Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Public Trust Board Meeting: Wednesday 13 September 2023**

**TB2023.89**

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| **Title:** | **Learning from deaths annual report 2022/23** |

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|---|---|
| **Status:** | **For Information** |
| **History:** | **This is an annual paper to the Trust Board** |

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|---|---|
| **Board Lead:** | **Chief Medical Officer** |
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| **Confidential:** | **No** |
| **Key Purpose:** | **Assurance** |

## Executive Summary

1. During 2022/23 there were 2719 inpatient deaths reported at Oxford University Hospitals NHS Foundation Trust (OUH). 2625 (97%) of cases were reviewed within 8 weeks. Divisions with deaths which were not reviewed within 8 weeks have been requested to complete a Level 1 screening review and compliance is monitored via the monthly Mortality Review Group meeting.
2. One death was judged more likely than not to have been due to problems in the care provided. This case was escalated to a serious incident requiring investigation (SIRI) following discussion at Mortality Review Group. Learning from this investigation is included in this report.
3. The Medical Examiners (ME) and Medical Examiner Officers service is well established at the organisation 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.
4. Key actions and learning points identified in mortality reviews completed during 2022/23 are presented to the Trust Board. This follows from the Quarterly reviews of Learning from Deaths which were presented in November 2022, January 2023, May 2023, and July 2023 - Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk)

## Recommendations

5. The Public Trust Board is asked to receive and discuss the learning identified from mortality reviews.

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# Learning from deaths annual report 2022/23

## 1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for 2022/23.

1.2. This report provides an overview of Trust-level mortality data and performance for the latest available Dr Foster Intelligence data, providing assurance that any highlighted concerns are investigated thoroughly, and appropriate action was taken.

## 2. Background

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:

- Preventing people from dying prematurely.
- 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 need a mortality 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 national criteria - NHS England » Learning from deaths in the NHS.

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. Mortality related actions are reported quarterly to MRG and included in Divisional quality reports presented to the Clinical Governance Committee.

2.8. 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 2022/23

During 2022/23 there were 2719 inpatient deaths reported at OUH with 2625 (97%) of cases reviewed within 8 weeks.

**Table 1: Number of mortality reviews 2022/23**

| Total deaths | Total reviews (L1, L2 or SJR) | % deaths not reviewed within 8 weeks |
|---|---|---|
| 2719 | 2625 (97%) | 94 (3%) |

3.1. All deaths involving COVID-19 are reviewed to confirm if inclusion in the nosocomial[1] SIRI is required.

3.2. On the 19th of May 2023, NHS England wrote to all NHS Trusts to confirm a step down from a level 3 NHS incident and the implications of this. Details of this letter can be found in Appendix 2.

3.3. Stepping down the incident is done in the knowledge that COVID-19 as a health issue itself, as well as the wider long-term impact of the pandemic, will continue to be significant for years to come. New waves and novel variants will continue to impact on patient numbers, as well as staff absences, and we will also need to continue to provide services for those suffering the effects of 'long COVID'.

3.4. Divisions with deaths which were not reviewed (94) within 8 weeks (as per policy) have been requested to complete a Level 1 screening review and compliance is monitored via the monthly Mortality Review Group meeting. All

[1] acquired in a hospital, especially in reference to an infection.

deaths during quarters 1 and 2 have been retrospectively reviewed and good progress has been made for quarters 3 and 4.

3.5. The main triggers for structured reviews remain patients with learning disabilities and concerns from staff.

3.6. Each Division maintains a log of actions from mortality reviews and monitors progress by their clinical units and are responsible for dissemination of the learning and implementation of actions. The Divisions provide updates on actions in the monthly quality reports to the Clinical Governance Committee and provide updates to the Mortality Review Group (MRG) on the previous quarter's actions as part of the next quarter's mortality report.

3.7. All Structured Mortality Reviews for people with Learning Disabilities are presented at the monthly Mortality Review Group meeting.

3.8. During Quarter 4 of 2022/23, one patient death was judged more likely than not to have been due to problems in the care provided. This case was escalated to a serious incident requiring investigation (SIRI) following discussion of a structured mortality review at MRG. Learning from this investigation is included in this report.

## 4. 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.

4.3. 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.

4.4. Medical Examiners (ME) and Medical Examiner Officers (MEO) 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 2023-24. Any issues identified with this extension into the community have been raised to the National Medical Examiner. There will be progress reports to the National ME office every quarter.

4.5. The Medical Examiners 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 structured review/SIRIs and changes to death documentation processes.

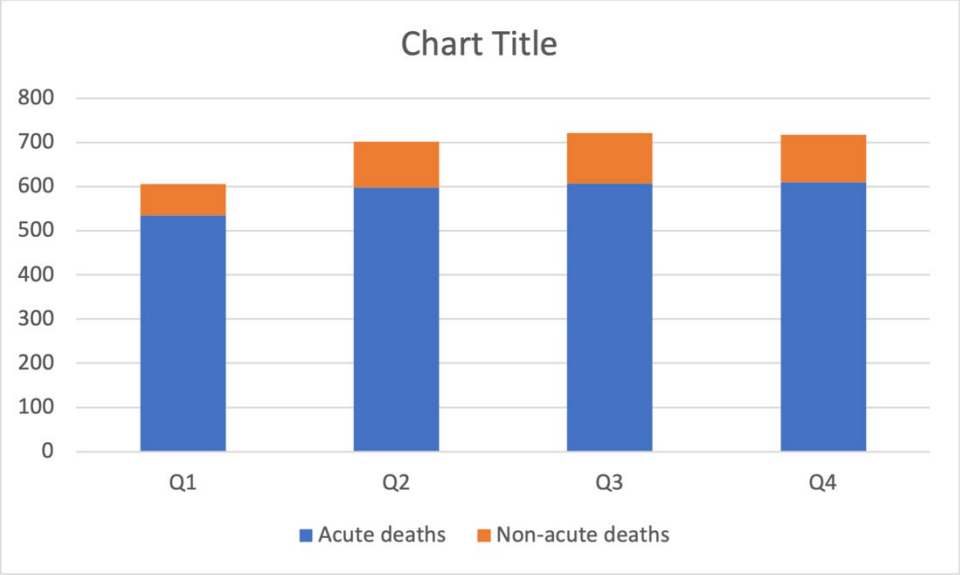
4.6. The feedback received by the MEs has been shared promptly with the ward teams. This has raised the profile of the ME system within the Trust and clinical teams are recognising and appreciating the ME role as an independent part of the existing Bereavement system.

4.7. The opportunity for families to discuss the care their relative received with an ME has been positively received.

4.8. The Lead Medical Examiner is meeting with external stakeholders ahead of the community roll out. Scrutiny of hospice deaths is already 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.

4.9. Data on the activity of the Trust's ME service are submitted every quarter to the National Medical Examiner. The data for 2022-23 provides evidence of the successful roll-out of the ME service for scrutiny of acute deaths, with a progressive increase in the proportion of deaths having been scrutinised each successive quarter:

**ME scrutiny of deaths 2022/23:**




4.10. By Q4, the total number of acute deaths scrutinised (excluding stillbirths which were not scrutinised by MEs) was 601, of which 10 were deaths of children.

4.11. 72 deaths were accepted by the Coroner for investigation. 81 deaths had a Medical Certified Cause of Death (MCCD) issued after referral to the Coroner (Part A), of which 64 were scrutinised.

4.12. The number of MCCDs not completed within 3 calendar days in Q4 was 68, which was by far the lowest of any quarter that year.

4.13. The number of deaths in Q4 for which a concern was raised through Learning from Deaths was 14.

4.14. During 2022-23, there were 31 deaths where a rapid release for faith reasons was requested and only one was not achieved.

4.15. The scrutiny of non-acute deaths was limited to deaths in the adult hospices which increased during the year. In Q4, 109 non-acute (Hospice) deaths were reported through the Trust, of which 7 were referred to the Coroner. No ME scrutiny occurred in 18 cases, giving a total scrutiny proportion of 82%.

4.16. Plans for 2023/24:

- Improvements to the Electronic Patient Record are being made which will increase the early availability of the Death Notification Summary.
- The scrutiny of child deaths has started and will continue to be embedded within the service.
- The non-acute deaths which are currently scrutinised are those occurring on the hospices. Ongoing work is needed to ensure that all hospice cases are covered.
- The expansion of the ME service to primary care will be the principal challenge of the coming year. National initiatives are under way, including a recent message to all doctors from the National Medical Director.
- The National ME and Undersecretary of State have outlined new guidance to be available in autumn 2023.
- Two new “community” MEOs started in June. The ME Office will be contacting all GP surgeries in the county to reintroduce the ME system, which will be followed up by webinars during the summer.
- There is IT support within the Trust and within the BOB ICB to support the introduction of a means of communication with the GP practices for referral of deaths.
- Further recruitment of 0.4 WTE ME during 2023 will enable the ME Office to deliver the service for all deaths in Oxfordshire.

4.17. As host Trust, the OUH has provided the support necessary to develop the ME Service in Oxfordshire.

## 5. Key learning and actions from mortality reviews 2022/23

5.1. The importance of accurate DNACPR endorsement on EPR has been highlighted, particularly when a patient is readmitted. A trust level safety message was issued in response to this.

5.2. Early communication to the families when a patient is at the end of life remains a recurring theme. The 5th OUH End of Life Care Symposium was delivered 11 May 2023. Several talks took place on a variety of subjects around Palliative and End of Life Care (EOLC). This was part of the scheduled events for the annual 'Dying Matters Week' held by Hospice UK for which the aim is to create an open culture in which staff in OUH are comfortable talking about death, dying and grief as well as equipping professionals with the knowledge and skills to improve the quality of all palliative and end of life care.

5.3. Managing parental expectations where outlook is poor and ensuring that Organ Donation is offered where relevant. This links to our current Quality Priority for increasing tissue donation.

5.4. The importance of accurate recording keeping using EPR has been highlighted and not ‘copying and pasting’ from previous entries which can lead to confusion if the clinical picture changes when new observations or results have been taken from the patient. This has been actioned via safety huddles and a Trust wide Safety Message.

5.5. The vital role of passports for patients with Learning Disabilities has been highlighted at Mortality Review Group as a source of guidance regarding support structures important to the individual. This provides a snapshot of the patient to underpin assessment of normal behaviours and coping mechanisms and Guidance re: appropriate interventions. The July quarterly governance newsletter (SHINE) produced and shared across the Trust included a message relating to this.

5.6. Education package/guidance has been produced for all OUH staff concerning transition of care of young adults with learning disabilities, including pain assessments in non-verbal patients.

5.7. Any patient who has demonstrated sensitivity to opioids and required naloxone should have a review of their analgesia prescription as a matter of urgency, and a review by the pain team (or on-call anaesthetist if out of hours) for advice. This also links to a Trust Quality Priority for the new financial year.

5.8. Strong opioids must not be administered to any patient if the appropriate observations have not happened. If equipment to perform these observations is missing or broken, then this must be escalated as far as required until this is resolved.

## 6 Serious Incident Requiring Investigations (SIRIs) with a related death

6.1 All SIRI related deaths are presented to MRG by the Lead Investigator upon completion.

6.2 During 2022/23, there were 23 SIRIs declared involving patients who died.

6.3 Cases of SIRIs involving a death also have a structured mortality review in accordance with national guidance. Relevant learning points and actions are included in section 5 of this report. During 2022/23, one patient death was judged more likely than not to have been due to problems in the care provided. The key aspects of the case were as follows:

6.3.1 A patient who underwent a knee replacement procedure at a private provider deteriorated and died shortly after transfer to the OUH. Concerns with the care provided were identified following completion of a structured mortality review.

6.3.2 Themes from the investigation concluded there were issues with communication, diagnostic tests, and escalation of care.

6.3.3 A Serious Incident Requiring Investigation (SIRI) report was completed jointly between OUH and the private provider. This was later escalated to a systems wide serious incident which is now being managed by the Integrated Care Board (ICB). The OUH SIRI final report was discussed at the May Mortality Review Group meeting.

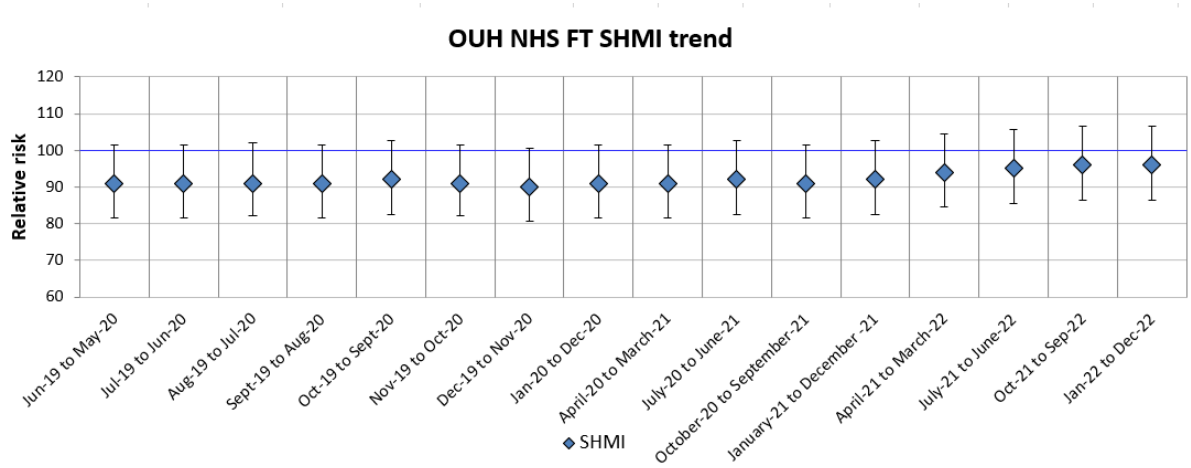
6.3.4 Details of this investigation were presented in the quarter 4 learning from death report which can be accessed here - Learning from deaths report - Quarter 4 2022/23 (ouh.nhs.uk)

## 7 Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

7.1 There have been no negative mortality outliers reported for OUH from the CQC or the Dr Foster Unit OUH level HSMR at Imperial College during 2022/23.

7.2 The SHMI for the latest data period is 0.96. This is rated ‘as expected.’ Chart 1 depicts the SHMI trend. The SHMI has remained rated ‘as expected.’

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

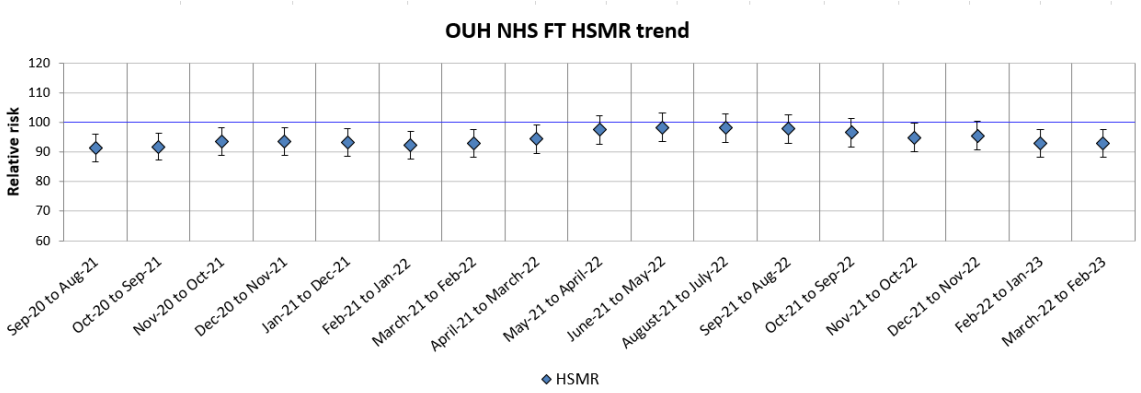



7.3 The HSMR is 92.4 for the data period April 2022 to March 2023. This is rated as 'lower than expected.' Chart 2 depicts the HSMR trend. The HSMR has remained rated 'lower than expected.' Differences between the HSMR and SHMI can be seen in Appendix 1.

7.4 COVID-19 activity is excluded from the SHMI. NHS Digital have advised that the SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included. Activity that is being coded as COVID-19, and therefore excluded, is monitored in a new contextual indicator 'Percentage of provider spells with COVID-19 coding'.

7.5 Admissions and deaths split by deprivation quintiles can be seen in each of the quarterly learning from death reports found here - [Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk)]

**Chart 2: HSMR trend & Shelford Group comparison**



The Shelford Group *

| Title | CUSUM | Vol | Obs | Exp | % | Relative risk |
|---|---|---|---|---|---|---|
| SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST | 2 | 89580 | 2300 | 2065.0 | 2.6 | 111.4 |
| UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST | 14 2 | 123210 | 4190 | 4108.0 | 3.4 | 102.0 |
| MANCHESTER UNIVERSITY NHS FOUNDATION TRUST | 17 1 | 81005 | 2595 | 2685.6 | 3.2 | 96.6 |
| KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST | 6 | 53330 | 2010 | 2091.2 | 3.8 | 96.1 |
| THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST | 1 | 78015 | 1645 | 1732.2 | 2.1 | 95.0 |
| **OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST** | 6 | 67614 | 2204 | 2384.6 | 3.3 | 92.4 |
| CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 19 | 59645 | 1315 | 1606.5 | 2.2 | 81.9 |
| GUY'S AND ST THOMAS' NHS FOUNDATION TRUST | 21 | 55620 | 1020 | 1293.7 | 1.8 | 78.8 |
| UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST | 18 | 54190 | 665 | 890.7 | 1.2 | 74.7 |
| IMPERIAL COLLEGE HEALTHCARE NHS TRUST | 51 | 68500 | 1530 | 2064.0 | 2.2 | 74.1 |

**Table 1 –** HSMR diagnoses with the highest numbers of deaths:

7.6 The major aims of the CUSUM control charts are to keep the process on target. The "cumulative sum" in this type of chart is the sum of the deviations of individual sample results or subgroup averages from the target.

7.7 A red bell indicates a negative alert has been identified for the diagnosis group during the reporting period selected.

7.8 A green bell indicates a positive alert has been identified for the diagnosis group during the reporting period selected.

Relative risk & CUSUM alerts

| Title | CUSUM | Vol | Obs | Exp | % | Relative risk | Trend |
|---|---|---|---|---|---|---|---|
| **All Diagnoses** | 9 4 | **195486** | **2823** | **3066.2** | **1.4** | 92.1 | |
| HSMR (56 diagnosis groups) | 6 | 67614 | 2204 | 2384.6 | 3.3 | 92.4 | |
| Pneumonia | 9 | 2994 | 267 | 382.5 | 8.9 | 69.8 | |
| Acute cerebrovascular disease | | 1462 | 253 | 232.9 | 17.3 | 108.6 | |
| Septicemia (except in labour) | | 866 | 163 | 164.6 | 18.8 | 99.0 | |
| Aspiration pneumonitis, food/vomitus | | 361 | 104 | 110.1 | 28.8 | 94.5 | |
| Congestive heart failure, nonhypertensive | 7 | 1499 | 83 | 137.1 | 5.5 | 60.6 | |
| Viral infection | 3 | 2750 | 81 | 118.9 | 2.9 | 68.1 | |
| Acute myocardial infarction | | 912 | 74 | 67.7 | 8.1 | 109.4 | |
| Intracranial injury | | 653 | 71 | 72.2 | 10.9 | 98.3 | |
| Chronic obstructive pulmonary disease and bronchiectasis | | 1504 | 65 | 64.1 | 4.3 | 101.4 | |
| Secondary malignancies | | 1221 | 64 | 56.3 | 5.2 | 113.6 | |

**Table 2** – HSMR diagnoses with the lowest numbers of deaths:

Relative risk & CUSUM alerts

| Title | | CUSUM | Vol | Obs | Exp | |
|---|---|---|---|---|---|---|
| All Diagnoses | | 10 8 | 192663 | 2653 | 2877.9 | |
| Hepatitis | 92 | 1 | 0.4 | 1.1 | 254.7 | |
| Genitourinary congenital anomalies | 447 | 1 | 0.6 | 0.2 | 167.2 | |
| Gastritis and duodenitis | 1350 | 1 | 2.1 | 0.1 | 48.5 | |
| Encephalitis | 103 | 1 | 3.8 | 1.0 | 26.0 | |
| Diseases of white blood cells | 118 | 1 | 1.4 | 0.8 | 73.1 | |
| Cancer of other urinary organs | 23 | 1 | 0.9 | 4.3 | 109.9 | |
| Calculus of urinary tract | 1628 | 1 | 1.1 | 0.1 | 90.1 | |
| Blindness and vision defects | 84 | 1 | 0.6 | 1.2 | 154.6 | |
| Asthma | 657 | 1 | 1.4 | 0.2 | 71.8 | |
| Anxiety, somatoform, dissociative, and personality disorders | 159 | 1 | 0.4 | 0.6 | 275.9 | |

7.9 Work remains ongoing to review and improve the Trust HSMR. The HSMR without Hospice data is 85.4 (95% CL 80.7 – 88.5) which remains 'lower than expected'.

7.10 There is no ethnicity data included in this report as it is in the process of being improved. This is part of a Quality Priority this year and once the data collection has improved, from containing a lot of 'unknown' this will be included and analysed.

7.11 The Trust HSMR is benchmarked:

- 4th of 8 acute non-specialist peers
- 3rd of 7 peers with on-site hospice
- 3rd of 10 teaching trusts with similar volume

Benchmarking peers Teaching Hospitals *

| Title | CUSUM | Vol | Obs | Exp | % | Relative risk | Trend |
|---|---|---|---|---|---|---|---|
| NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST | 1 4 | 87635 | 2715 | 2275.3 | 3.1 | 119.3 | |
| LEEDS TEACHING HOSPITALS NHS TRUST | 2 | 57515 | 2430 | 2171.6 | 4.2 | 111.9 | |
| SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST | 2 | 89580 | 2300 | 2065.0 | 2.6 | 111.4 | |
| NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 6 1 | 66185 | 2405 | 2197.0 | 3.6 | 109.5 | |
| BARTS HEALTH NHS TRUST | 5 1 | 58785 | 2320 | 2190.0 | 3.9 | 105.9 | |
| KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST | 6 | 53330 | 2010 | 2091.2 | 3.8 | 96.1 | |
| THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST | 1 | 78015 | 1645 | 1732.2 | 2.1 | 95.0 | |
| **OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST** | 6 | 67614 | 2204 | 2384.6 | 3.3 | 92.4 | |
| UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST | 18 | 54190 | 665 | 890.7 | 1.2 | 74.7 | |
| IMPERIAL COLLEGE HEALTHCARE NHS TRUST | 51 | 68500 | 1530 | 2064.0 | 2.2 | 74.1 | |

## 8 Corporate Risk Register and related Mortality risks

8.1 Relevant mortality risks from the Corporate Risk Register can be seen below:

8.1.1 Failure to care for patients correctly across providers at the right place at the right time.

8.1.2 Trust-wide loss of IT infrastructure and systems (e.g., from Cyber-attack, loss of services etc).

8.1.3 Failing to respond to the results of diagnostic tests.

8.1.4 Patients harmed because of difficulty finding information across two different systems (Paper and digital).

8.1.5 Potential harm to patients, staff, and the public from nosocomial COVID-19 exposure.

8.1.6 Lack of capacity to meet the demand for patients waiting 52 weeks or longer.

8.1.7 Ability to achieve the 85% of patients treated within 62 days of cancer diagnose across all tumour sites.

## 9 Mortality Review Governance

9.1 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.

9.2 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.

9.3 CIC reports to Clinical Governance Committee (CGC), Chaired by the Chief Medical Officer or the Chief Nursing Officer.

9.4 CGC reports via Trust Management Executive to the Integrated Assurance Committee (subcommittee of the Trust Board).

## 10 Conclusion

10.1 In accordance with national mortality guidance, the Trust has implemented a revised mortality review policy and implemented structured mortality reviews since quarter three of 2017/18. This paper summarises the learning identified in the mortality reviews completed during 2022/23.

10.2 The Medical Examiner role is well established, with good working process, governance and continues to see an increase in the quantity of reviews undertaken.

10.3 Compliance with the learning from deaths policy is well established, with consistently high levels of reviews undertaken within 8 weeks and appropriate trust wide learning shared accordingly.

## 11 Recommendations

11.1 The Public Trust Board is asked to receive and discuss the learning identified in mortality reviews.

Dr Anny Sykes

Chief Medical Officer (Interim)

Paper prepared by:

Jonathan Carruthers

Clinical Outcomes Manager

17 July 2023

## Appendix 1: Key differences between the SHMI and HSMR

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

b) 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.

c) 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 6: 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. |

**Appendix 2:**

**Implications of stepping down the NHS incident**

As we move away from incident arrangements for COVID-19, the following will change:

**COVID-19 Patient Notification System (CPNS):** As of 30 June 2023, we will no longer be collecting data where an individual has died from COVID-19 via the CPNS system. Instead, data on individuals who have died with COVID-19 will be recorded using the death certification process which is the same as other infectious diseases.

**Other COVID-19 data reporting:** We have been working with colleagues in the UK Health Security Agency to ensure there are no unintended consequences by changing the way we collect data on COVID-19. The acute COVID-19 data collection process will be stood down with a subset of data incorporated into the existing UEC data collection from June. This will ease the burden on NHS trusts.

**Outbreak reporting:** We are currently reviewing the outbreak reporting process and will be contacting you about this separately.

**Communications**: We have recognised the value of having a permanent operations structure to support you, disseminate information and collect data during declared incidents and/or other periods of heightened risk or disruption, e.g., industrial action and winter pressures. Our National and Regional Operations Centres will continue to operate, but we will review the hours of operation.