

|                              |   |
|------------------------------|---|
| <b>Meeting Title:</b>        | <b>Quality Committee</b>                                    |
| <b>Date of Meeting:</b>      | 23rd August 2022  |
| <b>Document Title:</b>       | <b>Mortality Report: Learning from deaths Qtr 1 2022-23</b> |
| <b>Responsible Director:</b> | Prof. Alastair Hutchison, Medical Director                  |
| <b>Author:</b>               | Prof. Alastair Hutchison, Medical Director                  |

|                               |        |
|-------------------------------|--------|
| <b>Confidentiality:</b>       | Public |
| <b>Publishable under FOI?</b> | Yes    |

| Prior Discussion           |                              |                          |
|----------------------------|------------------------------|--------------------------|
| Job Title or Meeting Title | Date                         | Recommendations/Comments |
| Hospital Mortality Group   | 17 <sup>th</sup> August 2022 | None specific            |
|                            |                              |                          |

|                              |   |
|------------------------------|---|
| <b>Purpose of the Paper</b>  | To inform the Quality Committee of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.  |
| <b>Summary of Key Issues</b> | The Trust's SHMI reported in Q1 (5 months in arrears - rolling years to Dec, Jan & Feb 22) fell into the 'Expected Range' (1.12, 1.11 and 1.11 respectively). SHMI continues to be influenced by delays in coding (as explained in the previous Q2 report), although a completed and updated HES submission was made by the final 2021/22 deadline of 19/05/22. No other local or national indicators suggest excess unexpected deaths are occurring at DCH. Structured Judgement Reviews are used to examine the care of an appropriate sample of people who died whilst in-patients, and to learn from any good practice or lapses in care identified. The DCH Medical Examiners review every death and highlight any obvious causes for concern. DCH is now taking on the ME function for community deaths, and has recruited 5 additional MEs for this work, with NHSE funding. NHSE expects all Trusts to have this service fully operation by April 2023. |
| <b>Action recommended</b>    | <p>The Quality Committee is recommended to:</p> <ol style="list-style-type: none"> <li>1. <b>NOTE</b> the report</li> <li>2. <b>APPROVE</b> the report for publication on the DCH internet website</li> <li>3. <b>Not publish</b> appendices 1 and 2 which contain patient-related data</li> </ol>  |

### Governance and Compliance Obligations

|  |   |  |
|--|---|--|
| <b>Legal / Regulatory</b>              | Y | 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.  |
| <b>Financial</b>                       | Y | Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.   |
| <b>Impacts Strategic Objectives?</b>   | Y | Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that an elevated SHMI is not a result of lapses in care requires regular scrutiny of various data and careful explanation to staff and the public. An elevated SHMI can have a negative impact on the Trust's reputation both locally and nationally.   |
| <b>Risk?</b>                           | Y | <ul style="list-style-type: none"> <li>• Reputational risk due to higher than expected SHMI</li> <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> <li>• Other mortality data sources (primarily from national audits) are regularly checked for any evidence of unexpected deaths.</li> </ul> |
| <b>Decision to be made?</b>            | N |  |
| <b>Impacts CQC Standards?</b>          | Y | 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 have adversely influenced coding and therefore recent SHMI figures are inaccurate.   |
| <b>Impacts Social Value ambitions?</b> | N |  |

|                             |   |  |
|-----------------------------|---|--|
| Equality Impact Assessment? | N |  |
| Quality Impact Assessment?  | N |  |

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- 5.0 MORBIDITY and MORTALITY MEETINGS
- 6.0 LEARNING FROM CORONER'S INQUESTS
- 7.0 LEARNING FROM CLAIMS Q1
- 8.0 SUMMARY

## 1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning. See appendix 1 and 2 for full reports (not published).

### 1.1 Family Services and Surgical Division Report - Quarter 1 Report

**Structured Judgement Review Results:** The Division had 38 deaths in quarter 1 that require SJR's to be completed. Across the Division 32 SJRs have been completed in quarter 1, 30 of which were completed for SJRs reported in previous months.

**SJR's in process:** The current number of outstanding SJR's for the Division is 56 (as of 4/7/22). The availability of the notes for these patients is being re-checked to ensure clinical staff can complete this work.

| January 22 | February 22 | March 22 | April 22 | May 22 | June 22 |
|------------|-------------|----------|----------|--------|---------|
| 1          | 5           | 4        | 10       | 9      | 16      |

#### Feedback from SJR's completed in quarter 1:

|              | Admission & Initial Management | Ongoing Care | Care during a procedure | Perioperative Care | End of Life Care | Overall Assessment Score |
|--------------|--------------------------------|--------------|-------------------------|--------------------|------------------|--------------------------|
| N/A or Blank | 1                              | 4            | 2                       | 24*                | 3                | 2                        |
| 1 Very Poor  | 0                              | 0            | 0                       | 0                  | 0                | 0                        |
| 2 Poor       | 3                              | 2            | 0                       | 0                  | 1                | 2                        |
| 3 Adequate   | 7                              | 3            | 5                       | 0                  | 6                | 4                        |
| 4 Good       | 8                              | 11           | 9                       | 3                  | 15               | 14                       |
| 5 Excellent  | 13                             | 8            | 3                       | 4                  | 6                | 10                       |

\*being checked for accuracy

#### Overall Quality of Patient Record:

| Blank | Score 1<br>Very poor | Score 2<br>Poor | Score 3<br>Adequate | Score 4<br>Good | Score 5<br>Excellent |
|-------|----------------------|-----------------|---------------------|-----------------|----------------------|
| 3     | 0                    | 2               | 5                   | 15              | 7                    |

#### Avoidability of Death Judgement Scores:

| Score 1<br>Definitely avoidable | Score 2<br>Strong evidence of avoidability | Score 3<br>Probably avoidable (more than 50:50) | Score 4<br>Possibly avoidable but not very likely (less than 50:50) | Score 5<br>Slight evidence of avoidability | Score 6<br>Definitely not avoidable |
|---------------------------------|--|---|---|--|-------------------------------------|
| 0                               | 0  | 0   | 0   | 6  | 23*                                 |

\*2 SJRs found to have missing final scores.

#### Action Recommendations:

| No Action required | Further Learning req'd | Referred to Trust Group / Committee | Repeat SJR from specific specialty | *Incomplete scoring |
|--------------------|------------------------|-------------------------------------|------------------------------------|---------------------|
| 26                 | 2                      | 1                                   | 1                                  | 2                   |

Report completed by: Richard Jee – Divisional Mortality Lead  
Michelle Purdue – Interim Quality Manager

## 1.2 Division of Urgent & Integrated Care – Quarter 1 Report

**Structured Judgement Review Results:** 165 deaths, 32 SJR's requested from these deaths and 45 were completed in total (completed SJR's not necessarily from this quarter).

|                               | April | May | June | Total YTD |
|-------------------------------|-------|-----|------|-----------|
| Deaths                        | 66    | 53  | 45   | 164       |
| In month deaths requiring SJR | 17    | 7   | 8    | 32        |
| Completed SJR's               | 14    | 18  | 14   | 46        |

Total outstanding SJR's (not including nosocomials) = 27

Outstanding SJR's >2 months (prior to 18/07/2022) = 15

21 Nosocomial deaths (not included in above figures) will be reviewed by James Metcalf and a summary report will be written for HMG (9 reviewed so far on 13/06/22), 12 still to review).

### Phase of Care score from 45 completed SJR's in Quarter 1:

|              | Admission & Initial Management | Ongoing Care | Care during a procedure | Perioperative Care | End of Life Care | Overall Assessment Score |
|--------------|--------------------------------|--------------|-------------------------|--------------------|------------------|--------------------------|
| N/A or Blank | 0                              | 6            | 28                      | 44                 | 7                | 0                        |
| 1 Very Poor  | 0                              | 0            | 0                       | 0                  | 0                | 1 *                      |
| 2 Poor       | 0                              | 0            | 0                       | 0                  | 2                | 0                        |
| 3 Adequate   | 7                              | 6            | 1                       | 0                  | 1                | 7                        |
| 4 Good       | 29                             | 22           | 9                       | 0                  | 22               | 26                       |
| 5 Excellent  | 9                              | 11           | 7                       | 1                  | 13               | 11                       |

\*Overall SJR score of 6, definitely not as a result of healthcare, however brought to HMG 11/05/2022 due to issues with inadequate DNAR/TEP completion.

### Overall Quality of Patient Record

| Blank | Score 1<br>Very Poor | Score 2<br>Poor | Score 3<br>Adequate | Score 4<br>Good | Score 5<br>Excellent |
|-------|----------------------|-----------------|---------------------|-----------------|----------------------|
| 1     | 0                    | 2               | 7                   | 22              | 13                   |

### Avoidability of Death Judgement Score

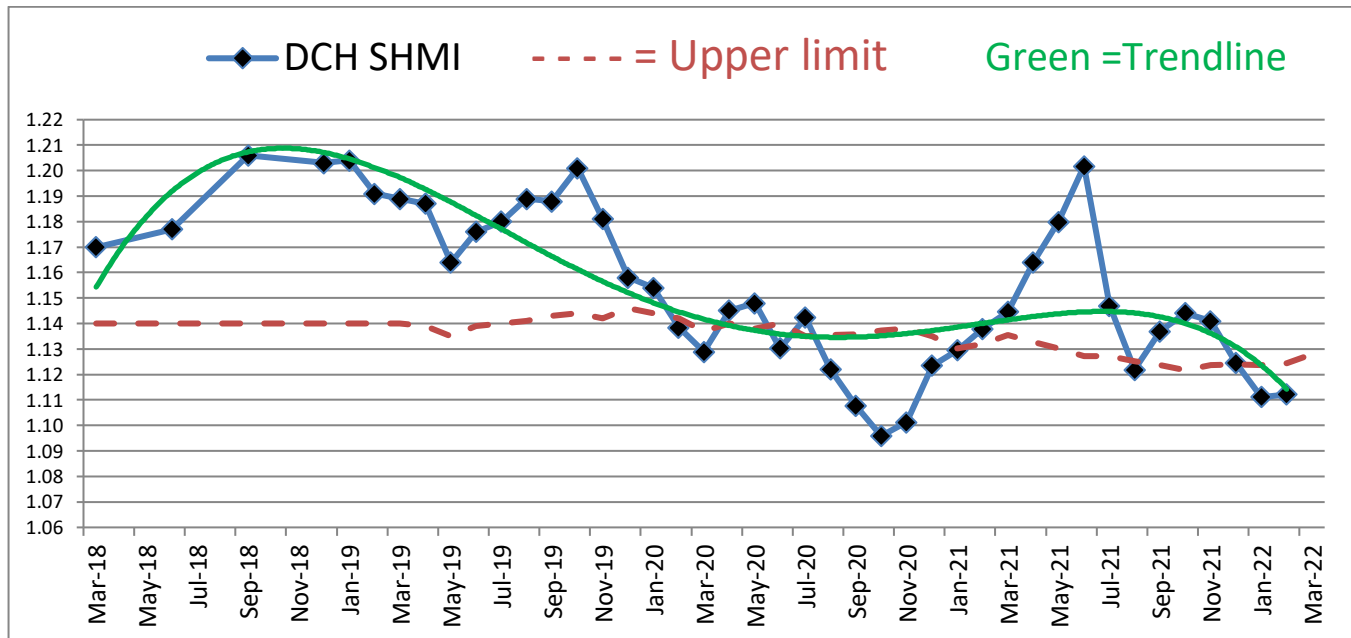
| Score 1<br>Definitely avoidable | Score 2<br>Strong evidence of avoidability | Score 3<br>Probably avoidable (> 50:50) | Score 4<br>Possibly avoidable but not very likely (<50:50) | Score 5<br>Slight evidence of avoidability | Score 6<br>Definitely not avoidable |
|---------------------------------|--|---|--|--|-------------------------------------|
| 0                               | 0  | 1                                       | 1  | 1  | 42                                  |

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 SHMI for the rolling years from October 2020 to June 2021 showed a clear reversal of the previous trend to improvement, but the latest data has stabilised around a SHMI of around 1.11 which is within the 'Expected Range'. However, we know that our data continues to be adversely influenced by difficulties in the Coding Department. Revised data was submitted for the end of year HES submission in mid May but will not feed through into the SHMI calculations until October 2022. Our senior coder - Sue Eve-Jones – has now left DCH to continue working for GIRFT. We would like to express our thanks to Sue, and we continue to try to appoint a replacement. The latest published SHMI 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 improvement in DCH's SHMI as a result of investment in the coding department which resulted in more accurate and timely coding returns to NHS Digital.

For a full explanation of recent coding difficulties please see the previous Q2 2022 report published on the DCHFT internet site.

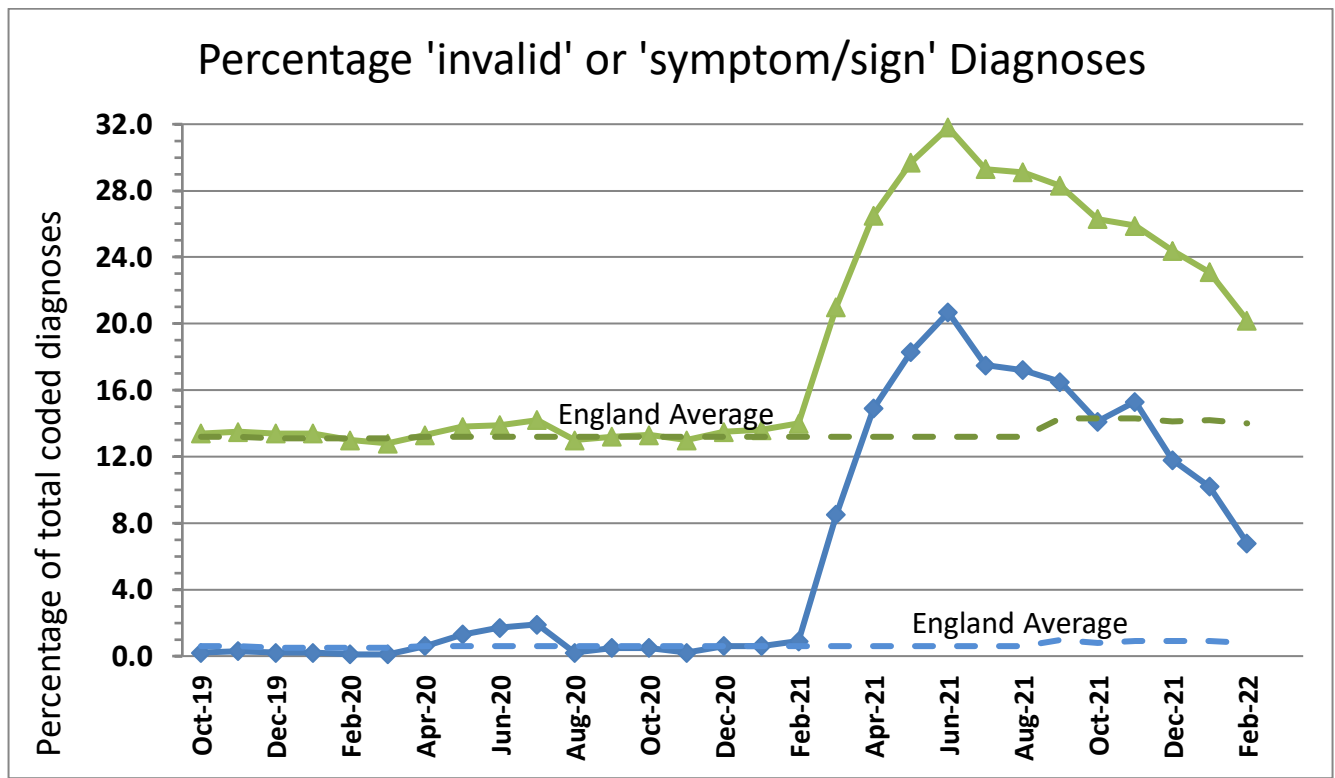
**2.2 Percentage of provider spells with a primary diagnosis which is a symptom or sign:** NHS Digital states "This indicator presents the percentage of finished provider spells with a primary diagnosis which is a symptom or sign (identified by ICD-10 codes beginning with the letter 'R'). A high percentage of provider spells with a primary diagnosis which is a symptom or sign compared to other similar trusts may indicate problems with data quality or timely diagnosis of patients".

DCH has recently had a very high but reducing number of spells with a primary diagnosis which is a symptom or sign – for example either no entry at all (uncoded), or 'chest pain' rather than 'myocardial infarction' – at 31.8% for June 2021 but improving progressively since then to a latest figure of 20.2% for February 2022. The England average is around 13%, and the increase seen in DCH data is largely due to uncoded cases which therefore have no recorded diagnosis. Such uncoded in-patient 'spells' are attributed a very low risk of death, since a symptom or sign only, does not suggest a life-threatening illness. This significantly reduces our expected number of deaths and hence increases the SHMI value.

**2.3 Percentage of provider spells with an invalid primary diagnosis code:** NHS Digital states "This indicator presents the percentage of finished provider spells with an invalid primary diagnosis code

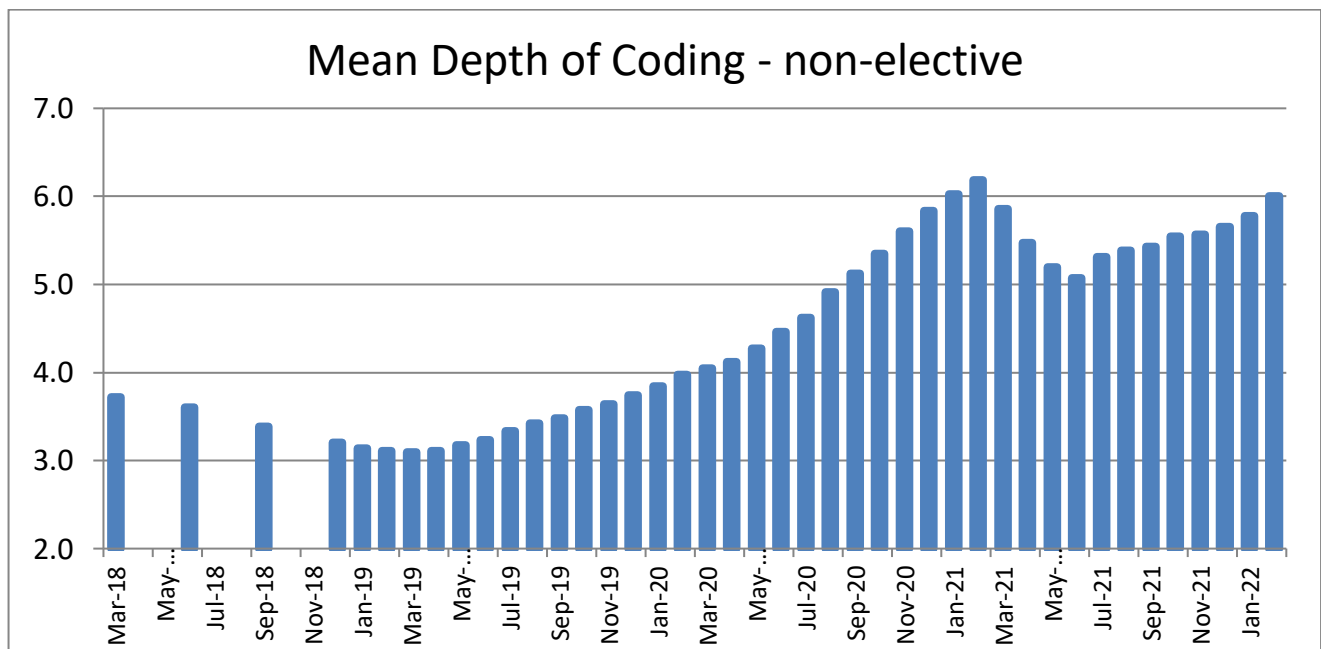
(identified as those spells where the primary diagnosis is given by the ICD-10 code R69X). A high percentage of provider spells with an invalid primary diagnosis code compared to other trusts may indicate a data quality problem.”

This metric is a subgroup of 2.2 above. A ‘spell’ is a continuous period of in-patient care. The graph below shows the change in these two metrics of coding accuracy over the past 30 months:



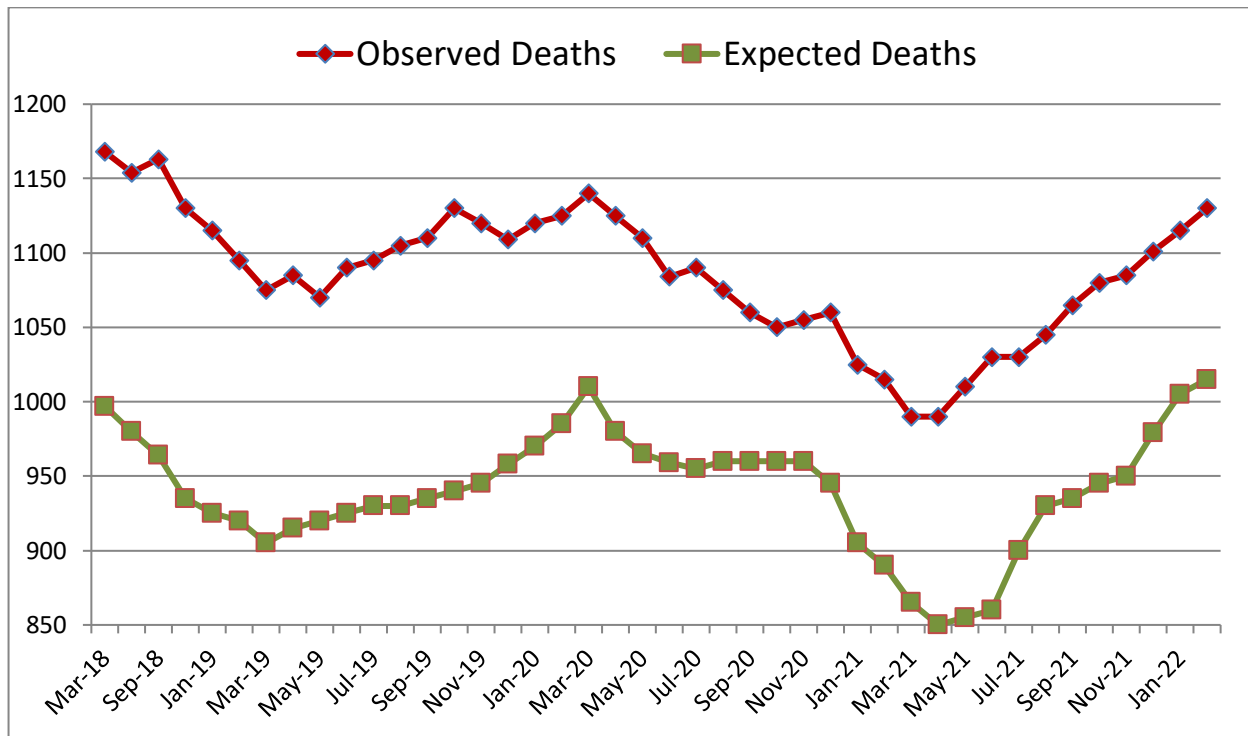
**2.4 Depth of coding:** NHS Digital states “As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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 February 2021 (see graph below), the fell but is now improving and this almost certainly reflects the same backlog problem in the coding department.



**2.5 Expected Deaths** (based on diagnoses across all admissions per rolling 12 months):

The chart below shows observed and expected deaths over the past 3 years (rolling years from March 18 to February 22), and whilst both observed (actual) and expected deaths have increased (as total number of in-patients increases post covid-19), the expected deaths have increased faster as a result of partial recovery of coding practice, thereby improving the SHMI ratio.



## 2.6 Communication with NHS Digital:

From: CLINICAL INDICATORS, Hscic (NHS DIGITAL) <clinical.indicators@nhs.net>  
02/08/2022

Good morning Alastair,

Thank you for your query. The HES data that you have submitted will be used in the 'Annual Refresh' HES data, which is referred to as M14. This hasn't yet been released so we are still using M13 data for the 2021/22 financial year. The Annual Refresh data for the financial year 2021/22 will be released on the 22nd September 2022, and therefore will impact the October SHMI publication release.

I hope this helps. If you have any further questions, please let me know and I will be happy to help.

Best wishes,

Emily

**Emily Davison**

Higher Information Analyst

Pronouns: she/her

[clinical.indicators@nhs.net](mailto:clinical.indicators@nhs.net)

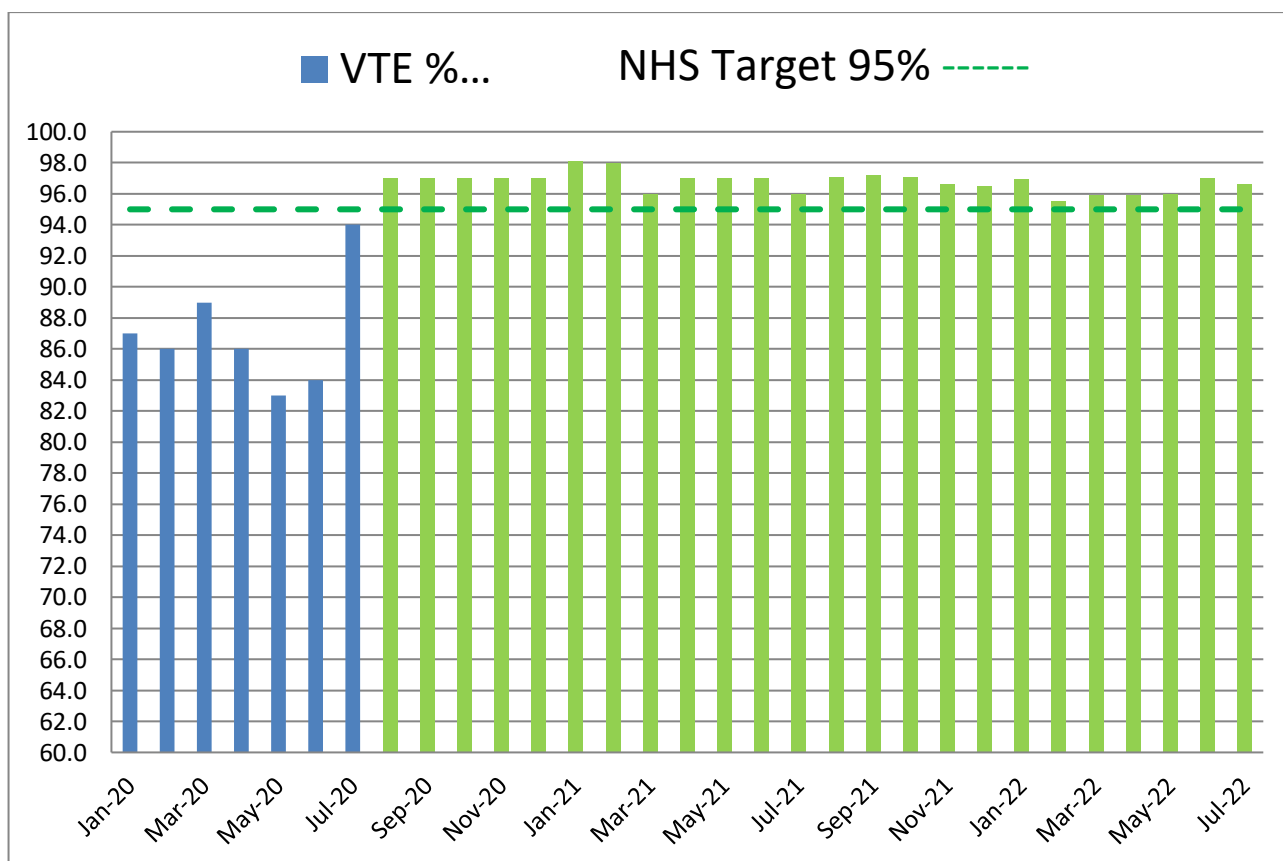


### 3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group regularly examines any other data which might indicate changes in standards of care and it continued to meet on a monthly basis throughout the COVID-19 crisis. 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 has not yet caught up again.

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 Chief Nursing Officer.

DCH VTE risk assessment recording reached 97% in August 2020 with the introduction of a more accurate reporting system, and after a process of data cleansing which removed a number of duplicate reports in Surgery it is clear that the Trust is now achieving the required standard. Dr Aruna Arjunan has taken over as chair of the VTE Group and is auditing compliance with the VTE prophylaxis policy which has been recently revised.



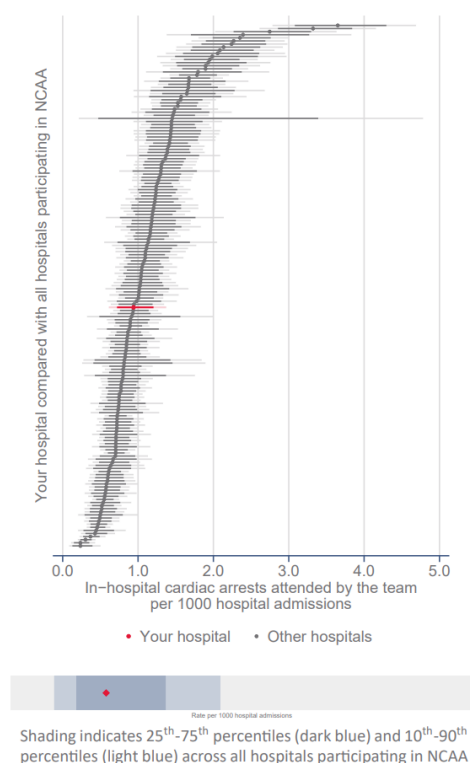
### 3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from January 2022 to March 2022 was published on 17/06/2022. A total of 16 cardiac arrest calls were recorded for this latest quarter, giving a total of 62 for the year to April 2022.

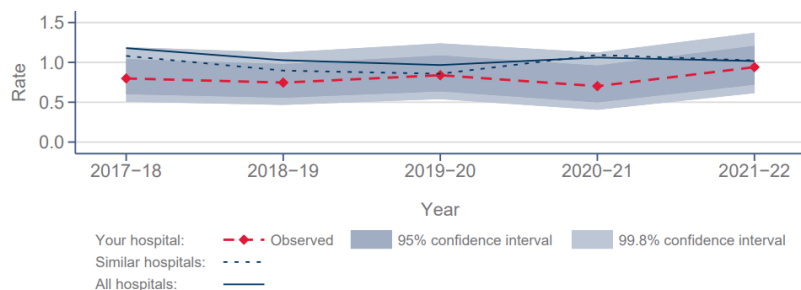
The graph below represents the number of in-hospital cardiac arrests attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the graph below it 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 | 16897               | 23                   | 1.36                              | (0.86, 2.04)            | (0.65, 2.49)              |
| Quarter 2 | 16736               | 10                   | 0.60                              | (0.29, 1.10)            | (0.18, 1.44)              |
| Quarter 3 | 16623               | 13                   | 0.78                              | (0.42, 1.34)            | (0.28, 1.71)              |
| Quarter 4 | 15677               | 16                   | 1.02                              | (0.58, 1.66)            | (0.41, 2.08)              |
| Full year | 65933               | 62                   | 0.94                              | (0.72, 1.21)            | (0.61, 1.37)              |



### 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

Dorset County Hospital  
 NCAA Report: 1 April 2021 to 31 March 2022

4

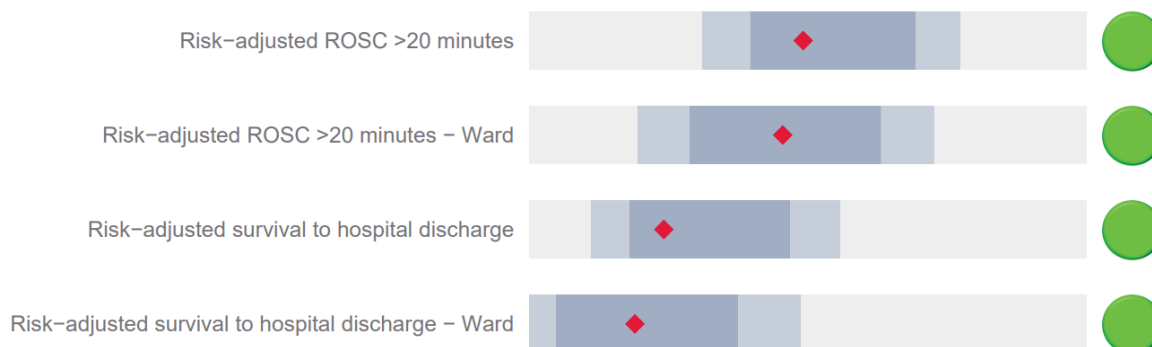
Date of report: 17/06/2022  
 ©Resuscitation Council (UK) & ICNARC

The graph below shows two outcome measures:

- 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 12 month period (Q1 to Q4 2021/22).

## 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. It has been announced that data collection will restart in Spring 2022 for publication in Summer next year.

| 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 in 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 19 May 2022; n = 640 patients.

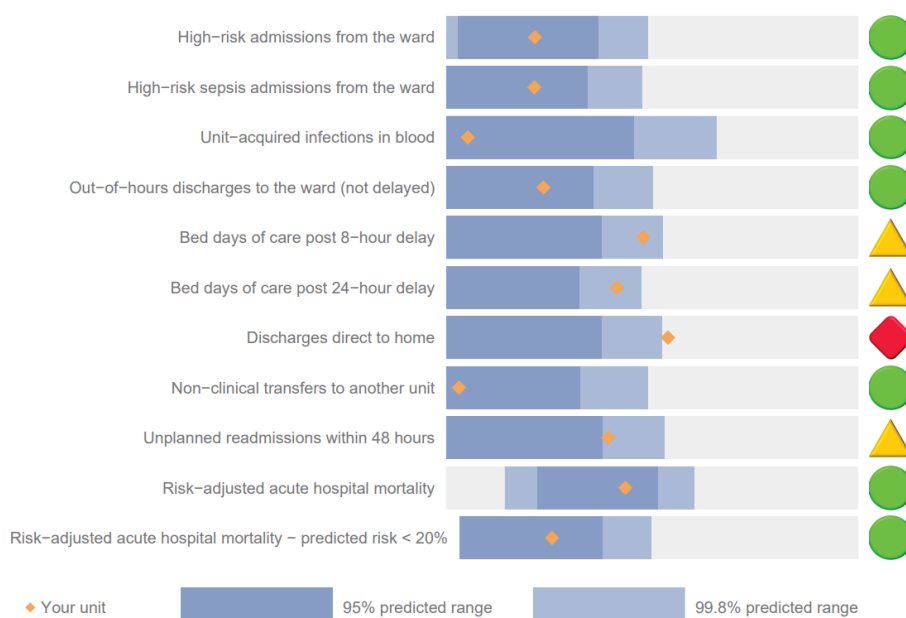
The amber and red indicators in the chart below indicate delays in being able to discharge patients from ICU, with some delays being long enough that the patient was discharged direct to home. This is an indicator of DCH bed pressures.

Unplanned readmissions will be audited to provide a detailed analysis.

Dorset County Hospital, Intensive Care/High Dependency Unit  
Quarterly Quality Report: 1 April 2021 to 31 March 2022



### Quality indicator dashboard



Date of report: 19/05/2022

3

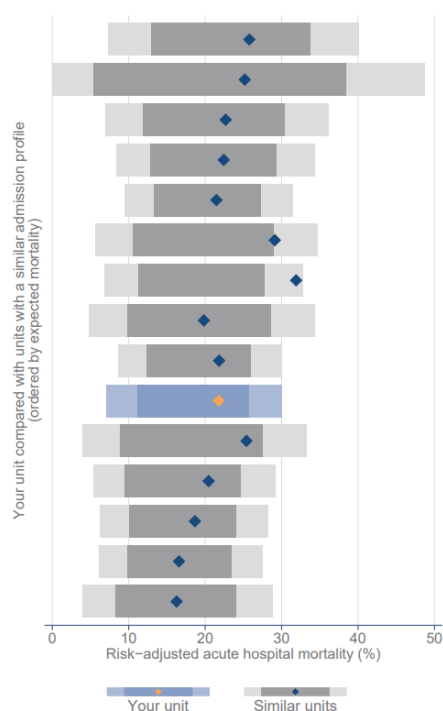
© ICNARC 2022

The charts below show the “risk adjusted acute hospital mortality” following admission to the DCH Critical Care Unit, Q1 to Q4 2021/22. They compare observed and expected death rates in a similar fashion to SHML.

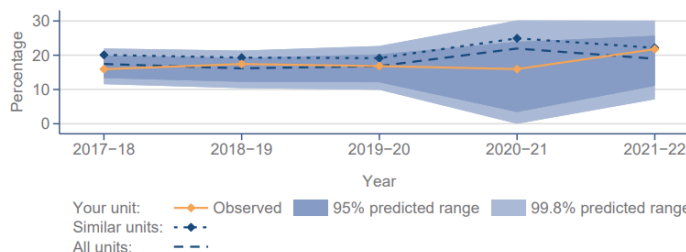
Dorset County Hospital, Intensive Care/High Dependency Unit  
Quarterly Quality Report: 1 April 2021 to 31 March 2022



## Risk-adjusted acute hospital mortality



|           | N   | Eligible | Observed percentage | Expected percentage | 95% predicted range | 99.8% predicted range |   |
|-----------|-----|----------|---------------------|---------------------|---------------------|-----------------------|---|
| Quarter 1 | 145 | 136      | 14.7                | 15.5                | (9.3, 21.5)         | (6.3, 25.4)           | ● |
| Quarter 2 | 157 | 153      | 24.8                | 18.8                | (7.6, 29.6)         | (2.0, 36.5)           | ● |
| Quarter 3 | 178 | 166      | 25.9                | 20.6                | (8.8, 31.9)         | (2.8, 39.2)           | ● |
| Quarter 4 | 160 | 142      | 20.4                | 18.3                | (10.4, 25.9)        | (6.5, 30.8)           | ● |
| Full year | 640 | 597      | 21.8                | 18.5                | (11.1, 25.7)        | (7.1, 30.1)           | ● |



### 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>H-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

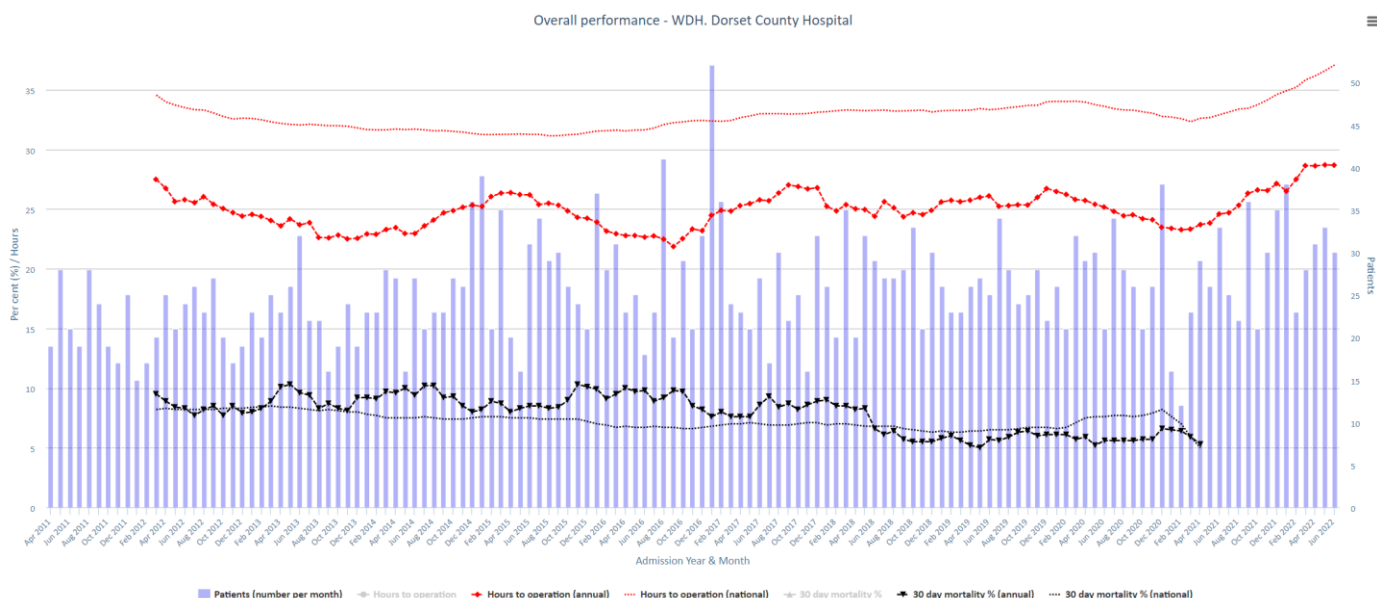
Date of report: 19/05/2022

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These results are within the expected range and have improved slightly compared to the last quarter.

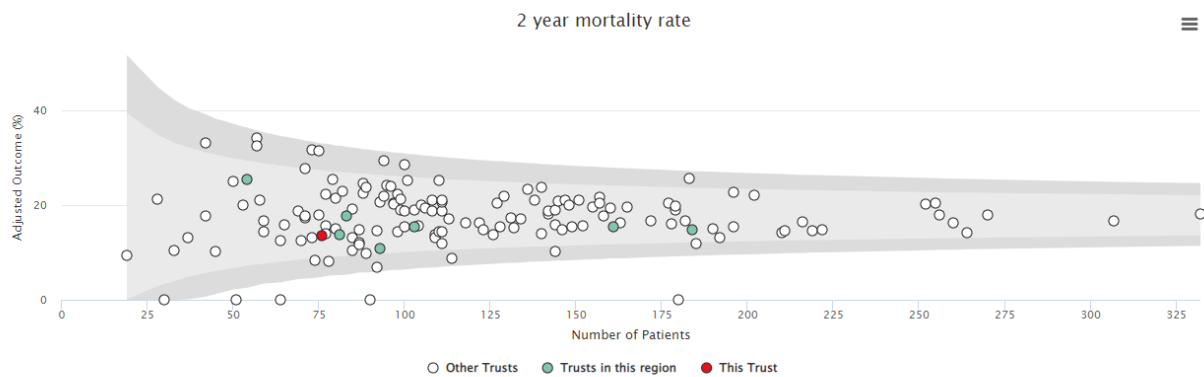
**3.5 National Hip Fracture database to April 2021.** Mortality data has apparently been delayed by contract negotiations with NHS Digital, and therefore this report only adds 2 months to the previous data which is now over 12 months in arrears.



The latest national average annualised mortality for hip fracture is 5.0%, with DCH's annualised mortality at 5.3% to April 2021 (latest available data). 'Hours to operation' remains significantly better than the national average for Q1 (28.6 vs 35.8 hours).

### 3.6 National Bowel Cancer Annual audit

No new data has been published for the year 2019/20 since the Q3 report. The graph below shows the latest available 2 year survival data for patients admitted in financial year 2019/20, compared to all other NHS Trusts, with other Wessex Trusts in green.



| Trust   | Number | Adjusted ? | Observed ? |
|---|--------|------------|------------|
| Dorset County Hospital NHS Foundation Trust   | 76     | 13.5%      | 15.9%      |
| Other trusts within the region: Wessex  |        |            |            |
| Hampshire Hospitals NHS Foundation Trust - Basingstoke and North Hampshire Hospital | 83     | 17.7%      | 14.2%      |
| Hampshire Hospitals NHS Foundation Trust - Royal Hampshire County Hospital          | 81     | 13.7%      | 11.6%      |
| Isle of Wight NHS Trust   | 54     | 25.5%      | 20.8%      |
| Portsmouth Hospitals NHS Trust  | 184    | 14.7%      | 11.6%      |
| University Hospital Southampton NHS Foundation Trust                                | 161    | 15.4%      | 14.9%      |
| Poole Hospital NHS Foundation Trust   | 93     | 10.8%      | 13.8%      |

### 3.7 Getting it Right First Time; reviews in Qtr 1

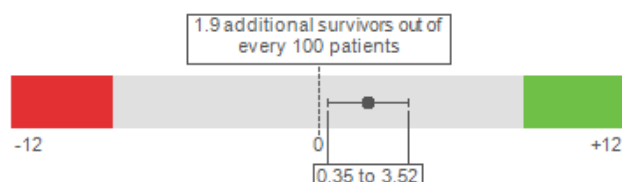
No GIRFT reviews have taken place in Qtr 1

### 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 the previous Q3 Learning from Deaths report. The data below is therefore unchanged and reports up to December 2021 only.

## Rate of Survival at this Hospital

Between January 1st 2019 and December 31st 2021

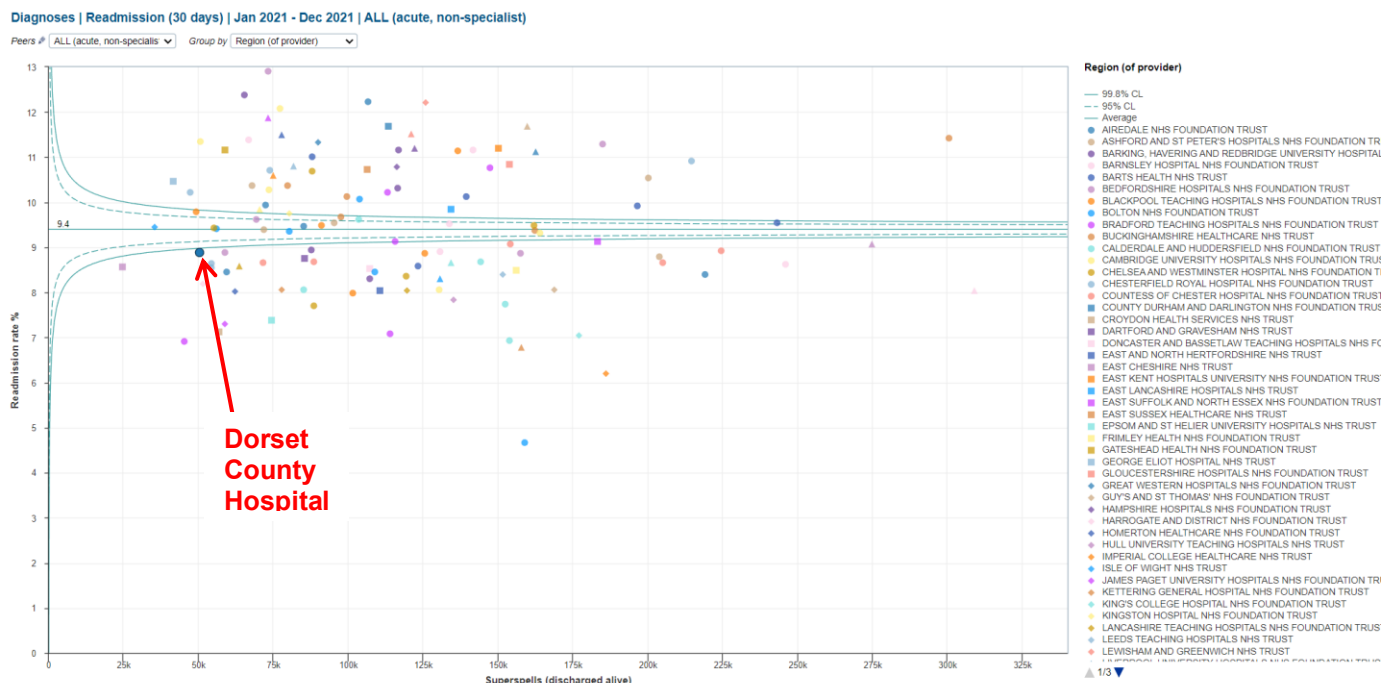


## Rate of Survival Breakdown at this Hospital

| Survival band % | Number in group | Expected survivors | Actual survivors | Difference* | Adjusted difference** |  |
|-----------------|-----------------|--------------------|------------------|-------------|-----------------------|--|
| 95 - 100        | 518             | 508                | 514              | 1.1         | 0.8                   | Unexpected deaths in minor/moderate injury<br>Usually due to poor management of co-morbidity and/or complications                                      |
| 90 - 95         | 190             | 176                | 177              | 0.4         | 0.1                   |  |
| 80 - 90         | 112             | 95                 | 102              | 5.4         | 0.5                   |  |
| 65 - 80         | 46              | 34                 | 33               | -2.2        | -0.1                  | Unexpected survivors with more serious injury<br>Usually indicates good initial resuscitation and the treatment of head injury in Neurological Centres |
| 45 - 65         | 15              | 8                  | 14               | 34.3        | 0.8                   |  |
| 25 - 45         | 4               | 1                  | 2                | 10.4        | 0.2                   |  |
| 0 - 25          | 4               | 0                  | 0                | -12.9       | -0.2                  |  |
| <b>Total</b>    | <b>889</b>      | <b>825</b>         | <b>842</b>       | <b>1.9</b>  | <b>1.9</b>            |  |

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. In this data there were 17 more survivors than expected.

### 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 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 considering adopting AGYLE for their A&E department, creating a single software system across the Dorset Acute Trusts and based at DCH.

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

## 5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers. Urology dates are to be confirmed – data not available at time of writing.

| Specialty                   | Contact                           | April    | May      | June     | July     | Aug      | Sep      |
|-----------------------------|-----------------------------------|----------|----------|----------|----------|----------|----------|
| Cardiology                  | Helen Dell                        | 12/04/22 | 24/05/22 |          | 05/07/22 |          |          |
| Renal                       | Kathleen O'Neill                  | 04/2022  | x        | 29/06/22 | 27/07/22 |          |          |
| Vascular                    | James Metcalfe                    |          |          |          |          |          |          |
| Diabetes                    |                                   |          |          |          |          |          |          |
| Oncology                    | Abi Orchard                       |          | 20/05/22 | 17/06/22 | 15/07/22 | 19/08/22 |          |
| Haematology                 | Sarah Attfield, Jill McCormack    |          |          |          |          |          |          |
| ED & Acute Medicine         | Andy Brett & James Ewer           |          |          | 16/06/22 |          |          |          |
| Respiratory (Quarterly M+M) | Marianne Docherty                 | 26/04/22 | 24/05/22 | 28/06/22 | 26/07/22 | 23/08/22 | 27/09/22 |
| Elderly Care & Stroke       | James Richards<br>Harold Proschel | X        | 13/05/22 |          |          |          |          |

| Specialty                    | July                                     | August                       | September   | October                       | November                       | December                       |
|------------------------------|--|------------------------------|---|-------------------------------|--------------------------------|--------------------------------|
| Anaesthetics                 |  |                              |   |                               |                                |                                |
| Gastroenterology             | 6 <sup>th</sup> July 2022                | 3 <sup>RD</sup> August 2022  | 7 <sup>th</sup> September 2022                      | 5 <sup>th</sup> October 2022  | 2 <sup>nd</sup> November 2022  | 7 <sup>th</sup> December 2022  |
| Breast Surgery               | Hosted by YDH – Checking on future dates |                              |   |                               |                                |                                |
| General Surgery + Colorectal | 8 <sup>th</sup> July 2022                | 5 <sup>th</sup> August 2022  | 2 <sup>nd</sup> and 30 <sup>th</sup> September 2022 | 28 <sup>th</sup> October 2022 | 25 <sup>th</sup> November 2022 | 23 <sup>rd</sup> December 2022 |
| Orthopaedics                 | 8 <sup>th</sup> July 2022                | 5 <sup>th</sup> August 2022  | 2 <sup>nd</sup> September 2022                      |                               |                                |                                |
| Perinatal                    | 27 <sup>th</sup> July 2022               | 24 <sup>th</sup> August 2022 | 21 <sup>st</sup> September 2022                     | 19 <sup>th</sup> October 2022 | 23 <sup>rd</sup> November 2022 | TBC                            |
| Urology                      |  |                              |   |                               |                                |                                |
| ENT                          | 15 <sup>th</sup> July 2022               | 26 <sup>TH</sup> August 2022 | 23 <sup>rd</sup> September 2022                     | TBC                           | TBC                            | TBC                            |

## **6.0 LEARNING FROM CORONER'S INQUESTS Q1**

DCH has been notified of 14 new Coroner's inquests being opened in the period April 2022 – June 2022.

7 inquests were held during Quarter 1. 3 inquests were heard as Documentary hearings, not requiring DCH attendance. 2 required the clinician to attend Court in person. 2 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 56 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 1 pre-inquest review was listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings. The coroner has requested from May 2022 that witnesses attend the court room at the Town Hall, Bournemouth in person. Authority will be required, if we wish the clinician to attend remotely.

## **7.0 LEARNING FROM CLAIMS Q1**

Legal claims are dealt with by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs.

Claims pattern this Quarter:

|                           |   |
|---------------------------|---|
| New potential claims      | 12                                      |
| Disclosed patient records | 10                                      |
| Formal claims             | 9 clinical negligence, 0 employee claim |
| Settled claims            | 3 clinical negligence, 0 employee claim |
| Closed - no damages       | 4 clinical negligence, 0 employee claim |

## **8.0 SUMMARY**

SHMI is expected to improve in the coming months since the backlog of uncoded notes has been cleared, and updated HES data for 2021/22 was submitted to NHS Digital by the deadline of 19<sup>th</sup> May 2022. However this will not change previously published figures which will remain on record although they are known to be inaccurate. The 5 month SHMI publishing delay means that the DCH SHMI will not accurately reflect in-patient activity until October 2022 at the earliest (see email from NHS Digital above).

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 several previously regular national mortality reports are themselves having difficulty in producing timely data. In particular TARN, ICNARC and NCAA data continue to be reassuring since unexpected deaths would be likely to show up first in these acute care audits.

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.

