Learning from Deaths Report Q3 2022/23

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	29 March 2023		
Document Title:	Learning from Deaths Q3 2022/23		
Responsible Director:	Prof Alastair Hutchison	Date of Executive Approval	14th Feb 2023
Author:	Prof Alastair Hutchison		
Confidentiality:	Public		
Publishable under FOI?	Yes		
Predetermined Report Format?	No. However formatted in line with SW Regional guidance		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	21st Feb 2023	Accepted
Hospital Mortality Group	15th Feb 2023	Accepted

3. 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. 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	The latest published SHMI data for DCH was above the 'Expected Range' for the rolling 12 months to July, August and September 2022 (page 7), 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% vs national standard of 10%), 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. Prof Hutchison will commence an audit of 50 consecutive deaths occurring in September 2022 to look for unexpected deaths, and report to the quality Committee separately as soon as this is complete.							
5. Action recommended	The Board of Directors is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Impact on CQC Standards	**Yes**		An elevated SHMI will raise concerns with NHS E&I and the CQC. The previous reduction in SHMI and improvements in coding are acknowledged, but Covid-19 and elective tariff incentivisation targets have adversely influenced coding and therefore recent SHMI figures are inaccurate
Risk Link	**Yes**		• 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.
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?** Understanding and reducing health inequalities		
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?** *If yes, please include the assessment in the appendix to the report.. If no, please state the reason in the comment box below. (Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	Not applicable
Quality Impact Assessment (QIA)			**No**	Not applicable

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.

1.1 Family Services and Surgical Division Report - Quarter 3 Report

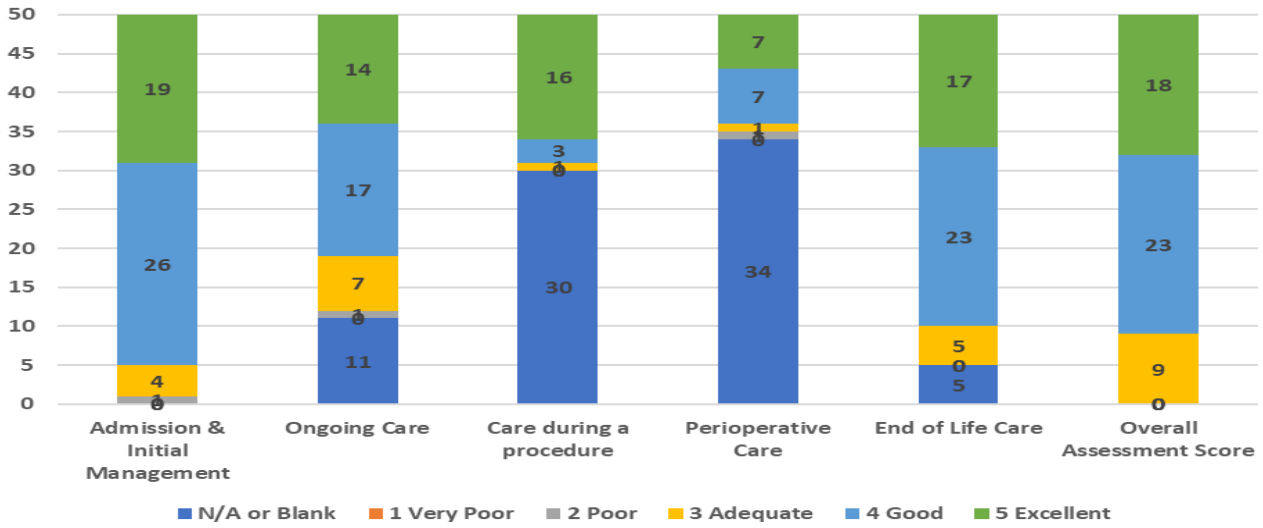
Structured Judgement Review Results: The Family Services & Division had 64 deaths in quarter 3, of which 48 require SJR's to be completed. Of these 6 have had a SJR completed. Within quarter 3 an additional 44 SJR's have also been completed from previous months.

Outstanding SJR's: The Division has completed a large number of SJR's from previous quarters and reduced the backlog significantly, with the oldest outstanding SJR now from quarter 2. The outstanding SJR's for the Division as at 31/01/2023 = 39:

September	October	November	December	January
10	11	5	4	9

Feedback from SJR's completed in quarter 3:

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	11	30	34	5	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	1	0	1	0	0
3 Adequate	4	7	1	1	5	9
4 Good	26	17	3	7	23	23
5 Excellent	19	14	16	7	17	18



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	9	25	16

- ED print out and issue 28 pages but mostly repetition or of no use. To discuss at HMG.
- Difficult to follow timeline re retrospective entries.
- Difficult to follow ED print out. Disconnect between ED documentation and specialist input.
- Theme of ED notes missing.
- Notes all loose in file and some in wrong order.
- Some handwriting difficult to decipher but overall good records. The fluid balance charts are poor, especially given patient's deteriorating renal function. They are mostly incomplete. The figures on the charts bear no relation to the output recorded on VitalPAC.
- Good documentation in general

Still having an issue of records being scanned before SJR. Process set up for any records with Medical Examiners notifications to have a sticker on the front not to be scanned before SJR completed, however this does not capture the records of those that do not have a ME notification but still require a SJR (Family & Surgery Division review all deaths).

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	**Score 2** Strong evidence of avoidability	**Score 3** Probably avoidable (more than 50:50)	**Score 4** Possibly avoidable but not very likely (less than 50:50)	**Score 5** Slight evidence of avoidability	**Score 6** Definitely not avoidable
0	0	0	3	9	38

Dates of Departmental M&M meetings:

Specialty	July	August	September	October	November	December
Anaesthetics	08/07/22	No meeting due to leave	30/09/22	05/10/22 Paediatrics	25/11/22 Obstetrics	Cancelled due to Christmas leave
Breast	08/07/22 - Yeovil	05/08/22 - DCH - Cancelled due to lack of staff (annual leave)	02/09/22 - Yeovil 30/09/22 - DCH	28/10/22 - Yeovil	25/11/22 - DCH – Replaced by AGM	23/12/22 - Yeovil – Cancelled due to lack of staff (annual leave)
Gastroenterology	06/07/22	Cancelled due to operational pressures	07/09/22	Cancelled due to operational pressures	Cancelled due to operational pressures	Cancelled due to operational pressures
General Surgery + Colorectal	08/07/22	Not quorate – delayed until beg. of Sept	02/09/22 + 30/09/22	28/10/22 – Meeting not quorate (A/L, on calls, sickness)	25/11/22	Due 23/12/22 – cancelled due to Christmas holidays
Orthopaedics	15/07/22	12/08/22	09/09/22	07/10/22	04/11/22	02/12/2022 30/12/2022 – cancelled due to Consultant A/L
Perinatal	21/07/22	24/08/22	28/09/22	26/10/22 See anaesthetics above	23/11/22	Cancelled due to operational pressures
Urology	08/07/22	04/08/22 - Cancelled due to operational pressures	02/09/22 & 29/09/22	27/10/22 - Cancelled due to number of apologies received	25/11/22 – Cancelled due to number of apologies received	22/12/22 – Cancelled due to number of apologies received

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

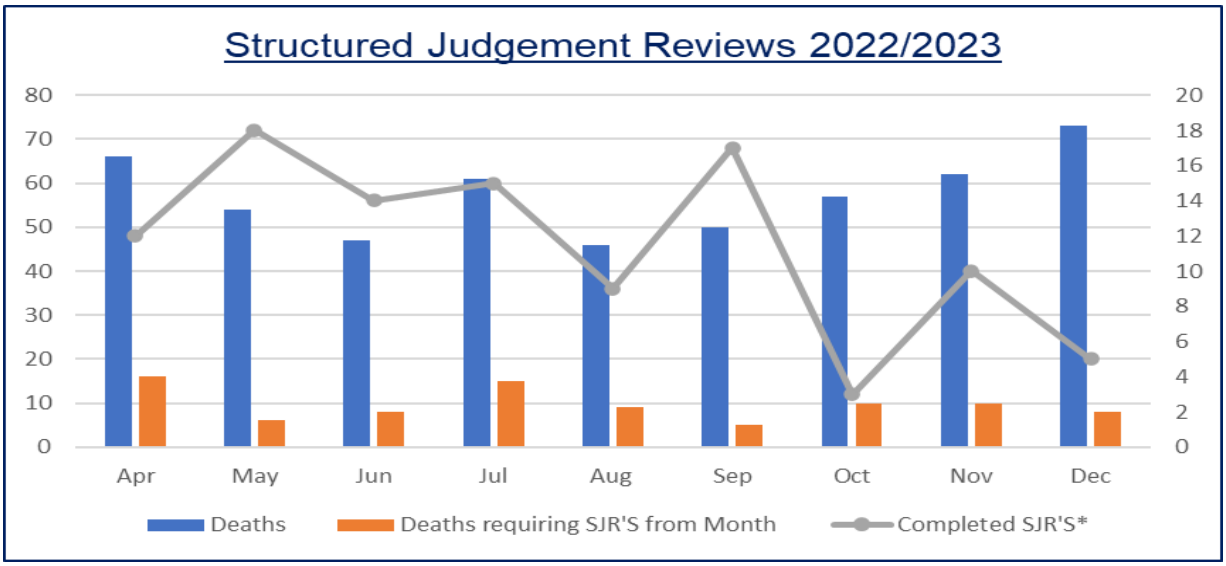
1.2 Division of Urgent & Integrated Care – Quarter 3 Report

Structured Judgement Reviews: In quarter 3 there were 192 deaths, 28 SJR's requested from these deaths and 18 were completed in total (completed SJR's not necessarily from this quarter).

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Deaths	66	54	47	61	46	50	57	62	73	516
Deaths requiring SJR'S from Month	16	6	8	15	9	5	10	10	8	87
Completed SJR'S*	12	18	14	15	9	17	3	10	5	103

Total outstanding SJR's (not including nosocomials) = **29 (15)**
Outstanding SJR's >2 months (prior to 30/11/2022) = **20 (8)**

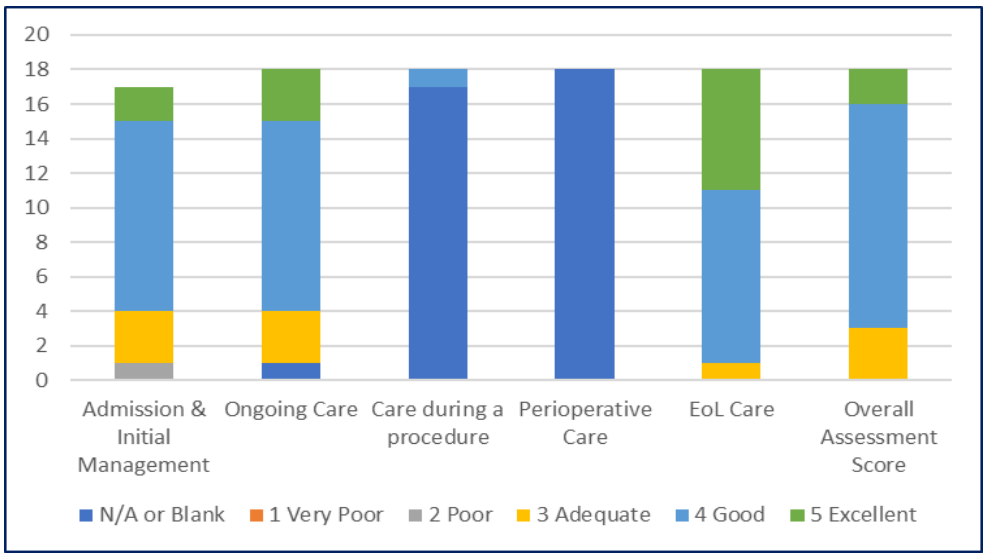
21 Nosocomial deaths (not included in above figures) will be reviewed by James Metcalf and a summary report will be written for HMG (9 reviewed so far on 13/06/22, 12 still to review). – JM Still pending review of final 12.



Phase score from 18 completed SJR's in Quarter 3:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	EoL Care	Overall Assessment Score
N/A or Blank	1*	1	17	18	0	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	0	0	0	0	0
3 Adequate	3	3	0	0	1	3
4 Good	11	11	1	0	10	13
5 Excellent	2	3	0	0	7	2

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



Overall quality of patient record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	1	3	11	3

- Comprehensive entries when consultant has documented their own encounter. Some omissions (Name, time etc) in entries from junior staff
- Poor completion of individual care plan
- Notes on DPR, not in chronological order so difficult to follow.
- Some handwritten entries illegible.
- Fluid balance charts incomplete.

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	0	18

Dates of 2022 M+M meetings:

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

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

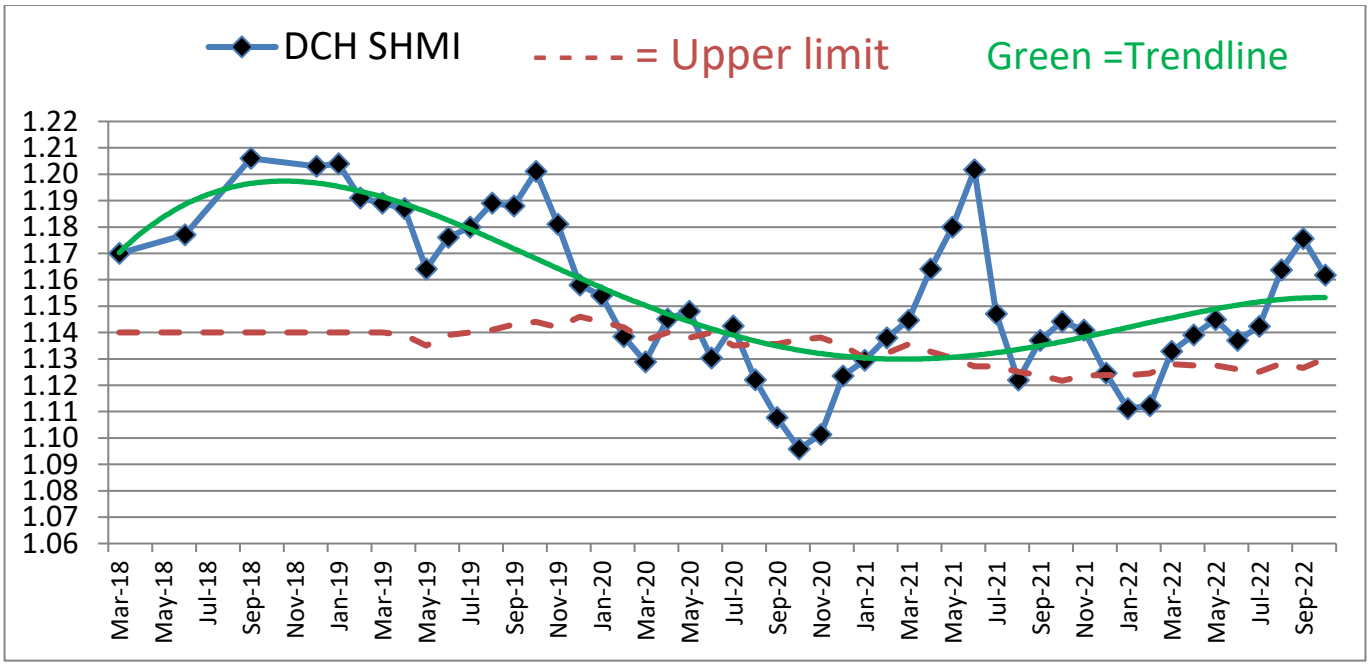
2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

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 March to September 2022 has risen outside the 'Expected Range' and we know that our data continues to be adversely influenced by short staffing in the Coding Department, and a possible under-reporting of 'sepsis' in the medical record. NHS Digital continues to exclude all deaths related a covid from the reported data.

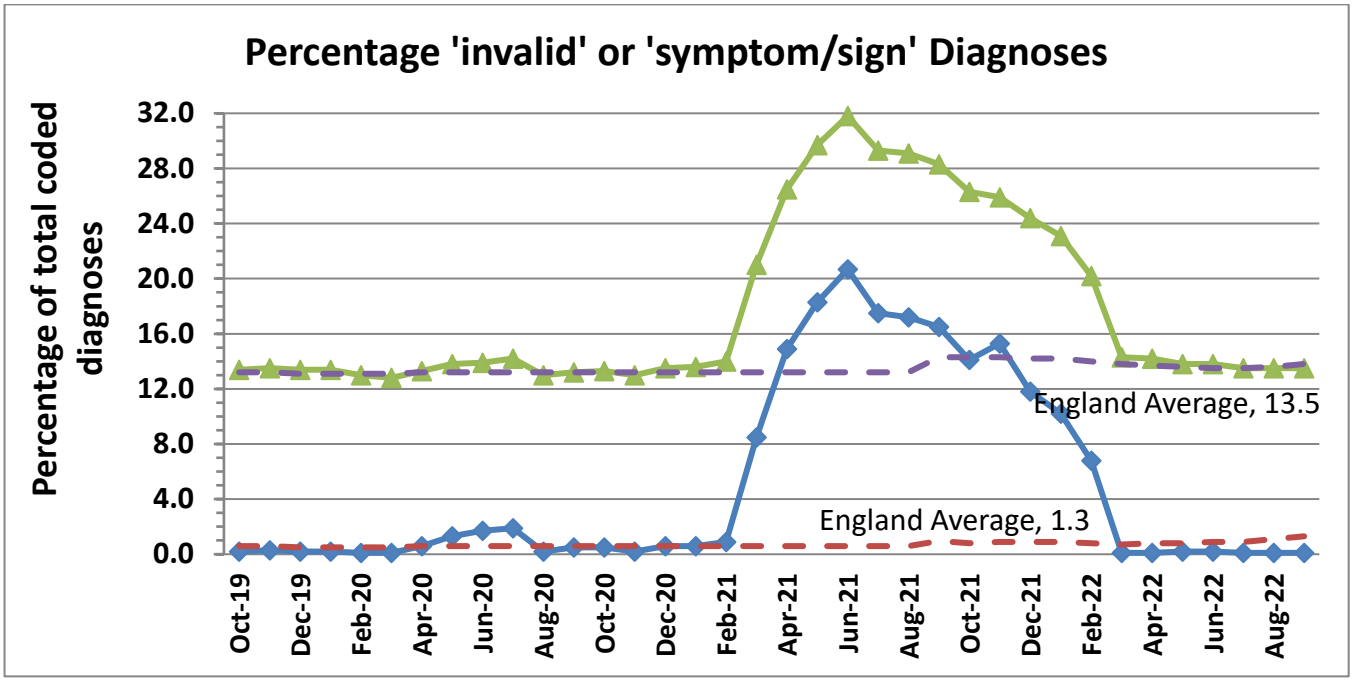
Victoria Stevens has taken up the post of Senior Clinical Coder and commenced work from the beginning of December 2022. She reports that the Clinical Coding Department has a stable coding backlog of approximately 4,000 SPELLS with 3 vacancies for qualified coders. These posts are covered by agency coders. Recruiting for these 3 vacancies would allow release of costly agency coders and effective cover of daily workloads, but will probably not improve the coding backlog. For the purpose of service development and continuity, as well as reducing and eliminating the coding backlog, we also need to recruit 2 trainee coders. 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 October 2022) is shown below:



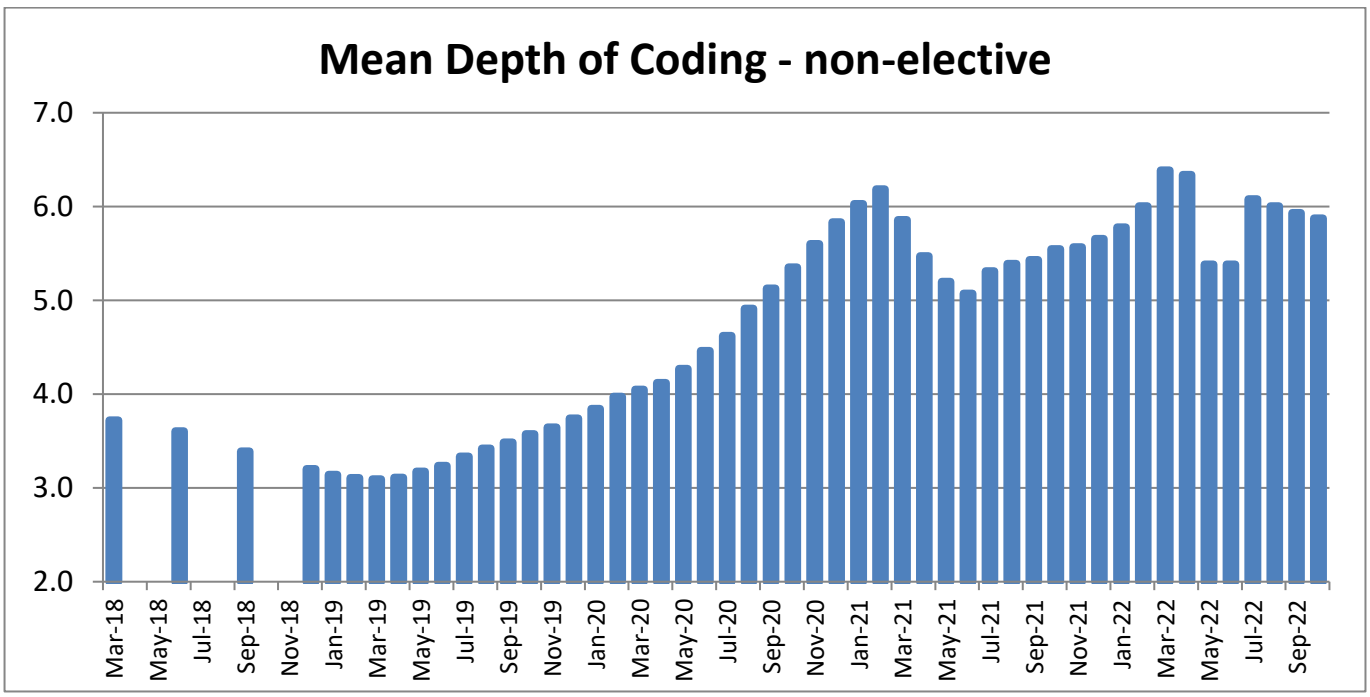
SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding of all admissions). From October 2019 onwards there had been a steady trend of improvement in DCH's SHMI as a result of investment in the coding department 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: 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 to below the average for England of 13.5%.



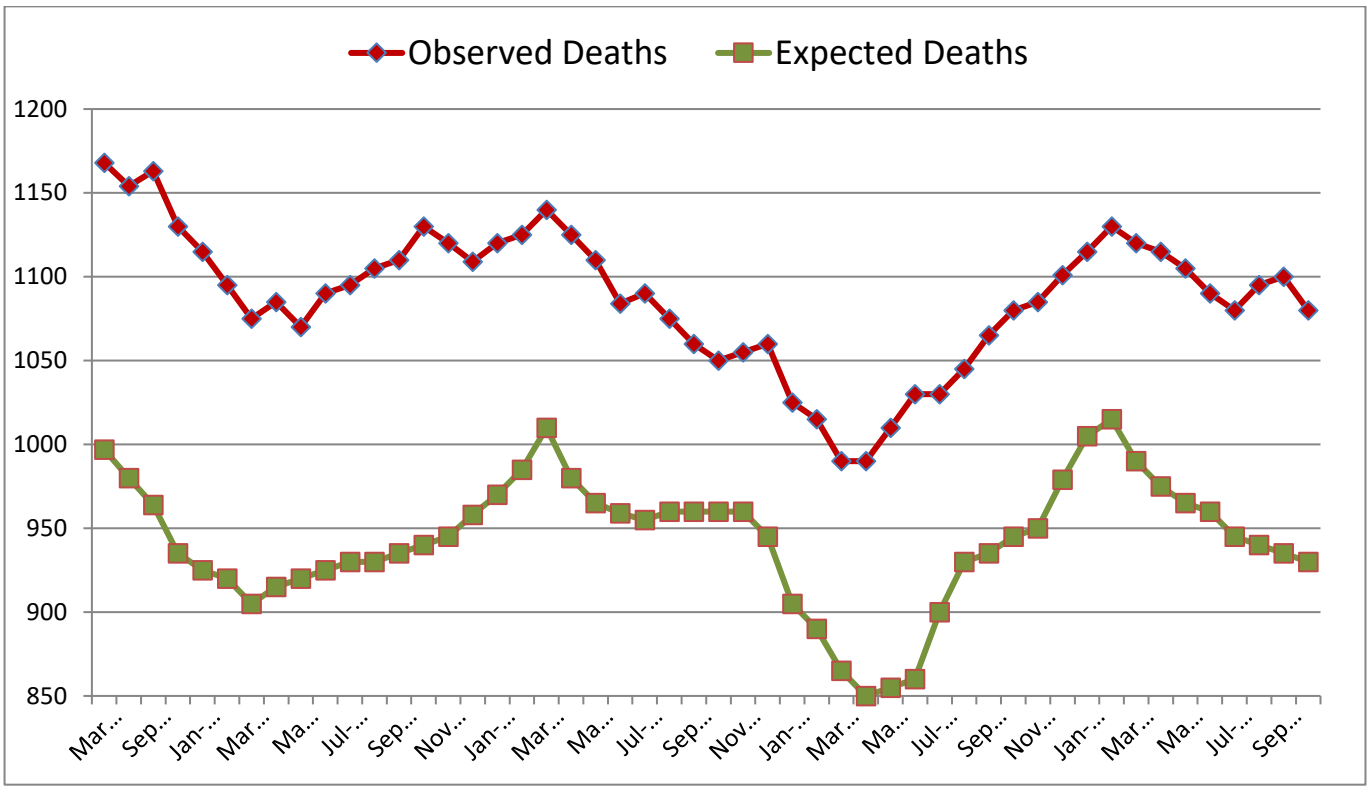
2.3 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected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

DCH's depth of coding had been improving steadily up to March 2022 (see graph below), but the most recently reported months which include the corrected M14 data show a significant decrease. It suggests that the coding department concentrated on primary diagnoses 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.



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

The chart below shows observed (actual) and expected deaths over the past 3+ years (rolling years from March 18 to Sept 22), and whilst both observed deaths have tended to increase (as the total number of in-patients increases post covid-19), the expected deaths have decreased over the 6 months to October 22, possibly as a result of the focus on recovery of the coding backlog.



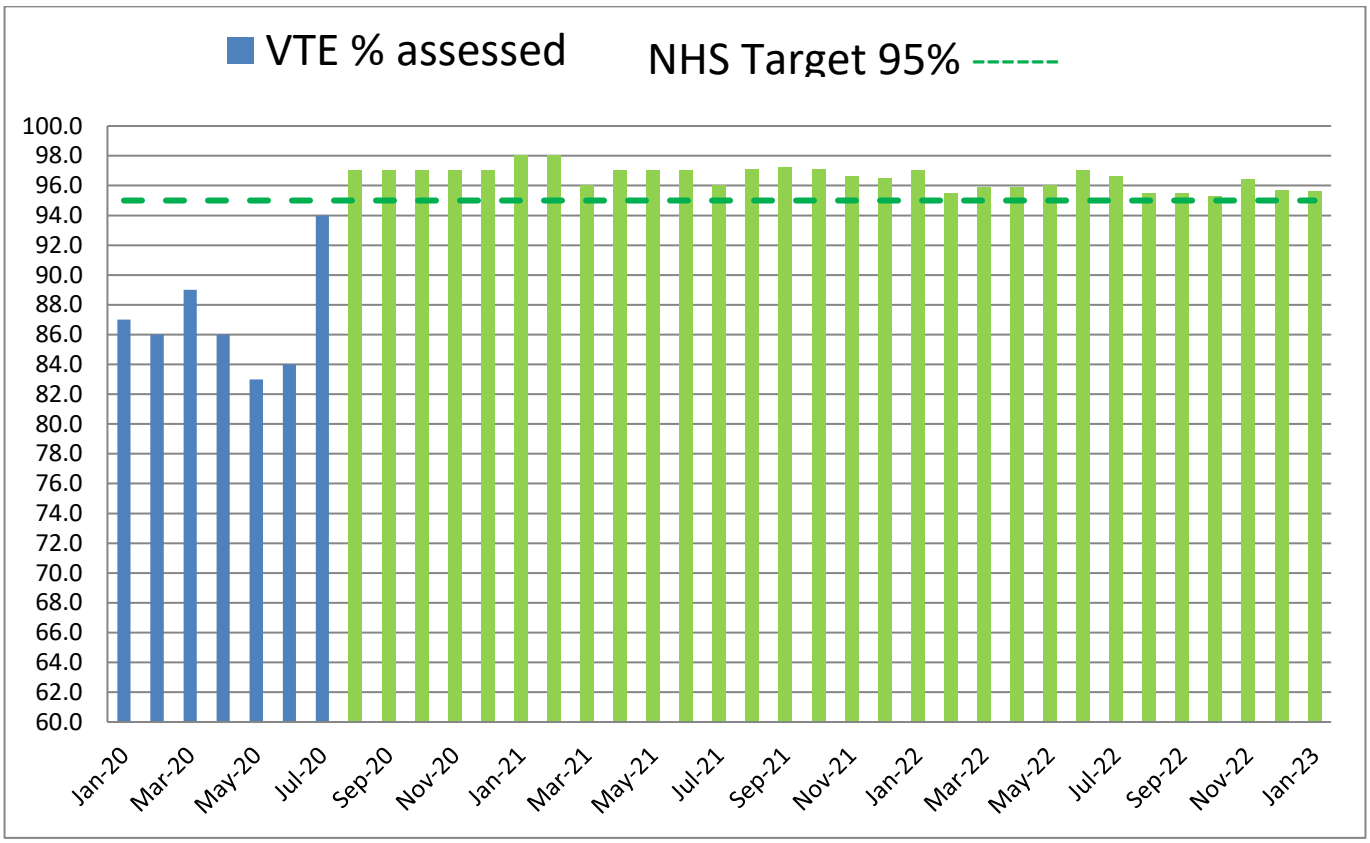
3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

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

For other metrics of care including complaints responses, sepsis data (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.

In light of various issues related to maternity units and excess deaths of both children and mothers, NHS Digital has now published the first iteration of a "National Maternity Dashboard". The Quality Committee is asked to consider whether any part of this dashboard should be duplicated in future DCH Learning from Deaths reports, or noted as part of the DCH Quality Dashboard.

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 consistently achieving the required standard of >95%. Dr Aruna Arjunan has taken over as chair of the VTE Group and is auditing compliance with the VTE prophylaxis policy which has been revised.

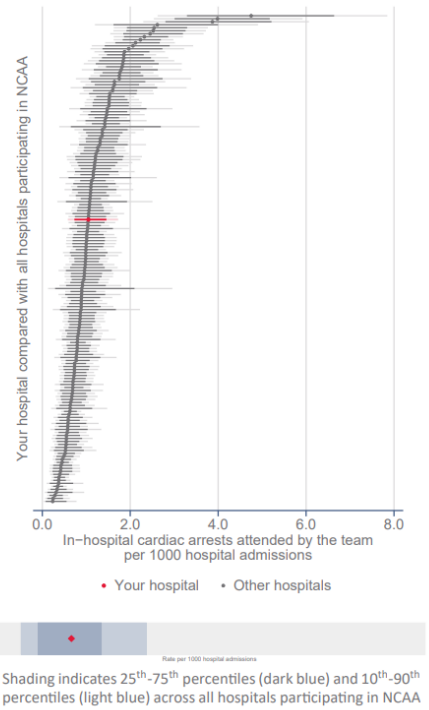


3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2022 to September 2022 (quarters 1 and 2) was published on 05/12/2022. Frequent cardiac arrest calls suggest unanticipated deterioration in a patient's condition, whereas fewer calls suggest higher standards of care, although this is unproven. A total of 35 cardiac arrest calls were recorded for this 6 month period, but not all were definite cardiac events since the cardiac arrest call is also used for any serious or unexpected patient event.

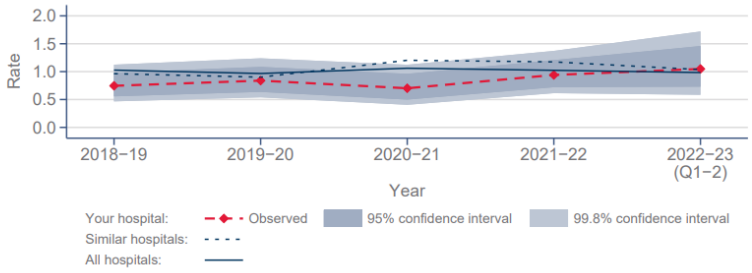
The graph below represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the graph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

Rate of cardiac arrests per 1000 hospital admissions



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

	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					
Quarter 4					
Year to date	33389	35	1.05	(0.73, 1.46)	(0.58, 1.72)



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

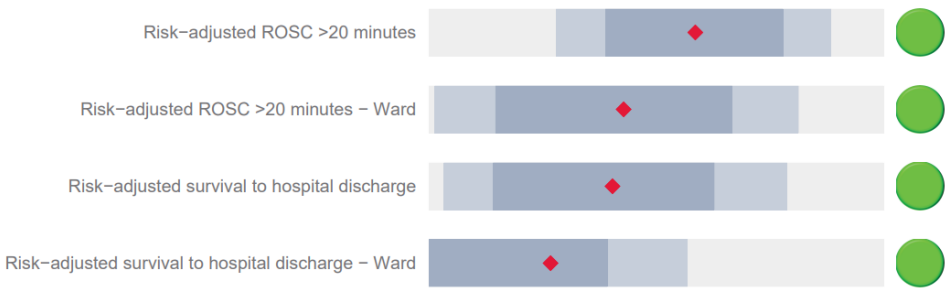
Dorset County Hospital
NCAA Report: 1 April 2022 to 30 September 2022

4

Date of report: 05/12/2022
©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 Quarters 1 2 (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.

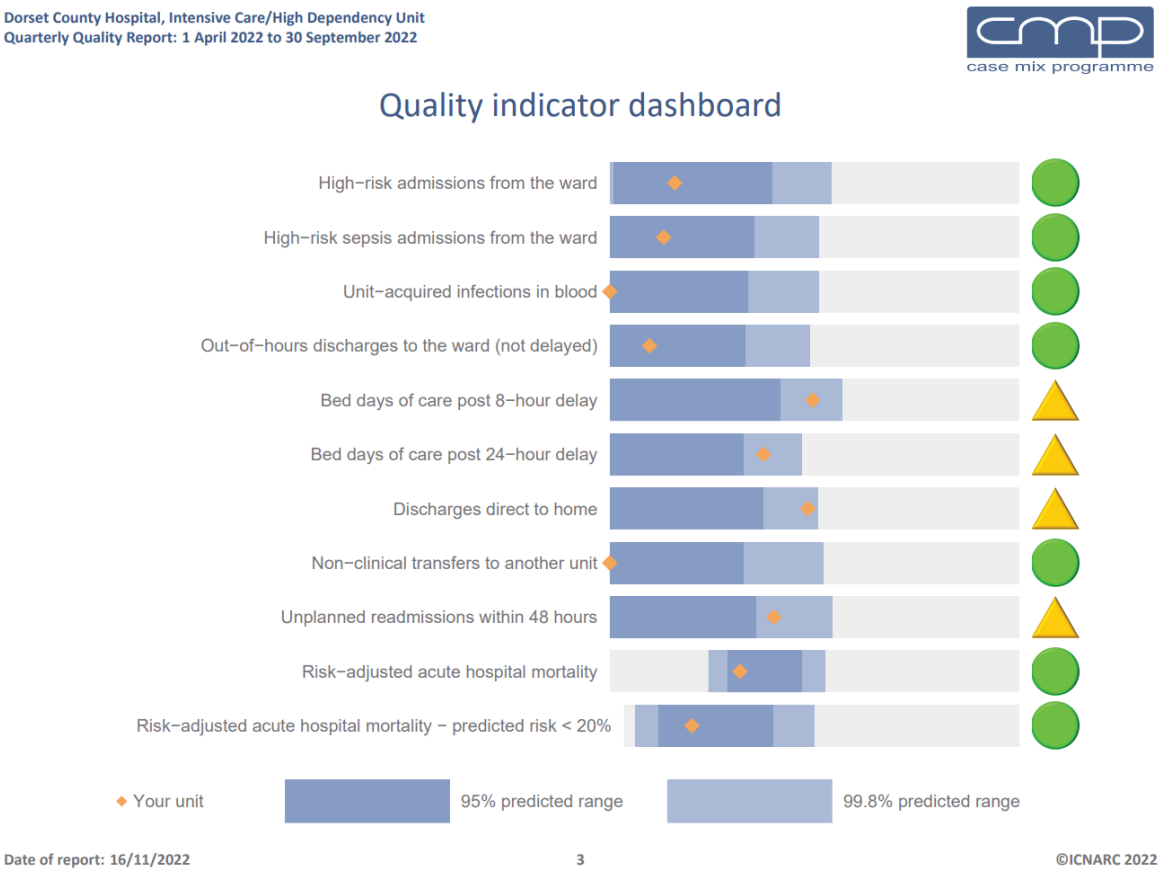
Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%	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 April to September 2022; published 06 December 2022; n = 311 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.

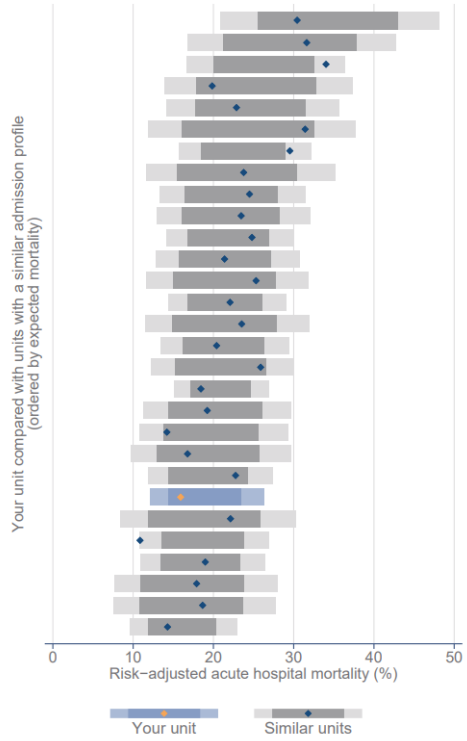
Unplanned readmissions were higher than expected in Q1 (4% versus expected 1%) but normalised during Q2 (1.0% versus expected 0.9%). However, the combined result for Q1 + Q2 remains higher than expected.



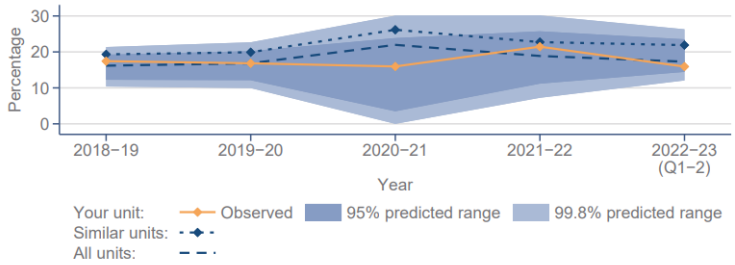
The charts below show the “risk adjusted acute hospital mortality” following admission to the DCH Critical Care Unit, Q1 + Q2 2022/23. They compare observed and expected death rates in a similar fashion to SHMI.

case mix programme

Risk-adjusted acute hospital mortality



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	146	135	14.8	18.7	(12.0, 25.1)	(8.7, 29.4)	
Quarter 2	165	154	16.9	19.3	(13.0, 25.4)	(9.8, 29.4)	
Quarter 3							
Quarter 4							
Year to date	311	289	15.9	19.0	(14.4, 23.5)	(12.1, 26.3)	



Definition

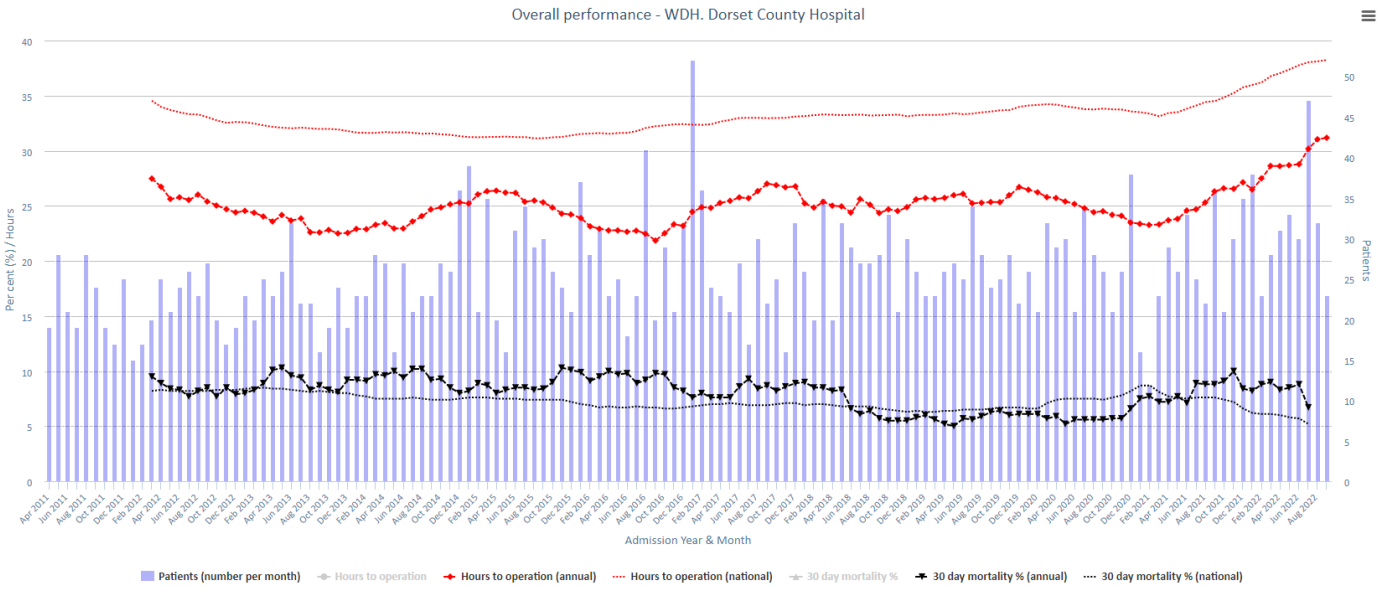
- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Observed percentage: The percentage of eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage 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: 16/11/2022 13 ©ICNARC 2022

These results are within the expected range and therefore score 'green'.

3.5 National Hip Fracture database to April 2021

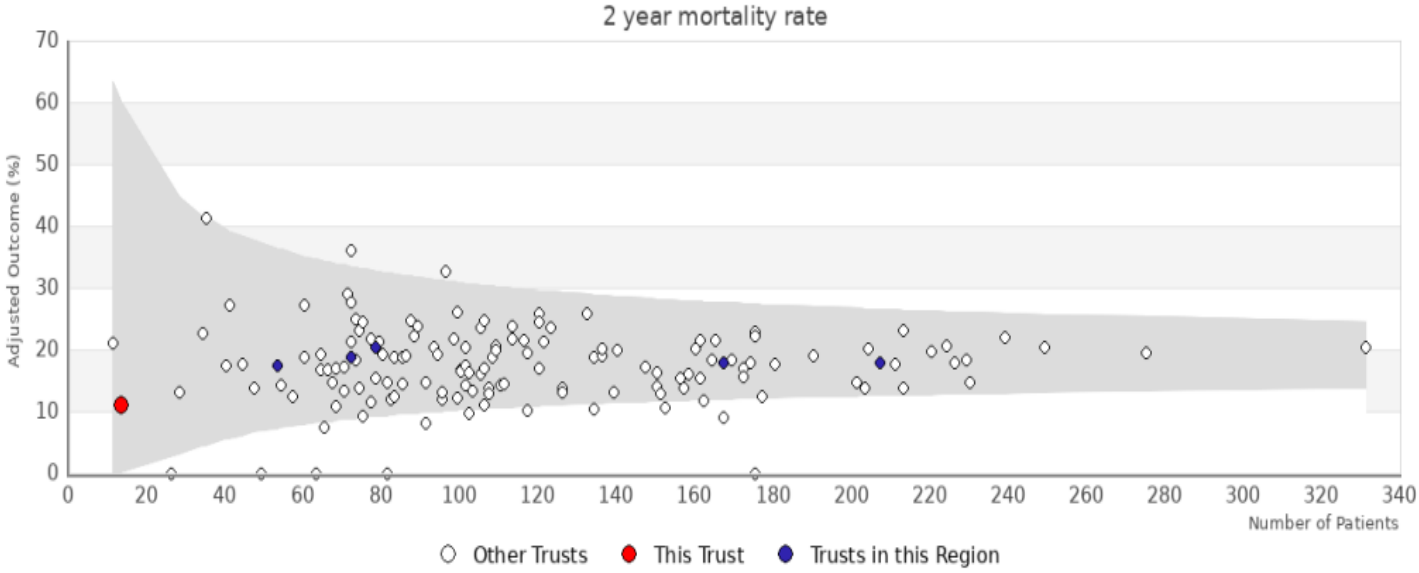
Mortality data had been delayed by contract negotiations with NHS Digital and were published in full for Q1, but it has not been updated from the previous Q1 report, and so the graph below is unchanged.



Therefore 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

New data has now been published for 2 year survival after bowel cancer surgery for patients in England and Wales diagnosed with bowel cancer 1 April 2020 – 31 March 2021. 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.



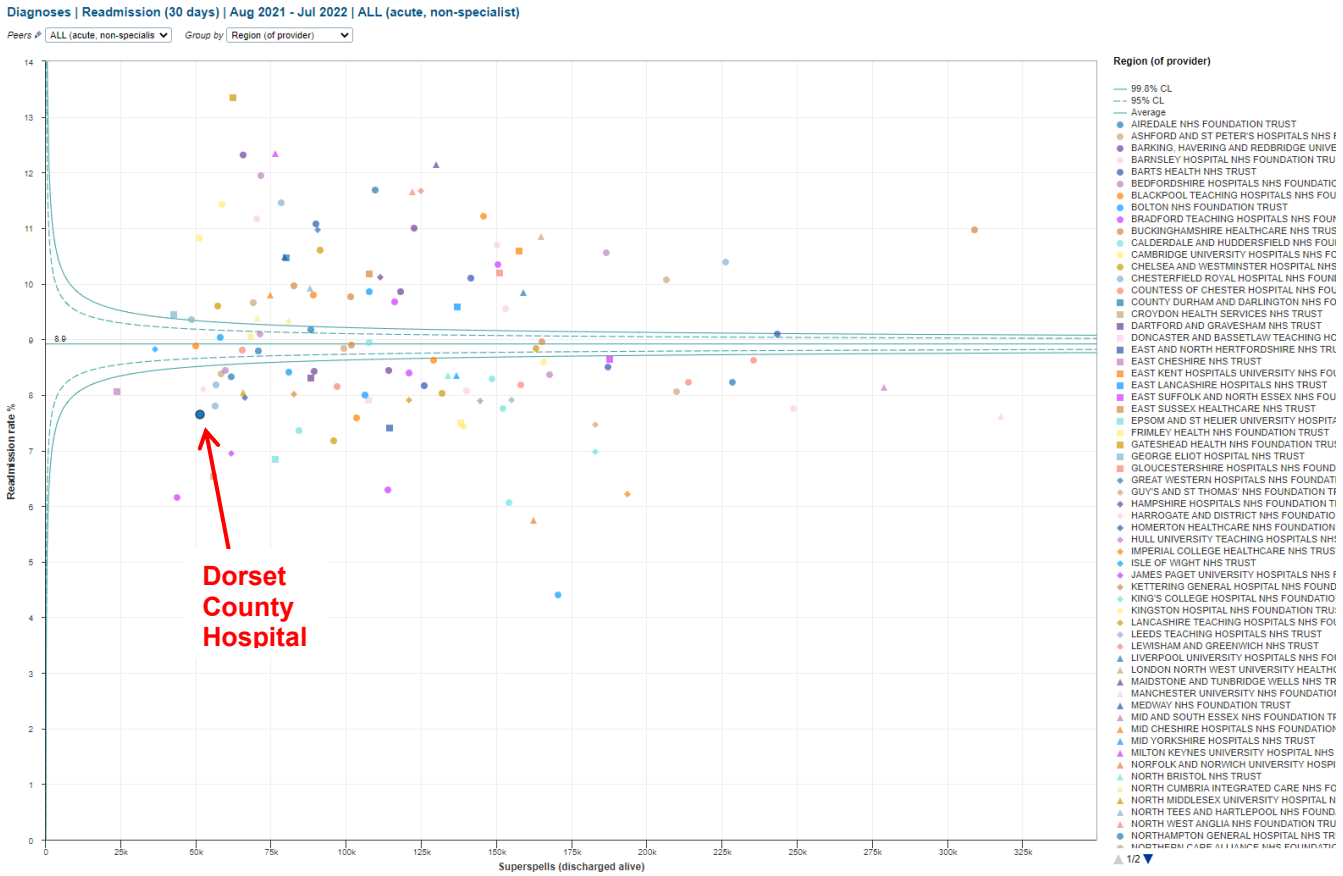
3.7 Getting it Right First Time; reviews in Qtr 3

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.

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. No new data has been published since that reported in the previous Q2 Learning from Deaths report. The data is therefore unchanged and reports up to December 2021 only. No explanation is currently available for this.

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 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 in March 2023 (strikes permitting) 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 Q3

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

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

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

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

7.0 LEARNING FROM CLAIMS Q3

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

Claims pattern this Quarter:

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

8.0 SUMMARY

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

No other metrics of in-patient care suggest that excess mortality is occurring at DCH and much of the national data suggests better than average mortality, although National Hip Fracture mortality is less good than it was. 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.