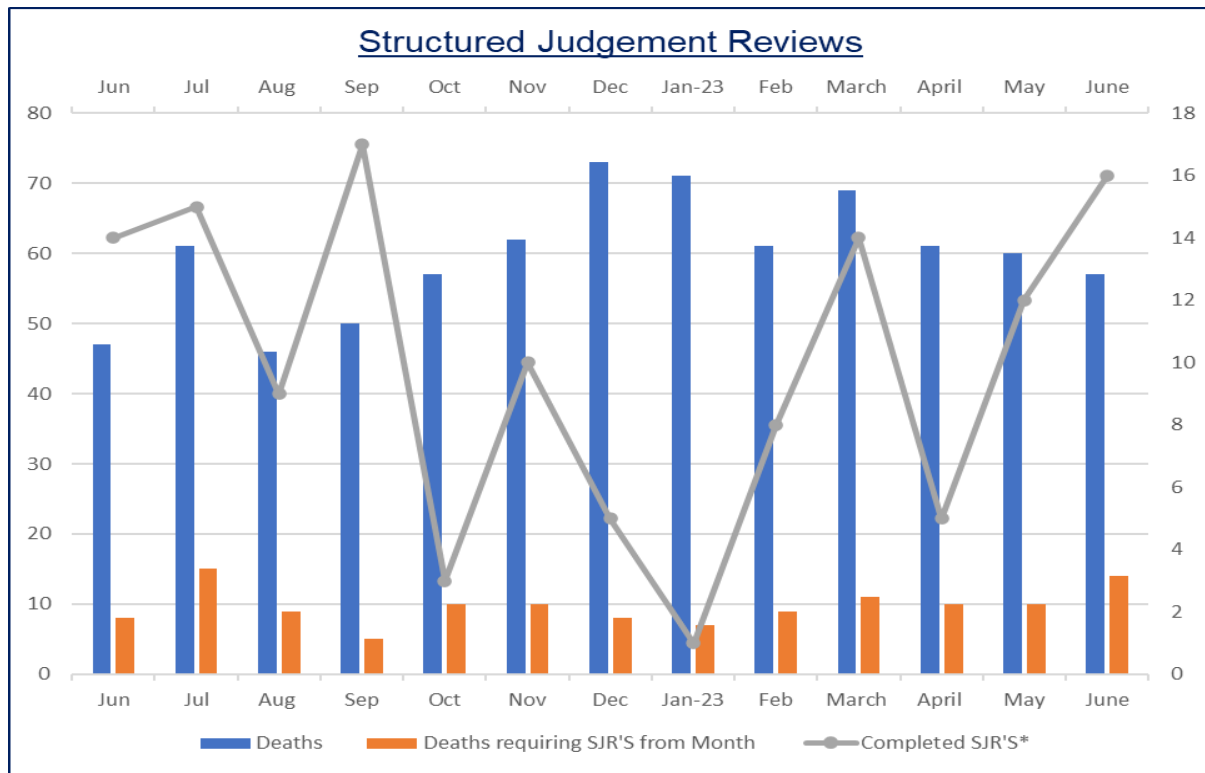
1.2 Division of Urgent & Integrated Care – Quarter 1 Report

Structured Judgement Reviews: In quarter 1 there were 178 deaths, 34 SJR's requested from these deaths and 33 SJR's were completed in total (completed SJR's not necessarily from this quarter).

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-23	Feb	March	April	May	June	Total YTD
Deaths	47	61	46	50	57	62	73	71	61	69	61	60	57	178
Deaths requiring SJR'S from Month	8	15	9	5	10	10	8	7	9	11	10	10	14	34
Completed SJR'S*	14	15	9	17	3	10	5	1	8	14	5	12	16	33

Total outstanding SJR's (not including allocated) = **40**

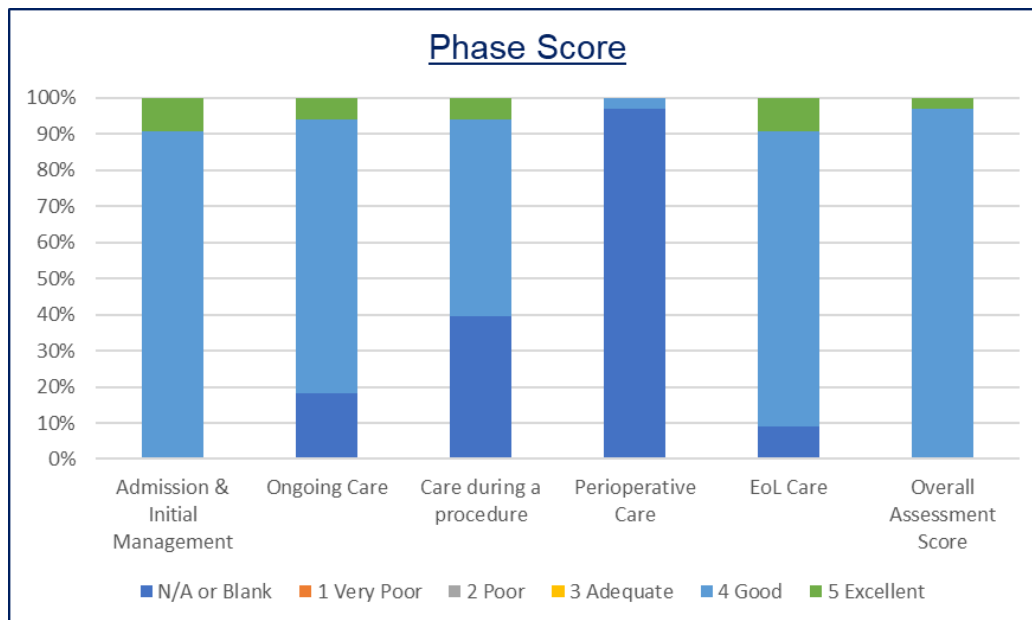
Outstanding SJR's >2 months = **13**



Nosocomial SJR Requests: 18 Nosocomial deaths (17/10/2021 – 30/04/2022), 8 reviewed by James Metcalf, 10 to review with Emma Hoyle – **Meeting in July cancelled – To be re-scheduled**

Phase score from 24 completed SJR's in Quarter 1:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	EoL Care	Overall Assessment Score
N/A or Blank	0	6	13	32	3	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	0
3 Adequate	0	0	0	0	0	0
4 Good	30	25	18	1	27	32
5 Excellent	3	2	2	0	3	1



Overall quality of patient record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	0	0	31	2

Quality of patient record improved on last quarter with all 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	0	1	32

Morbidity and Mortality Meeting Actions/Feedback Highlights

Good Practice

Elderly Care & Stroke:

- Prompt senior review
- Good MDT input
- Good involvement of patient's family with decision making
- Good involvement of Palliative Care Team

Cardiology:

- Good documentation
- Good family discussion and EOLCP put in place
- Early specialty review
- Excellent cardiology care regarding HF, AF and pericardial effusion management
- Timely and appropriate relevant referrals and work up were arranged

Diabetes:

- Good communication with patient and family
- Palliative care involved early and supported fast-track discharge planning
- Regular reviews by MDT

Respiratory:

- Good documentation, prompt medical reviews and appropriate second opinions sought

Actions/Areas for Improvement/Learning from review at M+M:

Elderly Care & Stroke:

- Haloperidol should not be continued after discharge from hospital, unless directed and closely monitored by the Community Mental Health Team (CMHT).
 - o Haloperidol can cause significant sedation. Highlight this with Pharmacy – should have been recognised at discharge.

Cardiology (No actions identified in Minutes):

- Documentation from on-call team could be clearer
- Not discussed with on call cons/RBH re ST elevation but likely too unwell to transfer
- Should have clearer documentation as to why ECHO not requested/done (had one 1 week prior to admission)
- Was patient appropriate for specialised cardiac ward or would she have been managed better/discharge planning been implemented sooner on a ward that deals with complex discharges more?

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

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

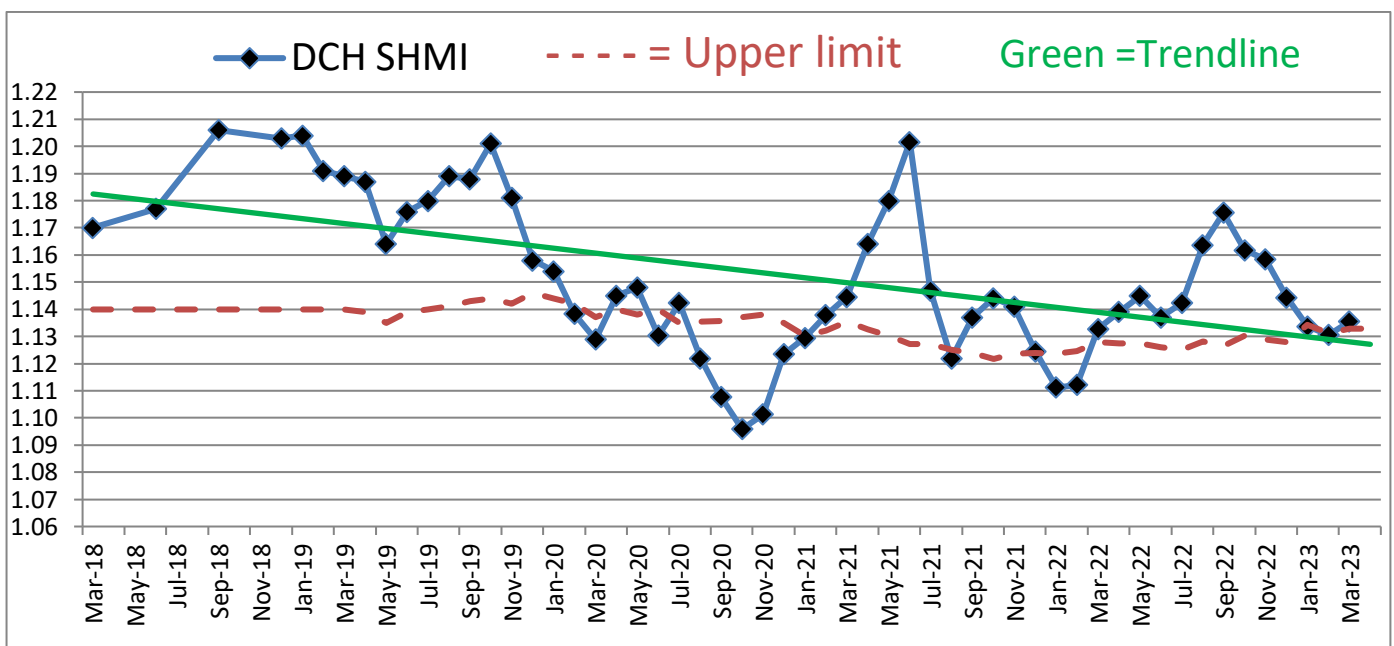
2.1 Summary Hospital-level Mortality Indicator (SHMI)

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 January and February was within the 'expected range', with March 2023 rising to just outside the range. We are aware that our data continues to be adversely influenced by short staffing/difficulty recruiting to two posts in the Coding Department, and a possible under-reporting of 'sepsis' in the written medical record.

Victoria Stevens (Clinical Coding Dept. Manager) reports that the Clinical Coding Department cleared the coding backlog prior to the final deadline for annual HES data submission, but the IT company responsible for uploading the submission failed to meet the deadline for data from DCH and 26 other Trusts. This is likely to continue to adversely influence the accuracy of DCH's SHMI data, until it is incorporated into the publication from November onwards. 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.

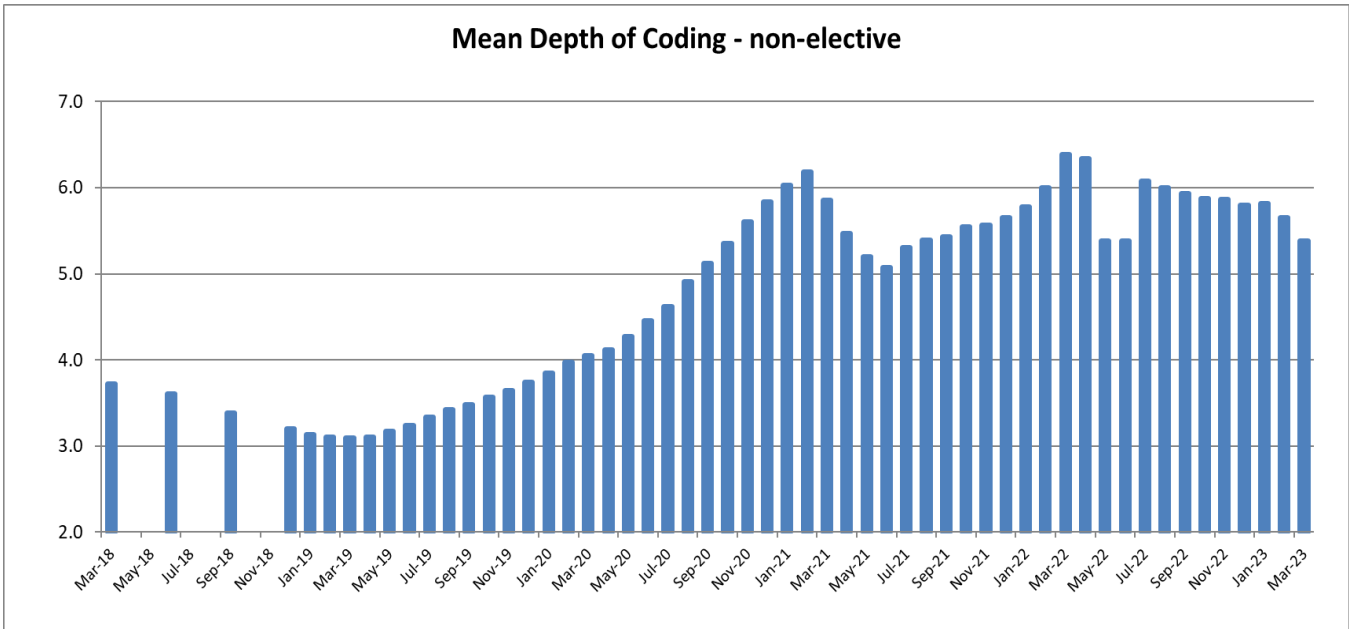
The latest published SHMI (rolling year to March 2023) is shown below:



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 associated with focus on SJRs, M&M meetings and a full Medical Examiner service, plus investment in the coding department which will result in more accurate coding returns to NHS Digital.

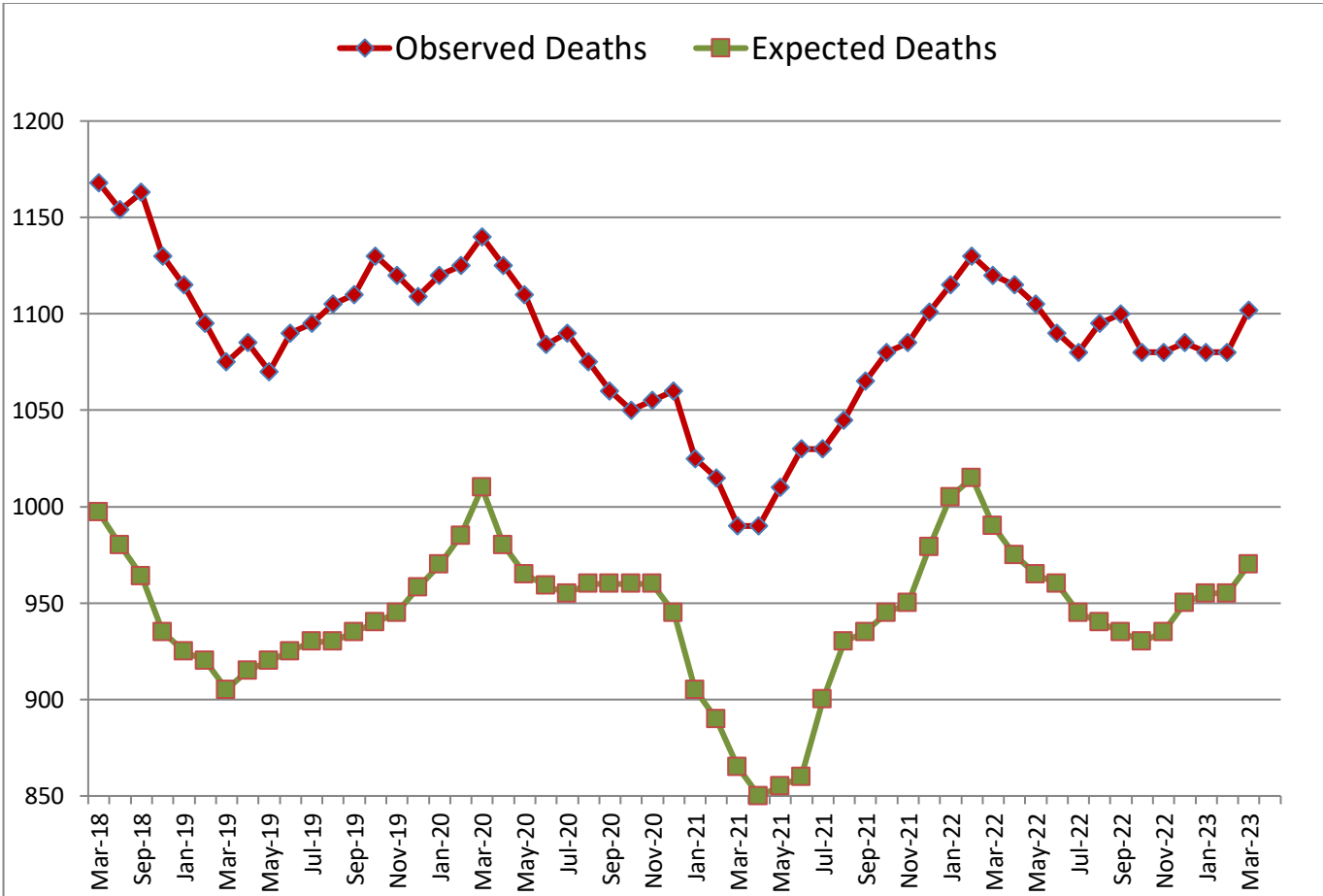
2.2 Depth of coding: NHS Digital states "As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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 show a tendency to decrease. This may partially explain the recent reduction in 'Expected Deaths' and consequent rise in SHMI. All data points represent 12 months of data.



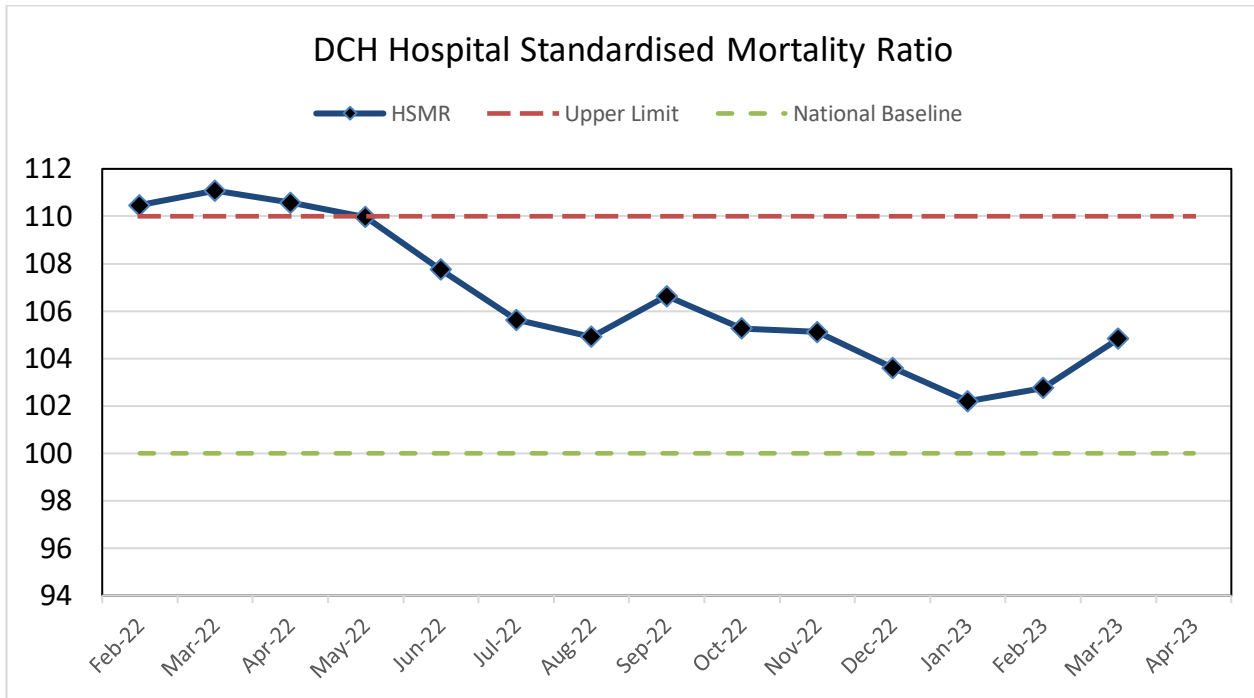
2.3 Expected Deaths (based on diagnoses across all admissions (except covid) per rolling 12 months):

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths over the past 4+ years (rolling years from March 18 to March 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 22 (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.

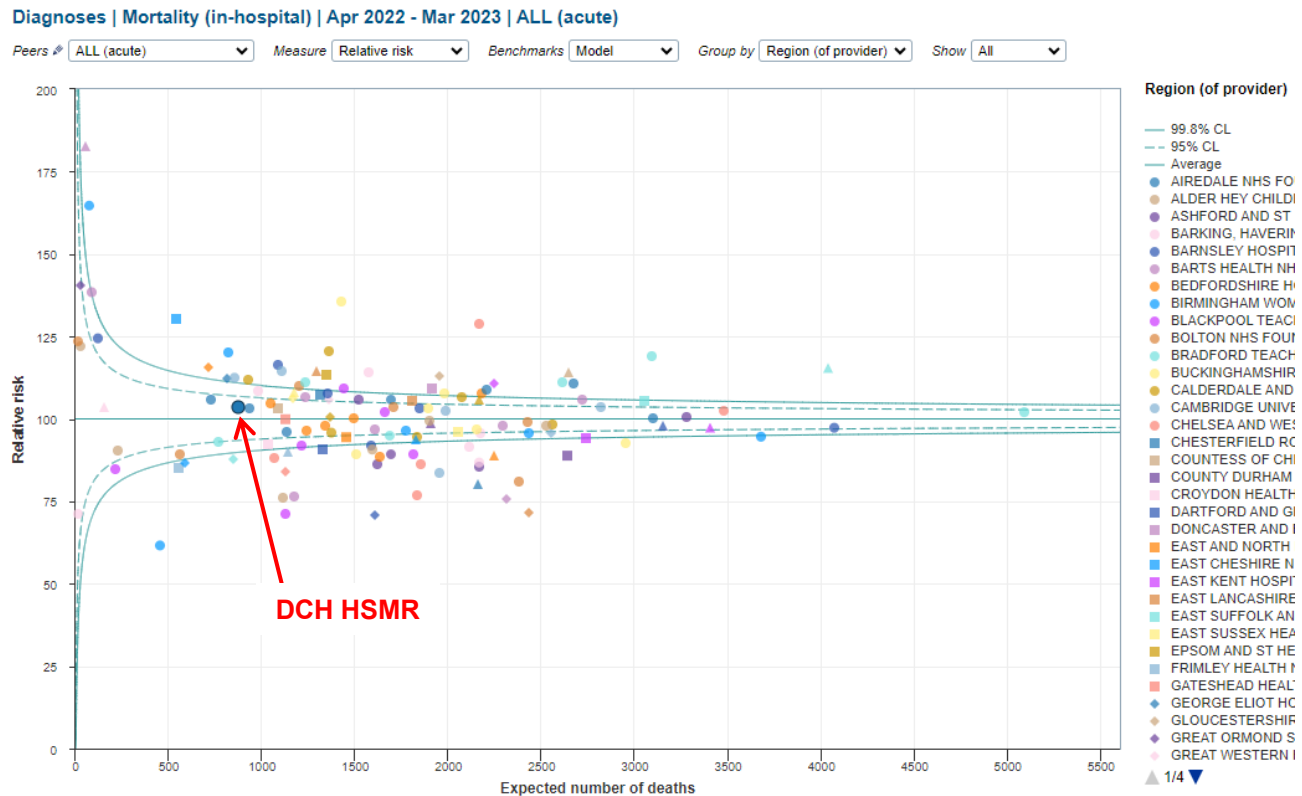


2.4 Hospital Standardised Mortality Ratio (HSMR): After discussions with Dr. Alyson O'Donnell (ICS Deputy CMO) and Dr. Sean Weaver (UHD Mortality lead) it was suggested that this report should include the latest HSMR figures. HSMR is a similar metric to, and was the forerunner of, SHMI. It differs in that it only includes the 56 most common in-patient diagnoses and does not include any deaths occurring after discharge from hospital. It is

calculated by a private provider – Telstra Healthcare. The upper limit of the ‘expected range’ for HSMR varies but for this retrospective data is approximately 110.0 and therefore DCH’s HSMR is well within the expected range. Correlation between SHMI and HSMR is poor – so for example Somerset NHS FT’s SHMI is excellent at 0.988 but HSMR is very high at 121.6 which has resulted in questions about its general validity.



The currently available ‘all acute NHS Trusts’ comparative HSMR data is for the rolling year to March 2023, shown below. 43 Trusts have higher HSMRs than DCH.



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 was interrupted by covid-19 and is 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.

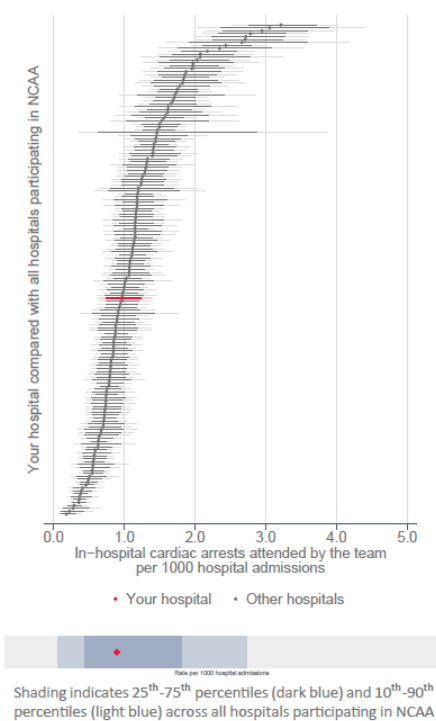
3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2022 to March 2023 (quarters 1, 2, 3 and 4) was published on 15/06/2023. Frequent cardiac arrest calls suggest unanticipated deteriorations in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven. A total of 66 cardiac arrest calls were recorded for this 12 month period, but not all were definite cardiac events since the cardiac arrest call is also used for any serious or unexpected patient event.

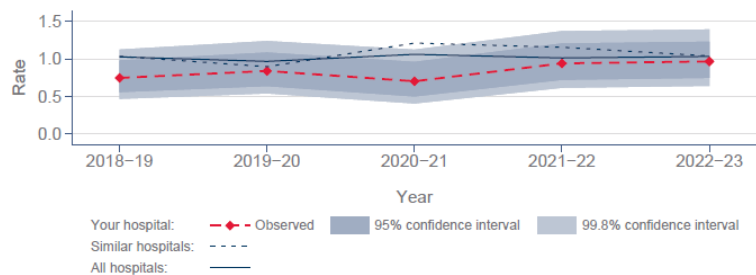
The graph below (left) represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the 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	17508	16	0.91	(0.52, 1.48)	(0.37, 1.86)
Full year	68343	66	0.97	(0.75, 1.23)	(0.64, 1.39)



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

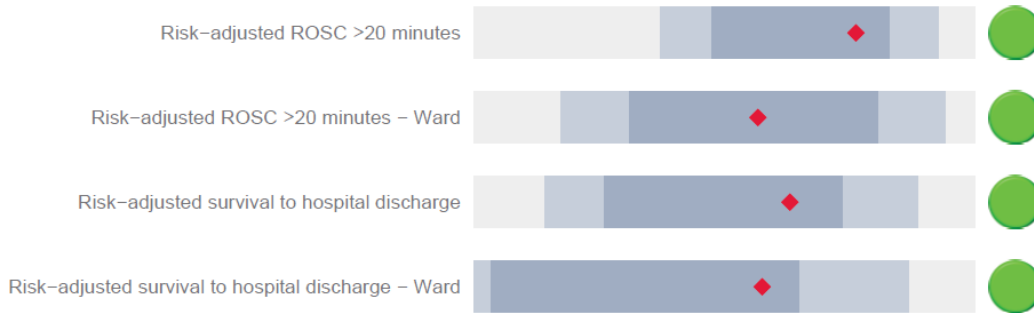
The dashboard below shows two important risk-adjusted outcome measures arising from a cardiac arrest:

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

These and all other measures in the report get a 'green' indicator for the most recently reported Quarters 1 - 4 (2022/23). The good rate of survival to discharge is notable.



Risk-adjusted outcomes: Dashboard

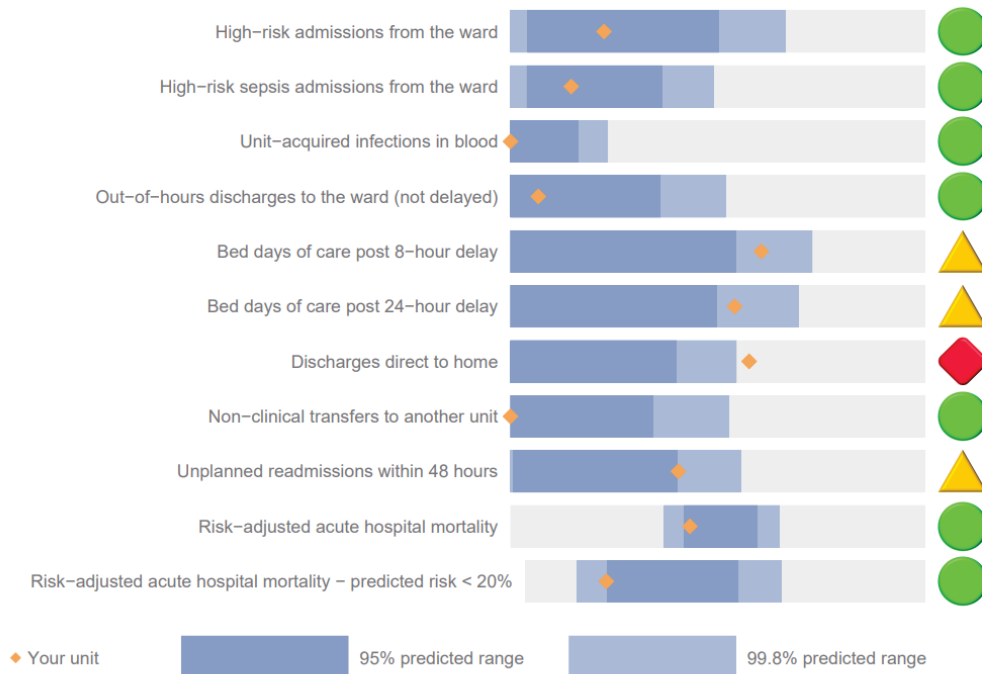


3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 (see below), and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 for publication in Summer this year.

3.3 ICNARC Intensive Care survival data for financial year 2022/23; published 12/06/2023; n = 612 patients.

The amber and red 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 for the year were just above the expected range.

Quality indicator dashboard



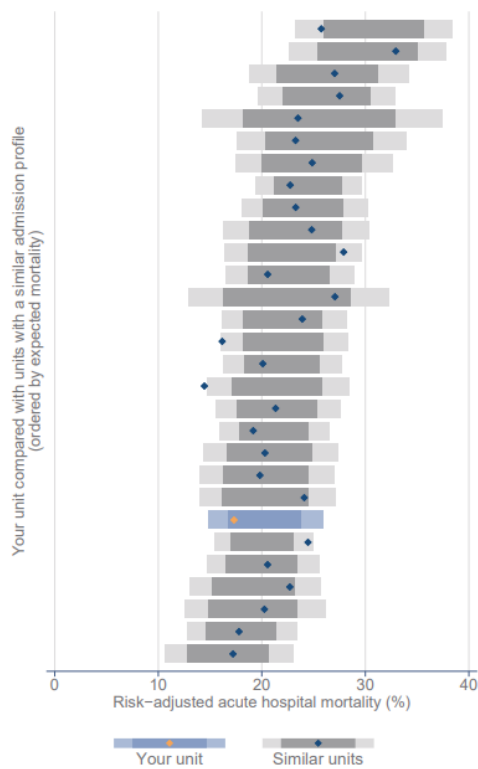
Date of report: 12/06/2023

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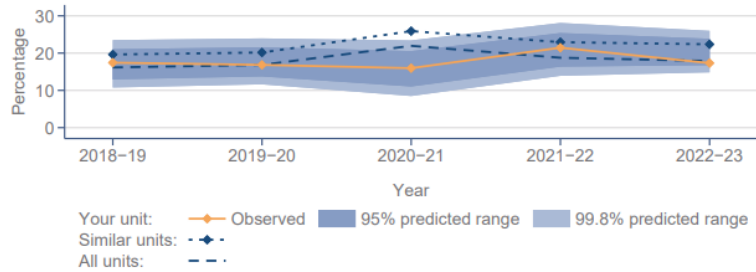
©ICNARC 2023

The charts below show the “risk-adjusted acute hospital mortality” following admission to the DCH Critical Care Unit in Q1 – Q4 2022/23. They compare observed and expected death rates in a similar fashion to SHMI, with expected deaths of 124 but actual deaths of only 106.

Risk-adjusted acute hospital mortality



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	146	134	14.2	16.1	(9.7, 22.2)	(6.7, 26.1)	●
Quarter 2	166	158	16.5	20.6	(14.2, 26.8)	(10.9, 30.8)	●
Quarter 3	179	174	20.1	21.5	(15.2, 27.5)	(12.1, 31.3)	●
Quarter 4	152	146	17.8	22.6	(15.6, 29.2)	(12.1, 33.4)	●
Full year	643	612	17.3	20.3	(16.8, 23.8)	(14.8, 26.0)	●



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_{H-2023} 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: 12/06/2023

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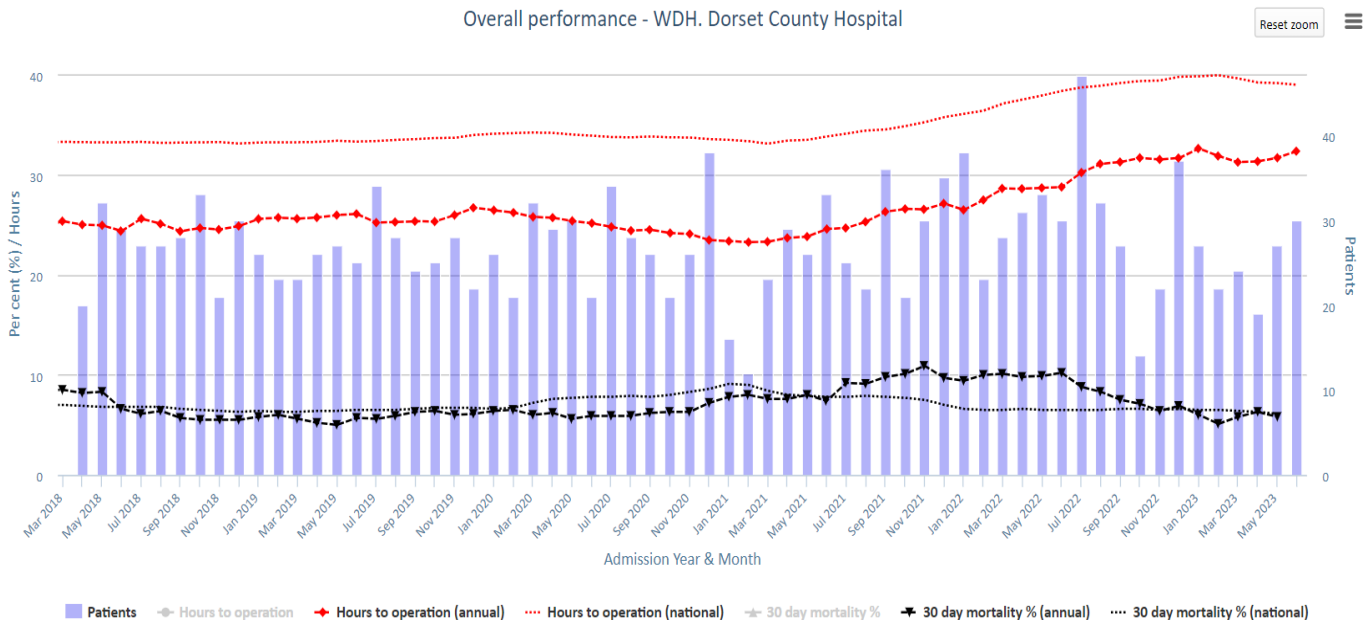
©ICNARC 2023

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 been below the national average for 5 consecutive months.

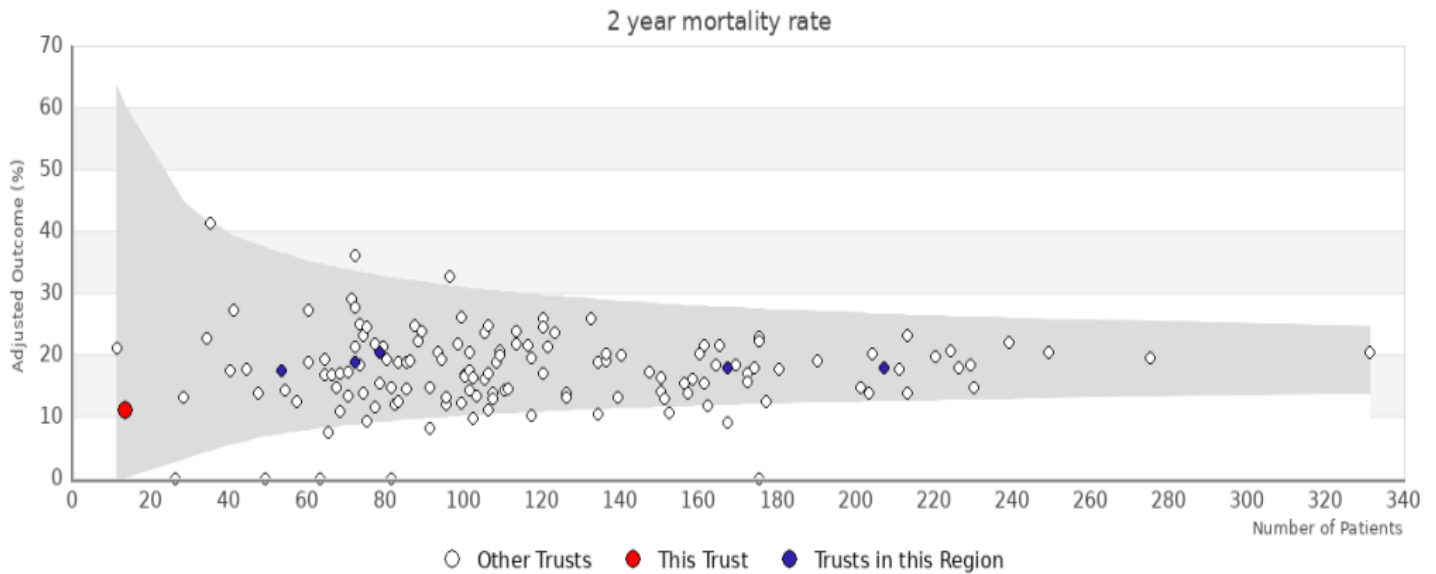
Overall performance - WDH. Dorset County Hospital



'Hours to operation' remains significantly better than the national average (31.7 vs 39.2 hours) and, after a post-covid rise from around 23 hours, is tending to decrease again.

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 1

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 individually reviewed during Q1.

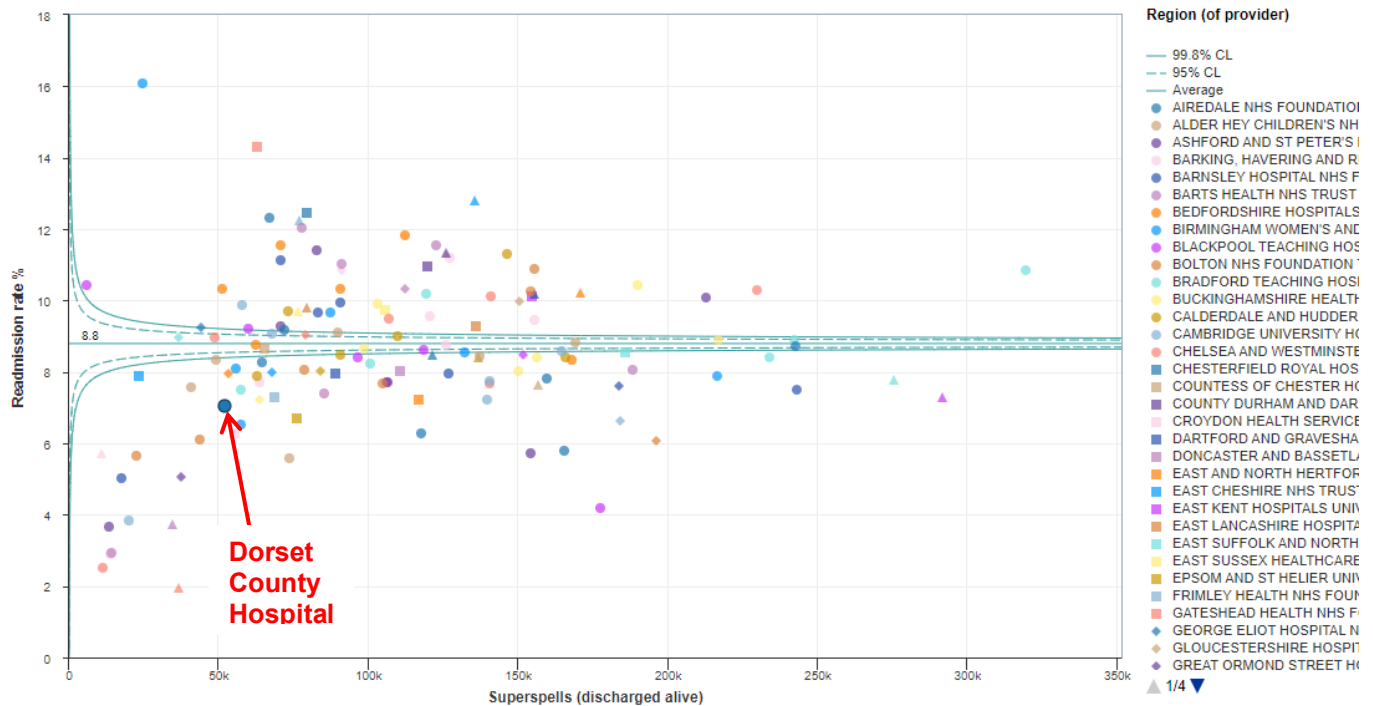
3.8 Trauma Audit and Research Network

DCH is a designated Major 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 31st May 2023, but currently the website is unavailable.

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

Diagnoses | Readmission (30 days) | Jan 2022 - Dec 2022 | ALL (acute)
 Admission type: Non-elective, Elective

Peers: ALL (acute) Group by: Region (of provider)



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.

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 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 to and reviewed by the Divisional Clinical Governance meetings. Dr. Richard Jee is producing a revised protocol for required actions arising from SJRs which identify possible poor outcomes, near misses or any other aspects that require further

investigation. This will take into account the change from RCA investigations to the more recent PSIRF approach.

6.0 LEARNING FROM CORONER'S INQUESTS Q1

DCH has been notified of 15 new Coroner's inquests being opened in the period 01 April 2023 – 30 June 2023.

13 inquests were held during Quarter 1. Five inquests were heard as Documentary hearings, not requiring DCH attendance. Five required the clinician to attend Court in person. Two required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams. One inquest was a hybrid – some clinicians attending in person and some joining remotely. One pre-Inquest Review hearing was held.

We also received a request from Swindon Coroner Service for records of a patient seen at DCH, we are awaiting the outcome of that hearing.

We currently have 38 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. No new pre-inquest reviews were listed during this period.

We continue to work with the Coroner's office, and will continue to support staff before, during and after 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.

7.0 LEARNING FROM CLAIMS Q1

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 process is currently under review.

Claims pattern Quarter 1 FY 23/24.

New potential claims	18
Disclosed patient records	27 (15 claims, 12 disclosures to the coroner)
Formal claims	4 clinical negligence, 1 employee claim
Settled claims	2 clinical negligence, 0 employee claims
Closed - no damages	1 clinical negligence, 0 employee claims

8.0 SUMMARY

SHMI improved as predicted in the rolling years to January and February 2023 and then rose slightly outside the expected range for the year to March 2023. All mortality data requires on-going scrutiny and an audit of approximately 50 deaths is in process 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. It has been delayed significantly by on-going industrial action and internal DCH/DHC issues and events. Additional external oversight has been arranged through the ICS and a link has been established with Dr Sean Weaver, mortality lead at UHD.

The coding department continues to attempt to recruit to establishment and is also in the process of recruiting three apprentice coders.

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.