Meeting Title:	**Board of Directors**
Date of Meeting:	30th November 2022
Document Title:	**Mortality Report: Learning from deaths Qtr 2 2022-23**
Responsible Director:	Prof. Alastair Hutchison, Medical Director
Author:	Prof. Alastair Hutchison, Medical Director

Confidentiality:	Public
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	16th November 2022	None specific
Quality Committee	22nd November 2022	

Purpose of the Paper	To inform the Board of Directors of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.
Summary of Key Issues	The latest published SHMI data for DCH was above the 'Expected Range' for the rolling 12 months to March, April, May & June 2022 (page 5), possibly influenced by a fall in the depth of coding. No other local or national indicators suggest excess unexpected deaths are occurring at DCH. Structured Judgement Reviews are used to examine the care of a significant sample of people who died whilst in-patients (around 20%), and to learn from any good practice or lapses in care identified. The DCH Medical Examiners review every death, speak to immediate relatives and highlight any obvious causes for concern.
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website

Governance and Compliance Obligations

Legal / Regulatory	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.
Financial	Y	Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.
Impacts Strategic Objectives?	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.
Risk?	Y	• Reputational risk due to higher than expected SHMI • 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 • Other mortality data sources (primarily from national audits) are regularly checked for any evidence of unexpected deaths.
Decision to be made?	N	
Impacts CQC Standards?	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.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

CONTENTS

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. See appendix 1 and 2 for full reports (not published).

1.1 Family Services and Surgical Division Report - Quarter 2 Report

Structured Judgement Review Results: The Family Services & Surgical Division had 60 deaths in quarter 2 that require SJR's to be completed. Across the Division 42 SJRs have been completed in quarter 2 however 34 of these SJRs were completed for deaths reported in previous months.
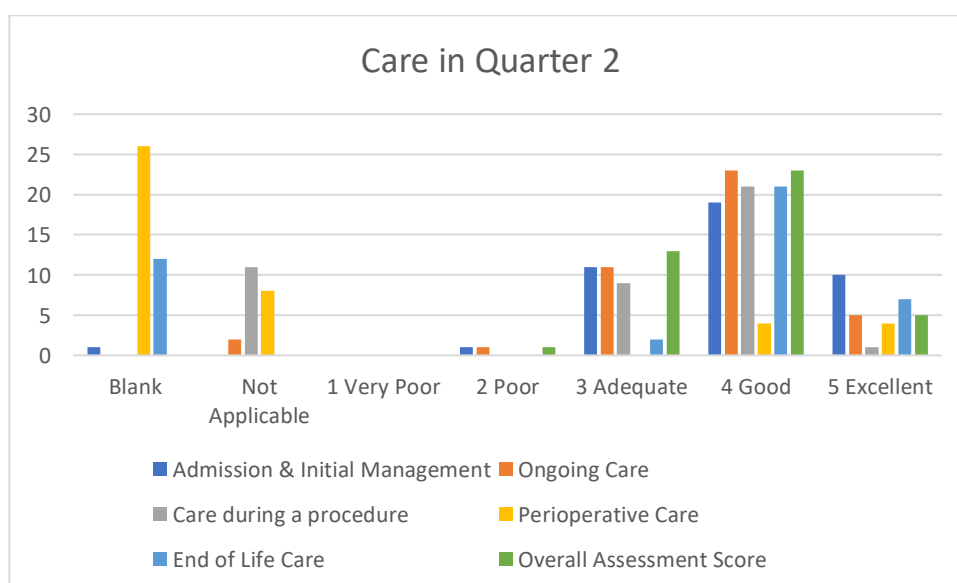
SJR Backlog (incomplete >2 months): Current number of outstanding SJR's for the Division is 48 (on 11/10/22)

Oct 21	Nov 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	July 22	Aug 22
3	2	4	5	2	4	2	5	5	16

The availability of the notes for these patients has been re-checked to ensure Clinical staff can complete this work. It has been identified that 23 sets of patient records are only available on DPR and so these SJR's will be unable to be completed.

Feedback from SJR's completed in quarter 2:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
Blank	1			26	12	
Not Applicable		2	11	8		
1 Very Poor						
2 Poor	1	1				1
3 Adequate	11	11	9		2	13
4 Good	19	23	21	4	21	23
5 Excellent	10	5	1	4	7	5

Overall Quality of Patient Records:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
3		3	8	24	4

Avoidability of Death Judgement Scores:

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	2	2	38

Learning from the Division:

In the previous quarter we noted a new Quality Manager who set the following workplan:

- Track completed SJRs with open actions DATIX to ensure actions are completed in line with recommendations. This is working well with SJRs closed off promptly and the mortality spreadsheet up to date.
- Capture SJRs that are not fully completed on DATIX due to missing scores. Any missing data is being challenged with the person responsible for the SJR so they can be promptly rectified, more work required to improve the reporting.
- Support the clinicians to manage the backlog by ensuring notes are available for outstanding SJRs. Medical notes have been requested for all the outstanding SJRs from the various departments. It has been noted that 23 patients identified for an SJR only have scanned notes on DPR which makes performing an SJR difficult.

Action Recommendations:

No Action required	Consideration for RCA	Further Learning required	Other Action	Referred to Trust Group / Committee	Blank / not recorded	For coroners review
32	1	1	5	1	1	1

Dates of 2022 M+M meetings:

Specialty	July	August	September	October	November	December
Anaesthetics	8th July 2022	5th August 2022	2nd and 30th September 2022	28th October 2022	25th November 2022	23rd December 2022
Gastroenterology	6th July 2022	3RD August 2022	7th September 2022	5th October 2022	2nd November 2022	7th December 2022
Breast Surgery	Hosted by YDH – Checking on future dates					
General Surgery + Colorectal	8th July 2022	5th August 2022	2nd and 30th September 2022	28th October 2022	25th November 2022	23rd December 2022
Head, Neck & Specialist	15/07/2022	12th August 2022	6th September 2022			
Orthopaedics						
Maternity Safety Report	15th July 2022	18TH August 2022	16th September 2022			
Perinatal	27th July 2022	24th August 2022	21st September 2022	19th October 2022	23rd November 2022	TBC
Paediatrics	6th July 2022	3rd August 2022	7th September 2022	5th October 2022		
Urology						
ENT	15th July 2022	26TH August 2022	23rd September 2022	TBC	TBC	TBC

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

## 1.2 Division of Urgent & Integrated Care – Quarter 2 Report

Structured Judgement Reviews: In quarter 2 there were 157 deaths, 29 SJRs requested from these deaths and 41 were completed in total (completed SJRs not necessarily from this quarter).

	Apr-22	May	June	July	Aug	Sep	Total YTD
Deaths	66	54	47	61	46	50	324
Deaths requiring SJR'S from Month	16	6	8	15	9	5	59
Completed SJR'S*	12	18	14	15	9	17	85

Total outstanding SJR's (not including nosocomial's) = **15 (27)**
Outstanding SJR's >2 months (prior to 14/08/2022) = **8 (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). – JM Still pending review of final 12.

Structured Judgement Reviews 2021/2022
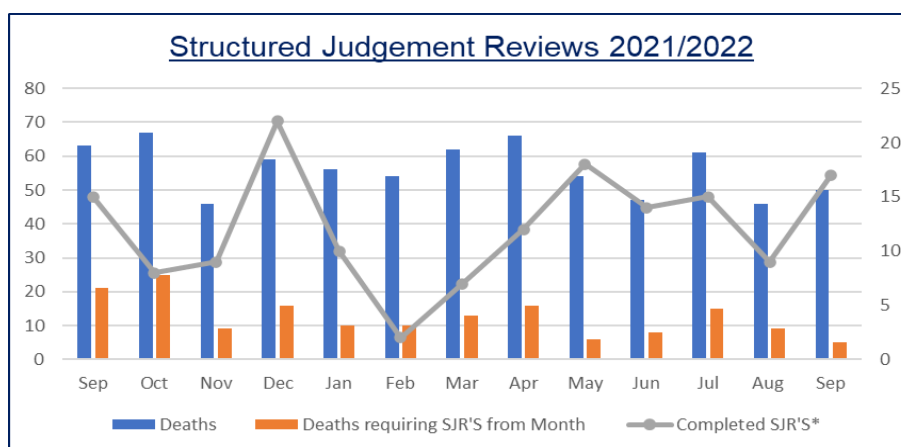
'Phase of care' score from 39 completed SJR's in Quarter 2:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	EoL Care	Overall Assessment Score
N/A or Blank	0	1	26	41	7	1*
1 Very Poor	0	0	0	0	0	0
2 Poor	0	2	0	0	1	0
3 Adequate	8	6	6	0	4	12
4 Good	28	29	8	0	25	25
5 Excellent	5	3	1	0	4	3

*Returned to clinician who completed for overall assessment score to be added – 14/10/22

Overall quality of patient record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
1	0	1	20	16	3

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	1	39

Dates of 2022 M+M meetings:

Specialty	Contact	April	May	June	July	Aug	Sep	Oct	Nov	Dec
Cardiology	Helen Dell E Boston-Griffiths	12/04/22	24/05/22	29/06/22	05/07/22		27/09/22		08/11/22	20/12/22
Renal	Kathleen O'Neill	04/2022	x	29/06/22	27/07/22	x				
Vascular	James Metcalfe	Weekly at DCH Monthly at Network Mtg's in Bournemouth 14/07/22 and 16/09/22								
Diabetes	Mo-Lee Wong		15/6/22	x	17/08/22 Rearranged	28/09/22	19/10/22 Rearranged	30/11/22	15/6/22	
Oncology	Abi Orchard		20/05/22	17/06/22						
Haematology	Sarah Attfield Jill McCormick	X	X	X	X	X	X	X	07/11/22	05/12/22
ED & AM	Andy Brett James Ewer			16/06/22		18/08/22				
Respiratory (1/4 M+M)	Marianne Docherty	26/04/22	24/05/22	28/06/22	26/07/22	23/08/22	27/09/22			
EC & Stroke	James Richards Harold Proschel	X	13/05/22	X	X	10/08/22	X	21/10/22	11/11/22	X

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, then stabilised around a SHMI of 1.11 (within the 'Expected Range'). However, the most recently published data for March to June 2022 has risen outside the 'Expected Range' 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 is included in the calculations for May and June 2022. However the depth of coding in this data appears to have been relatively poor – see section 2.4 below. A new Senior Coder has been appointed following the departure of Sue Eve-Jones, and is due to start work before the end of November. The latest published SHMI (rolling year to June 2022) is shown below:
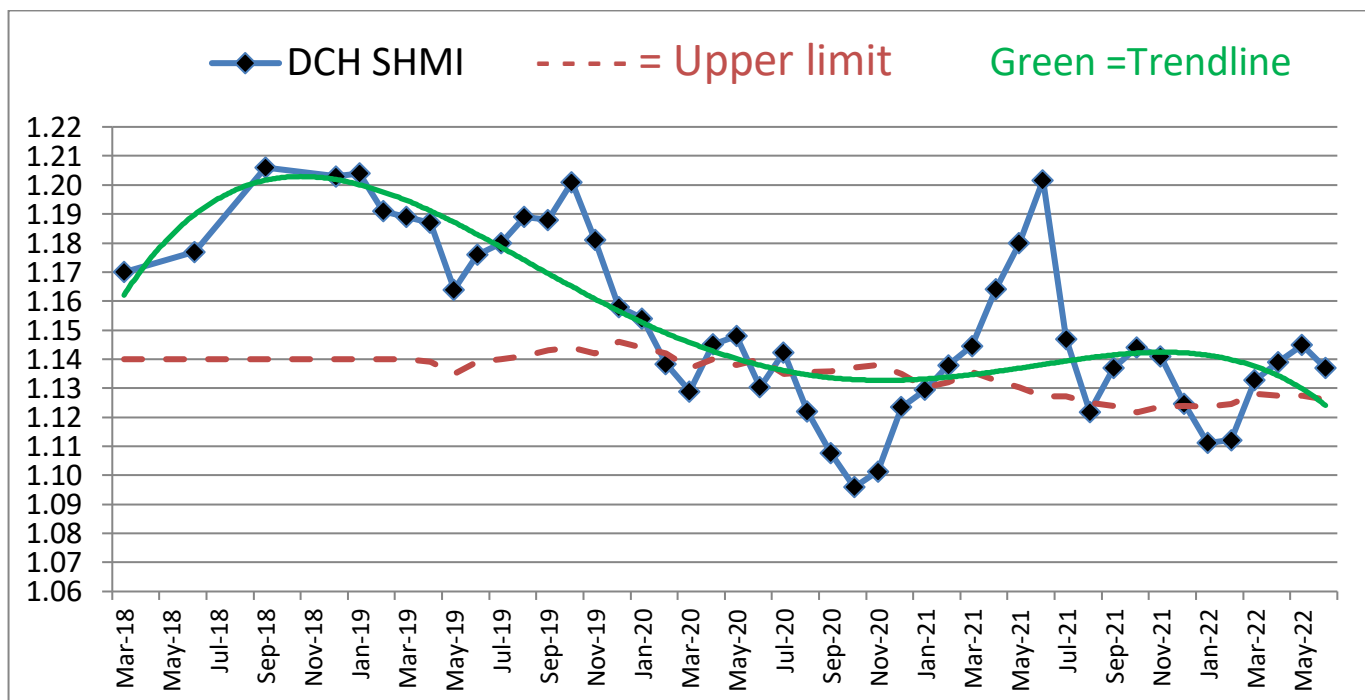

SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding of all admissions). From October 2019 onwards there had been a steady trend of improvement in DCH's SHMI as a result of investment in the coding department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

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 now normalised 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 13.8% for June 2022. The England average is around 13.5%.

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:

Percentage 'invalid' or 'symptom/sign' Diagnoses

England Average, 13.2

England Average, 0.6
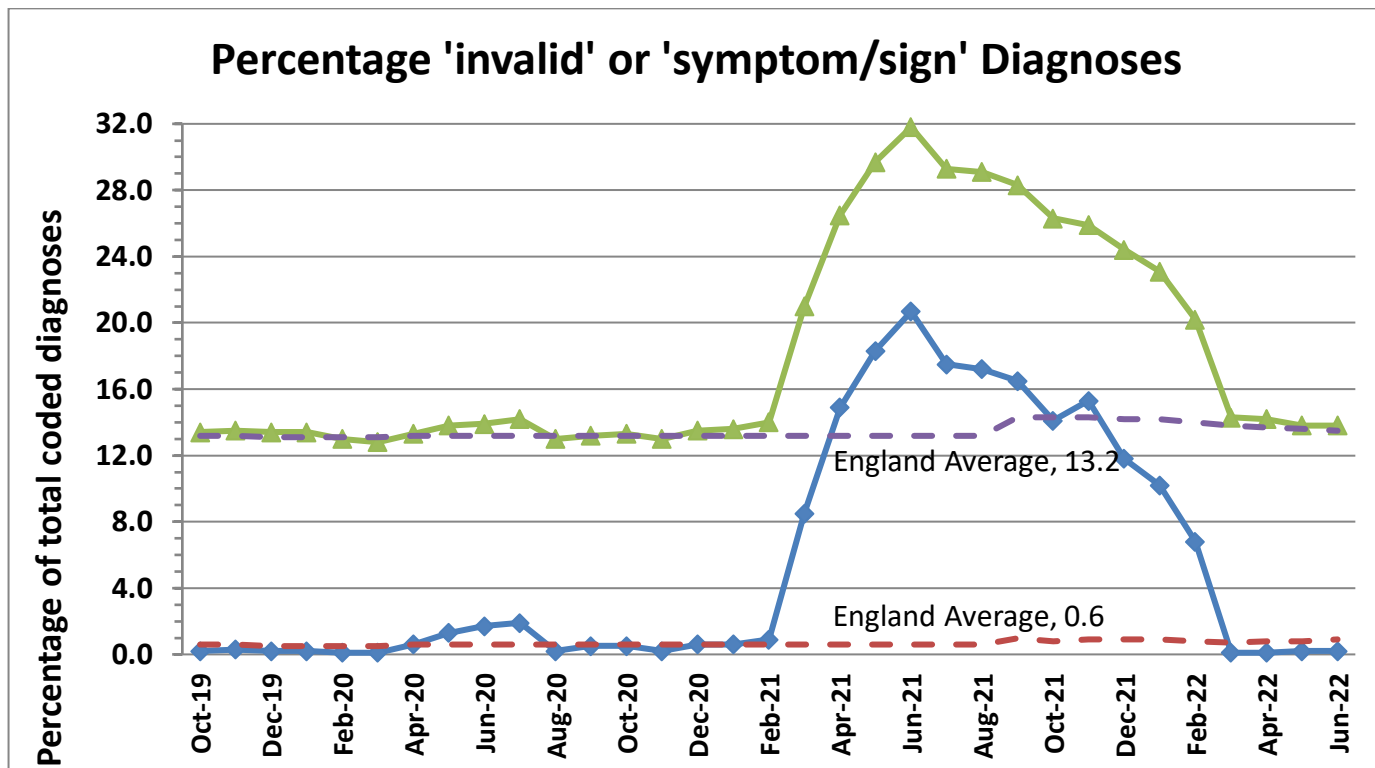
2.4 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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 March 2022 (see graph below), but the two most recently reported months which include the corrected M14 data show a significant decrease. It suggests that the coding department concentrated on primary diagnoses alone rather than depth of coding as they corrected the backlog of uncoded data. This may partially explain the recent reduction in 'Expected Deaths' and consequent rise in SHMI.


Mean Depth of Coding - non-elective
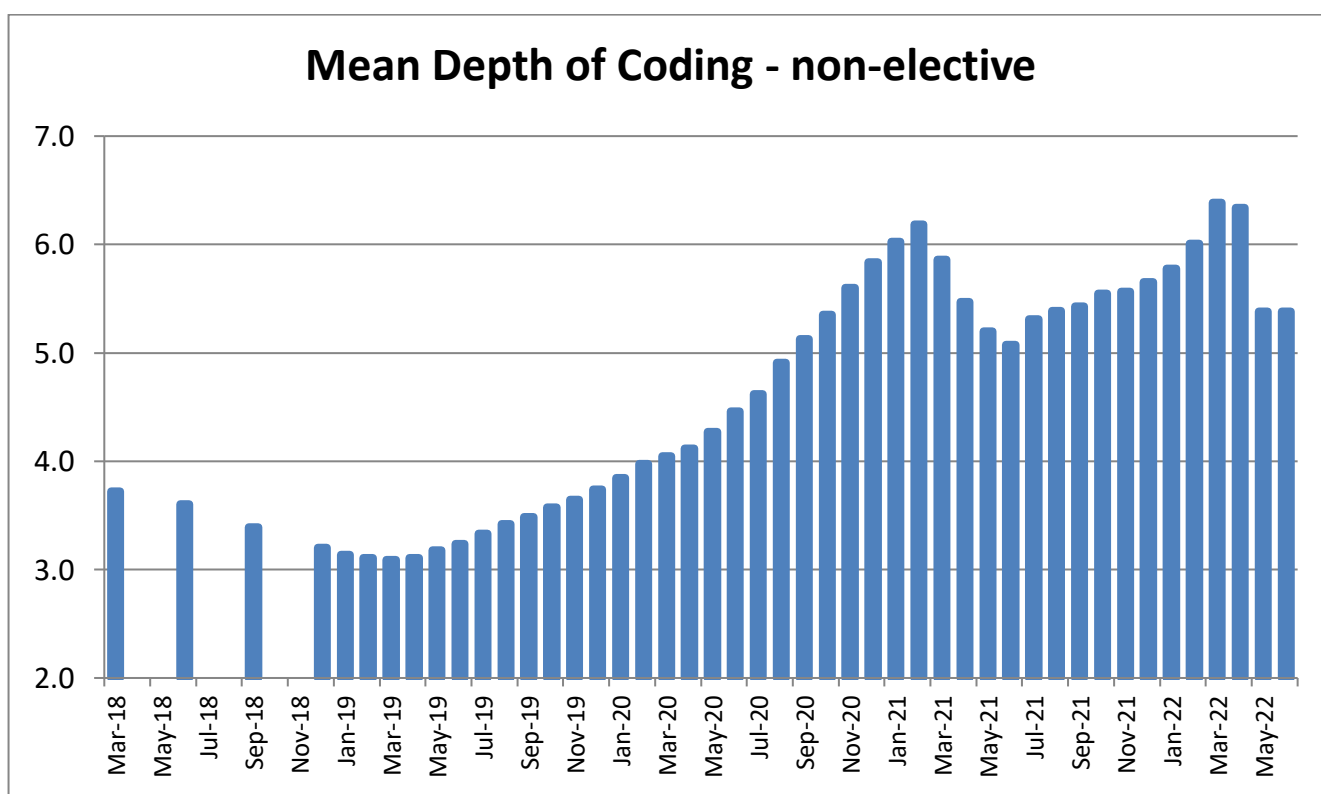
2.5 Expected Deaths (based on diagnoses across all admissions per rolling 12 months):

The chart below shows observed and expected deaths over the past 3+ years (rolling years from March 18 to June 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 decreased over the 4 months to June 22, possibly as a result of the focus on recovery of the coding backlog. Prof. Hutchison has arranged to meet the new Coding Manager as soon as she arrives on site to discuss this data in detail.
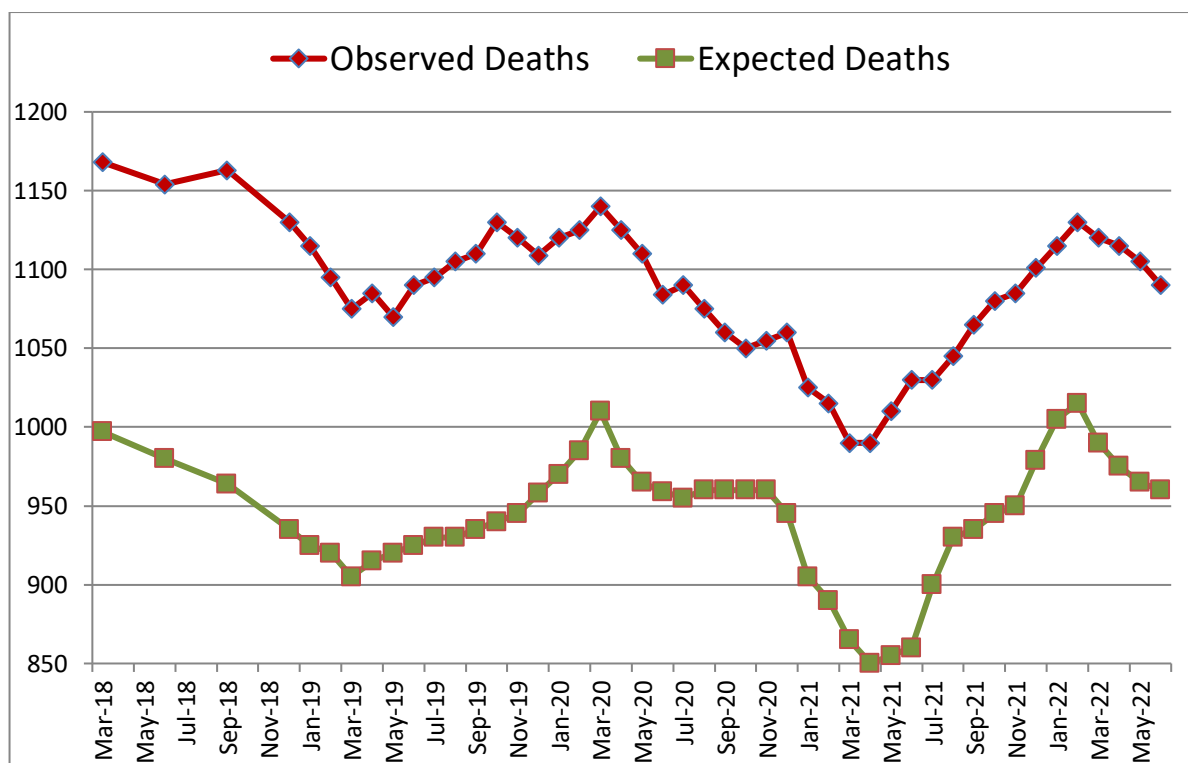
2.6 Comparison by 'Diagnostic Group Description'

Comparison of observed and expected deaths by diagnosis group
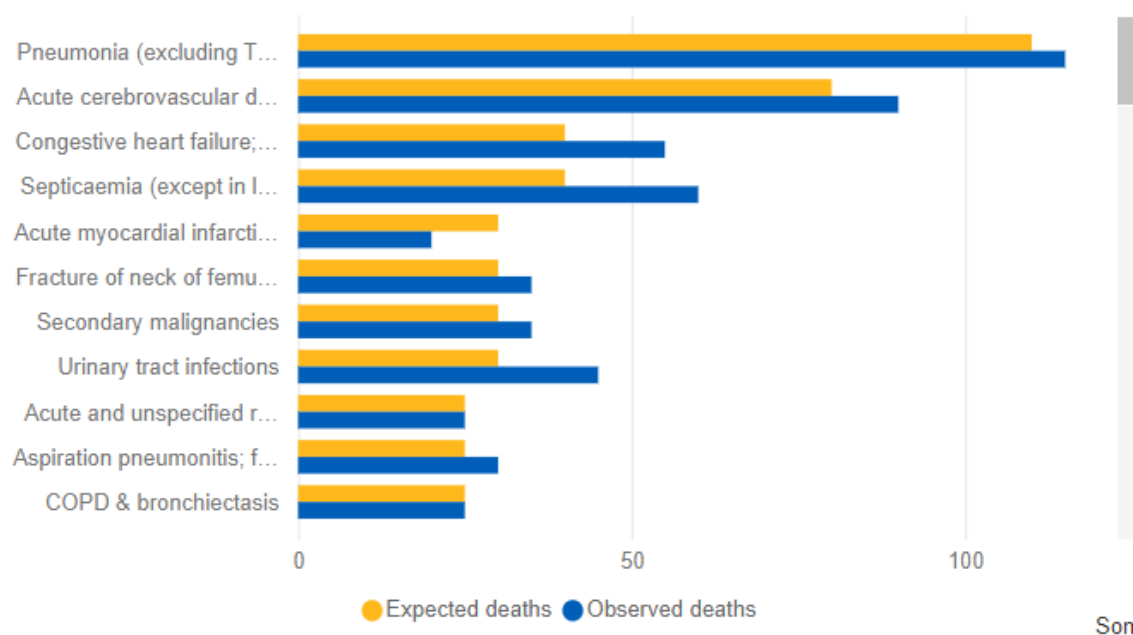
Several diagnosis groups have higher observed numbers of deaths than Expected although only one of these is statistically significant – Septicaemia. These groups are being investigated further where appropriate – the total number of cases differs significantly between grooups, so for example the data contains 620 cases of 'pneumonia' versus only 60 cases of 'aspiration pneumonitis'.

2.7 Communication with NHS Digital:

We continue to engage with NHS Digital who have suggested investigating **the SHMI Extract Service** which will enable us to examine the data we have submitted previously:

Good morning Alastair,

Apologies for the late response, I have been on annual leave.

I have looked at the HES extracts used for last month publication and the M14 data was used.

Are you aware of the SHMI Extract Service? I think it might be helpful for the investigation. Each month, when we publish the SHMI we also publish the corresponding record level data for each trust to access via a secure e-file transfer service (SEFT). Two people per trust are granted access to this. This allows trusts to reconcile any differences and to provide assurance with the data. I can see that Anthony Saunders currently has access for Dorset Country Hospital NHS Foundation Trust. If you would like to apply for access yourself, let me know and I can send over the details of how to apply. Once we receive your details it doesn't take long to create an account.

I look forward to hearing from you.

Best wishes,

Emily Davison
Higher Information Analyst
Pronouns: she/her
On behalf of
Population Health, Clinical Audit, and Specialist Care
*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.
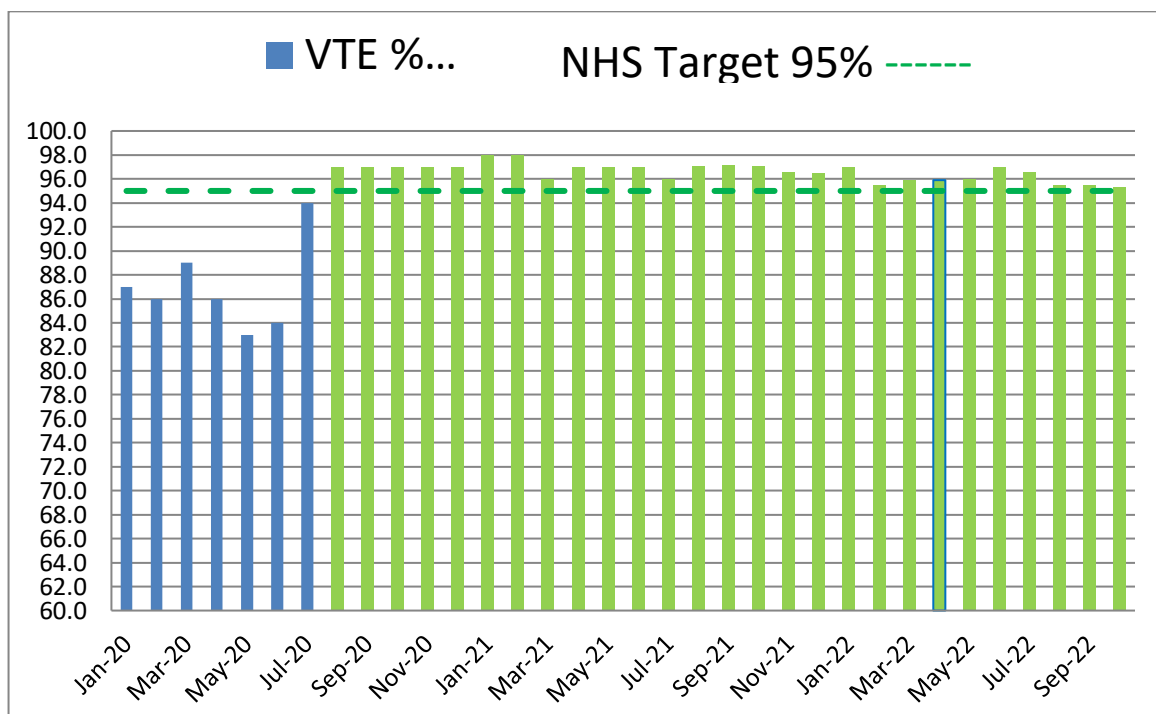
3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2022 to June 2022 was published on 23/8/2022. A total of 19 cardiac arrest calls were recorded for this first quarter of the year.
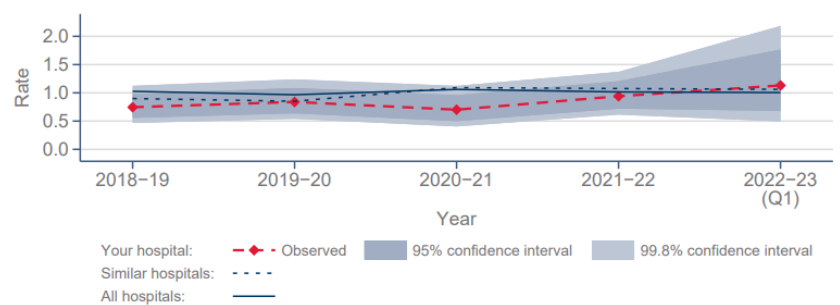
The graph below represents the number of in-hospital cardiac arrests attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the graph below it summarises the past 5 years.

Rate of cardiac arrests per 1000 hospital admissions
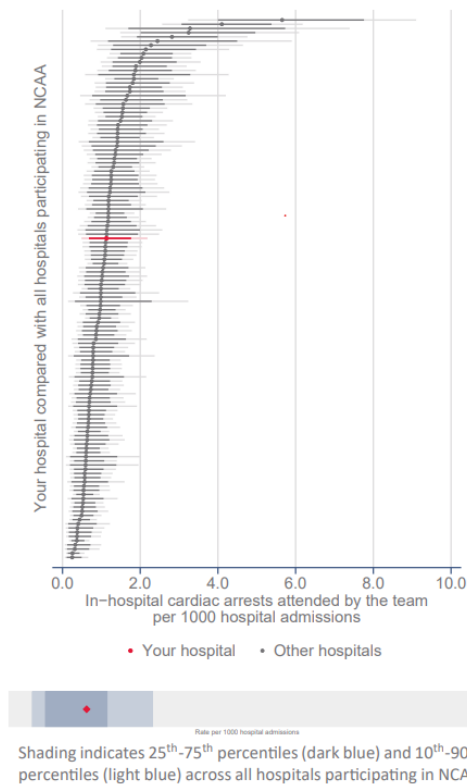
	Hospital admissions	Eligible team visits	Rate per 1000 hospital admissions	95% confidence interval	99.8% confidence interval
Quarter 1	16802	19	1.13	(0.68, 1.77)	(0.49, 2.18)
Quarter 2					
Quarter 3					
Quarter 4					
Year to date	16802	19	1.13	(0.68, 1.77)	(0.49, 2.18)

Your hospital: Observed — ◆ — 95% confidence interval ■ 99.8% confidence interval ■
Similar hospitals: - - - -
All hospitals: ———

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

Shading indicates 25th-75th percentiles (dark blue) and 10th-90th percentiles (light blue) across all hospitals participating in NCAA

Dorset County Hospital
NCAA Report: 1 April 2022 to 30 June 2022

4

Date of report: 23/08/2022
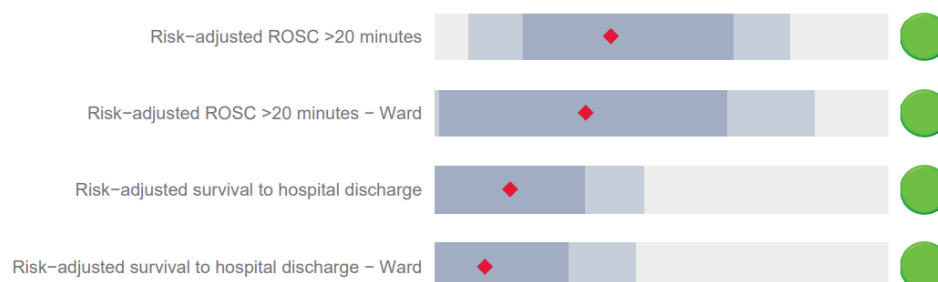**©Resuscitation Council (UK) & ICNARC**

The graph below shows two outcome measures:
a) 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 Quarter 1 (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. 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 for Aril to June 2022; published 22 August 2022; n = 146 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. This is an indicator of DCH bed pressures.

Unplanned readmissions (4% versus expected 1%) will be audited to provide a detailed analysis.

Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2022 to 30 June 2022

Quality indicator dashboard
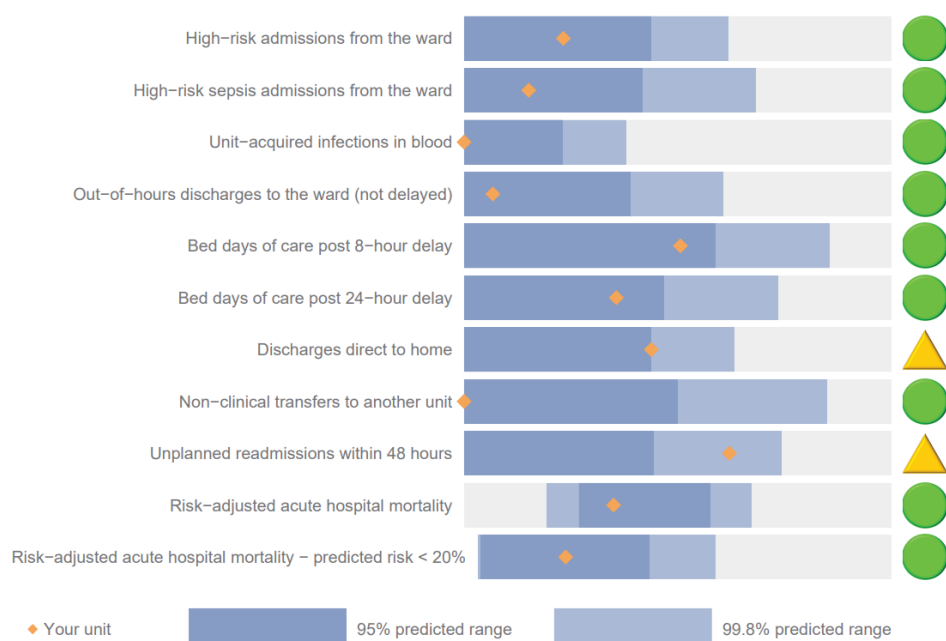
Date of report: 22/08/2022   3   ©ICNARC 2022
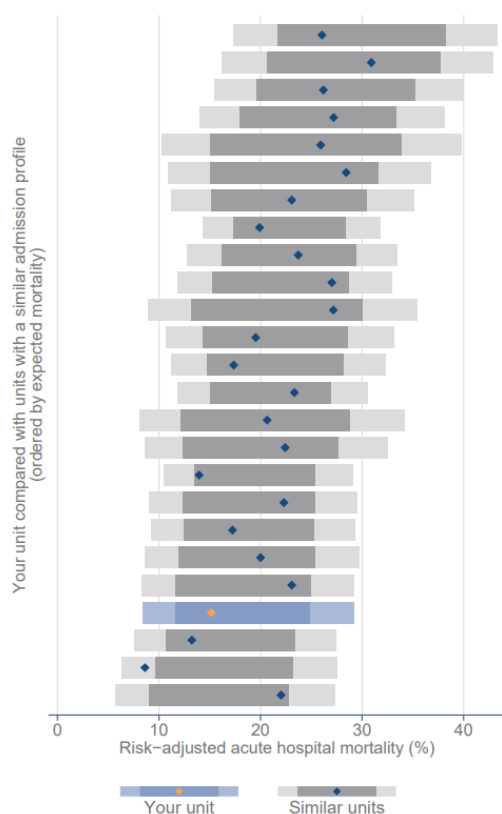
The charts below show the "risk adjusted acute hospital mortality" following admission to the DCH Critical Care Unit, Q1 2022/23. They compare observed and expected death rates in a similar fashion to SHMI.
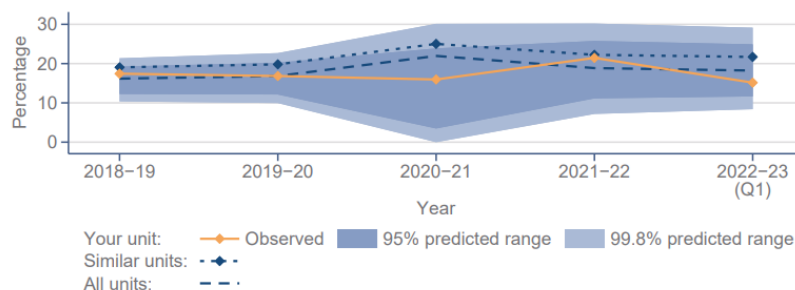
Risk-adjusted acute hospital mortality

	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	146	132	15.2	18.4	(11.6, 24.9)	(8.4, 29.1)	🟢
Quarter 2							
Quarter 3							
Quarter 4							
Year to date	146	132	15.2	18.4	(11.6, 24.9)	(8.4, 29.1)	🟢

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 $ICNARC_{H-2018}$ 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

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

**3.5** National Hip Fracture database to April 2021.

Mortality data had been delayed by contract negotiations with NHS Digital, but is now up to date and shows that the DCH crude mortality is now above the national average. The data has been flagged to the Orthopaedic Department and they are reviewing it.
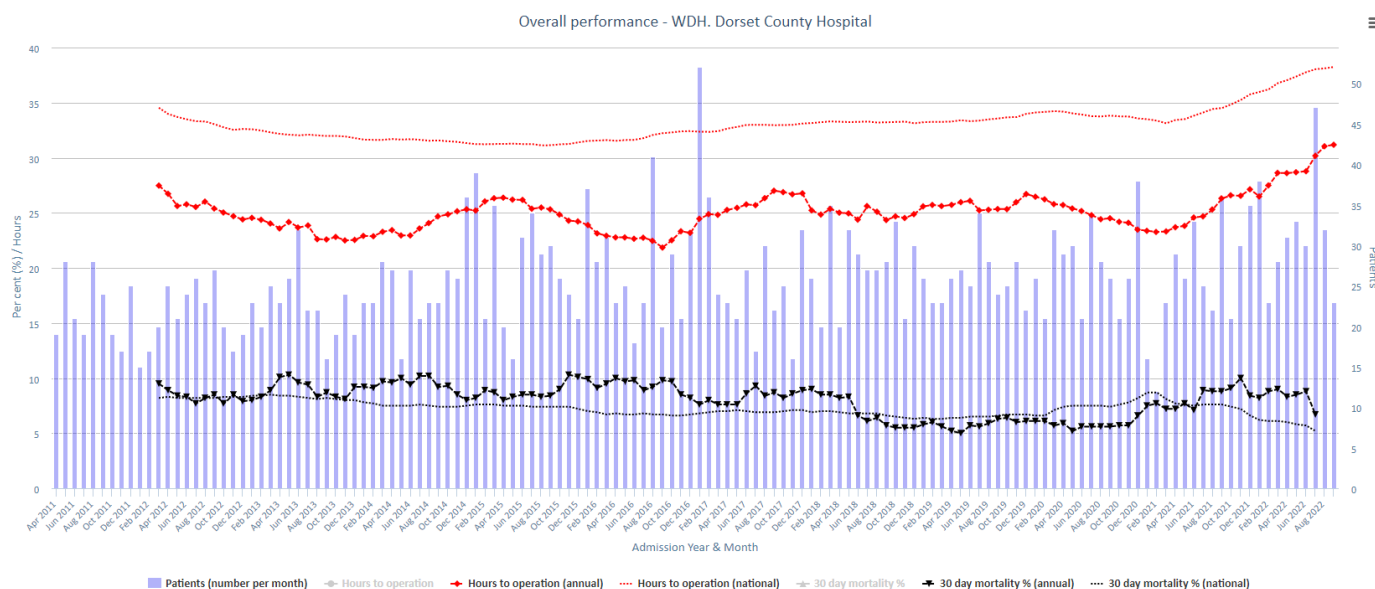
The latest national average annualised mortality for hip fracture is 5.2%, with DCH's annualised mortality at 6.7% to August 2022. 'Hours to operation' remains significantly better than the national average for Q2 (31.2 vs 38.3 hours) but there has been a steady rise across the country post covid..

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.
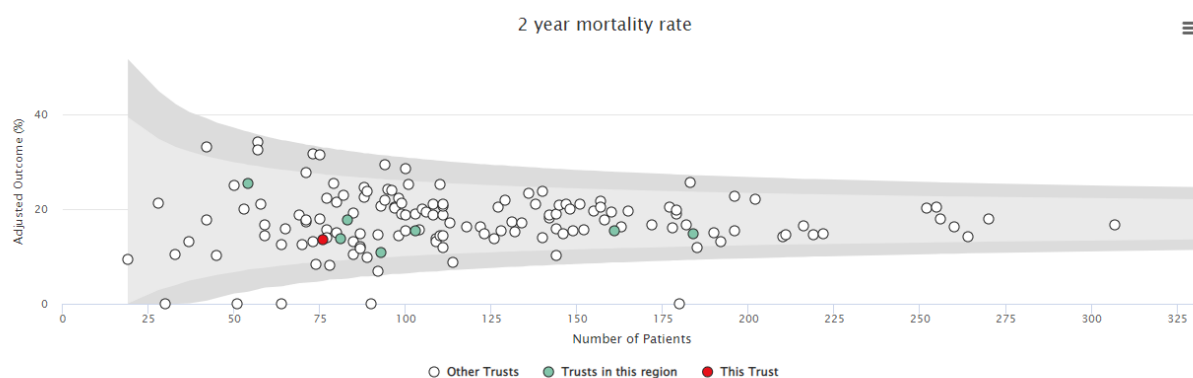
Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	76	13.5%	15.9%
Other trusts within the region: Wessex			
Hampshire Hospitals NHS Foundation Trust - Basingstoke and North Hampshire Hospital	83	17.7%	14.2%
Hampshire Hospitals NHS Foundation Trust - Royal Hampshire County Hospital	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 2

GIRFT are now responsible for 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.

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. No explanation is currently available for this.

Rate of Survival at this Hospital

Between January 1st 2019 and December 31st 2021

1.9 additional survivors out of every 100 patients

| -12 | 0 | +12 |

0.35 to 3.52
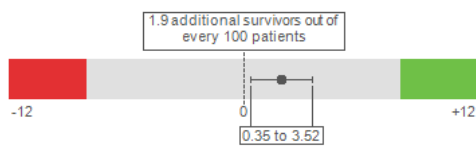
Rate of Survival Breakdown at this Hospital

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** 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** 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	
Total	**889**	**825**	**842**	**1.9**	**1.9**	

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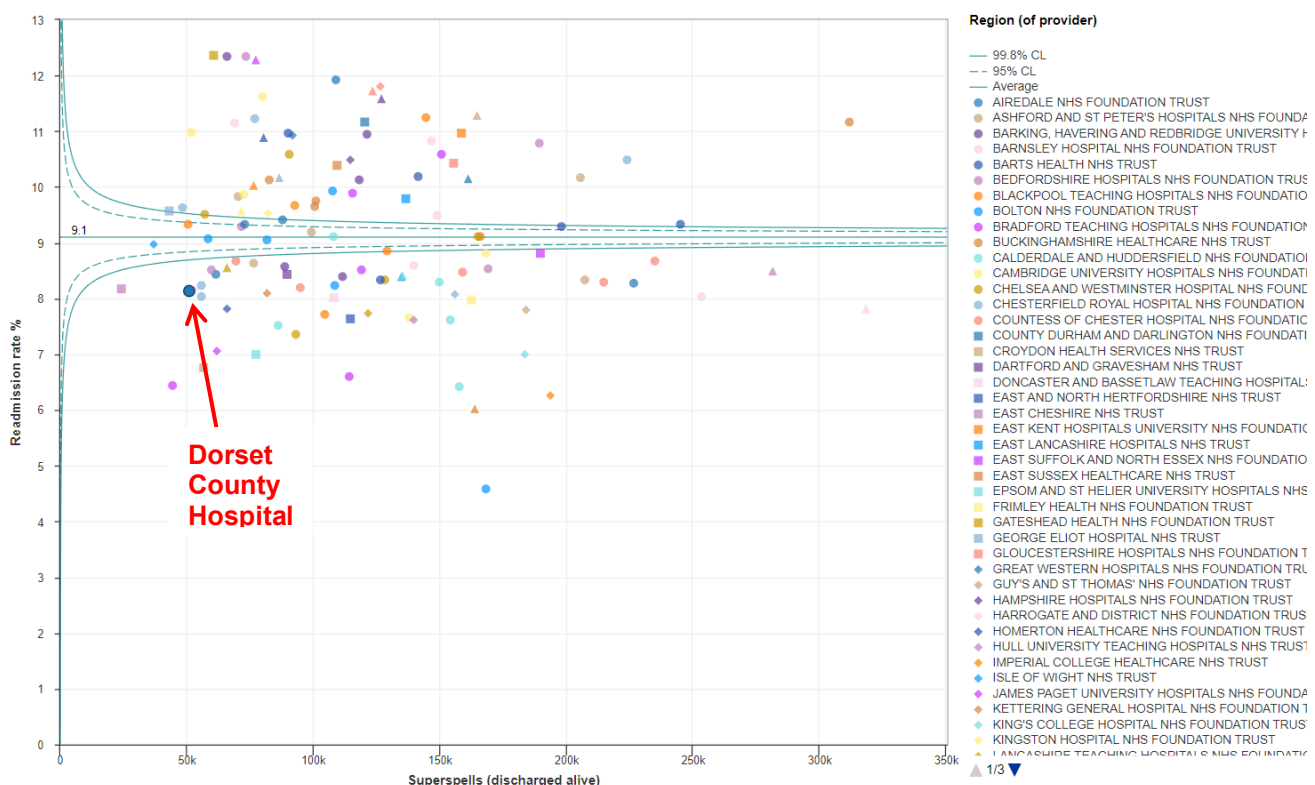
A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process. However, DCH's readmission rate continues to be significantly lower than the average of other acute Trusts.

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).

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.

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 Q2

DCH has been notified of 16 new Coroner's inquests being opened in the period July 2022 – September 2022.

10 inquests were held during Quarter 2. 5 inquests were heard as Documentary hearings, not requiring DCH attendance. 5 required the clinician to attend Court in person. 0 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 61 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 0 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 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 Q2

Legal claims are dealt with 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 early December.

Claims pattern this Quarter:

New potential claims	18
Disclosed patient records	11
Formal claims	10 clinical negligence, 0 employee claim
Settled claims	2 clinical negligence, 0 employee claim
Closed - no damages	1 clinical negligence, 0 employee claim

8.0   SUMMARY

SHMI has not improved as expected despite the backlog of uncoded notes having been cleared, and updated HES data for 2021/22 submitted to NHS Digital by the deadline of 19th May 2022. Although this was not going to change previously published figures which remain on record, it is surprising that there is no perceptible impact on the two latest SHMI values. This requires close scrutiny and our intention is to undertake an audit of approximately 50 deaths 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 is less good than it was.

The newly appointed Senior Coder starts work on 21st November 2022 and her input will be invaluable.

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.