The Dudley Group NHS
NHS Foundation Trust

For the Record – Press Statements

Publication	Halesowen News
Date of article	18/07/2013
Reporter	Sarah Cousin
Headline	Probe uncovers staff shortages
First paragraph/s of article	STAFF shortages and a failing complaints process are among the findings of a major investigation into Dudley's Russells Hall Hospital.
Press enquiry	Following the publication of the Keogh Review, Halesowen News asked for clarification with regards to what mortality indicators mean and whether they can be associated with actual numbers of deaths: Sarah Cousin asked: "*The trust has an overall SHMI of 106 for the period Dec 11 – Nov 11, 2012 meaning the number of actual deaths is higher than the expected level.* *Is 106 a number of bodies?* *How many deaths made up the expected level and what was the figure for the actual deaths?"*
Trust response	

COMMENT FROM PAULA CLARK, CHIEF EXECUTIVE, THE DUDLEY GROUP NHS FOUNDATION TRUST

Mortality data collection is not designed or intended to identify 'unnecessary' or 'excess' deaths nor does it measure quality and safety. They are a smoke alarm or flag that something might need further investigation and we are pleased the team noted the work we had done on improving our indicators. We are no longer outliers for the Hospital Summary Mortality Ratio (HSMR) or the Summary Hospital level Mortality Indicator (SHMI).

The most recent data from Dr Foster shows the Trust mortality index as 99.5 which is well within the expected range. Similarly, the SHMI shows a continuing

improvement over the last year and is within the expected range at 1.04 (October 2011 – September 2012).

Sir Bruce Keogh's overview report of the 'Review into the quality of care and treatment provided by 14 hospital trusts in England' states "However tempting it may be, it is clinically meaningless and academically reckless to use such statistical measures to quantify actual numbers of avoidable deaths."

To help understand the cause of and reducing avoidable deaths Sir Bruce Keogh will look to introduce a new national indicator on avoidable deaths in hospitals, measured through the introduction of systematic and externally audited case note review.*

The numbers cannot be related into actual individual deaths but are statistical estimates only and cannot be used to describe avoidable or unnecessary deaths.

*** ENDS ***

**Page 7 of the Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*