

Cover Sheet

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Title: Learning from deaths report – Quarter Q1 2022/23

Status: For Information

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Board Lead: Chief Medical Officer

Author: Jonathan Carruthers - Clinical Outcomes Manager, Helen Cobb
– Head of Clinical Governance, Dr Rustam Rea – Interim
Deputy Chief Medical Officer

Confidential: No

Key Purpose: Assurance

Executive Summary

1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2022/23 and performance for the latest available Dr Foster Intelligence data and provides assurance that any highlighted concerns are investigated thoroughly, and appropriate action is taken.
2. Investigating mortality, and reporting data, enable identification of further ways to improve patient outcomes and safety.
3. During Quarter 1 of 2022/23 there were 659 inpatient deaths reported at OUH. Compliance with mortality reviews as per the agreed policy is presented in Table 1. There were 641 (97%) cases reviewed within 8 weeks. Of these reviews, there were 307 (47%) comprehensive Level 2 reviews and 14 (2%) structured mortality reviews.
4. All COVID-19 related deaths are subjected to a Level 1 screening mortality review. There have been no COVID-19 related deaths judged more likely than not to have been due to problems in the care provided.
5. No death occurring during Quarter 1 was deemed to be 'avoidable'.
6. A detailed analysis of completed structured reviews during the quarter is included in this report.
7. The Summary Hospital-level Mortality Indicator (SHMI) for the data period April 2021 to March 2022 is 0.94. The SHMI remains banded 'as expected'.
8. The Trust's HSMR is 98.3 for June 2021 to May 2022. The value is rated 'as expected' (95% CL 94.1 – 102.6).

Recommendations

The Public Trust Board is asked to receive this paper for information.

Contents

Cover Sheet	1
Executive Summary	2
Learning from deaths report – Quarter Q1 2022/23.....	4
1. Purpose.....	4
2. Background and Policy	4
3. Mortality reviews during Quarter 1 of 2022/23.....	5
4. The Medical Examiner system	6
5. Child death overview process	7
6. Learning and actions from mortality reviews during Quarter 1 of 2022/23	8
7. Patient safety incidents with an impact of death and subsequent SIRI investigations declared during Quarter 1.....	9
8. Annual review of structured mortality reviews with a focus on end-of-life care .	10
Background:.....	10
Discussion and text detail of the SMRs included:.....	12
Conclusion:	13
9. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)	13
10. Analysis of mortality during Quarter 1:	15
11. Crude Mortality.....	18
12. Corporate Risk Register and related Mortality risks	20
13. Mortality Review Governance	20
14. Recommendations	20
Appendix 1 - Key differences between the SHMI and HSMR	21

Learning from deaths report – Quarter Q1 2022/23

1. Purpose

- 1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2022/23.
- 1.2. This report provides a quarterly overview of Trust-level mortality data for the period of Quarter 1: April 2022 to June 2022, and performance for the latest available Dr Foster Intelligence data, providing assurance that any highlighted concerns are investigated thoroughly, and appropriate action is taken.

2. Background and Policy

- 2.1. OUH is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework:
 - 2.1.1. Preventing people from dying prematurely.
 - 2.1.2. Treating and caring for people in a safe environment and protecting them from avoidable harm.
- 2.2. OUH uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation.
- 2.3. The Trust Mortality Review policy requires that all inpatient deaths be reviewed within 8 weeks of the death occurring. All deaths have a Level 1 review.
- 2.4. The aim is for all Level 1 mortality reviews to be completed by a Consultant independent of the case however with the current capacity constraints this is not possible in all cases. To mitigate this 25% of Level 1 reviews are selected at random for a Level 2 review and all (100%) of deaths undergo scrutiny from the Medical Examiner's office.

- 2.5. If there are any concerns identified, a comprehensive Level 2 review is completed involving one or more consultants not directly involved in the patient's care. A structured review, completed by a trained reviewer who was not directly involved in the patient's care, is required if the case complies with one of the mandated criteria.
- 2.6. Each Division maintains a log of actions from mortality reviews and monitors progress by their clinical units. The clinical units are responsible for disseminating learning and implementing the actions identified.
- 2.7. The Divisions provide updates on actions in the monthly quality reports to the Clinical Governance Committee (CGC). The Divisions also provide updates to the Mortality Review Group (MRG) on the previous quarter's actions as part of the next quarter's mortality report. The Mortality Review Group reports to the Clinical Improvement Committee.

3. Mortality reviews during Quarter 1 of 2022/23

Table 1: Number of mortality reviews completed during Quarter 1 of 2022/23:

Total deaths	Total reviews (L1, L2 or SJR)	Deaths not reviewed within 8 weeks
659	641	18

3.1 During Quarter 1 of 2022/23 there were 659 inpatient deaths reported at OUH. Compliance with mortality reviews as per the agreed policy is presented in Table 1. There were 641 (97%) cases reviewed within 8 weeks. Of these reviews, there were 307 (47%) comprehensive Level 2 reviews and 14 (2%) structured mortality reviews. The remaining 18 trust wide reviews have been escalated to the divisions with compliance reported monthly to the mortality review group.

3.2 The New Oxford Critical Care unit is now open. As bed numbers increase, it is anticipated that the case mix will change to a great extent to include a higher volume and proportion of level 2 patients¹. The HSMR as well as other quality metrics may be adversely affected due to increased bed numbers and case mix, these will be under close review during the transition and beyond. These metrics will be presented to the Mortality Review Group (MRG) as per the quarterly divisional mortality reports.

¹ Patients requiring increased levels of observations or interventions (beyond level 1) including basic support for two or more organ systems and those 'stepping down' from higher levels of care.

3.3 Trust wide, there were 14 structured reviews completed during Quarter 1 of 2022/23. The reasons for completing the structured review include individuals with a learning disability, concerns raised by staff of families and concerns raised during the Medical Examiner scrutiny. Learning and recommendations from the completed structured reviews are included in this report.

3.4 During Quarter 1 of 2022/23, there were no patient deaths at the OUH judged more likely than not to have been due to problems in the care provided.

4. The Medical Examiner system

4.1. The purpose of the Medical Examiner (ME) system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-Coronial deaths, ensure appropriate direction of deaths to a Coroner, provide a better service for the bereaved, provide an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data.

4.2. The MEs have been scrutinising deaths within the Acute Trust since June 2020. In quarter one (2022-23) over 90% of acute trust deaths received a review by a Medical Examiner. This additional scrutiny has revealed the high quality of clinical notes on EPR. Feedback from the bereaved during telephone discussions reflect a generally high degree of satisfaction for the care provided in the Trust. Any concerns or compliments raised by MEs or the bereaved are fed back through the central Learning from Deaths email and then shared appropriately with clinical teams. Many of these incidents had already been recognised and referred to the Trust's Patient Safety processes or to PALS.

4.3. Medical Examiners and Medical Examiner Officers are working closely with the Regional ME, the National ME and the Coroner's Office to extend the service to scrutinise deaths within the local hospices and in the community setting during 2022-23.

4.4. The Medical Examiners (MEs) have monthly meetings to review progress and discuss cases. The feedback received by the MEs from bereaved families as to how they are informed of the deaths of their relatives has led to discussion and review of processes clinically. Examples include escalation of reviews to trust level SIRIs and changes to death documentation processes.

4.5. The feedback received by the MEs has been shared promptly with the ward teams. This has raised the profile of the ME system within the Trust and

clinical teams are recognising and appreciating the ME role as an independent part of the existing Bereavement system.

- 4.6. The opportunity for families to discuss the care their relative received with an ME has been positively received.
- 4.7. Planning is now underway to confirm a process for the scrutiny of deaths by the ME in the community.

5. Child death overview process

- 5.1. The statutory requirement to establish a panel that would review every child death in their local area has been in place since 2006 (section 14 of the Children Act 2004). These regulations were further developed in Working Together to Safeguard Children (2018).
- 5.2. The specific functions as laid down in the statutory guidance require the panel to review the available information of deaths of all children up to the age of 18 years. This includes the deaths of infants less than 28 days, including those born before viability, but not those who are stillborn or are terminated pregnancies within the law.
- 5.3. The Oxfordshire child death overview process (CDOP) is committed to the process of systematically reviewing all children's deaths, ensuring the child death review process is grounded in respect for the rights of children and their families and focuses, where possible, on preventing future child deaths.
- 5.4. The administration of the Oxfordshire CDOP is hosted by Oxfordshire Integrated Care Board (ICB) and is chaired by the Director of Quality and Lead Nurse from the ICB. The Designated Doctor for Child Death is a Consultant Paediatrician at OUH and is commissioned by the ICB to undertake this role.
- 5.5. Child mortality is discussed monthly at the mortality review group meeting.
- 5.6. An annual report for child mortality in 2021/2022 has been completed and presented to MRG.
- 5.7. There was a total of 68 deaths in the Oxford Children's Hospital (CHOX) from 2021-2022, an increase of 36% from the previous year. Death in children occurred in the Emergency Department, (ED) Theatres, Paediatric Critical (PCC) and Newborn Care (NC) as well as on the Delivery Suite (DS). A named key worker was recorded as allocated in 80% of cases; this remains an area for development in the Trust's approach to the care of the family

when their child has died and is being actioned accordingly by the areas involved. A newly developed Neonatal Bereavement Advanced Nurse Practitioner role has been supported in 2022. The individual works closely with the CMT to function as a key worker for parents bereaved by the loss of their newborn. Reporting directly to the Neonatal Mortality and Morbidity forum and the CMT has enabled crucial feedback to reach clinical teams regarding the welfare of families following these tragedies.

- 5.8. 84% of electronic death notifications complied with the National Guidance time frame of 12 hours; 11% were delayed by more than 24 hours. This represented a significant improvement in reporting times enabling Child Death processes to be activated effectively.
- 5.9. The Trust is committed to meeting the needs of every family to ensure that the devastating impact of losing a child or baby is not exacerbated by a lack of support from the OUH. Significant inroads have been made into learning from child deaths. Further commitment and investment is needed for the equally important holistic end of life and bereavement care with a focus on access to paediatric palliative care, trained professional family liaison key workers and identifying a setting within the OUH where families may remain with their deceased baby or child.
- 5.10. New legislation has dictated that the Medical Examiner will now engage fully with all child deaths. This is a welcome augmentation of the Trust's responsibility to the bereaved family. Understanding the perspective of families who have lost a child will require close collaboration with experienced bedside clinicians and the team plan to outline an SOP going forward.
- 5.11. The Medical Examiner will work closely with the clinical teams to improve the sharing of information with families and professionals, and address the urgent need for better triangulation of all baby and child clinical records through the EPR system.

6. Learning and actions from mortality reviews during Quarter 1 of 2022/23

- 6.1. The key learning points to emerge from mortality reviews undertaken during Quarter 1 were:
- 6.1.1. Good communication to families when a patient is at the end of life remains vital.

- 6.1.2. Work is underway to improve collaborative working when oncology patients are admitted to outlying areas. Feedback and learning from this workstream will be presented to MRG in November 2022.
 - 6.1.3. The need for accurate EPR notes – the importance of not just ‘cutting and pasting’ and ensuring that the correct senior clinician name is entered at the top of ward round record. This was raised at the Clinical Improvement Committee (CIC) in October and work is now underway with the ePR team. This issue will also be raised at the next Clinical Governance Committee (CGC) meeting. A safety message relating to this was circulated 18/10/2022 (number 194).
 - 6.1.4. The importance of completing cognitive screens.
 - 6.1.5. The need for additional education around Organ Donation in neonates planned by Paediatric CLOD to avoid ‘missed’ potential donors.
 - 6.1.6. Highlighting that child death reporting systems applies to all children from birth to 18 years of age including any adolescent on an adult ward (AICU, Neuro ICU, Maternity).
 - 6.1.7. The benefits of the trust’s Chaplaincy service were highlighted. This will now be embedded into the child death process.
- 6.2. The Lead Medical Examiner is meeting with external stakeholders ahead of the community roll out in 2023. Scrutiny of hospice deaths is established. Meetings with the local ICS and two neighbouring ME Offices are underway to allow introduction of the ME service to the Community. There is capacity among the MEs to start this with further recruitment of MEs and MEOs already under way.
- 6.3. Medical Examiner scrutiny of child deaths is also planned to roll out in quarter 3 2022/2023.

7. Patient safety incidents with an impact of death and subsequent SIRI investigations declared during Quarter 1

7.1 Four incidents with an impact of death were declared as a Trust Level Serious Incident Requiring Investigation (SIRI) during Quarter 1 2022/23.

7.2 These concerned:

7.2.1 An investigation covering nosocomial COVID-19 infections.

- 7.2.2 A patient who died by suicide at the JR Hospital.
- 7.2.3 A patient who was admitted to the Emergency Department and received a CT angiogram. An addendum was added to the report sometime after admission, which was not acted upon, and the patient was discharged. The patient later died from pneumonia at another hospital.
- 7.2.4 A patient was admitted with a sub-arachnoid haemorrhage and treated with an external ventricular drain. They experienced a significant choking episode whilst an inpatient. Following this episode, the patient had a reduced Glasgow Coma Scale score and was continuously coughing. A second bleed on the opposite side of the brain was subsequently identified and review of imaging revealed a second aneurysm, requiring additional treatment. The patient subsequently passed away.

7.3 Any SIRS with an impact of death must be presented to MRG upon closure.

7.4 These investigations are currently in progress and any relevant learning will be included in section 6 of future learning from deaths reports.

8. Annual review of structured mortality reviews with a focus on end-of-life care

Background:

- 8.1. Structured mortality review blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.
- 8.2. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems, or difficulty in the care process.
- 8.3. Structured review is mandated in the following circumstances:

- 8.3.1. All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- 8.3.2. All in-patient, out-patient, and community patient deaths of those with learning disabilities.
- 8.3.3. All deaths in a service specialty, particular diagnosis, or treatment group where an 'alarm' has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator).
- 8.3.4. All deaths in areas where people are not expected to die, for example in relevant elective procedures.
- 8.3.5. Deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.
- 8.3.6. A further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall.
- 8.3.7. Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care (table 2).

Table 2: Analysis of Structured Reviews - Phase of care by score allocated: Data = number of patients

Phase of care score	Admission / initial management	Ongoing care	Procedure	Perioperative	EoLC	Overall score
Very poor (1)	0	0	1	0	0	0
Poor (2)	1	3	0	3	0	5.5
Satisfactory (3)	20	14	7	6	16	17.5
Good (4)	15	15	6	3	17	12
Excellent (5)	2	2	1	0	2	5
N/A or blank	1	4	24	27	4	2
% rated Good (4) or excellent (5) (excl. N/A)	45%	49%	47%	25%	54%	46%

Phase of care scores are recorded as - 1. Very poor care 2. Poor care 3. Adequate care 4. Good care 5. Excellent care

Comparative score by year in End of Life Care (EoLC) phase

Phase of care score	EoLC 18/19	EoLC 19/20	EoLC 21/22
Very poor (1)	0	0	0
Poor (2)	1	0	0
Satisfactory (3)	0	16	16
Good (4)	13	17	17
Excellent (5)	12	2	2
N/A	2	4	4
% rated 4 or 5 (excl. N/A)	25/26 (96%) (96%)	17/25 (68%)	19/37 (54%)

8.4. The EoLC phase was rated as good or excellent in 54% in 2021/22.

8.5. 2018/19 and 2021/22 include both expected and unexpected deaths, 2019/20 include expected deaths only.

8.6. 39 SMRs were completed between 01.04.2021 to 31.03.2022. The results include a minority of deaths from 20/21 as the SMR was undertaken in 21/22, and the results exclude some deaths as the SMR was not completed by year end. 2 people died at home, their data is included, 37 inpatient deaths is 1.34% of all adult deaths in OUH in 21/22.

8.7. The case where concerns were identified during the procedural stage of care has undergone further scrutiny and discussion at MRG.

8.8. The EoLC phase remains the most positively evaluated phase though more in keeping with other phases since the introduction of the quality indicators. Reading the summaries and the quality indicators, this judgement seems accurate and a fair reflection that care of high quality was delivered.

Discussion and text detail of the SMRs included:

8.9. Care at the end of life includes sudden and unexpected deaths. However, death is rarely instantaneous. Those friends and family who are important to the patient remain with staff in OUH for some time after the patient has died and need our ongoing care and support.

8.10. Five comments in the text of 39 reviews: “There was no end-of-life care as she suffered an unexpected death” “No end-of-life care provided as not required. The medical team also clearly communicated to the NOK that they were unsure if the patient would survive the admission” “N/A” “The patient was

not on a palliative pathway” “Therefore EOLC considerations were not applicable”

- 8.11. Recognition that the patient is likely to die should prompt urgent prescription of anticipatory medication as per NICE guidance. “The medical team prescribed morphine and midazolam, however, this was not done until the following morning”
- 8.12. Many compliments for Learning Disability teams and palliative care teams reported via Ulysses excellence reporting function.

Conclusion:

- 8.13. In 2021/22 the distribution of End-of-Life care scores is more in line with other domains across the SMR.
- 8.14. Training to complete reviews is provided internally monthly, the current number of trained reviewers by division can be seen in table 3.

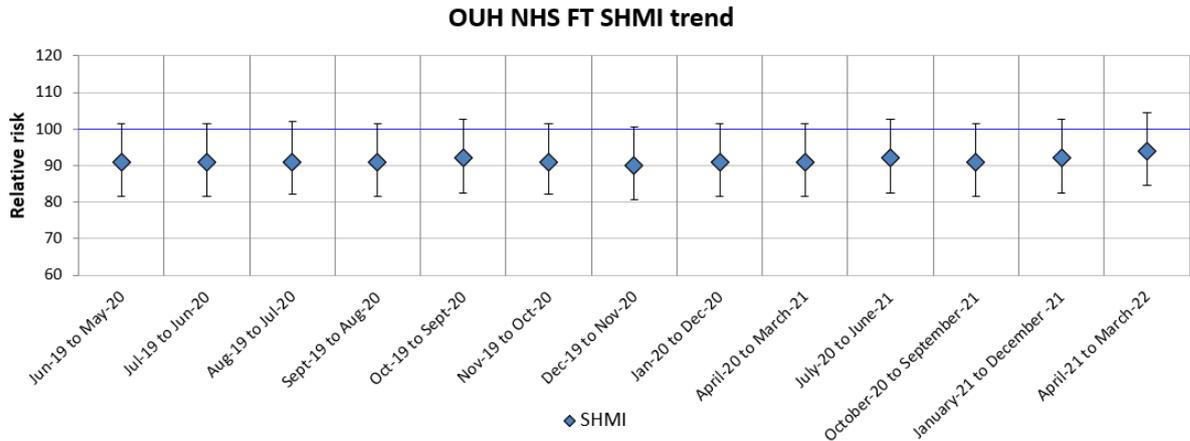
Table 3: Structure Review Training by profession

Division	Trained Lead Reviewers	Consultant	Nurses	Other (clinical governance team)
MRC	67	51	12	4
CSS	26	16	9	1
NOTSSCa N	35	22	11	2
SuWOn	59	33	19	7
Corporate	10	1	1	8
Trust total	197	122	50	22

9. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

- 9.1. There have been no mortality outliers reported for OUH from the CQC or NHS Digital during Quarter 1.
- 9.2. The Summary Hospital-level Mortality Indicator (SHMI) for the data period April 2021 to March 2022 is 0.94. The SHMI remains banded ‘as expected’.

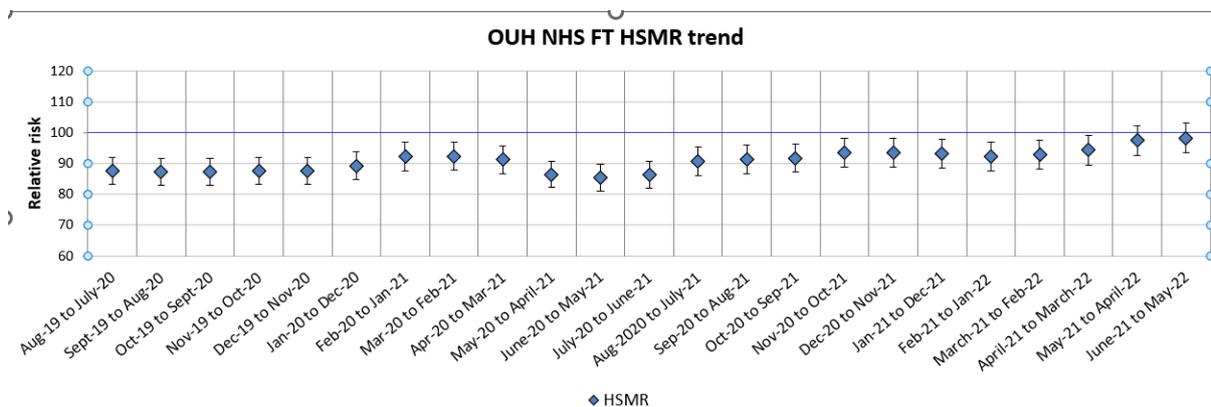
Chart 1: SHMI trend & Shelford comparison (Presented with a baseline of 100 to enable comparison to the HSMR)

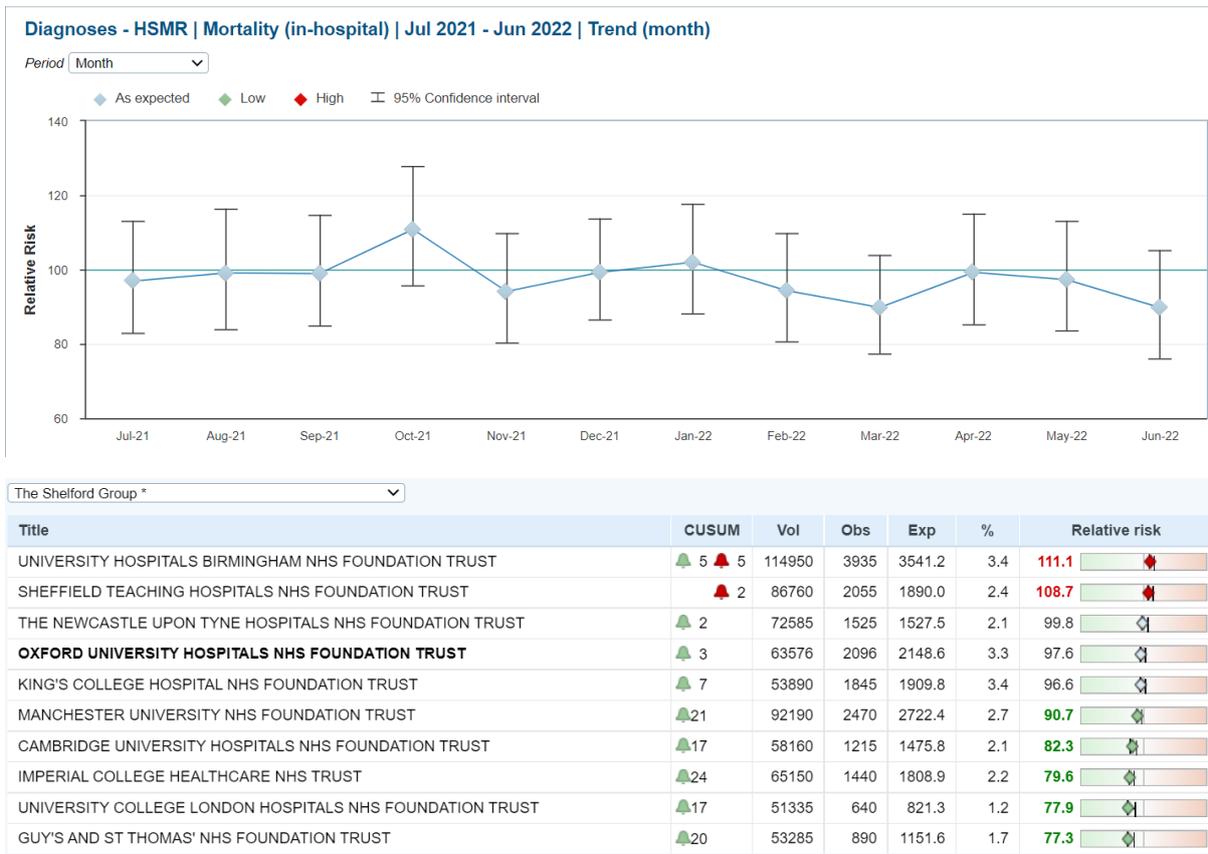


9.3. This chart shows the SHMI trend at various reporting points over between June 2019 and March 2022. The SHMI figure has consistently been between 0.9 and 0.94 which is within the ‘as expected’ band. As expected, means that the OUH is not an outlier.

9.4. The Trust’s HSMR is 98.3 for June 2021 to May 2022. The value is rated ‘as expected’ (95% CL 94.1 – 102.6). Chart 2 depicts the HSMR trend. This chart demonstrates the trust has been classified ‘as expected’ or ‘lower than expected’ between August 2019 and May 2022. This again demonstrates the trust is not an outlier. The recent rising HSMR is under investigation and a meeting with Dr Foster has been requested.

Chart 2: HSMR trend, SPC & Shelford comparison

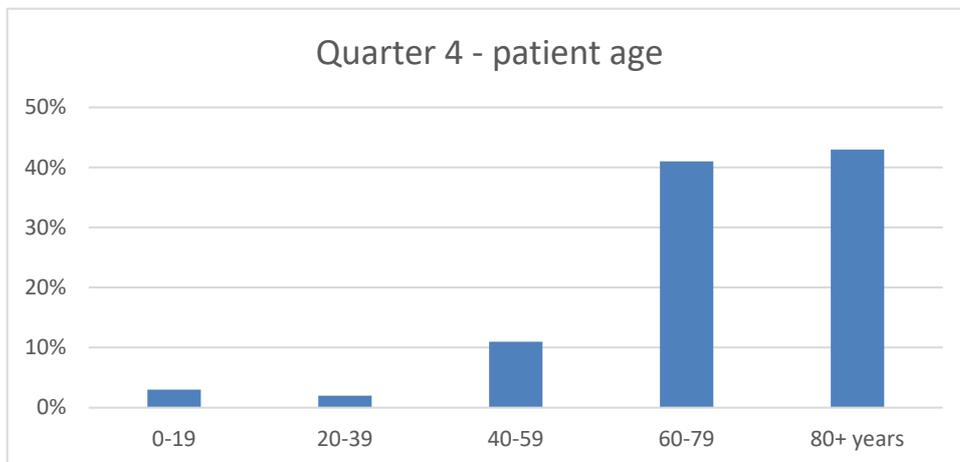




10. Analysis of mortality during Quarter 1:

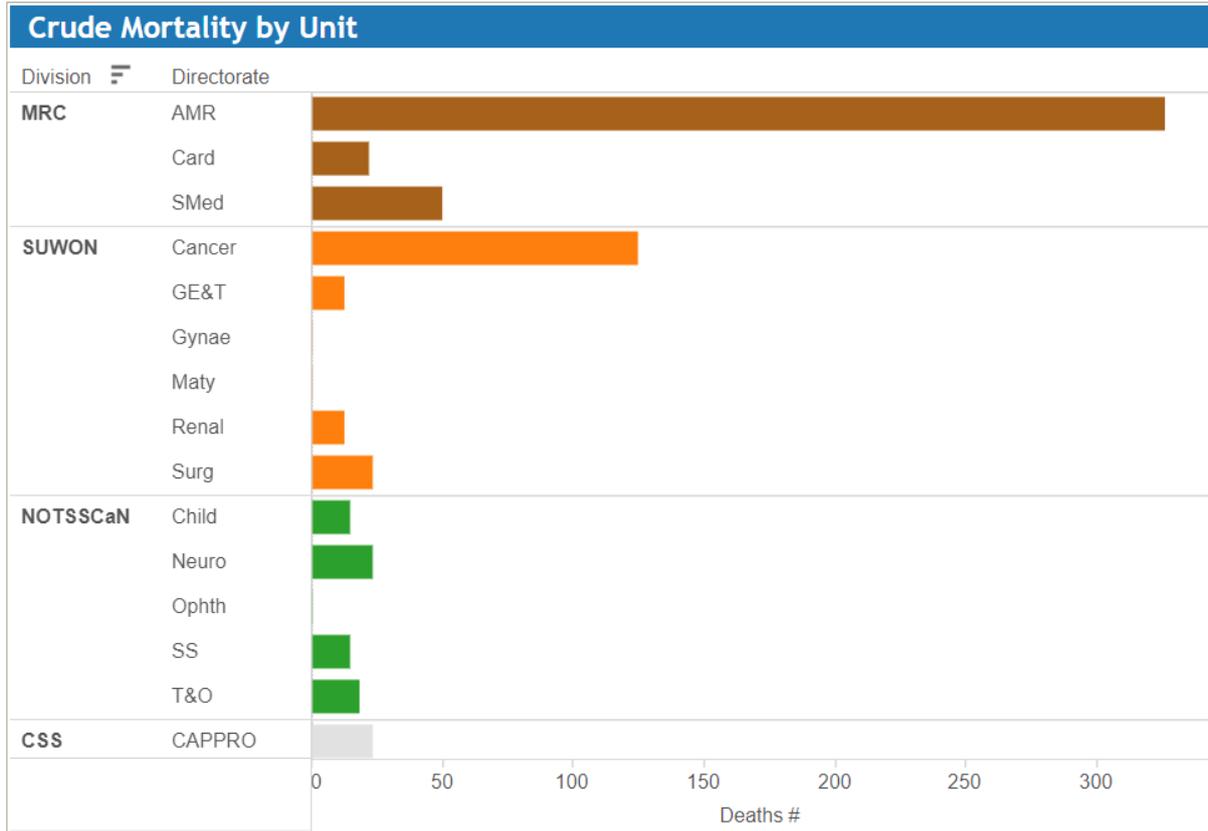
10.1. 37% of deaths occurred in patients aged 60 to 79 years and 48% in patients over 80 years of age (Chart 3). These statistics are in line with previous quarters.

Chart 3: Mortality – patient age



10.2. The highest number of deaths were admitted to the Acute Medicine and Rehabilitation (AMR) Directorate under the MRC Division (Chart 4). For comparison, section 11.3 includes information relating to total discharges vs mortality by Division.

Chart 4: Deaths by Directorate



10.3. Ethnicity data can be seen below in table 5.

Table 5: Death by ethnic background:

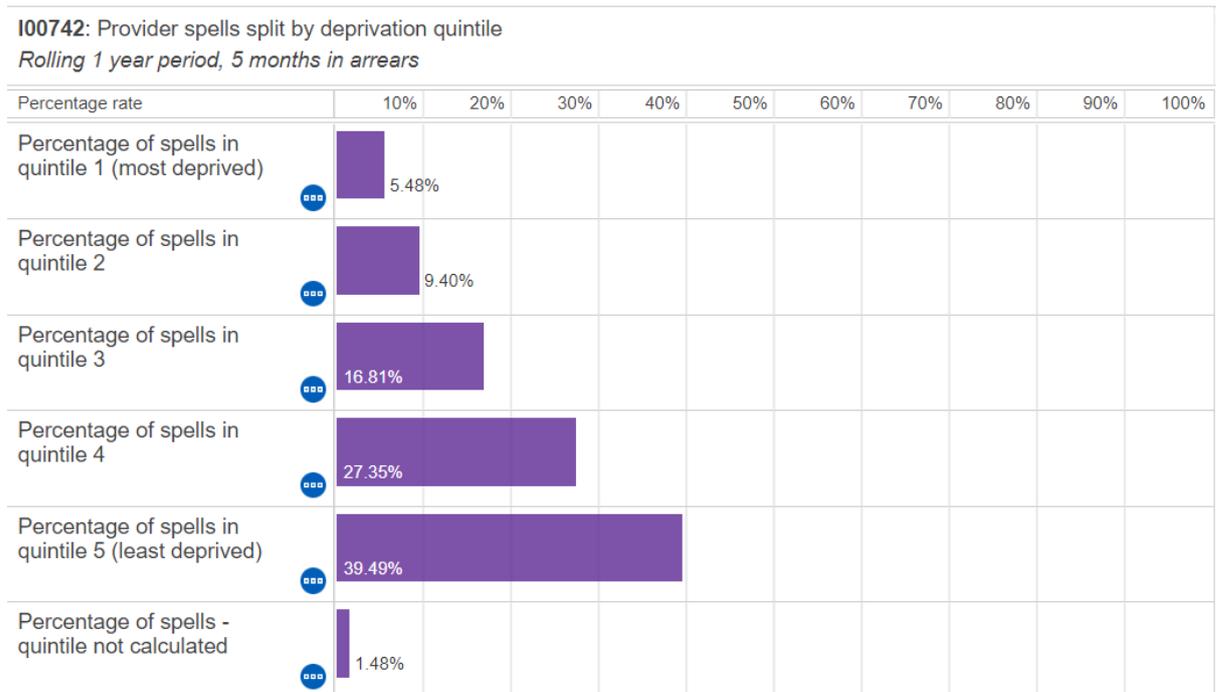
Ethnicity	Total
White British	279
Not Stated	40
Not Known	2
Any Other White Background	6
Any Other mixed background	2
White Irish	1
Any Other Asian Background	4
White and Black Caribbean	2
Pakistani	2
Indian	2
Caribbean	2

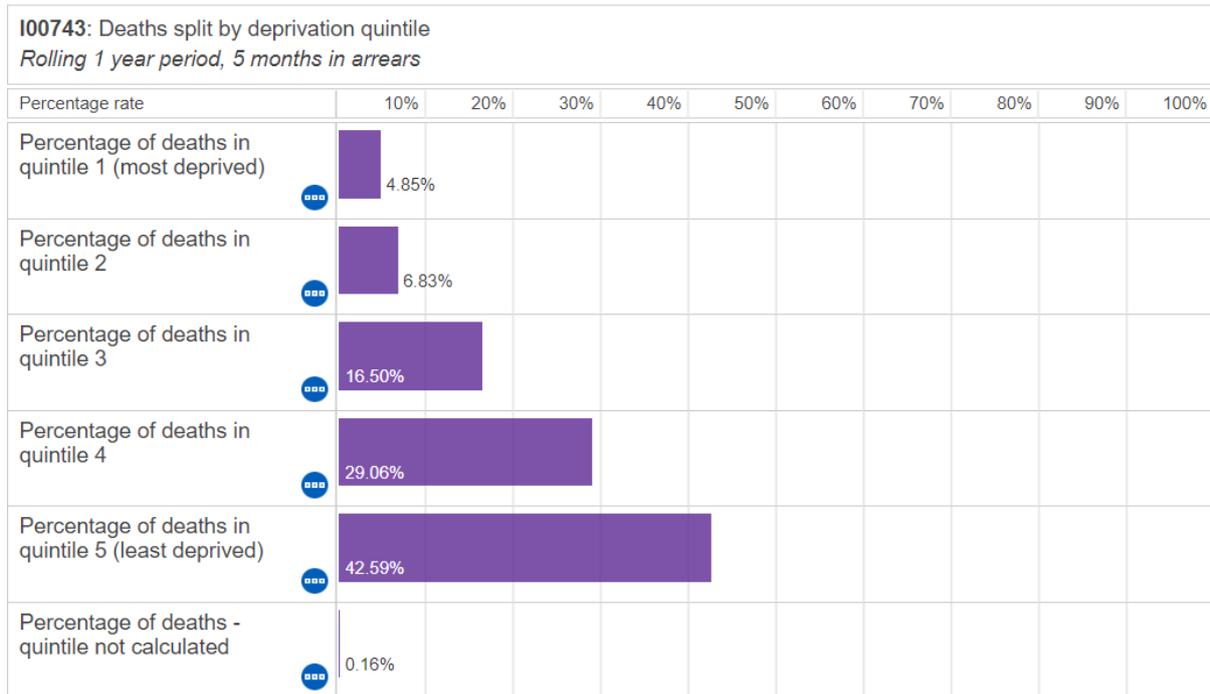
10.4. NHS Digital reference the same spell level information which was used to calculate the SHMI to report the percentage rates of deaths under each social deprivation quintile.

10.5. Deprivation quintiles are calculated using the Index of Multiple Deprivation (IMD) Overall Rank field in the Hospital Episodes Statistics (HES) dataset which is based on a weighted combination of factors such as income; employment; health deprivation and disability; education, skills, and training; barriers to housing and services; crime and living environment.

10.6. Chart 5 displays the percentage breakdown of spells and deaths by deprivation quintile. There is a marginally higher percentage of deaths in quintile 4 relative to the percentage of spells attributed to those quintiles.

Chart 5: % SHMI spells and deaths by deprivation quintile



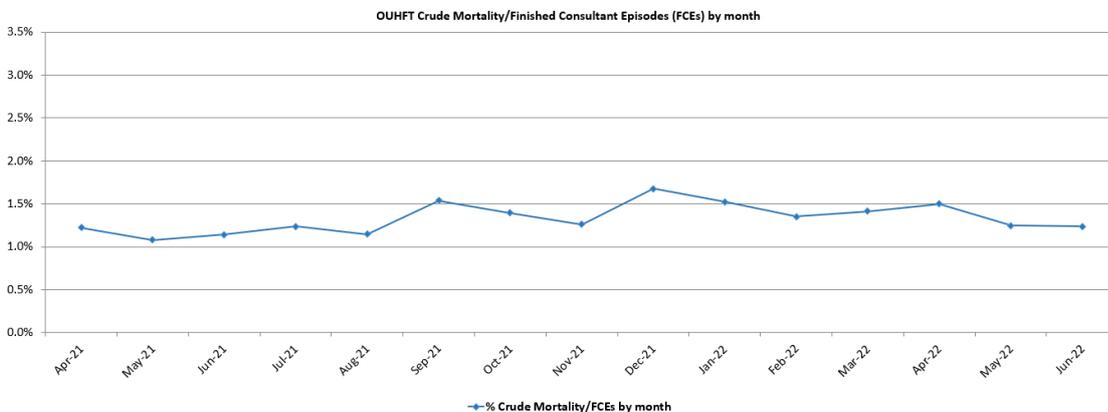


11. Crude Mortality

11.1. Crude mortality gives a contemporaneous, but not risk-adjusted, view of mortality across OUH.

11.2. There was a sharp increase in the mortality rate in April 2020 due to the increased number of deaths and decrease in activity related to the COVID-19 pandemic. There was a rise in the mortality rate in January 2021 resulting from the increase in the number of deaths related to the further wave of the COVID-19 pandemic. Chart 6 depicts the crude mortality rate by Finished Consultant Episodes (FCEs).

Chart 6: Crude mortality rate by Finished Consultant Episodes (FCEs)



11.3. During Quarter 1 of 2022/23:

11.3.1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children’s, and Neonatology Division reported that 64 patients died from a total of 15,241 discharges.

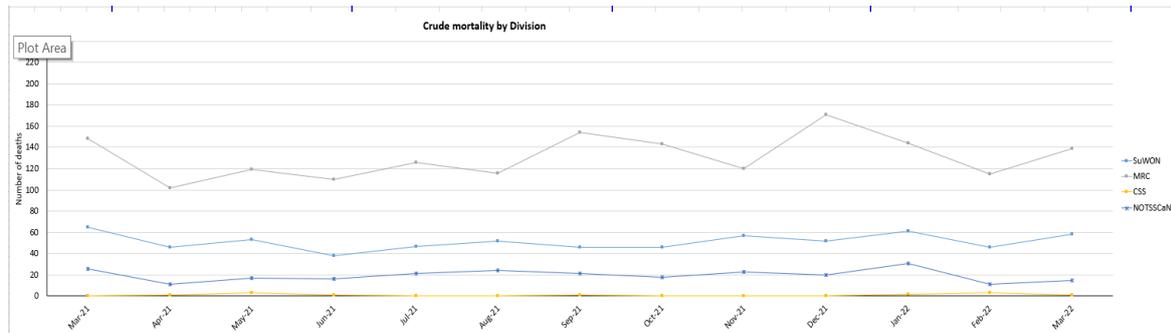
11.3.2. Medical Rehabilitation and Cardiac Division reported that 397 patients died from a total of 16,323 discharges.

11.3.3. Surgery, Women’s, and Oncology Division reported that 165 patients died from a total of 17,586 discharges.

11.3.4. Clinical Support Services Division reported 33 deaths in the Critical Care Units from a total of 597 discharges.

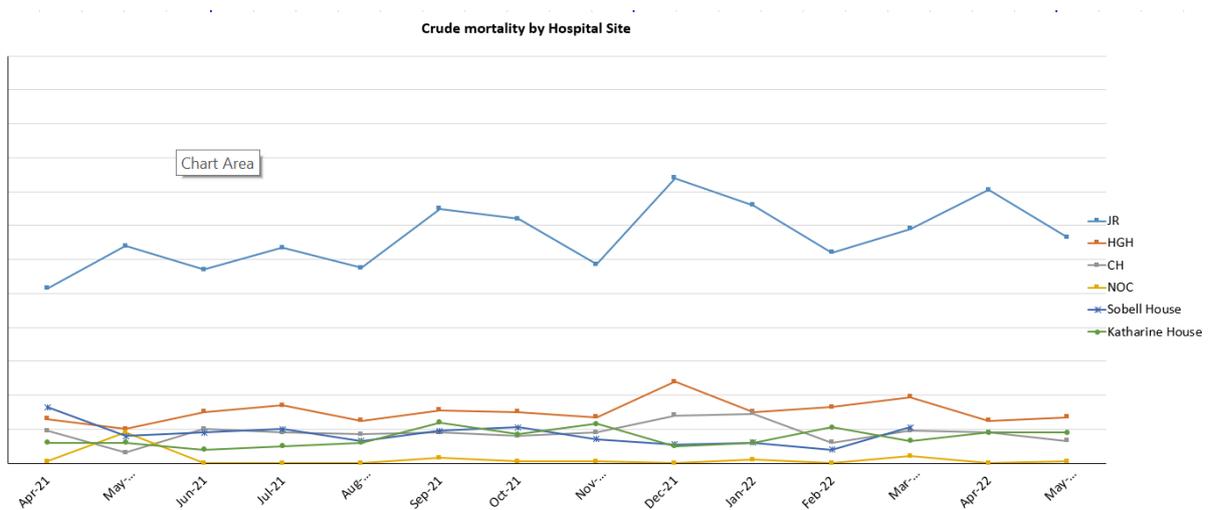
11.3.5. Chart 7 presents the crude mortality by Division.

Chart 7: Crude mortality by Division



11.4. Chart 8 depicts the crude mortality by hospital site. Most deaths occur at the John Radcliffe Hospital which has the highest activity.

Chart 8: Crude mortality by Site



12. Corporate Risk Register and related Mortality risks

- 12.1. Relevant mortality risks from the Corporate Risk Register can be seen below:
 - 12.1.1. Failure to care for patients correctly across providers at the right place at the right time.
 - 12.1.2. Trust-wide loss of IT infrastructure and systems (e.g., from Cyber-attack, loss of services etc).
 - 12.1.3. Failing to respond to the results of diagnostic tests.
 - 12.1.4. Patients harmed because of difficulty finding information across two different systems (Paper and digital).
 - 12.1.5. Potential harm to patients, staff, and the public from nosocomial COVID-19 exposure.
 - 12.1.6. Lack of capacity to meet the demand for patients waiting 52 weeks or longer.
 - 12.1.7. Ability to achieve the 85% of patients treated within 62 days of cancer diagnose across all tumour sites.

13. Mortality Review Governance

- 13.1. A quarterly summary of Directorate and Divisional mortality reports from their respective mortality and morbidity reviews are presented to the monthly Mortality Review Group (MRG) Chaired by the Director of Safety and Effectiveness.
- 13.2. Monthly MRG summary reports are then presented to the Clinical Improvement Committee (CIC) which is Co-Chaired by the Director of Clinical Improvement and a Divisional Nurse.
- 13.3. CIC reports to Clinical Governance Committee (CGC), Chaired by the Chief Medical Officer or the Chief Nursing Officer.
- 13.4. CGC reports via Trust Management Executive to the Integrated Assurance Committee (subcommittee of the Trust Board).

14. Recommendations

- 14.1. The Public Trust Board is asked to receive this paper for information and discuss the learning identified in mortality reviews.

Appendix 1 - Key differences between the SHMI and HSMR

The Trust references two mortality indicators: the SHMI, which is produced by NHS Digital, and the HSMR produced by Dr Foster Intelligence.

Both are standardised mortality indicators, expressed as a ratio of the observed number of deaths compared to the expected number of deaths adjusted for the characteristics of patients treated at a Trust.

While both mortality indicators use slightly different methodology to arrive at the indicator value; both aim to provide a risk adjusted comparison to a national benchmark (1 for SHMI or 100 for HSMR) to ascertain whether a trust's mortality is 'as expected', 'lower than expected' or 'higher than expected'.

Table 5: Key differences between the SHMI and HSMR

Indicator	Summary Hospital-level Mortality Indicator (SHMI)	Hospital Standardised Mortality Ratio (HSMR)
Published by	NHS Digital	Dr Foster Intelligence
Publication frequency	Monthly	Monthly
Data period to calculate indicator value	Rolling 12-month period for each release, approximately five months in arrears.	Provider-selected period, up to three months in arrears
Coverage	Deaths occurring in hospital or within 30 days of discharge. All diagnosis groups excluding stillbirths. Day cases and regular attenders are excluded.	In-hospital deaths for 56 selected diagnosis groups that accounts for 80% of in-hospital mortality. Regular attenders are excluded.
Assignment of deaths	Deaths that happen post transfer count against the transfer hospital (acute non-specialist trusts only).	Includes deaths that occur post transfer to another hospital (superspell effect).
Palliative Care	Not adjusted for in the model.	Adjusted for in the model.
Casemix adjustment	8 factors: diagnosis, age, sex, method of admission, Charlson comorbidity score, month of admission, year, birth weight (for individuals aged <1 year in perinatal diagnosis group).	12 factors: admission type, age, year of discharge, deprivation, diagnosis subgroup, sex, Charlson comorbidity score, emergency admissions in last comorbidity score, emergency admissions in last 12 months, palliative care, month of admission, source of admission, interaction between age on admission group and comorbidity admission group.