

**Trust Board
Report Summary**

Date of Meeting: 26th October 2023	
Title of Document: HSMR & Learning from Deaths	
To be presented by: Angela Tillet	Author: Abigail Graham/Julie Sage
1. Status: For Discussion/Noting/Information	
2. Purpose: To update the committee regarding mortality benchmarks/trends and shared learning from deaths.	
Relates to: SO4: Support and develop our staff	
Strategic Objective	SO1, SO2, SO3 and SO4
Operational performance	N/A
Quality	Benchmarked mortality data and to provide information around identified learning and actions to improve patient safety and care
Legal/Regulatory/Audit	Y
Finance	N/A
Governance	Y
NHS policy/public consultation	N/A
Accreditation/inspection	N/A
Anchor institutions	N/A
ICS/ICB/Alliance	N/A
Board Assurance Framework (BAF) Risk	N/A
Other	
3. Summary:	
<ul style="list-style-type: none"> • Mortality rates have increased locally and nationally by similar rates to end March 2023. • For 2022/23, the Trust had the third highest mortality rate for ordinary admissions in the peer group. The report provides some national and regional context and learning • Perinatal death rates are below 2020 benchmarks and are closely monitored to determine any trends and themes. • The Trust was an outlier in 2022/3 for HSMR and SMR but SHMI was still 'as expected'. • A new mortality review form (SJR) was discussed at the Learning from Deaths meeting, and has been developed to towards facilitate the sharing of learning. 	
4. Recommendations / Actions	
<ul style="list-style-type: none"> • The Board is asked to discuss and note for assurance 	

