

Document Title:	Learning from Deaths Qtr 4 2020/21
Responsible Director:	Prof. Alastair Hutchison, Medical Director
Author:	Prof. Alastair Hutchison, Medical Director

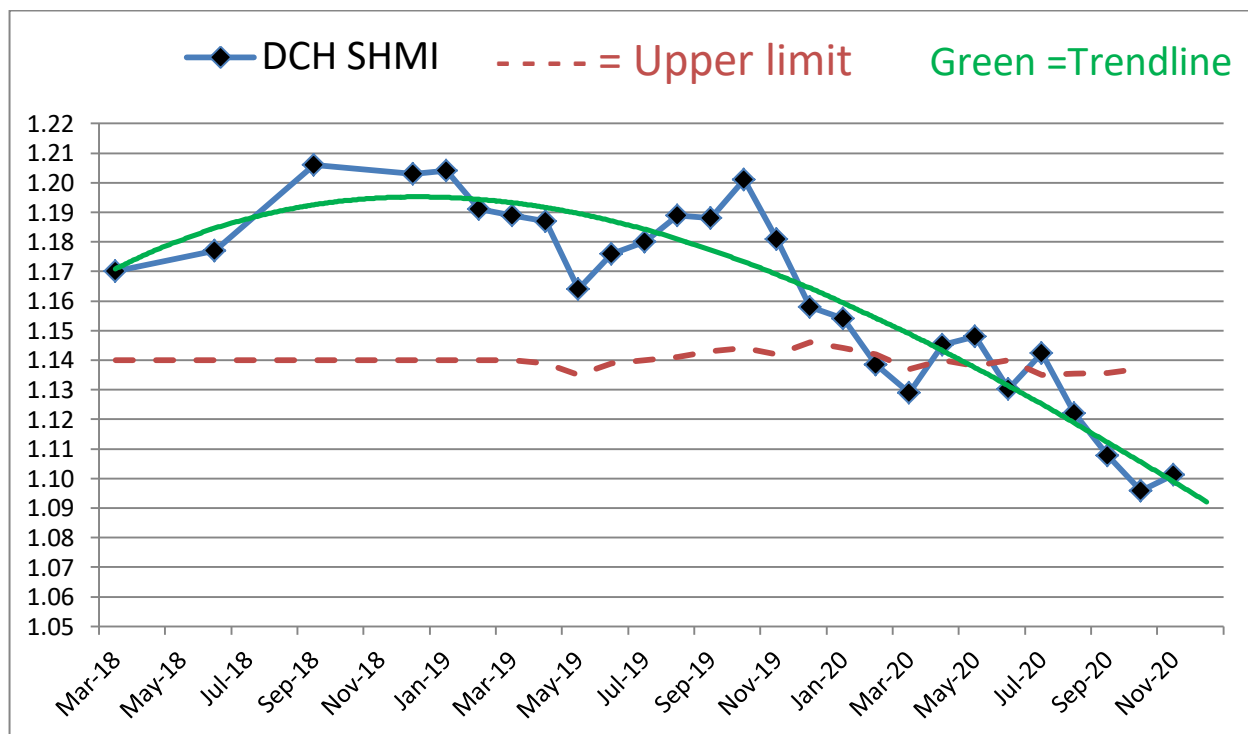
Approved for Publication by:

Meeting Title:	Board of Directors Part Two
Date of Meeting:	26 May 2021

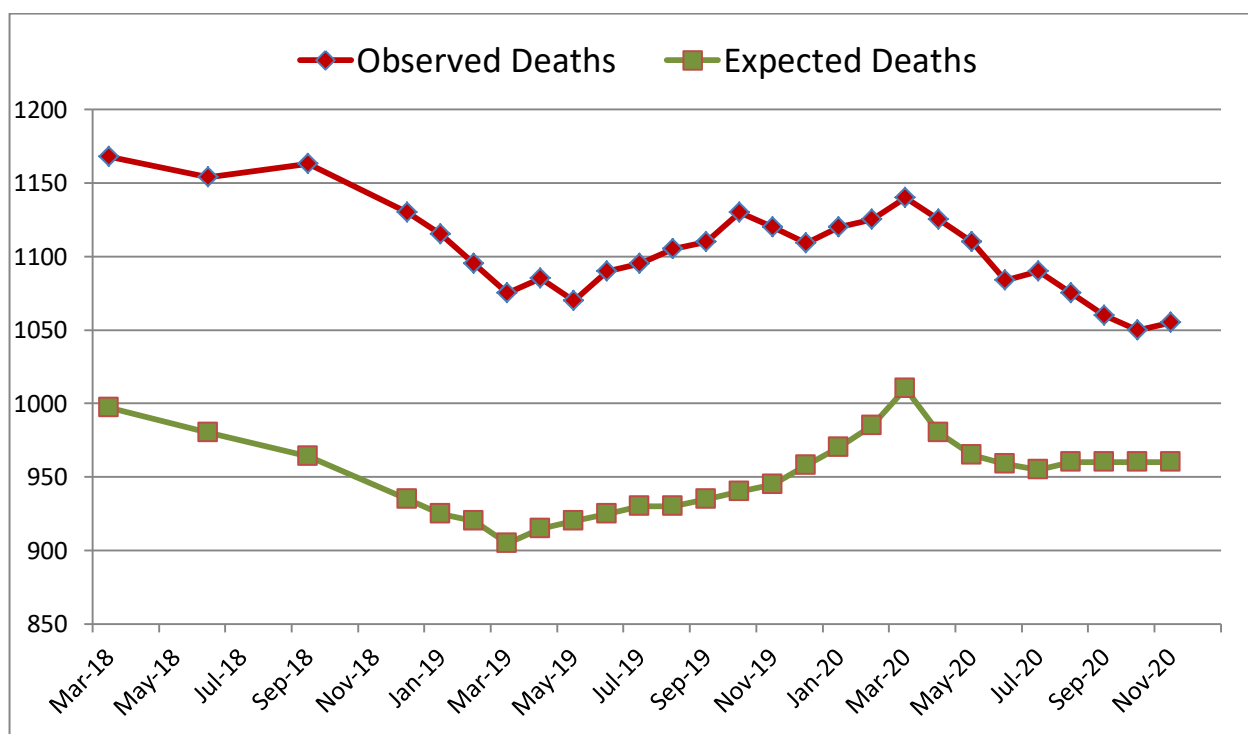
2.0 NATIONAL MORTALITY METRICS

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 occurring within 30 days of discharge. The SHMI for the rolling years from October 2019 to date shows a clear trend to improvement. The latest SHMI remains within the expected range, but has risen slightly.



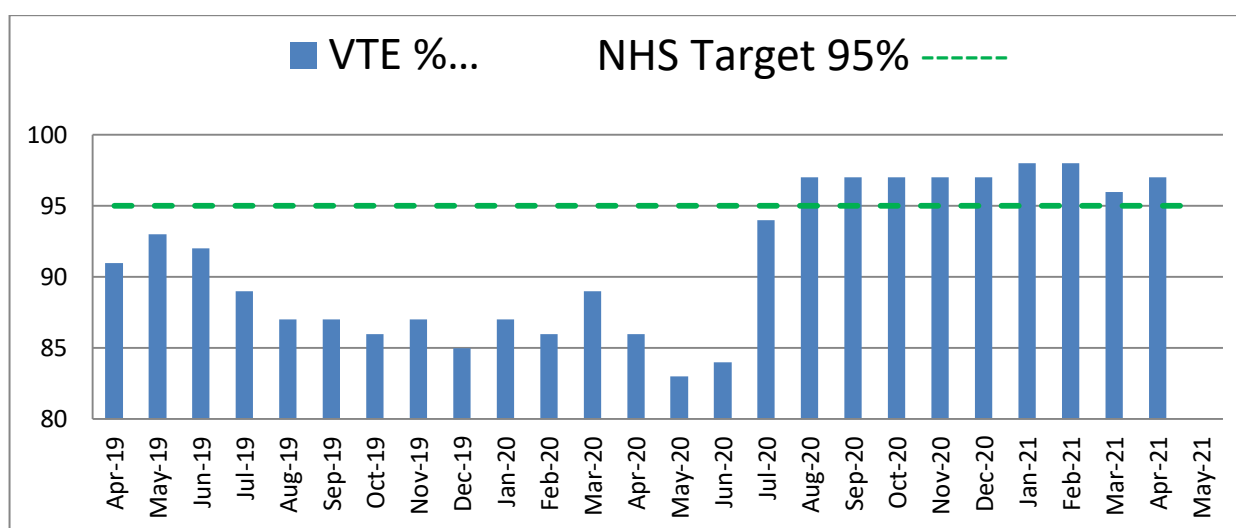
SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding data). The chart below shows observed and expected deaths over the past 2+ years (rolling years from March 18 to Nov 20).



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group regularly examines any other data which might indicate changes in standards of care, and has continued to meet on a monthly basis throughout the COVID-19 crisis. The following sections report data available from various national bodies who report on individual Trusts' performance.

For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Director of Nursing. DCH VTE risk assessments reached 97% in August with the introduction of a more accurate reporting system, and have exceeded the 95% target for every month since then.



3.1 NCAA Cardiac Arrest data

12 month Cardiac Arrest data for April 2019 to March 2020 was published in June 2020, and included in the previous Q1 report. The next data was expected in Nov 2020, but has not yet been published.

3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019

Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		n = 88	n = 10174
Gender	Male	43%	48%
	Female	57%	52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1	42%	47%
	2	31%	29%
	3-5	27%	24%
Inpatient mortality	Proportion deceased	7%	10%
Length of stay (discharged patients)	Median in days	3	5
Critical care admission	Yes - proportion	2%	5%
Readmission	Yes - proportion	8%	13%

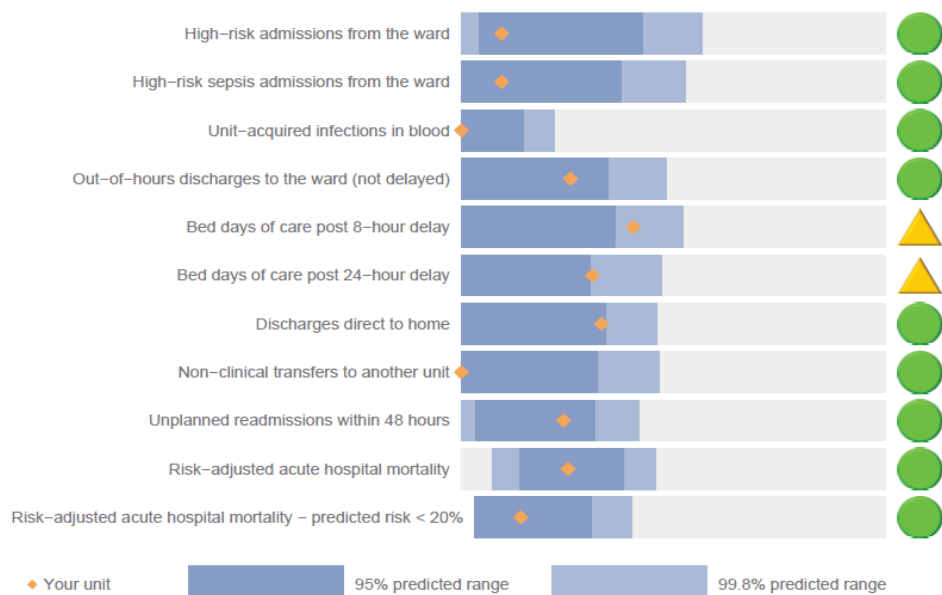
The results suggest that patients admitted to DCH 2018/19 tended to be more ill than the national average, but had a lower death rate and shorter length of stay, with fewer readmissions.

3.3 ICNARC Intensive Care survival latest data published 05 Mar 2021

Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2020 to 31 December 2020



Quality indicator dashboard



Date of report: 05/03/2021

3

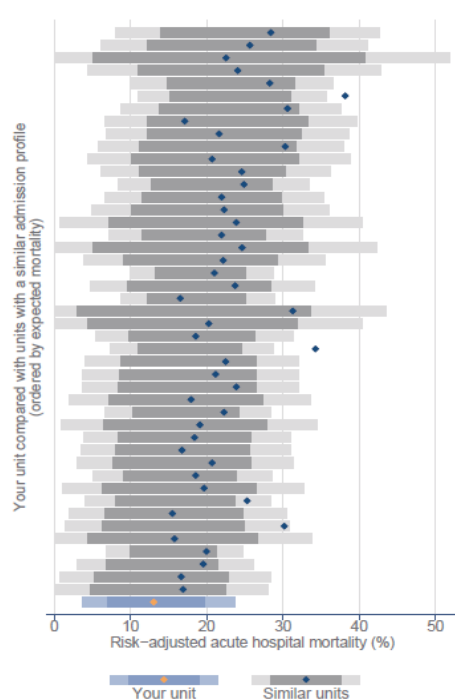
©ICNARC 2021

The charts below show the “risk adjusted acute hospital mortality” following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.

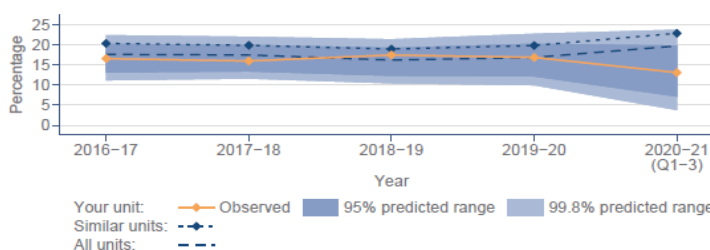
Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2020 to 31 December 2020



Risk-adjusted acute hospital mortality



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	174	167	9.0	11.8	(2.9, 20.4)	(0.0, 26.2)	Green circle
Quarter 2	185	180	13.9	14.2	(9.0, 19.2)	(6.5, 22.5)	Green circle
Quarter 3	179	173	16.2	14.5	(0.0, 29.1)	(0.0, 38.8)	Green circle
Quarter 4							
Year to date	538	520	13.1	13.5	(7.1, 19.8)	(3.8, 23.7)	Green circle



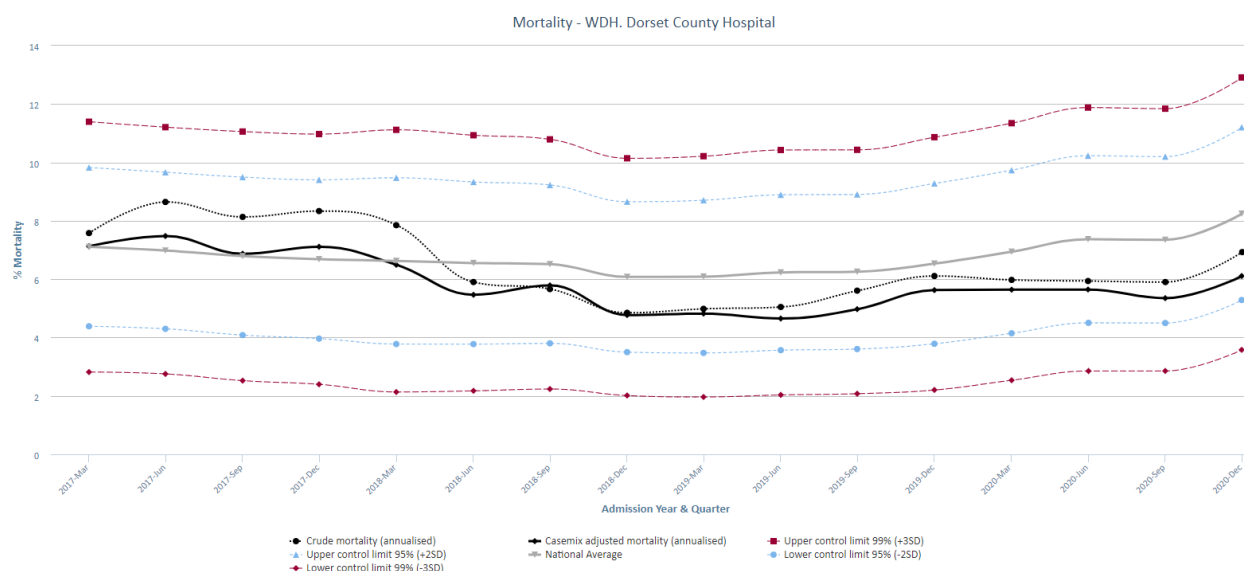
Definition	
• Eligible:	All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
• Observed percentage:	The percentage of eligible admissions that died before ultimate discharge from acute hospital
• Expected percentage:	The expected percentage of acute hospital deaths among eligible admissions, calculated as the mean predicted risk of death from the ICNARC _{H-2018} 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: 05/03/2021

13

©ICNARC 2021

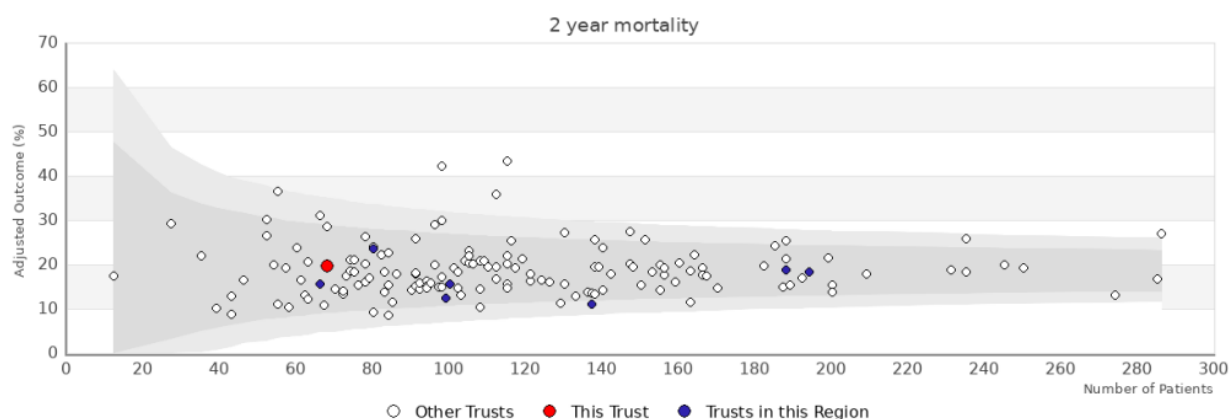
3.5 National Hip Fracture database to December 2020



The national average annualised mortality for hip fracture is 8.1%, with DCH's annualised mortality at 6.1%.

3.6 National Bowel Cancer Annual audit

No new data as yet this year - graph below shows latest available 2 year survival data for patients admitted in financial year 2018/19, compared to all other NHS Trusts, with other Wessex Trusts in dark blue.



Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	68	19.7%	19.3%

3.7 Getting it Right First Time; reviews in Q4

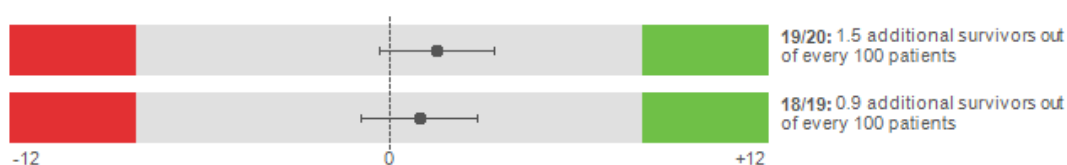
One shortened virtual GIRFT review was undertaken at DCH during this quarter – Gastroenterological Medicine. The full report is available within DCH from this link. As a result of COVID waves 2 and 3, all other visits were postponed for Q4.

Full reports from all previous GIRFT visits are available, and feedback from each review has previously been very positive. Action plans have been developed and are being worked through at present.

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. A summary of the [latest published data](#) (totals for 2018/19 and 2019/20, updated April 2021) is shown below. Data for 2020/21 is as yet incomplete:

Rate of Survival at this Hospital: Yearly Figures



Note: Data for the following years is not shown due to missing or incomplete data: 20/21

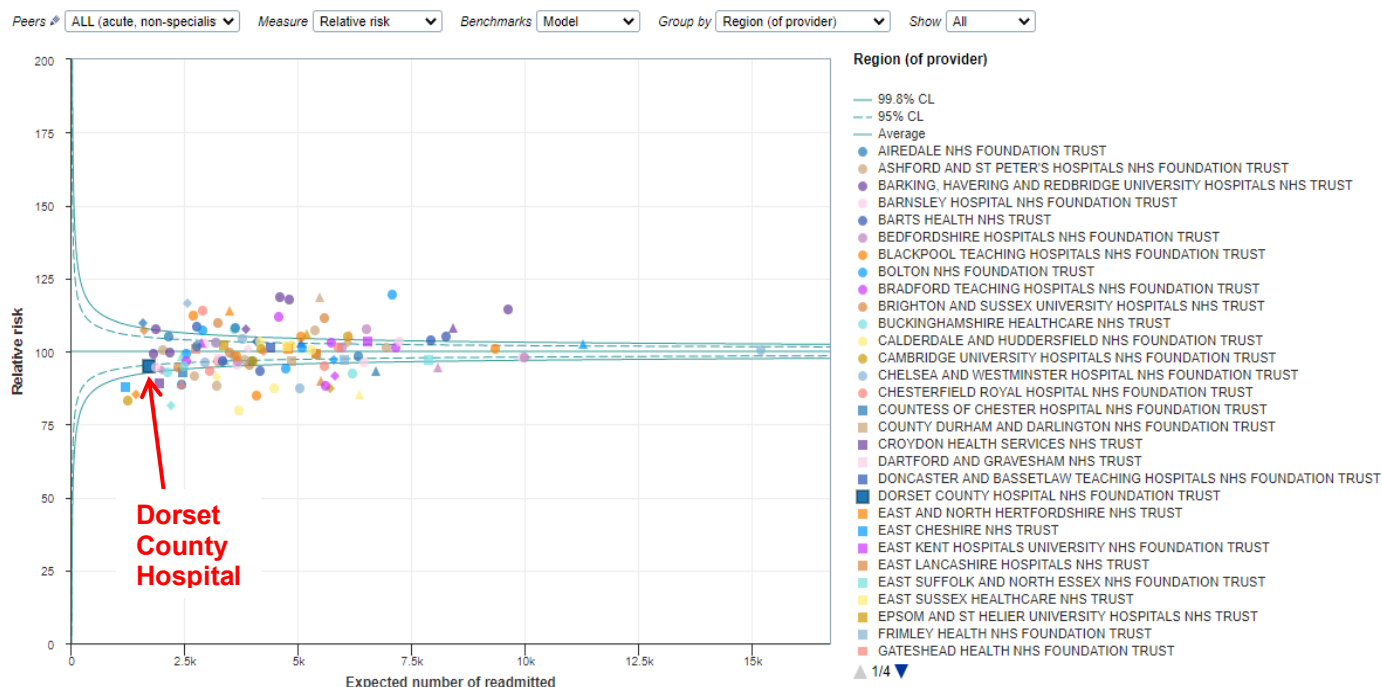
Rate of Survival Breakdown at this Hospital

Survival band %	Number in group	Expected survivors	Actual survivors	Difference*	Adjusted difference**	
95 - 100	532	522	529	1.2	0.8	Unexpected deaths in minor/moderate injury Usually due to poor management of co-morbidity and/or complications
90 - 95	177	164	165	0.4	0.1	
80 - 90	103	87	89	1.1	0.1	
65 - 80	46	34	33	-2.4	-0.1	Unexpected survivors with more serious injury Usually indicates good initial resuscitation and the treatment of head injury in Neurological Centres
45 - 65	15	8	11	17.1	0.4	
25 - 45	7	2	3	3.6	0.1	
0 - 25	5	0	0	-13.5	-0.2	
Total	885	820	830	1.0	1.1	

The first column categorises patients by percentage likelihood of survival, followed by the total number of patients seen at DCH, the calculated likely number of survivors and then the actual number of survivors.

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

Diagnoses - HSMR | Readmission (28 days) | Nov 2019 - Oct 2020 | ALL (acute, non-specialist)



Readmission to hospital within 30 days suggests inadequate initial treatment or a poorly planned discharge process. However DCH's latest readmission rate is lower than the majority of other acute Trusts.

3.10 Dr Foster Safety Dashboard

This dashboard compares DCH with other England and Wales Trusts for a variety of complications that might occur during an in-patient stay or during childbirth. Where the confidence intervals (horizontal T bars) overlap the national mean there is no statistical difference from the national average. DCH has a higher number of decubitus (pressure) ulcers (264 versus 226; significant difference), but fewer deaths in low-risk diagnosis groups (24 versus 44; significant difference).

Patient Safety Indicators

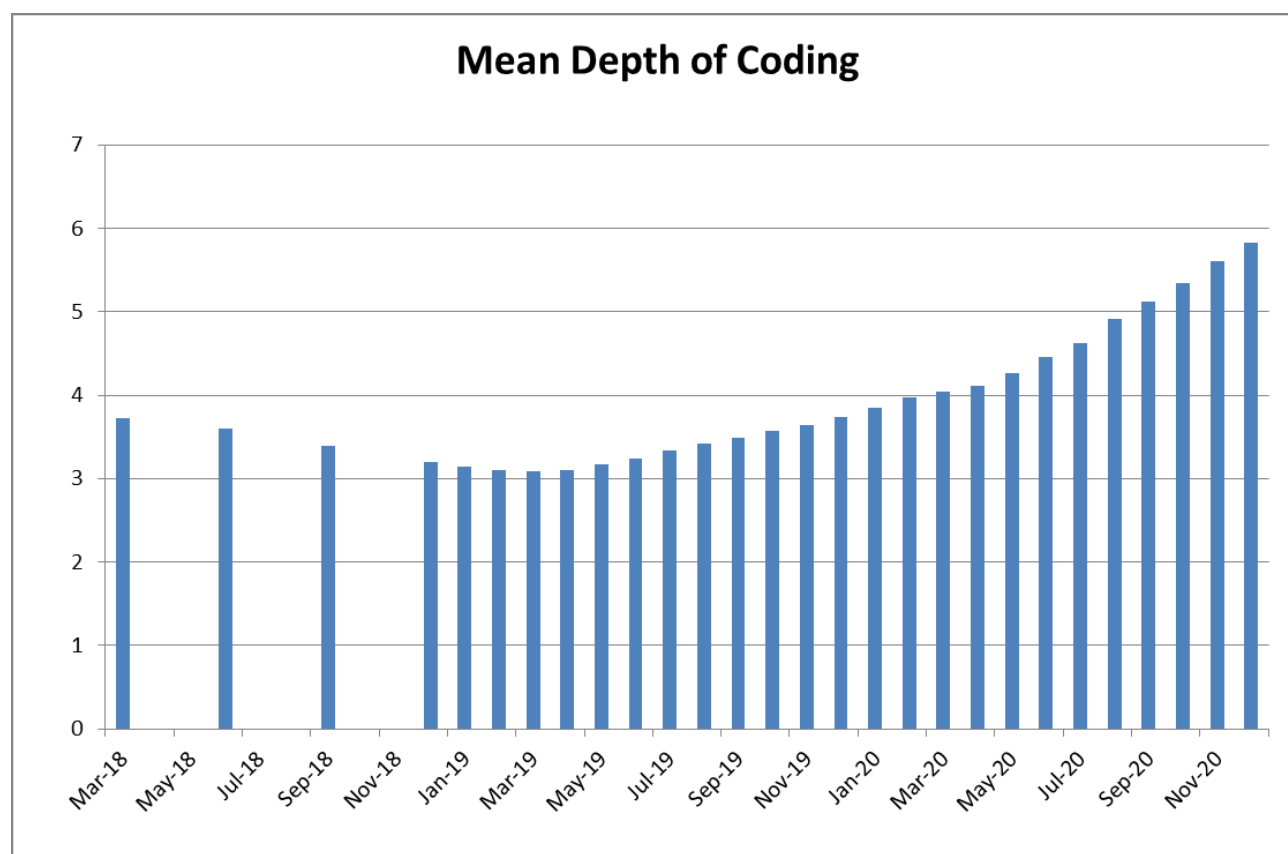
Period: 12 months (Feb 20 to Jan 21) Data lag: No lag

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk	Compare
Accidental puncture or laceration	28524	53	45.3	1.9	1.6	116.9	
Deaths after surgery	195	9	14.7	46.2	75.2	61.3	
Deaths in low-risk diagnosis groups	12626	24	44.2	1.9	3.5	54.3	
Decubitus ulcer	3785	264	225.9	69.7	59.7	116.9	
Infections associated with central line	5431	0	0.3	0	0.1	0.0	
Obstetric trauma - caesarean delivery	383	2	1.7	5.2	4.5	115.4	
Obstetric trauma - vaginal delivery with instrument	108	8	7.3	74.1	67.9	109.0	
Obstetric trauma - vaginal delivery without instrument	678	21	19.9	31.0	29.3	105.7	
Postoperative haemorrhage or haematoma	10920	4	4.1	0.4	0.4	98.1	
Postoperative physiologic and metabolic derangement	9377	0	1.7	0	0.2	0.0	
Postoperative pulmonary embolism or deep vein thrombosis	11005	33	30.3	3.0	2.8	109.0	
Postoperative respiratory failure	8572	5	8.8	0.6	1.0	56.6	
Postoperative sepsis	110	1	1.7	9.1	15.6	58.2	
Postoperative wound dehiscence	375	0	0.3	0	0.8	0.0	

4.0 CODING

4.1 Depth of coding

The DCH depth of patient coding for Charlson Co-morbidities has improved steadily from one of the lowest four in the UK, and is now above the mean value for all UK Trusts, at 5.83. As a result, the Trust's expected death rate had been rising to a level which more accurately represents the co-morbidities of admitted patients. The graph below plots the improvement in depth of coding over the past 3 years.



5.0 QUALITY IMPROVEMENT ARISING FROM SJRs

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

1. Poor quality of some admission clerking notes, particularly in surgery
2. Morbidity and Mortality meetings - standardization and governance

6.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers.

7.0 LEARNING FROM CORONER'S INQUESTS

DCH has been notified of 22 new Coroner's inquests being opened in the period January 2021 – March 2021. All Inquests that were listed in this quarter were adjourned by the Coroner due to CoVID-19 restrictions.

17 other inquests were held during Quarter 4. Nine inquests were heard as Documentary hearings, not requiring DCH attendance. None were attended at Court as this was the clinician's preference. Eight required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 52 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 6 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, an increasing number of which will be attended virtually. The virtual court room set up within Trust Headquarters appears to be working well, and Ms Mandy Ford (DCH) liaises with the coroner's officer to improve the technology and its use.

8.0 LEARNING FROM CLAIMS Q4

Legal claims are dealt with by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs. The latest scorecard will report on the past financial year and will be included in the next Quarterly Learning from Deaths report.

Claims pattern this Quarter:

New potential claims	2 (1 Orthopaedic, 1 ED)
Disclosed patient records	10 (2 Obst, 3 unknown, 1 colorectal, 2 ED, 1 IBD, 1 Ophthalmology)
Formal claims	6 (1 Max-facs, 1 Gen Med, 1 Obst, 1 Orthopaedics, 1 Urology, 1 ED)
Settled claims	3 (1 Obstetrics, 1 ED/Cardiology, 1 Orthopaedics)
Closed no damages	3 (1 Colorectal, 1 Haematology, 1 Orthopaedics)

9.0 SUMMARY

SHMI remains within the expected range, with evidence of a clear trend to improvement over the past 14 months. 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.

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 continue to improve.